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

ANNUAL REPORT 2022

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Statement of Performance

We present you here the results for the measures and standards as provided in our Statement of Performance Expectations.

To perform our functions well the actions we take must:

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

The measures chosen are a mixture of indicators of quantity, quality and timeliness in our priority areas. The measures and targets are outlined in our Statement of Performance Expectations for 2021/22[1] with the following section presenting the results achieved against the identified targets.

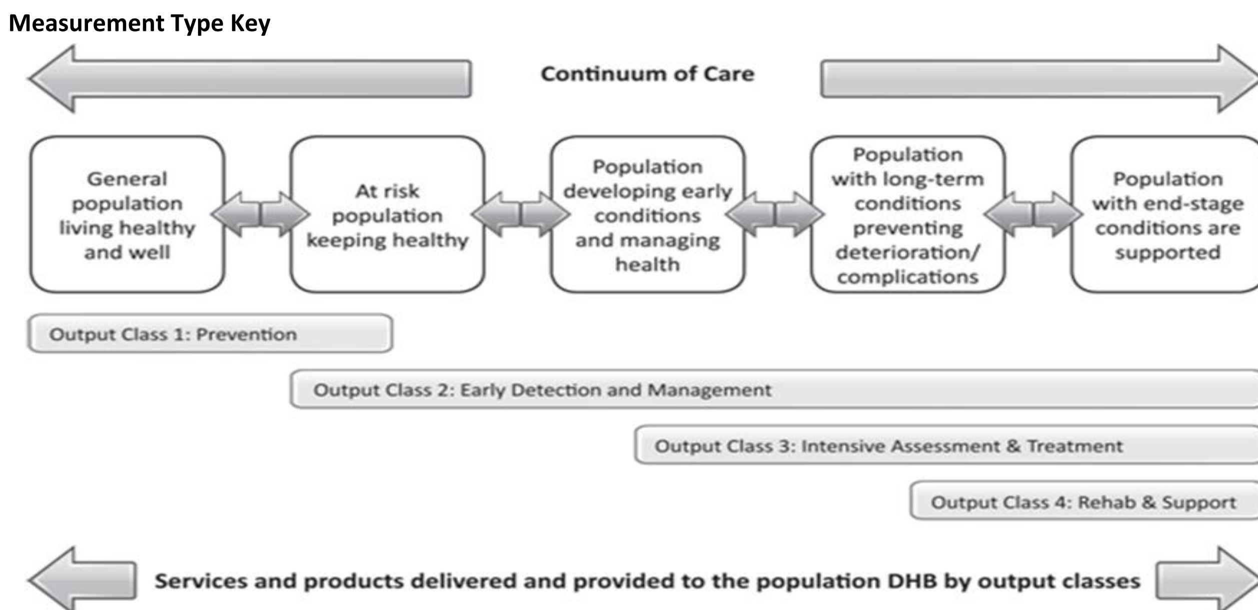
Structure of this section

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

Output Classes

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

Measurement Type Key

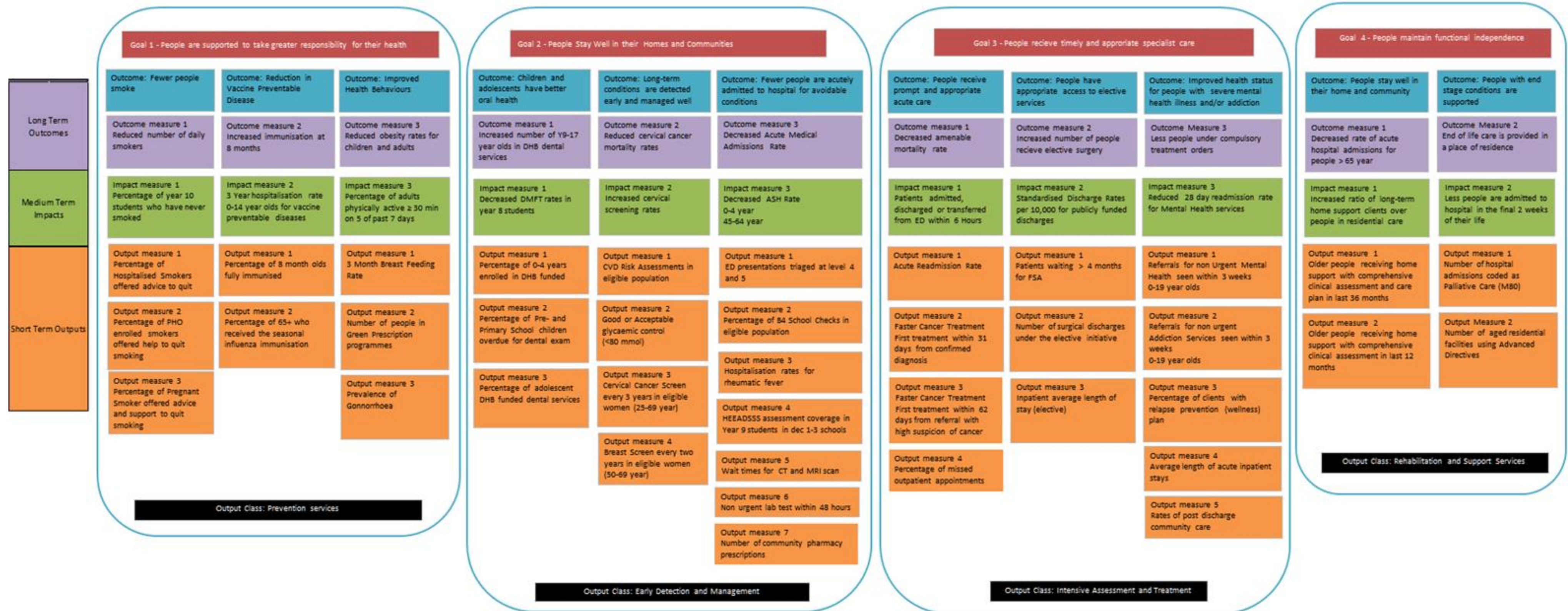


Trend column in performance measure tables in the following sections reflect the 2021/22 result compared to the latest NZ result and illustrate by arrow whether results are above or below latest NZ results.

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

[1] The statement of performance expectations is published in our 2021/22 Annual Plan : http://www.tdh.org.nz/about-us/documents-and-publications/accountability-documents/

Map of Indicators



2021/22 Performance Overview

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

Output class: PREVENTION SERVICES

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

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

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

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

2021/22 Prevention Services Performance

2021/22 had the largest impact of COVID-19 on performance and was only in quarter 4 that the effort to recover started. Prevention services where often redeployed to cover COVID-19 swabbing and undertaking the vaccination effort. Across Tairāwhiti in 2021/22 22,707 COVID-19 Polymerase Chain Reaction (PCR) swabs taken, 30,034 Rapid Antigen Test (RAT) results reported, and 92,850 COVID-19 vaccination given.

Compared to 2020/21, 2021/22 saw a decrease in all of the indicators linked to the provision of smoking cessation advice but we have seen a marked rise in the uptake of vaping within local youth. The rate of hospitalisation for vaccine preventable diseases increased, together with a fall in all but two groups for vaccination coverage for young children. The breastfeeding rate, referrals following B4Schools checks and the number of people undertaking programmes linked to Green Prescriptions all fell, while the rate of gonorrhoea increased.

Prevention services have been at the front of most of the effort in the response to COVID-19 and effort continued to increase capacity within this sector of the system to expand resilience and to reduce the dips in performance seen in 2021/22.

OUTCOME MEASURES - Long Term[2]

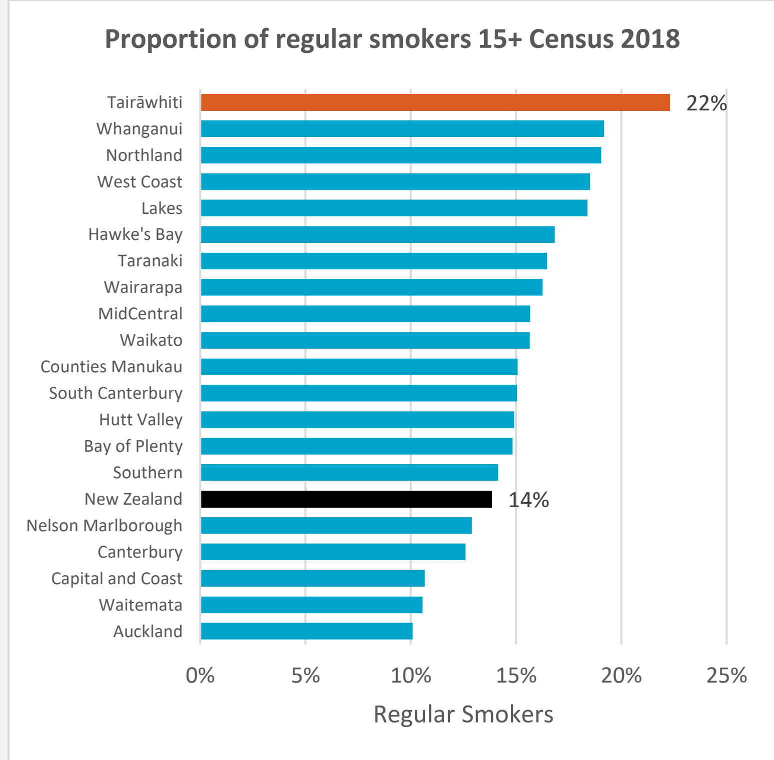
Outcome: Fewer people smoke

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

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

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

Outcome measure 1: Reduced number of daily smokers



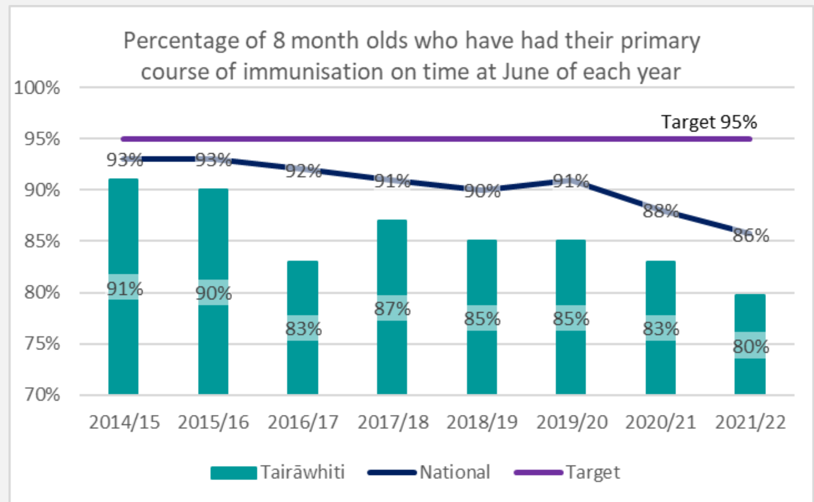
Data source: Census 2018 – Tatairanga Aotearoa (Stats NZ), April 2020

Outcome: Reduction in Vaccine Preventable Disease

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

8 months immunisation coverage				
	2018/19	2019/20	2020/21	2021/22
Tairāwhiti	85.0%	85.0%	83.0%	79.7%
National	90.0%	91.0%	88.0%	85.7%
Target	95.0%	95.0%	95.0%	95.0%

Outcome measure 2: Increased immunisation at 8 months



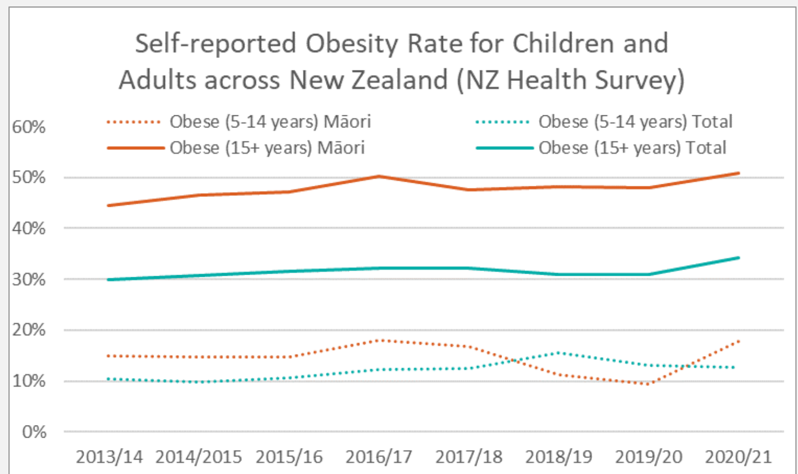
Data Source: National Immunisation Register (Ministry of Health) 2021/22

[2] Other entity information is unaudited

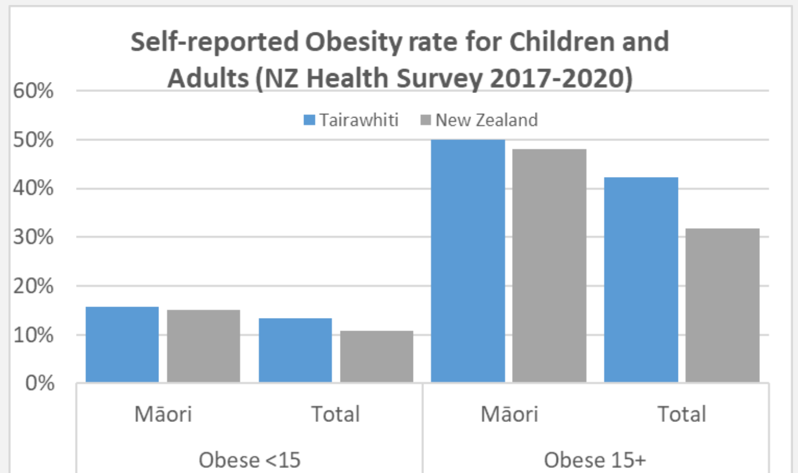
Outcome: Improved Health Behaviours

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

Outcome measure 3: Obesity Rates for Children and Adults decrease



Data Source: The 2020-21 NZ Health Survey, Dec 2021



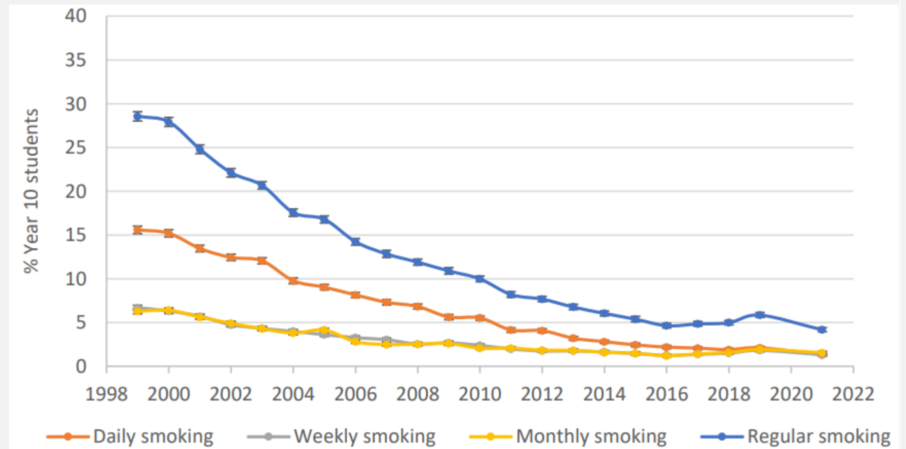
Data Source: The 2020-21 NZ Health Survey, October 2021

IMPACT MEASURES – Medium Term[3]

Outcome: Fewer People Smoke

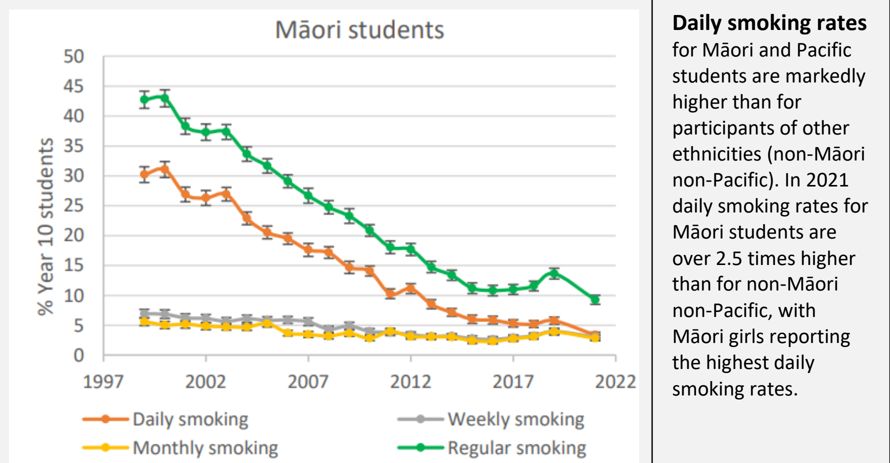
We see the highest prevalence of smoking among younger people, so preventing young people from taking up smoking is a key contributor to reducing smoking rates across the total population. Because the Māori and Pacific population groups have higher smoking rates, reducing the uptake amongst Māori and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

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



Data Source – ASH New Zealand 2021. National Year 10 ASH Snapshot Survey.[4]

A reduction in the uptake of smoking by young people is seen as a proxy indicator of the success of our health promotion activity and a change in the social and environmental factors that support healthier lifestyles. Although no local figures have been published since 2015, national figures for 2021 show smoking in Māori and Pacific youth remains disproportionally high, with the highest daily smoking rates for Māori girls.



