Southern Health
He hauora, he kuru pounamu

Southern District Health Board
Piki Te Ora

Annual Report

Quality and Performance Account

2021/22

E90

Key highlights

As of 27 September 2022, Southern's **COVID-19 vaccination programme** delivered 853,315 COVID-19 vaccinations across the district, with 92.6% of the 12+ population having completed their primary course and 74.6% of the 18+ population receiving a booster. The programme continues to work with general practices, pharmacies and Māori and Pacific Health providers to reach the region's widespread population. This includes pop-up clinics in rural areas and arranging home visits.

The Southern Health system began a new chapter and on July 1 2022. We are now united as Te Whatu Ora Health New Zealand and the Māori Health Authority.

In preparation for this change, the Southern District Health Board developed the Southern Transition Strategy and the Southern Transition website, to let Te Whatu Oa Health New Zealand and the Māori Health Authority know what is important to us and our community.

Piling for the New Dunedin Hospital's **Outpatient Building** began – the first step in delivering a fit-for-purpose new facility for our region.

A new **mental health crisis respite centre** is to open in Dunedin in September 2022 increasing capacity for emergency and planned mental health respite care. This is as a result of a expanded service contract between the Southern and community service provider Pact.

The five-bed facility will provide adults experiencing acute mental distress with 24-hour in-home support in a residential environment less than 10 minutes from Dunedin Hospital.

Dunedin has historically had a one-bed unit available for emergency respite care, so this capacity expansion is addressing a long-standing service gap. The new facility will increase current capacity from **365 bed nights to 1,825 bed nights per year**, freeing up hospital beds and staff. Inpatient hospital services will continue to be available for those who need them.

Digital infrastructure for the New Dunedin hospital business case was presented which will also include a targeted uplift of digital infrastructure and equipment for non – NDH facilities. This will be a digital solution across the southern Health system.

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Annual Report

Quality and Performance Account

2021/22

This Southern District Health Board Annual Report 2021/22 is presented to the House of Representatives pursuant to section 150(3) of the Crown Entities Act 2004.


HEALTHY TEETH!
FREE
REFILLS

Contents

Foreword from the Chair & Chief Executive

30 June 2022 marked the end of an era for Southern District Health Board, and more widely, District Health Boards in New Zealand.

Since 2001 Southern DHB has strived to deliver the best care to the people in our communities, and we are honoured to have been part of that journey for the last six years.

The last two years have been dominated by COVID-19. Firstly, keeping COVID-19 out of our community, then rolling out the vaccination programme. The last twelve months has seen the move to living with COVID-19 and providing much needed services across our district in both primary and secondary care. This has been an outstanding achievement which we acknowledge has come at considerable cost to all of us in terms of how we work, the risks that we all take coming into the work environment during the pandemic, and the sacrifices we have all had to make. We also recognise that the delays in planned care are extremely challenging and have placed the entire health care system under tremendous pressure. We have been, and remain, immensely proud of leading an organisation and health system that has stood up to these challenges and delivered an outstanding result for our community.

As both our careers in the health system and the era of District Health Boards draw to a close, we want to thank both the Board and the staff for your energy and commitment to the health of the people of the Southern district and for the support you have shown us throughout our time as Chair and Chief Executive Officer.

The change to Te Whatu Ora Health New Zealand and Te Aka Whai Ora Māori Health Authority is now upon us, and with that comes the appointment of Hamish Brown into the Interim District Director role for Southern DHB.

Hamish brings a wealth of knowledge of our health system, staff, and community to his new role. His leadership experience, strategic thinking, empathy, and relationship building skills suit the Southern DHB well in our transition to Te Whatu Ora. We would like to congratulate Hamish on this appointment and thank him for his hard work and dedication.

The changes are not going to be a sudden transformation of the health system but rather a process of change over an extended period of time. If there is ever a time in our history where we tackle the inequities in health outcomes for all New Zealanders, the time is now. The focus the Māori Health Authority is going to bring will be outstanding, and the mantra of Health New Zealand "Nationally Planned, Regionally Delivered, and Locally Tailored" is exactly what we need - a balance between consistent approaches across Aotearoa but one which recognises that delivering and accessing services in rural Southland will need to be slightly different to delivering and accessing services in metropolitan Auckland.

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

We would also like to sincerely thank the Southern District Health Board members, who have dutifully served the Southern region and weathered some challenging storms over the past few years. Thank you for your dedication and your loyalty to Southern DHB and the Southern community.

We wish everyone well, and we will be keeping a close interest in seeing your futures unfold over the coming months and years. We are immensely proud of the work our staff do every day to care for, and look after, the health and wellbeing of the Southern community. They are a testament to the values of Southern DHB: Manaakitanga (kind), Pono (open), Whaiwhakaaro (positive), and Whanaungatanga (community).

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

Pete Hodgson
Board Chair

Chris Fleming
Chief Executive Officer

Statement of Responsibility

For the 12 months ended 30 June 2022

Te Whatu Ora – Health New Zealand was established on 1 July 2022 under the Pae Ora (Healthy Futures) Act 2022.

As a result of the transitional arrangements in the Pae Ora Act all assets and liabilities of the Southern DHB (the Health Board) were transferred to Te Whatu Ora. By Ministerial approval under s 45J of the Public Finance Act 1989, Te Whatu Ora now has responsibility for providing the final annual report of the Health Board, which was disestablished at the end of 30 June 2022.

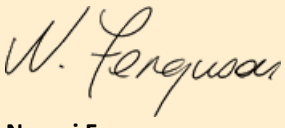
The Board and Management of Te Whatu Ora take responsibility for the preparation of the Southern District Health Board group's financial statements and statement of performance, and for the judgements made in them.

We are responsible for any end-of-year performance information provided by the Southern DHB group under section 19A of the Public Finance Act.

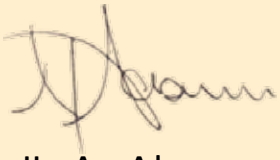
We are responsible for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting.

In our opinion, these financial statements and statement of performance fairly reflect the financial position and operations of the Southern District Health Board group for the year ended 30 June 2022.

Signed on behalf of the Te Whatu Ora Board:

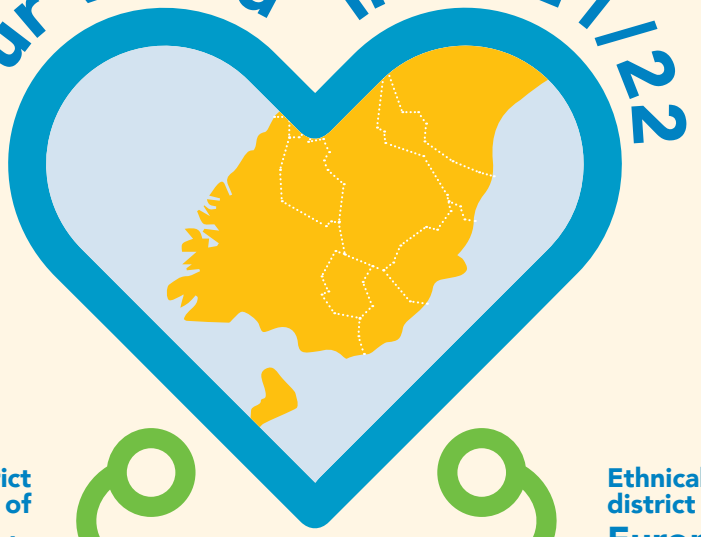


Naomi Ferguson
Acting Chair
06 March 2023



Hon Amy Adams
Board Member
06 March 2023

Our world in 2021/22



The Southern district has a population of **352,280** residents

62,356 km² The Southern district has the largest geographical area

Ethnically, the Southern district is predominantly **European at 79%.** 10% are Māori, 8% Asian and 3% Pacific.

5,610 staff employed by the DHB

1337 employees joined Southern DHB in 2021/2022

8.15 years – average tenure of employees at Southern DHB

4,564 people supported by Home and Community Support Services

10,763 elective operations or procedures

80,130 presentations to the Emergency Departments

3,062 babies born in DHB facilities in 2021/22

93% of children fully immunised by 8 months

Our population is slightly older when compared to the national average. **17.6%** are aged **65 and over** (1.4% higher than the national average)

6,692 people aged 65+ accessing community-based falls prevention 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.

Our 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

A central aim of DHBs was to achieve equitable health outcomes and promote positive changes in the health status of local populations. As the major funder and provider of health and disability services in the Southern district, the decisions Southern DHB made about the services to be delivered have a significant impact on the Southern population. If coordinated and planned well, these will improve the efficiency and effectiveness of the whole Southern health system.

The Statement of Service Performance (SSP) presents a view of the range and performance of services provided for the Southern population across the continuum of care in 21/22. There are two series of measures used to evaluate performance: outcome and impact measures which show the effectiveness over the medium to longer term (3-5 years) and output measures which show performance against planned outputs (what services we have funded and provided in the past year). Reference tables are provided at the end of the outcome and output measures sections (pages 29 and 49), showing the reporting periods used for each indicator.

Improving Health Outcomes for Our Population

Equity recognises that 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 undertaken, so a mix of population health and service access indicators are used as proxies to measure improvements in the health status of the Southern population.

South Island DHBs collectively identified three strategic outcomes and a core set of associated indicators, to monitor improvement in equitable outcomes for Māori.

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

Note that while the outcome measures include New Zealand performance figures for comparative reasons, New Zealand targets are not stated as they are not part of the performance objectives outline in the DHB's Statement of Intent.

The three strategic outcomes outlined in the 2021/22 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 population and in particular, Māori and Pasifika 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 wellbeing. Public health and prevention services that encourage and enable people to make healthy choices will help to decrease future demand for care and treatment and improve the quality of life and health status of our communities and whānau.

How has success been measured?

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.
- Avoidable Hospital Admissions for Children (Age 0-4 years).

Southern's performance:

Varied performance in the measured areas can be observed.

An overall decrease in both smoking and obesity is reported from the New Zealand Health Survey, however this data comes with a caveat that the results for the previous survey (2020/21) were impacted by COVID-19 and reduced respondent participation.

The Action on Smoking and Health year ten survey results were interrupted in 2020 due to the impacts of COVID-19 and lockdowns, but returned for 2021, showing an increase for both Southern and nationally.

The caries free rate for 5-year-olds remains largely static. The target of 70% was met for the total population. Work is being down to reduce the equity gap.

A reduction in Ambulatory Sensitive Hospitalisation rates (ASH rates) has been observed for 0-4 year olds since Pre COVID-19. The ASH rate for Southern was recorded below the target as well as below the National Performance.

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.

Data on the rate of smoking in the south is acquired from the NZ Health Survey. Unfortunately, due to the timing of publications, the 2021/22 data is not yet available, and we generally remain 12 months behind in our report.

2020/21 data is the most recent data for 'Percentage of the Population 15+ who Smoke'. The year saw a decrease 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 historical values may include variation for individual DHB values and DHB yearly results should also be considered alongside the three year "pooled" results that are available online.

Work in 2021/22 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. WellSouth PHN is also expanding the capacity for health practitioners to contact enrolled patients who are smokers through the WellSouth call centre.

Over the past year, 80% of smokers in primary care were seen or contacted by a health practitioner and offered brief advice and support to quit smoking which sits below the target of 90%, however this is up 4% from last year.

Percentage of the population 15+ who smoke

	2018/19	2019/20	2020/21	2021/22
Southern DHB	12.8%	14.6%	10.2%	Not available
New Zealand	14.9%	13.7%	10.9%	Not available

Data sourced from New Zealand Health Survey[1]

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 wellbeing and to preventing and better managing long-term conditions and disability at all ages.

Obesity data for the Southern population (for percentage of population 15+ who are obese) is acquired from the New Zealand Health Survey. As mentioned previously, we generally remain 12 months behind in our reporting for these measures and 2020/21 data is the latest data available this year. However, it is still possible to observe trends despite the lag.

Across 2021/22 the DHB 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 being 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 in relation to extending this opportunity to other primary care practices in Central Otago. Southern DHB maintained positive and successful relationships 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 continued to perform well in the Raising Healthy Kids target in 21/22. 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 Healthy Star Rating system

[1] Prior year results may differ from those published previously due to updated data

- 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.

The results of the New Zealand Health Survey have been impacted in both the 2019/20 and 2020/21 surveys due to COVID-19 and lockdowns across New Zealand, resulting in low survey participation as well as an altering of the time period the data represents.

Percentage of the population 15+ who are obese

	2018/19	2019/20	2020/21	2021/22
Southern DHB	34.0%	34.4%	34.3%	Not available
New Zealand	30.9%	31.2%	32.9%	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 historical DHB values, and DHB yearly results should also be considered alongside the three year "pooled" results that are produced and are available online.

Prior year results may differ from those previously reported.

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.

Free oral health care for children from birth to 18 years is available in the south. 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).

The COVID-19 lockdowns and subsequent high staff vacancy levels have led to high backlogs of patients. Arrears have been reducing since January 2022 however, and recovery of volumes through 2022/23 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
- Increased capacity with the added chair at the South Dunedin Clinic
- Training Dental Assistants to apply fluoride varnish
- Targeting additional resource for at-risk children
- Relocating vacant FTE to areas of higher need

Initiatives such as the development of an electronic portal for families, and guidelines for tele-dentistry are also 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

	2019	2020	2021	
	Actual	Actual	Target	Actual
Southern DHB	69%	68%	>70%	71%
Southern DHB Māori	56%	54%	>70%	59%
New Zealand	59%	57%	-	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 19 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. In 2020, the Action on Smoking and Health Year 10 survey was not completed as a result of COVID-19, however it returned in 2021.

Although there has been an increase from 2019, the result for Southern DHB of 81% sits below the target of 82.6 % and we perform well nationally, sitting below the national average of 83%.

'Never smoker' amongst year 10 students

	2019	2020	2021	
	Actual	Actual	Target	Actual
Southern DHB	79%	Not Available	>82.6%	81%
New Zealand	80%	Not Available	–	83%

Data Source: Action on Smoking and Health 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.

ASH rates for children 0-4 years, including Māori, have improved over the past 24 months in the south. The rates have rebounded after falling away significantly due to the impacts of COVID-19. The continued messaging around public health measures relating to the transmission of respiratory infections in the community due to COVID-19 remained a positive factor.

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

The equity gap between Southern Māori tamariki and non-Māori Tamariki has reduced since pre-COVID-19 times. Work continues with Southern's Kaupapa Māori Health services on this. This service is working within primary, community and secondary care services and are taking a targeted approach to improve the 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.

Development has begun in conjunction with Southland Hospital on a triaging and patient care solution (Emergency Q) which identifies patients whose symptoms would be best treated in a Primary Care setting. Emergency Q will work with local General Practices (two practices identified this year, a third has since been onboarded) to facilitate patients who have presented to Southland Hospital with symptoms that are best managed by General Practitioners.

The goal of Emergency Q is to alleviate wait time in the emergency department, which is geared for acute presentations. Low acuity patients that are deemed eligible are given the option of being transferred, treated, and managed at no cost in one of the participating general practices. Following treatment of the patient's presenting symptoms, the practice and patient can link in with WellSouth and the patient's enrolled General Practice to ensure a treatment and follow up plan is coordinated. As the solution is still in trial phase, no results have been seen yet, however it is anticipated to show a reduction in ASH rates over time.

Once the trial has been completed with Southland Hospital, it is anticipated that rollout will commence at Dunedin Hospital as well. The ultimate goal of Emergency Q is to connect the Southern Population to Primary Care, which is viewed as a validated solution to better manage chronic and easily treatable health conditions.

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

	2019/20	2020/21	2021/22	
	Actual	Actual	Target	Actual
Southern DHB	5,622	3,878	<5,678	5,025
New Zealand	6,467	4,469	–	5,772

Data Source: Nationwide Service Framework Library

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, but 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 has success been measured?

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.

Southern's performance:

Acute bed days per capita sits below the national rate and Southern performs well in this area, ranked below the national average and the third lowest DHB.

Meeting the demand for complex imaging (CT and MRI) remains a challenge. The additional diagnostic CT scanner for Dunedin was commissioned in September 2021 and has shown a dramatic performance increase of 26% from previous years.

Dunedin's second MRI scanner was installed in May 2022. While results of imaging performance for MRI are yet to be shown, it is anticipated that there will be an uplift of diagnostic wait time performance in the first quarters of 2022/23.

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 allocated to urgent care, allowing the health system to provide more planned care. Primary Care services play a key role in supporting this metric.

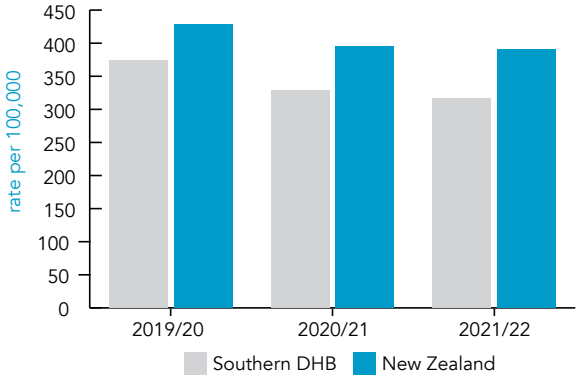
The rate of acute bed days per capita in the south sits below the national average and is ranked third lowest for 2021/22 year.

This year did see some challenges in general practices delivering the Health Care Homes programme and a number of them placed work on hold as they navigated the COVID-19 waves that New Zealand experienced. The third tranche of practices to take up the programme was rolled out in the previous financial year. Whilst operational, the programme includes 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)

	2019/20	2020/21	2021/22
Southern DHB	374	329	316
New Zealand	428	395	391



Data Source: Nationwide Service Framework Library

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

Outcome: People Living at Home

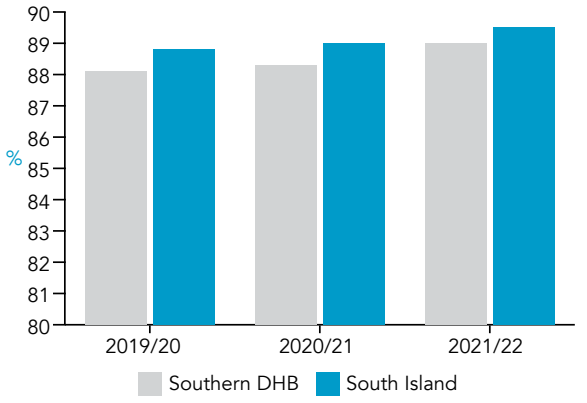
This measure looks at the proportion of the population aged 75+ living at home. Studies have shown a higher level of satisfaction and better long-term outcomes where people remain in their own homes and are positively connected to their communities. This indicator can be used as a proxy of how well the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

Southern 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 2021/22. This is positive as we know that many older people in the population have multiple chronic health conditions. The results of Southern's Restorative Model of Home & Community Support Services, investments in HOME Teams, and Home as My First Choice Campaign are seen through these results.

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

	2019/20	2020/21	2021/22
Southern DHB	88.1%	88.3%	89.0%
South Island	88.8%	89.0%	89.5%



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 was 43.6% for 2021/22, with compliance at 43.8% in June 2022. The greatest gaps between capacity and demand are experienced in Dunedin.

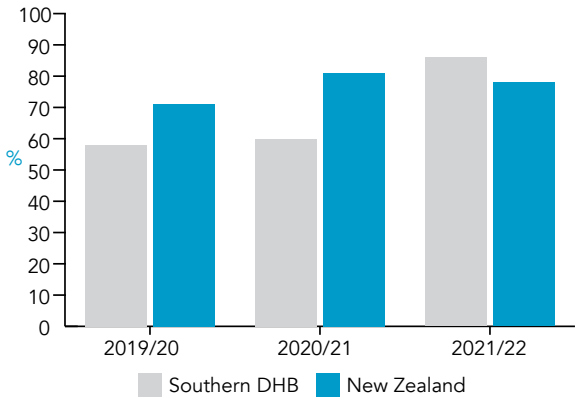
A second MRI scanner was installed at Dunedin and commenced operation in May 2022. Increased staffing in Southland and changes in patient flows have been undertaken to improve equity across the district. Additional outsourcing was undertaken to improve performance while waiting for the additional scanner to be installed. This had the effect of preventing further deterioration rather than resulting in a notable improvement.

An additional diagnostic CT for Dunedin was commissioned in September 2021 and additional staffing recruited. Sustained improvement in performance was noted subsequently, however staff dependent procedures (notably Microwave ablations and Guided Injections) are preventing further progress at the time of writing. Radiologist recruitment is key to addressing this.

GP access to high tech imaging from May 2022 now includes CT Head, supported by a new Health Pathway. Work continues on an US Pelvis pathway.

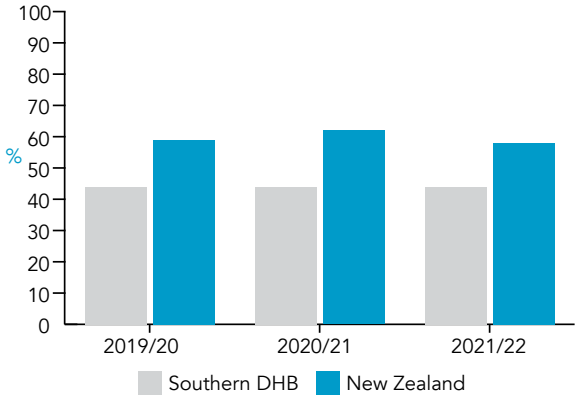
People receiving non-urgent CT scan within six weeks

	2019/20	2020/21	2021/22	
	Actual	Actual	Target	Actual
Southern DHB	58%	60%	>95%	86%
New Zealand	71%	81%	–	78%



People receiving non-urgent MRI within six weeks

	2019/20	2020/21	2021/22	
	Actual	Actual	Target	Actual
Southern DHB	44%	44%	>90%	44%
New Zealand	59%	62%	–	58%



Data sourced from Ministry of Health.

Medium Term Indicator: Falls Prevention

Approximately 18,000 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.

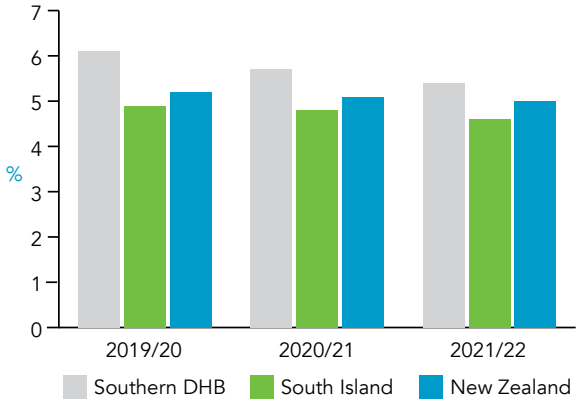
Southern reframed how it viewed frail elderly people in the health system, in order to take a more holistic approach. Work continues across the sector to improve identification of mild/moderate frailty and link into better falls prevention.

Southern's well established multi-agency Falls and Fracture Prevention Steering Group continues to take a sector-wide approach to falls and fracture prevention. This included engaging with the wider sector during regular educational forums, monitoring 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.

During 2021/2022, Southern's performance continued to improve, while still not reaching target. Falls and fracture prevention measures often lead to longer-term results, and results of investments made over previous years are now showing. Falls and fracture prevention is complex and has many contributing factors.

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

	2019/20	2020/21	2021/22	
	Actual	Actual	Target	Actual
Southern DHB	6.1%	5.7%	<5.0%	5.4%
South Island	4.9%	4.8%	–	4.6%
New Zealand	5.2%	5.1%	–	5.0%



Data Source: National Minimum Data Set

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

Error in previous calculation for 2020/21 means figures published above will not match those previously published.

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 Hospitalisations (ASH) rates, not only improving health outcomes for our population but also reducing unnecessary pressure on our hospital services.

The rates for 2021/22 are above the target for the Southern DHB total population. The rates for 2021/22 are just below the target for the Southern DHB total population. Work continues to reduce these numbers further however challenges remain however in addressing inequity within the region and COVID-19 has disrupted many programmes in trying to address this. Such programmes that are established to address ōritetanga include Hauora Wellness Checks for Māori populations aged 50+ years 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.

