Hauora
Tairāwhiti

ANNUAL REPORT 2017

VERSION #	DATE:	CHANGES:	REVIEW BY	REVIEW DATE:
V1.0	24.07.17	First draft created		
V1.1	31.08.17	Inclusion of financial accounts		
V1.2	22.09.17	Inclusion of SSP		24 September 2017
V1.3	11.10.17	Revised financial accounts	Craig Green	13 October 2017
V1.4	10.10.17	Modification of report format	Craig Green	13 October 2017
V1.5	30.10.17	Final changes to Audit NZ	Craig Green	30 October 2017

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Message from the Chair

Kia ora koutou

During 2016, the local body election (plus the ministerial appointments) delivered six new members around the Board table. This mix of people included a large proportion of 'youthful' members, which has definitely provided new energy and a new focus to the work of the Board.

This impetus has already been responsible for the addition of a youth member to both the Community & Public Health plus Aged Disability Support Committees with full participation and decision-making rights. Both of the youth members have been selected from the Gisborne District Council's Youth Council. Already I notice these youth members are asking questions; raising issues as well as providing commentary from a very different perspective. At this stage, the inclusion of these members has been extremely positive.

This electoral change also saw the end of an era for two stalwarts of health governance in this region. Mr Craig Bauld who had been a board member since the inception of the Tairāwhiti District Health Board in 2001 and Mrs Barbara Clark QSO who had been a Board member since 2002. Both members served the Tairāwhiti Community and the Board well with Mrs Clarke being the Deputy Chair of the Board from 2010 – 2016.

A highlight this year was the opportunity to present an example of Hauora Tairāwhiti innovation to the Midland Chairs and Chief Executives when they visited our district. Mr Reweti Ropiha Chief Executive of the NGO Tūranga Health and his staff displayed alternative ways to address the poor health statistics of Māori health. The focus of the presentation centred on 'taking the health services' to the people in their own work and home environments. This method utilises specially designed equipment for early-childhood, physical fitness, healthy eating and health checks. As an example the mobile clinic, fully equipped with both equipment and connection to the GP electronic network 'MedTech", travels out to horticultural field-workers, forestry workers in the paddocks or on the tree-felling, cable hauler and skid sites. One of the secrets of success is the way that the concept / initiative starts at the respective governance tables with the Chief Executives as well as the dedicated nurses who drive the vehicle and conduct the tests. Most times this means leaving Gisborne at any time between two and five am. The culture of this NGO is such that because they don't adhere to 'normal working hours' a great many emerging disease states are identified early with the appropriate follow-ups put in place. It was interesting to note because of the shift work many people told the team they never have time to visit the GP during normal hours.

This year has been a statistical record for the number of sick and un-well people who have passed through ED and been admitted as patients. Part of the reason no doubt is the large 1940-50 'baby boomer' bulge which is impacting on the health system. Also in this district, we have large numbers of people who are not diagnosed with serious conditions until the first time they enter ED. This means we have to re-double our effort to work with our highly skilled and caring general practices in encouraging people to both have a greater responsibility for their own health as well as ensuring they have regular health checks.

We are fortunate in Tairāwhiti to have a large health workforce who continually seek to both try new ideas as well as provide first class health care for us all and they are to be thanked sincerely for their tireless effort.

David S Scott MNZM, JP

Chair –Hauora Tairāwhiti Board
June 2017

Message from the Chief Executive

Starting this summary off I invariably return to my predictions for the year ahead made then of the equivalent summary in July 2016. I said: *So this year my prediction is for even more troubled waters for our waka. However, our crew are determined, innovative and strong. So I am predicting we will go a longer distance in 2016/17 with way less shipped water*. I believe that was remarkably accurate.

Our crew on the Hauora Tairāwhiti waka have been determined, innovative and strong as have the wider crew in health services across the district. The WAKA values have propelled us forward with record amounts of care provided for the community, new services and new service innovations. There has been an inexorable growth in the numbers presenting for care at Gisborne Hospital. The acute services load has at times meant elective services have had to be curbed in order to make sure people are treated in acceptable timeframes. We have therefore seen a small reduction in overall elective services production but still surpassed our targets. Services have been challenged at times to have the key staff to provide care and our staff have had to be nimble in how we have made sure people have had the care they require.

Despite this we have done well for Health Targets, once again meeting the hospital based targets for Emergency Department patient flow and elective discharges. The cancer treatment target performance has fluctuated during the year despite very close working with tertiary service providers to ensure our people had the diagnostics and treatments required as quickly as possible. We have perfected the local service delivery within the target timeframes but are still not achieving the overall target where we require services from out of district. Our PHO partners have down well on the Smoking Advice target but returning our childhood immunisation rate over 95% has been slow to rebuild although improving late in the year. Our comprehensive approach to the Childhood Obesity target will pay dividends in a forward looking focus to not only respond to the needs of children who are obese, with their families, but to also reduce the impact of obesity on our community.

Service developments throughout the year have been based around our Hauora Tairāwhiti values and aspirations. For example, how do we support people earlier so that the impact of ill health is prevented and the next generation has a step wise change in health outcomes? We have worked with our iwi provider partners to design a service to support women who are pregnant or who have young children, to maximise their own health potential and that of their children. The approach utilises Māori models of care to increase effectiveness. A similar design process is in place to radically improve early access to mental health services. We have planned with Primary Health Organisation, iwi provider and consumer advocacy to work with tangata whaiora and their whānau to promote earlier recovery and to reduce the need for hospital based services. We will improve care and develop a model that can be spread to accentuate the care we can provide for our community.

We have also used the spirit of the WAKA values of Hauora Tairāwhiti to move outside our health boundaries to add our weight to modifying the determinants of health in Tairāwhiti. Through Manaaki Tairāwhiti, the local social investment pilot, we have worked with iwi, government agencies and the council to begin the better lining up of care so that the inter-connections in health and social outcomes can be used to advance outcomes, not hold people back.

At present it looks like we may have turned a corner on the financials for Hauora Tairāwhiti as well. Our consolidated deficit of ($6.1m) is $0.5m better than the final result for 2015/16. Tairāwhiti people are getting care though, even if more of that care is to intervene with conditions we have to work with them to get ahead of, much earlier in life.

So to my 2017/18 prediction. That will unfortunately be for more troubled waters for our waka, especially as we grapple with the increased acute load, but with the support of our primary care partners. We will be installing some cyclors on our waka so we will be going faster.

Our District

Hauora Tairāwhiti funds and provides health and disability services for a large area of the northern East Coast of the North Island of New Zealand, stretching from beyond Hicks Bay in the north to the Wharerata Ranges in the south and inland to Motu in the west.

Hauora Tairāwhiti serves a population of 47,680 and covers 8,351 square kilometres, roughly 3% of New Zealand's land area. Tairāwhiti is the most sparsely populated North Island area, with a population density of 5.6 people per square kilometre.

A large proportion of our population live outside the main urban areas (approximately 27% per cent)[1] and our large rural population presents diverse challenges in service delivery and accessing health services. Significant points of interest in regard to our population include:

- The Tairāwhiti district has an average deprivation score of 7, where 1 indicates least deprived, and 10 most deprived.
- Deprivation scores in our district range from 2 (in the suburb of Wainui) to 10 in Ruatoria and Te Karaka[2].
- 67% of Māori and 30% of non-Māori in our district are considered to live in the most deprived areas; this is living in areas with deprivation deciles 9 or 10.
- 52% of children, 0-14 years, live in these most deprived areas.
- Health, Education, Agriculture, Horticulture, Forestry and Fishing are the largest employers of the workforce in our district.
- 40% of Māori and 50% of non-Māori are employed full time.
- 35% of Māori in our district (30% nationally) have no education qualifications[3]. For Non-Māori the rate is 27% (23% nationally).
- 28% of families in the Tairāwhiti district are single parent families compared to 18% nationally.
- 49% of non-Māori women aged 15 years and over in our district have had two or three children. For Māori this rate is 33%. 14% of Māori women, 15 years and older have had five or six children. For non-Māori the figure is 7%[4].
- 54% of households in the Gisborne district live in their own home and 38% rent.

A driving priority for Hauora Tairāwhiti remains the health of Māori. There is general acceptance that if we continue to do what we have always done, then we will get the results we have always got: for Māori this ultimately means a shorter life expectancy here in Tairāwhiti than in any other District Health Board (DHB) in New Zealand. This has fuelled growing momentum across health and social sectors to create a uniquely Tairāwhiti model to achieve better health outcomes more quickly, especially for Māori.

A critical component of this work is the implementation of a cross-sectorial collective impact approach within any service planning or design to ensure that the people of Tairāwhiti receive high value health and social care closer to home.

[1] MoH PHO Enrolment Demographics 2014Q4 (Oct- Dec 2014)
[2] http://www.health.govt.nz/publication/dhb-maps-and-background-information-atlas-socioeconomic-deprivation-new-zealand-nzdep2006
[3] http://www.stats.govt.nz/Census/2006CensusHomePage/QuickStats/AboutAPlace/SnapShot.aspx?pdf=1&id=1000005&type=region&ParentID=1000005
[4] http://www.health.govt.nz/publication/dhb-maps-and-background-information-atlas-socioeconomic-deprivation-new-zealand-nzdep2006

About Hauora Tairāwhiti

Our Mission Statement

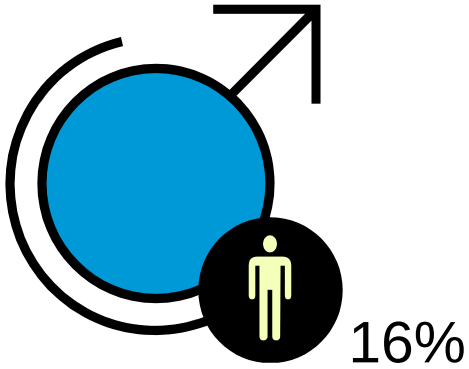
“Working together, to elevate the wellbeing of Tairāwhiti."
"Mahia nga mahi i roto i te kotahitanga kia piki ake te oranga o te Tairāwhiti.

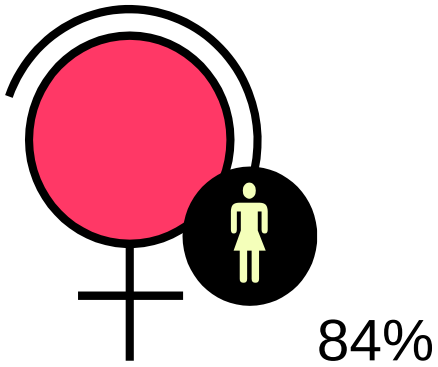
Our values

Whakarangatira/enrich - Enriching the health of our community by doing our very best
Awhi/support - Supporting our turoro/patients their whanau/families, our community partners and each other
Kotahitanga/togetherness - Together we can achieve more
Aroha/compassion - Empathy, we care for people and people want to be cared for by us.

Our values form the acronym WAKA. They reflect our past while guiding us on our journey to create a healthier Tairāwhiti by working together.

The DHB currently employs 936 people, a number of whom are multi-jobbed; with 968 positions held throughout the organisation. Of these 968 positions:





WORKFORCE PROFILE – by age bands	
<25	4.3%
25 - 35	15.6%
35 - 45	21.8%
45 - 55	26.5%
55 - 64	23.9%
65+	7.9%

WORKFORCE PROFILE – by occupational group	
Medical staff	8.7%
Nursing staff	48.3%
Allied Health staff	18.6%
Non-clinical support staff	5.1%
Management & admin staff	19.3%

WORKFORCE PROFILE – by ethnicity	
NZ European	52.6%
NZ Māori	26.8%
Pacific Island	1.0%
British & Irish	2.5%
Other ethnicities	16.5%
Not known	0.6%

EMPLOYEE STATUS	
Casual	7.8%
Full time	41.8%
Part time	50.4%

OUR HEALTH TARGETS

Tairāwhiti DHB Health Targets 2016/17[5]

Health Target	Indicator and National Target	Tairāwhiti DHB Target	2016/17 result				Target Achieved
	95 per cent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours.	95%	95%				
			Q1	Q2	Q3	Q4	
			96%	95%	95%	95%	
	Nationally, the volume of elective surgery will be increased by an average of 4,000 discharges per year.	2,574[6]	2,822				
			Q1	Q2	Q3	Q4	
			713	690	663	756	
	At least 85 per cent of patients referred with a high suspicion of cancer wait 62 days or less to receive their first treatment (or other management) to be achieved by July 2016, increasing to 90 per cent by June 2017.	90%	77%				
			Q1	Q2	Q3	Q4	
			74%	80%	79%	74%	
	95 per cent of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time.	95%	88%				
			Q1	Q2	Q3	Q4	
			91%	90%	85%	83%	
	90 per cent of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months	90%	90%				
			Q1	Q2	Q3	Q4	
			89.2%	86.4%	92%	92.7%	
	90 per cent of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.	90%	90%				
			Q1	Q2	Q3	Q4	
			86%	91%	95%	91%	
	By December 2017, 95% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.[7]	95%	66%				
			Q1	Q2	Q3	Q4	
			56%	66%	70%	74%	

[5] Health target results reflect the Ministry of Health's reported results as at 30 June 2017. These results may differ from those shown in the Statement of Service Performance as some Health Target Indicators are reported quarterly (indicated by*) while Statement of Service Performance results are annualised.

[6] total elective surgical discharges

[7] Data is based on all acknowledged referrals for obese children up to the end of the quarter from Before School Checks occurring in the six months between 1 December 2016 to 31 May 2017.

Report on good employer obligations

Leadership, Accountability and Culture

Hauora Tairāwhiti understands that in order to continue to make good decisions and consistently perform as a good employer it is essential to actively grow leadership by identifying, nurturing and supporting staff to improve leadership competence and capability.

Staff in designated leadership roles have also been given the opportunity to grow their leadership capability by attending local and regional health leadership training. These learnings have been supplemented by locally facilitated shorter learning opportunities found on the learning and development calendar which have been well attended. Over the past year Tairāwhiti has supported a further five middle managers to attend the Midlands Leadership in Practice training and two senior managers with the Midlands Advanced Leadership training. Both programmes are endorsed by the five regional District Health Boards and also allow for multi-disciplinary networking across the region.

A significant amount of work has been undertaken to improve working relationships with unions. Local bipartite meetings have been well attended and held regularly throughout the year. Tairāwhiti have been working with the unions to develop an annual work plan to ensure that there is proactive work happening outside of the meetings.

Recruitment, Selection and Induction

Hauora Tairāwhiti supports equal employment opportunities (EEO) through its recruitment practices by ensuring fairness, equity and transparency are applied when advertising and considering applications for employment. Tairāwhiti recognises the importance of diversity in the workplace and encourages practices to support ethnic minorities and recruiting applicants with disabilities. Tairāwhiti integrates health checks and assessments into all of its recruitment processes to evaluate baseline health and how that can be supported through workplace and workstation setup. Recruitment processes have also been enhanced to include credit checks for employees that handle finances, introduced competency-based questions, and included more rigor in relation to screening of staff that are working with vulnerable people including children and the elderly in line with the Vulnerable Children's Act (VCA). Tairāwhiti also have a regime for checking the existing workforce within the timeframes stipulated by the VCA.

Recruitment training has been made available throughout the year to recruiting managers to support best practice. Māori representation is also a requirement for all recruitment panels. To ensure there is an equal opportunity to apply for roles, all vacancies are advertised through Kiwi Health Jobs (KHJ) and the Hauora Tairāwhiti website. The DHB owned KHJ site attracts over 60,000 job seekers per month looking for careers in health.

Māori Workforce Planning

There has been a significant body of work completed to engage and connect with our Māori community in order to reduce health inequities and grow the Māori workforce representative of our community.

There has also been a targeted approach to promote health to ethnic minorities including Māori which included working alongside the Midlands regional Kia Ora Hauora (KOH) coordinator to tailor the messaging and promotional material toward Māori and whānau.

Tairāwhiti continues to support a bi-cultural induction and on-going training by providing all staff with a powhiri and training through tikanga best practice and marae based training through Te Kete Kawerua. During the rollout of Hauora Tairāwhiti all staff received the opportunity to attend training by our kaumatua specific to the WAKA values, which is an ongoing feature on the learning and development calendar.

Employee Development, Promotion and Exit
Hauora Tairāwhiti has a fair and equitable performance appraisal system in place, named 'You Time', which is supported by our policies. The Employment Relations Act, and Health and Safety Act continue to reinforce the need to maintain strong relationships with employees and unions. The Bipartite Union Committee continues to be the forum for union delegates to be engaged on the Transform and Sustain agenda to discuss common issues. Learning needs and career aspirations are identified through the appraisal tool called 'You-Time' which are then supported through on job training, projects, courses, sabbaticals and study.

All staff have access to the learning opportunities offered through the learning and development calendar. Tairāwhiti built a learning facility called Ko Matakerepo to support staff development, which includes a lecture room, two video suites, computer lab and library. Where possible, learning opportunities have been made available to community based organisations and contractors who work in health within the Tairāwhiti community.

Hauora Tairāwhiti continues to support the 'grow our own strategy' which focuses on developing and promoting talent from within the organisation. Secondments, projects, acting-up opportunities and fixed term positions are widely promoted to staff to provide the hands on experience and pay incentives to staff readying them for promotion opportunities when they become available.

Staff departing the organisation are offered an opportunity to complete an exit survey.

Hauora Tairāwhiti has an on the job learning programme for newly graduated nurses called the Nurse Entry To Practice programme (NETP) that supports graduate nurses through the beginning stages of their career. The programme supports Tairāwhiti graduates that have come through the local polytechnic provider and offers a safe working environment that grows new graduates into competent registered nurses. Tairāwhiti supported twelve graduate nurses through the programme over the past 12 months.

