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Southern District Health Board
Piki Te Ora

Southern Health
He hauora, he kuru pounamu

Annual Report

Quality and Performance Account

2019/20

Feature photos: Special thanks to our little superstars from Wakari Hospital Early Childhood Centre – Te Ariki, Avaley, Maia and Beau

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Annual Report

Quality and Performance Account

2019/20

This Southern District Health Board Annual Report 2019/20 is presented to the House of Representatives pursuant to section 150(3) of the Crown Entities Act 2004.

Contents

Foreword from the Chair & Chief Executive

Dr David Perez
Acting Board Chair

Chris Fleming
Chief Executive Officer

We will not be alone in reflecting on 2019/20 as a year of two halves.

The first half of the reporting period, when we were industriously engaged on numerous worthy projects and initiatives and life was normal, seems to belong to the annals of history.

From January our world progressively, and then suddenly, changed and every activity and decision since then has been made in the context, or shadow, of the COVID-19 pandemic.

So this reflection on the past year contains achievements, challenges and some important lessons.

These include appreciating that annual plans are executed at the mercy of greater forces. And that, in the face of a near and present danger, requiring rapid systems and services to be overhauled almost overnight, we have the skills, relationships and capacity to respond.

We're willing to chalk it up to coincidence that the first half of this reporting year was also the period where the DHB was governed by a Commissioner team, with the new board elected in October and taking office in December.

Suffice it to say it was a tumultuous induction for the new team, but also an opportunity to see the dedication and expertise of the Southern health system in action.

So reflecting on 2019/20 needs to begin with the events of its last quarter, as the Southern district became the hardest hit area by the presence of COVID-19, with two significant clusters in our district, 216 people being infected with the virus, of whom two died. We want to acknowledge those affected by this disease, and the tremendous efforts of health care staff, and the wider community, in stamping the virus out.

The impact of the virus is reflected throughout the reporting against our measures for 2019/20, as core services were disrupted, and business as usual was put on hold. Nevertheless, we do have important achievements to report, and areas that remain critical focuses for the future.

We are continuing to see improvements in people being supported in their own homes, as our Primary and Community Care Strategy and a range of initiatives including the 'Home Team' and the Older Persons Assessment and Liaison unit (OPAL) at Dunedin take increasing effect.

Significant progress was also made in reducing waiting times for first specialist appointments and elective surgery, following intensive focus in this area. The achievements are not entirely reflected in the results, as more than 900 surgeries and 16,000 outpatient visits were displaced during the COVID-19 lockdown period.

Other areas are stubbornly static, including lengthy waiting times in the Emergency Department. This remained the case, even as presentations plummeted during the lockdown period, and reinforces the need for more systemic changes in our management of patients awaiting specialist review and admission. We also remain concerned about persistent issues with colonoscopy referrals.

We continue to see inequities between our Māori and non-Māori populations, in areas from oral health to long-term conditions management, which are unacceptable.

Addressing these areas requires a comprehensive approach that touches upon all aspects of the Southern Health system.

In transitioning to the new governance for the Southern DHB, we acknowledge the important efforts of the Commissioner team in developing the strategic framework to ensure a strong pathway forward for Southern DHB, to continue to serve the health needs of the community into the future. The board has also welcomed new perspectives around the table, and will continue to shape the future of the Southern Health system, with a strong focus on equity, sustainability, risk identification and improved primary-secondary integration.

The following goals have provided the basis for reporting the Southern DHB's journey in recent years, and in 2019/20 we continued to make progress in these areas.

- 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 our people – so that people have the skills, support and systems to deliver the care our communities have asked for
- Systems for success – building systems that make it easy for people to manage care, and work together safely
- 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.

Significant progress has been made against this strategic programme of work, and achievements are highlighted in the pages ahead. Special mention

should be made of the work toward Detailed Business Case for the new Dunedin Hospital, behind which sits a mountain of planning and reflection on new ways of delivering a health system for the entire Southern district into the future.

We were excited to formally open the new emergency department at Lakes District hospital, and pleased to make good progress in engaging with the community regarding the needs for primary maternity facilities in the Central Otago/ Wanaka area.

The digital requirements of the future of the Southern health system have been increasingly mapped, and indeed received a significant boost during the COVID-19 lockdown period, demanding greater use of technology to meet the health care needs of the community.

Indeed, looking ahead, we have a precious opportunity to build on the insights afforded to us by this most unusual of years. Like no other time, we have been able to vividly see the areas that made the greatest difference in enabling a more effective health care system, as during crisis conditions the most important actions were pursued with urgency.

These reinforced our existing priorities, including reshaping our public health function; progressing a primary and community care strategy centred on increased technology and better supporting patients to be cared for outside of a hospital context; and streamlining our secondary services. However, the individual initiatives that could add greatest value to this direction were thrown into clarity, including virtual health, clinical health pathways, and opportunities for a specific programme for planned care that sees more services delivered in a primary setting and true collaboration with specialist services.

The challenge to ensure equity across our diverse populations, and to deliver services across our vast geographic area, remains top of mind for the Southern district.

We will also be guided by the Health and Disability System Review. While the government's response to this will inevitably inform our ongoing planning and opportunities, the alignment between what is being signalled, and our priorities as a Southern health system, is affirming.

We have also been reminded of the strengths of a strong culture, and professionals working collaboratively, creatively and to the top of their scope. Investment in leadership, building and looking ahead to workforce requirements of the future therefore remain a priority.

And of course, we must retain our capacity to respond to any future waves of COVID-19, as this newcomer to our global neighbourhood looks set to be with us for some time to come.

More than ever, the experiences of the past year endorse what we already well understand – that no part of the health system works in isolation. The health and well-being of all our community across our vast district depends on us truly working as a united Southern Health system.

We want to acknowledge the contributions of all our health care partners, including WellSouth PHN, general practices, Iwi providers, our rural hospitals, midwives, pharmacists, aged residential care and the many organisations (NGOs) that provide important community and primary health-care services in our communities every day, as well as the Community Health Council, which continues to provide constructive advice and feedback as a voice for patients and whānau.

We wish to extend a particular acknowledgement to Dave Cull, who was appointed Chair to the board following his election in 2019, and has stepped down for health reasons. We thank him for his leadership and commitment to the DHB.

The past year has surely tested us, as a health system, as a community, and as individuals. It has also revealed our core strengths and values. We are committed to drawing upon these to deliver the very best health system for our patients and their families in the Southern district.

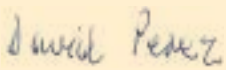
Dr David Perez, Acting Board Chair
Chris Fleming, Chief Executive Officer

Statement of Responsibility

For the 12 months ended 30 June 2020

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

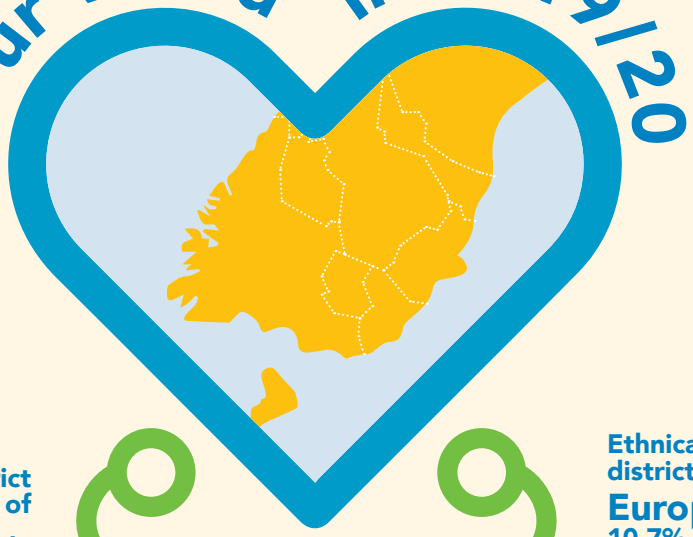
The board and management of Southern DHB accept responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial and non-financial reporting. In the opinion of the board and management of Southern DHB the financial statements and statement of service performance for the year ended 30 June 2020 fairly reflect the financial position and operations of Southern DHB.



Dr David Perez
Acting Board Chair
9 December 2020

Chris Fleming
Chief Executive Officer
9 December 2020

Our world in 2019/20



The Southern district has a population of **341,310** residents

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

Ethnically, the Southern district is predominantly **European at 80%.** 10.7% are Māori, 7% Asian and 2% Pacific.

4,993 staff employed by the DHB

860 employees joined Southern DHB in 2019/20

9.2 years – average tenure of employees at Southern DHB

4,474 people supported by Home and Community Support Services

216 Cases of COVID-19

Unite against COVID-19

9,966 acute surgical operations

11,179 elective operations or procedures

3,439 babies born in DHB facilities in 2019

77,331 presentations to the Emergency Departments

95% of children fully immunised by 8 months

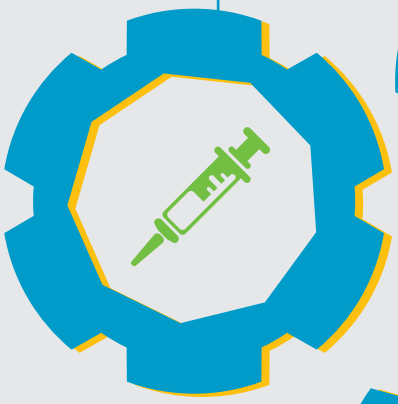
Our population is slightly older when compared to the national average. **17.3%** are aged **65 and over**

262,048 outpatient appointments across all servies

Key highlights

Our health system responded quickly to the threat of **COVID-19**, tracing **1060** contacts of **216** cases, and testing **19,637** people to 30 June 2020

95% target for immunisation rates at two years old was met, for both the **Southern population as a whole (95%)** and for **Māori (96%)**



Those over the age of **65 years** are having shorter lengths of stay in rehabilitation services, and their **physical functionality** scores are increasing

Six further general practices joined the Health Care Home programme, taking the total number to **14** participating throughout the Southern district

New **linear accelerator** was installed in radiation oncology

More people were able to access **brief interventions** from primary mental health services (total 7,025)

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 board of elected and government-appointed members. The board 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.

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 pathway towards enabling
Better health, better lives, Whanau Ora

Southern Future
It's up to us

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.

*Southern Future listening sessions, 2016

By 2026:
We work in partnership to create a truly integrated, patient-centred health care system

A health-enabling society, within which we deliver:

More accessible, extensive primary and community care with the right secondary and tertiary care when it's needed.

So that our people:

- are healthier and take greater responsibility for their own health
- stay well in their own homes and communities
- with complex illness have improved health outcomes.

Southern Health
He hauora, he kuru pounamu

How will we get there?

Improving experience and 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 re-design
Primary and secondary/tertiary services are better connected and integrated. Patients experience high quality, efficient services and care pathways that value their time.

Enabling success:

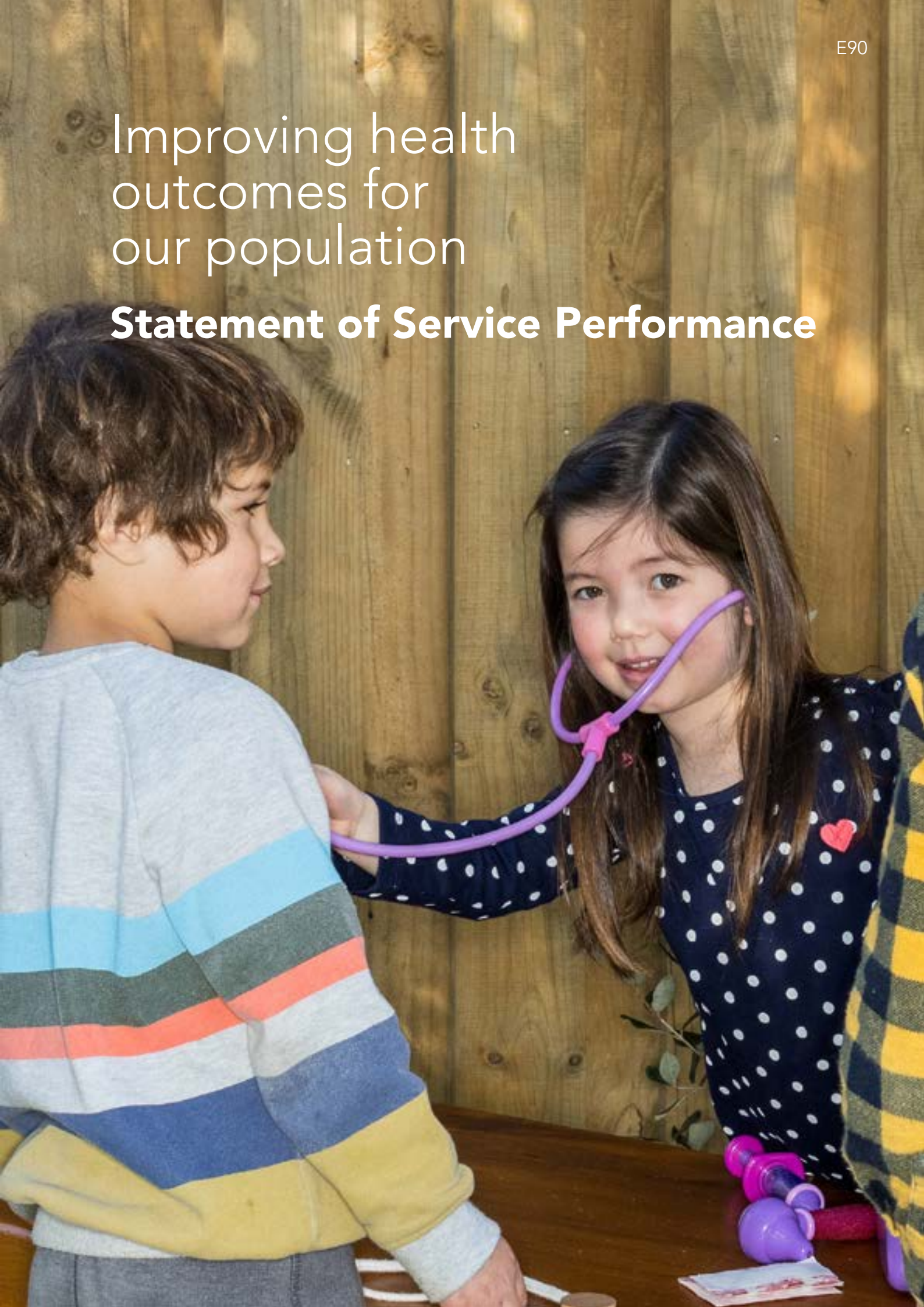
Enabling our people
Our workforce have the skills, support and passion to deliver the care our communities have asked for.

Systems for success
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.

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 meet equitable health outcomes and promote 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). Reference tables are provided at the end of the outcome and output measures sections (pages 27 and 45), showing the reporting periods used for each indicator.

Improving Health Outcomes for Our Population

Equity recognises different people with different levels of advantage require different approaches and resources to achieve equitable health outcomes. 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 improving equity for Māori and 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.

Note that while the outcome measures include New Zealand performance figures for comparative reasons, New Zealand targets are not stated as they are not part of the performance objectives outlined in our Statement of Intent. This differs from our approach last year.

The three strategic outcomes outlined in the 2019/20 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 bed days per capita • 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	• 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

Outcome One

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 significantly impact on health and wellbeing outcomes of our populations and in particular for Māori and Pacific populations.

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 encourage and enable 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 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 exceed target, while the caries free rate for 5-year olds remain largely static. 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.

Southern's smoking rate data is acquired from the NZ Health Survey; unfortunately, due to the timing of publications, the 2019/20 data is not yet available and we generally remain 12 months behind in our reporting for these measures.

2018/19 data is the most recent, and is being reported for the first time this year. The year saw a continued decrease 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 available online.

We have continued to focus on assisting people to quit smoking including incentivising commitment to quit, increasing access by improving referral pathways to smoking cessation services, and working to expand options (such as vaping) for smokers to switch from combustible tobacco.

Over the past year, 86 per cent of smokers in primary care were provided with brief advice and offered cessation support which sits below the target of 90 per cent.

Percentage of the population 15+ who smoke

	2016/17	2017/18	2018/19	2019/20
Southern DHB	19.3%	13.5%	12.8%	Not available
New Zealand	15.7%	14.9%	14.2%	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 equitable health outcomes which includes 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's obesity data is acquired from the NZ Health Survey; as mentioned previously we generally remain 12 months behind in our reporting for these measures. 2018/19 data is the latest data available this year.

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. As part of the ongoing support of this programme, Southern participated in a review of education methods to support the standards of professional development for those providing the programmes.

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).

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

Percentage of the population 15+ who are obese

	2016/17	2017/18	2018/19	2019/20
Southern DHB	31.4%	29.4%	34.0%	Not available
New Zealand	32.2%	32.2%	30.9%	Not available

Data sourced from national NZ Health Survey

Note 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.

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.

Service delivery in 2019/20 experienced interruptions due to COVID-19, and nationally, non-acute oral health services were temporarily suspended due to the risks associated with transmission and infection. Recovering these volumes through 2020/21 will be achieved through a combination of continuing annual check-ups and targeting additional resource for at risk children.

As part of this, development of an electronic portal for families is expected to support improvement in our caries free rate by allowing the targeting of resource and attention to those children most at risk.

Percentage of 5-year-olds who are caries free

	2017	2018	2019	
	Actual	Actual	Target	Actual
Southern DHB	67%	70%	>70%	69%
Southern DHB Māori	53%	55%	>70%	56%
New Zealand	61%	60%	-	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.

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'

	2017	2018	2019	
	Actual	Actual	Target	Actual
Southern DHB	83%	81%	>70%	79%
New Zealand	82%	81%	-	80%

Data Source: ASH Year 10 Survey

Outcome Two

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, improve equitable 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:

- Acute bed days per capita
- 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?

Acute bed days per capita sits below the national rate and Southern performs well in this area. Meeting the demand for complex imaging (CT and MRI) remains a challenge however with performance not meeting target. Initiatives to address the gap between demand and supply include increasing recruitment, expanding shifts and endorsement for a new CT scanner in Dunedin.

Rates of people staying in their own homes remains relatively stable. 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. Our rates of avoidable hospital admissions also remain relatively stable, but an inequity remains for Māori.

Outcome: Acute Bed Days per Capita

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

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

Southern DHB's acute bed days per capita sits below the national average and is ranked fourth lowest for the 2019/20 year.

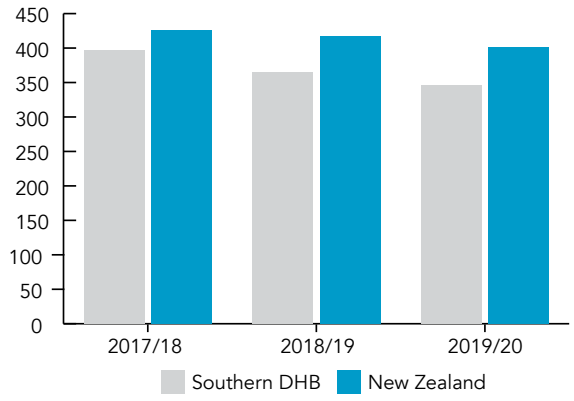
2019/20 saw a continuation of the rollout of General Practice "Health Care Homes", with further tranches of practices adopting the expanded suite of offers for their communities. These include expanded GP triage, acute daily appointment capacity and extended hours – all factors focussed on increasing patient access to care and preventing the need for acute medical admissions to hospital and therefore bed days.

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 ED presentations.

Examples include the respiratory diversion pathway, supporting appropriate patients that may be in respiratory distress to be cared for in the primary care setting and avoid unnecessary hospital admissions.

Acute Bed Days per Capita (age standardised, per 1,000 population)

	2017/18	2018/19	2019/20
Southern DHB	397	365	346
New Zealand	426	417	401



Data sourced from National Minimum Data Set.

