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2019 / 2020

ANNUAL REPORT

TE PŪRONGO A-TAU

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

HE HĀPORI ORA - THRIVING COMMUNITIES

MIHI

HE HONORE HE KORORIA HE MAUNGARONGO

KI RUNGA KI TE WHENUA HE WHAKAARO PAI

KI NGĀ TĀNGATA KATOA

HONOUR, PEACE AND GLORY TO
ALL MANKIND UPON THIS LAND

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

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NGĀ MOEMOEĀ, NGĀ KAUPAPA

OUR VISION & VALUES

***Our vision:** He Hāpori Ora - Thriving Communities*

Kaua e rangiruatia te hāpai o te hoe, e kore to tātou waka e ū ki uta.
Do not lift the paddle out of unison or our canoe will never reach the shore.

We foster an environment that places the patient and their family at the centre of everything we do - an environment which values:

- learning and improvement
- courage
- partnering with others
- building resilience.

We are:

- open and honest
- respectful and empathetic
- caring and considerate
- committed to fostering meaningful relationships
- family-centred.

He wāhi whakamana tangata whaiora, whakamana whānau! Ko te whai anō hoki i ngā waiaro:

- ka whai matauranga
- ka whai mana
- ka toro atu te ringa
- ka whai rangatiratanga.

Koi anei tātou:

- ka ū ki te pono
- ka aroha ki te tangata
- ka manaaki tangata
- ko te mea nui he tangata, he tangata me ōna āhuatanga katoa
- ko te whānau te pūtake.

Ko au ko tōku whānau, ko tōku whānau ko au

Nothing about me without me, and my whānau/family

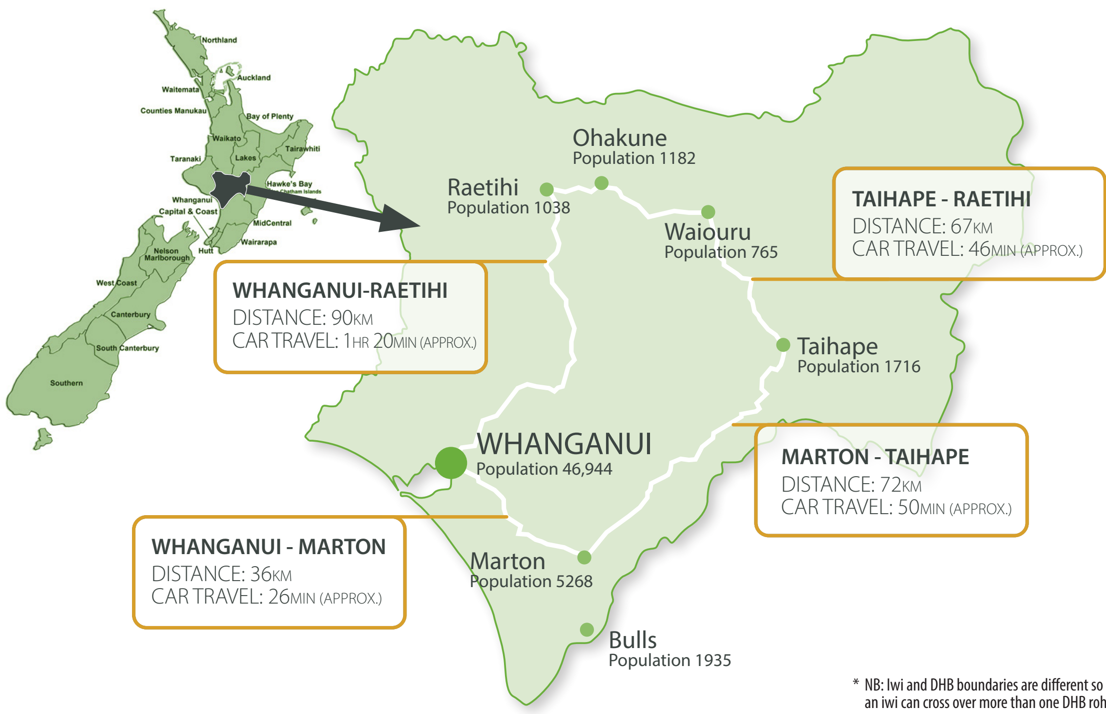
THE POPULATION WE SERVE

HE TANGATA, HE TANGATA, HE TANGATA

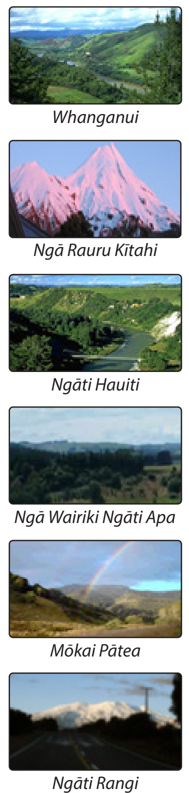
One of 20 district health boards (DHBs) in New Zealand, Whanganui District Health Board (WDHB) was established under the New Zealand Public Health and Disability Act 2000. This Act sets out the roles and functions of district health boards.

WHANGANUI DHB DISTRICT | TOTAL POPULATION: 68,395 (estimate) **| 9,742KM²**

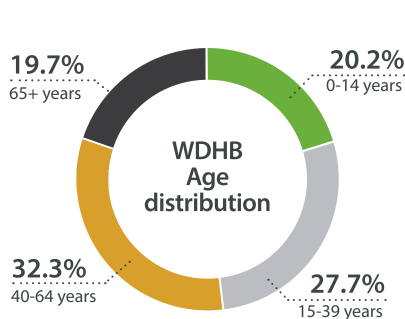
We acknowledge travel times for communities living in surrounding rural districts will be longer than indicated.

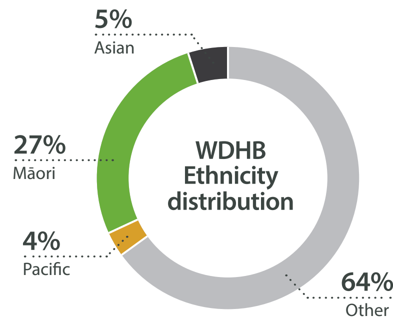


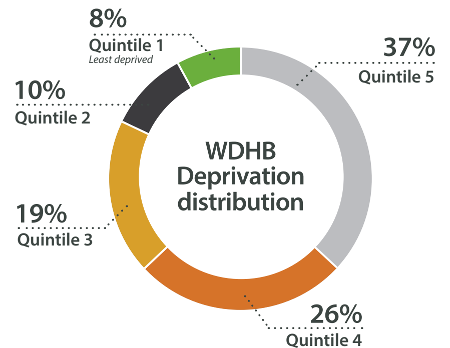
IWI IN THE ROHE*



* NB: Iwi and DHB boundaries are different so an iwi can cross over more than one DHB rohe







POPULATION AGE DISTRIBUTION - ALL NZ

0-19 years	25.56%
20-39 years	27.64%
40-59 years	25.15%
60-79 years	17.90%
80+	3.76%

ETHNICITY DISTRIBUTION - ALL NZ

European	52.0%
Māori	16.5%
Asian	15.0%
Pacific	8.1%
Other	8.4%

OUR DHB'S POPULATION

Whanganui District Health Board is responsible for ensuring the 68,395 people living in its district have access to a wide range of health and disability support services across primary, secondary and tertiary health care settings. This includes the secondary services provided at Whanganui Hospital as well as funding many primary services delivered in the community, and public hospital services delivered to our population outside the Whanganui District Health Board area. It is responsible for improving, promoting and protecting their health and the health of the communities in which they live.

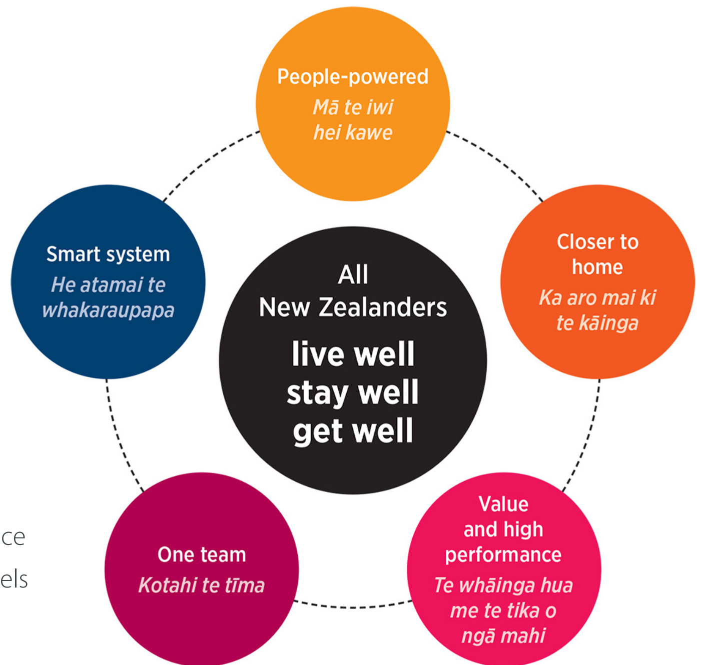
Whanganui District Health Board has a unique profile in that it has:

- high rates of deprivation compared to most other areas of New Zealand
- poor health status compared to most other areas of New Zealand
- a high and growing proportion of Māori
- a high and growing proportion of people aged over 65
- a small hospital servicing a widely-dispersed but small population base
- large travel distances to the bigger hospitals.

NEW ZEALAND HEALTH STRATEGY:
The Five Strategic Themes

GUIDING PRINCIPLES FOR THE SYSTEM

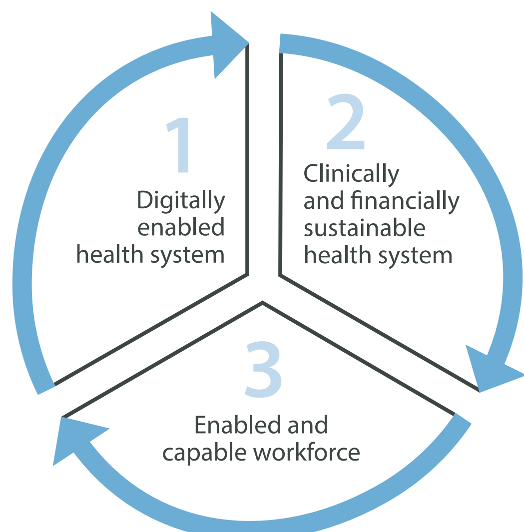
1. Acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi
2. The best health and wellbeing possible for all New Zealanders throughout their lives
3. An improvement in health status of those currently disadvantaged
4. Collaborative health promotion, rehabilitation and disease and injury prevention by all sectors
5. Timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay
6. A high-performing system in which people have confidence
7. Active partnership with people and communities at all levels
8. Thinking beyond narrow definitions of health and collaborating with others to achieve wellbeing.



CENTRAL REGION

Whanganui, MidCentral, Capital & Coast, Wairarapa, Hutt Valley and Hawke's Bay District Health Boards.

The Regional Services Plan is developed collaboratively by the region's six District Health Boards. The plan's focus is on ensuring equity of access and outcomes for all our population, in ways that make best use of advances in technology and are both clinically and financially sustainable.



OUR OPPORTUNITIES & CHALLENGES

Whanganui District Health Board operates in a complex and dynamic environment which poses many challenges. However, it also offers opportunities to support our efforts to reduce inequalities and improve the health and wellbeing of our community.

SIGNIFICANT ENVIRONMENTAL FACTORS

WORKFORCE

International labour market

CHALLENGES:
- Recruiting and retaining suitable specialist medical staff.
- Salary demands exceeding ability to pay.

OPPORTUNITIES:
- To promote lifestyle and cost-of-living advantages of regional New Zealand.
- To develop innovative initiatives for 'growing our own' and extending our talent pool.

HEALTH OF OUR POPULATION

Lifestyle and age-related diseases

CHALLENGES:
- Need for services for people with chronic medical conditions and degenerative diseases exceeds ability to provide and/or fund.
- Service demand in primary and secondary care increasing sharply and challenging available capacity.
- Persistent inequity in health outcomes for Māori whānau.

OPPORTUNITIES:
- To work collaboratively with other health and social agencies to enhance promotion and protection strategies.
- To improve equity of health outcomes for Māori.
- To develop models that increasingly empower patients and whānau.
- To improve service integration across the health and disability continuums.
- To develop models of care and service delivery which encourage all health professional groups to work to top-of-scope.
- To accelerate Māori health outcomes and improve equity by involving Te Ao Māori concepts and whānau-centred approaches.

ECONOMY AND DISTRICT HEALTH BOARD FUNDING

Fiscal constraint

CHALLENGES:
- Funding increases will not cover costs.
- Funding increases will need to be applied to meet demand for health services and reduce disparities.
- Demand for salary and price increases will likely exceed available funding.
- Existing business and service model mitigate against service change.
- Service change that reduces access to local services will not get political support (local and/or national).

OPPORTUNITIES:
- To review effectiveness and efficiency of current service models to improve productivity and/or new ways of delivering services.
- To lobby for, and influence the development of, business model changes and elective intervention rates.
- To continue with waste elimination, cost reduction and revenue generating initiatives.

INCREASED SPECIALISATION

Need for centralisation

CHALLENGES:
- Lack of scale leads to clinical and financial unsustainability.
- Service changes will not get political support (local and/or national).
- Community resists change.

OPPORTUNITIES:
- To use technology and visiting specialists to enable local delivery of ambulatory services to improve collaboration with other district health boards to ensure best use of physical and human resource across the region.
- To enhance travel and accommodation options.
- To improve community understanding of the impacts of specialisation.

CONSUMERISM

Increasing consumer expectations

CHALLENGES:
- Demand exceeds ability to fund and/or to provide service expectations.

OPPORTUNITIES:
- To increase consumer participation to improve health literacy across the region and to support the *Choosing Wisely* programme.

NEW POLICY DIRECTIONS AND HEALTH SECTOR REVIEW

Change in health policy and organisation of health structures

CHALLENGES:
- Re-focus to new policy directions.
- Major restructure of the health system.

OPPORTUNITIES:
- To contribute to the development and design of any new structural or policy direction.
- To prepare for any change from a position of strength.

OUR OVERVIEW OF PERFORMANCE

MAHI WHAKARITERITE

BOARD CHAIR'S REPORT

Taking over as chair of Whanganui District Health Board in October 2019, I already had some insight into the organisation, having done a bit of preliminary research.

I was attracted to the role by the belief that the DHB was extremely well-connected to both its stakeholders and to the community it served.

My first few months as chair have confirmed that view, and I believe we have an organisation that is making a difference at a community level.

Moving forward, we now have the He Hāpori Ora – Thriving Communities document which sets out our strategic vision with its focus areas of pro-equity, social governance and keeping people healthy at home.

This document is one of the best such frameworks that I have seen, and it sets us up for the future and reinforces my confidence in the strengths of Whanganui District Health Board.

Another document that will play a key role in our future progress is the Health & Disability System Review, led by Heather Simpson, which was released in June.

It is a long time since such a comprehensive study of the New Zealand health system was done, so this is a timely review and a real opportunity for all of us who work in the sector.

All systems need to take a close look at themselves from time to time and this is a chance to assess where we are at and where we need to go. I see this as an exciting opportunity to look at what we can do differently. I also believe Whanganui is well-positioned to move forward on the recommendations of the review.

Among other key developments this year, the funding to start two substantial infrastructure projects was a highlight. Plans to extend the Waimarino Health Centre in Raetihi got a $2 million boost, and this a fine example of supporting the provision of health services out in the community and of responding to and working with our communities.

It emphasises the point that we are not just about Whanganui but that we also have to look at our infrastructure out in more remote and rural areas.

The other project that got the go-ahead is the proposal for a new chemotherapy and infusions unit on the hospital campus. This reflects the importance of providing satellite services that increase access for our population and the unit will greatly reduce the need to travel for many of our patients.

The concepts of improving accessibility through satellite services is one which has been much discussed and supported among the chairs of the Central Region DHBs. We are very keen to see where we can collaborate and look at what we can do better together, and this should lead to improvements across the region.

Extending access to high-end tertiary services and to elective surgery will produce a more equitable health system, and this is very much at the forefront of our thinking.

Finally, I should acknowledge the new board that has come together in a governance role at the DHB. We have a good mixture in our group, and they offer some unique perspectives on health issues, both local and national.