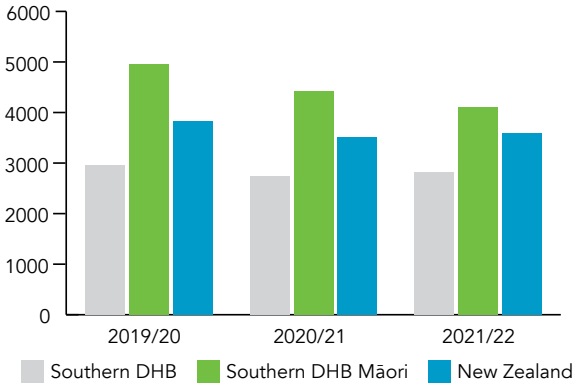
Rate of ambulatory sensitive hospital admission for adults (45-64)

	2019/20	2020/21	2021/22	
	Actual	Actual	Target	Actual
Southern DHB	2,952	2,739	<2,865	2,823
Southern DHB Māori	4,954	4,422	<2,865	4,104
New Zealand	3,818	3,502	–	3,590

Data Source: Ministry of Health Data Warehouse

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.



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 has success been measured?

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.

Southern's performance:

Acute readmissions within 28 days of discharge are a proxy measure for system performance and stable health in the community. Southern has a relatively stable hospital readmission rate, which sits equal to the New Zealand average. This suggests people are largely staying well in the community after hospital presentations.

Long term significant reductions in the rate of amenable mortality amongst the Maori population can be observed.

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 in these areas, discussed further overleaf.

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.

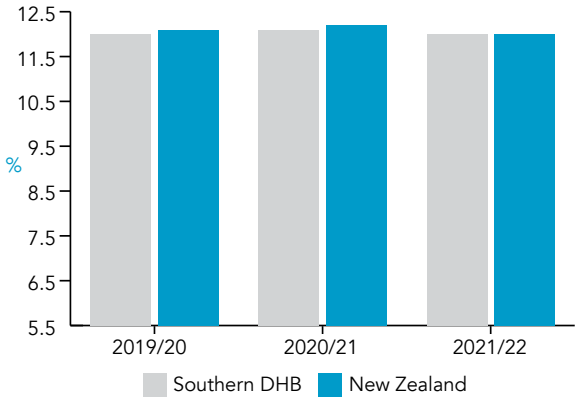
There has been significant work in our hospitals over the past three years focused on patient flow. Acute bed days per capita and average length of stay have both improved and this is balanced with a readmission rate that has remained relatively constant. This indicates that overall, the quality of care 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 to implement innovative primary health services to address acute readmissions. Examples include the use of the Primary Options for Acute Care (POAC) program across General Practice and establishing the Emergency Department avoidance funding for select regions and overseeing Care Plus Service funding. Work is underway currently to improve the uptake of an existing programme funding a COPD post discharge appointment in General Practice. Around 10% of eligible people had a COPD appointment in the past year. Using a call centre model, the patient and their practice will be connected to set up the appointment within 10 days of discharge. It is expected that this approach will remove some barriers to making the appointment and improve overall uptake. At the appointment, a COPD checklist was initiated during the patient's hospital stay, will be completed, offering opportunity for intervention on any areas where the patient needs support or additional treatment.

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



	2019/2020	2020/2021	2021/2022
Southern DHB	12.0%	12.1%	12.0%
New Zealand	12.1%	12.2%	12.0%

Data Source: Ministry of Health OS8

Results may differ slightly across years compared to past reports due to standardisation methodology.

Outcome: Amenable Mortality Rates

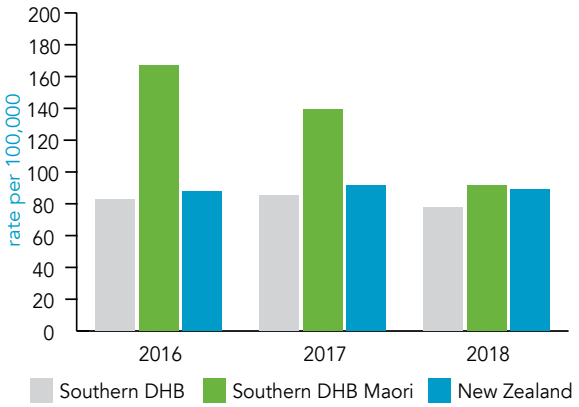
Amenable mortality is defined as premature death (before age 75) from conditions that could have been avoided through lifestyle change, earlier intervention, and the effective and timely management of long-term conditions. There are many economic, environmental, and behavioural factors that have an influence 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 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 timely and effective care. The rate of amenable mortality has been gradually declining since 2000 both nationally and for Southern. Amenable deaths in the south have reduced by 44% since 2000. For Māori aged under 75 years resident in the Southern region, around 35 Māori died prematurely each year on average. Over the five years to 2018, amenable mortality for Māori has been declining.

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

	2016	2017	2018
Southern DHB	82.5	85.0	77.6
Southern DHB Māori	166.7	139.0	105.5
New Zealand	87.9	91.5	88.9

Date Source: Nationwide 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.

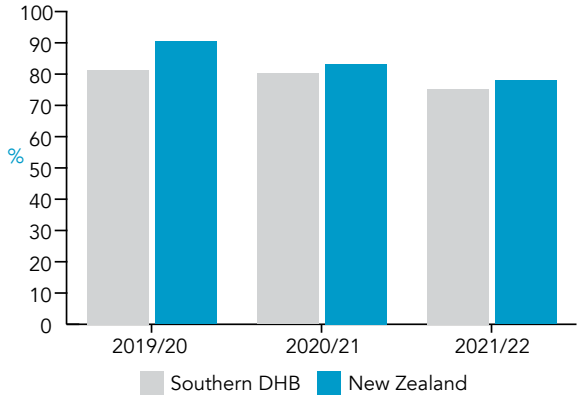
Current programmes to improve ED wait times that show this breadth include:

- Embedding the generalist model of admitting for Dunedin Hospital wards and developing the model of care for the 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 (under consultation) to better allow for flow which are aligned with the national direction
- Establishment and development of an Integrated Operations centre in both Dunedin and Southland
- The establishment of Patient Flow Managers in both Dunedin and Southland to lead work on improving patient flow and improving provision of urgent care.

People admitted, discharged or transferred from ED within 6 hours

	2019/20	2020/21	2021/22	
	Actual	Actual	Target	Actual
Southern DHB	81.3%	80.2%	>95.0%	75.2%
New Zealand	90.4%	83.3%	–	78.0%

Data Source: Ministry of Health Data Warehouse



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 2021/22 due to COVID-19 and the resulting bed shortages caused by staff sickness, staff vacancies and requirements for COVID-19 positive patients.

The latter half of 2021 through to June 2022 was particularly difficult with the COVID-19 wave combining with the opening of borders and the winter flu season to reduce theatre throughput and forcing the restrictions of elective admissions only to high priority patients.

Cancer patients continue to be prioritised over long-waiting deferrable surgical interventions and this has further deteriorated our ESPI 5 position (people receiving agreed treatment in under four months).

All services offering elective surgery have been impacted but particularly orthopaedics who have the most elective surgical lists and carry a high acute workload.

Throughout 2021/22 Southern has continued efforts to increase capacity:

- Outsourcing orthopaedic patients to South Canterbury DHB and maximising local outsourcing capacity
- Establishing a four-bed orthopaedic pod at Dunedin hospital
- Opening four additional beds on the Southland site
- Commencing ERAS (Enhanced Recovery after Surgery) for orthopaedic patients to reduce length of stay and improve mobilisation
- "Fit in Stand out" international recruitment campaign for Southland hospital for theatre staff groups

Projects started in the past year that are continuing are the recruitment of theatre staff to enable an increase in acute theatre time, the leasing of an off-site theatre for ophthalmology which will give theatre time to other services and a trial to extend Day Surgery hours and recovery time for patients which will reduce the cancellation rate.

Outpatient services have done well in maintaining throughput during this period and telehealth volumes have increased appreciably. In June 2022, the number of services using telehealth was 25 and the number of telehealth appointments was 3,184. This is considerable increase from June 2021 when 13 services were using telehealth and there were only 95 appointments.

Telehealth continues to be a focus for Southern and key goals for the coming year are to establish community hubs specifically for Māori and Pasifika and to further integrate telehealth into business-as-usual practice.

People receiving specialist assessment and treatment within set timeframes

	2019/20	2020/21	2021/22	
ESPI 2	**Actual**	**Actual**	**Target**	**Actual**
Southern DHB	65.2%	80.5%	100%	72.3%
New Zealand	75.6%	87.9%	–	74.5%

	2019/20	2020/21	2021/22	
ESPI 5	**Actual**	**Actual**	**Target**	**Actual**
Southern DHB	55.8%	62.5%	100%	47.2%
New Zealand	67.4%	77.0%	–	58.7%

Data source: Ministry of Health Data Warehouse.

Reporting period reference table: Outcome Measures

The following tables provides a guide to the reporting periods for the outcome measures used in the Statement of Service Performance. Unless otherwise specified, the period represented is the financial year 2021/22.

Measure	Period value represents
Percentage of the population 15 years and over who smoke	Annual Performance[2]
Percentage of the population 15 years and over who have obesity	Annual performance[2]
Percentage of 5-year-olds who are caries free	Annual Performance [3]
Percentage of Year 10 students who have 'never smoked'	Annual Performance[3]
Avoidable hospital admission standardised rates per 100,000 for the population aged 0-4	Year to Q3
Acute Bed Days per Capita (1,000 population)	Annual Performance
Percentage of the population (75 years and over) living in their own home	Annual Performance
Percentage of people waiting no more than 6 weeks for their CT scan	Annual Performance
Percentage of people waiting no more than 6 weeks for their MRI	Annual Performance
Avoidable hospital admission standardised rates per 100,000 for the population aged 45-64	Year to Q3
Percentage of the population (75 years and over) admitted to hospital as a result of a fall	Annual Performance
Rate of acute readmissions to hospital within 28 days of discharge	Year to Q3
Age standardised rates of mortality per 100,000	Annual Performance[2]
Percentage of people presenting at ED who are admitted, discharged, or transferred within 6 hours	Annual Performance
Percentage of people receiving their specialist assessment (ESPI 2) or agreed treatment (ESPI 5) in under four months	Annual Performance

[2] Annual Performance has a year delay due to data not being available
[3] Annual Performance is measured on the Calendar year (Jan-Dec)

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 were applicable to all DHBs.

- 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 2021/22 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%	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	69,403	17,201	52,193
Early Detection and Management Services	240,298	240,656	4,622
Intensive Assessment and Treatment	892,404	805,717	70,904
Rehabilitation and Support	174,905	180,329	808
Total Income	**1,377,010**	**1,243,903**	**128,527**
Expenditure			
Prevention Services	69,403	17,201	(52,193)
Early Detection and Management Services	242,631	239,131	(3,114)
Intensive Assessment and Treatment	926,296	833,320	(73,300)
Rehabilitation and Support	177,614	178,558	944
Total Expenditure	**1,415,944**	**1,268,210**	**127,663**
Surplus/(Deficit) for the year	**(38,934)**	**(24,307)**	**864**

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 2021/22 is $1,110.4 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 16 to 56.

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 looking to continue to improve these services in 2021/22, the DHB 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. Teams work with primary care, pharmacy, 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 by reducing the incidence of diseases and preventing them spreading to vulnerable people.

How did Southern perform?

Across the 2021/2022 year, the COVID-19 vaccination rollout continued to have an impact on Southern immunisation plans for childhood immunisation as staff supported the COVID-19 vaccination rollout. Implementation of a recovery plan was continued 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 2021/22, Southern DHB performed well compared to other DHBs and it was pleasing to note that Southern DHB was consistently in the top three DHBs across all childhood immunisation age groups measured for overall, Māori and Pasifika for 2021/22 (except the 8-month Pacific cohort):

- 8-month age group: Overall 2nd, Māori 3rd, Pasifika 5th
- 2-year age group: Overall 1st, Māori 2nd, Pasifika 2nd
- 5-year age group: Overall 1st, Māori 1st and Pasifika 3rd for the 2021/22 year.

Nationally, there has been a declining trend across all childhood immunisations, within Southern this has been minimal compared to the national figures and our 'Missed Immunisations' being some of the lowest in the country.

The school-based Human Papillomavirus (HPV) vaccination programme in Southern continued to perform above the national total in 2021/22 with 69% HPV-all coverage, compared to the national average of 54%. In 2021/22, Māori HPV-all coverage was 59%, demonstrating that an equity gap remains which required additional response.

The COVID-19 vaccination program is tracking positively against Kaupapa Māori Services, the Southern Māori directorate have developed a collaborative Outreach COVID-19 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, Pharmacy, Well Child Tamariki Ora services, Kaupapa Māori and Pasifika 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 to vaccinate on time and provided additional resource into Outreach Services during the 2021 lockdown to reduce access barriers as a result of a highly pressured Primary Care environment responding to COVID-19.

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

2021/22 Performance Results for Immunisation Services

Measure		2019/20 Actual	2020/21 Actual	2021/22 Target	2021/22 Actual	
Percentage of children fully immunised at 8 months	Total	94%	93%	>95%	93%	
	Māori	91%	89%	>95%	88%	
Percentage of children fully immunised at 2 years	Total	94%	91%	>95%	93%	
	Māori	94%	86%	>95%	87%	
Percentage of boys and girls fully immunised with HPV Vaccine	Total	64%	66%	>75%	69%	
	Māori	63%	59%	>75%	59%	
Percentage of people (≥65) having received a flu vaccination	Total	54%	62%	>75%	62%	
		44%	56%	>75%	56%	

Data Source: 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 Southern perform?

Southern DHB did not meet the primary care quit smoking target in 2021/22 (>90% of enrolled patients who smoke when seen by a health practitioner in primary care were offered brief advice and support to quit smoking).

WellSouth continue to invest 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 Pasifika people aged 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 continued in 2021/22 after being reviewed to include more robust performance and reporting measures with greater follow up requirements. 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. As this programme is still a pilot, it will be reviewed at the end of 2022 to understand the impact it had on smoking cessation and the health of our community.

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. Pregnant women are given vouchers if they commence a programme to stop smoking while pregnant. There is also an opportunity for their whānau to enter a stop smoking programme where they also receive vouchers.

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. WellSouth provides the Breast-Feeding Peer Support Programme.

Increasing breastfeeding rates of Māori and Pasifika women remains a priority. Southern DHB and Pacific Trust Otago ran a community breastfeeding support trial through to July 2022. This targeted Māori, Pasifika, those on the high deprivation index, refuges, and speakers of other languages. Due to its success, breastfeeding support training began in August 2022.

Southern DHB's updated Safe Sleep Policy has completed its second year and is planned for continued implementation in 2022/23. The priority under the SUDI prevention programme takes an holistic approach by incorporating smoke-free messaging, breastfeeding advice and support, and education in the factors that contribute toward the prevention of SUDI.

Rollout of safe sleep spaces continued in 2021/22, with wahakura created by local weavers. A transition is underway to exclusively provide wahakura rather than plastic pepe pods.

2021/22 Performance Results for Health Promotion and Education Service

Measure		2019/20	2020/21	2021/22		
		Actual	Actual	Target	Actual	
Percentage of enrolled patients who smoke and are seen by a health practitioner in primary care and offered brief advice and support to quit smoking	Total	78%	76%	>90%	80%	●
	Māori	77%	76%	>90%	78%	●
Infants exclusively or full breastfed at 3 months	Total	62%	63%	>60%	64%	●
	Māori	53%	54%	>60%	55%	●

Data Source: WellSouth PHN, 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% (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 earlier intervention and treatment to be applied.

Women aged 25 to 69 are eligible for funded cervical screening. 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 highly effective at preventing cancer.

B4 School Checks are a MoH specified national programme and include the Tamariki Ora/Well Child checks undertaken 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 Southern perform?

Measures for screening coverage remained stable in 2021/22 for the total population, with some improvements in performance in the past year for breast screening as reflected in the table on the next page. Work remains around improving equity results for both screening programmes.

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%). Performance in the south for population coverage remains above average compared to other districts, including coverage for Māori and Pasifika women, However, an equity gap still remains.

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

The continued redeployment of the Public Health Nursing service to support the prioritised COVID-19 vaccination programme in the Southern district in 2021/22 again affected the ability of the service to deliver the B4 School Check programme. A continued effort across the year occurred to maintain and catch up when required to provide B4 School Checks to priority groups including Māori, Pasifika, and Quintile 5 children/tamariki.

The universal hearing screening programme continues to screen babies both in hospital and community clinic settings.

2021/22 Performance Results for Population-Based Screening

Measure		2019/20 Actual	2020/21 Actual	2021/22 Target	2021/22 Actual	
Percentage of eligible women (50-69 years) having a breast cancer screen in the last 2 years	Total	66%	69%	>70%	72%	●
	Māori	63%	67%	>70%	64%	●
Percentage of eligible women (25-69 years) having a cervical cancer screen in the last 3 years	Total	71%	72%	>80%	70%	●
	Māori	63%	64%	>80%	58%	●
Percentage of 4-year-old children receiving a B4 School Check	Total	78%	94%	>90%	91%	●
	Quintile 5[4]	74%	91%	>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%	99%	>95%	95%	●

Data Source: 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 Pasifika health services, pharmacy, diagnostic imaging, laboratory services, and child and youth oral service.

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. Early contact with preventative services and good health promotion activities will hopefully lead to 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 Southern perform?

2021/22 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 the introduction of a risk assessment tool that identifies optimal recall frequency, taking many low risk children out to 18 month recalls rather than 12 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 26% in January 2022 to 20% by the end of 30 June 2022. The national arrears target is 10% of the enrolled population (percentage of children 0-12 years not examined based on planned recall). The service continues to work hard and slowly reduce this arrears despite the disruptions with vacancies and illness.

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 2021/22. A key focus has been on improving the equity of access to the service for those with the greatest need.

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

Innovative efforts the service is working on include the development of a portal for families to record oral health status and access interactive videos on caring for the oral health of the family. Tele-dentistry services are also being piloted with success.

The goal of these initiatives is to allow the Oral Health Service to engage with those families at greater risk of deteriorating oral health. In particular Southern Māori, Pasifika and rural communities.

Prevention also remains a key strategy. Increasing our fluoride varnish programme using our assistant workforce to support this and expanding the reach of these programmes into more preschools and schools is key to ensuring we support whānau to prevent caries in children.

2021 Performance Results for Oral Health

Measure		2019	2020	2021		
		Actual	Actual	Target	Actual	
Percentage of eligible preschool children enrolled in community oral health services	Total	84%	85%	>95%	88%	
	Māori	63%	71%	>95%	75%	
Percentage of children caries-free at five years of age	Total	69%	68%	>70%	71%	
	Māori	56%	54%	>70%	59%	

Date Source: Southern DHB Community Oral Health Service
Note: Oral Health data is measured on the Calendar year (Jan-Dec)

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.

How did Southern perform?

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

Pharmaceutical supply-chain constraints associated with COVID-19 continue to have a significant impact on repeat dispensing volume.

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 manage their long-term conditions in a partnership approach with their general practice team. The foundation of CLIC is built on principles of self-management. The CLIC programme is now available across all WellSouth Practices. The programme places an emphasis on effective care planning, and the use of both HIPS and Health Coaches has supported patients to have a higher level of involvement in their own care planning. WellSouth's Thalamus dashboard helps identify patients who will most likely benefit from the programme, and practices are encouraged to prioritise patients with diabetes.

WellSouth has continued to utilise the WellSouth Call Centre to support medical practices in their care for clinical risk consumers, including those with diabetes. The WellSouth Thalamus dashboard identifies each patient who is eligible and overdue for a Diabetes Annual Review (DAR) 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.

Southern is yet to meet the target of 60 per cent of the population identified with diabetes having good or acceptable glycaemic control, and this performance has continued to decline in 2021/22 as GP practices were faced with managing the increase in COVID-19 patient demand for COVID-19 Care in the Community. This was also coupled with practice staffing availability issues due to COVID-19 isolation requirements during the Omicron outbreaks in the last 2 quarters of the year and as such, many diabetes programs and annual reviews were placed on hold as the workload due to COVID-19 increased. This has contributed to the decrease in those patients that are managing their diabetes within acceptable levels.

Southern's diabetes system of care is continuing to evolve however challenges still remain to close the equity gap. The Local Diabetes Team (LDT) provided some guidance and support early on in 2021/22, however the response to COVID-19 impacted the ability for this team to meet and progress their initiatives. This group has in the past introduced a number of programs and resources that support the wellbeing of patients with diabetes and will re-establish their meeting schedule in 2022/23.

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 southern 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 'Walking Away' from diabetes programme which acts as a preventative programme for patients identified with pre-diabetes. WellSouth is not currently running the Diabetes Education and Self-Management for Ongoing and Newly Diagnosed (DESMOND) programme for patients with Type 2 Diabetes, as the mask wearing requirements are making it too difficult for attendees and staff. WellSouth has considered an online option, but it does detract from the prescribed format of the workshop.

In Southland, WellSouth has partnered with Diabetes New Zealand (DNZ) to establish a non-clinical Diabetes Community Coordinator (DCC) Hauora Kaimahi role. This DNZ funded role has its base in WellSouth, alongside the Long Term Conditions multi-disciplinary team. The aim of this role is to motivate behaviour change through a structured and supportive partnership with whānau. The DCC can receive referrals for people newly diagnosed with diabetes to provide initial structured education to them and their whānau in the community. This can be delivered at home with whānau, on a marae, in general practice, WellSouth office or wherever suits the patient. DNZ have indicated a willingness to consider this type of role in Otago once Southland is established.

2021/22 Performance Results for Long-Term Conditions Management

Measure		2019/20	2020/21	2021/22		
		Actual	Actual	Target	Actual	
Ratio of repeat prescriptions to new prescriptions dispensed in pharmacies	Total	–	–	< 1.0	0.75	●
Percentage of the population identified as having good or acceptable glycaemic control	Total	53.5%	57%	>60%	47.8%	●
	Māori	46.3%	50%	>60%	41.5%	●

Data Source: WellSouth PHN & Pharmac
Note: Pharmacy Prescriptions is a new measure in 2021/22 therefore data is unavailable for previous years

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 demand and capacity management. Improving access to diagnostics will improve 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 Southern 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.

An additional diagnostic CT for Dunedin was commissioned in September 2021. Performance at Dunedin has improved to the extent that this site's average performance for Q4 was 90.5% (compared with 58.3% Q4 2020/21). The barrier to meeting the indicator target is no longer restrained by the number of machines, but due to radiologist capacity as overdue examinations are now mostly procedures such as microwave ablations and injections. Southland and Queenstown-Lakes continue to average close to or at Target (94.4% Q4).

MRI scanning within 42 days has maintained a steady state in 2021/22. The overall MRI target compliance in the south was 43.6% for all of 2021/22 and 42.1% for June 2021.

A second MRI scanner has been installed in Dunedin and was commissioned in May 2022. Some small improvement has been observed since this time at Dunedin, rising from 34.7 to 37.2% at end June at Dunedin. Increased capacity is expected to bear fruit in Q1 – Q2 2022/23 with compliance anticipated for Q3.

The plan to extend access in primary care was successful with a CT Head pathway being launched in late May 2022.

Faster Cancer Treatment:

Southern DHB did not meet the 62-day target in any of the quarters in 2021/22. Discussion with the FCT South Island Leads Group, comparing results, profile of delay reasons and patient mix occurs monthly. There appears to be regional differences in terms of interpretation of the business rules for both data capture and reporting. Access to a single source and single FCT system would improve this along with a review and revision of the business rules. Opportunities to review / audit patients who did not meet the 62-day target are explored each month before data submission with a particular focus on delay codes.

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. This is in progress and again some delays in this work relate to COVID-19 and other priorities.

Improvement in access to high tech imaging in Dunedin will assist with the diagnostic phase of FCT. The FCT team are seeing a decrease in wait times for imaging as a result.

Daily stand-up meetings have been held with clinicians and schedulers for the services particularly impacted in the post COVID-19 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 occurred following concerns about waiting times in Medical Oncology, Haematology and Radiation Oncology. Southern DHB has provided an initial investment and has worked with Te Aho o Te Kau on reducing waiting times, benchmarking staffing levels and providing initiatives to attract staff to the district. This work included commissioning Ernst Young for service planning with immediate, intermediate, and long-term recommendations across a number of capacity and capability issues. Haines Attract developed a recruitment campaign which is in place now. Southern DHB has utilised outsourcing outside of the district to reduce patient waiting times for Radiation Oncology with good effect.

