Southern District Health Board
Piki Te Ora

Southern Health
He hauora, he kuru pounamu

Annual Report

Quality and Performance Account

2020/21

Key highlights

Progress implementing the **Primary Maternity Strategy** resulted in the establishment of Maternal and Child Hubs in Wanaka, Lumsden and Fiordland. Southern DHB has taken over management of the Primary Birthing Unit (PBU) in Alexandra, Central Otago, and agreed to develop two Primary Birthing Units in the Central Otago and Wanaka areas

A new state-of-the-art **Operating Theatre and Post Anaesthetic Care Unit** (PACU) at Queen Mary Maternity Unit at Dunedin Hospital opened at the beginning of 2021, bringing benefits for mothers, their babies, whānau, and staff

The Detailed Business Case for the **New Dunedin Hospital** was approved – building on extensive staff and community consultation and a major milestone for this critical project

Assessment, treatment and rehabilitation services. Assessment and Liaison (OPAL) unit provides a streamlined admission and assessment pathway, facilitating a quicker return home. OPAL has now expanded to 10 beds, through a reconfiguration of existing beds.

A comprehensive review of **Mental Health and Addictions** services across the Southern Health system was carried out, receiving over 1300 pieces of feedback, and paving the way for the transformation of these critical services

Fewer young children have needed to be admitted to hospital - **Ambulatory Sensitive Hospitalisation** (ASH) rates have declined for those aged 0-4 years

Southern's COVID-19 vaccination programme tracked well, achieving 80,544 vaccinations, with 49,230 (16.1% of the 305,500 eligible population) people having received at least one dose by 30 June. Alongside Kaupapa Māori services, the Southern Māori directorate developed a collaborative Outreach COVID vaccination programme for marae and rural areas.

The rate of rest home-level residential care continues to decrease, indicating more people are continuing to live in their own home, either supported or independently.

Southern District Health Board
Piki Te Ora

Southern DHB celebrated its remarkable staff from across the district at the Southern Excellence Awards in November 2020

A $200 million blueprint for the future of the digital transformation of the Southern Health system was developed, promising a powerfully technologically enabled future for health

The **Southern Disability Strategy** was launched, marking an ongoing commitment to removing barriers to healthcare for disabled people and providing equitable health and disability services throughout the Southern district.

Southern District Health Board
Piki Te Ora

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Annual Report

Quality and Performance Account

2020/21

This Southern District Health Board Annual Report 2020/21 is presented to the House of Representatives pursuant to section 150(3) of the Crown Entities Act 2004.


EXIT
RADIOLOGY
Southern District
BERNIE

Contents

Foreword from the Chair & Chief Executive

Pete Hodgson
Board Chair

Chris Fleming
Chief Executive Officer

1 July 2020 to 30 June 21 was the year New Zealand spent sheltering from a storm.

It was a brief zone of tenuous safety between the COVID outbreaks and national lockdowns of autumn 2020, and spring of 2021.

For the Southern health system, this meant a time for learning from our recent experience, catching up on the care we had been unable to provide, and preparing ourselves for how we would face any future outbreaks and adjust to a world where COVID was part of life as normal. And we needed to be ready for immediate action. At no time was it certain how long the ramparts would hold.

This context has shaped many of the challenges and highlights of the past year, and focused attention on the most urgent areas of our work.

These reinforced our existing priorities, including strengthening 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. It also underscored the importance of specific initiatives including virtual health (telehealth), 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.

It saw new partnerships and innovations, including a cross-sector response to the important psychosocial support needs of the hard-hit Queenstown-Lakes area, that now oversees a $3 million fund as part of a MBIE support package for the tourism sector. And it set in motion the historic undertaking of vaccinating our entire population against this new virus.

Most critically, however, it reminded us of the critical importance of addressing inequities in our health system, especially between our Māori and non-Māori populations, and ensuring no part of our community is left behind.

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

Underpinning this has been a reorientation of our partnership with Araiteuru and Murihiku rūnaka, with the signing of a renewed agreement between Southern DHB and WellSouth Primary Health Network, and the seven papatipu rūnaka. This establishes the principles of our partnership as we collectively address the unacceptable inequities in the current health system.

It is also being progressed in the context of a wide-ranging reform of the health system, the outline of which was announced in early 2021.

The following goals have provided the basis for reporting the Southern DHB's journey in recent years, and in 2020/21 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

Clinical service redesign – primary and secondary/tertiary services are better connected and integrated. Patients experience high quality, efficient services that value their time

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, and facilities across the Southern health system 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.

This includes making inroads in critical areas that will help shape the future direction of the Southern health system.

The Disability Strategy, launched in early 2021, was the culmination of an extensive engagement with our disabled community, and is now the driving work programme for the Disability Advisory Support Committee that advises the Southern District Health Board.

The Detailed Business Case for the New Dunedin Hospital was approved, a milestone achievement for the development of the state-of-the-art facilities that will transform the delivery of health services for the district. Behind the document is thousands of hours of planning and discussion, drawing out the needs, priorities and solutions of patients, clinical staff, design experts, health system planners, mana whenua and many more.

We launched our Digital Transformation Strategy, representing a $200 million investment in the digital architecture that will transform models of care for the future.

We carried out our Mental Health and Addictions System Review, garnering over 1300 items of feedback through hui, surveys and submissions, from those

who work in or have lived experience with the mental health system. The recommendations in the resulting report, *Time for Change – Te Hurihanga*, will shape the direction for this service through the years ahead.

We also commissioned a review from health systems consultant Leena Singh, whose expertise supported the progress of a strengthened performance and accountability framework.

This strategic development occurred while we also addressed the impact of the March/ April 2020 lockdown, which as well as collectively stamping out COVID-19 had wider consequences for the health system.

Some were superficially positive. In 2020/21 we are reporting lower than usual Ambulatory Sensitive Hospitalisation (ASH) rates, the result of fewer respiratory and influenza-like infections as a result of stamping these out along with COVID last year. (There are however indications that this may have triggered higher levels of RSV in 2021 however, as a layer of community-level immunity was lost.)

Other demands on our health services, including emergency department and mental health presentations, also reduced.

However, in many cases the reductions simply meant delays in seeking care – their health conditions becoming more acute in the meantime. This, coupled with the postponement of surgeries and procedures, led to significant bulges and bottlenecks in demand for services. The consequences were cancers being diagnosed later, and a burgeoning of those on waiting lists for elective surgeries. Efforts to address these challenges were exacerbated by a further reverberation of COVID-19 – closed borders added to difficulties recruiting nursing and specialist staff. In December, a decision was taken to cancel all elective surgeries to alleviate the pressure on our emergency departments and wards.

These serious challenges led, however, to renewed attention on our hospital systems. The patient flow workstream provided dedicated focus on preventing bed block in our hospitals. Escalation pathways were formalised. New approaches were explored for working with partners outside of the Southern district to provide cancer care. Approval was given for additional CT and MRI scanners, to reduce delays to diagnoses.

Meanwhile, with the oversight of gastroenterologist and Crown monitor Dr Andrew Connolly, our teams have been working to decisively tackle longstanding challenges relating to access to colonoscopy services.

In addition, we were pleased to make progress in further areas, including provision of primary maternity services in Central Otago, with approval to develop birthing units at Dunstan Hospital in Clyde, and in Wanaka.

These efforts were made in the context of continued expectation of financial prudence, and this year we reported a deficit of $30.9 million. While this exceeded our budgeted deficit, the core operating deficit represents an improvement on previous years.

Over the coming year, our focus will be on ensuring momentum in these key strategic areas as we transition to a new health system. While the reforms inevitably herald changes for how we are organised, the direction of travel signalled for New Zealand aligns strongly with the overall approach we have been taking in the Southern district for many years. We see a strong commitment to care closer to home, more streamlined services, leveraging the power of technology, and ensuring care is informed by our communities.

At the same time, the new system offers new approaches, in particular with the Māori Health Authority aiming to emphatically address the equity issues that trouble us all.

We are confident this places the people of Southern New Zealand in a good position for the ongoing development of a health system that meets their needs, and are determined to ensure we hand over a robust programme of work, with momentum behind it, and to support the success of the new structures.

Again, we are reminded 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.

Thank you for everything you do to support the wellbeing of everyone in our community. He hauora, he kuru pounamu.

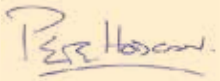
Pete Hodgson, Board Chair
Chris Fleming, Chief Executive Officer

Statement of Responsibility

For the 12 months ended 30 June 2021

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.

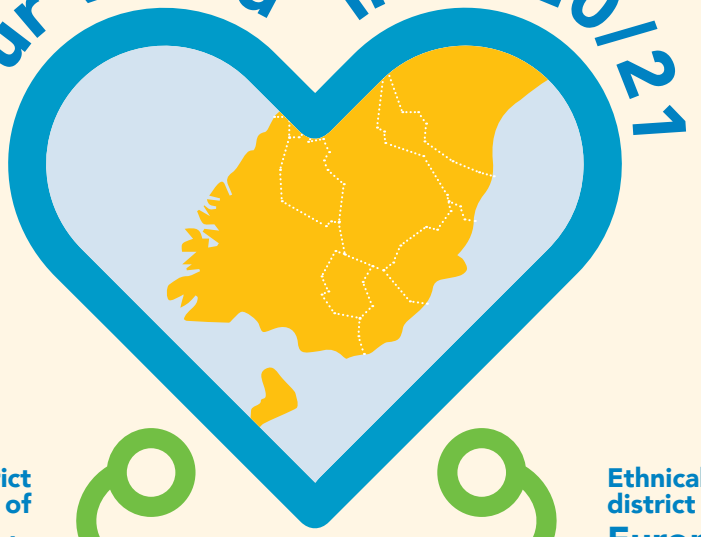
The board and management of Southern DHB accept responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial and non-financial reporting. In the opinion of the board and management of Southern DHB the financial statements and statement of service performance for the year ended 30 June 2021 fairly reflect the financial position and operations of Southern DHB.



Pete Hodgson
Board Chair
17 December 2021

Chris Fleming
Chief Executive Officer
17 December 2021

Our world in 2020/21



The Southern district has a population of **350,940** residents

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

Ethnically, the Southern district is predominantly **European at 79%.**
11% are Māori, 8% Asian and 2% Pacific.

5,368 staff employed by the DHB

1080 employees joined Southern DHB in 2020/21

8.61 years – average tenure of employees at Southern DHB

4,703 people supported by Home and Community Support Services

6,879 acute surgical operations

11,859 elective operations or procedures

3,248 babies born in DHB facilities in 2020

97,494 presentations to the Emergency Departments

93% of children fully immunised by 8 months

Our population is slightly older when compared to the national average.
17.2% are aged **65 and over**
(1.39% higher than last year)

277,861 outpatient appointments across all services

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

Southern DHB is governed by a board of elected and government-appointed members, and Crown monitors. The board works in partnership with the Iwi Governance Committee, and is advised by the Hospital Advisory Committee, Disability Support Advisory Committee, Community and Public Health Advisory Committee, Finance Audit and Risk Committee.

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.

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 a 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 15 March 2021, Murihiku and Araiteuru Rūnaka, Southern DHB and WellSouth Primary Health Network renewed its collective Principles of Relationship agreement to provide the framework for ongoing relations between Kā Papatipu Rūnaka and the administration entities for the Southern health system. All 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.

Ka Papatipu Rūnaka

The Iwi Governance Committee is made up of a representative from each of the seven papatipu rūnaka identified in Te Rūnanga o Ngai Tahu Act (1996) whose territory is in the Southern DHB region:

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

Mauri ora ki a tātou katoa.

"Collectively we understand that attending to these problems will ensure Māori have equity and best care in all systems. This includes the pathways by Māori for Māori approach that is supported by Southern DHB and WellSouth."

Manawhenua leadership

"The disparity between Māori and the general population is no longer just a matter of concern; it is a matter that demands resolution. This signing reasserts our absolute conviction that the current inequities are unacceptable, and our shared unwavering focus on making the changes that are needed."

Pete Hodgson,
Southern District Health Board Chair

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 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

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.

COVID-19 has remained a significant priority for Southern DHB over the past year. We have faced significant disruption to our health services, with increasing pressure on our systems that we are still working to address. We continue to reshape our public health function and progress a primary and community care strategy centred on increased technology and better supporting patients to be cared for outside of a hospital context, while streamlining our secondary services.

On 30 June, the Southern DHB reached a milestone of 81,516 vaccinations. (11.66 per cent of the eligible population) people having received at least one dose. Of these, 57 per cent were completed in the large Southern DHB run clinics in Dunedin and Invercargill. Increasing numbers (43 per cent) are being undertaken by primary care in rural areas. We were well into Group 3 of the government's scheduling framework with 28,834 (of 100,000) vaccinations completed.

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. 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). A guide to the measures is provided on pages 49-50.

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 for comparative reasons, New Zealand targets are not stated as they are not part of the performance objectives outlined in our Statement of Intent.

The three strategic outcomes outlined in the 2020/21 Annual Plan and the Southern DHB Statement of Intent Incorporating the Statement of Performance Expectations 2019/20-2021/22 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	• 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 amenable mortality
Impact Measures	• Fewer young people take up tobacco smoking • More children are caries Free • A reduction in avoidable hospital admissions for children (0-4)	• People wait no more than 6 weeks for scans (CT or MRI) • A reduction in number of people admitted to hospital due to a fall • A reduction in avoidable hospital admissions for adults (45-64)	• 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 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 support people to make healthy choices will help to decrease future demand for care and treatment and improve the quality of life and health status of our communities and whānau.

How have we measured our success?

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

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

The impact measures that contribute to these outcomes are:

- More 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. We are unable to report uptake smoking by youth (as measured by the year 10 ASH survey) as ASH did not undertake the survey in 2020 as a result of COVID-19. The caries free rate for 5-year olds remains 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.

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

Southern's smoking rate data is acquired from the NZ Health Survey; unfortunately, due to the timing of publications, the 2020/21 data is not yet available and we generally remain 12 months behind in our reporting for these measures.

2019/20 data is the most recent data for 'Percentage of the Population 15+ who Smoke'. The year saw an increase in the reported number of smokers. It should be noted that the New Zealand Health Survey is mainly designed to gain robust national figures, 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, 76 per cent of smokers in primary care were seen by a health practitioner and offered brief advice and support to quit smoking which sits below the target of 90 per cent.

Percentage of the population 15+ who smoke

	2017/18	2018/19	2019/20	2020/21
Southern DHB	13.5%	12.8%	14.20%	Not available
New Zealand	14.9%	14.2%	13.40%	Not available

Data sourced from New Zealand 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, including healthier body weight through improved nutrition and physical activity levels, is fundamental to improving health and well-being and to preventing and better managing long-term conditions and disability at all ages.

Southern's obesity data (for percentage of population 15+ who are obese) is acquired from the NZ Health Survey. As mentioned previously we generally remain 12 months behind in our reporting for these measures and 2019/20 data is the latest data available this year.

The B4 School Check (B4SC) Programme provides obesity data for 4 year old children. In the six months to 31 May 2021, the B4SC programme identified 8.8 per cent of 4 year olds as obese, with Māori at 12.2 per cent.

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.

Active Families is now delivered face-to-face in Oamaru. Green Prescription has extended face-to-face service delivery in one Central Otago General Practice. Discussions continue with Sport Otago and WellSouth PHO in relation to extending this opportunity to other primary care practices in Central Otago. Southern DHB is working with Green Prescription providers to increase focus on equity and preventative initiatives, including increased engagement with primary care to ensure understanding of opportunities within this programme.

Southern 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 children.

Refinement of programmes and resources has meant consistent messages for healthy living primarily across pregnancy, childhood and adolescence, including:

- 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. Examples include promoting breastfeeding friendly public spaces, venues (including sports venues) and retailers, and working with venues to encourage simple steps to make people feel comfortable about breastfeeding.

Percentage of the population 15+ who are obese

	2017/18	2018/19	2019/20	2020/21
Southern DHB	29.4%	34.0%	34.1%	Not available
New Zealand	32.2%	30.9%	30.9%	Not available

Data sourced from New Zealand Health Survey

Note that the New Zealand Health Survey is mainly designed to gain 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 2020/21 experienced interruptions due to COVID-19. Nationally, non-acute oral health services were temporarily suspended due to the risks associated with transmission and infection. Recovering Southern DHB volumes through 2021/22 will be achieved through a combination of:

- Equity based assessments filtering the high from low risk within the population
- Continuing annual check-ups which will range from 12 to 18 months depending on the risk assessment
- Rationalising mobile placement targeting areas of high arrears
- Adding fourth chair to South Dunedin
- Training Dental Assistants to apply fluoride varnish (clinics)
- Targeting additional resource for at-risk children.

Initiatives such as the development of an electronic portal for families, and guidelines for tele-dentistry are expected to support improvement in our caries free rate by allowing resources and attention to be targeted to those children most at risk.

Children caries-free at age five

	2018	2019	2020	
	Actual	Actual	Target	Actual
Southern DHB	70%	69%	>70%	68%
Southern DHB Māori	55%	56%	>70%	54%
New Zealand	60%	59%	-	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. We are unable to report uptake smoking by youth (as measured by the year 10 ASH survey) as ASH did not undertake the survey in 2020 as a result of COVID-19.

'Never smoker' amongst year 10 students

	2018	2019	2020	
	Actual	Actual	Target	Actual
Southern DHB	81%	79%	>82.6%	Not available
New Zealand	81%	80%	-	Not available

Data Source: ASH Year 10 Survey

Medium Term Indicator: Avoidable Hospital Admission Rates for children (0-4) years

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, thus reflecting a more integrated health system.

Southern DHB ASH rates for children 0-4 years, including Māori, have improved over the past 24 months. We believe this may be primarily related to the impacts of COVID-19, in particular with reduced transmission of respiratory infections as a result of lockdown and other public health measures.

We know that respiratory conditions (including asthma and upper and ENT respiratory infection infections) and dental problems comprise the main reasons behind ASH 0-4 admissions, especially for Māori.

There is still evidence of ongoing ōritetanga but the equity gap appears to be reducing. In response to ōritetanga that is apparent in our baseline data, our Kaupapa Māori Health Services within primary, community and secondary care services are taking a targeted approach to improve this measure, starting with a focus on conditions with the highest rates. For 2021/22, a new Māori Health Clinical Group will advise on clinical activity that impacts on admissions and readmissions.

Rate of ambulatory sensitive hospital admission for children (0-4)

	2018/19	2019/20	2020/21	
	Actual	Actual	Target	Actual
Southern DHB	5,869	5,496	<5,678	3,820
New Zealand	7,611	6,685	<5,678	3,737

Prior year results may differ from those previously reported.

The Ministry of Health recalculates prior year ASH rates based on updated extracts from the National Minimum Dataset (NMDS) and updated population estimates

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 and improves equitable health outcomes for whānau and our broader communities, it 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 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. The new CT due to open in Dunedin in September 2021 should provide better inpatient and outpatient access, reducing acute bed days further while meeting outpatient waiting times.

There has been approval for a second MRI scanner in Dunedin and planning for this is underway. This is likely to be installed around June 2022 and will assist with diagnostic waiting times.

Rates of people staying in their own homes shows a gradual increase over time. 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. Compared to national rates, Southern DHB rates for adults aged 45 to 64 are highly favourable.

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.

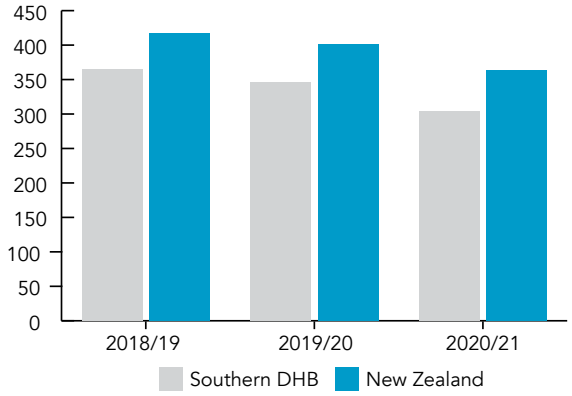
Southern DHB's acute bed days per capita sits below the national average and is ranked fourth lowest for the 2020/21 year.

2020/21 saw a continuation of the rollout of General Practice Health Care Homes programme, with further tranches of practices adopting an expanded suite of services for their communities. These include expanded GP triage, acute daily appointment capacity and extended hours – all factors focused 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 who 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)

	2018/19	2019/20	2020/21
Southern DHB	365	346	304
New Zealand	417	401	364



Data sourced from National Minimum Data Set.

Outcome: People Living at Home

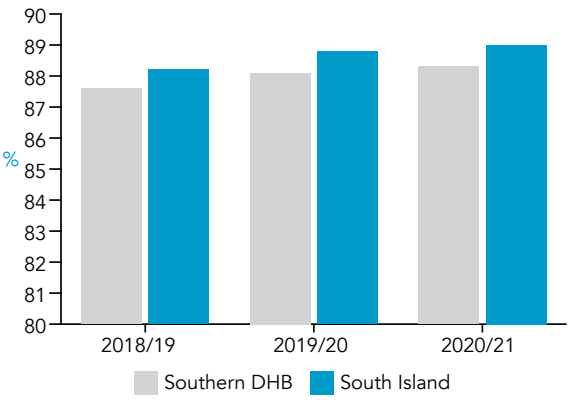
This measure looks at the proportion of the population aged 75+ living at home. Studies have shown a higher level of satisfaction and better long-term outcomes where people remain in their own homes and are positively connected to their communities. This indicator can be used as a proxy of how well the 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 past years, which has been maintained in 2020/21. This is positive as we know that many of our older people have multiple chronic health conditions.

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 home and manage their comorbidities, entering aged-residential care services older in age.

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

	2018/19	2019/20	2020/21
Southern DHB	87.6%	88.1%	88.3%
South Island	88.2%	88.8%	89.0%



Data source: National Minimum Data Set

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 and early and appropriate intervention, thereby 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 was 44 per cent for 2020/21, with compliance at 48 per cent in June 2021. The greatest gaps between capacity and demand are experienced in Dunedin.

A second MRI has been approved for Dunedin. This is estimated for instalment circa June 2022. Increased staffing in Southland and changes in patient flows have been undertaken to improve equity across the district. Additional outsourcing will be undertaken to improve performance while waiting for the additional scanner to be installed.

An additional diagnostic CT for Dunedin will be commissioned in September 2021 and additional staffing is being recruited. The new scanner should result in compliance with MoH indicators in the fourth quarter of 2021/22.

There will be an increase in GP access to high tech imaging during 2021/22 through revamped HealthPathways and GP liaison.

