NORTHLAND DISTRICT HEALTH BOARD

ANNUAL REPORT 2022

Waka Hourua represents inclusiveness and the deliberate and meaningful effort required to collectively work together, enable, and innovate to achieve our collective goals in honouring Te Tiriti o Waitangi and achieving equity for all within Te Tai Tokerau

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

NORTHLAND DISTRICT HEALTH BOARD
Te Poari Hauora Ā Rohe O Te Tai Tokerau

Reading our Annual Report

The annual report presents an account of Northland DHB's performance for the year from 1 July 2021 to 30 June 2022.

It sets out what Northland DHB committed to do in the year, and how we delivered on that commitment.

Each year, the board reviews progress on its vision and long-term strategy and identifies what will be achieved over the next twelve months. This is documented in the Annual Plan.

A Statement of Intent is also prepared annually and is the formal accountability document between Northland DHB and the Government. It provides a concise summary of Northland's intentions for the year ahead and covers both long-term and annual planning objectives.

This document, the Annual Report, tells you how Northland DHB performed against the Statement of Intent and Annual Plan. It provides a detailed account of how the health dollars allocated to this board were managed.

Key Components

Chair and Chief Executive Report A report from the chair and chief executive on the past year.

Introduction Northland District Health Board. A brief overview of Northland DHB's role, the district it covers, and resources it manages.

Statement of Performance A report on Northland DHB's performance against targets.

Highlights 2021 - 2022: A selection of highlights through the year.

Governance and Partnerships A report on how the board of Northland DHB is structured and operates.

Financial and Audit Reports The annual financial accounts of the organisation. Includes notes and disclosures regarding remuneration, dividend payments, and interest/shares in other organisations.

Photo Credit: Glen McMillan

Contents

MESSAGE FROM THE CHAIR & CHIEF EXECUTIVE

The Board and Executive Leadership team would like to sincerely thank and acknowledge our advisory committees and every one of our kaimahi for their continued outstanding commitment to the people of Northland.

Harry Burkhardt
Board Chair

Dr Nick Chamberlain
Chief Executive

This last year a lot of important new initiatives have commenced or been completed, new models of care developed in the community, and several new buildings have started being built or approved.

However, it's all of you, our kaimahi - the health sector of Tai Tokerau, are what we are most proud of - how hard you all worked during some of our toughest times, the relationships that were formed, and how we worked together, more united than we've ever been.

With the collective support of our community health provider colleagues, including general practices, pharmacists, Māori Health providers, and Iwi providers, we safely managed surges in COVID-19 community cases.

Our Care Coordination Hub saw multiple agencies, including our health services, NZ Police, Oranga Tamariki and the Ministry of Social Development, working together to provide manaaki to our people. The Clinical Hub became a backbone for community care, providing backup after hours and supporting community patients - particularly those not enrolled with a GP or where GPs cannot provide care. And the four kaupapa Māori hubs placed strategically around Te Tai Tokerau also provided manaaki services and some coordination for clinical services.

As you read through the achievements outlined in this Annual Report, please reflect on and celebrate all our successes.

A key milestone for the year was the Budget 2022 announcement that funding had been allocated to complete the first stage of Project Pihi Kaha, the Whangārei Hospital redevelopment.

Crown funding was also approved to build a radiation oncology facility at Whangārei Hospital with a Linear Accelerator (LINAC), two bunkers (one for future growth), a CT scanner and an expansion to the Jim Carney Cancer Treatment Centre (JCCTC).

Construction is estimated to be complete in 2025.

Other significant facility improvement of Te Kotuku Maternity Unit with paediatrics and Special Care Baby Unit (SCBU), a new laboratory and Stage 2 of the Bay of Islands Hospital. The refurbishment of Manaia House (Community Mental Health) and expansion of Te Kamo Community Oral Health Clinic.

Several new educational training programmes commenced this year, with Physiotherapy, Occupational Therapy, Oral Health, and Podiatry studies offered to students in the region. The programme will expand next year to include Psychology, Anaesthetic Techs, Paramedicine, and other child care services and Health Sciences studies. In addition, we have planned for a clinical training centre offering undergraduate and post-graduate training and research facilities to ensure we develop and strengthen a learning culture we can all aspire to, keep Northlanders in Northland, and significantly grow our Māori workforce.

Thanks to all those service providers, partners, volunteers, community groups, and caregivers who use their time to support our work.

We would also like to express the appreciation of the Board to the Kaunihera Council of Elders (kaumātua and kuia) for keeping us safe and ensuring we use our tikanga to move through complex but rewarding life realities purposely.

We acknowledge those staff who passed away during the year and give our heartfelt condolences to their family and whānau.

As the New Zealand Health System transitions under the ambitions of Te Pae Oranga, we have had the privilege to guide the Northland District Health Board to that nascency.

Taitokerau Rautaki Hauora (Te Tai Tokerau Health Strategy 2040) was completed and gifted to the new health entities, Te Whatu Ora and Te Aka Whai Ora, to ensure Te Tai Tokerau's priorities are considered about our future direction. The Strategy aims to ensure all tamariki born today achieve equitable outcomes by 2040, which coincides with the 200th anniversary of Te Tiriti o Waitangi.

There are many other attributes that will be gifted across that will reflect the work and passion of those who have been involved.

Firstly, we need to acknowledge the passion of those who work in the business of Health. Each one is dedicated to serving their communities. This is a human-centred organisation.

Secondly, we need to acknowledge the level of professionalism that underpins this servanthood. One can undervalue this as it is seamlessly and, at times, effortlessly applied.

Thirdly, constructing safe and inclusive pathways to acknowledge relationships and obligations while using generosity and reciprocity as notions to give effect to these dynamic ecosystems.

In times of crisis, these strengths find a prominent place. Through COVID-19, we learned to lean into each other while building trust. Trust is an element that needs to be protected and defended at all costs. This will serve us well in future crises.

It has been a privilege for us to have been active participants in these moments in time.

There is plenty to be optimistic about, particularly if we can continue to embrace change as we have been doing, accept a level of uncertainty, and be hopeful and excited for what the transition may bring us.

The critical point is that we are on our way to Te Tiriti finally being honoured in the health system making it more equitable and accessible to all.

Now is the time to shift the dial.

Harry Burkhardt
Board Chair NDHB

Dr Nick Chamberlain
Chief Executive NDHB

The whakataukī included on the taonga gifted to Minister of Health Andrew Little and Minister Peeni Henare at Waitangi on 1 July.

ABOUT NORTHLAND DHB

Who we are and what we do

Northland DHB is categorised as a Crown Agent under section 7 of the Crown Entities Act 2004. Responsible for providing or funding health and disability services for the people of Northland, the DHB covers a large geographical area from Te Hana in the south to Cape Reinga in the north. The DHB employs 3,889 staff. Acute services are provided through the DHB's four hospitals, based at Whangārei, Dargaville, Kawakawa and Kaitaia, with elective surgery performed at Whangārei and Kaitaia. These services are supplemented by a network of community-based, outpatient and mental health services, a range of Allied Health services, and a public and population health unit. Some specialist services, like radiation treatment and neurology services are provided from Auckland or through visiting specialists travelling to Northland. The DHB allocates funding across the health sector in Northland, contracting with a range of community-based service providers such as Primary Health Organisations, dentists, pharmacies and other non-government organisations.

Our Health Profile

Māori

Māori experience low health status across a range of health and socio-economic statistics. They comprise over one-third of Northland's total population, but 56 percent of the child and youth population, a key group for achieving long-term gains. Māori experience early onset of long-term conditions like cardiovascular disease and diabetes, and their life expectancy is about eight years less than non-Māori.

Child and Youth

The child and youth proportion of Northland's population is projected to decline from 31.6 percent in 2018 to 28.3 percent in 2033. However, it remains a priority because healthy children make for healthy adults, and children are more vulnerable than adults.

The deprivation index, which divides the population into ten groups according to their deprivation scores, placed 80 percent of Northland's child population on the most deprived half of the index.

Older People

In 2022, 21 percent of our population was aged 65 or more; that is projected to rise to 27 percent by 2033 (when the national figure will be only 21 percent). The ageing population places significant demands on health services provided specifically for older people (residential care, home and community support services, day care). It also increases the prevalence of long-term conditions that become more common with age.

Long-Term Conditions

About three-quarters of deaths in Northland are from cardiovascular disease (heart disease and stroke) or cancer (most commonly trachea-bronchus-lung, colorectal, prostate and breast).

Twenty percent of adult Northlanders have been told they have high blood pressure and 11 percent that they have high cholesterol, both known risk factors for cardiovascular disease.

Although diabetes is not a major killer itself, it is a primary cause of heart disease. A great deal of unnecessary illness and hospitalisation is related to poor management of diabetes.

Oral Health

Northland's Year 8 students have a higher number of decayed, missing or filled teeth (0.99 compared with 0.73 nationally). Our 5-year-olds have one of the lowest percentages of teeth without tooth decay (42 percent compared with 55.1 percent nationally).

Lifestyle Behaviours

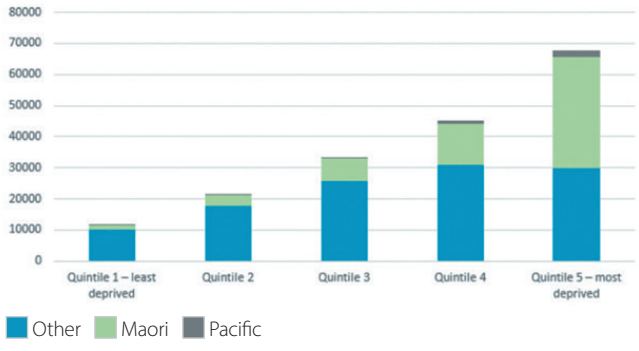
The way people live their lives and the behaviours they exhibit have an enormous effect on health status. There are many influences, but key ones are smoking, diet, alcohol and other drugs, and lack of physical activity.

Social Influences

Many causes of ill health rest with social and economic factors such as housing, education and economic prosperity. The health sector cannot affect these directly, but as a DHB, we work collaboratively with other government and local body organisations to achieve a healthier Northland.

Deprivation, 2021/22

Northland has a very high proportion of people in the most deprived section of the population while the least deprived section is under-represented.



Ref: Ministry of Health website Population of Northland DHB - Deprivation is reported in 'quintiles'. Quintile 1 represents the least deprived section of the population while quintile 5 represents the most deprived section.

WHERE THE MONEY GOES

$530m
Whangārei, Dargaville, Bay of Islands and Kaitaia Hospitals (surgical and medical services, emergency departments, imaging, laboratories, maternity), public health.

$114m
Primary Health (general practitioners, community dental services, radiology)

$90m
Health of older people (including residential care, rehabilitation)

$70m
Mental Health Services

$12m
Māori health services

$46m
Community pharmacies

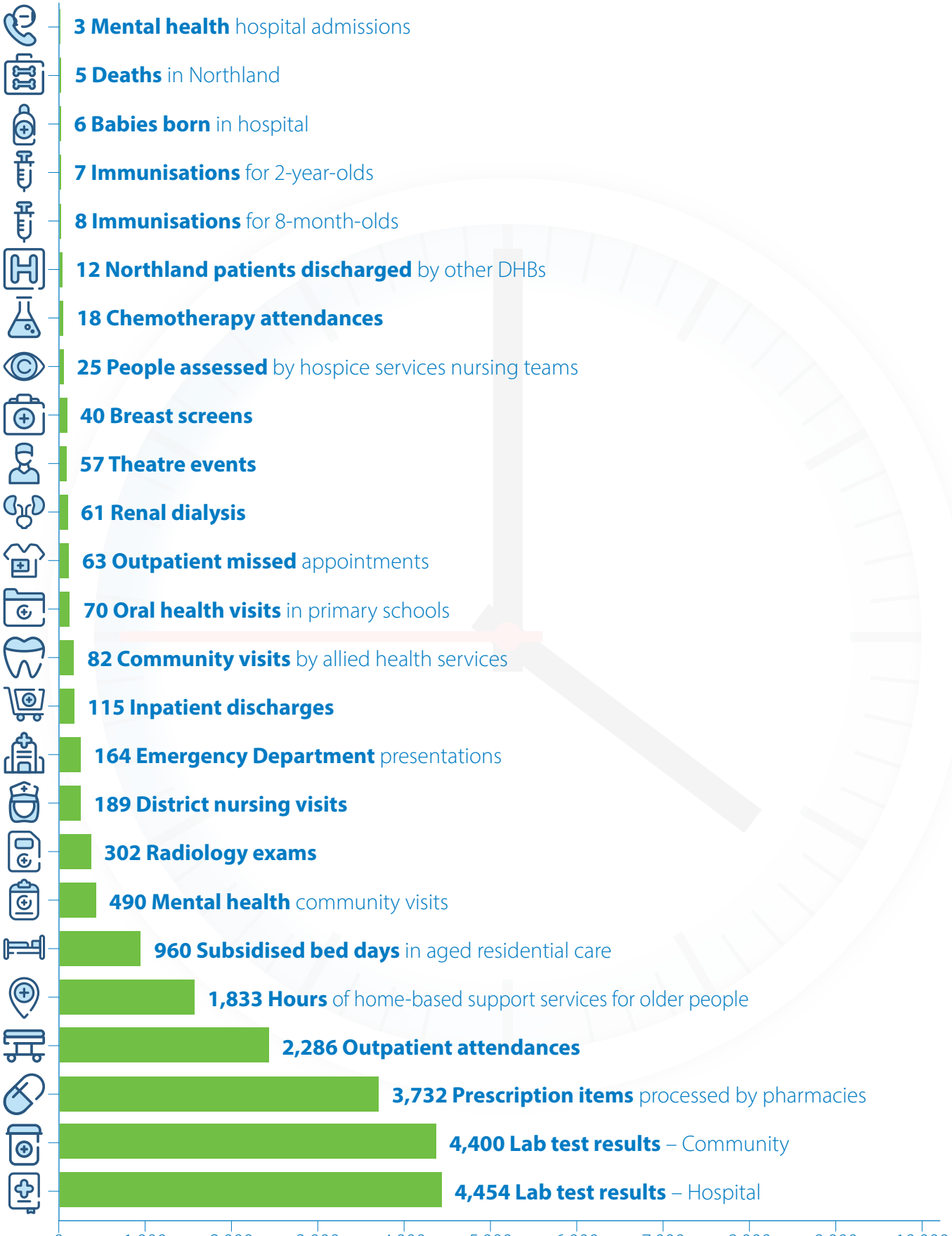
$8m
Community laboratory services

$108m
Inter-district flows (publicly-funded health services paid to other district health boards and others for services provided to Northland patients)

Total $978m

EACH DAY IN NORTHLAND

On average, each day in Northland there are:



OUR SERVICES

As at June 2022, there were 88 FTE GPs, 110 FTE practice nurses and 7.5 FTE nurse practitioners across 33 general practices providing primary healthcare to Northlanders enrolled with Mahitahi Hauora PHO.

There were 29 FTE GPs, 33 FTE practice nurses and one nurse practitioner across four general practices providing primary healthcare to Northlanders enrolled with Comprehensive Care.

Northland DHB has 374 contracts with 156 non-government organisations (NGOs) including Māori Health providers and Whānau Ora collectives that provide a range of public health, primary healthcare and community services across Northland.

Figure 1

Māori NGOs

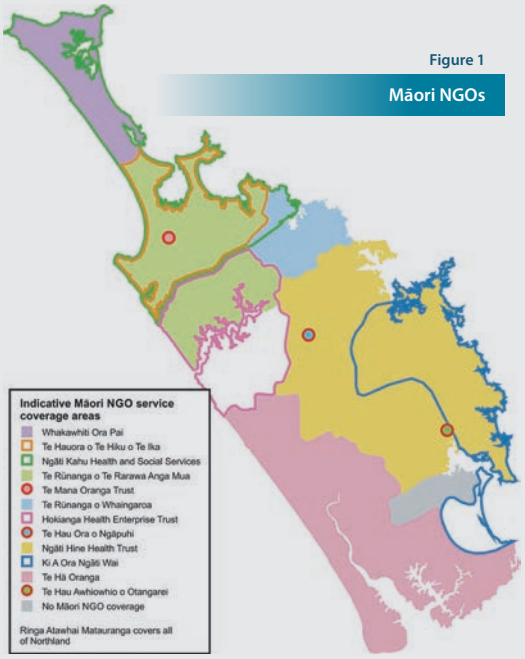


Figure 2

Northland Hospitals

Figure 3

Travel Distances

NORTHLAND DISTRICT HEALTH BOARD
Te Poari Hauora Ā Rohe O Te Tai Tokerau

OUR PEOPLE

He whakapapa, he mokopuna, he tamariki, he mātua, he tūpuna. He aha te mea nui. He tāngata, he tāngata, he tāngata.

Our people are central to all we do, and they drive our organisational culture. We pride ourselves on the five organisational values that form the foundation of the culture we continue to build on.

Demographics

Northland DHB workforce profile	Total workforce 3,889 active employees	
Age profile	Female average age Male average age	45.07 years 44.51 years
Ethnic profile	Māori Pasifika Asian Other Not stated	18.75 percent 1.36 percent 15.82 percent 61.31 percent 2.77 percent
Gender profile	Female (80.13 percent) Male (19.87 percent)	3,116 employees 773 employees

Leadership, Accountability and Culture

We strive to cultivate a culture that has strong leadership and accountability, and a climate in which everyone can contribute to the way the organisation develops, improves and adapts to change. We are committed to meeting our statutory, legal and ethical obligations to be a good employer.

Collaboration and leadership are encouraged across services, occupational groups and other organisations in the health sector.

This occurs at all levels of the organisation and helps staff feel engaged and innovative and that they belong.

A key focus and priority is achieving equity in our staffing levels. Evidence shows that patient outcomes improve when services are more culturally safe and the workforce reflects the community we serve.

The signing of Te Tiriti o Waitangi by ancestors of Te Tai Tokerau Māori guaranteed their tino rangatiratanga, and no cession of sovereignty took place. The four articles in the original Te Tiriti document are the foundation for our relationships with Māori.

We have a positive relationship with our union partners and work together within a cooperative environment. Central to the relationship is a Bipartite Forum that meets regularly to maintain constructive engagement with the unions that represent our employees.

Achievements in 2021/22

- Launch of Taitokerau Rautaki Hauora 2040, a shared vision and strategic plan for the transformation of health in Northland.
- Implementation of Whakamaua, MoH's Māori Health Action Plan 2020-2025, for Te Poutokomanawa, the Māori Health Directorate.
- Embedded the Affirmative Action Policy and grew the number of Māori in the workforce by 10 percent, with an increased overall participation rate of 18.75 percent.

Recruitment, Selection and Induction

We have a number of successful development projects that support more Māori to join the workforce and undertake health and disability training. This applies particularly to services in which Māori are under-represented as health professionals and over-represented in health need.

Our DHB is the Northern regional lead for the national Māori Health Workforce Development programme, Kia Ora Hauora. In 2021/22, the Northern region recruited 449 new Māori into a health career pathway, supported 152 Māori to transition into tertiary level health studies and supported 101 Māori moving into health sector employment.

We have a longstanding arrangement with the University of Auckland to support and train Year 5 and 6 medical students to progress through our Pūkawakawa programme.

To make sure future services will be able to meet rising demands we must attract, recruit and develop a talented workforce, so we have made a number of improvements to streamline the recruitment process.

Tū Tira Working Group from left Louisa Kingi, Rhys Manukau, Viv Beazley and Bubbie Rapana

Achievements in 2021/22

- Three successful international recruitment campaigns and service specific social media campaigns resulted in more candidate applications than previous years.
- A new surge workforce function was established that resulted in:
  - a pool of external candidates being job-ready in the event of a further pandemic surge (a collaboration between the Integrated Operations Centre, Hands Up national database and People and Capability)
  - implementation of new surge rosters to support acute areas, resourced by internal staff who had capacity to provide additional hours
  - active recruitment of students, mainly from tertiary education, to assist in screener roles.
- A new workforce skills and competency repository, the Staffing Register, was developed and used to support workforce inter-department deployment during COVID-19; the application has been implemented as a surge tool to assist with roster gaps and shift cover.
- Development of new Hiring Manager interview guides.

Employee Development, Promotion & Exit

We support staff to participate in various internal and external training courses, conferences, workshops, and other developmental opportunities to build capability and support career and personal development objectives.

We provide medical staff with continuing medical education support, and nurses and midwives with professional development recognition programmes.

The Workforce Development & Wellbeing department offers a range of professional and personal development training opportunities.

We work to achieve equity in employee development in several ways, especially through Te Kaupapa Whakaruruhau / The Māori Health Cultural Quality Programme, which provides opportunities to gain cultural competencies.

We have also committed to applying an equity lens over all organisational training.

E-learning development and implementation has continued to expand, so that our primary healthcare and community partners have more access to learning, communication, knowledge transfer and skill development.

An improved Exit Survey makes it easier for staff to provide feedback when leaving the organisation or transferring to another department. Reasons for leaving are tracked by ethnicity to help improve Māori staff retention.

Achievements in 2021/22

- Key learning modules, including the Honouring Te Tiriti and Engaging with Māori courses have been revised, are now delivered both virtually and face-to-face, and included in all new starter orientation.
- Planning undertaken to establish a new clinical training centre to provide undergraduate training for nursing, medical and several Allied Health services on-site in one facility, and to provide postgraduate training, research facilities and space for large meetings.
- New Allied Health educational programmes launched in collaboration with AUT, including a training programme offering Physiotherapy, Occupational Therapy, Oral Health and Podiatry studies.
- In our Pūkawakawa programme this year, a codesign process focusing on equity and Hauora Māori was implemented, resulting in fortnightly Kaupapa Māori Zoom sessions.
- Primary Care Workforce Development Programme established including recruitment support, deployment of Telehealth resources to reduce the burden of GP after-hours rosters and standing order training for nurses working in primary care was made available.
- We provided 60 courses on cultural, leadership and communication skills, with 295 internal organisational course events and 3,252 overall attendances. We also utilised 93 e-learning courses, clinical and non-clinical, specifically for the Northland workforce, along with 14 national e-Learning courses.

Flexibility and Work Design

We function 24 hours a day, seven days a week, providing full-time and part-time opportunities. Ongoing challenges, especially as a result of COVID-19, have seen us retain an Incident Management Team (IMT) more or less permanently. IMT's dual role is to manage crises as they occur and come up with innovative solutions for the short and medium term.

We sought to assist our colleagues in the Auckland DHBs while they were in Level 4, re-deploying more than twenty staff members to the region for several weeks during this challenging time. Work hours and often location can be flexed according to employee needs and the requirements of the position. Any specific impairment is recognised and is suitably provided for where possible. During COVID-19 high-alerts, many non-frontline staff were kept safe by enabling them to work from home.

We continue to be committed to a holistic primary-secondary partnership. We work closely with GPs, our PHO partners and other primary care stakeholders to safeguard the workforce, eliminate health inequalities, promote wellbeing, improve outcomes, and increase the value gained from the health dollar.

Jeanette Wedding speaking at the Tuia Te Ora - Commerce Central blessing

Achievements in 2021/22

- Tuia Te Ora ('connectedness') was opened in Commerce Street in central Whangārei to house all Public Health and community services under one roof. It includes District Nursing, Public Health Nursing, COVID-19 teams, community clinics, Te Puawai Ora Community Maternity, The Health Information Centre, Ngā Tai Ora (Public Health Northland), other school-based and community clinical services, along with Community Rehabilitation and Needs Assessment & Service Coordination services.
- Manaia House in central Whangārei is being developed into the service hub for Community Mental Health and Addiction services that will provide an accessible, centrally located, fit-for-purpose facility for tāngata whai ora, whānau, and staff.
- The Calderdale Framework was expanded with nine new facilitators trained this year. Since its implementation, 15 projects have been completed and are now embedded as business-as-usual across a range of services. Examples include upskilling of an Allied Health assistant to undertake preparation for Speech Language therapy videofluroscopic studies, dental assistants who are now able to apply fluoride varnish applications, and Allied Health assistants now supporting rural hospital physiotherapists and occupational therapists in the community.
- Support for working remotely was increased, linking remote clinical teams and upgrading capabilities. Also implemented was a hands-free patient communications system for clinicians to see and talk with patients in COVID-19 wards, reducing exposure risk and improving safety of staff and patients.
- Implemented after-hours specialist support to rural hospital clinical teams.

OUR PEOPLE

Remuneration, Recognition and Conditions

We adhere to the good employer requirements in section 118 of the Crown Entities Act 2004 which covers:

- good and safe working conditions
- an equal employment opportunities programme
- the impartial selection of suitably qualified persons for appointment
- recognition within the workplace of the aspirations and needs of Māori, other ethnic or minority groups, women and people with disabilities and/or impairments.

The concept of the 'good employer' is bound up with the principles of natural justice and requires employment procedures to be 'fair in all circumstances'. We recognise that all individuals and groups should have opportunities without barriers or biases.

Our workforce is covered by 23 collective employment agreements, with a minority of staff on individual employment agreements. Most employee groups have transparent job evaluation criteria and specific merit programme criteria that have been developed in consultation with relevant unions.

We are party to the national pay equity process which is collaborative between unions and DHBs. The Equal Pay Amendment Act 2020 has provided principles and allowed for a framework which addresses systemic, gender-based pay discrimination in female-dominated roles.

Achievements in 2021/22

- Our adoption of the Living Wage saw 177 employees receive an additional top-up allowance, and all employees now earn at least the living wage of $22.10.
- Settlement of the PSA Administration & Clerical Pay Equity claim, with administration roles being revalued in line with comparator occupations.
- Additional winter payments were implemented to attract and recognise employees working in vulnerable acute settings and hard-to-fill shifts.
- Additional staff recognition and welfare initiatives were launched during COVID-19 and high winter demand, including food baskets, meal and coffee deliveries, outdoor furniture and team events.
- Gift baskets were delivered to our primary and community providers to recognise their support and teamwork through the COVID-19 response.

Chief Nurse Dr Maree Sheard and her team preparing for International Day of the Nurse

Harassment and Bullying Prevention

Our zero tolerance to bullying and harassment is reinforced by our Managing Unacceptable Behaviour in the Workplace Policy, a supportive document that provides staff with clear guidelines.

The 'DATIX' electronic reporting tool continues to be the vehicle for reporting incidents of alleged violence, bullying and harassment. We have continued to engage with our union partners to refine and increase confidence in tools and processes to ensure that all employees are able to safely raise concerns.

Our Workplace Violence Prevention (WVP) Framework works at every level of the organisation to implement wide-reaching prevention measures and leadership, as well as reviewing, responding to and managing all forms of workplace violence. It has six Focus Areas.

Achievements in 2021/22

- An internal review saw over 800 staff provide suggestions, thoughts and recommendations on how to improve the management of bullying complaints, and the establishment of a remediation plan and steering group.
- 1,010 staff attended face-to-face Workplace Violence Prevention (WVP) training as well as 525 through an online module. CALM WVP facilitated online during COVID-19, and CALM-Plus training developed and rolled out for clinical staff. To respond to increased demand for training a WVP Educator role was established and on-call trainers are being recruited.
- Intensive six-month WVP Pilot Projects have been undertaken in service areas of high workplace violence risk (Mental Health and Addictions, and Maternity). Onsite counselling is now being accessed by Tumanako staff.

