Te Whatu Ora
Health New Zealand

Pūrongo-ā-tau | Annual Report

2022-23

Presented to the House of Representatives pursuant to section 150 of the Crown Entities Act 2004 and section 60 of the Pae Ora (Healthy Futures) Act 2022.

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Te Whatu Ora
Health New Zealand

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Introduction

Pūrongo-ā-tau 2022-23 (our Annual Report) highlights our financial and non-financial performance for the year ending 30 June 2023.

This reports against Te Whatu Ora's Statement of Performance Expectations 2022-23.

This is a statutory requirement under the Crown Entities Act 2004 that forms part of the accountability framework for Te Whatu Ora.

The annual report is presented in four parts:

Part 1: Overview

Part 2: Establishment

Part 3: Our Performance

Part 4: Financial Performance

Tūria, tūria te mata hau nō Rangi

Tūria, tūria te mata hau nō Papa

Paiheretia te tangata ki te kawa
tupua, ki te kawa tawhito

He kawa ora! He kawa ora!

He kawa ora ki te tangata

He kawa ora ki te whānau

He kawa ora ki te iti, ki te rahi

He kawa tātaki ki au mau ai

Tūturu o whiti, whakamaua
kia tīna

Hui e! Tāiki e!

Elevate and celebrate the
gifts of Rangi

Elevate and celebrate the
gifts of Papa

People are bound by the spiritual
forces of ancestry

Uplift the spirit! Support the spirit!

Raise up the health of people, of
family, of all.

A spirit that guides me

Hold fast! Uphold the essence.

Bring it together!
It is complete.

WRITTEN BY RĀHUI PAPA

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Mō te taha ki te Poari Matua o Te Whatu Ora, e harikoa ana au te tāpae atu i Te Pūrongo ā-Tau a Te Whatu Ora.

Ko te tikanga o te ingoa o Te Whatu Ora, ko 'te whatunga, ko te tuituinga o te oranga'. Koinei tā mātou mahi i Te Whatu Ora: he raranga haere i ngā weu o te mātauranga me ngā wheako a ō mātou tīma hei whakapai ake i ngā ratonga hauora e whakatutukitia ana.

I whakapūmautia Te Whatu Ora i raro i Te Ture Pae Ora 2022. Ko te kaupapa o tēnei Ture he tiaki, he whakatairanga, he whakapaipai hoki i te hauora o Aotearoa whānui; he whai kia tōrite ai ngā putanga hauora i ngā momo taupori katoa, arā, mā roto i te ārai atu i ngā rerekētanga hauora mō ngāi Māori; he whai hoki i te ara pae ora mō Aotearoa whānui.

I raro i te Ture, koinei ngā whāinga a Te Whatu Ora:

- He waihanga, he whakarite, he whakatutuki i ngā ratonga e hua ai te pae ora, ā, kia hāngai ki ngā mātāpono o te rāngai hauora
- He whakatenatena, he tautoko, he noho pūmau ki ngā mahi toro ki ngā hapori mō te āhua ki te whakapai ake i ngā take hauora, whakahaere ratonga hoki
- He whakatairanga, he ārai, he whakahiato, he whakaora i ngā māuiuitanga, tae noa ki te mahi ngātahi me ētahi atu tari kāwanatanga, wāhi mahi me te hunga whakaara ake i ngā kaupapa whakatika hauora.

He kaupapa tino nui te whakatōpūtanga mai o ngā hinonga e 28, i roto mai hoki i ngā kawenga mahi a Te Manatū Hauora, me te mea hoki, e kitea ana te pitomata ki te whakapaipai ake i te hauora mō Aotearoa whānui.

Ko te aronga i tō mātou tau tuatahi kia ū tonu mātou ki ngā mahi tautiaki i ēnei wā hurihuringa nei, me te whakatītina ake i ngā tikanga whai kiko ki tēnei wāhi mahi kia mārama kehokeho ai ngā momo wero me ngā āheinga ka hua mai ki a mātou, ā, he whai hoki i ngā ara whakatipu i ā mātou penapenatanga pūtea hei tuku ki ngā ratonga tautiaki. Ka tōmua mai ngā kaupapa tuatahi. Kei te pai tonu te haere o ngā mahi, engari, he nui tonu ngā mahi me whāia.

"HE KAUPAPA TINO NUI TE WHAKATŌPŪTANGA MAI O NGĀ HINONGA E 28, I ROTO MAI HOKI I NGĀ KAWENGA MAHI A TE MANATŪ HAUORA, ME TE MEA HOKI, E KITEA ANA TE PITOMATA KI TE WHAKAPAIPAI AKE I TE HAUORA MŌ AOTEAROA WHĀNUI."

Inā noa te nui o ngā wero. Kīhai i tōrite ai te whai wāhitanga atu ki ngā kaupapa me ngā putanga hua ki ētahi rōpū pēnei i a ngāi Māori, ngāi Pasifika, te hunga hauā, me ngā hapori noho tuawhenua, ā, me kaha ake te aro ki ēnei. Kei te kite mātou i te whanaketanga i ngā take mate hinengaro, engari, me kaha ake te mahi tahi me ngā hapori. Kei te pakeke haere tō mātou taupori, ā, kei te kaha ake te tono mai ki ngā ratonga hauora.

I kaha pēhi kino mai ngā take huarere ki te ao tautiaki hauora. I kaha pā mai a Huripari Gabrielle ki ngā mahi whakatutuki i ngā kaupapa tautiaki hauora i āna mahi tūkino i ngā whenua hora nui o Te Ika a Māui i te marama o Pēpuere 2023. Nō te tau nei kitea ai ngā whakaakoranga mai i hua ake i ngā mate urutā me ngā tūmomo whakararu mai o te wā, arā, ko ngā kōtuinga mahi ki te whakakaha i ngā hapori.

Nā ō mātou hua tahua o te otinga tau i tutuki ai ā mātou whāinga kia pai ake ā mātou whakahaerenga tahua. Kua hua ake ētahi momo pānga mai, arā, ko ngā whakataunga tōrite utu mā ngā nēhi, inā, i konei kitea ai te whakahokinga o te utu i te tau 2022-23, engari, i whakawhititia atu ngā pūtea i te tau 2023-24 me ngā rārangi taputapu o te KŌWHEORI-19 mai i Te Manatū Hauora hei tōritenga utu, ā, i utua e ngā pēke moni a Te Whatu Ora. Me tirohia ēnei i ngā wā e pānuitia ai ngā pūrongo ki te whakataurite i ngā hua, nā te mea, he take rerekē ēnei.

"NĀ Ō MĀTOU HUA TAHUA O TE OTINGA TAU I TUTUKI AI Ā MĀTOU WHĀINGA KIA PAI AKE Ā MĀTOU WHAKAHAERENGA TAHUA."

Ehara nā mātou anake ēnei mahi i whakatutuki – ka pātata tā mātou mahi tahi me Te Aka Whai Ora, ā, he wāhanga noa mātou nā te pūnaha tuku hauora whānui, nā te kōtuinga hono wāhi mahi hoki puta noa i Aotearoa.

Hei whakamutu ake, mō te āhua ki te Poari Matua, tēnei au te mihi atu nei ki ngā kaimahi katoa kei te pūnaha hauora mō ā koutou mahi hirahira, otirā, mō te ū tonu ki te whakatutuki i ngā ratonga, tautiaki hoki mō Aotearoa whānui.

Dame Dr Karen Poutasi
Chair

On behalf of the Board of Te Whatu Ora, I am pleased to present Health New Zealand | Te Whatu Ora's first annual report.

Te Whatu Ora's name means 'the Weaving of Wellness'. This is what we are doing in building Te Whatu Ora: we are weaving together the existing strands of the knowledge and experience of our teams to change and improve how health services are delivered. There is nothing more important to us than improving the support and care we offer all New Zealanders.

Te Whatu Ora was established under the Pae Ora (Healthy Futures) Act 2022. The purpose of the Act is to protect, promote and improve the health of all New Zealanders; achieve equity in health outcomes among all population groups, including by striving to eliminate health disparities, in particular for Māori; and build towards pae ora (healthy futures) for all New Zealanders.

Under the Act, Te Whatu Ora has the following objectives:

- to design, arrange, and deliver services to achieve Pae Ora in accordance with the health sector principles
- to encourage, support, and maintain community participation in health improvement and service planning
- to promote health and prevent, reduce, and delay ill-health, including by collaborating with other agencies, organisations, and individuals to address the determinants of health.

The consolidation of 28 entities, along with some functions of Manatū Hauora | Ministry of Health, has been a major undertaking with significant potential to improve the health of all New Zealanders.

Our first year has focused on ensuring continuity of care during significant change, embedding structures fit for one organisation, better understanding the challenges and opportunities we have inherited, and making early moves to generate the savings we need to reinvest in frontline care. We are making good progress but there is much more to be done.

"THE CONSOLIDATION OF 28 ENTITIES, ALONG WITH SOME FUNCTIONS OF MANATŪ HAUORA | MINISTRY OF HEALTH, HAS BEEN A MAJOR UNDERTAKING WITH POTENTIAL TO IMPROVE THE HEALTH OF ALL NEW ZEALANDERS."

The challenges we face are considerable. Inequity of access and outcomes for some groups such as Māori, Pacific, Tāngata whaikaha | Disabled people, and rural communities requires focus and energy to shift. We see exponential growth in mild to moderate mental health conditions that will require more significant effort working together with communities. Our population is ageing and the demand for health services more generally is increasing.

Weather events and their impact on healthcare and population health are very real. Cyclone Gabrielle put pressure on healthcare delivery when it severely damaged a wide area of the North Island in February 2023. This past year has shown that as we emerge from a pandemic and other outbreak responses, many of the lessons from building strong community partnerships help build resilience.

Our end-of-year financial result has met expectations of good financial management. There have been one-off impacts such as substantial pay equity settlements for nursing, where the backdated costs are recognised in 2022-23 but the revenue recognised in 2023-24, and also a significant ($284m) write-down of COVID-19 inventory transferred to us from the Ministry of Health. These matters need to be considered when reading future reports and making comparisons as they are unusual items.

"OUR END-OF-YEAR FINANCIAL RESULT HAS MET EXPECTATIONS OF GOOD FINANCIAL MANAGEMENT."

We have not done our work in 2022-23 alone: we work closely with Te Aka Whai Ora and are part of the wider healthcare system and network of organisations, of all kinds, across New Zealand.

Finally, on behalf of the Board, I would like to thank everyone who works in and alongside the health system for your significant and ongoing commitment to delivering services and care for New Zealanders.

Dame Dr Karen Poutasi
Chair

Chief Executive's report

Our first annual report shows Te Whatu Ora has begun to realise the benefits of reforms that would not have been possible in the previous environment with 28 separate entities.

In amalgamating the work of previous entities, we also inherited their separate ways of working, something that will take time to address and streamline as one organisation. This is a multi-year challenge and good early progress has been made. Our roadmap to transformation will continue over the next year, and we will determine the most critical systems to integrate to improve the frontline experience for our kaimahi and the people we serve, while enabling more care to be delivered closer to home.

Some of our first year's highlights are as follows.

- Standing up a strengthened National Public Health Service that suppressed clusters of measles, pertussis and monkeypox infections in the community.
- Extending the life of COVID-19 infrastructure and systems established during the pandemic that supported people's health at home.
- Early workforce actions include a $14.4m investment to increase the workforce in primary care, nursing and other professions. We note that the Nursing Council reports 3,042 more nurses registered during Quarter Four of 2022-23, compared to 934 registrations for the same quarter of 2021-22. Overall, our nursing workforce has increased from 31,126 as at 30 June 2022 to 32,345 as at 30 June 2023.
- Our first ever national Winter Plan offered New Zealanders additional support for winter illness, with over 30,000 people accessing a pharmacy consult by the end of June 2023, and expanded access to clinical support for community workforces using telehealth to reduce the likelihood of hospital presentations.

In addition to early interventions, for the first time we have developed a national Health Workforce Plan that quantifies the gaps and sets a 365-day timeline to address short-term gaps while providing a platform for growth by offering one health system voice to our tertiary education and training partners.

These and many other achievements outlined in this report occurred within a time of unprecedented demand – a significant COVID-19 outbreak in our first 6 months of establishment, overwhelming weather events impacting the North Island in the second half of the year, and an increase in demand for health services which has been exacerbated by deferred care since pre-COVID-19.

This demand was not just seen in one area of the system, but across primary care, in hospitals, and once again in the community. It is positive that we are now seeing health demands tracking back to pre-COVID-19 trends.

The year end financial operating result needs careful interpretation. The underlying operating result reflected strong financial management, underscoring our significant focus on both controlling cost growth and generating savings to reinvest in frontline services. However, there were one-off impacts to the overall financial result such as:

1. significant provisions for the pay equity settlements announced after balance date were required to be recognised in 2022-23. The funding to offset this will be recognised in 2023-24;
2. a write down of $284m against the Covid-19 inventory transferred to us from the Ministry of Health.

Our good financial management was also against a backdrop of many unexpected expenses ($30m relating to the additional public holiday for commemorating the passing of the Queen, $8.5m monkeypox vaccine and $14m contribution towards North Island weather event recovery). We have also learnt a lot about our cost structure and cost pressures in a fast-moving first year; this will really benefit our financial management ahead.

Our ability to live within our means was a result of leveraging our national size and scale – corporate cost savings of $53m (annualised $173m in 2023-24), reducing our management and administration headcount generating $23.69m in savings (annualised $70.5m) and reduction in contractors from 1,180 to 635.

We also inherited capital and data and digital infrastructure projects that need further prioritisation to ensure we are balancing investment to improve consumer experiences more directly.

We have begun to settle longstanding employment relations issues. Significant work was done during the year to advance Holidays Act 2003 remediation payments, and we pleasingly made the first payments just after the end of the financial year.

"I OFFER MY HUMBLE THANKS TO ALL IN OUR TEAM OF TEAMS WHO HAVE SUPPORTED AND CARED FOR NEW ZEALANDERS IN THIS CHALLENGING CONTEXT."

Around the same time, we also settled pay equity for nurses, an outcome which will cascade through to midwives and allied health kaimahi and other groups in 2023-24. We are committed to maintain the pace of timely resolution where the Government is in support.

We have made some mistakes – we moved too fast to implement rapid reporting in shifting from quarterly to monthly reports and given the quality of data and information systems we inherited; we are working hard to improve data integrity to ensure confidence in our performance reporting. The pace of change to settle structures to complete Unify to Simplify transformation also needs momentum tempered by careful consideration.

Enabling functions that support our health system are another area where we aim to transform how we work and look to create further cost reductions through harmonisation and automation of business systems and processes.

We will continue to reduce costs to enable reinvestment and reprioritisation to provide more care for New Zealanders.

New Zealanders can be proud of our healthcare workforce – both those employed and funded by Te Whatu Ora. I offer my humble thanks to all in our team of teams who have supported and cared for New Zealanders in this challenging context. I look forward to continued momentum in delivering the solutions that will support New Zealanders' health and wellbeing.

Fepulea'i Margie Apa
Chief Executive

System shifts in progress

For 2022-23, there were five key areas identified where change will make the biggest difference to the overall delivery of healthcare. To transform the health system, we need to shift to new ways of providing services. The five system shifts identified were that:

The Health System will honour Te Tiriti o Waitangi

People and whānau will be supported to stay well and connected to their communities

High-quality specialist and emergency care will be equitable and accessible to all when it is needed

Digital services and technology will provide more care in people's homes and communities

Our health workforce will be valued and well trained, ensuring we have enough skilled people to meet future needs

We are seeing early signs of these system shifts which have benefitted from a unified approach. The following icons in this section and throughout the Annual Report highlight where our mahi is making a difference to shift the system.

THROUGHOUT THIS REPORT WE WILL BE HIGHLIGHTING WHERE OUR MAHI IS MAKING A DIFFERENCE AND SHIFTING THE SYSTEM.

LOOK OUT FOR THESE ICONS

The Health System will honour Te Tiriti o Waitangi

To provide for the Crown's intention to give effect to the principles of Te Tiriti, the Pae Ora Act 2022 requires Te Whatu Ora to do a number of things including:

- being guided by the health sector principles which, among other things, are aimed at improving the health sector for Māori and improving hauora Māori health outcomes
- requiring the Board to maintain systems and processes to ensure that Te Whatu Ora has the capacity and capability to understand Te Tiriti o Waitangi, mātauranga Māori, and Māori perspectives of services.

Some of the ongoing work and programmes to embed Te Tiriti in the health system in accordance with the Pae Ora Act include:

- working together with Te Aka Whai Ora | Māori Health Authority to embed the health sector principles, which were intended to reflect Treaty principles in the context of the health system
- working with other agencies who are also key to improving Māori health outcomes including Manatū Hauora | Ministry of Health, Whaikaha | Ministry of Disabled People, and Pharmac | Te Pātaka Whaioranga
- ensuring that Te Aka Whai Ora | Māori Health Authority and Iwi Māori Partnership Boards are actively engaged in the planning and delivery of services that impact Māori

- co-leadership with Te Aka Whai Ora on system and service reviews, for example, around planned care, immunisation and winter preparedness
- a joint implementation of priorities, including on mental health Access and Choice, Kahu Taurima, locality planning and engagement with Iwi Māori Partnership Boards
- developing the first twelve prototype localities and engaging with whānau Māori and communities to determine their hauora (health and wellbeing) priorities
- initiating comprehensive Primary and Community Care teams, where the role of kaiāwhina is expected to play a significant part in supporting Māori and Pacific people to navigate health services.

ENSURE THAT TE WHATU ORA HAS THE CAPACITY AND CAPABILITY TO UNDERSTAND TE TIRITI O WAITANGI, MĀTAURANGA MĀORI, AND MĀORI PERSPECTIVES OF SERVICES

People and whānau will be supported to stay well and connected to their home and communities

The health system has a responsibility to meet the needs of communities and, where possible, to deliver that care closer to home. An integral part of this is helping people to stay well by doing things that support healthy lives, such as addressing whether people live in a dry, warm home.

There is significant work underway to support people and whānau to stay well in their communities.

- **Localities:** we have set up the first 12 prototype localities working towards delivering health services that are tailored to the needs of local areas, with work already underway to establish more.
- **Joined-up workforce**: a National Response Team was established to respond to Cyclone Gabrielle and was able to deploy resources with the help of more than 1,000 Te Whatu Ora kaimahi from across the motu who assisted colleagues in Cyclone-affected areas.

THE WINTER PLAN EXPANDED THE RANGE OF CARE THAT NEW ZEALANDERS COULD RECEIVE IN THEIR COMMUNITIES

- **The Winter Plan**: this initiative expanded the range of care that New Zealanders could receive in their communities, such as funding pharmacies to provide consultations for minor ailments, piloting remote patient monitoring to support rural Māori communities, and expanding access to urgent radiology in the community for acute conditions.

High-quality specialist and emergency care will be equitable and accessible to all when it is needed

When people are unwell, they need to be able to access the right care in a way that leads to equitable access and health outcomes across the motu.

This system shift is also about doctors and other medical professionals working together with community services to educate, support and keep people well, which aims to reduce the demand for secondary or tertiary hospital healthcare, keeping space available for those who need it most.

Good progress was made during the year.

- National clinical networks have started to be established to create national standards and models of care that identify ways to address variation in service quality and outcomes, and develop innovative, efficient and evidence-based solutions that can be applied across the system.
- A nationally-consistent system pressures operating model was put in place, which was designed to manage systems pressures, such as during winter, whenever and wherever they occur.
- An integrated operating model for health infrastructure projects was implemented to improve efficiency, performance, and capability of infrastructure delivery, including the 75 infrastructure projects currently in the design and construction phases.

Digital services and technology will provide more care in people's homes and communities

Better data systems and access to health services using digital technology will provide people with improved healthcare choices, including from their homes and communities.

Better use of technology will also help our workforce and providers by providing improved access to data and information that supports achieving better health outcomes. Good progress is being made.

- My Health Account now integrates with New Zealand's most widely used patient portal, Manage My Health, so consumers can use My Health Account to easily register and have better access to and control of their health information.
- In partnership with Te Aka Whai Ora, Manatū Hauora and other agencies, Te Whatu Ora launched the Zero Data programme, which enables people to access key health and government websites via their smart phone without incurring data usage charges, helping to remove barriers to information and services.
- The Rapid National Data Automation project, significantly advanced during the year, now provides a single national dashboard view of performance information, such as admissions and ward occupancy, to support improved clinical decision-making.
- A new National Data Platform business case was developed which will consolidate multiple data environments onto one consistent platform, creating a connected environment that will allow us to better understand and track the health system's performance.

Our health workforce will be valued and well trained, ensuring we have enough skilled people to meet future needs

We recognise the incredible work our kaimahi have done recently through so much change and pressure on demand for services.

To support, increase and sustain our highly skilled workforce, planning for future requirements is underway, including training programmes and recognising the development needs of staff.

The health workforce is being grown and valued.

- A new, centralised international recruitment centre for the health sector is now in operation, which has generated more than 1,300 expressions of interest so far.
- Working together with Te Aka Whai Ora, we developed the Health Workforce Plan 2023, which outlines how we will stabilise the staffing of the sector over the next year and take initial steps towards the longer-term transformation needed to create a sustainable workforce.
- A national review of health and safety risks across all regions has identified the key set of critical risks that we will now attend to as a priority.

PLANNING FOR FUTURE REQUIREMENTS IS UNDERWAY, INCLUDING TRAINING PROGRAMMES AND RECOGNISING THE DEVELOPMENT NEEDS OF STAFF

Statement of Service Performance

Te Whatu Ora is a Public Benefit Entity (PBE) and its objectives are to:

- Design, arrange, and deliver services to achieve the purpose of the Pae Ora (Healthy Futures) Act 2022 in accordance with the health sector principles
- Encourage, support, and maintain community participation in health improvement and service planning
- Promote health, and prevent, reduce, and delay ill-health, including by collaborating with other agencies, organisations, and individuals to address the determinants of health.

The Statement of Service Performance (Statement) of Te Whatu Ora has been prepared in accordance with the requirements of the Pae Ora (Healthy Futures) Act 2022 and the Crown Entities Act 2004, which include the requirement to comply with New Zealand Generally Accepted Accounting Practice (NZ GAAP). This Statement has been prepared in accordance with Tier 1 PBE financial reporting standards which have been applied consistently throughout the period and comply with PBE financial reporting standards.

ENCOURAGE, SUPPORT, AND MAINTAIN COMMUNITY PARTICIPATION IN HEALTH IMPROVEMENT AND SERVICE PLANNING

We have structured our annual report into four sections:

- Overview – Painting the Picture (pages 10-37)
- Establishment – Our people and set-up (pages 38-92)
- Our Performance – focusing on our non-financial measures (pages 93-231)
- Financial Statements (pages 232-300).

Our performance information is reported from page 28 to page 35 in our Overview section, pages 67, 71, 81, 82 and 83 in our Establishment section, and from page 95 to page 231 in Our Performance section.

We have structured the reporting within Our Performance according to our five funded output classes. The five output classes are:

- Public Health Services
- Primary and Community Services
- Hospital and Specialist Services
- Mental Health and Addictions
- National COVID-19 Response.

Additional information is also provided throughout the report to provide further context for Te Whatu Ora's performance.

We are tracking our performance using non-financial measures from our Statement of Intent 2022-24 incorporating the 2022-23 Statement of Performance Expectations, Vote Health and the Estimate of Appropriations 2022-23 from Budget 2022. These measures were already existing and were selected from measures previously used by Manatū Hauora to track the performance of the former district health boards, the Health System Indicators, Whakamaua (the Māori Health Plan 2020-25), and national datasets and delivery production plans to enable a view of our performance across the breadth of our health service delivery. A small number of measures were new and were selected from the interim Government Policy Statement on Health 2022-24 and Te Pae Tata, the interim New Zealand Health Plan 2022-24.

Our focus is on creating baseline reporting for Te Whatu Ora, but where it provides better context for our performance during 2022-23, we have included information from previous years. We have also highlighted and provided an update on special Budget 22 improvement initiatives throughout the report. Budget 22 initiative updates are situated in the report with the area of health service delivery to which they relate; however, these are not part of the service performance information in the report.

Reflecting that part of the Act's purpose is to achieve health equity, we also provide performance results in this report for the large majority of measures with ethnic breakdowns for Māori, Pacific peoples and the population that is Non-Māori/Non-Pacific. This reflects the way in which our expected performance was described in our Statement of Performance Expectations 2022-23. We are also working to improve the disaggregation of health data to include Asian ethnicities, and in some measures we also provide Asian ethnicity data in our breakdown.

OUR FOCUS IS ON CREATING BASELINE REPORTING FOR TE WHATU ORA, BUT WHERE IT PROVIDES BETTER CONTEXT FOR OUR PERFORMANCE DURING 2022-23

Additionally, we have aggregated the data we report to reflect our new national and regional structure to enable us to provide both a regional and national view of our performance.

Some performance measures are descriptive or qualitative, while many are numerical or quantitative in nature. To ensure accessibility and understandability of the data, we present our performance results both in text form following each performance measure, and in a visual way, often using bar or line graphs. We also individually disclose where there may be gaps or anomalies in the data, or in the wording or other aspects of the recorded measures to avoid confusion and increase understandability. Note that a number of performance measures from our Statement of Performance Expectations 2022-23 were not recorded with a target to report against. We provide a progress update in these cases.

Together with a status result, our narratives, disclosures and graphs for each measure provide a picture of our performance.

NON-FINANCIAL PERFORMANCE MEASURES KEY

- ✓ MEETS TARGET
- ↑ DOES NOT MEET TARGET, BUT PERFORMANCE IS IMPROVING
- ↓ DOES NOT MEET TARGET AND PERFORMANCE HAS DETERIORATED

Further information on our performance and publications can be found on our Te Whatu Ora website.

How we were funded in 2022–23

Te Whatu Ora has reporting responsibilities under the Public Finance Act 1989 for the appropriations set out in the table below:

Appropriation	Amount of each appropriation $'000s	Amount spent against each appropriation $'000s
Delivering Hospital and Specialist Services	13,113,854	12,917,202
Delivering Primary, Community, Public and Population Health Services	8,248,039	8,199,205
Problem Gambling Services	23,711	20,384
Capital Investment in Health New Zealand	35,241	23,181
Health Capital Envelope (MYA)	967,701	1,591,600
New Dunedin Hospital 2021-26	86,311	62,606
Standby Credit to Support Health System Liquidity	200,000	-
Implementing the COVID-19 Vaccine Strategy (non-departmental element only)	1,188,711	903,880
National Response to COVID-19 Across the Health Sector (non-departmental element only)	1,559,542	1,140,340

Te Whatu Ora does not receive all the funds from each appropriation as other agencies also receive funds from these appropriations.

Te Whatu Ora funded activity during 2022–23 sits across five output classes:

- National COVID-19 Response
- Public Health Services
- Primary and Community Services
- Hospital and Specialist Services
- Mental Health and Addictions.

National COVID-19 Response

The purpose of this output class is to support our ongoing implementation of a national response to COVID-19. We report on our delivery under this output class on pages 95 to 105 in Our Performance section.

Public Health Services

Public health services improve community health by preventing or minimising illness and disease. Te Whatu Ora is working towards the integration of public health services nationwide as new operating models are collaboratively established with other government departments. We report on our delivery under this output class on pages 106 to 136 in Our Performance section.

Primary and Community Services

Primary and community services comprise of an extensive network of providers and focus on prevention and mitigation of illness in order to support the provision of care and maintain an individual's independence. We report on our delivery under this output class on pages 137 to 170 in Our Performance section.

Hospital and Specialist Services

The focus for Hospital and Specialist Services is to ensure all people in Aotearoa New Zealand receive timely access to specialist outpatient and hospital services to prevent deterioration of their condition and improve their quality of life. We report on our delivery under this output class on pages 171 to 216 in Our Performance section.

Mental Health and Addictions

Mental health and addiction services provide support to people experiencing issues which cause distress or impact upon their wellbeing and ensure the availability of early intervention options in the community that are culturally safe and easily accessed. We report on our delivery under this output class on pages 217 to 231 in Our Performance section.

Output Class	In $ Millions	2022/23 Actual	2022/23 Budget	2022/23 Variance
National Covid-19 Response	Revenue	**1,583**	1,420	163
	Expenditure	**1,756**	1,420	336
	Net Surplus/(Deficit)	**(173)**	0	(173)
Public Health	Revenue	**469**	469	0
	Expenditure	**537**	469	68
	Net Surplus/(Deficit)	**(68)**	0	(68)
Primary & Community Services	Revenue	**8,086**	8,086	0
	Expenditure	**8,025**	8,086	(61)
	Net Surplus/(Deficit)	**61**	0	61
Hospital & Specialist Services	Revenue	**13,606**	12,715	891
	Expenditure	**14,309**	12,715	1,594
	Net Surplus/(Deficit)	**(703)**	0	(703)
Mental Health and Addictions	Revenue	**1,946**	1,946	0
	Expenditure	**2,077**	1,946	131
	Net Surplus/(Deficit)	**(131)**	0	(131)
Total	**Revenue**	**25,690**	**24,636**	**1,054**
	Expenditure	**26,703**	**24,636**	**2,067**
	Net Surplus/(Deficit)	**(1,013)**	**0**	**(1,013)**

Financial measure	Target per SPE	Result
Percentage spend of Te Whatu Ora's budget on public health (output class 1)	1.90%	2.01%
Percentage spend of Te Whatu Ora's budget on primary and community care (output class 2)	32.82%	30.05%
Percentage spend of Te Whatu Ora's budget on hospital and specialist services (output class 3)	51.61%	53.59%
Percentage spend of Te Whatu Ora's total budget on mental health (output class 4)	7.90%	7.78%
Percentage spend of Te Whatu Ora's total budget on COVID-19 Unlike the previous 4 financial measures, this measure was not included in our Statement of Performance Expectations 2022–23. Therefore, there is no target to report against.		6.58%

Every day in New Zealand

A typical day in our health system during 2022

BIRTHS

161
BABIES ARE BORN EACH DAY

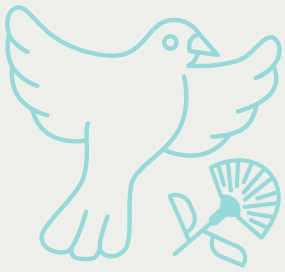
150
BABIES BORN IN HOSPITAL OR PRIMARY BIRTHING UNITS

10
NEWBORN BABIES BORN WITH LOW BIRTH WEIGHT (<2500GM)

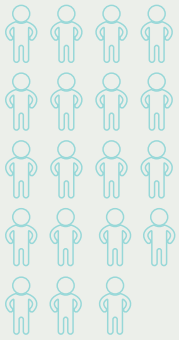
49
BABIES BORN BY CAESAREAN SECTION

DEATHS

106
PEOPLE DIE EACH DAY



19
PEOPLE UNDER AGE 65 DIE EACH DAY



EMERGENCY DEPARTMENT ATTENDANCE AND HOSPITALISATION

3,280
PEOPLE VISIT THE EMERGENCY DEPARTMENT EACH DAY

646
PLANNED ADMISSIONS

3,300
HOSPITAL ADMISSIONS (INCLUDING DAY STAYS)

GENERAL PRACTICE ATTENDANCE

86,300

GENERAL PRACTICE ATTENDANCE IN A TYPICAL WORKING DAY

PHARMACEUTICAL

235,000

PHARMACEUTICAL ITEMS DISPENSED

CHILDHOOD IMMUNISATION

807

UNIQUE IMMUNISATION EVENTS FOR CHILDREN UNDER 3 YEARS OF AGE

990

UNIQUE IMMUNISATION EVENTS FOR CHILDREN UNDER 5 YEARS OF AGE

Section 2

Establishment

Building Te Whatu Ora

The formation of Te Whatu Ora on 1 July 2022 meant creating the largest Crown entity in Aotearoa New Zealand while continuing to deliver health services that support New Zealanders and meet their health needs.

It is an enormous challenge to bring together the former district health boards, shared service entities and certain functions of Manatū Hauora into one. This is the largest merger ever undertaken in New Zealand.

Bringing together the disparate information systems to realise the cost savings from combining the former entities will be significant. For example, rationalising the 20 installations of 8 different payroll systems Te Whatu Ora has inherited will be the largest payroll project ever undertaken in this country.

We inherited 75 infrastructure projects that were already underway and over 4,000 different digital applications (both clinical and corporate) to evaluate and integrate.

An important starting point was simplifying our structure and reporting lines into one organisation. This was undertaken within three months of our establishment, changing the reporting lines of previous district health boards to four Regional Directors and establishing national leadership roles for new business groups.

Our next step was to unify our functions and groups to be fit for one organisation. This will enable the development of New Zealand-wide processes and information systems, enabling us to reduce duplication and improve delivery to frontline teams.

We are continuing to streamline our support for staff. Their hard work over this past financial year has meant that we are delivering quality health services to New Zealanders.

Our People

We are the largest Crown entity in New Zealand in terms of the number of our people.

OUR EMPLOYEES

Paid employment status	Employee count	Employed FTE	% Headcount
Permanent	78,349	67,145.7	93.0%
Fixed term	6,236	5,449	7.0%
Total	84,585	72,594.7	

EMPLOYEE ETHNICITY

	Ethnicity	Employee count	Employed FTE	
Permanent	Asian	20,765	18,620.3	
	Māori	6,487	5,581.5	
	Other	43,958	36,639.7	
	Pacific	3,901	3,530.8	
	Unknown	3,238	2,773.3	
		78,349	**67,145.7**	
Fixed term	Asian	1,477	1,365.6	
	Māori	641	567.4	
	Other	3,572	3,301.8	
	Pacific	280	255.7	
	Unknown	266	228.5	
		6,236	**5,449**	
				% Headcount
Combined	Asian	2,2242	19,985.9	26.3%
	Māori	7,128	6,148.9	8.43%
	Other	47,530	39,671.5	56.19%
	Pacific	4,181	3,786.5	4.94%
	Unknown	3,504	3,001.8	4.14%
		84,585	**72,594.7**	

EMPLOYEE GENDER

	Gender	Employee count	Employed FTE	
Permanent	Another Gender/ Diverse	36	32.8	
	F	61,578	51,775.7	
	M	16,719	15,322.8	
	U	16	14.4	
Fixed term	Another Gender / Diverse	4	4.0	
	F	4,419	3,740.8	
	M	1,812	1,703.2	
	U	1	1.0	
				% Headcount
Combined	Another Gender / Diverse	40	36.8	0.05%
	Female	65,997	55,516.6	78.0%
	Male	18,531	1,7026	21.9%
	Not Stated	17	15.4	0.02%
		84,585	**72,594.7**	

Note: as at 30 June 2023

Employee Count is a distinct count based on Employee Number. There is the potential for individuals to be counted more than once if they hold roles with more than one district, or if they hold roles in more than one occupation group.

Contracted FTE – 1 FTE = 2,086 hours per year. This is the number of hours that an employee is contracted to work. It is a simple and convenient calculation that is not subject to significant variation over time (i.e. it does not vary with sick leave, annual leave, accrued leave).

U = Undefined.

A Career in Health

NATALYA MAYNARD

Work exposure programmes can do wonders for influencing people into a career in health. Interacting with doctors, nurses and midwives and seeing how they operate on a daily basis can give students the motivation and confidence they need to pursue a career in health.

That was the case for Natalya Maynard who, after seven years of being involved with Māori Career Pathway Programme Kia Ora Hauora (KOH), has now become a fully qualified anaesthetic technician.

An anaesthetic technician assists an anaesthetist in helping put patients to sleep before they go through a procedure.

Natalya, who started getting involved in KOH's Work Exposure Days in 2014 while attending Kāpiti College, credits KOH for inspiring her.

"Being part of Kia Ora Hauora definitely helped in getting me where I am today. I always had an interest in choosing a career in health, but what Kia Ora Hauora did for me was show me how I could do it."

Natalya hails from the Rongowhakaata and Te Aitanga a Māhaki iwi in Gisborne. She said she cherishes her Māori heritage and wants to give back to her iwi one day by using her medical skills to help the wider community.

"BEING PART OF KIA ORA HAUORA DEFINITELY HELPED IN GETTING ME WHERE I AM TODAY."

Natalya said she encourages all youth, in particular Māori rangatahi, who want to become an anaesthetic technician one day to give it a crack.

"You won't get bored and you'll get to see a wide range of different operations which is really fun. So give it a go!"

Being a good employer

Te Whatu Ora is committed to meeting its statutory, legal and ethical obligations to be a good employer, including providing equal employment opportunities at all ages and stages of our employees' careers. This is supported by policy, our good employer practices and initiatives set out in our Health Workforce Plan. We strive to:

- Strengthen our organisational culture and values, building an inclusive and accessible organisation for all, including developing Te Mauri o Rongo The Health Charter and the Health Workforce Plan.
- Build workforce capability to uphold Te Tiriti o Waitangi and cultural safety by delivering e-learning and face to face programmes that cover all of these aspects. We are now building from these programmes to develop a nationally led option for all kaimahi.
- Grow and develop ngā Kaimahi Māori in partnership with Te Aka Whai Ora.
- Create a healthy workplace that promotes the wellbeing of our people. Over the last 12 months, we have continued to run various wellbeing initiatives and support programmes across the motu. During the impact of weather events, we stood up local wellbeing initiatives to support our workforce and their whānau.
- Attract and retain the talent we need to deliver a workforce that is fit for the future.
- Provide opportunities for development, career advancement and leadership development. We provide diverse and in-depth development opportunities across all of our professions. These development opportunities have been complemented by our Health Workforce Plan which prioritises aspects that are of most importance for our workforce.

Our first Ngātahitanga Pulse Survey occurred at the end of 2022 and provided invaluable information around how we can better support our leaders and workforce across the motu.

Workforce

Health Workforce Plan

The health system is staffed by hardworking, highly skilled and committed professionals. Despite workforce numbers having grown over the past decade, they have not grown enough, leaving a workforce under strain. The way our workforce is supported also needs to improve.

During the year, we developed our first Health Workforce Plan for 2023-24, which outlines how we intend to grow and support our whole health workforce, both employed and funded.

The plan was developed in partnership with Te Aka Whai Ora and drew on engagement with our frontline clinical workforce, professional bodies and unions.

Specific initiatives and actions outlined in the workforce plan include:

- growing rural and interdisciplinary training programmes to enable larger student intakes
- growing 'earn-as-you-learn' programmes across health professions
- creating 135 new training places a year for allied and scientific professionals, including paramedics, oral health therapists, radiation therapists, pharmacy prescribers and anaesthetic technicians
- seed funding for new programmes to grow these allied professions
- sustained investment in Return to Nursing and support for internationally qualified nurses to get ready to practise in New Zealand
- launch of a Return to Health project focused on flexible opportunities for those with health qualifications to return to work
- expanded access to cultural and hardship support for Māori and Pacific students in training to minimise student attrition and grow workforces faster
- funding for Māori providers to take more students on placement and to offer increased training and development roles.

The plan signals the shifts needed over time to build a sustainable health workforce. We need to reduce reliance on the global market, grow our rural health teams and build a workforce representative of communities across the motu.

Relationship with health unions

We place high importance on having strong relationships with the large number of unions representing the health workforce. Our focus is to work alongside unions, providing greater transparency and insight into the direction, opportunity and challenges facing us as an organisation – and as a whole system.

The establishment of He Ara Tapa Tahi, the National Tripartite Health and Safety Forum (Te Whatu Ora, unions and WorkSafe) and the funded sector engagement forum – are the foundations of that commitment. We support our leaders and union representatives to engage early and as close to the operations as possible to resolve issues, find innovative solutions and to engage constructively. The establishment of an engagement framework is ongoing and includes the National Bipartite forum which provides for national engagement and discussions on matters of operational importance.

Pay equity

On 29 June 2023 Te Whatu Ora, the New Zealand Nurses Organisation and the Public Service Association reached an historic agreement on a proposed settlement for the nurses' pay equity claim.

Under the agreement pay bands for Senior Nurses now range from $105,704 and $153,060 per annum, and $69,566 and $99,630 per annum for Registered Nurses. The pay agreement was backdated to 7 March 2022.

An additional $15,000 lump sum was paid to healthcare assistants and nurses to resolve all matters with the claim.

Ngātahitanga Pulse Survey

Creating a baseline for how we are tracking as an organisation, with regards to workforce engagement and experience, is key to continuous improvement. In December 2022, we took our first step on this journey with our survey.

We asked our people about their work environment, what was working well, and what we could do better. 27,764 people filled in the survey, providing valuable information to start measuring our progress.

There were some encouraging results but also areas where our people expressed genuine concerns and thought we could improve.

Our highest scoring survey question was 'I have capacity to be compassionate and caring to those around me', (95.6% of staff 'strongly agreed', 'agreed', or 'somewhat agreed' with this statement), showing that relationships remain strong as we work together to serve people and communities. There were also high scores for people feeling a sense of connection and belonging within their team (77.3% of staff 'strongly agreed', 'agreed', or 'somewhat agreed' with this statement).

Areas for improvement included:

- **Resources** – having the time, people, budget, facilities, equipment and better pay to perform their job well
- **Leadership and transformation** – ensuring our leaders are equipped to lead and that decision-making and change is inclusive and transparent at all levels
- **People experience** – training opportunities, recognition of hard work and a positive workplace culture
- **Working together** – feeling more connected to colleagues across the motu, working towards a better health system for all, together
- **Care and equity** – a common understanding of what equity means and providing a level of care we can all be proud of.

An important outcome from the survey is a heightened focus on improving resources, better communicating change, and addressing discrimination in all its forms, including through building cultural safety. Having these initial baseline results will help us measure progress and make further changes.

Holidays Act remediation

An estimated 270,000 current and historic employees are covered by the Holidays Act remediation project (across more than 20 payroll and rostering systems). The total cost of Holidays Act remediation payments for our workforce is estimated at $2.1 billion.

Project teams across New Zealand are working to recalculate our former and current kaimahi holiday pay as efficiently as possible. The majority of payments to current employees are expected to be completed by mid-2024.

Collective employment agreements

The majority of our people are party to collective employment agreements. The health sector is complex and the merging of previous entities to form Te Whatu Ora means there are significant complexities in the coverage of employment agreements and differences in terms and conditions.

Currently, there are 28 collective agreements that are negotiated nationally, with approximately 40 collective agreements that were negotiated locally. Our aim is to ensure we take a collaborative approach to simplifying these agreements and reducing the number of collectives over time.

Alongside collective bargaining, sectors of our workforce are within scope of fair pay agreements, including security workers, hospitality staff and cleaners.

Recruitment

We launched a dedicated International Recruitment Centre in November 2022 to help attract health professionals to New Zealand. The campaign includes other services for immigration, relocation and settlement to make it easier for overseas health workers to relocate. By the end of the year, Te Whatu Ora had received 2,502 expressions of interest, resulting in 115 candidates accepting a job offer.

Nurses

The International Qualified Nurses Competence Assessment Programme (CAP) Fund was launched in August 2022 and provides up to $10,000 to help overseas nurses complete a CAP to gain registration to work in New Zealand. The funding has so far supported 800 Internationally Qualified Nurses to gain their Annual Practising Certificates.

The Return to Nursing Support Fund commenced Round 3 in September 2022. The Fund provides up to $5,000 to New Zealand-enrolled or registered nurses without a current Annual Practising Certificate, or Internationally Qualified Nurses (IQNs) who are New Zealand residents or citizens and working as healthcare assistants/ support workers, to assist with the costs of gaining/regaining their New Zealand registration. 225 applications were approved for funding from Rounds 1 and 2.

As at June 2023, 264 applications had been received as part of Round 3 and are in various stages of the review/ approval process.

In the 2023 academic year, we increased funded Nursing Practitioners training places from 50 to 80.

Overseas doctors

The New Zealand Registration Examination (NZREX) pilot programmes commenced in January 2023, supporting 20 overseas doctors, who had passed their NZREX in the last five years, to gain full registration to work in New Zealand. A bridging programme focuses on internship training in hospitals and a primary care pathway focuses on careers in general practice/primary care.

Funding was provided to increase training slots/placements for radiology registrars over the next three years, with five places secured for 2023 (two in Auckland, one in Waitematā, one in Rotorua and one in Wellington). This will support the increase in capacity of cancer services as part of the Cancer Action Plan.

General Practitioners (GPs)

To help improve the attractiveness of becoming a GP, salary increases are in place for trainee GPs to match those of registrars working in hospitals, with increases of between 13% and 23%, as well as an increase in pay for teaching supervisors. Funding is also available to encourage the hosting of community-based training modules for medical graduate interns to provide them experience of General Practice.

Budget 22 Initiatives: updates
Health Workforce Development
This initiative provides funding for workforce training and development to underpin critical reform initiatives. Contingency funds not drawn down as at 30 June.
Support Workers (Pay Equity) Settlements Act 2017
This initiative provides funding for support worker wages increases from 1 July 2021 specified in the Support Workers (Pay Equity) Settlements Act 2017. All funding for the Pay Equity Labour Cost Index settlement uplift for support workers has been paid out to providers through a price uplift and is now built into the ongoing funding.

Getting to the heart

LANA SIMPSON

Lana Simpson became a Cardiac Physiologist because of a heart condition that was discovered when she was 28 years old.

In 2012, Lana was working in IT in Christchurch when her heart rate suddenly went up to 189 beats per minute (bpm) (normal at rest is 60 to 100 bpm).

After many trips to the Emergency Department, adenosine injections, tests and clinic appointments, a Radiofrequency Ablation delivered Lana the diagnosis of Atrioventricular Nodal Re-entrant Tachycardia (AVNRT).

AVNRT is a type of supraventricular tachycardia and is caused by a re-entry circuit in or around the AV node. It can occur spontaneously and is more common in women.

For some time afterwards, Lana was symptom free and working in photography. However, she remained compelled by her experience, so sent an email to the Christchurch Physiology team asking "how to become one of them." She then enrolled at the University of Otago to pursue a Bachelor's degree in Physiology and Anatomy, the first step on the path to becoming a Cardiac Physiologist.

"Part of my goal was to learn in-depth so I could explain to patients what's going on during what can be a stressful, anxiety-provoking time."

In 2016, her AVNRT returned with a heart rate of 182 bpm. Several trips to the Emergency Department followed. Almost daily symptoms called for a repeat ablation.

Once the AVNRT was under control, Lana was given a new diagnosis of Postural Orthostatic Tachycardia Syndrome (POTS), the symptoms of which she continues to manage with medication.

Lana finished her Bachelor's degree in 2019. After graduating, she entered the postgraduate programme in Medical Technology. In this two-year programme, you need to be employed in the second year. This second year of the post-grad programme is the point many people run out of luck and grit.

Fortunately, Lana didn't run out of grit, or luck, and is now a Cardiac Physiologist. Lana often cares for patients in their teens, twenties, and thirties and says they find comfort in being able to relate to her story of having a heart condition investigated at a young age.

Occupational Health, Safety and Wellbeing

The health, safety and wellbeing of our staff, patients, providers, whānau and communities is at the heart of everything we do. This relies on participation, leadership and accountability. Our focus for the 2022–23 year has been to:

- clearly establish roles and responsibilities for this important work
- build or integrate systems, policies and procedures that support us to operate nationally
- prioritise the management of, and our response to, critical risks
- form relationships and partnerships based on values and respect.

The Board and Executive Leadership Team have been active in leading and overseeing this critical work, given the importance of strong focus at both governance and management levels. In support of this, the Board has undertaken due diligence activity to understand and assess critical risks and gain assurance of appropriate responses by management.

Valuing relationships and partnering with others

We are committed to further strengthening our relationships with unions and WorkSafe New Zealand.

We are continuing to improve how we share information with and report to stakeholders. This includes investing in a national health, safety and wellbeing system to provide consistent, timely and relevant national data. We are currently relying on multiple information systems to gather and analyse this information.

We know that delivering our functions consistently, at scale, is a challenge. To support this, we are developing the following national frameworks and systems:

- Governance documentation (policies, strategies, and plans)
- Training programmes
- National integrated Occupational Health and Safety at Work management system
- Audit and monitoring for all critical risk groups.

Identifying and managing our critical health and safety risks

We have identified eight critical risks that pose health, safety and wellbeing harm to kaimahi:

1. Violence and aggression
2. Workplace injuries: moving and handling, slips and trips
3. Working in the community and lone working
4. Psychosocial harm, such as fatigue and stress
5. Contractor management
6. Hazardous substances
7. Transport and traffic safety management
8. Exposure to infectious diseases

In managing these risks, we have identified areas for priority attention, such as de-escalation training and support for staff to address violence and aggression.

Te Whatu Ora Board

As at 31 October 2023.

Dame Dr Karen Poutasi

Chair

Dame Karen is medically-qualified with a specialisation in public health and has significant governance and leadership experience in the health and education sectors. Her executive positions have included Chief Executive of the New Zealand Qualifications Authority and Director General of Health. Her governance roles have included Network for Learning, Commissioner for Waikato District Health Board, and she is also Chair of Taumata Arowai and Kāpuhipuhi Wellington Uni Professional.

Naomi Ferguson

Naomi is a highly accomplished leader with significant experience in both governance and executive roles. Most recently she served as Commissioner and Chief Executive of Inland Revenue successfully delivering the Business Transformation Programme. Naomi is a strong champion of diversity and inclusion and led this work across the Public Sector as co-chair of Papa Pounamu. Naomi is also currently Chair of Education Payroll Ltd.

Hon. Amy Adams

Amy is a lawyer by profession having been a partner in her firm specialising in commercial and property law before entering Parliament in 2008 where she served for 12 years. Amy's ministerial portfolios included being Minister for Justice and Courts, Social Investment, Communications and Information Technology, Environment, Internal Affairs and Associate Finance Minister. She also serves as Chancellor of the University of Canterbury.

Dr Jeff Lowe

Dr Jeff Lowe is currently Chair of General Practice New Zealand, and a Board member of Cosine PHO, the Federation of Primary Health Aotearoa New Zealand and Collaborative Aotearoa New Zealand. He also recently worked on the Te Whatu Ora Planned Care Taskforce and COVID-19 Health System Preparedness group.

Ms Tipa Mahuta

Waikato, Maniapoto, Ngāpuhi

Tipa is currently the Chair of the Taumata Arowai Māori Advisory Group, a councillor with the Waikato Regional Council, co-Chair of the Waikato River Authority and Board member with the Te Kotahi Research Centre.

"MY MARAE ESTABLISHED THE FIRST MARAE-BASED HEALTH CLINIC IN THE 1980S AS A MODEL OF CARE FOR OUR WHĀNAU AND TO INCREASE ACCESS TO HAUORA SERVICES. WAIKATO HAS HAD TO EMPLOY OUR OWN RESPONSES SINCE RAUPATU WHERE LANDLESSNESS, POVERTY AND EPIDEMICS HAVE CAUSED US TO CREATE OUR OWN STRATEGIES FOR SURVIVAL LIKE OTHER WHĀNAU AND COMMUNITIES AROUND THE MOTU."

Vanessa Stoddart

Vanessa is a graduate of the Australian Institute of Directors, a chartered fellow of the New Zealand Institute of Directors, Honorary Fellow of HRINZ and Companion of Engineering NZ. Previous government appointments include having been a member of the Better Public Services Advisory Group, DOC Audit and Risk Committee, Defence Employer Support Council, and Chair of MBIE's Audit and Risk Committee and Tertiary Education Commission. Vanessa is currently a member of the Financial Markets Authority and holds other board appointments for a range of companies, not for profits and charitable organisations. Prior to her governance career, Vanessa held legal, change management and senior executive transformation roles for Air New Zealand and Carter Holt Harvey.

Vanessa is passionate about diversity and inclusion, having previously chaired Global Women.

Dr Curtis Walker

Te Whakatōhea rāua ko Ngāti Porou

Dr Curtis Walker is the current Chair of the Medical Council, and has extensive experience in governance, clinical leadership and public policy. He works in Palmerston North Hospital as a Kidney Specialist.

"WE CANNOT UNDERESTIMATE THE IMPORTANCE OF THE OPPORTUNITY TO REFORM OUR PUBLIC HEALTH SYSTEM INTO A MORE COHESIVE AND EFFECTIVE WHOLE, WHERE HEALTH OUTCOMES ARE EQUITABLE FOR ALL. IT IS A PRIVILEGE TO SERVE AOTEAROA NEW ZEALAND ON THE BOARD AND A PRIVILEGE TO CONTINUE TO SERVE PATIENTS AS A PRACTISING DOCTOR."

Board committees

As at 30 June 2023

The Board has established and set terms of reference for seven committees with responsibilities for:

1. Capital and Infrastructure
2. Clinical Quality Assurance
3. Data, Digital and Innovation
4. Finance and Audit
5. Health, Safety and Wellbeing
6. People, Culture, Development and Change
7. Health Services (formerly Public Health, Primary and Community Care Committee)

Capital and Infrastructure Committee

Chair: Naomi Ferguson
ELT lead: Jeremy Holman
Te Aka Whai Ora attendee: Fiona Pimm
Members: Dame Dr Karen Poutasi, Hon. Amy Adams
Independent Members: Lale Ieremia, Mei Fern Johnston, Scott Pritchard

Clinical Quality Assurance Committee

Chair: Dr Curtis Walker
ELT lead: Dr Dale Bramley
Te Aka Whai Ora attendee: Dr Sue Crengle
Members: Dr Jeff Lowe, Dame Dr Karen Poutasi
Independent Member: Dr Marie Bismark

Data, Digital and Innovation Committee

Chair: Hon. Amy Adams
ELT lead: Stuart Bloomfield
Te Aka Whai Ora attendee: Dr Mataroria Lyndon
Members: Naomi Ferguson, Dr Jeff Lowe
Independent Member: Marcus Porter

Finance and Audit Committee

Chair: Marc Rivers (Independent Member)
ELT lead: Rosalie Percival
Te Aka Whai Ora attendee: Steven McJorrow
Members: Hon. Amy Adams, Naomi Ferguson, Vanessa Stoddart
Independent Member: Jonathan Oram

Health, Safety and Wellbeing Committee

Chair: Vanessa Stoddart
ELT lead: Andrew Slater
Te Aka Whai Ora attendee: Tipa Mahuta
Members: Dame Dr Karen Poutasi, Dr Curtis Walker, Naomi Ferguson

People, Culture, Development and Change Committee

Chair: Vanessa Stoddart
ELT lead: Andrew Slater
Te Aka Whai Ora attendee: Tipa Mahuta
Members: Dr Curtis Walker, Naomi Ferguson, Dame Dr Karen Poutasi
Independent Member: Vena Crawley

Health Services Committee (formerly Public Health, Primary and Community Care Committee)

Chair: Dame Dr Karen Poutasi
ELT lead: Dr Nick Chamberlain, Abbe Anderson, Fionnagh Dougan
Te Aka Whai Ora attendees: Te Awerangi Tamihere, Dr Sue Crengle
Members: Dr Jeff Lowe
Independent Members: Tevita Funaki, Michal Noonan

The Executive Team

Fepulea'i Margie Apa

Chief Executive

Margie's most recent role was as Chief Executive Officer, Counties Manukau Health. During this time, Margie led the organisation through major incidents including a measles epidemic, Whakaari White Island eruption, and was lead CEO of the Northern Region's COVID-19 outbreak response. Margie has a BCom from University of Auckland and an MPA (Exec) from Victoria University of Wellington. Fepulea'i is an honorific (or chief title) from her family village of Sale'aula, Savai'i, Samoa.

Fionnagh Dougan

National Director, Hospital & Specialist Services

Fionnagh was the Chief Executive of Capital and Coast and Hutt Valley DHBs from 2019 to 2022. Fionnagh has a background in Nursing and a communications degree. Fionnagh is on the board of the Health Roundtable and a Fellow of the Australian Institute of Company Directors.

Abbe Anderson

National Director, Commissioning

In her previous role, Abbe worked with the Institute for Urban Indigenous Health in Brisbane. She is also a director on the board of Beyond Blue, Australia's most recognised mental health charity. Originally from Colorado in the USA, Abbe is a dual citizen of New Zealand and Australia. She is passionate about equity and self-determination, is driven by a deep curiosity and excited by ingenuity.

Dr Nick Chamberlain

National Director, National Public Health Service

Dr Nick Chamberlain has specialist qualifications in Medical Administration and General Practice. He was CEO of Northland DHB for over ten years and held DHB lead Chief Executive roles in Primary Care and Public Health. He wants to broaden the reach of public and population health through our work with iwi, Māori and Pacifica providers, primary care and NGOs into all our communities and localities.

Dr Dale Bramley

National Director, Improvement and Innovation

Dr Dale Bramley, MBChB, MPH, MBA, FAFPHM, FNZCPHM, is a public health medicine specialist and experienced senior leader. A Harkness Fellow, he served as the Chief Executive Officer of Waitematā DHB for 11 years. Dale has previously served as Chair of the Health Quality and Safety Commission and as a member of New Zealand's National Health Committee, National Ethics Committee and the COVID-19 independent review and advice group.

He is an adjunct Professor at Auckland University of Technology. He has tribal affiliations to Ngā Puhi.

Markerita Poutasi

National Director, Pacific Health

Markerita (Meg) most recently held the role of Chief of Strategy at Te Whatu Ora Te Toka Tumai Auckland. She has also worked as the Director of Pacific Health for the Northern Region Health Coordination Centre where she led the regional (from Northland to Counties Manukau) approach to the Pacific health response to COVID-19 and partnered with the Pacific Provider Collective to develop a regional commissioning framework to deliver adaptive models of care.

Dr Richard Sullivan

Interim National Lead, Medical

Dr Richard Sullivan brings a wealth of experience as a medical oncologist and was Director Northern Region Cancer and Blood Services for 17 years. Dr Sullivan is regional clinical lead cancer, the Chair of National AYA Cancer and is a director at Canopy Cancer Care.

Rosalie Percival

Chief Financial Officer

Rosalie brings a depth of experience at managing significant funding and investment to improve equity of health outcomes across Aotearoa New Zealand. Rosalie's most recent roles prior to joining us as CFO have included serving as Chief Financial Officer for Te Whatu Ora Capital, Coast and Hutt Valley, and Auckland and Waitematā. Rosalie is a Fellow of Chartered Accountants Australia and New Zealand.

Leigh Donoghue

Chief of Data and Digital

Leigh leads the implementation of digital technology and data that improves access to care, enhances people's experience of work, and supports our strategic aims and key system shifts. He works in close partnership with Te Aka Whai Ora to ensure the principles of Te Tiriti and Māori data sovereignty are put into practice and opportunities for equity through digital means are enabled.

Andrew Slater

Chief of People Officer

Andrew joined Te Whatu Ora permanently in April 2023, following an earlier secondment as Transformation Advisor. Prior to this role Andrew was the Chief Executive Officer of Whakarongorau Aotearoa, New Zealand Telehealth Services. Andrew has held a number of senior roles across the health sector including in ambulance and primary care. Andrew leads the functions of HR, Communications, Payroll, Health and Safety and Occupational Health, Workforce Development and Planning, Emergency Management and Security.

Jeremy Holman

Chief Infrastructure and Investment Officer

Jeremy provides national leadership for the planning and delivery of capital projects across the motu and the maintenance of all existing health infrastructure. Jeremy held senior roles at Downer, Air New Zealand and Crown Infrastructure Partners. He was awarded an MBE in 2007 and holds a Master of Business Administration, is a Chartered Engineer and is a Fellow of the Institution of Mechanical Engineers (UK).

Peter Alsop

Chief of Staff

Peter leads the Office of the Chief Executive, which includes a range of support functions. Peter has led Corporate Services in five organisations, building on an earlier career in policy and regulatory management – working across the public, private and not-for-profit sectors. With four tamariki Māori, and whānau whakapapa to Ngāti Porou, Peter is committed to achieving health equity for Māori and other priority populations.

Mahaki Albert

Maiaka Whakaruruhau Tikanga (Chief of Tikanga)

Mahaki Albert is of *Te Whānau-ā-Apanui, Ngāi Tūhoe, Ngāti Porou, Te Aitanga-a-Hauiti and Waikato-Tainui* descent. Mahaki has been in the role of Maiaka Whakaruruhau Tikanga | Chief of Tikanga since December 2022 and is a member of the Executive Leadership Teams for both Te Whatu Ora and Te Aka Whai Ora.

Mahaki was previously the Chief Executive of Whare Tiaki Hauora, a Māori NGO. Mahaki also previously held the role of Tumu Tikanga at Counties Manukau Health for 5-6 years, and has held leadership positions within community service providers, a Primary Health Organisation, and the education sector. Mahaki is a member of various governance groups and maintains strong engagement and relationships with Crown and Iwi entities. Mahaki also holds governance roles in his local community within the education sector.

Note: The above ELT profiles are as at 30 June 2023. We have established our permanent executive leadership team as at 28 July 2023.

Risk Management

Understanding and managing risk is a key aspect of delivering a high-quality health system. The table below provides an overview of key areas of risk, and management activities to address those risks.

Risk Description	Key Management Activity
Delivering Health Reforms	
If Te Whatu Ora is unable to deliver the transition, associated culture and accountability change, then the benefits of the health sector reforms will not be delivered at the scale and pace expected.	Te Whatu Ora is working on the implementation of a national and local organisation structure that unifies and simplifies how we work. The structure streamlines services for back of house business functions. This will create savings which can be redirected into frontline resources to support the delivery of healthcare.
Workforce Capacity and Capability	
If Te Whatu Ora does not have a workforce that is appropriately qualified and sufficient to meet demand, then there will not be the capacity to deliver healthcare and services to the community.	Te Whatu Ora is focused on delivering the immediate initiatives to mitigate workforce pressures – international recruitment campaigns, supporting overseas trained doctors and nurses to register in New Zealand and supporting nurses to return to practise. Te Whatu Ora has engaged with staff on their experience through the Ngātahitanga Pulse Survey and delivered significant investments to strengthen the workforce.
Clinical Practice Quality	
If Te Whatu Ora is unable to deliver consistent high-quality services and care to the community, then the intent of the reforms will not be delivered.	Te Whatu Ora prioritised work on Planned Care, Acute and Seasonal Pressure, the Immunisation and Workforce Taskforces, at national and regional levels to support and enhance equitable provision of care. Te Whatu Ora is developing a national clinical governance framework that will support whole of system quality and patient safety.