Flexibility and Work Design
Hauora Tairāwhiti recognise how important it is to continually support the changing demands of life and support work life balance where that does not compromise care. The You-Time appraisal template now includes a section where staff can discuss how their changing circumstances may be supported by the organisation, such as reducing hours of work to support early retirement or being available for young children. The social needs of staff are also considered when designing rosters.

Remuneration, Recognition and Conditions
The majority of staff are employed under multi-employer collective agreements, which are negotiated nationally. The DHBs and unions ensure that remuneration in the health sector is fair and equitable based on the affordability of the health system. Hauora Tairāwhiti continues to use the Strategic Pay methodology to job evaluate roles for staff on individual employment agreements.

Harassment and Bullying Prevention
Tairāwhiti does not accept harassment and bullying in the workplace. Tairāwhiti has been undertaking a number of initiatives to embed appropriate behaviours in the workplace and reducing the prevalence of unwanted behaviours that include harassment and bullying. This has included the launch of behaviours that underpin the WAKA values and supporting services to embed appropriate behaviours, and develop processes to safely call inappropriate behaviours and foster safe working cultures. Tairāwhiti continue to run its awareness programme called 'Taking the Bully by the Horns'.

Safe and Healthy Environment
Hauora Tairāwhiti as a good employer provides a safe and healthy working environment. Tairāwhiti also operate an Employee Assistance Programme that offers support to staff that may be facing issues either at home or within the workplace that may affect their performance at work.

Governance Philosophy

Connection with Stakeholders

The Board acknowledges its responsibility to keep in touch with stakeholders and, in particular, remain cognisant of the Minister of Health's expectations.

Division of Roles between the Board and Management

The efficient running of Hauora Tairāwhiti requires a clear division between the roles of the Board and Management. The Board concentrates on setting policy, approving strategy, and monitoring progress towards meeting objectives. Management is concerned with implementing policy and strategy. The Board has clearly distinguished these roles by ensuring that the delegation of authority to the CE is concise and complete as delineated in the approved delegation policy.

Accountability

The Board holds meetings most months and monitors progress toward its strategic objectives. The Board also ensures Hauora Tairāwhiti actions and those of its subsidiary and associates adhere to Hauora Tairāwhiti policies.

Members' Interests

The Board maintains an Interests Register and ensures members are aware of their obligations to declare any interests they may have in matters under consideration by the Board or in the wider operations of Hauora Tairāwhiti.

At least on an annual basis, or as interests arise, the CE and direct reports to the CE are required to make a declaration of interests, which the Board Chair reviews for any conflicts, with associated management strategies put in place. These interests are also reported to the Board.

Internal Audit

Overall responsibility for maintaining effective systems of internal control ultimately rests with the Board. Internal controls include the policies, systems, and procedures established to provide assurance that specific objectives of the Board are achievable, and that reporting to the Board is reliable. The Board and Management have acknowledged their responsibility by signing the Statement of Responsibility which can be found on page 35 of this report. Hauora Tairāwhiti contracts an Internal Audit function through the Internal Audit division of Health Share, which is responsible for monitoring its systems of internal control and the quality and reliability of financial and non-financial information reported to the Board. Internal Audit operates independently of management and reports its findings directly to the Board's FAIT Committee, which in turn reports any issues or concerns to the Board. Internal Audit liaises closely with the external auditors, who review the systems of internal control to the extent necessary to support their audit opinion.

Risk Management

The Board acknowledges that it is ultimately responsible for the management of risks to Hauora Tairāwhiti. The Board has charged the CE, through its Risk Management Policy, with establishing and operating a risk management programme in accordance with the "Guidelines for Managing Risk in the Australian and New Zealand Public Sector SAA/NZSHB 143:1999". The FAIT committee receives three monthly reports on the risk management programme.

Legislative Compliance

The Board acknowledges its responsibility to ensure the organisation complies with all legislation. The CE has delegated authority from the Board to develop and operate a programme that systematically identifies compliance issues and ensures staff awareness of legislative requirements that are particularly relevant to them. The FAIT committee receives a quarterly report on the legislative compliance programme.

Governance and Accountability Statement

Tairāwhiti DHB is a crown entity, established on 1 January 2001, responsible for funding, providing, and ensuring the provision of personal health, mental health and Māori health services to the resident population of the district and disability support services for residents over 65 years of age. In 2015, Tairāwhiti DHB was rebranded to Hauora Tairāwhiti as the organisation signalled a change in how people access health services and how this can be improved.

Hauora Tairāwhiti 's role is three fold, namely Owner/Governance, Funder, and Provider of public health and disability services in the district.

The Funding arm, Te Puna Waiora (Spring of Wellness), leads the process of assessing the needs and planning for the services required by the people of Tairāwhiti. The team administers the agreements generated through the funding process. This includes the funding of all personal health, mental health, Māori health and disability support services for people over the age of 65 for the Tairāwhiti population. Te Puna Waiora also has a monitoring and auditing function in most part carried out through HealthShare, the Midland DHBs' Shared Services Agency.

The Provider arm, is the principal Provider of secondary health and disability services to the people of Tairāwhiti (Gisborne Hospital campus). These services include medical, surgical, women's health, child health, elderly, disability support, mental health, public health, and related support services.

Hauora Tairāwhiti also accesses health services for the people of Tairāwhiti from organisations outside the district, primarily through referrals to Waikato Hospital and Auckland Starship for tertiary services, and Wellington for other specialist services.

Role of the Board

Under Section 25 (1) of the Crown Entities Act 2004 (the CE Act), the Board is the governing body of Hauora Tairāwhiti, with the authority, in the DHB's name, to exercise the powers and perform the functions of Hauora Tairāwhiti. Under section 25 (2) of the CE Act, all decisions relating to the operation of Hauora Tairāwhiti must be made by, or under the authority of, the Board in accordance with the CE Act and the New Zealand Public Health and Disability Act 2000 (the NZPHD Act).

The focus of the Board is on governance and policy issues. The Board's primary responsibilities are:

- Representing the 'owner' (the Crown)
- Setting strategic direction and policies for Hauora Tairāwhiti
- Appointing and resourcing the CEO
- Delegating responsibility to the CEO and monitoring the CEO's performance
- Monitoring the implementation and performance of plans that will have a significant effect on the DHB
- Ensuring compliance with the NZPHD Act, the CE Act and all other relevant legislation
- Fostering community participation in health improvement, including participation by Māori.

The people of Tairāwhiti elected seven members to the Board in October 2016. The Minister of Health appointed a further four members to form the governing Board. All Board members are required to act in the best interests of Hauora Tairāwhiti. Members acknowledge that the Board must stand unified behind its decisions; individual members have no separate governing role outside the boardroom.

Profile of the Board

The Board carries out its governance role through regular formal meetings and through associated subcommittees. The Board has a partnership relationship with each of the Runanga in Tairāwhiti. It also has a Caucus Accord with local Māori representing iwi, Māori providers, and Māori organisations, through Te Waiora o Nukutaimemeha Māori Relationship Board. A partnership relationship also exists with the Pacific Islands Community Trust.

Board Members	
David Scott (Chair)	Appointed, June 2010 Reappointed, December 2010 Reappointed, December 2013 Reappointed, December 2016
Rehette Stoltz	Elected, October 2013 Re-elected October 2016
Geoff Milner (Deputy Chair)	Appointed, December 2010 Reappointed, December 2013 Reappointed, December 2016
Kathy Sheldrake	Elected, October 2010 Re-elected, October 2013 Re-elected, October 2016
Brian Wilson	Elected, October 2007 Re-elected, October 2010 Re-elected, October 2013 Re-elected, October 2016
Meredith Akuhata-Brown	Elected, October 2016
Josh Wharehinga	Elected, October 2016
Hiki Pihema	Elected, October 2016
Prue Younger	Elected, October 2016
Gavin Murphy	Appointed, December 2016
Na Raihania	Appointed, December 2016

Corporate Office	**Auditor**
Hauora Tairāwhiti Private Bag 7001 421 Ormond Road Gisborne 4040	Audit New Zealand For and on behalf of the Auditor General

Solicitors	**Transactional Bankers**
Nolans Gisborne Chapman Tripp Auckland	Westpac Banking Corporation Gisborne

Board Members Register of Interest

The following are particulars of entries in the Interest Register made by Board members for the period between 01 July 2016 and 30 June 2017.

Report of Permissions under Section 68(6) of the Crown Entities Act 2004				
Board Member	**Transaction / Matter**	**Conflict Arising**	**Nature of Conflict/s**	**Board Response / Action**
Dec-16				
Hiki Pihema	Item 8.1: Update report on Supporting Raising Healthy Kids Target	Ms Pihema's daughter was the author of the paper.	The Board agreed no conflict existed in real terms (as the paper was for information).	Ms Pihema was allowed to remain and participate in discussion.
Aug-16				
Na Raihania	Item 12.0: Ngati Porou Hauora Board re Tairawhti Annual Plan 2016-17	Mr Raihania is a Trustee on TRONPnui Board	Ngati Porou Hauora is a subsidiary of TRONPnui Board	Mr Raihania excused himself from the meeting during these discussions.
Feb-17				
Hiki Pihema	Item 13.1 Board Financial Action - Line x Line Review	In relation to her role as Dietician, Hauora Tairawhiti	The Review included service lines that could affect the Dietician Service and Ms Pihema's employment.	The Board agreed that Ms Pihema abstain from discussion.
Na Raihania	Item 13.1 Board Financial Action - Line x Line Review	Mr Raihania is a Trustee on TRONPnui Board	The review included service lines that could affect Ngati Porou Hauora, a subsidiary of TRONPnui.	The Board agreed that Mr Raihania abstain from the discussion.
Rehette Stoltz	Item 13.3 Board Financial Action: Impact Analysis of Elective Thresholds	Ms Stoltz's husband is employed by Hauora Tairawhiti as an Anaesthetist	The review could impact on the provison of Surgical Services and on her husband's employment.	Ms Stoltz abstained from discussions.
Apr-17				
Rehette Stoltz	Item 14.3b Board Financial Action - Line x Line Review	In relation to her role on the Sunshine Service	The Sunshine Service may be negatively impacted by the Review.	The Board agreed that Ms Stoltz be allowed to remain and participate in any discussion/decision apart from ones affecting the Sunshine Service.

Hiki Pihema	Item 14.3b Board Financial Action - Line x Line (Service) Review	In relation to her role as Dietician, Hauora Tairawhiti	The Review included service lines that could affect the Dietician Service and Ms Pihema's employment.	The Board agreed that Ms Pihema be allowed to remain and participate in any discussion/decision apart from ones affecting the Dieticians .
Na Raihania	Item11.3 FAIT Community member Appointment	In relation to his role as Trustee on TRONPnui Board	The nomination onto the FAIT Committee is an employee of TRONPnui.	It as agreed that Mr Raihania could remain in the meeting but not participate in the discussion.
May-17				
Hiki Pihema	Item 14.2d Allied Health Review update	Ms Pihema is employed in the Dieticians service in Hauora Tairawhti	She had been involved in data compliation for the report.	The Board agreed Ms Pihema could remain for discussion.
Hiki Pihema	Item 14.3 Gisborne Hospital Childcare Lease	A member of her staff was associated with the Childcare Facility.	Ms Pihema had been actively lobbied by her staff member.	The Board agreed Ms Pihema could remain but not participate in discussions.
Brian Wilson	Item 14.3 Gisborne Hospital Childcare Lease	President, YMCA	YMCA has childcare facilities and could be advantaged by any decision against Gisborne Hospital Childcare in relation to their lease.	The Board agreed Mr Wilson could remain but not participate in discussions.

Role of the Chief Executive

The Board has appointed a single employee, the Chief Executive (CE), to manage all DHB operations. The CE has appointed all other employees of Hauora Tairāwhiti. The Board directs the CE by delegating responsibility and authority for the achievement of objectives through setting policy.

The Board delegates to the CE, on such terms and conditions as are appropriate, the power to make decisions on operational and management matters within the framework of the Board's agreed strategic direction as set out in the Annual Plan. It endorses the CE, assigning defined levels of authority to other specified levels of management within the organisational structure.

Statutory Advisory Committees

The Board Advisory Committees, including those Statutory Committees required under the NZ Public Health and Disability Act 2000, were set up to provide a more detailed level of focus on particular issues. The committees have delegated authority for governance to action the Board's policies as well as monitoring the organisation's progress towards meeting Hauora Tairāwhiti's objectives. The committees also have formal budgetary delegations to fund services or approve expenditure on Hauora Tairāwhiti's behalf. The Board's standing committees (including the statutory permanent advisory committees) are:

Committee:

- Community and Public Health (CPHAC) - Bi-Monthly and Community Open Forums twice annually
- Aged & Disability Support Advisory (ADSAC) - Bi-Monthly and Community Open Forums twice annually
- Hospital Advisory (HAC) - Monthly
- Finance Audit & IT (FAIT) - Monthly
- Te Waiora o Nukutaimemeha Iwi Relationship Board (TWON) – Monthly
- Staffing & Governance Committee (S & G) - Quarterly or as required.

Advisory Committee Members

The Committees include, in addition to selected Board members, representatives from the Tairāwhiti community selected through an application process.

BOARD/Committee	Board/Committee Member	Community Members
Hauora Tairāwhiti Board	**David Scott (Chair)** Geoff Milner (Deputy Chair) Rehette Stoltz Brian Wilson Kathy Sheldrake Na Raihania Josh Wharehinga Hiki Pihema Prue Younger Meredith Akuhata-Brown Gavin Murphy	n/a
Finance, Audit & IT Committee (FAIT)	**Geoff Milner (Chair)** Rehette Stoltz Brian Wilson Gavin Murphy Kathy Sheldrake David Scott (ex officio)	John Hockey
Community & Public Health (CPHAC)	**Kathy Sheldrake (Chair)** Rehette Stoltz Na Raihania Hiki Pihema Josh Wharehinga David Scott (ex officio)	Te Aturangi Nepia-Clamp Murray Palmer Ngahuia Ngata (TWON) Catherine Jackman (Youth)
Aged & Disability Support Advisory Committee (ADSAC)	**Prue Younger Chair)** Na Raihania Meredith Akuhata-Brown Josh Wharehinga David Scott (ex officio)	Lois McCarthy-Robinson (TWON) Roimata Waihi Caroline Simmonds (Youth)
Hospital Advisory Committee (HAC)	**Brian Wilson (Chair)** Gavin Murphy Prue Younger Geoff Milner Hiki Pihema Meredith Akuhata-Brown David Scott (ex officio)	Jane Williams Barbara Clarke Juanita Timutimu (TWON)
Te Waiora o Nukutaimemeha (TWON)	**Na Raihania (Chair)** Josh Wharehinga	Molly Para Maaka Tibble Lois McCarthy-Robinson Juanita Timutimu Na Raihania (TRONP) Angus Ngarangioue (TROTAK) Ngahuia Ngata (Te Aitanga a Hauiti Hauora)
Staffing/Governance	**David Scott (Chair)** Geoff Milner Rehette Stoltz Brian Wilson Josh Wharehinga	n/a
TLab Directors	Brian Wilson Barbara Clarke	n/a
Tairāwhiti Laundry Services Ltd	Geoff Milner Rehette Stoltz	n/a

Quality Improvement

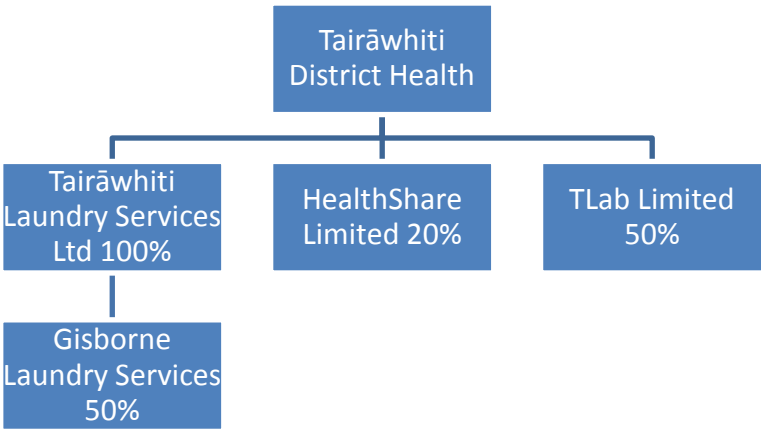
The Clinical Governance Committee oversees the quality improvement environment at Hauora Tairāwhiti reporting through the Chief Executive to the Board on patient safety matters and clinical quality improvement. Through these mechanisms, the Board guides the overall setting of the Hauora Tairāwhiti Quality Plan.

It is important to note that the Quality Plan for Hauora Tairāwhiti extends beyond its own provider services to include the operation of the funding arm and the activities of providers with agreements with Hauora Tairāwhiti.

The monitoring and audit plan for Hauora Tairāwhiti, completed in conjunction with HealthShare and the Ministry of Health's Sector Services, follows the quality improvement activity of providers. Reporting to the Board of audits for these providers is made through the FAIT Committee for overview.

Subsidiaries and Associates

Group Organisational Structure



Tairāwhiti Laundry Services Limited (TLSL)

TLSL (registered under the Companies Act 1993) is a wholly owned subsidiary of Hauora Tairāwhiti and is the holding company for its 50 percent investment in the Gisborne Laundry Services Partnership.

Gisborne Laundry Services (GLS)

GLS is a partnership between TLSL and Mahia Resort Limited that provides laundry services to Gisborne Hospital, its associated services, and other commercial laundry services to external customers.

Health Share Limited (HSL)

HSL (registered under the Companies Act 1993) is the Midland Region DHBs' shared services agency, which is owned in equal shares by the five DHBs of the Midland Region. The company provides specialist audit services to DHBs, other support service roles in areas such as internal audit, workforce development, regional planning and clinical network coordination, where this improves the effectiveness of DHB operations.

