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Hawke's Bay District Health Board | Annual Report 2022
Presented to the House of Representatives
Pursuant to section 150(3) of the Crown Entities Act

2022 Annual Report

HAWKE'S BAY
District Health Board
Whakawāteatia

Our Mission and Values

Vision

Whānau ora, Hāpori ora — healthy families, healthy communities

Mission

Working together to achieve equitable holistic health and wellbeing for the people of Hawke's Bay.

Our Values

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Part I - Overview

Message from the Chair and Chief Executive

The past year has seen much change and delivery of priorities within a pandemic environment. COVID-19 has woven itself into the fabric of Hawke's Bay life and the Care in the Community model successfully took over from Managed Isolation and Quarantine Facilities as the way to keep our people supported, safe and help them recover from COVID-19.

During this time Hawke's Bay District Health Board moved towards becoming part of the Te Whatu Ora – Health New Zealand model, with the new health entity officially taking over on 1 July 2022.

Recruitment challenges have continued through 2021/2022 due to border closures and ongoing competition from international health agencies and the New Zealand private health sector. It is fair to say the health sector is looking for innovative ways to keep staff motivated and inspired and encourage a new workforce of the future. Even during this high tempo of change, Hawke's Bay DHB continued to strive to ensure the needs of its communities were met and projects moved forward.

When the time came for Hawke's Bay DHB to hand over the korowai to Te Whatu Ora – Health New Zealand there were many things to be proud of and we entrust the new entity to continue the good work.

There is the ongoing Linac and medical oncology project which now has an extended scope to include medical oncology in a new site location. This will mean radiation therapy will be provided closer to home to help address inequity in service access.

The surgical services expansion project is half way through its construction to increase theatre capacity to eight theatres to meet population needs and help close the equity gap. While also improving patient flow through perioperative process and staff accommodation.

The hospital redevelopment programme is continuing to realise its once in a generation opportunity to reflect Te Ao Māori in service delivery and facility design.

While infrastructure is vital to delivering services, delivering the right service to reflect our communities' needs across their lifetime is essential.

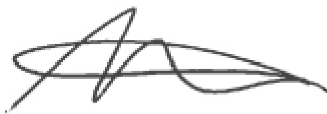
To this end we are proud of the Hau Te Kura review of our maternity services to ensure every child is born in a safe and caring environment. Improving early intervention and crisis response within our mental health and addictions service will result in reduced ED presentations and our rangatahi told us what they needed in a service model and we have listened, extending rangatahi access to 24 years of age regardless of ethnicity or enrolment status.

The Oranga kaumātua model of care changes designed with whānau and communities to ensure pakeke are supported to remain independent and receive the most appropriate care will allow them to be able to contribute to society.

As Hawke's Bay DHB draws to a close and we change into Te Whatu Ora -Te Matau a Māui, Hawke's Bay we look forward to the new Te Whatu Ora – Health New Zealand and Te Aka Whai Ora – Māori Health Authority and the changes both will bring to our rohe.

We would like to thank our staff and the wider health community for their extraordinary efforts in serving their community and we wish them all well for the future within New Zealand's health sector.

To all Board members past and present at this time of change, thank you for your invaluable service to the community and all our staff. Your dedication and commitment has been significant and the great work that has been done over the time of Hawke's Bay District Health Board has resulted in a better health future for the rohe.



Keriana Brooking
Chief Executive Officer

Shayne Walker
Chair, Hawke's Bay DHB

About Hawke's Bay District Health Board

Hawke's Bay's current population is 181,400. While the total population grew 1% or 1,800 people in the last year, our 65 years and over population grew by 3%. This is due to structural ageing of our population and we will continue to see an increase in the number of older people year on year in Hawke's Bay for at least the next 20 years. In the coming year, for the first time ever, people in Hawke's Bay over the age of 65 will out number those under the age of 15.

Compared to New Zealand averages, there are some important differences in the makeup of our population – we have a higher proportion of Māori (28% vs 17%), more people aged over 65 years (19% vs 16%) and more people living in areas with relatively high material deprivation (28% vs 20%).

Most of our population live in the urban areas of Napier (66,700) and Hastings, including Havelock North (65,250), located within 20 kilometres of each other that together account for 72.5% of the total numbers. About 14,380 (8%) of the population live in the small urban areas of Wairoa, Clive, Waipukurau and Waipawa and 3.5 % (6,480) live in small rural settlements[1] across the district. The remaining 16% live in rural and remote locations.

Within Hawke's Bay we do have demographic differences between our key localities Wairoa, Central Hawke's Bay, Napier and Hastings. Wairoa District has a high proportion of Māori (66%) compared to Napier City (23%), Hastings District (28%) and Central Hawke's Bay (24%).

Napier City has the highest proportion of older people with 20% of its population 65 years and over compared to Wairoa District 18%, Hastings District 17% and Central Hawke's Bay 21%.

Wairoa District has higher rates of relative material deprivation compare to other localities.

[1] Tuai,Frasertown,Nuhaka,Mahia beach,Whirinaki,Whakatu,Haumoana,Te Awanga,Waimarama,Tikokino,ongaonga,Takapau,Otane and Porangahau

Wairoa Health
Kitchener Street
PO Box 84
Wairoa
Phone: 06 838 7099

Napier Health
Wellesley Road
PO Box 447
Napier
Phone: 06 878 8109

Hawke's Bay Fallen Soldiers' Memorial Hospital
Omahu Road
Private Bag 9014
Hastings
Phone: 06 878 8109

Central Hawke's Bay Health Centre
Cook Street
PO Box 521
Waipukurau
Phone: 06 858 9090

Statement of Responsibility

For the 12 months ended 30 June 2022

Te Whatu Ora – Health New Zealand was established on 1 July 2022 under the Pae Ora (Healthy Futures) Act 2022.

As a result of the transitional arrangements in the Pae Ora Act all assets and liabilities of the Hawke's Bay DHB (the Health Board) were transferred to Te Whatu Ora. By Ministerial approval under s 45J of the Public Finance Act 1989, Te Whatu Ora now has responsibility for providing the final annual report of the Health Board, which was disestablished at the end of 30 June 2022.

The Board and Management of Te Whatu Ora take responsibility for the preparation of the Hawke's Bay District Health Board group's financial statements and statement of performance, and for the judgements made in them.

We are responsible for any end-of-year performance information provided by the Hawke's Bay DHB group under section 19A of the Public Finance Act.

We are responsible for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting.

In our opinion, these financial statements and statement of performance fairly reflect the financial position and operations of the Hawke's Bay District Health Board group for the year ended 30 June 2022.

Signed on behalf of the Te Whatu Ora Board:

Naomi Ferguson

Acting Chair

Dated: 25 May 2023

Hon Amy Adams

Board member

Dated 25 May 2023

Part II – Improving Outcomes

Performance Framework

What difference have we made for the health of our population?

Hawke's Bay DHB's performance framework demonstrates how the services we fund and the services we provide contribute to the health of our population and achieve our long term outcomes and the government's objectives. Our performance framework reflects national priorities and our local DHB priorities which informs our Annual Plan and our Statement of Performance Expectations (SPE).

Our performance framework focuses on two overall long-term population health outcomes:

- Increase healthy life expectancy for all, and
- Halve the life expectancy gap between Māori and non-Māori.

These are the long term outcomes of the Hawke's Bay Health Strategy Whānau Ora, Hāpori Ora: Healthy Families Healthy Communities (2019-2029) which sets out the Hawke's Bay DHB's strategic intentions over the next 10 years.

2021/22 marks the third year of our long term strategy. The nature of population health is such that it may take several years to see marked improvement against key outcome measures. Our focus here is on maintaining positive trends over time and reducing inequities.

Our medium term outcome goals are closely aligned to the Ministry of Health System Level Measures and other national health priorities such as improving cancer outcomes.

Locally we have also aligned our medium term outcome goals to Hawke's Bay DHB's Health System Priorities (First 1000 Days, Mental Health and Addictions, Long Term conditions, a Responsive Health System and, Frail and Older People).

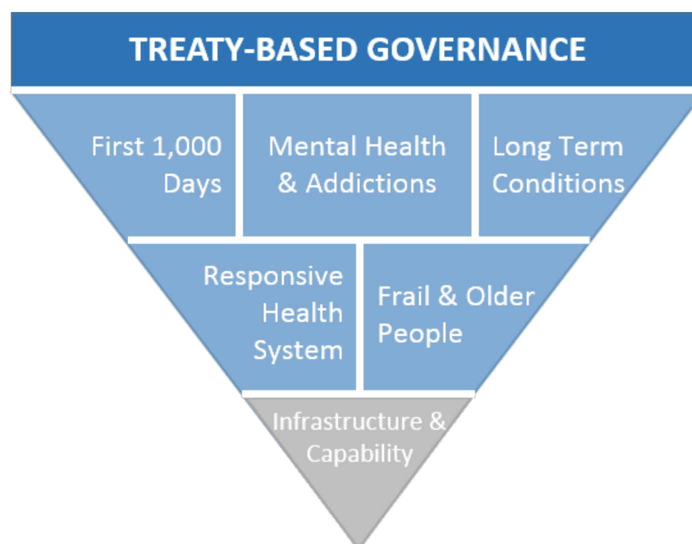


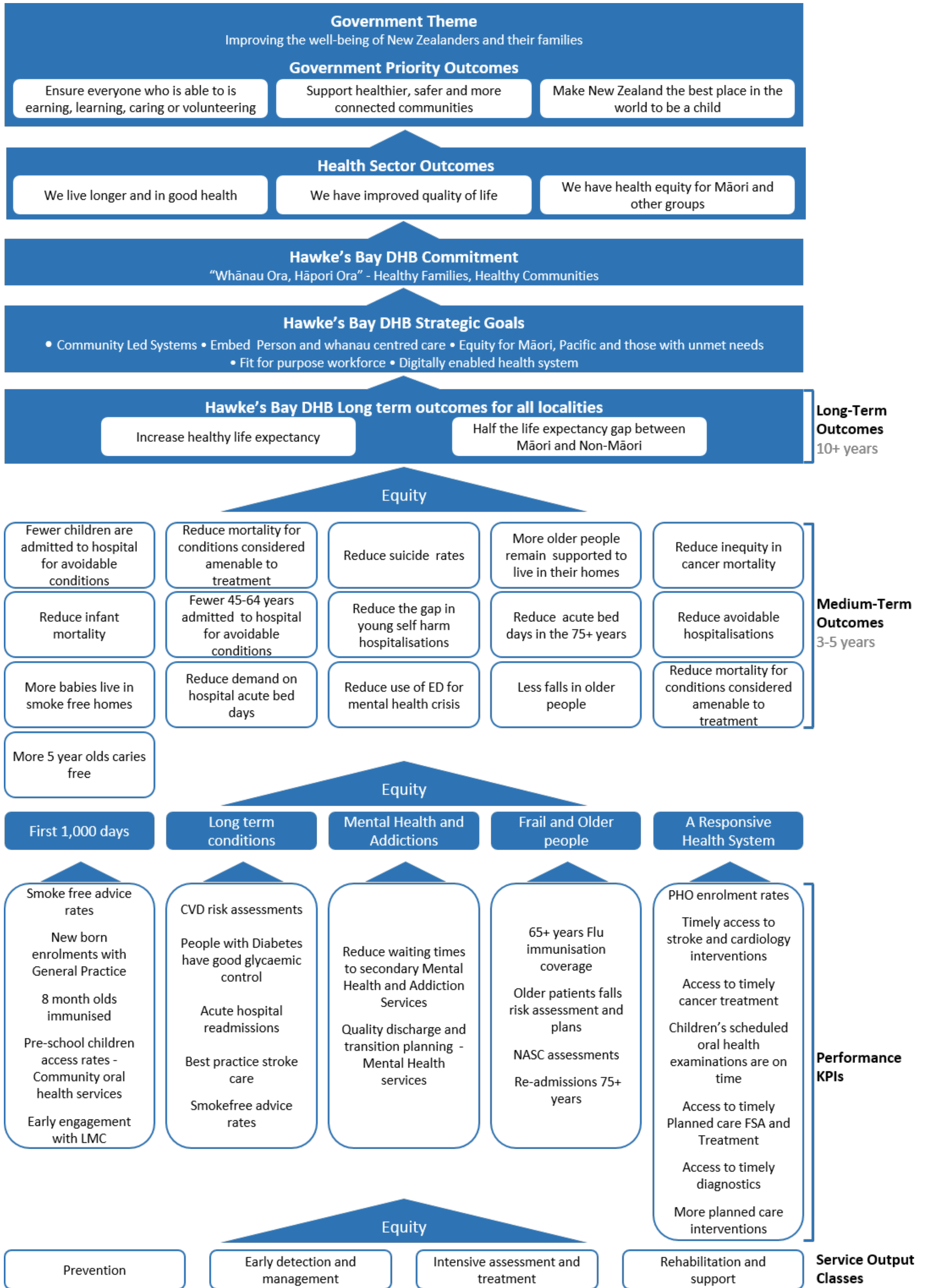
Figure 1: HBDHB System Priority Areas

Tracking our performance against the medium term outcomes helps us evaluate our success in areas that are important to the community and the Hawke's Bay DHB. Our priority is addressing inequity of health outcomes for our population. In doing this, we work in partnership with our community.

We use measurable short term key performance indicators (KPI's) to measure the success against our Health System priorities. Our KPI's are also mapped to four Service Output Classes; Prevention, Early Detection and Management, Intensive Assessment and Treatment, Rehabilitation and Support. We track our performance against the KPI's quarterly.

How well we have performed against these measures and targets in the 2021/22 year is presented in our Statement of Service Performance (outlined in the following section of this report).

Achieving equity is a goal at all levels of our performance framework. Our performance framework is shown below.


Government Theme
Improving the well-being of New Zealanders and their families
Government Priority Outcomes
Ensure everyone who is able to is earning, learning, caring or volunteering
Support healthier, safer and more connected communities
Make New Zealand the best place in the world to be a child
Health Sector Outcomes
We live longer and in good health
We have improved quality of life
We have health equity for Māori and other groups
Hawke's Bay DHB Commitment
"Whānau Ora, Hāpori Ora" - Healthy Families, Healthy Communities
Hawke's Bay DHB Strategic Goals
• Community Led Systems • Embed Person and whanau centred care • Equity for Māori, Pacific and those with unmet needs
• Fit for purpose workforce • Digitally enabled health system
Hawke's Bay DHB Long term outcomes for all localities
Increase healthy life expectancy
Half the life expectancy gap between Māori and Non-Māori
Long-Term Outcomes
10+ years
Equity
Fewer children are admitted to hospital for avoidable conditions
Reduce mortality for conditions considered amenable to treatment
Reduce suicide rates
More older people remain supported to live in their homes
Reduce inequity in cancer mortality
Reduce infant mortality
Fewer 45-64 years admitted to hospital for avoidable conditions
Reduce the gap in young self harm hospitalisations
Reduce acute bed days in the 75+ years
Reduce avoidable hospitalisations
More babies live in smoke free homes
Reduce demand on hospital acute bed days
Reduce use of ED for mental health crisis
Less falls in older people
Reduce mortality for conditions considered amenable to treatment
More 5 year olds caries free
Medium-Term Outcomes
3-5 years
Equity
First 1,000 days
Long term conditions
Mental Health and Addictions
Frail and Older people
A Responsive Health System
Smoke free advice rates
New born enrolments with General Practice
8 month olds immunised
Pre-school children access rates - Community oral health services
Early engagement with LMC
CVD risk assessments
People with Diabetes have good glycaemic control
Acute hospital readmissions
Best practice stroke care
Smokefree advice rates
Reduce waiting times to secondary Mental Health and Addiction Services
Quality discharge and transition planning - Mental Health services
65+ years Flu immunisation coverage
Older patients falls risk assessment and plans
NASC assessments
Re-admissions 75+ years
PHO enrolment rates
Timely access to stroke and cardiology interventions
Access to timely cancer treatment
Children's scheduled oral health examinations are on time
Access to timely Planned care FSA and Treatment
Access to timely diagnostics
More planned care interventions
Performance KPIs
Equity
Prevention
Early detection and management
Intensive assessment and treatment
Rehabilitation and support
Service Output Classes

Long Term Outcomes

Hawke's Bay DHB's two long term outcomes are improving healthy life expectancy for all and halving the gap in life expectancy between Māori and non-Māori.

The goal of a health system is to maximise the length of life lived in good health. Healthy life expectancy is the number of years a person can be expected to live independently: either free of any disability or with any limitation they can manage without assistance. Improving healthy life expectancy for all is a key long term outcome for our DHB.

Māori and Pasifika people in Hawke's Bay live less years in good health, with high prevalence of living with long-term conditions, such as diabetes, cancers, cardiovascular and respiratory diseases, musckuloskeletal disorders and mental illness. Our goal is to reduce the prevalence and risk of long term conditions in our population.

Life expectancy at birth is recognised as an overall measure of health status, and our overall objective is to halve the gap between Māori and non-Māori over the next 10 years. Gains in life expectancy can be attributed to a number of factors, including access to quality health services, healthier lifestyles and socioeconomic determinants of health such as access to good quality housing, employment and education.

LIFE EXPECTANCY (LE) IN HAWKE'S BAY REGION BY ETHNCITY AND GENDER						
	2005-2007		2012-2014		2017-19	
Sub-group	Hawke's Bay 2005-2007 LE	LE Gap	Hawke's Bay 2012 -14 LE	LE Gap	Hawke's Bay 2017 -19 LE	LE Gap
Male	77.1 years	4.1 years	78.6 years	3.8 years	78.5 years	3.7 years
Female	81.2 years		82.4 years		82.2 years	
Māori Male	69.1 years	9.6 years	71.7 years	8.2 years	72.4 years	7.7 years
non-Māori Male	78.7 years		79.9 years		80.1 years	
Māori - Female	73.8 years	8.7 years	75.9 years	7.7 years	76.3 years	7.3 years
non-Māori Female	82.5 years		83.6 years		83.6 years	

NOTE: these metrics are updated every five years after the New Zealand Census.

Life Expectancy (LE) for Māori males and females has increased more than non-Māori males and females in the last five years.

In the most recent period the LE gap between Māori and non-Māori males has reduced by 0.5 years (6% reduction) and for females 0.4 years (5% reduction) compared to LE in 2012-14.

Although the gap in life expectancy is decreasing between Māori and non-Māori, the gap remains high at 7.7 years for males and 7.3 years for females. Hawke's Bay Māori males' life expectancy at birth is 72.4 years and for Māori females it is 76.3 years compared to a life expectancy at birth of 80.1 years for non-Māori males and 83.6 years for non-Māori females.

Coronary heart disease, lung cancer and diabetes are some of the main causes of the gap in life expectancy between Māori and non-Māori.

Smoking is a major contributing factor to coronary heart disease, lung cancer and diabetes. There are large inequities in smoking rates, which are 31% for Māori compared to 12% for non-Māori (2018 Census).

While total life expectancy in Hawke's Bay has increased since 2005-2007 by 1.4 years for males and 1 year for females, overall life expectancy for both males and females has decreased in Hawke's Bay between 2012-14 and 2017-19. Hawke's Bay LE for males and females ranks the third lowest of 16 New Zealand regions.

Medium Term Outcomes

Maternal and Child Health

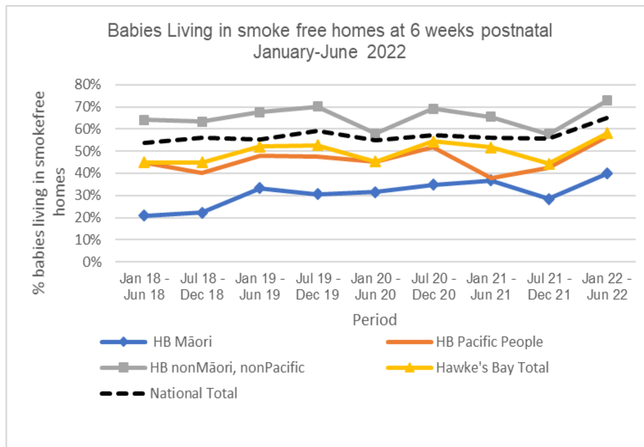
Ensuring that children have the best start in life is crucial to the health and wellbeing of the population. The first 1000 days of life have the biggest impact. Many challenges in later life have their roots in the early years of life, including obesity, heart disease and mental health. Well integrated maternal and child health services which support mothers and babies can prevent health problems and improve health outcomes in these early years. Our goal here is to increase the proportion of babies living in smoke free homes, reduce infant mortality, reduce the number of children admitted to hospital for avoidable conditions and increase the number of children who are caries-free at five years of age.

More babies live in smoke free homes

Hawke's Bay Health Equity report (2018) highlighted our maternal smoking rates are of great concern and smoking rates amongst wāhine Māori must remain a key health equity target.

Smoking in pregnancy and exposure to cigarette smoking in infancy strongly influences pregnancy and childhood health outcomes. This focus area promotes the role health providers collectively play to promote smoking cessation interventions across the maternal and child health continuum.

The desirable outcome is for babies to live in a smokefree environment. This measure is important because it aims to reduce the rate of infant exposure to cigarette smoke by focusing attention beyond maternal smoking to the home and family/whānau environment.



The target here is to gain equity between Māori and Other ethnicity rates.

This is a System Level Measure.

Note: The overall results for 2019/20 were impacted by COVID-19 response with less WTCO visits undertaken particularly during Alert Level 4.

In Jan- June 2022 there was change in how this measure is reported. The denominator no longer includes unvalidated NHI's. The impact has seen an increase in rates due to smaller denominators.

Well Child Tamariki Ora (WCTO) providers ask about household smoking status at babies six-week post-natal check. The focus here is to reduce the gap between Māori and Other ethnicity group babies living in smoke free homes.

Maori rates have increased to 40% in the Jan-June 2022 period compared to 37% in Jan- June 2021.

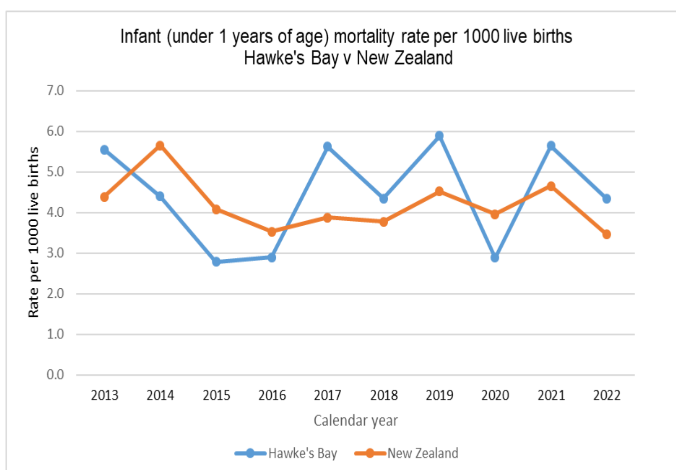
The inequity gap has steadily dropped over the last 5 years. However, a large gap still persists with Hawke's Bay Non-Maori non-Pacific rates 1.8 times higher compared to Maori rates.

The total Hawke's Bay rates is 58% and remains below the national rate of 65%.

Reduce infant mortality

Infant mortality is a long established measure of effective maternal and child health care, as well as the impact of broader social factors such as maternal education, smoking and relative deprivation.

Addressing inequities in infant mortality will also contribute to an improvement in life expectancy.



The medium-term goal here is to reduce rates.

Hawke's Bay infant mortality rates are variable due to small numbers.

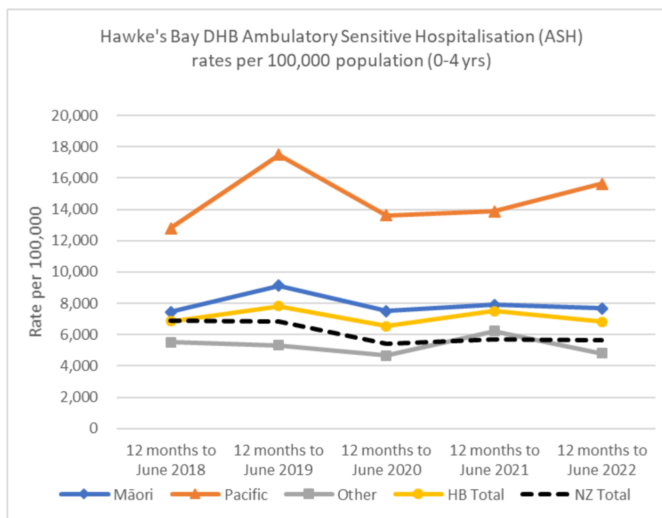
However, the 10 year trend indicates an increasing trend in infant mortality in Hawke's Bay compared to a decreasing trend nationally.

In the 2022 year Hawke's Bay infant mortality rate was 4.3 per 1000 live births which is slightly higher than the national infant mortality rate of 3.5 per 1000 births.

Fewer children are admitted to hospital for avoidable conditions

In Hawke's Bay, 39 % (810 events) of all child 0-4-year olds acute admissions to hospital are for conditions that are potentially avoidable through prevention, for instance; immunisation, dental care and management in primary care. These potentially avoidable acute admissions are known as Ambulatory Sensitive Hospitalisations (ASH). These conditions are predominantly respiratory illnesses, dental, gastroenteritis, and skin infections.

Health care access as well as underlying determinants of health (housing quality and crowding, exposure to secondhand cigarette smoke, and poverty) all contribute to ASH rates and the inequities seen in the performance against this measure. Access to population health programmes such as healthy housing interventions and tobacco cessation are important. ASH rates are higher in Māori and Pacific children.

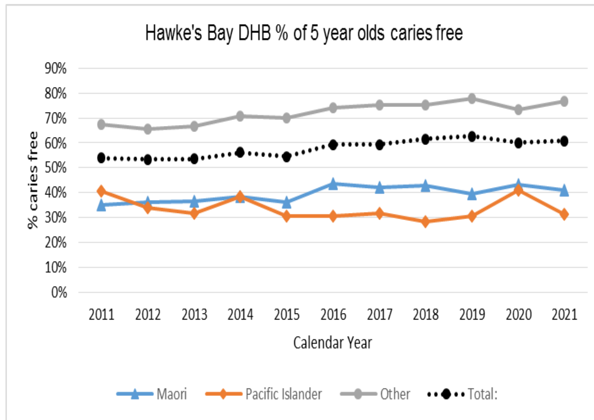


The target here is to maintain or reduce the Māori ASH (0-4 y) rate to equal to or less than 7323 per 100,000 in the 21/22 year.
This is a System Level Measure.

Hawke's Bay total ASH rates have declined 9 % between 20/21 and 21/22. Māori ASH rates have also declined 3 % to 7671 per 100,000 in the 21/22 year. However this reduction didn't meet the target to maintain or reduce rates to equal to or less than 7323 per 100,000 for Māori children. Respiratory and dental conditions remain the top causes of higher ASH rates in Māorii children. Pacific children ASH rates have increased 13 % driven by upper and ENT respiratory conditions.