Risk Description	Key Management Activity
Equitable Heath Outcomes	
If Te Whatu Ora does not have clear targeted and regularly monitored strategies, plans or programmes supported across the health sector to deliver equitable health outcomes for all New Zealanders, then Te Whatu Ora may fail to meet its obligations under Te Tiriti and not achieve the goal of improved health outcomes for all New Zealanders.	Te Whatu Ora is committed to building Māori/Pacific leadership/partnership and advisory workforce capacity, identifying equity gaps in services, quality of care and ongoing communication and collaboration with community groups and NGOs. Te Whatu Ora continues to engage with Te Aka Whai Ora on priority areas to ensure active pursuing of collaboration and alignment of targets and strategies. Programmes of work are appropriately resourced and milestone deliverables monitored with early treatment strategies implemented when required.
Financial Management	
If Te Whatu Ora does not meet its financial obligations in a sustainable way, then fiscal losses could occur, resulting in pressure on funding the reform change programme.	Te Whatu Ora continues to progress the National Finance Work Programme aimed at delivering integrated financial planning and reporting across the organisation to ensure financial obligations can be met to deliver ongoing organisational sustainability. Key streams of work include progressing onboarding the sector onto the Finance Procurement and Inventory Management System, developing a full operational and capital plan and implementing improvement to enhance cashflow forecasting to ensure that all financial obligations are met on a timely basis.
Health, Safety and Wellbeing	
If Te Whatu Ora is unable to manage, monitor or respond to the health, safety and wellbeing of its staff and visitors to its facilities then it will fail to meet its obligations under the Health and Safety at Work Act 2015.	Te Whatu Ora continues to provide a national occupational health, safety, and wellbeing support function. Te Whatu Ora continues to manage critical identified risks that pose health, safety, and wellbeing harm to kaimahi, patients, whānau, and communities.
Digital Systems and Services Enablement	
If Te Whatu Ora does not have a clear strategy to maintain current systems or enable investment in technology, then it may fail to meet future demand and models of care.	Te Whatu Ora is transitioning to the new Data and Digital operating model and has focused integrated planning aligned to Te Pae Tata commitments, Data and Digital Strategy & Roadmap and emerging Reform and Operating Plan priorities, to optimise value delivered within the current fiscal constraints.

Risk Description	Key Management Activity
Data and Information Management	
If Te Whatu Ora does not have a clear programme to ensure the accuracy and consistency of its data and protect against unauthorised access to information, then it may fail to meet future demand and its statutory obligations.	Te Whatu Ora's data and information accessibility is a priority area in the Data and Digital Strategy which identifies specific actions to improve the way the system manages data and partners with key stakeholders. Ongoing delivery of the cyber security uplift programme will strengthen the sector's ability to safeguard systems and data.
Significant Event Management	
If Te Whatu Ora is unable to effectively respond to incidents or events that have the potential to significantly disrupt health services and care, then there may not be the capacity to deliver healthcare and services to the community.	Te Whatu Ora has ongoing strengthening and coordination of incident and business continuity management structures and capability, ensuring service continuity during summer holiday period and responding to recent weather events.
Infrastructure and Asset Management	
If Te Whatu Ora does not understand the nature or condition of its infrastructure and assets to support future planning for maintenance and investment, then the required clinical services may not be able to be delivered.	Te Whatu Ora is committed to reducing risk by establishing and maintaining a contemporary, national view of the asset portfolio and identifying the strategy to manage it.
Māori Health Aspirations (Improving Health Outcomes)	
If Te Whatu Ora does not have shared strategies or plans or deliver programmes of work and approaches that explicitly give effect to the principles of Te Tiriti o Waitangi, it may fail to comply with its obligations under Te Tiriti o Waitangi.	Te Whatu Ora is committed to strengthening management and Board level partnership with Te Aka Whai Ora, delivering Te Pae Tata and embedding regional and local iwi/Māori partnerships through locality planning, and other related initiatives.

Health Infrastructure

Getting health infrastructure right is crucial to enabling our clinical workforce to deliver care safely and effectively and for people to receive high-quality care.

Improved health infrastructure is a key enabler of clinical services and improved health outcomes. Clinical services need specialist facilities in their design and their fit-out, which includes clinical and digital equipment. These facilities are among the most challenging to plan, design and build.

Under the previous health system, the management of health infrastructure was fragmented across 20 district health boards (DHBs) with notable variations in capability and capacity across the system. This resulted in uneven performance and outcomes and a growing infrastructure deficit.

The health reforms are bringing infrastructure management together, through Te Whatu Ora. This will then provide the opportunity to develop a unified model and approach, with clarity of roles and functions at the national, regional and local levels.

Progress so far

An early focus for Te Whatu Ora was the development of an integrated operating model for the infrastructure function, conceived of by a working group of external experts with wide stakeholder engagement and input. The operating model aims to improve efficiency, performance and capability of infrastructure delivery, as well as position infrastructure as a key enabler of health outcomes.

The work to date has already delivered tangible gains. Governance across the portfolio has been improved with the operation of the Capital and Infrastructure Committee and the setting up of new governance and delivery structures arrangements for New Dunedin Hospital, Whangārei Hospital, and Nelson Hospital redevelopment.

Te Kotuku Redevelopment, Whangārei

We have developed our capability in several ways, including managing cost escalation across the portfolio, lifting the standard of business case investment proposals, and ensuring compliance with the requirements of the Investment Management System. Procurement practices are also being strengthened through collaborative approaches to working with suppliers. Greater oversight and leadership have also been applied to the delivery of mental health infrastructure projects.

Our current work to plan for the future will be central to our infrastructure management ahead. In particular:

- The Infrastructure Investment Plan will establish the first plan that looks at health infrastructure across the entire country; and
- The National Asset Management Strategy (NAMS) will provide a roadmap for the lift of asset management practice.

Measure	Result	Target	Status
Deliver a national asset management plan and capital investment strategy and investment plan by 2023	Milestone report		↑

We are on track to deliver the national asset management plan by December 2023. This plan will outline how Te Whatu Ora will lift asset management practice across health infrastructure.

We have started work on a strategic Infrastructure Investment plan, which has a 10-year horizon. The plan will prioritise investments in health infrastructure and signal the planning required to support robust investment decisions and their contribution to strong health outcomes.

The Asset Management Policy has been drafted and will be presented in conjunction with the delivery of the NAMS.

The standardised asset hierarchy and condition assessment methodology is expected to be approved in Quarter One FY 2023-24. This will provide the methodology for baselining the heath estate.

Work is underway on the Asset Management Information System strategy, requirements, roadmap, and business case. This is expected to go to the Board early 2024 to confirm the capital required to implement an Asset Management Information System strategy.

Deliver the approved capital infrastructure projects that are underway, taking all practicable measures to ensure that project milestones are met, and anticipated benefits realised	Milestone report		↑

There are 75 approved capital infrastructure projects worth a total of $6 billion currently progressing through the design and construction phases of delivery. Nearly all are on track or being actively managed to deliver as expected. Only 12% are currently rated as Red and may require a change in scope or funding to proceed.

Strengthening of national functions and processes has enhanced the quality and practice of investment advice and monitoring.

We have strengthened our compliance with the Treasury expectations and requirements for investment management and are managing pressures through a portfolio management approach.

Hospital redevelopment project meets project milestones	46%	90%	↓

This measure, included in the Vote Health Supplementary Estimates of Appropriation 2022-23, tracks progress against planned performance on the New Dunedin Hospital project.

There were 13 milestones falling due in year ending 30 June 2023 of which 6 were completed (46%). The balance of the milestones were either partially completed or not completed due to the design reset agreed by the Ministers in December 2022 which noted the delay in the programme for the Inpatient Building.

Asset Management

Measuring the actual performance of our critical assets against our expected performance measures helps identify and manage both asset and service-related risks. Knowing our assets and their performance enables us to more effectively plan and implement the steps needed to meet continued growth in demand for our general and specialist healthcare services.

Some of our assets are of strategic importance to New Zealand as they provide national specialist health services for the country, for example: cancer services; organ donation and transplants; Starship Children's Hospital; plastic surgery; burns units; and spinal units.

Infrastructure Asset Portfolio

Current value of the health estate

The public health estate has a land value of $1.720 billion and more than 1,200 buildings with a net book value of $9 billion and an estimated replacement value of $38 billion. Te Whatu Ora also leases property with rental payments exceeding $80m plus GST each year.

Based on these values, Te Whatu Ora is an investment-intensive agency and is required to comply with Cabinet Office Circular CO (19) 6 Investment Management and Asset Performance in the State Services. Previously, eight of the 20 district health boards were covered by these expectations.

Compliance includes:

- managing assets to ensure they deliver current and intended levels of service
- demonstrating a level of asset management practice and performance that is appropriate to the scale of assets under their management and the criticality of those assets to the delivery of key public services
- having current asset management plans to inform strategic, tactical, and operational choices
- capturing and using, in internal management and decision-making processes, relevant indicators of past and projected asset performance, such as asset utilisation, condition and fitness-for-purpose
- reporting on relevant asset performance indicators in their annual reports.

What needs to be done

An assessment of asset management maturity, process and practices across the motu has shown there is variability across the regions and a significant amount of work is required to implement standardised processes and practices to get to where we need to be.

Several foundational pieces of work are required:

- **Developing an Asset Management Policy and Strategy** – the Policy will outline the Board's expectations in relation to asset management and the Strategy will outline how decisions related to assets will be made and outline a roadmap on how Te Whatu Ora will grow its competency in asset management.
- **Baselining the health estate** – this will confirm what assets are included in the health estate and their condition. We have established a standardised approach to assessing asset condition and asset condition assessments are expected to begin in the financial year 2023-24 and take approximately three years. This will allow condition performance reporting to be implemented as we work through assessing the health estate.
- **Developing and implementing an Asset Management Information System** – this system will capture the information from the baselining exercise and enable comprehensive analysis and reporting on the health estate, including asset performance reporting.

Implementing the building blocks of a best practice asset management framework across Te Whatu Ora is essential to standardising the way assets are managed and maintained across the motu. This will ensure that our asset investment is coordinated to optimise the value that the health estate provides for the provision of health services. Standardising how we assess and prioritise investment based on nationally set asset levels of service will also reduce the inequities in investment that occurred in the past.

What has been done?

We have established workstreams based on risk, ahead of full baseline assessments being undertaken. These workstreams include:

- **Seismic work programme** – A programme of work to understand our seismic risks and develop an approach to the prioritisation of mitigation work, to put in place a seismic policy and strategy, to develop technical guidance for new and existing buildings, and to put in place procedures and arrangements for post-earthquake response.
- **Risk and assurance campus-wide infrastructure projec**t – A standardised risk assessment of campus infrastructure for sites which provide medical or surgical services that helps us to understand risks and informs investment planning.
- **Climate change risk assessment** – The assessment helps us to understand priority areas for risk mitigation and adaptation planning. It will also help with communicating key risks and will be useful in broader planning, strategy, and investment prioritisation.

Further information on the first Infrastructure and Investment report back to the Minister of Health and Cabinet can be found in the Annual Report to Ministers on Enhancement of Infrastructure Management.

Asset Performance Disclosure

Asset levels of service, measures and targets for condition, fitness-for-purpose and use are required to enable asset performance reporting.

This is a large and complex task and we have yet to complete the national baseline assessments of condition that will enable complete asset performance reporting as at 30 June 2023.

As we mature our asset management processes and systems, more asset performance indicators will be added to include fitness-for-purpose and utilisation. It is important that the evidence supporting performance indicators is robust and auditable, to promote transparency of how the health estate is performing for all New Zealanders.

Further performance measures related to asset management

Measure	Result	Target	Status
Te Whatu Ora–Health New Zealand is seen as a high-quality asset manager for the health estate as measured by the Asset Management Maturity index for the health portfolio	32%	40–60%	↓

Using the asset management maturity assessment tool previously used by Treasury for the Investor Confidence Rating, our internal assessment suggests that, overall, we have achieved an average maturity score of 32% across the motu, which demonstrates a 'Minimum' rather than Core level of maturity as at June 2023.

There are pockets of better performance associated predominantly with the larger metro ex district health boards but this is balanced by significantly less mature asset management practices in the smaller ex district health boards.

With the establishment of the Infrastructure and Investment Group and the bringing together of the portfolio into a unified management approach, the National Asset Management Strategy, due December 2023, will include an improvement plan and roadmap that will show how Te Whatu Ora will improve its asset management maturity to a level that reflects the critical nature of the portfolio of which it is the kaitiaki.

Te Whatu Ora–Health New Zealand provides an annual update to the Ministers of Health and Finance on the improvement programme's enhancement of the asset and investment management framework	Achieved	Achieved	✓

The first annual report has been provided to Joint Ministers.

The extent to which actual benefits meet the expected benefits from those capital investments as set out in the relevant business case	Achieved	Achieved	✓

Capital investments made by Te Whatu Ora have a variety of drivers and business cases which articulate the key benefits arising from implementing the investments. To the best of our knowledge, investments are delivering the benefits including addressing asset related risks that would otherwise impact on service delivery, patient and staff safety, compliance, quality of services and outcomes for patients and consumers of our health services.

Data and Digital

Data and Digital has a crucial role to play in building a system which achieves Pae Ora and enables the data and digital vision for the future of health.

Te Whatu Ora inherited a complex legacy ICT landscape, managed under the former district health boards and shared services agencies, each of which had different digital strategies, priorities, and solutions. There were varying degrees of maturity, quality and consistency which have evolved organically over time to support the needs of their respective organisations.

Establishing a single Data and Digital entity is one of the most ambitious areas of the reform programme and reflects the largest IT system rationalisation and redevelopment attempted in Aotearoa New Zealand. While ambitious, the establishment of one entity provides an opportunity to modernise the health system and transform the delivery of healthcare in New Zealand.

We are making progress. Significant work has been undertaken to align and focus the work programme (including nationalising and rationalising the 4,000+ applications in the environment) and to re-allocate internal funding to support the reform. This work is forming the basis of the forward work programme and proposed Budget 2024 funding bid.

Whilst work is underway, there is significant investment required to complete post-merger acquisition and transition activities, maintain the reliability and operation of these systems during that process, and progressively modernise our systems.

Review of our current investments

Data and Digital inherited an Investment Portfolio which included circa 1,700 initiatives covering current and planned data and digital investments. A review of these was completed in late 2022. This work put a priority on continuing with investments which support the nationalisation and/or rationalisation of systems, and the pausing of investments which were not linked to the future national direction or priorities.

We are also focusing on balancing investment across the portfolio, for example to redirect investment to initiatives that target equity, to balance service continuity and mitigate operational risk, and to identify opportunities to enable system reform objectives. We are continuing to rationalise, unify and simplify our digital health ecosystem, so that we can make the most of the limited resources by solving problems once and leveraging proven solutions across the motu.

Development of a Data and Digital Strategy and Roadmap

During the year, a data and digital vision and strategic priorities were developed and mapped against Te Pae Tata and the interim Government Policy Statement, to describe what Data and Digital aspire to achieve in partnership with Te Aka Whai Ora and Iwi Māori Partnership Boards. We are focused on progressing to new models of care enabled by data and digital services.

During the pandemic, we saw how medical technology devices enabled more care in people's homes and communities, such as online consultations, mobile apps, wearable sensors, and home testing kits. We also saw how the medical technology industry responded quickly and collaboratively to deliver critical new functionality at pace and at a distance, such as ventilators, personal protective equipment, and vaccines.

These achievements have set the stage for a revolution in health that will be driven by technology and innovation. The Government's health reforms will build on this momentum and create a more integrated and equitable health system that will leverage data and digital capability to deliver better health outcomes for all New Zealanders. Our Data and Digital Strategy and Roadmap focuses on implementing modern national solutions that reflect this new approach.

Data and Digital delivery

Te Whatu Ora is part way through a multi-year programme of data and digital investments. In partnership with Te Aka Whai Ora, we are supporting a bold and broad reform agenda. This includes investing in new services and models of healthcare in parts of the sector that have historically been subject to limited investment.

Data and Digital is an enabler of service redesign and productivity improvement. It can push us to deliver care in new and more responsive ways, ways that more effectively support and leverage our highly valued health workforce. We need to invest more in digital technologies and redesign services to improve access, enhance equity, empower consumers and improve health outcomes, while managing costs.

We have established a national Whānau, Clinician and Consumer Digital Council which is a joint initiative between Te Whatu Ora and Te Aka Whai Ora. The Council helps shape data and digital technologies to enable improved and more equitable health outcomes. It provides an important link between data and digital leaders and clinicians, whānau, consumers, hāpori and communities. Led by co-chairs Jared Renata and Dr Robyn Whittaker, the Council co-designs digital services that will best serve the people who use the health system, with whānau at the forefront.

Within consumer and whānau-facing services, we are moving further towards care that empowers consumers by providing tools that give them more control, options for virtual care and better digital services, such as smartphone apps. This will mean those who choose to, can do more online to make healthcare more convenient and accessible and to free up capacity in the system.

Some of our work programmes are well advanced and others are still at the early stages of development (informed by service planning and emerging priorities).

Hira

Hira is a platform that will connect people's health and wellbeing information across different care settings and let people have more input and control over their own healthcare. The establishment of a single Data and Digital group has simplified the design, delivery and decision-making for this programme.

Hira will create a Patient Summary for every New Zealander based on the International Patient Summary Standard that will show their medicines, vaccinations, lab results, and more. Trusted healthcare providers will be able to access and update their data across different systems, so that they get the best care possible. Vendors will be able to build apps that people and their whānau want to support them to manage their own health. This platform is being developed with strong input from communities and whānau, so that what they need, is what is delivered.

Budget 21 included multi-year funding for Hira Tranche 1, of which $145.5m has been drawn down. This will deliver:

- a personal health record – an app/website allowing healthcare consumers/whānau to see their health information in one place and update some of it. Tranche 1 will deliver prioritised health data such as demographics, medicines and immunisations
- a platform allowing healthcare providers to access and update patient data held in different databases
- a secure, carefully controlled digital ecosystem enabling vendors to build apps for healthcare consumers, whānau and providers, to help people manage their own health.

Hira will be the connector of people's health and wellbeing information. The programme has successfully launched Hira Marketplace, a central hub through which digital health suppliers can find data and digital services to build and improve the health services they offer.

It has also supported the rollout of medicines consumer view software, meaning people will be able to access more of their medicines information, and started development of the Events Notification Service, which will let healthcare providers know when information relating to a patient has changed or when they have had an interaction with the healthcare system.

Cyber Security Uplift Programme

We have moved to a national approach for cyber security by appointing our first national Chief Information Security Officer and building a national security operations team. As a result, we are now implementing new security technologies on a national scale and are seeing the benefits this provides. We now have a better ability to oversee networks and safeguard and monitor in real time.

Budget 21 included multi-year funding for cyber security, of which $124.5m has been drawn down. Te Whatu Ora's Cyber Security Uplift Programme has a range of initiatives designed to protect kaimahi, patients and whānau from cyber threats and to keep private health information safe and secure.

This programme is progressing with a current focus on:

1. Implementing a new national cyber security training and education platform (including phishing simulation capabilities), starting with Te Whatu Ora and Te Aka Whai Ora offices and regions which do not currently have this capability
2. Cyber security incident response – planning national training with exercises for each region delivered on a quarterly schedule
3. Further development and real-world testing of our new third-party security risk automation platform
4. Continuing rollout across the motu of up-to-date security products
5. Surveying Te Whatu Ora and Te Aka Whai Ora kaimahi to understand better how we can make digital safety easier for everyone.

We worked with Te Pūkenga, Microsoft and TupuToa to establish the National Cyber Academy to grow the next generation of cyber security professionals, with a particular focus on increasing representation of Māori and Pasifika in the digital health sector. The first cohort of students began their study on 21 April 2023.

Population Health

Budget 2022 allocated $125.315m over four years to retain and expand selected population health and disease management digital capability and infrastructure developed in response to the COVID-19 pandemic. This presents the opportunity to not only retain and expand capability and infrastructure but to build on the experience gained during the pandemic of working differently to deliver large pieces of work in short timeframes.

In building on this experience, we are looking to bring systems and practice up to the same level of modern platforms. This is a key priority and multi-year programme of work, given the starting points can be quite varied.

The pandemic has taught us that we can deliver value to the health sector faster and more efficiently if we iterate on existing products and platforms. We iterated and honed our product-centric data and digital delivery model in 2021 and 2022. This model is being used to continue to extend our COVID-19 capabilities to broader disease management outcomes.

There are three broad areas in the future public heath operating model where we are extending our capability: quarantine and isolation coordination; notifiable disease management; and disease surveillance.

The following is an example of how we have put this new approach into practice:

Leveraging technology developed during the COVID-19 response, the National Contact Tracing System was extended and is now a secure electronic database that supports contact tracers to keep accurate records of all contact tracing activity. This means that public health can now operate on one national system and contact trace more effectively. This system was recently used to support and prevent measles cases from spreading. The team was able to quickly identify where the infected person had been and was able to take local action to prevent a community outbreak.

National Data Platform

The National Data Platform (NDP) will consolidate our many data environments onto one nationally consistent platform to create a connected environment. The NDP business case has been approved and work is underway to develop the platform. Te Aka Whai Ora is leading the development of the Māori Data Sovereignty Framework and we are working together to incorporate this work once it has been finalised. The NDP will allow us to understand and track the performance of the health system and to find improvements. This will help us to assist with service planning, resource prioritisation and to achieve more equitable health services and better overall outcomes.

Rapid National Data Automation

The Rapid National Data Automation project is a new digital dashboard providing better visibility of patient data nationally. It includes key information like admissions and ward occupancy. This provides a single national view to support improved clinical decision-making and prioritisation, which ultimately benefits patients and whānau. This project has continued to deliver value as an interim solution before the completion of the National Data Platform, with the ongoing addition of new datasets.

Delivering value to clinicians and consumers

Updated My Health Account

Our Te Whatu Ora My Health Account now integrates with New Zealand's most widely used patient portal, Manage My Health. This means that customers of Manage My Health, including health practices and patients from across the motu, can use My Health Account to easily confirm their digital identity and register, improving their overall experience. With My Health Account, Te Whatu Ora is supporting consumers and health information providers to establish their identity quickly and easily, meaning that New Zealanders can access and take control of their health information.

Launched the Zero Data programme

This cross-agency web portal, in partnership with Te Aka Whai Ora, Manatū Hauora and other agencies, enables people to access key health and government websites via their smart phone without incurring data usage charges. It is helping to remove barriers to information and services for people who need them the most whilst also increasing digital access.

Clinical Portal for the Central region

A digital Clinical Portal will connect the Central region. The first phase went live in March 2023, with Wairarapa implementing a new version of Clinical Portal linked to Capital Coast and Hutt Valley, allowing clinicians to see patient information across all three districts. The next phase will integrate the Wairarapa Portal with Whanganui/Mid-Central and Hawke's Bay, allowing all six districts to see across the whole region, providing a consistent user experience for clinicians and saving valuable time.

Launched My Health Account Workforce

In May, a new health workforce digital identity service pilot was launched. Through My Health Account Workforce, our non-Te Whatu Ora health workforce will be able to gain access to essential digital health services and health information relevant to their role via a trusted, secure platform. The product was created to enable the wider health sector workforce to establish their identity quickly and easily for access to health applications.

Launched the New Zealand Health Terminology Service

The New Zealand Health Terminology Service is an online service that makes it easy to use our standard terminologies and code sets for recording, using and sharing health information. Using the service's resources ensures health data is high quality and interoperable, enabling patients and clinicians to enjoy better communication and a more joined-up experience.

Budget 22 Initiatives: updates
Southern Health System Digital Transformation Programme
This initiative provides funding, to be held in contingency, for the digital infrastructure required for the New Dunedin Hospital.
Establishing the National Public Health Service – Digital and Data Infrastructure
This initiative provides funding to establish digital and data capabilities to enable the National Public Health Service to operate as a single national service for public health and enhance public and population health surveillance.
Health Data, Digital – Foundations and Innovation
This initiative builds on Budget 2021 investments to fund further investment in data, digital infrastructure and capability to improve health system performance and achieve the aims of health system reform. Contingency funds not drawn down as at 30 June.

DIGITAL HEALTHCARE IN ACTION

New Zealand's first Digital Public Hospital

Te Whatu Ora Southern Digital Transformation Programme Budget 2022 allocated $225m for the digital transformation investment needed to support the new hospital buildings in Dunedin.

- The new outpatient building will look and feel like a contemporary digital hospital, enabling consumers to easily attend their appointments and supporting the buildings to be more efficiently managed.
- Consumers will be able to easily navigate through the buildings, as digital wayfinding services and digital signage will lead them to the location of their appointment.
- Consumers will be able to check in via kiosks and any information that was previously collected on paper will be collected from the patient digitally via the kiosks. This information will then be available for the consultant to review as soon as it has been submitted.
- Once consumers reach the waiting area, they will be given a sense of how long the wait time is before the consultant is ready to see them. Options such as going to a nearby café for a coffee will be available to them, with alerts being sent via their phones when it is time for them to return for their appointment.

The digital infrastructure design and the related procurement deliverables developed for the Dunedin Hospital (New Zealand's first Digital Public Hospital) will be reused for the six planned future major redevelopment hospital projects and should enable $1m in cost savings per facility.

Reuse allows us to learn from experience and transfer knowledge to continuously improve the quality, standardisation, equity and associated outcomes. The Whangārei Hospital Redevelopment project will be the first to benefit from this new national approach, as well as the proposed Nelson Hospital rebuild.

Artist impression of the planned Dunedin Hospital

Data and Digital measures

Measure	Result	Status
Develop and implement a national plan to create consistency in data and digital capability across Te Whatu Ora	Milestone Report.	↑

Data and Digital are working to come together as a single, unified team – adopting modern digital platforms, harnessing the richness of our data, and embracing new ways of working. We are increasing our focus on developing nationally consistent ways of working, ensuring a high performing business group that delivers for our workforce, for whānau and for all communities across the motu.

Consultation on the proposed structure of the Data and Digital group has been completed and final decisions released. Data and Digital will have eight core functions: Strategy and Investment; Clinical Informatics; Sector Digital Channels; Integration and Delivery; Cyber Security; Data Services; Digital Enterprise Services; and Business Services. These functions are interwoven so that our mahi flows seamlessly through national, regional and local perspectives – with the person and whānau at the centre to enrich healthcare delivery.

Create a national near real time data platform for analytics underpinned by a common data model encompassing hospital operations, public health, primary care and workforce	Milestone Report.	↑

A Business Case for a National Data Platform was developed and approved on 23 June 2023.

The design and build stage to follow will deliver a worked example that draws from the Medicines Data Repository and demonstrates the end-to-end operation of the platform. This will be the first of seven priority national datasets that will be added to the platform in the first 12 months, and existing National Collections datasets will all be catalogued as part of the solution. While the National Data Platform work has been progressing, the Rapid National Data Automation project continues to deliver value as an interim solution.

Measure	Result	Status
Deliver the approved digital capital projects that are underway, taking all practicable measures to ensure that project milestones are met, and anticipated benefits realised	Milestone Report.	↑

In a challenging change environment, there has been a degree of delay for some approved capital projects. Both availability of skilled resource and the continuing impacts of supply chain challenges post COVID-19 continue to impact.

Governance and reporting processes have been further refined and strengthened over the last year, leading to increased oversight of approvals, delivery and earlier visibility of any potential challenges that require addressing.

Ensuring that potential investments are reviewed for national alignment and value has delayed some approvals where national direction has not yet been determined.

Further measures related to capital investment

Measure	Result	Target	Status
Joint agencies involved in any transfer of net assets agree to the changes	Achieved	Achieved	✓
$885.5m of assets transferred from Manatū Hauora to Te Whatu Ora on 1 July 2022 without issue.			
Percentage of drawdowns repaid in 10 business days or less	–	100%	–
Te Whatu Ora has a $200M Standby Credit Facility with the Crown, set up in May 2023. This has not been accessed to date as Te Whatu Ora has sufficient cash to meet its obligations.			

Procurement

Supply Chain and Health Technology Management

Procurement Supply Chain and Health Technology Management services support frontline staff to effectively care for their patients and whānau, irrespective of geographical location. Helping to reduce inequitable health outcomes and unmet health need by ensuring all staff have the resources they need, when they need them, is the measure of success.

Having a national function means we are better placed to reduce unwanted variations that lead to inefficiencies at all levels of the health system. This ensures a stronger focus on customer-centric service. A national approach to supply risks is the best mitigation for unavailable stock in normal operational and emergency situations. An aligned approach to supplier environmental sustainability and broader social outcomes engages national suppliers more effectively in achieving Te Whatu Ora's organisational goals.

Measure	Result	Status
Deliver the information solution strategy, requirements and road map for procurement and supply chain	Milestone Report.	↑
This action was identified prior to the development of an operational plan for the procurement function for 2022-23. Forward planning for the strategies is being progressed and a business case for investment, including technology, is in development.		
Establish the centre-led, nationally, regionally, and locally delivered procurement and supply function building on the existing operations	Milestone Report.	↑
The national leadership structure was established in December 2022, with the confirmed structure for the balance of Procurement and Supply Chain functions being released in August 2023. The second phase of the Health Technology Management consultation will be undertaken in the 2023-24 financial year.		

Health Technology Assets (Clinical Equipment)

"Medical devices save lives, improve health and quality of life, and are indispensable for the prevention, diagnosis, treatment, and management of all medical conditions, diseases, illnesses, and disabilities. Medical devices, and in particular, assistive devices, also are important for rehabilitation and enable people with disabilities to continue to function. Without medical devices, routine medical procedures – from bandaging a sprained ankle, to diagnosing HIV/AIDS or implanting an artificial hip – would be impossible." (World Health Organization, 2011).

A current state review was commissioned between April and June 2022 to establish how medical equipment was managed by the former district health boards. This identified pockets of exemplary practices and activities within some former district health boards, but also significant variability with consequent inconsistencies, duplication, inefficiencies, ineffectiveness, varied outcomes, possible waste and possible patient, commercial, brand and compliance risks.

Current State Position of Health Technology Assets

The health technology (clinical equipment) assets owned by Te Whatu Ora are summarised in the table below, including their purpose, capacity and indicative values.

The relevant performance measures for the health technology portfolio highlight the need to ensure the clinical assets of Te Whatu Ora are in acceptable condition, are well utilised, and comply with regulatory requirements:

Asset Portfolio	Asset Purpose	Quantity/Capacity (Nationally)	Book Value (Nationally)
Health Technology (Clinical Equipment)	To enable the delivery of high quality, timely clinical services through the availability of equipment that meets required clinical and safety standards	**Major Capital Items:** 24x Linear Accelerators 16x Magnetic Resonance Imaging (MRI) Systems 35x Computerized Tomography (CT) Systems **Minor Capital Items:** ~261,000 Medical Equipment (in-hospital and limited community-based items)[1]	Calculated net book value of assets fleet is $633.3m[2]. Calculated replacement value of assets fleet is between $1.7-1.8b[2]. The calculated net book value represents 34% of the active assets' replacement value.

1. Includes mainly in-hospital devices that are managed by Clinical Engineering and excludes items managed through other service provider support, e.g. leased items, laboratory and major radiology equipment. Includes clinical items that may not meet the financial definition of an asset. The data was obtained from various sources (n=13). The data will be confirmed as and when Te Whatu Ora migrates the data to a single Asset Management Information System (AMIS).
2. The data was not readily available and may include clinical items that may not meet the financial definition of an asset. The overall net book value and replacement values were calculated using the available data and asset information (n=7). The data will be confirmed as and when Te Whatu Ora migrates to a single clinical AMIS and the wider Te Whatu Ora migrates to a single Financial Procurement Information Management (FPIM) system.

Asset Performance Indicators for Health Technology Assets

Safe clinical service delivery requires that all clinical equipment assets are fully functional and fit for purpose. When assets fail against required standards, they are taken out of service. Clinical equipment availability is managed via Service Level Agreements for major assets (some of which are leased) and through built-in redundancy within the asset fleet to enable replacement as and when required.

The following table outlines the current national clinical equipment asset performance measures.

A significant piece of work is underway to inform and establish a single clinical asset management information system (AMIS). The clinical AMIS will be essential to capture, consolidate and harmonise the clinical assets data and provide systems and tools to monitor these critical assets' performance in the future.

Asset Group	Measure	2022/23 Ave Target	2022/23 Ave Actual
24x Linear Accelerators	Availability/Uptime	98%	98%
16x Magnetic Resonance Imaging (MRI) Systems	Availability/Uptime	98%	99%
35x Computerized Tomography (CT) Systems	Availability/Uptime	95.5%	99%
261,000 minor medical equipment items (In-hospital and community based)	Condition-Performance Verification	93%	81%

Sustainability

Te Whatu Ora has many opportunities to become a sustainable and resilient organisation by responding to climate change, protecting the natural environment and enabling better health outcomes. These include supporting whānau and communities to become climate resilient, embedding New Zealand's international commitments under the Paris Agreement and putting the United Nations Sustainable Development Goals into practice.

We have set three workstreams for our interim national work programme, which will guide practice until a broader sustainability approach is created and a formal Emissions Reduction Plan is in place.

Our sustainability reporting aligns to Carbon Neutral Government Programme Guidance, XRB Aotearoa New Zealand New Zealand Climate Standards, ISO 14064-1:2018 and the Greenhouse Gas Protocol. The greenhouse gas emissions inventory is verified by Toitū Envirocare.

Environment Sustainability and Climate Resilience workstreams

Health System Decarbonisation

To reduce health system carbon emissions in line with a 1.5-degree scenario.

Environment in All Practices

To realise co-benefits that include the environment alongside health, equity, social and economic values.

Health System Resilience and Adaptation

To ensure sector resilience by planning for and adapting to the impacts of climate change.

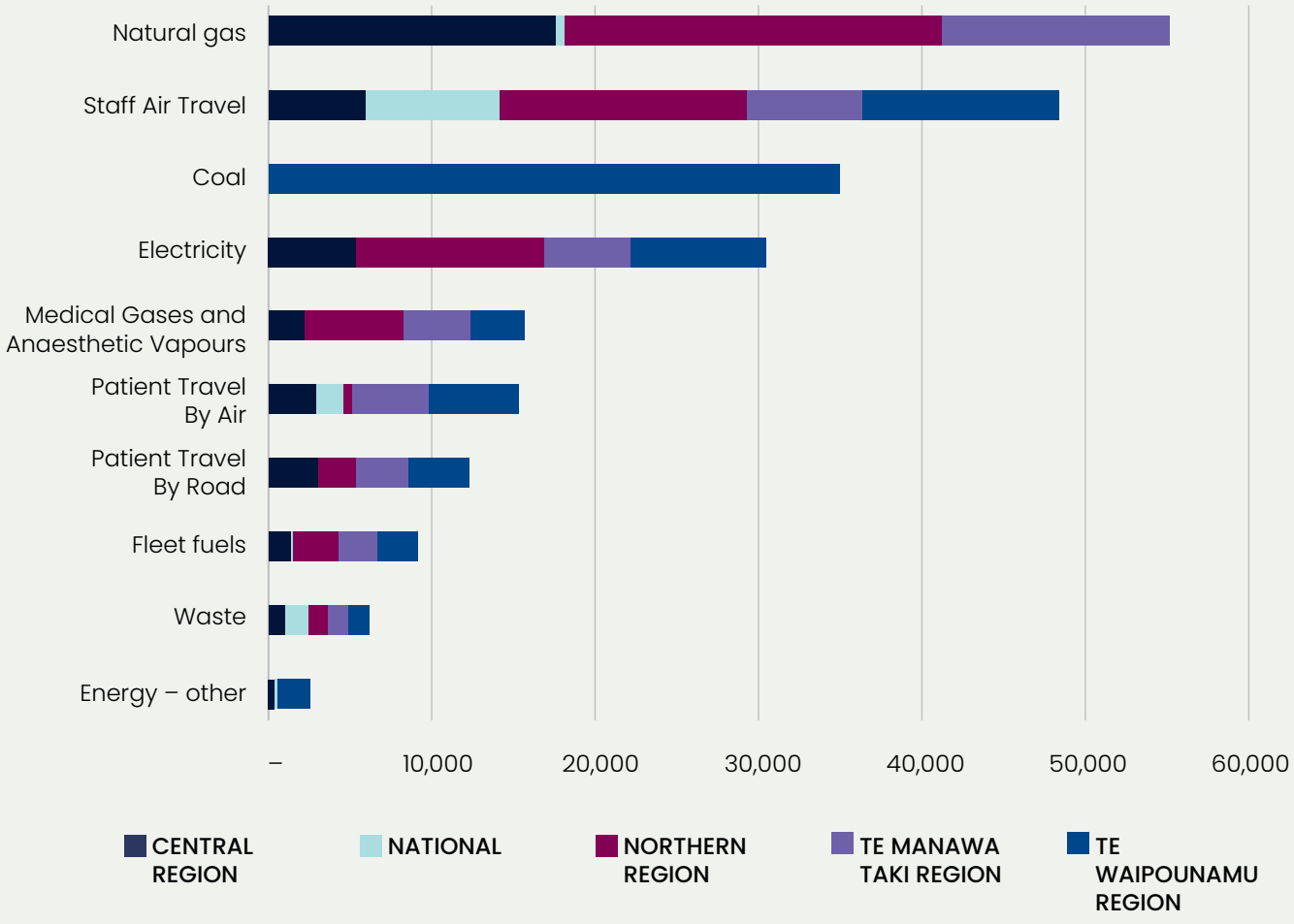
Emissions Reduction Plan

Over the next financial year, Te Whatu Ora will create its first Emissions Reduction Plan, in line with the Carbon Neutral Government Programme, which will include a formalised reporting and governance structure, with quarterly reporting mechanisms and status updates on key projects and investments.

Greenhouse gas emissions reporting

2022-23 is Te Whatu Ora's baseline year for greenhouse gas emissions reporting. The year saw emissions of 237,822 tonnes of carbon dioxide equivalent (tCO_2e), with the top five emissions sources being natural gas, staff air travel, coal, electricity, and medical gases and anaesthetic vapours.

TOP 10 EMISSIONS SOURCES BY VOLUME



Te Whatu Ora emissions profile by category		**tCO_2e**
1	Natural gas	52,909
	Coal	20,491
	Medical Gases – CO_2, N_2O, CH_4, Acetylene	15,097
	Fleet Fuels	9,213
	Stationary Diesel	1,660
	Refrigerants	1,424
	LPG	1,014
	Anaesthetic Vapours – Desflurane, Isoflurane, Sevoflurane	599
	Biomass – CH_4, N_2O	5
Category 1 Total		**102,413**
2	Electricity	27,367
	Purchased steam from coal	14,337
	Purchased steam from biomass and landfill gas	1
Category 2 Total		**41,705**
3	Staff air travel	48,412
	Patient travel by air – Medical plane	9,321
	Patient travel by road – Patient travel claims (NTA)	7,728
	Patient travel by road – Ambulances	4,540
	Patient travel by air – Airline	4,534
	Patient travel by air – Helicopter	3,517
	Accommodation Patients	1,167
	Accommodation Staff	689
	Staff travel other – taxis, rental vehicles	437
Category 3 Total		**80,343**
4	Waste to landfill	6,192
	Transmission and distribution losses gas and electricity	5,127
	Wastewater	1,651
	Distributed Energy	169
	Waste incinerated	102
	Water	120
Category 4 Total		**13,361**
Total gross emissions (tCO_2e)		**237,822**
Biogenic Emissions (tCO_2)		20,154

The table above shows Te Whatu Ora's greenhouse gas emissions profile broken down by emission category.

Due to the significant amount of change within our health system during the first financial year of Te Whatu Ora and the scale of emissions data gathering for all newly combined entities, we will take a phased approach to emissions reporting. This year's report reflects phase one of three phases.

Achievements during the year

The sustainability work across Te Whatu Ora during the year has been extensive and multifaceted. Initiatives over the past year have been both strategic and operational. There has been a significant focus on action in infrastructure, procurement and supply chain, circular economy and waste over the past year. Taking a national approach to these priority areas will deliver emissions reduction benefits, reduce environmental impacts and encourage innovation in years to come.

Climate Risk and Adaptation

Aotearoa New Zealand's National Adaptation Plan requires the health sector to assess its climate risk and help build adaptation implementation blueprints. To date, we have completed a high-level risk assessment of key infrastructure-related climate risks and are working through standardised processes in relation to climate risk and adaptation across the motu. Processes for identifying, assessing, and managing climate-related risk will take a whole of organisation approach linking with other organisational risk management activities.

The broader health sector has commenced work on creating climate change scenarios which will help guide Te Whatu Ora and other health providers' strategic and planning decisions. Over the coming financial year, these findings will help us to identify climate-related risks and opportunities.

Privacy

We are supporting our privacy maturity uplift programme. There are five principles that underpin our values and behaviours.

The five principles are:

- He Tāngata (focus on improving people's lives)
- Manaakitanga (respect and uphold the mana and dignity of the people, whānau, communities or groups who share their data and information)
- Mana Whakahere (empower people by giving choice and enabling their access to and use of their data and information)
- Kaitiakitanga (act as a steward in a way that people understand and trust)
- Mahitahitanga (work as equals to create and share valuable knowledge)

Weaving the principles throughout our day-to-day business reflects our commitment to nurture a culture of trust, transparency, accountability, and respect as stewards of personal and health information.

Advising the Business

Privacy Impact Assessments (PIA) are an essential tool used to identify the potential risks arising from the collection, use or handling of personal and/or health information. These assessments assist projects and teams to make informed decisions and better manage privacy risks.

We have reviewed and refreshed the current PIA template to include Artificial Intelligence (AI) and the guidance from the Office of the Privacy Commissioner. As privacy concerns continue to grow, PIAs play an important role in the responsible management and risk mitigation of the information that we hold.

As technology continues to advance, so do the risks associated with the information that we hold. Building templates, guidance and resources in the privacy space for all our kaimahi will provide the knowledge and tools necessary to understand privacy risk and implement best practice for data protection.

Privacy Maturity Assessment Framework

We have submitted the first Privacy Maturity Assessment Framework (PMAF) for Te Whatu Ora to the Government Chief Privacy Officer. Our maturity results indicate that we have a 'foundational maturity level' across the domains including Core Expectations, Planning, Policies and Practice, and Privacy Domains.

A 'foundational' result is defined as an organisation-wide approach to privacy developing. Good practice occurs in silos, but not at the wider organisational level. Any privacy work programme is driven by individual activities rather than being more embedded in organisation-wide practice.

This was not an unexpected result for a new organisation and the PMAF results will provide useful information when considering areas for focus in our privacy programme for 2023-24.

Privacy breaches

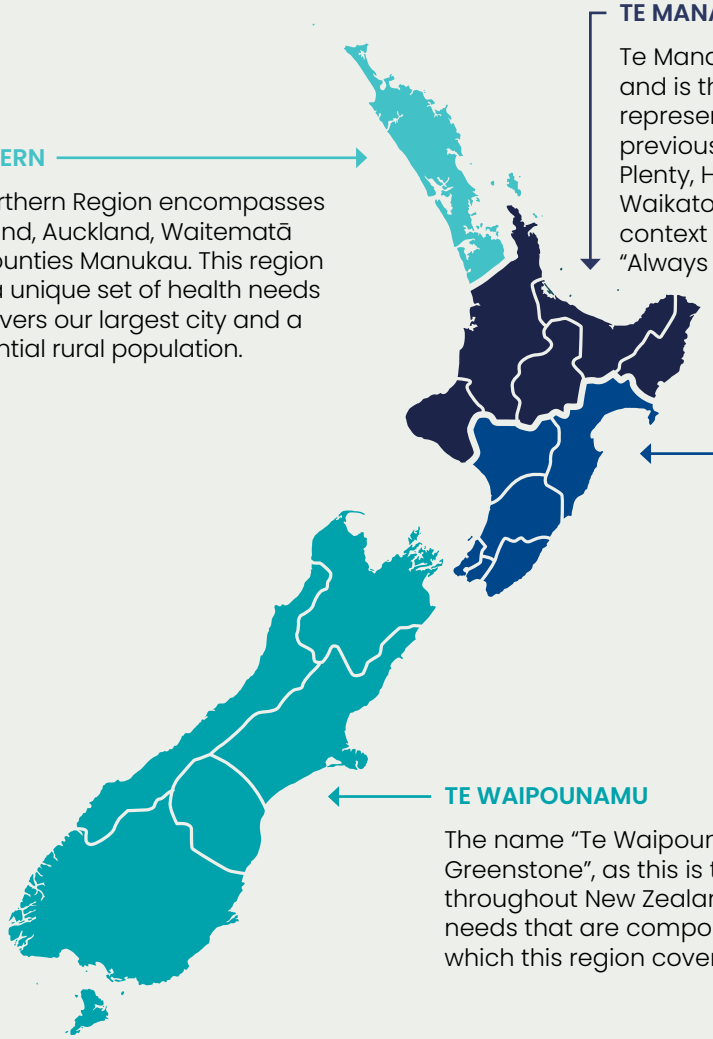
Information about privacy breaches helps to identify and address vulnerabilities within a system or process and we are aware that a low number of breaches are reported to us. A national breach reporting system is being developed and is essential to capture all potential and actual breaches. We are legally obligated to report breaches that may cause harm to the Office of the Privacy Commissioner, and this is done on a regular basis.

Section 3

Our Performance

Regions

Te Whatu Ora's health services are nationally led, regionally planned and locally delivered. We have created four regions to help focus our resources. Throughout this report, we have incorporated news, updates, case studies and performance reporting, where available, from all four regions. The brief descriptions below clarify the range of each region.



TE MANAWA TAKI

Te Manawa Taki means: "The Heartbeat" and is the name gifted and agreed upon to represent this region which encircles the five previous district health board areas of Bay of Plenty, Hauora Tairāwhiti, Lakes, Taranaki and Waikato. The name "Te Manawa Taki" in the context of the combined region represents "Always ready to go".

NORTHERN

The Northern Region encompasses Northland, Auckland, Waitematā and Counties Manukau. This region faces a unique set of health needs and covers our largest city and a substantial rural population.

CENTRAL

The Central Region also consists of five previous district health board areas, namely Whanganui, Capital Coast and Hutt Valley, Hawke's Bay, Mid Central and the Wairarapa. There is a lot of innovation occurring throughout this region.

TE WAIPOUNAMU

The name "Te Waipounamu" literally means "Water and Greenstone", as this is the only place that pounamu is found throughout New Zealand. Again, there is a complex range of needs that are compounded by the large geographical area which this region covers.

Output Class: National COVID-19 Response

Te Whatu Ora took over the operational management of COVID-19 on 1 July 2022, through the latter stages of the response phase and into the ongoing recovery phase. COVID-19 is one of our five output classes. The standard of delivery achieved against this output class is reported from pages 96 to page 104.

In addition to our continued management of the COVID-19 pandemic, we have successfully responded to other serious communicable diseases with outbreak potential such as measles, pertussis, and monkeypox. The ability to leverage each response off the enhanced capabilities developed during COVID-19 has been key to the positive outcomes that have been achieved. Specifically, our enhanced surveillance capability, sophisticated test and trace systems, and our ability to coordinate targeted clinical and manaaki support have considerably strengthened New Zealand's resilience to potential and emergent communicable disease threats.

Progress so far

Our response to COVID-19 has continued to evolve to reflect our high levels of immunity, better access to antivirals, and improved surveillance and diagnostics.

We have also developed a better understanding of the virus and the evolution of more immune evasive variants that can increase transmission without necessarily corresponding to a distinct 'wave' of cases.

We have a largely vaccinated population and an integrated model of care that brings together clinical, health and welfare support to provide wraparound care to individuals and their whānau in the community.

AS OF MIDNIGHT 14 AUGUST 2023, ALL COVID-19 RESTRICTIONS WERE LIFTED.

Key facts and figures

During the 2022-23 year:

- 1.065m COVID-19 cases were reported.
- More than 188m items of PPE, 36.6m RATs and 380,000 litres of hand sanitiser were distributed to over 6,000 health and disability support services.
- 1.45m doses of COVID-19 vaccine were administered.
- 156,491 courses of anti-viral therapeutics were dispensed.
- Our healthcare providers conducted a combined total of approximately 1.2m Polymerase Chain Reaction (PCR) tests and assisted Rapid Antigen Tests (RATs).
- Approximately 29,500 cases within the Māori and Pacific priority group (aged 35 years and over) completed their case investigation via the telehealth service. This contributed to the completion rate being 8% *higher* than the rest of the population. Without prioritised telehealth support for case investigation, the case investigation completion rate for the priority group was 15% *lower* than the rest of the population.
- 1,940 people died with COVID-19.

Case Mortality

Case mortality is the percentage of a country's population that dies as a result of a disease.

The New Zealand comprehensive whole-of-system response, including targeted healthcare services, contributed to a case mortality rate of 0.1% which is significantly lower than other countries such as Canada and United States with a rate of 1.1% each, the United Kingdom with a rate of 0.9%.

Evolving operational response

In September 2022, following the removal of the COVID-19 Protection Framework and in line with the Government's move to a long-term strategic approach to COVID-19, we increased our focus on building COVID-19 resilience by promoting community wellbeing, and targeting our response. This was done by:

- continuing to support cases to isolate in the community
- case investigations
- access to anti-viral therapeutics
- vaccination services to those most vulnerable to the virus.

Throughout the year, we worked alongside health agencies to review the public health settings for COVID-19 and supported the gradual removal of measures, proportionate to risk, with consideration of the impact this would have on communities and those most vulnerable to the virus.

Refined approach

Over the first six months of 2023, Aotearoa New Zealand's COVID-19 Response was further refined through a scaled approach to minimise the demand that COVID-19 places on the wider health system, instead targeting services and community-led programmes to those communities at greatest risk of serious illness from COVID-19.

COVID-19 services contribute to an integrated whole-of-system response. This includes access to testing and anti-viral therapeutics. Case investigation ensures that people can receive healthcare and support services in a timely manner, including those offered through the Care in the Community initiative.

Next steps

Looking ahead, we continue to transition to a new business-as-usual model in managing COVID-19 as an endemic communicable disease. The COVID-19 Strategic Framework recognises that while we work to transition our management of COVID-19 to a new business-as-usual model, COVID-19 still presents unique challenges. Equity and proportionality are principles of this framework.

Measure	Result	Target	Status
Continue COVID-19 response and integrate into business as usual		Milestone report	✓

We have refined the COVID-19 Response through a scaled approach to minimise the demand that COVID-19 places on the wider health system and to transition COVID-19 services to our "new" business-as-usual. This approach is focused on providing services and community-led programmes to those communities at greatest risk of serious illness from COVID-19, including Māori, Pacific peoples, Tāngata whaikaha | Disabled people, the elderly and the otherwise clinically vulnerable.

Measure	Result	Target	Status
% of 12+ who have completed a primary course since the beginning of the COVID-19 pandemic to 30 June 2023	Māori **83.1%**	–	–
	Pacific **88.8%**		
	Asian **94.3%**		
	Non-Māori/ Non-Pacific/ Non-Asian **90.8%**		
	Total **90.1%**		
% of eligible 18+ who have received a first booster since the beginning of the COVID-19 pandemic to 30 June 2023	Māori **55.9%**	–	–
	Pacific **61.1%**		
	Asian **75.4%**		
	Non-Māori/ Non-Pacific/ Non-Asian **76.8%**		
	Total **72.9%**		
% of eligible 50+ who have received a second booster since the beginning of the COVID-19 pandemic to 30 June 2023	Māori **46.1%**	–	–
	Pacific **40.2%**		
	Asian **39.2%**		
	Non-Māori/ Non-Pacific/ Non-Asian **58.2%**		
	Total **54.3%**		

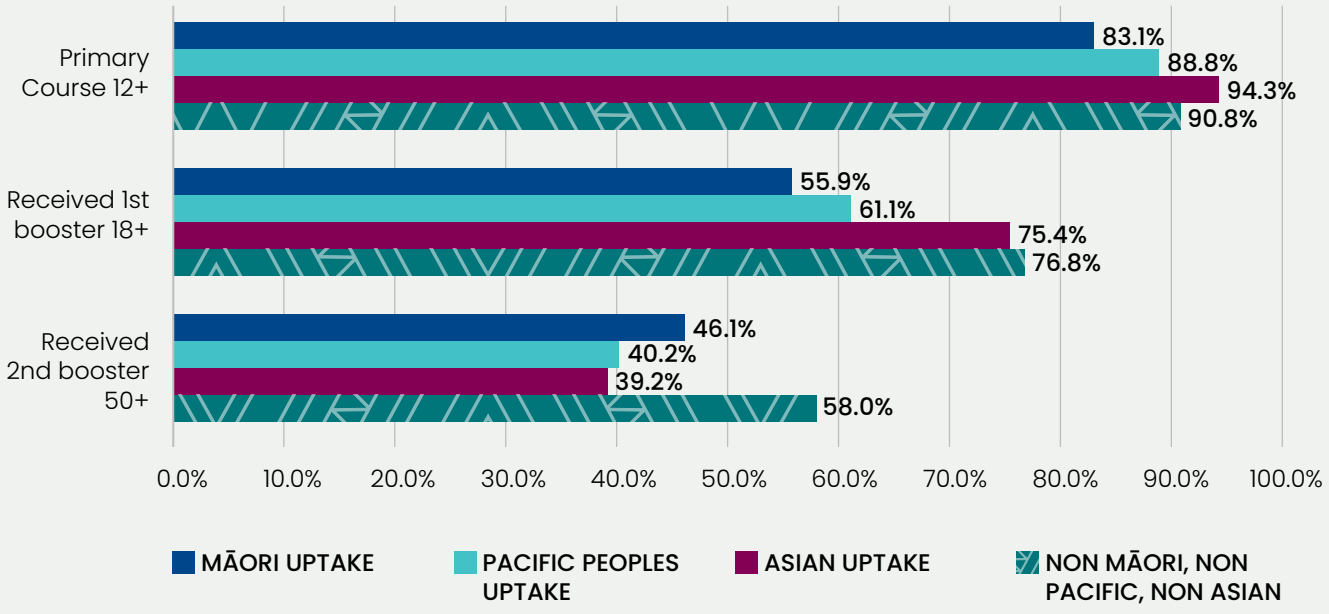
The National Immunisation Programme at Te Whatu Ora continues to track New Zealanders' uptake of COVID-19 vaccines. Monitoring levels of vaccine uptake enables us to understand the level of immunity to COVID-19 in our communities.

However, the National Immunisation Programme does not measure COVID-19 vaccinations as an annual uptake percentage, and therefore figures for the 2022-23 financial year are not able to be provided. Uptake is calculated cumulatively as at the end of June 2023, from the beginning of the COVID-19 Vaccination and Immunisation Programme (19 February 2021).

The data for this reporting was extracted on 07 September 2023. The HSU (Health Service User) population used is the most recent Calendar Year HSU population available – CY 2022. Comparing these numbers with what was published on 30 June 2023 on the Te Whatu Ora website, there will be slight differences due to retrospective data updates/changes.

The HSU is an estimate of the population using the health system in New Zealand. A person is included in the HSU if they use health services (including births and deaths) in the reference period or are enrolled in a primary health organisation (PHO), during the reference period.

COVID-19 VACCINATION UPTAKE SINCE THE BEGINNING OF THE COVID-19 PANDEMIC TO 30 JUNE 2023



More COVID-19 vaccine data can be found on our website at COVID-19 vaccine data – Te Whatu Ora – Health New Zealand including a view of vaccinations administered by week from the beginning of the COVID-19 vaccination programme in February 2021.

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[1]:

1. Census counts produced every 5 years with a wide range of disaggregations
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 Manatū Hauora using requested ethnic groupings and district health board 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 residents
- 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.

1. www.stats.govt.nz/reports/review-of-health-service-user-population-methodology/

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.'[2]

While Stats NZ is the preferred source of New Zealand population statistics, the HSU is considered by Manatū Hauora 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
- district health board
- 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).

2. 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/

Comparison of HSU 2021-22 to the Stats NZ Projected Resident Population

The differences between the HSU datasets and Stats NZ Projections of the Resident Population (PRP) are demonstrated in the New Zealand population by ethnicity tables, below, for HSU 2021-22.

Comparison of HSU 2021-22 to the Stats NZ PRP

As at 30 June 2022, there are 5.3m health service users in the HSU 2021-22. This is an increase of 144,656 people from the HSU 2022-21 as at 30 June 2021; and 157,211 more people than the Stats NZ PRP as at 30 June 2022.

New Zealand population by prioritised ethnicity: HSU 2021-22 and Stats NZ PRP comparison

Prioritised ethnic group	HSU 2021-22	Stats NZ PRP	Difference (Note 1)
Māori	819,289	889,100	-69,811
Pacific peoples	398,483	367,200	31,283
Asian	847,270	819,400	27,870
European and Other	3,216,169	3,048,300	167,869
Total (Note 1)	**5,281,211**	**5,124,000**	**157,211**

Note 1: The total population estimate based on HSU 2021-22 (as at 30 June 2022) is 5,281,211. This is 157,211 above the Stats NZ total projected population of 5,124,000 (as at 30 June 2022) taken from the customised 2018-base population projections Stats NZ produced in 2022.

Further measures related to our COVID-19 response

Measure	Result	Target	Status
Number of COVID-19 vaccine doses purchased by Te Pātaka Whaioranga-Pharmac and received by Te Whatu Ora-Health New Zealand in central storage facilities	Achieved	Achieved	✓
For the 2022-23 financial year period, a total of 5,584,190 COVID-19 vaccine doses were received by Te Whatu Ora in central storage facilities. Responsibility for the ongoing management and purchase of COVID-19 vaccines was transferred from Manatū Hauora to Te Pātaka Whaioranga-Pharmac from 1 July 2022.			
Number of approved COVID-19 vaccines administered to individuals in line with the policy setting	Achieved	Achieved	✓
During 2022-23, we delivered 1,452,256 COVID-19 vaccines to individuals across Aotearoa New Zealand in line with the policy setting of the time.			
Minimum of 90% of New Zealanders can access COVID-19 testing within a 20 minute drive to a testing point. This includes priority population groups and people at higher risk of serious illness from COVID-19	Achieved	Achieved	✓
>96% of the general population lived within a 20 minute drive of a collection site and >95% of Māori were within a 20 minute drive of a collection site in financial year 2022-23. This measure was important to ensuring that COVID-19 testing points were accessible when PCR samples were the diagnostic test for COVID-19. Access to COVID-19 testing increased in the 2022-23 year as Rapid Antigen Tests (RATS) were introduced as the primary mode of testing, alongside PCR, during the Omicron response in early 2022, and access to RATs further expanded as part of the Winter Package. This measure is calculated by looking at the number and geographic coverage of priority population groups by community providers contracted by Te Whatu Ora to deliver assisted Rapid Antigen Tests RATS (including Māori providers); the number and geographic coverage of RATs delivered to aged residential care facilities and the disability community etc.			
Providers are enabled to deliver COVID-19 vaccinations in line with national guidance, operations policies, and service standards	Achieved	Achieved	✓
During the 2022-23 year, COVID-19 immunisations were administered through 1,100 facilities across Aotearoa New Zealand. This is not where the vaccination took place and a facility will often supply the vaccines to multiple sites. During the 2022-23 year, COVID-19 immunisations were administered through 1,499 sites across Aotearoa New Zealand.			

Measure	Result	Target	Status
Monitoring border worker testing compliance through the Border Worker Testing Register (PCR testing)	Not applicable	Greater than 90% compliance	–
The COVID-19 Public Health Response (Required Testing) Order 2020 was revoked on 30 June 2022, and compliance activity ceased. Therefore, this performance measure ceased to be applicable for the financial year 2022-23.			
Maintain Public Health contact tracing and case management capacity through scalable telehealth services and digital pathways in line with response/ pandemic requirements	Achieved	Up to 1,000 cases per day	✓
The National Case Investigation Service (NCIS) maintained a significant level of case investigation capacity across the country which supported public health services throughout the 2022-23 year. The total number of cases from the period 1 July 2022 to 30 June 2023 was 1,050,072 which gives an average number of cases per day of 2,877. With the arrival of the Omicron variant in early 2022, case investigation services were refined to focus on priority populations and those most vulnerable. Use of digital enablers for case investigation and contact tracing also increased over this time. This resulted in 64% of case investigations being completed by the case (unassisted) and a further 11% of cases received assistance from the NCIS to complete their case investigation.			
Maintain an average of 12-week stock in Ministry's National Protective Equipment (PPE) and Critical Medical Supply Chain	Achieved	Achieved	✓
Te Whatu Ora manages a national stockpile of core PPE and other consumables for pandemic usage and to support continued preparedness and response for emergencies. Te Whatu Ora has maintained the minimum 12-week, high pandemic holding level across the majority of products, with breaches of short duration experienced across a few product lines due to peaks in demand around July 2022 while awaiting arrival of pending orders. There have been no breaches since October 2022, when systems were revised to better manage to the 12-week holding level. Product usage levels are now more stable which allows for greater certainty in product management.			

Budget 22 Initiative: updates

Population Health and Disease Management Digital Capability

This initiative provides ongoing funding to retain selected capability and infrastructure developed in response to the COVID-19 pandemic and to provide a basis for future population health and disease management digital capability.

HEALTHCARE IN ACTION

Connections were key to COVID-19 response

The COVID-19 Care in the Community team, at Te Whatu Ora Hawke's Bay, were the logistics engine which connected across health, welfare and social providers to deliver a successful and necessary wraparound service to those needing assistance during the pandemic. The Care in the Community team says people from all corners of the region worked collaboratively and put the needs of the community first in what was a difficult time for many.