Public Health staff at Tuia Te Ora - Commerce Central

Health, Safety and Wellbeing

Although COVID-19 stretched the health system, the risk to our workforce was kept low through effective infection prevention controls, testing and vaccination.

Our Values are centred around health, safety and wellbeing. We are committed to providing a culturally and physically safe workplace for employees, patients, whānau, visitors and contractors.

We have effective emergency and corporate risk management systems and processes in place that meet legislative and contractual obligations.

Staff wellbeing has always been a key focus. It is promoted in various ways across the organisation and led by the Workforce Development and Wellbeing department.

Achievements in 2021/22

- In response to COVID-19 several new health and safety functions were established including vulnerable employee risk assessments, mask fit testing, employee COVID-19 testing, vaccinations and exposure event management.
- Establishment of Tu Tangata, a wellbeing steering group and a wellbeing fund to which teams can apply to promote a team wellbeing initiative.
- Successful completion of the ACC Partnership Programme Audit (scope was reduced due to COVID-19, and primary accreditation attained).

Infection Prevention & Control clinical nurse specialist Premila Reddy and clinical nurse educator Jomish John

Whangārei Hospital volunteers Linda Tauariki and Naoko Watson

WHAT ARE WE TRYING TO ACHIEVE?

Our Vision is "A Healthier Northland, He Hauora Mo Te Tai Tokerau".

We aim to achieve this by working together in partnership under Te Tiriti o Waitangi to:

- improve population health and equity
- improve patient experience
- improve staff wellbeing and sustainability
- achieve value and financial sustainability.

We endeavour to work consistently according to our values:

Tāngata i te tuatahi – People first: our people are central to all we do.
Whakaute (tuku mana) – Respect: we treat others as they would like to be treated.
Manaaki – Caring: we nurture those around us, and treat all with dignity and compassion.
Whakawhitiwhiti Korero – Communication: we communicate openly, safely and with respect to promote clear understanding.
Te Hiranga – Excellence: our attitude of excellence inspires confidence and innovation.

HAVE WE MADE A DIFFERENCE?

Structure of the Statement of Performance

The Outcomes Framework describes how the measures used in the Statement of Performance relate to national outcomes.

The first main section, Performance on Outcome Measures, addresses whether we are making a difference to the health of our population. Its measures address the whole Northland population or significant groups within it. Outcome Measures have a long-term focus because the factors that affect them typically take years to change and often lie outside the direct influence of the health system.

The second section, Performance on Output Measures, covers services or behaviours that contribute to the outcomes. Changes to the way services are provided have more immediate impacts, so we monitor performance against them at least annually.

National performance measures

A new set of Health System Indicators was announced early in August 2021[1] which will measure how well the health system is performing to improve equity, and to track progress towards better health and wellbeing. The framework recognises that districts and communities should lift performance through system improvement at a local level rather than concentrating on nationally set performance targets, though it will also of course provide a picture of progress nationally.

Some indicators are still in development and a date for the system's adoption for formal reporting and monitoring has not yet been announced. In the short term the Ministry of Health, the Health Quality and Safety Commission and the Health and Disability Review Transition Unit will discuss the new system with the sector, and the Health Quality and Safety Commission is developing a reporting portal to pull the data together.

National	MoH Purpose and Role	Improve and protect the health of New Zealanders				
	MoH Strategic Priorities	Improved equity in health outcomes and independence for Māori and all other people	Sustainable and safe health and disability services	An integrated, collaborative and innovative health and disability system	People-centred services, support and advice that meet the needs of everyone	
Northland	Vision	A Healthier Northland		He Hauora Mo Te Tai Tokerau		
	Mission	Achieved by working together in partnerships under Te Tiriti o Waitangi to:				
		Improve population health and equity	Improve patient experience	Improve staff wellbeing and sustainability	Achieve value and financial sustainability	
	Outcome Measures	Life expectancy gap between Māori and non-Māori reduced by 2 years	Unplanned hospital admissions for Northlanders reduced[2]	>95% of patients report they would recommend the service provided	Decrease in infant mortality	Mortality rate, age-standardised
		Reduce gaps between: (a) Māori and non-Māori (b) Northland and NZ				
	Output Measures	Adults who are current smokers Full and exclusive breastfeeding at 3 months 8-month-olds fully immunised Breast cancer screening Cervical cancer screening	Obese children offered a referral to a health professional Ambulatory sensitive hospitalisations ages 0–4 Average number of decayed, missing or filled teeth in Y8 students Good blood sugar management in diabetics Eligible people receiving cardiovascular disease risk assessment in the last 5 years Pregnant women given brief advice and support to stop smoking	Faster Cancer Treatment 62-day indicator (time between referral and first treatment) % of people with enduring mental illness aged 20–64 who are seen over a year Elective surgical discharges Quality measures (hand hygiene, patient deterioration, hospital falls, surgical safety) Emergency department patients with length of stay less than 6 hours	HCSS[3] clients assessed using interRai tool HCSS providers certified ARRC[4] providers with at least 3-year certification	
	Output Classes	Prevention	Early detection and management	Intensive assessment and treatment	Rehabilitation and support	
	Enablers	Workforce	Information technology	Quality systems	Financial management	

[1] https://www.health.govt.nz/new-zealand-health-system/health-system-indicators
[2] The original target, to reduce unplanned admissions by 2,000 by 2017, was drawn from the Northland Health Services Plan, but its timeframe is now well past and no longer relevant, so the numerical threshold has been removed. Unplanned admissions will be retained as a high-level measure until new ones are introduced under Te Whatu Ora and Te Aka Whai Ora.
[3] Home and Community Support Services, which help people to continue living at home.
[4] Age Related Residential Care.

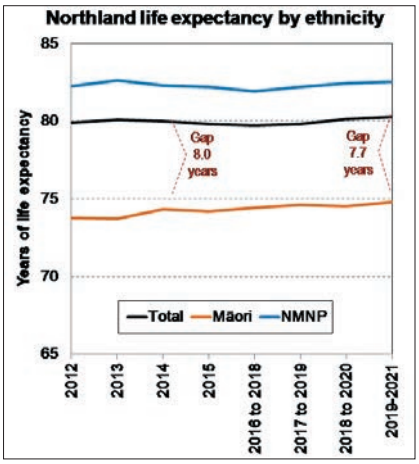
Performance on Outcome Measures

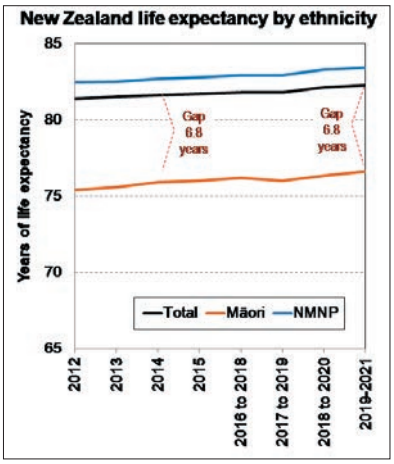
We are either making gains or holding steady across most of our outcome measures. The gap between Māori and non-Māori has been reducing for life expectancy and infant mortality, and there have been minimal increases in acute discharges from hospital in the face of significant and growing demographic pressures. Patient satisfaction appears to have worsened this year, but that is most likely due to changes in the wording of the survey questions; once two years' data is gathered under the new approach, a more realistic assessment will be possible.

Equity for Māori is still our biggest concern. In Northland, Māori live on average 7.9 years less than non-Māori, and Māori mortality (adjusted for their different age structure) is about twice as high.

Outcome Measures

Life expectancy





Results. Between 2012 and 2019-21 Northland life expectancy increased gradually for Māori (from 73.7 to 74.8 years) and markedly for Pacific (75.7 to 79.9 years) but remained relatively stable for non-Māori non-Pacific (82.2 to 82.5 years). Over that time the gap between Māori and non-Māori non-Pacific reduced by nearly a year from 8.5 to 7.7 years. New Zealand data shows a similar picture, though life expectancy for each ethnic group is higher by a year or two, a gap that has shown no real change over the years.

The measure. Life expectancy at birth is a high-level measure of the health of the population. About 40% of health status is due to social and economic factors such as education, income, employment and housing (of the remainder, 30% relates to individual behaviours, 20% the influence of the health system and the other 10% is driven by genetics). Northland is acknowledged to be one of the most deprived regions of New Zealand, and Māori are more deprived than non-Māori.

Infant mortality has a significant effect on the final life expectancy calculation; as the next heading shows, Northland's figures for infant mortality are slightly poorer than the national average.

A key influence on length of life is how we live it. Two of the most harmful behaviours are smoking and obesity, which cause some of the most prevalent lifestyle-related conditions such as heart disease, diabetes and cancers. The performance indicators section has measures relating to all of these.

Response. The government has set a national target of no more than 5 percent of the population smoking by 2025. In Northland smoking rates have been declining for both Māori (from 34.7 percent in 2016/17 to 32.3 percent in 2021/22) and for non-Māori (12.4 percent to 11.5 percent over the same period). Northland has a number of initiatives and services aimed at preventing smoking uptake and supporting people to quit, as described in the smoking-related narrative under the first output class.

Excess weight in Northland is a serious problem, worse now than smoking. 81% of Māori are either overweight or obese, compared with 69% of non-Māori [5]. Northland's health service providers have numerous initiatives aimed at encouraging healthier behaviours. Obesity is the target of the Under 5 Energise programme, Project Energise (aimed at school ages), advocacy on sugar-sweetened beverages, and the Northland Food Rescue Service.

About the data. Life expectancy data can be sourced from Statistics New Zealand, but they produce it only every five years. The estimates presented here are calculated by the Auckland and Waitemata DHBs' joint Planning, Funding and Outcomes team, using methodology that aligns with that of Statistics New Zealand. It uses a three-year aggregation of deaths and population to smooth out random yearly variations that can occur in numbers of deaths in some age groups and ethnicities. Life expectancy for '2019-21' includes preliminary data for all deaths registered in 2019, 2020 and 2021, and the 2019 update to the official DHB population projections.

Life expectancy data normally lags three or four years behind because the mortality data required for the calculations lags by that much; it is not released until all causes of death have been verified by coronial processes. The life expectancy data used in the Statement of Performance uses preliminary mortality data for the last two years, which should make no difference to the calculations because unresolved causes of death comprise tiny numbers.

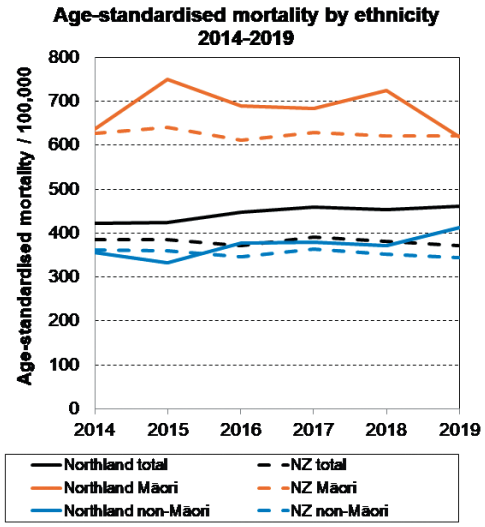
Life expectancy 2014-19 increased more for Māori than non-Māori.

The ethnic disparity is about a third of a year less than in 2014.

[5] 2017-20 pooled data from the NZ Health Survey https://minhealthnz.shinyapps.io/nz-health-survey-2017-20-regional-update/_w_fa277316/#!/subgroup-results.

HAVE WE MADE A DIFFERENCE?

Mortality overall



Māori mortality rates are about twice those of non-Māori.

Northland's rates are higher than NZ's for both ethnic groups.

Results. Age-standardised mortality rates for Māori in Northland have been about twice that of non-Māori for some years. That difference doesn't appear to be reducing, though it is harder to identify a trend in the Māori rate because their smaller population makes it more variable.

The measure. The Māori rate is higher principally because of earlier onset of diseases and lower rates of access to and use of primary care services. Among the reasons are:

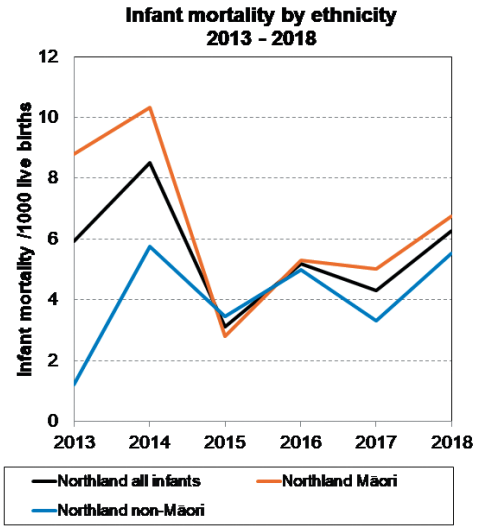
- Māori have higher rates of smoking and obesity
- in Northland Māori experience unmet need for primary health care more often (40%) than non-Māori (33%)[6]

Response. Recent years have seen an increased emphasis on services that intervene earlier in long-term conditions so they can be better managed. Advice to smokers is given in primary care and hospital. Faster cancer treatment has been a focus, colonoscopy rates have risen, people receive computerised tomography (CT) and magnetic resonance imaging (MRI) scans more quickly, access to services for stroke and acute heart conditions has improved, and primary care has continued to perform cardiovascular and diabetes risk assessments. Consultations with general practices on low-need issues are often conducted by telephone, thus freeing up time to deal with more complex needs, and consultation by remote means such as telehealth will increase over time.

About the data. Numbers of deaths were taken from the Ministry of Health's Mortality Data Tables, rates per age group were calculated, and the resulting numbers standardised as if both Māori and non-Māori populations had the same age structure (if this wasn't done the younger age structure of Māori would mask the higher proportion of deaths they experience in middle age). The resulting mortality rates are not 'real', but they can be compared.

This year the analysis uses 2018-base projections now that they have been released (previous years used 2013-base).

Infant mortality



Infant mortality rate in Northland varies considerably each year because of small numbers.

Māori rate is only slightly higher than non-Māori.

[6] 2017-20 pooled data from the NZ Health Survey https://minhealthnz.shinyapps.io/nz-health-survey-2017-20-regional-update/_w_fa277316/#!/subgroup-results.

Infant mortality continued

Results. In the last few years Māori infant mortality in Northland has been only slightly higher than non-Māori, though small numbers mean considerable variability year to year.

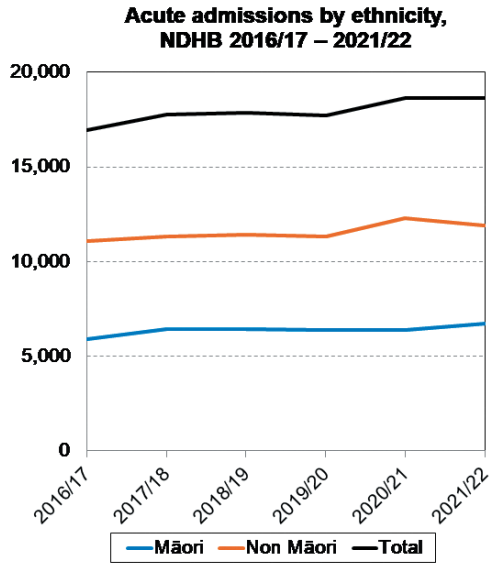
The measure. The infant mortality rate serves as an important measure of the wellbeing of infants, pregnant women and children generally because it is associated with a variety of factors such as maternal health, quality of and access to medical care, deprivation and public health practices.

Response. Northland health services have been making strenuous efforts in recent years to improve the health of infants, particularly Māori.

Breastfeeding contributes to create healthier, more resilient babies (see under output class 1). This year the Māori rate at three months is now close to the 60 percent national target at 58.4 percent (and the trend is upwards, because the latest half-yearly data puts it at 65 percent). Rates of sudden unexpected death of an infant have decreased in the wake of risk factor assessments and the adoption of safer sleeping practices for babies. Northland also has the 'High Five' notification form that tells a mother post-birth about enrolment of her baby in the five key service providers.

About the data. Data comes from the Ministry of Health.

Acute discharges from hospital



Over five years, growth in acute admissions was lower (10 percent) than:

- *Māori, 12 percent*
- *older people, 22 percent.*

Results. In the last five years acute discharges increased by 10 percent from 16,957 to 18,638.

Restricting acute demand growth to 10% over these five years is quite an achievement in the context of the population growth Northland has experienced over that time. The total population increased by just less than that amount (8%) between 2017 and 2022, but greater growth was experienced by Māori (12%) and older people (22%), population groups known to be associated with rises in acute demand and complexity.

36 percent of acute admissions in 2021/22 were Māori, which aligns closely with their proportion of the population. It has been consistently around this level for several years.

Acute admissions remain high and at a similar level to 2020/21. Covid-related admissions contribute to the overall total.

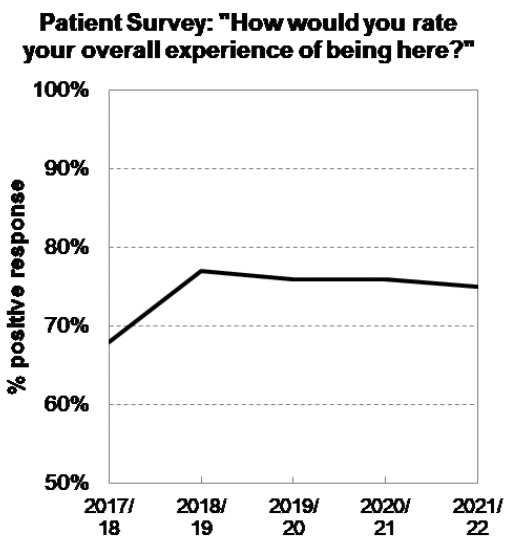
The measure. The rate of unplanned readmissions is an indicator of how well conditions, especially long-term conditions, are being managed by primary care services. There is no set definition of an unplanned readmission so as a proxy we have taken acute discharges because these patients appear urgently and without forewarning (in contrast to elective admissions that can be planned ahead of time).

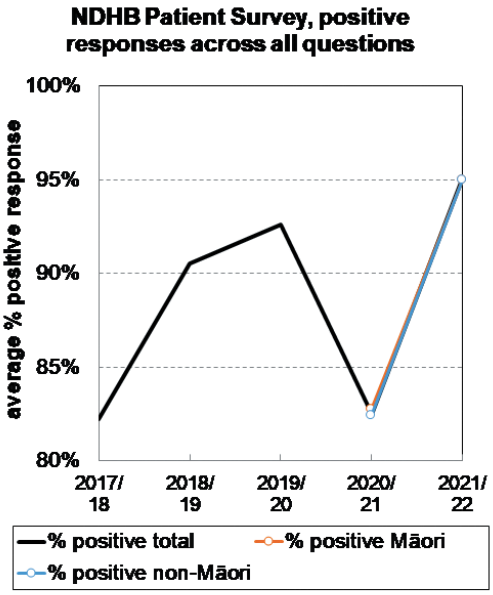
Response. The main source of referrals to hospital is the primary health sector, so its role is key. Long-term conditions need to be monitored and managed well in the community so that fewer complications arise and there will be fewer acute admissions. A core priority in Northland is to eliminate health inequities by targeting primary health care resources and improving how services are delivered.

About the data. Data comes from Northland DHB.

HAVE WE MADE A DIFFERENCE?

Patient satisfaction





Results. Performance on patient satisfaction can be addressed through the results of our internal patient survey, which contains a question on 'overall satisfaction' as well as questions covering a range of issues relating to a stay in hospital.

Since 2016/17 the score on the overall question of "How would you rate your overall experience of being here?" has increased from 64 percent to 75 percent (it has been between 75 percent and 77 percent for the last four years).

Across all the individual questions in the patient survey, the average positive response rose steadily from 73 percent in 2016/17 to 95% in 2021/22 (apart from a drop to 83 percent in 2020/21 due to a question rewording).

Overall, during 2021/22 Māori and non-Māori rated their stay in hospital equally highly at 95 percent.

Response. Surveys used to ask patients about how services were provided, but now Northland DHB encourages them to describe feelings and experiences, and questions are worded to elicit more details about issues requiring attention.

The measure. Evidence tells us that patient experience is a good indicator of the quality of health services. Better experience, stronger partnerships with consumers, and patient and family-centred care have been linked to improved health, clinical, financial, service and satisfaction outcomes.

About the data. Data comes from Northland DHB. The Ministry of Health, through the Health Quality and Safety Commission, has a different patient survey that forms part of the System Level Measures. MoH prefer their survey because it is applied to all DHBs and provides a consistent basis for comparison. However, it has a low response rate (about 20 percent), so we prefer to use our own survey because it has similar questions and its larger sample size makes it more valid and reliable.

The percentages quoted are Net Promoter Scores, derived by subtracting total 'detractor' responses (0–6 on a ten-point scale) from the total 'very satisfied' (9+10); 7s and 8s are ignored.

Overall experience of hospital stays has been consistently above 75%.

At 95 percent, Māori and non-Māori are equally highly satisfied.

STATEMENT OF PERFORMANCE

Performance on Output Measures

The Statement of Performance is a snapshot of how the services provided for the Northland population have been performing. It is divided into four output classes that cover the spectrum of services from those promoting health in the population, through primary and community care to hospital services and later-in-life care.

The Statement of Performance assesses how well we have done this year compared with the targets set during the previous year's planning cycle. The measures selected are a combination of national and local priorities that contribute collectively to the high-level outcomes described in the previous section. We have tried to keep the number of measures small by choosing a representative sample of key ones, while still covering the breadth of services.

The measures do not cover just Northland DHB's services. DHBs are legislatively responsible for the health of their populations, so as well as providing services we contract with and monitor other service providers in the health sector. Many of the measures, especially those in the first two output classes, describe performance outside the DHB.

Data from 2020/21 appears in two places in the tables. Data in the 'baseline' columns is copied from the 2021/22 Statement of Performance Expectations which, because it had to be prepared before 2020/21 ended, does not cover the whole year. The '2020/21 result' column captures data for the whole year, as reported in the Annual Report for that year.

Performance during 2021/22

Northland DHB has a total of 26 performance measures for 2021/22 with 59 targets. Of these three were met or exceeded, seven were close to target, 40 were below (of which 16 had improved from the previous year) and nine can't be assessed because of data issues.

The COVID-19 pandemic has affected several performance measures; the nature of the impact is described in the narrative for the relevant performance measures or in footnotes relating to them.

Achievement ratings

Achieved	Substantially achieved	Not achieved but progress made	Not achieved	No conclusion can be drawn
Target met or bettered	*Within 5% absolute of target*[7]	*More than 5% absolute from target, but progress made*	*Not achieved*	*Issues with data availability, changing measurements etc.*

[7] 5% is appropriate when the data is calculated out of 100%, as is the case with most of the measures. Three are different however: the smoking prevalence target is 5% and targets for mental health and oral health are based on small quantities. In those cases, the 5% is defined in relation to the figure in the "2021/22 target" column.

STATEMENT OF PERFORMANCE

Output Class 1: Prevention

Publicly funded services that protect and promote health across the whole population or particular subgroups of it. These services improve the health status of the population, as distinct from curative and rehabilitative services (the other three Output Classes) which repair or support illness and injury. The Output Class includes:

- health promotion to prevent illness
- statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases
- population health protection services (immunisation, screening etc)
- Well Child services.

Output measure	Ethnicity	2020/21 baseline from 2021/22 SPE		2020/21 result	2021/22 target	2021/22 result	Achievement
		Period	Data				
% of Northland adult population who are current smokers [8]	Total Māori Non-Māori	2020/21	18.3% 33.6% 11.3%	18.3% 33.4% 11.3%	No official target [9]	18.7% 32.3% 11.5%	
Full and exclusive breastfeeding at 3 months	Total Māori Non-Māori	2020/21	61% 52% 69%	60.2% 52.7% 67.8%	70%	65.7% 58.4% 72.3%	
% of 8-month-olds who are fully immunised	Total Māori Non-Māori	2020/21	81.0% 83.0% 77.6%	80.6% 76.7% 83.7%	95%	77.9% 71.9% 84.5%	
Breast cancer screening in eligible populations	Total Māori Pacific Other	2020/21	61.6% 63.6% 60.1% 60.9%	61.7% 63.5% 59.5% 53.4%	70%	62.8% 64.7% 61.6% 62.1%	
Cervical cancer screening in eligible populations	Total Māori Pacific Asian Other	2020/21	67.5% 60.4% 59.5% 64.5% 71.6%	68.3% 60.4% 59.5% 65.4% 73.0%	80%	67.2% 54.9% 55.7% 57.7% 74.4%	

Further information on results	
% of Northland adult population who are current smokers	New Zealand has for some years had a national target of 5% smokers by 2025. The proportion of smokers in Northland has not reduced in line with this, so that now with only three years to go we would need to achieve an annual reduction of 4.4% in our total population smoking rate (Māori 8.8%, non-Māori 2.1%). Our actual annual reduction in the last five years has been 0.11% (Māori 0.48%, non-Māori 0.19%). Ngā Tai Ora Public Health Intelligence Team undertakes tobacco retailer-focused research projects to provide local evidence for submission under the Smokefree Environments and Regulated Products (Vaping) Amendment Act. Ngā Tai Ora has, with the help of the regional Public Health Intelligence Team in Auckland, developed GIS maps for every council in New Zealand that show the proximity and density of tobacco and vape retailers (general and specialist vape retailers) within a 1km radius of schools. The maps also show areas of high deprivation and smoking rates. Ngā Tai Ora supports local councils in their efforts towards Smokefree 2025. They promoted a Vaping Remit at the Local Government NZ Conference, which passed with 79% support, to restrict the sale of vaping products and develop rules around the location and clustering of vaping product retailers to protect young people. Ngā Tai Ora works alongside the Māori Directorate to undertake Smokefree 2025 Action Plan community engagement of our Māori providers and whānau to give voice to community needs and the government's SF2025 goal. Ngā Tai Ora runs Controlled Purchase Operations (CPOs) in which underage youths are used to assess retailers' compliance with the Smokefree Environments and Regulated Products (Vaping) Amendment Act 2020. Our ability to carry out CPOs has been restricted recently because of staffing issues. Toki Rau is a free stop smoking service run by Te Hiku Hauora under contract to Te Poutokomanawa. It provides face-to-face support in individual, whānau or group settings, along with free nicotine replacement therapy (NRT) and advice about other products. The Hospital Smokefree Facilitator is responsible for systems, processes and education to improve smoking cessation interventions by clinicians across all services. The facilitator also ensures NRT and other supports are available to patients and has a role in training and mentoring community quit coaches. General practices offer smoking cessation support and free NRT to all patients, though they target Hapū Mama and Māori. Follow-up is either by the practice team or by referral to Toki Rau. The role of Pouarahi, Ngā Tātai Ihorangi, supports the SUDI prevention programme, ensuring integration of stop-smoking programmes from a whānau ora perspective into hapū māmā and whānau wānanga.

[8] Smoking rate data, sourced from primary care providers, isn't perfect because it relies on general practices to keep their records up to date, but it is available quarterly and PHO enrolments cover more or less the whole population. The NZ Health Survey also has data on adult smoking, but it is produced infrequently and each set of data covers several years so it is not useful for regular monitoring.

