Wairarapa DHB Annual Report 2021/22

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

Contents

Chair and Chief Executive's Forewords

Chair's Foreword

The past 12 months have been extraordinarily challenging for us. The most obvious of our challenges has been COVID-19 and responding to keep our communities and workforce safe.

Through the many challenges and difficulties brought on by COVID-19, our staff have continued to deliver their usual health care through a combination of hard work, dedication and innovation.

This past year we have achieved much, despite facing the unprecedented challenges of COVID-19 which has impacted on every aspect of medical care.

We have laid the foundation stones for better health outcomes for communities in the Wairarapa by working in partnership with stakeholders to build a vision for the future.

2030: Hauora Mō Tātou

In Wairarapa DHB has released its strategic direction for the year 2030: Hauora Mō Tātou. This sets out a clear picture of the challenges of health and social inequity for the Wairarapa community, and aims to address those inequities, particularly in recognition of slow progress in the past.

The plan identified a large number of focus areas for the DHB to develop. Two specific areas that were identified in Hauora Mō Tātou, recognising that continued planning will be needed for a range of other areas of the health system, are:

- **Strengthening Primary Care.** This area also addresses some aspects of the Improving Access to Health and Disability Services stream from the strategy, since the strategy identifies issues of access to primary and community care being as important for the Wairarapa. In particular, this stream considers issues around geographic access and extended hours access,:

- **A fit for purpose hospital.** A number of immediate actions were identified within this stream, and considerable activity has been undertaken to review the immediate effectiveness of hospital processes. This plan sets out the longer term direction for how hospital services can be delivered in the Wairarapa, considering the range of services and how they can be fitted within the wider context of hospital activity in neighbouring districts.

Te Rautaki Hauora Māori

Another major success for the Wairarapa DHB which we are intensely proud of was the completion of the Te Rautaki Hauora Māori, our Māori Health Strategy. The strategy was developed by Wairarapa District Health Board (DHB) in partnership with Te Oranga o Te Iwi Kainga (Wairarapa's Iwi partnership board). The Strategy reflects our commitment to a te Tiriti o Waitangi partnership and to improving health and wellbeing outcomes for Māori. Our Māori Strategy takes the work of Hauora Mō Tātau further by looking specifically at the goals and priorities for Māori health and wellbeing within our rohe.

Anticipating changes nationally in our health system, we have 'future proofed' the strategy and focussed on three issues:

- Focusing on the voices of Māori in the Wairarapa who have shared with us direct feedback on their current experiences of the health and disability sector (both good and bad) and their aspirations for healthy and well whānau.

- Influencing health and disability sector decision-makers regardless of the specific agencies or approaches that are put in place through the impending health reforms.

- Ensuring that Te Oranga o Te Iwi Kainga is with us every step of the way.

Wairarapa Wellbeing Plan

The purpose of this plan is to support the implementation of Hauora Mō Tātou through supporting the development of healthy neighbourhoods across the Wairarapa. Health care, including access to health services contributes only 20 percent toward a person's health and wellbeing so it is clear that if we want to improve overall health outcomes, then we need to focus on other circumstances and wider forces that contribute to people's health, wellbeing and quality of life. The plan focuses on community led approaches to support neighbourhoods and healthy behaviours that lead to improved wellbeing.

This is the last annual report to be written for the Wairarapa District Health Board. For the past twenty-one years our DHB has served the region and community making a significant difference to health outcomes for young and old alike.

On 1 July 2022, our DHB will become part of Te Whatu Ora – Health New Zealand, a new national health system.

Te Whatu Ora leads the day-to-day running of the health system across New Zealand, with functions delivered at local, district, regional and national levels. It weaves the functions of the 20 former District Health Boards into its regional divisions and district offices, ensuring continuity of services in the health system.

For us in the Wairarapa, the new organisation will bring a continuation of the high standards of service and care, together with the strengths and benefits of a regional approach.

Finally, I want to acknowledge and pay tribute on behalf of the Board to all staff for their everyday commitment to the care of our patients and communities across the Wairarapa. The last three years of the COVID-19 pandemic have been unprecedented and have called for new ways of working and thinking and I feel privileged to have seen first-hand the difference you all made.

Sir Paul Collins, Board Chair

Chief Executive's Foreword

The pandemic has taught us to be agile, to try new things, to think outside 'the square', to be risk takers, whilst always having a passion for caring for both our patients and community whether in a ward, the Emergency Department or our COVID-19 vaccination programme.

The impact of COVID-19

COVID-19 has significantly impacted on Wairarapa Hospital's capacity to provide sufficient isolation capability to meet the demands and we initiated an overflow response using a separate wing of Selina Sutherland Hospital to manage COVID-19 positive patients. Our staff response to the COVID-19 surges has been incredible and everyone and each service has worked far and above normal hours and provided additional support to maintain the provision of Hospital services to our community.

Immunisation programmes

Despite the challenges of COVID-19 we have continued to work with our Māori, Pacific and our local communities to undertake childhood immunisation programmes. At the end of June 2022, the immunisation coverage for Wairarapa DHB's five year old total population is 87.5 percent, Māori 82.5 percent and Pacific 90.9 percent. This is a fantastic result and reflects the work of Pacific Health Navigators and Māori providers.

We continue to work closely with existing service providers and explore opportunities to support providers to deliver the Measles Mumps Rubella or MMR vaccine. A team of vaccinators led and coordinated by Primary Care and supported by the DHB COVID-19 vaccination workforce is undertook a final push to deliver MMR in various community settings in the last three months of the campaign ending in June.

Unfortunately, COVID-19 has impacted on immunisation coverage, with challenges on workforce capacity and recruitment, families delaying immunisation and vaccine hesitancy.

COVID-19 Vaccination Programme

By 30 June 2022, the Wairarapa vaccination sites have delivered 109,823 vaccinations.

Wairarapa achieved the 90% target for the primary vaccination doses for all age groups over the age of 12 years. This target was also met for Māori and Pacific populations.

Workforce pressures

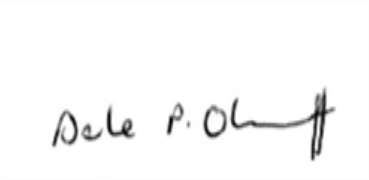
Ongoing recruitment continues for all vacancies and a number of work streams are being progressed to address the current crisis while building additional capacity in the mid to long term. These recruitment activities have been expanded to include international job fairs as part of a six DHB collaborative effort. Work is underway in partnership with UCOL to expand nursing education and training options to provide multiple local pathways into the nursing profession and health support work.

Healthpoint Agreement

The Wairarapa DHB entered into an agreement with Healthpoint to improve the information available to our community about local health and social services. Some examples of areas of information improvement include: After-hours virtual GP service: Practice Plus virtual after-hours service information is now included on participating Wairarapa GP practice Healthpoint profiles, providing visibility of this option for enrolled patients, as an alternative to Urgent Care or ED.

I would like to thank all staff for their resilience during this challenging period. It has been a privilege to lead such a dedicated, committed and skilled team of people. I would like to take the opportunity to recognise our team's dedication throughout the year.

Our achievements over the past year are a credit to their ongoing dedication and I feel confident that we are well placed to continue our excellent work through 2023.



Dale Oliff, Chief Executive

Our vision
Hauora pai mo te katoa Well Wairarapa - better health for all

Our Mission
To improve, promote and protect the health status of the people of the Wairarapa, and the independent living of those with disabilities, by supporting and encouraging healthy choices.

Our Values
Together we MAKE a difference
Manaakitanga - Respect We care for each other, showing kindness and empathy in all that we do
Auaha - Innovation We are committed to finding future focused solutions and take personal responsibility to be better every day
Kotahitanga - Relationships Our diversity is our strength, we back each other and work together in partnership
Eke Taumatua - Equity We are committed to doing the right thing by ensuring equity and Hauora are at the heart of everything we do

Our why

It is important to look to the past and learn from it, but not live in the past. Our nation, as we know it today, was built on two sets of traditions. Te Tiriti o Waitangi was the agreement which bound those traditions together and formed what we now call Aotearoa-New Zealand.

We are responsible for improving, promoting and protecting the health of people and communities, and reducing health disparities by improving health outcomes and reducing inequities. These expectations are reflected in our vision, mission and values and are at the heart of all we do.

We are serious about our role as a healthcare funder and provider and as public servants we are here to serve. We know that working alongside our people is critical to achieving our collective aims. We continue to see gaps in our delivery of services to the community and we are focussed on ways we can continually improve, and find equitable outcomes for those most at risk of experiencing poor health.

Our ‘why’ is our commitment to empower and enable whānau to take the lead in managing their own health and wellbeing, and to enjoy their best life for all of their life.

Ministerial directions

Section 151(1)(f) of the Crown Entities Act 2004 requires information on any new direction given to all DHBs by a Minister in writing under any enactment during that financial year, as well as other such directions that remain current. The following have been identified as Ministerial Directions:

- The 2011 Eligibility Direction issued under s.32 of the NZ Public Health and Disability Act 2000;
- The requirement to implement the New Zealand Business Number (NZBN) in key systems by December 2018, issued in May 2016 under s.107 of the Crown Entities Act;
- The direction to support a whole of government approach issued in April 2014 under s.107 of the Crown Entities Act. The three directions cover Procurement , ICT and Property and the former two apply to DHBs;
- The direction on the use of authentication services issued in July 2008, which continues to apply to all Crown agencies apart from those with sizeable ICT business transactions and investment specifically listed within the 2014 direction.

Governance

Role of the Board

The Board's governance responsibilities include:

- Communicating with the Minister and other stakeholders to ensure their views are reflected in the DHB's planning
- Delegating responsibility for achievement of specific objectives to the Chief Executive
- Monitoring organisational performance towards achieving objectives
- Reporting to stakeholders on plans and progress against them
- Maintaining effective systems of internal control

Structure of the DHB

DHB Operations

The Board appointed the Chief Executive to manage all DHB operations. All other employees of the DHB have been appointed by the Chief Executive either directly or via the Chief Executive's delegated authority. The Board directs the Chief Executive by delegating responsibility and authority for the achievement of objectives through setting policy.

Quality assurance

Wairarapa District Health Board has numerous processes to ensure the quality of the governance, funder and provider outputs.

Governance Philosophy

Over the past few years, we have taken a 'whole-of-health system' approach, including integrating clinical and support services where this provides benefits across the system.

We also continue to work closely with our neighbouring DHBs – Capital and Coast and Hutt Valley. While each Board continues to provide governance of local services ensuring local accountability, all three Boards provide collective governance over services that are shared or integrated.

Integrated service approaches are intended to deliver:

- preventative health and empowered self-care
- provision of relevant services close to home
- quality hospital care, including highly complex care for those who need it.

This requires a strong focus on relationships with primary and community care and working closely with staff and communities as we progress service design. The Boards' believe this gives us the best opportunity to address the challenges of balancing quality, cost and access.

Board membership

The elected and appointed Board members have diverse skills and experience in order to bring a wide range of thought to bear on policy issues. All members are required to act in the best interests of the DHB. Members are encouraged to contribute to Board decision-making processes, acknowledging that the Board must stand unified behind its decisions once made; individual members have no separate governing role outside the boardroom.

The Board acknowledges its responsibility to maintain communication with stakeholders and in particular remain cognisant of the Minister's expectations.

The members of the Board at 30 June 2022 are as follows:

Sir Paul Collins (Chair) – commenced December 2016

Leanne Southey – commenced December 2010

Ronald Karaitiana – commenced December 2013

Dr Tony Becker (Deputy Chair) – commenced December 2019

Joy Cooper – commenced December 2019

Dr Norman Gray – commenced December 2019

Helen Pocknall – commenced December 2019

Ryan Soriano – commenced December 2019

Yvette Grace – commenced December 2019

Jill Pettis – commenced December 2019

Jill Stringer – commenced December 2019

Disclosure of Interest

The Board maintains an interests' register. Board members are aware of their obligations to declare any potential conflicts of interests to ensure transparency in the decision making process.

Wairarapa District Health Board
Disclosure of Interests Register - as at May 2022

Name	Appointment Date	Health Sector Interests Disclosed	Other Interests Disclosed
Board Member			
Sir Paul Collins *Board Chair*	December 2019	• Director, New Zealand Health Partnerships Limited • Trustee of the Malaghan Institute of Medical Research • Member to Governance Board for Health Finance, Procurement & Information Management System Programme (FPIM) • Director of Technical Advisory Services Limited (TAS)	• Director of: Active Equity Holdings Limited (Chair) Hurricanes GP Limited Ides Limited Shott Beverages Limited • Director and shareholder of: AEL Managers Limited Beverage Holdings Limited Cohiba Traders Limited Tofino Trustee Limited
Dr Tony Becker *Deputy Chair*	December 2019	• Shareholder and Director (Clinical) Masterton Medical Limited • Shareholder and Director Wairarapa Skin Clinic • Wairarapa GP Trustee Tū Ora Compass Health • Wife contracts to Wairarapa District Health Board • Sister in law is an Associate Director of Nursing at Surgery Women's and Children's Directorate at CCDHB	• Trustee, Hau Kainga
Helen Pocknall *Member*	December 2019	• Contractor with Ministry of Health	• Nil Interests declared
Ryan Soriano *Member*	December 2019	• Registered Nurse Covid Response Team Wairarapa DHB (casual) • Health Worker Wairarapa Care Network (casual) • Member 3DHB DSAC Committee • Wife works as casual caregiver for Wairarapa Care Network	• Member, Pasifika O Wairarapa Charitable Trust • Officer, Wairarapa Filipino Society • Casual School Bus Driver GoBus
Joy Cooper *Member*	December 2019	• Nil Interests declared	• Chairperson Wharekaka Trust Board Incorporated

Name	Appointment Date	Health Sector Interests Disclosed	Other Interests Disclosed
Board Member			
Yvette Grace *Member*	December 2019	• Member of Māori Executive Board for Tū Ora Compass Health • Member, Hutt Valley District Health Board • Member Concurrent FRAC Hutt Valley and Capital and Coast DHBs • Member 3DHB Disabilities Committee for Hutt Valley DHB • Member Wairarapa CPHAC Committee • He Kāhui Wairarapa, Board member • Te Hauora Rūnanga o Wairarapa, Board member • Wairarapa Child and Youth Mortality Review Committee, Local Review member • Tiriti Implementation Lead – Occ Therapy Board NZ • Husband is a Family Violence Intervention Coordinator at Wairarapa District Health Board • Sister-in-law is a Nurse at Hutt Hospital • Sister-in-law is a Private Physiotherapist in Upper Hutt	• Trustee House of Science Wairarapa • Trustee Equippers Church and Oasis Trust • House of Science, Wairarapa Trustee
Jill Stringer *Member*	December 2019	• Member, Wairarapa DHB CPHAC committee • Member, 3DHB DSAC committee • Employed by Wairarapa DHB as Immunisation Vaccination	• Director, Touchwood Services Limited • Husband employed by Rigg-Zschokke Ltd • Trustee, Wellington Welfare Guardian Trust
Jill Pettis *Member*	December 2019	• Nil Interests declared	• Nil Interests declared
Leanne Southey *Board Member*	December 2019	• Chair, Wairarapa District Health Board, Finance Risk & Audit Committee • Chartered Accountant to Health Professionals including Selina Sutherland Hospital and Selina Sutherland Trust • Trustee, Wairarapa Community Health Trust • Board Member, Wellington Free Ambulance	• Chair of Lands Trust Masterton *(15 February 2016)* • Director, Southey Sayer Limited • Shareholder of Mangan Graphics Ltd • Director of Wellington Water Ltd

Name	Appointment Date	Health Sector Interests Disclosed	Other Interests Disclosed
Board Member			
Ronald Karaitiana *Board Member*	December 2019	• Member of Māori Executive Board for Tū Ora Compass Health • Member, Wairarapa District Health Board • Member, Wairarapa Te Iwi Kainga Committee • Member, Wairarapa District Health Board, Finance Risk & Audit Committee • Extended family members work in varying roles at DHB • Chief Executive, Te Hauora Runanga o Wairarapa • Whanau ora Collective Member Te Hauora and Whaiora via Te Pou Matakana • Board Director from Presbytarian Support Central	• Akura Lands Trust Chairman • RK Consulting Ltd, Business owner
Dr Norman Gray *Board Member*	December 2019	• Association of Salaried Medical Specialists (ASMS) Branch Representative for Wairarapa • Emergency Consultant and Clinical Lead, Wairarapa DHB • Board member Mid Central DHB	• Nil Interests declared

Division of responsibility between the Board and Management

Key to the efficient running of the DHB is that there is a clear division between the roles of the Board and management. The Board concentrates on setting policy, approving strategy and monitoring progress toward meeting objectives. Management is concerned with implementing policy and strategy.

Delegations

The Board has an approved delegation policy in accordance with clause 39 Schedule 3 of the New Zealand Public Health and Disability Act 2000. This Act requires (s26 (3)), and the policy allows the Board to delegate management matters of the Wairarapa DHB to the Chief Executive.

Accountability

The Board holds monthly meetings to monitor progress toward its strategic objectives and to ensure that the affairs of the DHB and its subsidiaries are being conducted in accordance with the DHB's policies.

Internal Audit

While many of the Board's functions have been delegated, the overall responsibility for maintaining effective systems of internal control ultimately rests with the Board.

The DHB uses external resources through the TAS regional internal audit programme to maintain an internal audit function, which is responsible for monitoring its systems of internal control, and the quality and reliability of financial and non-financial information reported to the Board. Internal Audit reports its findings directly to the Finance, Risk and Audit Committee established by the Board.