2021/22 Performance Results for Community Referred Tests

Measure	2019/20	2020/21	2021/22		
	Actual	Actual	Target	Actual	
Percentage of accepted referrals for Computed Tomography (CT) scans receiving procedure within 42 days	58%	60%	>85%	86%	●
Percentage of accepted referrals for Magnetic Resonance Imaging (MRI) scans receiving procedure within 42 days	44%	44%	>67%	44%	●
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	70%	68%	>90%	77%	●

Data Source: 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 Southern perform?

A lower level of Ambulatory Sensitive Hospital Admissions indicates the primary sector is performing well and successfully keeping people well in the community. The sharp increase in ASH rates from 2020/21 is due to the introduction of COVID-19 and Influenza like illnesses (ILI) into the community, however this is still lower than pre-COVID-19 rates. Supporting ASH rates involves the continued investment by Southern DHB and WellSouth 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 and the third in 2020/21.

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.

Continued rollout and strengthening of the Health Care Home model did see some challenges this year as a number of practices delivering this program needed to place development work on hold as they navigated the COVID-19 waves that New Zealand experienced in 2022.

Development of Southern's Primary Options for Acute Care (POAC) programme also continued and is accessed by many practices across the region. 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. Work continues to expand this program even further by offering extended services to a select number of rural practices in Southern.

Mental Health in primary care is also an important part of the sector. Adult brief intervention services are provided directly by WellSouth 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, Southern saw a decrease in people seeking these services, which provided an opportunity to reduce wait times, but volumes rebounded significantly post-outbreak. Targeted funding was provided in response to meet increased demand for some services. In addition, work has been done 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 Arā 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 services 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.

2021/22 Performance Results for Primary Health Care Services

Measure		2019/20	2020/21	2021/22		
		Actual	Actual	Target	Actual	
Avoidable Hospital Admissions[5] rates for children (0-4 years)	Total	6,938	3,823	< 5,570	5,025	●
	Māori	5,622	3,878	< 5,570	5,753	●
The number of people receiving a brief intervention from the primary mental health service	Total	2,135	3,001	>7,000	3,076	●

The large gap between Target and Actual has arisen due to a calculation error that meant past year's values were overstated, with corresponding increasing of the target value. Despite this calculation error, performance has still been increasing as the revised numbers show.

Data Source: Ministry of Health, WellSouth PHN/NGO reports

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

Output Class: Intensive Assessment and Management

Intensive assessment and treatment services are usually complex services provided by specialists and other healthcare 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.

There are a range of intensive treatment and complex specialist services provided in the south. Funding is also allocated for some intensive assessment and treatment services for the southern population that are provided in other districts or by private hospitals or other private providers. A proportion of these services are driven by demand which must be met, 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' appointments. 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 on where a person lives.

How did Southern perform?

Delivering timely access to some treatments has again been challenging in 2021/22 especially for outpatients and elective surgery. Despite this, various programmes of work to match capacity and demand have been undertaken.

Increasing the use of telehealth and providing training and support to teams across the region has been the focus this year for the new Telehealth Implementation Manager. The results have been pleasing and at the end of June 2022 there were 25 services utilising telehealth which was an increase of 12 over the course of the year. The volume of telehealth appointments was 3,184 for June 2021 compared to 95 in June 2020. Key goals for the coming year are to establish community hubs specifically for Māori and Pacifica and to further integrate telehealth into business-as-usual practice.

Additional funding from the Ministry via the Improvement Action Plan has been used to recruit to Clinical Nurse Specialist (CNS) roles in Gynaecology, Cardiothoracic, General Surgery and Vascular services. The CNS roles have worked to improve patient pathways, run follow up clinics which free up our Senior Medical Officers to see FSAs, and reduce length of stay with improved discharge management. The funding was also used to provide unbudgeted outsourcing and employ locum SMOs which has improved the end of year results for 2021/22.

Increasing capacity and throughput is a strategy we have continued to focus on in 2021/22. On the Southland site an additional four beds were opened in February. This has helped to reduce the pressure on surgical beds and improved throughput. On the Dunedin site a four-bed orthopaedic pod has been established and is managed by a Nurse Practitioner. Having beds set aside for orthopaedic patients will reduce the effect of cancellations which greatly affect the orthopaedic service. The service has also started a programme of work for Enhanced Recovery after Surgery (ERAS) which will reduce length of stay, speed up early mobilisation and improve patient satisfaction and safety.

On the Southland site we are trialling extended hours for recovery in the Day Surgery Unit (DSU) and this will greatly reduce the number of less complex cases cancelled at the end of lists due to there not being sufficient recovery time or an overnight bed for the patient. On the Dunedin site a plan to lease an off-site theatre for Ophthalmology is progressing well. This will enable additional lists to be allocated in the main theatre to our high need surgical services.

Service Improvement Projects funded by the Ministry are progressing but have been affected by COVID-19 since August 2021. The projects in Radiology and Diagnostics, Endocrinology, Respiratory and Rheumatology services all involve working more closely with primary care and improving pathways, support, and communication. Highlights include:

- Diagnostics – GPs now have access to the CT head pathway and work is ongoing to develop pathways for CT abdomen and improved access to ultrasound
- Rheumatology – specialist advice clinics for primary care established and pathways in place for GP access to Nuclear Bone Scanner
- Respiratory – a community based respiratory physician has been appointed and is working with GP practices to implement community testing and upskill GPs in respiratory medicine
- Endocrinology – GP liaison clinics, electronic communication with primary care and nurse led diabetes clinics are all in place.

Staffing and recruitment have been challenging over the past year. On the Southland site a bespoke recruitment campaign "Fit in Stand out" created in conjunction with Haines recruitment is now being run internationally. Created with the participation of staff from the Southland site, the campaign uses a new and innovative approach. Thus far, click throughs from adverts to the Southern recruitment site have been high and it is hoped this will translate into successful applicants. On the Dunedin site the recruitment team are developing a similar approach and working with Te Whatu Ora nationally to produce an advertising campaign for Southern.

2021/22 Performance Results for Elective Services

Measure	2019/20 Actual	2020/21 Actual	2021/22 Target	2021/22 Actual	
Number of elective surgical service discharges	11,179	11,803	>12,588	10,763	●
Percentage of elective and arranged surgery undertaken on a day case basis	57%	58%	>60%	57%	●
Percentage of people receiving their elective and arranged surgery on day of admission	88%	89%	>95%	87%	●
Number of inpatient elective and arranged surgical services (CWDs) delivered	17,292	17,910	>18,464	16,705	●

Data Source: Ministry of Health

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 Southern perform?

2021/22 has been a challenging year for Emergency Departments. The number of people accessing EDs is below last year's numbers and remain below target for the year. The number was exacerbated following the emergence of COVID-19 in the New Zealand community and the requirement for patients to be screened and streamed. Patients presenting to the ED are increasingly co-morbid and this in combination with COVID-19 has significantly increased the acuity and complexity of patients. Consistent with the rest of New Zealand, 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
- Embedding the generalist model of admitting for Dunedin Hospital wards and developing the model of care for the 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 (under consultation) to better allow for patient flow which are aligned with the national direction
- Establishment and development of an Integrated Operations centre in both Dunedin and Southland
- The establishment of Patient Flow Managers in both Dunedin and Southland to lead work on improving patient flow and provision of urgent care.

2021/22 Performance Results for Acute Services

Measure	2019/20 Actual	2020/21 Actual	2021/22 Target	2021/22 Actual	
People are assessed, treated, or discharged from ED in under 6 hours	81.3%	82%	>95%	75%	●
Number of people presenting at ED	77,331	86,181	<85,000	80,130	●

Data sourced from Ministry of Health

Maternity Services

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

How did Southern 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 is also relatively constant, with performance sitting just above target, rising 5% over the last year

Evidence shows culturally safe care supports good health outcomes. 2021/22 saw introduction of education and competency workshops. These will continue in 2022/23 with the aim of achieving 75% of maternity staff through these training packages by Q4.

Primary Maternity continues to progress work designed to increase access and utilisation of closer to home community facilities. This has included the establishment of telehealth, Gestational Diabetes, and Anti-D clinics in Central Otago and Wanaka. The number of new parents opting to transfer back to a Primary Birthing Unit for their postnatal stay is also improving, with nearly 50% of the pregnant population in Wanaka and Central Otago staying for at least one night in Central Otago Maternity Unit post-delivery.

This utilisation of closer to home postnatal care was supported by the improved transfer pathway from secondary and tertiary facilities back to primary maternity units. These measures are working well and have reduced burden for staff sending and receiving patients.

We were excited to sign off on the purchase of a new Primary Birthing Unit in Wanaka which, after some minor renovations, will be ready to open in the first part of 2023. The new Primary Birthing Unit in Clyde, which will house the existing Central Otago Maternity team, is progressing through the design phase well. The first round of community stakeholder design consultations was undertaken in April 2022, with a second scheduled for August 2022.

2021 Performance Results for Maternity Services

Measure		2018	2019	2020		
		Actual	Actual	Target	Actual	
Number of maternity deliveries in Southern DHB facilities[6]	Total	3,439	3,248	3,400	3,062	●
	Māori	543	502	560	503	●
Percentage of pregnant women registered with a Lead Maternity Carer in the first trimester	Total	79.2%	81%	>80%	86%	●

Data Source: Ministry of Health Data Warehouse

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

Assessment, Treatment and Rehabilitation Services (AT&R)

These are the services that restore functional ability and enable people to live as independently as possible following serious trauma or a medical condition. Services are delivered across two 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.

How did Southern perform?

Patients under the age of 65 years receive rehabilitation at the Puawai Rehabilitation Unit (PRU) within the Wakari Hospital grounds. Admissions are predominantly for stroke, traumatic brain injury and major traumatic injury. The total number of beds is relatively small (12 beds), but the complexity of patients is high. Supporting gains in physical function and ability to return home safely are key aims of the service.

Patients over the age of 65 receive rehabilitation in ward 6AT&R in Dunedin Public Hospital.

Both our rehabilitation wards submit data to The Australasian Rehabilitation Outcomes Centre (AROC), which provides bi-annual reports on the performance of the in-patient services. This includes information on length of stay, functional gain, and discharge destination. It shows our performance trends and a comparison of our data with other ATR units within New Zealand. As part of our data collection the unit demonstrates changes in the patient's functional ability by the use of the FIM ® instrument, which is a basic indicator of "burden of care" (i.e., the amount of assistance required from a carer).

The AROC report for January to December 2021 shows that 6AT&R continues to deliver improved outcomes for older patients, with 49% of our patients having higher functional outcomes in comparison to the benchmark facilities and 76% having a shorted length of stay. This is important as older people are returning back into the community with a much greater chance of maintaining their independence within their own home.

PRU also demonstrates improved performance against the benchmarked facilities, with higher functional gain and shorter lengths of stay.

COVID-19 and lockdown periods continued to impact on AT&R services, with 6AT&R being asked to relocate to another ward area within Dunedin Public Hospital for several months. This limited the rehabilitation bed numbers to 12. Since returning to the usual ward environment, bed numbers have fluctuated between 16 to 20 beds. This has been primarily due to staff sickness levels.

Despite the success of the 10 bed Older Person's Assessment and Liaison (OPAL) it has been difficult to maintain this model of care whilst the bed numbers fluctuated, and the ward was in a different location. When possible, the ward is still admitting suitable patients directly from the Emergency Department as we want to provide a streamlined admission and assessment pathway for as many patients as possible, facilitating a quicker return home. The ward also supports and provides rehabilitation for a small number of positive COVID-19 patients who are able to be isolated and yet continue to progress towards achieving their goals and returning to the community.

COVID-19 continues to complicate processes to support complex patients back into the community. This has resulted in an increased length of stay for those patients' requiring commencement of a care package. For those unable to return home and needing an Aged Residential Care facility there have been delays in their transfer.

2021/22 Performance Results for Assessment, Treatment and Rehabilitation Services (AT&R)

Measure		2019/20	2020/21	2021/22		
		Actual	Actual	Target	Actual	
Proportion of AT&R inpatients discharged to their own home rather than ARC[7]	<65 years	–	–	>85%	78.9%	●
	>65 years	–	–	>75%	67.3%	●

Data Source: Internal Systems

[7] This is a new measure for 2021/22

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 Southern 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 2021/22 period. This is also true for Māori accessing those specialist services for the 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 2021/22 although service pressures and COVID-19 have impacted on our performance in this area and compliance has dropped, primarily in community teams. We are working closely with clinical staff to support them to improve compliance. Despite the drop, we continue to maintain a focus on client's transition plans and the sharing of these plans with client' 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.

COVID-19, and increased staff vacancies in many areas, has also impacted on wait times with a drop in compliance with the three-week target over the year. Again, working with clinical staff to improve timely access remains a focus. Compliance rates for eight weeks have been maintained but remain slightly below target.

2021/22 has seen significant momentum with the implementation of Time for Change Te Hurihanga. Southern's Mental Health and Addiction System has been subject to independent review during the second half of 2020/21. The review was underpinned by extensive consultation with interested parties, in particular service users, and endorsed by the Southern DHB Board. 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.

Priority areas for Time for Change Te Hurihanga already subject to a Request for Proposal process include the establishment of a community/residential service to enable the closure of Ward 11 at Wakari Hospital, increased AOD capability in the greater Dunedin area with an additional 7 FTE, and a tender for the provision of enhanced crisis response services in the Central Lakes District.

A pilot programme between the Southern DHB, St John and the Otago Coastal Police was developed to reduce demand on police, and support on-scene mental health crises. The police led Co-Response team attends emergency mental health calls in the district and provides enhanced on-scene care to members of our community experiencing mental distress. The Crisis Response Team (CRT) trial has enabled the DHB to support 350 clients in their own home, reducing the number of people being unnecessarily transported to emergency departments or police stations.

One of our major areas of activity during the past 12 months has been working with WellSouth on the implementation of the Integrated Primary Mental Health Programme in primary care (Access and Choice). This programme has a focus on general health not just mental health and aims to provide greater access to mental health support in a primary care setting.

2021/22 Performance Results for Specialist Mental Health Services

Measure		2019/20	2020/21	2021/22		
		Actual	Actual	Target	Actual	
Percentage of young people (0-19 years) accessing specialist mental health services	Total	5.29%	5.19%	>3.75%	4.99%	●
	Māori	6.02%	5.78%	>3.75%	5.26%	●
Percentage of adults (20-64 years) accessing specialist mental health services	Total	4.33%	3.76%	>3.75%	3.71%	●
	Māori	8.96%	7.08%	>5.22%	6.92%	●
The percentage people who have a current transition (discharge) plan	Total	54%	63%	>70%	55%	●
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	70%	69%	>80%	61%	●
	<8 weeks	88%	90%	>95%	90%	●

Data Source: 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.

A 'restorative' approach to home support in the south, including individual packages of care 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 services complete a comprehensive assessment of a person's health, wellbeing, and function.

The assessor assists the person to determine the best mix of supports they require based on their strengths, resources, and goals.

The assessment is used to determine a person's eligibility and need for publicly funded support services and any non-funded options and services that will support the person to achieve their goals.

A support plan is developed that aims to enable and empower the person to live a good life. 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 Southern 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) Te Whatu Ora or Rural Hospital Clinical Needs Assessors undertake these assessments. If patients are non-complex (lower levels or need) these assessments are undertaken by their HCSS providers.

99% of clients who received long-term HCSS in 2020/21 has an InterRAI assessment undertaken.

2021/22 Performance Results for Needs Assessment & Service Coordination (NASC)

Measure		2019/20	2020/21	2021/22		
		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%	●
Percentage of clients admitted to an ARRC facility from the community who have been assessed using a Home Care or Palliative Care assessment in the 6 months before the ARRC facility admission date (InterRAI)	Total	89%	92%	>95%	92%	●

Data Source: 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 Southern 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.

COVID-19 has impacted Home & Community Support Service delivery significantly this year. Lockdowns and outbreaks have affected both the numbers of clients wanting services, and the available workforce to deliver those services. Our Alliance and Restorative Model of Care served us well, as providers understood the needs of their clients and were able to prioritise services to those most in need. Despite significant staff turnover, it was reassuring to see that the percentage of Support Workers achieving at least Level 2 qualifications, rose. We will continue to aim for over 85% of the workforce achieving this qualification.

Workforces are recovering very slowly, and it may be some time before Home & Community Support Services are able to provide services at former levels.

2021/22 Performance Results for Home and Community Support Services

Measure		2019/20 Actual	2020/21 Actual	2021/22 Target	2021/22 Actual	
Total number of eligible people aged over 65 years supported by home and community support services (HCSS)	Total	4,474	4,703	>4,800	4,564	●
The percentage of HCSS support workers who have completed at least Level 2 in the National Certificate in Community Support Services (or equivalent)	Total	86%	82%	>80%	83%	●

Data Source: Provider Files

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 occupational 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 Southern perform?

There was a major change to the delivery of Fracture Liaison Services in 2021/22, with ACC funding Fracture Liaison Services throughout New Zealand based on Osteoporosis New Zealand Clinical Standards. For Southern, this changed the focus from all fractures for older people, to fragility fractures. The services are working towards Best Practice recognition. While numbers are fewer than predicted under the former service model, we are confident that, using an evidence based model, outcomes will be superior.

2021/22 Performance Results for Rehabilitation Services

Measure		2019/20 Actual	2020/21 Actual	2021/22 Target	2021/22 Actual	
People (65+) accessing the community-based falls prevention service[8]	Total	–	–	>1,865	6,692	●

Data Source: WellSouth PHN

[8] This is a new measure for 2021/22

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 Southern 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. Outcomes from these initiatives often occur over time, and we are now seeing the results of prior investments.

2021/22 Performance Results for Age-Related Residential Care

Measure		2019/20 Actual	2020/21 Actual	2021/22 Target	2021/22 Actual	
Number of Rest Home Bed Days per capita of the population aged over 65 years	Total	5.8	5.59	<6.11	4.8	●

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

COVID-19

Public health response

Over the last 12 months the whole Public Health service has supported the national response to COVID-19. This involved a significant involvement in the August 2021 Auckland outbreak. There have been significant numbers of cases in the Southern district with our teams moving from full contact tracing response to exposure event management and through to high-risk exposure events and outbreaks as the Ministry has changed the priorities of work in each phase of the outbreak. Until May 2022 a large number of core public health staff continued to be involved in the COVID-19 outbreak response. Since May, the COVID-19 response team continues to manage any COVID-19 response work as well as proactive work in this space.

2021/22 saw development of a COVID-19 specific response team including, contact tracers, registered nurses and operational leads. Work has been ongoing to maintain a ready response for COVID-19 management with this team. 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.

Teams continue to work with large event organisers and businesses around COVID-19 plans and preparedness. A tabletop exercise was run in December 2021 to work through a range of different COVID-19 scenarios for the Rhythm and Alps event held at Cardrona. This was a success, and ensured that all parties were prepared for such an event and any changes to government requirements.

Public Health South worked alongside the Māori Health Directorate and WellSouth to ensure a culturally appropriate response was implemented. This included WellSouth linking unenrolled Māori and Pasifika people with a general practice for clinical management as well as support families to be connected with Māori and Pacific providers for manaaki and welfare support to these families.

The team have also been undergoing proactive work, reaching out to vulnerable priority population groups to assist them with preparedness and to work through any concerns or needs these groups might have that public health can assist with.

Maritime border response

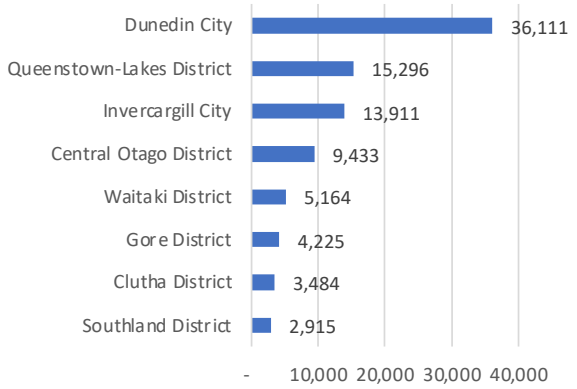
Southern has three international Maritime ports – Port Otago, South Port and Tiwai. Significant work has occurred to ensure compliance of maritime border orders and Ministry of Health requirements.

This continues to be managed by the on-call Health Protection Officers, but the work did reduce with the borders closing to all cruise ships and the recent changes to testing requirements.

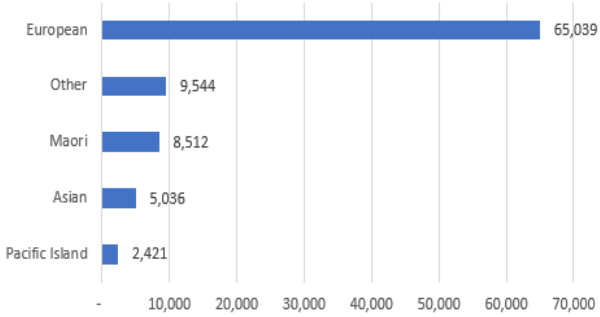
Community COVID-19 testing

Testing of individuals for COVID-19 was facilitated by WellSouth and General Practices. In the 2021/22 financial year, there were 102,807 presentations to a testing centre or facility with either COVID-19 symptoms, a known or potential exposure to a COVID-19 positive person, or the person believes they have COVID-19 without any symptoms. Of these presentations 90,552 people had swabs taken (88.1% of presentations).

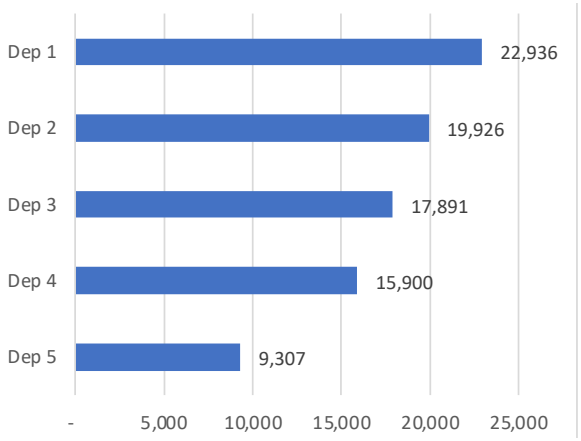
COVID-19 Testing numbers 1 July 2021 – 30 June 2022 by Territorial Authority



COVID-19 Testing numbers 1 July 2021 – 30 June 2022 by Ethnicity



COVID-19 Testing numbers 1 July 2021 – 30 June 2022 by Deprivation



The total number swabbed was 90,552 people, as shown in the ethnicity chart. Gaps in some individual-level demography data means Deprivation and Territorial Authority totals do not equal the total shown in the ethnicity chart

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 contact 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 Pasifika young people.

COVID-19 vaccination programme

The Southern COVID-19 Vaccination Programme started in early 2021 and by March was vaccinating border workers, who at the time were the most vulnerable to infection. By July, the programme had established two Mass Vaccination Centres, one in Dunedin and one in Invercargill, and was working with WellSouth to safely onboard providers across the district. At the height of the programme, the network of vaccination providers included 37 pharmacies; 63 GPs; 5 Māori and Pasifika providers; and several occupational health providers, in addition to the two Mass Vaccination Clinics.

This collaborative approach, and the establishment of an outreach programme for hard-to-reach cohorts, enabled us to meet the needs of the widely distributed population in the Southern District. The outreach programme is run out of the Mass Vaccination Centres in Dunedin and Invercargill, working with Māori and Pasifika providers, to stand up pop-up clinics in areas with low coverage and has included workplace vaccinations, pop-ups at university halls of residence, migrant and multi-cultural clinics and a "Farmgate Tour" in collaboration with Southland Mayors. The service also offers home visits to those unable to access a vaccination clinic.

Highlights

- During the snap lockdown in August 2021, 23,000 vaccinations were delivered across the district in a week.
- On Super Saturday, October 16, 9,788 people were vaccinated across the district in a single day.
- The programme's target was to double vaccinate 90% of the eligible population by Christmas 2021. Queenstown Lakes was the first to reach this target on 16 November 2021, followed by other territorial authorities. The whole district reached 90% double vaccinated in early January 2022.

