South Canterbury
District Health Board

E89

2020/21

Statement of Performance Expectations

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

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DATED: 28th of August 2020

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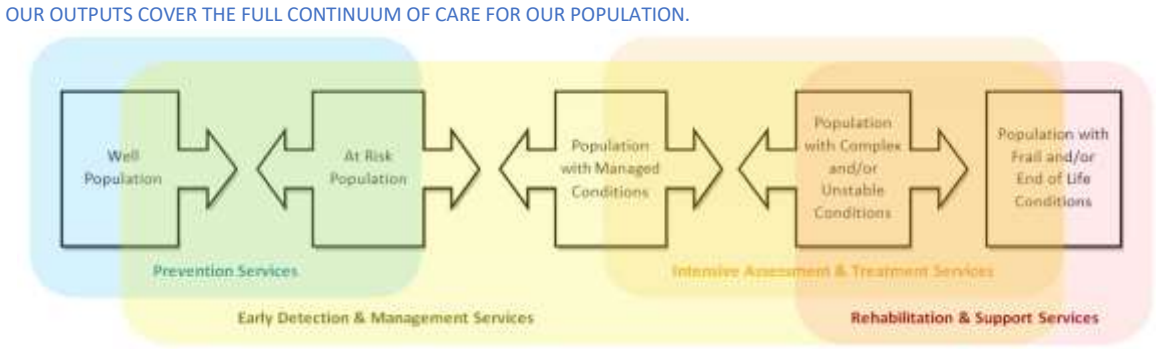
2.1 How will we measure our performance?

Over the long term, we aim to make positive changes in the health status of our population. As the major funder and provider of health and disability services in South Canterbury, the decisions we make about which services will be delivered utilising our limited pool of resources will have a significant impact on meeting the increasing health demands of our population. If coordinated and planned well, our response will improve the efficiency and effectiveness of the whole South Canterbury health system.

Understanding the dynamics of our population and the drivers of demand is fundamental when determining which services to fund for our population and at which level. Just as fundamental is our ability to assess whether the services we are purchasing and providing are making a measurable difference in the health and wellbeing of our population.

Figure 1: Scope of DHB operations – output classes against the continuum of care.



One of the functions of this document is to demonstrate how we will evaluate the effectiveness of the decisions we make on behalf of our population. Over the longer term, we do this by measuring our performance against a set of desired population health outcomes and impact measures. These longer-term health indicators are highlighted in our Statement of Intent.

Over the short term, we evaluate our performance on an annual basis by providing a forecast of our planned outputs (what services we will fund and deliver in the coming year) and the standards we expect to meet. We then report actual performance against this forecast in our end of year Annual Report.[1] The following sections presents the South Canterbury DHB's statement of performance expectations for 2020/21.

In order to present a representative picture of performance, outputs have been grouped into four *'output classes'*; Prevention Services; Early Detection and Management; Intensive Assessment and Treatment Services; and Rehabilitation and Support Services. These reflect the full health and wellbeing continuum (illustrated above); from keeping people healthy and well, through identifying and treating illness, to supporting people to age well.

Identifying a set of appropriate measures for each class is difficult. We cannot 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 therefore present a mix of measures that address four key aspects of performance: Quantity (V) – to demonstrate volumes of services

[1] *SCDHB Annual Reports can be found at www.scdhb.health.nz*

delivered; Quality (Q) – to demonstrate safety, effectiveness and acceptability; Timeliness (T) – to demonstrate responsive access to services; and Coverage (C) – to demonstrate the scope and scale of services provided.

The output measures chosen reflect a reasonable picture of activity across the whole of the South Canterbury health system and cover the activities with the potential to make the greatest contribution to the wellbeing of our population in the shorter term and to the health outcomes we are seeking over the longer term.

Setting standards

In setting performance standards, we have considered the changing demographics of our population, increasing demand for health services and the assumption that funding will be limited. Targets reflect the strategic goals of the DHB ensuring integrated person-centred care and health equity for all by increasing the coverage of prevention programmes, reducing acute or avoidable hospital admissions, and maintaining access to services by reducing waiting times and delays in treatment.

Where available, past years' results have been included in our forecast to give context in terms of current performance levels. Some data is provided to the DHB by external parties and is provided by calendar and not financial year, where this occurs this has been noted. National Targets are set to be achieved by the final quarter of any given year. In line with national performance reporting, baselines refer to the final quarter (April – June) result. Where measures are also included in 'DHB Performance Measures' which sets out the Ministry of Health's Performance Monitoring Framework, these are referenced as such. The following abbreviations are used: CW – Improving child wellbeing, MH – Improving mental wellbeing, PV – Improving wellbeing through prevention, SS – Better population health outcomes supported by a strong and equitable public health and disability system, PH – Better population health outcomes supported by primary health care.