Outcome: People Living at Home

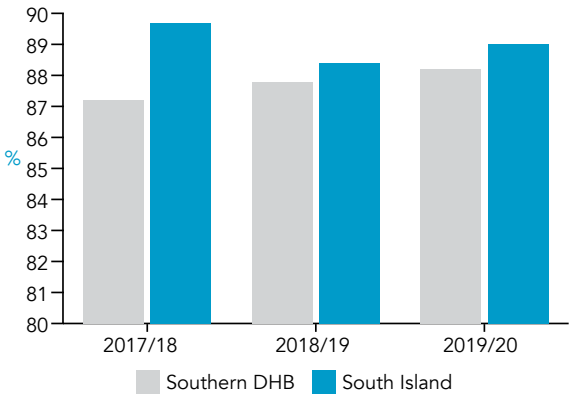
This measure looks at the proportion of the population aged 75+ living at home. Studies have shown a higher level of satisfaction and better long-term outcomes where people remain in their own homes and are positively connected to their communities. This indicator can be used as a proxy indicator of how well the health system is managing age-related and long-term conditions and responding to the needs of our older population.

We have been seeing a gradual and sustained increase in the proportion of older people supported in their own homes over the past years, and this trend has been maintained in to 2019/20.

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

	2017/18	2018/19	2019/20
Southern DHB	87.2%	87.8%	88.2%
South Island	89.7%	88.4%	89.0%



Results may differ slightly from those reported in previous years as population denominator values get updated.

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 equitable health outcomes for our population.

The radiology service continues to experience increasing levels of urgent acute demand which is negatively impacting on timeliness of planned appointments. The overall MRI target compliance at Southern has seen a deterioration over the last year: pre-COVID-19 (March 2020) it was 44 per cent; post-COVID-19 (April 2020) it was 29 per cent. The greatest gaps between capacity and demand were experienced in Dunedin.

To address the shortfalls in capacity, additional evening capacity and staffing are to be permanently introduced in Dunedin. Recruitment commenced late 2019/20 for this initiative, with an expectation for commencement in early 2020/21 (August 2020). There has also been endorsement to introduce a second CT scanner for Dunedin. This will address the low intervention rates and poor waiting times compared with Invercargill and other locations around the district.

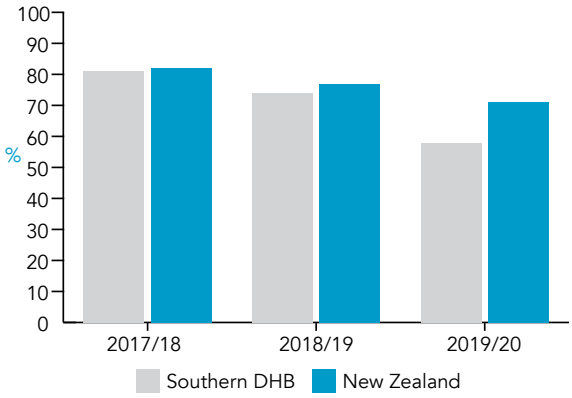
Percentage of people waiting no more than 6 weeks for their CT scan

	2017/18	2018/19	2019/20	
	Actual	Actual	Target	Actual
Southern DHB	81%	74%	>85%	58%
New Zealand	82%	77%	-	71%

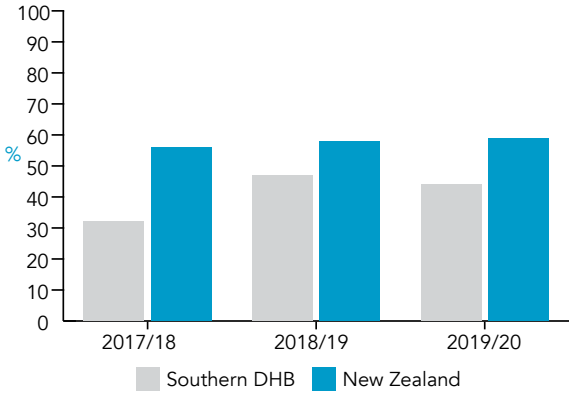
Percentage of people waiting no more than 6 weeks for their MRI scan

	2017/18	2018/19	2019/20	
	Actual	Actual	Target	Actual
Southern DHB	32%	47%	>67%	44%
New Zealand	56%	58%	-	59%

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

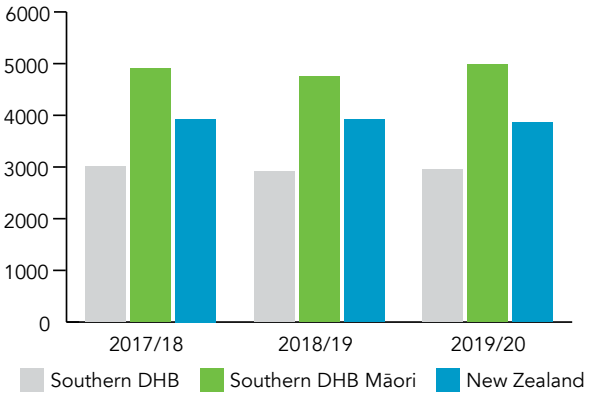
Keeping people well and supported to better manage their long-term conditions by providing appropriate and coordinated primary care should result in fewer hospital admissions not only improving health outcomes for our population but also reducing unnecessary pressure on our hospital services.

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 fluctuated in Southern over past years and challenges remain in addressing inequity. 2019/20 saw the formation of a youth system-level network with its objective being to reduce the rate of self-harm ED presentations. This group is reviewing the system of care, undertaking analysis of patient flows and causes, and is seeking to improve the access and uptake of primary and community care services to prevent community rates of self-harm.

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

	2017/18	2018/19	2019/20	
	Actual	Actual	Target	Actual
Southern DHB	3,006	2,914	<2,865	2,952
Southern DHB Māori	4,909	4,746	<2,865	4,976
New Zealand	3,928	3,925	-	3,858



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.

For 2019/20, our performance for this metric rose slightly, although remains below the rate in 2017/18.

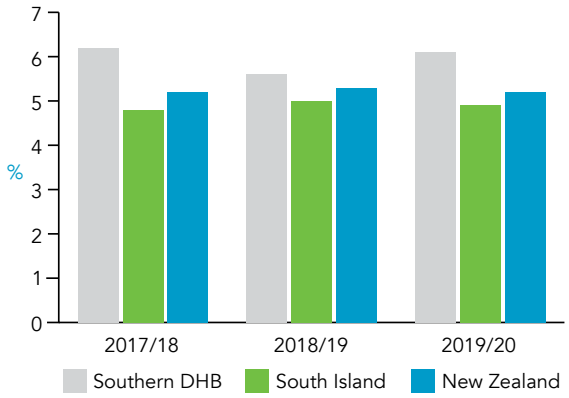
Our well-established multi-agency Southern Falls and Fracture Prevention Steering Group continues to take a sector-wide approach to falls and fracture prevention, engaging with the wider sector during an educational forum, monitoring our ACC/DHB investment in an integrated approach led by WellSouth (who as the lead agency provide fracture liaison and in-home strength and balance sessions), and continuously looking for opportunities to make a difference in the falls and fracture prevention arena. Under COVID-19, lockdown levels posed significant challenges for our falls and fracture prevention programmes for older people, as they were restricted to their very small bubbles. However, programmes swiftly adapted, offering online options which are likely to continue, providing more options for participation.

Preventing falls occurring in hospital is also a key priority. Patients who experience a fall while in hospital are more likely to have a prolonged hospital stay, loss of confidence, loss of conditioning and independence, and are at increased risk of entering institutional care.

Our rates of serious falls in hospital improved (reduced) in the last year. Generally, hospital patients are increasing in their acuity and complexity of illness and therefore their vulnerability to falls. 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 has been tested and is having a positive effect. We will continue to monitor this to provide assurance that this is sustainable.

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

	2017/18	2018/19	2019/20	
	Actual	Actual	Target	Actual
Southern DHB	6.2%	5.6%	<5.0%	6.1%
South Island	4.8%	5.0%	<5.0%	4.9%
New Zealand	5.2%	5.3%	-	5.2%



Data source: National Minimum Data Set

Outcome Three

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
- A reduction in amenable mortality

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

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, and stability in the community post-discharge from hospital.

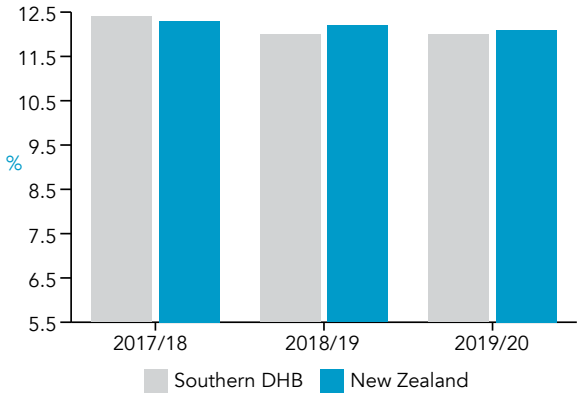
The key factors in reducing acute readmissions include safety and quality processes, effective treatment and appropriate support on discharge. Therefore, they are a useful marker of the quality of care being provided and the level of integration between services.

Southern readmission rates are stable and sit below the national average.

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

	2017/18	2018/19	2019/20
Southern DHB	12.4%	12.0%	12.0%
New Zealand	12.3%	12.2%	12.1%

Data source: Ministry of Health Performance Reporting OS8. Results may differ across years compared to past reports due to standardisation methodology.



These results differ to those published in 2016/17 following a further reset of the definition by the Ministry of Health in 2017/18.

Outcome: Amenable Mortality Rates

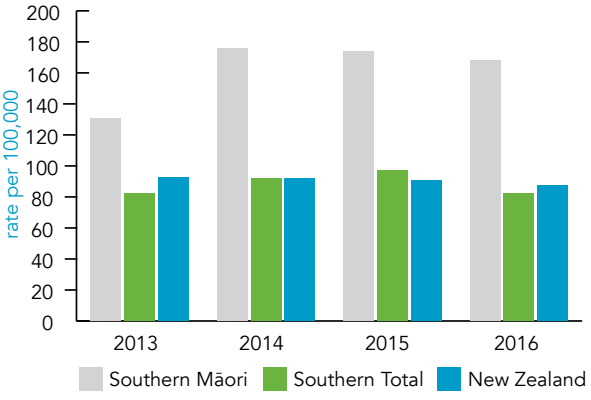
Amenable mortality is defined as premature death (before age 75) from conditions that could have been avoided through lifestyle change, earlier intervention, and the effective and timely management of long-term conditions.

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

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

Age standardised rates of amenable mortality per 100,000

	2013	2014	2015	2016
Southern Māori	130.4	175.9	173.5	167.9
Southern Total	81.9	92.2	96.9	82.5
New Zealand	92.8	91.6	90.8	87.6



Note: There is a delay in mortality data as the cause of death has to be established for all reported deaths and it can take some time for coronial cases to reach a verdict. Amenable mortality data is currently only available to 2016.
Source: National Service Framework Library

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.

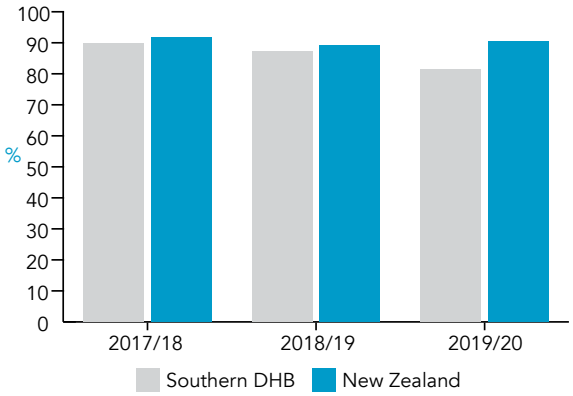
Solutions to reducing ED wait times span not only the departments themselves but the whole health system. In this sense, this indicator is a marker of how responsive the whole system is to the urgent care needs of the population.

Examples of current programmes to improve ED wait times that show this breadth, include progression towards a generalist model of admitting for Dunedin Hospital wards; embedding our Primary Options for Acute Care (POAC) across the district – to increase primary care capacity for urgent need; and using the Home Teams to support the stability of patients in their own homes (rather than risk deterioration and presentation in ED).

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

	2017/18	2018/19	2019/20	
	Actual	Actual	Target	Actual
Southern DHB	89.9%	87.2%	>95.0%	81.3%
New Zealand	91.8%	89.0%	-	90.4%

Data source: Ministry of Health Quarterly 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.

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 when they are diagnosed, treated, and return home quickly.

Delivering timely access to some treatments has again been challenging in 2019/20 especially for outpatients and elective surgery.

In the last financial year, Southern DHB has undertaken a range of programmes in outpatient services to match capacity and demand. Examples include introducing the Ministry of Health's Clinical Priority Criteria; implementation of an acuity index to support the prioritisation of follow-ups; and development of telehealth infrastructure to give greater flexibility for patients and whānau to attend clinics. Timely access to theatre has also been a priority with initiatives underway to increase acute theatre time in Dunedin and the use of private capacity in Southland – both to ensure greater throughput and reduce the risks of planned interventions facing cancellation due to acute procedures. Because results are reported as at June each year, the tail effect of the first COVID-19 wave in March 2020 is visible in the table below with the lower performance both locally and nationally.

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	90.6%	85.7%	100.0%	65.2%
New Zealand	97.8%	89.8%	100.0%	75.6%

	2016/17	2017/18	2018/19	
ESPI 5	Actual	Actual	Target	Actual
Southern DHB	83.9%	82.7%	100.0%	55.8%
New Zealand	90.1%	84.3%	100.0%	67.4%

Data source: Ministry of Health Data Warehouse.

Reporting period reference table: outcome measures

The following table provides a guide to the reporting periods for the outcome measures used in the Statement of Service Performance.

Measure	Period value represents
Percentage of the population 15+ who smoke	Annual performance (year delay)
Percentage of the population 15+ who are obese	Annual performance (year delay)
Percentage of 5-year-olds who are caries free	Annual performance (calendar year)
Percentage of Year 10 students who have 'never smoked'	Annual performance (calendar year)
Acute Bed Days per Capita (1,000 population)	Year to Q3
Percentage of the population (75+ years) living in their own home	Annual performance
Percentage of people waiting no more than 6 weeks for their CT scan	Annual performance
Percentage of people waiting no more than 6 weeks for their MRI	Annual performance
Avoidable hospital admission standardised rates per 100,000 for the population aged 45-64 (ASH SI1)	Year to Q3
Percentage of population (75 years and over) admitted to hospital as a result of a fall	Annual performance
The rate of acute readmissions to hospital within 28 days of discharge	Year to Q3
Age standardised rates of amenable mortality per 100,000	Annual performance (calendar year)
Percentage of people presenting at ED who are admitted, discharged or transferred within 6 hours	Annual performance
Percentage of people receiving their specialist assessment (ESPI 2) or agreed treatment (ESPI 5) in under four months	Annual performance

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 2019/20 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

	2019/20 Actual $000	2019/20 Budget $000	2019/20 Variance $000
Income			
Prevention Services	20,374	4,991	15,383
Early Detection and Management Services	205,533	205,836	11,562
Intensive Assessment and Treatment	726,237	729,183	(28,593)
Rehabilitation and Support	147,922	141,382	20,322
Total Income	**1,100,066**	**1,081,392**	**18,674**
Expenditure			
Prevention Services	20,374	4,991	(15,383)
Early Detection and Management Services	216,666	219,177	2,511
Intensive Assessment and Treatment	792,627	738,858	(19,516)
Rehabilitation and Support	160,853	156,878	(3,975)
Total Expenditure	**1,190,520**	**1,119,904**	**(36,363)**
Deficit for the year	**(90,454)**	**(38,512)**	**(17,689)**

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 2019/20 is $953.8 million which equals the Government's actual expenses incurred in relation to the appropriation. The performance measures are set out in the statement of service performance on pages 13 to 45.

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 2019/20, 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 risks. 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 both 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?

Across the 2019/20 year, immunisation rates remained relatively stable. During COVID-19, childhood vaccinations remained a MoH priority and the National Immunisation Register and immunisation teams were considered an essential service. A small percentage improvement was noted for the under twos over Q4, including for Māori and Pacific children. This is consistent with additional resourcing committed to immunisation during the COVID-19 response and more families being reachable at home.

Influenza vaccinations for older people remains a priority and COVID-19 has resulted in increased influenza vaccination requests across the District. A highlight was the development of a joined-up programme across primary care, Southern DHB's Outreach Immunisation Service, and kaupapa services to provide influenza vaccination on marae.

Immunisation coordinators also continued their ongoing commitment to working with the midwifery sector promoting vaccination in pregnancy and responsive baby vaccine schedules. During COVID-19, additional resourcing was required to keep up with the demands of practices for influenza vaccine and support redistribution of vaccine from occupational health providers and pharmacy. During this period, coordinators also supported new immunisation providers to train and increase their capacity to vaccinate.

The school-based Human Papillomavirus (HPV) vaccination programme was interrupted by COVID-19 due to schools closing. Partial completion of round one had occurred prior to the shut down of non-essential services, however, the majority of the programme was on hold. Following advice from the Ministry of Health, Southern DHB was able to resume the HPV school-based programme once schools reopened with a 22-week schedule between rounds one and two.

2019/20 Performance Results for Immunisation Services

Measure		2017/18 Actual	2018/19 Actual	2019/20 Target	2019/20 Actual	
Percentage of children fully immunised at 8 months (Health Target)	Total	94%	92%	>95%	94%	●
	Māori	94%	85%	>95%	91%	●
Percentage of children fully immunised at 2 years	Total	94%	94%	>95%	94%	●
	Māori	92%	95%	>95%	94%	●
Percentage of eligible girls fully immunised with 3 doses of HPV Vaccine	Total	68%	55%	>75%	64%	●
	Māori	71%	49%	>75%	63%	●
Percentage of people aged over 65 having received a flu vaccination	Total	52%	56%	>75%	54%	●
	Māori	44%	45%	>75%	44%	●

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 2019/20 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. A key reason for this was due to COVID-19 and the focus of both primary care teams and WellSouth support teams away from smoking cessation efforts.

Despite this, supported initiatives for smoking cessation that the year have been broad in scope, focussing on maintaining commitment to quit, increasing referrals, and supporting at risk groups. Integration of smoke-free messaging with other health promotion policy such as safe sleep for newborns has also been a priority.

2019/20 saw further evolutions of the Southern Stop Smoking Service (SSSS) that was established by Ngā Kete Matauranga Pounamu. For example, the programme has been extended to support mothers to quit after birth, whereas previously the programme was limited to pregnancy.

A pilot was also commenced in 2019/20 in Oamaru, Balclutha and Dunedin maternity units that introduced changes in approach and methodology to support engagement and referral to the Southern Stop Smoking Service. It is hoped that these changes will increase uptake for service users. While the outbreak of COVID-19 risked interrupting the delivery of these services, the programmes were continued in various forms such as via telephone (one-on-one) and group video parenting support services.

A major policy initiative also developed in 2019/20 was the "vape-to-quit" programme. This initiative will be rolled out in 2020/21 and will see a pilot of vape devices being offered to eligible smokers aged 18+ as a form of nicotine replacement to help transition from cigarettes on the journey of becoming smoke-free. The initial pilot of this programme will be rolled out across Māori health and outreach, Southern Stop Smoking Service, mental health services and selected community trial locations.

Increasing breastfeeding rates is another key health promotion area. Breastfeeding peer support, one-on-one and group parenting support sessions are pivotal programmes in supporting the improvement of breastfeeding rates and the confidence for young families.

Increasing rates of participation for Pasifika remains a priority, and 2019/20 saw a targeted pilot commence that increased resourcing and support for breastfeeding in this community. Safe Sleep has also been a major policy priority under the Oranga Pepi programme. Roll-out of safe-sleep devices continued in 2019/20, with changes to distribution to ensure greater access and availability for families. Part of this included working with local weavers to facilitate local production of wahakura to give choice to families beyond the existing plastic safe-sleep devices. Smoking cessation remains a key component in reducing the risk of sudden unexplained death in infancy (SUDI).

2019/20 Performance Results for Health Promotion and Education Service

Measure		2017/18	2018/19	2019/20		
		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	91%	88%	>90%	78%	🔴
	Māori	90%	87%	>90%	77%	🔴
Infants exclusively or fully breastfed at 3 months	Total	60%	63%	>60%	62%	🟢
	Māori	52%	49%	>60%	53%	🟡

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/WellChild checks done prior to a child turning five. The B4 School Check identifies any health, behavioural or developmental problems that may have a negative impact on the child's ability to learn and participate at school.

