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ANNUAL REPORT

for year ended 30 June 2021

Pūrongo ā-tau

MidCentral District Health Board
Te Poe Hauora o Ruahine o Tararua

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

2020/21 ANNUAL REPORT

MidCentral District Health Board
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Palmerston North 4440
NEW ZEALAND

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MIHI

Ka tangi te manu kōrere
Ka rongo te tangi kōrihi
Ka wāwā te mana ki roto
i te Wao-nui a Tāne
Tūturu whiti whakamaua kia tina!
Tina!
Haumi e! Hui e!
Tāiki e!

The birds cry shall flow endlessly
I hear its melancholy song
Pulsating from within the Great
Forest of Tāne
Fastened to be fixed! It is fixed!
In alliance! Gathered! Confirm!

Ka rere ngā tai o mihi ki ngā mana, ki ngā reo, ki ngā karangatanga maha o te tai whakarunga o te tai whakararo o te whitinga ki tai ata, o te urunga ki tai ahiahi.
Mauri tū, mauri ora ki a koutou katoa

May the tide of greetings flow to the powers, to the voices, to the many groupings from the north, south, east and west. May the active life force impart good health upon you all.

Maringi tonu te puna roimata
Ki a rātou kua rere ki tua o paerau, ki te huinga o te kahurangi. Nō reira e ngā mate, haere, haere, okiokitia rā.

The spring of tears still flows
For those who have gone to the distant horizon, to the gathering of spirits. Therefore dearly departed, leave to your eternal resting place.

Rātou ki a rātou, kia hoki mai ki a tātou te kanohi ora.

Returning towards we the living faces of those who have gone before.

E whakataukītia nei ākuanei a Kino tō ai me he rā, me he rā.
Kia uru-uru mai a hau-ora,
a hau-kaha, a hau-māia
ki runga, ki raro, ki roto, ki waho
Tīhei Mauri Ora!

It is said that unity will overcome adversity sooner or later.
Health, Wellbeing and Determination is pursued towards completeness
There is life!

REPORT FROM THE BOARD CHAIR AND CHIEF EXECUTIVE

Tēnā koutou katoa

We are pleased to present our Annual Report for the 2020/21 year.

As we reach the end of the financial year, it is time to reflect on our achievements. The 2020/21 year has continued the challenges of the previous year, most notably from the emergence of the COVID-19 pandemic. The impact of COVID-19 is still resonating across many of our services and teams. Our work to protect the community is still being seen across various programmes of work, including the ongoing testing programme and the rollout of the COVID-19 vaccine. Maintaining our COVID-19 readiness has also remained a key focus.

Our strategy

We want everyone in the MidCentral District Health Board's region to have access to high quality health and disability services, which support people and whānau to lead healthy lives as they flourish in their communities. Inspired by this ambition, we worked closely with our communities to form and refresh our Strategy during 2020.

At the very heart of this Strategy is Te Tiriti o Waitangi and its Articles, guiding MidCentral DHB in how it governs and conducts itself, how it develops true partnership with iwi and how it can be enhanced to improve Māori health outcomes.

There is deliberate and strengthened focus on unity within our Strategy, demonstrating our honest commitment to working in partnership with iwi, Māori, our multi-cultural communities, providers, cross-sector agencies and health professionals. We recognise the need to work collectively towards a shared goal if we are to reduce the inequities in our communities.

By working together and by placing people and whānau at the centre of everything we do, we can, and will, improve the health and wellbeing of our communities.

Our facilities

We continue to make advancements toward our SPIRE (Surgical Procedural Interventional Recovery Expansion) project, with the most recent development being the Laurie McCool Centre.

Looking ahead

Sector developments

As the country approaches a major reform to the health and disability system, it is well worth noting how well MDHB is positioned to adapt to these changes. We introduced our Integrated Service Model, Te Wao nui a Tāne, in 2017, to ensure we could deliver and provide services that are well connected, accessible and better suited to the needs of our people. The delivery of care that is seamless, safer, timely and equitable is one of the key drivers of the reforms. We can and have adapted to these principles at MDHB.

The Government intends to support the newly structured health system by taking a locality approach to the provision of services to communities. MDHB is well positioned as we already use a locality approach, which has included the formation of health and wellbeing plans for Palmerston North, Ōtaki, Manawatū, Horowhenua and Tararua. These plans are crucial to our understanding of the health needs of our localities and have allowed us to inform our approach to addressing the challenges people and whānau are facing.

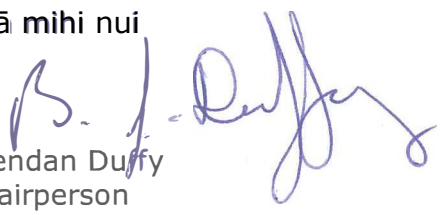
Our staff

We thank our staff for their support and commitment through what has been an incredibly difficult and challenging environment. COVID-19 has been a major distraction for everyone, and we are proud of how our teams have prepared for and are delivering services through this 'once in a century' pandemic. We thank you sincerely.

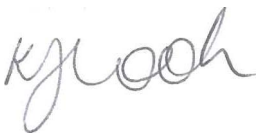
We are fortunate to have an array of talented staff and look forward to forging ahead together in our work for the health and wellbeing of our communities and to achieving better health outcomes and better health care for all. And only then will we truly be able to achieve:

Quality Living – Healthy Lives – Well Communities.

Ngā mihi nui



Brendan Duffy
Chairperson
MidCentral District Health Board



Kathryn Cook
Chief Executive
MidCentral District Health Board

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Quality Living – Healthy Lives – Well Communities.

HE ORANGA TANGATA, HE ORANGATA TAIAO
OUR HEALTH, OUR DISTRICT

MidCentral District Health Board is one of 20 District Health Boards (DHBs) in New Zealand established as a Crown owned entity under provisions of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004 (S.7).

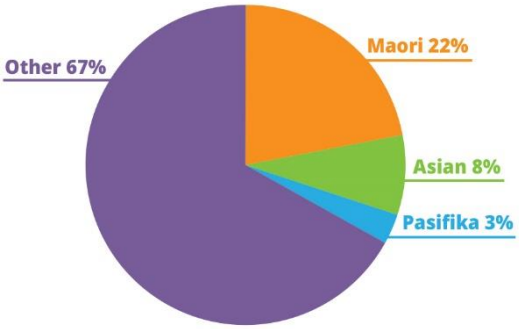
The MidCentral DHB district is located across the mid-lower North Island and includes the Ōtaki ward of the Kāpiti Coast district and the Territorial Local Authority districts of Horowhenua, Palmerston North City, Manawatū and Tararua.

MidCentral District Health Board (MDHB) funds and provides health and wellbeing services to approximately 188,200 residents across five local authority districts, referred to as localities.

Our district's age profile is similar to the national average but has a slightly higher proportion of older people, expected to continue nationally with 20 percent over 65 by 2030.

We have a higher proportion of Māori in comparison to the national average and two of our localities are now refugee resettlement areas. The number of refugees in Palmerston North City is steadily growing and Horowhenua's first intake of refugees is scheduled for 2021.

Our district has a higher proportion of people in the more deprived sections of the population. More than 46,000 people or 27 percent of our population are living in high deprivation (decile 9 or 10).



These statistics are important because people who are experiencing socio-economic disadvantage, Māori, and older people are known to have poorer health outcomes than other New Zealanders.

As a DHB, we employ over 2,700 staff directly and commission services from several organisations within and beyond our district.

Our geographical location enables us to be an effective regional centre for the provision of Regional Cancer Services to the Whanganui, Wairarapa, Hawke's Bay and Taranaki District Health Boards. Without this collaboration, patients would regularly have to travel further to reach the tertiary district health boards in Wellington or Waikato.

Our objectives

In accordance with legislation and objectives of the District Health Board (DHB), we:

- Plan the strategic direction for health and disability services within our region and our district, in collaboration with key stakeholders and our community (i.e. district group and clinical networks, iwi/Māori, Central Primary Health Organisation and non-Government organisations, Government departments/ agencies, Central Region's Technical Advisory Service, other DHBs and the Ministry of Health).
- Fund the provision of the majority of the publicly funded health and disability services in our district through the contracts we have with providers (such as general practitioners, iwi/Māori service providers, community pharmacies, dentists, age-related residential care facilities and non-Government organisations).
- Provide hospital and specialist services primarily for our population, but also for people referred from other DHBs and other DHB populations for whom we are a regional or sub-regional provider of services (such as renal services, or cancer treatment services as a regional cancer centre). We are also one of eight lead providers of the national breast screening programme provided to an extended region including Taranaki, Whanganui and Hawke's Bay districts.
- Promote, protect and improve our population's health and wellbeing through health promotion, health protection, health education and the provision of evidence-based public health programmes.

We received around $602 million in the 2020/21 year to undertake these obligations.

Our Māori Relationship Board – Manawhenua Hauora

MidCentral DHB's commitment to Māori health is formally recognised in a Memorandum of Understanding with Manawhenua Hauora – a consortium of the four iwi within the district, namely;

- Ngāti Kahungungu ki Tamaki Nui a Rua
- Ngāti Raukawa ki te Tonga
- Rangitaane o Manawatū and Rangitane o Tamaki Nui a Rua
- Muaūpoko.

Manawhenua Hauora is the formal Māori Relationship Board that sits as a Treaty partner to the MidCentral DHB's Board. Four fundamental principles underpin MidCentral DHB's and Manawhenua Hauora's commitment to Māori health:

- A common interest and commitment to advancing Māori health
- Building on the gains and understandings already made in improving Māori health
- Applying the principles of the Treaty of Waitangi to work to achieve the best outcomes for Māori health
- Partnership and mutual regard.

Improving health outcomes

Key findings from our Health Needs Assessments and Equity Snapshots identify that health inequities are experienced by our Māori and Pacific people and by people facing socio-economic disadvantage. Māori are least advantaged in our district with respect to both socio-economic opportunities for good health as well as mortality outcomes.

In terms of each locality area, inequities are evident in the Horowhenua district (as they have high proportions of Māori, Pacific and socio-economically disadvantaged people among their residents), and notable disadvantage may be emerging in the Tararua district.

The health status of our population has been gradually improving over time (as it has been for New Zealand overall). This is indicated by reducing age-adjusted mortality rates.

Life expectancy, mortality rates and morbidity (hospitalisation) data are useful indicators to monitor progress toward our long-term goals and outcomes and as a checkpoint to assess the health of our population over time. The data is used to help us in our strategic planning and to identify where we need to target our resources to address health inequalities and improve the health and wellbeing of our population.

Reducing mortality

Provisional data[1] shows that there were 1,575 deaths registered (all-causes) across MidCentral DHB's population in 2017 – an increase of 89 deaths compared to 2016. Just under ten percent (n.155) of the total deaths were in the Māori population. Forty-nine percent (n.769) of the total deaths were caused by either malignant neoplasms, ischaemic heart disease or cerebrovascular disease.

MidCentral DHB's age-adjusted all-cause mortality rate suggests a slightly worse health status than that of New Zealand overall. This may be expected because MidCentral DHB's population has higher proportions of higher needs groups (Māori, socio-economically disadvantaged people, and older people) than New Zealand overall.

There is a considerable difference between the age-adjusted rates of all-cause mortality for Māori versus non Māori in our district.

The factors that influence all-cause morality are much wider than health treatment service performance. They include lifestyle changes (healthier eating), greater physical activity), living conditions, economic conditions (unemployment, income, housing, food and other living costs) and better preventive care.

The term amenable mortality refers to potentially preventable deaths that might have been prevented if health sevices have been delivered more effectively or if patients had accessed services earlier. Amenable mortality analysis shows the same patterns and inequities that exist for all-cause mortality.

The amenable mortality aged standardised rates for the MidCentral DHB's total population aged 0 to 74 years tend to be higher than for the New Zealand population overall. MidCentral DHB's rate in 2016[2] was similar to the previous year, at 103 per 100,000 population compared to 87.6 for all New Zealand. The amenable mortality

[1] Ministry of Health: Mortality 2017 (Provisional), Deaths by DHB Region, December 2019
[2] Ministry of Health: Amenable Mortality Deaths by DHB, ethnicity, and year (2016 Provisional data) July 2019

rate for MidCentral DHB's Māori population however was much higher at 181.5 per 100,000 – the same as in 2015 and lower than the rate for all New Zealand Māori, which increased to 191.5 per 100,000 population in 2016 (188.8 per 100,000 in 2015). In 2016, the predominant cause of premature death was coronary disease, followed by chronic obstructive pulmonary disease, cerebrovascular disease, suicide and female breast cancer. While disease patterns are important, the importance of socio-economic and cultural factors to health status should not be underestimated in terms of seeking to improve health outcomes, including reducing premature death.

OUR VISION AND STRATEGIC FRAMEWORK

MDHB is committed to achieving its purpose of:

He whakapai ake I te hauora, hei oranga mō te katoa
Better health outcomes, better health care for all

and our vision of

quality living, healthy lives, well communities
Kia pai te noho, Kia ora te tangata, Kia ora te hapori

Our Strategy identifies the future we want with a ten-year outlook:

Our Strategy has four Strategic Imperatives which serve as our focus over the next five years, to achieve improvements in the health and wellbeing of people across our communities.

We see this as a shared responsibility – our staff, service users and communities and social service partners and providers need to commit to these priorities if we are to make a difference to the health and wellbeing of individuals, whānau, and communities. Individually and together, we will:

Key enablers to our success in achieving our goals are our ***people, partners, information, stewardship and innovation.***

These in turn are underpinned by our core values that reflect the way we work and culture we strive for:

Compassionate – Kia whai aroha ***Courageous – Kia mātātoa***
Respectful – Kia whai ngākau ***Accountable – Kia noho haepapa***

We worked closely with our communities to refresh our Strategy in 2020 which resulted in strengthening our commitment to Te Tiriti o Waitangi, improving Māori health outcomes, reducing inequities and our locality programme.

Our communities were strong in their messages to us in their need for timely and easy access to health care, where consideration of circumstances is the driving factor in where and when care occurs.

We continue to grow our relationships with our five communities to ensure we best meet their needs and aspirations. At the very heart of this Strategy is Te Tiriti o Waitangi and its Articles, which guide MidCentral DHB in how it governs and conducts itself, how it develops true partnership with iwi and how it can be enhanced to improve Māori health outcomes.

There is a deliberate and strengthened focus on unity within our Strategy, demonstrating our honest commitment to working in partnership with iwi, Māori, our multi-cultural communities, providers, cross-sector agencies and health professionals.

We recognise the need to work collectively towards a shared goal if we are to reduce the inequities in our communities. By working together and by placing people and whānau at the centre of everything we do, we can, and will, improve the health and wellbeing of our communities. And only then will we truly be able to achieve Quality Living – Healthy Lives – Well Communities.

In parallel, the district's Māori Health Strategy, Ka Ao, Ka Awatea, was refreshed in partnership with iwi and THINK Hauora, the district's primary health organisation, as a companion document to our strategy. This Strategy is the foundation for the contribution of the health and disability sector to Whānau Ora and provides a 'whole of health system' approach to advance Māori health. Ka Ao, Ka Awatea identifies three strategic goals we are seeking to achieve over time. These are:

- Māori providers are active leaders in defining priority investment areas to improve iwi and Māori health.
- A consistent and integrated approach for cultural competency across primary, secondary and tertiary services will be delivered, monitored and maintained.
- Barriers are identified, measured and removed through integrated health and social commitment to whānau wellbeing.

The MDHB Strategy and Ka Ao, Ka Awatea should be read together as they are companion documents.

OUR STRATEGIC COMMITMENTS

MidCentral District Health Board (MDHB) is committed to fulfilling its obligations under Te Tiriti o Waitangi through our continued work at a governance level in partnership with our Māori Relationship Board, Manawhenua Hauora. This is a consortium of the four iwi within our district: Ngāti Kahungungu ki Tamaki Nui a Rua, Ngāti Raukawa ki te Tonga, Rangitaane o Manawatū and Rangitane o Tamaki Nui a Rua, and Muaūpoko.

At the leadership and operational levels, we partner with our Hauora Māori Directorate (Pae Ora Paiaka Whaiora), Raukawa Whānau Ora and Te Tihi o Ruahine Whānau Ora Alliance (comprising nine iwi, hāpu and Māori organisations) to:

- improve the health and wellbeing of whānau
- advance our collective equity agenda
- address the health inequities experienced by Māori across our district.

We also work alongside our iwi and Māori provider network.

MDHB's Te Tiriti o Waitangi policy was refreshed in 2020 and lays out the expectations for how MDHB staff, as Crown entity employees, and Māori work in partnership at the governance, design, delivery and monitoring of health and disability service levels. The local primary health organisation, THINK Hauora, has adopted the policy to ensure consistency across the health sector within the district.

Our partnership at leadership and operational levels was formalised with the establishment of the Māori Alliance Leadership Team in 2020. The Māori Alliance Leadership Team is made up of Chief Executives and General Managers of iwi and Māori providers. They advise MDHB on advancing Māori health gains from a platform of Whānau Ora that draws on an integrated Māori health and social system approach to challenge inequity and re-orientate the system to support iwi and whānau health outcomes.

Our commitment continues to evolve to make courageous decisions and take affirmative action towards eliminating inequities in health outcomes for Māori, commissioning, Māori workforce development and to continue to include Māori and Māori providers in all planning and service development.

The **New Zealand Health Strategy (2016)** provides an overarching direction for the New Zealand public health system.

He Korowai Oranga is reflected in our Māori Health Strategic Framework – *Ka Ao, Ka Awatea, 2017-2021*, which sets the direction and support for realistic solutions to address challenges in health care and achieve equity of health outcomes across communities.

The **Healthy Ageing Strategy** and the **United Nations Convention on the Rights of Persons with Disabilities** are reflected in our Disability Strategy and the Health and Wellbeing Plan for Te Uru Whakamauora – Healthy Ageing and Rehabilitation.

Ola Manuia 2020-2025: Pacific Health and Wellbeing Action Plan informs and guides our work with our Pasifika community.

STRATEGIC PLANNING INTENTIONS

The high-level planning intentions and key focus areas for MidCentral DHB, as outlined in MDHB's Statement of Intent (2019-2023) reflect our local population health approaches and services and align with the national direction and strategic priorities.

To achieve our strategic intentions, MDHB retained the following strategic priorities for the 2020/21 year:

- Strengthening our financial position
- Reducing equities in health outcomes and engagement with the health system
- Addressing the needs of targeted priority populations
- Addressing our acute care demand
- Minimising the impact of long-term conditions
- Supporting our communities and engagement with the health system.

By implementing the Strategy, MidCentral DHB is seeking to make its contribution to better health outcomes for all and continuing to work toward our vision of 'Quality Living, Healthy Lives, Well Communities'. In Section 2 of this report, a range of indicators are used to measure our progress against the medium term impacts that contribute to reducing amenable mortality and reduced health loss with improved health and wellbeing of our communities.

Our Outcomes Framework (Figure 1) identifies the key community outcomes, and the medium impacts (or consequences) resulting from the outputs or activities we provide or contribute to.

Figure 1: MidCentral District Health Board Outcomes Framework

Wāhanga 1
Tirohanga Rautaki

Section 1
Strategic Overview

PROGRESSING OUR STRATEGIC INTENTIONS IN 2020/21 – HIGHLIGHTS

Reducing inequities in health outcomes

Our strategy has a focus on improving Māori health

Throughout our Strategy we have purposefully interwoven a focus on improving Māori health, including strengthening iwi and Māori leadership and decision making, prioritising initiatives which are aimed at reducing disparities for Māori and building our Māori workforce.

There is a deliberate and strengthened focus on unity within our Strategy, demonstrating our honest commitment to working in partnership with iwi, Māori, our multi-cultural communities, providers, cross-sector agencies and health professionals. We recognise the need to work collectively towards a shared goal if we are to reduce the inequities in our communities.

Our commitment to partner with our communities in all we do will also ensure barriers to accessing health care are reduced and services meet not only their health needs but will take peoples' culture and circumstances into consideration to ensure they and their whānau have a positive experience. By working together and by placing people and whānau at the centre of everything we do, we can, and will, improve the health and wellbeing of our communities. And only then will we truly be able to achieve Quality Living – Healthy Lives – Well Communities.

Replacement of linear accelerates cancer treatment

Treatment times have been significantly shortened thanks to the allocation of $25m of Government funds to purchase and install two new replacement linear accelerators (LINAC) for radiation oncology at Palmerton North Hospital. The first of these was installed in February and the second was installed in September, before being commissioned and used clinically in December 2020.

These new machines have made a fundamental change for people and their whānau at this difficult time. The treatment is easier to tolerate, enables greater precision and has increased the number of people able to be treated.

Breast cancer patients get the FastForward treatment

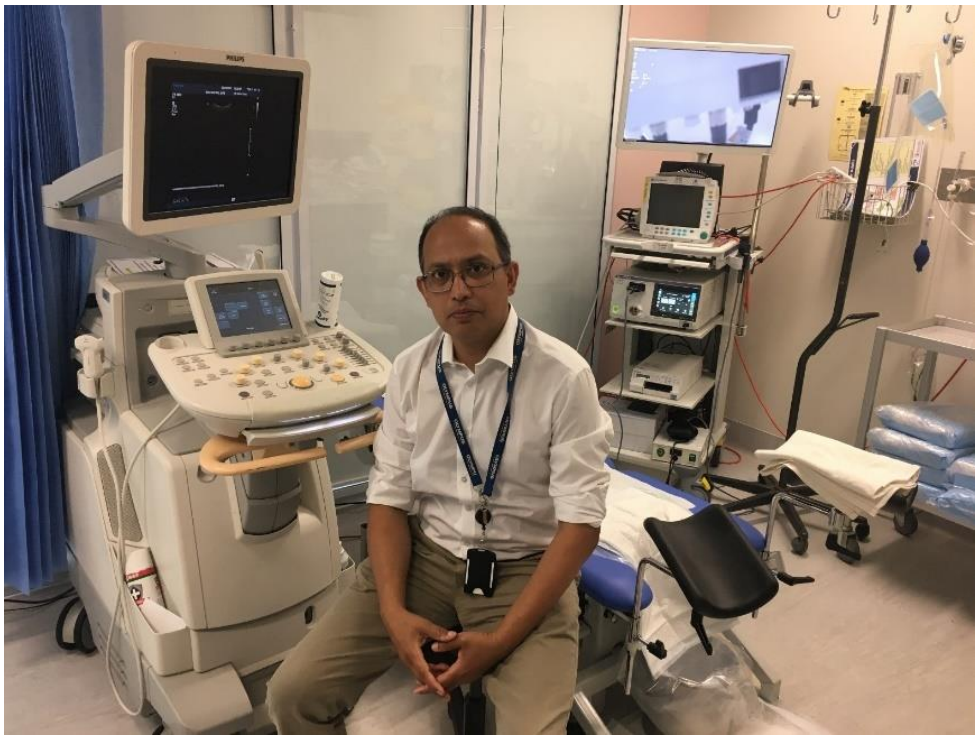
FastForward, a new cancer treatment protocol, devised in the United Kingdom and used by cancer treatment centres around the world, was introduced in October 2020. FastForward significantly reduces the treatment time for women with early-stage breast cancer.

The treatment timeframe has been reduced by two-thirds, providing patients with five doses over a one-week period compared with previously receiving 15 doses of radiation over a period of three weeks. The previous longer treatment term sometimes led some women who would be away from family and support people to either turn down treatment or opt for more invasive procedures, such as mastectomy. The new shorter treatment timeframe means less disruption for patients including travel time, and time away from their whānau, friends and work commitments. And is especially beneficial for people living outside the MidCentral DHB region.

Shortened treatment journey for women

In January 2020 a postmenopausal bleeding clinic started.

Gynaecologist Dr Sikhar Sircar said the new clinic reduced patient waiting times because it completed an ultrasound, biopsy and hysteroscopy during a patient's first appointment, rather than the patient having separate appointments for each procedure. Sircar said this may help diagnose women with cancer up to 12 to 15 weeks earlier and start appropriate treatment.



More than 140 women have been treated at the clinic in the first year. One patient said she had previously juggled appointments between traditional clinics when she lived in Auckland, but her first experience at the Palmerston North clinic was seamless. "I liked that I actually saw a consultant because I had been to other clinics and only seen a registrar. Everything they needed to do was done that morning."

Vape to Quit programme has potential to make a difference

MidCentral DHB has partnered with community pharmacies in the region to provide a Vape to Quit programme that enables individuals to use vaping as a smoking cessation strategy, and as an alternative to smoking cigarettes.

While a vaping device has yet to be approved as an official stop-smoking medicine, it has been agreed that it is a much less harmful way of delivering nicotine than burning tobacco. Vaping has helped many people quit smoking and is considered a legitimate way to become Smokefree – New Zealand's 2025 goal.

Following a pilot project which resulted in a 30% success rate, there have been 334 people participate in the programme over the year. A large proportion of participants were Māori (94%) and included 29 pregnant women.

Addressing the needs of targeted priority populations

Community vaccination event gathering successful for Pasifika population

The COVID-19 vaccination team held a vaccination event for our Pasifika community, at the Pasifika Centre in Palmerston North in May. The Pasifika community had suggested the temporary vaccination site be at Bill Brown Park Community Centre, as this is regular gathering place.

Prior to the event, the vaccination team collaborated with the Pasifika team who know the community well, with two doctors visiting the local Pasifika church to provide information and answer questions. Information booklets in a range of languages and assistance with transport to and from the event was provided to maximise the uptake of the COVID-19 vaccine and alleviate any nervousness.

The event was a success, with a great atmosphere ensuring those that attended had a good experience and were able to connect with others from their community.

Transformation of Star One Unit following Ombudsmen visit

In September 2020, an inspection of the Older Adult Mental Health Unit (Star 1) took place, authorised by the Chief Ombudsman, National Preventive Mechanism.

Six key areas were examined, assessing the conditions and treatment of patients detained in secured units.

Five recommendations were made, predominantly relating to approaches to de-escalation in the ward and the physical facility.

Following the visit, the interior décor of the facility has been upgraded to provide a light and bright feel and bedrooms are individualised with visual stimulation provided through the introduction of murals, plants, pictures and a tropical fish tank. There is now a sensory modulation room with appropriate resources, and patients are provided with the opportunity to engage in group activities.