Daily smoking rates for Māori and Pacific students are markedly higher than for participants of other ethnicities (non-Māori non-Pacific). In 2021 daily smoking rates for Māori students are over 2.5 times higher than for non-Māori non-Pacific, with Māori girls reporting the highest daily smoking rates.

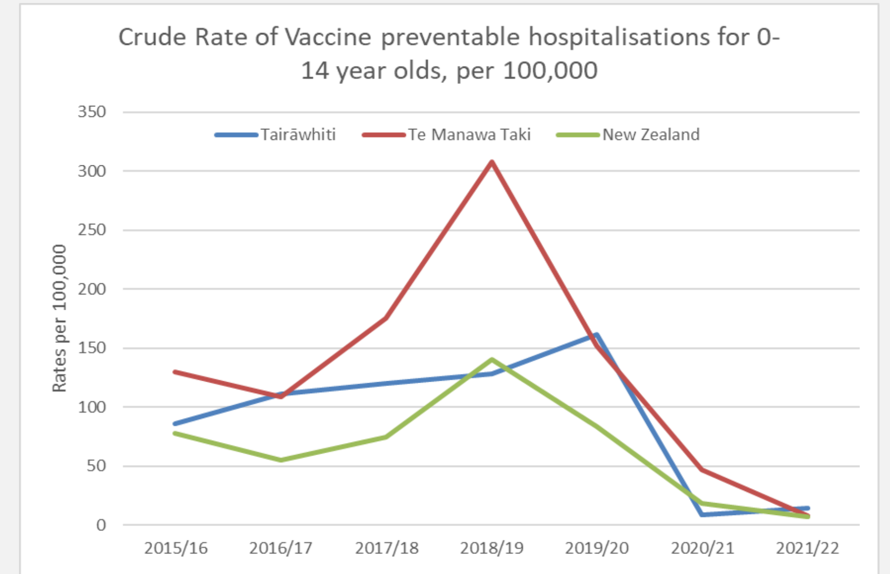
Outcome: Reduction in vaccine preventable diseases

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

Year	*Tairāwhiti*	*Te Manawa Taki*	*New Zealand*
15/16	86.1	129.5	78.1
16/17	111.0	109.1	55.2
17/18	120.4	175.2	74.8
18/19	128.5	307.8	140.7
19/20	161.7	151.9	83.7
20/21	8.5	46.9	18.2
21/22	14.5	8.0	7.3

Crude Rate per 100,000, Source - NMDS

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



Data Source : Ministry of Health Qlik Sense Hub Hospitalisations

[3] Other entity information is unaudited

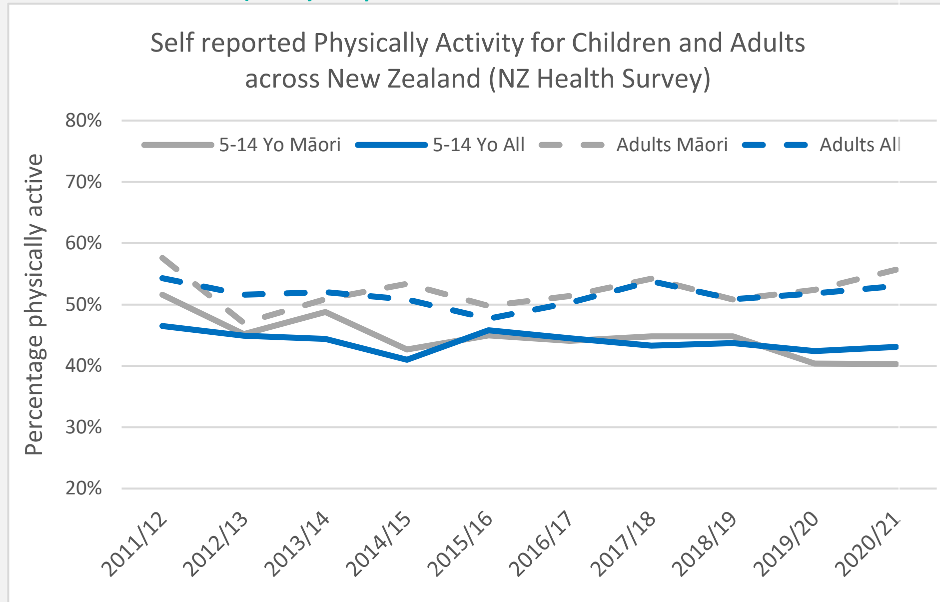
[4] No ASH Year 10 survey was undertaken in 2020 due to COVID-19

Outcome: Improving health behaviours

People gain weight when they consume more energy than they use. What a person eats and drinks, and how much activity they do directly affects their weight. But physical activity is beneficial in many other ways as well. People feel fitter, have more energy, and report improved sleeping quality and lower stress levels. The Ministry of Health recommends people aim for at least two and a half hours of physical activity a week. Improvements in physical activity levels and diets will lead to reductions in obesity levels.

Impact measure 3:

- **Percentage of adults physically active for 2.5 hours or more on 7 days**
- **5-14 year olds who usually uses active transport (walk, bike, skate or similar) to and from school (5-14 years)**



Source - NZ Health Survey, December 2021[5]

OUTPUTS – Short Term Performance Measures

Outcome: Fewer people smoke

Outcome Measure		Measure Type	2019/20 Result	2020/21 Result	2021/22 Target	2021/22 Result	Latest NZ Result	Trend
Percentage of hospitalised smokers offered advice to quit by a health provider in last 15 months (SLM, PH04)[6]	Māori	τ/ δ	92%	86%	≥90%	82.3%	N/A	⇓
	Non Māori	τ/ δ	91%	87%		79.8%		⇓
	Total Pop	τ/ δ	92%	86%		81.5%		⇓
Percentage of PHO enrolled smokers offered help to quit smoking by a health care practitioner in the last 15 months	Māori	τ/ δ	72%	68%	≥90%	52.4%	63.6%	⇓
	Non Māori	τ/ δ	79%	77%		60.2%	69.1%	⇓
	Total Pop	τ/ δ	80%	71%		54.6%	67.3%	⇓
Percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered advice and support to quit smoking	Māori	δ	98%	92%	≥90%	88.9%	N/A	⇓
	Non Māori	δ	88%	100%		35.3%		⇓
	Total Pop	δ	97%	93%		62.9%		⇓

[5] https://minhealthnz.shinyapps.io/nz-health-survey-2020-21-annual-data-explorer/_w_b82da1c3/#!/explore-topics
[6] Not included in Statement of performance and expectation for the 2020/21 year

Outcome: Reduction in Vaccine Preventable Disease

Indicator		Measure Type	2019/20 Result	2020/21 Result	2021/22 Target	2021/22 Result	Latest NZ Result	Trend
Percentage of 8 month olds fully immunised (Health Target, SLM) (12 months figure)	Māori	τ/ δ	83%	78%	≥95%	77.0%	72.2%	↓
	Non Māori	δ	90%	91%		85.7%	90.2%	↑
	Total Pop	δ	85%	84%		80.3%	85.6%	↓
Percentage of 24 month olds fully immunised (12 months figure)	Māori	δ	92%	82%	≥95%	68.7%	69.6%	↓
	Non Māori	δ	86%	83%		82.5%	88.3%	↓
	Total Pop	δ	88%	82%		74.2%	83.6%	↓
Percentage of five year olds fully immunised (12 months figure)	Māori	δ	90%	82%	≥95%	71.6%	73.5%	↓
	Non Māori	δ	91%	88%		86.0%	86.0%	↓
	Total Pop	δ	90%	84%		76.0%	82.7%	↓
Percentage of girls and boys fully immunised against HPV	Māori	δ	61%	63%	≥75%	56.1%	48.5%	↓
	Non Māori	δ	59%	69%		57.1%	55.8%	↓
	Total Pop	δ	61%	65%		56.5%	54%	↓
Percentage of people 65 and older years who have received the seasonal influenza immunisation	Māori	δ	59%	48%	≥75%	39.7%	39.5%	↓
	Non Māori	δ	66%	62%		40.3%	45.3%	↓
	Total Pop	δ	64%	59%		40.1%	44.9%	↓
Percentage of people 16 and older years who have received the at least one dose of COVID-19 Vaccination	Māori	δ	-	13%	≥75%	70%	-	↑
	Non Māori	δ	-	24%		81%	-	↑
	Total Pop	δ	-	19%		75%	-	↑
Percentage of people 16 and older years who have received the at least two doses of COVID-19 Vaccination	Māori	δ	-	8%	≥75%	71%	-	↑
	Non Māori	δ	-	15%		89%	-	↑
	Total Pop	δ	-	11%		80%	-	↑

Outcome: Improving Health Behaviours

Indicator		Measure Type	2019/20 Result	2020/21 Result	2021/22 Target	2021/22 Result	Latest NZ Result	Trend
Percentage of infants who are exclusively/fully breastfed at 3 Months [7]	Māori	δ	45%	40%	≥70%	N/A	N/A	-
	Non Māori	δ	66%	68%		N/A	N/A	-
	Total	δ	56%	52%		N/A	N/A	-
Raising healthy kids Percentage of obese children identified in the B4 School Check Programme who are offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions	Māori	δ	87%	85%	≥95%	100%	N/A	↑
	Non Māori	δ	78%	91%		85.7%	N/A	↓
	Total Pop	δ	85%	87%		94.4%	N/A	↑
The number of people participating in the Green Prescription programmes	Total Pop	δ	849	838[8]	**≥1024**	610	N/A	↓
Reduce the prevalence of gonorrhoea (Local Indicator)[9] (per 100,000)	Total Pop	δ	102 per 100,000	155	**≤60 per 100,000**	97[10]	127	↓

Output class: EARLY DETECTION AND MANAGEMENT SERVICES

Early detection and management services support people to better manage their long-term conditions and avoid complications, acute illness and crises. By promoting regular engagement with health services, we support people to maintain good health through earlier diagnosis and treatment, which provides an opportunity to intervene in less invasive and more cost-effective ways associated with better long-term outcomes. Success is defined by high coverage and utilisation of services, signalling engagement with and access to health services. Increase in access to diagnostics and agreed referral pathways, and reductions in avoidable hospital admissions reflect improvement.

Goal 2 - People stay well in their homes and communities

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

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

[7] Reporting against this indicator did not occur due to the impact of COVID and the redeployment of workforces within this sector

[8] Not included in 2019/20 Annual Report

[9] Sexually Transmitted Infection (STI) surveillance ESR report to Q4 2021 https://www.esr.cri.nz/our-services/consultancy/public-health/sti/

2021/22 Early Detection and Management Services Performance

The uptake of young children (0 to 4 year old) in the DHB oral health enrolment continues to be in well above target, but the impact of the COVID-19 pandemic resulted in an increase in those overdue for the scheduled examination. Coverage in adolescent remains an issue with only 40% of the rangatahi population having treatment completed in the period. Oral health like most sector of the health services was impacted during 2021/22 through workforce shortages which had a direct impact on services to achieved expected outcomes.

Screening and management of long term conditions have both been impacted by the last two years of COVID with community safety precautions having an impact on access rates to both screening and primary care which has resulted in fall in screening coverage for Breast and Cervical screening and decreased coverage in Cardiovascular risk assessment and patients with good or acceptable glycaemic control.

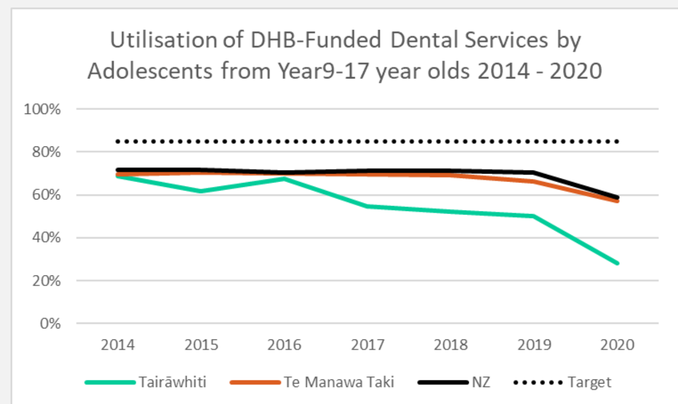
In the area of reducing hospitalisation for avoidable conditions has generally shown improvement across the most indicators.

OUTCOME MEASURES - Long Term[10]

Outcome: Children and adolescents have better oral health

Adolescents, in school Year 9 (13/14-year olds) up to and including 17 years of age, accessing DHB-funded oral health services. The decrease in DMFT (Diseased, Missing or Filled Teeth) at Year 8 however shows that the DHB has made an impact of promoting good oral health, by providing accessible publicly-funded adolescent oral health programmes. The programmes help reduce the prevalence and severity of oral disease in adolescents. This measure indicates the coverage of publicly-funded adolescent oral health services and provides a measure that can be used to demonstrate progress towards the population priority of "improving oral health" in the New Zealand Health Strategy.

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



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

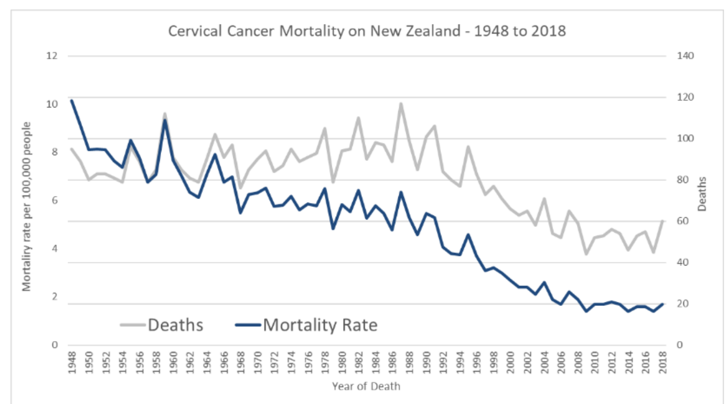
Outcome: Long-term conditions are detected early and managed well

Cervical cancer is the fourth-most common cause of cancer and the fourth-most common cause of death from cancer in women worldwide. New Zealand has seen the number of women who die from cervical cancer dropping by 60 per cent since 1990 thanks to the screening programme. But still about 50 women die from it each year[11]. To continue this decline we need to increase our cervical screening rates to ensure cell changes are picked up at a treatable stage.

Cervical Cancer Mortality in New Zealand 2014 to 2018					
Rate per 100,000	2014	2015	2016	2017	2018
Māori	3.00	3.60	3.00	3.20	3.20
All	1.40	1.60	1.60	1.40	1.70

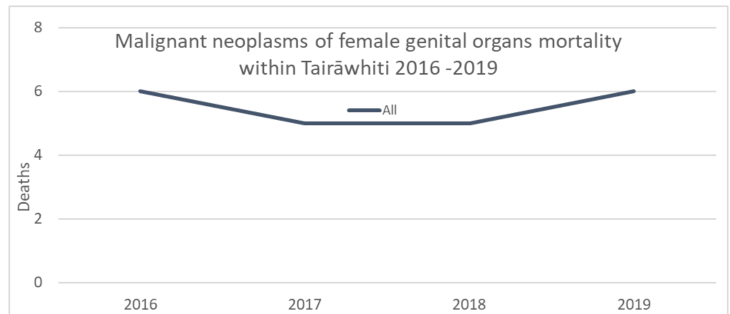
New Zealand cervical cancer mortality

Outcome measure 2: Reduced cervical cancer mortality rates



Source: Ministry of Health: Cancer Historical Summary 1948-2018[12].