TLab Limited (TLab)

TLab Ltd (registered under the Companies Act 1993) is the 50/50 joint venture company between Hauora Tairāwhiti and MedLab Central Ltd, which provides laboratory services at Gisborne Hospital and for the wider Tairāwhiti community. The Company was established on 1 September 2007.

Statement of Performance

To perform our functions well the actions we take must:

- Help deliver our outputs
- make the impacts we intend; and
- contribute to the achievement of our outcomes.

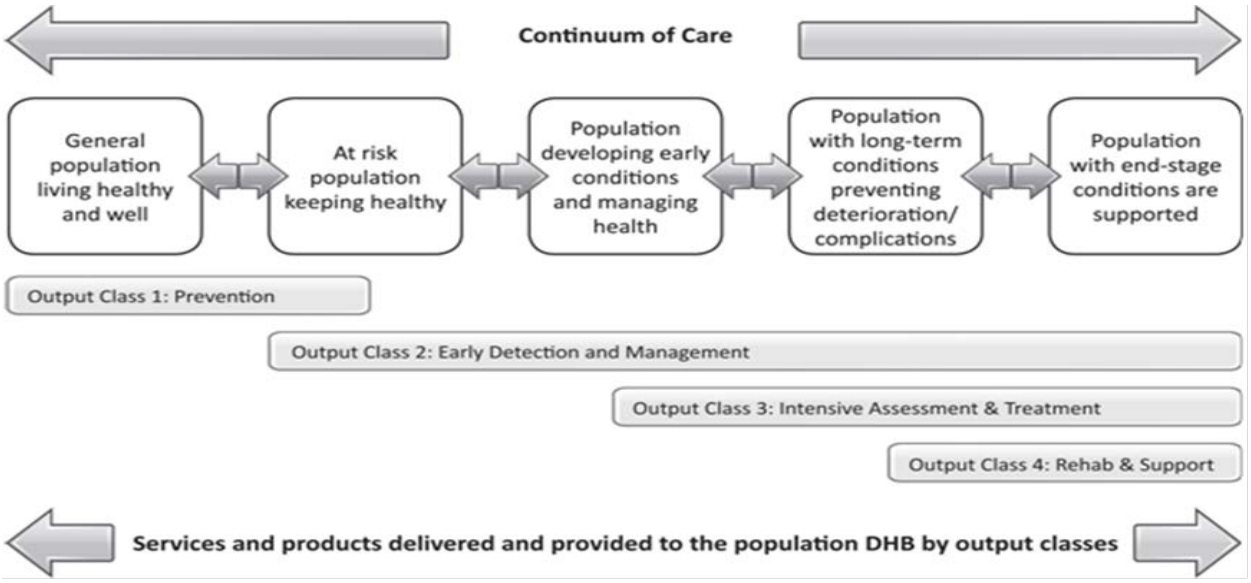
In order to do so we have identified a set of performance measures against which we can evaluate our performance as an organisation on an annual basis. The measures chosen are a mixture of indicators of quantity, quality and timeliness in our priority areas. The targets we set for these measures were determined by factors including national direction, population demographics, assumption of little increase in funding and the actions we will or have undertaken. The measures and targets are outlined in our Statement of Forecast Service Performance for 2016/17[8] with the following section presenting the results achieved against the identified targets.

Structure of this section

The map on the next page shows the linkages between the 4 output classes below and Hauora Tairāwhiti's 4 high level outcomes. By including short term, medium term and long term measures linking high level outcomes and output classes we can demonstrate clear pathways to improving the health of Tairāwhiti.

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:

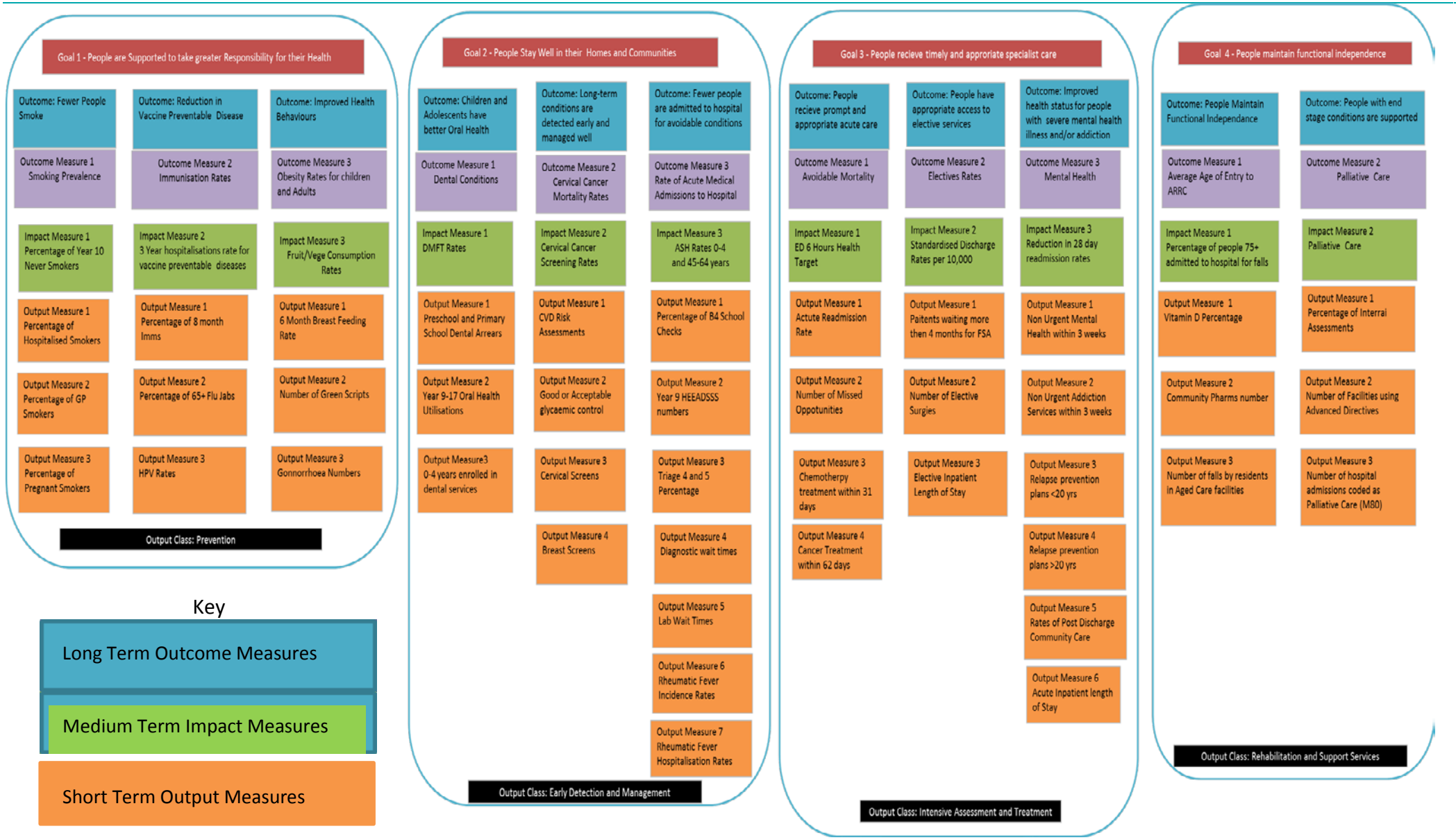


Key to Output Tables

Symbol	Definition
Ω	Measure of Quality
τ	Measure of Timeliness
δ	Measure of Quantity

[8] The statement of forecast service performance is published in our Statement of Intent : http://www.tdh.org.nz/about-us/documents-and-publications/accountability-documents/

Map of Indicators



2016/17 Performance Overview

2016/17 has seen another record year in terms of Tairãwhiti hospitalisation rates of 2.1 per 100,000 for acute rheumatic fever. We have seen further increases in the number of inpatients receiving advice and support to quit smoking during 2016/17 and have also seen the average length of inpatient stay fall.

Our rates of vaccination against the Human Papilloma Virus (HPV) are amongst the highest in the country with our rates of immunisation by Māori females under 20 years of age reaching 93% in 2016/17 and total population rates sitting at 75%. Immunisation rates for 8 month old infants fell during this year and along with raising the numbers of elderly in our region receiving influenza vaccinations will be a focus area for the coming year.

The number of people receiving a Green Prescription in 2016/17 was the highest in the past 3 years and is demonstrative of the Hauora Tairãwhiti commitment of 'A healthier Tairãwhiti by working together". This is further enhanced by the increased numbers of people receiving CVD risk assessments during the past year and the increased number of young people enrolled in DHB funded dental services.

Overall the results displayed in the following section are positive and reflective of the dedication of staff throughout all areas of the health system in Tairãwhiti. Each of the indicators below relies on input from Primary, Secondary and Community health providers and when all aspects work together.

PREVENTION SERVICES

Preventative health services promote and protect the health of our population by improving physical and social environments and supporting people to make healthier choices. These services include education programmes to raise awareness of risk behaviours, legislation and policy to protect people from environmental risks, and health protection services such as immunisation and lifestyle programmes that support people to modify their lifestyles and maintain good health. Success is defined by positive changes in behaviours and high coverage levels, which signal engagement in programmes and the effectiveness of positive health messaging and the quality of the support and advice being provided.

Goal 1 – People are supported to take greater responsibility for their health

Why is this outcome a priority?

New Zealand is experiencing a growing prevalence of long-term conditions such as diabetes and cardiovascular disease, which are major causes of poor health and account for a significant number of presentations in primary care and admissions to hospital and specialist services. We are more likely to develop long-term conditions as we age, and with an ageing population, the burden of long-term conditions will increase. The World Health Organisation (WHO) estimates more than 70% of all health funding is spent on long-term conditions.

Tobacco smoking, inactivity, poor nutrition and rising obesity rates are major and common contributors to a number of the most prevalent long-term conditions. These are avoidable risk factors, preventable through a supportive environment, improved awareness and personal responsibility for health and wellbeing. Supporting people to make healthy choices will enable our population to attain a higher quality of life and to avoid, delay or reduce the impact of long-term conditions.

OUTCOME MEASURES - Long Term[9]

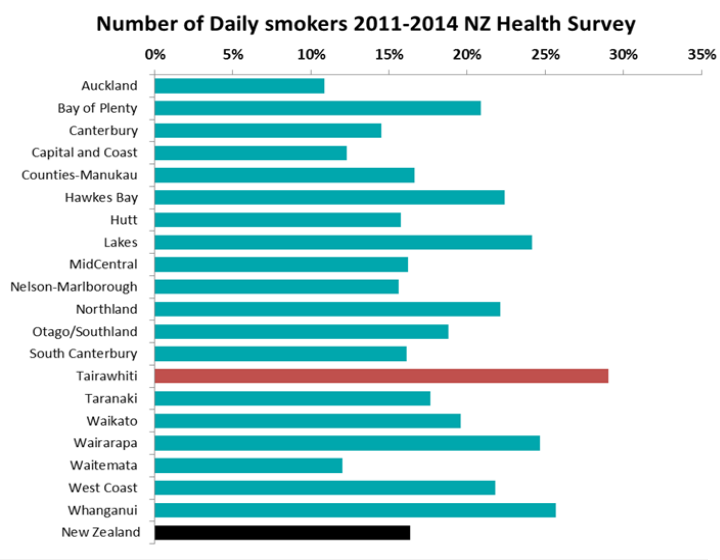
Outcome: Fewer People Smoke

Tobacco smoking kills an estimated 5,000 people in NZ every year and is a major risk factor for six of the eight leading causes of death worldwide. Smoking is also a major contributor to preventable illness and long-term conditions, such as heart and respiratory disease and cancer.

In addition, tobacco and poverty are inextricably linked. In some communities, a sizeable portion of household income is spent on tobacco, meaning less money for necessities such as nutrition, education and health.

Supporting people to say 'no' to smoking is our foremost opportunity not only to improve overall health outcomes but also to reduce inequalities in the health of our population.

Measure: The number of Daily Smokers decreases



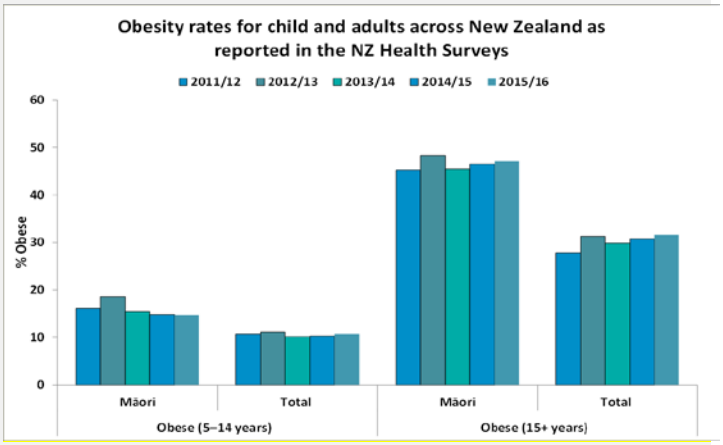
Data source: 2014/15 New Zealand Health Survey

Outcome: Improving health behaviours

Good nutrition is fundamental to health and prevention of disease and disability. Nutrition-related risk factors (such as high cholesterol, high blood pressure and obesity) jointly contribute to two out of every five deaths in New Zealand each year. By seeing a reduction in obesity, a proxy measure of successful health promotion and engagement, and a change in the social and environmental factors that influence people to make healthier choices.

Measure: Obesity Rates for Children and Adults decrease

Data Source: 2015/16 New Zealand Health Survey



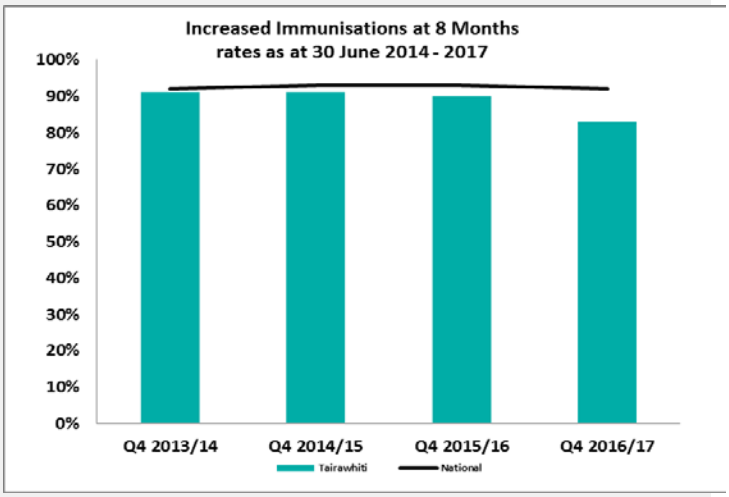
[9] Other entity information is unaudited

Outcome: Reduction in vaccine preventable diseases

Immunisation can prevent a number of diseases and is a very cost-effective health intervention. Immunisation provides protection not only for individuals but for the whole population by reducing the incidence of diseases and preventing them from spreading to vulnerable people or population groups.

	Q4 13/14	Q4 14/15	Q4 15/16	Q4 16/17
Tairawhiti	91%	91%	90%	83%
National	92%	93%	93%	92%

Measure: More Children are fullly Immunised at 8 months of age



Data Source: Health Targets Q4 2016-2017

IMPACT MEASURES – Medium Term[10]

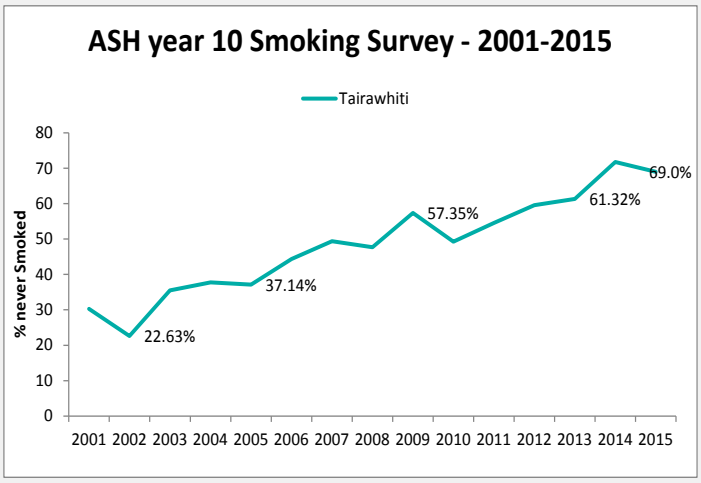
Outcome: Fewer People Smoke

The highest prevalence of smoking is amongst younger people and preventing young people from taking up smoking is a key contributor to reducing smoking rates across the total population. Because Māori and Pacific have higher smoking rates, reducing the uptake amongst Māori and Pacific youth provides a significant opportunity to improve long-term health outcomes for these population groups.

A reduction in the uptake of smoking by young people is seen as a proxy indicator of the success of our health promotion activity and a change in the social and environmental factors that support healthier lifestyles. ASH data has not been recorded since 2015.

Year 10 Students in Tairãwhiti who report they have never smoked		
2013	2014	2015
61%	72%	69%

Measure: The number of year 10 Students who have never smoked increases



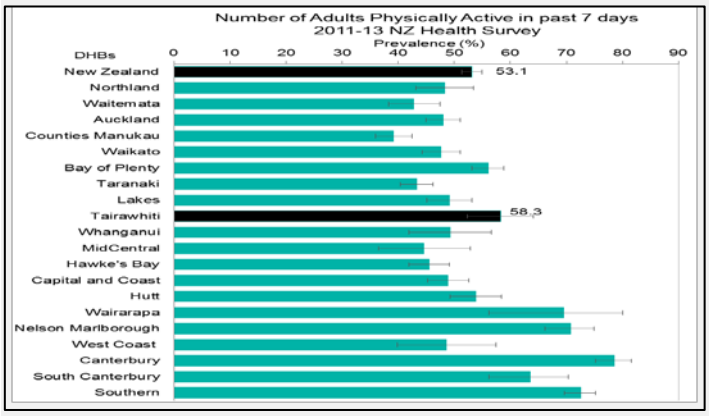
Data Source – ASH New Zealand.2015. National Year 10 ASH Snapshot Survey.

