Tairāwhiti District Health Board
Trading as

Hauora
Tairāwhiti

2019/20 – 2022/23 Statement of Intent

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

Hauora Tairāwhiti Statement of Intent 2019/20 through to 2022/23

(Issued under Section 39 of the New Zealand Public Health and Disability Act 2000)

This document presents our 2019/20 – 2022/23 Statement of Intent. Central to understanding this statement, is our performance story which sets out our key outcomes (what we are trying to achieve), our impacts (our shorter term contribution to an outcome), our outputs (goods and services supplied), and our inputs (resources).

Statement of Intent (2019/20 – 2022/23)

Gisborne: Tairāwhiti District Health Board trading as Hauora Tairāwhiti
Published in June 2019
by
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This document is available on the Hauora Tairāwhiti website: www.HauoraTairāwhiti.org.nz

Mihi

Tēnei te ara o Ranginui e tu nei, tēnei te ara o Papatuanuku e takoto nei
Tēnei te ara o Rangi raua ko Papa e takoto nei, tēnei te po nau mai te ao
Karangatia te ao kia ita, karangatia ko Tane i whakairihia i apiti ki runga, apiti ki raro
Tawhia mai i waho rarea mai i roto kia rarau te tapuwae o Tane Whakapiripiri, tu nei
Hikihiki nuku hikihiki rangi, watea tu ko te whaiao ko te ao marama
Marama ha roto ki to pia ki to uri e turuki nei e rangi
Turuturu o whiti, whakamaua kia tina, tina! Haumi e hui e taiki e!

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SECTION 1: Te Whakamahere Rautaki | Overview of Strategic Priorities

TAUIHU - The Prow
Te Ihu Haehae I Te Ara (The Front/First of the Journey)
The tauihu of a waka is the first part of the hull to meet the challenges of the open sea. "Kia tauihu to haere" – "Move forward decisively" The "tip of the wedge" Anything or person referred to as the tauihu is the figurehead or at the forefront.

STRATEGIC INTENTIONS/PRIORITIES

This Annual Plan articulates the Hauora Tairāwhiti commitment to meeting the Minister's expectations, and our continued commitment to our Board's vision of Whāia te hauora i roto i te kotahitanga - a healthier Tairāwhiti by working together.

There are four key areas of focus for Hauora Tairāwhiti for 2019/20, as agreed with the Ministry of Health. Actions to support these priorities are highlighted through Section 2 of this Plan. The areas of focus are:

- Achieving equity
    - Achieving equity is the primary area of focus for Hauora Tairāwhiti. Our goal is to achieve the happiest, healthiest children in the world in Tairāwhiti within one generation.
    - Hauora Tairāwhiti has four key ingredients to achieving equity
        - Supporting iwi to take a leadership role.
        - Enhancing understanding of equity.
        - Questioning current disparities at every opportunity.
        - Recognising that large proportions of the population are leading privileged lives.
- Sustainability
    - Hauora Tairāwhiti is currently operating in a deficit environment, which impacts on service provision and future planning. As a result, Hauora Tairāwhiti's investment pathway is small and makes tough decisions about which services will add the greatest health value.
    - Hauora Tairāwhiti is constantly looking at services currently provided out of district and where possible establish a local closer to home service.
- Workforce
    - Hauora Tairāwhiti is focused on increasing Māori representation within its workforce, and its approach is to employ Māori first, locals second and everyone else last.
    - As a small District Health Board, Hauora Tairāwhiti often faces challenges in ensuring vulnerable workforces are supported to ensure their long term sustainability.
- Collaboration
    - Hauora Tairāwhiti is part of the Iwi led cross sectoral group Manaaki Tairāwhiti, which looks at improving outcomes across Tairāwhiti through working across intersectoral boundaries.
    - Hauora Tairāwhiti supports the activities of the four local Māori health providers in their collaboration to optimise local arrangements and in reducing the fragmentation of health resources.
    - Gisborne District Council and Hauora Tairāwhiti are working together to improve the quality of drinking water across the Te Tairāwhiti.
    - Te Tairāwhiti health sector will continue to utilise a Matauranga Māori approach to service monitoring and planning to enable the development of co-location, multi-disciplinary teams and other innovative designs to address those social factors which influence health outcomes.

TREATY OF WAITANGI

The Treaty of Waitangi - Te Tiriti o Waitangi - is New Zealand's founding constitutional document and is often referred to in overarching strategies and plans throughout all sectors. Hauora Tairāwhiti values the importance of the Treaty. Central to the Treaty relationship and implementation of Treaty principles is a shared understanding that health is a 'taonga' (treasure).

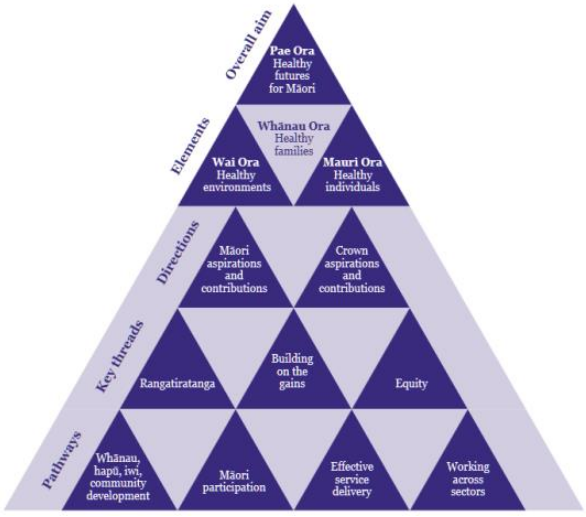
Treaty of Waitangi Principles mentioned in Health.

- **Partnership** involves working together with iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services.
- **Participation** requires Māori to be involved at all levels of the health and disability sector, including in decision-making, planning, development and delivery of health and disability services.
- **Protection** involves the Government working to ensure Māori have at least the same level of health as non-Māori, and safeguarding Māori cultural concepts, values and practices.

Note – other Treaty Principles will also apply to the "taonga" of Maori health

New Zealand Health Strategy

First and foremost is the updated New Zealand Health Strategy, which outlines the high level direction of the New Zealand Health system over the next 10 years along with a Roadmap of Actions. The Strategy outlines five strategic themes to ensure all New Zealanders live well, stay well and get well (People-powered; Closer to home; Value and high performance; One team and Smart system) and 27 areas for action between 2016 to 2026.



He Korowai Oranga

As New Zealand's Māori Health Strategy, He Korowai Oranga sets the overarching framework that guides the Government and the health and disability sector to achieve the best health outcomes for Māori.

The 4 pathways of the original He Korowai Oranga framework continue to tell us how to implement the strategy. These pathways are:

- supporting whānau, hapū, iwi and community development
- supporting Māori participation at all levels of the health and disability sector
- ensuring effective health service delivery
- working across sectors.

Healthy Ageing Strategy

This Strategy is designed to ensure our health system provides the care, support and treatment that older New Zealanders need and that level of care is sustainable. It has a strong focus on prevention, wellness and support for independence, recognising the importance of whānau and community in older people's lives.

United Nations Convention on the Rights of Persons with Disabilities

The Convention on the Rights of Persons with Disabilities is the first United Nations human rights treaty of the 21st century. The Convention makes it explicit that member countries must ensure the full realisation of all human rights and fundamental freedoms for all disabled people, on an equal basis with others, and

without discrimination of any kind on the basis of disability. It will also help to ensure that mainstream services are inclusive of disabled people and delivered in non-discriminatory ways.

ALA MO'UI: PATHWAYS TO PACIFIC HEALTH AND WELLBEING 2014–2018

To facilitate the delivery of high-quality health services that meet the needs of Pacific peoples, 'Ala Mo'ui has been developed. This builds on the successes of the former plan, 'Ala Mo'ui 2010–2014. It sets out the strategic direction to address health needs of Pacific peoples and stipulates new actions, which will be delivered from 2014 to 2018.

CLINICAL LEADERSHIP

Clinicians are passionate about the quality and safety of care they provide. These are key drivers of their work and resonate with their core values as professionals. Service development and improvements across Hauora Tairāwhiti are steered by clinical leadership through the Clinical Governance Committee which has representation on Te Kāhui Whakahaere (DHB leadership team) and actively supports decision making. The Clinical Governance Committee has key responsibilities around DHB clinical risks and quality improvements and includes representation from primary care as well as people who receive health care.

Across the Tairāwhiti, clinical leadership is represented on various service improvement forums which pull together all parts of the health sector within the district. Community, primary and secondary care clinical teams are engaged in a number of groups which range from information technology to integration and falls. The General Practitioner led Demand Management Group pulls primary and secondary care clinicians and managers together to look at initiatives which have positive practical implications on clinician's workloads in both sectors while addressing the demand pressures at this crucial interface.

DECISION MAKING

Hauora Tairāwhiti Board and advisory committees are supported by a number of different groups that ensure local health resources are put to the best possible use for health service delivery across the district, which is, in turn, effective and efficient for the population which it serves. Te Waiora o Nukutaimemeha (TWON) Māori Relationship Board is represented provides guidance and direction to Hauora Tairāwhiti in all Board decisions, ensuring responsibility is accorded for all aspects of Māori Health in Tairāwhiti. Other groups which support the Board's decision making process are Te Kāhui Whakahaere (Leadership Team) which provides the Board with an executive view on service improvements and delivery, Te Reo Rautaki (Startegic Leadership Team) providing advice on the strategic objectives of health across the district, and Te Rōpū Rauemi Rautaki (Funding Management Group) provides the Board with guidance on new initiatives and the implementation of community funding initiatives. Through these processes Hauora Tairāwhiti ensures that the local sector provides the optimum range of services within the available resources.

POPULATION HEALTH

The Tairāwhiti Population Health team (local Public Health Unit (PHU)) is located within the Te Puna Waiora (Planning and Funding) Group which ensures that within this district, a population health approach to service development and delivery is incorporated at all times. The DHB is committed to this approach and ensures that population health strategies are adopted in all service planning.

