Hauora
Tairāwhiti

Presented to the House of Representatives pursuant to section 150 of the Crown Entities Act 2004

ANNUAL REPORT 2018

VERSION #	DATE:	CHANGES:	REVIEW BY:	REVIEW DATE:
V1.0	04/09/18	First draft created	Craig Green	04/09/18
V1.1	17/09/18	Inclusion of financial accounts	Craig Green	17/09/18
V1.2	19/09/18	Inclusion of SSP	Craig Green	19/09/18
V1.3	19/09/18	Inclusion of Output Class data	Craig Green	19/09/18
V1.4	20/09/18	Revised Notes added and review complete	Craig Green	20/09/18
V1.5	24/09/18	Mission, values and behaviours; About Hauoara Tairawhiti and Board Member Register of Interest.	Craig Green	24/09/18
V1.6	18/10/18	Complete final adjustments to accounts and notes prior to going to Board for review	Craig Green	19/10/18
V1.7	26/10/18	Added "Legislative Compliance: Statement of Performance Expectations" to Note 1	Craig Green	26/10/18
V1.8	31/10/18	Pharmac rebate, reworking financials and updating notes: going concern and vlaues flowing from revenue change, updated SPE values, adding in the Audit NZ opinion. Submission to Audit NZ for final review.	Craig Green	31/10/18
V1.9	02/11/18	Final changes post Audit NZ review	Craig Green	02/11/18
V1.10	07/11/19	Final Final changes, post Audit NZ re-review	Craig Green	07/11/18

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Message from the Chair

Kia ora Koutou

The general election of October 2017 resulted in a change of Government to a Labour led Coalition Government. This change heralded Ministerial changes including Health. The incoming Minister Hon Dr David Clark has already stamped his influence over the portfolio.

Hon Dr David has been most explicit about his goals for the health System in New Zealand. He wishes to be remembered as the Minister who reduced inequities in health. This new approach to the portfolio has resulted in a closer relationship being forged between the Minister, the Ministry of Health and the NZ Health Boards. The minister regularly organises kanohi ki te kanohi (face to face) sessions at our quarterly NZ Health Board Chairs/CEOs meetings in Wellington. This year all health boards were able to discuss their annual budgets one on one with the Minister (along with the Director General of the Ministry of Health) in a relaxed non-threatening environment that was far superior and more worthwhile than the previous email traffic only with the Ministry.

This innovation by the Minister culminated in a joint pre-budget planning meeting in Wellington with the team from the Ministry of Health led by the DG Dr Ashley Bloomfield. We were able to take a team: Chief Executive Officer, Chief Financial Officer, Acting Chief Medical Officer, and Group Manager Planning & Funding to Wellington to participate in this discussion. The result of this meeting meant that for the first time in my time as Chair we were able to obtain a realistic budget i.e. we are being sanctioned to operate a deficit budget instead of as previously dictated a break-even budget.

This year one of our long-standing Surgeons died. Mr Ray Vasan (retired) had been a surgeon for Tairawhiti District Health for ten plus years. He was noted for his service to our Maori Community and operated on them via the mobile Surgical Bus when it visited Te Puia Springs. Ray also served a term on the Health Board Chairing the Hospital Advisory Committee.

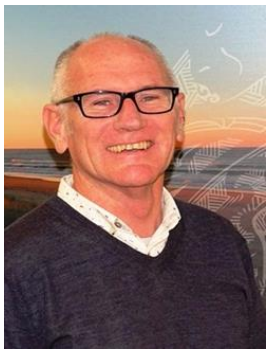
This year has seen a large increase of very sick patients being treated by the staff at Hauora Tairawhiti. The winter months saw the hospital full and the throughput in ED was notable. This winter surge has had the CEO and his leadership team already discussing the winter 18/19 year. A demand management group of hospital clinicians, managers, primary health and the PHO has been established to look at strategies for improved ways of dealing with the demand.

Once again, the people of Tairawhiti have been well served by a talented team of Primary & Secondary providers including all the clinicians, nurses, clinical, and administration support staff plus public health personnel.

We look forward to an ever better opportunity to innovate and serve supported by the new approach to health by our recently elected coalition government.

David S Scott MNZM, JP
Chair –TDH Board
June 2018

Message from the Chief Executive



At the start of this year I predicted far more troubled waters for our Hauora Tairāwhiti waka as we started to grapple with an increased acute load. I did however include in the prediction that efforts we were making to deal with the increased load would be successful. Unfortunately, as it has turned out, the load in the early part of the year created a new record for Hauora Tairāwhiti and while we can be proud of the effort under the circumstances, there remains the challenge of responding to the needs of our community for care.

A sustaining factor in our ability to respond has been the dedication and innovation of the Hauora Tairāwhiti workforce. Once again staff have not only risen to the challenge of providing more care, or supporting the delivery of that care, they have found new ways to be effective both in the hospital and community setting.

There has had to be a specific response to the issues troubling service provision. The clinically led review of the Hospital Out of Hours was a salient exercise in defining a problem and then seeking the direct advice of those people dealing with it to produce solutions. The report confirmed that many of the systems and processes we have in place for the management of the care of people coming through the hospital have not kept pace with the changing pattern of need for care. The traditional provision of services out of hours is no longer able to cope and the report identified a series of recommendations to bolster services, these recommendations being now progressively implemented such as increased staffing, changed roles and improving the safe operating environment.

Key to this also has been a stepped up level of cooperation between hospital and community based clinicians to better manage the care of people across the whole health continuum. Supported by the leadership within Hauora Tairāwhiti and our Primary Health Organisations there has been agreement and implementation of initiatives that will provide more care for people up front in the community, enabling people to remain well, and reducing the pressure on community and hospital services. Prominent in this has been the Winter 2018 project of measures for Tairāwhiti people to have much improved health this winter. Coupled with this are the internal winter preparations. The test of this will be in the months to come, however in the development and implementation we have a repeatable model of what can be achieved when clinicians across the spectrum apply joined up effort on a common problem.

To accommodate the increased load and to support the innovation, the workforce of Hauora Tairāwhiti has grown in clinical positions. We have recruited to improve the sustainability of some of the smaller services and to grow on our workforce so that we are less reliant on recruiting from the wider pool of people nationally or internationally. We still have gaps in some key roles however recruitment is showing signs of improvement. Not having the right numbers and mix of staff limits our ability to respond and a priority remains to find ways to utilise the talent we have locally, especially in our workforce who are Māori or our prospective workforce, to future proof our health services.

Of note in this regard was the transfer of the Cleaning, Orderly and Security services from contacted to employed status within Hauora Tairāwhiti. This has proven to be a very successful measure to improve our care for people and we have gained a resourceful and dedicated group of employees. We will be using this expanded staff base as part of our developmental plan for staff. The change also contributed to our annual savings programme which once again delivered to target.

The work outside of Hauora Tairāwhiti is also of prime importance in changing the trajectory of health and the impact on the health system of ill health and distress. Along with the working together initiatives mentioned already there are very significant new service models that have been implemented and are under consideration for their long-term benefit. Principal in these are the two mental health programmes of Te Kūwatawata and Te Hiringa Matua where, in conjunction with primary care partners and the consumer organisation, we are changing the focus of care to make it more effective across the whole range of people needing support with mental distress. These models are showing encouraging results and we will use them to spread the positives to other service delivery. Innovation and the spread of it is entrenched in the Tairawhiti way.

This is also expressed in the cross sector, iwi led, Manaaki Tairāwhiti initiative which is enabling better lives for Tairāwhiti people through better working relationships between agencies and better ways of providing support. The systems improvement work and the "50 Families" projects are delivering measurable benefits in the lives of people and in the systems we have to respond to need. We are testing new responses and learning to do better, for to do any less would squander the potential inherent in Tairāwhiti. Better lives for people results in better health. This is core to Hauora Tairāwhiti.

Financially, although we have arrested the declining financial position of Hauora Tairāwhiti, we have not made any appreciable gain. Our savings efforts have been successful and we have increased the productivity of our services, but we have not been able to respond to the burgeoning need, in the funding available.

Our efforts going forward remain focussed on trading our way through this. That is, understanding the drivers and intervening earlier, not being afraid to invest to help shape the destiny of the people of Tairāwhiti and therefore their health services. We will do more to keep people well, support them with longer healthier lives and have a responsive sustainable health system when they need it. That will deliver the best financial outcome as well.

Turning to my 18/19 prediction. The main factors in this will be the success of the measures we have being taking to better equip our community and ourselves for health service delivery in all the many facets that are essential. I am confident we have made further inroads in 17/18 which will flow through to 18/19. I intend to report on the success of those, summing up real progress in 12 months' time.

Hauora Tairāwhiti DHB mission, values and behaviours

Our mission

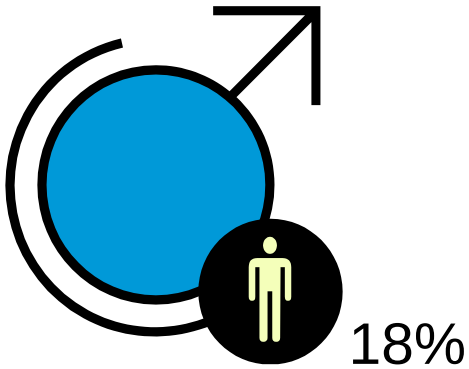
Working together, to elevate the wellbeing of Tairāwhiti."
"Mahia nga mahi i roto i te kotahitanga kia piki ake te oranga o te Tairāwhiti.

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

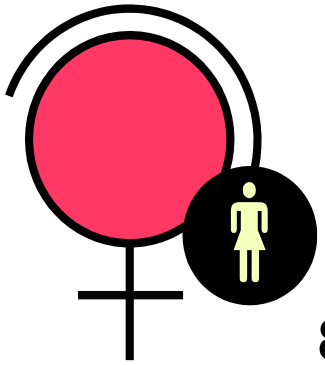
About Hauora Tairāwhiti

The DHB currently employs **1,010** people, a number of whom are multi-jobbed; with **1,054** positions held throughout the organisation.

Of these **1,054** positions:



18%



82%

WORKFORCE PROFILE – by age bands	
<25	4.3%
25 - 35	15.7%
35 - 45	18.0%
45 - 55	25.0%
55 - 64	26.0%
65+	11.0%

WORKFORCE PROFILE – by occupational group	
Medical staff	8.3%
Nursing staff	45.0%
Allied Health staff	21.4%
Non-clinical support staff	6.8%
Management & admin staff	18.5%

WORKFORCE PROFILE – by ethnicity	
NZ European	50.5%
NZ Māori	30.2%
Pacific Island	0.9%
British & Irish	1.5%
Other ethnicities	16.0%
Not known	0.9%

EMPLOYEE STATUS	
Casual	18.0%
Full time	36.0%
Part time	46.0%

Report on good employer obligations

Huora 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 42 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.

Directory

Board Members	
David Scott (Chair)	Appointed, June 2010 Reappointed, December 2010 Reappointed, December 2013 Reappointed, December 2016
Geoff Milner (Deputy Chair)	Appointed, December 2010 Reappointed, December 2013 Reappointed, December 2016
Brian Wilson	Elected, October 2007 Re-elected, October 2010 Re-elected, October 2013 Re-elected, October 2016
Kathy Sheldrake	Elected, October 2010 Re-elected, October 2013 Re-elected, October 2016
Rehette Stoltz	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	Bank of New Zealand Gisborne
Chapman Tripp Auckland	

Identifiers	
GST Number	61-243-240
NZ Business Number	9429000097956

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 2017 and 30 June 2018.

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
Aug-17				
Rehette Stoltz	Item 13.1 Board Action - Line x Line Review July Update	Management Team Leader For Sunshine Bus organisation.	Sunshine Bus Services were included in the overall list of funding lines for review.	The Board noted the a separate review ofSunshine Bus services had already been completed with no changes to the level of funding support from the DHB. For this reason the Board agreed Ms Stoltz could remain for discussion.
Brian Wilson	Item 14.1 Laboratory Services Agreement	Director of TLAB, the Provider Arm Laboratory Services provider.	The item considered the extent of funding contribution to the Laboratory Service.	The Board agreed that Mr Wilson could remain for discussion but not take part in discussions or the decision.
Sep-17				
Brian Wilson	Item 14.2 Gisborne Hospital Childcare & Education Centre	Chairman, YMCA	YMCA have three childcare centres. A potential conflict exists amongst the competing entities which might influence a decision in lease negotiations.	Mr Wilson excused himself from the meeting during this discussion.
Hiki Pihema	Item 14.2 Gisborne Hospital Childcare & Education Centre	Ms Pihema had a staff member closely involved with the discussions.	Ms Pihema had been privy to information outside of the Board's consideration.	Ms Pihema excused herself from the meeting during this discussion.
Oct-17				
Rehette Stoltz	Item 8.1 Obesity Reduction Planning	Trustee, Sport Gisborne	The Item outlined a policy approach in terms of planning for Obesity reduction in communities including promoting physical activity/sports.	The information item did not discuss strategies and proposals that affected Sport Gisborne in particular. For this reason the Board agreed Ms Stoltz could remain for the discusion.
Prue Younger	Item 8.1 Obesity Reduction Planning	Chair, Sport Gisborne	The Item outlined policy approach in terms of planning for Obesity reduction in communities including promoting physical activity/sports.	The information item did not discuss strategies and proposals that affected Sport Gisborne in particular. For this reason the Board agreed Ms Younger could remain for the discusion.
Nov-17				
Na Raihania	Item 9.1 Havelock North Enquiry Stage 2	In relation to his connections to the East Coast Community	Considerations around water supply to the East Coast affected Mr Raihania's whānau/Iwi.	As his interest was of a general nature, the Board agreed both members were allowed to remain for the discussion and vote on the matter.

Board Member	Transaction / Matter	Conflict Arising	Nature of Conflict/s	Board Response / Action
Hiki Pihema	Item 9.1 Havelock North Enquiry Stage 2	Ms Pihema has close ties and resides within the East Coast Community	Considerations around water supply to the East Coast affects Ms Pihema and her Iwi.	As her interest was of a general nature, the Board agreed both members were allowed to remain for the discussion and vote on the matter.
Hiki Pihema	Item 13.3 Hospice Tairāwhiti and Gisborne Hospital Childcare Centre Leases Update	Ms Pihema had a staff member closely involved with the negotiations	Ms Pihema had been privy to information outside of the Board's consideration.	Ms Pihema excused herself from the meeting during this discussion.
Feb-18				
Gavin Murphy	Mātai Lab	His role as Chief Executive of Eastland Community Trust	Matai Lab are seeking funding support from Eastland Community Trust for their venture.	The Board agreed that Mr Murphy could stay for the discussion but nto take part in the decision.
Apr-18				
Hiki Pihema	Item 8.2 Progress on Annual Plan (faster Cancer Treatment/ Living Well with Diabetes and Stroke	In respect to her role as a Dietician working for Hauora Tairāwhiti.	The Hauora Tairāwhiti Annual Plan outlines plans for service provision for the following financial year.	The Board agreed no conflict existed and she was asked to remain and contribue to discussion.
2017/18				
Hiki Pihema	Staffing & Governance	In respect to her role as a member of staff.	Staffing & Governance Committee report to the Board their evaluation of the Chief Executive's performance during the year.	Ms Pihema excused herself from all four of these Board discussions throughout the year.