[10] Other entity information is unaudited
[11] https://www.health.govt.nz/your-health/conditions-and-treatments/diseases-and-illnesses/cervical-cancer
[12] As at 3 October 2022, https://www.health.govt.nz/publication/historical-mortality



Tairawhiti cervical cancer mortality

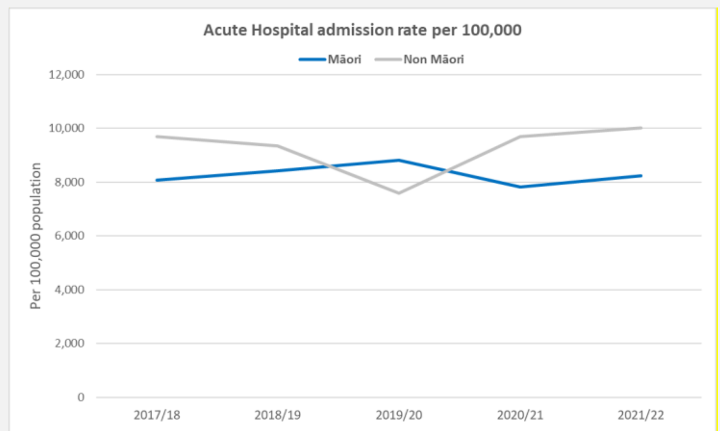
Source: Ministry of Health: Mortality data 2016 – 2019 (released 7 Sept 2022)

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

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

Demand across the health sector in Tairāwhiti have seen continued growth across all areas but specifically in acute admission for medicine.

Outcome measure 3: Decreased Acute Medical Admissions Rate



Data Source: Gisborne Hospital Reporting – Inpatient discharges

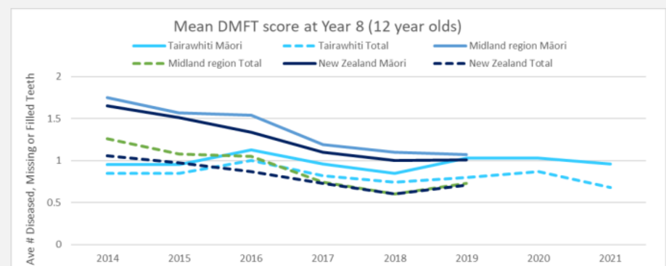
IMPACT MEASURES – Medium Term[13]

Outcome: Children and adolescents have better oral health

Improved oral health is a proxy measure of equity of access, and the effectiveness of mainstream services in targeting those most in need. DMFT is a count of decayed, missing or filled teeth in permanent dentition in a person's mouth. Around Year 8, children usually have lost their baby teeth and any damage at this stage is life long, so the lower a child's DMFT, the more likely that their teeth will last a life time. A continued decrease in the DMFT score of year 8 children will signal that we are succeeding.

	2016	2017	2018	2019	2020	2021
Tairāwhiti Māori	1.13	0.96	0.85	1.04	1.03	0.96
Tairāwhiti All	0.94	0.82	0.74	0.80	0.87	0.68
Midland Māori	1.54	1.19	1.23	1.07	N/A	
Midland All	1.05	0.74	0.78	0.73		
NZ Māori	1.34	1.1	1.12	1.01		
NZ All	0.87	0.73	0.74	0.71		

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



Data Source: Ministry of Health Performance Reporting

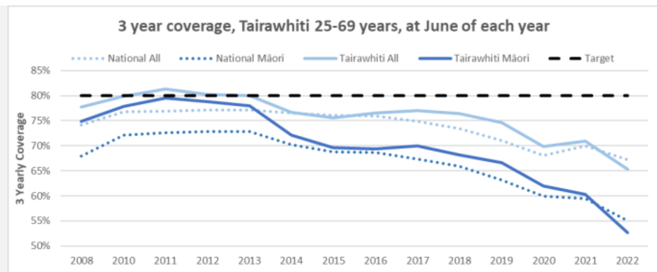
Outcome: Long-term conditions are detected early and managed well

Cervical cancer is one of the most preventable forms of cancer and screening every three years can reduce the risk of developing it by up to 90%. Identifying and treating cancers when they are small, is one

Impact measure 2: Increased cervical screening rates

[13] Other entity information is unaudited

of the most effective methods to reduce the impact of some cancers. Early detection will lead to either successful treatment, or delaying or reducing the need for hospital and specialist care.



Data Source: Ministry of Health, National Cervical Screening Programme (NCSP) New Zealand District Health Board Coverage Report 30 June 2022

Outcome: Fewer people are admitted to hospital for avoidable conditions

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

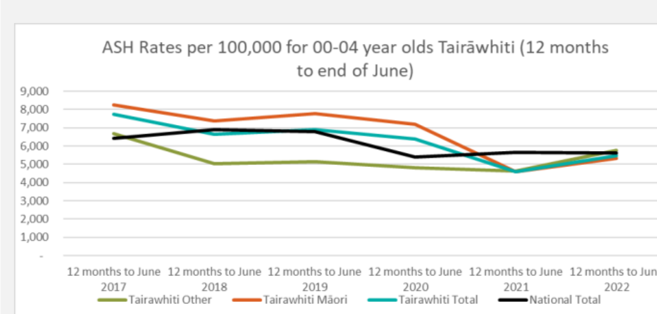
ASH rates for 12 months period to 30 June each year

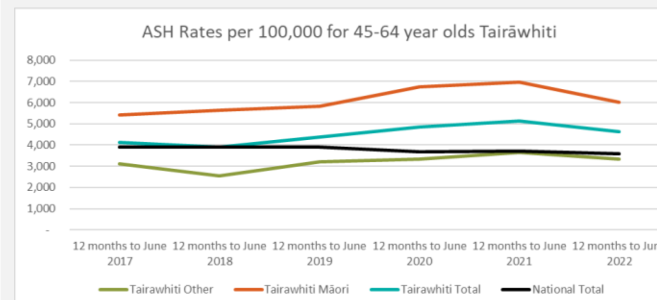
0-4	Ethnic Group	12 months to June 2017	12 months to June 2018	12 months to June 2019	12 months to June 2020	12 months to June 2021	12 months to June 2022
Tairawhiti	Other	6,667	5,042	5,143	4,819	4,640	5,782
Tairawhiti	Māori	8,240	7,390	7,782	7,177	4,593	5,326
Tairawhiti	Total	7,734	6,630	6,910	6,389	4,609	5,457
National	Total	6,409	6,904	6,804	5,397	5,662	5,618

45-64	Ethnic Group	12 months to June 2017	12 months to June 2018	12 months to June 2019	12 months to June 2020	12 months to June 2021	12 months to June 2022
Tairawhiti	Other	3,126	2,548	3,204	3,335	3,640	3,351
Tairawhiti	Māori	5,415	5,633	5,831	6,746	6,963	6,013
Tairawhiti	Total	4,119	3,918	4,392	4,861	5,132	4,640
National	Total	3,898	3,900	3,907	3,689	3,713	3,587

Tairāwhiti ASH rates 2017-22

Impact measure 3: Decreased rate of ambulatory sensitive hospital admissions





Data Source: Ministry of Health Performance Reporting

OUTPUTS – Short Term Performance Measures

Outcome: Children and adolescents have better oral health

Indicator		Measure Type	2019/20 Result	2020/21 Result	2021/22 Target	2021/22 Result	Latest NZ Result	Trend
Percentage of Children (0-4) enrolled in DHB funded dental service *	Māori	δ	101%	88%	≥ 95%	93%	N/A	↑
	Non Māori	δ	109%	133%		135%		↑
	Total	δ	104%	101%		105%		↑
Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination	Māori	δ	10.0%	18%	≤10%	42.2%		↑
	Non Māori	δ	5.4%	15%		41.6%		↑
	Total Pop	δ	8.3%	18%		43.4%		↑
Percentage of adolescent utilisation of DHB-funded dental services	Māori	Ω/ δ	-	-	≥85%	30.4%	41.7%	-
	Total Pop	Ω/ δ	50%	35%		40.8%	59.6%	↑

* For the year ended 31 December 2021

Outcome: Long term conditions are detected early and managed well

Indicator		Measure Type	2019/20 Result	2020/21 Result	2021/22 Target	2021/22 Result	Latest NZ Result	Trend
Percentage of assessed high risk patients who have had an annual review	Māori	δ	70.3%	78.5%	≥90%	83.4%	N/A	↑
	Non Māori	δ	59.5%	60.1%		64.1%		↑
	Total Pop	δ	65.0%	69.4%		72.2%		↑
Percentage of eligible population will have had their cardiovascular risk assessed in the last 5 years	Māori	δ /τ	84.7%	84.8%	≥90%	82.3%	76.4%	↑
	Non Māori	δ /τ	88.2%	87.1%		85.6%	77.1%	↓
	Total Pop	δ /τ	86.5%	86.0%		84.0%	77.0%	↓
Improve the proportion of patients with good or acceptable glycaemic control (HbA1c<64 mmol)	Māori	Ω	57%	32.5%	≥90%	33.1%	N/A	↑
	Non Māori	Ω	58%	45.5%		38.0%		↓
	Total Pop	Ω	57%	37.1%		34.8%		↓
Percentage of eligible women (25-69) have a Cervical Cancer Screen every 3 years	Māori	δ /τ	65%	60%	≥80%	52.7%	55.1%	↓
	Non Māori	δ /τ	80%	85%		80.2%	69.3%	↓
	Total	δ /τ	72%	72%		65.3%	67.2%	↓
Percentage of eligible women (50-69) who have had a Breast Screen in the last 2 years	Māori	δ /τ	59.1%	58%	≥70%	52.6%	59.3%	↓
	Non Māori	δ /τ	73.3%	75%		70.5%	67.1%	↓
	Total	δ /τ	67.3%	67.3%		62.0%	63.4%	↓

Outcome: Fewer people are admitted to hospital for avoidable conditions

Indicator		Measure Type	2019/20 Result	2020/21 Result	2021/22 Target	2021/22 Result	Latest NZ Result	Trend
Percentage of all Emergency Department presentations who triaged at level 4 & 5	Māori	δ	-	-	≤50%	65.3%	39.4%	
	Total		66%	69%		65.8%	36.0%	⇓
Percentage of eligible population who have their B4 School Checks completed [14]	High Needs	δ /τ	80.3%	93.4%	≥90%	87%	92%	⇓
	Total Pop	δ /τ	86.6%	94.6%		89%	93%	⇓
Hospitalisation rates per 100,000 for acute rheumatic fever	Total Pop	δ	4.1	4.1	≤2.8	5.8	1.5	⇑
Increased percentage of Year 9 students receiving HEEADSSS assessment in decile 1-3 schools	Total Pop	δ	31.8%	82.3%	≥95%	27.4%	-	⇓
Improved waiting times for diagnostic services - accepted referrals for CT and MRI receive their scan within 6 weeks[15]	CT Scans	Ω/τ	90.8%	95.7%	≥95%	98.3%	78.1%	⇑
	MRI Scans	Ω/τ	81.2%	91.7%	≥90%	92.1%	58.1%	⇑
Improved waiting times for diagnostic services – accepted referrals for non-urgent diagnostic colonoscopy	within 42 days	Ω/τ	80.1%	79.9%	≥70%	54.1%	50.1%	⇓
Non urgent community laboratory tests are completed and communicated to practitioners within the relevant category timeframes	Within 48 hours	Ω/τ	100%[16]	100%[17]	100%	90%	N/A	⇓
Number of community pharmacy prescription0s issued[18]	Total Pop	δ	475,760	493,676	450,000	515,248	50,882,320	⇑

[14] For 12 months to end May 2022

15 Indicator is for non-planned care diagnostic only, with start time the date the Radiology Department receives the Request and stop time the date the diagnostic was performed.

17 Not included in 2019/20 annual report

[18] Initial prescriptions

Output class: INTENSIVE ASSESSMENT AND TREATMENT SERVICES PERFORMANCE

Timely access to intensive assessment and treatment can significantly improve people's quality of life either through early intervention or corrective action.

Goal 3 - People receive timely and appropriate specialist care

For those who do need a higher level of intervention, timely access to high quality complex care improves health outcomes by restoring functionality, slowing the progression of illness and disease and improving the quality of life. The timeliness and availability of complex treatment and care is crucial in supporting people to recover from illness and/or maximise their quality of life. Shorter wait times are also indicative of a well-functioning system that matches capacity with demand by managing the flow of patients through services and reducing demand by moving the point of intervention earlier in the path of illness.

As providers of hospital and specialist services, DHBs are operating with limited resources under increasing demand and workforce pressure. Reducing the waiting times diagnostic tests, cancer treatment and elective surgery requires organisational and clinical innovation.

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

2021/22 Intensive assessment and treatment services performance

Variable results across this class in 2021/22 with a number of positive trends and a few negative results.

On the positive side people within Tairāwhiti subject to compulsory treatment order under Section 29 of the 1992 Mental Health Act continue to be well under the national average and tangata whaiora readmission rates seeing a slight increase between 2020/21 and 2021/22. While the Emergency Department attendances within Tairawhiti seen within 6 hours a small dip but remained above target and still well above the national and regional levels.

The impact of COVID-19 pandemic response on oncology services was of concern and while rates for patients to received confirmation within 31 days and treatment within 62 days decreased and is now just below the national target.

COVID-19 also appears to have had an impact on the number of outpatient appointments which were missed for one reason or another which increased in 2021/22. While the non-Māori rate remain under target and both the overall and Māori rate increased above the 10% target rate and were not achieved.

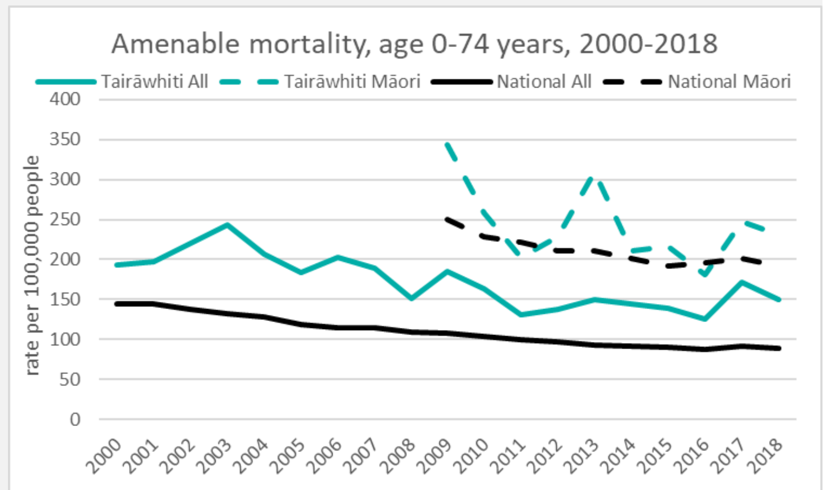
Planned care, previously called electives, was markedly impacted by staffing levels in the first half of 2021/22 and due to the covid-19 pandemic response this was not able to be made up in the later part of the year. The length of stay for planned care surgery increased in 2021/22 but remained within the target.

OUTCOME MEASURES – Long Term[19]

Outcome: People receive prompt and appropriate acute care

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

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

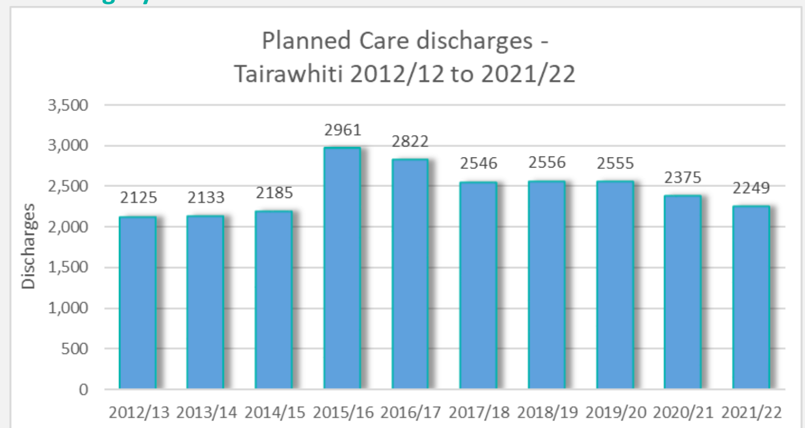


Data source: Amenable mortality SLM Data

Outcome: People have appropriate access to planned care services

Planned care services are an important part of the health system, as they improve a patient's quality of life by reducing pain or discomfort and improving independence and wellbeing. The Government wants more New Zealanders to have access to elective surgical services.

