E91

Hauora Tairāwhiti

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

ANNUAL REPORT 2021

Contents

Message from the Chair

Tuatahi, ka mihi atu ki tō tātou nei kaihangaia, nāna te timata, nāna te whakaoti ō ngā mea katoa. Tuarua, ki ngā tini aitua o te wā, kō rātou kua mene atu ki te pō, haere koutou ki ō mātua kī ō tīpuna e tātari ana mā koutou mē ō tātou nei matua nui i te rangi. Kō tātou nei e takatū tonu ana mā runga ī te whenua, hei urupā mō ngā moemoeā ō rātou kua wheturangihia, tēnā koutou, tēnā tātou.

Last year this part of the Annual Report was principally focused on the COVID-19 pandemic, and the impact it had on our local health system and community. Unfortunately, while occurring after the end of the 2020-21 financial year, I find myself again writing my comments for the Annual Report in the midst of another outbreak. Clearly, this pandemic is going to be with us for quite some time, although to date we have been fortunate in Te Tairāwhiti to escape its worst effects.

Our shift this year has been to plan for living with COVID-19, chief amongst which is, along with our iwi health providers, rolling out the vaccination programme. I cannot stress enough how important being fully vaccinated is, not only to protect your own health, but to protect the health of your whānau and our wider community.

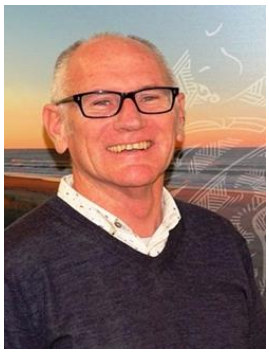
Last year I also commented on the Health System Review, which was released in June 2020. In April 2021 the Government announced its response to the review, signalling a significant programme of reform of the health system. The establishment of Health New Zealand in July 2022 year will see the disestablishment of all District Health Boards, which will be merged into a single national health service. Alongside this, a Māori Health Authority will be established to bring influence to bear on the performance of the system as a whole for Māori, and to commission innovative solutions to improve Māori health. We are excited by the opportunities the reforms present. The intent for a more effective and efficient system, that does away with 'post code health' and focuses health provision on those most in need means that regions such as ours will have access to the whole of system, and should be positioned to deliver better services and outcomes to our local communities. Our Board is committed to handing Hauora Tairāwhiti into Health New Zealand in the best shape that we possibly can.

During the year, because of work commitments, Gavin Murphy stepped back from his role as Deputy Chair of Hauora Tairāwhiti Board. I remain very grateful to Gavin for his service as Deputy Chair, for being willing to continue as a Board member, and for his on-going support. I was delighted that the Minister appointed Josh Wharehinga to the Deputy Chair role, and am similarly grateful for his mahi and support

I would like to thank the Board, and Jim and our staff, for their commitment and efforts over the course of the year. Our delivery of health services, alongside responding to the pandemic and preparing for the reform of the health sector has again made this a busier than anticipated period, but as always, we will continue to serve our communities in the best ways we can.

Kim Ngārimu,
Board Chair
Hauora Tairāwhiti Board
22 February 2022

Message from the Chief Executive



In the same report as this 12 months ago I made the following comments about the year ahead.

"So I think that 20/21 will be another year that is not like any other. There is a major list of projects we have signed up for, and with our community partners such as Mātai and Hospice Tairāwhiti, our regional and national work and our special relationship with iwi. Our equity actions will be a particular feature. Substantial progress will be set in place and we will see delivery on that by the year end. Buildings will come down, buildings will go up. New services will be implemented by Hauora Tairāwhiti and we will fund more than ever. We will be scrutinised more and work even more on the wider determinants of health. Can't forget what might happen with the Simpson review, although we have to see what happens in September first. It is therefore going to be a year on a grand scale, and it is full on already."

So out of that what has transpired?

Well fundamental has been the shadow of COVID-19 over our country and health in particular. While in the twelve months we have not had any significant resurgence event, and our protective measures have worked, there is an impact, sometimes in unforeseen ways of the lockdown and COVID-19 response. We have had higher rates of people now coming forward with conditions were coming to care was delayed, unavoidably. We are seeing a surge in disease as a result of people, in this case our youngest, not being exposed last winter.

The shadow of COVID-19 plays out in many other ways. Our difficulties in recruiting can in part be attributed to this and once more highlight our need to train and develop enough people for our health workforce in our country, and locally to pick up on the talent we have in our population, particularly young Māori. Where we do have to source people from overseas we get excellent candidates, but making the move to Aotearoa is difficult. While these factors have had an impact on our service operations they have also affected our bottom line. The cost of maintaining cover in specific services, not just medical, has expanded sharply. Our leave liability has grown.

There is the shadow of COVID-19 that looms larger now because of the Delta variant. The much higher infectivity rate means that we have to be even more vigilant with our daily lives, and in our work as a DHB to reduce the chances of a resurgence. Maintaining that level of intensity and attention to detail is difficult and at times as a country we have needed to be reminded. Our close neighbours Fiji and Australia provide clear examples of why we need to be diligent. And our health service is not magical. If put under the same stresses we have seen in other countries we will see overload and poor outcomes. So none of us have any intention of going there.

The vaccination programme is a response we have as a country and for Hauora Tairāwhiti taking a lead on getting our 76,000 doses needed by the end of October. We have delivered about 20% of that to date and for the rest of the campaign have to deliver at 3,600 a week. Our groundwork is in place but this is the biggest exercise of its kind ever in this country. So we have had some challenges along the way to enable all the pieces that need to fit together to make a successful outcome work, but getting it working is because our vaccination team are a committed group. A stand out feature has been the response of iwi. The leadership and drive, combined with that of their health providers Ngāti Porou Hauora and Tūranga Health has given us a great start, with a large part of the coming months ascribed to their efforts. Brilliant work and a further example of we can address equity – when you start at the start.

We have also turned back some of the effects of COVID-19. A really good example is in Planned Care. We have reduced the number of people waiting longer than 4 months for a First Specialist Assessment from 772 to 310 over the year. That is a 60% improvement and sets us up to eliminate the backlog this year. Similarly for people waiting for treatment longer than 4 months, also down by 60%, and on the trajectory for full compliance in the next year. These are big steps taken by our staff, with some assistance from other providers, plus the funding from government.

So what else from that first paragraph? Well we did demolish a building, but haven't put one up yet. That has been held up a bit with COVID-19 effects on building costs being a factor. We have completed our own review of Mental Health and Addictions services and implemented three new services in the community. We finally changed out our Clinical Work Station following many years of delay. There have been reviews of other services and from one we are about to create something never before seen in Tairāwhiti, a specialised service for our older people and its going to be focused on their hauora.

Finally, well this is also the last year of Hauora Tairāwhiti as well. The government's health reforms will have been implemented in structure by this time next year and there may not be an opportunity for a report such as this in that scenario. There will however be new opportunities the reforms will have created and for us here in Tairāwhiti those opportunities are very much designed for us to take, which we will! The last year will be another interesting, challenging and rewarding ride.

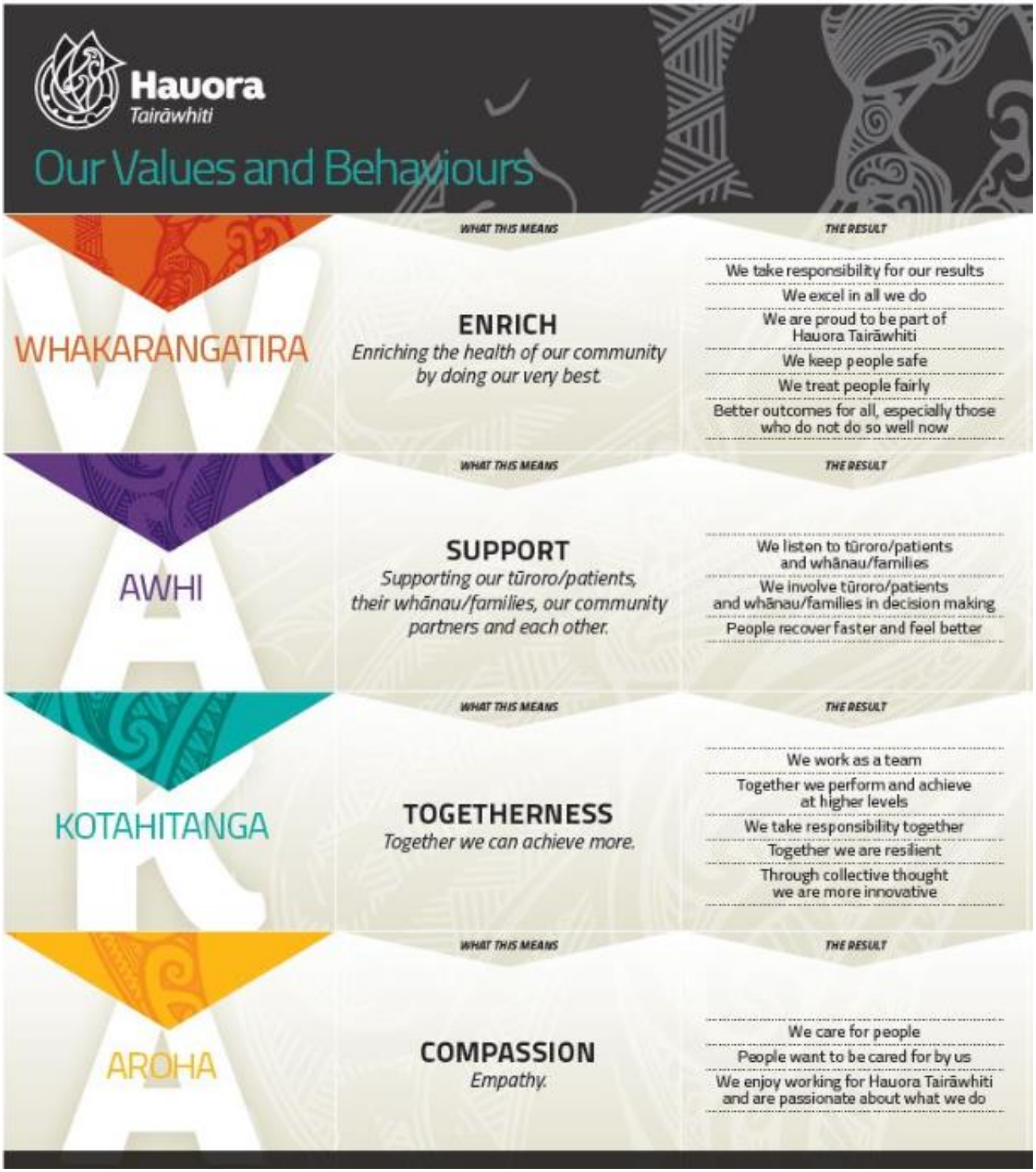
Jim Green

Chief Executive
Hauora Tairāwhiti Board
22 February 2022

Hauora Tairāwhiti DHB mission, values and behaviours

Our mission

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

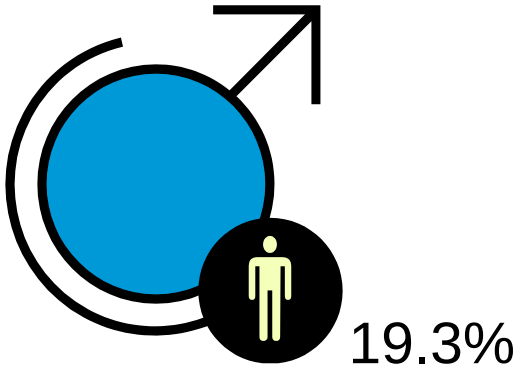


Our values form the acronym WAKA. They reflect our past while guiding us on our journey to create a healthier Tairāwhiti by working together.

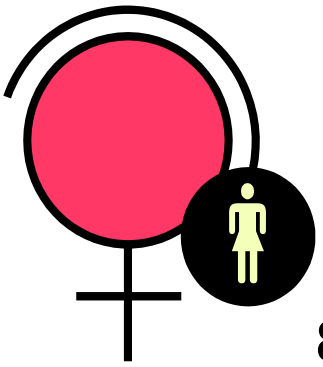
About Hauora Tairāwhiti

The DHB currently employs **1,080** people, a number of whom are multi-jobbed.

Of these **1,080** people:



19.3%



80.7%

WORKFORCE PROFILE – by age bands	
<25	4.4%
25 - 35	22.9%
35 - 45	18.8%
45 - 55	21.8%
55 - 64	21.4%
65+	10.6%

WORKFORCE PROFILE – by occupational group	
Medical staff	8.8%
Nursing staff	45.0%
Allied Health staff	19.7%
Non-clinical support staff	7.1%
Management & admin staff	19.4%

WORKFORCE PROFILE – by ethnicity	
NZ European	41.7%
NZ Māori	34.8%
Pacific Island	1.4%
British & Irish	3.2%
Other ethnicities	18.4%
Not known	0.4%

EMPLOYEE STATUS	
Casual	14.4%
Full time	40.8%
Part time	44.7%

Report on good employer obligations

Hauora Tairāwhiti understands that in order to continue to make good decisions and consistently perform as a good employer it is essential to actively grow leadership by identifying, nurturing and supporting staff to improve leadership competence and capability.

Staff in designated leadership roles have also been given the opportunity to grow their leadership capability by attending local and regional health leadership training. These learnings have been supplemented by locally facilitated shorter learning opportunities found on the learning and development calendar which have been well attended.

Over the past year, Hauora Tairāwhiti has hosted Midlands Leadership in Practice training and Midlands Advanced Leadership training for middle managers. This training was also opened to include other local public business management.

Both programs are supported by the five regional District Health Boards (Te Manawa Taki), which also allows for multi-disciplinary networking across the region.

A significant amount of work continues to be undertaken to strengthen working relationships with unions. Local bipartite meetings have been well attended and held regularly throughout the year. Tairāwhiti has been working with the unions to develop an annual work plan to ensure that there is proactive work happening outside of the meetings.

Recruitment, Selection and Induction

Hauora Tairāwhiti supports equal employment opportunities (EEO) through its recruitment practices by ensuring fairness, equity and transparency are applied when advertising and considering applications for employment. Tairāwhiti recognises the importance of diversity in the workplace and encourages practice to support ethnic minorities and recruiting applicants with disabilities. Extensive policy and process reviews have been completed to support the organisation in minimising the impact vacancies have on business performance.

Hauora Tairāwhiti integrates health checks and assessments into all of its recruitment processes to evaluate baseline health and how that can be supported through workplace and workstation setup. Recruitment processes have also been enhanced to include credit checks for employees that handle finances, introduced competency based questions, conflicts of interest, and more rigorous screening of staff that are working with vulnerable people, including children and the elderly in line with the Vulnerable Children's Act (VCA).

Recruitment training has been made available throughout the year to recruiting managers to support best practice. Māori representation is also a requirement for all recruitment panels. To ensure there is an equal opportunity to apply for roles, all vacancies are advertised through Kiwi Health Jobs (KHJ) and the Hauora Tairāwhiti website. The DHB owned KHJ site attracts over 60,000 job seekers per month.

Māori Workforce Planning

There has been a significant body of work completed to engage and connect with our Māori community in order to reduce health inequities and grow the Māori workforce representative of our community. There has also been a targeted approach to promote health to ethnic minorities including Māori and working alongside Te Manawa Taki (formerly Midlands Region) regional Kia Ora Hauora (KOH) coordinator to tailor the messaging and promotional material toward Māori and whānau.

Hauora Tairāwhiti continues to support a bi-cultural induction and on-going training by providing all staff with a powhiri and training in tikanga best practice. The new employee orientation day has been restructured to increase attendance and understanding. All Hauora Tairāwhiti staff have received the opportunity to attend training by our kaumatua specific to the WAKA values, which is an ongoing feature on the learning and development calendar.

Employee Development, Promotion and Exit
Hauora Tairāwhiti has a fair and equitable performance appraisal system in place, called 'You Time', which is supported by our policies. The Employment Relations Act, and Health and Safety Act continue to reinforce the need to maintain strong relationships with employees and unions. The Bipartite Union Committee continues to be the forum for union delegates to be engaged on the Transform and Sustain agenda to discuss common issues. Learning needs and career aspirations are identified through the appraisal tool 'You-Time' which are then supported through on job training, projects, courses, sabbaticals and study.