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 Whiti Timutimu (TWON)
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
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 Huhana Rokx-Potae (TWON)
Te Waiora o Nukutaimemeha (TWON)	**Na Raihania (Chair)** Josh Wharehinga	Molly Para Maaka Tibble Lois McCarthy-Robinson Whiti Timutimu Na Raihania (TRONP) Angus Ngarangioue (TROTAK) Huhana Rokx-Potae (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

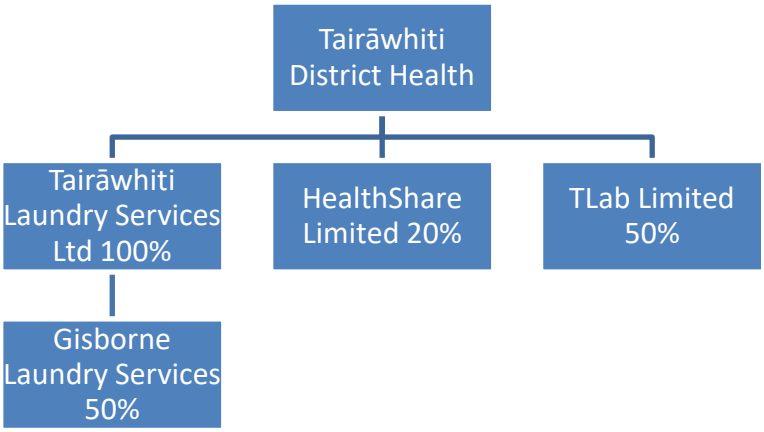
The Clinical Governance Committee oversees the quality improvement environment at Hauora Tairāwhiti reporting through the Chief Executive to the Board on patient safety matters and clinical quality improvement. Through these mechanisms, the Board guides the overall setting of the Hauora Tairāwhiti Quality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

We present you here the results for the measures and standards as provided in our Statement of Performance Expectations.
To perform our functions well the actions we take must:

- Help deliver our outputs
- Make the impacts we intend
- Contribute to the achievement of our outcomes

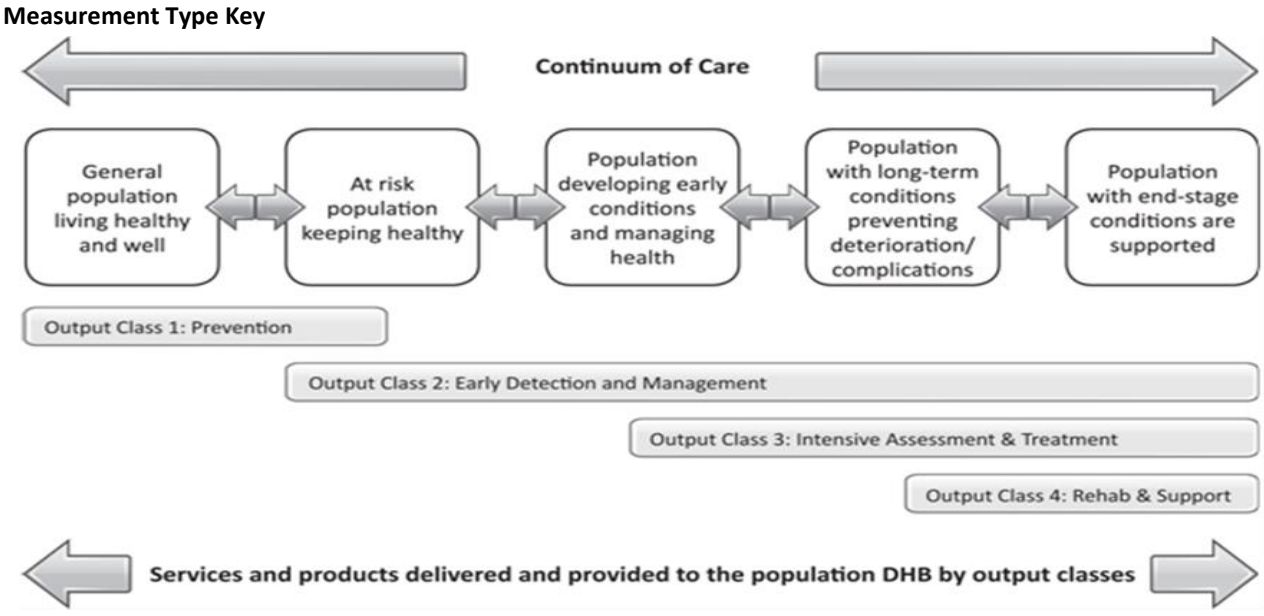
The measures chosen are a mixture of indicators of quantity, quality and timeliness in our priority areas. The measures and targets are outlined in our Statement of Forecast Service Performance for 2017/18[1] with the following section presenting the results achieved against the identified targets.

Structure of this section

The map on the next page shows the linkages between the 4 output classes below and four high level outcomes for Hauora Tairāwhiti. 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

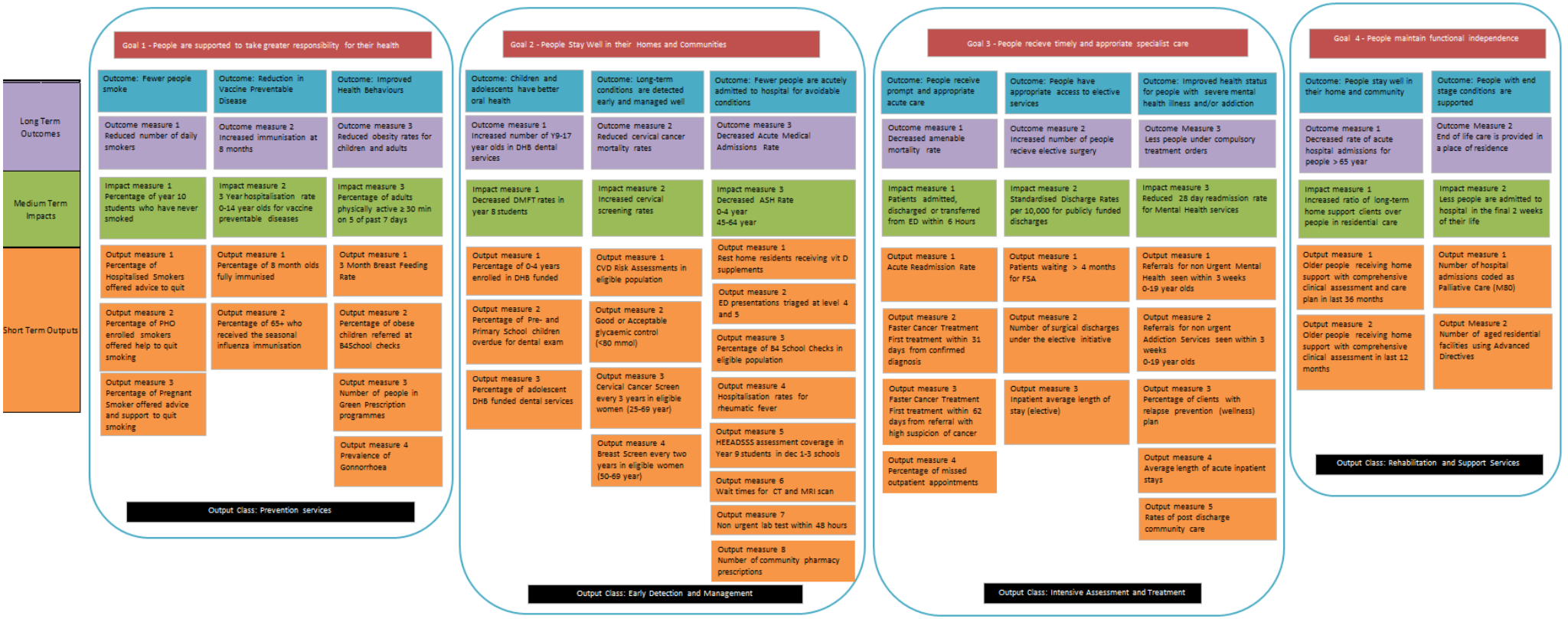
Outputs are goods and services that are supplied to someone outside our DHB. Output classes are an aggregation of outputs, or groups of similar outputs of a similar nature. The output classes used in our statement of forecast service performance are also reflected in our financial measures. The four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



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

[1] 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



2017/18 Performance Overview

The results displayed in the following section are reflective of the dedication of staff throughout all areas of the health system in Tairāwhiti. Each of the indicators below relies on input from primary, secondary and community health providers and aspects working together.

Output class: 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. We know however this is a long process that needs maintained effort to reach long term results.

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

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, poor nutrition, inactivity 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.

2017/18 Prevention Services Performance

Compared to 2016/17, 2017/18 saw an increase in the number of obese children who were identified at the before school checks and offered a referral to a health professional for clinical assessment and family-base nutrition, activity and lifestyle interventions, than in previous years. 2017/18 has also seen an increase in the number of people 65 years and over receiving seasonal influenza immunisation, and a significant decrease in the prevalence of gonorrhoea. Rates for gonorrhoea have been high for a long time and therefore our local target remains higher than the national target.

Local midwifes reached the target of offering >90% of smoking pregnant women help to quit. We hope this result can be an incentive to continue inspiring smoking pregnant women in Tairāwhiti to quit, even for the length of the pregnancy, especially in Māori.

In spite of ongoing efforts from all partners in maternity and early childhood care, the percentage of children exclusively/fully breastfed at 3 months has declined. Most mothers do start breastfeeding, and high rates of babies are exclusively breastfed at discharge from maternity, but we see a big drop off around 6 weeks. This area will be addressed in 2018/19, through more community support for these mums to help them to continue breastfeeding for longer.

Unfortunately, we did not succeed in reaching the immunisation target for 8 month old babies, with the percentage of children reached declining for all ethnicity groups. It remains hard to convince certain sub groups

within the population of the benefits and safety of vaccination. The importance of herd immunity in reducing hospitalisations for vaccine preventable diseases can't be neglected. We have plans to address this in 2018/19.

We also saw a decline in the number of people participating in the Green Prescription programmes, which is another area of focus in 2018/19.

OUTCOME MEASURES - Long Term[2]

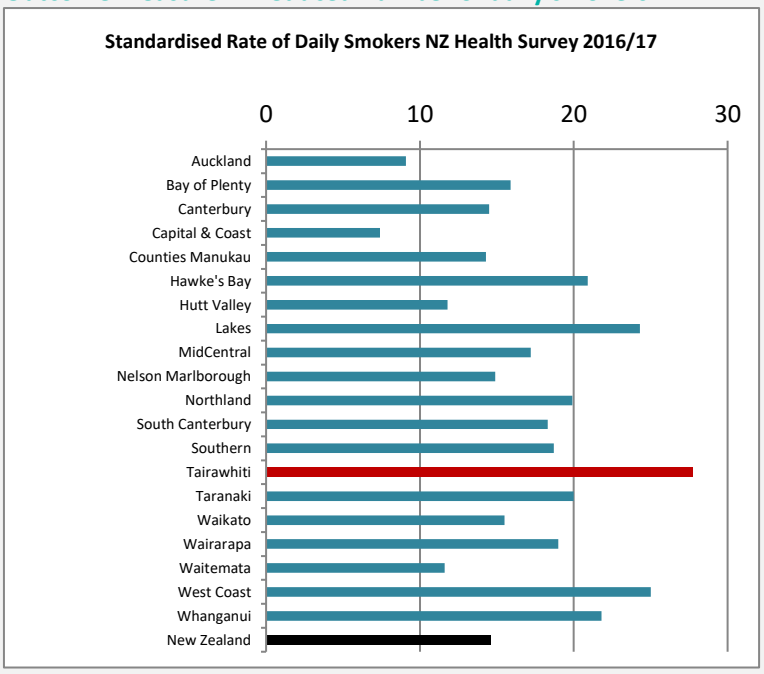
Outcome: Fewer people smoke

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 inequities in the health of our population.

Outcome measure 1: Reduced number of daily smokers



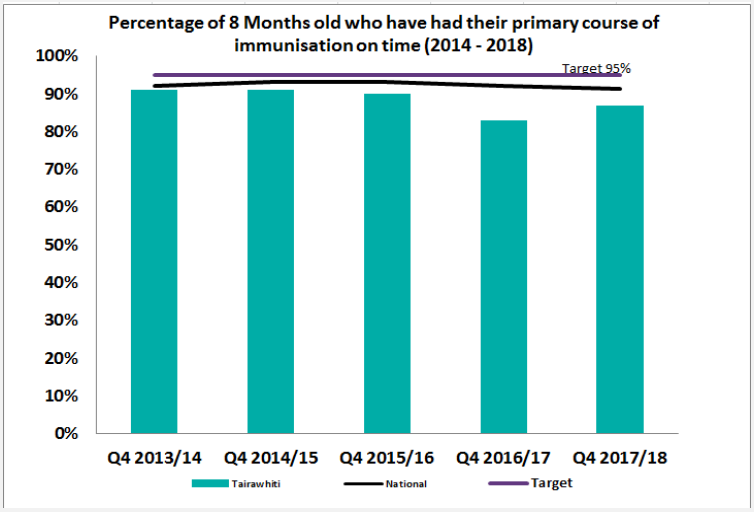
Data source: 2016/17 New Zealand Health Survey

Outcome: Reduction in Vaccine Preventable Disease

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 2013/14	Q4 2014/15	Q4 2015/16	Q4 2016/17	Q4 2017/18	Target
Tairawhiti	91%	91%	90%	83%	87%	95%
National	92%	93%	93%	92%	91%	95%

Outcome measure 2: Increased immunisation at 8 months (HT)



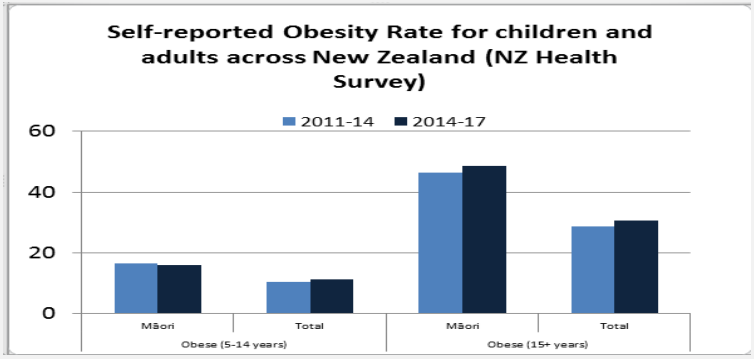
Data Source: Health Targets Q4 2017-2018

[2] Other entity information is unaudited

Outcome: Improved 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. We aim for 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.