POPULATION PERFORMANCE

The Ministry is exploring life course approaches as a way of understanding DHB population performance challenges. Therefore, DHBs are expected to identify within their Annual Plan (AP) the most significant

actions they expect to deliver in the 2019/20 year to address local population challenges for the following life course groupings:

Life course group	Significant action to be delivered in 2019/20 through to 2022/23
Pregnancy	Hapū Māmā are supported to engage and access all levels of maternal services within the first trimester and throughout the course of their pregnancy.
Early years and childhood	Implementation of a Tairāwhiti Integrated Child Health Services framework from conception up to six-years of age, with children and their families at the centre, thriving in their communities.
Adolescence and young adulthood	Implementation of the Youth Strategy and Action Plan for Tairāwhiti. Working with youth voice, leadership and diversity of age, need, cultural realities, locations, social and sexual orientation are key determiners of the plan and implementation.
Adulthood	Specifically addressing utilisation of health services that is amenable to change and to reversing inequity.
Older people	Implementation of new Home Care Support Service, which will recognise the restoration potential and independence of older people within our community

WHAKATAUAKI

"He rangi ta Matawhaiti

He rangi ta Matawhanui"

"The person with a narrow vision sees a narrow horizon

The person with a wide vision sees a wide horizon."

HE KORERO NĀ TE MANUKURA| MESSAGE FROM THE CHAIR

These aspirations seek to reflect the very core of the reasoning behind the decision made in 2014 to change our direction of travel. Many years of well-intended goals and aspirations, along with their associated health plans, failed to reduce equity, and in particular the annual mortality statistics for Māori.

This document indicates strategic intentions that involve working alongside other Government Agencies that have a financial and organisational stake in the lives of people who live in Tairāwhiti. It is important to note the emphasis on cooperation and partnership with key external organisations and entities as without their active involvement we would have continued to do what we always did and achieved the same results.

These strategic and operational priorities coupled with dedicated work from committed people will ensure both a reduction in inequity and a healthier happier Tairawhiti community.

David S Scott MNZM, JP

HE KORERO NĀ TE TUMUAKI| MESSAGE FROM THE CHIEF EXECUTIVE

Our commitment as Hauora Tairāwhiti is to deliver on all that our name as an organisation represents. We will advance health equity and improve health outcomes for Māori, while raising the overall health status of the whole population of our district.

To achieve this, our plan details how we will work with our community, our providers and our staff to deliver on a wide range of initiatives. Our plan is dynamic and responsive. The focus is on how we can make each action deliver for the people of our community.

Through our efforts, the efforts of the people in the health system across Tairāwhiti, and our support and respect for the efforts of our community members, especially iwi Māori, we will achieve still more to attain Hauora for all in Tairāwhiti.

Jim Green
June 2019

Hauora Tairāwhiti 2019/20 to 2022/23 Statement of Intent

SIGNATORIES

David Scott, MNZM, JP
Chair,
Hauora Tairāwhiti

Geoff Milner,
Deputy Chair,
Hauora Tairāwhiti

Jim Green
Chief Executive,
Hauora Tairāwhiti

SECTION 2 – Whakapūmautanga | Stewardship

TAURAPA - The Stern
The stern of the waka is where the Tohunga stands to observe the elements, the stars, clouds, winds, currents and navigate the safest, surest path forward.

This section provides an outline of the arrangements and systems that Hauora Tairāwhiti has in place to manage our core functions and to deliver planned services.

Te Whakahaere I To Tātou Pakihi | Managing Our Business

The environment in which we are operating is constantly changing and the level of our success over the next few years will depend on our ability to adapt to this changing environment. We acknowledge that iwi leadership is fundamental to improving the existing inequities in the health and well-being of the people of te Tairāwhiti. Whānau and community are central: we are committed to supporting and building on the strength of whānau and of communities.

Hauora Tairāwhiti has a statutory responsibility to improve, promote and protect the health of people and communities within te Tairāwhiti. To enhance the effectiveness of health services in these areas Hauora Tairāwhiti maintains its Population Health team in Te Puna Waiora Group. This group, which includes the Planning and Funding team, assists in supporting the Population Health team's regulatory function in protecting our community. This is achieved through participation in service planning that ensures health promotion and preventative services are at the forefront of all the district's health improvements and initiatives.

Organisational Performance Management

Hauora Tairāwhiti performance is assessed on both financial and non-financial measures, which are measured and reported at all levels of the organisation. These are reported daily, weekly, fortnightly, monthly or quarterly as appropriate.

Funding and Financial Management

Hauora Tairāwhiti's key financial indicators are comprehensive income (surplus/deficit), financial performance (surplus/deficit), financial position and cash flows. These are assessed against and reported through the Hauora Tairāwhiti performance management process to the Board, Board Committees, and the Ministry of Health on a monthly basis. Further information about the Hauora Tairāwhiti planned financial position for 2019/20 and out years is contained in the Financial Performance Summary section of this document, and in Statement of Performance Expectations.

Investment and Asset Management

All DHBs are required to complete a stand-alone Long Term Investment Plan (LTIP) covering at least 10 years. LTIPs are part of the new Treasury system for monitoring investments across government, the Investment Management and Asset Management Performance (IMAP) system. The Hauora Tairāwhiti DHB LTIP was completed in November 2016 and the DHB contributes to the National Asset Management Plan which assesses the DHBs assets by importance and service criticality. The DHBs Asset Management Plan is scheduled for update by June 2019.

SHARED SERVICE ARRANGEMENTS AND OWNERSHIP INTERESTS

Hauora Tairāwhiti has a part ownership interest in HealthShare Limited the Midland Shared Services Agency and New Zealand Health Partnerships Limited the National Shared Services Agency. The DHB does not intend to acquire shares or interests in other companies, trusts or partnerships at this time.

RISK MANAGEMENT

Hauora Tairāwhiti has a formal risk management and reporting system, which entails Executive and Board reporting. The DHB is committed to managing risk in accordance with the process set out in the Australian/New Zealand Joint Standard on Risk Management (AS/NZS ISO 31000:2009). Hauora Tairāwhiti is working on a regional DATIX Risk Module that will allow comparisons between DHBs. We have a three year roadmap to fully implement a 'whole of organisation approach'.

QUALITY ASSURANCE AND IMPROVEMENT

The Hauora Tairāwhiti approach to quality assurance and improvement is in line with the New Zealand Triple Aim: improved quality, safety and experience of care, improved health and equity for all populations, and, best value for public health system resources. We also have a fourth aim (quadruple aim) which includes attention to the health care workforce. Built into the approach are critical connections that enable continuous quality improvement cycles. Continuous Quality Improvement is delivered at a Service Level along with Clinical Audit. Contracted services are aligned with national quality standards and auditing of contracted providers includes quality audits.

BUILDING CAPABILITY

Workforce

Below is a short summary of the Hauora Tairāwhiti organisational culture, leadership and workforce development initiatives. Further detail about the Midland regional approach to workforce is contained in the 2019/22 Midland Regional Service Plan.

Workforce development and organisational health are central to Hauora Tairāwhiti to ensure the provision of high quality and effective services that meet the health needs of our community. We are committed to promoting a positive culture for our organisation and ensuring our workforce reflects the cultural mix of our service users. Through supporting flexibility and innovation; providing leadership and skill development opportunities and being a ‘good employer’ we continue to attract and retain a skilled workforce. The 2018 Health Round Table Staff Survey results for Hauora Tairāwhiti will provide the opportunity to benchmark against the Midland DHB results.

Our key mechanisms are the continued consolidation of the clinical governance structure, the continuation of Quality and Safety Walk-rounds and the well embedded learning and development systems for staff. Leadership development for clinical and non-clinical staff is provided through the well-established and successful Midland Leadership Programmes, the implementation and extension of leadership initiatives that fit with the Leadership Domains Framework as well as the national State Services Commission leadership and talent management processes.

We continue to build capacity with the strategic promotion of health careers through local / regional / national opportunities, for example, the Kia Ora Hauora programme and the national job portal (Kiwi Health Jobs), and other appropriate opportunities thereby increasing the numbers of key workforces as required, i.e. medical; mental health; rehabilitation; cancer and emergency department. We have a

developed programme of "growing our own", in 2019/20 we will continue to the "grow our own" programme to develop the talent we have in the Tairāwhiti community, eliminate inequity, and reduce reliance on out of Tairāwhiti trained clinicians.

Hauora Tairāwhiti also enables and enhances our workforce through leveraging off technology and other system opportunities wherever these present.

Co-operative developments

Hauora Tairāwhiti works and collaborates with a number of external organisation and entities, in fact, our kaupapa, "Whāia te hauora i roto I te kotahitanga" ("A healthier Tairāwhiti by working together") sends a strong signal with regard to our cross agency partnerships. These relationships include but are not restricted too:

- **Iwi** – Te Rūnanganui o Ngāti Porou and Te Rūnanga o Tūranganui a Kiwa
- **State Sector** – Department of Corrections, Ministry of Justice, Ministry of Social Development, Ministry of Education, New Zealand Police, Ministry of Health
- **Crown Agents** – Accident Compensation Corporation, Health Promotion Agency, Health Quality and Safety Commission, Health Research Council of New Zealand, Health Workforce New Zealand, Housing New Zealand Corporation, Pharmaceutical Management Agency, Other District Health Boards
- **Council** – Gisborne District Council
- **Tertiary education institutions** – University of Otago, Eastern Institute of Technology
- **DHB Shared Services** – HealthShare Limited, Central Technical Advisory Service, Health Alliance, Health Partnerships
- **Schools, Early Education Centres , Kura Kaupapa Māori and Kōhanga Reo**
- **Cross sectorial development agency** – Manaaki Tairāwhiti

WORKFORCE

Healthy Ageing Workforce

The 2019-20 Hauora Tairāwhiti Annual Plan builds on foundations set out in the 2019-22 Midland Regional Services Plan (RSP). The primary piece of work in the 2019-22 Midland RSP related to identifying workforces working with older people and their whānau, and developing a sustainable mechanism for collecting a minimum workforce data set outside of the DHB's provider functions.

Central Technical Advisory Services (CTAS) shared service agency takes the national lead for this work. The group is identifying the data set, reporting timeframes, collection process, data repository, and analytics and reporting.