Outcome measure 2: Increased number of people receive planned care surgery

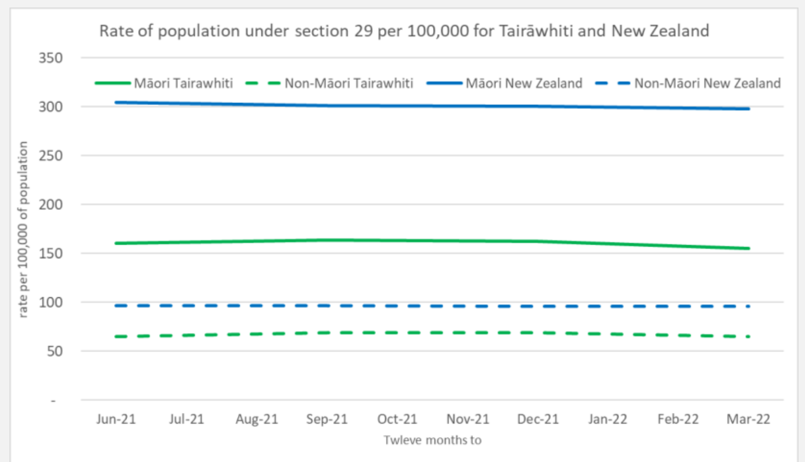


Data Source: Ministry of Health Performance Reporting for Gisborne Hospital

Outcome: Improved access to Mental Health services

It is estimated that at any one time, 20% of the New Zealand population will have a mental illness or addiction, and 3% are severely affected by mental illness. We work to reduce the high suicide rate and support our communities. By stimulating earlier access to mental health services and better access to community mental health services, we hope to see the number of people needing compulsory treatment decrease. For the future, we aim for a mental health care free of compulsory treatment and seclusion as these are a huge infringement of a person's freedom. This however, will need to be a long term goal as many factors contribute here.

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



Data Source: Ministry of Health Performance Reporting PP36

[19] Other entity information is unaudited

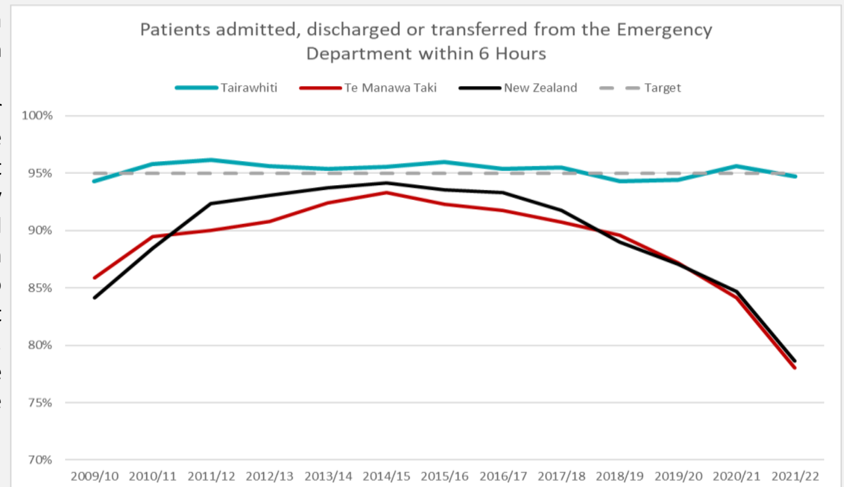
IMPACT MEASURES – Medium Term[20]

Outcome: People receive prompt and appropriate acute care

Emergency Departments (EDs) are often seen as a barometer of the efficiency and responsiveness of both the hospital and the wider health system.
Long waits in ED are linked to overcrowding, poor patient experience, longer hospital stays and negative outcomes for patients. Enhanced performance will not only contribute to improve patient outcomes by enabling early intervention and treatment, but will improve public confidence and trust in our health services. Solutions to reducing ED wait times need to address the underlying causes of delay and span not only our hospital services but the wider health system. In this sense, this indicator is a marker of the responsiveness of our whole system to the urgent care needs of our population.

Results:
2021 – 95%
2022 – 94%

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

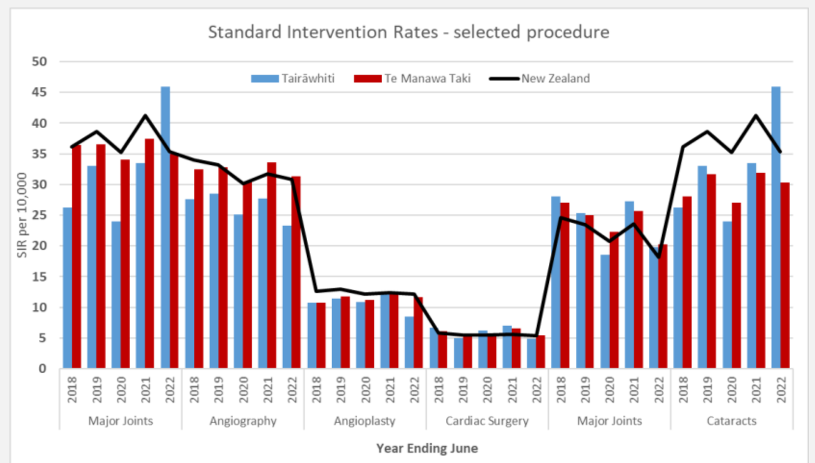


Data Source: Ministry of Heatlh

Outcome: People have appropriate access to elective services (Planned Care)

Performance against this measure is indicative of improved hospital productivity ensuring the most effective use of resources so wait times can be minimised and people in Tairāwhiti receive prompt and appropriate care when they need it.

Impact measure 2: Planned Care Interventions



Data source – Te Whatu Ora 26 August 2022

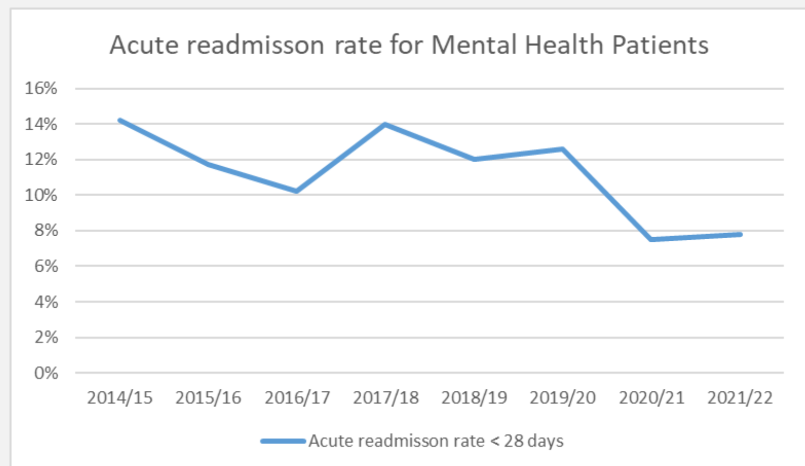
[20] Other entity information is unaudited

Outcome: Improved access to Mental Health services

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

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

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



Data Source: Local Mental Health Dashboard

OUTPUTS – Short Term Performance Measures

Outcome: People receive prompt and appropriate acute care

Indicator		Measure Type	2019/20 Result	2020/21 Result	2021/22 Target	2021/22 Result	Latest NZ Result	Trend
Acute Readmission rate	Total Pop	δ/Ω	12.3%	12.1%	≤6%	10.5%	-	↓
Faster Cancer Treatment – Proportion of patients with a confirmed diagnosis of cancer who receive their first cancer treatment within 31 days of diagnosis (SS01)	Total Pop	δ/ τ	87.9%	88.9%	≥90%	87.3%	87.3%	↓
Faster Cancer Treatment – Proportion of patients with a high suspicion of cancer who receive their first cancer treatment within 62 days or less (SS11)	Total Pop	δ/ τ	94.4%	86.1%	≥90%	88.7%	84.5%	↑
Percentage of missed outpatient appointments[21]	Māori	δ	14%	14.3%	≤10%	16.7%	N/A	↑
	Non Māori		3.4%	3.9%		6.0%		↑
	Total		7%	9.1%		10.7%		↑

***NOTE**: Hauora Tairāwhiti had a gap in 2022 of about 6 months (January-June) between the resignation and new recruitment of a Fast Cancer Tracker, which resulted in many pathways in that period not being looked into and hence not being adjusted in the Cancer Care System (CCS). As a consequence, the referral and treatment dates recorded in our CCS for some patients did not agree to the underlying information and the result reported for this performance measure may not accurately reflect the service performance achievement during the period. We are confident the patients have received care and no one was missed, therefore, we have not attempted to amend the existing data.*

[21] Hospital reporting – Outpatients 2021/22

Outcome: People have appropriate access to elective services

Indicator		Measure Type	2019/20 Result	2020/21 Result	2021/22 Target	2021/22 Result	Latest NZ Result	Trend
Percentage of patients waiting longer than four months for their first specialist assessment (Elective Service Performance Indicator 2)[22]	Total Pop	δ/ τ	25.7%	16.6%	0%	22.7%	N/A	⇑
Number of surgical discharges under the Planned Care (previously electives) initiative	Total Pop	δ	2,841	2,375	≥2,359	2,249	N/A	⇓
Inpatient average length of stay (planned)	Total Pop	δ/τ	0.56	1.00	≤1.45 days	1.44	N/A	⇑

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

Indicator		Measure Type	2019/20 Result	2020/21 Result	2021/22 Target	2021/22 Result	Latest NZ Result	Trend
Percentage of people referred for non-urgent mental health or addiction services are seen within 3 weeks (MH03)[25] Mental Health 0-19 yr olds		δ/ τ	91.4%	92%	≥80%	100%	91%	⇓
Percentage of people referred for non-urgent mental health or addiction services are seen within 3 weeks (Policy Priority 8) (MH03) Addictions 0-19 yr olds		δ/ τ	71.4%	69%	≥80%	100%	897%	⇑
Improving the percentage of clients with wellness and transition plan (MH02)	Māori	δ	N/A	N/A	≥95%	100%	N/A	-
	Non Māori		N/A	N/A		100%	N/A	-
	Total pop		100%	42%		100%	N/A	-
Average length of acute inpatient stays for mental health (KPI 8)		Ω/δ/τ	13.9 days	9.8 days	14-21 days	14.11 Days	N/A	⇑
Rates of post-discharge community care (KPI 18)		Ω/δ/τ	48%	62.3%	≥90%	N/A	N/A	-

[22] Ministry of Health website – Elective Services Patient Flow Indicators (ESPIs) – Final – % waiting in June.
[25] Data for 12 months from April 21 till March 2022.

Output class: REHABILITATION AND SUPPORT SERVICES

Goal 4 – People maintain functional independence

The vision of the New Zealand Healthy Ageing Strategy is for older people to leave well, age well and have a respectful end of life in age-friendly communities.

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

Clinicians, in cooperation with patients and their families, make decisions regarding treatment and care. Not all decisions should result in interventions to prolong life, but may focus on patient care such as pain management or palliative services to improve the quality of life.

As illness and disability effect an individual's functions, we need to support them in a way that maintains these functions as long as possible at the highest possible level. Support should be tailored to the individual's needs and evolve seamlessly with the changing functional abilities of that person. Regularly assessing these needs is a prerequisite for this. The interRAI assessment offers a very good picture of remaining functionality and support needs. The interRAI home care assessment is a prerequisite for home support, so all people receiving home support are assessed before they come into care. The care plan is an intrinsic part of this assessment. And this is how the indicator originally was interpreted. This does however not necessarily mean that people who remain in care longer are reassessed after that first assessment. For long-term home support clients, an assessment is required every three years, or if there is a significant change in their condition. Therefore, we changed the indicator to 'Percentage of older people receiving long-term home support who have had a comprehensive clinical assessment and a completed care plan in the last 36 months'. Analysis of the interRAI data shows us that indeed all home support clients have at least one inter RAI assessment in the last three years. We added the 12 months indicator as well, as this shows us how many people receiving home support, were assessed in the last year. The 25% result here shows that indeed one out of four home support clients had an assessment in the last 12 months, given the impact of COVID over the last few year this indicates that some work is still required to achieve the 100% for the 36 months indicator. Analysis of the assessments shows that indeed people were reassessed according to changes in their circumstances: after a hospital discharge and if their condition had deteriorated or routinely after they had been receiving home support for almost three years.

In the future, we hope to build a more flexible home support model, based on measured changes in client's needs. However, the time investment required to do an interRAI home care assessment does not allow us to increase the frequency of this assessment. Therefore, we might look possible shorter interRAI assessments that allow measuring a client's support and health needs more frequently.

Even if very little functional independence is left, people should be able to stay in control of their life. Advanced care plans are a very valuable instrument to make sure that a person can remain in charge even if he/she can't express his/her wishes anymore.

2021/22 Rehabilitation and Support Services performance

Performance within this class has been significantly impacted COVID19 and sector is still seeing lower staffing levels with increased restrictions on availability of international staff for Aged Related Residential Care and Home Care Support Service, particular for Register Nurses and Support Workers.

Acute admission for those 65 and over has decreased which is likely linked to the community measures put in place to reduce the spread of COVID19. The proportion of Older people supported to live independently at home compared to those entering residential care has decreased and is likely linked to the impact of COVID19 and changes within the Aged Care Sector.

OUTCOME MEASURES - Long Term

Outcome: People stay well in their home and community

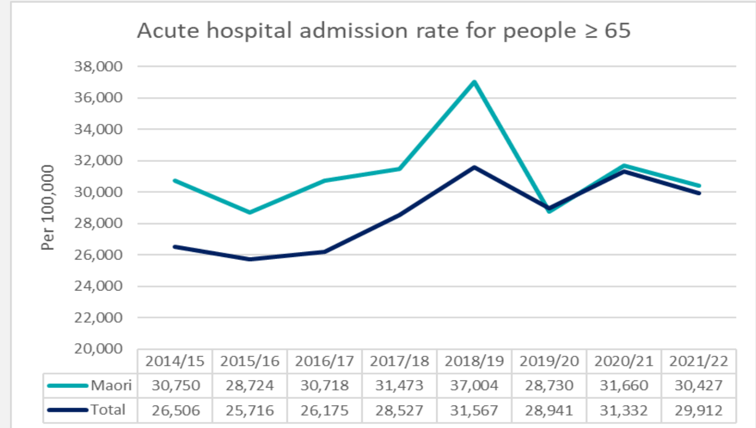
Elderly people take up a large part of acute hospital admissions. Hospital admissions are, apart from the financial impact on the Health Care budget, often very disturbing and even dangerous for these vulnerable elderly. Elderly admitted to hospital are at risk of developing delirium, hospital acquired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

Approximately a quarter of all local medical and surgical discharges in older adults were ambulatory sensitive admissions[26]. Some of these admissions could possibly have been avoided by better management of the multipathology of this geriatric population and improved home support. This requires coordinated care between all community partners (GP, Pharmacist, Community nurse, Home Support,..) in combination with secondary care, allied health services, social services and other support agencies.

Possible interventions[27]:

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

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



Acute hospital admissions for people ≥ 65 per 100,000 population 65+

Source: Hospital Reporting

Outcome: People with end stage conditions are supported

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

When asked about their wishes regarding end of life, most people say they would like to die at home.