Where does the money go?
The table on page 12 provides a summary of the 2020/21 budgeted financial expectations by output class.

Over time, we anticipate it will be possible to use this output class framework to demonstrate changes in allocation of resources and activity from one end of the continuum of care to the other.

Output Class
2.2 Prevention Services

Output class description
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 that engage, influence and support people to make healthier choices. These services include education programmes and services to raise awareness of risk behaviours and healthy choices, the use of legislation and policy to protect the public from toxic environmental risks and communicable diseases, and individual health protection services such as immunisation and screening programmes that support early intervention to modify lifestyles and maintain good health.

These services are the domain of many organisations across the region including: The Ministry of Health; Community and Public Health (the public health unit of Canterbury DHB which provides services for the South Canterbury region); primary care and general practice; a significant array of private and non-government organisations; and local and regional government. Services are provided with a mix of public and private funding.

Why is this output class significant for the DHB?

The four leading long term conditions, cancer, cardiovascular disease, diabetes and respiratory disease, make up 80% of the disease burden for our population. By improving environments and raising awareness, these services support people to make healthier choices, reducing the major risk factors that contribute to long term conditions and delaying or reducing the impact of these conditions. High needs and at-risk population groups are also more likely to engage in risky behaviours and to live in environments less conducive to making healthier choices. Prevention services are therefore also our foremost opportunity to target improvements in the health of high needs populations and to reduce inequalities in health status and health outcomes. Services are often designed to disseminate consistent messages to large numbers of people and can be cost-effective.

Successful provision of these services will reduce risk factors such as smoking and improve positive behaviours such as breastfeeding, which will improve the overall health and wellbeing of our population.

Output Subsets: Short Term Performance Measures 2020/21

Health Promotion and Education Services These services inform people about risks and support them to be healthy. Success is measured by greater awareness and engagement, reinforced by programmes that support people to maintain wellness, change personal behaviours and make healthier choices.	**Notes**	**Actual 2016/17**	**Actual 2017/18**	**Actual 2018/19**	**Target 2020/21**
Percentage of babies breast-fed (exclusive and full) in the district at 3 months of age. Refer CW06	C, Q [1]	N/A	63% (Jan-Jun18	59% (Jul- Dec18)	70%
Percentage of PHO enrolled patients who smoke who have been offered help to quit smoking by a health care practitioner in the last 15 months. Refer PH04	C	88.9%	92.6%	80.6%	90%
Percentage of pregnant women who identify as smokers upon registration with a DHB employed midwife or LMC offered brief advice and support to quit smoking. Refer PH04	C	92.3%	100%	100%	90%

[1] The proportion of women breastfeeding is seen as a measure of service quality, demonstrating the effectiveness of consistent, collective health promotion messages delivered during the antenatal period and the value of breast feeding support during the post-natal period.

Population Based Screening These services are mostly funded and provided through the National Screening Unit and help identify people at risk of illness earlier. They include breast and cervical screening. The DHB's role is to encourage uptake, as indicated by high coverage rates.	**Notes**	**Actual 2016/17**	**Actual 2017/18**	**Actual 2018/19**	**Target 2020/21**
Percentage of enrolled women aged 25 – 69 years who have had a cervical screen in the last three years. Refer PV02	T [2]	77.1%	77%	73.8%	80%
Percentage of Māori enrolled women aged 25 – 69 years who have had a cervical screen in the last three years. Refer PV02	T [2]	59.6%	65.3%	62.4%	80%
Percentage of enrolled women aged 50 – 69 years who have had breast screening mammography as part of the national	T [2]	77.3%	76.2%	75.8%	70%

mammography screening programme in the last two years. Refer PV01					
Percentage of Māori enrolled women aged 50 – 69 years who have had breast screening mammography as part of the national mammography screening programme in the last two years. Refer PV01	T [2]	72.3%	67.3%	62.6%	70%
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. Refer CW10	Q, C	79%	97%	100% (6month to May19)	95%

[2] The cervical and breast screening measures refer to participation in national screening programmes and standards are set nationally. Cervical cancer is one of the most preventable cancers and breast cancer one of the most common. Risk increases with age and regular screening reduces the risk of dying from cancer by allowing for earlier intervention and treatment. Results for cervical screening is based on NCSP. All results for mammography are taken from Breast Screen Aotearoa data.