[9] Northland DHB has not set a target for this but has tracked progress to compare the trajectory to date with the national target of 5 percent smokers by 2025 (see narrative above).

Output Class 1: Prevention

Breastfeeding at 3 months	Equity for Māori is being addressed by developing Ngā Wānanga o Hine Kōpū – Hapū māmā Antenatal Wānanga where midwives provide specifically targeted breastfeeding education and advocacy among other kaupapa. While our rates are slowly increasing, we have a way to go to reach the target. We have practitioners who are thinking outside the box and are providing whānau centred wholistic care to support mamas to breastfeed. Our recommendation is to look at enhancing the current breastfeeding support roles that Te Hiku Hauora and Te Rarawa offer, with further education and support. And most imperatively to look at contributing to a support package to encourage this specialist role within Kaitaia for Te Whatu Ora, as there is a clear equity and equality gap noted in this region. We are confident that our work supporting connection to te ao Māori will encourage and awhi more mama to exclusively breastfeed. More resource would further grow these spaces. Complex social situations and mental health challenges are increasingly becoming barriers to engaging with mama. Disengagement and transience of whānau are commonly recurring themes across the Kahu Taurima space. Whānau we are able to support and engage with, require more resource in the context of time and effort. Promotion around early ongoing support has been identified as a priority to grow this mahi and is being worked upon.
Breast cancer screening	Less than 80% of parents choose to vaccinate their 8-month-old children in Northland. Over the last three quarters of 2021/22 (data isn't available for Q1) 12% of parents either declined to have their children immunised or chose not to allow them to appear on the National Immunisation Register ('opted off'). Reasons for this include parents who are well informed and make a rational choice, those who remain adamantly opposed to immunisation, those who experience barriers to accessing services, and families who are under so much stress (because of poverty of income, food or housing) that immunisation is not a high priority. The failure to reach target is also due to 'missed' children (10% over the same three quarters) which covers a variety of reasons: whānau not giving consent (though not officially declining); not all the required vaccinations have been completed; families moving in and out of Northland; vaccinations scheduled and not yet completed; catch-up vaccinations are planned but gaps in timing are required between doses. Northland continues to implement multiple strategies to improve our coverage, including: · Immunisation Outreach Service covering all of Northland · robust systems to ensure all children have an opportunity for vaccination; children are identified and provided with support to GP and/or Outreach Service for timely vaccination · increased access to vaccination including an all-day clinic in central Whangārei and Public Health Nurses providing opportunistic vaccination · communications to promote immunisation as safe, and best protection against communicable disease.
Cervical cancer screening	Targets are raised regularly by the National Screening Unit in line with revisions in population projections. Each time this happens apparent performance drops overnight, and in recent years the service has been trying to catch up with rapidly increasing population numbers. Covid-related lockdowns have also affected coverage and contributed to a backlog. While we are below target, improvements have occurred across all ethnic categories.
Cervical cancer screening	Cervical screening is a sensitive subject for many women, and Northland's geography creates an additional challenge. A steering group meets quarterly with expertise from across the health system to identify opportunities to improve cervical screening rates. To reach priority women, an additional track-and-trace function is supplied through Support to Services.

STATEMENT OF PERFORMANCE

Output Class 2: Early Detection and Management

'Primary' or 'community' services, that can be directly accessed by people in the community. They are delivered by a range of providers including general practice, Māori health providers, pharmacies, and oral health services. The services are generalist (unlike the specialist services provided in hospitals for example) and the same type of services is typically provided in numerous locations across the community. The Output Class includes:

- primary health care
- oral health
- primary community care programmes
- pharmacy services
- community referred testing and diagnostics (laboratory and imaging services)
- primary mental health services.

Output measure	Ethnicity	2020/21 baseline from 2021/22 SPE		2020/21 result	2021/22 target	2021/22 result	Achievement
		Period	Data				
95% of obese children identified in the Before School Check programme will be offered a referral to a health professional	Total Māori Non-Māori	2020/21	57.7% 58.1% 57.6%	55.9% 57.0% 53.0%	95%	83.1% 79.2% 84.3%	
Ambulatory sensitive hospitalisation rate per 100,000, ages 0-4, unstandardised	Total Māori Non-Māori	2020/21	5,527 3,547 4,644[10]	6,192 7,153 5,000 (43% gap)	– 6,003[11] –	5,367 6,149 4,375 (41% gap)	
Average number of decayed, missing or filled teeth (DMFT) in Y8 students	Total Māori Non-Māori	2020/21	1.15 1.66 0.70	1.15 1.66 0.70	0.92[12]	0.99 1.35 0.52	
Good blood sugar management in diabetics (≤ 64 mmol/mol)	Total Māori Non-Māori	2020/21	52.7% 46.2% 59.4%	53.1% 46.7% 59.8%	80%	52.8% 45.9% 61.3%	
Eligible people receiving cardiovascular disease risk assessment in the last 5 years [13]	Total Māori Non-Māori	2020/21	85.7% 81.5% 87.7%	73.9% 75.7% 73.0%	90%	79.7% 76.5% 81.3%	
% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking	Total Māori Non-Māori	2019/20	76.8% 73.3% 77.7%	78.9% 84.2% 83.3%	95.0%	83.9% 81.8% 90.0%	

Further information on results	
Obese children offered referrals to a health professional	The B4 School Check Coordinator actively monitors to ensure all children with BMIs greater than the 98th percentile have an in-depth discussion and advice given by the Before School Check Nurse with a referral offered. A Northland B4 School Check Educator has recently been employed and is supporting nurses with the conversation and language around discussing unhealthy weight with whānau. This is covered extensively as part of the initial nurse training and part of update / professional development days. The B4 School Coordination Team are exploring options to be able to offer referral services to support whānau within the community.
Average number of decayed, missing or filled teeth in Y8 students	Until Northland has fluoride in reticulated water supplies it will be difficult to gain much traction on the higher rates of decayed teeth in Māori. We are investigating public health programmes in Northland such as supervised toothbrushing in schools with assistance from philanthropic funding.
Good blood sugar management in diabetics (equal to or less than 64 mmol/mol).	Northland continues to perform unfavourably in meeting appropriate metrics with patients maintaining good management of diabetes. The focus on the care of COVID positive patients in the community by health providers, particularly in the second half of FY2022, has driven focus away from key screening and other health prevention and promotion activities.
Eligible people receiving cardiovascular disease risk assessment in the last 5 years	Northland has failed to meet the 90% target for eligible people receiving cardiovascular disease risk assessment in the last 5 years. The focus on the care of COVID positive patients in the community by health providers, particularly in the second half of FY2022, has driven focus away from key screening and other health prevention and promotion activities.
Pregnant women smoking	Performance has improved more than the annual average suggests, because after a slow first quarter, the average over the last three quarters has been close to or over target (90.4% overall, 88.3% Māori and 95% non-Māori). Performance has improved since last year as a result of joint efforts between the hospital Smokefree facilitator and community midwives to identify needs and continually improve services. Regular audits are planned to augment this.

[10] The baseline data was recorded incorrectly in the SPE because it used the average of the two quarters available for 2020/21 at the time of writing (that is, Q1 and Q2). The preferred approach would have been to report just the data for Q2 because that covers the year ending in that quarter. In that case the numbers would be: total 4,438, Māori 5,336, non-Māori 3,327.

[11] Target based on SLM plan's target of 5% annual reduction for tamariki Māori. The focus here is on the rate (unstandardised) that has been used in the SP for a number of years, in preference to the number of events that the SLM plan uses.

[12] This target was not in the SPE, though it should have been copied from the performance measures section of the 2021/22 Annual Plan (from which the number in the table is sourced).

[13] 2021/22 data covers general practices under Mahitahi Hauora only. Systems to report on Northland practices under other PHOs have yet to be set up. Data covers the last five years.

Output Class 3: Intensive Assessment and Treatment

Usually known as 'secondary' or 'hospital' services, these are provided by particular specialties and can be accessed only after referral from a primary health practitioner. They are available in few locations; for Northlanders, almost all are in Whangārei, or in Auckland for more highly specialised services. The Output Class includes:

- inpatient services, both acute (treatment is needed now) and elective (treatment can be scheduled at a later date); includes diagnostic, therapeutic and rehabilitative services
- ambulatory services for people treated by a hospital but not admitted as an inpatient (includes outpatient, district nursing and day services) across the range of secondary preventive, diagnostic, therapeutic, and rehabilitative services
- emergency department services including triage, diagnostic and therapeutic services
- secondary mental health services
- secondary maternity services
- assessment treatment and rehabilitation.

Output measure		Ethnicity	2020/21 baseline from 2021/22 SPE		2020/21 result	2021/22 target	2021/22 result	Achievement
			Period	Data				
% of patients who receive their first cancer treatment (or other management) within 62 days referred urgently with a high suspicion of cancer and a need to be seen within two weeks		Total Māori Non-Māori	2020/21	69.8% 63.8% 72.7%	67.1% 61.4% 70.4%	90%	87.2% 95.5% 84.8%	● ● ●
% of people with enduring mental illness aged 20–64 who are seen over a year		Total Māori Non-Māori	2020/21 to Q2	5.68% 9.17% 3.84%	5.58% 8.86% 3.82%	6.07% 10.22% 4.17%	5.22% 7.96% 3.67%	● ● ●
Patients with an emergency department length of stay of less than 6 hours		Total Māori Non-Māori	2020/21	84.5% 86.6% 83.2%	84.4% 86.6% 83.2%	95%	81.8% 83.8% 80.5%	● ● ●
% hand hygiene compliance [14]		Total	2020/21	88%	86%	90%	85%	●
Patient deterioration	% of patients with early warning scores calculated correctly	Total	2020/21	0.84 (84%) [16]	85%	n/a [17]	[18]	●
	% of patients who triggered an escalation of care and received the appropriate response	Total	2020/21	0.66 (66%)	66%			●
Falls	% older patients assessed for risk of falling	Total	2020/21	69%	66.3%	90%	[19]	●
	% older patients assessed as at risk of falling who received an individualised care plan that addresses these risks	Total	2020/21	94%	90.3%	90%		●
% of hip and knee arthroplasty primary procedures where antibiotic given 0–60 minutes before 'knife to skin'		Total	2020/21	97%	95%	100%	[20]	●

[14] For the five quality measures (this one and the next four) data is not produced by ethnicity.
[15] July-Feb only; the impacts of Covid meant that no data was collected nationally by HQSC during March-June 2022.
[16] This and the baseline result in the next row were recorded as fractions of 1; the percentage equivalent is in brackets.
[17] The national reporting system from which these two measures are drawn does not have a target.
[18] Measures were stopped in 2021/22 because they required a manual audit and there were high demands from Covid. They were restarted in July 2022.
[19] Measures were no longer collected by HQSC in 2021/22. They were replaced by a new measure of 'fractures of neck of femur'.
[20] No data collected in 2021/22 because of COVID-19.

STATEMENT OF PERFORMANCE

Measures not included in 2021/22 SPE

In 2019/20 a new suite of Planned Care measures was introduced, among which was planned surgical operations and procedures which replaced the old elective operations measure. The new measures include, as well as operations, a range of DHB-funded treatments delivered in primary and community settings, making the two sets of data not comparable. The Planned Care measures were not in the SPE for 2021/22 but are included here because they are part of MoH's measures.

Output measure	Ethnicity	2020/21 baseline from 2021/22 SPE		2020/21 result	2021/22 target	2021/22 result	Achievement
		Period	Data				
Planned Care: [21] Inpatient surgical discharges Minor procedures Non-surgical interventions	Total	Not included in the 2021/22 SPE		12,967 7,799 5,168 0	13,075 8,512 4,365 198	12,182 7,856 4,326 0	
Northland acute bed days per 1000 (non-standardised)	Dep 4 Dep 5	Not included in the 2021/22 SPE		501.3 551.8	[22]	436.5 [23] 533.7	
	Total Māori Non-Māori, non-Pacific			434.4 405.8 455.0		448.4 425.0 466.8	
Shorter waits for non-urgent mental health and addiction services for 0-24-year old's - % of people seen within 3 weeks [24]	Total Māori Non-Māori	Not included in the 2021/22 SPE		84.4% 86.6% 83.2%	n/a [25]	73.5% 76.3% 70.5%	

Further information on results	
% of patients who receive their first cancer treatment (or other management) within 62 days referred urgently with a high suspicion of cancer and a need to be seen within two weeks	Performance for 2021/22 has improved markedly since last year, especially for Māori whose percentage is now higher than non-Māori. Also noteworthy is that the all-patient percentage rose from the mid-seventies in the first half of the year to reach the 90% target over the last half. This improvement has occurred through a collective effort to ensure patients on FCT pathways are progressing to first treatment before 31 or 62 days from the Decision to Treat. COVID-19 among staff has however had an impact on key roles that are crucial (and hard to backfill with short notice) to progress these patients. This has been achieved in the face of ongoing impacts from COVID-19 which have created challenges, complications and delays for Northland patients accessing treatment within Northland or from Auckland hospitals. There have also been staffing issues due to vacancies, leave and illness. Access to radiation therapy (delivered in Auckland) and access to surgery had the highest number of capacity breaches for patients' first treatments because they carry ongoing vacancies it hasn't been possible to fill. Access to treatment has improved as a result of our Tumour Stream Clinical Nurse Specialists and Tumour Stream Coordinators working closely together on their FCT list and identifying potential breaches and trending outcomes. This has highlighted areas of delay on the FCT pathway. Frequently breaches occurred in Radiology, especially reporting of scans, which delayed patients being referred to multidisciplinary meetings for development of treatment plan. More scans have since been sourced externally. Another big delay was pre-assessment for patients on the waitlist for surgery. Our breach analysis identified this as a resource and scheduling issue which was addressed through additional staff being put in place.
Shorter waits for non-urgent mental health and addiction services for 0-24-year old's - % of people seen within 3 weeks	This period included significant Child and Youth service change with the exit of the service manager and team leader, a seconded manager, and the appointment of a new service manager. During this time the C&Y service was reconfigured with additional roles now in place for clinical coordination and clinical leadership. Improvements have also now been made to the recording of contacts via training and process clarification. The period was also impacted in a range of ways by COVID-19, with a resulting tighter prioritisation and longer face-to-face waiting times for less urgent care.
Patients with an emergency department length of stay of less than 6 hours	In 2021/22 the majority of patients discharged from Emergency Departments in Whangārei and Kaitaia (90%) met the six-hour target. For those admitted to hospital (mostly to medical wards) 61% met the target.

[21] Measure wasn't included in 2021/22 SPE. Targets are the planned volumes negotiated between Northland DHB and MoH.
[22] Measure wasn't included in 2021/22 SPE. It was however part of the System Level Measure plan, which did not address acute bed days but ASH events, based on the idea that reducing ASH events in the community will reduce the demand for acute beds in hospital.
[23] All acute bed days data is available only until March 2022.
[24] Though the data (produced by MoH) nominally covers non-urgent patients, it actually includes urgent ones too. Since urgent patients are seen more quickly, the reported data will understate the reported waiting times for non-urgent patients.
[25] No target was included in 2021/22 SPE because MoH did not require one in the 2021/22 Annual Plan. MoH simply wanted us to "provide reports as specified".

Further information on results	

Planned Care interventions	Planned Care Interventions were down from expected and planned volumes related to:
	• staff illness from COVID-19 in addition to existing and ongoing vacancies. which curtailed the theatre and ward capacity for planned care case work
	• COVID-19 response necessitating the reassignment of clinical staff to support acute patient management and admissions
	• COVID-19 admissions and medical patient overflow into planned care surgical and orthopaedic ward beds. reducing planned care bed capacity
	• higher than previous acute surgical and orthopaedic volumes, filling inpatient bed capacity
	• COVID-19 mandatory order process and release of staff from service has contributed to reducing staff numbers
	• Minor procedure volumes are increased from planned volumes as a direct result of two key drivers.
	  • General Practitioner (GP) vacancy in Northland is significant; because practices have had to manage vacancies and have had difficulty in securing permanent GPs or locums, there have been fewer than half the number of GPs with a Special Interest in managing skin lesions (GPwSI) available than previously
	  • Northland has escalating demand for secondary care management of squamous cell and basal cell carcinoma skin procedures. Specific Northland research conducted in 2015 and published in 2016 by the Department of General Surgery and under the auspices of Clinical Director Christopher Harmston shows Northland has a high incidence of SCC and one of the highest reported incidences worldwide.

QSMs	The four measures below are Quality and Safety Measures, national measures created by the Health Quality and Safety Commission. QSMs require manual audits and could not be completed during 2021/22 due to the demands of COVID-19 and staff being re-deployed (they were begun again in the July-Sept 2022 quarter). % of patients with early warning scores calculated correctly % of patients who triggered an escalation of care and received the appropriate response (this is an area of concern and a report to wards and management is in progress; an audit check will be carried out to ensure consistency) % older patients assessed for risk of falling (changes to the nursing care plan have been in progress over two years, with the final draft out as of 1 December 2022; we are hoping to see a steady improvement with risk assessments both falls and pressure injuries) % older patients assessed as at risk of falling who received an individualised care plan that addresses these risks (falls care planning within the reviewed nursing care plan has continually improved through staff feedback and a dedicated working group)
% of hip and knee arthroplasty primary procedures where antibiotic given 0–60 minutes before 'knife to skin'	This is also a QSM. In October 2020, Northland District Health Board opted to transition the Orthopaedic Surgical Site Infection (SSI) Improvement Programme to Light Surveillance. This was an option offered by the HQSC to all DHBs to reduce time spent on data collection and to have more time to look into the specific cases which resulted in an SSI. Light Surveillance required reporting on only five parameters for all surgical procedures (the denominator): DHB, NHI, procedure code, procedure date, procedure location (hospital). As a result, we have stopped full surveillance and have discontinued collecting data on the other 30 parameters which include the antibiotic timing (0-60 minutes before knife to skin).

STATEMENT OF PERFORMANCE

Output Class 4: Rehabilitation and Support

Services for older people (home and community support services, residential care and services for dementia) and palliative care services:

- needs assessment and service coordination
- home based support
- age-related residential care beds
- respite care
- day services
- rehabilitation
- palliative care
- life-long disability services.

Output measure	Ethnicity	2020/21 baseline from 2021/22 SPE		2020/21 result	2021/22 target	2021/22 result	Achievement
		Period	Data				
% Home and Community Support Services (HCSS) clients assessed using InterRAI tool	Total	2020/21	98.8%	98.1%	98%	98%	●
% of HCSS providers certified	Total	2020/21	100%	100%	100%	91%	●
% of ARRC providers with at least 3-year certification	Total	2020/21	100%	95.8%	100%	96%	●

Further information on results	
% of HCSS providers certified	10 out of 11 HCSS providers (91%) are certified. A planned audit didn't occur due to COVID-19 issues so has been rescheduled to occur in September 2022.
% of ARRC providers with at least 3-year certification	Out of 24 providers, one required received a two-year accreditation due to the number of corrective actions required.

Statement of Financial Performance - By Output Class

Output Class Revenue	**2021-22**
Intensive Assessment & Treatment	617,792
Early Detection & Management	179,873
Prevention	33,682
Rehabilitation & Support Services	127,104
Total Revenue	958,452
Output Class Expenses	
Intensive Assessment & Treatment	610,306
Early Detection & Management	202,834
Prevention	39,246
Rehabilitation & Support Services	143,366
Total Operating Expenditure	995,753
Surplus / (Deficit) by Output Class	
Intensive Assessment & Treatment	7,486
Early Detection & Management	(22,961)
Prevention	(5,564)
Rehabilitation & Support Services	(16,262)
Net Surplus / (Deficit)	(37,301)

COVID-19 RESPONSE

Additional performance information: COVID-19 vaccinations and mortality

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

COVID-19 vaccinations

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

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

HSU 2021

People are included if they were:

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

HSU 2020

People are included if they were:

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

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

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

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

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

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

To determine the coverage of the COVID-19 vaccine across the population of Northland 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. [26]

Percentage of the eligible population who have completed their primary COVID-19 vaccination course [27] (HSU 2021 vs HSU 2020)

Year [28]	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
2020/21	10.87%	11.44%
2021/22	72.98%	76.81%
Total	**83.85%**	**88.26%**

Using HSU 2021 to determine the percentage of the eligible population who have completed their primary course, the coverage is calculated to be 83.85%, compared with 88.26% using HSU 2020 as at 30 June 2022.

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

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

[27] 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.

[28] Data as at 30 June 2021 for 2020/21 and 30 June 2022 for 2021/22.

STATEMENT OF PERFORMANCE

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

The counts in the table below measure the number of COVID-19 vaccination doses administered in Northland 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 [29]	Primary course				
	Dose 1	Dose 2	Booster 1	Booster 2	Total[30]
2020/21	33,930	18,299	0	0	52,229
2021/22	118,295	126,257	89,956	876	335,384
Total	**152,225**	**144,556**	**89,956**	**876**	**387,613**

By 30 June 2022, a total of 387,613 COVID-19 vaccinations had been administered, of which 86.5% were administered in 2021/22.

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

COVID-19 vaccine doses administered by age group

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

COVID-19 vaccine doses administered by age group [31]

Age group (years) [32]	Primary course				
	Dose 1	Dose 2	Booster 1	Booster 2	Total[33]
0 to 11	6,974	2,624	0	0	9598
12 to 15	9,561	8,816	5	1	18,383
16 to 19	7,250	7,081	1,438	0	15,769
20 to 24	7,405	7,168	2,622	2	17,197
25 to 29	8,102	7,873	3,328	0	19,303
30 to 34	9,006	8,898	4,573	2	22,479
35 to 39	8,343	8,337	4,884	2	21,566
40 to 44	7,638	7,642	4,944	3	20,227
45 to 49	8,713	8,848	6,195	8	23,764
50 to 54	9,068	9,825	7,993	32	26,918
55 to 59	9,094	10,316	9,430	48	28,888
60 to 64	8,633	10,367	10,548	104	29,652
65 to 69	6,487	9,246	10,284	164	26,181
70 to 74	5,104	8,087	9,542	197	22,930
75 to 79	3,200	5,242	6,727	164	15,333
80 to 84	2,060	3,392	4,244	98	9,794
85 to 89	1,084	1,652	2,094	36	4,866
90+	573	843	1,105	15	2,536
Total	**118,295**	**126,257**	**89,956**	**876**	**335,384**

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 on page 30 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.

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

The Project team happily throw out the old Care Plans

What Now visiting our Whangārei Hospital Children's Ward

STATEMENT OF PERFORMANCE

COVID-19 people vaccinated by age group during 2021/22 [33]

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).

Age group[34] (years)	Partial[35]		Primary course[36]			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	5,815	18%	2,247	7%	0	0%	0	0%
12 to 15	7,941	70%	6,737	59%	0	0%	0	0%
16 to 19	8,161	87%	7,851	83%	828	30%	0	0%
20 to 24	7,531	76%	7,295	73%	2,596	34%	0	0%
25 to 29	7,834	71%	7,647	70%	3,146	39%	0	0%
30 to 34	9,010	73%	8,881	72%	4,371	46%	0	0%
35 to 39	8,515	77%	8,527	77%	4,848	52%	0	0%
40 to 44	7,724	76%	7,753	77%	4,916	59%	0	0%
45 to 49	8,305	73%	8,446	74%	5,869	64%	0	0%
50 to 54	9,115	69%	9,735	74%	7,735	70%	30	3%
55 to 59	8,981	63%	10,024	71%	8,993	76%	51	4%
60 to 64	8,920	62%	10,516	73%	10,498	82%	95	6%
65 to 69	7,026	54%	9,486	72%	10,316	87%	149	8%
70 to 74	5,332	46%	8,280	72%	9,647	91%	207	11%
75 to 79	3,678	47%	6,008	76%	7,391	94%	172	11%
80 to 84	2,252	45%	3,779	76%	4,642	95%	102	11%
85 to 89	1,261	50%	1,967	79%	2,357	96%	43	9%
90+	677	49%	983	72%	1,262	102%	15	5%
Total	**118,078**	**58%**	**126,162**	**63%**	**89,415**	**69%**	**864**	**8%**

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[37] administered by ethnicity[38] (1 July 2021 – 30 June 2022)

Ethnicity (Note 1, 2)	Primary course				
	Dose 1	Dose 2	Booster 1	Booster 2	Total[30]
Asian	5,061	5,211	4,213	11	14,496
European/other	69,990	78,738	64,074	763	213,565
Māori	40,217	39,267	19,915	98	99,497
Pacific peoples	2,674	2,685	1,432	4	6,795
Unknown	353	356	322	0	1,031
Total	**118,295**	**126,257**	**89,956**	**876**	**335,384**

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).

[33] Data as at 30 June 2022 and includes all people who received COVID-19 vaccinations between 1 July 2021– 30 June 2022.
[34] Age groupings in this table reflect age of the persons at end of financial year.
[35] Partial vaccination refers to individuals who had received a single one dose of the COVID-19 vaccination (as at 30 June 2022).
[36] Primary course refers to the first two doses of the COVID-19 vaccine (dose 1 and dose 2).
[37] This excludes third primary doses administered and any subsequent boosters a person may have received after a second booster.
[38] Data as at 30 June 2022 and includes all vaccination doses being administered between 1 July 2021 – 30 June 2022.

COVID-19 RESPONSE

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 [39]

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	4665	69%	5076	75%	4206	74%	10	5%
Māori	37,778	71%	38,486	72%	19,772	55%	92	6%
European /other	66,901	63%	77,251	73%	63,679	75%	757	9%
Pacific Peoples	2,528	75%	2,650	79%	1,428	56%	4	4%
Unknown	391	64%	452	74%	330	59%	1	3%
Total	**112,263**	**66%**	**123,915**	**73%**	**89,415**	**69%**	**864**	**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.

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 % eligible, (50+)
Asian	6,181	92%	6,113	91%	4,206	74%	10	5%
Māori	44,210	83%	41,958	79%	19,772	55%	92	6%
European /other	92,380	87%	90,823	86%	63,680	75%	757	9%
Pacific Peoples	2,990	89%	2,900	86%	1,428	56%	4	4%
Unknown	607	99%	580	95%	330	59%	1	3%
Total	**146,368**	**86%**	**142,374**	**84%**	**89,416**	**69%**	**864**	**8%**

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

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

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

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

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

50+ age determined as at 30-Jun-2022

Basis of population is HSU2021 for 12+ years old

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

[39] Data as at 30 June 2022 and includes all people who received COVID-19 vaccinations between 1 July 2021 – 30 June 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: [40]

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

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

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

Stats NZ:

'The ERP and HSU have different target populations. In principle, the ERP is an estimate of the population usually living (resident) in New Zealand at a point in time, and the HSU is a measure of the population in New Zealand using (or potentially using) the health system at a point in time. For both the ERP and HSU, mean populations over a period of time can be derived from the point in time estimates.' [41]

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

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

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

- age
- ethnicity
- DHB
- gender

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

Comparison of HSU 2021 to the Stats NZ projected resident population

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

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

As at 31 December 2021, there are an estimated 201,855 health service users in the HSU 2021. This is an increase of 937 people from the HSU 2020 (an approximate 0.5% increase), and 3,855 more people than the Stats NZ PRP for 30 June 2021. DHB population by ethnicity: HSU 2021 and Stats NZ PRP comparison.[42]

[40] https://www.stats.govt.nz/methods/population-statistics-user-guide.
[41] 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/
[42] HSU 2021 data is as at 31 December 2021 and Stats NZ PRP data is as at 30 June 2021.