People were redeployed into hubs that worked in the community, enabling them to get a feel for what was needed and provide support quickly whether that be kai or hygiene packs for whānau or referring people on to the right service. Our hubs played a really important role to ensure that nobody slipped through the cracks.

Sonam Bhandari, a Community Connector for the Multicultural Association Hawke's Bay was one of the many working in a hub to provide information and education to the diverse communities in Hawke's Bay.

Coming together for the sake of the community was critical to the success of Hawke's Bay's COVID-19 response and the template is there for success in future health responses.

"DURING THE PEAK COVID-19 OUTBREAK, WE WERE CHECKING IN WITH FAMILIES, AND REFERRING THEM TO DIFFERENT SERVICES IF NEEDED. LANGUAGE IS STILL A BARRIER FOR MANY MULTICULTURAL FAMILIES, SO WE MADE SURE THEY UNDERSTOOD WHAT WAS GOING ON AND WHAT HELP WAS AVAILABLE TO THEM."

Care in the Community Hawke's Bay Team

Output Class: Public Health

Public health services improve community health and wellbeing by working with communities and whānau 'upstream' to promote health and wellbeing and prevent or minimise illness and disease.

As well as improving quality of life for people across Aotearoa New Zealand and boosting longevity, this helps to reduce the impact of illnesses on the health system. Public Health is one of our five output classes. The standard of delivery achieved against this output class is reported on page 107 to page 136.

The National Public Health Service (NPHS) has brought together public health teams across the motu including Te Hiringa Hauora (the Health Promotion Agency), the 12 public health units that covered 20 former district health boards, and several teams and units from Manatū Hauora.

As part of ensuring the best use of public health resources, the focus is on providing tailored solutions for communities that are more likely to be affected by illness and disease, including whānau Māori, Pacific peoples and Tāngata whaikaha I Disabled people. This new integrated approach is being used to improve everything from our immunisation and cancer screening programmes through to the management of infectious diseases and extreme weather events like Cyclone Gabrielle.

Why is this important?

Much ill health is preventable. We can reduce the burden of illness on families, and reduce demands on our healthcare services, by investing in preventative approaches before illness occurs.

The NPHS provides health interventions that help to promote good health and prevent or reduce the impact of illnesses and diseases, such as immunisations that protect people from getting sick from a range of illnesses from measles, whooping cough and polio through to the flu and COVID-19. We also help to detect diseases like cancer earlier through screening programmes, so that we can help people to access treatments earlier and improve their life expectancy.

Most illness and disease are caused by factors outside the health system. Public health services minimise the causes of illness by improving physical, social, economic, commercial and cultural environments. We work to minimise factors for ill health, such as alcohol and smoking, and promote healthy behaviours including healthy eating and physical activity.

We also work with other sectors to advocate for action on the determinants of health, which include factors like housing, transport and education that affect our opportunities to live healthy lives.

Progress so far

The National Public Health Service (NPHS) is being led with an equity-by-design perspective with input from Te Aka Whai Ora and Pacific Public Health.

The NPHS kaupapa is:

Manaakitia ngā whānau mō pae ora

Enable whānau and communities to lead lives of wellness

Measure	Result	Target	Status
Establish a nationally integrated public health service with consistent operating models	Milestone report		↑

The full establishment of an integrated public health service will be completed by December 2023 with the ongoing development of consistent operating models continuing through 2023-24. This was a Budget 22 initiative.

Promoting good health for all New Zealanders

Health promotion is a key part of our work to provide evidence-based health promotion initiatives that support all New Zealanders to live healthy lives. In 2022-23, the main programmes of mahi focused on:

- Alcohol: Using evidence-based advice to help improve alcohol policy and supporting interventions to improve the drinking culture in Aotearoa
- Mental Wellbeing: Responsibility for Nōku te Ao, and the depression.org.nz, Small Steps and thelowdown.co.nz websites
- Wellbeing Through Prevention: Tobacco control and minimising gambling harm
- Child and Youth Wellbeing: First 1000 Days and Youth Wellbeing
- Health Education Resources: A catalogue of health resources
- Additional activities and projects including a stroke F.A.S.T. campaign.

We delivered several important campaigns during the year including:

- an awareness campaign for Hepatitis C, which won the TVNZ Excellence in Public Sector/Government Marketing Strategy
- He Tuinga Aroha highlighting the protective benefits of strong communication within families
- Al – Let's Talk About Sex about providing supportive and informative kōrero about sex for rangatahi by rangatahi
- Nan's Song, reflecting on culture to protect communities from gambling harm
- Tapu Vā, providing a safe space for talanoa about sex and wellbeing.

Promotional image from Al – Let's talk about sex campaign

Cyclone Gabrielle Response

The National Public Health Service was able to respond quickly to Cyclone Gabrielle by creating key factsheets covering health, food safety, your home, water, silt, and sewage.

These were translated into four main languages (Māori, Fijian, Samoan and Tongan) and made into accessible formats including New Zealand Sign Language, Large Print, Audio and Braille versions.

Previously, each Public Health Service created its own documents that were not easily or quickly shared across regional boundaries and could contain inconsistent information. To have a single source of information saves time, resources and mitigates any conflicting messaging.

Te Whatu Ora's Team approach

We were able to respond quickly to Cyclone Gabrielle with better coordination supported by our 'team of teams' approach.

A National Response Team was established to coordinate and deploy resources from across the motu to where they were needed most. More than 1,000 kaimahi volunteered to travel to areas severely impacted by the cyclone to allow colleagues in the worst-hit areas to take much needed time out to focus on their own homes and families.

Our Data and Digital emergency management capability for major incident responses (including Emergency Operations Centre) was called on.

We established Critical Response Centres in Napier and Hastings, and our teams worked around the clock to facilitate recovery efforts. Our systems and interfaces were able to fully function, restoring reliable mobile communication not only for hospitals but for rural community health centres. Starlink devices were also deployed into the community, providing connectivity to those who needed it most.

HEALTHCARE IN ACTION

Healthcare and aroha being choppered to rural communities

Helicopters loaded with health professionals, medications and a hearty dose of aroha provided culturally-led, clinically-partnered outreach to cut-off rural Hawke's Bay communities.

Te Whatu Ora Pou Whirinaki Duayne Davies, who led the Isolated Rural Communities āwhina response, says general practitioners (GPs), nurse practitioners, kaiāwhina, psychologists, psychiatrists and mental health workers have visited at least 12 rural communities since the cyclone wreaked havoc on Hawke's Bay.

"Seeing the need through a cultural lens has been critical to our mission's success," Mr Davies says.

Te Whatu Ora worked in partnership with Te Aka Whai Ora and alongside the New Zealand Defence Force, Civil Defence, Police, Fire and Emergency NZ, St John, Ministry for Primary Industries, Ministry of Social Development, Red Cross and Iwi liaisons.

There were a number of Budget 22 initiatives to support severe weather events.

New Zealand Defence Force helicoptering Te Whatu Ora staff to isolated communities in the aftermath of Cyclone Gabrielle

Budget 22 Initiatives: updates

North Island Weather Events: Hospital and Specialist Services

This initiative provides funding for air and road transport enabling planned care, outreach, and other hospital services for isolated communities. It also funds alternative provision of acute healthcare, and urgent repairs to hospital facilities as a result of the impact of the North Island weather events.

Examples include providing air or road transportation for patients requiring acute services (e.g., outpatient appointments), flying clinicians into isolated areas to deliver outreach acute services, the establishment and operation of a temporary Emergency Department in Napier, locum clinics in Esk Valley and alternate provision of acute services to isolated communities in Northland and Tairāwhiti.

North Island Weather Events: Mental Health and Wellbeing Response

This initiative provides funding for locally led, community-based mental wellbeing initiatives to meet the psychosocial care need for populations in areas affected by the North Island weather events, including Māori, Pacific peoples and youth.

During the immediate response phase we provided additional local mental health and addiction capacity as required and since then a range of local and national mental wellbeing recovery initiatives have been put in place.

North Island Weather Events: Primary, Community, and Residential Care Recovery

This initiative provides funding to support provision of primary, community and residential care services to the population affected by the North Island weather events.

We provided Primary Care Workforce relief (general practice and pharmacy) including Locum GP, pharmacy, and nursing staff and covering salaries, accommodation and travel.

We increased national telehealth capacity and provided equipment for practices to be able to support high quality telehealth consultations (e.g., lighting, cameras, laptops).

North Island Weather Events: Transport and Power

This initiative provides funding for leasing suitable additional vehicles to provide for patient access where road infrastructure is compromised, and generators and diesel for the continued operation of health services while repairs are undertaken.

We purchased 32 generators to ensure business continuity during ongoing power outages.

Immunisation

Influenza vaccine

On 1 April 2023, access to the free influenza vaccine was widened to include all children under 12 years of age, and all Māori and Pacific people aged 55 to 64 years of age. It is estimated that an extra 870,000 people are now eligible to get funded vaccines. This year, we reached 1m doses faster than in any other year.

The flu vaccine provides people with important protection from getting very sick and ending up in hospital, which in turn helps to reduce the impact on health services over winter. It also provides some protection against people catching flu in the first place.

Measure	Result	Target	Status
Influenza immunisation rates for those aged 65+	Māori **54%** Pacific **52%** Asian **53%** Non-Māori/ Non-Pacific **65%** Total **62%**	75%	↓

Baseline period (Statement of Performance Expectations 2022-23): 2021 calendar year

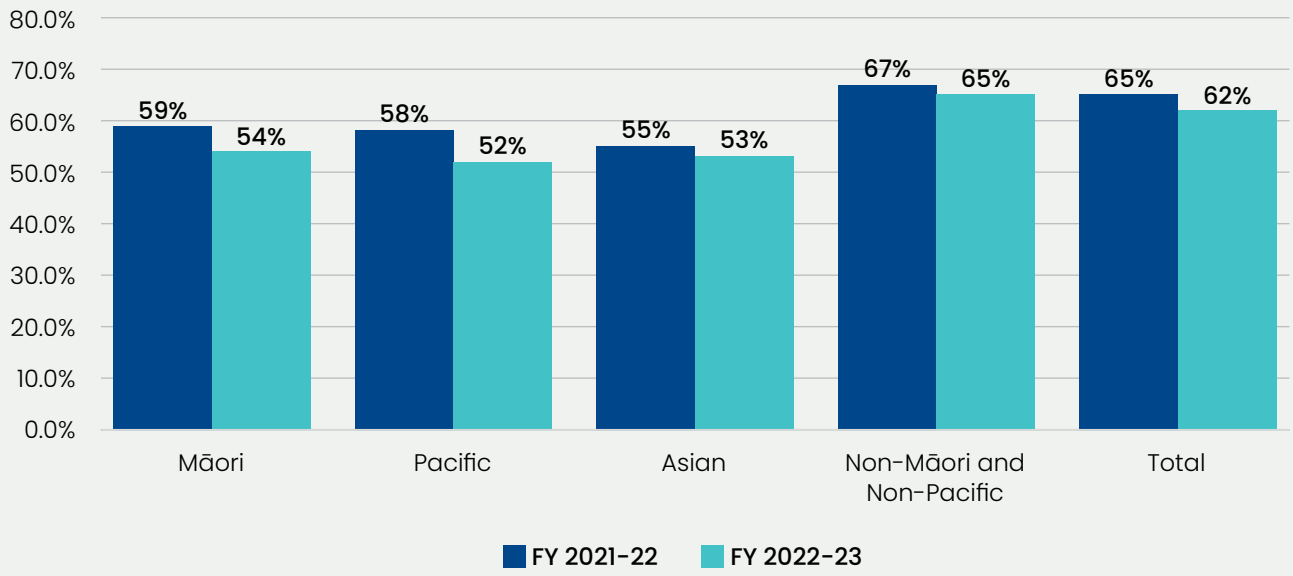
Baseline value: Māori 53%, Pacific 67%, Non-Māori and Non-Pacific 64%

This measure, as shown above, uses the wording from our Statement of Performance Expectations 2022-23. NOTE that the measure is recorded in the Vote Health Estimates of Appropriation 2022-23 with the alternative wording: Percentage of eligible people aged 65 years and over enrolled on the National Immunisation Register who have completed at least one influenza vaccination for the given vaccination year.

Winter is a particularly demanding time for our health system with parts of the system operating at high volumes. Influenza immunisation, available from 1 April each year before winter starts, is an important part of Te Whatu Ora's winter preparedness plan supporting our health system to continue operating effectively. Those over 65 years are at a higher risk of increased disease severity and likelihood of complications then other groups.

By measuring the rate of vaccination in this group we are focused on ensuring people are supported to live well in the community, avoiding unnecessary hospitalisations. We are continuing to progress and implement strategies to improve uptake of flu vaccinations for those over 65 years of age. This includes growing our Māori and Pacific immunisation workforce and providers to deliver this. More work is required in this area, and it is anticipated that the benefit of this will not be fully realised till 2024-25, noting that the delivery of flu vaccine crosses the financial years (April – October) and therefore measuring the outcome of activity and changes will not be fully visible till 2024-25.

INFLUENZA IMMUNISATION COVERAGE FOR THOSE AGED 65+, BY ETHNICITY



The Aotearoa Immunisation Register (AIR)

The AIR is replacing the ageing register known as the National Immunisation Register (NIR). The AIR is used to help control the spread of infectious diseases by providing information about immunisation coverage across the population and by keeping a record of the vaccinations New Zealanders have received or chosen not to receive.

We are now completing phase two of this project – building all the key components that are required to support the future state of the AIR, while co-existing with the NIR and COVID-19 Immunisation Register (CIR). The AIR vaccinator portal continues to support the flu 2023 campaign. The 200,000th flu immunisation was recorded by June 2023.

Human Papillomavirus (HPV) programme

HPV is a group of very common viruses that infect about 80% of people in their teenage years. HPV spreads through intimate skin-on-skin contact. Most HPV infections get better on their own, but sometimes they can cause a number of different cancers for all genders later in life – such as cervical and throat cancer.

HPV immunisation began in New Zealand in 2008. On 1 January 2017, HPV immunisation became free for everyone aged nine to 26, including non-residents under the age of 18. HPV immunisation aims to protect young people from HPV infection, the risk of developing cervical cancer and a range of other HPV-related diseases later in life.

The HPV vaccine, together with the cervical screening programme, plays an important role in reaching our goal of eliminating deaths from cervical cancer in Aotearoa New Zealand.

Measure	Result	Target	Status
HPV immunisation rates	56.7%	75%	↓

Baseline period (Statement of Performance Expectations 2022–23): 2021–22 financial year

Baseline value: Māori 57%, Pacific 67%, Non-Māori and Non-Pacific 65%

NOTE this measure is recorded with alternative wording in the Vote Health Estimates of Appropriate 2022–23: Percentage of girls and boys born in the relevant birth cohort who have completed their HPV immunisation course as per Schedule and recorded on the NIR fully immunised.

Human papillomaviruses (HPV) are a group of common viruses spread through skin-to-skin contact. Some are sexually transmitted and can cause genital warts and a range of types of cancer. There are more than 150 types of HPV, at least 14 of these are high-risk types linked to cancer. This measure is important as it enables us to monitor the proportion of our rangatahi who have been protected against these illnesses.

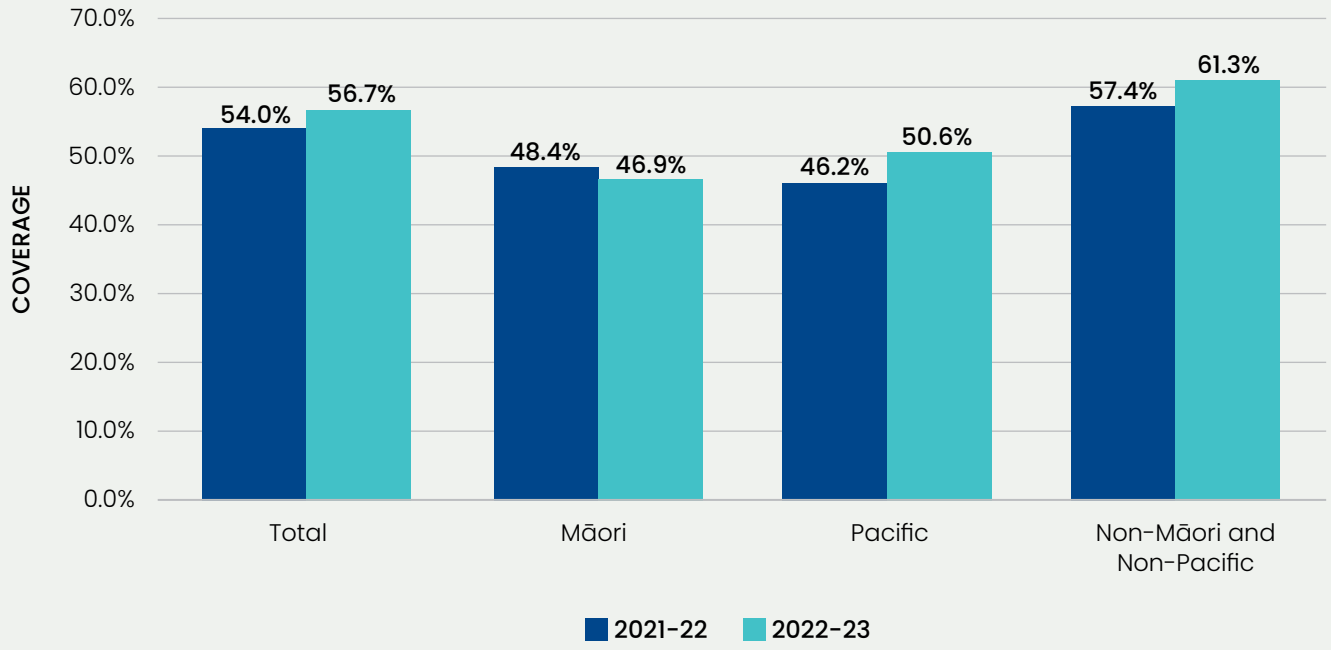
Rates of HPV immunisation are measured for a single birth cohort across a reporting (financial) year. Coverage is calculated as the percentage of rangatahi actively enrolled on the National Immunisation Register (NIR) who were born in the relevant year and are recorded as being fully immunised against HPV (as clinically indicated, however generally having received two doses) by 30 June. For the year 1 July 2021–30 June 2022, the 2008 birth cohort was measured and for 1 July 2022–30 June 2023 those born in 2009. The baseline in the Statement of Performance Expectations 2022–23 did not specify which cohort the baseline was calculated for.

Nationally, 56.7% of the 2009 birth cohort were considered fully immunised against HPV at the end of June 2022–23, compared to 54.0% of the 2008 birth cohort the previous year. At 30 June 2023, 70.5% of 2009 rangatahi had received at least one dose of HPV vaccine.

Within the total coverage, rates of Māori coverage decreased from 48.4% to 46.9% (1.5 percentage points), and Pacific coverage increased from 46.2% to 50.6% (4.4 percentage points). There is wide variation in the number of rangatahi fully immunised against HPV at a local level.

The HPV Immunisation Programme is working with an external provider to review the school-based immunisation programme, including HPV immunisation delivery, to identify strategies to support uptake of the vaccine, particularly for Māori and Pacific.

HPV IMMUNISATION RATES



*Data reported as at 07 July 2022 and 10 July 2023. National coverage includes those of unknown/unassigned address. The information contained in this report has been derived from the National Immunisation Register.

Increasing vaccination role for pharmacies

Pharmacies are offering an increasing range of healthcare services for our community, with Influenza, COVID-19, Tdap and MMR vaccinations now able to be administered by Pharmacist Vaccinators. For example, in the first week of April 2023, pharmacies delivered 84.6% of all COVID-19 vaccinations administered in primary care in Canterbury.

More generally pharmacies play an important role in helping us to reach a range of communities due to their proximity for many people, opening hours and ability to just 'walk in' without an appointment in many locations.

The benefit of childhood immunisation is well established, protecting children from avoidable health complications and contributing to a reduction in community transmission. This measure allows us to track the progress towards the achievement of the Kahu Taurima | Maternity and early years actions in Te Pae Tata, ensuring we lay the best foundations for lifelong health and wellbeing.

Te Whatu Ora is focused on enabling system design and the implementation of the Immunisation Taskforce recommendations. Meeting any targets will require a fundamental shift in placing Māori, Pacific and Tāngata whaikaha | Disabled people at the centre of any redesign of the immunisation system to create more flexible and culturally focused models of care that address current equity gaps. This will require a stepped target over two years, given the significant change required. Coverage of 95% is required to achieve population immunity and protects children from vaccine-preventable disease. All the following childhood immunisation coverage results are for the financial year 2022-23, with Quarter 1 being from 1 July 2022 to 30 September 2022 and so on.

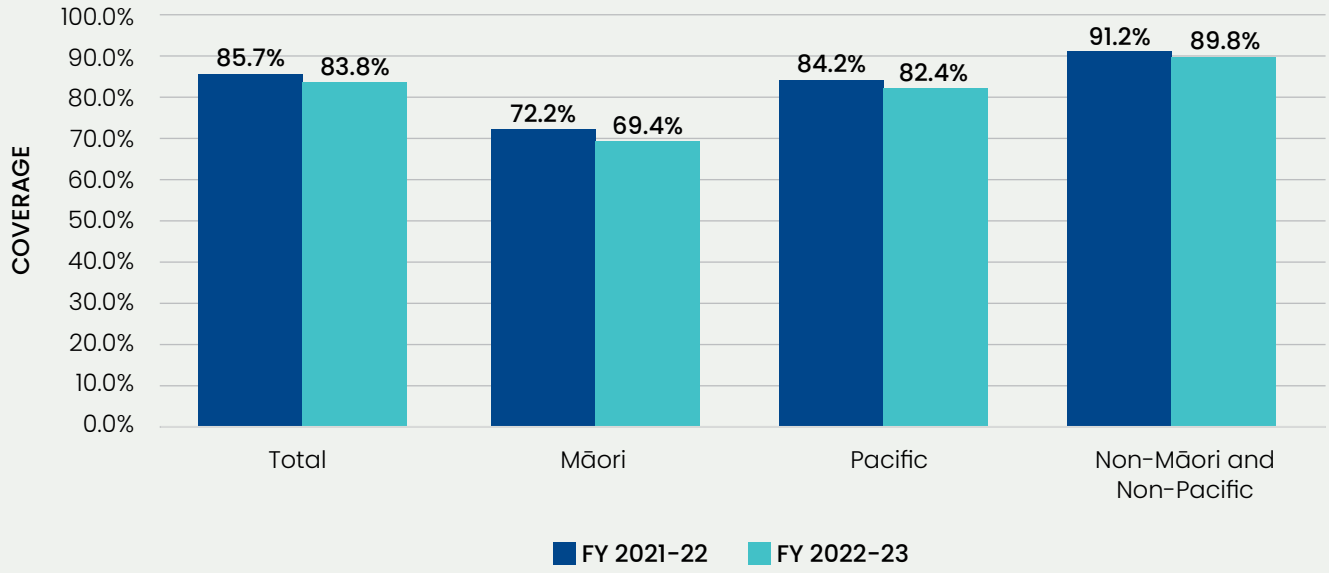
Measure	Result as at Q4 2022-23	Target	Status
Percentage of eligible eight-month-olds enrolled on NIR fully immunised – age-appropriate immunisations	Māori **69.4%**	Māori **95%**	↓
	Pacific **82.4%**	Pacific **95%**	
	Non-Māori and Non-Pacific **89.8%**	Non-Māori and Non-Pacific **95%**	
	Total population **83.8%**	Total population **95%**	

This important measure lets us track the uptake of key vaccines against avoidable illnesses that include diphtheria, tetanus, hepatitis B, polio and measles. This helps us know the extent to which our infants are protected from infections that can be serious.

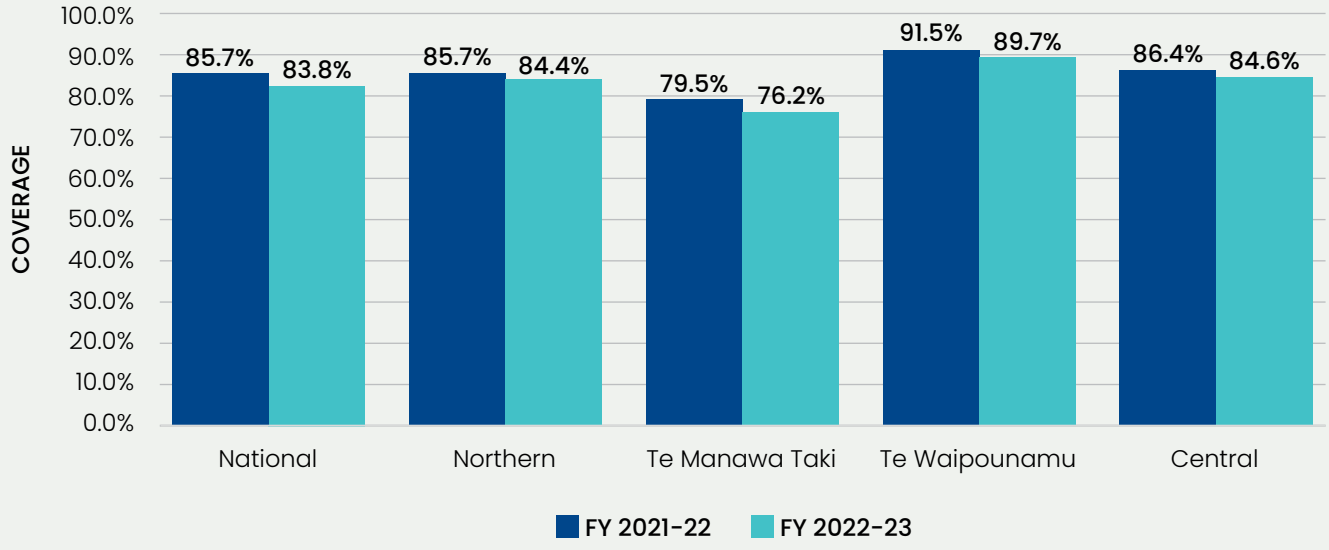
Immunisation coverage at age 8 months is calculated as the percentage of children enrolled on the National Immunisation Register (NIR) who turned 8 months old during the reporting period and are recorded as being fully immunised according to the National Immunisation Schedule by the time they turned 8 months.

Coverage rates for pēpi Māori are up to 20.4% lower than for Non-Māori and Non-Pacific for this age group. 2022-23 compared to 2021-22 coverage at 8 months remained largely unchanged within regions.

IMMUNISATION COVERAGE AT 8 MONTHS, 12-MONTH REPORTING PERIOD ENDING 30 JUNE 2023, BY ETHNICITY



IMMUNISATION COVERAGE AT 8 MONTHS, 12-MONTH REPORTING PERIOD ENDING 30 JUNE 2023, BY REGION



Measure	Result	Target	Status
Percentage of children with all their vaccinations by age 2 years	Māori **68.2%** Pacific **80.6%** Non-Māori and Non-Pacific **88.1%** Total population **82.4%**	95%	↓

NOTE that the Te Whatu Ora Statement of Performance Expectations 2022-23 also included this measure and recorded a target of 75%, instead of the 95% target recorded for the measure in the Vote Health Estimates of Appropriation 2022-23 which we report against here. We believe the Statement of Performance Expectations target to have been entered incorrectly.

Baseline period (Statement of Performance Expectations 2022-23): 2021-22 financial year

Baseline value: Māori 70%, Pacific 82%, Non-Māori and Non-Pacific 90%

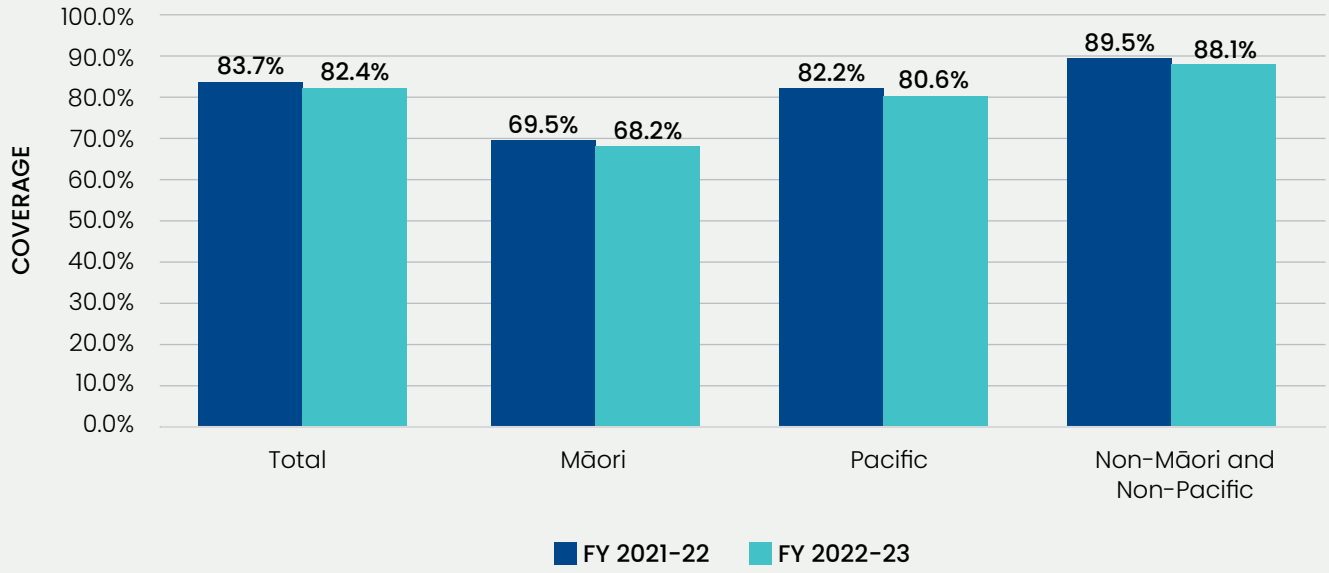
Like the previous measure, this important measure lets us track the uptake of key vaccines against avoidable illnesses that include diphtheria, tetanus, hepatitis B, polio and measles. This measure, focusing on our toddlers, helps us know the extent to which they are protected from infections that can be serious.

Quarterly immunisation coverage at age 24 months is calculated as the percentage of children actively enrolled on the National Immunisation Register (NIR) who turned 24 months old during the financial quarter and are recorded as being fully immunised according to the National Immunisation Schedule by the time they turned 24 months.

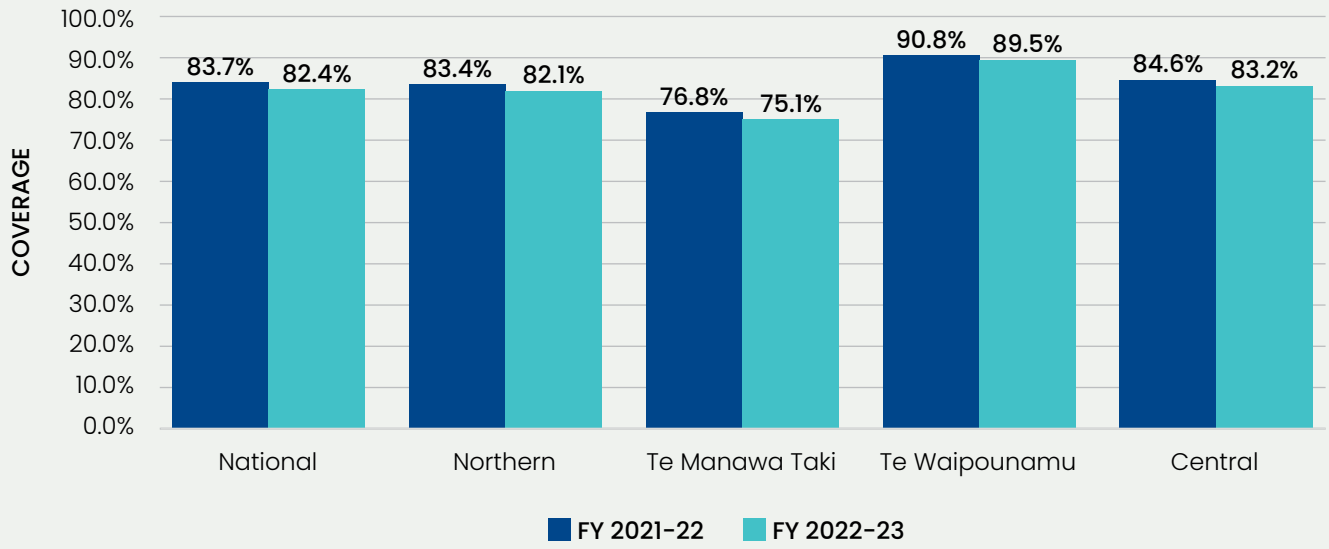
Nationally, coverage of immunisaton at 24 months for Māori remained the lowest comparing to other ethnicities, with 19.9% difference compared to Non-Māori and Non-Pacific.

Regionally, coverage of immunisation was highest in Te Waipounamu. However, largely unchanged in 2022-23 compared to 2021-22.

IMMUNISATION COVERAGE AT 24 MONTHS, 12-MONTH REPORTING PERIOD ENDING 30 JUNE 2023, BY ETHNICITY



IMMUNISATION COVERAGE AT 24 MONTHS, 12-MONTH REPORTING PERIOD ENDING 30 JUNE 2023, BY REGION



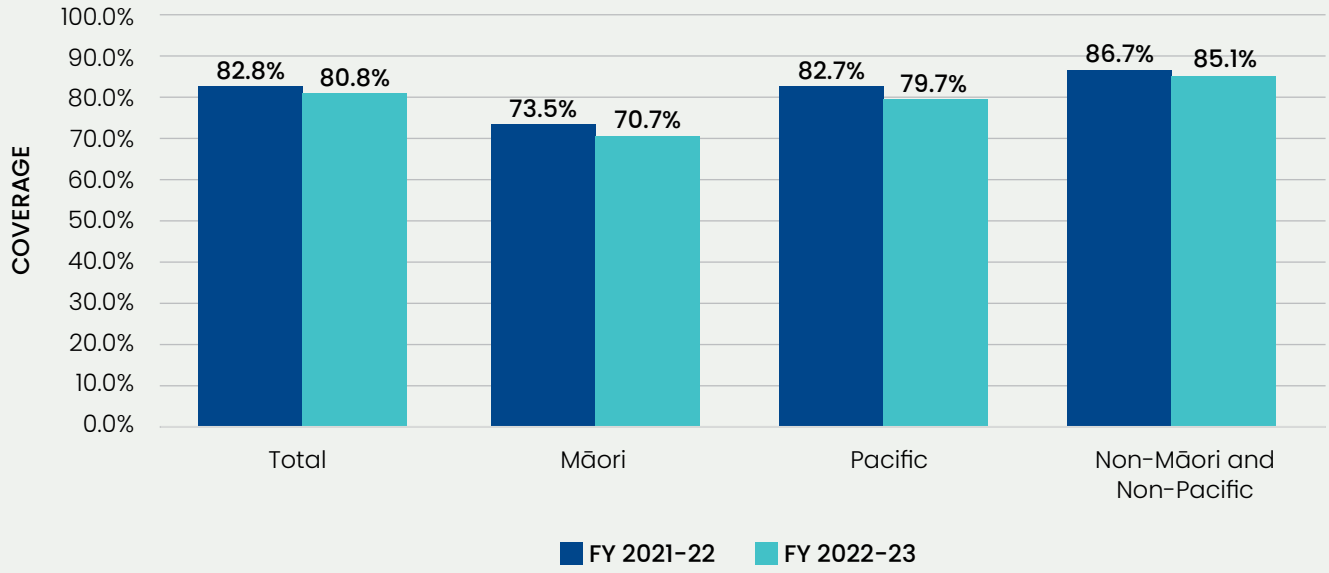
Measure	Result	Target	Status
Percentage of eligible five-year-olds enrolled on NIR fully immunised – age-appropriate immunisations	Māori **70.7%**	Māori **95%**	↓
	Pacific **79.7%**	Pacific **95%**	
	Non-Māori and Non-Pacific **85.1%**		
	Total population **80.8%**	Total population **95%**	

This measure, together with the two above, rounds out a picture of the extent to which our pēpi and tamariki are protected from avoidable diphtheria, tetanus, hepatitis B, polio and measles infections. The measure focuses on children at the end of their preschool years.

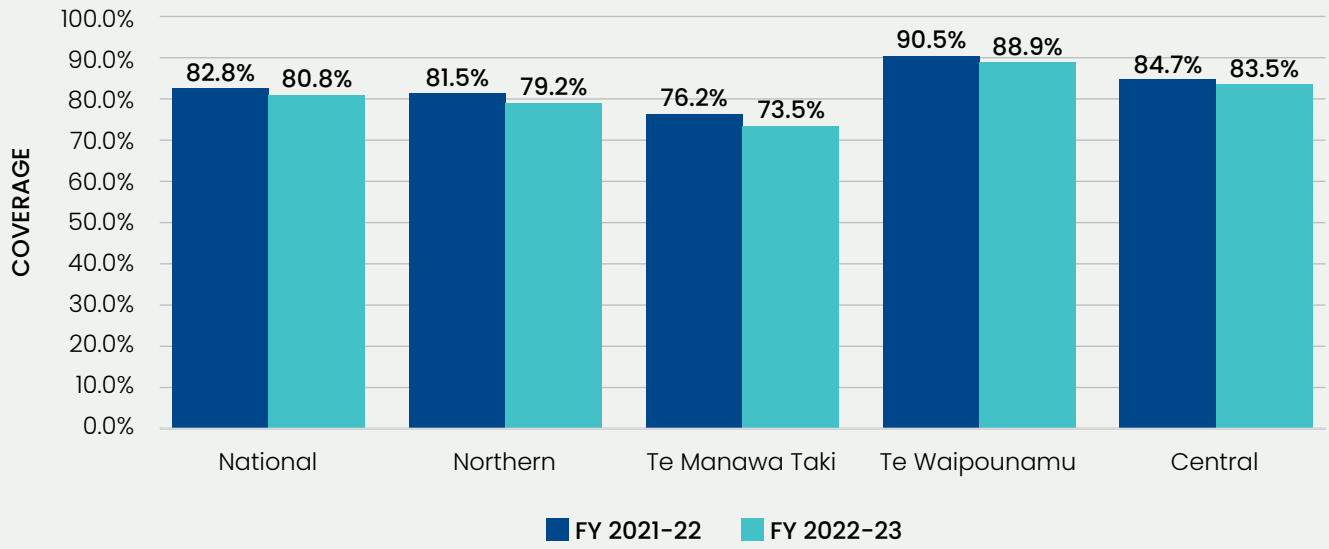
Immunisation coverage at 5 years of age is calculated as the percentage of children actively enrolled on the National Immunisation Register (NIR) who turned 60 months old during the reporting period and are recorded as being fully immunised according to the National Immunisation Schedule by the time they turned 60 months.

Total immunisation coverage at age 5 was steady during 2022-23, at around 81%. Within the overall rate, coverage for tamariki Māori decreased slightly and increased slightly for Pacific over the course of the year. The immunisation equity gap narrows noticeably in this age group, with Māori coverage being at most 14.4% lower than the equivalent Non-Māori and Non-Pacific rate.

IMMUNISATION COVERAGE AT 5 YEARS, 12-MONTH REPORTING PERIOD ENDING 30 JUNE 2023, BY ETHNICITY



IMMUNISATION COVERAGE AT 5 YEARS, 12-MONTH REPORTING PERIOD ENDING 30 JUNE 2023, BY REGION



Screening Programmes

Breast Screening

BreastScreen Aotearoa is New Zealand's free national breast screening programme for women aged 45 to 69 years. Early detection of breast cancer through a mammogram means a better chance breast cancer can be found and treated before it spreads.

An independent review of breast cancer screening has led to a range of recommendations currently being implemented to improve screening access and equity outcomes across Aotearoa New Zealand.

At present, Māori and Pacific women have lower survival rates from breast cancer. New initiatives include a Pae Whakatere governance group to oversee the implementation of the recommendations, co-design approaches to improve access to screening, consumer research, and consumer advisory groups.

Digital tools supporting breast screening

Text and email campaign digital tools used for COVID-19 have been repurposed to support breast screening. We now have an effective system to communicate with people to increase participation rates for breast screening. Successfully piloted in Counties Manukau, this is now being rolled out nationally. A new ICT system, including a national breast screening register, is also being implemented in 2024.

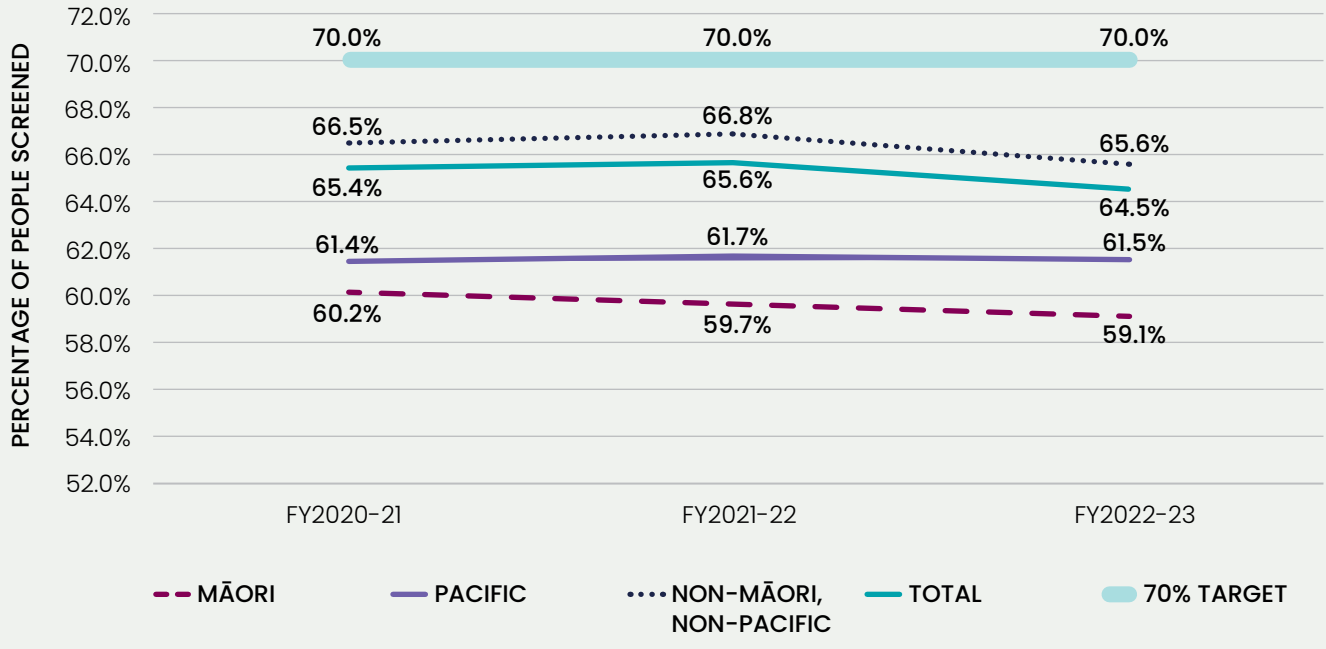
Measure	Result	Target	Status
Percentage of women aged 45-69 who have completed breast screening in the previous two years	64.5%	70%	↓

The aim of BreastScreen Aotearoa is to reduce women's morbidity and mortality from breast cancer by identifying cancers at an early stage, allowing treatment to begin sooner than might otherwise have been possible. The current coverage target is for two-yearly screening of 70% of eligible women.

The percentage of women who have completed breast screening in the previous two years is trending down slightly for Māori (60.2% vs 59.1%), with other ethnicities remaining relatively unchanged. The target of 70% of eligible women screened every two years has not been achieved. The impact of the COVID-19 pandemic has been seen across cancer screening programmes with the difference in coverage compared to Feb 2020 baseline being as high as -12.8% for Pacific, -4.9% for Māori, and -8.4% for Non-Māori, Non-Pacific. As at June 2023, Māori participants required 6,666 and Pacific participants 1,688 breastscreens respectively in order to reach equity in coverage. Further information can be found at https://tewhatuora.shinyapps.io/nsu-bsa-coverage/.

Like all screening, while participation is strongly promoted, it is voluntary. Despite this, the programme is seeing some positive signals that participation is starting to increase, but further work will be required to return to pre-pandemic levels.

PERCENTAGE OF WOMEN AGED 45-69 WHO HAVE COMPLETED BREAST SCREENING IN THE PREVIOUS TWO YEARS



Bowel Screening

The National Bowel Screening Programme is free for people aged 60 to 74 years. It aims to save lives by finding bowel cancer at an early stage when it can often be successfully treated.

The earlier bowel cancer is diagnosed, the higher the chance of survival. People who are diagnosed with bowel cancer and receive treatment when it is at an early stage have a 90% chance of long-term survival.

Budget 22 Initiative: updates
National Bowel Screening Programme – Lowering the Screening Age for Māori and Pacific Peoples
This initiative provides funding for the National Bowel Screening Programme to lower the age of screening eligibility for all Māori and Pacific from 60-74 years of age to 50-74 years of age. Contingency funds not drawn down as at 30 June. Evaluative implementation (pilot site) commenced in Waikato district in December 2022 as planned. Implementation in Tairāwhiti district was delayed due to severe impact of weather events.

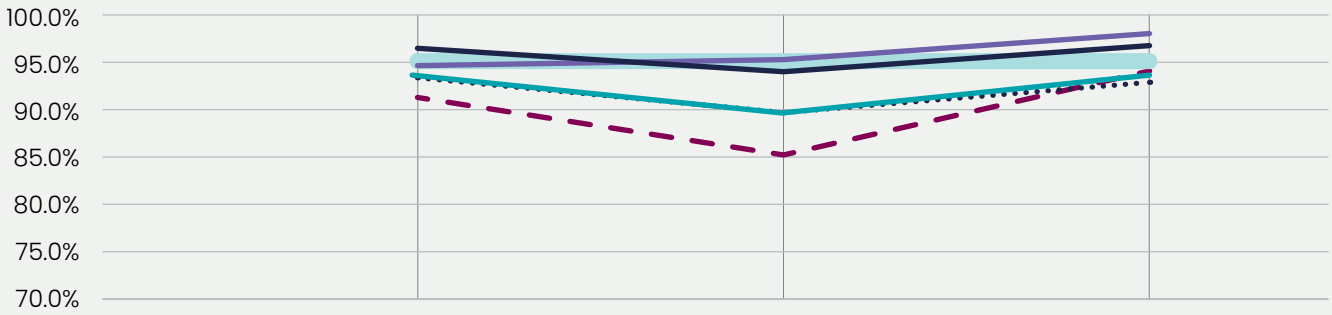
Measure	Result	Target	Status
Percentage of people who returned a positive Faecal Immunochemical Test (FIT) have a first offered diagnostic date that is within 45 working days or less of their FIT result being recorded in the NBSP IT system	See graph below	95%	↑

A Bowel Screening Programme standard to offer a colonoscopy or other diagnostic test within 45 working days of positive (abnormal) FIT result exists to reduce unnecessary anxiety to screening participants and to facilitate timely investigation of positive (abnormal) FIT results. Providing access to diagnostic assessment services in a timely manner depends on many factors including demand for colonoscopy services, capacity and waiting list management protocols.

The current target is 95% of participants to meet the 45 working day timeframe, with data being presented as a rolling 12 month average. The last reported data to June 2023 shows a positive trend upwards following the disruption of the pandemic to screening inititiaves.

As the Bowel Screening Programme continues to build momentum around the country and the recommendations of the planned care taskforce come to fruition, we expect the strong results to continue. Current performance is close to meeting the national target but ongoing colonoscopy capacity challenges remain and, as such, close monitoring of this metric will continue.

TIMELINESS OF FIRST OFFERED DIAGNOSTIC ASSESSMENT BY ETHNICITY



	Jun-21	Jun-22	Jun-23
MĀORI	91.1%	85.2%	93.8%
PACIFIC	94.7%	95.1%	97.7%
ASIAN	96.0%	93.8%	96.8%
NON-MĀORI, NON-PACIFIC, NON-ASIAN	93.2%	89.5%	92.7%
95% TARGET	95.0%	95.0%	95.0%
TOTAL	93.3%	89.6%	93.4%

Cervical Screening

Cervical cancer generally develops slowly, therefore it can be detected and treated early. Treatment can be as simple as removing the affected tissue and has a high success rate.

The first signs show up as 'abnormal' cells, which can take more than 10 years to develop into cancer. This is why there is a cervical screening test every 3 years – it gives us the best chance to find cell changes early.

Measure	Result	Target	Status
Percentage of women aged 25-69 who have completed cervical screening in the previous three years	68.2%	80%	↓

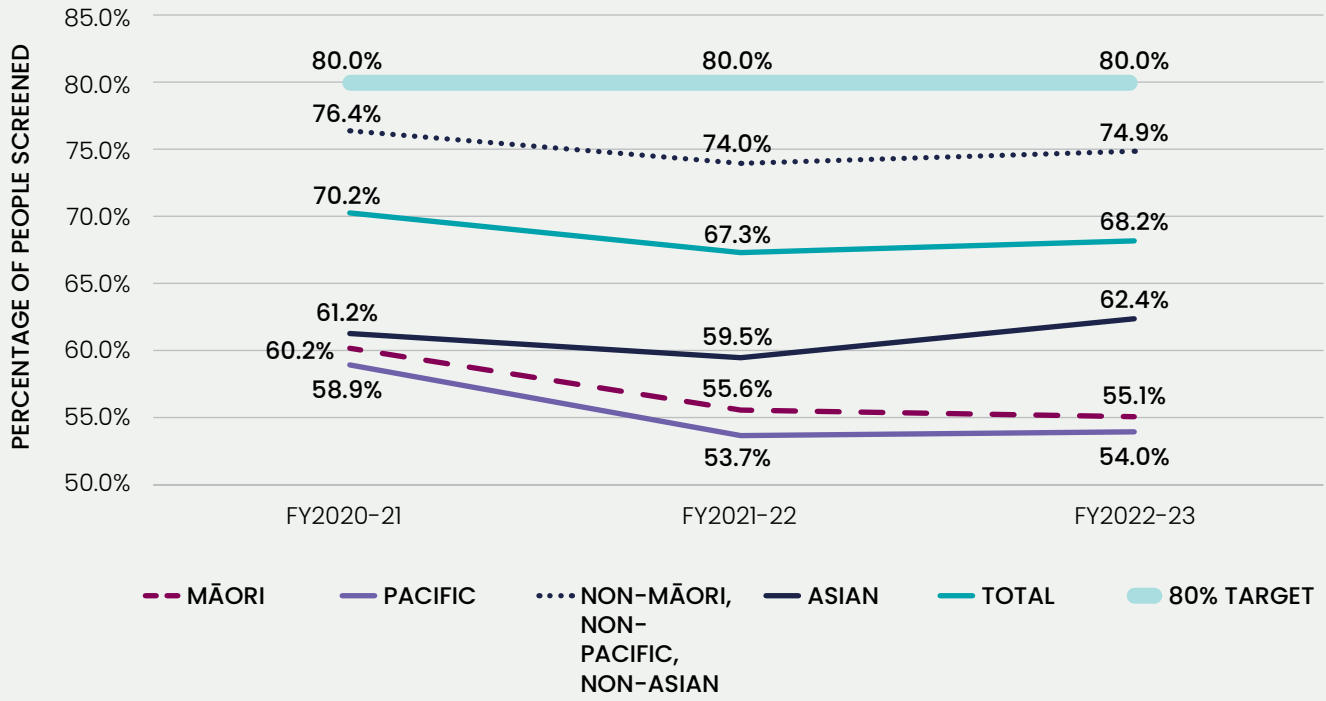
The National Cervical Screening Programme (NCSP) recommends regular cervical screening at three yearly intervals for women aged between 20 and 69 years who have ever been sexually active, with a primary aim of reducing the number of women who develop and die from cervical cancer. Coverage is defined as the proportion of women eligible for screening who have been screened in the previous three years. Our target is to reach 80% screening coverage for all eligible women, including separately for Māori, Pacific, and Asian population groups.

The percentage of women aged 25-69 who have completed cervical screening is trending downward for all ethnicities, with the exception of Asian persons. The target of 80% of eligible people has not been achieved. The impact of the COVID-19 pandemic has been seen throughout the screening programmes with the difference in coverage compared to February 2020 baseline, as -10.5% for Pacific, -8.4% for Māori, -2.5% for Asian population and -3% for other ethnicites. While the programme is seeing some positive signals that participation is starting to increase for Asian and other ethnicities, further work will be required for Māori and Pacific to return to pre-pandemic levels.

As at June 2023, Māori participants required 41,951, Pacific participants 19,087 and Asian participants 32,449 cervical screens respectively in order to reach equity in coverage. Further information can be found at https://tewhatuora.shinyapps.io/nsu-ncsp-coverage/.

This graph shows cervical screening participation in the year to June 2023, compared to the two previous years, by ethnicity.

PERCENTAGE OF WOMEN AGED 25-69 WHO HAVE COMPLETED CERVICAL SCREENING IN THE PAST THREE YEARS



Supporting tamariki to eat healthily

During the 2022-23 year, we have continued to support schools to promote healthy food and nutrition for all students. The implementation of the 2019 Healthy Active Learning (HAL) initiative, which established 30 health promoters, supports schools to improve the wellbeing of children and young people through improving the food environment and the provision of fruit in schools, along with free and healthy school lunches to schools with high levels of disadvantage among their student population.

Due to a number of social determinants, however, some tamariki are already affected by obesity prior to beginning at school. There is a process in place to ensure appropriate support is extended to children and whānau around nutritional advice, physical activity and lifestyle and other changes.

Measure	Result	Target	Status
Percentage of obese children referred to a specialist service	Māori **94%** Pacific **97%** Non-Māori/ Non-Pacific **95%** Total **95%**	95%	↑

Baseline period (Statement of Performance Expectations 2022-23): 2021-22 financial year

Baseline value: Māori 94%, Pacific 97%, Non-Māori and Non-Pacific 95%

NOTE that this measure was included in our Statement of Performance Expectations 2022-23 with the wording as recorded above, however, it was also included in the Vote Health Estimates of Appropriation 2022-23 with the more specific wording as follows: Percentage of obese children identified in the Before School Check programme offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions.

The health of our tamariki is to be protected and promoted to ensure each child can experience Pae Ora, healthy futures, when they grow up. Therefore, tracking child health in a number of ways is an important part of Te Whatu Ora monitoring activity.

The Before School Check aims to identify and address any health, behavioural, social or developmental concerns which could affect a child's ability to get the most benefit from school, such as a hearing problem or communication difficulty. It is the 12th core contact of the Well Child Tamariki Ora Schedule of Services.

This measure, while included in our Statement of Performance Expectations 2022-23, is now outdated. It is considered poor in its design as it cannot tell us what percentage of all tamariki who are affected by obesity are accessing appropriate health services – including but not limited to specialist care – to manage this.

The data we have to report against this measure is for the period July 2022 to June 2023.

More information and data on this and related topics, broken down by district, region and ethnicity, can be found in the reporting against Well Child Tamariki Ora Quality Improvement Indicators, published on the website of Manatū Hauora.

Smokefree Action Plan 2025

New Zealand has a goal to be smokefree by 2025. In practice this means fewer than 5% of all population groups will smoke daily. The Smokefree Action Plan was published in December 2021 to provide a pathway to the smokefree goal, to accelerate our progress towards a smokefree future and tackle the harm that smoking tobacco products causes the people of Aotearoa New Zealand.

The Public Health Agency in Manatū Hauora, Te Whatu Ora and Te Aka Whai Ora are jointly responsible for implementing the Smokefree Action Plan. Te Whatu Ora is leading work to increase health promotion and community mobilisation, and to increase evidence-based stop smoking services and compliance activities.

Significant regulatory and non-regulatory progress has been made in the implementation including scaling up stop smoking services, enhancing health promotion and community mobilisation and completing legislative changes to set the framework to support delivery of the action plan.

The New Zealand Health Survey shows there has been a dramatic reduction in smoking rates. Our daily smoking rate in New Zealand has reduced from 14.5% to 8% in the past seven years. The Survey also shows that more young people are vaping, with young people aged 15–17 years now accounting for 4% of all daily vapers.

Measure	Result for 15 months to Q4, 2022–23	Target	Status
Percentage of smokers offered to help quit in past 15 months	Māori **62%** Pacific **72.7%** Non-Māori/ Non-Pacific **66.8%** Total eligible population **65.3%**	90%	↓

Baseline period (Statement of Performance Expectations 2022-23): 2021-22 financial year

Baseline value: Māori 64%, Pacific 74%, Non-Māori and Non-Pacific 68%

The Better Help for Smokers to Quit (Primary Care) target was introduced as a health target in 2015-16 and publicly reported from 2016-17. It was retired when the health targets were removed in 2020 and replaced with the Health System Indicators. The measure was included in the Te Whatu Ora Statement of Performance Expectations 2022-23 (with abridged wording as shown above) while a new measure was developed to replace it, however, the measure is recorded in the Vote Health Estimates of Appropriation 2022-23 documentation with its full wording.

The PHO (Primary Health Organisation) data used to report on this target was provided quarterly (annual data is not available). The target was defined as 90% of PHO-enrolled patients who smoke have been offered help to quit smoking by a health practitioner in the last 15 months. This target has not been met for the 15-month period to 30 June 2023, in particular due to the emphasis PHOs have needed to place on supporting their communities with COVID-19. During 2023-24, smoking cessation service providers will further scale up services and enhance their health promotion activity.

This will be the final time we report on this measure. As it is limited to PHO-enrolled patients, it does not provide a good sense of the effectiveness of smoking cessation activities overall. It has been replaced by a new measure in the Te Whatu Ora Statement of Performance Expectations 2023-24: Percentage of smokers enrolled with a stop smoking service, who set a target quit date and will be CO_2 validated at 4 weeks.
This new measure will enable us to track progress against the goals of the Smokefree Action Plan.

Protecting youth from vaping

Vaping regulations announced in June 2023 are designed to help curb an increase in youth vaping rates. New specialist vape shops will not be able to open up in the immediate vicinity of schools and marae. Vape products and their packaging will only be able to have generic flavour descriptions.

The maximum nicotine strength allowed in single-use (disposable) vapes will also be reduced so they are less addictive, and all vaping products will have removable batteries and child-safety mechanisms to improve their safety and better protect young people.

Budget 22 Initiative: updates
Smokefree Aotearoa 2025 Action Plan
This initiative provides funding to establish a tobacco products regulator, ensure compliance and enforcement with the Smokefree regulations and implement the Smokefree Aotearoa 2025 Action Plan. The implementation plan for a suite of activities to improve smokefree compliance activity within the National Public Health Service is under way. Contingency funds were not drawn down as at 30 June 2023.

Human Immunodeficiency Virus (HIV) Action Plan

The new HIV Action Plan strives to eliminate local transmission of HIV and ensure people living with HIV in New Zealand have healthy lives free from stigma and discrimination.

In 2022, the AIDS Epidemiology Group Dashboard at the University of Otago recorded that there were 135 people notified with HIV in New Zealand. Of these, 76 were first diagnosed in New Zealand, 55 had previously been diagnosed overseas, and there were four people for whom the place of first diagnosis was unknown.

Budget 22 Initiative: updates
HIV Action Plan Implementation
This initiative will fund a strategic work programme in public health to prevent, detect, treat, and eliminate the transmission of HIV, as well as ensuring people living with HIV live healthy lives free from stigma. In 2022-23, we set up a contract with Toitū Te Ao, the new kaupapa Māori peer-led organisation to connect and empower Māori living with HIV, and completed the groundwork for workforce training to be rolled out in the first quarter of 2023-24 to increase the range of providers able to test the groups most at risk of HIV.

Health of Tāngata Whaikaha | Disabled People

Tāngata whaikaha | Disabled people make up nearly a quarter of New Zealanders. They belong to all age, ethnic and cultural groups, gender identities, sexualities, localities, socio-economic groups and every whānau and community.

The Disability actions in Te Pae Tata provide a commitment to and progressive vision for realising Te Whatu Ora's obligations under the Pae Ora Act 2022, and the Health of Disabled People Strategy, align strongly with New Zealand's human rights obligations including the UN Convention on the Rights of Persons with Disabilities (UNCRPD) and Te Tiriti o Waitangi.

This is the first time that disabled people have been formally recognised as a priority group in the New Zealand health system, and the first time the health system has made an organisational commitment to designing a new health system that will take responsibility for providing appropriate, accessible healthcare for Tāngata whaikaha | Disabled people.

In our first year, Te Whatu Ora has been implementing a work programme designed to:

- Build the foundations for a more inclusive, accessible and equitable health system for Tāngata whaikaha | Disabled people by
  - Understanding where we are now:
    - What resources we already have.
    - Our disability equity "maturity level" as an organisation.
  - Taking immediate foundational actions to:
    - Collect and apply disability data.
    - Improve accessible service provision at point of care.
    - Provide accessible health information.
    - Embed disability expectations and models of care throughout the organisation.

- Reframe how we see, value and work with Tāngata whaikaha | Disabled people by
  - Educating our workforce and changing the culture of our organisation.
  - Providing the right information, tools and support for Te Whatu Ora staff to uplift and improve their capacity.
  - Building a new relationship and way of working with the disability community, Tāngata Whaikaha | Disabled people and their families and whānau.
  - Creating the space, tools and support for the disability community to engage with the health system in a new, positive and equal way.