Outcome measure 3: Obesity Rates for Children and Adults decrease



Data Source: 2016/17 New Zealand Health Survey. Breakdown by ethnicity only for congregated years.

IMPACT MEASURES – Medium Term[3]

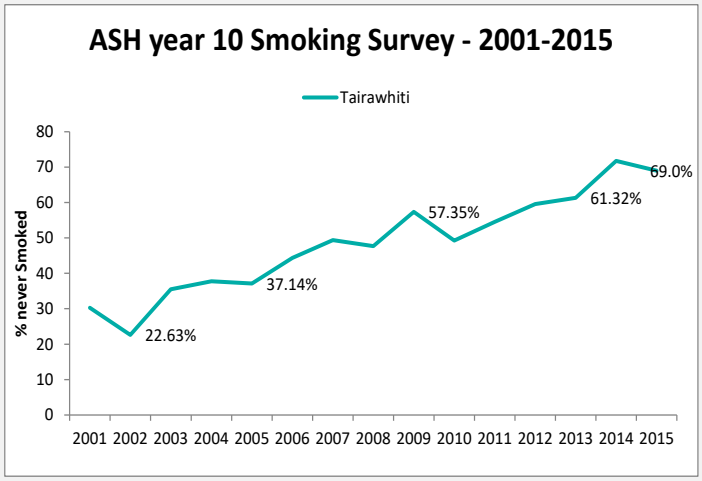
Outcome: Fewer People Smoke

We see the highest prevalence of smoking among younger people, so preventing young people from taking up smoking is a key contributor to reducing smoking rates across the total population. Because the Māori and Pacific population groups 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.

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

Impact measure 1: Percentage of year 10 students who have never smoked



Data Source – ASH New Zealand 2015. National Year 10 ASH Snapshot Survey. ASH data has not been recorded since 2015.

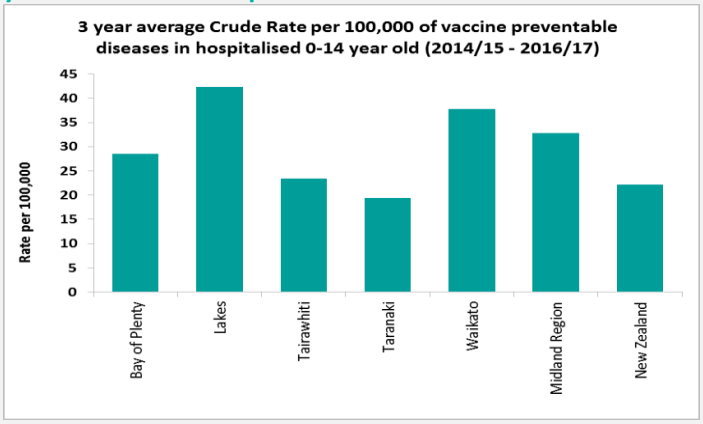
[3] Other entity information is unaudited

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 region	New Zealand
15/16	17.38	34.97	31.41
16/17	25.88	38.04	25.10
17/18	44.05[4]		

Impact measure 2: Three year hospitalisation rate for 0-14 year olds for vaccine preventable diseases

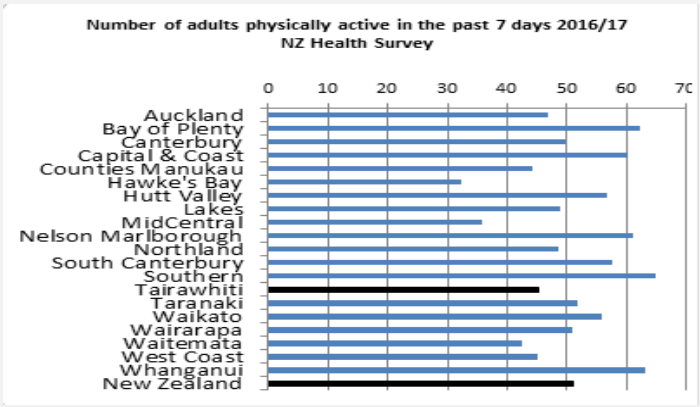


Data Source :National Minimum Data Set

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 their weight. But physical activity is beneficial in many other ways as well. People feel fitter, have more energy, and report improved sleeping quality and lower stress levels. 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.

Impact measure 3: Percentage of adults physically active for 30 minutes or more on 5 of past 7 days



The 2016-17 NZ Health Survey contains the most recent DHB level data.

[4] 5 admissions 0-14 year olds for ICDAM Diagnostic Codes A33-37 in 2017/18. 11,350 pop 0-14 year old.
The following diagnostic codes are defined as being vaccine preventable: tetanus, diphtheria, whooping cough, polio, hepatitis, measles, rubella and mumps (A33-37, A403,A80,B16,B18,B05,B06,B26 (excluded were M014 (Rubella arthritis) and P350(congenital rubella))

OUTPUTS – Short Term Performance Measures

Outcome: Fewer people smoke

Outcome Measure		Measure Type	2015/16 Result	2016/17 Result	2017/18 Target	2017/18	Latest NZ Result	Trend
Percentage of hospitalised smokers offered advice to quit (PP31)[5]	Māori	**δ/τ**	98%	96%	≥95%	96%	94%	➲
	Non Māori	**δ/τ**	98%	95%		94%	94%	ⓤ
	Total Pop	**δ/τ**	98%	96%		95%	94%	ⓤ
Percentage of PHO enrolled smokers offered help to quit smoking by a health care practitioner in the last 15 months (Health Target & SLM)	Māori	**δ/τ**	Not reported ethnically		≥90%	85%[6]	87%	
	Non Māori	**δ/τ**				90%	90%	
	Total Pop	**δ/τ**	92%	93%		88%	89%	ⓤ
Percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered advice and support* to quit smoking (Health Target)	Māori	**δ/τ**	88%	88%	≥90%	92%	91%	ⓝ
	Non Māori	**δ/τ**	87%	96%		100%	90%	ⓝ
	Total Pop	**δ/τ**	87%	90%		93%	91%	ⓝ

* Measure is % of smokers that were offered Advice as reported in HT5.

Outcome: Reduction in Vaccine Preventable Disease

Indicator		Measure Type	2015/16 Result	2016/17 Result	2017/18 Target	2017/18 Result	Latest NZ Result	Trend
Percentage of 8 month olds fully immunised (Health Target, SLM) (12 months figure)	Māori	**τ/Ω**	91%	85%	**≥95%**	83%	82%	ⓤ
	Non Māori	**τ/Ω**	94%	92%		89%	91%	ⓤ
	Total Pop	**τ/Ω**	92%	88%		85%	89%	ⓤ
Percentage of people >65 years who have received the seasonal influenza immunisation (PP21)	High Needs[7]	**τ/Ω**	53%	52%	**≥75%**	46%	49%	ⓤ
	Total Pop	**τ/Ω**	52%	52%		53%	53%	ⓝ

[5] Previous Health Target, and mentioned as such in 2017/18 Statement of performance expectations. Indicator reported on is 'Offered brief advice', not 'offered support to quit'

[6] Smoking Cessation figures Primary Care not available by ethnicity until Q3 1718.

[7] People over 65 who are of Pacific or Māori ethnicity and/or live in deprivation area 9-10.

Outcome: Improving Health Behaviours

Indicator		Measure Type	2015/16 Result	2016/17 Result	2017/18 Target	2017/18 result	Latest NZ Result[8]	Trend
Previous indicator: Percentage of infants who are exclusively/fully breastfed at 6 Months	Māori	**δ/τ**	54%	55%	**≥59%**	NA	NA	
	Non Māori	**δ/τ**	61%	70%				
	Total Pop	**δ/τ**	61%	73%				
New indicator: Percentage of infants who are exclusively/fully breastfed at 3* Months (PP37)	Māori	**δ/τ**	NA		**≥60%**	43% (Q4 2017)	47% (Q4 2017)	🡻
	Non Māori	**δ/τ**				64% (Q4 2017)	61% (Q4 2017)	🡻
	Total Pop	**δ/τ**				51% (Q4 2017)	58% (Q4 2017)	🡻
* Although Target is for breastfeeding at 6 months, the national reporting is for breastfeeding at 3 months (PP37). That is why this is reported here. All published data are preliminary. Only for last Quarter of 2017 numbers are available, so no % could be calculated for the whole year of 2017.								
Raising healthy kids Percentage of obese children identified in the B4 School Check Programme who are offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions (HT)	Māori	**δ/τ**	NA	66%	**≥95%**	**89%**	98%	🡹
	Non Māori	**δ/τ**		100%*		**100%**	98%	🡺
	Total Pop	**δ/τ**		66%		**92%**	98%	🡹
*no result for non-Māori for 6 months period 8/06/2016-07/12/2016								
The number of people participating in the Green Prescription programmes	Total Pop	**δ/τ**	1013	1101	**≥1024**	**914**	51,000[9] (2016/17)	🡻
Reduce the prevalence of gonorrhoea (Local Indicator) *figures till 31/12/2017	Total Pop	**δ/τ**	229 per 100,000	259 per 100,000	**≤72 per 100,000**	106 per 100,000	100 per 100,000	🡻

[8] Growing up in New Zealand 2017. http://www.growingup.co.nz/en/news-and-events/news/news-2017/new-research-gives-unique-insight-into-breastfeeding-in-new-zeal.html

[9] https://www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/surveys/new-zealand-health-survey/improving-health-new-zealanders

Output class: 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. Increase 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

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 care path, particularly in improving the management of care for people with long-term conditions.

A range of other health professionals support primary care 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 against a lower cost than countries with systems that focus on specialist level care.

2017/18 Early Detection and Management Services Performance

In 2017/18 we saw the continuation of improvements in a number of service areas. Our school and preschool dental services continue to reach more children. Virtually all children 0-4 are now enrolled in DHB funded services, well in excess of the 90% target. This increase can lead to improved diseased, missing, filled permanent teeth (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. The increased number of children overdue for their dental examination however needs further follow up, as we have seen a large decrease on the previous year.
More rest home residents receive vitamin D supplements, an effective preventative measure for at risk elderly, in preventing falls. Literature shows that rest home residents are particularly at risk of vitamin D supplements because of less exposure to sunlight. While we were not able to report on this indicator last year we have been able to obtain this year's rates.

Timely access to assessment and treatment can significantly improve people's quality of life. All non-urgent community laboratory tests for example, were completed and the results communicated to the health practitioners within 48 hrs (target). But, unfortunately we saw a decrease in the percentage of eligible children who had their B4 School Checks completed, especially in non-Māori. We will investigate why this occurred and the potential reasons for this in order to address this issue in 2018/19.

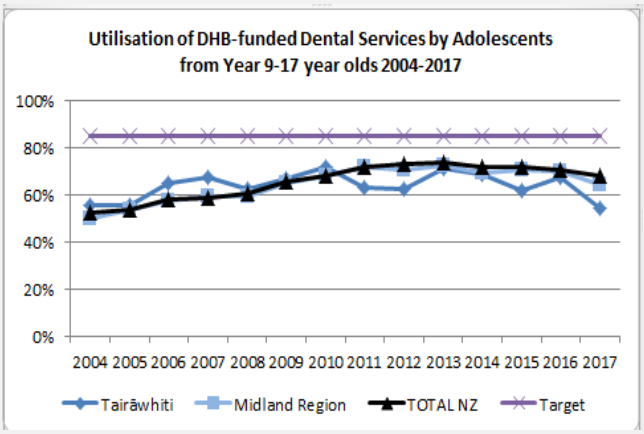
We had four hospitalisations for acute rheumatic fever in 2017/18 (three new cases). Due to the relatively small size of our population, this results in a significant increase of the rate. All services are alert on picking up possible cases and aware of the pathway to follow, and work closely addressing the known risk factors.

OUTCOME MEASURES - Long Term[10]

Outcome: Children and adolescents have better oral health

We did not succeed in increasing the number of adolescents, in school Year 9 (13/14-year olds) up to and including 17 years of age, accessing DHB-funded oral health services. The decrease in DMFT at Year 8 however shows that the DHB has made an impact of promoting good oral health, by providing accessible publicly-funded adolescent oral health programmes. The programmes 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.

Outcome measure 1: Increased number of Y9 – 17 year olds enrolled in DHB funded dental services



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

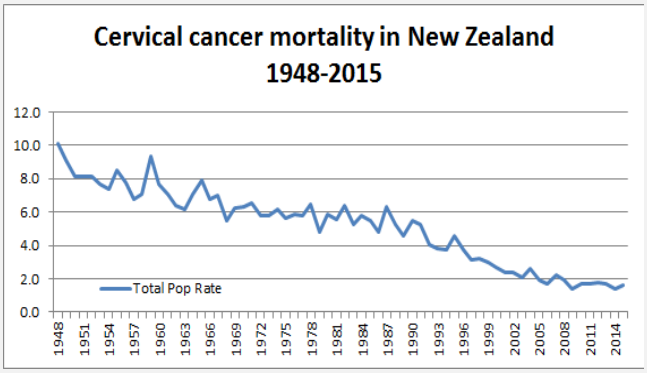
Outcome: Long-term conditions are detected early and managed well

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 seen the number of women who die from cervical cancer dropping by 60 per cent since 1990 thanks to the screening programme. But still about 50 women die from it each year[11]. To continue this decline we need to increase our cervical screening rates to ensure cell changes are picked up at a treatable stage.

Rates per 100,000	2011	2012	2013	2014	2015
Total Population	1.7	1.8	1.7	1.4	1.6
Māori	5.4	3.7	4	3	3.6

New Zealand cervical cancer mortality

Outcome measure 2: Reduced cervical cancer mortality rates



Source: Ministry of Health: Cancer Historical Summary 1948-2015.

Outcome: Fewer people are acutely admitted to hospital for avoidable conditions

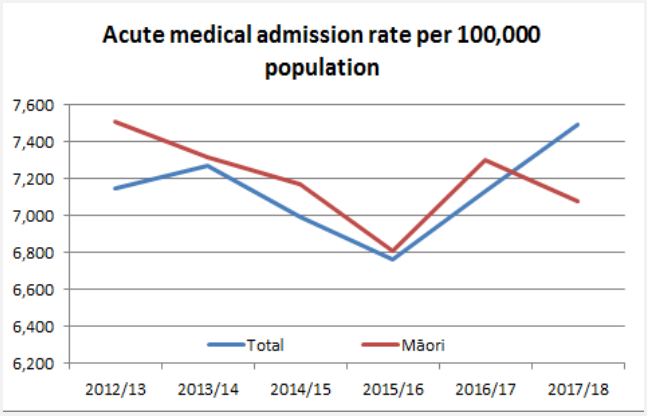
International research has shown around 14% of acute admissions could have been prevented through better management of conditions in primary and community settings. To achieve our outcome of people staying well in their homes and communities, seamless flow through the health system is required. This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

Outcome measure 3: Decreased Acute Medical Admissions Rate

[10] Other entity information is unaudited

[11] https://www.health.govt.nz/your-health/conditions-and-treatments/diseases-and-illnesses/cervical-cancer

be achieved when the rate of admissions for acute medical conditions decreases.