Ethnicity	HSU 2021	Stats NZ PRP	Difference (Note 1)
Māori	70,801	72,800	1,999
Pacific peoples	4,270	4,220	-50
Asian	8,276	8,150	-126
European/other	117,812	112,800	-5,012
Unknown	696	0	-696
Total (Note 1)	**201,855**	**198,000**	**-3,855**

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

Comparison of HSU 2020 to the Stats NZ PRP

For reference, we have provided the HSU 2020 comparison.

DHB population by ethnicity: HSU 2020 and Stats NZ PRP [42]

Ethnicity	HSU 2021	Stats NZ PRP	Difference (Note 1)
Māori	67,982	71,000	3,018
Pacific peoples	3,864	4,140	276
Asian	6,999	8,050	1,051
European/other	114,276	111,100	-3,176
Unknown	342	0	-342
Total (Note 1)	**193,463**	**194,400**	**937**

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

COVID-19 mortality rates

The data used to determine deaths attributed to COVID-19 comes from EpiSurv[44] 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 in processing the Cause of Death Certificates being updated in our systems. For example, where a paper-based death certificate is issued, the data will not be recorded as quickly as if it was submitted electronically.

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

COVID-19 Deaths by age group

The following outlines the total number of deaths associated to COVID-19 in Northland 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	5
70 to 79	7
80 to 89	17
90+	12
Total	**45**

COVID-19 deaths by ethnicity

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

Ethnicity	
Asian	0
European/other	29
Māori	14
Pacific peoples	1
Unknown[45]	1
Total	**45**

[43] HSU 2020 data is as at 1 July 2020 and Stats NZ PRP data is as at 30 June 2020.
[44] 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.
[45] 'Unknown' refers to individuals where no ethnicity can be satisfactorily determined.

ASSET PERFORMANCE 2021-22

Asset Portfolio Name	Asset Performance Measure	Asset Performance Indicator	Draft Target Level	Actual Performance 2021/22	Actual Performance 2020/21	Measure Description (may include how it's calculated)	Target Description
Property	% of occupied buildings classed as "Potentially earthquake prone"	Condition	<5%	3.0%	3.0%	Percentage of buildings housing patients that exceed the minimum "Potentially earthquake prone" seismic rating requirement .	% of potentally earthquake prone buildings
Property	Occupied buildings rated as "poor" or "very poor condition"	Condition	<5%	14.8%	15.5%	Percentage is based on percentage of overall buildings value. The assessment is based on the building condition criteria	This is a measure that is aimed at reducing the risk to staff and/or customers by identifying % of the buildings in the portfolio that are rated as poor or very poor national building standard assessments
Property	% of facilities complying with modern standards	Functionality	>85%	21.5%	19.5%	% of facilities complying with modern standards (i.e. fit for purpose, technology standards etc.)	% of facilities complying with modern standards (i.e. fit for purpose, technology standards etc)
Property	Average Medical/ Surgical occupancy Whangarei Hospital	Utilisation	>85%	93.7%	89.2%	Average occupation of inpatient beds throughout the year. (Excluding short stay and ICU beds)	The target was adopted by operational senior management in alignment with international best practice and averages the variation between peak winter and low summer demand.
Property	Average Medical/ Surgical occupancy District Hospitals	Utilisation	>85%	64.8%	66.6%	Average occupation of inpatient beds throughout the year. (Excluding short stay and ICU beds)	The target was adopted by operational senior management in alignment with international best practice and averages the variation between peak winter and low summer demand.
clinical equipment	Preventative Maintenance Jobs outstanding	Condition	<90%	42.9%	33.2%	percentage of clinical equipment that has outstanding preventative maintenance	100% compliance ensures assets operate safely and do not adversely impact health and safety of staff and patients.

New Hospital Development Visualisations

Celebrating the **past**

2000

2001
NZ Health Strategy

2011 - 2016
Balanced budgets until our DHB started getting its funding growth capped

2016
Values – Led organisational values refresh focusing on desired behaviours

2017
Implemented Neighbourhood Healthcare Homes. A locality approach to Healthcare Homes

2018
Ngā Tātai Ihorangi – Initiated Safe Sleep Wahakura, national rollout

2020 - 2022
COVID-19 Pandemic Leadership

2022
COVID-19 Care in Community with Clinical Hub, Regional Coordination Hub and four Kaupapa Māori Hubs

2001 - 2022
We thank our elected and appointed Board members

2011/12 & 18/19
Led two Meningococcal Vaccination campaigns (C and W strain) for Te Tai Tokerau

2014
Initiated Free under 13s for Primary Care a year ahead of national policy

2017
Te Ara Oranga Methamphetamine Demand Reduction

2017
Established Gastroenterology Service

2018
Te Tai Tokerau Waitangi Tribunal Hearing, Wai 2575

2021
Rongoā Māori pilot - Northland DHB partnered with the Rongoā community to co-design the kaupapa across Te Tai Tokerau

2022
Taitokerau Rautaki Hauora 2040 - a strategy and action plan for transforming health in Te Tai Tokerau

2012 - 2019
Reduced Northland's life expectancy gap between Māori and Non-Māori by 0.9-years, nationally was only a 0.2-year reduction in this gap

2013
Patient Safety & Quality Improvement external review with all recommendations implemented

2017
Traffic lights Hospital Road installed

2017
Oncology Service in Kaitaia

2018
Ngā Wānanga o Hine Kōpū - FREE kaupapa Māori labour, birth and parenting programme designed for wahine hapū and their whānau

2021
General Practice Workforce Fund

2021
Sustainability with vehicles
Heavily subsidised purchase of 150 EVs

2003
Formation of Primary Health Organisations

2012 – 2020
Social Wellbeing Governance Group, response to Youth Suicide outbreak (20 child and youth suicides in six months), Family Violence, COVID-19 response

2015
'Mental Health' initiated external review with all recommendations implemented

2018
After significant negotiation, our funding was returned to a true uncapped Population Based Formula for 2 years

2020
Expansion Cardiology Service

2011 – 2022
Staffing Increases
160 more Doctors
718 more Nursing/HCAs
169 more Allied Health
199 more Admin/Support

2022
Living wage paid to all Northland DHB staff and contracted staff

2022

Developments in the **last decade**

2010
Detox Unit - Dargaville

2011
Tumanako Mental Health Unit

2014
Jim Carney Cancer Centre, Whangārei Hospital

2015
Tohorā House Whangārei Hospital

2016
Te Kotuku Maternity Unit

2018
Bay of Islands Hospital Stage 1

2019
Tu Kaha Mental Health Sub-Acute Unit Mid North

2020
Endoscopy Unit Opened

2021
Cardiac Catheter Laboratory & Two Additional Operating Theatres Opened

2021
Acute Assessment Unit, Whangārei Hospital

2022
Approval Whangārei Hospital Rebuild; A further $130m capital works are underway - Bay of Islands Stage 2; Whangārei - Community Mental Health Facility, Te Kotuku Stage 2, New Laboratory, Paediatric Ward, SCBU and Radiotherapy Unit; Kaitaia - Second Operating Theatre, Bowel Screening Programme, Endoscopy Unit, mental Health Sub-Acute Unit

Welcoming the **future**

Taitokerau Rautaki Hauora 2040
Te Tai Tokerau Health Strategy 2040
Ko te mauri, he mea huna ki te moana
The life force is hidden in the ocean

We need to find a new way of doing things – that was the key message from extensive engagement across Te Tai Tokerau with communities, whānau, hapū, iwi, Ngāi Māori and health workers.

Our vision for Te Tai Tokerau is:

- People live longer in good health
- Have improved quality of life
- and there is equity between all groups.

This vision aligns with the direction of the nation's new health system that will achieve pae ora / healthy futures for all.

Achievement of this will be measured by the ability of tamariki born today to access and achieve equitable health outcomes as adults in 2040.

2040 is significant as it also represents the two hundredth anniversary of Te Tiriti o Waitangi.

From left Te Aka Whai Ora Board member Dr Mataroria Lyndon and chief executive Riana Manuel, Ministers Willow-Jean Prime, Peeni Henare, Andrew Little and Kelvin Davis and Tipa Mahuta

OUR COMMUNITY

Northland Community Foundation

Health begins where we live and work, learn and play. Northland DHB's commitment to supporting people to stay well in the community means we partner with various other agencies to support healthy lifestyles. The partnership between Northland DHB and Northland Community Foundation (NCF) focuses on encouraging community giving to benefit the health needs of all Northlanders, now and in the future.

Health Fund PLUS is the name given to the fundraising programme developed in 2016 to encourage larger gifts, donations and endowments to Northland DHB. The funds can be used for the optional extras that support and enhance the patient or family/whānau experience of care. In the year to the end of June 2022, the Foundation has received $440,698 on behalf of Northland DHB. The total anticipated bequests for Health Fund PLUS to 30 June 2022 was $2,875,000.

NCF also raises funds for Northland charitable causes, and for the year to end, June 2022, received $274,176 in donations for the community. In addition to the $2.8 million anticipated bequests for Health Fund PLUS, NCF is aware of bequests totalling $450k for the Northland Rescue Helicopter and $500k for St John Ambulance Services. At the end of June, the total bequests expected for NCF for northland charitable and health causes was 18,435,000.

Lungs4Life

The Koira4Rukahukahu: Lungs4Life programme was launched in partnership with Health Fund PLUS, Bronchiectasis Foundation of New Zealand (Te Tuapapa Mate Rukahukaku o Aotearoa) and Northland Community Foundation in early July 2021.

Koira4Rukahukahu: Lungs4Life is being rolled out across all four Auckland and Northland DHBs and paves the way for an innovative new model of care for the early identification and intervention of children under two years of age at risk of chronic respiratory conditions.

The programme is designed to prevent Bronchiectasis (chronic scarring and infection of the lungs) and other preventable health conditions. In addition, it aims to reduce inequity in health outcomes for tamariki across Te Tai Tokerau and Auckland. Māori and Pasifika tamariki are disproportionately affected by Bronchiectasis and are diagnosed later with more severe diseases than other groups. Tamariki participating in the intensive programme will be involved until they are at least five years of age.

The programme prioritises nurse-led, relationship-based and patient-centred care with flexibility in delivery. Health care specialists will utilise a hub-and-spoke network of health professionals and Koira4Rukahukahu: Lungs4Life champions working alongside whānau and other key stakeholders, including Healthy Homes providers.

Paediatrician Dr Ailsa Tuck and the Child Health Lungs4life team thanked Health Fund PLUS for their partnership in this project and their generous donation of $15,000 worth of equipment needed to initiate the programme through their donor programme. This equipment includes stethoscopes and will support our nursing team in clinical assessment and management of children, help with data collection, and help our tamariki on the journey to getting and staying well.

Marae support care packs for whānau isolating at home

In early 2022 Northland, Community Foundation became involved with the Māori COVID-19 Philanthropic Network. Te Tai Tokerau was identified as a significant region in need of support. Moana Tane (former general manager for the Te Poutokomanawa Māori Health Directorate at the Northland DHB) presented Tai Tokerau Māori needs to the network.

A total of $70,000 was donated by The Todd Foundation, Weave – Working Together, The Tindall Foundation, and Northland Community Foundation, and was allocated for Marae Support Care packs to help whānau isolating with COVID-19.

In April 2022, eight Marae across Northland were supported, either with packs containing items such as non-perishable food and first aid essentials or with grants to enable them to purchase these items themselves. The remainder of the funds were used to create individual whānau kits, including rongoā items to increase overall wellbeing and whānau resilience, which were distributed through Kaupapa Māori Hubs, Community Connectors, and Māori Health Providers.

Supervised Toothbrushing Programme Launched in Far North

In late June 2022, the Northland DHB-supervised tooth brushing programme commenced in the Far North, starting at Pukenui and Pukepoto schools, where our oral health team visited the first of an initial 4,300 children.

The total cost per annum to run this programme is expected to be around $650,000 and a substantial portion of the costs were generously covered by the Clare Foundation.

The Wellington-based philanthropic foundation was founded by investor and social entrepreneur Anna Stuck. The Foundation aims to improve oral health outcomes as one of four key focus areas by investing in initiatives that create tangible impact and drive extraordinary change for all.

"As a former dentist, I am really passionate about everyone having the benefit of good oral health," says Ms Stuck. "It is really exciting to support a locally-led initiative that has shown such promising results in the pilot developed by Ellen Clark and the team at Northland DHB."

Alice Montague, Clare Foundation Chief Executive, notes that the rollout of major healthcare projects like the supervised toothbrushing programme is likely to have positive flow-on effects.

"The Clare Foundation has a systems-level focus, so we are supporting an evaluation alongside the project, and based on the results, we hope that this provides evidence for a wider rollout around the country. This is a great opportunity to invest in a project with the potential to have positive health outcomes for all our tamariki."

The funding provided by Clare Foundation has been managed by Northland Community Foundation as part of Health Fund PLUS.

Each child enrolled in the Programme will be supervised each day at school, brushing their teeth with their gifted toothbrush and case and toothpaste. An assigned oral health coordinator will also provide ongoing oral health education at the schools participating in the Programme.

Roll out of the Supervised Toothbrushing programme is phased, with the new model starting with schools in the Hokianga and northern Kaitaia communities. Northland DHB chose to start in these areas to address the higher decay rates of 5-12-year olds living there.

The long-term plan is for the supervised toothbrushing programme to be rolled out at all schools in Northland.

Pukepoto students having their toothbrushing supervised

CHART Fund Sensory Library Purchases

Under Health Fund PLUS, Northland Community Foundation manages and invests the CHART (Child Health Advancement Research Trust) Endowment Fund. Last year they were able to deliver the first grant from the interest. The fund was established as a perpetual fund so that the interest from the funds will continue to support children in Northland forever. The goal is to grow the 'forever fund', through donations, to at least $100,000 to enable more interest to be delivered annually.

In 2021, the fund's interest was utilised to expand the sensory library, which now includes items like fidget toys, weighted sheets, chewies, headphones, and visual timers.

These carefully selected items are designed to support our clients to modulate themselves in their respective environments. Sensory items are often costly for whānau and families, so it is beneficial to be able to lend them to whānau to experiment with.

Sensory processing refers to how the brain registers and interprets sensory inputs (e.g. loud noise), which informs the behavioural response (e.g. hands over ears). The sensory systems are sight, sound, taste, touch, smell, body awareness, balance and interoception (internal body awareness).

When someone has a sensory processing difficulty, it affects how they participate in everyday life. For example, they may be unable to sit at the kai table because of a need to move. Or they have a meltdown in a crowded area because they are overwhelmed by auditory and visual input. This is more common in children living with conditions such as autism, trisomy 21, learning challenges or trauma backgrounds.

Clients also would benefit from wobble stools, interactive wall panels and sensory swings, and we hope to expand the resources via further donations.

Thank you letter from Elle's mother

Our 11-year-old daughter Elle was diagnosed with autism spectrum disorder (ASD) in 2019. As a family, we did not understand much about sensory sensitivities that can come with ASD.

Once we received more education about sensory supports from occupational therapy with the Child Health Centre, we were able to try methods that could help Elle to regulate more. We didn't realise that Elle was already creating sensory supports without us knowing. For example, Elle would put three blankets on her bed to make them heavier because she liked the pressure. With the sensory library, we trialled the weighted blanket, and she was able to confirm the pressure/weight was what she was seeking. As a new family to ASD, we thought she was getting more blankets as she was cold.

We are now planning to purchase a weighted blanket for Elle and can make this expense confidently due to being able to use the sensory item library.

Elle also took a shining to the weighted dogs on her lap. She will put them on her legs while sitting and concentrating, which has helped with her flicking her feet and legs around, which can be distracting for others.

Thank you, Marie, at Child Health and the funders who have provided us with knowledge and support for our daughter Elle to regulate.

11 year old Elle, pictured with a weighted dog borrowed from the Sensory Library at Whangārei Hospital

OUR COMMUNITY

Whangārei Children's Ward Refurbishment Update

A total of $190,310 has been raised towards our goal of $561,019 for the Whangārei Children's Ward Refurbishment. Donations have been received from many generous donors, including some large gifts and grants from the Oxford Sports Trust, Lotteries and the Lindsay Foundation.

Judith Hapi, Whangārei Children's Ward manager, said she was grateful for the support and generosity from the donors, Trusts and Foundations.

"The donations have enabled us to purchase nearly all of the medical equipment on our wish list. In addition, the recent grants from the Lindsay Foundation and Oxford Sports Trust will enable us to purchase recliner chairs for the new Ward and play equipment for children in our Hospital."

The Whangārei Children's Ward Refurbishment aims to ensure that every child who becomes a patient at Whangārei Hospital benefits fully from a calm and supportive environment. Donations will provide items such as comfortable chairs and beds for patients and caregivers, distraction devices (interactive wall designs, graphite wall wraps, treatment room monitors, TVs for patient rooms, special learning equipment, laptops, gaming consoles), upgraded furniture and new whiteware.

Support for Te Reo Māori resources (wall decals, books, and games) and additional paediatric medical equipment specifically designed to support the clinical needs of our tamariki are needed. These resources will have the added benefit of helping to reduce the pressure on an already stretched health system. And the donations will allow us to go above and beyond the traditional clinical setting, which is more conducive to the care and environment we want to provide for our tamariki in Hospital.

The Lindsay Foundation provided a $25,000 grant for the Children's Ward Play Equipment, and Lindsay Foundation CEO Andrew Higgott said, when he was given a tour through the Whangārei Children's Ward, it highlighted the significant need for resourcing and support that the Ward and Hospital urgently requires.

"Our Trustees also saw in the news the significant lack of resources for the Whangārei Hospital, and this all encouraged us to give our donation to support the Children's Ward."

Judith thanked the Lindsay Foundation and said their wish for play equipment had been answered.

"We can now purchase gaming systems, Lego sets, board games, art packs, toy sets, and sensory items for children with special needs for the Whangārei Children's Ward. Our children will be so happy that they can use these during their stay. It's going to make a real difference for staff and caregivers as well, in helping to distract them from their illnesses and ailments, stay calm for treatments, and perhaps even enjoy a little bit of their time here in Hospital as they recover. Thank you so much, Lindsay Foundation!"

Donations and grants so far have been received for new medical equipment, recliner chairs and play & education equipment for children in the Hospital. Funding is still required for upgraded furniture & whiteware, interactive wall designs, graphite wall wraps, treatment room monitors, TVs for patient rooms, and te reo Māori resources.

to remove the rurality challenge for some of our patients. While it doesn't remove the need for a good old face-to-face chat, it gives us another tool to use to help our people in Northland with diabetes.

Bay of Islands Physiotherapy Donation

In 2021, the Physiotherapy department at Bay of Islands Hospital received an extremely generous donation of $50,000, via Health Fund PLUS, from a local Northland couple.

The donor had participated in the Better Breathing Programme at Bay of Islands Hospital and was concerned about the lack of gym equipment to rehabilitate people in the mid north and felt the community deserved decent exercise equipment. This donation will improve the quality of the rehabilitation available in the mid north, not only for this group of people but for everyone that needs help.

The Better Breathing programme is designed for people in the community who suffer from different types of lung disease. Participants take part twice a week during a seven week period for a progressive exercise programme and education to improve their knowledge about healthy habits, quitting smoking, nutrition, medication, pacing of activities, stress and anxiety tools, and breathing management.

The donation has helped create a gym for the breathing management group of patients and enabled the Physiotherapy department to add an inpatient gym for patients needing further rehabilitation while on the General Ward. They also updated telehealth technology to support patients at home and can now supply breathing devices not ordinarily available through the DHB. The gym will also be open to staff after hours to encourage healthy habits.

Commercial grade exercise equipment – a treadmill, upright and recumbent bikes, a dual cable weight machine, Pilates reformer, boxing bag and gloves, portable exercise pedals, mirrors, and parallel bars and inspiratory muscle trainers and other respiratory devices were purchased along with a new large screen and computer to enable telehealth exercise sessions.

Another mid north couple donated funds to create professional videos of the Better Breathing exercises, so people can continue the exercises at home after completing their course with us.

Nateele Howarth, team leader of Physiotherapy, Occupational Therapy and CARS at the Hospital, said they are forever grateful for these amazing gifts, "The ongoing effect for our community is priceless."

Physiotherapy patients using the new equipment at the Bay of Islands Hospital Gymnasium

HIGHLIGHTS 2021-22

National Bowel Screening Programme Rolled Out in Northland

On 2 November 2021, the National Bowel Screening Programme began offering free bowel screening to around 40,000 Northland residents, potentially detecting 44 cancers in the first year here in Northland. Half of the eligible population, aged 60-74 years, are being sent an invitation to screen in the first year (around their birth date), and the remaining half will be invited the following year.

These participants will receive a simple test in the mail, which they complete at home and mail back for laboratory testing. If a test result is positive, they will be invited to undergo further investigations at Whangārei or Kaitaia Hospital. This is usually a colonoscopy, or other investigations if this is not appropriate.

Dr Byron Theron, clinical lead for the programme, says that a positive test does not necessarily mean that a person has bowel cancer but often represents bleeding from polyps. "Polyps detected during screening colonoscopies have the potential to develop into cancer. These polyps are often removed during the procedure. Therefore, the programme aims to prevent bowel cancer from developing in addition to detecting cancers."

Detecting any potential cancers in the early stages is key to a positive outcome. Bowel Screening Programme manager, Carolyn Jones, says that bowel cancer is often curable if it is picked up in the early stages, but chances decrease the longer it is left untreated. "People diagnosed with bowel cancer, who receive treatment at an early stage, have a 90 percent chance of long-term survival compared to around 10 percent if picked up late," she says.

Screening is for people who are not experiencing any symptoms of bowel cancer. People of any age with concerns about their bowel health must seek medical advice without delay. "It is important that they talk to their GP, Nurse Practitioner or Māori Health Provider if they have any symptoms," Jones says. Common signs and symptoms of bowel cancer may include a change in your normal pattern of going to the toilet that continues for several weeks, abdominal pain or blood in your bowel motion. Although other conditions often cause these symptoms, it is important to get them checked.

Pitotori (Peter) Naera, Northland Bowel Screening Programme Champion, and Stuart Selkirk, Northland DHB Health Promotion Lead for the Northland Bowel Screening Programme

A key focus of the programme is equity, therefore connecting with priority populations, including Māori, Pacific, disabled, low dep, remote and rural participants is important. The team has been working in Northland communities and with Māori Health Providers, Pacific groups, general practices and community groups. The team's health promotion lead, Stuart Selkirk, has also been busy connecting with Māori across Te Tai Tokerau. Eleven "Tangata Rongonui" have agreed to promote the Programme in different areas across Te Tai Tokerau and a series of videos of them promoting the programme have been used widely on social media and on the Northland DHB website. Four of our team's "Tangata Rongonui" also featured on "the Hui" TV programme talking about bowel cancer and the importance of screening.

Stuart and the programme's other health promoter, Tina Quitta, also use a large inflatable bowel as an educational tool in towns and events to stimulate conversations about the programme and bowel cancer in general.

Whangārei Man Living Proof of Cath Lab Success

Grant Kewene is living proof of the benefits of Whangārei Hospital's Cardiac Catheter Laboratory in providing Northland residents with the coronary care they need sooner and closer than ever before. The Catheter Laboratory (cath lab), named Te Whare Manawa (House of Heart), marked its first anniversary in late May 2022 and has seen breakthrough improvement in wait-times for treatment, contributing to better health outcomes. Between 90 and 95 percent of Northland patients with acute coronary syndromes have been receiving an angiogram within 72 hours of a cardiac event. This significantly exceeds the 70 percent target for DHBs set by the Ministry of Health and makes Northland one of the best-performing regions in the country.

Grant Kewene

An angiogram is an x-ray to show the extent and location of any narrowing in the heart's arteries, which is often the cause of a heart attack, and determine if the patient needs a coronary stent or bypass surgery to improve blood flow. In Grant's case, late last year, he had been referred by his GP to Whangārei Hospital after a couple of nights of restless sleep due to discomfort lying down, as well as an episode of shortness of breath one afternoon that week. An angiogram showed that he had severe coronary artery disease and severe cardiac impairment. Grant was helicoptered down to Auckland Hospital for the surgery he needed – a quintuple bypass – open-heart surgery to bypass blocked arteries. Northland's Cardiology

Clinical Lead Marcus Lee said there were grave concerns that Grant would not survive the procedure due to his severely impaired heart.

"However, the cardiac MRI also performed here in Whangārei gave the Auckland cardiac surgical team the confidence that Grant had a good chance and would benefit from coronary artery bypass grafting." Grant said the hospital staff were amazed that he had been able to walk in off the street, considering his circumstances. "Ironically, I had had no concerns about my heart. For a couple of years, I'd been experiencing a lack of energy, but I do have Type 2 Diabetes and was slightly overweight, so I thought it may have been related to that," he said.

"Ending up under hospital care all happened so quickly, but I always felt like I was in very safe hands. And, to have a cath lab facility here in Northland is just wonderful and I'm so impressed by the outstanding calibre of people who staff it. You can see the dedication and passion they have for what they do, which is amazing work. I can't speak highly enough of them and the service." Clinical Nurse Manager Lea Callan says that Grant deserves credit himself for seeking medical help when he needed to. "I think it is fair to say that Grant would have been at real risk of cardiac arrest had we not identified his disease when we did," she said.

"However, having percutaneous coronary intervention or cardiac surgery is not solely curative. Significant effort is required by the patient to get their health back after such procedures. Grant has certainly put in this hard work, through his cardiac rehab programme and following a lifestyle that supports his ongoing health. This is such an integral part of the healing process. Now he's enjoying a level of health far improved from where he was." Grant is enjoying feeling well, being able to exercise regularly and be back at work. "I have energy again. I can walk the Hatea Loop in under 50 minutes. I'm sleeping well. My heart rate has come down. Even my vision is better. It feels good."

Jason Haitana Wins Prestigious Scholarship to Attend International Conference in Italy

Jason Haitana

Consumer and Family Leader for Mental Health and Addiction Services Jason Haitana won the prestigious David B. Feinsilver Award for 2022 based on submitting the best research or clinical paper on psychotherapeutic treatment. The paper was based on Jason's research into "Te Reo Orooro – An indigenous Māori perspective on hearing voices", which he has been working on for some years. Jason explains that "te reo orooro" means 'the language of vibration and energy'.

"This means understanding that fundamentally, we connect to nature through these things. Te reo orooro is a means where we understand the many positive forces and voices in nature and protection against those that are negative. It also allows us a place of refuge and safety in understanding. Most of all, it is about accepting identity.

"Te reo orooro, as such, is a language that we use to understand our very connections and accept the dissonance in our lives. This language is based on the use of ritual and ceremony, incantations and prayers passed down through the generations. It incorporates an understanding of the environment and how it is used in this context.