In 2022-23, Te Whatu Ora began to build the foundations for a more inclusive, accessible and equitable health system for Tāngata whaikaha | Disabled people by:

- Developing an organisation-wide stocktake survey to identify disability-related resources and work happening around New Zealand within Te Whatu Ora, assess where local resources and initiatives can be expanded, consolidated, adapted or updated, and identify gaps for further development.
- Working with disability community leaders to develop and begin application of a world-leading Disability Capability Framework, designed as a tool Te Whatu Ora can use to assess baseline disability capability and inform plans to improve organisational approach to delivery of equitable services.
- Scoping phase 1 of Patient Profile NHI (PPNHI), the first comprehensive attempt to develop digital solutions and data ecosystems to collect disability data and access information. PPNHI is of significant interest across government and has links to other national data projects.
- Building on the accessible information and communications work undertaken through the COVID-19 response and applying the model to subsequent public health responses including Cyclone Gabrielle and the ongoing work of the National Immunisation Programme, ensuring that vital public health information is available in plain language and alternate formats.
- Providing disability expertise to inform the RFP (Request for Proposal) process and development of the national Bowel Screening campaign, resulting in the first inclusive and fully accessible (NZSL) public health advertising campaign.
- Developing policy guidance to ensure that equity for Tāngata whaikaha | Disabled people is an integral part of new reworked internal policy.

We also continued our transformational commitment to reframe how we see, value and work with Tāngata whaikaha | Disabled people by:

- Continuing delivery of existing and development of new educational opportunities for Te Whatu Ora staff at all levels of the organisation. High uptake and excellent feedback from staff all over Te Whatu Ora and beyond have emphasised the impact these learning opportunities have on improving staff and patient experiences in healthcare. These include the following initiatives developed and delivered in 2022-23:
  - **Disability Equity – eLearning:** an introductory module about what disability and impairments are and how to engage with people, remove barriers, and achieve equity through a rights-based approach.
  - **Reframing Disability – workshops**: the history of disability in the New Zealand Health System, the commitment to disability equity in Te Pae Tata, and how the principles and priorities will shape the new health system.
  - **Applying Enabling Good Lives in Health – eLearning:** what the Enabling Good Lives principles mean, why they are important and how they can be applied in health settings.
  - **Frontline Professional Development – workshops**: the inequities Tāngata Whaikaha | disabled people face, what inclusive healthcare looks like and how to make adaptations to clinical practice which enhance disabled people's journey through the health system.
- Continuing expansion of Disability Resource Hub, a rich collection of resources on the Capital Coast and Hutt Valley intranet, including research, guidance for staff, posters, communication cards, and other useful information and tools developed by the team. These resources and tools are frequently requested by healthcare staff, teams and services nationwide.
- Developing a localities guide, including key steps and guidance for localities to take to ensure that equity for Tāngata whaikaha | Disabled people is an integral part of building community-based care.

Te Whatu Ora continues to implement the Disability Strategy Work Programme and take steps to embed Te Whatu Ora's commitment to disability equity across the organisation.

Budget 22 Initiative: updates

Payment to Family Members for Support Services

This initiative will ensure people receiving disability supports have the option to choose to pay a family member to provide those supports.

Implementation began in January 2023.

Widespread communications plan underway, with a specific focus on Māori and Pacific communities.

Output Class: Primary and Community Services

Keeping people well in their communities

Primary and community services are vital to detecting and managing health problems early and close to home. It means people can maintain their independence and wellbeing. These services are provided by health professionals in general practice, Māori health providers, Pacific health services, community pharmacies, child and adolescent dental health services, physiotherapists and many others. Primary and Community Services is one of our five output classes. The standard of delivery achieved against this output class is reported on page 137 to page 170.

Why is this important?

Timely access to primary and community services allows people at risk of becoming unwell, or who have early-stage problems to get diagnosed and treated quickly to help manage their condition, in many cases avoiding further sickness.

Primary and community services are important for chronic conditions like diabetes, respiratory problems, gout, cardiovascular disease and stroke. People can manage these conditions with the help of their local general practice or community services and continue to live as well as possible in their community.

Budget 22 Initiatives: updates
Improving Access to Primary Health Care Services for Transgender People
This initiative provides funding for primary and community health providers to deliver gender-affirming services to transgender people, updated national guidelines for gender-affirming healthcare and a lead referral pathway for gender-affirming services and supports, along with training and workforce development resources to improve workforce responsiveness to transgender people. Service delivery has begun, and an advisory group of clinical and community expertise has been formed to support this work.
Primary Care Funding Formula – Equity Adjustments
This initiative provides additional funding of $86m over four years, to more equitably allocate primary care funding to general practices on the basis of their enrolled high needs populations. Funding allocations have been reviewed by the primary care sector and with Te Aka Whai Ora. There have been six additional primary care teams assessed by Te Aka Whai Ora as Māori Hauora practices and these have been included in the equity adjuster payments.
Preventing Family Violence and Sexual Violence: Services for Victims of Non-fatal Strangulation
Funding was provided in Budget 2020 to establish a service for victims of non-fatal strangulation. This initiative provides additional funding to ensure all victims of non-fatal strangulation are able to receive appropriate specialist services. The service is established and in place.

Older people

Older Peoples Assessment and Liaison Community Service teams have been implemented in Horowhenua/Ōtaki and Palmerston North/Manawatū. This is a community-based service, incorporating kaupapa Māori approaches in its service, to achieve equitable outcomes for Kaumātua, focusing on preventative care to keep older people with frailty, living well at home, as independently as possible.

Budget 22 Initiative: updates
Dementia Mate Wareware Action Plan – Implementation Support Funding
This initiative provides funding to deliver four post-diagnostic support trials. It also provides funding to deliver innovative respite care to enable family and whānau carers to continue caring for their whānau members. Engagement with the sector on this initiative has been expedited as effectively as possible via the Dementia Leadership and Advisory Group.

Te Waipounamu region

Te Whatu Ora is supporting our Māori Health and Social Services provider, Poutini Waiora, to deliver general practice sessions by sharing Te Whatu Ora GP resources to support improved and alternative access to our Māori communities. This is also linked to our work partnering with Poutini Waiora to support our Māori community who have long term health conditions with the use of kaiāwhina and working in a Whānau Ora way.

Localities

What are localities?

Localities are geographical areas home to unique communities with their specific hauora (health and wellbeing) aspirations. Te Whatu Ora aims to achieve better, more equitable health outcomes for all New Zealanders through the localities approach.

The impact of localities is reshaping the way we think about health, fostering inclusivity and responsiveness in healthcare for Aotearoa New Zealand.

Localities are a collective-impact approach.

Unleashing the potential of localities

Te Whatu Ora and Te Aka Whai Ora are leading the implementation of the localities across the country.

The objective is clear – to enable local communities and whānau to influence the design, funding, and delivery of their local healthcare services. This will be done by creating a locality plan tailored to the unique needs of each area.

By putting whānau and community voices at the forefront of decision-making, localities will help ensure health services are tailored to the unique needs of each place.

Localities use a collective-impact approach, which means bringing together different organisations, groups and people to work towards a common goal. This recognises that complex health challenges and social issues require coordinated effort to solve. By working collaboratively, people in localities can achieve greater impact than they could individually.

Progress so far

The first 12 localities are prototypes and were put in place before Te Whatu Ora itself was established. The prototypes focus on local arrangements to support health service delivery, while also giving us the opportunity to evaluate and learn from them. Each were selected as they cover a range of geographical and population demographic groups, including high Māori and Pacific populations, rural, and urban with high socio-economic deprivation.

Collaborative efforts with local stakeholders and mana whenua have led to the establishment of Locality Partnership Groups.

Budget 22 Initiative: updates
Service Integration for Locality Provider Networks
This initiative provides funding for network integration and change management to enable the delivery of joint, multidisciplinary services within locality provider networks. Te Whatu Ora continues to support locality prototype development and to prepare for the broader rollout of localities.

Locality determination

- Engaging IMPBs, local government and communities to **determine locality boundaries.**
- Build local relationships

Locality establishment

- Support local stakeholders to establish **local working arrangements** that support collective action
- Document working arrangements into a locality relationship agreement

Locality planning

- Engage with whānau, hapori and providers to **identify wellbeing needs and priorities** to inform locality plans
- Partner with IMPBs, Te Whatu Ora and Te Aka Whai Ora

Delivery

- Align **contract and funding arrangements** to locality plans and start delivery
- Implement **new models of care and community wellbeing initiatives**
- Improve service integration through better networked providers

Measure	Result	Target	Status
Localities are established.		Milestone report	↑

Twelve prototype localities have been established so far, have confirmed their locality partnership working arrangements, and engaged with whānau Māori and communities to determine their hauora (health and wellbeing) priorities.

Localities will be rolled out and cover all of Aotearoa New Zealand by July 2024.

Challenges and learnings from the first localities

During this early prototyping phase, the first localities have provided valuable opportunities for learning and iteration. In this first year, several challenges were identified that will contribute to improving how we develop localities moving forward.

1. **Fostering whakawhanaungatanga and effective engagement**: Building and maintaining diverse relationships within localities is crucial and requires dedicated time, transparency, and a collective understanding among partners to navigate the iterative and evolving environment. Additionally, effective engagement with whānau and community voices is essential for comprehensively informing locality plans.
2. **Iwi Māori leadership at inception**: the announcement of the first localities was made in April 2022, while the Iwi Māori Partnership Boards were still being established. This raised challenges as both localities and Iwi Māori Partnership Boards worked hard to understand their unique roles and how they would interface – something that we are still learning about as we go.
3. **Achieving health equity for Māori requires a commitment to Te Tiriti o Waitangi**: we must recognise Māori as tangata whenua (people of the land) and be steadfast in our commitment to give effect to the principles of Te Tiriti o Waitangi through delivering on a range of requirements and expectations embedded in the Pae Ora (Healthy Futures) Act.
4. **Build and support community leadership**: Time, limited resources, and skill recruitment, particularly in rural settings, presented a challenge when working to foster community capacity in the locality. Giving communities the time, funding and support required to develop effective leadership and capability is essential. As a system, we also need to be prepared to step back and let communities lead.
5. **Intentional representation in locality decision-making**: To ensure inclusivity and representation, it is essential that locality partnership and governance groups represent the communities they serve. This includes ensuring Tangata whaikaha I Disabled people, Pasifika, other ethnic communities, rural and rainbow interests are represented, acknowledging the important and unique perspectives that different groups bring and the different health needs they have.

LOCALITIES IN ACTION

Horowhenua – Inclusivity and Empowerment

The Horowhenua locality partnership group set intentional goals to capture the voices of often underrepresented groups, including people with intellectual disabilities, people who have immigrated to Aotearoa, individuals with English as a second language, and members of the rainbow community.

Creative workshops were held in Horowhenua, allowing people to express their aspirations and hauora dreams through art, collage, and film. These accessible events empowered individuals who faced challenges with reading and writing to express their aspirations through visual storytelling. This intentional approach ensured that individuals who might not engage in traditional survey methods could voice their perspectives, providing valuable insights. This engagement revealed a desire for inclusive and safe spaces to do exercise and other activities, free from judgement.

Engagements with mana whenua in the Horowhenua rohe (area) highlighted the significance of whānau ora, emphasising the importance of nature, wholesome kai, and connections with family and friends. Whānau Māori also stressed the need for healthcare services tailored to their community – for Māori, by Māori.

Inclusivity also remained at the forefront during engagement with the Pacific community. This included a culturally appropriate approach centred on open and honest dialogue, revealing the critical role faith and community connections have in their wellbeing.

The community exhibit showcasing the needs and aspirations heard in Horowhenua exemplifies the commitment to giving back the "taonga" (treasure) of community voices. This display not only celebrates their unique perspectives but also invites additional input to confirm priorities and ensure that these voices in the community are genuinely heard and acted upon.

Primary and Community Care teams

New primary and community care teams will help to provide services that are accessible, affordable, and appropriate for their communities. This will include introducing new roles such as kaiāwhina, physiotherapists, pharmacists, care coordinators, and in some rural areas, paramedics, expanding the workforce, and bringing complementary skills and capacity to improve the access and range of care that is delivered locally.

Comprehensive Primary and Community teams are providing for new ways of working, through tightly integrated interdisciplinary teams. Local tailoring for these teams in early localities was informed by locality collected whānau and community voices. Areas without established localities included hauora Māori and Pacific partners, general practices, PHOs and commissioning teams working collectively to identify roles(s), FTE (full-time equivalent) and employer(s) for the identified resource across a geographical area.

Implementation of Comprehensive Primary and Community teams will be enabled through Service Integration funding supporting the change management. In addition, there are allocations for workforce development within primary and community care.

The role of kaiāwhina is expected to play a significant part in supporting people, particularly Māori and Pacific people, in the navigation of health services and delivery of holistic care.

Comprehensive Primary and Community teams

The Hokonui locality has worked with its partners including hauora Māori, primary care, rural hospital and Hato Hone | St John to plan for which roles will add the most value to the population and community.

This will result in a larger number of community-based roles centred around caring for people, prioritising those who are at risk of hospitalisation including Maori, Pacific people or those at risk of poor health outcomes. These roles are designed to enhance staff connection with a range of providers across the locality and with the kaiāwhina employed by the hauora Māori partner that are also being introduced.

This was a Budget 22 initiative.

Budget 22 Initiative: updates
Comprehensive Primary Care Teams
This initiative allocated $102m over three years to support general practice by funding a broader range of clinical roles (including kaiāwhina, physiotherapists, pharmacists, care coordinators, and in some rural areas, paramedics) that will come together as tightly integrated primary care teams within locality provider networks.

Registered Nurse Prescribing in Community Health

Twenty-four registered nurses graduated the Registered Nurse Prescribing in Community Health programme in Hawke's Bay.

The Registered Nurse Prescribing in Community Health programme was implemented to provide better healthcare by enabling nurse prescribing of medications for contraception, sexual health and minor skin infections.

Hawke's Bay is one of the first districts to implement the programme and to date, this is the largest group, outside Auckland, to graduate.

Measure	Result	Target	Status
Provider networks are established	Milestone report		↓

The intention of provider networks is to support the provision of primary and community care services which are informed by locality plans (which, in turn, are informed by communities).

New provider networks have not yet been started and will be part of the redesign of primary and community care services that is commencing. The redesign has a longer, multi-year timeframe out to 2027. In the interim, we continue to support in the delivery of primary care.

Winter 2023 Preparedness Plan

Communities, hospital staff and primary healthcare will continue to see seasonal and concurrent surges of COVID-19, Respiratory Syncytial Virus (RSV), the flu, and other diseases that will put additional pressure on our system.

Te Whatu Ora launched a range of initiatives to address health system pressures for winter and beyond, regionally planned to support effective implementation in local communities.

These actions focused on a combination of improving access to health services for people closer to where they live, as well as measures to help manage the demand for hospital-level care over winter and reducing demand for emergency and acute care.

The plan included a focus on more convenient and equitable access to care in the community including use of clinical telehealth, pharmacy advice and care, and longer-term initiatives to ensure more services are available – especially for Māori, Pacific, Tāngata whaikaha I Disabled people, and older people.

The first line of defence against serious illness in winter is to ensure high rates of immunisation across the country. We encourage all people to get the flu vaccine and the COVID-19 booster to ensure they have the best protection available.

Kahu Taurima – Maternity and Early Years

Kahu Taurima is the joint Te Aka Whai Ora and Te Whatu Ora approach to maternity and early years (pre-conception to 5 years of age, or the First 2,000 Days of life) for all whānau in Aotearoa New Zealand.

The name 'Kahu Taurima' has many connections to maternity and early years.

'Kahu' speaks to the korowai of services and support that wraps around whānau. 'Taurima' speaks to caring, nurturing, and fostering our most cherished pēpi, tamariki and whānau.

The tohu (logo) is intended to reflect hapūtanga, protection, development, and growth. It also represents the connection between māmā and pēpi.

Mama and Pēpi

Progress so far

As a priority in Te Pae Tata, the Kahu Taurima programme of change will shift system settings and redesign the model of care and service delivery models to ensure health is making its greatest contribution to intergenerational wellbeing.

For a child's first 2,000 days from conception to five years of age, Kahu Taurima will:

- remove barriers and silos in the existing universal service model
- integrate our primary care, community, and specialist services to improve quality, safety and equity of outcomes
- deliver well-connected, easy to navigate, culturally affirming health services for all whānau, no matter who they are, and where they live
- provide wraparound services and extra support for whānau when needed.

Kahu Taurima

Why Kahu Taurima is important

In Aotearoa New Zealand, we have more than 60,000 babies born each year – that is over 60,000 opportunities to support a healthier future for whānau.

Evidence shows that by investing in whānau antenatally and in the early years of life we can make the biggest difference to lifelong, and intergenerational, wellbeing.

Most brain development happens in the early years and is influenced by the environment in which tamariki are nurtured. Mātauranga Māori, along with clinical evidence, supports investment in and for the first 2,000 days so every child gets the strongest start to life. This means we must support families welcoming and raising babies during these first 2,000 days.

What is known about how to support whānau to thrive?

A model of care that delivers integrated services and has the flexibility to simplify or intensify services, depending on what matters to whānau, can improve equity of outcomes.

The Kahu Taurima approach is drawing learnings from reviews, including Well Child Tamariki Ora, Maternity Action Plan, pilot programmes including enhanced support pilots, and reviews from the Health Quality and Safety Commission, which recognise and demonstrate different ways of working to achieve improved outcomes for whānau.

Christchurch Community Midwife service for hapū wāhine

The service has been rebranded and relaunched to support hapū wāhine who are unable to register with a Lead Maternity Carer. Through a quality improvement programme, the Whānau Mai community-led midwifery team increased the number of midwives, improved systems and processes and digitised maternity records. This enables GPs to refer directly to the service and supports a self-referral system for hapū wāhine.

Capital & Coast / Hutt Valley

A hapū whānau hub opened in March 2023 in Porirua, thanks to a collaboration between Ngāti Toa, Te Whatu Ora and Te Tatai Hauora o Hine (the National Centre for Women's Health Researchers) to provide access to dedicated and tailored support for hapū wāhine.

Children's Act 2014

Under the Children's Act 2014, Te Whatu Ora is required to develop and adopt a Child Protection Policy as soon as practicable. The policy must be published on our website and reviewed every three years. Te Whatu Ora must ensure that any contracted service providers that provide children's services have a child protection policy in place.

Te Whatu Ora is developing a Child Protection Policy which will set out a standard approach to identifying and responding to suspected child abuse and neglect. While the national policy is developed, policies and protocols that Te Whatu Ora inherited from previous organisations are still able to be used for responding to suspected abuse and neglect.

Budget 22 Initiative: updates
Well Child Tamariki Ora – Continuation of the Enhanced Support Pilots
This initiative provides funding to continue the current three Well Child Tamariki Ora (WCTO) Enhanced Support pilots in Lakes, Counties Manukau and Tairāwhiti.
Neonatal Retinopathy Screening
This initiative provides funding for the operation of portable retinal cameras to ensure equitable access to Retinopathy screening for premature babies. The implementation plan was completed in September 2022.
Introducing a Rights-based Approach to Health Care for Intersex Children and Young People
This initiative provides funding to support health practitioners to provide best practice healthcare to intersex children and young people and to empower intersex children and young people and their whānau to make informed decisions about medical interventions.
Well Child Tamariki Ora – Strengthening Services
This initiative provides funding, to be held in contingency, to strengthen and reduce inequities in the Well Child Tamariki Ora programme. Contingency funds had not been drawn down as at 30 June.

Enrolment with general practice providers

The first few months of a baby's life are important formative stages. It is important that pēpi are enrolled early with a range of health providers, such as general practice and oral health, to ensure parents have access to the support they need, and the reassurance and care required.

Measure	Result	Target	Status
Percentage of children enrolled with general practice or a kaupapa Māori provider by age 6 weeks	73.5%	55%	✓

This measure refers to babies enrolled with general practices including those operated by a kaupapa Māori general practice provider.

It allows us to track the progress towards the achievement of the Kahu Taurima | Maternity and early years actions in Te Pae Tata, ensuring we lay the best foundations for lifelong health and wellbeing. It also provides us with a snapshot of the accessibility of primary care services to a potentially vulnerable group and allows us to target initiatives to address non-enrolment.

The enrolment rate for the total population in the year to June 2023 was 73.5%. However, there are disparities in enrolment rates by ethnicity, with Māori and Pacific babies less likely to be enrolled (with enrolment rates of 59.9% and 63.9% respectively).

New-born general practice or kaupapa Māori enrolment by 6 weeks of age

	Annual Enrolment Rate		
Ethnicity	**Jun 2022**	**Jun 2023**	**Change**
Māori	54.3%	59.9%	↑ 5.6%
Pacific	59.7%	63.9%	↑ 4.2%
Asian	75.1%	79.8%	↑ 4.7%
Non-Māori/Non-Pacific/ Non-Asian	77.4%	82.0%	↑ 4.6%
Total	**68.9%**	**73.5%**	**↑ 4.7%**

Measure	Result	Target	Status
Percentage of children enrolled with general practice or a kaupapa Māori provider by age 3 months	87.7%	85%	✓

Baseline period: Sampled at 1 April 2022

Baseline value: Māori 67%, Pacific 80%, Non-Māori and Non-Pacific 95%

The June 2023 update of the SPE 2022-23 incorrectly stated the baseline period was sampled on 1 July 2022. The correct baseline sample period is 1 April 2022.

This measure refers to infants attaining the age of 3 months over the reporting period who were enrolled with a PHO at that age milestone. It allows us to track the progress towards the achievement of the Kahu Taurima | Maternity and early years actions in Te Pae Tata, ensuring we lay the best foundations for lifelong health and wellbeing. It also provides us with a snapshot of the accessibility of primary care services to a potentially vulnerable group and allows us to target initiatives to address non-enrolment.

Our Statement of Performance Expectations 2022-23 set a target of 85% for enrolment by 3 months of age. The June 2023 figures, shown in the tables below, record an increase across all ethnicities, with progress being made towards achieving the target for Māori (69.7% in the year to June 2023) and Pacific (80.2%).

	Annual result of new-born enrolment by 3 months of age by ethnicity		
Ethnicity	**Jun 2022**	**Jun 2023**	**Change**
Māori	67.3%	69.7%	↑ 2.5%
Pacific	79.6%	80.2%	↑ 0.6%
Asian	90.9%	93.0%	↑ 2.1%
Non-Māori/Non-Pacific/ Non-Asian	96.2%	99.1%	↑ 2.9%
Total	**85.5%**	**87.7%**	**↑ 2.2%**

Region	Annual result of new-born enrolment by 3 months of age by region year to June 2023
Northern	87%
Te Manawa Taki	86%
Central	86%
Te Waipounamu	92%
National	**88%**

Other measures related to Kahu Taurima

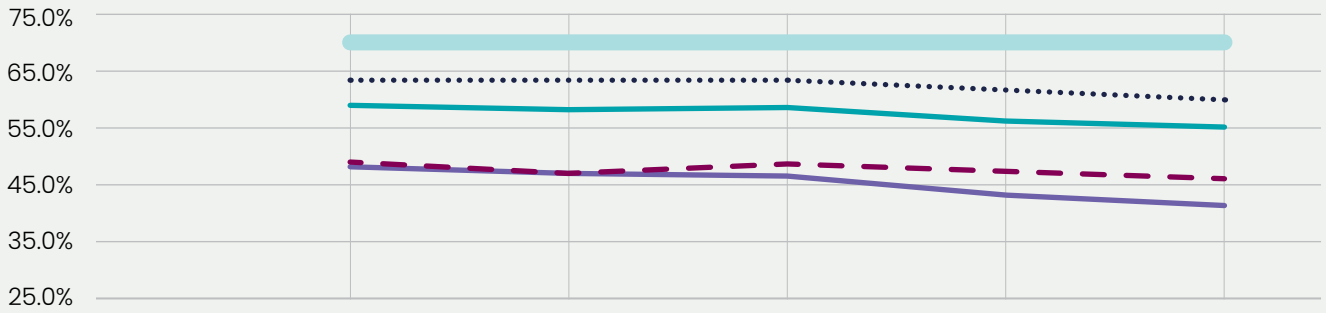
Measure	Result	Target	Status
Percentage of infants fully breastfed at three months of age as recorded on the WCTO NHI dataset	55.2%	70%	↓

Pēpi benefit from breastfeeding in many ways, and it is a key tool in ensuring both their early and later health as they grow. It provides exactly the right nutrition they need as babies, gives them immune system protection against illnesses like gastroenteritis, ear infections, asthma and meningitis, and helps reduce their risk of later obesity. It also has many benefits for mothers, including helping them bond with their baby, helping with weight loss after pregnancy, and providing protection against pre-menopausal breast cancer.

This measure is reported as part of the Well Child Tamariki Ora Quality Improvement Framework developed in 2013, drawing on New Zealand and international research. The Framework and quality indicators provide a mechanism to drive improvement in the delivery of WCTO services. Ultimately, they aim to support the WCTO programme to ensure all children and their families/whānau are supported to achieve their health and wellbeing potential.

This year end result shows a further decline in the proportion of infants fully breastfed at three months, falling 1% overall and 2% for those of Pacific ethnicity. The total population has dropped almost 3.9% since the 2019 financial year. This result is a clear indication of the importance of the Kahu Taurima workstream and the need for innovation to support better outcomes for our pēpi in their formative years.

PERCENTAGE OF INFANTS FULLY BREASTFED AT THREE MONTHS OF AGE



	Jun-19	Jun-20	Jun-21	Jun-22	Jun-23
TOTAL	59.1%	58.4%	58.9%	56.2%	55.2%
MĀORI	48.6%	47.1%	48.6%	46.9%	45.9%
PACIFIC	48.2%	47.0%	46.5%	43.3%	41.4%
NON-MĀORI, NON-PACIFIC	63.4%	63.2%	63.3%	60.9%	60.1%
70% TARGET	70.0%	70.0%	70.0%	70.0%	70.0%

Measure	Result	Target	Status
Percentage of children enrolled with an oral health service	97.3%	95%	✓

Baseline period (Statement of Performance Expectations 2022-23): Sampled at 1 April 2022

Baseline value: Māori 80%, Pacific 92%, Non-Māori and Non-Pacific 100%

NOTE that in the wording of the measure above, taken from the Statement of Performance Expectations 2022-23, 'children' is defined for reporting as those aged 0-4 years. This measure is also included in the Vote Health Supplementary Estimates of Appropriation 2022-23 with alternative wording, Percentage of children aged 0 to 4 years of age inclusive, who are enrolled with Te Whatu Ora – Health New Zealand/Te Aka Whai Ora – Māori Health Authority funded oral health services.

This measure is reported as a full calendar year of January-December 2022. The 2023 data is expected in July 2024. We note that there remain some reporting issues with data at a regional level, and by ethnicity, with some districts experiencing IT system or mode of collection issues. Further, issues with the denominator (total eligible population) make it difficult to report national figures by ethnicity.

The measure is an important one, however, as it enables us to track the proportion of our tamariki aged 0-4 years who have the opportunity to have their teeth checked by a dental therapist. This means that children with oral health problems such as cavities can have these attended to, saving them pain and other potential issues that can then lead to them missing out on proper nutrition, socialising and learning at school. Healthy teeth and gums when children are young also promotes good oral health later in life.

At a national level, 97.3% of all eligible pre-school age children are enrolled with an oral health service, exceeding the target of 95%. To support optimal enrolment by Māori whānau and Pacific aiga, Te Whatu Ora and Te Aka Whai Ora are establishing a National Oral Health Equity Programme that aims to address inequities in oral health for Māori and Pacific and will include actions to address enrolment and service access, a key Kahu Taurima action in Te Pae Tata.

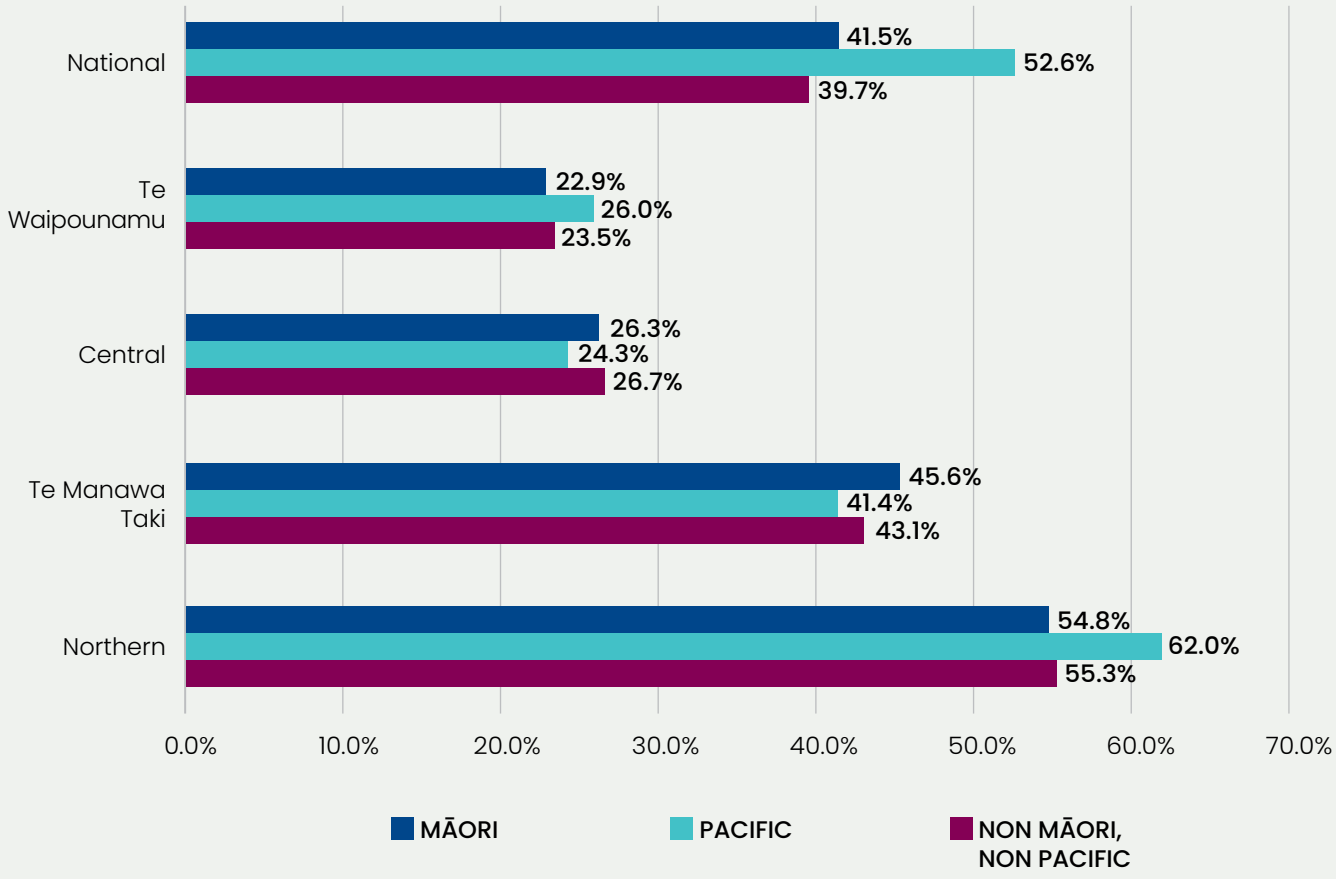
Measure	Result	Target	Status
Percentage of pre-school and primary school children enrolled with Te Whatu Ora-Health New Zealand/Te Aka Whai Ora-Māori Health Authority funded oral health services that are overdue for their scheduled examinations	Māori 41.5% Pacific 52.6% Non-Māori/ Non-Pacific 39.7%	10% or lower	↑

This measure is reported as a full calendar year of January-December 2022. The 2023 data is expected in July 2024.

This measure goes further than the oral health measure above and identified the proportion of our tamariki who have, for whatever reason, not accessed the funded examination of their teeth scheduled for them. It helps Te Whatu Ora (and Te Aka Whai Ora) understand the extent to which there are issues of access to these oral health services.

Data shown below for full year 2022 shows that a significant percentage of school-aged children are missing their scheduled examinations (missing the target of 10% or lower) and that, nationally, the rate is higher for Māori and Pacific children. Te Whatu Ora and Te Aka Whai Ora are establishing a National Oral Health Equity Programme that aims to address inequities in oral health for Māori and Pacific and will include actions to address enrolment and service access, a key Kahu Taurima action in Te Pae Tata.

CHILDREN UP TO SCHOOL YEAR EIGHT OVERDUE FOR SCHEDULED EXAMINATIONS IN THE COMMUNITY ORAL HEALTH SERVICE (JANUARY-DECEMBER 2022)



Reducing acute admissions to hospital

In young children

Acute admissions to hospitals can potentially be reduced through good primary care. The technical term used to measure this is Ambulatory Sensitive Hospitalisations or ASH.

Child ASH rates were dramatically affected by the response to COVID-19, falling by 31% in the year to March 2021 compared to the pre-pandemic year to March 2020. They have since returned to higher levels for all ethnicities, close to the pre-2020 rates. The increase was most rapid in Pacific children.

The most common reasons for these young children to go to hospital are for asthma, upper and ear nose and throat respiratory infections, gastroenteritis, and dehydration. All of these illnesses are highly sensitive to living conditions and to early and effective primary care services.

Measure	Result	Target	Status
Children 0-4 years: Rate of hospital admissions for an illness that might have been prevented or better managed in the community	Māori **8,192** Pacific **14,639** Non-Māori/ Non-Pacific **6,616** Overall **7,752**	Reduce from baseline (trend to decrease)	↓

Baseline period: Q4 2021 to Q3 2022

Baseline value: Māori 6,590, Pacific 10,258, Non-Māori and Non-Pacific 4,802 (per 100,000 of population)

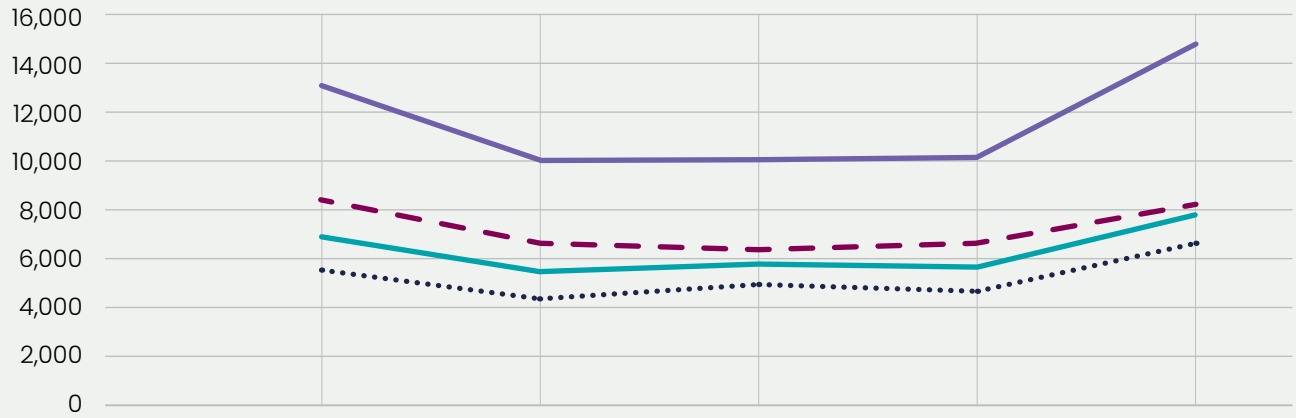
NOTE that in our Statement of Performance Expectations 2022-23, the target for this measure was recorded incorrectly as 'Reduce from baseline (trend to increase)'. And, while we report an overall result for the year to June 2023, no overall baseline was given for the baseline period in the Statement of Performance Expectations 2022-23.

ASH is when someone is hospitalised for a condition that could have been treated or managed in primary or community care, preventing the hospitalisation. In the ideal scenario, primary and community care will effectively manage the health of as much of the population as possible. For children, this can be quite distressing as they are away from home in an environment that is unfamiliar. However, remaining home is not always possible, and, in some cases, inpatient treatment is unavoidable.

Multiple factors including social and environmental determinants have a large impact on ASH rates and this measure provides context for further analysis. Results are presented as a rate per 100,000 population. Rates are calculated as the number of ASH admissions to hospital for children aged between 0 and 4 years divided by the number of children in the population.

In the period we see an increase in the rate of hospitalisation across all groups, particularly for Pacific people with a rise from 10,092 to 14,639 per 100,000 children. Change was likewise seen for Māori and all populations in the system. This is in part from the effect of the health system returning to normal functioning post-pandemic, however further investigation will be undertaken to understand the drivers of this increase in avoidable hospitalisations.

CHILDREN 0-4 YEARS, ASH RATE PER 100,000 POPULATION



	12 months to June 2019	12 months to June 2020	12 months to June 2021	12 months to June 2022	12 months to June 2023
ALL ETHNICITIES	6,933	5,506	5,782	5,729	7,752
MĀORI	8,351	6,645	6,335	6,692	8,192
PACIFIC	13,016	10,042	9,931	10,092	14,639
NON-MĀORI, NON-PACIFIC	5,506	4,414	4,987	4,710	6,616

Note: A recent review has found that children aged over 4 years but less than 5 years with certain respiratory diagnoses (wheeze and lower respiratory infection) were formerly excluded from the ASH calculation for ages 0-4. Children with any other ASH condition between 4 and 5 years old were included. We estimate that the total number of ASH events for children aged 0-4 was formerly undercounted by between 1.9% and 3.1% annually over the years 2019-22.

The 45-64 age group

Acute admissions to hospitals for adults can also potentially be reduced through good primary care. Cardiovascular conditions due to smoking, diet and high body weight can be managed by good advice and access to regular preventive medicines. Cellulitis hospitalisations are avoidable given better living conditions and quick access to primary care.

All are a measure of the accumulation of disadvantage throughout childhood and early adulthood due to exposure to the risk factors and to adverse environments.

The 45-64 age group is chosen for the indicator as it is the age group most sensitive to these accumulating risks. We know that Māori and Pacific are diagnosed with diabetes and cardiovascular disease 10-15 years younger than New Zealand Europeans, which contributes to their more than doubled rate of hospitalisation shown here.

Two of the top three ASH conditions are cardiovascular: angina and myocardial infarction. The second most common in Pacific and Māori populations is cellulitis.

Measure	Result f	Target	Status
Adults 45-64 years: Rate of hospital admissions for an illness that might have been prevented or better managed in the community	Māori **6,981** Pacific **8,127** Overall **3,739**	Reduce from baseline (trend to decrease)	↓

Baseline period: Q4 2021 to Q3 2022

Baseline value: Māori 6,739, Pacific 7,370, Non-Māori and Non-Pacific 4,802 (per 100,000)

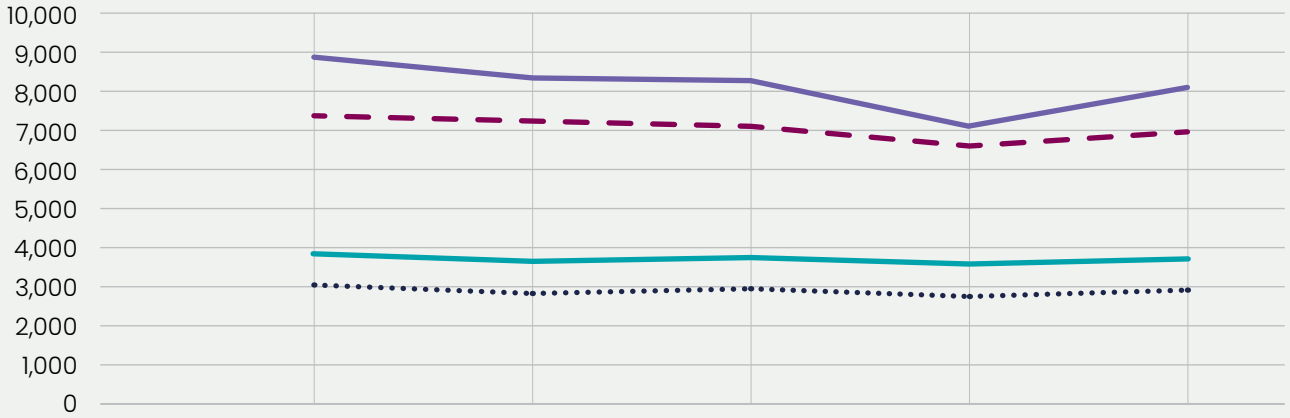
NOTE that in our Statement of Performance Expectations 2022-23, the target for this measure was recorded incorrectly as 'Reduce from baseline (trend to increase)'. Further, while we report an overall result for 2022-23, no overall baseline value was provided in our Statement of Performance Expectations 2022-23.

ASH is when someone is hospitalised for a condition that could have been treated or managed in primary or community care, preventing the hospitalisation. In the ideal scenario, primary and community care effectively manages the health of as much of the population as possible. However, this isn't always possible and, in some cases, inpatient treatment is unavoidable. Multiple factors including social and environmental determinants have a large impact on ASH rates and this measure provides context for further analysis.

Results are presented as a rate per 100,000 population. Rates are calculated as the number of ASH admissions to hospital for adults aged between 45 and 64 years divided by the number of adults in the population. Adult ASH rates are standardised to the Māori population's age structure, to support comparisons between ethnicities.

In the period we saw a slight increase for Māori and total population, with Pacific moving to a 1,000 per 100,000 rate increase for avoidable hospitalisation in this cohort. Given the emphasis that Te Pae Tata places on keeping people well in the community, work will continue to reduce these hospital events.

ADULTS 45-64 YEARS, STANDARDISED ASH RATE (AGE STANDARDISED TO STATS NZ POPULATION)



	12 months to June 2019	12 months to June 2020	12 months to June 2021	12 months to June 2022	12 months to June 2023
ALL ETHNICITIES	3,868	3,689	3,713	3,556	3,739
MĀORI	7,434	7,233	7,074	6,655	6,981
PACIFIC	8,878	8,414	8,350	7,113	8,127
NON-MĀORI, NON-PACIFIC	3,051	2,897	2,938	2,850	2,944

Access for adult New Zealanders to primary care

Ready access to primary care services when you most need them is an important part of the system and allows us to reserve emergency department care for those with acute care needs.

An established relationship with a provider also supports the goal of keeping people well in their communities, with individual needs and experience being understood more clearly.

Measure	Result f	Target	Status
Percentage of people enrolled with a general practice or a kaupapa Māori provider	Māori **83%** Pacific **95%** Non-Māori/ Non-Pacific **98%** Total **95%**	95%	↓

Baseline period: Sample at 1 July 2022

Baseline value: Māori 83%, Pacific 97%, Non-Māori and Non-Pacific 96%

This measure refers to people enrolled with general practices including those operated by a kaupapa Māori provider. It is important as it provides us with a snapshot of the accessibility of primary care services and allows us to target initiatives to address non-enrolment.

A PHO (Primary Health Organisation) provides primary health services either directly or through its general practice providers. The services provided aim to improve and maintain the health of the enrolled population, ensuring that general practice services are connected with other health services to ensure a seamless continuum of care.

Enrolment is important as it provides us with a snapshot of the accessibility of primary care services and allows us to target initiatives to address non-enrolment.

There was a 1% increase in estimated enrolment overall from 94% in July 2022. The percentage of Māori remained the same (83%), Pacific peoples saw a decline of 2% (from 97%) and the Non-Māori and Non-Pacific grouping increased by 2% (from 96%). The percentage of people enrolled is necessarily estimated, as the underlying population number comes from StatsNZ population predictions.

	Percentage of people enrolled with a general practice or a kaupapa Māori provider at 30 June 2023		
Region	**Total Enrolled**	**Total Population**	**Percentage**
Northern	1,864,022	1,919,500	97%
Te Manawa Taki	965,610	1,035,375	93%
Central	916,014	979,525	94%
Te Waipounamu	1,163,905	1,210,360	96%
Total	**4,909,551**	**5,144,760**	**95%**

Measure	Result	Target	Status
Percentage of the Māori population enrolled with a PHO	83%	95%	↓

This measure refers specifically to Māori enrolled with PHOs. A PHO provides primary health services either directly or through its general practice providers. The services provided aim to improve and maintain the health of the enrolled PHO population, ensuring that general practice services are connected with other health services to ensure a seamless continuum of care.

The measure is important as it contributes to building our picture of the accessibility of primary care services across all population groups and allows us to target initiatives to address non-enrolment.

The estimated percentage of Māori enrolled remained the same compared to a sample at 1 July 2022, at 83%. The percentage of people enrolled is necessarily estimated, as the underlying population number comes from StatsNZ population predictions.

Measure	Result	Target	Status
Percentage of people who report they can get primary care when they need it	Māori **72.4%** Pacific **73.8%** Asian **76.1%** Non-Māori/ Non-Pacific/ Non-Asian **78.5%** Total **77.3%**	Improve from baseline (trend to increase)	↓

Baseline period: Q4 2021 to Q3 2022

Baseline value: Māori 73%, Pacific 77%, Non-Māori and Non-Pacific 80%

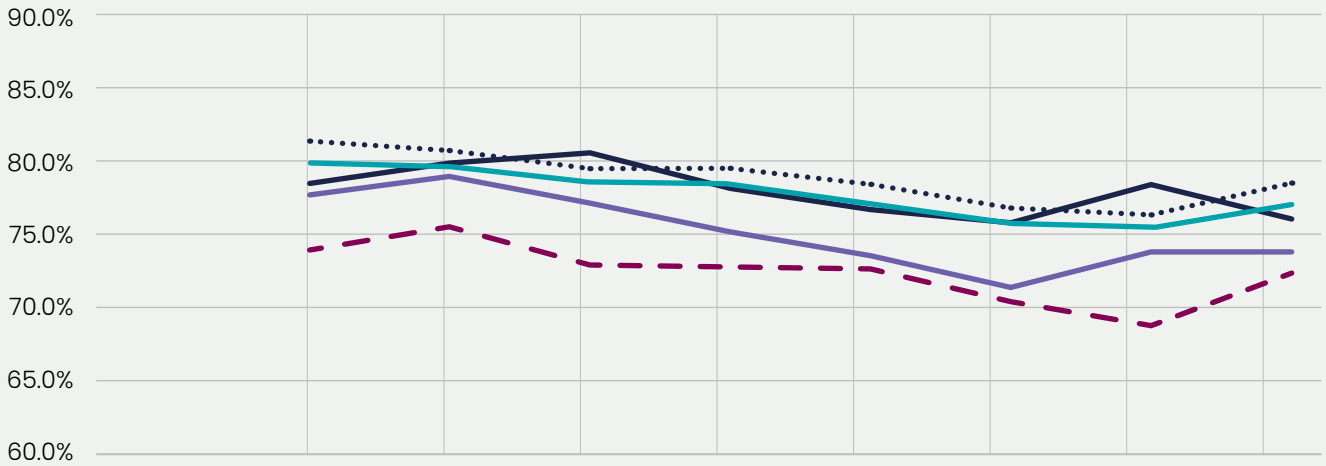
Providing timely and convenient access to primary care is an important way of giving people and their whānau the ability to have ownership over their health.

The health system has been placed under significant pressure over the past few years responding to the COVID-19 pandemic. Workforce pressures, particularly the recruitment and retention of GPs and nurses, have impacted the ability of general practices being able to accept new patients. In some areas this has caused longer wait times to see a GP.

Overall 77.3% of those surveyed in the Patient Experience Survey in May 2023 (a survey run by Te Tāhū Hauora | Health Quality & Safety Commission) reported they were able to access a general practice when they needed it. Focusing on this question over time as below, we can see a decline in affirmative responses to this question as the impacts of the pandemic response continue to affect the health system, with Māori reporting the lowest rate at 72.4%.

The adult primary care survey received 34,658 responses for the May 2023 sample representing a reponse rate of 17.4%. The margin of error for this question is + / – 0.4%.

PERCENTAGE OF PEOPLE WHO REPORT THEY CAN GET PRIMARY CARE WHEN THEY NEED IT



	Aug-21	Nov-21	Feb-22	May-22	Aug-22	Nov-22	Feb-23	May-23
MĀORI	73.9%	75.5%	72.9%	72.9%	72.6%	70.4%	68.8%	72.4%
PACIFIC	77.7%	78.9%	77.2%	75.2%	73.5%	71.4%	73.8%	73.8%
ASIAN	78.5%	79.9%	80.6%	78.1%	76.7%	75.8%	78.5%	76.1%
NM/NP/NA	81.4%	80.8%	79.5%	79.5%	78.3%	76.8%	76.3%	78.5%
TOTAL	80.0%	79.9%	78.7%	78.4%	77.2%	75.6%	75.5%	77.3%

Leveraging technology to improve primary care access

Communications, connections and data possibilities are changing the way we all live, work and access services.

Health is no different and we are harnessing the benefits of technology to make healthcare easier to access and in a way that people want.

Measure	Result	Target	Status
Improve digital access to primary and mental health care to improve access and choice, including virtual after-hours and telehealth, with a focus on rural communities.	Milestone report		✓

Fully funded 24/7 clinical telehealth services have been provided nationally to support eligible general practices with after hours and overflow services. There has also been a range of Te Whatu Ora clinical and virtual telehealth services provided to take pressure off emergency departments and primary care.

A national rural clinical telehealth service was designed and the request for proposals was published in June 2023. This service will support rural communities to have better access to primary care services, GP and nurse consults.

Consumers and whānau are part of decision-making about their healthcare

The *Code of expectations for health entities' engagement with consumers and whānau* (the Code) was released in August 2022 by HQSC, setting out the expectations for how health entities must work with consumers, whānau and communities in the planning, design, delivery and evaluation of health services.

Health entities (as defined in the Act) must report annually on how they have given effect to the Code.

Practical guidance and resources to support staff across the health sector to work in a way that is consistent with these expectations has been developed as a collaborative effort by health entities, including Te Whatu Ora. This guidance is now live on the Te Tāhū Hauora website.

Measure	Result	Target	Status
Percentage of people who report they were involved as much as they wanted to be, in making decisions about their treatment in general practice care	Māori **85.8%** Pacific **85.2%** Asian **84.4%** Non-Māori/ Non-Pacific/ Non-Asian **87.2%** Total **86.7%**	Improve from baseline (trend to increase)	✓

Baseline period (Statement of Performance Expectations 2022-23): Q4 2021 to Q3 2022

Baseline value: Māori 84%, Pacific 84%, Non-Māori and Non-Pacific 86%

The June 2023 update of the SPE 2022-23 incorrectly added a baseline value for Tāngata whaikaha | Disabled people.

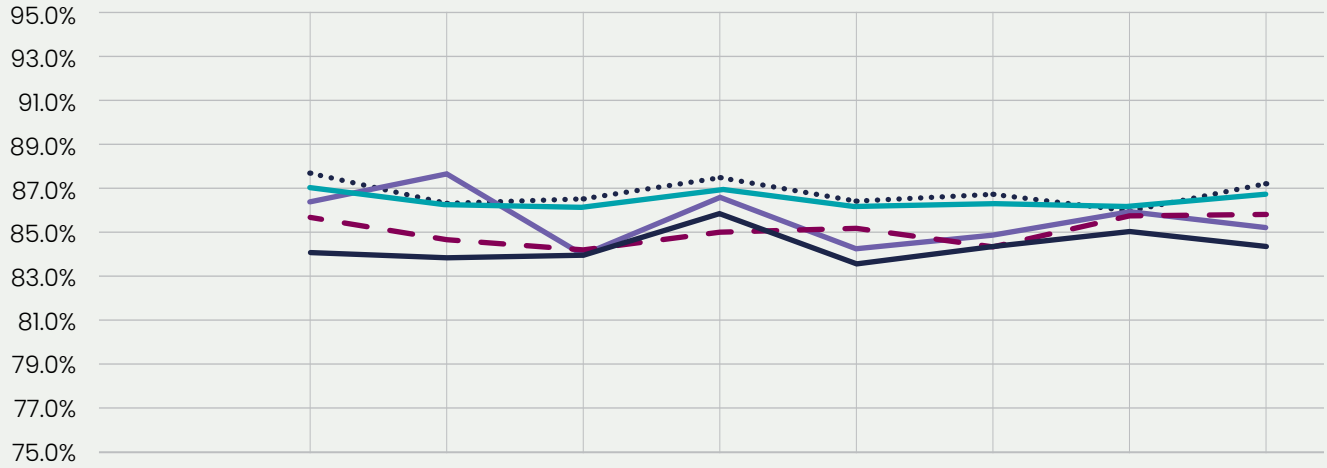
A trip to general practice can be difficult for both patient and whānau, where results are communicated and important decisions may need to be made. Therefore, it is important that our system allows people the opportunity to have their views heard.

This measure is important as it provides us a sense of the extent to which people are feeling they are being given an opportunity to participate in decision-making about their care when unwell. 86.7% of those surveyed in the Patient Experience Survey (run by Te Tāhū Hauora | Health Quality & Safety Commission) in May 2023 reported they feel fully involved in decision-making with respect to treatment, with a further 10.5% feeling somewhat involved.

Analysing this question in the survey over time, such as by ethnicity below, shows this result is relatively consistent across all ethnic groups surveyed, with Asian people reporting the least involvement at 84.4%, and Māori and Pacific reporting 85.8% and 85.2% respectively.

The adult primary care survey received 34,658 responses for the May 2023 sample representing a reponse rate of 17.4%. The margin of error for this question is + / - 0.4%.

PERCENTAGE OF PEOPLE WHO REPORT THEY WERE INVOLVED AS MUCH AS THEY WANTED TO BE



	Aug-21	Nov-21	Feb-22	May-22	Aug-22	Nov-22	Feb-23	May-23
MĀORI	85.7%	84.7%	84.2%	85.1%	85.2%	84.4%	85.8%	85.8%
PACIFIC	86.4%	87.7%	84.0%	86.6%	84.3%	84.9%	86.0%	85.2%
ASIAN	84.1%	83.8%	84.0%	85.9%	83.6%	84.4%	85.2%	84.4%
NM/NP/NA	87.7%	86.4%	86.5%	87.5%	86.4%	86.7%	86.0%	87.2%
TOTAL	87.1%	86.0%	85.9%	87.0%	85.8%	86.1%	85.9%	86.7%

Measure	Result	Target	Status
The approved New Zealand Health Plan sets out mechanisms to be developed to elevate the voices of people with lived experience in the design of primary and community care services	Achieved	Achieved	✓

This measure relates to Te Pae Tata, the interim New Zealand Health Plan.

Work has begun and is in the formative stages to elevate the voices of consumers and whānau across our health system.

Existing patient experience surveys in both hospitals and primary care provide valuable insights from consumers and whānau. Building on this, Te Pae Tata sets out a number of actions to elevate the voices of people with lived experience in the design of all areas of health delivery. Te Whatu Ora is collaborating with Te Tāhū Hauora to build the co-design of service models with consumers into our health system, with a focus on Pacific voices, the voices of Tāngata whaikaha | Disabled people, and the voices of ethnic communities and the rainbow community.

Further measures related to primary and community healthcare

Measure	Result	Target	Status
Actual investment decisions ensure balanced investment across appropriations and time horizons [short (up to 2 years), medium (3-5 years) and longer-term (5+ years)] to shift investment into primary and community care services	Achieved	Achieved	✓

Te Whatu Ora continues the work to ensure that development of services in primary and community services is prioritised, to prevent unnecessary illness and treat people before they need Hospital and Specialist Services. This is supported by the development of a culture of continuous improvement, to drive productivity and changes in models of service delivery to ensure Hospital and Specialist Services are making best use of resources to meet the specialist needs of our communities.

Service coverage expectations (appended to the interim Government Policy Statement) are fully met for Primary, Community, Public and Population Health Services	100%	100%	✓

The Government's Minimum Service Coverage Expectations for the health sector are set out in the Service Coverage Schedule 2021-22. This Service Coverage Schedule is the foundation for the nationwide service specifications for Hospital and Specialist Services and is being fully met.

Measure	Result	Target	Status
All approved NZHP milestones agreed with the Minister for Primary, Community, Public and Population health services are delivered or adjusted milestones are agreed	63%	100%	↓
The interim New Zealand Health Plan (NZHP), or Te Pae Tata, laid out 70 actions for Primary, Community, Public and Population health services for financial year 2022-23. As at 31 June 2023, 44 of the 70 actions reached the agreed milestones and the remainder have been adjusted accordingly. The key achievements relate to the creation of a more unified, smarter, sustainable and equity-led health system – section 3 of Te Pae Tata. The actions that Primary, Community, Public and Population Health Services are accountable for in this section encompass support for healthy ageing, continuum of care, resilience and capability for pandemic responses, and adopting new healthcare technologies.			
The New Zealand Health Plan sets out a path in agreed service areas to improve the consistency of primary and community care service provision to align with population need over time	Achieved	Achieved	✓
This measure relates to Te Pae Tata, the interim New Zealand Health Plan. Change to drive improvements is already happening through implementation of Te Pae Tata which sets out actions such as the development of Comprehensive Primary and Community teams and aligning funding to need with changes to the primary care funding formula. The overall redesign of primary and community care has a longer, multi-year timeframe out to 2027.			
Improvement plans are in place for agreed Health System Indicators relevant to annual Ministerial priorities for primary and community care by the date agreed by the Minister of Health	Achieved	Achieved	✓
Improvement plans were put in place by the date agreed for Health System Indicators within the remit of primary and community health and in accordance with Ministerial priorities.			
Percentage of PHOs that have implemented, trained staff and audited the quality of ethnicity data using EDAT within the past three-year period	–	100%	–
EDAT is an acronym for Ethnicity Data Audit Toolkit. This measure was selected in 2022 as part of supporting information provided alongside the Vote Health Estimates of Appropriation for 2022-23. However, it was never part of the contractual agreements of PHOs, and therefore they have not collected data that enables us to report against this target.			

Measure	Result	Target	Status
Percentage of PHOs with Stage 3 EDAT results that show a level of match in ethnicity data of greater than 90 percent	–	100%	–
This measure was selected in 2022 as part of supporting information provided alongside the Vote Health Estimates of Appropriation for 2022-23. However, it was never part of the contractual agreements of PHOs, and therefore they have not collected data that enables us to report against this target. EDAT is an acronym for Ethnicity Data Audit Toolkit.			
Percentage of people enrolled with a PHO aged 15-74 with diabetes on the health virtual diabetes register with a most recent HbA1c during the past 12 months of equal to or less than 100mmol/mol; and greater than 100mmol/mol)	–	Less than or equal to 8% for all ethnic groups	–
Unable to report. Data collection stopped as of June 2022 when district health boards were disestablished.			
Percentage of people enrolled with a PHO aged 15-74 with diabetes on the health virtual diabetes register with a most recent HbA1c during the past 12 months of equal to or less than 64mmol/mol	–	95-100% for all ethnic groups and overall	–
Unable to report. Data collection stopped as of June 2022 when district health boards were disestablished.			
Percentage of people enrolled with a PHO aged 15-74 with diabetes on the health virtual diabetes register with a most recent HbA1c during the past 12 months of equal to or less than 80mmol/mol	–	More than 60% for all ethnic groups and overall	–
Unable to report. Data collection stopped as of June 2022 when district health boards were disestablished.			

Pacific Health

Our vision is a health system that delivers equitable health outcomes for Pacific people and a future where Pacific families live longer, healthier lives.

Ola Manuia Interim Pacific Health Plan 2022–24 is a companion document to Te Pae Tata, the interim New Zealand Health Plan. It was developed following an in-depth needs analysis and extensive engagement with community, leaders and Pacific health providers.

Ola Manuia both strengthens enablers while taking actions on priorities, and the approach which is data-led and community informed has allowed us to rapidly prioritise what our partners and providers need, and to identify priority outcomes for our community where we have focused our attention.

During 2022–23, we made important progress in engaging with Pacific communities and responding to their health needs. Highlights included:

- The formation of the National Pacific Health Senate Fatu Fono Ola, a network of senior Pacific clinicians from various disciplines and areas across the motu in November 2022. The Senate provides Te Whatu Ora with Pacific equity leadership and objective, strategic advice on Pacific health transformation initiatives.
- The establishment of the Pacific Health pipeline to enable targeted pathways and service improvements at a system level for Pacific health priorities. The Pacific Health Senate was supported by the Service and Improvement Innovation Unit to endorse three priority areas to explore within the pipeline: endometrial cancer, chronic kidney disease and rheumatic fever. Other key health priorities that were endorsed by the Senate include diabetes and oral health.
- The processes for the National Diabetes Action Plan are underway and due for completion in line with Te Pae Tata 2024–27 planning.
- The Pacific provider networks were strengthened nationally, by
  - Pacific Provider Development Funding to support the improvement of capacity and capability.
  - Confirming Outreach Contracts that will enable Pacific providers to pivot the COVID-19 workforce to deliver services including immunisations and screening, support for those with long term conditions and surge capacity.
  - Developing outcome-based, integrated contracts to remove complexity by creating one contract per provider.

Budget 22 Initiatives: updates
Addressing the Burden of Diabetes for Pacific Communities
This initiative provides funding to implement a diabetes prevention and treatment programme for targeted Pacific communities in South Auckland.
Pacific Primary and Community Care Provider Development
This initiative provides a funding uplift to the Pacific Provider Development Fund. It will secure the advanced primary and community care capability developed by Pacific providers and funded by time-limited COVID-19 funding and ensure these are supported in the reformed system.

Further progress

Commissioning work is underway to streamline Pacific investments from the organisations we inherited into a single management plan and approach for Te Whatu Ora.

We have been supporting the Auckland floods and Cyclone Gabrielle response by establishing two emergency centres in South Auckland, ensuring the 24/7 operation of these centres, and partnering with others including NEMA, Civil Defence, Pacific health providers and churches to provide wraparound support for Pacific people.

Pasifika Mapu o le Kaha'u

Pasifika Mapu o le Kaha'u (Pasifika Young People of the Future) is a locally led initiative that started in Dunedin Hospital, by introducing Pacific secondary students to learn about various health careers. This is now being expanded to Southland Hospital.

Output Class: Hospital and Specialist Services

Hospitals and specialist services are there when you need them. The effective management of medical and surgical emergencies and planned treatment of chronic conditions makes a significant impact on people's wellbeing.

Hospital and Specialist Services is one of our five output classes. The standard of delivery achieved against this output class is reported on page 173 to page 216.