Pharmacies and general practice have continued to vaccinate as part of their day-to-day business, with the former providing essential coverage through walk-in and out of hours vaccinations, and the latter playing an instrumental part in vaccinating the Aged Residential Care Sector.

On 27th May 2022, the Mass Vaccination Centre in Dunedin's Meridian Mall relocated to Hanover Street, becoming the Dunedin Immunisation Centre Te Puna Āraimate ki Ōtepoti. Whilst operating at a smaller scale, it offers an increased variety of vaccinations and continues to run outreach work. In June, the Invercargill Mass Vaccination Centre also reduced its size and became the Invercargill Immunisation Centre. With provider coverage lower in Invercargill the centre remains busy and uses outreach teams to vaccinate residents at aged residential care facilities.

Vaccination Uptake (Age 12 and over) as of 30 June 2022

Southern	Fully vaccinated	First booster
Total	97.5%	74.7%
Māori	92.7%	60.2%
Pacific	99%	60.8%

National	Fully vaccinated	First booster
Total	95.2%	73%
Māori	88.5%	56%
Pacific	96.9%	60.1%

Paediatric COVID-19 Vaccinations

In January 2022, vaccinations were approved for those aged 5 to 11-years-old and by February, 70 providers across the Southern District were offering vaccinations to this age group.

Specialist Paediatric COVID-19 Vaccination Clinics continue to be held at Dunedin Hospital and Southland Hospital to assist tamariki who are unable to receive their COVID-19 vaccination through community clinics or home visits. This may be due to extreme needle phobia, neurodevelopmental needs such as intellectual disability, autism spectrum disorder or other complex health needs. Play Specialists, Paediatricians (for sedation where necessary) and Psychologists are available for input alongside the COVID-19 vaccinators.

During Tamariki Week in February 2022, an initiative to boost childhood COVID-19 vaccination rates, 799 paediatric doses were delivered across the district.

Southern remains ahead of the national average in paediatric vaccinations.

Paediatric Vaccination Uptake as at 30 June 2022

Southern	Partially vaccinated	Fully vaccinated
Total	52.9%	22.9%
Māori	41.4%	17.8%
Pacific	55.2%	18.4%

National	Partially vaccinated	Fully vaccinated
Total	54.7%	27.3%
Māori	35.6%	13.2%
Pacific	48.3%	17.1%

Māori and Pasifika Providers

The Southern COVID-19 Vaccination Programme continues to work collaboratively with Māori and Pasifika providers to facilitate a community-based approach to COVID-19 vaccinations. In addition to establishing two permanent general practice-based clinics, Mō Tātou Tipuna located in Dunedin and He Puna Waiora in Invercargill, Māori health providers have always been extremely adaptable. In the August 2021 lockdown, Te Kāika established the Edgar Centre drive through vaccination clinic, the first of its kind in the district and the largest COVID-19 vaccination drive through in New Zealand, delivering the highest number of vaccinations in one day (1409 doses) for any provider on South Island. It later launched the vaccination bus in partnership with Otakou Health Limited, Southern Health, Ritchie Transport and Dunedin City Council, targeting areas with low vaccination uptake and high Māori and Pasifika populations.

In February 2022, the Māori population in Southern reached the 90% double vaccinated target.

The Māori and Pasifika providers continue to vaccinate against COVID-19, Influenza and Measles, Mumps and Rubella at all their clinics and outreach activity.

Aged Residential Care

As a vulnerable cohort, those in ARC facilities have been a key focus throughout the programme, with delivery supported but general practices, pharmacies, and the teams from the Mass Vaccination Centres. Primary vaccinations for both residents and staff at Aged Residential Care facilities were completed in August 2021 and, once the booster was announced in November 2021, the programme quickly reapplied the model, completing booster delivery by February 2022. The delivery of second boosters, announced in June 2022, has been challenged by COVID-19 outbreaks and the required three-month interval between COVID-19 infection and vaccination. Therefore, the rollout to ARCs has necessarily been staggered but we anticipate completing second boosters for this group in November 2022. Influenza and MMR vaccinations are offered at the same time.

Mental Health, Addiction and Disability Services

The programme works closely with mental health, addiction, and disability services across the district to support those they work with to access vaccination. In some cases, this has simply meant providing information and booking details, in others, on-site vaccinations and home-visit outreach has been arranged.

In December 2021, Southern reached 90% double vaccinated for the disability cohort and we continue to work with service providers to ensure there are no barriers for those eligible to access booster and second booster doses.

Vaccines

COVID-19

The national vaccination rollout began with a two-dose course of Adult Pfizer, with AstraZeneca and Novavax introduced later to provide greater options for the population aged 18 and over. Pfizer remains the preferred vaccine type in New Zealand. Booster doses were introduced for those aged 18 and over in November 2021, six months after the completion of a primary course (the interval was reduced to four months in January, then three months in February). Paediatric Pfizer vaccinations were introduced in February 2022 for ages 5 to 11, in April boosters were introduced for those aged 16 and 17 at a 6-month interval, and in June 2022 second boosters commenced for those most at risk of COVID-19.

Influenza

On the 1st of April 2022, the Influenza vaccination rollout began and was offered at both COVID-19 Mass Vaccination Centres and at pop-up clinics.

Measles Mumps and Rubella (MMR)

Population Health Services were significantly disrupted as COVID-19 developed in New Zealand in 2020. MMR was introduced to the Mass Vaccination Centres and pop-up clinics in March 2022. The Programme works closely with the Measles Campaign Manager, to include COVID-19 and MMR vaccinations together at any vaccinating opportunity.

Boostrix

Boostrix was introduced to the Mass Vaccination Centres and pop-up clinics in April 2022.

Workforce

Our directorate from the Ministry of Health during 2021 was to ensure a surge workforce was available to focus on any COVID-19 outbreak areas, or any other areas in an ever-changing landscape.

Through the Mass Vaccination Centres, 250 people were onboarded and trained to increase delivery capacity and allow for a flexible outreach service with the ability to pivot to demand. In Dunedin, this included the onboarding of over 30 third year Otago Polytechnic nursing students to vaccinate under supervision. This was a successful initiative, and we saw the students gain confidence through their contribution to the programme.

The Invercargill Mass Vaccination Centre was used as a placement for Invercargill nursing students, vaccinating under supervision. Two of the students went on to be onboarded and work regular shifts in the clinic.

As the numbers of vaccinations dropped, and COVID-19 outbreaks had a larger impact in the community, the workforce at the Centres was reduced and staff were reallocated to support other areas of the organisation, for example placing nurses in Aged Residential Care facilities and administrators in hospitals to provide visitor screening.

Plan for 2022/2023

Looking ahead to the 2022/23 financial year, the programme will continue to focus on accessibility and equity, offering vaccination information and access to everyone eligible in our community. It will continue to develop an all-immunisation model, including COVID-19, Influenza, MMR and Boostrix, to increase vaccination rates across the Southern District.

Additional performance information: COVID-19 vaccinations and mortality

To determine the vaccination rates of the eligible population and deaths that are attributed to COVID-19 in Aotearoa, we have included additional information for the performance measures pertaining to Implementing the COVID-19 Vaccine Strategy.

COVID-19 vaccinations

The Ministry of Health uses health service user (HSU) data as the denominator to determine the COVID-19 vaccination coverage. This section describes the percentage of the eligible population who have received the vaccination. Individuals are included in the HSU if they were enrolled with a primary health organisation, or if they received health services in a given calendar year (shown in the box, below).

As of 8 August 2022, there are two versions of the HSU available for determining COVID-19 vaccination coverage:

HSU 2021

People are included if they were:

- alive on 31 December 2021
- enrolled with a primary health organisation or received health services in the 2021 calendar year.

HSU 2020

People are included if they were:

- alive on 1 July 2020,
- enrolled with a primary health organisation or received health services in the 2020 calendar year.

During 2021/22, the Ministry reported the COVID-19 vaccination coverage using HSU 2020. This information was routinely referenced publicly, as well as in published reports and updates.

On 8 August 2022, the HSU 2020 version was officially superseded by HSU 2021. While the HSU 2021 was not used to report COVID-19 vaccination coverage during 2021/22, it is the preferred version to use in this report as the data is more up to date and relevant.

Any persons who have moved DHB since 30th June 2022 are counted in their current DHB as at 23:59 13/12/2022.

More information on the HSU data, including a comparison against Stats NZ population data, is available in 'Further notes on the HSU datasets', at the end of this section.

Percentage of the eligible population who have completed their primary COVID-19 vaccination course: Comparing HSU 2021 and HSU 2020

To determine the coverage of the COVID-19 vaccine across the population of Southern DHB we have used the HSU 2021 data as the denominator (the figure which the total eligible population vaccinated is divided by). The suitability of the HSU for this purpose was reviewed by Stats NZ, with their findings and recommendations published on 4 August 2022.[1]

Percentages over 100% occur where there are more vaccinated persons than was expected in the HSU 2021 data. This is mostly seen in small populations. As the HSU is a point in time denominator, any movement of persons into or out of an area are not captured and percentages above 100% can occur.

Percentage of the eligible population who have completed their primary COVID-19 vaccination course[2] (HSU 2021 vs HSU 2020)

Year[3]	HSU 2021 Percentage of the eligible population who have completed their primary course
2020/2021	10.57%
2021/2022	82.16%
Total	**92.73%**

Year[3]	HSU 2020 Percentage of the eligible population who have completed their primary course
2020/2021	11.16%
2021/2022	86.71%
Total	**97.86%**

Using HSU 2021 to determine the percentage of the eligible population who have completed their primary course, the coverage is calculated to be 10.57%, compared with 11.16% using HSU 2020 as at 30 June 2022.

The difference in the percentage of the eligible population vaccinated using HSU 2021, compared with using HSU 2020, reflects an increase in the number of individuals

interacting with the health system during the 2021 calendar year compared with 2020. This is partly due to the COVID-19 vaccination programme successfully vaccinating individuals who had not engaged with the health system during 2020 and as such, were not captured in HSU 2020. Additionally, it reflects the demographic changes between 1 July 2020 and 31 December 2021. This includes births, deaths and people ageing into the eligible population and migration.

COVID-19 vaccine doses administered by dose type and year

The counts in the table below measure the number of COVID-19 vaccination doses administered in Southern DHB during 2021/22 and the prior financial year (2020/21). This information was obtained from the COVID-19 Vaccination and Immunisation Programme (CVIP) database.

Year[4]	Primary course				
	Dose 1	Dose 2	Booster 1	Booster 2	Total[5]
2020/2021	49,577	31,578	0	0	81,155
2021/2022	248,959	256,239	194,514	1,633	701,345
Total	**298,536**	**287,817**	**194,514**	**1,633**	**782,500**

[1] https://www.stats.govt.nz/reports/review-of-health-service-user-population-methodology
[2] Individuals who have received dose 1 and dose 2 of the COVID-19 vaccine are considered to have completed their primary course. This definition supersedes the term 'fully vaccinated' reported in our 2020/21 annual report.
[3] Data as at 30 June 2021 for 2020/21 and 30 June 2022 for 2021/22.
[4] Data as at 30 June for each financial year, and respectively covers all vaccination doses administered between 1July-30 June.
[5] Excludes third primary doses administered and any subsequent boosters a person may have received after the second booster vaccination.

By 30 June 2022, a total of 782,500 COVID-19 vaccinations had been administered, of which 89.6% were administered in 2021/22.

There are two similar but distinct metrics used within the following tables: Doses administered and People vaccinated. Doses administered focuses on vaccination program activities while people vaccinated uses people's vaccination status as the primary measurement. People vaccinated includes vaccinations received overseas and recorded in CIR. Furthermore deceased persons are removed from the people vaccinated counts. Doses administered includes deceased and doesn't include overseas vaccinations. This causes some variation between the two measures and exact comparisons are not feasible.

COVID-19 vaccine doses administered by age group

The counts in the table below measure the number of COVID-19 vaccination doses administered by the age group of the individual who received the dose. This information was obtained from the CVIP database.

COVID-19 vaccine doses administered by age group[6]

Age group	Primary course				
(years)[7]	Dose 1	Dose 2	Booster 1	Booster 2	Total[8]
12 to 15	16407	15782	11	0	32200
16 to 19	18922	18774	7809	1	45506
20 to 24	20930	21503	13860	2	56295
25 to 29	20345	20463	11716	9	52533
30 to 34	20563	20805	13522	17	54907
35 to 39	18057	18363	13265	29	49714
40 to 44	16696	17015	13555	34	47300
45 to 49	17288	17691	14925	48	49952
50 to 54	17254	17845	16301	74	51474
55 to 59	17390	18086	17599	122	53197
60 to 64	16650	17829	18256	162	52897
65 to 69	10525	13798	16108	286	40717
70 to 74	8505	11768	14291	360	34924
75 to 79	5658	7923	10041	254	23876
80 to 84	4120	5671	7136	158	17085
85 to 89	2243	3128	3835	64	9270
90+	1114	1676	2284	13	5087
Total	**248959**	**256239**	**194514**	**1633**	**701345**

Note 1: Some demographic breakdowns appear to show more doses administered for Dose 2 compared to Dose 1. This is due to COVID-19 vaccination doses being administered in the previous financial year (2020/21).

COVID-19 people vaccinated by age group

The counts and the percentages in the table below measure the number of people who received COVID-19 vaccination doses during 2021/22. This data was obtained from the CVIP database (broken down by age group), and the percentages calculated using HSU 2021 as the denominator.

Please note, as this table refers to people vaccinated (and the respective percentage of a given demographic per row), it is not comparable to the table above (COVID-19 doses administered by age group).

[6] Data as at 30 June 2022 and covers all vaccination doses administered between 1 July 2021-30 June 2022.
[7] Age groupings in this table reflect the age of the person at the time of the vaccination being administered.
[8] Excludes third primary doses administered to individuals and any subsequent boosters which may have been administered after the second booster vaccination.

COVID-19 vaccine doses administered by age group[9]

Age group (years)[10]	Partial[11]		Primary course[12]			Booster Course		
	Partially vaccinated	Partially vaccinated (% eligible)	Completed primary course	Completed primary course (% eligible)	Received first booster (18+)	First booster (% eligible) (18+)	Received second booster (50+)	Received second booster % eligible (50+)
0 to 11	13810	30%	7062	15%	0	0%	0	0%
12 to 15	14304	85%	12643	75%	0	0%	0	0%
16 to 19	16909	98%	16837	97%	4533	56%	0	0%
20 to 24	23014	86%	23424	88%	14590	58%	0	0%
25 to 29	20013	79%	20145	80%	11462	52%	0	0%
30 to 34	21077	80%	21394	81%	13224	56%	0	0%
35 to 39	18892	81%	19157	82%	13423	64%	0	0%
40 to 44	17015	82%	17363	83%	13390	70%	0	0%
45 to 49	16909	79%	17309	81%	14456	75%	0	0%
50 to 54	17679	80%	18219	83%	16192	79%	69	4%
55 to 59	16883	76%	17601	79%	16800	84%	115	6%
60 to 64	17324	79%	18304	84%	18396	88%	159	8%
65 to 69	11981	65%	14648	79%	16410	91%	264	11%
70 to 74	8834	55%	12090	76%	14399	94%	349	16%
75 to 79	6398	59%	8920	82%	10921	96%	269	15%
80 to 84	4450	57%	6162	80%	7495	98%	163	14%
85 to 89	2531	60%	3466	83%	4180	101%	74	12%
90+	1412	57%	2046	83%	2598	107%	17	4%
Total	**249435**	**71%**	**256790**	**73%**	**192469**	**75%**	**1479**	**11%**

COVID-19 vaccine doses administered by ethnicity

The counts in the table below measure the number of COVID-19 vaccine doses administered by the ethnicity of the individual who received the dose. This information was obtained from the COVID-19 Vaccination Immunisation Programme database.

COVID-19 vaccine doses[13] administered by ethnicity[14] (1 July 2021 – 30 June 2022)

Ethnicity (Note 1, 2)	Primary course				
	Dose 1	Dose 2	Booster 1	Booster 2	Total
Asian	18176	18001	14042	27	50246
European/other	200384	208491	163861	1503	574239
Māori	22451	21740	11620	81	55892
Pacific peoples	6510	6506	3766	13	16795
Unknown	1438	1501	1225	9	4173
Total	**248959**	**256239**	**194514**	**1633**	**701345**

[9] Data as at 30 June 2022 and includes all people who received COVID-19 vaccinations between 1 July 2021-30 June 2022.
[10] Age groupings in this table reflect age of the persons at end of financial year.
[11] Partial vaccination refers to individuals who had received a single one dose of the COVID-19 vaccination (as at 30 June 2022).
[12] Primary course refers to the first two doses of the COVID-19 vaccine (dose 1 and dose 2).
[13] This excludes third primary doses administered and any subsequent boosters a person may have received after a second booster.
[14] Data as at 30 June 2022 and includes all vaccination doses being administered between 1 July 2021 – 30 June 2022.

Note 1: Ethnicity is based on the prioritised ethnicity classification system. This allocates each individual to a single ethnic group, based on the ethnic group (or groups) they identify with. Where people identify with more than one ethnic group, they are prioritised as: Māori, Pacific peoples, Asian, European/other, Unknown. For example, if a person identifies as being Māori and New Zealand European, the person is counted as Māori in this dataset. 'Unknown' is where a person has not disclosed any ethnicity.

Note 2: Some demographic breakdowns appear to show more doses administered for Dose 2 compared to Dose 1. This is due to COVID-19 vaccination doses being administered in the previous financial year (2020/21).

COVID-19 people vaccinated by ethnicity

The counts in the table below measure the number of people receiving doses (obtained from the COVID-19 Vaccination and Immunisation Programme database).

COVID-19 people vaccinated by ethnicity during 2021/22[15]

Ethnicity (Note 1)	Partially vaccinated (12+)	Partially vaccinated (12+) (% eligible)	Completed Primary Course (12+)	Completed primary course (12+) (%)	Received First Booster (18+)	Received first booster (18+) (% eligible)	Received second booster 50+	Received second booster (% eligible, 50+)
Asian	16898	80%	17436	83%	13939	75%	16	6%
Māori	20665	82%	20951	83%	11508	60%	68	11%
European/ other	190129	76%	203054	82%	162015	76%	1381	11%
Pacific peoples	6295	89%	6512	92%	3751	60%	7	5%
Unknown	1638	78%	249728	82%	192469	75%	1479	11%
Total	**235625**	**88%**	**1775**	**95%**	**1256**	**59%**	**7**	**9%**

Note 1: Ethnicity is based on the prioritised ethnicity classification system. This allocates each individual to a single ethnic group, based on the ethnic group (or groups) they identify with. Where people identify with more than one ethnic group, they are prioritised as: Māori, Pacific peoples, Asian, European/other, Unknown. For example, if a person identifies as being Māori and New Zealand European, the person is counted as Māori in this dataset. 'Unknown' is where a person has not disclosed any ethnicity.

COVID-19 people vaccinated by ethnicity from 1 July 2020 to 30 June 2022

Ethnicity (Note 1, 2)	Partially vaccinated (12+)	Partially vaccinated (12+) (% eligible)	Completed Primary Course (12+)	Completed primary course (12+) (%)	Received First Booster (18+)	Received first booster (18+) (% eligible)	Received second booster 50+	Received second booster (% eligible, 50+)
Asian	20261	96%	20072	95%	13939	75%	16	6%
Māori	23212	92%	22471	89%	11508	60%	68	11%
European/ other	233169	94%	230106	93%	162015	76%	1381	11%
Pacific peoples	7194	101%	7036	99%	3753	60%	7	5%
Unknown	2222	119%	2174	117%	1256	59%	7	9%
Total	**286058**	**94%**	**281859**	**93%**	**192471**	**75%**	**1479**	**11%**

Note 1 Ethnicity is based on the prioritised ethnicity classification system. This allocates each individual to a single ethnic group, based on the ethnic group (or groups) they identify with. Where people identify with more than one ethnic group, they are prioritised as: Māori, Pacific peoples, Asian, European/other, Unknown. For example, if a person identifies as being Māori and New Zealand European, the person is counted as Māori in this dataset. 'Unknown' is where a person has not disclosed any ethnicity.

Note 2 Partially Vaccinated counted for 12+ years old (age as at 30-Jun-2022)
Completed Primary Course counted for 12+ years old (age as at 30-Jun-2022)
Rec'd First Booster counted for 18+ years old (age as at 30-Jun-2022)
Rec'd Second Booster counted for 18+ years old (age as at 30-Jun-2022)
50+ age determined as at 30-Jun-2022
Basis of population is HSU2021 for 12+ years old
All counts exclude those who died prior to 30-Jun-2022

[15] Data as at 30 June 2022 and includes all people who received COVID-19 vaccinations between 1 July 2021 – 30 June 2022.

Further notes on the HSU dataset

While the health system uses the HSU to determine vaccination coverage within the eligible population, the HSU is not a total population estimate and it does not include people who do not use health services.

The HSU is an estimate of the number of people in New Zealand in a given 12-month period, based on information about who used health services in that period. The HSU 2020 was developed and used for the roll-out of the COVID-19 vaccine to calculate the proportion of the eligible population who were vaccinated against COVID-19.

While we use the HSU to determine vaccination coverage within the eligible population, the HSU is not a total population estimate and it is likely to miss highly marginalised groups.

For example, our 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 ethnicities.

There are other datasets that measure the number of people living in New Zealand produced by Stats NZ[16]:

1. Census counts produced every 5 years with a wide range of disaggregations
2. Population estimates (ERP) which include adjustments for people not counted by census:
   a. National population estimates (produced quarterly)
   b. Subnational population estimates (produced every year)
3. Population projections which give an indication of the future size and composition of the population:
   a. Official national and subnational projections
   b. Customised population projections (produced every year by Stats NZ for the Ministry of Health using requested ethnic groupings and DHB areas).

Differences between the HSU and Stats NZ population statistics arise because the population measures are:

- conceptually different – for example, the HSU includes people who may be visitors to New Zealand who used health services during their short stay, but are not in New Zealand long enough (for at least 12 months) for Stats NZ to define as a resident
- 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 response.

Stats NZ:

'The ERP and HSU have different target populations. In principle, the ERP is an estimate of the population usually living (resident) in New Zealand at a point in time, and the HSU is a measure of the population in New Zealand using (or potentially using) the health system at a point in time. For both the ERP and HSU, mean populations over a period of time can be derived from the point in time estimates.'[17]

While Stats NZ is the preferred source of New Zealand population statistics, the HSU is considered by the Ministry of Health to be the best option for estimates of vaccine coverage disclosed above.

The HSU allows for the assignment of the same demographics (location and ethnicity) to people in the numerator (the number of people vaccinated, from the CVIP database) as can be found in the denominator (the HSU dataset).

The HSU is available for every demographic contained in health data, including:

- age
- ethnicity
- DHB
- gender

These can be used separately or in combination. Other information such as neighbourhood deprivation, Statistical Area 2, or territorial local authority can also be added. It is also possible to generate flags for health-related information on the HSU (for example, those who are likely to have a long-term condition).

Comparison of HSU 2021 to the Stats NZ projected resident population

The differences between the HSU datasets and Stats NZ projections of the resident population (PRP), prepared for the Ministry of Health in 2021, are demonstrated in the New Zealand population by ethnicity tables, below, for both HSU 2021 and HSU 2020.

Comparison of HSU 2021 to the Stats NZ PRP for the DHB

As at 31 December 2021, there is an estimated 350,281 health service users in the HSU 2021. This is an increase of 15,036 people from the HSU 2020 (an approximate 4.4% increase), and 1,119 less people than the Stats NZ PRP for 30 June 2021. DHB population by ethnicity: HSU 2021 and Stats NZ PRP

[16] https://www.stats.govt.nz/methods/population-statistics-user-guide.
[17] More information on the findings from the Stats NZ review of the HSU is available at: stats.govt.nz/reports/review-of-health-service-user-population-methodology/
[18] HSU 2021 data is as at 31 December 2021 and Stats NZ PRP data is as at 30 June 2021

comparison[18]

Ethnicity	HSU 2021	Stats NZ PRP	Difference (Note 1)
Māori	33298	39000	5702
Pacific peoples	9043	8460	-583
Asian	25299	28300	3001
European/ other	280713	275600	-5113
Unknown	1928	0	-1928
Total (Note 1)	**350281**	**351400**	**1119**

Note 1: The total population estimate based on HSU 2021 (as at 31 December 2021) is 5,233,600. This is 111,000 above the Stats NZ total projected population of 5,122,600 (as at 30 June 2021) taken from the customised 2018-base population projections Stats NZ produced in 2021.