Lastly, te reo orooro is ancient. Its application, though, is very new, along with a growing set of knowledge still to be discovered. This is both the question and the answer. My research looks at Māori healing practises used to connect to nature, to ancestry, and to the various forces of the elements," says Jason. "It is grounded in this knowledge system and the activist edge of the First Nations struggle. It explains things through an understanding of our interactions with nature and with the spiritual that connects us all.

"Many indigenous cultures experience the light and the dark. Our world has both, just like the sun rising every day. Cultures often had initiations where people were faced with significant spiritual challenges and hardships. Understanding the ritual, the myths and legends as a language for understanding also help towards healing."

Jason was also one of three finalists in the national PWC New Zealand Lived Experience Leadership Award at the 2021 HeadFit Awards. This award category recognises an individual with lived experience of neurodiversity, mental illness, or mental distress who has demonstrated leadership by role modelling, reducing stigma, and driving positive mental health conversations.

As a younger person, Jason had personal experience of anxiety and depression and recalls having suicidal thoughts, hearing voices, and seeing things. He has been able to transform his life since that time and believes that exploring his identity and whakapapa was instrumental in that process.

Jason says that he hopes his successes will provide hope and inspiration for others with lived experience working in the mental health sector and for all his colleagues. "I am them, and they are me. This award is for us all."

Climate Champion - Shout Out to the Anaesthetic Team

As Northland DHB actively works towards becoming a low carbon DHB, most people are aware of what we are doing to achieve our target of halving emissions by 2030. This includes successfully phasing out fossil fuel use in our district hospitals, increasing the use of telehealth to reduce travel and winning a bid to fund transitioning half of our vehicle fleet to electric vehicles.

One of the lesser-known emissions in the healthcare setting is emission from medical gases. These are nitrous oxide, predominantly used in Entonox for pain relief and Desflurane and sevoflurane. Desflurane is used in theatres for general anaesthesia. However, it has a very high global warming potential of 2,540 times that of carbon dioxide. A small bottle of 240ml has the same emissions as driving a car to Invercargill and back to Whangārei.

Our anaesthetic team have spent the last four years working to reduce the use of Desflurane to the point of phasing it out completely to support our organisation's efforts to minimise emissions. First, by improving practices and later with a switch to IV pumps, which has, in turn, avoided the use of multiple 50 ml syringes. So far, this has saved 587 tCO2e in emissions which is equal to an avoided 2.2 million kilometres driven in a car. An additional benefi t to this change was a significant reduction in cost to the hospital.

Anaesthetic staff involved with Earth day project - Lauren Elizabeth, Alice Hickey, Sebastian Ang

Besides reducing medical gases, Theatres implemented a recycling programme for laparoscopic and other single-use instruments like staplers used in surgery. On 22 April, to coincide with Earth Day, the Anaesthesia department took part in the annual project Operation Clean Up, a trainee-led sustainability event across hospitals in Australia and New Zealand. This year's focus was refusing Desflurane (which we are already achieving), reducing disposable absorbent pads (blueys/greenies/incopads), and recycling where possible.

Blueys and greenies are high-use disposables that can take over 100 years to break down. Its manufacturing process alone has significant potential for polluting air, water and soil through sourcing raw materials, chemical processing, manufacturing and transporting. They were initially designed to reduce the risk of dermatitis and pressure sores due to prolonged skin exposure to fluids but are unfortunately often used for non-indicated uses in clinical settings due to convenience and availability.

On Earth Day, the team educated staff about the appropriate use of these items and suggested more sustainable ways to help reduce usage and waste.

Some initiatives have already been instituted, including using alternative materials like pillowcases for arm boards in Theatre, using old packaging to remove contaminated airways, halving blueys for twice the use and removing them from Theatre to reduce accessibility. The day also highlighted the need for more education about recycling in operating theatres and improvements needed to achieve sustainability in healthcare.

Xray fleet raises the standards for Imaging Precision, Infection Control and Health Equity for Northland

Whangārei Hospital has expanded access to state-of-the-art imaging in the Northland region by investing in New Zealand's first fleet of MOBILETT Elara Max systems, which, together with the Ysio MAX, deliver cutting-edge digital X-ray imaging.

The upgraded X-ray fleet will future-proof the Whangārei and Bay of Islands Radiology Departments through an innovative approach to infection control, increase equitable access to precision medicine in the community, and support the hospitals in meeting a greater demand for imaging services.

"The roll-out of the MOBILETT Elara Max and Ysio MAX will allow us to provide state-of-the-art x-ray imaging for people across the Northland region," said Mark McGinley, general manager Surgical and Support Services.

"The systems have greatly improved workflow efficiency while delivering the highest quality imaging possible and therefore have the added benefit of potentially decreasing wait times."

"We know state-of-the-art facilities and equipment can help hospitals to attract and retain the best talent, which, in turn, further improves patient experience and health outcomes across the region."

"The new systems, provided by one of the world's leading medical technology companies, Siemens Healthineers, will benefit over 1,000 patients across the community each week, providing all types of X-ray procedures, including static and mobile imaging in the intensive care unit, special care baby unit, recovery and resuscitation units."

"The installations at the now fully-digitised Radiology Departments will bring significant health benefits to the community, including increased efficiencies for patient care and reduced wait times. The technology delivers consistent, optimised image quality with increased precision through digitally developed scans, resulting in faster X-ray times and lower radiation doses for patients, compared to that of previous systems."

"As the first of its kind in New Zealand, Northland DHB is proud to be providing best practice support to all patients and future-proofing care in our region", offered Andrew Howes, Northland DHB Radiology Manager.

The powerful and flexible MOBILETT Elara Max provides more efficient X-ray procedures as it is easily transported across the Hospital, bringing care to patients with complex and emergency medical issues without needing to relocate them. In addition, instant visualisation of patient imaging allows clinical intervention to be streamlined and delivered faster.

Critically, the mobile X-ray imaging system features a unique anti-microbial paint, signalling the next generation of patient safety as one of the first machines in New Zealand with this type of hygienic coating. The system's easy-to-clean design and integrated cables make cleaning 2.8 times better and are expected to further lower site infection rates at the hospitals. With infection control measures being of paramount concern in delivering care in a COVID-19 world and beyond, the anti-microbial layer provides a timely reassurance for patients and staff.

The installation follows Northland DHB's position statement, published in July 2020, outlining the Board's commitment to providing equitable healthcare in the region.

The DHB noted in the position statement that equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes – a statement which is supported by the flexibility, quality and increased access of the new installation.

Toni Sinclair, Siemens Healthineers general manager – New Zealand, said, "With the roll-out of the MOBILETT Elara Max and Ysio MAX at Whangārei Hospital, Siemens Healthineers is proud to be supporting Northland DHB.

Siemens Chest Xray

HIGHLIGHTS 2021-22

Bay of Islands Hospital Second Stage Blessed by Prime Minister on her Birthday

Prime Minister Jacinda Ardern and Minister of Health Andrew Little officially blessed the commencement of the second stage development at Bay of Islands Hospital on the Prime Minister's birthday on 26 July 2021.

Prime Minister Jacinda Ardern getting creative

Kaumātua Te Ihi brought the Prime Minister and her party onto the building site and took the opportunity to let the crowd know that it was her birthday. The group subsequently sang happy birthday in te reo Māori and English, much to her delight.

The project's second stage includes building an Integrated Family Health Centre to accommodate primary health and outpatient services and form a new entry to the hospital.

Primary health services will be run by the local iwi health provider Ngāti Hine Health Trust (NHHT), who will lease part of the new building from the DHB.

Primary health general practitioner services in the area are currently delivered from several different locations. The project will allow NHHT to integrate with primary and secondary health services.

The civil works will now prepare the foundations and retaining walls for the building construction programmed to commence in December 2021. The construction is expected to be completed by mid-2023.

The new building will form the entry point to the hospital and primary general practitioner health services, providing the following:

- Outpatients
- Five extra consult clinic rooms
- Audiology booth
- Orthopaedic clinic room
- Ultrasound / Echo / Colposcopy clinic room
- Primary Health
- Twelve consult clinic rooms
- Three treatment rooms
- Renal Services
- Ten chair spaces
- Two treatment rooms
- Consult / treatment room
- Oncology / Haematology
- Five chair spaces
- Consult / negative pressure treatment room.

There are also shared open plan offices, clinical support areas, public spaces including security office and building plant rooms. The helicopter pad will be upgraded and car parking issues across the site addressed. At the end of the blessing, the Prime Minister joined representatives of the DHB, NHHT and the community to create a handprint artwork.

Taumata Rongoā o Hauora Hokianga traditional practices to re-frame hospital as a place of wellbeing and healing

Hauora Hokianga is planting more native trees to develop their Ara Rongoā Hikoi Whakaora, wellbeing and healing pathway, which will eventually loop around the entire hospital site. Their vision is to reframe the hospital from a place of illness to a place of wellbeing and healing. Taumata Rongoā o Hauora Hokianga service spokesperson Hone Taimona shared that the traditional practice of rongoā Māori recognises the reciprocal relationship between people and our environment. "The land can keep us well, but we have a responsibility to keep the land well," said Hone "When we heal the whenua, we heal the people". The utilisation of the land around the hospital as an Ara rongoā will provide a natural and holistic environment that facilitates healing, learning, understanding and connection.

"The Ara Rongoā will envelop the full hospital site as a literal pathway and as a wellbeing pathway. We have just planted more native trees and have the beginning of a Māra kai - food garden. We will be planting fruit trees and establishing gardens with plants we can use in our wellbeing plans," said Jessie McVeagh, Manutaki or project manager of the Ara Rongoā Hikoi Whakaora. Volunteer Kairongoā practitioners established the Taumata Rongoā service in 2020. It recently became part of Hauora Hokianga health service after receiving funding and support from the Northland DHB Rongoā Māori pilot programme initiated following the call from whānau for greater access to Rongoā services.

Having the Taumata Rongoā service within Hauora Hokianga enables treatment choice for patients, with conventional medicines now offered alongside traditional healing practices. "We want to enable rongoā in all its forms, and that means we're considering more than just physical health. We want to beautify our spaces, so they become places of connection, healing, peace and refuge," said Hone. "The Ara Rongoā Hikoi Whakaora can support all people regardless of where they are in their health journey. From new life through to the end of life, access to rongoā is available throughout the whole spectrum of human experience," Hone explained.

Hauora Hokianga partnered with local rongoā practitioner Amy Bristow and Ringa Atawhai Matauranga training establishment to support the service provision. Ringa Atawhai Matauranga runs wānanga Rongoā Level 3 and 4 certificate programmes where more than 25 hospital staff and 70 local community members are learning the art of traditional healing practices. These partnerships educate the community and staff on the benefits of rongoā while increasing the number of qualified practitioners, making the service sustainable.

Hauora Hokianga is keen to see the community actively engaged in reclaiming their spaces of health. "We would love to see our whānau coming in to utilise the gardens, to enjoy the kai grown in the mara, to use the fruit from the trees, and to contribute to its growth by giving of your time to plant and harvest kai, or by bringing cutting of plants or seedlings from home," said Jessie. "There are many ways you can contribute to the health and wellbeing of your community. Small contributions can make a big difference."

Last years Puanga and Matariki planting

Research Putting Northland on the Map

Most Northlanders have no idea that behind the scenes in the General Surgery Department at Whangārei Hospital, a team of surgeons, registrars and trainee doctors conduct nationally and internationally recognised research helping to improve the health of our people.

At the helm of this research is colorectal and general surgeon Chris Harmston. Chris trained in general surgery in the West Midlands and undertook a fellowship year at the John Radcliffe Hospital in Oxford. He migrated to New Zealand in 2015 to work at Northland DHB after six years of consultant practice in a large university hospital in the United Kingdom. After seeing that only small amounts of research and well-designed clinical audits were being performed in Whangārei, he set about building them into the General Surgery department.

He also helped set up and sits on the expert advisory group for Surgical Trainee Research, Audit and Trials Aotearoa (STRATA). The group's objective is to establish a New Zealand-based collaborative of future surgeons designing and undertaking research, audit and clinical trials.

Under Chris's guidance, the research undertaken in the General Surgery department sits under three project areas – local, regional (Northland and Auckland) and national. He uses his experience to help decide what research topics are investigated. Junior doctors in the department are encouraged to participate in international collaborative studies. These have included assessing the impact of COVID-19 on outcomes in General Surgery and studies into analgesia post colorectal surgery, to which many patients in Whangārei contributed and made an impact internationally.

The department also hosts Masters Degree candidates for a 12 to 18 months to complete their Research Masters. The students spend half their time working in General Surgery and the remainder performing research to deliver their thesis. Chris encourages candidates to develop research topics they are particularly interested in. For example, the first Research fellow, Dr Brodie Elliot, led a national study on appendicitis and the differences in outcomes between rural and urban populations. The second Fellow, Dr Matthew McGuiness, was interested in chest trauma and led the RiBZ study, which focused on improving outcomes in patients with chest trauma and broken ribs.

Chris said both of their manuscripts were exceptional, and he is confident current Masters student Dr Henry Witcomb-Cahill's study on provision and barriers to patients receiving bariatric surgery in provincial centres will also be. Last year, the University of Auckland recognised Chris's leadership and research accomplishments by awarding him an associate professorship. He said this had enabled him to forge a stronger relationship with the University and broaden what his team can do here. His primary goal is to develop a research unit in Whangārei to benefit the community and draw medical staff to the region. Chris noted that often data that informs guidelines isn't relevant to Northland. Therefore, it's vital to perform local studies to ask questions and get answers to guide quality improvement and improve outcomes for our population.

"For instance, in a colorectal study, we looked at the time on the pathway. We didn't find a difference due to rurality or ethnicity. If we had, we would have been able to provide targeted intervention in that area. However, in the paediatric appendicitis study, we found that rural children did worse and did a qualitative analysis asking why. We are hoping to use the answers from that qualitative analysis to help us do some intervention in that area. "In the RiBZ study, we found that the rate of pneumonia in patients over 55 was higher than it should be. So, we designed a specific pathway for rib patients in the Hospital to try and improve outcomes. "Local research allows us to ask a question and target intervention."

The department also contributed to an international study, OPERA, run by a group called Tasman in Australia with centres worldwide. OPERA looks at opioid prescribing post most surgery, and Whangārei is the third most significant contributor to that study. Opportunities to be part of studies like this attract a high calibre of people to Whangārei. Chris believes a research facility will draw better candidates across a range of jobs and encourage connections with other academic institutes.

Mr Chris Harmston

"We've become more lucrative to a group of junior doctors because we offer a research-type environment, which allows us to attract students, registrars, and consultants. We have Pūkawakawa, our intern programme, and we get medical students here. But I believe we can strengthen our relationship with the University of Auckland because we have a lot to offer." Currently, all this research is done on a shoestring budget. Chris and his colleagues do a lot of work in their own time, and he said they often self-fund because they find it rewarding and a worthwhile investment, "Every dollar you invest in research, you get it back and then some. So even if you don't get it back from that study, the bubble around that research moves things forward – even giving people the skills to perform research and audit is useful."

He acknowledged Northland DHB for allowing registrars to do the work and allocating him time to provide supervision. He also thanked the Auckland Medical Research Foundation for funding specific projects. However, to develop a recognised Research Unit and body in the Hospital with a structure, Chris said they need to secure a whole extra level of funding. He believes the way to do this is to engage our local population to support research projects through benefactors.

"It's an under-tapped and unused resource, and I'd like to work with people to work out how we set up a research fund and engage the local community to get behind this – I think we'd be surprised at how engaged the local community would be with it." Although research in New Zealand has tended to be concentrated in a small number of institutions, Chris wants to show that a peripheral centre can lead and perform collaborative national studies. "Whangārei is one of the few regional units with Masters students and the ability to run a proper research programme. I believe we have demonstrated that it's feasible.

"A research unit will bring together the body of people performing research and move us on to the next level. In General Surgery, we are there and have a pretty well-structured programme. Now it's about moving to the next level by bringing other areas, enrolling patients into studies in Whangārei, and celebrating that. I think we're almost there. We just need some investment. Then we can say 'let's do this.'"

"The goals we are trying to achieve in General Surgery are to investigate our local population to provide answers to clinical questions, enable early years researchers, and enrol patients in clinical trials. We are unlikely to conduct laboratory-based research or lead large randomised clinical trials here. But we can get people started on their research and audit pathway and give them the skills and tools they need to move on and perform independent research to continue their research careers, and the word is out that this is the place to come." The Strategic Projects team are investigating the development of a clinical training centre on the grounds of Whangārei Hospital that would incorporate a research unit, pre-university, undergraduate and post graduate programmes.

Te Kotuku's 2021 Workplace Violence Prevention campaign featured health care assistant Hemo Harris and her whānau

GOVERNANCE AND PARTNERSHIPS

Northland DHB Board elected 12 October 2019

Left to right - Nicole Anderson, Vince Cocurullo, John Bain, Sally Macauley, Dr Kyle Eggleton, Dr Carol Peters, Dr Nick Chamberlain (CE), Ngaire Rae (Deputy Chair) and Harry Burkhardt (Board Chair). Absent: Debbie Evans, Libby Jones, Dr Mataroria Lyndon.

Northland DHB Appropriation and other Statutory Information

	Parent	
	2022	2021
	$000	$000
Appropriation Revenue		
Original	761,244	701,814
Supplementary	22,683	5,115
Total Appropriation Revenue	783,927	706,929

The Appropriation Revenue received equals the Government's actual expenses incurred in relation to the appropriation which is a required disclosure from the Public Finance Act. It has been appropriated towards the provision of personal and mental health services including services for the health of older people, provision of hospital and related services and management outputs by Northland DHB. The Northland DHB has provided these services in alignment with Government priorities; the strategic direction set for the health sector by the Ministry of Health; the needs of the district population and regional considerations.

The performance measures of these services and outputs are outlined in the Statement of Intent reported in the Statement of Performance.

Ministerial Direction

Directions issued by a Minister during the 2019/20 year, or that remain current are as follows:

- COVID-19 Response Direction 2020, issued on 17 March 2020 under section 32 of the New Zealand Public Health and Disability Act 2000 and section 103 of the Crown Entities Act 2004. The purpose of this direction is to ensure a nationally coordinated and consistent approach to the outbreak of COVID-19 across District Health Boards

Direction to act consistently with national plans;

In accordance with District Health Boards' responsibilities under section 23 of the New Zealand Public Health and Disability Acct 2000 to plan and coordinate at local regional and national levels for the most effective and efficient delivery of health services, all District Health Boards must act consistently with the following national-level plans and policies:

a. The Government Response to the COVID-19 pandemic, informed by the New Zealand Influenza Pandemic Plan, a framework for action (Ministry of Health 2017); and

b. The National Health Emergency Plan (Minsitry of Health 2015)

- Direction to support a whole of government approach as to implementation of a New Zealand Business Number, issued in May 2016 under section 107 of the Crown Entities Act. http://www.mbie.govt.nz/info-services/business/better-for- business/nzbn
- Health and Disability Services Eligibility Direction 2011, issued under section 32 of the New Zealand Public Health and Disability Act 2000. http://www.health.govt.nz/system/files/documents/pages/eligibility- direction-2011.pdf.
- Directions to support a whole of government approach, issued in April 2014 under section 107 of the Crown Entities Act. The three directions cover Procurement, ICT and Property, and the former two apply to DHBs. http://www.ssc.govt.nz/whole-of-govt-directions-dec2013
- The direction on the use of authentication services, issued in July 2008, continues to apply to all Crown agents apart from those with sizeable ICT business transitions and investment specifically listed within the 2014 direction. www.ssc.govt.nz/sites/all/files/AoG-direction-shared-authentication-services-july08.PDF

GOVERNANCE AND PARTNERSHIPS

Northland DHB Attendance at Board and Committee Meetings July 2021– June 2022

2021-2022

Board Members:

Term commenced 9 December 2019

Harry Burkhardt* - Chair (Ngāti Kuri)
Debbie Evans
Dr Carol Peters
Dr Kyle Eggleton
Dr Mataroria Lyndon* (Ngāti Hine Ngāti Whātua, Ngāpuhi)
John Bain Vince Cocurullo
Libby Jones
Nicole Anderson* (Ngāpuhi)
Sally Macauley

Equity in Community Committee:
(previously CPHAC/DiSAC)

This committee advises the Board on the health needs of Northlanders, including disability supports needs, and any factors it believes may adversely affect the overall health status of the population. That advice must ensure that all service interventions funded and provided maximise the overall health gain such as the independence in society of people with disabilities.

Ngaire Rae (Chair)
Beryl Wilkinson
Dr Carol Peters
Dr Kyle Eggleton
Harry Burkhardt
John Bain
Jonathan Tautari
Jonny Wilkinson
Libby Jones
Sally Macauley

Equity in Hospitals Committee:
(previously HAC)

Dr Mataroria Lyndon (Chair)
Debbie Evans
Dr Carol Peters
Dr Kyle Eggleton
Harry Burkhardt
John Bain
Libby Jones
Sally Macauley
Vince Cocurullo

Equity with the Resources Committee:
(previously FRAC)

Nicole Anderson (Chair)
Dr Carol Peters
Dr Kyle Eggleton
Harry Burkhardt
John Bain
Libby Jones
Sally Macauley
Vince Cocurullo

MEMBER ATTENDANCE - Financial Year - 1 JULY 2021 - 30 JUNE 2022

	2021						2022					
BOARD	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
Harry Burkhardt (Chair)	✓	✓via Zoom		✓via Zoom	✓via Zoom			✓via Zoom	✓via Zoom	✓	✓	
Nicole Anderson	✓	✓via Zoom		✓via Zoom	✓via Zoom			✓via Zoom	×	✓via Zoom	✓	
John Bain	✓	✓via Zoom		✓	✓			✓via Zoom	✓via Zoom	✓	✓	
Vince Cocurullo	✓	✓via Zoom		✓	✓			✓via Zoom	✓via Zoom	✓	✓	
Kyle Eggleton	✓	✓via Zoom		✓	✓			✓via Zoom	×	✓via Zoom	✓via Zoom	
Debbie Evans	×	✓via Zoom		✓via Zoom	✓via Zoom			✓via Zoom	✓via Zoom	✓via Zoom	✓via Zoom	
Libby Jones	✓	✓via Zoom		✓	✓			✓via Zoom	✓via Zoom	✓	✓	
Mataroria Lyndon	✓	✓via Zoom		✓via Zoom	✓via Zoom			✓via Zoom	✓via Zoom	✓via Zoom	✓	
Sally Macauley	✓	✓via Zoom		✓	✓			✓via Zoom	✓via Zoom	×	✓	
Carol Peters	×	✓via Zoom		✓via Zoom	✓			×	✓via Zoom	✓via Zoom	✓	
Ngaire Rae (Deputy Chair)	✓	✓via Zoom		✓via Zoom	✓			✓via Zoom	×	✓via Zoom	✓	

No Meeting Held

MEMBER ATTENDANCE - Calendar Year - 1 JULY 2021 - 30 JUNE 2022

	2021						2022					
Equity with Resources Committee	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
Nicole Anderson (Chair from 9/3/2020)			✓via Zoom			✓via Zoom						
John Bain			×			×						
Harry Burkhardt			×			✓via Zoom						
Vince Cocurullo			✓			✓						
Kyle Eggleton			✓via Zoom			×						
Libby Jones			✓via Zoom			✓						
Sally Macauley			✓			✓						
Carol Peters			✓via Zoom			✓via Zoom						
Ngaire Rae			✓			✓						

No Meeting Held

Northland DHB Attendance at Board and Committee Meetings July 2021– June 2022

MEMBER ATTENDANCE - Calendar Year - 1 JULY 2021 - 30 JUNE 2022

	2021						2022					
Equity in Hospital Committee	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
Mataroria Lyndon (Chair)	✓				✓via Zoom							
John Bain	✓				✓							
Harry Burkhardt	✓				✓via Zoom							
Vince Cocurullo	✓				✓							
Kyle Eggleton	✓				✓							
Debbie Evans	×				✓via Zoom							
Libby Jones	✓				✓							
Sally Macauley	✓				✓							
Carol Peters	×				✓							
Ngaire Rae	✓				✓							

No Meeting Held

MEMBER ATTENDANCE - Calendar Year - 1 JULY 2021 - 30 JUNE 2022

	2021						2022					
Equity in the Community	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
Ngaire Rae (Chair)			✓			✓						
John Bain			✓			✓						
Harry Burkhardt			✓via Zoom			✓via Zoom						
Kyle Eggleton			✓via Zoom			×						
Libby Jones			✓via Zoom			✓						
Sally Macauley			✓			✓						
Carol Peters			✓via Zoom			✓						
Jonathan Tautari			✓via Zoom			✓via Zoom						
Jonny Wilkinson			✓via Zoom			✓via Zoom						
Beryl Wilkinson			✓via Zoom			✓via Zoom						

No Meeting Held

Members of the Northland Sports Coalition Executive Board ready to ride to Tohorā House

Some of the Whangārei Hospital Theatre nursing team enjoying their new space

FINANCIAL & AUDIT REPORTS

For the year ended 30 June 2022

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 Northland 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 Northland 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 Northland 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 Northland District Health Board group for the year ended 30 June 2022.

Signed on behalf of the Te Whatu Ora Board:

Naomi Ferguson
Interim Board Chair
Te Whatu Ora

13 March 2023

Hon Amy Adams
Board Member
Te Whatu Ora

13 March 2023

Board Report

The Board has pleasure in submitting the Financial Statements and Statement of Performance for Northland District Health Board for the year to 30 June 2022.

Principal Activities

The entity's principal activities during the period were funding and the provision of health and disability services for the people of Northland with specialist treatment, community nursing, health promotion and health protection services, most of which were based on contractual arrangements with the Ministry of Health.

Northland District Health Board operates the following hospitals and related services:

- Whangārei Hospital
- Kaitaia Hospital
- Bay of Islands Hospital (Kawakawa)
- Dargaville Hospital
- Primary and community health services providing community, district and public health nursing, public health services, health promotion and health protection services.

The group result comprises of Northland DHB and its controlled entity the Kaipara Total Health Care Joint Venture (54 percent owned)

	2022	2021
Results and Distribution - Group	**$000s**	**$000s**
Surplus/(deficit)	(38,007)	(17,688)
Financial Position		
Equity was represented by:		
Current Assets	64,119	40,004
Less Current Liabilities	(210,340)	(149,780)
Plus Non-Current Assets	455,637	381,951
Less Non-Current Liabilities	(19,298)	(18,789)
Total Equity	290,118	253,386

Review of the Operations

A review of the entity's operations accompanies this report under the heading of Message from the Chair and Chief Executive.

Distributions to Owners

The Board have made payments by way of a specified health payment (capital charge) based on net equity which is treated as an expense, not a distribution.

Board Member Fees

No board member of the entity has, since the establishment of the Board, received or become entitled to receive a benefit, except for board and committee member fees and travel allowances, as set by the Ministry of Health. Fees paid to Board and Committee members are detailed in Note 18 of the Financial Statements.

Statement of Information

There were no notices from the Board members requesting to use the information received in their capacity as Board Members which would not otherwise have been available to them.

Interest Register

All relevant and required disclosures relating to Board members' interests have been effected during the year.

Board Members' Insurance

Northland District Health Board and its Board Members have taken out liability insurance providing cover against particular liabilities.