Te Whatu Ora is focused on effectively establishing joined-up, national specialist and hospital networks to optimise the capacity of these services, to achieve the goal that everyone can access the same standards of care and service.

An important part of providing a joined-up service across the country is strong national clinical leadership and governance. We are strengthening our clinical leadership and governance, and the establishment of new national clinical networks, with the first of these being networks for the trauma, stroke, cardiac and adrenal specialties. With common operating approaches and membership from professional disciplines across hospital and primary care, we support clinicians across the system to lead and drive change through the development of national standards and models of care.

This in turn supports the delivery of consistent service quality and outcomes, including the reduction of access and equity gaps, across the country. Te Pae Tata identifies the establishment of regional and national networks as a key step in removing unwarranted variations in access to care, waiting times and clinical practice.

Providing emergency medical care

Our emergency departments around the motu are a critical part of our health system. They are there when New Zealanders have emergency and acute health needs.

As a result of COVID-19 and other winter season illnesses, our EDs have experienced severe pressure. Our Winter Preparedness Plan has included a number of initiatives to lift some of that pressure and ensure that people can also access urgent care for many issues closer to home.

Other initiatives during the year focused on enhancing Māori experiences of emergency departments and ensuring access to emergency care through the availability of air and road ambulances to New Zealanders in both urban and rural locations. Additional funding in Budget 2022 enables ambulance services the necessary infrastructure and new frontline staff to deliver additional ambulance capacity to meet growth in emergency ambulance callouts.

Pou Manaaki Mana Initiative

Taranaki was the first emergency department in the country to start the Pou Manaaki Mana Initiative to improve the health equity of our Māori population. The vision of this strategy is that emergency departments in Aotearoa New Zealand will embody Pae Ora, providing excellent, culturally safe care to Māori, in an environment where Māori patients, whānau and staff feel valued, and where leaders actively seek to eliminate inequities.

It is now implemented and recently won the Australasian College of Emergency Medicine Al Spilman award for the most culturally safe Emergency Department.

Budget 22 Initiatives: updates

Additional Funding for Emergency Air Ambulance Services

This initiative provides additional funding to ensure that emergency air ambulance services continue to be available to all New Zealanders with the required level of infrastructure and resource availability. A 12% increase in flying hours was delivered in 2022-23. Budget 22 investment had increased capacity that enabled this service to redeploy aircraft and crew to support Search and Rescue during Cyclone Gabrielle without having to reduce emergency air ambulance services.

South Island services were enhanced from November 2022 with one new aircraft and additional 12-hour shift (one additional helicopter, pilots, and clinical crew) to operate in Queenstown.

Central Region services were enhanced with an additional leased aircraft to provide additional aircraft maintenance cover (due to the increased flying hours) which improved service availability. A near new Airbus H145 was funded and began operational missions from June 2023.

Northern Region services were enhanced with a fixed wing and a road patient transport service to support inter-hospital transport between the Far North and Auckland. The service provider was contracted to upgrade their aged aircraft and is working to source the new/newer aircraft.

Additional Funding for Emergency Road Ambulance Services

This initiative provides additional funding to support essential emergency road ambulance services for Aotearoa New Zealand's urban and rural communities. Road ambulance attended callouts increased by 4% for the year of which 69.7% (2021-22 69.2%) were transported to the emergency department.

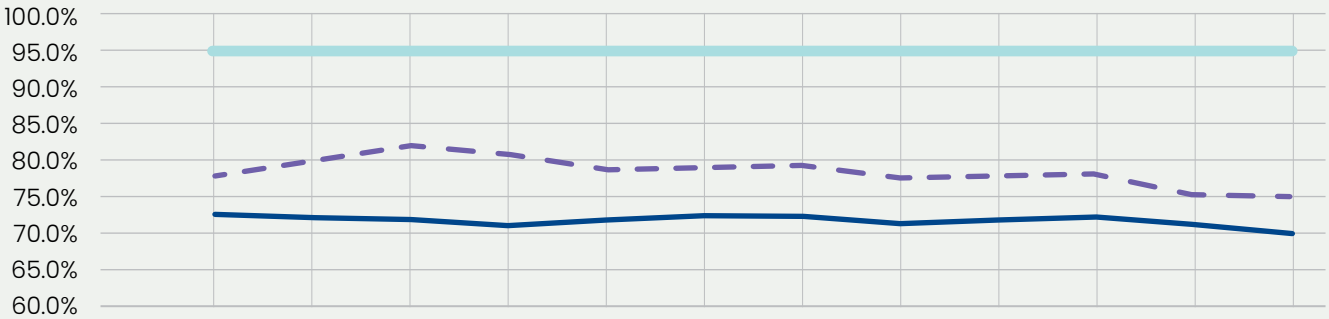
Ambulance providers advised that they have increased the frontline workforce by 176 FTE, from 1,722 to 1,898 FTE as at 30 June 2023.

Measure	Result	Target	Status
Percentage of patients admitted, discharged or transferred from an emergency department (ED) within six hours	FY 2022-23 Māori **75.9%** Pacific **70.2%** Asian **73.9%** Non-Māori/ Non-Pacific/ Non-Asian **70.3%** Total **71.8%**	95%	↓

Our emergency departments are designed to provide urgent care for those most in need when they need it. There is increasing evidence that both long stays and overcrowding in emergency departments are linked to negative clinical outcomes and distress for people and their whānau.

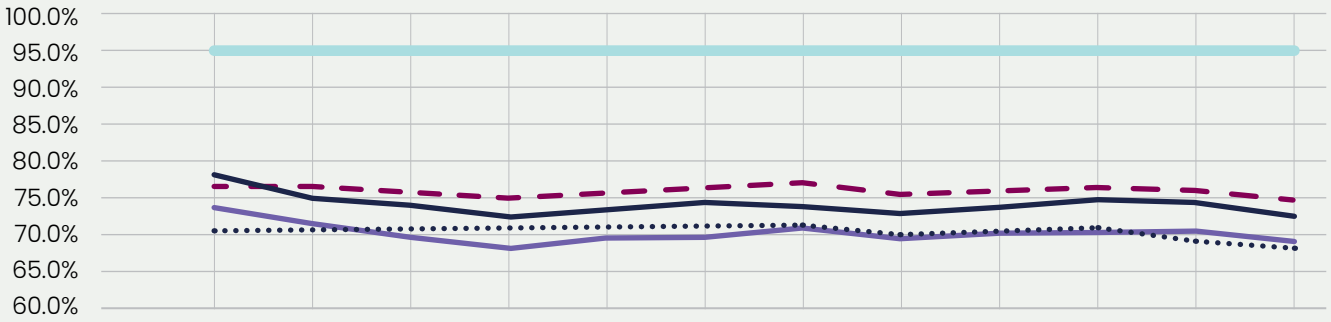
This measure reports a yearly average from regular monitoring that occurs in the system at present. The reason for a decrease or increase in achievement can be complex and this measure will support more in-depth analysis of the root cause. This is a multi-year target and operational planning currently underway for 2023-24 and outyears will address specific actions to achieve.

PERCENTAGE OF PATIENTS ADMITTED, DISCHARGED OR TRANSFERRED FROM AN EMERGENCY DEPARTMENT WITHIN SIX HOURS



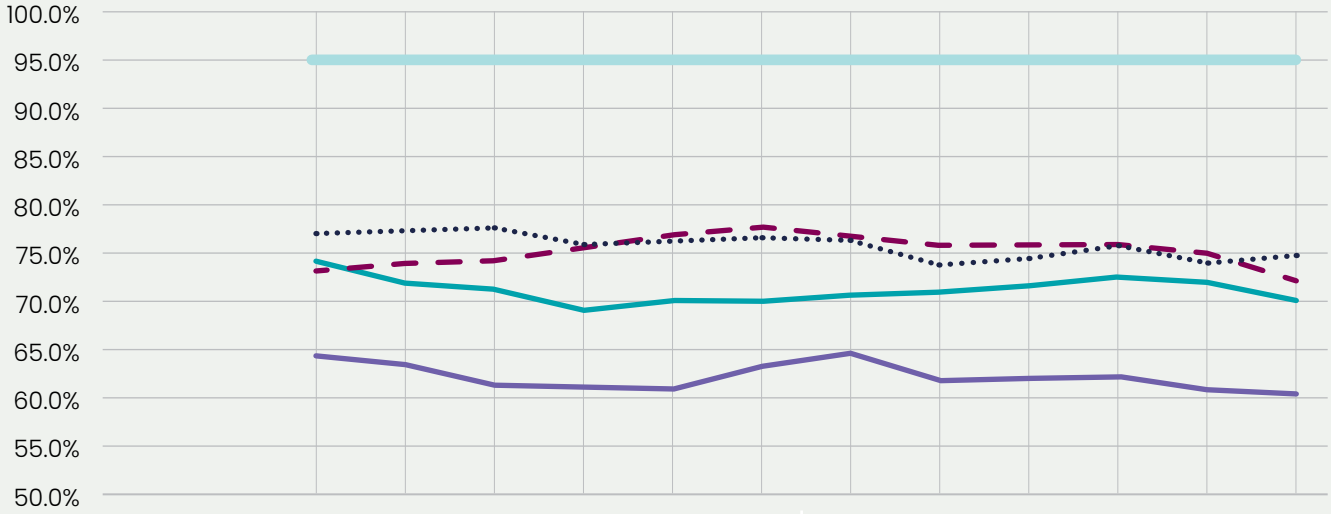
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY 22	78.0%	79.8%	82.1%	80.7%	79.0%	79.2%	79.1%	77.6%	78.1%	78.2%	75.3%	74.8%
FY 23	72.8%	72.4%	72.0%	71.2%	71.7%	72.5%	72.7%	71.3%	71.8%	72.4%	71.3%	70.1%
TARGET	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

PERCENTAGE OF PATIENTS ADMITTED, DISCHARGED OR TRANSFERRED FROM AN EMERGENCY DEPARTMENT WITHIN SIX HOURS BY ETHNICITY (FY23 ONLY)



	2022						2023					
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
MĀORI	76.6%	76.6%	75.5%	74.9%	75.8%	76.7%	77.0%	75.4%	76.1%	76.3%	75.9%	74.6%
PASIFIKA	73.5%	71.3%	69.5%	68.1%	69.4%	69.6%	70.9%	69.6%	70.2%	70.4%	70.5%	69.0%
ASIAN	78.1%	74.7%	73.9%	72.3%	73.0%	74.2%	73.7%	72.8%	73.6%	74.6%	74.4%	72.3%
NM/NP/NA	70.6%	70.6%	70.7%	70.1%	70.4%	71.2%	71.3%	69.9%	70.2%	71.0%	69.1%	68.1%
TARGET	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

PERCENTAGE OF PATIENTS ADMITTED, DISCHARGED OR TRANSFERRED FROM AN EMERGENCY DEPARTMENT WITHIN SIX HOURS



	2022						2023					
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
NORTHERN	73.8%	71.9%	71.1%	69.1%	70.1%	69.9%	70.5%	70.9%	71.7%	72.3%	72.1%	70.0%
TE MANAWA TAKI	73.2%	73.9%	74.2%	75.4%	76.8%	77.5%	76.5%	75.6%	76.0%	75.8%	74.8%	72.2%
CENTRAL	64.4%	63.4%	61.3%	61.2%	60.8%	63.3%	64.6%	61.8%	62.1%	62.2%	60.9%	60.3%
TE WAIPOUNAMU	77.1%	77.4%	77.7%	76.0%	76.1%	76.6%	76.6%	73.9%	74.4%	75.9%	74.1%	74.7%
TARGET	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

Planned care

Our current focus within planned care is ensuring those people who have been waiting the longest for treatment are prioritised for surgery. Progress is being made and we are starting to see results.

The goal is to have anyone who has been waiting longer than 365 days scheduled for treatment by the end of the next financial year (30 June 2024).

Ongoing work to standardise how data is collected is well underway. We now have greater visibility on a national basis to validate waitlists. A national templated letter has been developed for districts to send to patients who have been waiting longer than four months for surgery and are yet to be scheduled for surgery. This nationally consistent letter will also allow waitlists to be validated as patients are asked to feedback and update their records if they are outdated.

The overall planned care improvement implementation plan areas of focus include:

- reduction of treatment wait lists
- reducing inequity in those waiting a long time for treatment
- reduction of the wait list for first specialist assessment
- theatre optimisation
- clinical prioritisation
- clinical pathways
- innovative service models that can be delivered through one health system.

Measure	Result	Target	Status
Number of planned care interventions, including: **inpatient surgical discharges, minor procedures delivered in inpatient, outpatient and community settings and non-surgical interventions, such as early intervention musculoskeletal programmes**	318,789	Improve from baseline (trend to increase)	✓

Baseline period: Financial year 2021-22

Baseline values: Māori 31,905, Pacific 16,617, Non-Māori and Non-Pacific 251,172, Total 299,694

Demand for planned care services is increasing for several reasons, including both the increasing size of our ageing population and new technologies that mean more types of treatments are available. The planned care vision is that 'New Zealanders experience timely, appropriate access to quality planned care which achieves equitable health outcomes', aligning with the direction of Te Pae Tata.

This measure is important as it provides the means to monitor the responsiveness of planned care services and to support ongoing efforts to remove barriers to accessing timely care.

The total national result for FY2022-23 is 318,789 interventions – which is 108.7% of the planned level of 293,285. We are unable to disaggregate this further by ethnicity at this time and further analytical work will be required to do so to reconcile against baseline figures from the Statement of Performance Expectations.

	Planned	Actual	Percentage
FY2022-23	293,285	318,789	108.7%
FY2021-22	293,285	299,694	102.2%

Measure	Result	Target	Status
Percentage of Planned Care Inpatient treatment case mix included elective and arranged discharges from a surgical specialty, or from a medical specialty where a surgical procedure has been provided are no less than the discharges planned to be delivered nationally by DHBs in 2021-22	FY 2022-23 89.1%	100%	↑

The planning of discharges by the districts in 2021-22 is based on the New Zealand Casemix Framework For Publicly Funded Hospitals and the target of 100% is brought forward into Te Whatu Ora's 2022-23 Budget Standard.

The 2022-23 result, which missed the target of 100%, reflects the continued impacts of COVID-19 including higher levels of staff absenteeism, reduced international recruitment and shortfall in specialist roles (such as Anaesthetic Technicians).

This resulted in an inability to run all operating rooms and has driven higher volumes of non-complex cases being completed as day cases in outpatient, non-theatre facilities as they do not require a theatre to be set up and the patient does not stay overnight. Some of these procedures are counted rather than case-mix coded, which may also contribute to the result. Additionally, high hospital occupancy reduced the number of beds available to be used post complex surgeries..

Despite the challenges, the percentage of planned care inpatient treatment surgical case mix performed in FY2022-23 increased by 5% with 9,433 more surgeries than FY2021-22. We are unable to disaggregate this further by ethnicity at this time and further analytical work will be required to do so to reconcile against baseline figures from the Statement of Performance Expectations.

	Planned	Actual	Percentage
FY2022-23	188,691	168,126	89.1%
FY2021-22	188,691	158,693	84.1%

Measure	Result	Target	Status
Percentage of Planned Care minor Interventions comprised of elective or arranged non-case mix surgical procedures, which are completed in an inpatient setting and coded to NMDS and Outpatient or Community based minor procedures, which are completed in an outpatient or community setting and coded to NNPAC, that are delivered are no less than the interventions planned by DHBs in 2021-22	FY 2022-23 146.6%	100%	✓

NNPAC - National Non-admitted Patient Collection

Continued impacts following COVID-19 have resulted in higher levels of staff absenteeism, reduced international recruitment and shortfall in specialist roles (such as Anaesthetic Technicians) which results in an inability to run all operating rooms and has driven higher volumes of non-complex cases being completed. Operating rooms used for complex procedures are often being used for high turnover non-complex procedures due to staff shortages and other procedures can be delivered as day cases in outpatient, non-theatre facilities as they do not require the patient to stay overnight, which has resulted in the increase in minor procedures reported. There is also a drive to treat patients waiting over 365 days which contributes to the increased volumes reported. Regardless, more minor interventions day surgeries were delivered than planned in order to optimise the use of available theatre capacity.

	Planned	Actual	Percentage
FY2022-23	101,066	148,160	146.6%
FY2021-22	101,066	138,572	137.1%

Measure	Result	Target	Status
First specialist assessments per 100,000 people	Māori **9,994**	Improve from baseline (trend to increase)	✓
	Pacific **10,206**		
	Asian **7,751**		
	Non-Māori/ Non-Pacific/ Non-Asian **12,586**		
	Total **11,193**		

Baseline period: Q4 2021 to Q3 2022

Baseline value: 11,010

Despite the challenges of post-COVID-19 recovery and workforce pressures, the rate of first specialist assessments in FY2022-23 has gone up by 1.7% improving from baseline. One of the initiatives to manage first specialist assessment wait list is the Musculoskeletal prototype for the Orthopaedic specialty. The strategies taken include prioritising districts with high volumes of patients waiting, and optimisation of wait list with allied health-physiotherapy assessments. As a result, 546 patients no longer required an assessment by an orthopaedic surgeon.

Next steps for FY2023-24, a new clinical pathway is being developed for managing referrals to Orthopaedics from GPs.

Elective Services Patient Flow Indicators

There are five Elective Services Patient Flow Indicators (ESPIs) that measure whether the system is meeting the required performance standard at a number of key decision, or indicator, points on a person's journey through the planned care system. We recognise that waiting for assessment by a specialist doctor or for treatment is an anxious time for patients and are committed to ensuring that patients can move through the different points in the system as quickly as possible.

Data broken down geographically by district is available for the ESPIs on the Te Whatu Ora website.

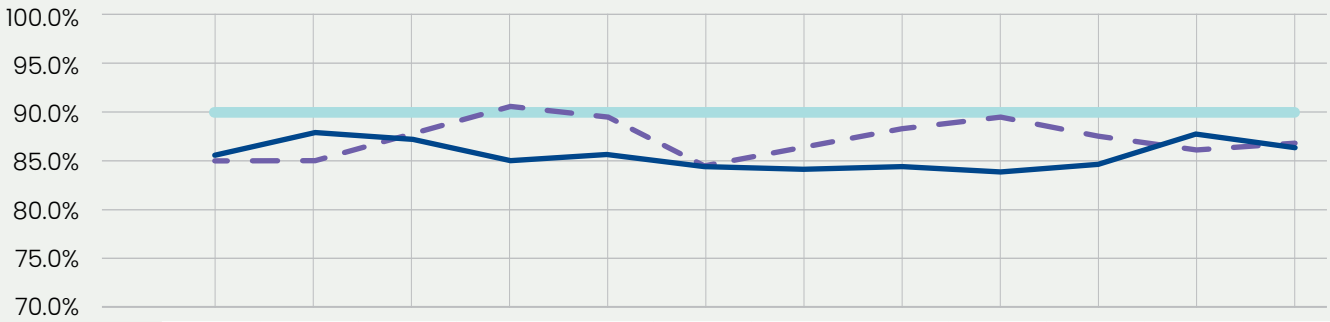
Measure	Result	Target	Status
ESPI 1 – Percentage of services that report that more than 90% of referrals within the service are processed in 15 calendar days or less	FY 2022-23 86.3%	100%	↓

Following a request for a specialist opinion, a patient and their primary care practitioner are to be advised in 15 calendar days or less whether or not a first specialist assessment (FSA) is indicated and can be provided (within 4 months). If an FSA is not offered, advice on alternative care options should be provided if applicable.

This measure is important because it enables us to track whether services appropriately acknowledge and process patient referrals in 15 calendar days or less. For the full year to end June 2023, the result was 86.3% of referrals that were processed in 15 calendar days or less.

Over the past 2 financial years, at a national level the target of 90% has not been met consistently, though some regions have achieved this. This is a direct effect of pandemic-related disruption for both patients and clinicians, in addition to ongoing work to address planned care services being at different stages at a district level.

ESPI 1 – PERCENTAGE OF SERVICES THAT REPORT THAT MORE THAN 90% OF REFERRALS WITHIN THE SERVICE ARE PROCESSED IN 15 CALENDAR DAYS OR LESS



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY 22	84.9%	85.1%	87.7%	90.3%	89.5%	84.5%	86.3%	88.4%	89.4%	87.7%	86.0%	86.7%
FY 23	85.6%	88.0%	87.3%	85.1%	85.6%	84.4%	84.2%	84.4%	84.1%	84.6%	87.8%	86.3%
90% TARGET	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%

Measure	Result	Target	Status
ESPI 2 – Patients waiting longer than four months for their first specialist assessment (FSA)	As at June 2023 30.4%	0%	↓

Baseline period: Q4 2021 to Q3 2022

Baseline value: 26%

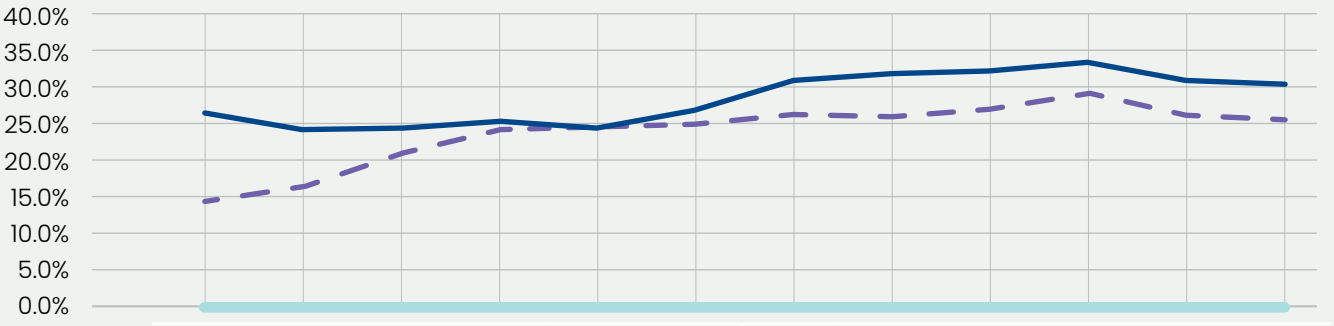
All patients accepted for a first specialist assessment (FSA) should be seen within 4 months of the date of referral.

This measure is important as it enables us to monitor the extent to which we are meeting this goal. The measure focuses on the time taken to see a specialist to inform treatment planning, and, in combination with other measures, gives an indication of progress. The result for 2022-23 was that 30.4% of patients waited longer than 4 months for their FSA. The target is 0% – no patients waiting longer than 4 months.

In the past two finanical years, the system has been under the direct effect of the pandemic which has disrupted service provision with the knock-on effects of fluctuating staffing resource and operating capacity affecting efforts to achieve the desired 0% target.

The measure is currently reported at a national level for the whole population, a focus on ethnicity and geographical areas is the preferred approach for future versions. This is a multi-year target and operational planning currently underway for 2023-24 and outyears will address specific actions to achieve this.

ESPI 2 – PATIENTS WAITING LONGER THAN FOUR MONTHS FOR THEIR FIRST SPECIALIST ASSESSMENT (FSA)



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY 22	14.3%	16.3%	20.9%	24.2%	24.6%	25.1%	26.2%	26.1%	27.0%	28.9%	26.1%	25.6%
FY 23	26.4%	24.3%	24.6%	25.1%	24.5%	27.2%	30.9%	31.9%	32.3%	33.4%	30.8%	30.4%
TARGET	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Measure	Result	Target	Status
ESPI 3 – Percentage of patients in Active Review with a priority score above the actual Treatment Threshold (aTT)	-	0%	-

This measure allows us to track the number of patients above health services' aTT who have not been given a commitment to treatment. The goal is to have no patients above the aTT without a commitment to treatment.

We are no longer able to provide reporting against this measure. While the measure has not been formally retired, a key component (the Active Review patient category) has been, and this means it is no longer possible to calculate a result.

Measure	Result	Target	Status
ESPI 5 – Patients given a commitment to treatment but not treated within four months	As at June 2023 38.1%	0%	↓

NOTE that the wording of this measure, above, is as recorded in our Statement of Performance Expectations 2022-23. The same measure is also included in the Vote Health Estimates of Appropriation 2022-23 with the following wording: Percentage of patients who are waiting over 120 days for treatment. The difference in wording does not represent a difference for the calculation and reporting of the relevant data.

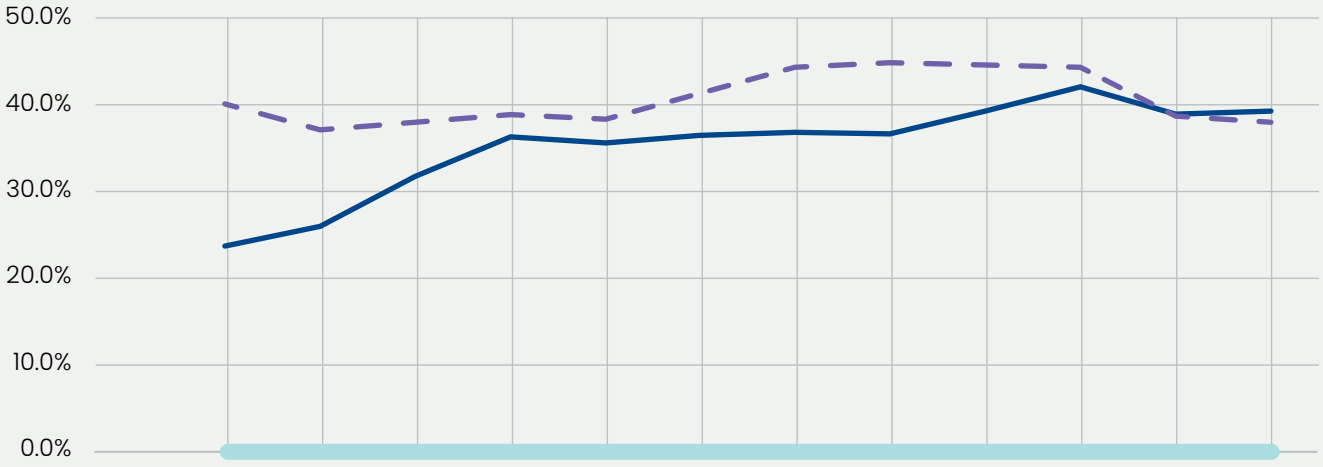
Baseline period: Q4 2021 to Q3 2022

Baseline value: 41%

All patients given a commitment to treatment should receive it within 4 months. The goal of this measure is to monitor that no patients with this status remain untreated after 4 months. The measure focuses on the time taken to see a specialist to inform treatment planning, and, in combination with other measures, gives an indication of progress. The result for the year to June 2023 was 38.1%, compared to a result of 39.4% for the 2021-22 year.

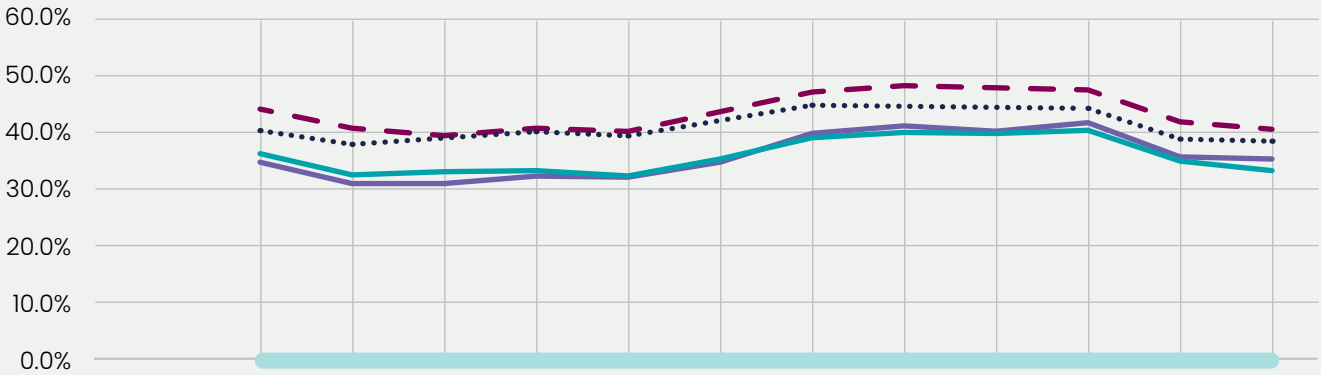
The measure is currently reported at a national level for the whole population, a focus on ethnicity and geographical areas is the preferred approach for future versions. This is a multi-year target and operational planning currently underway for 2023-24 and outyears will address specific actions to achieve this.

ESPI 5 – PATIENTS GIVEN A COMMITMENT TO TREATMENT BUT NOT TREATED WITHIN FOUR MONTHS



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY22	23.9%	26.1%	31.9%	36.3%	35.7%	36.6%	37.0%	36.6%	39.3%	42.0%	39.0%	39.4%
FY23	40.3%	37.3%	38.1%	39.1%	38.4%	41.5%	44.4%	45.0%	44.5%	44.3%	38.8%	38.1%
TARGET	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

ESPI 5 – PATIENTS GIVEN A COMMITMENT TO TREATMENT BUT NOT TREATED WITHIN FOUR MONTHS (FY23 ONLY)



	2022						2023					
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
MĀORI	44.2%	40.6%	39.4%	40.7%	40.0%	43.6%	47.2%	48.3%	47.8%	47.6%	41.9%	40.5%
PACIFIC	34.8%	30.8%	30.8%	32.1%	32.0%	34.7%	39.9%	41.2%	40.3%	41.8%	35.7%	35.3%
ASIAN	36.2%	32.4%	33.0%	33.3%	32.2%	35.3%	39.1%	40.1%	39.9%	40.4%	34.9%	33.1%
NM/NP/NA	40.3%	37.7%	39.1%	40.1%	39.4%	42.5%	44.9%	45.1%	44.7%	44.2%	38.8%	38.5%
TARGET	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

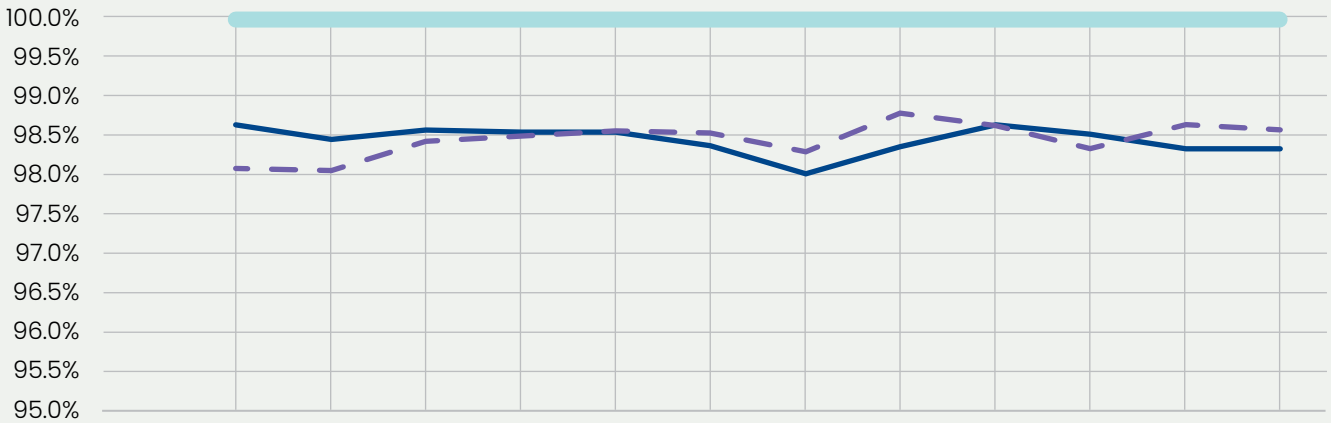
Measure	Result	Target	Status
ESPI 8 – Percentage of patients prioritised using an approved national or nationally recognised prioritisation tool	As at June 2023 98.3%	100%	↓

A number of prioritisation tools are available to assist clinicians to assign a priority to patients.

This measure enables us to track the percentage of patients prioritised using national or nationally recognised processes or tools. The goal is to have all patients prioritised using nationally recognised processes or tools.

The results for the past two financial years show a close to target achievement nationally. Similar to other ESPI targets there is some geographical variation, however, this result is a positive indication of the system working New Zealand-wide in a uniform manner to deliver planned care services.

ESPI 8 – PERCENTAGE OF PATIENTS PRIORITISED USING AN APPROVED NATIONAL OR NATIONALLY RECOGNISED PRIORITISATION TOOL



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY22	98.1%	98.0%	98.4%	98.5%	98.6%	98.5%	98.3%	98.8%	98.6%	98.3%	98.6%	98.6%
FY23	98.6%	98.4%	98.6%	98.5%	98.5%	98.4%	98.0%	98.4%	98.6%	98.5%	98.3%	98.3%
TARGET	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

HEALTHCARE IN ACTION

Significant reduction in planned care waitlists for Northern Region

The Northern Region has seen a significant reduction in the number of people waiting more than 365 days for planned care. This includes a drop in the number of patients waiting more than 365 days for treatment from 1,807 people at 30 June 2022 to 441 as at 30 June 2023 – a 76% reduction.

In addition, the number of patients waiting more than 365 days for a first specialist appointment has also fallen from 1,822 people at 30 June 2022 to 527 as at 30 June 2023 – a 71% reduction. Forecasting indicates the number of patients waiting more than 365 days on both waitlists will continue to reduce.

The 'starting positions' for different areas vary, but the region aligned to ensure no patient was left behind in any district. Regional leadership groups created commonality of purpose and rapid decision-making, which has provided the platform for a regional approach to planned care waitlist management.

Cardiac care

Cardiac surgery is undertaken within five districts within New Zealand: Auckland, Waikato, Capital and Coast, Canterbury and Southern. The treatment of cardiovascular diseases in a timely way is important to save lives and prevent long term disability, thereby improving health outcomes for New Zealanders.

Like all health services, cardiac surgery experienced constraints on its ability to deliver through 2022-23 as a result of managing COVID-19, ICU and ward capacity restrictions, workforce shortages, increased demand and elective treatments being displaced by acute presentations. These have resulted in patients waiting longer than the recommended timeframe for treatment, as the waiting lists increased in number, and acute presentations displaced planned elective treatment.

The National Cardiac Programme was established to identify strategies to address the length of time patients waited for treatment and to improve equity and access. We have reduced the number of patients waiting for cardiac surgery from a high of 483 in January 2023 to 394 as at the end of June 2023. Work continues into the 2023-24 year to improve access and eliminate patients waiting beyond their urgency timeframe for treatment.

Measure	Result	Target	Status
Percentage of patients (both acute and elective) who are waiting for their cardiac surgery and are within the urgency timeframe based on their clinical urgency	Result as at Quarter 4: 41.4%	100%	↓

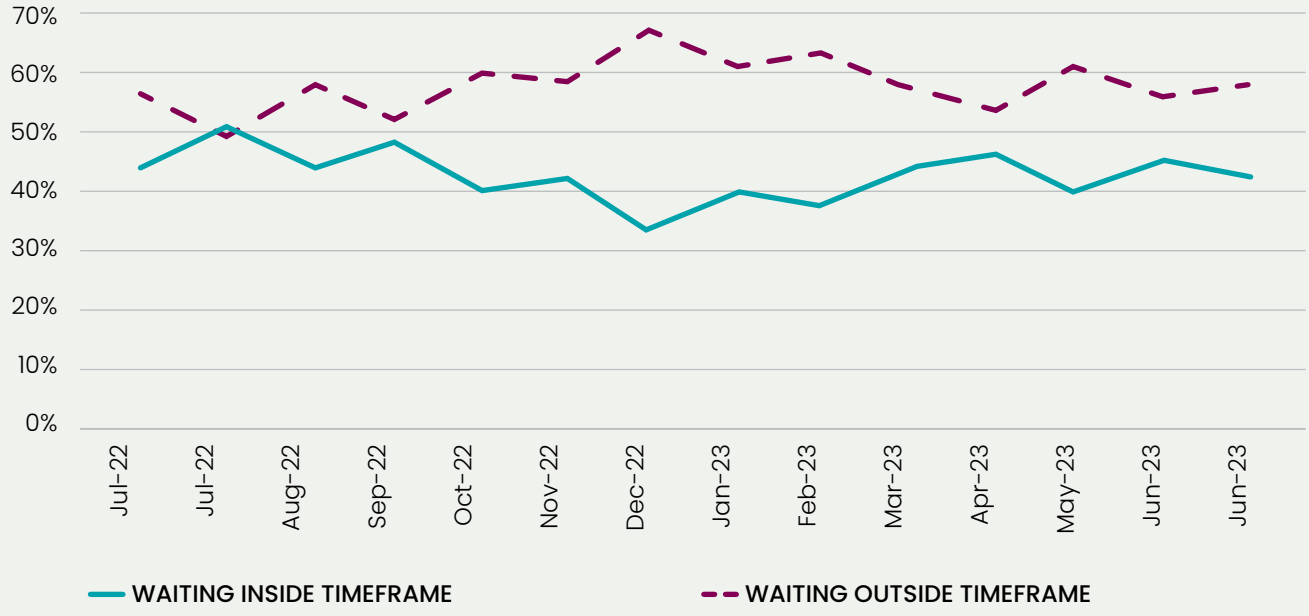
Cardiac results are generally collected on a weekly basis. At points in 2022-23, data was only collected every two weeks. The quarterly results in the table below are based on the available weekly result closest to the end of each quarter.

Information supporting this measure is provided by the five locations where cardiac surgery occurs. There was not a consistent approach to record keeping across these five locations nor a centralised information point. Some locations were unable to provide supporting records for this measure as the relevant information systems are live and the patient waiting times at particular points in a year cannot practically be reproduced. As a result we were unable to verify the accuracy of our reporting against this measure.

Note that this measure was recorded in the Vote Health Estimates of Appropriation 2022-23 erroneously as *Percentage of patients (both acute and elective) who receive their cardiac surgery within the urgency timeframe based on their clinical urgency*. Due to the difficulty involved in verifying the previous financial year's data, we are unable to report the result against the measure. Therefore, we have substituted this alternative metric above which is indicative of activity levels and demand within cardiac care.

Target Area	Target	Q1	Q2	Q3	Q4
Percentage of patients (both acute and elective) who are waiting for cardiac surgery within their urgency timeframe based on clinical priority	100%	54.8%	30.9%	43.3%	41.4%

CARDIAC PATIENTS WAITING INSIDE/OUTSIDE TIMEFRAME FINANCIAL YEAR 2022–23



Radiology improvements

The installation of an additional MRI magnet at Auckland City Hospital will provide greater MRI capacity for cardiac patient scans. The additional onsite capacity for cardiac scans means other onsite imaging assessments or procedures can be performed alongside the MRI appointment, helping to streamline the patient pathway.

In addition, an upgrade of the MRI scanner at Greenlane Clinical Centre will extend the life of the current machine, which was installed in 2014 with an indicated lifespan of 8-10 years. New state-of-the-art components will soon be installed around the existing bore or magnet. The upgraded machine functions like a new Siemens Magnetom Vida scanner but at a fraction of the cost of a new machine.

North Shore Hospital introduced a newly upgraded Northern Regional Interventional Radiology Unit with another significant boost to radiology services following the addition of a $1.7m replacement CT scanner and echocardiogram.

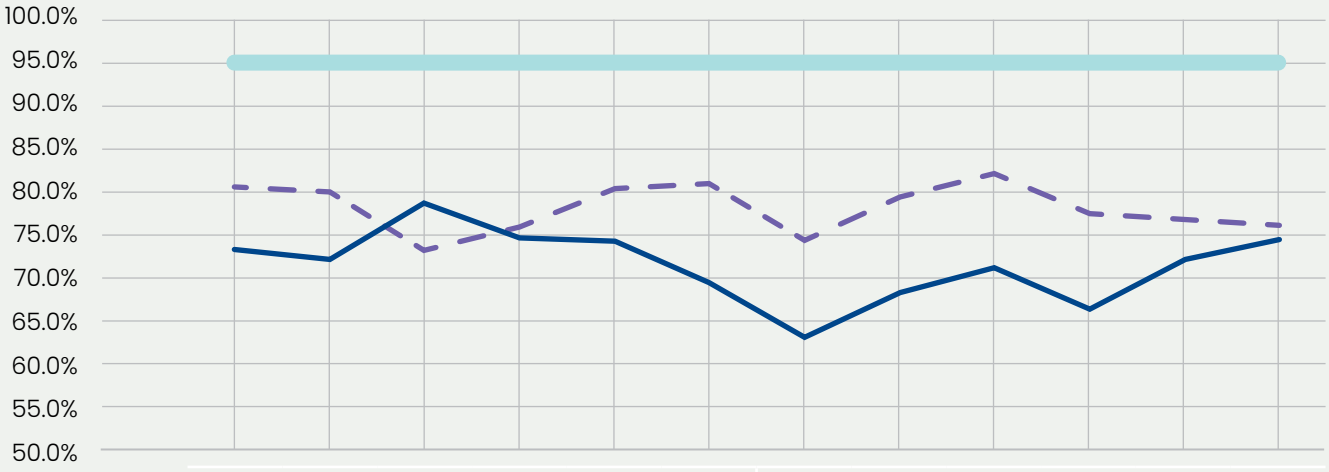
Kaitaia Hospital's X-ray Department has undergone a complete overhaul and now features state-of-the-art equipment with scenic images by local artists adorning its walls. Renovations to the department include the installation of MOBILETT Elara Max and Ysio MAX equipment, which, compared to the previous equipment, provides increased image quality, faster x-ray times and lower radiation doses. Whangārei and Bay of Islands hospitals have also had equipment upgrades, and Dargaville Hospital is due to have new equipment installed later this year.

Measure	Result	Target	Status
Percentage of patients with accepted referrals for CT scans who receive their scan, and the scan results are reported, within 6 weeks (42 days)	71.6%	95%	↓

A computerized tomography or CT scan combines a series of x-ray images taken from different angles around your body and uses computer processing to create cross-sectional images of the bones, blood vessels and soft tissues inside your body to complement other tests to diagnose conditions.

Performance over the 2022 and 2023 financial years has fallen below the desired 95% target for completion of CT referral and reporting within 42 days. In the 2023 financial year, Te Whatu Ora has seen an average of 71.6% of patients receiving their procedure within 42 days, compared to 78.1% in the financial year prior. Radiology services have faced challenges from the resourcing and physical constraints of the COVID-19 pandemic, in addition to variation of capacity of regional services. There is an increased focus on developing radiology services and returning to the target of 42 days from acceptance to reporting and this will be a central focus for services in this coming year.

PERCENTAGE OF PATIENTS WITH ACCEPTED REFERRALS FOR CT SCANS WHO RECEIVE THEIR SCAN, AND THE SCAN RESULTS ARE REPORTED, WITHIN 6 WEEKS (42 DAYS)



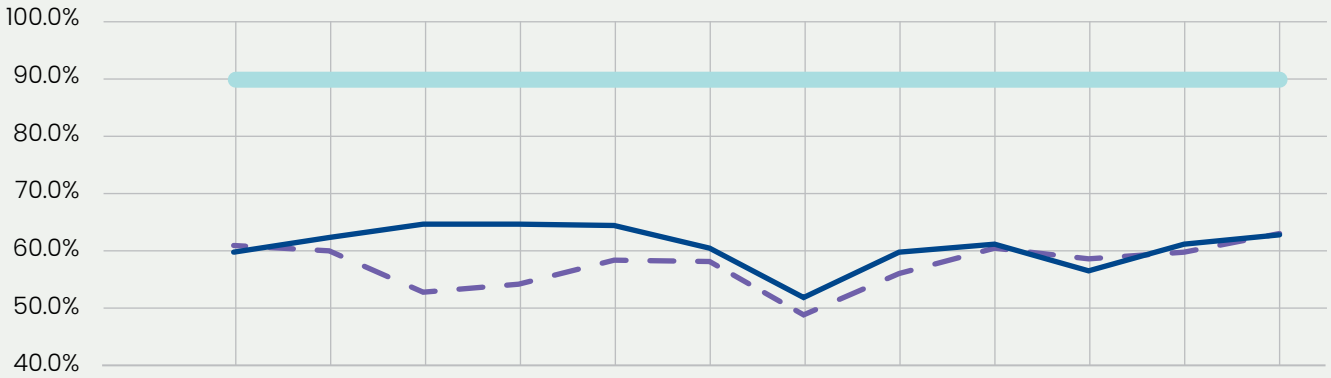
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY22	80.6%	79.9%	73.4%	75.9%	80.4%	80.9%	74.5%	79.4%	82.0%	77.5%	76.6%	76.1%
FY23	73.3%	72.2%	78.7%	74.7%	74.2%	69.5%	63.3%	68.4%	71.2%	66.5%	72.2%	74.5%
TARGET	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

Measure	Result	Target	Status
Percentage of patients with accepted referrals for MRI scans who receive their scan, and the scan results are reported, within 6 weeks (42 days)	61.2%	90%	↓

Magnetic resonance imaging (MRI) is a medical imaging technique that uses a magnetic field and computer-generated radio waves to create detailed images of the organs and tissues in your body. These detailed images can be used by clinicians to diagnose certain types of conditions and plan appropriate treatment.

Performance over the 2022 and 2023 financial years has fallen below the desired 90% target for completion of MRI referral and reporting within 42 days. In the 2023 financial year, Te Whatu Ora has seen an average of 61.2% of patients receiving their procedure within 42 days, compared to 58.1% in the financial year prior. Radiology services have faced challenges from the resourcing and physical constraints of the COVID-19 pandemic, in addition to variation of capacity of regional services given the specialist nature of MRI scanning facilities. There is an increased focus on developing radiology services and returning to the target of 42 days from acceptance to reporting and this will be a central focus for services in this coming year.

PERCENTAGE OF PATIENTS WITH ACCEPTED REFERRALS FOR MRI SCANS WHO RECEIVE THEIR SCAN, AND THE SCAN RESULTS ARE REPORTED, WITHIN 6 WEEKS (42 DAYS)



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY22	61.4%	60.5%	53.4%	54.8%	58.8%	58.6%	49.3%	56.5%	61.0%	59.0%	60.3%	63.4%
FY23	60.2%	62.7%	65.0%	65.1%	64.7%	60.9%	52.4%	60.3%	61.6%	57.0%	61.6%	63.2%
TARGET	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%

Aotearoa New Zealand All Cardiology Services Quality Improvement Programme

The primary aim of the Aotearoa New Zealand All Cardiology Services Quality Improvement programme (ANZACS-QI) is to support appropriate, evidence-based management of cardiac disease for patients admitted to hospitals across New Zealand.

Acute Coronary Syndrome (ACS) Clinical Indicators

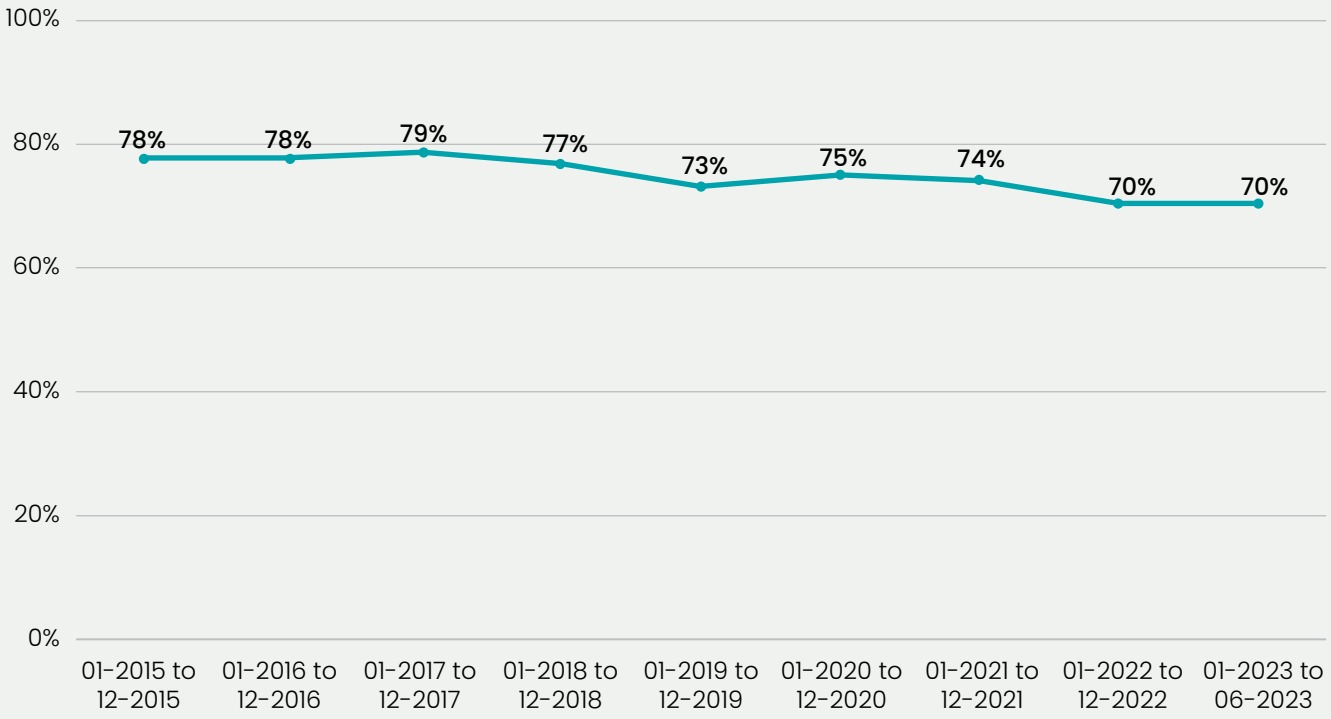
These indicators capture the three pillars of ACS management – timely intervention, cardiac function assessment, and use of prevention medications.

Measure	Result	Target	Status
Percentage of Acute Coronary Syndrome patients undergoing coronary angiogram meeting ANZACS-QI indicator door to cath timelines of within 3 days	70%	70%	✓

Acute coronary syndrome (ACS) is an umbrella term for situations where blood supply to the heart is blocked and time is criticial for a catheter to be inserted to the heart and a "balloon" inflated to reopen the affected vessel. Performance in this measure has remained strong since 2015 meeting the target of 70% at a national level. This is due to the hard work of clinicians and their teams around the country and has required services to adapt to the resourcing and physical constraints of the COVID-19 pandemic. However, the drop from close to 80% is clinically important and ongoing efforts to return to this level should be an ongoing focus.

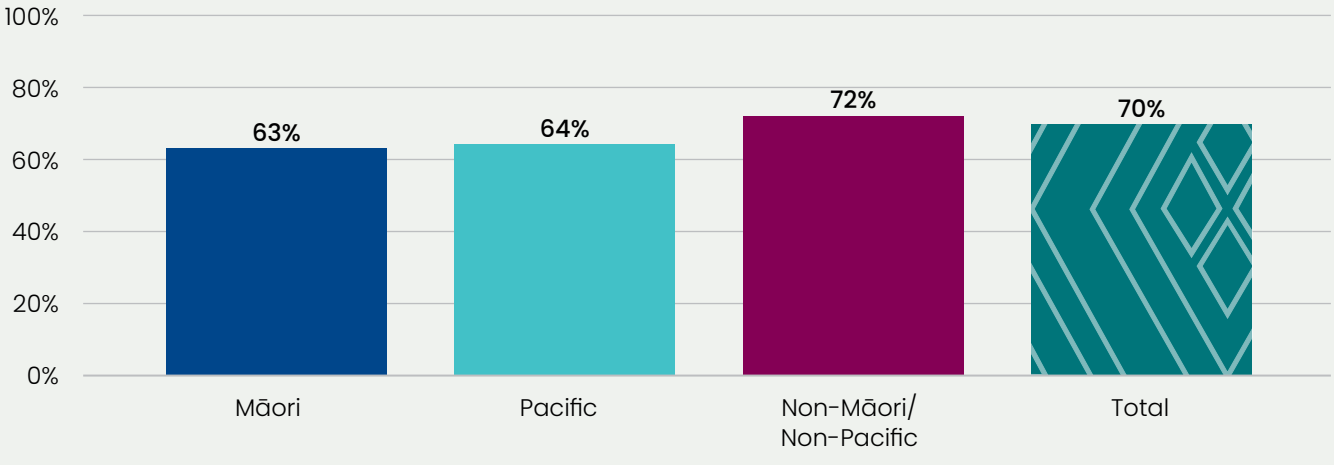
Analysing the 2022-23 financial year by ethnicity shows achievement of the target for Non-Māori and Non-Pacific at 72%, however Māori and Pacific patients when analysed separately fell below this at 63% and 64% respectively. A focus on eliminating the barriers to accessing optimal timely care will be a focus in future years.

DOOR TO CATH LAB WITHIN 3 DAYS



Please note the 2023 data in the above graph is a 6 month period only, as opposed to the 12 month periods reported for all other years.

DOOR TO CATH LAB WITHIN 3 DAYS – FY23

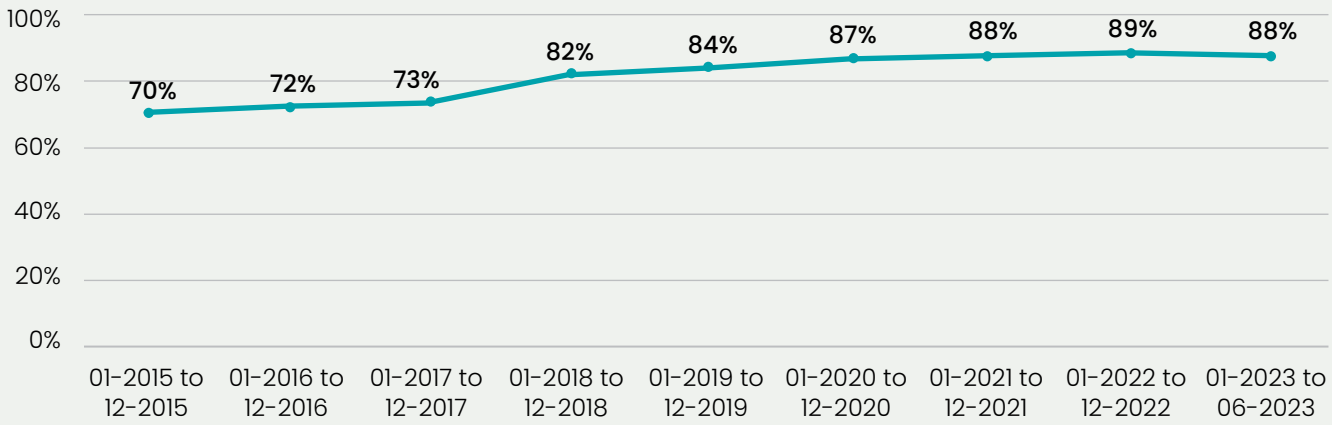


Measure	Result	Target	Status
Percentage of Acute Coronary Syndrome patients who undergo coronary angiogram and have a pre-discharge echocardiogram or LVgram	88%	85%	✓

An LVgram or Ventriculography is where a catheter is inserted into the left ventricular to apply contrast so the amount of blood the heart pumps in a single beat, known as the ejection fraction, can be visually estimated.

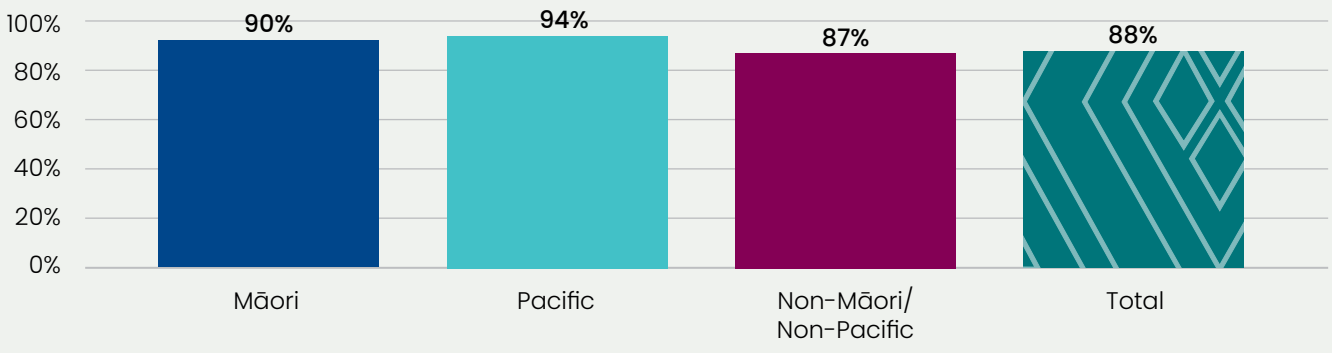
Performance in this measure has improved since 2015, now exceeding the target of 85% at a national level, in addition to meeting it for all ethnic groups. This is a positive indication of the programme's success in aligning services to best practice guidelines.

ASSESSMENT OF LEFT VENTRICULAR EJECTION FRACTION



Please note the 2023 data in the above graph is a 6 month period only, as opposed to the 12 month periods reported for all other years.

ASSESSMENT OF LEFT VENTRICULAR EJECTION FRACTION – FY23

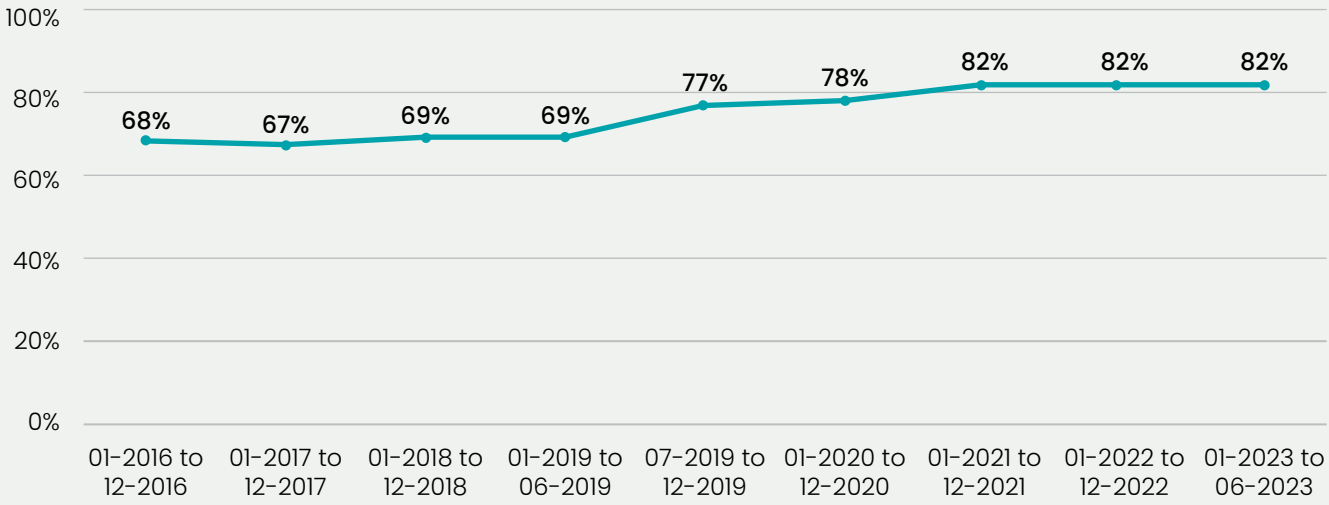


Measure	Result	Target	Status
Percentage of Acute Coronary Syndrome patients who undergo coronary angiogram and are prescribed a secondary prevention medication at discharge (in the absence of a documented contraindication/intolerance)	83%	85%	↑

The provision of a medication to reduce the risk of further heart attacks is a best practice indication to discharge. In New Zealand, we have seen a gradual increase in this indicator from 2019 to 2021 to reach a consistent 82% achievement in the past two and a half years.

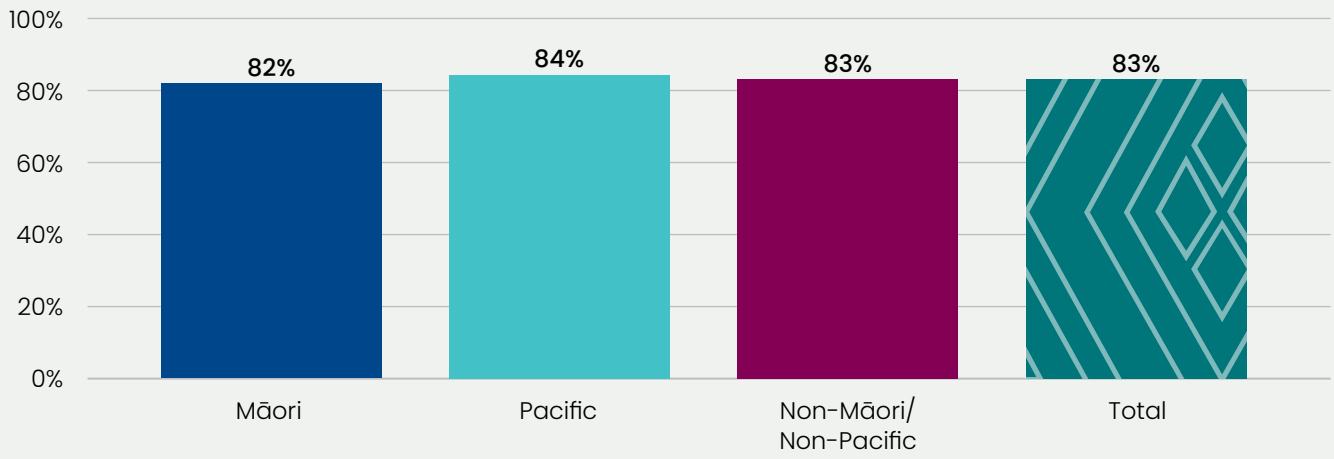
Similarly, in the 2023 financial year, all three ethnic groups fell short of the desired 85% target and thus a continued focus will be placed on this in the coming year.

COMPOSITE MEDICATION INDICATOR PRESCRIPTION AT DISCHARGE



Please note the 2023 data in the above graph is a 6 month period only, as opposed to the 12 month periods reported for all other years.