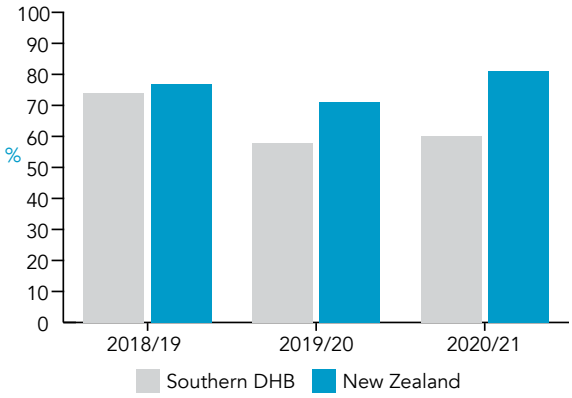
People receiving non-urgent CT scan within six weeks

	2018/19	2019/20	2020/21	
	Actual	Actual	Target	Actual
Southern DHB	74%	58%	>95%	60%
New Zealand	77%	71%	-	81%

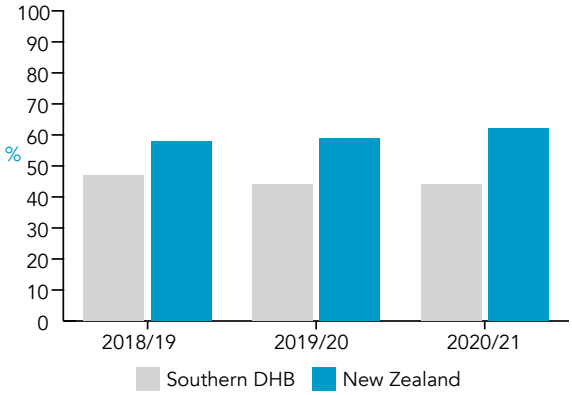
People receiving non-urgent MRI within six weeks

	2018/19	2019/20	2020/21	
	Actual	Actual	Target	Actual
Southern DHB	47%	44%	>75%	44%
New Zealand	58%	59%	-	62%

Percentage of CT scans within 6 weeks



Percentage of MRI scans within 6 weeks



Data sourced from Ministry of Health.

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.

Our well-established multi-agency Southern Falls and Fracture Prevention Steering Group continues to take a sector-wide approach to falls and fracture prevention. This includes engaging with the wider sector during regular educational forums, monitoring our ACC/DHB investment in an integrated approach led by WellSouth and continuously looking for opportunities to make a difference in the falls and fracture prevention arena. WellSouth are the Lead agency for community strength and balance and provide fracture liaison and in-home strength and balance sessions.

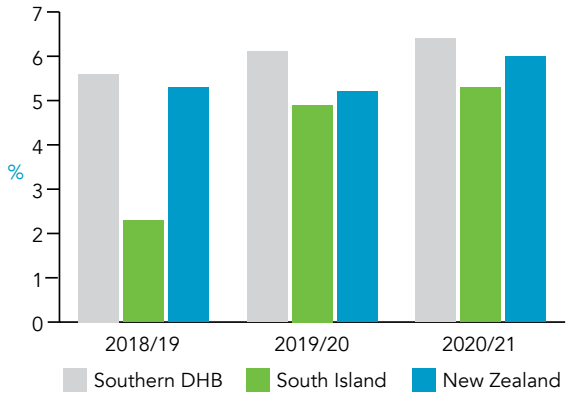
For 2020/21, our performance for this metric improved slightly; performance was above the <5.0% target. ACC data provides a better insight into falls and the impact of falls. Neck of Femur (NOF) fractures have the biggest impact on an older person's quality of life and the rate of NOF fractures is decreasing. Admissions due to other fractures remains steady; admissions due to non-fractures is increasing.

Overall, even though admissions linked to falls are increasing, the severity of injury and the impact of the falls is decreasing. Attribution to specific falls prevention activity is difficult. Falls prevention is complex and has many contributing factors.

The DHB is reframing how we view frail elderly people in the system, in order to take a more holistic approach. We continue to work across the sector to improve identification of mild/moderate frailty and link into better falls prevention.

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

	2018/19	2019/20	2020/21	
	Actual	Actual	Target	Actual
Southern DHB	5.6%	6.1%	<5.0%	6.4%
South Island	2.3%	4.9%	<5.0%	5.3%
New Zealand	5.3%	5.2%	-	6.0%



Data source: National Minimum Data Set

Medium Term Indicator: Avoidable Hospital Admissions (45-64)

Keeping people well and supported to better manage their long term conditions by providing appropriate and coordinated primary care should result in fewer avoidable hospital admissions, measured as Ambulatory Sensitive Hospitalisation (ASH) rates, not only improving health outcomes for our population but also reducing unnecessary pressure on our hospital services.

The rates for 2020/21 are favourable and the target for the Southern DHB total population has been met but challenges remain in addressing inequity. To address ōritetanga, Hauora Wellness Checks for Māori populations aged 50+ years have been implemented through the WellSouth Call Centre, with a specific focus on tikanga, manaakitanga and whanaungatanga. The aim is to minimise and reduce admissions to hospital by:

- Enrolment to General Practice/Designated Practice, for those unenrolled
- Re-engaging Māori with their General Practice for self-management of care and access to screening programmes.

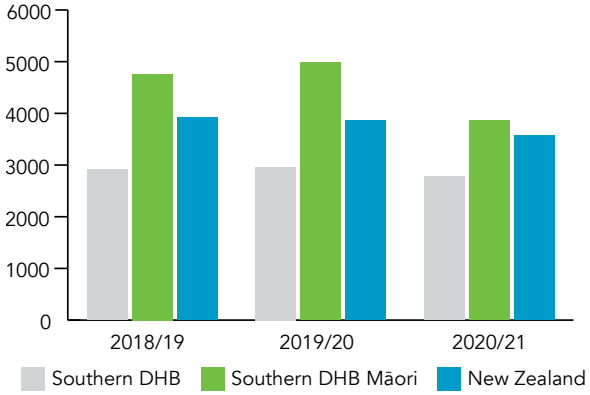
A youth system-level network was established in 2019/20 with the objective to reduce the rate of self-harm ED presentations. This group is reviewing the system of care, undertaking analysis of patient flows and causes and seeking to improve the access and uptake of primary and community care services to prevent community rates of self-harm. This work was curtailed during 2020/21 due to the residual impacts of COVID-19 and the need to complete the review of the Southern Mental Health and Addiction System. This work is expected to continue in 2021/22.

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

	2018/19	2019/20	2020/21	
	Actual	Actual	Target	Actual
Southern DHB	2,914	2,963	<2,865	2,780
Southern DHB Māori	4,762	4,990	<2,865	4,536
New Zealand	3,924	3,862	-	3,572

Prior year results may differ from those previously reported.

The MoH recalculates prior year ASH rates based on updated extracts from the National Minimum Dataset (NMDS) and updated population estimates.



This indicator is based on the national performance indicator SS05 and covers hospitalisations for a range of conditions which are considered preventable including: asthma, diabetes, angina, vaccine-preventable diseases, dental conditions and gastroenteritis.

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

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

There has been significant work in our hospitals over the past two years focused on patient flow. Acute bed days per capita and average length of stay have both improved and this is balanced with a readmission rate that has remained relatively constant. This indicates that overall the quality of care is improving.

The introduction of the Home Team in 2019 has made a difference for some of our most vulnerable patients by supporting them home from ED, preventing a hospital admission. The Home Team continues to evolve, with recognition that there are more opportunities to proactively prevent readmissions.

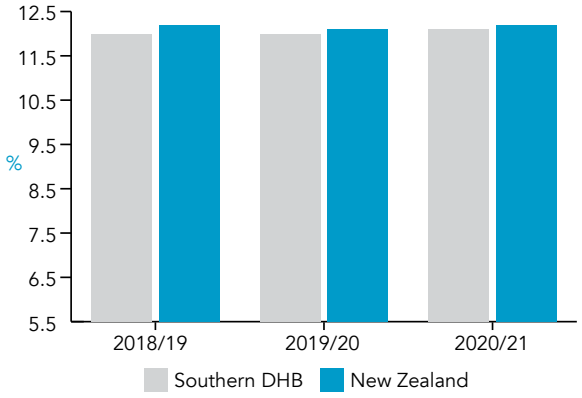
Southern DHB has worked in partnership with WellSouth PHO to implement innovative primary health services to address acute readmissions. Examples include Health Care Homes (HCH), with 29 GP practices now working within this model of care.

Domains include provision of urgent and unplanned care and proactive care for those with more complex needs. Another initiative is Client Led Integrated Care (CLIC) which supports patients with long-term conditions to self-manage their health.

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

	2018/19	2019/20	2020/21
Southern DHB	12.0%	12.0%	12.1%
New Zealand	12.2%	12.1%	12.2%

Data sourced from Ministry of Health Performance Reporting SS07. Results may differ slightly across years compared to past reports due to standardisation methodology.



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.

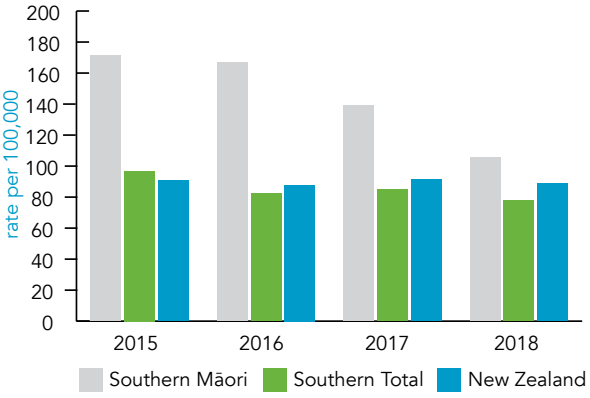
There are many economic, environmental and behavioural factors that have an influence on people's life expectancy. However, timely diagnosis, improved management of long-term conditions and access to safe and effective treatment are crucial factors in improving survival rates for complex illnesses such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

Rate of amenable mortality for people aged under 75 (age standardised, per 100,000 people)[1]

	2015	2016	2017	2018
Southern Māori	171.3	166.7	139.0	105.5
Southern Total	96.9	82.5	85.0	77.6
New Zealand	90.8	87.9	91.5	88.9

[1] Variance in reported figures is due to updated data



Note: There is a delay in mortality data as the cause of death has to be established for all reported deaths. Amenable mortality data is currently only available to 2018 and is still provisional.

Data sourced form 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.

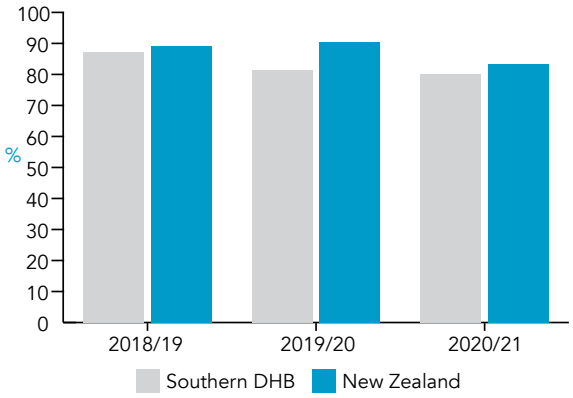
Current programmes to improve ED wait times that show this breadth include:

- Commencing a generalist model of admitting for Dunedin Hospital wards and the planning and development of a Medical Assessment Unit
- Working with primary care to plan for and ultimately provide options for patients attending for urgent care in Invercargill
- Planning redevelopment of the Invercargill Emergency Department
- Developing escalation plans for Dunedin (completed) and Southland Hospitals to better allow for flow
- The establishment of the Patient Flow Task Force specifically tasked to improve patient flow and therefore reduce overcrowding in the Emergency Department.

People admitted, discharged or transferred from ED within 6 hours

	2018/19	2019/20	2020/21	
	Actual	Actual	Target	Actual
Southern DHB	87.2%	81.3%	>95.0%	80.2%
New Zealand	89.0%	90.4%	-	83.3%

Data sourced from Ministry of Health Performance 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 or 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 particularly challenging in 2020/21 post COVID especially for outpatients and elective surgery.

The latter half of 2020 was particularly difficult with the latent effect of the COVID wave affecting surgical throughput.

Post COVID high peak demand for cancer surgery (Sept – Nov 2020) deteriorated the ESPI 5 position (people receiving agreed treatment in under four months) further as cancer patients were prioritised over long-waiting deferrable surgical interventions.

The cancer treatment surge was then followed by a shortage of nursing staff which significantly reduced access to inpatient beds. This was particularly significant for orthopaedics from December 2020 through to March 2021. Further beds were temporarily closed in June 2021.

The full implementation of ward-based Care Capacity Demand Management (CCDM) is expected to assist with bed access issues if staff can be recruited to over the next year. A recruitment campaign is underway and all New Zealand new graduates were appointed. There remain challenges with bringing new staff into New Zealand due to border restrictions.

In the last financial year, Southern DHB has undertaken a range of programmes in outpatient services to match capacity and demand. Examples include:

- Continued introduction of the Ministry of Health's prioritisation tool

- Implementation of an acuity index to support the prioritisation of First Specialist Appointments
- 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 further initiatives underway to extend acute theatre time in Dunedin. A targeted programme for use of private capacity for orthopaedic surgery has been developed.

People receiving specialist assessment and treatment within set timeframes

	2018/19	2019/20	2020/21	
ESPI 2	**Actual**	**Actual**	**Target**	**Actual**
Southern DHB	85.7%	65.2%	100.0%	80.5%
New Zealand	89.8%	75.6%	100.0%	87.9%

	2018/19	2019/20	2020/21	
ESPI 5	**Actual**	**Actual**	**Target**	**Actual**
Southern DHB	82.7%	55.8%	100.0%	62.5%
New Zealand	84.3%	67.4%	100.0%	77.0%

Data source: Ministry of Health Data Warehouse.

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 2020/21 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

	2020/21 Actual $000	2020/21 Budget $000	2020/21 Variance $000
Income			
Prevention Services	20,530	10,877	9,653
Early Detection and Management Services	222,996	220,998	1,998
Intensive Assessment and Treatment	795,179	771,806	23,373
Rehabilitation and Support	160,217	162,799	(2,582)
Total Income	**1,198,922**	**1,166,480**	**32,442**
Expenditure			
Prevention Services	20,530	10,877	(9,653)
Early Detection and Management Services	230,459	223,672	(6,787
Intensive Assessment and Treatment	809,979	776,944	(33,035)
Rehabilitation and Support	168,886	165,905	(2,981)
Total Expenditure	**1,229,854**	**1,177,398**	**(52,456)**
Surplus/(Deficit) for the year	**(30,932)**	**(10,918)**	**(20,014)**

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 2020/21 is $1,035.2 million which equals the Government's actual expenses incurred in relation to the appropriation. The performance measures are set out in the statement of service performance on pages 13 to 50.

Output Class: Prevention

Preventative 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 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 2020/21, Southern has also advanced a 'Health in All Policies' approach to engaging across sectors to improve the determinants of health.

Immunisation Services

Immunisation reduces the transmission and impact of vaccine-preventable diseases. Southern DHB works with primary care and allied health professionals to improve the provision of immunisations across all age groups both routinely and in response to specific 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 2020/21 year, the COVID-19 Vaccination roll out did have an impact on Southern immunisation plans for childhood immunisations as staff supported the COVID-19 rollout. A recovery plan was put in place to ensure catch up of missed immunisations once staff returned to their business as usual services.

While we have not reached our immunisation targets in 2020/21, Southern DHB continues to perform well compared to other DHBs. It is pleasing to note that Southern DHB was consistently in the top three DHBs across all Childhood immunisation age groups measured for overall and Māori 2020/21. Pacific Childhood immunisations performed above the national average for every age group. However, it should be noted that Southern coverage for Māori and Pacific has decreased, increasing the equity gap in Southern.

The school-based Human Papillomavirus (HPV) vaccination programme in Southern continued to perform above the national total in 2020/21 with 66 per cent HPV-all coverage, compared to the national average of 62.5 per cent. In 2020/21, Māori HPV-all coverage was 59 per cent, demonstrating that an equity gap remains which requires additional response.

The COVID-19 vaccination program is tracking positively against National targets. Alongside Kaupapa Māori services, the Southern Māori directorate have developed a collaborative Outreach COVID vaccination programme for Marae and rural areas.

Influenza vaccinations for older people remain a priority. We continued to maintain a collaborative programme across primary care, Southern DHB services and Kaupapa Māori services to provide influenza vaccination across the district, working alongside our Māori providers.

Immunisation Coordinators continued their ongoing commitment to working with the midwifery sector, General Practices, Well Child Tamariki Ora services, Kaupapa Māori and Pacific services to promote the uptake of immunisations, inclusive of new schedule changes. The National Immunisation Register (NIR) and Outreach services worked closely together to identify children/tamariki early in order to vaccinate on time.

Immunisation Coordinators also supported new immunisation providers to train and increase their capacity to vaccinate. Southern DHB has invested considerable effort into resourcing and supporting Kaupapa Māori services to build equity for vaccination services. Currently the Māori Health Directorate and Immunisation Coordinators are working collaboratively with Māori providers to increase capacity to deliver all vaccines.

2020/21 Performance Results for Immunisation Services

Measure		2018/19 Actual	2019/20 Actual	2020/21 Target	2020/21 Actual	
Percentage of children fully immunised at 8 months	Total	92%	94%	>95%	93%	
	Māori	85%	91%	>95%	89%	
Percentage of children fully immunised at 2 years	Total	94%	94%	>95%	91%	
	Māori	95%	94%	>95%	86%	
Percentage of boys and girls fully immunised with HPV Vaccine	Total	55%	64%	>75%	66%	
	Māori	49%	63%	>75%	59%	
Percentage of people (≥65) having received a flu vaccination	Total	56%	54%	>75%	62%	
	Māori	45%	44%	>75%	56%	

Data sourced from Ministry of Health performance reporting

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 2020/21 for >90% of enrolled patients who smoke who are seen by a health practitioner in primary care being offered brief advice and support to quit smoking. WellSouth have invested considerable resource into this target this year to improve performance and support a General Practice workforce that is also supporting COVID-19 swabbing and vaccinations. WellSouth employs three FTE in their call centre to make smoking cessation calls on behalf of practices. In addition, the call centre has been making wellbeing calls to Māori and Pacific people over 50 years on behalf of practices to encourage the connection with general practice and promote healthy lifestyle choices, including help to stop smoking. As part of the Access & Choice programme, WellSouth has implemented Health Improvement Practitioners (HIPs) and Health Coaches in a number of practices across the district and they have been trained to provide brief advice to stop smoking.

A Vape-to-Quit pilot commenced in 2020/21 and carries over to 2021/22. This pilot entails vape devices being offered to eligible smokers aged 18+ as a form of nicotine replacement to help transition from cigarettes on the journey to becoming smoke-free. There is an equity focus to the pilot, with referrals across Māori health and outreach, Southern Stop Smoking Service, Mental Health services and select community trial locations.

Smoking cessation initiatives focusing on pregnant women also remain a key component in reducing the risk of sudden unexplained death in infancy (SUDI). The Southern Stop Smoking Service (SSSS) provided by Ngā Kete Matauranga Pounamu continued to provide support to mothers to quit, antenatally and postnatally. In the past year, Southern DHB applied learnings from the 2019/20 pilot conducted in Oamaru, Balclutha and Dunedin Maternity Units to support engagement and referral to the Southern Stop Smoking Service, focusing on use of e-referrals to remove barriers to referrals for LMCs. However, acceptance of support offered to pregnant women has been low. Service changes implemented during the COVID-19 outbreak include use of telephone (one-on one) and group video parenting support services and are expected to increase uptake for service users. Other options to support stop smoking are being considered.

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. Breastfeeding networks across the district continue to meet, providing support and information for breastfeeding women and promoting World Breastfeeding Week. The Baby Friendly Hospital initiative is implemented across the district to promote, protect and support breastfeeding.

Increasing breastfeeding rates of Māori and Pacific women remains a priority. Southern DHB has extended the Pacific Trust Otago community breastfeeding support trial until July 2022 – targeting Māori, Pacific, those on the high deprivation index, refugees and speakers of other languages.

Southern DHB socialised its new Safe Sleep Policy in 2020/21. This is a major policy priority under the SUDI prevention programme that incorporates smoke-free messaging, benefits of breastfeeding as a protective factor against SUDI and other health promotion policy.

Rollout of safe sleep spaces continued in 2020/21, with changes to distribution to ensure greater access and availability for families. This included the launch of wahakura in 2020 for distribution to Māori and Pacific followed by five wahakura wānanga to increase the capacity of local weavers to produce wahakura. As part of this initiative, weavers will share harm reduction messaging for newborn babies through their casual conversations with whānau.

2020/21 Performance Results for Health Promotion and Education Service

Measure		2018/19 Actual	2019/20 Actual	2020/21 Target	2020/21 Actual	
Percentage of enrolled patients who smoke and are seen by a health practitioner in primary care and offered brief advice and support to quit smoking	Total	88%	78%	>90%	76%	🔴
	Māori	87%	77%	>90%	76%	🔴
Infants exclusively or fully breastfed at 3 months	Total	63%	62%	>60%	63%	🟢
	Māori	49%	53%	>60%	54%	🟠

Data sourced from WellSouth PHO; Ministry of Health

Population-Based Screening

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

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

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

How did we perform?

Southern DHB's coverage for screening measures remained stable in 20/21, with some improvements in performance in the past year as reflected in the table on the next page.

One of the main National Cervical Screening Programme (NCSP) performance measures is coverage, defined as the proportion of women eligible for screening who have been screened in the previous three years (target is 80%). Southern DHB remains above average for population coverage compared to other DHBs, including coverage for Māori and Pacific women. However, an equity gap still remains.

The redeployment of the Public Health Nursing service to support and initiate the COVID-19 vaccination programme in the Southern district for 10 weeks affected the ability of the service to deliver the B4 School Check programme in 2020/21. A concerted effort occurred in the fourth quarter to catch up and provide B4 School Checks to priority groups including Māori, Pacific and Quintile 5 children and tamariki. Consequently, the Southern B4SC programme has managed to exceed all targets for quarter 4 except for the Māori target; the Southern district was two per cent (11 tamariki) short of meeting the Māori target.

Southern DHB plans to achieve equity in B4 School Checks through the close engagement of Public Health Nurses with the education sector and with Kaupapa Māori and Well Child Tamariki Ora services. Public Health Nurses encourage, promote and support screening and assessment where required to ensure that equity is at the forefront of our B4 School Check programme going forward.

The Southern DHB universal hearing screening programme continues to screen babies both in hospital and community clinic settings. Facilitated through audiology services, a catch-up programme was initiated and completed for all babies that were missed during COVID-19 lockdown.

2020/21 Performance Results for Population-Based Screening

Measure		2018/19 Actual	2019/20 Actual	2020/21 Target	2020/21 Actual	
Percentage of eligible women (50-69 years) who have had a BSA mammogram breast screen examination in the past 2 years	Total	75%	66%	>70%	69%	●
	Māori	69%	63%	>70%	67%	●
Percentage of eligible women (25-69 years) who have had a cervical screening event in the past 36 months	Total	75%	71%	>80%	72%	●
	Māori	69%	63%	>80%	64%	●
The percentage of 4 year old children receiving a B4 School Check	Total	91%	78%	>90%	94%	●
	Quintile 5[2]	91%	74%	>90%	91%	●
Percentage of obese children identified in the B4 School Check programme offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions	Total	92%	92%	>95%	99%	●

Data sourced from National Screening Unit Breast Screening Aotearoa, National Screening Unit National Cervical Screening Programme, Ministry of Health B4 School Check Information System

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?