Risk Management

The Board acknowledges that it is ultimately responsible for the management of risks to the DHB. The Board has charged the Chief Executive through its risk management policy with establishing and operating a risk management programme in accordance with the Joint Australian/New Zealand Standard requirements on risk management.

Legislative compliance Disclosure Ultra Vires Transactions

The Board acknowledges its responsibility to ensure the organisation complies with all relevant legislation.

Wairarapa DHB has not entered any transactions during the year that have been enforced under section 20(3) of the Crown Entities Act 2004.

Permission to Act despite being interested in a Matter

A member who is interested in a matter relating to a DHB must not vote or take part in any discussion or decision of the Board or any committee relating to that matter under section 66 of the Crown Entities Act 2004. However, under section 68 of the Crown Entities Act 2004, the Chair of the DHB may exempt one or more Board members from this requirement if it is in the public interest to do so. Where such an exemption is given, this must be disclosed in the annual report. No permissions were provided under section 68 during the 2020-21 year.

Board members' meeting attendance

The table shows the attendance of Board members at Board and Committee meetings during the financial year. The numbers in brackets below shows the total meetings of the Board/Committee during the member's Board or committee membership.

The references to the committees listed in the table are as follows:

FRAC	Finance, Risk and Audit Committee
CPHAC	Community and Public Health Advisory Committee
DSAC	Disability Services Advisory Committee 3DHB – Wairarapa/Hutt/Capital & Coast combined
HAC	Hospital Advisory Committee (this is incorporated into the Board meeting).

Board and committee memberships for the year ended 30 June 2022

Board Members from July 2021 to June 2022	Board	CPHAC	DSAC	FRAC
Paul Collins (Chairperson)	Chair			Member
Tony Becker (Deputy Chair & CPHAC Chair)	Deputy Chair	Chair		
Joy Cooper	Member	Member		
Norman Gray	Member			Member
Helen Pocknall	Member	Deputy Chair		
Ryan Soriano	Member		Member	
Leanne Southey (FRAC Chair)	Member			Chair
Jill Stringer	Member	Member	Member	
Yvette Grace	Member	Member	Member	
Ron Karaitiana	Member			Member
Jill Pettis	Member		Member	

Board and committee meeting attendances for the year ended 30 June 2022

Board Members from July 2021 to June 2022	Board (11)	CPHAC (10)	DSAC (3)	FRAC (11)
Paul Collins (Chairperson)	11	0	0	10
Tony Becker (Deputy Chair & CPHAC Chair)	10	9	0	0
Joy Cooper	11	9	0	0
Norman Gray	11	0	0	8
Helen Pocknall	11	8	0	0
Ryan Soriano	9	0	0	0
Leanne Southey (FRAC Chair)	10	0	0	10
Jill Stringer	9	9	3	0
Yvette Grace	10	10	2	0
Ron Karaitiana	9	0	0	11
Jill Pettis	11	0	3	0

Implementing the COVID-19 Community Response Strategy

By 30 June 2022 the Wairarapa area had seen 12,459 COVID-19 positive cases with 11,963 people recovered from COVID-19 and 23 people died who were reported to have COVID-19 positive status (note this does not mean they died from COVID-19).

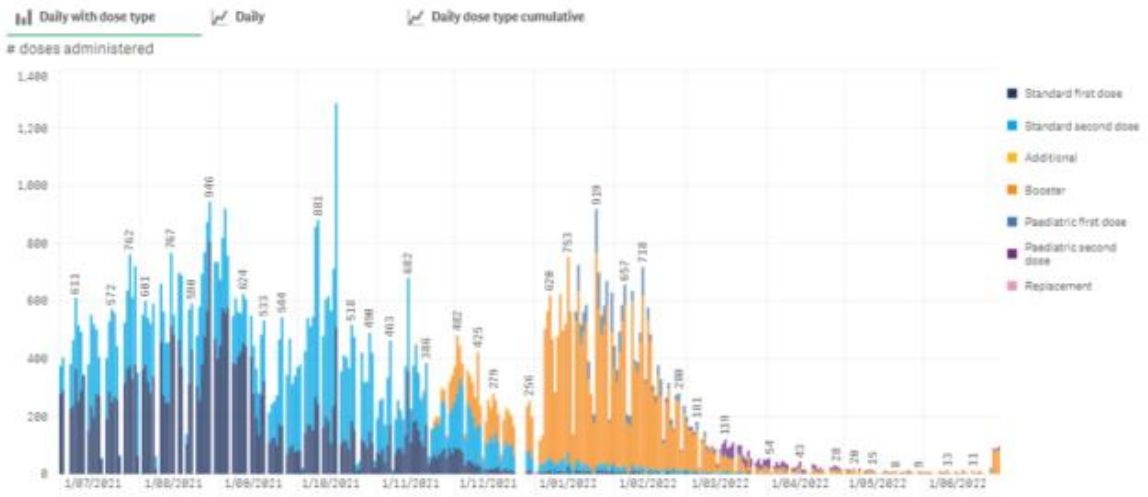
Our COVID-19 community response during 2021/22 had three delivery streams:

1. Vaccination- prevent and reduce the impact of illness
2. Testing- identify who has COVID-19 to reduce contact and protect our vulnerable communities from illness
3. Care in the Community Services (CITC)- monitor those with the illness and support them to stay isolated and support them during the illness

Vaccinations

During 2021/22 vaccinations were delivered by the Wairarapa District Health Board at several sites: Department Building, Masterton, Featherston Community Centre, Drive Through (temporary) and at peoples homes and outreach venues. The number of vaccinations delivered in the Wairarapa was 97,155 doses and 80% of the vaccinations delivered during the 12 months were from the DHB sites. Tekau Mā Iwa (Iwi led clinic) and Wairarapa Pharmacies delivered the balance.

The graph below shows vaccinations delivered by our vaccination sites.



During 2021/22 Pfizer was the vaccine delivered to the majority of the Wairarapa population. People over the age of 12 were able to access the primary dose which consisted of does 1 and dose 2. A booster dose became available for people who met the eligibility criteria during the year. Children aged five to eleven were eligible for a paediatric version of the vaccine which also consisted of dose 1 and dose 2.

Wairarapa achieved the 90% target for the primary vaccination doses for all age groups over the age of 12 years. This target was also met for Māori and Pacific populations.

Additional performance information: COVID-19 vaccinations and mortality

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

COVID-19 vaccinations

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

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

HSU 2021

People are included if they were:

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

HSU 2020

People are included if they were:

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

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

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

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

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

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

To determine the coverage of the COVID-19 vaccine across the population of Wairarapa DHB we have used the HSU 2021 data as the denominator (the figure which the total eligible population vaccinated is divided by). The suitability of the HSU for this purpose was reviewed by Stats NZ, with their findings and recommendations published on 4 August 2022.[1]

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

Percentages over 100% occur where there are more vaccinated persons than was expected in the HSU 2021 data. This is mostly seen in small populations. As the HSU is a point in time denominator, any movement of persons into or out of an area are not captured and percentages above 100% can occur.

Percentage of the eligible population who have completed their primary COVID-19 vaccination course[2] (HSU 2021 vs HSU 2020)

Year[3]	HSU 2021 Percentage of the eligible population who have completed their primary course	HSU 2020 Percentage of the eligible population who have completed their primary course
2020/2021	10.10%	10.53%
2021/2022	81.41%	84.88%
Total	**91.51%**	**95.41%**

Using HSU 2021 to determine the percentage of the eligible population who have completed their primary course, the coverage is calculated to be 91.51%, compared with 95.41% using HSU 2020 as at 30 June 2022.

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

COVID-19 vaccine doses administered by dose type and year

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

[2] Individuals who have received dose 1 and dose 2 of the COVID-19 vaccine are considered to have completed their primary course. This definition supersedes the term 'fully vaccinated' reported in our 2020/21 annual report.
[3] Data as at 30 June 2021 for 2020/21 and 30 June 2022 for 2021/22.

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

Year[4]	Primary course				
	Dose 1	Dose 2	Booster 1	Booster 2	Total[5]
2020/21	8,240	4,391	0	0	12,631
2021/22	34,014	35,964	26,949	265	97,192
Total	42,254	40,355	26,949	265	109,823

By 30 June 2022, a total of 109,823 COVID-19 vaccinations had been administered, of which 88% were administered in 2021/22.

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

overseas vaccinations. This causes some variation between the two measures and exact comparisons are not feasible.

COVID-19 vaccine doses administered by age group

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

COVID-19 vaccine doses administered by age group[6]

Age group	Primary course				
(years)[7]	Dose 1	Dose 2	Booster 1	Booster 2	Total[8]
0 to 11	2264	926	0	0	3190
12 to 15	2525	2394	0	0	4919
16 to 19	1936	1918	450	0	4304
20 to 24	1993	1977	804	1	4775
25 to 29	2195	2180	1076	0	5451
30 to 34	2410	2415	1334	0	6159
35 to 39	2223	2220	1425	2	5870
40 to 44	2264	2280	1669	4	6217
45 to 49	2561	2600	2018	2	7181

[4] Data as at 30 June for each financial year, and respectively covers all vaccination doses administered between 1July-30 June.
[5] Excludes third primary doses administered and any subsequent boosters a person may have received after the second booster vaccination.
[6] Data as at 30 June 2022 and covers all vaccination doses administered between 1 July 2021-30 June 2022.
[7] Age groupings in this table reflect the age of the person at the time of the vaccination being administered.
[8] Excludes third primary doses administered to individuals and any subsequent boosters which may have been administered after the second booster vaccination.

Age group	Primary course				
(years)[7]	Dose 1	Dose 2	Booster 1	Booster 2	Total[8]
50 to 54	2796	2869	2488	10	8163
55 to 59	2852	2979	2709	7	8547
60 to 64	2872	3059	3049	16	8996
65 to 69	2138	2706	2926	43	7813
70 to 74	1364	2296	2706	53	6419
75 to 79	740	1496	1931	66	4233
80 to 84	464	946	1317	37	2764
85 to 89	275	469	664	15	1423
90+	142	234	383	9	768
Total	34014	35964	26949	265	97192

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

COVID-19 people vaccinated by age group

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

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

COVID-19 people vaccinated by age group during 2021/22[9]

Age group[10] (years)	Partial [11]		Primary course [12]				Booster course	
	Partially vaccinated	Partially vaccinated (% eligible)	Completed primary course	Completed primary course (% eligible)	Received first booster (18+)	First booster (% eligible) (18+)	Received second booster (50+)	Received second booster % eligible (50+)
0 to 11	1894	27%	803	11%	0	0%	0	0%
12 to 15	2136	82%	1828	70%	0	0%	0	0%
16 to 19	2195	95%	2159	94%	254	34%	0	0%
20 to 24	1984	83%	1967	83%	814	40%	0	0%
25 to 29	2131	80%	2117	79%	1007	45%	0	0%
30 to 34	2476	84%	2479	84%	1314	50%	0	0%
35 to 39	2244	84%	2260	85%	1398	58%	0	0%
40 to 44	2274	83%	2288	84%	1635	66%	0	0%
45 to 49	2407	79%	2451	80%	1894	71%	0	0%
50 to 54	2813	82%	2882	84%	2461	78%	8	4%
55 to 59	2779	79%	2894	82%	2606	81%	7	3%
60 to 64	2907	78%	3083	83%	3046	87%	16	5%
65 to 69	2357	70%	2784	83%	2929	91%	38	11%
70 to 74	1560	51%	2359	76%	2739	94%	54	13%
75 to 79	863	40%	1702	79%	2099	96%	65	17%
80 to 84	496	35%	1067	75%	1401	98%	38	12%
85 to 89	303	41%	545	74%	742	102%	19	11%
90+	176	40%	297	68%	429	107%	8	7%
Total	33995	68%	35965	71%	26768	74%	253	10%

[9] Data as at 30 June 2022 and includes all people who received COVID-19 vaccinations between 1 July 2021– 30 June 2022.
[10] Age groupings in this table reflect age of the persons at end of financial year.
[11] Partial vaccination refers to individuals who had received a single one dose of the COVID-19 vaccination (as at 30 June 2022).
[12] Primary course refers to the first two doses of the COVID-19 vaccine (dose 1 and dose 2).

COVID-19 vaccine doses administered by ethnicity

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

COVID-19 vaccine doses[13] administered by ethnicity[14] (1 July 2021 – 30 June 2022)

Ethnicity (Note 1, 2)	Primary course				
	Dose 1	Dose 2	Booster 1	Booster 2	Total
Asian	1351	1330	957	3	3641
European/other	25889	28115	22628	248	76880
Māori	5808	5550	2718	9	14085
Pacific peoples	794	781	487	2	2064
Unknown	172	188	159	3	522
Total	34014	35964	26,949	265	97192

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

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

COVID-19 people vaccinated by ethnicity

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

COVID-19 people vaccinated by ethnicity during 2021/22[15]

Ethnicity (Note 1)	Partially vaccinated (12+)	Partially vaccinated(12+) (% eligible)	Completed Primary Course (12+)	Completed primary course (12+) (%)	Received First Booster (18+)	Received first booster (18+) (% eligible)	Received second booster, 50+	Received second booster (% eligible, 50+)
Asian	1233	83%	1288	87%	958	74%	2	8%
Māori	5403	80%	5412	80%	2699	55%	8	5%

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

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

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

European /other	24534	73%	27466	81%	22462	78%	238	11%
Pacific peoples	755	82%	798	86%	487	63%	2	10%
Unknown	176	69%	198	77%	162	68%	3	14%
Total	32101	74%	35162	81%	26768	74%	253	10%

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

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

Ethnicity (Note 1, 2)	Partially Vaccinated 12+	Partially Vaccinated 12+ % of HSU2021	Completed Primary Course 12+	Completed Primary Course 12+ % of HSU2021	Received First Booster 18+	Received First Booster 18+ % of Eligible	Received Second Booster 50+	Received Second Booster % of Eligible (50+)
Asian	1450	97%	1438	97%	959	74%	2	8%
Māori	6060	90%	5804	86%	2699	55%	8	5%
European /other	31651	94%	31158	92%	22462	78%	238	11%
Pacific peoples	902	98%	876	95%	487	63%	2	10%
Unknown	257	100%	248	97%	162	68%	3	14%
Total	40320	93%	39524	92%	26769	74%	253	10%

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

Note 2 Partially Vaccinated counted for 12+ years old (age as at 30-Jun-2022)

Completed Primary Course counted for 12+ years old (age as at 30-Jun-2022)

Rec'd First Booster counted for 18+ years old (age as at 30-Jun-2022)

Rec'd Second Booster counted for 18+ years old (age as at 30-Jun-2022)

50+ age determined as at 30-Jun-2022

Basis of population is HSU2021 for 12+ years old

All counts exclude those who died prior to 30-Jun-2022

Further notes on the HSU dataset

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

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

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

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

There are other datasets that measure the number of people living in New Zealand produced by Stats NZ :[16]

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 the Ministry of Health using requested ethnic groupings and DHB areas).

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

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

Stats NZ:

'The ERP and HSU have different target populations. In principle, the ERP is an estimate of the population usually living (resident) in New Zealand at a point in time, and the HSU is a measure of the population in New Zealand using (or potentially using) the health system at a point in time. For both the ERP and HSU, mean populations over a period of time can be derived from the point in time estimates.' [17]

[16] https://www.stats.govt.nz/methods/population-statistics-user-guide.
[17] 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/

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

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

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

- age
- ethnicity
- DHB
- gender

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

Comparison of HSU 2021 to the Stats NZ projected resident population

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

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

As at 31 December 2021, there is an estimated 50,331 health service users in the HSU 2021. This is an increase of 1,713 people from the HSU 2020 (an approximate 3.5% increase), and 431 more people than the Stats NZ PRP for 30 June 2021. DHB population by ethnicity: HSU 2021 and Stats NZ PRP comparison[18]

Ethnicity	HSU 2021	Stats NZ PRP	Difference (Note 1)
Māori	8984	9240	256
Pacific peoples	1155	1090	-65
Asian	1848	1620	-228
European/other	38065	38000	-65
Unknown	279	0	-279
Total (Note 1)	50331	49900	-431

Note 1: The total population estimate based on HSU 2021 (as at 31 December 2021) is 5,233,600. This is 111,000 above the Stats NZ total projected population of 5,122,600 (as at 30 June 2021) taken from the customised 2018-base population projections Stats NZ produced in 2021

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

Comparison of HSU 2020 to the Stats NZ PRP

For reference, we have provided the HSU 2020 comparison

DHB population by ethnicity: HSU 2020 and Stats NZ PRP[19]

Ethnicity	HSU 2020	Stats NZ PRP	Difference
Māori	8587	9010	423
Pacific peoples	1065	1070	5
Asian	1530	1610	80
European/other	37254	37400	146
Unknown	182	0	-182
Total (Note 1)	48618	49000	382

Note 1: The total population estimate based on HSU 2020 (as at 1 July 2020) is 5,000,500. This is 89,700 below the Stats NZ total projected population of 5,090,200 (at 30 June 2020) taken from the customised 2018-base population projections Stats NZ produced in 2021.

COVID-19 mortality rates

The data used to determine deaths attributed to COVID-19 comes from EpiSurv20 and the National Contact Tracing Solution (NCTS) databases. The data received through these systems is extensively checked for duplications using national health index (NHI) data.