Immunisation These services reduce the transmission and impact of vaccine-preventable diseases including unnecessary hospitalisations. The DHB works with primary care and allied health professionals to improve the provision of immunisations across all age groups both routinely and in response to specific risk. A high coverage rate is indicative of a well-coordinated, successful service.	**Notes**	**Actual 2015/16**	**Actual 2016/17**	**Actual 2018/19**	**Target 2020/21**
Percentage of infants aged 8 months who have completed their primary course of immunisation (six weeks, three months and five months immunisation events) on time. Refer CW05	T, C	92.9%	95%	95%	95%
Percentage of 2 year olds fully immunised on time. Refer CW08	T, C	94.3%	95%	95%	95%
Percentage of 5 year olds fully immunised on time. Refer CW05	T, C	91.6%	95%	93%	95%
Percentage of the eligible population receiving the flu vaccination. Refer CW05	C	70%	68.4%	60% (Sept 2018)	75%
Percentage of eligible girls and boys(from 2019/20) fully immunised with HPV vaccine. Refer CW05	C [4]	53.9% (This result if for girls only)	51% (This result if for girls only)	40% (This result if for girls only)	75%

[4] The Human Papillomavirus (HPV) vaccination aims to protect young people from HPV infection and the risk of developing HPV related cancers later in life. Prior to 2019/20 this measure was based on young women 12 - 18. (Two injections of Gardasil 9 are given at least six months apart for those aged 14 and under and three injections are given over six months for those aged 15 and older). From 2019/20 the target is the proportion of both boys and girls born in 2006 completing the programme and the NIR enrolled population will form the denominator rather than the census population projections. The timing of this measure is a calendar year.

Output Class

2.3 Early Detection and Management

Output class description

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

These services are by nature more generalist, usually accessible from multiple providers and a number of different locations. They include general practice, primary and community services, personal and mental health services, Māori and Pacific health services, diagnostic services, and child oral health services.

Services are provided with a mix of public and private funding and may include co-payments for general practice services and pharmaceuticals.

Why is this output class significant for us?

New Zealand is experiencing an increasing prevalence of long term conditions, so called because once diagnosed, people usually have them for the rest of their lives. Some population groups suffer from these conditions more than others, and prevalence also increases with age.

By promoting regular engagement with health services, we support people to maintain good health through earlier diagnosis and treatment, which provides an opportunity to intervene in less invasive and more cost-effective ways associated with better long term outcomes. By promoting regular engagement with primary and community services people are better supported to manage their long term conditions, stay well, identify issues earlier and reduce complications, acute illness and crises resulting in unnecessary hospital admissions. Reducing the diversion of critical resources into managing acute demand will have a major impact in freeing up hospital and specialist services for more complex and planned interventions. The integration of services presents a unique opportunity to reduce inefficiencies across the health system and provide access to a wider range of publicly funded services closer to home.

Output Subsets: Short Term Performance Measures 2020/21

Primary Health Care These services are offered in local community settings by a primary care team including general practitioners (GPs), registered nurses, nurse practitioners and other primary healthcare professionals, aimed at improving, maintaining or restoring people's health. High levels of enrolment with general practice are indicative of engagement, accessibility and responsiveness of primary care services.	**Notes**	**Actual 2016/17**	**Actual 2017/18**	**Actual 2018/19**	**Target 2020/21**
Percentage of ethnicity reported accurately in PHO registers. Refer PH02	C	98.7%	99.64%	99.7%	90%
Percentage of Māori enrolled in a general practice. Refer PH03	C	76%	83%	84%	95%
Avoidable Hospital Admission (ASH) 0 – 4 years (Total) rate. Refer PH01 (SLM Plan)	Q[1]	3,826	3,868	3,920 (to Mar 2019)	≤4,195
Avoidable Hospital Admission (ASH) 45 - 64 years (Total) rate. Refer SS05	Q[1]	4,027	3,207	3,373 (to Mar 2019)	3,331

1. Some admissions to hospital are seen as preventable through appropriate early intervention. These admissions provide an indication of the access and effectiveness of primary care and an improved integration between primary and secondary services. For 2015/16, results were changed to a rate rather than a percentage and as such are not comparable with the previous year.

Long Term Conditions Programme These services are targeted at people with high needs due to long term conditions and aim to reduce deterioration, crises and complications. Success is demonstrated through identification of need, regular monitoring and outcomes that demonstrate good conditions management. A focus on early intervention, self-management strategies and additional services available in the community will help to reduce the negative impact of long term conditions and the need for hospital admission.	**Notes**	**Actual 2016/17**	**Actual 2017/18**	**Actual 2018/19**	**Target 2020/21**
Percentage of people who receive an annual diabetes review with an HbA1c<64mmols. Refer SS13	C	38%	76%	97%	60%