2020/21 was a challenging year as the service worked through the arrears built up prior to and during COVID-19. The service continues to experience difficulty recruiting to the Southern district but acknowledges that this is a national problem.

Since emerging from lockdown in April 2020 the service has steadily worked through the backlog of arrears. One of the actions taken to address arrears has been to introduce an assessment tool that identifies those requiring frequency of review and those who can be assigned 18 month recalls. The service has also diverted a mobile clinic and its staff from their normal schedule area to an area with high arrears with the result that the service has managed to make headway in reducing the backlog.

Arrears have been reduced from 33 per cent in January 2021 to 19 per cent by the end of 30 June 2021. The national acceptable arrears rate is 10 per cent of the population (percentage of children 0-12 years not examined based on planned recall) which the service is on track to clear by December 2021.

It is well known that different levels of oral health are experienced differently among different communities and deprivation levels contribute significantly to deteriorating oral health and access to oral health care. The Oral Health Service has been working on a multi-strategic approach for both catch up around annual checks and arrears reduction in 2020/21. A key focus has been on improving the equity of access to the service for those with the greatest need. Efforts include the development of a portal for families to record oral

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

health status and access interactive videos on caring for the oral health of the family coupled with the creation of a district wide oral health power BI dashboard which provides the service with up to date data.

The service is also participating in a spatial equity project which is looking at equitable distribution of oral health services across the district and use of a tool for resource distribution. Another initiative being developed is a trial of tele-dentistry. The goal of these initiatives is to allow the Oral Health Service to engage with those families at greater risk of deteriorating oral health.

Along the same lines of pursuing equity, the service has been engaging with the Māori Health Directorate and local Iwi, seeking assistance from Runaka on the best ways to provide oral health services in the Marae setting. 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. Planning and staff training were undertaken in 2020/21 to enable an increased and concerted effort in preventative fluoride varnish prevention programmes.

2020/21 Performance Results for Oral Health

Measure		2018	2019	2020		
		Actual	Actual	Target	Actual	
Percentage of 0-4 enrolled in community oral health services	Total	93%	84%	>95%	85%	●
	Māori	71%	63%	>95%	71%	●
The percentage of children caries-free at five years of age	Total	70%	69%	>70%	68%	●
	Māori	55%	56%	>70%	54%	●

Note: All oral health data is reported on a calendar year
Date sourced from Southern DHB Community Oral Health Services

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 Assessment (CVDRA) ensures these people are identified early and can therefore be managed appropriately.

How did we perform?

In the Southern district we employ a range of initiatives to address long-term outcomes and targets.

The CLIC (Client Led Integrated Care) 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. The foundation of CLIC is built on the patient's own declared self-management capability via Flinders Partners in Health Tool. The CLIC programme is almost fully implemented across all 81 WellSouth Practices.

WellSouth PHO has launched the WellSouth Call Centre to support medical practices in their care for clinical risk consumers, including those with CVD and Diabetes. WellSouth Thalamus dashboard identifies each patient who is eligible and overdue for a CVDRA so the practice can easily recall them. WellSouth Outreach nursing service also works with practices to support patients who have not engaged in practice recall.

WellSouth continues to prioritise CVDRA for Māori men aged 35 to 44 years but the Southern district is yet to reach the 90 per cent target for CVD checks. Of note, the Māori rate for CVD risk assessment is slightly higher than the total population rate. WellSouth has recently extended the eligibility for claiming CVDRA's to include all people with severe and enduring mental health and people of South Asian ethnicity as reflected in the national guidelines. This has helped to increase the number of completed CVDRAs in the Southern district.

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 for both Māori and overall. Our diabetes system of care is continuing to evolve. In 2020/21, Southern DHB re-established the Local Diabetes

Team (LDT) with new TOR and agreed membership. This group has supported a number of initiatives that support the wellbeing of patients with diabetes. This includes

- A new high risk diabetic foot health pathway to a single point of entry to secondary services
- A new MDT service for the diabetic foot in Invercargill
- A new nurse led model for type two patients in secondary care
- Full reassessment of each diabetic standard and planning to prioritise further initiatives.

The PHO have taken a whole of organisation approach to supporting diabetes in primary care, including the establishment of a Diabetes Strategic Working Group. The Group have been analysing and reviewing our Annual Diabetes Review (DAR) data to highlight gaps in service delivery and have developed project objectives

- Every person with diabetes has an annual DAR
- To understand why DARs have reduced at all levels: patients, practices and PHO
- To support practices with a range of ideas to increase DARs

WellSouth continues to offer the Diabetes Education and Self-Management for Ongoing and Newly Diagnosed (DESMOND) programme for patients with Type 2 Diabetes, while the 'Walking Away' from diabetes programme acts as a preventative programme for patients identified with pre-diabetes.

2020/21 Performance Results for Long-Term Conditions Management

Measure		2018/19	2019/20	2020/21		
		Actual	Actual	Target	Actual	
Percentage of the eligible population who have had a CVD Risk Assessment in the last 5 years[3]	Total	81%	76%	>90%	74%	●
	Māori	80%	77%	>90%	75%	●
Percentage of the population identified with diabetes having good or acceptable glycaemic control	Total	45%	53.5%	>60%	57%	●
		38%	46.3%	>60%	50%	●

Data sourced from WellSouth PHO

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

There is a particular challenge with CT performance in Dunedin city. Southland (including Lakes) CT performance was at an estimated 94 per cent at the end of June 2021 while Dunedin was 61 per cent. However, CT performance in Dunedin has improved over the year due to introduction of evening shifts, moving patients around the district for scans and outsourcing to private providers.

An additional diagnostic CT for Dunedin will be commissioned in September 2021. The service is planning how this will be utilised, and recruiting for staff. The new scanner should result in compliance with MOH indicators by the fourth quarter.

MRI scanning within 42 days has maintained a steady state in 2020/21. The overall MRI target compliance at Southern was 44 per cent for all of 2020/21 and 48 per cent for June 2021. The greatest gaps between capacity and demand are experienced in Dunedin.

A second MRI has been approved for Dunedin with estimated instalment circa June 2022.

We are expecting modest gains until such time that the new MRI is installed in Dunedin, with improvements resulting from implementation of evening shifts in Southland, changes to patient flows across the district and increased outsourcing to private providers.

[3] Note: There have been changes in the Ministry of Health's 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 the CVDRAMPC has been progressive, with calculations based on the new algorithms implemented over time, results must be interpreted with caution and comparison between those years with inconsistent denominators is not recommended.

There will be an increase in GP access to high tech imaging during the year through revamped health pathways and GP liaison.

Faster Cancer Treatment:

Southern DHB did not meet the 62-day target in any of the quarters in 2020/21. A review has been undertaken between Southern DHB and other DHBs, comparing results, profile of delay reasons and patient mix. It has been identified that opportunities to review patients who did not meet the 62 day target are not fully explored each month before data submission. This is estimated to have had deteriorated our results by 7-9 per cent each month during 2020/21. Additional resource has been added in this area.

A working group has been established to ensure our data collection is as accurate as possible and that patients are reviewed with a view to 'unblock' the patient pathway wherever possible.

Coordination and oversight of cancer pathways have been identified as a challenge for clinicians, patients and pathway navigators. For this reason an electronic whiteboard/application is being designed for external development. This will assist clinicians and coordinators to escalate treatment plans where necessary and appropriate. It will also provide ongoing KPIs for all departments involved in the different tumour streams; this will assist in reducing flow variation and improve timeliness and communication for patients.

Improvement in access to high tech imaging in Dunedin will assist with the diagnostic phase of FCT.

Daily stand-up meetings have been held with clinicians and schedulers for the services particularly impacted in the post COVID surge. These were particularly helpful in supporting the team to allocate resources quickly, including time in theatre, time in clinics and diagnostics. This model will be activated when needed during 2021/22.

A review of 20 consecutive Māori patients diagnosed with lung cancer has been concluded. This showed similar results to published papers – patients present with late stage disease and outcomes are poor. Once patients were identified as having cancer, there was no apparent difference in waiting times between Māori and non-Māori. Further work is to be undertaken looking at referral patterns from GPs and where patients live.

A project group looking at equity in Outpatients and Radiology has been established to support early diagnosis of cancer and other conditions. Baseline metrics are being developed including referral rates, waiting times and frequency of DNA. Workshops are being held with outpatient and radiology staff to co-construct approaches to improve equity and are likely to involve the use of an equity tool to identify two streams of patients for different types of contact and invitation to attend clinics. Additional resources for the Oncology services have also been identified following concerns raised regarding waiting times in Medical Oncology, Haematology and Radiation Oncology. Southern DHB has provided an initial investment and is working with Te Aho o Te Kahu on reducing waiting times, benchmarking staffing levels and providing initiatives to attract staff to the district. Southern DHB is also utilising outsourcing outside of the district to reduce patient waiting times for Radiation Oncology.

2020/21 Performance Results for Community Referred Tests

Measure	2018/19	2019/20	2020/21		
	Actual	Actual	Target	Actual	
Percentage of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks	79%	70%	>90%	68%	●
The percentage of accepted referrals for CT scans receiving procedure within 42 days	74%	58%	>85%	60%	●
The percentage of accepted referrals for MRI scans receiving procedure within 42 days	47%	44%	>67%	44%	●

Data sourced from Ministry of Health

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 Admissions indicates the primary sector is performing well and successfully keeping people well in the community. Supporting ASH rates 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, followed by the second tranche in 2019/20. 2020/21 saw delivery of a third tranche in 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 and removes the need for patients to enter into secondary services to access specific interventions.

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 through a range of NGO providers. One of these providers was successful in attracting Access and Choice funding to extend the age range of clients they are able to see, to include the 19-24 age group.

During the COVID-19 outbreak we saw a decrease in people seeking these services, which provided an opportunity to reduce wait times, but volumes rebounded significantly post-outbreak. We have responded by providing targeted funding to meet increased demand for some services. In addition, we have worked with our primary care partner (WellSouth) to commission a new service, the Integrated Primary Mental Health Service. This new service, based on Access and Choice funding from He Ara Oranga, has seen the establishment of Health Improvement Practitioners and Health Coaches/Community Support Workers across eighteen General Practices in the Southern DHB catchment (period ending 30 June 2021). It is intended that this new service will complement the existing adult brief intervention service which has been up and running for some years.

One of the key lessons learned during the COVID-19 lockdown period was how to use technology more effectively to support different formats for service delivery including increased use of video and phone appointments.

2020/21 Performance Results for Primary Health Care Services

Measure		2018/19	2019/20	2020/21		
		Actual	Actual	Target	Actual	
Avoidable Hospital Admissions[4] rates for children (0-4 years)	Total	5,869	5,496	<5,570	3,820	●
	Māori	7,611	6,685	<5,570	3,737	●
The number of people receiving a brief intervention from the primary mental health service	Total	6,606	7,025	>7,000	6,625	●

Data sourced from WellSouth/NGO reports

[4] 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 wellbeing. 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 2020/21 especially for outpatients and elective surgery. Despite this, Southern has undertaken various programmes of work to match capacity and demand.

Using the Ministry of Health's clinical prioritisation tool – which uses referral assessments undertaken using direct patient phone surveys (about impact on life) and clinical assessment of factors including likelihood to deteriorate within six months – has improved alignment of capacity and demand in several services. The tool has recently been introduced into Gynaecology and further roll-out of the tool is planned for 2021/22.

Implementation of an acuity index introduced in 2019/20 is now well established for first specialist appointments and further roll out is planned for follow-up appointments. Such indexes assist audit and prioritisation, ensuring patients are booked in the correct order according to clinical need.

A telehealth steering group was established in 2020 to enable widespread use of the strategy for providing consultations to patients, whānau and support clinicians. The new role of Telehealth Implementation Manager was appointed to in June 2021 and this role is expected to improve the delivery of telehealth services and implementation of training programmes to staff, both of which will lead to improved and more timely outcomes for patients.

Increasing theatre capacity and throughput is another strategy to ensure a match between capacity and demand. For example, utilising private capacity in in Southland has meant that there has been a more balanced allocation of acute theatre time, reducing the urgent need for cancellation of electives. In addition to using existing outsource providers, from May 2021 Southern DHB has also contracted with South Canterbury DHB to operate on orthopaedic patients. Dunedin has also undertaken planning for an increase in acute theatres with the aim of reducing 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. In addition, a new theatre is being planned in the Main Operating area for day surgery to raise capacity there. The Ministry of Health have provided approval and funding to build a fifth theatre on the Southland site; a project team has been formed to ensure its successful completion.

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 year 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.

2020/21 Performance Results for Elective Services

Measure	2018/19 Actual	2019/20 Actual	2020/21 Target	2020/21 Actual	
Percentage of elective and arranged surgery undertaken on a day case basis	63%	57%	>60%	58%	●
Percentage of people receiving their elective and arranged surgery on day of admission	88%	88%	>95%	89%	●
The number of elective surgical services discharges	11,584	11,179	>12,237	11,803	●
The number of elective surgical services case-weights (CWDs) delivered	18,099	17,292	>18,464	17,910	●

Data sourced from Ministry of Health[5]

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?

2020/21 has been a challenging year 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. This was exacerbated in the months following the COVID-19 lockdown period with significant challenges regarding presentations and acuity being felt in the ED. Meeting the ED six hour target is an ongoing challenge and requires a system-wide approach as the majority of patients who do not meet the target are admitted to the hospital.

Examples of programmes to improve patient flow and therefore performance against the ED target include:

- Encouragement of early specialist assessments to increase the speed of ED decision-making
- Commencing a generalist model of admitting for Dunedin Hospital wards and the planning and development of a Medical Assessment Unit (to be opened 2022)
- Working with primary care to plan for and ultimately provide options for patients attending for urgent care in Invercargill
- Planning redevelopment of the Invercargill Emergency Department
- Developing escalation plans for Dunedin (completed) and Southland Hospitals to better allow for flow
- Establishment of the Patient Flow Task Force specifically tasked to improve patient flow by the identification and removal of barriers and therefore reduce overcrowding in the Emergency Department.

2020/21 Performance Results for Acute Services

Measure	2018/19 Actual	2019/20 Actual	2020/21 Target	2020/21 Actual	
People are assessed, treated or discharged from the emergency department (ED) in under six hours	85%	81.3%	>95%	82%	●
Number of people presenting at ED	82,467	77,331	<85,000	86,181	●

Data sourced from Ministry of Health

[5] The measure definitions for both discharges and case weights have been updated by the Ministry of Health. Past year results (2018/19 and 2019/20) 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.

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 above target. In 2020/21 new information leaflets were created and distributed to GP surgeries, churches and community centres with information on how to find a midwife and options for place of birth and postnatal stay across the district. The leaflet was published and distributed with partner Pasifika and Māori agencies.

2020/21 saw a range of service developments and improvements rolling on from the release of the Southern Primary Maternity Strategy in 2018/19. Progress implementing the Primary Maternity Strategy has resulted in the establishment of Maternal and Child Hubs in Wanaka, Lumsden and Fiordland. Southern DHB has also taken over management of the Primary Birthing Unit (PBU) in Alexandra, Central Otago.

Following extensive public consultation, agreement has been reached to develop two Primary Birthing Units in the Central Otago and Wanaka areas. This decision was endorsed by Southern DHB Board in June. The site for the Central Otago PBU will be in Clyde on land owned by Southern DHB. The site of the Wanaka PBU is yet to be confirmed.

A Project Manager for Primary Maternity has been appointed with a key focus of progressing the planning of these two Primary Birthing Units with the Ministry of Health.

Telemedicine has become a key component in service delivery since the COVID-19 outbreak and we are actively growing the use of telehealth technology throughout the district. Telehealth clinics have been established at the Wanaka and Alexandra facilities. Other opportunities for telehealth are being explored.

A final area of significant work in 2020/21 involved improving the transfer pathway from secondary and tertiary facilities back to primary maternity units. We created a new transfer checklist and a new Record of Verbal Clinical Handover Form. An associated Hospital to Primary Maternity Unit Transfer Guideline was also developed and is under review. Work continues to refine these processes.

2020 Performance Results for Maternity Services

Measure		2018	2019	2020		
		Actual	Actual	Target	Actual	
Number of maternity deliveries in Southern DHB facilities	Total	3,119	3,439	3,400	3,248	●
	Māori	481	543	560	502	●
Percentage of pregnant women registered with a Lead Maternity Carer in the first trimester	Total	78.9%	79.2%	>80%	81%	●

Data sourced from Ministry of Health

Assessment, Treatment and Rehabilitation Services (AT&R)

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

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

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

How did we perform?

The substantive changes in 6AT&R in 2018/19 continue to deliver improved outcomes for older patients.

Length of stay has reduced further to an average of 16.3 days for those age 65 and older, while the measured functional gains while in hospital have increased. This is important as older people are returning back into the community with a much greater chance of maintaining their independence.

The initial success of the four-bedded Older Person's Assessment and Liaison (OPAL) unit has seen this now expanded to 10 beds, achieved through a reconfiguration of existing beds in 6TA&R. OPAL provides a streamlined admission and assessment pathway, facilitating a quicker return home.

COVID-19 and lockdown did impact on AT&R services, with 6AT&R relocating to Wakari Hospital for seven months. While this did limit bed numbers for a time, with the support of the community teams most patients were able to be returned home quickly.

COVID-19 has complicated supporting very complex patients back into the community which is reflected in the increased length of stay for people under 65 years. However, there was also a significant increase in functional gain for this group of inpatients.

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 they are a very complex patient group. Length of stay can vary considerably, but the gains in physical functionality are most important to the patient.

2020/21 Performance Results for Assessment, Treatment and Rehabilitation Services (AT&R)

Measure		2018/19	2019/20	2020/21		
		Actual	Actual	Target	Actual	
Average length of stay for inpatient AT&R services	<65 years	25.4	28.2	<21.8	24.5	🔴
	>65 years	21.2	16.4	<18.5	16.3	🟢
AT&R patients have improved physical functionality on discharge	<65 years	24.3	29.4	>26.1	24.4	🟠
	>65 years	19.7	21.4	>19.7	19.4	🟡

Data sourced from Australasian Rehabilitation Outcomes Centre Impairments Report

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, for all age groupings (0-19 years, 20-64 years and 65+) continued to compare favourably against targets set for the 2020/21 period. This is also true for Māori accessing those specialist services for these same age groupings. It is important to note that services across the Southern district continue to observe an increased complexity of all referrals in presentation and risk. However, this is being monitored very closely and potential service risks are managed if and when they arise.

Improving transition planning continued to remain a priority in 2020/21 and is a work underway to improve our performance in this area. We have commenced an internal process relating to quality of data collection and expect to see the benefits of this work in 2021/22.

Across the Southern DHB catchment we continue to maintain a focus on clients' transition plans and the sharing of these plans with clients' GPs and whānau. All clients who are discharged from inpatient settings have in place a discharge plan that is uploaded into Health Connect South and accessible by GPs and WellSouth.

Major strategic developments have also occurred during this period. The Southern Mental Health and Addiction System has been subject to independent review during the second half of 2020/21. The work of the Review was underpinned by extensive consultation with interested parties, in particular service users. The report of the Review has been considered by the Board of Southern DHB and the recommendations of the report are now beginning to be implemented for 2021/22. The recommendations provide the basis for significant change to the current system with a focus on improved outcomes for clients, equity of access to services and improved sustainability for the Southern mental health and addiction system.

Further, in response to He Ara Oranga (the government inquiry into Mental Health and Addiction), 2020/21 saw Southern making greater investments in a range of mental health services. These included commissioning a new community based forensic step down service, increasing mental health education resourcing in Emergency Departments and the roll out and subsequent extension to the Integrated Primary Mental Health and Addiction Programme in General Practice. The commissioning of a new community based Alcohol and Other Drugs (AoD) withdrawal service for Invercargill, Lakes District and Southland District is also underway with the service expected to be established in the first quarter of 2021/22.

Funding from He Ara Oranga has also been utilised locally to extend services under the Access and Choice banner, principally with some of our mental health and addiction NGOs, to either extend the availability of existing services or create new services such as Te Mahana, a Kaupapa Māori mental health and addiction service in Dunedin.

2020/21 Performance Results for Specialist Mental Health Services

Measure		2018/19	2019/20	2020/21		
		Actual	Actual	Target	Actual	
Percentage of young people (0-19 years) accessing specialist mental health services	Total	4.40%	5.29%	>3.75%	5.19%	●
	Māori	4.90%	6.02%	>3.75%	5.78%	●
Percentage of adults (20-64 years) accessing specialist mental health services	Total	3.70%	4.33%	>3.75%	3.76%	●
	Māori	7.50%	8.96%	>5.22%	7.08%	●
The percentage people who have a current transition (discharge) plan	Total	29%	54%	>70%	63%	●
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	58%	70%	>80%	69%	●
	<8 weeks	81%	88%	>95%	90%	●

Data sourced from Ministry of Health

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 provides a 'restorative' approach to home support, including individual packages of care that that are tailored to better meet people's needs and support their goals. This may include complex packages of care for people assessed as eligible for residential care who prefer to remain in their own homes and can safely do so with supports. With an ageing population, it is vital we monitor the effectiveness of these services, and that we use the InterRAI (International Residential Assessment Instrument) comprehensive clinical assessment tool to ensure people receive equitable access to clinically appropriate support services that best meet their needs.

Needs Assessment & Service Coordination

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

How did we perform?

The foundation of our Restorative Model of long-term Home & Community Support Services (HCSS) for older people is now well established. 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 aged residential 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.

99 per cent of clients who received long-term HCSS in 2020/21 had an InterRAI assessment undertaken.

2020/21 Performance Results for Needs Assessment & Service Coordination (NASC)

Measure		2018/19	2019/20	2020/21		
		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%	●

Data sourced from Provider files

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 82 per cent of our HCSS Support Workers have a Level 2 or greater qualification, surpassing our target of 80 per cent.

Pay equity legislation has supported this education. Our clients benefit from a well-trained workforce, especially our older people in their homes who are increasingly living with multiple chronic health conditions. Training for Support Workers is not limited to national qualifications but also includes other forms of training such as identifying 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.

2020/21 Performance Results for Home and Community Support Services

Measure		2018/19 Actual	2019/20 Actual	2020/21 Target	2020/21 Actual	
Total number of eligible people aged over 65 years supported by home and community support services (HCSS)	Total	4,565	4,474	>4,800	4,703	●
The percentage of HCSS support workers who have completed at least Level 2 in the National Certificate in Community Support Services (or equivalent)	Total	82%	86%	>80%	82%	●

Rehabilitation Services

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

How did we perform?

The WellSouth (Primary Health Network) CLIC programme (Client Led Integrated Services) is now implemented in most of the 81 General Practices across Southern; this includes assessment for falls and fracture risk.

