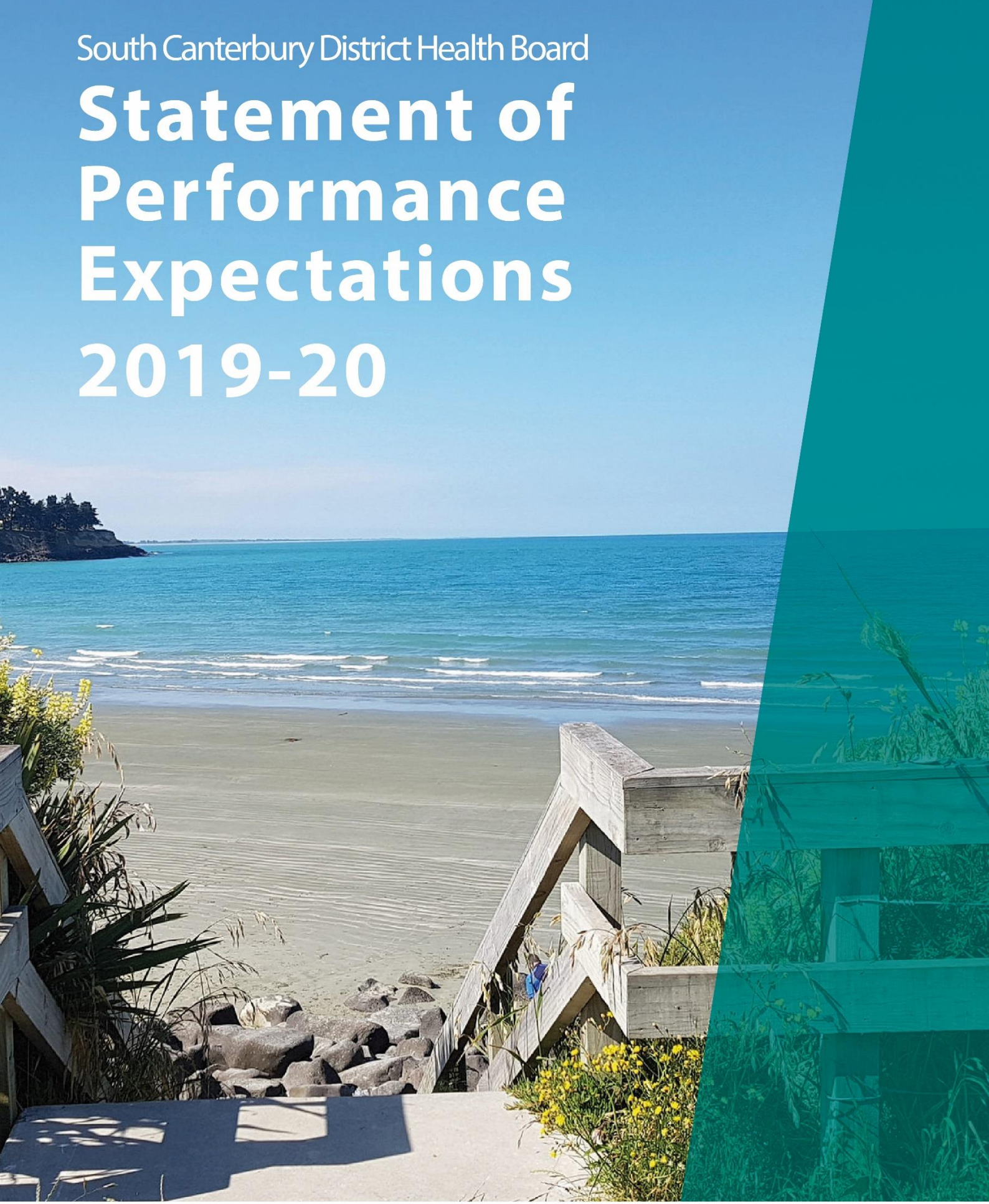
South Canterbury District Health Board

Statement of Performance Expectations 2019-20



South Canterbury District Health Board

EVERY moment MATTERS

Enhancing the health and independence of the people of South Canterbury

Contents

1.0 SIGNATORIES

DATED THIS 20th DAY OF JUNE 2019

Ron Luxton Chairperson of the Board

Paul Annear Deputy Chairperson of the Board

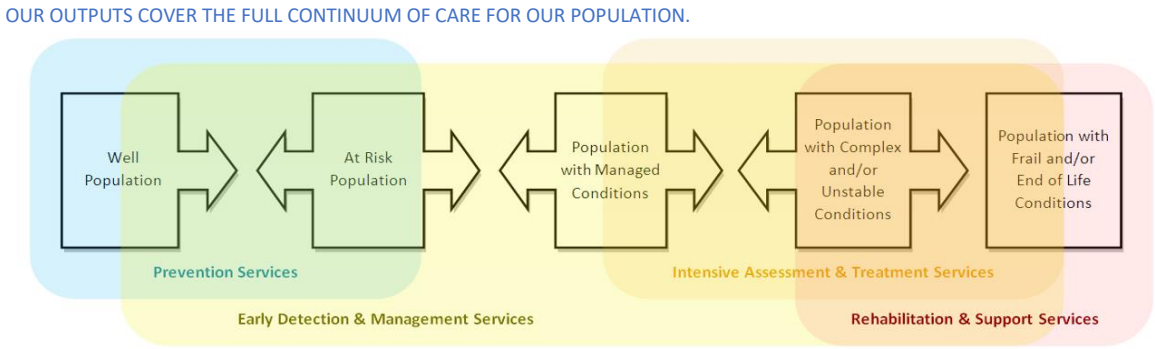
2.0 ANNUAL OPERATING INTENTIONS – NON-FINANCIAL PERFOMANCE

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 2019/20.

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

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

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 provide 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 Health 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: PP – Policy Priorities, SI – System Integration, and OS – Ownership.

Where does the money go?
The table on page 14 provides a summary of the 2019/20 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 2019/20

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 2015/16**	**Actual 2016/17**	**Actual 2017/18**	**Target 2019/20**
Percentage of babies breast-fed (exclusive and full) in the district at 3 months of age. Refer CW06	C, Q [1]	55%	N/A	63% (Jan-Jun18	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	89.2%	88.9%	92.6%	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 CW09	C	91.7%	92.3%	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 2015/16**	**Actual 2016/17**	**Actual 2017/18**	**Target 2019/20**
Percentage of enrolled women aged 25 – 69 years who have had a cervical screen in the last three years. Refer SS08	T [2]	76.3%	77.1%	77%	80%
Percentage of Māori enrolled women aged 25 – 69 years who have had a cervical screen in the last three years. Refer SS08	T [2]	60.1%	59.6%	65.3%	80%