Midlands DHBs will utilise the outcome from the national work to develop any sector wide workforce plans for the older persons' workforce. Hauora Tairāwhiti will determine how best to map its workforce to develop an understanding of the specialist and non-specialist workforce it provides, and will map the workforce it provides to older people.

Hauora Tairāwhiti is supportive to the wider sector providers including age care in including these partners in learning and training opportunities which are available within the organisation. We encourage inter provider professional development.

Health Literacy

Improving health literacy for our whānau remains a challenge and an opportunity for our clinicians, and will contribute towards improving health literacy for people across Tairāwhiti. Some of the initiatives that are planned or ongoing in this area are:

- Training of staff on the need to deliver key health messages in a manner that is understood by all
- Reviewing existing and future patient education resources to remove jargon
- Co-designing services with whānau input (consumer and community involvement) at every level

- Enable opportunities for people to seek support when they are unfamiliar with health information

Community Based Attachments

Hauora Tairāwhiti is fully committed to the intent and application of the Medical Council's requirement for all interns to complete a three month attachment in a community setting at some point during their first two post graduate years. Currently, there are attachments of one run across the year within General Practices in Gisborne and a second within Public Health and General Practice. From November 2019 there will be a third and final run in another community based disciple that will then complete the requirements to make the runs available for all Resident Medical Officers.

Care Capacity Demand Management

Hauora Tairāwhiti remains committed to rolling out all programme elements for Care Capacity Demand Management (CCDM) to achieve business as usual status by June 2021. Scheduled reports will be provided to the Safe Staffing Healthy Workplace Unit and Ministry of Health.

TrendCare will enable Hauora Tairāwhiti to implement Hospital at a Glance (HaaG) to indicate the staffing resource available and utilised in each ward for patient care, and work on this continues. This will also enable staff to quickly assess at any time of the day what the hospital capacity is, what mix of patients there are across all specialties and wards, plus trace patients' progress throughout their stay. Hauora Tairāwhiti continues to work collaboratively with local unions on the programme's implementation.

INFORMATION TECHNOLOGY

To support this Statement of Intent, and as part of a longer strategic view, IT services at Hauora Tairāwhiti are engaged in progressing the following, please note milestones italicised and bracketed):

Primary Care Integration

With the vast majority of care contacts and care taking place at the local level, significant impetus needs to be given to improving (or removing) the interface between Primary and Secondary care and supporting the move to an integrated shared care model supported by linked/shared information systems and processes.

IS Initiatives

- Primary Secondary information systems integration – Indici (*expect to have integrated care plans by December 2020)*
- BPAC Referrals Response – direct electronic link back to primary care on referrals for care *(completed for all services by Dec 2020 with sequential service by service roll-out)*

Service Efficiency & Effectiveness

This provides for systems and processes, data and tool access to ensure we are achieving our aims and being able to quickly and easily recognise deviation and or opportunities both from a care and operational management perspective. It promotes the optimal use of resources and their application and effectiveness by strengthening the use of analytics to support service planning, risk identification and mitigation, and service demand management.

IS Initiatives:

- Hospital at a Glance (*complete by 30 September 2019*)
- Care Capacity Demand Management (*complete by 30 December 2019)*
- Business Intelligence (*ongoing development responding to needs*)
- Video-conferencing *(full utilisation of ZooM to support business VC by 30 December 2019)*
- Virtual clinics to reduce regional travel & rural isolation *(full utilisation of ZooM to support remote clinics by 30 December 2019)*
- Telehealth/Virtual Health service established & resourced *(full utilisation of ZooM to support by 30 December 2019)*

- Secondary / Tertiary Video Conference enabled service delivery *(full utilisation of ZooM by 30 December 2019)*

Engagement

Providing for people receiving care to access/receive information and services, and the ability to participate in their care. Enabling transactional activities such as bookings to be undertaken and enabling self-care and supporting "health in the home"

IS Initiatives:

- Patient portals/Shared Care plans (*regional Clinical Portal due for Go-live April 2020)*
- On line booking systems (*regional Clinical Portal due for Go-live April 2020)*
- Electronic communications - letters, appointment reminders, alerts, instructions, guidelines, prescriptions. (*Regional Clinical Portal due for Go-live April 2020)*
- Targeted health programmes/patient cohorts support (*development and roll out of a variety of Registers – Rheumatic Fever, Vulnerable People, Cardiology, HEEEADSSS by 30 Dec 2019*)

Virtual Healthcare

Health solutions are available to support healthcare in the home and community settings, and access to specialist services is not dependent on location of either the person or the specialists

IS Initiatives:

- Home Care applications (*not yet clinically identified*)
- Virtual clinics/telemedicine (*mobile ZooM implementation and uptake – incremental throughout year*)

Mobility

Supporting an increasingly mobile and flexible workforce, with access to data, information and systems to be provided regardless of locations of either systems or users.

IS Initiatives

- Mobilised applications for point of care decision support and transactional activities *(roll-out of mobile access to Patient Management System for selected allied health services by October 2019*)
- Technology options (*deployment of appropriate technology to users*)
- Communications links and services (*upgrade to communications links and services as required to support above)*

Electronic Medical Record (EMRAM)

This aims to address the difficulties and inefficiencies inherent in manual and paper based systems, and provide instead digital and online systems. It involves adopting an ethos of "Digital by Default" and a programme of increasing digital utilisation and reducing/removing non-digital options to improve service delivery and workflows. It requires a programme of system replacement/upgrade to expand on digital opportunity. Note: In assessing NZ hospitals' use of digital technology, the Ministry of Health has adopted the international Healthcare Information and Management Systems Society's (HIMSS) seven step framework for digital capability – the Electronic Medical Record Adoption Maturity (EMRAM) model. This initiative will see progression to higher levels of that framework

IS Initiatives:

- Electronic prescribing and administration (*regional Clinical Portal due for Go-live April 2020)*
- Electronic referral and response system *(completed for all services by Dec 2020 with sequential service by service roll-out)*
- Electronic orders for Radiology (*regional Clinical Portal due for Go-live April 2020)*
- Digital documents – Outpatient clinic letters (*regional Clinical Portal due for Go-live April 2020)*

Infrastructure & Security

This requires that a sound and commensurate infrastructure is efficiently maintained while protecting ourselves and the information we hold against threats to security. It means quality and value based investment decisions are made where the output aligns to the organisations strategic aims. It incorporates and seeks to limit our reliance on locally owned and operated software/hardware where this is appropriate and efficient.

IS Initiatives:

- IS Asset management
- Infrastructure/Software as a Service
- Adoption of Cloud Based Services
- Security Awareness/Security Assurance programmes
- Unified Communications
- Mobile device strategy
- Windows Migration
- Clinical Device Integration
- Video Conference expansion

Operating Parameters and Principles

The development, building, maintenance and deployment of these initiatives must occur within a number of parameters and be the subject of a number of principles. Bespoke systems and processes that do not align to these are unlikely to be either successful or supported for implementation.

In an environment characterised by shared service and multiparty participation, of particular relevance will be adherence to:

NZ Health Information System Framework (HISF) – which is designed to support health and disability sector organisations and practitioners holding personally identifiable health information to improve and manage the security of that information.

NZ Health Information Governance Guidelines (HIGG) - provide guidance to the health and disability sector on the safe sharing of health information. The Guidelines outline policies, procedures and other useful details for health providers who collect and share personal health information, enabling them to do these legally, securely, efficiently and effectively. The four major subject areas in the guidelines include:

- maintaining quality and trust
- upholding consumer rights and maintaining transparency
- appropriate disclosure and sharing
- ensuring security and protection of personal health information.

Initiative	Planned Delivery in 2019-20
Primary Care Integration	
Primary Secondary information systems workforce integration	Dependent upon the PHO acceptance and uptake of Indici, Hauora Tairāwhiti will work with Pinnacle to encourage PHO uptake, and then jointly to initiate connectivity to progress shared care plans
BPAC Referrals Response – direct electronic link back to primary care on referrals for care	Successful implementations in 2018-19 have led to a demand for the system to be further rolled out.
Service Efficiency & Effectiveness	
Hospital at a Glance	Delivered in the 2018-19 year, but the requirement to upgrade Trendcare and its use will mean further development of the system.

Initiative	Planned Delivery in 2019-20
Care Capacity Demand Management	Reliant upon upgrade and refreshed utilisation of Trendcare.
Business Intelligence	Expansion of access to and variety of reports and data sets.
Video-conferencing	Improve access to and utilisation of VC to offset travel costs and improve shared capabilities and information. Incorporates expansion of ZOOM implementation completed in 2018-19.
Telehealth/Virtual Health service established & resourced	Priority is to establish specific needs and services to be supported and have clinical engagement and agreement. Largely people and process issues to be resolved first, followed by the implementation of appropriate technology solutions.
Application and System Upgrades	Multiple system and application upgrades, either to remain within contracted support criteria or to take up and utilise new features and products sets.
Secondary / Tertiary Video Conference enabled service delivery	As above.
Engagement	
Patient portals/Shared Care plans	Midland Clinical Portal being delivered by e-SPACE programme under Healthshare Ltd. EDD is April 2020. Noting that Shared care plans are of bigger significance between Primary and Secondary – *see above.*
Electronic communications - letters, appointment reminders, alerts, instructions, guidelines, prescriptions.	*As for patient portal above, and noting also development of BPAC referrals response above*.
Targeted health programmes/patient cohorts support.	Multiple items here, including: National Bowel Screening Programme – timetable yet to be agreed with MoH. Hep C treatment programme – in progress.
Virtual Healthcare	
Home care applications - remote monitoring of chronic conditions	Focus in year will be on identifying with the relevant services the needs and developing plans to address.
Virtual clinics/telemedicine	*See above*
Mobility	
Mobilised applications for point of care decision support and transactional activities	Examining a variety of technology options with clinical staff to support care at the bedside
Technology options	Device reviews, smartphones, Internet of Things, tracking devices etc
Communications links and services	Review of VPN services to diversify the media to be used to access applications.
Electronic Medical Record (EMRAM)	
Electronic prescribing and administration	Incorporated within the e-SPACE programme – but no reliable information on timeline at this stage.
Electronic referral and response system	Further development and implementation of BPAC and the local electronic response system
Electronic orders for Radiology	Now incorporated as part of the e-SPACE programme.
Other electronic documents	Notwithstanding the inclusion of this within the e-

Initiative	Planned Delivery in 2019-20
	SPACE programme, failure to deliver has prompted Hauora Tairāwhiti to re-visit developments previous put on hold. In particular Hauora Tairāwhiti will progress the development of electronic Outpatient letters.