I am pleased with the way we are working with chief executive Russell Simpson who is a very grounded leader of the organisation and shows a good understanding of the wider health requirements.

And, of course, I must thank and pay tribute to our staff for the tremendous work they have done in a very trying year. The huge impact of the coronavirus pandemic has put extra strain on our people and our systems, but we have found that when the challenges come, people stand up to meet them.

Our people have been outstanding, and I and the rest of the board thank them for their efforts.

Ken Whelan
Toihau - WDHB Board Chair

CHIEF EXECUTIVE'S REPORT

The 2019-2020 year has been one like no other, and the health system and our society as a whole has been challenged in a way that many of us have never experienced. The coronavirus pandemic has cast a long shadow over the second half of the 2019-2020 year, just as it has over the world at large.

The arrival of the virus in New Zealand – the first case was reported on 28 February – represented a huge challenge for the country's health services, and Whanganui was no exception even though, as things turned out, we were impacted much less than many other district health boards. The pandemic proved to be a rigorous test of our ingenuity and agility, and I am proud that Whanganui was able to produce such an effective health response.

Our role was to keep the community safe and that meant keeping the virus out of the hospital (while preparing a 32-bed isolation ward in case of a severe outbreak); treating people out in the community; and initiating a region-wide testing regime.

We also had to mitigate the impacts on our staff, particularly those on the frontline where extra pressures, stress and anxiety all had to be contended with.

It is heartening to be able to report that we achieved all that, and that Whanganui had just nine cases of COVID-19, all dealt with in isolated settings rather than hospital and all happily recovered. While the pandemic is not over, we remain prepared should we need to enact our community and hospital plans.

We owe a lot to the skill, commitment and adaptability of our staff and the staff of many other health providers and community organisations. We also owe a lot to the important relationships we had already established with numerous agencies, and those relationships have come through the crisis stronger than ever. The emergency operations team and recovery team were both strikingly multi-agency and our close relationships with iwi meant Māori health concerns were always at the fore.

Most significantly, our partnership with the Whanganui Regional Health Network was crucial in the delivery of widespread testing for the virus.

There is a saying, bandied around a lot in recent months, along the lines of: "Never let a good crisis go to waste." And the idea that the pandemic might be a catalyst for change has some resonance with Whanganui District Health Board.

During the coronavirus crisis we had to move quickly, and the introduction of video consultations and 'pop-up' testing centres, and the focus of treating people in the community and being less hospital-centric all pointed to a way forward in the development of our health services.

We have an opportunity to build on the positive system changes and lessons learned from COVID-19, and these steps in our evolution and shifts in ways of working will underpin our vision of He Hāpori Ora - Thriving Communities and the new strategy we are developing.

The re-shaping of our services began pre-COVID with a restructure of the organisation – Transition 2019. We needed a new structure to best represent our new strategic goals of a more community-focused approach that put the patient and their whānau/family at the centre of things. Transition 2019 was a lengthy and complex process involving extensive consultation with staff, but it was very necessary as it has set the foundation for our future direction.

Going hand-in-hand with this progress has been our investment in technology. The introduction of Microsoft's Office 365 system and innovations such as telehealth virtual consultations (ensuring patients don't have to always travel to attend appointments) will make us a more efficient and nimble organisation and will save us money in the long run.

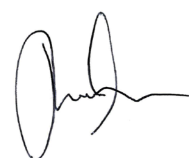
I have been heartened by the way our staff, across all disciplines, have taken on board the changes and adapted to new ways of working. Their commitment gives us optimism for the future and the challenges that lie ahead. The year ahead, 2020-2021 will not be any easier as COVID-19 continues to pose a threat.

We welcome the findings of the Health and Disability review and are excited by what the future holds for the New Zealand Health system. The review highlights the importance of the collective workings with other government and non-government agencies, a way of working this DHB commenced approximately three years ago.

I would like to thank my board chair, Ken Whelan, for his leadership, guidance and wisdom which has been invaluable, particularly when navigating a global pandemic. To the current board members, thank you for your continued support. And a special note of thanks for their service to our community to those board members whose term came to a close over the past year – Dame Tariana Turia, Darren Hull, Jenny Duncan and our previous chair Dot McKinnon.

To Mary Bennett and Hauora ā Iwi, thank you for your commitment to improving the health outcomes for Māori across our rohe and for your guidance as we progress as a pro-equity organisation. To our primary health organisations, the Whanganui Regional Health Network and National Hauora Coalition, I have appreciated how we are moving towards working as one system, and the leadership of Judith MacDonald and Rawiri Jansen needs to be acknowledged.

Thanks to my executive team and the 1200 staff at Whanganui District Health Board. Your commitment to our community, dedication and professionalism makes it a privilege to be your kaihautū hauora, chief executive. Finally to our region's 69,000 residents, you have a health service we can all be proud of and your continued feedback and support is always appreciated.



Russell Simpson
Kaihautū Hauora - WDHB Chief Executive

HAUORA Ā IWI - MĀORI RELATIONSHIP BOARD

Our relationship with the six iwi is strong and continues to grow through the partnership board, Hauora ā Iwi, which has advised and worked with the district health board and committee members contributing to annual and regional planning, executive recruitment and the wider work of the statutory committees. The two boards have met together throughout the year.

Mary Bennett is chair of Hauora ā Iwi and we acknowledge Mary's commitment and leadership.

As at 30 June 2020, the members of Hauora ā Iwi are:

- **Whanganui:** Te Aroha McDonnell and Sharlene Tapa-Mosen
- **Ngarauru Kītahi:** Mary Bennett (Chair) and Wheturangi Walsh-Tapiata
- **Ngā Wairiki Ngāti Apa:** James Allen and (Dr) Cherryl Smith
- **Mōkai Patea:** Barbara Ball and Maraea Bellamy
- **Ngāti Hauiti:** (Dr) Heather Gifford
- **Ngāti Rangi:** Hayley Robinson

We appreciate this relationship and thank each of the members and their iwi for their ongoing commitment to improving the community's health and their willingness to contribute to the success of our district health board. We are pleased to include the following report from Hauora ā Iwi.

'Ohinepani landing. Above the silence' *- Charles Ranginui*

HAUORA Ā IWI REPORT

E te Pōari, tēnei te reo o ngā mana whenua o tō tātou rohe e maioha atu ana ki a koutou katoa.
Ko ngā mate kua huri ki tua o pae maumahara, rātou kua okioki.
Ki a tātou, ngā morehurehu, tēnā tātou katoa.

As the tides of change ebb and flow, so too does iwi representation around the Hauora ā Iwi table. Cherryl Smith and Hayley Robinson joined Hauora ā Iwi in 2020, to represent Ngā Wairiki-Ngāti Apa and Ngāti Rangi respectively. Cherryl brings academic rigour and challenge from years of study and research in the environment and health spheres. Hayley injects some youthful and inquisitive kōrero to our debates and has recently completed her nursing training. We welcome them both into our midst.

The new Whanganui District Health Board took office in December 2019. Hauora ā Iwi acknowledge and congratulate the ministerial appointments of Soraya Peke-Mason and Materoa Mar as Māori representatives on the Board. Materoa, who is not from our rohe, advocated for local iwi representation on the Board and stood down from the role. He mihi maioha ki a koe Materoa ki te whakanui i a tātou o Hauora ā Iwi, te Pōari Hauora o Whanganui hoki, ka nui te aroha ki a koe i runga tou huarahi. At the time of writing we are still awaiting the appointment of a new member to fill the second Māori representative vacancy.

We also congratulate Talia Anderson-Town, a ministerial appointment who is also tangata whenua. Talia brings finance and audit skills and experience to the Board table and is the Chair of the Finance, Risk and Audit Committee.

COVID-19 was a significant challenge for our health system in 2020. Our rohe response demonstrated how collaboration and focus can make a significant difference to our communities. Iwi mobilised to ensure whānau and hapū were well informed and able to access the services they needed. The entire health system joined forces to keep communities safe, introducing mobile services, virtual consultations and other models of care that had whānau wellbeing at the core.

Pop-up clinics offered flu vaccinations and immunisations alongside COVID-19 testing. Our Māori Health Providers were in the thick of it and we wish to thank you all for your hard work, continued support and commitment to improving the health and wellbeing of our people.

Part of our reflection on that time is to gain a better understanding of the real impact of COVID-19 on our communities and any unintended consequences, due to postponed appointments or treatments and the like, from the whole situation. We look forward to sharing our findings in the near future.

The final report from the Health and Disability System Review, Pūrongo Whakamutunga was released in June 2020. The Report is detailed and complex, and Hauora ā Iwi has taken time to unpack and digest everything. We stand poised to receive the incoming Government's response to the review recommendations. Of particular interest are the responses to the possible establishment of a Māori Health Authority, Hauora Māori and ensuring equitable outcomes across the system. Leadership, collaboration and innovation will be critical as we commit to transforming the Health and Disability System. We support the kōrero from a number of our national Māori leaders; calling for a more ambitious approach by Government to health reform if we really want to alter the trajectory of Māori health inequalities.

The Pro-Equity Check-up commissioned by the Whanganui District Health Board in 2018 is now firmly entrenched within the organisation, with equity underpinning all activity in the Annual Plans. Achieving equity of access to health services and equity in health outcomes, more especially for Māori, remains a priority. This was of particular concern during the first wave of COVID-19 Alert Levels 3 and 4 where racism and bias could have impacted negatively on our most vulnerable populations. Due to our very low COVID-19 infection rates, our WDHB health system has not been tested in this regard. In the coming year we will pay particular attention to the equity agenda and the changes needed to achieve health equity and better outcomes for Māori.

COVID-19 interrupted the release of the Whanganui District Health Board Strategy document, He Hāpori Ora - Thriving Communities. It also tested the three Strategic Focus Areas of Mana Taurite - Pro-Equity; Kāwanatanga Hāpori - Social Governance and; Noho ora pai i tōu kāinga - Healthy at home: Every bed matters. The Strategy challenges the current system to be more creative about how and where services are delivered to communities, with a sharp focus on collaborative leadership that more deliberately addresses the social determinants of health. The Strategy has a three-year life span and Hauora ā Iwi will challenge progress and achievement of the Strategy over that period.

More than ever before we have been exposed to what a smarter whānau and community-centred health system might look like. With their networks and connections to hard to reach communties, our Māori workforce are critical to achieving those goals. Whether you work within the system or in the community, thank you for all you do for our people and the wider community.

Nā
Hauora ā Iwi

CHIEF FINANCIAL OFFICER'S REPORT

The Whanganui District Health Board recorded a deficit of $15.4 million in 2019/20, an increase of $1.75 million, compared to 2018/19 ($13.65 million deficit). The 2019/20 result does include $2.8 million of additional Holiday Act Compliance costs. The total provision for the remediation of the Holiday Act now stands at $7.0 million which is expected to start to be paid out to employees (current and past) in 2021.

The deficit is higher than budget by $2.8 million compared to budgeted deficit of $12.60 million. Excluding the movement in the Holiday Act provision, the Whanganui District Health Board achieved it's operating budget – a notable achievement in light of the financial impact of COVID-19 and cost of treatments outside of the region (inter-district flows).

Compared to 2018/19, revenue increased by $13.9 million (5.2%) to $279.7 million. Costs increased by $15.6 million (5.6%) to $295.2 million.

The underlying population-based funding increase in 2019/20 was 3.6%, which was then topped up to cover higher than anticipated wage settlements and price uplift for various service contracts.

The cost increase of $15.6 million included an increase in the Holidays Act remediation provision of $2.8 million. The remaining $12.8 million increase included staff costs of $2.4 million due to significant national multi-employer collective agreement wage settlements and increase in staff numbers. This increase was partly driven by the need to meet roster requirements in the multi-employer collective agreements and patient acuity. Other cost increases include $1.5 million for clinical, infrastructure and non-clinical supplies, $0.3 million in outsourced clinical service mainly relating to radiology, $3.7 million relating to health of older people, mental health and other community service due to price uplift, $1.5 million in inter-district outflow, the growth has been due to cardiology, cardiothoracic and vascular surgery, neurology and haematology and $3.5 million of new non-health board provider costs relating to COVID-19.

Investment in regional health information systems projects has slowed, with the regional network now operationally-focused.

An investment of $0.6 million has been applied to enhancing and maintaining existing regional systems. A further $2.2 million was invested in clinical equipment and facilities.

Cash position has improved by $0.8 million at the financial year end from $3 million at 30 June 2019 to $3.8 million at 30 June 2020.

The improvement in cash position is due to $7 million deficit support received from Ministry of Health. The operating deficit of $15.4 million, while significant, has not had a similar cash impact due to depreciation less capital expenditure and other non-cash items. Investment in property, plant, equipment and intangible assets were $3.1 million.

The financial results over the past few years has shown a worsening trend as the cost base has grown faster than revenue. The gap between revenue and cost has grown over the years. However, with the uplift in funding for 2020-21 year's budget, the Whanganui District Health Board has put plans in place to significantly improve the deficit position with an aim of moving to a break-even position within the next two years.

The main drivers of this improved deficit position in 2020/21 are an increase in population-based funding due to increased population, improved integration service across health and the wider social sector, internal efficiencies, improved utilisation of workforce improved referral systems to maximise use of existing capacity.

To maintain financial viability in 2020/21, the board will need to access its available bank overdraft facility funding of up to $12.2 million.

Andrew McKinnon
General Manager Corporate (Chief Financial Officer)

	2020 Actual	2020 Budget	2019 Actual
Revenue			
Revenue	**279,679**	**275,766**	**265,799**
Expense			
Personnel (including outsourced, excluding Holiday Act costs)	(104,425)	(104,250)	(98,414)
Outsourced service	(7,502)	(7,519)	(7,190)
Clinical and Infrastructure & Non-Clinical Supplies	(42,466)	(42,269)	(40,993)
Other health provider	(92,623)	(91,035)	(85,470)
Inter district outflow	(45,247)	(43,290)	(43,778)
Expense (excluding Holiday Act Compliance)	**(292,263)**	**(288,363)**	**(275,845)**
Deficit before Holiday Act Compliance expense	**(12,584)**	**(12,597)**	**(10,046)**
Expenses			
Holiday Act Compliance expense	(2,820)	(-)	(3,608)
Deficit	**(15, 404)**	**(12, 597)**	**(13, 654)**

in thousands of New Zealand dollars

FINANCIAL SUMMARY

The 2019/20 financial result of $12.6 million deficit before considering Holiday Act Compliance costs in line with budgeted deficit of $12.6 million. Including Holiday Act Compliance costs the result is $2.8 million adverse to budget.

Revenue breakdown

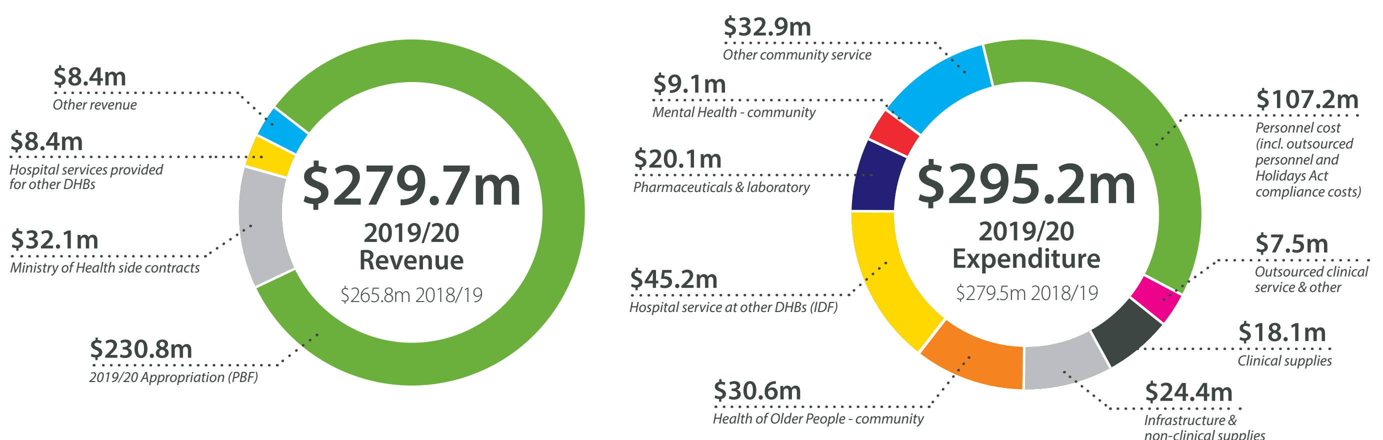
Revenue for the year of $279.7 million was $13.9 million, or 5.2% higher when compared with prior year revenue of $265.8 million.