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

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

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

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

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

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

COVID-19 Deaths by age group

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

Age group (years)	
<10	-
10 to 19	-
20 to 29	-
30 to 39	-
40 to 49	1
50 to 59	-
60 to 69	3
70 to 79	2
80 to 89	6
90+	7
Total	**19**

COVID-19 deaths by ethnicity

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

Ethnicity	
Asian	-
European/other	16
Māori	3
Pacific peoples	-
Unknown[21]	-
Total	**19**

Testing

The primary testing modality was PCR tests with Rapid Antigen Tests (RATs) being introduced widely for use by people in the community.

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

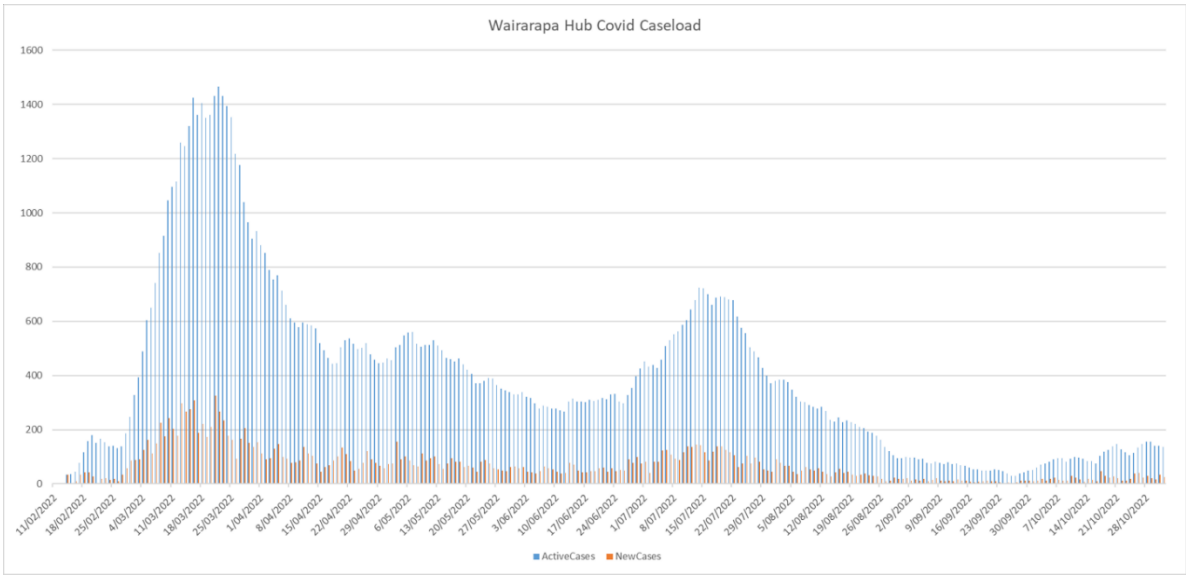
The Wairarapa District testing model for PCRs was through designated Medical Centre testing sites. Each of our seven practices and our primary care After Hours service provided testing to the people in the Wairarapa area (including unenrolled people). Pharmacies were our primary vehicle for the distribution of RATs during the year although our DHB RATs site also arranged for delivery to our community where required.

During the year 1 July 2021 to 30 June 2022 there were 21,038 PCR tests delivered to the Wairarapa population.

During the year 1 July 2021 to 30 June 2022 there were 19,506 RATs undertaken by the Wairarapa population and 12,514 tests reported as positive for COVID-19.

Care in the Community

Our first notable surge of COVID-19 cases began in February 2022 and peaked in March 2022. The CiTC Coordination Service has been operational since February 2022. To date, the CiTC team have averaged 680 clinical and non clinical support and welfare calls each week since mid-April 2022. The largest number of calls per day stands at just over 1625 calls. Below is graph showing the case load for the CiTC service.



Inclusion and Diversity

We want the Wairarapa DHB to be a safe and inclusive place to work, where people have a strong sense of belonging, are comfortable bringing their whole selves to work, feel safe to raise concerns around non-inclusive behavior and are supported in their opportunities for growth. We are committed to being a good employer that provides equal employment opportunities and creates an environment where employees feel valued and respected, and where difference is celebrated and diversity encouraged.

Employee remuneration

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

	2022		2021	
	Number of Clinical Staff	Number of Non-Clinical Staff	Number of Clinical Staff	Number of Non-Clinical Staff
$100,000 - $109,999	21	5	18	3
$110,000 - $119,999	13	1	7	4
$120,000 - $129,999	19	1	6	1
$130,000 - $139,999	6	5	2	2
$140,000 - $149,999	4	1	4	
$150,000 - $159,999	2			2
$160,000 - $169,999	1		1	
$170,000 - $179,999	1		1	
$180,000 - $189,999		1		1
$190,000 - $199,999		1		
$200,000 - $209,999			2	1
$210,000 - $219,999			1	
$220,000 - $229,999		1	1	1
$230,000 - $239,999				
$240,000 - $249,999	3		6	
$250,000 - $259,999	1			
$260,000 - $269,999	2			
$270,000 - $279,999	2		2	
$280,000 - $289,999			1	
$290,000 - $299,999	2			
$300,000 - $309,999	2		2	
$310,000 - $319,999	1			
$320,000 - $329,999	2		1	1
$330,000 - $339,999	2	1	2	
$340,000 - $349,999	2		2	
$350,000 - $359,999	1		1	
$380,000 - $389,999	1		1	
$390,000 - $399,999	1			
$400,000 - $409,999			1	
$410,000 - $419,999	1			
$420,000 - $429,999	1		1	
$430,000 - $439,999	1			
$490,000 - $499,999			1	
$530,000 - $539,999			1	
	92	17	65	16

Performance Highlights

Wairarapa DHB is required to complete its Statement of Performance Expectations by the start of the financial year under section 149C of the Crown Entities Act 2004. This requirement has been met for the 2021/22 year.

Wairarapa DHB continues to provide high quality and timely services for our population. In 2021/22:

- Wairarapa DHB exceeded its smoking cessation target for offering advice and/or help to quit to 90% of pregnant women who smoke (actual performance - 100%).
- In Wairarapa DHB, the standardised inpatient Average Length Of Stay (ALOS) for Elective events is lower than the target of 1.45 days (1.30 days in 2021/22).
- The percentage of patients referred to non-urgent addiction services and seen within the targeted 8 weeks was at 98.6%, exceeding the 95% target.
- Wairarapa DHB continues to work to reduce the number of inpatient falls causing harm. In the last year this was 0.15 per 1,000 bed days which met the target of ≤ 0.15 per 1,000 bed days.
- Medication errors causing harm met the target of 0.05 per 1,000 bed days in 2021/22.
- The percentage of people over 75 years of age living in their own home was 93% which exceeded the target of ≥92%.
- The standardised acute readmission rate for people over 75 years of age of ≤12% was exceeded for both Maori 10.9% and the total population 11.6%.

Statement of Performance

For the year ended 30 June 2022

Output Classes contributing to desired outcomes

One of the functions of this Annual Report is to evaluate the effectiveness of the decisions we make on behalf of our population. We do this by evaluating the services (or outputs) that we funded and provided in the 2021/22 year.

Our four Output Classes and their related services are:

1. Prevention

- Public Health Protection and Regulatory Services
- Health Promotion and Preventative Intervention Services
- Immunisation services
- Smoking cessation services
- Screening services

2. Early Detection and Management

- Primary care (GP) services
- Oral health services
- Pharmacy services

3. Intensive Assessment and Treatment

- Medical and surgical services
- Cancer services
- Mental health and addictions services

4. Rehabilitation and Support

- Disability services
- Health of older people services

The outputs reflect health service activity across the whole of the Wairarapa health system. We choose outputs that make the greatest contribution to the wellbeing of our population in the short term, and to the health outcomes that we are seeking to achieve over the longer term.

The outputs have been grouped into four 'output classes' that are a logical fit with the stages spanning the continuum of care.

Interpreting our performance

Types of measures

Identifying appropriate measures for each output class is important, as we wish to do more than measure just the volumes of patients and consumers through our system. The number of services delivered or the number of people who receive a service is often less important than whether the right person or enough of the right people received the right service, and whether the service was delivered at the right time. As such, we report on a mix of output measures that help us to evaluate different aspects of our performance.

The outputs are categorised by the *Type of measure*, which shows whether the output is targeting coverage, quality, quantity (volume), or timeliness and also by the *MOH indicator* - these indicators being part of the MOH National non-financial Performance monitoring framework except for those marked "WPI" which are local Wairarapa DHB Performance indicators. When possible and relevant, we have also broken our performance down by ethnicity.

Type of Measure	***Abbreviation***
Coverage	C
Quality	Q
Volume	V
Timeliness	T

Ethnicity	***Abbreviation***
Māori	M
Pacific	P
Total (all ethnicities)	T

Standardisation

Different populations have different characteristics, and these different population characteristics can lead to different rates between populations. One such characteristic is the age structure of a population. It would be unreasonable to compare the hospital average length of stay in Wairarapa, which has a large proportion of elderly, directly to Capital & Coast, which has a smaller proportion of elderly.

By standardising for age, we can see what the rates would have been if the two populations had the same proportion of people in each age group, and therefore draw comparisons. In the following outputs, if measures have been standardised (often by the Ministry of Health to allow comparison between DHBs), we have noted why and how.

Targets and Estimates

Some of our performance measures are demand-based, and are included to show a picture of the services that the DHB funds and provides. For these measures, no specific targets are set because there are no assumptions about whether an increase or decrease is desirable. For performance measures that are demand-based, under the heading of "target", we have provided an estimate of our 2021/22 performance (indicated with 'Est.'), based on historical and population trends.

Appropriation reporting

	Budget 2022 $000	Actual 2022 $000	Actual 2021 $000
Appropriation revenue	179,158	183,187	166,653

The Appropriation revenue received by Wairarapa DHB equals the Government's actual expenses incurred in relation to the appropriation, which is a required disclosure from the Public Finance Act.

COVID-19

The COVID-19 pandemic did not reduce our ability to deliver key services, but did impact our hospital operations and limit our ability to achieve some of our targets again this year.

Output class: Prevention Services

Description

'Preventative' health services promote and protect the health of the whole population, or identifiable sub-populations, and target population-wide changes to physical and social environments to influence and support people to make healthier choices.

These prevention services also support people to address any risk factors that contribute to both acute events (e.g. alcohol-related injury) and the development of long-term conditions (e.g. diabetes). A focus for these services is high health need and at-risk population groups (low socio-economic, Māori, and Pacific), who are more likely to be exposed to environments that are less conducive to making healthier choices.

Preventative services are our best opportunity to target improvements in the health of high need populations to reduce inequalities in health status and improve population health outcomes. These services ensure that threats to the health of the community such as communicable disease, water quality and imported disease-carrying pests are detected early and prevented. They also ensure we have the ability to respond to emergency events such as pandemics or earthquakes.

Outputs

Public Health Protection and Regulatory services: enable people to increase control over their health and its determinants. This is done to address the prerequisites of health, such as income, housing, food security, employment, and quality working conditions. Health protection activity is enacted through a range of platforms, as described by the Ottawa Charter: public policy, reorienting the health system, environments, community action, and supporting individual personal skills. While the Health system has a significant role here, it requires a whole of sector approach and our DHB and Regional Public Health services work with other sectors (housing, justice, education) to enable this.

***Health Promotion and Preventative Intervention services*:** inform people about health matters and health risks, and support people to be healthy. Success begins with awareness and engagement, reinforced by community health programmes that support people to maintain wellness or assist them to make healthier choices.

Immunisation services: work to prevent the outbreak of vaccine-preventable diseases and unnecessary hospitalisations. The work spans primary and community care and allied health services to optimise provision of immunisations across all age groups, both routinely and in response to specific risk. A high coverage rate is indicative of a well-coordinated, successful service.

Smoking cessation services: are provided by clinical staff to smokers to help smokers quit. Clinicians follow the ABC process[1]: **A**sk all patients whether they smoke and document their response; if the patient smokes, provide **B**rief advice to quit smoking; and if patient agrees, provide **C**essation support (e.g., a prescription for nicotine gum or a referral to a provider like Quitline).

[1] ABC for Smoking Cessation Quick Reference Card, PHARMAC

Screening services: These services help to identify people at risk of ill-health and to pick up conditions earlier. They help early identification of breast and cervical cancer, and carry out newborn hearing testing, and antenatal HIV screening.

How we measure the performance of our Prevention Services:

Outputs measured by	Type of Measure	MOH Indicator	Target/Est. 2021/22	Baseline	Baseline data date	20/21 Performance	21/22 Performance	Achievement
Health promotion and education								
Number of adult referrals to the Green Prescription program.	V	WPI	≥ 250	243	19/20 Q4	167	85	Not Achieved
Smoking cessation								
Percentage of PHO enrolled patients who smoke and have been offered help to quit smoking by a healthcare practitioner in last 15 months.	C	PH04	≥90%	87%	2020/21 Q1	65.7%	28%	Not Achieved
Percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or LMC being offered brief advice and support to quit smoking.	Q	CW09	≥90%	100%	2020/21 Q1	100%	100%	Achieved
Babies living in Smokefree Homes at 6 weeks post-natal	Q	WPI	Total ≥70% Māori ≥50% Pacific ≥50%	Total 59% Maori 40% Pacific 64%	Average of Q2 & Q4 2019 and 2020	60% 45% 43%	44.3% 29.6% 31.6%	Not Achieved
Immunisation								
Percentage of 8-month olds fully vaccinated	C	W08	≥95%	Total 89.9% Māori 89.5% Pacific 85.7% Other 90.0%	2020/21 Q2	90.1% 85.6% 86.7% 92.6%	88.2% 78.5% 92.0% 92.6%	Not Achieved
Percentage of 5-year olds fully immunised	C	CW05	≥95%	Total 93.5% Māori 96.0 % Pacific 100% Other 89.4%	2020/21 Q2	89.8% 90.2% 88.2% 89.6%	87.5% 82.5% 90.9% 89.8%	Not Achieved
Percentage of year 7 children provided Boostrix vaccination in Wairarapa district.	C	WPI	≥95%	Total 92% Māori 94% Pacific 113% Other 90%	2019/20 Q4	New measure in 21/22	75.4% 65.0% 70.6% 80.0%	Not Achieved
Percentage of girls and boys fully immunised – HPV vaccine.	C	CW05	≥75%	Total 66% Māori 67% Pacific 76% Other 66%	2019/20 Q4	70.7% 66.2% 77.3% 70.7%	70.9% 65.8% 75.0% 72.8%	Only Achieved for Pacific
Percentage of people aged 65+yrs who have completed their annual influenza immunisation.	C	CW05	≥75%	Total 77% Māori 63% Other 78%	2020/21 Q1	72.0% 57.5% 73.0%	71.2% 55.7% 72.3%	Not Achieved

Outputs measured by	Type of Measure	MOH Indicator	Target/Est. 2021/22	Baseline	Baseline data date	20/21 Performance	21/22 Performance	Achievement
Breastfeeding								
Percentage of infants fully or exclusively breastfed at 3-months.	Q	CW06	≥70%	Total 59% Maori 44% Pacific 67%	Q3 20/21	59.0% 44.0% 67.0%	57.0% 33.0% 46.0%	Not Achieved
Population based screening services								
Percentage of obese children identified in the Before School Check (B4SC) programme offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions.	C	CW10	≥95%	Other 92% Maori 100%	2020/21 Q2	New measure in 21/22	80% 80%	Not Achieved
Percentage of eligible women (25-69 years) having cervical screening in last 3 years.	C	PV02	>80%	Total 70% Māori 70% Pacific 63% Other 70%	2020/21 Q1	72.1% 69.9% 77.4% 72.7%	68.6% 64.0% 69.2% 69.1%	Not Achieved
Percentage of eligible women (45-69 years) having breast screening in the last 2 years.	C	PV01	>70%	Total 69% Māori 65% Pacific 64% Other 69%	2020/21 Q1	65.9% 59.6% 55.7% 66.9%	61.8% 66.3% 64.3% 61.1%	Not Achieved

Commentary

Public health protection and regulatory services

COVID-19

COVID-19 continued to have an impact on service delivery. RPH was intrinsic to the public health response in the greater Wellington region, coordinating and leading case and contact management, contributing to programmes at the border, and providing a conduit between national policy and local practice. In addition, RPH as part of the national network of public health units collectively responded to community resurgence occurring across the country, including supporting other public health units. Of significant note for the Wairarapa COVID-19 response, in November 2021 RPH worked closely with Whaiora in managing a significant community outbreak within a highly transient community.

The service remains intrinsic to the public health response in the Greater Wellington Region, and COVID-19 is still an ongoing work stream for public health units around the country. Albeit a reduced response, the service maintains a focus on priority populations and exposures, including marae and tangihanga, aged residential care, corrections, disability and vulnerable housing facilities alongside future-focused work on reduction, readiness, response and recovery. The service is maintaining capacity and capability of the response workforce to ensure readiness should a future emergency arise.

Notifiable Diseases

The majority of RPH staff returned to BAU in February 2022, resuming work that had been placed on hold as a result of the COVID-19 Pandemic. The Health Protection Cluster has continued to follow up all notifiable diseases and outbreaks in the Wairarapa DHB for the reporting period.

Notified Diseases for the period 01/07/2021 to 30/06/2022 for the Wairarapa DHB

Disease	Count of Disease
Campylobacteriosis	29
COVID-19	870
Cryptosporidiosis	2
Invasive pneumococcal disease	3
Lead absorption	2
Leptospirosis	1
Salmonellosis	1
VTEC/STEC infection	11
Yersiniosis	4
Grand Total	**923**

Of note:

- The Communicable Disease team supported Tū Ora Compass/refugee nurse to initiate their refugee programme in Wairarapa.
- An Interpreting Services Workshop is planned for July 2022.