More five-year olds are caries-free

Dental decay (dental caries) is one of the most common preventable chronic diseases. Poor dental health in childhood can carry on into adulthood. Dental treatment for caries is a leading cause of avoidable hospitalisations in children. Good oral health indicates that families have received health information, and health promotion and prevention services are engaging effectively with whānau for instance through early enrolment in the community oral health services. Good oral health is part of overall life-long health supporting diet, self-esteem and quality of life.



The goal in the 21/22 year is greater than and equal to 62% of 5-year olds are caries free.

The overall percentage of five-year old's caries-free in Hawke's Bay increased slightly from 60% in 2020 to 61% in 2021 (978 children out of 1607 treated were caries free).

However, during this period, we have seen some deterioration in the percentage of Māori and Pacific five-year old's caries-free. As a result, the gap in inequity has widened.

While the long-term trend is an increase in the % of Māori children caries free at 5 years of age, the percentage of Māori five-year old's caries-free decreased from 43% in 2020 to 41% in 2021 (245 out of 600 treated were caries free).

The percentage of Pacific five-year old's caries-free decreased from 39.8% in 2020 to 31% in 2021 (27 out of 86 treated were caries free).

Long Term Conditions

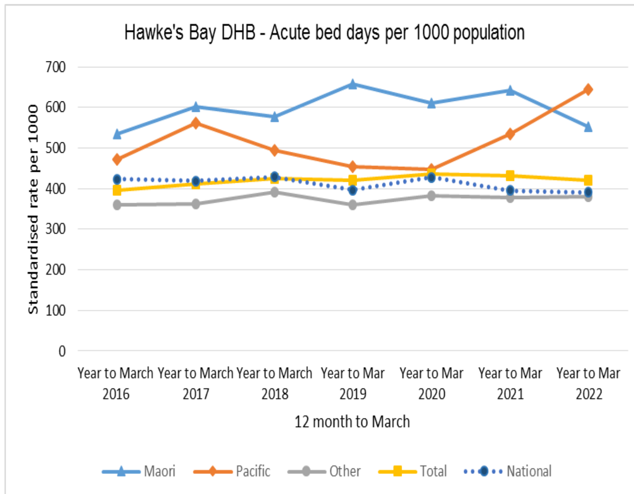
We aim to reduce the prevalence of long-term conditions, and to provide the services people need to manage their long-term conditions more effectively to reduce avoidable hospitalisations, premature mortality and frailty in older age.

The demand on acute care services is increasing due to an ageing population and the increase in prevalence of long term conditions such as cardiovascular disease, respiratory disease, chronic obstructive pulmonary disease and diabetes. We need to strengthen our ability to manage acute demand, deliver more planned care in the community, be innovative to support people to manage long term conditions and support healthy ageing.

Reduce acute bed days per 1000 population

Acute hospital bed days per capita is a measure of the use of acute services in secondary care. It is used as to assess how effective intervention and treatment in primary care is, and integration of health services across the sector including access to diagnostics. Acute hospital bed days can also be influenced by optimising patient flow within the hospital, discharge planning, community support services and good communication between health care providers.

Overall Hawke's Bay DHB's acute bed days per 1000 population in the 12 months to March 2022 are 8 % above target. COVID 19 hospitalisations and the national wide RSV outbreak



The 21/22 target is a 390 acute bed days per 1000 population (3% decrease from baseline of 403 per 1000 (12 months to Dec 2019). This is a System Level Measure

have contributed to this increase in acute hospitalisations.

Māori acute bed day rates (552 per 1000 population) in the 12 months to March 2022 have decreased 14 % compared to 642 per 1000 the same period in 2021.
Pacific rates 645 per 1000 population in the 12 months to March 2022 have increased 21 % compared to 534 per 1000 population in the 12 months to March 2021. Pacific rates are the highest of all ethncity groups.

Māori rates remain 45% higher compared to Other rates in the 12 months to March 2022. However, this gap has narrowed considerably compared to the previous 12 months to March 2021.

The top conditions based on Diagnostic Related Group (DRG's) contributing to the highest acute bed days in the 12 months to March 2022 were respiratory conditions, cardiovascular including, stroke, back injuries, oesophatigitis and gastroenteritis and hip and femur procedures.

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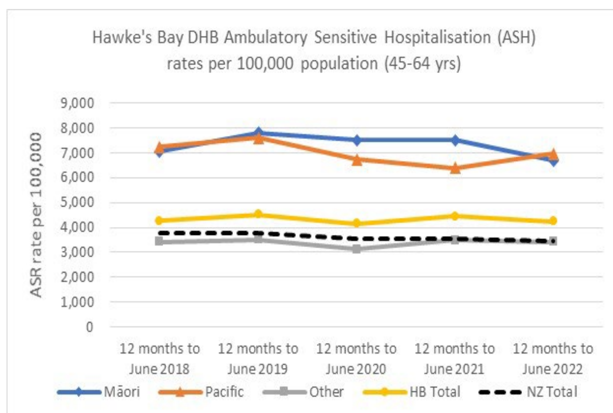
Reduce avoidable hospitalisations in 45-64 year age group

Ambulatory Sensitive Hospitalisations (ASH 45-64) reflect hospital admissions that are considered amenable to out of hospital management and therefore should be avoided. In the 45-64 year age group ASH hospitalisations can serve as a proxy measure for good access to primary care, and care coordination and management of long term conditions. In Hawke's Bay there are large inequities evident in ASH rates for 45-64 year olds. For people aged 45-64 the top ASH conditions are angina and chest pain, myocardial infarction, respiratory infections (chronic obstructive pulmonary disease (COPD) and pneumonia) and cellulitis.

In the 12 months to June 2022 there were 2,070 admissions in the 45-64-year age group which were potentially avoidable.



The goal is a reduction in rates to less than and equal to 4209 per 100,000 population in the 21/22 year.
Age standardisation rate (ASR) is based on World Health Organisation (WHO) standardisation.

The overall Hawke's Bay DHB 45-64-year olds ASH rate decreased by 5% to 4,244 in the 12 months to June 2022 compared to the previous 12 months to June 2021 This result was 1% above target.

The Māori 45-64-year-old ASH rate decreased 11% in the 12 months to June 2022 compared to the same period in 2021. ASH conditions with largest absolute drop were myocardial infarction, stroke, congestive heart failure and cellulitis.
Pacific rates increased 9% in 12 months to June 2022 compared to the same period 2021. This represented an increase in nine ASH hospitalisations.

While the gap between Māori 45-64 years ASH rates and the Other ethnicity group has narrowed, large inequities remain with Māori rates 1.9 times higher than Other ethnicity rates in the 12 months to June 2022. Pacific rates are twice the Other ethnicity rates in the 12 months to June 2022.

Mental Health and Addictions

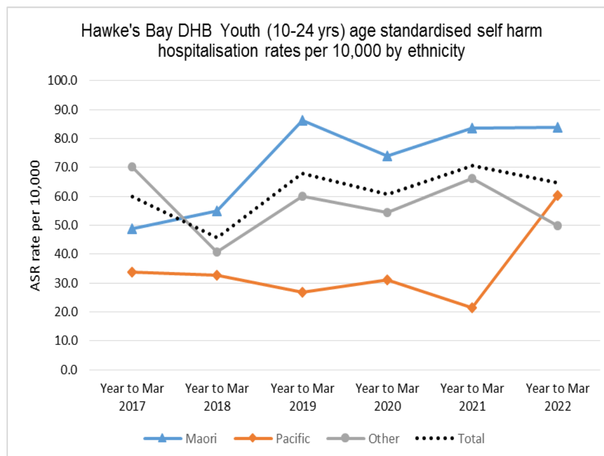
Mental health and addictions impact the lives of many people in Hawke's Bay. Each year, around one in five of our population experience mental illness or significant mental distress. Whānau have told us alcohol and drug addiction, particularly methamphetamine, is having a significant impact on whānau wellbeing in our district.

Specialist mental health and addiction services are funded for people severely affected by mental illness or addictions. Better and timely access to a broad range of services improves people's mental health and wellbeing and contributes to better outcomes and recovery. A new model of primary mental health support (Te Uru Matai) is being implemented across our health system. The model puts mental health and wellbeing at the heart of general practice with Health Improvement Practitioners and Health Coaches working as part of the general practice team. This model is expected to support earlier mental health and addictions intervention and continuity of care for our population.

Reduce self-harm hospitalisations in young people

Intentional self-harm is indicative of young people in distress. This may indicate problems in accessing primary mental health and referral pathways and cross sector/community support.

The measure here is the number of young people (10-24 years) who live in Hawke's Bay who are admitted to hospital for intentional self- harm.



The goal is a 10% reduction in rates (Baseline = 64.7 for year to Dec 2020) which is less than or equal to 58 per 10,000 population 10-24 year olds This is a System Level Measure.

Note: This data has been updated for previous years and may differ to that reported in the 2021 Annual Report .

Hawke's Bay DHB youth self-harm hospitalisation rates have decreased by 8% from 70.7 per 10,000 young people (10-24 years) in the 12 months to March 2021 to 64.8 per 10,000 in March 2022 (201 events). Despite the decrease rates remain 11 % higher than the target 58 per 10,000 population 10-24 yrs.

Rates for Māori youth has remained the same at 84 per 1000 population (108 events) between the 12 months to March 2021 and the 12 months to March 2022 and are 44% higher than target.

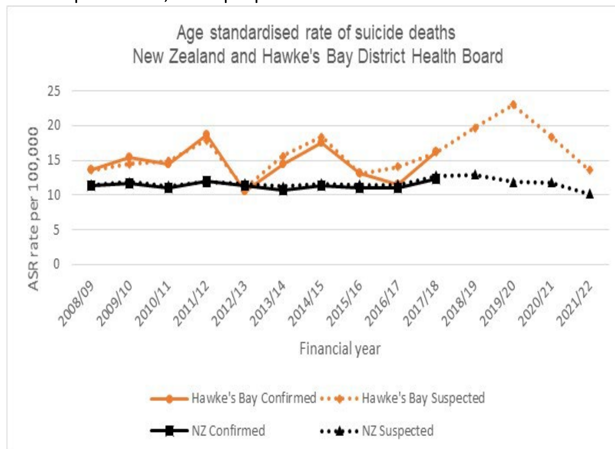
Pacific young people self-harm hospitalisations have increased by 179% to 60.2 per 10,000 population in the same period rates which is 3 % above target.The Other rate in the 12 months to March 2022 is below target at 49.8 per 10,000 population.

Māori rates are 68% higher than the Other ethnicity group in the 12 months to March 2022.

The investment in, and roll-out of, primary mental health services in general practices is aimed to reduce this growing mental health issue.

Reduce suicide rates

Intentional self-harm age standardised mortality rates per 100,000 population.



Source: New Zealand Mortality Collection (confirmed suicides); Ministry of Justice's case management system (suspected suicides).The goal is to see a decrease in rates.

Hawke's Bay DHB has mostly higher age standardised confirmed suicide rates compared to national rates in the 10 years up until 2017/18 period but these differences are not statistically significant However Hawke's Bay suspected suicide rates in the 2018/19 and 2019/20 period increased significantly and these rates were statistically significantly higher than national rates.

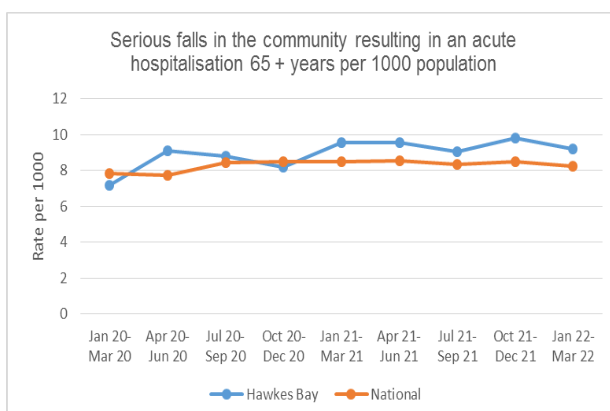
It is pleasing to see suspected suicide rates decreasing in the 2020/21 year and again in the 2021/22 year.

Frail and Older People

With an aging and growing older population in Hawke's Bay, managing frailty and the health and wellbeing of our older population is a priority. Promoting healthy lifestyles including good nutrition, exercise and long term condition management can help people avoid developing and/or exacerbating long term health conditions and the progression towards frailty. Early detection and management of frailty and access to primary care and prevention service, for instance falls prevention services, is vital to supporting older people to live independently in the community. As is fair and equitable access to home based support services. Reducing acute hospitalisations in our older population is a key goal in this priority area and gives us assurance that our older people are supported to live well in their communities.

Reduce serious falls resulting in acute hospitalisation

Falls in older people are common and a leading cause of hospitalisation in Hawke's Bay DHB. Serious falls leads to injury and hospitalisation, a loss of independence, and an increased risk of admission to residential care.



The goal is a reduction in rates.

This is an indicator from the national "Live Stronger for Longer" Falls prevention outcome framework.

The rate of serious falls resulting in an acute hospitalisation for older people 65 years and over in Hawke's Bay is hgher compared to overall national rates.

In the last quarter reported Jan - March 2022, 311 older Hawke's Bay people had a fall resulting in injury and hospitalisation or 9.2 per 1000. This is 12% higher than the national rate of 8.2 per 1000 population.

The DHB continue's to work with our cross sector partners to

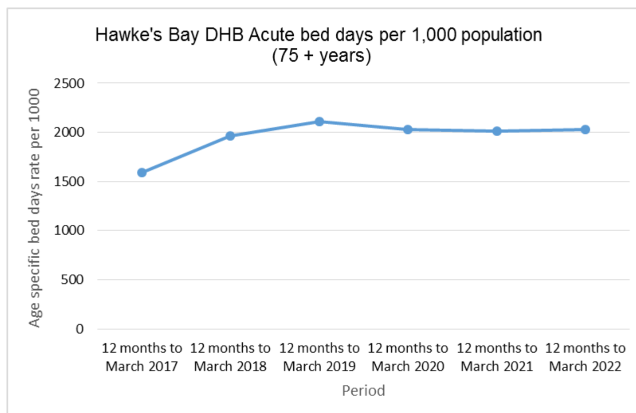
This programme is a partnership between ACC, Health Quality and Safety Commision and the Ministry of Health and DHB's.

support falls prevention programmes. Early identification of people at risk of falls, for instance in assessment's by General Practitioner/Nurse visits or when in hospital is shown to be effective in a reducing falls in our older population.

In 2021/22 90.9% of older people in hospital were given a falls risk assessment and 96% of those assessed at-risk were given an individualised care plan.

Reduce the acute bed days in 75+ population.

This is a measure of how well our older people 75+ years are supported to remain out of hospital.

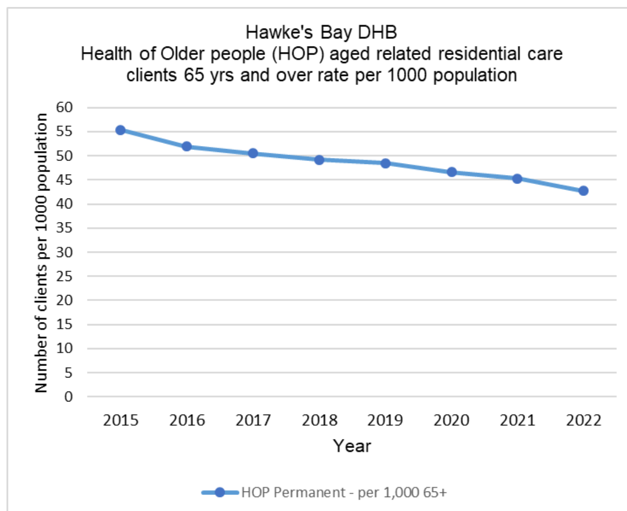


The goal is a reduction in rates.
This is a System Level Measure.

Acute bed days per 1000 population in the 75 years and older age group while increasing between 12 months to March 2017 and 12 months to March 2019 rates have since remained stable. In the 12 months to March 2022 the rate was 2,029 acute bed days per 1000 population compared to 2,016 acute bed days per 1000 population in the same period in 2021. While we haven't seen a reduction in rates, this is a good result and means that we have maintained our rate of hospitalisation in this age group despite there being a world wide pandemic.

The absolute acute bed days for the 75 years and over increased 2 % between 12 months to March 2021 and the same period 2022 driven predominantly by an increase in the 75 years and over population. Top conditions for acute hospitalisation in this age group are stroke, respiratory conditions and injuries.

Increase the 65 years and over population remaining independent in their own homes



The goal is to see a reduction in rates.
This is a local DHB outcome measure.

We continue to see a pleasing reduction in the number of clients 65 years and over living in age related residential care. This gives us assurance that we are supporting more of our older people to live independently in the community.

Responsive Health System

A key priority for Hawke's Bay DHB is our people have access to appropriate and responsive health care when health events occur. This could be primary, secondary or tertiary health services.

Access to timely services across the health continuum from prevention through to end-of-life is vital to support wellness and quality of life in our population. Our aim here is for fewer people to die prematurely from potentially avoidable conditions such as cardiovascular disease, cancer and diabetes.

Examples of this is the early, timely and equitable access to cancer treatment including diagnostics, surgery, chemotherapy and radiation oncology which contributes to improved survival rates and improved life expectancy outcomes for our population.

Reduce inequity in cancer mortality

Cancer is one of the leading causes of mortality in Hawke's Bay and contributes to a high proportion of premature deaths. The DHB continues to achieve national Faster Cancer Treatment targets with 87% of people provided with urgent cancer treatment within the target timeframe in 2021/22.

Cancer mortality rates	
Cancer age standardised mortality rates per 100,000 population	This measure is not available as updated age standardised rates are not curently available.

Reduce premature mortality in conditions that are amenable to treatment

The amenable mortality rate measures the number of deaths under age 75 years that could be avoided through effective health prevention, detection and management interventions. Top amenable mortality conditions are coronary heart disease, cancers, diabetes, stroke, chronic obstructive pulmonary disease and suicide.

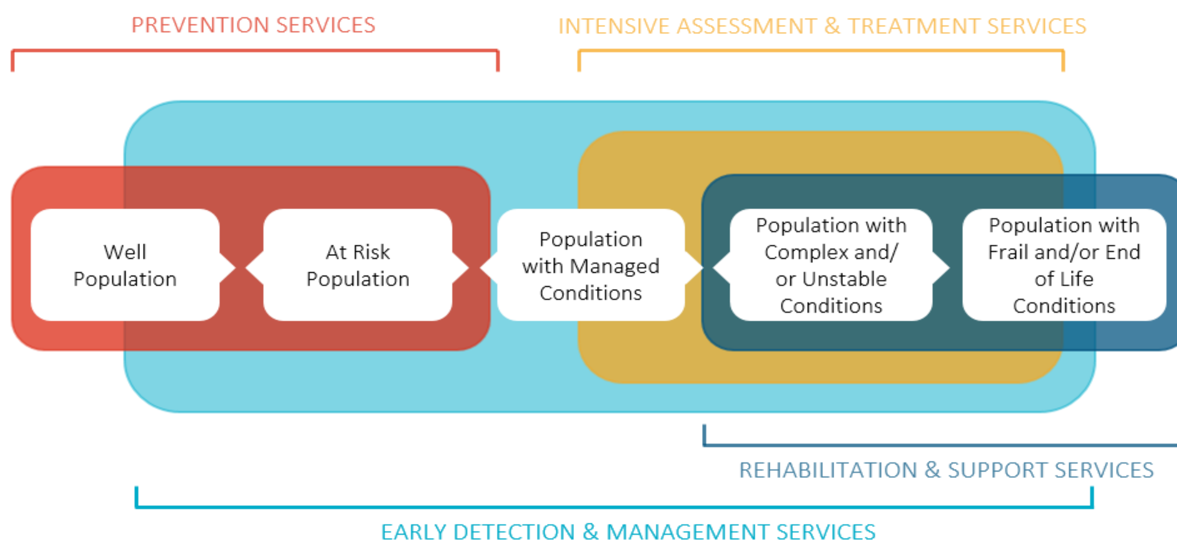
The top cause of amenable mortality for Māori is coronary heart disease (CVD), using a Cardio Vascular Disease Risk Assessment (CVDRA) is one way to identify the risks of CVD early; lifestyle and drug interventions can reduce the risks and severity of the disease. 76.3% of the eligible population in 21/22 had a CVD risk in the last 5 years which is lower than the 90% or greater national target.

Large inequities exist in Hawke's Bay for premature coronary heart disease deaths. Sixty three percent of the 105 Māori who died from this cause of death in the 2017-2019 period were under the age of 74 years compared to 24 % of the 591 non Māori coronary heart disease deaths in the same period.

Premature mortality rates	
Amenable age standardised mortality rates per 100,000 population	This measure is not available as there is no updated age standardised rates post 2018 which was reported in the 20/21 Hawke's Bay DHB Annual Report.

Part III – Statement of Performance

Output Overview



The Statement of Performance (SP) presents a snapshot of the services provided for our population and how these services are performing, across the continuum of care provided. The SP is grouped into four output classes that are a logical fit with the stages of the continuum of care (see diagram above) and are applicable to all DHBs:

- Prevention Services,
- Early Detection and Management,
- Intensive Assessment and Treatment, and
- Rehabilitation and Support Services.

These measures help to evaluate the DHB's performance over time are reported for each output class, recognising the funding received, Government priorities, national decision-making and Board priorities.

The performance measures chosen are not an exhaustive list of all our activity, but they provide a good representation of the range of outputs that we fund and/or provide. They also have been chosen to reflect outputs which contribute to the achievement of national, regional, and local outcomes. Where possible, we have included with each measure past performance as a baseline[2] data to support evaluation of our performance.

The criteria against which we measure our output performance is applied to each indicator in the Output Measures section.

Criteria	Rating	
On target or better	Achieved	🟢
0.1-5% away from target	Substantially achieved	🔵
>5% to 10% away from target	Not achieved but progress made	🟡
>10% away from target	Not achieved	🔴

[2] Baseline is as reported in Annual Plan for 2021/22

Output Class 1: Prevention Services

Prevention services help to protect and promote health in our population. A broad view of prevention services encompasses; health promotion to help prevent the development of disease, statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases, and population health protection services (e.g. immunisation and screening services).

Statement of Performance Output Class 1
Prevention Services are publicly funded services that protect and promote good health in the whole population or identifiable sub-populations comprising services designed to enhance the health status of the population, as distinct from treatment services which repair or support health and disability dysfunction. Prevention Services address individual behaviours by targeting population-wide physical and social environments to influence health and well-being. Prevention Services include: health promotion and education services; statutory and regulatory services; population-based screening programmes; immunisation services; and, well child and school services.

On the continuum of care, Prevention Services are population-wide and are designed to focus attention on wellness of the general population and on keeping the “at risk” population healthy. It is important to emphasise that the concept of wellness extends to the entire population, including those who already have a health condition or disability.

Through collective action with communities and other sectors, we aim to protect the general population from harm and keep them informed about good health so that they are supported to be healthy and empowered to take control of their well-being. We aim to reduce inequities in health outcomes as quickly as practicable and we recognise that they often arise out of issues that originate outside the health system. Prevention programmes include the use of legislation, policy, education and community action to increase the adoption of healthy practices amongst the population and to overcome environmental barriers to good health.

Output measure	Baseline Period	Baseline	Previous Year (2020/21)	Current year (2021/22)	Target	Rating
BETTER HELP FOR SMOKERS TO QUIT						
% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.	12m to Jun 20	90.90%	81.32%	73.44%	≥ 90%	●
Māori		89.50%	82.72%	73.21%		●
% of Primary Health Organisation (PHO) enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months	15m to Jun 20	61%	50.2%	38.1%	≥ 90%	●
Māori		56%	47.5%	36.8%		●
Pasifika		56%	40.1%	29.7%		●
Other		65%	53.6%	40.1%		●

By ensuring better help for smokers to quit in primary care settings, DHBs assist in the delivery of Government's priority to support healthier, safer and more connected communities and help support the Government's aspirational goal of a Smokefree New Zealand by 2025.

In order to improve the provision of smoking advice and support to pregnant women in Hawke's Bay, carbon monoxide monitors for Lead Maternity Carers (LMC) and midwives have been purchased by the DHB. Smokefree screening has been updated to reflect vaping or being vape free and, during the last 12 months, HBDHB has been involved in the community Smokefree Cars campaign, which reached over 37,000 people.

However, the midwifery and smokefree resource has been severely depleted in the 21/22 year which has led to the drop in the number of women whom are identified as smokers given brief advice and support to quit.

The provision of smoking advice to PHO enrolled patients by health care practitioners has not met targets for 2021/22, largely due to the change in the general practice model during the COVID-19 outbreak. This saw a reduction of in-person appointments, and a resulting reduction in opportunistic discussions around smoking cessation.

Output measure	Baseline Period	Baseline	Previous Year (2020/21)	Current year (2021/22	Target	Rating
IMPROVE BREAST SCREENING RATES						
% of women aged 50-69 years receiving breast screening in the last 2 years	2y to Dec 20[3]	72%	69%	68.99%	≥ 70%	
Māori		70%	59%	55.71%		
Pasifika		66%	60%	54.69%		
Other		75%	71%	73.09%		
IMPROVE CERVICAL SCREENING COVERAGE						
% of women aged 25-69 years who have had a cervical screening event in the past 36 months	3y to Mar 20	74%	69%	66.71%	≥ 80%	
Māori		74%	62%	52.34%		
Pasifika		76%	62%	54.79%		
Other		75%	73%	72.59%		

Cervical and breast cancer screening measures refer to participation in national screening programmes and standards are set nationally. Cervical cancer is one of the most preventable cancers and breast cancer one of the most common. Risk increases with age and regular screening reduces the risk of dying from cancer by allowing earlier intervention and treatment.

Rates for cervical and breast screening in Hawke's Bay are both below national targets, particularly for Māori and Pasifika. Events focused on Māori and Pasifika wāhine have been held to allow both screenings to take place at the same time and at the same venue. While these have been moderately successful, staffing issues caused by a number of factors

[3] Date for this measure in Annual Report was 24m to Dec-19. This was an error.

including the redirection of resources into COVID-19 vaccinations, staff resignations due to vaccine mandates and COVID-19 related sickness and isolation (both for staff and wāhine), continue to impact on delivery. The use of the Breast Screen Aotearoa (BSA) mobile unit has proven to be effective for screening delivery in regional Hawke's Bay and use of this resource will continue in 2022/23.