The facility now has fit for purpose areas for quiet time outside of bedrooms, providing the opportunity to interact with other patients, and visitors and engaging in cultural and religious groups and activities, physical exercise and relaxation outdoors.

Improved access to information regarding feedback and complaints for patients and their whānau has also been introduced.

Addressing our acute care demand

Integrated ED observation area and MAPU given green light

A business case for the establishment of a new integrated Emergency Department Observation Area (EDOA) and Medical Assessment Planning Unit (MAPU) was approved by the MidCentral DHB Board in July 2020.

This is an interim solution to the current capacity issues faced by these services, and careful consideration has been taken in the placement of the pods to ensure they do not encroach on the footprint of the long-term solution, an Acute Services Block.

The temporary facilities are based on prefabricated pods being placed in front of, and linked to, the Emergency Department. The new layout will enable the 'home to home' model of care to be implemented and for MAPU to receive referrals directly from General Practice Teams.

Implementation planning got underway this year, with the detailed design process nearing completion. The consenting process will follow, together with the development of tender specifications. The construction of this new facility is scheduled to begin in October 2021.

Mahi Tahi programme expands across organisation

Mahi Tahi Better Together, is an initiative that acknowledges and recognises the important role loved ones have in the ongoing care of patients whether they are whānau, friends or caregivers.

We know health outcomes are better for those who are supported by loved ones, so our aim is to foster, support and respect the key role whānau, friends and caregivers have in the healthcare journey.

The programme is now available across the hospital.

Mahi Tahi means to work together as one. The Mahi Tahi Better Together programme is guided by this principle to work collectively with whānau, friends and caregivers to improve the patient journey. The value of manaakitanga underpins the existing relationship of whānau, friends and caregivers, and can be defined simply as hospitality, kindness, generosity and support.

MidCentral DHB's Māori Health Directorate Pae Ora has gifted the Mahi Tahi Better Together programme the following metaphorical concept resembling the characteristics of whānau, friends and caregivers:

Motu Rākau Mānuka – A grove of tea tree

The Mahi Tahi Better Together programme involves patients having a Kaimanaaki Partner in Care during their hospital stay. This can be a whānau member, friend or a caregiver.

A Kaimanaaki Partner in Care is the name given to someone who actively provides support, takes care of, gives hospitality to, protects, looks out for, and shows respect, generosity and care for others. The Kaimanaaki Partner in Care can enter the ward their loved one is admitted to at any time, are encouraged to help with care where appropriate and will be a main point of communication for staff on matters involving their loved one.

Patient letters improved through co-design approach

An improvement project was established in 2020 to ensure patient letters sent to our consumers, such as clinic appointments, bookings and referrals were accessible and able to be easily understood by people and their whānau.

A co-design approach was adopted, which saw a team of stakeholders and consumers analyse existing letters. The result has been using clearer language is used, whilst at the same time ensuring the clinical requirements of the communication are included. The new letters make it easier for patients to fully understand their journey, including where to come, what preparation may be

needed, what will happen during and after any treatment, as well as a contact number if they have any further questions.

Reducing harm through the Deteriorating Patient programme

The Health Quality Safety Commission's five-year 'Deteriorating Patient Programme' officially concluded in June 2021; the programme set out to reduce harm from failures to recognise or respond to acute physical deterioration among all adult inpatients. MidCentral DHB has implemented all three work streams of the programme:

- *recognition and response systems* – this has seen a standardised national vital signs chart with early warning score and localised clinical escalation implemented, benefiting patients, clinicians and the system as a whole.
- *Kōrero mai – patient, family and whānau escalation* **–** Mahi Tahi, Better Together, an initiative that acknowledges and recognises the important role loved ones have in the ongoing care of patients. This programme involves patients having a Kaimanaaki Partner in Care during their hospital stay.
- *Shared goals of care* – engagement and discussion with patients and whānau to explore the patient's values, the care and treatment options available and agreeing the goal of care for the current admission and if the patient deteriorates.

Minimising the impact of long-term conditions

Improving equity in bowel screening

A variety of healthcare workers including programme managers, kaitakawaenga, health promoters and equity leads came together for a bowel screening equity forum in Palmerston North, for DHBs located in the central region.

The focus was to share learnings on improving equity for Māori, Pacific peoples and those residing in high deprivation areas.

Achieving higher participation rates in the community to detect and treat bowel cancer earlier is a key focus in this region. Partnering with our Māori and Pacific communities to increase their knowledge of the programme, having kōrero about the benefits of the programme and the reasons to participate as well as working towards breaking down identified barriers will improve our participation rates.

Work to increase the profile of the programme through engagement with kaumatua and matua and involving the entire whānau in the process is underway.

Implementation of sustainable telehealth practices

Telehealth was rapidly introduced across MidCentral DHB during the COVID-19 lockdown in March and April 2020. This enabled patient care to continue with clinicians when the lockdown restrictions were in place and travel was limited. In some services, this was an extension and expansion of current telehealth services, whilst in other services it was a completely new way of working.

During this time, the proportion of patients who did not engage with outpatient appointments significantly reduced and many clinicians and patients liked this new way of interacting for appointments. There was a wish to leverage off the opportunities that were provided during March and April 2020 so telehealth use would continue across the DHB as an alternative to in person consultations.

A governance and project group was established to develop a clear telehealth policy, guidelines to support clinicians and implementation of digital equipment. This has seen many appointments now being done via phone or video consultation to minimise the need for people to travel to the hospital. Many people are appreciating being able to receive consultations via telephone, video or utilise email services without needing to get transport – particularly from the wider region without the stress of having to organise time away from work.

Assessing and addressing barriers to telehealth implementation has also occurred and consideration is being to develop district-based community hubs for those unable to access telehealth in their own homes.

Supporting our communities

Whāngai Ora Milk Bank established in Palmerston North

The Whāngai Ora Milk Bank, based out of the Te Papaioea Birthing Centre, was established in May to collect and distribute safe donor milk to those in need. The donors are screened, and the milk is pasteurised to make it the safest option of all supplements or alternatives to a mother's own milk for the pēpi of the communities, or those who had or are receiving care, within MidCentral DHB's district. It is the third milk bank in New Zealand and the first in the North Island.

Hearing the voice of communities across our localities

Part of our locality approach is to ensure we are regularly engaging with different communities within our five localities and gaining regular feedback about issues affecting the health and wellbeing of local people and whānau.

Annual public forums continue to be held annually in each locality, quarterly e-newsletters are produced, and MidCentral DHB attends regular locality network meetings. Hui with target population groups including local iwi, youth/rangatahi, older people, rural and Pasifika communities continue. The communities have expressed that they appreciate the presence of the DHB at local hui and that we genuinely want to hear their community voice.

Engagement with existing groups where possible or having key community people organise the engagement has been an effective strategy, as people feel comfortable in their existing groups and appreciate when an effort is made to come to them.

The Tūngia te Ururua project has completed a community engagement process in three different localities during the year. This engagement was done to hear the voice of mothers and whānau in Horowhenua, Ōtaki and Tararua who have birthed and/or cared for pēpi in their first 1000 days in recent years. The engagement process included surveys (paper and online) and focus groups held at local playgroups and playcentres. The engagement completed for this project aligns with the ten-year outcome statement in our strategy: *Our five communities are partners in planning and designing healthcare in their communities.* The analysis of the information gathered will be used to inform future service provision.

Housing has become evident as a key issue affecting the health and wellbeing of whānau throughout our rohe. Two housing forums have been held in the Manawatu and Tararua districts this year, bringing together local key stakeholders and government agencies to discuss the significance of this issue for the local community and identify potential local solutions.

SuperGrans Manawatū recipient of Minister of Health's Volunteer Awards

SuperGrans Manawatū was the recipient of the Health Care Provider Service Outstanding Team Award, as part of the Minister of Health's Volunteer Awards. These awards are an opportunity to recognise the thousands of unsung heroes who support New Zealand's health and disability services.

SuperGrans' vision is to have skills and knowledge flowing between generations and communities. There are approximately 25 SuperGrans in the Manawatū area, actively fulfilling this vision by passing on skills for healthy, low-impact budget living. They do this through one-on-one in-home mentoring and hands-on workshops, providing participants with the chance to develop practical skills such as cooking, sewing, gardening and budgeting. All skills that will assist people in their daily lives and help them flourish.

Volunteers visit clients weekly in their homes and help them towards their chosen goals. They also host a variety of events, classes and workshops.

SuperGrans also create merino wool blankets to keep babies warm; one of the recipients is Palmerston North Hospital's Te Uru Pā Harakeke Directorate who are sincerely grateful for their donations.

School dental service celebrates century of looking after children's teeth

School dental services across New Zealand this year celebrated a century of providing oral health and hygiene care to school children.

Past and present staff members gathered in May to mark the important milestone and swap memories of their time with the service.

Initially five dental officers were appointed and in 1921 the first group of women started training as school dental nurses. A few years on, the first school to welcome the service in the MidCentral DHB region was Terrace End School. Now, the Child and Adolescent Oral Health Service serves 111 schools across the region, using both fixed and mobile sites.

Enabling our success

Our workforce

Long Service Awards

Every person who works for MidCentral DHB plays a vital part in the delivery of person and whānau-centred care for our community. This year, MDHB introduced Long Service Awards to recognise the contribution made by more than a thousand people across all parts of our health community.

Staff who have accumulated 10 or more years of service to MidCentral DHB are being recognised for the years they've spent serving the community. General Manager of Quality and Innovation, Judith Catherwood, said the awards are important in honouring staff who have dedicated so much of their time and care to communities they serve. It was important to acknowledge the personal investment and commitment demonstrated by our staff across their time with this organisation. Our people, their care and dedication to serve is what our communities' value the most at their time of greatest need.

Inaugural 'Living our Values' Awards introduced

In December 2020, MidCentral DHB introduced 'Living our Values' Awards to acknowledge individuals, teams, leaders and volunteers who have shown exceptional alignment with our core values of ka whai aroha – compassion, ka whai ngākau – respect, ka mātātoa – courage, and ka noho haepapa – accountability.

A large number of nominations were received for these awards, which is testament to the hard work and commitment our staff have towards improving the health and wellbeing of our communities. The inaugural recipients were recognised during the end-of-year staff barbeque and were presented by our Board Chair, Brendan Duffy.

All the winners and nominees should be congratulated for their efforts to ensure our DHB has been able to provide a high-quality service to people and whānau, especially during such a challenging year.

Our partners

The Year of the Immunisation campaign

Our primary health care partners THINK Hauora have led a coordinated approach to the implementation of the 'Year of the Immunisation' campaign.

An early focus of the year was on providing the opportunity for young people aged 15 to 30 years to receive the measles vaccinations.

Free walk-in clinics were held within the community, with regular clinics held at the THINK Hauora office in Palmerston North, at Te Waka Huia in Highbury and Raukawa Ora in Levin.

Other pop-up events including the Pasifika Celebration Day at the Levin Domain, and the Central Pulse netball game, made it easier for whānau to find clinics where they could receive catch-up vaccinations.

Our facilities

SPIRE project gets underway

In January 2020, MidCentral DHB was allocated $27.5 million in funds as part of the Government's $300 million infrastructure investment project for health, to go towards some important infrastructure upgrades at Palmerston North Hospital.

These funds are a significant contribution towards our SPIRE (Surgical Procedural Interventional Recovery Expansion) project, and in achieving our key objectives: providing people and whānau with better access to the surgical care they need; safer and more efficient pre and post-operative spaces; earlier diagnosis and faster treatment for bowel cancer patients; and rapid diagnosis and earlier intervention for people with cardiac conditions.

This will be achieved through increasing our surgical services and procedural capacity, increasing our interventional capability, and improving the recovery facility as well as providing us with the ability to expand other supporting clinical and non-clinical resources.

Progress to date has seen the developed design process commence and the tender process underway for a construction company. Major construction work is scheduled to begin by November 2021, and the current focus is on finalising the planning process to enable this to start on time. The construction will be done in two stages: Stage One involves creating the new Day of Surgery Unit, Recovery Unit, Gastroenterology suite and a staff area.

The detailed design work for Stage Two which will involve the creation of two new theatres, reconfiguration of a further theatre, the Cath Lab and the fit-out of an existing Procedure Room will be completed by the end of 2021.

The SPIRE project is expected to be completed by the end of 2022.

Enhancement of our training facilities

Training and nurturing health professionals is a major undertaking and one MidCentral DHB is committed to doing well.

The former Clinical Records building has been transformed into a new learning centre – a key facility to support our health experts in their ongoing careers and learning.

The new Laurie McCool Learning Centre is aptly named after Laurence Alexander McCool, a supporter and patron of Palmerston North Hospital, as well as a former patient. Establishing a learning centre for ongoing research and education for all medical and other clinical professions at Palmerston North was seen by the Palmerston North Hospital Medical Trust as a fitting ongoing acknowledgement of Laurie's philanthropy. It gave $280,000 to provide the technology requirements for this new area, which was formally blessed during July 2021.

Local artist creates colourful mural at entrance to Birthing Suite

Local artist, and UCOL Creative Media graduate, Heneriata Te Whata has transformed the Birthing Suite entrance by creating a visual story surrounding Hine te iwaiwa at Palmerston North Hospital.

A plaque next to the Birthing Suite sign in the link corridor explains "Hine te iwaiwa epitomises the journey of birth, growth, knowledge and kaitiakitanga. Just as the harakeke embodies the roles of whānau, support and metamorphosis, she too breathes life into our world and spreads a message of hope". On the entrance door, another plaque says "As you begin your journey of birth, growth, and renewal, allow nature and our sacred waters to lift, support and guide you. Just as the wing supports the Manu, so too do our whānau and those with knowledge support us during this journey".

Our drive to become more environmentally sustainable

MidCentral DHB has taken another important step in mitigating our environmental impact after we were awarded project funding from the State Sector Decarbonisation fund. The purpose of this fund is to support state sector agencies to fast-track projects that result in reductions in their greenhouse gas emissions.

This funding was used to support infrastructure and transport projects aimed at reducing our carbon footprint. More than half of the funding was used to upgrade one of the hospital's main chillers, used to keep the building cool, with a new and more environmentally friendly modifications.

The remainder of the funding was used to install charging infrastructure for Electric Vehicles (EVs), the addition of an EV carpark shuttle and plug-in hybrids to the fleet.

These projects are part of the DHB's broader Environmental Sustainability Strategy and these vehicles and charging stations form part of our effort to transition to a low-emission fleet and join our growing fleet of hybrid vehicles. We aim to reduce fleet vehicle carbon emissions by at least one-third over the next five years.

Wāhanga 2

Tauāki o Te Ratonga me te Whakatutukitanga Pūtea

Section 2

Statements of Service and Financial Performance

STATEMENT OF RESPONSIBILITY

The Board and management of MidCentral District Health Board accept responsibility for the preparation of the annual Financial Statements and Statement of Service Performance and the judgements made in the process of preparing these statements and information.

We are responsible for the preparation of the MidCentral District Health Board group's financial statements and statement of performance, and for the judgements made in them.

We are responsible for any end-of-year performance information provided by the District Health Board under section 19A of the Public Finance Act 1989. We are responsible for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting.

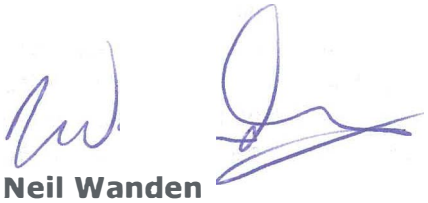
In our opinion, these financial statements and statement of performance fairly reflect the financial position and operations of the MidCentral District Health Board group for the year ended 30 June 2021.

Signed on behalf of the Board and management:

Brendan Duffy
Chairperson
MidCentral District Health Board
22 December 2021

Oriana Paewai
Deputy Chairperson
MidCentral District Health Board
22 December 2021

Kathryn Cook
Chief Executive Officer
MidCentral District Health Board
22 December 2021



Neil Wanden
General Manager Finance and Corporate
MidCentral District Health Board
22 December 2021

STATEMENT OF SERVICE PERFORMANCE (SSP)

A key role of the health sector is to make positive changes to the health status of the population. Many of the determinants of health are influenced by the lifestyle choices, environmental and socio-economic status of our population. While the DHB contributes to the prevention of disease and the promotion and protection of health and wellbeing in our communities, there are other key contributors and factors that influence healthy and well communities. Government priorities, national policy and decision-making, other public sector and social agencies, and individuals, families and whānau themselves all have a part to play in making gains on health status and sustaining a healthy population.

As the major planner, funder and provider of publicly funded health services in our district, MidCentral DHB is committed to ensuring we deliver on the most effective and efficient health service arrangements that we can for our population. Assessments of the health status and needs of our population together with understanding the determinants of health and drivers of demand for health and disability services inform what and how much we plan, fund and provide with the funds made available to us from Government each year.

We received around $602 million in the 2020/21 year to undertake these obligations.

As part of these obligations, we monitor our progress toward our strategic intentions as well as measuring our achievements against the planned activities and services (or outputs) that were expected to be delivered in the year as outlined in our Statement of Performance Expectations (SPE). Our performance is assessed against each indicator using the following reference criteria and grading system. A rating has not been given to demand driven services.

Criteria Description	**Rating**		**Rating**
Achieved	On target or better		●
Substantially achieved	95 – 99.9%	0.1% - 5% away from target	●
Not achieved, but progress made	90 – 94.9%	5.1% - 10% away from target	●
Not achieved	<90%	>10% away from target	●

This Statement of Service Performance (SSP) is organised into four 'Output Classes': Prevention Services; Early Detection and Management Services; Intensive Assessment and Treatment Services; and Rehabilitation and Support Services. The service outputs that are measured within each Output Class are a logical fit with the population health care continuum as outlined in the following figure.

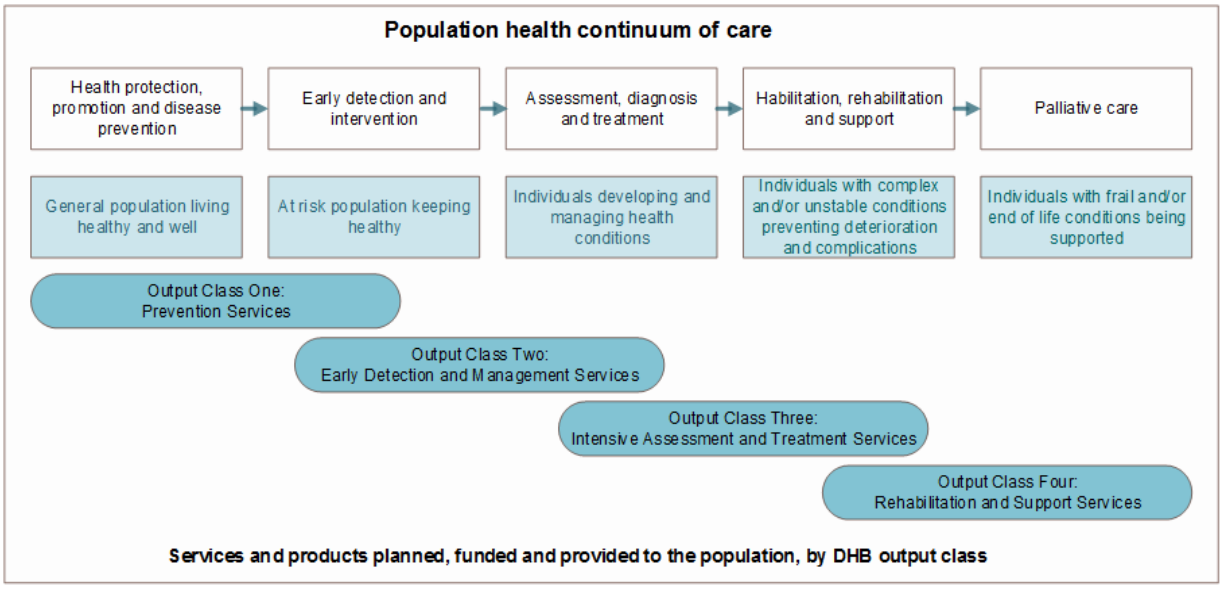


Figure 2: Population health continuum of care

The following pages set out in detail how well we did against what we planned for the period from 1 July 2020 to 30 June 2021 and how we have contributed to our goals (outcomes) for our health care system and health service users.

1 Output Class: Prevention Services

Output class description

Prevention services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations comprising services designed to enhance the health status of the population. Prevention services address individual behaviours by targeting physical and social environments to influence health and wellbeing. They include health promotion and education activities to ensure that illness is prevented and inequalities in health outcomes are reduced, statutorily mandated health protection services to protect the public from environmental risk and communicable diseases, and services such as immunisation to help prevent infections and screening programmes to detect disease at an early stage.

(Refer to Appendix 1 for a description of these outputs)

What do we want to achieve? (Impacts)

- All children have the best start to life
- Individuals and whānau are engaged with safe and healthy lifestyles
- More women participate in cervical and breast screening programmes
- Individuals and whānau are supported to make informed decisions about their health care
- Individuals and whānau live and work in protected healthy environments.

How will we measure our progress? (Indicators)

- Reducing prevalence of tobacco smoking
- Increasing the proportion of Māori and Pacific people participating in physical/nutritional programmes
- Increasing the proportion of Māori infants exclusively or fully breast feeding
- Reducing equity gap in on time immunisation coverage rates
- Increasing breast and cervical screening coverage rates by Māori and Pacific women
- Increasing enrolment in Well Child services
- A high proportion of children receiving a health check.

How did we progress over the year? (Results)

- Two notable programmes of work, the Hapu Mama Stop Smoking initiative and the Wahine Māori programme, both targeted at smoking cessation for Māori women aged between 18 and 30 years has resulted in a significant increase in the proportion of pregnant Māori women identified as current smokers who were offered smoking cessation services compared to previous years. We exceeded the target for both wahine hapu Māori and non-Māori pregnant women.
- Similarly, the proportion of the primary health organisation enrolled population recorded as 'current smokers' has declined for both Māori and non-Māori – meeting targets.
- No major change in the proportion of women who were breastfeeding their babies at three months of age, although there was a small increase by non-Māori women.
- Immunisation rates in all milestone ages for both Māori and non-Māori children continued to decline this year
- Significant improvement in the proportion of children receiving their B4 School Check this year – exceeding targets for both High Deprivation population and the total population.

All children have the best start to life						
Indicators		**2018/19 Actual**	**2019/20 Actual**	**2020/21 Target**	**2020/21 Result**	
Percentage of infants that are exclusively or fully breast feeding at 3 months of age[3]	Māori	49.4%	50.1%	≥75%	47.5%	🔴
	Non Māori	58.2%	57.1%		59.0%	🔴
Percentage of infants who receive all Well Child Tamariki Ora core contacts (1 – 5) in their first year of life[4]	Māori	69.9%	68.9%	≥90%	42.9%	🔴
	Non Māori	80.7%	80.3%		58.4%	🔴
Percentage of high deprivation and total population of eligible children who have received their B4 School Check	High Dep	92.7%	77.9%	≥90%	101.2%	🟢
	Total	91.1%	83.6%		100.6%	🟢
Percentage of newborns enrolled with General Practice by 3 months of age	Māori	n/a	n/a	≥85%	66.1%	🔴
	Non Māori	n/a	n/a		98.2%	🟢
Percentage of children identified as obese in the B4 School Check programme offered a referral to a health professional for clinical assessment and family-based nutrition, activity, and lifestyle interventions	Māori	97.1%	96.4%	≥95%	85.4%	🟠
	Non Māori	95.4%	96.1%		84.8%	🔴

Individuals and whānau are partners in actively managing their own health and wellbeing						
Indicators		**2018/19 Actual**	**2019/20 Actual**	**2020/21 Target**	**2020/21 Result**	
Proportion of PHO enrolled population (aged 15 – 74 years) recorded as 'current smokers'	Māori	35.2%	31.2%	≤36%	29.0%	🟢
	Non Māori	14.9%	12.7%	≤15%	12.0%	🟢
Percentage of pregnant women identified as current smokers and seen by Lead Maternity Carers who were offered smoking cessation services	Māori	67.9%	78.8%	≥75%	93.1%	🟢
	Non Māori	68.4%	68.6%		95.6%	🟢
Percentage of people enrolled with THINK Hauora (CPHO) being seen by clinical dieticians and/or by physical activity educators	Māori	3.8%	2.5%	≥4%	3.9%	🔵
	Non Māori	2.5%	1.9%	≥2%	3.5%	🟢
Percentage increase in the number of referrals to Green Prescription programmes (Adults and Active Families) for additional physical activity support over the year	Māori	-24.1%	-6.0%	≤2%	44.2%	🔴
	Non Māori	8.4%	-32.9%	≤1%	19.9%	🔴

[3] Data is sourced from the Well Child Tamariki Ora Framework indicators, as reported by the Ministry of Health for the six month periods to 31 December 2018, 2019 and 2020 respectively.

[4] Refers to report period at March 2019, 2020 and 2021 (data is lagged by 3 months – data collated for period to December each year), Ministry of Health: Well Child Tamariki Ora Report

More women participate in cervical and breast screening programmes

Indicators		2018/19 Actual	2019/20 Actual	2020/21 Target	2020/21 Result	
Percentage of MidCentral domiciled women aged 25 – 69 years who have had a cervical screening event in the last three years (hysterectomy adjusted population)[5]	Māori	64.6%	64.9%	≥80%	59.0%	
	Non Māori	78.3%	72.8%		71.2%	
Percentage of MidCentral domiciled women aged 50 – 69 years who received a mammogram in the last two years (breast screening programme)[6]	Māori	65.8%	65.7%	≥70%	60.6%	
	Non Māori	78.2%	78.2%		74.8%	

Individuals and whānau are engaged with safe and healthy lifestyles

Indicators		2018/19 Actual	2019/20 Actual	2020/21 Target	2020/21 Result	
Percentage of eligible 8 month infants who receive their first course immunisations on time	Māori	85.9%	79.3%	≥95%	74.7%	
	Non Māori	92.1%	92.2%		90.4%	
Percentage of eligible 4 year old children who are fully immunised by 5 years of age	Māori	90.0%	87.2%	≥95%	82.0%	
	Non Māori	91.2%	91.7%		87.9%	
Percentage of the total population aged 65+ years vaccinated for seasonal influenza[7]	Māori	40.2%	57.3%	≥75%	56.3%	
	Non Māori	58.2%	69.9%		69.9%	
Percentage of eligible girls fully immunised for Human Papillomavirus (HPV)[8]	Total	48.1%	58.5%	≥75%	55.0%	

What did we spend on this Output Class?