How did we perform?

Southern DHB remained relatively stable early in 2019/20 with coverage for screening measures. However, with COVID-19, performance dropped between 4 per cent and 9 per cent for cervical and breast screening.

One of the main NCSP performance measures is coverage. Coverage is defined as the proportion of women eligible for screening who have been screened in the previous three years with an 80 per cent target. Southern DHB remains above average for population coverage, including for Māori, Pasifika and Asian women. However, an equity gap still remains.

The Southern DHB universal hearing screening programme continued as an essential service during COVID-19 lockdown however servicing was limited to hospital births only, until the restrictions were lifted to enable screening of all home births. A catch-up programme has been facilitated through audiology for all babies that were missed during COVID-19 lockdown. The service is now fully operational.

The percentage of children receiving their B4 School Check exceeded target pre-COVID-19 restrictions, however services were required to cease during level 4 restrictions. All staff were redeployed to Public Health COVID-19 response. Consequently, targets have now fallen short of the planned end of year total eligible population targets. Recovery is underway with priority given to follow up of outstanding referrals. As the service continues to recover, priority is given to delivering B4 School Checks to children who are close to five years of age, as well as quintile 5, Māori and Pasifika children. A full recovery plan is in place for the 2020/21 B4 School Check programme.

2019/20 Performance Results for Population-Based Screening

Measure		2017/18 Actual	2018/19 Actual	2019/20 Target	2019/20 Actual	
Percentage of eligible women (50-69 years) who have had a BSA mammogram breast screen examination in the past 2 years (MHP).	Total	74%	75%	>70%	66%	🟡
	Māori	67%	69%	>70%	63%	🟠
Percentage of eligible women (25-69 years) who have had a cervical screening event in the past 36 months (MHP).	Total	77%	75%	>80%	71%	🟠
	Māori	68%	69%	>80%	63%	🔴
The percentage of 4 year old children receiving a Before School Check (B4SC).	Total	91%	91%	>90%	78%	🔴
	Quintile 5[1]	90%	91%	>90%	74%	🔴
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	94%	92%	>95%	92%	🟡

[1] 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?

2019/20 was a challenging year for Oral Health service delivery due to the impact of COVID-19 and the need to restrict service delivery due to the risks of COVID-19 transmission. Despite this, overall performance has remained steady without significant negative variation against many of our metrics. To offset lost volumes and appointments, a dual strategy has commenced of either redirecting children to local clinics, or focusing on catching up in 2020/21 annual check-ups.

Levels of oral health are experienced differently among different communities and deprivation levels. A key focus in 2019/20 has been on how to improve the equity of access to services for those with greatest need. Efforts include the development of an electronic portal for families to record oral health status and interactions. The intent is that this will allow the oral health service to engage more readily with those families at greater risk of deteriorating oral health, while also not risking the over-intervention for children whose oral health is excellent and stable.

Along the same lines of pursuing equity, the service has been engaging with the Māori Health Directorate and local Iwi looking to seek assistance from rūnaka on the best ways to provide oral health services in the marae setting. This form of delivery is greatly aided by the use of our mobile oral health buses, and a hybrid model of delivery will ensure the oral health service is able to engage with different communities in ways that are best suited to their requirements.

Prevention also remains a key strategy, with planning and staff training undertaken in 2019/20 to enable an increased and concerted effort in preventative fluoride varnish prevention programmes for 2020/21.

2019/20 Performance Results for Oral Health

Measure		2017	2018	2019		
		Actual	Actual	Target	Actual	
The percentage of eligible preschool children enrolled in school and community oral health services	Total	79%	93%	>95%	84%	●
	Māori	68%	71%	>95%	63%	●
The percentage of children caries-free at five years of age	Total	67%	70%	>70%	69%	●
	Māori	53%	55%	>70%	56%	●

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. They can be defined as any ongoing, long term or recurring conditions that can have a significant impact on people's lives, and include conditions such as diabetes, cancers, cardiovascular diseases, respiratory diseases, mental illness, chronic pain, chronic kidney disease and dementia. Improvements for the management and care of these conditions accordingly span multiple areas of our health system.

Cardiovascular disease (CVD) is of particular interest as 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?

There are a range of new initiatives to address long-term outcomes and targets.

2019/20 saw the launch of a new CVD Risk Assessment algorithm. This was rolled out nationally to support the identification and support of those at risk of deterioration. Aligned to this new risk assessment tool will be a new approach to the CVD incentive programme. WellSouth continues to prioritise CVDRA for Māori men aged 35 to 44 years but Southern DHB is yet to reach the 95 per cent target for CVD checks.

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.

Our diabetes system of care continued to evolve this year. 2019/20 also saw development of an enhanced multidisciplinary and district-wide model of care for the treatment and stabilisation of diabetic feet, including setting up virtual support, creating a single point of entry in to the service, aligning services across the district and the refinement of health pathways. 2020/21 will see expansion of this improvement work to include the broader model of care for those with diabetes.

The DHB is yet to meet the target of 60 per cent of the population identified with diabetes having good or acceptable glycaemic control, although results have improved overall. WellSouth continues to offer the Diabetes Education and Self-Management for Ongoing and Newly Diagnosed (DESMOND) programme for patients with Type 2 Diabetes, while 'Walking Away from Diabetes' acts as a preventative programme for patients identified with pre-diabetes.

2019/20 Performance Results for Long-Term Conditions Management

Measure		2017/18	2018/19	2019/20		
		Actual	Actual	Target	Actual	
Percentage of the eligible population who have had a CVD Risk Assessment in the last 5 years[2]	Total	84%	81%	>90%	76%	●
	Māori	83%	80%	>90%	77%	●
Percentage of the population identified with diabetes having good or acceptable glycaemic control	Total	48%	45%	>60%	53.5%	●
		41%	38%	>60%	46.3%	●

[2] There have been changes in the method for determining the denominator for CVD Assessment and Management for Primary Care (CVDRAMPC) compared to past years. This includes expanding the number of included population cohorts. Additionally, as the implementation of CVDRAMPC has been progressive, with calculations based on the new algorithm implemented progressively, results must be interpreted with caution and comparison between those years with inconsistent denominators is not recommended.

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?

High tech imaging:

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).

There is a particular problem in Dunedin city for CT. CT performance in Dunedin 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 are performed during weekday evenings. This was successful in matching capacity and demand, and recruitment to permanently increase this capacity commenced in late 2019/20. We have also had approval to outsource CT scans, as well as for the implementation of an additional CT scanner. These changes will go some way to address the backlog issue in Dunedin and should raise our performance.

There have been significant gains in MRI scanning within 42 days due to increased staffing and implementation of weekend scanning. 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.

Faster Cancer Treatment:

Southern DHB did not meet the 62-day target in any of the quarters and had a particularly poor result in the last quarter.

In 2019/20 several planning meetings were held, including a multi-disciplinary planning workshop in November 2019 and a Māori hui held in February 2020. The aim of these meetings was to identify and address the main causes of delays in diagnosis and treatment for cancer.

Key reasons for underperformance include insufficient coordination of complex patient pathways; delays in diagnosis (for example complex imaging); and delays in access to treatment (in particular surgery). To address these gaps, additional Clinical Nurse Specialist resourcing has been approved for recruitment in 2020/21; the earlier-discussed increases in CT imaging capacity will increase the timeliness of diagnostics for patients; and changes to theatre schedules have been made to increase capacity for cancer surgery. The sum of these additions to capacity is expected to improve performance.

2019/20 Performance Results for Community Referred Tests

Measure	2017/18	2018/19	2019/20		
	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	85%	79%	>90%	70%	●
The percentage of accepted referrals for CT scans receiving procedure within 42 days	81%	74%	>85%	58%	●
The percentage of accepted referrals for MRI scans receiving procedure within 42 days	32%	47%	>67%	44%	●

Primary Health Care Services

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

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

How did we perform?

A lower level of Ambulatory Sensitive Hospital (ASH) admissions indicates the primary sector is performing well and successfully keeping people well in the community. Meeting our ASH rate targets is challenging, however a range of initiatives have been developed and will roll out through 2019/20 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 admissions for 0 to 4 year-olds, especially for Māori.

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 2018/19, and 2019/20 saw delivery of a second tranche of GP practices 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.

Development of our Primary Options for Acute Care (POAC) programme is also well underway. Through this service General Practices 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. 2019/20 saw a renewed focus on scaling the number of practices offering POAC services and expanding service offerings. An example is increasing the number of GPSIs (General Practitioners trained in Special Interest skillsets) able to offer skin lesion removal in Southland. This removes the need for patients to enter into secondary services to access this intervention.

Mental health in primary care is also an important part of the sector. Adult brief intervention services are provided directly by WellSouth PHO and brief intervention services for young people are delivered in the NGO sector. 2019/20 saw an increasing demand for these services. During the COVID-19 outbreak we saw a decrease in people seeking services, which provided an opportunity to reduce wait times, but volumes rebounded significantly post-outbreak. Service continuity was maintained during the outbreak period with different formats being offered for those seeking support (for example, telephone and video appointments). It is expected that these differing models of care delivery will be maintained to provide different forms for patient access in the future.

2019/20 Performance Results for Primary Health Care Services

Measure		2017/18	2018/19	2019/20		
		Actual	Actual	Target	Actual	
Ambulatory Sensitive Hospital (ASH) admission rates (per 100,000) for children aged 0-4 years[3]	Total	5,756	5,869	<5,370	5,496	🟡
	Māori	6,323	7,611	<5,370	6,685	🔴
The number of people receiving a brief intervention from the primary mental health service	Total	6,882	6,606	>6,000	7,025	🟢

[3] 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?

Delivering timely access to some treatments has again been challenging in 2019/20 especially for outpatients and elective surgery. Despite this, Southern has undertaken various programmes of work to match capacity and demand.

Some of the initiatives involve ensuring the correct prioritisation and scheduling of patients. For example, the Ministry of Health's Clinical Priority Criteria for new patient appointments was introduced which sees referral assessments undertaken using direct patient phone surveys about impact on life and clinical assessment of factors. These include the likelihood of deterioration within six months, consequence of deterioration and ability to benefit from proposed care. This has been implemented in Urology in Dunedin, General Surgery in Southland, and Orthopaedics in Dunedin, and has meant both a better alignment of capacity and demand and more certainty for patients about wait times. Further rollout will be undertaken in 2020/21.

Implementation of an acuity index also progressed in 2019/20. Such indexes assist audit and prioritisation, ensuring patients are booked in the correct order according to clinical need.

A telehealth steering group was also established to enable widespread use of the strategy for providing consultations to patients, whānau and support clinicians. It is unclear at this stage if it will increase the capacity in the system, however we anticipate that patients and whānau will find it easier and less expensive to attend a clinic.

Increasing theatre capacity and throughput is another strategy to match capacity and demand. For example, utilising private capacity in in Southland has meant there has been a more balanced allocation of acute theatre time, reducing the urgent need for cancellation of electives. Dunedin has also undertaken planning for an increase in acute theatres. The aim is to reduce cancellations of elective surgery, waitlists and the bed-stay for acute patients getting to theatre.

Other constraints on theatre capacity in Dunedin include the physical setting of sterile services and suitability of day surgery facilities. In response, the development of a new sterile services complex has been signed off by the Board and planning is underway for delivery, while a new theatre is being planned in the Main Operating area for day surgery to raise capacity there.

Optimising operating theatre utilisation has also continued, including full production planning. This has been undertaken and monitored throughout the year including testing of the delivery model prior to the start of the financial and daily, weekly and monthly monitoring of performance. One of the visible outcomes has been a reduction in dropped lists over key times of the year such as school holidays and statutory weekends.

2019/20 Performance Results for Elective Services

Measure	2017/18	2018/19	2019/20		
	Actual	Actual	Target	Actual	
Percentage of elective and arranged surgery undertaken on a day case basis	67%	63%	>60%	59%	●
Percentage of people receiving their elective and arranged surgery on day of admission	83%	88%	>95%	89%	●
The number of elective surgical services discharges	11,380	11,584	>12,588	11,179	●
The number of elective surgical services case-weights (CWDs) delivered[4]	15,863	18,099	>18,311	17,292	●

[4] The measure definitions for both discharges and case weights have been updated by the Ministry of Health. Past year results (2017/18 and 2018/19) have been recalculated according to this definition to provide consistency in the above table. The values will accordingly not reconcile with past Statements of Service Performance.

Acute Services

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

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

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

How did we perform?

2019/20 was a complex year for service delivery for Emergency Departments. 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. System improvements were underway in a number of areas, but the COVID-19 outbreak required major shifts in models of care-delivery that interrupted the implementation of planned improvement programmes.

Examples of these programmes include a trial of early specialist assessments to increase the speed of ED decision-making, together with the establishment of an Older Person's Assessment Liaison service to support timely admission of those over the age of 75 (Dunedin). A new generalist acute medical admitting model is also being progressively implemented. The aim of the generalist model is to reduce acute admitting streams and therefore improve the efficiency of patients departing the Emergency Departments. Work has also been undertaken on improving discharge processes across Southern DHB with trial of discharge lounges and 'Home for Lunch' initiatives. The viability of a Medical Assessment Unit or dedicated short stay unit in Southland Hospital continues to be assessed alongside engagement with primary care with a view to addressing or validating the number of attendances to the department.

These initiatives have been clinically supported but as mentioned the majority of activity was postponed through the COVID-19 outbreak. To ensure the delivery of safe services during the outbreak, models of delivery for Emergency Departments were required to rapidly shift.

A key component involved streaming patients by "red" and "green" streams depending on risk status, together with new processes to maintain safety. These changes, together with unfamiliarity with the new working environment both in the ED and on the wards, meant that the anticipated improvement in flow through the department was not realised. Reasons for this include:

- Patients screened as 'red' were required to be treated in a separate area with full PPE being utilised
- The physical space and staffing resource in the Emergency Department was split between 'red' and 'green' areas (effectively reducing economies of scale)
- There was a desire to treat 'red' patients out of the hospital so much as was possible, leading to extended lengths of stay in the ED
- The requirements for the ED and wards regarding COVID-19 were fluid and never fully embedded as the dynamic situation fluctuated in intensity, and therefore requirements also fluctuated.

2019/20 Performance Results for Acute Services

Measure	2017/18	2018/19	2019/20		
	Actual	Actual	Target	Actual	
People are assessed, treated or discharged from the emergency department (ED) in under six hours	90%	85%	>95%	81.3%	●
Number of people presenting at ED	82,403	82,467	<80,000	77,331	●

Maternity Services

Maternity services are provided to women and their whānau through pre-conception, pregnancy, childbirth and up to six weeks post-natally. 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 our district continues to be relatively constant with minor variation from year to year. The rate of women registering with LMCs in their first trimester also is relatively constant, with performance sitting just below target.

2019/20 saw a range of service developments and improvements rolling on from the release of the Southern Primary Maternity Strategy in 2018/19. Two independent reviews of areas relating to this strategy were undertaken during the year – each of which contributed to refinements through their associated recommendations.

The local outbreak of COVID-19 delayed strategy implementation in some areas, but notable achievements include the completion of the five maternal and child hubs announced in the strategy, and appointment of a strategy implementation project manager to lead the signalled improvements across the sector. A series of community engagement and consultation workshops were also held in the Central Otago area regarding the preferred location of a new Primary Birthing Unit: after a detailed assessment of the themes and feedback it is expected that a decision regarding the placement will be made early 2020/21 with implementation following suit.

System changes also occurred directly as a result of the COVID-19 outbreak. For example, we saw a large increase in families choosing home-births as their preferred option; antenatal obstetric clinics transitioned to an almost full telehealth model; and facilities rapidly reconfigured to ensure the safety of families. A series of stakeholder engagement sessions were also completed late in the financial year: these sought to quantify the impact of COVID-19 on stakeholders, consolidate learnings, assess the changes that were considered beneficial and ought to be retained, and identify opportunities for further improvements and resilience in the system of care.

A final area of significant performance improvement is in the space of reducing the rate of third and fourth degree perineal tears. Between 2017 and 2019, there was a 20 per cent drop, from 3.5 per cent to 2.8 per cent of all vaginal births. This progress has been as a result of concerted efforts in education, training and practice changes, culminating in improved outcomes for women in our district.

2019/20 Performance Results for Maternity Services

Measure		2017	2018	2019		
		Actual	Actual	Target	Actual	
The number of births in the DHB region	Total	3,312	3,119	3,400	3,439	
	Māori	517	481	560	543	
Percentage of pregnant women registered with a Lead Maternity Carer in the first trimester	Total	78.1%	78.9%	>80%	79.2%	●

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 AT&R services in Dunedin have made substantial changes in ward 6AT&R over the past 12-18 months which has resulted in significantly improved outcomes for older patients. This included the introduction of the four bed Older Person's Assessment and Liaison (OPAL) unit, which provides a streamlined admission and assessment pathway, facilitating a quicker return home. This was enabled by the whole team – medical, nursing, allied health, and management – co-designing and implementing a new team-based model of care.

The impact of this has been significant for patients, families and staff. Length of stay in the AT&R ward has reduced by nearly four days, and functional improvement has increased. This was achieved with 24 beds, eight fewer than the previous year. Working closely with the Home Team, a greater number of older people have been able to remain in their own homes.

The Older Person's Health team responsible for 6AT&R were recognised in the Southern Health Excellence Awards as the Team of the Year, and OPAL was runner-up in the Innovation of the Year. Southland AT&R were also recognised for the second year running in the national AROC quality forum as the top rehabilitation service in New Zealand.

Patients under 65 years receive rehabilitation at Wakari Hospital. Admissions are predominantly for stroke, traumatic brain injury, and major trauma. The total number of patients is relatively small but are a very complex patient group. Length of stay can vary considerably, but the gains in physical functionality are most important to the patient.

2019/20 Performance Results for Assessment, Treatment and Rehabilitation Services (AT&R)

Measure		2017/18	2018/19	2019/20		
		Actual	Actual	Target	Actual	
Average length of stay for inpatient AT&R services	<65 years	21.8	25.4	<21.8	28.2	●
	>65 years	20.2	21.2	<18.5	16.4	●
AT&R patients have improved physical functionality on discharge	<65 years	26.1	24.3	>26.1	29.4	●
	>65 years	18.3	19.7	>18.3	21.4	●

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 are continuing to perform well and maintain access levels close to the target, with access for Māori well above target levels.

Improving transition planning continues to remain a priority and is a work underway to improve our performance in this area. The focus during 2019/20 saw an increase in staff education, development of revised discharge templates and supported pathways. Quarterly performance has improved on past results as a result of these changes, however continued work is required in this area to meet our target levels of performance.

Major strategic developments have also occurred. Firstly, following the refresh of our Southern Strategic Plan for Mental Health and Addiction Services, 2019/20 saw expanded stakeholder engagement with the broader mental health network leadership and sector planning groups resulting in the development of new action plan for implementation in the coming months. While COVID-19 delayed implementation, this action plan is expected to be rolled out in 2020/21.

Further, in response to He Ara Oranga (the government inquiry into Mental Health and Addiction), 2019/20 saw Southern investing greater amounts in a range of mental health services. These included expanded funding for postvention; increasing mental health education resourcing in Emergency Departments; increased funding for adult and youth forensic services; and implementing an "Access and Choice" RFP. This RFP/model of care is designed to see greater options for patient support in primary care – for example health coaches and health improvement practitioners – and following the planning work that was undertaken this year, the model is expected to be rolled out in 2020/21. Planning work is also well underway to pilot GPSIs (General Practitioners with Special Interest) with an expanded mental health scope to improve options available to communities and individuals in need.