Oral Health These services are provided by registered oral health professionals to help people maintain healthy teeth and gums. High enrolment indicates engagement, while timely examination and treatment indicates a well-functioning, efficient service.	**Notes**	**Actual 2016**	**Actual 2017**	**Actual 2018**	**Target 2020**
Percentage of children under five years enrolled in DHB funded dental services. Refer CW03	C	82.4%	73.5%	69.6%	≥95%
Percentage of adolescents accessing DHB funded oral health services. Refer CW04	C	83.1%	84%	80.7%	>85%
Percentage of children caries free at five years of age. Refer CW01	C	66%	64%	67%	68%
Oral Health Decayed, Missing and Filled Teeth score at year eight. Refer CW02	C	0.85	0.82	0.82	<0.73
Percentage of enrolled preschool and primary school children overdue for their scheduled examination. Refer CW03	T	12%	14%	11%	≤10%

Community Referred Tests and Diagnostic Services These are services to which a health professional may refer a person to help diagnose a health condition, or as part of treatment. They are provided by personnel such as, radiographers. To improve performance, we will target improved primary care access to diagnostics without the need for a hospital appointment to improve clinical referral processes and decision making.	**Notes**	**Actual 2016/17**	**Actual 2017/18**	**Actual 2018/19**	**Target 2020/21**
Percentage of accepted referrals for a MRI scan receive their scan within six weeks. Refer SS07	T	98%	98.4%	98.7%	90%
Percentage of accepted referrals for a CT scan receive their scan within six weeks. Refer SS07	T	94.9%	98%	98.6%	95%
Percentage of people accepted for an urgent diagnostic colonoscopy who receive their procedure within 14 calendar days. Refer SS15	T[3]	100%	87.5%	88.9%	90%
Percentage of people accepted for a non-urgent diagnostic colonoscopy who receive their procedure within six weeks. Refer SS15	T[3]	71.3%	45.2%	60.6%	70%
Percentage of people waiting for a surveillance colonoscopy will wait no longer than 12 weeks beyond the planned date. Refer SS15	T[3]	89.5%	52.4%	50%	70%

3. A colonoscopy is a test that looks at the inner lining of a person's large intestine (rectum and colon). A colonoscopy helps find ulcers, colon polyps, tumours, and areas of inflammation or bleeding to determine treatment

Output Class

2.4 Intensive Assessment and Treatment Services

Output class description

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

We provide an extensive range of intensive treatment and complex specialist services for our population and we also fund some intensive assessment and treatment services for our population that are provided by other DHBs. A proportion of these services are driven by demand which we must meet, such as acute services. However, others are planned services for which provision and access are determined by capacity, clinical triage, national service coverage agreements and treatment thresholds.

Why is this output class significant for us?

Equitable, timely access to intensive assessment and treatment can significantly improve people's quality of life either through early intervention (e.g. removal of an obstructed gallbladder so the patient does not have repeat attacks of abdominal pain) or through corrective action (e.g. major joint replacements). Responsive services and timely treatment support improvements across the whole system and give people confidence that complex intervention is available when needed. People are then able to establish more stable lives, resulting in improved public confidence in the health system.

As an owner and provider of these services, we are also concerned with the quality of the services being provided. Quality improvement in service delivery, systems and processes will improve patient safety, reduce the number of events causing injury or harm and provide improved outcomes for people in our services. Adverse events and delays in treatment, as well as causing harm to patients, drive unnecessary costs and redirect resources away from other services. Appropriate and quality service provision will reduce readmission rates and better support people to recover from complex illness and / or maximise their quality of life.

Government has set clear expectations for the delivery planned care volumes, a reduction in waiting times for treatments and increased clinical leadership to improve the quality of care. In meeting these expectations, we are introducing innovative clinically led service delivery models and reducing waiting time within our hospital services.

Output Subsets: Short Term Performance Measures 2020/21

Acute Services These are medical or surgical services for illnesses that have an abrupt onset or progress rapidly creating an urgent need for care. For more complex acute conditions, hospital-based services include emergency services, acute medical and surgical services and intensive care services	**Notes**	**Actual 2016/17**	**Actual 2017/18**	**Actual 2018/19**	**Target 2020/21**
Percentage of patients admitted, discharged or transferred from ED within 6 hours. Refer SS10	T	95.6%	96.9%	95.9%	95%
Standardised acute hospital stays bed days per 1,000 population. – Refer PH01 (SLM Plan)	V	421	374.5	400.2 (to Dec 2018)	<411
Percentage of patients who receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks. Refer SS11	T	75.8%	77.5%	87.8%	90%
Percentage of older patients assessed as at risk of falling. QSM	Q[1]	96.1%	98%	90%	95%