Data Source: Hospital Reporting – Inpatient discharges

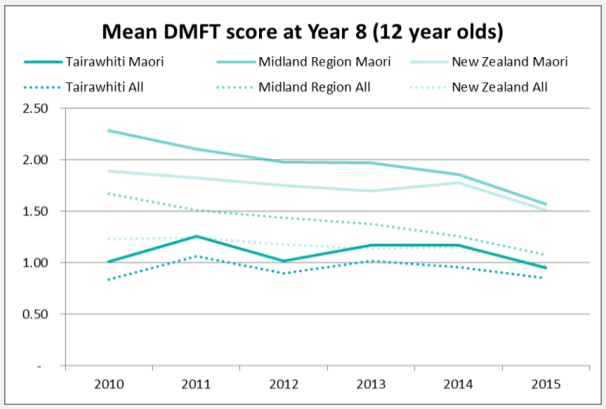
IMPACT MEASURES – Medium Term[12]

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. DMFT is a count of decayed, missing or filled teeth in permanent dentition in a person's mouth. Around Year 8, children usually have lost their baby 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.

	2015	2016	2017
Tairāwhiti Māori	0.95	1.13	0.96
Tairāwhiti All	0.85	0.94	0.82
Midland Māori	1.57	*	
Midland All	1.08	*	
NZ Māori	1.51	1.34	
NZ All	0.97	0.87	
Target			0.99

Impact measure 1: Decreased Rate of Diseased Missing Filled Teeth in year 8 students (PP10)

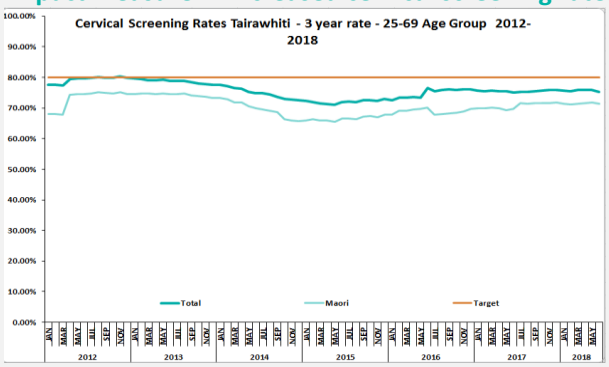


Data Source: Ministry of Health Performance Reporting

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.

Impact measure 2: Increased cervical screening rates



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

[12] Other entity information is unaudited

Outcome: Fewer people are admitted to hospital for avoidable conditions

There are a number of hospital admissions 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.

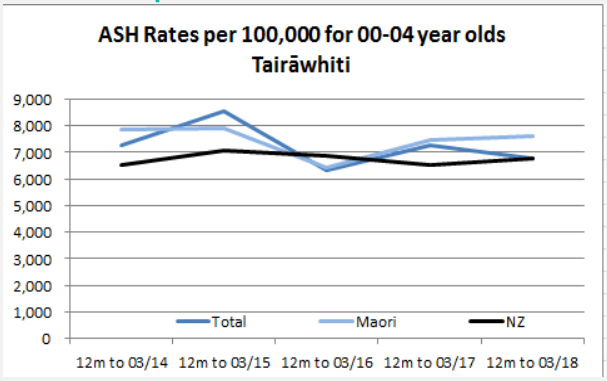
ASH rates for 12 months period to 31/03

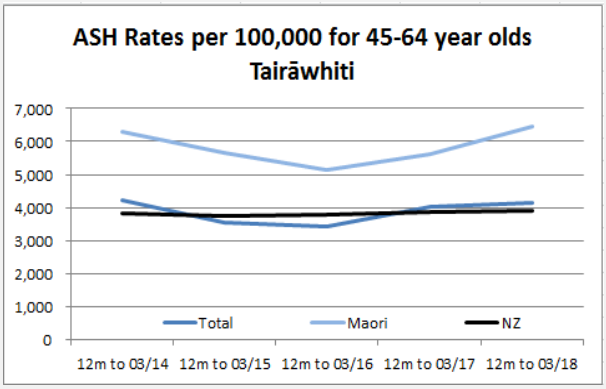
00-04	13/14	14/15	15/16	16/17	17/18
Māori	7876	7899	7470	7470	7589
Non Māori	5969	6160	6160	6803	4937
Total	7242	8538	6323	7253	6748

45-64	13/14	14/15	15/16	16/17	17/18
Māori	6280	5647	5150	5623	6441
Non Māori	2894	2191	2316	2946	2622
Total	4209	3544	3447	4031	1464

Tairāwhiti ASH rates 2013-18

Impact measure 3: Decreased rate of ambulatory sensitive hospital admissions





Data Source: Ministry of Health Performance Reporting

OUTPUTS – Short Term Performance Measures

Outcome: Children and adolescents have better oral health

Indicator		Measure Type	2015/16 Result	2016/17 Result	2017/18 Target	2017/18 result	Latest NZ Result	Trend
Percentage of Children (0-4) enrolled in DHB funded dental service (PP13a)	Māori	Ω	93%	96%	≥ 90%	104%		↑
	Total Pop	Ω	95%	101%		107%		↑
Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination (PP13b)*	Total Pop	τ	5%	6%	≤10%	13%	15%	↑
Percentage of adolescent utilisation of DHB-funded dental services (PP12)	Total Pop	Ω	54%	67%	≥85%	55%	68%	↓

* For the year ending 31 December 2017

Outcome: Long term conditions are detected early and managed well

Indicator		Measure Type	2015/16 Result	2016/17 Result	2017/18 Target	2017/18 Result	Latest NZ Result	Trend
Percentage of eligible population will have had their cardiovascular risk assessed in the last 5 years (Health Target, PP20, SLM)	Māori	δ	91%	90%	≥90%[13]	89%	86%	↓
	Non Māori	δ	94%	93%		93%	89%	→
	Total Pop	δ	92%	92%		91%	89%	↓
Improve the proportion of patients with good or acceptable glycaemic control (<80 mmol) (PP20)	Total	Ω	71%	67%	≥90%	52%*	NA	↓
* Q4 2017/18. Total pop as PHO's did not give numbers for 15-74 age groups								
Percentage of eligible women (25*-69) have a Cervical Cancer Screen every 3 years (SLM, SI10)	Māori	δ/τ	70%	70%	≥75%	71%[14]	67%	↑
	Non Māori	δ/τ	85%	80%		79%	74%	↓
	Total	δ/τ	78%	75%		75%	73%	→
*Reporting group is 25-69 now, not 20-69 as for previous years.								
Percentage of eligible women (50-69) who have had a Breast Screen in the last 2 years	Māori	δ/τ	67%	69%	≥70%	67%	65%	↓
	Non Māori	δ/τ	71%	72%		72%	72%	→
	Total	δ/τ	70%	71%		70%	73%	↓

Outcome: Fewer people are admitted to hospital for avoidable conditions

Indicator		Measure Type	2015/16 Result	2016/17 Result	2017/18 Target	2017/18 Result	Latest NZ Result	Trend
Percentage of rest home residents receiving vitamin D supplements[15]	Total Pop	Ω	84%	71%[16]	≥70%	75%	67%	↑
Percentage of all Emergency Department presentations who triaged at level 4 & 5	Total Pop	Ω	65%	68%	≤50%	67%	67%	↓
Percentage of eligible population who have their B4 School Checks completed	High Needs	δ/τ	102%[17]	96%	≥90%	95%	92%	↓
	Total Pop	δ/τ	95%	97%		93%	92.5%	↓
Hospitalisation rates per 100,000 for acute rheumatic fever (PP28)	Total Pop	δ/τ	4.2	2.1	≤2.8**	8.3	3.4[18]	↑

*All Rheumatic fever cases are reported through the hospital. Therefore it is no longer necessary to report on incidence and hospitalisation separately. We had three new cases of Rheumatic fever, and one reoccurring.

**Although the national target is 1.4, the local target is still higher as our region historically has a high incidence of rheumatic fever.

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

[14] Coverage in eligible women (25-69) in the three years ending 30/06/2018.

[15] https://public.tableau.com/profile/lisa.hunkin#!/vizhome/LiveStrongerforLongerFallsFracturesOutcomesFramework/Landing

[16] This data was not reported on in 2016/17 as we had no longer access to this data. Since January 2018, the HQSC has been reporting this indicator again and also released the 2016/17 rate.

[17] 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.

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

Indicator		Measure Type	2015/16 Result	2016/17 Result	2017/18 Target	2017/18	Latest NZ Result	Trend
Increased coverage numbers of Year 9 students receiving HEEADSSS assessment in decile 1-3 schools (not reported ethnically) (PP25)	Total Pop	δ/τ	551	656	≥650	542	NA	↓
Improved wait times for diagnostic services - accepted referrals for CT and MRI receive their scan within 6 weeks[19] (PP29)	CT Scans	Ω	91%	97%	≥85%	92%	85%	↓
	MRI Scans	Ω	89%	98%	≥90%[20]	85%	58%	↓
Non urgent community laboratory tests are completed and communicated to practitioners within the relevant category timeframes (48 hrs)	Within 48 hours*	τ/Ω	100%	100%	100%	100%	NA	→
Number of community pharmacy prescriptions	Total Pop	δ	460,460	481,595	450,000	475,732	NA	↓

[19] Data Q4 1718 have not published yet as per 08/08/18.

[20] National Target was 90%. In the AP2017/18, the targets were incorrect, and were therefore corrected here.

Output class: 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.

Goal 3 - People receive timely and appropriate specialist care

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 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 with limited resources under increasing demand and workforce pressure. Reducing the waiting times diagnostic tests, cancer treatment and elective surgery requires organisational and clinical innovation.
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.

2017/18 Intensive assessment and treatment services performance

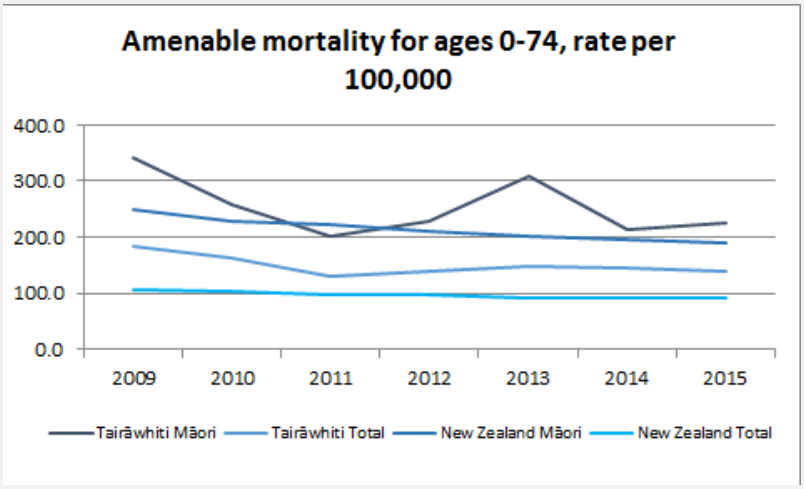
In the past year, we saw the time young people wait for mental health treatment decrease, with 71% of 0-19 year olds seen within 3 weeks. Continued effort is necessary to reduce the waiting times for youth addiction services to a similar level. A big improvement was made in the Faster Cancer Treatment health target with 88% of patients with a high suspicion of cancer receiving their first cancer treatment within 62 days, just below the 90% target.
While the average length of inpatient stay further decreased to 1.41 days, it unfortunately went along with an increase in the number of acute readmissions. As these two indicators are often intertwined, further investigation is required into the influencing factors to allow us to target the right balance..
Please note that the mental health indicator 'Improving the percentage of long-term clients with up to date relapse prevention/treatment plans* (Policy Priority 7) has been changed as it now includes all mental health clients, not just those in long-term care or the under 20's. This indicator is not reported on by ethnicity, so we can only report a total population figure.

OUTCOME MEASURES – Long Term[21]

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 manageable 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. Although local rates follow the national decrease, they remain well above the national level.

Outcome measure 1: Decreased amenable mortality rate (SI9, SLM)



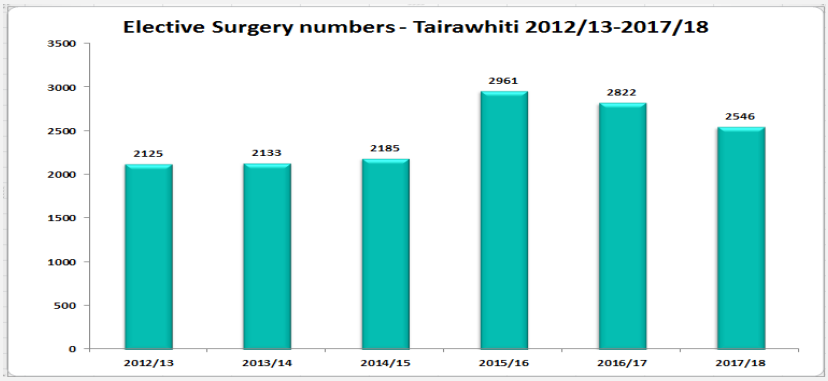
Data source: Amenable mortality SLM Data

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.

Outcome measure 2: Increased number of people recieve elective surgery (HT)

Data Source: Ministry of Health Performance Reporting

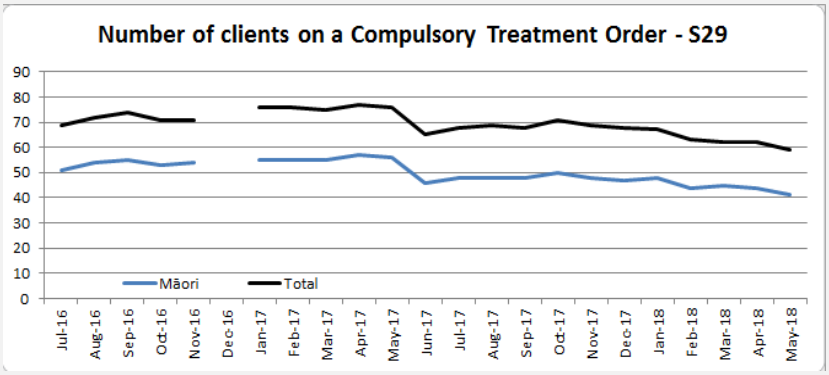


Outcome: Improved access to Mental Health services

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. We work to reduce the high suicide rate and support our communities. By stimulating earlier access to mental health services and better access to community mental health services, we hope to see the number of people needing

Outcome measure 3: Reduce the number of Māori subject to compulsory treatment orders under section 29 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (PP36).