Comparison of HSU 2020 to the Stats NZ PRP

For reference, we have provided the HSU 2020 comparison

DHB population by ethnicity: HSU 2020 and Stats NZ PRP[19]

Ethnicity	HSU 2020	Stats NZ PRP	Difference
Māori	31764	37900	6136
Pacific peoples	8022	8240	218
Asian	20986	27700	6714
European/ other	273793	275500	1707
Unknown	680	0	-680
Total (Note 1)	**335245**	**349400**	**14155**

Note 1: The total population estimate based on HSU 2020 (as at 1 July 2020) is 5,000,500. This is 89,700 below the Stats NZ total projected population of 5,090,200 (at 30 June 2020) taken from the customised 2018-base population projections Stats NZ produced in 2021.

COVID-19 mortality rates

The data used to determine deaths attributed to COVID-19 comes from EpiSurv[20] and the National Contact Tracing Solution (NCTS) databases. The data received through these systems is extensively checked for duplications using national health index (NHI) data.

The definition of COVID-19 deaths that the Ministry now uses in most situations, including in this section, is defined as 'deaths attributed to COVID-19'.

'Deaths attributed to COVID-19' include deaths where COVID-19 was the underlying cause of death, or a contributory cause of death. This is based on Cause of Death Certificates which are coded by the Mortality Coding Team within the Ministry.

There can be delays processing the Cause of Death Certificates being updated in our systems. For example, where a paper-based death certificate is issued, the data will not be recorded as quickly as if it was submitted electronically.

Whether an individual's death is attributed to COVID-19 relies on a variety of sources. These include self-declaration, notifications via health records, or additional tests that are undertaken after death.

COVID-19 Deaths by age group

The following outlines the total number of deaths associated to COVID-19 in Southern DHB by age group at the time of death (as at 30 June 2022).

Age group (years)	
<10	0
10 to 19	0
20 to 29	0
30 to 39	0
40 to 49	0
50 to 59	4
60 to 69	7
70 to 79	15
80 to 89	37
90+	21
Total	**84**

COVID-19 deaths by ethnicity

The following outlines the total number of deaths associated to COVID-19 in Southern DHB by the ethnicity of the individual (as at 30 June 2022).

Ethnicity	
Asian	0
European/other	82
Māori	2
Pacific peoples	0
Unknown[21]	0
Total	**84**

[19] HSU 2020 data is as at 1 July 2020 and Stats NZ PRP data is as at 30 June 2020.
[20] EpiSurv is a secure national system used by Primary Health Units to report cases of notifiable diseases. It is operated by the Institute of Environmental Science and Research (ESR), on behalf of the Ministry of Health
[21] 'Unknown' refers to individuals where no ethnicity can be satisfactorily determined.

Reporting period reference table: Output Measures

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

Measure	Period value represents
Percentage of children fully immunised at age 8 months	Annual performance
Percentage of children fully immunised at age 2 years	Annual performance
Percentage of eligible boys and girls fully immunised with HPV vaccine	Annual performance
Percentage of people (≥65 years) having received a flu vaccination	2021 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[9]
Infants exclusively or fully breastfeeding at 3 months	Annual performance[10]
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 year olds enrolled in community oral health services	Annual performance[10]
Percentage of children caries-free at five years of age	Annual performance[10]
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
Ratio of repeat pharmacy prescriptions to new prescriptions dispensed in pharmacies	Year to Q3
Percentage of the population identified as 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 discharge from ED in under 6 hours	Annual performance
Number of people presenting at ED	Annual performance
Number of elective surgical service discharges	Annual performance
Percentage of elective and arranged surgery undertaken on a day cases 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[10]
Percentage of pregnant women registered with a Lead Maternity Carer in the first trimester	Annual performance[10]
Proportion of AT&R inpatients discharged to their own home rather than ARRC	Year to Q3[11]
Percentage of clients admitted to an ARRC facility from the community who have been assessed using a Home Care or Palliative Care Assessment in the six months before the ARRC facility admission date	Annual performance

Percentage of people ≥ 65 years receiving long term home support who have a Comprehensive Clinical Assessment & 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 workers who have completed at least Level 2 in the National Certificate in Community Support services (or equivalent)	Snapshot reported as at 30 June
People (65+) accessing the community-based falls prevention service	Annual Performance
Number of Rest Home Bed Days per capita of the population aged over 65 years	Annual Performance

[9] This measure is reported as Annual Performance to align with previously published reports

[10] Annual Performance for this measure is for the Calendar Year of 2021

[11] Due to the time of extraction, this data represents Year until Q3

Improving patient experiences and quality of care

Creating an Environment for Good Health

Creating conditions that support wellness is a core foundation of the health system in the Southern District. This effort is led by Public Health South (PHS) with the aim to improve, promote and protect the health and wellbeing of our populations and reduce inequities.

For the past year COVID-19 has been the main focus for PHS. This has meant many of the regular public health programmes of work were not able to be completed due to staff focusing on the COVID-19 response.

The PHS COVID-19 response began in July 2021 when fifteen cases of the Delta variant were detected aboard the cargo ship, The Mattina. An Emergency Operations Centre was stood up to manage cases, contacts, and logistics including organising food, transport, quarantine, and external housing for crew.

PHS had a public health team stationed at Queenstown International Airport as part of the Quarantine Free Travel arrangement until the end of July 2021. The team provided temperature testing and screening of all passengers to ensure that they met the requirements for entry into New Zealand.

In August 2021 the PHS COVID-19 response team became part of the national response to support the Auckland COVID-19 outbreak. The service provided a remote team working seven days a week undertaking case management and contact tracing for the Auckland response. To support Auckland, PHS sent multiple staff to the region. This provided additional capacity and enabled some of the key staff in Auckland to have a break. As the national outbreak progressed the PHS team began supporting Toi te Ora public health unit as their case numbers increased. This work transitioned into the local COVID-19 response when the first Southern cases of Omicron were confirmed in February 2022.

Desktop exercises were run with major event organisers such as Rhythm and Alps, to discuss possible scenarios if there were COVID-19 outbreaks at these major events. These were attended included attendance by emergency and medical services.

Over the last twelve months the COVID-19 response work priorities have changed as the pandemic has evolved. Work has shifted from individual contact tracing to outbreak management and identifying high-risk priority exposure events. The PHS team continues to respond to high-risk exposure events which are now predominantly in Aged Residential Care Facilities (ARC). The PHS team is working alongside the Southern DHB ARC team to effectively manage these.

The PHS Southern COVID-19 public health response also included extensive involvement in Care in the Community work and Supported Isolation and Quarantine (SIQ) for COVID-19 positive cases who were unable to safely isolate at home. This work involved wider health and welfare requests and required clinical staff to assist with decision making around whether people met the requirements for SIQ support. The PHS team had four dedicated staff for this extensive work.

The PHS team's COVID-19 response is ongoing. The team continue to work in partnership with WellSouth to distribute free masks and RATs to our vulnerable populations as well as community outreach activities and involvement in community events.

The PHS Health Emergency Response work has also included:

- COVID-19 Technical Advisory Group Te Whatu Ora Southern: Dr Susan Jack - chair, Dr Michael Butchard - deputy chair
- South Island COVID-19 TAG – Dr Susan Jack as Southern DHB representative
- PHS representatives on various COVID-19 response groups: Southern DHB Emergency Command Centre, Southern Integrated COVID-19 Care Safety and Quality Group, University of Otago COVID-19 response group, Community Care Hub Supported Isolation and Quarantine group
- Milford track norovirus outbreak response (Jan 2022) - this included transporting patients off the track and sourcing appropriate accommodation for them

The PHS team has also been involved in important wider health and community initiatives including

adopting a "Health in All Policies" (HiAP) approach. The HiAP approach strives to encourage all Southern organisations to apply a health lens to all decision making so that health and wellbeing are included and accounted for in all future policy decisions. The PHS team has focused on developing the capacity for this work and explore ways of working with other agencies that will maximise the ability of PHS to affect change.

Te Hau Toka Southern Lakes Wellbeing Group

Concerns regarding the psychosocial needs of the Central Lakes District community in the wake of the COVID-19 outbreak led to the formation of a multi-agency group, guided by the national Kia Kaha, Kia Māia, Kia Ora Aotearoa: called the COVID-19 Psychosocial and Mental Wellbeing Plan.

Initially known as the Central Lakes Wellbeing Recovery Group, Te Hau Toka members include health system organisations, Councils and several non-Government organisations that have a wellbeing focus. The group has partnered with agencies and networks to help coordinate an overall picture of ongoing needs including sharing wellbeing concerns, monitoring mental health service capacity, and working together on ways to improve wellbeing in communities.

Te Hau Toka Southern Lakes Wellbeing Group secured COVID-19 recovery funding from the Ministry of Business Innovation and Employment which was used to establish a wellbeing grants scheme. Te Hau Toka administrates this scheme and plans are in place to have the grants scheme effectiveness evaluated on the improvement of community wellbeing outcomes.

Measles and Monkeypox

The National Public Health Operations Group led by the Ministry of Health, supports the planning and response for emergent diseases such as Measles and Monkeypox. This group has been able to pivot resources from the COVID-19 response for use in preparing for other potential infectious disease outbreaks. National Standard Operating Procedures and a Surveillance Prevention and Response Framework supports this groups work. PHS team members sit on equity, technical advisory, and operational groups to ensure future responses are tailored for local needs, take a manaaki first approach, and provide expert clinical oversight.

Smokefree environments

In June 2022 the Government introduced a Smokefree Bill that amends the Smokefree Environments and Regulated Products Act 1990 and the Customs and Excise Act 2018. The aim of the Bill is to reduce retail availability, amend the age limits for sale of smoked tobacco products, and reduce the appeal and addictiveness of smoked tobacco products.

Health Promoters contacted key partners at councils across the Southern district, including Smokefree Otakau, a local network of organisations working together towards Smokefree 2025, to raise awareness of the Bill and provide information about the vaping remit that three northern councils presented at the Local Government New Zealand Conference. Councils are important partners in smokefree work and the PHS team values the relationships that have been developed with these organisations through collective work in the smokefree space.

Kia Haumaru te Kāika

Kia Haumaru te Kāika is a pilot project that aims to reduce child hospital readmissions for housing-attributable conditions such as warmth, draughts, and dampness though assessing the whānau home against healthy homes standards. The project builds on the warmer homes evidence created by Dr Phillipa Howden-Chapman and has been replicated in Healthy Homes initiatives running in several North Island health regions where there is a high prevalence of rheumatic fever.

Funding was obtained from community groups in Dunedin and Invercargill to roll out the pilot project to 50 participants. The pilot programme commenced in Dunedin in April 2021 with Invercargill joining the programme near the end of 2021.

Since inception there have been 48 referrals to the project that has generated 31 home performance assessments. Overall, the assessments have resulted in 20 homes having heating, insulation, draught and humidity issues addressed. Of the homes referred 22 (46%) are private rentals, 12 (25%) are social housing and 13 (27%) are privately owned.

Kia Haumaru te Kāika is in the process of being transitioned into the Healthy Homes Initiative which the Ministry of Health will be rolling out nationally from 1 January 2023. Aukaha has been selected as the preferred provider for the Southern component of the Healthy Homes Initiative. The Kia Haumaru te Kāika programme is in the process of being evaluated. We expect the findings of the evaluation will be used to inform the planning of the rollout of the Southern component of the Healthy Homes Initiative.

As the Healthy Homes Initiative does not include funding of the interventions needed to render homes warm and healthy, Aukaha will work with community funders and other programmes to provide this component of the service. Given that roughly only 50% of the community funding obtained for Kia Haumaru te Kāika has been used to date, we have negotiated with those funders to transfer the unspent funds to the Southern component of the Healthy Homes Initiative when this programme begins.

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-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 highlights the importance of more flexible, digitally-enabled ways of working, such as using electronic communications for consultations.

Southern Health Care Home programme

It has been a somewhat different year during 2021/2022, with delivery of COVID-19 care in the community dominating many of WellSouth's customary practices and care programmes. Providing an opportunity for practices to go on hold for a few months during the peak of COVID-19 was utilised by many. Changes in practice ownership in the region has caused a re-set for a few practices within the HCH programme.

There are 32 GP practices who have completed, or are completing the HCH Enhanced Model of care, or the HCH Building Blocks Model of care. The total number of enrolled patients who have access to at least parts of the HCH model of care is now 204,591 (*175,000), or 63.8% (*56%) of total patients in the region. This includes 19,894 Māori or 63.8% (*56%) and 5540 Pasifika or 73.6% (*65%).

*Spanning 2019-2021 year in brackets.

A highlight of the year was supporting Gore Medical Centre (GMC) to become the first practice in the region to achieve external HCH credentialing from Collaborative Aotearoa, the national organisation that supports the Health Care Home model throughout the country. The credentialing is the culmination of more than four years of work and includes initiatives that help improve patient access to care and experience of care, support workforce sustainability, and promote quality improvements within the practice. Prioritising equity in all programmes of work – a New Zealand-specific criteria – is another feature introduced since Gore Medical Centre and three other practices in Southern started the programme in 2018. A consistent commitment to making progress has helped Gore Medical Centre to be the first to reach the HCH milestone. They have a history of being innovative, whether in response to securing workforce or embracing innovative technology, and it has helped them to reorientate themselves to ongoing changes. They continue in their work for the benefit of the community. The WellSouth HCH team is available to support any practice that has completed the HCH programme to also apply for this credentialing.

The results of some of the changes GMC has implemented, are best expressed by a patient. Here's what Kirsty has to say about being a patient at GMC:

On GP/clinical Triage:

"The big benefit of GP triage means you talk to a doctor on the day, and they can assess the urgency of your need. I have the reassurance that I can get treated on the same day if needed rather than the stress of my previous experiences of having to wait and my condition or pain potentially getting worse."

On patient Portal:

"I find the portal helpful for repeat prescriptions. It's also good to be able to see my lab results. It is stressful trying to remember everything the doctor says to me in an appointment so being able to see my notes afterwards is very helpful."

We continue to track various data, such as secondary care acute admissions, CLIC – including Care Planning data, Clinical (GP/NP) triage, and supporting practices to build equity measures into their plans and quality improvement.

Client Led Integrated Care data:

- HCH practices have completed a total of 7633 CHAs (Comprehensive Health Assessment), or 66% of the total CHAs completed.
- Of these 65% have one or more Care Plans (compared to 53% for non HCH practices) with 59% of Maori and 62% of Pasifika people having one or more care plans completed.
- 29% of level 3 patients have had an MDT, however 34% of Maori level 3 patients and 32% Pasifika have had an MDT.

Clinical Triage (GP/NP) data:

- 37,442 triage calls were recorded via WellSouth portal, involving 23,749 patients
- 13,509 calls were resolved, approx. 36% of all calls with Maori (35%) and Pasifika (33%).
- Of the top 20 users of Triage, 19 are HCH practices.

While there are no more new practices able to join the programme due to contract timeframes, the HCH facilitators are using HCH learnings and tools to support the Practice Relationship Managers in the roll out of the Practice Development Plans and Quality Improvement initiative.

The HCH team recently attended the Collaborative Aotearoa Symposium, where some of the focus was on the importance of listening to "Lived Experience Advisors". The HCH model supports co-design/ patient engagement with patients. Understanding how best to hear from patients in our practices, will support design of services and sustainability of practices that are responsive to patients' needs.

Health Care Home practices as of 30 June 2022:

3 Year HCH Programme:
Amity Medical
Aspiring Medical
Broadway Medical Centre
Clutha Health First
Gore Health Centre
Gore Medical Centre (Credentialed with Collaborative Aotearoa)
Health Central (Alexandra)
Invercargill Medical
Junction Health (Cromwell)
Mornington Health
North End (Oamaru)
Queenstown Medical
Te Kāika
Wanaka Medical

2 Year Building Blocks HCH Programme:
Alex Family
Aurora Health
Catherine St Medical
Central Medical (Oamaru)
Dunedin Health
Dunedin North Medical
Dunedin South Medical
Fiordland Medical
Gaius (Year 1, Plan pending)
He Puna Waiora Wellness Centre
Maori Hill
Mosgiel Health
Murihiku
Oamaru Drs (Year 1, Plan pending)
Queens Park
South City Medical (Paused)
Te Hau o Te Ora/Mataura Medical
Winton Medical Services

Southern Health Pathways

At the end of the 2021/22 year 773 Pathways are now live in Southern. The average number of sessions per month across the financial year was 10,363 per month, while an average of 5,151 user sessions per month since the launch over eight years ago. This demonstrates an increasing user engagement of Southern HealthPathways.

The HealthPathways team continues to localise, review and consolidate pathways. A significant proportion of HealthPathways work for the year was around engagement and leading national pieces including COVID-19, diabetes, Monkeypox, sexual health and equity projects.

Work continues in strengthening connections with the following groups:

- WellSouth Primary Health Network and GP liaison roles in education, radiology (high spec imaging) and fracture liaison service.
- Secondary care: particularly around service-model changes with Medical Director Primary and community – e.g. telehealth, development of long COVID-19 clinics.
- Strategy and primary clinical projects, e.g. frailty.

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

The Tō Tātou Pūkete team worked with multiple stakeholders including the University of Otago, WellSouth Primary Health Network, Māori Health Directorate, Rūnaka, Community Health Council and others to bring this project to fruition. Tō Tātou Pūkete aligns with He Korowai Oranga – New Zealand's Māori Health Strategy, and honours Māori as tangata whenua.

The new website, captures and explores data of Southern Health's communities and whanau. There is a focus on four key areas: Demography - Who lives in Southern?; Health Drivers – What keeps us healthy?; Health Status – How well are we?; and Health Services – Where and how do we get healthcare?

Tō Tātou Pūkete moves away from the traditional method of publishing public health data and provides easy access to important health information for a wide audience. The datasets enhance planning not only for the health service, but for the wider community – councils, non-government organisations, and primary care.

Members of the public are also invited to explore Tō Tātou Pūkete to increase their awareness of what is happening in health in their region and to equip communities to identify and develop new health related initiatives.

Tō Tātou Pūkete is a big part of the Southern DHB's support for New Zealand's digital transformation, health reforms, and transition to Te Whatu Ora Health New Zealand.

The datasets look at a wide range of information from characteristics of a population (e.g. numbers of people, births and deaths) to specific questions like rates of breastfeeding, smoking and bowel screening.

Primary maternity

Work continues across the Southern district to improve the experience and quality of care for pregnant people and their whānau. This has included increasing closer-to-home services, communication of birthing options, improving facility design to support patient care, and mapping service gaps.

A key focus in 2021/22 was Child and Maternal Hubs and telehealth services being established as routine services in their communities. This happened successfully and will free up resource to start the next phase of bridging gaps into integrated rural Primary Maternity care.

As part of the Quality Improvement programme work commenced across the whole maternity service on informing pregnant people of their birthing options. This includes base hospitals, primary birthing units, and home birth. Communication is anticipated to be via written and visual media.

The business case for two new Primary Birthing Units, one in Clyde and the other in Wanaka, was approved by the Ministry of Health on 1 December 2021. This was followed by a tender for Architectural providers which closed at the end of January 2022. It is expected that the detailed designs will be finalised towards the end of 2022. In early 2022, a residential house was purchased to house the new Wanaka Birthing Unit. Some minor alterations are required for the house to be fit for purpose and it is expected to open in early 2023. The Clyde Birthing Unit is expected to open in 2024.

These facilities will provide both inpatient and outpatient space, enabling closer to home care for pregnant people within the Central Otago region. Providing the service associated with these facilities will improve patient experience and offer closer to home pregnancy care.

Te Kāika Wellbeing Hub

The development of the Te Kāika Wellbeing Hub is the first of a number of health hubs to be developed across the Southern district.

In 2021-22, the development progressed with resource consent. A developed design of the facility will deliver health and social services via the three partners – Te Whatu Ora, Te Kāika Primary Care, and Ministry of Social Development (MSD).

The construction phase has commenced and service co-design is being led by Te Kāika. The end goal will be the development an innovative model of care centred on the needs for Māori, Pasifika and all consumers in the South Dunedin area.

With a projected opening date in April 2024, Southern will be working closely alongside these organisations to develop a model of care that fits the needs of the local people and is digitally enabled, supporting new ways of working for the Te Whatu Ora, MSD and Te Kāika.

The key aims for the Te Kāika Wellbeing Hub is to provide a "one stop shop" for local communities, ensuring that healthcare and social support is highly accessible and appropriate. This is an exciting development with the potential to significantly

transform the delivery of health care for our communities. The key focus is on addressing the social determinants which have disadvantaged whānau in our community across generations.

Mental health and addictions

The Southern Primary and Community Care Strategy and Raise Hope – Hāpai te Tūmanako 2019-2023 endorsed in 2021, painted a clear direction for Southern's 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. Work to support the implementation of the recommendations has commenced.

The one-year programme Time for Change is six months in and continues to make practical changes to transition Southern's current mental health and addictions system to a new future as told to us by our communities and tangata whaiora (those seeking wellbeing). The direction is set for Southern's mental health and addiction services to work within communities, to help people develop their own capability to live well, and to deliver services in culturally responsive ways to meet the needs and priorities of local communities. The projects being worked on aim to improve access to quality care for all and range from supporting 'by Māori for Māori' investment in mental health and addiction services, increasing local crisis support options and expanding AOD (alcohol and other drug services), to developing peer-led wellbeing services. Many of the projects include a collaborative design process to ensure there is cross-sector support and that appropriate community solutions can be developed closer to home, based on the needs of people with lived experience and whānau.

Two fundamental and necessary components have been embedded for the delivery of the programme's goals: the voice of persons with lived experience of mental distress, and role modelling pro-equity action, meaningful partnerships, behaviours and thinking. The Pou-Tātaki - Project Manager & Māori Equity Lead and the Project Manager with Lived Experience provide guidance and expert advice across all projects, in addition to leading Te Hurihanga projects on "By Maori for Maori investment framework" and "Peer-support workforce" and "Peer support wellbeing services".

The voice of those with lived experience in mental distress is important in all aspects of the Te Hurihanga programme from the co-design of what the community says is needed, through to the commissioning of the best provider.

There are a variety of ways that the Programme actively seeks and listens to the voice of those with lived experience including membership on advisory groups of persons who have identified as having lived experience (for example on Southern's Cross Sector Advisory Group), contracting with persons with lived experience for specific pieces of work within a project (for example, Southern's peer support workforce survey, and participation in the evaluation panel for assessment of proposals for alcohol and drug services), and inviting those with lived experience to workshops as part of collaborative design (for example, alcohol and drug co-design forums in Dunedin and Oamaru that were facilitated by persons with lived experience, for persons and whanau with lived experience of mental distress)

The influence of Te Hurihanga to Maori health inequities is by: the strategic development and implementation of an Investment Framework for Māori by Māori, and using the resources and mandate of Time for Change - Te Hurihanga to role model equity and challenge inequity within the Te Hurihanga – Time for Change programme of work. The role of the Pou Tātaki is necessary for this work, the Te Hurihanga programme approach is not a quick fix, but a shift to role model pro-equity action and to ensure meaningful partnerships, behaviours and thinking within the Te Hurihanga – Time for Change team and initiatives.

This year has seen the continued implementation of He Arā 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 18.7 FTE Health Improvement Practitioners and 26 FTE Health Coaches/Community Support Workers in 35 General Practices across the Southern region. This new service complements existing services rather than replacing them.

Our expectation is that this service will continue to evolve over time and feedback received indicating the service is well received by service users.