All staff have access to the learning opportunities offered through the learning and development calendar. The Hauora Tairāwhiti learning facility Ko Matakerepo supports staff development, which includes a lecture room, two video suites, computer lab and library. Where possible, learning opportunities have been made available to community based organisations and contractors who work within the Tairāwhiti community.

Hauora Tairāwhiti continues to support the 'grow our own strategy' which focuses on developing and promoting talent from within the organisation. Secondments, projects, acting-up opportunities and fixed term positions are widely promoted to staff to provide the hands on experience and pay incentives to staff readying them for promotion opportunities when they become available. This includes development as identified above others designed to develop coaching skills, for example the "Coaching Clinic".

Staff departing the organisation are encouraged to complete an exit survey.

Hauora Tairāwhiti has an on the job learning programme for newly graduated nurses called the 'Nurse Entry to Practice' programme (NETP) that supports graduate nurses through the beginning stages of their career. The programme supports Tairāwhiti graduates that have come through the local polytechnic provider and offers a safe working environment that grows new graduates into competent registered nurses. Hauora Tairāwhiti supported extra graduate nurses into the programme over the past 12 months to accommodate the extra numbers graduating.

Flexibility and Work Design
Hauora Tairāwhiti recognises how important it is to continually support the changing demands of life and support work life balance where that does not compromise care. The 'You Time' appraisal template includes a section where staff can discuss how their changing circumstances may be supported by Hauora Tairāwhiti, such as reducing hours of work to support early retirement or being available for young children. The social needs of staff are also considered when designing rosters. This year has also seen a need to adapt and think outside the box to support staff and changing needs to meet the ever changing COVID-19 scene. This added a new dimension on working remotely where applicable.

Remuneration, Recognition and Conditions
The majority of staff are employed under multi-employer collective agreements, which are negotiated nationally. The DHB and unions ensure that remuneration in the health sector is fair and equitable based on the affordability of the health system. Hauora Tairāwhiti continues to use the Strategic Pay methodology to job evaluate roles for staff on individual employment agreements.

Harassment and Bullying Prevention
Hauora Tairāwhiti does not accept harassment and bullying in the workplace. Hauora Tairāwhiti has been undertaking a number of initiatives to embed appropriate behaviours in the workplace and to reduce the prevalence of unwanted behaviours that include harassment and bullying. This has included the launch of behaviours that underpin the WAKA values and supporting services to embed appropriate behaviours, and develop processes to safely call inappropriate behaviours and foster safe working cultures.

Safe and Healthy Environment
Hauora Tairāwhiti as a good employer provides a safe and healthy working environment and offers support to staff via an Employee Assistance Programme. This programme is available to staff who may be facing issues either at home or within the workplace that may affect their performance at work.

Governance Philosophy

Connection with Stakeholders

The Board acknowledges its responsibility to keep in touch with stakeholders and, in particular, remain cognisant of the Minister of Health's expectations.

Division of Roles between the Board and Management

The efficient running of Hauora Tairāwhiti requires a clear division between the roles of the Board and Management. The Board concentrates on setting policy, approving strategy, and monitoring progress towards meeting objectives. Management is concerned with implementing policy and strategy. The Board has clearly distinguished these roles by ensuring that the delegation of authority to the Chief Executive (CE) is concise and complete as delineated in the approved delegation policy.

Accountability

The Board holds meetings most months and monitors progress toward its strategic objectives. The Board also ensures Hauora Tairāwhiti actions and those of its subsidiary and associates adhere to Hauora Tairāwhiti policies.

Members' Interests

The Board maintains an Interests Register and ensures members are aware of their obligations to declare any interests they may have in matters under consideration by the Board or in the wider operations of Hauora Tairāwhiti.

At least on an annual basis, or as interests arise, the CE and direct reports to the CE are required to make a declaration of interests, which the Board Chair reviews for any conflicts, with associated management strategies put in place. These interests are also reported to the Board.

Internal Audit

Overall responsibility for maintaining effective systems of internal control ultimately rests with the Board. Internal controls include the policies, systems, and procedures established to provide assurance that specific objectives of the Board are achievable, and that reporting to the Board is reliable. The Board and Management have acknowledged their responsibility by signing the Statement of Responsibility which can be found on page 42 of this report. Hauora Tairāwhiti contracts an Internal Audit function through the Internal Audit division of Health Share, which is responsible for monitoring its systems of internal control and the quality and reliability of financial and non-financial information reported to the Board. Internal Audit operates independently of management and reports its findings directly to the Board's Finance, Risk and Audit Committee (FRAC), which in turn reports any issues or concerns to the Board. Internal Audit liaises closely with the external auditors, who review the systems of internal control to the extent necessary to support their audit opinion.

Risk Management

The Board acknowledges that it is ultimately responsible for the management of risks to Hauora Tairāwhiti. The Board has charged the CE, through its Risk Management Policy, with establishing and operating a risk management programme in accordance with the "Guidelines for Managing Risk in the Australian and New Zealand Public Sector SAA/NZSHB 143:1999". The FRAC committee receives three monthly reports on the risk management programme.

Legislative Compliance

The Board acknowledges its responsibility to ensure the organisation complies with all legislation. The CE has delegated authority from the Board to develop and operate a programme that systematically identifies compliance issues and ensures staff awareness of legislative requirements that are particularly relevant to them. The FRAC committee receives a quarterly report on the legislative compliance programme.

Governance and Accountability Statement

Tairāwhiti DHB is a crown entity, established on 1 January 2001, responsible for funding, providing, and ensuring the provision of personal health, mental health and Māori health services to the resident population of the district and disability support services for residents over 65 years of age. In 2015, Tairāwhiti DHB was rebranded to Hauora Tairāwhiti as the organisation signalled a change in how people access health services and how this can be improved, specifically in equity of health outcomes for Māori.

Hauora Tairāwhiti's role is three fold, namely Owner/Governance, Funder, and Provider of public health and disability services in the district.

The Funding arm, Te Puna Waiora (Spring of Wellness), leads the process of assessing the needs and planning for the services required by the people of Tairāwhiti. The team administers the agreements generated through the funding process. This includes the funding of all personal health, mental health, Māori health and disability support services for people over the age of 65 for the Tairāwhiti population. Te Puna Waiora also has a monitoring and auditing function in most part carried out through HealthShare, Te Manawa Taki's Shared Services Agency.

The Provider arm, is the principal Provider of secondary health and disability services to the people of Tairāwhiti. These services include medical, surgical, women's health, child health, elderly, disability support, mental health, public health, and related support services.

Hauora Tairāwhiti also accesses health services for the people of Tairāwhiti from organisations outside the district, primarily through referrals to Waikato Hospital and Auckland Starship for tertiary services, and Wellington for other specialist services.

Role of the Board

Under Section 25 (1) of the Crown Entities Act 2004 (the CE Act), the Board is the governing body of Hauora Tairāwhiti, with the authority, in the DHB's name, to exercise the powers and perform the functions of Hauora Tairāwhiti. Under section 25 (2) of the CE Act, all decisions relating to the operation of Hauora Tairāwhiti must be made by, or under the authority of, the Board in accordance with the CE Act and the New Zealand Public Health and Disability Act 2000 (the NZPHD Act).

The focus of the Board is on governance and policy issues. The Board's primary responsibilities are:

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

All Board members are required to act in the best interests of Hauora Tairāwhiti. Members acknowledge that the Board must stand unified behind its decisions; individual members have no separate governing roles outside the boardroom.

Profile of the Board

The Board carries out its governance role through regular formal meetings and through associated subcommittees. The Board has a partnership relationship with each of the iwi in Tairāwhiti. It also has a Caucus Accord with local Māori representing iwi, Māori providers, and Māori organisations, through Te Waiora o Nukutaimemeha Māori Relationship Board. A partnership relationship also exists with the Pacific Islands Community Trust.

Directory

Board Members	
Kim Ngarimu (Chair)	Appointed, December 2019
Josh Wharehinga (Deputy Chair)	Elected, October 2016 Re-elected December 2019 Appointed, Deputy Chair April 2021
Meredith Akuhata-Brown	Elected, October 2016 Re-elected December 2019
Hiki Pihema	Elected, October 2016 Re-elected December 2019
Gavin Murphy	Appointed, December 2016 Re-appointed December 2019 Resigned, Deputy Chair April 2021
Na Raihania	Appointed, December 2016 Reappointed,
Robyn Rauna	Elected December 2019
Amy Wray	Elected December 2019
Andy Cranston	Elected December 2019
Sandra Faulkner	Elected December 2019
Tony Robinson	Elected December 2019
Heather Robertson	Elected December 2019

Corporate Office	**Auditor**
Hauora Tairāwhiti Private Bag 7001 421 Ormond Road Gisborne 4040	Audit New Zealand For and on behalf of the Auditor General
Solicitors	**Transactional Bankers**
Nolans Gisborne Chapman Tripp Auckland	Bank of New Zealand Gisborne

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

Board Members Register of Interests

The following are particulars of entries in the Interest Register made by Board members for the period between 01 July 2020 and 30 June 2021.

Report of Permissions under Section 68(6) of the Crown Entities Act 2004.

Board Member	Transaction / Matter	Conflict Arising	Nature of Conflict/s	Board Response / Action
July 20				
Na Raihania	Item 10 Action Item (Board) Meeting with Ngāti Porou Hauora	In relation to his role as a member of Ngāti Porou Rūnanga.	Financial information was discussed.	Mr Raihania excused himself from this discussion.
Te Aturangi Nepia-Clamp	Item 6.3 (Hiwa I Te Rangi) Te Rōpu Matua Presentation	In relation to his role as a Director for Tūranga Health	Presentation lead by Tūranga Health	The committee agreed the member could remain for item 6.3 and participate in discussion.
August 20				
Hiki Pihema	Item 13.4 (Board anc Hiwa I Te Rangi) Provider Internal Service level Agreement	In respect to her role as a member of staff	Dietetics funding was discussed	Ms Pihema excused herself from this discussion.
Kim Ngarimu	Item 6.2 (Hiwa I Te Rangi) Oranga Tamariki Review	In respect to her role on the Waitangi Tribunal panel		Ms Ngarimu excused herself from the meeting during this discussion.
Hiki Pihema	Item 13.3 (Hiwa I Te Rangi_ High Package of Care	In respect to her role as a member of staff	As part of the Dietitian team are involved with the PEG feeding	Ms Pihema excused herself from this discussion.
November 20				
Gavin Murphy	Item 12 Correspondence (Board) received regarding Chelsea Hospital	In relation to his role as Trust Tairāwhiti Chief Executive		Mr Murphy excused himself from this discussion.
Na Raihania	Item 13.1 (Hiwa I Te Rangi) Equity Funding – Pay Parity Item 13.2 (Hiwa I Te Rangi) Well Child Tamariki Ora Service and Enhanced Support Pilot	In relation to his role as a member of Ngāti Porou Rūnanga.		The Committee agreed that Mr Raihania could stay for the discussion but abstained from supporting the recommendations
Jim Green	Item 13.1 (Hiwa I Te Rangi) Equity Funding – Pay Parity Item 13.2 (Hiwa I Te Rangi) Well Child Tamariki Ora Service and Enhanced Support Pilot	In respect to his wife is a nurse at Well Child Tamariki Ora Tūranga Health		The Committee agreed Mr Green could remain and contribute to discussion.

Board Member	Transaction / Matter	Conflict Arising	Nature of Conflict/s	Board Response / Action
Te Aturangi Nepia-Clamp	Item 13.1 (Hiwa I Te Rangi) Equity Funding – Pay Parity Item 13.2 (Hiwa I Te Rangi) Well Child Tamariki Ora Service and Enhanced Support Pilot	In relation to his role as a Director for Tūranga Health		The Committee agreed that Mr Te Aturangi Nepia - Clamp could stay for the discussion but abstained from supporting the recommendations.
December 20				
Robyn Rauna	Item 13.1 (Board) Western Rural Property Sales	In relation to her role as a negotiator for the historical Treaty claims of Te Aitanga A Mahaki	The property sales are within her tribes rohe	The Board agreed the member could stay for discussion but not take part in any decision making.
February 21				
Robyn Rauna	Item 13.6 (Board) Western Rural Property Sales	In relation to her role as a negotiator for the historical Treaty claims of Te Aitanga A Mahaki	The property sales are within her tribes rohe	The Board agreed the member could stay for discussion but not take part in any decision making.
Te Aturangi Nepia-Clamp	Item 13.6 (Hiwa I Te Rangi) EOI Health and Wellbeing of Young People in Tairāwhiti	In relation to his role as a Director for Tūranga Health		The committee agreed the member could remain for item 13.6 and participate in discussion.
Na Raihania	Item 13.7 (Hiwa I Te Rangi) RFP for Adolescent Dental Services	In relation to his role as a member of Ngāti Porou Rūnanga.		The Committee agreed that Mr Raihania could stay for the discussion but abstained from supporting the recommendations.
April 21				
Te Aturangi Nepia-Clamp	Item 6.6 (Hiwa I Te Rangi) Tranche One Funding – Māori COVID-19 Vaccinations Readiness	In relation to his role as a Director for Tūranga Health		The committee agreed the member could remain for item 6.6 and participate in discussion.
May 21				
Hiki Pihema	Item 12.2 (Hiwa I Te Rangi) Developing Tairāwhiti Rangatahi Health Services	In respect to her daughter is a service co-ordinator at Atawhai Charitable Trust		The Committee agreed Ms Pihema could remain but was excused herself from this discussion.
June 21				
Te Aturangi Nepia-Clamp	Item 6.1 (Hiwa I Te Rangi) Hauora Tairāwhiti COVID-19 Vaccination Update June 2021	In relation to his role as a Director for Tūranga Health		The committee agreed the member could remain for item 6.1 and participate in discussion.

Role of the Chief Executive

The Board has appointed a single employee, the Chief Executive (CE), to manage all DHB operations. The CE has appointed all other employees of Hauora Tairāwhiti. The Board directs the CE by delegating responsibility and authority for the achievement of objectives through setting policy.

The Board delegates to the CE, on such terms and conditions as are appropriate, the power to make decisions on operational and management matters within the framework of the Board's agreed strategic direction as set out in the Annual Plan. It endorses the CE, assigning defined levels of authority to other specified levels of management within the organisational structure.

Statutory Advisory Committees

The Board Advisory Committees, including those Statutory Committees required under the NZ Public Health and Disability Act 2000, were set up to provide a more detailed level of focus on particular issues. The committees have delegated authority for governance to action the Board's policies as well as monitoring the organisation's progress towards meeting Hauora Tairāwhiti's objectives. The committees also have formal budgetary delegations to fund services or approve expenditure on Hauora Tairāwhiti's behalf. The Board's standing committees (including the statutory permanent advisory committees) are:

Committee:

- Finance, Risk & Audit (FRAC) – Monthly
- Hiwa I Te Rangi (Advisory Committee) - Monthly
- Te Waiora o Nukutaimemeha Iwi Relationship Board – Monthly
- Staffing & Governance Committee (S & G) - Quarterly or as required

Advisory Committee Members

The Committees include, in addition to selected Board members, representatives from the Tairāwhiti community selected through an application process.