Percentage of 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 SS07	T [2]	78.4%	77.3%	76.2%	70%
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 SS07	T [2]	78.3%	72.3%	67.3%	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	57%	79%	97%	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 2017/18**	**Target 2019/20**
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 CW08	T, C	92.9%	95%	94%	95%
Percentage of 2 year olds fully immunised on time. Refer CW05	T, C	94.3%	95%	98%	95%
Percentage of 5 year olds fully immunised on time. Refer CW05	T, C	91.6%	95%	92%	95%
Percentage of the eligible population receiving the flu vaccination. Refer CW05	C	70%	68.4%	60% (Sept 2017)	75%
Percentage of eligible girls fully immunised with HPV vaccine. Refer CW05	C [4]	53.9%	51%	44%	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 2019/20

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 2015/16**	**Actual 2016/17**	**Actual 2017/18**	**Target 2019/20**
Percentage of ethnicity reported accurately in PHO registers. Refer PH02	C	99.9%	98.7%	99.64%	99%
Percentage of Māori enrolled in a general practice. Refer PH03	C	76.55%	76%	83%	90%
Avoidable Hospital Admission (ASH) 0 – 4 years (Total) rate. Refer SS (SLM Plan)	Q[1]	4,167	3,826	3,868	≤4,195
Avoidable Hospital Admission (ASH) 45 - 64 years (Total) rate. Refer SS02	Q[1]	3,337	4,027	3,207	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 2015/16**	**Actual 2016/17**	**Actual 2017/18**	**Target 2019/20**
Percentage of people assessed as high risk who have received an annual review. Refer SS13	C[2]	N/A	N/A	N/A	New -to be established

2. This is a new measure which reflects the changing focus in CVD for those assessed as high risk to demonstrate good management. Baseline data to be established in year 1.