2019/20 Performance Results for Specialist Mental Health Services

Measure		2017/18 Actual	2018/19 Actual	2019/20 Target	2019/20 Actual	
Percentage of young people (0-19 years) accessing specialist mental health services	Total	4.30%	4.40%	>3.75%	5.29%	●
	Māori	4.90%	4.90%	>3.75%	6.02%	●
Percentage of adults (20-64 years) accessing specialist mental health services	Total	3.80%	3.70%	>3.75%	4.33%	●
	Māori	7.70%	7.50%	>5.22%	8.96%	●
The percentage people who have a current transition (discharge) plan	Total	30%	29%	>95%	54%	●
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	67%	58%	>80%	70%	●
	<8 weeks	84%	81%	>95%	88%	●

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 and Community Support Services (HCSS) for older people is now well-established. InterRAI assessments are a clinical assessment tool used to ensure clients are receiving support packages corresponding to their needs and goals, and to assess eligibility for rest-home level care.

If patients are complex (high-need) these assessments are usually undertaken by DHB or rural hospital clinical needs assessors. If patients are non-complex (lower levels of need) these assessments are undertaken by their HCSS providers.

In 2019/20, 99 per cent of clients who received long-term HCSS had an assessment undertaken. As a result of COVID-19 lockdown levels, some of these assessments were required to occur using the telephone and virtually.

2019/20 Performance Results for Needs Assessment & Service Coordination (NASC)

Measure		2017/18	2018/19	2019/20		
		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	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. In addition to increasing numbers of older people, 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 86 per cent of our HCSS Support Workers with a Level 2 or greater qualification. This has increased on the year prior (82 per cent). Pay equity legislation has supported this education. Our clients benefit from a well-trained workforce, especially our older people in their homes have increasing frailty and chronic health conditions. Training for support workers is not limited to national qualifications, but also includes other forms of training such as to identify when things have changed for their clients, and when to seek additional support.

We continue to provide supports in the community to an increasing number of older people, many of whom are continuing to live independently with minimal supports in our restorative service.

Service delivery changed during COVID-19 Alert Levels Three and Four, with a number of support workers unavailable to work, increased family support available to older people, and a desire by many older people to limit the number of people in their bubbles.

2019/20 Performance Results for Home and Community Support Services

Measure		2017/18 Actual	2018/19 Actual	2019/20 Target	2019/20 Actual	
Total number of eligible people aged over 65 years supported by home and community support services (HCSS)	Total	4,464	4,565	>4,400	4,474	●
The percentage of HCSS support workers who have completed at least Level 2 in the National Certificate in Community Support Services (or equivalent)	Total	76%	82%	>80%	86%	●

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 CLIC programme (Client Led Integrated Services) is now implemented in almost all of the 83 general practices across Southern. The CLIC initiative means that more patients have been assessed for falls and fracture risk. By allowing this approach, we have reached 1,865 patients in the last year, which was more than predicted.

The growth in assessments is positive and will continue to grow as the CLIC assessments are refined and become embedded into all general practices. The opportunities to prevents falls and fracture is significant, however we also know more work is needed especially around proactive bone health and referrals from general practice for strength and balance. This is an area we are working on and hope to have more good news next year.

2019/20 Performance Results for Rehabilitation Services

Measure		2017/18 Actual	2018/19 Actual	2019/20 Target	2019/20 Actual	
Number of people assessed by the GP (primary care procedure) for fracture risk using the portal	Total	849	2,108	>1,050	1,865	●

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 an ongoing success story for the community services at Southern DHB including our Home and Community Support Services, our HOME Team, our specialist nursing services and our Home as My First Choice campaign. Mostly, however, it is a success story for the older members of our community who are able to Age in Place, in their own homes.

InterRAI assessment performance fluctuated significantly this year due to COVID-19. While our results earlier in the year averaged well over 90 per cent, and met or exceeded the national averages, our final quarter result was poor. Home Care Assessments are usually done in the person's home. However, to keep older people safe and comply with lockdown regulations, our Clinical Needs Assessors used the interRAI Contact Assessment over the phone with older people. We have since returned to using the Home Care Assessment in people's homes.

2019/20 Performance Results for Age-Related Residential Care

Measure		2017/18	2018/19	2019/20		
		Actual	Actual	Target	Actual	
Number of Rest Home Bed Days per capita of the population aged over 65 years	Total	6.70	6.11	<6.8	5.8	●
Percentage of aged care residents who have had an InterRAI assessment within 6 months of admission	Total	97%	93%	>95%	89%	●

Reporting period reference table: output measures

The following table provides a guide to the reporting periods for the output measures used in the Statement of Service Performance.

Measure	Period value represents
Percentage of children fully immunised at age 8 months	Annual performance*
Percentage of children fully immunised at age 2 years	Annual performance*
Percentage of eligible girls and boys fully immunised with HPV vaccine	Annual performance
Percentage of people (≥ 65 years) having received a flu vaccination	2019 flu season
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	Annual performance*
Infants exclusively or fully breastfeeding at 3 months	Annual performance (calendar year)*
Percentage of 4 year old children receiving a B4 School Check	Annual performance
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	Annual performance
Percentage of eligible women (50-69 years) having a breast cancer screen in the last 2 years	Previous two years
Percentage of eligible women (25-69 years) having a cervical cancer screen in the last 3 years	Previous five years
Percentage of eligible preschoolers enrolled in community oral health services	Annual performance (calendar year)
Percentage of children caries-free at five years of age	Annual performance (calendar year)
Avoidable Hospital Admissions rates for children (0-4 years)	Year to Q3
Number of people receiving a brief intervention from the primary mental health service	Annual performance
Percentage of the eligible population who have had a CVD Risk Assessment in the last 5 years	Previous five years
Percentage of the population identified with diabetes having good or acceptable glycaemic control	Annual performance
Percentage of accepted referrals for Computed Tomography (CT) scans receiving procedure within 42 days	Annual performance
Percentage of accepted referrals for Magnetic Resonance Imaging (MRI) scans receiving procedure within 42 days	Annual performance
Percentage of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within 2 weeks	Annual performance*
Percentage of young people (0-19 years) accessing specialist mental health services	Year to Q3
Percentage of adults (20-64 years) accessing specialist mental health services	Year to Q3
Percentage of people who have a transition (discharge) plan	Year to Q3
Percentage of people (0-19 years) referred for non-urgent mental health or addiction DHB Provider services who access services in a timely manner	Year to Q3
People are assessed, treated or discharged from ED in under 6 hours	Annual performance*
Number of people presenting at ED	Annual performance
Number of elective surgical service discharges	Annual performance
Percentage of elective and arranged surgery undertaken on a day case basis	Annual performance*
Percentage of people receiving their elective and arranged surgery on day of admission	Annual performance*
Number of elective surgical services (CWDs) delivered (elective initiative)	Annual performance
Number of maternity deliveries in Southern DHB facilities	Annual performance (calendar year)
Percentage of pregnant women registered with a Lead Maternity Carer in the first trimester	Annual performance (calendar year)
Average length of stay (days) for inpatient AT&R services	Annual performance (calendar year)
Patients have improved physical functionality on discharge	Annual performance (calendar year)
Percentage of aged care residents who have had an InterRAI assessment within 6 months admission	Annual performance*
Percentage of people ≥ 65 years receiving long-term home support who have a Comprehensive Clinical Assessment and an Individual Care Plan	Annual performance*
Total number of eligible people aged over 65 years supported by home and community support services	Average annual performance
Percentage of HCSS support workers who have completed at least Level 2 in the National Certificate in Community Support Services (or equivalent)	Snapshot reported as at 30 June
Number of people assessed by the GP (primary care procedure) for fracture risk using the portal	Annual performance
Number of Rest Home Bed Days per capita of the population aged over 65 years	Annual performance

Annual Performance refers to financial years unless otherwise specified. Past year values for those measures with * are Q4 performance values. The measure period has been updated for 19/20 to include the whole year performance values.

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, applying a health lens to our legislative and policy framework. 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.

In doing so over 2019/20, the first six months were business as usual, plus a focus on how to structure our service to better deliver on our aims to improve, promote and protect the health and wellbeing of populations and to reduce inequities. This was suddenly disrupted during the second half of the year, from January to June 2020, as the emergence of a global pandemic saw the public health unit at the front-line of the COVID-19 response.

Southern DHB's public health unit, Public Health South, has faced probably the most extraordinary public health challenge in a century during the 2019/20 year.

COVID-19 public health response

News of the Novel Coronavirus (Wuhan) began emerging in January, and public health staff were quickly brought in to the daily monitoring, discussions and planning as the virus began to spread first inside China and then across the world.

The Public Health Unit set up an Emergency Operation Centre to co-ordinate public health activities as part of the district's wider COVID-19 response, in recognition of how complex, demanding and sustained their role was likely to be.

Public health staff around the district undertook several essential roles. This included meeting flights into the districts international airports, working at ports with cruise ships and commercial shipping, and working as contact tracers. Staff played a key role and in following up Covid19 cases and identifying and following up their close contacts. This included daily checks to ensure people remained isolated and check on their health.

Staff also played a key role in providing public information reinforcing what was required at the different alert levels and reinforced messaging around testing, cough and sneeze hygiene and physical distancing.

Throughout the COVID-19 response, public health staff worked closely with WellSouth, GP practices, hospitals and aged care facilities.

In addition to following the progress of each suspected COVID-19 patient, cluster and community, the Medical Officer of Health was the public health spokesperson for the COVID-19 response in the district, and involved with daily messaging to staff, stakeholders and the public, both advising and encouraging safe practices around physical and mental wellbeing.

The first wave of COVID-19 in Southern resulted in 216 COVID-19-positive patients throughout the district and sadly, two deaths. The Alert Level 4 lockdown, stringent testing, rigorous contact tracing and community co-operation around hygiene and physical distancing helped us eliminate COVID-19 in the Southern District, with the last two cases reported on 18 April.

With the virus continuing to spread across the globe, the public health team has undertaken intensive planning for further outbreaks. This has included ensuring contact tracing capacity to meet standards set by the Ministry of Health.

At the time of writing, community testing continues, as does public health's encouragement to maintain good hygiene practices and physical distancing. Public health staff continue to be involved in the ongoing COVID response and it looks as though that will remain the case for the foreseeable future.

Measles

COVID-19 has not been alone as a serious infectious disease requiring attention in the past year. The Queenstown measles outbreak required a significant and prolonged response, with 74 confirmed cases and hundreds of people contact-traced during this time. The Southern measles outbreak was declared over on 22 December 2019. Public Health South staff from throughout the service were heavily involved in all levels of the response including supporting the Emergency Operations Centre, case management and contact tracing, supporting vaccination clinics, management of MMR vaccine distribution and communications with the public as well as primary care. This has greatly impacted on our ability to continue some programmed work in this reporting period with some work not being completed or significantly delayed.

Pēhea Tou Kāinga – How's your Home?

The research report Pēhea Tou Kāinga – How's your Home? was released in 2019. Public Health South undertook this work to understand the health impacts of housing and inform evidence-based action. Findings showed significant concerns about housing shortages and that housing is a key contributor to poor health outcomes and inequity in Central Otago. One of the key recommendations from the report was to form a multi-agency taskforce and develop a Central Otago Housing Action Plan. Following this a multi-agency housing meeting took place in Alexandra in late November, bringing together key stakeholders to discuss the report findings. Participants included representatives from several government and non-government agencies and Queenstown Lakes and Central Otago District Councils. While the report was initiated by Southern DHB and the outcomes are health related, the levers to make a difference are not controlled by Southern DHB. By working together, we can better influence the decision-making required to make positive changes to the housing situation in the Central Otago and Queenstown-Lakes districts.

Supporting accessible outdoor spaces

Community parks and reserves are important aspects of a healthy environment. However, not all are accessible for people of all levels of ability, such as older and disabled people, and those using pushchairs, limiting their opportunities to benefit from these spaces. Public Health South, working with CCS Disability, used an evaluation tool developed by the Parks for Activity and Recreation in the Community Study (PARCS), to audit the built environment in the upgraded Caversham Reserve in Dunedin. Results showed that the reserve entrance and recently installed picnic tables and seating are not accessible.

The DCC is currently looking at making changes to the built environment to make it more accessible to people with disabilities and families with push chairs. Drinking fountain/bottle filler guidelines were developed to guide the purchase, and work to promote installation of accessible drinking fountains has continued. A new accessible drinking fountain was installed in Caversham Reserve, and Public Health South has also been working with Invercargill City Council, Southland District Council and Gore District Council on this initiative.

Towards a smokefree society

In November two one-day vaping seminars were held in Invercargill and Dunedin. Presentations included smokefree legislation, research, awareness of vaping as a way to stop smoking, and a masterclass on vaping by local vaping retailers. The seminars included a focus on how vaping can be used as a harm reduction tool that can help some people stop smoking, with 76 per cent of respondents agreeing the seminar increased their confidence in talking about vaping with patients or clients.

Queenstown Lakes District Council (QLDC) approved a smokefree beaches trial running from 16 December 2019 to 31 March 2020. The QLDC councillors took the proposal further and included vaping. The purpose of the trial was to test which outdoor spaces may become smokefree in the future. It aimed to discourage smoking at four destination beaches in Queenstown, Wanaka, Frankton and Glenorchy, and focused on education and awareness rather than taking a punitive approach. Support for this trial, plus the evidence from the Fresh Air Project (2018-19), will help QLDC to draft and enact a new smokefree policy for QLDC in 2020.

Primary and Community Care

Goals from the Southern DHB- WellSouth Primary and Community Care Strategy, launched 2018.

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

Ensuring care is accessible, coordinated and delivered closer to home remains central to our progress as the Southern Health System.

We began the year continuing to make significant progress implementing the Southern DHB-WellSouth Primary and Community Strategy and Action Plan, which is our guiding blueprint for the future of services in the Southern district.

As COVID-19 emerged in China and began to spread rapidly, our primary and community services realised the importance of planning the safe and effective delivery of services, where possible, in the community under lockdown conditions.

The restrictions imposed by COVID-19 triggered a truly all-of-system response, as primary, community, secondary and tertiary services all worked together to care for our patients and support each other in this rapidly evolving situation.

New methods of working, such as using electronic communications for consultations, additional use of PPE and safety precautions, new policies and procedures were quickly implemented to keep staff and patients safe.

With the return to lower alert levels, we resumed full services, still mindful of the threat of COVID-19 and the need to support the Government's efforts to eliminate it. We also resumed our work implementing the Primary and Community Care Strategy and Action Plan, most notably with consultation over the location of primary birthing facilities in Central Otago.

We thank our community and health partners for their patience and support during this extraordinary year which, while unprecedented, certainly brought us together to work and support each other even more closely.

Transforming our health system

2019/20 commenced with a renewed focus on the collaborative work that needs to underpin a truly integrated health system. In Quarters One and Two, a series of workshops were undertaken in partnership with WellSouth PHO, with representation from across the health system including primary and secondary care, our rural hospital network, Māori health providers and many others. The goal was to bring together the roadmaps underpinning both the Primary and Community Care Strategy and Action Plan, and planning for the New Dunedin Hospital – both of which envisage care being delivered in new ways in the future.

These set a strong foundation, leading to greater clarity for the future direction of Community Health Hubs, better processes for developing new models of care, and stronger conversations and relationships needed to reshape the health system together.

Alliance South

Alliance South has continued to be the vehicle by which collective priorities across the DHB and our Primary Health Organisation partner WellSouth are determined. Alliance activity is overseen by the Alliance Leadership Team, which transitioned to a new Chair in 2020 and is now headed by former WellSouth Chair Stuart Heal.

Alliance activity, like many other key strategic projects, struggled to maintain the pace of desired change when our COVID-19 response was at its peak. This was heightened by the fact that senior clinical and management roles within the Alliance became responsible for our front line COVID-19 delivery response, across either swabbing or contact tracing programmes.

Despite this, the key deliverables of the 2019/20 Alliance work programme are further outlined below but have broadly encompassed the second phase of the roll out of Healthcare Homes, the establishment of the Central Lakes Locality Network and oversight of the implementation of the Integrated Primary Maternity System of Care.

In the 2020/21 year we look forward to progressing our reinvigorated work programme, which concentrates our efforts across a smaller number of key areas. This year will also see the first of the substantial evaluation components completed which will give the Alliance Leadership Team valuable insight into the difference that the Primary and Community Care Strategy is making on the Southern population.

Health Care Homes

Since the start June 2019 a further six general practices have joined the programme, taking the total number to 14 participating throughout the Southern district.

Practices in the programme include: Amity Health Centre, Gore Health, Gore Medical Centre, Queenstown Medical Centre, which were the initial participants in Tranche 1a; Aspiring Medical Centre, Broadway Medical Centre, Junction Medical Centre, Wanaka Medical Centre, which joined in November 2018 as Tranche 1b; and Health Central Medical Centre, Clutha Health First, Invercargill Medical Centre, Te Kaika Caversham, Mornington Health Centre and North End Health Centre, which joined in June 2019 as Tranche 2.

COVID-19 had a huge influence on general practice. Feedback from Health Care Home (HCH) practices was largely that the programme prepared them well for COVID-19, especially regarding organised change teams and processes. Like most practices, the HCH practices experienced significant patient and staff stress in June due to the cumulative effect of COVID-19 and patients returning in person to practices. COVID-19 especially impacted virtual consultations (which were largely by telephone, not video). Practices were required to work virtually in Levels 4 and 3, and subsequently have become more open to working in this way. Overall, telephone consultations reduced in May/June as New Zealand moved back down alert levels.

With the Health Care Home programme now in its second year, we are seeing the transformative impact of the initiative in our district.

- Admission rates to acute care are lower, and the gap is widening between HCH practices and non HCH practices. This is likely due to a number of aspects of the programme, including GP triage. This frees up time, resulting in daily acute appointments being held within the HCH practices.
- GP triage has resulted in some significant efficiencies in the system with a range of routine issues resolved over the phone, avoiding time-consuming and unnecessary face to face visits. We expect further gains in this area with increased use of virtual consultations, e-prescriptions and e-lab orders.
- Triage in primary care has also resulted in changes to the use of nursing workforce. Nursing is delivering more consultations to patients as they are triaged to an appropriate provider.
- Overall, the HCH programme has a greater number of consultations occurring virtually, again evidence of more flexible approaches to providing care.

Community Health Hubs

A new project for the development of Community Health Hubs has been presented to Alliance South. The aim of the project is to identify, design and implement a new set of delivery solutions within community settings all across the District to bring together primary and secondary teams in a way that adds additional value to the community.

Our aims is to reduce the inequity gaps, particularly for Māori, by improving the connections between services. Through targeted intervention we want to identify vulnerable populations and improve their health outcomes.

Next steps will include:

- Establishing a group of integrated care champions to begin to socialise what integrated care services, delivered in communities could begin to look like.
- Drafting a 2020/21 work programme outlining what the key priorities for the first 12 months of hub development will look like.
- Undertaking expressions of interest across General Practice/primary care to gauge interest in the sector to deliver integrated care services in a community setting, including capital requirements.

Mental health and addictions

The Southern Primary and Community Care Strategy and Raise Hope – Hāpai te Tūmanako 2019-2023, which was endorsed this year, have painted a clear direction for our mental health and addiction services.

A key first step is an independent review of the Southern Mental Health and Addiction System which will commence early in the 2020/21 year. The Southern Mental Health and Addiction System, led by the Mental Health and Addiction Network Leadership Group, includes primary mental health and addiction for people experiencing mild to moderate distress and concerns, through to specialist mental health and addiction services provided by the DHB along with a number of NGOs for those most severely affected by mental illness, addictions or intellectual disability.

This year has seen the implementation of He Ara Oranga, with investment particularly in primary mental health giving increased options for young people and adults experiencing mild to moderate mental health concerns in our community. A range of services are provided including crisis response, assessment, diagnosis and treatment. Utilisation rates are monitored across ethnicities and age groups to ensure service levels are maintained and to demonstrate responsiveness.

Services have had a busy year with all areas reporting increased demand. Access to specialist services has increased across all ages and is significantly above the target access level, with services for Māori well above target levels. Services are more responsive, with more people this year being seen within eight weeks of referral. The number, acuity and complexity of referrals received, combined with the impact of COVID-19 restrictions, all impact on services' ability to respond in a timely way. During COVID-19 mental health and addiction services quickly moved to delivering 80 per cent of activity by telehealth, and maintained 75 per cent of contacts as for the same time in the previous year. Recruitment and retention of a specialist workforce continues to be a challenge.