[10] Other entity information is unaudited

Outcome: Improving health behaviours

People gain weight when they consume more energy than they use. What a person eats and drinks, and how much activity they do directly affects whether they gain, lose or stay the same weight. As well as helping you reach or maintain a healthy weight, regular activity can lower your stress levels, improve your posture, help you sleep better, and keep your bones and muscles strong. The Ministry of Health recommends people aim for at least two and a half hours of physical activity a week. Improvements in physical activity levels and diets will lead to reductions in obesity levels.

Measure: Percentage of Adults physically acitve for 30 minutes or more on 5 of the past 7 days



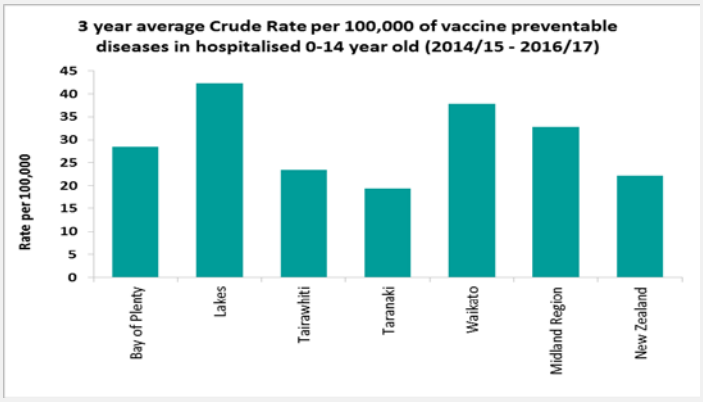
The 2011-13 NZ Health Survey contains the most recent DHB level data. The 2015-16 NZ Health Survey only contains national results.

Outcome: Reduction in vaccine preventable diseases

Population benefits only arise with high immunisation rates (herd immunity) and New Zealand's historical rates were low by international standards and insufficient to prevent or reduce the impact of preventable diseases such as measles or pertussis (whooping cough).

Year	Tairāwhiti	Midland	New Zealand
14/15	27.08	25.44	10.18
15/16	17.38	34.97	31.41
16/17	25.88	38.04	25.10
3 year Ave	**23.45**	**32.82**	**22.23**

Measure: The number of children 0-14 admitted to hospital for a Vaccine Preventable disease decreases



Data Source :National Minimum Data Set

OUTPUTS – Short Term Performance Measures

Fewer People Smoke

Indicator		Measure Type	2014/15 Result	2015/16 Result	2016/17 Target	2016/17 Result	Latest NZ Result	Trend
Percentage of hospitalised smokers offered advice to quit (Health Target).	Māori	δ/τ	96%	98%	≥95%	96%		↓
	Non Māori	δ/τ	97%	98%		95%		↓
	Total Pop	δ/τ	96%	98%		96%		↓
Percentage of PHO enrolled smokers offered advice to quit (Health Target).	Māori	δ/τ	98%		≥90%	Not reported Ethnically		
	Non Māori	δ/τ	91%					
	Total Pop	δ/τ	98%	92%		93%	88%	↑
Percentage of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer are offered advice and support to quit (Health Target and MHP).	Māori	δ/τ	96%	88%	≥90%	88%	94% (only total pop reported nationally)	→
	Non Māori	δ/τ	97%	87%		96%		↑
	Total Pop	δ/τ	97%	87%		90%		↑

Reduction in Vaccine Preventable Disease

Indicator		Measure Type	2014/15 Result	2015/16 Result	2016/17 Target	2016/17 Result	Latest NZ Result	Trend
Percentage of 8 month olds fully immunised (Health Target, IPIF & MHP)	Māori	τ/Ω	91%	91%	≥95%	**85%**	89%	➲
	Non Māori	τ/Ω	93%	94%		**92%**	93%	➲
	Total Pop	τ/Ω	91%	92%		**88%**	92%	➲
Percentage of people >65 years who have received the seasonal influenza immunisation (PPP & MHP)	High Needs	τ/Ω	60%	53%	≥75%	**52%**	48%	➲
	Total Pop	τ/Ω	62%	52%		**52%**	56%	➲
Percentage of girls having completed their 3rd HPV vaccination (additional measure to Annual Plan)	Māori	τ/Ω	75%	98%	≥70%	**93%**	73%	➲
	Total Pop	τ/Ω	63%	81%		**75%**	65%	➲

Improving Health Behaviours

Indicator		Measure Type	2014/15 Result	2015/16 Result	2016/17 Target	2016/17 result	Latest NZ Result	Trend
Percentage of infants who are partially, fully or exclusively breastfeeding at 6 Months (MHP) (2015/16 rates as at 31 March 2016)	Māori	δ/τ	62%	54%	≥59%	**55%**	53%	➲
	Non Māori	δ/τ	66%	61%		**70%**	66%	➚
	Total Pop	δ/τ	66%	61%		**73%**	66%	➚
The number of people participating in the Green Prescription programmes	Total Pop	δ/τ	962	1013	**≥1024**	**1101**	18,849	➚
Reduce the prevalence of gonorrhoea (Local Indicator)	Total Pop	δ/τ	319 per 100,000	229 per 100,000	**≤60 per 100,000**	259 per 100,000	70 per 100,000	➚

2016/17 Prevention Services Performance

During the past year we have seen a slight decrease in the number of patients receiving brief advice and support to quit smoking while they are admitted to hospital. The number of women in Tairãwhiti who smoke during and after pregnancy is still too high however we have seen pleasing results in the increased numbers of year 10 students who report that they have never smoked.

Immunisation rates in our district have remained steady over the past year with the decrease in influenza vaccine rates being more reflective of changes in data sources from IPIF reporting to the National Immunisation Register than changes in vaccine uptakes. This decrease in rates has been noted across the midlands region. HPV rates in Tairãwhiti are markedly higher than the national rates with Māori rates out performing total population rates.

More people in Tairãwhiti are participating in the Green Prescriptions programme which is a health professional's written advice to become more physically active as part of a person's overall health management process, success in this area along with increased consumption of fruit and vegetables will see obesity rates in Tairãwhiti decrease.

EARLY DETECTION AND MANAGEMENT SERVICES

Early detection and management services support people to better manage their long-term conditions and avoid complications, acute illness and crises. 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. Success is defined by high coverage and utilisation of services, signalling engagement with and access to health services. Increases in access to diagnostics and agreed referral pathways and reductions in avoidable hospital admissions also reflect improvement.

Goal 2 - People stay well in their homes and communities

Why is this outcome a priority?

For most people, their general practice team is their first point of contact with health services. Primary care can deliver services sooner and closer to home and prevent disease through education, screening, early detection and timely provision of treatment. Primary care is also vital as a point of continuity and effective coordination across the continuum of care, particularly in improving the management of care for people with long-term conditions.

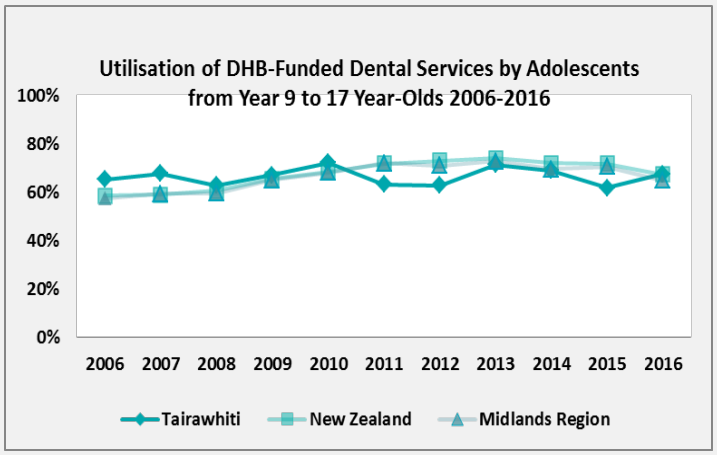
Supporting primary care is a range of other health professionals including midwives, community nurses, social workers, aged residential care providers, personal health providers and pharmacists. These providers have prevention and early intervention perspectives that link people with other health and social services and support them to stay well. Studies show countries with strong primary and community care systems have lower rates of death from heart disease, cancer and stroke, and achieve better health outcomes for lower cost than countries with systems that focus on specialist level care.

OUTCOME MEASURES - Long Term[11]

Outcome: Children and adolescents have better oral health

Increasing the proportion of adolescents, in school Year 9 (13/14-year olds) up to and including 17 years of age, who have accessed DHB-funded oral health services will show that the DHB has made an impact of promoting good oral health, by providing accessible publicly-funded adolescent oral health programmes. The programmes will help reduce the prevalence and severity of oral disease in adolescents. This measure indicates the coverage of publicly-funded adolescent oral health services and provides a measure that can be used to demonstrate progress towards the population priority of "improving oral health" in the New Zealand Health Strategy.

Measure: the number of Year 9 – 17 year olds enrolled in DHB Funded dental services increases



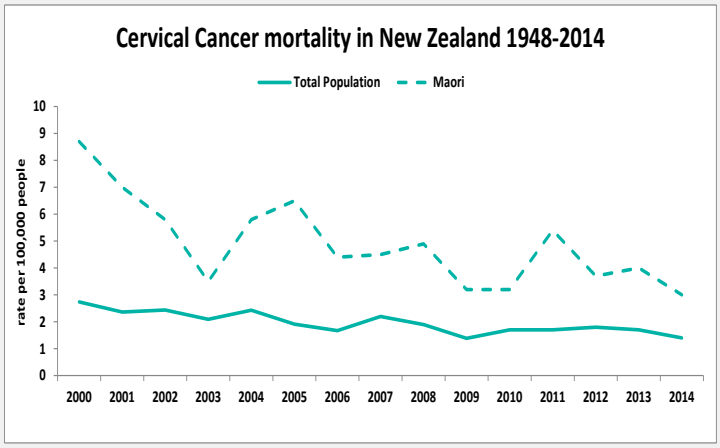
Data above is calendar year data and is reported in quarter 3 each year.

Outcome: Long-term conditions are detected early and managed well

Cervical cancer is the fourth-most common cause of cancer and the fourth-most common cause of death from cancer in women worldwide. New Zealand has one of the best screening programmes in the world, with the number of women who die from cervical cancer dropping by 60 per cent since 1990. To continue this decline we need to increase our cervical screening rates to ensure anomalies are picked up at a treatable stage. Improvement in this indicator will indicate the ability of New Zealanders to access primary care.

Rates per 100,000	2011	2012	2013	2014
Total Population	1.7	1.8	1.7	1.4
Māori	5.4	3.7	4	3

Measure: The number of Women dying from Cervical Cancer is reduced

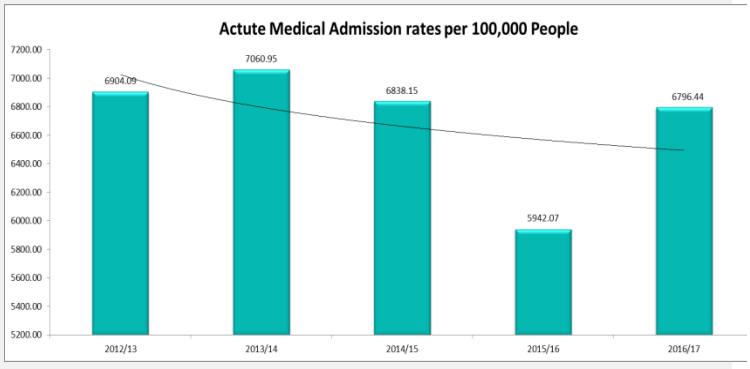


Source: Ministry of Health: Mortality 2014 Data Table. 2014 mortality data is the most up to date as data is reliant upon the release of coroner's findings and is usually 18 months-2 years behind.

Outcome: Fewer people are admitted to hospital for avoidable conditions

International research has shown around 14% of acute admissions could have been prevented through better management of conditions in primary and community settings. To achieve our outcome of people staying well in their homes and communities, seamless flow through the health system is required, this will be achieved when the rates of admissions for acute medical conditions decreases.

Measure: The rate of Acute Medical admissions to hospital decreases



Data Source: Ministry of Health Performance Reporting

[11] Other entity information is unaudited

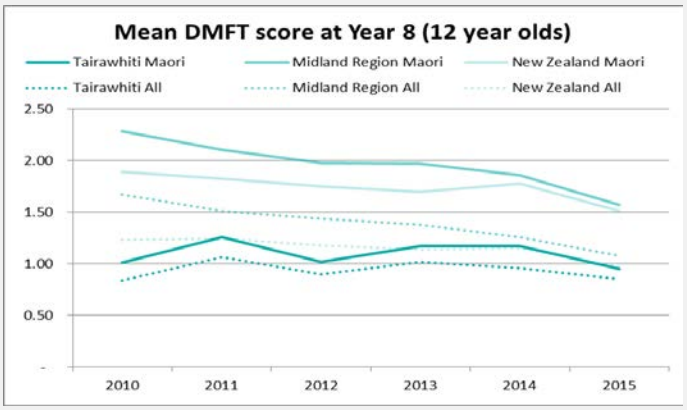
IMPACT MEASURES – Medium Term[12]

Outcome: Children and adolescents have better oral health

Improved oral health is a proxy measure of equity of access, and the effectiveness of mainstream services in targeting those most in need. Diseased, Missing or Filled Teeth (DMFT) is a count of Diseased, Missing or Filled Teeth in permanent dentition (permanent teeth) in a person's mouth. By Year 8, children's teeth should be their permanent teeth and any damage at this stage is life long, so the lower a child's DMFT, the more likely that their teeth will last a life time. A continued decrease in the DMFT score of year 8 children will signal that we are succeeding.

	2014	2015	2016
Tairãwhiti Māori	1.17	0.95	1.13
Tairãwhiti All	0.96	0.85	0.94
Midland Māori	1.86	1.57	*
Midland All	1.26	1.08	*
NZ Māori	1.78	1.51	*
NZ All	1.15	0.97	*

Measure: The rate of Diseased Missing Filled Teeth in year 8 students decreases

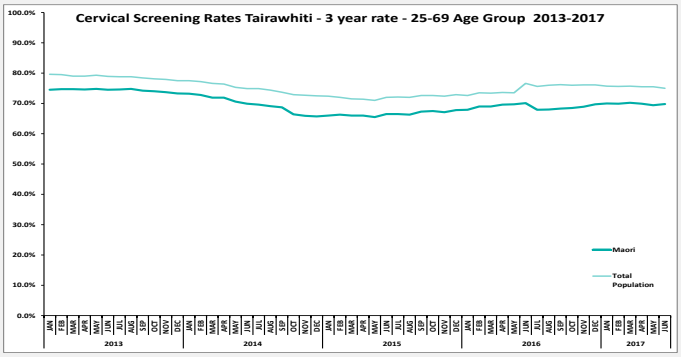


Data Source: Ministry of Health Performance Reporting

Outcome: Long-term conditions are detected early and managed well

Cervical cancer is one of the most preventable forms of cancer and screening every three years can reduce the risk of developing it by up to 90%. Identifying and treating cancers when they are small, is one of the most effective methods to reduce the impact of some cancers. Early detection will lead to either successful treatment, or delaying or reducing the need for hospital and specialist care.

Measure: The percentage of women who have had a cervical Screen in the past 3 years increases



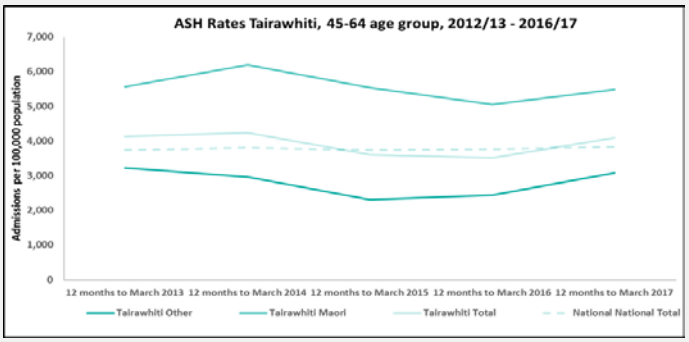
Data Source: Ministry of Health, NCSP New Zealand District Health Board Coverage Report 30 June 2017

Outcome: Fewer people are admitted to hospital for avoidable conditions

There are a number of admissions to hospital for conditions which are seen as avoidable through appropriate early intervention and a reduction in risk factors. As such, these admissions provide an indication of the effectiveness of screening, early intervention and community-based care. A reduction in these admissions will reflect better management and treatment of people across the whole system, will free up hospital resources for more complex and urgent cases, and support enhanced delivery of the Government's priority of "better, sooner, more convenient" healthcare.