- In response to a request from the Ministry of Health, a public health nurse initiated conversations with Recognised Seasonal Workers (RSE) employers within the Wairarapa region to establish MMR vaccination status of their RSE employees. The employers identified their RSE workers had been vaccinated against MMR off-shore, before starting employment in New Zealand.

A focus for health protection was re-establishing previous networks with councils, iwi and other stakeholders in the region. During this time the team identified historical lead notifications and some postponed Vertebrate Toxic Agent (VTA) applications. RPH also investigated an E.Coli contamination issue at the Riversdale Holiday Park in January 2022. This was during the transition period of regulatory function for drinking water safety from RPH to Taumata Arowai, the new national drinking water regulator.

In the Wairarapa in the year ended 30 June 2022, RPH continued to provide drinking water support to the district. RPH retained the Drinking Water Assessor (DWA) as business as usual from 2020 through to November 2021. The Opaki, Masterton, Tinui and Carterton drinking water supplies were audited in October 2021 for annual compliance. South Wairarapa drinking water supply was audited by a Ministry-appointed DWA. Under RPH's mandate to provide public health risk assessment to resource consent, the team provided comment on South Wairarapa, Carterton and Masterton District Councils Global Stormwater Consent, Featherston Wastewater Treatment Plan and Wainuioru Rural Water Scheme Water Bore Extraction.

RPH worked closely with Masterton District Council Environmental Health Officers and their planning team to address lead-based paint occupational exposure. RPH provided public health risk advice on noise limits as well as responses to transgression notifications for water and sewage.

Thirty-five alcohol licensing applications have been considered in detail in close consultation with the applicants, resulting in no opposition to the applications.

Health promotion and preventive intervention services

Pēpe Ora

Pēpe Ora aims to engage community services to deliver key public health messages around immunisation, oral health, breastfeeding and nutrition. The Pēpe Ora Programme continues to develop, with good attendance and rates of return postnatally.

Key developments of Pēpe Ora included extending to include postnatal mums and completing a local South Wairarapa survey for hapū mothers, to inform the introduction of P.O.P.S in the South Wairarapa. Additionally, there has been work alongside Capital and Coast and Hutt Valley DHBs to provide an online Pēpe Ora platform accessible by all whānau. As part of the Smokefree May promotion in collaboration with RPH and Tū Ora Compass Health, Pēpe Ora hosted a First 2000 Days Professional and Community Training: Māramatanga - Traditional Māori Birth Practices.

Pēpe Ora, Tū Ora Pasifika Health Navigator and the Pasifika Executive Lead Wairarapa DHB have worked together to employ a Pasifika Kaimahi. This role predominantly works alongside the Pēpe Ora Kaiawhina, to engage with Pasifika communities and develop a Pasifika Antenatal Education component within the current P.O.P.S programme.

Breastfeeding

The Antenatal Breastfeeding Video Series continues, with the first edit completed and now in translation. This will be presented to the Working Group and will assist in planning the six-part series filming over the remainder of 2022.

Kōhanga and ECE

RPH and Pēpe Ora Kaiawhina have delivered interactive Healthy Lunchbox workshops to two kōhanga reo with the aim of improving food and nutrition knowledge. These workshops were well attended by whānau. RPH, in collaboration with Tū Ora and Green Guerilla, has also supported and funded the implementation of organic vegetable gardens at two kōhanga reo. The gardens have been designed to be sustainable with efficient design, compost systems which align with Para Kore and whānau/tamariki education.

Other work has included providing head lice packs to Ngāti Hāmua, Hinetearorangi, Wahi Reka, Cloud Kids Educare and Ko Te Aroha as part of our ongoing Blitz the Nits campaign, and Whānau Oral Health packs to Ngāti Hāmua, Hinetearorangi and Cloud Kids, alongside teaching resources for kaimahi to focus on oral health key messaging.

Green Prescriptions

The impact of COVID-19 on our referral numbers in 2021-22 was significant, across the Wairarapa, Hutt Valley and Capital and Coast regions. This was more evident in the Wairarapa where barriers to accessibility were compounded by alert level changes and reduced capacity of primary care. There were strong public health messages to reduce the risk of catching COVID-19 by limiting exposure, which had a detrimental impact on service demand. Our whānau also reported an increase in competing priorities e.g. ensuring basic needs were met or greater stress juggling school closures, etc. As a mitigation, Nuku Ora prioritised our community presence and engagement in 2022. We launched a Promotion and Marketing campaign with digital and physical advertising emphasising self-referrals, alongside stakeholder engagement across primary and secondary care, and community groups. We're pleased to report we have seen a subsequent increase in referrals, reporting 43 referrals in Quarter 1 of 2022-23 (consistent with pre-COVID-19 referral numbers). Supporting accessibility to the service in the Wairarapa is an ongoing focus.

Smoke Cessation Services

A surge in COVID-19, the arrival of Flu, staff shortages and staff illness this quarter, have meant that practices have not been able to focus on Quit smoking strategies to meet the recommended targets. Once the current surge has subsided mitigation and service improvement strategies can be picked up. The Smokefree Service plan to take a more integrated approach looking at an engagement strategy with Health Services across the Wairarapa in late 2022/2023 alongside the practice liaison teams. The aim of this will be to both improve and generate referrals to the smoking cessation programme from within Primary Care, General Practices, Childhood Health and screening services.

However, there have been multiple success factors helping to increase referral rates to the Stop Smoking Services (SSS) from January to June 2022.
Things such as; re-branding of the Hapū Māmā Programme, changing incentives from Warehouse vouchers to Car Seats, new quit coaches, supportive management at Whaiora, collaboration with the Pēpe Ora Collective and Safe Sleep Partners and attending the Ahuru Mōwai and POPS Antenatal Education programmes (Pēpe Ora Parenting Support).

The Wairarapa SSS and the Pēpe Ora Collective delivered 600 smokefree car sunshades (with Health Promotion Agency branding) to the Wairarapa Kohanga, Kura Kaupapa, Āhuru Mōwai, Plunket, Tamariki Ora, Family Start, Wairarapa Maternity. An 'Uptown Pop Up' was also held in Masterton giving away smokefree health promotion and collecting referrals. Public Health have also supplied smokefree car billboards to be placed in venues throughout the Wairarapa, SSS are organising this with key providers.

We have collaborated with key stakeholders to co-design community events and professional development sessions looking at; Māramatanga for World Smokefree day, Nau Mai E Tama looking at traditional Wairarapa Ori Ori, Perinatal Mental Health Expo. Additional opportunities is the Safe Sleep Magnet supporting the Pēpe Ora Collective with Hapai te Hauora. Every Wairarapa newborn will receive this resource in the mail out of immunisation key messages, as part of the Tū Ora Compass Health initiative. Smokefree has also been supporting Masterton District Council with their smokefree policy. Ngāti Hamua Kōhanga Reo and Cloud Kids have updated their policies to include vaping.

Wairarapa DHB continues to meet the maternity health target each quarter. Smokefree monitor the discharges of women who smoke from Maternity, this has significantly dropped from 61 in January – June 2021, to 15 in January – June 2022. Of those discharged, 60% were Māori and 7% Pasifika.

Immunisation services

Childhood immunisation

The COVID-19 Omicron outbreak and winter illness has had an impact on our local immunisation programme and service delivery. In 2021/22, the Wairarapa did not achieve the 95% childhood immunisation coverage target for the 8 month, 24 month and 5 year old age group for all ethnicities.

The 8 month immunisation coverage rate for Māori at 78% was lower than for 24 month (85%) and 5 year old (83%) rate. This was noticed nationally, where the 2021/22 national average for Māori 8 month coverage rate was 72%. Due to the COVID-19 and winter illness, parents and whānau especially of children younger than 12 month of age had to cancel appointments or defer immunisation. Primary care was also under enormous pressure with appointments cancelled due to staff off sick. Feedback from the sector indicated that some whānau and parents did not want to take their 'well' child into a 'sick' (medical centres for example) place.

The Mumps, Measles and Rubella (MMR) catch-up project initiated in quarter 2 of 2021/22 for children up to 5 years of age; targeting Maori and Pacific children who had zero or only one dose of MMR vaccine helped improved coverage rate for the 24 month age group. The MMR catch-up project involved additional funding support for the Outreach Immunisation Service (OIS) and the use of Maori COVID-19 vaccination workforce, infrastrature and resources at Whaiora through mobile, home visits and additional clinics to improve access for whanau. As a result, the 24 month immunisation coverage rate for Maori increased by 10% from 75% in quarter 2, 2021/22 to 85% at the end of 2021/22. For the Pacific, the coverage rate for 24 month age group would have been 100% if 3 children have not opted off or declined immunisation.

For the 5 year old immunisation coverage, Maori 5 year old coverage showed the biggest improvement in 2021/22. During the height of the COVID-19 Omnicron outbreak, the equity gap between the 5 year old Total population and Māori was as wide as 12%. However, at the end of 2021/22 the equity gap decreased to 5%. The improvement can be attributed to the access to COVID-19 vaccination and funded flu vaccines this age group has, thus, the opportunity to be engaged with the COVID-19 vaccination team through static clinics, home and mobile outreach programmes. In addition, the requirement to be immunised before starting school is a

contributing factor to the improved coverage; and parents are more comfortable to give consent for vaccination as they feel their children are old enough to be vaccinated.

School Based Immunisation Programme

As part of the school based vaccination programme HPV Gardasil is delivered to students who are Year 8 in primary and intermediates in Wairarapa. Ponatahi Christian School (at the school's request) is the only school where this does not occur.

Despite the challenges of delivering the School Based Immunisation Programme, Regional Public Health has remained on track due to scheduling a lot of catch-up clinics to get those who were not at school at the first clinic. In addition, Regional Public Health works closely with whānau to support referral to primary care when needed.

Seasonal Influenza

Wairarapa DHB's influenza campaign for people aged 65 and over was well underway by 30 June 2022 with the coverage rate for the Total population, Māori and Pacific well over 60% by 30 June 2022.

The Wairarapa District's COVID-19 vaccination team worked with Pasifika o Wairarapa Trust to provide mobile outreach flu vaccination to eligible Pacific. This proved to work well.

Winter wellness initiatives were delivered in the community targeting Māori and rural communities. The initiatives were planned and delivered collaboratively by key stakeholders such as the Māori health service providers, Pasifika o Wairarapa, Tū Ora, the District and communities involved.

Community pharmacies also performed an important role in the delivery of flu vaccine, MMR and COVID-19 vaccine. Their involvement and willingness to support the delivery of immunisation service has improved access to vaccination and contributed greatly to the improvement of the immunisation coverage for the Wairarapa.

Overall, our Immunisation Service through the Immunisation Operations Group which has representative from key stakeholders worked collaboratively to improve immunisation rate and prioritise closing the equity gap for Māori, Pacific and vulnerable communities. The Immunisation Operations Group identifies issues and challenges and developed mitigating strategies to improve immunisation rate through a holistic whānau approach.

The collaborative approach between the Immunisation Coordination Service, Pacific Health Navigator and the Director of Pacific Peoples to identify and capture Pasifika families with children due or overdue for immunisation worked well. This model is being replicated with Maori whānau who are disengaged with the health services.

As evident, despite the complexities brought on by the COVID-19 pandemic, our primary care sector, OIS and the COVID-19 vaccination team supported, delivered and looked for ways to improve immunisation service in the Wairarapa; this must be acknowledged.

Population based screening services in the Wairarapa continue to be a challenge reaching the overall coverage target of 80% for cervical screening, 70% for breast screening and other specific targeted rates for priority populations. Regional Screening Services in partnership with Tū Ora Compass Health, are focusing on engaging eligible Māori and Pacific women into the screening pathway and or to Colposcopy Services within the community. Clear referral processes are established along with increased collaboration with General Practices

and stakeholders within the Wairarapa region. There is an increase in enrolments into the BreastScreen Aotearoa (BSA) program as a result of the PHO data matching. Regional Screening Services are establishing a fixed mammography screening site in Masterton with the site expected to be operational June/July 2023. This will give a year round service that is in the community serving Maori, Pacifica and disability women.

Output Class: Early Detection & Management Services

Description

Early detection and management services are delivered by a range of health and allied health professionals in private, not-for-profit and government service settings. These services include general practice, community and Māori health services, Pharmacist services, Community Pharmaceuticals and child and adolescent oral health and dental services. These services are by nature more generalist, and are focused on individuals and smaller groups of individuals.

Outputs

***Primary care services*:** are offered in local community settings by teams of general practitioners (GPs), registered nurses, nurse practitioners, and other primary health care professionals, aimed at improving, maintaining, or restoring health. These services keep people well by intervening early to detect, manage, and treat health conditions (e.g. health checks), providing education and advice so people can manage their own health, and reaching those at risk of developing long-term or acute conditions.

***Oral health services*:** are dental services provided to children (pre-school, primary school and intermediate school children) and adolescents (year 8 up to their 18th birthday) by registered oral health professionals to assist people in maintaining healthy teeth and gums.

Pharmacy services: include the provision and dispensing of medicines, and are demand-driven. Community pharmacies provide medicine management to people living in the community. Medication management is particularly important to ensure people are able to obtain optimal benefit from the medicines they have been prescribed.

How we measure the performance of our Early Detection and Management services:

Outputs measured by	Type of Measure	MOH Indicator	Target/Est. 2021/22	Baseline	Baseline data date	20/21 Performance	21/22 Performance	Achievement
Primary Care services / Long term conditions management								
Newborn enrolment with General Practice	C	CW07	≥85%	Total 92.9% Māori 74.0% Other 105%	Dec-20	95.6% 90.0% 98.2%	90.1% 75.0% 96.1%	Achieved Not Achieved Achieved
Percentage of DHB-domiciled population enrolled in a PHO.	C	WPI	All ethnicities 100%	Total 97% Maori 93% Pacific 96% Other 98%	Jan-21	97.3% 92.1% 96.2% 98.6%	96.2% 91.2% 97.7% 97.4%	Not Achieved
ASH Rates (avoidable hospitalisations) for 0-4 years (rate per 100,000)	Q	WPI	Total ≤ 4,000 Māori ≤ 4,000 Other ≤4,000	Total 4,323 Māori 4,574, Other 4,208	12 months to Sep 2020	4488 4421 4488	4652 5417 4237	Not Achieved
ASH Rates (avoidable hospitalisations) for 45-64 years	Q	SS05 (WPI)	Total ≤ 3,000 Māori ≤ 5,000 Other ≤2,500	Total 3,203 Māori 5,548 Other 2,883	12 months to Sep 2020	3347 5756 2994	3082 5669 2696	Not Achieved
Percentage of DHB-domiciled population (15-74 yrs) enrolled in a PHO with well managed diabetes (HbA1c ≤ 64 mmol/mol)	C	SS13 FA2	≥60%	Total 59% Māori 53% Pacific 58% Other 61%	2020/21 Q2	64.0% 57.4% 60.9% 66.3%	63.1% 53.2% 63.0% 66.1%	Achieved Not Achieved Achieved Achieved
Oral health								
Children Carries Free at 5 years of age	Q	CW01 (WPI)	Total ≥68%	Total 67% Māori 41% Pacific 45% Other 77%	2020/21 Q3	66.9% 40.8% 45.5% 76.9%	70.2% 52.3% 69.2% 77.9%	Achieved Not Achieved Achieved Achieved
Mean DMFT (Decayed, Missing, Filled Teeth) score at school year 8. (This is the average number of decayed, missing or filled teeth per person at school yr 8)	Q	CW02 (WPI)	Total <0.51	Total 0.54 Māori 0.99 Pacific 0.08 Other 0.37	2020/21 Q3	0.54 0.99 0.08 0.37	0.53 0.83 0.50 0.40	Not Achieved Not Achieved Achieved Achieved
Percentage of children under 5 years enrolled in DHB-funded dental services.	C	CW03	≥95%	Total 92% Māori 83% Pacific 81% Other 98%	2020/21 Q3	92.2% 83.3% 81.1% 97.6%	92% 83% 81% 98%	Not Achieved Not Achieved Not Achieved Achieved

Commentary

Primary Care Services / Long term conditions management

Newborn Enrolments

We note specifically this target has not been achieved for Māori. There has been reduced capacity in Primary Care which has been impacted by the following factors;

- Growing populations in Wairarapa
- Complex health needs noted across the region
- Health workforce shortage. These shortages are not exclusive to the Wairarapa and are currently being experienced globally within the health system. Unfortunately the challenges are compounded in Wairarapa which is a rural/provincial area with aging GP workforce is our biggest challenge currently.

This has resulted in a significant number of unenrolled people. To address this issue we have;

- developed a mechanism whereby unenrolled people can receive GP services
- Adopted Practice Plus as an option for telephone consults which link back to GP practices
- Working with the PHO and Primary Care to develop mechanisms to address enrolment limitations – Increasing capacity.
- In response to workforce challenges impacting on enrolment status, Tu Ora has partnered with Employment Plus which is a dedicated recruitment service specifically focused on supporting Wairarapa recruitment. This partnership was in response to feedback received from Practices who continue to struggle with recruit. The aim for Tu Ora has been to alleviate some of the recruitment challenges faced by our practices.
- Tu Ora has a number of workforce workstreams which we are hopeful will address some of the capacity issues over the coming years. Most workstreams are medium to long term projects.
- It is important to note that newborns are priorities are part of any waiting list system that practices have in place when their books are closed. Newborns are routinely enrolled when a parent has enrolment status at a practice. To ensure important childhood immunisations are not delayed as a result of non-enrolment, the Tu Ora NIR coordinator is responsible for monitoring all immunisation milestones of babies born within the district. Any outstanding or overdue immunisations are referred to OIS to ensure timely immunisation.