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 2015**	**Actual 2016**	**Actual 2017**	**Target 2019**
Percentage of children under five years enrolled in DHB funded dental services. Refer CW04	C	82.4%	82.4%	73.5%	≥95%
Percentage of adolescents accessing DHB funded oral health services. Refer CW03	C	84.2%	83.1%	84%	85%
Percentage of children caries free at five years of age. Refer CW02	C	64%	66%	64%	66%
Oral Health Decayed, Missing and Filled Teeth score at year eight. Refer CW01	C	0.88	0.85	0.82	0.77
Percentage of enrolled preschool and primary school children overdue for their scheduled examination. Refer CW04	T	14%	12%	14%	≤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 2015/16**	**Actual 2016/17**	**Actual 2017/18**	**Target 2019/20**
Percentage of accepted referrals for a MRI scan receive their scan within six weeks. Refer	T	97.8%	98%	98.4%	95%
Percentage of accepted referrals for a CT scan receive their scan within six weeks. Refer	T	95.5%	94.9%	98%	95%
Percentage of people accepted for an urgent diagnostic colonoscopy who receive their procedure within 14 calendar days. Refer SI15	T[3]	89.3%	100%	87.5%	90%
Percentage of people accepted for a non-urgent diagnostic colonoscopy who receive their procedure within six weeks. Refer SI15	T[3]	53.5%	71.3%	45.2%	70%
Percentage of people waiting for a surveillance colonoscopy will wait no longer than 12 weeks beyond the planned date. Refer SI15	T[3]	50%	89.5%	52.4%	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 of elective surgical 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 2019/20

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 2015/16**	**Actual 2016/17**	**Actual 2017/18**	**Target 2019/20**
Percentage of patients admitted, discharged or transferred from ED within 6 hours. Refer SS10	T	96.3%	95.6%	96.9%	95%
Standardised acute hospital stays bed days per 1,000 population. – Refer SS (SLM Plan)	V	457	421	374.5	<384
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	65.9%	75.8%	77.5%	90%
Percentage of older patients assessed as at risk of falling. QSM	Q[1]	99%	96.1%	98%	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 2015/16**	**Actual 2016/17**	**Actual 2017/18**	**Target 2019/20**
No. inpatient surgical discharges (planned care interventions).	Q[1]	NEW	NEW	NEW	3,129

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 2015/16**	**Actual 2016/17**	**Actual 2017/18**	**Target 2019/20**
Percentage of young people (aged 0 – 19) who have accessed specialist mental health services. Ref MH01	C	5.75% (March 2016)	5.48% (March 2017)	5.75%	5%
Access rates to Primary Mental Health Brief Intervention – 12-19 Years Refer MH04	T	4.24%	4.36%	4.5%	4.7%
Access rates to Primary Mental Health Brief Intervention – 20+ Years Refer MH04	T	2.3%	2.9%	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	Māori 166 Non-Maori 93	Māori 159 Non-Maori 103	Māori 133 Non-Maori 102	Māori 133 Non-Maori 102	Māori 120 Non-Maori 92

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 2019/20

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 2015/16**	**Actual 2016/17**	**Actual 2017/18**	**Target 2019/20**
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%	87%	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	New	87%	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 2015/16**	**Actual 2016/17**	**Actual 2017/18**	**Target 2019/20**
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]	100% (Q4) (10 days)	96%	85 %	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	NEW	80%	60%
Percentage of mental health & addiction clients with a transition (discharge) plan. Refer MH02	C[3]	NEW	NEW	81%	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]3.0 ANNUAL OPERATING INTENTIONS – FINANCIAL PERFOMANCE