00-04	12/13	13/14	14/15	15/16	16/17*

Measure: The rate of avoidable admissions to hospital decreases

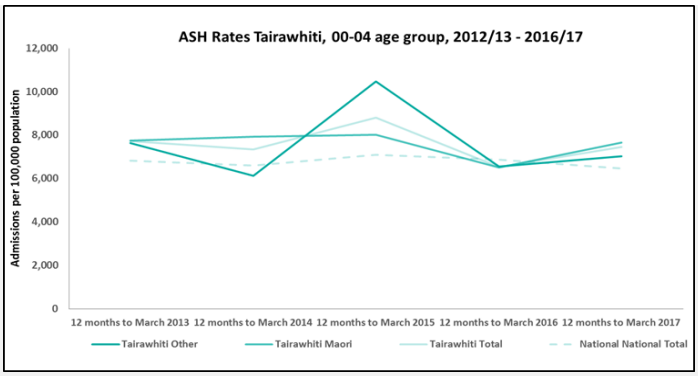


Data Source: Ministry of Health Performance Reporting

[12] Other entity information is unaudited

Māori	7,506	7,499	7,052	7,534	7,661
Non Māori	5,473	5,540	8,679	6,989	7,034
Total	**6,781**	**6,751**	**7,643**	**7,336**	**7,459**
45-64	12/13	13/14	14/15	15/16	16/17*
Māori	4,207	4,192	3,461	3,813	5,489
Non Māori	2,246	2,197	1,885	2,435	3,082
Total	**3,019**	**2,984**	**2,543**	**3,010**	**4,094**

*2016/17 Results to 28 June 2017



Data Source: Ministry of Health Performance Reporting

OUTPUTS – Short Term Performance Measures

An Improvement in Childhood Oral Health

Indicator		Measure Type	2014/15 Result	2015/16 Result	2016/17 Target	2016/17 Result	Latest NZ Result	Trend
Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination (PP13)*	Total Pop	τ	9%	5%	**≤10%**	6%	N/A	↑
Percentage of adolescent utilisation of DHB-funded dental services (PP12)	Total Pop	Ω	69%	54%	**≥85%**	67%	N/A	↑
Percentage of Children (0-4) enrolled in DHB funded dental service (PP12)	Māori	Ω	90%	93%	**≥ 90%**	96%	N/A	↑
	Total Pop	Ω	93%	95%		101%	N/A	↑

Long term Conditions are Detected Early and Managed Well

Indicator		Measure Type	2014/15 Result	2015/16 Result	2016/17 Target	2016/17 Result	Latest NZ Result	Trend
Percentage of eligible population will have had their cardiovascular risk assessed in the last 5 years (Health Target, IPIF & MHP).	Māori	δ	88%	91%	**≥90%** [13]	90%	86%	↓
	Non Māori	δ	91%	94%		93%	91%	↓
	Total Pop	δ	90%	92%		92%	90%	→
Improve the proportion of patients with good or acceptable glycaemic control (PP20)	Total	Ω	38%	71%	**≥90%**	67%	N/A	↓
Percentage of eligible women (20-69) have a Cervical Cancer Screen every 3 years (IPIF &MHP)	Māori	δ/τ	73%	70%	**≥75%**	70%	66%	→
	Non Māori	δ/τ	78%	85%		80%	78%	↓
	Total	δ/τ	77%	78%		75%	77%	↓
Percentage of eligible women (50-69) who have a Breast Screen every 3 years (MHP) *Results to 31 March	Māori	δ/τ	69%	67%	**≥70%**	69%	64%	↑
	Non Māori	δ/τ	73%	71%		72%	71%	↑
	Total	δ/τ	70%	70%		71%	70%	→

[13] For the 12 months 1 April 2016 to 31 March 2017

Fewer People are admitted to Hospital for Avoidable Conditions

Indicator		Measure Type	2014/15 Result	2015/16 Result	2016/17 Target	2016/17 Result	Latest NZ Result	Trend
Percentage of Rest Home residents receiving vitamin D supplements	Total Pop	Ω	73%	84%	**70%**	Data no longer collected		
Percentage of all Emergency Department presentations who are triaged at level 4 & 5	Total Pop	Ω	66%	65%	**≤20%**	**68%**	45%	↑
Improved wait times for diagnostic services - accepted referrals for CT and MRI receive their scan within 6 weeks	CT Scans	Ω	91%	91%	**≥95%**	**97%**	87%	↑
	MRI Scans	Ω	86%	89%	**≥85%**	**98%**	63%	↑
Non urgent community laboratory tests are completed and communicated to practitioners within the relevant category timeframes	Within 48 hours*	τ/Ω	99%	100%	**100%**	**100%**	N/A	→
Number of community pharmacy prescriptions	Total Pop	δ	450,265	460,460	**450,000**	481,595	N/A	↑
Incidence rates per 100,000 for rheumatic fever	Total Pop	τ/Ω	14.8	4.2	**≤15.0**	**2.1**	2.8	↓
Hospitalisation rates per 100,000 for acute rheumatic fever	Total Pop	τ/Ω	19.1	4.2	**≤2.8 per 100,000 people**	**2.1**	2.2	↓
Percentage of eligible population who have their B4 School Checks completed	High Needs	δ/τ	93%	**102%**[14]	**≥90%**	**96%**	93%	↓
	Total Pop	δ/τ	94%	95%		**97%**	92%	↑
Increased coverage numbers of Year 9 students receiving HEEADSSS assessment in decile 1-3 schools (not reported ethnically)	Total Pop	δ/τ	448	551	**≥650**	**656**	N/A	↑

*Community Laboratory indicator changed from within 96 hours to within 48 hours to match provider reporting

2016/17 Early Detection and Management Services Performance

2016/17 has seen the continuation of improvements in a number of service areas. Our school and preschool dental service continues to reduce the number of children in our district who are overdue for their schedule dental exams with 94% of all eligible children seen during 2016/17. This service has also increased the number of children enrolled in these services. These increases will lead to improved DMFT scores at year 8 and hopefully increased numbers of year 9-17 year olds who utilise DHB funded dental services in the next 5-10 years. More of our people had a CVD risk assessment during the 2016/17 year which is a credit to the focus put on the reduction of heart disease and a portion of these services are driven by demand that we must meet, such as emergency (acute) and maternity services. However, others are planned (elective) services where access is determined by capacity, clinical need and treatment thresholds.

Timely access to intensive assessment and treatment can significantly improve people's quality of life either through early intervention or corrective action. Success is therefore also defined by increased access to services and timely treatment.

[14] B4 School Check High Needs result is greater than 100% as the denominator population used to calculate this rate is an estimate. A result higher than 100% means our B4 School Check team has seen more children classified as high needs then was expected.

INTENSIVE ASSESSMENT AND TREATMENT SERVICES PERFORMANCE

Timely access to intensive assessment and treatment can significantly improve people's quality of life either through early intervention or corrective action. Success is therefore defined by increased access to services and timely treatment.

Goal 3 - People receive timely and appropriate specialist care

Why is this outcome a priority?

Clinicians, in cooperation with patients and their families, make decisions with regards to complex treatment and care. Not all decisions result in interventions to prolong life, but may focus on patient care such as pain management or palliative services to improve the quality of life. For those who do need a higher level of intervention, timely access to high quality complex care improves health outcomes by restoring functionality, slowing the progression of illness and disease and improving the quality of life. The timeliness and availability of complex treatment and care is crucial in supporting people to recover from illness and/or maximise their quality of life. Shorter waiting lists and wait times are also indicative of a well-functioning system that matches capacity with demand by managing the flow of patients through services and reducing demand by moving the point of intervention earlier in the path of illness.

As providers of hospital and specialist services, DHBs are operating under increasing demand and workforce pressures, and Government is concerned that patients wait too long for diagnostic tests, cancer treatment and elective surgery. The expectations around reducing waiting times, coupled with the current fiscal situation, mean DHBs need to develop innovative ways of treating more people and reducing waiting times with limited resources.

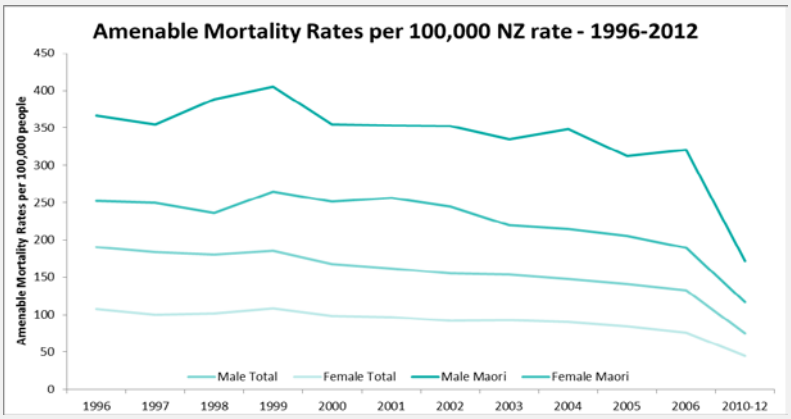
This goal reflects the importance of ensuring that hospital and specialist services are sustainable and that the Midland Region has the capacity to provide for the complex needs of its population now and into the future.

Outcome Measures – Long Term[15]

Outcome: People receive prompt and appropriate acute care

About half the deaths under 75 years of age in New Zealand are classified as amenable. That is, they are 'untimely, unnecessary' deaths from causes amenable to health care. These causes range from some cancers to pregnancy complications to chronic disorders. Decreases in these rates are reflective of a high performing health system with seamless flow between Primary and Secondary Care Services.

Measure: The rate of mortality from potentially avoidable conditions decreases

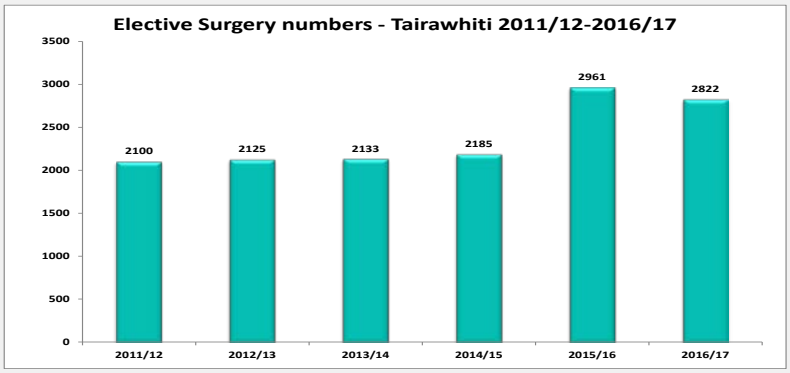


Amenable Mortality Rates have not been published at a national level since 2012

Outcome: People have appropriate access to elective services

Elective services are an important part of the health system, as they improve a patient's quality of life by reducing pain or discomfort and improving independence and wellbeing. The Government wants more New Zealanders to have access to elective surgical services. Continued Improvement in this indicator in Tairāwhiti is a credit to the work led by our surgical services department.

Measure: The number of people receiving elective surgery increases



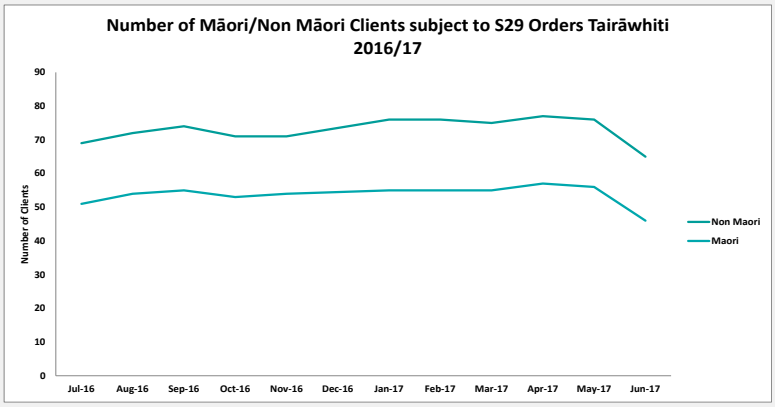
[15] Other entity information is unaudited

Data Source: Ministry of Health Performance Reporting

Outcome: Improved access to Mental Health services

It is estimated that at any one time, 20% of the New Zealand population will have a mental illness or addiction, and 3% are severely affected by mental illness. With high suicide rates in some of our communities, we are working to reduce this rate and support our communities with Whanau Ora initiatives.

Measure: The number of people subject to compusory treatment orders under section 29 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 is reduced.



Data Source: Ministry of Health Performance Reporting

IMPACT MEASURES – Medium Term[16]

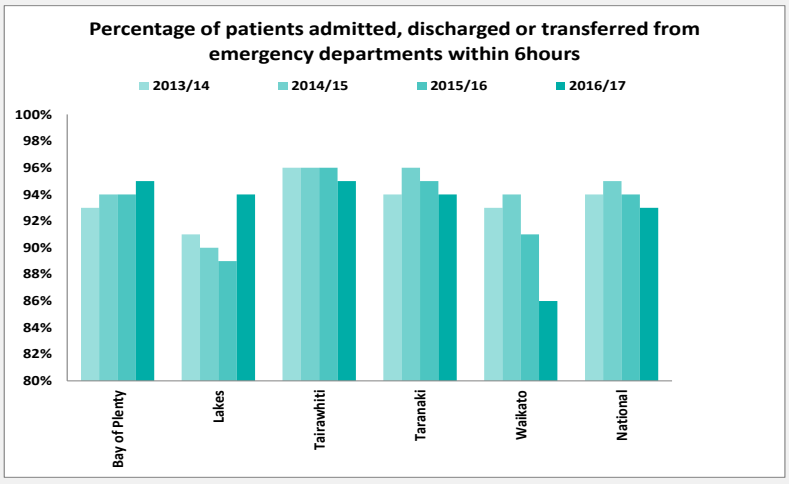
Outcome: People receive prompt and appropriate acute care

Emergency Departments (EDs) are often seen as a barometer of the efficiency and responsiveness of both the hospital and the wider health system.

Long waits in ED are linked to overcrowding, poor patient experience, longer hospital stays and negative outcomes for patients. Enhanced performance will not only contribute to improve patient outcomes by enabling early intervention and treatment, but will improve public confidence and trust in our health services.

Solutions to reducing ED wait times need to address the underlying causes of delay and span not only our hospital services but the wider health system. In this sense, this indicator is a marker of the responsiveness of our whole system to the urgent care needs of

Measure: Percentage of Patients admitted, discharged or transferred from ED within 6 hours



Data Source: DHB Patient Management System

DHB	12/13	13/14	14/15	15/16	16/17
Bay of Plenty	90%	93%	94%	94%	95%
Lakes	92%	91%	90%	89%	94%

[16] Other entity information is unaudited

our population.

Tairāwhiti	95%	96%	96%	96%	95%
Taranaki	96%	94%	96%	95%	94%
Waikato	88%	93%	94%	91%	86%
National	**93%**	**94%**	**95%**	**94%**	**93%**

Outcome: People have appropriate access to elective services

Improved performance against this measure is indicative of improved hospital productivity ensuring the most effective use of resources so wait times can be minimised and people in Tairãwhiti receive prompt and appropriate care when they need it. Decreases in these rates are reflective of a higher performing primary care sector with conditions been diagnosed and treated earlier preventing them from reaching the surgical stage.

Measure: Standardised Discharge Rates per 10,000 for publicly funded discharges

Procedure*	2014/15 Result	2015/16 Result	2016/17 Result
Cardiac Surgery	6.60	6.24	6.91
Major Joint Replacement	27.80	27.33	23.51
Cataract Proceedures	25.56	36.91	22.27
Percutaneous Revascularization	9.38	8.40	11.08
Coronary Angiography	26.24	28.53	32.06

*All rates as at 31 March

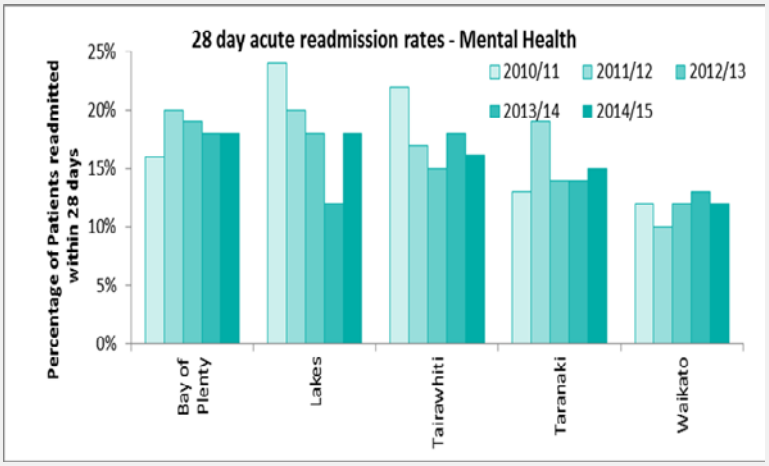
Data Source: Ministry of Health Performance Reporting

Outcome: Improved access to Mental Health services[17]

Measure: The 28 day acute readmission rate for Mental Health services reduces

Access is the key to improving health status for people with a severe mental illness. Our goal is to build on our existing, and well established cooperation between primary / community and secondary services, by offering programmes to individuals and groups from a broad range of ages – children and youth, adults and older people.

If we improve access, and providing we provide services to people at the right time, and in the right place, and can expect to see a reduction in our 28 day readmission rate. This will, in turn, assist in reducing pressure on our hospital services.



