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ANNUAL REPORT

for year ended 30 June 2022

Pūrongo ā-tau

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

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

2021/22 ANNUAL REPORT

MidCentral District Health Board
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NEW ZEALAND

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This report concludes MidCentral operating as a district health board. From 1 July 2022, all district health boards were disestablished and transitioned to Te Whatu Ora – Health New Zealand.

MIHI

Ka piki ake i ngā tihi o Ruahine, o Tararua	Ascending to the peaks of Ruahine and Tararua
Kai ana ngā mata ki waho ki te taitamawāhine	Gazing outward towards the eastern ocean
Ki te taitamatāne	towards the western ocean
E hora atu ana ko te taunahanahatanga o ngā	Spread out are the ancestral lands and
tīpuna ko ngā wai tuku kiri o kui mā o koro mā	the cleansing waters of those gone long before
Te tai rā, te tai rā	There is the tide, there is the tide
Ketekete atu, ketekete mai	Murmuring back and forth
E pari ana te tai ki whea?	Where is the tide flowing?
E pari ana te tai ki te kauheke, kaumātua ki te	It is flowing away like the illustrious elders and
hunanga o te tangata hokinga kore ki muri nei	to those who have gone never to return
Tātai whetū ki te rangi tū tonu, tū tonu	As the multitudes of stars the remain in the
Tātai tangata ki te whenua ngaro noa, ngaro	sky so are the people on land who disappear
noa. E te hunga mate kāti ki a koutou!	Final acknowledgement to the dearly departed
Hoki whiwhia, hoki rawea	Return to that which is attained, that is bound
Ki a tātou te kanohi ora!	To the living
Tēnei te whanatū nei	This is the activation
Tēnei te takatū nei	This is the preparation
Whakauru tū ki tawhiti	To reach the distant shores
Whakauru rangi ki mamao	To reach the attainable heights
Ki te ao hou kei mua i te aroaro	Of the new beginning that lays before us
Ahakoa e tō ana te rā, tau mai rā e te Poari	As we edge closer to the disestablisment of the
hauora-ā-rohe	district health board on July 1
E hoki ana ngā mahara ki te tau kua hori ā ki te	We reflect on the achievements and
tōnuitanga o te tau, Kia eke panuku, eke	developments of the past year and continue to
tangaroa kia rarau ai ki te tapuwae nui o Tāne	strive towards ensuring those who live in the
	MidCentral continue to enjoy healthy lives
Nō reira kei aku nui, kei rahi tēnā koutou, tēnā	Therefore to one and all, we acknowledge and
koutou tēnā koutou katoa	thank you

Wāhanga 1
Tirohanga Rautaki

Section 1
Strategic Overview

REPORT FROM THE DISTRICT DIRECTOR

Tēnā koutou katoa

I am pleased to present MidCentral District Health Board's Annual Report for the 2021/22 year.

This will be the final report of the district health board, following the disestablishment of all district health boards on 30 June 2022.

I acknowledge the contribution of all Board members, and particularly those of Brendan Duffy, our board chair. I also thank Kathryn Cook, our chief executive of more than seven years. Kath stepped down on 30 June 2022, and many of the initiatives you see in this report are due to her leadership and foresight.

Our staff

Our staff have delivered excellent care to patients under very difficult circumstances. I am not overstating things when I say that this past year has been tougher than any other year we've faced.

While we benefited from having time to prepare, this year is when COVID-19 has most affected our community. It has continued to have significant impacts on the way care can be delivered, and we're still seeing increased demand on our services.

Despite the pressure, our staff have been phenomenal – every single day I can see teams making an incredible effort, whether that's with their patients or in behind-the-scenes roles. I am exceptionally proud of every one of them, and thank them for all their mahi. A special acknowledgement to our Emergency Department, who face the front end of our pressured health system with dignity and true devotion to their community.

In the Ngā Paerewa Health and Disability Services Standards Audit Report (received after the financial year but covering performance in this time), we have evidence that our staff are contributing to better health outcomes. The audit's feedback made note of the exceptionally high standard of care, and we were commended in several areas.

Our strategy

This year we've further embedded our integrated services model and the localities across our rohe. This has set us up well for the model that Te Whatu Ora – Health New Zealand will be moving forward with, and we are eager to share what we've learned with our regional partners.

As we move toward our joint future, our team has been focused on preparing for this change. This includes fostering relationships for future collaboration and making sure we bring our staff with us on the journey. They remain our most precious taonga, and the need to ensure their wellbeing has been a cornerstone of all our decision-making this year.

Our facilities

The development of our new Acute Services Block at Palmerston North Regional Hospital is a critical component of future acute care capacity in the lower North Island. We continue to progress the business case, ensuring that is aligned with the needs of both local and neighbouring populations. This will have a significantly expanded Emergency Department (ED), theatres and critical care capacity, together with the additional beds we need to support patient services.

As an interim measure, work is well underway on our SPIRE (Surgical Procedural Interventional Recovery Expansion) project and on the establishment of a combined EDOA/MAPU (Emergency Department Observation Area/Medical Assessment and Planning Unit) facility adjacent to our ED.

We're pleased that the new Acute Mental Health Unit has advanced through the design phase in preparation for construction work to commence.

Looking ahead

The next year will be a time of change, as we become a part of Te Whatu Ora. Our focus is on maintaining our progress through this transition, while navigating the promises of the new journey. We are proud to be Te Pae Hauora o Ruahine o Tararua | MidCentral and will retain this identity as we strengthen relationships and find new collaborative opportunities.

The kaimahi we have here are tremendous – they are truly dedicated to their mahi and do everything they can to help support their patients. At a senior level, our role is to proudly support them.

Ngā mihi nui

Dr Jeff Brown
Kaitaki Takiwā **|** District Director
Te Pae Hauora o Ruahine o Tararua **|** MidCentral
MidCentral Health

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).

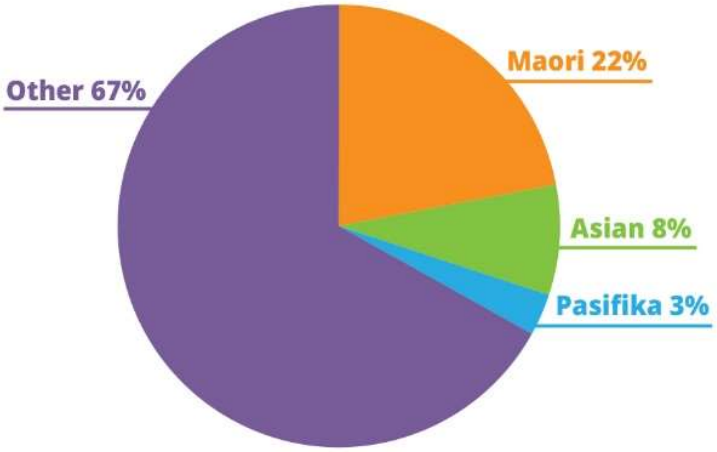
The MidCentral DHB district is located across the mid-lower North Island and includes the Ōtaki ward of the Kāpiti Coast district and the Territorial Local Authority districts of Horowhenua, Palmerston North City, Manawatū and Tararua.

MidCentral District Health Board (MDHB) funds and provides health and wellbeing services to approximately 190,390 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 (65+). This rate is expected to continue with projections indicating our older population will be 24 percent by 2030, compared to the national average of 20 percent for the same age group by 2030.

We have a higher proportion of Māori in comparison to the national average (22 percent compared to 17 percent nationally) and two of our localities are now refugee resettlement areas. The number of refugees in Palmerston North City is steadily growing and Horowhenua will have its first intake of refugees in the 2022/23 year.

Our district has a higher proportion of people in the more deprived sectors of the population. More than 49,000 people (26 percent of our population) are living in high deprivation (decile nine or 10).



These statistics are important because people who are experiencing socio-economic disadvantage are known to have poorer health 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 (ie district group and clinical networks, iwi/Māori, THINK Hauora 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 providing service 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 $631 million in the 2021/22 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 Kahungunu ki Tāmaki nui-a-Rua
- Ngāti Raukawa ki te Tonga
- Rangitāne o Manawatū and Rangitāne o Tamaki nui-ā-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 is 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

Ministry data[1] shows there were 1,537 deaths registered (all-causes) across MidCentral's population in 2019 – similar numbers to previous years. MidCentral's death rate is consistently between four and five percent of the national rate.

The rate of deaths in the Māori population in MidCentral sits between nine and 11 percent (171 in 2019). Death rates for the MidCentral Pasifika population is consistently between one and two percent (26 in 2019).

MidCentral's age-adjusted all-cause mortality rate suggests a slightly worse health status than that of New Zealand overall. This is somewhat expected because MidCentral'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 mortality 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 may have been prevented if health sevices were 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.

In the period 2014-2018, the predominant causes of death were disease of the circulatory system (32.2 percent) and neoplasms (29.5 percent). 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.

[1] Ministry of Health: Mortality Summary (2019)

OUR VISION AND STRATEGIC FRAMEWORK

MDHB committed to achieving its purpose of:

He whakapai ake I te hauora, hei oranga mō te katoa

Better health outcomes, better healthcare for all

and our vision of

Kia pai te noho, Kia ora te tangata, Kia ora te hapori

Quality living, healthy lives, well communities

Our strategy identified the future we wanted with a 10-year outlook:

Our strategy's four strategic imperatives served as our focus over 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 committed to these priorities to make a difference to the health and wellbeing of individuals, whānau, and communities. Individually and together, we aimed to:

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

These in turn were underpinned by our core values that reflected the way we worked and culture we strived for:

Compassionate – Kia whai aroha

Respectful – Kia whai ngākau

Courageous – Kia mātātoa

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 healthcare, where consideration of circumstances was the driving factor in where and when care occurs.

We continued to grow our relationships with our five communities to ensure we best met their needs and aspirations. At the very heart of this strategy is Te Tiriti o Waitangi and its Articles, which guided MidCentral DHB in how it governed and conducted itself, how it developed true partnership with iwi and how it could be enhanced to improve Māori health outcomes.

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

We recognised the need to work collectively towards a shared goal, to reduce the inequities in our communities. By working together and by placing people and whānau at the centre of everything we did, we improved the health and wellbeing of our communities. Only then were we truly 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 was the foundation for the contribution of the health and disability sector to Whānau Ora and provided a 'whole of health system' approach to advance Māori health. Ka Ao, Ka Awatea identified three strategic goals we sought to achieve over time:

- Māori providers were 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 was delivered, monitored and maintained.
- Barriers were 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) committed to fulfilling its obligations under Te Tiriti o Waitangi through continued work at a governance level in partnership with the Māori Relationship Board, Manawhenua Hauora. This was a consortium of four iwi within our district: Ngāti Kahungunu ki Tāmaki nui-a-Rua, Ngāti Raukawa ki te Tonga, Rangitāne o Manawatū and Rangitāne o Tamaki nui-ā-Rua, and Muaūpoko.

At the leadership and operational levels, we partnered with 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 worked 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 was made up of chief executives and general managers of iwi and Māori providers. They advised MDHB on advancing Māori health gains from a platform of Whānau Ora that drew 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 continued 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, 2020-2022*, which is a significant step towards further health gains for Māori. The purpose is to shift the focus towards the promotion of wellness and the prevention of disease. It aimed to address challenges in healthcare 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 2021/22 year:

- Strengthening our financial position.
- Reducing inequities 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.

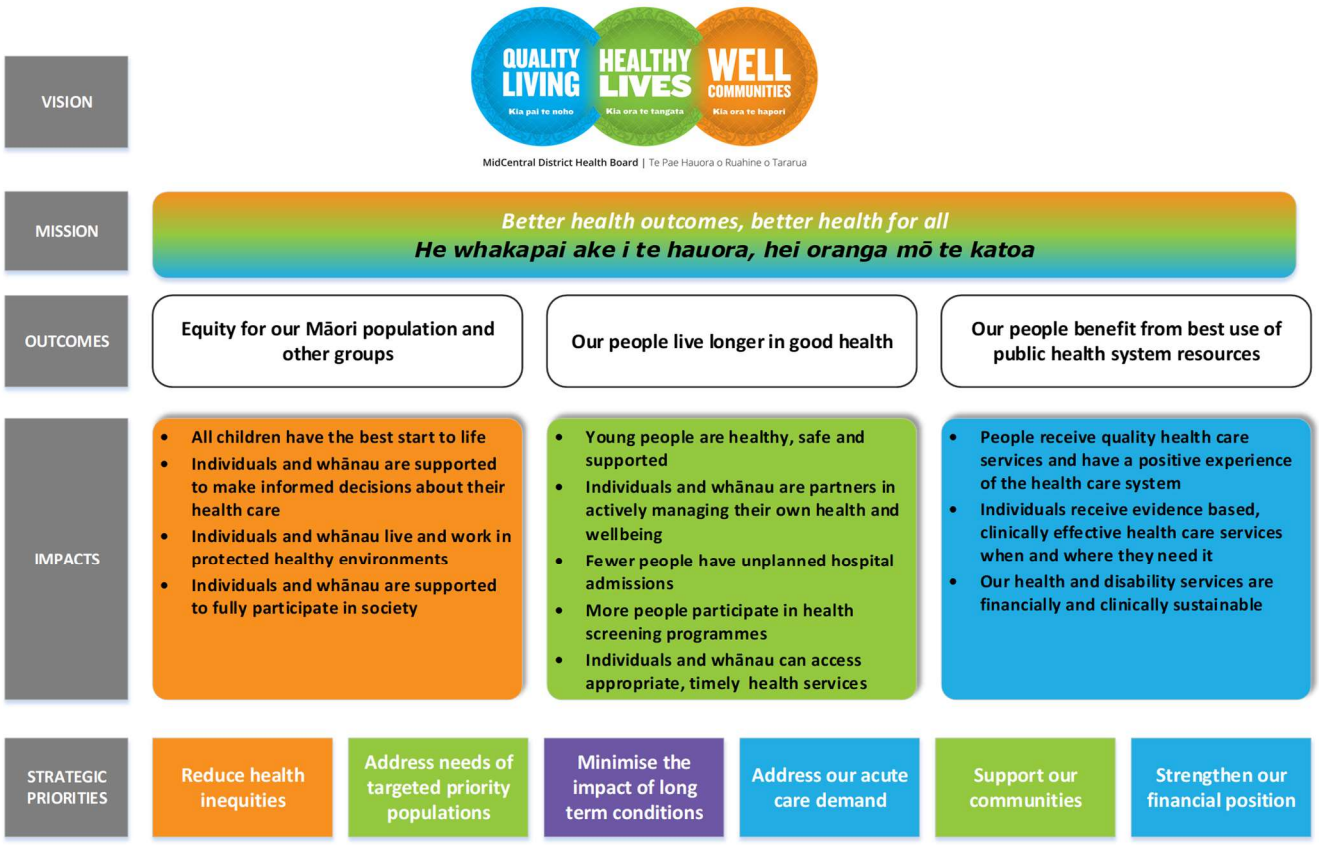


Figure 1: MidCentral District Health Board Outcomes Framework

PROGRESSING OUR STRATEGIC INTENTIONS IN 2021/22 – HIGHLIGHTS

COVID-19 pandemic

COVID-19 TACKLING A ONCE IN A LIFETIME PANDEMIC

From nationwide lockdowns and virus variants, to managing one of the largest vaccination rollouts in our history – the events of the last two years have been unprecedented for this generation.

After holding COVID-19 at bay through strict border controls and lockdowns for 18 months, the arrival of Delta in late 2021 and Omicron in 2022 saw the virus take hold, sweeping through our country in a matter of weeks. In MidCentral, over 47,000 people tested positive for COVID-19, more than a quarter of our population.

The arrival of Delta saw the Government hasten the rollout of the existing COVID-19 vaccine programme. This meant that by the time Omicron arrived on our shores, the MidCentral population was already largely protected against serious illness.

Over the past two years, our partners and the COVID-19 response team have delivered over 400,000 doses across the rohe, including over 95,000 booster doses, administered countless PCR tests, distributed the game-changing Rapid Antigen Test (RAT) kits and created the health framework to support people to isolate themselves safely at home.

Dr Kelvin Billinghurst, MidCentral DHB's Chief Medical Officer, first heard about the emerging virus in January 2020, while enjoying a holiday. "I had been involved with infectious disease work in the past, having been part of the response to the SARS 1 outbreak, so alarm bells started ringing for me when I heard a news bulletin about the outbreak of a respiratory disease in China. I remember checking at the time, what details were on the web and I started to wonder if we might need to cut our holiday short."

Kelvin believes the overall response to the pandemic in Aotearoa New Zealand has been, and is exceptional. "I think New Zealand's management of the pandemic is often under-appreciated. We had an early response and a rapid lockdown supporting the elimination strategy. When we did get COVID-19 in the community, it was with a strain less virulent, occurring in a highly vaccinated population. As a result, we saw patients and the workforce protected along with the whole health system. I often think about what could have happened when looking at other countries. The timing is nothing short of miraculous really."

Kelvin believes the success of the COVID-19 response comes down to the collective effort from the people and teams at MidCentral DHB and our partner organisations. "In particular, I am thankful for the work of the Māori and iwi teams and how they helped to get mobile services out to expand our reach into the wider rohe. Looking at our numbers, the hospital team, vaccination team, and public health team have done wonderfully – honestly, the list goes on. As a district we are incredibly fortunate to see and receive the hard work and efforts of so many."

MĀORI AND IWI COVID-19 RESPONSE TEAM

As a key member of the COVID-19 Response Team, Adele Small, Māori and Iwi Programme Lead, was responsible for ensuring equitable access to vaccination, testing, information and care in the community support throughout the pandemic.

"We are aware of what happened in past pandemics, and we know that Māori in particular are vulnerable to serious illness from respiratory illnesses. The only way through this pandemic for us was to reinforce partnerships with iwi and Māori so we could actively work to prioritise Māori, ensuring equitable access to the tools they needed to keep whānau safe. Working in partnership, to remove barriers that people may have previously experienced, when seeking healthcare, was key to achieving a high vaccine uptake."