Data Source: Ministry of Health Performance Reporting



[21] Other entity information is unaudited

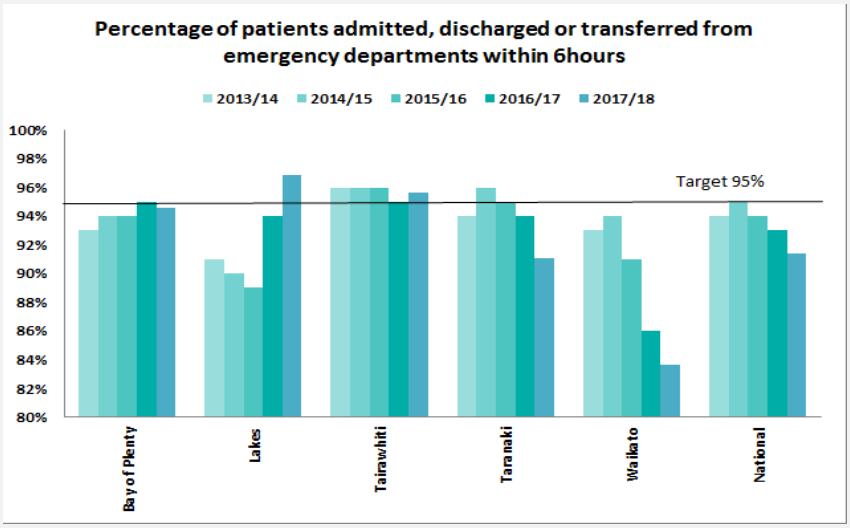
compulsory treatment decrease. For the future, we aim for a mental health care free of compulsory treatment and seclusion as these are a huge infringement of a person's freedom. This however, will need to be a long term goal as many factors contribute here.

IMPACT MEASURES – Medium Term[22]

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 our population.

Impact measure 1: Patients admitted, discharged or transferred from ED within 6 hours (HT)



Data Source: MOH – non financial reporting – HT1 - Q4 results

[22] Other entity information is unaudited

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 Tairāwhiti receive prompt and appropriate care when they need it.

Impact measure 2: Standardised Discharge Rates per 10,000 for publicly funded discharges

Procedure*	2014/15 Result	2015/16 Result	2016/17 Result	2017/18 Result	2017/18 Target
Cardiac Surgery	6.60	6.24	6.91	6.84	6.5
Major Joint Replacement	27.80	27.33	23.51	27.47	21
Cataract Procedures	25.56	36.91	22.27	31.10	27
Angioplasty	9.38	8.40	11.08	10.22	12.5
Coronary Angiography	26.24	28.53	32.06	29.23	34.7

*All rates as at 31 March

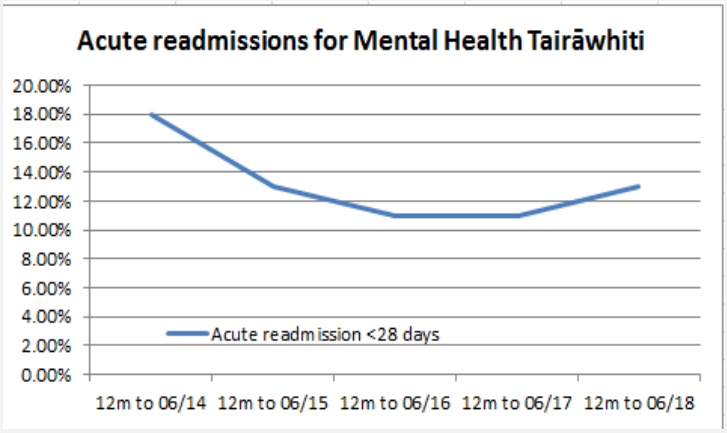
Data Source: Ministry of Health Performance Reporting

Outcome: Improved access to Mental Health services[23]

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.

Impact measure 3: Reduced 28 day acute readmission rate for Mental Health services



Data Source: Local Mental Health Dashboard

[23] Other entity information is unaudited

OUTPUTS – Short Term Performance Measures

Outcome: People receive prompt and appropriate acute care

Indicator		Measure Type	2015/16 Result	2016/17 Result	2017/18 Target	2017/18 Result	Latest NZ Result	Trend
Acute Readmission rate (OS8)	Total Pop	δ/τ/ Ω	6.40%	6.50%	≤6%	11%	12%	↑
*Readmission within 28 days. Standardised rate as at 31 March 2018[24]								
Faster Cancer Treatment – Proportion of patients with a confirmed diagnosis of cancer who receive their first cancer treatment within 31 days of diagnosis (PP30)	Total Pop	δ/τ	86%	89%	100%	88%	89%	↓
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%	77%	≥90%*	88%	91%	↑
* Target in statement of performance expectations was ≥85%, but this target was augmented to ≥90% nationally since 01/07/2017								
Percentage of missed outpatient appointments	Māori	δ/τ	16%	17%	**≤10%**	18%		↑
	Non Māori		8%	5%		6%		↑
	Total		12%	11%		11%		➲

Outcome: People have appropriate access to elective services

Indicator		Measure Type	2015/16 Result	2016/17 Result	2017/18 Target	2017/18 Result	Latest NZ Result	Trend
Percentage of patients waiting longer than four months for their first specialist assessment (Elective Service Performance Indicator 2)[26]		δ/τ	1%	4.8%	0%	19.9%[27]		
Number of surgical discharges under the elective initiative (Health Target)		δ	2961	2822	≥2574	2,546 [28]	202,519	↓
Inpatient average length of stay (elective) (Ownership Dimension 3)	Total Pop	δ/τ	1.39	1.57	≤1.59 days	1.41[29]	1.56	↓

[24] Ministry of Health – Non financial quarterly report 2017/18 Q4– OS8 – Acute readmissions to hospital. http://www.moh.govt.nz/apps/dhbq.nsf/0/8bb747e9b0ac0440cc2582a20075be78/$FILE/ACR_DHB_Rpt_2018Q1_(30APR2018)_forQ4.xlsx

[25] Hospital reporting – Outpatients 201718.

[26] Ministry of Health website – Elective Services Patient Flow Indicators (ESPIs) https://www.health.govt.nz/system/files/documents/pages/february-2018-espi2.xls

[27] Number of patients waiting in June 2018.

[28] Tairawhiti DHB 201718 Electives Initiative Report – Health Target Result

[29] Q4 result year ending 31/03/2018

Outcome: Improved health status for people with severe mental illness and/or addictions

Indicator		Measure Type	2015/16 Result	2016/17 Result	2017/18 Target	2017/18 Result	Latest NZ Result	Trend
Percentage of people referred for non-urgent mental health or addiction services are seen within 3 weeks (PP 8) **Mental Health 0-19 yr olds**		δ/τ	67%	56%	≥80%	71%	69%	↑
Percentage of people referred for non-urgent mental health or addiction services are seen within 3 weeks (Policy Priority 8) **Addictions 0-19 yr olds**		δ/τ	70%	72%	≥80%	56%	84%	↓
Previous indicator: Improving the percentage of long-term clients with up to date relapse prevention/treatment plans* (PP7) 0-19 yr olds	Māori	Ω/δ/τ	NA	85%	≥95%	NA	NA	
	Non-Māori			86%				
	Total			86%				
Previous indicator: Improving the percentage of long-term clients with up to date relapse prevention/treatment plans (PP7)* 20+ yr olds	Māori	Ω/δ/τ	80%	measure no longer reported nationally			NA	
	Non-Māori		95%					
	Total		95%					
New indicator: Improving the percentage of clients with wellness plan (PP7)*				NA	≥95%	76%		

* Measure looks at entire population now, there is no age breakdown. It also no longer looks at long-term clients only.
Relapse prevention/treatment plan is reported as 'Wellness Plan" as also in the PP7 Performance measure 'Improving the health status of people with severe mental illness using wellness and transition (discharge) planning' in our 2017/18 Annual Plan.
Due to paper based files and recording issues with a number of mental health teams this is not complete. Audits reveal that a significantly higher proportion of clients discharged have a transition plan than what is recorded.

Average length of acute inpatient stays (KPI 8)	Ω/δ/τ	16 days	18 days	≥14 days[30]	20 days	NA	↑
Rates of post-discharge community care (KPI 18)	Ω/δ/τ	55%	53%	≥90%	42%	NA	↓

[30] Target in the local MHA Dashboard is 15-21 days

Output class: REHABILITATION AND SUPPORT SERVICES

Goal 4 – People maintain functional independence

The vision of the New Zealand Healthy Ageing Strategy is for older people to leave well, age well and have a respectful end of life in age-friendly communities. The constant evolution of medical sciences has allowed more people to live longer as more conditions can be cured and controlled. As people live longer, they often experience the effects of chronic conditions. Healthy ageing therefore, this has not equally increased the quality of life in those extra years. For many people with chronic conditions, their quality of life is impacted significantly. We need to focus on adding more quality to those gained years. An important factor for people in their quality of life is to stay in control, to remain as independent as possible.

Clinicians, in cooperation with patients and their families, make decisions regarding treatment and care. Not all decisions should 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.

As illness and disability effect an individual's functions, we need to support them in a way that maintains these functions as long as possible at the highest possible level. Support should be tailored to the individual's needs and evolve seamlessly with the changing functional abilities of that person. Regularly assessing these needs is a prerequisite for this. The interRAI assessment offers a very good picture of remaining functionality and support needs. The interRAI home care assessment is a prerequisite for home support, so all people receiving home support are assessed before they come into care. The care plan is an intrinsic part of this assessment. And this is how the indicator originally was interpreted. This does however not necessarily mean that people who remain in care longer are reassessed after that first assessment. For long-term home support clients, an assessment is required every three years, or if there is a significant change in their condition. Therefore, we changed the indicator to 'Percentage of older people receiving long-term home support who have had a comprehensive clinical assessment and a completed care plan in the last 36 months'. Analysis of the interRAI data shows us that indeed all home support clients have at at least one inter RAI assessment in the last three years. We added the 12 months indicator as well, as this shows us how many people receiving home support, were assessed in the last year. The 33% result here shows that indeed one out of three home support clients had an assessment in the last 12 months, so we are on track to maintain the 100% for the 36 months indicator. Analysis of the assessments shows that indeed people were reassessed according to changes in their circumstances: after a hospital discharge and if their condition had deteriorated or routinely after they had been receiving home support for almost three years.

In the future, we hope to build a more flexible home support model, based on measured changes in client's needs. However, the time investment required to do an interRAI home care assessment does not allow us to increase the frequency of this assessment. Therefore, we might look possible shorter interRAI assessments that allow measuring a client's support and health needs more frequently. Even if very little functional independence is left, people should be able to stay in control of their life. Advanced care plans are a very valuable instrument to make sure that a person can remain in charge even if he/she can't express his/her wishes anymore.

2017/18 Rehabilitation and Support Services performance

We have seen a number of improvements in this area including all providers of aged residential care now use advanced directives to make sure the wishes of clients regarding their treatment are respected, even if that client is no longer able to make or express these health care choices. We have also continued to achieve the indictor that all clients receiving long term home support had a comprehensive interRAI assessment taken at the start of the support, and have added an additional indicator to ensure that all long term care clients receive an InterRAI assessment at least once every three year.

The number of admissions coded as palliative, remained very low. Health professionals still appear to be reluctant to note the palliative status of a patient's illness. But even for people with a palliative diagnosis, only a fraction of their admissions are coded as being 'palliative'. It could be palliative care is too often constringed to terminal care, restricted to the very last part of one's life, resulting in too many people with end-of life condition dying in hospital.

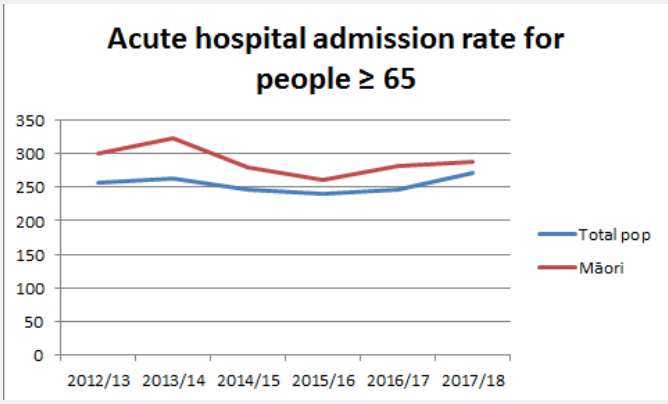
OUTCOME MEASURES – Long Term[31]

Outcome: People stay well in their home and community

Elderly people take up a large part of acute hospital admissions. Hospital admissions are, apart from the financial impact on the Health Care budget, often very disturbing and even dangerous for these vulnerable elderly. Elderly admitted to hospital are at risk of developing delirium, hospital acquired infections, and loss in their capability of daily life activities.

Approximately a quarter of all medical and surgical discharges in older adults were ambulatory sensitive admissions[32]. Some of these admissions could possibly have been avoided by better management of the multipathology of this geriatric population and improved home support. This requires coordinated care between all community partners (GP, Pharmacist, Community nurse, Home Support,..) in combination with secondary care, allied health services, social services and other support agencies.

Outcome measure 1: Decreased rate of acute admissions for people > 65 years



Acute hospital admissions for people ≥ 65 per 100,000 population 65+
Source: Hospital Reporting

Possible interventions[33]:

- Social history patient
- Preventive measures: influenza and pneumococcal vaccination
- Support independence: Fall prevention, Assess nutritional status, vit D supplements,
- Regular medicine review
- Coordination of care

Outcome: People with end stage conditions are supported

When people reach the months and weeks of their life, they have the right to be cared for in a proactive, holistic way.

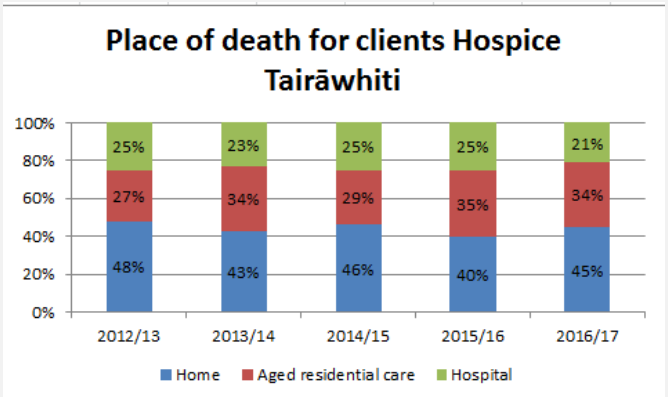
When asked about their wishes regarding end of life, most people say they would like to die at home. Unfortunately too many people still die in hospital.