Inpatient occupancy averaged 83 per cent across the year and, while slightly down on the previous year, all inpatient areas have found it hard to meet demand at times, often flexing up to close to or over 100 per cent. The average length of stay and readmission rates overall are consistent with national averages.

Work towards improving transitions (discharge planning) through participation in the HQSC project Connecting Care Improving Transitions has been successful, with 100 per cent of people discharged from inpatient care and 82.6 per cent of people in the service for a year or more having a transition/wellness plan in place. This is a marked improvement on the 2018/19 year.

Southern HealthPathways

At the end of the 2019/20 year 684 Pathways are now live in Southern DHB and there has been an average of 30,634 (2018/19) page views per month on the HealthPathways site.

HealthInfo, the patient focused information website that supports HealthPathways, was introduced in the Southern district in December 2019. At the end of the 2019/20 year there has been an average of 1,888 page views per month.

With the localisation programme of both HealthPathways and HealthInfo well underway, work has continued on the three yearly review of pathways.

COVID-19 resulted in a change of focus from our planned work programme to the development of COVID-19 specific pathways that included information and management for Aged Residential Care activity, Palliative Care and Paediatrics.

To support fully integrated clinical networks across the Southern Health system and build on the collaborative and collegial approach, the HealthPathways team have continued to encourage and support the establishment of workgroups. This has covered a wide range of specialities that has included areas such as Mental Health, Addictions and Intellectual Disability, Oral Health, Skin Lesions, Public Health and Infection Prevention and Control.

Primary maternity

A significant area of focus this year has been the implementation of the Integrated Primary Maternity System of Care, and work to deliver on its nine actions continued throughout 2019/2020.

In October of 2019 the Executive Leadership Team commissioned an independent review to ascertain what had gone well in the first year of implementation, and what lessons we could take forward into the next year. There was also a review undertaken of several rapid births following the contested downgrade of Lumsden Primary Birthing Unit to a Maternal and Child Hub. Following the recommendations of the review of the strategy implementation, the DHB strengthened the professional and project management support to the implementation of the strategy with the appointment of a Project Manager.

The Integrated Primary Maternity System of Care aimed to take a holistic view and to direct resources differently, and increase the reach of services across the whole district. In December 2019, all five Maternal and Child Hubs had been established and created an additional layer of support for midwives in those communities. Maternal and Child Hub Coordinators were funded in Lumsden and Wanaka to support the utilisation and coordination of the hubs for midwives and women.

The appointment of the coordinator in Lumsden and continued stakeholder engagement has been important as the community adjusted to the change from a Primary Birthing Unit to a Maternal and Child Hub. There has been greater utilisation of the Hub space and the local midwives agreed on an E-text network to keep in touch and problem-solve in emergencies. To further support the area, a leaflet was designed and shared with 22 local organisations that outlined the services available at the Lumsden hub and the midwives available in the Northern Southland area.

Improving communication and consultation remained a strong theme in our work this year. Two pamphlets were produced to improve the information available to women and families for decision-making. The Early Engagement leaflet encourages women to engage with a midwife as soon as they are pregnant. Production of this leaflet involved engagement with nine community agencies serving Pasifika and Māori women throughout the district. The *Your Options* pamphlet was produced to help women and families make informed decisions about place of birth and inpatient postnatal care. This aligns with our goal to promote primary birthing options for well women having uncomplicated pregnancies, and for rural women to know their closer-to-home options for inpatient postnatal care.

We also continued to invest in the sustainability of the remote rural workforce.

Additional 'sustainability' payments continued with 37 midwives across the district taking up this additional remuneration, and around $450,000 in payments made since the scheme was introduced in 2018.

Our Covid-19 response including providing support to primary maternity facilities in terms of advice, identifying pathways of care for women who were impacted, coordinating PPE gear and sharing national body information to ensure a coordinated and consistent response across the district.

Looking towards the future, work began on determining the best location for primary maternity facilities for Central Otago/ Wanaka, starting with an initial round of public consultation that resulted in over 330 responses.

Former refugee support

Southern DHB, in tandem with other service providers, was able to provide resettlement support for a new ethnicity in Dunedin – refugees from Afghanistan.

Internationally, former refugees are noted as being at risk for negative health outcomes that are often a result of poor access to and engagement with health care. Appointment attendance is used to gauge engagement with healthcare. For 2019/20, former refugees across Southern DHB (Dunedin and Invercargill) have attended 97 per cent of their healthcare appointments. The attendance rate for the general population is 92 per cent. This success can be attributed to components of the refugee health model such as WellSouth Health Navigators, face-to-face interpreting and Cultural and Linguistic Diversity (CALD) training for staff.

Southern DHB and WellSouth leveraged social media during the COVID-19 lockdown by communicating with former refugees via WhatsApp. We also collaborated with Dunedin City Council (DCC) in producing lockdown announcements and information in Arabic, Chinese and Dari. These were disseminated via OAR Radio, DCC website, WhatsApp and Chinese WeChat.

In response to increases in mental health needs across all resettlement populations, videos were also produced by Southern DHB and WellSouth in Arabic, Dari and Spanish and shared across social media. The responses from former refugees have been favourable.

Clinical service redesign

Work continues on a range of initiatives to deliver our services in ways that value the time of those using them in our hospitals and beyond.

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

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

Over the past year the role and function of the Clinical Council has been reviewed, and a new Clinical Practice Committee and Mortality Review Committee has been established. This means clinicians, managers and other staff now have more pathways to work together to help improve the provision of safe patient care and our patients' experience and outcomes. The Clinical Practice Committee looks at the safe introduction of new techniques and technologies that advance our service provision.

We've also seen our teams adapt as we continue to manage healthcare during the COVID-19 outbreak, and a success story has been the use of telehealth enabling patients to continue their care during the lockdown in March and April. Telehealth was such as success that it is being rolled out across our hospitals.

Beyond our hospitals an ongoing focus is the provision of more timely care by better integration between the primary and secondary care sectors, and through the Primary and Community Strategy we continue to work with Primary care partners on its implementation.

Looking forward, the new Dunedin Hospital rebuild brings new and exciting opportunities to use our successful change initiatives to plan how healthcare will look in the future and effectively manage the increasing demands on health services in the best possible way.

Telehealth rolls out

Pictured: Patient Janice McDrury having a telehealth consultation with Prof Patrick Manning

The COVID-19 lockdown saw an increased use of telehealth across our services with positive feedback from patients and staff. Following this success, a steering group and an interest group with over 70 representatives from across the Southern Health system has been set up to look at how to use telehealth in the best possible way in the future. The project is rolling out Microsoft Teams as the common platform to services, the booking system continues to be streamlined, staff are being trained, and patient information is being updated. The group want to improve access for health care professionals and patients wherever they are in the district. In the long term they want to see patients able to consult with their clinician from home, the office or a clinic nearer to home.

Less travel for cardiac patients

Pictured: Patient Derek McKinnel and his wife Helen during his recovery after having an ICD fitted at Dunedin Hospital

A successful application to the Clinical Practice Committee means that Southern DHB cardiac patients can now have an Implantable Cardioverter/ Defibrillator (ICDs) fitted in Dunedin rather than having to travel to Christchurch for the procedure.

The cardiology team are able to provide a better service for patients and value their time, the procedure is more cost effective, staff have been able to upskill, and having the ability to fit ICDs is a positive factor for the future recruitment of new staff members to the team.

Bowel screening programme success

Pictured: The Southern DHB's National Bowel Screening Programme marked its second anniversary in April. To the end of June, the programme detected 177 cases of bowel cancer across the district, and identified a further 1267 patients with polyps, which can develop into cancer over time.

Southern participation rates remain high at 73 per cent overall, compared with 61 per cent nationally. Notably, Māori participation is at 75 per cent in the south – considerably higher than the national rate of 55 per cent. It is pleasing to note that Māori participation in the Southern district has equalled or exceeded overall participation every month since the programme began.

Improvement Academy empowers staff

Pictured: enthusiastic staff at a training session

Southern DHB has set up an Improvement Academy to encourage and empower staff to improve the systems around them. At the beginning of 2020, Southern DHB staff were offered a fully funded part time improvement course from the Institute for Healthcare Improvement (IHI) leading to a Basic Certificate in Quality and Safety. Only 50 places were initially available, but after overwhelming interest, funding was expanded to allow over 250 staff to enrol on the course. Having so many staff who will have the tools and enthusiasm for change is exciting progress in our journey to embed quality and safety in everything we do. The DHB looks forward to offering the course again next year.

OPAL unit goes from strength to strength

An Older Person's Assessment and Liaison Unit (OPAL Unit) at Dunedin Hospital continues to support older patients to receive the best support and treatment in the best place.

A multidisciplinary team is able to assess patients in one ward and either discharge them with support, or support them with their recovery in hospital.

KEY STATS

Between 1 July 2019 and 30 June 2020

- 225 patients went through the OPAL unit and received a Comprehensive Geriatric Assessment (CGA) carried out by the interdisciplinary team (medical, nursing and allied health).
- 63 admissions came direct from the community. These patients were able to bypass ED completely and avoid delays prior to getting to an OPAL bed. The remainder came via ED – avoiding admission to internal medicine or other acute wards.
- 70% of patients coming through OPAL are discharged back to their home (this includes going back to the same level of care if from residential care originally)

Theatre assistant improves efficiency

Pictured: Some of the Theatre 6 cataract team

Simple changes can make a big difference to our patient experience. A designated theatre suite assistant (TSA) for theatre 6 at Dunedin Hospital has made such a difference to patient flow that the team are now operating on 14 more patients a month than last year, an approximately 20 per cent increase.

Bringing care to patients' homes

More patients continue to be leave hospital sooner and recover at home thanks to the Home Team in Dunedin and Invercargill. The team of nurses, physiotherapists, social workers and rehabilitation assistants provides appropriate and coordinated support to patients.

KEY STATS

Between 1 July 2019 and 30 June 2020

- The Home Teams in Dunedin and Invercargill received a total of 2048 referrals
- The Dunedin team made an average of 660 patient visits per month
- The Invercargill team made an average of 117 patient visits per month

Sustainability

Towards a greener health-care system

Continued progress is being made to pursue our goals of delivering health care in a way that also supports the health of the planet. The DHB has joined CEMARS (Certified Emissions Measurement and Reduction Scheme) by Enviromark™ to measure and reduce annual greenhouse gas emissions. We continue to work towards zero coal consumption and reduced electricity usage, and have joined the Dunedin Energy Leaders Accord to support collaborative efforts in use energy more efficiently in the city. A waste audit and stocktake of recycling facilities has been undertaken, with initiatives identified to reduce waste across the organisation. We continue to transition the staff vehicle fleet to electric vehicles (EV) and hybrids, with 18 per cent of the fleet now in this category, and have also supported and promoted the government's e-bike initiative among staff. Opportunities to improve environmental impacts are taken into consideration across our building and maintenance programme, including the design of the new Dunedin Hospital. This not only includes physical building, but the opportunities to introduce greater digital architecture and new ways of working. Critically, significant investments are being made in the Digital Hospital Strategy, focused on the needs for the New Dunedin Hospital, with a vision of reducing paper use across the health system.

Hearing from our Communities

Report from Community Health Council – Empowering community, whānau and patients

The Community Health Council (CHC) is 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 11 community members from a range of backgrounds and experiences, and Mrs Karen Browne was appointed Chairperson February 2019.

A key highlight for the 2019/20 year was hosting the first CHC Symposium for CHC advisors in Dunedin, October 2019. The purpose of the Symposium was to celebrate the achievements of the CHC since it was established. This included overviewing the engagement activities that have occurred since the launch of the CHC Engagement Framework and Roadmap. It was a time to reflect with both staff involved in engagement activities, and CHC advisors and ask the question of how we know the engagement occurring is genuine and that is not a tick box exercise.

The event was well attended and positive feedback was received from both staff and CHC advisors. Some roadshows were scheduled to occur around the district to share learnings from the Symposium but this was cancelled due to COVID-19.

As the year has progressed, so have the number of projects the CHC advisors have become involved with. A summary of engagement activities for the 2019/20 year are outlined on the CHC webpage.

Another exciting aspect this year has been the engagement with the new Dunedin Hospital which continues to be a large, long- term and complex project.

Future Plans

As we move into 2020/21 the Health Quality and Safety Commission has developed a new Quality Safety Marker focused on consumer engagement, which all DHBs are expected to report on. This will allow some benchmarking between DHBs as well as sharing of ideas. The CHC believes Southern DHB is in a particularly good position based on the work undertaken with developing the CHC Engagement Framework and Roadmap.

Other work on the horizon, which again was temporarily delayed with Covid-19, is profiling some Clinical Champions in the Southern district who have willingly engaged with CHC advisors and learn from them about their experiences. The CHC has also developed some resources from the Symposium about learnings from CHC advisors and staff about engagement and these will be shared on the website.

Read more about the Community Health Council in their full annual report which can be found at: www.southernhealth.nz/community-health-council

Report from the Central Lakes Locality Network

Health services oriented to local communities

The Central-Lakes Locality Network (CCLN) is a skill based committee of clinicians and community members that represent the Central-Lakes community interests to Alliance South (Southern DHB and WellSouth PHO). Our vision is for health services that are oriented to local communities; alongside Health Care Homes (general practice led) and Community Health Hubs (integrated services).

Since August 2019, CLLN has been partnering with Queenstown Lakes District Council, rural hospitals, public and private health providers to understand the issues for community and health services specific to the Central-Lakes area.

During this time, we have learned that there is value in having a locality based, independent view of health services and that gaining relevance with community and providers takes time. The Central-Lakes region has unique challenges with equity of health outcomes and access to health services; due to growing population in a rural geography, lack of health infrastructure and health service limits.

Key work during this period has been partnering with Southern DHB in community consultations to decide the location of a new Primary Birthing Unit. CLLN have worked with the project team to consider the community need, analyse options and will recommend a location to the DHB Board in November. This is an opportunity to invest in infrastructure and design a model of care that improves safety and quality of care for families in Central-Lakes.

With the release of the Alliance South Work plan for 2020, CLLN have identified three new work streams relevant to Central Lakes to support: planned care, rural health and care coordination. At the same time, CLLN will continue to support the work in Locality Networks, Community Health Hubs, Health Needs Assessment and implementation of the Primary and Community Care Strategy. While the role of CLLN is still evolving we are an active team with more to offer in supporting Alliance South and the Central-Lakes community.

Central Lakes Locality Network Chair Helen Telford

Engaging online

A new website has been established to make engaging with our communities easier. It has supported hearing views about planning for the new Dunedin Hospital, the location of primary maternity facilities in Central Otago/Wanaka, and the Southern DHB Disability Strategy.

Visit it at **www.engage.southernhealth.nz**

The Community Health Council for the Southern health system

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.

This section of the report – Improving Patient Experiences and Quality of Care – includes the Serious Adverse Events reported at Southern DHB during 2019/20. It also outlines processes for gaining feedback from our patients and communities, and quality improvement initiatives.

Our performance against other outcome measures identified in our Annual Plan is detailed in the first section of this report: Improving Health Outcomes for our Population (page 13).

Further information about our work to improve quality and patient experiences were outlined in the section of Clinical Service Redesign (page 54). 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.

What have we learned from our adverse events – Severity Assessment Code level 1 & 2?

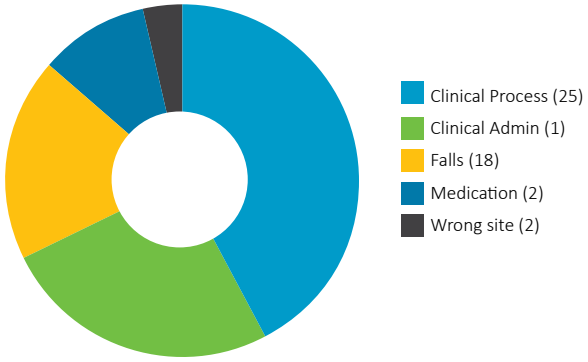
Adverse events with a Severity Assessment Code (SAC) of 1 and 2 are reported by health and disability providers in accordance with the Health Quality and Safety Commission's national reportable events policy. In general, these reflect those incidents that have resulted or contributed to a patient suffering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

The information about adverse events is included in the Quality Account/Annual Report to look specifically at what we as an organisation are able to learn 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.

We note that a number of planned actions have been delayed due to our need to focus on COVID-19 particularly in Q3 and 4 of the 2019/20 year.

In addition to the reporting of SAC 1 and 2 events, staff are encouraged to report near-miss and low harm events. These are potential harms that have been identified early and where interventions have been put in place to avoid a more serious event occurring.

What were the main groups of adverse events in 2019/20?



In the 2019/20 year, there were 59 events that were classified SAC 1 and 2 at Southern DHB.

As indicated by the graph above, the largest group of these relate to clinical processes at 42 per cent (assessment, diagnosis, treatment, general care), followed by falls at 19 per cent (serious harm from falling, for example a broken hip), medication error at 10 per cent (dispensing, prescribing or administration of medications), clinical administration at 15 per cent (handover, referral, discharge resources/organisation), and three per cent where the wrong site for a surgical or other procedure has been identified.

Clinical Processes

Pressure injuries

Southern DHB pressure injury adverse events are increasing over time. In 2018/19 Southern DHB reported seven pressure injury adverse events; 11 were reported in 2019/20. The increase in pressure injury adverse events mirrors an overall trend of increasing Southern DHB hospital-acquired pressure injuries across all classifications.

While this is a concern we believe a reason for the increasing trend has been our focus on the importance of reporting all pressure injuries to provide an accurate picture of patient harm and drive our service

improvement activities. Key initiatives to support pressure injury prevention and optimal pressure injury management include working with Southern patients/consumers and family/whānau to share their powerful experiences of pressure injuries at regional workshops and creating patient and family focussed health promotion resources to use across the sector.

With the significant support of the Southern DHB Wound Nurse Specialists and the Releasing Time to Care Team, the Southern DHB Pressure Injury Prevention Programme has led the development and implementation of a new Southern DHB Pressure Injury Prevention Training Module. This was provided initially as a face-to-face learning and quality improvement opportunity, and subsequently adapted to a virtual format in response to the challenges of COVID-19 restrictions. To support primary care and community services a Southern Pressure Injury HealthPathway has been developed and it now live.

Southern DHB has also partnered with ACC to develop enhanced national guidelines for pressure injury ACC treatment injury claiming. This will help ensure that all those people who do experience harm as a result of a treatment related pressure injury are able to access support from ACC where they have an entitlement.

Review of pressure injury adverse events has also highlighted the importance of communicating pressure injury risk assessments, prevention plans and where necessary wound management plans at points of patient transition across care settings. A review of Southern DHB and aged residential care facility transfer documentation has now been completed and rolled out.

Recognition and response – Deteriorating patients

The Health Quality and Safety Commission (HQSC) reported a national problem of delays in recognising and responding to patients when there is a deterioration in their condition, and developed a programme of work for improvement. This included the implementation of the National Early Warning Scores (EWS) and vital signs chart that included DHB-agreed local 'escalation of concerns' pathways. Implementation occurred in Dunedin in June 2019, followed by Southland in September 2019.

Implementation in other areas within Southern DHB have been a focus with Rehabilitation Services at Wakari Hospital going live in December 2019, and Lakes District Hospital in February 2020. Mental Health Services at Wakari Hospital have finalised their pathway, and are aiming for go-live in September 2020. These areas have required specific work to match the mandatory escalation pathway with the staff they have on site, and the triggers to escalate and transfer to the Dunedin or Southland Hospitals.

The national Maternity Early Warning Score (MEWs) was implemented in the Dunedin Hospital's antenatal and postnatal wards in February 2020. Planning is underway for Southland to commence the programme in September 2020. Once the three sites have implemented, planning will occur for the implementation at Lakes District Hospital, and for all pregnant women requiring observation in hospital.

In addition we have responded to the clinical staff feedback relating to out of hours staffing/expertise. As a result, the Clinical Team Coordinator (CTC) model has been established this year. The CTCs are senior registered nurses who are 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 an 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.