BOARD/Committee	Board Member until 30 June 2021	Community Members until 30 June 2021
Hauora Tairāwhiti Board	**Kim Ngarimu (Chair)** Josh Wharehinga (Deputy Chair) Gavin Murphy Robyn Rauna Amy Wray Andy Cranston Sandra Faulkner Tony Robinson Hiki Pihema Meredith Akuhata-Brown Heather Robertson	n/a
Finance, Risk & Audit Committee (FRAC)	Heather Robertson (Chair) Gavin Murphy Tony Robertson Robyn Rauna Meredith Akuhata-Brown Kim Ngarimu (ex officio)	John Hockey
Hiwa I Te Rangi (Advisory Committee)	Josh Wharehinga (Chair) Hiki Pihema Amy Wray Andy Cranston Kim Ngarimu (ex officio)	Te Aturangi Nepia-Clamp Na Raihania
Te Waiora o Nukutaimemeha	Josh Wharehinga Kim Ngarimu (ex officio)	Na Raihania (TRONP)/Chair Molly Para Lois McCarthy-Robinson Whiti Timutimu Angus Ngarangioue (TROTAK) Tomairangi Chaffey-Aupouri Te Aturangi Nepia-Clamp Māori Health Provider representative
Staffing/Governance	Kim Ngarimu (Board Chair) Heather Robertson (FRAC Chair)	n/a
TLab Directors	Gavin Murphy (as at 1 April 2020) Craig Green (as at 1 April 2020)	n/a
Tairāwhiti Laundry Services Ltd	Kim Ngarimu (as at 1 April 2020) Tony Robinson (as at 1 April 2020)	n/a

Quality Improvement

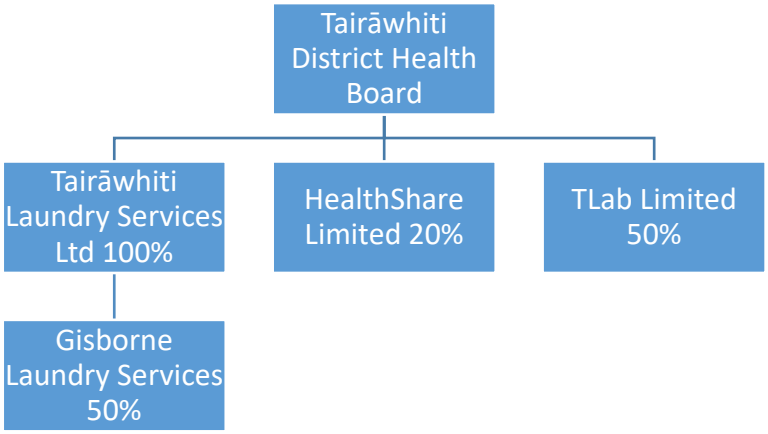
The Clinical Governance Committee oversees the quality improvement environment at Hauora Tairāwhiti reporting through the CE to the Board on patient safety matters and clinical quality improvement. Through these mechanisms, the Board guides the overall setting of the Hauora Tairāwhiti Quality Plan.

It is important to note that the Quality Plan for Hauora Tairāwhiti extends beyond its own provider services to include the operation of the funding arm and the activities of providers with agreements with Hauora Tairāwhiti.

The monitoring and audit plan for Hauora Tairāwhiti, completed in conjunction with HealthShare and the Ministry of Health's Sector Services, follows the quality improvement activity of providers. Reporting to the Board of audits for these providers is made through the FRAC for overview.

Subsidiaries and Associates

Group Organisational Structure



Tairāwhiti Laundry Services Limited (TLSL)

TLSL (registered under the Companies Act 1993) is a wholly owned subsidiary of Hauora Tairāwhiti and is the holding company for its 50 percent investment in the Gisborne Laundry Services Partnership.

Gisborne Laundry Services (GLS)

GLS is a partnership between TLSL and Mahia Resort Limited that provides laundry services to Gisborne Hospital, its associated services, and other commercial laundry services to external customers.

Health Share Limited (HSL)

HSL (registered under the Companies Act 1993) is Te Manawa Taki DHBs' shared services agency, which is owned in equal shares by the five DHBs of Te Manawa Taki Region. The company provides specialist audit services to DHBs, other support service roles in areas such as internal audit, workforce development, regional planning and clinical network coordination, where this improves the effectiveness of DHB operations.

TLab Limited (TLab)

TLab Ltd (registered under the Companies Act 1993) is the 50/50 joint venture company between Hauora Tairāwhiti and MedLab Central Ltd, which provides laboratory services at Gisborne Hospital and for the wider Tairāwhiti community. The Company was established on 1 September 2007.

Statement of Performance

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

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

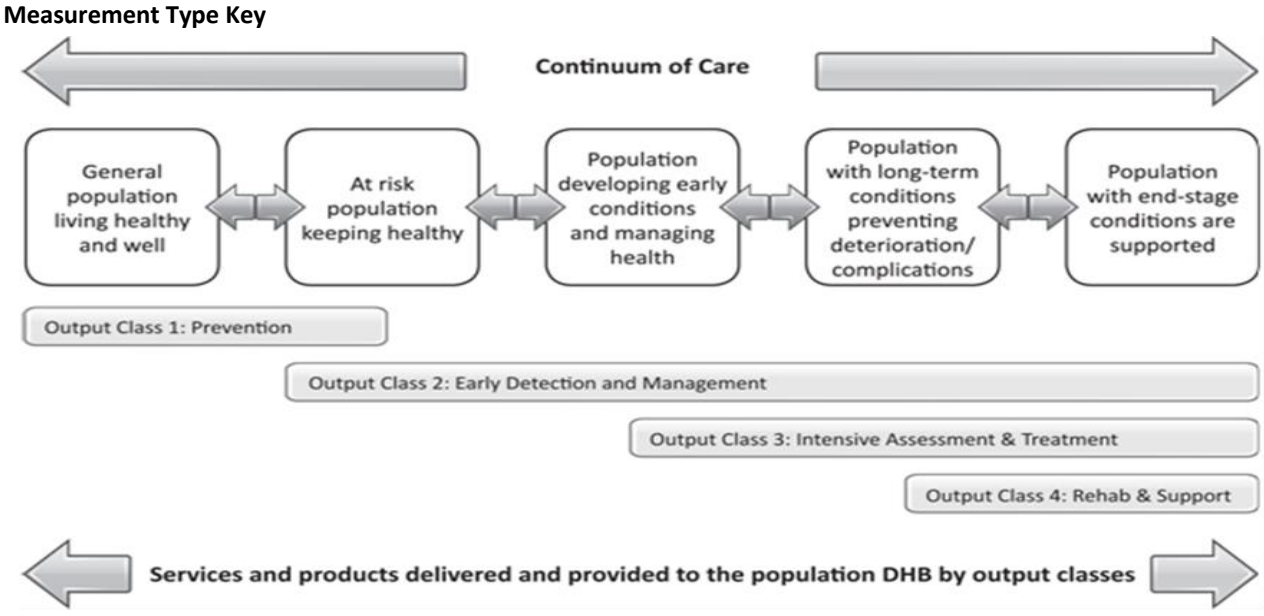
The measures chosen are a mixture of indicators of quantity, quality and timeliness in our priority areas. The measures and targets are outlined in our Statement of Performance Expectations for 2020[1] with the following section presenting the results achieved against the identified targets.

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

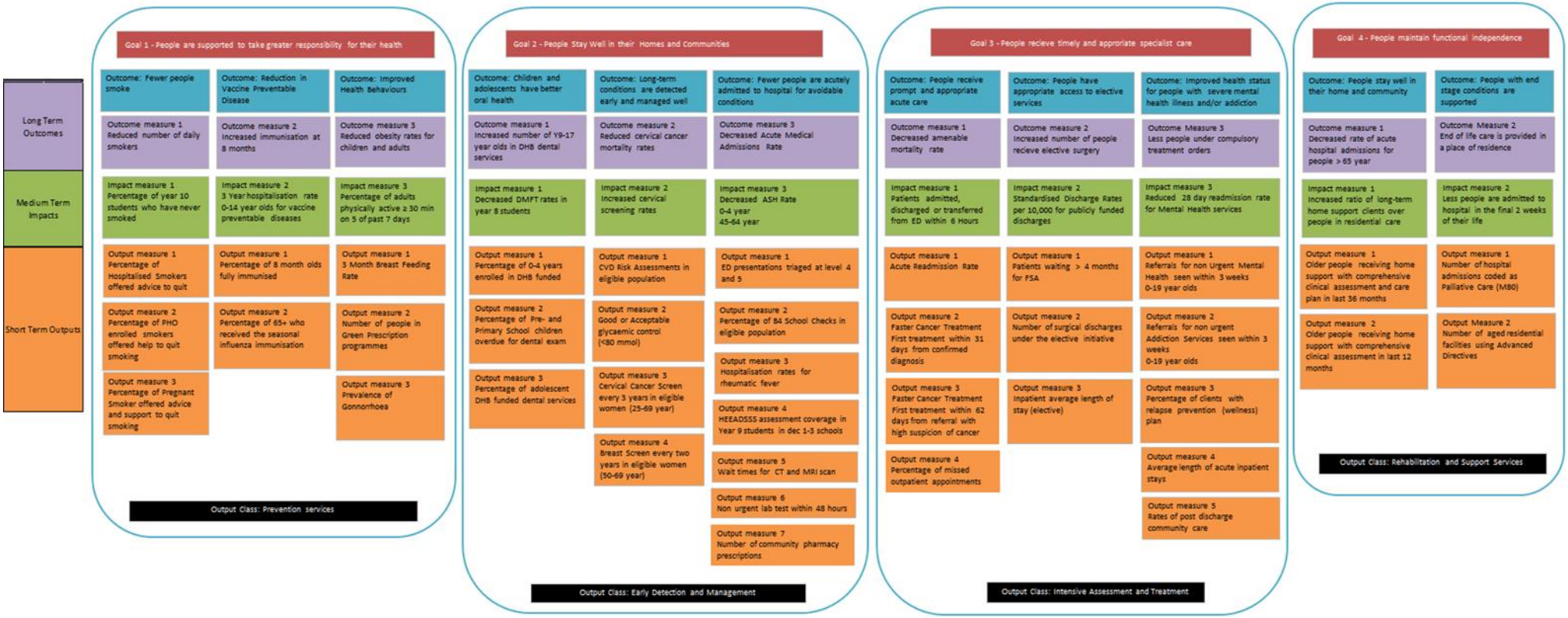
Outputs are goods and services that are supplied to someone outside our DHB. Output classes are an aggregation of outputs, or groups of similar outputs of a similar nature. The output classes used in our statement of performance expectations are also reflected in our financial measures. The four output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



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

[1] The statement of performance expectations is published in our 2020/21 Annual Plan : http://www.tdh.org.nz/about-us/documents-and-publications/accountability-documents/

Map of Indicators



2020/21 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.

2020/21 Prevention Services Performance

2020/21 saw the continuing impact of COVID-19 on performance and the effort to recover. Prevention services where often redeployed to cover COVID-19 swabbing and undertaking the vaccination effort. Within Tairāwhiti across 2020/21 9,570 COVID-19 swabs where provided and between March and June 2021 11,622 COVID-19 vaccination given in the period ending 30 June 2021.

Compared to 2019/20, 2020/21 saw a decrease in the all but one of the indicators linked to the provision of smoking cessation advice. While the rate of hospitalisation of vaccine preventable diseases decreased vaccination coverage for young children fell in all but two groups. 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 is being made to increase capacity within this sector of the system to expand resilience to reduce the dips in performance seen in 2020/21.

OUTCOME MEASURES - Long Term[2]

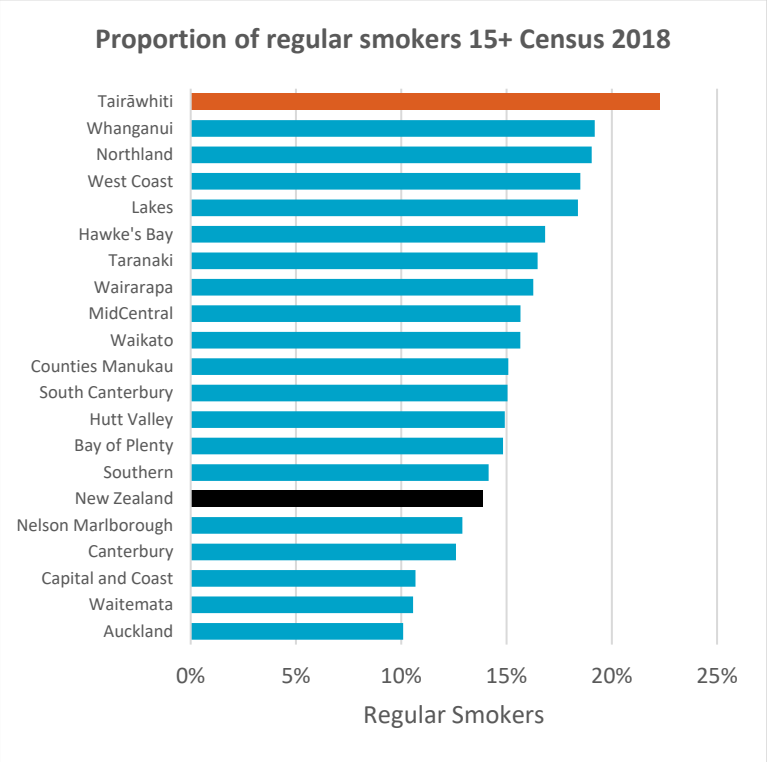
Outcome: Fewer people smoke

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



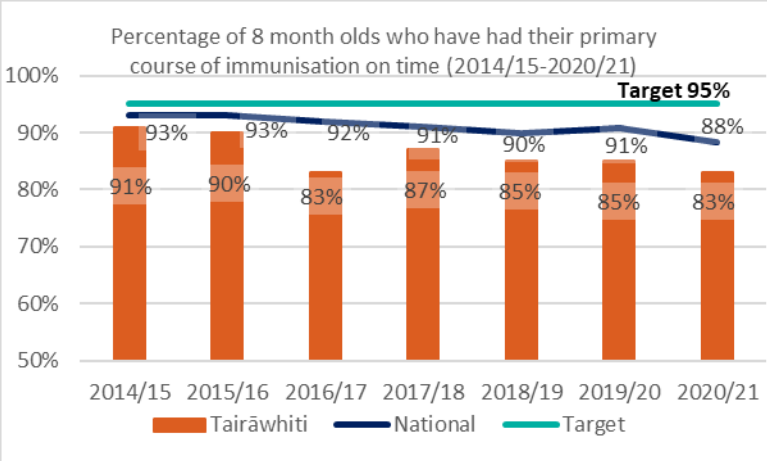
Data source: Census 2018 – Tatairanga Aotearoa (Stats NZ), April 2020

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 - 12 months data				
	2017/18	2018/19	2019/20	2020/21
Tairāwhiti	87%	85%	85%	83%
National	91%	90%	91%	88%
Target	95%	95%	95%	95%

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



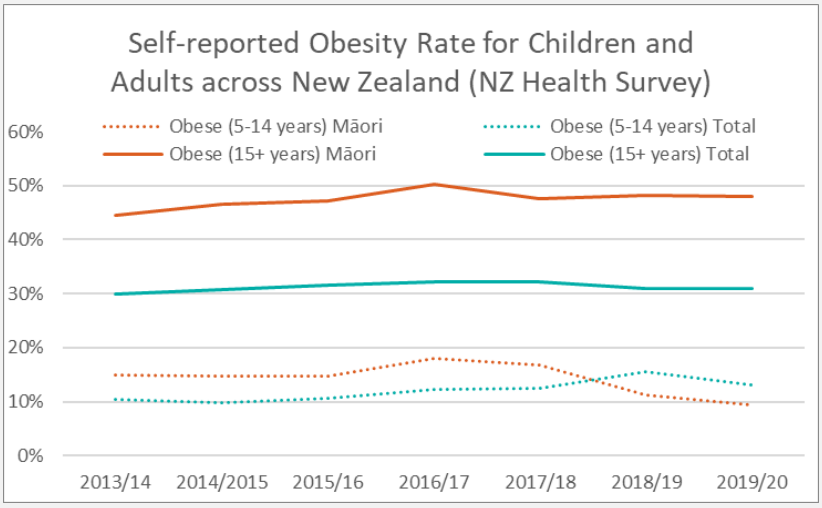
Data Source: Health System Indicators 2020/21

[2] Other entity information is unaudited

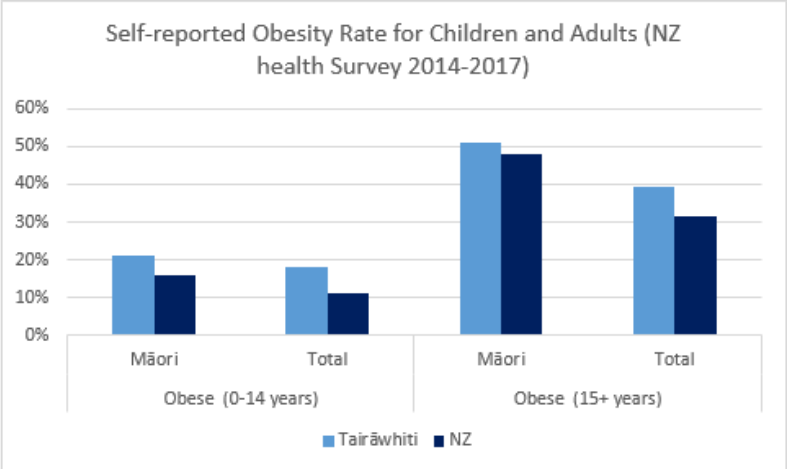
Outcome: Improved Health Behaviours

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 2019-20 NZ Health Survey, Dec 2020



Data Source: The 2016-17 NZ Health Survey, March 2018[3]

[3] Regional data from the survey has not been released since March 2018 for the 2016/17 year

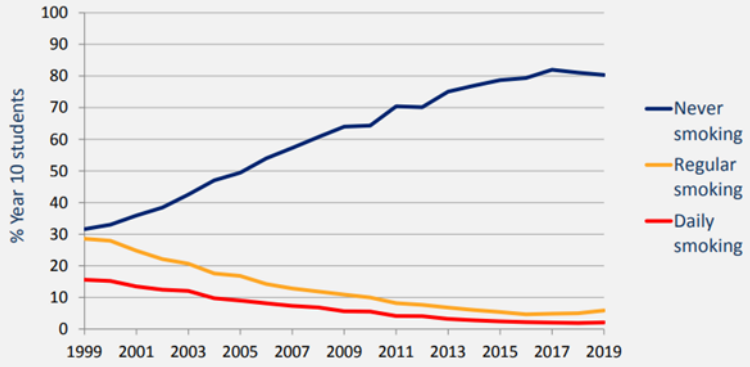
IMPACT MEASURES – Medium Term[4]

Outcome: Fewer People Smoke

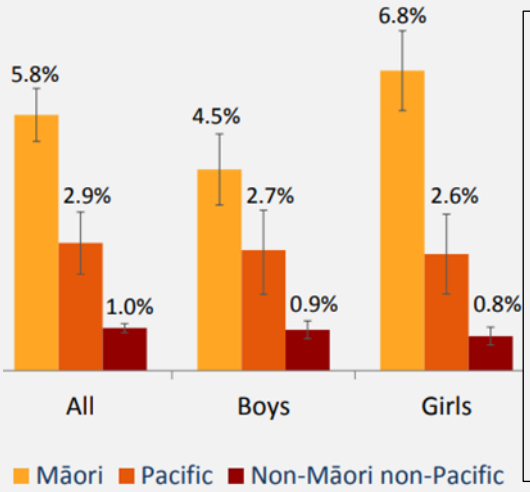
We see the highest prevalence of smoking among younger people, so preventing young people from taking up smoking is a key contributor to reducing smoking rates across the total population. Because Māori and Pacific population groups have higher smoking rates, reducing the uptake amongst Māori and Pacific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

A reduction in the uptake of smoking by young people is seen as a proxy indicator of the success of our health promotion activity and a change in the social and environmental factors that support healthier lifestyles. Although no local figures have been published since 2015, national figures for 2018 show smoking in Māori and Pacific youth remains disproportionally high, with the highest daily smoking rates for Māori girls.