South Canterbury District Health Board Consolidated Financial Performance 2019/2020	2017/18 Audited Actual	2018/19 Forecast	2019/20 Plan	2020/21 Plan	2021/22 Plan	2022/23 Plan
Patient Care Revenue	197,572	205,521	209,700	214,383	219,468	224,556
Other Revenue	2,451	2,403	2,015	2,055	2,080	2,120
Finance Revenue	1,009	813	611	200	150	-
TOTAL OPERATING REVENUE	201,032	208,736	212,326	216,638	221,699	226,676
	-	-	-	-	-	-
Personnel Benefit Costs	65,861	68,412	70,593	71,161	73,187	75,283
Outsourced Services	8,195	10,766	9,086	9,268	9,453	9,643
Clinical Supplies	12,246	10,715	11,421	11,881	12,145	12,413
Infrastructure & Non-Clinical Supplies	9,281	9,941	9,845	9,351	9,380	9,767
Payments to Non DHB health providers	98,942	102,158	104,626	108,051	110,339	112,459
Depreciation and Ammortisation expenses	4,065	4,243	4,424	4,593	4,946	4,946
Finance Costs	38	-	-	-	-	-
Capital Charge	2,376	2,380	2,304	2,232	2,148	2,064
TOTAL OPERATING EXPENDITURE	201,004	208,615	212,299	216,537	221,598	226,576
SURPLUS/(DEFICIT)	**28**	**121**	**27**	**100**	**100**	**100**

[1] Please note: As the 2019/20 SCDHB Annual Plan financials have not been approved by the MOH at the time of publishing, these may be subject to change once the 2019/20 financials have been approved.

South Canterbury District Health Board
Consolidated Financial Position
2019/2020

	2017/18 Audited Actual	2018/19 Forecast	2019/20 Plan	2020/21 Plan	2021/22 Plan	2022/23 Plan
Public Equity						
General Funds	16,662	16,481	16,264	16,011	15,758	15,505
Accumulated Surplus	10,205	10,326	10,353	10,453	10,553	10,653
Equity from Donated Assets	1,608	1,572	1,536	1,500	1,464	1,428
Revaluation Reserve	12,783	12,783	12,783	12,783	12,783	12,783
Total Equity	41,258	41,162	40,936	40,747	40,558	40,369
ASSETS						
Current Assets						
Cash and cash equivalents	8,311	10,003	4,203	3,203	6,003	6,003
Financial Assets	-	-	-	-	-	-
Debtors and other receivables		-	-	-	-	-
Debtors & Other Receivables	8,217	6,750	6,650	6,650	6,650	6,650
Invetories	1,061	1,170	1,170	1,170	1,170	1,170
Total Current Assets	17,589	17,923	12,023	11,023	13,823	13,823
Non Current Assets						
Financial Assets	13,713	13,634	13,925	7,340	1,147	1,147
Propert, plant and equipment	37,055	36,765	40,812	46,097	49,848	49,381
Intangible Assets	516	500	2,254	4,086	3,806	3,526
Total Non Current Assets	51,284	50,899	56,991	57,523	54,801	54,054
TOTAL ASSETS	68,873	68,822	69,014	68,546	68,624	67,877
LIABILITIES						
Current Laibilities						
Creditors and other payables	11,782	12,383	11,841	11,709	11,875	12,017
Employee Entitlements	8,819	8,671	8,765	8,634	8,735	8,735
Borrowings	-	-	-	-	-	-
Total Current Liabilities	20,601	21,054	20,606	20,343	20,610	20,752
Non Current Liabilities						
Finance Lease Laibility	506	506	506	506	506	506
Term Loans	49	-	16	-	-	-
Employee Entitlements	6,459	6,100	6,950	6,950	6,950	6,250
Total Non Current Liabilities	7,014	6,606	7,472	7,456	7,456	6,756
TOTAL LIABILITIES	27,615	27,660	28,078	27,799	28,066	27,508
NET ASSETS	**41,258**	**41,162**	**40,936**	**40,747**	**40,558**	**40,369**