Feedback from staff has been very positive and improvements in applying the standards of practice as set by the national programme is evident. However we continue to have a number (4) adverse events related to recognising and responding effectively to a patient's deteriorating condition. Actions taken in response to the learning reviews for these events include specific teams receiving additional education and training, increased nursing leadership focus and monitoring, changes in guidelines for specific conditions and identification of the need for further work with the Paediatric EWS (PEWS) system.

Some rural sites have implemented the national EWS chart including Dunstan Hospital and Clutha Health, whilst some have looked at a modified version. Work has occurred with one of these sites to look at a full transition to the national EWS chart.

Further work in 2020/21 will include analysis on why escalation of concerns in some cases did not occur in line with the standardised process, and developing corrective actions. The Clinical Council will also be engaged to look at the ongoing DHB-wide 'Governance of the Critically Unwell Patient' and the implementation of 'Goals of Care' for all inpatients.

Falls

While rising rates of serious falls had been reported in the previous two years, we are pleased to see a reduction in the past year. In last year's report we noted that our hospital patients are generally increasing in their acuity and complexity of illness and therefore their vulnerability to falls. Whilst the HQSC falls prevention programme of work had been implemented we looked for further interventions to reduce the number of falls. All falls are reported on our Safety1st incident management system and analysed to design improvement actions.

Also reported last year was our focus on improving our patient assessment and care planning methods and documentation. A package of tools and documents have been developed, and testing of these on the wards will take place in the second quarter of 2020/21. The aim has been to provide comprehensive assessment with concise documentation that removes multiple tools with duplication of information. This reduces the amount of time it takes our clinical staff to record the assessment and plan and ensures focus on key elements of safe patient centred care.

The HQSC Frailty Care Guidelines have been a key tool in the development of the documentation. Whilst the focus of these guidelines is for Aged Residential Care settings, with the increased acuity and complexity of our frail elderly patients as outlined above, there is significant benefit in ensuring alignment in our acute care hospitals. Increased focus is on ensuring patients do not become deconditioned during their stay in hospital with standardised attention to nutrition and hydration, managing delirium, mobilisation and standardised methods to prevent falls and pressure injury harm.

Medication

Southern DHB reports four medication events at the SAC 1 and 2 level this year. In July 2019 Southern DHB welcomed the opportunity to partner with ACC and work on an initiative to reduce harm and prevent medication errors, with a specific focus on medication administration. Two very successful workshops in this programme of work were held in November 2019 and February 2020, identifying the need to ensure greater consistency in processes in line with documented procedures and guidelines.

The final stages of reviewing and finalising the report and recommendations were delayed due to COVID-19, and will occur in 2020/21 followed by implementation of the recommendations for improvement.

Education in best practice for independent double-checking of medications prior to administration has also been ongoing throughout the year.

CASE STUDY

Review leads to better medication for patient

A specific oral medication sometimes used for the treatment of constipation can result in an unintended reduction of renal (kidney) function. However, at times, it is difficult to easily identify those who may be vulnerable to this negative impact.

Following an adverse event relating to this medication, a reporting and learning review was carried out that has already made a difference to improving patient safety.

This involved reducing the availability and accessibility of the medication by removing it from clinical areas. The medication is still available via the pharmacy but will only be supplied via a named patient order (charting) and is likely to be questioned.

Since making this change, the improvement in patient safety has already been noticed. On one instance a prescription was made for medication and submitted to the pharmacy, which did question the order. Following specialist advice this resulted in the prescription being changed to something more appropriate for the individual patient, reducing the risk of harm.

Enabling success: Organisational resilience and sustainability

Enabling Our People

People are at the heart of any health system. We continue to prioritise building a strong workforce with the skills, support and passion to deliver the health care our people have asked for.

Workforce strategy

An ongoing focus this year has been the development of the Workforce Strategy and Action Plan, to meet the needs of the 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.

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.

So far, several of the milestones in the Plan have been met. We have continued to embed our organisational culture work through Southern Future and Valuing Patients' Time, and implemented Essential Corporate training for all Managers, alongside tailored leadership initiatives to build capability, accountability and trust.

We have also invested in data analytics to provide real-time feedback about our current workforce, along with insights into what our future priority workforce will look like – a fundamental component in the New Dunedin Hospital project.

Southern Future

Strengthening our culture

One of the major focuses of the Southern Future programme is to provide a positive and supportive environment for our staff. While we continue to build a strong and safe internal culture, the programme has also been focusing on engaging, listening, and celebrating our incredible staff.

Celebrating our staff

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

Following an unprecedented few months fighting COVID-19, our staff and health care partners were acknowledged for their enormous efforts, contributions and the work collectively achieved as a Southern Health system.

- 6,616 Zoom meetings were held
- 15,492 swabs were taken in the Southern region between 22 January – 22 May 2020
- Normal monthly use of surgical masks went up from 13,750 to 126,070 in May 2020
- One litre of hand gel was used every four hours in the Dunedin Hospital Foyer
- In March 2020, our telephonists took a total of 86,087 calls in Dunedin
- 4,035 telehealth appointments in April 2020
- Thousands of dollars in donations rolled into staff cafes, shouting hospital staff coffees

Engagement workshops

We have made an ongoing commitment to ensuring our workplace is safe and supportive, as we continue on our journey towards Better health, better lives, Whānau Ora. One of the many ways we engage with our staff is through interactive workshops.

In 2019, 50 workshops were run for staff to provide more in-depth feedback on specific themes highlighted in the 2018 Staff Engagement Survey. As a result, the following priority areas were highlighted:

- Eradicate rudeness and bullying
- Poor performance and process
- How leaders communicate more visibility
- Improve communications to all staff
- Enhance professional development.

Significant progress has been made under each priority over the last year including compassionate assertiveness training for managers, Speaking Up Safely, E-Learning and a wellbeing programme for all staff, Get Dotted training, and the launch of a new Southern Health e-newsletter.

Southern Excellence Awards

Southern DHB celebrated its remarkable staff from across the district at the second annual Southern Excellence Awards in November 2019.

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

Ten award categories have been established to represent the diversity in healthcare delivery and services.

"This year's nominees and winners are an exceptional group of people who have excelled in their roles and deserve to be thanked and acknowledged. This is the second year we have run the Southern Excellence Awards and it hasn't got any easier to choose winners from among our 4,000 dedicated staff. Nominees come from across our diverse teams and include leaders, clinical staff, technicians, carers and change-makers," 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."

The new 'Graham Crombie Outstanding Leadership Award' was presented to Strategy, Primary and Community Directorate's General Manager, Glenn Symon, by Graham Crombie's sons Michael and David.

The other awards included Behind the Scenes (Unsung Hero), Team of the Year, Improvements of the Year Award, Breaking Boundaries, Rising Star, Outstanding Care and Compassion, Southern Future Values Champion and the Māori Health Development Award.

Wendi Raumati (front row, fourth from left) presenting handwoven Ipu Whenua to representatives from Queen Mary Maternity Unit, Day Surgery Unit, and Southland Hospital

Living our values

Ipu Whenua gifting

In 2018 Wendi Raumati, Kaiawhina with the Māori Health Unit, was the recipient of the Māori Health Development Award.

Wendi used her prize to establish a series of workshops, where staff from Southern DHB could take part in cultural and professional development sessions to learn about, and create, handwoven Ipu Whenua.

An Ipu Whenua is a container made to house the placenta following childbirth, which is then returned to the earth. After the birth of a baby it is customary Māori practice to plant the whenua (afterbirth) in the land, most often in a place with ancestral connections. Central to this important cultural practice is the belief that humans were first made from earth, from the body of Papatūānuku (the earth mother).

The vision from her prize was put into action, and culminated with the gifting of the Ipu Whenua to representatives from Queen Mary Maternity Unit, Day Surgery Unit, and Southland Hospital.

"These will be used in times of celebration and in times of sadness, but every recipient will be eternally grateful for this gift," says Heather LaDell, acting Director of Midwifery.

Southern DHB Māori Health Manager Graeme Thompson was full of praise for Wendi's initiative, saying, "It is an honour to have this opportunity to support and promote all who participated and those recipients of the weaving completed, to have the opportunity to thank Wendi for her vision and Manakitanga to this cause."

Wendi responded to the occasion beautifully, simply stating, "Mō tātou, ā, mō kā uri ā muri ake nei (For us and our children after us)."

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 reinforced 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 community consultation processes supported by a new website engage.southernhealth.nz. Further initiatives are outlined in the previous section of this report, Improving Patient Experiences and Quality of Care (page 47).

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 includes a warm welcome 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 into 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 was introduced for all employees in 2016 whose continuous service to Southern DHB is greater than 10 years.

Southern DHB also launched the 'Southern Excellence Awards' in 2018 (see page 65). 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.

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 4,993 employees across Otago, Southland and Central Otago. 21.9 per cent of our employee base is male; 78.1 per cent are female.

There is 51.1 per cent male and 48.9 per cent female junior medical staff, and at a senior medical level female representation is 39.3 per cent of the workforce.

The nursing profession comprises 14.1 per cent male employees, whilst midwifery remains 100 per cent female. Service support staff, such as drivers, trades, security staff, are predominantly male (92.1 per cent).

Of the 4,892 employees who detailed their ethnicity, 230 (4.7 per cent) identify as Māori or Pacific.

New Zealand European/Pakeha employees represent 64.6 per cent of our employee population, which includes a total of 44 different ethnicities. Southern DHB is committed to ensuring equal employment opportunities and is continuing to look at ways to improve diversity across all levels of the organisation.

Employees with disabilities

Previously, Southern DHB has not recorded details of staff with disabilities. To address this area, in 2016 the Employee Contact Details Form was revised and now 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.

Age of Employees	Female	Male	% of Employees identified as Māori/Pacific
0-19	0.20%	0.08%	0.97%
20-29	13.20%	3.34%	20.87%
30-39	17.50%	6.05%	21.36%
40-49	15.62%	4.65%	21.36%
50-59	18.57%	4.35%	24.27%
60-69	12.36%	3.06%	10.19%
70-79	0.66%	0.32%	0.49%
80+	0.00%	0.04%	0.49%
Grand Total	78.11%	21.89%	4.13%
Total employees			**4,993**

*Data correct as at 30 June 2020

Occupational Group	Gender	Grand Total	Māori	Pacific	Asian	Other	Not Stated
Allied & Scientific	F	776	31	1	11	710	23
	M	164	11	1	5	139	8
Corporate & other	F	687	25	1	7	620	34
	M	167	9	1	1	155	1
Midwifery	F	110	4	0	0	100	6
	M	0	0	0	0	0	0
Nursing	F	2,021	99	11	28	1,874	9
	M	333	15	2	6	306	4
RMO	F	170	2	2	18	147	1
	M	178	4	3	24	140	7
SMO	F	132	1	0	3	125	3
	M	204	4	1	11	183	5
Support	F	4	0	0	0	4	0
	M	47	1	1	0	45	0
Grand Total		4,993	206	24	114	4,548	101

Systems For Success

The importance of ensuring our people are enabled and supported, including through high quality business and IT systems, has been highlighted as an ongoing priority for Southern DHB.

Digital Strategy and Action Plan

Southern DHB's Southern Digital Strategy and Action plan recognises that in a changing health environment, long-term planning for the digital health system needs to outlive any changes in organisational structure, service delivery or delivery location. The action plan prioritises activities and identifies resources required, reflecting the need to take clear steps forward while managing current funding limitations and changes in care delivery models.

The strategy sits with 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'.

Our aim is to create a digital culture that embraces change, providing the capability and framework to deliver digital transformation. At its core the strategy is underpinned by three key priorities:

- Digital Environment – Laying the foundations, providing secure, sustainable and scalable digital environments
- Digital Solutions – Enabling the people of Southern Health to achieve better health, better lives Whānau Ora via digital solutions
- Digital Insights – Bringing our people and information together by capturing, storing, securing and analysing data to provide digital insights.

IT projects

Over the past year, a number of significant Information Technology developments enhanced the way we were able to provide care for our community. These ranged from a more robust wireless network, through to a new bespoke paging system.

Building on the success of the Tap 2 Go system pilot – which means with a simple tap of their security card, clinical staff are able to transfer patient data between devices quickly and easily – this has now been rolled out in Dunedin Hospital and Southland Hospital Rehabilitation. Some key benefits of the Tap 2 Go system are the protection of patient data and safety, along with improved efficiency, with the removal of manual logins and the ability for staff to bring up patient notes securely from anywhere in the hospital.

Improving patient experience is at the heart of many IT initiatives, and this year we further strengthened and expanded our free wireless services for patients and staff inside our hospitals.

A new pharmacy stock control management system was also launched called ePharmacy, which improved the functionality of Southern DHB Pharmacy services, streamlined reporting outcomes and reduced operational costs for the organisation.

COVID-19

Urgent and new COVID-19 requirements meant some projects were accelerated including and iMedx, a new transcription service to allow for quick dictation via mobile devices.

We also fast-tracked the deployment of Microsoft Office 365, ensuring staff could remain connected while working remotely. The cloud-based system provides robust security and reliability, and staff can access email, files and Office programmes from any location and any device.

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 project

A new design team joined the New Dunedin Hospital project in December 2019. Renowned New Zealand architectural firm Warren and Mahoney were announced as lead architects, supported by international health planning and architecture firm HDR and Dunedin architects McCoy Wixon. Since their appointment, the team has been working with Facilities in Transformation (FiT) user groups that represent different areas of the new facility. These groups are made up of Southern DHB clinical staff, and Community Health Council advisors to reflect clinician and patient needs throughout the design process. Supporting this work and providing expert clinical advice to the project's governance, the Clinical Leadership Group, chaired by Dr John Adams, has continued to closely analyse design and planning. The group's central principle of placing "patients and whānau first" remains at the core of their work.

A completed Concept Design was delivered in September 2020. This is a design that shows where departments are located, and how staff, patients and logistics flow throughout the new facility. The Design Team and FiT groups will now be working on the

Preliminary Design stage, which is concerned with defining the spaces allocated to each area of the hospital and mapping out individual rooms.

The impacts of COVID-19 did little to slow progress on the New Dunedin Hospital project. Under Alert Level 3 the newly appointed demolition contractors, Ceres NZ, were able to ramp up work in the demolition of the former Cadbury factory distribution warehouse. With this work completed in a matter of weeks, an internal 'soft strip' of the factory buildings to remove asbestos and remaining plant material continued. Simultaneously, the demolition project moved north, across St Andrews Street to the former Otago Polytechnic and Ministry of Social Development buildings that sit on the Wilson's Parking block. This block is the site of the planned Outpatients building, with the larger acute Inpatient building set to sit on the southern Cadbury block. Both buildings will be linked by bridging over St Andrews Street.

One of the most positive features of the demolition work has been the commitment to sustainable practices. At the time of writing, of the 1021 tonnes of materials removed from the site throughout demolition, 78 per cent has been recycled or salvaged.

MyLab

Planning has begun to develop a physical and virtual space to demonstrate technologies that will enhance patient and staff experience. This planning is in direct response to the need for strong change management alongside the New Dunedin Hospital project.

The vision for MyLab is to take people on an interactive journey to highlight the possibilities of healthcare in the future, and the positive changes they can bring to our communities.

One of the main goals for MyLab is to provide the ability to research and understand the impact on change in people's behaviour and health outcomes as a result of the new models of care and technology enablers. MyLab also aims to provide a space for feedback into design elements and plans for new facilities, such as the New Dunedin Hospital.

ICU – Te puna wai ora

Work continues in the delivery of the second stage of Te puna wai ora, the new Intensive Care Unit at Dunedin Hospital. Ventilation issues continued to hamper progress throughout the year, with specialist mechanical engineers brought in to provide solutions. Stage 2 will reflect the design and layout of the first stage, providing 12 intensive care beds, with a modern, light-filled design and open lines of sight. Improved acoustic design will also make the space quieter, improving critical care patients' comfort, and more space will be provided for patients' Whānau, with modern waiting and reception areas.

Queen Mary Maternity Centre refurbishment

In February Southern DHB confirmed that a $1.6 million redevelopment of the Queen Mary Maternity Centre would begin. Among the many upgrades to the facility that this project will provide, the scope of the $1.6 million refurbishment project includes the removal of wall linings and services in the existing theatre to allow a full rebuild to create improved patient flow and upgraded services. The current obstetric theatre was commissioned in its current location following a move to the second floor of Dunedin Hospital in 1990.

Prior to the refurbishment beginning, between nine and 13 acute and elective caesareans were performed in the theatre each week, with approximately six or seven of these occurring in regular hours.

The project is progressing well, with the second phase underway, which includes the commissioning of the temporary theatre so that work can begin on the main theatre. Refurbishment within an active and acute facility always poses a risk of disturbance to staff and patients, however, the peri-operative and midwifery services are working extremely well together to facilitate the smoothest transition possible, and the careful liaising with contractors has kept any disruption to an absolute minimum. The theatre completion date is tracking to end in February of 2021, with the benefits for mothers, babies and staff of this work set to be far-reaching, particularly in terms of providing a safe operating environment, improved patient flows, and a fit-for-purpose facility.

Asset Performance Indicators

Improving Asset Management

Southern DHB is committed to and is working to improve 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 the areas that will enable us to achieve the greatest benefit for our asset maturity management.

Asset Portfolio	Asset Classes within Portfolios	Asset Purpose	2018/19 Net Book Value ($000)	2019/20 Net Book Value ($000)
Property	Land, buildings, furniture and fittings, motor vehicles	To provide a base for the provision of health services	271,119	272,340
Clinical Equipment	Equipment and machinery	To enable the delivery of health services through diagnosis, monitoring or treatment	43,543	46,740
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	8,387	15,379

Property Portfolio Performance

Asset Performance Indicators	Indicator Class	2018/19 Result	2019/20 Standard	2019/20 Result
Percentage of buildings within the DHB's property portfolio with a current Building Warrant of Fitness[1]	Condition	96%	100%	93%

[1] Three occupied buildings within the SDHB do not have building warrant of fitness certification. The Clinical Services Building and Ward Block Building are due to ongoing asbestos issues but this is expected within 12 months once inspections and 12A certification requirements are met. The Leith St premises has remedial works that have been identified, and are expected to be completed in the next fiscal year, the building warrant of fitness certification to follow.