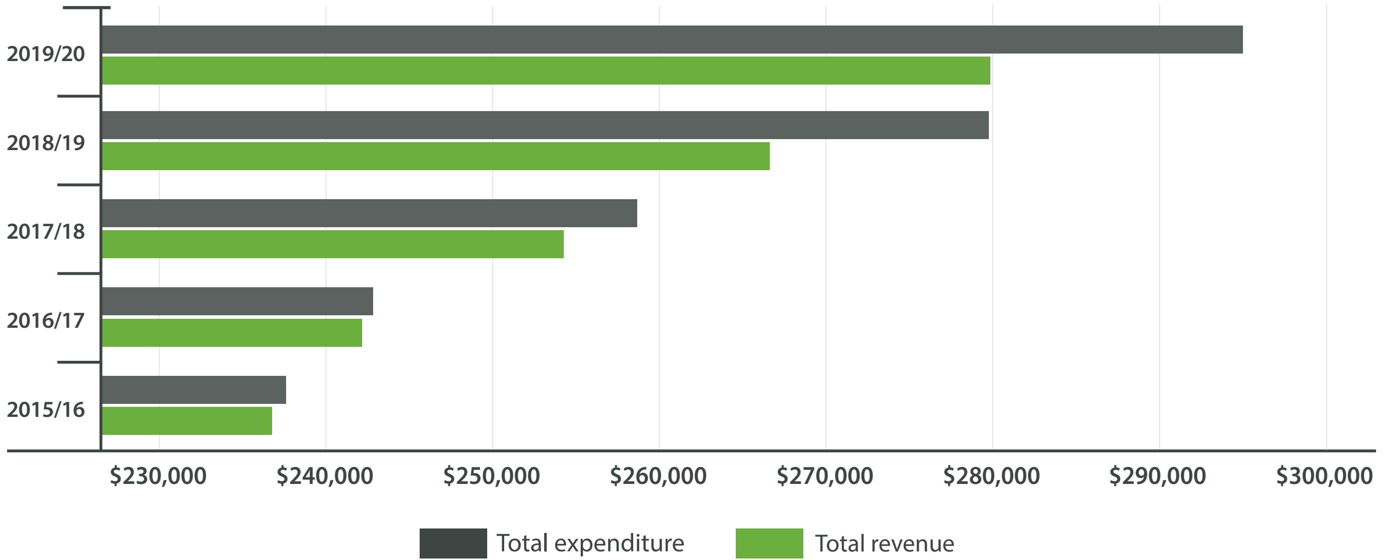
- Population-based funding was $8.1 million or 3.6% higher than the prior year.
- COVID-19 funding was $3.9 million, this revenue was passed on to other health providers.
- Primary care funding for Community Services Card holders, CarePlus and Very Low Cost Access for under-6s and under-14s was $1.3 million higher than the prior year. This revenue was passed on to primary care providers.
- Home and community support (care and support workers) pay equity settlement was $1.2 million higher than the prior year, this revenue was passed on to home and community support providers.
- Elective initiative funding was $0.5 million, higher than the prior year due to an increase in annual funding to improve access to care.
- Integrated Primary Mental Health & Addiction Service, bowel screening and school-based health funding grew by $0.6 million compared to the prior year.
- One-off Care Capacity and Demand Management (CCDM) funding for implementing a programme to align patient demand with staff resourcing of $0.7 million received in the prior year did not continue in to the current year.
- Accident compensations (ACC) revenue was $1 million lower than the prior year due to the impact of COVID-19 and in the prior year revenue of $0.7 million was received for a single patient which was not received in the current year.

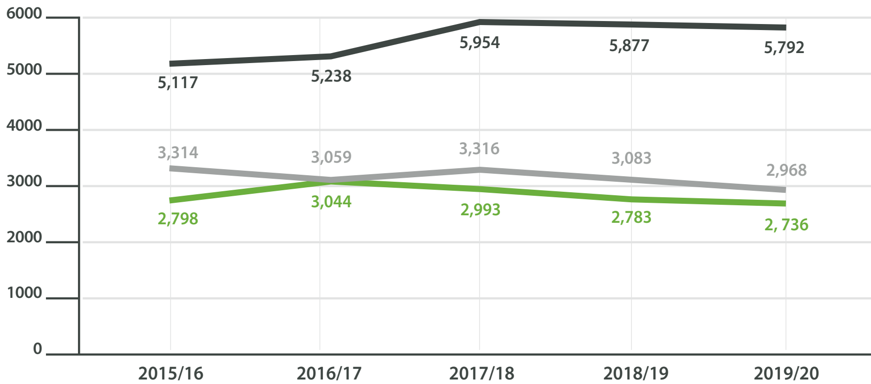
Expenditure breakdown

Expenditure for the year of $295.2 million was $16.4 million, or 5.2% higher when compared with the prior year expense of $279.5 million.

- Personnel costs (including outsourced and excluding Holiday Act costs) were $6 million, or 6.1% higher than the prior year, due to increases in the multi-employer collective agreement.
- Outsourced service costs were $0.3 million, or 4.3% higher than the prior year, due to high demand for radiology services.
- Clinical supplies, infrastructure and non-clinical supplies were $1.5 million, or 3.6% higher than the prior year, due to COVID-19 costs, telecommunication and information technology (IT) Microsoft software license cost.
- The purchase of services from other health board providers was $7.2 million or 8.4% higher than the prior year, due to COVID-19 costs of $3.5m, increased spend on health of older people, primary care capitation, pay equity and price uplifts - this was partly offset by additional funding received for primary care capitation and pay equity.
- Inter-district outflow to other district health boards were $1.5 million or 3.36% higher than the prior year, primarily due to demand for haematology, cardiology, cardiothoracic and vascular surgery at Capital and Coast District Health Board; and for general surgery and price uplifts.
- Holiday Act Compliance - Refer to Note 15 in the financial statements.

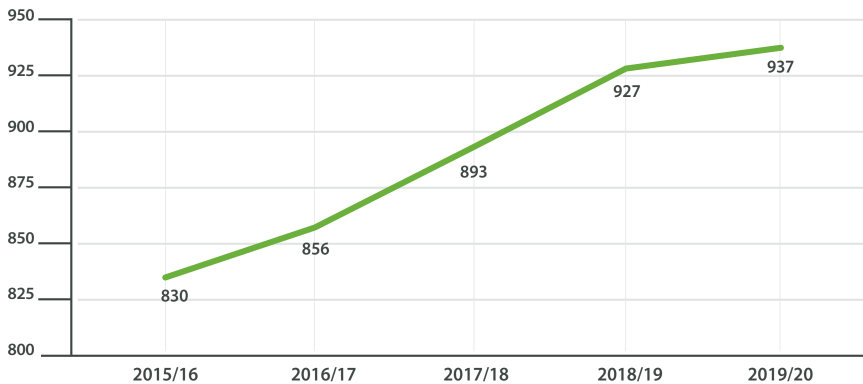






Overall inpatient caseweight volume was 2.1% lower than the prior year, mainly due to the impact of COVID-19 on service.

- Acute Medical
- Acute surgical
- Elective surgical



Full time equivalents were 1.07% higher than the prior year, mainly in nursing due to meeting the Care Capacity and Demand Management (CCDM) of clinical need.

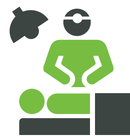
- Full time equivalents (FTE)

WHAT WE PROVIDED IN 2019/20

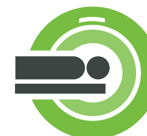
PROVIDER DIVISION (Whanganui Hospital and Waimarino and Rangitikei rural health centres)

21,163
PATIENTS THROUGH EMERGENCY DEPARTMENT
2018/19: 21,697

8,356
INPATIENT STAYS
2018/19: 8,604



3,558
OPERATIONS
2018/19: 4,274



54,688
RADIOLOGY TESTS
2018/19: 54,899

937
FULL TIME EQUIVALENT (FTE) STAFF
2018/19: 927

257
NEW INPATIENT ADMISSIONS TO MENTAL HEALTH
2018/19: 249

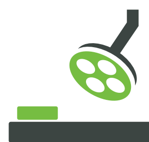
45,558
SPECIALIST OUTPATIENT APPOINTMENTS*
2018/19: 45,658

$98m
TOTAL WAGE BILL
2018/19: $94.1m

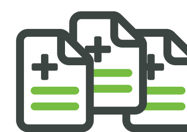
705
BIRTHS
IN WHANGANUI HOSPITAL/RURAL HEALTH SERVICE
2018/19: 728

SUPPORTED **185**
PEOPLE WHO DIED IN HOSPITAL
2018/19: 160

2,681
ALL ELECTIVE SURGICAL OPERATIONS*
(WITH ANAESTHETIC)
2018/19: 3,337

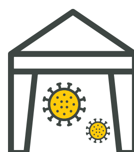


877
ALL ACUTE EMERGENCY OPERATIONS*
(WITH ANAESTHETIC)
2018/19: 937



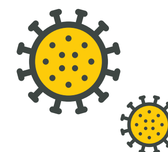
184
PEOPLE HAVING MORE THAN 3 ACUTE ADMISSIONS
2018/19: 192

COVID-19 PANDEMIC



6,069
ATTENDANCE
AT ASSESSMENT CENTRE

4,724
SWABS TAKEN



9
POSITIVE CASES
ALL RECOVERED

* Definition for these measures has changed from similar measures reported in previous years.

OUR ORGANISATION

TE RŌPŪ WHAKAHAERE

PURPOSE & OBJECTIVES

Whanganui District Health Board is a body corporate owned by the Crown and operates as an agent of the Crown. It was established under the New Zealand Public Health and Disability Act 2000.

Whanganui District Health Board has four key functions or core areas of business:

i. Assessment of health needs, planning and monitoring of health and disability services

ii. Funding and purchasing health and disability services

iii. Providing health and disability services, through a directly managed, Crown-owned public hospital, and home and community-based services

iv. Governance, administration and management of the Whanganui District Health Board in regard to the function or core business areas above.

To carry out its functions and deliver on its core business areas, Whanganui District Health Board is organised into three divisions:

- Service and Business Planning Division
- Provider Division
- Corporate Services & Governance and Administration.

SERVICE AND BUSINESS PLANNING DIVISION

The primary responsibility of the Service and Business Planning division is to plan, fund and purchase health and disability services for the community within the Whanganui region with particular attention to:

- personal health (primary and secondary)
- mental health
- Māori health
- disability support services (people aged 65 and above).

This division also funds access to specialist services that are not delivered by the Provider division within the Whanganui region.

In these core health and disability services, the Service and Business Planning division undertakes to:

- determine population health and disability needs
- develop health improvement strategies
- monitor service quality and address quality issues
- ensure service coverage for the resident population
- manage contracts and funding
- manage provider relationships.

PROVIDER DIVISION (Whanganui Hospital / rural health centres)

The Provider division provides secondary and community specialist health services which are funded at a revenue level of about $134m per annum. These secondary level services include:

- medical, rehabilitation, community and rural
- surgical
- maternity and child health
- public health
- mental health
- Māori health
- disability support.

A comprehensive range of diagnostic and commercial services such as medical imaging, laboratory, medical records, building maintenance and finance supports these services.

CORPORATE SERVICES DIVISION

Corporate Services provides corporate infrastructure and information systems to support both the Strategy Commission and Public Health divisions. The support includes:

- financial management and payroll services
- information technology and management
- legal and commercial risk and quality systems
- facilities and contract management
- materials management: supply and distribution.

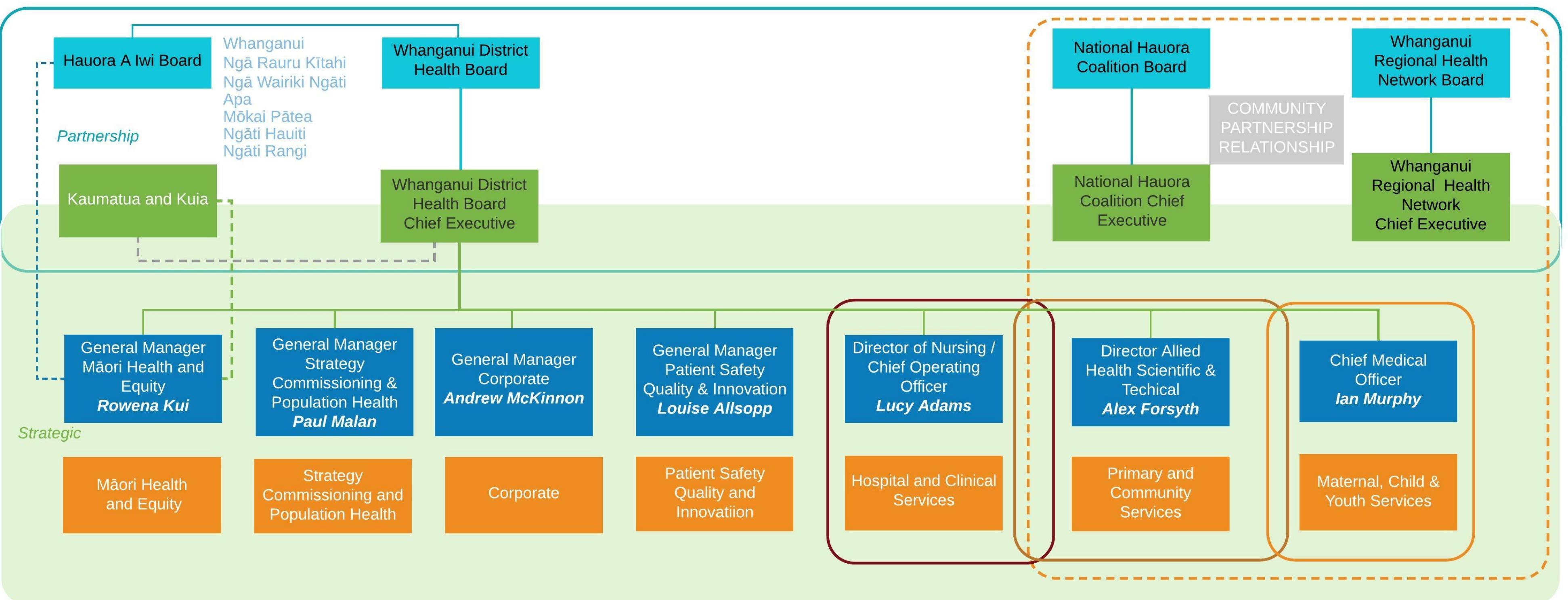
There are a number of other functions that are directly responsible to the chief executive officer and provide a service across both the Strategy Commission and Public Health divisions. These include media and communications, human resources and industrial relations.

CORPORATE GOVERNANCE

Whanganui District Health Board has a set of values that recognise responsibilities to stakeholders, patients, employees, the community and the environment.

The board places great importance in the highest standards of governance and continually reviews its governance practices to address Whanganui District Health Board's obligations as a responsible corporate citizen.

WHANGANUI DISTRICT HEALTH BOARD ORGANISATIONAL STRUCTURE as at 30 June 2020



KEY	
Chief Executive	Coloured solid direct reporting line
Executive	
Senior Clinical	Coloured dotted professional reporting lines
Senior Manager	Grey dash is functional relationship
Responsibility	

Community partnership relationships
- District Councils
- Regional council
- TePuni Kokiri
- Office of Treaty Settlements
- Iwi Provider Organisations
- Health Families
- Safer Whanganui
- Ruapehu Whānau Transformation Trust
- Oranga Tamariki
- FLOW
-Others

ROLE OF THE BOARD

The board is responsible to its owner, the Crown, through the Minister of Health for the overall governance and performance of Whanganui District Health Board.