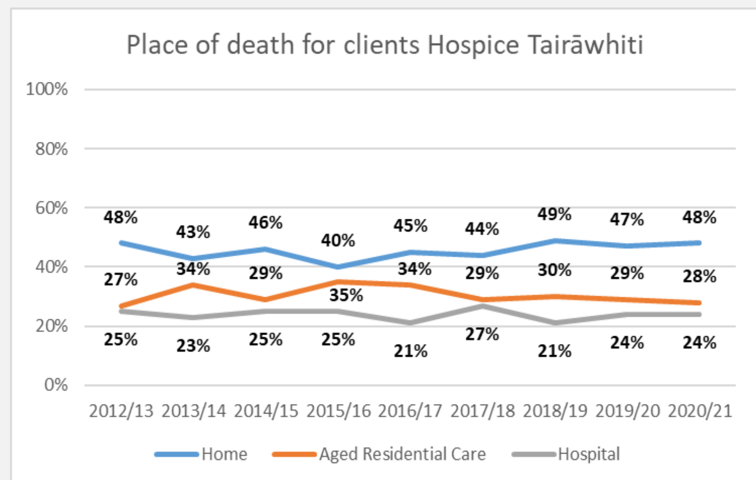
Unfortunately too many people still die in hospital.

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

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

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

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



Source: Hospice Tairāwhiti Annual Report

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

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

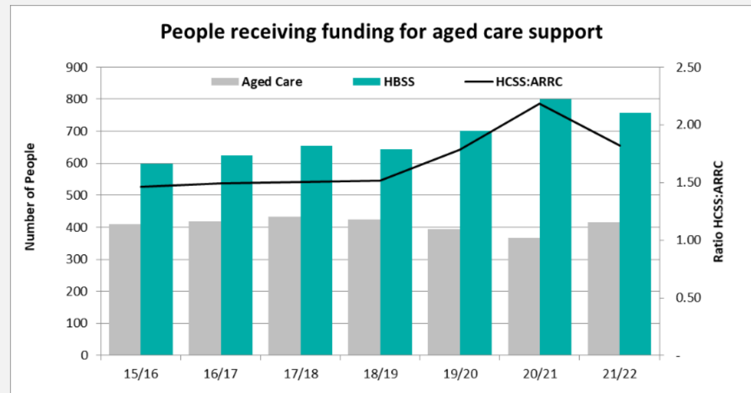
IMPACT MEASURES – Medium Term[28]

Outcome: People stay well in their home and community

Most elderly people hope to live in their own home or with whānau in their community for as long as possible. Most of them dread a possible move into residential care. When people's ability to perform every day life activities decreases, they often rely on whānau, neighbours and friends for support. If this is not sufficient or the care for the person becomes too hard for these people, a move into residential care often seems to be the only solution.
Residential care is, apart from not being the home of choice for many elderly, also costly for both the client and their whānau as for the public health system.

By better supporting the vulnerable elderly and their whānau, residential care admission often can be delayed or even avoided. Yearly approximately 6% of our population 65 and over, receive some funding for Aged Related Residential Care (ARRC), and 9% for Home Based Support Services. This proportion has been the same for the last 5 years.

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

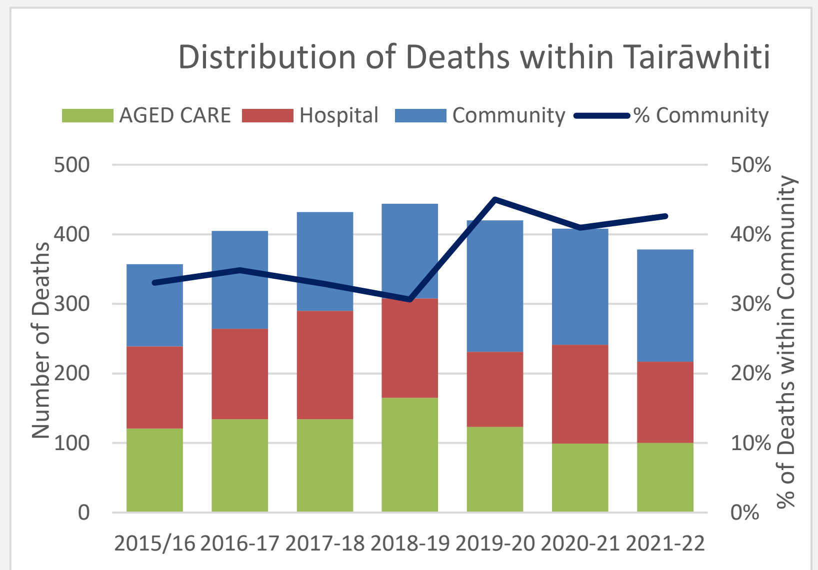


Source – Client Claims Processing System (CCPS)

Outcome: People with end stage conditions are supported

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

Impact measure 2: People can die at home



Source: Stats NZ Deaths Gisborne Region, ARRC and Hospital Statistics

[28] Other entity information is unaudited

OUTPUTS – Short Term Performance Measures

Outcome: People stay well in their home and community

	Measure Type	2019/20 Result	2020/21 Result	2021/22 Target	2021/22 Result	Latest NZ Result	Trend
Percentage of older people receiving long-term home support who have had a comprehensive clinical assessment and an individual care plan in the last 36 months	δ /τ	95%	88.4%	100%	91.2%	N/A	⇧
Percentage of older people receiving home support who have had a comprehensive clinical assessment and an individual care plan in the last 12 months	Ω/ δ /τ	34%	44.5%	60%	25.2%	N/A	⇩

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

Outcome: People with end stage conditions are supported

Indicator	Measure Type	2019/20 Result	2020/21 Result	2021/22 Target	2021/22 Result	Latest NZ Result	Trend
Number of hospital admissions under Health Speciality Code M80 (Palliative Care)	Ω	5	24	Increase	5	N/A	⇩
Number of falls in Aged Residential Care Facility resulting in admission[29]	Ω	New Measure	N/A	Decrease	N/A	N/A	-
Number of pressure injuries[30]	Ω	New Measure	66	Decrease	N/A	N/A	-

[29]Data for the 2021/22 year is incomplete due to the impact of COVID19 on Aged Related Residential Care
[30] Data for the 2021/22 year is incomplete due to the impact of COVID19 on Aged Related Residential Care and home support

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 Tairāwhiti, 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]
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.

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

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	10.28%	10.75%
2021/2022	76.55%	80.03%
Total	86.82%	90.78%

Using HSU 2021 to determine the percentage of the eligible population who have completed their primary course, the coverage is calculated to be 86.82%, compared with 90.78% using HSU 2020 as at 30 June 2022.

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

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 Tairāwhiti during 2021/22 and the prior financial year (2020/21). This information was obtained from the COVID-19 Vaccination and Immunisation Programme (CVIP) database.

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

Year[4]	Primary course				
	Dose 1	Dose 2	Booster 1	Booster 2	Total[5]
2020/21	7,220	4,489	0	0	11,709
2021/22	34,303	34,617	22,988	157	92,065
Total	41,523	39,106	22,988	157	103,774

By 30 June 2022, a total of 103,774 COVID-19 vaccinations had been administered, of which 88.7% 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.

[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.
[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.

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	2,837	1,315	-	-	4,152
12 to 15	3,060	2,847	3	-	5,910
16 to 19	2,377	2,353	592	-	5,322
20 to 24	2,455	2,386	1,014	-	5,855
25 to 29	2,745	2,683	1,204	-	6,632
30 to 34	2,767	2,772	1,433	-	6,972
35 to 39	2,345	2,323	1,431	1	6,100
40 to 44	2,250	2,253	1,558	1	6,062
45 to 49	2,354	2,386	1,842	5	6,587
50 to 54	2,427	2,504	2,056	-	6,987
55 to 59	2,382	2,501	2,268	14	7,165
60 to 64	2,267	2,438	2,425	14	7,144
65 to 69	1,568	2,042	2,285	28	5,923
70 to 74	1,105	1,618	1,940	24	4,687
75 to 79	610	974	1,265	22	2,871
80 to 84	413	675	919	19	2,026
85 to 89	216	351	455	9	1,031
90+	125	196	298	20	639
Total	34,303	34,617	22,988	157	92,065

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).

[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.

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

Age group[10] (years)	Partial[11]		Primary course[12]		Booster course			
	Partiallyvaccinated	Partiallyvaccinated (% eligible)	Completedprimary course	Completedprimary course (% eligible)	Received first booster (18+)	First booster (% eligible) (18+)	Received second booster (50+)	Received second booster % eligible (50+)
0 to 11	2,381	26%	1,126	12%	-	0%	-	0%
12 to 15	2,653	80%	2,286	69%	-	0%	-	0%
16 to 19	2,609	87%	2,529	84%	343	37%	-	0%
20 to 24	2,507	80%	2,443	78%	989	38%	-	0%
25 to 29	2,659	74%	2,613	73%	1,168	41%	-	0%
30 to 34	2,834	78%	2,836	78%	1,403	46%	-	0%
35 to 39	2,478	80%	2,484	80%	1,461	54%	-	0%
40 to 44	2,254	75%	2,261	75%	1,490	59%	-	0%
45 to 49	2,286	73%	2,321	74%	1,776	68%	-	0%
50 to 54	2,445	76%	2,513	78%	2,051	72%	1	0%
55 to 59	2,352	74%	2,455	77%	2,220	79%	12	5%
60 to 64	2,338	72%	2,501	77%	2,442	83%	15	4%
65 to 69	1,759	63%	2,136	76%	2,281	89%	23	7%
70 to 74	1,179	52%	1,681	74%	2,001	92%	28	8%
75 to 79	727	51%	1,112	77%	1,384	93%	19	8%
80 to 84	438	43%	740	73%	972	98%	21	14%
85 to 89	260	52%	418	83%	511	99%	8	15%
90+	155	46%	256	76%	346	107%	22	42%
Total	34,314	65%	34,711	65%	22,838	67%	149	8%

[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	1,167	1,133	839	2	3,141
European/other	14,889	15,977	12,670	124	43,660
Māori	17,109	16,382	8,762	29	42,282
Pacific peoples	964	958	589	2	2,513
Unknown	174	167	128	-	469
Total	34,303	34,617	22,988	157	92,065

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	1,068	75%	1,091	76%	838	71%	2	10%
Māori	15,704	75%	15,779	76%	8,687	58%	25	4%
European /other	14,058	70%	15,530	77%	12,592	76%	121	10%
Pacific peoples	927	82%	999	89%	589	60%	1	5%
Unknown	176	77%	186	81%	132	58%	0	0%
Total	**31,933**	73%	**33,585**	77%	22,838	67%	149	8%

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

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.

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	1,293	90%	1,279	90%	838	71%	2	10%
Māori	18,204	87%	17,384	83%	8,687	58%	25	4%
European /other	18,350	91%	18,103	90%	12,592	76%	121	10%
Pacific peoples	1,119	99%	1,088	96%	589	60%	1	5%
Unknown	254	110%	241	105%	132	58%	0	0%
Total	**39,220**	89%	38,095	87%	22,838	67%	149	8%

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

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

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

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

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

50+ age determined as at 30-Jun-2022

Basis of population is HSU2021 for 12+ years old

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

Further notes on the HSU dataset

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

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

While we use the HSU to determine vaccination coverage within the eligible population, the HSU is not a total population estimate and it is likely to miss highly marginalised groups.
For example, our analysis suggests that groups underrepresented in the HSU include young people aged 15-45 years (men in particular), and people of Asian and Middle Eastern, Latin American and African ethnicities.

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

1. Census counts produced every 5 years with a wide range of disaggregation's

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

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

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]

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 53,161 health service users in the HSU 2021. This is an increase of 1,722 people from the HSU 2020 (an approximate 3.4% increase), and 1,661 more people than the Stats NZ PRP for 30 June 2021. DHB population by ethnicity: HSU 2021 and Stats NZ PRP comparison[18]

[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/

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

Ethnicity	HSU 2021	Stats NZ PRP	Difference (Note 1)
Māori	26,789	28,200	1,411
Pacific peoples	1,359	1,220	-139
Asian	1,742	1,270	-472
European/other	22,991	20,800	-2,191
Unknown	280	-	-280
Total (Note 1)	**53,161**	**51,500**	**-1,661**

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

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	25,919	27,600	1,681
Pacific peoples	1,193	1,210	17
Asian	1,396	1,260	-136
European/other	22,769	21,100	-1,669
Unknown	162	-	-162
Total (Note 1)	51,439	51,100	-339

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 EpiSurv[20] and the National Contact Tracing Solution (NCTS) databases. The data received through these systems is extensively checked for duplications using national health index (NHI) data.
The definition of COVID-19 deaths that the Ministry now uses in most situations, including in this section, is defined as 'deaths attributed to COVID-19'.

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

There can be delays processing the Cause of Death Certificates being updated in our systems. For example, where a paper-based death certificate is issued, the data will not be recorded as quickly as if it was submitted electronically.
Whether an individual's death is attributed to COVID-19 relies on a variety of sources. These include self-declaration, notifications via health records, or additional tests that are undertaken after death.

COVID-19 Deaths by age group

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

[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

Age group (years)	
<10	0
10 to 19	0
20 to 29	0
30 to 39	0
40 to 49	0
50 to 59	0
60 to 69	2
70 to 79	5
80 to 89	0
90+	3
Total	**10**

COVID-19 deaths by ethnicity

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

Ethnicity	Tairāwhiti
Asian	0
European/other	4

Māori	6
Pacific peoples	0
Unknown[21]	0
Total	**10**

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

Summary of Revenue and Expenses by Output Class

Statement of Intent

The Crown Entities Act 2004 requires DHBs to report revenue and expenses for each Output Class. There are four output classes for 2021/22

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

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

Output Class Funding Allocation

	Actual 2020/21 $000's	Budget 2021/22 $000's	Actual 2021/22 $000's
Income			
Prevention	($62,918)	($66,197)	($65,718)
Early Detection and Management	($137,814)	($140,514)	($163,502)
Intensive Assessment and Treatment Services	($10,081)	($8,829)	($13,373)
Rehabilitation and Support	($22,458)	($27,119)	($24,503)
Total Income	**($233,271)**	**($242,659)**	**($267,096)**
Expenditure			
Prevention	$53,903	$68,729	$63,786
Early Detection and Management	$152,481	$144,490	$195,383
Intensive Assessment and Treatment Services	$7,819	$9,167	$5,764
Rehabilitation and Support	$25,818	$28,156	$29,006
Total Expenditure	**$240,022**	**$250,542**	**$293,938**
Surplus/(Deficit)	**($6,752)**	**($7,883)**	**($26,841)**

Statutory Information

New Zealand Public Health and Disability Act 2000

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

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

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

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

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

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

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

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

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

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

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

(k) To be a good employer.

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

(a) To ensure the provision of services for its resident population and for other people as specified in its Crown funding agreement:

- All Crown Funding Agreement (CFA) actions for the period completed as required.
- Compliance with the Service Coverage Schedule for both Hauora Tairāwhiti provider and other community providers via service agreements (excluding those exceptions to meeting the schedule, as outlined in Hauora Tairāwhiti's Annual Plan).
- Overall outputs for the provider arm met – with variation between service lines.

(b) To actively investigate, facilitate, sponsor, and develop co-operative and collaborative arrangements with persons in the health and disability sector or in any other sector to improve, promote, and protect the health of people, and to promote the inclusion and participation in society and independence of people with disabilities:

- Hauora Tairāwhiti has developed a series of clinical alliances with other DHBs and providers both locally and across the country in order to achieve its aims.

- Hauora Tairāwhiti is a member of DHB Shared Services, the joint agency for all DHBs. Hauora Tairāwhiti contributes to, and gains benefit from collaborative action to advance the aims of Hauora Tairāwhiti and the health sector in general.

(c) To issue relevant information to the resident population, persons in the health and disability sector, and persons in any other sector working to improve, promote, and protect the health of people for the purposes of paragraphs (a) and (b):

- Hauora Tairāwhiti has a positive relationship with the local media, particularly the newspaper.
- All matters of importance are communicated to the Tairāwhiti population.
- Regular contact with other providers is maintained.
- Regular reporting to the MoH.
- Regular reporting to Board and Advisory Committees via public accountability system.

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

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

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

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

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 Dec 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.

Statement of Responsibility for the Year Ended 30 June 2022

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 Hauora Tairawhiti 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.

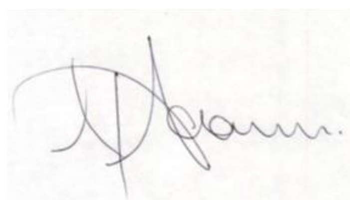
The Board and Management of Te Whatu Ora take responsibility for the preparation of Hauora Tairawhiti group's financial statements and statement of performance, and for the judgements made in them.