Clinical Equipment Portfolio Performance

Asset Performance Indicators	Indicator Class	2018/19 Result	2019/20 Standard	2019/20 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	99%	>98%	99%
Percentage of CT uptime vs. operational hours	Utilisation	98%	>98%	100%
Percentage of Linac uptime vs. operational hours	Utilisation	Linac installation delays	>98%	Linac installation delays

Information Communication and Technology (ICT) Portfolio Performance

Asset Performance Indicators	Indicator Class	2018/19 Result	2019/20 Standard	2019/20 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	97%	85%	96%
Annual network penetration test risk level (5-critical, 4-high, 3-medium, 2-low, 1-informational)	Functionality	1	2	2

Financial statements

Statement of Comprehensive Revenue and Expense
For the year ended 30 June 2020

	Note	2020 Actual $000	2020 Budget $000	2019 Actual $000
Patient revenue	2	1,091,873	1,074,047	1,023,476
Other revenue	2	7,885	7,158	8,407
Interest revenue		308	187	157
Total revenue		**1,100,066**	**1,081,392**	**1,032,040**
Personnel costs	3	477,433	431,381	442,010
Depreciation, amortisation and impairment expense	10,11	25,063	28,012	28,567
Outsourced services		48,797	44,863	49,437
Clinical supplies		98,877	93,260	96,111
Infrastructure and non-clinical expenses		59,307	52,982	51,827
Other district health boards		46,996	44,176	44,046
Non-health board provider expenses		419,741	410,527	394,874
Other expenses	6	4,334	4,043	3,370
Interest expense	5	320	160	126
Capital charge	4	9,652	10,500	11,017
Total expenses		**1,190,520**	**1,119,904**	**1,121,385**
Deficit for the year	17	**(90,454)**	**(38,512)**	**(89,345)**
Other comprehensive revenue				
Revaluation of land and buildings	17	-	-	-
Total other comprehensive revenue/(expense)		-	-	-
Total comprehensive revenue/(expense)		**(90,454)**	**(38,512)**	**(89,345)**

Statement of Changes in Equity
For the year ended 30 June 2020

	Note	2020 Actual $000	2020 Budget $000	2019 Actual $000
Balance at 1 July		**172,410**	**172,410**	**192,584**
Total comprehensive revenue and expense		(90,454)	(38,512)	(89,345)
Owner transactions				
Capital contributions from the Crown (deficit support and project equity funding)		84,744	54,550	69,878
Return of capital		(707)	(707)	(707)
Balance at 30 June	17	**165,993**	**187,741**	**172,410**

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 2020

	Note	2020 Actual $000	2020 Budget $000	2019 Actual $000
Current assets				
Cash and cash equivalents	7	31,011	7	7
Trade and other receivables	8	49,819	45,213	47,353
Inventories	9	6,095	5,235	5,762
Total current assets		**86,925**	**50,455**	**53,122**
Non-current assets				
Property, plant and equipment	10	324,107	346,288	323,050
Intangible assets	11	5,664	10,393	4,505
Total non-current assets		**329,771**	**356,681**	**327,555**
Total assets		**416,696**	**407,136**	**380,677**
Liabilities				
Current liabilities				
Cash and cash equivalents	7	-	44,587	9,895
Payables and deferred revenue	12	64,588	62,805	63,845
Borrowings	13	962	784	922
Employee entitlements	14	88,644	91,600	112,595
Provisions	15	80	80	80
Total current liabilities		**154,274**	**199,856**	**187,337**
Non-current liabilities				
Borrowings	13	1,091	783	1,568
Employee entitlements	14	95,338	18,756	19,362
Total non-current liabilities		**96,429**	**19,539**	**20,930**
Total liabilities		**250,703**	**219,395**	**208,267**
Net assets		**165,993**	**187,741**	**172,410**
Equity				
Contributed capital	17	385,006	354,812	300,969
Property revaluation reserves	17	108,502	108,502	108,502
Accumulated deficit	17	(327,515)	(275,573)	(237,061)
Total equity		**165,993**	**187,741**	**172,410**

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 2020

	2020 Actual $000	2020 Budget $000	2019 Actual $000
Cash flows from operating activities			
Cash receipts from Ministry of Health and patients	1,097,687	1,082,593	1,029,740
Payments to suppliers	(678,769)	(649,566)	(628,610)
Payments to employees	(425,100)	(453,068)	(404,428)
Interest received	308	187	157
Interest paid	-	-	(20)
Goods and services tax (net)	493	7	(14)
Capital charge	(9,651)	(10,500)	(11,017)
Net cash flow from/to operating activities	**(15,032)**	**(30,347)**	**(14,192)**
Cash flows from investing activities			
Proceeds from sale of property, plant and equipment	3	-	24
Purchase of property, plant and equipment	(24,829)	(48,541)	(32,630)
Purchase of intangibles	(2,514)	(8,598)	(658)
Net cash flow from/to investing activities	**(27,340)**	**(57,139)**	**(33,264)**
Cash flows from financing activities			
Capital contributions from the Crown	84,744	54,550	69,878
Drawdown/(repayment) of borrowings	(1,473)	(1,756)	(1,933)
Net cash flow from/to financing activities	**83,271**	**52,794**	**67,945**
Net increase/(decrease) in cash and cash equivalents	**40,899**	**(34,692)**	**20,489**
Cash and cash equivalents at beginning of year	(9,888)	(9,888)	(30,377)
Cash and cash equivalents at the end of the year	**31,011**	**(44,580)**	**(9,888)**

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 2020 (continued)

Reconciliation of net deficit for the year with net cash flows from operating activities

	2020 Actual $000	2020 Budget $000	2019 Actual $000
Net deficit for the period	**(90,454)**	**(38,512)**	**(89,345)**
Add/(less) non-cash items:			
Depreciation and assets written off	25,063	28,012	28,567
Increase/(decrease) in financial liability fair value	329	126	34
Increase/(decrease) in provision for doubtful debts	(2,617)	-	-
Total non-cash items	**22,775**	**28,138**	**28,601**
Add/(less) items classified as investing or financing activity:			
Net loss/(gains) on disposal of property, plant and equipment	62	-	(8)
Total items classified as investing or financing activites	**62**	**-**	**(8)**
Movements in working capital:			
(Increase)/decrease in trade and other receivables	150	2,139	(3,621)
(Increase)/decrease in inventories	(332)	528	(730)
Increase/(decrease) in trade and other payables	1,123	(1,038)	17,189
Increase/(decrease) in employee benefits	51,644	(21,602)	33,722
Net movements in working capital	**52,585**	**(19,973)**	**46,560**
Net cash inflow/(outflow) from operating activities	**(15,032)**	**(30,347)**	**(14,192)**

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 2020

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 2020 and were approved for issue by the Board on 9 December 2020.

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 Board 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 prior to the 2020/21 Annual Plan being approved by 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

Nil.

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 accordingly changed its measurement of accounts receivable impairment (provisioning for doubtful debts) for the years ended 30 June 2019 and 30 June 2020.

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 2019/2020 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 Board 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 surplus/deficit in the same period as the related expenditure. Research costs are recognised in the surplus/deficit as an 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, Revenue from Exchange Transactions, 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

	2020 Actual $000	2019 Actual $000
Health and disability services (MoH contracted revenue)	1,048,846	982,799
ACC contract revenue	10,336	10,506
Inter-district patient inflows	23,687	21,324
Other revenue	9,004	8,847
Total Patient care revenue	**1,091,873**	**1,023,476**

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

Breakdown of other revenue

	2020 Actual $000	2019 Actual $000
Gain on sale of property, plant and equipment	4	24
Donations and bequests received	404	1,359
Rental revenue	2,945	2,936
Other revenue	4,532	4,088
Total other revenue	**7,885**	**8,407**

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

	2020 Actual $000	2019 Actual $000
Salaries and wages	414,554	395,013
Defined contribution plans employer contributions	10,773	9,810
Increase/(decrease) in employee entitlements	52,106	37,187
Total personnel costs	**477,433**	**442,010**

EMPLOYEE REMUNERATION

There were 1,024 employees who received remuneration and other benefits of $100,000 or more for the year ending 30 June 2020 (2019: 866). The year on year increase reflects the combined impact of additional FTE, MECA settlements and additional payments made during the COVID-19 response.

Total Remuneration and Other Benefits $000	Number of Employees	
	2020	2019
100 - 110	239	214
110 - 120	161	121
120 - 130	106	84
130 - 140	73	55
140 - 150	55	42
150 - 160	41	23
160 - 170	29	20
170 - 180	20	26
180 - 190	18	18
190 - 200	19	16
200 - 210	18	18
210 - 220	14	26
220 - 230	15	13
230 - 240	16	9
240 - 250	20	14
250 - 260	16	16
260 - 270	17	10
270 - 280	16	12
280 - 290	13	14
290 - 300	16	14

300 - 310	16	14
310 - 320	10	8
320 - 330	7	10
330 - 340	4	8
340 - 350	3	6
350 - 360	8	6
360 - 370	7	6
370 - 380	9	6
380 - 390	6	5
390 - 400	2	5
400 - 410	2	4
410 - 420	2	2
420 - 430	4	4
430 - 440	1	2
440 - 450	4	3
450 - 460	3	2
460 - 470	2	-
470 - 480	3	3
480 - 490	3	1
490 - 500	1	1
530 - 540	-	1
540 - 550	1	1
550 - 560	2	1
560 - 570	-	1
570 - 580	1	1
580 - 590	1	-
	1,024	**866**

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 1,024 employees in this category, 813 were regulated health professionals (2019: 866 employees, of which 696 were regulated health professionals).

The Chief Executive's remuneration and other benefits either paid or accrued are in the band 550-560.

EMPLOYEE TERMINATION PAYMENTS

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

The total payments were $119,152 (2019: 20 employees totalling $444,803).

BOARD AND COMMISSIONER TEAM REMUNERATION

The year ended 30 June 2020 was a transitional year with the Commissioner Team replaced by the elected Board on 9 December 2019.

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

	2020 Actual $000	2019 Actual $000
Kathy Grant	99	168
Graham Crombie	-	32
Richard Thomson	22	40
David Perez ONZM	18	10
Jean O'Callaghan	15	12
Total Commissioner team remuneration	**154**	**262**

There were payments made to the independent Chairperson of the Finance, Audit and Risk Committee, appointed by the Commissioner since September 2015. Payments totalled $30,000 (2019: $29,100).

The total value of remuneration paid or payable to the Board during the year was:

	2020 Actual $000	2019 Actual $000
David Cull	26	-
David Perez MNZM	16	-
Jean O'Callaghan	13	-
Ilka Beekhuis	13	-
John Chambers	13	-
Kaye Crowther QSO	13	-
Lyndell Kelly	13	-
Terrence King MNZM	13	-
Tuari Potiki	13	-
Lesley Soper	13	-
Reremoana Theodore	13	-
Total Board Members remuneration	**159**	**-**

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

	2020 Actual $000	2019 Actual $000
Hospital Advisory Committee		
Odele Stehlin	1	1
Total Remuneration	1	1
Community and Public Health Advisory Committee/ Disability Support Advisory Committee		
Justine Camp	-	1
Total Remuneration	-	1
Iwi Governance Committee		
Taare Hikurangi Bradshaw	-	-
Sumaria Beaton	1	2
Justine Camp	1	1
Ann Wakefield	1	1
Donna Matahaere-Atariki	1	1
Odele Stehlin	2	2
Total Remuneration	**6**	**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 2019 and 1 January to 30 June 2020 was 6%. The amount charged during the period was $9.7 million (2019: 6%, $11.0 million).

5. FINANCE COSTS

ACCOUNTING POLICY

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

Breakdown of finance costs

	2020 Actual $000	2019 Actual $000
Interest on secured loans	235	20
Interest on finance leases	85	106
Total finance costs	**320**	**126**

6. OTHER EXPENSES

ACCOUNTING POLICY

Breakdown of other expenses

	Note	2020 Actual $000	2019 Actual $000
Impairment of trade receivables		706	228
Loss on disposal of property, plant and equipment		66	17
Audit fees		227	209
Audit fees (for the audit of financial statements 2018)		-	30
Fees paid to other auditors for assurance and related services including internal audit		135	84
Board/Commissioners fees	3	313	262
Operating lease expenses		2,882	2,531
Koha		5	9
Total other expenses		**4,334**	**3,370**

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 (56%), premises rental (27%), with the balance being clinical equipment and other equipment rental (17%).

Operating leases as lessee

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

	2020 Actual $000	2019 Actual $000
Non-cancellable operating lease rentals are payable as follows:		
Less than one year	1,520	890
Between one and five years	2,789	820
More than five years	105	119
Total non-cancellable operating leases	**4,414**	**1,829**

The majority of the non-cancellable operating lease expense relates to 283 fleet car leases. These leases have terms of 3.8 to 6 years, the last ones expiring October 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 2020 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

	2020 Actual $000	2019 Actual $000
Cash at bank and on hand	7	7
Demand funds with New Zealand Health Partnerships Limited	31,004	(9,895)
Cash and cash equivalents in the Statement of Cash Flows	**31,011**	**(9,888)**

WORKING CAPITAL FACILITY

At 30 June 2020, 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 $53.5m.

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.

Breakdown of receivables and further information

	2020 Actual $000	2019 Actual $000
Receivables (gross)	50,896	51,047
Less: provision for uncollectability	(1,077)	(3,694)
Total receivables	**49,819**	**47,353**
Total receivables comprise:		
Receivables (non-exchange transactions)	27,549	27,268
Other accrued income (exchange transactions)	22,270	20,085
	49,819	**47,353**

The expected credit loss rates for receivables at 30 June 2020 and 1 July 2019 are based on the payment profile of revenue on credit over the prior two 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:

	2020 Actual $000	2019 Actual $000
Opening allowance for credit losses as at 1 July	3,694	3,694
Increase in loss allowance made during the year	706	228
Receivables written off during the year	(3,323)	(228)
Balance as at 30 June	**1,077**	**3,694**

Trade receivables ageing profile

	2020				2019			
	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	8,754	0%	1	-	9,580	0%	-	-
Less than six months past due	3,428	25%	318	-	2,149	25%	248	-
Between six months and one year past due	803	75%	265	-	653	75%	212	-
Between one and two years past due	442	75%	170	-	464	75%	349	-
Greater than two years past due	798	75%	223	-	1,685	75%	944	-
Specific Debtors	106	95%	-	100	1,951	95%	-	1,861
Specific Debtors	-	100%	-	-	80	100%	-	80
Total	**14,331**		**977**	**100**	**16,562**		**1,753**	**1,941**

* Estimate of losses % is applied to specific classes of receivables, not total receivables.

Note: Trade receivables of $14.3 million are included in Receivables (gross) figure, $50.9 million (page 87).

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

	2020 Actual $000	2019 Actual $000
Pharmaceuticals	2,734	2,367
Surgical & medical supplies	3,361	3,395
Total inventories	**6,095**	**5,762**

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	7 to 79 years
Plant and Equipment	4 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 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**
Balance at 1 July 2019	37,997	230,801	177,307	2,354	15,894	464,353
Additions	-	-	-	-	24,829	24,829
Transfers from Work in Progress	-	12,290	17,896	3	(30,189)	-
Disposals	-	(6)	(2,635)	(3)	-	(2,644)
Balance at 30 June 2020	**37,997**	**243,085**	**192,568**	**2,354**	**10,534**	**486,538**
Depreciation and impairment losses						
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)
Balance at 30 June 2019	**-**	**10,152**	**129,007**	**2,144**	**-**	**141,303**
Balance at 1 July 2019	-	10,152	129,007	2,144	-	141,303
Depreciation charge for the year	-	11,039	12,568	98	-	23,705
Disposals	-	(6)	(2,570)	(1)	-	(2,577)
Balance at 30 June 2020	**-**	**21,185**	**139,005**	**2,241**	**-**	**162,431**
Carrying amounts						
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**
At 1 July 2019	37,997	220,649	48,300	210	15,894	323,050
At 30 June 2020	**37,997**	**221,900**	**53,563**	**113**	**10,534**	**324,107**

Capital Commitments

	2020 Actual $000	2019 Actual $000
Buildings	5,640	10,313
Clinical equipment	6,642	6,305
Computer equipment	3,776	2,111
Non-clinical equipment	137	68
Intangibles	-	6
Total capital commitments	**16,015**	**18,803**

Capital commitments represent capital expenditure contracted for at balance date but not yet incurred.
The prior year comparative values have been updated to match the change in methodology in recognition of the capital commitments.

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 2020 have been included at cost.

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 2020 is $17.5 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.

In return for payments made in previous years, Southern DHB gained rights to access the Health, Finance, Procurement and Information System (FPIM) asset. In the event of liquidation or dissolution of New Zealand Health Partnerships Limited (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 2020, 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 $5.1 million was recognised as an expense in the Statement of Comprehensive Revenue and Expense in 2019. No further impairment charge was required at 30 June 2020.

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	5 to 10 years	10-20%

Breakdown of intangible assets

	FPIM	Software & development costs	Total
Cost	**$000**	**$000**	**$000**
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**
Balance 1 July 2019	5,127	24,888	30,015
Additions	-	2,514	2,514
Disposals	-	-	-
Balance at 30 June 2020	**5,127**	**27,402**	**32,529**
Amortisation and impairment losses			-
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**
Balance 1 July 2019	5,127	20,383	25,510
Amortisation charge for the year	-	1,355	1,355
Impairment	-	-	-
Disposals	**-**	**-**	**-**
Balance at 30 June 2020	5,127	21,738	26,865
Carrying amounts			
At 1 July 2018	4,469	6,415	10,884
At 30 June 2019	**-**	**4,505**	**4,505**
At 1 July 2019	-	4,505	4,505
At 30 June 2020	**-**	**5,664**	**5,664**

The above balance includes $2.7 million of work in progress, the major contributing items being $0.8 million relating to the South Island Patient Management System, $0.6 million to the E-Pharmacy System and $0.6 million to the Finance, Procurement and Information Management System. (2019: $0.8 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

	2020 Actual $000	2019 Actual $000
Trade payables to non-related parties	7,451	15,045
GST payable	6,062	5,564
Revenue in advance relating to contracts with specific performance obligations	1,684	2,441
Other non-trade payables and accrued expenses	49,391	40,795
Total payables and deferred revenue	**64,588**	**63,845**

	2020 Actual $000	2019 Actual $000
Total payables comprise:		
Exchange transactions	56,842	55,840
Non-exchange transactions	7,746	8,005
	64,588	**63,845**

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

	2020 Actual $000	2019 Actual $000
Current		
Current portion of secured loans	604	600
Current portion of unsecured loans	-	53
Current portion of finance lease liabilities	358	269
Total current portion	**962**	**922**
Non-current		
Secured loans	-	516
Finance lease liabilities	1,091	1,052
Total non-current portion	**1,091**	**1,568**
Total borrowings	**2,053**	**2,490**

Secured loans

Southern DHB previously had 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

	2020 Actual $000	2019 Actual $000
Interest rate summary		
Secured loans - fixed interest	-	-
Repayable as follows:		
Within one year	604	653
One to two years	-	516
Two to three years	-	-
Three to four years	-	-
Four to five years	-	-
Later than five years	-	-
	604	**1,169**
Term loan facility limits		
Secured loans	-	-

Breakdown of finance leases

	2020 Actual $000	2019 Actual $000
Within one year	359	269
One to two years	235	93
Two to three years	112	103
Three to four years	122	112
Four to five years	131	122
Later than five years	490	622
	1,449	**1,321**

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

	2020 Actual $000	2019 Actual $000
Current portion		
Long-service leave	4,037	3,856
Sabbatical leave	192	181
Retirement gratuities	4,077	3,516
Annual leave	53,705	83,270
Sick leave	304	317
Continuing medical education	7,571	5,905
Salary and wages accrual	18,758	15,550
Total current portion	**88,644**	**112,595**
Non-current portion		
Annual leave	75,528	-
Long-service leave	5,562	4,967
Sabbatical leave	2,313	2,160
Retirement gratuities	11,935	12,235
Total non-current portion	**95,338**	**19,362**
Total employee entitlements	**183,982**	**131,957**

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 methodology for determination of individual employee earnings and 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 the 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 2020/21 and potentially into the 2021/22 financial year. The final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed. However, during the 2019/20 financial year the review process agreed as part of the MOU has commenced. Southern DHB has made progress in its review, however we have assessed there is further work required to reach a reliable estimate of the historic non-compliance under the MoU.

Notwithstanding, as at 30 June 2020, in preparing these financial statements, the Southern DHB recognises it has an obligation to address any historical non-compliance under the MOU. The DHB has made estimates and assumptions to determine a potential liability based on its review of payroll processes for instances of non-compliance with the Act and against the requirements of the MOU.

The liability has been estimated at $75.5 million by calculating the underpayment for employees over the full period of liability based on known non-compliances at 30 June 2020. This 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 significant uncertainties as to the actual amount the DHB will be required to pay to current and former employees. The estimates and assumptions may differ to the subsequent actual results as further work is completed. This may result in further adjustment to the carrying amount of the provision within the next financial year or payments to employees that differ significantly from the estimation of liability.

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

	2020 Actual $000	2019 Actual $000
Current Portion		
Restructuring	80	80
Total current portion	**80**	**80**
Non-current portion		
Restructuring	-	-
Total non-current portion	**-**	**-**
Total Provisions	**80**	**80**

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 2018	464
Additional provisions made	-
Amounts used	(384)
Unused amounts reversed	-
Balance at 30 June / 1 July 2019	**80**
Additional provisions made	-
Amounts used	-
Unused amounts reversed	-
Balance at 30 June 2020	**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 employment related matters.

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 Board.