Revenue and expenditure by Output Class	2019/20 Actual		2020/21 Budget		2020/21 Actual	
	Revenue	Expenditure	Revenue	Expenditure	Revenue	Expenditure
	$000	$000	$000	$000	$000	$000
Health promotion and education	5,572	5,654	5,817	5,861	5,988	6,293
Statutory regulation, environmental health	4,617	4,664	4,819	4,834	4,960	5,191
Population based screening	6,563	7,028	6,851	7,282	7,051	7,821
Immunisation	1,722	1,760	1,798	1,825	1,851	1,959
Well child services	2,042	2,074	2,132	2,150	2,194	2,308
Total Prevention Services	**20,516**	**21,180**	**21,417**	**21,952**	**22,044**	**23,572**

[5] Refers to the three-year coverage rate to March 2021. National Screening Unit, National Cervical Screening Programme, MidCentral DHB coverage report

[6] Refers to the projected population for the mid-point of the monitoring period, i.e. for coverage rate for the two-year period ending March 2021, the projected population is as at March 2020 (June 2018 Update Census 2013 Base)

[7] Refers to the influenza season for the applicable year, from March to September.

[8] Refers to eligible females in the 2006 and 2007 birth cohorts in the 2018/19 and 2019/20 years respectively. Data to June 2021 measured at final dose. Data source: Ministry of Health National Immunisation Register.

2 Output Class: Early Detection and Management Services

Output class description

Early detection and management services are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. They include general practice, community and Māori health services, community diagnostic and pharmacist services, community pharmaceuticals (the Schedule) and child and adolescent oral health services. Early detection and management services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations across the district. These services are focused on, and delivered to, individuals and smaller groups of individuals.

(Refer to Appendix 1 for a description of these outputs)

What do we want to achieve? (Impacts)

- Fewer people have unplanned hospital admissions
- Young people are healthy, safe and supported
- Individuals and whānau are partners in actively managing their own health and wellbeing
- Individuals and whānau can access appropriate, timely health services
- More children and young people have better oral health.

How will we measure our progress? (Indicators)

- Reducing ambulatory sensitive hospitalisations by Māori
- Increasing enrolment by Māori with a primary health organisation (PHO)
- Increasing service utilisation ratio of 'high need' PHO enrolled population
- Containing growth in attendances at Emergency Department
- Increasing the proportion of Māori with diabetes who have good glycaemic control
- Increasing the proportion of eligible adults who have their cardiovascular health check
- Increasing the proportion of pre-school Māori children enrolled in the community oral health service
- Increasing caries free rate in five-year-old Māori and Pacific children
- Reducing self-harm hospitalisations by young people.

How did we progress over the year? (Results)

- The rates for ambulatory sensitive hospitalisations continued to reduce for the 45 to 64 year old age group – exceeding targets for both Māori and non-Māori populations; a pathway for patients with Chronic Obstructive Pulmonary Disease (COPD) has been agreed from the inpatient setting to primary health care, utilising a Primary Options for Acute Care approach. Once established for COPD, this programme of work will extend to other respiratory and long-term conditions.
- Increase in the proportion of people registered and using e-portal, achieving target.
- Notable increase in the proportion of 0 to four-year-old Māori children enrolled with DHB funded oral health services – exceeding the target for the total population.
- We were close to target for the proportion of all five-year-old children seen in the year who were caries free; a large gap still exists between Māori children being caries free compared to other children.
- Slight increase in the proportion of people living with diabetes that have good glycaemic control – achieving target for non-Māori population and an increase for Māori compared to previous year.
- While there has been an increase in the average consultation rate per month for THINK Hauora registered patients across all population groups compared with the previous year, we did not achieve target for all population groups.

Individuals and whānau can access appropriate, timely health services						
Indicators		**2018/19 Actual**	**2019/20 Actual**	**2020/21 Target**	**2020/21 Result**	
Percentage of MidCentral population (medium projections) enrolled with any PHO at end of financial year[9]	Māori	78.9%	80.5%	≥90%	79.0%	🔴
	Non Māori	93.4%	96.7%		97.0%	🟢
Average consultation rate per month of THINK Hauora (Central PHO) registered patients	Māori	0.35	0.17	≥0.35	0.26	🟠
	Pacific	0.29	0.16	≥0.29	0.22	🔵
	Other	0.46	0.21	≥0.47	0.36	🟠

Fewer people have unplanned hospital admissions						
Indicators		**2018/19 Actual**	**2019/20 Actual**	**2020/21 Target**	**2020/21 Result**	
Percentage of people assessed a high risk (>15 percent) of cardiovascular disease who have received an annual review[10]	Māori	-	-	≥70%	49.3%[11]	🔴
	Non Māori	-	-		48.0%[12]	🔴
Ambulatory sensitive (avoidable) hospitalisation rate per 100,000 domiciled population, 0 – 4 year old children (non – standardised)	Māori	6,617	6,186	≤6,300	6,453	🔵
	Non Māori	5,177	4,807	≤5,100	3,483	🟢
Ambulatory sensitive hospitalisation rate per 100,000 domiciled population, 45 – 64 year old adults (standardised)	Māori	7,687	7,073	≤7,200	6,412	🟢
	Non Māori	3,838	3,659	≤3,800	3,208	🟢
Rate per 10,000 population aged 10 – 24 years (age standardised) admitted to hospital with intentional self-harm (DHB of Domicile)	Māori	48.1	40.5	≤45	46.8	🔵
	Non Māori	50.8	52.4	≤52	51.1	🟢

[9] Data source: Ministry of Health, PHO Enrolment Demographics as at 1 July each year.
[10] New indicator that took affect from 1 July 2019; data not available for the 2019/20 year due to the transition of data management, warehousing and reporting systems at THINK Hauora over the 2019/20 year
[11] Result is Māori aged 30 – 74 years that have been assessed as high risk of cardiovascular disease who have received an annual review
[12] Result is non Māori aged 45 – 74 years that have been assessed as high risk of cardiovascular disease who have received an annual review

Individuals and whānau are partners in actively managing their own health and wellbeing						
Indicators		**2018/19 Actual**	**2019/20 Actual**	**2020/21 Target**	**2020/21 Result**	
Percentage of CPHO enrolled population registered and using e-portal	Total	13.4%	21.7%	≥25%	30.46%	🟢
Percentage of enrolled people aged 15 – 74 in the PHO with diabetes and the most recent HbA1c during the past 12 months of equal to or less than 64mmol/mol	Māori	44.7	53.1	≥60%	54.8%	🟠
	Non Māori	55.5	63.5		64.3%	🟢
Ambulatory sensitive hospitalisation rate (non – standardised) in the 45 – 64 year old population age group for certain cardiac and respiratory diseases, stroke and diabetes[13][14]	Māori	4,992	4,461	≤4,300	4,245	🟢
	Non Māori	2,342	2,190	≤2,400	2,028	🟢

All children have the best start to life						
Indicators		**2018/19 Actual**	**2019/20 Actual**	**2020/21 Target**	**2020/21 Result**	
Percentage of Year 9 students receiving a health assessment (HEEADSSS) by the school based health service (SBHS) in the calendar year[15]	Total	85.3%	73.9%	≥95%	76.2%	🔴
Mean score of Decayed, Missing and Filled Teeth of Year 8 children seen in the year[16]	Māori	0.95	0.63	≤0.76	1.71	🔴
	Total	0.66	0.44		1.10	🔴
Percentage of 5 year old children seen in the year who are caries free[17]	Māori	49.4%	43.0%	≥50%	41.1%	🟠
	Total	64.2%	61.8%	≥63%	61.8%	🔵
Proportion of 0 – 4 year population enrolled with DHB funded oral health service[18]	Māori	51.7%	56.0%	≥95%	63.8%	🔴
	Total	96.0%	100.1%		101.3%	🟢
Proportion of adolescent population utilising DHB-funded dental services[19]	Total	80.9%	83.1%	≥85%	73.1%	🔴

[13] Includes ambulatory sensitive hospitalisations for the following conditions: angina/chest pain, asthma, congestive heart failure, chronic obstructive pulmonary disease, diabetes, hypertensive disease, myocardial infarction, other ischaemic disease, and stroke.
[14] Refers to 12 month periods ending 31 March 2019, 2020 and 2021 respectively.
[15] Refers to the 2018, 2019, and 2020 calendar years respectively.
[16] Refers to the calendar years for 2018. 2019 and 2020
[17] Refers to the calendar years for 2018. 2019 and 2020
[18] Refers to the calendar years for 2018. 2019 and 2020
[19] Source: Nationwide Service Framework Library: Utilisation of Preventative Services – Adolescent oral health utilisation services to 31 December 2020

What did we spend on this Output Class?						
Revenue and expenditure by Output Class	2019/20 Actual		2020/21 Budget		2020/21 Actual	
	Revenue	Expenditure	Revenue	Expenditure	Revenue	Expenditure
	$000	$000	$000	$000	$000	$000
Primary health care	48,355	49,597	50,480	51,406	51,956	55,198
Child & adolescent oral health	3,374	6,724	3,522	6,969	3,625	7,483
School based and youth health services	2,371	2,591	2,475	2,686	2,547	2,884
Primary community care	7,667	7,838	8,004	8,123	8,238	8,723
Community pharmacy services	50,340	51,452	52,552	53,327	54,090	57,261
Community referred testing & diagnostics	19,064	19,816	19,901	20,539	20,483	22,054
Total Early Detection and Management Services	**131,171**	**138,018**	**136,934**	**143,050**	**140,939**	**153,603**

3 Output Class: Intensive Assessment and Treatment Services

Output class description

Intensive assessment and treatment services are delivered by a range of secondary and tertiary providers using public funds. These services are usually integrated into facilities that enable co-location of clinical expertise and specialised equipment such as a hospital. These services are generally complex and provided by health care professionals that work closely together. They include:

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

These services are at the complex end of treatment services and are focused on and delivered to individuals.

A proportion of these services are driven by demand which the DHB must meet, such as acute (unplanned and urgent) medical and surgical services and maternity services. Other services are planned (elective) for which provision and access are determined by capacity, clinical triage, national service coverage agreements and treatment thresholds.

What do we want to achieve? (Impacts)

- Individuals and whānau can access appropriate, timely health services
- Fewer people have unplanned hospital admissions
- Individuals have equitable access to specialist assessment and treatment on time
- People receive quality health care services and have a positive experience of the health care system
- Individuals receive evidence based, clinically effective health care services.

How will we measure our progress? (Indicators)

- Reducing waiting times for specialist assessment and treatment
- Reducing acute bed day utilisation per capita
- Reducing acute admissions and average lengths of stay in hospital
- Improving patient experience of care.

How did we progress over the year? (Results)

- The acute bed day utilisation rate per capita increased over the year, continuing to achieve target.
- The proportion of patients presenting to the Emergency Department that waited six or more hours before being admitted, discharged, or transferred from the department continued to decline.
- The proportion of adults with non-urgent referrals being seen within three weeks by the DHB's Mental Health and Addiction Service remained much the same as the previous year, although the waiting time for the 0 to 19-year-old age group was below target.
- There was a diminished rate of acute readmissions to hospital for people who were discharged from the Assessment, Treatment and Rehabilitation services.
- Significantly exceeded the target for the proportion of people receiving planned care interventions (included surgical discharges, minor procedures and non-surgical interventions).

People receive quality health care services and have a positive experience of the health care system					
Indicators	**2018/19 Actual**	**2019/20 Actual**	**2020/21 Target**	**2020/21 Result**	
Percentage of people presenting to the Emergency Department that are discharged, admitted or transferred within six hours	80.1%	77.2%	≥95%	75.1%	🔴
Surgical site infections per 100 hip and knee operations	0.98	1.3[20]	≤1.0	0.02	🟢
Average number of in-hospital falls per month causing a fractured neck of femur over the year	0.08	0.08	≤0.12	0.00	🟢
Hospital acquired bacteraemia rate per 1,000 patients	1.2	0.18	≤1.7	0.98	🟢

Individuals receive evidence based, clinically effective health care services when and where they need it						
Indicators		**2018/19 Actual**	**2019/20 Actual**	**2020/21 Target**	**2020/21 Result**	
Percentage of women (DHB of residence) giving birth at secondary maternity facility[21]		84.7%	75.5%	≤85%	79.9%	🟢
Percentage of emergency caesarean section deliveries for women giving birth – DHB of residence (calendar year)[22]		15%	17%	≤17%	13.6%	🟢
Percentage of preterm births at Palmerston North Hospital (calendar year)[23]		8.9%	7.9%	≤9%	9.1%	🔵
Percentage of women discharged from PNH Maternity services who were exclusively or fully breast feeding on discharge from hospital	Māori	64.0%	70.4%	≥75%	69.7%	🟠
	Total	-	70.2%		72.3%	🔵

Fewer people have unplanned hospital admissions					
Indicators	**2018/19 Actual**	**2019/20 Actual**	**2020/21 Target**	**2020/21 Result**	
Percentage of Emergency Department presentations resulting in an acute admission to inpatient services	28%	26.9%	≤28%	25.2%	🟢
Percentage of acute readmissions to hospital within 28 days of a previous discharge (standardised, all ages, DHB of Service)[24]	12.6%	12.6%	≤12.5%	12.3%	🟢
Standardised acute bed days per 1,000 population (DHB of Domicile)[25]	390.3	381.4	≤410	404.0	🟢

[20] Refers to the 9-month period to March 2020 only – suspended reporting of manually collected and submitting data to HQSC in fourth quarter

[21] Refers to the calendar years of 2017, 2018 and 2019. Data is lagged by one year. Data source: Ministry of Health, data to be published October 2021: New Zealand Maternity Clinical Indicators, 2021

[22] Refers to the calendar years of 2017, 2018 and 2019. Data is lagged by one year. Data source: Ministry of Health, data to be published October 2021: New Zealand Maternity Clinical Indicators, 2021

[23] Refers to the calendar years of 2017, 2018 and 2019. Data is lagged by one year. Data source: Ministry of Health, data to be published October 2021: New Zealand Maternity Clinical Indicators, 2021

[24] Refers to the 12 month period ending 31 March 2019, 2020 and 2021 respectively. Data source: Ministry of Health

[25] Refers to the 12 month period ending 31 March 2019, 2020 and 2021 respectively. Data source: Ministry of Health

Individuals and whānau can access appropriate, timely health services						
Indicators		**2018/19 Actual**	**2019/20 Actual**	**2020/21 Target**	**2020/21 Result**	
Percentage of people accepted for a non-urgent diagnostic colonoscopy receiving (or waiting for) their procedure in 42 working days or less		73.4%	73.8%	≥70%	51%	🔴
Percentage of people with accepted referrals for a computed tomography (CT) scan or magnetic resonance imaging (MRI) receive their scan within 6 weeks (42 days)	CT	70.5%	78.1%	≥95%	86.5%	🟠
	MRI	100%	73.6%	≥90%	93.6%	🟢
Percentage of the population accessing specialist mental health and addiction services (all ages)[26]	Māori	6.2%	5.6%	≥5.0%	5.8%	🟢
	Non Māori	3.4%	2.9%	≥3.0%	3.6%	🟢
	Total	4.0%	3.5%	≥3.5%	4.0%	🟢
Percentage of people referred for non-urgent mental health and addition services seen within 3 weeks (DHB Mental Health and Addictions service provider only)[13]	0 – 19 yrs	83.8%	76.0%	≥80%	70.7%	🟠
	20 – 64 yrs	82.4%	87.7%		87.4%	🟢
	65+ yrs	82.6%	88.0%		88.4%	🟢
Average length of time between referral from acute inpatient services to transfer to AT&R services (days)		1.6	1.4	≤1.5	3.2	🔴
Average length of stay (raw) – AT&R (geriatric) inpatient services		15.6	16.0	≤16.0	16.95	🟠
Percentage of acute readmissions to hospital within 28 days with a pervious discharge from AT&R inpatient services (geriatric)		6.6%	7.8%	≤7.5%	8.8%	🔴
Percentage of annual planned care interventions delivered by end of June (includes surgical discharges, minor procedures and non-surgical interventions (DHB of domicile)		N/A	90%	≥95%	111.6%	🟢
Standardised intervention rates for specific surgical procedures per 10,000 population (All Admission types)[27]	Cataract	33.0	32.55	≥27.0	26.8	🔵
	Major Joints	21.0	21.66	≥21.0	20.4	🔵
	Angiography	32.0	29.77	≥34.7	29.4	🟠
Percentage of people receiving their first cancer treatment (or other management) within 31 days from date of decision to treat		84.2%	86.9%	≥85%	90.1%	🟢
Percentage of patients waiting greater than four months for their first specialist assessment (as at end of June each year)		7.3%	6.5%[28]	≤1%	4.5%	🔴
Percentage of patients given a commitment to treatment (surgery) but not treated within four months (as at end of June each year)		41.3%	56.4%[29]	≤1%	37.7%	🔴

[26] Data source: Ministry of Health (PRIMHD), July 2021, MH Dashboard April 2019 – March 2020 and MH Dashboard April 2020 – March 2021.
[27] Refers to the 12-month periods ending 31 March 2019, 2020 and 2021 respectively.
[28] Planned care, affecting outpatient first specialist assessments and surgical procedures was deferred over three months in the latter part of 2019/20 as a result of the nation-wide COVID-19 response
[29] Planned care, affecting outpatient first specialist assessments and surgical procedures was deferred over three months in the latter part of 2019/20 as a result of the nation-wide COVID-19 response

What did we spend on this Output Class?						
Revenue and expenditure by Output Class	2019/20 Actual		2020/21 Budget		2020/21 Actual	
	Revenue	Expenditure	Revenue	Expenditure	Revenue	Expenditure
	$000	$000	$000	$000	$000	$000
Emergency department	21,888	25,801	22,849	26,742	23,517	28,715
Medical services	70,355	68,041	73,446	70,522	75,594	75,724
Surgical / ICU / Anaesthetic services	90,441	96,475	94,418	99,992	97,179	107,368
Regional Cancer Treatment services	51,123	49,854	53,369	51,671	54,930	55,483
Women's and children's services	39,337	40,757	41,065	42,243	42,266	45,359
Elder health services	13,881	18,245	14,490	18,910	14,914	20,305
Rehabilitation and Therapy services	2,222	2,738	2,319	2,838	2,387	3,048
Mental health and addiction services	38,226	43,640	39,905	45,232	41,072	48,568
Clinical support services	7,522	8,612	7,852	8,926	8,082	9,585
Inter district flows	60,188	61,519	62,833	63,762	64,670	68,465
Total Intensive Assessment and Treatment Services	**395,183**	**415,682**	**412,546**	**430,838**	**424,611**	**462,620**

4 Output Class: Rehabilitation and Support Services

Output class description

Rehabilitation and support services are delivered following a 'need assessment' process and coordination input by Needs Assessment and Service Coordination (NASC) Services for a range of services such as home-based support services and residential care services for older people. In MidCentral DHB's district, the NASC service is known as 'SupportLinks'. The rehabilitation and support services also include palliative care services for people with end-stage conditions and services that support people with a disability.

MidCentral DHB contracts for the provision of these services from a wide range of providers, including Arohanui Hospice, aged residential care facilities and home-based support agencies.

A key provider of disability support services is Enable New Zealand – a division of MidCentral DHB that provides services across New Zealand. These services are not funded by the DHB; they are provided under contract with the Ministry of Health and ACC. The processes and services delivered by the division of the entity Mana Whaikaha that is managed by Enable New Zealand, are essentially funding and infrastructural support for individualised funding and the anticipated outcomes of the 'Enabling Good Lives' principles.

(Refer to Appendix 1 for a description of these outputs)

What do we want to achieve? (Impacts)

- Individuals and whānau are supported to fully participate in society
- Individuals and whānau are supported to make informed decisions about their health care
- Individuals who are dying, and their whānau, have access to quality end of life care.

How will we measure our progress? (Indicators)

- Increasing proportion of eligible individuals receiving on time needs assessment and home-based support services
- Increasing proportion of people referred to community rehabilitation following an acute stroke seen on time
- Increasing access to respite care / carer relief to eligible older people and their whānau
- Sustaining access to specialist and primary care based palliative care.

How did we progress over the year? (Results)

- The proportion of older people being supported in the community with packages of temporary supports continued to increase.
- The waiting time for a face-to-face contact with people who have had a stroke and needing community rehabilitation services post-discharge from hospital has remained steady, although remaining well below the target.
- The proportion of people with a non-malignant diagnosis being seen by the hospital-based specialist palliative care team has increased, and is above target.
- All people aged 65 or older receiving publicly funded long term home-based support services have had a comprehensive clinical assessment and a completed care plan.

Individuals and whānau are supported to make informed decisions about their health care					
Indicators	**2018/19 Actual**	**2019/20 Actual**	**2020/21 Target**	**2020/21 Result**	
Percentage of older people with a new (urgent and routine) referral to NASC service who wait less than 20 days for an interRAI assessment	65.1%	77.9%	≥75%	67%	🟠
Percentage of people aged 65 or older receiving publicly funded long term home-based support services who have a comprehensive clinical assessment and a completed care plan	100%	100%	≥95%	100%	🟢

Individuals and whānau are supported to fully participate in society					
Indicators	**2018/19 Actual**	**2019/20 Actual**	**2020/21 Target**	**2020/21 Result**	
Proportion total needs assessments completed for MidCentral DHB domiciled people that resulted in a service coordination outcome of home based support services	70.0%	67.6%	≥60%	56%	🔵
Percentage of eligible people aged 65+ years receiving community initiated Packages of Temporary Support (PoTS) as a proportion of total people receiving PoTS	32.7%	40.0%	≥33%	46%	🟢
Percentage of population aged 65+ years receiving DHB funded support in long term aged related residential care facilities	5.6%	N/A[30]	≤6%	4.2%	🟢
Percentage of total ARC beds utilised by people for dementia care	12.5%	12.1%	≤15%	14%	🟢
Percentage of people discharged from hospital following an acute stroke and referred to DHB community rehabilitation services and seen within seven days of discharge	27.3%	21.3%	≥60%	21.3%	🔴
Proportion of MidCentral DHB individuals who had respite care/carer relief as a service coordination outcome following a first assessment during the year	20.5%	28.2%	≥18%	17%	🔵

[30] Refers to data not being available due to a change in Ministry of Health's data source of claims for individuals receiving DHB funded support in long term aged related residential care.

People receive quality health care services and have a positive experience of the health care system					
Indicators	**2018/19 Actual**	**2019/20 Actual**	**2020/21 Target**	**2020/21 Result**	
Proportion of patients referred to the hospital-based Palliative Care team who have a non-malignant diagnosis	41.1%	36.2%	≥35%	39%	●
Percentage increase/decrease from previous year in the number of new referrals to primary palliative care programme[31]	-11.4%	-4.8%	N/A	D	- -

What did we spend on this Output Class?						
Revenue and expenditure by Output Class	2019/20 Actual		2020/21 Budget		2020/21 Actual	
	Revenue	Expenditure	Revenue	Expenditure	Revenue	Expenditure
	$000	$000	$000	$000	$000	$000
Needs assessment and service coordination	3,987	4,190	4,162	4,342	4,284	4,663
Age related residential care beds	65,122	66,559	67,984	68,984	69,970	74,071
Home based support services	18,798	19,217	19,624	19,918	20,198	21,387
Rehabilitation services	18,345	18,956	19,151	19,648	19,711	21,097
Palliative care services	4,223	4,511	4,408	4,676	4,537	5,021
Lifelong disability services	40,533	40,641	42,315	42,123	43,552	45,230
Respite care services	4,170	4,377	4,353	4,537	4,481	4,872
Day services	2,673	2,846	2,790	2,950	2,872	3,168
Inter district flows	6,553	6,699	6,841	6,943	7,041	7,455
Total Rehabilitation and Support Services	**164,404**	**167,996**	**171,628**	**174,121**	**176,646**	**186,964**

[31] Data not available at time of report; expected by 30 September 2021.

Implementing the COVID-19 vaccine strategy

Protection against COVID-19 has been uppermost in everyone's mind this year, and the COVID-19 vaccination rollout began in the MidCentral DHB district in March 2021 after working through a complex set of logistics involving cold storage, transport, and vaccination.

With a plan to deliver 290,000 doses of the Pfizer vaccine for an eligible population of 145,000 people in the MidCentral DHB district, the delivery has been via both fixed vaccination sites set up in localities, in conjunction with mobile and temporary sites to ensure that vaccination is accessible to all.

Border workers and our own vaccinator workforce received the first round of vaccinations, followed by household contacts of our border and MIQ workers. In April we commenced frontline staff and some of the very vulnerable in the community including older Māori and health workers. Aged care workers were vaccinated in May alongside residents in aged care and disability residential facilities around the district. From late May the focus moved to older people, and those with underlying health conditions.

Pae Ora Paiaka Whaiora worked closely with Te Tihi o Ruahine on iwi and Māori engagement in the MidCentral DHB region with plans also progressing to ensure vaccination clinics cater for people living with disabilities and those located in remote rural areas.

The following tables set out progress with the COVID-19 vaccination rollout as at 30 June 2021.