COVID had a significant impact on general practice in 2020, firstly with lockdowns and then comprehensive COVID swabbing. This limited total number of CLIC assessments and subsequently number of referrals to the Fracture Liaison Service (FLS). Despite this, general practice have assessed 1,525 patients for fracture risk using the portal in 2020/21. The number of assessments is positive and will continue to grow as CLIC assessments are refined and embedded into all General Practices.

ACC has targeted their falls and fracture reduction investment towards the Fracture Liaison Service (FLS) in 2021/22. WellSouth has worked closely with ACC and Osteoporosis NZ to refine and redevelop the FLS model for implementation from July 2021.

There are many opportunities to prevents falls and fractures, however we know more work is also needed especially around proactive bone heath and referrals from General Practice for strength and balance.

2020/21 Performance Results for Rehabilitation Services

Measure		2018/19 Actual	2019/20 Actual	2020/21 Target	2020/21 Actual	
Number of people assessed by the GP (primary care procedure) for fracture risk using the portal	Total	2,108	1,865	>2,000	1,525	●

Data sourced from WellSouth PHO

Age-Related Residential Care

These services are provided to meet the needs of an older 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, but mostly it is a success story for the older members of our community who are able to Age in Place, in their own homes.

After the COVID-19 lockdown during 2019/20, InterRAI assessment performance has returned to expected levels. We note that in exceptional circumstances a resident may enter aged residential care without an InterRAI assessment, for example if someone were initially admitted to an aged residential care facility under a different funding stream.

2020/21 Performance Results for Age-Related Residential Care

Measure		2018/19 Actual	2019/20 Actual	2020/21 Target	2020/21 Actual	
Number of Rest Home Bed Days per capita of the population aged over 65 years	Total	6.11	5.8	<6.11	5.59	●
Percentage of clients admitted to an ARC facility from the community who have been assessed using a Home Care or Palliative Care assessment in the 6 months before the ARC facility admission date[6]	Total	93%	89%	>95%	92%	●

Data sourced from CCPS data from facilities, with up to a 90 day lag so accrued beds are included

COVID-19

Public health response

While there have not been any COVID-19 cases in the Southern district, COVID-19 has remained the top priority for the service. Work has been ongoing to be prepared for future cases and contacts of COVID-19. This has involved ensuring that adequate numbers of staff are trained to use the National Contact Tracing Solution (NCTS) – the national system where all COVID-19 cases and contact information is stored, as well as remaining up to date with protocols and procedures.

Throughout the year the focus has moved to national support for any local responses and Public Health staff have been involved in supporting contact tracing in relation to cases that have occurred in other parts of New Zealand. Several staff have provided support to Auckland Regional Public Health Service throughout the year including a NCTS super-user to provide on-site training in Auckland, a Medical Officer of Health, Response Manager and four contact tracers.

Large event organisers are being provided with information on the government's guidelines for running safe events. This includes having QR codes prominently displayed, the event sector voluntary code for reducing the risk of COVID-19, toolkits for informing and reminding the public about good hygiene practices, Public Health contact details, information about testing and a range of posters and resources. A table-top exercise was held in December 2020 to work through a range of different COVID-19 scenarios for the Rhythm and Alps event held at Cardrona. This was a success to ensure that all parties were prepared for such an event.

Public Health continues to build relationships with Māori Health and Pacific providers across the district. A number of hui have now been held which have provided an opportunity to engage with each and share information on what we do when we get an outbreak in our district.

Maritime border response

Southern has three international Maritime ports – Port Otago, South Port and Tiwai. Significant work has occurred to ensure compliance with the frequent changes in requirements, and surveillance of maritime

[6] This measure has been amended to provide further clarification

workers and crew to meet these maritime border orders and Ministry of Health requirements.

This is taking up a lot of on-call Health Protection Officer time to achieve this, as well as significantly increasing testing requirements for crew members wanting shore leave.

Quarantine-Free Travel

In April Quarantine-Free Travel commenced between Queenstown and Australia. Public Health staff visited Community and Public Health in Christchurch to shadow their staff for three days and learn their border processes for when the air borders reopened.

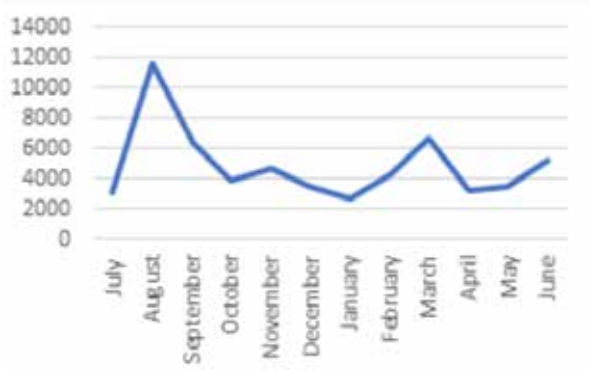
A team of 15 new staff members were recruited for this seven-day-a-week response. They ensure passengers and aircrew wear, change and remove face coverings as required, conduct temperature checks on passengers, conduct secondary health assessments and make recommendations to any passenger that appears unwell, is symptomatic or is identified as having a temperature of 38oC or higher as part of screening at arrival.

The introduction of pre-departure testing requirements in late June had a significant impact as any passenger who does not meet the Quarantine-Free Travel requirements is required to enter a Managed Isolation Facility in Christchurch. The reasons passengers do not meet the Quarantine Free Travel requirements include no pre-departure test within the appropriate 72-hour timeframe, or they had been through areas in Australia that were partially paused for travel.

Community COVID-19 testing

Testing of individuals for COVID-19 has been undertaken by WellSouth and General Practices. An 0800 phone number and call centre direct people to the appropriate practice undertaking testing. Over the last 12 months 58,773 tests were undertaken in the community.

COVID-19 Testing numbers 1 July 2020 – 30 June 2021



COVID-19 vaccination programme

On 30 June, Southern DHB had delivered 80,571 vaccinations. Of these, 57 per cent were completed in the large Southern DHB run clinics in Dunedin and Invercargill. Increasing numbers (43 per cent) were being undertaken by primary care in rural areas. We were well into Group 3 of the government's scheduling framework with 28,834 (of 100,000) vaccinations completed.

Māori and Pacific population rollout

We are working collaboratively with 16 different Māori and Pacific providers to provide a community-based approach to COVID-19 vaccinations, with 4,399 vaccinations already completed within this cohort by 30 June. Two permanent general practice-based clinics have been established, Mō Tātou Tipuna located in Caversham and He Puna Waiora in Invercargill. Our Māori health providers have collaborated to deliver successful outreach clinics in Alexandra, Hokonui Rūnanga in Gore and the Pacific Islands Advisory and Cultural Trust in Invercargill.

Vaccine doses administered by ethnicity to 30 June 2021

Ethnicity	Dose 1	Dose 2	Total
Asian	3,163	2,547	5,710
European or other	42,563	26,828	69,391
Māori	2,365	1,442	3,807
Pacific Peoples	759	468	1,224
Unknown	255	184	439
Total	**49,105**	**31,466**	**80,571**

Eligible population fully vaccinated by ethnicity (note 5)

Ethnicity	Proportion fully vaccinated (note 1)
Asian	16.01%
European or other	11.82%
Māori	6.91%
Pacific Peoples	8.56%
Unknown	26.36%
Total	**11.66%**

Aged Residential Care

Vaccinations of our older populations in Aged Residential Care facilities was well underway. Our teams vaccinated residents and staff onsite, with the vaccine delivery supported by General Practices, pharmacies and 'flying squads'. Of the 65 facilities across the district, all received their first dose by the end of June 2021.

Mental health residential

All mental health residential services in the district had been contacted regarding their resident's eligibility for vaccination and booking information has been supplied. In some cases, we arranged onsite vaccinations by pharmacists and General Practices, where attendance at the mass clinics was not appropriate for individuals.

Disability residential support services

We are working closely with Disability Residential Support Services to vaccinate the residential population who fall into Group 2 of the government's scheduling framework. By 30 June 2021, almost 50 per cent of the 1,000 disability residential recipients in the Southern district had received a vaccination, with the remainder to be delivered via a mixed delivery model to suit each provider, including vaccination clinics at tailored community-based locations.

Eligible population fully vaccinated by age group as at 30 June 2021

Age range (years) fully vaccinated	%
12-15	-
15-19	2.79
20-24	8.89
25-39	8.08
30-34	8.56
35-39	8.39
40-44	8.55
45-49	9.12
50-54	10.68
55-59	11.46
60-64	12.10
65-69	20.86
70-74	21.92
75-79	21.65
80-84	22.04
85-89	21.31
90+	29.38
Total	**11.66**

Vaccine doses administered by age group (note 4)

Age range (years)	Dose 1	Dose 2	Total
12-15	3	0	3
15-19	780	498	1,278
20-24	2,725	2,042	4,767
25-39	2,244	1,811	4,055
30-34	2,460	1,950	4,410
35-39	2,161	1,750	3,911
40-44	2,129	1,675	3,804
45-49	2,496	1,928	4,424
50-54	2,831	2,232	5,063
55-59	3,368	2,557	5,925
60-64	3,643	2,526	6,169
65-69	6,946	3,707	10,653
70-74	6,583	3,352	9,935
75-79	4,502	2,259	6,761
80-84	3,138	1,563	4,701
85-89	1,795	898	2,693
90+	1,301	718	2,019
Total	**49,105**	**31,466**	**80,571**

Population health services were significantly disrupted as COVID-19 developed in New Zealand in 2020. The majority of disruption has been felt in the B4 School Checks Programme (B4SC), Immunisation Outreach, Vaccine Preventable Disease (VPD) team and Measles Campaign for 15 to 30-year olds.

Nursing and administration staff were redeployed to support the organisational response to COVID-19 including contract tracing and case management. This included the setup of COVID-19 vaccination clinics. Ongoing, staff have continued to be requested to support the COVID-19 vaccination programme. The services have now fully resumed except work to support the national measles campaign for 15 to 30-year olds which is on hold nationally until later in 2021. This campaign aims to reduce the risk of future measles outbreaks and targets 15 to 30-year olds who missed their Measles, Mumps and Rubella (MMR) vaccines as children, with a focus on Māori and Pacific young people.

Additional information on the vaccination coverage in Southern DHB is as follows:

Vaccine doses administered by sequencing group (note 4)

Sequencing group (note 3)	Dose 1	Dose 2	Dose 3
Group 1	3,116	2,808	5,924
Group 2	25,123	18,878	44,001
Group 3	19,755	9,079	28,834
Group 4	1,111	701	1,812
Total	**49,105**	**31,466**	**80,571**

Note 1: Fully vaccinated means two doses have been administered to an individual.

Note 2: The health service user (HSU) population used for COVID-19 vaccine coverage reporting provides information about the number of people in New Zealand who used health services in 2020. People are included if they were alive as at 30 June 2020, were 12 years of age as of 30 June 2020, (note that this was initially 16 years but was reduced to 12 years when the eligibility criteria changed), and if they were enrolled with a primary health organisation or received health services in the 2020 calendar year. There are other data sets that estimate the total number of people in New Zealand.

These include three datasets produced by StatsNZ: Estimated Resident Population (produced every 5 years, following each Census), Subnational Population Estimates (produced every year), and non-official population projections produced by StatsNZ for the Ministry of Health (produced every year).

The Stats NZ population estimates are based on Census data adjusted for the number of people who are born, who have died, and who have migrated to or from New Zealand. The Stats NZ population estimates and projections are of people usually resident in New Zealand, including those usually resident who are temporarily overseas, while the HSU includes everyone in New Zealand who used health services in a given period.

The HSU was chosen by the Ministry of Health as the denominator for COVID-19 vaccine coverage reporting because it allows for the assignment of the same demographics (eg, location and ethnicity) to people in the numerator (the number of people vaccinated) as the denominator (reference population). The HSU is available for every demographic contained in health data including age, ethnicity, DHB, and gender, separately or in combination. Other information such as neighbourhood deprivation, Statistical Area 2, or territorial local authority can also be added. It is possible to generate flags for health-related information on the HSU, for example, those who are likely to have a long-term condition. Official Stats NZ estimates are not as flexible. For example, StatsNZ estimates by age, sex and Statistical Area 2/Territorial Authority/DHB are produced every year, but estimates that also include ethnicity are only produced every 5 years, the most recent being estimates for 2018. The projections StatsNZ produces for the Ministry every year do provide information by age, sex and broad ethnic group, but are only available at the DHB level.,.

The Total population estimate based on HSU as at 30 June 2020 is 335,245. This is 14,725 below the Stats NZ total projected population of 349,970 (from the non-official population projections StatsNZ produced in 2020). When classifying the population into ethnicity, age and DHB there are further differences. For example, a summary of the differences by ethnicity are summarised in the table below. These differences arise as the populations are derived from different sources. For example, an individual may identify as one ethnicity when registering with a health service and a different ethnicity when completing a census declaration.

By definition, the HSU is not a total population estimate and is likely to miss highly marginalised groups. For example, analysis suggests that groups underrepresented in the HSU include young people aged 15-45 years (men in particular), and people of Asian and Middle Eastern, Latin American and African ethnicity.

The HSU is considered by the Ministry of Health to be the best option for estimates of vaccine coverage, as it removes bias from calculated rates by ensuring demographic information in the numerator and denominator is consistent. For example, the ethnic group(s) with which someone identifies, and their location.

Total population	HSU	Stats NZ	Difference
Māori	31,764	37,700	(5,936)
Pacific	8,022	8,070	(48)
Asian	20,986	27,500	(6,514)
Other	274,473	276,700	(2,227)
Total	**335,245**	**349,970**	**(14,725)**

Note 3: Group 1 includes border and managed isolation and quarantine employees and the people they live with. Group 2 includes high-risk frontline health care workforces; workers and residents in long-term residential environments; older Māori and Pacific peoples cared for by whānau, the people they live with, and their carers; people aged 65 years and older; people with relevant underlying health conditions. Group 3 includes people aged 65 years and older; people with relevant underlying health conditions; disabled people; and adults in custodial settings. Group 4 includes people aged 16 years and over. These definitions and population groups were occasionally updated based on operational and Cabinet decisions or updated estimates of the sizes of each group.

Note 4: The data in this table is based on the DHB of service (where the vaccine dose was administered).

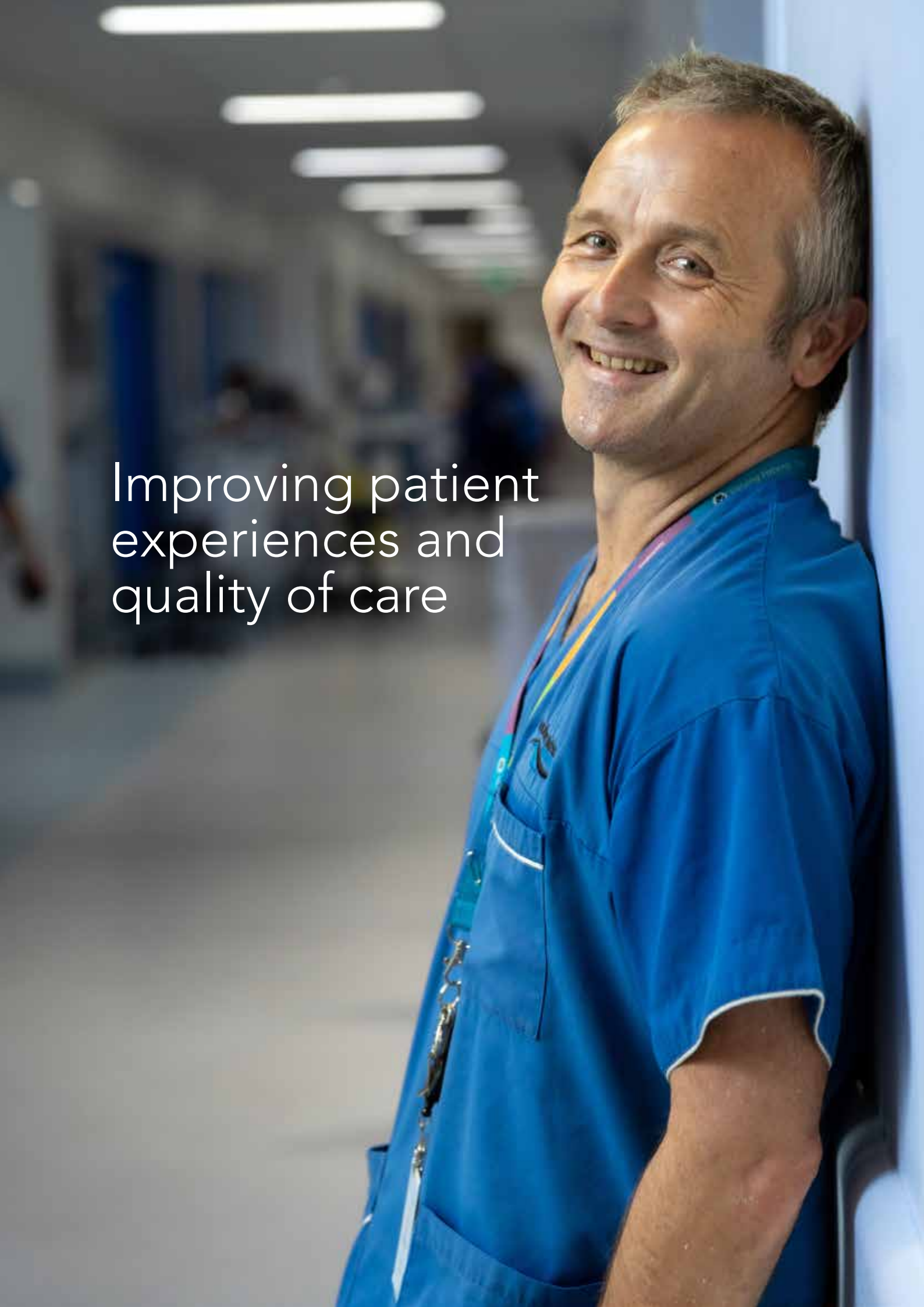
Note 5: The data in this table is based on the DHB of residence of the individual receiving the vaccines. Ethnicity is based on the prioritised ethnicity classification system which allocates each person to a single ethnic group, based on the ethnic groups they identify with. Where people identify with more than one group, they are assigned in this order of priority: Māori, Pacific peoples, Asian, and European/Other. So, if a person identifies as being Māori and New Zealand European, the person is counted as Māori.

Appendix: Explanation of reporting periods

Outcome measures

Measure	Period value represents
Proportion of the population (15+) who smoke	Annual performance (year delay)
Proportion of the population (15+) who have obesity	Annual performance (year delay)
Children caries-free at age five	Annual performance (calendar year)
'Never smokers' amongst Year 10 students	Annual performance (calendar year)
Rate of ambulatory sensitive hospital admission for children (0-4)	Year to Q3
Rate of acute hospital bed-days (age standardised, per 1,000 people)	Year to Q3
Proportion of the population (75+) living in their own home	Annual performance
People receiving non-urgent CT scan within six weeks	Annual performance
People receiving non-urgent MRI within six weeks	Annual performance
Rate of ambulatory sensitive hospital admission for adults (45-64)	Year to Q3
Population (75+) admitted to hospital as a result of a fall	Annual performance
Rate of acute readmissions to hospital within 28 days of discharge (standardised) per 100,000 people	Year to Q3
Rate of amenable mortality for people aged under 75 (age standardised, per 100,000 people)	Annual performance (calendar year)
People admitted, discharged or transferred from ED within 6 hours	Annual performance
People receiving specialist assessment and treatment within set timeframes	Annual performance
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 boys and girls fully immunised with HPV vaccine	Annual performance
Percentage of people (≥ 65 years) having received a flu vaccination	2020 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 0-4 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 inpatient elective and arranged 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 inpatient elective and arranged surgical services (CWDs) delivered	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 clients admitted to an ARC facility from the community who have been assessed using a Home Care or Palliative Care Assessment in the six months before the ARC facility admission date	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



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.

COVID-19 has remained a significant priority for this team, and indeed for the DHB.

At the same time, the team has supported a number of other important health and community issues. 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.

Te Hau Toka Southern Lakes Wellbeing Group

Concerns regarding the psychosocial needs of the heavily impacted Central Lakes area led to the formation of a multi-agency group, guided by the national Kia Kaha, Kia Māia, Kia Ora Aotearoa: COVID-19 Psychosocial and Mental Wellbeing Plan

Initially known as the Central Lakes Wellbeing Recovery Gtroup, Te Hau Toka members include the Southern District Health Board, WellSouth Primary Health Network, Queenstown Lakes District Council, Central Lakes Family Services, Tāhuna-Whakatipu Māori Community, the Southern Mental Health and Addiction Network Leadership Group, and the Fiordland Wellbeing Collective. The group has been partnering with agencies and networks to help co-ordinate an overall picture of ongoing needs which includes sharing wellbeing concerns, monitoring mental health service capacity, and working together on ways to tackle the wellbeing effects in communities.

By combining knowledge and resources, Te Hau Toka hopes to build awareness of services that are available, connect people with the support they may need and help them to stay well.

Its work has included:

- Supporting the Queenstown Lakes District Council's multi-agency Kia Kaha Hub
- Scoping and establishing a new Mental Wellbeing Navigator role. With Lisa's support, we are coordinating events and programmes to better connect people with mental health and wellbeing support in their communities.
- Supporting the fast-tracking of WellSouth's national 'Access and Choice' mental health initiatives like embedding new Health Improvement Practitioners (HIPs), health coaches and community support workers into primary care, and social workers into school
- Rolling out the Mental Health 101 psychological first aid programme as well as raising local awareness of the free 1737 counselling support helpline and the Mental Health Foundation's Getting Through Together campaign
- Better online access to detailed information about health and wellbeing services and regular updates.

Lead

Public Health South provided health advice to residents of Waikouaiti, Karitane and Hawkesbury, as well as the Dunedin City Council, following the detection of elevated levels of lead in the communities' water supply in February.

The Medical Officer of Health advised issuing a Do Not Drink Notice, and community clinics to test residents' blood levels were conducted, as Public Health South investigated whether residents may have experienced chronic exposure to lead in the drinking water.

Those tested were also asked to complete a questionnaire, detailing other activities such as working with lead-based paint, hunting, or lead-lighting that could mean they had a higher exposure to lead.

In July 2021, the Southern DHB Medical Officer

of Health recommended the Do Not Drink notice (DNDN) could be lifted.

This followed a months-long comprehensive investigation by the Dunedin City Council into elevated lead levels that had been detected in the area, finding customer pipes, fittings and tapware leaching into the water were the most likely cause if the high lead results at the Waikouaiti Golf Course and the Karitane Bowls Club. The most likely cause of the high lead results in the raw water reservoir was lead in sediment from the spike in sediment in water turbidity. Sediment is filtered out by the treatment process, so does not reach the treated water. However, it was recommended that people at the Waikouaiti Golf Course and Karitane School still do not drink the water.