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 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**
Balance at 1 July 2019	300,969	108,502	(237,061)	172,410
Capital contributions from the Crown (Deficit Support and Project Equity Funding)	84,744	-	-	84,744
Equity repayment to the Crown	(707)	-	-	(707)
Movement in revaluation of land and buildings	-	-	-	-
Deficit for the period	-	-	(90,454)	(90,454)
Balance at 30 June 2020	**385,006**	**108,502**	**(327,515)**	**165,993**

Equity is made up of:

	2020 Actual $000	2019 Actual $000
Equity	161,896	167,948
Restricted equity*	4,097	4,462
Total equity	**165,993**	**172,410**

* 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:

	2020 Actual $000	2019 Actual $000
Board Members		
Remuneration	159	-
Full time equivalent members	0.2 FTE	-
Total Board Members remuneration	**159**	**-**
Total Board Members full time equivalent	**0.2 FTE**	**-**
Commissioner Team		
Remuneration	154	262
Full time equivalent members	1.2 FTE	1.3 FTE
Total Commissioner team remuneration	**154**	**262**
Total Commissioner team full time equivalent	**1.2 FTE**	**1.3 FTE**
Executive Management		
Remuneration	2,963	2,848
Termination payments	-	48
Full time equivalent members	11.0 FTE	11.3 FTE
Total Executive Management remuneration	**2,963**	**2,896**
Total Executive Management full time equivalent	**11.0 FTE**	**11.3 FTE**
Total remuneration	**3,276**	**3,158**
Total full time equivalent	**12.4 FTE**	**12.6 FTE**

The full time equivalent (FTE) for the Board and Commissioner team has been determined on the frequency and length of meetings and the estimated time to prepare for meetings.

An analysis of Board and 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 24.8 per cent of total receivables). It is assessed to be a low risk and high-quality entity due to its nature as the government funded purchaser of health and disability support services.

At balance date there were no significant other concentrations of credit risk. The maximum exposure to credit risk is represented by the carrying amount of each financial asset, including derivative financial instruments, in the Statement of Financial Position.

LIQUIDITY RISK

Liquidity risk represents Southern DHB's ability to meet its contractual obligations. Southern DHB evaluates its liquidity requirements on an ongoing basis 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
2020							
Secured loans	604	604	-	604	-	-	-
Unsecured loans	-	-	-	-	-	-	-
Finance lease liabilities	1,449	1,449	179	179	235	365	491
Payables and deferred revenue	64,588	64,588	64,588	-	-	-	-
Total	**66,641**	**66,641**	**64,767**	**783**	**235**	**365**	**491**
Inflow	-	-	-	-	-	-	-
Outflow	66,641	66,641	64,767	783	235	365	491
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

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.

2020

	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	-	604	-	604	-	-	-
Unsecured Bank Loans	-	-	-	-	-	-	-
Finance lease liabilities*	7.16% - 12.55%	1,449	179	179	235	365	491

* These assets/liabilities bear interest at fixed rates

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

	Note	2020 Actual $000	2019 Actual $000
Opening Balance – Crown Loans	13	1,116	1,683
Increase Crown Loans		-	-
Repayment of Crown Loans		(512)	(567)
Conversion of loans to equity		-	-
Closing Balance – Crown Loans		**604**	**1,116**

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 2020, 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 (2019: $0.01 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	Carrying amount Actual $000	Fair value Actual $000
2020			
Trade and other receivables	8	49,819	49,819
Cash and cash equivalents	7	31,011	31,011
Secured loans	13	604	604
Finance lease liabilities	13	1,449	1,449
Payables and deferred revenue	12	64,588	64,588
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

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, for the year ending 30 June 2019 Southern DHB elected not to restate the information for previous years to comply with PBE IFRS 9. Adjustments arising from the adoption of PBE IFRS 9 were 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 2020 has resulted in a deficit of $4.8 million (2019: $4.6 million) for Mental Health services. Additionally Southern DHB has a brought-forward overspend of $12.3 million; meaning that the carry-forward overspend is $17.1 million (2019: $12.3 million).

23. EVENTS AFTER BALANCE DATE

The following events occurred subsequent to 30 June 2020:

- On 14 September 2020, the Minister of Health Chris Hipkins advised that Cabinet had approved in principle the Detailed Business Case for the new Dunedin Hospital.
- The Chairman of Southern District Health Board David Cull announced his resignation on 9 October 2020 due to personal health challenges. The Deputy Chair, David Perez is Acting Chairman of Southern District Health Board until the Minister of Health announces a permanent appointment.

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 2020 was $51.9 million.

Revenue

Total Revenue was $18.7 million higher than budget. Government and Crown contracted revenue accounted for $18.6 million of this, largely due to additional funding for the COVID-19 response, In-Between Travel and Pay Equity.

Personnel Costs and Outsourcing

Personnel costs were unfavourable to budget by $46.1 million.

The COVID-19 response added $7.2 million to personnel costs, across all workforce types. To a large extent the additional cost reflects the increase in leave entitlements during the Levels three and four lockdown periods when staff were unable to take planned leave.

Additional recognition of the estimated historical liability to identify, rectify and remediate any Holidays Act 2003 non-compliances added a further $37.8 million to personnel costs this financial year.

The actuarial calculation of the liability for non-vested employee entitlements at 30 June 2020 was $1.3 million higher than budget, reflecting a larger drop in Treasury discount rates and CPI rates than expected.

Outsourced Services (Includes Outsourced Personnel)

Outsourced Clinical Services were $3.9 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 the COVID-19 response. Similarly the services from other DHBs were $2.3 million more than expected.

Total caseweights were 4 per cent or 2,243 lower than budgeted, largely as a result of COVID-19. This disruption had a similar negative effect on elective delivery, being 5 per cent lower than the previous year. Until COVID-19 lockdown occurred in March 2020, Southern DHB was on track to meet its elective and other delivery targets for the year ending June 2020.

Clinical Supplies

Clinical supplies were $5.6 million over budget due to a range of factors. As expected, Personal Protective Equipment costs were higher as a result of COVID-19 response, however there has also been a continued increase in the cost and demand for blood, ostomy and continence products, implants and prostheses, plus high cost pharmaceutical products. Air ambulance costs have also been higher with high-cost Neurosurgery transfer missions impacting on the total spend through the year.

Infrastructure and non-clinical expenses

Total infrastructure and non-clinical expenses were $6.3 million higher than budget, largely as a result of the one-off adjustment of $4.6 million on expenditure for the new Dunedin Hospital project incurred since 2017. This expenditure had been treated as work in progress and which was subsequently defined in accordance with the accounting standards as feasibility expenses because the New Dunedin Hospital Detailed Business Case has not been approved.

Non-Health Board Provider Payments

Provider payments to NGOs were $9.2 million higher budget. The majority of this was reflected in the COVID-19 response which included "pass-through" payments to Aged Care, GP Practices, CBAC facilities and Pharmacies across the district. This was however funded by the Crown.

STATEMENT OF FINANCIAL POSITION

Cash and Cash Equivalents

Cash at year end was $75.6 million better than budget with net equity funding being $30.2 million higher than the annual plan. In addition, investment in property, plant & equipment and intangibles was $29.8 million lower than expected with a number of projects delayed or deferred.

Trade and Other Receivables

Trade and Other Receivables were $4.6 million higher than budget with higher than expected amounts owing in Planned Care and other Government funding sources.

Property, Plant and Equipment

Property Plant and Equipment was $22.2 million lower than budget reflecting the timing of purchasing and completion of capital work programmes. The capital expenditure on stage two of the new ICU facility and linear accelerator replacements have experienced unforeseen project delays, while various items of clinical and infrastructural equipment and deferred maintenance programmes have in part been delayed by COVID-19 but continue into the new financial year.

In addition, a one-off adjustment of $4.6 million was made to Capital Work in Progress for expenditure to date of the New Dunedin Hospital project as above.

Intangible Assets

Intangible assets were $4.7 million lower than budget with underspends on the Health Finance, Procurement and Information Management System (FPIM) and other software projects, impacted by COVID-19.

Employee Entitlements

Aggregated employee entitlements are $72.6 million higher than budget with the planned remediation of the estimated liability for any non-compliance with the Holidays Act 2003 not progressed by 30 June 2020. The Holidays Act 2003 component of the liability has also been re-classified as non-current.

Contributed Capital

Contributed Capital is $30.2 million more than budget. This is largely a result of the additional equity funding received from the Ministry of Health.

STATEMENT OF CASH FLOWS

Net Cash Flow from Operating Activities is $15.3 million higher than budget. Cash Receipts from the Ministry of Health were $15.1 million higher than budget, however this was more than offset by Payments to Suppliers being well above budget.

Both are to a large extent the result of the COVID-19 response. Payments to employees were $28.0 million under budget with the Holidays Act remediation not proceeding as above.

Cash Flows from Investing Activities are $29.8 million favourable to budget due to the timing of capital project expenditure.

Net Cash Flow from Financing Activities is $30.5 million higher than budget. This comprises the additional deficit funding, offset by the Holidays Act remediation funding not being required.

25. COVID-19

BACKGROUND

On 11 March 2020, the World Health Organisation declared the outbreak of COVID-19 a pandemic and two weeks later the New Zealand Government declared a State of National Emergency. The country was in lockdown at Alert Level 4 from 26 March to 27 April 2020 and then remained in lockdown at Alert Level 3 until 13 May 2020. The country operated at Alert Level 2 until 9 June 2020 when we achieved Alert Level 1.

In January 2020, the Ministry of Health requested that all District Health Boards prepare and plan for the COVID-19 pandemic.

At Southern DHB the preparation and planning included the integration of both the primary health care and the rural hospital network with the Southern DHB hospitals at Queenstown Lakes, Southland and Dunedin.

In preparation for COVID-19, the Chief Executive Officer was given a special dispensation from the Minister of Health which enabled him to approve unbudgeted expenditure. The priority was to assess the additional capital resources required to meet the forecast demand and reconfigure hospital facilities to enable clinical teams to deliver care. The Chief Executive Officer approved capital expenditure of $1.4 million, of which $785,000 was committed to ventilators, CPAP machines and extension of other equipment to resource up to the forecast level of demand.

Southern DHB began experiencing COVID-19 cases during March 2020. There were two large clusters known as the "Bluff Wedding" with 98 cases and the "World Hereford Conference" with 39 cases. The total cases in Southern reached 216, which unfortunately included two deaths.

For the most part, the patients were able to recover in their own homes. Overall, we had 13 admissions for COVID-19 of which one required ICU care including the support of a ventilator. All other patients were treated in our general/medical wards. These admissions were during the period 21 March 2020 to 22 April 2020.

Following the initial wave of COVID-19 there are have been no reported cases for Southern DHB.

The effect on our operations is reflected in these financial statements, based on the information available to the date these financial statements are signed. At this time, it is difficult to determine the full ongoing effect of COVID-19 and therefore some material uncertainties remain. There could also be other matters that affect Southern DHB in the future, of which we are not yet aware.

The main impacts on Southern DHB's financial statements due to COVID-19 are explained below.

OPERATING ACTIVITY

All essential services including emergency and urgent healthcare services were maintained throughout the State of Emergency and lockdown period. In accordance with instructions from the Ministry of Health, the planned care and elective activity was reduced to create capacity within the hospitals for COVID-19 patients. As a result the hospitals operated at circa 50 per cent capacity throughout the Alert Lockdown at Levels 2 to 4.

As at 29 February 2020, Southern DHB had delivered to planned care targets within 68 caseweights. However, with the preparation for COVID-19 and scaling back of activity across the hospital system, the planned care targets deteriorated from March to 30 June 2020 with the result we ended the financial year 1,048 caseweights behind on delivery.

Overall the delivery of healthcare services was impacted by the lockdown with cancellations of inpatient, outpatient and community interventions. These cancellations delayed care and as lockdown lifted the focus was directed to rescheduling patients.

As Alert levels dropped back to 1, the level of activity within the hospitals increased and it is now at usual or higher levels for this time of year.

REVENUE

Government funding

The Ministry of Health approved funding for Public Health to assist with the COVID-19 response. The Ministry of Health confirmed that Planned Care funding would continue despite the Planned Care delivery not being fully achieved subject to delivery of 85 per cent of target in June 2020 and the submission of an acceptable Improvement Action Plan to reduce Planned Care waiting lists. Southern DHB fulfilled these requirements for the Planned Care funding. In addition, the Ministry of Health announced additional funding to support community health providers impacted by the COVID-19 lockdown. This funding was distributed through Southern DHB to WellSouth (Primary Health Organisation), General Practitioners, Pharmacists and Aged Care Providers.

Other Revenue

Rent relief was granted to tenants operating within the hospitals who were unable to trade during the lockdown.

Ineligible Patient (Non-Resident) revenue has decreased with the borders closed to tourists.

EXPENDITURE

Workforce expenses

Southern DHB was not eligible for the Government Wage Subsidy.

Although the directive from the Ministry of Health was to reduce the clinical activity in the hospitals the

workforce activity continued. A contributing element was the requirement to prepare for the potential impact on services of the COVID-19 pandemic.

The COVID-19 lockdown limited the opportunity for employees to travel and resulted in employees cancelling planned leave. Therefore the leave liability across all workforce types has significantly increased in the months since March 2020.

The treatment of Continuing Medical Education (CME) entitlements under clause 36.2 (b) of the ASMS – DHBS Senior Medical and Dental Officers' MECA was modified to allow any affected Senior Medical Officer to carry over expiring CME or professional development funds that are at risk due to travel restrictions beyond the stated three-year limit in the MECA. This extension is not subject to the requirements around approval of a specific plan for usage, but is subject to five year maximum accrual in recognition that there was significant disruption to the ability of, and opportunity for, DHB-employed Senior Medical Officers to access regular CME activities such as national, Australasian and international courses or conferences.

The Public Services Commission (formerly the State Services Commission) instructed that casual workers were to be paid during Alert Levels 3 and 4 based on prior period earnings even though they were not working.

During the lockdown those employees identified as vulnerable were unable to work in clinical environments and were paid special leave if they were unable to work remotely.

Other expenses

Across a range of expenditure there has been variability arising from the lockdown and COVID-19 response. This includes increases in Personal Protective Equipment (use of disposable masks, gloves), laundry (use of scrubs), cleaning (deep cleans) and information technology (remote services). By contrast there were decreases in travel (lockdown limited travel), hotel services (patient meals during lockdown) and clinical supplies (cancelled surgery during lockdown).

ASSETS

Capital Expenditure

The incident response planning included additional capital expenditure directly related to preparation for the COVID-19 pandemic. While there was capital equipment expenditure that was brought forward, the majority of the expenditure was unplanned and unbudgeted. The original plan for capital required for the COVID-19 response was estimated at $2 million; of that approximately $1.2 million was purchased.

The capital projects in progress and scheduled for the period during the Alert Level lockdown were delayed. As a result projects have not been completed by 30 June 2020 and have been rolled forward into 30 June 2021. These delays potentially impact both service delivery and the cost of the projects.

Property – Land and Buildings

Based on the fair value assessment there was no requirement for a formal revaluation at 30 June 2020 (fair value assessment indicates that the 30 June 2020 carrying value for the portfolio is not materially different to what a formal revaluation would produce). For the majority of Southern DHB's property assets, construction costs (replacement costs) is the key market-based assumption that will influence value changes. The impact of COVID-19 on construction costs anecdotally has not materially impacted pricing at the current time particularly when we returned to Alert Level 1 within New Zealand. Obviously, this could change in the future depending on global and domestic events.

LIABILITIES

Accounts Payable

The Public Service Commissioner (formerly State Service Commissioner) Peter Hughes' letter to all Chairs and Chief Executives requested that we support government suppliers by targeting payment of 95 per cent of invoices within 10 business days. We continue to action this directive by making all supplier terms immediate and completing a payment process every Friday. This has a one-off timing impact on our cashflow, redistributing the 20th month payment to the weekly payment of creditors.

RISK ASSESSMENT

Extensive risks were identified during the COVID-19 period and there were dramatic changes to configuration of service delivery. Unbudgeted capital expenditure was incurred to mitigate the risks, and considerable unbudgeted operating expenditure was incurred. The risks were related to potential adverse clinical outcomes for anyone contracting COVID-19 and risks associated with delays in accessing necessary health care. These risks were all mitigated by prioritising essential health care services, deploying telehealth and mobile technology to enable staff to work remotely where possible and for patients to access services electronically where possible. Within the hospital we set up red, orange and green stream activities. In primary care we supported the uptake in telehealth, and we established Community Based Assessment Centres (CBACs). In residential services as well as home and community-based services we provided necessary Personal Protective Equipment (PPE) as well as Infection Prevention Control (IPC) advice.

GOING CONCERN

The going concern assessment is challenged this year as in prior years. There is limited impact from COVID-19 on the going concern assessment. Overall, the position remains subject to the same levels of scrutiny as for prior years.

Information on Ministerial Directions

Directions issued by a Minister during the 2019/20 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-servicesjuly08.PDF
- COVID-19 Response direction 2020, under section 32 of the New Zealand Public Health and Disability Act 2000 and section 103 of the Crown Entities Act.

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 2020

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 76 to 106, that comprise the statement of financial position as at 30 June 2020, the statement of comprehensive income, 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 14 to 44.

Qualified opinion on the financial statements

In our opinion, except for the possible effects of the matter described in the Basis for our qualified opinion section of our report, the financial statements of the Health Board on pages 76 to 106:

- present fairly, in all material respects:
    - its financial position as at 30 June 2020; 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.

Unmodified opinion on the performance information

In our opinion, the performance information of the Health Board on pages 14 to 44:

- presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2020, 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 9 December 2020. This is the date at which our opinion is expressed.

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

Basis for our qualified opinion on the financial statements and unmodified opinion on the performance information

As outlined in note 14 on page 96, the Health Board has been investigating issues with the way it calculates holiday pay entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues.

The provision for employee entitlements includes $75.5 million for the estimated amounts owed to current and past employees. Due to the complex nature of health sector employment arrangements, the Health Board's process is ongoing, and there is a high level of uncertainty over the amount of the provision. Because of the work that is yet to be completed, we have been unable to obtain sufficient appropriate audit evidence to determine if the amount of the provision is reasonable.

We were also unable to obtain sufficient appropriate audit evidence of the $37.1 million provision as at 30 June 2019. We accordingly expressed a qualified opinion on the financial statements for the year ended 30 June 2019.

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 the basis for our qualified opinion on the financial statements and the basis for our opinion on the performance information.

Emphasis of matters

Without further modifying our opinion, we draw attention to the following disclosures in the financial statements.

The Health Board is reliant on financial support from the Crown

Note 1 on page 80 summarises the Board's use of the going concern basis of accounting in preparing the financial statements. The Board has considered the circumstances which could affect the validity of the going concern assumption, including its responsibility to settle the estimated historical Holidays Act 2003 liability. There is uncertainty whether the Health Board will be able to settle this liability, if it becomes due within one year from approving the financial statements. To support the Board's going concern assumption, a letter of comfort was obtained from the Ministers of Health and Finance. The letter outlines that the Crown is committed to working with the Health Board over the medium term to maintain its financial viability. The Crown acknowledges that equity support may need to be provided, where necessary, to maintain viability.

Impact of Covid-19

Note 25 on page 105 outlines the impact of Covid-19 on the Health Board.

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

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

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

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

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

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

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

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

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

- 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 Board and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast a significant doubt on the Health Board'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 Board regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Our responsibilities arise from the Public Audit Act 2001.

Other information

The Board is responsible for the other information. The other information comprises the information included on pages 1 to 13, 47 to 74, and 107 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: International Code of Ethics for Assurance Practitioners issued by the New Zealand Auditing and Assurance Standards Board.

For the year ended 30 June 2020 and subsequently the independent Chair of the Health Board's Finance, Audit and Risk Committee is a member of the Auditor-General's Audit and Risk Committee. The Auditor-General's Audit and Risk Committee is regulated by a Charter that specifies that it provides independent advice to the Auditor-General and does not assume any management functions. There are appropriate safeguards to reduce any threat to auditor independence, as the member of the Auditor-General's Audit and Risk Committee has no involvement in, or influence over, the audit of the Health Board.

Other than in our capacity as auditor, and the relationship with the Auditor-General's Audit and Risk Committee, we have no relationship with, or interests, in the Health Board.

John Mackey
Audit New Zealand
On behalf of the Auditor-General
Dunedin, New Zealand

Southern District Health Board
Piki Te Ora

Southern Health
He hauora, he kuru pounamu