Hospice Tairāwhiti, provides palliative care and support to make it possible for peope to die in their preferred setting. We see the number of people they care for increasing.

In our aim to provide a safe and serene care setting, it is important to avoid unnecessary hospital admissions, transfers and diagnostics or unhelpful treatment. Focus should be on supporting the quality of the life that is left.

Open and timely discussion about their wishes regarding their end of life (palliative and terminal phase) is of high importance for tailored end of life care later on. This starts with the open recognition of the end stage of their condition by clinicians.

Outcome measure 2: End of life care is provided in a place of residence



Source: Hospice Tairāwhiti Annual Report

[31] Other entity information is unaudited

[32] https://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/atlas-of-healthcare-variation/older-adult-ambulatory-sensitive-hospitalisations/

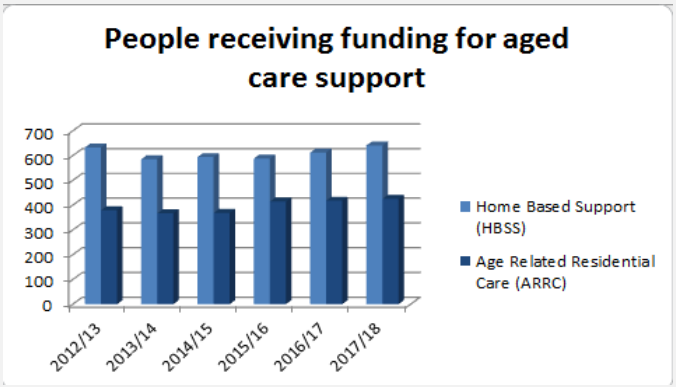
[33] Prevention is better than cure: five tips for keeping older people healthy and out of hospital during winter. Bpac Best Practice Journal, 2015. https://bpac.org.nz/BPJ/2015/June/tips.aspx

IMPACT MEASURES – Medium Term[34]

Outcome: People stay well in their home and community

Most elderly people hope to live in their own home or with whānau in their community for as long as possible. Most of them dread a possible move into residential care. When people's ability to perform every day life activities decreases, they often rely on whānau, neighbours and friends for support. If this is not sufficient or the care for the person becomes too hard for these people, a move into residential care often seems to be the only solution.
Residential care is, apart from not being the home of choice for many elderly, also costly for both the client and his whānau as for the public health system.
By better supporting the vulnerable elderly and his whānau, residential care admission often can be delayed or even avoided. Yearly approximately 6% of our population 65 and over, receive some funding for Aged Related Residential Care (ARRC), and 9% for Home Based Support Services. This proportion has been the same for the last 5 years.

Impact measure 1: Increased ratio of long-term home support clients over people in residential care

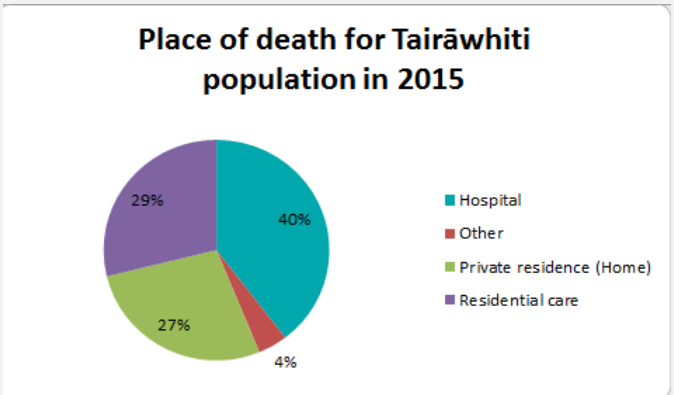


Source – Client Claims Processing System (CCPS)

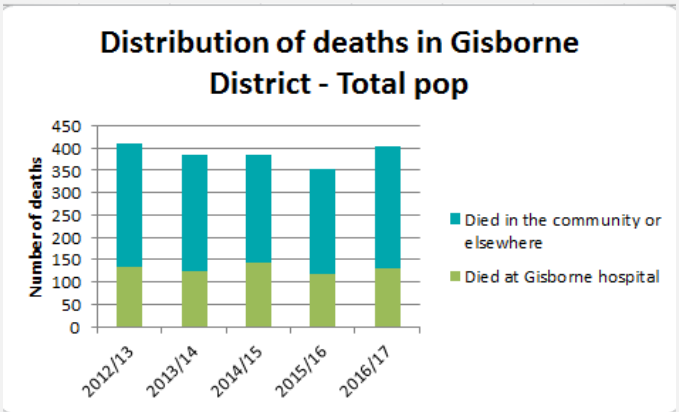
Outcome: People with end stage conditions are supported

International research has shown that, when asked about their own death, most people would prefer to die at home. A lot of people however, are still rushed to hospital in their final days. By stating what matters to them about their end-of life care in an advanced care plan, people can trust that their wishes will be the guideline for their end of life stage, even if they are no longer able to express those wishes.
Providing everyone with the right level of care in their place of residence, will allow more people to also spend their final days there.
Although place of death is recorded on the death certifcate, this is not coded and therefore not reported in the mortality statistics.

Impact measure 2: People can die at home



Source: Chris Lewis , Ministry of Health Analytical Services



Source: Stats NZ Deaths Gisborne Region and Hospital Statistics for hospital deaths

[34] Other entity information is unaudited

OUTPUTS – Short Term Performance Measures

Outcome: People stay well in their home and community

Indicator	Measure Type	2015/16 Result	2016/17 Result	2017/18 Target	2017/18 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 36 months	δ/τ	100%	100%	100%	100%	N/A	
Percentage of older people receiving home support who have had a comprehensive clinical assessment in the last 12 months	Ω	N/A	N/A	33%	33%	N/A	

*Every client receiving home support has a clinical assessment. As required by the Ministry, reassessment of clients receiving long-term home support is only done every three years unless major changes to their condition. Care Plans are part of the clinical assessment. As people are only reassessed within a three year period if their condition has changed significantly, the number of home support clients receiving an assessment compared to the total number of clients can be a quality indicator for the provided care.

Outcome: People with end stage conditions are supported

Indicator	Measure Type	2015/16 Result	2016/17 Result	2017/18 Target	2017/18 Result	Latest NZ Result	Trend
Number of hospital admissions under Health Speciality Code M80 (Palliative Care)	Ω	7	15	Increase	5	N/A	
Number of aged residential facilities utilising Advanced Directives	δ	2	2	Increase	6[35]	N/A	

We suspect not all palliative patients are registered as such when admitted to the hospital but without further research it is hard to determine the reasons for this. 13 people died in the hospital

[35] All the local rest homes use advanced directives in some form.

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 2017/18:

- 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 2016/17 $000's	Budget 2017/18 $000's	Actual 2017/18 $000's
Income			
Prevention	($6,660)	($8,416)	($86,183)
Early detection and management	($46,032)	($46,038)	($44,814)
Intensive assessment and treatment	($104,746)	($106,369)	($40,204)
Rehabilitation and support	($18,326)	($23,430)	($18,681)
Total Income	**($175,764)**	**($184,253)**	**($189,882)**
Expenditure			
Prevention	$4,163	$8,416	$4,007
Early detection and management	$45,016	$46,038	$46,766
Intensive assessment and treatment	$115,029	$106,369	$122,503
Rehabilitation and support	$17,648	$23,430	$22,277
Total Expenditure	**$181,856**	**$184,253**	**$195,553**
Surplus/(Deficit)	**($6,092)**	**$0**	**($5,671)**

Statutory Information

New Zealand Public Health and Disability Act 2000

Report on the extent to which Hauora Tairāwhiti has met its objectives under section 22 [s.42 (3) (b)];
This information can be found in the Statement of Service Performance commencing on page 16. Each objective included in the Statement of Service Performance is referenced back to objectives (a) to (k) from section 22 of the New Zealand Public Health and Disability Act 2000.

(a) To improve, promote, and protect the health of people and communities.

(b) To promote the integration of health services, especially primary and secondary health services.

(c) To promote effective care or support for those in need of personal health services or disability support services.

(d) To promote the inclusion and participation in society and independence of people with disabilities.

(e) To reduce health disparities by improving health outcomes for Māori and other population groups.

(f) To reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders.

(g) To exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges the provision of services.

(h) To foster community participation in health improvement and in planning for the provision of services and for significant changes to the provision of services.

(i) To uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations.

(j) To exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations.

(k) To be a good employer.

Statement of how Hauora Tairāwhiti has given effect and intends to give effect to its functions specified in section 23(1) (a) to (e) [s.42 (3) (i)];

(a) To ensure the provision of services for its resident population and for other people as specified in its Crown funding agreement:
- All Crown Funding Agreement (CFA) actions for the period completed as required.
- Compliance with the Service Coverage Schedule for both Hauora Tairāwhiti provider and other community providers via service agreements (excluding those exceptions to meeting the schedule, as outlined in Hauora Tairāwhiti's Annual Plan).
- Overall outputs for the provider arm met – with variation between service lines.

(b) To actively investigate, facilitate, sponsor, and develop co-operative and collaborative arrangements with persons in the health and disability sector or in any other sector to improve, promote, and protect the health of people, and to promote the inclusion and participation in society and independence of people with disabilities:
- Hauora Tairāwhiti has developed a series of clinical alliances with other DHBs and providers both locally and across the country in order to achieve its aims.
- Hauora Tairāwhiti is a member of DHB Shared Services, the joint agency for all DHBs. Hauora Tairāwhiti contributes to, and gains benefit from collaborative action to advance the aims of Hauora Tairāwhiti and the health sector in general.

(c) To issue relevant information to the resident population, persons in the health and disability sector, and persons in any other sector working to improve, promote, and protect the health of people for the purposes of paragraphs (a) and (b):
- Hauora Tairāwhiti has a positive relationship with the local media, particularly the newspaper.
- All matters of importance are communicated to the Tairāwhiti population.
- Regular contact with other providers is maintained.

- Regular reporting to the MoH.
- Regular reporting to Board and Advisory Committees via public accountability system.

(d) To establish and maintain processes to enable Māori to participate in, and contribute to, strategies for Māori health improvement:

- The Māori Caucus Te Waiora o Nukutaimemeha sits alongside the Hauora Tairāwhiti Board at a governance level, therefore ensuring active participation and contribution by Māori.
- The Board of Hauora Tairāwhiti meets with Boards of Māori providers on an annual basis
- The Board of Hauora Tairāwhiti meets once a year with representatives of the Runanga with which it has signed Memorandum of Understanding. The two Runanga are Te Runanganui o Ngāti Porou and Te Runanga o Turanganui a Kiwa.
- Involvement of Koroua / Kuia in services.

(e) To continue to foster the development of Māori capacity for participating in the health and disability sector and for providing for the needs of Māori:

- Funding of Māori providers.
- Joint application of the Māori provider development funding held by the MoH.

Statement of Responsibility

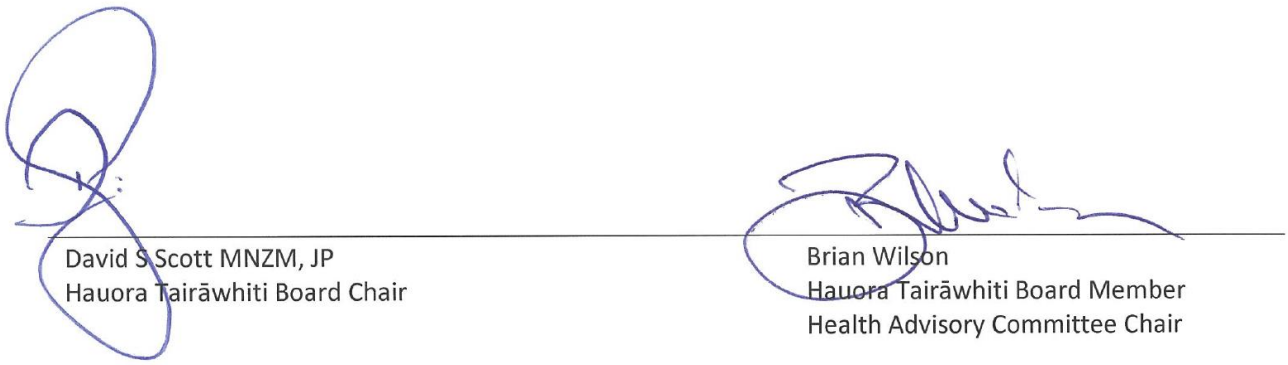
The Board accepts responsibility for the preparation of the Financial Statements and Statement of Service Performance and for the judgements used in them.

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 2018 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: 09 November 2018

Brian Wilson
Hauora Tairāwhiti Board Member
Health Advisory Committee Chair

Date: 09 November 2018

Independent Auditor's Report

To the readers of Tairāwhiti District Health Board's financial statements and performance information for the year ended 30 June 2018

The Auditor-General is the auditor of Tairāwhiti District Health Board (Hauora Tairāwhiti). 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, including the performance information for an appropriation, of Hauora Tairāwhiti on his behalf.

Opinion

We have audited:

- the financial statements of Hauora Tairāwhiti on pages 47 to 70, that comprise the statement of financial position as at 30 June 2018 the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flow 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 Hauora Tairāwhiti on pages 17 to 39.

In our opinion:

- the financial statements of Hauora Tairāwhiti on pages 47 to 70:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2018; 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; and
- the performance information of Hauora Tairāwhiti on pages 17 to 39:
    - presents fairly, in all material respects, its performance for the year ended 30 June 2018, 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 9 November 2018. This is the date at which our opinion is expressed.

The basis for our opinion is explained below, and we draw your attention to other matters. 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.

Hauora Tairāwhiti is reliant on financial support from the Crown

We draw your attention to the disclosures made in note 1 on page 52 that outline that the Board, in reaching the conclusion that Hauora Tairāwhiti is a going concern, has taken into consideration the letter of support received from the Ministers' of Health and Finance. The letter confirms that the Crown will provide Hauora Tairāwhiti with financial support, should it be necessary, to maintain viability. We consider the disclosures to be appropriate and our opinion is not modified in respect of this matter.

Compliance with the Holidays Act 2003

District Health Boards (DHBs) have been investigating issues associated with the calculation of employee entitlements under the Holidays Act 2003. A national approach is being taken to remediate these issues. Due to the nature of DHB employment arrangements, this is a complex and time consuming process. This matter may result in significant liabilities for some DHBs. Hauora Tairāwhiti has provided further disclosure about this matter in note 21 on page 67. Our opinion is not modified in respect of this matter.

Failure to complete the statement of performance expectations for the reporting period beginning 1 July 2018

We draw your attention to the disclosures made in note 1 on page 53 about the failure to comply with section 149C of the Crown Entities Act 2004, which requires the DHB to complete its statement of performance expectations before the start of the financial year. We consider the disclosures to be appropriate and our opinion is not modified in respect of this matter.