"We've achieved over and above what we expected for Māori vaccination rates. We've been bringing the vaccine right to people's doorsteps, with people they know, trust and respect, and reaching right into communities. It is because of the partnership with iwi and Māori that we were able to achieve this. This demonstrates the value in iwi and Māori leadership and what we can do working together. Iwi and Māori providers deliver exceptional services and can have an equal footing alongside GP practices for clinical care and wrap-around services."

"The model we have and the way in which we have operated is really sound and is certainly something we will be looking to continue beyond COVID-19. We know the strength of our partnerships and what we can achieve – whatever comes next, we will work together to get through."

COVID-19 RESPONSE MANAGEMENT

MidCentral DHB's COVID-19 Response Manager, Bronwen Warren, celebrated the collective effort from staff and credits them for the success of MidCentral's COVID-19 response.

"Following the nationwide lockdown in August 2021, the Government set all DHBs a target to get to 90 percent vaccination coverage. This felt very aspirational at the time, and with a health response this big we needed as many hands as possible to ensure we were ready to act."

"To support this drive, they launched the Super Saturday campaign – something I am sure that most of us working through this time will never forget! We were given less than 10 days' notice to get together, plan this campaign, and pull off one of the biggest vaccine drives in our history."

"Our staff brought a real level of enthusiasm to what they were doing to make this day happen – the impact of which didn't just help increase vaccination uptake, it proved to our team that we can do this." Bronwen admires MidCentral DHB staff for their perseverance and dedication to the COVID-19 response.

"It's been a hard slog, but our staff have just kept going. Their sense of duty to the community blows me away. The sacrifices our team and our partners have made, to be out there testing, vaccinating and educating – to give up time with their families to help our community during a time of crisis is truly admirable and I am so grateful for their contribution."

LOOKING AHEAD

Reflecting on the past two years, Dr Kelvin Billinghurst agrees with Adele and Bronwen about the value that has come from experiencing the response. "If anything, this experience has been incredibly helpful – shoring up partnerships and developing more equitable approaches to healthcare. To all the people and teams who have helped us to pull this off – thank you, it's an incredible thing we've done. In short, it has prepared us for whatever comes next."

Reducing inequities in health outcomes

CHILD HEALTH COMMUNITY TEAM AND NURSE PRACTITIONER CLINICS

The child health community team is an initiative that was fostered to reduce the likelihood of preventable admissions to MidCentral Children's Ward. Eczema and asthma were two areas in particular that were considered.

A diagnosis of eczema or asthma is used as an entry point to the service which General Practitioners (GPs), well-child providers or whānau can refer into. While this is used as an entry point, the team take a holistic approach and will work with whatever challenges the child and family are facing. The service provides education and treatment to the family. They advise and educate primary health providers on best practice; engage whānau with paediatric social workers; link with other health professionals; and advocate for whānau. Since the team has begun, eczema and asthma admissions have drastically decreased.

Nurse Practitioners have an extended scope of practice, which enables them to assess, order and interpret investigations; educate; diagnose; and prescribe both pharmacological and non-pharmacological treatment. Having this scope of practice allows Nurse Practitioners within Te Uru Pā Harakeke to see any paediatric presentation, both primary or secondary, which increases access for tamariki and their whānau. Nurse Practitioners deliver secondary clinics outside of the hospital in a range of community settings, which brings care closer to home, in a setting that is more appropriate for whānau – settings such as Te Kete, Te Aroha Noa, schools etc, with a concentrated focus on the Horowhenua and Tararua regions.

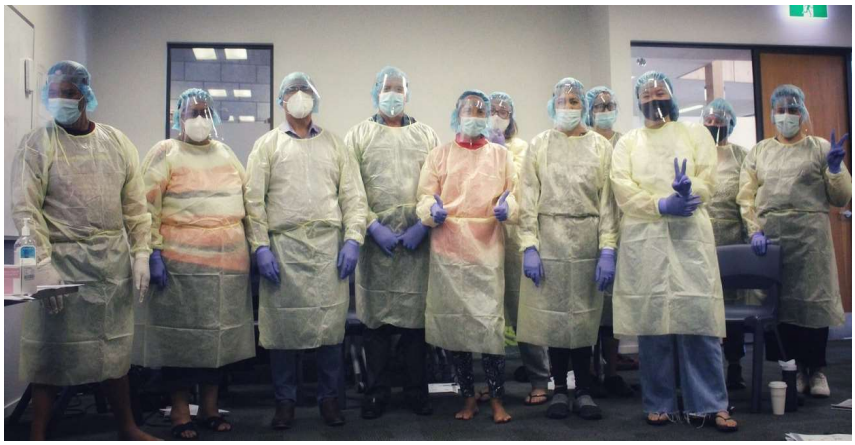
ANNUAL INTERNATIONAL DAY OF PERSONS WITH DISABILITIES

The theme for 2021's International Day of People with Disabilities was fighting for rights in the post-COVID-19 era, and celebrating the challenges, barriers and opportunities for people who live with disabilities, in the context of a global pandemic.

A team from MidCentral DHB attended a Disability Responsiveness Workshop, aimed at enabling frontline staff to better understand the New Zealand Disability Strategy to help increase confidence and improve equity from a disabled perspective. The course was delivered by Raewyn Cameron from Enable New Zealand, along with Mana Whaikaha and Pam MacNeill from Disability Responsiveness New Zealand.

COVID-19 IMMUNISATION PROGRAMME

Māori Clinical Lead, COVID-19 response, and Māori Engagement, along with members of the COVID-19 testing team from MidCentral worked together to provide training with Ngāti Kahungunu ki Tāmaki nui-a-Rua and Rangitāne o Tamaki nui-ā-Rua from Dannevirke, and Ngāti Raukawa from Ōtaki to help prepare the teams for COVID-19 surge demands.



The teams, from a variety of backgrounds, responded to the calls for volunteers to help look after their whānau and communities, and trained in COVID-19 testing, infection control and using Personal Protective Equipment (PPE). The teams now have knowledge in COVID-19 testing and will supplement the clinical workforce in their regions, and are able to respond to COVID-19 testing demands.

INAUGURAL MĀORI SCHOLARSHIPS

To increase Māori representation among its workforce, MidCentral District Health Board has released its inaugural Māori Scholarship programme to current students and kaimahi working or seeking to work in health across the MidCentral region.

The Pae Ora Paiaka Whaiora Hauora Scholarship programme is in line with MidCentral DHB's strategy of connecting and transforming primary, community and specialist care and achieving equity of outcomes across communities for Māori.

Equity for Māori is one of MidCentral's key priorities. Kaimahi Ora, Whānau Ora, is the MDHB Māori Health Workforce Development Implementation Plan 2017-2022 and aspires to achieve a flourishing workforce: flourishing whānau. Having a strong and capable Māori health workforce leads to improved health outcomes for whānau Māori by creating culturally responsive and engaging environments.

MidCentral District Health Board governance and leadership are committed to investing in strengthening the cultural responsiveness of our workforce.

Bonnie Matehaere, Registered Nurse (RN), Ngāti Raukawa – Kaiwhakahaere Kaiwhakaako Tāpuhi – Nurse Educator Māori Health is delighted with the workforce initiatives underway for Māori stating, "The scholarships will help to get more Māori to pursue a career as a health professional."

While the scholarship funding focuses on building the capacity and capability of the Māori health workforce, MidCentral DHB also offers Te Tiriti o Waitangi and tikanga (Māori Cultural Responsiveness in Practice) training throughout the year for all staff. "We needed more training sessions last year - so we have locked more in this year."

"Our people are more responsive to someone who understands their needs not only from a health perspective, but from a 'Te whare tapa whā' perspective. As a Māori Registered Nurse who was brought up in our culture, this approach came naturally and wasn't something that had to be taught or learned", she said.

Addressing our acute care demand

PATIENT AT RISK NURSE

The Patient At Risk (PAR) Nurse role is designed to optimise teams' skills more, so wait times can be reduced as well as potential harm to patients and stress on hospital resources. The nurses' support will mean a reduction in the number of times doctors, junior doctors and Intensive Care Unit/Coronary Care Unit (ICU/CCU) staff need to visit a patient, making the process faster for quicker release and reducing interruptions to those other staff members.

Seeing patients faster means the risk of deterioration is reduced and can be managed more effectively, which will reduce the chance that the patient will need to be admitted for further care.

FLEXIBLE ACUTE FLOW UNIT

A 10-bed facility has opened to facilitate increased bed numbers, given winter and COVID-19 demand.

In April 2022 we restructured our short-term patient ward to help accommodate our ongoing growing seasonal demand. MidCentral recognises that we don't have enough space to facilitate patient flow due to the ongoing constraints of shortages across the board. Therefore, utilisation of this space and the new induction of the 'Acute Flow Unit' has been very successful. The increase of bed numbers has resulted in 10 new beds being available.

MAJOR TRAUMA PATHWAY

As part of a national collaboration to improve the quality of care for patients who have experienced major trauma, a group of staff from our Nursing, Allied Heath, Pae Ora and Quality teams have worked with the support of the Health Quality and Safety Commission, and the National Trauma Network, to develop a clinical pathway. The project's objective was to ensure all patients receive a timely and consistent approach to care from admission to discharge and post discharge follow-up. This includes administration of all required assessments, referrals to external agencies and follow-up care.

The working group has developed, trialled and evaluated the pathway over a three-month period, which has shown considerable improvement in coordination and consistency of care across the patient journey. The pathway is now ready to 'go live' and will be available on the MidCentral District Health Board document management system. We are proud to acknowledge that the pathway has been accepted as a poster presentation by the Agency for Clinical Innovation NSW, Australia for the Annual Rehabilitation Network Education Forum 2022, as well as at the New Zealand National Trauma Symposium, in Wellington as an oral presentation.

Supporting our communities

BREASTSCREEN COAST TO COAST

In February 2022, BreastScreen Coast to Coast, in partnership with Te Tihi o Ruahine and Pae Ora Paiaka Whaiora commissioned two new artworks for the BreastScreen Coast to Coast building on Amesbury Street in Palmerston North – one in the reception area and one in the meeting room.

The reveal of the artworks involved a whakanoa (removal of spiritual restrictions), and instilling mauri (life-essence) through karakia and acknowledging the skill and work of the Ringatoi (artist).

The painting in the reception, named 'Te Ira Tangata', was inspired by the whakataukī 'Me aro ki te hā o Hineahuone', which means 'Pay heed to the life-force of women'. In Māori lore, wāhine are the physical embodiment of Atua Wāhine (Celestial female beings) including Hineahuone, the first woman.

The mahi toi whakairo (carved wooden wall hanging) which hangs in the staff meeting room named 'Te Hā o Hineahuone' reflects the sentiment of its companion 'Te Ira Tangata' and together reinforces the importance of cultural responsiveness in the delivery of health services.

Formed from the red earth of Kurawaka, Hineahuone was shaped and moulded by the hands of Tāne te Waiora and given life when he placed his nose to hers, sharing 'the first breath', thus the phrase 'Tihei Mauri Ora'. This expression heralded the coming and the potential for humankind, where Te Whare Tangata (the womb) is the Sacred House of Life where it would forever reside and be protected within Te Ira Wāhine (womanhood).

The artist is Nikau Tonihi, who is part of Tihi o Ruahine. "I am very honoured to have been given the privilege to create such a meaningful artwork that speaks to wāhine and their whānau around hauora/wellbeing and the protection of whakapapa. It has been a beautiful and humbling experience to see this tāonga reach it's final resting place at the BreastScreen Coast to Coast Centre."

Tawhiti Kunaiti – Pou Whakarae, Prinicipal Cultural Leader, from Te Tihi o Ruahine said "As a whānau ora organisation, Te Tihi is pleased to have been engaged by the Equity and Bicultural Programme Leads for cancer to contribute towards elevating wāhine and the mana they have within the whānau unit via the creation of the 'Te Ira Tangata' artwork. We trust the tāonga will serve as a beacon of light for all wāhine and their whānau, and especially so for the kaimahi (staff) and whare (workplace, premises) that provide the screening service as this art piece has been made with a lot of thought, energy and aroha".

Michael Whareaitu, Tikanga and Cultural Advisor from Pae Ora Paiaka Whaiora said "Staff participation in tikanga processes such as the huranga taonga which took place in February helps to build on the big picture of cultural safety and cultural responsiveness. Both the painting and the carving go hand in hand (hoa haere – companions) in creating a visual representation of the importance of using Tikanga-based practice to improve health outcomes for Māori."

Yvonne Hewson, BreastScreen Coast to Coast Regional Equity Coordinator, said "the artworks are the embodiment of a kaupapa Māori wāhine-centred service delivery model 'Te Hā o Hineahuone' that BreastScreen Coast to Coast have adopted to encourage and support wāhine Māori to access breast screening. These artworks convey the message of the importance of looking after our health and wellbeing to protect ourselves and our whakapapa from the harms of breast cancer."

BreastScreen Coast to Coast would like to thank all of those who were involved in the process, and in particular the artists who took a concept and captured it beautifully in the expression of their art. Other pieces of art are displayed throughout the premises to complement the commissioned artworks and enhance the environment and the service model that we deliver.

SUPPORTING OUR REFUGEE COMMUNITIES

A programme to help improve the health outcomes of former refugee and refugee-like migrant communities in the MidCentral district was officially launched at a potluck dinner in February.

The RIMA ([former] Refugee, Internally displaced person, [refugee-like] Migrant and Asylum seeker) programme connects the RIMA community for wellbeing through improved participation, greater empowerment, and a more culturally inclusive healthcare experience.

It's led by Febry Suharto, RIMA Wellbeing Coordinator following research she completed during her Masters degree at Massey University. The programme is run in collaboration with MidCentral and Ora Konnect Alliance. After migrating back to Palmerston North from Indonesia, Febry became involved with the Red Cross Migrant Team as an intern and a Refugee Support Volunteer.

"My passion for working alongside former refugee communities comes from my background in social work and it soon became clear to me that lots needed to be done to help bridge the gaps for former refugee communities being able to access better healthcare services."

Febry wanted to understand more about the barriers to access, and undertook a research project as part of her Masters. Five main barriers for former refugees accessing health services in Palmerston North were language, housing and transportation, cultural misunderstanding, stereotypes and lack of information.

The programme is working to strengthen network connections with the RIMA community as well as with service providers and agencies, and it focuses heavily on 'bridging health barriers' by having the communities as the heart of the programme. Programmes are tailored to address the needs of the communities – one example being the development of the RIMA Health and Disability Codes of Rights that has been translated into five different languages so far.

It was found that many people in the RIMA community have a very limited understanding of their rights, so it is important to support them by developing a new template that is an easy read version, with pictures that represent the meaning of the rights and in languages that they understand.

For communities keen to find out more about the initiatives and support the RIMA programme can provide, Febry has launched a new regular RIMA Kōrero which is a talkshow that is available on-air at Manawatū People's Radio as well as on-demand, covering a range of topics.

Febry has also run a number of events, aimed at encouraging the RIMA community to discover more about the healthcare options available to them, including hosting a World Refugee Day event at Te Manawa museum in Palmerston North. It was an event filled with kai from all around the world and community conversation included representation from organisations such as Diabetes Trust, Let's Talk English, Health Disability, Oral Health, Community Pharmacy, and Zilch Food Rescue. The THINK Hauora immunisation team were also on hand offering free influenza (flu) vaccines to attendees.

TE PUNA WAI DROP-IN CENTRE

Te Puna Wai drop-in centre offers a warm, calm haven for the lonely and distressed. It is an after-hours venue that has opened to provide a safe space where people can enjoy food, activities, and supportive companionship to keep anxieties in check.

This is the first service of its kind outside of Auckland. Te Puna Wai is run by Mana o te Tangata Trust in partnership with MidCentral, which funded setting up and staffing the service.

The centre is located at 601 Featherston Street. Hours of operation are 5pm to 10pm on Fridays, and 3pm to 10pm on Saturdays and Sundays. This is a no referral walk-in support system, that acts as a 'safe space' for those who may feel down, lonely, or distressed while struggling with mental health and addiction(s).

Te Puna Wai offers an additional level of support to those experiencing mental health crises, from those who can understand what they are going through. It will likely also help relieve pressure on the Emergency Department by providing a homely environment where many people can receive the support they need.

Peer support workers cook dinner for anyone who shows up at Te Puna Wai.

COMMUNITY INFUSION SERVICE

A Community Infusion Service (CIS) has been set up in three district locations: Tararua Health Group (Dannevirke); Kauri Health (Palmerston North); and The Palms (Palmerston North) to deliver infusions that were previously delivered at the Palmerston North Hospital site.

Funding came from the Ministry of Health in the form of Financial Support for Planned Care Improvement Action Plan Capital Expenditure Projects (effectively $50 million of funding allocated by the Government to enhance Planned Care delivery, to address waiting lists and the impact of COVID-19). The DHB was invited to make a submission and the CIS Pilot was approved.

A key driver of the service was the increasing desire to move activities historically provided in the hospital/secondary care setting, to a community setting, along with managing the increasing demand on existing facilities at MDHB. The pilot focused on patients who received their infusions in the Transitory Care Unit. A select group of IV infusions were identified (Infliximab and Intragam P), supported by the Primary Options for Acute Care (POAC) programme. The criteria for those appropriate for Community Infusion Services were equity focussed. The process to identify the community sites considered and prioritised the locality and population they serve. We sought to identify if access and equity gaps existed with a focus on Māori, Pasifika and high deprivation groups.

A key success factor to the service is the Community Infusion Service Co-ordinator Role. This role builds on existing relationships with patients and their whānau; is key to establishing relationships with new patients; and walks alongside the patient as they transition to the community.

The model of care requires all new infusion patients to receive their induction series of infusions in the hospital setting. When they are clinically stable, in consultation with the Consultant, they are transitioned to the community.

This Co-ordinator role is key to liaison, community, streamlining processes and providing support/education for primary care.

The benefits of a Community Infusion Service include:

- consumers being able to receive their services closer to home
- transition of appropriate services from a hospital setting to a community-based setting, freeing up space for other care
- partnering with community providers utilising skills in community settings
- collaboration between clinical teams, the community providers, pharmacy and the New Zealand Blood Service (NZBS).