THE BOARD

The board primarily represents the long-term interest of shareholders by:

- providing strategic direction to Whanganui District Health Board through constructive engagement with the executive leadership team in the development, execution and modification of the District Strategic Plan and Whanganui District Health Board Annual Plan
- appointing the chief executive
- monitoring the performance of the chief executive
- approving remuneration strategies and policies
- reporting to the Minister of Health/Ministry of Health and ensuring that all legislative and regulatory requirements are met
- ensuring appropriate compliance frameworks and controls are in place
- approving recommendations regarding major capital expenditure and significant changes to major financing arrangements
- making decisions in relation to initiatives or matters otherwise not dealt with as part of the District Strategic Plan and Whanganui District Health Board Annual Plan process
- approving policies governing the operations of Whanganui District Health Board
- monitoring financial results on an ongoing basis
- ensuring the board's effectiveness in delivering best practice governance
- ensuring Whanganui District Health Board's business is conducted ethically and transparently
- reviewing strategic risk management including identifying areas of significant business risk, monitoring risk management policies and procedures, overseeing internal controls and reviewing major assumptions in the calculation of risk exposures
- listening and responding to the Minister of Health's view on the management and direction of Whanganui District Health Board
- considering the interest of the community and stakeholders.

BOARD COMPOSITION AND SIZE

The size of the board is determined through the New Zealand Public Health and Disability Act 2000, which provides for a maximum of 11 board members. Seven members are elected by the community and four are appointed by the Minister of Health. The chairperson and deputy chairperson of the board are appointed by the Minister of Health. Board members are elected/appointed for a term of three years.

HAUORA Ā IWI

Whanganui District Health Board has a legislative requirement to build and maintain relationships with iwi Māori under section 4 of the New Zealand Public Health and Disability Act 2000. Hauora ā Iwi has been established by Whanganui District Health Board to contribute to the advancement of Māori health outcomes and to ensure access and delivery of health services to Māori.

Hauora ā Iwi is made up of iwi (tribal entities which have influence within or partly within the Whanganui District Health Board region) and their organisations that represent tangata whenua. The functions of the Hauora ā Iwi Māori Relationship Board is to give advice to Whanganui District Health Board on behalf of the iwi collectives on the needs and aspirations of the Māori population. Whanganui District Health Board acknowledges Hauora ā Iwi for their ongoing partnership and support over the 2019/20 financial year.

The iwi recognised by Whanganui District Health Board under Hauora ā Iwi are:

- Tupoho/Whanganui
- Ngā Wairiki Ngāti Apa
- Ngāti Hauiti
- Ngāti Rangi
- Ngā Rauru Kitahi
- Mokai Patea
- Tamaupoko Whanganui

The ***Manatu Whakaaetanga Memorandum of Understanding*** between Hauora ā Iwi and Whanganui District Health Board 2017-20 describes how the boards work in partnership to improve equity in health outcomes for Māori whānau, residing in the Whanganui District Health Board area.

The boards share the guiding principles of a common interest and commitment to improving equity and advancing Māori health; building on gains already made in improving Māori health; acknowledging the impact of health determinants and the importance of cross-sector collaboration; taking responsibility for where they can influence and effect change. Recognising their various roles and accountabilities, the boards work collaboratively across the sector to ensure the values, beliefs, and practices of both organisations are considered and respected when taking into account any legal obligations of a Crown agency, public sector organisation or iwi entity.

The aim is to build a relationship that enables an effective partnership that takes them beyond their legislative requirements to achieve the goals. The goals are:

1. Giving effect to Whānau Ora – the right service, at the right time, in the right place, in the right way.
2. Achieving health equity for Māori - monitoring performance through reporting.
3. Improving capacity and enhancing capability – systems, delivery options and workforce.

Hauora ā Iwi advise and participate in governance decision making related to Māori health and have representation on district health board statutory committees. The boards meet regularly and jointly monitor achievement in improving equity in health outcomes for Māori and priority service improvements and initiatives.

He Korowai Oranga, NZ Māori Health Strategy, provides strategic direction and guidance to Whanganui District Health Board governance and management for Māori health improvement with an overarching aim of Pae Ora – healthy futures.

CONDUCT OF BOARD BUSINESS

The board holds formal meetings each year, and will also meet whenever necessary to carry out its responsibilities.

When conducting board business, board members have a duty to question, request information, raise issues of concern, fully canvas all aspects of any issue confronting Whanganui District Health Board and vote on any resolution according to their judgement.

Board members keep confidential board discussions, deliberations and decisions that are not required to be disclosed publicly.

CONFLICT OF INTEREST

Board members are required to continually monitor and disclose any potential conflict of interest that may arise. Board members must:

- disclose to the board any actual or potential conflicts of interest that may exist as soon as situations arise.
- take necessary and reasonable steps to resolve any potential conflict of interest within an appropriate period, if required by the board or deemed appropriate by the board member.
- comply with the New Zealand Public Health and Disability Act 2000 and Crown Entities Act 2004 requirements about disclosing interests and restrictions on voting.

ACCESS TO INFORMATION

Board members are encouraged to access members of the executive leadership team, through the chief executive, to request relevant information.

Board members are entitled to seek independent advice on Whanganui District Health Board related matters at the expense of the organisation. Board members must ensure that the costs are reasonable, can be met within budget and must seek the chairperson's approval before the advice is sought. This advice must be made available to the rest of the board.

CORPORATE ASSURANCE

The board receives regular reports about the financial condition and operational results of Whanganui District Health Board.

The board receives and considers annual confirmation from the chief executive and general manager corporate, stating that:

- the organisation's financial results present a true and fair view of the financial position and performance
- the risk management and internal compliance and control systems are sound, appropriate and operating efficiently and effectively in all material aspects.

RISK MANAGEMENT

The board has overall responsibility for ensuring there is a sound system of risk management, internal compliance and control across the business. It also has responsibility for establishing risk management policies and the risk appetite of the organisation and ensuring these are implemented.

Specific monitoring and evaluation of the effectiveness of risk management and the internal control environment are delegated to the Finance, Risk and Audit Committee made up of four board members and two independent members.

The committee meets five times a year. The Finance, Risk and Audit Committee monitors and evaluates a wide range of activity within the Whanganui District Health Board.

Key areas of focus for the committee include:

Risk framework and monitoring risk

The committee maintains oversight of the risk framework and receives reports on clinical and financial risks. All strategic and operational risks with a high rating are reported to the committee.

The committee ensures the adequacy of the insurance programme and annual renewal process. Patient safety is a key focus area. Financial performance and forecasts are also monitored by the committee, particularly adverse trends.

Monitoring health and safety

The committee monitors key risks and the annual health and safety system audit assurance activities. Health and safety matters are reported to the full board.

External and internal audit assurance programme, internal control systems

After considering key risks and the audit cycle around key financial systems, the committee establishes an annual internal audit programme. This programme covers both clinical and financial systems and can include issue-based audits. The audits are diverse and include for example such matters as the equity of health outcomes for Māori, clinical governance systems and the management of Accident Compensation Corporation revenue.

Our external auditors, Deloitte Limited (appointed by the Office of the Auditor-General), carry out an independent financial audit of the financial statements and statement of service performance annually. The committee provide input into the audit plan and monitor management progress on system improvements.

Through the work of internal and external auditor, the Finance, Risk and Audit Committee is able to form a view of the effectiveness of internal control systems.

Monitoring clinical governance, patient safety and privacy

Significant adverse events are reported to the committee and then the board. Clinical governance and clinical leaders advise the committee on key issues, risks and mitigation plans. Complaint, incident and privacy trends are monitored and reported to the committee.

Monitoring external provider performance

A contract performance audit programme is maintained for external providers, including progress on performance improvements. This audit programme covers a wide range of providers, including rest home providers, community pharmacies and primary health organisations.

Emergency management readiness and business continuity

The committee receives a report on the organisation's emergency management plan and readiness annually as well as response outcomes from mass casualty events.

Monitoring fraud and corruption

The committee receives regular reports on fraud management, including fraud detection activities undertaken by the Ministry of Health, of the centralised external provider payment system. Any suspicions of fraud are investigated and outcomes reported to the committee. The committee is advised of any reports made to the national Health Integrity Line that involve staff or providers of this district health board.

THE COMMITTEES

The board has established committees to consider certain issues and functions in further detail. The chairperson of each committee reports on any matter of substance at the next full board meeting. All committee papers and minutes are made available to the board.

There are two standing committees:

- Combined Statutory Advisory Committee*
- Finance, Risk and Audit Committee

* Denotes statutory board committee as per the New Zealand Public Health and Disability Act 2000. Other committees may be formed from time to time, as required. Each committee has its own terms of reference, approved by the board and reviewed regularly, with additional reviews when appropriate.

The board appoints and reviews membership of external appointees to statutory committees.

The structure and membership of the board and its committees is summarised in the table below.

Committees of the Whanganui District Health Board as at 30 June 2020

Chair	Board members	External members	Functions
Combined Statutory Advisory Committee			
Stuart Hylton *(chair from July 2019 to Dec 2019)* Annette Main *(chair from Dec 2019 to June 2020)*	Charlie Anderson Graham Adams Phillipa Baker-Hogan *(July 2019 to Dec 2019)* Maraea Bellamy Jenny Duncan Darren Hull Judith MacDonald Dot McKinnon Tariana Turia *(Dec 2019 to June 2020)* Josh Chandul-Mackay Ken Whelan Soraya Peke-Mason	Frank Bristol Heather Gifford *(July 2019 to Sep 2019)* Grace Taiaroa *(July 2019 to Dec 2019)* Andrew Brown Leslie Gilsenan Matthew Rayner *(Oct 2019 to June 2020)* Te Aroha McDonnell *(Dec 2019 to June 2020)* Maraea Bellamy Deborah Smith Christie Teki	Assess health needs, disability support needs and health status of the resident population. Advise the board on health funding priorities and promote policy that maximises gains, and improves equity, in health outcomes. Annual purchasing plan and framework as part of business planning. Monitor financial and operational performance of the hospital and related services. Assess strategic issues and governance policy relating to provision of hospital services.
Finance, Risk and Audit Committee			
Darren Hull *(chair from July 2019 to Dec 2019)* Talia Anderson-Town *(chair from Dec 2019 to June 2020)*	*(July 2019 to Dec 2019)* Annette Main Dot McKinnon Tariana Turia Jenny Duncan *(Dec 2019 to June 2020)* Stuart Hylton Judith MacDonald Ken Whelan	Anne Kolbe *(July 2019 to Dec 2019)* Malcolm Inglis *(Dec 2019 to June 2020)* Matthew Doyle	Clinical and business risk management framework including compliance and internal controls. Integrity of Financial Statements and Statement of Performance. Relationship with external auditor.

BOARD & COMMITTEE MEMBER ATTENDANCE RECORD

1 July 2019 to 30 June 2020

The board meets on a six-weekly basis and holds extra meetings when required for planning or other specific issues.

	Board	Combined WDHB & HAI	Combined Statutory Advisory Committee	Finance, Risk and Audit Committee
Number of meetings held	**7**	**2**	**6**	**5**
Board members				
Mr Ken Whelan *(chair from Dec 2019)*	**4**	**1**	N/A	**2**
Dot McKinnon *(chair to Dec 2019)*	**3**	**1**	**2**	**3**
Annette Main *(deputy chair from Dec 2019)*	**7**	**1**	**5**	**2**
Stuart Hylton *(deputy chair to Dec 2019)*	**4**	**1**	**4**	**2**
Philippa Baker-Hogan	**5**	**1**	**4**	N/A
Judith MacDonald	**5**	**2**	**3**	**2**
Graham Adams	**4**	**2**	**6**	N/A
Charlie Anderson	**7**	**1**	**5**	N/A
Jenny Duncan (*to Dec 2019*)	**2**	**0**	**3**	**2**
Tariana Turia (*to Dec 2019*)	**2**	**0**	**3**	**1**
Darren Hull (*to Dec 2019*)	**3**	**1**	**4**	**3**
Maraea Bellamy (*to Dec 2019*)	**2**	**0**	**4**	N/A
Talia Anderson-Town (*from Dec 2019*)	**2**	**1**	N/A	**2**
Josh Chandulal-Mackay (*from Dec 2019*)	**4**	**1**	**2**	N/A
Soraya Peke-Mason (*from Dec 2019*)	**4**	**0**	**1**	N/A
External committee members				
Frank Bristol			**6**	N/A
Heather Gifford			**5**	N/A
Te Aroha McDonnell			**2**	N/A
Grace Taiaroa *(to Sep 2019)*			**2**	N/A
Andrew Brown *(to Dec 2019)*			**2**	N/A
Matthew Rayner *(to Dec 2019)*			**4**	N/A
Anne Kolbe			N/A	**4**
Leslie Gilsenan *(to Dec 2019)*			**1**	N/A
Malcolm Inglis *(to Dec 2019)*			N/A	**2**
Christie Teki *(from Dec 2019)*			**2**	N/A
Deborah Smith *(from Dec 2019)*			**2**	N/A
Matthew Doyle *(from Dec 2019)*			N/A	**1**

Hauora ā Iwi	Hauora ā Iwi		
	12		
Mary Bennett *(chair)*	**12**	**1**	N/A
Barbara Ball	**10**	**0**	N/A
Maraea Bellamy	**11**	**0**	**5**
Te Aroha McDonnell	**12**	**1**	**4**
Hayden Potaka *(to July 2019)*	**0**	**0**	N/A
James Allen	**10**	**1**	N/A
Heather Gifford	**9**	**1**	**5**
Grace Taiaroa *(to Sep 2019)*	**3**	**0**	**2**
Sharlene Tapa-Mosen	**7**	**0**	N/A
Valanique Callaghan *(to July 2019)*	**0**	**0**	N/A
Wheturangi Walsh-Tapiata *(from Aug 2019)*	**11**	**1**	N/A
Cherryl Smith *(from May 2020)*	**2**	**0**	N/A
Hayley Robinson *(from June 2020)*	**1**	**0**	N/A

OUR BOARD

KEN WHELAN | *Toihau - Board chair*

"My background is in nursing but I've been in management for more than 20 years. Overall, I have had more than 40 years' experience in both the New Zealand and Australian health sectors.

"Currently I'm Crown Monitor for Counties and Waikato DHBs and chair the Eastern Bay of Plenty primary health organisation. Previously I was chief executive of Northland and Capital Coast District Health Boards and Deputy Director General of Health Performance and Purchasing in New South Wales.

"In Queensland I was chief executive of the Townsville health district, a large tertiary facility in north Queensland where the population was spread over a large geographical area which meant equity of access to care was a significant challenge.

"Prior to returning to New Zealand, I was chief executive of Metro North in Brisbane.

"As the new chair of Whanganui DHB, I'm looking forward to working with the Māori advisory board, Hauora ā Iwi, local health providers and other community organisations."

ANNETTE MAIN | *Deputy board chair*

"Joining the Whanganui District Health Board in October 2017 has given me the opportunity to share the knowledge and understanding of our community gained when I held the position of Whanganui mayor for six years.

"This followed 12 years as an elected member on the Manawatu Whanganui Regional Council which provided me with the wider regional view needed. I have a balanced perspective on the intersect between the health sector and wider aspirations for the wellbeing of our communities."

GRAHAM ADAMS

"I was first elected to the district health board in 2004 and served just the one term. I was elected again in 2016.

"My working career has been in the finance industry - primarily in banking but also as a sharebroker/financial adviser. Although born in Whanganui it was not until 1974 that I first came to live here when I was appointed to manage the National Bank branch, a term lasting six years before being appointed Funds Manager in head office, Wellington. I resigned in 1984 and returned to live here permanently.

"I am a board member of Age Concern and sole remaining original trustee of the Akoranga Education Trust founded in 1985 whose "raison-d'etre" is to provide scholarship and assistance to students from Whanganui."

CHARLIE ANDERSON

"During the 1970s when there were no dedicated rescue helicopters or fixed wing air ambulances, I was a helicopter pilot who regularly flew sick or injured people to the closest hospital. During my 40-year career as a helicopter pilot, I was privileged to witness, and be part of, the establishment and growth of New Zealand's excellent air ambulance and rescue services. In 1996 I was again privileged to be awarded the Queen's Service Medal for my role in rescue work and life-saving flights.

"In my time as chief executive for Air Wanganui Commuter, we carried out approximately 500 air ambulance flights a year from Whanganui alone. I remain committed to the development of aero medical support, Whanganui's air ambulance service, the Whanganui District Health Board and our district's health services overall. In addition to my role as a first-term district health board member, I am also a second-term district councillor."

TALIA TIORI ANDERSON-TOWN

"Ko Talia Tiori Anderson-Town tōku ingoa. I te taha ō tōku matua ko Ngāti Maru (Hauraki) tōku iwi, I te taha ō tōku whaea ko Ngā Wairiki Ngāti Apa, Ngā Rauru, Ngāti Tuwharetoa, Te Atihaunui-a-Pāpārangi me Ngāti Kahungungu. Nō reira ko Rātana tōku tūrangawaewae, tōku kainga.