Events Subsequent to Balance Date

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

Staff Remuneration

The number of staff with total cost to the entity for senior staff packages including salary and other benefits, such as superannuation, with totals in excess of $100,000 for the year to 30 June 2022 (in $10,000 bands):

	Actual 2022	Actual 2021		Actual 2022	Actual 2021		Actual 2022	Actual 2021
$100,001 - $110,000	273	173	$250,001 - $260,000	9	11	$400,001 - $410,000	2	3
$110,001 - $120,000	213	126	$260,001 - $270,000	3	10	$410,001 - $420,000	6	2
$120,001 - $130,000	131	53	$270,001 - $280,000	5	5	$420,001 - $430,000	1	0
$130,001 - $140,000	76	37	$280,001 - $290,000	9	3	$440,001 - $450,000	1	1
$140,001 - $150,000	50	41	$290,001 - $300,000	10	3	$450,001 - $460,000	1	0
$150,001 - $160,000	35	23	$300,001 - $310,000	16	17	$510,001 - $520,000	0	1
$160,001 - $170,000	23	15	$310,001 - $320,000	8	8	$530,001 - $540,000	0	1
$170,001 - $180,000	13	16	$320,001 - $330,000	9	6	$540,001 - $550,000	0	1
$180,001 - $190,000	10	11	$330,001 - $340,000	6	8	$550,001 - $560,000	0	1
$190,001 - $200,000	17	11	$340,001 - $350,000	11	11	$560,001 - $570,000	1	0
$200,001 - $210,000	21	8	$350,001 - $360,000	9	4	$570,001 - $580,000	1	0
$210,001 - $220,000	12	9	$360,001 - $370,000	4	9	$600,001 - $610,000	1	0
$220,001 - $230,000	11	5	$370,001 - $380,000	3	6	$710,001 - $720,000	1	0
$230,001 - $240,000	13	9	$380,001 - $390,000	4	3	$740,001 - $750,000	1	0
$240,001 - $250,000	11	10	$390,001 - $400,000	1	2			

Of the 1032 (2021:663) staff shown above, 323 (2021:285) are or were medical or dental staff (doctors). The Other staff category contains a mixture of senior clinical and administrative staff. This includes active staff at the end of the financial year and those who left the organisation during the financial year.

If the remuneration of part-time staff were grossed-up to an FTE basis, the total number of staff with FTE salaries of $100,000 or more would be 1335 (2021:937), compared with the actual total number of staff of 1032 (2021:663). This data includes active staff at the end of the financial year and those who left the organisation during the financial year.

During the year ended 30 June 2022, 83 (2021: 9) employees received compensation and other benefits in relation to cessation totalling $1,720,261 (2021: $421,651).

Donations

No donations were made for the year to 30 June 2022, (2021: $0).

Changes in Accounting Policies

There have been no changes in accounting policies from those adopted in the Northland District Health Board's last audited financial statements, other than those required by new standards or amendments adopted as detailed in the accounting policies.

Auditor's Remuneration

The Controller and Auditor-General is appointed under section 15 of the Public Audit Act 2001. Audit New Zealand is contracted to provide audit services on behalf of the Auditor-General. Audit New Zealand in their capacity as Auditors are due $284,516 (2021: $225,494) for audit fees for the group.

Good Employer Obligations

In accordance with section 151(1)(g) of the Crown Entities Act 2004 Northland District Health Board is compliant with its obligation to be a good employer (including its equal employment opportunities programme).

Northland District Health Board has a comprehensive range of human resource management policies and procedures in place in order to uphold its good employer status. These include but are not restricted to appointment, orientation, recruitment, leave, continuing education, credentialing, performance management, disciplinary procedures, harassment protection, impaired staff, work and family, workplace rehabilitation and equal employment opportunities.

For and on behalf of the Board of Northland District Health Board.

Naomi Ferguson
Interim Board Chair
Te Whatu Ora

Independent Auditor's Report

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

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

We have audited:

- the financial statements of the Group on pages 60 to 86, that comprise the statement of financial position as at 30 June 2022, the statement of comprehensive revenue and expenditure, statement of changes in equity, statement of cash flows and statement of accounting policies for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Group on pages 14 to 33 and 47.

Opinion

Qualified opinion on the financial statements

In our opinion, except for the possible effects of the matter described in the Basis for our opinion section of our report, the financial statements of the Health Board on pages 60 to 86, which have been prepared on a disestablishment basis:

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

Unmodified opinion on the performance information

In our opinion, the performance information of the Group on pages 14 to 33 and 47:

- presents fairly, in all material respects, the Group's performance for the year ended 30 June 2022, including:

- for each class of reportable outputs:
  - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
  - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
- what has been achieved with the appropriation; and
- the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and

- complies with generally accepted accounting practice in New Zealand.

Our audit on the financial statements and the performance information was completed on 13 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 and our responsibilities relating to the financial statements and the performance information we comment on other information, and we explain our independence.

Basis for our opinion

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

As outlined in note 15 on page 75, 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 provision for employee entitlements includes a provision of $35,1 million for the estimated amounts owed to current and past employees as at 30 June 2022.

During December 2022, the sector received legal advice on how to decide whether a day is an 'otherwise working day' when calculating the estimated holiday pay entitlements. The calculation has not been amended to include an estimate of this factor and work in this regard was ongoing at the date of signing this report. We have therefore been unable to obtain adequate evidence to determine if the amount of the provision is reasonable. We did not calculate the effect of this advice on the total provision as it was impracticable for us to do so.

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.

The financial statements have been appropriately prepared on a disestablishment basis

The statement of Accounting Policies on page 80 outlines that the company has prepared its financial statements on a disestablishment basis because the assets, liabilities, and employees of the company were transferred to Health New Zealand on 1 July 2022. There have been no changes to the values of the company's assets and liabilities as a result of the disestablishment basis of preparation.

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

The Covid-19 response page 32 outlines the information used by the Group to report on its Covid-19 vaccine coverage. The Group uses the Health Service User (HSU) population data rather than the population data provided by Statistics New Zealand (Stats NZ), for the reasons set out in The Covid-19 response. The note outlines that there would be differences in the reported results for the overall population if the Stats NZ population data was used. There would be further differences in the reported results of vaccination coverage if the Stats NZ population data is classified by ethnicity and age. The Group has provided a table that highlights the differences in the ethnicity groupings between the HSU population data and the Stats NZ population data.

Impact of Covid-19

Note 22 on page 79 of the financial statements and pages 27 to 33 of the performance information which outlines the impact of Covid-19 on the Group.

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

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

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

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 Group's statement of performance expectations.

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

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

- We identify and assess the risks of material misstatement of the financial statements and the performance information, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- We obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Group's internal control.
- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board of Te Whatu Ora.
- We evaluate the appropriateness of the reported performance information within the Group's framework for reporting its performance.

- We conclude on the appropriateness of the use of the disestablishment basis by the Board of Te Whatu Ora.
- We evaluate the overall presentation, structure and content of the financial statements and the performance information, including the disclosures, and whether the financial statements and the performance information represent the underlying transactions and events in a manner that achieves fair presentation.

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

Our responsibilities arise from the Public Audit Act 2001.

Other Information

The Board of Te Whatu Ora is responsible for the other information. The other information comprises the information included on pages 2 to 13, 34 to 46, 48 to 53, 59 and 87, 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.

Carl Wessels
Audit New Zealand
On behalf of the Auditor-General
Auckland, New Zealand

Raena Croad and Kuia Ihapera Nathan at the Cardiac Catheter Laboratory Blessing

Statement of Comprehensive Revenue and Expenditure

For the Year Ended 30 June 2022

	Notes	Group Budget 2022 $000	Group 2022 $000	Group 2021 $000	Parent Budget 2022 $000	Parent 2022 $000	Parent 2021 $000
Revenue							
Patient Care Revenue	1	849,909	950,764	797,520	849,909	950,764	797,520
Finance Revenue		121	287	198	120	284	195
Other Revenue	1	5,758	6,992	7,093	6,187	7,421	7,521
Total Revenue		855,788	958,043	804,811	856,216	958,469	805,236
Expenditure							
Personnel Costs	3	323,802	383,359	316,807	323,802	383,359	316,807
Depreciation and Amortisation Expense	10,11	23,526	22,846	16,347	22,700	22,000	15,740
Outsourced Services		49,082	61,227	54,094	49,082	61,227	54,094
Clinical Supplies		68,956	80,169	59,460	68,956	80,169	59,460
Infrastructure and Non-Clinical Expenses	2	39,246	44,727	36,388	39,796	45,277	36,938
Payments to other District Health Boards		105,919	107,934	96,071	105,919	107,934	96,071
Payments to Non-Health Board Providers		258,540	283,190	236,540	258,540	283,190	236,540
Finance Costs		117	171	396	117	171	396
Capital Charge	5	7,101	12,427	6,396	7,101	12,427	6,396
Total Expenditure		876,289	996,050	822,499	876,013	995,754	822,442
Surplus/(deficit)		(20,501)	(38,007)	(17,688)	(19,798)	(37,285)	(17,206)
Deficit attributable to:							
Northland District Health Board		(20,242)	(37,739)	(17,530)	(19,798)	(37,285)	(17,206)
Minority Interest		(259)	(268)	(158)	0	0	0
Other Comprehensive Revenue and Expenditure							
Movements on Property Revaluations	12	0	56,782	113,865	0	53,861	110,888
Total other Comprehensive Revenue and Expenditure		0	56,782	113,865	0	53,861	110,888
Total Comprehensive Revenue and Expenditure		(20,501)	18,775	96,177	(19,798)	16,576	93,682
Total Comprehensive Revenue and Expenditure attributable to:							
Northland District Health Board		(20,242)	17,699	94,966	(19,798)	16,576	93,682
Minority Interest		(259)	1,076	1,211	0	0	0

Explanations of major variances against budget are detailed in note 21.

The accompanying accounting policies and notes form part of these financial statements.

Statement of Changes in Equity

For the Year Ended 30 June 2022

	Notes	Group Budget 2022 $000	Group 2022 $000	Group 2021 $000	Parent Budget 2022 $000	Parent 2022 $000	Parent 2021 $000
Balance at 1 July		158,959	253,386	136,516	148,346	243,034	128,539
Total Comprehensive Revenue and Expenditure		(20,501)	18,775	96,177	(19,798)	16,576	93,682
Capital Contribution	12	25,147	18,077	20,813	25,147	18,077	20,813
Balance at 30 June	12	163,605	290,238	253,506	153,696	277,687	243,034
Distributions made to Minority Interest		(120)	(120)	(120)	0	0	0
Balance at 30 June	12	163,485	290,118	253,386	153,696	277,687	243,034
Total Equity attributable to:							
Northland District Health Board		158,173	283,471	247,695	153,696	277,687	243,034
Minority Interest		5,312	6,647	5,691	0	0	0
Balance at 30 June		163,485	290,118	253,386	153,696	277,687	243,034

Explanations of major variances against budget are detailed in note 21.
The accompanying accounting policies and notes form part of these financial statements.

Statement of Financial Position

As at 30 June 2022

	Notes	Group Budget 2022 $000	Group 2022 $000	Group 2021 $000	Parent Budget 2022 $000	Parent 2022 $000	Parent 2021 $000
Assets							
Cash and Cash Equivalents	6	117	117	114	10	10	10
Trade and Other Receivables	7	31,304	55,131	32,220	31,304	55,131	32,220
Term Deposits	8	373	374	373	0	0	0
Inventories	9	5,437	6,508	5,331	5,437	6,508	5,331
Prepayments		2,124	1,557	1,259	2,124	1,557	1,259
Trust/Special Fund Assets	12	646	432	707	646	432	707
Total Current Assets		40,001	64,119	40,004	39,521	63,638	39,527
Property, Plant and Equipment	10	271,787	434,905	360,414	260,573	421,052	348,634
Intangible Assets	11	2,195	917	1,053	2,195	917	1,053
Investments in controlled entities	8	0	0	0	1,896	1,896	1,896
Investments in jointly controlled entities	8	24,198	19,815	20,484	24,198	19,815	20,484
Term Deposits	8	0	0	0	0	0	0
Total Non-Current Assets		298,180	455,637	381,951	288,862	443,680	372,067
Total Assets		338,181	519,756	421,955	328,383	507,318	411,594
Equity							
Crown Equity	12	125,416	122,547	104,470	125,416	122,547	104,470
Other Reserves	12	110,031	277,643	221,970	102,568	267,493	213,397
Accumulated Surplus/(Deficit)	12	(77,920)	(117,151)	(79,452)	(74,935)	(112,785)	(75,540)
Trust/Special Fund Assets	12	646	432	707	646	432	707
Total Equity Attributable to Northland District Health Board		158,173	283,471	247,695	153,695	277,687	243,034
Minority Interest	12	5,312	6,647	5,691	0	0	0
Total Equity		163,485	290,118	253,386	153,695	277,687	243,034
Liabilities							
Trade and Other Payables	13	60,740	65,711	60,621	60,733	65,704	60,612
Interest Bearing Loans and Borrowings	6,14	24,881	30,192	6,551	24,880	30,192	6,551
Employee Entitlements	15	70,414	114,437	82,608	70,414	114,437	82,608
Provisions	16	0	0	0	0	0	0
Total Current Liabilities		156,035	210,340	149,780	156,027	210,333	149,771
Interest Bearing Loans and Borrowings	6,14	1,414	1,526	1,832	1,414	1,526	1,832
Employee Entitlements	15	17,247	17,772	16,957	17,247	17,772	16,957
Total Non-Current Liabilities		18,661	19,298	18,789	18,661	19,298	18,789
Total Liabilities		174,696	229,638	168,569	174,688	229,631	168,560
Total Equity and Liabilities		338,181	519,756	421,955	328,383	507,318	411,594

Explanations of major variances against budget are detailed in note 21.

The accompanying accounting policies and notes form part of these financial statements.

Statement of Cash Flows

For the Year Ended 30 June 2022

	Notes	Group Budget 2022 $000	Group 2022 $000	Group 2021 $000	Parent Budget 2022 $000	Parent 2022 $000	Parent 2021 $000
Cash Flows from Operating Activities							
Cash Receipts from Ministry of Health and Patients		855,548	938,171	795,421	855,976	938,598	795,850
Cash Paid to Suppliers		(521,956)	(575,020)	(479,243)	(522,506)	(565,570)	(479,793)
Cash Paid to Employees		(322,701)	(352,608)	(300,766)	(322,701)	(352,608)	(300,766)
Cash Generated from Operations		10,891	10,543	15,412	10,769	10,420	15,291
Interest Received		150	294	164	149	291	158
Interest Paid		(117)	(171)	(396)	(117)	(171)	(396)
Capital Charge Paid		(7,101)	(12,427)	(6,396)	(7,101)	(12,427)	(6,396)
Net Cash Flows from Operating Activities		3,823	(1,761)	8,784	3,700	(1,887)	8,657
Cash Flows From Investing Activities							
Proceeds from Sale of Property, Plant and Equipment		0	0	11	0	0	11
Acquisition of Property, Plant and Equipment		(43,750)	(39,739)	(32,002)	(43,750)	(39,739)	(32,002)
Acquisition of Intangible Assets		0	(48)	(320)	0	(48)	(320)
Acquisition of Investments in Associates	8	(3,000)	261	(1,648)	(3,000)	261	(1,648)
Acquisition of Investments		(0)	(1)	(4)	0	0	0
Net Cash Flows from Investing Activities		(46,750)	(39,527)	(33,963)	(46,750)	(39,526)	(33,959)
Cash Flows from Financing Activities							
Borrowings Raised		18,436	23,944	6,161	18,436	23,944	6,161
Capital Contribution	12	25,147	18,077	20,813	25,147	18,077	20,813
Borrowings (Repaid)		(532)	(608)	(6,412)	(532)	(608)	(6,412)
Distributions (Paid)	12	(120)	(121)	(120)	0	0	0
Net Cash Flows from Financing Activities		42,931	41,291	20,442	43,051	41,413	20,562
Net Increase/(Decrease) in Cash and Cash Equivalents		3	3	(4,737)	1	0	(4,740)
Cash and Cash Equivalents at Beginning of Year		114	114	4,851	10	10	4,750
Cash and Cash Equivalents at End of Year	6	117	117	114	11	10	10

The accompanying accounting policies and notes form part of these financial statements.

Statement of Cash Flows

Reconciliation of Deficit for the period with Net Cash Flows from Operating Activities

	Notes	Group 2022 $000	Group 2021 $000	Parent 2022 $000	Parent 2021 $000
Surplus/(deficit) for the Period		(38,007)	(17,688)	(37,285)	(17,206)
Add back Non-Cash Items:					
Depreciation, Amortisation and Assets Written Off		22,910	16,342	22,062	15,735
Other non cash items		0	0	0	0
Movements in Working Capital:					
(Increase)/Decrease in Trade and Other Receivables		(23,222)	(12,170)	(23,222)	(12,173)
(Increase)/Decrease in Inventories		(1,177)	(471)	(1,177)	(471)
Increase/(Decrease) in Trade and Other Payables		5,092	7,399	5,092	7,400
Increase/(Decrease) In Employee Entitlements		32,643	15,636	32,643	15,636
Increase/(Decrease) in Provisions		0	(264)	0	(264)
Net Movement in Working Capital		13,336	10,130	13,336	10,128
Net Cash Inflow from Operating Activities		(1,761)	8,784	(1,887)	8,657

Reconciliation of movements in liabilities arising from Financing Activities

The table below provides a reconciliation between the opening and closing balance of finance lease liabilities for the year ended 30 June 2022.

	Group 2022	Parent 2022
Finance Leases		
Balance at 1 July 2021	2,259	2,259
Cash outflows	(466)	(466)
New leases	234	234
Balance at 30 June 2022	2,027	2,027
Crown Energy Efficiency Loan		
Balance at 1 July 2021	142	142
Cash outflows	(142)	(142)
New loans	0	0
Balance at 30 June 2022	0	0
Overdraft with NZ Health Partnerships Limited		
Balance at 1 July 2021	5,982	5,982
Cash outflows	0	0
New borrowings	23,709	23,709
Balance at 30 June 2022	29,691	29,691

Notes to Financial Statements

1 Revenue

	Notes	Group 2022 $000	Group 2021 $000	Parent 2022 $000	Parent 2021 $000
Patient Care Revenue					
Ministry of Health population-based funding		863,375	757,385	863,375	757,385
Ministry of Health other contracts		57,535	20,104	57,535	20,104
PPE and RATS received free of charge ex MOH		8,095	0	8,095	0
Inter-district flows		13,397	12,069	13,397	12,069
ACC contract revenue		6,227	6,263	6,227	6,263
Other patient care related revenue		2,135	1,699	2,135	1,699
Total Patient Care Revenue		950,764	797,520	950,764	797,520
Other Revenue					
Donation Revenue		0	683	0	683
Other Revenue		6,992	6,410	7,421	6,838
Total Other Revenue		6,992	7,093	7,421	7,521

2 Infrastructure and Non-Clinical Expenses

		Group 2022 $000	Group 2021 $000	Parent 2022 $000	Parent 2021 $000
Included in Infrastructure and Non-Clinical Expenses:					
Impairment (reversal) of Trade Receivables (Bad and Doubtful Debts)	7	18	(126)	18	(126)
Loss/(Gain) on disposal of Property, Plant and Equipment		62	(5)	62	(5)
Audit Fees paid to Audit New Zealand for Audit of Financial Statements		285	226	279	220
Board and Committee Member Fees and Expenses		318	300	318	300
Amortisation of FPIM assets	11	134	183	134	183

Northland DHB pays the audit fee of the Kaipara Total Health Care Joint Venture on the controlled entity's behalf. The fee was $6,570 (2021: $6,126).

3 Personnel Costs

	Group 2022 $000	Group 2021 $000	Parent 2022 $000	Parent 2021 $000
Wages and Salaries	340,312	292,238	340,312	292,238
Contributions to Defined Contribution Schemes	10,403	8,933	10,403	8,933
Increase /(Decrease) in Employee Entitlements	32,644	15,636	32,644	15,636
	383,359	316,807	383,359	316,807

Employer contributions to defined contribution schemes include contributions to Kiwisaver, National Provident Scheme and the Government Superannuation Fund.

4 Operating Lease Commitments

	Group 2022 $000	Group 2021 $000	Parent 2022 $000	Parent 2021 $000
Less than one year	3,918	2,346	4,468	2,896
One to two years	3,125	1,533	3,675	2,083
Two to five years	5,598	2,838	7,248	4,488
Over five years	657	1,699	2,263	3,305
Total Operating commitments	13,298	8,416	17,654	12,772

Northland DHB leases a number of buildings, vehicles and office equipment (mainly photocopiers) under operating leases. The leases run for various lengths of time depending on requirements (for buildings) and typically 5 years (for vehicles and office equipment), with an option to renew the lease after that date. None of the leases include contingent rentals.
During the year ended 30 June 2022, $7,938K was recognised as an expense in the statement of comprehensive revenue and expenditure in respect of operating leases (2021: $5,143K).

5 Capital Charge

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

6 Cash and Cash Equivalents

	Group		Parent	
	2022 $000	2021 $000	2022 $000	2021 $000
Cash On Hand and at Bank	117	114	10	10
Cash on Deposit with NZ Health Partnerships Limited	0	0	0	0
Balance at 30 June	117	114	10	10

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

7 Trade and Other Receivables

	Group		Parent	
	2022 $000	2021 $000	2022 $000	2021 $000
Gross Receivables	55,257	32,328	55,257	32,328
Less: Allowance for credit losses	(126)	(108)	(126)	(108)
Net Receivables	55,131	32,220	55,131	32,220
Receivables consist of:				
Receivables for MOH	31,229	18,115	31,229	18,115
Other Accrued Revenue	10,709	12,115	10,709	12,115
Other Receivables	13,319	2,098	13,319	2,098
Balance at 30 June	55,257	32,328	55,257	32,328

As at 30 June, the allowance for credit losses is detailed below:

	Group		Group	
	Gross Receivable 2022 $000	Expected Credit Loss 2022 $000	Gross Receivable 2021 $000	Expected Credit Loss 2021 $000
Not past due	45,412	0	29,562	12
Past due 0-30 days	7,176	19	271	13
Past due 31-60 days	434	0	235	10
Past due 61-90 days	70	8	328	9
Past due >91 days	2,165	99	1,932	64
Total	55,257	126	32,328	108

The allowance for credit losses has been calculated based on expected losses for the Northland DHB's pool of debtors. Expected losses have been determined based on an analysis of the Northland DHB's losses in previous periods and current and foward-looking factors that might affect the recoverability of receivables, and review of specific debtors.

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

	Group		Parent	
	2022 $000	2021 $000	2022 $000	2021 $000
Balance 1 July	108	234	108	234
(Reduction)/Increase in loss allowance made during the year	73	(60)	73	(60)
Receivables written off during the period	(55)	(66)	(55)	(66)
Balance at 30 June	126	108	126	108

8 Investments

	Group		Parent	
	2022	2021	2022	2021
	$000	$000	$000	$000
Investment in Controlled Entity (at cost)	0	0	1,896	1,896
Investment in Joint Ventures	19,815	20,484	19,815	20,484
Term deposits - Current portion	374	373	0	0
Term deposits - Non Current portion	0	0	0	0
Balance at 30 June	20,189	20,857	21,711	22,380

The carrying amounts of term deposits approximate their fair value. A loss allowance for expected credit losses is recognised if the estimated loss allowance is not trivial.

Investment in Controlled Entity
General Information

Name of Entity	Principal Activity	Interest Held 2022	Interest Held 2021	Balance Date
Kaipara Total Health Care Joint Venture	Landlord of Dargaville Hospital	54%	54%	30 June

Investment in Associate (equity accounted investee)
General Information

Name of Entity	Principal Activity	Interest Held 2022	Interest Held 2021	Balance Date
healthAlliance N.Z. Limited	The operation of non-clinical shared services and an ICT platform for Northland, Waitemata, Auckland and Counties Manukau District Health Boards	25%	25%	30 June
HealthSource New Zealand Limited	The operation of shared services for Northland, Waitemata, Auckland and Counties Manukau District Health Boards	10%	10%	30 June
NZ Health Partnerships Limited	Provision of services to provide savings to the NZ health sector	3%	3%	30 June

During 2022 $657k of information technology and related capital expenditure (2021: $1,831k) was added to the carrying amount of the investment in healthAlliance. A long term receivable of $1,325k owed to healthAlliance was offset against class C shares. As at 30 June 2022 Northland DHB held 10.0% of allocated C class shares (2021: 10.1%).

healthAlliance N.Z. Limited

Northland DHB holds both Class A and Class C shares in healthAlliance N.Z. Limited. Class A shares carry the ability to appoint directors and have voting rights. Class C shares have rights to the distributions of capital or income, rights to dividends, however confer no ability to appoint directors and have no voting rights. As the Class A shares carry voting rights, they determine the extent of the interest Northland DHB has in healthAlliance N.Z. Limited.

HealthSource New Zealand Limited

Northland DHB holds a 10% (2021: 10%) ordinary shares in HealthSource New Zealand Limited.

NZ Health Partnerships Limited

Northland DHB holds both Class A and Class B shares in NZ Health Partnerships Limited. Class A shares carry the right to vote and appoint directors, they have rights to dividends and share of distribution of surplus assets on liquidation.

NZ Health Partnerships Limited has issued Class B shares to DHBs for the purpose of funding the development of the FPIM programme shared services. The following rights are attached to these shares:

- Class B Shares confer no voting rights.
- Class B shareholders shall have the right to access the FPIM programme shared services.
- Class B Shares confer no right to a dividend, other than a dividend to be made out of any surplus earned by NZ Health Partnerships from the FPIM programme shared services only.
- Holders of Class B Shares have the same rights as Class A shares to receive notices, reports and accounts of the Company and to attend general meetings of the Company.
- On liquidation or dissolution of the Company, each Class B shareholder shall be entitled to be paid from surplus assets of the Company an amount equal to the holder's proportional share of the liquidation value of the FPIM Programme shared services assets based upon the proportion of the total number of issued and paid up Class B Shares that it holds. Otherwise, each paid up Class B Share confers no right to a share in the distribution of the surplus assets. This payment shall be made in priority to any distribution of surplus assets in respect of Class A Shares.
- On liquidation or dissolution of the Company, each unpaid Class B Share confers no right to a share in the distribution of the surplus assets.

8 Investments *(Continued)*

Financial Information relating to jointly controlled entities is provided below:

	2022			2021		
	healthAlliance NZ Limited $000	HealthSource New Zealand Limited $000	NZ Health Partnerships Limited $000	healthAlliance NZ Limited $000	HealthSource New Zealand Limited $000	NZ Health Partnerships Limited $000
Dividends or similar distributions received	0	0	0	0	0	0
	unaudited	**unaudited**	**unaudited**			
The following amounts represent summarised financial information of jointly controlled entities						
Current assets	33,591	10,746	721,636	42,384	8,876	533,882
Non-current assets	207,861	288	38,367	197,263	206	38,453
Current liabilities	35,875	8,597	716,250	32,058	6,706	526,978
Non-current liabilities	16,037	1,665	21,639	9,639	1,663	18,238
Net assets	189,540	772	22,114	197,950	711	27,119
Revenue	177,497	44,604	49,942	152,357	42,265	38,394
Tax expense	0	0	0	0	0	0
Surplus or (deficit)	(5,804)	71	(5,004)	(80)	76	(2,487)
Other comprehensive revenue and expense	0	0	0	0	0	0
Total comprehensive revenue and expense	(5,804)	71	(5,004)	(80)	76	(2,487)

The 2022 financial information for jointly controlled entities HealthSource New Zealand Limited and NZ Health Partnerships Limited is provided as a draft and is subject to final audit clearance. The 2021 numbers have been restated to reflect the final result.