Vaccine doses administered by MidCentral DHB (DHB of service)	Dose 1	Dose 2	Total
	27,668	**13,678**	**41,346**

Vaccine doses administered by ethnicity (note 4)	Dose 1	Dose 2	Total
Asian	1,910	1,270	3,180
European or other	21,967	10,263	32,230
Māori	2,956	1,701	4,657
Pacific peoples	587	321	908
Unknown	248	123	371
Total	**27,668**	**13,678**	**41,346**

Vaccine doses administered by age group (note 4)	Dose 1	Dose 2	Total
12 to 15 years	1	0	1
16 to 19 years	287	186	473
20 to 24 years	736	551	1,287
25 to 29 years	1,031	794	1,825
30 to 34 years	1,099	837	1,936
35 to 39 years	1,070	816	1,886
40 to 44 years	994	749	1,743
45 to 49 years	1,146	831	1,977
50 to 54 years	1,564	1,052	2,616
55 to 59 years	1,950	1,191	3,141
60 to 64 years	2,161	1,262	3,423
65 to 69 years	3,569	1,169	4,738
70 to 74 years	4,079	1,231	5,310
75 to 79 years	3,441	1,023	4,464
80 to 84 years	2,338	810	3,148
85 to 89 years	1,359	666	2,025
90 years and older	843	510	1,353
Total	**27,668**	**13,678**	**41,346**

Vaccine doses administered by sequencing group (note 4)	Dose 1	Dose 2	Total
Sequencing group (note 3)			
Group 1	617	581	1,198
Group 2	11,097	8,761	19,858
Group 3	14,330	3,766	18,096
Group 4	1,624	570	2,194
Total	**27,668**	**13,678**	**41,346**

Eligible population fully vaccinated by MidCentral DHB (DHB of residence) (note 1) (note 5)	**11.67% (note 1)**

Eligible population fully vaccinated by ethnicity (note 5)	Proportion fully vaccinated (note 1)
Asian	14.02%
European or other	11.60%
Māori	10.59%
Pacific peoples	11.41%
Unknown	20.47%
Total	**11.67%**

Eligible population fully vaccinated by age group (note 5)	Proportion fully vaccinated (note 1)
12 to 15 years	0.00%
16 to 19 years	2.98%
20 to 24 years	9.25%
25 to 29 years	11.32%
30 to 34 years	11.00%
35 to 39 years	10.70%
40 to 44 years	9.97%
45 to 49 years	9.71%
50 to 54 years	11.38%
55 to 59 years	11.31%
60 to 64 years	12.44%
65 to 69 years	12.48%
70 to 74 years	14.21%
75 to 79 years	16.09%
80 to 84 years	19.49%
85 to 89 years	27.43%
90 years and older	39.20%
Total	**11.67%**

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 use 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, followed by 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 or 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 181,787. This is (5,653) below the Stats NZ total projected population of 187,440 (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.

Ethnicity	HSU	Stats NZ	Difference
Māori	33,592	39,800	(6,208)
Pacific	5,994	6,090	(96)
Asian	12,998	15,350	(2,352)
Other	129,203	126,200	3,003
Total	181,787	187,440	(5,653)

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.

FINANCIAL STATEMENTS

Statement of Comprehensive Revenue and Expense for the year ended 30 June 2021

	Notes	Group Actual 2021 $000	Budget 2021 $000	Actual 2020 $000
Revenue				
Patient care revenue	2(i)	773,670	754,202	713,632
Interest revenue		456	204	712
Other revenue	2(ii)	13,690	10,641	10,852
Total revenue		787,816	765,047	725,196
Expenses				
Personnel costs	3	305,407	270,293	250,068
Depreciation and amortisation expense	12,13	23,259	24,053	20,189
Outsourced services		42,618	28,755	36,553
Clinical supplies		64,212	57,984	55,522
Infrastructure and non-clinical expenses		65,696	60,292	56,037
Other district health boards		64,240	65,791	63,233
Non-health-board provider expenses		241,745	245,099	242,307
Capital charge	4	8,009	9,585	10,231
Interest expense		69	65	75
Other expenses	5	11,630	8,044	8,754
Total expenses		826,885	769,961	742,969
Share of associate surplus/(deficit)	11	126	-	93
Surplus/(deficit)		**(38,943)**	**(4,914)**	**(17,680)**
Other comprehensive revenue and expense				
Item that will not be reclassified to surplus/(deficit)				
Revaluation of land and buildings	19	82,227	-	-
Total other comprehensive revenue and expense		82,227	-	-
Total comprehensive revenue and expense		**43,284**	**(4,914)**	**(17,680)**

Explanations of major variances against budget are provided in Note 24.

The accompanying notes form part of these financial statements

Statement of Financial Position as at 30 June 2021

	Notes	Group Actual 2021 $000	Budget 2021 $000	Actual 2020 $000
Assets				
Current assets				
Cash and cash equivalents	6	34,489	5,666	24,984
Receivables from exchange contracts	7	16,631	16,648	15,674
Receivables from non-exchange contracts	7	10,904	10,915	11,587
Investments	8	2,000	2,000	2,000
Inventories	9	4,853	4,460	4,454
Total current assets		*68,877*	*39,689*	*58,699*
Non-current assets				
Investments	8	-	-	-
Investment in associate	11	1,269	1,164	1,143
Property, plant, and equipment	12	263,253	203,478	181,382
Intangible assets	13	28,865	38,471	31,144
Total non-current assets		*293,387*	*243,113*	*213,669*
Total assets		**362,264**	**282,802**	**272,368**
Liabilities				
Current liabilities				
Payables from exchange contracts	14	54,740	49,892	49,787
Payables from non-exchange contracts	14	9,546	8,761	8,743
Borrowings	16	205	205	268
Employee entitlements	17	83,554	42,890	47,517
Total current liabilities		*148,045*	*101,748*	*106,315*
Non-current liabilities				
Borrowings	16	915	915	1,120
Employee entitlements	17	2,901	4,250	3,890
Trust /special funds	18	2,462	2,460	2,703
Total non-current liabilities		*6,278*	*7,625*	*7,713*
Total liabilities		**154,323**	**109,373**	**114,028**
Net assets		**207,941**	**173,429**	**158,340**
Equity				
Crown equity	19	125,838	141,611	119,521
Accumulated surpluses/(deficits)	19	(102,835)	(70,892)	(63,892)
Property revaluation reserves	19	184,938	102,710	102,711
Total equity		**207,941**	**173,429**	**158,340**

Explanations of major variances against budget are provided in Note 24.

The accompanying notes form part of these financial statements.

Statement of Changes in Equity for the Year Ended 30 June 2021

	Notes	Group Crown equity	Property revaluation reserves	Accumulated surpluses / (deficits)	Total equity
		$000	$000	$000	$000
Balance at 30 June 2019		117,504	102,711	(46,212)	174,003
Surplus/(deficit) for the year		-	-	(17,680)	(17,680)
Total comprehensive revenue and expense		-	-	*(17,680)*	*(17,680)*
Capital contributions from the Crown		2,650	-	-	2,650
Distributions to the Crown		(633)	-	-	(633)
Balance at 30 June 2020		**119,521**	**102,711**	**(63,892)**	**158,340**
Surplus/(deficit) for the year		-	-	(38,943)	(38,943)
Revaluation of land and buildings		-	82,227	-	82,227
Total comprehensive revenue and expense		-	*82,227*	*(38,943)*	*43,284*
Capital contributions from the Crown		6,950	-	-	6,950
Distributions to the Crown		(633)	-	-	(633)
Balance at 30 June 2021	19	**125,838**	**184,938**	**(102,835)**	**207,941**

Explanations of major variances against budget are provided in Note 24.

The accompanying notes form part of these financial statements.

Statement of Cash Flows for the Year Ended 30 June 2021

	Notes	Group Actual 2021 $000	Group Budget 2021 $000	Group Actual 2020 $000
Cash flows from operating activities				
Receipts from Ministry of Health		774,958	753,033	715,146
Receipts from other revenue		13,813	11,507	12,151
Payments to suppliers		(487,822)	(465,822)	(459,810)
Payments to employees		(269,806)	(274,682)	(242,430)
Capital charge		(8,009)	(9,585)	(10,231)
GST (net)		249	98	715
Net cash flow from operating activities		*23,383*	*14,549*	*15,541*
Cash flows from investing activities				
Receipts from sale of property, plant, and equipment		1	-	25
Purchase of property, plant, and equipment		(17,535)	(45,203)	(13,847)
Purchase of intangible assets		(2,539)	(8,272)	(5,965)
Decrease / (increase) in investments		-	(21)	138
Interest received		456	204	712
Trust/special funds		(241)	(243)	(267)
Net cash flow from investing activities		*(19,858)*	*(53,535)*	*(19,204)*
Cash flows from financing activities				
Interest paid		(69)	(65)	(75)
Capital contributions from the Crown		6,950	20,635	2,650
Return of capital to the Crown		(633)	(633)	(633)
Repayment of loans		(74)	(74)	(126)
Repayment of finance leases		(194)	(194)	(184)
Net cash flow from financing activities		*5,980*	*19,669*	*1,632*
Net (decrease)/increase in cash and cash equivalents		9,505	(19,317)	(2,031)
Cash and cash equivalents at the start of the year		24,984	24,983	27,015
Cash and cash equivalents at the end of the year	6	**34,489**	**5,666**	**24,984**

Equipment totalling $nil (2020: $nil) was acquired by means of finance leases during the year.

Explanations of major variances against budget are provided in Note 24.

The accompanying notes form part of these financial statements

Statement of Cash Flows for the Year Ended 30 June 2021 (continued)

Reconciliation of Net Surplus/ (Deficit) to Net Cash Flow from Operating Activities

	Actual 2021 $000	Actual 2020 $000
Net surplus/(deficit)	**(38,943)**	**(17,680)**
Add/(less) non-cash items		
Depreciation	18,441	17,397
Amortisation	4,818	2,792
Impairment	-	-
Donated equipment	(1,000)	-
Share of associate surplus	(126)	(93)
Total non-cash items	*22,133*	*20,096*
Add/(less) items classified as investing or financing activities		
Items relating to investing and financing activities	(387)	(637)
Net (gains)/losses on disposal of property, plant, and equipment	450	80
Total items classified as investing or financing activities	*63*	*(557)*
Add/(less) movements in statement of financial position items		
(Increase)/Decrease in receivables and prepayments	(274)	(261)
(Increase)/Decrease in inventories	(399)	(568)
Increase/(Decrease) in payables	5,755	7,146
Increase/(Decrease) in employee entitlements	35,048	7,365
Net movement in working capital	*40,130*	*13,682*
Net cash flow from operating activities	**23,383**	**15,541**

The accompanying notes form part of these financial statements

Notes Index to the Financial Statements for the Year Ended 30 June 2021

1 Statement of Accounting Policies

REPORTING ENTITY

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

The group consists of MDHB and its associate Allied Laundry Services Limited (ALSL, 16.7% owned) and an investment in Central Region's Technical Advisory Service Limited (CTAS, 16.7% owned). ALSL is equity-accounted. In addition, the group includes wholly owned subsidiary Enable New Zealand Limited (Enable NZ), which is non-trading. As of November 2002 all the assets, liabilities and activities of Enable NZ were vested in the MDHB. As a result, Enable NZ has no balances as at 30 June 2021 (2020: nil). The DHB's subsidiary and associates are incorporated and domiciled in New Zealand.

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

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

The financial statements for the group are for the year ended 30 June 2021 and were approved for issue by the Board on 22 December 2021.

BASIS OF PREPARATION

Health Sector Reforms

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

The reforms will replace all 20 District Health Boards (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, these financial statements have been prepared on a disestablishment basis. No changes have been made to the recognition and measurement, or presentation in these financial statements, because all assets, liabilities, functions and staff of the DHBs and shared services agencies will transfer to Health New Zealand.

Operating and cash flow forecasts

Operating and cash flow forecasts indicate that MDHB will have sufficient funds (including equity funding from the Crown for approved capital projects) to meet the forecast operating and investing cash flow requirements for the 2021/22 financial year. However, if DHB's are required to settle the holiday pay liability disclosed in note 17 prior to 1 July 2022, additional financial support would be needed from the Crown.

Letter of comfort

The Board has received a letter of comfort dated 13 October 2021 from the Ministers of Health and Finance. The letter of comfort states that the Government is committed to working with MDHB to maintain its financial viability and acknowledges that, if required over the period up until Health New Zealand is established, the Crown will provide equity support where necessary to maintain viability.

Statement of compliance

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

The financial statements have been prepared in accordance with and comply with Public Benefit Entity International Public Sector Accounting Standards (PBE IPSAS) (Tier 1).

Presentation currency and rounding

The financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars ($000), other than remuneration disclosed in Note 3 which are rounded to the nearest dollar.

Changes in accounting policies

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

Standards issued, not yet effective and not early adopted

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

Cash flow statement

An amendment to PBE IPSAS 2 requires entities to provide disclosures that enable users of 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 reporting periods beginning on or after 1 January 2021, with early application permitted. This amendment will result in additional disclosures. MDHB has not early adopt the amendment.

Service performance reporting

PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 Presentation of Financial Statements and is effective for reporting periods beginning on or after 1 January 2022, with earlier adoption permitted.

The timing of MDHB adopting this standard will be guided by the Treasury's decision on when the Financial Statements of the Government will adopt this standard. MDHB has not yet assessed the effect of this new standard.

Financial instruments

PBE IPSAS 41 replaces PBE IFRS 9 Financial Instruments and is effective for reporting periods beginning on or after 1 January 2022, with earlier adoption permitted. MDHB has assessed that there will be little change as a result of adopting the new standard as the requirements are similar to those contained in PBE IFRS 9. The timing of MDHB adopting this standard will be guided by the Treasury's decision on when the Financial Statements of the Government will adopt this standard.

Standards issued, not yet effective and early adopted

MDHB early adopted the following revisions to accounting standards, which had a presentational or disclosure effect only:

- PBE IFRS 9 Financial Instruments (effective 1 January 2022, early adoption permitted).

MDHB early adopted the standard in its financial statements for the year ended 30 June 2019. MDHB applied PBE IFRS 9 retrospectively, but elected not to restate comparative information. On 1 July 2018, certain assets were reclassified from 'Loans and receivables' to 'Financial assets at amortised cost' (refer to note 23).

The standard also introduced a new expected credit losses model that replaced the incurred

loss impairment model used in PBE IPSAS 29 for calculating the provision for doubtful debts. MDHB applied the expected credit losses model to the loans advanced however the impact of this was not material to MDHB.

Accounting policies were updated to comply with PBE IFRS 9. The main updates were:

- Trade and other receivables: this policy was updated to reflect that the impairment of short-term receivables is now determined by applying an expected credit loss model.

SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Significant accounting policies are included in the notes to which they relate. Significant accounting policies that do not relate to a specific note are outlined below.

Foreign currency transactions

Foreign currency transactions (including those for which forward foreign exchange contracts are held) are translated into NZ dollars (the functional currency) using the exchange rates prevailing at the dates of the transactions. Foreign exchange gains and losses resulting from the settlement of such transactions and from the translation at year-end exchange rates of monetary assets and liabilities denominated in foreign currencies are recognised in the surplus or deficit.

Goods and services tax

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

Income tax

MDHB is a public authority and consequently is exempt from the payment of income tax. Accordingly, no provision has been made for income tax.

Budget figures

The budget figures are derived from the 2020/21 Statement of Performance Expectations in the Annual Plan. The budget figures have been prepared in accordance with GAAP, using accounting policies that are consistent with those adopted by the Board in preparing these financial statements.

Cost allocation

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

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

Direct costs are charged directly to outputs. Indirect costs are charged to outputs based on cost drivers and related activity or usage information.

Depreciation is charged on the basis of asset utilisation.

Personnel costs are charged on the basis of actual time incurred. Property and other premises costs, such as maintenance, are charged on the basis of floor area occupied for the production of each output. Other indirect costs are assigned to outputs based on the proportion of direct staff costs for each output.

There have 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, the Board has made estimates and assumptions concerning the future. These estimates and assumptions might differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances.

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

- Estimating the fair value of land and buildings – refer to Note 12
- Measuring long service leave and retirement gratuities – refer to Note 17
- Holidays Act 2003 compliance – refer to Note 17.

Critical judgements in applying accounting policies

Management has exercised the following critical judgements in applying accounting policy:

- Revenue recognition and income in advance – refer to Note 14.

2 Revenue

Accounting Policy

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

Ministry of Health population-based revenue

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

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

Ministry of Health contract revenue

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

Other contracts are treated as non-exchange and the total funding receivable under the contract is recognised as revenue immediately, unless there are substantive conditions in the contract. If there are substantive conditions, revenue is recognised when the conditions are satisfied. A condition could include the requirement to provide services to the satisfaction of the funder to receive or retain funding.

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

Inter-district flows

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

ACC contract revenue

ACC contract revenue is recognised as revenue when eligible services are provided, and any

contract conditions have been fulfilled.

Interest revenue

Interest revenue is recognised using the effective interest method.

Rental revenue

Rental revenue under an operating lease is recognised as revenue on a straight-line basis over the lease term.

Lease incentives granted are recognised as an integral part of the total rental income over the lease term on a straight-line basis.

Sale of goods

Revenue is measured at fair value of consideration received and recognised when risks and rewards of ownership are transferred.

Provision of other services

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

Donations and bequests

Donated and bequeathed financial assets are recognised as revenue, unless there are substantive use or return conditions. A liability is recorded if there are substantive use or return conditions and the liability released to revenue as the conditions are met. For example, as the funds are spent for the nominated purpose.

Grants revenue

Grants are recognised as revenue when they become receivable unless there is an obligation in substance to return the funds if conditions of the grant are not met. If there is such an obligation, the grants are initially recorded as grants received in advance and recognised as revenue when conditions of the grant are satisfied.

Vested or donated physical assets

For assets received for no or nominal consideration, the asset is recognised at its fair value when the group obtains control of the asset. The fair value of the asset is recognised as revenue, unless there is a use or return condition attached to the asset.

The fair value of vested or donated assets is usually determined by reference to the cost of purchasing the asset if the asset is new, or reference to market information for assets of a similar type, condition, or age for used assets.

Donated services

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

Breakdown of Patient Care and Other Revenue

2(i) Patient care revenue

	Actual 2021 $000	Actual 2020 $000
Exchange transactions [for approximate equal value]		
MoH other contracts	39,856	39,146
Inter-district flows	58,020	53,621
ACC contract revenue	26,113	21,850
Other patient care related revenue	668	609
Total exchange transactions	*124,657*	*115,226*
Non-exchange transactions [without directly receiving equal value]		
MoH population-based funding*	602,056	540,770
MoH other contracts	46,957	57,636
Total non-exchange transactions	*649,013*	*598,406*
Total patient care revenue	**773,670**	**713,632**

* The appropriation revenue received by MidCentral DHB equals the government's actual expenditure against their appropriation. The government's budgeted appropriation was $602,102,000 prior to top-slices and other allocations (2020: $540,792,000). This is a required disclosure in terms of the Public Finance Act. Performance against this appropriation is reported in the Statement of Service Performance.

2(ii) Other revenue

	Actual 2021 $000	Actual 2020 $000
Exchange transactions [for approximate equal value]		
Rental revenue	1,083	1,178
Facilities revenue	1,537	1,415
Other revenue	9,863	8,176
Total exchange transactions	*12,483*	*10,769*
Non exchange transactions [without directly receiving equal value]		
Donations and bequests received	1,206	60
Total non-exchange transactions	*1,206*	*60*
Other transactions		
Gain on sale of property, plant, and equipment	1	23
Total other transactions	*1*	*23*
Total other revenue	**13,690**	**10,852**

Operating leases as lessor

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

	Actual 2021 $000	Actual 2020 $000
Not later than one year	520	590
Later than one year and not later than five years	1,575	1,600
Later than five years	903	840
Total non-cancellable operating lease revenue	**2,998**	**3,030**

Operating leases relate to the lease of buildings to a number of third parties providing support or health services from MDHB's facilities. The lessees do not have an option to purchase the properties at the expiry of the lease periods.

3 Personnel Costs

Accounting Policy

Salaries and wages

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

Superannuation schemes

Defined contribution schemes

Employer contributions to KiwiSaver, the Government Superannuation Fund, and the National Provident Fund are accounted for as defined contribution schemes and are recognised as an expense in the surplus or deficit as incurred.

Defined benefit schemes

MDHB makes employer contributions to the National Provident Fund, which is managed by the Board of Trustees of the National Provident Fund. The scheme is a multi-employer defined benefit scheme.

Insufficient information is available to use defined benefit accounting, as it is not possible to determine from the terms of the scheme the extent to which the surplus/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. Further information on this scheme is disclosed in Note 20.

Breakdown of Personnel Costs and Further Information

	Actual 2021 $000	Actual 2020 $000
Salaries and wages	262,306	235,165
Defined contribution plan employer contributions	8,053	7,538
Increase in liability for employee entitlements	35,048	7,365
Total personnel costs	**305,407**	**250,068**

Employee remuneration

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

	Actual 2021 $000	Actual 2020 $000
Total remuneration paid or payable:		
$100,000 – 109,999	149	135
$110,000 – 119,999	86	81
$120,000 – 129,999	60	50
$130,000 – 139,999	29	35
$140,000 – 149,999	22	20
$150,000 – 159,999	22	18
$160,000 – 169,999	16	16
$170,000 – 179,999	11	10
$180,000 – 189,999	12	11
$190,000 – 199,999	8	10
$200,000 – 209,999	13	11
$210,000 – 219,999	9	15
$220,000 – 229,999	13	10
$230,000 – 239,999	12	10
$240,000 – 249,999	17	4
$250,000 – 259,999	4	10
$260,000 – 269,999	10	10
$270,000 – 279,999	8	11
$280,000 – 289,999	11	8
$290,000 – 299,999	13	8
$300,000 – 309,999	7	8
$310,000 – 319,999	5	7
$320,000 – 329,999	10	5
$330,000 – 339,999	8	4
$340,000 – 349,999	2	3
$350,000 – 359,999	2	3
$360,000 – 369,999	2	2
$370,000 – 379,999	2	2
$380,000 – 389,999	2	-
$400,000 – 409,999	-	1
$410,000 – 419,999	1	1
$430,000 – 439,000	1	-
$440,000 – 449,999	-	1
$490,000 – 499,999	1	1
$510,000 – 519,999	1	-
$530,000 – 539,999	-	1
$540,000 – 549,999	1	-
Total employees	**570**	**522**

Of the total of 570 (2020: 522) staff paid more than $100,000, 487 (2020: 447) are clinical (medical, nursing and allied health).

The Chief Executive was the highest remunerated employee of the organisation in 2021. The CEO's remuneration includes the value of the DHB's contributions to KiwiSaver, the value of an additional week's leave and a vehicle allowance. These and other non-cash benefits are not included in the salary data for other employees.

During the year ended 30 June 2021, 8 employees received compensation and other benefits in relation to cessation totalling $153,000 (2020: 16 employees received total of $830,000).

Board member remuneration

Non-executive board members received no remuneration or provision of benefits except for standard fees and additional fees for extra duties of a special nature, as approved by the Minister of Health.

District Health Board elections were held in October 2019 and Board members took office from 9 December 2019.

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

	Actual 2021 $000	**Actual 2020 $000**
Board members		
B Duffy, Chairperson (from Dec 2019; Deputy Chairperson to Nov 2019)	46	40
O Paewai, Deputy Chairperson (from Dec 2019)	29	28
D McKinnon, Chairperson (to Nov 2019)	-	22
D Anderson (to Nov 2019)	-	11
A Broad (to Nov 2019)	-	8
H Browning (from Dec 2019)	24	14
B Cameron (to Nov 2019)	-	11
A Chapman (to Nov 2019)	-	12
V Dennison (from Dec 2019)	24	14
M Feyen (to Nov 2019)	-	11
L Findlay (from Dec 2019)	23	14
N Gray (from Dec 2019)	22	14
M Hancock (from Dec 2019)	23	14
N Manoharan (to Nov 2019)	-	11
M Mar (from Dec 2019)	23	14
K Naylor	23	26
B Robson (to Nov 2019)	-	12
J Waldon (from Dec 2019)	25	14
J Warren (from Dec 2019)	23	14
Board members total	*285*	*304*
Committee members		
S Allan	3	-
V Beagley	-	1
T Hartevelt	4	4
G Munro	6	-
A Kolbe	-	2
S Paewai	-	3
J Waldon	-	1
Committee members total	*13*	*11*
Board and committee members total	**298**	**315**

No Board members received compensation or other benefits in relation to cessation (2020: $nil). The above does not include expenses reimbursed to Board members.

MDHB has effective Directors' and Officers' Liability and Professional Indemnity insurance cover during the financial year in respect of the liability or costs of Board members, senior staff and members of the Clinical and Consumer Council.

4 Capital Charge

Accounting Policy

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

Further Information

The group pays a capital charge every six months to the Crown. The charge is based on the previous six-month actual closing equity balance at 31 December and 30 June. The capital charge rate for the year ended 30 June 2021 was 5% (2020: 6%).

5 Other Expenses

Accounting Policy

Operating leases

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

Lease payments under an operating lease are recognised as an expense on a straight-line basis over the lease term.

Lease incentives received are recognised in the surplus or deficit as a reduction of lease expense over the lease term.

Financing Costs

Financing costs comprise interest paid and payable on borrowings calculated using the effective interest rate method.

The interest expense component of finance lease payments is recognised in profit or loss using the effective interest rate method.

Breakdown of Other Expenses and Further Information

	Actual 2021 $000	Actual 2020 $000
Fees to auditor		
- Fees to Deloitte for audit of financial statements	235	231
- Fees to Technical Advisory Services (TAS) for internal audit	148	152
Operating lease expense	3,740	3,717
Impairment of receivables (refer Note 7)	170	80
Board member fees and expenses	341	328
Loss of disposal of property, plant and equipment (refer Note 12)	450	103
Consultancy	5,621	3,064
Staff travel	925	1,079
Impairment to intangible assets	-	-
Other expenses	-	-
Total other expenses	**11,630**	**8,754**

Operating leases as lessee

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

	Actual 2021 $000	Actual 2020 $000
Not later than one year	2,521	1,839
Later than one year and not later than five years	4,919	2,473
Later than five years	890	1,054
Total non-cancellable operating leases	**8,330**	**5,366**

MDHB leases a number of buildings, vehicles, and office equipment under operating leases. The lease terms typically range between one and 10 years, with some including rights of renewal options.

6 Cash and Cash Equivalents

Accounting Policy

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

Breakdown of Cash and Cash Equivalents and Further Information

	Actual 2021 $000	Actual 2020 $000
New Zealand Health Partnerships Limited	34,027	24,281
Trusts / special funds	462	703
Term deposits with maturity less than 3 months	-	-
Total cash and cash equivalents	**34,489**	**24,984**

MDHB does not administer funds on behalf of patients.

MDHB is party to a DHB Treasury Services Agreement between NZ Health Partnerships Limited (NZHPL) and participating DHBs. This Agreement enables NZHPL to 'sweep' DHB bank accounts and invest surplus funds on their behalf. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with NZHPL, which will incur interest at the credit interest rate received by NZHPL plus an administrative margin. The maximum borrowing facility that is available to any DHB is the value of the Provider Arm's planned monthly Crown revenue used in determining working capital limits. This is defined as one twelfth of the annual planned revenue paid by the Funder Arm as denoted in the most recent agreed Annual Plan inclusive of GST. As at 30 June 2021, this was $33.4 million (2020: $30.1 million).