1. This is a NZ Health Quality and Safety Marker.

Planned Care These are services (which incorporate elective services) are for people who do not need immediate hospital treatment and are 'booked' or 'arranged' services. This includes surgery and specialist assessments. National Elective Services Patient Flow Indicators (ESPIs) are indicative of a successful and responsive service, addressing population need.	**Notes**	**Actual 2016/17**	**Actual 2017/18**	**Actual 2018/19**	**Target 2020/21**
No. inpatient surgical discharges (planned care interventions).SS07	Q[1]	NEW	NEW	NEW	3,124

1. The definition for this measure has been revised again in 2019. As such it is not comparable with previous years.

Specialist Mental Health Services These are services for the most severely affected by mental illness or addictions. They include assessment, diagnosis, treatment, rehabilitation and crisis response when needed. Utilisation and wait times are monitored to ensure service levels are maintained and to demonstrate responsiveness to need.	**Notes**	**Actual 2016/17**	**Actual 2017/18**	**Actual 2018/19**	**Target 2020/21**
Percentage of young people (aged 0 – 19) who have accessed specialist mental health services. Ref MH01	C	5.48% (March 2017)	5.75%	5.9% (to Mar 2019)	5%
Access rates to Primary Mental Health Brief Intervention – 12-19 Years Refer MH04	T	4.36%	4.5%	4.6%	5%
Access rates to Primary Mental Health Brief Intervention – 20+ Years Refer MH04	T	2.9%	2.5%	3.5%	3%
Rate of Māori per 100,000 under the Mental Health (Compulsory Assessment and Treatment) Act 1992: section 29 community treatment orders relative to other ethnicities. Refer MH05	Q	Māori 159 Total 103	Māori 133 Non-Maori 102	Māori 171 Non-Maori 86	Māori 136.8 Non-Māori 77.4

Output Class

2.5 Rehabilitation and Support Services

Output class description

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

Why is this output class significant for us?

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 admissions 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.

In preventing deterioration and acute illness or crisis, these services have a major impact on the sustainability of hospital and specialist services and on the wider health system in general by reducing acute demand, unnecessary emergency department presentations and the need for more complex intervention. These services also support the flow of patients and improved recovery after an acute illness or hospital admission – helping to reduce readmission rates and supporting people to recover from complex illness and/or maximise their quality of life.

Living in Aged Related Residential Care (ARRC) has been associated with a more rapid functional decline than 'ageing in place' and is a more expensive option. Resources can be better utilised providing appropriate levels of support to people to help them stay in their own homes and to moderate the need for residential care and hospital level services.

We have taken a 'restorative' approach and have introduced individual packages of care to better meet people's needs, including complex care packages for people assessed as eligible for ARRC who would rather stay in their own homes. With an ageing population, it is vital we monitor the

effectiveness of these services, and we use the InterRAI (International Residential Assessment Instrument) tool to ensure people receive equitable access to clinically appropriate support services that best meet their needs.

Output Subsets: Short Term Performance Measures 2020/21

Needs Assessment and Support These are services that determine a person's eligibility and need for publicly funded support and the best mix of supports based on the person's strengths, resources and goals. The supports are delivered by an integrated team in the person's own home or community. The delivery of assessments and the use of evidence-based tools indicate quality, equity of access and responsiveness.	**Notes**	**Actual 2016/17**	**Actual 2017/18**	**Actual 2018/19**	**Target 2020/21**
Percentage of residents who have had a subsequent InterRAI long term care facility assessment completed within 230 days of the previous assessment.	T[1]	87%	95%	95%	90%
Percentage of clients who have been admitted to an Aged Related Care (ARC) facility from the community who have been assessed using the InterRAI Home Assessment Tool within six months of admission to the ARC facility.	Q	New	87%	93%	95%

1. The International Residential Assessment Instrument (InterRAI) is a suite of evidence-based geriatric assessment tools used nationally. The tools support clinical decision making and care planning. Evidence-based practice guidelines ensure assessments are of high quality and people receive appropriate and equitable access to services irrespective of where they live. The definition of this measure changed for the 2017/18 year.

Rehabilitation	**Notes**	**Actual 2016/17**	**Actual 2017/18**	**Actual 2018/19**	**Target 2020/21**
Percentage of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission. Refer SS13	T[2]	96%	85 %	74.5%	80%
Percentage of patients referred for community rehabilitation seen face to face by a member of the community rehabilitation team within 7 calendar days of hospital discharge. Refer SS13	Q[3]	NEW	80%	63%	60%
Percentage of mental health & addiction clients with a transition (discharge) plan. Refer MH02	C[3]	NEW	81%	80%	95%

2. Prior to the 2016/17 year the definition for this measure was against a timeframe of 10 days.
3. Monitoring of this measure is from the second quarter of 2016/17 onwards and is the average of the three quarters
4. A transition (discharge) plan is a plan on discharge which includes relapse prevention and ensuring integration within community resources.