Output measure	Baseline Period	Baseline	Previous Year (2020/21)	Current year (2021/22)	Target	Rating
INCREASE IMMUNISATION						
% of eight-month-olds olds fully immunised.	12m to Jun 20	91%	90%	86%	≥ 95%	● (yellow)
Māori		90%	83%	77%		● (red)
Pasifika		96%	96%	92%		● (blue)
Other		92%	94%	92%		● (blue)
% of five-year-olds have completed all age-appropriate immunisations due between birth and five year of age.	12m to Jun 20	91.00%	88.06%	84.45%	≥ 95%	● (red)
Māori		90.20%	86.05%	79.64%		● (red)
Pasifika		96.00%	85.16%	84.13%		● (red)
Other		91.90%	90.35%	88.92%		● (yellow)
% of two-year-olds have completed all age-appropriate immunisations due between birth and age two years	12m to Jun 20	93.5%	89.6%	88.1%	≥ 95%	● (yellow)
Māori		92.8%	85.8%	85.4%		● (yellow)
Pasifika		97.8%	94.6%	91.8%		● (yellow)
Other		93.6%	92.0%	89.8%		● (yellow)

Improving childhood immunisation coverage is part of our system's early investment to lay foundations for life-long wellbeing and will support the Government priority to 'Make New Zealand the best place in the world to be a child'. Immunisation supports the health system outcome that New Zealander's live longer in good health and is one of the most cost-effective public health interventions..

It has been challenging for Hawke's Bay to reach immunisation targets during 2021/22, particularly for Māori, with vaccine fatigue and the reallocation of vaccination resources to provide COVID-19 vaccinations having an impact. HBDHB's outreach Immunisation service has continued to provide more care than they are resourced for, however, there are some whānau that have been difficult to engage despite repeated efforts. 2% of children in the 8-month group were delayed immunisations due to sickness. There has also been an increase in the decline rate for Māori over the 21/22 year.

In order to improve immunisation rates, a community immunisation clinic has been established in Napier and is well attended. Plans to establish a second clinical in Hastings are underway. Hawke's Bay DHB is currently reviewing the policy relating to upskilling vaccinators to administer infant immunisations to improve the timeliness of the process. This will result in increased vaccination capacity.

Output measure	Baseline Period	Baseline	Previous Year (2020/21)	Current year (2021/22)	Target	Rating
% of girls and boys fully immunised - HPV vaccine	12m to Jun 20	61.00%	63.00%	65.90%	≥ 75%	🔴
Māori		64.00%	64.10%	63.70%		🔴
Pasifika		68.00%	67.90%	68.30%		🟡
Other		58.00%	78.20%	71.85%		🔵
% of 65+ year olds immunised - flu vaccine	6m to Sep 19	60%	73%	67%	≥ 75%	🔴
Māori		53%	77%	63%		🔴
Pasifika		46%	66%	68%		🟡
Other		61%	74%	67%		🔴

Hawke's Bay DHB's HPV vaccination rates have not met target across all population groups and have been impacted greatly by worsening school attendance rates in Hawke's Bay, which has in turn impacted on permission slip returns for vaccinations (and the vaccination events themselves). Hawke's Bay is currently involved in a multi-agency programme to improve attendance rates. It is hoped that this will help improve HPV vaccination rates in the future.

Timing of the COVID vaccine rollout occurred at same time as the influenza vaccine in 2021. Low influenza disease in the community with borders closed meant many people were not concerned with the risk of influenza in 2021 and therefore uptake in the 65 years and over age group deteriorated in the 21/22 year. Communications promoting influenza continue. Concurrent vaccination of those presenting for covid boosters and promotion of influenza vaccines in these settings also continues.

The delivery of influenza vaccines for our over 65s has changed significantly for the 2022 season. Use of COVID-19 structures and resources has seen the use of HBDHB clinics and mobile sites along with more delivery by Māori Health Providers than previous years. There have been significant issues with influenza data and data recording by PHO and providers. The HBDHB COVID-19 directorate is working with the PHO to clean and clear data backlog of errors and entry.

Output Class 2: Early Detection and Management

Statement of Performance Output Class 2

Early Detection and Management services are delivered by a range of health and allied health professionals in various private, not-for-profit and Government service settings to individuals and small groups of individuals. The Output Class includes primary health care, primary and community care programmes, child and adolescent oral health and dental services, pharmacist services, and community referred tests and diagnostic services. The services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the district.

On the continuum of care these services are mostly concerned with the “at risk” population and those with health and disability conditions at all stages.

By promoting regular engagement with health services, we support people to maintain good health through earlier detection and management services based in the community. These services provide an opportunity to intervene in less invasive and more cost-effective ways, and reduce the burden of long-term conditions through supported self-management (avoidance of complications, acute illness and crisis). These services deliver coordination of care, ultimately supporting people to maintain good health.

Output measure	Baseline Period	Baseline	Previous Year (2020/21)	Current year (2021/22)	Target	Rating
BETTER ORAL HEALTH						
% of preschool children (aged 0-4 years of age) enrolled in and accessing community oral health services (Yr1)	12m to Dec 19	91.0%	92.5%	95.1%	≥ 95%	🟢
Māori		75.9%	77.4%	79.7%		🔴
Pasifika		83.1%	84.9%	85.2%		🔴
Other		106.8%^	108.3%	111.3%		🟢
% of children (aged 0-12 years of age) overdue for their scheduled examinations with Community Oral health service (Yr1)	12m to Dec 19	14.00%	23.99%	25.05%	≤ 10%	🔴
Māori		15.18%	20.44%	27.20%		🔴
Pasifika		21.50%	16.52%	28.44%		🔴
Other		12.00%	27.03%	23.27%		🔴
% utilisation of DHB funded dental services by adolescents for school Year 9 up to and including 17 years (Yr1)	12m to Jun 20	61.1%	33.20%	58.9%	≥ 85%	🔴
Māori		No Data	No Data	41.3%		🔴
Pasifika		No Data	No Data	26.9%		🔴
Other		No Data	No Data	75.2%		🔴

^ there remains an issue with the denominator “estimated population” in this measure particularly for the Other ethnicity result where there are more 0-4 year old Other children enrolled in the Community Oral Health Service compared to the estimated population. This could indicate a data quality issue in the ethnicity data capture in the Oral Health Information System or an undercount of the other ethnicity estimated population.

Delivery of measures relating to better oral health support the vision for the New Zealand health and disability system of Pae Ora - healthy futures. Publicly funded oral health services are available to children and adolescents from birth to 17 years of age, through the Community Oral Health Service (COHS), provided by DHBs throughout New Zealand, DHB-funded contracts with Māori oral health providers to provide child oral health services, and DHB-funded contracts with private dentists and Māori oral health providers to provide adolescent oral health services.

Engagement for pre-schoolers in oral health services is a strong focus for the Hawke's Bay COHS, which is currently piloting Hub Administrator roles to facilitate better connections with whānau. While inequity still exists in this measure, early results both from whānau feedback and qualitative data are very positive and this pilot has been extended.

Arrears in appointment schedules have been strongly impacted by COVID - including lockdown periods, restrictions in dental work able to be delivered and, most recently, due to staff sickness/redeployment. Positively, the numbers of pre-schoolers beginning to be serviced by Mobile Dental Units is increasing with a greater focus on engagement and working with whānau to offer appointments at mutually agreed times and locations. Over 200 preschool tamariki have been seen via the mobile vans in 2021.

There has been a significant increase in adolescent rates in the 21/22 year over rates in the 20/21 year. The 20/21 year was impacted by COVID lock downs and secondary school closures which resulted in a marked drop in young people accessing dental services. While the 21/22 year is showing some improvement in access, current rates are still well below pre- pandemic rates. The current service delivery model for adolescent dental services is under review as we have noted there are problems for our Māori and Pasifika communities accessing the service, for instance hours of work and access to transport. However, the Hawke's Bay COHS is working alongside a private provider to facilitate adolescents primarily from our lower decile regions to access dental care (with delivery via our Dental Hubs and the Mobile Dental Unit when on site at a Kura). It is actively supported by the DHB Adolescent Dental Coordinator and has been welcomed by the kura/ schools/ alternative education providers who have been involved to date. Pathways to access Dentist care are being confirmed with approximately 10% of rangatahi requiring an onward referral. In addition, a mobile dental unit has been given to the Te Taiwhenua O Heretaunga (TTOH) oral health team, who are now working in partnership with the HBDHB COHS to design a strategy and workplan to address adolescent dental utilisation.

Output measure	Baseline Period	Baseline	Previous Year (2020/21)	Current year (2021/22)	Target	Rating
IMPROVED ACCESS PRIMARY CARE						
% of Māori population enrolled in the PHO	As at Jun 20				≥ 95% Māori	
Māori		99%	87%	85%		●

By improving Māori enrolment in PHOs, DHBs will assist in delivery of Government's priority to support healthier, safer and more connected communities and our health system outcome that we have health equity for Māori and other groups.

The decline in Māori enrolments during 2021/22 has been impacted by the availability of general practitioners in Hawke's Bay, with a current shortage of 23 GPs. Through the PHO's Priority Population Programme, some practices have started to enrol any Māori patient that presents to improve enrolment numbers. In addition, a supported enrolment pathway from Urgent Care to General Practices is currently being implemented.

Output measure	Baseline Period	Baseline	Previous Year (2020/21)	Current year (2021/22)	Target	Rating
IMPROVED MANAGEMENT OF LONG- TERM CONDITIONS (CVD, ACUTE HEART HEALTH, DIABETES, AND STROKE)						
% of the eligible population will have had a Cardiovascular disease (CVD) risk assessment in the last five years	5y to Jun 20	81.20%	80.30%	76.25%	≥ 90%	●
Māori		78.50%	77.00%	69.40%		●
Pasifika		76.40%	75.90%	66.13%		●
Other		83.90%	82.00%	79.36%		●
% of PHO enrolled people with diabetes who have good or acceptable glycaemic control (HbA1c<64mmols)	12m to Jun 20	39.1%	31.0%	59.7%	≥ 60%	●
Māori		32.7%	23.1%	52.5%		●
Pasifika		33.3%	21.6%	65.3%		●
Other		43.5%	36.9%	49.9%		●

Long-term conditions comprise the major health burden for New Zealand now and into the foreseeable future. Cardiovascular disease, including heart attacks and strokes, are substantially preventable with lifestyle advice and treatment for those at moderate or higher risk. Diabetes is also important as a major and increasing cause of disability and premature death and is a good indicator of the responsiveness of a health service to the people in most need.

Cardiovascular disease risk assessment rates have fallen during 2021/22, with COVID-19 affecting the service delivery model in general practice and opportunities to provide CVD risk assessments. In addition, general practice capacity has continued to be under pressure with only 50 % open to new enrolments at the end of June 2022. Some outreach services have been able to continue to support CVD risk assessment rates and these will continue into 2022/23.

There has been significant improvement (29 % increase between 20/21 and 21/22) in the percentage of diabetics who have good or acceptable diabetes control. There has been a focus in general practice to improve diabetics management through pharmacist facilitators and improvements in data quality, but opportunities still exist to improve equity for Māori. Pathway development for diabetes has been delayed by COVID-19 and access to schools - however a rangitahi redesign service specifications are in contract with a new provider collective which encompasses a number of Māori health providers. The School Based Health Service (SBHS) redesign is expected to be implemented during the 22/23 year and Health Hawkes Bay representation is participating in this to ensure alignment and linkages. Rangitahi Advisors (x2) now in place at the DHB and Health Hawkes Bay(PHO) (x1) will connect with rangitahi as to diabetes awareness and the impact on their wellbeing and whānau.

Output measure	Baseline Period	Baseline	Previous Year (2020/21)	Current year (2021/22)	Target	Rating
IMPROVING NEW-BORN ENROLMENT IN GENERAL PRACTICE						
% of new-borns enrolled in general practice by 6 weeks of age	12m to Jun 20	69%	66%	59%	≥ 55%	●
Māori		57%	50%	43%		●
Pasifika		85%	67%	56%		●
Other		80%	82%	74%		●
% of new-borns enrolled in general practice by 3 months of age	12m to Jun 20	85.00%	80.69%	71.73%	≥ 85%	●
Māori		73.10%	62.17%	53.54%		●
Pasifika		95.10%	83.33%	71.76%		●
Other		97.30%	99.21%	88.74%		●

Improving child wellbeing is one of the Government's top five health priorities. Early newborn enrolment with general practice supports this. Enrolment of all children at birth with a primary care provider is recommended by the Children' Commissioner and is supported by the Paediatric Society of New Zealand to support timely engagement with health services.

Newborn enrolment rates for Hawke's Bay have declined over the 2021/22 year - highlighting a significant and growing equity gap. General practice capacity in Hawke's Bay has continued to reduce in the 21/22 year with only 50 % open to new enrolments at the end of June 2022. This is impacting on new born enrolment rates particularly Māori and Pasifika who have lower general practice enrolment rates . To address this gap, a quality improvement process is underway between the Health Hawke's Bay and DHB to deep dive into this indicator by matching and following up enrolment information from the Maternity booking sheets and National Immunisation Register. Health Hawke's Bay has assigned a resource to this process to ensure an audit of current enrolment information, touch points and a communications plan to general practices to prioritise enrolment of hāpu wahine when requested to support the onward impact of newborn enrolment.

Output measure	Baseline Period	Baseline	Previous Year (2020/21)	Current year (2021/22)	Target	Rating
INCREASE REFERRALS OF OBESE CHILDREN TO CLINICAL ASSESSMENT AND FAMILY BASED NUTRITION, ACTIVITY AND LIFESTYLE INTERVENTIONS						
% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions.	12m to Jun 20	99.6%	100.0%	100.0%	≥ 95%	
Māori		100.0%	100.0%	100.0%		
Pasifika		100.0%	100.0%	100.0%		
Other		99.0%	100.0%	100.0%		

Performance for this measure has met targets for 2021/22.

Output measure	Baseline Period	Baseline	Previous Year (2020/21)	Current year (2021/22)	Target	Rating
LESS WAITING FOR DIAGNOSTIC SERVICES						
% of patients with accepted referrals for Computed Tomography (CT) scans who receive their scan, and scan results are reported, within 6 weeks (42 days)	12m to Jun 20	72.0%	78.0%	79.6%	≥ 95%	
Māori		No Data	78.0%	78.8%		
Pasifika		No Data	76.0%	75.8%		
Other		No Data	78.0%	80.5%		
% of patients with accepted referrals for MRI scans who receive their scan, and the scan results are reported, within 6 weeks (42 days).	12m to Jun 20	67.0%	45.0%	46.2%	≥ 90%	
Māori		No Data	49.0%	46.7%		
Pasifika		No Data	56.0%	49.3%		
Other		No Data	44.0%	47.4%		

CT and MRI diagnostic measures are national DHB performance measures and refer to non-urgent scans.

Hawke's Bay DHB has not achieved targets both for CT and MRI scans for 2021/22. This has been hampered by a high level of acute presentations and Faster Cancer Treatment (FCT) demand.

Outsourcing of CT scans has continued, but is limited by local capacity of IANZ accredited facilities. Some increase in scan volumes has also been achieved via in house weekend sessions. An upgrade to the onsite MRI scanner has been completed, reducing scan times and improving image quality, while project work continues on options for the installation of a second CT scanner and MRI machine.

Output measure	Baseline Period	Baseline	Previous Year (2020/21)	Current year (2021/22)	Target	Rating
MORE PREGNANT WOMEN UNDER THE CARE OF A LEAD MATERNITY CARER (LMC)						
% of women booked with a Lead Maternity Carer (LMC) by week 12 of their pregnancy[4]	12m to Jun 20	57%	57%	66%	≥ 80%	
Māori		49%	49%	55%		
Pasifika		43%	43%	45%		
Other		65%	65%	74%		

This is a national quality measure for maternity services. Early registration with an LMC is encouraged to promote the good health and wellbeing of mother and the developing baby.

Hawke's Bay's rates of women booked with an LMC by week 12 of their pregnancy have increased in the last year, but still have significant room for improvement, particularly to achieve equity. Nga Maia and Māori midwives advise many Māori women do not see the benefit of early engagement with an LMC. Additionally, there may be some reluctance to disclose a pregnancy that could have impacts on work and income benefits. There is an active programme of work to improve early engagement with LMCs.

Output measure	Baseline Period	Baseline	Previous Year (2020/21)	Current year (2021/22)	Target	Rating
REDUCE ASH 45-64						
Ambulatory sensitive hospitalisations (ASH) rate per 100,000 45-64 years (World Health Organisation age standardised rate)	12m to Jun 20	4209	4665	4244	≤ 4209	
Māori		7843	8219	6690		
Pasifika		7454	7141	6960		
Other		3121	3623	3418		
REDUCE THE DIFFERENCE BETWEEN MĀORI AND OTHER RATE FOR ASH ZERO-FOUR - SLM						
Ambulatory Sensitive Hospitalisation (ASH) rate per 100,000 zero - 4 years	12m to Jun 20	6436	N/A	N/A	≤ 7323 Māori	
Māori		7323	7680	7671		

Ambulatory Sensitive Hospitalisations (ASH) are hospital admissions which could have been avoided through access and interventions in primary care. ASH rates in the age group 45-65 years reflect how effective primary care is in supporting people with long term conditions to manage their conditions and stay out of hospital. The target was set to achieve equity between Māori, Pacific and the Other ethnicity group.

There have been significant improvements in ASH rates in the 45-65 year age group for Māori and Pasifika in 21/22 compared to the 20/21 year. While rates are still below target,

[4] NOTE: Full ethnicity breakdowns were not reported in the 2020/21 Annual Report but reported this year to support the DHB's equity focus.

a number of actions of focused support for Māori and Pasifika continue, including community outreach with a CVD focus for Māori.

In the ASH age group 0-4 years, the target has a focus to improve Māori ASH rates. Māori ASH rates for this age group have decreased over the previous year. During 2021/22 an investment into a collaborative model with the paediatric homecare service was prioritised to ensure sustainability beyond previous winter-based pilots. This included employment of a specific ASH Kaiāwhina to support whānau who presented to ED and/or were admitted to Paediatric services. The service provides intensive one-on-one support to whānau, putting in place a plan that is responsive to whānau needs on discharge, including engagement with the child's primary care provider and any necessary follow-up support in the home. Results to date are encouraging.

Output Class 3: Intensive Assessment and Treatment Services

Impact

Complications of health conditions are minimised and illness progression is slowed down.

Statement of Performance Output Class 3

Intensive Assessment and Treatment Services are delivered by a range of secondary, tertiary and quaternary providers. This Output Class includes: Mental Health services; Elective services (including outpatients, surgery, inpatient, and cancer services); Acute services, (including ED, Inpatient and Intensive Care services); Maternity services; and, Assessment, Treatment and Rehabilitation (AT&R) services. These services are usually integrated into facilities that enable co-location of clinical expertise and specialised equipment, such as a 'hospital', and they are generally complex in nature and provided by specialists and other health care professionals who work closely together. There are also important links with community-based services before people come into hospital services and after they are discharged – these links must be well coordinated and work as seamlessly as possible.

HBDHB provides most of this Output Class through the Provider Arm, Health Services. However, some more specialised hospital services are funded by HBDHB to be provided by other DHBs, private hospitals, or other providers. Where this happens, other providers are monitored in terms of the Operational Policy Framework or specific contracts and in accordance with industry standards. On the continuum of care these services are at the complex end of "conditions" and are focused on individuals with health conditions and prioritised to those identified as most in need.

People who are suffering from injury or illness will be diagnosed accurately and offered the most effective treatment available as early as possible. We will coordinate activities that support people to reduce the complications of disease, injury and illness progression so that they have better health, in terms of survival, and are also able to participate effectively in society and be more independent. It is important that identified inequities are also reduced as quickly as possible.

Output measure	Baseline Period	Baseline	Previous Year (2020/21)	Current year (2021/2)	Target	Rating
EQUITABLE ACCESS TO CARE FOR STROKE PATIENTS						
% of patients with ischaemic stroke thrombolysed and/or treated with clot retrieval (Service provision 24/7)	12m to Jun 20	9%	10%	20%	≥ 12%	● (green)
Māori		9%	14%	20%		● (green)
Pasifika		N/A	N/A	17%		● (green)
Other		9%	N/A	20%		● (green)
% of acute stroke patients admitted to a stroke unit or organised stroke service with a demonstrated stroke pathway within 24 hours of their presentation to hospital	12m to Jun 20	74.0%	70.2%	74.5%	≥ 80%	● (yellow)
Māori		74.0%	68.3%	79.3%		● (blue)
Pasifika		75.0%	80.0%	71.4%		● (red)
Other		74.0%	70.4%	73.3%		● (yellow)

All DHBs will provide an organised acute and rehabilitation stroke service for their population as recommended in the Australian Clinical Guidelines for Stroke Management. These measures help track performance against these guidelines.

The results for stroke thrombolisation have substantial improved this year. This has been the result of an upgrade of the regional tele-stroke service to a 24/7 service. While the targets for stroke thrombolisation have been met, there is still some work to do to achieve 80% on the second measure. A small percentage of our stroke patients are discharged from the Assessment Unit as per HBDHB pathway and referred on to our outpatient stroke/TIA clinic with the lead stroke physician. COVID disrupted our stroke ward and our ability to function as a stroke MDT with some stroke patients being admitted to other wards.

Output measure	Baseline Period	Baseline	Previous Year (2020/21)	Current year (2021/22)	Target	Rating
FASTER CANCER TREATMENT (FCT)						
% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.	12m to Jun 20	87.00%	89.76%	86.44%	≥ 85%	
Māori		83.00%	95.68%	91.67%		
Pasifika		75.00%	88.89%	66.67%		
Other		89.00%	88.47%	85.71%		
% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.	12m to Jun 20	81.50%	87.68%	86.84%	≥ 90%	
Māori		77.00%	96.88%	100.00%		
Pasifika		0.00%	50.00%	100.00%		
Other		83.00%	85.58%	83.87%		

Target achieved or almost achieved other than for Pasifika for the first measure. This is due to a small Pasifika patient cohort which has impacted on results.

Output measure	Baseline Period	Baseline	Previous Year (2020/21)	Current year (2021/22)	Target	Rating
FEWER MISSED OUTPATIENT APPOINTMENTS						
Did not attend (DNA) rate across first specialist assessments	12m to Jun 20	6.0%	5.9%	6.3%	≤ 6%	
Māori		12.0%	12.3%	11.7%		
Pasifika		13.0%	13.3%	15.0%		
Other		3.6%	3.8%	4.7%		

This is a local indicator. Māori and Pasifika First Specialist Assessment Did Not Attend (DNA) rates remain consistently above target. Despite a focused programme within the Pacific Health Team, Pasifika DNA rates have remained stubbornly high impacted by illnesses, whānau responsibility and accessibility.

Output measure	Baseline Period	Baseline	Previous Year (2020/21)	Current year (2021/22)	Target	Rating
IMPROVING MENTAL HEALTH SERVICES USING DISCHARGE PLANNING						
Community services transition (discharge) plans: % of clients discharged from community MH&A will have a transition (discharge) plan	12m to Jun 20	80.00%	74.57%	64.00%	≥ 95%	●
% of clients discharged from adult inpatient MH&A services have a transition (discharge) plan	12m to Jun 20	64.70%	35.00%	40.23%	≥ 95%	●
% of clients with an open referral to MH&A services of greater than 12 months have a wellness plan	12m to Jun 20	99.0%	95.96%	76.0%	≥ 95%	●

These measures are national DHB performance measures. Maintaining and improving patient engagement through the use of a transition/discharge plan ensures that services are responsive to patient needs and that people are better able to manage their mental health condition.

Work continues to ensure that transition plans are completed or updated within the 14 days prior to closure of the primary referral to be counted as compliant.

Output measure	Baseline Period	Baseline	Previous Year (2020/21)	Current year (2021/22)	Target	Rating
LESS WAITING FOR ED TREATMENT						
% of patients admitted, discharged or transferred from an emergency department (ED) within six hours.	12m to Jun 20	79.0%	74.8%	75.4%[5]	≥ 95%	●
Māori		82.9%	79.7%	80.7%		●
Pasifika		84.9%	82.6%	81.3%		●
Other		76.7%	71.7%	72.2%		●

Long stays in emergency departments are linked to overcrowding of the ED, negative clinical outcomes and compromised standards of privacy and dignity for patients.

Hospital overcrowding, increasing numbers of COVID-19 presentations and inpatients, and stranded patient awaiting ARC admission are all factors in this target not being achieved. In order to achieve targets in 2022/23, the hospital has engaged the Francis group to work on hospital flow, primary pathways and improved discharging. In addition, Co-ordinated Primary Options (CPO) pathways are in development and the Mental Health and Addiction Service has introduced a new telephone triaging service so that minor cases can be deferred to teams the next day and mental health clinicians can therefore be freed up to see more unwell patients.

[5] In the 21/22 year a workflow change in the DHB patient management system created an issue whereby staff recorded incorrect discharge times into the discharge field if the patient was admitted as an inpatient or discharged home. This has impacted the accuracy of the final 21/22 result. This has now been addressed with staff training and daily audit reports. Patients who were transferred to ED Obs were not affected by this issue.

Output measure	Baseline Period	Baseline	Previous Year (2020/21)	Current year (2021/22)	Target	Rating
MORE APPROPRIATE ELECTIVE SURGERY						
Number of planned care procedure discharges for people living within the HBDHB region.	12m to Jun 20	6009	7386	6142	≥ 7427	●

Planned care procedure discharges from March to June were significantly affected by COVID-19 which caused a large reduction in our onsite production. Without this, the DHB was on track to achieve target.

The production plan in the 22/23 year continues the planned care principles and the DHB has approval to lease two theatres in the private sector and outsource some procedures.

Output measure	Baseline Period	Baseline	Previous Year (2020/21)	Current year (2021/22)	Target	Rating
PATIENTS WITH ACS RECEIVE SEAMLESS, COORDINATED CARE ACROSS THE CLINICAL PATHWAY						
% of Acute Coronary Syndrome (ACS) patients undergoing coronary angiogram - door to cath within 3 days	12m to Jun 20	54.0%	61.0%	58.1%	≥ 70%	●
Māori		49.0%	61.3%	57.4%		●
Pasifika		50.0%	66.7%	71.4%		●
Other		60.0%	61.1%	57.5%		●

This is an Australia and New Zealand Acute Coronary Syndrome Quality Improvement (ANZACS-Q1) indicator and measures quality standards to acute heart services such as timeliness to Cath Lab. ACS patients who have an angiogram also have a pre-discharge echocardiogram of LV gram (LVEF) and prescribing of prevention medication.

Non-compliance with this indicator is ongoing due to limited availability in the HBDHB angiography suite and reliance on other DHBs to perform these procedures.