DHB Domiciled PHO enrolled Diabetes/Long Term Conditions

For the total population this target has been achieved, however we note for Māori it has not.

Work over the last quarter has been focused on establishing new community workforce development initiatives. This is part of a wider goal of Māori development. The new Tu Ora programme is centred around supporting our Wairarapa Māori and Pacific health workforce in diabetes management, self-management tools, and increasing health literacy. The first education forum is scheduled for 10/11 August 2022.

PHO have been working with Wairarapa DHB and Featherston Medical supporting the implementation of their Haumanu project. This is providing coaching and support to patients for lifestyle changes to reduce the burden of type 2 diabetes. It aims to equitably distribute resource to community affected by type 2 diabetes to help manage, or reverse their type 2 diabetes diagnosis. This intervention is split into two arms; moderate carbohydrate healthy diet and low carb high fat diet. Of the 63 patients enrolled in the programme, 36 patients have reduced their HbA1C and 20 have reduced their diabetes medication. It is hoped this programme might be rolled out within other Wairarapa GP practices into 2023.

A respiratory wellness programme commenced in quarter 1 2022/23. This service continues to be promoted and further service development work is underway in quarter 2 22/23.

Primary Care has struggled to put a lot of time into growing the Diabetes and other Long Term Conditions with continuing capacity issues, other than seeing patients who attend their practice when unwell. This is due to the continued impact of COVID-19 in the first half of this quarter and in addition the Flu. These two situations are compounded by the continuing GP and Practice Nurse shortages affecting Primary Care. This has been further compounded with sickness in Primary Care of their staff.

Health Care Home

Due to ongoing demands of COVID-19 surges, flu season and significant workforce constraints, progression in some planned HCH activities has been a challenge for practices to complete. In response to this we have;

- Expanded on an extended care team with the introduction of the Clinical Assistant role, implemented to support the GPs manage their inbox. The role has developed and other tasks have included streamlining processes, patient recalls and audits on missing patient lists.
- Practice Plus is implemented in 6 HCH practices.
- Prioritise and focus on Proactive Care; ongoing development of the care planning tool is nearing its final stages. The Hauora Care Planning tool will enable clinicians and extended workforce to streamline the process in engaging with patients to develop a patient-centred holistic care plan.

The Clinical Assistant role continues to progress. Last quarter we held the 2 day bootcamp to kick off the pilot and have held monthly peer groups which assist in the development of the role, provides peer support, and provides our team with valuable feedback. There has been more interest in the role from practices within our network as well as external interest. For this reason, we will be holding another Clinical Assistant bootcamp in quarter one. An abstract was submitted and accepted for the GP Conference which takes place in July.

What About You? – Alcohol, Drug and Mental Wellness Campaign

Tū Ora Wairarapa is working with Te Hiringa Hauora (HPA) to support the 'What about you?' alcohol, drug and mental wellness campaign. Particular focuses are supporting alcohol sponsorship replacement and culture change with Wairarapa Bush Rugby Union (WBRU), working with Iwi, Pasifika and youth as well as continuing to support the campaign network partners. Planned activities have included, culturally appropriate co-designed resources with individual groups, social media tiles developed for community events such as Matariki to support messaging, tailored activity sessions on wellbeing, representation from community groups added to the campaign network, information incorporated into health curriculum for year 7-8 students.

Self-Management Courses

Due to COVID-19 and increasing cases it has not been possible to run our group self- management courses this year (January to June 2022). We have committed resource to a review and stocktake of Wairarapa self-management services. Initial planning for this has occurred during May/June 2022. The review will occur over the months July to November 2022 with a report of recommendations produced in January 2023. The stocktake and report on self-management services across the Wairarapa aims to identify and discover:

- Processes within current programmes and services that are working as effective self-management tools.
- Which services meet the needs of Māori and Pasifika
- With the services that do not meet the needs of Māori and Pasifika can they be altered to be more appropriate

- Are referral pathways and services clear
- Do people know what services/support is available to them
- Does the workforce require skill development
- Are new models of self-management services required? If yes, what could they look like?
- What resources are available and required for self-management services

Palliative Care

A series of palliative care education sessions was planned to be held, but currently primary care workload pressures prevent us from doing this. We will set this up once we have managed to increase workforce.

The communication difficulty continues with no quick and/or direct communication channels between Wairarapa District Health Board Kahukura staff and primary care clinicians. Further discussion is needed in this area to agree on a solution. However, there is still general understanding of the Gold Standards Framework (GSF) model and for all referrals into the palliative register GPs have to use the GSF coding to indicate prognosis/acuity.

Six of the seven practices have established regular palliative MDT meetings, but recently three have had to abandon the meetings due to workload/workforce pressures.

Four case reviews have been conducted and the following improvement opportunities have been identified:

- Reinforcement of the referral guidance that emphasises the GP as main provider of palliative care
- Consideration of the adoption of a policy regarding administration of subcutaneous fluids in a palliative patient
- Production of a bowel care guideline for the palliative nursing team and that will be rolled out to nursing homes. Bowel care education provided to palliative nursing team
- Identification in all primary care practices of a fast method to contact GPs regarding palliative patients
- Development of a clear response to out of hours requests for assistance by patients not known to the palliative nursing team

There is to be a full-service review of the Wairarapa palliative care services commencing in August and the Tū Ora Palliative GP Liaison is on the review group.

Oral Health Services

All new-born babies are enrolled at birth and the Kaiawhina phones them before 6 months to give relevant oral health information. We changed from the old face to face system as parents were uncomfortable coming in groups during these times of COVID-19 infection possibility.

With the COVID-19 cases showing no sign of abating we have concentrated on our low decile schools to ensure they were seen first during this 12 months.

We are routinely applying fluoride to children at each revision unless it is not appropriate or the parent wishes the child not to have it.

We are transferring all year 9 children to the Community Dental Agreement service providers and our adolescent co-ordinator actively follow up with private practices to ensure the attendance of adolescents.

Pharmacy Services

The 2021/22 year continued to prove challenging for community pharmacies. While supply chain disruptions were somewhat less than the previous year, they still had an impact. Significant workforce limitations affecting the whole country added to the strain for pharmacies but they still responded to requests to provide even more services in 2021/22. Community pharmacies provided 9% more influenza vaccinations in 2021/22 than in 2019/2020 when record high numbers of people were vaccinated.

In addition to their existing dispensing and advice workload, pharmacies provided the majority of the COVID-19 vaccinations so now exceed general practice provision. This took some of the strain from general practice. In addition pharmacies made a significant contribution by providing COVID-19 care in the community in the form of:

- deliveries to people with COVID-19 isolating at home
- patient assessment and provision of anti-viral medication to people diagnosed with COVID-19
- distribution of Rapid Antigen Testing kits to households with COVID-19 symptoms
- supervised testing of people with COVID-19 symptoms (verify the timing of this).

A clinical pharmacist service started in 2021/22 based in two general practices with a focus on older people. He undertook 256 medication reviews of older patients that were frail or at risk of falls. The pharmacist also undertook medication reviews of people referred by GPs and answered many ad-hoc questions about medications, including optimal medications for diabetes management, since it places such a high disease burden on patients. Approval of funding for a second pharmacist (with recruitment underway) will enable a focus on improving equity by examining underuse of medication in the community, for example in people not regularly taking medication that would enable better control of their diagnosed long term conditions.

Output Class: Intensive Assessment & Treatment Services

Description

Intensive assessment and treatment services are delivered by a range of secondary, tertiary providers using public funds. These services are usually integrated into facilities that enable co-location of clinical expertise and specialised equipment, such as a hospital. These services are generally complex and provided by health care professionals that work closely together. On a continuum of care, these services are at the complex end of treatment services and focused on individuals.

They include:

- Ambulatory services (including outpatient, district nursing and day services) across the range of secondary preventive, diagnostic, therapeutic and rehabilitative services
- Inpatient services (acute and elective) including diagnostic, therapeutic and rehabilitative services
- Emergency department services including triage, diagnostic, therapeutic and disposition services.

Medical and surgical services: Unplanned hospital services (Acute services) are for illnesses that have an abrupt onset and are often of short duration and rapidly progressive, creating an urgent need for care. Hospital-based acute services include emergency departments, short-stay acute assessments and intensive care services. Planned services (elective surgery) are services for people who do not need immediate hospital treatment and are 'booked' services. This also includes non-medical interventions (coronary angioplasty) and specialist assessments (first assessments, follow-ups, or preadmission assessments).
Cancer services: include diagnosis and treatment services. Cancer treatment in the sub-region is delivered by the Wellington Blood and Cancer Centre.

Mental health and addiction services: Specialist Mental Health Services are services for people who are most severely affected by mental illness or addictions and include assessment, diagnosis, treatment and rehabilitation, as well as crisis response when needed and as required under the Mental Health Act. Currently the expectation established in the National Mental Health Strategy is that specialist services (including psychiatric disability services) will be available to 3% of the population. Utilisation rates are monitored across age groups and ethnicities to ensure service levels are maintained and to demonstrate responsiveness.

How we measure the performance of our Intensive Assessment & Treatment Services

Outputs measured by	Type of Measure	MOH Indicator	Target/Est. 2021/22	Baseline	Baseline data date	20/21 Performance	21/22 Performance	Achievement
Mental Health and Addiction services								
Percentage of patients referred to non-urgent mental health services & seen within 8 weeks.	T	MH03	≥95%	87.70%	2020/21 Q2	New measure in 21/22	93.28%	Not Achieved
Percentage of patients referred to non-urgent Addiction services & seen within 8 weeks.	T	MH03	≥95%	98.40%	2020/21 Q2	New measure in 21/22	98.56%	Achieved
Percentage of clients with transition (discharge) plan	C	MH02	≥95%	50%	2020/21 Q2	51.0%	57.0%	Not Achieved
Percentage of people discharged from an acute mental health inpatient service that were seen by the mental health community team in the 7 days following discharge.	Q	WPI	≥90% (Nat'l ≥90%)	78.10%	2020/21 Q3	New measure in 21/22	74.70%	Not Achieved
Elective and Acute (Emergency Dept.) inpatient/outpatient								
Number of surgical elective discharges.	V	SS07 (PCM1)	≥3,404	2,276	2020/21 Q2	4,181	2,023	Not Achieved
Percentage of patients admitted, discharged or transferred from ED within 6 hours.	T	SS10	≥95%	91.30%	2020/21 Q2	90.7%	77.7%	Not Achieved
Standardised inpatient average length of stay ALOS (Acute).	T	WPI	≤2.35	2.66	2020/21 Q2	2.43	2.53	Not Achieved
Standardised inpatient average length of stay ALOS (Elective).	T	WPI	≤1.45	1.47	2020/21 Q2	1.31	1.30	Achieved
Standardised Acute Readmissions	Q	SS07 (PCM6)	Total ≤10.5%	Total 10.9% Māori 10.2%	2020/21 Q2	11.2% 11.9%	10.7% 10.7%	Not Achieved Not Achieved
Quality and safety								
Rate of inpatient falls causing harm per 1,000 bed days.	Q	WPI	≤0.15	0.19	2020/21 Q3	0.19	0.15	Achieved
Rate of hospital acquired pressure injuries per 1,000 bed days.	Q	WPI	≤0.15	0.17	2020/21 Q3	0.62	0.76	Not Achieved
Rate of identified medication errors causing harm per 1,000 bed days.	Q	WPI	≤0.05	0.08	2020/21 Q3	0.05	0.05	Achieved
Percentage Did Not Attend (DNA) appointments for outpatient First Specialist assessments.	Q	WPI	≤8%	8.20%	2019/20	6.6%	8.62%	Not Achieved
Percentage DNA appointment for follow-up Specialist appointments.	Q	WPI	≤6%	6.50%	2019/20	4.5%	7.42%	Not Achieved

Outputs measured by	Type of Measure	MOH Indicator	Target/Est. 2021/22	Baseline	Baseline data date	20/21 Performance	21/22 Performance	Achievement
Patient experience (Note: the Patient Experience Survey format changed during the year meaning the original planned measures no longer exist. The following is an extract from the System Level Measures Performance Dashboard which replaced the original Patient Experience Survey)								
Primary Care survey								
In the last 12 months, was there ever a time when you wanted health care from a GP or nurse, but you couldn't get it?	Q	WPI	77.4%	75.9%	Aug-21	New measure in 21/22	76.4%	Not Achieved
Did the health care professional involve you as much as you wanted to be in making decisions about your treatment and care?	Q	WPI	89.9%	88.1%	Aug-21	85.9%	79.5%	Not Achieved
Adult Inpatient survey								
Were you involved as much as you wanted to be in making decisions about your treatment and care?	Q	WPI	85.3%	83.6%	Aug-21	81.4%	77.8%	Not Achieved
Did hospital staff include your family/whānau or someone close to you in discussions about the care you received during your visit?	Q	WPI	76.5%	75.0%	Aug-21	84.8%	66.7%	Not Achieved
Did you have enough information about how to manage your condition or recovery after you left hospital?	Q	WPI	69.6%	68.2%	Aug-21	80.0%	70.3%	Achieved
Were you told the possible side effects of the medicine (or prescription for medicine) you left hospital with, in a way you could understand?	Q	WPI	63.4%	62.2%	Aug-21	75.0%	65.1%	Achieved
Cancer services								
Percentage of patients receiving their first cancer treatment (or other management) within 31 days from date of decision-to-treat.	T	SS01	≥85%	93%	2020/21 Q2	88.3%	86.6%	Achieved
Percentage of patients with a high suspicion of cancer and a need to be seen within 2 weeks that received their first cancer treatment (or other management) within 62 days of being referred.	T	SS11	≥90%	93%	2020/21 Q2	88.6%	88.1%	Not Achieved

Commentary

Quality

The Inpatient Falls (causing harm Severity Assessment Code or SAC 1-3) target was achieved. Patient falls are acknowledged as a high area of harm. Falls are complex and falls prevention is everyones business. The need to strengthen the post fall pathway and putting a spotlight on falls prevention has been identified. A new 0.1 FTE fixed term position to assist with strengthen strategies is due to commence in December 2022.

The Pressure Injuries (Hospital acquired) target was not achieved. The DHB is actively participating in the HQSC Pressure Injury Quality Safety Marker Programme. The combined Pressure Injury and Falls Prevention Committee has multi-disciplinary membership and now meets monthly to provide oversight and governance of the prevention programmes. Trends form part of pre reading data for the Committee monthly meetings which report through to the Clinical Board. The ACC funded pressure injury prevention project continues with monthly meetings between the DHB and with ACC. Weekly clinical lead input with clinical area pressure injury prevention champions for 0.1 FTE due to commence in January 2023.

The Medication Errors (causing harm Severity Assessment Code or SAC 1-3) target was achieved. Encouragement to report errors continues to ensure learning occurs from events and auditing of prescribing continues.

Mental health and addiction services

The Wairarapa Mental Health Service across all age groups continues to experience vacancies within a number of roles across adult and child/youth service, despite an energised effort to recruit. Location and local available workforce with appropriate skills appears to be the main contributor to this with medical staff recruitment particularly challenging. The shortfall in medical cover has resulted in numerous cancellations of routine client clinic work and in conjunction with COVID-19 restrictions the service focus has prioiritised crisis interventions. The sub-regional model of mental health delivery has resulted in leveraging additional medical time including assessments via Zoom in order to mitigate against delays.

With the re-introduction of a single Mental Health and Addictions service development manager role supporting the mental health and addiction portfolio within the Wairarapa, there has been a great deal of opportunity to consider the current service provision and engage with providers regarding potentials for service development. We have been able to identify areas in youth, older persons and addiction services in particular that have had investment in order to improve outcomes in the local community. We are reviewing of our crisis respite facility with a goal of formulating a business plan aimed at reproviding the service in a community setting in line with best practice models across the country.

During 2022 the mental health nurse educator role has been filled and is showing very positive signs in terms of engagement and support for frontline ED staff

Finally, we have commenced work on collaborative co-design process funded by MoH to support transformational development of MHS across the Wairarapa. Formation of consumer groups across all age groups is key to this and we have some improved involvement to support this activity.

Medical and surgical services

2021/22 Emergency Department presentations remain consistent this year with the previous 12 months by volume however the average treatment time in Emergency Department has extended. COVID-19 screening and constrained access to primary care has meant treatment times have increased with more complex chronic conditions and screening precautions adding to workloads in the department. Only two practices in South Wairarapa are accepting new patients whilst all practices in Masterton remain to have substantively closed books for new enrolments. Reduced staffing due to nursing vacancies and unprecedented sickness and absenteeism has meant 6 hour waiting time targets have declined sharply in the last 12 months. This is consistent with results from other Emergency departments around the country. Vacancies and recruitment challenges for Orthopaedic Surgeons has led to the reduction of onsite Orthopaedic Services with some work transferred to neighbouring districts. Joint appointments with neighbouring hospitals are being advanced to rebuild the Orthopaedic Surgeon workforce onsite. Whilst additional capacity lost due to these vacancies has been diverted to other specialities the resulting total elective surgical discharges have reduced compared to previous years. The major contributor to these reduced volumes were the extended periods of lock down and impacts of COVID-19 upon surgical management of cases in a hospital setting. Readmission rates were only marginally above the target and elective LOS goals were achieved. Acute ALOS were impacted by reduced access to Aged Residential Care beds for transferring patients increasing the facilities overall Acute ALOS .