Data Source: DHB Patient Management System

28 Day acute re-admission rate

DHB	2012/13	2013/14	2014/15	2015/16	2016/17
Bay of Plenty	19%	18%	18%	*	*
Lakes	18%	12%	18%	*	*
Tairāwhiti	15%	18%	16%	12%	11%
Taranaki	14%	14%	15%	18%	18%
Waikato	12%	13%	12%	*	*

* 2015/16 & 2016/17 numbers yet to be confirmed

[17] Other entity information is unaudited

OUTPUTS – Short Term Performance Measures

People receive Prompt and Appropriate Acute and Arranged Care

Indicator		Measure Type	2014/15 Result	2015/16 Result	2016/17 Target	2016/17 Result	Latest NZ Result	Trend
Acute Readmission rate *Rate as at 31 March 2016	Total Pop	**δ/τ/ Ω**	6.4%	6.40%	**<6.1%**	6.50%	7.90%	➲
Inpatient average length of Stay (elective) ***Rate as at 31 March**	Total Pop	**δ**	2.95 days	1.39 days	**<1.59 days**	1.57 days	1.61 days	🡑
Faster Cancer Treatment – Proportion of patients with a confirmed diagnosis of cancer who receive their first cancer treatment within 31 days of diagnosis[18]	Total Pop	**δ/τ**	88%	86%	**100%**	89%	86%	🡑
Faster Cancer Treatment – Proportion of patients with a high suspicion of cancer who receive their first cancer treatment within 62 days or less (Health Target)	Total Pop	**δ/τ**	69%	69%	**≥85%**	77%	74%	➲
Percentage of patients who require radiation or chemotherapy are treated within 4 weeks	Total Pop	**δ/τ**	100%	100%	**100%**	100%	100%	➲

People have appropriate access to Elective Services

Indicator		Measure Type	2014/15 Result	2015/16 Result	2016/17 Target	2016/17 Result	Latest NZ Result	Trend
Percentage of patients waiting longer than four months for their first specialist assessment (Elective Service Performance Indicator 2)	Total Pop	**δ/τ**	0%	1%	**0%**	4.8%	0.8%	🡑
Number of Surgical discharges under the Elective initiative (Health Target)	Total Pop	**δ/τ**	2185	2961	**≥2552**	2822	200,323	🡓
Percentage of missed outpatient appointments [19]	Māori	**δ/τ**	16%	16%	**≤10%**	17%	16%	➲
	Non Māori		8%	8%		5%	8%	🡓
	Total		12%	12%		11%	9%	➲

[18] Measure not included in the Statement of Intent 2016/17
[19] Measure not included in the Statement of Intent 2016/17

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

Indicator		Measure Type	2014/15 Result	2015/16 Result	2016/17 Target	2016/17 Result	Latest NZ Result	Trend
Percentage of people referred for non-urgent mental health or addiction services seen within 3 weeks (PP8)								
Mental Health	00-19 years	δ/τ	69%	67%	**≥80%**	**56%**		
	20-64 years				Change in National reporting – measure no longer reported			
	65+ years							
Addiction Services	00-19 years	δ/τ	80%	70%	**≥80%**	**72%**		
	20-64 years				Change in National reporting – measure no longer reported			
	65+ years							
Improving the percentage of long-term clients with up to date relapse prevention/treatment plans (PP7)								
<20 yr olds	Maori	δ/τ/ Ω	58%	Not reported	**≥95%**	**85%**	N/A	
	Non Maori		95%			**86%**	N/A	
	Total		76%			**86%**	N/A	
20+ yr olds	Maori	δ/τ/ Ω	89%	80%	Change in National reporting – measure no longer reported			
	Non Maori		71%	95%				
	Total		81%	95%				
Average length of Acute Inpatient Stays*(KPI8) Result to 31 Dec 2015	Total Pop	δ/τ/ Ω	16 days	16 days	**14-21 days**	**18 days**	N/A	
Rates of Post discharge community care (KPI18)	Total Pop	δ/τ/ Ω	60%* Rate to 31 May 2015	55%* Rate to 31 May 2016	**≥90%**	**53%**	N/A	

2016/17 Intensive Assessment and Treatment Services Performance

2016/17 has seen the length of stay for patients in Gisborne Hospital continues to meet the National target for both Acute and Elective inpatients. A project is underway at Hauora Tairãwhiti to reduce the number of missed outpatient appointments, This project began in 2016 and is starting to produce results with 2016/17 rates on par with 2015/16 rates and local rates currently on par with the National rates.

Our short term output indicators for people receiving prompt and appropriate acute and arranged care for 2016/17 show consistent results with 2015/16 rates. This is a pleasing result as it shows that even with increased numbers of elective surgeries been performed in 2016/17 the day to day activities performed by Hauora Tairãwhiti have not suffered.

REHABILITATION AND SUPPORT SERVICES

Rehabilitation and support services assist people to regain functional independence after an illness or disability. Even when returning to full health is not possible, timely access to responsive support services helps people to manage their needs and remain safe and well in their own homes. In preventing deterioration and acute illness or crisis, these services have a major impact on the sustainability of the wider health system, reducing acute demand for services and the need for more complex intervention. By providing ongoing care for patients and improving recovery after an acute illness or hospital admission, these services also help to reduce hospital readmission rates.

Services that support people in their own homes typically provide a much higher quality of life, as a result of people staying active and positively connected to their communities. Success is therefore defined by increased access to community-based services, less dependence on hospital and residential care and a reduction in illness or deterioration that leads to acute admission or readmission.

Goal 4 - People maintain functional independence

Why is this outcome a priority?

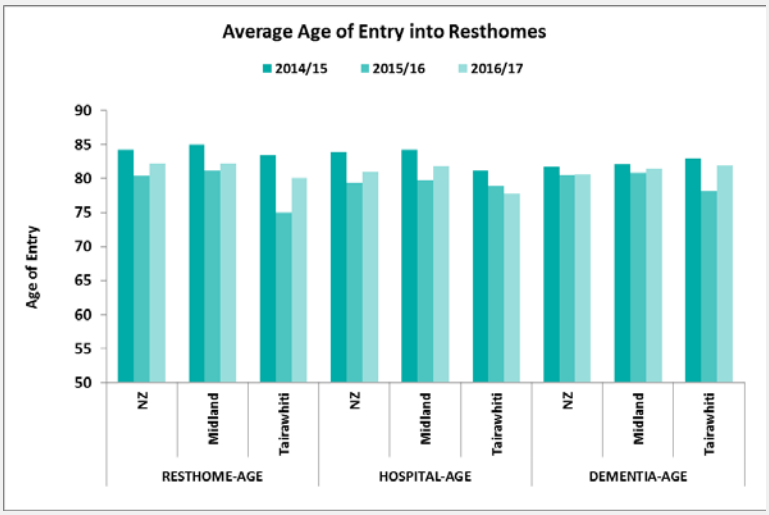
If we are to deliver on our twin goals of improving health outcomes and reducing or eliminating health inequalities for our older population, we need to support people to maintain functional independence. As our ageing population increases, so does demand on our constrained funding. We are looking to manage the expected growth in demand, as a consequence of an ageing population, by improved models of care that support people to remain independent and living in their own homes for as long as possible.

Outcome Measures – Long Term[20]

Outcome: People stay Well in their homes and communities

Ideally we would like to promote a model of care that reduces the length of time an older person requires aged related residential care facilities (ARRC). As we do not currently capture this information, our best proxy indicator is to monitor the increase in the average age at which an older person enters ARRC. Increases in the age of entry will see decreases in age related residential care with increases in home based support services with people remaining resident in their own homes longer.
2014/15 results are the most complete results available at this stage. Work continues to identify up to date data sources for this measure.

Measure: Average age of people entering Age Related Residential Care increases



Data Source: DHB Patient Management System

	Care level	2014/15	2015/16	2016/17
Average Age of Entry to Residential Care (years)	Rest Home	83.3	75.0	80.1
	Hospital	81.2	78.9	77.8
	Dementia	83.0	78.2	81.9

[20] Other entity information is unaudited

Outcome: People with end stage conditions are supported

Palliative and end of life care provides people with humane and dignified support and services as they face a life limiting condition. In order to develop a service that meets the need of people requiring Palliative Care support system wide improvements are required. Proper identification and coding of these clients across the health system will allow for improved management and development of Palliative Care in Tairāwhiti.

Measure: The number of patients identified as requiring Palliative Care assistance increases

Financial Year	2014/15	2015/16	2016/17
Number of Patients admitted under Health Speciality Code M80	16	7	15

Data Source: DHB Patient Management System

IMPACT MEASURES – Medium Term

Outcome: People stay Well in their homes and communities

Many older people would prefer to remain resident in their own homes for as long as possible. To support people in our community to do this we need to increase the services we provide in these people's homes. Measuring the spend ratio of Home Based Support Services to Age Related Care alongside the average age of entry to aged related care provides us with an indication as to the effectiveness of these services.

Measure: Home Based Support Services to Age Related Care spend Ratio increase

Financial Year	2014/15	2015/16	2016/17
Home Based Support Services	0.21	0.24	0.28
Age Related Residential Care	0.79	0.76	0.72

Data Source: DHB Patient Management System

Outcome: People with end stage conditions are supported

In New Zealand palliative care is delivered in a variety of settings with palliative care generally available where the patient is – be that home, hospital, residential care or hospice. Hospice Tairāwhiti provides community based hospice care for the people of Tairāwhiti. By increasing the numbers of people with end stage conditions who receive support from Hospice Tairāwhiti we can ensure end of life care in Tairāwhiti is patient centred, culturally appropriate and in line with national guidelines.[21]

Measure: Number of Palliative Care clients supported by Hospice Tairāwhiti increases

Number of Paliative Care patients supported		
2014/15	2015/16	2016/17
166	183	222

Data Source: Hospice Tairawhiti Annual Report 2016/17

[21] Reported in output People at the end of life are supported in a manner appropriate to them (the number of hospice providers who have no critical/ moderate issues), see below.

OUTPUTS – Short Term Performance Measures

People stay well in their homes and communities

Indicator		Measure Type	2014/15 Result	2015/16 Result	2016/17 Target	2016/17 Result	Latest NZ Result	Trend
Number of falls by residents in Aged Care Facilities[22]	Rest Home Level	**δ**	472	**261**	**Decrease in the number of falls**	884	N/A	↑
	Hospital Level	**δ**	267	**426**		115	N/A	↓
	Dementia Level	**δ**	144	**119**		220	N/A	↑

Palliative Care (new set of measures from Annual Plan)

Indicator		Measure Type	2014/15 Result	2015/16 Result	2016/17 Target	2016/17 Result	Latest NZ Result	Trend
Percentage of older people receiving long-term home support who have had a comprehensive clinical assessment and a completed care plan in the last 12 months.	Total Pop	**Ω/τ**	100%	**100%**	**100%**	100%	N/A	→
Number of Aged residential Facilities utilising advanced directives.	Total Pop	**δ**	2	**2**	**Increase**	2	N/A	→
Number of hospital admissions under Health Speciality Code M80 (Palliative Care)	Total Pop	**δ**	16	**7**	**Increase**	15	N/A	↑
People at the end of life are supported in a manner appropriate to them (the number of hospice providers who have no critical/ moderate issues)[23]	Total Pop	**Ω**	**100%**	**100%**	**100%**	**100%**	N/A	→

2016/17 Rehabilitation and Support Services Performance

2016/17 has seen further development in terms of the indicators measured in this area with the emergence of Palliative Care as an area of increased focus nationally. Locally we have increased the number of people who receive palliative care support from Hospice Tairãwhiti and we have seen increased numbers of prescriptions dispensed at pharmacies across the region.

2016/17 has seen a decrease in the number of falls by aged care residents at hospital level with increases at rest home and dementia level care reflective of increases in resident numbers at this level.

[22] Measure not in the Statement of Intent 2016/17.

[23] Reflects impact measure number of palliative care clients supported by Hospice Tairāwhiti increases, as per above.

Summary of Revenue and Expenses by Output Class

Statement of Intent

The Crown Entities Act 2001 requires DHBs to report revenue and expenses for each Output Class.
There are four output classes for 2016/17

- Prevention
- Early detection and management
- Intensive assessment and treatment
- Rehabilitation and support.

Hauora Tairāwhiti has allocated the revenues and expenses to each output class for the periods covered by this report and the results are as per the table below:

Output Class Funding Allocation

	Actual 2015/16 $000's	Budget 2016/17 $000's	Actual 2016/17 $000's
Income			
Prevention	($5,706)	($5,655)	($6,660)
Early detection and management	($42,577)	($44,581)	($46,032)
Intensive assessment and treatment	($102,652)	($103,876)	($104,746)
Rehabilitation and support	($16,672)	($20,877)	($18,326)
Total Income	**($167,607)**	**($174,989)**	**($175,763)**
Expenditure			
Prevention	$5,790	$5,627	$4,163
Early detection and management	$43,862	$44,357	$45,016
Intensive assessment and treatment	$107,456	$103,362	$115,065
Rehabilitation and support	$17,157	$20,777	$17,648
Total Expenditure	**$174,265**	**$174,123**	**$181,891**
Surplus/(Deficit)	**($6,658)**	**$866**	**($6,128)**

Statement of Responsibility

The Board accepts responsibility for the preparation of the Financial Statements and Statement of Service Performance and for the judgements used in them.

The Board accepts responsibility for any end-of-year performance information provided by Hauora Tairāwhiti under section 19A of the Public Finance Act 1989.

The Board accepts responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting.

In the opinion of the Board, the Financial Statements and Statement of Service Performance for the year ended 30 June 2017 fairly reflect the financial position and operations of Hauora Tairāwhiti.

Signed on behalf of the Board of Hauora Tairāwhiti:

David S Scott MNZM, JP
Hauora Tairāwhiti Board Chair

Date: 31 October 2017

Geoff Milner
Hauora Tairāwhiti Board Member
Finance, Audit and Information Technology Committee Chair

Date: 31 October 2017

Independent Auditor's Report

To the readers of Tairawhiti District Health Board's financial statements and performance information for the year ended 30 June 2017

The Auditor-General is the auditor of Tairawhiti District Health Board (the DHB). The Auditor-General has appointed me, Chrissie Murray, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and the performance information of the DHB on his behalf.

We have audited:

- the financial statements of the DHB on pages 40 to 67 that comprise the statement of financial position as at 30 June 2017, the statement of comprehensive revenue and expenditure, statement of changes in equity, and statement of cash flows for the year ended on that date, and the notes to the financial statements that include accounting policies and other explanatory information; and

- the performance information of the DHB on pages 15 to 34, that comprises the statement of performance.

Opinion

Unmodified opinion on the financial statements
In our opinion, the financial statements of the DHB:

- present fairly, in all material respects:
    - its financial position as at 30 June 2017; and
    - its financial performance and cash flows for the year then ended; and
- comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards.

Qualified opinion on the performance information because of limited controls on information from third-party health providers in the prior year
In respect of the 30 June 2016 comparative information only, some significant performance measures of the DHB, (including some of the national health targets, and the corresponding district health board sector averages used as comparators), relied on information from third-party health providers, such as primary health organisations. The DHB's control over much of this information was limited, and there were no practical audit procedures to determine the effect of this limited control. For example, the primary care measure that included advising smokers to quit relied on information from general practitioners that we were unable to independently test.

The limited control over information from third-party health providers meant that our work on the affected performance information contained in the statement of performance for the comparative year was limited, and our audit opinion on the statement of performance for the year ended 30 June 2016 was modified accordingly.

The limited control over information from third parties has been resolved for the 30 June 2017 year, however, the limitation cannot be resolved for the 30 June 2016 year, which means that the DHB's performance information reported in the statement of performance for the 30 June 2017 year may not be directly comparable to the 30 June 2016 performance information.

In our opinion, except for the matters described above, the performance information of the DHB:

- presents fairly, in all material respects, the DHB's performance for the year ended 30 June 2017, including:
    - for each class of reportable outputs:
        - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
        - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
    - what has been achieved with the appropriation; and
    - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and
- complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 31 October 2017. This is the date at which our opinion is expressed.

The basis for our opinion is explained below. In addition, we outline the responsibilities of the Board and our responsibilities relating to the financial statements and the performance information, we comment on other information, and we explain our independence.

Basis for our opinion

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

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

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

Responsibilities of the Board for the financial statements and the performance information

The Board is responsible on behalf of the DHB for preparing financial statements and performance information that are fairly presented and comply with generally accepted accounting practice in New Zealand.

The Board is responsible for such internal control as it determines is necessary to enable it to prepare financial statements and performance information that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements and the performance information, the Board is responsible on behalf of the DHB for assessing the DHB's ability to continue as a going concern. The Board is also responsible for disclosing, as applicable, matters related to going concern and using the going concern basis of accounting, unless there is an intention to merge or to terminate the activities of the DHB, or there is no realistic alternative but to do so.

The Board's responsibilities arise from the Crown Entities Act 2004, the New Zealand Public Health and Disabilities Act 2000 and the Public Finance Act 1989.

Responsibilities of the auditor for the audit of the financial statements and the performance information

Our objectives are to obtain reasonable assurance about whether the financial statements and the performance information, as a whole, are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit carried out in accordance with the Auditor General's Auditing Standards will always detect a material misstatement when it exists. Misstatements are differences or omissions of amounts or disclosures, and can arise from fraud or error. Misstatements are considered material if, individually or in the aggregate, they could reasonably be expected to influence the decisions of readers, taken on the basis of these financial statements and the performance information.

We were unable to determine whether there are material misstatements in the statement of performance because the scope of our work was limited, as we referred to in our opinion.

For the budget information reported in the financial statements and the performance information, our procedures were limited to checking that the information agreed to the DHB's Annual Plan 2016/17.

We did not evaluate the security and controls over the electronic publication of the financial statements and the performance information.

As part of an audit in accordance with the Auditor-General's Auditing Standards, we exercise professional judgement and maintain professional scepticism throughout the audit. Also:

- We identify and assess the risks of material misstatement of the financial statements and the performance information, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- We obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the DHB's internal control.

- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board.

- We evaluate the appropriateness of the reported performance information within the DHB's framework for reporting its performance.

- We conclude on the appropriateness of the use of the going concern basis of accounting by the Board and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast a significant doubt on the DHB's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements and the performance information or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the DHB to cease to continue as a going concern.

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

We communicate with the Board regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Our responsibilities arise from the Public Audit Act 2001.

Other information

The Board is responsible for the other information. The other information comprises the information included on pages 1 to 14 and 35, but does not include the financial statements and the performance information, and our auditor's report thereon.

Our opinion on the financial statements and the performance information does not cover the other information and we do not express any form of audit opinion or assurance conclusion thereon.

In connection with our audit of the financial statements and the performance information, our responsibility is to read the other information. In doing so, we consider whether the other information is materially inconsistent with the financial statements and the performance information or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on our work, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Independence

We are independent of the DHB in accordance with the independence requirements of the Auditor-General's Auditing Standards, which incorporate the independence requirements of Professional and Ethical Standard 1 (Revised): Code of Ethics for Assurance Practitioners issued by the New Zealand Auditing and Assurance Standards Board.