[1]3. ANNUAL OPERATING INTENTIONS – FINANCIAL PERFOMANCE

South Canterbury District Health Board Consolidated Financial Performance 2020/2021	2018/19 Audited Actual	2019/20 Forecast	2020/21 Plan	2021/22 Plan	2022/23 Plan	2023/24 Plan
Patient Care Revenue	205,217	222,496	225,678	235,652	245,507	255,788
Other Revenue	2,464	2,185	1,717	1,715	1,715	1,715
Finance Revenue	815	666	611	51	-	-
TOTAL OPERATING REVENUE	208,496	225,347	228,006	237,418	247,222	257,503
	-	-	-	-	-	-
Personnel Benefit Costs	82,686	74,524	77,449	79,877	80,463	82,315
Outsourced Services	10,779	10,267	9,188	10,268	10,454	10,689
Clinical Supplies	10,468	11,443	11,669	11,940	12,107	12,901
Infrastructure & Non-Clinical Supplies	10,978	10,067	11,241	11,121	10,783	11,583
Payments to Non DHB health providers	101,726	114,175	112,025	117,309	124,781	130,888
Depreciation and Ammortisation expenses	4,436	4,323	4,742	5,162	5,497	5,502
Finance Costs	4	-	-	-	-	-
Capital Charge	2,389	1,648	1,620	1,620	1,620	1,620
TOTAL OPERATING EXPENDITURE	223,466	226,447	227,934	237,297	245,705	255,498
SURPLUS/(DEFICIT)	**(14,970)**	**(1,100)**	**72**	**121**	**1,517**	**2,005**

South Canterbury District Health Board Consolidated Financial Position 2020/2021	2018/19 Audited Actual	2019/20 Forecast	2020/21 Plan	2021/22 Plan	2022/23 Plan	2023/24 Plan
Public Equity						
General Funds	16,480	16,300	16,049	15,798	15,545	15,293
Accumulated Surplus	(4,762)	(5,862)	(5,790)	(5,669)	(4,152)	(2,147)
Equity from Donated Assets	1,572	1,534	1,503	1,471	1,435	1,399
Revaluation Reserve	15,450	15,450	15,450	15,450	15,450	15,450
Total Equity	28,740	27,422	27,212	27,050	28,278	29,995
ASSETS						
Current Assets						
Cash and cash equivalents	7,673	8,145	2,181	2	2	4,099
Financial Assets	12,778	7,600	-	-	-	-
Debtors and other receivables	7,307	5,912	7,210	7,210	6,810	6,760
Invetories	1,242	1,188	1,200	1,200	1,100	1,100
Total Current Assets	29,000	22,845	10,591	8,412	7,912	11,959
Non Current Assets						
Financial Assets	201	5,379	201	201	201	50
Property, plant and equipment	40,958	43,096	56,109	61,820	66,243	64,083
Intangible Assets	787	803	5,120	5,896	6,447	6,998
Total Non Current Assets	41,946	49,278	61,430	67,917	72,891	71,131
TOTAL ASSETS	70,946	72,123	72,021	76,329	80,803	83,090

[1] ***Please note: As the 2020/21 SCDHB Annual Plan financials have not been approved by the MOH at the time of publishing, these may be subject to change once the 2020/21 financials have been approved.***

LIABILITIES						
Current Liabilities						
Bank Overdraft	-	-	-	3,432	3,036	-
Creditors and other payables	11,043	11,723	11,197	12,238	12,728	13,152
Employee Entitlements	23,585	25,545	25,993	25,993	26,692	27,143
Borrowings	-	-	-	-	-	-
Total Current Liabilities	34,628	37,268	37,190	41,663	42,456	40,295
Non Current Liabilities						
Finance Lease Liability	337	169	169	169	169	1,200
Term Loans	-	-	-	-	-	-
Employee Entitlements	7,241	7,264	7,450	7,450	9,900	11,600
Total Non Current Liabilities	7,578	7,433	7,619	7,619	10,069	12,800
TOTAL LIABILITIES	42,206	44,701	44,809	49,282	52,525	53,095
NET ASSETS	**28,740**	**27,422**	**27,212**	**27,047**	**28,278**	**29,995**