COMPOSITE MEDICATION INDICATOR PRESCRIPTION AT DISCHARGE – FY23

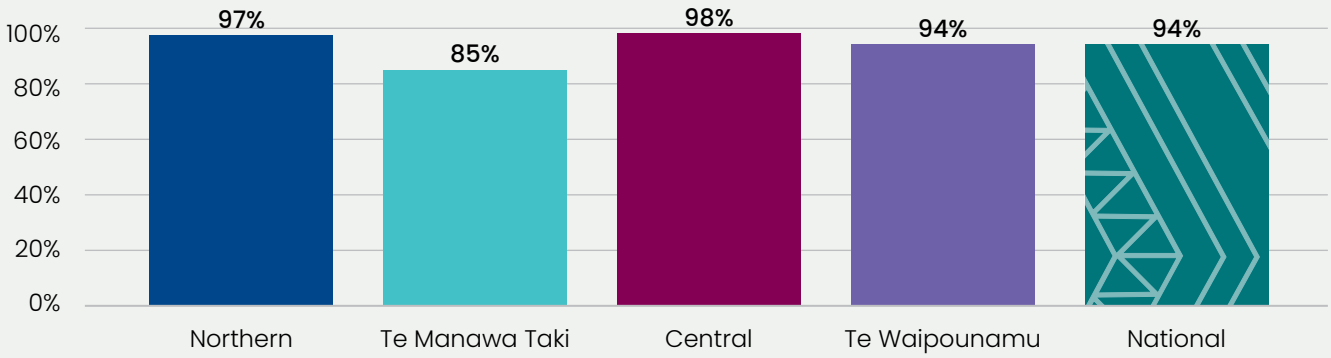


Measure	Result	Target	Status
Percentage of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS-QI ACS and Cath/PCI registry data collection within 30 days of discharge	94%	95%	↑
Percentage of patients who have pacemaker or implantable cardiac defibrillator implantation / replacement and have completion of ANZACS-QI Device PPM forms completed within 2 months of the procedure	87%	99%	↓
Percentage of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS-QI ACS and Cath/PCI registry data collection within 3 months of discharge	82%	99%	↓

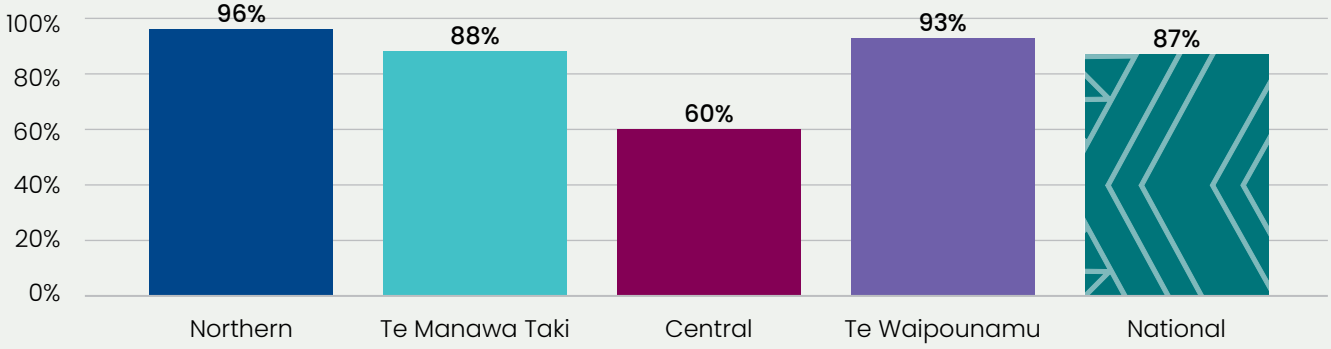
Completion of the registry information is an important facet of quality assurance and improvement of patient care which with the competing priorities of service provision and aftercare can sometimes be delayed.

These indicators did not meet the desired targets regionally or nationally. Increased emphasis will be placed on these in the coming year as resources increase post-pandemic.

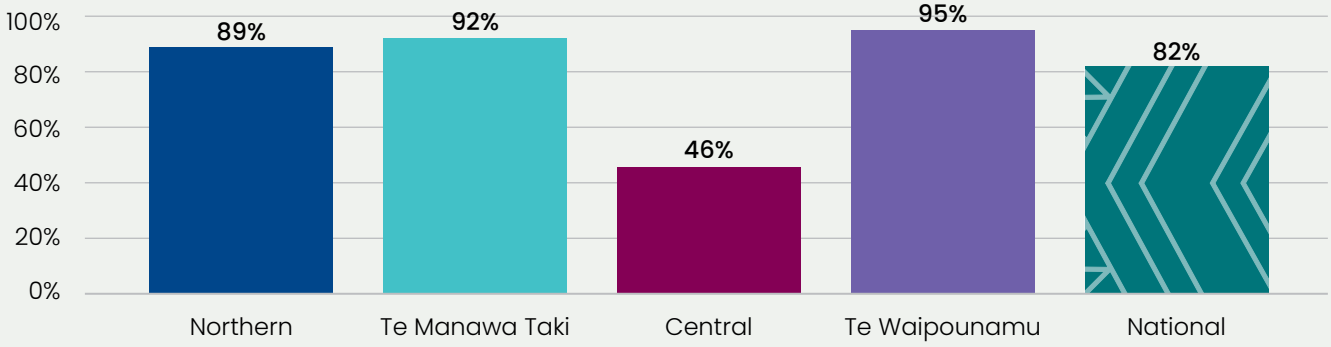
ACS REGISTRY COMPLETION AT 30 DAYS – FY23



DEVICE REGISTRY COMPLETION PPM – MAY 2022 - APR 2023



DEVICE REGISTRY COMPLETION ICD – MAY 2022 - APR 2023



Cardiac Implantable Device Clinical Indicators

There are 2 further indicators that track the timely implantation of pacemakers (PPMs) and implantable cardiac defibrillators (ICDs).

While they are beyond the scope of this annual report, this information is important to understand any constraints on accessing the system when needed.

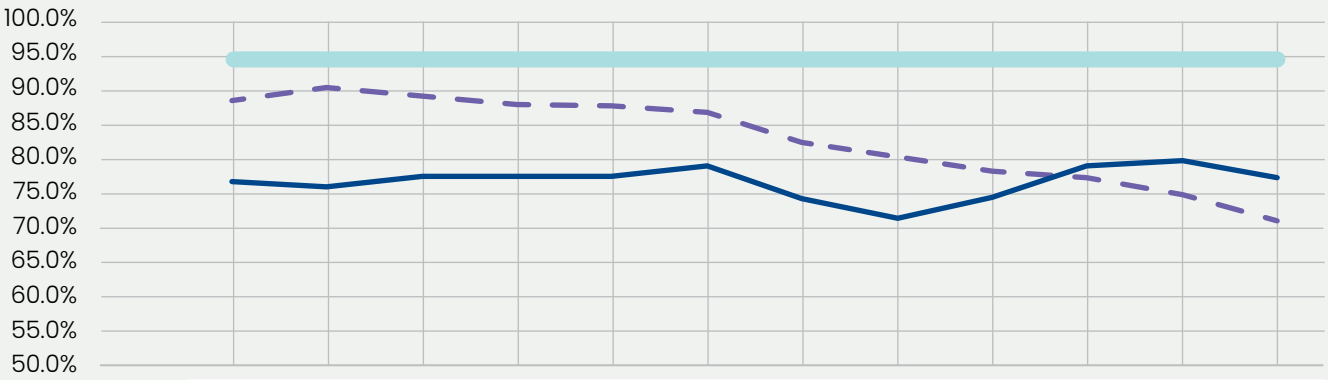
Further measures related to coronary angiography

Measure	Result	Target	Status
Percentage of patients with accepted referrals for elective coronary angiography who receive their procedure within 3 months (90 days)	76.7%	95%	↓

Coronary angiography is a procedure that uses a special dye (contrast material) and x-rays to see how blood flows through the arteries in your heart. The test is generally done to see if there's a restriction in blood flow going to the heart and if any further action is required to avoid more serious medical complications.

In the 2023 financial year, Te Whatu Ora has seen an average of 76.7% of patients receiving their procedure within 90 days, compared to 82.9% in the financial year prior. The resourcing and physical constraints of the COVID-19 pandemic have presented major challenges for services to adapt to and returning to the August 2021 level of 90.4% and above will be a focus in the coming year.

PERCENTAGE OF PATIENTS WITH ACCEPTED REFERRALS FOR ELECTIVE CORONARY ANGIOGRAPHY WHO RECEIVE THEIR PROCEDURE WITHIN 3 MONTHS (90 DAYS)



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY22	88.6%	90.4%	89.5%	88.0%	87.8%	86.9%	82.4%	80.0%	78.2%	77.3%	74.9%	71.0%
FY23	76.8%	75.9%	77.5%	77.5%	77.5%	79.0%	74.2%	71.5%	74.5%	79.0%	79.8%	77.3%
TARGET	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

HEALTHCARE IN ACTION

Breaking barriers for better health with AAA/AF equity-focused initiative

The Abdominal Aortic Aneurysm (AAA) and Atrial Fibrillation (AF) screening programme is focused on identifying and preventing AAA in our Māori and Pacific people.

AAA can lead to a ruptured aortic artery, a life-threatening medical emergency. But AAA can easily be detected through screening and repair, helping prevent avoidable deaths.

In 2015 an initial pilot study in the Waitematā and Auckland districts found Māori were three times more likely to have an AAA than non-Māori. The study was also the first to screen women for AAA. Previous research in New Zealand found Māori develop AAA approximately 8 years earlier than non-Māori and are more likely to die from a ruptured AAA.

Three successful pilot programmes were conducted during 2022-23 in different areas of Te Tai Tokerau, all of which had significant Māori populations. The screening process used a simple and portable ultrasound to screen for the presence of an enlargement or aneurysm in the abdomen.

These pilots aimed to assess uptake in rural settings, test community engagement processes, and confirm earlier findings showing a higher prevalence of AAA in Māori males aged 60-74 years (3% prevalence, where a prevalence of 1% is considered a cost-effective health intervention).

The community's response was incredibly positive, with a remarkable 75% uptake of the invitation to AAA/AF screening. Community engagement and testing in familiar environments, like local halls or marae, helped overcome accessibility challenges and played a crucial role in the initiative's success.

With additional funding support from the Health Research Council and the Northern Region Laboratory Harmonisation Programme, the Northland pilot programmes provided an opportunity to explore what other health interventions in the screening session would be supported by participants, community, and health providers.

One of the pilots included an offer of point of care blood testing (POCT) for cardiovascular and diabetes risk assessment during the AAA screening visit, with over 95% of participants embracing the opportunity. Results of their scan and blood tests were shared during the appointment, along with the result implications and recommendations that could improve their health. Results were provided to GPs with follow-up from the screening team on abnormal results, ensuring timely care and necessary action.

Patients were also invited to participate in a sub-study looking at a biochemical marker related to smoking exposure. This involved taking extra blood at the same time as the POCT sample. This sub-study, supported by researchers from the University of Auckland and the University of Otago, will help establish the foundation for future breakthroughs.

Participant feedback on the overall initiative was overwhelmingly positive. Many described the screening programme as 'very worthwhile', easy to understand, and highly beneficial for their health. They appreciated the opportunity to receive prompt results and felt that the programme helped them take better care of their health.

Others expressed gratitude for the initiative, emphasising its importance in addressing health disparities and promoting better access to healthcare for Māori and Pacific individuals. They also highlighted the significance of community engagement and testing in familiar environments, making the programme more accessible and comfortable.

The success of the Māori Health Pipeline initiative highlights the importance of community engagement and testing in familiar environments, promoting equitable healthcare for all communities.

Kaumātua Rex Nathan with Erin Chambers, Māori Health Pipeline AAA/AF Project Manager and Kaimatawai Puku (AAA Screener) with Craig McDougal, Kaimatawai Puku.

Kaumātua Rex Nathan blessed the Dargaville screening rooms.

Ensuring faster recovery from stroke

Improving access to rehabilitation-skilled staff and services helps ensure patients start their rehabilitation as soon as medically stable, giving faster recovery following a stroke. Additionally, faster scanning times with upgraded radiology technologies means more patients can be scanned per day than before. This, along with new imaging technology, allows our clinical teams greater insights into patients' clinical conditions.

The new integrated stroke units at North Shore and Waitakere Hospitals were opened in refurbished spaces specifically designed to co-locate acute and rehabilitative stroke services. The new-look service at both sites will improve patient and whānau experience – catering to individual and cultural needs while maximising each patient's health outcomes.

The new Integrated Stroke Service – Kāhui Tiāki Ohōtata – (Ward 15) at North Shore Hospital is part of a wider programme of service redesign to co-locate acute and rehabilitative stroke services together and complements the Integrated Stroke Service that was launched at Waitakere Hospital.

The Acute Stroke Unit (ASU) with 10 beds at Whangārei Hospital opened after engagement with community and whānau, and a Model of Care and Service Delivery was developed with the underlying belief of when we get this right for Māori, our service to all consumers will improve.

Measure	Result	Target	Status
Percentage 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	Unable to report. Data collection stopped as of June 2022 when district health boards were disestablished.		
Percentage of patients with ischaemic stroke thrombolysed and/or treated with clot retrieval	Unable to report. Data collection stopped as of June 2022 when district health boards were disestablished.		
Percentage of patients admitted with acute stroke who are transferred to in-patient rehabilitation services within 7 days of acute admission	Unable to report. Data collection stopped as of June 2022 when district health boards were disestablished.		
Percentage of stroke patients referred for community rehabilitation who are seen face to face by a member of the community rehabilitation team (i.e., RN/PT/OT/SLT/SW/Dr/Psychologist) within 7 calendar days of hospital discharge	Unable to report. Data collection stopped as of June 2022 when district health boards were disestablished.		

Colonoscopy

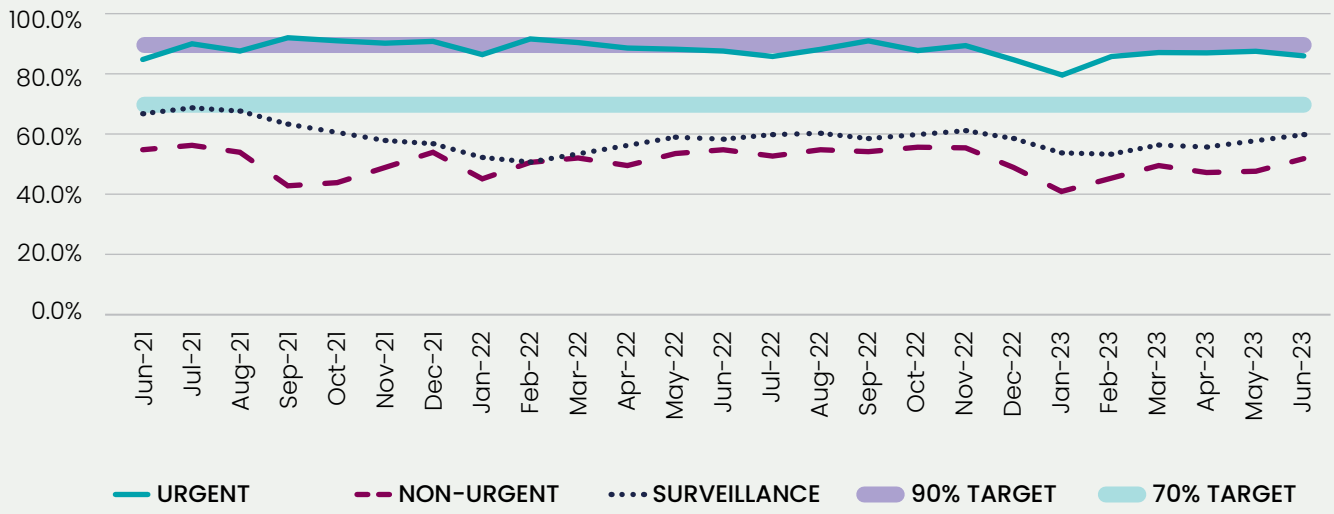
Measure	Result	Target	Status
90% of people accepted for an urgent diagnostic colonoscopy receive (or are waiting for) their procedure 14 calendar days or less, 100% within 30 days or less	81.8%	90%	↓
70% of people accepted for a non-urgent diagnostic colonoscopy will receive (or are waiting for) their procedure in 42 calendar days or less, 100% within 90 days or less	51.9%	70%	↓
70% of people waiting for a surveillance colonoscopy receive (or are waiting for) their procedure in 84 calendar days or less of the planned date, 100% within 120 days or less	64.2%	70%	↓

These measures provide us a sense of the timeliness with which people can access colonoscopy procedures, and have the presence of any bowel cancer confirmed. Surveillance colonoscopy is part of monitoring individuals known to be at increased risk of developing colorectal cancer. Diagnostic colonoscopy is a vital tool on the path to accessing appropriate treatment, especially for the highest non-acute diagnostic priority as defined by the National Referral Criteria for Direct Access Outpatient Colonoscopy.

The percentage of people receiving urgent and non-urgent diagnostic colonoscopies within the specified timeframe decreased slightly in FY2022-23 by 1.8% and 3.2% respectively, comparative to FY2021-22.

The challenges faced in FY2022-23 were attributed to COVID-19 recovery, resourcing, and capacity along with increased demand. There are a number of initiatives in place such as improvements to scheduling processes and outsourcing to private providers to support the increased demands. We will also be exploring opportunities to use the Faecal Immunochemical Test (FIT test) to manage patients currently on the waitlist for first specialist assessment and patients referred from primary care.

NATIONAL COLONOSCOPY WAIT TIME INDICATORS



	Urgent	Non-urgent	Surveillance		Urgent	Non-urgent	Surveillance
Jun-21	84.4%	55.2%	66.9%	Jul-22	85.6%	53.1%	59.9%
Jul-21	90.1%	56.8%	69.0%	Aug-22	88.4%	55.4%	60.3%
Aug-21	87.5%	54.5%	67.9%	Sep-22	91.3%	54.6%	58.5%
Sep-21	92.3%	42.7%	63.3%	Oct-22	88.0%	56.1%	59.6%
Oct-21	91.1%	43.8%	60.8%	Nov-22	89.4%	55.9%	61.1%
Nov-21	90.3%	49.0%	57.9%	Dec-22	84.5%	49.1%	58.6%
Dec-21	90.9%	54.5%	56.8%	Jan-23	79.2%	40.8%	53.7%
Jan-22	86.3%	45.2%	52.2%	Feb-23	85.9%	45.2%	53.3%
Feb-22	91.8%	50.9%	50.6%	Mar-23	87.1%	49.7%	56.3%
Mar-22	90.5%	52.4%	53.8%	Apr-23	86.9%	47.4%	55.6%
Apr-22	88.9%	49.8%	56.5%	May-23	87.5%	47.8%	58.1%
May-22	88.1%	53.9%	59.0%	Jun-23	85.7%	52.1%	60.0%
Jun-22	87.5%	55.3%	58.3%	Jul-23	81.8%	51.9%	64.2%

Measure	Result	Target	Status
Colonoscopies per 100,000 people	Māori **739** Pacific **592** Asian **599** Non-Māori/ Non-Pacific/ Non-Asian **1,601** Total **1,219**	Improve from baseline (trend to increase)	✓

Baseline period: Q4 2021 to Q3 2022

Baseline value: 1,268

This measure was recorded in our Statement of Performance Expectations 2022-23, however, it has been difficult to report confidently. We have been unable, for example, to replicate the number published in the SPE as the baseline value from the Q4 2021 to Q3 2022 period.

For the purpose of reporting this measure, we have interpreted it to refer to colonoscopies performance per 100,000 within the financial year, and the baseline value of 1,268 to refer to total colonoscopies performed, however, the result reported below should be read alongside the result for the Colonoscopy Wait Time Indicators, which is evidence-based, benchmarked and developed on a par with international research.

The result for FY2022-23 is broken down by ethnicity along with the national total. The result is based on data from the National Minimum Dataset (NMDS) and National Non-Admitted Patient Collection for publicly funded hospital discharge information relating to all colonoscopies performed, whether diagnostic or surveillance.

The total number of colonoscopy procedures performed per 100,000 was 1,219 . A focus of Hospital & Specialist Services for FY2023-24 is to manage the waitlist for first specialist assessment and referrals from primary care using the Faecal Immunochemical Test (FIT test).

Category	FY22	FY23
Māori	652	739
Pacific	525	592
Asian	540	599
Non-Māori, Non-Pacific, Non-Asian	1,490	1,601
Total	1,268	1,219

*Note data extracted 26 Sep 2023

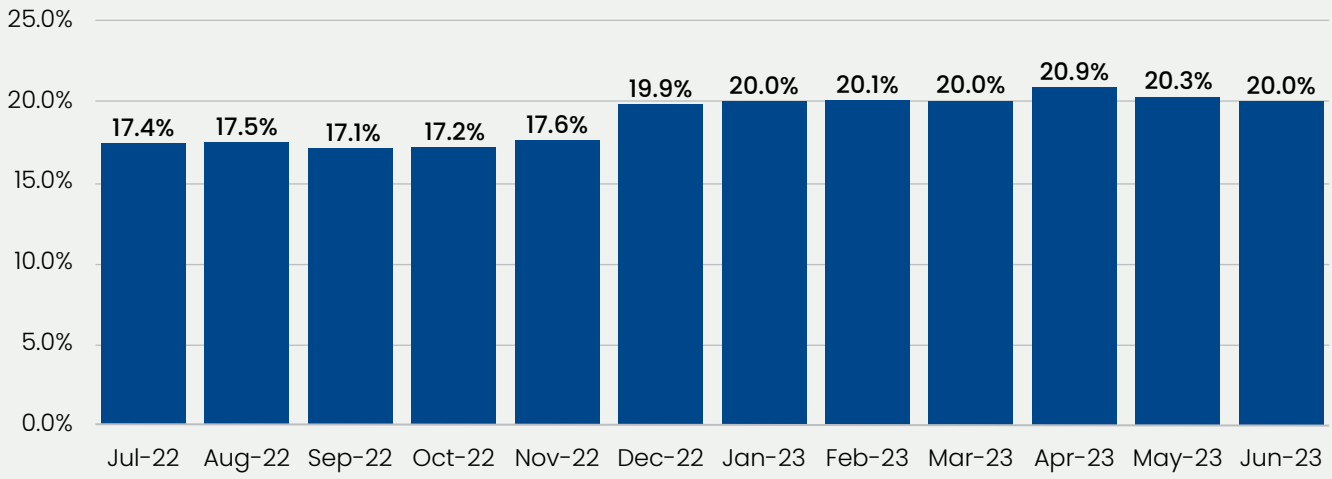
Ophthalmology

Measure	Result	Target	Status
Percentage of ophthalmology patients who wait no more than or equal to 50% longer than the intended time for their appointment	**20%**	100%	↓

In this measure, the 'intended time for their appointment' is the recommendation made by the responsible clinician of the timeframe in which the patient should next be reviewed by the ophthalmology service.

**As at June 2023, 20% of ophthalmology patients waited 50% longer than the intended time for their appointment, a 2.6% increase compared to June 2022.*

OPHTHALMOLOGY PATIENTS OVERDUE <50% OF INTENDED WAIT TIME



Further measures related to Hospital and Specialist Services

Measure	Result	Target	Status
Number of acute bed nights spent in hospital	Māori **383,525** Pacific **183,843** Non-Māori/ Non-Pacific **1,706,842** Total **2,274,210**	Improve from baseline (trend to decrease)	↓

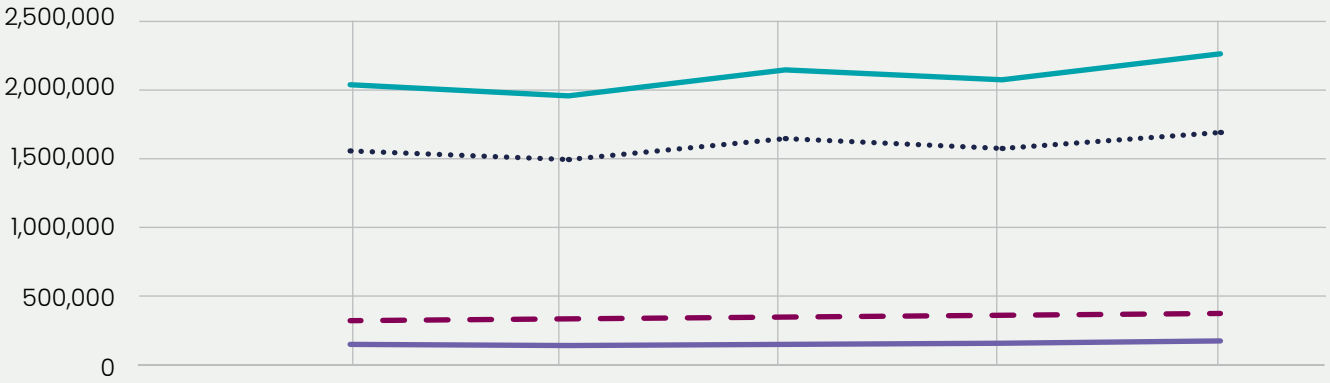
Baseline period: Q4 2021 to Q3 2022

Baseline values: Māori 341,366, Pacific 154,929, Non-Māori and Non-Pacific 1,577,694

Hospital and Specialist Services are important to restore people's health and improve patient and whānau outcomes when they require more immediate care. A central focus of Te Pae Tata is keeping people well in their community through the provision of a wider range of services and modes of access that suit them best. While this is preferable, it is not always possible and inpatient care is sometimes required.

This measure focuses attention on the number of the bed nights spent in hospital and specialist care in the given period and, along with other available system measures, will signal when further analysis may be required to address causes of any increases. In the 2023 financial year, 2,274,210 bed nights were spent in hospital with 17% and 8% for Māori and Pacific respectively. There is also a trend upwards since 2020 for all ethnicities. Further investigation will be required to ensure 2024 and subsequent years see a decrease.

NUMBER OF ACUTE BED NIGHTS SPENT IN HOSPITAL



	12 months to June 2019	12 months to June 2020	12 months to June 2021	12 months to June 2022	12 months to June 2023
ALL ETHNICITIES	2,054,314	1,970,107	2,162,510	2,084,267	2,274,210
MĀORI	327,562	314,008	348,330	343,451	383,525
PACIFIC	157,735	149,573	155,059	159,455	183,843
NON-MĀORI, NON-PACIFIC	1,569,016	1,506,525	1,659,120	1,581,361	1,706,842

Measure	Result	Target	Status
Standardised rate of acute readmissions within 28 days of discharge	Māori 13.0% Pacific 12.3% Non-Māori/ Non-Pacific 12.4% Total 12.5%	12%	↓

Baseline period: Q4 2021 to Q3 2022

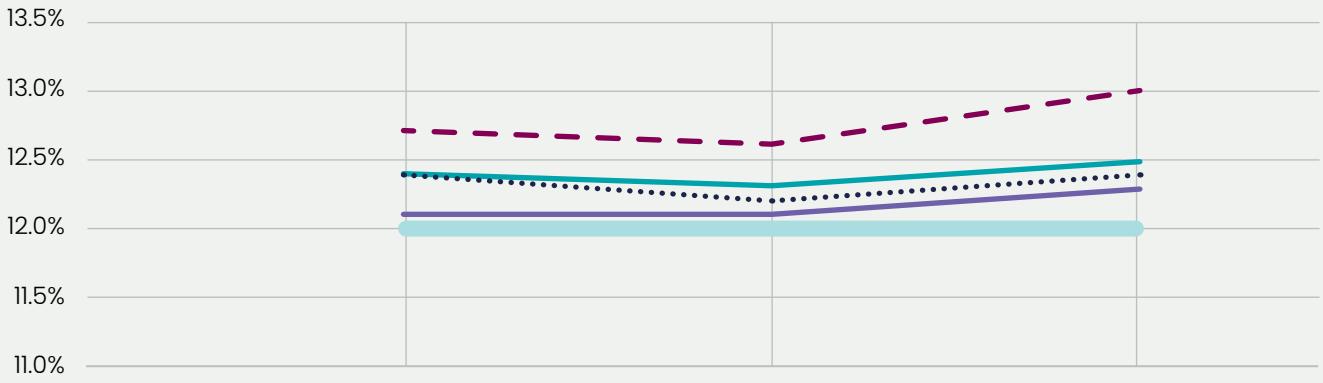
Baseline values: Māori 12%, Pacific 12%, Non-Māori and Non-Pacific 12%

Acute readmission rate analysis is a well-established method of quality improvement, evaluating clinical practices and whole-of-system improvement. Acute readmissions may sometimes be a part of an expected course of patient care and can be unavoidable. However, with the focus of keeping people well in the community under Te Pae Tata, it is important to remain focused on reducing unnecessary hospitalisation where possible.

This measure forms a basis to focus on the quality of post-discharge experiences. Owing to operational processes and data validation, this measure is reported as "Year to March" meaning the average from April to March of the reported year. The result has been standardised to the Stats NZ population.

This latest result shows all population groups have fallen within 1 percentage point of the desired target, with Māori at 13% and Pacific 12.3%. Over the three time periods, we can see an upward trend in this measure, signalling further investigation is indicated. This is a multi-year target and operational planning currently underway for 2023-24 and outyears will address specific actions to achieve it.

STANDARDISED RATE OF ACUTE READMISSIONS WITHIN 28 DAYS OF DISCHARGE



	Year to Mar 2021	Year to Mar 2022	Year to Mar 2023
OVERALL	12.4%	12.3%	12.5%
MĀORI	12.7%	12.6%	13.0%
PACIFIC	12.1%	12.1%	12.3%
NON-MĀORI, NON-PACIFIC	12.4%	12.2%	12.4%
TARGET	12.0%	12.0%	12.0%

Measure	Result	Target	Status
The percentage of patients who were acutely re-admitted post discharge improves from average DHB base level from 2019-20 to 2021-22	0.2% Improvement	Improve	✓

At a national level, the rate of acute re-admissions post discharge in 2019-20 was 12.2% and 2021-22 it was 12%. This is a reduction of 0.2%.

Measure	Result	Target	Status
Percentage of people in adult inpatient care, who report they were involved as much as they wanted to be in making decisions about their treatment	Māori **82.8%** Pacific **84.8%** Asian **90.9%** Non-Māori/ Non-Pacific/ Non-Asian **82%** Overall **82.9%**	Improve from baseline (trend to increase)	✓

Baseline period: Q4 2021 to Q3 2022

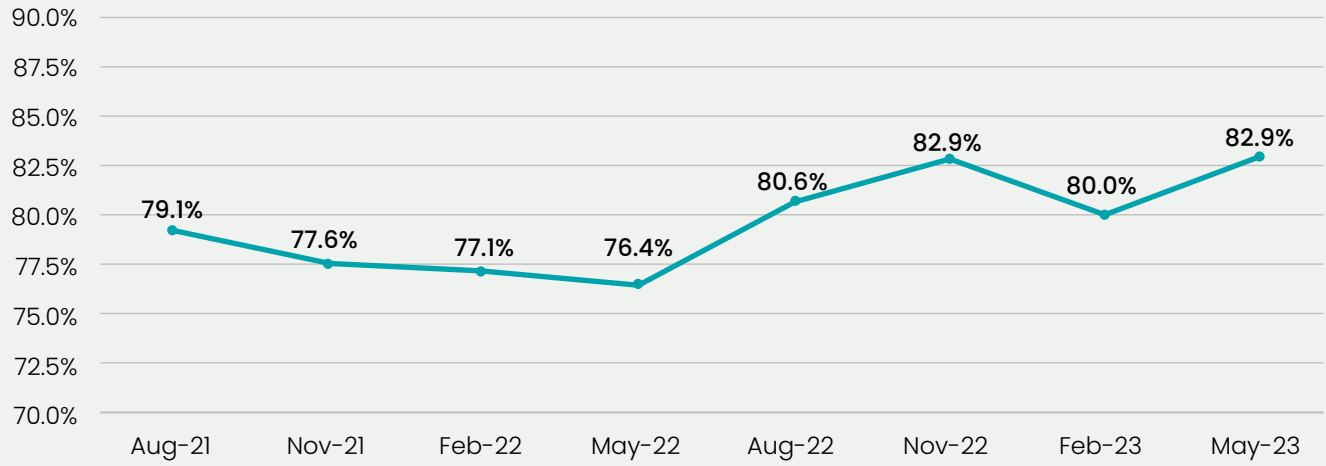
Baseline value: Māori 77%, Pacific 77%, Non-Māori and Non-Pacific 78%

Te Pae Tata places a strong emphasis on placing people and their whānau at the centre of their healthcare journey, empowering them to influence the design and forward planning of care in their local area. An inpatient stay can be a very stressful time for both patient and whānau, so it is important that our system allows the opportunity to have their views heard.

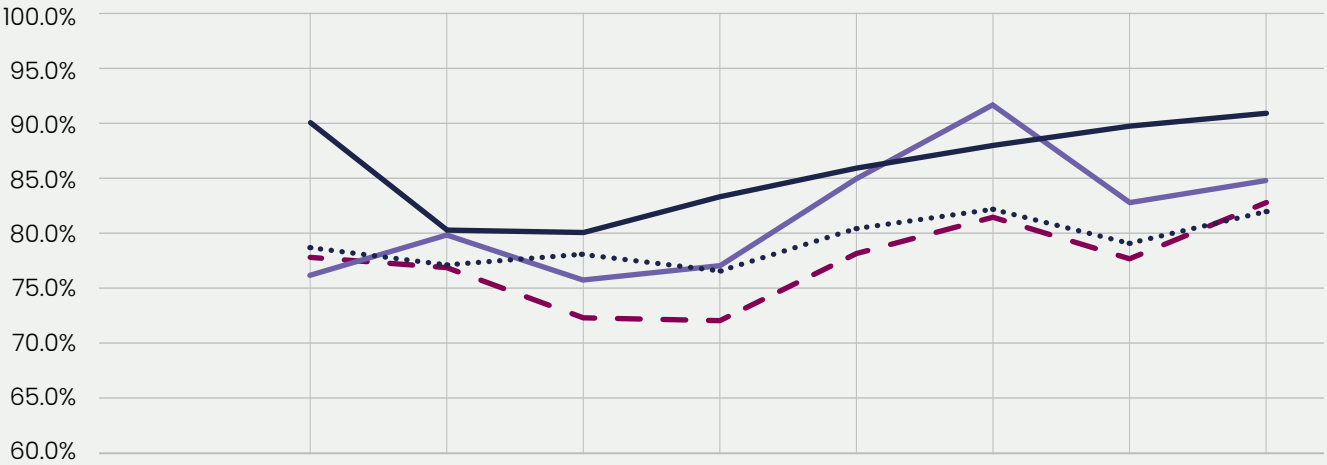
82.9% of those surveyed in the Patient Experience Survey in May 2023 reported they feel fully involved in decision-making with respect to treatment, with a further 12.7% feeling somewhat involved. Comparison by ethnicity shows 91% of Asian patients reporting satisfaction with their involvement compared to 82% for Māori and 84.8% for Pacific. Overall, the responses have improved from baseline and focus in the coming year will be on maintaining this upward trend.

The Adult inpatient care survey received 3,842 responses for the May 2023 sample representing a reponse rate of 28.9%. The margin of error for this question is + / - 1.1%.

PERCENTAGE OF PEOPLE IN ADULT INPATIENT CARE, WHO REPORT THEY WERE INVOLVED AS MUCH AS THEY WANTED TO BE



PERCENTAGE OF PEOPLE IN ADULT INPATIENT CARE, WHO REPORT THEY WERE INVOLVED AS MUCH AS THEY WANTED TO BE



	Aug-21	Nov-21	Feb-22	May-22	Aug-22	Nov-22	Feb-23	May-23
MĀORI	77.9%	76.9%	72.3%	72.1%	78.2%	81.5%	77.8%	82.8%
PACIFIC	76.1%	79.9%	75.8%	77.1%	85.0%	91.7%	83.1%	84.8%
ASIAN	90.4%	80.4%	80.2%	83.3%	85.9%	88.0%	89.8%	90.9%
NM/NP/NA	78.7%	77.3%	78.2%	76.8%	80.5%	82.2%	79.2%	82.0%

Measure	Result	Target	Status
Actual investment decisions ensure balanced investment across appropriations and time horizons [short (Up to 2 years), medium (3-5 years) and longer-term (5+ years)] to maintain hospital and specialist services	Achieved	Achieved	✓

Te Whatu Ora continues the work to ensure that development of services in primary and community services is prioritised, to prevent unnecessary illness and treat people before they need Hospital and Specialist Services. This is supported by the development of a culture of continuous improvement, to drive productivity and changes in models of service delivery to ensure Hospital and Specialist Services are making best use of resources to meet the specialist needs of our communities.

The approved New Zealand Health Plan provides evidence of mechanisms to elevate the voices of people with lived experience in the design of hospital and specialist services	Achieved	Achieved	✓

This measure relates to Te Pae Tata, the interim New Zealand Health Plan.

Work has begun and is in the formative stages to elevate the voices of consumers and whānau across our health system.

Existing patient experience surveys in both hospitals and primary care provide valuable insights from consumers and whānau. Building on this, Te Pae Tata sets out a number of actions to elevate the voices of people with lived experience in the design of all areas of health delivery. Te Whatu Ora is collaborating with Te Tāhū Hauora to build the co-design of service models with consumers into our health system, with a focus on Pacific voices, the voices of Tāngata whaikaha | Disabled people, the voices of ethnic communities, and the rainbow community.

All approved NZHP milestones agreed with the Minister for hospital and specialist services are delivered or adjusted milestones are agreed	68%	100%	↓

This measure relates to Te Pae Tata, the interim New Zealand Health Plan.

19 actions with corresponding milestones as laid out for interim NZHP for HSS. As at end of June 2023, 1 programme is red (Working with Pharmac to support equitable implementation of new cancer drugs). 6 milestones are at amber with remediation work ongoing. 7 milestones were reached including mental health timely solutions developed with communities and NZ Police. The Reset and Restore Planned Care successfully met the interim NZHP milestone hospital-based treatment and diagnostic procedures achieving 69% and 59% completion rate respectively.

Measure	Result	Target	Status
Service coverage expectations (appended to the interim Government Policy Statement) are fully met for hospital and specialist services	100%	100%	✓
The minimum standard as set out in the Service Coverage Schedule 2021-22 which in the interim Government Position Statement called the Government's Minimum Service Coverage Expectations for the health sector is the foundation for the nationwide service specifications for Hospital and Specialist Services and is being fully met.			
Improvement plans are in place for the agreed Health System Indicators relevant to annual Ministerial priorities for hospital and specialist services	Achieved	Achieved	✓
Improvement plans were put in place for planned care and acute patient flow in accordance with Ministerial priorities around winter-related health system pressures and waitlists.			
The New Zealand Health Plan sets out a path in agreed service areas to improve the consistency of hospital and specialist service provision to align with population need over time	Achieved	Achieved	✓
This measure relates to Te Pae Tata, the interim New Zealand Health Plan. In accordance with Te Pae Tata, work is underway to improve national consistency in access to services and developing national approaches to procurement, outsourcing and improving cancer care.			
The percentage of patients who were acutely re-admitted	Achieved	Achieved	✓
This measure relates to Te Pae Tata, the interim New Zealand Health Plan. In accordance with Te Pae Tata, work is underway to improve national consistency in access to services and developing national approaches to procurement, outsourcing and improving cancer care.			

Service Improvement and Innovation

There are many great examples of pioneering research, service improvement and innovation, and population health interventions already under way across the motu. The health reform provided an enormous opportunity to work across the motu and in partnership with Te Aka Whai Ora to accelerate whānau-centric improvement and innovation projects to improve access, equity, and population health outcomes.

A key focus has been developing, testing, and scaling pro-equity programmes to address life expectancy gaps between Māori and Non-Māori and Pacific and Non-Pacific populations. In partnership with Te Aka Whai Ora, seven programmes commenced in 2022-23 with the two largest (lung cancer and AAA screening) moving into national scaling. Of the seven programmes listed below, the first four are Māori Health Pipeline, the last two are Pacific Health Pipeline, and the Endometrial Cancer programme is shared.

- Te Oranga Pūkahukahu (Lung cancer screening)
- Abdominal Aortic Aneurysm (AAA) and Atrial Fibrillation (AF) screening
- HPV self-testing for cervical screening (Māori focus)
- Hepatitis C targeted testing
- Endometrial Cancer development of a screening test
- Rheumatic Heart Disease echo screening implementation approach
- Chronic Kidney Disease (CKD) treatment support.

Regional initiatives

Waikato Emergency Department upgrade

A triple-phase project is underway to provide a better patient and staff experience with a new entrance, reception, triage areas with multiple assessment rooms, improved waiting area and new toilets. Phases one and two are completed.

Waikato Hospital ICU expansion

The upgrade, which added four permanent isolation rooms and two negative pressure rooms for COVID-19 and other infectious diseases, was completed in March 2023. Additional staff are also being recruited including doctors, nurses, nutrition experts, healthcare assistants and Allied Health staff.

Taupō outpatients expansion

The outpatients expansion in Taupō from 10 to 18 rooms will assist in delivering more services closer to home, reducing costs to patients, and increasing convenience for patients. This is planned for completion in September.

Bay of Plenty

A second Cardiac Catheterisation Laboratory (Cath Lab) has been opened at Tauranga Hospital and it will provide greater access for Bay of Plenty cardiology patients, meeting the needs of the ever-growing population. The building of a second Cath Lab was the natural evolution of the invasive cardiology services that have been developed for the last two decades, providing access to high quality care for patients in the Bay of Plenty.

Since its inception in 2021, the Community Orthopaedic Triage Service (COTS) has seen more than 4,000 people with musculoskeletal (MSK) conditions and 30% have been referred for a specialist assessment, thereby not only reducing demand on specialist services but providing a more holistic approach to individuals with MSK conditions. COTS is a community-based, proactive enablement approach which utilises highly skilled physiotherapists to sustainably support and improve equitable access to Orthopaedic services.

Taranaki

The new Renal Centre, Te Huhi Raupo, was opened for patients in November 2022, and officially opened by the Health Minister in March 2023. This building is up for two Green Building Council awards.

Hawke's Bay

Hawke's Bay Hospital's last of three digital radiography rooms have been upgraded and are now being used, complete with new digital radiography systems.

Midcentral

A New Emergency Department Observation Area and Medical Assessment Planning Unit at Palmerston North Hospital were opened.

A new procedure suite has opened in Hutt Valley Hospital, increasing the capacity for providing surgical services across the region, with an expected 500 procedures to be carried out in the new suite each year.

Te Waipounamu

We have delivered Buller's new integrated health facility, Te Rau Kawakawa. It houses a range of services including general practice, acute care services, primary birthing and post-natal care, palliative care, urgent care and child dental services.

Northern

New stroke units and radiology scanners have significantly bolstered the Northern Region's ability to serve its communities. The Northern Region has opened three new integrated stroke units (Waitakere, North Shore and Whangārei) and new radiology scanners in Auckland City Hospital, Greenlane Clinical Centre and North Shore Hospital.

Mate pukupuku | People with Cancer

Cancer is the single biggest cause of death in New Zealand. Each year, approximately 25,000 people are diagnosed with cancer in Aotearoa, with nearly 3,000 of those people being Māori. Most people living in New Zealand will have experienced cancer or are supporting whānau or friends with cancer.

Over the past 20 years, cancer survival rates in Aotearoa have increased substantially, with more people surviving their cancer than ever before. However, our survival rates are not improving as quickly as survival rates in other high-income countries. Treatment of cancers is constantly improving, especially if they are discovered early, which is why we are focused on prevention, screening, and treatment.

Te Aho o Te Kahu is a government agency created in recognition of the impact cancer has on the lives of New Zealanders and the need to do better for whānau affected by cancer. They lead and unite efforts related to cancer control, with a focus on improving cancer prevention, detection, treatment and data.

They report directly to the Minister of Health and work closely with Te Whatu Ora on the delivery of cancer screening, prevention and treatment. They collaborate with Manatū Hauora and Te Aka Whai Ora on cancer related policy and wider issues. Te Aho o Te Kahu is guided by the goals and outcomes in the National Cancer Action Plan 2019-29.

Linear Accelerator for Waikato Hospital

A new LINAC machine was delivered and installed in November 2022 completing the replacements of four machines. With advances in technology the newer machines offer greater efficiencies, reducing cancer treatment times compared to the older machinery.

Cancer screening

The bowel screening programme has been extended to Māori and Pacific aged 50+ in the Waikato. This initiative aims to help improve cancer outcomes for these groups, who are more likely to die from bowel cancer. This programme is to be used to inform further rollout of this initiative across the country.

Taranaki

Demolition of the former hospital buildings is nearing completion, paving the way for construction of the new Cancer Centre which started in July 2023 with a view to have the hospital finished in mid-2025. A blessing for the new site was held in August.

LINAC machine

Radiation Oncology in Te Waipounamu

Southern district continues to work closely with our Canterbury colleagues as part of a Te Waipounamu working group. The aim of this group is to identify opportunities to maximise our regional capacity and capability in the context of a workforce shortage. This work is part of a wider national approach to Radiation Oncology services which aims to ensure people can receive care sooner.

A national radiation oncology forum has been set up to work towards a national clinical network with the goal of achieving a sustainable radiation oncology service for Aotearoa.

Faster Cancer Treatment

Throughout this financial year, Faster Cancer Treatment performance continues to be reported and monitored. Services are supported by Regional Cancer Managers where improvements are required.

Measure	Result	Target	Status
Percentage of patients who receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat	84.9%	85%	↑
Percentage of patients who receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks	80.1%	90%	↓

A diagnosis of cancer can be a daunting time for a patient and their whānau, with a great deal of information and treatment options to consider. The time taken to navigate the system from diagnosis through to treatment can be an anxious wait and needs to balance the required clinical workup against best practice guidelines for care and system capacity. These measures place an emphasis on the timeliness of key points in the cancer care journey. Patients are eligible for inclusion in the 31 and/or 62 day targets depending on their mode of presentation and clinical pathway.

The data has been provided from January 2022 onwards and we have reported these measures by ethnicity for a complete financial year and by region for a complete quarter. This has been done to ensure sufficient numbers are available to make calculations and results meaningful.

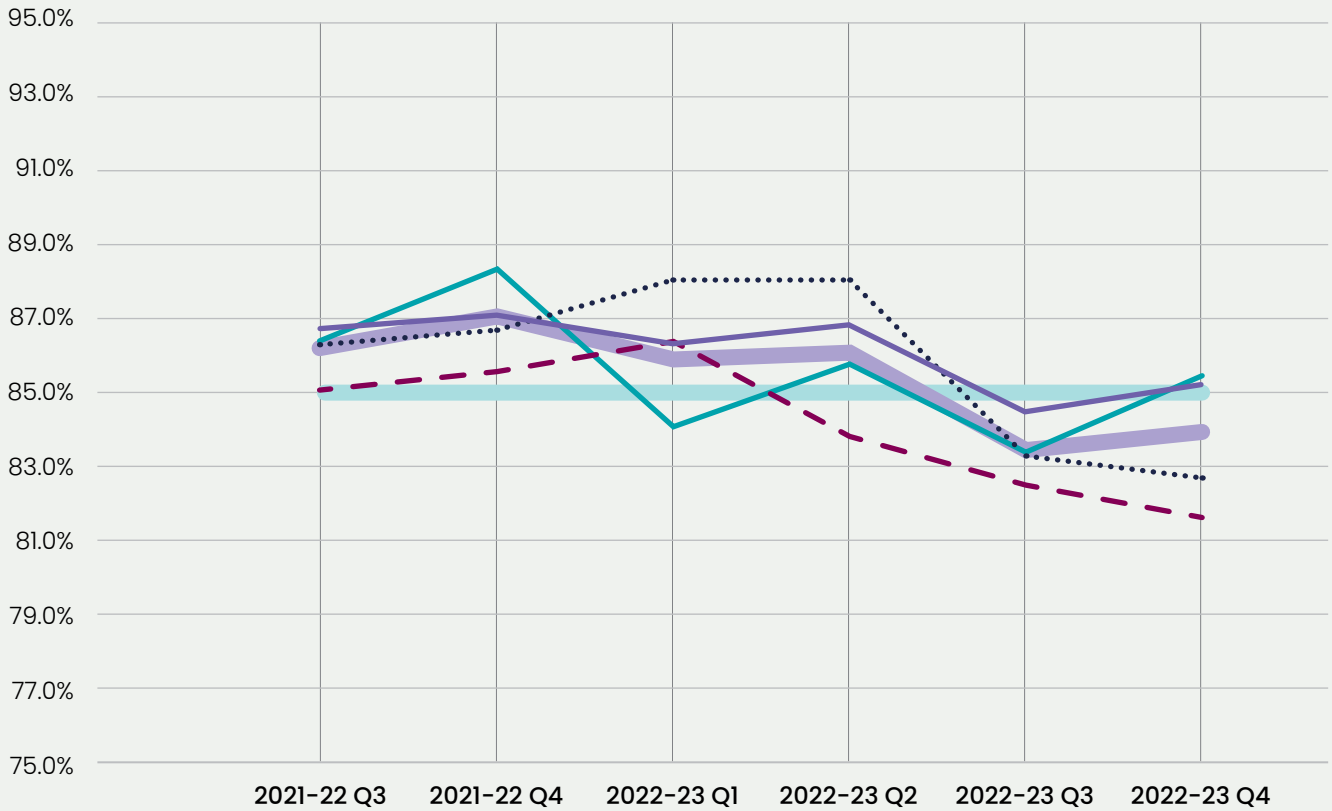
For the 31 day target, overall at a national level the target of 85% was not met by 0.1% and when examined by ethnicity we see both Māori and Non-Māori and Non-Pacific and Non-Asian also fall below the desired target. Viewing quarterly by region, we can see a decrease in achievement over time from the start of 2022 with all regions achieving 85% or more to just 1. For the 62 day target, the desired 90% has not been achieved, with the greatest gap for Pacific at 68.9% and 80.1% for the year overall.

These targets will need a sharpened focus in the next financial year as the system moves to address staffing and capacity shortages. As indicated above, construction of new facilities and a programme of infrastructure upgrades are underway across the motu and this, in combination with the ongoing work of Te Aho o Te Kahu and clinicians nationwide, will serve to address the shortfalls.

31 Day Target	
FY 2022-23	
Māori	84.8%
Pacific	86.2%
Asian	85.6%
NM/NP/NA	84.7%
Overall	84.9%

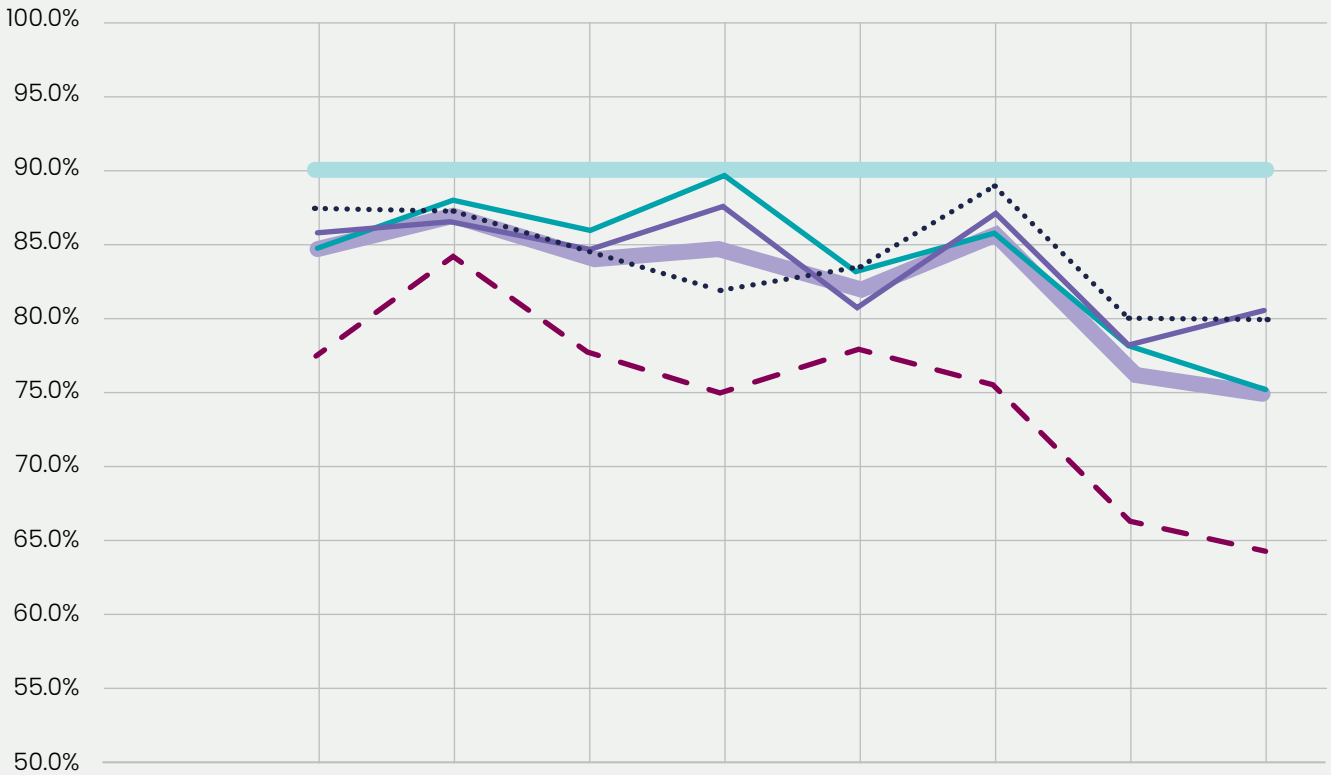
62 Day Target	
FY 2022-23	
Māori	77.5%
Pacific	68.9%
Asian	79.1%
NM/NP/NA	81.3%
Overall	80.1%

PERCENTAGE OF PATIENTS WHO RECEIVE THEIR FIRST CANCER TREATMENT (OR OTHER MANAGEMENT) WITHIN 31 DAYS FROM DATE OF DECISION-TO-TREAT



	2021-22 Q3	2021-22 Q4	2022-23 Q1	2022-23 Q2	2022-23 Q3	2022-23 Q4
NORTHERN	86.4%	88.3%	84.1%	85.8%	83.5%	85.5%
TE MANAWA TAKI	85.1%	85.5%	86.3%	83.8%	82.5%	81.6%
CENTRAL	86.7%	87.1%	86.4%	86.9%	84.5%	85.2%
TE WAIPOUNAMU	86.5%	86.7%	88.1%	88.1%	83.4%	82.7%
NATIONAL	86.2%	87.1%	85.9%	86.1%	83.4%	84.0%
TARGET	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%

PERCENTAGE OF PATIENTS WHO RECEIVE THEIR FIRST CANCER TREATMENT (OR OTHER MANAGEMENT) WITHIN 62 DAYS



	2021-22 Q1	2021-22 Q2	2021-22 Q3	2021-22 Q4	2022-23 Q1	2022-23 Q2	2022-23 Q3	2022-23 Q4
NORTHERN	85.1%	87.9%	86.4%	89.7%	83.0%	86.2%	78.1%	75.1%
TE MANAWA TAKI	77.2%	84.1%	77.7%	74.8%	77.6%	75.1%	65.5%	63.6%
CENTRAL	85.9%	86.7%	84.9%	87.7%	81.0%	87.3%	78.1%	80.5%
TE WAIPOUNAMU	87.5%	87.3%	84.8%	82.0%	83.6%	89.1%	80.0%	79.9%
NATIONAL	84.6%	86.8%	84.1%	84.5%	81.8%	85.1%	76.2%	75.1%
TARGET	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%

As a material measure, the 62-day FCT target has been reported for two full financial years, this provides us with the ability to accurately report trends.

Output Class: Oranga Hinengaro | Health services for mental health and addictions

Mental health and addiction services support people's wellbeing and recovery through episodes of mental ill health. Over 50% of people across Aotearoa will experience mental distress and addiction challenges at some point in their lives.

Mental health and addictions is one of our five output classes. The standard of delivery achieved against this output class is reported on page 222 to page 231.

Mental health and addiction services make a positive difference to people's health and wellbeing, enabling people to get through a challenging time without serious or lasting disruption to their lives. Earlier intervention can be enabled through strengthened primary care practices with expertise to provide a comprehensive approach to health and wellbeing.

People can recover in their communities through community-based and kaupapa Māori services, for support and therapeutic interventions when problems are more serious. These services engage families and whānau, recognising that whānau play an important support role and may also need considerable help.

People with serious mental health problems may need help from specialist inpatient services, followed by support on discharge that enables them to live well in the community. Good quality wraparound mental health services help to reduce future admissions to acute services. They help people with mental health problems maintain relationships, retain jobs and enjoy valued activities.

Budget 22 Initiatives: updates

Increasing Availability of Specialist Mental Health and Addiction Services

This initiative provides funding to increase the availability and trial new models of specialist mental health and addiction services to support people with specific needs in targeted areas across the country.

The funding is for the expansion of Eating Disorders, Maternal Mental Health, Infant Child and Youth, Kaupapa Māori, and Acute Crisis responses in targeted parts of the country.

Agreements are in place for new and expanded services across all of these workstreams with recruitment and procurement of services underway. The funding increases over four years which will see further expansion of these types of services over the next few years.

Piki – Continuation of Integrated Primary Mental Health and Addiction Support for Young People in Greater Wellington

This initiative provides funding to continue the Integrated Psychological Therapies Pilot, now known as Piki. This will enable continued access to free integrated primary mental health and addiction support for young people aged 18–25 years in the greater Wellington area.

Continuing the Alcohol and Other Drug Treatment Courts

This initiative provides funding to continue the existing Alcohol and Other Drug Treatment Courts initiative in Auckland, Waitakere and Waikato on a permanent basis.

Existing Courts in Auckland and Waitakere (established 2012) and Waikato (established 2021) continue to operate.

The Budget 2022 funding to make these Courts sustainable and permanent has been allocated through to June 2026.

Extending School Based Health Services

This initiative will expand School Based Health Services into activity centres and increase service delivery levels in kura kaupapa.

Relationships with peak bodies for kura Māori (Te Rūnanga Nui o Ngā Kura Kaupapa Māori o Aotearoa and Ngā Kura ā Iwi o Aotearoa) have been developed and we are building our understanding of their priorities, the needs of their students, and how to work together.

Mana Ake – Expansion of Mental Wellbeing Support for Primary and Intermediate School Students

This initiative provides funding to enable ongoing delivery of Mana Ake (early intervention to promote wellbeing and positive mental health) in Canterbury and Kaikōura and the commencement of Mana Ake for primary and intermediate school-aged students in Northland, Counties Manukau, Bay of Plenty, Lakes and West Coast areas.

HEALTHCARE IN ACTION

Psychology hubs a particular highlight in busy year for Mental Health and Addiction workforce

Growing and developing the workforce has continued to be one of the key priorities for mental health during the 2022-23 financial year. As part of the Budget 2022 investment in specialist mental health and addiction services, an additional $10m over four years has been allocated for workforce development.

There have been several important initiatives continuing to produce strong results throughout the financial year. Highlights included a successful mental health nursing campaign which has contributed to the growth in the number of nursing graduates choosing mental health as their specialty. Because of this, we have grown the fully funded Nurse Entry to Specialist Practice (NESP) places for nurses to over 280 annually with 303 nurses participating this year. This has been complemented by an increase in Social Workers and Occupational Therapists entering into the Allied Health NESP programme.

Another key initiative is to increase the training pipeline into psychology careers. As such, we have tripled the number of fully-funded internships since 2018 from 12 to 38 this year and increased the payment interns receive by 40%.

This financial year also saw an ambitious new targeted pilot get underway to grow the capacity for services to accommodate and benefit from the psychology internship scheme. The key to this initiative includes the development of a Clinical Psychology Intern Hub Service model. The Intern Hub Service model is a two-year pilot being delivered in four locations across the motu.

Each hub includes up to five psychology interns supported by a supervisor, a peer network and cultural supervision, and coordinates different intern experiences in different locations. The model is aimed at improving the management of intern workloads, better liaison with academic psychology programmes and the promotion of easy recruitment pathways. The new Hubs include two NGO Kaupapa Māori Services (secondary and primary Mental Health Services) and two in Te Whatu Ora Mental Health and Addiction Services.

The early benefits of this model include better communication with tertiary education providers, simplified and improved recruitment processes, and expanding recruitment opportunities from local to national for the internship year.

Expanding the reach of Specialist Withdrawal Services

First conceptualised in 2019-20, there is now an established hub and spoke network of withdrawal management (detox) nurses in place across Te Waipounamu. This work is supported by a clinical coordinator in Canterbury and detox nurses across the wider region including 6.5 FTE new roles.

Having the service in place increases options for people wanting to withdraw from alcohol and other drugs in their own communities and will reduce the need for people to travel away from their whānau and support networks for treatment.

Hauora a Toi Bay of Plenty

The Child Health Integrated Response Pathway (CHIRP) project was recently recognised as the most impactful innovation in the patient access category in Australia and New Zealand (as chosen by peers); and was second in the top 8 Rapid Fire rounds at the Health Round Table. CHIRP sees child-facing services (Child Mental Health, Paediatrics, Child Development Services, School-based Mental Health (Mana Ake) and Education) come together to form a single point of entry, and a coordinated response for children with neurodevelopmental, associated mental health and behavioural concerns.

Access and Choice programme

The Access and Choice programme has continued to grow its national coverage and its contracted FTE positions have grown to more than 1,200. The country's largest counselling association, the New Zealand Association of Counsellors, has also voted in favour of opt-in accreditation, so counsellors can now be employed as clinical staff in publicly-funded mental health and addiction roles.

Hillmorton campus

We are delivering improved, modernised and transformed buildings and facilities at Hillmorton as part of a masterplan to ensure it will meet the needs of our community and support staff to deliver contemporary mental Healthcare and support people's treatment and recovery.