Other than in our capacity as auditor, we have no relationship with, or interests, in the DHB.

Chrissie Murray
Audit New Zealand
On behalf of the Auditor-General
Wellington, New Zealand

Statement of Comprehensive Revenue & Expense

For the year ended 30 June 2017

	Notes	Economic Entity		
		Actual 2017 $000	Budget 2017 $000	Actual 2016 $000
Revenue				
Patient care revenue	2	172,990	173,791	165,477
Interest revenue		79	110	113
Other revenue	3	1,742	737	1,778
Total revenue		174,811	174,638	167,368
Expenses				
Personnel Cost	4	65,547	63,906	64,890
Depreciation and amortisation expenses				
Property, plant and equipment	13	2,776	2,739	2,657
Intangible	14	288	371	274
Outsourced services		7,281	4,763	6,174
Clinical Supplies		14,390	14,370	13,782
Infrastructure and non-clinical expenses		9,702	8,065	9,207
Other district health boards		22,349	20,007	20,507
Non-health-board provider expenses		56,148	55,866	53,103
Capital charge	5	1,683	2,574	2,458
Interest expense		472	690	714
Other expense	6	930	771	793
Total expenses		181,566	174,122	174,559
Share of associate surplus / (deficit)	12	663	350	534
Surplus / (deficit)		(6,092)	866	(6,657)
Other comprehensive revenue and expense item that will not be reclassified to surplus / (deficit)				
Revaluation of land and buildings		(36)	0	0
Total other comprehensive revenue and expense		(36)	0	0
Total comprehensive revenue and expense		(6,128)	866	(6,657)

Explanations of major variances against budget are provided in Note 31.

The accompanying notes form part of these financial statements.

Statement of Financial Position

As at 30 June 2017

	Notes	Economic Entity		
		Actual 2017	Budget 2017	Actual 2016
Assets		$000	$000	$000
Current assets				
Cash & cash equivalents	7	24	28	27
Receivables	8	3,884	3,361	4,937
Prepayments		1,338	928	932
Inventories	10	1,753	1,678	1,819
Total current assets		6,999	5,995	7,715
Non-current assets				
Investments in subsidiary and associates	12	818	738	707
Property, plant and equipment	13	58,866	60,969	59,742
Intangible assets	14	2,366	2,522	2,558
Total non-current assets		62,050	64,229	63,007
Total assets		69,049	70,224	70,722
Liabilities				
Current Liabilities				
Health Partnership NZ Ltd	7	3,456	4,470	6,804
Payables and deferred revenue	15	10,838	7,271	9,341
Borrowings	17	129	129	1,820
Employee entitlements	18	9,932	9,924	9,593
Provisions	19			
Total current liabilities		24,355	21,794	27,558
Non-current Liabilities				
Borrowings	17	849	15,678	14,107
Employee entitlements	18	558	827	789
Provisions	19	0	0	0
Total non-current liabilities		1,407	16,505	14,896
Total liabilities		25,762	38,299	42,454
Net Assets		43,287	31,925	28,268
Equity	20			
Crown equity		40,745	19,215	19,598
Accumulated surpluses / (deficits)		(34,174)	(24,042)	(28,082)
Property revaluation reserves		36,689	36,725	36,725
Trust funds and bequests		27	27	27
Total equity		43,287	31,925	28,268

Explanations of major variances against budget are provided in Note 31.

The accompanying notes form part of these financial statements.

Statement of Changes in Equity

For the year ended 30 June 2017

	Notes	Economic Entity		
		Actual 2017 $000	Budget 2017 $000	Actual 2016 $000
Balance at 1 July		28,268	31,441	31,307
Total comprehensive revenue and expense		(6,128)	866	(6,657)
Owner transactions	20			
Capital contribution		6,700	0	4,000
Crown loans converted to equity		14,829		
Repayment of capital		(382)	(382)	(382)
Balance at 30 June		43,287	31,925	28,268

Explanations of major variances against budget are provided in Note 31.

The accompanying notes form part of these financial statements.

Statement of Cash Flow[25]

For the year ended 30 June 2017

	Notes	Economic Entity		
		Actual 2017 $000	Budget 2017 $000	Actual 2016 $000
Cash flows from operating activities				
Receipts from patient care				
Ministry of Health		169,657	168,265	157,781
Other District Health Boards		2,190	2,168	2,057
Other		2,784	2,245	4,004
Interest receipts		79	110	113
Receipts from other revenue		1,742	1,459	1,777
Payments to suppliers		(87,774)	(83,456)	(81,300)
Payments to Other District Health Boards		(22,349)	(20,007)	(20,507)
Payments to employees		(65,439)	(63,906)	(65,241)
Capital charge		(1,683)	(2,574)	(2,458)
Interest paid		(569)	(678)	(716)
GST (net)		(12)	0	212
Net Cash flow from operating activities		(1,374)	3,626	(4,278)
Cash flow from investing activities				
Advance from subsidiary company		552	350	565
Receipts from sale of property, plant, and equipment		145	0	0
Purchase of property, plant and equipment		(2,080)	(2,615)	(1,453)
Purchase of intangible assets		(96)	(375)	(279)
Acquisition of investments		0	0	0
Net cash Flow from investing activities		(1,479)	(2,640)	(1,167)
Cash flow from financing activities				
Capital contributions from the crown		6,700	0	4,000
Repayment of capital to the Crown		(382)	(382)	(382)
Repayment of loans		0	0	0
Proceeds from borrowings		0	0	0
Repayment of finance leases		(120)	(120)	(112)
Net cash flow from financing activities		6,198	(502)	3,506
Net (decrease) / increase in cash and cash equivalents		3,345	484	(1,939)
Cash and cash equivalents at the start of the year		(6,777)	(4,926)	(4,838)
Cash and cash equivalents at the end of the year		(3,432)	(4,442)	(6,777)

Explanations of major variances against budget are provided in Note 31.

The accompanying notes form part of these financial statements.

[25] The disclosed budget numbers do not directly reflect those in the 2016/17 annual plan due to interest revenue and expense being disclosed in operating cash flows as appose to financing and investing

Notes to the Financial Statements

Note 1: Statement of Accounting Policies

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 (TLSL), which holds the associated partnership share in Gisborne Laundry Services (GLS), *and its associated companies HealthShare Limited and TLab Limited (TLab).*

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

The financial statements are for the year ended 30 June 2017, and were authorised by the Board on 31 October 2017.

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 2016/17 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 2017 from the Ministers of Health and Finance which states that deficit support will be provided where necessary to maintain viability.

Capital injection of $6.7m 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 the DHB 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 the DHB 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 at Hauora 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 lessor 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 Procurement Supply Chain, including National Oracle Solution
The Finance Procurement Supply Chain (FPSC), which includes the National Oracle Solution (NOS), is a national initiative funded by DHBs and facilitated by NZ Health Partnerships Limited (NZHPL) to deliver sector wide benefits. NZHPL 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 NZPHL 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 indefinitely. 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 consists 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 approraiate 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's 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 cashflows.

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 Tairawhiti 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 the fair value of land and buildings.

The significant assumptions applied in determining the fair value of land and buildings are disclosed in note 10.

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.

Retirement and long service leave. Note 18 provides an analysis of the exposure in relation to estimates and uncertainties surrounding retirement and long service leave liabilities.

Note 2 Patient Care Revenue

	Actual 2017 $000	Actual 2016 $000
MoH population-based Funding	154,125	147,136
MoH other contracts	13,719	13,862
Inter-district Flows (other DHBs)	2,190	2,056
Other patient care related revenue	2,956	2,423
Total Patient care revenue	172,990	165,477

Performance against the MoH population based funding is reported in the Statement of service performance section of this Annual Report

The MoH population based funding received by Tairawhiti DHB equals the Governments actual expenses incurred in relation to this appropriation, which is a required disclosure from the Public Finance Act.

Note 3 Other Revenue

	Actual 2017 $000	Actual 2016 $000
Donated equipment	187	1
Cash donation received	32	16
Rental revenue	245	217
Other revenue	1,278	1,544
	1,742	1,778

Note 4 Personnel costs

	Actual 2017 $000	Actual 2016 $000
Salaries and wages	63,770	63,887
Defined contribution plan employer contributions	1,437	1,354
Increase / (decrease) in liability for employee entitlements	340	(351)
	65,547	64,890

Note 5 Capital Charge

Hauora Tairāwhiti pays a capital charge every six months to the crown. The charge is based on the previous six month actual closing equity balance as at 31 December and 30 June. The capital charge rate for the year ended 30 June 2017 was 6% per annum (2016: 8%)

Note 6 Other Expenses

		Actual 2017 $000	Actual 2016 $000
Fees to auditor			
- Audit NZ for audit of the financial statements		106	103
- Other external auditor		3	3
- Internal audit fees		98	84
Bad debts written off		6	4
Operating lease expense		281	269
Board member fees	25	283	278
Board election expenses		62	0
Loss on disposal of property, plant and equipment		0	2
Other Expenses		91	50
		930	793

Note 7 Cash and cash equivalents

	Actual 2017 $000	Actual 2016 $000
Cash at bank and on hand	12	15
Deposits with maturities less than 3 months	12	12
	24	27
NZ Health Partnership Ltd	(3,456)	(6,804)
Total cash and cash equivalents	(3,432)	(6,777)

Hauora Tairāwhiti is a party to a DHB Treasury Services Agreement between Health Partnership NZ Ltd (HPNZ) and all DHBs. This agreement enables HPNZ to sweep DHB bank accounts and invest surplus funds on their behalf. The Agreement also allows individual DHBs to borrow from HPNZ, which will incur interest at an on-call interest 5ate received by HPNZ plus an administrative margin. The maximum borrowing facility available to any DHB is the value of one month's Provider Arm funding plus GST. As at 30 June 2016 this limit was $8.652 million (2016: $8.382million).

Financial assets recognised subject to restrictions
Included in cash and cash equivalents and investments (Note 9) are unspent funds with restrictions on expenditure. Further information about trusts funds is provided in Note 20.

Note 8 Receivables

	Actual 2017 $000	Actual 2016 $000
Receivables from the sale of goods and services (exchange transactions)	3,986	4,998
Receivables from grants (non-exchange transactions)	0	0
Less: provision for impairment	(102)	(61)
	3,884	4,937

The ageing profile of receivables at year-end is detailed below:

	2017			2016		
	Gross $000	Impairment $000	Net $000	Gross $000	Impairment $000	Net $000
Current	2318		2318	3759		3759
Past due 1 - 30 days	982		982	1139		1139
Past due 31 - 60 days	551		551	15		15
Past due over 60 days	135	(102)	33	85	(61)	24
Total	3,986	(102)	3,884	4,998	(61)	4,937

All receivable greater than 30 days in age are considered to be past due.

Due to the large number of other receivables, the impairment assessment is generally performed on a collective basis, based on an analysis of past collection history and write-offs.

Movements in the provision for impairment of receivables are as follows:

	Actual 2017 $000	Actual 2016 $000
Balance as at 1 July	61	109
Additional provisions / (reversal)	47	(44)
Receivable written off	(6)	(4)
	102	61

Note 9 Investments

Term deposits with maturities less than 3 months are included in cash and cash equivalents (Note 7).

The carrying amounts of term deposits with maturities less than 12 months approximate their fair value.

There is no impairment provision for term deposits.

Note 10 Inventories

	Actual 2017 $000	Actual 2016 $000
Held for distribution inventories		
Pharmaceuticals	219	213
Surgical and medical supplies	680	680
Main store	689	780
Other supplies	165	146
	1,753	1,819

The amount of inventories recognised as an expense during the year was $14,359k (2016: $2,936k) which is included in a number of expense lines in the statement of comprehensive revenues and expenses.

The net write down of inventories held for distribution amounted to $(1)k (2016: $(1)k)
Minor variances occur throughout the year result of periodic stock counts.

No inventories are pledged as security for liabilities (2016: $nil). However some inventories are subject to retention of title clauses.

Note 11 Non-current assets held for sale

As at balance date there were no assets held for resale (2016: $nil)

Note 12 Investments in subsidiaries and associates

Investment in Subsidiary

Entity	Tairāwhiti Laundry Services Limited (TLSL)
Principle activity	Partner in Gisborne Laundry Services
Ownership interest	100%
Balance Date	30 June

Financial information for subsidiary has been included in these consolidated Hauora Tairāwhiti results.

Investment in Associates

Entity	**HealthShare Limited**
Principle activity	Midland region DHBs shared service agency
Ownership interest	20% (100 shares)
Balance Date	30 June

Summaries financial information (Hauora Tairāwhiti's share)	Actual 2017 $000	Actual 2016 $000
Assets	2,982	2,992
Liabilities	2,684	2,796
Revenue	2,772	2,396
Surplus	149	15
Hauora Tairāwhiti's share of contingent liabilities	0	0

Entity	**TLab Limited**
Principle activity	Provision of laboratory services
Ownership interest	50% (85,000 shares)
Balance Date	30 June

Summaries financial information (Hauora Tairāwhiti's share)	Actual 2017 $000	Actual 2016 $000
Assets	571	625
Liabilities	235	265
Revenue	2,359	2,339
Surplus	201	219
Hauora Tairawhiti's share of contingent liabilities	0	0

Entity	**Gisborne Laundry Services**
Principle activity	Provision of laundry services in Gisborne and Hawkes Bay
Ownership interest	50% (partnership via Tairāwhiti Laundry Services Ltd)
Balance Date	30 June

Summaries financial information (Hauora Tairāwhiti's share)	Actual 2017 $000	Actual 2016 $000
Assets	326	220
Liabilities	142	69
Revenue	935	892
Surplus	313	300
Hauora Tairāwhiti's share of contingent liabilities	0	0

Total investment in associates (share of assets less liabilities)	818	707
Total share of associate results	663	534

Note 13 Property, plant and equipment

	Land	Buildings	Clinical Equipment	Other Equipment	Information Technology	Vehicles	Work in Progress	Total
	$000	$000	$000	$000	$000	$000	$000	$000
Cost or Valuation								
Balance 1 July 2015	2,145	49,033	15,112	980	2,341	2,700	223	72,534
Additions		132	836	120	367			1,455
Disposals			(432)	(52)	(46)		(2)	(532)
Revaluation								0
Balance 30 June 2016	2,145	49,165	15,516	1,048	2,662	2,700	221	73,457
Balance 1 July 2016	2,145	49,165	15,516	1,048	2,662	2,700	221	73,457
Additions	0	35	1,216	66	524	29	216	2,086
Disposals	(18)	(172)	(230)	(63)	(186)			(669)
Revaluation								0
Balance 30 June 2017	2,127	49,028	16,502	1,051	3,000	2,729	437	74,874
Accumulated depreciation								
Balance 1 July 2015		(14)	(7,507)	(688)	(1,557)	(1,820)		(11,586)
Depreciation expense		(737)	(1,415)	(70)	(316)	(119)		(2,657)
Elimination on disposals		0	430	52	46	0		528
Revaluation								0
Balance 30 June 2016	0	(751)	(8,492)	(706)	(1,827)	(1,939)	0	(13,715)
Balance 1 July 2016	0	(751)	(8,492)	(706)	(1,827)	(1,939)	0	(13,715)
Depreciation expense		(738)	(1,520)	(74)	(322)	(122)		(2,776)
Elimination on disposals		13	221	63	186	0		483
Revaluation								0
Balance 30 June 2017	0	(1,476)	(9,791)	(717)	(1,963)	(2,061)	0	(16,008)
Carrying amounts								
As at 1 July 2015	2,145	49,019	7,605	292	784	880	223	60,948
At 30 June and 1 July 2016	2,145	48,414	7,024	342	835	761	221	59,742
At 30 June 2017	2,127	47,552	6,711	334	1,037	668	437	58,866

Valuation

The most recent valuation of land and buildings was performed by an independent registered valuer Jones LaSelle Ltd as at 30 June 2015. This excluded some assets in rural areas subject to review for disposal, with a book value of $0.346 million.

Land

Land is valued at fair value using market-based evidence based on its highest and best use with reference to comparable land values. This excludes the rural land referred to above which remains at it's 2012 valuation of $45k, which is assessed as approximating its current market value.

Adjustments have been made to the "unencumbered" land value for land where there is a designation against the land or the use of the land is restricted. These adjustments are intended to reflect the negative effect on the value of the land where an owner is unable to use the land more intensely. Restrictions on Hauora Tairāwhiti's ability to sell land would normally not impair the value because it has operational use of the land for the foreseeable future and will receive substantially the full benefits of outright ownership.

Buildings

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

Depreciated replacement cost is determined using a number of significant assumptions. These include:

- the replacement asset is based on the replacement with modern equivalent assets, with adjustments where appropriate for optimisation due to over-design or surplus capacity.
- the replacement cost is derived from recent construction contracts of similar assets and Property Institute of New Zealand cost information.
- for earthquake-prone buildings that are expected to be strengthened, these costs have been deducted
- the remaining useful life of assets is estimated using recent asset management information.
- straight-line depreciation has been applied in determining the depreciated replacement cost value.

Non-specialised buildings (for example, residential buildings) are valued at fair value using market based evidence. Market rents and capitalisation rates were applied to reflect market value.

Restrictions on title

Hauora Tairāwhiti does not have full title to the Crown land it occupies, but transfer is arranged if and when land is sold. Some of the land is subject to Waitangi Tribunal claims. The disposal of certain properties may be subject to the provisions of section 40 of the Public Works Act 1981.

Titles to land transferred from the Crown to the DHB are subject to a memorial in terms of the Treaty of Waitangi Act 1975. The effect on the value of assets resulting from potential Waitangi Tribunal claims cannot be quantified and is therefore not reflected in the value of the land.