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



Data Source – ASH New Zealand 2019. National Year 10 ASH Snapshot Survey.[5]



Daily smoking rates for Māori and Pacific students are markedly higher than for participants of other ethnicities (non-Māori non-Pacific). In 2019 daily smoking rates for Māori students are over 5 times higher than for non-Māori non-Pacific, with Māori girls reporting the highest daily smoking rates.

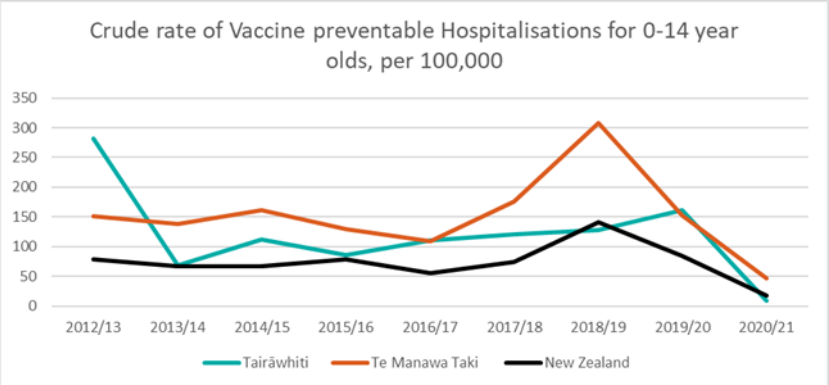
Outcome: Reduction in vaccine preventable diseases

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

Crude Rate per 100,000, source – MoH NMDS

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



Data Source: MoH National Minimum Data Set (NMDS)

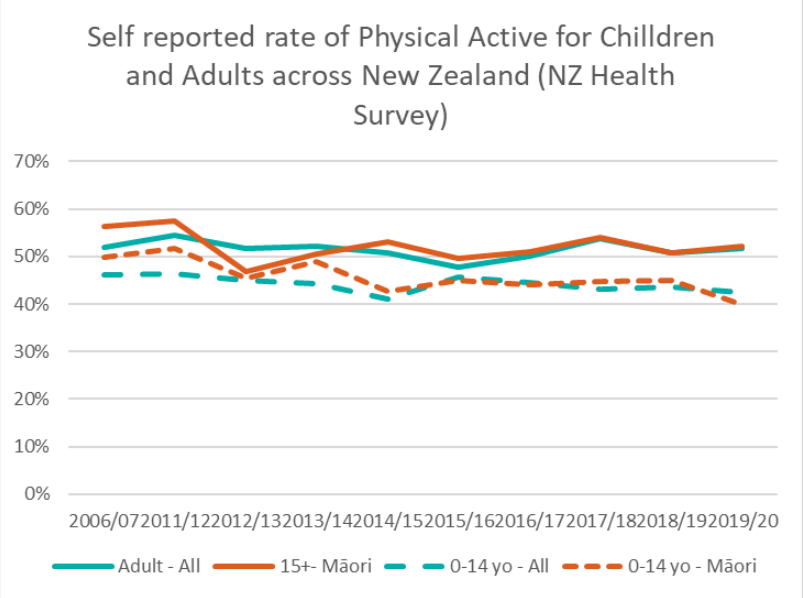
[4] Other entity information is unaudited

[5] 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 30 minutes or more on 5 of past 7 days



Source - NZ Health Survey, December 2020[6]

OUTPUTS – Short Term Performance Measures

Outcome: Fewer people smoke

Outcome Measure		Measure Type	2018/19 Result	2019/20 Result	2020/21 Target	2020/21 Result	Latest NZ Result	Trend
Percentage of hospitalised smokers offered advice to quit (not included in Statement of performance and expectation for the 2020/21 year)	Māori	**τ/ δ**	94%	92%	≥95%	86%	N/A	🡻
	Non Māori	**τ/ δ**	92%	91%		87%		🡻
	Total Pop	**τ/ δ**	93%	92%		86%		🡻
Percentage of PHO enrolled smokers offered help to quit smoking by a health care practitioner in the last 15 months (SLM) (PH04)	Māori	**τ/ δ**	82%	72%	≥90%	68%	75%	🡻
	Non Māori	**τ/ δ**	90%	79%		77%	79%	🡻
	Total Pop	**τ/ δ**	84%	80%		71%	77%	🡻
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 (PH04)	Māori	**τ/ δ**	96%	98%	≥90%	92%	N/A	🡻
	Non Māori	**τ/ δ**	100%	88%		100%		🡹
	Total Pop	**τ/ δ**	96%	97%		93%		🡻

[6] https://minhealthnz.shinyapps.io/nz-health-survey-2019-20-annual-data-explorer/_w_ba8a6675/#!/home

Outcome: Reduction in Vaccine Preventable Disease

Indicator		Measure Type	2018/19 Result	2019/20 Result	2020/21 Target	2020/21 Result	Latest NZ Result	Trend
Percentage of 8 month olds fully immunised (Health Target, SLM) (12 months figure) (CW05)	Māori	**τ/ δ**	84%	83%	**≥95%**	78%	79%	↓
	Non Māori	**τ/ δ**	88%	90%		91%	93%	↑
	Total Pop	**τ/ δ**	85%	85%		84%	90%	↓
Percentage of 24 month olds fully immunised (12 months figure) (CW05)	Māori	**τ/ δ**	84%	92%	**≥95%**	82%	79%	↓
	Non Māori	**τ/ δ**	85%	86%		83%	91%	↓
	Total Pop	**τ/ δ**	84%	88%		82%	88%	↓
Percentage of five year olds fully immunised (12 months figure) (CW05)	Māori	**τ/ δ**	89%	90%	**≥95%**	82%	81%	↓
	Non Māori	**τ/ δ**	88%	91%		88%	88%	↓
	Total Pop	**τ/ δ**	89%	90%		84%	87%	↓
Percentage of girls and boys fully immunised against HPV (CW05)[7]	Māori	**τ/ δ**	80%	61%	**≥75%**	63%	57%	↑
	Non Māori	**τ/ δ**	52%	59%		69%	71%	↑
	Total Pop	**τ/δ**	69%	61%		65%	63%	↑
Percentage of people >65 years who have received the seasonal influenza immunisation (CW05)	Māori	**τ/δ**	49%	59%	**≥75%**	48%	53%	↓
	Total Pop	**τ/δ**	54%	66%		59%	63%	↓

[7] 2018/19 reflects coverage for girls only as vaccine was only offered to them at this time

Outcome: Improving Health Behaviours

Indicator		Measure Type	2018/19 Result	2019/20 Result	2020/21 Target	2020/21 Result	Latest NZ Result	Trend
Percentage of infants who are exclusively/fully breastfed at 3 Months (CW06)	Māori	**τ/δ**	36%	45%	**≥70%**	40%	47%	↓
	Non Māori	**τ/δ**	60%	66%		68%	61%	↑
	Total	**τ/δ**	48%	56%		52%	58%	↓
Raising healthy kids Percentage of obese children identified in the B4 School Check Programme who are offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions (HT, CW10)	Māori	**δ**	97%	87%	**≥95%**	85%	94%	↓
	Non Māori	**δ**	100%	78%		91%	96%	↑
	Total Pop	**δ**	97%	85%		87%	94%	↑
The number of people participating in the Green Prescription programmes	Total Pop	**τ/δ**	1027	849	**≥1024**	838	N/A	↓
Reduce the prevalence of gonorrhoea (Local Indicator)[8]	Total Pop	**τ/δ**	112 per 100,000	102 per 100,000	**≤60 per 100,000**	155	147	↑

Output class: EARLY DETECTION AND MANAGEMENT SERVICES

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

Goal 2 - People stay well in their homes and communities

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

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

[8] Sexually Transmitted Infection (STI) surveillance ESR report to Q2 2020 https://www.esr.cri.nz/our-services/consultancy/public-health/sti/

2020/21 Early Detection and Management Services Performance

The uptake of young children 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 half of those covered having treatment completed in the period, this is a focus area in 2021 where plans to address the uptake in rural areas expected to show results in the latter half of the year.

In the area of long term conditions being detected early and managed well attendance indicators have been maintained at a level similar to 2018/19 and 2019/20 but control of the glycaemic control for people with diabetes has decreased markedly with only 32.5% of Māori who have diabetes maintaining a good/acceptable level of control. This potentially is a consequence of the stresses within the population around COVID-19 resurgence and the increasing use of virtual consultations within the health system.

The continued progress on eradicating rheumatic fever from the community continues and further decreases may have been seen if it had not been for the COVID-19 pandemic response. The response saw additional overcrowding in some households may have contributed to a number of the cases hospitalised in 2019/20.

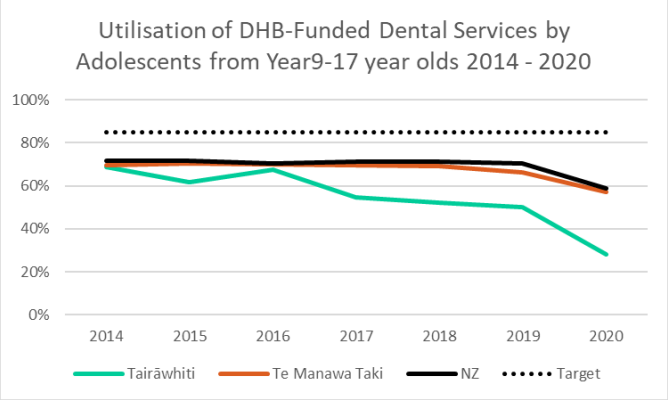
In the area of reducing hospitalisation for avoidable conditions has generally shown improvement across the most indicators.

OUTCOME MEASURES - Long Term[9]

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.

[9] Other entity information is unaudited

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

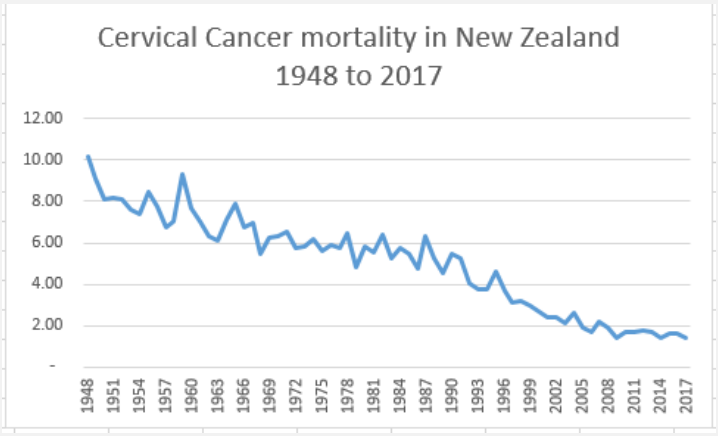
Cervical cancer is the fourth-most common cause of cancer and the fourth-most common cause of death from cancer in women worldwide. New Zealand has seen the number of women who die from cervical cancer dropping by 60 per cent since 1990 thanks to the screening programme. But still about 50 women die from it each year[10]. 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 2011 to 2017

Rate per 100,000	2011	2012	2013	2014	2015	2016	2017
Total Population	1.7	1.8	1.7	1.4	1.6	1.6	1.4
Maori	5.4	3.7	4	3	3.6	3	3.2

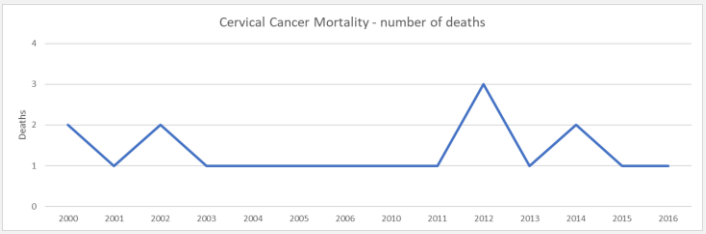
New Zealand cervical cancer mortality

Outcome measure 2: Reduced cervical cancer mortality rates



Source: Ministry of Health: Cancer Historical Summary 1948-2017[11].