Output measure	Baseline Period	Baseline	Previous Year (2020/21)	Current year (2021/22)	Target	Rating
PLANNED CARE						
% of services that report Yes (that more than 90% of referrals within the service are processed in 15 calendar days or less) (ESPI 1)	12m to Jun 20	74.00%	100%	95.00%	= 100 %	
Māori		N/A	94.74%	84.21%		
Pasifika		N/A	88.89%	86.67%		
Other		N/A	100.00%	94.74%		
% of patients waiting over four months for FSA (ESPI 2)	As at Jun 20	45%	21%	34%	= 0%	
Māori		46%	23%	37%		
Pasifika		41%	22%	37%		
Other		43%	20%	32%		
% of patients waiting over 120 days for treatment (ESPI 5)	As at Jun 20	44.0%	36.6%	50.3%	= 0%	
Māori		42.0%	34.5%	51.2%		
Pasifika		46.0%	31.6%	45.1%		
Other		44.0%	37.7%	50.2%		
% of Ophthalmology patients that wait more than or equal to 50% longer than the intended time for their appointment.	As at Jun* 20	31.7%	28.9%	31.5%	= 0%	
Acute readmissions to hospital	12m to Mar 20	12.00%	12.19%	12.50%	≤ 12%	
Māori		12.40%	11.76%	12.5%		
Pasifika		11.60%	11.05%	13.4%		
Other		11.80%	12.43%	12.4%		

*The baseline from the 21/22 SPE which was presented as a volume of people waiting has been converted to a %

DHBs must manage patient flow processes effectively, in line with the principles of Planned Care. Patient flow processes are measured by a suite of performance indicators referred to as Elective Services Patient Flow Indicators (ESPIs). ESPI 2 is a timeliness measure with a target that no patient waits longer than 4 months for a First Specialist assessment. ESPI 5 is also a timeliness measure with a target that no patient given certainty for treatment waits longer than 4 months. The results for both are reported as at the end of June 2022.

In 2021/22, the HBDHB continued to experience workforce issues with staff resigning due to vaccine mandate, ability to recruit and staff sickness. There was also a change in the local focus to manage COVID in the hospital and nationally a move away from monitoring waitlist trajectories. HBDHB continues to use the locally developed trajectories to inform decision making, however the disruption to FSA and surgical capacity due to COVID has led KPIs to worsen not improve.

Output measure	Baseline Period	Baseline	Previous Year (2020/21)	Current year (2021/22)	Target	Rating
QUICKER ACCESS TO DIAGNOSTICS						
% of patients with accepted referrals for elective coronary angiography receive their procedure within 3 months (90 days)	12m to Jun 20	88.0%	85.7%	83.2%	≥ 95%	Red
% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within 2 weeks (14 calendar days, inclusive),	12m to Jun 20	88.0%	91.4%	82.7%	≥ 90%	Amber
Māori		80.0%	84.3%	83.3%		Amber
Pasifika		75.0%	100.0%	100.0%		Green
Other		90.4%	92.8%	82.1%		Amber
% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within 6 weeks (42 calendar days)	12m to Jun 20	34.0%	48.5%	39.5%	≥ 70%	Red
Māori		34.0%	41.8%	37.1%		Red
Pasifika		17.0%	48.0%	57.1%		Red
Other		34.0%	49.9%	39.7%		Red
% of people waiting for a surveillance colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date	12m to Jun 20	42.0%	52.2%	39.8%	≥ 70%	Red
Māori			51.5%	33.3%		Red
Pasifika			45.5%	100.0%		Green
Other			52.3%	40.7%		Red
% of people who returned a positive faecal immunochemical test (FIT) have a first offered diagnostic date that is within 45 working days or less of their FIT result being recorded in the NBSP information system.	12m to May 20	94%	100%	98%	≥ 95%	Green
Māori		90%	100%	98%		Green
Pasifika		100%	100%	100%		Green
Other		95%	100%	No data		

Diagnostics are a vital step in the pathway to accessing appropriate treatment. Improving access to and waiting times for diagnostics, can reduce delays to a patient's episode of care from receipt of referral to provision of diagnostic service.

HBDHB has made significant progress in working towards achieving a recovery plan to improve colonoscopy wait times and have been delivering additional sessions to accommodate some of the backlog. The fourth quarter has seen significant pressure on delivery of the recovery plan with the recommissioning of the Endoscopy suite into a COVID recovery ward. This reduced the volume of colonoscopy through put in the last quarter of the year which substantially impacted on the colonoscopy wait times for non-urgent procedures.

HBDHB continues to prioritise urgent, National Bowel Screening Programme, Māori and Pasifika in the first instance and is reporting monthly to MOH on patients waiting longer than maximum and any potential negative effects if any this is having.

Output measure	Baseline Period	Baseline	Previous Year (2020/21)	Current year (2021/22)	Target	Rating
REDUCING WAITING TIMES SHORTER WAITS FOR NON-URGENT MENTAL HEALTH AND ADDICTION SERVICES FOR ZERO-24 YEAR OLDS						
% of zero to 24-year olds seen within 3 weeks of referral to a Mental health provider arm[6]				80.2%	≥ 80%	●
Māori				83.0%		●
Pasifika				88.9%		●
Other				77.9%		●

These are Mental Health and Addiction service wait time measures with targets set nationally. There has been significant improvement over 2020/21 results and this indicator Is now reaching target overall and for two out of three population groups.

[6] This is a new measure introduced in the 21/22 year and no baseline was published for this measure in the 2021/22 Statement of Performance Expectations (SPE). NOTE: our 21/22 SPE indicated we would be measuring two new indicators for 3 week waiting time and two new indicators for 8 weeks waiting time to be seen by secondary and non- government organisations (NGO) Mental Health and Addictions services for a new age group 0-24 years. However only one new measure was introduced by the Ministry of Health and the results are reported in the table above..

Output Class 4: Rehabilitation and support services

Statement of Service Performance Output Class 4

This output class includes: Needs Assessment and Service Coordination (NASC); palliative care; rehabilitation; home-based support; aged residential care; respite care and day care for adults. Many of these services are delivered following a 'needs assessment' process and involve coordination of input from a range of providers. Rehabilitation and Support services assist people with enduring conditions and disabilities to live independently or to receive the support that they need either temporarily or over the rest of their lives. Hawke's Bay DHB provides NASC services through NASC Hawke's Bay (in the provider arm). Other services are provided by our Provider Arm, general practice and a number of community-based NGOs and private organisations. On the continuum of care these services provide support for individuals who have complex, complicated or frail and/or end of life conditions.

Where returning to full health is not possible we will work with our stakeholders to support and care for people so that they are able to maintain maximum function with the least restriction and the most independence. For people in our population who have end-stage conditions, it is important that they and their family/whānau are supported to cope with the situation, so that the person is able to live comfortably and to die without undue pain or suffering.

Output measure	Baseline Period	Baseline	Previous Year (2020/21)	Current year (2021/22)	Target	Rating
BETTER COMMUNITY SUPPORT FOR OLDER PEOPLE						
Acute readmission rate: 75 years +	12m to Mar 20	12.0%	12.7%	12.6%	≤ 12%	Amber
Māori		10.8%	11.6%	11.9%		Green
Pasifika		10.7%	5.9%	11.5%		Green
Other		12.2%	12.9%	12.7%		Amber

The rate of acute readmissions is one of seven measures designed to monitor planned care. Performance overall for HBDHB has been impacted by workforce capacity issues and alternative operating models (e.g. virtual vs face to face consults) while providers have been actively responding to COVID-19 with ongoing planning, vaccinations and testing.

Output measure	Baseline Period	Baseline	Previous Year (2020/21)	Current year (2021/22)	Target	Rating
BETTER COMMUNITY SUPPORT FOR OLDER PEOPLE						
Acute bed days per 1000 population (in the last 12 months) 65 years + (Māori and Pacific) and 75 years + (Other)	12m to Jun 20	1800	1929	1920	≤ 2,002[7]	
Number of Needs Assessment and Service Coordination (NASC) completed assessments (first assessment, reassessments and 3-year routine assessments).	12m to Jun 20	1795	1910	1620	≥ 1795	
The average number of subsidised permanent Health of Older People (HOP) and Long-Term Support - Chronic Health Conditions (LTS-CHC) residential beds per night per 1,000 of the 65+ population.	12m to Jun 20	31.4[8]	31.46	29.196	≤ 35[9]	

Two out of three of these measures have reached target, however NASC completed assessments is significantly lower than the five year trend and has been impacted by staff sickness and lower numbers of referrals. Referral numbers are likely to have decreased as a result of national and local messaging which indicated that referrals with immediate support needs would be prioritised.

We continue to see a pleasing reduction in the number of clients 65 years and over living in age related residential care. This gives us assurance that we are supporting more of our older people to live independently in the community.

Output measure	Baseline Period	Baseline	Previous Year (2020/21)	Current year (2021/22)	Target	Rating
MORE OLDER PATIENTS RECEIVE FALLS RISK ASSESSMENT AND CARE PLAN						
% of older patients given a falls risk assessment	12m to Jun 20	91.0%	89.6%	90.9%	≥ 90%	
% of older patients assessed as at risk of falling receive an individualised care plan	12m to Jun 20	92%	93%	96%	≥ 90%	

This is a local measure and provides an indication of the effectiveness of DHB Health of Older People Services.

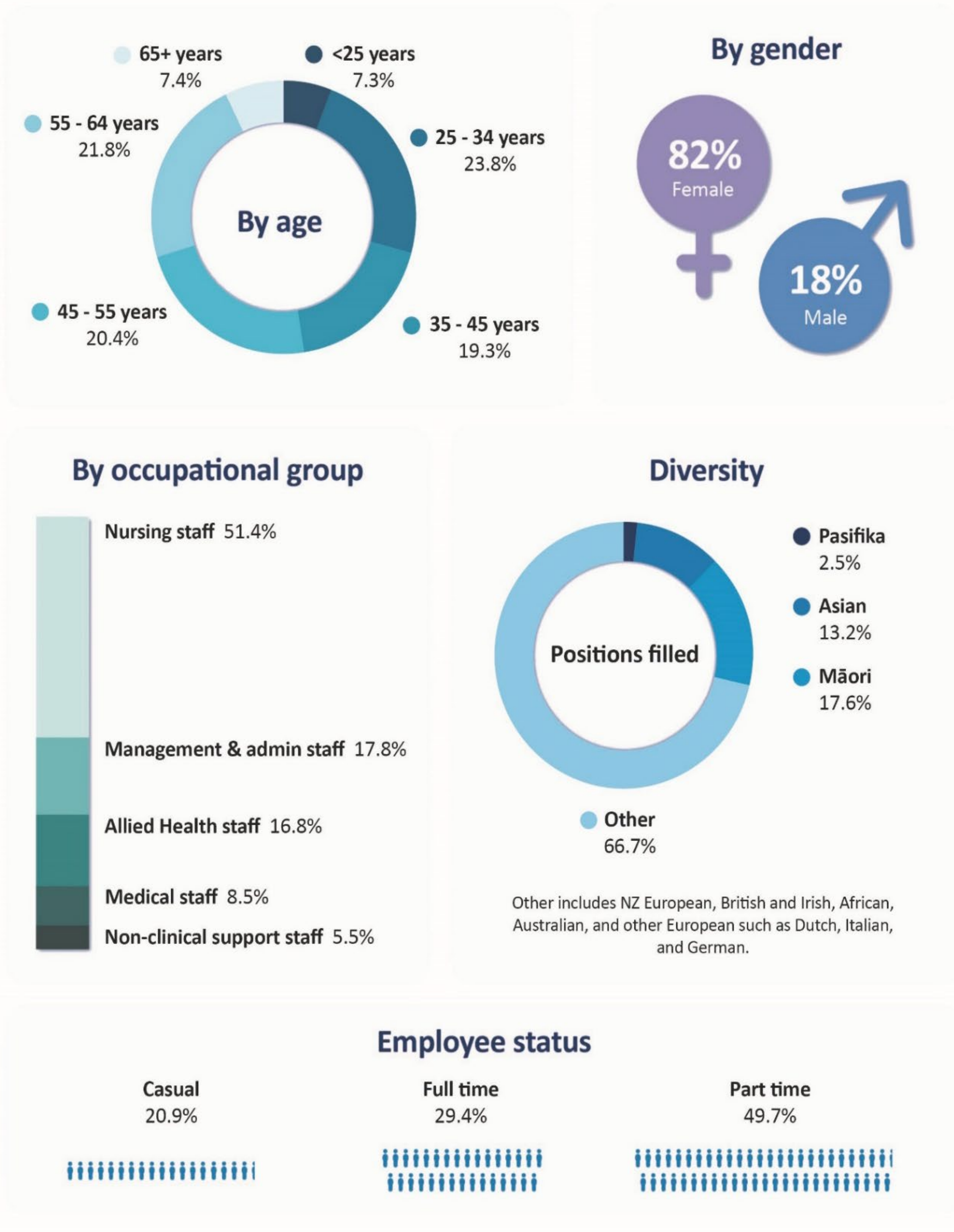
This measure has been unable to have been reported after December 2021 due to resource constraints.

[7] Acute bed days per 1,000 population

[8] Per 1,000

[9] Per 1,000

Our People



Report on good employer obligations

Hawke's Bay DHB's employment practice is to recruit the best person for the role based on professional skills and values fit to the organisation. Our Human Resource (HR) policies and systems are continuously reviewed and updated to ensure they meet legal compliance, they embody our equity, diversity and inclusion principles, and reinforce they consistency and fairness for all our staff.

Our recruitment and employment procedures are both fair and equitable. There is an active commitment to equal opportunity and the removal of institutional barriers to encourage inclusion. Hawke's Bay DHB takes seriously its legal and moral obligation to honour the Treaty of Waitangi and to be a good employer.

Our updated People Plan puts the values and behaviours of the organisation at the centre of the way we do things. This Plan includes our commitment to actively build an environment which is safe and enhances wellbeing.

The focus of the People Plan:

- Effective short and long term recruiting and building an inclusive representative workforce.
- Embedding the values of the organisation in all we do
- Team development and collaboration
- Ensuring the wellbeing of our workforce
- Taking positive action to build a safe and healthy workplace

Leadership, Accountability and Culture:

Developing leadership capability, remains a priority for Hawke's Bay DHB, as does increasing the capability of our whole workforce. Our focus over the last twelve months has been to develop targeted training programmes to increase our leaders' competence including strengths-based coaching, constructive feedback and effective performance appraisal. A Leadership Development framework (including national collaboration) has been established, with programmes at all levels, from Executive to aspiring leaders. We have prioritised a development programme for frontline leaders, which will be rolled out in Q4 of the 2022 calendar year. We are developing a suite of team development and collaboration tools to build our organisational capability in this area. Various team development workshops have been undertaken.

As an organisation we continue to engage with our staff through established forums including our Joint Consultative Committee, Bipartite and Nursing forums, and through our Safety & Wellbeing Committee.

Recruitment, Selection and Induction:

Hawke's Bay DHB has a centralised recruitment function to co-ordinate processes across multiple professions and disciplines.

Our applicant management system tracks the progress of candidates through the recruitment journey. Hawke's Bay DHB has a continued focus on increasing Māori and Pasifika uptake into health careers.

The People & Culture team work collaboratively with the Māori Health team to deliver the Māori and Pasifika Workforce Strategy.

Hiring Managers are supported through the recruitment process to ensure efficiency and consistency of recruitment and we focus on competent applicants who also align to the values of the organisation through a values-based recruitment programme.

A key strategic priority is to provide recruitment-based workforce solutions to address short- and long-term talent shortages by diversifying our channels into the labour market. This includes participation in an International Job Fair (UK and Ireland) for clinical roles, forming talent pipelines and talent-pools in nursing via an additional 1.0 FTE in Nursing recruitment, investment in the Seek candidate search database tool and international recruitment campaigns (including regional and national collaboration). Recruitment is challenging in today's labour market and a significant risk.

Employee Development, Promotion and Exit:

To ensure all staff have clarity about performance expectations, Hawke's Bay DHB utilise a performance appraisal system based on strengths-based coaching, incorporating the principles of positive psychology. The process is well documented and available to all staff to enable constructive conversations to occur on a regular basis, where the staff member is able to identify personal development needs and document career aspirations.

The health workforce is diverse, highly qualified and often highly specialised. The training and development needs reflect this diversity. Hawke's Bay DHB is committed to supporting all staff to access the appropriate training in accordance with their needs. This is in multiple forms including face-to-face, assessments and online learning through our online learning system, Ko Awatea. This blended approach provides Hawke's Bay DHB the ability to provide training opportunities which are effective and efficient for our clinical and non-clinical staff.

The Employment Relations Act, and the Health and Safety at Work Act 2015, continue to underpin our relationships with employees and unions. The Bipartite Union Committee continues to be the forum for union delegates to be engaged and to discuss common issues.

Hawke's Bay DHB has an agreed Health and Safety Strategy to ensure that as an organisation we are meeting our obligations and create a Safe Place, Safe People and Safe Care culture. The union organisers also participate in the Safety & Wellbeing Committee to help us design the best systems and processes we can.

An approved programme for the 2022/23 financial year is an Exit Survey & Data Framework, involving organisation-wide leavers survey, exit interviews, data analytics and retention strategy.

Flexibility and Work Design:

Hawke's Bay DHB considers flexible work practices to accommodate staff wherever practical. Guidelines to assist managers to respond to requests for flexible work arrangements requests are available on Our Hub (intranet). Post-COVID-19 lockdown, "Working from Home" guidelines have been updated to embed these new ways of working and provide more flexibility within the system.

The People & Culture team works closely with managers and the Bipartite Union Committee as required to implement change in work practice that meets the needs of staff and assists the organisation to achieve its service and financial performance objectives.

Remuneration, Recognition and Conditions:

Our objective is to build organisational capability through the provision of best practice and create a place of work which attracts, develops and retains talented people. Its remuneration processes are transparent and based on being equitable.

Hawke's Bay DHB utilises a number of communication media to engage all staff and key local health sector leaders, which are effective tools in recognising staff and team achievements. These include telling the stories of success, innovation, achievement and excellence in patient care through Our Hub (intranet) and annual health sector–wide health awards where success and achievement is celebrated.

Harassment and Bullying Prevention:

Hawke's Bay DHB has a zero-tolerance policy which is supported with resources such as clearly defined process, manager and staff training, posters throughout the organisation which emphasise respect and acceptable and unacceptable behaviours, and intranet resources provide a centralised information resource for all staff to access.

Employee Wellbeing:

Hawke's Bay DHB undertoook an organisation-wide employee survey on Wellbeing/Psychosocial Health via the 'AskYourTeam' platform in November 2021 with a pleasing 56% response rate from circa 3,500 employees. This provided all teams and managers in the organisation with helpful information to make improvements, including the identification of 35 teams as a priority cohort for support. At a strategic level, the survey provides a baseline of data to track progress over time and guides the priorities of our organisation-wide Wellbeing programme of work. To assess progress, follow up spot surveys are part of the package.

Approved programmes include anti-bullying, stress and resilience and management of violence and aggression against employees.

Safe and Healthy Environment:

Hawke's Bay DHB is continuing to make changes to our policies and procedures to ensure effective Health & Safety system implementation.

We promote and provide opportunities for employees to participate effectively in the ongoing management and improvement of health and safety in the workplace via Safety & Wellbeing Representatives and within the Safety & Wellbeing Committee. The Executive Leadership Team are committed to ensuring that health and safety is embedded across the organisation and that all obligations are met. The organisation has also undertaken an assessment through Safe365 online tool to identify any gaps in health and safety requirements and will continue to build the capability of all and develop a culture whereby health and safety is embedded in everything we do. To further verify our progress, we have commenced the accreditation process for ISO 45001.

Commencing in quarter four of the 2021 calendar year, a number of key initiatives were commenced. This has included the investment in an additional 2.0 FTE in the Safety &

Wellbeing team, commencing the installation of a specialist health and safety management software package (‘Assura’), and improvement programmes in Hazardous Substances and Violence & Aggression

Hawke’s Bay DHB maintains its ACC partnership programme which recognises that appropriate systems support a safe environment and are implemented throughout the organisation.

Staff Ethnicity:

Increasing the number of Māori employees is a priority for Hawke’s Bay DHB. A KPI measuring the number of positions where incumbents identify as Māori is reported on a quarterly basis. The target is set at 10 percent improvement on previous year with the ultimate aim that the workforce reflects the Hawke’s Bay population mix. The aim of this programme is that in the future we will reflect the population within our workforces and therefore the final aim is to have 27 percent Māori represented.

As at the end of the 2021/22year progress was made, although the target of 18% of staff identifying as Māori was not reached.

Target 2021/22	684	18%
Actual at 30 June 2022	670	16.4%
Gap	14 employees	

Staff Disability:

The organisation is focussed on supporting our staff with identifiable disabilities. Hawke’s Bay DHB has reviewed its people-based policies in relation to recruitment and retention of staff with disabilities, with 0.3 percent of staff identifying as having a disability. We have identified obstacles with those staff and have removed or reduced those obstacles where possible. We will continue to monitor these situations and address issues as they arise.

Employee Remuneration

The number of employees whose income was in the specified band are as follows:

	30 June 2022	30 June 2021		30 June 2022	30 June 2021
100,000-109,999	229	166	310,000-319,999	11	8
110,000-119,999	165	105	320,000-329,999	6	2
120,000-129,999	111	41	330,000-339,999	9	6
130,000-139,999	63	34	340,000-349,999	2	3
140,000-149,999	28	26	350,000-359,999	2	4
150,000-159,999	20	12	360,000-369,999	3	2
160,000-169,999	16	17	370,000-379,999	2	2
170,000-179,999	14	15	380,000-389,999	2	1
180,000-189,999	10	12	390,000-399,999	3	4
190,000-199,999	10	8	400,000-409,999	1	3
200,000-209,999	11	6	410,000-419,999	2	3
210,000-219,999	5	9	420,000-429,999	1	-
220,000-229,999	11	6	430,000-439,999	2	-
230,000-239,999	12	10	450,000-459,999	-	1
240,000-249,999	14	10	460,000-469,999	1	1
250,000-259,999	9	8	470,000-479,999	1	1
260,000-269,999	10	9	480,000-489,999	-	1
270,000-279,999	7	10	490,000-499,999	1	2
280,000-289,999	4	10	500,000-509,999	2	-
290,000-299,999	8	6	530,000-539,999	-	1
300,000-309,999	2	4	560,000-569,999	2	-

During the year, one (30 June 2021: two) employee received compensation and other benefits in relation to cessation totalling $26,105 (30 June 2021: $19,114).

Corporate Governance

Role of the Board

Under Section 25 (1) of the Crown Entities Act 2004 (the CE Act), the Board was the governing body of Hawke's Bay District Health Board (HBDHB), with the authority, in HBDHB's name, to exercise the powers and perform the functions of HBDHB. Under section 25 (2) of the CE Act, all decisions relating to the operation of HBDHB were 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 was on governance and policy issues. The Board's primary responsibilities were:

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

Role of the CEO

The Board delegated to the CEO, on such terms and conditions as were 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 endorsed the CEO, assigning defined levels of authority to other specified levels of management within the organisational structure.

Advisory Committees

A DHB was required to establish three statutory advisory committees: Community and Public Health Advisory Committee (CPHAC); Disability Support Advisory Committee (DSAC); Hospital Advisory Committee (HAC) but could establish other committees for a particular purpose. Whilst HBDHB had established the three Statutory Advisory Committees, on which all Board members sat, they no longer routinely met. No DSAC, CPHAC and HAC meetings were held in 2020/21.

The Board could assign defined levels of authority to its advisory committees which operated under terms of reference and could advise the Board on issues which had been referred to them. Committees could meet collectively as required to discuss the Annual Plan and other strategic issues.

The other two Board Committees - Finance Risk and Audit Committee (FRAC) and Māori Relationship Board (MRB) met on a regular basis, however MRB ceased in September 2021 and was replaced by the Iwi-Māori Partnership Board known as Tihei Tākitimu Partnership Board.

Finance Risk and Audit Committee

The purpose of the Finance Risk and Audit Committee (FRAC) was to advise and assist the HBDHB to meet governance responsibilities relating to finance, risk, safety and quality management, audit and compliance.

Māori Relationship Board (MRB)

The purpose of the Māori Relationship Board (MRB) was to maximise the relationship between the Hawke's Bay DHB and Ngāti Kahungunu Iwi Incorporated (NKII), to benefit the Māori population within the Kahungunu rohe, principally by identifying and removing health inequities and instituting processes that supported Māori centric models of health care.

Other components of HBDHB's governance structures included:

- The Hawke's Bay Clinical Council
- Hawke's Bay Health Consumer Council; and the
- Pacific Population Board

The Board obtained stakeholder and community input and advice directly and indirectly through these structures.

Note:

- The Hawke's Bay Clinical Council and Hawke's Bay Health Consumer Council were management
- committees, reporting through the CEOs of HBDHB and Health HB Ltd.
- The Pacific Population Board was a sub-committee of the Community and Public Health Advisory Committee

Board and Committee Membership

There were 10 Board members, who collectively possessed a broad range of skills, knowledge and experience. Six of those members were elected through the triennial local government elections, and four were appointed by the Minister of Health. In making the appointments, the Minister ensures any skills gaps are met, including a minimum of two Māori Board members.

Board and Committee Member Attendance

Board and committee member attendance for 2021/22 is set out in the following table, with the with the number of meetings held noted in parentheses.

- HBDHB Board (10)
- FRAC Finance, Risk and Audit Committee (FRAC) (10)
- MRB Māori Relationship Board (MRB) (3)

Member	Board	FRAC	MRB
Hayley Anderson	9	9	-
Ana Apatu	10	10	2
Kevin Atkinson	8	8	-
David Davidson	9	9	-
Evan Davies	10	10	-
Peter Dunkerley	10	10	-
Joanne Edwards	7	7	0
Charlie Lambert	10	8	2
Heather Skipworth	9	8	3
Shayne Walker	10	10	2

Payments for committee meetings include the Finance, Risk and Audit Committee (FRAC), and Māori Relationship Board. Payments were also made to Hayley Anderson who as chair of the Community and Public Health Advisory Committee attended the Pasifika Health Leadership Group and reported back to the Board.

The total value of remuneration paid or payable to each Board member during the year was:

in whole New Zealand Dollars	30 June 2022 Board	30 June 2022 Committees	30 June 2021 Board	30 June 2021 Committees
Shayne Walker *Chair (appointed member)*	46,403	2,750	46,403	3,250
Evan Davies *Deputy Chair (appointed member)*	28,963	3,120	28,963	3,125
Hayley Anderson	23,171	4,000	23,171	4,000
Ana Apatu	23,171	2,875	23,171	5,375
Kevin Atkinson	23,171	1,750	23,171	2,500
David Davidson	23,171	2,000	23,171	2,500
Peter Dunkerley	23,171	2,500	23,171	2,500
Joanne Edwards *(appointed member)*	23,171	1,750	23,171	3,000
Charlie Lambert *(appointed member)*	23,171	2,000	23,171	2,500
Anna Lorck *(resigned October 2020)*	-	-	5,347	750
Heather Skipworth	23,171	2,250	23,171	4,000
	260,734	24,995	266,081	33,500

Remuneration – Committee members who are not board members or employees

There are no statutory committee members other than Board members. Consumer input is now sought through the non-statutory Consumer Council, Māori Relationship Board and the Pasifika Health Leadership Group.