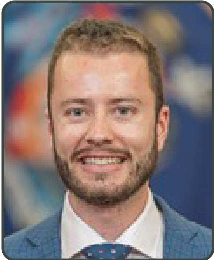
"I am a director and audit partner of Silks Audit Chartered Accountants Limited Whanganui. I am a Chartered Accountant and Qualified Auditor with Chartered Accountants Australia New Zealand, Appointed Auditor of the Office of the Auditor General and Licensed Auditor registered with the Financial Markets Authority. I have over 15 years of audit experience while having the roles of graduate, senior auditor, audit manager and engagement partner.

"I was appointed to Whanganui DHB in December 2019. I am very pleased to be able to contribute to the governance of the Whanganui DHB and as a mother of three young children it is important to me to maintain and enhance existing health services and to provide easy access and progressive outcomes for our whānau and our people."

PHILIPPA BAKER-HOGAN

"I was elected on the Whanganui District Health Board in 2004 and have also been a councillor for the Whanganui District Council since 2006.

"I have over 20 years experience in the health system. I am a qualified medical radiation technologist. Our board employs many committed health professionals and support staff but has massive challenges in providing equitable health services to our diverse community, which has high health needs. I'm committed to using my experience and strong voice to support improved health outcomes for our most vulnerable."



JOSH CHANDULAL-MACKAY

"I feel privileged to have been elected to the Whanganui District Health Board and to be able to contribute to our public health system. My involvement in health extends back to my school years when I began volunteering at Nazareth Rest Home and the Home of Compassion, providing assistance to diversional therapists and interacting with elderly people dealing with loneliness, cognitive decline and dementia, bereavement and loss of independence.

"While studying psychology and politics at Massey University I completed training as a voluntary Youthline counsellor and carried out that role for two years. In 2016 I completed my degree and returned to Whanganui where I was elected as a Whanganui district councillor and, in 2019, re-elected for a second term.

"I am deputy chair of Youth Services Trust Whanganui which provides healthcare services for people aged between 10-24, and I joined the board of Age Concern Whanganui in 2019. I hold governance roles on St Anne's Catholic School board of trustees and the Hakeke Street Community Centre Trust. I am also an independent marriage and civil union celebrant, enjoy a full social life in Whanganui and am looking forward to focusing on equity and outcomes during my term on the DHB."

STUART HYLTON

"I was appointed to the board in June 2014 and elected for a second term in 2016, appointed as deputy board chair and chair of the Combined Statutory Advisory Committee. I'm Whanganui born and educated and currently run my own consultancy business offering services that include strategic development, business planning, policy advice, regulatory management and waste management advice. I hold the statutory role of Whanganui's District Licensing (Alcohol) Commissioner. My academic qualifications and professional background traverse 25+ years in local government covering a multitude of disciplines.

"I have held a number of director or trustee roles and am involved in both the Central Districts and Whanganui Cancer Society executive, a director in Whanganui Rotary Club, a Waimarie Operations Trustee, a Whanganui Education Trustee and a George Boulton Trustee.

"I've always believed living a healthy, active lifestyle assists overall health, wellbeing and independence. Therefore, I generally advocate for emphasis within our primary and preventative healthcare systems. I look forward to serving on the Whanganui District Health Board and working with management to continually improve community access to a responsive and integrated healthcare system."

JUDITH MACDONALD

"I was elected to the Whanganui District Health Board in 2010. I have worked in the Whanganui district as a clinician and senior manager since the early 1980s initially at Taihape Hospital and latterly in Whanganui.

"I hold a range of directorships and chair multiple committees related to health and social issues. Currently, I am a director of Taihape Health, Whanganui Accident and Medical, and Gonville Health Ltd. My family and I have lived in this district all our lives and it is important to me that we have a range of quality health services for our people."

SORAYA PEKE-MASON

(Ngāti Rangi, Ngāti Apa, Atihau-nui-a Paparangi, Ngāti Uenuku, Ngāti Haua, Ngāti Tuwharetoa, Ngāti Tamateraa – Hauraki Waikato, Te Iwi Morehu)

"It was humbling to be appointed to the Whanganui District Health Board in December 2019. I come with experience in private enterprise, iwi, community and land development and have sound governance experience.

"I spent many years working in Australia in the construction, tourism, and hospitality sectors with a short stint in health before returning home to Whanganui in 2000. Since then I have been immersed in local and central government politics, iwi and Māori land development and am director of my company, Land Trust Management Services Ltd. From 2007-2019 I was a member of Rangitikei District Council.

"Based in Ohakune, I am chair of the post-settlement governance entity, Te Totarahoe o Paerangi – Ngati Rangi, and have been appointed to Whanganui Community Foundation. I also sit on marae and land trusts.

"I am humbled and pleased to continue being of service to the people of our districts' and putting good governance experience to sound use in this important role on Whanganui District Health Board"

OUR EXECUTIVE LEADERSHIP TEAM

RUSSELL SIMPSON | *Kaihautū Hauora - Chief Executive*

“I have worked in both the public and private sector at clinical, management and executive levels. My previous role was as a national general manager in the home and community support sector. Prior to that I worked across Hutt Valley and Wairarapa district health boards as an executive director.

"I originally trained as a physiologist specialising in pain management and neurophysiology. I am passionate about improving the health of our community with a strong whole-of-health system approach, in partnership with our intersectoral partners and our community.”

ANDREW McKINNON | *General Manager, Corporate (Chief Financial Officer)*

"I began this role in November 2019 and I am happy to be back in Whanganui, as I spent my early childhood growing up in the region at Koriniti and Aberfeldy.

"Before taking up this role, I spent 13 years as chief financial officer at University of Waikato. Previously I was finance manager at Victoria University of Wellington and prior to that, treasurer at Tranzrail Limited. My career began as an auditor at KPMG in Wellington.

"Throughout my career I have always focused on supporting organisations by developing solutions to enable organisational objectives. I am both solutions and customer service focused and am looking forward to continually improve what we do here at the Whanganui District Health Board to achieve our vision of He Hāpori Ora - Thriving Communities."

LUCY ADAMS | *Director of Nursing and Chief Operating Officer*

"I took up the role of director of nursing at Whanganui District Health Board in May 2019. Prior to this I was employed at Waitemata District Health Board as an associate director of nursing and have had clinical governance nursing director positions in Queensland, Australia.

"I trained as a comprehensive nurse in the late 1980s and worked at Auckland District Health Board, and specialised in neurosurgery and neurointensive care before transferring to emergency nursing. During my tenure there I was involved in the change management programme and was an occupational health and safety adviser. I then joined the New Zealand Police and continued in an occupational health and safety role and was a key project manager for the implementation of stab resistant body armour, along with other projects. I was then appointed to St John as a health emergency manager where I implemented the Ministry of Health emergency management project, the Emergo Train system. I have worked in Australia, New Zealand and the Caribbean, in public and private hospitals, on cruise ships and in rural and remote areas. I have a Bachelor of Nursing, Masters in Health Sciences and an MBA.”

LOUISE ALLSOPP | *General Manager Patient Safety Quality and Innovation*

"I am originally from the Dorset in the south of England. I trained as a pharmacist in Bath before moving to New Zealand in 2002.

"I joined the Whanganui District Health Board as a mental health pharmacist, and then became pharmacy manager and Allied Health manager before taking over in Patient Safety.

"I have enjoyed a number of leadership roles including, most recently, being incident controller at the Emergency Operations Centre during the COVID-19 pandemic."

ALEX FORSYTH | *Director Allied Health Scientific and Technical*

"I initially trained as a speech and language therapist and have over 20 years clinical experience across different areas of health from cradle to grave and home to hospital, based mainly in Christchurch and Auckland, before moving to the UK in 2004. In the UK, I worked as a clinical specialist at Great Ormond Street Hospital for Children in London, and in a senior leadership position at Hertfordshire Community NHS Trust, before returning to New Zealand to work as the Allied Health Lead at Whakatane Hospital, for the Bay of Plenty District Health Board.

"When our family moved back to New Zealand we wanted a sense of community and work/life balance. Connection and the outdoors are very important to us and we believe Whanganui is a place that can offer us the community we want our young children to grow up in. My passion is to ensure Whanganui District Health Board continues to work with the community and within the community to empower people to take charge of their own health. DHBs are part of a wider health system and we need to work with others to ensure we give the greatest benefit to its users. I am passionate about reducing inequity for Māori and ensuring we honour Te Tiriti o Waitangi in all we do."

ROWENA KUI | *Kaiuringi Māori Health and Equity*

"I am of Te Ātiawa descent. I am a nurse and midwife by training and have extensive experience working in Māori health, rural health, and health service planning and development. I enjoy leadership and the opportunity to impart my knowledge and experience to support others to grow and develop.

"I am passionate about Māori health. I believe that the Māori concept of whānau ora provides the perfect framework for the district health board and community providers to deliver services in such a way that collectively we can make a significantly positive impact on the health of Māori whānau and the health of our most vulnerable population groups."

PAUL MALAN | *General Manager Service and Business Planning*

"Before coming to Whanganui District Health Board in September 2018, I spent 12 years with Hawke's Bay District Health Board – first in finance and then in planning and funding. Prior to that, I worked in the private sector gaining experience in financial services, investment banking, business consultancy, tourism, manufacturing and agriculture.

"My academic training is in economics and public health and that complements my interest in the public sector's role in a well-functioning, developed economy. I am passionate about effectiveness of the public sector and how we partner with the private for-profit and not-for-profit sectors to provide equitable and valuable services to the communities we are part of.

"I grew up in a rural community in Zimbabwe and have always admired the ingenuity that is evident in small communities with a strong identity – I get a sense of those factors in Whanganui. My wife grew up in Hastings and we returned to Aotearoa New Zealand with our two sons in 2001."

IAN MURPHY | *Chief Medical Officer*

"I trained at the Auckland University School of Medicine before working at Waikato Hospital as a junior doctor. That was followed by sports and exercise medicine fellowship (FACSEP) training, initially in Auckland followed by a stint in Australia where I began a long involvement with professional team sport.

"Returning to New Zealand, I spent seven seasons with the Hurricanes Super Rugby franchise as well as working in private practice. In 2012, I became chief medical officer with the NZ Rugby Union, a job which has evolved to include improved player safety and welfare. I have also held similar roles with NZ Cricket and Paralympics New Zealand through this time.

"Alongside my role with the Whanganui District Health Board, I am currently employed as a principal clinical adviser with ACC.

"I grew up in the rural Whanganui community of Brunswick and attended school here. I moved back to Whanganui four years ago with my wife and four children and am loving every minute of it."

OUR PEOPLE

TE HUNGA ORA

WORKFORCE PROFILE

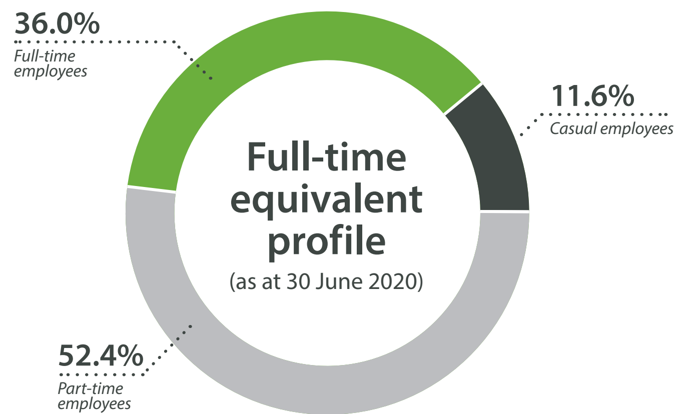
The Whanganui District Health Board workforce is made up of Medical (8.5%), Nursing (48.4%), Midwifery (2.3%), Allied Health (18.9%), Administration/Management (21.4%) and Support (0.4%) employees.

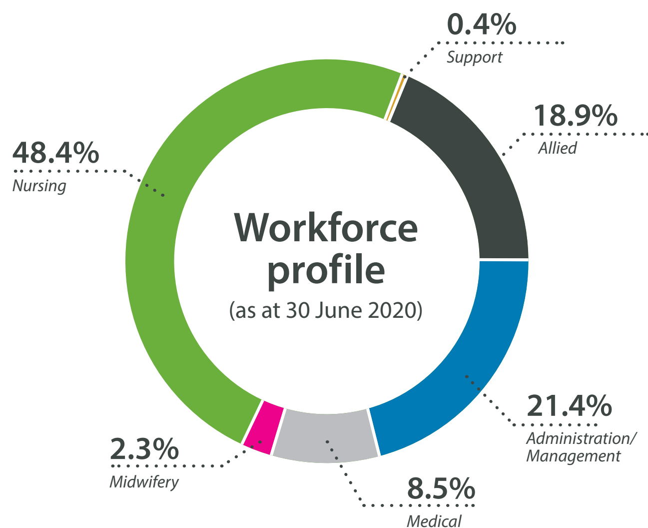
Whanganui District Health Board enjoys a stable employee complement with an average length of employee service of 9.7 years. The organisational employee turnover was 7.3 % for the financial year.

Employee gender, age, ethnicity and disability information are provided on a voluntary basis. The tables (right) depict the Whanganui District Health Board 's age, gender, ethnicity, and disability profile of participating employees, include permanent and temporary employees, excluding casual staff working at the Whanganui District Health Board.

Notes:

- Report includes: permanent and temporary employees
- Report excludes: Casual employees
- Full-time Equivalent (FTE) = 862
- Headcount = 1030





AGE PROFILE

Age band	Count	Percentage
20-29	123	11.9%
30-39	187	18.2%
40-49	233	22.6%
50-59	291	28.3%
60-69	188	18.3%
70+	8	0.8%

MEDIAN AGE PROFILE

Median female age	48 years
Median male age	51 years

GENDER PROFILE

Gender	Count	Percentage
F	836	81.2%
G	1	0.1%
M	193	18.7%

ETHNICITY PROFILE

NZ European/Pakeha	51.7%
European	15.4%
Māori	12.4%
Asian	8.4%
Other	7.0%
African	2.5%
Pacific	1.2%
Middle Eastern	0.2%
Latin American	0.2%
Not stated	0.9%

DISABILITY PROFILE

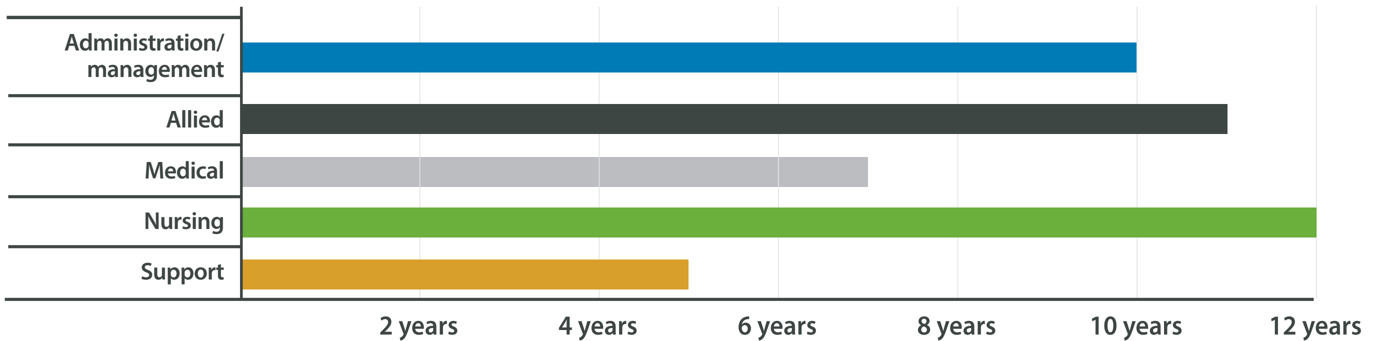
Employees	Percentage
13	1.3%

GENDER BY OCCUPATIONAL CATEGORY

Occupational category	F	G	M
Administration/ Management	184	-	36
Allied	164	-	31
Medical	32	-	56
Midwifery	24	-	-
Nursing	429	1	69
Support	3	-	1

Service profile

(as at 30 June 2020)



ETHNICITY PROFILE BY OCCUPATIONAL CATEGORY

Occupational category	African	Asian	European	Latin American	Māori	Middle Eastern	NZ European	Pacific	Other	Not stated
Administration /Management	5	7	33	-	28	-	127	-	20	-
Allied	5	10	21	1	29	-	116	1	11	1
Medical	9	23	29	-	2	2	8	1	8	6
Midwifery	-	-	9	-	1	-	12	-	2	-
Nursing	7	47	67	1	65	-	269	10	31	2
Support	-	-	-	-	3	-	1	-	-	-

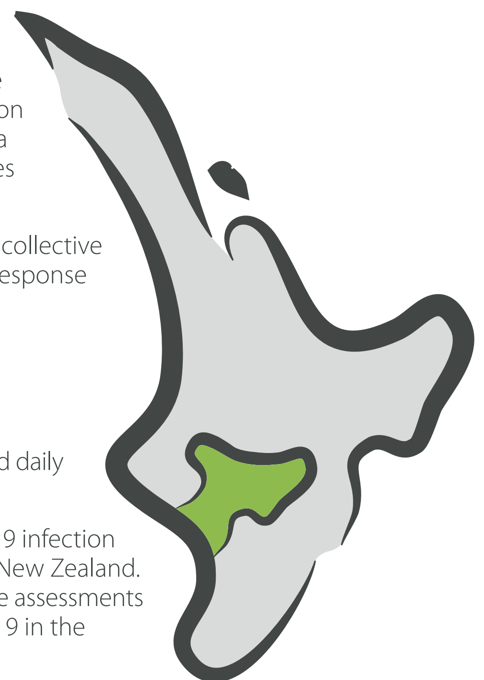
GENDER PAY GAP

	Female	Male
Median	$75, 945	$83, 712
Gender pay gap	9.3%	

ETHNICITY PAY GAP

	Asian	Māori	Pacific	Other
Median	$77, 886	$67, 126	$72, 945	$77, 386
Pay gap	-0.6%	13.3%	5.7%	

NATIONALLY & REGIONALLY



Whanganui District Health Board works collaboratively with the five other DHBs in the Central Region (MidCentral, Capital & Coast, Hawkes Bay, Hutt Valley and Wairarapa) on regional and vulnerable services, including workforce matters. All 20 DHBs support a strong national workforce and work collaboratively supporting national programmes and policies and promoting health as a career of choice.