Outcomes of the service include:

- sixty patients have been transitioned to receiving their care in the community locations
- positive feedback from patients and their whānau
- a service focus of ‘wellness’, as opposed to being a sick patient.

Recommendations from the initial rollout include expanding the service to more locations, and to increase the range of care available to be delivered. The next focus will be on transitioning patients from the Medical Oncology Day Ward, with a plan to expand to include the locality delivery into Horowhenua and Feilding.

Sustainability

ELECTRIC FLEET

Over the past year, 100 vehicles in our 160-vehicle fleet have been replaced with 40 electric vehicles (EVs) and 60 hybrid vehicles.

This means over 60 percent of our fleet is now electric or hybrid – and makes our DHB fleet one of the eco-friendliest in New Zealand.

The vehicles have been allocated to District Nursing, STAR, Mental Health and Addiction Services and the general pool vehicle fleet, meaning if you are based at Palmerston North Hospital, you can book them if travelling offsite. To support the introduction of these vehicles, 28 electric vehicle charging stations have been installed on the Palmerston North Hospital site.

The EVs purchased are Hyundai Konas. They have a 'real world' range of 480km when charged, so can go to Pongaroa and back twice, or Ōtaki and back three times on one charge.

The introduction of these vehicles is part of the DHB's Environmental Sustainability Strategy, which aims to decarbonise the entire fleet of vehicles by 2026. This new addition alone looks to reduce our fleet's CO_2 emissions by 215 tonnes of CO_2 equivalent (t CO_2e) per year. For comparison, the average passenger vehicle emits 4.6t CO_2e per year, based on an average of 11,500km a year – so that's a huge saving! It is also estimating a saving of $170,000 in fuel over the next three years.

MidCentral DHB successfully obtained funding to cover 50 percent of the EV charging stations and vehicle lease costs, with the DHB covering the other 50 percent. The funding came from the State Sector Decarbonisation Fund.

Enabling our success: Our workforce

HEALTH ROUNDTABLE APP

Invented by Mayo Clinic, the Well-Being Index is a 100 percent anonymous tool that evaluates multiple dimensions of distress in nine questions. This app allows doctors, nurses, nurse practitioners, allied health professionals and other healthcare professionals (including non-clinical) to accurately assess wellbeing. It also provides resources, allows users to track wellness over time and compare their wellbeing to peers, and establishes a more accurate scale of wellness across the industry.

The nine questions address issues such as:

- burnout
- worry
- depression and hopelessness
- sleeping
- physical health
- work/life balance.

Upon completing the questions an individualised index score is shown to the user and resources specific to the given answers are provided to the user. Wellbeing can then be measured over time as set by the user.

MidCentral staff are encouraged to look after their wellbeing and the use of the app may help identify if a little extra support is needed, or if they need someone to talk to.

APPRECIATION OF OUR STAFF

Thank you vouchers – When COVID-19 hit the MidCentral region, staff went above and beyond to cater to the needs and demands of our community. 'Thank You' voucher booklets were distributed to all staff members as a way to acknowledge the dedication of our teams during this challenging time.

Each booklet included a total of 10 vouchers which covered the cost for a beverage and a cabinet food item, redeemable at various cafes around the rohe.

Christmas lunch for staff – COVID-19 was hard on everyone in 2021, especially for our essential workers. MidCentral wanted to ensure that staff efforts were still shown appreciation, even if that meant an alternative to our annual BBQ gathering prior to the Christmas season.

With all restrictions considered, we asked our workforce what they thought would be a reasonable alternative. The majority agreed that having food delivered to them so they could celebrate in their own 'bubbles' was a great idea.

Staff were provided the option of a ham, chicken or vegetarian themed meal, that included a fruit mince pie, strawberries and chocolate. Individual food boxes were supplied to each staff member and employee across our workforce in the last weeks of December 2021. Feedback was very positive, especially from our community-based teams.

WĀHINE CONNECT

MidCentral have subscribed to a national mentor programme called 'wāhine connect' – a national mentoring network for New Zealand women in medicine and health. The emphasis for this programme is to create a foundation for junior staff which will enable 'wellbeing and professional development of women in the NZ health sector'.

Wāhine connect focuses on:

- creating communities of women in health to provide peer support in both professional and personal lives
- utilising collective resources as a network of women to facilitate career development and contribute to the development of a strong wāhine health sector workforce.

Full details are available on the wāhineconnect.nz website.

ALLIED HEALTH AWARDS

Allied Health Awards were awarded for the first time in October 2021 to celebrate allied health staff working across the organisation. There were seven categories for staff to nominate colleagues:

- Leadership
- New entry to practice
- Teamwork
- Assistants
- Cultural awareness
- Research
- Outstanding clinician.

The awards day coincided with World Allied Health Day and will become an annual celebration.

Allied Health professionals are medical professionals who aren't covered in dentistry, nursing and medicine. They are our vital diagnostic, technical, therapeutic and support services including social services, physio and speech therapy, podiatry and many more. As well as awards for outstanding work in their disciplines, some long service awards were also presented to several staff to mark significant milestones.

Enabling our success: Our partners

PŪHORO STEMM ACADEMY PARTNERSHIP

Representatives from MidCentral, Pūhoro Science, Technology, Engineering, Mathematics and Medicine (STEMM) Academy, and Manawhenua Hauora came together to sign a partnership to help grow and nurture Māori students into STEMM subjects and into careers in the health sector.

Pūhoro STEMM academy work to guide Māori students who are school year 11 to 13 through a number of subjects, whilst learning and being able to immerse themselves with their Māori culture. This agreement will offer these students internships, work experience and study support, that can ultimately lead to long and fulfilling careers for Māori in health.

Students, in collaboration with MidCentral DHB's Gateway programme have the opportunity to gain vital work experience in a health setting, spending time at the hospital and in the community with current health workers. Students get the opportunity to experience nursing, medicine, midwifery, orderlies, administration, community health and allied health roles, allowing them to find the area of health that appeals to them most and encourage them to pursue a career in health.

We are proud to be the first district health board to partner with Pūhoro STEMM Academy. This is a huge step forward towards achieving an equitable workforce and health service for Māori. It will ensure a future where our rangatahi grow, flourish and succeed, and our healthcare system is strengthened with more Māori health workers.

GATEWAY STUDENTS

The MidCentral DHB Gateway programme works with our regional kura and rangatahi who are considering purusing a career in health. It opens up the opportunity for those in school years 12 and 13 to experience a variety of health roles to really find out what they enjoy, and what they may choose to pursue as a career when choosing their tertiary education options.

In April, Palmerston North Hospital and Community Health teams welcomed 35 students from a number of schools in Palmerston North and Ōtaki to their teams. Students went as indviduals or in pairs, and rotated through a number of areas including medicine, nursing, midwifery, allied health, administration, orderly services and domestic services. This also included some community services, so they got an opportunity to see locality health initiatives in action in the community.

As the students continue their learning, they participate in other unit standards including Māori cultural training, and professional and ethical behaviours. This programme also contributes towards their NCEA Level 2 and 3 qualifications.

We rely on all health workers to support clinical placement and inspire our students to continue their interest and path into a health career. We are excited to continue growing this programme and open avenues for more students to pursue a career in health.

Enabling our success: Our facilities

RENOVATIONS TO 20 ALLARDICE STREET, MENTAL HEALTH FACILITY IN DANNEVIRKE

Renovations to 20 Allardice Street, Dannevirke Mental Health and Addiction Services' building in Tararua has made a positive difference. The building provides mental health and addiction services to the Tararua region, with a multi-disciplinary team providing assessments, treatment, education, crisis prevention and support for adults with known or suspected moderate to severe mental illness.

The facility was renovated to improve its look and feel, to make it a more welcoming place for patients, friends and whānau to support loved ones who may be suffering with mental health and is the first of three locality refurbishment projects.

The renovations included fresh paint and carpet throughout the facility, foyer and waiting area with new furniture, improvements to the internet services to improve telehealth communications, new clinical meeting rooms to meet with whānau whaiora in a more welcoming environment, bookable rooms for consultations, group therapy space, and a clinical room. The paint and carpeting tenders were kept local, using Dannevirke-based businesses for these services. Two organisations were chosen nationally for the new furniture, project tools and desks. The staff offices were also updated to include more hot desk options to allow anyone from MidCentral working in Tararua to be able to log in from the office, and provide improved collaboration spaces, storage and staff meeting rooms.

DEVELOPMENTS UNDERWAY AT PALMERSTON NORTH HOSPITAL

Surgical Procedural Interventional Recovery Expansion (SPIRE) is a project to improve facilities at Palmerston North Hospital. The development will result in two new theatres. This will increase the number of theatres from seven to nine, along with creating additional procedure and recovery rooms. The project will also create a cardiac catheterisation laboratory to enable stenting of cardiac patients. Benefits of the project include:

- improved access to specialist services – increasing theatre capacity will reduce waiting times
- safer and more efficient spaces for both pre-operative and post-operative care
- earlier diagnosis and faster treatment for bowel cancer patients
- rapid diagnosis and earlier intervention for people with cardiac conditions.

MAPU/EDOA: Good progress is being made at Palmerston North Hospital to create new facilities and extend and/or enhance existing buildings to meet the MidCentral's growing demand. Outside the front of the hospital, foundations have been laid for an expanded Medical Assessment Planning Unit (MAPU) and Emergency Department Observation Area (EDOA).

On the other side of the hospital campus, the plan for a new acute mental health unit is now in the development of the detailed design phase. Feedback on the design has been very positive and work is underway on the final part of the design process, to define fit-out details of each space, the construction specifications and drawings, and cross sections of the infrastructure.

Oxygen/Medical Gas Upgrade – The site for the new 10 million gaseous litre oxygen tank is being prepared. In the meantime, to ensure increased oxygen supply is available, the Ministry of Health has funded a temporary high pressure oxygen connection point near the kitchen block. This will permit rapid connection of a mobile emergency oxygen container consisting of a storage vessel and two vaporisers. This can be onsite within eight hours if needed. The connections required to link to the container and our recently installed distribution system have been established.

NEW FLUOROSCOPY MACHINE

The new fluoroscopy machine came into use in late February 2022.

Fluoroscopy is a medical imaging technique which allows clinicians to obtain real time moving images of human tissue using pulsing x-ray beams. The service has been managing without a fluoroscopy machine for some time and are enjoying having this modality once again.

Medical Lead Medical Imaging Dr Arshad Sheriff said: "We have been mostly

making our way through a backlog of video fluoroscopy swallows in conjunction with the speech and language therapy team. Prior to this often the elderly and patients with comorbidities have had to travel to Masterton for this procedure. We have also doubled our ERCP* lists which will ease pressure on the gastroenterology service."

"As with any new equipment there is often a learning curve for the operators involved. Patients and staff seem to be happy so far. We haven't had any formal feedback from patients here, but we are still in the very early days of this machine being live."

* ERCP (Endoscopic retrograde cholangiopancreatography), a procedure that combines upper gastrointestinal (GI) endoscopy and x-rays to treat problems of the bile and pancreatic ducts. Clinicians can see, for example, what happens when a patient swallows.

THIRD LINEAR ACCELERATOR BEGINS SERVICE

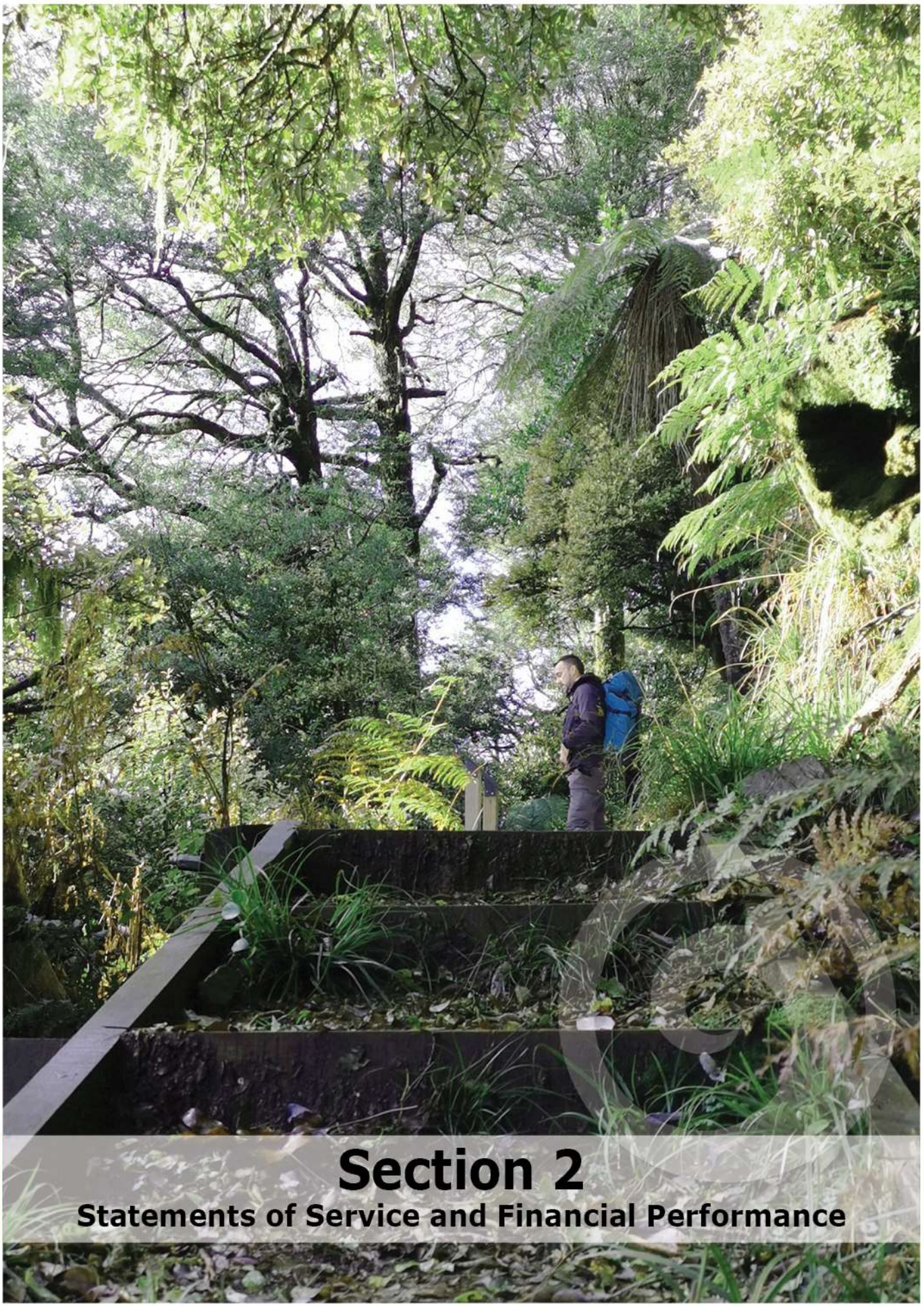
A third Varian True Beam linear accelerator has commenced service at Palmerston North Hospital. This linear accelerator was installed mid-way through 2021, following the failure of one of the hospital's older linear accelerators. Linear accelerators deliver radiation therapy, an effective form of cancer treatment, that is involved in about 40 percent of all cancer cures.

The installation and commissioning of the new linear accelerator progressed as planned to enable the new machine to begin treating patients. Though there were some disruptions due to our COVID-19 response, all patients continued to be treated within timeframes during the installation process. The first patient was treated in September this year.

This is an exciting time for the service to introduce a third new linear accelerator, further improving the treatment delivery options available to patients within the Regional Cancer Treatment Service.

Wāhanga 2

Tauāki o Te Ratonga me te Whakatutukitanga Pūtea



Section 2

Statements of Service and Financial Performance

STATEMENT OF RESPONSIBILITY

For the 12 months ended 30 June 2022

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

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

The Board and Management of Te Whatu Ora take responsibility for the preparation of the Mid Central 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 Mid Central DHB group under section 19A of the Public Finance Act.

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

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

Signed on behalf of the Te Whatu Ora Board:

Naomi Ferguson
Acting Chair

Dated: 20 March 2023

Hon Amy Adams
Board member

Dated: 20 March 2023

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 $631 million in the 2021/22 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
- Rehabilitation and support services

The service outputs that are measured within each Output Class are a logical fit with the population healthcare continuum as outlined in the following figure.

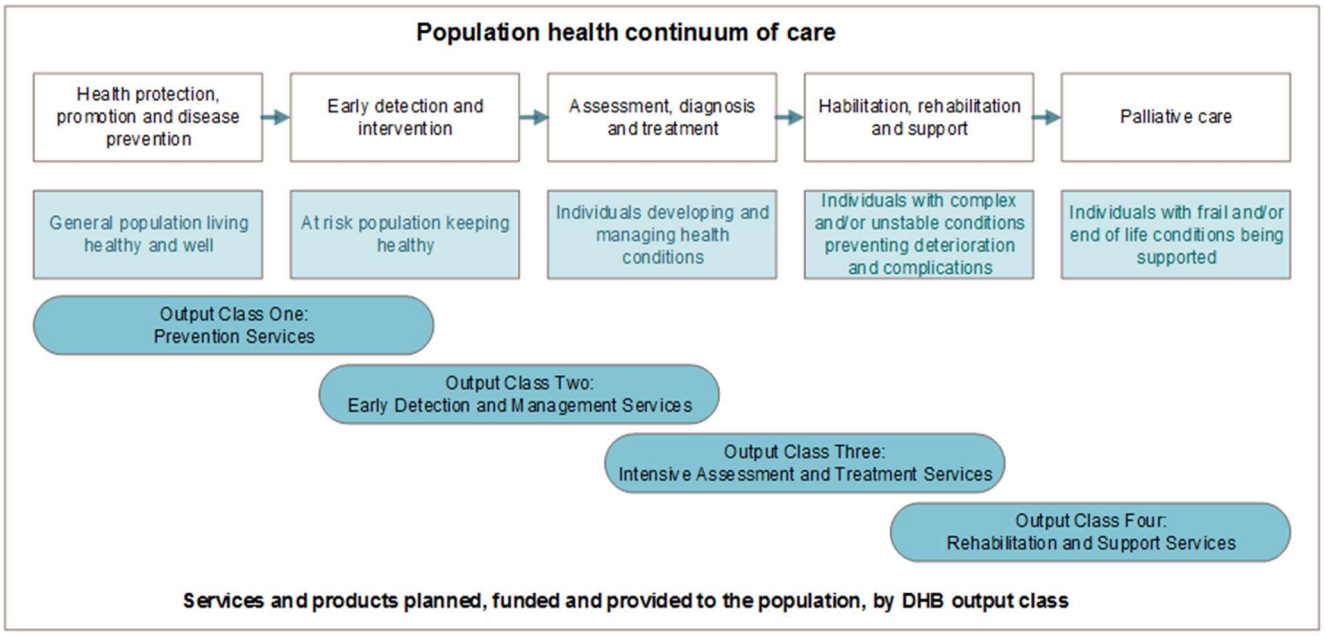


Figure 2: Population health continuum of care

The following pages set out in detail how well we did against what we planned, for the period from 1 July 2021 to 30 June 2022 and how we have contributed to our goals (outcomes) for our healthcare system and health service users.

