South Canterbury
District Health Board

E89

2021/22

Statement of Performance Expectations

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

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1. SIGNATORIES

DATED:

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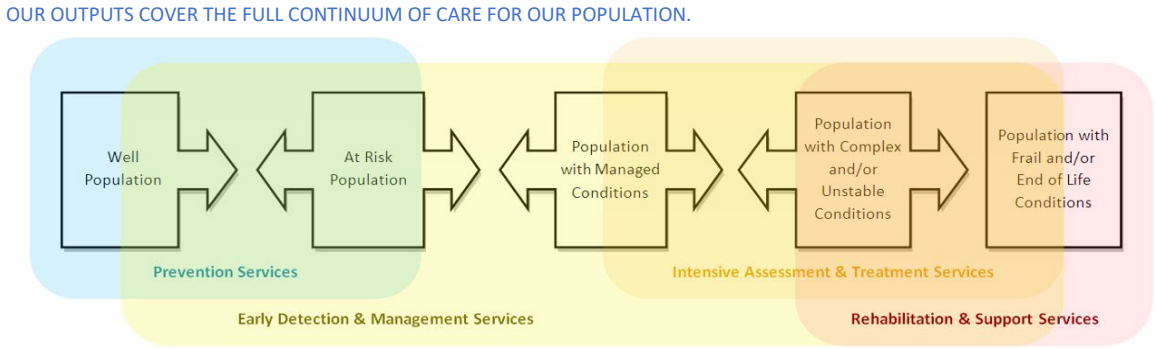
2. ANNUAL OPERATING INTENTIONS – NON-FINANCIAL PERFOMANCE

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 2021/22.

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,

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

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 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 12 monthly result where possible. 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 2021/22 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 2021/22

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 2017/18**	**Actual 2018/19**	**Actual 2019/20**	**Target 2021/22**
Percentage of babies breast-fed (exclusive and full) in the district at 3 months of age. Refer CW06	C, Q [1]	60.1%	63%	64.2%	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	92.6% (Q4)	80.6% (Q4)	82.6% (Q4)	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	89%	100%	98%	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 2017/18**	**Actual 2018/19**	**Actual 2019/20**	**Target 2021/22**
Percentage of enrolled women aged 25 – 69 years who have had a cervical screen in the last three years. Refer PV02	T [2]	77%	73.8%	70.2%	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]	65.3%	62.4%	59.2%	80%
Percentage of enrolled women aged 45 – 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] C[3]	New	New	70.2%	70%
Percentage of Māori enrolled women aged 45 – 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] C[3]	%	%	62.7%	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	87% (12month to 31 May18)	96% (12month to 31 May19)	98% (12month to 31 May20)	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.

[3] The age range for Breastscreening has increased to start at 45 years of age and the performance measure has been adjusted accordingly.

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 2017/18**	**Actual 2018/19**	**Actual 2019/20**	**Target 2021/22**
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	93%	93%	94%	95%
Percentage of 2 year olds fully immunised on time. Refer CW08	T, C	94%	93%	93%	95%
Percentage of 5 year olds fully immunised on time. Refer CW05	T, C	91%	91%	93%	95%
Percentage of the eligible population receiving the flu vaccination. Refer CW05	C	60% (Sept 2017)	60% (Sept 2018)	61% (Sept 2019)	75%
Percentage of eligible girls and boys (from 2019/20) fully immunised with HPV vaccine. Refer CW05	C [4]	New	New	53.5%	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 2021/22

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 2017/18**	**Actual 2018/19**	**Actual 2019/20**	**Target 2021/22**
Percentage of ethnicity reported accurately in PHO registers. Refer PH02	C	99.64% (Q4)	99.7% (Q4)	99.9% (Q4)	>95%
Percentage of Māori enrolled in a general practice. Refer PH03	C	83% (Q4)	84% (Q4)	82% (Q4)	95%
Avoidable Hospital Admission (ASH) 0 – 4 years (Total) rate. Refer PH01 (SLM Plan)	Q[1]	3,868	3,925	4,065	≤3,885