Compensations

No loans are made to board members, and no short-term employee, post-employment, termination, or other long-term benefits are paid to executive officers other than their annual salary, which may or may not include performance payments, employer contributions to superannuation schemes and the payment of professional fees.

Hawke’s Bay DHB has taken out 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.

Additional performance information: COVID-19 vaccinations and mortality

To determine the vaccination rates of the eligible population and deaths that are attributed to COVID-19 in Aotearoa, we have included additional information for the performance measures pertaining to Implementing the COVID-19 Vaccine Strategy.

COVID-19 vaccinations

The Ministry of Health uses health service user (HSU) data as the denominator to determine the COVID-19 vaccination coverage. This section describes the percentage of the eligible population who have received the vaccination. Individuals are included in the HSU if they were enrolled with a primary health organisation, or if they received health services in a given calendar year (shown in the box, below).

As of 8 August 2022, there are two versions of the HSU available for determining COVID-19 vaccination coverage:

HSU 2021

People are included if they were:

- alive on 31 December 2021
- enrolled with a primary health organisation or received health services in the 2021 calendar year.

HSU 2020

People are included if they were:

- alive on 1 July 2020,
- enrolled with a primary health organisation or received health services in the 2020 calendar year.

During 2021/22, the Ministry reported the COVID-19 vaccination coverage using HSU 2020. This information was routinely referenced publicly, as well as in published reports and updates.

On 8 August 2022, the HSU 2020 version was officially superseded by HSU 2021. While the HSU 2021 was not used to report COVID-19 vaccination coverage during 2021/22, it is the preferred version to use in this report as the data is more up to date and relevant.

Any persons who have moved DHB since 30th June 2022 are counted in their current DHB as at 23:59 13/12/2022.

More information on the HSU data, including a comparison against Stats NZ population data, is available in 'Further notes on the HSU datasets', at the end of this section.

Percentage of the eligible population who have completed their primary COVID-19 vaccination course: Comparing HSU 2021 and HSU 2020

To determine the coverage of the COVID-19 vaccine across the population of Hawke's Bay DHB, we have used the HSU 2021 data as the denominator (the figure which the total eligible population vaccinated is divided by). The suitability of the HSU for this purpose was reviewed by Stats NZ, with their findings and recommendations published on 4 August 2022.[10]

Percentage of the eligible population who have completed their primary COVID-19 vaccination course[11] (HSU 2021 vs HSU 2020)

Year[12]	HSU 2021 Percentage of the eligible population who have completed their primary course	HSU 2020 Percentage of the eligible population who have completed their primary course
2020/2021	11.56%	12.21%
2021/2022	79.81%	84.28%
Total	91.37%	96.50%

Using HSU 2021 to determine the percentage of the eligible population who have completed their primary course, the coverage is calculated to be 91.4%, compared with 96.5% using HSU 2020 as at 30 June 2022.

The difference in the percentage of the eligible population vaccinated using HSU 2021, compared with using HSU 2020, reflects an increase in the number of individuals interacting with the health system during the 2021 calendar year compared with 2020. This is partly due to the COVID-19 vaccination programme successfully vaccinating individuals who had not engaged with the health system during 2020 and as such, were not captured in HSU 2020. Additionally, it reflects the demographic changes between 1 July 2020 and 31 December 2021. This includes births, deaths and people ageing into the eligible population and migration.

[10] https://www.stats.govt.nz/reports/review-of-health-service-user-population-methodology

[11] Individuals who have received dose 1 and dose 2 of the COVID-19 vaccine are considered to have completed their primary course. This definition supersedes the term 'fully vaccinated' reported in our 2020/21 annual report.

[12] Data as at 30 June 2021 for 2020/21 and 30 June 2022 for 2021/22.

COVID-19 vaccine doses administered by dose type and year

The counts in the table below measure the number of COVID-19 vaccination doses administered in Hawke's Bay DHB during 2021/22 and the prior financial year (2020/21). This information was obtained from the COVID-19 Vaccination and Immunisation Programme (CVIP) database.

COVID-19 vaccine doses administered by dose type and year (HSU 2020)

Year[13]	Primary course				
	Dose 1	**Dose 2**	**Booster 1**	**Booster 2**	**Total[14]**
2020/21	26,650	17,745	0	0	44,395
2021/22	121,904	123,873	90,937	653	337,367
Total	148,554	141,618	90,937	653	381,762

By 30 June 2022, a total of 381,762 COVID-19 vaccinations had been administered, of which 88.4 % were administered in 2021/22.

There are two similar but distinct metrics used within the following tables: Doses administered and People vaccinated. Doses administered focuses on vaccination program activities while people vaccinated uses people's vaccination status as the primary measurement. People vaccinated includes vaccinations received overseas and recorded in CIR. Furthermore, deceased persons are removed from the people vaccinated counts. Doses administered includes deceased and doesn't include overseas vaccinations. This causes some variation between the two measures and exact comparisons are not feasible.

[13] Data as at 30 June for each financial year, and respectively covers all vaccination doses administered between 1July-30 June.

[14] Excludes third primary doses administered and any subsequent boosters a person may have received after the second booster vaccination.

COVID-19 vaccine doses administered by age group

The counts in the table below measure the number of COVID-19 vaccination doses administered by the age group of the individual who received the dose. This information was obtained from the CVIP database.

COVID-19 vaccine doses administered by age group[15]

Age group (years)[16]	Primary course Dose 1	Dose 2	Booster 1	Booster 2	Total[17]
0 to 11	8240	3252	0	0	11492
12 to 15	9735	9197	10	0	18942
16 to 19	7510	7467	1874	1	16852
20 to 24	8136	8148	3755	1	20040
25 to 29	8971	9040	4796	2	22809
30 to 34	9421	9616	5809	3	24849
35 to 39	8240	8395	5618	3	22256
40 to 44	8202	8291	6098	4	22595
45 to 49	8885	9075	7229	9	25198
50 to 54	9055	9329	8034	20	26438
55 to 59	8962	9329	8710	42	27043
60 to 64	8384	9073	9270	70	26797
65 to 69	5986	7435	8533	90	22044
70 to 74	4967	6591	8116	157	19831
75 to 79	3270	4425	5821	129	13645
80 to 84	2137	2899	3975	91	9102
85 to 89	1232	1568	2127	19	4946
90+	571	743	1162	12	2488
Total	121904	123873	90937	653	337367

Note 1: Some demographic breakdowns appear to show more doses administered for Dose 2 compared to Dose 1. This is due to COVID-19 vaccination doses being administered in the previous financial year (2020/21).

COVID-19 people vaccinated by age group

The counts and the percentages in the table below measure the number of people who received COVID-19 vaccination doses during 2021/22. This data was obtained from the CVIP database (broken down by age group), and the percentages calculated using HSU 2021 as the denominator.

[15] Data as at 30 June 2022 and covers all vaccination doses administered between 1 July 2021-30 June 2022.

[16] Age groupings in this table reflect the age of the person at the time of the vaccination being administered.

[17] Excludes third primary doses administered to individuals and any subsequent boosters which may have been administered after the second booster vaccination.

Please note, as this table refers to people vaccinated (and the respective percentage of a given demographic per row), it is not comparable to the table above (COVID-19 doses administered by age group).

COVID-19 people vaccinated by age group during 2021/22[18]

Age group[19] (years)	Partial[20]		Primary course[21]		Booster course			
	Partially vaccinated	Partially vaccinated (% eligible)	Completed primary course	Completed primary course (% eligible)	Received first booster (18+)	First booster (% eligible) (18+)	Received second booster (50+)	Received second booster % eligible (50+)
0 to 11	6939	24%	2799	10%	0	0%	0	0%
12 to 15	8309	79%	7211	69%	0	0%	0	0%
16 to 19	8279	91%	8126	89%	1077	37%	0	0%
20 to 24	8353	82%	8429	83%	3679	41%	0	0%
25 to 29	9047	79%	9230	80%	4603	46%	0	0%
30 to 34	9879	81%	10210	84%	5681	51%	0	0%
35 to 39	8715	83%	8900	85%	5651	58%	0	0%
40 to 44	8269	81%	8445	83%	6021	64%	0	0%
45 to 49	8589	77%	8807	79%	6908	70%	0	0%
50 to 54	9292	80%	9554	82%	8047	75%	21	3%
55 to 59	8778	75%	9112	78%	8383	80%	39	4%
60 to 64	8761	76%	9347	81%	9357	86%	67	6%
65 to 69	6510	65%	7698	77%	8614	91%	86	7%
70 to 74	5117	56%	6691	73%	8116	94%	149	12%
75 to 79	3682	57%	4956	76%	6311	96%	139	13%
80 to 84	2367	54%	3266	75%	4285	97%	96	14%
85 to 89	1354	58%	1746	74%	2282	100%	26	7%
90+	766	59%	966	74%	1366	106%	12	4%

[18] Data as at 30 June 2022 and includes all people who received COVID-19 vaccinations between 1 July 2021– 30 June 2022.

[19] Age groupings in this table reflect age of the persons at end of financial year.

[20] Partial vaccination refers to individuals who had received a single one dose of the COVID-19 vaccination (as at 30 June 2022).

[21] Primary course refers to the first two doses of the COVID-19 vaccine (dose 1 and dose 2).

Total	123006	67%	125493	69%	90381	71%	635	8%

COVID-19 vaccine doses administered by ethnicity

The counts in the table below measure the number of COVID-19 vaccine doses administered by the ethnicity of the individual who received the dose. This information was obtained from the COVID-19 Vaccination Immunisation Programme database.

COVID-19 vaccine doses[22] administered by ethnicity[23] (1 July 2021 – 30 June 2022)

Ethnicity (Note 1, 2)	**Primary course**				
	Dose 1	**Dose 2**	**Booster 1**	**Booster 2**	**Total**
Asian	7546	7364	5387	10	20307
European/other	78500	81418	66356	535	226809
Māori	29668	28300	14022	99	72089
Pacific peoples	5449	5992	4496	5	15942
Unknown	741	799	676	4	2220
Total	121904	123873	90937	653	337367

Note 1: Ethnicity is based on the prioritised ethnicity classification system. This allocates each individual to a single ethnic group, based on the ethnic group (or groups) they identify with. Where people identify with more than one ethnic group, they are prioritised as: Māori, Pacific peoples, Asian, European/other, Unknown. For example, if a person identifies as being Māori and New Zealand European, the person is counted as Māori in this dataset. 'Unknown' is where a person has not disclosed any ethnicity.

Note 2: Some demographic breakdowns appear to show more doses administered for Dose 2 compared to Dose 1. This is due to COVID-19 vaccination doses being administered in the previous financial year (2020/21).

[22] This excludes third primary doses administered and any subsequent boosters a person may have received after a second booster.

[23] Data as at 30 June 2022 and includes all vaccination doses being administered between 1 July 2021 – 30 June 2022.

COVID-19 people vaccinated by ethnicity

The counts in the table below measure the number of people receiving doses (obtained from the COVID-19 Vaccination and Immunisation Programme database).

COVID-19 people vaccinated by ethnicity during 2021/22[24]

Ethnicity (Note 1)	Partially vaccinated (12+)	Partially vaccinated (12+) (% eligible)	Completed Primary Course (12+)	Completed primary course (12+) (%)	Received First Booster (18+)	Received first booster (18+) (% eligible)	Received second booster, 50+	Received second booster (% eligible, 50+)
Asian	7004	84%	7183	86%	5388	72%	10	9%
Māori	27638	76%	27670	77%	13921	54%	96	9%
European /Other	74291	73%	79453	78%	65863	78%	523	8%
Pacific peoples	6264	95%	7448	113%	4520	59%	3	3%
Unknown	870	95%	940	103%	689	63%	3	10%
Total	116067	75%	122694	80%	90381	71%	635	8%

Note 1: Ethnicity is based on the prioritised ethnicity classification system. This allocates each individual to a single ethnic group, based on the ethnic group (or groups) they identify with. Where people identify with more than one ethnic group, they are prioritised as: Māori, Pacific peoples, Asian, European/other,Unknown. For example, if a person identifies as being Māori and New Zealand European, the person is counted as Māori in this dataset. 'Unknown' is where a person has not disclosed any ethnicity.

[24] Data as at 30 June 2022 and includes all people who received COVID-19 vaccinations between 1 July 2021 – 30 June 2022.

COVID-19 people vaccinated by ethnicity from 1 July 2020 to 30 June 2022

Ethnicity (Note 1, 2)	Partially Vaccinated 12+	Partially Vaccinated 12+ % of HSU2021	Completed Primary Course 12+	Completed Primary Course 12+ % of HSU2021	Received First Booster 18+	Received First Booster 18+ % of Eligible	Received Second Booster 50+	Received Second Booster % of Eligible (50+)
Asian	8224	98%	8127	97%	5388	72%	10	9%
Māori	31630	88%	30216	84%	13921	54%	96	9%
European /other	93940	92%	92659	91%	65864	78%	523	8%
Pacific peoples	8499	129%	8331	126%	4520	59%	3	3%
Unknown	1179	129%	1137	125%	689	63%	3	10%
Total	143472	93%	140470	91%	90382	71%	635	8%

Note 1 Ethnicity is based on the prioritised ethnicity classification system. This allocates each individual to a single ethnic group, based on the ethnic group (or groups) they identify with. Where people identify with more than one ethnic group, they are prioritised as: Māori, Pacific peoples, Asian, European/other, Unknown. For example, if a person identifies as being Māori and New Zealand European, the person is counted as Māori in this dataset. 'Unknown' is where a person has not disclosed any ethnicity.

Note 2 Partially Vaccinated counted for 12+ years old (age as at 30-Jun-2022)
Completed Primary Course counted for 12+ years old (age as at 30-Jun-2022)
Rec'd First Booster counted for 18+ years old (age as at 30-Jun-2022)
Rec'd Second Booster counted for 18+ years old (age as at 30-Jun-2022)
50+ age determined as at 30-Jun-2022
Basis of population is HSU2021 for 12+ years old
All counts exclude those who died prior to 30-Jun-2022

Further notes on the HSU dataset

While the health system uses the HSU to determine vaccination coverage within the eligible population, the HSU is not a total population estimate and it does not include people who do not use health services.

The HSU is an estimate of the number of people in New Zealand in a given 12-month period, based on information about who used health services in that period. The HSU 2020 was developed and used for the roll-out of the COVID-19 vaccine to calculate the proportion of the eligible population who were vaccinated against COVID-19.

While we use the HSU to determine vaccination coverage within the eligible population, the HSU is not a total population estimate and it is likely to miss highly marginalised groups.

For example, our analysis suggests that groups underrepresented in the HSU include young people aged 15-45 years (men in particular), and people of Asian and Middle Eastern, Latin American and African ethnicities.

There are other datasets that measure the number of people living in New Zealand produced by Stats NZ :[25]

1. Census counts produced every 5 years with a wide range of disaggregation's
2. Population estimates (ERP) which include adjustments for people not counted by census:
    a. National population estimates (produced quarterly)
    b. Subnational population estimates (produced every year)
3. Population projections which give an indication of the future size and composition of the population:
    a. Official national and subnational projections
    b. Customised population projections (produced every year by Stats NZ for the Ministry of Health using requested ethnic groupings and DHB areas).

Differences between the HSU and Stats NZ population statistics arise because the population measures are:

- conceptually different – for example, the HSU includes people who may be visitors to New Zealand who used health services during their short stay, but are not in New Zealand long enough (for at least 12 months) for Stats NZ to define as a resident
- derived from different sources – for example, an individual may identify as one ethnicity when registering with a health service and a different ethnicity when completing a census response.

Stats NZ:

'The ERP and HSU have different target populations. In principle, the ERP is an estimate of the population usually living (resident) in New Zealand at a point in time, and the HSU is a measure of the population in New Zealand using (or potentially using) the health system at a point in time. For both the ERP and HSU, mean populations over a period of time can be derived from the point in time estimates.' [26]

While Stats NZ is the preferred source of New Zealand population statistics, the HSU is considered by the Ministry of Health to be the best option for estimates of vaccine coverage disclosed above.

The HSU allows for the assignment of the same demographics (location and ethnicity) to people in the numerator (the number of people vaccinated, from the CVIP database) as can be found in the denominator (the HSU dataset).

The HSU is available for every demographic contained in health data, including:

- age
- ethnicity

[25] https://www.stats.govt.nz/methods/population-statistics-user-guide.

[26] More information on the findings from the Stats NZ review of the HSU is available at: stats.govt.nz/reports/review-of-health-service-user-population-methodology/

- DHB
- gender

These can be used separately or in combination. Other information such as neighbourhood deprivation, Statistical Area 2, or territorial local authority can also be added. It is also possible to generate flags for health-related information on the HSU (for example, those who are likely to have a long-term condition).

Comparison of HSU 2021 to the Stats NZ projected resident population

The differences between the HSU datasets and Stats NZ projections of the resident population (PRP), prepared for the Ministry of Health in 2021, are demonstrated in the New Zealand population by ethnicity tables, below, for both HSU 2021 and HSU 2020.

Comparison of HSU 2021 to the Stats NZ PRP for the DHB

As at 31 December 2021, there is an estimated 182,254 health service users in the HSU 2021. This is an increase of 7,750 people from the HSU 2020 (an approximate 4.4% increase), and 854 less people than the Stats NZ PRP for 30 June 2021. DHB population by ethnicity: HSU 2021 and Stats NZ PRP comparison[27]

Ethnicity	HSU 2021	Stats NZ PRP	Difference (Note 1)
Māori	47891	50800	2909
Pacific peoples	8311	7990	-321
Asian	10274	9820	-454
European/other	114765	112800	-1965
Unknown	1013	0	-1013
Total (Note 1)	182254	181400	-854

Note 1: The total population estimate based on HSU 2021 (as at 31 December 2021) is 182,254. This is 854 less the Stats NZ total projected population of 181,400 (as at 30 June 2021) taken from the customised 2018-base population projections Stats NZ produced in 2021

Comparison of HSU 2020 to the Stats NZ PRP

For reference, we have provided the HSU 2020 comparison

DHB population by ethnicity: HSU 2020 and Stats NZ PRP[28]

Ethnicity	HSU 2020	Stats NZ PRP	Difference (Note1)
Māori	45960	49700	3740
Pacific peoples	6760	7820	1060
Asian	8327	9650	1323
European/other	112999	112500	-499
Unknown	458	0	-458
Total (Note 1)	174504	179600	5096

Note 1: The total population estimate based on HSU 2020 (as at 1 July 2020) is 174,504. This is 5096 above the Stats NZ total projected population of 179,600 (at 30 June 2020) taken from the customised 2018-base population projections Stats NZ produced in 2021.

[27] HSU 2021 data is as at 31 December 2021 and Stats NZ PRP data is as at 30 June 2021

[28] HSU 2020 data is as at 1 July 2020 and Stats NZ PRP data is as at 30 June 2020.

COVID-19 mortality rates

The data used to determine deaths attributed to COVID-19 comes from EpiSurv[29] and the National Contact Tracing Solution (NCTS) databases. The data received through these systems is extensively checked for duplications using national health index (NHI) data.

The definition of COVID-19 deaths that the Ministry now uses in most situations, including in this section, is defined as 'deaths attributed to COVID-19'.

> 'Deaths attributed to COVID-19' include deaths where COVID-19 was the underlying cause of death, or a contributory cause of death. This is based on Cause of Death Certificates which are coded by the Mortality Coding Team within the Ministry.

There can be delays processing the Cause of Death Certificates being updated in our systems. For example, where a paper-based death certificate is issued, the data will not be recorded as quickly as if it was submitted electronically.

Whether an individual's death is attributed to COVID-19 relies on a variety of sources. These include self-declaration, notifications via health records, or additional tests that are undertaken after death.

COVID-19 Deaths by age group

The following outlines the total number of deaths associated to COVID-19 in Hawke's Bay DHB by age group at the time of death (as at 30 June 2022).

Age group (years)	Number of Deaths
<10	0
10 to 19	0
20 to 29	0
30 to 39	0
40 to 49	0
50 to 59	1
60 to 69	1
70 to 79	6
80 to 89	12
90+	8
Total	**28**

[29] EpiSurv is a secure national system used by Primary Health Units to report cases of notifiable diseases. It is operated by the Institute of Environmental Science and Research (ESR), on behalf of the Ministry of Health

COVID-19 deaths by ethnicity

The following outlines the total number of deaths associated to COVID-19 in Hawke's Bay DHB by the ethnicity of the individual (as at 30 June 2022).

Ethnicity	Number of Deaths
Asian	0
European/other	25
Māori	3
Pacific peoples	0
Unknown[30]	0
Total	**28**

[30] 'Unknown' refers to individuals where no ethnicity can be satisfactorily determined.

Part V - Financial Performance

Result

The result for 2021/22 is a $30.05 million deficit against a planned deficit of $28 million. The underlying operating result includes provision for Holidays Act remediation of $20.7 million and COVID-19 pandemic cost recoveries from MOH, relating to the previous year, of $21.2 million.

The lower than planned operating deficit is largely the result of challenges filling staff vacancies in the current labour market, and the lead times developing some of the new services planned for 2021/22.

Cash flow

The $17.8 million operating cash surplus, and equity injections for capital projects ($14.8 million), provided the funding used for the $27.7 million investment in long term assets, the repayment of $0.4 million of equity, and the $3.8 million reduction in bank overdraft.

Auditors

The Auditor-General is required under section 15 of the Public Audit Act 2001 and section 43 of the New Zealand Public Health and Disability Act 2001, to audit the financial statements and performance information presented by the Board. Audit New Zealand has been appointed to provide these services. Audit fees, relating to the audit of the 2021/22 annual report, amount to $199,000.

The Annual Reporting and Timeframes Extensions Legislation Act was enacted in July 2021 extending audit timelines in the Crown Entities Act 2004 by up to two months for entities with a 30 June balance date. The extension seeks to mitigate a shortage of auditors on obtaining robust audit opinions and applies for the 2020/21 and 2021/22 financial years.

Ministerial directions

Directions that remain current include:

- The direction on the use of authentication services (2008)
- The Health and Disability Services Eligibility Direction (2011)
- Directions to support a whole of government approach to procurement, ICT and property (2014)
- The requirement to implement the NZ Business Number (NZBN) in key systems by December 2018 (2016)

The COVID-19 Public Health Response Act was passed as standalone legislation to provide a different legal framework for responding to COVID-19. The Act allows the Minister of Health (or the Director General of Health in specified circumstances) to make orders under section 11 to give effect to the public health response to COVID-19 in New Zealand.

Several associated directives, epidemic notices and orders have since been issued by Government to manage specific matters during the COVID-19 pandemic and the DHB is working in line with this national direction.

Five-year financial performance summary

The table below provides a comparison between the forecast financial performance measures, with actual performance achieved during the year. The table also provides a comparison with the four previous financial years.

Performance Indicator	Target	2022	2021	2020	2019	2018
Return on net funds employed	(15.4)%	(19.1)%	(19.6)%	(39.5)%	(12.9)%	(0.1)%
Operating margin to revenue	(3.4)%	(3)%	(3.5)%	(9.0)%	(3.4)%	0.0%
Revenue to net funds employed	5.2	6.4	5.6	4.8	3.8	3.8
Net result before financing & abnormal	(23.8)m	(24.2)m	(23.6)m	(54.6)m	(19.8)m	(0.2)m
Net result	(28.0)m	(30.1)m	(28.3)m	(62.9)m	(28.4)m	(8.6)m
Ratio of earnings to revenue	(1.2)%	0.9%	(1.2)%	(6.7)%	(1.3)%	2.4%
Average cost per paid FTE	$105,054	$114,999	$103,976	$98,526	$94,114	$89,090
Average revenue per paid FTE	$257,406	$277,571	$249,775	$238,548	$241,417	$238,336

Statement of comprehensive revenue and expense

For the year ended 30 June 2022

in thousands of New Zealand Dollars

	Notes	30 June 2022	Budget 30 June 2022	30 June 2021
Patient care revenue	2.5	798,687	702,221	669,709
Interest revenue		293	44	90
Other operating revenue	2.6	8,752	3,286	7,412
Total revenue		807,732	705,551	677,211
Personnel costs	2.7	334,647	287,952	282,004
Outsourced services		27,139	18,754	26,806
Clinical supplies		62,576	73,881	58,500
Infrastructure and non-clinical expenses		41,862	30,797	32,283
Payments to other DHBs		70,340	69,644	63,034
Payments to non-health board providers		264,550	224,603	215,955
Other operating expenses	2.8	14,123	6,014	6,941
Depreciation and amortisation expense	3.6, 3.7	16,808	17,702	15,476
Financing costs	2.9	14	249	184
Capital charge	2.10	5,821	4,000	4,569
Impairment losses	3.7	-	-	-
Total expenses		837,880	733,596	705,752
Share of associate surplus/(deficit)	3.9	98	-	230
Surplus/(deficit)		**(30,050)**	**(28,045)**	**(28,311)**
Other comprehensive revenue and expense				
Revaluation of land and buildings	3.6	26,766	-	14,932
Total comprehensive revenue and expense		**(3,284)**	**(28,045)**	**(13,379)**

Explanations of major variance against budget are provided in note 2.2.

DHBs are required to abide by restrictions on the uses of funding supplied for mental health purposes. Mental health funding for the year ended 30 June 2022 was overspent by $3.2 million (2021: overspent by $0.9 million). Mental health payments were $3.8 million more than funding over the twenty-one years since 1 July 2001 (30 June 2021: $0.6 million more than funding).

Some of the budget figures are not directly comparable to the 2021/22 Annual Plan due to more detailed reporting requirements for those financial statements.

The notes and accounting policies form part of, and should be read in conjunction with, these financial statements.

For the year ended 30 June 2022
in thousands of New Zealand Dollars

	Notes	30 June 2022	Budget 30 June 2022	30 June 2021
Balance at 1 July		118,125	122,649	101,673
Total comprehensive revenue and expense		(3284)	(28,045)	(13,379)
Owner transactions				
Equity injections from the Crown		14,816	45,020	30,188
Equity repayments to the Crown		(357)	(357)	(357)
Balance at 30 June	**4.5**	**129,300**	**139,267**	**118,125**

Explanations of major variance against budget are provided in note 2.2.

The notes and accounting policies form part of, and should be read in conjunction with, these financial statements.