PUHORO - Movement The Ebb & Flow of the Journey's Path The influence.
The Puhoro design is a very waka/water orientated design, often seen painted on the underside of the prow of a waka and represents speed and movement. In its natural form it is the swirl of water when the paddles push water to propel a waka or it is the wake that trails behind the waka as it moves through the water. It is the symptom of influence. It is the ebb and flow of a waka journey.

SECTION 3 – 2019/20 TAUĀKĪ O TE TŪMANAKO MŌ NGĀ MAHI | STATEMENT OF PERFORMANCE EXPECTATIONS

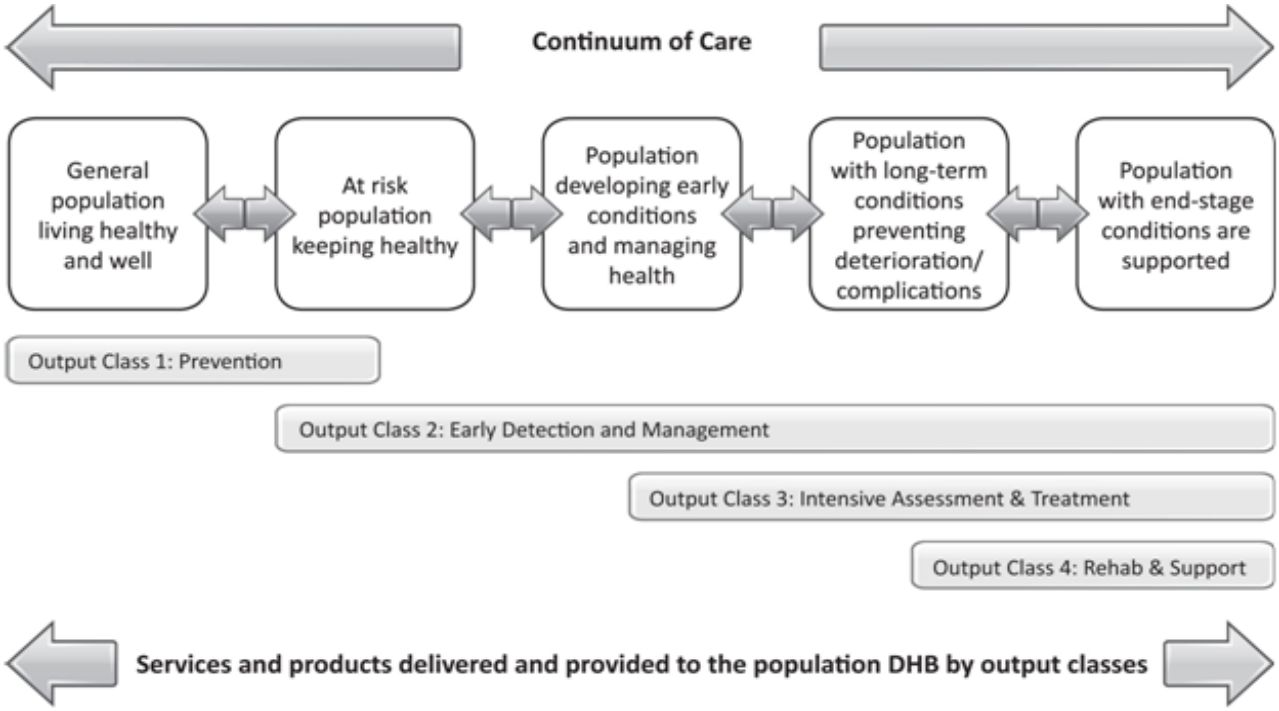
We have worked with other DHBs in the Midland region, our primary care partners, as well as other key stakeholders to develop the Statement of Performance Expectations (SPE) in which we provide measures and forecast standards of our output delivery performance. The actual results against these measures and standards will be presented in our Annual Report 2019/20. The performance measures chosen are not an exhaustive list of all of our activity, but they do reflect a good representation of the full range of outputs that we fund and / or provide. They also have been chosen to show the outputs which contribute to the achievement of national, regional and local outcomes. Where possible, we have included with each measure past performance as baseline data.

GUIDE TO READING THE STATEMENT OF PERFORMANCE EXPECTATIONS

Activity not mentioned in this section will continue to be planned, funded and/or provided to a high standard. We report quarterly to the Ministry of Health and / or our Board on our performance related to this activity.

OUTPUT CLASSES

DHBs must provide measures and standards of output delivery performance under aggregated output classes. Outputs are goods and services that are supplied to someone outside our DHB. Output classes are an aggregation of outputs, or groups of similar outputs of a similar nature. The output classes used in our statement of forecast service performance are also reflected in our financial measures. The four output classes that have been agreed nationally are described below. They represent a continuum of care, as follows:



OUTPUT CLASS	*DEFINITION*
Prevention	Preventative services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations comprising services designed to enhance the health status of the population as distinct from treatment services which repair/support health and disability dysfunction. Preventative services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing. Preventative services include health promotion to ensure that illness is prevented and unequal outcomes are reduced; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and, population health protection services such as immunisation and screening services. On a continuum of care these services are public wide preventative services.
Early Detection and Management	Early detection and management services are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. Include general practice, community and Māori health services, Pharmacist services, Community Pharmaceuticals (the Schedule) and child and adolescent oral health and dental services. These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB. On a continuum of care these services are preventative and treatment services focused on individuals and smaller groups of individuals.
Intensive Assessment and Treatment Services	Intensive assessment and treatment services are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are usually integrated into facilities that enable co-location of clinical expertise and specialised equipment such as a 'hospital'. These services are generally complex and provided by health care professionals that work closely together. They include: Ambulatory services (including outpatient, district nursing and day services) across the range of secondary preventive, diagnostic, therapeutic, and rehabilitative services, Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services, Emergency Department services including triage, diagnostic, therapeutic and disposition services. On a continuum of care these services are at the complex end of treatment services and focussed on individuals.
Rehabilitation and Support	Rehabilitation and support services are delivered following a 'needs assessment' process and coordination input by NASC Services for a range of services including palliative care services, home-based support services and residential care services. On a continuum of care these services provide support for individuals.

Prospective Financial Performance by Output Class for the four years ending 30 June 2020, 2021, 2022 and 2023 (Yet to be Agreed)

Prospective Summary of Revenues and Expenses by Output Class	2018/19 Forecast $'000	2019/20 Plan $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000
Prevention					
Total Revenue	$5,139	$5,268	$5,426	$5,589	$5,756
Total Expenditure	$5,139	$5,268	$5,426	$5,589	$5,756
Net Surplus / (Deficit)	$0	$0	$0	$0	$0
Early Detection					
Total Revenue	$51,672	$55,198	$56,854	$58,559	$60,316
Total Expenditure	$51,672	$55,198	$56,854	$58,559	$60,316
Net Surplus / (Deficit)	$0	$0	$0	$0	$0
Intensive Assessment & Treatment					
Total Revenue	$117,651	$119,510	$123,053	$126,745	$130,546
Total Expenditure	$129,804	$131,509	$134,879	$138,426	$142,078
Net Surplus / (Deficit)	-$12,153	-$11,999	-$11,826	-$11,681	-$11,532
Rehabilitation & Support					
Total Revenue	$23,600	$23,754	$24,467	$25,201	$25,957
Total Expenditure	$23,600	$23,754	$24,467	$25,201	$25,957
Net Surplus / (Deficit)	$0	$0	$0	$0	$0
Consolidated Surplus / (Deficit)	-$12,153	-$11,999	-$11,826	-$11,681	-$11,532

The following points provided should be kept in mind when reading this document:

- Baseline and national/regional figures for the output performance measures are for the 2017/18 financial year unless otherwise stated.
- In the performance measures table, and where available, the average column presents the national or regional average for the output performance measure.
- Most measures have been adopted regionally.
- Some measures fall across more than one impact. Where this is the case they have only been included once.
- Measurement type key:
    - QN = Quantity,
    - T = Timeliness,
    - QL = Quality.
- There are some services we provide that support the rest of the health system so we have included these in a "Support Services" section of our performance story.

NOTE: N/A denotes rates Not Available

PEOPLE ARE SUPPORTED TO TAKE GREATER RESPONSIBILITY FOR THEIR HEALTH

Long Term Impact	People are supported to take greater responsibility for their health		
Intermediate Impacts	Fewer people smoke	Reduction in vaccine preventable diseases	Improving health behaviours

Fewer People Smoke

Outputs	Output Class	Measure Type	Tairāwhiti 2017/18	Target 2019/20	3 Year Planned Rate	National
Percentage of PHO enrolled smokers offered advice to quit by a health practitioner in the last 15 months (PH04 & SLM)	1	QN/T				
Māori			85%	≥90%	≥90%	87%
Non Māori			90%	≥90%	≥90%	90%
Total			88%	≥90%	≥90%	89%
Percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Care are offered Advice to quit smoking (PH04, CW09)	1	QN/T				
Māori			92%	≥90%	≥90%	91%
Non Māori			100%	≥90%	≥90%	90%
Total			93%	≥90%	≥90%	91%

Reduction in Vaccine Preventable Diseases

Outputs	Output Class	Measure Type	Tairāwhiti 2017/18	Target 2019/20	3 Year Planned Rate	National
Percentage of eight month olds fully immunised (CW08, SLM, CW05)[1]	1	QN/T				
Māori			83%	≥95%	≥95%	86%
Non Māori[2]			89%	≥95%	≥95%	93%
Total			85%	≥95%	≥95%	91%
Percentage of two year olds fully immunised (CW05, previously PP21)	1	QN/T				
Māori			88%	≥95%	≥95%	88%
Non Māori[3]			87%	≥95%	≥95%	92%
Total			88%	≥95%	≥95%	91%
Percentage of five year olds fully immunised (CW05, previously PP21)	1	QN/T				
Māori			89%	≥95%	≥95%	85%
Non Māori[4]			91%	≥95%	≥95%	88%
Total			90%	≥95%	≥95%	89%

[1] Figure reported on is the 12 months figure.
[2] Non-Maori is sum of New Zealand European, Pacific, Asian and Other ethnicity group.
[3] Non-Maori is sum of New Zealand European, Pacific, Asian and Other ethnicity group.
[4] Non-Maori is sum of New Zealand European, Pacific, Asian and Other ethnicity group.