We are responsible for any end-of-year performance information provided by Hauora Tairawhiti group under section 19A of the Public Finance Act."

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

In our opinion, these financial statements and statement of performance fairly reflect the financial position and operations of Hauora Tairawhiti group for the year ended 30 June 2022.

Signed on behalf of the Te Whatu Ora Board:



Naomi Ferguson
Acting Chair
Dated: 16 March 2023

Hon Amy Adams
Board member
Dated: 16 March 2023

Independent Auditor's Report

To the readers of

Hauora Tairawhiti's group financial statements and performance information for the year ended 30 June 2022

The Auditor-General is the auditor of Hauora Tairawhiti Group (the Group). The Auditor-General has appointed me, Kelly Rushton, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and the performance information, including the performance information for an appropriation, of the Group on his behalf.

We have audited:

- the financial statements of the Group on pages 43 to 67, that comprise the statement of financial position as at 30 June 2022, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flow for the year ended on that date, and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Group on pages 3 to 33.

Qualified opinion

In our opinion, except for the possible effects of the matters described in the Basis for our qualified opinion section of our report:

- the financial statements of the Group on pages 43 to 67, 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; and
- the performance information of the Group on pages 3 to 33:
    - presents fairly, in all material respects, the Group's performance for the year ended 30 June 2022, including:
        - for each class of reportable outputs:

        - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
        - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
    - what has been achieved with the appropriation; and
    - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and
- complies with generally accepted accounting practice in New Zealand.

Our audit on the financial statements and the performance information was completed on 16 March 2023. This is the date at which our qualified opinion is expressed.

The basis for our qualified 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 qualified opinion

The financial statements are qualified due to uncertainties over the provision for holiday pay entitlements under the Holidays Act 2003

As outlined in note 18 on pages 62 and 63, the Group 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 provision for employee entitlements includes a provision of $23.472 million for the estimated amounts owed to current and past employees. Work on the provision is ongoing, due to the complex nature of health sector employment arrangements, and there is a high level of uncertainty over the amount of the provision. We have therefore been unable to obtain adequate evidence to determine if the amount of the provision is reasonable.

We were also unable to obtain adequate evidence of the $10.397 million provision as at 30 June 2021. We accordingly expressed a qualified opinion on the financial statements for the year ended 30 June 2021.

The performance information is qualified due to recorded dates not agreeing to underlying records for the *"Faster Cancer Treatment – Proportion of patients with a high suspicion of cancer who received their first cancer treatment within 62 days or less"* performance result

An important part of the Group's performance information is reporting the proportion of patients with a high suspicion of cancer who received their first cancer treatment within 62 days or less. As disclosed on page 18 there were issues with recorded referral and treatment dates for some patients not agreeing to underlying information. As a result, our work was limited and there were no practicable audit procedures we could apply

to obtain assurance whether the reported result for this performance measure is materially correct.

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

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

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

Emphasis of matters

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

The financial statements have been prepared on a disestablishment basis

Note 1 on page 48 outlines that the Group has prepared its financial statements on a disestablishment basis because the Group 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 Group'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

Pages 24 to 32 outlines the information used by the Group to report on its Covid-19 vaccine coverage. The Group 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 29 to 31. Page 31 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 Group 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 30 on page 66 to the financial statements outlines the ongoing impact of Covid-19 on the Group.x

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 Group is the responsibility

of the Board of Te Whatu Ora.

The Board of Te Whatu Ora is responsible on behalf of the Group 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 Group 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 Group'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 Group'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 Group'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 obtain sufficient appropriate audit evidence regarding the financial statements and the performance information of the entities or business activities within the Group to express an opinion on the consolidated financial statements and the consolidated performance information. We are responsible for the direction, supervision and performance of the group audit. We remain solely responsible for our audit opinion.

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, 2, 34 to 36, 68, and 69, 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 Group 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 Group.

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

Statement of Comprehensive Revenue and Expense

Statement of Comprehensive Revenue and Expense
For the year ended 30 June 2022

	Notes	Actual 2022 $000	Budget 2022 $000	Actual 2021 $000
Revenue				
Patient care revenue	2 i	258,163	241,933	231,618
Interest revenue		89	110	118
Other revenue	2 ii	8,844	617	1,619
Total revenue		267,096	242,660	233,355
Expenses				
Personnel Cost	3	117,840	96,612	89,031
Depreciation and amortisation expenses				
Property, plant and equipment	12	3,504	3,451	3,252
Intangible assets	13	619	424	292
Outsourced services		16,661	7,241	12,280
Clinical Supplies		20,663	19,197	19,206
Infrastructure and non-clinical expenses		15,137	10,817	10,450
Other district health boards		28,803	29,598	25,141
Non-health-board provider expenses		87,831	81,239	78,193
Capital charge	4	2,343	1,900	1,903
Interest expense		16	64	55
Other expenses	5	1,300	(380)	1,068
Total expenses		294,716	250,163	240,871
Share of associate surplus / (deficit)	11	780	380	764
Surplus / (deficit)		(26,841)	(7,883)	(6,752)
Other comprehensive revenue and expense				
Revaluation of land and buildings		9,389	0	15,512
Total other comprehensive revenue and expense		9,389	0	15,512
Total comprehensive revenue and expense		(17,452)	(7,883)	8,760

Explanations of major variances against budget are provided in Note 28.
The accompanying notes form part of these financial statements.

Statement of Financial Position

Statement of Financial Position
As at 30 June 2022

	Notes	Actual 2022 $000	Budget 2022 $000	Actual 2021 $000
Assets				
Current Assets				
Cash & cash equivalents	6	438	2,542	2,587
Receivables	7	18,989	5,621	11,282
Prepayments		1,693	1,455	1,206
Inventories	9	1,935	1,983	2,126
Total current assets		23,055	11,601	17,201
Non-current assets				
Investments in subsidiary and associates	11	1,395	1,198	1,250
Property, plant and equipment	12	89,355	63,641	77,481
Intangible assets	13	3,268	2,997	3,450
Total non-current assets		94,018	67,836	82,181
Total assets		117,073	79,437	99,382
Liabilities				
Current Liabilities				
NZ Health Partnership Ltd	6	5,692	0	0
Payables and deferred revenue	14	32,903	18,783	22,335
Borrowings	16	184	159	171
Employee entitlements	17	43,622	14,554	25,549
Total current liabilities		82,401	33,496	48,055
Non-current Liabilities				
Borrowings	16	45	403	232
Employee entitlements	17	898	10,276	885
Total non-current liabilities		943	10,679	1,117
Total liabilities		83,344	44,175	49,172
Net Assets		33,729	35,262	50,210
Equity	19			
Crown equity		80,703	88,096	79,717
Accumulated surpluses / (deficits)		(110,892)	(91,838)	(84,051)
Property revaluation reserves		63,905	39,004	54,516
Trust funds and bequests		13		28
Total equity		33,729	35,262	50,210

Explanations of major variances against budget are provided in Note 28.
The accompanying notes form part of these financial statements.

Statement of Changes in Equity

Statement of Changes in equity
For the year ended 30 June 2022

	Notes	Actual 2022 $000	Budget 2022 $000	Actual 2021 $000
Balance at 1 July		50,210	35,526	41,832
Total comprehensive revenue and expense		(17,452)	(7,883)	8,760
Owner transactions	19			
Capital contribution		1,368	8,000	0
Crown loans converted to equity		0	0	0
Repayment of capital		(382)	(382)	(382)
Bequest Trusts interest		(15)	0	0
Balance at 30 June		33,729	35,261	50,210

Explanations of major variances against budget are provided in Note 28.
The accompanying notes form part of these financial statements.

Statement of Cash Flow

Statement of Cash Flows
For the year ended 30 June 2022

	Notes	Actual 2022 $000	Budget 2022 $000	Actual 2021 $000
Cash flows from operating activities				
Receipts from patient care				
Ministry of Health		232,771	229,819	215,359
Other District Health Boards		2,850	2,934	2,999
Other		15,599	8,845	8,733
Receipts from other revenue		8,844	1,015	1,618
GST (net)		(444)	0	138
Payments to suppliers		(131,589)	(133,865)	(120,089)
Payments to Other District Health Boards		(28,803)	(29,598)	(25,141)
Payments to employees		(99,754)	(81,239)	(87,427)
Capital charge		(2,343)	(1,966)	(1,903)
Net Cash flow from operating activities		(2,869)	(4,055)	(5,713)
Cash flow from investing activities				
Distributions from subsidiary company		635	110	712
Interest receipts		89	0	118
Receipts from sale of property, plant, and equipment		0	0	0
Purchase of property, plant and equipment		(6,035)	(4,251)	(4,105)
Purchase of intangible assets		(437)	(424)	(985)
Net cash Flow from investing activities		(5,748)	(4,565)	(4,260)
Cash flow from financing activities				
Capital contributions from the crown		1,368	8,000	0
Interest paid		(20)	(63)	(56)
Repayment of capital to the Crown		(382)	(382)	(382)
Repayment of finance leases		(190)	0	(161)
Net cash flow from financing activities		776	7,554	(599)
Net (decrease) / increase in cash and cash equivalents		(7,841)	(1,066)	(10,572)
Cash and cash equivalents at the start of the year		2,587	4,935	13,159
Cash and cash equivalents at the end of the year	6	(5,254)	3,870	2,587

Explanations of major variances against budget are provided in Note 28.
The accompanying notes form part of these financial statements.

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

For the year ended 30 June 2022	Actual 2022 $000	Actual 2021 $000
Net surplus / (deficit)	(26,841)	(6,752)
Add / (less) non-cash items		
Share of associates surplus	(780)	(764)
Increase in non-current employee entitlements	13	(75)
Depreciation and amortisation expense	4,123	3,544
Other non-cash items	0	46
Net change on financial instruments and term liabilities	104	58
Total non-cash items	3,460	2,809
Add / (less) items classified as investing or financing activities		
Interest reclassified in the current year	0	0
Total items classified as investing or finance activities	0	0
Add / (less) movements in statement of financial position items		
(Increase) / decrease in receivables	(7,707)	(6,989)
(Increase) / decrease in prepayments	(487)	249
(Increase) / decrease in inventories	191	(143)
Increase / (decrease) in payables	10,442	3,434
Increase / (decrease) in employee entitlements	18,073	1,679
Net movements in working capital items	20,512	(1,770)
Net cash (outflow) / inflow from operating activities	(2,869)	(5,713)

The accompanying notes form part of these financial statements.

Notes to the Financial Statements

Note 1: Statement of Accounting Policies

Reporting / Economic Entity
Hauora Tairāwhiti is a Health Board established by the New Zealand Public Health and Disability Act 2000. Hauora Tairāwhiti is a crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand.

The group consists of Hauora Tairāwhiti, its subsidiary company Tairāwhiti Laundry Services Limited (TLSL), which holds the associated partnership share in Gisborne Laundry Services (GLS), *and its associated companies HealthShare Limited and TLab Limited (TLab).*

The group activities involve delivering health and disability services and mental health services in a variety of ways to the community. Hauora Tairāwhiti does not operate to make a financial return.

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

The financial statements for the group are for the year ended 30 June 2022 and were approved for issue by the Health New Zealand board on XXXXX

Basis of preparation
The financial statements for the year ended 30 June 2022 has be prepared on a disestablishment basis due to the disestablishment of all DHBs on 1 July 2022.

Generally, we would not expect any adjustments to the measurement or classification of assets and liabilities due to the disestablishment basis of preparation as these transfer to, and remain relevant to, Health New Zealand.

Statement of Compliance
The financial statements of Hauora Tairāwhiti have been prepared in accordance with the requirements of the NZ Public Health and Disability Act 2000 and the Crown Entities Act 2004, which include the requirement to comply with GAAP, with the exception of Note 31, breach of the statutory reporting timeframe. The financial statements have been prepared in accordance with Tier 1 PBE accounting standards.

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

Changes in accounting Policies
There have been no changes in accounting policies.

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

PBE IPSAS 41 Financial Instruments
The XRB issued *PBE IPSAS 41 Financial Instruments* in March 2019. This standard supersedes *PBE IFRS 9* Financial Instruments, which was issued as an interim standard. It is effective for reporting periods beginning on or after 1 January 2022. Although Hauora Tairāwhiti has not assessed the effect of the new standard, it does not expect any significant changes as the requirements are similar to *PBE IFRS 9*.

PBE FRS 48 Service Performance Reporting
PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 and is effective for the year ending 30 June 2023. Hauora Tairāwhiti has not yet determined how application of PBE FRS 48 will effect is statement of performance.

New Amendment Applied
Amendment to PBE IPSAS 2 Statement of Cash Flows

An amendment to *PBE IPSAS 2 statement of Cash Flows* requires entities to provide disclosures that enable users of the financial statements to evaluate changes in liabilities arising from financing activities, including both changes arising from cash flows and non-cash changes. This amendment is effective for annual periods beginning on or after 1 January 2021.

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

Goods and services tax
All items in the financial statements are exclusive of goods and services tax (GST) with the exception of receivables and payables, which are stated with GST included. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense. The net GST recoverable or payable is included as part of receivables or payables in the Statement of Financial Position. All GST paid or received is classified as an operating cash flow in the Statement of cash flows.

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

Budget figures
The budget figures are those approved by the Board and published in its Statement of Performance Expectations and have been prepared in accordance with GAAP and are consistent with the accounting policies adopted by the Board.

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

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

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

Critical accounting estimates and assumptions
In preparing these financial statements, Hauora Tairāwhiti has made estimates and assumptions concerning the future. These estimates and assumptions might differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances.

The estimates and assumptions that have risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are:

- Retirement and Long Service Leave – refer to Note 17
- Holidays Act compliance – refer to Note 18

Note 2: Revenue

Accounting Policy

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

Ministry of Health population based revenue

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

Ministry of Health contract revenue

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

Revenue from other District Health Boards

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

ACC contract revenue

Revenue is recognised when eligible services are provided and contract conditions have been fulfilled.

Interest Revenue

Revenue recognised using the effective interest method.

Rental Revenue

Revenue recognised over a straight-line basis over the lease term.

Other Service Revenue

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

Donations, grants and bequests

Revenue recognised immediately unless there are conditions to be fulfilled, in which case a liability is recorded and then released as the conditions are fulfilled.

Where a physical asset is gifted to or acquired by Hauora Tairāwhiti for nil consideration or a subsidised cost, the asset is recognised at fair value and the difference between the fair value and consideration provided is recognised as revenue.

Donated services

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

i Patient Care Revenue	**Actual 2022 $000**	**Actual 2021 $000**
MoH population-based Funding	202,845	190,870
MoH other contracts	31,521	26,981
COVID funding (MoH)	8,858	0
Inter-district Flows (other DHBs)	2,850	2,999
Other patient care related revenue	12,089	10,768
Total Patient care revenue	258,163	231,618

Performance against the MoH population based funding is reported in the Statement of Performance section of the Annual Report.

As required by the Public Finance Act 1989, Hauora Tairāwhiti received $209,240k of revenue from the Crown as part of the Vote Health appropriations. This amount equals the actual expenses incurred by the Government in relation to the appropriation. Hauora Tairāwhiti has considered the Direction 2011 "Health and Disability Services Eligibility" issued by the Minister of Health pursuant to section 32 of the NZ Public Health and Disability Act 2000, when establishing patient's eligibility for funded services from the DHB.

ii Other Revenue	Actual 2022 $000	Actual 2021 $000
Donated equipment	0	0
Donated consumables *	3,929	0
Cash donation received	146	485
Rental revenue	237	274
Other revenue	4,532	859
	8,844	1,618

* Donated consumables - Personal Protective Equipment and RATs provided direct from Ministry of Health

Note 3: Personnel costs and employee remuneration

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

Employee entitlements
- Annual, parental and conference leave are based on an actual entitlement basis at current rates of pay.
- Long service and retirement provisions are calculated on an actuarial basis.
- Sick leave is recognised to the extent that compensated absences in the coming year are expected to be greater than the leave entitlements earned in the coming year.
- Other leave provisions are based upon the amount expected to be used in the coming year
- During the year provision has been made in relation to compliance with the Holidays Act 2003 of $13,261k (2021; $1,082k including a provision $150k fpr [project work). This provision has been calculated using a script on a copy of the payroll database. The figures in the table below also includes a provision of $800k to complete the work required to meet this liability.