Statement of financial position

As at 30 June 2022

in thousands of New Zealand Dollars

	Notes	30 June 2022	Budget 30 June 2022	30 June 2021
Assets				
Current assets				
Cash and cash equivalents (excluding bank overdraft)	3.1	4,438	-	624
Short term investments	3.1	2,107	2,055	1,443
Receivables and prepayments	3.2	45,817	20,047	22,480
Inventories	3.4	5,723	4,569	4,975
Total current assets		58,085	26,671	29,522
Non-current assets				
Property, plant and equipment	3.6	246,637	228,519	208,997
Intangible assets	3.7	14,881	14,661	16,572
Investment property	3.8	209	209	209
Investment in associate	3.9	1,448	1,341	1,350
Total non-current assets		263,175	244,730	227,128
Total assets		**321,260**	**271,401**	**256,650**
Liabilities				
Current liabilities				
Bank overdraft	3.1	-	9,757	42
Payables and deferred revenue	4.2	60,368	32,452	43,177
Employee entitlements	4.3	68,992	43,736	53,760
Provisions	4.4	59,861	39,900	38,457
Finance Leases		-	367	-
Total current liabilities		189,221	126,212	135,436
Non-current liabilities				
Employee entitlements	4.3	2,739	3,289	3,089
Finance Leases		-	2,633	-
Total non-current liabilities		2,739	5,922	3,089
Total liabilities		**191,960**	**132,134**	**138,525**
Net assets		**129,300**	**139,267**	**118,125**
Equity				
Contributed capital	4.5	157,170	186,861	142,711
Property revaluation reserves	4.5	137,801	111,604	111,035
Restricted funds	4.5	2,107	-	2,014
Accumulated surpluses/(deficits)	4.5	(167,778)	(159,198)	(137,635)
Total equity		**129,300**	**139,267**	**118,125**

Explanations of major variance against budget are provided in note 2.2.

The notes and accounting policies form part of, and should be read in conjunction with, these financial statements.

For the year ended 30 June 2022
in thousands of New Zealand Dollars

	Notes	30 June 2022	Budget 30 June 2022	30 June 2021
Cash flows from operating activities				
Receipts from patient care		779,459	705,097	668,691
Receipts from donations, bequests and clinical trials		543	-	517
Other receipts		8,614	-	11,645
Payments to suppliers		(463,953)	(422,792)	(405,524)
Payments to employees		(296,761	(287,045)	(266,434)
Goods and services tax (net)		(4,522)	-	334
Cash generated from operations		23,380	(4,740)	9,229
Interest received		293	44	90
Interest paid		(14)	(489)	(184)
Capital charge paid		(5,821)	(4,000)	(4,569)
Net cash inflow/(outflow) from operating activities		**17,838**	**(9,185)**	**4,566**
Cash flows from investing activities				
Proceeds from sale of property, plant and equipment		25	(73)	90
Proceeds from sale of investment property		-	-	415
Acquisition of property, plant and equipment		(25,534)	(36,178)	(18,292)
Acquisition of intangible assets		(2,170)	(1,500)	(2,802)
Acquisition of investments		-	-	-
Net cash inflow/(outflow) to investing activities		**(27,679)**	**(37,751)**	**(20,589)**
Cash flows from financing activities				
Proceeds from finance leases		-	3,000	-
Proceeds from equity injections by the Crown		14,817	45,020	30,188
Net proceeds from short term investments		(763)	-	7
Repayment of equity to the Crown		(357)	(357)	(357)
Net cash inflow/(outflow) from financing activities		**13,697**	**47,663**	**29,838**
Net increase/(decrease) in cash and cash equivalents		3,856	727	13,815
Add: opening cash		582	(9,879)	(13,233)
Cash and cash equivalents at end of year	3.1	**4,438**	**(9,152)**	**582**

The payments to supplier's component of operating activities reflects the net Goods and Services Tax (GST) paid and received with the Inland Revenue Department. GST has been presented on a net basis, as the gross amounts do not provide meaningful information for financial statement purposes.

Explanations of major variance against budget are provided in note 2.2.

The notes and accounting policies form part of, and should be read in conjunction with, these financial statements.

Reconciliation of surplus for the period with net cash flows from operating activities

For the year ended 30 June 2022
in thousands of New Zealand Dollars

	Notes	30 June 2022	30 June 2021
Surplus/(deficit) for the year		**(30,050)**	**(28,311)**
Add back non-cash items:			
Share of associate surplus		(98)	(230)
Depreciation and amortisation		16,808	15,476
Increase in provisions		23,606	4,119
Add back items classified as investing activity:			
Net loss/(gain) on disposal of property, plant and equipment		1,688	391
Movement in working capital:			
(Increase)/decrease in receivables and prepayments		(23,240)	(1,353)
(Increase)/decrease in inventories		(748)	(349)
Increase/(decrease) in payables and deferred revenue		15,476	6,505
Increase/(decrease) in employee entitlements		16,948	8,904
Increase/(decrease) in provisions		(2,202)	(386)
Net movement in working capital		6,234	13,321
Other movements not in working capital			
Increase/(decrease) in employee entitlements		(350)	(200)
Net cash inflow/(outflow) from operating activities		**17,838**	**4,566**

Reconciliation of liabilities arising from financing activities

For the year ended 30 June 2022
in thousands of New Zealand Dollars

Cash flows from financing activities had no impact on the DHB's liabilities. The financing cash flows included injections and repayment of equity, and movements in short term deposits relating to special funds and clinical trials. In consequence no reconciliation has been provided.

The notes and accounting policies form part of, and should be read in conjunction with, these financial statements

Notes to the financial statements

For the year ended 30 June 2022
in thousands of New Zealand Dollars

In preparing the 2022 financial statements, the notes have been grouped into sections under five key categories which are considered to be the most relevant for stakeholders and other users.

- Reporting entity and basis of preparation
- Result for the year
- Resourcing the DHB's activities
- Financing the DHB's activities
- Other disclosures

Significant accounting policies have been incorporated throughout the notes to the financial statements adjacent to the disclosure to which they relate. All accounting policies are included within a shaded box. Where possible, wording has been simplified to provide clearer commentary on the financial performance of the DHB. The accounting policies set out below have been applied consistently to all periods presented in the financial statements.

1. Reporting entity and basis of preparation

1.1 Reporting Entity

The Hawke's Bay District Health Board (HBDHB) was a DHB established by the New Zealand Public Health and Disability Act 2000. HBDHB was a crown entity as defined by the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand. The DHB was a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004.

HBDHB's primary objectives were the funding and provision of health, disability and mental health services to the people of Hawke's Bay. Accordingly, the DHB was a public benefit entity (PBE) for financial reporting purposes.

The financial statements of HBDHB comprise the DHB, its 16.7% interest in associate Allied Laundry Services Limited (see note 3.9), its 16.7% investment in Central Region's Technical Advisory Services Limited (TAS), and its 3.7% investment in New Zealand Health Partnerships Limited (NZHP).

TAS provided regional services to the central region DHBs, and national services to the DHB and wider health sectors. This included national programme management, education and support, audit and assurance services, planning and collaboration, business insights and analysis, and strategic workforce services. TAS had a mostly independent board that combined with its ownership and activities, meant HBDHB did not have significant influence over the company. Consequently, the interest in TAS was treated as an investment.

NZHP provided national services to the DHB sector, including arranging banking and insurance services, national procurement and development of the Finance, Procurement and Information Management system. The minor holding in the company meant HBDHB did not have significant influence over the company. Consequently, the interest in NZHP was treated as an investment.

The financial statements for HBDHB are for the year ended 30 June 2022, and were approved by the Health NZ.

1.2 Basis of preparation

Health Sector Reforms

The Hawke's Bay District Health Board (HBDHB) was disestablished by the Pae Ora (Healthy Futures) Act 2022 on 1 July 2022. All assets, rights, liabilities, contracts, entitlements, undertakings and engagements became those of Health New Zealand.

Due to the disestablishment of HBDHB, the financial statements of the DHB have been prepared on a disestablishment basis. No changes have been made to the recognition and measurement, or presentation in these financial statements, as the assets, rights, liabilities, contracts, entitlements, undertakings and engagements of the DHB continue as part of Te Whatu Ora Health New Zealand.

Notes to the financial statements (continued)

For the year ended 30 June 2022

in thousands of New Zealand Dollars

Health Sector Reforms

On 21 April 2021, the Minister of Health announced the health sector reforms in response to the Health and Disability System Review.

The reforms replaced all 20 District Health Boards (DHBs) and the Health Promotion Agency with a new Crown, Health New Zealand (Te Whatu Ora) responsible for running hospitals and commissioning primary and community health services. The legislation enabling the reform, the Pae Ora (Healthy Futures) Act, took effect on 1 July 2022, formally creating Te Whatu Ora, along with two other entities – the Maori Health Authority (Te Aka Whai Ora) to monitor the state of Maori health and commission services directly, and the Public Health Authority, which resides within the Ministry of Health to lead and strengthen public health.

The Act disestablished all DHs and the Health Protection Agency and transferred the HBDHB's assets and liabilities to Te Whatu Ora on 1 July 2022. As a result, the financial statements have been prepared on a disestablishment basis.

However, because health services will continue to be provided through Te Whatu Ora, no changes have been made to the recognition and measurements basis, or presentation of assets and liabilities in these financial statements due to the disestablishment basis of preparation.

Statement of compliance

The financial statements of the DHB have been prepared in accordance with the requirements of the Crown Entities Act 2004, which includes the requirement to comply with generally accepted accounting practice in New Zealand (NZ GAAP). The financial statements have been prepared in accordance with Tier 1 PBE accounting standards, and comply with those standards.

Presentation currency and rounding

The financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars ($'000) unless otherwise specified.

Standards issued and not yet effective and not early adopted

Standards and amendments, issued but not yet effective, that have not been early adopted are:

PBE FRS 48 Service Performance Reporting

PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 *Presentation of Financial Statements* and is effective for the year ending 30 June 2023, with earlier adoption permitted. The DHB has determined the main impact of the new standard is that additional information will need to be disclosed on those judgements that have the most significant effect on the selection, measurement, aggregation, and presentation of service performance information.

PBE FRS 41 Financial Instruments

PBE IPSAS 41 replaces PBE IFRS 9 *Financial Instruments* and is effective for the year ended 30 June 2023, with earlier adoption permitted. The DHB has assessed that there will be little change as a result of adopting the new standard as the requirements are similar to those contained in PBE IRFS 9. The DHB does not intend to early adopt the standard.

2. Result for the year

2.1 Performance by Arm

Hawke's Bay DHB's annual plan includes separate operating statements for funding, governance and funding administration and providing health services. The following table compares performance against the plan for the 2021/22 year.

	Achieved $m	Plan $m	Variance $m
Revenue			
Funding health services	697.6	677.1	20.5
Governance and funding administration	4.1	4.1	-
Providing health services	445.7	435.3	10.4
Covid-19	76.3	-	76.3
Eliminations	(416.0)	(410.9)	(5.1)
	807.7	705.6	102.1
Surplus/(Deficit)			
Funding health services	(19.85)	(28.0)	8.15
Governance and funding administration	(0.4)	-	(0.4)
Providing health services	(31.0)	-	(31.0)
Covid-19	21.2	-	21.2
	(30.05)	(28.0)	(2.05)

Providing health services includes $10.5 million (2021: $9.6 million) of claims for pharmaceutical expenditure through Ministry of Health Sector Services that were ultimately paid for from the funding health services category. These claims are eliminated in the financial statements, but are included in the above table to provide a more useful comparison.
Eliminations are transactions between funding of health services, governance and funding administration and providing of health services, which need to be eliminated when the income of these arms are consolidated.
The favourable result for funding health services arises largely from MOH funding for pay equity, for which costs were incurred in the previous year. The impact of Covid-19 on internal travel within New Zealand reduced net Inter-District patient costs, and community pharmaceuticals were also lower than planned.
The adverse variance from providing health services reflects challenges achieving planned efficiencies, an increase in the provision for Holidays Act remediation, and an allowance for MECA settlements, partly offset by the impact on costs of staff vacancies and supply chain issues – both relating to the Covid-19 pandemic.
The favourable result for the Covid-19 response reflects cost reimbursements by MOH relating to prior years.

2.2 Performance against budget

Accounting Policy

The budget figures are those approved by HBDHB in its statement of performance expectations. The budget figures were prepared in accordance with NZ GAAP, using accounting policies that were consistent with those adopted by the DHB for the preparation of the financial statements.

The financial information contained in the statement of performance expectations is prospective financial information in terms of PBE FRS 42 *Prospective Financial Statements*. PBE FRS 42 requires the DHB to present a comparison of the prospective financial information with the actual financial results being reported. This requirement is met by including the budget information in the financial statements.

Financial Performance

The surplus for the year is $3.3 million unfavourable to plan, including:

- $21.2 million in reimbursements by MOH for COVID-19 expenditure incurred in previous years;
- $9.9 million in pay equity revenue from MOH for pay equity payments recognised in 2021/22;
  less:
- $20.7 million of increased provisioning for Holidays Act remediation;
- $7.2 million for MECA settlements;
- $6.7 million of reduced revenue for planned care services not provided in 2021/22;
- $1.3m committed to outsource endoscopy procedures to be delivered in 2022/23, and
- $0.8 million of underlying operating deficit.

Financial Position

Equity at 30 June 2022 was $9.9 million less than projected in the annual plan. This reflects the $30.2 million lower drawdown of equity injections for capital projects due to slippage, the $4.6 million opening balance difference from plan, and the $3.3 million adverse result, offset by the $26.8 million land and building revaluations.

Assets were $49.8 million higher than budget largely due to the slippage in capital projects, and partly offset by the land and buildings revaluation. Liabilities were $61.1 million higher than plan including: provisioning for Holidays Act remediation; allowance for MECA settlements; the impact of COVID-19 on leave balances; the treatment of the remaining 2021/22 MOH planned care revenue as income in advance; significant commitments incurred in June; and capital project spend to be paid in 2022/23.

Cash Flow

Cash from operating activities was $27 million higher than plan, and included reimbursement from MOH for $21.2 of COVID-19 expenditure incurred in prior years. The remainder includes $2.6 million from increased MOH revenue treated as income in advance. Cash outflow to investment activities, mainly the purchase of property, plant and equipment, was $10.1 million lower than plan reflecting slippage in projects due to supply chain issues relating to the COVID-19 pandemic, and from lead times to achieve equity funding approvals. Financing cash flow was $33.3 million lower than plan reflecting reduced equity needed, due to the lower capital spend and the COVID-19 reimbursement relating to expenditure in prior years.

2.3 Critical accounting estimates and assumptions

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

- Note 3.6: Estimating the fair value of land and buildings
- Note 3.7: Estimating useful lives of intangible assets with definite lives
- Note 4.3: Measuring the liability for long service leave, retirement gratuities, sabbatical leave, sick leave, and continuing medical education leave.
- Note 4.4: Measuring the liability for Holidays Act 2003 remediation and the ACC Accredited Employers Programme.

2.4 Critical judgements in applying accounting policy

In the process of applying HBDHB's accounting policies, management makes various judgements that can significantly affect the amounts recognised in the financial statements. The critical judgements management has exercised in applying accounting policies are included in the note to which they relate, namely: Note 3.7: Impairment of intangible assets with indefinite lives

2.5 Patient care revenue

Accounting policy

Ministry of Health population-based revenue

Hawke's Bay DHB received annual funding from the Ministry of Health via the Population Based Funding Formula (PBFF) which determined Hawke's Bay's share of funding based on population, rurality and other demographics. Changes in population and demographics impacted the PBFF over time. Revenue for the financial year is recognised based on the funding entitlement for that year.

Ministry of Health contract revenue

For contracts where the amount of revenue was substantively linked to the provision of quantifiable units of service (exchange contracts), revenue was recognised as services were provided.

For other contracts (non-exchange) the total revenue receivable under the contract was recognised as revenue immediately, unless there were substantive conditions in the contract. If there were substantive conditions, revenue was recognised when the conditions were satisfied. A condition could include the requirement to provide services to the satisfaction of the funder to receive or retain funding. Revenue for future periods was not recognised where the contract contained substantive termination provisions for failure to comply with the service requirements of the contract. Conditions and termination provisions needed to be substantive, which was assessed by considering factors such as the past practice of the funder. Judgement was often required in determining the timing of revenue recognition for contracts that span a balance date and multi-year funding arrangements.

Revenue from other DHBs

Inter district patient inflow revenue occurred when a patient treated within HBDHB region was domiciled outside of Hawke's Bay, and was recognised at time of discharge. The Ministry of Health credited HBDHB with a monthly amount based on estimated patient treatment for non-Hawke's Bay residents within Hawke's Bay. An annual wash-up occurred at year end to reflect the actual non-Hawke's Bay patients treated at HBDHB.

Other Crown entity contracted revenue

Other Crown entity contract revenue was recognised as revenue when services were provided and contract conditions had been met.

	30 June 2022	30 June 2021
Ministry of Health population-based revenue	633,234	584,865
Ministry of Health contract revenue	138,458	63,014
Revenue from other DHBs	18,501	14,322
Other Crown entity contracted revenue	7,062	6,006
Other patient care related revenue	1,432	1,502
	798,687	**669,709**

Other Crown entity contract revenue includes funding from the Ministry of Education for early childhood education purposes. Receipts in 2021/22 amounted to $174 thousand (2021: $173 thousand), and the balance of funds as at 30 June 2022, included in Note 4.2 under income in advance, amounted to $104 thousand (30 June 2021: $56 thousand).

Reconciliation of Vote Health: Health & Disability Support Services – Hawke's Bay DHB appropriation to population-based revenue

	30 June 2022	30 June 2021
Budget appropriation	628,229	584,103
Supplementary estimates	17,284	4,000
Pay equity funding devolution	(9,864)	-
Combined Pharmaceutical Budget (CPB) adjustments	-	2,004
Contract income treated as income in advance	-	(5,242)
Other	(2,415)	-
Ministry of Health population-based revenue	**633,234**	**584,865**

Ministry of Health population-based revenue is the income received by the DHB and equals the Government's actual expenses incurred in relation to the appropriation, which is a required disclosure under the Public Finance Act 1989.

2.6 Other operating revenue

Accounting policy

Revenue was measured at the fair value of consideration received or receivable.

Interest revenue

Interest revenue was recognised using the effective interest rate method.

Rental revenue

Rental revenue from investment property was recognised in the surplus or deficit on a straight-line basis over the term of the lease. Lease incentives granted were recognised as an integral part of the total rental revenue over the lease term.

Sale of goods

Revenue from goods sold was recognised when HBDHB transferred to the buyer the significant risks and rewards of ownership of the goods and the DHB did not retain either continuing managerial involvement to the degree usually associated with ownership nor effective control over the goods sold.

Provision of services

Services provided to third parties on commercial terms are exchange transactions. Revenue from these services was recognised in proportion to the stage of completion at balance date.

Vested assets

Where a physical asset was gifted to or acquired by HBDHB for nil or nominal cost, the fair value of the asset received was recognised as revenue when control over the asset was obtained.

Donated services

The activities of HBDHB were reliant on services provided by volunteers. Volunteers services received were not recognised as revenue or expenditure by the DHB.

	30 June 2022	30 June 2021
Donations and bequests received	336	874
Rental revenue	815	900
Cafeteria and food sales	623	932
Other operating revenue	6,912	4,371
Gain on sale of property, plant and equipment	66	335
Clinical trials income transferred to an independent charitable trust	-	-
	8,752	**7,412**

2.7 Personnel costs

Accounting policy

Salaries and wages

Salaries and wages were recognised as an expense as employees provided services

Superannuation schemes

Defined contribution schemes

Employer contributions to Kiwisaver, the Government Superannuation Fund, and other schemes were accounted for as defined contribution schemes and were recognised as an expense in surplus or deficit as incurred.

Defined Benefit Plan Contributors Scheme

The DHB made 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 or 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.

The funding arrangements for the scheme are governed by section 44 of the National Provident Fund Restructuring Act 1990 and by a Trust Deed. This Act requires that any increase or decrease to the employer contribution rate should result in contributions being at a level which, on reasonable assumptions, is likely to achieve nether a surplus nor deficit in the trust fund of the scheme at the time that the last contributor ceases to contribute. The Trust Deed specifies that immediately before the scheme is wound up, the assets and interests of all contributors in the scheme will be transferred to the DBP Annuitants Scheme. Employers have no right to withdraw from the plan.

In practice, at present, a single contribution rate is determined for all employers, which is expressed as a multiple of the contributions of members of the scheme who are employees of that employer. The current employer contribution rate is four times contributor contributions, inclusive of Employer Contribution Withholding Tax. The Actuary has recommended the employer contribution rate of four times contributor contributions continues.

There is no minimum funding requirement.

As at 31 March 2022, the scheme had a past service deficit of $0.6 million or 1.7% of past service liabilities (2021: $1.3 million surplus or 2.2% of the liabilities. This amount was exclusive of employer superannuation contribution tax. This deficit was calculated using a discount rate equal to the expected return on the assets but otherwise the assumptions and methodology were consistent with the requirements of PBE IPSAS 39 *Employee Benefits*.

The Scheme had 64 members (2021: 91) at 31 March 2022, two (2021: two) of whom are employees of the DHB.

	30 June 2022	30 June 2021
Salaries and wages	296,467	265,520
Employer contributions to defined contribution plans	9,203	8,425
Increase/(decrease) in employee entitlements	28,976	8,059
	334,647	**282,004**

Remuneration – Board members

Board member Hayley Anderson was remunerated for her work as an Incident Controller for the Coordinated Incident Management System (CIMS) during 2020/21 and into 2021/22. The remuneration was what would be paid in a normal supplier relationship on terms and conditions no more favourable than those the DHB would have adopted if dealing with those individuals at arm's length in the same circumstances.

2.8 Other operating expenses

Accounting policy

Operating lease payments

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset to the lessee. Lease payments under an operating lease are recognised as an expense on a straight-line basis over the term of the lease. Lease incentives received are recognised in the surplus or deficit as a reduction of rental expense over the lease term.

	30 June 2022	30 June 2021
Impairment of receivables (bad and doubtful debts)	132	5
Loss on disposal of property, plant and equipment	1,732	691
Fees to auditor for the audit of the financial statements	199	157
Fees to board members	286	300
Operating lease expenses	7,778	5,653
Increase/(decrease) in provisions	3,105	133
Koha	891	2
	14,123	**6,941**

2.9 Financing costs

Accounting Policy

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

Attributed interest on finance leases are charged to the surplus or deficit over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability.

Overdraft interest expense was $14 thousand (2021: $184 thousand). The DHB had no other borrowings or finance leases at balance date.

2.10 Capital charge

Accounting policy

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

DHBs paid a capital charge to the Crown on their taxpayers' funds as at 30 June and 31 December each year. The charge was based on actual closing equity as at 30 June and 31 December each year. The capital charge rate for the year ended 30 June 2022 was 5% (2021: 5%).

Notes to the financial statements (continued)

For the year ended 30 June 2022

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3. Resourcing the DHB's activities

3.1 Cash and cash equivalents and short-term investments

Accounting policy

Cash and cash equivalents includes cash on hand, deposits held on call with banks, other short-term highly liquid investments with original maturities of three months or less, and bank overdrafts. Bank overdrafts are presented separately in current liabilities in the statement of financial position.

Investments in bank term deposits are initially measured at the amount invested. After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest rate method, less any provision for impairment.

Cash and cash equivalents	30 June 2022	30 June 2021
Cash	4	4
Bank balances	1,180	48
30 day deposits – special funds	-	315
30 day deposits – clinical trials	-	257
Cash and cash equivalents (excluding bank overdraft)	**1,184**	**624**
NZ Health Partnerships (BNZ sweep arrangement)	3,254	(42)
Cash and cash equivalents	**4,438**	**582**

Short term investments		
Term deposits – special funds	1,592	1,219
Term deposits – clinical trials	515	224
	2,107	**1,443**

The carrying amount of term deposits with maturities less than 12 months approximate their fair value. There are no term deposits with a duration greater than 12 months. There is no impairment provision for short term investments.

The entity had $54.4 million (2021: $63.9 million) of undrawn equity injections from the Ministry of Health that was available when expenditure on approved capital projects was incurred.

Financial assets recognised subject to restrictions

Included in cash and cash equivalents and short term investments are unspent funds with restrictions that relate to the delivery of health services (special funds) and participation in clinical trials by the DHB. The delivery of health services was usually restricted by specialty, location or patient type.

Special funds		
Opening balance	1,533	1,621
Donations and bequests	182	23
Interest received	16	21
Expenditure during the year	(139)	(132)
	1,592	**1,533**

Clinical Trials	30 June 2022	30 June 2021
Opening balance	481	1,021
Receipts	180	122
Interest received	3	4
Expenditure during the year	(149)	(187)
Transfer to charitable trust	-	(479)
	515	**481**

DHB Treasury Services Agreement

Hawke's Bay DHB was a party to the DHB Treasury Services Agreement between NZ Health Partnerships Limited (NZHP) and participating DHBs. The agreement enabled NZHP to "sweep" DHB bank account balances and invest the pool of surplus funds on their behalf. The agreement also allowed individual DHBs to have a negative balance that would incur interest at the credit interest rate received by NZHP plus an administrative margin. The maximum borrowing facility available to any DHB was the value of one month's provider arm funding plus GST. As at 30 June 2022 this limit for HBDHB was $39 million (2021: $35 million).

Expected credit losses

While cash and cash equivalents at 30 June 2022 are subject to the expected credit loss requirements of PBE IFRS 9 *Financial Instruments*, no allowance has been recognised because the estimated loss allowance for credit losses is trivial.

Credit card facility

Hawke's Bay DHB had a $200 thousand BNZ Business Visa Card facility.

3.2 Receivables and prepayments

Accounting policy

Short-term receivables are recorded at the amount due, less an allowance for credit losses. The DHB applies the simplified expected credit loss model of recognising lifetime expected credit losses for receivables.

In measuring expected credit losses, short-term receivables have been assessed on a collective basis for customer categories that possess shared credit risk characteristics. They have been grouped based on the days past due.

Short-term receivables are written off when there is no reasonable expectation of recovery. Indicators that there is no reasonable expectation of recovery include failure to make contractual payments for a period of greater than 90 days past due.

Receivables with no allowances for credit losses	30 June 2022	30 June 2021
Ministry of Health receivables and accrued revenue	38,876	17,070
Other accrued revenue	2,248	2,123
Prepayments	2,525	1,936
	43,649	**21,129**
Receivables with allowances for credit losses		
Trade receivables (gross)	2,519	1,640
Less: Allowance for credit losses	(351)	(289)
	2,168	**1,351**
Receivables and prepayments	**45,817**	**22,480**

Receivables and prepayments comprise	30 June 2022	30 June 2021
Receivables from the sales of goods and services (exchange transactions)	6,987	5,410
Receivables from devolved funding (non-exchange transactions)	40,770	17,070
	47,757	**22,480**

The expected credit loss rates for receivables as at 30 June 2022 and 30 June 2021 are based on the payment profile of revenue on credit over a number of years, and the historical credit losses experienced over that period for a number of customer categories. The historical loss rates are adjusted for current and forward-looking macroeconomic factors that might affect the recoverability of receivables. Given the short period of credit risk exposure, the impact of macroeconomic factors is not considered significant.