COVID-19 disrupted many of the 2019/20 year's planned activities, but supported a collective response to the pandemic. The national district health board COVID-19 workforce response was based on collaboration, flexibility, agility, duty of care and focussed on:

- Staff wellbeing
- Employment relations
- Workforce deployment.
- Occupational health and safety
- Business continuity

The COVID-19 approach emphasised regular local and national union engagement and daily chief executive communication to all staff.

A risk assessment framework for identifying staff possibly vulnerable to the COVID-19 infection was developed by district health board occupational health specialists from across New Zealand. The assessment framework categorised individuals in one of four risk categories. These assessments were then applied against local circumstances, including the prevalence of COVID-19 in the community, work function, role and work area.

Whanganui District Health Board employees participated in a survey to assess the impact of COVID-19 on employees and results were shared with all staff. Nationally an audit of the impact of COVID-19 on DHB employees was undertaken.

BEING A GOOD EMPLOYER

As a good employer, Whanganui District Health Board is committed to:

- a safe, healthy and supportive environment for all
- the equal employment and fair and equal treatment of all employees
- upholding any legislative requirements.

A key measure of our success is a place where staff want to work, and where they want their whānau/ family and themselves to receive treatment when needed. Staff retention figures provides an indication of being a good employer. The average length of service (retention) of Whanganui District Health Board employees is 9.7 years.

OUR LEGAL RESPONSIBILITIES

In accordance with section 118 of the Crown Entities Act 2004, the Whanganui District Health Board actively maintains and implements programmes, policies and initiatives to promote equity, fairness and a safe and healthy work environment.

- Good and safe working conditions
- An equal employment opportunities programme
- Impartial selection of suitably qualified persons for appointment
- Recognition within the workplace of the aims, aspirations and cultural differences of Māori, other ethnic or minority groups, women and persons with disabilities
- Opportunities for the enhancement of the abilities of individual employees
- Staff and union partners actively participate in employment policy and procedure development and review.

OUR WORKFORCE COMMITMENT

Building a workforce with the right number of people, with the right skills, in the right place, at the right time, with the right attitude, doing the right work, at the right cost and with the right work output (World Health Organization, 2010 Workload indicators of staffing needs).

The executive leadership team (ELT) champions equal employment opportunities and leads fair and equal treatment of all employees.

We are committed to:

- an open and transparent organisation
- a healthy and just workplace
- ensuring every staff member enjoys coming to work and goes home feeling stimulated, challenged but professionally rewarded
- enabling every staff member to grow professionally; to develop and feel physically and emotionally safe at work
- putting patient safety first and always taking precedence over 'balancing the budget'
- expecting staff to hold the executive leadership team to their commitments
- policies and procedures for the fair and proper treatment of employees in all aspects of their employment.

We want all our staff to be able to make a personal commitment to practice in a truly patient and whānau/family-centred way, rather than provider or management-centred way, and to:

- be part of an organisation that really listens to the voice of patients and their whānau
- put themselves in the shoes of the patient and whānau and want for them what we would want for our own whānau
- welcome the community into Whanganui Hospital and encourage family participation in care and decision-making
- give a high level of understanding and support to those who make a mistake, with zero tolerance for hiding or not acknowledging our errors
- take personal responsibility for having our own voice heard so that every idea to make our environment safer and healthier for patients, whānau/families and staff is considered
- have the personal courage to stand up and speak out against workplace bullying.

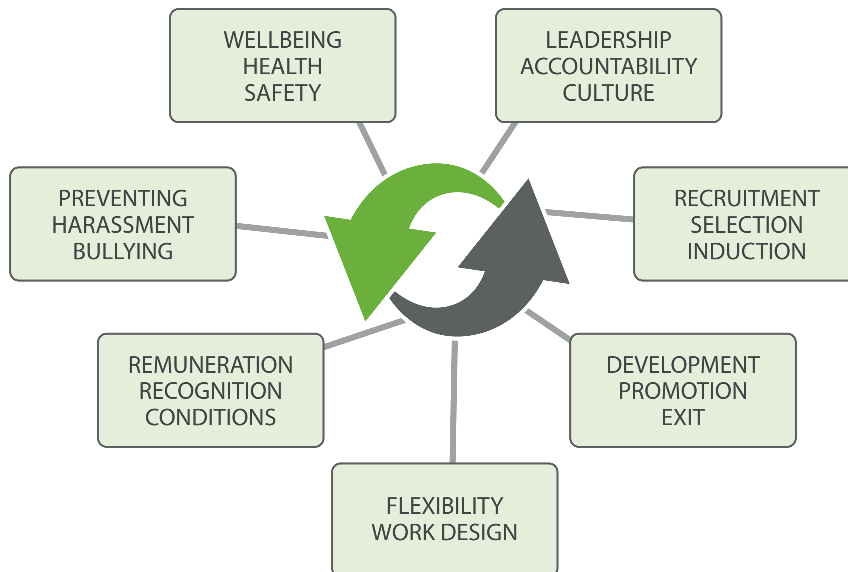
Following a board strategy refresh, the Whanganui District Health Board's strategy was defined as He Hāpori Ora - Thriving Communities.

The three strategic focus areas are:

- **Mana Taurite** - Pro-equity
- **Kāwanatanga Hāpori** - Social Governance
- **Noho ora pai i tōu ake kāinga** - Healthy at home: every bed matters.

GOOD EMPLOYER: THE SEVEN KEY ELEMENTS

Whanganui District Health Board continue to invest in the seven elements which make up a good employer.



The Whanganui District Health Board's ambitions and activities to achieve the seven key elements of being a good employer are summarised below:

Leadership, accountability and culture

OUR AMBITIONS

- Employees, patients and community trust in us.
- Visible clinical and devolved leadership.
- Governance processes provide assurance.
- Clear direction and articulation of our strategy.
- Employees at all levels are engaged.
- Employees participate at every opportunity.

OUR ACTIONS

- Reporting culture – we actively encourage patients to complain and staff to report all accidents, incidents and near misses in order to learn and improve our practices, processes and systems.
- During 2019/20 our Kōrero Mai - Speak Up and Be Heard programme was relaunched. This programme aims to address engagement issues between staff and patients and their whānau, and to overcome barriers to earlier identification of deteriorating patients.
- Open disclosure conversations with whānau following adverse outcomes.
- Engaged board and executive leadership team.
- Leaders visible in the organisation and district.
- Visibility of key organisational activities at executive and governance level i.e. health and safety, patient care, service delivery, system improvement, risks, etc.
- Vision and values articulated in the annual plan and endorsed by the board of Whanganui District Health Board.
- Whānau ora philosophy and cultural competencies socialised at Hapai to Hoe (organisational orientation programme) for all new staff.
- He Waka Hourua as the next step in Whanganui District Health Board's cultural training programme focussing on equity, pro-equity and health literacy.
- Appropriate appointments at all levels. Recruitment panels for leadership roles includes a member of the Te Hau Ranga Ora team. Recruitment panels for executive roles includes a member of the Hauora ā Iwi board.
- Clinical leadership across medical, nursing and allied health, scientific and technical workforces.
- Support restorative practices and remedy problems as efficiently as possible, while being respectful of the individual.

- Speaking up for Safety™ programme contributing to preventing unintended patient harm. Speaking up for Safety™ encourage and enable all staff to feel comfortable in speaking up about safety and quality issues. This fits with our organisation's commitment to achieving the safest and best care for our patients, and providing a safe environment for our staff.
- Use of Te Reo Māori across the system – greetings, signage, information to whānau and improved pronunciation through Te Reo Māori sessions onsite.
- Implementation of a new organisational structure, focusing on accountability with an executive lead for each service.
- Leading the district's response to COVID-19 with a focus on 'Reset, Redesign and Recovery', a collaborative team comprising of representation from Whanganui District Health Board, Whanganui District Council, Rangitikei District Council, Ruapehu District Council, Whanganui Regional Health Network, iwi and supporting agencies, and focus on economic, health and social aspects of recovery.
- Build Māori workforce and Māori health equity and equity capability with the appointment of two kaitakitaki with Te Hau Ranga Ora Māori Health Service. Their mahi focus on increasing Māori workforce, improving capability and building Māori leadership capacity across the health system alongside our commitment to pro-equity for Māori and whānau ora.
- Agreed equity framework and targets for the Central Region.
- Regional ethnicity data collection and reporting.

Recruitment, selection & induction

OUR AMBITIONS

- Robust and transparent recruitment and selection processes.
- No barriers or biases to the employment of the best person for the job.
- Whanganui District Health Board employee demographics appropriately reflect the community it serves.

OUR ACTIONS

- Fair and transparent recruitment and selection to ensure we meet current and future workforce needs and retain employees.
- Not compromising appointment decisions just for the sake of having someone in the role.
- Appointments based on values, fit, whānau ora and equity with the Whanganui District Health Board.
- Grow Māori workforce across the health district – implementation of Whanganui District Health Board Māori workforce pipeline and the Ministry of Health Raranga Tupuake – Māori Workforce Development Plan.
- Proactively promote Health Workforce New Zealand (HWNZ) funding for Māori particularly in kura kaupapa settings.
- Activities supporting growing our own workforce i.e. health careers promotion in schools and health career days.
- Pro-equity review of our activities with action plans to improve shared understanding of equity and its drivers, championing a pro-equity approach and everyone taking responsibility for Māori health.
- Review of the Whanganui District Health Board recruitment policy and procedures in consultation with unions to support robust recruitment and retention of Māori and Pacific staff.
- Development and implementation of a dashboard providing key data on the recruitment and retention of Māori and Pacific in the Central Region and DHBs.
- Disability training programme for all staff implemented in 2019/20.

Employee development, promotion & exit

OUR AMBITIONS

- Transparent and fair performance practices.
- Supporting career growth, creativity, innovation and service delivery.
- Employees engaged in personal and professional growth.
- Fostering key clinical and high performing employees.
- Skills and expertise to ensure quality safe service delivery.
- Succession planning for key roles.
- Development of required technical, managerial and leadership skills.
- Employees speak positively of the Whanganui District Health Board; apply their best efforts to their work and want to remain part of the Whanganui District Health Board.

OUR ACTIONS

- Equitable training and development opportunities for all employees. COVID-19 resulted in increased online training opportunities available to more staff.
- Various MECA clauses supporting professional development.
- Encouraging and supporting formal and informal growth and development opportunities.
- A focus on growing our own workforce.
- Career growth opportunities for internal staff.
- Support programme for all new graduate Māori nurses - tuākana tāina.
- Review and implementation of Whanganui District Health Board continuing education/professional development policy and procedure in consultation with unions.
- Phase two of the Whanganui District Health Board education centre development completed to support our growing focus on workforce development.
- Cementing a relationship with the University of Otago Wellington for training interns on site at the Whanganui District Health Board.
- Low staff turnover compared with other organisations.
- Feedback processes for all exiting staff with more than sixty percent of leavers participating in the Whanganui District Health Board exit survey.
- Support the further development of skill sharing in the region by developing the Calderdale infrastructure and project support tools and resources. Two fully endorsed Calderdale practitioners and local governance groups in each region.

Flexibility & work design

OUR AMBITIONS

- Employee requirements for work/life balance are respected and taken into consideration.
- Work design supports healthy and safe workplaces.

OUR ACTIONS

- Of Whanganui District Health Board's staff, 89% were permanently employed (41% of the permanent employees work fulltime and 59% of the permanent employees work part-time) and 11% casual staff were employed. During the financial year, 1% of staff were on paid parental leave.
- Actively utilising safer staffing and rostering principles and tools (CCDM and TrendCare) to determine FTE staffing requirements.
- Dashboards (hospital at a glance) and bed management meetings enable robust conversations regarding staff numbers and skill requirements underpinned by flexible staffing.
- Workstation (ergonomic) evaluations and appropriate equipment to support individual health.
- Availability of job sharing arrangements.
- Identification and management of fatigue.

Remuneration, recognition & conditions

OUR AMBITIONS

- Employees treated as vital and equal partners.
- Recognition for contribution.

OUR ACTIONS

- All employee groups, with the exception of those Individual Employee Agreements (IEA), are governed by Multi-Employer Collective Agreements (MECAs) and remuneration and conditions are in line with the collective agreements.
- More than 80% of staff are union members.
- Staff benefits exceeding the minimum legislative requirements e.g. annual and sick leave.
- Participation in national programmes of work to review pay equity claims for various staffing groups.
- The Whanganui District Health Board supports and actively promotes professional work day's recognition such as International Nurses' Day, International Social Workers' Day, World Physiotherapy day, Administrative Professionals Day.
- Non-financial staff recognition include team functions, awards, and letters of thanks, compliments from patients and visitors, and visibility in newsletters.
- Gender pay equity negotiations underway for PSA administrative staff.
- Supporting the government's direction for pay restraint in the public sector.
- Implemented accrual of annual leave approach for all casual employees.

Harrassment and bullying prevention

OUR AMBITIONS

- Zero-tolerance approach.
- No harrassment or bullying.
- Employee confidence in Whanganui District Health Board commitment and action

OUR ACTIONS

- Zero-tolerance of all forms of harassment and bullying.
- Policies and procedures in place for dealing with harassment and/or bullying complaints and acts quickly to address complaints.
- Training for all managers in code of conduct investigations.
- Staff accountability and personal courage to stand up and speak out against workplace bullying is supported and taking action rather than inaction promoted.
- The Speaking up for Safety™ programme and Safety CODE contribute to providing a safe environment for our staff.
- A formal internal complaints procedure is in place for employees to report incidents of unacceptable behaviour, harassment or bullying, including provision of appropriate, confidential and accessible support for employees involved in or wishing to report these situations in the workplace.
- Actively supporting a Restorative Practices approach to resolving harm and repairing relationships between staff.
- Restorative leadership workshop with Whanganui District Health Board leaders, union partners, union delegates (staff) and other stakeholders.
- Support the workforce to be healthy, resilient and safe by implementing the family violence workforce support programme.
- Developing a shared regional approach for the prevention of occupational violence.

Wellbeing, healthy and safe environment

OUR AMBITIONS

- Pro-active approach to employee health and wellbeing.
- Employee participation.
- Employees are physically, culturally and psychologically safe.
- No workplace obstacles to accommodate people with disabilities.