In 2021 Southern continued the expansion to better access and choice for primary mental health and addiction services under the Wellbeing Budget 2019. Mental health and addiction support funded through the expanding Access and Choice initiative included targeted funding for youth-focused services (ages 12-24 years) who are experiencing mild to moderate distress. The resulting service, Thrive Te Pae Ora is delivered by Adventure Development in the Southern Region. The Thrive Te Pae Ora service continues to exceed expectations despite disruptions within the wider health sector due to COVID-19. The number of individual sessions (218) and number of people seen (129) in June 2022 was the highest recorded this financial year.

This year has seen the implementation of a community alcohol and other drug managed withdrawal service provided by Ngā Kete Matauranga Pounamu Charitable Trust. This covers the Southland region with plans to extend this service to Central Otago in 2023. This service offers a tailored managed withdrawal programme with home-based detox which is co-ordinated by nurses who support clients on their journey to improved health, recovery, and wellness.

A five-bed home to expand Dunedin's capacity for emergency mental health respite services has recently been commissioned. This service will open in September 2022, providing a 24-hour in-home support in a residential environment less than 10 minutes from Dunedin Hospital for adults experiencing acute mental distress. A procurement process has also recently been completed for the establishment of an AOD support service in Dunedin for people needing assessment, treatment, and support for moderate to severe issues with alcohol and other drugs in a community-based setting. This service is expected to be operational in late 2022.

Clinical service redesign

Providing care that values our patients' time and helps improve the flow of patients through our health system, improving outcomes, improving quality and reducing harm has been the focus of several initiatives over the past year.

The 2021/22 year has presented many challenges to our teams with managing the COVID-19 planning and the response following the COVID-19 outbreak. The pressure on our health system and on our hospitals has been significant as patients with high acuity and complex needs have been managed alongside concurrent workforce issues. Staff have worked tirelessly to manage the increasing demands on health services with associated vacancies and COVID-19 related absenteeism.

Our Clinical Governance Framework continues to be strengthened within our teams to promote greater accountability at the right levels within the organisation. This is another means for clinicians, managers and other staff to have a pathway to work together to improve patient safety.

A greater focus has been placed on system flow with the creation of roles to better coordinate resources within the hospital as well as transfers between the hospitals. This is part of a programme of work building towards an Integrated Operations Centre.

With the new Dunedin Hospital we are working towards a future system that can deliver better, more consistent and more equitable care. Changes in the way we deliver services such as a shift to a Generalist vs Specialist admitting model to better support the frail elderly and those with complex medical needs in Dunedin Hospital will support this change. Increasing integration of services with primary care and greater use of digital technology to share information will enable care closer to home, and more self-management of healthcare.

Telehealth will be an integral part of the future health system and has been well tested through the COVID-19 pandemic with many services shifting to a virtual approach successfully. Sustaining and building on this approach will be critical to effectively manage the increasing demands on the health service as well as the challenges of rurality.

We have focussed on embedding solutions that move the system towards more equitable outcomes for Māori with learnings from COVID-19 and the COVID-19 Vaccination programme.

Quality Account

The staff of Southern strive to deliver the highest quality of care to the patients and whānau who use our services on a daily basis. Our key goal in improving the quality of patient care and experience is to make sure people leave our services without unintended consequences.

Quality and safety markers

The Health Quality Safety Commission (HQSC) has designated a set of indicators around quality and safety markers that allow us to focus on reducing specific areas of harm. Using these indicators, we can capture what we are doing well and where we can offer better care to our patients and their whānau. As the markers are used by all DHB's across New Zealand, these provides us with the knowledge of how we are performing compared to other districts.

Falls

What good looks like: Southern monitors the harm from patient falls that occur in our facilities aligning with the HQSC. In particular, we monitor falls that result in the patient having a fractured neck of femur (hip).

How did we do: In the 21/22 year, Southern had an average of 7 falls in every 100,000 admissions resulting in a hip fracture. This is well below the national average of 9.7.

The patient safety and quality improvement teams have been focusing on reducing falls by working closely with staff on the wards.Staff now have the support to complete the necessary assessments and patients will be provided with up-to-date information on how they can avoid falls whilst in our care.

Pressure injury

What good looks like: Pressure areas, areas of skin that are at risk or have developed a wound due to frailty, are monitored for assessment and plans are recorded in the patient's notes. We also carefully measure the number of pressure areas.

How did we do: In the first two quarters assessments were completed for over 82% of patients. Due to the pressures that COVID-19 had on our staff, the number of assessments documented in the last two quarters were reduced. However, we were effective at catching pressure areas early in their development before harm could be caused. Because of this we were at or below the national average in relation to the comparison statistics for more serious pressure areas.

Significant work has been completed in these areas to educate staff on what to look for and how to work with patients to ensure they are keeping safe. This includes explaining to patients about the importance of wearing the right footwear.

Hand Hygiene

What good looks like: The HQSC expects 80% compliance, and the national average is 87%.

How did we do: Southern achieved 85% in the 21/22 year. The "5 Moments of Hand Hygiene" are internationally recognised as an essential way to prevent the spread of infection by health care workers amongst patients and is a process we emphasise with our staff. During the COVID-19 outbreak from February – June 2022, we were unable to collect hand hygiene information. Hand hygiene monitoring has since restarted.

SSI - Orthopaedic

What good looks like: We would want to see Southern have a rate of orthopaedic surgical site infections sitting below the national average.

How did we do: At the start of the year, Southern was slightly above the national average but this has since improved over the year.

From July 2021 Southern moved to light surveillance. This means that we no longer collect information on the timing of antibiotic delivery and skin preparation for joint replacement cases.

SSI - Cardiac

What good looks like: The HQSC expects the correct dose of antibiotics given up to 1 hour before surgery, with skin preparation used every time.

How did we do: Southern achieved timeliness 88% of the time, correct antibiotic 97% of the time and correct skin preparation 97% of the time.

Deteriorating patient

What good looks like: The HQSC has set a target for patients to have their early warning score of vital signs calculated at 90%. The target percentage of patients who have their condition escalated appropriately.

How did we do: Southern achieved 92% consistently and correctly calculated across the year but our audits show our escalation does not always occur in the desired timeframes.

The Recognition and Response Committee meets regularly to examine barriers and opportunities in this important area of patient care.

Risk process

Clinical risk management within the Southern District has developed at a rapid pace. Clinical risks have been discussed with the operational teams and risk registers have been reviewed and updated by the operational management.

We have implemented the use of a electronic record management system, Safety1st. Having our risk within an electric system allows risks to be managed in real time by all services.

In addition, we use Safety1st to communicate risks efficiently and effectively throughout the organisation ensuring openness and transparency on how we are managing and mitigating risks.

Risk management training for all staff has been ongoing throughout the year and the benefits are starting to show. The future focus for 2022-23 is on maintaining this momentum and increasing engagement throughout the organisation.

Patient tracer audits – certification

Southern gained certification in November 2021 with a lowering of corrective actions overall. We had a number of corrective actions which have now been addressed. Due to COVID-19 risk the auditing process was developed into a digital platform for the first time. This meant that 97 people were able to attend the wrap up meeting. Patient tracer audits were used for the first time.

Documentation

Southern has changed its former document library, previously called MIDAS, to a more modern SharePoint site now called Southern Documents (Ka Tuhika Ki Te Toka). The new system is more accessible for staff meaning our policies and procedures are more easily accessible for staff.

A special COVDI-19 policy group was formed to ensure any documentation needed in relation to COVID-19 was accurate, rapid and assisted the Emergency Coordination Centre.

Clinical governance

A focus of the year has been the journey to reinvigorate the clinical governance structure of Southern. Clinical governance is about making sure our systems, processes and people have the best opportunities to deliver the highest level of care to our patients. We have refreshed our policies and the Clinical Council has been meeting regularly to discuss any issues. This has resulted in the Clinical Council sub-committees receiving more support when needed.

Adverse events

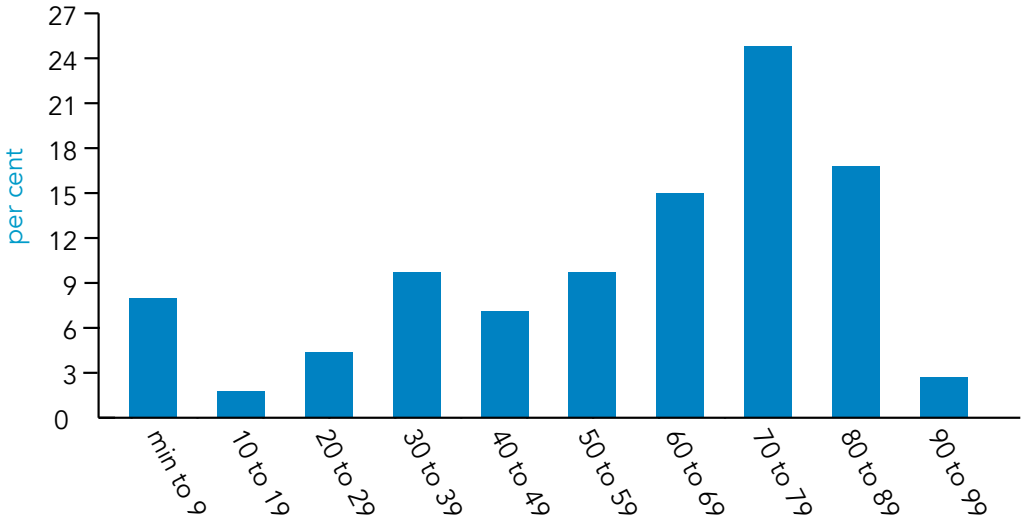
During this year there were 113 serious adverse or always report and review events at Southern. The average patient represented by these events is a female of European decent aged 70+.

Falls followed by provision of care and skin and tissue were the top events recorded. The number of non-Europeans with serious adverse events and always report and reviews are much lower than expected based on the population of Southern.

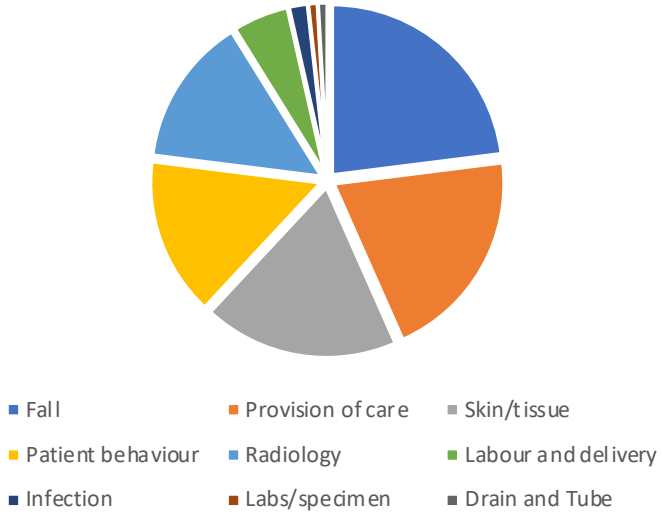
Our adverse events are managed in our regional Safety1st database which we share across the South Island. The number of adverse events and always report and reviews remain similar to previous years.

Each of the events recorded are reviewed by a clinical team and recommendations are made to help improve our systems which result in the delivery of safer and better care to our patients and whanau.

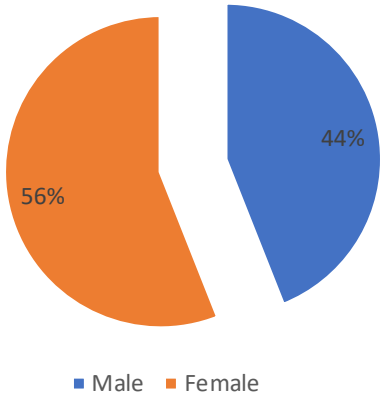
SAE SAC 1, 2 and ARR by age grouping (actualised date is within fiscal 2021/2022)



Serious adverse events and always report and review by event type



Serious adverse and always report and review events 2021/22 by gender



Enabling success: Organisational resilience and sustainability

Enabling Our People

Good Employer Obligations Report

At Southern we strive to provide the best care for everyone. We believe that a healthy and engaged workforce delivers excellent care. We are committed to meeting our statutory, legal and ethical obligations to be a good employer as an Equal Employment Opportunities (EEO) employer.

We are committed to fostering a positive culture and living our values every day. We acknowledge that our healthcare system faces many challenges and that our people work hard to ensure better health outcomes for all despite the challenges. We acknowledge that the year has again been dominated by the COVID-19 pandemic adding further strain on a stretched workforce and that taking care of our people remains a top priority.

Our commitment as a Good Employer is supported by our human resources policy and People Strategy that encompasses the requirements for fair and proper treatment of employees in all areas of their employment. We have actively focused on removing barriers to equal employment opportunities by reviewing our recruitment policy and barriers which prevent applicants from diverse backgrounds from being successful in their applications for employment with Southern. We have invested significantly in improving our staff's use and adoption of Te Reo Māori in communication and have appointed a Māori Workforce Development Specialist to support strategies that focus on the development of our Māori workforce teams.

At Southern we aim 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 as well as our Effective Working Relationships policy for all employees and those who are involved in the operation of Southern.

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

Southern 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, Mata Cherrington who succeeded Gilbert Taurua, who sits on the Executive Leadership Team.

Enabling People and Capability

People strategy

Our main focus areas have been on Talent Management, Leadership Development, Diversity and Inclusion, Culture and Engagement, and Capability Development to support creating a sustainable and contemporary workforce and improving workplace culture.

This includes embedding our organisational culture work through Southern Health and Valuing Patients' Time, and implemented tailored leadership initiatives to build capability, accountability and trust.

We also introduced our new recruitment and onboarding platform 'SuccessFactors' which supports our efforts in attracting and retaining the best talent for Southern and values the time of our managers and staff.

Strengthening our culture

Staff Pulse Surveys

We made an ongoing commitment to ensuring our workplace is safe and supportive, as we continue our journey towards Better Health, Better Lives, Whānau Ora.

One of the many ways we engage with our staff is through the Staff Pulse Surveys, particularly in relation to wellbeing. This included developing ways to capture ideas and feedback and to respond quickly to address any concerns. Our Aukaha Kia Kaha Committee ensured that we had the appropriate governance in place for supporting and coordinating wellbeing initiatives as a result of staff survey responses. This also included the sponsorship of a staff wellbeing app called Chnnl which is being piloted in our Emergency Department and Intensive Care Unit.

Southern Excellence Awards

Southern called for nominations in 2021 to celebrate its remarkable staff from across the district. Unfortunately due to COVID-19 in the community and ongoing seasonal pressures, the difficult decision was made not to host an awards evening.

Over 90 nominations were received for teams and individuals to celebrate the dedication and exceptional work being done across the Southern Health system.

Nominees come from across our diverse teams and include leaders, clinical and allied heath staff, and non-clinical support staff.

The Awards acknowledge staff and the very important roles they play in providing care and support across Southern.

The awards categories include Behind the Scenes (Unsung Hero) Award, Excellence in Health and Safety Award, the Graham Crombie Outstanding Leadership Award, Māori Health Development Award, Outstanding Care and Contribution Award, Rising Star Award, Southern Health Values Champion Award, Southern Innovation Challenge Award and Team of the Year Award.

All nominees were acknowledged, and further recognition programs and initiatives will be reviewed in line with wider Te Whatu Ora strategy in this regard.

Living our values

Southern DHB wellbeing programme rolled out

Our Aukaha Kia Kaha Committee aims to work together with staff to strengthen ties across the health care system by supporting the wellbeing of all our staff and service providers. This committee supports our Workwell accredited programme pulling together current and future wellbeing initiatives, and acts as a hub for new wellbeing ideas with a specific focus on key health areas including mental health, physical activity and eating healthier food. Highlights this year included individual wellbeing care packages for all staff, e-bike giveaways, walking groups, gym member discounts and staff yoga and mindfulness sessions.

Our values

Our 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. An emerging focus has been on diversity and inclusion We have held several workshops in support of Gender and Sexual Diversity for all staff. We have also held a successful pilot within Allied Health for pro-equity recruitment processes that support Māori. This programme is now being rolled out across the entire health care system. We have also introduced Te Ao Māori for Professionals with Southern DHB being awarded an Engagement and Participation Award by the training provider, Education Perfect in ealry 2022.

EEO

Our Equal Employment Opportunities Policy is currently under review and expected to be released as a national document from Te Whatu Ora Health New Zealand in the next six months.

Leadership, accountability and culture

We have continued our investment in leadership development by revising our Leadership Exploration and Development Programme (LEADS) with greater emphasis placed on leading through times of uncertainty. We now run three NZVQ accredited leadership courses which includes Introduction to Team Leadership, First Line Manager and Facilitation skills. We have developed an emerging

leader's programme within nursing by using talent management tools that highlight sustained performance and high potential. We have introduced strengths-based team tools for workshops that focus on leading teams and optimising individual contributions within each team. We have introduced team culture workshops using contemporary tools that seek to improve the emotional culture of a team, building upon previous workshops which focused solely on the cognitive aspects (i.e the understanding of what makes for a positive culture).

The launch of the Southern Disability Strategy and Working Group marked an ongoing commitment by the DHB to removing barriers to healthcare for disabled people and providing equitable health and disability services. We have developed monthly Disability Awareness Workshops for staff (Accessibility Game) and enhanced our support to all staff via e-learning modules.

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 and offer guidance, mentoring and professional development.

The 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 the wider Learning and Development Framework and our Essential Corporate Training for Managers programme.

Our Orientation process for onboarding new staff members has run virtually this year, but has retained a warm welcome with a Mihi, meet and greet with members of the Executive, Senior Leadership and employee's line manager. This is followed by a presentation by the CEO. A revised onboarding process has meant that inductions is now a more streamlined process with technology being an enabler including quicker access to network access and online learning modules.

Employee development, promotion and exit

Systematic performance and development review processes have been developed for several workforce groups including corporate, nursing and allied health. Essential Corporate Training sessions for people managers have been held throughout the year including coaching effective performance, how to have difficult conversations, managing performance review processes and how to effectively use SuccessFactors (recruitment system for people managers).

To further support mental wellbeing at work, Psychological First Aid, 5 Ways to Wellbeing and Change Cycle workshops and access to a comprehensive wellbeing toolkit and a newly developed wellbeing SharePoint site are available to all staff.

We actively monitor the reasons for employee exit (capturing both internal transfers and external moves) to understand and identify risk areas which can be proactively managed.

Remuneration, recognition and conditions

A market-based job evaluation process is in place for all staff on Independent Employee Agreements (IEA) 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. As a Crown Entity, Southern has complied with the Public Sector Commission's directives in the past year in relation to pay restraint following the impact of COVID-19 on the wider community.

Progress has also been made in relation to pay equity claims for previously female dominated roles which were undervalued in comparison to male dominated roles. Pay equity claims will be worked through in the next financial year.

Harassment and bullying prevention programme

We have refreshed our 'Speak Up' campaign and have developed Speak Up Guides (volunteer staff), Speak Up e-learning resources, and implemented restorative practice workshops such as supporting accreditation for internal facilitators. We have developed a Speak Up SharePoint site which is easily accessible to all staff. This includes resources, tools and points of contact for support. Speak Up Workshops continue to run across the Southern system as we focus on improving our organisational capacity and capability to support a culture where staff feel comfortable, supported and safe to highlight concerns and resolve issues at the earliest opportunity.

Safe and healthy environment for all workers, and other persons

Southern DHB recognises that its staff are the most important resource. All prospective employees, including current staff transferring positions, must complete a pre-employment health declaration. A dedicated Occupational Health and Safety team are proactively ensuring we meet our obligations under the Health and Safety at Work Act (2015), Regulations, and underlying policies and processes. This includes;

- Worker engagement participation and representation of over 150 Health and safety representatives in place across the Southern district
- Occupational health and safety hazards and risks are identified, controlled, monitored and reviewed and to ensure the efficacy of current controls and potential improvement opportunities
- Safety1st incident reporting has been further developed through regional consultation Primary

accreditation and an active ACC partnership programme is in place

- Health, Safety and Welfare Governance structure is in place with the district executive leadership team in attendance to review monthly reporting and ensure compliance with relevant legislation
- A 24/7 employee assistance programme is available to all staff for both personal counselling and critical incident debriefing. Extension approvals are granted to family members where an associated need has been identified
- Return to work rehabilitation has been successful in facilitating safe and sustainable return to work.

EMPLOYEE REMUNERATION

There were 1,661 employees who received remuneration and other benefits of $100,000 or more for the year ending 30 June 2022 (2021: 1206)

Remuneration Bands $000	Number of Employees	
	2022	2021
100 - 110	376	284
110 - 120	313	190
120 - 130	239	129
130 - 140	127	82
140 - 150	100	60
150 - 160	71	50
160 - 170	43	37
170 - 180	38	26
180 - 190	30	25
190 - 200	24	17
200 - 210	22	15
210 - 220	11	18
220 - 230	14	19
230 - 240	14	17
240 - 250	16	14
250 - 260	21	16
260 - 270	15	21
270 - 280	10	13
280 - 290	10	12
290 - 300	17	14
300 - 310	14	9
310 - 320	23	11
320 - 330	15	15
330 - 340	7	14
340 - 350	13	9
350 - 360	12	10
360 - 370	10	9
370 - 380	8	9
380 - 390	2	5
390 - 400	5	10
400 - 410	8	1
410 - 420	2	9
420 - 430	8	5
430 - 440	3	2
440 - 450	2	1
450 - 460	2	1

460 - 470	5	2
470 - 480	2	5
480 - 490	-	-
490 - 500	-	4
500 - 510	-	3
510 - 520	-	2
520 - 530	2	1
530 - 540	1	3
540 - 550	1	1
550 - 560	-	-
560 - 570	-	1
570 - 580	2	2
580 - 590	-	1
590 - 600	-	1
600 - 610	2	1
610-620	-	-
620-630	-	-
630-640	-	-
640-650	-	-
650-660	1	-
	1,661	**1,206**

Each year, as required by the Crown Entities Act 2004, our annual report shows numbers of employees receiving total remuneration over $100,000 per year, in bands of $10,000.

Of the 1,661 employees in this category, 1,378 were regulated health professionals (2021: 1,206 employees, of which 933 were regulated health professionals).

The Chief Executive's remuneration and other benefits either paid or accrued, are in the band 650-660.

COMMITTEE MEMBERS

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

	2020 Actual $000	2021 Actual $000
Hospital Advisory Committee		
Odele Stehlin	-	1
Total remuneration	**-**	**1**
Iwi Governance Committee		
Taare Hikurangi Bradshaw	2	1
Ann Margaret Johnstone	1	-
Justine Camp	2	1
Ann Wakefield	-	1
Donna Matahaere-Atariki	1	1
Odele Stehlin	2	2
Total remuneration	**8**	**6**

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

Systems For Success

Digital transformation

The digital business case proposes an investment in digital solutions and digital infrastructure. In preparation the New Dunedin Hospital project. our proposed investment in digital solutions will benefit the entire Southern health system and will lead to better sharing of clinical information and improvements in how care is provided.

Modern digital solutions provide us with opportunities to improve how care is delivered to those who need it the most, including those who live rurally. To honour our Te Tiriti obligations and by working in partnership we will co-design solutions which work for Māori, on the basis that if solutions are designed to work for Māori, then they will work for us all.

Implementation of the preferred investment option will deliver:

1. The full digital infrastructure for NDH. In addition, a targeted uplift of digital infrastructure and equipment at non-NDH facilities would also be delivered (e.g. installation of kiosks and outpatient flow solutions)

2. Digital solutions across the Southern health system. This includes the NDH, Southland and Lakes District hospitals and the rural trust hospitals where appropriate. Any investment in digital solutions will also consider interactions with primary and community services and Non-Government Organisations (NGO), e.g. making information accessible through interoperability and putting in place a collaboration platform open to non-hospital clinicians.

The minimal option will deliver the digital infrastructure required for the new Dunedin buildings and develop existing solutions to work with the new buildings whilst a future case is considered for transforming solutions in a national context.

The strategic context has changed

Since the Indicative Business Case (IBC) was completed in April 2021. the Government confirmed the details of the health system reforms. In the future health system, consumers will have a better balance of national consistency for hospital and specialist services, and local tailoring of primary and community care. This will improve care quality and equity while ensuring that services that are locally accessible reflect the needs and preferences of local communities.