There have been no changes during the reporting period in the estimation techniques or significant assumptions used in measuring the loss allowance.

The aggregated allowance for credit losses across all customer categories at 30 June 2022 and 30 June 2021 are as follows:

30 June 2022	Current	More than 30 days	More than 60 days	More than 90 days	Total
Expected credit loss rate	0.0%	0.1%	0.9%	15.7%	1.4%
Gross carrying amount	35,430	5,118	1,056	2,039	43,643
Lifetime expected credit loss	15	6	10	320	351

30 June 2021	Current	More than 30 days	More than 60 days	More than 90 days	Total
Expected credit loss rate	0.1%	1.0%	4.1%	66.7%	1.4%
Gross carrying amount	19,745	399	317	372	20,833
Lifetime expected credit loss	24	4	13	248	289

The movement in the allowance for credit losses is as follows:

	30 June 2022	30 June 2021
Opening allowance for credit losses as at 1 July	289	382
Increase in loss allowance made during the year	132	(6)
Receivables written-off during the year	(70)	(87)
Balance at 30 June	**351**	**289**

3.3 Loans

Accounting policy
Loans are initially recognised at fair value, then at amortised cost using the effective interest rate method.

The DHB has no loans outstanding with any other organisations.

3.4 Inventories

Accounting Policy

Inventories held for distribution

Inventories held for distribution, or consumption in the provision of services, that are not supplied on a commercial basis are measured at cost on a first in first out basis, adjusted where applicable for any loss of service potential. Where inventories are acquired through non-exchange transactions, cost is the fair value at the date of acquisition.

Inventories held for sale

Inventories held for sale or use in the provision of goods and services on a commercial basis are valued at the lower of cost and net realisable value. The cost of purchased inventory is determined using the weighted average cost method.
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.

Inventories held for distribution	30 June 2022	30 June 2021
Pharmaceuticals	841	1,050
Surgical and medical supplies	3,014	2,477
Other supplies	1,868	1,448
	5,723	**4,975**

Write-down of inventories amounted to $36 thousand (2021: $43 thousand). No reversal of previously recognised write-downs was made in the current year. The amount of inventories recognised as an expense during the year was $47.4 million (2021: $48.1 million). No inventories were held at current replacement cost at 30 June 2022 (30 June 2021: Nil). No inventories are pledged as security for liabilities, but some inventories are subject to retention of title clauses. The value of stocks subject to such clauses cannot be quantified due to the inherent difficulties in identifying the specific inventories affected at period end.

3.5 Non-current assets held for sales

Accounting policy

Non-current assets held for sale are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. Non-current assets held for sale, are measured at the lower of their carrying amount and fair value less costs to sell.

Any impairment losses for write-downs of non-current assets held for sale are recognised in the surplus or deficit. Any increase in fair value (less costs to sell) are recognised up to the level of any impairment losses that have been previously recognised.
Non-current assets held for sale are not depreciated or amortised while they are classified as held for sale.

HBDHB had no non-current assets held for sale.

Notes to the financial statements (continued)
For the year ended 30 June 2022
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3.6 Property, plant and equipment

Accounting policy

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

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

Revaluations

Land and buildings are revalued with sufficient regularity to ensure that the carrying amount does not differ materially from fair value, and at least every five years. The carrying value of land and buildings are assessed annually to ensure that they do not differ materially from fair value. If there is evidence supporting a material difference, then the asset class will be revalued. Land and building revaluation movements are accounted for on a class-of-asset basis.

The net revaluation results are credited or debited to other comprehensive revenue and expense and are accumulated to an asset revaluation reserve in equity for that class of asset. Where this would result in a debit balance in the asset revaluation reserve, this balance is not recognised in other comprehensive revenue and expense 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 and expense. Surplus property is carried at the book value on the date the property was declared surplus less impairment losses until it is disposed of.

Additions

The cost of an item of property, plant and equipment is recognised as an asset only when it is probable that future economic benefits or service potential associated with the item will flow to the DHB and the cost of the item can be measured reliably. Work in progress is recognised at cost, less impairment, and is not depreciated. In most instances, an item of property, plant and equipment is initially recognised at its cost. Where an asset is acquired through a non-exchange transaction, it is recognised at its fair value as at the date of acquisition.

Disposals

Gains and losses on disposals are determined by comparing the proceeds with the carrying amount of the asset. Gains and losses on disposals are reported net in the surplus or deficit. When revalued assets are sold, the amounts included in the revaluation reserve are transferred to accumulated surpluses/(deficits).

Subsequent costs

Costs incurred subsequent to initial acquisition are capitalised only when it is probable that future economic benefits or service potential associated with the item will flow to HBDHB and the cost of the item can be measured reliably. The costs of day-to-day servicing of property, plant and equipment are recognised in the surplus or deficit as they are incurred.

Depreciation

Depreciation is provided on a straight-line basis on all property, plant and equipment other than land, at rates that will write-off the cost (or valuation) of the assets to their estimated residual values over their useful lives. The useful lives and associated depreciation rates have been estimated as follows:

Class of asset	Estimated life	Depreciation rate
Buildings	2 to 57 years	1.75% to 50%
Clinical equipment	3 to 20 years	5% to 33.33%
Information technology	2 to 10 years	10% to 50%
Motor vehicles	3.75 to 20 years	5% to 26.67%
Other equipment	3 to 30 years	3.33% to 33.33%

Leasehold improvements are depreciated over the unexpired period of the lease or the estimated remaining useful lives of the improvements, whichever is the shorter.

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

Impairment of property, plant and equipment

Hawke's Bay DHB does not hold any cash generating assets. Assets are considered cash-generating where their primary objective is to generate a commercial return.

Property, plant and equipment held at cost that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable service amount. The recoverable service amount is the higher of an asset's fair value less costs to sell and value in use. Value in use is determined using 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 the availability of information.

If an asset's carrying amount exceeds its recoverable service amount, the asset is regarded as impaired and the carrying amount is written down to the recoverable amount. Impairment losses and reversal of impairment losses are recognised in the surplus or deficit, unless the asset is carried at a revalued amount. Any impairment loss or reversal relating to a revalued asset are treated as revaluation adjustments.

Critical accounting estimates and assumptions

Estimating the fair value of land and buildings

The most recent valuation of land and buildings was performed by an independent registered valuer, John Reid MPropertyStudies BCom FNZIV FPINZ of Added Valuation Limited. The desk top valuation only was carried out effective as at 30 June 2022. The valuations of land and buildings were updated to reflect the movement in building costs in Hawke's Bay.

Land

Land is valued at fair value using market-based evidence based on its highest and best use with reference to comparable land values. Restrictions on the DHB's ability to sell land, would normally not impair the value of the land 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 including:

- Cost is based on replacement with modern equivalent assets, adjusted where appropriate for physical deterioration and optimisation due to over-design or surplus capacity.
- Cost is derived from historical cost records plus other construction data including: Rawlinsons 2007 Construction handbook; Rider Levett Bucknall Costings; Maltbys (Quantity Surveyors and Construction Cost Managers) cost data and indices; Opus International Consultants (Quantity Surveyor Advice), and other data collected by Added Valuation Limited.
- In determining obsolescence and physical depreciation regard has been given to the period that the DHB expects to make use of each asset.
- The estimated remaining life has been applied in determining depreciated replacement cost, using recent asset management plans.

Non-specialised buildings are valued at fair value using market-based evidence. Market rents and capitalisation rates were applied to reflect market value.

The Board believes that the net book value of plant and equipment is the fair value at 30 June 2022.

Assessing the appropriateness of useful life estimates requires the DHB to consider a number of factors such as the physical condition of the asset and advances in medical technology. An incorrect assessment of the useful life or residual value will affect the depreciation expense recognised in the surplus or deficit and the asset's carrying value. The DHB minimises the risk of this estimation uncertainty by physical inspection of the assets and asset replacement programmes. The DHB has not made significant changes to past assumptions concerning useful lives.

Cash Flow

The DHB acquired plant, property and equipment with an aggregate cost of $25.534 million during the year (2021: $18.292 million). Of this amount $14.816 million (2021: $5.188 million) was reimbursed by the Ministry of Health through equity injections. Cash payments of $25.534 million (2021: $17.620 million) were made to purchase property, plant and equipment.

No liabilities arose from financing activities relating to property, plant and equipment, during the year, as the activities resulted from either movement in short term investments or the equity injections. Equity injections provided to purchase property, plant and equipment are not subject to capital charge.

Impairment

An impairment assessment has not identified a need to reduce the carrying value of any of the DHB's assets. Consequently no impairment losses have been recognised in either of the year ended 30 June 2021 and the year ended 30 June 2022. No reversals of impairment losses have occurred during the year.

Restrictions

Hawke's Bay DHB did not have full title to the Crown land it occupied, but transfer was arranged if and when land is sold. The disposal of certain properties might 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.

Notes to the financial statements (continued)

For the year ended 30 June 2022

in thousands of New Zealand Dollars

30 June 2022	1 July 2021									30 June 2022		
Owned assets	Cost/ Valuation	Accumulated Depreciation	Carrying Amount	Acquisitions /transfers from investment properties	Transfers from work in progress	Revaluation of land and buildings	Disposals	Depreciation expense	Depreciation write back on disposal/ revaluation	Cost/ valuation	Accumulated Depreciation	Carrying Amount
Land	15,248	-	15,248	-	-	1,477	-	-	-	16,725	-	16,725
Buildings	159,491	-	159,491	-	6,370	16,704	-	(8,584)	8,584	182,565	-	182,565
Clinical equipment	40,665	(24,549)	16,116	-	4,800	-	(4,037)	(3,554)	3,936	41,428	(24,167)	17,261
Information tech.	10,751	(7,185)	3,566	-	1,219	-	-	(1,810)	-	11,970	(8,995)	2,975
Motor vehicles	1,765	(1,547)	218	-	806	-	(10)	(103)	10	2,561	(1,640)	921
Other equipment	5,064	(2,486)	2,578	-	1,175	-	(98)	(402)	98	6,141	(2,790)	3.351
	232,984	(35,767)	197,217	-	14,370	18,181	(4,145)	(14,453)	12,628	261,390	(37,592)	223,798
Leased assets												
Alterations	1,916	(1,038)	878	-	-	-	-	(105)	-	1,916	(1,143)	773
	1,916	(1,038)	878	-	-	-	-	(105)	-	1,916	(1,143)	773
Work in Progress												
Buildings	9,249	-	9,249	14,000	(6,370)	-	-	-	-	16,879	-	16,879
Clinical equipment	1,157	-	1,157	7,089	(4,800)	-	-	-	-	3,446	-	3,446
Information tech.	265	-	265	1,750	(1,219)	-	-	-	-	796	-	796
Motor vehicles	41	-	41	1,156	(806)	-	-	-	-	391	-	391
Other equipment	190	-	190	1,539	(1,175)	-	-	-	-	554	-	554
	10,902	-	10,902	25,534	(14,370)	-	-	-	-	22,066	-	22,066
	245,802	(36,805)	208,997	25,534		18,181	(4,145)	(14,558)	12,628	285,372	(38,735)	246,637

Notes to the financial statements (continued)

For the year ended 30 June 2022

in thousands of New Zealand Dollars

30 June 2021	1 July 2020									30 June 2021		
Owned assets	Cost/ Valuation	Accumulated Depreciation	Carrying Amount	Acquisitions /transfers from investment properties	Transfers from work in progress	Revaluation of land and buildings	Disposals	Depreciation expense	Depreciation write back on disposal/ revaluation	Cost/ valuation	Accumulated Depreciation	Carrying Amount
Land	12,127	-	12,127	70	152	2,899	-	-	-	15,248	-	15,248
Buildings	156,129	(7,748)	148,381	-	7,034	(3,658)	(14)	(7,948)	15,696	159,491	-	159,491
Clinical equipment	38,377	(24,560)	13,817	-	5,852	-	(3,564)	(3,441)	3,452	40,665	(24,549)	16,116
Information tech.	10,165	(6,407)	3,758	-	1,547	-	(961)	(1,738)	960	10,751	(7,185)	3,566
Motor vehicles	1,864	(1,591)	273	-	66	-	(165)	(121)	165	1,765	(1,547)	218
Other equipment	4,802	(2,201)	2,601	-	382	-	(120)	(362)	77	5,064	(2,486)	2,578
	223,464	(42,507)	180,957	70	15,033	(759)	(4,824)	(13,610)	20,350	232,984	(35,767)	197,217
Leased assets												
Alterations	1,771	(821)	950	-	146	-	(1)	(218)	1	1,916	(1,038)	878
	1,771	(821)	950	-	146	-	(1)	(218)	1	1,916	(1,038)	878
Work in Progress												
Buildings	6,016	-	6,016	10,565	(7,332)	-	-	-	-	9,249	-	9,249
Clinical equipment	1,477	-	1,477	5,532	(5,852)	-	-	-	-	1,157	-	1,157
Information tech.	236	-	236	1,576	(1,547)	-	-	-	-	265	-	265
Motor vehicles	-	-	-	107	(66)	-	-	-	-	41	-	41
Other equipment	61	-	61	511	(382)	-	-	-	-	190	-	190
	7,790	-	7,790	18,291	(15,179)	-	-	-	-	10,902	-	10,902
	233,025	(43,328)	189,697	18,361		(759)	(4,825)	(13,828)	20,351	245,802	(36,805)	208,997

3.7 Intangible assets

Accounting policy

Software acquisition and development

Acquired software licenses are capitalised on the basis of the costs incurred to acquire and bring to use the specific software. Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include costs of materials and services, employee costs and any directly attributable overheads. Staff training costs are recognised as an expense when incurred.

Costs associated with maintaining computer software are recognised as an expense when incurred. Costs of software updates or upgrades are capitalised only when they increase the usefulness or value of the asset.

Rights in shared software developments are considered to have indefinite useful life, as the DHB has the ability and intention to review any service level agreement indefinitely. As the rights are considered to have indefinite life, the intangible asset is not amortised and is tested for impairment annually.

Amortisation

The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life. Amortisation begins when the asset is available for use and ceases at the date the asset is derecognised. The amortisation charge for each financial year is recognised in the surplus or deficit.

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

Type of asset	Estimated life	Amortisation rate
Acquired computer software	3 to 20 years	10% to 33.33%
Developed computer software	3 to 10 years	10% to 33.33%

Impairment of intangible assets

Hawke's Bay DHB does not hold any cash generating assets. Assets are considered cash-generating where their primary objective is to generate a commercial return.

Intangible assets held at cost that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable service amount. The recoverable service amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is determined using 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 the availability of information.

If an asset's carrying amount exceeds its recoverable service amount, the asset is regarded as impaired and the carrying amount is written down to the recoverable amount. The total impairment loss is recognised in the surplus or deficit. The reversal of an impairment loss is recognised in the surplus or deficit.

Intangible assets subsequently measured at cost that have an indefinite useful life, or are not yet available for use, are not subject to amortisation and are tested annual for impairment.

Critical accounting estimates and assumptions

Estimating useful lives of intangible assets with definite lives

Assessing the appropriateness of useful life estimates requires the DHB to consider a number of factors such as the extent to which the asset meets the DHB's needs and advances in technology. An incorrect assessment of the useful life or any residual value will affect the amortisation expense recognised in the surplus of deficit and the asset's carrying value. The DHB minimises the risk of this estimation uncertainty by review of asset effectiveness and technology platforms. The DHB has not made significant changes to past assumptions concerning useful lives.

Critical judgements in applying accounting policies

Impairment of intangible assets with indefinite lives

The investment in the Health Finance, Procurement and Information Management System (FPIM) was impaired in 2018/19 for its full remaining value of $2.638 million. The DHB will be able to implement the system at a future date, should it become economic to do so, by contributing its share of any further development costs incurred by the DHBs who implement the system.

The Regional Digital Health Service (RDHS) provides a number of clinical systems for the Central Region DHBs, which are subject to an annual impairment test. HBDHB remains committed to the RDHS programme but has determined that it will defer joining the regional version of the Web-based patient administration system (WebPAS). Instead HBDHB will continue to access the additional functionality currently available in its local WebPAS solution and interface with the regional solution. The combined regional/local solution is expected to provide the information requirements of HBDHB, and the DHBs investment in the regional solution was necessary for those information requirements to be met. Consequently, the investment in RDHS has not been impaired.

Notes to the financial statements (continued)

For the year ended 30 June 2022

in thousands of New Zealand Dollars

	1 July 2021								30 June 2022		
30 June 2022 Owned assets	Cost/ Valuation	Accumulated Amortisation	Carrying Amount	Acquisitions	Transfers	Disposals/ Impairment	Amortisation Expense	Amortisation written back	Cost/ Valuation	Accumulated Amortisation	Carrying Amount
Software	25,875	(11,463)	14,412	-	1,709	(2,169)	(2,250)	557	25,415	(13,156)	12,259
	25,875	(11,463)	14,412	-	1,709	(2,169)	(2,250)	557	25,415	(13,156)	12,259
Work in Progress											
Software	1,836	-	1,836	2,171	(1,385)	-	-	-	2,622	-	2,622
Health Sector Catalogue	324	-	324	-	(324)	-	-	-	-	-	-
	2,160	-	2,160	2,171	(1,709)	-	-	-	2,622	-	2,622
	28,035	(11,463)	16,572	2,171		(2,169)	(2,250)	557	28,037	(13,156)	14,881

Health Sector Catalogue is the DHB's share of the assets comprising the Health Sector Catalogue project facilitated by NZ Health Partnerships Limited (NZHP). The intangible asset recognises the DHB's right to use the catalogue, and its ownership of a proportion of the systems assets.

Cash Flow

The DHB acquired intangible assets with an aggregate cost of $2.171 million during the year. Cash payments of $2.171 million were made to purchase intangible assets.

No liabilities arose from financing activities relating to intangible assets as the activities resulted from movements in short term investments.

Notes to the financial statements (continued)

For the year ended 30 June 2022

in thousands of New Zealand Dollars

	1 July 2020								30 June 2021		
30 June 2021 Owned assets	Cost/ Valuation	Accumulated Amortisation	Carrying Amount	Acquisitions	Transfers	Disposals/ Impairment	Amortisation Expense	Amortisation written back	Cost/ Valuation	Accumulated Amortisation	Carrying Amount
Software	16,484	(10,927)	5,557	-	10,826	(1,435)	(1,647)	1,111	25,875	(11,463)	14,412
	16,484	(10,927)	5,557	-	10,826	(1,435)	(1,647)	1,111	25,875	(11,463)	14,412
Work in Progress											
Software	10,186	-	10,186	2,440	(10,826)	-	-	-	1,836	-	1,836
Health Sector Catalogue	-	-	-	324	-	-	-	-	324	-	324
	10,186	-	10,186	2,764	(10,826)	-	-	-	2,160	-	2,160
	26,670	(10,927)	15,743	2,764		(1,435)	(1,647)	1,111	28,035	(11,463)	16,572

3.8 Investment property

Accounting policy

Investment properties are properties which are held either to earn rental income or for capital appreciation or for both. Investment properties are stated at fair value. If there is evidence supporting a material difference in value an external, independent valuation company, having an appropriate recognised professional qualification and recent experience in the location and category of property being valued will provide an assessment on the fair values of the properties. The fair values are based on market values, being the estimated amount for which a property could be exchanged on the date of valuation between a willing buyer and a willing seller in an arm's length transaction after proper marketing where the parties had each acted knowledgeably, prudently and without compulsion.

Any gain or loss arising from a change in fair value is recognised in the surplus or deficit. Rental income from investment property is accounted for as described in the accounting policy on rental income (see above). When an item of property, plant and equipment is transferred to investment property following a change in its use, any differences arising at the date of transfer between the carrying amount of the item immediately prior to transfer and its fair value is recognised directly in equity if it is a gain. Upon disposal of the item the gain is transferred to retained earnings. Any loss arising in this manner is recognised immediately in the surplus or deficit.

If an investment property becomes owner-occupied, it is reclassified as property and its fair value at the date of reclassification becomes its cost for accounting purposes of subsequent recording. When HBDHB begins to redevelop an existing investment property for continued future use as investment property, the property remains an investment property, which is measured based on the fair value model, and is not reclassified as property, plant and equipment during the redevelopment.

	30 June 2022	30 June 2021
Balance at beginning of year	209	694
Transfers to property, plant and equipment	-	(70)
Disposals	-	(415)
Balance at end of year	209	209

No revaluation was completed for investment properties as at 30 June 2022 due to the minimal value of the properties. The properties were last revalued as at 30 June 2018 by John Reid of Added Valuation, who holds an annual practicing certificate and has held registration since 1985. The fair value of the investment properties was determined using market-based evidence.

3.9 Investment in associates

Accounting policy

An associate is an entity over which the DHB has significant influence, and that is neither a subsidiary nor an interest in a joint venture. The DHB's investment in its associate entity is accounted for using the equity method. The investment is initially recognised at cost and the carrying amount is increased or decreased to recognise the DHB's share of the surplus or deficit of the associate after the date of acquisition. Distributions received from an associate reduce the carrying amount of the investment in the statement of financial position.

If the share of deficits of an associate equal or exceed the DHB's interest in the associate, further deficits are not recognised. After the DHB's interest is reduced to zero, additional deficits are provided for, and a liability is recognised, only to the extent that the DHB has incurred legal or constructive obligations or made payments on behalf of the associate. If the associate subsequently reports surpluses, the DHB will resume recognising its share of those surpluses only after its share of the surpluses equals the share of deficits not recognised.

Notes to the financial statements (continued)

For the year ended 30 June 2022

in thousands of New Zealand Dollars

Hawke's Bay DHB had an investment in one associate entity, Allied Laundry Services Limited (ALSL), whose principal activity is the provision of laundry services. The interest held at 30 June 2022 was 16.67% (30 June 2021: 16.67%). ALSL has been treated as an associate entity because its shares are held equally by six DHB shareholders, who appoint one director each, and contribute 91% (2021: 92%) of the company's income. The associates balance date is 30 June. There were no significant restrictions on the ability of the associate to transfer funds to HBDHB in the form of cash dividends.

Summarised financial information of Allied Laundry Services Limited	30 June 2022	30 June 2021
Presented on a gross basis		
Assets	13,538	13,017
Liabilities	4,851	4,612
Revenue	13,776	13,087
Surplus/(deficit)	283	656
HBDHB ownership interest	16.67%	16.67%
Share of ALSL's contingent liabilities incurred jointly with other investors	-	-
Capital commitments	-	-

Allied Laundry Services Limited is an unlisted company, and accordingly, has no published price quotation. The figures above are for the Company as they appear in their unaudited draft accounts as at 30 June 2022, and their audited financial statements as at 30 June 2021.

4. Financing the DHB's activities

4.1 Borrowings and finance leases

The DHB had no borrowings or finance leases at balance date, other than the overdraft facility through New Zealand Health Partnerships.

4.2 Payables and deferred revenue

Accounting policy

Payables and deferred revenue are recorded at their face value.

Payables and deferred revenue under exchange transactions	30 June 2022	30 June 2021
Trade payables	1,319	3,902
Income in advance relating to contracts with specific performance obligations	9,493	6,207
Other non-trade payables and accrued expenses	47,676	29,951
	58,488	40,060
Payables and deferred revenue under non-exchange transactions		
ACC levy payable	313	235
Goods and services tax	1,567	2,882
	1,880	3,117
Total payables and deferred revenue	**60,368**	**43,177**

Payables and deferred revenue are non-interest bearing and are normally settled within 10 days of processing into the DHB's accounts payable system or on 7-day terms, therefore the carrying value of payables and deferred revenue approximates their fair value.

Notes to the financial statements (continued)

For the year ended 30 June 2022

in thousands of New Zealand Dollars

4.3 Employee entitlements

Accounting policy

Short-term employee entitlements

Employee entitlements that are due to be settled within 12 months after the end of the period in which the employee renders the related service are measured based on accrued entitlements at current rates of pay.

These include salaries and wages accrued up to balance date, annual leave and continuing medical education leave earned, but not yet taken at balance date, retiring and long service leave entitlements expected to be settled within 12 months, and sick leave.

The liability for sick leave is recognised to the extent that 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 on balance date, to the extent that it will be used by staff to cover those future absences.

The liability and an expense are recognised for bonuses where it is a contractual obligation or where there is a past practice that has created a constructive obligation and a reliable estimate of the obligation can be made.

Long-term employee entitlements

Employee entitlements that are due to be settled beyond 12 months after the end of the period in which the employee renders the related service, such as long service leave and retirement gratuities, have been calculated on an actuarial basis. The calculations are based on: likely future entitlements accruing to staff, based on years of service, years to entitlement, the likelihood that staff will reach the point of entitlement and contractual entitlement information; and the present value of the estimated future cash flows.

Presentation of employee entitlements

Annual leave, sick leave, continuing medical education leave, and sabbatical leave that are available for use are classified as a current liability. Long service leave and retirement gratuities expected to be settled within 12 months of balance date are also classified as a current liability. All other employee entitlements are classified as a non-current liability.

Critical accounting estimates and assumptions

Employee entitlement provisions

The calculation of sick leave, sabbatical leave, long service leave, and retirement gratuity liabilities are based on demographic assumptions and discount rate estimates. Demographic assumptions relating to life expectancy and future earnings potential are inherently uncertain as are discount rate estimates based on government bond rates over long periods of time. The carrying amount of the liability relating to these employee provisions is $6.112 million (2021: $6.146 million).

The present value of sick leave, sabbatical leave, long service leave, and retirement gratuities obligations depend on a number of factors that are determined on an actuarial basis by external independent actuary, Paul Dalebroux BSc(Hons), FIA, FNZSA. Two key assumptions used in calculating these liabilities are the discount rate and the salary inflation factor. Any change in these assumptions will affect the carrying amount of the liability.

Expected future payments are discounted using forward discount rates derived from the yield curve of New Zealand government bonds, published by Treasury. The discount rates used have maturities that match, as closely as possible, the estimated future cash outflows, and vary from 3.34% (2021: 0.38%) in year one to 4.30% (2021: 4.30%) after 40 (2021: 30) years. The salary inflation factor is the DHB's best estimate forecast of salary increments after discussions with the actuary.

If the discount rates are 1% lower, or salary increases 1% higher, from that used with all other factors held constant, the carrying amount of the sick leave, sabbatical leave, long service leave and retirement gratuities would be an estimated $238 thousand higher (2021: $309 thousand higher). Conversely if the discount rates are 1% higher, or salary increases 1% lower, from that used with all other factors held constant, the carrying amount of the sick leave, sabbatical leave, long service leave and retirement gratuities would be an estimated $215 thousand lower (2021: $279 thousand lower).