Superannuation schemes
Defined contribution schemes
Employer contributions to Kiwisaver, government superannuation and the State sector retirement saving scheme are accounted for as defined contribution schemes and are recognised as an expense as incurred.

Defined benefit schemes
Hauora Tairāwhiti makes employer contributions to the Defined Benefit Plan Contributors Scheme (the scheme), which is managed by the Board of Trustees of the National Provident Fund. The scheme is a multi-employer defined benefit scheme. Insufficent information is available to use defined benefit accounting, as it not possible to determine from the terms of the scheme the extent to which the surplus/deficit will affect future contributions by individual employers, as there is no prescribed basis for allocation. The scheme is therefore accounted for as a defined contribution scheme.

Breakdown of personnel costs	Actual 2022 $000	Actual 2021 $000
Salaries and wages	97,808	85,592
Defined contribution plan employer contributions	1,946	1,835
Increase / (decrease) in liability for employee entitlements	4,025	522
Holidays Act Compliance	14,061	1,082
	117,840	89,031

During the year ended 30 June 2022, 3 (2021:0) employees received compensation and other benefits in relation to cessation totalling $23K (2021: $0K).

Note 4: Capital charge

The capital charge is recognised as an expense in the financial year to which the charge relates. Haoroa Tairāwhiti pays capital charge every six months to the Crown based upon the closing equity balance for the previous six months. The capital charge rate of the year was 5% (2021 5%).

Note 5: Other expenses

	Note	Actual 2022 $000	Actual 2021 $000
Fees to auditor			
- Audit NZ for audit of the financial statements		166	133
- Audit of Subsidiary Accounts		3	3
- Internal audit fees		94	102
Bad debts written off		(1)	(2)
Operating lease expense		743	556
Board member fees	32	233	245
Board election expenses		0	0
Loss on disposal of property, plant and equipment		29	29
Other Expenses		33	2
		1,300	1,068

Note: Fees above for Board members are inclusive of fees and expenses related to attendance. Figures included in Note 32 include the fees for attending meetings not the expenses.

Accounting Policy

Leases where the lessor effectively retains substantially all the risks and benefits of ownership of the leased items are classified as operating leases and are recognised as expense in the periods in which they are incurred.

Note 6: Cash and cash equivalents

Accounting Policy

Cash and cash equivalents comprise cash balances, call deposits with maturities less than three months.

	Actual 2022 $000	Actual 2021 $000
Cash at bank and on hand	296	2,370
Deposits with maturities less than 3 months	142	217
	438	2,587
NZ Health Partnership Ltd	(5,692)	0
Total cash and cash equivalents	(5,254)	2,587

Hauora Tairāwhiti is a party to a DHB Treasury Services Agreement between NZ Health Partnership Ltd (NZHP) and all the DHBs. This agreement allows NZHP to sweep all the DHB banks accounts and invest surplus funds on DHB behalf. The agreement also allows DHBs to borrow from NZHP, which will incur interest at an on-call interest rate received by NZHP plus an administration margin. The maximum borrowing facility available to any DHB is the value of one twelfth of the Provider arm funding plus GST. As at 30 June this year the amount was $11.901 million (2021: $10.973 million).

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

Included in cash and cash equivalents are unspent funds with restrictions on expenditure. Further information about trust funds is provided in note 19.

Note 7: Receivables

Accounting Policy

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

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

A receivable is considered impaired when there is evidence that Hauora Tairāwhiti will not be able to collect the amount due. The amount of the impairment is the difference between the carrying amount of the receivable and the present value of the amounts expected to be collected.

	Actual 2022 $000	Actual 2021 $000
Receivables from the sale of goods and services (exchange transactions)	19,115	11,402
Less: provision for impairment	(126)	(120)
	18,989	11,282

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

	2022			2021		
	Gross $000	Impairment $000	Net $000	Gross $000	Impairment $000	Net $000
Current	11,839		11,839	8,910		8,910
Past due 1 - 30 days	3,163		3,163	371		371
Past due 31 - 60 days	727		727	370		370
Past due over 60 days	3,386	(126)	3,260	1,751	(120)	1,631
Total	19,115	(126)	18,989	11,402	(120)	11,282

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

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

Movements in the provision for impairment of receivables are as follows:	Actual 2022 $000	Actual 2021 $000
Balance as at 1 July	120	114
Additional provisions / (reversal)	6	10
Receivable written off		(4)
	126	120

Note 8: Investments

Investments, including those in subsidiaries, are stated at fair value. Any decreases are recognised in the Statement of Comprehensive Revenue and Expense.

After initial recognition, these investments are measured at their fair value with gains and losses recognised in other comprehensive revenue and expenses, except for impairment losses that are recognised in the surplus or deficit.

Term deposits with maturities less than 3 months are included in cash and cash equivalents (Note 6).
The carrying amounts of term deposits with maturities less than 12 months approximate their fair value. There is no impairment provision for term deposits.

Note 9: Inventories

Inventories held for distribution in the provision of services that are not supplied on a commercial basis are measured at cost, determined on weighted average cost basis.
Inventories acquired through non-exchange transactions are recorded at fair value at the time of acquisition.

The amount of any write-down for loss of service potential or from cost to net realisable value is recognised in the surplus or deficit in the period of write down.

	Actual 2022 $000	Actual 2021 $000
Held for distribution inventories		
Pharmaceuticals	174	433
Surgical and medical supplies	680	680
Main store	899	832
Other supplies	182	181
	1,935	2,126

The amount of inventories recognised as an expense during the year was $14,976k (2021: $14,259k) which included a number of expense lines in the statement of comprehensive revenues and expenses.

The net write down of inventories held for distribution amounted to ($3,744) (2021 ($1k)). Adjustment for issue of stock direct from Ministry of Health in relation to Personal Protective Equipment and other minor variances occur throughout the year as a result of periodic stock takes.

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

Note 10: Non-current assets held for sale

At balance date there were no non-current assets held for re-sale (2021: $nil)

Note 11: Investments in subsidiaries and associates

Subsidiary

The DHB consolidates in the group financial statements those entities it controls. Control exists where the DHB is exposed, or has rights, to variable benefits (either financial or non-financial) and has the ability to affect the nature and amount of those benefits from its power over the entity. Power can exist over an entity if, by virtue of its purpose and design, the relevant activities and the way in which the relevant activities of the entity can be directed has been predetermined by the DHB.

Investment in Subsidiary

Entity	Tairāwhiti Laundry Services Limited (TLSL)
Principle activity	Partner is Gisborne Laundry Services.
Ownership interest	100%
Balance date	30 June

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

Associate

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

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

Where the group transacts with an associate, gains and losses are eliminated to the extent of the interest in the associate.

Investment in Subsidiary

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

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

Investment in Associates

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

Summaries financial information (Hauora Tairāwhiti's share)

	Actual 2022 $000	**Actual 2021 $000**
Assets	6,938	7,455
Liabilities	6,279	6,878
Revenue	3,730	4,270
Surplus	79	17
Share of contingent liabilities	0	0

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

Summaries financial information (Hauora Tairāwhiti's share)

	Actual 2022 $000	**Actual 2021 $000**
Assets	759	724
Liabilities	219	241
Revenue	2,422	2,546
Surplus	325	322
Share of contingent liabilities	0	0

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

Summaries financial information (Hauora Tairāwhiti's share)

	Actual 2022 $000	**Actual 2021 $000**
Assets	363	382
Liabilities	167	192
Revenue	1,168	1,215
Surplus	376	425
Share of contingent liabilities	0	0
Total investment in associates (share of assets less liabilities)	1,395	1,250
Total share of associate results	**780**	**764**

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

Note 12: Property, plant and equipment

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

Property, plant and equipment vested from the Hospital and Health Service.

Under section 95(3) of the NZ Public Health and Disability Act 2000, the assets of Tairāwhiti Healthcare Limited (a Hospital and Health Service) were vested in Hauora Tairāwhiti on 1 January 2001. Accordingly, assets were transferred at their net book values as recorded in the books of the Hospital and Health Service. In effecting this transfer, the Board has recognised the cost and accumulated depreciation amounts within its records. The vested assets will continue to be depreciated over their remaining useful lives.

Property, plant and equipment acquired since the establishment of Hauora Tairāwhiti.

Assets acquired by the Board since its establishment, other than those vested above and land and buildings, are recorded at cost less accumulated depreciation. This includes all appropriate costs of acquisition and installation, including materials, labour, direct overheads, financing and transport costs.

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

Land and buildings are valued by an independent qualified valuer at least 3 yearly to confirm that their carrying value in the financial statements reflect their fair value. Valuations will be undertaken more regularly if necessary to ensure that no class of assets included at a valuation that is materially different from its fair value. Where fair value of an asset is not able to be reliably determined using market-based evidence, optimised depreciated replacement cost is considered the most appropriate basis for determination of fair value. Land and building revaluation movements are accounted for on a class-of-asset.

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

The results of revaluing land and buildings are credited or debited to an assets valuation reserve for that class of asset. Where a revaluation results in a debit balance in the asset revaluation reserve, the debit balance will be expensed in the Statement of comprehensive revenue and expense. Additions between revaluations are recorded at cost less accumulated depreciation.

Any gain or loss on disposal is determined by comparing the proceeds with the carrying amount of the asset and this amount is included in the net surplus or deficit.

Subsequent costs

Costs incurred subsequent to initial acquisition are capitalised only when it is probable that future economic benefits or service potential associated with the item will flow to the group and the cost of the item can be measured reliably.

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

Disposals

Gain or loss on disposals is determined by comparing the proceeds with the carrying amount of the asset. Net gain or loss on disposals is reported in surplus or deficit. When revalued assets are sold, the amounts included in the property revaluation reserves in respect of those assets are transferred to accumulated surplus or deficit in equity.

Impairment

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

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

Depreciation
Depreciation is provided on a straight-line basis on all property, plant and equipment other than land, at rates which will write-off the cost (or revaluation) of the assets to their estimated residual values over their useful lives.

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

Buildings – structure	67 years	1.5%
Buildings – fit out	5 to 67 years	1.5 to 20%
Equipment	3 to 25 years	4 to 33.33%
Information Technology	2 to 12.5 years	8 to 50%
Intangible assets	3 to 12.5 years	8 to 33.33%
Motor vehicles	6.7 to 12 year	6.77 to 15%

The residual value and useful life of an asset is reviewed, and adjusted if applicable, at each financial year end. Work in progress (WIP) is recognised at cost less impairment and is not depreciated. The total cost of a project is transferred to the relevant asset category on its completion and then depreciated.

	Land	Buildings	Clinical Equipment	Other Equipment	Information Technology	Vehicles	Work in Progress	Total
	$000	$000	$000	$000	$000	$000	$000	$000
Cost or Valuation								
Balance 1 July 2020	2,657	51,075	18,943	1,086	2,706	2,993	725	80,185
Additions		634	2,955	180	592	4	(219)	4,146
Disposals	(27)	(143)	(546)	(71)	(11)		0	(798)
Revaluation	3,120	10,201						13,321
Balance 30 June 2021	5,750	61,767	21,352	1,195	3,287	2,997	506	96,854
Balance 1 July 2021	5,750	61,767	21,352	1,195	3,287	2,997	506	96,854
Additions	0	1,790	2,290	172	287	228	1,350	6,117
Disposals	0	0	(2,774)	(302)	(46)		0	(3,122)
Revaluation	650	7,680	0	0				8,330
Balance 30 June 2022	6,400	71,237	20,868	1,065	3,528	3,225	1,856	108,179
Accumulated depreciation								
Balance 1 July 2020		(1,527)	(12,554)	(822)	(1,724)	(2,396)		(19,023)
Depreciation expense		(779)	(1,753)	(90)	(536)	(94)		(3,252)
Elimination on disposals		19	515	69	12			615
Revaluation		2,287						2,287
Balance 30 June 2021	0	0	(13,792)	(843)	(2,248)	(2,490)	0	(19,373)
Balance 1 July 2021	0	0	(13,792)	(843)	(2,248)	(2,490)	0	(19,373)
Depreciation expense		(935)	(1,860)	(120)	(490)	(99)		(3,504)
Elimination on disposals			2,775	302	41			3,118
Revaluation		937						937
Balance 30 June 2022	0	0	(12,877)	(661)	(2,697)	(2,589)	0	(18,822)
Carrying amounts								
As at 1 July 2020	2,657	49,548	6,389	264	982	597	725	61,162
At 30 June and 1 July 2021	5,750	61,767	7,560	352	1,039	507	506	77,481
At 30 June 2022	6,400	71,237	7,991	404	831	636	1,856	89,355

Valuation
The most recent revaluation of land and buildings was performed by an independent registered valuer, Jones La Selle, as at 30 June 2022.

Land
Land is at fair value using market-based evidence based on its highest and best use with reference to comparable land values. Adjustments have been made to the “unemcumbered” land value for land where there is a designation against the land or the use of the land is restricted. These adjustments are intended to reflect the negative effect on the value of the land where an owner is unable to use the land more intensely. Restrictions on Hauora Tairāwhiti’s ability to sell land would normally not impair the value because it has operational use of the land for the foreseeable future and will receive substantially the full benefits of outright ownership.

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

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

- The replacement asset is based on the replacement with modern equivalent assets, with adjustments where appropriate for optimisation due to over-design or surplus capacity.
- The replacement cost is derived from recent construction contracts of similar assets and Property Institute of New Zealand cost information.
- Straight line depreciation has been applied in determining the depreciated replacement cost value.

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

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

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

Finance Leases
The net carrying amount of assets held under finance leases is $nil. (2021: $nil) for buildings and $232k (2021: $403k) for other equipment. Note 16 provides further information about finance leases.

Note 13: Intangible assets

Acquired computer software is capitalised on the basis of costs incurred to acquire and bring to use. Ongoing staff training and maintenance are recogised as expenses when incurred.

The carrying value of an intangible assets with a finite life is amortised on a straight line basis over its useful life. The amortisation charge is recognised in the Statement of comprehensive revenue and expense.

There are no restrictions of the title of intangible assets. No intangible assets are pleadged as security for liabilities.

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

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

	Software	FPIM Rights	WIP Software	Total
	$000	$000	$000	$000
Cost or Valuation				
Balance 1 July 2020	3,750	0	2,234	5,984
Additions	3,056	0	(2,069)	987
Disposals	(2)			(2)
Revaluation				0
Balance 30 June 2021	6,804	0	165	6,969
Balance 1 July 2021	6,804	0	165	6,969
Additions	592		(23)	569
Disposals	(1,016)			(1,016)
Impairment				0
Balance 30 June 2022	6,380	0	142	6,522
Accumulated amortisation				
Balance 1 July 2020	(3,227)			(3,227)
Amortisation expense	(292)			(292)
Elimination on disposals				0
Balance 30 June 2021	(3,519)	0	0	(3,519)
Balance 1 July 2021	(3,519)			(3,519)
Amortisation expense	(619)			(619)
Elimination on disposals	884			884
Balance 30 June 2022	(3,254)	0	0	(3,254)
Carrying amounts				
As at 1 July 2020	523	0	2,234	2,757
At 30 June and 1 July 2021	3,285	0	165	3,450
At 30 June 2022	3,126	0	142	3,268

Note 14: Payables and deferred revenue

Short-term payables are recorded at the amount payable.

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

	Actual 2022 $000	Actual 2021 $000
Payables and deferred revenue under exchange transactions		
Creditors	7,218	6,019
Accrued expenses	24,406	14,523
Total payables and deferred revenue under exchange transactions	31,624	20,542
Payables and deferred revenue under non-exchange transactions		
GST payable	1,117	1,561
Capital Charge payable	0	0
Trusts and bequests with substantive conditions	129	205
Other	33	27
Total payables and deferred revenue under non-exchange transactions	1,279	1,793
Total payables and deferred revenue	32,903	22,335

Note 15: Derivative financial instruments

Foreign exchange transactions are converted to NZ dollars at the time of payment or receipt. No derivative financial instruments have been used in the current year (2021: none).

Note 16: Borrowings

Borrowings are initially recognised at their fair value plus transaction costs. After initial recognition, all borrowings are measured at amortised cost using the effective interest method and are classified as current unless Hauora Tairāwhiti has an unconditional right to defer settlement of the liability for at least 12 months after balance date.