Output Class 1: 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 healthcare
- 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 breastfeeding
- 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)

- B4 School Checks for eligible children in both high deprivation and total populations dropped a little from the previous year's achievement, while remaining above target.
- Continuing with the work for B4 School Checks, all children (100 percent) identified as obese were offered a referral to a health professional for clinical assessment – this is for all populations.
- Newborn non-Māori children's enrolment in General Practice at three months remains above target. Māori rates are consistent with the previous year, but still considerably below the target.
- 'Current smokers', based on recorded data, continue to remain below the target for both Māori (36 percent or below) and non-Māori (15 percent or below). These rates have been consistent over the previous three years.
- Mammogram rates for MidCentral non-Māori women, aged 50-69 (in the last two years) continue to exceed the 70 percent target. Rates for Māori have improved within the last year but remain eight percent away from the target.

All children have the best start to life						
Indicators		**2019/20 Actual**	**2020/21 Actual**	**2021/22 Target**	**2021/22 Result**	
Percentage of infants that are exclusively or fully breastfeeding at three months of age[2]	Māori	50.1%	47.5%	≥70%	50.1%	🔴
	Non-Māori	57.1%	59.0%		58.6%	🔴
Percentage of infants who receive all Well Child Tamariki Ora core contacts (1 to 5) in their first year of life[3]	Māori	68.9%	42.9%	≥90%	60.1%	🔴
	Non-Māori	80.3%	58.4%		77.9%	🔴
Percentage of high deprivation and total population of eligible children who have received their B4 School Check	High Dep	77.9%	101.2%	≥90%	93.8%	🟢
	Total	83.6%	100.6%		95.7%	🟢
Percentage of newborns enrolled with General Practice by three months of age	Māori	N/A	66.1%	≥85%	66.9%	🔴
	Non-Māori	N/A	98.2%		91.7%	🟢
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	96.4%	85.4%	≥95%	100.0%	🟢
	Non-Māori	96.1%	84.8%		100.0%	🟢

[2] Data is sourced from the Well Child Tamariki Ora Framework indicators.
[3] Refers to report period at March Ministry of Health: Well Child Tamariki Ora Report.

Individuals and whānau are partners in actively managing their own health and wellbeing						
Indicators		**2019/20 Actual**	**2020/21 Actual**	**2021/22 Target**	**2021/22 Result**	
Proportion of PHO enrolled population (aged 15 – 74 years) recorded as 'current smokers'	Māori	31.2%	29.0%	≤36%	28.9%	●
	Non-Māori	12.7%	12.0%	≤15%	11.6%	●
Percentage of pregnant women identified as current smokers and seen by Lead Maternity Carers who were offered smoking cessation services	Māori	78.8%	93.1%	≥90%	100%	●
	Non-Māori	68.6%	95.6%		90.0%	●
Percentage of people enrolled with THINK Hauora (CPHO) being seen by clinical dieticians and/or by physical activity educators	Māori	2.5%	3.9%	≥4%	1.30%	●
	Non-Māori	1.9%	3.5%	≥2%	1.10%	●
Percentage increase in the number of referrals to Green Prescription programmes (Adults and Active Families) for additional physical activity support over the year	Māori	-6.0%	44.2%	≤2%	42.0%	●
	Non-Māori	-32.9%	19.9%	≤1%	14.0%	●

More women participate in cervical and breast screening programmes						
Indicators		**2019/20 Actual**	**2020/21 Actual**	**2021/22 Target**	**2021/22 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)[4]	Māori	64.6%	59.0%	≥80%	54.6%	●
	Non-Māori	72.8%	71.2%		70.4%	●
Percentage of MidCentral domiciled women aged 50–69 years who received a mammogram in the last two years (breast screening programme)[5]	Māori	65.7%	60.6%	≥70%	62.1%	●
	Non-Māori	78.2%	74.8%		75.0%	●

[4] Refers to the three-year coverage rate to March. National Screening Unit, National Cervical Screening Programme, MidCentral DHB coverage report.
[5] Refers to the projected population for the mid-point of the monitoring period, i.e. for coverage rate for the two-year period ending June 2021, the projected population is as at June 2020 (June 2021 Update Census 2018 Base).

Individuals and whānau are engaged with safe and healthy lifestyles						
Indicators		**2019/20 Actual**	**2020/21 Actual**	**2021/22 Target**	**2021/22 Result**	
Percentage of eligible 8 month infants who receive their first course immunisations on time	Māori	79.3%	74.7%	≥95%	66.5%	🔴
	Non-Māori	92.2%	90.4%		87.3%	🟠
Percentage of eligible 4 year old children who are fully immunised by five years of age	Māori	87.2%	82.0%	≥95%	76.5%	🔴
	Non-Māori	91.7%	87.9%		86.7%	🟠
Percentage of the total population aged 65+ years vaccinated for seasonal influenza[6]	Māori	57.3%	56.3%	≥75%	50.1%	🔴
	Non-Māori	69.9%	69.9%		67.9%	🟠
Percentage of eligible girls fully immunised for Human Papillomavirus (HPV)[7]	Total	58.5%	55.0%	≥75%	33.9%	🔴

What did we spend on this Output Class?						
Revenue and expenditure by Output Class	**2020/21 Actual**		**2021/22 Budget**		**2021/22 Actual**	
	Revenue	Expenditure	Revenue	Expenditure	Revenue	Expenditure
	$000	$000	$000	$000	$000	$000
Health promotion and education	5,988	6,293	6,237	6,572	7,035	7,562
Statutory regulation, environmental health	4,960	5,191	5,167	5,421	5,828	6,238
Population based screening	7,051	7,821	7,345	8,168	8,286	9,398
Immunisation	1,851	1,959	1,928	2,046	2,174	2,354
Well child services	2,194	2,308	2,285	2,411	2,578	2,774
Total Prevention Services	**22,044**	**23,572**	**22,962**	**24,618**	**25,901**	**28,326**

[6] Refers to the influenza season for the applicable year, from March to September.
[7] Refers to eligible females in the 2006, 2007 and 2008 birth cohorts in the 2019/20, 2020/21, 2021/22 years respectively. Data source: Ministry of Health National Immunisation Register.

Output Class 2:
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)

- Enrolment percentage for those with any PHO from MidCentral remains within the target, for non-Māori, but is showing a decrease on the previous two years.
- Ambulatory sensitive hospitalisations for the 45 to 64-year-old age group continues to exceed targets for both Māori and non-Māori populations.
- Intentional self-harm rates for those aged 10-24 years has decreased for non-Māori, and is now within the target.
- Diabetes for those aged 15-74, for all populations, shows improved rates for their most recent HbA1c being less than 64mmol/mol – with Māori now achieving target and rates for non-Māori continuing to increase compared to the previous year.

Individuals and whānau can access appropriate, timely health services						
Indicators		**2019/20 Actual**	**2020/21 Actual**	**2021/22 Target**	**2021/22 Result**	
Percentage of MidCentral population (medium projections) enrolled with any PHO at end of financial year[8]	Māori	80.5%	79.0%	≥90%	74.1%	🔴
	Non-Māori	96.7%	97.0%		91.3%	🟢
Average consultation rate per month of THINK Hauora (Central PHO) registered patients	Māori	0.17	0.26	≥0.35	0.28	🔴
	Pacific	0.16	0.22	≥0.29	0.26	🔴
	Other	0.21	0.36	≥0.47	0.36	🔴

Fewer people have unplanned hospital admissions						
Indicators		**2019/20 Actual**	**2020/21 Actual**	**2021/22 Target**	**2021/22 Result**	
Percentage of people assessed as high risk (>15 percent) of cardiovascular disease who have received an annual review[9]	Māori	-	49.3%[10]	≥70%	51.02%	🔴
	Non-Māori	-	48.0%[11]		50.97%	🔴
Ambulatory sensitive (avoidable) hospitalisation rate per 100,000 domiciled population, 0 to 4 year old children (non-standardised)	Māori	6,186	6,453	≤6,300	6,754	🟠
	Non-Māori	4,807	3,483	≤5,100	5,197	🔵
Ambulatory sensitive hospitalisation rate per 100,000 domiciled population, 45 to 64 year-old adults (standardised)[12]	Māori	7,073	6,412	≤7,200	6,121	🟢
	Non-Māori	3,659	3,208	≤3,800	3,618	🟢
Rate per 10,000 population aged 10 to 24 years (age standardised) admitted to hospital with intentional self-harm (DHB of domicile)[13]	Māori	40.5	46.8	≤45	50.0	🔵
	Total	52.4	51.1	≤52	47.1	🟢

[8] Data source: Ministry of Health, PHO Enrolment Demographics as at 1 July each year.
[9] New indicator that took effect 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.
[10] Result is Māori aged 30 – 74 years that have been assessed as high risk of cardiovascular disease who have received an annual review.
[11] Result is non Māori aged 45 – 74 years that have been assessed as high risk of cardiovascular disease who have received an annual review.
[12] Years to December.
[13] Years to March.

Individuals and whānau are partners in actively managing their own health and wellbeing						
Indicators		**2019/20 Actual**	**2020/21 Actual**	**2021/22 Target**	**2021/22 Result**	
Percentage of CPHO enrolled population registered and using e-portal	Total	21.7%	30.46%	≥25%	17.0%	🟠
Percentage of enrolled people aged 15 to 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	53.1	54.8%	≥60%	61.8%	🟢
	Non-Māori	63.5	64.3%		70.7%	🟢
Ambulatory sensitive hospitalisation rate (non – standardised) in the 45 to 64-year-old population age group for certain cardiac and respiratory diseases, stroke and diabetes[14][15]	Māori	4,461	4,245	≤4,300	3,742	🟢
	Non-Māori	2,190	2,028	≤2,400	2,286	🟢

All children have the best start to life						
Indicators		**2019/20 Actual**	**2020/21 Actual**	**2021/22 Target**	**2021/22 Result**	
Percentage of Year 9 students receiving a health assessment (HEEADSSS) by the school-based health service (SBHS) in the calendar year[16]	Total	73.9%	76.2%	≥95%	48.2%	🔴
Mean score of Decayed, Missing and Filled Teeth of Year 8 children seen in the year[17]	Māori	0.63	1.71	≤0.61	1.90	🔴
	Total	0.44	1.10		1.24	🔴
Percentage of 5-year-old children seen in the year who are caries free[18]	Māori	43.0%	41.1%	≥50%	39.7%	🔴
	Total	61.8%	61.8%	≥63%	55.2%	🟠
Proportion of 0 to 4 year population enrolled with DHB funded oral health service[19]	Māori	56.0%	63.8%	≥95%	78.3%	🔴
	Total	100.1%	101.3%		107.2%	🟢
Proportion of adolescent population utilising DHB-funded dental services[20]	Total	83.1%	73.1%	≥85%	66.1%	🔴

[14] 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.
[15] Calendar years 2019, 2020 and 2021.
[16] Calendar years 2019, 2020 and 2021.
[17] Calendar years 2019, 2020 and 2021.
[18] Calendar years 2019, 2020 and 2021.
[19] Calendar years 2019, 2020 and 2021.
[20] Source: Nationwide Service Framework Library: Utilisation of Preventative Services – Adolescent oral health utilisation services to 31 December 2021.

What did we spend on this Output Class?						
Revenue and expenditure by Output Class	**2020/21 Actual**		**2021/22 Budget**		**2021/22 Actual**	
	Revenue	Expenditure	Revenue	Expenditure	Revenue	Expenditure
	$000	$000	$000	$000	$000	$000
Primary healthcare	51,956	55,198	54,119	57,649	61,047	66,329
Child and adolescent oral health	3,625	7,483	3,776	7,815	4,260	8,992
School-based and youth health services	2,547	2,884	2,653	3,012	2,993	3,465
Primary community care	8,238	8,723	8,581	9,110	9,680	10,482
Community pharmacy services	54,090	57,261	56,340	59,805	63,552	68,810
Community referred testing and diagnostics	20,483	22,054	21,336	23,034	24,068	26,502
Total Early Detection and Management Services	**140,939**	**153,603**	**146,805**	**160,425**	**165,600**	**184,580**

Output Class 3:
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 healthcare professionals who 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.

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

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 healthcare services and have a positive experience of the healthcare system
- Individuals receive evidence-based, clinically effective healthcare 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)

- Pre-term birth rates at Palmerston North Hospital have decreased over the year, and currently come under the nine percent or below target.
- Breastfeeding rates of women discharged from Palmerston North Hospital Maternity Services, who were exclusively or fully breastfeeding on discharge improved significantly (more than 10 percent over the year) for both Māori and all women, now meeting the target.
- Emergency caesarean section delivery rates (DHB of residence) remain similar to the 2020/21 year, an improvement on the 2019/20 year, and well under the 17 percent target.
- Acute readmission rates to hospital within 28 days of a previous discharge, continue to reduce and remain under target for the second consecutive year.
- The percentage of people with accepted referrals for a Computed Tomography (CT) scan, who received their scan within six weeks (42 days) continues to increase and remain above target.
- Access to specialist mental health and addiction services (for all ages and all populations – Māori, non-Māori and total) continues to be above target.
- Annual planned care interventions delivered by the end of June (including surgical discharges, minor procedures and non-surgical interventions – by DHB of domicile), remains above the 95 percent target.
- Standardised intervention rates for cataract surgeries (per 10,000 population) has increased by more than 10 percent and is now exceeding the target rate.
- Percentage of people receiving their first cancer treatment (or other management) within 31 days, from date of decision to treat, remains above the 85 percent target.

People receive quality healthcare services and have a positive experience of the healthcare system						
Indicators		**2019/20 Actual**	**2020/21 Actual**	**2021/22 Target**	**2021/22 Result**	
Percentage of people presenting to the Emergency Department that are discharged, admitted or transferred within six hours		77.2%	75.1%	≥95%	62.8%	🔴
Surgical site infections per 100 hip and knee operations		1.3[21]	0.02	≤1.0	1.4	🔵
Average number of in-hospital falls per month causing a fractured neck of femur over the year		0.08	0.00	≤0.12	0.08	🟢
Hospital acquired bacteraemia rate per 1,000 patients		0.18	0.98	≤1.7	1.60	🟢

Individuals receive evidence based, clinically effective healthcare services when and where they need it						
Indicators		**2019/20 Actual**	**2020/21 Actual**	**2021/22 Target**	**2020/21 Result**	
Percentage of women (DHB of residence) giving birth at secondary maternity facility[22]		75.5%	79.9%	≤85%	85.2%	🔵
Percentage of emergency caesarean section deliveries for women giving birth – DHB of residence (calendar year)[23]		17%	13.6%	≤17%	13.7%	🟢
Percentage of preterm births at Palmerston North Hospital (calendar year)[24]		7.9%	9.1%	≤9%	6.7%	🟢
Percentage of women discharged from PNH maternity services who were exclusively or fully breastfeeding on discharge from hospital	Māori	70.4%	69.7%	≥75%	80.8%	🟢
	Total	70.2%	72.3%		82.9%	🟢

[21] Refers to the 9-month period to March 2020 only – suspended reporting of manually collected and submitting data to HQSC in fourth quarter.
[22] Data source: MCIS.
[23] Data source: MCIS.
[24] Data source: MCIS.

Individuals and whānau can access appropriate, timely health services						
Indicators		**2019/20 Actual**	**2020/21 Actual**	**2021/22 Target**	**2021/22 Result**	
Percentage of people accepted for a non-urgent diagnostic colonoscopy receiving (or waiting for) their procedure in 42 working days or less		73.8%	51%	≥70%	25.6%	🔴
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	78.1%	86.5%	≥95%	77.1%	🔴
	MRI	73.6%	93.6%	≥90%	97.4%	🟢
Percentage of the population accessing specialist mental health and addiction services (all ages)[25]	Māori	5.6%	5.8%	≥5.0%	5.6%	🟢
	Non-Māori	2.9%	3.6%	≥3.0%	3.4%	🟢
	Total	3.5%	4.0%	≥3.5%	3.9%	🟢
Percentage of people referred for non-urgent mental health and addiction services seen within 3 weeks (DHB Mental Health and Addictions service provider only)	0 to 19 yrs	76.0%	70.7%	≥80%	74.5%	🟠
	20 to 64 yrs	87.7%	87.4%		89.8%	🟢
	65+ yrs	88.0%	88.4%		93.5%	🟢
Average length of time between referral from acute inpatient services to transfer to AT&R services (days)		1.4	3.2	≤1.5	3.0	🔴
Average length of stay (raw) – AT&R (geriatric) inpatient services		16.0	16.95	≤16.0	17.35	🟠
Percentage of acute readmissions to hospital within 28 days with a pervious discharge from AT&R inpatient services (geriatric)		7.8%	8.8%	≤7.5%	9.3%	🔴
Percentage of annual planned care interventions delivered by end of June (includes surgical discharges, minor procedures and non-surgical interventions (DHB of domicile)		90%	111.6%	≥95%	106.3%	🟢
Standardised intervention rates for specific surgical procedures per 10,000 population (All Admission types)[26]	Cataract	32.55	26.8	≥27.0	37.0	🟢
	Major Joints	21.66	20.4	≥21.0	16.7	🔴
	Angiography	29.77	29.4	≥34.7	28.9	🔴
Percentage of people receiving their first cancer treatment (or other management) within 31 days from date of decision to treat		86.9%	90.1%	≥85%	87.1%	🟢
Percentage of patients waiting greater than four months for their first specialist assessment (as at end of June each year)		6.5%[27]	4.5%	≤1%	5.2%	🔴
Percentage of patients given a commitment to treatment (surgery) but not treated within four months (as at end of June each year)		56.4%[28]	37.7%	≤1%	58.5%	🔴

[25] Data source: Ministry of Health (PRIMHD), MH Dashboard April–March respective years.
[26] Refers to the 12-month periods ending 31 March respectively.
[27] 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.
[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.