Notes to the financial statements (continued)

For the year ended 30 June 2022

in thousands of New Zealand Dollars

Non-current liabilities	30 June 2022	30 June 2021
Long service leave	2,720	3,069
Retirement gratuities	19	20
	2,739	**3,089**

Current liabilities	30 June 2022	30 June 2021
Accrued salaries and wages	21,872	15,466
Annual leave	36,105	29,119
Sick leave	578	518
Continuing medical education leave and expenses	7,642	6,118
Sabbatical leave	578	609
Long service leave	2,140	1,815
Retirement gratuities	77	115
	68,992	**53,760**

4.4 Provisions

Accounting policy

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 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 included in financing costs.

Critical accounting estimates and assumptions

This note provides information about estimates and assumptions applied in determining the DHB’s liability under the ACC Partnership Programme, and Holidays Act remediation.

	30 June 2022	30 June 2021
Balance at beginning of year	38,457	34,724
Additional provisions made	23,606	4,119
Amounts used	(2,202)	(386)
Unused amounts reversed	-	-
Balance at end of year	**59,861**	**38,457**

All provisions are classified as current.

ACC Accredited Employers Programme

Hawke's Bay DHB belonged to the ACC Accredited Employers Programme's full self-cover plan, whereby the DHB accepted the management and financial responsibility for employee work related illnesses and accidents. Under the programme, the DHB was liable for all claim's costs for a period of five years after the end of the cover period in which the injury occurred. At the end of the five-year period, the DHB paid a premium to ACC for the value of residual claims, and from that point the liability for ongoing claims passed to ACC.

Liability valuation

The liability for the ACC Accredited Employers Programme is measured at the present value of anticipated future payments to be made in respect of the employee injuries and claims up to the reporting date using actuarial techniques. Consideration was given to expected future wage and salary levels, and experience of employee claims and injuries. Expected future payments are discounted using market yields at balance date on government bonds with terms to maturity that match, as closely as possible, the estimated future cash outflows.

Exposures arising from the programme were managed by promoting a safe and healthy working environment by:

- implementing and monitoring health and safety policies;
- induction training on health and safety;
- actively managing workplace injuries to ensure that employees returned to work as soon as practical;
- recording and monitoring workplace injuries and near misses to identify risk areas and implementing mitigating actions; and
- identifying workplace hazards and implementation of appropriate safety procedures.

Hawke's Bay DHB chose a stop loss limit of 250% of the industry premium. The stop loss limit means that the DHB would have carried the total cost of claims up to $2.6 million (2021: $2.7 million) for each year of cover, which runs from 1 April to 31 March. If the claims for a year exceeded the stop loss limit, the DHB would have continued to meet the costs of claims and would have been reimbursed by ACC for the costs that exceeded the stop loss limit.

The DHB was not exposed to any significant concentrations of insurance risk, as work-related injuries generally are the result of an isolated event involving an individual employee.

An independent consulting actuary, Peter Davies B.Bus.Sc, FIA, FNZSA has calculated the DHB's liability, and the valuation is effective 30 June 2022. The actuary has attested he is satisfied as to the nature, sufficiency and accuracy of the data used to determine the outstanding claims liability. There are no qualifications contained in the consulting actuary's report.

In the valuer's opinion, there are insufficient potential long-term claims to be able to carry out any meaningful discounting. Accordingly, all liabilities have been taken at their face value.

Any changes in liability valuation assumptions do not have a material effect on the financial statements.

Holidays Act remediation

A number of New Zealand's public and private organisations have identified issues with the calculation of leave entitlements under the Holidays Act 2003 ("the Act"). Work has been ongoing since 2016 on behalf of the 20 DHBs and the New Zealand Blood Service (NZBS), with the Council of Trade Unions (CTU), health sector unions and Ministry of Business Innovation and Employment (MBIE) Labour Inspectorate, for an agreed and national approach to identify, rectify and remediate any Holidays Act non-compliance by DHBs.

DHBs agreed to a Memorandum of Understanding (MOU), which contains a method for determination of individual employee earnings, for calculation of liability for any historical non-compliance.

For employers such as the DHBs that have workforces that included differential occupational groups with complex entitlements, non-standard hours, allowances and/or overtime, the process of assessing non-compliance with the Act and determining any additional payment is time consuming and complicated.

The remediation project associated with the MOU is a significant undertaking and work to assess all non-compliance was substantially complete by the second half of 2022/23. The Holidays Act compliant system will be operational after the calculation of corrected entitlements, expected in late calendar 2023.

Hawke's Bay DHB reassessed the likely liability at $58.2 million (2021: $37.5 million), based on further clarification of the calculation rules, an estimation of the liability by Grant Thompson based on increased sample size (98.5%), recognition of growth since 1 July 2021, and increased administrative costs of the remediation process. The financial liability was originally calculated based on identified areas of non-compliance with the Holidays Act, and the recalculation of a sample of current and former employees, extrapolated to the full population of affected people. The additional liability this year has been recognised in personnel care except for those relating to remediation costs (payroll system rectification costs, remediation partner costs, project team costs, licensing costs for the portal and any other anticipated project spend), these are recognised under other operating expenses.

The liability amount is HBDHB's best estimate at this stage of the remediation project, however there remains a level of uncertainty until the project is complete. Estimates and assumptions may change as further work is completed, and result in further adjustment to the carrying amount of the provision, or payments to current and former employees that differ significantly from the estimation of the liability.

A number of DHBs have allowed some employees transferring between DHBs to take their leave balances with them. The DHB the employee was leaving has usually compensated the other DHB for the value of the leave transferred. This practice is contrary to the Holidays Act, that requires an employee to be paid out when they leave an organisation. At 30 June 2022 a provision has been made for the value of the leave that was not paid out.

4.5 Equity

	Crown Equity	Property Revaluation Reserves	Restricted Funds	Accumulated Deficit	Total Equity
Balance at 1 July 2021	142,711	111,035	2,014	(137,635)	118,125
Surplus/(deficit) for the year	-	-	-	(30,050)	(30,050)
Revaluation of land and buildings	-	26,766	-	-	26,766
Transfers between reserves	-	-	93	(93)	-
Injection from the Crown	14,816	-	-	-	14,816
Repayment to the Crown	(357)	-	-	-	(357)
Balance at 30 June 2022	**157,170**	**137,801**	**2,107**	**(167,778)**	**129,300**

Notes to the financial statements (continued)

For the year ended 30 June 2022

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	Crown Equity	Property Revaluation Reserves	Restricted Funds	Accumulated Deficit	Total Equity
Balance at 1 July 2020	112,880	96,103	2,163	(109,473)	101,673
Surplus/(deficit) for the year	-	-	-	(28,311)	(28,311)
Revaluation of land and buildings	-	14,932	-	-	14,932
Transfers between reserves	-	-	(149)	149	-
Injection from the Crown	30,188	-	-	-	30,188
Repayment to the Crown	(357)	-	-	-	(357)
Balance at 30 June 2021	**142,711**	**111,035**	**2,014**	**(137,635)**	**118,125**

Property Revaluation Reserves

These reserves result from the revaluation of land and buildings to fair value. The revaluation reserve consists of amounts as follows:

	30 June 2022	30 June 2021
Land	15,033	13,556
Buildings	122,767	97,479
	137,800	**111,035**

Restricted Funds

Restricted funds represent the unspent portion of donations, bequests and clinical trial revenue that is subject to restrictions. The restrictions generally specify how the donations, bequests and clinical trial revenue are required to be spent in providing specified deliverables.

5. Other disclosures

5.1 Taxes

Accounting policy

Goods and services tax

All items in the financial statements are presented exclusive of goods and services tax (GST), except for receivables and payables that are presented on a GST inclusive basis. Where GST is not recoverable as an input tax, it is recognised as part of the related asset or expense.

The net amount of GST recoverable from, or payable to, the Inland Revenue Department is included as part of receivables or payables in the statement of financial position.

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

GST relating to revenue from the Crown is recognised when the revenue is accrued in accordance with section 9(7) of the Goods and Services Tax Act 1985.

Commitments and contingencies are disclosed exclusive of GST.

Income tax

Hawke's Bay DHB is a public authority and consequently is exempt from the payment of income tax under section CB3 of the Income Tax Act 2007.

Notes to the financial statements (continued)

For the year ended 30 June 2022

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5.2 Capital commitments and operating leases

Capital commitments	30 June 2022	30 June 2021
Property, plant and equipment		
Buildings	7,499	12,538
Clinical equipment	2,595	2,954
Plant	55	384
Information technology	26	139
Motor vehicles	130	724
Intangible assets		
Software	36	5
Regional Digital Health Service (RDHS)	1,169	1,216
Health Sector Catalogue	-	333
	11,510	18,293

Capital commitments include orders issued for property, plant and equipment, and future agreed contributions to RDHS.

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

Non-cancellable commitments – operating leases	30 June 2022	30 June 2021
Not more than one year	4,231	3,381
One to five years	13,465	10,520
Later than five years	11,423	9,629
	29,119	23,530

Hawke's Bay DHB leased a number of buildings, vehicles and office equipment (mainly photocopiers) under operating leases. The main property leases are listed below.

- The Napier Health Centre lease was extended in February 2021 from the December 2023 expiry date for a further ten years ending December 2033, with a right of renewal for a further two periods of six years each. Rent reviews are annual consumer price index adjustments capped at 5% for the extended period. If renewed in December 2033, the rent review will be to market on renewal and then every three years, with annual consumer price index adjustments capped at 5% for the intervening years.
- The lease of the administration building at 100 McLeod Street was varied in February 2018, for a ten-year period, with two right of renewal periods of four years each. There will be a 2% increase each year, a review to market on the fifth anniversary, and on each renewal sate.
- The new lease of the store building on Omahu Road was entered into from April 2021, for a term of 10 years with two rights of renewal periods of five years each, with a fixed 2% increase each year and a review to market on each renewal date.
- The Central Hawke's Bay Health Centre was renewed from July 2015, for four years, with a right of renewal for a further two periods of four years each, and an escalation clause allowing for annual increases in line with the consumer price index.
- The lease of a building used by Ta Ara Manapau in Queen Street, Hastings for and eight-year period from 1 December 2021 with two rights of renewal of four years each. Rent increases are fixed at 2% annually, with a review to market on the fourth anniversary of the lease, and again on renewal.
- The lease of a building for child services in Avenue Road, Hastings for ten years from 1 March 2022 with two rights of renewal of five years each. Rent is reviewed to the consumer price index on each third anniversary, and to market on each sixth anniversary of the commencement date.

Notes to the financial statements (continued)

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5.3 Financial instruments

a. Financial instrument categories

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

Financial Assets		
Financial assets measured at amortised cost	30 June 2022	30 June 2021
Cash and cash equivalents	4,438	624
Short term investments	2,107	1,442
Receivable and prepayments	45,817	22,480
	52,362	**24,546**
Financial Liabilities		
Financial liabilities measured at amortised cost		
NZ Health Partnerships	-	42
Payables and deferred revenue	60,368	43,177
	60,368	**43,219**

b. Fair value hierarchy disclosures

Hawke's Bay DHB recognises no financial instruments at fair value in the statement of financial position.

c. Financial instrument risks

Hawke's Bay DHB's activities exposed it to a variety of financial instrument rate risks, including market risk, credit risk and liquidity risk. The DHB had a series of policies to manage the risks associated with financial instruments and sought to minimise exposure from financial instruments. These policies did not allow any transactions that were speculative in nature to be entered into.

Market risk

Price risk

Price risk is the risk that the value of a financial instrument will fluctuate as a result of changes in market prices, The DHB had no financial instruments that give rise to price risk.

Fair value interest rate risk

Fair value interest rate risk is the risk that the value of a financial instrument will fluctuate due to changes in market interest rates. HBDHB's exposure to fair value interest rate risk was to bank deposits that were at fixed rates of interest at balance date.

Cash flow interest rate risk

Cash flow interest rate risk is the risk that the cash flows from a financial instrument will fluctuate because of changes in market interest rates. The DHB's exposure to cash flow interest rate risk was limited to bank deposits. That exposure was not considered significant and was not actively managed.

Notes to the financial statements (continued)

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Hawke's Bay DHB's investment policy required a spread of investment maturity dates, and a spread of interest rate re-pricing dates to limit the exposure to short-term interest rate movements. The DHB had no variable interest rate investments.

In respect of income-earning financial assets and interest-bearing financial liabilities, the following table indicates their effective interest rates at the balance date and the periods in which they re-price. The re-pricing gap is the net value of financial instruments which will cease to be at fixed interest rates in each period after the balance date.

30 June 2022	Effective Interest Rates	Total	6 months or less	6 months to 1 year	1 year to 2 years
Cash and cash equivalents					
Cash	-	4	4	-	-
Bank balances	-	1,180	1,180	-	-
NZHP (BNZ sweep arrangement)	2.00%	3,254	3,254	-	-
Short term investments	1.65%	2,107	1,834	-	273
Repricing gap		**6,545**	**6,272**	**-**	**273**

30 June 2021	Effective Interest Rates	Total	6 months or less	6 months to 1 year	1 year to 2 years
Cash and cash equivalents					
Cash	-	4	4	-	-
Bank balances	-	48	48	-	-
Short term deposits	0.58%	572	572	-	
Short term investments	1.65%	1,442	1,182	-	260
Repricing gap		**2,066**	**1,806**	**-**	**260**

Currency risk

Currency risk is the risk that the fair value or future cash flows on a financial instrument will fluctuate because of changes in foreign exchange rates. HBDHB purchased clinical equipment from overseas, which could require transactions denominated in in foreign currencies and, as a result, exposure to foreign currency risk could arise.

The DHB's policy was to hedge foreign currency risks arising from contractual commitments and liabilities, by entering into forward foreign exchange contracts for purchases over NZ$100,000 to manage the foreign currency risk exposure.

The DHB had no foreign currency contracts over NZ$100,000 during 2021/22 (2021: Nil), and no outstanding foreign denominated payables over NZ$100,000 at 30 June 2022 (2021: Nil).

Credit risk

Credit risk is the risk that a third party will default on its obligations to HBDHB, causing it to incur a loss.

Financial instruments, which potentially subjected the DHB to concentrations of risk consisted principally of cash, short-term deposits and accounts receivable. The DHB placed its cash with New Zealand Health Partnerships, a low risk and high quality entity due to its status as a Crown Entity which among other activities, invested surplus cash on behalf of the DHBs.

Concentrations of credit risk from accounts receivable were limited due to the large number and variety of customers. The Ministry of Health was the largest single debtor at 96% (30 June 2021: 96%) of the DHB's revenue. The Ministry of Health

was assessed to be a low risk and high-quality entity due to its nature as the government funded purchaser of health and disability support services.

At balance date there were no significant other concentrations of credit risk. The maximum exposure to credit risk is represented by the carrying amount of each financial asset, including derivative financial instruments, in the statement of financial position.

No collateral or other credit enhancements are held for financial instruments that give rise to credit risk.

Sensitivity analysis

At 30 June 2022, it is estimated that a general increase of one percentage point in interest rates would have minimal impact on earnings in 2022/23, as the DHB has no term debt, and only the net interest from cash holdings would be affected.

Credit quality of financial assets

The credit quality of financial assets that are neither past due nor impaired can be assessed by reference to Standard and Poor's credit ratings (if available) and counterparties without credit rating are mainly made up of receivables from the Crown and entities related to the Crown.

	30 June 2022	30 June 2021
Counterparties with credit ratings		
Cash, cash equivalents and investments		
AA-	2,107	2,014
Total cash and cash equivalents	2,107	2,014
Counterparties without credit ratings		
Cash and cash equivalents		
NZ Health Partnerships – no defaults in the past	3,254	-

All instruments in this table have a loss allowance based on 12-month expected credit losses.

Liquidity risk

Liquidity risk is the risk that HBDHB would encounter difficulty raising liquid funds to meet commitments as they fall due. Prudent liquidity risk management implies maintaining sufficient cash, the availability of funding through an adequate amount of committed credit facilities, and the ability to close out market positions. The DHB mostly managed liquidity risk by continuously monitoring forecast and actual cash flow requirements and maintaining an overdraft facility.

Contractual maturity analysis of financial liabilities

Hawke's Bay DHB's financial liabilities comprised payables and deferred revenue that had a contractual maturity date of six months or less.

Forecasted transactions

Hawke's Bay DHB did not hedge forecasted transactions.

5.4 Contingent assets

There were no contingent assets at 30 June 2022 (2021: Nil).

Notes to the financial statements (continued)

For the year ended 30 June 2022

in thousands of New Zealand Dollars

5.5 Contingent liabilities

Lawsuits against the DHB

Hawke's Bay DHB had exposure to contingent losses in respect of employment disputes and consumer grievances. It is uncertain whether the liabilities, if any, would have fallen on the DHB or some other party. An assessment of the financial effect of the disputes and grievances cannot be made. The DHB was exposed to the same type of contingent losses last year, and no assessment of the financial effect could be made.

5.6 Related party transactions

Hawke's Bay DHB was a wholly owned entity of the Crown.

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

There were no related party transactions during the year (2021: Nil).

Key management personnel compensation

	30 June 2022	30 June 2021
Board Members		
Remuneration	286	300
Full time equivalent members	*1.2*	*1.2*
Executive management team		
Remuneration	3,443	2,765
Full time equivalent members	*13.3*	*10.4*
Total key management personnel remuneration	**3,729**	**3,065**
Total full-time equivalent personnel	**14.5**	**11.6**

The full time equivalent for Board members has been determined based on the expectation that members and chairs will spend 30 days and 50 days respectively on board business per annum. "There were no executive positions that were covered by contractors on an interim basis for parts of the year including accommodation and transport values at the cost incurred by the DHB (2021 : one)." One executive position was held by an employee of Health Hawke's Bay, the Hawke's Bay PHO, and has been excluded from the table.

Notes to the financial statements (continued)

For the year ended 30 June 2022

in thousands of New Zealand Dollars

5.7 Summary cost of services by output class

Accounting policy

Cost allocation

The cost of outputs has been determined using the cost allocation system outlined below.

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.

Direct costs are charged directly to outputs. Indirect costs are charged to outputs based on 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.

	Achieved 30 June 2022 $m	Plan 30 June 2022 $m	Achieved 30 June 2021 $m
Revenue			
Prevention	8.8	7.8	8.6
Early detection and management	202.7	160.2	156.7
Intensive assessment and treatment	482.7	454.5	428.3
Rehabilitation and support	113.5	83.0	83.6
Total revenue	807.7	705.5	677.2
Less:			
Expenditure			
Prevention	11.4	9.2	9.8
Early detection and management	217.0	170.2	180.1
Intensive assessment and treatment	496.2	459.4	422.1
Rehabilitation and support	113.4	94.7	93.5
Total expenditure	837.8	733.5	705.5
Surplus/(Deficit)	**(30.05)**	**(28.0)**	**(28.3)**

5.8 Capital management

Hawke's Bay DHB's capital was its equity, which comprised Crown equity, reserves, restricted funds and accumulated surpluses/ (deficits). The DHB was subject to the financial management and accountability provisions of the Crown Entities Act 2004, which imposed restrictions in relation to borrowings, acquisition of securities, issuing guarantees and indemnities, and the use of derivatives. The DHB managed its equity by prudently managing revenues, expenses, assets, liabilities, investments, and general financial dealings to ensure that it effectively achieved its objectives and purposes, while remaining a going concern.

5.9 Events after balance date

On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, replacing the New Zealand Public Health and Disability Act 2000, and establishing Te Whatu Ora – Health New Zealand and the Te Aka Whai Ora Māori Health Authority. District Health Boards were legally disestablished, and their assets and liabilities transferred to Health New Zealand on this date.

On 14 February 2023 Cyclone Gabrielle had a devastating impact on Hawke's Bay which ultimately resulted in flood damage to transport infrastructure and disruption road access to outlying areas, specifically road access to Wairoa Hospital and Health Centre.

5.10 COVID-19

During 2021/22 the Omicron variant of COVID-19 impacted the DHB in a number of ways. Vaccination and testing costs continued to be incurred, and treatment and care costs for patients with COVID-19 symptoms increased significantly. Staff availability declined due to illness from COVID-19 or influenza, and/or the requirement to isolate. International supply chain issues compromised the supply of some product lines, and the international market for health workers was challenging for filling vacancies.

Overall these issues reduced the operating capacity of the DHB.

Government funding

The MOH provided funding of $76.3 million to the DHB to assist with the COVID-19 response, of which $21.2 million was for the reimbursement of costs incurred in prior years.

Personnel expenses

Personnel expenses of $12.2 million were incurred including staff providing vaccinations, of involved with community support and community testing. Also included were costs relating to backfilling and special leave for staff who needed to isolate.

Primary care expenses

Payments were made to non DHB providers of $32.1 million, relating to community support, providing vaccinations, and community testing. Also incurred were costs for public health and isolation service.

Other expenses

The remaining $10.8 million was spent on consumable items, including facilities, incentives and supplies for vaccinations and testing,

Valuation of land and buildings

A desktop revaluation of the DHB's buildings was completed as at 30 June 2022, to recognise the impact of increased building material and supply chain costs on replacement values. The increased costs are to some extent directly attributable to the economic impact of COVID-19.

5.11 Breach of statutory deadline

The 2021/22 annual report of Hawke's Bay District Health Board was not completed by 31 December 2022, as required by section 156 of the Crown Entities Act 2004 (as amended by the Annual Reporting and Audit Time Frames Extensions Legislation Act 2021 which extended the reporting timeframes in the Crown Entities Act 2004 by two months). This timeframe was not met because Audit New Zealand was unable to complete the audit within this timeframe due to an auditor shortage and the consequential effects of Covid-19, including lockdowns.

Part VI - Independent Auditors Report

Independent Auditor's Report

To the readers of

Hawke's Bay District Health Board's financial statements and performance information for the year ended 30 June 2022

The Auditor-General is the auditor of Hawke's Bay District Health Board (the Health Board). The Auditor-General has appointed me, Kelly Rushton, 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 the Health Board on his behalf.

We have audited:

- the financial statements of the Health Board on pages 73 to 113, that comprise the statement of financial position as at 30 June 2022, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date, and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Health Board on pages 12 to 23, 25 to 45 and 56 to 70.

Opinion

Unmodified opinion on the financial statements

In our opinion, the financial statements of the Health Board on pages 73 to 113, which have been prepared on a disestablishment basis:

- present fairly, in all material respects:
  - its financial position as at 30 June 2022; and
  - its financial performance and cash flows for the year then ended; and
- comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards.

Qualified opinion on the performance information

In our opinion, except for the possible effects of the matter described in the Basis for our opinion section of our report, the performance information of the Health Board on pages 12 to 23, 25 to 45 and 56 to 70:

- presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2022, 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 on the financial statements and the performance information was completed on 25 May 2023. This is the date at which our opinion is expressed.

The basis for our opinion is explained below and we draw attention to other matters. In addition, we outline the responsibilities of the Board of Te Whatu Ora – Health New Zealand and our responsibilities relating to the financial statements and the performance information, we comment on other information, and we explain our independence.

Basis for our opinion

Our opinion on the performance information is qualified due to times not being correctly recorded for the performance measure *"Percentage of patients admitted, discharged or transferred from an emergency department within 6 hours".*

An important part of the Health Board's performance information is reporting the proportion of patients admitted, discharged or transferred from an emergency department within 6 hours of presentation.

Our audit testing of a sample of emergency department patients identified issues with some patients' recorded emergency department length of stay not agreeing to their underlying patient records. In addition, as disclosed on page 39 systemic issues were identified in the way the Health Board records admission and discharge times in the system. As a result, our work was limited and there were no practicable audit procedures we could apply to obtain assurance whether the reported result for this performance measure is materially correct.

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.

Emphasis of matters

Without further modifying our opinion, we draw attention to the following matters:

The financial statements have been prepared on a disestablishment basis

Note 1.2 on page 78 outlines that the Health Board has prepared its financial statements on a disestablishment basis because the Health Board was disestablished, and its functions transferred to Te Whatu Ora – Health New Zealand on 1 July 2022. There have been no changes to the values of the Health Board's assets and liabilities as a result of preparing the financial statements on a disestablishment basis.

Uncertainties in estimating the holiday pay provision under the Holidays Act 2003

Note 4.4 on pages 102 to 104, which outlines that the Health Board has been investigating issues with the way it calculates holiday pay entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues. The matters are complex and have resulted in underpayments of holiday pay to current and past employees over a number of years. The Health Board has estimated a provision of $58.2 million, as at 30 June 2022 to remediate these issues. However, until the process is completed, there are uncertainties surrounding the amount of this provision.

HSU population information was used in reporting Covid-19 vaccine strategy performance results

Pages 56 to 70 outlines the information used by the Health Board to report on its Covid-19 vaccine coverage. The Health Board uses the Health Service User (HSU) population data rather than the population data provided by Statistics New Zealand (Stats NZ), for the reasons set out on pages 56 to 70. Page 68 outlines that there would be differences in the reported results for the overall population if the Stats NZ population data was used. There would be further differences in the reported results of vaccination coverage if the Stats NZ population data is classified by ethnicity and age. The Health Board has provided a table that highlights the differences in the ethnicity groupings between the HSU population data and the Stats NZ population data.

Impact of Covid-19

Note 5.10 on page 112 to the financial statements, which outlines the ongoing impact of Covid-19 on the Health Board.

Responsibilities of the Board of Te Whatu Ora – Health New Zealand for the financial statements and the performance information

The preparation of the final financial statements and performance information for the Health Board is the responsibility of the Board of Te Whatu Ora.

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

Up until 30 June 2022, the Health Board was responsible for such internal control as it determined necessary to enable it to prepare financial statements and performance information that were free from material misstatement, whether due to fraud or error. From 1 July 2022, the Board of Te Whatu Ora took over these responsibilities to enable the completion of the financial statements and performance information.

The responsibilities of the Board of Te Whatu Ora arise from the transition provisions in the Pae Ora (Healthy Futures) Act 2022.

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 the Health Board'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 the Health Board's internal control.
- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board of Te Whatu Ora.
- We evaluate the appropriateness of the reported performance information within the Health Board's framework for reporting its performance.
- We conclude on the appropriateness of the use of the disestablishment basis by the Board of Te Whatu Ora.
- 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 of Te Whatu Ora 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 of Te Whatu Ora is responsible for the other information. The other information comprises the information included on pages 1 to 11, 22, 24, 46 to 55, 71, 72, and 114, but does not include the financial statements and the performance information, and our auditor's report thereon.

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

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

Independence

We are independent of the Health Board in accordance with the independence requirements of the Auditor-General's Auditing Standards, which incorporate the independence requirements of

Professional and Ethical Standard 1: International 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, the Health Board.

Kelly Rushton
Audit New Zealand
On behalf of the Auditor-General
Wellington, New Zealand

HAWKE'S BAY DISTRICT HEALTH BOARD

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