OUR ACTIONS

- Staff, patient, visitor and contractor safety is integral to everything the Whanganui District Health Board does.
- Management and disclosure of adverse events to ensure a safe quality working environment.
- Ongoing training for managers and team leaders regarding their health and safety and injury management responsibilities.
- Executive leadership team visibility of long-term absences and injury management activities, progress and support.
- Staff reporting injuries and incidents on our Riskman incident database. Investigation of injuries/incidents.
- The Whanganui District Health Board remains a tertiary-level ACC accredited employer programme (AEP) member following the 2020 audit.
- Staff returning to work from a work/non-work injury or a medical condition are given the same support.

- Updated hazard management registers.
- Review and implementation of the Whanganui District Health Board stress management procedure in consultation with unions.
- Ongoing manual handling training.
- Purchasing more and new manual handling equipment.
- Maintaining bronze accreditation for our wellbeing programme (WorkWell). Staff identified three key priorities: physical activity, healthy eating and mental health & wellbeing.
- Participating in the Accident Compensation Commission (ACC) / 20 DHB Health and Safety Forum, sharing insights and best practice; assessing current situations, challenges, barriers and gaps; developing strategies and ideas to make the Whanganui District Health Board a safer environment; prioritising and improving the health and safety culture for all employees and essentially those who are routinely putting the wellbeing of others before themselves.
- Participate in Kāhui Oranga, a collaborative group (rōpū) made up of members from DHBs, Unions, the Ministry of Health, NZ Blood Service, and the Mental Health Foundation to support employee wellbeing in the health sector.
- Wellbeing resources available for all health employees at: ***wellbeingforhealth.co.nz/***
- In response to COVID-19, the Kāhui Oranga national wellbeing group focussed on a responsive activity that captured the themes of compassionate leadership, positive mental health and Hauora approach and developed a 'Leading for Wellbeing' webinar series, supported by video, discussion and toolsets. The following webinars are under development:
  - Compassionate leadership
  - Wellbeing in times of continued change/transition.
  - Wellbeing for all
  - Creating safety
- Promoting the positive drivers of workplace wellbeing is a priority for DHBs and our union partners. These enable our people to do and be their very best and respond to the challenges of wellbeing. We have a collective commitment to create environments in which all people can thrive at work.
- Working nationally with MBIE to further improve the guidelines for violence in the health and disability sector.

HEALTH & SAFETY

Accredited Employer Programme (AEP)

Whanganui District Health Board has participated in AEP since 2001 and has held tertiary level status since 2005.

Our tertiary status means that we show continuous improvement and best practice framework evidence that our workplace health and safety and injury management systems are in place and are effective. Tertiary status also means that Whanganui District Health Board's health and safety systems are audited biennially and injury management systems annually by an accredited ACC auditor.

High-risk hazards

Whanganui District Health Board has two high-risk hazards (aggression and manual handling) that require managing closely. The health and safety report to the board includes a graph that shows the rolling average, actual three-year breakdown of monthly incidents and a trend line over a three-year period.

Manual handling

Whanganui District Health Board manages manual handling risk by creating a culture where staff understand the risks involved and how to work safely. This is enabled by the employment of a dedicated manual handling trainer and the purchasing of specialised manual handling equipment.

The dedicated manual handling trainer provides a full-day orientation for new staff, three one-day manual training sessions (per month) for existing clinical staff, bariatric study days, unit-specific training, on-line manual handling training for clinical and non-clinical staff and training on how to use manual handling equipment. Staff participating in return to work programmes receive refresher manual handling training.

Over the past year, Whanganui District Health Board has continued to add to the existing manual handling equipment; including more sara stedy and maxi transfer sheets for Assessment Treatment and Rehabilitation Ward. An equipment review and maintenance programme is in place.

Continuous improvement includes:

- Exploring installation of a ceiling hoist in at-risk areas with specialised attachments such as a limb lifter.
- Purchasing additional specialised equipment.
- Further training for managers to enable them to identify manual handling injury risks at unit level.
- Increased focus on the behaviour change required to sustain safe work practices.
- Develop information and guidance for staff on how to take care of themselves in relation to physically demanding jobs.
- One-on-one training with ward champions to develop sustainable area specific training.

Management of aggression

Whanganui District Health Board, and specifically the hospital, is a place of healing and we recognise when people are unwell their behaviour may change. In many instances, patients are confused and this influences their behaviour. Being unwell and potentially under the influence of alcohol or drugs, further impacts negatively on behaviour.

Currently in place:

- Trained health and safety representatives.
- Safe rostering practices.
- Reporting on the incident management system.
- Ongoing training e.g. staff working on the wards are trained in managing patients with dementia and de-escalating challenging situations.
- Broset violence checklist which assesses confusion, irritability, verbal and physical threats – this enables improved pre-emption of potential changes in behaviour.
- Hub nursing.
- Staff huddles throughout the day to manage workload, pick up changes in the patient and better communication.
- Full investigation of critical incidents.
- Policies and procedures on managing escalating situations and working safely in the community.
- Care plans e.g. close observations for at-risk patients.
- Increased focus on high risk areas.
- Use of security and police e.g. in aggressive or difficult to manage situations.
- A more responsive alarm system with wider coverage in Te Awhina.
- Monthly discussions with local police regarding what is happening in our community and the impact on care.
- Te Hau Ranga Ora/Māori Health Service haumoana team who provide advice, guidance and support with escalating situations.
- Debrief workgroup in the initial stages of strengthening debrief procedures.
- Six-monthly follow up with managers to review hazards and actions.

Continuous improvement includes:

- Worked with WorkSafe in developing good practice guidance for managing the risk of violence in the health and disability sector.
- Further improve data collection and intelligence.
- Ongoing education and development of specific training for reception and administrative staff.
- Strengthening investigations and ensuring follow up actions are implemented.
- Staff and union engagement in addressing concerns and developing solutions.
- Strengthen health and safety monitoring of staff working in the community.
- Review of all Whanganui District Health Board alarm systems.
- Further strengthen aggression training.
- Implement debrief procedures identified by the workgroup.
- Further strengthen links with the police and other social agencies.

Managing aggression and de-escalating difficult situations is a top priority for Whanganui District Health Board – staff, managers, board members and union partners.

STATEMENT OF PERFORMANCE

For the year ended 30 June 2020

The Statement of Service Performance shows how the Whanganui District Health Board has performed when compared with the Statement of Performance Expectations that we published for 2019/20.

WHANGANUI DISTRICT HEALTH BOARD'S INTERVENTION LOGIC:

A key role of the health sector is to make positive changes to the health status of the population. Many of the determinants of health are beyond the district health board's influence: government priorities, national policy and decision-making, other public sectors and individuals, whānau and family themselves all have a part to play in making gains on health status.

However, as a major funder and provider of public health and disability services in the Whanganui district, decisions the district health board make have a significant impact on its population and, if well planned and coordinated, will contribute to an improved, effective and efficient healthcare system.

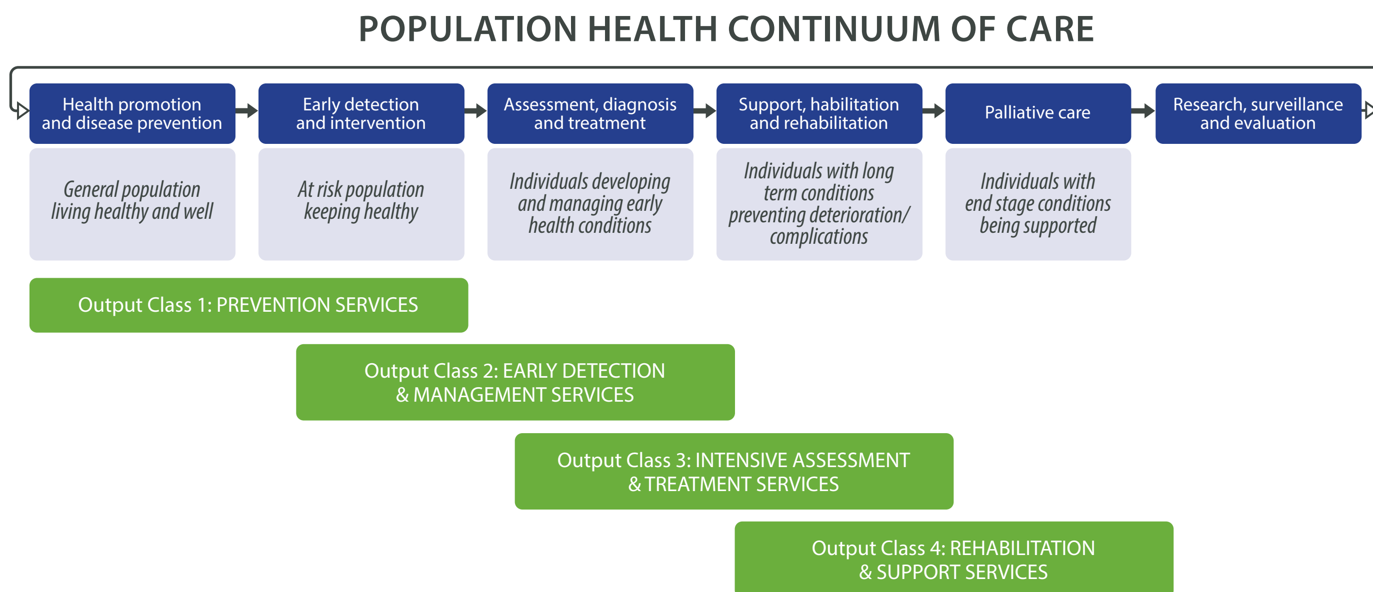
On a continuum of care, our work covers the whole population, from the many who are living healthy and well, through to the few who need support for end stage conditions. For reporting purposes we group our work into four output classes:

- **Output Class 1:** Prevention services
- **Output Class 2:** Early detection and management services
- **Output Class 3:** Intensive assessment and treatment services
- **Output Class 4:** Rehabilitation and support services.

POPULATION HEALTH CONTINUUM OF CARE

There is a relationship between the population health continuum of care and the output classes. This is depicted in diagram 1, showing that the health system responds to intensifying need with increasingly intensive and specialised health and disability services.

Diagram 1: Relationship between population health continuum of care and outputs



Services and products planned, funded and provided to the population, by district health board output classes

This shows that the district health board has obligations to meet the health needs of the population it serves ranging from promoting healthy lifestyles to the general population right through to treating and supporting individuals and their whānau/family in end of life care. In doing so, the district health board, as a Crown entity, must respond to the requirements of Parliament and the expectations and priorities of government for the public health sector.

IMPACT OF COVID-19 RESPONSE

The rise of the COVID-19 pandemic and the control measures implemented to minimise the pandemic's impact have created a number of challenges for the community, the health system and the Whanganui District Health Board. The disruption that resulted from COVID-19 required reprioritisation of resources and activities along with innovative responses to new challenges and existing systems. This is expected to continue for some time.

There were a number of rapid funding changes implemented, with the priority of enabling the health system to meet the existing health needs of the population who were now living in a more challenging environment. An integrated emergency planning approach through this period helped remove barriers and speed up the process. Changes in how some of the services were funded were also put in place to give providers surety of revenue while dealing with uncertainty around service delivery challenges and service level demands.

The reprioritisation of resources and service delivery goals as a result of the COVID-19 pandemic resulted in some less critical activities being delayed. The consolidation and publishing of health performance measures from the Ministry of Health was delayed impacting on the timeliness of information used for the Whanganui District Health Board performance reporting.

Planning information for the 2021/22 year also experienced delays as the Ministry of Health and district health boards focused planning resources on meeting the immediate needs of the community in a time of the year traditionally focused on developing the following year's annual plans.

With New Zealand and the globe continuing to feel the impacts of COVID-19, new ways of planning, funding and delivering of health services will need to be examined. Through strong integration across the social sector and the He Hāpori Ora – Thriving Communities strategy, Whanganui District Health Board is well placed to meet these challenges.

The following sections are arranged by Output Class and provide an overview across a range of measures within each, making reference to the focus areas above. The measures discussed do not cover everything we do, but are designed to give an idea of the breadth of our services and how we have performed against our expectations in the 2019/20 financial year.

A summary of 2019/20 financial performance is also included for each Output Class.

HOW TO READ THE FOLLOWING TABLES

N/A | Not available – may be due to change in reporting where ethnicity details were not available

In the non-financial performance tables 3, 5, 7 and 9, where the measure description includes a "*" followed by a date period, this refers to the period covered by the reported 2019/20 actual results.

ACHIEVEMENT COLUMN

- 🟢 Target met or exceeded
- 🟠 Target missed by less than 10%
- 🔴 Target missed by 10% or more

CHANGE COLUMN

- 🟢 No change from previous year, or an improvement
- 🟠 A negative change of less than 10% on previous year
- 🔴 A negative change of 10% or more on previous year

SUMMARY OF 2019-20 FINANCIAL PERFORMANCE BY OUTPUT CLASS

Table 1 | SUMMARY OF FINANCIAL PERFORMANCE BY OUTPUT CLASS

Consolidated	Prevention	Early detection & management	Intensive Assessment & Treatment	Support & Rehabilitation	Total
Revenue					
Crown	9, 249	53, 193	170, 446	36, 989	269, 877
Other Income	6	77	1, 325	18	1, 426
Inter-district Inflows	72	2, 040	5,053	1, 211	8, 376
Total revenue	**9, 327**	**55, 310**	**176, 824**	**38, 218**	**279, 679**
Expenditure					
Personnel costs	(1,983)	(7, 866)	(85, 461)	(2, 684)	(97, 994)
Capital charge	(192)	(382)	(2, 648)	(285)	(3, 507)
Depreciation	(12)	(215)	(5, 302)	(36)	(5, 565)
Other	(1, 594)	(7, 557)	(39, 228)	(1, 768)	(50, 147)
Other Provider Payments	(6, 954)	(40, 682)	(12, 820)	(32, 167)	(92, 623)
Inter-district Outflows	(54)	(3, 512)	(38, 614)	(3, 067)	(45, 247)
Total expenditure	**(10,789)**	**(60, 214)**	**(184, 073)**	**(40, 007)**	**(295, 083)**
(Deficit) / Surplus	**(1, 462)**	**(4, 904)**	**(7, 249)**	**(1, 789)**	**(15, 404)**

in thousands of New Zealand dollars

OUTPUT CLASS 1: PREVENTION

Prevention services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations comprising of services designed to enhance the health status of the population as distinct from treatment services which repair and support health and disability dysfunction.

On a continuum of care these services are public-wide preventative services.

Why is this output class significant?

The district health board assists people to take more responsibility for their own health and reduce the prevalence and impact of long-term illness or disease.

Reducing risk factors such as tobacco smoking, physical inactivity and alcohol consumption together with health and environmental protection factors will contribute to improved health of our population and reduce the potential for untimely and avoidable illness and death.

What outcomes are we contributing to?

- People enjoy healthy lifestyles within a healthy environment.
- The needs of specific age-related groups, e.g. older people, children/youth, are addressed .
- The healthy will remain well.

2019/20 Performance overview

A growing population increases pressures on our health services, both at hospital level and within the community, where primary care services are best placed to protect and promote health.

Whanganui is undergoing a population growth and changing demographics bring new challenges for us which we must adapt to. Services across health, and beyond, have felt these pressures, and collaborative efforts are required more than ever between agencies to alleviate the growing health needs of our district.

Following the Whanganui District Council finalising the 'Whanganui Age Friendly Plan' in August 2019, the plan was endorsed by the district's Positive Ageing Forum. Whanganui District Health Board has worked in collaboration with council to achieve this. We continued to engage with and provide support to community development initiatives as identified by the Raetihi-Ohakune-Waiouru collaboration project.

To support reaching priority populations and communities, future planning opportunities were identified to work in collaboration on Rā Hauora awareness days held at Marae across the region in 2020. Opportunities were also discussed to work together at whānau and iwi events such as Ratana and Pakaitore celebrations.

Despite the increase of community-based health care as we promote services delivered closer to the home and in communities, Whanganui District Health Board is resisting pressure to add to our current vehicle fleet. We are gaining efficiencies through initiatives that include:

- Encouraging staff to ride share to out-of-town destinations
- Replacing vehicles with hybrids. We currently have three hybrids which have proven to be suitable for community services and popular with staff.
- Being committed to upgrading the fleet with the most efficient vehicles, that are appropriate for the service they will support.