The weighted average interest rate on deposits at 30 June 2021 was 0.62% (2020: 1.18%).

Financial assets recognised subject to restrictions

Included in the bank balance is $462,000 (2020: $703,000) of special funds which relate to the liability explained in Note 18.

7 Receivables

Accounting Policy

Short-term receivables are recorded at the amount due, less any expected credit losses.

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

Breakdown of Receivables and Further Information

	Actual 2021 $000	Actual 2020 $000
Receivables under exchange contracts		
Receivables from sale of goods and services	13,765	12,881
Receivables from related parties	353	630
Prepayments	2,719	2,404
Less: expected credit losses	(206)	(241)
Total exchange contracts	*16,631*	*15,674*
Receivables under non-exchange contracts		
Receivables from Ministry of Health	10,904	11,587
Total non-exchange contracts	*10,904*	*11,587*
Total receivables	**27,535**	**27,261**

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

	2021			2020		
	Gross $000	Expected credit losses $000	Net $000	Gross $000	Expected credit losses $000	Net $000
Not past due	23,872	-	23,872	23,304	-	23,304
Past due 1-30 days	192	-	192	137	-	137
Past due 31-60 days	348	-	348	612	-	612
Past due over 61 days	610	-	610	1,045	-	1,045
Expected credit losses	-	(206)	(206)	-	(241)	(241)
Total	**25,022**	**(206)**	**24,816**	**25,098**	**(241)**	**24,857**

No interest is charged on the trade receivables.

All non-resident receivables greater than 30 days in age without an agreed payment plan are handed over to a collection agency. The expected credit losses is based on all non-resident receivables over 90 days.

The assessment of receivables write-off is performed annually prior to year-end and is based on an analysis of past collection history.

Movements in the expected credit losses of receivables are as follows:

	Actual 2021 $000	Actual 2020 $000
Balance as at 1 July	241	179
Additional provisions made during the year (Note 5)	170	80
Receivables written off during the year	(205)	(18)
Balance at 30 June	**206**	**241**

8 Investments

Accounting Policy

Bank term deposits

Bank term deposits are initially measured at the amount invested. Interest is subsequently accrued and added to the investment balance.

Breakdown of investments and further information

	Actual 2021 $000	Actual 2020 $000
Current portion		
Trusts / special funds	2,000	2,000
Term deposits	-	-
Total current portion	*2,000*	*2,000*
Non-current portion		
Trusts / special funds	-	-
Term deposits	-	-
Total non-current portion	-	-
Total investments	**2,000**	**2,000**

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

9 Inventories

Accounting Policy

Inventories held for distribution or consumption in the provision of services and those supplied on a commercial basis are held at the lower of cost and current replacement value. The cost is measured at the weighted average cost per unit, adjusted, when applicable, for any loss of service potential.

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

Breakdown of inventories and further information

	Actual 2021 $000	Actual 2020 $000
Held for distribution inventories		
Surgical and medical supplies	3,459	3,145
Pharmaceuticals	1,394	1,309
Total inventories	**4,853**	**4,454**

The amount of inventories recognised as an expense during the year was $40,984,000 (2020: $37,392,000), which is included in the clinical supplies line item of the statement of comprehensive revenue and expense.

The write-down of inventories held for distribution amounted to $203,000 (2020: write-down $15,000).

No inventories are pledged as security for liabilities (2020: $nil).

10 Non-Current Assets Held for Sale

Accounting Policy

A non-current asset is classified as held for sale if it's carrying amount will be recovered principally through sale rather than through continuing use.

Immediately before classification as held for sale, the measurement of the assets (and all assets and liabilities in a disposal group) are brought up-to-date in accordance with applicable PBE IPSAS. Then, on initial classification, non-current assets held for sale are measured at the lower of their carrying amount and fair value less costs to sell.

Any impairment losses for write-downs of non-current assets held for sale, while classified as held for sale, are recognised in the surplus or deficit, even when the asset was previously revalued.

Any increases in fair value (less costs to sell) are recognised up to the level of any impairment losses that have been previously recognised.

Non-current assets held for sale (including those that are part of a disposal group) are not depreciated or amortised while they are classified as held for sale.

There are no non-current assets held for sale in the current year (2020: $nil).

11 Investment in Associates

Accounting Policy

The group's associate investment is accounted for using the equity method. An associate is an entity over which the group has significant influence, but not control, and that is neither a subsidiary nor an interest in a joint venture. 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 equals or exceeds the group's interest in the associate, further deficits are not recognised. 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, surplus or deficits are eliminated to the extent of the interest in the associate.

Breakdown of investment in associates and further information

	Actual 2021 $000	Actual 2020 $000
MidCentral DHB's ownership interest		
Allied Laundry Services Limited	16.7%	16.7%
Summarised financial information of associate presented on a gross basis		
Assets	13,026	11,899
Liabilities	4,651	4,565
Revenue	13,031	11,761
Surplus	626	753

	Actual 2021 $000	Actual 2020 $000
Investments in associates		
Carrying amount at the beginning of the year	1,143	1,188
Share of total recognised revenue and expense	126	93
Share of dividend	-	(138)
Carrying amount at end of year	**1,269**	**1,143**
Share of associates' contingent liabilities incurred jointly with other investors	-	-
Contingent liabilities that arise because of several liability	-	-

Allied Laundry Services Limited

Allied Laundry Services Limited is a profit-oriented entity incorporated and domiciled in New Zealand, and is a company registered under the Companies Act 1993.

Allied Laundry Services Limited commenced operations on 2 December 2002, has a balance date of 30 June and operates a laundering service. MDHB has a 16.7% (2020: 16.7%) shareholding and participates in its commercial and financial policy decisions.

Allied Laundry Services Limited is an unlisted company. Accordingly, there are no published price quotations for this investment.

The summary financial information detailed above is based on draft unaudited accounts and as such MDHB's share of 30 June 2021 surplus has not been recognised in 2021. The share of surplus recognised by MDHB in 2021 relates to Allied Laundry Services Limited's final audited result for the year ended 30 June 2020.

Central Regional Technical Advisory Services Limited

Central region's Technical Advisory Services Limited is a non-profit oriented entity incorporated and domiciled in New Zealand, and is a company registered under the Companies Act 1993.

MDHB holds a 16.7% (2020: 16.7%) shareholding in the central region's Technical Advisory Services Limited and participates in its commercial and financial policy decisions. Five other district health boards in the region each hold 16.7% (2020: 16.7%) of the shares.

Central Region's Technical Advisory Services Limited was incorporated on 6 June 2001. The total share capital of $600 remains uncalled and as a result no investment has been recorded in the Statement of Financial Position for this investment.

12 Property, Plant, and Equipment

Accounting Policy

Property, plant and equipment consists of the following classes: freehold land, freehold buildings, plant, equipment, vehicles, work in progress and fixtures and fittings.

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

The cost of self-constructed assets includes the cost of materials, direct labour, the initial estimate, where relevant, of the costs of dismantling and removing the items and restoring the site on which they are located, and an appropriate proportion of direct overheads. Where material parts of an item of property, plant and equipment have different useful lives, they are accounted for as separate components of property, plant and equipment.

Rental property is included in property, plant and equipment in accordance with PBE IPSAS as the rental property is held for strategic and social purposes rather than for rental income, capital appreciation or both.

Leasehold improvements are capitalised and the cost is depreciated over the lease or the estimated useful life of the improvements, whichever is the shorter.

Revaluations

Land and buildings are revalued with sufficient regularity to ensure that the carrying amount does not differ materially from fair value and at least every three years. Valuations undertaken in accordance with generally accepted accounting practice and standards issued by the New Zealand Property Institute are used where available. Otherwise, valuations are conducted in accordance with the Rating Valuation Act 1998, which have been confirmed by an independent valuer.

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

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

Accumulated depreciation at revaluation date is eliminated against the gross carrying amount so that the carrying amount after revaluation equals the revalued amount.

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

Additions

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

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

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

Subsequent costs

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

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

Disposals

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

Depreciation

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

Freehold buildings	1 to 80 years
Plant, equipment and motor vehicles	3 to 20 years
Fixtures and fittings	3 to 25 years

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

Borrowing Costs

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

Impairment of property, plant, and equipment

The group does not hold any cash-generating assets. Assets are considered cash-generating where their primary objective is to generate a commercial return.

Non-cash-generating assets

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

Value in use is determined using an approach based on either a depreciated replacement cost approach, a restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and availability of information.

If an asset's carrying amount exceeds its recoverable service amount, the asset is regarded as impaired and the carrying amount is written down to its recoverable amount.

The total impairment loss is recognised in the surplus or deficit.

The reversal of an impairment loss is recognised in the surplus or deficit.

An impairment loss on property, plant and equipment revalued on a class of asset basis is recognised directly against any revaluation reserve in respect of the same class of asset to the extent that the impairment loss does not exceed the amount in the revaluation reserve for the same class of asset.

Critical accounting estimates and assumptions

Estimating the fair value of land and buildings

The most recent valuation of land and buildings was performed by an independent registered valuer, P Todd of RS Valuation Limited. The valuation was effective as at 30 June 2021.

Land

Land is valued at fair value using market-based evidence. This is based on its highest and best use, that is, the most probable use of the asset that is physically possible, appropriately justified, legally permissible, and financially feasible, and is referenced to sales of comparable land.

Restrictions on the group's ability to sell land would normally not impair the value of the land because it has operational use of the land for the foreseeable future and will receive substantially the full benefits of outright ownership.

Buildings

Non-specialised buildings are valued at fair value using market-based evidence.

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

A comparison of the carrying value of buildings valued using depreciated replacement cost and buildings valued using market-based evidence is as follows:

	Actual 2021 $000	**Actual 2020 $000**
Depreciated replacement cost	212,346	155,744
Market-based evidence	949	912
Internally assessed remediation costs	(6,873)	(6,296)
Total carrying value of buildings	**206,422**	**150,360**

As part of the 30 June 2021 valuation process, MDHB internally assessed mould and asbestos contamination. The cost of remediation has been estimated as $6,873,000, and this has been offset against the buildings valuation movement (2018 valuation: $6,296,000). The reason being that remediation costs will be capitalised as they are incurred.

Breakdown of property, plant and equipment and further information

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

	Land	Buildings	Plant, equipment & vehicles	Fixtures & fittings	Work in progress	Total
	$000	$000	$000	$000	$000	$000
Cost or valuation						
Balance at 30 June 2019	11,553	145,092	75,322	4,114	12,967	249,048
Additions	-	25	1,952	27	15,987	17,991
Disposals	-	-	(5,092)	(134)	-	(5,226)
Transfers	-	5,243	4,895	362	(14,644)	(4,144)
Elimination on revaluation	-	-	-	-	-	-
Revaluation increase	-	-	-	-	-	-
Balance at 30 June 2020	11,553	150,360	77,077	4,369	14,310	257,669
Additions	-	118	2,480	19	17,305	19,922
Disposals	-	-	(8,745)	(114)	-	(8,859)
Transfers	-	14,672	6,923	180	(23,162)	(1,387)
Elimination on revaluation	-	(31,061)	-	-	-	(31,061)
Revaluation increase	9,894	72,333	-	-	-	82,227
Balance at 30 June 2021	21,447	206,422	77,735	4,454	8,453	318,511
Accumulated depreciation						
Balance at 30 June 2019	-	9,931	51,443	2,634	-	64,008
Depreciation	-	10,416	6,699	282	-	17,397
Disposals	-	-	(4,984)	(134)	-	(5,118)
Elimination on revaluation	-	-	-	-	-	-
Balance at 30 June 2020	-	20,347	53,158	2,782	-	76,287
Depreciation	-	10,714	7,441	286	-	18,441
Disposals	-	-	(8,295)	(114)	-	(8,409)
Elimination on revaluation	-	(31,061)	-	-	-	(31,061)
Balance at 30 June 2021	-	-	52,304	2,954	-	55,258
Carrying amounts						
At 30 June 2019	11,553	135,161	23,879	1,480	12,967	185,040
At 30 June 2020	11,553	130,013	23,919	1,587	14,310	181,382
At 30 June 2021	21,447	206,422	25,431	1,500	8,453	263,253

The difference between transfers from work in progress to buildings, plant, equipment and vehicles and fixtures & fittings relates to transfers to intangibles disclosed in Note 13.

Restrictions on title

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

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

Work in progress

Buildings in the course of construction total $4,845,000 (2020: $11,602,000).

Asset sales

There were no significant asset sales in the current and prior year.

Finance leases

The net carrying amount of assets held under finance leases is $1,207,000 (2020: $1,363,000) for clinical equipment.

Capital commitments

	Actual 2021 $000	Actual 2020 $000
Buildings	3,480	1,483
Plant and equipment	7,256	4,154
Total capital commitments	**10,736**	**5,637**

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

13 Intangible Assets

Accounting Policy

Intangible assets that are acquired by MDHB are stated at cost less accumulated amortisation and impairment losses.

Software acquisition and development

Acquired computer software licenses are capitalised on the basis of the costs incurred to acquire and bring to use the specific software.

Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include the costs of materials and services, employee costs, and any directly attributable overheads.

Staff training costs are recognised as an expense when incurred.

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

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

Information technology shared services rights

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

Amortisation

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

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

Software	3 to 10 years

Disposals

Realised gains and losses arising from disposal of intangible assets are recognised in profit or loss in the period in which the transaction occurs.

Impairment of intangible assets

Refer to the policy for impairment of property, plant, and equipment in Note 12. The same approach applies to the impairment of intangible assets, except for intangible assets that are still under development.

Intangible assets that are under development and not yet ready for use are tested for impairment annually, irrespective of whether there is any indication of impairment.

Breakdown of intangible assets and further information

	IT shared rights	Acquired software	Internally developed software	Total
	$000	$000	$000	$000
Cost				
Balance at 30 June 2019	12,847	33,863	-	46,710
Additions	928	894	-	1,822
Disposals	-	(254)	-	(254)
Transfers	(2,578)	6,721	-	4,143
Balance at 30 June 2020	11,197	41,224	-	52,421
Additions	1,016	7,693	40	8,749
Disposals	-	-	-	-
Transfers	(7,596)	1,386	-	(6,210)
Balance at 30 June 2021	4,617	50,303	40	54,960
Accumulated amortisation and impairment losses				
Balance at 30 June 2019	3,594	15,148	-	18,742
Amortisation	-	2,792	-	2,792
Impairment losses	-	-	-	-
Disposals	-	(257)	-	(257)
Balance at 30 June 2020	3,594	17,683	-	21,277
Amortisation	-	4,805	13	4,818
Impairment losses	-	-	-	-
Disposals	-	-	-	-
Balance at 30 June 2021	3,594	22,488	13	26,095
Carrying amounts				
At 30 June 2019	9,253	18,715	-	27,968
At 30 June 2020	7,603	23,541	-	31,144
At 30 June 2021	1,023	27,815	27	28,865

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

The DHB has contractual capital commitments of $1,640,000 (2020: $296,000) in relation to intangible assets under development.

IT shared services rights

The national IT shared services project was undertaken for the purpose of reducing costs for the public health sector. The project is funded by the issue of 'B' class shares in New Zealand Health Partnerships Limited to all DHBs across the country.

As at 30 June 2021, MDHB had paid $3,594,000 (2020: $3,594,000) as its share of the project funding, which represents its rights to use the systems when developed. These rights have been tested for impairment by comparing the carrying amount of the intangible asset to its depreciated replacement cost (DRC), which is considered to equate to MDHB's share of the

DRC of the underlying IT assets. Accumulated impairment, identified in impairment testing taking into account advice from New Zealand Health Partnerships Limited, is $3,594,000 (2020: $3,594,000).

IT regional services rights

The central region's shared service project is led by Central TAS. On 1 December 2014, ownership of the assets of Central TAS were transferred to reflect the percentage of capex funding provided from the DHBs to Central TAS for the creation of the assets. MDHB's total capital percentage funding is 22.3%.

As at 30 June 2021, MDHB has paid $14,243,000 (2020: $13,230,000) as its share of the project funding, which represents its rights to use the systems when developed. As part of this investment, $13,220,000 (2020: $5,627,000) has been capitalised in respect of software. The rights have been tested for impairment by comparing the carrying amount of the intangible asset to its depreciated replacement cost (DRC), which is considered to equate to MDHB's share of the DRC of the underlying IT assets. There was no impairment identified in impairment testing (2020: nil).

14 Payables, Provisions and Deferred Revenue

Accounting Policy

Short-term payables are recorded at the amount payable.

A provision is recognised for future expenditure of uncertain amount or timing when:

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

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

Restructuring

A provision for restructuring is recognised when MDHB has approved a detailed and formal restructuring plan, and the restructuring has either commenced or has been announced publicly. Future operating costs are not provided for.

ACC Accredited Employers Programme

The group belongs to the ACC Accredited Employers Programme (the 'Full Self Cover Plan') whereby the group accepts the management and financial responsibility for employee work-related illnesses and accidents. Under the programme MDHB is liable for all its claims costs for a period of two years up to a specified maximum. At the end of the two-year period, MDHB pays a premium to ACC for the value of residual claims, and from that point the liability for ongoing claims passes to ACC.

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

Critical judgements in applying accounting policies

Revenue Recognition and Income in Advance

In determining whether or not revenue has been earned a degree of judgment is required based on information included within the funding agreements. Where the funding agent has the right to demand repayment, income in advance is recognised for the unearned portion of the funding received.

Breakdown of payables, provisions and deferred revenue

	Actual 2021 $000	Actual 2020 $000
Payables from exchange transactions		
Creditors	8,743	7,996
Income in advance	6,416	4,045
Accrued expenses	39,581	37,746
Total payables from exchange transactions	*54,740*	*49,787*
Payables from non-exchange transactions		
Taxes payable (e.g. GST and rates)	8,830	8,025
Other	716	718
Total payables from non-exchange transactions	*9,546*	*8,743*
Total payables, provisions and deferred revenue	**64,286**	**58,530**

15 Derivative Financial Instruments

Accounting Policy

Derivative financial instruments are used to manage exposure to foreign exchange risk arising from the group's operational activities. The group does not hold or issue derivative financial instruments for trading purposes. The group has not adopted hedge accounting.

Derivatives are initially recognised at fair value on the date a derivative contract is entered into and are subsequently remeasured at their fair value at each balance date with the resulting gain or loss recognised in the surplus or deficit.

Forward foreign exchange derivatives are classified as current if the contract is due for settlement within 12 months of balance date. Otherwise, the fair value of foreign exchange derivatives is classified as non-current.

Further information
The fair values of forward foreign exchange contracts are determined using a discounted cash flows valuation technique based on quoted market prices. The inputs into the valuation model are from independently sourced market parameters such as currency rates. Most market parameters are implied from forward foreign exchange contract prices.

There are no notional principal amounts of outstanding forward foreign exchange contracts at 30 June 2021 (2020: $nil).

16 Borrowings

Accounting Policy

Overdraft facility

Amounts drawn under the New Zealand Health Partnerships Limited (NZHPL) banking facility are recorded at the amount payable plus accrued interest.

Finance leases

A finance lease is a lease that transfers to the lessee substantially all the risks and rewards incidental to ownership of an asset, whether or not title is eventually transferred.

At the commencement of the lease term, finance leases are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased item or the present value of the minimum lease payments.

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

The amount recognised as an asset is depreciated over its useful life. If there is no certainty as to whether the group will obtain ownership at the end of the lease term, the asset is fully depreciated over the shorter of the lease term and its useful life.

Critical judgements in applying accounting policies

Leases classification

Determining whether a lease agreement is a finance lease or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to the group.

Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term and determining an appropriate discount rate to calculate the present value of the minimum lease payments. Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant, and equipment, whereas for an operating lease no such asset is recognised.

Management has exercised its judgement on the appropriate classification of leases and has determined that some lease arrangements are finance leases.

Breakdown of borrowings and further information

	Actual 2021 $000	Actual 2020 $000
Current portion		
Secured loan	-	74
Finance leases	205	194
Total current portion	*205*	*268*
Non-current portion		
Secured loan	-	-
Finance leases	915	1,120
Total non-current portion	*915*	*1,120*
Total borrowings	**1,120**	**1,388**

MDHB has a maximum borrowing limit of $33.4 million (2020: $30.1million) with NZHPL as at 30 June 2021. Refer to Note 6 for further information.

Restrictions

Without the Ministry of Health's prior written consent, MDHB cannot perform the following actions:

- create any security over its assets except in certain circumstances
- lend money to another person or entity (except in the ordinary course of business and then only on commercial terms) or give a guarantee
- make a substantial change in the nature or scope of its business as presently conducted or undertake any business or activity unrelated to health
- dispose of any of its assets except disposals at full value in the ordinary course of business.

Analysis of finance leases

	Actual 2021 $000	Actual 2020 $000
Minimum lease payments payable:		
No later than one year	260	260
Later than one year and not later than five years	1,016	1,038
Later than five years	-	237
Total minimum lease payments	*1,276*	*1,535*
Future finance charges	(156)	(221)
Present value of minimum lease payments	*1,120*	*1,314*
Present value of minimum lease payments payable:		
No later than one year	205	194
Later than one year and not later than five years	915	888
Later than five years	-	232
Total present value of minimum lease payments	*1,120*	*1,314*

Description of finance leasing arrangements

MDHB has entered into finance leases for clinical equipment. The net carrying amount of the leased items within each class of property, plant, and equipment is shown in Note 12.

There are no restrictions placed on MDHB by the finance leasing arrangement.

Finance lease liabilities are effectively secured, as the rights to the leased asset revert to the lessor in the event of default in payment.

17 Employee Entitlements

Accounting Policy

Short-term employee entitlements

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

These include salaries and wages accrued up to balance date, annual leave earned but not yet taken at balance date, continuing medical education leave, 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.

Termination payments are recognised in profit or loss only where there is a demonstrable commitment to either terminate employment prior to normal retirement date or to provide such benefits as a result of an offer to encourage voluntary redundancy. Termination benefits settled in 12 months are reported as the amount expected to be paid, otherwise they are reported as the present value of the estimated future cash flows.

Long-term employee entitlements

Employee entitlements that are due to be settled beyond 12 months after the end of the year in which the employee renders the related service, such as sabbatical leave, long service

leave, and retirement gratuities, have been calculated on an actuarial basis. The calculations are based on:

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

Presentation of employee entitlements

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

Critical accounting estimates and assumptions

Long service leave and retirement gratuities

MDHB's net obligation in respect of long service leave and retirement gratuities is the amount of future benefit that employees have earned in return for their service in the current and prior periods.

The present value of long service leave and retirement gratuities obligations depend on a number of factors that are determined on an actuarial basis. Two key assumptions used in calculating these liabilities are the discount rate and the salary inflation factor. Any changes in these assumptions will affect the carrying amount of the liability.

Expected future payments are discounted using discount rates derived from the yield curve of New Zealand government bonds. The discount rates used have maturities that match, as closely as possible, the estimated future cash outflows. The salary inflation factor has been determined after considering historical salary inflation patterns and after obtaining advice from an independent actuary. A weighted average discount rate of 1.1% for long service leave (2020: 0.2 %) and 1.1% for retirement gratuities (2020: 0.2%) were used. The discount rates used are those advised by the Treasury. The salary inflation factor is the group's best estimate forecast of salary increments.

Continuing medical education leave

The continuing medical education leave liability assumes that the utilisation of the annual entitlement, which can be accumulated up to 3 years, will on average be 54% (2020: 56%) of the full entitlement. This utilisation assumption is based on recent experience.

Defined Contribution Plan

MDHB has a number of employees that are part of a defined contribution scheme. The total expenses recognised in profit or loss of $8,053,000 (2020: $7,538,000) represents contributions paid or payable to the plans for the year. MDHB has no other liability in respect of these schemes.

Defined Benefit Plan

MDHB has a small number of employees that are part of a multi-employer scheme. Under the plan the employees are entitled to retirement benefits. No other post-retirement benefits are provided. MDHB did not contribute to the scheme in 2021 and 2020 and has no other liability in respect of the above scheme.

Should there be a deficit in the fund all the benefit payments are guaranteed by the Crown and as a result the scheme is accounted for as a defined contribution scheme by MDHB.

Compliance with Holidays Act 2003

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) 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 progressed during the 2020/21 financial year. The final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed.

Notwithstanding, in preparing these financial statements MDHB recognises it has an obligation to address any historical non-compliance under the MOU and has made estimates and assumptions to determine a potential liability based on its own review of payroll processes which identified instances of non-compliance with the Act and the requirements of the MOU. This was based on selecting a sample of current and former employees, making a number of early assumptions, calculating an indicative liability for those current and former employees, and extrapolating the result.

MDHB has estimated its liability as at 30 June 2021 to be $47,397,000 (2020: $10,997,000). This indicative liability amount is MDHB's best estimate at this stage of the outcome from this project. However, until the project has progressed further, there remain substantial uncertainties as to the actual amount that MDHB will be required to pay to current and former employees.

The estimates and assumptions may differ to the subsequent actual results as further work is completed. This may result in further adjustment to the carrying amount of the liability within the next financial year, or payments to current and former employees that differ significantly from the estimation of the liability.

Breakdown of employee entitlements

	Actual 2021 $000	**Actual 2020 $000**
Current portion		
Accrued salaries and wages	4,282	7,436
Annual leave	28,183	25,935
Holidays Act 2003 remediation	47,397	10,997
Sick leave	471	402
Long service leave	1,969	1,950
Retirement gratuities	887	432
Other provision	365	365
Total current portion	*83,554*	*47,517*
Non-current portion		
Long service leave	1,190	1,061
Retirement gratuities	1,711	2,829
Total non-current portion	*2,901*	*3,890*
Total employee entitlements	**86,455**	**51,407**

18 Trusts and Special Funds

	Actual 2021 $000	Actual 2020 $000
Balance at 1 July	2,703	2,970
Transfers from retained earnings in respect of:		
Interest received	25	61
Donations and funds received	594	541
Transfers to retained earnings in respect of:		
Funds spent	(860)	(869)
Balance at 30 June	**2,462**	**2,703**

Trust and special funds are funds from donations, bequests, clinical trials and research. The use of these assets must comply with the specific terms of the source from which the funds were derived. These funds are held in bank and investment accounts which are separate from MDHB's normal banking facility.