The Medical Officer of Health also called for greater awareness of the potential exposures of lead in the environment, either through our water via customer pipes, fittings or tapware, or other sources such as lead-based paint found on older houses – and the steps that can be taken to mitigate these risks.

Public Health South will continue to work with the DCC, Ministry of Health and other agencies to raise awareness of these risks, and support public health measures to reduce exposure to lead in our environment.

Bore water

In late March 2021, Southern DHB, Queenstown Lakes District Council and Otago Regional Council jointly hosted community information sessions in Queenstown and Wānaka to discuss private water supplies whereby water is taken from outside of the town supply.

The community information sessions clarified the responsibilities of private water suppliers and provided guidance around the roles of the respective agencies in the oversight of the supply of water.

The sessions aimed to help those managing or consuming water from a private supply to better understand where the water comes from, the inherent risks associated with taking water from different sources (with a focus on groundwater bores), as well as recommended testing and security measures.

The presentation also outlined proposed changes to the regulatory framework as part of the Government-led Three Water Reform Programme (Water Services Bill).

Advice was also available on how to improve bore security and where to find more information on testing private supplies of water.

Measles

The Southern measles campaign is a joint effort between Southern DHB/Public Health South, WellSouth, General Practice, community providers, including Māori and Pasifika providers, participating pharmacies and Student Health. One of the important aims of the campaign is increasing equity by developing innovative approaches to engage with Māori and Pacifica aged 15-30 years. Increasing MMR coverage of these young people is a priority.

The campaign began in July 2020 with Southern General Practices being the first places to offer the free vaccinations. Public Health South and WellSouth staff have worked closely with GP practices to support them in contacting enrolled patients aged 15-30 years to offer the free vaccine.

In December, 20 Southern pharmacies came on board to offer free MMR vaccinations for measles, as a convenient option for people.

Over 600 people in the targeted 15-30-year age group were vaccinated by Southern DHB-based providers as part of the MMR campaign from July 2020 to the beginning of March 2021.

From March, while General Practices in the district continue to recall enrolled patients they believe to be due or overdue for their MMR vaccine, including those in this age group, the wider campaign was paused, as the nation's public health teams focus on the COVID-19 vaccine rollout.

Kia Haumaru Te Kāika ('a safe and secure home')

Public Health South, Aukaha and Habitat for Humanity Dunedin in 2021 launched a new joint initiative to reduce the number of children being admitted to hospital with housing-related respiratory illnesses, by supporting families to make their homes warmer and drier.

Kia Haumaru Te Kāika builds on the success of the Healthy Homes Initiatives (HHIs) across New Zealand.

Families with children under 15 years of age admitted to Dunedin Hospital overnight with bronchiolitis, a respiratory infection, or another housing-related condition will be eligible for the initiative.

Eligible families can have their home inspected by one of Habitat's Home Performance Assessors to see what support they need – prioritising simple, effective measures to make a home warm and dry such as draft-stoppers, hygrometers, and window insulation film.

Public Health South, Aukaha and Habitat for Humanity Dunedin have received funding for the first 50 families' homes from the Healthcare Otago Charitable Trust for the initiative. Referrals for Kia Haumaru Te Kāika opened at the start of July 2021. A similar project was also planned for Invercargill.

Primary and Community Care

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

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

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

The Southern DHB-WellSouth Primary and Community Strategy and Action Plan remains our guiding blueprint for the future of services in the Southern district.

Its importance has only been emphasised by the impact of COVID-19, requiring 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. This underlined the importance of more flexible, digitally enabled ways of working, such as using electronic communications for consultations

Southern Health Care Home programme

Health Care Home (HCH) grew in leaps and bounds over 2020/21, with 10 new practices bringing 55,000 patients into HCH. Twenty-four practices are now underway, with an enrolled population of nearly 175,000, covering 55 per cent of all Southern patients, 56 per cent of Māori, and 65 per cent of Pasifika patients. An additional five practices start HCH on 1 July 2021.

The focus on equity within HCH nationally and in the South has only been given more emphasis with the coming health reforms. For all HCH practices, this has meant prioritising work that supports Māori and Pasifika patients, and considering how they can form the relationships with whānau and communities needed for better outcomes. We consistently see practices identifying patients with higher health needs and working hard to connect with them. Results from the first eight HCH practices include:

- 49 per cent of total Comprehensive Health Assessments (CHAs) for Māori, with 36 per cent of the Māori population
- 61 per cent of total CHAs for Pasifika, with 40 per cent of the Pacific population
- Care plans for Māori at about a 50 per cent higher rate than the overall population
- Multi-disciplinary team meetings for Māori at 3 times the rate of the overall population, and 4.6 times the rate for Pasifika.

We continue to track a number of secondary care acute demand measures. During the course of this year we completed the first robust analysis of acute demand for a large Dunedin practice: it showed a marked decrease in Dunedin ED presentations from this practice beyond what might be expected by random variation (and controlling for the effect of COVID-19), which we believe was caused by a large increase in same and next-day appointment availability. In general, we see no signs of negative

effects from HCH on secondary care acute demand, and some encouraging signs of improvements, particularly with individual practices. Essentially though, it is too early to determine with certainty the benefits of HCH on secondary care, given the multiple factors that determine secondary acute care demand.

The University of Otago completed an evaluation of the implementation of Southern HCH, based on interviews with tranche one and two HCH practices. The recommendations were consistent with our observations and with some of the adaptations that have occurred within the HCH programme, including to be flexible with adapting key HCH tools into a practice, consideration of the financial implications of changes, and the need for on-going dialogue with the DHB. Pleasingly, the evaluation found HCH helped to make practical efforts to improve equity, and that the practices were focusing on how to be more culturally welcoming. While not part of the evaluation, we are nonetheless acutely aware of the need to better understand patients' experiences of HCH and the difference it makes. This will be a focus in the coming year.

2021/22 is likely to be the last year in which a practice can start HCH, given the capped funding. The prospect of living with COVID-19 in the community, and the stresses and opportunities this creates, make it even more important for practices to take the opportunity HCH provides to offer all patients improved services, while focusing on sustainability. A good example of this is one of the first four Southern HCH practices: they found:

"Our involvement in Health Care Home and the changes we have made to our practice, has had a positive impact on our financial results. We have increased capacity in our clinicians' days which has allowed us to take 760 more patients with only a 0.3FTE lift."

Health Care Home practices at 30 June 2021:
Gore Health
Gore Medical
Queenstown Medical
Amity Health
Broadway Medical
Aspiring Medical
Junction Health (Cromwell)
Wanaka Medical
Clutha Health First
Invercargill Medical
North End (Oamaru)
Te Kāika
Mornington Health
Health Central

STARTED 2020/21:
He Puna Waiora
South City Medical
Catherine St Medical
Aurora Health
Central Medical (Oamaru)
Fiordland Medical
Dunedin North Medical
Dunedin South Medical
Dunedin Health Centre
Mosgiel Health

Te Kaika Community Health Hub

The development of Community Health Hubs were envisaged as a core plank of the Primary and Community Care Strategy, and this effort made important progress in 2020/21.

Following an RFP process in December 2020, Te Kaika has now initiated the next stage of their Community Health Hub project. This will see the Ministry of Social Development, Southern DHB and Te Kaika collaboratively working together to provide an innovative model of care centred around the needs for Māori and Pasifika people in the South Dunedin area.

Over the next 24 months we will be working closely alongside these organisations developing a model of care that fits the needs of the local people and is digitally enabled, supporting new ways of working for the SDHB, MSD and Te Kaika.

The key aims for the Te Kaika Community Hub is to provide a "one stop shop" for local communities, ensuring that healthcare and social support is highly accessible and appropriate to their needs. This is an exciting development with the potential to significant transform the delivery of health care for our communities.

Mental health and addictions

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

The key first step, an independent review of the Southern Mental Health and Addiction System, has been completed. The resulting report, 'Time for Change, Te Hurihanga, A Review of the Mental Health and Addiction System' was released in August 2021. The report has been endorsed by the Board and work to support the implementation of the recommendations has commenced.

This year has seen the continued 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.

There are now approximately 13 FTE Health Improvement Practitioners and 15 FTE Health Coaches/Community Support Workers working in 21 General Practices across the Southern DHB. This new service complements existing services rather than replaces them.

Our expectation is that this service will continue to evolve over time and the feedback we are getting indicates the service is well received by service users. We have seen new services commissioned during this period through our mental health and addiction NGO providers including an extension of counselling services for young people aged 12 to 24 and a new Kaupapa Māori service based in Dunedin but with outreach to our rural areas.

We have recently commissioned a four-bed forensic community-based step-down service. This service is now operational and has a recovery-based philosophy of service delivery with a strong emphasis on goal orientation and skill development for residents. We have also recently completed a procurement process for the establishment of a home-based detoxification service for the geographic area covered by Invercargill, rural Southland and Queenstown Lakes. We expect this service to be operational in late 2021.

Clinical services have had a busy year, with an eight per cent increase in referrals received compared to the previous year. Demand has increased across all ages and ethnicities, with the 0-18 and 65+ age groups showing the highest increase in demand. Despite the increased demand services have remained responsive, with 83 per cent of people being seen within eight weeks of referral. This is a slight improvement over last year's responsiveness despite the increasing complexity of presentations. There are no significant differences in access rates by ethnicity, or in the volume of referrals received. Inpatient occupancy averaged 80.4 per cent across the year and, while slightly down on the previous year although this has not been consistent across areas with higher pressure on general adult beds and the Invercargill Mental Health Unit experiencing significant periods of over occupancy.

Southern HealthPathways

At the end of the 2020/21 year 764 Pathways are now live in Southern DHB and there has been an average of 9,000 user sessions per month on the HealthPathways site.

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

COVID-19 remained important through this year while there was also a focus was on Diabetes and Gynaecology related pathways.

The Southern Health system continues to build a collaborative and collegial approach, and the HealthPathways team has continued to encourage and support the establishment of workgroups. This has covered a wide range of specialities that has included areas such as skin lesions and carpel tunnel.

Te Aro Matewai ki Te Māra o Hauroa – Southern Health Needs Assessment

A project has been underway to better understand and present an analysis of the health needs of our district.

All District Health Boards in New Zealand are required to look at the health and health needs of their people; this process is called a Health Needs Assessment.

Southern DHB has been developing an online repository of information as part of the Southern Health website, with a goal of ultimately presenting around 100 indicators that provide information about the health needs in our community.

Tō Tātou Pūkete/Our Health Profile includes information about who lives in Southern, what keeps us healthy, how we get healthcare, and how healthy we are. Due to go live in early 2022, this information helps health planners decide how best to provide the healthcare we need now and in the future.

Tō Tātou Pūkete/Our Health Profile honours Māori as tangata whenua and is aligned with He Korowai Oranga - New Zealand's Māori Health Strategy and Te Tiriti o Waitangi.

Primary maternity

Work continues to be focused around the Integrated Primary Maternity System of Care actions, and the recommendations of the one-year review. Significant progress has been made to date.

Child and Maternal Hubs have been established across the Southern DHB region. The aim of these hubs is to extend service equity to rural areas and allow for better information sharing in pregnancy and early childhood. Work is being undertaken in these Hubs to design a singular service specification to enable consistency of service, whilst still allowing the Hubs design to be community-led.

A telehealth clinic is being run once a month in Wanaka, allowing women to access the secondary Obstetric services as Dunedin Hospital without the expense of travel and accommodation. The same service is about to be trialled in Lumsden to service the needs of Te Anau and Lumsden women who would usually travel to Invercargill for secondary appointments.

Sustainability payments have continued for Wanaka and Te Anau Lead Maternity Carers (LMCs). This is continually being reviewed. At present it is not considered beneficial to stop these payments as they are allowing midwives to continue delivery of services.

It is expected that the new birthing unit in Wanaka will fill this gap in the future. A locum midwife has also been arranged for the Christmas/New Year period.

There continues to be pamphlets updated and available providing information on engaging with an LMC, and your options for antenatal and postnatal care in Southland DHB. These pamphlets were recently renewed again to ensure continued relevance.

The design and build of our Primary Birthing Unit continued to be the large focus for the 2020/21 year and comprises a decent amount of planning for the 2021/22 year. Land has been identified co-located with Dunstan Hospital in Clyde, and second site is under discussion in Wanaka. Regarding design, a plan has been approved for the Primary Unit in the new Dunedin Hospital build. A plan for the Wanaka and Clyde facilities is underway with a Southern DHB draughting team, and costed by a Quantity Surveyor in the second half of 2021. The general layout will be the same for both facilities, with slight variations depending on site differences.

The next step for this floor plan is to send it to the Maternity Steering Group and stakeholders for feedback. After returning an estimate, this information will be added to the Business Case underway for the Ministry of Health. The Business Case will be submitted to the Executive Leadership Team, and following that the Ministry of Health, in the second half of 2021. This document outlines the case for receiving capital funding for the build of the two new Primary Birthing Units in Wanaka and Clyde.

Three different Requests for Proposals are underway to contract an architect, building company, and service provider. These will go through the steering group and have members of the steering group sitting on the decision panel.

Reporting also continues to be a work in progress. The project manager is reporting into monthly and annual reports. There is now a current status document which monitors ongoing work and key project developments. A risk register has also been started. The next step is to provide the steering group with regular updates as the project gains pace.

Disability strategy

The Southern Disability Strategy was launched in April 2020, marking an ongoing commitment by the DHB to removing barriers to healthcare for disabled people and providing equitable health and disability services throughout the Southern district.

The Strategy was developed in consultation with the wider Southern disability community over the previous two years, and in partnership with the Donald Beasley Institute.

Its vision is that within the Southern district all disabled people, tāngata whaikaha, and Deaf people will have an equal opportunity to achieve their best possible health outcomes, enabling their participation in their community.

The implementation of the Strategy will be supported and guided by a Disability Working Group which will connect through to the Disability Support Advisory Committee (DSAC), Community Health Council (CHC) and the Iwi Governance Committee (IGC).

"I'm really appreciative that the DHB has consulted widely with the disabled population and I'm looking forward to the rolling out of the action plan and seeing the difference it will make."

Paula Waby, Community Health Council member

Clinical service redesign

Providing care that values our patients' time and also helps improve the flow of patients through our hospitals and beyond has been the focus of a number of initiatives over the past year.

This year has presented many challenges to our teams following the COVID-19 outbreak and the aftermath of the postponed non-urgent elective surgeries and procedures during this time. The pressure on our hospitals has been evident, as it has across the country with high acuity and staffing issues. Staff have worked tirelessly to manage the increasing demands on health services in the most effective and responsible way.

A Patient Flow programme of work to look at ways to manage the volumes of acutely unwell people presenting to our emergency departments was launched in early 2021. This has involved initially a focus on embedding Rapid Rounds in our hospital wards.

Our Clinical Governance Framework continues to be strengthened with a recently formed Response and Recognition committee. This is another means for clinicians, managers and other staff to have a pathway to work together to improve patient safety.

A Telehealth Steering Group has continued to support the roll out of telehealth across services. With such a large geographical area, many appointments by telehealth can save both the patients and clinicians time. Going forward the aim is to give as many patients as possible the option of using telehealth where it is clinically appropriate.

With the new Dunedin Hospital we are working towards a future system that can deliver better, more consistent and more equitable care. Greater use of digital technology will enable care closer to home, and more self-management of healthcare. To make this happen, telehealth will be an integral part of the future health system and will help effectively manage the increasing demands on the health service.

Integrated service for COPD patients supports patients stay healthy at home

Photo above of the 'Click to Tick' electronic COPD checklist being used by Respiratory Specialist Dr Jack Dummer and Ward 7A Associate Charge Nurse Manager Bex Browne

An electronic standardised discharge process for patients admitted to Dunedin hospital with acute Chronic Obstructive Pulmonary Disease (COPD) means patients have more integrated care between hospital and general practice, rehabilitation and community-based services.

The comprehensive 'Click to Tick' electronic COPD checklist used in Ward 7A at Dunedin Hospital 9 ensures patients receive referrals and advice for correct medicine and inhaler use, pulmonary rehabilitation options, and information about smoking cessation, healthy homes, and advance care planning. Booking a fully funded follow-up general practice appointment one to two weeks post discharge is also part of the 'Click to Tick' process.

The COPD checklist is a simple way to help patients stay well at home and prevent hospital readmissions.

Diabetes Nurse Specialists run clinics at Dunedin Hospital

Pictured: Diabetes Nurse Educator Gavin Hendry, Endocrinology Clinical Lead, Professor Patrick Manning and Diabetes Nurse Educator, Jenny Rayns

A new model of care for diabetes patients at Dunedin Hospital means nearly all new referrals, as well as planned patients for diabetes specialist consultations are seen by a Diabetes Nurse Specialist.

The only difference for patients is that their consultation is with one of the highly skilled Clinical Nurse Specialists who have considerable expertise in the management of all aspects of diabetes rather than a Consultant.

These clinics are supervised by a Diabetes Physician who is available to assess patients and provide the Diabetes Nurse Specialists with advice and support as necessary.

The new model of care is part of the Endocrinology teams' plans for the future. They are exploring a number of initiatives including ensuring they have one service across the DHB, integration with primary care, a move to "population-based" care for diabetes, the creation of a virtual diabetes centre and above all the use of telehealth to support these changes. All these initiatives are to ensure the model of care for the service is contemporary, patient centred and will streamline into the new Dunedin Hospital.

New unit opens at Dunedin Hospital Emergency Department

Left to right: Dunedin Hospital Emergency Department Charge Nurse Manager, Janet Andrews, Clinical Director, Dr Rich Stephenson and SDHB Chief Executive, Chris Fleming with Kaiawhina Te Ara Hauora, Wendi Raumati trying out one of the chairs

Dunedin Hospital Emergency Department has put an end to patients lying down on trolleys and stretchers if they are well enough to sit or stand.

A new Ambulatory Care unit in Dunedin Emergency Department opened in November 2020. Eight relaxing chairs allow patients who are able walk, and who are not confined to bed to have a comfortable space while they are seen by the Emergency Department team.

Having chairs instead of beds means more patients can be seen in the emergency department as two chairs take the space of one bed, and it allows beds to be freed up for patients who are too ill to sit in a chair. Patients also benefit by staying as active as possible – if they are independent they are more likely to go home sooner.

The new unit ties in with the "Sit up, Get Dressed, Keep Moving,' initiative by keeping patients out of bed, dressed and moving to help get them home sooner.

Telehealth roll out continues

Pictured: Dunedin Hospital Speech Language Therapist Amy Rosenfeld in a telehealth consultation with patient Ian and his wife Gaynor

Over the last year a Telehealth Steering Group supported by telehealth champions has continued to provide support and resources for services using and setting up telehealth.

To make using telehealth as simple and accessible as possible Microsoft Teams has been rolled out as the common platform for services to use, the booking system has been streamlined, staff have been trained and patient information has been updated.

Several services are offering telehealth where many would be surprised to see it used including physiotherapy, speech language therapy, oncology and ophthalmology.

With such a large geographical region, many appointments can be by telehealth to save both the patients and clinicians time. Providing this option to patients will ultimately enhance their experience and contribute to better health outcomes.

Quality Account

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

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

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

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

This section of the report – Improving Patient Experiences and Quality of Care – includes the Serious Adverse Events reported at Southern DHB during 2020/21. It also outlines processes for gaining feedback from our patients and communities, and quality improvement initiatives.

Our performance against the outcome measures identified in our Annual Plan is detailed in the first section of this report: Improving Health Outcomes for our Population (pages 13-50).

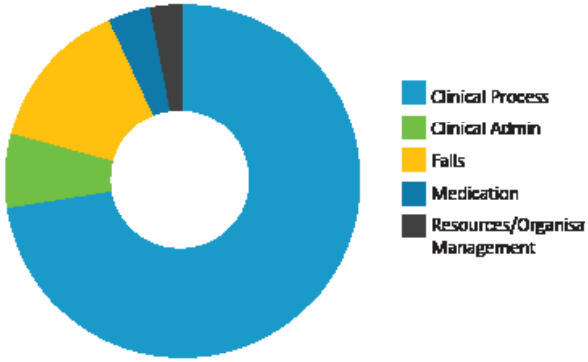
Further information about our work to improve quality and patient experiences were outlined in the section of Clinical Service Redesign (page 58). In addition, initiatives to develop an organisational culture based on collaboration and safety – with the goal of continually improving our services to patients – 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 (SAC) level 1 & 2?

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

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

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



In the 2020/21 year, there were 73 events that were classified SAC 1 and 2 at Southern DHB.

As indicated by the graph above, the largest group of serious adverse events SAC 1 and 2 relates to clinical processes at 74 per cent (assessment, diagnosis, treatment, general care), followed by falls at 14 per cent (serious harm from falls, for example a broken hip), clinical administration at seven per cent (handover, referral, discharge, resources/organisation), medication error at four per cent (dispensing, prescribing or administration of medications) and resources/organisation management at three per cent (such as delay due to resource).

We have provided a summary of the main harms within these categories and the work to date plus work planned to prevent similar events in occurring in the future.

As with the previous year, COVID-19 continues to have an impact on planned actions.

Clinical Processes

Pressure injuries

The Intensive Care Unit at Dunedin Hospital has undertaken an initiative to review management of pressure injuries in their unit. There has been an increase focus on risks for the individual patient and care planning identifying targeted interventions to reduce harm from pressure injuries in this vulnerable patient group.

Opportunities are also being explored to collaborate with other initiatives, for example the activity around patient safety undertaken by the Quality Improvement/ Nursing Lead. This includes providing information in clinical areas to support opportunities for improvement, such as ensuring the number of pressure injuries are available at ward/service quality meetings, and providing information for display in

clinical areas to better enable the area to articulate their improvement focuses.

Recognition and response – Deteriorating patients

Implementation of the national Early Warning Score observation chart has been completed, but work is ongoing to improve the systems for escalation and response. This will be supported with the establishment of the Recognition and Response Committee, reporting to Clinical Council.

The national Maternity Early Warning Score (MEWs) has been fully implemented on the Dunedin and Invercargill sites. Changes are due to the adult inpatient EWS chart in late 2021, at which time the process for using the MEWs chart for all pregnant women requiring observation in hospital will be implemented.

Southern DHB hosted a focus group, facilitated by the Health Quality and Safety Commission, to look at the Paediatric Early Warning Score observation chart, and aims to be an early adopter once this chart is ready to pilot.

Shared Goals of Care is the key project being facilitated by the Patient Safety Team, with implementation in Southland commencing in late 2021. Shared Goals of Care is when clinicians, patients, families and whānau explore patients' wishes, the care and treatment options available and agree the goal of care for the current admission, if the patient condition deteriorates. The plan is for full implementation across Southern DHB by the end of 2022.

When shared goals provide the basis for clinical treatment plans, there is less risk of a patient receiving unwanted or unwarranted treatments which is especially important if their condition deteriorates. Evidence shows that engaging patients and whānau results in better health and care outcomes. The patient and whānau are more likely to feel valued and involved in their treatment, and their experience in hospital is better.