The NDH will be part of a national digitally connected network of hospitals owned by Health New Zealand (HNZ) and co-commissioned with the Māori Health Authority (MHA). It will also be integrated into multiple population health and wellbeing networks that will deliver holistic, integrated, digitally enabled primary and community care services. By doing so, SDHB will be a key enabler of the Reform objective to deliver more equitable health services through digital solutions.

The Southern Digital Programme has identified the system reforms as an opportunity to improve connections and ensure alignment with the rest of the health system, thereby reducing design and delivery risk. In response, the approach of the design team has been to proactively connect with the Transition Unit to understand and discuss the future from a HNZ and MHA perspective.

The programme is aligned to national strategies including Hira. The approach to design and procurement aims to be as adaptable as possible. Digital solutions are being designed in a way that can be applied to other hospitals and community settings nationally.

A stronger focus on equity

The future health system will have an even greater focus on equity and, in particular, equity for Māori. Implementation of digital solutions provides us with the opportunity to improve equity outcomes for the Southern population and to progress our obligations under Te Tiriti o Waitangi. The creation of the MHA presents a new opportunity to ensure equity for Māori is at the forefront of digital design.

We will also seek to establish a strong partnership with the MHA to ensure that Māori voices are embedded in planning and design. The MHA will partner with HNZ to ensure design and priorities reflect the diverse needs of the community, including for Māori. This requires us to partner and co-construct digital solutions from the outset. A key task in the digital

transformation project is understanding the issues, barriers and priorities for consumers and people who will be working and engaging in the region's health and disability system. A central theme is, 'what works for Māori will work for all'. The partnership process will be iwi-led but is expected to include multiple hui and focused engagement with the region's rūnanga and rūnaka.

Engagement to date has identified initial examples of how digital can contribute to our equity goals by improving health literacy, improving access to health services (particularly in rural settings), reducing variation in healthcare, and using data insights to support equitable representation in systems and services.

Achieving the above in turn leads to sizeable system benefits being delivered – we will enable productive and efficient hospitals, we will deliver an improved experience for consumers and reduce patient harm. We will also improve our workforce wellbeing and we will achieve better and more equitable patient outcomes.

Facilities for the Future

New Dunedin Hospital (NDH) and the Interprofessional Learning Centre (ILC)

The construction of the NDH will be the largest vertical health infrastructure project in New Zealand's history. It will be underpinned by a Digital Transformation programme necessary for the NDH to function as a contemporary and modern hospital.

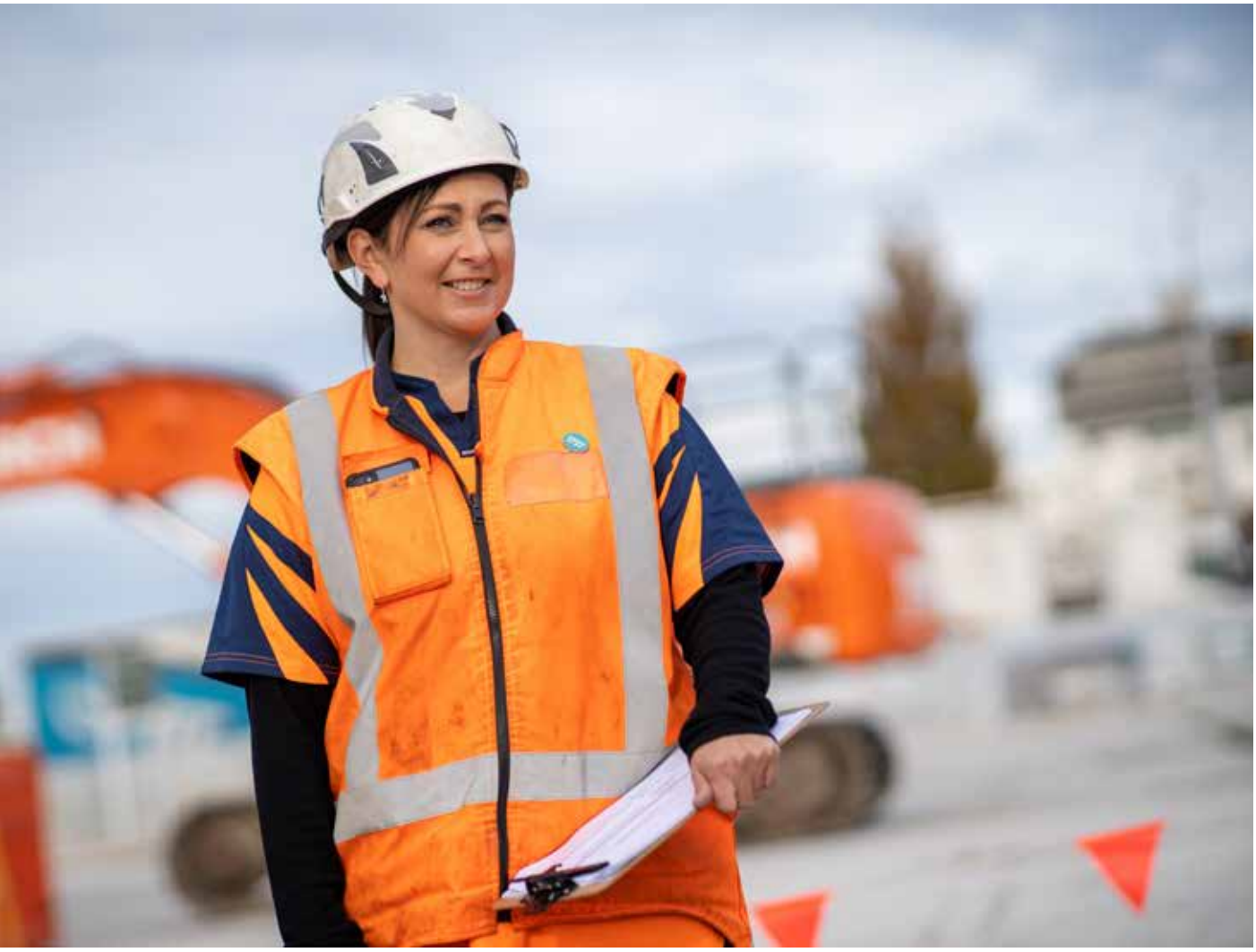
The Outpatients' Building (OPB) is planned to be completed in 2025 and the Inpatients' Building (IPB) in 2028.

Alongside the NDH's design and upcoming construction activity, Te Whatu Ora Southern's Programme Management Office (PMO) will continue to facilitate programmes of work to support changes in practice, transitions to new and contemporary ways of working, relocation of services, and workforce development. Priority will be given to the OPB's Transition Programme that will guide our migration to, and commissioning of, these facilities ahead of the OPB opening.

Taken together, these activities will help us to realise the benefits of this investment for and on behalf of our staff, our patients and their whānau and the Southern health system.

More broadly, a Business Case for the Interprofessional Learning Centre (ILC) – a collaboration between Te Whatu Ora Southern, University of Otago and Otago Polytechnic – is underway. The ILC is planned to open in 2027. It will be an integrated, collaborative and comprehensive education facility to support interprofessional learning and team-based activity. The ILC was a core component of Te Whakaari – the former Southern DHB's Health and Education Precinct Site Masterplan. Further developments aligned to this Site Masterplan will follow.


MARCH



Asset Performance Indicators

Improving Asset Management

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

Asset Portfolio	Asset Classes within Portfolios	Asset Purposes	2020/21 Net Book Value ($000)	2021/22 Net Book Value ($000)
Property	Land, buildings, furniture and fittings, motor vehicles	To provide a base for the provision of health services	262,483	448,422
Clinical Equipment	Equipment and machinery	To enable the delivery of health services through diagnosis, monitoring or treatment	51,897	55,828
Information Communication Technology (ICT)	Computer hardware and computer software	To enable the delivery of core health service by aiding decision making at the point of care	17,437	14,094

Property Portfolio Performance

Asset Performance Indicators	Indicator Class	2020/21 Result	2021/22 Standard	2021/22 Result
Percentage of buildings within the DHB's property portfolio with a current Building Warrant of Fitness or Building System Statement Reports[12]	Condition	44%	100%	55%

Clinical Equipment Portfolio Performance

Asset Performance Indicators	Indicator Class	2020/21 Result	2021/22 Standard	2021/22 Result
Percentage of MRIs compliant with manufacturer specification standards	Condition	100%	100%	100%
Percentage of CTs and Linacs compliant with the requirements of the Radiation Protection Act	Condition	100%	100%	100%
Percentage of MRI uptime vs. operational hours	Utilisation	97%	>98%	99%
Percentage of CT uptime vs. operational hours	Utilisation	98%	>98%	98%
Percentage of Linac uptime vs. operational hours	Utilisation	96%	>98%	98%

[12] Compliance works are ongoing, and all occupied buildings should have a current BWOF by June 2024.

Information Communication and Technology (ICT) Portfolio Performance

Asset Performance Indicators	Indicator Class	2020/21 Result	2021/22 Standard	2021/22 Result
Percentage of available capacity for storage	Condition	20%	20%	20%
Percentage uptime for critical applications	Utilisation	99%	99%	99%
Customer satisfaction level with service desk	Functionality	95%	85%	95%
Annual network penetration test risk level (5-critical, 4-high, 3-medium, 2-low, 1-informational)	Functionality	2	2	2

Financial statements

Statement of Comprehensive Revenue and Expense
For the year ended 30 June 2022

	Note	2022 Actual $000	2022 Budget $000	2021 Actual $000
Patient care revenue	2	1,363,395	1,235,975	1,188,171
Other revenue	2	12,984	7,592	10,366
Interest revenue		631	336	385
Total revenue		**1,377,010**	**1,243,903**	**1,198,922**
Personnel costs	3	553,576	497,375	472,752
Depreciation, amortisation and impairment expense	10,11	32,772	33,077	29,157
Outsourced services		64,370	51,072	56,360
Clinical supplies		118,341	107,437	110,453
Infrastructure and non-clinical expenses		71,629	60,721	57,756
Other district health boards		53,733	51,610	48,501
Non-health board provider expenses		509,349	455,190	441,454
Other expenses	6	5,891	4,482	5,445
Interest expense	5	73	104	78
Capital charge	4	6,210	7,142	7,898
Total expenses		**1,415,944**	**1,268,210**	**1,229,854**
Surplus/(deficit) for the year	17	**(38,934)**	**(24,307)**	**(30,932)**
Other comprehensive revenue				
Items that will not be reclassified to surplus/(deficit) Revaluation of land and buildings	17	196,583	-	-
Total other comprehensive revenue/(expense)		196,583	-	-
Total comprehensive revenue/(expense)		**157,649**	**(24,307)**	**(30,932)**

Statement of Changes in Equity
For the year ended 30 June 2022

	Note	2022 Actual $000	2022 Budget $000	2021 Actual $000
Balance at 1 July		**135,686**	**138,188**	**165,993**
Total comprehensive revenue and expense		157,649	(24,307)	(30,932)
Owner transactions				
Capital contributions from the Crown (deficit support and project equity funding)		5,117	9,313	1,332
Return of capital to the Crown	17	(707)	(707)	(707)
Balance at 30 June		**297,745**	**122,487**	**135,686**

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 2022

	Note	2022 Actual $000	2022 Budget $000	2021 Actual $000
Current assets				
Cash and cash equivalents	7	7	-	7,582
Trade and other receivables	8	85,505	48,474	61,439
Inventories	9	7,295	5,235	6,159
Total current assets		**92,807**	**53,709**	**75,180**
Non-current assets				
Property, plant and equipment	10	523,540	362,457	321,144
Intangible assets	11	14,720	20,704	10,672
Total non-current assets		**538,260**	**383,161**	**331,816**
Total assets		**631,067**	**436,870**	**406,996**
Liabilities				
Current liabilities				
Cash and cash equivalents	7	4,917	33,656	-
Payables and deferred revenue	12	87,463	69,371	71,996
Borrowings	13	208	1,979	235
Employee entitlements	14	222,668	88,253	178,732
Provisions	15	-	80	80
Total current liabilities		**315,256**	**193,339**	**251,043**
Non-current liabilities				
Borrowings	13	1,389	10,754	856
Employee entitlements	14	16,677	110,290	19,411
Total non-current liabilities		**18,066**	**121,044**	**20,267**
Total liabilities		**333,322**	**314,383**	**271,310**
Net assets		**297,745**	**122,487**	**135,686**
Equity				
Contributed capital	17	390,041	495,163	385,631
Property revaluation reserves	17	305,085	108,500	108,502
Accumulated surplus/(deficit)	17	(397,381)	(481,176)	(358,447)
Total equity		**297,745**	**122,487**	**135,686**

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 2022

	2022 Actual $000	2022 Budget $000	2021 Actual $000
Cash flows from operating activities			
Cash receipts from Ministry of Health and patients	1,344,293	1,250,570	1,192,145
Payments to suppliers	(801,982)	(719,719)	(723,712)
Payments to employees	(514,118)	(498,454)	(455,545)
Interest received	631	336	385
Interest paid	-	(50)	-
Goods and services tax (net)	(946)	(2,604)	1,341
Capital charge	(6,210)	(7,142)	(7,898)
Net cash flow from/to operating activities	**21,668**	**22,937**	**6,716**
Cash flows from investing activities			
Proceeds from sale of property, plant and equipment	93	-	6
Purchase of property, plant and equipment	(37,896)	(55,230)	(25,907)
Purchase of intangibles	(566)	(16,672)	(3,907)
Net cash flow from/to investing activities	**(38,369)**	**(71,902)**	**(29,808)**
Cash flows from financing activities			
Capital contributions from the Crown	5,825	9,313	1,332
Proceeds/(repayment) of borrowings	(1,616)	(1,586)	(1,669)
Net cash flow from/to financing activities	**4,209**	**7,727**	**(337)**
Net increase/(decrease) in cash and cash equivalents	**(12,492)**	**(41,238)**	**(23,429)**
Cash and cash equivalents at beginning of year	7,582	7,582	31,011
Cash and cash equivalents at the end of the year	**(4,910)**	**(33,656)**	**7,582**

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 2022 (continued)

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

	2022 Actual $000	2022 Budget $000	2021 Actual $000
Net deficit for the period	**(38,934)**	**(24,307)**	**(30,932)**
Add/(less) non-cash items:			
Depreciation, amortisation and assets written off	32,770	33,077	29,157
Increase/(decrease) in financial liability fair value	-	1	5
Increase/(decrease) in provision for doubtful debts	(547)	-	356
Total non-cash items	**32,223**	**33,078**	**29,518**
Add/(less) items classified as investing or financing activity:			
Net loss/(gains) on disposal of property, plant and equipment	404	-	430
Total items classified as investing or financing activities	**404**	**-**	**430**
Movements in working capital:			
(Increase)/decrease in trade and other receivables	(23,519)	15,213	(11,977)
(Increase)/decrease in inventories	(1,136)	925	(65)
Increase/(decrease) in trade and other payables	11,193	(16,613)	5,816
Increase/(decrease) in employee benefits	41,437	14,641	13,926
Net movements in working capital	**27,975**	**14,166**	**7,700**
Net cash inflow/(outflow) from operating activities	**21,668**	**22,937**	**6,716**

Notes to the Financial Statements

1. Statement of accounting policies for the year ended 30 June 2022

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 2022 and were approved for issue by the Te Whatu Ora Health New Zealand Board on 06 March 2023.

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 replace all 20 District Health Boards (DHBs) and the Health Promotion Agency with a new Crown entity, Te Whatu Ora - Health New Zealand, responsible for running hospitals and commissioning primary and community health services. The legislation enabling the reform, the Pae Ora (Healthy Futures) Act 2022 (the Act), took effect on 1 July 2022, formally creating Te Whatu Ora - Health New Zealand, along with two other entities – Te Aka Whai Ora - Maori Health Authority to monitor the state of Maori health and commission services directly, and the Public Health Agency, which resides within the Ministry of Health to lead and strengthen public health.

The Act disestablished all DHBs and the Health Promotion Agency and transferred Southern DHB's assets and liabilities to Te Whatu Ora – Health New Zealand on 1 July 2022. As a result, the financial statements have been prepared on a disestablishment basis.

However, because health services will continue to be provided through Te Whatu Ora – Health New Zealand, no changes have been made to the recognition and measurement basis, or presentation of assets and liabilities in these financial statements due to the disestablishment basis of preparation.

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.

New Standards, amendments applied

PBE IPSAS 2 Cash Flow Statement

An amendment to PBE IPSAS 2 Cash Flow Statements 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. The new information required by this amendment has been disclosed in Note 13.

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.

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 2021/2022 statement of performance expectations. The budget figures have been prepared in accordance with GAAP, using accounting policies that are consistent with those adopted by the Board in preparing these financial statements.

Cost allocation

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

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

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

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

Critical accounting estimates and assumptions

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

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

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

- Asbestos Impairment, note 10
- Fixed assets revaluations, note 10

- Deferred maintenance, note 10
- Remaining useful lives, note 10
- Intangible assets impairment, note 11
- Employee entitlements, note 14.

Comparative data

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

2. REVENUE

ACCOUNTING POLICY

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

MoH 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

	2022 Actual $000	2021 Actual $000
MoH population based funding	1,092,777	1,027,683
MoH other contracted revenue	218,613	111,957
ACC contract revenue	15,205	12,013
Inter-district patient inflows	27,613	26,870
Other patient care revenue	9,187	9,648
Total Patient care revenue	**1,363,395**	**1,188,171**

Breakdown of other revenue

	2022 Actual $000	2021 Actual $000
Gain on sale of property, plant and equipment	96	5
Donations and bequests received	5,181	3,632
Rental revenue	1,847	2,086
Other revenue	5,860	4,643
Total other revenue	**12,984**	**10,366**

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

	2022 Actual $000	2021 Actual $000
Salaries and wages	514,286	447,227
Defined contribution plans employer contributions	13,765	11,715
Increase/(decrease) in employee entitlements	25,465	13,810
Total personnel costs	**553,516**	**472,752**

EMPLOYEE TERMINATION PAYMENTS

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

The total payments were $324,179 (2021: 18 employees totalling $406,888).

BOARD MEMBER REMUNERATION

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:

	2022 Actual $000	2021 Actual $000
David Cull	-	13
David Perez MNZM	-	23
Jean O'Callaghan	23	23
Ilka Beekhuis	8	23
John Chambers	23	23
Kaye Crowther QSO	23	23
Lyndell Kelly	23	23
Pete Hodgson	46	23
Peter Crampton	-	6
Terrence King MNZM	23	23
Tuari Potiki	23	23
Lesley Soper	23	23
Reremoana Theodore	23	23
Total Board Members remuneration	**238**	**272**

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 (2021: nil).

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 2022 was 5 per cent. The amount charged during the period was $6.2 million (2021: 5 per cent, $7.9 million).

5. FINANCE COSTS

ACCOUNTING POLICY

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

Breakdown of finance costs

	2022 Actual $000	2021 Actual $000
Interest on secured loans	-	4
Interest on finance leases	73	74
Total finance costs	**73**	**78**

6. OTHER EXPENSES

ACCOUNTING POLICY

Breakdown of other expenses

	Note	2022 Actual $000	2021 Actual $000
Impairment of trade receivables		(547)	1,084
Bad debts written off		956	-
Loss on disposal of property, plant and equipment		500	435
Audit fees (for the audit of financial statements 2022)		295	232
Audit fees (for the audit of financial statements 2021)		30	-
Audit fees (for the audit of financial statements 2020)		-	30

Fees paid for internal audit and related services		66	128
Board Expenses	3	328	317
Operating lease expenses		4,011	3,214
Koha		252	5
Total other expenses		**5,891**	**5,445**

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 41% (2021: 50%), premises rental 36% (2021: 30%), with the balance being clinical equipment and other equipment rental 22% (2021: 20%).

Operating leases as lessee

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

	2022 Actual $000	2021 Actual $000
Non-cancellable operating lease rentals are payable as follows:		
Less than one year	1,617	1,957
Between one and five years	1,491	2,128
More than five years	160	99
Total non-cancellable operating leases	**3,268**	**4,184**

The majority of the non-cancellable operating lease expense relates to 291 fleet car leases. These leases have terms between 3.75 and 6 years with remaining terms of 0 to 5.4 years, the last ones expiring November 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 2022 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

	2022 Actual $000	2021 Actual $000
Cash at bank and on hand	7	6
Demand funds with New Zealand Health Partnerships Limited	(4,917)	7,576
Cash and cash equivalents	**(4,910)**	**7,582**

WORKING CAPITAL FACILITY

At 30 June 2022, 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 $63.6m (2021: $61.0m).

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

	2022 Actual $000	2021 Actual $000
Receivables (gross)	86,391	62,872
Less: allowance for credit losses	(886)	(1,433)
Total net receivables	**85,505**	**61,439**

The expected credit loss rates for receivables at 30 June 2022 and 30 June 2021 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:

	2022 Actual $000	2021 Actual $000
Opening allowance for credit losses as at 1 July	1,433	1,077
Increase in loss allowance made during the year	409	1,084
Receivables written off during the year	(956)	(728)
Balance as at 30 June	**886**	**1,433**

Trade receivables ageing profile

	2022				2021			
	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	21,525	0%	-	-	16,326	0%	147	-
Less than six months past due	8,468	25%	135	-	1,759	25%	180	-
Between six months and one year past due	832	75%	15	-	370	75%	234	-
Between one and two years past due	151	75%	16	209	517	75%	92	209
Greater than two years past due	408	75%	35	525	349	75%	45	525
Specific Debtors	190	95%	-	181	220	95%	-	-
Specific Debtors	504	100%	-	504	525	100%	-	-
Total	**32,078**		**201**	**685**	**20,066**		**698**	**734**

Note: Trade receivables of $32.1 million are included in Receivables (gross) figure, $85.5 million (pg. 77).

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

	2022 Actual $000	2021 Actual $000
Pharmaceuticals	2,398	2,077
Surgical & medical supplies	4,897	4,082
Total inventories	**7,295**	**6,159**

The amount of inventories recognised as an expense during the year was $34.4 million (2021: $32.6 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 (2021: nil).

No inventories are pledged as security for liabilities (2021: 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 property, plant and equipment 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.

The net revaluation results are credited or debited to other comprehensive revenue and expense and are accumulated to an asset revaluation reserve in equity for that class of asset. Where this would result in a debit balance in the asset revaluation reserve, this balance is not recognised in other comprehensive revenue and expense but is recognised in surplus or deficit. Any subsequent increase on revaluation that reverses a previous decrease in value recognised in surplus or deficit will be recognised first in surplus or deficit up to the amount previously expensed, and then recognised in other comprehensive revenue and 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 property, plant and equipment other than land, at rates which will write off the cost (or revaluation) of the assets to their estimated residual values over their useful lives.

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

Buildings	3 to 73 years
Plant and Equipment	4 to 40 years
Motor Vehicles	5 to 12 years

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

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

Impairment

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

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

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

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

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

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

	Land (at valuation)	Buildings (at valuation)	Plant and equipment	Vehicles	Work in progress	Total
Cost	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**
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**
Balance at 1 July 2021	37,997	247,492	166,622	2,321	11,376	465,808
Additions	-	-	-	-	36,430	36,430
Transfers from Work in Progress	-	11,892	23,374	-	(35,266)	-
Revaluation increase	64,349	132,236	-	-	-	196,585
Depreciation writeback on Revaluation		(48,711)	-	-	-	(48,711)
Reclassification	-	(297)	297	-	-	-
Disposals	-	-	(25,981)	-	-	(25,981)
Balance at 30 June 2022	**102,346**	**342,612**	**164,312**	**2,321**	**12,540**	**624,131**
Depreciation and impairment losses						
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**
Balance at 1 July 2021	-	32,998	109,420	2,246	-	144,664
Depreciation charge for the year	-	15,839	14,460	44	-	30,343
Reclassification	-	(126)	126	-	-	-
Disposals	-	-	(25,705)	-	-	(25,705)
Elimination on Revaluation	-	(48,711)	-	-	-	(48,711)
Balance at 30 June 2022	**-**	**-**	**98,301**	**2,290**	**-**	**100,591**
Carrying amounts						
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**
At 1 July 2021	37,997	214,494	57,202	75	11,376	321,144
At 30 June 2022	**102,346**	**342,612**	**66,011**	**31**	**12,540**	**523,540**

Capital Commitments

	2022 Actual $000	2021 Actual $000
Buildings	10,747	2,921
Clinical equipment	8,072	3,821
Computer equipment	1,958	863
Non-clinical equipment	-	520
Intangibles	1,219	-
Total capital commitments	**21,996**	**8,125**

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 the land and buildings of Southern DHB was performed by an independent registered valuer, Marvin Clough (FPINZ) of Beca Projects NZ Limited, and is effective as at 30 June 2022.