Tairawhiti cervical cancer mortality



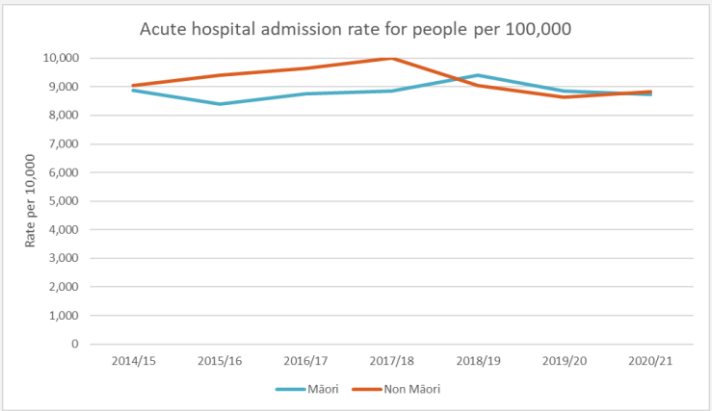
Source: Ministry of Health: Mortality data 2000 - 2016

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: Hospital Reporting – Inpatient discharges

[10] https://www.health.govt.nz/your-health/conditions-and-treatments/diseases-and-illnesses/cervical-cancer
[11] As at 3 October 2019, https://www.health.govt.nz/publication/historical-mortality

IMPACT MEASURES – Medium Term[12]

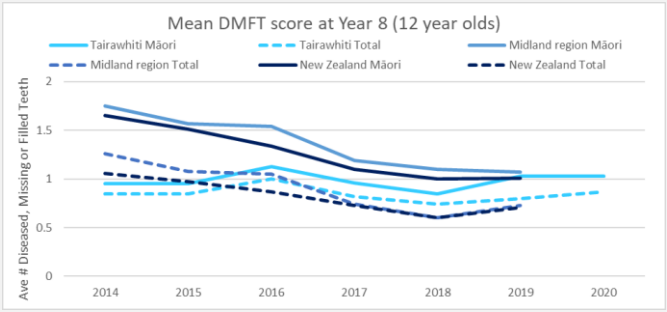
Outcome: Children and adolescents have better oral health

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

	2016	2017	2018	2019	2020
Tairāwhiti Māori	1.13	0.96	0.85	1.04	1.03
Tairāwhiti All	0.94	0.82	0.74	0.80	0.87
Midland Māori	1.54	1.19	1.23	1.07	
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	

Released Dec 2021

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

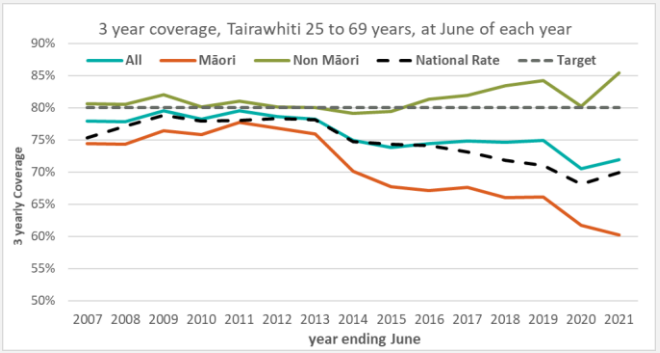


Data Source: Ministry of Health Performance Reporting

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

Impact measure 2: Increased cervical screening rates



Data Source: Ministry of Health, National Cervical Screening Programme (NCSP) New Zealand District Health Board Coverage Report 30 June 2021

[12] Other entity information is unaudited

Outcome: Fewer people are admitted to hospital for avoidable conditions

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

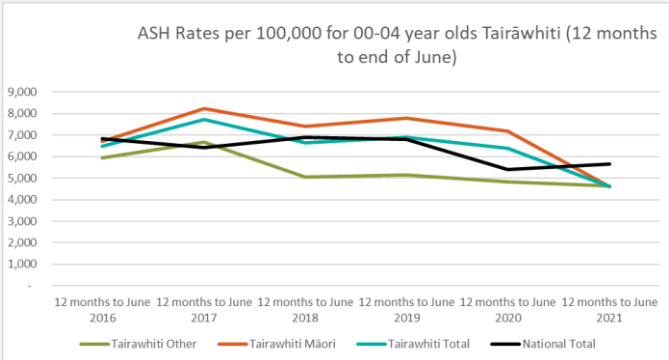
ASH rates for 12 months period to 30 June each year

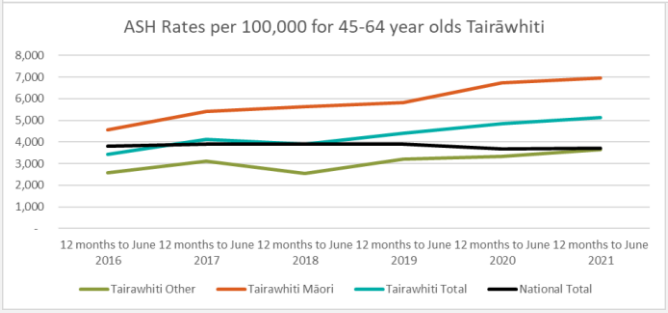
0-4	Ethnic Group	12 months to June 2016	12 months to June 2017	12 months to June 2018	12 months to June 2019	12 months to June 2020	12 months to June 2021
Tairawhiti	Other	5,957	6,667	5,042	5,143	4,819	4,640
Tairawhiti	Māori	6,720	8,240	7,390	7,782	7,177	4,593
Tairawhiti	Total	6,476	7,734	6,630	6,910	6,389	4,609
National	Total	6,842	6,409	6,904	6,804	5,397	5,662

45-64	Ethnic Group	12 months to June 2016	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
Tairawhiti	Other	2,572	3,126	2,548	3,204	3,335	3,640
Tairawhiti	Māori	4,569	5,415	5,633	5,831	6,746	6,963
Tairawhiti	Total	3,422	4,119	3,918	4,392	4,861	5,132
National	Total	3,795	3,898	3,900	3,907	3,689	3,713

Tairāwhiti ASH rates 2016-21

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	2018/19 Result	2019/20 Result	2020/21 Target	2020/21 Result	Latest NZ Result	Trend
Percentage of Children (0-4) enrolled in DHB funded dental service (CW01) *	Māori	δ	104%	101%	≥ 95%	88%	N/A	🡻
	Non Māori	δ	114%	109%		133%		🡹
	Total	δ	107%	104%		101%		🡻
Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination (CW03)*	Māori	δ	5%	10.0%	≤10%	18%		🡹
	Non Māori	δ	3%	5.4%		15%		🡹
	Total Pop	δ	4%	8.3%		18%		🡹
Percentage of adolescent utilisation of DHB-funded dental services (CW04) *	Total Pop	Ω/ δ	52%	50%	≥85%			

* For the year ending 31 March 2021

Outcome: Long term conditions are detected early and managed well

Indicator		Measure Type	2018/19 Result	2019/20 Result	2020/21 Target	2020/21 Result	Latest NZ Result	Trend
Percentage of assessed high risk patients who have had an annual review (SS13 FA3)	Māori	δ	54.4%	70.3%	≥90%	78.5%	N/A	🡹
	Non Māori	δ	57.0%	59.5%		60.1%		🡹
	Total Pop	δ	55.7%	65.0%		69.4%		🡹
Percentage of eligible population will have had their cardiovascular risk assessed in the last 5 years (SS13, SLM) (new measure)	Māori	Ω	85.1%	84.7%	≥90%	84.8%	78.5%[13]	🡹
	Non Māori	Ω	89.4%	88.2%		87.1%	79.3%[13]	🡻
	Total Pop	Ω	87.3%	86.5%		86.0%	79.2%[13]	🡻

[13] Note: Rates have not been calculated where there were fewer than four cases. This is because the small numbers will result in unreliable estimates of rates.

Improve the proportion of patients with good or acceptable glycaemic control (HbA1c<64 mmol) (SS13)	Māori	Ω	50%	57%	≥90%	32.5%	N/A	🡻
	Non Māori	Ω	68%	58%		45.5%		🡻
	Total Pop	Ω	57%	57%		37.1%		🡻
Percentage of eligible women (25*-69) have a Cervical Cancer Screen every 3 years (SLM, PV02)	Māori	δ /τ	74%	65%	≥80%	60%	59%	🡻
	Non Māori	δ /τ	80%	80%		85%	72%	🡹
	Total	δ /τ	77%	72%		72%	70%	➲
Percentage of eligible women (50-69) who have had a Breast Screen in the last 2 years[14]	Māori	δ /τ	67%	59.1%	≥70%	58%	62%	🡻
	Non Māori	δ /τ	73%	73.3%		75%	70%	🡹
	Total	δ /τ	70%	67.3%		67.3%	69%	➲

Outcome: Fewer people are admitted to hospital for avoidable conditions

Indicator		Measure Type	2018/19 Result	2019/20 Result	2020/21 Target	2020/21 Result	Latest NZ Result	Trend
Percentage of all Emergency Department presentations who triaged at level 4 & 5	Total	δ	68%	66%	≤50%	69%	42%	🡹
						69%	39%	🡹
Percentage of eligible population who have their B4 School Checks completed (CW10)	High Needs	δ /τ	91.5%[15]	80.3%	≥90%	93.4%	91.2%	🡹
	Total Pop	δ /τ	96.2%	86.6%		94.6%	93.2%	🡹
Hospitalisation rates per 100,000 for acute rheumatic fever (CW13)	Total Pop	δ/τ	4.2	4.1	≤2.8	4.1	N/A	➲
Increased percentage of Year 9 students receiving HEEADSSS assessment in decile 1-3 schools (CW12)	Total Pop	δ/τ	41.5%	31.8%	≥95%	82.3%[16]	N/A	🡹
Improved waiting times for diagnostic services - accepted referrals for CT and MRI receive their scan within 6 weeks[17]	CT Scans	δ/τ	94%	90.8%	≥95%	95.7%	82.1%	🡹
	MRI Scans	δ/τ	81%	81.2%	≥90%	91.7%	63.3%	🡹
Improved waiting times for diagnostic services – accepted referrals for non-urgent diagnostic colonoscopy	within 42 days	Ω/τ	63.8%	80.1%	≥70%	79.9%	54.5%[18]	🡻
Non urgent community laboratory tests are completed and communicated to practitioners within the relevant category timeframes	Within 48 hours	Ω/τ	N/A	N/A	100%	100%	N/A	➲
Number of community pharmacy prescriptions[19]	Total Pop	δ	476,117	475,760	450,000	493,676	49,179,167	🡹

[14] Note that 2018/19 and 2019/20 are for the age group 50-69 yo
[15] Changed from High Needs in 2018/19 to Māori in 2019/20
[16] January to December 2020
[17] 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.
[18] National value is the latest data which reflects activity to 31 May 2021
[19] 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.

2020/21 Intensive assessment and treatment services performance

Variable results across this class in 2020/21 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 under the national average and tangata whaiora readmission rates seeing a 4% decrease between 2019/20 and 2020/21. While the Emergency Department attendances within Tairawhiti saw a small dip just below target this was 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 decreased slightly the rates for those receiving treatment within 62 days increased and is now above the national target.

Another positive in 2020/21 was the increase in the number of outpatient appointments which were not missed for one reason or another. While overall and non-Māori rate was well under target and the Māori rate fell markedly the target rate was not achieved.

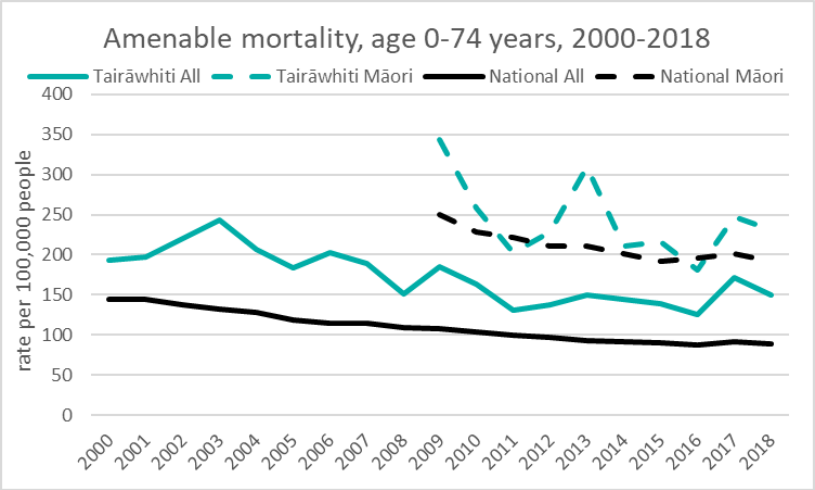
Planned care, previously called electives, was markedly impacted by staffing levels in the first half of 2020/21 and due to the COVID-19 pandemic response this was not able to be made up in the later part of the year. With the reduction in the higher complexity surgery the length of stay for planned care surgery dropped markedly, this was also impacted by the additional effort placed into achieving colonoscopies in preparation for the rollout of the Bowel Screening programme in 2020/21.

OUTCOME MEASURES – Long Term[20]

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)

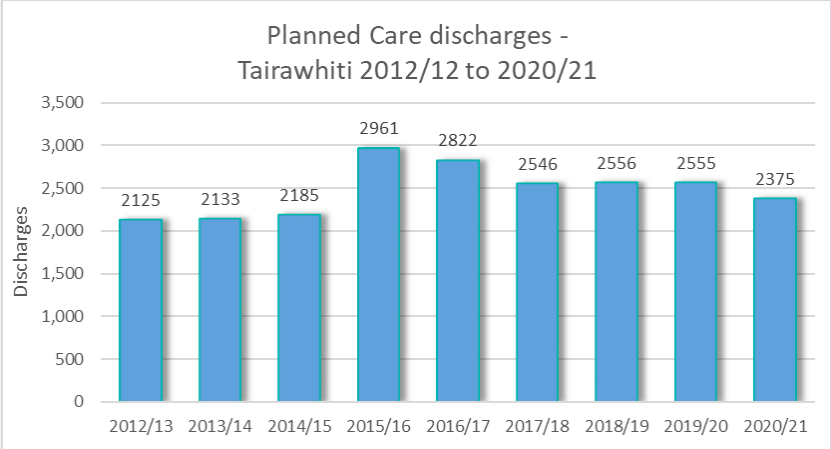


Data source: Amenable mortality SLM Data

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

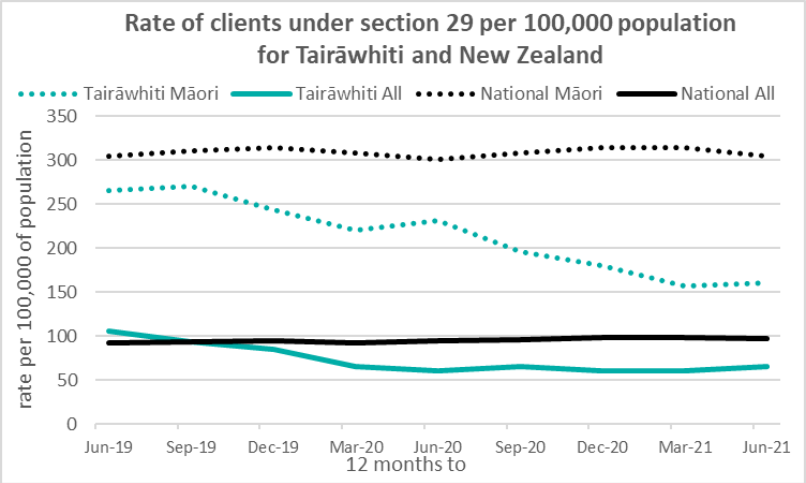


Data Source: Ministry of Health Performance Reporting for Gisborne Hospital

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

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



[20] Other entity information is unaudited

however, will need to be a long term goal as many factors contribute here.	*Data Source: Ministry of Health Performance Reporting PP36*

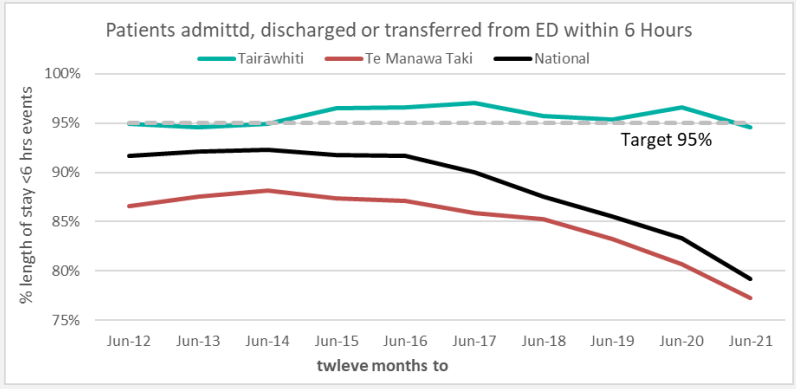
IMPACT MEASURES – Medium Term[21]

Outcome: People receive prompt and appropriate acute care

Emergency Departments (EDs) are often seen as a barometer of the efficiency and responsiveness of both the hospital and the wider health system.