Falls

All falls are reported on our Safety1st system, and we continue to analyse the information/data captured on this system to design an improvement action. We are pleased to note that we have continued with the reduction in falls with harm in our hospitals with 10 this year (11 the previous year).

Also reported last year was our focus on improving our patient assessment and care planning methods and documentation. The package of tools and documents developed is now being tested in clinical areas, with the aim to move on to full implementation facilitated by the Chief Nursing and Midwifery office. The aim is to provide a 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.

Medication

Southern DHB reports three medication events at the SAC 1 and 2 level this year.

The work undertaken with ACC was delayed due to COVID response. This has now been concluded and has provided excellent information and reassurance that our processes are in line with best practice. There is always opportunity for improvement however and a project charter has now been drafted including recommendations for a patient safety improvement programme.

Community Health Council

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 Council is highly valued, and contributions are greatly appreciated.

In 2020/21 its priorities for focus have been to:

- Continue raising the profile of the CHC Engagement Framework and Roadmap across the Southern health system. Community, whānau and patient engagement may be increasingly seen as the "right thing to do", but without systematic evaluation how do we stop good intentions becoming tick-box tokenism?
- Continue evaluating what difference engaging CHC advisors on projects is making, and ask the questions: are staff genuinely engaging, listening and acting to what CHC advisors are raising on projects? A similar evaluation occurs with staff members.
- Continue to work closely with the Clinical Council and key clinicians across the Southern health system to raise the profile and ensure consistent messaging is going out about the CHC Engagement Framework.
- Profiling Clinical Champions who support engagement between staff, patients and whānau has been delayed due to Covid-19, now the vaccination roll out as well as the Patient Flow Taskforce work, but will continue throughout the remainder of 2021.
- Profile services where engagement has occurred with CHC advisors, identify what has been learnt, what could have been done better and what improvements have been made to service delivery.
- The CHC undertook a large amount of work around understanding the feedback process (commonly referred to as the Complaints Procedure) at the DHB and had developed some initiatives for change. The CHC is still keen to progress this work as members believe that there are valuable lessons to be learnt from the feedback process and also potentially with services where engagement with CHC advisors could be encouraged. This is important particularly as the amount of feedback coming into the DHB has increased exponentially.
- Patient Stories is again something the CHC believes provides a powerful and meaningful tool for allowing people/staff to listen about people's experiences. CHC has progressed some of this work related in particular to the Disability Strategy, and work had been collated around the process of collecting patient stories, the use and storage of these to ensure appropriate consent is applied to their application. CHC would like to see further discussion around this, and work on the formation of an organisation wide policy for this.
- Developing a plan on a page, incorporating some of the above work streams but also allowing flexibility for items to flow into the CHC from services as needed.

The Community Health Council was established in 2018. What do we know four years on?

- The community (who are aware of the CHC) feel they have an opportunity to feed into the health system
- Staff working with consumers do need to explain aspects of the project clearly and logically – this can be challenging and does take more time.
- Staff will be held to account for the work they are undertaking.
- We have had acknowledgement that consumers can bring aspects of some groups into focus. A consumer presence and the consumer lens is bringing about positive change and professional collegiality between group members, e.g. in the Endoscopy Oversight Group.

Covid-19 and the community

With the recent changes to the alert levels and an outbreak of the more virulent Delta strain, CHC members are well positioned to maintain contact with their own networks and communities. The regular Southern Health Covid-19 Updates circulated to members informs of testing, vaccination locations and contact tracing, as well as hospital activities during this time. We are also kept up to date with monthly reports from the Covid Vaccination Team, who attend CHC meetings. This is valuable and enables up to date and correct information to be disseminated to our communities. This also provides the Team with solid feedback and comment from the community, which the Vaccination Team requested CHC members provide each month.

New Dunedin Hospital

Community engagement with the new Dunedin Hospital continues, with some FiT groups having now completed the design work in areas of the Ambulatory Services Building. A sound relationship is enjoyed with the PMO team, and in July 2021 John Adams presented to CHC meeting, thanking all consumers involved to date, with encouragement to remain active and involved as the In Patient Building moves through design phases, and also the transition into "moving into and occupying the ASB" is planned. CHC thanked John for his support during his tenure as Chair of the CLG, and his positive feedback on how our consumers have been accepted into the various FiT groups. The New Dunedin Hospital build has been an avenue for some services to be introduced to the CHC and CHC Advisors. This work will continue to be a big priority over the coming years.

Disability Strategy

The Disability Strategy was officially launched in April 2021. CHC members played a role in getting this work underway, and now have an active role in The Disability Working Group, of which John Marrable is the Chair. The Disability Working Group and the CHC will ensure that information is shared between these groups.

Paula Waby, CHC member, is also a member of the Disability Support Advisory Committee (DSAC).

After-Hours Access in Southland

CHC members have played a strong part in the work occurring in Invercargill with WellSouth, in the establishment of a Primary Health practice for those who are not enrolled in existing practices, and an After Hours service. CHC members originally raised community concern to WellSouth two years ago, and are pleased to see this work now occurring.

HQSC – QSM for Consumer Engagement

The Health Quality and Safety Commission (HQSC) launched the Quality Safety Marker (QSM) for Consumer Engagement in July 2020, with the first upload of submitted data made in March 2021, and now available to view on HQSC website.

There needs to be support from and partnership with Clinical Council, with additional members needed to join the initial Oversight Group – it is considered this needs to be a mix of consumers, Executives and Clinical staff. The CHC Chair and Facilitator presented on the Consumer Engagement Marker to Clinical Council in April 2021. The goal of this QSM is to address 'what does successful consumer engagement look like, and (how) does it improve the quality and safety of services?' The data will now be collected bi-annually.

CHC Engagement Framework and Roadmap

For the January – June 2021 period there were 31 CHC advisors working alongside staff on approximately 22 projects across the Southern health system. The majority of these projects were at a strategic partnership level and not so many projects occurring at a service level. This may change with the incorporation of QSM for consumer engagement which will increase the profile of CHC. Information about the CHC engagement is incorporated into service planning so we will monitor how this progresses. Appendix 3 provides a summary of other work the CHC has fed into over the last six months.

In April 2021, CHC presented to Clinical Council about consumer engagement to date, and asked the question: "how can Clinical Council influence where engagement should be occurring?" Clinical Council agreed that CHC needs to be better known throughout the organisation and moved that Clinical Council members will ensure CHC will be discussed at Service Level Teams/Medical Directors meetings.

Health Care Homes

Health Care Homes have been introduced into Primary Care. CHC has provided some guidance to WellSouth in regards to consumer engagement within HCH practices, and has regular updates from WellSouth about how this occurs. Further tranches of practices are moving to becoming HCH practices.

Patient Flow Taskforce

At the end of 2020, CHC raised serious community concerns about several aspects of healthcare in the Southern region. Since this time, CHC has been involved in the work of the Patient Flow Taskforce, adding the consumer voice and applying the consumer lens to some areas of this work. CHC is appreciative of this involvement, and can offer constructive feedback from real patient experience. CHC will seek to evaluate if this involvement has made a difference and assisted with this work.

Patient Tracer Audits

CHC has engaged in some work with the Director of Quality and her team, as updates to material was required. CHC members provided some valuable consumer insight into language used, presentation and ways to gain meaningful engagement with selected patients.

Patient Feedback report by Consumer Experience Manager

In June 2021, CHC received a presentation showing the number, type, reason and mode of complaints made to SDHB. Questions were asked about the sharp rise in the number of complaints, and also CHC expressed real concern for the staff working in this area as it is possible the high volume of complaints may have a negative impact for them.

Southern DHB Policies

CHC is now engaged with the DHB's recently appointed Policy Advisor around some specific policies, and also those identified by members as appropriate to have a consumer lens applied, noting that some DHBs routinely pass all policies due for review past their Consumer Council for comment.

Localities

CHC is engaged with the Project Manager as work progresses on drafting a pilot for submitting to the Transition Unit for the establishment of Localities under Health NZ. More consumers will become involved as this work progresses.

Enabling success: Organisational resilience and sustainability

Enabling Our People

Good Employer Obligations Report

The people who work in the Southern health system are at the heart of everything we do, and we are committed to supporting them to have the skills, support and passion they need to deliver the care our communities have asked for.

In doing so, Southern DHB is committed to meeting its statutory, legal and ethical obligations to be a good employer. 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, professional development and work conditions for employees.

Our Equal Employment Opportunities Policy is currently under review and expected to be released towards the end of 2021.

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 wellbeing 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.

Workforce strategy

Our focus continues to be on the delivery of the Workforce Strategy and Action plan aimed at transforming our Southern health system through creating a sustainable and contemporary workforce, and improving workplace culture.

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

We also implemented a new recruitment and onboarding platform 'SuccessFactors' – streamlining our processes and supporting our efforts in attracting and retaining the best talent for the Southern Health system.

Strengthening our culture

Staff Engagement Survey

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 the Staff Engagement Survey, which we opened up to all staff in 2020.

Pleasingly, the best results were around patient care, dignity and safety, which is at the heart of everything we do. Staff are also telling us we need to do better in the areas of organisational change, leadership and addressing performance issues.

We have undertaken some significant groundwork to address some of the priority areas, including the development of psychological first-aid workshops, leadership programmes including the Leading Others through Change workshop, and a revision of the Speak Up programme to better support our staff.

We have also made significant inroads into investing in staffing levels in several areas, to help alleviate some of the workload burden.

Southern Excellence Awards

Southern DHB celebrated its remarkable staff from across the district at the Southern Excellence Awards in November 2020.

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.

The awards included: the Graham Crombie Outstanding Leadership Award, Behind the Scenes (Unsung Hero), Team of the Year, Breaking Boundaries, Rising Star, Outstanding Care and Compassion, Southern Future Values Champion and the Māori Health Development Award. The winners of each category will receive a professional development grant.

The challenge of COVID-19 to our health system and the response on Southern DHB staff featured prominently in this year's awards. The Graham Crombie Outstanding Leadership Award was won by Southern DHB Medical Officer of Health, Dr Susan Jack for her Public Health leadership, and the Team of the Year Award went to the district-wide Public Health COVID-19 Response Team.

"2020 has been an extraordinary year for everyone, especially those working in Health. 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 third year we have run the Southern Excellence Awards. 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."

Living our values

Southern DHB wellbeing programme rolled out

Southern DHB launched a new wellbeing programme to help foster a healthy and productive workplace in early 2021.

Aukaha Kia Kaha – which relates to working together to strengthen bindings – takes a grassroots approach to wellbeing at Southern DHB.

"Unlike other wellbeing programmes, Aukaha Kia Kaha is driven by our staff for our staff," says Southern DHB General Manager Occupational Health and Safety, James Knapp. "Meaning we want to empower and enable our staff to drive this initiative, and to work together to strengthen wellbeing at Southern DHB."

The WorkWell-accredited programme acts in two ways: as an overarching framework pulling together

current and future wellbeing initiatives, and as a hub for new wellbeing ideas, with a specific focus on key health areas including mental health, physical activity and eating healthier food.

"We are encouraging all staff to discuss wellbeing at team meetings," says James. "If a staff member or a team has a wellbeing idea that will have a positive impact on the organisation, they are encouraged to send their ideas through to the Aukaha Kia Kaha Committee – made up of staff from across the organisation – for consideration and endorsement or support.

"No idea is too big or small. For example, we've recently approved the installation of picnic tables on the Wakari Hospital site so more staff can enjoy eating their lunch outside. Small changes can have a big impact on our wellbeing, and we're excited to see what our staff come up with."

Pictured: Administrator Emma Laing and General Manager of Occupational Health, James Knapp with a Aukaha Kia Kaha staff suggestion box

Our values

Our shared organisational values of Open, Kind, Positive and Community underpin our people-related policies and processes. 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.

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 Health programme of work reflects the importance placed on leadership development, including the Leadership Exploration and Development programme @Southern (LEADS) programme – designed to empower leaders that champion health and positive workplace culture and have great potential for sustainable leadership. In addition, we have also introduced two accredited leadership programmes for team leaders and line managers new to people management.

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.

The launch of the Southern Disability Strategy and Working Group in early 2021 marked an ongoing commitment by the DHB to removing barriers to healthcare for disabled people and providing equitable health and disability services throughout the Southern district.

Further initiatives are outlined in the previous section of this report, Improving Patient Experiences and Quality of Care (page 51).

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 Framework and our Essential Corporate Training for Managers programme.

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

Systematic performance and development review processes have been progressed for a number of workforce groups including corporate, nursing and allied health. This has also been supported with Essential Corporate Training for people managers held throughout the year which includes coaching effective performance, have difficult conversations and effectively managing performance review processes.

To further support mental wellbeing at work, Psychological First Aid, Change Cycle workshops and access to a comprehensive wellbeing toolkit are available to all staff.

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.

Harassment and bullying prevention programme

We have been refreshing our 'Speak Up' campaign in recent months, developing Speak Up Guides (volunteer staff), Speak Up e-learning resources, implementing restorative practice workshops and facilitating more Speak Up Workshops across the Southern system. Our focus is to keep on improving our organisational capacity and capability to support a culture where it is safe to highlight concerns and resolve issues at the earliest opportunity.

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 Board.

Current practices include:

- More than 160 elected and trained 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
- Primary 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.
- A focus on supporting staff to return to work safely and as soon as possible following an injury with dedicated resource now appointed.

Employee demographics

Southern DHB currently employs 5,368 employees across Otago, Southland and Central Otago. 21.5 per cent of our employee base is male; 78.5 per cent are female.

Our junior medical staff have even numbers of men and women, while at a senior level 41 per cent of the workforce are women.

The nursing profession comprises 12.9 per cent male employees, whilst midwifery remains 100 per cent female. Service support staff, such as drivers, trades, security staff, are predominantly male (92.5 per cent).

Of the 5,227 employees who detailed their ethnicity, 290 (5.4 per cent) identify as Māori or Pacific, a slight increase from 4.7 per cent the previous year.

New Zealand European/Pakeha employees represent 63.6 per cent of our employee population, which includes a total of 42 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

Prior to 2016, Southern DHB did not record details of staff with disabilities. To address this area, the Employee Contact Details Form was revised and now asks new employees if they identify as having a disability. In 2021, it is planned for further this effort with a survey of existing staff, to gain more information to aid Southern DHB as an equal opportunity employer. Currently 14 employees have identified themselves as having a disability.

Age of Employees	Female	Male	% of total Māori/Pacific Employees in each age band
0-19	0.19%	0.09%	0.69%
20-29	13.62%	3.09%	25.52%
30-39	18.33%	6.35%	23.10%
40-49	15.11%	4.28%	19.31%
50-59	17.98%	4.30%	21.03%
60-69	12.37%	3.02%	10.00%
70-79	0.88%	0.35%	0.34%
80+	0.02%	0.02%	0.00%
Grand Total	78.48%	21.52%	5.40%
Total employees			**5368**

Occupational Group	Gender	Asian	Māori	Not Stated	Other	Pacific	Grand Total
Allied Health	F	28	36	24	677	8	773
	M	19	12	9	124	2	166
Management/Admin	F	25	29	40	676	7	777
	M	17	10	2	165	3	197
Nursing	F	299	108	29	1872	20	2328
	M	115	14	5	207	5	346
RMO	F	30	8	3	139	5	185
	M	52	5	7	117	5	186
SMO	F	10	1	8	127	0	146
	M	30	5	14	161	1	211
Support	F	0	0	0	4	0	4
	M	1	4	0	42	2	49
Grand Total		626	232	141	4311	58	5368

Systems For Success

Digital transformation

The Indicative Business Case (IBC) for our future-focused technology solutions was completed in 2020, signed off by the Southern DHB Board early 2021, and later endorsed by the Ministry of Health in preparation for Cabinet approval.

The IBC was developed to ensure the New Dunedin Hospital will open with modern, fit for purpose solutions that empower clinicians to transform the ways in which they deliver healthcare.

The IBC leverages the opportunities provided by the new hospital build, but the entire Southern health system will benefit from the investment. Our new digital solutions aim to

seamlessly unite patients, doctors, staff, assets and information throughout the new hospital and the region.

The key design principles for the transformation are:

- **Digitally capable** – capable of supporting current and emerging technologies and trends.
- **Highly integrated** – minimises manual data entry by being highly integrated on all levels.
- **Data hungry** – stores all data generated throughout the facility for analysis and reporting.
- **Highly mobile** – staff and devices are not tethered to locations.
- **Deeply interactive** – all information communication technology (ICT) is accessible, intuitive and encourages interaction.
- **Always available** – all ICT infrastructure and systems are architected to be highly available.
- Device agnostic – information is accessible from a broad range of device types.
- **Paper light** – an emphasis on a full digital health record and full digital corporate records.

The principles are underpinned by three key goals:

- **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.

Although the new Dunedin hospital will reuse and extend some existing ICT systems from the current facility, the new facility will also be a catalyst for innovation and implementation of new and enhanced health systems and technologies across the district.

Digital projects

Digital projects delivered during the financial year include:

- A new radiology system
- Wi-Fi improvements across Dunedin sites, delivering almost 100% coverage
- ePharmacy, a modern new pharmacy stock management inventory system
- SuccessFactors Recruitment and Onboarding modules, a new recruitment system
- Tap to Go, a 'follow me' login that enables health practitioners to securely log into any enabled device to access their programmes and files

These improvements have facilitated increased efficiency, greater integration of systems, and reduced use of paper.

COVID-19

Following the COVID-19 Alert Level 4 and 3 lockdown we continued the rollout of the secure, cloud-based collaboration system Microsoft Teams, and continued to implement and improve online tools such as the iMedx digital transcription service.

The COVID-19 vaccination effort began in February 2021. Healthcare workers, essential workers and those most at risk were vaccinated first, with the Digital Team developing booking systems to support the smooth delivery of vaccinations. Because of the highly urgent nature of the work a basic system was quickly developed in-house, followed by a collaboration with Waikato DHB and external vendors which provided a more robust solution.

[Note the Ministry of Health solution – the National Immunisation Booking System – was adopted in July.]

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

Considerable progress was made on the planning for the New Dunedin Hospital. It was determined that the facility, which will serve the Southern region, will be built in two stages:

An Outpatient Building (planned to open January 2025). This will include ambulatory services, clinic rooms, day procedures and non-urgent radiology.

An Inpatient Building and Logistics Building on Bow Lane (both planned to open April 2028). This includes an emergency department, operating theatres and other services including a dedicated primary birthing unit.

The new hospital will include 421 beds, 16 theatres (expandable to 21 theatres) and 30 ICU or high dependency beds (expandable to 40) with the outpatient building supporting greater delivery of ambulatory care. The use of latest technology will mean greater efficiency, faster service and better access to diagnostics. Design work to ensure the hospital is able to cope with future pandemics is also progressing as a priority. The project will inject $429 million GDP to the local economy and employ thousands of construction workers over the lifetime of the project.

In August 2020 the Ministry of Health acquired land between Cumberland and Castle Streets through an agreed sale under the Public Works Act. In September the Government agreed the preferred design for the New Dunedin Hospital, and on 19 April 2021 Cabinet approved the final Detailed Business Case for the New Dunedin Hospital project at a total value of $1.47 billion.

Demolition of the Wilsons site and much of the Cadbury site was completed during the financial year. Preliminary design for the Outpatients' Building was completed, as was concept design for the Inpatients' Building.

The project is also creating strong community relationships. Led by Fibresafe NZ, construction workers were given a three-day training course in asbestos removal at the New Dunedin Hospital project offices. The demolition site flew the 'Mates in Construction' flag to show support and raise awareness of suicide prevention in the construction industry, and Mates in Construction held awareness-raising sessions at the project offices. And Dunedin school children employed augmented reality and robotics to share their visions for our new hospital. A variety of public and staff forums were also held to keep people informed about the development of the project.

ICU – te puna wai ora

For a number of reasons, the original design for the Intensive Care Unit (ICU), which connected the new floor to existing systems, did not provide adequate air turns for an ICU environment. Southern DHB has worked closely with contractors on a remediation plan for the heating, ventilation and air conditioning of the new ICU. Some specialist remedial work needs to be completed before the new system is constructed. Southern DHB remains committed to remediating the ICU to enable the full facility to open. It has been agreed that the ICU could be used if necessary during an outbreak of COVID-19.

Queen Mary Maternity Centre refurbishment

A new state-of-the-art Operating Theatre and Post Anaesthetic Care Unit (PACU) at Queen Mary Maternity Unit at Dunedin Hospital opened at the beginning of 2021 brings benefits for mothers, their babies, whānau, and staff.

The refurbishment included the removal of wall linings and services in the existing theatre to allow a full rebuild of the theatre. To ensure the main operating theatres weren't impacted by the upgrade, another room was upgraded and used as an operating theatre. This additional theatre worked well and is still used to provide more operating theatre capacity for the unit.

Further enhancements such as passive fire upgrades, the completion of a storeroom and ventilation alterations were made after the opening. The refurbishment has upgraded services and improved patient flow. Parents are able to be cared for in a state-of-the-art space that meets contemporary standards, and the clinical teams now have a modern environment to work in.

Pictured left to right: Megan Boivin, General Manager Operations; Nicky Vaughan, Charge Nurse Manager Anaesthesia and Pain Management; Michael Burrows, Project Manage; Sue Chambers, Perioperative Registered Nurse; Jane Wilson, Chief Nursing and Midwifery Office; Adele McBride, Associate Charge Nurse Manager; Fiona Thompson, Charge Midwife Manager; Heather LaDell, Director Of Midwifery

Southland Radiology

The Southland radiology MRI suite has seen significant improvement. The sixteen-year-old MRI scanner was replaced with a reliable and modern new machine, and the scanner room and control room were modified. A cannulation room and a patient change area were created, and a window from the control room was added to enable clinicians to speak with the patients before entering the room. Two patients can now use the suite at the same time, meaning scan and appointment times can be shorter. There are also patient safety benefits, as there is now more room for the anaesthetics team to set up and work with anaesthetised patients. Due to COVID-19 related supply chain difficulties, the project was concluded shortly after the end of the 2020/21 year.

Financial statements

Statement of Comprehensive Revenue and Expense
For the year ended 30 June 2021

	Note	2021 Actual $000	2021 Budget $000	2020 Actual $000
Patient care revenue	2	1,188,171	1,158,419	1,091,873
Other revenue	2	10,366	7,828	7,885
Interest revenue		385	232	308
Total revenue		**1,198,922**	**1,166,479**	**1,100,066**
Personnel costs	3	472,752	456,558	477,433
Depreciation, amortisation and impairment expense	10,11	29,157	27,834	25,063
Outsourced services		56,360	49,122	48,797
Clinical supplies		110,453	96,513	98,877
Infrastructure and non-clinical expenses		57,756	56,584	59,307
Other district health boards		48,501	47,531	46,996
Non-health board provider expenses		441,454	426,490	419,741
Other expenses	6	5,445	4,026	4,334
Interest expense	5	78	134	320
Capital charge	4	7,898	12,605	9,652
Total expenses		**1,229,854**	**1,177,397**	**1,190,520**
Surplus/(deficit) for the year	17	**(30,932)**	**(10,918)**	**(90,454)**
Other comprehensive revenue				
Items that will not be reclassified to surplus/(deficit) Revaluation of land and buildings	17	-	-	-
Total other comprehensive revenue/(expense)		-	-	-
Total comprehensive revenue/(expense)		**(30,932)**	**(10,918)**	**(90,454)**

Statement of Changes in Equity
For the year ended 30 June 2021

	Note	2021 Actual $000	2021 Budget $000	2020 Actual $000
Balance at 1 July		**165,993**	**206,398**	**172,410**
Total comprehensive revenue and expense		(30,932)	(10,918)	(90,454)
Owner transactions				
Capital contributions from the Crown (deficit support and project equity funding)		1,332	46,500	84,744
Return of capital		(707)	(707)	(707)
Balance at 30 June	17	**135,686**	**241,273**	**165,993**

Explanations of major variances against budget are provided in note 23
The accompanying notes form part of these financial statements.