Land

Land is valued at fair value using market-based evidence based on its highest and best use with reference to comparable land values. Adjustments have been made to the "unencumbered" land value for land where there is a designation against the land, or the use of the land is restricted. These adjustments are intended to reflect the negative effect on the value of the land where an owner is unable to use the land more intensely. The adjustments were at 30% across the majority of sites.

Restrictions on the group's ability to sell land would normally not impair the value of the land because it has operational use of the land for the foreseeable future and will receive substantially the full benefit of outright ownership.

Building

Specialised hospital buildings are valued at fair value using depreciated replacement cost because no reliable market data is available for such buildings.

Depreciated replacement cost is determined using a number of significant assumptions including:

- The replacement asset is based on the reproduction cost of the specific assets with adjustments where appropriate for optimisation due to over-design or surplus capacity.
- The replacement cost is derived from recent construction rates of similar assets and reviewed at a high level against construction rates in the region.
- The estimated asbestos remediation costs in Southern DHB's buildings has been deducted off the depreciated replacement cost in estimating fair value.
- The remaining useful life of assets is estimated after considering factors such as the condition of the asset, DHB's future maintenance and replacement plans, and experience with similar buildings.
- Straight-line depreciation has been applied in determining the depreciated replacement cost value of the asset.

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 2022 is $12.0 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 2022, 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 2022.

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 12 years	8-20%

Breakdown of intangible assets

	FPIM	Software & development costs	Total
Cost	**$000**	**$000**	**$000**
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**
Balance 1 July 2021	5,127	30,737	35,864
Additions	-	6,700	6,700
Reclassification	-	-	-
Disposals	-	(1,240)	(1,240)
Balance at 30 June 2022	**5,127**	**36,197**	**41,324**
Amortisation and impairment losses			-
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**
Balance 1 July 2021	5,127	20,065	25,192
Amortisation charge for the year	-	2,429	2,429
Reclassification	-	-	-
Disposals	**-**	(1,017)	**(1,017)**
Balance at 30 June 2022	**5,127**	**21,477**	**26,604**
Carrying amounts			
At 1 July 2020	-	5,664	5,664
At 30 June 2021	**-**	**10,672**	**10,672**
At 1 July 2021	-	10,672	10,672
At 30 June 2022	**-**	**14,720**	**14,720**

The above balance includes $7.4 million of work in progress (2021: $4.4 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

	2022 Actual $000	2021 Actual $000
Trade payables to non-related parties	10,419	-
GST payable	6,612	7,405
Revenue in advance relating to contracts with specific performance obligations	2,608	7,945
Other non-trade payables and accrued expenses	67,824	56,646
Total payables and deferred revenue	**87,463**	**71,996**

	2022 Actual $000	2021 Actual $000
Total payables comprise:		
Exchange transactions	78,243	56,646
Non-exchange transactions	9,220	15,350
	87,463	**71,996**

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

	2022 Actual $000	2021 Actual $000
Current		
Current portion of secured loans	-	-
Current portion of unsecured loans	-	-
Current portion of finance lease liabilities	208	235
Total current portion	**208**	**235**
Non-current		
Secured loans	-	-
Finance lease liabilities	1,389	856
Total non-current portion	**1,389**	**856**
Total borrowings	**1,597**	**1,091**

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 finance leases

	2022 Actual $000	2021 Actual $000
Within one year	208	235
One to five years	1,255	506
Later than five years	135	350
	1,597	**1,091**

Finance leases have been entered into for various items of clinical equipment and computer equipment.

Reconciliation of movements in liabilities arising from financing activities

The table below provides a reconciliation between the opening and closing balance of finance lease liabilities.

	Finance Leases $000
Balance at 1 July 2021	1,091
Cash outflows	(235)
New Leases	741
Balance at 30 June 2022	**1,597**

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

	2022 Actual $000	2021 Actual $000
Current portion		
Long-service leave	4,868	4,365
Sabbatical leave	253	192
Retirement gratuities	4,639	4,373
Annual leave	154,708	141,177
Sick leave	293	274
Continuing medical education	16,186	11,984
Salary and wages accrual	41,721	16,367
Total current portion	**222,668**	**178,732**
Non-current portion		
Long-service leave	4,948	5,492
Sabbatical leave	2,270	2,645
Retirement gratuities	9,459	11,274
Total non-current portion	**16,677**	**19,411**
Total employee entitlements	**239,345**	**198,143**

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.

The final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed. Southern DHB has made progress in its review, however we are awaiting national decisions before completion.

Notwithstanding, as at 30 June 2022, 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 $88.2 million (2021: $82.6 million) by extrapolation/calculating the underpayment for employees over the full period of liability based on known non-compliances at 30 June 2022. This liability amount is the DHB's best estimate at this stage of the outcome from this project. 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 3.34% (2021: 0.38%) and an inflation factor of 5.37% (2021: 3.38%) 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% (2021: 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.

15. PROVISIONS

ACCOUNTING POLICY

General

A provision is recognised for future expenditure of uncertain amount or timing when:

- there is a present obligation (either legal or constructive) as a result of a past event
- it is probable that an outflow of future economic benefits will be required to settle the obligation
- a reliable estimate can be made of the amount of the obligation.

Provisions are measured at the present value of the future payments for which Southern DHB has responsibility using a risk free discount rate. The value of the liability may include a risk margin that represents the inherent uncertainty of the present value of the expected future payments.

Restructuring

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

Breakdown of provisions

	2022 Actual $000	2021 Actual $000
Current portion		
Restructuring	-	80
Total current portion	**-**	**80**
Non-current portion		
Restructuring	-	-
Total non-current portion	**-**	**-**
Total provisions	**-**	**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 2020	80
Additional provisions made	-
Amounts used	-
Unused amounts reversed	-
Balance at 30 June/1 July 2021	**80**
Additional provisions made	-
Amounts used	-
Unused amounts reversed	(80)
Balance at 30 June 2022	**-**

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 and patient 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 (2021: 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 has been a $196.6 million increase to the reserve this year due to the revaluation of land and buildings at 30 June 2022. (2021: no change).

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 is subject to the financial management and accountability provisions of the Crown Entities Act 2004, which impose restrictions in relation to borrowings, acquisition of securities, issuing guarantees and indemnities, and the use of derivatives.

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 2020	385,006	108,502	(327,515)	165,993
Capital contributions from the Crown (Deficit Support and Project Equity Funding)	1,332	-	-	1,332
Return of capital to the Crown	(707)	-	-	(707)
Deficit for the year	-	-	(30,932)	(30,932)
Balance at 30 June 2021`	**385,631**	**108,502**	**(358,447)**	**135,686**
Balance at 1 July 2021	385,631	108,502	(358,447)	135,686
Capital contributions from the Crown (Deficit Support and Project Equity Funding)	5,117	-	-	5,117
Return of capital to the Crown	(707)	-	-	(707)
Movement in revaluation of land and buildings	-	196,583	-	196,583
Deficit for the period	-	-	(38,934)	(38,934)
Balance at 30 June 2022	**390,041**	**305,085**	**(397,381)**	**(297,745)**

Equity is made up of:

	2022 Actual $000	2021 Actual $000
Equity	290,855	131,521
Restricted equity*	6,890	4,165
Total equity	**297,745**	**135,686**

* 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. This company has been disestablished in March 2022.

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:

	2022 Actual $000	2021 Actual $000
Board Members		
Remuneration	238	272
Full time equivalent members	0.5 FTE	0.5 FTE
Total Board Members remuneration	**238**	**272**
Total Board Members full time equivalent	**0.5 FTE**	**0.5 FTE**
Executive Management		
Remuneration	3,365	3,212
Termination payments	136	113
Full time equivalent members	11.0 FTE	11.5FTE
Total Executive Management remuneration	**3,501**	**3,325**
Total Executive Management full time equivalent	**11.0 FTE**	**11.5 FTE**
Total remuneration	**3,739**	**3,597**
Total full time equivalent	**11.4 FTE**	**12.0 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.

Total Executive Management remuneration paid and payable includes employer contributions to defined contribution plans totalling $119,649 (2021: $84,306).

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 79.4% 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.

	Carrying Amount $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
2022							
Finance lease liabilities	1,597	1,597	102	106	459	796	135
Payables and deferred revenue	87,463	87,463	87,463	-	-	-	-
Total	**89,060**	**89,060**	**87,565**	**106**	**459**	**796**	**135**
2021							
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**

	Liability carrying amount $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
2022							
Finance lease liabilities							
Inflow	-	-	-	-	-	-	-
Outflow	1,597	1,597	102	106	459	796	135
Payables and deferred revenue							
Inflow	-	-	-	-	-	-	-
Outflow	87,463	87,463	87,463	-	-	-	-
2021							
Finance lease liabilities							
Inflow	-	-	-	-	-	-	-
Outflow	1,091	1,091	117	117	112	393	352
Payables and deferred revenue							
Inflow	-	-	-	-	-	-	-
Outflow	71,996	71,996	71,996	-	-	-	-

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.

2022

	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%	1,598	102	106	459	796	135

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 *							
Finance lease liabilities*	7.16% - 12.55%	1,091	117	117	112	393	352

* These assets/liabilities bear interest at fixed rates

	Note	2022 Actual $000	2021 Actual $000
Opening Balance – Crown Loans	13	-	604
Increase Crown Loans		-	-
Repayment of Crown Loans		-	(604)
Conversion of loans to equity		-	-
Closing Balance – Crown Loans		**-**	**-**
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 2022, 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 $0.02 million (2021: $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	2022 Actual $000	2021 Actual $000
Financial assets measured at amortised cost			
Cash and cash equivalents	7	7	7,582
Trade and other receivables	8	85,505	61,439
		85,512	69,021
Financial liabilities measured at amortised cost			
Cash and cash equivalents	7	4,917	-
Payables (excluding deferred revenue and taxes)	12	73,440	49,974
Borrowings	13	1,597	1,091
		79,954	51,065

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 2022 has resulted in a deficit of $9.5 million (2021: $2.6 million) for Mental Health Services. Additionally, Southern DHB has a brought-forward overspend of $19.7 million; meaning that the carry-forward overspend is $29.2 million (2021: $19.7 million).

22. EVENTS AFTER BALANCE DATE

The following events after balance date event disclosure for the disestablishment of District Health Boards has been agreed with Te Whatu Ora – Health New Zealand:

On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, replacing the New Zealand Public Health and Disability Act 2000 and establishing Te Whatu Ora – Health New Zealand and Te Aka Whai Ora – Maori Health Authority. District Health Boards were legally disestablished, and their assets and liabilities transferred to Te Whatu Ora – Health New Zealand on this date.

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 favourable variance in total comprehensive revenue and expenses against budget for the year ended 30 June 2022 was $182.0 million.

Revenue

Total Revenue was $133.1 million higher than budget. This was due to a combination of additional Government and Crown contracted revenue funding for the COVID-19 response, Surveillance & Testing and Vaccination programme, Pay Equity Funding for Nurses and Support Workers, plus Accident Compensation Corporation revenue.

Personnel Costs and Outsourcing

Personnel costs were unfavourable to budget by $56.1 million.

The COVID-19 response added $21.6 million to personnel costs, across all workforce types. The unbudgeted cost of the COVID-19 Vaccination programme was $8.3 million while the balance represents COVID-19 resurgence prevention and public health costs plus 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 $6.0 million to personnel costs this financial year. The Unsettled Nursing Pay Equity contributed a $15.5million un-budgeted impact

Also contributing has been a further increase in average FTE, by some 248. This has been mostly driven by the Nursing area, filling long-term vacancies and Care Capacity Demand Management requirements, to better match acuity and resourcing in both acute and planned care. In addition there are slightly higher numbers in Medical and Management/ Admin areas, filling both vacancies and project requirements

Outsourced Services (Includes Outsourced Personnel)

Outsourced Services were $13.3 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 the challenges of both ongoing capacity constraints within the hospitals and recovery of under-delivery due to the ongoing COVID-19 response

Total case weights were 9.4% or 1,758 lower than budgeted, largely as a result of flow-on COVID-19 disruptions plus ongoing capacity constraints. Elective delivery was also 6.3% lower than the prior year due to the ongoing effects of COVID-19 on both staff resourcing and patients

Clinical Supplies

Clinical supplies were $10.9 million over budget. The high cost of pharmaceutical products has continued to impact, although partially offset by additional funding. Air ambulance costs have also remained high with high-cost Neurosurgery and Paediatric Intensive Care Unit (PICU) transfer missions impacting on the total spend through the year. During the year Southern DHB received from the Ministry of Health COVID-19 related clinical supplies valued at $4.6million.

Infrastructure and Non-Clinical

Infrastructure and Non-Clinical Expenses were $10.9m over budget. Outsourced Cleaning and Orderlies costs were circa $1.0m higher than budget due to ongoing COVID-19 and resourcing issues. Facilities costs were $4.0m over budget, including extra costs in Security due to COVID-19, Maintenance of Buildings & Plant and higher than expected spend on Utilities being Electricity and Steam. Information technology costs were some $2.8m over budget with higher than planned activity in outsourced services and Software Licences.

Infrastructure and Non-Clinical

Infrastructure and Non-Clinical Expenses were $10.9m over budget. Outsourced Cleaning and Orderlies costs were circa $1.0m higher than budget due to ongoing COVID-19 and resourcing issues. Facilities costs were $4.0m over budget, including extra costs in Security due to COVID-19, Maintenance of Buildings & Plant and higher than expected spend on Utilities being Electricity and Steam. Information technology costs were some $2.8m over budget with higher than planned activity in outsourced services and Software Licences

Non-Health Board Provider Payments

Provider payments to NGOs were $54.2 million higher than budget. The majority of this was reflected in the COVID-19 response, included "pass-through" payments to Aged Care, GP Practices and Pharmacies across the district as well as the WellSouth PHO for delivery of Care in the Community and Surveillance & Testing. This was however funded by the Crown. There were also Pay Equity payments for Aged Care.

STATEMENT OF CHANGES IN EQUITY

Total Comprehensive Revenue and Expense was $182.0 million greater than budgeted due to the revaluation of Property, Plant & Equipment – Land & Buildings, offset by the surplus and deficit explanations provided above.

The capital contributions from the Crown were $4.2 million lower than budgeted with lower drawdowns for capital projects than planned.

STATEMENT OF FINANCIAL POSITION

Cash and Cash Equivalents

Cash at year end was $28.7 million better than budget. Investment in property, plant & equipment and intangibles was $33.5 million lower than expected with a number of projects delayed, cancelled or deferred. Offsetting this was Capital Contributions from the Crown $3.5 million lower than planned due to delayed capital Projects.

Trade and Other Receivables

Trade and Other Receivables were $37.0 million higher than budget with greater than expected amounts owing for COVID-19 and other Government funding sources.

Property, Plant and Equipment

Property Plant and Equipment was $161.1 million higher than budget reflecting the revaluation of land and buildings as detailed in Note 10 above, but partially offset by the timing of purchasing and completion of capital work programmes. Significant building projects have continued to be delayed, reflecting the challenging environment in project manager resourcing and the construction sector generally. Major projects delayed and/or cancelled include the Dunedin Tenth Operating Theatre/Post Anaesthesia Care Unit, Dunedin Sterile Services Facility and Southland Emergency Department/ Main Operating Theatre, along with various items of clinical and infrastructural equipment and deferred maintenance programmes which continue into the new financial year.

Intangible Assets

Intangible Assets are $6.0 million lower than budgeted with the South Island Patient Information Care System (SIPICS) now well underway, but completion now expected in the 2023/24 financial year.

Payables and Deferred Revenue

Payables and Deferred Revenue are $18.1 million higher than budgeted. The total includes higher than expected amounts owing to the Crown for COVID-19 activities and Air Ambulance flight costs.

Employee Entitlements

Current and Non-Current Employee Entitlements are an aggregated $40.8 million higher than budgeted. This is a combination of the increase to the Holidays

Act 2003 liability in 2020/21 after the 2021/22 budget was finalised and the delayed remediation of the estimated liability for any non-compliance with the Holidays Act 2003 by 30 June 2022. It also reflects the increased Annual Leave hours across all Employee types with COVID-19 impacting on staff abilities to take leave as well as the Unsettled Nursing Pay Equity recognition.

Borrowings

Current and Non-Current Borrowings are an aggregated $11.1 million lower than budgeted. The 2021/22 budget allowed for several Clinical Equipment items including MRI and CT scanners to be procured on a leased basis, however not all of the leases were in place by June 2022.

Property Revaluation Reserves

Property revaluation reserves are $196.5 million higher than budgeted due to the revaluation detailed in Note 10 above.

STATEMENT OF CASH FLOWS

Net Cash Flow from Operating Activities is only $1.3 million lower than budget. Cash receipts from the Ministry of Health were $93.7 million higher than budget, including $82.0 million of COVID-19 funding and $23.0 million for MECA and Pay Equity settlements. Payments to Suppliers were $82.3 million higher than budget, largely the result of COVID-19 activity plus higher Outsourced and Clinical Supplies costs as noted above. Payments to Employees were $15.7 million higher than budget largely due to Nursing and Support Workers Multi Employer Collective Agreement (MECA) settlements, funded as above.

Cash Flows from Investing Activities are $33.5 million lower than budget due to the timing of capital expenditure as noted above.

Cash Flow from Financing Activities is $3.5 million lower than budget. This is driven by Capital injections from the Crown lower than planned with delivery delays to funded capital works programmes.

24. COVID-19

During August 2021 New Zealand moved back into Alert Level 4 and while other regions stayed at higher levels, Southern District moved progressively to Alert Level 2 in September 2021.

New Zealand then transitioned to the Traffic Light System in December 2021 with Southern District at Orange setting until moving back to Red setting with the rest of New Zealand in January 2022. All of New Zealand moved back to Orange in April 2022.

At Alert Level 4 Southern DHB Planned Care activities were significantly affected, while at both Alert Level 2 and Traffic Light setting Orange the operating capacity of Southern DHB remained reduced.

Government funding

The Ministry of Health provided funding of $92.9 million for Southern DHB to assist with the ongoing COVID-19 response. Of this, $60.3 million was distributed through Southern DHB to various NGOs, including WellSouth (Primary Health Organisation) for Care in the Community plus Surveillance & 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 $37.8 million of the total funding.

Personnel expenses

Personnel expenses included $21.7 million for permanent and casual staff, including $8.3 million for Vaccination programmes. In addition, some staff have continued to take less leave during the pandemic.

Other expenses

Clinical and infrastructure and non-clinical supply costs of $4.5 million were incurred in COVID-19 activities. This was driven by the administration of the COVID-19 vaccine programme delivery and included 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-19 Related Equipment and Clinical Supplies

During the year Southern DHB received no further items of donated clinical equipment from the Ministry of Health, however total capex spend on COVID-19 related equipment was $2.3 million. Also donations of personal protective equipment were recognized for $4.6 million.

COVID-19 Vaccinations

Southern DHB continued to implement the Government's Vaccination programme in conjunction with the MoH and community organisations. This was fully funded by the MoH and amounted to $37.8 million total cost to 30 June 2022. The largest components were $8.3 million for workforce and $2.0 million for infrastructure, facilities and other costs.

Valuation of land and buildings

Overall, Southern DHB does not consider there to be any material impacts of COVID-19 on the value of land and buildings that are not already reflected in the valuations recorded as at 30 June 2022. Southern DHB engaged an independent valuer to perform a revaluation exercise at 30 June 2022 as detailed in note 10 above and their assessment considered market evidence and information as a result of the impacts of COVID-19.

25. BREACH OF STATUTORY REPORTING DEADLINE

The 2021/22 annual report of Southern District Health Board was not completed by 31 December 2022, as required by section 156 of the Crown Entities Act 2004 (as amended by the Annual Reporting and Audit Time Frames Extensions Legislation Act 2021 which extended the reporting timeframes in the Crown Entities Act 2004 by two months).

Independent Auditor's Report

To the readers of Southern District Health Board's financial statements and statement of service performance for the year ended 30 June 2022

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 statement of service performance, including the performance information for an appropriation, of the health board, on his behalf.

We have audited:

- the financial statements of the health board on pages 82 to 111, that comprise the statement of financial position as at 30 June 2022, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the statement of service performance of the health board on pages 14 to 28 and 30 to 56.

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 82 to 111, which have been prepared on the disestablishment basis:

- present fairly, in all material respects:
    - its financial position as at 30 June 2022; 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 statement of service performance of the health board on pages 14 to 28 and 30 to 56:

- presents fairly, in all material respects, the health board's performance for the year ended 30 June 2022, 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 statement of service performance was completed on 6 March 2023. 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 of Te Whatu Ora – Health New Zealand and our responsibilities relating to the financial statements and the statement of service performance, 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 100, 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 $88.2 million for the estimated amounts owed to current and past employees. Work on the provision is ongoing, due to the complex nature of health sector employment arrangements, and there is a high level of uncertainty over the amount of the provision. We have therefore been unable to obtain adequate evidence to determine if the amount of the provision is reasonable.

We were also unable to obtain sufficient appropriate audit evidence of the $82.6 million provision as at 30 June 2021. We accordingly expressed a qualified opinion on the financial statements for the year ended 30 June 2021.

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the Professional and Ethical Standards and the International Standards on Auditing (New Zealand) issued by the New Zealand Auditing and Assurance Standards Board. Our responsibilities under those standards are further described in the Responsibilities of the auditor section of our report.

We have fulfilled our responsibilities in accordance with the Auditor-General's Auditing Standards.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Emphasis of matters

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

The financial statements have been prepared on a disestablishment basis

Note 1 on page 86 outlines that the health board has prepared its financial statements on a disestablishment basis because the health board was disestablished, and its functions transferred to Te Whatu Ora - Health New Zealand on 1 July 2022. There have been no changes to the values of the health board's assets and liabilities as a result of preparing the financial statements on a disestablishment basis.

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

Pages 48 to 54 outline the information used by the health board to report on its Covid-19 vaccine coverage. The health board uses HSU population data rather than the population data provided by Statistics New Zealand (Stats NZ), for the reasons set out on page 53. Pages 53 to 54 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

Note 24 on page 109 to the financial statements and page 48 to 54 of the performance information, which outlines the ongoing impact of Covid-19 on the health board.

Responsibilities of the board of Te Whatu Ora – Health New Zealand for the financial statements and the statement of service performance

The preparation of the final financial statements and statement of service performance for the health board is the responsibility of the board of Te Whatu Ora.

The board of Te Whatu Ora is responsible on behalf of the health board for preparing financial statements and statement of service performance that are fairly presented and comply with generally accepted accounting practice in New Zealand.

Up until 30 June 2022, the health board was responsible for such internal control as it determined necessary to enable it to prepare financial statements and performance information that were free

from material misstatement, whether due to fraud or error. From 1 July 2022, the board of Te Whatu Ora took over these responsibilities to enable the completion of the financial statements and performance information.

The responsibilities of the board of Te Whatu Ora arise from the transition provisions in the Pae Ora (Healthy Futures) Act 2022.

Responsibilities of the auditor for the audit of the financial statements and the statement of service performance

Our objectives are to obtain reasonable assurance about whether the financial statements and the statement of service performance, 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 statement of service performance.

For the budget information reported in the financial statements and the statement of service performance, 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 statement of service performance.

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 statement of service performance, 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 of Te Whatu Ora.
- We evaluate the appropriateness of the reported statement of service performance 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 of Te Whatu Ora.

- We evaluate the overall presentation, structure and content of the financial statements and the statement of service performance, including the disclosures, and whether the financial statements and the statement of service performance represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with the board of Te Whatu Ora 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 of Te Whatu Ora is responsible for the other information. The other information comprises the information included on pages 1 to 13, 29 and 57 to 81 but does not include the financial statements and the statement of service performance, and our auditor's report thereon.

Our opinion on the financial statements and the statement of service performance 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 statement of service performance, 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 statement of service performance 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