Outputs	Output Class	Measure Type	Tairāwhiti 2017/18	Target 2019/20	3 Year Planned Rate	National
Percentage of eligible girls and boys[5] fully immunised with HPV vaccine		QN/T				
Māori			86%	≥75%	≥75%	66%
Non Māori[6]			80%	≥75%	≥75%	67%
Total			81%	≥75%	≥75%	67%
Percentage of the population >65 years who have received the seasonal influenza immunisation (PP21, CW05)	1	QN/T				
Māori			52%	≥75%	≥75%	45%
Non Māori[7]			55%	≥75%	≥75%	57%
Total			54%	≥75%	≥75%	56%

Improving Health Behaviours

Outputs	Output Class	Measure Type	Tairāwhiti 2017/18	Target 2019/20	3 Year Planned Rate	National
Percentage of infants who are exclusively/fully breastfed at 3 months (PP37, CW06)[8]	1	QN/T				
Māori			44%	≥70%	≥70%	47%
Non Māori			68%	≥70%	≥70%	62%
Total			53%	≥70%	≥70%	59%
Raising healthy kids Percentage of obese children identified in the B4 School Check Programme who are offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions (HT, CW10)						
Māori			89%	≥95%	≥95%	98%
Non Māori			100%	≥95%	≥95%	98%
Total			92%	≥95%	≥95%	98%
The number of people participating in the GRx (Green Prescription) programmes	1	QN/T	1,169[9]	≥1,024	≥1,024	NA
Reduce the prevalence of gonorrhoea (local indicator)	1	QN/T	82 per 100,000[10]	≤60 per 100,000	≤60 per 100,000	104 per 100,000

[5] Before 2019/20, the indicator did not include coverage for boys

[6] Non-Maori is sum of New Zealand European, Pacific, Asian and Other ethnicity group

[7] Non-Maori is sum of New Zealand European, Pacific, Asian and Other ethnicity group

[8] Percentages are calculated by summing the numbers of the two six month reports.

[9] Number of green prescription referrals received by Sport Tairawhiti in 2017/18. Source: Annual Report Sports Tairawhiti.

[10] 40 cases in 2017/18 for population of 49,000. Source: Public Health Surveillance reports and Tableau Public https://www.esr.cri.nz/our-services/consultancy/public-health/sti/

PEOPLE STAY WELL IN THEIR HOMES AND COMMUNITIES

Long Term Impact	People stay well in their homes and communities			
Intermediate Impacts	An improvement in childhood oral health	Long-term conditions are detected early and managed well	Fewer people are admitted to hospital for avoidable conditions	More people maintain their functional independence

An improvement in childhood oral health

Outputs	Output Class	Measure Type	Tairāwhiti 2017/18	Target 2019/20	3 Year Planned Rate	National
Percentage of preschool children (0-4) enrolled in DHB funded dental services (PP13a, CW03)	2	QN				
Māori			104%	≥95%	≥95%	N/A
Non-Maori			Not reported	≥95%	≥95%	N/A
Total			107%	≥95%	≥95%	N/A
Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination (PP13b, CW03)	2	QN/T				
Māori			Not reported	≤10%	≤10%	N/A
Non-Maori			Not reported	≤10%	≤10%	N/A
Total			13%	≤10%	≤10%	15%
Percentage of adolescent utilisation of DHB funded dental services (PP12, CW04)	2	QN	55%	≥85%	≥85%	68%

Long-Term Conditions are Detected Early and Managed Well

Outputs	Output Class	Measure Type	Tairāwhiti 2017/18	Target 2019/20	3 Year Planned Rate	National
Percentage of assessed high risk patients who have had an annual review (SS13 FA3)[11]	2	QN				
Māori			Not reported	≥90%	≥90%	Not reported
Non Māori				≥90%	≥90%	
Total				≥90%	≥90%	
Improve the proportion of patients with good glycaemic control (HbA1c ≤64 mmol) (PP20, SS13 FA2)[12]	2	QL				
Māori			Not reported	≥90%	≥90%	Not reported
Non Māori			Not reported	≥90%	≥90%	
Total			40%	≥90%	≥90%	
Percentage of eligible women (25[13]-69) who have had a cervical cancer screen every 3 years (SLM, SL10, PV01)	1	QN/T				
Māori			71%	≥80%	≥80%	67%
Non Māori			79%	≥80%	≥80%	75%

[13] New indicator
[14] New Indicator
[13] Data for three years period ending June 2018 as published by the national screening unit.

Outputs	Output Class	Measure Type	Tairāwhiti 2017/18	Target 2019/20	3 Year Planned Rate	National
Total			75%	≥80%	≥80%	74%
Percentage of eligible women (50-69) who have had a breast screening mammogram in the last 2 years (PV01, SL11)[14]	1	QN/T				
Māori			67%	≥70%	≥70%	65%
Non Māori			72%	≥70%	≥70%	72%
Total			70%	≥70%	≥70%	72%

Fewer People are admitted to Hospital for Avoidable Conditions

Outputs	Output Class	Measure Type	Tairāwhiti 2017/18	Target 2019/20	3 Year Planned Rate	National
Percentage of all Emergency Department presentations who are triaged at level 4 & 5	2&3	QN	67%	≤50%	≤20%	67%
Percentage of eligible population who have had their B4 school checks completed[15]	1	QN/T				
High Needs			95%	≥90%	≥90%	92%
All			93%	≥90%	≥90%	93%
Hospitalisation rates per 100,000 for acute rheumatic fever (CW13, PP28) Total	2&3	QN/T	8.3	≤2.8	≤2.8	3.4[16]
Increased Percentage of Year 9 students receiving HEEADSSS assessment in decile 1-3 schools (CW12, PP25)	1	QN/T	44%	≥95%	≥95%	N/A
Improved wait times for diagnostic services - accepted referrals for CT and MRI receive their scan within 6 weeks (PP29)[17]	2	QL/T				
CT			92%	≥95%	≥95%	82%
MRI			85%	≥90%	≥90%	56%

14 BSA New Zealand Coverage Report https://www.nsu.govt.nz/system/files/page/bsa_new_zealand_tairawhiti_district_health_board_coverage_report_-_period_ending_30_june_2018.doc

15 Ministry of Health B4 School Check data only contains percentages which do not allow for regional rates to be calculated.

16 Rate for December 2017. https://www.health.govt.nz/our-work/diseases-and-conditions/rheumatic-fever/reducing-rheumatic-fever

17 Year figure calculated as sum of number of people who had CT/MRI scan within 42 days divided by sum of monthly number of people waiting.

Outputs	Output Class	Measure Type	Tairāwhiti 2017/18	Target 2019/20	3 Year Planned Rate	National
Improved waiting times for diagnostic services – accepted referrals for non-urgent diagnostic colonoscopy within 42 days[18]	2	QL/T	83%	≥70%	≥70%	60%
Non urgent community laboratory tests are completed and communicated to practitioners within the relevant category timeframes (48h).	2	QL/T	100%	100%	≥95%	NA
Number of community pharmacy prescriptions issued	2	QN	475,732	≥450,000	450,000	NA

PEOPLE RECEIVE TIMELY AND APPROPRIATE SPECIALIST CARE

Long Term Impact	People receive timely and appropriate care		
Intermediate Impacts	People receive prompt and appropriate acute and arranged care	People have appropriate access to elective services	Improved health status for people with a severe mental health illness and/or addiction

People Receive Prompt and Appropriate Acute and Arranged Care

Outputs	Output Class	Measure Type	Tairāwhiti 2017/18	Target 2019/20	3 Year Planned Rate	National
Acute Readmission rate (OS8)[19]	3	QN/T/QL	11%	≤6%	≤6.1%	12%
Faster Cancer Treatment – Proportion of patients with a confirmed diagnosis of cancer who receive their first cancer treatment (or other management) within 31 days of diagnosis[20] (SS01, PP30)[21]	3	QN/T	88%	≥90%	≥90%	89%
Faster Cancer Treatment – Proportion of patients with a high suspicion of cancer receive their first cancer treatment within 62 days or less (SS11)	3	QN/T	92%	≥92%	≥94%	92%

[18] As the national bowel screening programme is introduced locally, we want to follow up on its possible impact on waiting times for diagnostic colonoscopies. Year figure calculated as sum of number of people who had non-urgent colonoscopy within 42 days divided by sum of monthly number of people waiting.

[19] Standardised readmission Rate for readmission within 28 days.