Statement of Financial Position
As at 30 June 2021

	Note	2021 Actual $000	2021 Budget $000	2020 Actual $000
Current assets				
Cash and cash equivalents	7	7,582	7	31,011
Trade and other receivables	8	61,439	48,830	49,819
Inventories	9	6,159	5,235	6,095
Total current assets		**75,180**	**54,072**	**86,925**
Non-current assets				
Property, plant and equipment	10	321,144	355,122	324,107
Intangible assets	11	10,672	20,149	5,664
Total non-current assets		**331,816**	**375,271**	**329,771**
Total assets		**406,996**	**429,343**	**416,696**
Liabilities				
Current liabilities				
Cash and cash equivalents	7	-	16,259	-
Payables and deferred revenue	12	71,996	64,373	64,588
Borrowings	13	235	955	962
Employee entitlements	14	178,732	85,575	164,172
Provisions	15	80	80	80
Total current liabilities		**251,043**	**167,242**	**229,802**
Non-current liabilities				
Borrowings	13	856	1,018	1,091
Employee entitlements	14	19,411	19,810	19,810
Total non-current liabilities		**20,267**	**20,828**	**20,901**
Total liabilities		**271,310**	**188,070**	**250,703**
Net assets		**135,686**	**241,273**	**165,993**
Equity				
Contributed capital	17	385,631	531,749	385,006
Property revaluation reserves	17	108,502	108,502	108,502
Accumulated surplus/(deficit)	17	(358,447)	(398,978)	(327,515)
Total equity		**135,686**	**241,273**	**165,993**

Explanations of major variances against budget are provided in note 23
The accompanying notes form part of these financial statements.

Statement of Cash Flows
For the year ended 30 June 2021

	2021 Actual $000	2021 Budget $000	2020 Actual $000
Cash flows from operating activities			
Cash receipts from Ministry of Health and patients	1,192,145	1,167,279	1,097,687
Payments to suppliers	(723,712)	(675,364)	(678,769)
Payments to employees	(455,545)	(499,569)	(425,100)
Interest received	385	232	308
Interest paid	-	(30)	-
Goods and services tax (net)	1,341	(486)	493
Capital charge	(7,898)	(12,605)	(9,651)
Net cash flow from/to operating activities	**6,716**	**(20,543)**	**(15,032)**
Cash flows from investing activities			
Proceeds from sale of property, plant and equipment	6	-	3
Purchase of property, plant and equipment	(25,907)	(53,612)	(24,829)
Purchase of intangibles	(3,907)	(18,681)	(2,514)
Net cash flow from/to investing activities	**(29,808)**	**(72,293)**	**(27,340)**
Cash flows from financing activities			
Capital contributions from the Crown	1,332	8,650	84,744
Proceeds/(repayment) of borrowings	(1,669)	36,923	(1,473)
Net cash flow from/to financing activities	**(337)**	**45,573**	**83,271**
Net increase/(decrease) in cash and cash equivalents	**(23,429)**	**(47,263)**	**40,899**
Cash and cash equivalents at beginning of year	31,011	31,011	(9,888)
Cash and cash equivalents at the end of the year	**7,582**	**(16,252)**	**31,011**

Explanations of major variances against budget are provided in note 23
The accompanying notes form part of these financial statements.

Statement of Cash Flows
For the year ended 30 June 2021 (continued)

Reconciliation of net surplus/(deficit) to net cash flows from operating activities

	2021 Actual $000	2021 Budget $000	2020 Actual $000
Net deficit for the period	**(30,932)**	**(10,918)**	**(90,454)**
Add/(less) non-cash items:			
Depreciation, amortisation and assets written off	29,157	27,834	25,063
Increase/(decrease) in financial liability fair value	5	140	329
Increase/(decrease) in provision for doubtful debts	356	-	(2,617)
Total non-cash items	**29,518**	**27,974**	**22,775**
Add/(less) items classified as investing or financing activity:			
Net loss/(gains) on disposal of property, plant and equipment	430	-	62
Total items classified as investing or financing activities	**430**	**-**	**62**
Movements in working capital:			
(Increase)/decrease in trade and other receivables	(11,977)	2,182	150
(Increase)/decrease in inventories	(65)	860	(332)
Increase/(decrease) in trade and other payables	5,816	(35,671)	1,123
Increase/(decrease) in employee benefits	13,926	(4,970)	51,644
Net movements in working capital	**7,700**	**(37,599)**	**52,585**
Net cash inflow/(outflow) from operating activities	**6,716**	**(20,543)**	**(15,032)**

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 2021

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 2021 and were approved for issue by the Southern DHB Board on 17 December 2021.

BASIS OF PREPARATION

Health Sector Reforms

On 21 April 2021 the Minister of Health announced the health sector reforms in response to the Health and Disability System Review.

The reforms will replace all 20 District Health Boards (DHBs) with a new Crown entity, Health New Zealand, that will be responsible for running hospitals and commissioning primary and community health services. It will have four regional divisions.

As a result of the reforms, responsibility for public health issues will rest with a new Public Health Authority. A new Māori Health Authority will monitor the state of Māori health and commission services directly.

Legislation to establish the new entities and disestablish DHBs is scheduled to come into effect on 1 July 2022.

Because of the expected date of these reforms the financial statements of the DHB have been prepared on a disestablishment basis. No changes have been made to the recognition and measurement, or presentation in these financial statements, because all assets, liabilities, functions and staff of the DHBs and shared services agencies will transfer to Health New Zealand.

Operating and cash flow forecasts

Operating and cash flow forecasts indicate that the DHB will have sufficient funds (including equity funding from the Crown for approved capital projects) to meet the forecast operating and investing cash flow requirements of the DHB for the 2021/22 financial year. However, if the DHB was required to settle the holiday pay liability disclosed in note 14 prior to 1 July 2022, additional financial support would be needed from the Crown.

Letter of comfort

The Board has received a letter of comfort dated 13 October 2021 from the Ministers of Health and Finance. The letter of comfort states that the Government is committed to working with the DHB to maintain its financial viability and acknowledges that, if required over the period up until Health New Zealand is established, the Crown will provide equity support where necessary to maintain viability.

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 accounting standards.

Presentation currency and rounding

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

Changes in accounting policies

There have been no changes in Southern DHB's accounting policies since the date of the last audited financial statements.

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

PBE IPSAS 2 Cash Flow Statement

An amendment to PBE IPSAS 2 requires entities to provide disclosures that enable users of financial statements to evaluate changes in liabilities arising from financing activities, including both changes arising from cash flows and non-cash changes. This amendment is effective for the year ending 30 June 2022, with early application permitted. This amendment will result in additional disclosures. Southern DHB does not intend to early adopt the amendment.

PBE IPSAS 41 Financial Instruments

PBE IPSAS 41 replaces PBE IFRS 9 Financial Instruments and is effective for the year ending 30 June 2023, with earlier adoption permitted. Southern DHB has assessed that there will be little change as a result of adopting the new standard as the requirements are similar to those contained in PBE IFRS 9. Southern DHB does not intend to early adopt the standard.

PBE FRS 48 Service Performance Reporting

PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 Presentation of Financial Statements and is effective for the year ending 30 June 2023, with earlier adoption permitted. Southern DHB has not yet determined how application of PBE FRS 48 will affect its Statement of Service Performance and does not plan to early adopt the standard.

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

Nil.

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. Foreign exchange gains and losses resulting from the settlement of such transactions and from the translation at year-end exchange rates of monetary assets and liabilities denominated in foreign currencies are recognised in the surplus or deficit.

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.

The net amount of GST recoverable from, or payable to, the Inland Revenue is included as part of receivables or payables in the statement of financial position.

The net GST paid to, or received from the Inland Revenue, including the GST relating to investing and financing activities, is classified as a net operating cash flow in the statement of cash flows.

Commitments and contingencies are disclosed exclusive of GST.

Income tax

Southern DHB is a public authority and consequently is exempt from the payment of income tax.

Accordingly, no provision has been made for income tax.

Budget figures

The budget figures are derived from the 2020/2021 statement of performance expectations. The budget figures have been prepared in accordance with GAAP, using accounting policies that are consistent with those adopted by the Commissioner in preparing these financial statements.

Cost allocation

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

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

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

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

Critical accounting estimates and assumptions

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

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

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

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

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

Comparative data

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

2. REVENUE

ACCOUNTING POLICY

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

MoH population-based revenue

The DHB receives annual funding from the Ministry of Health (MoH), which is based on population levels within the Southern DHB district.

MoH population-based revenue for the financial year is recognised based on the funding entitlement for that year.

MoH contract revenue

The revenue recognition approach for MoH contract revenue depends on the contract terms. Those contracts where the amount of revenue is substantively linked to the provision of quantifiable units of service are treated as exchange contracts and revenue is recognised as the DHB provides the services. For example where funding varies based on the quantity of services delivered, such as number of screening tests or heart checks.

Other contracts are treated as non-exchange and the total funding receivable under the contract is recognised as revenue immediately, unless there are substantive conditions in the contract. If there are substantive conditions, revenue is recognised when the conditions are satisfied. A condition could include the requirement to provide services to the satisfaction of the funder to receive or retain funding. Revenue for future years is not recognised where the contract contains substantive termination provisions for failure to comply with the service requirements of the contract. Conditions and termination provisions need to be substantive, which is assessed by considering factors such as the past practice of the funder. Judgement is often required in determining the timing of revenue recognition for contracts that span a balance date, and multi-year 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. Inter-district patient inflow revenue is recognised when eligible services are provided. 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 other services

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

Donations and bequests

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

Research revenue

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

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

Breakdown of Patient Care revenue

	2021 Actual $000	2020 Actual $000
MoH population based funding	1,027,683	945,394
MoH other contracted revenue	111,957	102,867
ACC contract revenue	12,013	10,336
Inter-district patient inflows	26,870	23,687
Other patient care revenue	9,648	9,589
Total Patient care revenue	**1,188,171**	**1,091,873**

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

Breakdown of other revenue

	2021 Actual $000	2020 Actual $000
Gain on sale of property, plant and equipment	5	4
Donations and bequests received	3,632	404
Rental revenue	2,086	2,945
Other revenue	4,643	4,532
Total other revenue	**10,366**	**7,885**

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 schemes are recognised as an expense in the Statement of Comprehensive Revenue and Expense as incurred.

Breakdown of personnel costs

	2021 Actual $000	2020 Actual $000
Salaries and wages	447,227	414,554
Defined contribution plans employer contributions	11,715	10,773
Increase/(decrease) in employee entitlements	13,810	52,106
Total personnel costs	**472,752**	**477,443**

EMPLOYEE REMUNERATION

There were 1,206 employees who received remuneration and other benefits of $100,000 or more for the year ending 30 June 2021 (2020: 1,024). The year on year increase reflects the combined impact of additional FTE, MECA settlements and additional payments made during the ongoing COVID-19 response.

Remuneration Bands $000	Number of Employees	
	2021	2020
100 - 110	284	239
110 - 120	190	161
120 - 130	129	106
130 - 140	82	73
140 - 150	60	55
150 - 160	50	41
160 - 170	37	29
170 - 180	26	20
180 - 190	25	18
190 - 200	17	19
200 - 210	15	18
210 - 220	18	14
220 - 230	19	15
230 - 240	17	16
240 - 250	14	20
250 - 260	16	16
260 - 270	21	17
270 - 280	13	16
280 - 290	12	13
290 - 300	14	16
300 - 310	9	16
310 - 320	11	10
320 - 330	15	7
330 - 340	14	4
340 - 350	9	3
350 - 360	10	8
360 - 370	9	7
370 - 380	9	9
380 - 390	5	6
390 - 400	10	2
400 - 410	1	2
410 - 420	9	2
420 - 430	5	4
430 - 440	2	1
440 - 450	1	4
450 - 460	1	3
460 - 470	2	2
470 - 480	5	3
480 - 490	-	3
490 - 500	4	1
500 - 510	3	-
510 - 520	2	-

520 - 530	1	-
530 - 540	3	-
540 - 550	1	1
550 - 560	-	2
560 - 570	1	-
570 - 580	2	1
580 - 590	1	1
590 - 600	1	-
600 - 610	1	-
	1,206	**1,024**

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 1,206 employees in this category, 933 were regulated health professionals (2020: 1,024 employees, of which 813 were regulated health professionals).

The Chief Executive's remuneration and other benefits either paid or accrued, are in the band 580-590.

EMPLOYEE TERMINATION PAYMENTS

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

The total payments were $406,888 (2020: 8 employees totalling $119,152).

BOARD MEMBER REMUNERATION

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

There were payments made to the independent Chairperson of the Finance, Audit and Risk Committee, appointed by the Commissioner since September 2015 and who stepped down in February 2021. Payments totalled $20,000 (2020:$30,000).

Mr Roger Jarrold was appointed as a Southern DHB Crown Monitor by the Minister, subsequently to this appointment the Southern DHB Board appointed Mr Roger Jarrold as the Chairperson of the Southern DHB Finance Audit & Risk Committee (FARC). This is not viewed as a conflict by either the Ministry of Health or Southern DHB, both entities view this appointment as complementary. Both the Crown Monitor role and Chairperson FARC require Governance level knowledge of the risks, controls and financial position of Southern DHB. No additional remuneration was provided for the Chairperson FARC role.

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

	2021 Actual $000	2020 Actual $000
David Cull	13	26
David Perez MNZM	23	16
Jean O'Callaghan	23	13
Ilka Beekhuis	23	13
John Chambers	23	13
Kaye Crowther QSO	23	13
Lyndell Kelly	23	13
Pete Hodgson	23	-
Peter Crampton	6	-
Terrence King MNZM	23	13
Tuari Potiki	23	13
Lesley Soper	23	13
Reremoana Theodore	23	13
Total Board Members remuneration	**272**	**159**

Section 90 of the New Zealand Public Health and Disability Act 2000 provides indemnity to Board members for certain activities undertaken in the performance of the DHB's functions.

Directors and Officers Liability and Professional Indemnity Insurance cover has been provided in respect of the liability or costs of Board members.

No Board members received compensation or other benefits in relation to cessation (2020: nil).

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

	2021 Actual $000	2020 Actual $000
Hospital Advisory Committee		
Odele Stehlin	1	1
Total Remuneration	1	1
Iwi Governance Committee		
Taare Hikurangi Bradshaw	1	-
Sumaria Beaton	-	1
Justine Camp	1	1
Ann Wakefield	1	1
Donna Matahaere-Atariki	1	1
Odele Stehlin	2	2
Total Remuneration	**6**	**6**

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

4. CAPITAL CHARGE

ACCOUNTING POLICY

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

FURTHER INFORMATION ON THE CAPITAL CHARGE

Southern DHB pays capital charge to the Crown twice yearly. This is based on closing equity balance of the entity at 30 June and 31 December respectively. The capital charge rate for the year ending 30 June 2021 was 5 per cent. The amount charged during the period was $7.9 million (2020: 6 per cent, $9.7 million).

5. FINANCE COSTS

ACCOUNTING POLICY

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

Breakdown of finance costs

	2021 Actual $000	2020 Actual $000
Interest on secured loans	4	235
Interest on finance leases	74	85
Total finance costs	**78**	**320**

6. OTHER EXPENSES

ACCOUNTING POLICY

Breakdown of other expenses

	Note	2021 Actual $000	2020 Actual $000
Impairment of trade receivables		1,084	706
Bad debts written off		-	-
Loss on disposal of property, plant and equipment		435	66
Audit fees (for the audit of financial statements 2021)		232	227
Audit fees (for the audit of financial statements 2020)		30	-
Fees paid to other auditors for internal audit and related services		128	135
Board/Commissioners fees	3	317	313
Operating lease expenses		3,214	2,882
Koha		5	5
Total other expenses		**5,445**	**4,334**

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 50% (2020: 56%), premises rental 30% (2020: 27%), with the balance being clinical equipment and other equipment rental 20% (2020: 17%).

Operating leases as lessee

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

	2021 Actual $000	2020 Actual $000
Non-cancellable operating lease rentals are payable as follows:		
Less than one year	1,957	1,520
Between one and five years	2,128	2,789
More than five years	99	105
Total non-cancellable operating leases	**4,184**	**4,414**

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 2027.

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 2021 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

	2021 Actual $000	2020 Actual $000
Cash at bank and on hand	6	7
Demand funds with New Zealand Health Partnerships Limited	7,576	31,004
Cash and cash equivalents in the Statement of Cash Flows	**7,582**	**31,011**

WORKING CAPITAL FACILITY

At 30 June 2021, 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 $61.0m (2020: $53.5m).

8. TRADE AND OTHER RECEIVABLES

ACCOUNTING POLICY

Trade and other receivables are recorded at the amount due, 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

	2021 Actual $000	2020 Actual $000
Receivables (gross)	62,872	50,896
Less: allowance for credit losses	(1,433)	(1,077)
Total net receivables	**61,439**	**49,819**

The expected credit loss rates for receivables at 30 June 2021 and 30 June 2020 are based on the payment profile of revenue on credit over the prior 2 years at the measurement date and the corresponding historical credit losses experienced for that period.

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

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

	2021 Actual $000	2020 Actual $000
Opening allowance for credit losses as at 1 July	1,077	3,694
Increase in loss allowance made during the year	1,084	706
Receivables written off during the year	(728)	(3,323)
Balance as at 30 June	**1,433**	**1,077**

Trade receivables ageing profile

	2021				2020			
	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	16,326	0%	147	-	8,754	0%	1	-
Less than six months past due	1,759	25%	180	-	3,428	25%	318	-
Between six months and one year past due	370	75%	234	-	803	75%	265	-
Between one and two years past due	517	75%	92	209	442	75%	170	-
Greater than two years past due	349	75%	45	525	798	75%	223	100
Specific Debtors	220	95%	-	-	106	95%	-	-
Specific Debtors	525	100%	-	-	-	100%	-	-
Total	**20,066**		**698**	**734**	**14,331**		**977**	**100**

Note: Trade receivables of $20.1 million are included in Receivables (gross) figure, $61.4 million (pg. 84).

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

	2021 Actual $000	2020 Actual $000
Pharmaceuticals	2,077	2,734
Surgical & medical supplies	4,082	3,361
Total inventories	**6,159**	**6,095**

The amount of inventories recognised as an expense during the year was $32.6 million (2020: $28.4 million), which is included in the clinical supplies line item of the statement of comprehensive revenue and expense.

There have been no write downs or reversals of write-downs of inventories in the period (2020: nil).

No inventories are pledged as security for liabilities (2020: nil).

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:

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.

Buildings	7 to 54 years
Plant and Equipment	4 to 40 years
Motor Vehicles	5 to 12 years

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.

For assets not carried at a revalued amount, the reversal of an impairment loss is recognised in surplus or 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 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**
Balance at 1 July 2020	37,997	243,085	192,568	2,354	10,534	486,538
Additions	-	-	-	-	27,072	27,072
Transfers from Work in Progress	-	6,074	20,142	14	(26,230)	-
Reclassification	-	(926)	(7,985)	11	-	(8,900)
Disposals	-	(741)	(38,103)	(58)	-	(38,902)
Balance at 30 June 2021	**37,997**	**247,492**	**166,622**	**2,321**	**11,376**	**465,808**
Depreciation and impairment losses						
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**
Balance at 1 July 2020	-	21,185	139,005	2,241	-	162,431
Depreciation charge for the year	-	13,530	13,935	52	-	27,517
Reclassification	-	(976)	(5,806)	11	-	(6,771)
Disposals	-	(741)	(37,714)	(58)	-	(38,513)
Balance at 30 June 2021	**-**	**32,998**	**109,420**	**2,246**	**-**	**144,664**
Carrying amounts						
At 1 July 2019	37,997	220,649	48,300	210	15,894	311,965
At 30 June 2020	**37,997**	**221,900**	**53,563**	**113**	**10,534**	**323,050**
At 1 July 2020	37,997	221,900	53,563	113	10,534	324,107
At 30 June 2021	**37,997**	**214,494**	**57,202**	**75**	**11,376**	**321,144**

Capital Commitments

	2021 Actual $000	2020 Actual $000
Buildings	2,921	5,640
Clinical equipment	3,821	6,642
Computer equipment	863	3,776
Non-clinical equipment	520	137
Intangibles	-	-
Total capital commitments	**8,125**	**16,015**

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

Revaluation

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

The revaluation of land and buildings of Southern DHB was carried out as at 30 June 2018 by Tony Chapman, an independent registered valuer with Colliers International and a member of the New Zealand Institute of Valuers. That valuation conformed to International Valuation Standards and was based on an optimised depreciation replacement cost methodology because no reliable market data is available for such buildings. The valuer was contracted as an independent valuer. Additions to land and buildings between 1 July 2018 and 30 June 2021 have been included at cost.

Restriction

The DHB does not have full legal title to the Crown land it occupies, but transfer is arranged if and when the land is sold.

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 2021 is $13.0 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 2021, 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 2021.

Impairment

Refer to the policy for impairment of property, plant and equipment in Note 10. The same approach applies to the impairment of intangible assets, except for intangible assets that are still under development.

Intangible assets that are under development and not yet ready for use are tested for impairment annually, irrespective of whether there is any indication of impairment.

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	20-33%

Breakdown of intangible assets

	FPIM	Software & development costs	Total
Cost	**$000**	**$000**	**$000**
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**
Balance 1 July 2020	5,127	27,402	32,529
Additions	-	4,579	4,579
Reclassification	-	8,900	8,900
Disposals	-	(10,144)	(10,144)
Balance at 30 June 2021	**5,127**	**30,737**	**35,864**
Amortisation and impairment losses			-
Balance 1 July 2019	5,127	20,833	25,510
Amortisation charge for the year	-	1,355	1,355
Disposals	-	-	-
Balance at 30 June 2020	**5,127**	**21,738**	**26,865**
Balance 1 July 2020	5,127	21,738	26,865
Amortisation charge for the year	-	1,638	1,638
Reclassification	-	6,771	6,771
Disposals	**-**	(10,082)	(10,082)
Balance at 30 June 2021	**5,127**	**20,065**	**25,192**
Carrying amounts			
At 1 July 2019	-	4,505	4,505
At 30 June 2020	**-**	**5,664**	**5,664**
At 1 July 2020	-	5,664	5,664
At 30 June 2021	**-**	**10,672**	**10,672**

The above balance includes $4.4 million of work in progress (2020: $2.7 million).