Share of profit/(loss) of Jointly Controlled Entities

	Group		Parent	
	2022 $000	2021 $000	2022 $000	2021 $000
Share of profit/(loss)	(1,444)	(13)	(1,444)	(13)

The DHB's share of profits of all Joint Ventures are not recorded in the financial statements of Northland DHB as they are not considered material to the financial position or performance of the DHB.

Investments in Jointly Controlled Entities

	Group		Parent	
	2022 $000	2021 $000	2022 $000	2021 $000
healthAlliance N.Z. Limited	19,748	20,417	19,748	20,417
HealthSource New Zealand Limited	67	67	67	67

The jointly controlled entites are unlisted companies. Accordingly, there are no quoted market price for these investments. The investment in healthAlliance N.Z. Limited represents the issue of Class C shares - these shares are non-voting and have no impact on the calculation of the DHB's share of profit/(loss).

Contingencies

NZHP has contracts for the provision of IaaS relating to the NTS Programme (FPIM Hardware platform), for which stop-cost contract penalties could result in the event FPIM Hardware platform was discontinued.

If any IaaS provision was required as a result of the FPIM Programme and IT infrastructure risk mitigation reviews, and after any subsequent negotiations to mitigate any potential contract penalties, these costs would be passed through to DHBs as FPIM Programme operating expenditure. In the unlikely event that there was a discontinuance of FPIM Hardware platform and a rquirement to stop the contract, for any resulting stop-cost penalties NZHP would have a contingent liability to the supplier, and an equal and corresponding contingent asset as a receivable from the DHBs. (2021 : $nil)

healthAlliance group has no known potential contingent liabilities as at 30 June 2022 (2021:$nil).

9 Inventories

	Group		Parent	
	2022 $000	2021 $000	2022 $000	2021 $000
Pharmaceuticals	403	329	403	329
Surgical and Medical Supplies	6,105	5,002	6,105	5,002
Balance at 30 June	6,508	5,331	6,508	5,331

No inventories are pledged as security for liabilities. However some inventories are subject to retention of title clauses.
Write-down of Inventories to net realisable value amounted to $0 for 2022 (2021: $0).
The amount of inventories recognised as an expense during the year was $61.532m (2021: $46.034m), which is included in the clinical supplies line item in the Statement of Comprehensive Revenue and Expenditure.

10 Property, Plant and Equipment

(a) Group

	Freehold land $000	Freehold buildings $000	Plant, equipment and vehicles $000	Work in progress $000	Total $000
Cost					
Balance at 1 July 2020	11,772	204,107	82,683	19,884	318,446
Additions	0	0	0	32,002	32,002
Disposals	0	0	(12,705)	0	(12,705)
Movement due to Revaluation	13,225	69,898	0	0	83,123
Transfer from Trust	0	0	0	0	0
Transfers	0	11,509	9,698	(21,207)	0
Balance at 30 June 2021	24,997	285,513	79,676	30,679	420,866
Balance at 1 July 2021	24,997	285,513	79,676	30,679	420,866
Additions	753	0	0	39,026	39,779
Disposals	0	(15)	(17,992)	0	(18,007)
Movement due to Revaluation	3,372	37,510	0	0	40,882
Transfer from Trust	290	0	0	0	290
Transfers	0	20,410	7,010	(27,420)	0
Balance at 30 June 2022	29,412	343,418	68,695	42,285	483,810

	Freehold land $000	Freehold buildings $000	Plant, equipment and vehicles $000	Work in progress $000	Total $000
Depreciation and Impairment Losses					
Balance at 1 July 2020	0	19,584	68,141	0	87,725
Depreciation Charge for the year	0	10,560	5,550	0	16,110
Movement due to Revaluation	0	(30,143)	(538)	0	(30,681)
Disposals	0	0	(12,701)	0	(12,701)
Balance at 30 June 2021	0	0	60,452	0	60,452
Balance at 1 July 2021	0	0	60,452	0	60,452
Depreciation Charge for the year	0	16,280	6,381	0	22,661
Movement due to Revaluation	0	(16,266)	0	0	(16,266)
Disposals	0	(14)	(17,928)	0	(17,942)
Balance at 30 June 2022	0	0	48,905	0	48,905

	Freehold land $000	Freehold buildings $000	Plant, equipment and vehicles $000	Work in progress $000	Total $000
Carrying amounts					
At 1 July 2020	11,772	184,523	14,542	19,884	230,721
At 30 June 2021	24,997	285,513	19,224	30,679	360,413
At 1 July 2021	24,997	285,513	19,224	30,679	360,413
At 30 June 2022	29,412	343,418	19,790	42,285	434,905

10 Property, Plant and Equipment *(Continued)*

(b) Parent

	Freehold land	Freehold buildings	Plant, equipment and vehicles	Work in progress	Total
	$000	$000	$000	$000	$000
Cost					
Balance at 1 July 2020	11,596	193,659	82,683	19,884	307,822
Additions	0	0	0	32,002	32,002
Disposals	0	0	(12,705)	0	(12,705)
Movement due to Revaluation	12,949	69,018	0	0	81,967
Transfers	0	11,509	9,698	(21,207)	0
Balance at 30 June 2021	24,545	274,186	79,676	30,679	409,086
Balance at 1 July 2021	24,545	274,186	79,676	30,679	409,086
Additions	753	0	0	39,026	39,779
Disposals	0	(15)	(17,992)	0	(18,007)
Movement due to Revaluation	3,323	35,485	0	0	38,808
Transfer from Trust	290	0	0	0	290
Transfers	0	20,410	7,010	(27,420)	0
Balance at 30 June 2022	28,911	330,066	68,694	42,285	469,956

	Freehold land	Freehold buildings	Plant, equipment and vehicles	Work in progress	Total
	$000	$000	$000	$000	$000
Depreciation and Impairment Losses					
Balance at 1 July 2020	0	18,908	67,603	0	86,511
Depreciation Charge for the year	0	9,952	5,550	0	15,502
Movement due to Revaluation	0	(28,860)	0	0	(28,860)
Disposals	0	0	(12,701)	0	(12,701)
Balance at 30 June 2021	0	0	60,452	0	60,452
Depreciation and Impairment Losses					
Balance at 1 July 2021	0	0	60,452	0	60,452
Depreciation Charge for the year	0	15,434	6,381	0	21,815
Movement due to Revaluation	0	(15,420)	0	0	(15,420)
Disposals	0	(14)	(17,929)	0	(17,943)
Balance at 30 June 2022	0	0	48,904	0	48,904

	Freehold land	Freehold buildings	Plant, equipment and vehicles	Work in progress	Total
	$000	$000	$000	$000	$000
Carrying Amounts					
At 1 July 2020	11,596	174,751	15,080	19,884	221,311
At 30 June 2021	24,545	274,186	19,224	30,679	348,634
At 1 July 2021	24,545	274,186	19,224	30,679	348,634
At 30 June 2022	28,911	330,066	19,790	42,285	421,052

10 Property, Plant and Equipment *(Continued)*

Work in progress

Property, plant and equipment in the course of construction by class of asset is detailed below	Parent 2022 $000	Parent 2021 $000
Buildings	32,958	26,455
Plant, equipment and vehicles	9,327	4,224
Total work in progress	42,285	30,679

Capital Commitments

	Group 2022 $000	Group 2021 $000	Parent 2022 $000	Parent 2021 $000
Buildings	65,873	15,020	65,873	15,020
Plant, equipment and vehicles	0	0	0	0
Total	65,873	15,020	65,873	15,020

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

Impairment
No Impairments were recognised in the current year (2021: $0).

Property, Plant and Equipment held under Finance Lease
The net carrying amount of assets held under finance leases is $nil (2021: $nil) for land and buildings and $2.02m (2021: $2.6m) for other equipment.

Revaluation
Current Crown accounting policies require all Crown Entities to revalue land and buildings in accordance with PBE IPSAS 17, Property, Plant and Equipment. Current valuation standards and guidance notes have been developed in association with the Treasury for the valuation of hospitals and tertiary institutions.

The revaluation of land and buildings was carried out as at 30 June 2022 by Peter Todd, an independent registered valuer of Darroch Limited and a member of the Property Institute of New Zealand. The valuations conform to International Valuation Standards. Land has been valued on a market basis and buildings excluding work in progress have been valued on a depreciated replacement cost basis because no reliable market data is available for such buildings.

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

- The replacement asset is based on the replacement with modern equivalent assets, with adjustments where appropriate for optimisation due to over-design or surplus capacity.
- The replacement cost is derived from recent construction contracts of similar assets and Property Institute of New Zealand cost information.
- For earthquake-prone buildings that are expected to be strengthened, the estimated earthquake strengthening costs have been deducted off the depreciated replacement cost in estimating fair value.
- The remaining useful life of assets is estimated using recent asset management information.
- Straight-line depreciation has been applied in determining the depreciated replacement cost value of the asset."

Restrictions

Northland DHB does not have full title to Crown land it occupies but transfer is arranged if and when land is sold. Some of the land is subject to Waitangi Tribunal claims. The disposal of certain properties may be subject to the provision of section 40 of the Public Works Act 1981.

Titles to land transferred from the Crown to Northland DHB are subject to a memorial in terms of the Treaty of Waitangi Act 1975 (as amended by the Treaty of Waitangi (State Enterprises Act 1988)). The effect on the value of assets resulting from potential claims under the Treaty of Waitangi Act 1975 cannot be quantified.

11 Intangible Assets

Parent and Group

FPIM Rights (B Class Shares in NZ Health Partnerships Limited)	Notes	2022 $000	2021 $000
Cost			
Balance at 1 July		961	1,144
Amortisation Charge	2	(134)	(183)
Balance at 30 June		827	961

Software	2022 $000	2021 $000
Cost		
Balance at 1 July	1,416	1,411
Additions	48	137
Disposals	(1,003)	(132)
Balance at 30 June	461	1,416
Amortisation		
Balance at 1 July	1,324	1,401
Amortisation Charge for the Year	51	55
Disposals	(1,004)	(132)
Balance at 30 June	371	1,324
Carrying Amounts		
Balance at 1 July	92	10
Balance at 30 June	90	92
Total Intangible Assets at 30 June	917	1,053

12 Equity

		Group		Parent	
	Notes	2022 $000	2021 $000	2022 $000	2021 $000
General Funds					
Balance at 1 July		104,470	83,657	104,470	83,657
Capital Contribution		18,077	20,813	18,077	20,813
Balance at 30 June		122,547	104,470	122,547	104,470
Accumulated Surplus/(Deficit)					
Balance at 1 July		(79,452)	(61,921)	(75,540)	(58,333)
Surplus/(Deficit)		(37,739)	(17,530)	(37,285)	(17,206)
Transfer to Trust Funds		(15)	(1)	(15)	(1)
Other Movements		55	0	55	0
Transfer from Trust Funds		0	0	0	0
Balance at 30 June		(117,151)	(79,452)	(112,785)	(75,540)
Reserves					
Revaluation Reserve					
Balance at 1 July		221,970	109,534	213,397	102,569
Revaluations		55,438	112,436	53,861	110,828
Other Movements		235	0	235	0
Balance at 30 June		277,643	221,970	267,493	213,397
Revaluation Reserve consists of:					
Land		25,613	22,035	25,209	21,886
Buildings		252,030	199,935	242,284	191,511
Total Revaluation Reserve		277,643	221,970	267,493	213,397

12 Equity *(Continued)*

	Group		Parent	
	2022 $000	2021 $000	2022 $000	2021 $000
Fair value through other Comprehensive Revenue Reserve				
Balance at 1 July	0	0	0	0
Net Revaluation gains/(losses) on bonds	0	0	0	0
Balance at 30 June	0	0	0	0
Total Reserves	277,643	221,970	267,493	213,397
Trust/Special Funds				
Balance at 1 July	707	646	707	646
Funds received	12	1	12	1
Interest received	3	0	3	0
Funds spent	0	0	0	0
Revaluations	0	60	0	60
Other Movements	(290)	0	(290)	0
Balance at 30 June	432	707	432	707
Minority Interest				
Balance at 1 July	5,691	4600	0	0
Surplus/Deficit for period	1,076	1,211	0	0
Distributions made	(120)	(120)	0	0
Total Minority Interest	6,647	5,691	0	0
Total Equity at 30 June	**290,118**	**253,386**	**277,687**	**243,034**

All trust funds are held in bank accounts that are separate from Northland DHB's normal banking facilities.
Included in the minority interest (deficit)/surplus for the period is $1,343k (2021:$1,369K) of movements on property revaluations.

13 Trade and Other Payables

	Group		Parent	
	2022 $000	2021 $000	2022 $000	2021 $000
Payables under exchange transactions				
Trade Payables to Non-related Parties	2,810	8,219	2,810	8,219
Amounts due to Related Parties	0	1,326	0	1,326
Revenue in Advance	11,719	7,960	11,719	7,960
Other Non-trade Payables and Accrued Expenses	43,299	33,074	43,299	33,074
Total payables under exchange transactions	57,828	50,579	57,828	50,579
Payables under non-exchange transactions				
Taxes payable (GST, PAYE, FBT, Withholding tax and rates)	7,883	10,042	7,876	10,033
Total payables under non-exchange transactions	7,883	10,042	7,876	10,033
Total Trade and Other Payables	65,711	60,621	65,704	60,612

Trade and Other Payables are at fair value and payable within 12 months.

14 Interest Bearing Loans and Borrowings

	Group		Parent	
	2022 $000	2021 $000	2022 $000	2021 $000
Current				
Overdraft with NZ Health Partnerships Limited	29,691	5,982	29,691	5,982
Crown Energy Efficiency Loan	0	142	0	142
Term loans - Finance Leases	501	427	501	427
	30,192	6,551	30,192	6,551
Non-Current				
Crown Loans	0	0	0	0
Term loans - Finance Leases	1,526	1,832	1,526	1,832
	1,526	1,832	1,526	1,832
Total Interest Bearing Loans and Borrowings	31,718	8,383	31,718	8,383

Finance lease liabilities are effectively secured, as the rights to the leased asset revert to the lessor in the event of default. The net carrying amount of assets held under finance leases is disclosed in note 10.

Analysis of Financial Leases		Group		Parent	
	Notes	2022 $000	2021 $000	2022 $000	2021 $000
Minimum Lease payments payable					
Within one year		501	427	501	427
Two to five years		1,526	1,832	1,526	1,832
Total	10	2,027	2,259	2,027	2,259

15 Employee Entitlements

	Group		Parent	
	2022 $000	2021 $000	2022 $000	2021 $000
Current Liabilities				
Liability for Long Service Leave and Retirement Gratuities	5,107	4,185	5,107	4,185
Liability for Annual Leave	39,404	29,801	39,404	29,801
Holidays Act 2003 remediation	35,101	29,225	35,101	29,225
Liability for Sick Leave	380	674	380	674
Liability for Sabbatical Leave	37	24	37	24
Liability for Continuing Medical Education Leave	13,208	10,888	13,208	10,888
Salary and Wages Accrual	20,534	7,214	20,534	7,214
ACC Partnership Programme Liability	666	597	666	597
	114,437	82,608	114,437	82,608
Non-Current Liabilities				
Liability for Long Service Leave and Retirement Gratuities	16,979	15,710	16,979	15,710
Liability for Sabbatical Leave	468	317	468	317
Liability for Sick Leave	325	930	325	930
	17,772	16,957	17,772	16,957
Total Employee Entitlements	132,209	99,565	132,209	99,565

15 Employee Entitlements *(Continued)*

Actuarial Valuations

The long service leave, retirement gratuities, sick and sabbatical leave were valued by an independent actuary.

The present value of the retirement, sabbatical and long service leave obligations depend on a number of factors that are determined on an actuarial basis using a number of assumptions. Two key assumptions used in calculating this liability include the discount rate 3.9% (2021: 0.38%) and the salary inflation factor 4.25% (2021: 2%). Any changes in these assumptions will impact on the carrying amount of the liability.

The discount rates used were obtained by finding weighted averages of returns on Government stock of different terms. The salary inflation factor has been determined after considering historical salary inflation patterns.

The valuation result is most sensitive to the assumed rates of salary growth, based on all other assumptions being unaltered, an increase in the salary inflation factor of 1% would increase the employee entitlements by $1,877k. A 1% decrease would reduce the employee entitlements by $1,612k.

Continuing medical education leave

The continuing medical education leave liability assumes that the utilisation of the annual entitlement, which can be accumulated indefinately, will on average be 100% (2021: 100%) of the full entitlement. The liability has not been calculated on an actuarial basis because the present value is trivial.

ACC Accredited Employers Programme

Exposures arising from the Programme are managed by promoting a safe and healthy working environment by:

- implementing and monitoring health and safety policies;
- induction training on health and safety;
- actively managing workplace injuries to ensure that employees return to work as soon as practical;
- recording and monitoring workplace injuries and near misses to identify risk areas and implementing mitigating actions; and
- identifying workplace hazards and implementation of appropriate safety procedures.

The group has chosen a stop loss limit of 181% of the industry premium. The stop loss limit means that the group will carry the total cost of claims up to only $1.5m for each year of cover, which runs from 1 April to 31 March. If the claims for a year exceed the stop loss limit, the group will continue to meet the costs of claims and will be reimbursed by ACC for the costs that exceed the stop loss limit.

The group is not exposed to any significant concentrations of insurance risk, as work-related injuries are generally the result of an isolated event involving an individual employee.

An independent actuarial valuer, Simon Ferry of Aon New Zealand, has calculated the group's liability, and the valuation is effective as at 30 June 2022. The valuer has attested that they are satisfied as to the nature, sufficiency, and accuracy of the data used to determine the outstanding claims liability. There are no qualifications contained in the valuers report.

Average inflation has been assumed to be 2.38% for the years ending 30 June 2023 through to 30 June 2027. An average discount rate of 1.15% over the five years to 30 June 2027 has been used.

Any changes in liability valuation assumptions will not have a material effect on the financial statements.

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

For employers such as the DHBs that have workforces that include differential occupational groups with complex entitlements, non-standard hours, allowances and/or overtime, the process of assessing non-compliance with the Act and determining any additional payment is time consuming and complicated.

In preparing these financial statements, Northland DHB recognises it has an obligation as at 30 June 2022 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 involved creating a copy of the payroll system, modifying the system configuration and running scripts to recalculate the value of the liability on an individual employee basis.

The remediation project associated with the MOU is a significant undertaking and work to assess all non-compliance continues. Northland DHB has made significant progress with its review however, uncertainties remain. This is because the sector received legal advice in December 2022 on how to decide whether a day is an 'otherwise working day' when calculating the estimated holiday pay entitlements. Northland DHB has not amended its provision for this advice and work in this regard was ongoing at the date of signing these financial statements.

Further adjustment to the carrying amount of the provision may therefore be required by Te Whatu Ora, Health New Zealand. The final outcome of the remediation project and timeline for addressing any non-compliance will not be determined until this work is completed.

16 Provisions

	Group		Parent	
	2022	2021	2022	2021
	$000	$000	$000	$000
Balance at 1 July	0	264	0	264
Provision made during the year	0	0	0	0
Provision used/reversed during the year	0	(264)	0	(264)
Total Provisions	0	0	0	0

Provisions have been made for legal actions against Northland DHB, employee cessation costs and contract penalties.

17 Financial Instruments

The DHB's activities expose it to a variety of financial instrument risks, including market risk, credit risk, foreign currency risk and liquidity risk. The DHB has a series of policies to manage the risks associated with financial instruments and seeks to minimise exposure from financial instruments. These policies do not allow any transactions that are speculative in nature to be entered into.
Financial instruments, which potentially subject Northland DHB to concentrations of risk, consist principally of cash, short-term deposits and accounts receivable.

Credit Risk

Credit risk is the risk that a third party will default on its obligations to the DHB, causing it to incur a loss. The DHB places its investments with high-quality financial institutions and the DHB has a policy that limits the amount of credit exposure to any financial institution.
Concentrations of credit risk from accounts receivable are limited due to the large number and variety of customers. Northland DHB receives most of its revenue from the Ministry of Health, who is also the largest single debtor. It is assessed to be a low risk and high-quality entity due to its nature as the Government funded purchaser of health and disability support services.

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.
The status of trade receivables at the reporting date is shown in note 7.

Contractual maturity analysis of financial liabilities

The table below analyses the Northland DHB's maximum credit exposure as a result of the financial instruments it is party to. The amounts disclosed are the contractual undiscounted cashflows.

		Group		Parent	
	Notes	2022	2021	2022	2021
		$000	$000	$000	$000
Cash on Hand and at Bank	6	117	114	10	10
Term Deposits	6	374	373	0	0
Trusts/Special Funds		432	707	432	707
Trade and Other Receivables	7	55,131	32,220	55,131	32,220
Total		56,054	33,414	55,573	32,937

At balance date there were no significant other concentrations of credit risk. The maximum exposure to credit risk is represented by the carrying amount of each financial asset in the statement of financial position.

Credit Quality of Financial Assets

		Group		Parent	
	Notes	2022	2021	2022	2021
Counterparties with credit ratings		$000	$000	$000	$000
Cash and cash equivalents and Investments AA-		481	477	0	0
Counterparties without credit ratings					
Debtors and other receivables with no default in the past		55,131	32,220	55,131	32,220
Total Counterparties without credit ratings		55,131	32,220	55,131	32,220

Liquidity Risk

Management of liquidity risk

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

The DHB mostly manages liquidity risk by continuously monitoring forecast and actual cash flow requirements and maintaining an overdraft facility through the "DHB Treasury Services Agreement" between NZHP and DHB's.

Contractual maturity analysis of financial liabilities

The table below analyses financial liabilities into relevant maturity groupings based on the remaining period at balance date to the contractual maturity date. Future interest payments on floating rate debt are based on the floating rate of the instrument at balance date. The amounts disclosed are the contractual undiscounted cash flows.

17 Financial Instruments *(Continued)*

	Notes	Carrying Amount $000	Contractual Cashflows $000	Less than 1 year $000	1-5 years $000	More than 5 years $000
Parent & Group 2022						
Finance Leases		2,027	2,250	600	1,650	0
Trade and Other Payables		46,109	46,109	46,109	0	0
Total		48,136	48,359	46,709	1,650	0
Parent & Group 2021						
Crown Energy Efficiency Loan		142	142	142	0	0
Finance Leases		2,258	2,480	545	1,935	0
Trade and Other Payables		42,619	42,619	42,619	0	0
Total		45,019	45,241	43,306	1,935	0

Market Risk

Price risk

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

Fair value interest rate risk is the risk that the fair value of a financial instrument will fluctuate due to changes in market interest rates. The DHB's exposure to fair value interest rate risk arises from bank deposits and bank loans that are at fixed rates of interest. Northland DHB does not consider there to be any significant exposure to the interest risk rate on investments.

The Board has a series of policies providing risk management for interest rates and the concentration of credit. The Board is risk averse and seeks to minimise exposure from its treasury activities.

Foreign Currency Risk

Foreign exchange risk is the risk that the fair value of future cash flows of a financial instrument will fluctuate because of changes in foreign exchange rates.

Northland DHB does not consider there to be any significant exposure to foreign currency risk. Only a small amount of purchases are denominated in a foreign currency, none of which were outstanding at 30 June.

Sensitivity Analysis

As at 30 June 2022, if floating interest rates had been 100 basis points higher/lower, with all other variables held constant, the surplus/deficit to Northland DHB's surplus would have been approximately $10,000 (2021: $20,000) lower/higher.

Categories of Financial Assets and Liabilities

The classification and fair values together with the carrying amounts in the statement of financial position are as follows:

	Group		Parent	
	2022	2021	2022	2021
Financial Assets at Amortised Cost	$000	$000	$000	$000
Trade and Other Receivables	55,131	32,220	55,131	32,220
Trust/Special Fund Assets	432	707	432	707
Cash and Cash Equivalents	0	0	10	10
Short Term Deposits	374	373	0	0
Total Financial Assets at Amortised Cost	55,937	33,300	55,573	32,937
Financial Liabilities at Amortised Cost				
Trade and Other Payables	46,109	42,619	46,109	42,619
Interest Bearing Loans and Borrowings	31,718	8,383	31,718	8,383
Total Financial Liabilities at Amortised Cost	77,827	51,002	77,827	51,002

Treasury Services Agreement

Northland DHB is a party to the "DHB Treasury Services Agreement" between the NZHP and the participating DHBs. This Agreement enables NZHP to "Sweep" DHB bank accounts and invest surplus funds. The DHB Treasury Service Agreement provides for individual DHBs to have an overdraft with NZHP, which will incur interest at the credit interest rate received by NZHP plus an administrative margin. The maximum balance that is available to any DHB is the value of provider arm's planned monthly Crown revenue, used in determining working capital limits, is defined as 1/12th of the annual planned revenue paid by the funder arm to the provider arm as denoted in the most recent agreed Annual Plan inclusive of GST. For Northland DHB that equates to $44,249k. Due to the PBE IPSAS 30 disclosure requirements for the credit quality of the financial assets, the money with NZHP is classified under "counterparties with no credit ratings".

18 Related Parties

Related party disclosures have not been made for transactions with related parties that are within a normal supplier or client/recipient relationship on terms and condition no more or less favourable than those that it is reasonable to expect Northland DHB would have adopted in dealing with the party at arms length in the same circumstances. Further, transactions with other government agencies (for example Government Departments and Crown Entities) are not disclosed as related party transactions when they are consistent with the normal operating arrangements between government agencies and undertaken on the normal terms and conditions for such transactions.

Key Management Personnel Compensation

	Group		Parent	
	2022	2021	2022	2021
	$000	$000	$000	$000
Board members				
Remuneration	284	297	284	297
Full time equivalent members	11	11	11	11
Executive team				
Remuneration	3,371	3,287	3,371	3,287
Full time equivalent members	11	12	11	12
Total key management personnel remuneration	3,655	3,584	3,655	3,584
Total full time equivalent personnel	22	23	22	23

The full time equivalent for Board members has been determined based on 1 full time equivalent (FTE) per board member as it is difficult to quantify the estimated time for Board members.

Key management personnel costs include any compensation or other benefits paid or payable. Key management personnel consist of the CE, seven General Manager roles, Chief Medical Advisor, Director of Nursing and Midwifery and Director Allied Health, Scientific and Technical.

Board Member Fees

Current Board Members	2022	2021
Harry Burkhardt (Chairman)	$46,350	$47,188
Ngaire Rae (Deputy Chair)	$29,525	$29,570
Dr Carol Peters	$23,670	$24,688
Debbie Evans	$22,170	$23,420
John Bain	$23,170	$24,965
Dr Kyle Eggleton	$23,420	$24,670
Libby Jones	$23,920	$25,593
Dr Mataroria Lyndon	$22,545	$24,215
Nicole Anderson	$22,858	$22,670
Sally Macauley	$23,670	$25,342
Vince Cocurullo	$22,920	$24,465

19 Subsequent Events

There are no significant events subsequent to balance date.