Avoidable Hospital Admission (ASH) 45 - 64 years (Total) rate. Refer SS05	Q[1]	3,290	3,517	3,236	3,331

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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 2017/18**	**Actual 2018/19**	**Actual 2019/20**	**Target 2021/22**
Percentage of PHO enrolled people with an HbA1c<64mmols. Refer SS13	C	N/A	N/A	60.2%	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 2017**	**Actual 2018**	**Actual 2019**	**Target 2021**
Percentage of children under five years enrolled in DHB funded dental services. Refer CW03	C	73.5%	69.6%	77.1%	≥95%
Percentage of adolescents accessing DHB funded oral health services. Refer CW04	C	84%	80.7%	78.1%	>85%
Percentage of children caries free at five years of age. Refer CW01	C	64%	67%	72%	68%
Oral Health Decayed, Missing and Filled Teeth score at year eight. Refer CW02	C	0.82	0.82	0.81	<0.73
Percentage of enrolled preschool and primary school children overdue for their scheduled examination. Refer CW03	T	14%	11%	9%	≤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 2017/18**	**Actual 2018/19**	**Actual 2019/20**	**Target 2021/22**
Percentage of accepted referrals for a MRI scan receive their scan within six weeks. Refer SS07	T	98.3%	98.3%	88.1%	90%
Percentage of accepted referrals for a CT scan receive their scan within six weeks. Refer SS07	T	96.1%	98.1%	91%	95%
Percentage of people accepted for an urgent diagnostic colonoscopy who receive their procedure within 14 calendar days. Refer SS15	T[3]	96.2%	95.4%	97.7%	90%
Percentage of people accepted for a non-urgent diagnostic colonoscopy who receive their procedure within six weeks. Refer SS15	T[2]	47.2%	50.9%	85.6%	70%
Percentage of people waiting for a surveillance colonoscopy will wait no longer than 12 weeks beyond the planned date. Refer SS15	T[3]	76.5%	61.9%	90.4%	70%

2. 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 2021/22

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 2017/18**	**Actual 2018/19**	**Actual 2019/20**	**Target 2021/22**
Percentage of patients admitted, discharged or transferred from ED within 6 hours. Refer SS10	T	97.1%	96.6%	87.1%	95%
Standardised acute hospital stays bed days per 1,000 population. – Refer PH01 (SLM Plan)	V	374.5	441.9	401.7	<401
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	85.3%	88.6%	69%	85%
Percentage of older patients assessed as at risk of falling. QSM	Q[1]	97%	95%	97%	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 2017/18**	**Actual 2018/19**	**Actual 2019/20**	**Target 2021/22**
No. inpatient surgical discharges (planned care interventions).SS07	Q[2]	NEW	NEW	2,773	TBA

2. 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 2017/18**	**Actual 2018/19**	**Actual 2019/20**	**Target 2021/22**
Percentage of young people (aged 0 – 19) who have accessed specialist mental health services. Ref MH01	C	5.75% (March 2018)	5.9% (to Mar 2019)	5.9% (March 2020)	5%
Access rates to Primary Mental Health Brief Intervention – 12-19 Years Refer MH04	T	4.5%	4.6%	6.0%	4.7%
Access rates to Primary Mental Health Brief Intervention – 20+ Years Refer MH04	T	2.5%	3.5%	2.5%	2.8%
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 133 Non-Maori 102 5.75% (March 2018)	Māori 171 Non-Maori 86 5.9% (to Mar 2019)	Māori 160 Non-Maori 89 5.9% (March 2020)	Māori 173.7 Non-Māori 86.4

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 2021/22

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 2017/18**	**Actual 2018/19**	**Actual 2019/20**	**Target 2021/22**
Percentage of residents who have had a subsequent InterRAI long term care facility assessment completed within 230 days of the previous assessment.	T[1]	89%	93%	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	94%	91%	91%	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.