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 opinion.

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

The board is responsible on behalf of Hauora Tairāwhiti 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 they determine is necessary to enable them 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 Hauora Tairāwhiti for assessing Hauora Tairāwhiti'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 liquidate Hauora Tairāwhiti 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 Disability 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.

For the budget information reported in the financial statements and the performance information, our procedures were limited to checking that the information agreed to Hauora Tairāwhiti's statement of performance expectations.

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 DHB's internal control.
- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the the Board.
- We evaluate the appropriateness of the reported performance information within 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 Hauora Tairāwhiti'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 Hauora Tairāwhiti 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 achieves 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 70, 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 Hauora Tairāwhiti 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 the audit, we have no relationship with, or interests in, Hauora Tairāwhiti.

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 2018

	Notes	Actual 2018 $000	Budget 2018 $000	Actual 2017 $000
Revenue				
Patient care revenue	2 i	189,016	183,682	172,990
Interest revenue		76	50	79
Other revenue	2 ii	790	521	1,742
Total revenue		189,882	184,253	174,811
Expenses				
Personnel Cost	3	70,374	66,369	65,547
Depreciation and amortisation expenses:				
Property, plant and equipment	12	2,897	2,956	2,776
Intangible	13	284	277	288
Outsourced services		8,491	6,064	7,281
Clinical Supplies		15,745	13,708	14,390
Infrastructure and non-clinical expenses		8,466	10,787	9,702
Other district health boards		21,129	22,304	22,349
Non-health-board provider expenses		65,405	59,476	56,148
Capital charge	4	2,422	2,541	1,683
Interest expense		98	121	472
Other expense	5	924		930
Total expenses		196,235	184,603	181,566
Share of associate surplus / (deficit)	11	682	350	663
Surplus / (deficit)		(5,671)	0	(6,092)
Other comprehensive revenue and expense				
Item that will not be reclassified to surplus / (deficit)				
Revaluation of land and buildings		2,315	0	(36)
Total other comprehensive revenue and expense		2,315	0	(36)
Total comprehensive revenue and expense		(3,356)	0	(6,128)

Explanations of major variances against budget are provided in Note 28.

The accompanying notes form part of these financial statements.

Statement of Financial Position

As at 30 June 2018

	Notes	Actual 2018 $000	Budget 2018 $000	Actual 2017 $000
Assets				
Current assets				
Cash & cash equivalents	6	149	25	24
Receivables	7	5,659	4,718	3,884
Prepayments		1,026	1,332	1,338
Inventories	9	1,862	1,754	1,753
Total current assets		8,696	7,829	6,999
Non-current assets				
Investments in subsidiary and associates	11	923	722	818
Property, plant and equipment	12	61,482	58,802	58,866
Intangible assets	13	2,769	1,811	2,366
Total non-current assets		65,174	61,335	62,050
Total assets		73,870	69,164	69,049
Liabilities				
Current Liabilities				
Health Partnership NZ Ltd	6	1,649	3,457	3,456
Payables and deferred revenue	14	10,745	10,748	10,838
Borrowings	16	138	129	129
Employee entitlements	17	10,587	9,654	9,932
Total current liabilities		23,119	23,988	24,355
Non-current Liabilities				
Borrowings	16	711	789	849
Employee entitlements	17	990	721	558
Total non-current liabilities		1,701	1,510	1,407
Total liabilities		24,820	25,498	25,762
Net Assets		49,050	43,666	43,287
Equity	19			
Crown equity		49,863	40,362	40,745
Accumulated surpluses / (deficits)		(39,845)	(33,412)	(34,174)
Property revaluation reserves		39,004	36,689	36,689
Trust funds and bequests		28	27	27
Total equity		49,050	43,666	43,287

Explanations of major variances against budget are provided in Note 28.

The accompanying notes form part of these financial statements.

Statement of Changes in Equity

For the year ended 30 June 2018

	Notes	Actual 2018 $000	Budget 2018 $000	Actual 2017 $000
Balance at 1 July		43,287	44,048	28,268
Total comprehensive revenue and expense		(3,356)	0	(6,128)
Owner transactions	19			
Capital contribution		9,500	0	6,700
Crown loans converted to equity		0	0	14,829
Repayment of capital		(382)	(382)	(382)
Bequest Trusts interest		1	0	0
Balance at 30 June		49,050	43,666	43,287

Explanations of major variances against budget are provided in Note 28.

The accompanying notes form part of these financial statements.

Statement of Cash Flow

For the year ended 30 June 2018

	Notes	Actual 2018 $000	Budget 2018 $000	Actual 2017 $000
Cash flows from operating activities				
Receipts from patient care				
Ministry of Health		181,045	178,014	169,657
Other District Health Boards		2,228	2,172	2,190
Other		3,068	2,608	2,784
Receipts from other revenue		790	1,409	1,742
Payments to suppliers		(98,050)	(90,156)	(87,774)
Payments to Other District Health Boards		(21,129)	(22,304)	(22,349)
Payments to employees		(69,287)	(66,369)	(65,439)
Capital charge		(2,422)	(2,541)	(1,683)
GST (net)		73	0	(12)
Net Cash flow from operating activities		(3,684)	2,833	(884)
Cash flow from investing activities				
Advance from subsidiary company		577	350	552
Interest receipts		76	50	79
Receipts from sale of property, plant, and equipment		0	0	145
Purchase of property, plant and equipment		(3,239)	(2,652)	(2,080)
Purchase of intangible assets		(687)	(72)	(96)
Net cash Flow from investing activities		(3,273)	(2,324)	(1,400)
Cash flow from financing activities				
Capital contributions from the crown		9,500	0	6,700
Interest paid		(100)	0	(569)
Repayment of capital to the Crown		(382)	(382)	(382)
Repayment of finance leases		(129)	(128)	(120)
Net cash flow from financing activities		8,889	(510)	5,629
Net (decrease) / increase in cash and cash equivalents		1,932	(1)	3,345
Cash and cash equivalents at the start of the year		(3,432)	(3,431)	(6,777)
Cash and cash equivalents at the end of the year	6	(1,500)	(3,432)	(3,432)

Explanations of major variances against budget are provided in Note 28.

Interest received has been reclassified as investing activity and interest paid as financing activity.

The accompanying notes form part of these financial statements.

Reconciliation of Net Surplus/Deficit to net cash flow from operating activities

	Actual 2018 $000	Actual 2017 $000
Net surplus / (deficit)	(5,671)	(6,092)
Add / (less) non-cash items		
Share of associates surplus	(682)	(663)
Increase in non-current employee entitlements	432	(231)
Depreciation and amortisation expense	3,181	3,063
Other non-cash items	8	0
Net change on financial instruments and term liabilities	58	0
Total non-cash items	2,997	2,169
Add / (less) items classified as investing or financing activities		
Interest reclassified in current year	0	491
Total items classified as investing or finance activities	0	491
Add / (less) movements in statement of financial position items		
(Increase) / decrease in receivables	(1,775)	1,052
(Increase) / decrease in prepayments	312	(406)
(Increase) / decrease in inventories	(109)	66
Increase / (decrease) in payables	(93)	1,497
Increase / (decrease) in employee entitlements	655	339
Net movements in working capital items	(1,010)	2,548
Net cash (outflow) / inflow from operating activities	(3,684)	(884)

Explanations of major variances against budget are provided in Note 28.

Interest received has been reclassified as investing activity and interest paid as financing activity.

The accompanying notes form part of these financial statements.

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. Hauora Tairāwhiti does not operate to make a financial return.

Hauora Tairāwhiti is designated as a public benefit entity (PBE) for the purposes of complying with generally accepted accounting practice (GAAP).

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 2017/18 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.

Operating and Cash flow forecasts
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 2017/18 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 Performance Expectations).

The key considerations are set out below:

- Operating and Cash flow forecasts:
  The Board has considered forecast information relating to operating viability and cash flow requirements. Without deficit support, the Board is not satisfied there will be sufficient cash flows generated from operating activities to meet its cash flow requirements of the DHB as set out in its current draft Statement of Performance Expectations and based on current trading conditions and legislative requirements.

  The forecast for the next year prepared by the DHB shows that if deficit support of $11 million is received in January 2019, the DHB's peak borrowing requirement would not exceed its available borrowing facilities. Furthermore, with deficit support the forecast borrowing requirements can be met without breaching covenants or other borrowing restrictions.

- Letter of comfort
  The Board has received a letter of comfort, dated 2 October 2018, from the Ministers of Health and Finance which states that deficit support will be provided where necessary to maintain viability.

  As at the date of publishing these financial statements, no agreement has been reached with the Ministry of Health as to the actual value and timing of any deficit support to be provided to the DHB in accordance with the letter of comfort.

  Capital injection of $9.5m was received during the current financial year.

Statement of Compliance
The financial statements of Hauora Tairāwhiti have been prepared in accordance with the requirements of the NZ Public Health and Disability Act 2000 and the Crown Entities Act 2004, which include the requirement to comply with GAAP. The financial statements have been prepared in accordance with Tier 1 PBE accounting standards.

Legislative Compliance:

- **Statement of Performance Expectations**
  Section 149c of the Crown Entities Act 2004 requires Hauora Tairāwhiti to complete its Statement of Performance Expectations by the start of the financial year to which it relates. This requirement has not been met for the 2018/19 year. As at 31 October 2018 the 2018/19 Statement of Performance Expectations is yet to be signed by the Board and approved by the Minister.

- **Audit Report on the Financial Statements and Non-Financial Statements**
  Section 156(2) of the Crown Entities Act 2004 requires the Auditor-General to provide to Hauora Tairāwhiti an audit report on the financial statements and performance within 4 months after the end of each financial year (by 31 October). This requirement has not been met for the 2017/18 year. The audit was completed on 09 November 2018, which is the same date the Board authorised the financial statements and performance information for issue.

Ministerial Directions

- The 2011 Eligibility Direction issued under s.32 of the NZ Public Health and Disability Act 2000.
- The direction to support a whole of government approach issued in April 2014 under s.107 of the Crown Entities Act. The three directions cover Procurement , ICT and Property and the former two apply to DHBs.
- The direction on the use of authentication services issued in July 2008, which continues to apply to all Crown agencies apart from those with sizeable ICT business transactions and investment specifically listed within the 2014 direction.

Presentation currency and Rounding
The financial statement are presented in NZ dollars rounding to the nearest thousand ($000) except for Note 23 which is in whole dollars.

Changes in accounting Policies
There have been no changes in accounting policies since the date of the last audited financial statements.

Significant Accounting Policies
Significant accounting policies are included in the notes to which they relate, other policies are listed below.

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 or payable is included as part of receivables or payables in the Statement of Financial Position. All GST paid or received is classified as an operating cash flow in the Statement of cash flows.

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

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 GAAP and are consistent with the accounting policies adopted by the Board.

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

Cost allocation
Direct costs are those costs directly attributed to an output. Indirect costs are those costs that cannot be identified in an economically feasible manner with a specific output.

Indirect costs are charged to outputs based upon cost drivers and related activity or usage information.
There have been no changes to the cost allocation methodology since the date of the last audited financial statements.

Note 2 Revenue

Accounting Policy

The specific accounting policies for significant revenue items are explained below.

Ministry of Health population-based revenue

Hauora Tairāwhiti receives annual funding from the ministry, which is based on population of our district. This funding is restricted in its use for the purpose of Hauora Tairāwhiti meeting its objectives as specified in the statement of intent and is recognised based on the funding the funding entitlement for the year.

Ministry of Health contract revenue

Revenue recognition depends upon the contract terms, those contracts where the amount of revenue is linked to the provision of quantifiable units of service are treated as exchange contracts and revenue is recognised as the services are provided, other contracts are treated as non-exchange and the total receivable is recognised as revenue immediately, unless there are substantive conditions in the contract.

Revenue from other District Health Boards

Hauora Tairāwhiti receives inflow revenue when a patient is treated who is domiciled outside of our district, this revenue is recognised when the eligible services are provided.

ACC contract revenue

ACC contract revenue is recognised as revenue when eligible services are provided and contract conditions have been fulfilled.

Interest Revenue

Interest revenue is recognised using the effective interest method.

Rental Revenue

Rental revenue is recognised as revenue over a straight-line bases over the lease term.

Provision of other services

Revenue derived through the provision of other services to third parties is recognised in proportion to the stage of completion, based on the actual service provided as percentage of the total service to be provided.

Donations, grants and bequests

Donated and bequeathed financial assets are recognised as revenue immediately, unless there are conditions. A liability is recorded if there are conditions and the liability released to revenue as the conditions are fulfilled.

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 assets is recognised as revenue.

Donated services

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

i Patient Care Revenue	Actual 2018 $000	Actual 2017 $000
MoH population-based Funding	160,239	154,125
MoH other contracts	21,046	13,719
Inter-district Flows (other DHBs)	2,228	2,190
Other patient care related revenue	5,503	2,956
Total Patient care revenue	189,016	172,990

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 Tairāwhiti DHB equals the Governments actual expenses incurred in relation to this appropriation, which is a required disclosure from the Public Finance Act.

Hauora Tairāwhiti has considered the Direction 2011 "Health and Disability Services Eligibility" issued by the Minister of Health pursuant to section 32 of the NZ Public Health and Disability Act 2000, when establishing patients eligibility for funded services from the DHB.

ii Other Revenue

	Actual 2018 $000	Actual 2017 $000
Donated equipment	0	187
Cash donation received	52	32
Rental revenue	219	245
Other revenue	519	1,278
	790	1,742

Note 3 Personnel costs and employee remuneration

Accounting policy

Salaries and wages

Salaries and wages are recognised as an expense as employees provide services.

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 year 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.

Breakdown of personnel costs

	Actual 2018 $000	Actual 2017 $000
Salaries and wages	67,802	63,770
Defined contribution plan employer contributions	1,485	1,437
Increase / (decrease) in liability for employee entitlements	1,087	340
	70,374	65,547

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. 2018	Staff No. 2017
100,000	109,999	12	15
110,000	119,999	7	6
120,000	129,999	4	5
130,000	139,999	2	1
140,000	149,999	2	4
150,000	159,999	2	5
160,000	169,999	4	0
170,000	179,999	1	0
180,000	189,999	0	2
190,000	199,999	1	3
200,000	209,999	1	0
210,000	219,999	4	1
230,000	239,999	1	2
240,000	249,999	3	1
250,000	259,999	2	2
260,000	269,999	3	2
270,000	279,999	2	1
280,000	289,999	2	5
290,000	299,999	1	1
300,000	309,999	4	2
310,000	319,999	3	4
320,000	329,999	2	3
330,000	339,999	3	5
340,000	349,999	2	4
350,000	359,999	4	3
360,000	369,999	2	2
370,000	379,999	3	3
380,000	389,999	1	1
390,000	399,999	2	1
400,000	409,999	2	4
410,000	419,000	3	1
420,000	429,999	1	0
430,000	439,999	2	0
440,000	449,999	0	1
450,000	459,999	1	0
460,000	469,999	1	0
560,000	469,999	1	0
620,000	629,999	0	1
		91	91

During the year ended 30 June 2018, 5 (2017:2) employees received compensation and other benefits in relation to cessation totalling $52k (2017:$37k).