Fewer people have unplanned hospital admissions					
Indicators	**2019/20 Actual**	**2020/21 Actual**	**2021/22 Target**	**2021/22 Result**	
Percentage of Emergency Department presentations resulting in an acute admission to inpatient services	26.9%	25.2%	≤28%	26.8%	●
Percentage of acute readmissions to hospital within 28 days of a previous discharge (standardised, all ages, DHB of Service)[29]	12.6%	12.3%	≤12.5%	11.4%	●
Standardised acute bed days per 1,000 population (DHB of domicile)[30]	381.4	404.0	≤410	418.1	●

What did we spend on this Output Class?						
Revenue and expenditure by Output Class	**2020/21 Actual**		**2021/22 Budget**		**2021/22 Actual**	
	Revenue	Expenditure	Revenue	Expenditure	Revenue	Expenditure
	$000	$000	$000	$000	$000	$000
Emergency department	23,517	28,715	24,496	29,990	27,632	34,506
Medical services	75,594	75,724	78,741	79,087	88,821	90,996
Surgical / ICU / Anaesthetic services	97,179	107,368	101,221	112,137	114,181	129,021
Regional Cancer Treatment services	54,930	55,483	57,216	57,947	64,541	66,672
Women's and children's services	42,266	45,359	44,026	47,374	49,662	54,507
Elder health services	14,914	20,305	15,535	21,207	17,524	24,400
Rehabilitation and Therapy services	2,387	3,048	2,487	3,183	2,805	3,662
Mental health and addiction services	41,072	48,568	42,782	50,725	48,259	58,363
Clinical support services	8,082	9,585	8,418	10,010	9,496	11,517
Inter district flows	64,670	68,465	67,362	71,506	75,986	82,273
Total Intensive Assessment and Treatment Services	**424,611**	**462,620**	**442,284**	**483,166**	**498,907**	**555,917**

[29] Refers to the 12 month period ending 31 March 2020, 2021 and 2022 respectively. Data source: Ministry of Health.
[30] Refers to the 12 month period ending 31 March 2020, 2021 and 2022 respectively. Data source: Ministry of Health.

Output Class 4: Rehabilitation and support services

OUTPUT CLASS DESCRIPTION

Rehabilitation and support services are delivered following a 'needs 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 healthcare.
- 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)

- 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. The rate of 100% achievement is consistent over the last three years.
- The proportion of older people being supported in the community with packages of temporary supports remains above target, but has decreased in the last 12 months.
- Those aged 65 plus and receiving district health board funded support in long-term age-related residential care facilities remains consistent and within target.

Individuals and whānau are supported to make informed decisions about their healthcare					
Indicators	**2019/20 Actual**	**2020/21 Actual**	**2021/22 Target**	**2021/22 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	77.9%	67.0%	≥75%	38.0%	🔴
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	**2019/20 Actual**	**2020/21 Actual**	**2021/22 Target**	**2021/22 Result**	
Proportion total needs assessments completed for MidCentral DHB domiciled people that resulted in a service coordination outcome of home based support services	67.6%	56%	≥60%	42.0%	🔴
Percentage of eligible people aged 65+ years receiving community-initiated Packages of Temporary Support (PoTS) as a proportion of total people receiving PoTS	40.0%	46%	≥33%	42.5%	🟢
Percentage of population aged 65+ years receiving DHB funded support in long-term aged related residential care facilities	N/A[31]	4.2%	≤6%	4.0%	🟢
Percentage of total ARC beds utilised by people for dementia care	12.1%	14%	≤15%	15.6%	🔵
Percentage of people discharged from hospital following an acute stroke and referred to DHB community rehabilitation services and seen within seven days of discharge	21.3%	21.3%	≥60%	21.1%	🔴
Proportion of MidCentral DHB individuals who had respite care/carer relief as a service coordination outcome following a first assessment during the year	28.2%	17%	≥18%	16.9%	🟠

People receive quality healthcare services and have a positive experience of the healthcare system					
Indicators	**2019/20 Actual**	**2020/21 Actual**	**2021/22 Target**	**2021/22 Result**	
Proportion of patients referred to the hospital-based palliative care team who have a non-malignant diagnosis	36.2%	39%	≥35%	34%	🔵
Percentage increase/decrease from previous year in the number of new referrals to primary palliative care programme[32]	-4.8%	D	N/A	0%	- -

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

What did we spend on this Output Class?						
Revenue and expenditure by Output Class	**2020/21 Actual**		**2021/22 Budget**		**2021/22 Actual**	
	Revenue	Expenditure	Revenue	Expenditure	Revenue	Expenditure
	$000	$000	$000	$000	$000	$000
Needs assessment and service coordination	4,284	4,663	4,462	4,870	5,033	5,603
Age-related residential care beds	69,970	74,071	72,885	77,364	82,216	89,010
Home-based support services	20,198	21,387	21,038	22,337	23,732	25,700
Rehabilitation services	19,711	21,097	20,531	22,034	23,160	25,352
Palliative care services	4,537	5,021	4,726	5,244	5,331	6,033
Lifelong disability services	43,552	45,230	45,364	47,240	51,172	54,352
Respite care services	4,481	4,872	4,667	5,088	5,264	5,854
Day services	2,872	3,168	2,991	3,308	3,374	3,807
Inter district flows	7,041	7,455	7,334	7,786	8,273	8,959
Total Rehabilitation and Support Services	**176,646**	**186,964**	**183,998**	**195,271**	**207,555**	**224,670**

IMPLEMENTING THE COVID-19 VACCINE STRATEGY

Additional performance information: COVID-19 vaccinations and mortality

Source: Ministry of Health

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

COVID-19 VACCINATIONS

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

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

HSU 2021

People are included if they were:

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

HSU 2020

People are included if they were:

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

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

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

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

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

PERCENTAGE OF THE ELIGIBLE POPULATION WHO HAVE COMPLETED THEIR PRIMARY COVID-19 VACCINATION COURSE: COMPARING HSU 2021 AND HSU 2020

To determine the coverage of the COVID-19 vaccine across the population of MidCentral DHB, we have used the HSU 2021 data as the denominator (the figure which the total eligible population vaccinated is divided by). The suitability of the HSU for this purpose was reviewed by Stats NZ, with their findings and recommendations published on 4 August 2022.[33]

Percentage of the eligible population who have completed their primary COVID-19 vaccination course[34] (HSU 2021 vs HSU 2020)

Year[35]	HSU 2021 Percentage of the eligible population who have completed their primary course	HSU 2020 Percentage of the eligible population who have completed their primary course
2020/2021	10.33%	10.86%
2021/2022	80.41%	84.49%
Total	**90.74%**	**95.35%**

Using HSU 2021 to determine the percentage of the eligible population who have completed their primary course, the coverage is calculated to be 90.74%, compared with 95.35% using HSU 2020 as at 30 June 2022.

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

[33] https://www.stats.govt.nz/reports/review-of-health-service-user-population-methodology
[34] Individuals who have received dose 1 and dose 2 of the COVID-19 vaccine are considered to have completed their primary course. This definition supersedes the term 'fully vaccinated' reported in our 2020/21 annual report.
[35] Data as at 30 June 2021 for 2020/21 and 30 June 2022 for 2021/22.

COVID-19 vaccine doses administered by dose type and year

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

COVID-19 VACCINE DOSES ADMINISTERED BY DOSE TYPE AND YEAR (HSU 2020)

Year[36]	Primary course				
	Dose 1	Dose 2	Booster 1	Booster 2	Total[37]
2020/21	30,562	16,613	0	0	47,175
2021/22	125,223	132,417	97,424	579	355,643
Total	**155,785**	**149,030**	**97,424**	**579**	**402,818**

By 30 June 2022, a total of 402,818 COVID-19 vaccinations had been administered, of which 88.29% were administered in 2021/22.

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

COVID-19 VACCINE DOSES ADMINISTERED BY AGE GROUP

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

[36] Data as at 30 June for each financial year, and respectively covers all vaccination doses administered between 1 July-30 June.
[37] Excludes third primary doses administered and any subsequent boosters a person may have received after the second booster vaccination.

COVID-19 vaccine doses administered by age group[38]

Age group (years)[39]	Primary course Dose 1	Dose 2	Booster 1	Booster 2	Total[40]
0 to 11	9,220	4,346	0	0	13,566
12 to 15	9,853	9,421	3	0	19,277
16 to 19	8,426	8,356	2,538	0	19,320
20 to 24	9,801	9,849	5,502	3	25,155
25 to 29	9,594	9,630	5,731	4	24,959
30 to 34	9,555	9,648	6,318	8	25,529
35 to 39	8,470	8,621	6,346	12	23,449
40 to 44	8,182	8,270	6,454	14	22,920
45 to 49	8,535	8,749	7,124	8	24,416
50 to 54	8,849	9,291	8,312	25	26,477
55 to 59	9,108	9,796	9,040	43	27,987
60 to 64	8,599	9,504	9,569	71	27,743
65 to 69	5,967	8,278	8,624	68	22,937
70 to 74	4,685	7,469	8,114	91	20,359
75 to 79	2,909	5,263	6,062	100	14,334
80 to 84	1,970	3,457	4,187	72	9,686
85 to 89	992	1,666	2,263	31	4,952
90+	508	803	1,237	29	2,577
Total	125,223	132,417	97,424	579	355,643

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

COVID-19 people vaccinated by age group

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

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

[38] Data as at 30 June 2022 and covers all vaccination doses administered between 1 July 2021-30 June 2022.
[39] Age groupings in this table reflect the age of the person at the time of the vaccination being administered.
[40] Excludes third primary doses administered to individuals and any subsequent boosters which may have been administered after the second booster vaccination.

COVID-19 people vaccinated by age group during 2021/22[41]

Age group[42] (years)	Partial [43]		Primary course [44]		Booster course			
	Partially vaccinated	Partially vaccinated (% eligible)	Completed primary course	Completed primary course (% eligible)	Received first booster (18+)	First booster (% eligible) (18+)	Received second booster (50+)	Received second booster % eligible (50+)
0 to 11	7,853	27%	3,778	13%	0	0%	0	0%
12 to 15	8,475	82%	7,517	72%	0	0%	0	0%
16 to 19	8,597	90%	8,483	89%	1,363	43%	0	0%
20 to 24	10,063	81%	10,099	81%	5,447	50%	0	0%
25 to 29	9,553	75%	9,595	75%	5,672	52%	0	0%
30 to 34	9,807	77%	9,953	78%	6,262	56%	0	0%
35 to 39	8,704	78%	8,850	79%	6,306	63%	0	0%
40 to 44	8,230	79%	8,412	81%	6,414	68%	0	0%
45 to 49	8,225	76%	8,428	78%	6,896	73%	0	0%
50 to 54	9,002	77%	9,406	81%	8,234	77%	27	3%
55 to 59	8,751	73%	9,344	78%	8,688	82%	37	4%
60 to 64	9,008	77%	9,854	84%	9,738	86%	67	6%
65 to 69	6,543	65%	8,408	84%	8,706	90%	66	8%
70 to 74	4,932	53%	7,568	82%	8,126	94%	87	11%
75 to 79	3,340	50%	5,848	87%	6,527	96%	108	14%
80 to 84	2,183	47%	3,912	84%	4,491	97%	69	12%
85 to 89	1,157	47%	1,976	79%	2,433	100%	36	9%
90+	662	47%	1,034	74%	1,434	106%	33	11%
Total	125,085	66%	132,465	70%	96,737	74%	530	8%

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

COVID-19 vaccine doses administered by ethnicity

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

COVID-19 vaccine doses[45] administered by ethnicity[46] (1 July 2021 – 30 June 2022)

Ethnicity (Note 1, 2)	Primary course				
	Dose 1	Dose 2	Booster 1	Booster 2	Total
Asian	10,673	10,709	8,117	24	29,523
European/other	87,538	95,344	75,015	500	258,397
Māori	21,660	21,021	10,916	40	53,637
Pacific peoples	4,210	4,160	2,370	4	10,744
Unknown	1,142	1,183	1,006	11	3,342
Total	125,223	132,417	97,424	579	355,643

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

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

[45] This excludes third primary doses administered and any subsequent boosters a person may have received after a second booster.
[46] Data as at 30 June 2022 and includes all vaccination doses being administered between 1 July 2021 – 30 June 2022.

COVID-19 people vaccinated by ethnicity

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

COVID-19 people vaccinated by ethnicity during 2021/22[47]

Ethnicity (Note 1)	Partially vaccinated (12+)	Partially vaccinated (12+) (% eligible)	Completed Primary Course (12+)	Completed primary course (12+) (%)	Received First Booster (18+)	Received first booster (18+) (% eligible)	Received second booster,50 +	Received second booster (% eligible, 50+)
Asian	9,624	79%	10,190	84%	8,101	77%	17	9%
Māori	19,849	75%	20,338	77%	10,850	56%	33	5%
European /other	82,763	72%	92,858	81%	74,411	77%	468	9%
Pacific peoples	3,839	78%	4,040	82%	2,358	61%	4	3%
Unknown	1,157	75%	1,261	81%	1,017	68%	8	12%
Total	117,232	73%	128,687	80%	96,737	74%	530	8%

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

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

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

Ethnicity (Note 1, 2)	Partially Vaccinated 12+	Partially Vaccinated 12+ % of HSU2021	Completed Primary Course 12+	Completed Primary Course 12+ % of HSU2021	Received First Booster 18+	Received First Booster 18+ % of Eligible	Received Second Booster 50+	Received Second Booster % of Eligible (50+)
Asian	11,726	97%	11,606	96%	8,101	77%	17	9%
Māori	23,517	89%	22,642	86%	10,850	56%	33	5%
European /other	106,294	92%	104,920	91%	74,411	77%	468	9%
Pacific peoples	4,618	94%	4,507	92%	2,359	61%	4	3%
Unknown	1,586	102%	1,549	100%	1,017	68%	8	12%
Total	147,741	92%	145,224	91%	96,738	74%	530	8%

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

Note 2: Partially Vaccinated counted for 12+ years old (age as at 30-Jun-2022). Completed Primary Course counted for 12+ years old (age as at 30-Jun-2022). Received First Booster counted for 18+ years old (age as at 30-Jun-2022). Received Second Booster counted for 18+ years old (age as at 30-Jun-2022). 50+ age determined as at 30-Jun-2022. Basis of population is HSU2021 for 12+ years old. All counts exclude those who died prior to 30-Jun-2022.

FURTHER NOTES ON THE HSU DATASET

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

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

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

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

There are other datasets that measure the number of people living in New Zealand produced by Stats NZ:[48]

1. Census counts produced every 5 years with a wide range of disaggregation's
2. Population estimates (ERP) which include adjustments for people not counted by census:
    a. National population estimates (produced quarterly)
    b. Subnational population estimates (produced every year)
3. Population projections which give an indication of the future size and composition of the population:
    a. Official national and subnational projections
    b. Customised population projections (produced every year by Stats NZ for the Ministry of Health using requested ethnic groupings and DHB areas).

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

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

STATS NZ

'The ERP and HSU have different target populations. In principle, the ERP is an estimate of the population usually living (resident) in New Zealand at a point in time, and the HSU is a measure of the population in New Zealand using (or potentially using) the health system at a point in time. For both the ERP and HSU, mean populations over a period of time can be derived from the point in time estimates.'[49]

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

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

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

- age
- ethnicity
- DHB
- gender

[48] https://www.stats.govt.nz/methods/population-statistics-user-guide.
[49] More information on the findings from the Stats NZ review of the HSU is available at: stats.govt.nz/reports/review-of-health-service-user-population-methodology/

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

COMPARISON OF HSU 2021 TO THE STATS NZ PROJECTED RESIDENT POPULATION

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

COMPARISON OF HSU 2021 TO THE STATS NZ PRP FOR THE DHB

As at 31 December 2021, there is an estimated 189,276 health service users in the HSU 2021. This is an increase of 7,489 people from the HSU 2020 (an approximate 4.12% increase), and 176 more people than the Stats NZ PRP for 30 June 2021. DHB population by ethnicity: HSU 2021 and Stats NZ PRP comparison.[50]

Ethnicity	HSU 2021	Stats NZ PRP	Difference (Note 1)
Māori	35,801	41,100	5,299
Pacific peoples	6,421	6,290	-131
Asian	15,185	15,300	115
European/other	130,182	126,500	-3,682
Unknown	1,687	0	-1,687
Total (Note 1)	189,276	189,190	-86

Note 1: The total MidCentral population estimate based on HSU 2021 (as at 31 December 2021) is 189,276. This is 86 above the Stats NZ total projected population of 189,190 (as at 30 June 2021) taken from the customised 2018-base population projections Stats NZ produced in 2021.

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

COMPARISON OF HSU 2020 TO THE STATS NZ PRP

For reference, we have provided the HSU 2020 comparison.