South Canterbury District Health Board
Statement of Changes in Equity
2019/2020

	2017/18 Audited Actual	2018/19 Forecast	2019/20 Plan	2020/21 Plan	2021/22 Plan	2022/23 Plan
Total Equity at start of period	41,447	41,258	41,162	40,935	40,747	40,558
Net Surplus/ (Deficit) for year	28	121	27	100	100	100
Capital Movements						
Repayment to Crown	(217)	(217)	(217)	(217)	(217)	(217)
Other Movements	-	-	(36)	(71)	(72)	(72)
Total Equity at end of period	**41,258**	**41,162**	**40,935**	**40,747**	**40,558**	**40,369**

CASHFLOW & BANK
2019/2020

	1-Jul-17 Opening Balance	2017/18 Audited Actual	2018/19 Forecast	2019/20 Plan	2020/21 Plan	2021/22 Plan	2022/23 Plan
Total Receipts		196,938	208,736	211,781	216,638	221,700	226,678
Total payments		(198,080)	(204,197)	(207,958)	(206,136)	(210,687)	(222,954)
CASH FLOW FROM OPERATING ACTIVITIES		(1,142)	4,539	3,823	10,502	11,012	3,724
CASH FLOW FROM INVESTING ACTIVITIES		(2,609)	(2,847)	(9,623)	(11,502)	(8,212)	(3,724)
CASH FLOW FROM FINANCING ACTIVITIES		(490)	-	-	-	-	-
NET CASH FLOW		(4,241)	1,692	(5,800)	(1,000)	2,800	(0)
Plus: Cash (Opening)		12,552	8,311	10,003	4,203	3,203	6,003
YTD Net cash movements		(4,241)	1,692	(5,800)	(1,000)	2,800	(0)
Cash (Closing)	**12,552**	**8,311**	**10,003**	**4,203**	**3,203**	**6,003**	**6,003**

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	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	Total
Buildings, Plant & Equipment excl Clinical	289	295	301	307	313	320	326	332	339	346	3,169
Clinical Equipment	1,201	1,225	1,249	1,274	1,300	1,326	1,352	1,379	1,407	1,435	13,149
Other Equipments											-
IT/IS - devices/hardware	443	452	461	470	479	489	499	509	519	529	4,848
Intangible Assets (Software)	536	153	153	153	153	153	153	153	153	153	1,913
Vehicles	200	204	208	212	216	221	225	230	234	239	2,190
Contingency	255	260	265	271	276	282	287	293	299	305	2,792
Minor capital	219	223	228	232	237	242	247	252	257	262	2,398
Total General	3,143	2,812	2,865	2,920	2,975	3,031	3,089	3,148	3,208	3,269	30,459

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	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	Total
Infrastructure	200	204	208	212	216	221	225	230	234	239	2,190
Dishwasker for Kitchen											-
Boilders	1,100										1,100
Morgue Chiller	150										150
Radiology	145										145
Front of Hospital Build/ Hospital Refurbishment		3,104	4,500								7,604
Emergency Upgrade	1,928										1,928
Cafeteria new	1,099	623									1,722
Outpatients Upgrade	669										669
Ambulance Bay	237										
Café-Outpatients Grounds/General areas	120	1,320									
Environmental Upgrades (Theatre Ventiliation)	200										200
Total Special	5,848	5,251	4,708	212	216	221	225	230	234	239	15,707

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	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	Total
Data Warehouse / architecture	150	-									150
E-Medication Reconciliations	51	48									99
E-Ordering Laboratory	-	64									64
E-Ordering Radiology	75	-									75
E-Pharmacy	374	-									374
E-Prescription Repository	10	-									10
E-Referrals - Stage 3 Triage	106	-									106
E-Referrals - Inter / Intra DHB	150	-									150
Growth Charts	6	-									6
MDM	12	-									12
Mental Health Module	112	-									112
Patient Track	300	-									300
Problem Lists	12	-									12
Provider Index	51	-									51
Emergency Department Solution	51	-									51
South Island PICS	1,000	2,000									3,000
National Oracle Solution (NOS) Tech 1	160										160
	2,620	2,112									4,732

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.