20 Performance measure PP30 uses the criterion 'decision to treat' instead of diagnosis.

21 National target is 85%

Outputs	Output Class	Measure Type	Tairāwhiti 2017/18	Target 2019/20	3 Year Planned Rate	National
Percentage of missed outpatient appointments[22]	3	QN/T				
Māori			18%	≤10%	≤10%	NA
Non Māori			6%	≤10%	≤10%	
Total			11%	≤10%	≤10%	

People Have Appropriate Access to Elective Services

Outputs	Output Class	Measure Type	Tairāwhiti 2017/18	Target 2019/20	3 Year Planned Rate	National
Percentage of patients waiting longer than four months for their first specialist assessment (Elective Service Performance Indicator 2)[23]	3	QN/T	19.9%[24]	0%	0%	NA
Number of surgical discharges under the elective initiative	3	QN	2,546[25]	≥2,359	≥2,359	NA
Inpatient average length of stay (elective) (Ownership Dimension 3)	3	QN/T	1.57 days	≤1.45 days	≤1.59 days	1.61 days

Improved Health Status for those with Severe Mental Illness and/or addictions

Outputs	Output Class	Measure Type	Tairāwhiti 2017/18	Target 2019/20	3 Year Planned Rate	National
Percentage of people referred for non-urgent mental health services seen within 3 weeks (MH03)	3	QN/T				
0-19 yr. olds			71%	≥80%	≥80%	
Percentage of people referred for non-urgent addiction services seen within 3 weeks (MH03),	3	QN /T				
0-19 yr. olds			56%	≥80%	≥80%	
The percentage of clients with transition plan (MH02)	3	QN/T/QL				
Māori			NA	≥95%	≥95%	
Non Māori			NA	≥95%	≥95%	
Total			76%	≥95%	≥95%	
Average length of acute inpatient stays (KPI 8)	3	QN/T/QL	20 days	14-21 days	≥14 Days	
Rates of post-discharge community care (KPI 18)	3	QN/T/QL	42%	≥90%	≥90%	

22 Hospital reporting – Outpatients 201718
23 Ministry of Health website – Elective Services Patient Flow Indicators (ESPIs) https://www.health.govt.nz/system/files/documents/pages/february-2018-espi2.xls
24 Number of patients waiting in June 2018.
25 Tairawhiti DHB 201718 Electives Initiative Report – Health Target Result

PEOPLE MAINTAIN FUNCTIONAL INDEPENDENCE

Long Term Impact	People maintain functional independence	
Intermediate Impacts	People stay Well in their homes and communities	People with end stage conditions are supported

People stay well in their homes and communities

Outputs	Output Class	Measure Type	Tairāwhiti 2017/18	Target 2019/20	3 Year Planned Rate	National
Percentage of older people receiving long-term home and community support who have had a comprehensive clinical assessment and an individual care plan in the last 36 months (SS04,PP23)	4	QN/T	86%[26]	100%	100%	N/A
Percentage of older people receiving long-term home and community support who have had a comprehensive clinical assessment and an individual care plan in the last 12 months[27]	4	QN/T	54%	60%	60%	N/A

People with end stage conditions are supported

Outputs	Output Class	Measure Type	Tairāwhiti 2017/18	Target 2019/20	3 Year Planned Rate	National
Number of hospital admissions under Health Speciality Code M80 (Palliative Care)	4	QL	5	Increase	Increase	-
Number of falls in Aged Residential Care Facility resulting in admission	4	New measure no baseline				
Number of pressure injuries	4	New measure no baseline				

[26] For all clients who received home support in 2017/18, the percentage of clients who had had an assessment between 01/07/2015 and 01/07/2018: 554/647 clients.

[27] Every client receiving home support has a clinical assessment. As required by the Ministry, reassessment of clients receiving ling-term home support is only done every three years unless major changes to their condition. Care Plans are part of the clinical assessment. As people are only reassessed within a three year period if their condition has changed significantly, the number of home support clients receiving an assessment compared to the total number of clients can be a quality indicator for the provided care. National performance indicator PP23 does not include a time frame and the target there is 95%.

SECTION 4 – 2019/20 FINANCIAL PERFORMANCE

AWHI - Support
The Takitoru is a weaving pattern and part of the Paepaeroa or mat/carpet which is about support.

STATEMENT OF SIGNIFICANT UNDERLYING ASSUMPTIONS

The DHB continues its commitment to manage expenditure and live within our means. The DHB is committed to achieving the agreed deficit result for the plan year, i.e. from 1 July 2019 to 30 June 2020.
The budgeted financials are very much based on a "business as usual" scenario adjusted for the possible financial effects of anticipated savings and efficiency activities. In relation to this, the key points that underpin the financial budgets are:

- Revenue – The base funding package provides a 3.14% increase after allowing for top slices, etc. The total revenue increment available for 2019-20 is calculated to be approximately 5.34%
- Expenditure – It is expected that continuing to work with NGO Providers will enable population health community expenditure on primary care to be well-managed and therefore the associated total cost constrained, allowing for future-based investment
- Inter-District Flows – It is expected that the work of the population health team, complemented by a historically healthy staffing situation in the DHB Provider will enable IDF outflows to be managed to a below-budget level
- National initiatives – DHBs have invested heavily in national programmes at the behest of government, and continue to do so. The minimum expected returns from these investments have been built into the budgeted savings programmes and it is essential for the achievement of the budgeted financial results that the agencies involved – healthAlliance, PHARMAC and NZ Health Partnerships Ltd - deliver on them;
- Personnel costs – have been budgeted to increase at almost double the rate of CPI for the last year through government support to raise salaries for some health professions. The clinical labour force is a significant factor in the overall cost of providing health services, as they are generally quite labour-intensive. Negotiation and settlement of national MECAs is an area of risk for small, provincial DHBs that tend to have lower funding increments, while the risk for NGO Providers is in their ability to maintain appropriate permanent staffing levels.

FINANCIAL PERFORMANCE SUMMARY

PROSPECTIVE STATEMENT OF FINANCIAL PERFORMANCE (comprehensive income) for the four years ended 30 June 2020, 2021, 2022 and 2023 (yet to be agreed)

Statement of Comprehensive Income

$000	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
	Audited	**Forecast**	**Plan**	**Plan**	**Plan**	**Plan**
REVENUE						
Ministry of Health Revenue	181,285	188,949	194,375	200,207	206,213	212,399
Other Government Revenue	5,212	5,658	5,973	6,153	6,337	6,527
Other Revenue	3,385	3,455	3,382	3,440	3,544	3,650
Total Revenue	189,882	198,062	203,730	209,800	216,094	222,576
EXPENDITURE						
Personnel	70,374	77,172	82,909	85,395	87,958	90,597
Outsourced	8,492	9,117	6,273	6,462	6,655	6,855
Clinical Supplies	15,760	17,058	17,647	18,176	18,722	19,284
Infrastructure and Non Clinical	8,757	9,543	9,817	10,037	10,338	10,647
Payments to Non-DHB Providers	86,535	91,202	92,962	95,251	97,608	100,036
Interest	30	185	185	191	196	202
Depreciation and Amortisation	3,183	3,227	3,497	3,602	3,710	3,822
Capital Charge	2,422	2,711	2,439	2,512	2,588	2,665
Total Expenditure	195,553	210,215	215,729	221,626	227,775	234,108
Other Comprehensive Income	0	0	0	0	0	0

Revaluation of Land and Building	2,315	0	0	0	0	0
Total Comprehensive Income/(Deficit)	-3,356	-12,153	-11,999	-11,826	-11,681	-11,532

Prospective Statement of Changes in net assets /equity (Yet to be agreed)

$000	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
	Audited	Forecast	Plan	Plan	Plan	Plan
Crown equity at start of period	43,288	49,050	47,515	47,134	46,752	46,370
(Surplus)/Deficit for the period	-5,671	-12,153	-11,999	-11,826	-11,681	-11,532
Contributions from Crown	9,500	11,000	12,000	11,826	11,681	11,532
Distributions to Crown	-382	-382	-382	-382	-382	-382
Revaluation & other movements	2,315					
Crown Equity at end of period	49,050	47,515	47,134	46,752	46,370	45,988

Consolidated Prospective Statement of Financial Position as at 30 June (Yet to be agreed)

$000	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
	Audited	Forecast	Plan	Plan	Plan	Plan
CROWN EQUITY						
Current Assets	8,696	8,698	8,698	8,698	8,698	8,698
Non-Current Assets	65,174	66,127	65,579	65,014	64,431	63,832
TOTAL ASSETS	73,870	74,825	74,277	73,712	73,129	72,530
Current Liabilities	23,119	25,607	25,440	25,259	25,058	24,841
Non-Current Liabilities	1,701	1,701	1,701	1,701	1,701	1,701
TOTAL LIABILITIES	24,820	27,308	27,141	26,960	26,759	26,542
NET ASSETS	49,050	47,517	47,136	46,752	46,370	45,988

Consolidated Statement of Prospective Cash Flows (Yet to be agreed)

$000	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
	Audited Actual	Forecast	Plan	Plan	Plan	Plan
CASH FLOWS FOR THE PERIOD						
Operating cash flows	-3,684	-8,993	-8,490	-8,212	-7,958	-7,697
Investing cash flows	-3,273	-4,022	-2,844	-2,929	-3,017	-3,108
Financing cash flows	8,889	10,527	11,501	11,324	11,175	11,022
NET TOTAL CASH FLOWS	1,932	-2,488	167	183	200	217
Net increase/(decrease) in cash held	1,932	-2,488	167	183	200	217
Add opening cash balance	-3,432	-1,500	-3,988	-3,821	-3,638	-3,438
CLOSING CASH BALANCE	-1,500	-3,988	-3,821	-3,638	-3,438	-3,221
made up from						
Balance Sheet Cash, Bank, and Short Term Investments	-1,500	-3,988	-3,821	-3,638	-3,438	-3,221

FINANCIAL ASSUMPTIONS

The financial statements have been prepared in accordance with Generally Accepted Accounting Practice in New Zealand (NZGAAP).

The financial estimates are based on informed judgments on the expected price and cost movements over the period of the plan, including the funding intentions of government and the Ministry. No significant changes in PBFF share has been assumed over the forecast period.

The anticipated quantum of funding over the 2019/20 year and beyond, presents considerable challenges in work to actively restrain cost growth and consideration of service changes. The financial plan for the period is highly geared towards business as usual and carries little or no flexibility to accommodate unplanned cost movements. The operating budget carries financial risks and is highly dependent upon the realisation of targeted savings.

The estimated financial effects of savings expected to arise from efficiency gains have been incorporated into the financial plan, as have savings expected to result from Government and cooperative initiatives, the tripartite Health Sector Relationship Agreement and enhanced clinical leadership. Cost savings anticipated flowing through to Hauora Tairāwhiti from national (NZ Health Partnerships Ltd and Pharmac) and regional (HealthShare) initiatives have been included at the estimated additional cost of the programmes that will generate the savings.

Service level expectations, and the increasing cost impact of legislative compliance, will place considerable pressure on forecast expenditure, within the Provider Arm. The Funder Arm will face other additional issues, such as uncertainty over Aged care trends within the community, and IDF growth.