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

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

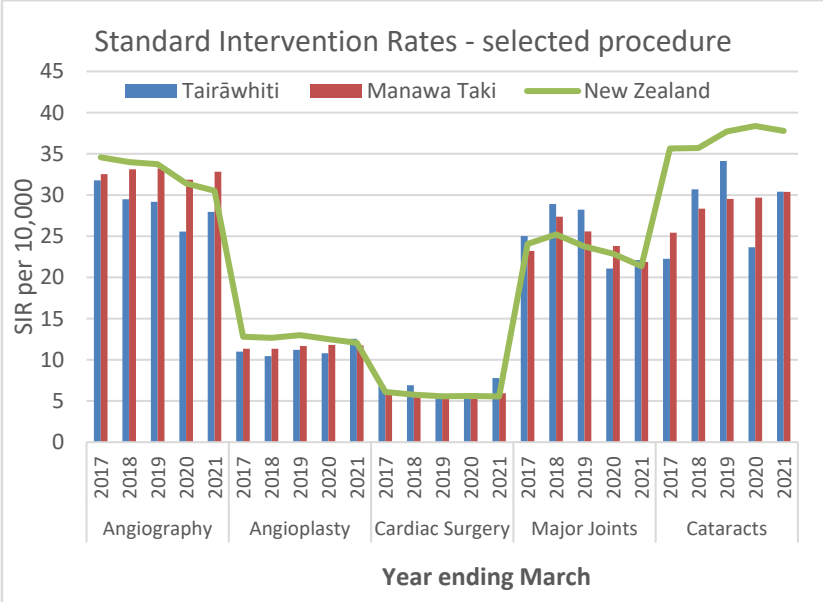


Data Source: Ministry of Heatlh

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

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

Impact measure 2: Planned Care Interventions



Data source - Ministry of Health 8 June 2021

* For the year ending 31 March 2021

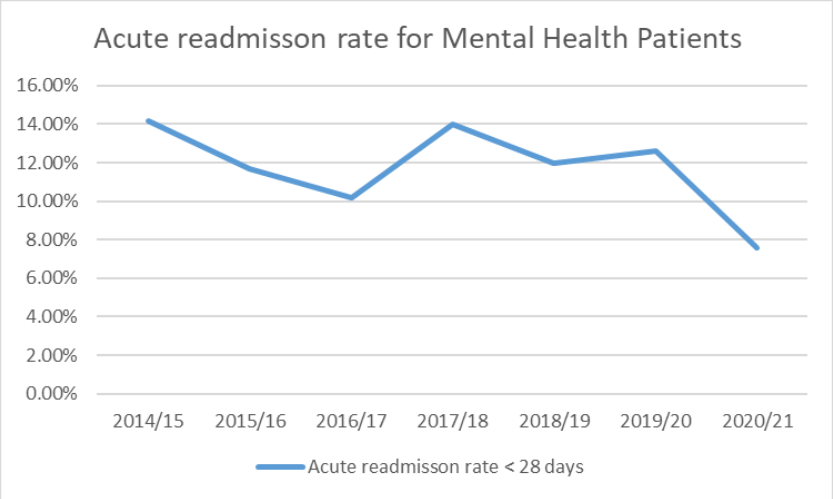
[21] Other entity information is unaudited

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	2018/19 Result	2019/20 Result	2020/21 Target	2020/21 Result	Latest NZ Result	Trend
Acute Readmission rate (SS08)	Total Pop	**δ/Ω/τ**	11.7%	12.3%	≤6%	12.1%	12.1%	🡻
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**	92%	87.9%	≥90%	88.9%	86.0%	🡻
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**	89%	94.4%	≥92%	86.1%	86.5%	🡻
Percentage of missed outpatient appointments[22]	Māori	**δ/ τ**	20%	14%	≤10%	14.3%	13.1%	🡹
	Non Māori		6%	3.4%		3.9%	6.0%	🡹
	Total		12%	7%		9.1%	9.0%	🡹

[22] Hospital reporting – Outpatients 2020/21

Outcome: People have appropriate access to elective services

Indicator		Measure Type	2018/19 Result	2019/20 Result	2020/21 Target	2020/21 Result	Latest NZ Result	Trend
Percentage of patients waiting longer than four months for their first specialist assessment (Elective Service Performance Indicator 2)[23] (SS07)		**δ/ τ**	18.9%	25.7%	0%	16.6%	N/A	🡻
Number of surgical discharges under the Planned Care (previously electives) initiative (SSO7)		**δ**	3,257	2,841	≥2,359	2,375	N/A	🡻
Inpatient average length of stay (planned) (SS07)	Total Pop	**δ/τ**	1.45	0.56	≤1.45 days	1.00	N/A	🡹

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

Indicator		Measure Type	2018/19 Result	2019/20 Result	2020/21 Target	2020/21 Result	Latest NZ Result	Trend
Percentage of people referred for non-urgent mental health or addiction services are seen within 3 weeks (MH03)[24] Mental Health 0-19 yr olds		**δ/ τ**	90%	91.4%	≥80%	92%	70.9%	🡹
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**	87%	71.4%	≥80%	69%	80.4%	🡻
Improving the percentage of clients with wellness and transition plan (MH02)[23]	Māori	**δ**	N/A	N/A	≥95%	-	N/A	-
	Non Māori		N/A	N/A		-	N/A	-
	Total pop		73%	100%		42%	N/A	🡹
Average length of acute inpatient stays for mental health (KPI 8)		**Ω/δ/τ**	20 days	13.9 days	14-21 days	98 days	N/A	🡻
Rates of post-discharge community care (KPI 19)		**Ω/δ/τ**	45%	48%	≥90%	62.3%	N/A	🡹

[23] Ministry of Health website – Elective Services Patient Flow Indicators (ESPIs) – Final – % waiting in June.
[24] Data for 12 months from April 20 until March 2021.

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 interRAI assessment in the last three years. We added the 12 months indicator as well, as this shows us how many people receiving home support, were assessed in the last year. The 33% result here shows that indeed one out of three home support clients had an assessment in the last 12 months, so we are on track to maintain the 100% for the 36 months indicator. Analysis of the assessments shows that indeed people were reassessed according to changes in their circumstances: after a hospital discharge and if their condition had deteriorated or routinely after they had been receiving home support for almost three years.

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

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

2020/21 Rehabilitation and Support Services performance

Performance within this class has seen activity rebound from the impact of COVID19 on this class of services. Acute admission for those 65 and other has increased as the number of older people admitted has increased. The proportion of Older people supported to live independently at home compared to those entering residential care and this is reflected the proportion of people choosing to die at home with their loved ones rather than in the hospital.

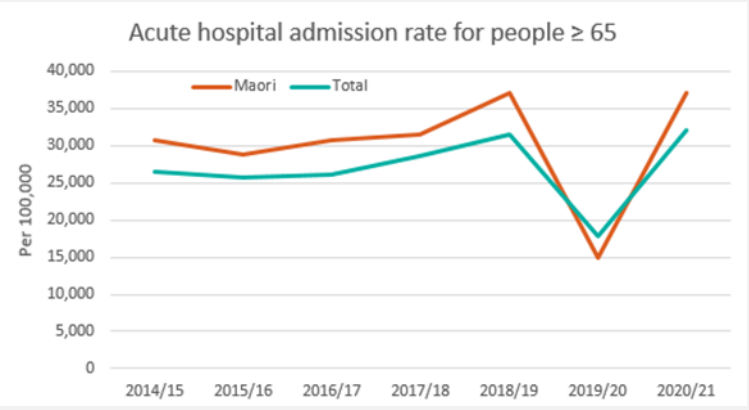
OUTCOME MEASURES - Long Term

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 medical and surgical discharges in older adults were ambulatory sensitive admissions[25]. Some of these admissions could possibly have been avoided by better management of the multipathology of this geriatric population and improved home support. This requires coordinated care between all community partners (GP, Pharmacist, Community nurse, Home Support,..) in combination with secondary care, allied health services, social services and other support agencies.

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



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

Possible interventions[26]:

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

Outcome: People with end stage conditions are supported

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

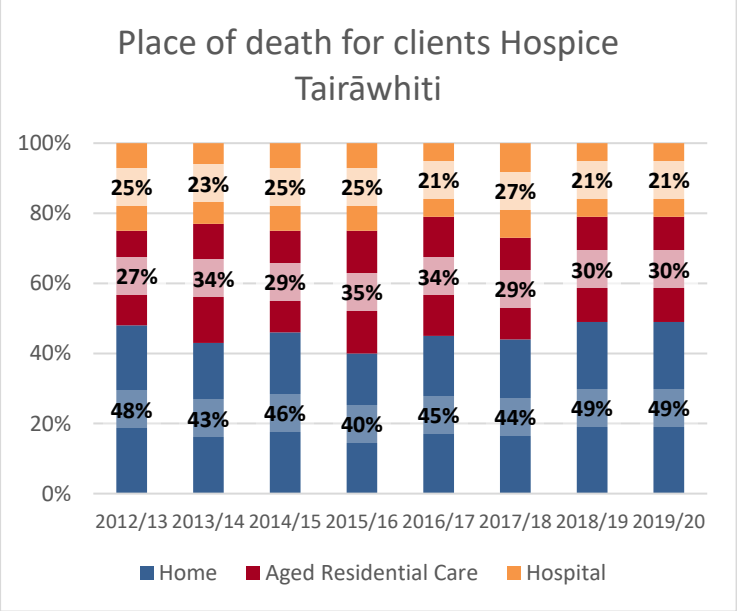
When asked about their wishes regarding end of life, most people say they would like to die at home. Unfortunately too many people still die in hospital.

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

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

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

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



Source: Hospice Tairāwhiti Annual Report

IMPACT MEASURES – Medium Term[27]

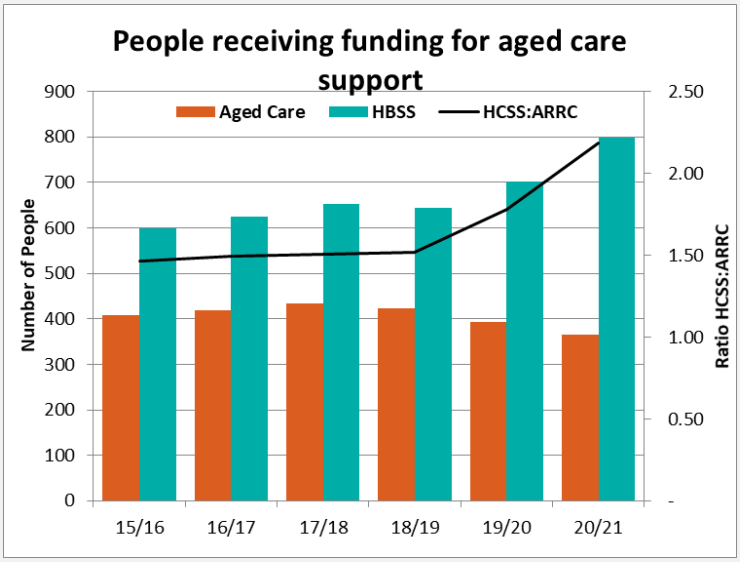
Outcome: People stay well in their home and community

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

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



Source – Client Claims Processing System (CCPS)

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

[26] 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

[27] Other entity information is unaudited

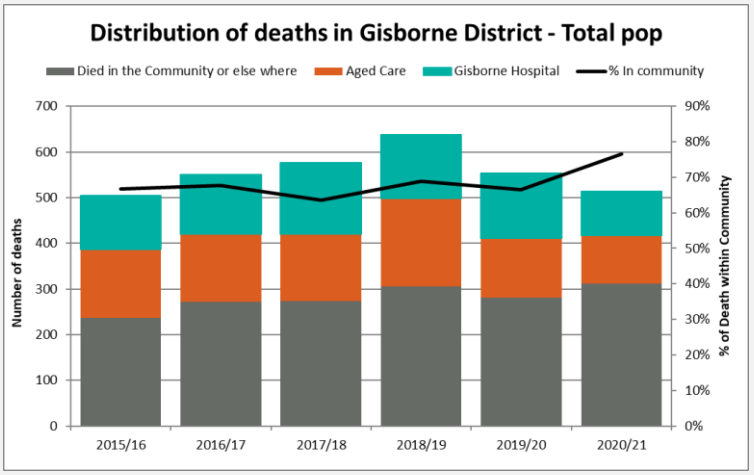
Outcome: People with end stage conditions are supported

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

OUTPUTS – Short Term Performance Measures

Outcome: People stay well in their home and community

	Measure Type	2018/19 Result	2019/20 Result	2020/21 Target	2020/21 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**	93%	95%	100%	88.4%	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**	49%[28]	34%	60%	44.5%	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	2018/19 Result	2019/20 Result	2020/21 Target	2020/21 Result	Latest NZ Result	Trend
Number of hospital admissions under Health Speciality Code M80 (Palliative Care)	**Ω**	8	5	Increase	24	N/A	↑
Number of falls in Aged Residential Care Facility resulting in admission	**Ω**	New Measure		Decrease	N/A	N/A	-
Number of pressure injuries	**Ω**	New Measure		Decrease	66	N/A	↓
Number of aged residential care facilities utilising Advanced Directives (New measure – not included in statement of performance expectations)	**δ**	6	6	Increase	6	N/A	→

[28] Clients receiving care as per 30/06/2019 who had an interRAI assessment after 20/06/2018.

Implementing the COVID-19 vaccine strategy - as of 30th June 2021

Vaccine doses administered by DHB

DHB of Service	Dose 1	Dose 2	Total
Tairāwhiti	7,183	4,439	11,622

By DHB: Eligible population fully vaccinated by DHB of residence (note1) (note 5)

DHB of residence	Proportion fully vaccinated (note 1)
Tairāwhiti	11.68%

Vaccine doses administered by age group (note 4)

Age range (years)	Dose 1	Dose 2	Total
12 to 15	0	0	0
16 to 19	78	39	117
20 to 24	200	153	353
25 to 29	267	209	476
30 to 34	311	228	539
35 to 39	261	205	466
40 to 44	338	280	618
45 to 49	392	298	690
50 to 54	440	314	754
55 to 59	553	404	957
60 to 64	665	457	1,122
65 to 69	999	516	1,515
70 to 74	979	484	1,463
75 to 79	744	366	1,110
80 to 84	519	255	774
85 to 89	265	132	397
90+	172	99	271
Total	7,183	4,439	11,622

Eligible population fully vaccinated by age group (note 5)

Age range (years)	Proportion fully vaccinated (note 1)
12 to 15	0.00%
16 to 19	2.04%
20 to 24	5.86%
25 to 29	6.19%
30 to 34	7.03%
35 to 39	7.27%
40 to 44	10.00%
45 to 49	9.88%
50 to 54	10.18%
55 to 59	12.87%
60 to 64	15.16%
65 to 69	18.85%
70 to 74	22.96%
75 to 79	26.30%
80 to 84	28.30%
85 to 89	25.61%
90+	34.51%
Total	11.68%

Vaccine doses administered by ethnicity (note 4)

Ethnicity	Dose 1	Dose 2	Total
Asian	225	203	428
Euorpean or other	4,317	2,589	6,906
Māori	2,430	1,531	3,961
Pacific peoples	166	86	252
Unknown	45	30	75
Total	7,183	4,439	11,622

Eligible population fully vaccinated by ethinicity (note 5)

Ethnicity	Proportion fully vaccinated (note 1)
Asian	17.52%
Euorpean or other	13.81%
Māori	9.13%
Pacific peoples	9.52%
Unknown	18.84%
Total	11.68%

Vaccine doses administered by sequencing group (note 4)

Sequencing group (note 3)	Dose 1	Dose 2	Total
Group 1	206	213	419
Group 2	3,239	2,583	5,822
Group 3	3,200	1,275	4,475
Group 4	538	368	906
Total	7,183	4,439	11,622

Note 1: Fully vaccinated means two doses have been administered to an individual.

Note 2: The health service user (HSU) population used for COVID-19 vaccine coverage reporting provides information about the number of people in New Zealand who used health services in 2020. People are included if they were alive as at 30 June 2020, were 12 years of age as of 30 June 2020, (note that this was initially 16 years but was reduced to 12 years when the eligibility criteria changed), and if they were enrolled with a primary health organisation or received health services in the 2020 calendar year. There are other data sets that estimate the total number of people in New Zealand.
These include three datasets produced by StatsNZ: Estimated Resident Population (produced every 5 years, following each Census), Subnational Population Estimates (produced every year), and non-official population projections produced by StatsNZ for the Ministry of Health (produced every year).

The Stats NZ population estimates are based on Census data adjusted for the number of people who are born, who have died, and who have migrated to or from New Zealand. The Stats NZ population estimates and projections are of people usually resident in New Zealand, including those usually resident who are temporarily overseas, while the HSU includes everyone in New Zealand who used health services in a given period.

The HSU was chosen by the Ministry of Health as the denominator for COVID-19 vaccine coverage reporting because it allows for the assignment of the same demographics (e.g. location and ethnicity) to people in the numerator (the number of people vaccinated) as the denominator (reference population). The HSU is available for every demographic contained in health data including age, ethnicity, DHB, and gender, separately or in combination. Other information such as neighbourhood deprivation, Statistical Area 2, or territorial local authority can also be added. It is possible to generate flags for health-related information on the HSU, for example, those who are likely to have a long-term condition. Official Stats NZ estimates are not as flexible. For example, StatsNZ estimates by age, sex and Statistical Area 2/Territorial Authority/DHB are produced every year, but estimates that also include ethnicity are only produced every 5 years, the most recent being estimates for 2018. The projections StatsNZ produces for the Ministry every year do provide information by age, sex and broad ethnic group, but are only available at the DHB level.