Cancer services

The DHB overall average performance against the 62 day target of 90% for the 2021/22 year was slightly below target at 88.1%. The service has achieved the 31 day target with an annual performance of 86.6% compliance against the target of 85%. Performance in both measures has been impacted by the COVID-19 response however it was pleasing to exceed one target and be very close to the other over the course of the year. The focus is to continue to fast track patients and to meet the MOH targets when capacity allows.

Output Class: Rehabilitation & Support Services

Description

Rehabilitation and support services provide people with the support that they need to maintain their independence, either temporarily while recovering from illness or disability, or over the rest of their lives. Rehabilitation and support services are provided mostly for older people, mental health clients, and clients with complex health conditions. A 'needs assessment', coordinated by Needs Assessment and Service Coordination (NASC), determines which services a person may require.

These services may be provided at home, as personal care, community nursing, or community services. Alternatively, people may require long- or short-term residential care, respite, or day services. Support services also include palliative care services for people who have end-stage conditions. Rehabilitation and support services may be delivered in coordination with other organisations and agencies, and may include public, private, and part-funding arrangements.

Outputs

Disability services: Many disability services are accessed through a Needs Assessment and Service Co-ordination (NASC) service. NASCs are organisations contracted to the Disability Support Services, which work with disabled people to help identify their needs and to outline what disability support services are available. They allocate Ministry-funded support services and assist with accessing other supports.

Health of older people services: These are services provided to enable older people to live as independently as possible and to restore functional ability. Services are delivered in specialist inpatient units, outpatient clinics and also in home and work environments. Specialist geriatric and allied health expertise and advice is also provided to GPs, home and community care providers, residential care facilities and voluntary groups.

How we measure the performance of our Rehabilitation & Support services

Outputs measured by	Type of Measure	MOH Indicator	Target/Est. 2021/22	Baseline	Baseline data date	20/21 Performance	21/22 Result	Achievement
% People > 75 living in their own home	C	SS04 (WPI)	≥92%	92%	2020/21 Q2	92%	93%	Achieved
Standardised acute readmission rate for people >75 years of age	C	SS04 (WPI)	Total ≤ 12% Māori ≤12%	Total 12.6% Maori 11%	2020/21 Q2 2020/21 Q2	12.6% 14.1%	11.6% 10.9%	Achieved
Rate of hip (neck of femur) fractures due to an out of hospital fall per 1,000 people >50 years of age	C	WPI	Total ≤0.7500 per 1,000 population	0.7483	2020/21 Q2	0.8447	1.1308	Not Achieved
% people who have received a LTCF residing in ARC or Residential Facilities within timeframes	Q	SS04 (WPI)	≥95%	96%	2020/21 Q2	New measure in 21/22	93%	Not Achieved
% of residential care providers being awarded 3-year (or more) certification in the planned year	Q	WPI	100%	100%	2020/21 Q2	100%	92%	Not Achieved

Commentary

Health of older people services

The proportion of older people receiving DHB support funding who are being supported to live at home is in line with our strategy and achieves the target.

Falls in the community have increased. We have a new Falls Co-ordinator who has worked with GPs, the NASC and Allied Health services to streamline falls risk and interventions amongst the elderly in the community, and we have seen the rate of falls overall slow.

InterRAI time frames reflect the lask of RN avaiableity in ARC and is a national issue.

Ten of eleven ARC facilities have achieved certification for three years or more. One facility had a two year certification. The facility with two years certification will be re audited 2023.

Financial Statements

CONTENTS

Statement of Responsibility

For the 12 months ended 30 June 2022

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

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

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

We are responsible for any end-of-year performance information provided by the Wairarapa DHB under section 19A of the Public Finance Act.

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

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

Signed on behalf of the Te Whatu Ora Board:

Naomi Ferguson

Acting Chair

Dated: 6 March 2023

Hon Amy Adams

Board member

Dated: 6 March 2023

Independent Auditor's Report

To the readers of Wairarapa District Health Board's financial statements and performance information for the year ended 30 June 2022

The Auditor-General is the auditor of Wairarapa District Health Board (the Health Board). The Auditor-General has appointed me, John Whittal, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and the performance information, including the performance information for an appropriation, of the Health Board on his behalf.

We have audited:

- the financial statements of the Health Board on pages 64 to 96, that comprise the statement of financial position as at 30 June 2022, the statement of comprehensive income and expense, statement of changes in net equity and statement of cash flows for the year ended on that date, and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Health Board on pages 16 to 28 and 30 to 56.

Opinion

In our opinion, the financial statements of the Health Board on pages 64 to 96, which have been prepared on a disestablishment basis:

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

The performance information of the Health Board on pages 16 to 28 and 30 to 56:

- presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2022, including:
    - for each class of reportable outputs:
        - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and

- its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and

- what has been achieved with the appropriation; and

- the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and

- complies with generally accepted accounting practice in New Zealand.

Our audit was completed late

Our audit was completed on 6 March 2023. This is the date at which our opinion is expressed.

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

Basis for our opinion

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

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

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

Emphasis of matters

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

The financial statements have been prepared on a disestablishment basis

The Basis of preparation on page 69 outlines that the Health Board has prepared its financial statements on a disestablishment basis because the Health Board was disestablished, and its functions transferred to Te Whatu Ora – Health New Zealand on 1 July 2022. There have been no changes to the values of the Health Board's assets and liabilities as a result of preparing the financial statements on a disestablishment basis.

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

The information on pages on pages 17 to 28 outlines the information used by the Health Board to report on its Covid-19 vaccine coverage. The Health Board uses the Health Service User (HSU) population data rather than the population data provided by Statistics New Zealand (Stats NZ), for the reasons set out on pages 24 and 25. The notes on page 25 outlines that there would be differences in the reported results for the overall population if the Stats NZ population data was

used. There would be further differences in the reported results of vaccination coverage if the Stats NZ population data is classified by ethnicity and age. The Health Board has provided a table that highlights the differences in the ethnicity groupings between the HSU population data and the Stats NZ population data.

Impact of Covid-19

Note 22 on page 96 to the financial statements and page 33 of the performance information, which outlines the ongoing impact of Covid-19 on the Health Board.

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

Note 13 on pages 86 to 88, which outlines that the Health Board has been investigating issues with the way it calculates holiday pay entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues. The matters are complex and have resulted in underpayments of holiday pay to current and past employees over a number of years. The Health Board has estimated a provision of $16.8 million, as at 30 June 2022 to remediate these issues. However, until the process is completed, there are uncertainties surrounding the amount of this provision.

Seismic status of main hospital building

Note 10 on page 81 outlines the seismic status of the Health Board's main hospital building, the basis used to fair value the building at 30 June 2022, and future decisions about remediation to a higher level of New Build Standards that may impact the carrying value of the building in coming years.

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

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

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

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

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

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

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

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit carried out in accordance with the Auditor General's Auditing Standards will always detect a material misstatement

when it exists. Misstatements are differences or omissions of amounts or disclosures, and can arise from fraud or error. Misstatements are considered material if, individually or in the aggregate, they could reasonably be expected to influence the decisions of readers taken on the basis of these financial statements and the performance information.

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

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

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

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

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

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

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

- We conclude on the appropriateness of the use of the disestablishment basis by the Board of Te Whatu Ora.

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

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

Our responsibilities arise from the Public Audit Act 2001.

Other Information

The Board of Te Whatu Ora is responsible for the other information. The other information comprises the information included on pages 1 to 96, but does not include the financial statements and the performance information, and our auditor's report thereon.

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

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

Independence

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

Other than the audit, we have no relationship with, or interests in, the Health Board.

John Whittal
Audit New Zealand
On behalf of the Auditor-General
Wellington, New Zealand

Statement of Comprehensive Revenue and Expenses

For the year ended 30 June 2022

	Note	Budget 2022 $000	Actual 2022 $000	Actual 2021 $000
Revenue				
Patient care revenue	2	203,669	221,996	191,613
Interest revenue		69	124	62
Other revenue	2	5,327	5,288	5,297
Total revenue		**209,065**	**227,408**	**196,972**
Expenditure				
Personnel costs	3	53,718	67,689	50,722
Outsourced services		10,212	13,390	15,909
Clinical supplies		12,700	11,480	12,591
Infrastructure and non-clinical expenses		9,355	13,395	9,260
External providers		66,139	69,145	61,111
Inter district flows		53,015	55,790	45,151
Capital charge	4	1,358	1,186	1,424
Interest expense		0	0	0
Depreciation and amortisation expense	10, 11	2,937	5,342	2,564
Impairment expense	10, 11	0	0	1,494
Other expenses	5	1,731	2,053	1,852
Total expenses		**211,165**	**239,470**	**202,078**
Surplus/(deficit)		**(2,100)**	**(12,062)**	**(5,106)**
Other comprehensive revenue and expense				
Item that will not be reclassified to surplus/(deficit)				
Revaluation of land and building	15	2,100	16,844	0
Total other comprehensive revenue and expense		**2,100**	**16,844**	**0**
Total comprehensive revenue and expense		**0**	**4,782**	**(5,106)**

The accompanying notes form part of the financial statements. Explanations of major variances against budget are provided in note 20..

Statement of Financial Position

As at 30 June

	Note	Budget 2022 $000	Actual 2022 $000	Actual 2021 $000
Assets				
Current assets				
Cash & cash equivalents	6	767	5,846	4,750
Receivables	7	5,370	10,320	6,473
Prepayments		230	796	260
Investments	8	83	0	84
Inventories	9	1,100	768	993
Total current assets		7,550	17,730	12,560
Non-current assets				
Property, plant & equipment	10	50,795	62,968	45,290
Intangible assets	11	5,748	2,288	4,794
Total non-current assets		56,543	65,256	50,084
Total assets		64,093	82,986	62,644
Liabilities				
Current liabilities				
Payables and deferred revenue	12	15,055	18,876	18,382
Employee entitlements	13	20,035	29,815	18,646
Total current liabilities		35,090	48,691	37,028
Non-current liabilities				
Employee entitlements	13	566	458	531
Restricted Funds	14	91	35	91
Total non-current liabilities		657	493	622
Total liabilities		35,747	49,184	37,650
Net assets		28,346	33,802	24,994
Equity				
Crown equity	15	105,267	107,595	103,569
Revaluation reserve	15	13,334	28,078	11,234
Retained earnings	15	(90,255)	(101,871)	(89,809)
Total equity		28,346	33,802	24,994

2022

The accompanying notes form part of the financial statements. Explanations of major variances against budget are provided in note 20.

Statement of Changes in Equity

For the year ended 30 June 2022

	Note	Budget 2022 $000	Actual 2022 $000	Actual 2021 $000
Balance at 1 July		**26,646**	**24,994**	**30,103**
Net surplus / (deficit) for the year		(2,100)	(12,062)	(5,106)
Other comprehensive revenue and expense		2,100	16,844	0
Total comprehensive revenue and expense		0	4,782	(5,106)
Equity injection from the Crown		1,700	4,029	0
Repayment of equity to the Crown		0	(3)	(3)
Movements in equity for the year		1,700	4,026	(3)
Balance at 30 June	15	**28,346**	**33,802**	**24,994**

The accompanying notes form part of the financial statements. Explanations of major variances against budget are provided in note 20.

Statement of Cash Flows

For the year ended 30 June 2022

	Budget 2022 $000	Actual 2022 $000	Actual 2021 $000
Cash flows from operating activities			
Operating receipts:			
Government & crown agency revenue	204,062	218,752	191,461
Other	5,364	4,438	5,281
Interest received	69	110	61
Payments to suppliers & employees	(207,392)	(221,323)	(194,334)
Capital charge paid	(1,358)	(1,186)	(1,424)
Goods and Services Tax (net)	(131)	2	144
Net cash flows from operating activities	614	793	1,189
Cash flows from investing activities			
Increase in investment	0	28	7
Proceeds from sale of property, plant & equipment	0	777	60
Acquisition of property, plant & equipment	(5,688)	(3,290)	(1,789)
Acquisition of intangible assets	(609)	(1,238)	(634)
Net cash flows from investing activities	(6,297)	(3,723)	(2,356)
Cash flows from financing activities			
Equity injected	1,700	4,029	0
Repayments of loans	0	0	0
Repayment of equity	0	(3)	(3)
Net cash flows from financing activities	1,700	4,026	(3)
Net increase / (decrease) in cash & cash equivalents	(3,983)	1,096	(1,170)
Cash & cash equivalents at beginning of year	4,750	4,750	5,920
Cash & cash equivalents at end of year	767	5,846	4,750

Reconciliation of net deficit to net cash flow from operating activities

	Actual 2022 $000	Actual 2021 $000
Net surplus / (deficit)	(12,062)	(5,106)
Add/(less) non-cash items		
Depreciation and amortisation expense	5,342	2,564
Impairment of Intangibles	0	1,494
Net movement in non-cash items	5,342	4,058
Add/(less)items classified as investing or financing activities		
Net (gains)/losses on disposal of property, plant & equipment	(398)	(60)
Net movement in investing or financing activities	(398)	(60)
Add/(less) movements in statement of financial position items		
(Increase)/decrease in receivables	(3,847)	(779)
(Increase)/decrease in inventories	225	89
(Increase)/decrease in payables	972	2,719
Increase/(decrease) in prepayments	(536)	(32)
Increase/(decrease) in provisions	11,097	300
Net movement in working capital items	7,911	2,297
Net cash flow from operating activities	793	1,189

The accompanying notes form part of the financial statements. Explanations of major variances against budget are provided in note 20.

Notes to the Financial Statements for the year ended 30 June 2022

Notes Index

1. Statement of Accounting Policies

REPORTING ENTITY

Wairarapa District Health Board (the DHB) is a Crown Entity as defined by the Crown Entities Act 2004 and is domiciled and operates in New Zealand. The relevant legislation governing the DHB's operations is the Crown Entities Act 2004 and the New Zealand Public Health and Disability Act 2000. The DHB's ultimate parent is the New Zealand Crown.

The DHB's primary objective is to deliver health, disability and mental health services to the community within its district. The DHB does not operate to make a financial return.

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

The financial statements for the DHB are for the year ended 30 June 2022 and were approved for issue by the Te Whatu Ora Health New Zealand Board on 6 March 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 replace all 20 District Health Boards (DHBs) and the Health Promotion Agency with a new Crown entity, Health New Zealand (Te Whatu Ora), responsible for running hospitals and commissioning primary and community health services. The legislation enabling the reform, the Pae Ora (Healthy Futures) Act 2022 (the Act), took effect on 1 July 2022, formally creating Te Whatu Ora, along with two other entities – the Maori Health Authority, which resides within the Ministry of Health to lead and strengthen public health.

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

No changes have been made to the recognition and measurement, or presentation in these financial statements, because all assets, liabilities, functions and staff of the DHBs and shared services agencies will transfer to Health New Zealand.

Statement of compliance

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

The financial statements have also been prepared in accordance with and comply with PBE Accounting Standards.

The 2021/22 annual report of Wairarapa District Health Board was not completed by 31 December 2022, as required by section 156 of the Crown Entities Act 2004 (as amended by the Annual Reporting and Audit Time Frames Extensions Legislation Act 2021 which extended the reporting timeframes in the Crown Entities Act 2004 by two months).

Presentation currency and rounding

The financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars ($000), other than remuneration disclosed in accordance with section 152 of the Crown Entities Act 2004 in Note 3 and the related party transaction disclosures in Note 17, which are rounded to the nearest dollar.

Changes in accounting policies

There have been no changes in the DHB's accounting policies since the date of the last audited financial statements.

Standards issued and not yet effective and not early adopted

Standards and amendments, issued but not yet effective that have not been early adopted, and which are relevant to the DHB are:

PBE IPSAS 41 Financial Instruments

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

PBE FRS 48 Service Performance Reporting

PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 *Presentation of Financial Statements* and is effective for the year ending 30 June 2023, with earlier adoption permitted. The DHB has not yet determined how application of PBE FRS 48 will affect its statement of performance. It does not plan to early adopt the standard.

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.

Foreign currency transactions

Foreign currency transactions are translated into NZ Dollars (the functional currency) using the exchange rates 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 the surplus or deficit.

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

The DHB is a public authority and consequently is exempt from the payment of income tax, as a result no provision has been made for income tax.

Budget figures

The budget figures are as published in the 2021/22 Statement of Performance Expectations. The budget has been prepared in accordance with GAAP, using accounting policies that are consistent with those adopted by the Board in preparing these financial statements.

Critical accounting estimates and assumptions

In preparing these financial statements, 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 expectation of future events that are believed to be reasonable under the circumstances.

The estimates and assumption 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 10.
- Impairment of intangible assets – refer to Note 11.
- Holidays Act liability – refer to Note 13.

2. Revenue

Accounting policy

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

MoH population-based revenue

The DHB receives annual funding from the Ministry of Health (MoH), which is based on population levels within the Wairarapa DHB district.

MoH population-based revenue for the financial year is recognised based on the funding entitlement for that year.

MoH contract revenue

The revenue recognition approach for MoH contract revenue depends on the contract terms. Those contracts where the amount of revenue is substantively linked to the provision of quantifiable units of service are treated as exchange contracts and revenue is recognised as the DHB provides the services. For example, where funding varies based on the quantity of services delivered, such as number of screening tests or heart checks.