Baseline capital expenditure is planned to exceed depreciation provisions by $2.5M, after allowing for capital repayments and finance lease principal. Given service level expectations, and e-SPACE project contributions, this is not easily sustainable.

The DHB has made a number of significant assumptions in arriving at its Prospective Financial Performance Statements which are yet to be agreed but are summarised below:

Assumption	2018/19	2018/19	2019/20	2020/21	2021/22
Crown CFA Revenue	3.0%	3.0%	3.0%	3.0%	3.0%
Sector Cost Increases	3.0%	3.0%	3.0%	3.0%	3.0%
Staff Costs (average movement)	3.0%	3.0%	3.0%	3.0%	3.0%
Staff Costs (numbers)	771	771	771	771	771
Interest Rate	4.6%	4.6%	4.6%	4.6%	4.6%
Interest Rate - Working Capital	5.5	5.5	5.5	5.5	5.5
Capital Charge Rate	6%	6%	6%	6%	6%
NZD[1]/AUD[2]	0.93	0.93	0.93	0.93	0.93
NZD/USD[3]	0.64	0.64	0.64	0.64	0.64

[1] New Zealand Dollar
[2] Australian Dollar
[3] United States of America Dollar

MITIGATION OF FINANCIAL RISK

It is recognised that it will be challenging to meet these targets. However, management will be working intensively to ensure that expenditure on core services is constrained where possible. As stated above, the cost inflation rates are based upon Treasury economic forecasts, combined with trend analysis of cost inflation within Hauora Tairāwhiti. A risk assessment and sensitivity analysis relating to these key cost assumptions is set out below:

Assumption	Risk	Assessed potential effect
Revenue	Revenue expectations are not met.	Hauora Tairāwhiti budgeted consolidated revenue totals approximately $204M. For every 1% that revenue is lower than the budgeted levels, there is a potential financial detriment to Hauora Tairāwhiti of $2.04M.
	While there are good indications in relation to base CFA funding, there is a risk that actual funding may be curtailed and/or other revenue streams are less than anticipated.	To mitigate this risk, Hauora Tairāwhiti actively works to maintain, develop and diversify its revenue streams. 96% of revenue is MoH provided, therefore subject to service delivery there is little risk of significant variations to budget.
Labour cost inflation	Labour cost inflation is higher than expected, driving above-budget staff and outsourced services costs.	For every 1% that wage settlements exceed the budgeted levels, there is a potential additional expense of $873k in the cost of staff and outsourced services. To mitigate this risk, Hauora Tairāwhiti uses collaborative negotiating and informs employee representatives of the Minister's expectations and the net increase that has been allocated to Hauora Tairāwhiti for the planning period. Outsourced services present significant risks particularly in regard to cover for employee vacancies for medical staff.
Supply cost inflation	Supply cost inflation is higher than expected, driving above-budget clinical, infrastructure and non-clinical supply costs.	For every 1% increase in inflation above budgeted levels, there is a potential additional expense of ~$324k. To mitigate this risk, Hauora Tairāwhiti utilises collaborative procurement options, preferred supplier arrangements, fixed price agreements, outsourcing of support services and tender processes.
Exchange rate	NZ Dollar is less robust than expected, driving above-budget clinical supply costs.	For every 10% reduction in the value of the NZD against the currencies of the countries from which clinical supplies are sourced, there is a potential additional expense. Given the wide range of operating and capital expenditure categories that could potentially be affected, it is difficult to provide a meaningful estimate of the effect. To mitigate this risk, Hauora Tairāwhiti uses the same mechanisms as those used to mitigate supply cost inflation.
IDF Payments	Payments for services provided by other DHB's for Tairāwhiti domiciled patients is higher than anticipated.	As a small outlying DHB, Tairāwhiti is particularly sensitive to uncertainties around the IDF model. 11.7% of our expenditure is budgeted to IDF's, and there are very significant risks in this line, a 10% variation reflects a risk of 2.4m. There is little we can do to mitigate this.
Demand-driven costs	Demand-driven costs exceed budget and revenue, creating a deficit situation in the Funds function.	Hauora Tairāwhiti monitors all demand-driven costs and proactively works to address cost overruns with providers, including NASC services.

SIGNIFICANT ACCOUNTING POLICIES

The accounting policies used in the preparation of the financial statements can be found in the Tairāwhiti DHB 2017/18 Annual Report. There have been no significant changes in the accounting policies, which are reproduced hereunder:

REPORTING / ECONOMIC ENTITY

Reporting / Economic Entity
Hauora Tairāwhiti is a Health Board established by the New Zealand Public Health and Disability Act 2000. Hauora Tairāwhiti is a crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand.

Hauora Tairāwhiti is a public benefit entity (PBE), as defined in the external reporting board standard A1.

The group consists of Hauora Tairāwhiti, its subsidiary company Tairāwhiti Laundry Services Limited, which holds the associated partnership share in Gisborne Laundry Services, and its associated companies HealthShare Limited and TLab Limited.

The group activities involve delivering health and disability services and mental health services in a variety of ways to the community.

Basis of preparation
The financial statements have been prepared on a going concern basis, and the accounting policies have been applied consistently throughout the period.

Statement of Going Concern
The going concern principle has been adopted in the preparation of these financial statements. The Board, after making enquiries, has a reasonable expectation that the DHB has adequate resources to continue operations for the foreseeable future based on current trading terms and legislative requirements. The Board has reached this conclusion having regard to circumstances which it considers likely to affect the DHB during the period of one year from the date of signing the 2018/19 financial statements, and to circumstances which it knows will occur after that date which could affect the validity of the going concern assumption (as set out in its current Statement of Intent). The key considerations are set out below.

Letter of comfort
The Board has received a letter of comfort, dated 21 September 2018 from the Ministers of Health and Finance which states that deficit support will be provided where necessary to maintain viability.

Capital injection of $8.5m was received during the current financial year.

Operating and Cash flow forecasts
The Board has considered forecast information relating to operational viability and cash flow requirements. The Board is satisfied that there will be sufficient cash flows generated from operating activities to meet the investing and financing cash flow requirements of the DHB as set out in its current Statement of Intent and based on current trading terms and legislative requirements.

Borrowing covenants and forecast borrowing requirements
The forecast for the next year prepared by Hauora Tairāwhiti shows that the peak borrowing requirement will not exceed the available borrowing facilities. Furthermore, the forecast borrowing requirements can be met without breaching covenants or other borrowing restrictions.

While the Board is confident in the ability of Hauora Tairāwhiti to continue as a going concern, if the forecast information relating to operational viability and cash flow requirements is not achieved there would be significant uncertainty as to whether the DHB would be able to continue as a going concern based on current trading terms and legislative requirements.

Statement of Compliance

The financial statements of Hauora Tairāwhiti have been prepared in accordance with the requirements of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004, which include the requirement to comply with generally accepted accounting practice in New Zealand (NZ GAAP).

The financial statements have been prepared in accordance with Tier 1 PBE accounting standards.

Presentation currency and Rounding

The financial statements are presented in New Zealand Dollars rounded to the nearest thousand ($000).

Significant Accounting Policies

Revenue

Revenue from the Crown

Hauora Tairāwhiti is primarily funded from the Crown, which is restricted in its use for the purpose of Hauora Tairāwhiti meeting its objectives as specified in the statement of intent. The fair value of revenue from the Crown has been determined to be equivalent to the amounts due in the funding arrangements.

Revenue from Other DHB's

Hauora Tairāwhiti receives revenue when a patient from another area is treated in Tairāwhiti, this revenue is paid via an Inter District Flows mechanism after the patient is discharged.

Interest

Interest revenue is recognised using the effective interest method.

Donated services

Certain operations of Hauora Tairāwhiti are partially reliant on services provided by volunteers. Volunteer services received are not recognised as revenue or expenditure.

Donated assets

Where a physical asset is gifted to or acquired by Hauora Tairāwhiti for nil consideration or at a subsidised cost, the asset is recognised at fair value and the difference between the consideration provided and fair value of the asset is recognised as revenue.

Expenditure

Capital charge

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

Borrowing costs

Borrowing costs are recognised as an expense in the financial year in which they are incurred.

Finance Leases

Leases, which effectively transfer to Hauora Tairāwhiti substantially all the risks and benefits incident to ownership of the leased items, are classified as finance leases. These are capitalised at the lower of the fair value of the asset or the present value of the minimum lease payments. The leased assets and corresponding lease liabilities are recognised in the statement of financial position. The leased assets are depreciated over the period the Hauora Tairāwhiti is expected to benefit from their use.

Operating Leases
Leases where the leaser effectively retains substantially all the risks and benefits of ownership of the leased items are classified as operating leases. Payments under these leases are recognised as expenses in the periods in which they are incurred.

Finance and Procurement, including National Oracle Solution
The Finance and Procurement programme, which includes the National Oracle Solution (NOS), is a national initiative funded by DHBs and facilitated by NZ Health Partnerships Limited to deliver sector wide benefits. Health Partnerships holds an intangible asset recognised at the capital cost of development relating to this programme. Hauora Tairāwhiti holds an asset at cost of capital invested by Hauora Tairāwhiti in the FPSC programme. This investment represents the right to access the FPSC assets and are considered to have an indefinite life. DHBs have the ability and intention to review the service level agreement indefinitely and the fund established by Health Partnerships through the on-charging of depreciation and amortisation on the assets to the DHBs will be used to, and is sufficient to, maintain the assets standard of performance or service potential. As the rights are considered to have an indefinite life, the intangible asset is not amortised and will be tested for impairment annually.

Cash and Cash equivalents
Cash and cash equivalents comprises cash balances, call deposits with a maturity of no more than three months.

Receivables
Short-term receivables are recorded at their face value, less any provision for impairment. A receivable is considered impaired when there is evidence that Hauora Tairāwhiti will not be able to collect the amount due. The amount of the impairment is the difference between the carrying amount of the receivable and the present value of the amounts expected to be collected.

Investments
Investments, including those in subsidiaries, are stated at fair value. Any decreases are recognised in the Statement of comprehensive revenue and expense.

After initial recognition, these investments are measured at their fair value with gains and losses recognised in other comprehensive revenue and expense, except for impairment losses that are recognised in the surplus or deficit.