South Canterbury District Health Board Statement of Changes in Equity 2020/2021	1-Jul-18 **Opening Balance**	2018/19 **Audited Actual**	2019/20 **Forecast**	2020/21 **Plan**	2021/22 **Plan**	2022/23 **Plan**	2023/24 **Plan**
Total Equity at start of period		41,258	28,740	27,422	27,212	27,047	28,278
Net Surplus/ (Deficit) for year		(14,970)	(1,100)	72	121	1,517	2,005
Movement in Revaluation Reserve		2,667	-	-	-	-	-
Equity Injection Deficit Support		-	-	-	-	-	-
Capital Repaid		(217)	(217)	(217)	(217)	(217)	(217)
Other Movements		2	(1)	(65)	(69)	(69)	(71)
Total Equity at end of period		**28,740**	**27,422**	**27,212**	**27,047**	**28,278**	**29,995**

CASHFLOW & BANK 2020/2021	1-Jul-18 **Opening Balance**	2018/19 **Audited Actual**	2019/20 **Forecast**	2020/21 **Plan**	2021/22 **Plan**	2022/23 **Plan**	2023/24 **Plan**
Total Receipts		208,635	221,472	227,395	237,565	247,816	258,493
Total payments		(203,593)	(214,908)	(209,166)	(236,701)	(240,973)	(248,553)
CASH FLOW FROM OPERATING ACTIVITIES		5,042	6,564	18,229	864	6,843	9,940
CASH FLOW FROM INVESTING ACTIVITIES		(5,223)	(5,875)	(24,410)	(20,692)	(6,664)	(3,024)
CASH FLOW FROM FINANCING ACTIVITIES		(457)	(217)	217	14,217	217	217
NET CASH FLOW		(638)	472	(5,964)	(5,611)	396	7,133
Plus: Cash (Opening)		8,311	7,673	8,145	2,181	(3,430)	(3,034)
YTD Net cash movements		(638)	472	(5,964)	(5,611)	396	7,133
Cash (Closing)	**8,311**	**7,673**	**8,145**	**2,181**	**(3,430)**	**(3,034)**	**4,099**

[1] Please note: As the 2020/21 SCDHB Annual Plan financials have not been approved by the MOH at the time of publishing, these may be subject to change once the 2020/21 financials have been approved.

3.1 Fiscal Sustainability - Planned Net Results

South Canterbury District Health Board has a history of achieving breakeven or better on its financial plans and will submit a break-even plan for 2019/20. The DHB continues to face significant challenges and risks to achieving this plan. These include:

- indicative annual funding increases are at the minimum level years 2-4;
- employee industrial settlements have been negotiated for the sector at rates higher than South Canterbury District Health Board's indicative annual funding increase and comprise 68% of annual costs;
- greater demand for services delivered at home and in communities;
- cost pressures in hospital, specialist services and the non-government sector;
- reserve funds for future years to support District Health Board capital investment in the medium term and/or provide an organisational operational contingency;
- strategic investment to progress integrated system approach regionally and nationally; and
- investment for improved outcomes in specific population groups e.g. child and youth, Māori and mental health service clients.

The allowance for cost growth in our funding envelope from the Ministry of Health this year is 3.48%. This is an increase from the Funding Envelope in 2019/20 of $6.4m.

When recognising industrial settlement pressures, step increases, inflationary and other cost and quality pressures, the South Canterbury District Health Board was not able to find enough financial efficiency gains in a single year to offset the noted pressures. To offset planned deficits in the Provider Arm, a number of reviews of service reconfiguration will be required to lower the cost base. This presents a significant challenge over the next two years.

The Plan financials include productivity and efficiency savings. Savings will be generated through local initiatives. South Canterbury District Health Board has been containing cost growth and reviewing revenue from other activities to ensure that over the next three years we can continue to live within the funding available while maintaining service delivery.

3.2 Fixed Assets

The Board considers the appropriateness of the valuation of its land and buildings each year in June. A full revaluation of the District Health Board land and buildings was completed as at June 2016. This revaluation realised a gain of $1.21m on the value of District Health Board assets and included the completed works for Kensington, the Gardens Block, the Records Building, the pending changes at Talbot Park and a large number of information services projects.

A full revaluation is next due to be completed in June 2019. No impact on capital charge, as a result of any requirement to adopt a new valuation, has been provided in either income or expenditure.

Disposal of Land

South Canterbury District Health Board will ensure that disposal of land transferred to or vested in pursuant to the Health Sector (Transfers) Act (1993) will be subject to approval by the Minister of Health. The District Health Board will ensure that the relevant protection mechanisms that address the Crown's governance obligations in relation to Māori sites of significance and that the requirements of section 40 of the Public Works Act are addressed. Any such disposals will be planned in accordance with s42 (2) of the NZPHD Act 2000. No land disposals have been planned in 2019/20.