We are opening two new Hillmorton campus facilities which will provide specialist mental health services. The buildings have been designed using valuable input from iwi, clinicians, and people with lived experience, and support evidence-based models of care in a modern, therapeutic environment, including centralised courtyards, single rooms with ensuites and flexible spaces.

Nelson Marlborough

Mental Health and Addiction Intentional Peer Support Staff have been embedded into the Emergency Department with great success. The feedback from the nurses, doctors and mental health crisis teams has been overwhelmingly positive. Feedback from those people who have used the service is also very positive. Comments include how helpful it is to have someone to navigate the process with them, someone who understands and does not judge.

Te Whatu Ora 'in-house' training has been shared with our Mental Health and Addiction NGO partners and a more collaborative approach to training is being encouraged.

The new Youth Primary Mental Health and Addiction Service is progressing well under Nelson Bays Primary Health, Marlborough Primary Health and Health Action Trust. There is good collaboration with the community, young people and health services as this initiative is implemented.

Refurbished facilities at Hillmorton campus

Measure	Result	Target	Status
Total number of mental health contacts	Māori **1,264,841** Pacific **304,045** Asian **228,038** Non-Māori/ Non-Pacific/ Non-Asian **2,173,572** Total **3,970,496**	Improve from baseline (trend to increase)	↓

Baseline period: Financial year 2021-22

Baseline values: Māori 1,242,416, Pacific 304,963, Non-Māori and Non-Pacific 2,538,657 (Total 4,086,036)

Te Pae Tata places a strong emphasis on the priority area of Oranga Hinengaro | People living with mental distress, illness, and addictions. The need to engage with this part of the health system can be a very stressful time for both patients and their whānau, so it is important that we are responsive to demand.

In the 2022-23 financial year, the mental health system was contacted 3,970,496 times, of which 31.9% were by those who identify as Māori, 7.7% Pacific and 5.7% Asian.

The baseline values recorded in the Statement of Performance Expectations 2022-23 (SPE) also included numbers for addictions cases. The difference between the full year 2021-22 data extracted on 25 October 2023 and presented in the table below, versus the baseline values from the SPE is due to the data extractions occurring on different dates as the Programme for the Integration of Mental Health Data (PRIMHD) is a dynamic dataset. PRIMHD is a living data collection, which continues to be revised and updated as data reporting processes are improved.

This measure has been replaced in the Statement of Performance Expectations 2023-24 in favour of more meaningful measures of system activity given the wide range of complexities.

Category	FY2021-22	FY2022-23
Māori	1,300,441	1,264,841
Pacific	311,3811	304,045
Asian	241,651	228,038
Non-Māori, Non-Pacific, Non-Asian	2,371,588	2,173,572
Total	**4,086,036**	**3,970,496**

Measure	Result	Target	Status
Percentage of under 25-year-olds accessing specialist mental health within three weeks from referral	Māori **75.5%** Pacific **79.1%** Non-Māori/ Non-Pacific **63.9%** Overall **68.3%**	80%	↓

Baseline Period: Q4 2021 to Q3 2022

Baseline Value: Māori 79%, Pacific 87%, Non-Māori and Non-Pacific 68%

Note this measure was originally published with the erroneous addition of 'addiction services' and is corrected here to focus on mental health only.

The onset of serious mental illness mostly occurs before the age of 25 and, if ineffectively treated, can become a more complex lifelong condition. Given the vulnerability of this time of development, it is important to focus on the specific needs of young people presenting with a first episode of illness to empower them to live to their full potential.

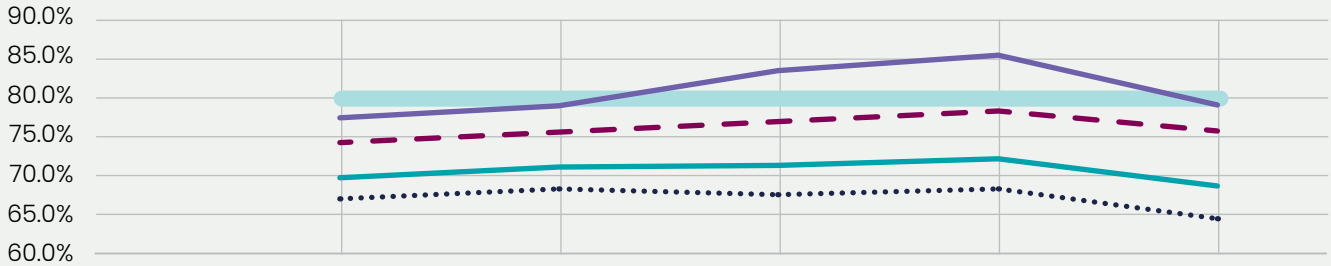
Children and young people experiencing mental distress may be referred to specialist infant child and adolescent mental health services delivered by hospital and specialist services if they are under 18 years or still at school. These clinical services are present in all districts and provide assessment and treatment for those experiencing serious mental health concerns. If they are between the ages of 18 and 25 years, they would be seen by adult mental health services. They may also be seen in sub-specialty services, for example, eating disorders or early intervention psychosis. Timely assessment and intervention is important to prevent deterioration and reduce disruption to the lives of the young person and their whānau. Those with urgent needs will always be prioritised.

It continues to be challenging to meet the 80% target in most areas due to increased service demand, particularly post-COVID-19, and critical workforce shortages. The specialist child and adolescent clinical workforce has been particularly difficult to source in a number of areas.

Through Budget 2022, $100m funding over 4 years was targeted at specialist mental health services for expansion in areas that had the highest need. This includes funding for crisis response services, maternal and infant mental health services, child and adolescent mental health and addiction services, eating disorders services, and kaupapa Māori services.

Child and adolescent mental health should continue to be a priority for further investment to meet increasing demand. A range of services in schools, universities and primary care have been enhanced with the intention of intervening early and reducing pressure on specialist services. However, the increase in complexity and severity of presentations as well as the quantum of referrals means that services will struggle to meet the target with their current level of resources and workforce shortages.

PERCENTAGE OF UNDER 25-YEAR-OLDS ACCESSING SPECIALIST MENTAL HEALTH WITHIN THREE WEEKS FROM REFERRAL



	12 months to Jun 2019	12 months to Jun 2020	12 months to Jun 2021	12 months to Jun 2022	12 months to Jun 2023
ALL ETHNICITIES	69.7%	71.2%	71.5%	72.4%	68.3%
MĀORI	74.2%	75.8%	77.8%	78.5%	75.5%
PACIFIC	77.4%	79.0%	83.7%	85.8%	79.1%
NON-MĀORI, NON-PACIFIC	67.1%	68.5%	67.7%	68.5%	63.9%
80% TARGET	80.0%	80.0%	80.0%	80.0%	80.0%

Measure	Result	Target	Status
Māori access as a percentage of all people accessing primary mental health and addiction: Access and Choice services	20.1%	20% Māori	✓

The 2022-23 result of 20.1%, whilst meeting target, observed a slight decrease of 1.4% comparing to 2021-22.

The ongoing development of the integrated primary mental health and addiction service, the removal of barriers to accessing support when required, and the integration of specialist services with NGO, primary and community providers are priority actions under the Oranga Hinengaro priority of Te Pae Tata.

The result is extracted from the Integrated Primary Mental Health and Addiction programme only.

Measure	Result	Target	Status
People served by specialist and NGO mental health services per 100,000 people	Māori **4,424** Pacific **2,115** Non-Māori/ Non-Pacific **2,556** Overall **9,095**	Improve from baseline (trend to increase)	↓

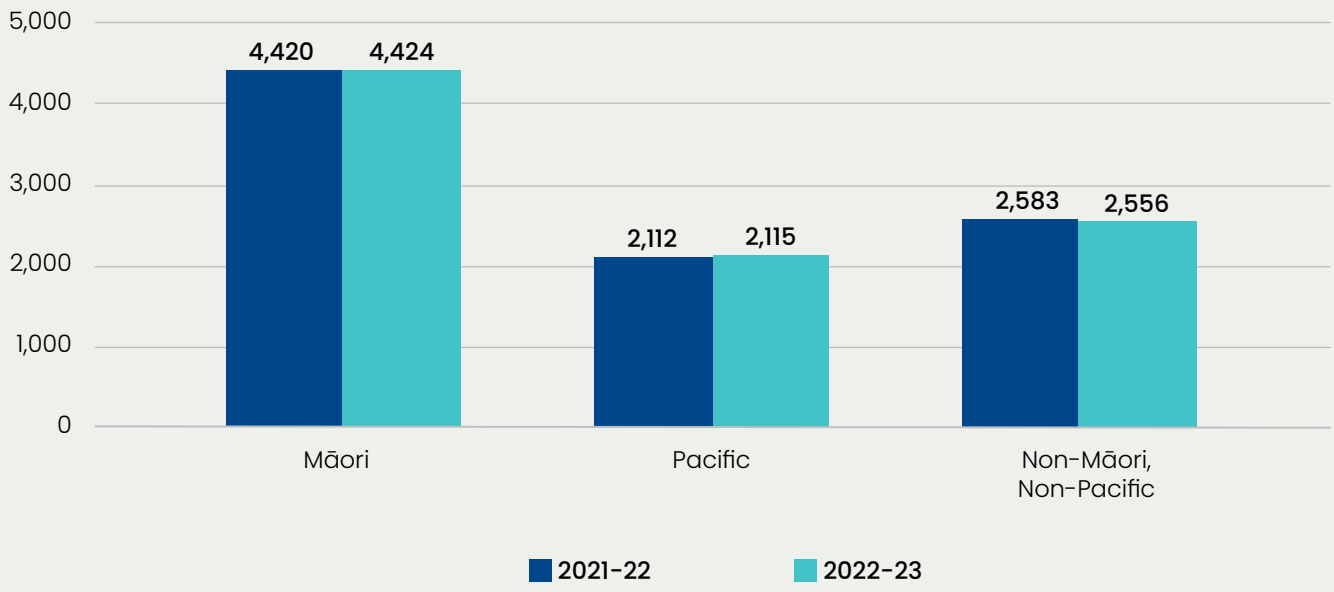
Baseline period: Q4 2021 to Q3 2022

Baseline values: Māori 5,650, Pacific 2,905, Non-Māori and Non-Pacific 2,988. Overall 9,095 per 100,000 people were served by specialist and NGO mental health services, equating to 78.79% of the baseline.

Supporting people to stay well and access primary and community care close to home is an important objective of the health reforms. However, more complex case presentation requires specialist mental health services where dedicated staff can support the pathway to wellbeing.

By focusing a measure on the complex end of care, we can monitor need in the community and prepare a basis for further analysis where indicated. Operational planning is currently underway to establish a specific target in this area.

PEOPLE SERVED BY SPECIALIST AND NGO MENTAL HEALTH SERVICES PER 100,000 PEOPLE



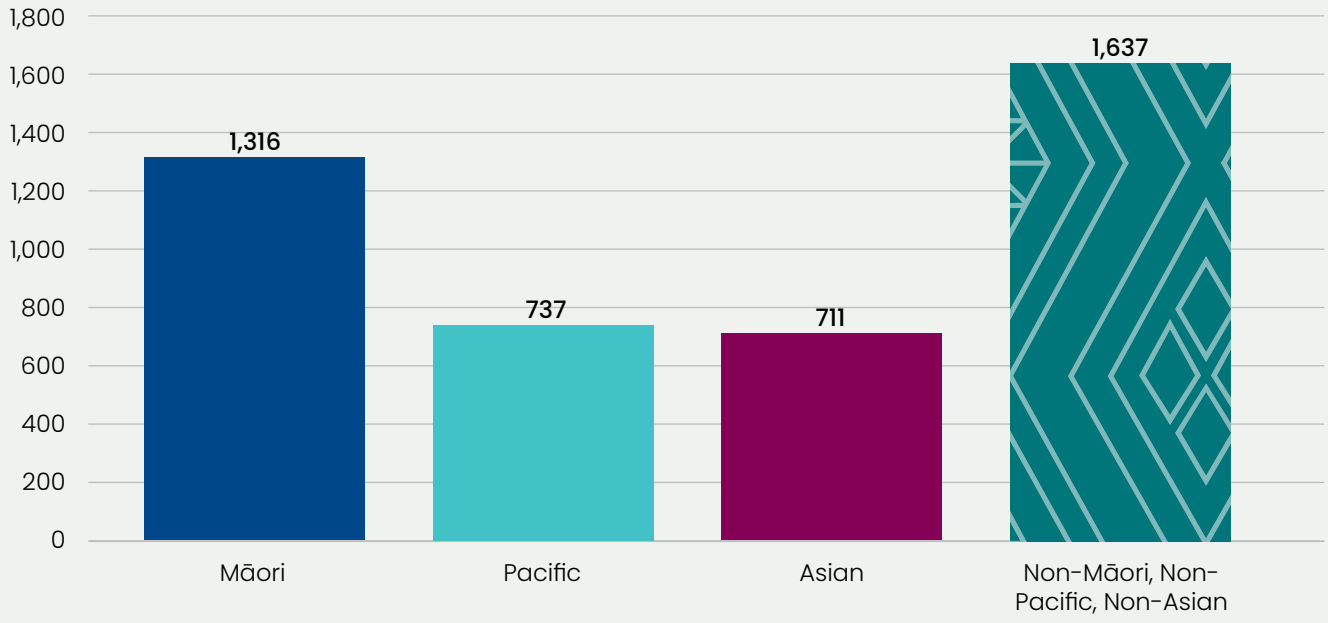
Measure	Result	Target	Status
The number of people accessing support from problem gambling services	Māori **1,316** Pacific **737** Asian **711** Non-Māori/ Non-Pacific/ Non-Asian **1,637** Total **4,401**	6,750	↓

Gambling harm disproportionately affects Māori, Pacific peoples and some Asian communities more than other populations.

This is reflected in the graph below of the number of people accessing gambling harm services in 2022-23. It indicates 29.9% of tāngata whai ora/service users were Māori, 16.8% were Pacific and 16.2% from an Asian population, which is above or in line with the proportion of these groups within the New Zealand population. Overall, 4,401 tāngata whai ora/service users accessed services in this financial year, equating to 65.2% of the desired 6,750.

In line with the Strategy to Prevent and Minimise Gambling Harm 2022-23 to 2024-25, Te Whatu Ora currently has an open market procurement process underway to commission new public health, intervention, and support services to prevent and minimise gambling harm. A focus of the procurement is to improve access and address health outcome inequities.

NUMBER OF PEOPLE ACCESSING SUPPORT FROM PROBLEM GAMBLING SERVICES – FY23



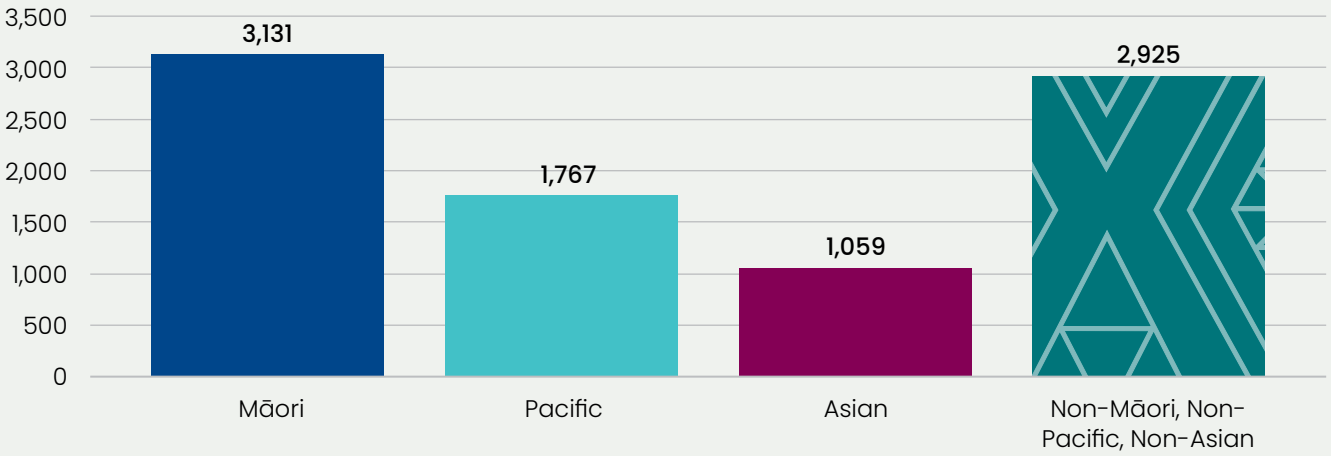
Note: This is a count of clients. Excludes clients receiving brief interventions only.
This result also includes services contracted by Te Aka Whai Ora.

Measure	Result	Target	Status
The number of brief only interventions delivered	Māori **3,131** Pacific **1,767** Asian **1,059** Non-Māori/ Non-Pacific / Non-Asian **2,925** Total **8,782**	6,000	✓

Brief intervention, as discussed here, refers to first responses offered to people presenting with mild to moderate levels of gambling harm, as opposed to more complex presentations that require referral to specialist services.

This measure relates to sessions provided as opposed to a count of people. The result indicates 35.3% of sessions were accessed by those who identify as Māori, 19.9% by Pacific and 11.9% of sessions to members of the Asian community. Overall, 8,782 sessions were delivered to tāngata whai ora/service users in this financial year, exceeding the desired number of 6,000.

NUMBER OF BRIEF ONLY INTERVENTIONS DELIVERED – FY23



Note: This is a count of sessions not clients. Includes brief interventions sessions only.

Measure	Result	Target	Status
Number of mental health bed nights	Māori **392,269** Pacific **73,601** Asian **37,657** Non-Māori/ Non-Pacific/ Non-Asian **502,586** Total **1,006,113**	Improve from baseline (trend to increase)	↓

Baseline period: Financial year 2021-22

Baseline values: Māori 321,522, Pacific 68,202, Non-Māori and Non-Pacific 519,569

In the 2022-23 financial year, the number of mental health bed nights for Maori and Pacific increased whilst numbers markedly reduced for Non-Māori, Non-Pacific compared to the previous financial year.

The baseline values in the Statement of Performance Expectations 2022-23 include addictions as well. The slight difference of FY21-22 extracted on 25 October 2023 versus the baseline in the SPE is due to different extraction date at the source because PRIMHD is a dynamic dataset. PRIMHD is a living data collection, which continues to be revised and updated as data reporting processes are improved. For this reason, previously published data may be liable to amendments.

Category	FY2021-22	FY2022-23
Māori	340,830	392,269
Pacific	71,784	73,601
Asian	37,008	37,657
Non-Māori, Non-Pacific, Non-Asian	516,112	502,586

Measure	Result	Target	Status
Mental health expenditure ringfence expectations are met	Achieved	Achieved	✓

Expenditure met and exceeded the mental health ringfence for financial year 2022-23.

HEALTHCARE IN ACTION

A Taranaki partnership

He mihi tēnei ki koutou e hāpai ana tēnei kaupapa tino whakahirahira ki ngai tātou te iwi Māori. E mihi kauana ki koutou.

It is recognised that we must reorient our approach to mental health and addiction to one that is genuinely grounded in wellbeing. This involves expanding existing services, growing new types of services and supports, and developing a diverse and resilient workforce.

No single service will supply the full range of options needed for a community. Therefore, we all must work collaboratively, cooperatively and in partnership to ensure the full range of services are provided in an effective, cohesive, and complementary manner and are responsive to Whaiora whānau needs.

The Hydration Station in the Hope Centre

Tui Ora and Taranaki Retreat have been enabled through a high trust model and funding methodology by Te Whatu Ora and Te Aka Whai Ora to identify whānau and community needs, collectively determine a way to bridge the current gaps and support whānau aspirations.

Te Waimanako and Taranaki Retreat

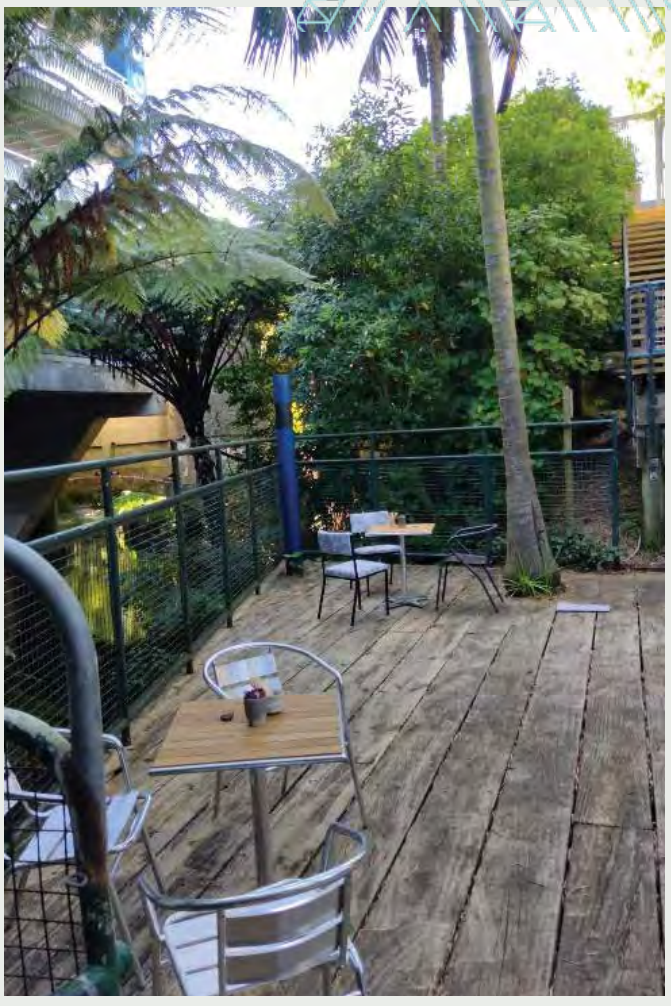
Te Waimanako is a community-based, peer-led mental health and wellness walk-in service that is being supported through this partnership. Te Waimanako | The Hope Centre implements care models that include local mātauranga and tikanga Māori on how best to strengthen the community.

"In many ways, Te Waimanako is a pilot initiative – designed in concept to enable health and social support services to operate collaboratively, sharing kaupapa from an accessible and comfortable walk-in physical base," says the Chief Executive of Taranaki Retreat, Jamie Allen.

The 'on the turf' nature of Waimanako (among the shops in the CBD) provides a threshold that people who may be mistrustful of clinical services, feel comfortable crossing, including members of our unhoused community. At the Kai-for-Koha Café, people can access immediate listening ear support, or simply de-stress over a good coffee, bowl of soup or big breakfast.

Partnered working enables countless benefits to whānau through the combining (and thus strengthening) of resources, disciplines and approaches while allowing services to retain their distinctive tikanga. This avoids the waste of duplication and facilitates mutual referrals in the simplest possible way – as per the vision of He Ara Oranga.

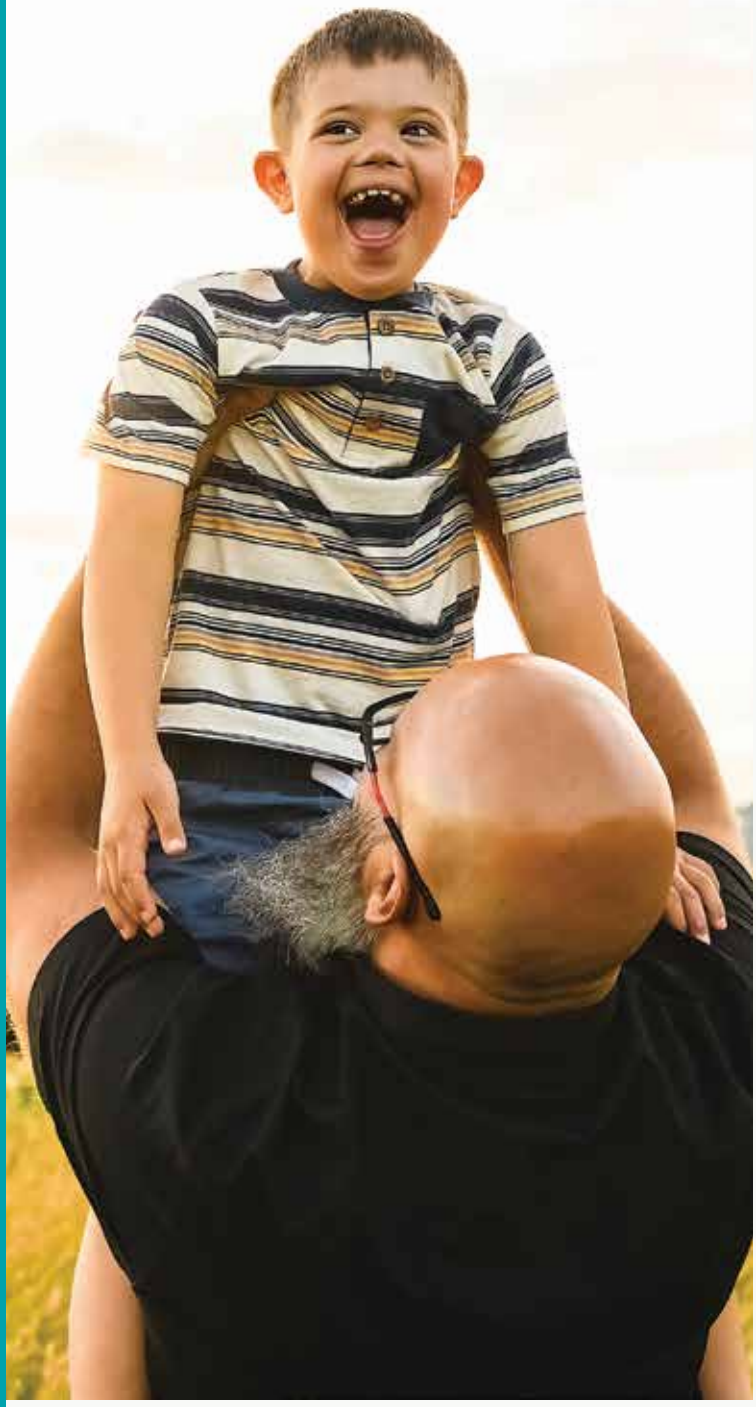
"PARTNERSHIP WITH TUI ORA IS AN EXCITING AND THOROUGHLY POSITIVE OUTCOME FOR OUR COMMUNITY."



The Waimanako site in New Plymouth

Section 4

Financial Performance



Statement of Responsibility

We are responsible for the preparation of the Te Whatu Ora – Health New Zealand group's financial statements and the statement of performance, and for the judgements made in them.

We are responsible for any end-of-year performance information provided by Te Whatu Ora – Health New Zealand group under section 19A of the Public Finance Act 1989.

We have the responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial and service performance reporting.

In our opinion, these financial statements and statement of performance fairly reflect the financial position and operations of the Te Whatu Ora – Health New Zealand group for the year ended 30 June 2023.

Signed on behalf of the Board:

Dame Dr Karen Poutasi

Chair – Te Whatu Ora – Health New Zealand
Dated: 31 October 2023

Naomi Ferguson

Board Member – Te Whatu Ora – Health New Zealand
Dated: 31 October 2023

Statement of comprehensive revenue and expense for the year ended 30 June 2023

		Group	
	Notes	Actual 2023 $m	Budget 2023 $m
Revenue			
Crown funding (from the MoH)	2	22,180	21,844
Other funding from the Crown/Crown Entities	2	2,963	1,843
Interest revenue		90	-
Other revenue	2	457	951
Total revenue		25,690	24,638
Expenditure			
Personnel costs	3	11,327	9,938
Outsourced personnel		490	324
Outsourced services		889	1,333
Clinical supplies		2,533	2,264
Depreciation and amortisation costs	12, 13	737	791
External service providers		8,546	8,029
Capital charge	4	424	329
Interest expense		7	-
Infrastructure, non-clinical supplies and other expenses	5	1,750	1,630
Total expenditure		26,703	24,638
Surplus/(Deficit)	25	**(1,013)**	**-**
Other comprehensive revenue and expense			
Gain/(Loss) on property revaluations		1,091	-
Total other comprehensive revenue and expense		1,091	-
Total comprehensive revenue and expense		**78**	**-**

Explanations of major variances against budget are provided in note 26.

The accompanying notes form part of these financial statements.

Statement of changes in equity for the year ended 30 June 2023

		Group	
	Notes	Actual 2023 $m	Budget 2023 $m
Balance as at 1 July 2022	24	8,567	8,754
Capital contributions from the Crown		686	556
Capital contribution returned to the Crown		(12)	-
Adjustments for capital contributions accrued		(7)	-
Movements in trust and special funds		1	-
		9,235	9,310
Comprehensive Income			
Surplus/(Deficit) for the year		(1,013)	-
Other comprehensive revenue and expense			
Gain/(Loss) on property revaluations		1,091	-
Total comprehensive revenue and expense for the year		**78**	**-**
Balance at 30 June	19	**9,313**	**9,310**

Explanations of major variances against budget are provided in note 26.

The accompanying notes form part of these financial statements.

Statement of financial position as at 30 June 2023

		Group		
	Notes	Actual 2023 $m	Budget 2023 $m	Actual 1 July 2022 $m
Assets				
Current assets				
Cash and cash equivalents	6	2,019	2,427	686
Receivables	7	566	945	1,578
Prepayments		94	205	177
Investments	8	53	-	55
Inventories	9	382	813	569
Assets held for sale	10	13	-	15
Total current assets		3,127	4,390	3,080
Non-current assets				
Prepayments		6	12	10
Investments	8	113	103	105
Investments in associates and joint ventures	11	7	689	5
Property, plant and equipment	12	13,109	12,321	11,532
Intangible assets	13	429	265	407
Total non-current assets		13,664	13,390	12,059
Total assets		**16,791**	**17,780**	**15,139**
Liabilities				
Current liabilities				
Payables and deferred revenue	14	1,857	4,267	2,153
Borrowings	15	28	-	10
Employee entitlements	16	5,072	3,827	4,037
Provisions	18	134	-	10
Total current liabilities		7,091	8,094	6,210
Non-current liabilities				
Borrowings	15	82	107	92
Employee entitlements	16	296	268	261
Restricted funds	17	1	-	1
Provisions	18	8	2	8
Total non-current liabilities		387	376	362
Total liabilities		**7,478**	**8,470**	**6,572**
Net assets		**9,313**	**9,310**	**8,567**
Equity	19			
Crown equity		3,080	3,193	2,413
Accumulated surpluses/(deficits)		(1,013)	-	-
Revaluation Reserves		7,175	6,079	6,084
Trust and special funds		64	34	63
Minority interests		7	4	7
Total equity		**9,313**	**9,310**	**8,567**

Explanations of major variances against budget are provided in note 26.

The accompanying notes form part of these financial statements.

Statement of cash flows for the year ended 30 June 2023

	Notes	Group Actual 2023 $m	Group Budget 2023 $m
Cash flows from operating activities			
Funding from the Crown/Crown Entities		25,574	24,724
Interest received		112	200
Other revenue		426	1,156
Payments to employees		(10,122)	(10,108)
Payments to suppliers		(13,577)	(13,411)
Capital charge		(424)	(415)
Interest paid		(7)	-
GST (net)		(67)	196
Net cash flows from operating activities		1,915	2,342
Cash flows from investing activities			
Receipts from sale of Property, Plant and Equipment		2	-
Receipts from sale or maturity of investments		568	-
Funds placed on short term deposit >3months		(601)	
Purchase of Property, Plant and Equipment		(1,115)	(1,147)
Purchase of Intangible assets		(110)	-
Net cash flows from investing activities		(1,256)	(1,147)
Cash flows from financing activities			
Capital contributions from the Crown		686	556
Capital contribution returned to the Crown		(12)	-
Net cash flows from financing activities		674	556
Net (decrease)/increase in cash and cash equivalents		**1,333**	**1,751**
Cash and cash equivalents at the start of the year		686	676
Cash and cash equivalents at the end of the year	6	**2,019**	**2,427**

Explanations of major variances against budget are provided in note 26.

The accompanying notes form part of these financial statements.

Statement of cash flows for the year ended 30 June 2023 (continued)

Reconciliation of reported operating surplus/(deficit) with net cash inflow/(outflow) from operating activities

		Group
	Notes	Actual 2023 $m
Reported Net Surplus/(Deficit) for the Year		(1,013)
***Add Non-Cash Items*:**		
Depreciation and amortisation expense	12, 13	737
Total non-cash items		**737**
***Add Items Classified as Investing Activities*:**		
Gains on disposal of property, plant and equipment		(1)
Total items classified as investing or financing activities		**(1)**
***Add Movements in Statement of Financial Position Items*:**		
Decrease in Debtors and Other Receivables		1,012
Decrease in Prepayments		87
Decrease in Inventories		187
Increase/(Decrease) in Creditors and Other Payables		(288)
Increase in Provisions		124
Increase in Employee Entitlements		1,070
Net movements in working capital items		**2,192**
Net Cash Inflow from Operating Activities		**1,915**

The accompanying notes form part of these financial statements.

Notes to the financial statements

1. Statement of accounting policies for the year ended 30 June 2023

REPORTING ENTITY

Te Whatu Ora-Health New Zealand is a Crown entity as defined by the Crown Entities Act 2004 (CEA) and is domiciled and operates in New Zealand. The relevant legislation governing Te Whatu Ora's operations is the CEA and the Pae Ora (Healthy Futures) Act 2022 (the Act). Te Whatu Ora's ultimate parent is the New Zealand Crown.

The consolidated financial statements of Te Whatu Ora for the year ended 30 June 2023 comprise Te Whatu Ora (the parent entity) and its subsidiaries (**Note 11**), together referred as "group". Its interests in associates and joint ventures (**Note 11**) are equity-accounted into the group financial statements. Te Whatu Ora's subsidiaries, associates and joint ventures are incorporated and domiciled in New Zealand.

Te Whatu Ora's primary objective is to deliver health, disability, and mental health services to the communities across New Zealand. Te Whatu Ora does not operate to make a financial return.

Te Whatu Ora is designated as a public benefit entity (PBE) for the purposes of complying with generally accepted accounting practice (GAAP). The financial statements for the Te Whatu Ora group are for the year ended 30 June 2023 and were approved for issue by the Board on 31 October 2023.

BASIS OF PREPARATION

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) with a new Crown entity, Te Whatu Ora, that is responsible for running hospitals and commissioning primary and community health services. Te Whatu Ora includes four regional divisions. Additionally, under the Health Sector (Transfers) Act, certain assets, liabilities, contracts and employees of Ministry of Health (MoH) and eight Shared Service Agencies (SSAs) were transferred to Te Whatu Ora by way of two Orders in Council. The following entities were combined into Te Whatu Ora on 1 July 2022 and are referred to as the Combining Entities:

1. Northland DHB
2. Waitemata DHB
3. Auckland DHB
4. Counties-Manukau DHB
5. Waikato DHB
6. Lakes DHB
7. Bay of Plenty DHB
8. Tairāwhiti DHB
9. Taranaki DHB
10. Whanganui DHB
11. Hawke's Bay DHB
12. MidCentral DHB
13. Hutt Valley DHB
14. Capital and Coast DHB
15. Wairarapa DHB
16. Nelson Marlborough DHB
17. West Coast DHB
18. Canterbury DHB
19. South Canterbury DHB
20. Southern DHB
21. HealthShare Limited
22. HealthSource New Zealand Limited
23. Te Hiringa Hauora/Health Promotion Agency
24. Central Region's Technical Advisory Services Limited
25. healthAlliance N.Z. Limited
26. South Island Shared Services Agency Limited. (Removed from companies register on 25 March 2022)
27. Northern Regional Alliance Limited
28. New Zealand Health Partnerships Limited

1. Statement of accounting policies for the year ended 30 June 2023 (continued)

As a result of the reforms, responsibility for public health policy, strategy, monitoring and intelligence rests with a new Public Health Agency that resides within MoH. A new statutory entity, Te Aka Whai Ora-Māori Health Authority (MHA) has been formed to work in partnership with Te Whatu Ora and MoH to ensure the health system works well for Māori. The MHA will lead changes in the way the health system understands and responds to Māori, develop strategy and policy, commission kaupapa Māori services and monitor systems performance to reduce inequities for Māori. Legislation to establish the new entities and disestablish DHBs came into effect on 1 July 2022.

Measurement of the Assets and Liabilities on amalgamation

The assets and liabilities of the Combining Entities were measured at their carrying amount as of the amalgamation date in accordance with the requirements in PBE standards, with adjustments made where required to conform to Te Whatu Ora's accounting policies and to eliminate balances between the Combining Entities.

Going Concern:

The financial statements have been prepared on a going concern basis. The Board, after making enquiries, has a reasonable expectation that Te Whatu Ora has adequate resources to continue operations for the foreseeable future. The Board has reached this conclusion having regard to circumstances which it considers likely to affect Te Whatu Ora during the period of one year from the date of signing the 2022-23 financial statements, and to circumstances which it knows will occur after that date which could affect the validity of the going concern assumption. The key considerations are set out below:

- Forecast financial performance and cashflows prepared using funding expectations indicate that Te Whatu Ora will have sufficient funds (including equity funding from the Crown for approved capital projects) to meet forecast operating and investing cash flow requirements for 2023-24 year and beyond.
- Detailed capital plans developed have sufficient funding to implement the projects.
- Te Whatu Ora is required to settle the holiday pay liability disclosed in note 16 and payments will be funded by the Crown. Funding has been appropriated for this.
- Te Whatu Ora is developing three year financial forecasts which indicate an ability to live within the funding advised which will enable Te Whatu Ora to operate in a financially sustainable manner.

Statement of compliance

The financial statements have been prepared in accordance with the requirements of the CEA which includes the requirement to comply with GAAP.

The financial statements have been prepared in accordance with and comply with the PBE Reporting Standards.

Presentation currency and rounding

The financial statements are presented in New Zealand dollars (NZ dollars) and all values, other than the board and co-opted committee members disclosures in Note 3, are rounded to the nearest million dollars ($m). The board and co-opted committee members disclosures are rounded to the nearest thousand ($000).

1. Statement of accounting policies for the year ended 30 June 2023 (continued)

Changes in accounting policies

Te Whatu Ora is a new entity that was created and commenced operations on 1 July 2022, and this is the first reporting period. Accordingly, there are no accounting policy changes.

New standards adopted

PBE IPSAS 41 Financial instruments

PBE IPSAS 41 replaces PBE IFRS 9 Financial Instruments and is effective for the year ending 30 June 2023, with earlier adoption permitted. There was a non-significant impact as a result of adopting the new standard as the requirements are similar to those contained in PBE IFRS 9.

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 main impact of the new standard is that additional information has been disclosed on those judgements that have the most significant effect on the selection, measurement, aggregation, and presentation of service performance information.

Standards, amendments, and interpretations issued but not yet effective

2022 Omnibus Amendments to PBE Standards

2022 Omnibus Amendments to PBE Standards makes changes to the following standards that are relevant to Te Whatu Ora and are effective for the year ending 30 June 2024:

- PBE IPSAS 30 *Financial Instruments: Disclosures*
- PBE IPSAS 13 *Leases*
- PBE IPSAS 21 *Impairment of Non-Cash-Generating Assets* and PBE IPSAS 26 *Impairment of Cash-Generating Assets*
- PBE IPSAS 22 *Disclosure of Financial Information about the General Government Sector*
- PBE IPSAS 41 *Financial Instruments*
- PBE IPSAS 19 *Provisions, Contingent Liabilities and Contingent Assets*
- PBE IPSAS 19 *Provisions, Contingent Liabilities and Contingent Assets: Application Guidance Changes in Existing Decommissioning, Restoration and Similar Liabilities*
- PBE IPSAS 17 *Property, Plant and Equipment*
- PBE IPSAS 5 *Borrowing Costs*

Disclosure of Fees for Audit Firms' Services (Amendments to PBE IPSAS 1)

Disclosure of Fees for Audit Firms' Services (Amendments to PBE IPSAS 1) amends the disclosures for fees relating to services provided by the audit or review provider, including a requirement to disaggregate the fees into specific categories. The amendment will be effective for the year ending 30 June 2025. Early adoption is permitted.

Te Whatu Ora has not yet assessed the impact of the new standards or amendments. Te Whatu Ora does not intend to early adopt the standards/amendments.

1. Statement of accounting policies for the year ended 30 June 2023 (continued)

Comparatives

Te Whatu Ora is not required to present comparative information on the face of its financial statements for the periods prior to the amalgamation date. Management has determined that the disclosure of comparative information for each of the Combining Entities would result in lengthy financial statements being presented that may unnecessarily confuse the users of its financial statements. As such, no comparative information has been presented. The effects of amalgamation have been disclosed in the financial statements as required.

SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Significant accounting policies are included in the notes to which they relate.

Significant accounting policies that do not relate to a specific note are outlined below.

1. Statement of accounting policies for the year ended 30 June 2023 (continued)

Basis of consolidation

Te Whatu Ora consolidates in the group financial statements all entities where Te Whatu Ora has the capacity to control financing and operating policies so as to obtain benefits from the activities of subsidiaries. This power exists where Te Whatu Ora controls the majority voting power on the governing body or where financing and operating policies have been irreversibly predetermined by Te Whatu Ora.

The group financial statements are prepared by adding together like items of assets, liabilities, equity, revenue, expenses, and cash flows of entities in the group on a line-by-line basis. All intra-group balances, transactions, revenue and expenses are eliminated on consolidation.

The group financial statements are prepared using uniform accounting policies for like transactions and other events in similar circumstances. The consolidation of an entity begins from the date Te Whatu Ora obtains control of the entity and ceases when Te Whatu Ora loses control of the entity.

Foreign currency transactions

Foreign currency transactions (including those for which forward foreign exchange contracts are held) are translated into NZ dollars (the functional currency) using the spot exchange rate prevailing at the date of the transaction. Foreign exchange gains and losses resulting from the settlement of such transactions and from the translation at year-end exchange rates of monetary assets and liabilities denominated in foreign currencies are recognised in surplus or deficit.

Patient trust money

Te Whatu Ora administers funds on behalf of certain patients, which are held in bank accounts that are separate from Te Whatu Ora's normal banking facilities. Interest earned on the funds is allocated to individual patients. Patient fund transactions and balances are not recognised in Te Whatu Ora's financial statements.

Goods and services tax

All items in the financial statements are presented exclusive of goods and services tax (GST), except for receivables and payables, which are presented on a GST-inclusive basis. Where GST is not recoverable as 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 (IR) is included as part of receivables or payables in the statement of financial position.

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

Commitments and contingencies are disclosed exclusive of GST.

Income tax

Te Whatu Ora is a public authority and consequently is exempt from the payment of income tax. Accordingly, no provision has been made for income tax.

1. Statement of accounting policies for the year ended 30 June 2023 (continued)

Budget figures

The budget figures are derived from the amended 2022-23 statement of performance expectations (dated 23 June 2023, that was tabled in Parliament on 4 August 2023). The budget figures have been prepared in accordance with GAAP, using accounting policies that are consistent with those adopted by the Board in preparing these financial statements. Refer to Note 26 for further detail about the budget figures.

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/usage information. Depreciation is charged on the basis of asset utilisation. Personnel costs are charged on the basis of actual time incurred. Property and other premises costs, such as maintenance, are charged on the basis of floor area occupied for the production of each output. Other indirect costs are assigned to outputs based on the proportion of direct staff costs for each output.

Critical judgements in applying accounting policies

Management has exercised the following critical judgements in applying accounting policies:

- Classification of Leases – refer to note 15.
- Determining whether Te Whatu Ora is a principal or an agent of Pharmac in relation to community pharmaceutical funding and expenditure transactions – as there is no written agreement between Te Whatu Ora and Pharmac, judgement has been exercised in assessing which party has exposure to the significant risks and rewards associated with the supply of community pharmaceuticals.

  Management has reached the view that Te Whatu Ora is acting as a principal, and has therefore recognised the funding from Pharmac as revenue and the payment of claims from community pharmacies for their dispensation of funded pharmaceuticals as expenditure based on the following indicators:
  - Te Whatu Ora is primarily responsible for the supply of pharmaceuticals to community pharmacy service users as set out in the Pae Ora (Healthy Futures) Act 2022, and contracts with community pharmacies across New Zealand to dispense pharmaceuticals.
  - The funding that Te Whatu Ora receives from Pharmac is reimbursement for Te Whatu Ora's expenditure on community pharmaceuticals.

1. Statement of accounting policies for the year ended 30 June 2023 (continued)

Critical accounting estimates and assumptions

The Board has made estimates and assumptions concerning the future. These estimates and assumptions might 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 in respect of:

- Estimating the fair value of land and buildings – refer to **Note 12**
- Measuring the liabilities for Holidays Act 2003 remediation, long service leave, retirement gratuities, sabbatical leave, and continuing medical education leave – refer to **Note 16**
- Estimated useful life of property, plant and equipment – refer to **Note 12**
- Estimated useful life of intangible assets – refer to **Note 13**
- Provision for expected credit losses – refer to **Note 7**
- Provision for Covid-19 inventory obsolescence – refer to **Note 9**

2. Revenue

Accounting Policy

Crown funding

Te Whatu Ora receives annual funding from MoH, which is based on appropriations made from the Treasury as part of Vote Health, to support the health sector.

Crown funding is restricted in its use for the purpose of meeting the objectives specified in its founding legislation and the scope of the relevant appropriations of MoH. Funding is recognised as revenue when it becomes receivable unless there is an obligation in substance to return the funds if conditions are not met. If there is an obligation, the funding is initially recorded as deferred revenue and recognised as revenue when conditions of the funding are satisfied. The fair value of revenue from the Crown has been determined to be equivalent to the amounts due in the funding arrangements.

Other funding from Crown/Crown entities

Te Whatu Ora receives funding from the Ministry for Disabled People for specific services to support disabled people and from Pharmac to reimburse Te Whatu Ora for hospital and community pharmaceutical expenditure.

The Crown funding accounting policy also applies for funding from the Ministry for Disabled People.

Pharmac funding is recognised as revenue when Te Whatu Ora is entitled to be reimbursed for the pharmaceutical expenditure, which is when the pharmaceuticals have been dispensed.

ACC contract revenue

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

Sale of goods

Revenue from goods sold is recognised when Te Whatu Ora has transferred to the buyer the significant risks and rewards of ownership of the goods have been transferred to the buyer and Te Whatu Ora does not retain either continuing managerial involvement to the degree usually associated with ownership nor effective control over the goods sold.

Other services rendered

Revenue from services is recognised, to the proportion that a transaction is complete, when it is probable that the receivable associated with the transaction will flow in and that it can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied by the service provider.

All services are provided on commercial terms and are considered to be exchange transactions.

Interest revenue

Interest revenue is recognised using the effective interest method.

Rental revenue

Rental revenue under an operating lease is recognised as revenue on a straight-line basis over the lease term. Lease incentives granted are recognised as an integral part of the total rental revenue over the lease term.

2. Revenue (continued)

Accounting Policy (continued)

Donations and bequests

Donated and bequeathed financial assets are recognised as revenue unless there are substantive use or return conditions. A liability is recorded if there are substantive use or return conditions, and the liability released to revenue as the conditions are met. For example, as the funds are spent for the nominated purpose.

Donated services

Certain operations are reliant on services provided by volunteers. Volunteers' services received are not recognised as revenue or expenditure by Te Whatu Ora.

Vested or donated physical assets

For assets received for no or nominal consideration, the asset is recognised at its fair value when the entity obtains control of the asset. The fair value of the asset is recognised as revenue, unless there is a use or return condition attached to the asset.

The fair value of vested or donated assets is usually determined by reference to the cost of purchasing the asset if the asset is new, or reference to market information for assets of a similar type, condition, or age for used assets.

Grants revenue

Grants are recognised as revenue when they become receivable unless there is an obligation in substance to return the funds if conditions of the grant are not met. If there is such an obligation, the grants are initially recorded as grants received in advance and recognised as revenue when conditions of the grant are satisfied.

Research revenue

For an exchange research contract, revenue is recognised on a percentage completion basis when the conditions of the contracts have been met. The percentage of completion is measured by reference to the actual research expenditure incurred as a proportion to total expenditure expected to be incurred. A liability reflects funds that are subject to conditions that, if unfulfilled, are repayable until the condition is fulfilled.

For a non-exchange research contract, the total funding receivable under the contract is recognised as revenue immediately, unless there are substantive conditions in the contract. If there are substantive conditions, revenue is recognised when the conditions are satisfied. Revenue for future periods is not recognised where the contract contains substantive termination provisions for failure to comply with the requirements of the contract. Conditions and termination provisions need to be substantive, which is assessed by considering factors such as contract monitoring mechanisms of the funder and the past practice of the funder.

Dividend revenue

Revenue is recognised when the right to receive payment has been established.

2. Revenue (continued)

Patient care revenue

	Group
	Actual 2023 $m
Crown funding – health services	20,714
Crown funding – Covid-19 response	1,466
Total Crown funding	**22,180**
ACC Contract revenue	371
Other funding from the Crown/Crown Entities	2,592
Total other Crown Entities	**2,963**
Total patient care revenue	**25,143**

Other revenue

	Group
	Actual 2023 $m
Gain on sale of property, plant and equipment	1
Donations & bequests received	27
Rental and accommodation revenue	23
Direct charges revenue	35
Drug trial revenue	8
Research grants	33
Other revenue	330
Total other revenue	**457**

Non-cancellable leases as a lessor

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

	Group
	Actual 2023 $m
Not later than one year	22
Later than one year and not later than five years	35
Later than five years	11
Total non-cancellable operating lease commitments as lessor	**68**

3. Personnel costs

Accounting Policy

Salaries and wages

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

Superannuation schemes

Defined contribution schemes

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

Defined benefit schemes

Te Whatu Ora makes employer contributions to the Defined Benefit Plan Contributors Scheme, which is managed by the Board of Trustees of the NPF, and to the ASB Group Master Trust Scheme (collectively the schemes). The schemes are multi-employer defined benefit schemes.

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

The funding arrangements for the Defined Benefit Plan Contributors 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 neither a surplus nor deficit in the trust fund of the scheme at the time that the last contributor to that scheme ceases to so contribute. The Trust Deed specifies that immediately before the scheme is wound up, the assets and the interests of all contributors in the scheme will be transferred to the DBP Annuitants Scheme. Employers have no right to withdraw from the plan.

Breakdown of personnel costs and further information

	Group
	Actual 2023 $m
Salaries and wages	9,928
Defined contribution plan employer contributions	273
Movement in employee entitlements liability	860
Movement in Holidays Act remediation liability	210
Movement in restructuring provision	56
Total personnel costs*	**11,327**

*This includes provisions of $644m for nurses, $48m for midwives and $167m for Allied Health pay equity settlements announced after balance date. Refer to Note 23, Events after balance date, for further detail.

3. Personnel costs (continued)

Board and co-opted Committee member remuneration

	Group
	Actual 2023
Board member remuneration – in thousands	**$000**
Dame Dr Karen Poutasi (Chair, from 1 July 2023)	94
Naomi Ferguson (Interim Chair, from 1 March 2023)	145
Hon Amy Adams	70
Dr Jeff Lowe	59
Ms Tipa Mahuta (Waikato, Maniapoto, Ngāpuhi)	21
Ms Vanessa Stoddart	84
Dr Curtis Walker (Te Whakatōhea rāua ko Ngāti Porou)	44
Mr Rob Campbell (Chair, until 28 February 2023)	175
Total board member remuneration	**692**

Co-opted committee members – in thousands	$000
Jonathan Oram	6
Lale Ieremia	8
Marc Rivers	37
Marcus Porter	6
Mei Fern Johnson	8
Michal Noonan	8
Professor Marie Bismark	10
Scott Pritchard	12
Tevita Funaki	5
Vena Crawley	8
Total co-opted committee members	**108**

Te Whatu Ora has provided a deed of indemnity to Directors and Board Members for certain activities undertaken in the performance of Te Whatu Ora's functions. Te Whatu Ora has renewed Directors' and Officers' Liability and Professional Indemnity insurance cover during the financial year in respect of the liability or costs of Board members and employees.

No Board members received compensation or other benefits in relation to cessation.

4. Capital charge

Accounting Policy

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

Further Information

Te Whatu Ora pays a capital charge every six months to the crown. The charge is based on the previous six-month actual closing equity balance as at 31 December and 30 June. The capital charge rate for the year ended 30 June 2023 was 5.00%.

5. Infrastructure, non-clinical supplies and other expenses

Accounting Policy

Operating leases

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset to Te Whatu Ora.

Lease payments under an operating lease are recognised as an expense on a straight-line basis over the lease term.

Lease incentives received are recognised in surplus or deficit as a reduction of operating lease expense over the lease term.

Breakdown of other expenses and further information

	Group
	Actual 2023 $m
Audit New Zealand fees for audit of financial statements	6
Rental expenses including operating leases	160
Software - annual license fees	205
ITC/IT other expenses	122
Impairment loss on receivables (Note 7)	4
Expected credit losses expense	22
Board member fees	1
Loss on disposal of property, plant and equipment	3
Loss on disposal of intangible assets	2
Impairment of WIP	19
Transport and travel	66
Food and laundry services	272
Utilities	111
Maintenance	120
Other facilities expenses	124
Compliance and corporate	162
Other expenses	351
Total infrastructure, non-clinical supplies and other expenses	**1,750**

In addition to the Audit New Zealand audit fees above, total fees to firms other than Audit New Zealand for the audit of the financial statements of subsidiaries of Te Whatu Ora were $0.26m. There were $0.12m fees paid to Audit New Zealand for assurance services over the project management and procurement for some construction projects.

5. Infrastructure, non-clinical supplies and other expenses (continued)

Non-cancellable operating lease commitments as lessee

Te Whatu Ora leases a number of buildings, vehicles and office equipment under operating leases.

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

	Group
	Actual 2023 $m
Not later than one year	72
Later than one year and not later than five years	175
Later than five years	81
Total non-cancellable operating lease commitments as lessee	**328**

6. Cash and cash equivalents

Accounting Policy

Cash and cash equivalents include cash on hand, deposits held at call with banks, and other short-term highly liquid investments with original maturities of three months or less, and bank overdrafts. Bank overdrafts that are considered to form an integral part of cash management are included as a component of cash and cash equivalents. All other bank overdrafts are presented within borrowings in current liabilities in the statement of financial position.

Loss allowance

While cash and cash equivalents are subject to the expected credit loss requirements of PBE IPSAS 41, no loss allowance has been recognised because the estimated loss allowance for credit losses is trivial.

Breakdown of cash and cash equivalents and further information

	Group
	Actual 2023 $m
Current assets	
*Bank balance and cash on hand**	66
Te Whatu Ora BNZ Cash Offset Balance	1,953
Total cash and cash equivalents in the statement of cash flows	**2,019**

* includes $4m deposit maturing < 3 months

6. Cash and cash equivalents (continued)

Treasury Services Agreement

Te Whatu Ora is party to a Treasury Services Agreement with two of its wholly owned subsidiaries (Enable New Zealand Limited and Allied Laundry Services Limited) and with Te Aka Whai Ora. Under this Agreement, Te Whatu Ora invests surplus funds to maximise interest revenue and manage combined cash flow efficiently. Each Participating Combining Entity under this Agreement must ensure that the debit balance owing by it and its subsidiaries at any given time will not exceed an amount equal to one month's operating budget of the relevant Participating Combining Entity, inclusive of GST.

Te Whatu Ora also has a Cash Offset Arrangement with Bank of New Zealand across its bank accounts, the accounts of two of its wholly owned subsidiaries (Enable New Zealand Limited and Allied Laundry Services Limited) and with Te Aka Whai Ora. Under this arrangement, individual accounts can be in debit but there must be a positive net balance overall at all times. In addition, the Maximum Gross Debit Balance must not exceed $2.0 billion.

Te Whatu Ora has a $200m Standby Credit Facility with the Crown available for drawdowns of up to 10 days to manage fluctuations in working capital and treasury management liquidity.

7. Receivables

Accounting Policy

Short-term receivables are recorded at the amount due, less an allowance for credit losses. Te Whatu Ora 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 debtor category basis as each category possess different 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, the debtor being in liquidation or a failure to make contractual payments for a period of greater than 90 days past due. Receivable balances have to be written off before they can be referred to external debt collectors.

The expected credit loss rates for receivables are based on the payment profile of revenue on credit at the measurement date and the corresponding historical credit losses experienced for that period. 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 macro-economic factors is not considered significant.

7. Receivables (continued)

Breakdown of receivables and further information

	Group
	Actual 2023 $m
Receivables	187
Other accrued income*	403
Less: Allowance for expected credit loss	(24)
Total receivables	**566**

* Includes $297m accrual for Pharmac funding

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

	Group	
Receivables days past due	Gross 2023 $m	Expected credit loss allowance 2023 $m
Not past due	495	-
Past due 0-30 days	14	(4)
Past due 31-90 days	26	(5)
Past due 91-360 days	34	(7)
Past due more than 1 year	21	(8)
Total	**590**	**(24)**

Allowance for expected credit loss is calculated based on a review of significant debtor balances and an assessment of impairment using an "expected credit loss" model. The impairment assessment is based on an analysis of the likelihood to pay based on current circumstances and past collection history and write-offs. The expected credit loss rate is variable depending on the debtor category.

Movements in the allowance for expected credit loss are as follows.

	Group
	Actual 2023 $m
Balance 1 July	(18)
Additional allowances (made)/released	(15)
Written off during year	9
Balance at 30 June	**(24)**

8. Investments

Accounting Policy

Bank term deposits

Bank term deposits are initially measured at the amount invested. Interest is subsequently accrued and added to the investment balance. A loss allowance for expected credit losses is recognised if the estimated loss allowance is not trivial. Fair value has been calculated based on discounted cash flows, using market quoted interest rates for term deposits with terms to maturity similar to the relevant investments.

Trust/special fund assets

The assets are funds held by Te Whatu Ora and comprise donated/endowed and research funds. The use of the funds must comply with the specific terms of the sources from which the funds were derived. The revenue and expenditure in respect of these funds are recognised in the surplus or deficit and is transferred from/to trust funds in equity.

Loan receivable

The long-term loan receivables are initially measured at fair value plus transaction costs. The loans receivable has been measured at fair value through surplus or deficit.

Residential care loan

Interest free loans are provided to eligible rest home patients. The loans are secured over the property of the borrower and repayable at the earlier of sale of the secured property or death of the borrower. The loans are recorded at valuation based on an actuarial valuation carried out by Deloitte Ltd using the property prices as at 31 May 2023 based on the return in the Reserve Bank of New Zealand (RBNZ) House Price Index. The discount rate applied is based on the risk-free spot rates prescribed by the Treasury for use for valuations as at 31 May 2023.

Equity investments

Te Whatu Ora designates short-term investments at fair value through other comprehensive revenue or expense which are initially measured at fair value plus transaction costs. After initial recognition, these investments are measured at their fair value with gains and losses recognised in other comprehensive revenue and expense. When sold, the cumulative gain or loss previously recognised in other comprehensive revenue and expense is transferred within equity to accumulated surplus/deficit. Portfolio investments and some equity investments are measured at fair value through surplus or deficit, having been designated as such on initial recognition. The fair value of portfolio investments and some equity investments has been calculated based on quoted market prices at the balance sheet date without deduction for transaction costs.

8. Investments (continued)

Breakdown of investments and further information

Investments are comprised of term investments and on-call deposits with All of Government Banking services providers and the banks that have Standard & Poor's Rating of "A+" or better.

	Group
	Actual 2023 $m
Current assets	
Short term deposits > 3 months < 12 months	43
Portfolio investments	10
Total current portion	**53**
Non-Current assets	
Term deposits	27
Portfolio investments	31
Residential Care Loan	52
Other investments	3
Total non-current portion	**113**
Total Investments	**166**

The carrying value of the current portion of investments approximates their fair value. Portfolio investments are measured at fair value through the surplus or deficit, having been designated as such on initial recognition.

The fair value of non-current investment with a remaining duration greater than 12 months is $113m.

9. Inventories

Accounting Policy

Inventories held for distribution or consumption in the provision of services that are not supplied on a commercial basis are measured at cost (using the weighted average cost method), adjusted, when applicable, for any loss of service potential.

Inventories acquired through non-exchange transactions are measured at fair value at the date of acquisition.

The amount of any write-down for the loss of service potential is recognised in surplus or deficit in the year of the write-down.

The inventories mainly comprise of pharmaceuticals, surgical, medical supplies and COVID-19 stocks. No inventories are pledged as security for liabilities. However, some inventories are subject to retention of title clauses.

9. Inventories (continued)

Breakdown of inventories and further information

	Group
	Actual 2023 $m
Current assets	
Pharmaceuticals	30
Surgical and medical supplies	339
Other supplies	13
Total Inventories	**382**

The amount of inventories recognised as an expense during the year was $1,850m, which is included in the clinical supplies line item in the statement of comprehensive revenue and expense.

This includes a $284m write-down of Covid-19 inventories that may become obsolete. This has been calculated based on product expiry dates and the expected future usage given the current national pandemic response settings. There have been no reversals of write-downs. No inventories are pledged as security for liabilities. However, some inventories are subject to retention of title clauses.

10. Assets held for sale

Accounting Policy

Non-current assets held for sale

A non-current asset is classified as held for sale if its carrying amount will be recovered principally through sale 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, while classified as held for sale, are recognised in surplus or deficit.

Any increases 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 (including those that are part of a disposal group) are not depreciated or amortised while they are classified as held for sale.

Breakdown of assets held for sale

	Group
	Actual 2023 $m
Land	12
Buildings	1
Total assets held for sale	**13**

11. Investments in subsidiaries, associates, and joint ventures

Accounting Policy

Subsidiaries

Te Whatu Ora consolidates in the group financial statements those entities it controls. Control exists where Te Whatu Ora is exposed, or has rights, to variable benefits (either financial or non-financial) and has the ability to affect the nature and amount of those benefits from its power over the entity. Power can exist over an entity if, by virtue of its purpose and design, the relevant activities and the way in which the relevant activities of the entity can be directed has been predetermined by Te Whatu Ora.