A significant or prolonged decline in the fair value of the investment below its cost is considered objective evidence of impairment. If impairment evidence exists, the cumulative loss recognised in other comprehensive revenue and expense is reclassified from equity to the surplus or deficit.

Inventories
Inventories held for distribution in the provision of services that are not supplies on a commercial basis are measured at cost, determined on weighted average cost basis.

Inventories acquired through non-exchange transactions are recorded at fair value at the date of acquisition. The amount of any write-down for the loss of service potential or from cost to net realisable value is recognised in the surplus or deficit in the period of the write down.

Property, plant and equipment
Property, plant and equipment consist of the following asset classes: land, buildings, clinical equipment, other equipment, information technology and vehicles.

Property, plant and equipment vested from the Hospital and Health Service.
Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets of Tairāwhiti Healthcare Limited (a Hospital and Health Service) were vested in Hauora Tairāwhiti on 1 January 2001.

Accordingly, assets were transferred at their net book values as recorded in the books of the Hospital and Health Service. In effecting this transfer, the Board has recognised the cost and accumulated depreciation amounts from the records of the Hospital and Health Service. The vested assets will continue to be depreciated over their remaining useful lives.

Property, plant and equipment acquired since the establishment of Hauora Tairāwhiti.
Assets acquired by the Board since its establishment, other than those vested from the Hospital and Health Service and land and buildings, are recorded at cost less accumulated depreciation. This includes all appropriate costs of acquisition and installation, including materials, labour, direct overheads, financing, and transport costs.

Land is measured at fair value, and buildings are measured at fair value less accumulated depreciation. All other asset classes are measured at cost, less accumulated depreciation and impairment losses.

Revaluations
Land and buildings are valued by an independent qualified valuer at least 3 yearly to confirm that their carrying value in the financial statements of the organisation reflect their fair value. Valuations will be undertaken more regularly if necessary to ensure that no class of assets is included at a valuation that is materially different from its fair value. Where fair value of an asset is not able to be reliably determined using market-based evidence, optimised depreciated replacement cost is considered the most appropriate basis for determination of fair value.

Land and buildings revaluation movements are accounted for on a class-of-asset basis.

The net revaluation results are credited or debited to other comprehensive revenue and are accumulated to an asset revaluation reserve in equity for that class of asset. Where this would result in debit balance in the asset revaluation reserve, this balance is not recognised in other comprehensive revenue but is recognised in the surplus or deficit. Any subsequent increase on revaluation that reverses a previous decrease in value recognised in the surplus or deficit will be recognised first in the surplus or deficit up to the amount previously expensed, and then recognised in other comprehensive revenue.

The results of revaluing land and buildings are credited or debited to an asset revaluation reserve for that class of asset. Where a revaluation results in a debit balance in the asset revaluation reserve, the debit balance will be expensed in the Statement of comprehensive revenue and expense.
Additions between revaluations are recorded at cost less depreciation

Disposals
Any gain or loss on disposal is determined by comparing the proceeds with the carrying amount of the asset and this amount is included in the net surplus or deficit.

Depreciation
Depreciation is provided on a straight-line basis on all property, plant and equipment other than land, at rates which will write-off the cost (or revaluation) of the assets to their estimated residual values over their useful lives.

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

Buildings - Structure	67 years	(1.5%)
Buildings - Fit out	5 - 67 years	(1.5 - 20%)
Equipment	3 - 25 years	(4 – 33.33%)
Information Technology	2 - 12.5 years	(8 – 50%)
Intangible Assets	3 - 12.5 years	(8 – 33.33%)
Motor vehicles	6.7 - 12 years	(6.67 - 15%)

The residual value and useful life of an asset is reviewed, and adjusted if applicable, at each financial year end.

Work in progress is recognised at cost less impairment and is not depreciated. The total cost of a project is transferred to the relevant asset category on its completion and then depreciated.

Intangibles
Acquired computer software costs are capitalised on the basis of costs incurred to acquire and bring to use. Ongoing staff training and maintenance costs are recognised as expenses when incurred.
The carrying value of an intangible asset with a finite life is amortised on a straight line basis over its useful life. The amortisation charge is recognised in the Statement of comprehensive revenue and expense

Impairment
Hauora Tairāwhiti does not hold any cash-generating assets. Assets are considered cash-generating where their primary objective is to generate a commercial return.

Property, plant and equipment and Intangible assets that have a finite useful life are reviewed for impairment each year. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount. The recoverable amount is the higher of an asset's fair value less costs to sell and value in use.

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

Creditors and payables
Creditors and other payables are measured at fair value, and subsequently measured at amortised cost using the effective interest rate method.

Provisions
A provision is recognised for future expenditure of uncertain amount or timing when there is a present obligation (either legal or constructive) as a result of a past event, it is probable that an outflow of future economic benefits will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation.

Provisions are measured at the present value of the expenditure expected to be required to settle the obligation using a pre-tax discount rate that reflects current market assessments of the time value of money and the risks specific to the obligation. The increase in the provision due to the passage of time is recognised as an interest expense and is included in "finance costs".

Borrowings
Borrowings are initially recognised at their fair value plus transaction costs. After initial recognition, all borrowings are measured at amortised cost using the effective interest method.

Borrowings are classified as current liabilities unless Hauora Tairāwhiti has an unconditional right to defer settlement of the liability for at least 12 months after balance date. Borrowings where Hauora Tairāwhiti has an unconditional right to defer settlement of the liability for at least 12 months after balance date are classified as current liabilities if Hauora Tairāwhiti expects to settle the liability within 12 months of the balance date.

Employees
Employee entitlements
Provision is made in respect of Hauora Tairāwhiti liability for annual, parental, long service, sick, leave sabbatical, retirement, and conference leave. Annual leave, Parental Leave and Conference leave have been calculated on an actual entitlement basis at current rates of pay whilst Long Service and Retirement provisions have been calculated on an actuarial basis. The liability for sick leave is recognised, to the extent

that compensated absences in the coming year are expected to be greater than the sick leave entitlements earned in the coming year. The amount is calculated based on the unused sick leave entitlement that can be carried forward at balance date; to the extent the DHB anticipates it will be used by staff to cover those future absences.

Superannuation Schemes

Defined contribution schemes

Employer contributions to Kiwisaver, the Government Superannuation Fund, and the State Sector Retirement Savings Scheme are accounted for as defined contribution schemes and are recognised as an expense in the surplus or deficit as incurred.

Defined benefit schemes

The DHB makes employer contributions to the Defined Benefit Plan Contributors Scheme (the scheme), which is managed by the Board of Trustees of the National Provident Fund. The scheme is a multi-employer defined benefit scheme.

Insufficient information is available to use defined benefit accounting, as it is not possible to determine from the terms of the scheme the extent to which the surplus/deficit will affect future contributions by individual employers, as there is no prescribed basis for allocation. The scheme is therefore accounted for as a defined contribution scheme.

Equity

Equity is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified into the following components.

- contributed capital
- accumulated surplus/(deficit);
- revaluation reserves
- other reserves

Budget figures

The budget figures are those approved by the Board and published in its Statement of Intent and have been prepared in accordance with generally accepted accounting practice and are consistent with the accounting policies adopted by the Board for the preparation of the financial statements.

Goods and services tax

All items in the financial statements are exclusive of goods and services tax (GST) with the exception of receivables and payables, which are stated with GST included. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

The net GST recoverable from or payable to the Inland Revenue Department is included as part of receivables or payables in the Statement of Financial Position.

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

Taxation

Hauora Tairāwhiti is a public authority under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under Section CB3 of the Income Tax Act 2007.

Trusts and bequest funds

Donations and bequests to Hauora Tairāwhiti are recognised as revenue when control over assets is obtained or entitlement to receive money is established. A liability, rather than revenue, is recognised where fulfilment of any restrictions attached to those assets is not probable. Those donations and bequests with restrictive conditions are appropriated from Retained Earnings to the Trust Funds component of

Equity. When expenditure is subsequently incurred in respect of these funds, it is recognised in the Statement of comprehensive revenue and expense, an equivalent amount is transferred from the Trust Funds component of Equity to Retained Earnings.

Financial instruments

Hauora Tairāwhiti and the Group is party to financial instruments as part of its normal operations. These financial instruments include bank accounts, short term deposits, investments, debtors, creditors, and loans. All financial instruments are recognised in the Statement of Financial Position and all revenues and expenses in relation to financial instruments are recognised in the Statement of comprehensive revenue and expense.

Except for loans, which are recorded at cost, and those items covered by a separate accounting policy, all financial instruments are shown at their estimated fair value.

Cost of service statements

The cost of service statements, as reported in the statement of objectives and service performance, reports the net cost of services for the outputs of Hauora Tairāwhiti and are represented by the cost of providing the output less all the revenue that can be allocated to these activities.

Cost allocation

Direct costs are charged directly to output classes.

Indirect costs, those which cannot be identified in an economically feasible manner to a specific output class, are charged to output classes based on cost drivers and related activity/usage information.

The cost of internal services not directly charged to outputs is allocated as overheads using appropriate cost drivers such as actual usage, staff numbers, and floor area.

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

Critical accounting estimates

In preparing these financial statements, Hauora Tairāwhiti has made estimates and assumptions concerning the future. These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed below.

Estimating useful lives and residual values of property, plant, and equipment

At each balance date, the useful lives and residual values of property, plant, and equipment are reviewed. Assessing the appropriateness of useful life and residual value estimates of property, plant, and equipment requires a number of factors to be considered such as the physical condition of the asset, expected period of use of the asset by Hauora Tairāwhiti, and expected disposal proceeds from the future sale of the asset.

An incorrect estimate of the useful life or residual value will affect the depreciation expense recognised in the surplus or deficit, and carrying amount of the asset in the statement of financial position. Hauora Tairāwhiti minimises the risk of this estimation uncertainty by:

- physical inspection of assets;
- asset replacement programs;
- review of second hand market prices for similar assets; and
- analysis of prior asset sales.

Hauora Tairāwhiti has not made significant changes to past assumptions concerning useful lives and residual values.