Note 4 Capital Charge

Accounting policy

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

Further information

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 2018 was 6% per annum (2017: 6%)

Note 5 Other Expenses

Accounting policy

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 and are recognised as expenses in the periods in which they are incurred.

	Note	Actual 2018 $000	Actual 2017 $000
Fees to auditor			
- Audit NZ for audit of the financial statements		109	106
- Other external auditor		3	3
- Internal audit fees		97	98
Bad debts written off		33	6
Operating lease expense		262	281
Board member fees	23	279	283
Board election expenses		0	62
Other Expenses		141	91
		924	930

Note 6 Cash and cash equivalents

Accounting policy

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

	Actual 2018 $000	Actual 2017 $000
Cash at bank and on hand	10	12
Deposits with maturities less than 3 months	139	12
	149	24
NZ Health Partnership Ltd	(1,649)	(3,456)
Total cash and cash equivalents	(1,500)	(3,432)

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 2018 this limit was $8.652 million (2017: $8.652million).

Financial assets recognised subject to restrictions
Included in cash and cash equivalents and investments (Note 8) are unspent funds with restrictions on expenditure. Further information about trusts funds is provided in Note 19.

Note 7 Receivables

Accounting policy

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.

	Actual 2018 $000	Actual 2017 $000
Receivables from the sale of goods and services (exchange transactions)	5,755	3,986
Less: provision for impairment	(96)	(102)
	5,659	3,884

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

	2018			2017		
	Gross	mpairment	Net	Gross	Impairment	Net
	$000	$000	$000	$000	$000	$000
Current	4087		4087	2318		2318
Past due 1 - 30 days	982		982	982		982
Past due 31 - 60 days	551		551	551		551
Past due over 60 days	135	(96)	39	135	(102)	33
Total	5,755	(96)	5,659	3,986	(102)	3,884

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 2018 $000	Actual 2017 $000
Balance as at 1 July	102	61
Additional provisions / (reversal)	27	47
Receivable written off	(33)	(6)
	96	102

Note 8 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.

Term deposits with maturities less than 3 months are included in cash and cash equivalents (Note 6).
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 9 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.

	Actual 2018 $000	Actual 2017 $000
Held for distribution inventories		
Pharmaceuticals	244	219
Surgical and medical supplies	680	680
Main store	756	689
Other supplies	182	165
	1,862	1,753

The amount of inventories recognised as an expense during the year was $15,745k (2017: $14,359k) 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 $(42)k (2017: $(1)k)
Minor variances occur throughout the year result of periodic stock counts.

No inventories are pledged as security for liabilities (2017: $nil). However some inventories are subject to retention of title clauses.

Note 10 Non-current assets held for sale

As at balance date there were no assets held for resale (2017: $nil)

Note 11 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 2018 $000	Actual 2017 $000
Assets	4,209	2,982
Liabilities	3,834	2,684
Revenue	3,077	2,772
Surplus	106	149
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 2018 $000	Actual 2017 $000
Assets	560	571
Liabilities	197	235
Revenue	2,400	2,359
Surplus	242	201
Hauora Tairāwhiti'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 2018 $000	Actual 2017 $000
Assets	310	326
Liabilities	125	142
Revenue	950	935
Surplus	334	313
Hauora Tairāwhiti's share of contingent liabilities	0	0
Total investment in associates (share of assets less liabilities)	923	818
Total share of associate results	682	663

All of the subsidiaries and associates are unlisted. Accordingly there are no published price quotations.

Note 12 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.

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

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.

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 (WIP) 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.

	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 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
Balance 1 July 2017	2,127	49,028	16,502	1,051	3,000	2,729	437	74,874
Additions	0	230	1,443	64	491	264	698	3,190
Disposals	0	0	(84)	(16)	(927)	0	0	(1,027)
Revaluation	530	(396)	0	0	0	0	0	134
Balance 30 June 2018	2,657	48,862	17,861	1,099	2,564	2,993	1,135	77,171
Accumulated depreciation								
Balance 1 July 2016	0	(751)	(8,492)	(706)	(1,827)	(1,939)		(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)
Balance 1 July 2017	0	(1,476)	(9,791)	(717)	(1,963)	(2,061)	0	(16,008)
Depreciation expense		(738)	(1,593)	(75)	(365)	(126)		(2,897)
Elimination on disposals		0	72	16	927	0		1,015
Revaluation		2,201	0	0	0	0		2,201
Balance 30 June 2018	0	(13)	(11,312)	(776)	(1,401)	(2,187)	0	(15,689)
Carrying amounts								
As at 1 July 2016	2,145	48,414	7,024	342	835	761	221	59,742
At 30 June and 1 July 2017	2,127	47,552	6,711	334	1,037	668	437	58,866
At 30 June 2018	2,657	48,849	6,549	323	1,163	806	1,135	61,482

Valuation

The most recent valuation of land and buildings was performed by an independent registered valuer Jones LaSelle Ltd as at 30 June 2018.

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 (2017: $nil) for buildings and $1,169k (2016: $1,363k) for other equipment.

Note 13 Intangible assets

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

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

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

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 Partnership Ltd. (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.

	FPSC Rights $000	Software $000	FPSC Rights $000	WIP Software $000	Total $000
Cost or Valuation					
Balance 1 July 2016		3,468	836	464	4,768
Additions		209	0		209
Disposals		(110)		(114)	(224)
Balance 30 June 2017	0	3,567	836	350	4,753
Balance 1 July 2017	0	3,567	836	350	4,753
Additions		57		700	757
Disposals		(1)			(1)
Revaluation			(71)		(71)
Balance 30 June 2018	0	3,623	765	1,050	5,438
Accumulated depreciation					
Balance 1 July 2016		(2,209)			(2,209)
Depreciation expense		(288)			(288)
Elimination on disposals		110			110
Balance 30 June 2017	0	(2,387)	0	0	(2,387)
Balance 1 July 2017	0	(2,387)	0	0	(2,387)
Depreciation expense		(284)	0	0	(284)
Elimination on disposals		2		0	2
Balance 30 June 2018	0	(2,669)	0	0	(2,669)
Carrying amounts					
As at 1 July 2016	0	1,259	836	464	2,559
At 30 June and 1 July 2017	0	1,180	836	350	2,366
At 30 June 2018	0	954	765	1,050	2,769

There are no restrictions over the title of intangible assets. No intangible assets are pledged as security for liabilities.
At 30 June 2018, Hauora Tairāwhiti had made payments totalling $836k (2017: $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 dissolution 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 14 Payables and deferred revenue

Short-term payables are recorded at the amount payable.

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

	Actual 2018 $000	Actual 2017 $000
Payables and deferred revenue under exchange transactions		
Creditors	3,206	2,542
Accrued expenses	6,327	7,288
Total payables and deferred revenue under exchange transactions	9,533	9,830
Payables and deferred revenue under non-exchange transactions		
GST payable	1,062	989
Trusts and bequests with substantive conditions	127	0
Other	23	20
Total payables and deferred revenue under non-exchange transactions	1,212	1009
Total payables and deferred revenue	10,745	10,839

Note 15 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. (2017: none).

Note 16 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 and 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.

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.

Overdraft facility

Amounts drawn under the NZHPL banking facility are recorded at the amount payable plus accrued interest.

Breakdown of borrowings	Actual 2018 $000	Actual 2017 $000
Current Portion		
Finance Leases	138	129
Non-current portion		
Finance Leases	711	849
Total Borrowings	849	978
Borrowing facility Limits		
NZ Health Partnership Ltd (refer to note 6)	8,951	8,382
Total borrowing facility limits	8,951	8,382

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 2018	Actual 2017
Westpac	7.14%	7.14%
NZ Health Partnership	2.86%	3.29%

Analysis of financial lease		
Minimum lease payments payable:		
No later than one year	138	129
Later than one year and not later than five years	659	659
Later than five years	52	190
Total minimum lease payments	849	978
Future finance charges		
Present value of minimum lease payments	849	978

Present value of minimum lease payments payable:		
No later than one year	138	129
Later than one year and not later than five years	659	659
Later than five years	52	190
Total present value of minimum lease payments	849	978

Hauora Tairāwhiti has entered into finance leases for MRI equipment. The net carrying amount of this equipment is included in Note 12.

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 17 Employee entitlements

	Actual 2018 $000	Actual 2017 $000
Current portion		
Accrued salaries and wages	1,379	1,883
Annual leave	6,946	6,276
Sick leave and shift leave	117	110
Sabbatical leave	579	298
Continuing medical education leave	850	786
Long service leave	590	527
Retirement gratuities	126	52
	10,587	9,932
Non-current portion		
Long service leave	396	383
Retirement gratuities	594	175
	990	558
Total employee entitlements	11,577	10,490

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 18 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.

Hauora Tairāwhiti has no material provisions (2017: Nil). Minor amounts are included with Accounts payable.

Note 19 Equity

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

i) contributed capital
ii) accumulated surplus / (deficit)
iii) revaluation reserves
iv) other reserves

	Actual 2018 $000	Actual 2017 $000
Crown equity		
Balance at 1 July	40,745	19,598
Capital contributions from the crown	9,500	6,700
Capital contributions by way of loan conversion	0	14,829
Repayment of capital to the crown	(382)	(382)
Balance at 30 June	49,863	40,745
Accumulated surpluses / (deficits)		
Balance at 1 July	(34,174)	(28,082)
Surplus / (deficit) for the year	(5,671)	(6,092)
Balance at 30 June	(39,845)	(34,174)
Revaluation reserves		
Balance at 1 July	36,689	36,725
Revaluations	2,315	(36)
Balance at 30 June	39,004	36,689
Bequest Trusts and Capital reserve		
Balance at 1 July	27	27
Interest on trust deposits	1	0
Balance at 30 June	28	27
Total equity	49,050	43,287

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 injections. Loans converted in 2017 were $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 $4,505K of funding above the mental health ring-fence. This accumulated total represents $1,380 of 2017/18 funding with the rest coming from carry over since ring fence was established.

Note 20 Capital commitments and operating leases

	Actual 2018 $000	Actual 2017 $000
Capital commitments	2,006	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 2018 $000	Actual 2017 $000
Not later than one year	138	399
Later than one year and not later than five years	659	164
Later than five years	52	0
Total non-cancellable operating leases	849	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 21 Contingencies

Legal proceedings

Hauora Tairāwhiti has not been informed of any legal actions against it so has no contingent liabilities (2017:$nil)

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.

Compliance with the Holidays Act 2003

The labour inspectorate (an enforcement arm of the Ministry of Business, Innovation and Employment) has found, based on dealing with cases of non-compliance, that there may be a range of issues leading to widespread non-compliance with the Holidays Act. Hauora Tairāwhiti and it's software suppliers have conducted a review of our processes and do not believe we have material non-compliance. The calculations are being worked through and will impact on future years results.

Contingent assets

Hauora Tairāwhiti has no contingent assets (2017:$nil)

Note 22 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 2018 $000	Actual 2017 $000
Board members		
Remuneration	250	258
Full time equivalent members	1	1
Leadership Team		
Remuneration	3,777	3,599
Full time equivalent members	17	17
Total key management personnel remuneration	4,027	3,857
Total full-time equivalent personnel	18	18

Note 23 Board Member Remuneration

	Actual 2018 $	Actual 2017 $
Board Members		
C Bauld	0	9,718
C Bibby	0	8,468
M Akuhata-Brown	19,570	11,602
B A Clarke	0	12,286
G Milner	25,650	24,658
G Murphy	18,570	11,102
H Pihema	19,820	11,352
N Raihania	22,382	15,542
E Reedy	0	7,718
D Scott (Chair)	41,350	43,183
K Sheldrake	20,444	19,819
R Stoltz	19,820	19,820
M Todd	0	11,270
M Tibble	0	8,843
J Wharehinga	17,820	9,602
B Wilson	25,207	21,570
P Younger	19,570	11,602
	250,203	258,154
Maori Caucus & Community Members	$	$
W Burdett	0	1,250
B A Clarke	5,821	0
A Hawea	0	750
P Henare	0	1,250
J Hockey	2,000	1,500
C Jackman	250	500
L McCarthy-Robinson	5,993	4,250
Te A Nepia-Clamp	1,250	750
A Ngarangione	2,802	4,250
N Ngata	0	1,000
M Palmer	1,500	1,500
M Para	2,080	2,750
C Simmonds	250	250
B Thomas	0	1,250
M Tibble	1,273	0
J Timutimu	1,829	500
B Turnpenny	0	750
R Waihi	1,250	500
J Williams	2,250	2,250
	28,548	25,250
Total governance remuneration	278,751	283,404

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 (2017:$nil).

Note 24 Events after balance date

There were no significant events after balance date.

Note 25 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

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

	Actual 2018 $000	Actual 2017 $000
Fair value through surplus or deficit		
Cash and cash equivalents	139	12
Receivables	5,659	3,884
Investments in associates	923	818
	6,721	4,714
Financial liabilities measured at amortised cost		
Payables (excluding income in advance and taxes payable)	21,332	20,770
Borrowings	0	0
Finance leases	849	978
Total financial liabilities measured at amortised cost	22,181	21,748

Note 26 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 Tairāwhiti 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 27 Early Childhood Care

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

	Actual 2018 $000	Actual 2017 $000
Revenue from the Ministry of Education	68	68
Expenditure		
Personnel costs	(50)	(50)
Operation expenses	(5)	(4)
	(55)	(54)
Net surplus / (deficit)	13	14

Note 28 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 $4.0 million or 6.0%. For a variety of reasons:
Bringing "in-house" the cost of cleaning, securities and orderlies - this was previously infrastructure cost
Provision for backdated salary settlements

Outsourced services were over budget by $2.4 million

Infrastructure and non-clinical expenses under budget by $2.3 million; clinical supplies up $2.0 million, Pharmaceuticals up $1.1 million, and Patient Transport/Lodging up $405k.

Payments to other district health boards were $1.2 million or 5% under budget caused by reduced usage by Tairāwhiti residents of the other DHBs.

Statement of changes in equity
The deficit was $6 million below the budgeted result due to the reasons given above and unrealistic budget. The DHB also received deficit support equity of $9.5 million.

Statement of financial position
Current assets are $429k lower than budget with prepayments and receivables lower than budget.
Non-current assets are $3.8 million higher than budget mainly the result of revaluation of land and buildings.
Liabilities are under budget mainly due to the timing of the receipt of deficit support.

Note 29 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 Tairāwhiti 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 collectively working towards incorporating the NZBN within their systems.