The Total population estimate based on HSU as at 30 June 2020 is 51,439. This is 679 above the Stats NZ total projected population of 50,760 (from the non-official population projections StatsNZ produced in 2020). When classifying the population into ethnicity, age and DHB there are further differences. For example, a summary of the differences by ethnicity are summarised in the table below. These differences arise as the populations are 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 declaration.

By definition, the HSU is not a total population estimate and is likely to miss highly marginalised groups. For example, 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 ethnicity.

The HSU is considered by the Ministry of Health to be the best option for estimates of vaccine coverage, as it removes bias from calculated rates by ensuring demographic information in the numerator and denominator is consistent. For example, the ethnic group(s) with which someone identifies, and their location.

Total population	HSU	Stats NZ	Difference
Māori	25,919	27,500	(1,581)
Pacific	1,193	1,210	(17)
Asian	1,396	1,250	146
Other	22,931	20,800	2,131
Total	51,439	50,760	679

Note 3: Group 1 includes border and managed isolation and quarantine employees and the people they live with. Group 2 includes high-risk frontline health care workforces; workers and residents in long-term residential environments; older Māori and Pacific peoples cared for by whānau, the people they live with, and their carers; people aged 65 years and older; people with relevant underlying health conditions. Group 3 includes people aged 65 years and older; people with relevant underlying health conditions; disabled people; and adults in custodial settings. Group 4 includes people aged 16 years and over. These definitions and population groups were occasionally updated based on operational and Cabinet decisions or updated estimates of the sizes of each group.

Note 4: The data in this table is based on the DHB of service (where the vaccine dose was administered).

Note 5: The data in this table is based on the DHB of residence of the individual receiving the vaccines. Ethnicity is based on the prioritised ethnicity classification system which allocates each person to a single ethnic group, based on the ethnic groups they identify with. Where people identify with more than one group, they are assigned in this order of priority: Māori, Pacific peoples, Asian, and European/Other. So, if a person identifies as being Māori and New Zealand European, the person is counted as Māori.

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 2020/21

- 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 2019/20 $000's	Budget 2020/21 $000's	Actual 2020/21 $000's
Income			
Prevention	($47,177)	($61,293)	($62,918)
Early Detection and Management	($124,431)	($130,104)	($137,814)
Intensive Assessment and Treatment Services	($10,158)	($8,175)	($10,081)
Rehabilitation and Support	($25,706)	($25,110)	($22,458)
Total Income	**($207,472)**	**($224,682)**	**($233,271)**
Expenditure			
Prevention	$47,571	$62,384	$53,903
Early Detection and Management	$140,073	$132,420	$152,481
Intensive Assessment and Treatment Services	$6,790	$8,321	$7,819
Rehabilitation and Support	$27,462	$25,557	$25,818
Total Expenditure	**$221,896**	**$228,682**	**$240,022**
Surplus/(Deficit)	**($14,424)**	**($4,000)**	**($6,752)**

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.
- In addition DHBs were advised in March 2020 by the Minister of Health that he had issued COVID-19 response direction.

Statement of Responsibility

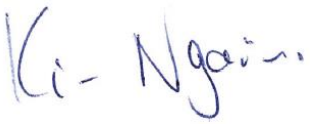
The Board accepts responsibility for the preparation of the Financial Statements and Statement of Service Performance and for the judgements used in them.

The Board accepts responsibility for any end-of-year performance information provided by Hauora Tairāwhiti under section 19A of the Public Finance Act 1989.

The Board accepts responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting.

In the opinion of the Board, the Financial Statements and Statement of Service Performance for the year ended 30 June 2021 fairly reflect the financial position and operations of Hauora Tairāwhiti.

Signed on behalf of the Board of Hauora Tairāwhiti:



Kim Ngarimu
Board Chair
Hauora Tairāwhiti
22 February 2022

Heather Robertson
Board Member
Hauora Tairāwhiti
22 February 2022

Independent Auditor's Report

To the readers of Hauora Tairāwhiti's Group financial Statements and performance information for the year ended 30 June 2021

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 51 to 76, that comprise the statement of financial position as at 30 June 2021, the statement of revenue and expenses, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Group on pages 18 to 42.

Opinion

Qualified opinion on the financial statements

In our opinion, except for the possible effects of the matter described in the Basis for our opinion section of our report, the financial statements of the Group on pages 51 to 76, which have been prepared on a disestablishment basis:

- present fairly, in all material respects:
    - its financial position as at 30 June 2021; 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.

Unmodified opinion on the performance information

In our opinion, the performance information of the Group on pages 18 to 42:

- presents fairly, in all material respects, the Group's performance for the year ended 30 June 2021, including:
    - for each class of reportable outputs:
        - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
        - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
    - what has been achieved with the appropriation; and
    - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and
- complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 22 February 2022. This is the date at which our opinion is expressed.

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

Basis for our opinion

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 69 - 70, 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 $10.397 million for the estimated amounts owed to current and past employees. Due to the complex nature of health sector employment arrangements, the Group's process is ongoing, and there is a high level of uncertainty over the amount of the provision. Because of the work that is yet to be completed, we have been unable to obtain sufficient appropriate audit evidence to determine if the amount of the provision is reasonable.

We were also unable to obtain sufficient appropriate audit evidence of the $9.316 million provision as at 30 June 2020. We accordingly expressed a qualified opinion on the financial statements for the year ended 30 June 2020.

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 the basis for our opinion.

Emphasis of matters

Without further modifying our opinion, we draw attention to the following disclosures.

The financial statements have been appropriately prepared on a disestablishment basis

Note 1 on page 55 outlines the health sector reforms announced by the Minister of Health on 21 April 2021. Legislation to disestablish all District Health Boards and establish a new Crown entity, is expected to come into effect on 1 July 2022. The Group therefore prepared its financial statements on a disestablishment basis. The values of assets and liabilities have not changed because these will be transferred to the new Crown entity.

The Group is reliant on financial support from the Crown

Note 1 on page 55 outlines that Crown support would be required if the Group was required to settle the estimated historical Holidays Act 2003 liability prior to its disestablishment. The Group therefore obtained a letter of comfort from the Ministers of Health and Finance, which confirms that the Crown will provide the Group with financial support, where necessary.

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

Implementing the Covid-19 vaccine strategy performance information on pages 39 to 41 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 40 and 41. This 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 31 on page 75 of the financial statements outlines the impact of Covid-19 on the Group.

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

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

The Board is responsible for such internal control as it determines is necessary to enable it to prepare financial statements and performance information that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements and the performance information, the Board is responsible on behalf of the Group for assessing the Group's ability to continue as a going concern. If the Board concludes that the going concern basis of accounting is inappropriate, the Board is responsible for preparing financial statements on a disestablishment basis and making appropriate disclosures.

The Board's responsibilities arise from the Crown Entities Act 2004, the New Zealand Public Health and Disability Act 2000 and the Public Finance Act 1989.

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

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

Reasonable assurance is a high level of assurance but is not a guarantee that an audit carried out in accordance with the Auditor General's Auditing Standards will always detect a material misstatement when it exists. Misstatements are differences or omissions of amounts or disclosures and can arise from fraud or error. Misstatements are considered material if, individually or in the aggregate, they could reasonably be expected to influence the decisions of readers taken on the basis of these financial statements and the performance information.

For the budget information reported in the financial statements and the performance information, our procedures were limited to checking that the information agreed to 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.

- 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 of accounting by the Board.
- 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 of the group audit. We remain solely responsible for our audit opinion.

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

Our responsibilities arise from the Public Audit Act 2001.

Other Information

The Board is responsible for the other information. The other information comprises the information included on pages 1 to 17, and 43 to 45, 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 2021

	Notes	Actual 2021 $000	Budget 2021 $000	Actual 2020 $000
Revenue				
Patient care revenue	2 i	231,618	224,050	205,241
Interest revenue		118	60	70
Other revenue	2 ii	1,619	572	2,161
Total revenue		233,355	224,682	207,472
Expenses				
Personnel Cost	3	89,031	87,888	84,756
Depreciation and amortisation expenses				
Property, plant and equipment	12	3,252	3,530	3,027
Intangible assets	13	292	202	269
Outsourced services		12,280	6,384	9,333
Clinical Supplies		19,206	18,136	17,649
Infrastructure and non-clinical expenses		10,450	9,996	9,119
Other district health boards		25,141	24,720	24,055
Non-health-board provider expenses		78,193	75,515	71,373
Capital charge	4	1,903	1,900	1,898
Interest expense		55	60	69
Other expenses	5	1,068	1	1,106
Total expenses		240,871	228,332	222,654
Share of associate surplus / (deficit)	11	764	350	758
Surplus / (deficit)		(6,752)	(4,000)	(14,424)
Other comprehensive revenue and expense				
Revaluation of land and buildings		15,512	0	0
Total other comprehensive revenue and expense		15,512	0	0
Total comprehensive revenue and expense		8,760	(4,000)	(14,424)

Explanations of major variances against budget are provided in Note 29.
The accompanying notes form part of these financial statements.

Statement of Financial Position

Statement of Financial Position
As at 30 June 2021

	Notes	Actual 2021 $000	Budget 2021 $000	Actual 2020 $000
Assets				
Current Assets				
Cash & cash equivalents	6	2,587	10	13,159
Receivables	7	11,282	4,975	4,292
Prepayments		1,206	1,467	1,455
Inventories	9	2,126	1,952	1,983
Total current assets		17,201	8,404	20,889
Non-current assets				
Investments in subsidiary and associates	11	1,250	0	1,198
Property, plant and equipment	12	77,481	78,412	61,162
Intangible assets	13	3,450	3,917	2,757
Total non-current assets		82,181	82,330	65,117
Total assets		99,382	90,734	86,006
Liabilities				
Current Liabilities				
NZ Health Partnership Ltd	6	0	(2,485)	0
Payables and deferred revenue	14	22,335	13,034	18,782
Borrowings	16	171	148	159
Employee entitlements	17	25,549	21,170	23,870
Total current liabilities		48,055	31,867	42,811
Non-current Liabilities				
Borrowings	16	232	590	403
Employee entitlements	17	885	1,156	960
Total non-current liabilities		1,117	1,746	1,363
Total liabilities		49,172	33,613	44,174
Net Assets		50,210	57,121	41,832
Equity	19			
Crown equity		79,717	96,715	80,099
Accumulated surpluses / (deficits)		(84,051)	(78,598)	(77,299)
Property revaluation reserves		54,516	39,004	39,004
Trust funds and bequests		28	0	28
Total equity		50,210	57,121	41,832

Explanations of major variances against budget are provided in Note 29.
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 2021

	Notes	Actual 2021 $000	Budget 2021 $000	Actual 2020 $000
Balance at 1 July		41,832	47,503	49,050
Total comprehensive revenue and expense		8,760	(4,000)	(14,424)
Owner transactions	19			
Capital contribution		0	14,000	20,000
Crown loans converted to equity		0	0	0
Repayment of capital		(382)	(382)	(382)
Bequest Trusts interest		0	0	0
Balance at 30 June		50,210	57,121	41,832

Explanations of major variances against budget are provided in Note 29.
The accompanying notes form part of these financial statements.

Statement of Cash Flow

Statement of Cash Flows
For the year ended 30 June 2021

	Notes	Actual 2021 $000	Budget 2021 $000	Actual 2020 $000
Cash flows from operating activities				
Receipts from patient care				
Ministry of Health		215,359	213,403	196,925
Other District Health Boards		2,999	2,920	2,449
Other		8,733	7,416	7,221
Receipts from other revenue		1,618	943	2,161
GST (net)		138	0	334
Payments to suppliers		(120,089)	(109,501)	(104,044)
Payments to Other District Health Boards		(25,141)	(25,594)	(24,055)
Payments to employees		(87,427)	(87,888)	(82,252)
Capital charge		(1,903)	(1,966)	(1,898)
Net Cash flow from operating activities		(5,713)	(267)	(3,159)
Cash flow from investing activities				
Distributions from subsidiary company		712	0	570
Interest receipts		118	0	69
Receipts from sale of property, plant, and equipment		0	0	0
Purchase of property, plant and equipment		(4,105)	(17,612)	(2,568)
Purchase of intangible assets		(985)	(105)	(745)
Net cash Flow from investing activities		(4,260)	(17,717)	(2,674)
Cash flow from financing activities				
Capital contributions from the crown		0	14,000	20,000
Interest paid		(56)	0	(71)
Repayment of capital to the Crown		(382)	(382)	(382)
Repayment of finance leases		(161)	0	(149)
Net cash flow from financing activities		(599)	13,617	19,389
Net (decrease) / increase in cash and cash equivalents		(10,572)	(4,367)	13,565
Cash and cash equivalents at the start of the year		13,159	6,862	(406)
Cash and cash equivalents at the end of the year	6	2,587	2,495	13,159

Explanations of major variances against budget are provided in Note 29.
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 2021	Actual 2021 $000	Actual 2020 $000
Net surplus / (deficit)	(6,752)	(14,424)
Add / (less) non-cash items		
Share of associates surplus	(764)	(758)
Increase in non-current employee entitlements	(75)	651
Depreciation and amortisation expense	3,544	3,296
Other non-cash items	46	0
Net change on financial instruments and term liabilities	58	58
Total non-cash items	2,809	3,247
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	(6,989)	408
(Increase) / decrease in prepayments	249	12
(Increase) / decrease in inventories	(143)	(31)
Increase / (decrease) in payables	3,434	5,776
Increase / (decrease) in employee entitlements	1,679	1,853
Net movements in working capital items	(1,770)	8,018
Net cash (outflow) / inflow from operating activities	(5,713)	(3,159)

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).

Basis of preparation
On 21 April 2021, the Minister of Health announced the health sector reforms in response to the Health and Disability System Review. The reforms will replace all 20 DHBs with a new Crown entity, Health New Zealand, that will be responsible for running hospitals and commissioning primary and community health services. It will have four regional divisions. As a result of the reforms, responsibility for public health issues will rest with a new Public Health Authority. A new Māori Health Authority will monitor the state of Māori health and commission services directly. Legislation to establish the new entities and disestablish DHBs is scheduled to come into effect on 1 July 2022. Because of the expected date of these reforms the financial statements of the DHB have been prepared on a disestablishment basis. No changes have been made to the recognition and measurement, or presentation in these financial statements, because all assets, liabilities, functions and staff of the DHBs and shared services agencies will transfer to Health New Zealand.

Operating and Cash flow forecasts
The key considerations are set out below:

- Operating and Cash flow forecasts:
  The Board has considered forecast information relating to operating viability and cash flow requirements. Based on current forecasts the Board is satisfied there will be sufficient cash flows generated from operating activities to meet its cash flow requirements of the DHB as set out in it the 2021/22 Statement of Performance Expectations and based on current trading conditions and legislative requirements.

- Letter of comfort
  Crown support would be required if Hauora Tairāwhiti was to settle the estimated Holidays Act 2003 liability prior to disestablishment as such the Board has received a letter of comfort, dated 13 October 2021, from the Ministers of Health and Finance which states that deficit support will be provided where necessary to maintain viability.

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

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:

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, with early application permitted. Hauora Tairāwhiti does not intend to early adopt the amendment.

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 reporting periods beginning on or after 1 January 2021. Hauora Tairāwhiti has not yet determined how application of PBE FRS 48 will effect is statement of performance.

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 2021 $000	Actual 2020 $000
MoH population-based Funding	190,870	171,761
MoH other contracts	26,981	24,447
Inter-district Flows (other DHBs)	2,999	2,449
Other patient care related revenue	10,768	6,584
Total Patient care revenue	231,618	205,241

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

As required by the Public Finance Act 1989, Hauora Tairāwhiti received $191,236k 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 2021 $000	Actual 2020 $000
Donated equipment	0	0
Cash donation received	485	68
Rental revenue	274	259
Other revenue	859	1,834
	1,618	2,161

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 $932k (2020; $847k) all of which is a long term liability at this stage. This provision has been calculated on a sample of 40 employees over a period of nine years and adjusted for the current Headcount. The figures in the table below also includes a short term provision of $150k 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 2021 $000	Actual 2020 $000
Salaries and wages	85,592	80,537
Defined contribution plan employer contributions	1,835	1,715
Increase / (decrease) in liability for employee entitlements	522	1,507
Holidays Act Compliance	1,082	997
	89,031	84,756

Employee remuneration

The number of employees or former employees during 20/21 who received remuneration and other benefits of $100,000 or more within specified $10,000 bands were as follows:

From	To	Staff No. 2021	Staff No. 2020
100,000	109,999	35	26
110,000	119,999	35	21
120,000	129,999	13	9
130,000	139,999	9	5
140,000	149,999	5	1
150,000	159,999	4	5
160,000	169,999	7	4
170,000	179,999	5	1
180,000	189,999	2	
190,000	199,999		1
200,000	209,999	1	
210,000	219,999		2
220,000	229,999	2	2
230,000	239,999		1
240,000	249,999		
250,000	259,999		2
260,000	269,999	3	4
270,000	279,999	4	1
280,000	289,999	1	2
290,000	299,999	5	2
300,000	309,999	3	
310,000	319,999	1	6
320,000	329,999		7
330,000	339,999	5	4
340,000	349,999	4	1
350,000	359,999	5	3
360,000	369,999	1	3
370,000	379,999	3	2
380,000	389,999	1	3
390,000	399,999	2	1
400,000	409,999	1	2
410,000	419,000	2	1
420,000	429,999	1	2
430,000	439,999	2	3
440,000	449,999	2	
450,000	459,999	1	
460,000	469,999	1	1
470,000	479,999		1
480,000	489,999		
490,000	499,999	1	1
570,000	579,999	1	
		168	130

During the year ended 30 June 2021, 0 (2020:3) employees received compensation and other benefits in relation to cessation totalling $0K (2020: $75K).