DHB population by ethnicity: HSU 2020 and Stats NZ PRP[51]

Ethnicity	HSU 2020	Stats NZ PRP	Difference (Note 2)
Māori	33,592	40,000	6,408
Pacific peoples	5,994	6,160	166
Asian	12,998	15,100	2,102
European/other	128,044	126,200	-1,844
Unknown	1,159	0	-1,159
Total (Note 1)	181,787	187,460	5,673

Note 2: The total MidCentral population estimate based on HSU 2020 (as at 1 July 2020) is 181,787. This is 5,673 below the Stats NZ total projected population of 187,460 (at 30 June 2020) taken from the customised 2018-base population projections Stats NZ produced in 2021.

COVID-19 MORTALITY RATES

The data used to determine deaths attributed to COVID-19 comes from EpiSurv[52] and the National Contact Tracing Solution (NCTS) databases. The data received through these systems is extensively checked for duplications using national health index (NHI) data.

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

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

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

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

[51] HSU 2020 data is as at 1 July 2020 and Stats NZ PRP data is as at 30 June 2020.
[52] EpiSurv is a secure national system used by Primary Health Units to report cases of notifiable diseases. It is operated by the Institute of Environmental Science and Research (ESR), on behalf of the Ministry of Health.

COVID-19 DEATHS BY AGE GROUP

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

Age group (years)	
<10	0
10 to 19	0
20 to 29	0
30 to 39	0
40 to 49	1
50 to 59	3
60 to 69	0
70 to 79	5
80 to 89	16
90+	15
Total	**40**

COVID-19 DEATHS BY ETHNICITY

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

Ethnicity	
Asian	0
European/other	40
Māori	0
Pacific peoples	0
Unknown[53]	0
Total	**40**

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

FINANCIAL STATEMENTS

Statement of comprehensive revenue and expense for the year ended 30 June 2022

	Notes	Group Actual 2022 $000	Budget 2022 $000	Actual 2021 $000
Revenue				
Patient care revenue	2(i)	908,113	825,847	773,670
Interest revenue		684	220	456
Other revenue	2(ii)	31,054	11,218	13,690
Total revenue		939,851	837,285	787,816
Expenses				
Personnel costs	3	340,884	299,465	305,407
Depreciation, amortisation and impairment losses	12,13	37,005	30,498	23,259
Outsourced services		69,833	42,776	42,618
Clinical supplies		69,846	64,937	64,212
Infrastructure and non-clinical expenses		113,676	75,293	65,696
Other district health boards		71,992	71,036	64,240
Non-health-board provider expenses		265,362	257,252	241,745
Capital charge	4	10,301	10,612	8,009
Interest expense		59	58	69
Other expenses	5	14,667	11,553	11,630
Total expenses		993,625	863,480	826,885
Share of associate surplus/(deficit)	11	132	-	126
Surplus/(deficit)		**(53,642)**	**(26,195)**	**(38,943)**
Other comprehensive revenue and expense				
Item that will not be reclassified to surplus/(deficit)				
Revaluation of land and buildings	19	61,815	-	82,227
Total other comprehensive revenue and expense		61,815	-	82,227
Total comprehensive revenue and expense		**8,173**	**(26,195)**	**43,284**

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 2022

	Notes	Group Actual 2022 $000	Budget 2022 $000	Actual 2021 $000
Assets				
Current assets				
Cash and cash equivalents	6	29,037	723	34,489
Receivables from exchange contracts	7	30,335	15,652	16,631
Receivables from non-exchange contracts	7	17,195	8,872	10,904
Investments	8	2,000	1,500	2,000
Inventories	9	6,511	4,530	4,853
Total current assets		*85,078*	*31,277*	*68,877*
Non-current assets				
Investments	8	-	-	-
Investment in associate	11	1,401	1,230	1,269
Property, plant, and equipment	12	333,738	310,501	263,253
Intangible assets	13	16,461	42,786	28,865
Total non-current assets		*351,600*	*354,517*	*293,387*
Total assets		**436,678**	**385,794**	**362,264**
Liabilities				
Current liabilities				
Bank overdraft	6	-	1,967	-
Payables from exchange contracts	14	68,691	59,489	54,740
Payables from non-exchange contracts	14	6,992	10,374	9,546
Borrowings	16	216	216	205
Employee entitlements	17	126,694	92,827	83,554
Total current liabilities		*202,593*	*164,873*	*148,045*
Non-current liabilities				
Borrowings	16	699	699	915
Employee entitlements	17	2,505	3,564	2,901
Trusts and special funds	18	2,937	2,220	2,462
Total non-current liabilities		*6,141*	*6,483*	*6,278*
Total liabilities		**208,734**	**171,356**	**154,323**
Net assets		**227,944**	**214,438**	**207,941**
Equity				
Crown equity	19	137,668	160,162	125,838
Accumulated surpluses/(deficits)	19	(156,477)	(131,464)	(102,835)
Property revaluation reserves	19	246,753	185,740	184,938
Total equity		**227,944**	**214,438**	**207,941**

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 2022

	Notes	Group			
		Crown equity	Property revaluation reserves	Accumulated surpluses/ (deficits)	Total equity
		$000	$000	$000	$000
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		**125,838**	**184,938**	**(102,835)**	**207,941**
Surplus/(deficit) for the year		-	-	(53,642)	(53,642)
Revaluation of land and buildings		-	61,815	-	61,815
Total comprehensive revenue and expense		-	*61,815*	*(53,642)*	*8,173*
Capital contributions from the Crown		12,463	-	-	12,463
Distributions to the Crown		(633)	-	-	(633)
Balance at 30 June 2022	19	**137,668**	**246,753**	**(156,477)**	**227,944**

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 2022

	Notes	Group Actual 2022 $000	Group Budget 2022 $000	Group Actual 2021 $000
Cash flows from operating activities				
Receipts from Ministry of Health		890,924	827,921	774,958
Receipts from other revenue		15,715	12,230	13,813
Payments to suppliers		(581,638)	(512,859)	(487,822)
Payments to employees		(300,087)	(290,735)	(269,806)
Capital charge		(10,301)	(10,612)	(8,009)
GST (net)		(606)	103	249
Net cash flow from operating activities		*14,007*	*26,048*	*23,383*
Cash flows from investing activities				
Receipts from sale of property, plant and equipment		9	-	1
Purchase of property, plant and equipment		(30,106)	(70,426)	(17,535)
Purchase of intangible assets		(1,853)	(13,936)	(2,539)
Decrease / (increase) in investments		-	469	-
Interest received		684	220	456
Trusts and special funds		474	(240)	(241)
Net cash flow from investing activities		*(30,792)*	*(83,913)*	*(19,858)*
Cash flows from financing activities				
Interest paid		(59)	(58)	(69)
Capital contributions from the Crown		12,230	32,869	6,950
Return of capital to the Crown		(633)	(633)	(633)
Repayment of loans		-	-	(74)
Repayment of finance leases		(205)	(205)	(194)
Net cash flow from financing activities		*11,333*	*31,973*	*5,980*
Net (decrease)/increase in cash and cash equivalents		(5,452)	(25,892)	9,505
Cash and cash equivalents at the start of the year		34,489	24,648	24,984
Cash and cash equivalents at the end of the year	6	**29,037**	**(1,244)**	**34,489**

Equipment totalling $nil (2021: $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 2022 (continued)

RECONCILIATION OF NET SURPLUS/(DEFICIT) TO NET CASH FLOW FROM OPERATING ACTIVITIES

	Actual 2022 $000	Actual 2021 $000
Net surplus/(deficit)	**(53,642)**	**(38,943)**
Add/(less) non-cash items		
Depreciation	22,748	18,441
Amortisation	14,258	4,818
Impairment	-	-
Donated equipment	(1,360)	(1,000)
Share of associate surplus	(132)	(126)
Total non-cash items	*35,514*	*22,133*
Add/(less) items classified as investing or financing activities		
Items relating to investing and financing activities	(625)	(387)
Net (gains)/losses on disposal of property, plant, and equipment	39	450
Total items classified as investing or financing activities	*(586)*	*63*
Add/(less) movements in statement of financial position items		
(Increase)/Decrease in receivables and prepayments	(19,765)	(274)
(Increase)/Decrease in inventories	(1,658)	(399)
Increase/(Decrease) in payables	11,400	5,755
Increase/(Decrease) in employee entitlements	42,744	35,048
Net movement in working capital	*32,721*	*40,130*
Net cash flow from operating activities	**14,007**	**23,383**

The accompanying notes form part of these financial statements.

Notes index to the financial statements for the year ended 30 June 2022

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, its subsidiary Enable New Zealand Limited (100 percent owned), its associate Allied Laundry Services Limited (ALSL, 16.7 percent owned) and an investment in the Central Region's Technical Advisory Service Limited (CTAS, 16.7 percent owned). ALSL is equity-accounted. 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 2022, and were approved for issue by Te Whatu Ora – Health New Zealand Board on 1 March 2023.

BASIS OF PREPARATION

Health sector reforms

On 21 April 2021, the Minister of Health announced the health sector reforms in response to the Health and Disability System Review. The reforms replace all 20 District Health Boards (DHBs) and the Health Promotion Agency with a new Crown entity, Te Whatu Ora – Health New Zealand, responsible for running hospitals and commissioning primary and community health services. The legislation enabling the reform, the Pae Ora (Healthy Futures) Act 2022 (the Act), took effect on 1 July 2022, formally creating Te Whatu Ora, along with two other entities – Te Aka Whai Ora – Māori Health Authority, to monitor the state of Māori health and commission services directly, and Te Pou Hauora Tūmatanui – the Public Health Agency, which resides within Manatū Hauora – Ministry of Health, to lead and strengthen public health.

The Act disestablished all DHBs and the Health Promotion Agency and transferred MDHB's assets and liabilities to Te Whatu Ora on 1 July 2022. As a result, the financial statements have been prepared on a disestablishment basis. However, because health services will continue to be provided through Te Whatu Ora, no changes have been made to the recognition and measurement basis, or presentation of assets and liabilities in these financial statements due to the disestablishment basis of preparation.

Refer to Note 22 for further information in relation to the change in ownership.

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.

NEW AMENDMENT APPLIED

An amendment to PBE IPSAS 2 Cash Flow Statements 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. The new information required by this amendment has been disclosed in Note 26.

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:

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 services tax (GST), except for receivables and payables, which are presented on a GST-inclusive basis. Where GST is not recoverable as input tax, it is recognised as part of the related asset or expense.

The net amount of GST recoverable from, or payable to, the Inland Revenue 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 2021/22 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

Accident Compensation Corporation (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 2022 $000	Actual 2021 $000
Exchange transactions [for approximate equal value]		
MoH other contracts	42,804	39,856
Inter-district flows	63,587	58,020
ACC contract revenue	60,545	26,113
Other patient care related revenue	464	668
Total exchange transactions	*167,400*	*124,657*
Non-exchange transactions [without directly receiving equal value]		
MoH population-based funding*	630,790	602,056
MoH other contracts	109,923	46,957
Total non-exchange transactions	*740,713*	*649,013*
Total patient care revenue	**908,113**	**773,670**

* The appropriation revenue received by MDHB equals the government's actual expenditure against their appropriation. The government's budgeted appropriation was $630,882,000 prior to top-slices and other allocations (2021: $602,102,000). 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 2022 $000	Actual 2021 $000
Exchange transactions [for approximate equal value]		
Rental revenue	1,029	1,083
Facilities revenue	1,358	1,537
Other revenue	11,759	9,863
Total exchange transactions	*14,146*	*12,483*
Non exchange transactions [without directly receiving equal value]		
Donations and bequests received	16,899	1,206
Total non-exchange transactions	*16,899*	*1,206*
Other transactions		
Gain on sale of property, plant, and equipment	9	1
Total other transactions	*9*	*1*
Total other revenue	**31,054**	**13,690**

OPERATING LEASES AS LESSOR

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

	Actual 2022 $000	Actual 2021 $000
Not later than one year	520	520
Later than one year and not later than five years	1,222	1,575
Later than five years	737	903
Total non-cancellable operating lease revenue	**2,479**	**2,998**

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 2022 $000	Actual 2021 $000
Salaries and wages	289,102	262,306
Defined contribution plan employer contributions	9,038	8,053
Increase in liability for employee entitlements	42,744	35,048
Total personnel costs	**340,884**	**305,407**

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 2022	Actual 2021
Total remuneration paid or payable:		
$100,000 – 109,999	210	149
$110,000 – 119,999	144	86
$120,000 – 129,999	94	60
$130,000 – 139,999	40	29
$140,000 – 149,999	36	22
$150,000 – 159,999	17	22
$160,000 – 169,999	18	16
$170,000 – 179,999	12	11
$180,000 – 189,999	13	12
$190,000 – 199,999	6	8
$200,000 – 209,999	14	13
$210,000 – 219,999	13	9
$220,000 – 229,999	17	13
$230,000 – 239,999	10	12
$240,000 – 249,999	12	17
$250,000 – 259,999	8	4
$260,000 – 269,999	10	10
$270,000 – 279,999	10	8
$280,000 – 289,999	9	11
$290,000 – 299,999	11	13
$300,000 – 309,999	3	7
$310,000 – 319,999	9	5
$320,000 – 329,999	8	10
$330,000 – 339,999	9	8
$340,000 – 349,999	3	2
$350,000 – 359,999	3	2
$360,000 – 369,999	2	2
$370,000 – 379,999	5	2
$380,000 – 389,999	3	2
$390,000 – 399,999	2	-
$400,000 – 409,999	1	-
$410,000 – 419,999	1	1
$420,000 – 429,999	1	-
$430,000 – 439,000	-	1
$440,000 – 449,999	1	-
$490,000 – 499,999	-	1
$510,000 – 519,999	-	1
$540,000 – 549,999	1	1
$580,000 – 589,999	1	-
$930,000 – 939,999	1	-
Total employees	**758**	**570**

Of the total of 758 (2021: 570) staff paid more than $100,000, 674 (2021: 487) are clinical (medical, nursing and allied health).

The Chief Executive (CE) was the highest remunerated employee of the organisation in 2022. The CE'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. The CE's employment contract terminated on 30 June 2022, and their remuneration also includes their final pay on termination.

During the year ended 30 June 2022, 11 employees received compensation and other benefits in relation to cessation totalling $561,000 (2021: 8 employees received total of $153,000).

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 2022 $000	**Actual 2021 $000**
Board members		
B Duffy, Chairperson	49	46
O Paewai, Deputy Chairperson	32	29
H Browning	26	24
V Dennison	26	24
L Findlay	24	23
N Gray	24	22
M Hancock	24	23
M Mar	24	23
K Naylor	24	23
J Waldon	26	25
J Warren	24	23
Board members total	*303*	*285*
Committee members		
S Allan	3	3
T Hartevelt	5	4
G Munro	-	6
Committee members total	*8*	*13*
Board and committee members total	**311**	**298**

No Board members received compensation or other benefits in relation to cessation (2021: $nil). The above does not include expenses reimbursed to Board members.

MDHB has effected Directors' and Officers' Liability and Professional Indemnity insurance cover during the financial year in respect of the liability or costs of Board members, 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 2022 was 5 percent (2021: 5 percent).

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 2022 $000	Actual 2021 $000
Fees to auditor		
- Fees to Deloitte for audit of financial statements	285	235
- Fees to Central TAS for internal audit	123	148
Operating lease expense	5,307	3,740
Impairment of receivables (refer Note 7)	120	170
Board member fees and expenses	326	341
Loss of disposal of property, plant and equipment (refer Note 12)	48	450
Consultancy	7,276	5,621
Staff travel	1,182	925
Other expenses	-	-
Total other expenses	**14,667**	**11,630**

OPERATING LEASES AS LESSEE

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

	Actual 2022 $000	Actual 2021 $000
Not later than one year	2,722	2,521
Later than one year and not later than five years	3,951	4,919
Later than five years	630	890
Total non-cancellable operating leases	**7,303**	**8,330**

MDHB leases a number of buildings, vehicles, and office equipment under operating leases. The lease terms typically range between one and ten 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, 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 2022 $000	Actual 2021 $000
New Zealand Health Partnerships Limited	28,100	34,027
Trusts and special funds	937	462
Term deposits with maturity less than 3 months	-	-
Total cash and cash equivalents	**29,037**	**34,489**

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 2022, this was $35.7 million (2021: $33.4 million).

The weighted average interest rate on deposits at 30 June 2022 was 0.93 percent (2021: 0.62 percent).

Financial assets recognised subject to restrictions

Included in the bank balance is $937,000 (2021: $462,000) 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 2022 $000	Actual 2021 $000
Receivables under exchange contracts		
Receivables from sale of goods and services	26,187	13,765
Receivables from related parties	312	353
Prepayments	4,067	2,719
Less: expected credit losses	(231)	(206)
Total exchange contracts	*30,335*	*16,631*
Receivables under non-exchange contracts		
Receivables from Ministry of Health	17,195	10,904
Total non-exchange contracts	*17,195*	*10,904*
Total receivables	**47,530**	**27,535**

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

	2022			2021		
	Gross $000	Expected credit losses $000	Net $000	Gross $000	Expected credit losses $000	Net $000
Not past due	38,935	-	38,935	23,872	-	23,872
Past due 1-30 days	2,154	-	2,154	192	-	192
Past due 31-60 days	1,088	-	1,088	348	-	348
Past due over 61 days	1,517	-	1,517	610	-	610
Expected credit losses	-	(231)	(231)	-	(206)	(206)
Total	**43,694**	**(231)**	**43,463**	**25,022**	**(206)**	**24,816**

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 2022 $000	Actual 2021 $000
Balance as at 1 July	206	241
Additional provisions made during the year (Note 5)	120	170
Receivables written off during the year	(95)	(205)
Balance at 30 June	**231**	**206**

8 Investments

ACCOUNTING POLICY

Bank term deposits

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

BREAKDOWN OF INVESTMENTS AND FURTHER INFORMATION

	Actual 2022 $000	Actual 2021 $000
Current portion		
Trusts and special funds	2,000	2,000
Term deposits	-	-
Total current portion	*2,000*	*2,000*
Non-current portion		
Trusts and 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 2022 $000	Actual 2021 $000
Held for distribution inventories		
Surgical and medical supplies	4,928	3,459
Pharmaceuticals	1,583	1,394
Total inventories	**6,511**	**4,853**

The amount of inventories recognised as an expense during the year was $52,365,000 (2021: $40,984,000), which is included in the clinical supplies line item and the non-clinical expenses line item of the statement of comprehensive revenue and expense.