Finance leases

The net carrying amount of assets held under finance leases is $nil (2016: $nil) for buildings and $1,169k (2016: $1,363k) for other equipment.

Note 14 Intangible assets	FPSC Rights	Software	WIP FPSC Rights	WIP Software	Total
	$000	$000	$000	$000	$000
Cost or Valuation					
Balance 1 July 2015		3,454	836	205	4,495
Additions		20	0	259	279
Disposals		(6)			(6)
Balance 30 June 2016	0	3,468	836	464	4,768
Balance 1 July 2016	0	3,468	836	464	4,768
Additions		209	0		209
Disposals		(110)		(114)	(224)
Revaluation					
Balance 30 June 2017	0	3,567	836	350	4,753
Accumulated depreciation					
Balance 1 July 2015		(1,941)			(1,941)
Depreciation expense		(274)			(274)
Elimination on disposals		6			6
Balance 30 June 2016	0	(2,209)	0	0	(2,209)
Balance 1 July 2016	0	(2,209)	0	0	(2,209)
Depreciation expense		(288)	0	0	(288)
Elimination on disposals		110			110
Balance 30 June 2017	0	(2,387)	0	0	(2,387)
Carrying amounts					
As at 1 July 2015	0	1,513	836	205	2,554
At 30 June and 1 July 2016	0	1,259	836	464	2,559
At 30 June 2017	0	1,180	836	350	2,366

There are no restrictions over the title of intangible assets. No intangible assets are pledged as security for liabilities.
At 30 June 2017, Hauora Tairāwhiti had made payments totalling $836k (2016: $836k) in relation to the Finance, Procurement and Supply Chain (FPSC) programme. This is a national initiative and is managed on behalf of DHBs by NZ Health Partnerships Limited (NZHPL).

In return for these payments, Hauora Tairāwhiti gained rights to access the FPSC asset, which includes National Oracle Solution (NOS) programme. In the event of liquidation or disolution of NZPHL, Hauora Tairāwhiti shall be entitled to be paid from the surplus assets, an amount equal to their proportionate share of the liquidation value based on its proportional share of the total FPSC/NOS rights that have been issued.

The FPSC/NOS rights have been tested for impairment by comparing the carrying amount of the intangible asset to its depreciated replacement cost (DRC), which is considered to equate to Hauora Tairāwhiti's share of the DRC of the underlying FPSC assets.

The current expectation of the Board is that the FPSC/NOS programme will proceed as planned. In this scenario, the DRC of the FPSC/NOS rights is consider to equate to, in all material respects, to the costs capitalised to date such that the FPSC/NOS rights are not impaired.

Note 15 Payables and deferred revenue

	Actual 2017 $000	Actual 2016 $000
Payables and deferred revenue under exchange transactions		
Creditors	2,542	1,960
Accrued expenses	7,288	6,360
Other	0	0
Total payables and deferred revenue under exchange transactions	9,830	8,320
Payables and deferred revenue under non-exchange transactions		
GST payable	989	1,001
Capital Charge payable	0	0
Other	20	20
Total payables and deferred revenue under non-exchange transactions	1,009	1021
Total payables and deferred revenue	10,839	9,341

Note 16 Derivative financial instruments

Foreign exchange transactions are converted to NZ dollars are the time of payment or receipt.
No derivative financial instruments have been used in the current year. (2016: none).

Note 17 Borrowings

	Actual 2017 $000	Actual 2016 $000
Current Portion		
Finance Leases	129	120
Crown loans - fixed interest	0	1,700
	129	1,820
Non-current portion		
Finance Leases	849	978
Crown loans - fixed interest	0	13,129
Total non-current portion	849	14,107
Total Borrowings	978	15,927
Borrowing facility Limits		
Crown loan facility	0	14,829
NZ Health Partnership Ltd (refer to note 7)	8,382	8,382
Total borrowing facility limits	8,382	23,211

Crown loans

The crown loans were secured by a negative pledge.

Without the MoH's prior written approval, the DHB cannot perform the following actions:

- create any security over it's assets, except in certain defined circumstances;
- lend money to another person or entity (except in the ordinary course of business and then only on commercial terms) or give a guarantee;
- make a substantial change in the nature or scope of it's business as presently conducted; or
- dispose of any of it's assets, except disposals in the ordinary course of business or disposal for full value.

The crown loans were converted to equity. Refer to note 20 for more detail.

Fair value

The fair value of borrowings has been determined using contractual cash flows discounted using a rate based on market borrowing rates.

The carrying value of borrowings approximates the fair value at balance date.

Interest rate summary	Actual 2017	Actual 2016
Crown		2.21%-6.49%
Westpac	7.14%	7.14%
NZ Health Partnership	3.29%	3.38%

Analysis of financial lease		
Minimum lease payments payable:		
No later than one year	129	112
Later than one year and not later than five years	659	866
Later than five years	190	232
Total minimum lease payments	978	1210
Future finance charges		
Present value of minimum lease payments	978	1,210

Present value of minimum lease payments payable:		
No later than one year	129	112
Later than one year and not later than five years	659	866
Later than five years	190	232
Total present value of minimum lease payments	978	1,210

Description of finance leasing arrangements

Hauora Tairāwhiti has entered into finance leases for MRI equipment. The net carrying amount of this equipment is shown in Note 13.

There are no restrictions in place for any of the finance lease arrangements. These are effectively secured as the rights to the assets revert to the lessor in event of default in payment.

Note 18 Employee entitlements

	Actual 2017 $000	Actual 2016 $000
Current portion		
Accrued salaries and wages	1,883	1,764
Annual leave	6,276	5,978
Sick leave and shift leave	110	154
Sabbatical leave	298	307
Continuing medical education leave	786	784
Long service leave	527	500
Retirement gratuities	52	105
	9,932	9,592
Non-current portion		
Long service leave	383	324
Retirement gratuities	175	465
	558	789
Total employee entitlements	10,490	10,381

Key assumptions in measuring retirement and long service leave obligations

The present value of sabbatical leave, long service leave and retirement gratuities obligations depend on a number of factors including:

- assessment of leave required based upon prior years
- review of the maximum potential liability in each class of leave reduced by the above.

Note 19 Provisions

Hauora Tairāwhiti has no material provisions (2016: Nil). Minor amounts are included with Accounts payable.

Note 20 Equity

	Actual 2017 $000	Actual 2016 $000
Crown equity		
Balance at 1 July	19,598	15,980
Capital contributions from the crown	6,700	4,000
Capital contributions by way of loan conversion	14,829	0
Repayment of capital to the crown	(382)	(382)
Balance at 30 June	40,745	19,598
Accumulated surpluses / (deficits)		
Balance at 1 July	(28,082)	(21,425)
Surplus / (deficit) for the year	(6,092)	(6,657)
Transfer from / (to) trust funds	0	0
Balance at 30 June	(34,174)	(28,082)
Revaluation reserves		
Balance at 1 July	36,725	36,725
Revaluations	(36)	0
Balance at 30 June	36,689	36,725

Bequest Trusts and Capital reserve		
Balance at 1 July	27	27
Transfer from / (to) trust funds	0	0
Balance at 30 June	27	27
Total equity	43,287	28,268

In September 2016 Cabinet agreed that the DHB sector should no longer access Crown debt and agreed to convert all existing debt to Crown equity.

On the 15 February 2017 all exiting Crown loans were converted into Crown equity and from that day onward all Crown contributions would be via Crown equity euity injections. Loans converted $14,829k

The termination of the loan agreement and the conversion of existing Crown loans to equity was completed by a non-cash transaction, other than for interest due at the conversion date.

As a consequence of the changes there has been a decrease due to the interest cost avoided from the conversion date until the end of the year and increasing appropriations for increased capital charge costs thereafter.

Trust funds and capital reserves represent the unspent portion of donations and bequests subject to restrictions. The restrictions generally specify how the donations and bequests are required to be spent in providing specific deliverables of the bequests.

Included in the accumulated surpluses / (deficits) are $3,125 overspent(2016: $162) of overspent mental health ring fenced funding representing the excess funding received over relevant mental health expenses since this funding was established.

Note 21 Reconciliation of net surplus / (deficit) to net cash flow from operating activities

	Actual 2017 $000	Actual 2016 $000
Net surplus / (deficit)	(6,128)	(6,657)
Add / (less) non-cash items		
Share of associates surplus	(663)	(534)
Donated assets revenue	0	(1)
Increase in non-current employee entitlements	(231)	(38)
Depreciation and amortisation expense	3,063	2,935
Net change on financial instruments and term liabilities	0	0
Total non-cash items	2,169	2,362
Add / (less) items classified as investing or financing activities		
Money ex subsidiary	0	0
Net (gains) losses on disposal of property, plant, and equipment	36	0
Total items classified as investing or finance activities	36	0
Add / (less) movements in statement of financial position items		
(Increase) / decrease in receivables	1,052	(1,577)
(Increase) / decrease in prepayments	(406)	(4)
(Increase) / decrease in inventories	66	(141)
Increase / (decrease) in payables	1,497	2,052
Increase / (decrease) in provisions	0	0
Increase / (decrease) in employee entitlements	339	(313)
Net movements in working capital items	2,548	17
Net cash (outflow) / inflow from operating activities	(1,375)	(4,278)

Note 22 Capital commitments and operating leases

	Actual 2017 $000	Actual 2016 $000
Capital commitments	435	435

Capital commitments represent capital expenditure contracted for at balance date but not yet incurred.

Operating leases as lessee

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

	Actual 2017 $000	Actual 2016 $000
Not later than one year	399	399
Later than one year and not later than five years	164	164
Later than five years	0	0
Total non-cancellable operating leases	563	563

Hauora Tairāwhiti lease a number of buildings and equipment under operating leases.

The details of the main leases are as follows:

Tangata rite building is leased with an expiry date of 8 July 2018.

MRI equipment finance lease has an expiry date of 19 July 2023.

Note 23 Contingencies

Legal proceedings

Hauora Tairāwhiti has not been informed of any legal actions against it so has no contingent liabilities (2016:$50k)

Earthquake Prone building

The Morris Adair building has been assessed as being an earthquake-prone building. An engineering assessment is being carried out to determine what is required in order to remediate this situation. The decision regarding this future work or alternatively of demolition of the building has not been finalised at this time. Cost of either option has yet to be quantified.

Contingent assets

Hauora Tairāwhiti has no contingent assets (2016:$nil)

Note 24 Related party transactions

Hauora Tairāwhiti is wholly owned by the Crown.

Related party disclosures have not been made for transactions with related parties, including associates, that are within a normal supplier or client / recipient relationship on terms and conditions no more or less favourable than those that is reasonable to expect that it is reasonable to expect that a group would have adopted in dealing with the party at arm's length in the same circumstances. Further, transactions with other government agencies are not disclosed as related party transactions when they are consistent with the normal operating arrangements between government agencies and undertaken on normal terms and conditions for such transactions.

Key management personnel compensation	Actual 2017	Actual 2016
Board members	$000	$000
Remuneration	258	246
Full time equivalent members	1	1
Leadership Team		
Remuneration	3,599	2,907
Full time equivalent members	17	15
Total key management personnel remuneration	3857	3153
Total full-time equivalent personnel	18	16

Note 25 Board Member Remuneration

Board Members	Actual 2017 $	Actual 2016 $
C Bauld	9,718	20,820
C Bibby	8,468	20,070
M Akuhata-Brown	11,602	0
B A Clarke	12,286	25,495
G Milner	24,658	22,445
G Murphy	11,102	0
H Pihema	11,352	0
N Raihania	15,542	0
E Reedy	7,718	18,070
D Scott (Chair)	43,183	41,100
K Sheldrake	19,819	19,320
R Stoltz	19,820	20,320
M Todd	11,270	19,070
M Tibble	8,843	17,695
J Wharehinga	9,602	0
B Wilson	21,570	21,339
P Younger	11,602	0
	258,154	245,744

Maori Caucus & Community Members	$	$
W Burdett	1,250	1,500
A Hawea	750	1,750
P Henare	1,250	2,250
J Hockey	1,500	1,500
C Jackman	500	0
L McCarthy-Robinson	4,250	3,500
Te A Nepia-Clamp	750	0
A Ngarangione	4,250	4,000
N Ngata	1,000	0
M Palmer	1,500	1,250
M Para	2,750	4,750
N Raihania	0	5,250
C Simmonds	250	0
B Thomas	1,250	1,750
J Timutimu	500	0
B Turnpenny	750	2,500
R Waihi	500	0
J Williams	2,250	2,250
	25,250	32,250
Total governance remuneration	283,404	277,994

Hauora Tairāwhiti has provided a deed of indemnity to Board members for certain activities undertaken in the performance of the DHB's functions.

Hauora Tairāwhiti has effected Directors and officers liability and professional indemnity insurance cover during the financial year in respect of the liability or costs of Board members and employees.

No Board members received compensation or other benefits in relation to cessation (2016:$nil).

Note 26 Employee remuneration

The number of employees or former employees who received remuneration and other benefits of $100,000 or more within specified $10,000 bands were as follows:

From	To	Staff No. 2017	Staff No. 2016
100,000	109,999	15	12
110,000	119,999	6	6
120,000	129,999	5	5
130,000	139,999	1	4
140,000	149,999	4	4
150,000	159,999	5	2
160,000	169,999	0	2
170,000	179,999	0	0
180,000	189,999	2	1
190,000	199,999	3	1
200,000	209,999	0	2
210,000	219,999	1	2
220,000	229,999	0	0
230,000	239,999	2	3
240,000	249,999	1	3
250,000	259,999	2	3
260,000	269,999	2	3
270,000	279,999	1	5
280,000	289,999	5	4
290,000	299,999	1	4
300,000	309,999	2	5
310,000	319,999	4	1
320,000	329,999	3	4
330,000	339,999	5	2
340,000	349,999	4	6
350,000	359,999	3	1
360,000	369,999	2	3
370,000	379,999	3	1
380,000	389,999	1	1
390,000	399,999	1	0
400,000	409,999	4	2
410,000	419,000	1	1
420,000	429,999	0	0
430,000	439,000	0	0
440,000	450,000	1	0
620,000	629,999	1	0
		91	93

During the year ended 30 June 2017, 2 (2016:3) employees received compensation and other benefits in relation to cessation totalling $37k (2016:$36k).

Note 27 Events after balance date

There were no significant events after balance date.

Note 28 Financial Instruments

The carrying amounts of financial assets and liabilities in each of the financial instrument categories are as follows:

	Actual 2017 $000	Actual 2016 $000
Fair value through surplus or deficit		
Cash and cash equivalents	12	12
Receivables	3,884	4,937
Investments in associates	818	707
	4,714	5,656
Financial liabilities measured at amortised cost		
Payables (excluding income in advance and taxes payable)	20,770	18,935
Borrowings	0	14,829
Finance leases	978	1,098
Total financial liabilities measured at amortised cost	21,748	34,862

Note 29 Capital Management

Hauora Tairāwhiti's capital is its equity, which comprises accumulated funds, revaluation reserves and crown equity Equity is represented by net assets.

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

Hauora Tairawhiti has complied with the financial management requirements of the Crown Entities Act 2004 during the year. Equity is managed as a by-product of prudently managing revenues, expenses, assets, liabilities, investments, and general financial dealings to ensure that Hauora Tairāwhiti achieves its objectives and purpose while remaining a going concern.

Note 30 Early Childhood Care

Hauora Tairāwhiti receives funding from the Ministry of Education to fund part of children's ward

	Actual 2017 $000	Actual 2016 $000
Revenue from the Ministry of Education	68	83
Expenditure		
Personnel costs	(50)	(53)
Operation expenses	(4)	(2)
	(54)	(55)
Net surplus / (deficit)	14	28

Note 31 Major Variations from the statement of intent

Explanations for major variances from Hauora Tairāwhiti's budgeted figures in the Statement of Intent are as follows:

Statement of comprehensive revenue and expense

Personnel Costs were over budget by $1.6 million or 2.6%. For a variety of reasons:
Successful recruitment of Doctors and Specialist and unrealistic budgeted savings.

Outsourced services were over budget by $2.5 million partially result of delay in reducing service as doctors recruited.

Infrastructure and non-clinical expenses over budget by $1.6 million; treatment disposables up $213k, Pharmaceuticals up $731k, Air Ambulance up $300k and Patient Transport/Lodging up $276k.

Payments to other district health boards were $2.3 million or 11% over budget caused by increase usage by Tairāwhiti residents of the other DHBs.

Statement of changes in equity
The deficit was $7 million below the budgeted result due to the reasons given above.
The DHB also received deficit support equity of $6.7 million and had crown loans converted to equity $14.8 million.

Statement of financial position
Current assets are $1 million higher than budget with prepayments $410k up, receivables lower than last year but higher than budget.

Liabilities are under budget through the conversion of crown loans to equity $14.8 million.

Note 32 Breach of legislation

Last year (2016) delivery of information to Audit New Zealand was delayed due to the Board's decision on 25 October to seek a letter of support from the Ministers of Health and Finance. The letter was received on 16 November 2016 and provided to the auditor the same day.

The delay meant that the Auditor-General was unable to meet the statutory obligation under the Crown Entities Act (section156[2]) to provide an audit report within 4 months after the end of the financial year.

Note 33 New Zealand Business Number (NZBN)
Under the terms of the New Zealand Business Number Act 2016 the DHB is required to adopt and support the use of NZBN. These numbers will allow businesses to update their core information in one place and it will automatically update on other databases, especially business partners and government agencies.
For the purposes of NZBN Hauora Tairawhiti is a Tier Two agency and as such must:
a) by Dec 2018 be able to identify and interact with NZBN entities without requiring any additional identifier
b) by Dec 2020 be able to fully access and use the NZBN register.

Progress to date includes working with our software suppliers to enable recording of these numbers, all DHBs are collectivly working towards incoporating the NZBN within their systems.