Finance Leases

Leases, which effectively transfer to Hauora Tairāwhiti substantially all the risks and benefits incident to ownership of the leased items, are classified as financial leases. These are capitalised at the lower of fair value of the asset or the present value of the minimum lease payments. The leases assets and corresponding lease liabilities are recognised in the statement of financial position. The lease assets are depreciated over the period of expected benefit from their use.

Overdraft facility

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

Breakdown of borrowings	**Actual 2022 $000**	**Actual 2021 $000**
Current Portion		
Finance Leases	184	171
	184	171
Non-current portion		
Finance Leases	45	232
Total non-current portion	45	232
Total Borrowings	229	403
Borrowing facility Limits		
NZ Health Partnership Ltd (refer to note 6)	11,652	10,973
Total borrowing facility limits	11,652	10,973

Fair Value

The fair value of borrowings has been determined using contractual cash flow discount using a rate based on market borrowing rates. The carrying value of borrowings approximates the fair value at balance date.
Hauora Tairāwhiti has entered into finance leases for MRI equipment. The net carrying amount of this equipment is included as part of Clinical equipment in Note 12.

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

Interest rate summary	Actual 2022	Actual 2021
Westpac - MRI Lease	7.14%	7.14%
NZ Health Partnership	4.56%	0.00%
Analysis of financial lease		
Minimum lease payments payable:		
No later than one year	184	171
Later than one year and not later than five years	45	232
Later than five years	0	0
Total minimum lease payments	229	403
Future finance charges		
Present value of minimum lease payments	229	403
Present value of minimum lease payments payable:		
No later than one year	184	171
Later than one year and not later than five years	45	232
Later than five years	0	0
Total present value of minimum lease payments	229	403

Note 17: Employee entitlements

Short-term employee entitlements

Employee entitlements that are expected to be settled wholly before 12 months after the end of the reporting period in which the employees render the related service are measured based on accrued entitlements at current rates of pay. These include salaries and wages accrued up to balance date, annual leave earned but not yet taken at balance date, and sick leave.

A liability and an expense are recognised 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 employees render the related service, such as sabbatical leave, continuing medical education leave, long service leave, and retirement gratuities, have been calculated on an actuarial basis. The calculations are based on:

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

	Actual 2022 $000	Actual 2021 $000
Current portion		
Accrued salaries and wages	6,089	2,786
Annual leave	10,809	9,385
Holidays Act Compliance	23,472	10,397
Sick leave and shift leave	94	94
Sabbatical leave	567	501
Continuing medical education leave	1,589	1,306
Long service leave	716	753
Retirement gratuities	286	327
	43,622	25,549
Non-current portion		
Long service leave	487	492
Retirement gratuities	411	393
	898	885
Total employee entitlements	44,520	26,434

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

Sabbatical Leave, long service leave, retirement gratuities and continuing medical education leave
The value of leave balances can be significantly impacted by recent earnings and are valued in line with the higher of the prior four weeks earnings, the prior 12 months earnings or the base salary. Movement in these earnings has a direct effect on the value of the overall liabilities.

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

- Assessment of leave balances required based upon prior years.
- Review of the maximum potential liability in each class of leave reduced by the above.

Note 18: Provisions

A provision is recognised for future expenditure of uncertain amount or timing when there is a present obligation (either legal or constructive) as a result of a past event, it is probable that an outflow of future economic benefits will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation.

Provisions are measured at the present value of the expenditure expected to be required to settle the obligation using a pre-tax discount rate that reflects current market assessments of the time value of money and the risks specific to the obligation. The increase in the provision due to the passage of time is recognised as an interest expense and is included in finance costs.

Hauora Tairāwhiti has made provision in relation to Compliance with the Holidays Act 2003 in 2021/22 of $13,261k (2021 $1,082k). These amounts are added to the overall provision which as at 30 June 2022 is $23,472k and classified as a current liability.

A number of New Zealand's public and private organisations have identified issues with the calculation of leave entitlements under the Holidays Act 2003 ("the Act").

Work has been ongoing since 2016 on behalf of 20 District Health Boards (DHBs) and the New Zealand Blood Service (NZBS), with the Council of Trade Unions (CTU), health sector unions and Ministry of Business Innovation and Employment (MBIE) Labour Inspectorate, for an agreed and national approach to identify, rectify and remediate any Holidays Act non-compliance by DHBs. DHBs 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 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 will continue through the 2022/23 financial year. The final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed.

Notwithstanding, as at 30 June 2022, in preparing these financial statements, Hauora Tairāwhiti recognises it has an obligation to address any historical non-compliance under the MOU. The DHB has made estimates and assumptions to determine a potential liability based on its review of payroll processes for instances of non-compliance with the Act and against the requirements of the MOU.

The liability has been estimated through the use of scripts applied to the payroll system and completed individual by individual where appropriate in relation to different pay elements

Where no appropriate calculation exist for pay elements the estimate has been based on

- selecting a sample of current and former employees for the element;

- Calculating the underpayment for these employees over the full period of liability; and
- extrapolating the result across all current and former employees

This liability amount is the DHB's best estimate at this stage of the outcome from this project. However, until the project has progressed further, there remain uncertainties as to the actual amount the DHB will be required to pay to current and former employees. This may result in further adjustment to the carrying amount of the provision within the next financial year or payments to employees that differ significantly from the estimation of liability.

Note 19: Equity

Equity is measured as the difference between total assets and total liabilities.

	Actual 2022 $000	Actual 2021 $000
Crown equity		
Balance at 1 July	79,717	80,099
Capital contributions from the crown	1,368	0
Repayment of capital to the crown	(382)	(382)
Balance at 30 June	80,703	79,717
Accumulated surpluses / (deficits)		
Balance at 1 July	(84,051)	(77,299)
Surplus / (deficit) for the year	(26,841)	(6,752)
Transfer from / (to) trust funds	0	0
Balance at 30 June	(110,892)	(84,051)
Revaluation reserves		
Balance at 1 July	54,516	39,004
Revaluations	9,389	15,512
Balance at 30 June	63,905	54,516
Bequest Trusts and Capital reserve		
Balance at 1 July	28	28
Interest on trust deposits	(15)	0
Balance at 30 June	13	28
Total equity	33,729	50,210

Included in the 2021/22 accumulated surplus/(deficits) are $701k of funding below the 2021/22 ring fence expectation of $19,896,000. The accumulated total represents $10,26M of funding above ring-fence since its establishment (2020/21 $9,56M).

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

Note 20: Capital commitments and operating leases

	Actual 2022 $000	Actual 2021 $000
Capital commitments	2,821	2,761

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

Operating leases as lessee

Hauora Tairāwhiti only holds one operating lease this is for the Tangata Rite building and is on a month by month basis pending renegotiation.

Note 21: Contingencies

Legal Proceedings

Hauora Tairāwhiti has two Health Disability Commissioner investigations underway against it. Both actions are covered by insurance and the DHB's liability will be the amount of the excess on policy for each. (2021: $nil)

Contingent assets

Hauora Tairāwhiti has no contingent assets (2021: $nil)

Note 22: Related party transactions

Hauora Tairāwhiti is wholly owned by the Crown.

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

Key management personnel compensation	Actual 2022	Actual 2021
Board members	$000	$000
Remuneration	219	219
Full time equivalent members	1	1
Leadership Team		
Remuneration	4,219	4,169
Full time equivalent members	20	20
Total key management personnel remuneration	4,438	4,388
Total full-time equivalent personnel	21	21

Note 23: Events after balance date

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

Note 24: Financial instruments

Hauora Tairāwhiti and the Group is party to financial instruments as part of its normal operations. These financial instruments include bank accounts, short term deposits, investments, debtors, creditors, and loans. All financial instruments are recognised in the Statement of financial position and all revenues and expenses in relation to financial instruments are recognised in the Statement of comprehensive revenue and expense. Except for loans, which are recorded at cost, and those covered by a separate accounting policy, all financial instruments are shown at their estimated fair value.

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

	Actual 2022 $000	Actual 2021 $000
Financial assets measured at amortised cost		
Cash and cash equivalents	142	217
Receivables	18,989	11,282
	19,131	11,499
Financial liabilities measured at amortised cost		
Overdraft Facility	5,692	0
Payables (excluding income in advance and taxes payable)	31,786	37,637
Borrowings	0	0
Finance leases	229	403
Total financial liabilities measured at amortised cost	37,707	38,040

Note 25: Risk management

Credit Risk

Is the risk that a third party will default on its obligation to Hauora Tairāwhiti, causing it to incur a loss.
Hauora Tairāwhiti is exposed to credit risk from cash and term deposits with banks (through NZHP) and receivables. For each of these the maximum credit exposure is best represented by the carrying amount in the statement of financial position.
Hauora Tairāwhiti receives the majority of income from government sources and has no significant concentration of risk from this source. It also received income from Patients, predominantly non-residents. This does present some risk to the organisation, however our credit department liaises with Immigration NZ to manage some of this risk, overall this is not significant.

Liquidity Risk

Is the risk that Hauora Tairāwhiti will encounter difficulty raising liquid funds to meet commitments as they fall due.
Hauora Tairāwhiti manages liquidity risk by continuously monitoring forecast and actual cash flow requirements and requesting deficit support from the Ministry of Health when required.

Note 26: Capital management

Hauora Tairāwhiti's capital is its equity (Note 19) is represented its net assets.

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

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

Note 27: Early childhood care

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

	Actual 2022 $000	Actual 2021 $000
Revenue from the Ministry of Education	67	65
Expenditure		
Personnel costs	(65)	(63)
Operation expenses	0	(1)
	(65)	(64)
Net surplus / (deficit)	2	1

Note 28: Major variations from the statement of performance expectations

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

Statement of comprehensive revenue and expense

Revenue saw significant increases due to increased funding in relation to COVID 19 and vaccinations.

Personnel Costs were over budget $7.967M or 8.2% (Excluding Holidays Act Provision – see comment below) for a variety of reasons:

- A number of pay settlements above that expected were made during the year and Pay Equity Settlement for Nursing $5.6M (including the impact on value of leave liability). Personnel costs for COVID 19 were $2.8M, this is funded.
- Additional provision has been made at year end for non-compliance with the Holidays Act 2003 of $13,261k, plus $800k for work to see project to fruition.

Outsourced services costs continue to be high - $9.4m over budget as we continue to experience difficulties recruiting and retaining skilled staff. COVID 19 related costs of $4.9M that are funded.

Clinical supplies are $1.5m over budget, a result of increased costs related to COVID 19, catch up in planned care from the previous outbreaks of COVID 19 and increased pharmaceuticals and air ambulance costs.

Non Health Board provider costs are $6.6m over budget as a result of increasing costs for aged residential care (community and hospital) of $600k, cost in relation to home care support (includes in between travel $839k,in the year and payments of $2.9M to providers in relation to COVID 19.

Statement of changes in Equity

The deficit was $16.2M above the budgeted result due to the reasons given above and the additional provision made for holidays Act compliance of $13.3M.

Statement of financial position

Current assets are higher than budget accruals of $11.3M relating to COVID 19 income.

Non-current assets are higher than budget as a result of PPE valuations in 2020/21 and 2021/22 increasing value of PPE by $21.7M.

Liabilities are $39.2M higher than budget due to unbudgeted Holidays Act Compliance provision of $23.5M, and significant accrued creditors $918k Holidays Act Compliance project work, $4M related to staffing and outsourced staffing costs, $3.4M relating to Mental Health and $2M relating to Equity programmes.

Note 29: New Zealand Business Number (NZBN)

Under the terms of the New Zealand Business Number Act 2016 the DHB is required to adopt and support the use of NZBN. These numbers will allow businesses to update their core information in one place and it will automatically update on other databases, especially business partners and government agencies. For the purposes of NZBN Hauora Tairāwhiti is a Tier Two agency and as such must:

- By Dec 2018 be able to identify and interact with NZBN entities without requiring any additional identifier
- By Dec 2020 be able to fully access the NZBN register

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

Note 30: COVID-19 Impact

All of New Zealand entered Alert Level 4 on 17 August 2021 and from 31 August through to 2 December 2021 different parts moved through different levels as COVID cases rose in different areas of the country. On 2 December 2021 all of New Zealand moved to the COVID-19 Protection Framework (Traffic Lights)

At Alert Level 2, the operating capacity of the DHB was reduced. At Alert Level 1, the DHB resumed to normal business activity and in some instances at a higher level than pre-COVID-19. This was because planned care was delayed during Alert Levels 3 and 4 in the prior financial year was rescheduled to take place at lower Alert levels.

In 2021/22 the MoH approved funding of $1.374 million for the DHB to assist with the COVID-19 response of which $675k was allocated to support community providers to prepare for COVID, this funding was distributed through the DHB to community providers. During 2021/22 we also received $699k for COVID 19 Public Health response, $28k for Community Pharmacy Telehealth Support and $647k for Extraordinary one-off fixed costs funding support for General Practice and Community Pharmacy.

Personnel expenses

Personnel expenses have increased by $489k due to an increase in permanent and casual staff. Combined with this staff have taken less leave since the pandemic declaration and sick leave due to COVID has increased.

Other expenses

There was an increase in clinical and infrastructure and non-clinical supply costs of $658k, mainly driven by the administration of the Covid-19 vaccine roll out such as leasing additional premises, hygienic and sanitation supplies, pharmaceutical, patient transport, security management, advertising and building alteration costs to ensure safer access to the hospital site for the community and staff and public health costs.

Note 31: Breach of Statutory Reporting Deadline

The 2021/22 annual report of Tairāwhiti 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).

The Audit of Hauora Tairāwhiti's accounts was completed on 14th March 2023. This is the date the audit opinion is expressed.

Note 32: Board member and employee remuneration

Board Member Remuneration

	Actual 2022	Actual 2021
Board Members	**$**	**$**
M Akuhata-Brown	20,677	16,251
A Cranston	21,540	18,070
S Faulkner	20,038	18,329
G Murphy (Deputy Chair)	20,805	20,366
K Ngarimu (Chair)	37,764	34,498
H Pihema	23,024	19,818
R Rauna	19,539	16,820
H Robertson	23,040	19,757
A Robinson	21,787	20,070
J Wharehinga	28,252	18,820
A Wray	12,563	16,320
	249,029	219,119
Maori Caucus & Community Members	**$**	**$**
Bacon	1,750	
Hockey		1,250
Johnson	1,875	
McCarthy-Robinson	3,621	3,674
Nepia-Clamp	5,906	5,250
Ngarangioue		1,877
Brooking	1,542	
Para	3,271	2,000
Raihania	6,570	6,584
Timutimu	2,475	1,250
Dewes	750	
Chaffey-Aupouri	2,302	3,000
Procter	1,935	750
Downes	1,500	
Kumar	2,000	
Niuvao-fine	250	
Paku	1,750	
	37,497	25,635
Total governance remuneration	286,526	244,754

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

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

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

The full-time equivalent for Board members has been determined based on the frequency and length of Board and Committee meetings including the estimated time for Board members to prepare for meetings.

Employee remuneration

The number of employees or former employees during 21/22 who received remuneration and other benefits of $100,000 or more within specified $10,000 bands were as follows:

From	To	Staff No. 2022	Staff No. 2021
100,000	109,999	59	35
110,000	119,999	50	35
120,000	129,999	30	13
130,000	139,999	16	9
140,000	149,999	10	5
150,000	159,999	4	4
160,000	169,999	2	7
170,000	179,999	10	5
180,000	189,999		2
190,000	199,999	4	
200,000	209,999	2	1
220,000	229,999	2	2
230,000	239,999	1	
240,000	249,999	2	
250,000	259,999	3	
260,000	269,999		3
270,000	279,999	1	4
280,000	289,999	4	1
290,000	299,999		5
300,000	309,999	1	3
310,000	319,999	1	1
320,000	329,999	6	
330,000	339,999	3	5
340,000	349,999	4	4
350,000	359,999	3	5
360,000	369,999	1	1
370,000	379,999	7	3
380,000	389,999	3	1
390,000	399,999	3	2
400,000	409,999	2	1
410,000	419,000		2
420,000	429,999	2	1
430,000	439,999	1	2
440,000	449,999	2	2
450,000	459,999		1
460,000	469,999		1
470,000	479,999	2	
490,000	499,999	1	1
530,000	539,999	1	
570,000	579,999		1
		243	168