Associates

An associate is an entity over which the group has significant influence and that is neither a subsidiary nor an interest in a joint venture. The group's associate investment is accounted for using the equity method of accounting. The investment in an associate is initially recognised at cost and the carrying amount in the financial statements is increased or decreased to recognise the group'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 group financial statements.

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

Where the group transacts with an associate, gains and losses are eliminated to the extent of the interest in the associate.

Joint Arrangements

Investments in joint arrangements are classified as either joint ventures or joint operations. The classification depends on the contractual rights and obligations of each investor.

Joint Ventures

A joint venture is a binding arrangement whereby two or more parties are committed to undertake an activity that is subject to joint control. Joint control is the agreed sharing of control over an activity. The consolidated financial statements include Te Whatu Ora's joint interest in jointly controlled entities, using the equity method, from the date that joint control commences until the date that joint control ceases.

Joint Operations

A joint operation is a joint arrangement whereby the parties that have joint control of the arrangement recognise their direct right to the assets, liabilities, revenues and expenses of joint operations and their share of any jointly held or incurred assets, liabilities, revenues and expenses. These have been incorporated in the financial statements under the appropriate headings.

11. Investments in subsidiaries, associates, and joint ventures (continued)

Breakdown of subsidiaries, associates and joint arrangements

	Group
General Information	Interest held 2023 %
Name of subsidiaries	
Kaipara Total Health Care Joint Venture	54%
Three Harbours Health Foundation	100%
Auckland Hospitals Research and Endowment Fund	100%
Auckland Health Foundation	100%
Waikato Health Trust	100%
Spectrum Health Limited	100%
Lakes District Hospitals Charitable Trust	100%
Tairawhiti Laundry Services	100%
Enable New Zealand	100%
Canterbury Linen Services Limited	100%
Brackenridge Services Limited	100%
New Zealand Health Innovation Hub Management Limited	100%
Allied Laundry Services Limited	100%
South Canterbury Eye Clinic Limited	100%
Name of associate	
TLab Limited	50%
Gisborne Laundry Services	50%
Streamliners	20%
Name of joint ventures	
HealthOne (2021) Limited Partnership	50%

TLab Limited

TLab Limited is an unlisted limited liability company providing laboratory services. Accordingly, there were no published price quotations for this investment.

Gisborne Laundry Services

Gisborne Laundry Service is an unlisted partnership with Tairāwhiti Laundry Services Ltd providing laundry services in Gisborne and Hawkes Bay. Accordingly, there were no published price quotations for this investment.

Streamliners

Streamliners is owned by The Joined Up Systems Trust (JUST) and Te Whatu Ora Health New Zealand (through New Zealand Health Innovation Hub Management Ltd).

11. Investments in subsidiaries, associates, and joint ventures (continued)

Streamliners provides a common platform called HealthPathways which is an online manual used by clinicians to help make assessment, management, and specialist request decisions for over 550 conditions.

HealthOne (2021) Limited Partnership

Te Whatu Ora held 50% interest in HealthOne (2021) Limited Partnership through its wholly owned subsidiary NZ Health Innovation Hub Management Ltd (NZHIH) with Pegasus Health (Charitable) Limited. HealthOne (2021) Limited Partnership is an unlisted limited partnership. Accordingly, there was no quoted market price for this investment.

Breakdown of investment and further information

	Group
	Actual 2023 $m
HealthOne (2021) Limited Partnership	1.2
Streamliners	5.3
Gisborne Laundry Services	0.2
TLab Limited	0.3
Total Investments in subsidiaries and associates	**7.0**

Joint operations

Awhina Waitakere Health Campus is a jointly controlled operation between Unitec Institute of Technology and Te Whatu Oraper the terms of the joint venture agreement dated March 2011. Each party has provided certain capital inputs and share the operating costs of the Simulation Centre and conference facilities.

In 2018/19, Te Whatu Ora Canterbury entered into a joint property lease with Ara Institute of Canterbury for the new Health Research Educational Facility known as the Manawa building. The arrangement is by way of jointly controlled operations.

Te Whatu Ora Auckland entered into a long-term agreement (joint operation) with Slade Health to provide a sterile compounding facility and services for delivery of chemotherapy, antibiotics, analgesics and nutritional infusions. Previously, Te Whatu Ora Auckland compounded chemotherapy and other sterile products in-house. The outsourcing of this service to Slade means that patient specific infusions can be compounded quicker with less wastage and reduced potential for medication errors – while also keeping up with the demand for these services which is expected to double by 2040. The price for the medicines produced by Slade is governed by the PHARMAC (Pharmaceutical Management Agency) pricing schedule.

12. Property, plant and equipment

Accounting Policy

Property, plant, and equipment consist of the following asset classes: land, buildings (including fit out, leasehold improvements and underground infrastructure), clinical equipment, other equipment, IT/ ITC equipment, motor vehicles and work in progress.

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

Work in progress (WIP) is recognised at cost less impairment and is not depreciated.

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 three years.

The carrying values 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 surplus or deficit. Any subsequent increase on revaluation that reverses a previous decrease in value recognised in surplus or deficit will be recognised first in surplus or deficit up to the amount previously expensed, and then recognised in other comprehensive revenue and expense.

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 Te Whatu Ora and the cost of the item can be measured reliably.

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.

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 Te Whatu Ora 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 surplus or deficit as they are incurred.

12. Property, plant and equipment (continued)

Accounting Policy (continued)

Disposals

Gains or losses on disposals are determined by comparing the proceeds with the carrying amount of the asset. The net gain or loss on disposals is reported in the surplus or deficit. When revalued assets are sold, the amounts included in the property revaluation reserves in respect of those assets are transferred to accumulated surpluses or deficits in equity.

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 of major classes of property, plant, and equipment have been estimated as follows:

Buildings	5 to 80 years
Leasehold improvements	over the lease term ranging from 2 to 30 years
Clinical equipment	5 to 25 years
Other equipment	5 to 25 years
IT/ITC equipment	3 to 8 years
Motor vehicles	5 to 15 years

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

Property, plant and equipment that has a finite useful life is reviewed for impairment at each reporting date. Property, plant, and equipment is reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount might 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 an approach based on either a depreciated replacement cost approach, a restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and availability of information.

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 its recoverable amount. For revalued assets, the impairment loss is recognised in other comprehensive revenue and expense and decreases the revaluation reserve for that class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised in surplus or deficit.

For assets not carried at a revalued amount, the total impairment loss is recognised in surplus or deficit.

The reversal of an impairment loss on a revalued asset is recognised in other comprehensive revenue and expense and increases the asset revaluation reserve for that class of asset. However, to the extent that an impairment loss for that class of asset was previously recognised in surplus or deficit, a reversal of an impairment loss is also recognised in surplus or deficit.

12. Property, plant and equipment (continued)

For assets not carried at a revalued amount, the reversal of an impairment loss is recognised in surplus or deficit.

Critical accounting estimates and assumptions

Estimating the fair value of land and buildings

Each of the 20 districts in the Group that relate to the former District Health Boards (DHBs) engaged their previous independent valuers to perform valuations of the land and building assets at 30 June 2023.

Independent valuer	District(s)	Valuation approach	Carrying value of land ($m)	Carrying value of buildings ($m)
TelferYoung from CBRE	Auckland	Desktop/indexed movement	378	1,004
	Canterbury	Desktop/indexed movement	167	1,429
	Taranaki[1]	Full valuation	17	204
	Waitemata	Desktop/indexed movement	328	622
	Whanganui	Desktop/indexed movement	6	104
RS Valuation Limited	Bay of Plenty	Full valuation	54	419
	Counties Manukau	Full valuation	274	1,189
	Lakes	Full valuation	30	264
	Mid Central	Full valuation	25	313
	Northland	Full valuation	26	395
	Waikato	Full valuation	101	1,090
Colliers	Capital and Coast[1]	Full valuation	57	645
	South Canterbury	Desktop/indexed movement	7	57
CBRE Limited	Hutt Valley	Desktop/indexed movement	32	250
	Wairarapa	Desktop/indexed movement	5	54
Beca	Southern	Desktop/indexed movement[2]	140	361
	Nelson Marlborough[1]	Desktop/indexed movement	40	186
Added Valuation Limited	Hawkes Bay	Full valuation	20	187
JLL	Tairawhiti	Full valuation	6	80
Coast Valuations Limited	West Coast	Desktop/indexed movement	9	183
Total			**1,720**	**9,044**

1 Previous full valuation undertaken at 30 June 2021. Others at 30 June 2022.
2 Full valuation undertaken for New Dunedin Hospital site acquired.

12. Property, plant and equipment (continued)

Critical accounting estimates and assumptions (continued)

Full valuations had been undertaken by 17 of the former DHBs at 30 June 2022, and by the three remaining DHBs at 30 June 2021.

The Group has used the information obtained from the valuations, which include full valuations, desktop valuations and indexed movements, to record a valuation increase of $1.149 billion at 30 June 2023. The desktop valuations and indexed movements are less robust than full valuations as they do not involve the depth of analysis undertaken for a full valuation.

Land

Land is valued at fair value using market-based evidence based on its highest and best use with reference to comparable land values. The comparable land value rates ($/m^2) that have been applied across Te Whatu Ora land vary from site to site across New Zealand.

Titles to land transferred from the Crown to Te Whatu Ora are subject to a memorial in terms of the Treaty of Waitangi Act 1975 (as amended by the Treaty of Waitangi (State Enterprises) Act 1988).

Some of the land is subject to Right of First Refusal (RFR) in favour of certain iwi under the Ngai Tahu Claims Settlement Act 1998 and the Tamaki Collective Deed of Settlement.

Land held in the Auckland Region is subject to Section 148 of Nga Mana Whenua o Tamaki Makaurau Collective Redress Act 2014 ("The Act") which means that the land is RFR land as defined in section 118 and is subject to Subpart 1 of Part 4 of The Act, which restricts disposal, including leasing of the land.

The disposal of certain properties may also be subject to the provision of section 40 of the Public Works Act 1981.

As Te Whatu Ora does not have full title to Crown land it occupies but transfer is arranged if and when land is sold.

Restrictions on Te Whatu Ora's ability to sell land would normally not impair the value of the land because Te Whatu Ora has operational use of the land for the foreseeable future and will substantially receive the full benefit of outright ownership. However, adjustments have been made to some "unencumbered" land values for where there is a designation against the land, or the use of the land is restricted. These adjustments vary from site to site, depending on the designation/ restriction, and are intended to reflect the negative effect on the value of the land where an owner is unable to use the land more intensely or at its highest and best use.

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. Significant assumptions include:

- The replacement asset is based on the reproduction cost of the specific assets with adjustments where appropriate for optimisation due to over-design or surplus capacity.
- The replacement cost is derived from recent construction contracts awarded for similar assets, Quantity Surveyor (QS) cost estimates or by applying relevant indices (e.g., Property Institute of New Zealand) to previous replacement costs.

12. Property, plant and equipment (continued)

Critical accounting estimates and assumptions (continued)

- For earthquake-prone buildings that are expected to be strengthened, the estimated earthquake-strengthening costs have been deducted off the depreciated replacement cost in estimating fair value. Where no decision has been made to strengthen earthquake-prone buildings, the remaining useful life has been reduced if Te Whatu Ora is required to remediate the buildings within a specific timeframe.
- The estimated cost of asbestos/other remediation works have been deducted off the building depreciated replacement cost in estimating fair value.
- The remaining useful life of assets is estimated after considering factors such as the condition of the asset, future maintenance and replacement plans, and experience with similar buildings.
- Straight-line depreciation has been applied in determining the depreciated replacement cost value of the asset.

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

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

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

An incorrect estimate of the useful life or residual value will affect the depreciation expense recognised in the surplus or deficit and the carrying amount of the asset in the Statement of Financial Position. Te Whatu Ora minimise the risk of this estimation uncertainty by:

- regular/cyclical physical inspection of critical buildings and associated plant
- asset replacement programmes
- review of second-hand market prices for similar assets; and
- analysis of prior asset sales.

Te Whatu Ora have not made significant changes to past assumptions concerning useful lives and residual values.

12. Property, plant and equipment (continued)

Breakdown of property, plant and equipment and further information

Movements for each class of property, plant and equipment are as follows.

	Group							
	Land $m	Buildings $m	Clinical Equip. $m	Other Equip. $m	IT/ITC $m	Motor Vehicles $m	Work in Progress $m	Total $m
Cost								
Balance at 1 July 2022	1,728	7,786	1,775	229	427	93	1,263	13,301
Transfers from WIP	2	540	222	50	51	10	(875)	-
Additions	49	88	-	-	-	-	1,041	1,178
Impairment Losses	-	-	-	-	-	-	(20)	(20)
Disposals/transfers between classes	-	-	(159)	(5)	(25)	(2)	(6)	(197)
Transfers to Intangibles	-	-	-	-	(56)	-	(1)	(57)
Revaluation	(59)	683	-	-	-	-	-	624
Balance at 30 June 2023	**1,720**	**9,097**	**1,838**	**274**	**397**	**101**	**1,402**	**14,829**
Depreciation and impairment losses								
Balance at 1 July 2022	-	97	1,140	135	322	75	-	1,769
Depreciation	-	436	139	22	46	6	-	649
Impairment Losses	-	-	(1)	-	-	-	-	(1)
Disposals/transfers between classes	-	(13)	(110)	(25)	(31)	(2)	-	(181)
Transfers to Intangibles	-	-	-	-	(49)	-	-	(49)
Reversal of accum depn on revaluation	-	(466)	-	-	-	-	-	(466)
Balance at 30 June 2023	**-**	**54**	**1,168**	**132**	**288**	**79**	**-**	**1,721**
Carrying Amount								
At 1 July 2022	1,728	7,689	635	94	105	18	1,263	11,532
At 30 June 2023	**1,720**	**9,044**	**669**	**142**	**109**	**22**	**1,402**	**13,109**

Work in progress

Property, plant and equipment in the course of construction by class of asset are detailed below:

	Group
	Actual 2023 $m
Buildings	1,219
Clinical equipment	91
Information technology	68
Motor Vehicles	2
Other equipment	22
Total work in progress	**1,402**

12. Property, plant and equipment (continued)

Leased assets

Te Whatu Ora has entered into finance leases for the lease of equipment. The net carrying amount of the leased items within each class of property, plant and equipment is included above. Refer finance leasing arrangements in **Note 15**.

Capital commitments

	Group
	Actual 2023 $m
Property	1,361
Intangible assets and other equipment	75
Total capital commitments	**1,436**

13. Intangible assets

Accounting Policy

Software acquisition and development

Acquired computer software licenses are capitalised on the basis of the costs incurred to acquire and bring to use the specific software.

Computer software acquired, which is not an integral part of a related hardware item, is recognised as an intangible asset. The costs incurred internally in developing computer software are also recognised as intangible assets where the group has a legal right to use the software and the ability to obtain future economic benefits from that software. Acquired software licences are capitalised on the basis of the costs incurred to acquire and bring to use the specific software. Cloud based software/infrastructure-as a-service arrangements are recognised as an intangible asset where the group has the right to use and the ability to control and obtain future economic benefits.

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 that the asset is derecognised. The amortisation charge for each financial year is recognised in surplus or deficit.

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

Acquired & internally developed computer software	2 – 20 years

Impairment of intangible assets

Intangible assets are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount might 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.

Intangible assets that are under development and not yet ready for use are tested for impairment annually, irrespective of whether there is any indication of impairment.

13. Intangible assets (continued)

Breakdown of intangible assets and further information

Movements for each class of intangibles are as follows:

	Group		
	Software development $m	Work in Progress $m	Total $m
Cost			
Balance at 1 July 2022	904	142	1,046
Additions from WIP	102	(102)	-
Additions	5	105	110
Transfers from Property, plant and equipment	56	1	57
Disposals	(35)	(1)	(36)
Balance at 30 June 2023	**1,032**	**145**	**1,177**
Accumulated depreciation and impairment losses			
Balance at 1 July 2022	639	-	639
Amortisation	88	-	88
Impairment losses	1	-	1
Transfers from Property, plant and equipment	49	-	49
Disposals	(29)	-	(29)
Balance at 30 June 2023	**748**	**-**	**748**
Carrying Amount			
At 1 July 2022	265	142	407
At 30 June 2023	**284**	**145**	**429**

14. Payables and deferred revenue

Accounting Policy

Short-term payables are measured at the amount payable. Deferred revenue represents revenues received in advance (**Note 2 Revenue**).

Breakdown of payables and deferred revenue

	Group
	Actual 2023 $m
Payables under exchange transactions	
Creditors	1,566
Deferred revenue	74
Total payables under exchange transactions	**1,640**
Payables under non exchange transactions	
GST, WHT, PAYE & FBT payable	217
Total payables under non exchange transactions	**217**
Total payables and deferred revenue	**1,857**

Creditors and other payables are non-interest bearing and are normally settled on 30-day term. Therefore, the carrying value of creditors and other payables approximates their fair value.

15. Borrowings

Accounting Policy

Interest bearing borrowings are recognised initially at fair value less attributable transaction costs. Subsequent to initial recognition, interest bearing borrowings are stated at amortised cost with any difference between cost and redemption value being recognised in the surplus or deficit over the period of the borrowings on an effective interest basis. Borrowings are classified as current liabilities unless Te Whatu Ora has an unconditional right to defer settlement of the liability for at least 12 months after balance date.

Overdraft facility

Bank overdrafts that are considered to form an integral part of cash management are included as a component of cash and cash equivalents. All other bank overdrafts are presented within borrowings in current liabilities in the statement of financial position and are recorded at the amount payable plus accrued interest.

Finance leases

A finance lease is a lease that transfers to Te Whatu Ora substantially all the risks and rewards incidental to ownership of an asset, whether or not title is eventually transferred.

At the commencement of the lease term, finance leases are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased item or the present value of the minimum lease payments.

15. Borrowings (continued)

Accounting Policy (continued)

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

The amount recognised as an asset is depreciated over its useful life. If there is no certainty as to whether Te Whatu Ora will obtain ownership at the end of the lease term, the asset is fully depreciated over the shorter of the lease term and its useful life.

Critical judgements in applying accounting policies

Leases classification

Determining whether a lease agreement is a finance lease or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to Te Whatu Ora. Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term and determining an appropriate discount rate to calculate the present value of the minimum lease payments. Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant, and equipment and intangible assets, whereas for an operating lease no such asset is recognised. Te Whatu Ora has exercised its judgement on the appropriate classification of leases.

Operating leases

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset to Te Whatu Ora.

Lease payments under an operating lease are recognised as an expense on a straight-line basis over the lease term.

Lease incentives received are recognised in surplus or deficit as a reduction of operating lease expense over the lease term.

Breakdown of borrowings and further information

	Group
	Actual 2023 $m
Current	
Finance Leases	28
Total current portion	**28**
Non-current	
Finance Leases	80
Other	2
Total non-current portion	**82**
Total borrowings	**110**

15. Borrowings (continued)

The net carrying amount of the leased items within each class of property, plant, and equipment is included in Note 12. There are no restrictions placed on the group by any of the finance leasing arrangements. Finance lease liabilities are effectively secured, as the rights to the leased asset revert to the lessor in the event of default in payment.

Fair Value

The fair value of finance leases is $108m. Fair value has been determined from discounted contractual cash flows using the relevant rate to each finance lease.

Analysis of finance leases

	Group
	Actual 2023 $m
Minimum lease payments payable:	
No later than one year	46
Later than one year and not later than five years	111
Later than five years	16
Total minimum lease payments	**173**
Future finance charges	(65)
Present value of minimum lease payments	**108**
Present value of minimum lease payments payable:	
No later than one year	28
Later than one year and not later than five years	70
Later than five years	10
Total present value of minimum lease payments	**108**

16. Employee entitlements

Accounting Policy

Short-term employee entitlements

Employee entitlements that are expected to be settled wholly before 12 months after the end of the reporting period in which the employees render 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 earned but not yet taken at balance date, and sick leave.

16. Employee entitlements (continued)

Accounting Policy (continued)

Long-term employee entitlements

Employee entitlements that are not expected to be settled wholly before 12 months after the end of the reporting period in which the employees render the related service, such as sabbatical leave, continuing medical education leave, long service leave, and retirement gratuities, have been calculated on an actuarial basis. The calculations are based on:

- likely future entitlements accruing to employees, based on years of service, years to entitlement, the likelihood that employees will reach the point of entitlement, and contractual entitlement information; and
- the present value of the estimated future cash flows.

Presentation of employee entitlements

Sick leave, continuing medical education leave, annual leave, long service leave that is available for use, and sabbatical leave that is available for use are classified as a current liability. Long service leave, sabbatical 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

Long service leave and retirement gratuities

The present value of sabbatical leave, long service leave, and retirement gratuities obligations depend on a number of factors that are determined on an actuarial basis. Two key assumptions used in calculating these liabilities are the discount rate and the salary inflation factor. Any changes in these assumptions will affect the carrying amount of the liability.

Expected future payments are discounted using discount rates derived from the yield curve of New Zealand government bonds. The discount rates used have maturities that match, as closely as possible, the estimated future cash outflows. The salary inflation factor has been determined after considering historical salary inflation patterns and after obtaining advice from an independent actuary.

The discount rates used are those advised by the New Zealand Treasury published risk-free discount rates as at 30 June 2023 and range between 4.30% and 5.43%. The salary inflation factor is 4.5% which is Te Whatu Ora's best estimate forecast of salary increments.

If the discount rate were to differ by 1% from that used, with all other factors held constant, the carrying amount of the long service leave and retirement gratuities obligations would be an estimated $21.6m higher/$31.1m lower. If the salary inflation factor were to differ by 1% from that used, with all other factors held constant, the carrying amount of the long service leave and retirement gratuities obligations would be an estimated $21.1m higher/$31.4m lower.

Holidays Act 2003 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 Holidays Act).

16. Employee entitlements (continued)

Critical accounting estimates and assumptions (continued)

Work has been ongoing since 2016 on behalf of Te Whatu Ora and the New Zealand Blood Service, with the Council of Trade Unions, health sector unions, and the Ministry of Business, Innovation and Employment Labour Inspectorate, for an agreed and national approach to identify, rectify and remediate any Holidays Act non-compliance. Prior to the establishment of Te Whatu Ora, 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.

The health sector has a workforce that includes differential occupational groups with complex entitlements, non-standard hours, allowances/overtime. The process of assessing non-compliance with the Holidays 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 progressed during the current financial year. As a result, Te Whatu Ora recognises it has an obligation to address any historical non-compliance under the MOU and has made estimates and assumptions to determine the liability based on its own review of payroll processes which identified instances of non-compliance with the Holidays Act and the requirements of the MOU. The liability as at 30 June 2023 is based on the opening balance transferred to Te Whatu Ora from combining entities on 1 July 2022, that had previously been developed on the following basis:

- Districts either used remediation scripts (where 100% of the population is recalculated) or used a sample and extrapolated variances across the population. The remediation script and sample method generated an estimate by using both terminated and current employees. Employees were taken from each District that were employed between 1 May 2010 and 30 June 2022 (being the agreed remediation period). Estimations for the programme costs to complete the remediation work were also included into the liability estimates for each district.

For 2022-23, no further sampling and extrapolation has been completed given the progress made on remediation projects, with a number of these nearing the point of making payments to current employees (current tenure). Also, further sampling and extrapolation would be unlikely to provide a significantly different financial liability estimate.

Sampling estimates that were prepared by Ernst & Young for Te Whatu Ora components make up 85% of the total liability. The Ernst & Young modelling was therefore used to project forward the 30 June 2022 liability balance to that required at 30 June 2023.

- The key assumption used to establish this forward projection is that the level of non-compliance is consistent across years on a district-by-district basis. A level of non-compliance of 3.09% of gross pays on average has been assumed as the level of ongoing non-compliance in 2022-23. This assumes that no corrective actions are taken to reduce non-compliance with the Holidays Act and that there is no ongoing non-compliance issue relating to leave transfers.
- For Districts that used remediation scripts, the liability uplift was from a combination of district level reassessments of remediation scripts and forward projections to estimate their balances. A review was also completed on the components that were included in those estimations to ensure consistency with the components included in the Ernst & Young model.

16. Employee entitlements (continued)

Critical accounting estimates and assumptions (continued)

The liability recognised is Te Whatu Ora's best estimate at 30 June 2023. Until the remediation projects are completed for all components, there remain substantial uncertainties as to the actual amount Te Whatu Ora will be required to pay to current and former employees.

The estimates and assumptions may differ to the subsequent actual results as further work is completed. This may result in further adjustment to the carrying amount of the liability within the next financial year or payments to current and former employees that differ significantly from the estimation of the liability.

Payments to settle this provision commenced in July 2023.

Breakdown of employee entitlements

	Group
	Actual 2023 $m
Current	
Accrued salaries and wages	61
Annual leave	1,170
Holidays Act 2003 remediation	2,101
Continuing education leave and expenses	313
Sick leave	33
Long service leave	47
Retirement gratuities	47
Other employee entitlements*	1,300
Total current portion	**5,072**
Non-current	
Long service leave	77
Retirement gratuities	177
Other entitlements	42
Total non-current portion	**296**
Total employee entitlements	**5,368**

*This includes provisions of $644m for nurses, $48m for midwives and $167m for Allied Health pay equity settlements announced after balance date. The provisions are based on modeling and cost estimates completed during the bargaining process. The actual cost of these pay equity settlements will not be known until the final calculations are completed and the payments are made. Refer to Note 23, Events after balance date for further detail.

17. Restricted funds

Breakdown of restricted funds

	Group
	Actual 2023 $m
Non-current liabilities	
Balance 1 July	1
Balance 30 June	**1**
Total restricted funds	**1**

This interest earning fund was from sale proceeds on an endowment property, to be used in conjunction with Te Whatu Ora Auckland Treaty partner, Ngāti Whātua.

18. Provisions

Accounting Policy

A provision is recognised for future expenditure of uncertain amount or timing when:

- there is a present obligation (either legal or constructive) as a result of a past event
- it is probable that an outflow of future economic benefits will be required to settle the obligation; and
- a reliable estimate can be made of the amount of the obligation

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

Restructuring

A provision for restructuring is recognised when an approved detailed formal plan for the restructuring has either been announced publicly to those affected or has already started being implemented.

Onerous contracts

A provision for onerous contracts is recognised when the expected benefits or service potential to be derived from a contract are lower than the unavoidable cost of meeting the obligations under the contract.

The provision is measured at the present value of the lower of the expected cost of terminating the contract and the expected net cost of continuing with the contract.

ACC Accredited Employers Programme

Te Whatu Ora belongs to the ACC Accredited Employers Programme (the Programme) whereby Te Whatu Ora accepts the management and financial responsibility for employee work-related illnesses and accidents.

Under the Programme, Te Whatu Ora is liable for all claim costs for a period of two years after the end of the cover period in which the injury occurred. At the end of the two-year period Te Whatu Ora pays a premium to ACC for the value of residual claims, and from that point the liability for ongoing claims passes to ACC.

18. Provisions (continued)

Accounting Policy (continued)

The liability for the Programme is measured using actuarial techniques at the present value of expected future payments to be made for employee injuries and claims up to balance date. Consideration is given to anticipated 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 to possible, the estimated future cash outflows.

Breakdown of provisions and further information

	Group
	Actual 2023 $m
Current	
ACC Accredited Employers Programme	12
Holidays Act Remediation Project	66
Restructuring Provision	56
Total current	**134**
Non-current	
ACC Accredited Employers Programme	4
Other	4
Total non-current	**8**
Total provisions	**142**

Movement for each class of provisions, are as follows:

	Group
	Actual 2023 $m
ACC Accredited Employers Programme	
Opening balance	16
Additional provisions made	5
Amounts used	(4)
Closing balance	**16**
Holidays Act Remediation Project	
Opening balance	76
Additional provisions made	9
Amounts used	(19)
Closing balance	**66**
Restructuring Provision	
Opening balance	0
Provisions made	56
Closing balance	**56**
Other	
Opening balance	2
Additional provisions made	2
Closing balance	**4**

19. Equity

Accounting Policy

Te Whatu Ora's capital is its equity, which consists of Crown equity, accumulated surplus or deficit, revaluation reserves, and trust funds. Equity is represented by net assets.

Te Whatu Ora is subject to the financial management and accountability provisions of the CEA, which impose restrictions in relation to borrowings, acquisition of securities, issuing guarantees and indemnities, and the use of derivatives.

Te Whatu Ora manages its equity as a by-product of prudently managing revenues, expenses, assets, liabilities, investments, and general financial dealings to ensure that it effectively achieves its objectives and purposes while remaining a going concern.

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

- Crown Equity
- Accumulated surplus or deficit
- Revaluation reserves
- Trust and special funds

Contributions from/(repayment to) the Crown

This relates to funding from the Crown for Crown approved capital projects.

Revaluation reserves

These reserves relate to the revaluation of property, plant and equipment to fair value.

Trust and special funds

The receipt of donations, bequests, and investment revenue earned on trust funds, is recognised as revenue and then transferred to the trust funds' reserve from accumulated surplus or deficit. Application of trust funds on the specified purpose is recognised as an expense, with an equivalent amount transferred to accumulated surplus or deficit from the trust funds' reserve.

This reserve records the unspent amount of unrestricted donations and bequests provided to Te Whatu Ora.

19. Equity (continued)

Breakdown of equity and further information

	Group
	Actual 2023 $m
Crown Equity	
Opening balance 1 July	2,413
Capital contributions from the Crown	686
Adjustment for Capital Contributions accrued	(7)
Capital contribution returned to the Crown	(12)
Balance at 30 June	**3,080**
Accumulated surpluses/(deficits)	
Opening balance 1 July	-
Surplus/(deficit)	(1,013)
Balance at 30 June	**(1,013)**
Revaluation reserves	
Opening balance 1 July	6,084
Revaluations	1,091
Balance at 30 June	**7,175**
Trust and special funds	
Opening balance 1 July	63
Movements in trust and special funds	1
Balance at 30 June	**64**
Minority interests	
Opening balance 1 July	7
Balance at 30 June	**7**
Total Equity	**9,313**
Revaluation reserves consist of	
Land	1,640
Buildings	5,535
Total revaluation reserves	**7,175**

20. Contingencies

Contingent Liabilities

Unquantifiable contingent liabilities as at 30 June 2023

- Te Whatu Ora is a participating employer in the DBP Contributors Scheme ("the Scheme"), which is a multi-employer defined benefit scheme. If the other participating employers ceased to participate in the Scheme, Te Whatu Ora could be responsible for the entire deficit of the Scheme. Similarly, if a number of employers ceased to participate in the Scheme, Te Whatu Ora could be responsible for an increased share of the deficit. Based on historic trends there is no deficit to fund.
- Stafford litigation: Crown Law is acting for the Attorney-General on behalf of the Crown in Stafford v Attorney-General, in which it is claimed that the Crown breached trust, fiduciary and other equitable obligations relating to land transactions in the top of the South Island in the 1840s. The plaintiff seeks the return of land they say the Crown holds on trust for the successors of the original owners and compensation, or other relief. This extends to land currently owned by a number of Crown entities, including Te Whatu Ora, and an SOE. In February 2017, the Supreme Court held that the Crown owed a fiduciary duty in relation to the land transactions concerned, but remitted matters of breach, defences and remedy to the High Court for a further hearing or hearings. The matter is large and complex and could take many years to resolve.

21. Related party transactions

Related parties include:

- The Crown, as the ultimate controlling entity of Te Whatu Ora.
- Other entities subject to common control, such as government departments, Crown entities, and state-owned enterprises.
- Associates (refer to Note 11).
- Key management personnel and their close family members. Key management personnel are Board Members and the Leadership Team, and their close family members are their spouses, children and dependants.

There are no other related parties as no other parties are controlled by Te Whatu Ora, other than those that are consolidated into the group's financial statements.

Related party disclosures have not been made for transactions with related parties, including associates that are:

- within a normal supplier or client/recipient relationship; and
- on terms and conditions no more or less favourable than those that it is reasonable to expect that the group 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.

21. Related party transactions (continued)

Key management personnel compensation

	Group
	Actual 2023
Board Members	
Remuneration	$0.69m
Full-time equivalent members	2.67
Leadership Team	
Remuneration	$10.66m
Full-time equivalent members	19.70
Total key management personnel remuneration	**$11.35m**
Total full time equivalent personnel	**22.37**

The Leadership Team comprises the Chief Executive Officer and Executive Team Members. Appointments to the Executive Leadership Team occurred at various times throughout the year. The full-time equivalent for Board members has been determined on the frequency and length of Board meetings and the estimated time for Board members to prepare for meetings. An analysis of Board member remuneration is provided in Note 3.

22. Financial Instruments

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

	Group
	Actual 2023 $m
Financial assets measured at amortised cost	
Cash and cash equivalents	2,019
Receivables	566
Term deposits	70
Total financial assets measured at amortised cost	**2,655**
Financial assets measured at fair value through surplus or deficit	
Portfolio investments	41
Residential care and other loans	55
Total financial assets measured at fair value through surplus or deficit	**96**
Financial liabilities measured at amortised cost	
Payables (excluding revenue in advance and taxes payable)	1,588
Borrowings and finance leases	110
Restricted funds	1
Total financial liabilities measured at amortised cost	**1,699**

22. Financial Instruments (continued)

Fair value hierarchy disclosures

For those instruments recognised at fair value in the Statement of Financial Position, fair values are determined according to the following hierarchy:

- Quoted market price (level 1) – Financial instruments with quoted prices for identical instruments in active markets.
- Valuation technique using observable inputs (level 2) – Financial instruments with quoted prices for similar instruments in active markets or quoted prices for identical or similar instruments in inactive markets and financial instruments valued using models where all significant inputs are observable.
- Valuation techniques with significant non-observable inputs (level 3) – Financial instruments assets valued using models where one or more significant inputs are not observable.

The following table analyses the basis of the valuation of classes of financial instruments measured at fair value in the Statement of Financial Position:

		Valuation technique		
	Total $m	Quoted market price $m	Observable inputs $m	Significant non-observable inputs $m
Group 30 June 2023				
Financial Assets				
Portfolio investments	41	-	41	-
Residential care and other loans	55	-	55	-

Financial Instrument risks

Te Whatu Ora's activities expose it to a variety of financial instrument risks, including market risk, credit risk, and liquidity risk. Te Whatu Ora have a series of policies to manage the risks associated with financial instruments which seek to minimise exposure from financial instruments. These policies do not allow any transactions that are 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. Te Whatu Ora have no financial instruments that give rise to price risk.

Fair value interest rate risk

Fair value interest rate risk is the risk that the fair value of a financial instrument will fluctuate due to changes in market interest rates. Te Whatu Ora's exposure to fair value interest rate risk arises from bank deposits that are at fixed rates of interest. The exposure to fair value interest rate risk is not actively managed by the group, as bank deposits are generally held to maturity.

22. Financial Instruments (continued)

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. Te Whatu Ora's exposure to cash flow interest rate risk is limited to on-call deposits. This exposure is not considered significant and is not actively managed.

Sensitivity analysis

As at 30 June 2023, if floating interest rates had been 100 basis points higher/lower, with all other variables held constant, there would have been an insignificant impact on the deficit for the year.

Currency risk

Currency risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate due to changes in foreign exchange rates. As at year end Te Whatu Ora had no direct exposure to foreign currency risk.

Sensitivity analysis

As at 30 June 2023, if the New Zealand dollar had weakened/strengthened against any foreign currency, there would have been an insignificant impact on the deficit for the year. Te Whatu Ora have no outstanding foreign denominated payables at balance date.

Credit risk

Credit risk is the risk that a third party will default on its obligation to Te Whatu Ora, causing it to incur a loss. Due to the timing of the Te Whatu Ora's cash inflows and outflows, surplus cash of the group is invested with registered banks. In the normal course of business, exposure to credit risk arises from cash and term deposits with banks, debtors and other receivables. For each of these, the maximum credit risk exposure is best represented by the carrying amount in the statement of financial position. Funds include term investments and on-call deposits with All of Government Banking services providers and the banks whom have Standard & Poor's Rating of "A+" or better. Unlimited amounts can be placed with those banks. There were no defaults of interest or principal payments.

Concentrations of credit risk for debtors and other receivables are limited due to the large number and variety of customers. The Ministry of Health is the largest debtor and is assessed as a low-risk and high-quality entity due to being a government-funded purchaser of health and disability services. No collateral or other credit enhancements are held for financial instruments that give rise to credit risk.

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) or to historical information about counterparty default rates.

22. Financial Instruments (continued)

Credit risk (continued)

	Group
	Actual 2023 $m
Counterparties with credit ratings	
Cash, cash equivalent and bank term deposits	
A+	-
AA-	2,089
Total counterparties with credit ratings	**2,089**
Counterparties without credit ratings	
Portfolio Investments – no defaults in the past	41
Residential care and other loans – no defaults in the past	55
Receivables	
Existing counterparty with no defaults in the past	566
Existing counterparty with defaults in the past	-
Total counterparties without credit ratings	**662**

Liquidity risk

Management of liquidity risk

Liquidity risk is the risk that the group will encounter difficulty raising liquid funds to meet commitments as they fall due. Prudent liquidity risk management implies maintaining sufficient cash, availability of funding through an adequate amount of committed credit facilities, and the ability to close out market positions.

Te Whatu Ora mostly manages liquidity risk by continuously monitoring forecast and actual cash flow requirements and maintaining an overdraft facility.

Contractual maturity analysis of financial liabilities, excluding derivatives

The table below analyses financial liabilities (excluding derivatives) into relevant maturity groupings based on the remaining period at balance date to the contractual maturity date. The amounts disclosed are the contractual undiscounted cash flows and include interest cash outflows. Trade and other payables exclude revenue in advance and taxes payable.

			Group			
2023	Carrying amount $m	Contractual cash flow $m	Less than 1 year $m	1-2 years $m	2-5 years $m	More than 5 years $m
Trade and other payables	1,588	1,588	1,588	-	-	-
Borrowing and finance leases	108	173	45	40	72	16
Total	**1,696**	**1,761**	**1,633**	**40**	**72**	**16**

23. Events after balance date

Significant Events after balance date include:

1. The finalisation of the agreement between Te Whatu Ora and the New Zealand Nurses Organisation (NZNO) with respect to pay equity. A provision of $644m has been included in employee entitlements for the 2022-23 cost impact of this settlement. See also, Note 26.
2. The finalisation of the agreement between Te Whatu Ora and the NZNO and MERAS Midwives with respect to pay equity. A provision of $48m has been included in employee entitlements for the 2022-23 cost impact of this settlement. See also, Note 26.
3. The finalisation of the agreement between Te Whatu Ora and the Allied, Public Health, Scientific and Technical health workers with respect to pay equity. A provision of $167m has been included in employee entitlements for the 2022-23 cost impact of this settlement. See also, Notes 26.

24. Establishment of Te Whatu Ora

For information related to the Health Sector Reforms refer to **Note 1** *Health Sector Reforms.*

Adjustments made to the carrying amounts of assets and liabilities and net assets on amalgamation

Te Whatu Ora has made the following adjustments to the carrying amounts of assets and liabilities recorded by each combining entity as at 1 July 2022:

	Group		
	Sum of Combining Entities (CE's)* $m	Elimination of transactions between CE's $m	Financial Position as at 1 July 2022 $m
Current Assets			
Cash and cash Equivalents	686	-	686
Receivables	2,180	(602)	1,578
Prepayments	205	(28)	177
Investments	55	-	55
Inventory	569	-	569
Assets held for sale	15	-	15
	3,710	**(630)**	**3,080**
Non-current Assets			
Prepayments	22	(12)	10
Investments	112	(7)	105
Investments in subsidiaries and associates	213	(208)	5
Property, plant and equipment	11,542	(10)	11,532
Intangible assets	429	(21)	407
	12,318	**(258)**	**12,059**
Total Assets	**16,028**	**(888)**	**15,139**
Current Liabilities			
Trade payables and deferred revenue	2,817	(664)	2,153
Borrowings	10	-	10
Employee entitlements	4,037	-	4,037
Provisions	10	-	10
	6,874	**(664)**	**6,210**
Non-current Liabilities			
Borrowings	92	-	92
Employee entitlements	261	-	261
Restricted special funds	1	-	1
Provisions	8	-	8
	362	**-**	**362**
Total Liabilities	**7,236**	**(664)**	**6,572**
Net Assets	**8,792**	**(224)**	**8,567**

*Sum of the Combining Entities does not constitute Te Whatu Ora's consolidated position as at 1 July 2022.

There were no adjustments necessary to conform to Te Whatu Ora's accounting policies.

24. Establishment of Te Whatu Ora (continued)

Net assets/equity analysis on amalgamation

Te Whatu Ora has made the following adjustments to the net assets/equity recorded by each Combining Entities as at 1 July 2022:

	Group		
	Sum of Combining Entities (CE's)* $m	Elimination of transactions between CE's $m	Financial Position as at 1 July 2022 $m
Crown Equity	2,637	(224)	2,413
Revaluation Reserves	6,084	-	6,084
Special/trust funds	63	-	63
Minority interests	7	-	7
Net Assets	**8,791**	**(224)**	**8,567**

*Sum of the Combining Entities does not constitute Te Whatu Ora's consolidated position as at 1 July 2022.

Te Whatu Ora has not elected to present financial statements for the combining entities for periods prior to 1 July 2022. Financial statements of the combining entities for periods prior to amalgamation are available on the Te Whatu Ora website.

25. Significant items affecting the financial result

Te Whatu Ora recorded a deficit of $1.013 billion for the financial year. Significant items affecting the financial result include:

1. There were a number of pay equity negotiations that were agreed after balance date for which an amount of $859 million relates to the 2022-23 financial year. Accounting standards require Te Whatu Ora to recognise those costs in the 2022-23 financial statements. We expect that these costs will be fully funded by Manatū Hauora/Ministry of Health in the 2023-24 financial year.
2. Te Whatu Ora had responsibility for a significant part of the Covid-19 response. As set out in note 9, part of the costs incurred during the 2022-23 financial year was a $284 million write-down of Covid-19 inventories that may become obsolete.

26. Explanation of major variances against budget

The statement of performance expectations (SPE) prepared by Te Whatu Ora as soon as practicable after the entity was established (dated 30 September 2022) did not contain a complete set of forecast financial statements (as required by section 149E of the Crown Entities Act 2004). This version of the SPE only included a forecast "profit and loss statement". Further work was required to complete the consolidated balance sheet for Te Whatu Ora and to finalise Covid-19 transfers from the Ministry of Health and, for this reason, revenue and costs associated with separately funded COVID responses were excluded from the forecasts.

26. Explanation of major variances against budget (continued)

Te Whatu Ora subsequently amended its SPE in accordance with section 149K of the Crown Entities Act 2004. The amended SPE (dated 23 June 2023) included a complete set of forecast financial statements. Only a high-level summary of the changes made between the two versions of the SPE is provided below as income and expenses were not consistently disaggregated in the two versions of the SPE:

	Group		
	Amended SPE dated 23 June 2023 $m	SPE dated 30 Sept 2022 $m	Variance $m
Total income (note 1. below)	24,638	22,494	2,144
Total expenses (note 2. below)	24,638	22,494	2,144
Net surplus or (deficit)	**-**	**-**	**-**

1. Additional funding of $1.622 billion allocated to Te Whatu Ora, including Covid funding of $1.42 billion, and correction in the way some funding from Pharmac was presented.
2. Expenses were increased by the same amount of the additional funding ($1.622 billion), and correction in the way some funding from Pharmac was presented.

The budget figures included in the financial statements are from the amended SPE (dated 23 June 2023) and the comparison of the actual financial statements has been performed against this budget.

The major variances in the Statement of Comprehensive Revenue and Expenses

Crown Funding revenue is favourable to budget by $336m mainly due to $163m more Covid revenue and additional funding received mainly for interim pay equity payments.

Other Funding from the Crown/Crown Entities revenue is favourable to budget by $1.12 billion. The annual budget was compiled at a high level and the consolidation of the former District Health Board (DHB) budgets provided greater detail, which then resulted in a re-classification of revenue between the Other Crown Entities and Other Revenue lines – contributing heavily to this variance. Additional revenue was also received from PHARMAC (Pharmaceutical Management Agency) for the funding of additional pharmaceutical costs.

Other Revenue is unfavourable to budget as a result of the revenue classification changes detailed under Other Crown Entities revenue above.

Personnel costs are over budget by $1.389 billion with most of this relating to accruals for pay equity settlements completed post balance date ($859m) and, the balance reflects greater than budget expenditure mainly Holidays Act liability uplift, actuarial valuation of Long Service Leave and Retiring Gratuities, interim pay equity payments, MECAs settled above budgeted assumptions, provision for redundancy and costs for funded initiatives (with funding offsets).

26. Explanation of major variances against budget (continued)

The major variances in the Statement of Comprehensive Revenue and Expenses (continued)

Outsourced Personnel costs are overspent as a result of the additional Covid contract staff and additional cover for rosters for staff on sick leave/isolation requirements.

Outsourced Services are overall underspent against budget mainly due to budget classifications for the pandemic response spend - the original Covid budget was transferred to Te Whatu Ora shortly before the new entity was established, with the detailed breakdown by budget category not clear at the time of budgeting. A larger portion of the budget was placed under outsourced services however the actual costs are mainly in personnel costs, resulting in a favourable variance in outsourced services costs. This favourable Covid variance offset an over spend in outsourced clinical services for additional elective volume contracts in order to reduce national waiting lists caused by Covid.

Clinical Supplies costs are over budget, mainly as a result of the extended national Covid response (including an unbudgeted $284 million write-down of Covid-19 inventories that may become obsolete), as well as additional pharmaceutical costs that were funded by PHARMAC.

External Service Providers costs were over budget mainly due to Covid for which additional revenue was received to offset this, with additional offsets in Aged Residential Care costs that were below budget.

Capital Charge was overspent as a result of unbudgeted asset revaluations as at June 2022 and additional equity that transferred from Manatū Hauora/Ministry of Health to Te Whatu Ora at opening balance date which incurs capital charge. Additional revenue was received to offset this.

Infrastructure, non clinical supplies and other costs were over budget mainly due to Covid related facilities costs for which additional revenue was received to offset this.

The major variances in the Statement of Financial Position

Some restricted funds were incorrectly classified as non-current liabilities in the SPE. These funds have been reclassified to equity in the budget and actual figures in the annual report.

Cash and Cash Equivalents are under budget. The budget for Te Whatu Ora was the best estimate created prior to amalgamation of the District Health Boards, their shared services and prior to transfer of services and functions from Manatū Hauora/Ministry of Health. The actual cash and cash equivalent reflects the true consolidated position post amalgamation.

Receivables are under budget mainly because the budget was set at a higher level based on the consolidated view of prior DHBs and their shared services. The actuals reflect the consolidated position after a national review of balance sheets of all Te Whatu Ora components to ensure consistent accounting treatment.

26. Explanation of major variances against budget (continued)

The major variances in the Statement of Financial Position (continued)

Investments in Associates and Joint Ventures. At the time of initial budget preparation, it was undetermined as to whether Shared Service Agencies, other associate companies and joint ventures would be consolidated into Te Whatu Ora or not. Subsequently, Cabinet decided to transfer ownership of the Shared Service Agencies directly into Te Whatu Ora. As a result, the previously held investment balances have been eliminated within Te Whatu Ora actual results, which is a requirement under accounting standards for public sector combinations.

Inventories are under budget largely due to the inclusion of a $284m provision for obsolescence of Covid-19 inventories that has been calculated based on product expiry dates and the expected future usage given the current national pandemic response settings.

Property, Plant and Equipment increase reflects the revaluation of land and buildings that were undertaken effective 30 June 2023 and not budgeted for.

Payables and Deferred Revenue is under budget. This is due to eliminating last year's inter entity balance sheet accounts as part of amalgamation adjustments, capital charge was paid before year end and there were reduced Covid commitments at year end as compared to prior year DHB balance sheets.

Employee entitlements over budget is largely driven by pay equity settlements agreed post balance date ($859m) and various movements in other employee liabilities.

Property Revaluation Reserves above budget mainly reflecting the impact of asset revaluations completed at 30 June 2023 that were not budgeted for.

The major variances in the Statement of Cash Flows

Funding from the Crown/Crown Entities is favourable to budget. Funding for the national Covid response was extended to 30 June 2023 and additional funding was received during the year for the interim nurses pay equity payments. The annual budget was compiled at a high level and the consolidation of the former DHB budgets provided greater detail, which then resulted in a re-classification of cash receipts between the Other Crown Entities and Other Revenue lines – contributing heavily to this variance.

Other Revenue is unfavourable to budget, as a result of the revenue classification change detailed under Crown Entities cashflow above.

Payments to Employees are close to budget, but there are two offsetting matters contributing to this. A portion of the Covid expenditure was budgeted within Employee Costs, but the actual costs were incurred by external suppliers.The interim nurses pay equity payments made during 2022-23 were unbudgeted and offset the favourable Covid variance.

Payments to Suppliers are over budget, due to the extended Covid response costs which were not fully budgeted for in this cost category and were offset by additional revenue. Other underlying variances included increased pharmaceutical costs (for which additional funding was received) and increased outsourced costs.

Capital charge payments were budgeted under cashflows from financing activities in the SPE. The budget and actuals have been reclassified to the cashflows from operating activities.

Additional Disclosures – Employee Remuneration

During the year, the following number of employees of Te Whatu Ora received remuneration over $100,000 on an annualised basis.

Remuneration range	Actual 2023	Remuneration range	Actual 2023
$100,000 – $109,999	7,328	$540,000 – $549,999	15
$110,000 – $119,999	6,279	$550,000 – $559,999	19
$120,000 – $129,999	4,941	$560,000 – $569,999	9
$130,000 – $139,999	3,249	$570,000 – $579,999	4
$140,000 – $149,999	2,210	$580,000 – $589,999	6
$150,000 – $159,999	1,546	$590,000 – $599,999	4
$160,000 – $169,999	1,086	$600,000 – $609,999	9
$170,000 – $179,999	778	$610,000 – $619,999	3
$180,000 – $189,999	644	$620,000 – $629,999	3
$190,000 – $199,999	535	$630,000 – $639,999	4
$200,000 – $209,999	451	$640,000 – $649,999	5
$210,000 – $219,999	391	$650,000 – $659,999	4
$220,000 – $229,999	332	$660,000 – $669,999	1
$230,000 – $239,999	322	$670,000 – $679,999	6
$240,000 – $249,999	298	$680,000 – $689,999	4
$250,000 – $259,999	413	$690,000 – $699,999	3
$260,000 – $269,999	254	$700,000 – $709,999	3
$270,000 – $279,999	242	$720,000 – $729,999	1
$280,000 – $289,999	252	$730,000 – $739,999	2
$290,000 – $299,999	240	$740,000 – $749,999	1
$300,000 – $309,999	202	$750,000 – $759,999	2
$310,000 – $319,999	197	$760,000 – $769,999	1
$320,000 – $329,999	213	$770,000 – $779,999	1
$330,000 – $339,999	160	$790,000 – $799,999	1
$340,000 – $349,999	165	$800,000 – $809,999	3
$350,000 – $359,999	143	$810,000 – $819,999	1
$360,000 – $369,999	158	$820,000 – $829,999	1
$370,000 – $379,999	132	$830,000 – $839,999	1
$380,000 – $389,999	127	$840,000 – $849,999	2
$390,000 – $399,999	130	$870,000 – $879,999	2
$400,000 – $409,999	98	$880,000 – $889,999	1
$410,000 – $419,999	93	$890,000 – $899,999	1
$420,000 – $429,999	86	$910,000 – $919,999	2
$430,000 – $439,999	69	$960,000 – $969,999	1
$440,000 – $449,999	66	$970,000 – $979,999	1
$450,000 – $459,999	55	$1,010,000 – $1,019,999	1
$460,000 – $469,999	44	$1,020,000 – $1,029,999	1
$470,000 – $479,999	39	$1,060,000 – $1,069,999	1
$480,000 – $489,999	43	$1,100,000 – $1,109,999	1
$490,000 – $499,999	28	$1,120,000 – $1,129,999	1
$500,000 – $509,999	30	$1,130,000 – $1,139,999	1
$510,000 – $519,999	18	$1,150,000 – $1,159,999	1
$520,000 – $529,999	16	$1,280,000 – $1,289,999	1
$530,000 – $539,999	11		
		Total	**34,249**

Of these employees, 359 received compensation and other benefits in relation to cessation totaling $9,684,713.

CONTROLLER AND AUDITOR-GENERAL
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INDEPENDENT AUDITOR'S REPORT

TO THE READERS OF THE GROUP FINANCIAL STATEMENTS AND PERFORMANCE INFORMATION OF TE WHATU ORA – HEALTH NEW ZEALAND FOR THE YEAR ENDED 30 JUNE 2023

I have audited the financial statements and performance information, including the performance information for each appropriation, of Te Whatu Ora - Health New Zealand (the Group) for the year ended 30 June 2023, using my staff and resources.

The financial statements on pages 234 to 289 comprise the statement of financial position as at 30 June 2023, 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.

The performance information is contained on pages 28 to 35, 67, 71, 81 to 83 and 95 to 231.

Opinion

Unmodified opinion on the Group financial statements

In my opinion, the financial statements of the Group:

- present fairly, in all material respects:
  - its financial position as at 30 June 2023; 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 Group performance information

In my opinion, except for the possible effects of the matter described in the Basis for my opinion section of my report, the Group's performance information for the year ended 30 June 2023:

- presents fairly, in all material respects, 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
- presents fairly, in all material respects, for the appropriations:
  - what has been achieved with the appropriations; and
  - the actual expenses or capital expenditure incurred as compared with the expenses or capital expenditure appropriated or forecast to be incurred; and
- complies with generally accepted accounting practice in New Zealand.

My audit was completed on 31 October 2023. This is the date at which my opinion is expressed.

The basis for my opinion is explained below, I outline the key audit matters addressed in my audit, and I draw attention to the source of the budget figures included in the financial statements for comparison with the historical financial statements. I outline the responsibilities of the Board for the financial statements and the performance information, and my responsibilities. I also comment on other information and explain my independence.

Basis for my opinion

An important part of the Group's performance information is reporting on whether it has undertaken cardiac surgery within timeframes based on clinical urgency. As disclosed on page 186 adequate records were not maintained to be able to verify the reported performance for that measure. As a result, my work was limited and there were no practical procedures I could apply to obtain assurance whether the reported result for this performance measure is materially correct.

I carried out my 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. My responsibilities under those standards are further described in the Responsibilities of the auditor section of this report.

I have fulfilled my responsibilities in accordance with the Auditor-General's Auditing Standards.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Key audit matters

Key audit matters are those matters that, in my professional judgement, were of most significance in my audit of the financial statements and the performance information of the Group for the current year. In making this determination, I considered those matters that are complex, have a high degree of uncertainty, or are important to the public because of their size or nature.

These key audit matters were addressed in the context of my audit of the financial statements and the performance information of the Group as a whole, and in forming my opinion thereon, and I do not provide a separate opinion on these matters. In addition to the matter described in the Basis for my opinion section, I have determined the matters described below to be the key matters to be communicated in my report.

Fair value of buildings	**How we addressed this matter**
As outlined in note 12, the Group owns a large portfolio of building assets with a carrying value of $9.044 billion at 30 June 2023. Due to the specialised nature of most of the Group's buildings, they are valued using a depreciated replacement cost (DRC) methodology. A small number of non-specialised buildings are valued using a market-based approach. Revaluations are carried out regularly, or when there is a material difference between fair value and carrying value. This year the previous independent valuers of the former District Health Boards (DHBs) were engaged by the Group to perform valuations of the building assets at 30 June 2023.	We obtained an understanding of the controls in place over the revaluation process. We considered the valuation reports and, as required, held discussions with valuers to confirm our understanding of the valuation methods, key judgments made, and assumptions and source data used in the valuations. We assessed each valuer's expertise for the work and their objectivity. We assessed the valuation methods and disclosures in the financial statements for compliance with the requirements of PBE IPSAS 17, *Property, Plant and Equipment.* We developed an auditor's range for the fair value of the buildings, and evaluated whether the carrying value of buildings falls within this range.

The Group has used the information obtained from the valuations, which include full valuations, desktop valuations and indexed movements, to record a valuation increase of $1.149 billion at 30 June 2023. I considered the fair value of buildings to be a key matter because of the significance of the amount and the judgements and assumptions involved in determining fair value.	We reviewed the source data for errors and omissions and assessed the reasonableness of key judgements made and assumptions applied, including estimates of useful lives and remaining useful lives and unit rates for replacement costs. We tested the calculations in the valuations and assessed whether the valuation movements have been correctly calculated and accounted for. We assessed the overall valuation changes and sought explanations from the valuers for any significant or unusual changes in value. I am satisfied that the value of building assets held at fair value in the Group's financial statements is reasonable.

Entitlements under the Holidays Act 2003	**How we addressed this matter**
As outlined in note 16, the provision for employee entitlements includes $2.1 billion for amounts owing to employees who have been paid less than their legal entitlements under the Holidays Act 2003. We have been reporting on this matter for a number of years in the audit reports for the former DHBs and progress on resolving this complex matter and paying out affected employees has been slow. Many public and private sector entities have had challenges in interpreting the Holidays Act 2003 and paying employees amounts that comply with the legislation. Since this issue was first identified, the majority of public entities have calculated the historical amounts owing, paid these to staff, and fixed payroll systems so that staff are subsequently paid at the correct rates. However, the former DHBs did not manage to achieve this, and the Group has not yet finished determining the final amounts they owe to current and former employees. Until remediation is completed, there continues to be uncertainty about the actual payments required to be made to current and former employees. A sufficiently reliable estimate of the Group's liability has been made, bringing forward the opening provision, and adding an estimate of the amount required for the additional year of non-compliance. I considered this to be a key matter due to the significant amount of public money involved, the judgements and assumptions involved in estimating the liability and the impact on many thousands of current and former health sector employees.	We considered the progress made during the year in resolving the issues associated with calculating the amounts owed to affected employees. We reviewed the changes in the provision since the establishment of Te Whatu Ora and considered the support for any significant movements. We made enquiries of management to obtain an understanding of the method, data and assumptions used to estimate the amount required for the additional year of non-compliance. We assessed the method for compliance with the requirements of PBE IPSAS 39, *Employee Benefits*. We considered the appropriateness and reasonableness of key judgements made and assumptions applied and tested the source data used and calculations of the additional amount of the provision for this year. We performed analytical procedures to assess the reasonableness of the additional amount of the provision. We assessed whether the Group has adequately addressed estimation uncertainty, including making appropriate disclosures. I am satisfied that the provision of $2.1 billion for employees who have been paid less than their legal entitlements under the Holidays Act 2003 is reasonable.

Emphasis of matter – source of the budget figures in the financial statements

Without further modifying my opinion, I draw attention to note 26 on pages 286 to 289 which outlines that the Group has presented a comparison of the actual financial statements with the revised forecast financial statements contained in the amended statement of performance expectations (dated 23 June 2023), rather than a comparison against the forecast financial statements prepared at the start of the year as required by the Crown Entities Act 2004.

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

The Board is responsible on behalf of the Group for preparing financial statements and performance information that are fairly presented and comply with generally accepted accounting practice in New Zealand. The Board is responsible for such internal control as it determines is necessary to enable it to prepare financial statements and performance information that are free from material misstatement, whether due to fraud or error.

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

The Board's responsibilities arise from the Pae Ora (Healthy Futures) Act 2022, the Crown Entities Act 2004 and the Public Finance Act 1989.

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

My 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 my opinion.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted 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, my procedures were limited to checking that the information agreed to the Group's statement of performance expectations dated 23 June 2023.

I 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, I exercise professional judgement and maintain professional scepticism throughout the audit. Also:

- I 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 my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, because fraud can involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- I obtain an understanding of internal controls 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 Group's internal control.
- I evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board.
- I evaluate the appropriateness of the performance information which reports against the Group's statement of performance expectations and appropriations.
- I conclude on the appropriateness of the use of the going concern basis of accounting by the Board and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Group's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial statements and the performance information or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the Group to cease to continue as a going concern.
- I 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.
- I obtain sufficient appropriate audit evidence regarding the financial statements and the performance information of the entities or business activities within the Group to express an opinion on the consolidated financial statements and the consolidated performance information. I am responsible for the direction, supervision and performance of the Group audit. I remain solely responsible for my audit opinion.

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

From the matters communicated with the Board, I determine those matters that were of most significance in my audit of the financial statements and the performance information for the current year and are therefore the key audit matters described in this report.

My responsibilities arise from the Public Audit Act 2001.

Other information

The Board is responsible for the other information. The other information comprises the information included on pages 2 to 27, 36 to 66, 68 to 70, 72 to 80, 84 to 94, 233 and 290 but does not include the financial statements and the performance information, and my auditor's report thereon.

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

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

Independence

While carrying out this audit, my staff and I complied with the Auditor-General's independence requirements, which incorporate the independence requirements of Professional and Ethical Standard 1: International Code of Ethics for Assurance Practitioners (including International Independence Standards) (New Zealand) (PES 1) issued by the New Zealand Auditing and Assurance Standards Board.

My staff and I use publicly funded health services on the same basis as others. This has not impaired my staff's independence, or me in exercising my functions and powers under the Public Audit Act 2001 as the auditor of public entities.

In addition to the audit, my staff and appointed auditors and their staff have carried out the assurance engagements outlined in note 5 of the financial statements, which are compatible with those independence requirements. This has not impaired my independence as auditor of the Group. Other than these engagements, and in exercising my functions and powers under the Public Audit Act 2001 as the auditor of public entities, I have no relationship with or interests in Te Whatu Ora or any of its subsidiaries or controlled entities.

John Ryan
Controller and Auditor-General |
Tumuaki o te Mana Arotake
Wellington, New Zealand

www.TeWhatuOra.govt.nz

Te Kāwanatanga o Aotearoa
New Zealand Government