19 Equity

Accounting Policy

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

- Crown equity
- accumulated surpluses/(deficits), and
- property revaluation reserves.

Property revaluation reserves

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

Breakdown of equity and further information

	Actual 2021 $000	Actual 2020 $000
Crown equity		
Balance at 1 July	119,521	117,504
Capital contributions from the Crown	6,950	2,650
Return of capital to the Crown	(633)	(633)
Balance at 30 June	125,838	119,521
Accumulated surpluses/(deficits)		
Balance at 1 July	(63,892)	(46,212)
Surplus/(deficit) for the year	(38,943)	(17,680)
Balance at 30 June	(102,835)	(63,892)
Property revaluation reserves		
Balance at 1 July	102,711	102,711
Revaluations	82,227	-
Balance at 30 June	184,938	102,711
Property revaluation reserves consist of:		
Land	20,417	10,523
Buildings	164,521	92,188
Total revaluation reserves	184,938	102,711
Total equity	**207,941**	**158,340**

Capital management

The group's capital is its equity, which consists of Crown equity, accumulated surpluses/(deficits) and property revaluation reserves. Equity is represented by net assets.

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

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

20 Contingencies

Contingent liabilities

Lease of land

MDHB leases land to Manawatū Community Trust. The lease provides that at the expiration of the 34 years and 11 months lease, MDHB is obligated to purchase the building on the land from the trust for $1,800,000 should both parties not complete a new lease agreement. Where the lease is terminated prior to the expiration of the lease term for whatever reason, MDHB shall purchase the building at a price to be agreed by both parties.

Superannuation schemes

MDHB is a participating employer in the National Provident Fund which is a multi-employer defined benefit scheme. If the other participating employers ceased to participate in the scheme, MDHB could be responsible for any deficit of the scheme. Similarly, if a number of employers ceased to participate in the scheme, the group could be responsible for an increased share of any deficit

Contingent assets

The group has no contingent assets (2020: $nil).

21 Related Party Transactions

MDHB is controlled by the Crown.

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

- within a normal supplier or client/recipient relationship, and
- on terms and conditions no more or less favourable than those that it is reasonable to expect that the group would have adopted in dealing with the party at arm's length in the same circumstances.

Further, transactions with other government agencies (for example, government departments and Crown entities) are not disclosed as related party transactions when they are consistent with the normal operating arrangements between government agencies.

Related party transactions required to be disclosed

Enable New Zealand Limited – No transactions occurred between MDHB and the wholly owned subsidiary during the financial year (2020: $nil). There was no amount outstanding to or from at year end.

Allied Laundry Services Limited – MDHB purchased the supply of laundry services totalling $2,442,000 during the year (2020: $2,333,000). There is a payable amount of $249,000 outstanding at 30 June 2021 (2020: $192,000). MDHB leased a building and charged lease and utility costs to Allied Laundry Services Limited totalling $909,000 (2020: $801,000). There is a receivable amount of $100,000 outstanding at 30 June 2021 (2020: $142,000).

Central TAS Limited – MDHB purchased IT regional services rights (refer Note 13), internal audit and consultancy services totalling $5,547,000 during the year (2020: $4,006.000). There is a payable amount of $4,000 outstanding at 30 June 2021 (2020: $nil). MDHB charged for reimbursements totaling $nil (2020: $nil) and there is a receivable amount of $nil outstanding at 30 June 2021 (2020: $nil).

NZ Health Partnerships Limited – MDHB entered into a pre-paid services agreement for the supply of Health System Catalogue services, and purchased treasury, insurance and project services totalling $951,000 during the year (2020: $306,000). There is a payable amount of $nil outstanding at 30 June 2021 (2020: $nil).

There are no other organisation's that are regarded as a related party as a result of MDHB board members holding a senior management position (Chief Executive Officer or equivalent) with the organisations.

Key management personnel remuneration

	Actual 2021 $000	Actual 2020 $000
Board and committee members	298	328
Executive leadership team	4,930	5,233
Total key management personnel remuneration	**5,228**	**5,561**
Executive leadership team - full time equivalent members	18	18

An analysis of Board member remuneration is provided in Note 3.

22 Events After the Balance Date

There were no significant events after the balance date.

23 Financial Instruments

23a Non derivative financial instruments

Non derivative financial instruments include cash and cash equivalents, receivables (excluding prepayments), investments, payables, accruals and borrowings. These are recognised initially at fair value plus or minus any directly attributable transaction costs.

A financial instrument is recognised if MDHB becomes a party to the contractual provisions of the instrument. Financial assets are derecognised if MDHB's contractual rights to the cash flows from the financial assets expire or if MDHB transfers the financial asset to another party without retaining control or substantially all risks and rewards of the asset. Regular way purchases and sales of financial assets are accounted for at trade date, ie the date MDHB commits itself to purchase or sell the asset. Financial liabilities are derecognised if MDHB's obligations specified in the contract expire or are discharged or cancelled.

Subsequent to initial recognition, non derivative financial instruments are recognised as described below.

Financial assets

Cash and cash equivalents, receivables (excluding prepayments), and investments and under Notes 6, 7 and 8 respectively.

Financial liabilities

Payables and accruals and borrowings under Notes 14 and 16 respectively.

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	34,489	24,984
Receivables	24,816	24,857
Investments	2,000	2,000
Total financial assets measured at amortised cost	*61,305*	*51,841*
Financial liabilities measured at amortised cost		
Loans and borrowings	1,120	1,388
Payables (excluding deferred revenue and taxes)	49,040	46,460
Total financial liabilities measured at amortised cost	*50,160*	*47,848*

23b Fair value hierarchy

The only financial instruments the group measures at fair value in the statement of financial position are forward foreign exchange contracts. The fair value of forward foreign exchange contracts, as represented by their carrying amount in the statement of financial position, is determined using a valuation technique that uses observable market inputs (level 2).

23c Financial instrument risks

The group's activities expose it to a variety of financial instrument risks, including market risk, credit risk, and liquidity risk. The group has a series of policies to manage the risks associated with financial instruments and seeks to minimise exposure from financial instruments. These policies do not allow any transactions that are speculative in nature to be entered into.

Market risk

Price risk

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

Fair value interest rate risk

Fair value interest rate risk is the risk that the fair value of a financial instrument will fluctuate due to changes in market interest rates. The group's exposure to fair value interest rate risk arises from bank deposits that are at fixed rates of interest. The exposure to fair value interest rate risk is not actively managed by the group, as investments are generally held to maturity.

Cash flow interest rate risk

Cash flow interest rate risk is the risk that the cash flows from a financial instrument will fluctuate because of changes in market interest rates. The group's exposure to cash flow interest rate risk is limited to on-call deposits. Deposits with banks at year end are on fixed rates.

Sensitivity analysis

No sensitivity analysis to determine the exposure to interest rate has been carried out as the borrowings and deposits at year end are on fixed terms.

Currency risk

Currency risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate due to changes in foreign exchange rates.

The group purchases clinical equipment from overseas, which requires it to enter into transactions denominated in foreign currencies. As a result of these activities, exposure to currency risk arises.

The group's policy is to manage foreign currency risks arising from contractual commitments and liabilities by entering into forward foreign exchange contracts for material purchases to manage the foreign currency risk exposure.

Sensitivity analysis

No sensitivity analysis has been carried out due to there being no forward foreign exchange contracts held at balance date.

The group has no material outstanding foreign-denominated payables at balance date (2020: $nil).

Credit risk

Credit risk is the risk that a third party will default on its obligation to the group, causing it to incur a loss. Due to the timing of the DHB's cash inflows and outflows, surplus cash is invested with registered banks or NZHPL.

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

MDHB places its cash and short-term deposits with high-quality financial institutions and MDHB has a policy that limits the amount of credit exposure to any one financial institution. Credit exposure and credit limits are continuously monitored, reviewed and approved by the Board.

MDHB is a party to a "DHB Treasury Services Agreement" between NZ Health Partnerships Limited and participating DHBs. Refer to Note 6 for further details on this agreement. Funds with NZ Health Partnerships Limited is classified under "counterparties without credit rating".

Concentrations of credit risk for receivables are limited due to the large number and variety of customers. The Ministry of Health is the largest debtor at approximately 39.6% (2020: 42.5%). It is assessed as a low-risk and high-quality entity due to being a government-funded purchaser of health and disability services.

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

Credit quality of financial assets

The credit quality of financial assets that are neither past due nor impaired can be assessed by reference to Standard and Poor's credit ratings (if available) or to historical information about counterparty default rates.

	Actual 2021 $000	Actual 2020 $000
Counterparties With Credit Ratings		
Cash at bank and on hand, and investments:		
AA-	2,462	2,703
Total counterparties with credit ratings	*2,462*	*2,703*
Counterparties Without Credit Ratings		
Cash and cash equivalents:		
NZ Health Partnerships Limited - no defaults in the past	34,027	24,281
Receivables:		
Trade and other receivables	24,816	24,857
Total counterparties without credit ratings	58,843	49,138
Total	***61,305***	***51,841***

Liquidity risk

Management of liquidity risk

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

The group mostly manages liquidity risk by continuously monitoring forecast and actual cash flow requirements and maintaining an overdraft facility.

Contractual maturity analysis of financial liabilities, excluding derivatives

The table below analyses financial liabilities (excluding derivatives) into relevant maturity groupings based on the remaining period at balance date to the contractual maturity date. The amounts disclosed are the contractual undiscounted cash flows and include interest cash outflows.

	Carrying amount $000	Contractual cash flows $000	Less than 1 year $000	1-2 years $000	More than 2 years $000
2021					
Payables	49,040	49,040	49,040	-	-
EECA loan	-	-	-	-	-
Finance leases	1,120	1,276	260	260	756
Total	**50,160**	**50,316**	**49,300**	**260**	**756**
2020					
Payables	46,460	46,460	46,460	-	-
EECA loan	74	74	74	-	-
Finance leases	1,314	1,535	260	260	1,015
Total	**47,848**	**48,069**	**46,794**	**260**	**1,015**

24 Explanation of Major Variances Against Budget

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

Statement of comprehensive revenue and expense

Patient care revenue was $19.5 million higher than budgeted due to additional Ministry of Health funding, including specific funding received for Covid-19 related activities (see note 25).

Other operating revenue was $3.0 million higher than budgeted, mainly due to Enable revenue contracts and Ministry of Health donated equipment.

Personnel costs were $35.1 million higher than budgeted due to the increase in the Holidays Act 2003 remediation provision (see note 17).

Outsourced services were $13.9 million higher than budgeted, mainly due to higher than anticipated use of locum medical staff and higher than anticipated outsourcing of clinical services, including Covid-19 related activities (see note 25).

Clinical supplies were $6.2 million higher than budgeted, mainly due to higher than anticipated clinical need.

Infrastructure and non-clinical expenses were $5.4 million higher than budgeted, mainly due to an increase in costs associated with additional Enable revenue contracts and community pharmacy revenue, and increased facilities and maintenance contract costs, including costs associated with establishing Covid-19 vaccination facilities (see note 25).

Other operating expenses were $3.6 million higher than budgeted, $1.4 million of which was associated with the Holidays Act 2003 remediation project (see note 17).

Statement of financial position

Property, plant, and equipment was $59.8 million higher than budgeted due to the revaluation of land and buildings. This was partially offset by timing of capital expenditure projects being later than anticipated.

Intangible assets were $9.6 million less than budgeted due to the timing of capital expenditure projects being later than anticipated.

Trade and other payables were $5.6 million higher than budgeted mainly due to timing differences in contractor payments and revenue recognition.

Employee entitlements were $40.7 million higher than budgeted, $36.4 million of which relates to an increase in the Holidays Act 2003 remediation provision (see note 17). In addition to this Covid-19 related travel restrictions have continued to impact on the ability of staff to take annual leave which contributed to an increase in the annual leave liability.

Statement of changes in equity

The deficit was $34.0 million higher than budgeted due to the statement of comprehensive revenue and expense explanations provided above.

Property revaluation reserves were $82.2 million higher than budgeted due to the revaluation of land and buildings (see note 12).

Capital contributions from the Crown, being equity injections, were $13.7 million less than budgeted due to the timing of the SPIRE and mental health capital expenditure projects being later than anticipated.

Statement of cash flows

Cash and cash equivalents were $28.8 million greater than budgeted due to higher than budgeted revenue from the Ministry and lower than expected capital expenditure. This was

offset by lower than budgeted capital contributions from the Crown and higher than budgeted expenditure as per the explanations provided above.

25 COVID-19

On 11 March 2020, the World Health Organization declared a global pandemic as a result of the outbreak and spread of COVID-19 (a novel Coronavirus).

An Alert System was introduced by the New Zealand Government in March 2020 to manage and minimise the risk of COVID-19, and New Zealand went into a full lockdown of all non-essential services when the Government moved to Alert Level 4 on 25 March 2020.

On 15 March 2020, MidCentral DHB established an Incident Management Team (IMT) in response to the COVID-19 pandemic, and started working under the Emergency Operations Centre Standard Operating Procedures by establishing an Emergency Operations Centre (EOC). Business continuity plans were activated, and critical and non-essential services were identified for both the hospital and the community. Essential services were prioritised and both clinical and non-clinical staff were redeployed to support critical services.

The hospital was decompressed, and a designated COVID-19 ward was established. Clinical pathways were established for inpatients, outpatients and primary care, and testing stations and Community Based Assessment Centres (CBACs) were established. Clinical appointments were offered virtually, and any work that was noted to be a non-urgent clinical priority was deferred during Level 4. This significantly impacted on our planned care performance.

On 27 April 2020 New Zealand moved to Alert Level 3, and some elective surgery and non-urgent appointments were re-started.

Confirmed COVID-19 cases in the MidCentral DHB district remained relatively low and when New Zealand moved to Alert Level 2 on 14 May 2020 there were 27 confirmed cases and five probable cases of COVID-19 in our district.

On 18 May 2020 MidCentral DHB's EOC was stood down to partial activation, and on 8 June 2020 the country moved down to Alert Level 1. At this point the DHB and hospital moved back to normal working arrangements.

Following new cases of community transmission in the South Auckland region, on 12 August 2020 all areas of New Zealand outside of Auckland moved back to Alert Level 2. At this time there were no new cases of COVID-19 in the MidCentral DHB district, and no community transmission. This alert level remained in force until 21 September 2020 when our region dropped back to Alert Level 1. Further cases of community transmission were recorded in the Auckland region in February 2021 and our region moved back into Alert Level 2 until March 2021.

A nationwide Covid-19 vaccine rollout commenced during February 2021, and this continues to be a high priority for both the country and DHBs.

On 17 August 2021 New Zealand went into a Level 4 lockdown following the discovery of community cases of the highly contagious COVID-19 Delta variant in the Auckland region. MDHB’s EOC was reactivated, and all non-urgent care, including elective surgeries and outpatient appointments were postponed.

COVID-19 continues to be a serious global threat to public health, and New Zealand remains on high alert for any new outbreaks. Measures to contain the virus have significantly impacted on the world economy and the global markets remain sensitive.

COVID-19 specific funding has been received from the Ministry of Health, however costs were incurred in 2019/20 preparing both the hospital and the community for potentially hundreds of cases and multiple fatalities. In 2020/21 COVID-19 expenditure was largely funded by the Ministry of Health. While there is a certain amount of uncertainty surrounding the financial impact of any future outbreaks, we do not believe COVID-19 has impacted on MidCentral

DHB's ability to continue with its operations until the disestablishment expected on 1 July 2022.

Details of COVID-19 specific revenue and expenses are shown in the table below.

	Actual 2021 $000	Actual 2020 $000
Revenue		
Ministry of Health revenue	5,365	4,111
Other revenue	-	(126)
Total COVID-19 revenue	*5,365*	3,985
Expenditure		
Personnel costs	1,397	1,184
Outsourced personnel & support	179	70
Outsourced clinical services	1,877	878
Clinical supplies	83	343
Infrastructure & non-clinical supplies	1,232	1,993
Non-health-board provider expenses	698	3,275
Total COVID-19 expenditure	*5,466*	7,743
Net COVID-19 expenditure	**(101)**	**(3,758)**

26 Summary Cost of Services

	Actual 2021 $000	Budget 2021 $000	Actual 2020 $000
Revenue			
Prevention services	22,044	21,417	20,516
Early detection and management services	140,939	136,934	131,171
Intensive assessment and treatment services	424,611	412,546	395,183
Rehabilitation and support services	176,646	171,628	164,404
Funding not allocated – Funding Division surplus	23,576	22,522	13,922
Total revenue	*787,816*	*765,047*	*725,196*
Expenditure			
Prevention services	23,572	21,952	21,180
Early detection and management services	153,603	143,050	138,018
Intensive assessment and treatment services	462,620	430,838	415,682
Rehabilitation and support services	186,964	174,121	167,996
Total expenditure	*826,759*	*769,961*	*742,876*
Surplus/deficit	**(38,943)**	**(4,914)**	**(17,680)**

Deloitte.

INDEPENDENT AUDITOR'S REPORT

TO THE READERS OF MIDCENTRAL DISTRICT HEALTH BOARD'S FINANCIAL STATEMENTS AND PERFORMANCE INFORMATION FOR THE YEAR ENDED 30 JUNE 2021

The Auditor-General is the auditor of Midcentral District Health Board (the Health Board). The Auditor-General has appointed me, Bruno Dente, using the staff and resources of Deloitte Limited, to carry out the audit of the financial statements and the performance information, including the performance information for appropriations, of the Health Board on his behalf.

We have audited:

- the financial statements of the Health Board on pages 52 to 94, that comprise the statement of financial position as at 30 June 2021, the statement of comprehensive revenue and expense, statement of changes in net assets/equity and statement of cash flows for the year ended on that date, and the notes to the financial statements that include accounting policies and other explanatory information; and

- the performance information of the Health Board on pages 32 to 51.

Opinion

Qualified opinion on the financial statements

In our opinion, except for the possible effects of the matter described in the Basis for our qualified opinion section of our report, the financial statements of the Health Board on pages 52 to 94:

- 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 Health Board on pages 32 to 51:

- presents fairly, in all material respects, the Health Board'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 appropriations; 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 December 2021. 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 prior year financial statements were qualified due to uncertainties over the provision for holiday pay entitlements under the Holidays Act 2003

As outlined in note 17 on pages 82-84, the Health Board has been investigating issues with the way it calculates holiday pay entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues.

Because of the work required in the prior year to remediate these issues, we were unable to obtain adequate evidence to determine whether the Health Board's provision of $11 million as at 30 June 2020 was reasonable. We accordingly expressed a qualified opinion on the financial statements for the year ended 30 June 2020.

The Health Board made progress during the current year in estimating the amount of the provision. We obtained adequate evidence that the provision of $47 million as at 30 June 2021, is reasonable. However, until the process is completed, there are uncertainties surrounding the amount of the provision.

Our opinion on the current year's financial statements is qualified because of the possible effects of this matter on the comparability of the current year's provision and the 2020 provision due to the material difference between the two provisions.

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.

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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 qualified opinion on the financial statements and the basis for our opinion on the performance information.

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 58, which 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 Health Board 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 Health Board is reliant on financial support from the Crown

Note 1 on page 58, which outlines the Health Board's financial performance difficulties. There is uncertainty whether the Health Board will be able to settle its liabilities, including the estimated historical Holidays Act 2003 liability if they were to become due within one year of approving the financial statements. The Health Board therefore obtained a letter of comfort from the Ministers of Health and Finance, which confirms that the Crown will provide the Health Board with financial support, where necessary.

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

On pages 48 - 51 outlines the information used by the Health Board to report on its Covid-19 vaccine coverage. The Health Board uses the Health Service User (HSU) population data rather than the population data provided by Statistics New Zealand (Stats NZ), for the reasons set out in pages 50 - 51. The notes on pages 50 - 51 outlines that there would be differences in the reported results for the overall population if the Stats NZ population data was used. There would be further differences in the reported results of vaccination coverage if the Stats NZ population data is classified by ethnicity and age. The Health Board has provided a table that highlights the differences in the ethnicity groupings between the HSU population data and the Stats NZ population data.

Impact of Covid-19

Note 25 on page 93 to the financial statements and pages 48 – 51 of the performance information, which outlines the ongoing impact of Covid-19 on the Health Board.

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

The Board is responsible on behalf of the Health Board 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 Health Board for assessing the Health Board's ability to continue as a going concern. The Board is also responsible for disclosing, as applicable, matters related to going concern and using the going concern basis of accounting, unless there is an intention to liquidate the Health Board or there is no realistic alternative but to do so.

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 Health Board's statement of performance expectations.

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

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

- We identify and assess the risks of material misstatement of the financial statements and the performance information, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- We obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Health Board's internal control.
- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board.
- We evaluate the appropriateness of the reported performance information within the Health Board's framework for reporting its performance.
- We conclude on the appropriateness of the use of the going concern basis of accounting by the Board and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast a significant doubt on the Health Board's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements and the performance information or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Health Board to cease to continue as a going concern.
- 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 Health Board 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 Health Board 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 29 and pages 98 to 129 but does not include the financial statements and the performance information, and our auditor's report thereon.

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

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

Independence

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

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

Bruno Dente, Partner
for Deloitte Limited
On behalf of the Auditor-General
Hamilton, New Zealand

Wāhanga 3

Arotakenga o Te Pae Hauora o Ruahine o Tararua me te Kāwanatanga

Section 3

Overview of MidCentral DHB and Governance

GOVERNANCE STATEMENTS

Effective governance of a District Health Board requires a committed Board and robust systems and processes. On the following pages, MidCentral DHB's governance practices are detailed.

Meet the Board

The Board has 11 members, seven elected by the public and four appointed by the Minister of Health. Each Board member serves a three-year term. The latest DHB elections were held in October 2019. The 2019-2022 term for Board Members commenced on 9 December 2019. Profiles of the Board members for the 2019-22 term follow.

Brendan Duffy, Chairperson, ONZM, JP
Appointed Member | Commenced 2016

Horowhenua businessman, Brendan Duffy has been involved in local body government for 21 years, having served as Mayor, Horowhenua District Council from 2004-2016. During this time he was instrumental in establishing services for children and youth as part of inter-sectoral initiatives with the DHB, Police, Child, Youth and Family, Education and other government agencies.

Brendan was the vice president of Local Government New Zealand (LGNZ) for three years, Chairperson of the Provincial Sector of LGNZ for six years and Chairperson of Zone 3 for LGNZ for six years. Brendan initiated the Lake Horowhenua Accord, led significant infrastructure projects across the Horowhenua district including building the new council building, establishing Te Takeretanga o Kura-hau-pō community centre in Levin and Te Awahou Nieuwe cultural and community centre in Foxton, waste water and main street upgrades.

Committee membership: Chairperson of the Remuneration Committee. Member of the Finance, Risk and Audit Committee and the Health and Disability Advisory Committee. Brendan was the Board's Deputy Chairperson until his appointment as Chairperson in December 2019.

Interests: Local Government Commissioner; Trustee, Electra Trust; member, Ministry of the Environment's Environmental Legal Assistance Fund; and chairperson, Business Kapiti Horowhenua (BKH).

Oriana Paewai, Deputy Chairperson
Appointed Member | Commenced 2015

Oriana became involved in the health sector in 2001 when she joined MidCentral DHB's Public Health Service as a Health Promotion Advisor. Shortly after, she was appointed Māori Health Manager for MidCentral Health and in 2006 moved to the role of Health Manager, Te Kete Hauora o Rangitane (health and social service provider under Rangitane o Tamaki nui a Rua).

Oriana represents her iwi on many organisations, including Manawhenua Hauora which she currently chairs.

Committee membership: Chairperson of the Finance, Risk and Audit Committee, member of the Health and Disability Advisory Committee and Remuneration Committee. Oriana took up the role of Deputy Chairperson of the Board, from 2020.

Interests: Member, Te Rūnanga o Raukawa Governance Group; Chairperson, Manawhenua Hauora; co-ordinating chairperson, Te Whiti ki te Uru; member, Manawatū District Council's Ngā Manu Tāiko; member, Te Tihi o Ruahine Whānau Ora Alliance; Board member, Cancer Society Manawatū; appointed member, Massey University Council; trustee, Manawatū/ Whanganui Children's Health Charitable Trust Board; member, Governance Board, Mana Whaikaha.

Heather Browning
Elected Member | Commenced 2019

Heather has over 40 years' experience in the health and disability sector. She has been a physiotherapist, advocate, manager and consultant for disability services.

Committee membership: member of the Health and Disability Advisory and the Finance, Risk and Audit Committees.

Interests: Director, HB Partners Limited; Board member and Chair, HR Committee, Workbridge; Director Mana Whaikaha Ltd (resigned December 2020); member, Te Aho o Te Kahu (Cancer Control Agency) Consumer Reference Group; and Project Manager, Mana Whaikaha (Ministry of Health).

Vaughan Dennison
Elected Member | Commenced 2019

Vaughan Dennison has been a Palmerston North City Councillor for 18 years. His is particularly interested in ensuring the delivery of quality and accessible services and bringing services closer to home.

Committee membership: member of the Health and Disability Advisory Committee, Finance, Risk and Audit Committee, and the Remuneration Committee.

Interests: Councillor, Palmerston North City Council; member of Palmerston North City Council Infrastructure Committee.

Lew Findlay
Elected Member | Commenced 2019

Lew is a six-term Palmerston North City Councillor and has been involved with Grey Power and Age Concern. He is presently President of Grey Power and Coordinator of Palmerston North Van Inc. He has worked with people with mental health issues through the Shepherd's Rest Trust.

Committee membership: member of the Health and Disability Advisory Committee.

Interests: President, Manawatū Branch and Director Central District, Grey Power; Councillor, Palmerston North City Council; member, Abbeyfield; and vice president Manawatū Branch and board member of Grey Power New Zealand.

Norman Gray
Appointed Member | Commenced 2019

Norman Gray is lead doctor in the Emergency Department in Wairarapa Hospital. Before working for the DHB he spent time overseas gaining specialist skills and maintained a secondary career in the military and in disaster medicine. He was elected to the Wairarapa DHB in the 2019 elections.

Committee membership: member of the Health and Disability Advisory Committee.

Interests: Employee, Wairarapa DHB, and branch representative Association of Salaried Medical Specialists.