There are no restrictions over the title of the DHB's intangible assets. No intangible assets are pledged as security for liabilities.

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

	2021 Actual $000	2020 Actual $000
Trade payables to non-related parties	-	7,415
GST payable	7,405	6,062
Revenue in advance relating to contracts with specific performance obligations	7,945	1,684
Other non-trade payables and accrued expenses	56,646	49,391
Total payables and deferred revenue	**71,996**	**64,588**

	2021 Actual $000	2020 Actual $000
Total payables comprise:		
Exchange transactions	56,646	56,842
Non-exchange transactions	15,350	7,746
	71,996	**64,588**

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.

Leases classification

Determining whether a lease agreement is a finance lease, or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to the DHB.

Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term, and determining an appropriate discount rate to calculate the present value of the minimum lease payments. Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant, and equipment, whereas for an operating lease no such asset is recognised.

Management has exercised its judgement on the appropriate classification of leases and has determined that a number of lease arrangements are finance leases.

Breakdown of interest bearing loans & borrowings

	2021 Actual $000	2020 Actual $000
Current		
Current portion of secured loans	-	604
Current portion of unsecured loans	-	-
Current portion of finance lease liabilities	235	358
Total current portion	**235**	**962**
Non-current		
Secured loans	-	-
Finance lease liabilities	856	1,091
Total non-current portion	**856**	**1,091**
Total borrowings	**1,091**	**2,053**

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

	2021 Actual $000	2020 Actual $000
Interest rate summary		
Secured loans - fixed interest	-	-
Repayable as follows:		
Within one year	-	604
One to two years	-	-
Two to three years	-	-
Three to four years	-	-
Four to five years	-	-
Later than five years	-	-
	-	**604**
Term loan facility limits		
Secured loans	-	-

Breakdown of finance leases

	2021 Actual $000	2020 Actual $000
Within one year	235	359
One to five years	506	235
Later than five years	350	490
	1,091	**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

	2021 Actual $000	2020 Actual $000
Current portion		
Long-service leave	4,365	4,037
Sabbatical leave	192	192
Retirement gratuities	4,373	4,077
Annual leave	141,177	129,233
Sick leave	274	304
Continuing medical education	11,984	7,571
Salary and wages accrual	16,367	18,758
Total current portion	**178,732**	**164,172**
Non-current portion		
Long-service leave	5,492	5,562
Sabbatical leave	2,645	2,313
Retirement gratuities	11,274	11,935
Total non-current portion	**19,411**	**19,810**
Total employee entitlements	**198,143**	**183,982**

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 progressed during the 2019/20 and current financial years.

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 2020/21 financial year the review process agreed as part of the MOU continued. 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 2021, 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 $82.6 million (2020: $75.5 million) by calculating the underpayment for employees over the full period of liability based on known non-compliances at 30 June 2021. 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.

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

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

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

The salary inflation factor has been determined after considering historical salary inflation patterns and after obtaining advice from an independent actuary. A discount rate of 0.38% (2020: 0.22%) and an inflation factor of 3.38% (2020: 2.53%) were used.

Continuing medical education leave

The continuing medical education leave liability assumes that the utilisation of the annual entitlement, will on average be 70% (2020: 70%) of the full entitlement. Normally this can be accumulated for up to three years, however due to the impacts of COVID-19 it has been agreed to extend this to up to five years. This utilisation assumption is based on recent experience. The liability has not been calculated on an actuarial basis because the present value effect is immaterial.

RECLASSIFICATION OF HOLIDAYS ACT PROVISION

The Holidays Act Provision contained in the Annual Leave entitlement comparative for 2020 has been reclassified from Non-Current to Current Liabilities to comply with the technical interpretation of PBE IPSAS 1.

Employee entitlements	Current portion	Non-current portion
Original value	88,644	95,338
Change	75,528	-75,528
Reclassified value	**164,172**	**19,810**

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.

Breakdown of provisions

	2021 Actual $000	2020 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 2019	80
Additional provisions made	-
Amounts used	-
Unused amounts reversed	-
Balance at 30 June/1 July 2020	**80**
Additional provisions made	-
Amounts used	-
Unused amounts reversed	-
Balance at 30 June 2021	**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. These matters are being contested and there is uncertainty as to what the legal outcomes might be.

There were no other contingent liabilities at year end.

Contingent Assets

Southern DHB has no contingent assets (2020: nil).

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 2019	300,969	108,502	(147,716)	192,584
Capital contributions from the Crown (Deficit Support and Project Equity Funding)	84,744	-	-	69,878
Return of capital to the Crown	(707)	-	-	(707)
Deficit for the year	-	-	(90,454)	(90,454)
Balance at 30 June 2020	**385,006**	**108,502**	**(327,515)**	**165,993**
Balance at 1 July 2020	385,006	108,502	(327,515)	165,993
Capital contributions from the Crown (Deficit Support and Project Equity Funding)	1,332	-	-	1,332
Equity repayment to the Crown		-		
Movement in revaluation of land and buildings	(707)	-	-	(707)
Deficit for the period	-	-	(30,932)	(30,932)
Balance at 30 June 2021	**385,631**	**108,502**	**(358,447)**	**135,686**

Equity is made up of:

	2021 Actual $000	2020 Actual $000
Equity	131,521	161,896
Restricted equity*	4,165	4,097
Total equity	**135,686**	**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:

	2021 Actual $000	2020 Actual $000
Board Members		
Remuneration	244	159
Full time equivalent members	0.5 FTE	0.2 FTE
Total Board Members remuneration	**244**	**159**
Total Board Members full time equivalent	**0.5 FTE**	**0.2 FTE**
Commissioner Team		
Remuneration	-	154
Full time equivalent members	-	1.2 FTE
Total Commissioner team remuneration	**-**	**154**
Total Commissioner team full time equivalent	**-**	**1.2 FTE**
Executive Management		
Remuneration	3,212	2,963
Termination payments	113	-
Full time equivalent members	11.5 FTE	11.0 FTE
Total Executive Management remuneration	**3,325**	**2,963**
Total Executive Management full time equivalent	**11.5 FTE**	**11.0 FTE**
Total remuneration	**3,569**	**3,276**
Total full time equivalent	**12.0 FTE**	**12.4 FTE**

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

An analysis of Board 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 43.8 % 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
2021							
Secured loans	-	-	-	-	-	-	-
Finance lease liabilities	1,091	1,091	117	117	112	393	352
Payables and deferred revenue	71,996	71,996	71,996	-	-	-	-
Total	**73,087**	**73,087**	**72,113**	**117**	**112**	**393**	**352**
Inflow	-	-	-	-	-	-	-
Outflow	73,087	73,087	72,113	117	112	393	352
2020							
Secured loans	604	604	-	604	-	-	-
Finance lease liabilities	1,449	1,449	179	179	235	365	491
Payables and deferred revenue	64,587	64,587	64,587	-	-	-	-
Total	**66,640**	**66,640**	**64,766**	**783**	**235**	**365**	**491**
Inflow	-	-	-	-	-	-	-
Outflow	66,640	66,640	64,766	783	235	365	491

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.

2021

	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	-	-	-	-	-	-	-
Finance lease liabilities*	7.16% - 12.55%	1,091	117	117	112	393	351

* These assets/liabilities bear interest at fixed rates

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	-	-	-
Finance lease liabilities*	8.78% - 18.34%	1,449	179	179	235	365	491

* These assets/liabilities bear interest at fixed rates

	Note	2021 Actual $000	2020 Actual $000
Opening Balance – Crown Loans	13	604	1,116
Increase Crown Loans		-	-
Repayment of Crown Loans		(604)	(512)
Conversion of loans to equity		-	-
Closing Balance – Crown Loans		**-**	**604**
Opening Balance – Contributed Capital	17	97,400	97,400
Capital contribution from/(repayment to) the Crown		-	-
Conversion of Crown loans to Crown equity		-	-
Closing Balance – Contributed Capital		**97,400**	**97,400**

FOREIGN CURRENCY RISK

Foreign exchange risk is the risk that the fair value of future cash flows of a financial instrument will fluctuate because of changes in foreign exchange rates.

Southern DHB is exposed to foreign currency risk on sales and purchases that are denominated in a currency other than NZD. The currencies giving rise to this risk are primarily United States and Australian dollars.

SENSITIVITY ANALYSIS

In managing interest rate and currency risks, Southern DHB aims to reduce the impact of short-term fluctuations on Southern DHB's earnings. Over the longer term, however, permanent changes in foreign exchange and interest rates would have an impact on earnings. At 30 June 2021, 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 (2020: $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
2021			
Trade and other receivables	8	61,439	61,439
Cash and cash equivalents	7	7,582	7,582
Secured loans	13	-	-
Finance lease liabilities	13	1,091	1,091
Payables and deferred revenue	12	71,996	71,996
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

FAIR VALUE HIERARCHY

The only financial instruments measured at fair value in the statement of financial position are Finance Leases. The fair value of finance leases as represented by their carrying amount in the statement of financial position, is determined using a valuation technique that uses observable market inputs (level 2).

FINANCE LEASE LIABILITIES

The fair value is estimated as the present value of future cash flows, discounted at market interest rates for homogenous lease agreements. The estimated fair values reflect change in interest rates.

TRADE AND OTHER RECEIVABLES/PAYABLES

For receivables/payables with a remaining life of less than one year, the notional amount is deemed to reflect the fair value. All other receivables/payables are recorded at approximate fair value.

21. MENTAL HEALTH RING-FENCE

The Mental Health blueprint is a model that proposes levels of funding required for effective Mental Health services. Within the context of the blueprint model the Mental Health ring-fence policy is designed to ensure that funding allocated for Mental Health is expended in full for mental health services. The Mental Health ring-fence is calculated by taking the expenditure base in the previous year, adding specific 'blueprint' funding allocations and adding a share of demographic funding growth plus a share of any inflationary growth funding. Any underspend resulting in a surplus within the service must be reinvested in subsequent periods.

During the 2011/12 year there was a change in the ring-fence calculation to include community dispensed anti-psychotic drugs, and primary mental health initiatives. Also, the mental health specific demographic rate is now used in calculating the demographic component of the ring-fence, rather than the District Health Boards' (DHBs) average demographic rate.

The year ended 30 June 2021 has resulted in a deficit of $2.6 million (2020: $4.8 million) for Mental Health Services. Additionally, Southern DHB has a brought-forward overspend of $17.1 million; meaning that the carry-forward overspend is $19.7 million (2020: $17.1 million).

22. EVENTS AFTER BALANCE DATE

The following events have taken place after 30 June 2021, these events do not have a material impact on the in the information in Southern DHB's financial statements.

Covid-19 lockdown in August 2021 may have an impact on Southern DHB planned care delivery (elective procedure and outpatients), either financial or volume delivery. In addition with Covid-19 moving to endemic, Southern DHB is standing up services to respond, it is anticipated that these services will be fully funded otherwise there will be an impact on the 2022 budget financial outcomes.

Settlement of the Nurses and Midwifes multi-employer collective agreements (meca) was ratified post 30 June 2021. The settlement has two components, the first being the settlement of the collective which is funded by the DHB. The other is a part payment for the pay equity claim that has been lodged by the Unions on behalf of the Nurses and Midwifes, this payment is fully funded by the Crown.

DHB funded component:

- $1,300 lump sum payment per employee pro rata to their FTE, this totalled $2.5m. This relates to the time between the expiry of the meca and settlement, SDHB has fully accrued this in the 2020/21 accounts.
- $1,800p.a pay increase on all base rates effective on 6 September 2021, this is higher than the increase assumed in the 2021/22 budget so will have an impact on the financial result as at 30 June 2022.

Crown funded Component

- $6,000 lump sum payment per employee pro rata to their FTE. This relates to the time between the pay equity claims being lodged and is a contribution to the back pay from that date.
- $1,000 lump sum payment per employee pro rata to their FTE. The parties agreed that if the claim was not settled by 30 November 2021 a further lump sum would be paid as a contribution to the back pay.
- $4,000p.a pay increase on all base rates effective on 6 September 2021, this increase is related to a potential settlement of the pay equity claims.

The costs related to the three Crown funded points above total $11.4m, this is spread across both the 2020/21 financial year and the 2021/22 finical year. As the costs are fully funded by the Crown the net effect on the 30 June 2021 financial year is nil.

23. EXPLANATION OF FINANCIAL VARIANCES FROM BUDGET

Explanations for major variances from Southern DHB's budgeted figures are as follows:

STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSE

The unfavourable variance in total comprehensive revenue and expenses against budget for the year ended 30 June 2021 was $20.0 million.

Revenue

Total Revenue was $32.4 million higher than budget. Government and Crown contracted revenue accounted for $32.2 million of this, largely due to additional funding for the COVID-19 response, Surveillance & Testing and Vaccination programme plus Primary Mental Health & Addiction contracts and Inter District Flows.

Personnel Costs and Outsourcing

Personnel costs were unfavourable to budget by $16.2 million.

The COVID-19 response added $4.1 million to personnel costs, across all workforce types. The unbudgeted cost of the COVID-19 Vaccination programme was $2.0 million while the balance represents COVID-19 resurgence prevention costs and the increase to Continuing Medical Education liabilities.

Additional recognition of the estimated historical liability to identify, rectify and remediate any Holidays Act 2003 non-compliances added a further $7.6 million to personnel costs this financial year.

Also contributing has been the overall increase in FTE. This has been driven in part by the filling of some long-term vacancies in Medical and Allied Health areas. In addition, as information around Care Capacity Demand Management matures, Nursing staff levels are increasing to better match acuity and resourcing in both acute and planned care.

Outsourced Services (Includes Outsourced Personnel)

Outsourced Clinical Services were $7.2 million over budget, reflecting the outsourcing of services (including outsourced personnel working in our facilities) to meet the demand for delivery of planned care services. This is due to both ongoing capacity constraints within the hospitals and recovery of under-delivery resulting from the prior year COVID-19 response.

Total caseweights were 2.2 per cent or 413 lower than budgeted, largely as a result of flow-on COVID-19 disruptions plus ongoing capacity constraints. Elective delivery was however 15 per cent higher than the COVID-19 affected previous year.

Clinical Supplies

Clinical supplies were $13.9 million over budget due to a range of factors. There has been a continued increase in the cost and demand for blood and other treatment disposable products, instruments and equipment, cardiac implants and pacemakers plus high cost pharmaceutical products. Air ambulance costs have also remained higher despite a new national contract with high-cost Neurosurgery transfer missions impacting on the total spend through the year.

Non-Health Board Provider Payments

Provider payments to NGOs were $15.0 million higher budget. The majority of this was reflected in the COVID-19 response which included "pass-through" payments to Aged Care, GP Practices and Pharmacies across the district as well as the WellSouth PHO for delivery of Surveillance & Testing. This was however funded by the Crown.

Capital Charge

The Capital Charge was $4.7 million lower than budget due to a combination of the rate decreasing from 6% to 5% and a lower actual Equity base value. This was largely the result of the Holidays Act liability increase in the June 2020 financial statements, finalised after the 2020/21 budget was approved.

STATEMENT OF CHANGES IN EQUITY

The deficit was $20.0 million greater than budgeted due to the statement of comprehensive revenue and expense explanations provided above.

The capital contributions from the Crown were $45.2 million lower than budgeted with Holidays Act 2003 funding not required.

STATEMENT OF FINANCIAL POSITION

Cash and Cash Equivalents

Cash at year end was $23.8 million better than budget. Investment in property, plant & equipment and intangibles was $42.8 million lower than expected with a number of projects delayed or deferred. Offsetting this was a higher operating deficit, net of Holidays Act 2003 remediation that did not proceed.

Trade and Other Receivables

Trade and Other Receivables were $12.6 million higher than budget with greater than expected amounts owing in COVID-19 and other Government funding sources.

Property, Plant and Equipment

Property Plant and Equipment was $34.0 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 continued to be delayed, as have the Tenth Operating Theatre/PACU and the new Sterile Services Facility, along with various items of clinical and infrastructural equipment and deferred maintenance programmes which continue into the new financial year 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.

Intangible Assets

Intangible Assets are $9.5 million lower than budgeted with the South Island Patient Information Care System (SI PICS) delayed into the 2021/22 financial year while the Patientrack project was cancelled.

Employee Entitlements

Current and Non-Current Employee Entitlements are an aggregated $92.8 million higher than budgeted. This is a combination of the increase to the Holidays Act 2003 liability in 2019/20 after the 2020/21 budget was finalised and the non-progression of remediation of the estimated liability for any non-compliance with the Holidays Act 2003 by 30 June 2021. It also reflects the increased Annual Leave hours across all Employee types.

STATEMENT OF CASH FLOWS

Net Cash Flow from Operating Activities is $27.3 million higher than budget. Cash receipts from the Ministry of Health were $24.1 million higher than planned while Payments to Suppliers were $48.3 million higher than budget. Both are largely the result of COVID-19 activity plus higher Outsourced and Clinical Supplies costs as noted above. Payments to Employees were $44.0 million lower than budget with the Holidays Act 2003 remediation not proceeding as above.

Cash Flows from Investing Activities are $42.5 million lower than budget due to the timing of capital expenditure as noted above.

Cash Flow from Financing Activities is $45.9 million lower than budget. Holidays Act 2003 funding was not required and capital injections from the Crown were lower than budgeted with delays to funded capital works programmes.

24. COVID-19

During August and September 2020 and February and March 2021, the Auckland Region moved into Alert Levels 3 and 2 while the Southern District moved into Alert Levels 2 and 1 in the corresponding time periods.

At Alert Level 2, the operating capacity of Southern DHB was reduced. At Alert Level 1, Southern DHB resumed to normal business activity and in some instances at a higher level then pre-COVID-19. This was because planned care that was delayed during Alert Levels 3 and 4 in the prior financial year was rescheduled to take place at lower Alert levels.

Government funding

The Ministry of Health provided funding of $15.5 million for Southern DHB to assist with the ongoing COVID-19 response. Of this, $10.9 million was distributed through Southern DHB to various NGOs, including WellSouth (Primary Health Organisation) for surveillance and testing activity. This amount also included support for general practitioners, pharmacists, aged care and other providers. The Vaccination programme delivered by Southern DHB accounted for a further $2.7 million of the total funding.

Personnel expenses

Personnel expenses have increased by $4.1 million due to an increase in permanent and casual staff, including $2.0 million for vaccination programmes. Also, some staff have continued to take less leave since the pandemic declaration.

Other expenses

There was an increase in clinical and infrastructure and non-clinical supply costs of $1.3 million. This was driven in part by the administration of the COVID-19 vaccine roll-out such as leasing additional premises, hygienic and sanitation supplies, pharmaceutical, patient transport, security management, advertising and building alteration costs to ensure safer access to hospital and other sites for the community and staff.

COVID-related Equipment and Clinical Supplies

During the year Southern DHB received from the Ministry of Health clinical equipment valued at $2.6 million and clinical supplies or consumables valued at $0.7 million.

COVID Vaccinations

In March 2021 Southern DHB began implementing the Government's vaccination programme in conjunction with the MoH and community organisations. This was fully funded by the MoH and amounted to $2.7 million total cost to 30 June 2021. The largest components were $2.0 million for workforce and $0.7 million for infrastructure, facilities and other costs.

Valuation of land and buildings

Overall, Southern DHB does not consider there to be any material impacts on the value of land and buildings as at 30 June 2021. Southern DHB engaged an independent valuer to perform a desktop review to determine whether there had been a material movement in the Board's land and buildings between 30 June 2020 and 30 June 2021. Their assessment considered market evidence and information as a result of the impacts of COVID-19. The valuer concluded that there is not sufficient market evidence to suggest there has been any material impact on our land and building values since 30 June 2020. Southern DHB concurs with this assessment and there have been no fair value adjustments to land and buildings as at 30 June 2021.

Independent Auditor's Report

To the readers of Southern District Health Board's financial statements and performance information for the year ended 30 June 2021

The Auditor-General is the auditor of Southern District Health Board (the health board). The Auditor-General has appointed me, Julian Tan, 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 105, that comprise the statement of financial position as at 30 June 2021, the statement of revenue and expenses, 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 28 and 30 to 48.

Opinion

Qualified opinion on the financial statements

In our opinion, except for the possible effects of the matter described in the basis for our opinion section of our report, the financial statements of the health board on pages 76 to 105, which have been prepared on a disestablishment basis:

- present fairly, in all material respects:
    - its financial position as at 30 June 2021; 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 28 and 30 to 48:

- presents fairly, in all material respects, the health board's performance for the year ended 30 June 2021, 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 17 December 2021. 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 opinion

The financial statements are qualified due to uncertainties over the provision for holiday pay entitlements under the Holidays Act 2003

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 a provision of $82.6 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 $75.5 million provision as at 30 June 2020. We accordingly expressed a qualified opinion on the financial statements for the year ended 30 June 2020.

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 opinion.

Emphasis of matters

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

The financial statements have been appropriately prepared on a disestablishment basis

Note 1 on page 80 outlines the health sector reforms announced by the Minister of Health on 21 April 2021. Legislation to disestablish all district health boards and establish a new Crown entity, is expected to come into effect on 1 July 2022. The health board therefore prepared its financial statements on a disestablishment basis. The values of assets and liabilities have not changed because these will be transferred to the new Crown entity.

The health board is reliant on financial support from the Crown

Note 1 on page 80 outlines the health board's financial performance difficulties. There is uncertainty whether the health board will be able to settle its liabilities, including the estimated historical Holidays Act 2003 liability, if they were to become due prior to its disestablishment. The health board therefore obtained a letter of comfort from the Ministers of Health and Finance that confirms that the Crown will provide the health board with financial support, where necessary.

Health Service User (*HSU) population information was used in reporting Covid-19 vaccine strategy performance results*

Pages 45 to 48 outline the information used by the health board to report on its Covid-19 vaccine coverage. The health board uses the HSU population data rather than the population data provided by Statistics New Zealand (Stats NZ) for the reasons set out on Page 48. The information outlines that there would be differences in the reported results for the overall population if the Stats NZ population data was used. There would be further differences in the reported results of vaccination coverage if the Stats NZ population data is classified by ethnicity and age. The health board has provided a table that highlights the differences in the ethnicity groupings between the HSU population data and the Stats NZ population data.

Impact of Covid-19

The performance information on pages 45 to 48 and note 24 to the financial statements on page 105 outline 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. If the board concludes that the going concern basis of accounting is inappropriate, the board is responsible for preparing financial statements on a disestablishment basis and making appropriate disclosures.

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 disestablishment basis of accounting by the board.
- 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 in the key highlights page and on pages 3 to 13, 29, and 49 to 75 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.

Other than the audit, we have no relationship with, or interests in, the health board.

Julian Tan
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