The write-down of inventories held for distribution amounted to $8,251,000 (2021: $203,000), which included $8,237,000 relating to the write-down of COVID-19 Rapid Antigen Tests (RATs) provided by the Ministry of Health. The write-down of inventories is included in the infrastructure and non-clinical expenses line item of the statement of comprehensive revenue and expense, and is offset by donation revenue (see Note 2(ii)).

No inventories are pledged as security for liabilities (2021: $nil).

10 Non-current assets held for sale

ACCOUNTING POLICY

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

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 (2021: $nil).

11 Investment in subsidiaries and associates

ACCOUNTING POLICY

Subsidiaries

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

Transactions eliminated on consolidation

Intragroup balances and any unrealised gains and losses or income and expenses arising from intragroup transactions, are eliminated in preparing the consolidated financial statements.

Associates

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 SUBSIDIARIES AND FURTHER INFORMATION

	Actual 2022	Actual 2021
MidCentral DHB's ownership interest		
Enable New Zealand Limited	100%	100%

Enable New Zealand Limited is a non-profit oriented entity which provides disability services in New Zealand. It is incorporated and domiciled in New Zealand, is a company registered under the Companies Act 1993, and has a balance date of 30 June.

In November 2002 all assets, liabilities and activities of Enable New Zealand Limited were vested in MDHB, and the company became a non-trading entity. On 30 June 2022 the net assets and activities of Enable New Zealand (an operating division of MDHB, which provides disability information services, disability equipment, and housing and vehicle modification services) were sold to Enable New Zealand Limited.

BREAKDOWN OF INVESTMENT IN ASSOCIATES AND FURTHER INFORMATION

	Actual 2022 $000	Actual 2021 $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	13,538	13,026
Liabilities	4,839	4,651
Revenue	13,776	13,031
Surplus	295	626

	Actual 2022 $000	Actual 2021 $000
Investments in associates		
Carrying amount at the beginning of the year	1,269	1,143
Share of total recognised revenue and expense	132	126
Share of dividend	-	-
Carrying amount at end of year	**1,401**	**1,269**
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 percent (2021: 16.7 percent) 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 final audited financial statements. The share of surplus recognised by MDHB in 2022 relates to Allied Laundry Services Limited's final audited result for the year ended 30 June 2021.

Central Region's 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 percent (2021: 16.7 percent) shareholding in 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 percent (2021: 16.7 percent) 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 2022.

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 2022 $000	**Actual 2021 $000**
Depreciated replacement cost	260,765	212,346
Market-based evidence	1,127	949
Internally assessed remediation costs	(7,552)	(6,873)
Total carrying value of buildings	**254,340**	**206,422**

As part of the 30 June 2022 valuation process, MDHB internally assessed mould and asbestos contamination. The cost of remediation has been estimated as $7,552,000, which has been

offset against the building's valuation movement (2021 valuation: $6,873,000). 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 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
Additions	-	13	2,920	1,509	27,983	32,425
Disposals	-	-	(3,272)	(231)	-	(3,503)
Transfers	-	4,414	8,030	248	(13,651)	(959)
Elimination on revaluation	-	(14,166)	-	-	-	(14,166)
Revaluation increase	4,158	57,657	-	-	-	61,815
Balance at 30 June 2022	25,605	254,340	85,413	5,980	22,785	394,123
Accumulated depreciation						
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
Depreciation	-	14,166	7,850	417	-	22,433
Impairment losses	-	-	315	-	-	315
Disposals	-	-	(3,224)	(231)	-	(3,455)
Elimination on revaluation	-	(14,166)	-	-	-	(14,166)
Balance at 30 June 2022	-	-	57,245	3,140	-	60,385
Carrying amounts						
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
At 30 June 2022	25,605	254,340	28,168	2,840	22,785	333,738

The difference between transfers from work in progress to buildings, plant, equipment and vehicles, and fixtures and 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 $16,040,000 (2021: $4,845,000).

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 $1,051,000 (2021: $1,207,000) for clinical equipment.

Capital commitments

	Actual 2022 $000	Actual 2021 $000
Buildings	16,764	3,480
Plant and equipment	8,396	7,256
Total capital commitments	**25,160**	**10,736**

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 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
Additions	719	987	-	1,706
Disposals	-	(11,025)	-	(11,025)
Transfers	(811)	131	827	147
Balance at 30 June 2022	4,525	40,396	867	45,788
Accumulated amortisation and impairment losses				
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
Amortisation	-	5,239	220	5,459
Impairment losses	-	8,798	-	8,798
Disposals	-	(11,025)	-	(11,025)
Balance at 30 June 2022	3,594	25,500	233	29,327
Carrying amounts				
At 30 June 2020	7,603	23,541	-	31,144
At 30 June 2021	1,023	27,815	27	28,865
At 30 June 2022	931	14,896	634	16,461

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 $nil (2021: $1,640,000) 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 2022, MDHB has paid $3,594,000 (2021: $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 (2021: $3,594,000).

IT regional services rights

The central region's shared service project is led by Central Region's Technical Advisory Services Limited (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 percent.

As at 30 June 2022, MDHB has paid $14,962,000 (2021: $14,243,000) as its share of the project funding, which represents its rights to use the systems when developed. As part of this investment, $14,031,000 (2021: $13,220,000) 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 (2021: 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 2022 $000	Actual 2021 $000
Payables from exchange transactions		
Creditors	9,586	8,743
Income in advance	8,791	6,416
Accrued expenses	50,314	39,581
Total payables from exchange transactions	*68,691*	*54,740*
Payables from non-exchange transactions		
Taxes payable (e.g. GST and rates)	6,221	8,830
Other	771	716
Total payables from non-exchange transactions	*6,992*	*9,546*
Total payables, provisions and deferred revenue	**75,683**	**64,286**

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 2022 (2021: $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 2022 $000	Actual 2021 $000
Current portion		
Secured loan	-	-
Finance leases	216	205
Total current portion	*216*	*205*
Non-current portion		
Secured loan	-	-
Finance leases	699	915
Total non-current portion	*699*	*915*
Total borrowings	**915**	**1,120**

MDHB has a maximum borrowing limit of $35.7 million (2021: $33.4 million) with NZHPL as at 30 June 2022. 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 2022 $000	Actual 2021 $000
Minimum lease payments payable:		
No later than one year	260	260
Later than one year and not later than five years	756	1,016
Later than five years	-	-
Total minimum lease payments	*1,016*	*1,276*
Future finance charges	(101)	(156)
Present value of minimum lease payments	*915*	*1,120*
Present value of minimum lease payments payable:		
No later than one year	216	205
Later than one year and not later than five years	699	915
Later than five years	-	-
Total present value of minimum lease payments	*915*	*1,120*

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 3.3 percent for long service leave (2021: 1.1 percent) and 3.3 percent for retirement gratuities (2021: 1.1 percent) 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 three years, will on average be 48 percent (2021: 54 percent) of the full entitlement. This utilisation assumption is based on recent experience.

Defined contribution plan

MDHB has a number of employees who are part of a defined contribution scheme. The total expenses recognised in profit or loss of $9,038,000 (2021: $8,053,000) 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 who 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 2022 and 2021 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. 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 2021/22 financial year. The final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed.

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 2022 to be $78,501,000 (2021: $47,397,000). 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 2022 $000	Actual 2021 $000
Current portion		
Accrued salaries and wages	12,159	4,282
Annual leave	32,161	28,183
Holidays Act 2003 remediation	78,501	47,397
Sick leave	456	471
Long service leave	2,151	1,969
Retirement gratuities	901	887
Other provision	365	365
Total current portion	*126,694*	*83,554*
Non-current portion		
Long service leave	1,244	1,190
Retirement gratuities	1,261	1,711
Total non-current portion	*2,505*	*2,901*
Total employee entitlements	**129,199**	**86,455**

18 Trusts and special funds

	Actual 2022 $000	Actual 2021 $000
Balance at 1 July	2,462	2,703
Transfers from retained earnings in respect of:		
Interest received	25	25
Donations and funds received	1,384	594
Transfers to retained earnings in respect of:		
Funds spent	(934)	(860)
Balance at 30 June	**2,937**	**2,462**

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)
- 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 2022 $000	Actual 2021 $000
Crown equity		
Balance at 1 July	125,838	119,521
Capital contributions from the Crown	12,463	6,950
Return of capital to the Crown	(633)	(633)
Balance at 30 June	137,668	125,838
Accumulated surpluses/(deficits)		
Balance at 1 July	(102,835)	(63,892)
Surplus/(deficit) for the year	(53,642)	(38,943)
Balance at 30 June	(156,477)	(102,835)
Property revaluation reserves		
Balance at 1 July	184,938	102,711
Revaluations	61,815	82,227
Balance at 30 June	246,753	184,938
Property revaluation reserves consist of:		
Land	24,575	20,417
Buildings	222,178	164,521
Total revaluation reserves	246,753	184,938
Total equity	**227,944**	**207,941**

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 (2021: $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 – On 30 June 2022 the net assets and activities of Enable New Zealand (an operating division of MDHB) were sold to Enable New Zealand Limited, a wholly owned subsidiary of MDHB (see Note 11). No other transactions occurred between MDHB and Enable New Zealand Limited during the financial year (2021: $nil). There is a receivable amount of $283,000 outstanding (2021: $nil), and a payable amount of $5,500,000 outstanding at 30 June 2022 (2021: $nil).

Allied Laundry Services Limited – MDHB purchased the supply of laundry services totaling $2,544,000 during the year (2021: $2,442,000). There is a payable amount of $271,000 outstanding at 30 June 2022 (2021: $249,000). MDHB leased a building and charged lease and utility costs to Allied Laundry Services Limited totaling $1,089,000 (2021: $909,000). There is a receivable amount of $233,000 outstanding at 30 June 2022 (2021: $100,000).

Central Region's Technical Advisory Services Limited (Central TAS) – MDHB purchased IT regional services rights (refer Note 13), internal audit and consultancy services totaling $5,485,000 during the year (2021: $5,547,000). There is a payable amount of $249,000 outstanding at 30 June 2022 (2021: $4,000). MDHB charged for reimbursements totaling $1,000 (2021: $nil) and there is a receivable amount of $nil outstanding at 30 June 2022 (2021: $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 totaling $1,006,000 during the year (2021: $951,000). There is a payable amount of $nil outstanding at 30 June 2022 (2021: $nil).

There are no other organisations who 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 2022 $000	**Actual 2021 $000**
Board and committee members	311	298
Executive leadership team	5,296	4,930
Total key management personnel remuneration	**5,607**	**5,228**
Executive leadership team – full time equivalent members	16	18

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

22 Events after the balance date

Health sector reforms

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

Nursing pay equity - Employment Relations Authority interim order

In May 2022, the New Zealand Nurses Organisation and the New Zealand Public Service Association applied to the Employment Relations Authority (ERA) for a determination fixing pay equity rates.

On 14 December 2022, following a request by Te Whatu Ora, the ERA issued interim orders increasing nurses' pay rates while the unions' application progresses. The increased pay rates set out in the ERA's interim orders are backdated to 7 March 2022, and are expected to be implemented by the end of February 2023.

The liability in Note 17 was appropriately adjusted to reflect the impact of the post balance sheet adjusting event.

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 2022 $000	Actual 2021 $000
Financial assets measured at amortised cost		
Cash and cash equivalents	29,037	34,489
Receivables	43,463	24,816
Investments	2,000	2,000
Total financial assets measured at amortised cost	*74,500*	*61,305*
Financial liabilities measured at amortised cost		
Loans and borrowings	915	1,120
Payables (excluding deferred revenue and taxes)	60,671	49,040
Total financial liabilities measured at amortised cost	*61,586*	*50,160*

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 (2021: $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 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 percent (2021: 39.6 percent). 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 2022 $000	Actual 2021 $000
Counterparties With Credit Ratings		
Cash at bank and on hand, and investments:		
AA-	2,937	2,462
Total counterparties with credit ratings	*2,937*	*2,462*
Counterparties Without Credit Ratings		
Cash and cash equivalents:		
NZ Health Partnerships Limited - no defaults in the past	28,100	34,027
Receivables:		
Trade and other receivables	43,463	24,816
Total counterparties without credit ratings	71,563	58,843
Total	***74,500***	***61,305***

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
2022					
Payables	60,671	60,671	60,671	-	-
EECA loan	-	-	-	-	-
Finance leases	915	1,016	260	260	496
Total	**61,586**	**61,687**	**60,931**	**260**	**496**
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**

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 $82.3 million higher than budgeted due to additional Ministry of Health funding, including specific funding received for pay equity payments and COVID-19 related activities (see Note 25), and increased ACC revenue associated with the Managed Rehabilitation Equipment Services (MRES) contract.

Other operating revenue was $19.8 million higher than budgeted, mainly due to Enable revenue contracts and Ministry of Health donated stock and equipment.

Personnel costs were $41.4 million higher than budgeted due to an increase in the Holidays Act 2003 remediation provision (see Note 17), and pay equity costs, some of which was offset by funding received from the Ministry of Health.

Depreciation, amortisation and impairment losses were $6.5 million higher than budgeted due to the impairment of intangible assets (see Note 13).

Outsourced services were $27.1 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 $4.9 million higher than budgeted, mainly due to higher than anticipated clinical need including COVID-19 related activities (see Note 25).

Infrastructure and non-clinical expenses were $38.4 million higher than budgeted, mainly due to an increase in costs associated with additional Enable revenue contracts, increased facilities costs associated with COVID-19 vaccination and CBAC facilities (see Note 25), and the write-down of COVID-19 RATs (see Note 9).

Non-health board provider expenses were $8.1 million higher than budgeted due to increased community provider contract payments, including COVID-19 related contracts (see Note 25).

STATEMENT OF FINANCIAL POSITION

Property, plant, and equipment was $23.2 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 $26.3 million less than budgeted due to the timing of capital expenditure projects being later than anticipated, the move towards Software as a Service (SaaS) for digital solutions, and the impairment of software assets.

Trade and other receivables were $23.0 million higher than budgeted due to the new ACC MRES contract, planned care funding accruals and COVID-19 related funding accruals.

Trade and other payables were $5.8 million higher than budgeted mainly due to COVID-19 related expenditure and community provider contract payments.

Employee entitlements were $32.8 million higher than budgeted due to an increase in the Holidays Act 2003 remediation provision (see Note 17) and pay equity accruals.

STATEMENT OF CHANGES IN EQUITY

The deficit was $27.4 million higher than budgeted due to the statement of comprehensive revenue and expense explanations provided above.

Property revaluation reserves were $61.8 million higher than budgeted due to the revaluation of land and buildings.

Capital contributions from the Crown, being equity injections, were $20.4 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 $30.3 million greater than budgeted due to higher than budgeted revenue from the Ministry of Health 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 the outbreak of COVID-19 a global pandemic.

An alert system was introduced by the New Zealand Government in March 2020, and New Zealand went into a full lockdown of all non-essential services when the Government moved to Alert Level Four on 25 March 2020. Since then, the country has moved between alert/traffic light levels and has operated with a range of domestic restrictions and border controls to limit the spread of the virus. A nationwide COVID-19 vaccine rollout commenced during February 2021 has continued to be a high priority throughout 2021 and 2022.

The emergence of the highly contagious COVID-19 Delta variant in August 2021 and the Omicron variant in December 2021 resulted in a significant increase in positive cases across the country, including the MidCentral region. This impacted on both the hospital and community providers and delayed the delivery of planned care procedures.

Funding has been received from the Ministry of Health to assist with response costs for community, managed isolation and the vaccine rollout. Details of COVID-19 specific revenue and expenses are shown in the table below.

	Actual 2022 $000	Actual 2021 $000
Revenue		
Ministry of Health revenue	36,961	5,365
Other revenue	5,483	-
Total COVID-19 revenue	*42,444*	*5,365*
Expenditure		
Personnel costs	7,316	1,397
Outsourced personnel & support	1,172	179
Outsourced clinical services	20,833	1,877
Clinical supplies	4,660	83
Infrastructure & non-clinical supplies	3,981	1,232
Non-health-board provider expenses	4,445	698
Total COVID-19 expenditure	*42,407*	*5,466*
Net COVID-19 revenue/(expenditure)	**37**	**(101)**

26 Reconciliation of movements in liabilities arising from financing activities

	Actual 2022 $000	Actual 2021 $000
Finance Leases		
Balance at 1 July	1,120	1,314
Net cash flows	(205)	(194)
New leases	-	-
Other charges	-	-
Balance at 30 June	**915**	**1,120**

27 Summary cost of services

	Actual 2022 $000	Budget 2022 $000	Actual 2021 $000
Revenue			
Prevention services	25,901	22,962	22,044
Early detection and management services	165,600	146,805	140,939
Intensive assessment and treatment services	498,907	442,284	424,611
Rehabilitation and support services	207,555	183,998	176,646
Funding not allocated – Funding Division surplus	41,888	41,236	23,576
Total revenue	*939,851*	*837,285*	*787,816*
Expenditure			
Prevention services	28,326	24,618	23,572
Early detection and management services	184,580	160,425	153,603
Intensive assessment and treatment services	555,917	483,166	462,620
Rehabilitation and support services	224,670	195,271	186,964
Total expenditure	*993,493*	*863,480*	*826,759*
Surplus/deficit	**(53,642)**	**(26,195)**	**(38,943)**

28 Breach of statutory reporting deadline

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

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 2022

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 61 to 114, that comprise the statement of financial position as at 30 June 2022, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year ended on that date, and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Health Board on pages 31 to 48.

Opinion

Unmodified opinion on the financial statements

In our opinion the financial statements of the Health Board on pages 61 to 114:

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

Unmodified opinion on the performance information

In our opinion, the performance information of the Health Board on pages 31 to 48:

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

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Our audit of the financial statements and the performance information was completed on 20 March 2023. This is the date at which our opinion is expressed.