20 Capital Management

Northland DHB's capital is its equity, which comprises of crown equity, reserves, trust/special funds and accumulated comprehensive revenue and expenditure. Equity is represented by net assets. The Northland DHB manages its revenues, expenses, assets, liabilities and general financial dealings prudently in compliance with the budgetary processes. The Northland DHB's policy and objectives of managing the equity is to ensure the Northland DHB effectively achieves its goals and objectives, whilst maintaining a strong capital base. The Northland DHB policies in respect of capital management are reviewed regularly by the governing Board. There have been no material changes in the Northland DHB's management of capital during the period.

21 Variance Analysis

Overall the DHB (parent) reported an operating deficit of $37.3m, $17.2m unfavourable to budget. The result from business as usual operations for the year was $6.9m ($8.4m favourable to budget) costs in relation to the unfunded COVID-19 response $2.9m and additional provision for Holidays Act non-compliance $5.9m.

21 Variance Analysis *(Continued)*

Key Financial Information	Group Actual 2022 $000	Group Budget 2022 $000	Variance $000
Operational Revenue	958,043	855,788	102,255

The revenue budget is based on the funding envelope advised by the Ministry of Health. Subsequent to this advice, further funding was made available to fund the community based COVID-19 response costs ($54.5m) and for additional services, including pharmacy and primary care services.

	Group Actual 2022	Group Budget 2022	Variance
Operational Cost (including Capital Charge)	996,050	876,289	119,761

The major factors contributing to the increase in operational expenditure are unbudgeted services provided due to COVID-19, a provision made for the estimated cost of remediation in relation to compliance with the Holidays Act.

Total Assets (excluding cash and term deposits)	519,265	337,691	181,574

The variance in total assets is largely due to the $72M increase in land and buildings value attributable to additions of $40M and revaluations of $32M. Trade and other receivables were greater than budget due to an increase in funding revenue due from the Ministry.

Total Liabilities (excluding loans)	197,920	148,402	49,518

Liabilities are higher than budget due to larger employee entitlement accruals, including the estimated cost of remediation in relation to compliance with the Holidays Act and an increase in continuing medical education liability caused by postponed training due to Covid-19. Trade supplier balances were greater than budget due to increased activity.

Cash Resources (cash, deposit and investment balances less loans)	(31,227)	(25,804)	(5,423)

Cash Resources are lower than budget primarily due to unbudgeted COVID - 19 pandemic response costs and additional PHARMAC spending.

Total Equity	290,118	163,485	126,633

The variance of Equity to budget is largely due to the asset revaluations and additions described in the Total Assets note above.

22 COVID-19

Healthcare services are front line in the response to the COVID-19 pandemic.

Since March 2020 Northland DHB has been reporting to the MOH the financial impacts of the pandemic in the COVID-19 Tracker financial reporting template. Reporting moved from weekly to a monthly basis from July 2021.

For the year ended 30 June 2022 the DHB incurred unfunded covid related costs of $0.8m net in operational and $2.1m in capital costs. The large scale COVID-19 vaccination roll out and preparation for and occurrence of Delta and Omicron variants in New Zealand resulted in substantial expansion in the scope of COVID-19 response activities. Specific funding streams for COVID-19 Community Testing, Community Supported Isolation and Quarantine, Vaccination, Care & Community, Maori Health, Pacific Health and Public Health enabled the DHB to track and recoup all costs relating to these activities. Unfunded Covid Hospital Response costs in excess of $1.1m were incurred and partially offset by $0.3m surplus funding for COVID-19 Laboratory Tests. Total operational expenditure on covid related costs during 2021-22 amounted to $66.8m. This level `of expenditure is expected to be progressively reduced during 2022-23.

The DHB did not incur any financial penalties in relation to planned care performance during the year despite ongoing impacts from COVID-19. Recovery of planned care and ensuring available capacity to meet acute demand growth will be an on-going challenge for 2022-23.
The DHB did not incur any financial penalties in relation to planned care performance during the year despite ongoing impacts from COVID-19. Recovery of planned care and ensuring available capacity to meet acute demand growth will be an on-going challenge

Northland DHB assessed the impact of COVID-19 on all balance sheet accounts. Overall the DHB does not consider there to be any material impacts as at 30 June 2022. In terms of the valuation of land and buildings, the DHB engaged an independent valuer to complete a valuation as at 30 June 2022. . Their assessment considered market evidence, including current significant input cost inflation. . The valuation policy included a Covid 19 paragraph which states as a result of the COVID 19 pandemic, market uncertainty has increased. Market risk has also increased due to future uncertainties. Therefore the values provided are subject to a wider range of variation than in the past. Northland District Health Board concurs with the revaluation assessment.

23 Contingent Liabilities and assets

Northland DHB and group has no Contingent liabilities or assets as at 30 June 2022. (2021 $NIL)

24 Breach of statutory reporting deadline

The 2021/22 annual report of Northland DHB 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).

Statement of Accounting Policies

For the year ended 30 June 2022

Reporting entity

Northland District Health Board (Northland DHB) is a Health Board established by the New Zealand Public Health and Disability Act 2000. Northland DHB has designated itself as a Public Benefit Entity (PBE) for financial reporting purposes. It is domiciled and operates in New Zealand. Northland DHB is a Crown Entity as defined by the Crown Entities Act 2004. Northland DHB's ultimate parent is the Crown.

The consolidated financial statements of Northland DHB and group for the year ended 30 June 2022 comprise Northland DHB, its controlled entity the Kaipara Total Health Care Joint Venture (54% owned) and its jointly controlled entities healthAlliance N.Z. Limited (25% owned) and HealthSource New Zealand Limited (10% owned).

Northland DHB's activities involve funding and delivering health and disability services in a variety of ways to the community.

The financial statements were authorised for issue by the Board on 09 March 2023.

Basis of preparation

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

The Act disestablished all DHBs and the Health Promotion Agency and transferred the Northland DHB'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.

The Group is reliant on financial support from the Crown

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

Statement of compliance

The financial statements have been prepared in accordance with the requirements of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004, which include the requirement to comply with generally accepted accounting practice in New Zealand (NZGAAP). The financial statements comply with PBE and other applicable Financial Reporting Standards, as appropriate for public benefit entities.

Presentation currency and rounding

The financial statements are presented in New Zealand Dollars and all values are rounded to the nearest thousand dollars ($000). The functional currency of the Northland DHB and its subsidiary is New Zealand dollars (NZ$).

The accounting policies as set out below have been applied consistently to all periods presented in these consolidated financial statements.

Critical accounting estimates and assumptions

The preparation of financial statements in conformity with PBE accounting standards requires management to make judgements, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, revenue and expenses. The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances, the results of which form the basis of making the judgements about carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates will be recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

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 discussed below:

Land and buildings revaluations

Note 10 provides information about the estimates and assumptions applied in the measurement of revalued land and buildings.

Long service leave, retirement gratuities and Holidays Act 2003 liability

Note 15 provides an analysis of the exposure in relation to estimates and uncertainties surrounding retirement and long service leave liabilities, as well as leave entitlements under the Holidays Act 2003.

Estimating useful lives and residual values of property, plant and equipment

The useful lives and residual values of property, plant and equipment are reviewed at each balance date. Assessing the appropriateness of useful life and residual value estimates requires Northland DHB to consider a number of factors such as the physical condition of the asset, advances in medical technology, expected period of use of the asset by Northland DHB, and expected disposal proceeds (if any) from the future sale of the asset.

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 Northland DHB.

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.

Northland DHB has exercised its judgement on the appropriate classification of leases, and has classified finance lease appropriately.

Changes in accounting policies

There have been no changes in accounting policies during the financial year.

Standards early adopted

There have been no standards early adopted during the financial year.

Standards issued and not yet effective and not early adopted

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

New amendment to PBE IPSAS 2 Statement of Cash Flows applied

An amendment to PBE IPSAS 2 Statement of Cash Flows 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 6.

PBE IPSAS 41 Financial Instruments

The XRB issued PBE IPSAS 41 Financial Instruments in March 2019. This standard supersedes most of PBE IPSAS 29 Financial Instruments: Recognition and Measurement and PBE IFRS 9 Financial Instruments, which was issued as an interim standard. It is effective for reporting periods beginning on or after 1 January 2022.

The main changes compared to PBE IPSAS 29 that are relevant to the DHB are:

- New financial asset classification requirements for determining whether an asset is measured at fair value or amortised cost.
- A new impairment model for financial assets based on expected losses, which might result in the earlier recognition of impairment losses.

Northland DHB does not intend to early adopt the amendment.

Although Northland DHB has not assessed the effect of the new standard, it does not expect any significant changes as the requirements are similar to PBE IFRS 9.

PBE FRS 48 Service Performance Reporting

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

Basis for consolidation

Subsidiaries

Subsidiaries are entities controlled by Northland DHB. Control exists when Northland DHB is exposed, or has rights to, variable benefits (either financial or non-financial) and has the ability to affect the nature and amount of those benefits from its power over the entity. The financial statements of subsidiaries are included in the consolidated financial statements from the date that control commences until the date that control ceases. The group financial statements are prepared using uniform accounting policies for like transactions and other events in similar circumstances.

The consolidated financial statements include the parent (Northland DHB) and its subsidiary. The subsidiary is accounted for using the acquisition method, which involves adding together corresponding assets, liabilities, revenues and expenses on a line by line basis.

Transactions eliminated on consolidation

All intragroup balances, transactions, revenue and expenses are eliminated in preparing the consolidated financial statements.

Investments in subsidiaries are carried at cost in Northland DHB's own "parent entity" financial statements.

Investments in Joint Ventures

Joint Ventures are those entities over whose activities Northland DHB has joint control, established by contractual agreement and requiring unanimous consent for strategic financial and operating decisions. Joint Ventures are not accounted for using the equity method as they are not material.

Investments in Joint Ventures are carried at cost in Northland DHB's own parent entity and group financial statements.

Budget figures

The group budget figures presented in the financial statements comprise of the Northland DHB parent figures that were approved in its statement of performance expectations and the subsidiary's budget figures that were approved by its own board. The budget figures have been prepared in accordance with NZGAAP using accounting policies that are consistent with those adopted by the Board in preparing these financial statements.

Foreign currency transactions

Transactions in foreign currency are translated at the foreign exchange rate ruling at the date of the transaction. Monetary assets and liabilities denominated in foreign currencies at the balance sheet date are translated to NZD at the foreign exchange rate ruling at that date. Foreign exchange differences arising on translation are recognised in the surplus or deficit. Non-monetary assets and liabilities that are measured in terms of historical cost in a foreign currency are translated using the exchange rate at the date of the transaction.

Cash and cash equivalents

Cash and cash equivalents include cash on hand, cash on deposit with NZ Health Partnerships Limited, deposits held on call with banks and other short-term highly liquid investments with original maturities of three months or less.

Trade and other receivables

Short-term receivables are recorded at the amount due, less an allowance for credit losses.

Northland DHB bases the measurement of expected credit losses on forward-looking information, as well as current and historic information. They have been grouped based on the days past due.

Short term receivables are written off when there is no reasonable expectation of recovery.

Trade and other payables

Trade and other payables are recorded at their face value.

Investments

Bank term deposits

Investments in bank term deposits are initially measured at the amount invested.

After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest method, less any provision for impairment.

Inventories

Inventories held for distribution in the provision of services that are not supplied on a commercial basis are measured at cost (using the weighted average cost method) and adjusted when applicable, for any loss of service potential.

Inventories acquired through non-exchange transactions are measured at fair value at the date of acquisition.

Inventories held for use in the provision of goods and services on a commercial basis are valued at the lower of cost (using the weighted average cost method) and net realisable value.

Net realisable value is the estimated selling price in the ordinary course of business, less the estimated costs of completion and selling expenses.

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 period of the write-down.

Interest bearing borrowings

Interest bearing borrowings are recognised initially at fair value less attributable transaction costs. Subsequent to initial recognition, interest bearing borrowings are stated at amortised cost with any difference between cost and redemption value being recognised in the surplus or deficit over the period of the borrowings on an effective interest basis. Borrowings are classified as current liabilities unless Northland DHB has an unconditional right to defer settlement of the liability for at least 12 months after balance date.

Property, plant and equipment

Property, plant and equipment consists of the following asset classes: land, buildings and plant, equipment and motor vehicles

Owned assets

Except for land and buildings and the assets vested from the hospital and health service (see below), items of property, plant and equipment are stated at cost, less accumulated depreciation and accumulated 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.

Revaluations

Land and buildings are revalued to fair value as determined by an independent registered valuer at least every three years or, where there is evidence of a significant change in fair value. The net revaluation results are credited or debited to other comprehensive revenue and is 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 but is recognised in the surplus or deficit.

Any subsequent increase on revaluation that offsets 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.

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

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.

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

Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets of Northland Health Limited (a hospital and health service company) were vested in Northland DHB on 1 January 2001. Accordingly, assets were transferred to Northland DHB at their net book values as recorded in the books of the hospital and health service. In effecting this transfer, the Northland DHB has recognised the cost and accumulated depreciation amounts from the records of the hospital and health service. The vested assets will continue to be depreciated over their remaining useful lives.

Disposal of property, plant and equipment

Where an item of plant and equipment is disposed of, the gain or loss recognised in the surplus or deficit is calculated as the difference between the net sales price and the carrying amount of the asset. The gain or loss is recognised in the reported net surplus or deficit in the period in which the transaction occurs. Any balance attributable to the disposed asset in the asset revaluation reserve is transferred to retained earnings.

Additions to property, plant and equipment

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

In most instances, an item of property, plant and equipment is 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

Subsequent costs are added to the carrying amount of an item of property, plant and equipment when that cost is incurred, if it is probable that the service potential or future economic benefits embodied within the new item will flow to Northland DHB. All other costs are recognised in the statement of comprehensive revenue as an expense as incurred. The costs of day-to-day servicing of property, plant and equipment are recognised in the surplus or deficit as they are incurred.

Depreciation

Depreciation is provided using the straight line method on all property plant and equipment other than land, and recognised in the surplus or deficit.

Depreciation is set at rates that will write off the cost or fair value of the assets, less their estimated residual values, over their useful lives. The estimated useful lives of major classes of assets and resulting rates are as follows:

Class of asset	Estimated life	Depreciation rate
Buildings (including components)	10 to 70 years	(1.4% - 10%)
Plant and Equipment	1 to 15 years	(6.6% - 100%)
Motor Vehicles	5 to 15 years	(6.6% - 20%)

The residual value of assets is reassessed annually to determine if there is any indication of impairment.

Work in progress is recognised at cost less impairment and is not depreciated. The total cost of a project is transferred to the appropriate class of asset on its completion and then depreciated.

Borrowing costs

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

Intangible Assets

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

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

Costs that are directly associated with the development of software for internal use, are recognised as an intangible asset. Direct costs can include the software development employee costs and an appropriate portion of relevant overheads.

Subsequent expenditure

Subsequent expenditure on intangible assets is capitalised only when it increases the service potential or future economic benefits embodied in the specific asset to which it relates. All other expenditure is expensed as incurred.

Finance, Procurement and Information Management System (FPIM)

The Finance, Procurement and Information Management System (FPIM) is a national initiative funded by DHBs and facilitated by NZ Health Partnerships Limited (NZHPL) to deliver sector wide benefits. NZHPL holds an intangible asset recognised at the capital cost of development relating to this programme.

Northland DHB holds:

-an intangible asset for the cost of capital invested by Northland DHB in the FPIM application. This is reviewed for impairment at each balance date;

-an intangible asset for the cost of capital invested by Northland DHB in the FPIM central implementation costs. This will be amortised over 15 years from when the asset was brought into use in February 2022; and

-a prepayment for the costs paid in relation to the core build of the FPIM Hardware. This will be recognised as an expense over a five year period from February 2022.

Amortisation

Amortisation is provided in the surplus or deficit on a straight-line basis over the estimated useful lives of intangible assets unless such lives are indefinite. Intangible assets with an indefinite useful life are tested for impairment at each balance sheet date. Other intangible assets are amortised from the date they are available for use.

Class of asset	Estimated life	Amortisation rate
Software	2 to 3 years	(33% - 50%)
FPIM	14 to 15 years	(6.6% - 100%)

Impairment of property, plant and equipment and intangible assets

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

Intangible assets that have an indefinite useful life, or not yet available for use, are not subject to amortisation and are tested annually for impairment.

Assets that have a finite useful life are reviewed for indicators of impairment at each balance date. When there is an indicator of impairment the asset's recoverable amount is estimated. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount. The recoverable amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is depreciated replacement cost for an asset where the fair value of an asset cannot be reliably determined by reference to market based evidence. Specialised Hospital Buildings are an example of this.

If an asset's carrying amount exceeds its recoverable amount, the asset is impaired and the carrying amount is written down to the recoverable amount. For revalued assets, the impairment loss is recognised in other comprehensive revenue to the extent the impairment loss does not exceed the amount in the revaluation reserve in equity for that same class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised in the surplus or deficit.

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

Employee benefits

Defined contribution schemes

Obligations for contributions to defined contribution plans are recognised as an expense in the surplus or deficit as incurred.

Defined benefit schemes

Northland DHB makes employer contributions to the Defined Benefits Plan Contributors Scheme (the scheme), which is managed by the Board of Trustees of the National Provident Fund. The scheme is a multi-employer defined benefit scheme.

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.

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.

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.

Bonuses

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.

Provisions

A provision is recognised at fair value when Northland DHB has a present legal or constructive obligation as a result of a past event, and it is probable that an outflow of economic benefits will be required to settle the obligation and that a reliable estimate can be made. If the effect is material, provisions are determined by discounting the expected future cash flows at a pre-tax rate that reflects current market rates and, where appropriate, the risks specific to the liability. The movement in provisions are recognised in the surplus or deficit.

Restructuring

A provision for restructuring is recognised when an approved detailed formal plan for the restructuring has either been announced publicly to those affected, or for which implementation has already commenced.

ACC Accredited Employers Programme

Northland DHB belongs to the ACC Accredited Employers Programme (the "Full Self Cover Plan") whereby Northland DHB accepts the management and financial responsibility for employee work-related illnesses and accidents. Under the programme, Northland DHB is liable for all claims costs for a period of two years after the end of the cover period in which the injury occurred. At the end of the two-year period, Northland DHB 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 Accredited Employers 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 balance 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 close as possible, the estimated future cash outflows.

Equity

Equity is the community's interest in Northland DHB and is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified into a number of components.

The components of equity are Retained Earnings, Revaluation Reserve (consisting of Land and Buildings), non-controlling interest in the group and Trust/Special Funds. The minority interest in the group is represented by the joint venture partner in the controlled entity.

Trust/Special Funds

Trust/Special funds are funds donated or bequeathed for a specific purpose. The use of these assets must comply with the specific terms of the sources from which the funds were derived. The revenue and expenditure in respect of these funds is included in the surplus or deficit. An amount equal to the expenditure is transferred from the trust fund component of equity to retained earnings. An amount equal to the revenue is transferred from revenue earnings to trust funds.

Property revaluation reserve

This reserve relates to the revaluation of property, plant, and equipment to fair value.

Fair value through other comprehensive revenue and expense reserves

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

Revenue

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

Ministry of Health population-based revenue

Northland DHB receives annual funding from the Ministry of Health, which is based on population levels within the Northland DHB region.

Ministry of Health 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 Ministry of Health 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 Northland 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 periods 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.

Goods sold and services rendered

Revenue from goods sold is recognised when Northland DHB has transferred to the buyer the significant risks and rewards of ownership of the goods and Northland DHB does not retain either continuing managerial involvement to the degree usually associated with ownership nor effective control over the goods sold.

Revenue from services is recognised, to the proportion that a transaction is complete, when it is probable that the payment associated with the transaction will flow to Northland DHB and that payment can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied by Northland DHB.

Revenue from other DHBs

Inter-district patient inflow revenue occurs when a patient treated within the Northland DHB region is domiciled outside of Northland. The Ministry of Health credits Northland DHB with a monthly amount based on an estimated patient treatment for non-Northland residents within Northland. An annual wash-up occurs at year end to reflect the number of non-Northland patients treated at Northland DHB.

Donated services

Certain operations of the Northland DHB are reliant on services provided by volunteers. Volunteer services received are not recognised as revenue or expenditure by Northland DHB.

ACC contract revenue

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

Rental revenue

Rental revenue is recognised in the surplus or deficit on a straight-line basis over the term of the lease. Lease incentives granted are recognised as an integral part of the total rental revenue over the lease term.

Interest

Interest revenue is recognised using the effective interest method.

Expenses

Operating leases

An operating lease is a lease whose term is short compared to the useful life of the asset or piece of equipment and does not transfer substantially all the risks and rewards incidental to ownership of the asset to the lessee.

Payments made under operating leases are recognised in the surplus or deficit on a straight-line basis over the term of the lease. Lease incentives received are recognised in the surplus or deficit over the lease term as an integral part of the total lease expense.

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 where Northland DHB is the lessee 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.

Financing costs

Net financing costs comprise interest paid and payable on borrowings, calculated using the effective interest rate method and are recognised as an expense in the financial year in which they are incurred.

Capital charge

The capital charge is recognised as an expense in the financial year to which the charge relates. The intention of the capital charge is to make explicit the true costs of the taxpayers' investment by requiring recognition of those costs.

Contingent liabilities

Contingent liabilities are recorded in the Statement of Contingent Liabilities at the point at which the contingency is evident. Contingent liabilities are disclosed if the possibility that they will crystallise is not remote.

Cost of service (Statement of Performance)

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

Cost allocation

Northland DHB has arrived at the net cost of service for each significant activity using the cost allocation system outlined below:

Statement of Accounting Policies

Cost allocation policy

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

Direct costs are those costs directly attributable to an output class.

Indirect costs are those costs that cannot be identified in an economically feasible manner with a specific output class.

The cost of internal services not directly charged to outputs is allocated as overheads using appropriate cost drivers such as actual usage, staff numbers and floor area.

Income tax

Northland DHB is a crown entity under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under section CB3 of the Income Tax Act 1994.

Goods and services tax

All items in the financial statements are presented exclusive of GST, except for receivables and payables, which are presented on a GST inclusive basis. Where GST is not recoverable as input tax then 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 disclosed in combination with supplier payments and classified as an operating cash flow in the statement of cash flows.

Commitments and contingencies are disclosed exclusive of GST.

Sheryl Poutai, Lynn Hoterene and Louisa E Kingi outside Whangārei Hospital Whānau House - Whaea Ō Te Iwi

Acronyms

Acronym	Meaning
AAU	Acute Assessment Unit
ALOS	Average length of stay
ARC	Aged residential care
ASH	Ambulatory sensitive hospitalisation, a subset of avoidable hospitalisations (sometimes also Action on Smoking and Health)
ASMS	Association of Salaried Medical Specialists
BAU	Business as usual
BMI	Body Mass Index (a measure of healthy weight)
COPD	Chronic obstructive pulmonary disease
CVD	Cardiovascular disease
DHB	District Health Board
DMFT	Decayed, missing, filled teeth; a measure of total damaged teeth in the mouth
DNA	Did not attend
ECMS	Enterprise Content Management System, a large file-holding and file-sharing database
ED	Emergency Department
ELT	Executive Leadership Team (of Northland DHB)
FSA	First specialist appointment
FTE	Full time equivalent (= 40 hours a week of work time)
GDP	Gross Domestic Product
GP	General Practitioner
HCSS	Home and community support services (for older people)
HOP	Health of older people
HQSC	Health Quality and Safety Commission
IFHC	Integrated family health centre
interRai	A collaborative network of researchers in over 30 countries who promote evidence-based clinical practice and policy to improve healthcare for persons who are elderly, frail, or disabled
IT	Information technology
KPI	Key performance indicator
KRONOS	A business support financial system
LTC(s)	Long-term condition(s)
MELT	Medical Executive Leadership Team
NDHB	Northland District Health Board
NGO	Non-government organisation
NHSP	Northland Health Services Plan
PBF(F)	Population Based Funding (Formula)
PHO	Primary Health Organisation
POPN	Primary Options Programme Northland
PRIMHD	Programme for the Integration of Mental Health Data
Q	Quarter (of the year); either Jul-Sep, Oct-Dec, Jan-Mar or Apr-Jun
ROERS	Radiology orders and eResults sign-off
OMG	Operational Management Group
SMO	Senior Medical Officer
SPE	Statement of Performance Expectations What we expect to achieve in the coming year, included as an appendix in our Annual Plan. When the year is over, the SPE becomes the basis upon which the Statement of Performance is prepared
Statement of	Performance Expectations What we expect to achieve in the coming year, included as an appendix in our Annual Plan. When the year is over, the SPE becomes the basis upon which the Statement of Performance is prepared
STI	Sexually transmitted infection
SUDI	Sudden unexpected death in infancy (also sometimes sudden unexplained death in infancy)
SWOT	Strengths, weaknesses, opportunities, threats
TLA	Territorial Local Authority
VfM	Value for money

Directory

BOARD MEMBERS AS AT 30 JUNE 2022

* DHB Boards were disbanded on 30 June
*Appointed by the Minister of Health

Harry Burkhardt* – Chair (Ngāti Kuri)
Carol Peters
Debbie Evans
John Bain
Kyle Eggleton
Libby Jones
Mataroria Lyndon* (Ngāti Hine, Ngāti Whātua, Ngāpuhi)
Ngaire Rae* (Deputy Chair)
Nicole Anderson* (Ngāpuhi)
Sally Macauley
Vince Cocurullo

EXECUTIVE OFFICERS AS AT 30 JUNE 2022

Dr Andrew Miller, **GP Representative**
Dr Chris Harmston, **Clinical Director - Innovation and Transformation**
Dr David Hammer, **Clinical Director - Innovation and Transformation**
Dr Jenny Walker, **Associate Chief Medical Officer**
Dr Jo Coates, **Clinical Director - Innovation and Transformation**
Dr Maree Sheard, **Chief Nurse & Midwifery Officer**
Dr Michael Roberts, **Chief Medical Officer**
Dr Moana Tane, **General Manager, Māori Health**
Dr Nick Chamberlain, **Chief Executive**
Ian McKenzie, **General Manager, Mental Health & Addiction Services**
Jeanette Wedding, **General Manager, Rural, Family and Community**
John Wansbone, **General Manager, Planning, Integration, People & Performance**
Liz Inch, **Communications Manager**
Mark McGinley, **General Manager, Surgical, Pathology and Ambulatory Services**
Michael Kelly, **General Manager, Finance, Funding & Commercial Services**
Pip Zammit, **Director of Scientific, Technical, Allied Health**
Tracey Schiebli, **General Manager, Medical and Elder Services**

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www.northlanddhb.org.nz

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Audit New Zealand on behalf of the Office of the Controller & Auditor General

BANKERS
Bank of New Zealand

SOLICITORS
Webb Ross Lawyers, Whangārei

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www.northlanddhb.org.nz

NORTHLAND DISTRICT HEALTH BOARD
Te Poari Hauora Ā Rohe O Te Tai Tokerau