Muriel Hancock, JP
Elected Member | Commenced 2019

Muriel has more than 40 years' experience in the health and disability sector. During that time, she has worked at MidCentral DHB as a registered nurse with a lengthy period in District Nursing where she implemented the 24-hour service. Her final role, prior to leaving the DHB in 2018, was in a senior leadership role as Director Patient Safety and Clinical Effectiveness.

Committee membership: member of the Health and Disability Advisory Committee.

Interests: Sister is casual employee at MidCentral DHB; sister-in-law is employed as a registered nurse at Whakapai Hauora; and volunteer, MidCentral DHB Medical Museum.

Materoa Mar
Appointed Member | Commenced 2019

Materoa is the current Upoko Whakarae for Te Tihi o Ruahine Whānau Ora Alliance. A trained nurse, she has a background in Māori Mental Health and has been Chair of the Mental Health Foundation and on the Board of Directors of Te Rau Matatini. Materoa is of Ngā Puhi, Ngāti Porou, Te Roroa and Ngāti Whatua descent.

Committee membership: Deputy Chairperson of the Health and Disability Advisory Committee.

Interests: Employee of Te Tihi o Ruahine Whānau Ora Alliance; Chair, EMERGE Aotearoa; member, Matanga Mauri Ora; Chair, 'A Better Start – E Tipu Rea', National Science Challenge, Liggins Institute, University of Auckland; member of Māori Alliance Leadership Team, MidCentral DHB; and member of local Child and Youth Mortality Review Group.

Karen Naylor
Elected Member | Commenced 2010

Karen is a Registered Nurse, who has worked at the Palmerston North Hospital for 23 years. She is currently working in the women's health service. Karen is an active New Zealand Nurses Organisation workplace delegate.

Karen is a Palmerston North City Councillor.

Committee membership: member of the Health and Disability Advisory Committee.

Interests: employee, MidCentral District Health Board; member and workplace delegate, New Zealand Nurses Organisation; and Councillor, Palmerston North City Council.

John Waldon
Elected Member | Commenced 2019

John, who has a PhD in Māori Studies, served on the MidCentral DHB Clinical Board until he was elected to the DHB's Board in October 2019. John has been a Cancer Society volunteer for 20 years and is a member of the Paediatrics Society of New Zealand. He has been Vice-President of the Public Health Society of New Zealand and has held other health governance roles.

Committee membership: Chairperson of the Health and Disability Advisory Committee, member of the Remuneration Committee and the Finance, Risk and Audit Committee.

Interests: co-director and co-owner, Churchyard Physiotherapy Limited; co-director and researcher, 2 Tama Limited; and president, Cancer Society (Manawatū).

Jenny Warren
Elected Member | Commenced 2019

Jenny worked in banking and management and then spent 10 years working in maternal health as a pregnancy, childbirth and parenting educator – a service she leads across the MidCentral DHB area. She has served on the Maternity Clinical Governance Group at MidCentral DHB, the Maternal Morbidity Working Group at Health, Quality and Safety Commission and on the Koputaroa School Board of Trustees, the last two years as Board Chair.

Committee membership: member of the Health and Disability Advisory Committee.

Interests: employee, Barnardos, New Zealand; National executive committee member, On Track Network, Liggins Institute Auckland University; pregnancy and parenting education contractor, Palmerston North Parents' Centre; and member of Locality Advisory Group for both Tararua and Ōtaki/Horowhenua for the Primary Maternity Project.

The Role of the Board

The role and functions of the Board are broadly determined by the obligations as set out in legislation under which District Health Boards were established – the New Zealand Public Health and Disability Act 2000, and the subsequent amendments including the New Zealand Public Health and Disability (Planning) Regulations 2011, and the Crown Entities Act 2004.

The role and functions of the Board include:

- planning and purchasing health and disability services for the population of MidCentral DHB's district
- providing, or arranging for the provision of, health and disability services for its communities. These services include medical, surgical, women's health, child health, elder health, disability support, mental health, public health and related support services
- governing the District Health Board
- delegating management of the District Health Board to the Chief Executive
- approving major strategic and policy documents, including the Strategic Plan, Annual Plan, capital expenditure plan and operational budgets
- considering recommendations on key health and disability service issues, such as the findings of the health needs assessments and subsequent funding investment plan
- maintaining and developing an effective working relationship with Manawhenua Hauora, its iwi partner
- monitoring the implementation of the Annual Plan and budget, and ensuring all measures and initiatives are successfully achieved
- monitoring the operating performance of the DHB
- ensuring the District Health Board acts legally and responsibly on all matters
- appointing, evaluating and remunerating the performance of the Chief Executive.

The District Health Board has three statutory committees, being the Community and Public Health Advisory Committee, the Disability Support Advisory Committee, and the Hospital Advisory Committee. These committees work together, operating as the Health and Disability Advisory Committee.

The DHB also has a Finance, Risk and Audit Committee and Remuneration Committee. An Enable New Zealand Governance Group was in place to monitor the performance of Enable New Zealand, a division of the DHB. This committee was wound up on 30 November 2018, with oversight of Enable New Zealand now being carried out by the Health and Disability Advisory Committee.

These committees and their principal functions are outlined below.

The Finance, Risk and Audit Committee

- Ensures appropriate reporting processes are in place to monitor the DHB's financial and commercial affairs
- Monitors the overall financial performance of the DHB, including capital expenditure
- Ensures quality improvement at a system level is monitored
- Ensures there are integrated systems of governance to actively manage patient safety and quality risks

- Monitors and reviews the identification, assessment and prioritisation of enterprise risk, including elimination or mitigation of risk
- Provides assurance that all audit processes required by statute are completed, and that there is an effective internal control environment and assurance programme in place
- Ensures all issues identified by audit are appropriately remedied and contribute to ongoing business improvement
- Ensures the DHB is complying with all relevant statutory, regulatory and policy obligations
- Reviews and advises on aspects of the DHB's annual plan and budget related to risk, finance, safety and quality.

The Health and Disability Services Advisory Committee

- Advises on the needs, including the disability needs, of the district and priorities for funding
- Leads the development of strategies and plans to enable better health outcomes and better health care, and to advance the DHB's vision and strategic framework
- Ensures the DHB's strategies and plans are focused on achieving equity of outcomes
- Ensures the DHB's service interventions and policies maximise overall health gain
- Ensures the DHB's disability support services and policies promote the inclusion and participation in society, and maximise the independence of people with disabilities
- Ensures consumers and/or carers are supported to actively participate in improving the patient experience and patient health outcomes
- Promote and encourage people and whānau to manage their own health and wellbeing
- Support and foster whole-of-system changes for the planning and delivery of health and disability services
- Support and encourage partnership and inter-sectoral involvement in planning
- Monitors the financial and operational performance of service clusters and hospitals of the DHB, and assesses strategic issues relating to these.

Remuneration Committee

- Provides advice on employment matters relative to the Chief Executive, including recruitment, conditions of employment, and remuneration
- Monitors the performance of the Chief Executive
- Considers the DHB's Remuneration Strategy, Policy and Annual Remuneration Parameters for staff employed on Individual Employment Agreements (IEAs)
- Considers any recommended changes to the remuneration packages for the Chief Executive's direct reports that exceed the IEA parameters.

Board and Committee Membership

There are 11 Board members, who collectively possess a broad range of skills, knowledge and experience. Seven of these members are elected through the triennial local government elections, and four are appointed by the Minister of Health. In making the appointments, the Minister ensures any skills gaps are met, including a minimum of two Māori Board members. The election term is for three years. The last DHB election was held in October 2019, linked to the local body election process, and the new Board took office on 9 December 2019.

Membership of the Board's committees is reviewed three-yearly. Board members make up the majority of committee members, and the Board uses its legislative power to appoint additional members to assist each Committee to carry out its role. The three-year appointment term of external committee members has been timed to commence one year after the election of Board members to enable continuity of governance through the DHB election process. Board membership of the Committees is reviewed as part of the triennial board election process.

External committee members during 2020/21:

Health and Disability Advisory Committee	**Finance, Risk and Audit Committee**
Gail Munro	Simon Allan Tony Hartevelt

Board and Committee Member Attendance

Board and committee member attendance for 2020/21 is set out in the following table. This lists the name of the Board and Committee meetings, with the number of meetings held noted in parentheses.

Board	Board (10 meetings)
FRAC	Finance, Risk and Audit Committee (8 meetings)
HDSAC	Health and Disability Services Advisory Committee (6 meetings)
Rem	Remuneration Committee (3 meetings)

Board Members	Board	HDSAC	FRAC	Rem
Browning, H	10	6	7	
Dennison, V	10	6	8	3
Duffy, B	10	6	8	3
Findlay, L	10	6		
Gray, N	6	1		
Hancock, M	10	6		
Mar, M	8	6		
Naylor, K	9	6		
Paewai, O	8	5	4	1
Waldon, J	10	6	8	2
Warren, J	10	6		
Committee Members				
Allan, S			6	
Hartevelt, T			8	
Munro, G		5		

Shaded boxes – not a member

Ministerial Directions

Under Section 151(1)(f) of the Crown Entities Act 2004 ("the Act"), the DHB is obliged to state in its Annual Report any new direction[32] given to it by a Minister in writing under any enactment during that financial year, as well as other such directions that remain current.

There were no new Ministerial Directions in the 2020/21 year, but the following Directions remain relevant:

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

[32] "Direction" is defined in the Act as "a direction given by a Minister under this Act or the entity's Act to an entity or to a member or employee or office holder of an entity (for example, a direction on government policy, a direction to perform an additional function [issued under section 112 of the Act], or a direction relating to the entity's statement of intent).

BEING A GOOD EMPLOYER

MidCentral DHB takes its role as an employer seriously and invests a lot of resources and time into our people – both on a group and individual basis.

MidCentral DHB's refreshed People Plan supports the DHB's strategic direction, vision and values which are now well embedded within the organisation. This plan outlines the work environment we seek to provide for our people to enable them to be successful in their roles, and in their careers, and to maximise the contribution our people make as a key enabler to the achievement of this plan.

As a result of MDHB's 2020 staff engagement survey results, two priority areas were identified at an organisational level - health and wellbeing, and employees feeling valued and recognised. In response to this feedback MidCentral DHB initiated three key responses which included establishing an Awards and Recognition Group, developing a Psychosocial Wellbeing Strategy, and requesting each Directorate puts in place an engagement action plan at team level to address the team's survey results.

We are committed to working with Māori to build strong connections with whānau, hapū and Iwi to bring about quality living, healthy lives, well communities, and achieve equitable health outcomes for our Māori population. A Māori health equity dashboard has been developed and provides governance with a monitoring system that focuses on the DHB's performance in specific areas where improvements in Māori health is required.

MidCentral's Pae Ora Paiaka Whaiora Hauora Māori directorate (Pae Ora) is partnering with the DHB's clusters/directorates to implement equity focused workforce roles. These partnership roles encapsulate the intent and commitment of directorates such as Te Uru Rauhī (Mental Health and Addiction), Te Uru Mātai Matengau (Cancer Screening, Treatment and Support), Te Uru Pā Harakeke (Women, Children and Youth) to give effect to the Articles of Te Tiriti o Waitangi with a shared approach to improve the outcomes for Māori experiencing the challenges of access to services.

As a DHB we are actively promoting a shift towards inclusivity in our employment practices and workplace culture. We continue to support staff networks that represent diversity and minority groups to lead programmes and initiatives in this space and we run a range of events and promotional activities centrally each year.

Key measures around our workforce are closely monitored, and the DHB works in partnership with unions and staff to continue to improve our working environment.

COVID-19 had a significant impact on MidCentral DHB and its operations. MidCentral established an Incident Management Team to manage all aspects of hospital and community based health functions. This team was operational for several months and during this time developed four Incident Action Plans to coincide with the scaling up/down of National Alert Levels and to support the health and disability system's pandemic response activities. The DHB remains focused on supporting our staff, and our communities are in a state of readiness should a resurgence of the virus cause Alert Levels to change in our district.

Workforce profile

Over 2,700 people work for MidCentral DHB equating to 2,402.5 full time equivalents (FTEs). The majority of these people work as health professionals. The profile of our staff is set out below:

Ethnicity Profile	FTEs	Age Profile	FTE	Head Count
NZ European	1345.5	15 – 19	1.0	1
NZ Māori	215.7	20 – 24	86.9	98
European	168.8	25 – 29	278.5	304
Pacific	34.5	30 – 34	279.6	325
Asian	378.4	35 – 39	263.8	311
Other	229.8	40 – 44	229.0	271
Not Stated	30.0	45 – 49	229.9	265
Total	**2402.5**	50 – 54	279.6	320
		55 – 59	303.3	343
		60 – 64	295.8	342
Disability Profile	**Head Count**	65 – 69	124.4	153
Yes	39	70+	30.8	40
Not Stated	2734			
Total	**2,773**	**Total**	**2402.5**	**2773**

Good Employer Policies and Practices

There are seven elements to being a good employer. Examples of some of the work we've undertaken over the 2020/21 year is outlined on the following pages together with the policies and practices relating to each of these elements.

1 Leadership, accountability and culture

MidCentral DHB's Strategy

MidCentral's Strategic Framework is supported by our organisational development plan, which sets out a clear vision and programme of work for the next three to five years to create the required work environment for our people, focused on the following key themes:

- A positive and productive working environment, driven by a values based, patient centred culture
- Credible, capable and engaged leadership that is strongly connected with the teams they lead
- A sustainable workforce that meets both current and future capability and capacity needs, and is reflective of the communities we serve
- A capable, accountable, empowered and supported workforce, where diversity is supported and embraced
- Working together, better and smarter to drive system-level improvements in healthcare.

When developing our People Plan we also used the wealth of information derived from the staff safety culture surveys and from other workshops and forums held with staff, including engagement with our union partners. Our People Plan is updated regularly to take account of feedback from staff and to incorporate the findings of our annual staff survey.

Most of our senior and clinical leaders have attended a specific leadership programme. This programme includes a full 360° assessment and feedback process to inform individual development plans. An executive coaching process has been put in place to support our senior leadership development plans. The leadership framework that guides and directs this is underpinned by the leadership success profile as published by the Public Service Commission.

Acknowledgement of Māori culture and tikanga also influences how we engage, work and practice within our organisation. We will ensure that we uphold the Treaty of Waitangi through developing Māori employee experiences, recognising Māori aspirations and mātauranga Māori and enabling a whānau-centred culture that influences and creates positive outcomes for Māori. Cultural identity and access to te Ao Māori will be enhanced through our commitment to standing up to racism within our organisation. We will ensure that all employees have the support and tools required to feel culturally confident.

Transformational Leadership Programme

Leadership development is well recognised as an essential component of safe and effective care, improved staff satisfaction, succession planning and staff retention.

The Transformational Leadership Programme (TLP), established in 2009, blends

theory and experiential learning so that staff are equipped with the knowledge and skills to apply models and frameworks in their workplace at the end of the programme.

This is supported by access to coaches for the duration of the programme to support integration of theory and practice and the completion of an adaptive change project. As at 30 June 2021, over 560 participants have completed the programme.

MidCentral also participates in the internationally recognised 'Leading an Empowered Organisation' (LEO) programme, using a mixture of evidence-based learning, practical exercises, storytelling and reflection. It is an intense three-day programme with a one-day follow-up two to three months after completion of the course for reflections and presentation of a clinical improvement project.

A leadership programme is also in place for our emerging leaders and those in their first leadership role. This programme is well attended and most employees then take up the Transformational Leadership programme which builds on the learnings from this programme.

Ngā Manukura o Apopo

Māori nurses have been supported to attend, and have graduated, Ngā Manukura o Apopo and Kurawaka a Māori Nursing and Midwifery Leadership programme held at Turangawaewae Marae, Ngāruawāhia. These Māori leadership programmes were wananga based and look at growing the skills and leadership capabilities through a mātauranga Māori worldview. There is a commitment to clinical leadership and supporting the professional leadership as tomorrow's leaders.

Formal Policies and Procedures

- Equal Employment Opportunities Policy
- Disclosure of Serious Wrongdoing Policy
- Organisational Koha Policy
- Code of Conduct (MidCentral DHB's shared approach to work principles, and State Services Commissioner's standards of integrity and conduct)
- Confidentiality Policy
- Fraud, Theft and Corrupt Actions Prevention Policy.

MidCentral DHB Response

- MidCentral DHB's People Strategy
- MidCentral DHB's Kaimahi Ora, Whānau Ora Māori Health Workforce Development Strategy and Implementation Plan 2017 – 2022
- Te Wao Nui a Tāne–Pu Rongoa overarching mātauranga Māori approach to organisational strategy and structures
- Clinical governance structures (DHB-wide, primary, and secondary)
- Consumer and Clinical Councils providing an independent perspective on health services have been established
- Professional leadership structure, including professional advisory roles and reference groups
- Clinical leadership framework for MidCentral DHB
- Clinical management partnership structure within MidCentral DHB
- Leadership development programmes (MidCentral DHB and joint DHB/THINK Hauora)
- Treaty of Waitangi training

- Cultural Competency in Practice workshops
- MidCentral DHB Bicultural Model of Care
- Emerging leadership programme
- Leadership coaching in place
- Combined union/management meetings with a partnership focus – work plan in place
- Commitment to Equal Employment Opportunities – member of the Diversity Works NZ Employer Group
- Human Resources Manual (on-line)
- Human Resources update "blog" for team leaders
- Regular staff forums and workshops
- Consultation with staff over major service changes
- Clinical leadership of major projects, such as clinical networks
- Clinical leadership forms part of the Chief Executive Officer's and senior management's performance measures
- Internal communication framework, including forums, staff newsletters, and updates
- Regular reporting to Board regarding workforce plans and progress being made.

2 Recruitment, Selection and Induction

During 2020/21 we continued to have low vacancy levels across most health professional groups. However, like most DHBs we are experiencing difficulties in recruiting to some positions, for example, Radiologists, Psychiatrists and Midwives. We undertake targeted recruitment initiatives when needed and have been successful in making offers to some of these positions and have secured locums where possible to cover roster gaps. Overall, our medical vacancies have decreased as a result of the initiatives we have in place.

To meet current demand for planned and acute surgical and cardiac care, the DHB is implementing the Surgical Procedural Interventional Recovery Expansion (SPIRE) programme. This programme requires increased staffing across medical, nursing and allied health. A recruitment plan is in place to ensure the staffing requirements are met. This includes both local, national and overseas recruitment drives.

We also work closely with our Central Region DHB partners and the Ministry of Health's Health Workforce Directorate in implementing the workforce programme outlined in the Central Region's Regional Service Plan.

Our Kaimahi Ora, Whānau Ora Māori Health Workforce Development Strategy and Implementation Plan informs, guides and supports the active recruitment, retention, and competence of Māori and non-Māori staff across the district aimed at creating culturally responsive and engaging environments for Māori whānau.

The DHB's Pae Ora Paiaka Whaiora Hauora Māori directorate (Pae Ora) actively supports staff new to the organisation to participate in the DHB's Powhiri process alongside Pae Ora Tikanga and Cultural Facilitators. Staff have the opportunity to visit Te Whare Rapuora, the onsite marae style accommodation for whānau, where they are introduced to the concept of equity and informed about how the Pae Ora Whānau Care team works to support whānau and staff while at MidCentral DHB.

Pathways to Developing the Māori Health Workforce Capacity

Pae Ora has further developed their relationship with Massey University and Universal College of Learning (UCOL) over the past few years, collectively looking at opportunities to support and develop students to understand and gain an insight into clinical and cultural competency within the DHB. These opportunities have led to Pae Ora participating in first year Powhiri with Massey and providing support for lectures on nursing fundamentals framed around Te Whare Tapa Whā and Kawa Whakaruruhau.

Massey University has also extended an invitation to Pae Ora as stakeholders around curriculum development and placements for the Master of Clinical Nursing programme. This engagement helps to ensure that the programme addresses and integrates Māori health in a regional and national context that supports the nursing workforce in bicultural practice.

Massey University's Puhoro STEM Academy is another key component of Te Ara Māhuri pathway for Year 11, 12 and 13 rangatahi Māori. STEM stands for science, technology, engineering, and math. The cohort remains part of the Puhoro programme for all 3 years before rangatahi graduate.

Pae Ora engages with UCOL to strengthen and support Māori student experiences on placement. Students are extended an invitation to attend Te kāhui kāore nama I te korero. The Māori nurses' forum provides an opportunity where they can be connected with Māori nursing role models. Māori nurse leaders provide workshops, discussions and whakawhanaungatanga across the community, Māori and iwi providers and the DHB. The Māori nursing forum is an excellent opportunity to promote "Te Ara Māhuri"- the pipeline for rangatahi into health while building a network and growth opportunities for new and emerging Māori nursing professionals.

Pae Ora also works in partnership with Kia Ora Hauora to actively engage rangatahi/youth into health as a profession. Students can be connected with the Kia Ora Hauora programme, which offers support for scholarship applications, transition to work payments and other resources that may be required to enable successful completion of their tertiary student education and placements.

Kia Ora Hauora provides an entry point for Te Ara Māhuri and targets rangatahi from Year 9 to Year 13 who have an aspiration for a career in the health sector. Central Region's Kia Ora Hauora programme provides a grant to DHBs to organise and support Y13 rangatahi in the six-week Kia Ora Hauora Summer Internship programme. This year the summer internship was undertaken by two Year 13 scholarship recipients, who worked alongside Pae Ora and other health professionals at the DHB enabling them to gain first-hand experience and develop their knowledge and networks with the health community.

The Careerforce Gateway programme is also part of the Te Ara Māhuri pathway. Careerforce has established the course outline, unit standards for Year 13 rangatahi/secondary school students from the Manawatū who are pursuing a career in health. This programme is a first for MidCentral DHB.

Nursing and Midwifery

Implementation of our Nursing and Midwifery Workforce Plan and our Nursing and Midwifery Recruitment and Retention Plan continues. Both these plans guide the development of the DHB's nursing and midwifery workforce that reflects our community demographics, is sustainable, highly qualified and appropriately

credentialed so that we can respond to the changing needs of our communities.

Pae Ora also partners with Nga Manu Teka – Education and Practice Development team to support the recruitment of Māori graduates for the Nursing Entry to Practice and New Entry to Specialist Practice programmes.

Formal Policies and Procedures

- Nursing and Midwifery Recruitment and Retention Plan
- Kaimahi Ora, Whānau Ora Māori Health Workforce Development Strategy and Implementation Plan 2017 - 2022
- Recruitment/appointment policy
- Appointment of honorary staff policy
- Orientation policy
- Core skills policy
- Child/young person abuse and/or neglect 'child in need' policy – pre-employment screening procedures for safety checking of newly employed or engaged core and non-core children's workers, in accordance with the Vulnerable Children's Act.

MidCentral DHB Response

- Participation in local Manawatū careers events – some activities postponed due to COVID-19
- MidCentral DHB Careers in Health days (annual) for secondary school students – postponed due to COVID-19
- Visiting schools within MidCentral DHB's district to talk about careers in health has continued
- A return to nursing and midwifery session was held which resulted in several nurses and midwives returning to practice
- Training placement site for Universal College of Learning (UCOL) and Massey University students: nursing, midwifery, social work, clinical psychology and medical radiation therapy
- Nursing and midwifery entry to practice programme
- Midwifery education grants
- On-line recruitment available
- Internal recruitment bulletin on-line
- Administration recruitment assessment tools
- Recruitment and selection education programmes
- Medical Administration Unit – a one-stop-shop for medical recruitment and support to Resident Medical Officers and Senior Medical Officers
- Medical Recruitment Consultant provides on-boarding
- Nursing recruitment coordinator provides on-boarding, specifically for nursing and midwifery
- Central resource of promotional material
- MidCentral DHB orientation programme and Powhiri
- Targeted overseas recruitment drives for shortage specialties
- Accredited training hospital for first year house officers and registrars in most specialties
- General practice rotations for Resident Medical Officers
- Outreach site for University of Otago Wellington Clinical School providing clinical placements for final year medical students

- Physiotherapy Clinical Hub (in conjunction with University of Otago) to provide clinical placements for final year physiotherapy students
- Family Violence Intervention training for all MidCentral DHB staff working with children and women.

3 Employee Development, Promotion and Exit

Over the past year, MidCentral DHB held internal education sessions that were attended by over 1,452 staff members (some staff attend more than one session). Those completing online learning programmes totalled 1,982.

Senior Medical Officers are able to take sabbatical leave for the purposes of strengthening or acquiring clinical knowledge or skills.

Throughout the year, staff leave to take up new roles, move location, or retire. Exit interviews are offered to all staff so that we can learn what they liked or did not like about working at MidCentral DHB. This information is very useful and used to improve the working environment for our current staff. We have an Alumni programme in place to keep connected with past employees.

Building Resilience

MidCentral DHB's building resilience and managing stress workshops have continued to be very well received. Those who have attended report they can apply their learnings to their home and working lives.

Communication

The communication education sessions continue to be very well attended. These three communication modules which build on each other can be attended separately or as a series. Due to demand, extra courses have been put in place. All MidCentral DHB staff are eligible to attend and the sessions are appropriate to all staff. Excellent feedback has been received from those attending these sessions including staff providing examples of how they have put their learnings into practice.

The programme 'Keeping Safe at Work' which was targeted specifically to frontline staff who may deal with aggressive or other behaviours have been well attended as has the programme 'Delivering Excellence in Customer Service' and 'Defusing Challenging Situations'.

An eLearning Platform

Our e-Learning platform Ko Awatea is well utilised by our staff and we are steadily increasing the modules on the site. This enables staff to complete education and professional development at a time which is suitable for them, rather than attending a planned face-to-face session.

Cultural Responsiveness and Treaty of Waitangi

Māori cultural responsiveness is a MidCentral DHB priority to ensuring we address inequity of health service provision and therefore achieve health outcomes for Māori as promised by the Te Tiriti o Waitangi. Our approach is to support staff through effective appropriate training opportunities to create self-confidence and competence in Māori cultural best practice and give guidance to where more appropriate solutions may be found outside the staff/service capacity or capability.

Formal Policies and Procedures

- Performance Management Policy
- Core Skills Policy
- Continuing Education/Professional Development/Sabbatical Leave Policy
- Management of staff surplus Policy
- Retirement/Farewell Functions Policy
- Credentialing of Senior Medical and Dental Officers Policy.