Front of Hospital Redevelopment

The Front of Hospital business case incorporating changes to emergency, outpatients, day stay services, hospital reception and the Café with a spend of $7m, which was approved by the Board in 2015. These projects are in the final design stage, with building works continuing during 2019/20. In addition to this, work to improve environmental components of the existing central services building is underway to ensure energy efficiency, site infrastructure and preventative maintenance are optimal.

3.3 Capital Expenditure

Capital expenditure is provided in three components:

1. General Capital Expenditure

$000s	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	Total
Buildings, Plant & Equipment excl Clinical	295	366	250	250	250	255	260	265	271	276	282	2,725
Clinical Equipment	1,225	1,261	1,411	1,430	1,430	1,459	1,488	1,518	1,548	1,579	1,610	14,733
Other Equipments		232	267	275	275	281	286	292	298	304	310	2,818
IT/IS - devices/hardware	452	145	151	155	155	158	161	164	168	171	175	1,603
Intangible Assets (Software)	153	134	140	144	144	147	150	153	156	159	162	1,489
Vehicles	204	200	208	214	214	218	223	227	232	236	241	2,213
Contingency	260	300	312	321	321	327	334	341	347	354	361	3,319
Minor capital	223	174	181	186	186	190	194	197	201	205	209	1,924
Total Baseline Capex	2,812	2,812	2,920	2,975	2,975	3,035	3,095	3,157	3,220	3,285	3,350	30,824

2. Special Capital Projects

Special capital projects are targeted funding which is not available for redistribution should these projects not proceed. Explicit approval for each of these items is required before proceeding.

$000s	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	Total
Boilers	204	4,000	-	-	-	-	-	-	-			4,000
Morgue Chiller		150										150
New Café/Outpatients/Front Entrance		3,500										3,500
Level 2 Maternity/ Paediatrics		3,500										3,500
Level 1 new Build Ward		3,800										3,800
Stores/ maintenance	3,104	800										800
Level 1 ATR/ Mental health Refurbishment				2,500								2,500
Level 3 Medical Floor	623		3,500									3,500
Level 4 Theatres/Day Stay				3,500								3,500
Level 5 Surgical Floor			3,500									3,500
Building Fees	1,320	500	500	500								1,500
Environmental Upgrades (Theatre Ventiliation)		200										200
CT Scanner		1,700										1,700
Total Special	5,251	18,150	7,500	6,500	-	-	-	-	-			32,150

3. Regional/National Projects

These are regional / national projects that have been agreed. Explicit approval for each of these items is required before proceeding.

$000s	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	Total
Data Warehouse / architecture	-	150										150
E-Medication Reconciliations	48	48										48
E-Ordering Laboratory	64	64										64
E-Ordering Radiology	-	75										75
E-Pharmacy	-	-										-
E-Prescription Repository	-	-										-
E-Referrals - Stage 3 Triage	-	106										106
E-Referrals - Inter / Intra DHB	-	-										-
Growth Charts	-	-										-
MDM	-	-										-
Mental Health Module	-	112										112
Patient Track	-	-										-
Problem Lists	-	-										-
Provider Index	-	-										-
Emergency Department Solution	-	51										51
South Island PICS	2,000	1,852	212									2,064
FPIM		931										931
South Island/Regional Projects		1,000	1,000	1,000								3,000
Total Strategic	2,112	4,389	1,212	1,000	-	-	-	-	-	-	-	6,601

$000s	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	Total
General	2,812	2,812	2,920	2,975	2,975	3,035	3,095	3,157	3,220	3,285	3,350	30,824
Special Capital Projects	5,251	18,150	7,500	6,500	-	-	-	-	-	-	-	32,150
Regional/National Projects	2,112	4,389	1,212	1,000	-	-	-	-				6,601
Total	**10,175**	**25,351**	**11,632**	**10,475**	**2,975**	**3,035**	**3,095**	**3,157**	**3,220**	**3,285**	**3,350**	**69,575**

3.4 Method of Capital Prioritisation

South Canterbury District Health Board sets the capital budget, which is informed by the budgeting process.

The capital budget is compiled from prioritised bottom-up requests and management knowledge. Prioritisation is based on clinical, quality or compliance driven need or financial justification to which various thresholds/hurdles apply, depending on the nature and quantum of the proposed investment.

All capital expenditure will be from internally generated funds or existing debt facilities already in place and subject to approval by Joint Ministers, the Minister of Health and Minister of Finance.

3.5 Debt and Equity

South Canterbury District Health Board has no additional borrowing facility or equity requirements during the four years of this financial plan.

Changes in Lenders, Limits and Borrowing Arrangements
South Canterbury District Health Board joined the New Zealand Health Partnership Banking and Treasury arrangements during 2017/18 and continues to be party to this arrangement. Where the District Health Board can attain a preferential rate for term deposits outside this arrangement it has retained the right to do so.