Other contracts are treated as non-exchange and 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. A condition could include the requirement

to provide services to the satisfaction of the funder to receive or retain funding. Revenue for future years is not recognised where the contract contains substantive termination provisions for failure to comply with the service requirements of the contract. Conditions and termination provisions need to be substantive, which is assessed by considering factors such as the past practice of the funder. Judgement is often required in determining the timing of revenue recognition for contracts that span a balance date and multi-year funding arrangements.

Inter-district flows

Inter district patient inflow revenue occurs when a patient treated within the DHB's district is domiciled outside of the Wairarapa. Inter-district patient inflow revenue is recognised when eligible services are provided.

ACC contract revenue

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

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.

Provision of other services

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

Donations and bequests

Donations 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.

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.

Vested or donated physical assets

For assets received for no or nominal consideration, the asset is recognised at its fair value when the DHB 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.

Donated services

Volunteer services received are not recognised as revenue or expenses by the DHB.

Breakdown of patient care and other revenue

i. Patient care revenue

	Actual 2022 $000	Actual 2021 $000
MoH population-based funding	183,187	166,653
MoH other contracts	27,828	15,218
Inter-district flows	5,614	4,852
ACC contract revenue	2,920	2,680
Other patient care related revenue	2,447	2,210
Total patient care revenue	**221,996**	**191,613**

ii. Other revenue

	Actual 2022 $000	Actual 2021 $000
Gain on sale of property, plant and equipment	436	60
Cash donations and bequests received	205	56
Rental revenue	1,489	1,471
Other revenue	3,158	3,710
Total other revenue	**5,288**	**5,297**

3. Personnel costs

Accounting policy

Salary and wages

Salary 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 other State Sector Retirement Savings Scheme are accounted for as defined contribution schemes and are recognised as an expense in the surplus or deficit as incurred.

Breakdown of personnel costs and further information

	Actual 2022 $000	Actual 2021 $000
Salaries and wages	54,895	48,956
Defined contributions plan employer contributions	1,698	1,466
Increase/(decrease) in liability for employee entitlements	11,096	300
Total personnel costs	**67,689**	**50,722**

Employee remuneration

During the year no payments, either as redundancy compensation or in equalisation payments upon completion of a service review, were paid by the DHB (2021: nil).

Board member remuneration

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

	2022 Board Fee	2022 Committees	2022 Total Fees	2021 Total Fees
Sir Paul Collins (Chairman)	34,117	2,500	36,617	35,809
Dr Tony Becker (Deputy Chair)	20,714	2,524	23,238	22,857
Leanne Southey (FRAC Chair)	16,571	3,125	19,696	19,383
Ronald Karaitiana (HAC Chair)	16,571	2,750	19,321	18,569
Joy Cooper	16,571	1,750	18,321	18,569
Yvette Grace	16,571	2,000	18,571	18,820
Dr Norman Gray	16,571	2,000	18,571	18,570
Jill Pettis	16,571	750	17,321	16,319
Helen Pocknall	16,571	1,500	18,071	18,320
Ryan Soriano	16,571	0	16,571	16,319
Jill Stringer	16,571	2,750	19,321	18,569
TOTAL	**203,970**	**21,649**	**225,619**	**222,103**

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

The DHB has effected Directors' and Officers' Liability and Professional Indemnity insurance cover during the financial year in respect of the liability or costs of Board members and employees.

No Board members received compensation or other benefits in relation to cessation (2021: $nil).

4. Capital charge

Accounting policy

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

Further information

The DHB pays a capital charge every six months to the Crown. The charge is based on the previous six months actual closing equity balance at 31 December and 30 June. The capital charge rate for the year ended 30 June 2022 was 5% (2021: 5%).

5. Other expenses

Accounting policy

Operating lease payments

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset.

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 the surplus or deficit as a reduction of lease expense over the lease term.

Breakdown of other expenses and further information

	Actual 2022 $000	Actual 2021 $000
Operating lease and rental expenses	1,572	1,436
Audit fees (Audit NZ for annual financial statements)	148	139
Audit fees (CRTAS for other assurance services)	48	64
Impairment of receivables (bad & doubtful debts)	(5)	(39)
Board member fees & expenses	252	252
Loss on disposal of property, plant and equipment	38	0
Total other expenses	**2,053**	**1,852**

Operating leases as lessee

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

	Actual 2022 $000	Actual 2021 $000
Not later than one year	732	572
Later than one year and not later than five years	989	699
Later than five years	5	20
Total non-cancellable operating leases	**1,726**	**1,291**

The DHB leases a number of buildings, vehicles and clinical equipment under operating leases.

6. Cash and cash equivalents

Accounting policy

Cash and cash equivalents includes 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 are shown within borrowings in current liabilities in the statement of financial position.

Breakdown of cash and cash equivalent and further information

	Actual 2022 $000	Actual 2021 $000
Current Assets:		
Cash on hand	6	4
Westpac account	5	(4)
Bank - BNZ / NZHP Sweep	5,835	4,750
Current Liabilities:		
Bank overdraft - BNZ / NZHP Sweep	0	0
Total cash and cash equivalents	**5,846**	**4,750**

The DHB is party to a DHB Treasury Services Agreement between New Zealand Health Partnerships Limited (NZHPL) and participating DHBs. This Agreement enables NZHPL to "sweep" DHB bank accounts and invest surplus funds on their behalf. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with NZHPL, which will incur interest at the credit interest rate received by NZHPL plus an administrative margin. The balance held by the DHB within this Agreement is shown as bank overdraft within the table above. The maximum borrowing facility available to any DHB is the value of one month's Provider Arm funding inclusive of GST. As at 30 June 2022 this limit was $7.57m (2021: $7.19 million).

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

Financial assets recognised subject to restrictions

Included in cash and cash equivalents and investments (refer to Note 8) are unspent funds with restrictions that relate to the delivery of health service by the DHB. Other than for trust funds, it is not practicable for the DHB to provide further detailed information about the restrictions. Further information about trust funds is provided in Note 14.

The carrying value of cash and cash equivalents approximates their fair value.

7. Receivables

Accounting policy

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

In measuring expected credit losses, short-term receivables have been assessed on a collective basis as they possess share 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.

Breakdown of receivables and further information

	Actual 2022 $000	Actual 2021 $000
Gross receivables	10,344	6,502
Less: Allowance for credit losses	(24)	(29)
Total receivables	**10,320**	**6,473**
Receivables consist of		
Receivables from MoH	6,495	3,814
Other receivables	1,057	1,086
Other accrued revenue	2,792	1,602
Less: Allowance for credit losses	(24)	(29)
Total receivables	**10,320**	**6,473**

	Receivables days past due				
30 June 2022	Current	1-30 days	31-90 days	More than 90 days	Total
Expected credit loss rate	0.0%	0.0%	13.3%	18.6%	
Gross carrying amount ($000)	8,686	281	1,289	88	**10,344**
Lifetime expected credit loss ($000)	-	-	4	20	**24**

	Receivables days past due				
30 June 2021	Current	1-30 days	31-90 days	More than 90 days	Total
Expected credit loss rate	0.0%	0.0%	9.5%	31.6%	
Gross carrying amount ($000)	6,231	87	90	94	**6,502**
Lifetime expected credit loss ($000)	-	-	12	17	**29**

The expected credit loss rates for receivable as at 30 June 2022 and 30 June 2021 are based on the payment profile of revenue on credit over the previous two years at the measurement date and the corresponding historical credit losses experience for that period. Given the short period of credit risk exposure, the impact of macroeconomic factors is not considered significant.

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

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

	Actual 2022 $000s	Actual 2021 $000s
Balance at 1 July	29	69
Additional provisions made/(provisions released)	(2)	(33)
Receivables written off during the year	(3)	(7)
Balance at 30 June	**24**	**29**

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.

Breakdown of investments and further information

	Actual 2022 $000	Actual 2021 $000
Current Portion		
Term deposits with maturites less than 3 months	0	84
Term deposits with maturites less than 12 months	0	0
Total investments	**0**	**84**

The DHB considers there has not been a significant increase in credit risk for investments in term deposits because the issuer of the investment continues to have low credit risk at balance date. Term deposits are held with banks that have a long-term AA- investment grade credit rating, which indicates that the bank has a strong capacity to meet its financial commitments. This facility was only used for restricted funds and is no longer being used because of the small balance of funds now held.

No loss allowance for expected credit losses has been recognised because the estimated 12-month expected loss allowance for credit losses is trivial.

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

9. Inventories

Accounting policy

Inventories held for distribution or consumption in the provision of service that are not supplied in a commercial basis are measured at weighted average cost, 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 or from cost to net realisable value is recognised in the surplus or deficit in the year of the write-down.

Breakdown of inventories and further information

	Actual 2022 $000	Actual 2021 $000
Central Warehouse	447	614
Pharmaceuticals	147	205
Surgical and medical supplies (held in Theatre and Wards)	274	274
Less: provision for obsolete stock	(100)	(100)
Total trade inventories	**768**	**993**

The amount of inventories recognised as an expense during the year was $2.59m (2021: $2.74m), which is included in the clinical supplies line item of the statement of comprehensive revenue and expense.

The write-down of inventories held for distribution amounted to $100k (2021: $100k). There have been no reversals of write-downs.

No inventories are pledged as security for liabilities (2021: $nil), however, some inventories are subject to retention of title clauses.

10. Property, plant and equipment

Accounting policy

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

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

Revaluations

Land and buildings are revalued with sufficient regularity to ensure that the carrying amount does not differ materially from fair value and at least every five years.

The carrying values of land and buildings are regularly assessed by independent valuers to ensure that they do not differ materially from fair value. If there is evidence supporting a material difference, then the asset class will be revalued.

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

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

Additions

The cost of an item of property, plant, and equipment is recognised as an asset only when it is probable that future economic benefits or service potential associated with the item will flow to the DHB and the cost of the item can be measured reliably.

Work in progress is recognised at cost less impairment and is not depreciated.

In most instances, an item of property, plant and equipment is initially recognised at its cost. Where an asset is acquired through a non-exchange transaction, it is recognised at its fair value as at the date of acquisition.

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 items will flow to the DHB and the cost of the item can be measured reliably.

The costs of day-to-day servicing of property, plant, and equipment are recognised in the surplus or deficit as they are incurred.

Disposals

Gains and losses on disposals are determined by comparing the proceeds with the carrying amount of the asset. Net gains or losses on disposals are reported in the surplus or deficit. When revalued assets are sold, the amounts included in revaluation reserves in respect of those assets are transferred to accumulated surplus or deficit in equity.

Depreciation

Depreciation is provided in 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:

Class of asset	Estimated life	Depreciation Rates
Buildings (including components)	1 to 50 years	1% - 50%
Clinical equipment	2.5 to 15 years	6.67% - 40%
Information technology	2.5 to 15 years	6.67% - 40%
Motor vehicles	5 to 12.5 years	8% - 20%
Other plant and equipment	2.5 to 15 years	6.67% - 40%

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 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.

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 mount 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 the surplus or deficit.

For assets not carried at a revalued amount, the total impairment loss is recognised in the 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 the class of asset. However, to the extent that an impairment loss for the class of asset was previously recognised in the surplus or deficit, a reversal of an impairment loss is also recognised in the surplus or deficit.

For assets not carried at a revalued amount, the reversal of an impairment loss is recognised in the surplus or deficit.

Critical accounting estimates and assumptions

Estimating the fair value of land and buildings

Wairarapa DHB engaged an Independent Registered Valuer (CBRE Limited) to revalue buildings to fair value as at 30 June 2022. The buildings are specialised and were valued using Optimised Depreciated Replacement Cost (ODRC). Optimisation is applied via replacement with modern equivalent material and construction techniques.

The valuation was completed on the basis that the main hospital building is 100% New Building Standard (NBS) on an Importance Level 4 (IL4) basis. Therefore the revalued amount represents the cost of replacing the existing the building with a modern day equivalent building of the same age.

The DHB also received a detailed seismic assessment on the 28 June 2019, which concludes that the main hospital (other than some peripheral structures that are planned to be strengthened) has met the minimum legal seismic requirements of NBS of 34%. However, it also concludes that the building would not meet its service requirements in the event of a 1 in 500 year earthquake.

The Board is confident that this issue does not affect the current operation and services provided by the Hospital, and it is considering what it can do to improve the building.

The Board has already requested additional seismic reports on the main hospital, including costs to remediate to higher levels of NBS. The outcome of this work may impact the carrying value of the buildings in coming years. Once the outcome is known the Board will decide what, if any, additional remediation is required.

Land

The value of the land has been determined with reference to market data analysed to a rate per square metre. Factors taken into account when assessing the value include shape and size of the land blocks, zoning, title implications and subdivision/development potential.

Buildings

Specialised buildings have been valued using optimised depreciated replacement cost because no reliable market data is available for such buildings.

Depreciated replacement cost is determined using a number of significant assumptions, which include:

- The improvements are valued using the replacement cost. The notional replacement cost estimates reflect current materials and technology that provide the same level of utility as the present assets. Reference has been made to industry data and information regarding the original construction costs and component breakdowns.

- The replacement cost has been assessed based on current building costs in the local region, and also the national market. It has been derived from recent construction contracts of modern equivalent assets and Property Institute of New Zealand cost information. Construction costs for modern hospital buildings range from $8,000 to $14,000 per square metre excluding fees.
- Depreciation is then applied on a straight-line basis following the indicative life ranges as provided by independent advice, industry experience together with reference to the Treasury Guidelines. Where appropriate variance has been made for such factors as upgrading, level of maintenance, standard of construction and use.
- The depreciated replacement costs is componentised into building structure, services and in some circumstance's fit out. Services are further componentised into categories where appropriate.
- The remaining useful life of assets adopted in the valuation are a reflection of the indicative life adjusted for relevant factors as indicated. Building assets have been valued on a basis of the optional degree of componentisation being structure, services and fit-out.

Movements for each class of property, plant and equipment are as follows:

	Land	Buildings	Clinical equipment	IT, Motor vehicles and other plant and equipment	Total
	$000	$000	$000	$000	$000
Cost / valuation					
Balance at 1 July 2020	2,890	38,757	9,230	3,694	54,571
Additions	0	175	1,593	207	1,975
Disposals	0	0	(56)	0	(56)
Balance at 30 June 2021	**2,890**	**38,932**	**10,767**	**3,901**	**56,490**
Balance at 1 July 2021	2,890	38,932	10,767	3,901	56,490
Additions	0	320	1,323	1,177	2,820
Revaluation Change	1,980	12,659	0	0	14,639
Other - Reclassifications	0	0	0	2,133	2,133
Disposals	(340)	(218)	(51)	(660)	(1,269)
Balance at 30 June 2022	**4,530**	**51,693**	**12,039**	**6,551**	**74,813**
Accumulated Depreciation & impairment losses					
Balance at 1 July 2020		801	6,030	2,764	9,595
Depreciation charge for the year		788	596	277	1,661
Elimination on disposal		0	(56)	0	(56)
Balance at 30 June 2021		**1,589**	**6,570**	**3,041**	**11,200**
Balance at 1 July 2021		1,589	6,570	3,041	11,200
Depreciation charge for the year		792	706	483	1,981
Revaluation Change		(2,411)	0	0	(2,411)
Other - Reclassifications		0	0	1,755	1,755
Elimination on disposal		(12)	(36)	(632)	(680)
Balance at 30 June 2022		(42)	**7,240**	**4,647**	**11,845**
Carrying amounts					
At 1 July 2020	2,890	37,956	3,200	930	44,976
At 30 June 2021	**2,890**	**37,343**	**4,197**	**860**	**45,290**
At 30 June 2022	**4,530**	**51,735**	**4,799**	**1,904**	**62,968**

The DHB has contractual commitments at balance date of $0.507m (2021: $0.416m) in relation to property, plant and equipment.

As part of the implementation project of our new Financial Information System, we have analysed the fixed asset register and made adjustments to resolve inconsistencies between the register and the general ledger, resulting in a net reclassification adjustment of $0.4m.

Restrictions on title

The DHB does not have full legal title to the Crown land it occupies, but transfer is arranged if and when land is sold. The disposal of certain properties might be subject to the provisions of section 40 of the Public Works Act 1981.

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

11. Intangible Assets

Accounting policy

Software acquisition and development

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

Costs of software updates or upgrades are capitalised only when they increase the usefulness or value of the asset.

Costs associated with the developing and maintaining the DHB's website are recognised as an expense when incurred.

Software as a Service 'SaaS'

As per the Treasury issued guidance in February 2022, the acquisition or development of software licences which grant a right of use only and/or where the DHB does not obtain control of the software are recognised as an expense in the period they are incurred.

Information technology shared service rights

The DHB has provided funding for the development of information technology (IT) shared service across the DHB sector and the rights to the shared services is recognised as an intangible asset at the cost of the DHB's capital investment.

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 the surplus or deficit.

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

Type of asset	Estimated life	Depreciation Rates
Software	2 to 10 years	10% - 50%

No differentiation between acquired computer software or internally developed software is made.

Impairment of intangible assets

Refer to the policy for impairment of property, plant, and equipment in Note 10. The same approach applies to the impairment of intangible assets, except for intangible assets that are still under development.

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.