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% (last year 6%).

Note 5: Other expenses

	Note	Actual 2021 $000	Actual 2020 $000
Fees to auditor			
- Audit NZ for audit of the financial statements		133	129
- Audit of Subsidiary Accounts		3	3
- Internal audit fees		102	154
Bad debts written off		(2)	9
Operating lease expense		556	471
Board member fees	23	245	254
Board election expenses		0	65
Loss on disposal of property, plant and equipment		29	7
Other Expenses		2	14
		1,068	1,106

Note: Fees above for Board members are inclusive of fees and expenses related to attendance. Figures included in Note 23 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 2021 $000	Actual 2020 $000
Cash at bank and on hand	2,370	12,952
Deposits with maturities less than 3 months	217	207
	2,587	13,159
NZ Health Partnership Ltd	0	0
Total cash and cash equivalents	2,587	13,159

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 $10.973 million (2020: $9.851 million).

While cash and cash equivalents at 30 June 2021 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 2021 $000	Actual 2020 $000
Receivables from the sale of goods and services (exchange transactions)	11,402	4,406
Less: provision for impairment	(120)	(114)
	11,282	4,292

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

	2021			2020		
	Gross $000	Impairment $000	Net $000	Gross $000	Impairment $000	Net $000
Current	8,910		8,910	3,656		3,656
Past due 1 - 30 days	371		371	245		245
Past due 31 - 60 days	370		370	114		114
Past due over 60 days	1,751	(120)	1,631	391	(114)	277
Total	11,402	(120)	11,282	4,406	(114)	4,292

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 2021 $000	Actual 2020 $000
Balance as at 1 July	114	108
Additional provisions / (reversal)	10	15
Receivable written off	(4)	(9)
	120	114

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 2021 $000	Actual 2020 $000
Held for distribution inventories		
Pharmaceuticals	433	289
Surgical and medical supplies	680	680
Main store	832	832
Other supplies	181	182
	2,126	1,983

The amount of inventories recognised as an expense during the year was $14,259k (2020: $12,815k) 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 ($1k) (2020 ($78k)). Minor variances occur throughout the year as a result of periodic stock takes.

No inventories are pledged as security for liabilities (2020: $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 (2020: $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 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 2021 $000	Actual 2020 $000
Assets	7,455	7,609
Liabilities	6,878	7,092
Revenue	4,270	3,726
Surplus	17	88
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 2021 $000	Actual 2020 $000
Assets	724	686
Liabilities	241	224
Revenue	2,546	2,458
Surplus	322	280
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 2021 $000	Actual 2020 $000
Assets	382	346
Liabilities	192	127
Revenue	1,215	1,055
Surplus	425	390
Share of contingent liabilities	0	0
Total investment in associates (share of assets less liabilities)	1,250	1,198
Total share of associate results	**764**	**758**

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 years	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 2019	2,657	50,220	18,835	1,046	2,430	2,993	564	78,745
Additions		855	1,220	54	278	1	161	2,569
Disposals			(1,112)	(14)	(2)	(1)		(1,129)
Revaluation								
Balance 30 June 2020	2,657	51,075	18,943	1,086	2,706	2,993	725	80,185
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
Accumulated depreciation								
Balance 1 July 2019		(760)	(12,034)	(765)	(1,271)	(2,295)		(17,125)
Depreciation expense		(767)	(1,632)	(71)	(455)	(102)		(3,027)
Elimination on disposals			1,112	14	2	1		1,130
Revaluation								
Balance 30 June 2020	0	(1,527)	(12,554)	(822)	(1,724)	(2,396)	0	(19,023)
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)
Carrying amounts								
As at 1 July 2019	2,657	49,460	6,801	281	1,159	698	564	61,620
At 30 June and 1 July 2020	2,657	49,548	6,389	264	982	597	725	61,162
At 30 June 2021	5,750	61,767	7,560	352	1,039	507	506	77,481

Valuation

The most recent revaluation of land and buildings was performed by an independent registered valuer, Jones La Selle, as at 30 June 2021.

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. (2020: $nil) for buildings and $403k (2020: $562k) for other equipment.

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

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.

	Software	WIP Software	Total
	$000	$000	$000
Cost or Valuation			
Balance 1 July 2019	3,731	1,508	5,239
Additions	19	726	745
Disposals			0
Revaluation			0
Balance 30 June 2020	3,750	2,234	5,984
Balance 1 July 2020	3,750	2,234	5,984
Additions	3,056	(2,069)	987
Disposals	(2)		(2)
Impairment			0
Balance 30 June 2021	6,804	165	6,969
Accumulated amortisation			
Balance 1 July 2019	(2,958)		(2,958)
Amortisation expense	(269)		(269)

Elimination on disposals			0
Balance 30 June 2020	(3,227)	0	(3,227)
Balance 1 July 2020	(3,227)		(3,227)
Amortisation expense	(292)		(292)
Elimination on disposals			0
Balance 30 June 2021	(3,519)	0	(3,519)
Carrying amounts			
As at 1 July 2019	773	1,508	2,281
At 30 June and 1 July 2020	523	2,234	2,757
At 30 June 2021	3,285	165	3,450

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 2021 $000	**Actual 2020 $000**
Payables and deferred revenue under exchange transactions		
Creditors	6,019	3,727
Accrued expenses	14,523	13,397
Total payables and deferred revenue under exchange transactions	20,542	17,124
Payables and deferred revenue under non-exchange transactions		
GST payable	1,561	1,423
Capital Charge payable	0	0
Trusts and bequests with substantive conditions	205	203
Other	27	32
Total payables and deferred revenue under non-exchange transactions	1,793	1,658
Total payables and deferred revenue	22,335	18,782

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 (2020: 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 NZHPL banking facility are recorded at the amount payable plus accrued interest.

Breakdown of borrowings	Actual 2021 $000	Actual 2020 $000
Current Portion		
Finance Leases	171	159
	171	148
Non-current portion		
Finance Leases	232	403
Total non-current portion	232	562
Total Borrowings	403	562
Borrowing facility Limits		
NZ Health Partnership Ltd (refer to note 6)	10,973	9,851
Total borrowing facility limits	10,973	9,851

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 2021	Actual 2020
Westpac - MRI Lease	7.14%	7.14%
NZ Health Partnership	0.00%	0.00%
Analysis of financial lease		
Minimum lease payments payable:		
No later than one year	171	159
Later than one year and not later than five years	232	403
Later than five years	0	0
Total minimum lease payments	403	562
Future finance charges		
Present value of minimum lease payments	403	562
Present value of minimum lease payments payable:		
No later than one year	171	159
Later than one year and not later than five years	232	403
Later than five years	0	0
Total present value of minimum lease payments	403	562

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 2021 $000	Actual 2020 $000
Current portion		
Accrued salaries and wages	2,786	3,349
Annual leave	9,385	8,658
Holidays Act Compliance	10,397	9,316
Sick leave and shift leave	94	94
Sabbatical leave	501	474
Continuing medical education leave	1,306	1,053
Long service leave	753	661
Retirement gratuities	327	265
	25,549	14,554
Non-current portion		
Long service leave	492	567
Retirement gratuities	393	393
	885	10,276
Total employee entitlements	26,434	24,830

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 provisions in relation to Compliance with the Holidays Act 2003 of $1,082k (2020 $997k). These amounts are additions to the overall provision which as at 30 June 2021 is $10,397k and classified as a current liability. Other minor amounts are included with Accounts payable.

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 2021/22 financial year. The final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed.

However, during the 2019/20 financial year the review process agreed as part of the MOU has rolled out in tranches to the DHBs and NZBS. DHB readiness and availability of resources (internal and external to the DHB) has determined when a DHB can commence the process. Hauora Tairāwhiti has assessed that further audit work is required to reach a reliable estimate of its historic non-compliance under the MOU

Notwithstanding, as at 30 June 2021, 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 by

- selecting a sample of current and former employees;
- 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 significant uncertainties as to the actual amount the DHB will be required to pay to current and former employees.

The estimates and assumptions may differ to the subsequent actual results as further work is completed. This may result in further adjustment to the carrying amount of the 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 2021 $000	Actual 2020 $000
Crown equity		
Balance at 1 July	80,099	60,481
Capital contributions from the crown	0	20,000
Repayment of capital to the crown	(382)	(382)
Balance at 30 June	79,717	80,099
Accumulated surpluses / (deficits)		
Balance at 1 July	(77,299)	(62,875)
Surplus / (deficit) for the year	(6,752)	(14,424)
Transfer from / (to) trust funds	0	0
Balance at 30 June	(84,051)	(77,299)
Revaluation reserves		
Balance at 1 July	39,004	39,004
Revaluations	15,512	0
Balance at 30 June	54,516	39,004
Bequest Trusts and Capital reserve		
Balance at 1 July	28	28
Interest on trust deposits	0	0
Balance at 30 June	28	28
Total equity	50,210	41,832

Included in the 2020/21 accumulated surplus/(deficits) are $5,224k of funding above the 2020/21 ring fence expectation of $18,900,000. The accumulated total represents $9,565k of funding above ring-fence since its establishment (2019/20 $317K).

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 2021 $000	Actual 2020 $000
Capital commitments	2,761	3,235

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

Operating leases as lessee

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

	Actual 2021 $000	Actual 2020 $000
Not later than one year	171	159
Later than one year and not later than five years	232	403
Later than five years	0	0
Total non-cancellable operating leases	403	562

Hauora Tairāwhiti lease a number of buildings and equipment under operating leases.
The details of the main leases are as follows:

- Tangata Rite building is on a month by month basis pending renegotiation.
- MRI equipment finance has an expiry date of 19 July 2023.

Note 21: Contingencies

Legal Proceedings
Hauora Tairāwhiti has two HDC 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. (2020: $nil)

Contingent assets
Hauora Tairāwhiti has no contingent assets (2020: $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 2021 $000**	**Actual 2020 $000**
Board members		
Remuneration	219	210
Full time equivalent members	1	1
Leadership Team		
Remuneration	4,169	3,740
Full time equivalent members	20	20
Total key management personnel remuneration	4,388	3,950
Total full-time equivalent personnel	21	21

Note 23: Board member remuneration

Board Members	**Actual 2021 $**	**Actual 2020 $**
M Akuhata-Brown	16,251	16,559
A Cranston	18,070	7,163
S Faulkner	18,329	8,160
G Milner (Deputy Chair - Outgoing)		14,947
G Murphy (Deputy Chair)	20,366	18,282
K Ngarimu (Chair)	34,498	10,597
H Pihema	19,818	17,639
N Raihania		14,225
R Rauna	16,820	5,649
H Robertson	19,757	6,649
A Robinson	20,070	7,908
D Scott (Chair - Outgoing)		19,533
K Sheldrake		9,407
R Stoltz		9,032
J Wharehinga	18,820	17,372
B Wilson		10,632
A Wray	16,320	6,527
P Younger		10,041
	219,119	210,319

Maori Caucus & Community Members	$	$
B A Clarke		1,138
J Hockey	1,250	1,750
C Johnson		1,250
L McCarthy-Robinson	3,674	3,808
Te A Nepia-Clamp	5,250	1,250
A Ngarangioue	1,877	500
M Palmer		750
M Para	2,000	750
N Raihania	6,584	1,274
J Timutimu	1,250	500
R Waihi		1,000
T Chaffey-Aupouri	3,000	
D Procter	750	
J Williams		1,250
	25,635	15,220
Total governance remuneration	244,754	225,539

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 (2020: $nil).

Note 24: Events after balance date

There were no significant events after balance date (2020: None)

Note 25: Financial instruments

Hauora Tairāwhiti and the Group is party to financial instruments as part of its normal operations. These financial instruments include bank accounts, short term deposits, investments, debtors, creditors, and loans. All financial instruments are recognised in the Statement of financial position and all revenues and expenses in relation to financial instruments are recognised in the Statement of comprehensive revenue and expense. Except for loans, which are recorded at cost, and those 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 2021 $000	Actual 2020 $000
Financial assets measured at amortised cost		
Cash and cash equivalents	217	207
Receivables	11,282	4,292
	11,499	5,697
Financial liabilities measured at amortised cost		
Payables (excluding income in advance and taxes payable)	37,637	33,336
Borrowings	0	0
Finance leases	403	562
Total financial liabilities measured at amortised cost	38,040	33,898

Note 26: 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 27: 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 28: Early childhood care

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

	Actual 2021 $000	Actual 2020 $000
Revenue from the Ministry of Education	65	57
Expenditure		
Personnel costs	(63)	(60)
Operation expenses	(1)	0
	(64)	(60)
Net surplus / (deficit)	1	(3)

Note 29: 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 increased funding in relation to COVID 19 and vaccinations.

Personnel Costs were over budget $1.1m or 1.35% for a variety of reasons:
A number of pay settlements above that expected were made during the year. Additional provision has been made at year end for non-compliance with the Holidays Act 2003 of $931k.

Outsourced services costs continue to be high - $5.9m over budget as we continue to experience difficulties recruiting and retaining skilled staff.

Clinical supplies are $1m over budget, a result of increased costs related to COVID 19 (PPE), catch up in planned care from the first outbreak of COVID 19 and increased pharmaceuticals and air ambulance costs (COVID 19 related)

Non Health Board provider costs are $2.7m over budget as a result of increasing costs for Inter District Flows (IDF) outflows of $400k in the year and payments to providers in relation to COVID 19.

Statement of changes in Equity

The deficit was $2.75m above the budgeted result due to the reasons given above.

Statement of financial position

Current assets are $8.8m higher than budget predominantly as a result of accruals relating to planned care $3m, PHARMAC $2m and COVID 19 income.

Non-current assets are $149k lower than budget mainly as a result of the pace of the capital programme.

Liabilities are $16m higher than budget due to unbudgeted HAC provision of $1m and significant accrued creditors in the funder are of $11.2m.

Note 30: 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 31: COVID-19 Impact

During August and September 2020 and February and March 2021, the Auckland Region moved into Alert Levels 3 and 2 and other parts of the country, which includes the DHB's service area, moved into Alert level 2.

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 then pre-Covid-19. This was because planned care that was delayed during Alert Levels 3 and 4 in the prior financial year was rescheduled to take place at lower Alert levels.

Government funding The MoH approved funding of $1.136 million for the DHB to assist with the Covid-19 response. In addition, the MoH announced additional funding of $558k to support community health providers impacted by the Covid-19 lockdown. This funding was distributed through the DHB to Pinnacle (Primary Health Organisation), iwi provider, general practitioners, pharmacists, and aged care providers.

Personnel expenses
Personnel expenses have increased by $650k due to an increase in permanent and casual staff. Also, staff have taken less leave since the pandemic declaration.

Other expenses
There was an increase in clinical and infrastructure and non-clinical supply costs of $1.93 million, 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.

Valuation of land and buildings
Overall, the DHB does not consider there to be any material impacts on the value of land and buildings as at 30 June 2021.

Note 32: Late Completion of Audit

The Audit of Hauora Tairāwhiti's accounts was completed on 22nd February 2022. This is the date the audit opinion is expressed. Audit New Zealand acknowledge the audit was completed later than required by Legislation. This was due to and auditor shortage in New Zealand and the consequential effects of Covid-19, including lockdowns which have resulted in the annual report not being available before 31 December 2021.