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

Basis for our opinion

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

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

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

Emphasis of matters

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

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

Note 17 on page 99, which outlines that the Health Board has been investigating issues with the way it calculates holiday pay entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues. The matters are complex and have resulted in underpayments of holiday pay to current and past employees over a number of years. The Health Board has estimated a provision of $78.5 million, as at 30 June 2022 to remediate these issues. However, until the process is completed, there are uncertainties surrounding the amount of this provision.

The financial statements have been appropriately prepared on a disestablishment basis

Note 1 on page 67 outlines that the Health Board has prepared its financial statements on a disestablishment basis because the Health Board was disestablished, and its functions transferred to Te Whatu Ora - Health New Zealand on 1 July 2022. There have been no changes to the values of the Health Board's assets and liabilities as a result of preparing the financial statements on a disestablishment basis.

Impact of Covid-19

Note 25 on page 111 to the financial statements, which outline(s) the ongoing impact of Covid-19 on the Health Board.

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

Page 49 to 60 outlines the information used by the Health Board to report on its Covid-19 vaccine coverage. The Health Board uses the Health Service User (HSU) population data rather than the population data provided by Statistics New Zealand (Stats NZ), for the reasons set out on page 49 to 60 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Our responsibilities arise from the Public Audit Act 2001.

Other Information

The Board of Te Whatu Ora is responsible for the other. The other information comprises the information included on pages 4 to 30, 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.

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

"I would like to say a huge thank you to the amazing staff at Te Whare Rapuora! Because I was able to be at the whare, it helped being close to my older daughter whilst she was in another part of the hospital.
It feels as close to home, it's given me sanity and you guys are so warm and welcoming - there's no other place I'd rather be!"

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 District Health Board's (MDHB) 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 MDHB elections were held in October 2019. The 2019-2022 term for Board members commenced on 9 December 2019 and ended on 30 June 2022 upon the disestablishment of all 20 District Health Boards (DHB).

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 Government for 21 years, having served as Mayor, Horowhenua District Council from 2004 to 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, wastewater 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 Chair and Commissioner; Member, Representation Commission; Chairperson, Business Kāpiti Horowhenua Incorporated; Trustee, Eastern and Central Community Trust; Chairperson, Horowhenua Health and Wellbeing Hub Stakeholder Advisory Group.

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 and in 2006 moved to the role of Health Manager, Te Kete Hauora o Rangitāne (health and social service provider under Rangitāne o Tamaki nui-ā-Rua) until April 2021.

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, Te Tihi o Ruahine Whānau Ora Alliance; appointed member, Massey University Council; trustee, Manawatū/Whanganui Children's Health Charitable Trust Board; member, Governance Board, Mana Whaikaha; Co-Chair, Regional Skills Leadership Group, Manawatū-Whanganui.

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 and resumed in August 2021); member, Te Aho o Te Kahu (Cancer Control Agency) Consumer Reference Group; member, Support and Consultation for End of Life Choice in New Zealand Group (Ministry of Health) and Project Manager, Mana Whaikaha (Ministry of Health) from February to December 2021.

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; director, Social Impact Property; partner, Dennison Rogers-Dennison; Trustee, Manawatū-Whanganui Disaster Relief Fund; Board member, Softball New Zealand.

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 District Health Board (MDHB) as a registered nurse with a lengthy period in district nursing where she implemented the 24-hour service. Her final role, prior to leaving MDHB 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 MDHB; sister-in-law is employed as a registered nurse at Whakapai Hauora; and volunteer MDHB 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 District Health Board (MDHB); member of local Child and Youth Mortality Review Group; member of Te Ahu Whenua Māori Land Trust; member, Māori Provider Expert Reference Group for Transitional Health Unit.

Karen Naylor
Elected Member | Commenced 2010

Karen is a Registered Nurse, who has worked at the MidCentral District Health Board (MDHB) 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 MDHB; 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 District Health Board (MDHB) Clinical Board until he was elected to the Board in October 2019. John has been a Cancer Society volunteer for 20 years and is a member of the Paediatric 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; President, Cancer Society (Manawatū); Research Advisor to Massey University.

Jenny Warren
Elected Member | Commenced 2019

Jenny worked in banking and management and then spent ten years working in maternal health as a pregnancy, childbirth and parenting educator – a service she leads across the MidCentral District Health Board (MDHB) area. She has served on the Maternity Clinical Governance Group at MDHB, the Maternal Morbidity Working Group at the 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: National executive committee member, On Track Network, Liggins Institute Auckland University; member of consumer focus group, Enhancing NZ Clinical Trials; contract with Horowhenua Life to the Max; contract with The Horowhenua Company.

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 District Health Board's (MDHB) 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 MDHB
- delegating management of MDHB 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 MDHB
- ensuring MDHB acts legally and responsibly on all matters
- appointing, evaluating and remunerating the performance of the chief executive.

The DHB 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 a 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 then 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 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 healthcare, 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 MDHB election was held in October 2019, at the same time as the local body election process and the new Board took office on 9 December 2019. Due to the transition of all DHBs to Te Whatu Ora – Health New Zealand from 1 July 2022, the term of this Board ended on 30 June 2022.

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 2021/22:

Health and Disability Advisory Committee	**Finance, Risk and Audit Committee**
Gail Munro *(until November 2021)* Stephen Paewai *(from November 2021)*	Simon Allan Tony Hartevelt

Board and committee member attendance

Board and committee member attendance for 2021/22 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 (eight meetings)

HDAC Health and Disability Advisory Committee (five meetings)

Rem Remuneration Committee (three meetings)

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

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[54] 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 2021/22 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.

[54] "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 District Health Board (MDHB) takes its role as an employer seriously and invests a lot of resources and time into its people – both on a group and individual basis.

Our refreshed people plan (A Plan for our People) supports MDHB'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.

We took into account the feedback we received from our employees when refreshing the people plan, including feedback from the engagement surveys undertaken. Two priority areas were identified at an organisational level – health and wellbeing, and employees feeling valued and recognised. In response to this feedback MDHB 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 their team's survey results.

Our He Rakau Tu Wao Psychosocial Wellbeing Strategy 2022/23 is now in place and has six focus areas with programmes of work within each of these areas. These are: minimising psychological harm; leading organisational wellbeing; supporting individual wellbeing; encouraging early outreach; supporting employee recovery and return to work; and enabling healthy and inclusive relationships.

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 MDHB'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 MDHB's 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 (Healthy 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.

A key area of focus has been to grow our Māori workforce and our efforts have seen a growth of 20 percent over the past year.

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 MDHB works in partnership with unions and staff to continue to improve our working environment.

COVID-19 has had, and continues to have, a significant impact on MidCentral and its operations. The organisation remains focused on supporting our staff, and our communities, recognising that this is a continual challenge as staff levels fluctuate due to our employees testing positive for COVID-19 and other sicknesses.

WORKFORCE PROFILE

Over 2,700 people work for MidCentral equating to 2,437 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	1,724	<25	152	172
NZ Māori	257	20 – 24	279	305
Pacific	32	30 – 34	289	318
Asian	392	35 – 39	280	332
Not Stated	32	45 – 49	222	261
Total	**2,437**	50 – 54	239	272
		55 – 59	271	310
		60 – 64	293	332
Disability Profile	**Head Count**	65 – 69	290	318
Yes	40	70+	122	153
Not Stated	2,733			
Total	**2,773**	**Total**	**2,437**	**2,773**

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 2021/22 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 DISTRICT HEALTH BOARD'S (MDHB) STRATEGY

MidCentral's Strategic Framework is supported by our Plan for Our People, 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 Plan for Our People 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 over 10 years ago blends theory and experiential learning so 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 2022, over 580 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 development as tomorrow's leaders.

FORMAL POLICIES AND PROCEDURES

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

MIDCENTRAL DISTRICT HEALTH BOARD (MDHB) RESPONSE

- MDHB People Strategy
- MDHB 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 (district-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 MDHB
- Clinical management partnership structure within MDHB
- Leadership development programmes (joint MDHB and THINK Hauora)

- Treaty of Waitangi training
- Cultural Competency in Practice workshops
- MDHB 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 (online)
- 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 2021/22 our vacancy levels have grown across most health professional groups and like most districts we are experiencing difficulties in recruiting to some positions, for example, radiologists, psychiatrists, midwives and nursing in some specialty areas. 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.

To meet current demand for planned and acute surgical and cardiac care, the organisation 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 local, national and overseas recruitment drives.

We also work closely with our central region District Health Board (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.

Pae Ora Paiaka Whaiora Hauora Māori directorate (Pae Ora) actively supports staff new to the organisation to participate in MDHB'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 MDHB. Cultural responsiveness workshops are also held.

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 MDHB. 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 Pūhoro STEMM Academy is another key component of Te Ara Māhuri pathway for Year 11, 12 and 13 rangatahi Māori. STEMM stands for science, technology, engineering, mathematics and medicine. The cohort remains part of the Pūhoro programme for all three 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 MDHB. 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 Year 13 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 MDHB 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 MDHB.

A dashboard for reporting DHB performance has been developed and is reported to MidCentral's leadership team and nationally as required.

NURSING AND MIDWIFERY

Implementation of our Nursing and Midwifery Workforce Plan and our Nursing and Midwifery Recruitment and Retention Plan continues. Both plans guide the development of MDHB's nursing and midwifery workforce. This reflects our community demographics; is sustainable; highly

qualified; and appropriately credentialed. This enables us to respond to the changing needs of our communities.

Pae Ora also partners with Nga Manu Teka – an 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 DISTRICT HEALTH BOARD (MDHB) RESPONSE

- Participation in local Manawatū careers events
- MidCentral Careers in Health days (annual) for secondary school students – postponed due to COVID-19
- Visiting schools within MidCentral'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
- Online recruitment available
- Internal recruitment bulletin online
- 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
- MDHB new staff day (orientation) programme and pōwhiri
- 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 MDHB staff working with children and women.

3 Employee development, promotion and exit

Over the past year, MidCentral held internal education sessions that were attended by over 1,844 staff members (some staff attend more than one session). Those completing online learning programmes totalled 1,745 and 10,413 course events were completed.

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. This information is very useful and is 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'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 MDHB 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 have the programmes 'Delivering Excellence in Customer Service' and 'Defusing Challenging Situations'.

AN E-LEARNING PLATFORM

Our e-Learning platform Ko Awatea is well utilised by our staff and we continue to steadily increase 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 MDHB priority to ensure we address inequity of health service provision and therefore achieve health outcomes for Māori as promised by 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 DISTRICT HEALTH BOARD (MDHB) 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
- MDHB 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)
- Onsite 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 MDHB.

4 Flexibility and work design

The vast majority of MDHB'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.

MDHB'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.

Our working remotely guidelines were reviewed and updated, and staff were encouraged to familiarise themselves with these. They include guidance on ensuring their health and safety is maintained while working remotely.

Good progress is being made as MDHB 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 workstation in their office makes a huge impact for many staff, both clinical and non-clinical.

CARE CAPACITY DEMAND MANAGEMENT (CCDM)

The Care Capacity Demand Management (CCDM) programme continues to be rolled out across our nursing workforce. Plans are in place to implement the programme 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 of nursing and midwifery is in place to oversee the programme. Our union partners are involved with this. Results of CCDM inform the FTEs required for our nursing workforce, based on those that have implemented the programme.

INTEGRATED OPERATIONS CENTRE (IOC)

Our Integrated Operations Centre (IOC) is an enabler to our clusters. The IOC is responsible 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 DISTRICT HEALTH BOARD (MDHB) RESPONSE

- Rostering module
- Implementing the Care Capacity and Demand Management programme – good progress is being made
- Flexible work guidelines
- Working remotely 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 were 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 percent) 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.

It is pleasing to report that the pay equity claim raised by the Public Service Association on behalf of clerical and administration employees has been settled and implemented. Most of these staff received significant increases in remuneration. The settlement has addressed this workforce which had historically been undervalued.

MDHB collects data and is able to report on the gender and ethnicity pay gap which helps us inform our workforce planning and identify areas where there is a pay gap which needs addressing. We are also able to compare our results against other DHBs.

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 DISTRICT HEALTH BOARD (MDHB) 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

MDHB 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.

MDHB's Preventing Unacceptable Behaviour, Harassment and Bullying Policy, and Code of Conduct gives guidance to employees on the standards of performance and conduct required. Employees are expected to uphold the DHB's values and shared approach to work principles.

The results of our recent staff survey has also informed 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 embedded 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

MDHB 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 DISTRICT HEALTH BOARD (MDHB) RESPONSE

- A Plan for Our 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

MDHB 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 MDHB
- 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 include:

- Worker Participation Agreement revised with our union partners
- increased number of health and safety workplace inspections
- reporting to the Board and Board Committees strengthened
- introduction of Health and Safety Awards
- increased visibility of our Board and senior management by introduction of structured quality and safety walk-arounds
- provision of 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, MDHB 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. An example is:

- the establishment of the MidCentral Rainbow Forum which works to create safe and inclusive spaces for gender and sexually diverse staff, patients/clients and whānau. The forum has carried out a number of inclusivity initiatives throughout 2021/22.

Building Rainbow competencies among our staff by:

- providing 10 Gender and Sexual Diversity at Work trainings for a total of 125 staff. Almost all (98 percent) reported that the training increased their awareness of gender and sexual minorities. Some of the feedback from the workshops included: "My knowledge was limited/ sheltered and it has opened my thought processes and awareness of those around me." "This has been one of the most rewarding courses I've ever done. The tutors were utterly excellent, great wealth of knowledge, very well presented, open to questions, made one feel comfortable to ask and left us all with tools and links so we can further train."
- updating the Gender Inclusive Practice Guideline, which provides information to staff on expectations and standards, and where further resources and support can be found.
- responding to requests from staff and services across the organisation on a wide range of issues, from how to create more inclusive spaces to providing advice and support on individual issues.

Celebrating diversity and creating awareness by:

- increasing awareness of national and regional Rainbow support organisations, by updating and distributing the Rainbow Groups in Manawatū resource
- communication to staff, for example, information in newsletters and highlighting awareness days.

Supporting staff by:

- presenting at four new staff orientation days for around 150 staff about available professional development and staff support. Staff representative included in the orientation package for all new staff.
- drafting Transition at Work – Guideline, which sets out how Te Pae Hauora o Ruahine o Tararua MidCentral will support its transgender, non-binary, and otherwise gender diverse staff as they transition during their employment.

Working with the community by:

- developing cards available for transgender and gender diverse patients/clients and whānau to communicate that the information under the NHI might not match their name or pronouns
- providing professional development and support to external organisations such as the Universal College of Learning (UCOL), Massey University and Tararua Health Group.
- networking Rainbow organisations, such as Malgra and InsideOUT.

HEALTH AND WELLBEING

MDHB's approach to health and wellbeing was completely reviewed during the 2020/2021 period and has been progressively implemented during 2021/22. 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 the psychosocial wellbeing of staff
- metrics to assess distress, wellbeing and/or resilience
- connecting principles of wellbeing and resilience into coaching and mentorship networks
- setting up self-assessment and self-care resources across all elements of Te Whare Tapa Whā
- consistent organisational critical stress incident response process
- investigating 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.

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

- The 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.

MDHB's Occupational Health and Safety team is very active in ensuring the needs of employees are met both by 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 MDHB 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 work 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 DISTRICT HEALTH BOARD (MDHB) 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
- Onsite occupational health unit
- TrendCare acuity programme
- Health and Safety Committee structures and representatives throughout MDHB, and health and safety training
- Significant events debriefing.

MIDCENTRAL DISTRICT HEALTH BOARD 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
Scott Ambridge	Operations Executive, Mental Health and Addictions
Keyur Anjaria	General Manager, People and Culture
Kelvin Billinghurst	Executive Director, Medical (Chief Medical Officer) and Clinical Executive, Public, Primary and Community Health Services
Jeff Brown	Clinical Executive, Healthy Women, Children and Youth
Vanessa Caldwell	Clinical Executive, Mental Health and Addictions (to September 2021)
Judith Catherwood	General Manager, Quality and Innovation (to December 2021)
Deborah Davies	Operations Executive, Primary, Public and Community Health Services and Interim GM, Strategy Planning and Performance (from October 2021)
Celina Eves	Executive Director, Nursing and Midwifery
Sarah Fenwick	Operations Executive, Healthy Women, Children and Youth and Operations Executive, Cancer Treatment, Screening and Support
Chiquita Hansen	Chief Executive, Central Primary Health Organisation and Interim GM, Strategy Planning and Performance (to October 2021)
Claire Hardie	Clinical Executive, Cancer Screening, Treatment and Support
Lyn Horgan	Operations Executive, Acute and Elective Specialist Services and Operations Executive, Healthy Ageing and Rehabilitation
Steve Miller	Chief Digital Officer
Michelle Riwai	General Manager, Enable New Zealand
Gabrielle Scott	Executive Director, Allied Health and Interim GM Quality and Innovation (from January 2022)
Tracee Te Huia	General Manager, Māori Health
Neil Wanden	General Manager, Finance and Corporate Services
Syed Zaman	Clinical Executive, Healthy Ageing and Rehabilitation

REGISTERED OFFICE

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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

"Working with inpatients across the hospital is a privilege, to be able to help them achieve their goals, which is often including them to get back home."

"My community role is a different role. This involves working with the patients in their own home assisting with and accessing equipment to keep them safe in their homes. This is sometimes a 'hard sell' for patients who at times don't feel they need this. I do enjoy my varied role and being a part of the Physiotherapy Team."

Appendices

APPENDIX ONE: 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, 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 HEALTHCARE 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 healthcare 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. The focus is on reducing risk of illness, 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 are intended 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) 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 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: LIFELONG 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, seven 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, e.g. when primary carers/family/ whānau are in urgent and immediate need of temporary relief from caregiving.

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 healthcare 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.

'We are so grateful for the amazing staff of the children's ward during our stay in hospital. They were attentive, caring, efficient, diligent and genuine people. Thanks for making our long stay go smoothly and less scary for our daughter.'

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