MidCentral DHB Response

- People Strategy
- Regional post graduate training hubs
- Online exit interviews
- Alumni programme
- Professional development and recognition programme (PDRP) accredited by the New Zealand Nursing Council
- Accredited medical training institution
- MidCentral DHB internal education and development programme
- Cultural responsiveness education
- Treaty of Waitangi education
- Education and development steering group
- Performance management education programmes
- Customer service and communication sessions
- Building resilience and management stress sessions
- Defusing Challenging Situations
- Delivering Excellence in Customer Service
- Dedicated recruitment advisors (nursing and medical)
- On-site library facility
- Yourself portal (direct staff access to their education and development information)
- Education/development fund for all major staff disciplines
- Centralised process in place for external education and development approval – ensures fairness and equity across MidCentral DHB.

4 Flexibility and Work Design

The vast majority of MidCentral DHB's staff work in a 24/7 environment and this provides greater scope for us to agree work hours and shifts that suit their personal situation while at the same time delivering care on a 24/7 basis. Around 40 percent of our employees work part time.

MidCentral DHB's Flexible Working Arrangements guideline provides a transparent and consistent approach across the organisation and provides the opportunity for employees to request flexible working arrangements.

Good progress is being made as MidCentral DHB continues to implement the Care Capacity Demand Management programme which is a set of tools and processes that assist in matching care with patient demand.

The move to a wireless campus is also having a positive impact. More staff are being equipped with mobile devices which gives them much more flexibility to manage the administrative part of their job.

A vast proportion of written communication is now electronic and the ability to stay

on top of this without having to return to the work station in their office makes a huge impact for many staff, both clinical and non-clinical.

Care Capacity Demand Management (CCDM)

The CCDM programme continues to be rolled out across our nursing workforce with plans in place to implement for midwifery and allied health as soon as possible. The goal of CCDM is quality patient care, quality work environment and best use of health resources. A CCDM Governance Council led by the Executive Director Nursing and Midwifery is in place to oversee the programme. Our union partners are part of this. The results of CCDM inform the FTEs required for our nursing workforce that have implemented the programme.

Integrated Operations Centre (IOC)

Our IOC is an enabler to our clusters with responsibility for delivering day-to-day facility management (including 24-hour cover and on call management), patient flow and bed management support to all clusters.

Formal Policies and Procedures

- Work and Family Policy
- Impaired Staff Policy.

MidCentral DHB Response

- Rostering module
- Implementing care capacity and demand management programme – good progress is being made
- Flexible work guidelines
- Rostering guidelines
- Nursing staff bureau (enables flexible working arrangements)
- Releasing time to care, and productive ward programmes
- Investing in digital technology, including iPads and phones
- Web-based collaboration sites for staff enabling local and inter-organisational collaboration.

5 Remuneration, Recognition and Conditions

Leave management

The focus continues to be on reducing annual leave balances to allow our employees the opportunity for rest and recreation, and to enjoy regular breaks from the workplace.

While progress is being made to reduce the proportion of staff with accrued annual leave balances in excess of two years, it is acknowledged that this is taking longer than expected to achieve. COVID-19 continues to have an impact on our annual leave as many of our staff who would usually travel overseas are no longer able to do so.

We have taken numerous steps to address our high leave balances, for example, specific reporting has been introduced to assist managers to monitor and manage leave and leave management plans are in place for those staff with high leave balances. Where appropriate temporary staff will be recruited to enable leave to be taken.

We are taking a 'wellness' approach to supporting staff when sick leave usage is higher than usual.

Employment Agreements

The majority of staff (93%) have terms and conditions covered by transparent multi-employer collective agreements (MECA) which ensure consistency and relativity of remuneration and conditions across the NZ public health sector. For those on individual employment agreements (IEAs), the annual review is based on external market data and is in line with the Government's Expectations for Pay and Employment. Job size is determined using a job evaluation methodology. Ministry of Health support for both MECA and IEA strategies is secured.

Formal Policies and Procedures

- Annual Leave Policy
- Management of Employee Absences Policy
- Bereavement/Tangihanga Leave Policy
- Casual Employment Policy
- Leave Without Pay Policy
- Superannuation Policy.

MidCentral DHB Response

- Individual employment contracts (reviewed annually)
- Multi-employer collective agreements
- Nurses' prizegiving
- Annual Christmas function held for staff
- Professional work days recognised, such as International Nurses' Day, Administration Appreciation Day
- 'Yourself' portal, providing staff direct access to their remuneration information.

6 Harassment, Bullying and Unacceptable Behaviour Prevention

MidCentral DHB seeks to create an environment where our values (compassion, courage, respect, and accountability) define and drive the way we conduct ourselves, the way we interact with our patients, their families and carers, other healthcare providers, other key stakeholders, and with each other. We are committed to taking action to improve the work environment for our people and acknowledge that this will require investment and courage to achieve. Key strategies to support this are contained in our People Strategy.

MidCentral DHB's Preventing Unacceptable Behaviour, Harassment and Bullying policy, and Code of Conduct gives guidance to employees on the standards of performance and conduct required, and employees are expected to uphold the DHBs values and Shared Approach to work principles.

The results of our recent staff survey will also inform our approach to ensuring that our workplace is free from bullying and unacceptable behaviours by implementing additional strategies if needed.

Quality and Safety in our Workplace

A programme to strengthen quality and safety in our workplace is now well imbedded within the organisation. The programme addresses behaviours which undermine quality and safety and enables all staff to feel comfortable in speaking up, and support our values of being compassionate, courageous, respectful and accountable. We have partnered with an external organisation to implement this programme which:

- supports our values and address individual behaviours that undermine these
- has been developed by clinicians
- builds a high-performance culture of safety and reliability.

All staff are encouraged to attended education sessions. An overview of the programme is delivered to new employees at Orientation and the programme is well used by our staff.

Employee Assistance Programme

MidCentral DHB continues to offer an independent Employee Assistance Programme (EAP) to all staff. This is provided free-of-charge and staff can self-refer or can be referred (formally or informally) by their manager. EAP is well utilised by our staff. The majority of referrals are for personal issues, such as relationships, anxiety and family.

Formal Policies and Procedures

- Shared Approach to Work Principles Policy
- Speaking up for Safety and Promoting Professional Accountability Programme Policy and Guidelines
- Preventing Unacceptable Behaviour, Harassment and Bullying Policy
- Code of Conduct Policy.

MidCentral DHB Response

- People Strategy
- Speaking up for Safety Programme
- Employee Assistance Programme (EAP)
- Process for escalation of issues
- Team development programme
- Designated support people for all major professional groups (medical, nursing, allied health, clerical, midwifery)
- Occupational Health and Safety Unit
- Human Resource Department.

7 Safe and Healthy Environment

MidCentral DHB seeks to provide an environment that ensures the health, safety and wellbeing of its staff, visitors, patients and other organisations and contractors. It aims to build a culture where all employees feel that their contribution is valued

and appreciated. In doing this we comply with the requirements of the Health and Safety at Work Act 2015, and demonstrate our commitment to providing a work environment that is free from harm. We have a focused health and safety strategy that provides a framework to achieve the highest standards of work health, safety, health prevention and wellbeing.

In consultation with our union partners, our staff and other key stakeholders, our Health and Safety Strategy and Plan sets the direction to:

- improve governance, leadership and awareness of workplace health, safety and wellbeing that supports a positive safety culture across all areas of the DHB
- improve staff engagement on matters related to health and safety
- develop and implement meaningful initiatives and programmes to prevent harm and promote health and safety in the workplace.

Some of the key initiatives undertaken to strengthen our safety culture are:

- We have revised our Worker Participation Agreement with our union partners
- Increased the numbers of health and safety workplace inspections
- Strengthened our reporting to the Board and Board Committees
- Introduced Health and Safety Awards
- Increased the visibility of our Board and senior management by introducing structured quality and safety walk-arounds
- Provided a platform to connect all Health and Safety Committees.

Progress against our Health and Safety plan is analysed and appropriate action taken when needed.

As part of our People Strategy, MidCentral DHB has recognised the importance of creating a supportive and inclusive workplace environment for staff who are part of diversity and minority groups. We are actively promoting a shift towards inclusivity in our employment practices and workplace culture. We continue to actively support staff networks that represent diversity and minority groups to lead programmes and initiatives in this space and we run a range of events and promotional activities centrally each year. Education for staff that supports cultural competence and LGBTQ+ inclusivity continues to be delivered regularly and accessible online modules are being developed by MidCentral DHB staff that will be shared with DHB's nationally once complete.

Health and Wellbeing

The MidCentral District Health Board's approach to health and wellbeing was completely reviewed during the 2020/2021 period. It was decided that a holistic approach will be undertaken based on the core principles of Te Whare Tapa Whā, based on feedback from staff. This approach will further advance inclusive and diverse workforce approaches with the vision to create both a psychological and physical safe environment for our staff. Driving a core staff experience characterised by staff feeling 'safe with us' – Haumaru ki a tatou. Initiatives under investigation to progress a holistic psychosocial wellbeing approach include:

- Implementation of the Occupational Violence Prevention Strategy
- Micro skills for managers to feel confident supporting psychosocial wellbeing of staff
- Metrics to assess distress, wellbeing and/or resilience

- Connect principles of wellbeing and resilience into coaching and mentorship networks
- Set-up self-assessment and self-care resources across all elements of Te Whare Tapa Whā
- Consistent organisational critical stress incident response process
- Investigate opportunities to establish evidence-based Wellbeing Officers training programmes to establish a capable peer support network
- Education and awareness programmes (unconscious bias, restorative relationship practices, bullying, harassment prevention).

These organisational initiatives, investigations, frameworks and programmes will be run and quality checked through an already established working group of subject matter experts, the Wellbeing and Psychosocial Response Working Group.

An Awards and Recognition working group was also established. This group is pivotal in developing a framework to consistently approach awards and recognition across the organisation, for example, these include values awards, daisy awards, long service recognition awards and the development of informal recognition guidelines for leaders.

In response to those employees who may be experiencing or affected by family violence/harm the organisation has put in place policies and procedures which provide a work environment in which employees can safely seek support about their concerns related to family violence/harm. Most managers have attended education sessions on how to recognise, respond and support their staff. Family Violence Support people are also in place to be able to listen and respond to those disclosing harm to them.

A culture of engagement is also in place at a team level. An engagement action planning toolkit has been developed and introduced within each Directorate. This process is designed to encourage people to be involved in engagement activities by exploring the impact of those put in place at an individual, team, leadership and organisational level.

MidCentral DHB is very proud of its healthy staff programme, which offers a range of activities and benefits to all staff, for example:

- MidCentral DHB's Staff at MidCentral Advantage Scheme (SMASCH) continues to be developed and is very well received by staff. A good number of new organisations continue to join the scheme.
- As part of valuing our staff an end of year function is held. This provides the opportunity for recognising and acknowledging the work of our staff. These functions are very well received by all.
- A number of other healthy staff activities are held, for example, Sports Manawatū programmes are promoted throughout the year.

MidCentral DHB's Occupational Health and Safety team is very active in ensuring the needs of employees are met both on appointment and on an ongoing basis.

The team takes every opportunity to explore and provide employment opportunities for those with disabilities. As a provider of health and disability services, we have immediate access to in-house resources who can make assessments as to what reasonable accommodation can be made to meet the specific needs of employees with disabilities. An example of this resource is our Occupational Health Physician and the Occupational Health Unit team, which includes an Occupational Health Physiotherapist and an Occupational Health Nurse.

If a potential employee has uncertainties about their ability to fulfil a particular role, they are advised that MidCentral DHB welcomes the opportunity to discuss how the organisation can make every reasonable accommodation to meet their needs. They are also advised that they are welcome to discuss their needs with members of the Occupational Health and Safety Unit, Infection Prevention and Control or the Human Resource Department.

Where a problem is identified with either the employee or the workplace, which makes it difficult for an employee to continue to fulfil their role within the organisation, staff within the relevant department works with the employee (and their support person/union representative) to address any concerns raised.

Formal Policies and Procedures

- Health and Safety Policy
- Responsive Workplace (Family Violence/Harm) Policy and Guidelines
- Manual Handling Injury Prevention Policy
- Incident Reporting Policy
- Nutrition and Physical Activity Policy
- Safe Staffing Policy
- Smokefree Policy.

MidCentral DHB Response

- ACC Partnership Programme
- Care Capacity Demand Management programme
- Employee Assistance Programme
- Free seasonal influenza immunisation, Healthy food choices (staff café), Pilates, smoking cessation support
- No-lift policy and training
- COVID-19 vaccinations
- Smokefree workplace
- Staff discount scheme (with local businesses)
- Comprehensive orientation programme for new staff, including manual handling and health and safety training
- Wellness approach to staff sickness
- Return to work safety programme
- Workplace assessments for all staff
- On-site occupational health unit
- TrendCare acuity programme
- Health and Safety Committee structures and representatives throughout DHB, and health and safety training
- Significant events debriefing.

MidCentral DHB Directory

Board Members

Brendan Duffy, Chairperson
Heather Browning
Lew Findlay
Muriel Hancock
Karen Naylor
Jenny Warren
Oriana Paewai, Deputy Chairperson
Vaughan Dennison
Norman Gray
Materoa Mar
John Waldon

Executive Officers

Kathryn Cook	Chief Executive
Andrew Nwosu	Operations Executive, Healthy Ageing and Rehabilitation (to June 2021)
Celina Eves	Executive Director, Nursing and Midwifery
Chiquita Hansen	Chief Executive, Central Primary Health Organisation
Chiquita Hansen	Interim General Manager, Strategy Planning and Performance (from March 2021)
Claire Hardie	Clinical Executive, Cancer Screening, Treatment and Support
Craig Johnston	General Manager, Strategy Planning and Performance (to October 2020)
Cushla Lucas	Operations Executive, Cancer Screening, Treatment and Support (to November 2020)
Deborah Davies	Operations Executive, Public, Primary and Community Health Services
Gabrielle Scott	Executive Director, Allied Health
Jeff Brown	Clinical Executive, Healthy Women, Children and Youth
Judith Catherwood	General Manager, Quality and Innovation
Kelvin Billinghurst	Executive Director, Medical (Chief Medical Officer) (from July 2020)
Kelvin Billinghurst	Clinical Executive, Public, Primary and Community Health Services (from July 2020)
Keyur Anjuria	General Manager, People and Culture
Lyn Horgan	Operations Executive, Acute and Elective Specialist Services
Michelle Riwai	General Manager, Enable New Zealand
Neil Wanden	General Manager, Finance and Corporate Services
Sarah Fenwick	Operations Executive, Healthy Women, Children and Youth
Syed Zaman	Clinical Executive, Healthy Ageing and Rehabilitation
Scott Ambridge	Operations Executive, Mental Health and Addictions
Tracee Te Huia	General Manager, Māori
Tracee Te Huia	Interim General Manager, Strategy Planning and Performance (October 2020 to February 2021)
Steve Miller	Chief Information Officer
Vanessa Caldwell	Clinical Executive, Mental Health and Addictions

Registered Office

Board Office	Heretaunga Street, Palmerston North
Postal Address	PO Box 2056, Palmerston North 4440, New Zealand
Telephone	+64 6 350 8061

Auditor

Deloitte, on behalf of the Office of the Auditor-General New Zealand

Bankers

BNZ, Palmerston North

Solicitors

Buddle Findlay, Wellington
Fitzherbert Rowe, Palmerston North

Appendix: Output Descriptions

Output Class 1: Prevention Services

Output: Health Promotion and Education

Health promotion services support individuals, families/whānau and communities to take control over the factors that influence their health. Health promotion staff utilise the Ottawa Charter and Te Tiriti o Waitangi and other equity tools as frameworks to improve health and to reduce inequity, focusing both on healthy lifestyles and on the physical and social environments in which people live, work and play. This involves advocacy for healthy public policy and for healthy, sustainable communities as well as providing education around risk factors and behaviours that contribute to health and wellbeing.

Output: Health Protection, Regulation, Environmental Health and Communicable Disease Control

Health protection services work within the framework created by various health-related legislation, including the Health Act (1956), Sale and Supply of Liquor Act 2012 and Smokefree Environments Act 1990 and their associated regulations. The emphasis is around increasing compliance with the legislation in order to protect the health of individuals and of communities. This involves working with a range of agencies to maintain a healthy physical environment, ensuring that food and water are safe to consume, that communities are protected from hazardous substances and are as prepared as possible for emergencies such as earthquakes, floods and pandemics. The regulatory function includes oversight of the sales and supply of liquor and tobacco in accordance with legislation through controlled purchase operations. Surveillance and control of communicable diseases such as tuberculosis, measles and influenza are also important functions, with immunisation a key tool in maintaining a healthy population (see separate immunisation output section).

Output: Population Based Screening

Screening programmes can detect some conditions and reduce the chance of developing or dying from some conditions. In some cases (for example, breast screening), screening may detect cancer at an early stage. In others (such as newborn metabolic screening) screening may find conditions which can be treated before the baby develops a preventable illness or disability.

Output: Immunisation

Publicly funded immunisation services provide National Immunisation Schedule vaccinations together with a range of education and support services to ensure a high immunisation coverage rate for the district's population.

Output: Well Child Services

The Well Child/Tamariki Ora (WCTO) service framework covers screening, education and support services offered free to all New Zealand children from birth to five years, and their families/whānau. Well child services include health education and promotion, health protection and clinical assessment, and family/whānau support. The services also ensure that parents are linked to other early childhood services such as early childhood education and social support services, if required. Under the current well child national schedule, 12 health checks are offered. Eight of these checks are offered between the ages of six weeks and five years. Additional services are also offered to first time parents and to families who are identified as needing more support.

Output Class 2: Early Detection and Management Services

Output: Primary Health Care Services

Primary and community services support people to access intervention, diagnostics and treatment and to better manage illness or long term conditions. These services assist people to detect health conditions earlier, making treatment and interventions easier and reducing the complications of injury and illness. For most people, their general practice team is their first point of contact with health services. Primary care can deliver services sooner and is one of the most effective ways to prevent disease through screening, early detection and timely provision of treatment. Primary care is also vital as a point of continuity and effective coordination across the continuum of care, and for improving the management of care for people with long term conditions.

Output: Primary Community Care Programmes

Primary and community care programmes are geared toward initiatives that rely on a team of health care professionals to provide a range of services for people with high health needs, in particular those with a long term condition such as diabetes and/or cardiovascular disease, focused on reducing risk of illness and timely diagnosis, assessment and treatment of illness or disease.

Output: Oral Health Services for Children and Adolescents

Child and Adolescent Oral Health Services cover the provision of a range of dental care to assist the maintenance of a functional natural dentition and to bring about an improvement in oral health status of the population. It includes preventive care, oral health promotion and education, treatment of oral disease and the restoration of tooth tissue. The client group comprises all children in the following age groups:

- Pre-schoolers until school entry (to enable access for at-risk children at any age)
- All children of primary school and intermediate school age
- Children older than 13 years who do not yet attend secondary school
- Adolescents attending school from year 8 up to their 18th birthday, who otherwise would not have access to oral health services

Output: Community Pharmacy Services

Community pharmacies provide medicine management services to people living in the community. MidCentral DHB funds community pharmacies to assess an individual person's need for a medicine, assist with the selection of a medicine appropriate for the individual's needs, prepare and supply subsidised medicine(s) to eligible people, and provide assistance to people so that outcomes from medicines are optimised.

Output: Community Referred Testing and Diagnostic Services

A range of diagnostic services is provided on direct referral from General Practitioners and certain other health professionals to help diagnose a condition or as part of treatment. They include radiology, laboratory and various other specialty diagnostic tests.

Output Class 3: Intensive Assessment and Treatment Services

Output: Mental Health and Addiction Services

Specialist mental health and addiction services are delivered to those eligible people who are most severely affected by mental illness or addiction.

The services include assessment, diagnosis, treatment and rehabilitation, as well as crisis response when needed. Mental health and addiction services aim to reduce the impact of mental illness and reduce harm caused by drug and alcohol dependency or addiction through a recovery-focused, consumer oriented approach to early assessment and treatment.

Output: Hospital-Based Elective Services (inpatient and outpatient)

Elective services are medical or surgical services which will improve quality of life for someone suffering from a significant medical condition, but can be delayed because they are not required immediately. A service becomes known as an "elective" if it is provided seven or more days after the decision to proceed with treatment. Electives do not include services such as disability support, maternity, mental health, primary health or public health programmes.

Access to elective services is based on a referral from a general practitioner, and gives priority to those most in need and who will benefit most. A booking system is therefore used. The referral guidelines and access criteria are part of the national electives programme overseen by the Ministry of Health. A key priority of Government is to ensure equitable access to elective services, deliver more elective surgery as well as to reduce waiting times.

Output: Hospital-Based Acute Services

Specialist (acute) medical and surgical services are provided to people of all ages whose condition is of such severity or complexity that it is beyond the capacity and technical support of the referring service. Services intended are to achieve an integrated continuum of care that provides effective shared care across all settings from primary to tertiary, and includes cure of disease, relief of pain, effective screening and prevention of unnecessary or long term complications and access to information by patients and other practitioners. Hospital acute services will also advise and plan for care that prevents or reduces acute exacerbation of chronic disease to minimise likelihood of inappropriate hospital admissions and promote improved quality of life.

Output: Hospital-Based Maternity Services

Maternity Services that are funded by DHBs include primary, secondary and tertiary maternity care for pregnant women and their babies until six weeks after the birth. The service supports continuity of care, and is delivered in community, outpatient and inpatient settings. The national Maternity Referral Guidelines identify clinical reasons for consultation with a specialist and are published by the Ministry of Health from time to time.

Hospital-based maternity services are provided at primary, secondary and tertiary levels. Secondary maternity services are those provided where women and/or their babies experience complications that need additional maternity care involving obstetricians, paediatricians, other specialists and secondary care teams. Tertiary maternity services are additional maternity care provided to women and their babies who have highly complex clinical needs and require consultation with and/or transfer of care to a multi-disciplinary specialist team.

Output: Assessment, Treatment and Rehabilitation Services

Multi-disciplinary inpatient assessment treatment and rehabilitation (AT&R) for people with complex medical, cognitive, functional and social needs with the aim of enabling them to live independently in the community. Includes aged, physical, sensory and intellectual AT&R service(s). The AT&R service aims to improve functional independence of patients in usual

age-related roles and activities and/or return to the workforce or other activity with limitation of disease progression by active risk factor management and early, effective rehabilitation.

These are services provided to restore functional ability and enable people to live as independently as possible.

Output Class 4: Rehabilitation and Support

Output: Needs Assessment and Service Coordination

Needs Assessment is a process of determining the current abilities, resources, goals and needs of a person and defining those needs which are most important to the person. Needs Assessment is provided to:

- A person who has been identified as having a physical, intellectual, sensory or aged related disability (or a combination of these); and
- Which is likely to continue for a minimum of six months; and
- Results in a reduction of independent function to the extent that ongoing support is required

Service coordination is a process of identifying, planning and reviewing the packages of services required to meet the priorities, needs and goals of the person assessed. The process also determines which of these needs can be met by funded services and which can be met by other services. The process explores all options and linkages for addressing the person's prioritised needs and goals.

Output: Home-Based Support Services

The purpose of the home support services is to promote and maintain the independence of people who are experiencing difficulty caring for themselves because of an illness or chronic medical condition, or as a result of hospitalisation. The home support service is long term support provided by support workers for people with chronic health conditions in their own home or other private accommodation in the community. The service is delivered by private organisations, upon authorised referral following confirmation of eligibility and an individual needs assessment process, and is accountable for the quality of services delivered. The services have a restorative focus that promotes and maintains the independence of the service user.

Output: Age Related Residential Care Beds

Age related residential care (ARRC) beds comprise rest home care beds, dementia care beds and hospital continuing care beds. Psychogeriatric care beds are also available, which provide for more complex care needs.

Output: Life Long Disability Services

Government, through Vote: Health, funds ongoing support services for people with a wide range of disabilities and impairments. These services are referred to as disability support services for some groups, and long-term support services for others. Support options need to be flexible, responsive and needs based (refer to the earlier sections on Needs Assessment and Service Coordination services, residential care, rehabilitation and home-based support services). They focus on the person and, where relevant, their family and whānau, and enable people to make informed decisions about their own lives.

This output focuses on the services provided by Enable New Zealand – a division of MidCentral District Health Board – in two main areas: disability information and advisory services and equipment modification services. Enable New Zealand provides services to the greater population of New Zealand. The new EASIE Living Centre (opened in February 2016) enjoys a strong community profile regionally and acts as a community hub, engaging with community organisations and service providers to remove the barriers that preclude disabled people from actively participating in their communities.

Output: Rehabilitation Services

These services restore or maximise people's health or functional ability following a health-related event. They include community rehabilitation programmes, physical or occupational therapy, treatment of pain or inflammation and retraining to compensate for specific lost

functions. Success is measured through increased referral of the right people to these services.

Output: Respite and Day Care Services

Day programme services for older people are planned activities that meet the specific needs and interests of older people, where well-trained staff will assist service users in a stimulating and safe environment. Day programme services are aimed at assisting to maintain independence for older people, are closely integrated with other community support services available to older people and are also a form of support for carers of older people.

Respite care services for people with age related or long term disabilities are based on a 24-hour, 7 day a week service. The service provides both planned and emergency (or crisis) respite care for primary carers/family/whānau who care for family members with chronic health conditions and long term support needs. The duration of respite is short term and intermittent, or episodic for the service user. Access to respite care is based on need and approved by the Needs Assessment and Service Coordination (NASC) service.

Planned respite care is provided for specific periods as agreed with the primary carers/family/whānau. Emergency respite care is provided in times of crises, eg when primary carers/family/whānau are in urgent and immediate need of temporary relief from care-giving.

Output: Palliative Care Services

Specialist palliative care is palliative care provided by those who have undergone specific training and/or accreditation in palliative care or medicine, and who are working in the context of an expert inter-disciplinary team of palliative care health professionals. Specialist palliative care may be provided by hospices (community), hospital-based palliative care services, or paediatric specialist palliative care teams.

Specialist palliative care services are provided to people, their family and whānau when and where their complex palliative care need exceeds the resources of the generalist provider. Generalist palliative care is provided for those with life-limiting illness as an integral part of clinical practice by any health care professional who is not part of a specialist palliative care team (e.g. general practice teams, district nurses, allied health professionals, aged residential care staff etc). Providers of generalist palliative care services have defined links with specialist palliative care team(s) for the purposes of support and advice, access to education and training, and referral pathways for people with complex needs.

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