Rehabilitation	**Notes**	**Actual 2017/18**	**Actual 2018/19**	**Actual 2019/20**	**Target 2021/22**
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	85 %	74.5%	84.1%	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	80%	63%	71%	60%
Percentage of mental health & addiction clients with a transition (discharge) plan. Refer MH02	C[2]	N/A*	N/A*	81%	95%

2. A transition (discharge) plan is a plan on discharge which includes relapse prevention and ensuring integration within community resources.

3. ANNUAL OPERATING INTENTIONS – FINANCIAL PERFOMANCE

3.1 Fiscal Sustainability - Planned Net Results

TBC

Financial tables to be inserted following Ministry approval

3.2 Fixed Assets

The South Canterbury DHB is undertaking a refurbishment programme which includes some new buildings, this programme covers emergency, outpatients, day stay services, hospital reception, Café and all Wards in the Timaru Hospital. The Ministry has provided $2m towards the refurbishment of the Child and Maternity Ward. The refurbishment programme will involve a number of projects over the next three years with a total cost of approximately $25m, which will be funded by the DHB.

As part of minimising our carbon footprint, the DHB will be replacing the current coal boilers to a more efficient energy source. The Ministry has provided $4m towards this replacement.

3.3 Capital Expenditure

Capital expenditure is provided in three components:

1. General Capital Expenditure

$000s	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	239	250	250	250	255	260	265	271	276	282	2,598
Clinical Equipment	1,855	1,561	1,561	1,430	1,459	1,488	1,518	1,548	1,579	1,610	15,608
Other Equipments	270	267	275	275	281	286	292	298	304	310	2,856
IT/IS - devices/hardware	205	151	155	155	158	161	164	168	171	175	1,663
Intangible Assets (Software)	140	140	144	144	147	150	153	156	159	162	1,495
Vehicles	274	208	214	214	218	223	227	232	236	241	2,287
Contingency	400	312	321	321	327	334	341	347	354	361	3,419
Minor capital	225	181	186	186	190	194	197	201	205	209	1,975
Total Baseline Capex	3,608	3,070	3,106	2,975	3,035	3,095	3,157	3,220	3,285	3,350	31,901

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	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	Total
Boilers	3,721	-	-	-	-	-	-	-			3,721
Theatre Ventiliation	325										325
Stores/Maintenance Building (Old Boiler House)	716										716
Morgue Chiller											-
New Café/Outpatients/Front Entrance	351										351
Café Fitout											-
Level 1 AT&R	5,100										5,100
Level 2 Maternity/Paeds	2,832										2,832
Level 3 Medical Fllor	3,750										3,750
Level 4 Theatre/ Day Patients	-	900									900
Level 5 Surgical Fllor	1,500	2,000									3,500
AT&R Outpatients		3,000									3,000
Lift Replacement	600										600
CT Scanner	1,700										1,700
Endoscopy Upgrade	2,000										2,000
Talbot Upgrade	300										300
Total Special	22,895	5,900	-	-	-	-	-	-	-	-	28,795

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	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	Total
Data Warehouse / architecture											-
E-Medication Reconciliations											-
E-Ordering Laboratory											-
E-Ordering Radiology											-
E-Referrals - Stage 3 Triage											-
Health System Catolgue											-
Local/Regional IT Projects	600	200									800
SI PICs	500										500
											-
Total Strategic	1,100	200	-	-	-	-	-	-	-	-	1,300

$000s	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	Total
General	3,608	3,070	3,106	2,975	3,035	3,095	3,157	3,220	3,285	3,350	31,901
Special Capital Projects	22,895	5,900	-	-	-	-	-	-	-	-	28,795
Regional/National Projects	1,100	200	-	-	-	-	-	-	-	-	1,300
											-
Total	**27,603**	**9,170**	**3,106**	**2,975**	**3,035**	**3,095**	**3,157**	**3,220**	**3,285**	**3,350**	**61,996**

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.