Breakdown of intangible assets and further information

	Software $000	Work in progress $000	Total $000
Cost			
Balance at 1 July 2020	9,231	732	9,963
Additions	0	670	670
Additions (transfer)	(27)	27	0
Assets Impaired	(894)	(600)	(1,494)
Balance at 30 June 2021	**8,310**	**829**	**9,139**
Balance at 1 July 2021	8,310	829	9,139
Additions	0	1,229	1,229
Additions (transfer)	802	(802)	0
Other Reclassifications	(1,200)	0	(1,200)
Assets Retired	(482)	0	(482)
Balance at 30 June 2022	**7,430**	**1,256**	**8,686**
Accumulated amortisation & impairment losses			
Balance at 1 July 2020	3,442	0	3,442
Amortisation charge for the year	903	0	903
Balance at 30 June 2021	**4,345**	**0**	**4,345**
Balance at 1 July 2021	4,345	0	4,345
Amortisation charge for the year	3,361	0	3,361
Other Reclassifications	(1,116)	0	(1,116)
Assets Retired	(192)	0	(192)
Balance at 30 June 2022	**6,398**	**0**	**6,398**
Carrying amounts			
Balance at 1 July 2020	5,789	732	6,521
Balance at 30 June 2021	3,965	829	**4,794**
Balance at 1 July 2021	3,965	829	4,794
Balance at 30 June 2022	**1,032**	**1,256**	**2,288**

There are no restrictions over the title of the DHB's intangible assets. No intangible assets are pledged as security for liabilities.

The DHB has contractual capital commitments of $0.473m (2021: $1.748m) in relation to intangible assets under development.

As part of the implementation project of our new Financial Information System, we have analysed the fixed asset register and made adjustments to resolve inconsistencies between the register and the general ledger, resulting in a net reclassification adjustment of -$0.08m.

12. Payables and deferred revenue

Accounting policy

Short-term payables are recorded at the amount payable.

Breakdown of payables and deferred revenue

	Actual 2022 $000	Actual 2021 $000
Payables and deferred revenue under exchange transactions		
Trade creditors and accruals	4,282	4,196
Revenue received in advance	4	9
Total payables and deferred revenue under exchange transactions	4,285	4,205
Payables and deferred revenue under non-exchange transactions		
Trade creditors and accruals	11,734	11,143
GST and other taxes	1,693	2,051
Revenue received in advance	1,163	983
Total payables and deferred revenue under non-exchange transactions	14,590	14,177
Total payables and accruals	**18,876**	**18,382**

13. Employee entitlements

Accounting policy

Short-term employee entitlements

Employee entitlements that are due to be settled wholly before 12 months after the end of the reporting period in which the employee 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, continuing medical education costs, and sick leave.

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

Long-term employee entitlements

Employee entitlements that are not expected to be settled wholly before 12 months after the end of the reporting period in which the employee renders the related service, such as sabbatical leave, long service leave, and retirement gratuities, have been calculated on an actuarial basis. The calculations are based on:

- likely future entitlements accruing to staff, based on years of service, years to entitlement, the likelihood that staff will reach the point of entitlement, and contractual entitlement information: and
- the present value of the estimated cash flows.

Presentation of employee entitlement

Sick leave, continuing medical education costs, 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

Sabbatical leave, long service leave, and retirement provisions

The present value of 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 this liability include 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 forward 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. Weighted average discount rates of 3.72% for long service leave (2021: 1.15%) and 3.86% for retirement gratuities (2021: 1.6%) and a salary increase assumption of 2% (2021: 2%) were used. The discount rates used are based on market yields at balance date. The salary inflation factor is the DHB's best estimate forecast of salary increments.

Continuing medical education costs

The continuing medical education liability assumes that the utilisation of the annual entitlement, which can be accumulated up to three years, will on average be 50% (2021: 50%) of the full entitlement. This utilisation assumption is based on recent experience. The liability has not been calculated on an actuarial basis because the present value effect is trivial.

Holiday pay provision

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).

Work has been ongoing since 2016 on behalf of all DHBs and the New Zealand Blood Service, with the Council of Trade Unions (CTU), health sector unions and Ministry of Business, Innovation and Employment Labour Inspectorate, for an agreed and national approach to identify, rectify and remediate any Holidays Act non-compliance by DHBs. DHBs have agreed to a Memorandum of Understanding (MOU), which contains a method for determination of individual employee earnings, for calculation of liability for any historical non-compliance.

For employers such as the DHBs that have workforces that include differential occupational groups with complex entitlements, non-standard hours, allowances and/or 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 2019/20 and current financial years. The final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed.

As a result the DHB recognises it has an obligation to address any historical non-compliance under the MOU and has made estimates and assumptions to determine a potential 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 National Programme Management Office ("NPMO") identified variability in the methodologies used to calculate the financial liability estimates across DHBs due to the DHBs self-determining the approach to the financial estimate in the absence of a national guidance (including with respect to re-forecasting estimates), and variability in the cost components included within the estimates.

In January 2022, a financial liability estimate exercise was undertaken by all the DHBs to develop a Holidays Act Remediation Programme ("HARP") financial liability guidance to support DHBs in reporting consistent, complete and reasonable financial liability estimates.

In line with the guidance provided the DHB utilised the sample based recalculation approach to complete the financial liability estimate for the DHB for the period 1 May 2010 to 30 June 2022.

Wairarapa District has estimated the liability to be $16,790,420 (excluding programme costs) as at 30 June 2022. This estimated liability is based on the current available information provided, the basis of the calculation undertaken, the information available for the sample 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.

The DHB expects for remediation payments to current and former staff to commence in the 23/24 financial year.

Breakdown of employee entitlements:

	Actual 2022 $000	Actual 2021 $000
Current portion		
Accrued salary and wages	5,376	1,495
Annual leave	5,553	4,480
Holidays Act 2003 remediation	16,791	10,388
Stat Days and Days in Lieu	870	1,080
Sick leave	83	87
Maternity grant	0	12
Continued medical education expenses	410	362
Long service leave	484	441
Retirement gratuities	248	301
Total current portion	29,815	18,646
Non-current Portion		
Long service leave	264	292
Retirement gratuities	194	239
Total non-current portion	458	531
Total employee entitlements	**30,273**	**19,177**

14. Restricted Funds

	Actual 2022 $000	Actual 2021 $000
Balance at beginning of year	91	85
Funds received	26	12
Funds spent	(82)	(6)
Balance at end of year	**35**	**91**

Wairarapa DHB receives donations and bequests for specific purposes. If for any reason Wairarapa DHB is not able to use the funds as specified, then Wairarapa DHB is obligated to return the donation to the donor. Funds are separately accounted for and is offset by the balance in investments covered in Note 8 above.

15. Equity

Accounting policy

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

- Crown equity
- Property revaluation reserves and
- Retained earnings.

Property revaluation reserves
These reserves relate to the revaluation of property, plant, and equipment to fair value.

	Crown equity $000	Property revaluation reserve $000	Retained earnings $000	Total $000
Balance at 1 July 2020	103,572	11,234	(84,703)	30,103
Total recognised revenue & expenses	0	0	(5,106)	(5,106)
Contribution from the Crown	0	0	0	0
Repayment to the Crown	(3)	0	0	(3)
Movement in revaluation of land & buildings	0	0	0	0
Balance at 30 June 2021	**103,569**	**11,234**	**(89,809)**	**24,994**
Balance at 1 July 2021	103,569	11,234	(89,809)	24,994
Total recognised revenue & expenses	0	0	(12,062)	(12,062)
Contribution from the Crown	4,029	0	0	4,029
Repayment to the Crown	(3)	0	0	(3)
Movement in revaluation of land & buildings	0	16,844	0	16,844
Balance at 30 June 2022	**107,595**	**28,078**	**(101,871)**	**33,802**

Capital management

The DHB's capital is its equity, which consists of Crown equity, accumulates surpluses or deficits and property revaluation reserves. Equity is represented by net assets.

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

The DHB manages its equity as a by-product of prudently managing revenue, expenses, assets, liabilities, investments, and general financial dealings to ensure that it effectively achieves its objectives and purposes while remaining a going concern.

16. Contingencies

Contingent liabilities and assets

The DHB currently has no legal claims against it and therefore assess that there are no contingent liabilities as at 30 June 2022 (2021: $nil). Likewise, the DHB has no contingent assets as 30 June 2022 (2021: $nil).

17. Related party transactions

The DHB is controlled by the Crown.

Related party disclosures have not been made for transactions with related parties, including associates that are:

- within a normal supplier or client/recipient relationship; and
- on terms and conditions no more or less favourable than those that it is reasonable to expect that the DHB would have adopted in dealing with the party at arms' 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.

Key management personnel compensation:

	Actual 2022 $000	Actual 2021 $000
Board Members		
Remuneration	226	222
Full-time equivalent members	0.9	1.0
Leadership Team		
Remuneration	1,863	1,968
Full-time equivalent members	8.2	8.4
Total key personnel remuneration	**2,090**	**2,190**
Full-time equivalent personnel	**9.1**	**9.4**

The full-time equivalent for Board members has been determined based 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.

COVID-19 Vaccination program:

As part of the COVID-19 Vaccination program, the DHB contracted Te Hauora Runanga o Wairarapa to provide support services to the Wairarapa COVID-19 Vaccination Programme to the value of $54,911.03. At the time of the transaction, Ronald Karaitiana was a Board member of the DHB and Chief Executive of Te Hauora Runanga o Wairarapa, and Yvette Grace was a Board Member of the DHB and a Board Member of Te Hauora Runanga o Wairarapa.

18. Events after balance date

There are no material events after balance date.

19. Financial Instruments

19A Financial instrument categories

The carrying amounts of financial assets and liabilities in each of the PBE IFRS 9 financial instrument categories are as follows:

	Note	Actual 2022 $000s	Actual 2021 $000s
Financial assets measured at amortised cost:			
Cash and cash equivalents	6	5,846	4,754
Trade and other receivables	7	10,320	6,473
Investments	8	0	84
Total financial assets measured at amoritised cost		**16,166**	**11,311**
Financial liabilities measured at amortised cost:			
Payable & accruals (excluding deferred revenue and taxes)	12	16,016	15,339
Cash and cash equivalents -Overdraft	6	0	4
Total financial liabilities measured at amortised cost		**16,016**	**15,343**

19B Fair value hierarchy

The only financial instruments the DHB would measure at fair value in the statement of financial position would be forward foreign exchange contracts. At balance date the DHB does not hold any forward foreign exchange contracts (2021:$nil).

19C Financial instrument risks

The DHB's activities expose it to a variety of financial instrument risks, including market risk, credit risk, and liquidity risk. The DHB has a series of policies to manage the risks associated with financial instruments and

seeks 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. The DHB has no financial instruments that give risk 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. The DHB'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 DHB, as investments are generally held to maturity.

Cash flow interest rate risk

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

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.

The DHB purchases clinical equipment from overseas, which requires it to enter into transactions denominated in foreign currencies. As a result of these activities, exposure to currency risk arises. The total value of foreign transactions over the financial year was less than $150k so the DHB's foreign currency risk exposure is not considered material and is not actively managed.

Credit risk

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

Due to the timing of the DHB's cash inflows and outflows, surplus cash is invested with NZHPL.

In the normal course of business, exposure to credit risk arises from cash and term deposits with banks and NZHPL, receivables, and forward foreign exchange contracts in an asset position. For each of these, the maximum credit risk exposure is best represented by the carrying amount in the statement of financial position.

Investments and forward foreign exchange contracts are entered into only with registered banks that have a rating of at least AA- by Standard and Poor's.

Concentrations of credit risk for receivables are limited due to the large number and variety of customers. The Ministry of Health is the largest debtor (2022: 63% (2021: 59%)). It 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 risk exposure by credit risk grades, excluding receivables

The gross carrying amount of financial assets, excluding receivables, by credit rating is provided below by reference to Standard and Poor's credit rating (if available).

	Actual 2022 $000s	Actual 2021 $000s
COUNTERPARTIES WITH CREDIT RATINGS		
Cash at bank and investments		
AA-	0	80
Total cash at bank and investments - with credit ratings	0	80
COUNTERPARTIES WITHOUT CREDIT RATINGS		
Cash and cash equivalents		
NZ Health Partnerships Ltd	5,835	4,750

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

Liquidity Risk

Management of liquidity risk

Liquidity risk is the risk that the DHB will encounter difficulty raising liquid funds to meet commitments as they fall due. Prudent liquidity risk management implies maintain sufficient cash, availability of funding through an adequate amount of committed credit facilities, and the ability to close out market positions.

The DHB mostly manages liquidity risk by continuously monitoring forecast and actual cash flow requirements and maintain 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 periods at balance date to the contractual maturity date. The amounts disclosed are the contractual undiscounted cash flows and include interest cash outflows.

30 June 2022	Carrying amount $000s	Contractual cash flows $000s	Less than 6 months $000s	6-12 months $000s	More than 1 year $000s
Payables & accruals (excluding deferred revenue and taxes)	16,016	16,016	16,016	0	0

30 June 2021	Carrying amount $000s	Contractual cash flows $000s	Less than 6 months $000s	6-12 months $000s	More than 1 year $000s
Payables & accruals (excluding deferred revenue and taxes)	15,339	15,339	15,339	0	0

20. Explanation of major variances against budget

Explanations for major variances from the DHB's budgeted figures in the statement of performance expectations are as follows:

Statement of comprehensive revenue and expense

Net Result

Overall the net result (excluding revaluation movement) of ($12.062m) for Wairarapa DHB was ($9.962m) adverse to budget however this included unplanned adjustments of ($6.550m) in relation to the Holidays Act, and ($2.758m) for nurses pay equity leaving a net deficit on operating activites of only ($0.654m).

Revenue

Revenue was $18.343m favourable with $17.205m of additional revenue received from the Ministry of Health, with additional revenue from other DHBs of $0.458m, higher ACC revenue of $0.623m and with less revenue from other sources of ($0.057m).

Expenditure

Expenditure was ($28.305m) more than budgeted including:

- ($13.971m) higher personnel costs with the variance including:
  - ($4.685m) in nursing costs and ($2.251m) higher management and administration costs which were partly covered by additional MOH funding.
  - ($2.758m) adjustment to nursing costs for pay equity liability
  - $1.248m favourable doctors cost although these were offset by higher locum costs.
  - ($6.465m) increase in leave liability in relation to the Holidays Act.
- ($3.178m) higher outsourced costs including:
  - ($2.190m) higher outsourced personnel costs which includes ($1.681m) for locum doctors to cover vacancies and leave.
  - ($0.988m) higher other outsourced costs for medical and surgical services.
- ($3.006m) higher funder expenditure where additional covid-19 related costs were ($6.261m) and this was offset by lower costs for Health of Older People services.
- ($2.775m) higher IDF outflows payable to other DHBs for services received for our population particularly in relation to acute orthopaedic services.
- ($2.405m) higher depreciation costs because of higher rates applied to some intangible asssets to reflect their reduction in economic life.

Statement of financial position

Assets

- The bank account was $5.079m favourable as a result of additional equity funding of $2.3m received in January 2022 and lower spend on capital expenditure.
- Property, plant and equipment was $12.173m higher than budget following a revaluation of land and buildings as at 30 June 2022.

- Intangible assets was ($3.460m) lower than budget which is mainly due to planned expenditure on IT projects being deferred.

Liabilities

- Payables was ($3.821m) higher than budget but the increase was only ($0.494m) from last year end.
- Employee entitlements was ($9.708m) higher than budget with ($6.465m) from the increase in provision of leave payable in relation to the Holidays Act, ($2.758m) liability for nurses pay equity and the balance because of an increase in the unpaid days at the end of the year.

Statement of changes in equity

- The opening balance was ($1.652m) less than budget due to the higher deficit in 2020/21 not reflected in the budget.
- The deficit for the current year was ($9.962m) higher than budgeted due to the statement of comprehensive revenue and expense explanations provide above.
- The planned equity injection was $1.7m but $4.0m was received together wi th a further $0.029m for funded projects.

Statement of cash flows

- The closing balance was $5.079m better than expected which was because of the $2.3m additional equity funding received and lower than expected capital expenditure during the year.

21. Summary cost of services

Accounting policy

Cost allocation

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

Direct costs are those 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 charge to outputs based on cost drivers and related activity or 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.

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

	Budget 2022 $000	Actual 2022 $000	Actual 2021 $000
Revenue			
Prevention services	5,938	6,461	5,600
Early detection and management services	32,460	32,905	32,426
Intensive assessment and treatment services	137,387	153,307	126,291
Rehabilitation and support services	33,280	34,735	32,655
Total revenue	**209,065**	**227,408**	**196,972**
Expenditure			
Prevention services	6,682	6,712	6,092
Early detection and management services	32,846	33,540	32,680
Intensive assessment and treatment services	140,035	168,986	136,316
Rehabilitation and support services	31,602	30,232	26,990
Total expenditure	**211,165**	**239,470**	**202,078**
Land and Buldings revaluation not allocated	2,100	16,844	0
Total comprehensive revenue and expense	**0**	**4,782**	**(5,106)**

22. Impact of COVID-19 on the DHB

Wairarapa DHB is deemed an essential service and operations continued during the changes to COVID-19 alert levels.

Statement of Comprehensive Revenue and Expenses

Government funding
The DHB received MOH revenue of $12.823m to assist with the COVID-19 response and particularly for GP based assessments, pharmacies, aged care providers, COVID-19 vaccination costs, Care in the Community, and hospital response.

Personnel expenses
Personnel expenses have increase by $3.712m due to an increase in permanent and casual staff for the vaccination programme, hospital response and Care in the Community.

Other expenses
There was an increase in clinical and infrastructure and non-clinical supply costs of $2.720m, mainly driven by the COVID-19 vaccine roll-out and the hospital response such as leasing additional premises, hygienic and sanitation supplies, security costs and vaccination incentives.

Other provider payments
$6.402m was paid to GP's, community pharmacies, PHO's, aged care providers and other NGO's to assist with the COVID-19 response.

There is no material impact on the balance sheet.