Whanganui District Health Board committed to promoting and leading implementation of healthier food and drink environments as a protective factor to preventing health loss in our region.

Two priority areas of focus for the year were the development of a Healthy Food and Drink Policy, which is making progress but is reliant on equivalent progress against a new national policy, and the creation of supportive environments for healthy eating. Supporting education settings to improve Māori health outcomes, and to promote and model healthy food and drink environments was also an important factor.

Immunisation

Despite the best efforts of the Immunisation Outreach team, numbers of parents declining to have their children vaccinated, or opting-off the programme continues to adversely impact our ability to achieve success against the 8 month immunisation measure. Improving immunisation rates continues to be a focus as does finding innovative ways to reach our target populations. During COVID-19 non-traditional pathways were used and assisted greatly in improving influenza vaccinations, in particular for Māori.

HPV vaccination rates have been impacted adversely by COVID-19 with a decline in vaccination rates compared to last year. The catch-up programme has been implemented to help mitigate the disruption caused by the pandemic. The catch-up programme is a multi-faceted approach towards increasing HPV vaccination rates amongst the population that includes outreach, education and advertising.

Influenza vaccinations among the over 65s have seen a sharp increase, particularly for Māori. The aged are particularly vulnerable to the effects of COVID-19 and with increased efforts and awareness around protecting against COVID-19, greater awareness emerged around maintaining good health and protecting against other viruses.

Smokefree 2025

The prevalence of smoking in our district continues to be higher than the national average which is reflective of our profile of increased overall population, a high and growing population of Māori and high levels of deprivation. While efforts continue on several fronts, we are not seeing these translate into improved measurable results. People enrolled with the PHO are being offered advice to quit smoking at similar rates as last year, however this still remains below the target rate.

Increased messaging around the importance of a healthy environment is, however having the desired effect, particularly among Māori mothers. Consistent and repeated encouragement, via LMC engagement, SUDI education, and Well child Tamariki Ora programmes is having a positive effect, with improved rates of pēpē being born into smokefree homes with the measure for Māori improving by more than double compared to last year. Our overarching priority is to eliminate inequity for Māori and Pacific people, who are unreasonably over-represented in smoking rates, along with pregnant women and people with mental health conditions. Therefore our intention is to redesign the current framework and focus on a model underpinned by a whānau ora concept to shift the focus from smoking cessation to providing a person-centered pathway to becoming smokefree.

Cervical screening

While we missed achieving our target of screening 80% of all women aged 25-69, we did an extra 314 screens this year - up 138 for Māori women, and 176 for non Māori. This is a considerable improvement on last year.

An integrated approach is expected to reduce barriers for women alongside robust health promotion and messaging which will support screening for priority group women – (Māori, Pacific Island and Asian women).

A localised flyer has been developed and is currently being trialed for feedback. The flyer contains simple, clear localised screening messages and information appropriate for Māori, Pacific and Asian women, developed through the combined communications network.

Led by the Health Promotion and Outreach Service, activity including promotion of the Smear your Mea campaign in September 2019 raised awareness of cervical screening across the region.

Regular stakeholder hui ensure a collaborative approach that includes review of progress against the action plan, and these are undertaken quarterly.

Mental health

Extended mental health consults for youth and adults in general practice was impacted, especially for adults, by increased pressures on GPs, particularly during COVID-19.

While the same number of youth were seen this year as last, GP consults for adults have declined by about 500 from last year (1791).

Ambulatory sensitive hospitalisations

Children under four attending hospital for preventable causes are on target overall, and heading in the right direction, however Māori children continue to present at hospital at a much higher rate compared to the national average. Work continues to try and address this inequity.

Dental

Children reach five years of age caries free in greater numbers than before, and although Māori lag behind - there has been an improvement compared to last years rates with the rate for Māori just short of the 2019/20 target rate. About 41% of Māori children are now caries free, compared to 35% last year.

Due to unavailability of data the following measures in the 2019/20 Annual Plan can not be included in this Annual Report:

- Proportion of infants exclusively or fully breastfed at six weeks
- Proportion of eligible population who have had their cardiovascular risk assessed in the last five years.

Table 2 | 2019/20 FINANCIAL PERFORMANCE: PREVENTION SERVICES

Output Class 1 - PREVENTION	2019/20 Actual
Revenue	
Crown	9, 249
Other Income	6
Inter-district Inflows	72
Total revenue	**9, 327**
Expenditure	
Personnel costs	(1, 983)
Capital charge	(192)
Depreciation	(12)
Other	(1, 594)
Other Provider Payments	(6, 954)
Inter-district Outflows	(54)
Overheads	-
Total expenditure	**(10, 789)**
(Deficit) / Surplus	**(1, 462)**

in thousands of New Zealand dollars

Table 3 provides the results for all the measures in this output class and includes a visual marker (green, orange, red) for the target and the trend. We are now reporting as many measures as we can by ethnicity – this reflects our commitment to equity for Māori and continues to show where Māori are disadvantaged.

Table 3 | NON-FINANCIAL PERFORMANCE: PREVENTION SERVICES

Measures description	Ethnicity	2018/19 Actual	2019/20 Actual	2019/20 Target	A Achievement	C Change
Ambulatory Sensitive Hospitalisations (ASH) rates for children 0-4 years of age (compared to the national rate) *12 months to March 2020	All Māori Non-Māori	104.1% 142.4% 73.1%	93.8% 125.5% 67.1%	≤110.0% ≤115.0% ≤110.0%	Green Red Green	Green Red Red
Children caries-free at five years of age *12 months to December 2019	All Māori Non-Māori	56.6% 35.4% 64.2%	58.6% 40.9% 64.8%	≥58.0% ≥58.0% ≥58.0%	Green Orange Green	Green Green Green
Immunisation coverage rates at milestone at eight months of age *Due to data availability - 3 months to June 2020	All Māori Non-Māori	87.1% 81.5% 91.6%	85.8% 79.4% 91.2%	≥95.0% ≥95.0% ≥95.0%	Red Red Orange	Orange Orange Orange
Babies in a smokefree household at six weeks of age *July to December 2019	All Māori Non-Māori	40.6% 13.7% 60.6%	48.1% 32.9% 60.3%	≥38.0% ≥28.0% ≥58.0%	Green Green Green	Green Green Orange
Proportion of youth who have received the HPV vaccine *2018/19 figure has been restated to include males who were not previously included	All Māori Non-Māori	77.3% 72.5% 81.0%	69.5% 68.1% 70.5%	≥75.0% ≥75.0% ≥75.0%	Red Red Red	Orange Orange Orange
Cervical screening three-year coverage rate for women aged 25-69 years *12 months to March 2020	All Māori Non-Māori	76.2% 72.3% 77.4%	74.5% 73.9% 74.7%	≥80.0% ≥80.0% ≥80.0%	Orange Orange Orange	Orange Green Orange
Percentage of PHO enrolled patients who smoke have been offered help to quit smoking by a healthcare practitioner in the last 15-months	All Māori Non-Māori	90.3% 89.6% 90.9%	88.3% 88.2% 88.3%	≥95.0% ≥95.0% ≥95.0%	Orange Orange Orange	Orange Orange Orange
Number of extended consults delivered by a GP or practice nurse	Total Youth Adult	1791 152 (8.5%) 1639 (91.5%)	1290 152 (11.8%) 1138 (88.2%)	2228 446 1782	Red Red Green	Red Green Red
Proportion of enrolled population aged 65+ years who have received flu vaccination	All Māori Non-Māori	70.3% 73.1% 70.0%	77.6% 84.7% 76.9%	≥75.0% ≥75.0% ≥75.0%	Green Green Green	Green Green Green

OUTPUT CLASS 2: EARLY DETECTION AND MANAGEMENT

Early detection and management services are delivered by a range of health and allied health professionals in various private, not-for-profit, and government service settings. They include: general practice, community and Māori health services, community diagnostic and pharmacy services and child and adolescent oral health services.

These diagnostic and treatment services are focused on, and delivered to, individuals and smaller groups of individuals.

Why is this output class significant?

For most people, their general practice team is their first point of contact with health services. Primary care is also vital as a point of continuity and effective coordination across the continuum of care with the ability to deliver services sooner and closer to home.

Supporting primary care are a range of health professionals including midwives, community nurses, social workers, aged residential care providers, Māori health providers and pharmacists who work in the community, often with the neediest whānau/families.

What outcomes are we contributing to?

- Health and disability services are accessible and delivered to those most in need.
- The health and wellbeing of Māori is improved.
- The needs of specific age-related groups, including older people, vulnerable children and youth, and people with chronic conditions are addressed.
- The quality of life is enhanced for people with diabetes, cancer, respiratory illness, cardiovascular disease and other chronic (long duration) conditions.

2019/20 Performance overview

Improving the health and wellbeing of the population is supported by the integration of health services, both primary and secondary - where access to the right care, in the right place, at the right time, by the right workforce is co-constructed through a system-wide approach.

Midwifery

The development of the midwifery workforce plan has been delayed due to several factors relating to the Whanganui District Health Board restructure which identified a new position for a director of midwifery. The recruitment process has been prolonged as several attempts were made before securing a director. COVID-19 has had an impact on the recruitment process which was halted during Level 4 restrictions.

The proportion of pregnant women accessing DHB funded pregnancy and parenting education was disappointing this year. Just 19.6% of mothers attended, with only 13.3% of Māori mothers. The focus for next year will be first time mothers attending as it is this group which benefits the most.

First 1000 days (conception to around 2 years of age)

The organisational re-structure has seen the establishment of the maternal child and youth health service group that will enable increased integration across the continuum. In addition, a service level alliance for this continuum has been progressed to the establishment of a terms of reference and membership of the group.

School-based health services (SBHS)

With the move to Level 1 response to the COVID-19 pandemic, the SBHS nurses redesigned the service to focus on priority students. They sought help from the schools to help identify at risk students and utilised the SBHS data to support this. Additional resource for administration and nurse support has been channelled to the SBHS assessments.

Dental

It is great to see an increased proportion of adolescents using DHB funded dental services this year, as we move closer to reaching the target rate of 85.0%. This achievement is even more significant when you consider that about 425 more adolescents were enrolled this year (3058) than last year (2632).

Population mental health

The proportion of youth aged 12-19 years seen each quarter in primary care for mental health has increased slightly overall, however Māori youth rates have increased to be in line with the target rate of 2%.

Shorter waits for non-urgent mental health and addiction services (0-19 yrs) have achieved target in most areas and the rates remain comparable with last year. However, Māori have dropped below the threshold of 80.0% slightly, at 78.2%. Overall, about 98.0% are seen before eight weeks.

Activities have continued with the implementation of the specialist adult mental health and addiction network model of care (hubs link all general practice teams to secondary teams and includes kaupapa Māori NGO partners). The model supports integration of Mental Health & Addiction services with physical health care, including transition across the continuum of care. This includes coordination of community resources to improve equity for Māori, Pacific and all tangata whaiora/service users regarding their overall wellbeing. While an early intervention service has not been developed, ongoing primary care discussion in the GP practices promote awareness of early intervention referrals.

While Covid -19 significantly impacted on the development of some improvement activities, particularly those reliant on quantitative reports or data, most activities have progressed or are ongoing.

Ambulatory sensitive hospitalisations (ASH)

We have achieved our target overall, and rates for Māori have improved compared to last year, however 45-64 year olds in our district are hospitalised for preventable illness at 162.9% of the national rate (Māori 265.3%). Improvement is required in our ability to prevent deteriorating long-term conditions resulting in hospitalisation. Angina, congestive heart disease & chest pain account for over a third of all hospitalisations in this age group.

We continue working with general practice to improve patient monitoring and care in the primary setting in order to reduce hospital admission.

Whanganui District Health Board are embarking on an Acute Demand Project, and ASH for the 45-64 year age group will be a particular focus area (among others). We are also using findings from a primary care data review to inform general practice co-designed strategies to respond to quantified risk to improve equity in health outcomes for Māori and Pacific people.

Diabetes and other long-term conditions

Whanganui District Health Board has a high prevalence of long-term conditions attributed to an increase in lifestyle risk factors, socioeconomic determinants and the ageing population. An integrated response supports better management of long-term conditions, through patient-centred approaches which empower patients and whānau to self-manage their conditions, provide proactive coordinated care and reduce disparities for Māori.

The proportion of patients with good or acceptable glycaemic control (HbA1C < 64 mmol/mol) has declined compared to last year from 61.3% to 55.3%.

Consistent health messaging is occurring through the Health Matters newsletters - a collaborative cross-system health promotion initiative.

Educational programmes have been designed and delivered to support improved health literacy i.e. through community dietitian, self-management wellbeing tool programmes, renal, CVD, diabetes, eczema and asthma and use of the health navigator website and materials.

Programme for CVD risk assessments for Māori & Pacific men through targeted approaches across settings (live, learn, work & play) remains ongoing.

Bowel screening

Whanganui District Health Board joined the National Bowel Screening Programme in October 2019.

It is important we ensure patients referred for urgent, non-urgent and surveillance colonoscopy are managed within the recommended and maximum colonoscopy wait times.

The percentage of people accepted for an urgent diagnostic colonoscopy and received their procedure within two weeks (14 days) remains high, at 93.5% against a target of 90.0%. The surveillance target result increased throughout the year but remained under the required level at year end. 100% of bowel screening participants were offered diagnostic assessment within the required timeframe. Bowel screening participation rates were consistently above target level.

Tatou tutu fa'atasi' mole Lumana'i o Fanau
Stand together for our whānau's future
This simple test could save your life
FREE BOWEL CANCER SCREENING
People aged 60 to 74 years who are eligible will receive a test kit in the mail over the next two years. The test helps find bowel cancer early. It is simple, clean and you can do it at home.
Make sure your doctor has your correct address so you don't miss out.
TO FIND OUT MORE GO TO www.timetoscreen.nz
Free phone 0800 924 432
or talk to your doctor
Ministry of Health
New Zealand Government
Time to screen
National Bowel Screening Programme

Table 4 | 2019/20 FINANCIAL PERFORMANCE: EARLY DETECTION & MANAGEMENT

Output Class 2 - EARLY DETECTION & MANAGEMENT	2019/20 Actual
Revenue	
Crown	53, 193
Other Income	77
Inter-district Inflows	2, 040
Total revenue	**55, 310**
Expenditure	
Personnel costs	(7, 866)
Capital charge	(382)
Depreciation	(215)
Other	(7, 557)
Other Provider Payments	(40, 682)
Inter-district Outflows	(3, 512)
Overheads	-
Total expenditure	**(60, 214)**
(Deficit) / Surplus	**(4,904)**

in thousands of New Zealand dollars

Table 5 provides the results for all the measures in this output class and includes a visual marker (green, orange, red) for the target and the trend. We are now reporting as many measures as we can by ethnicity – this reflects our commitment to equity for Māori and continues to show where Māori are disadvantaged

Table 5 | NON-FINANCIAL PERFORMANCE: EARLY DETECTION & MANAGEMENT

Measures description	Ethnicity	2018/19 Actual	2019/20 Actual	2019/20 Target	A Achievement	C Change
Proportion of pregnant women accessing DHB funded pregnancy and parenting education	All	24.7%	19.6%	≥ 40.0%		
	Māori	N/A	13.3%	≥ 40.0%		
	Non-Māori	N/A	24.7%	≥ 40.0%		
Proportion of adolescent population utilising DHB funded dental service *12 months to December 2019	All	69.2%	77.0%	≥ 85.0%		
Proportion of children enrolled in the Community Oral Health Service who have treatment according to plan *12 months to December 2019	All	97.0%	94.3%	≥ 90.0%		
	Māori	96.2%	93.3%	≥ 90.0%		
	Non-Māori	97.5%	95.0%	≥ 90.0%		
Proportion of youth (12-19 years old) seen each quarter by primary mental health services	All	1.2%	1.4%	≥ 2.0%		
	Māori	1.4%	2.0%	≥ 2.0%		
	Non-Māori	1.0%	1.1%	≥ 2.0%		
Shorter waits for non-urgent mental health and addiction services (0-19 years old) *We are restating the 2018/19 figure total to include ethnicity (July 2018 - June 2019)	**< 3 weeks**					
	Total	86.0%	81.6%	≥ 80.0%		
	Māori	84.9%	78.2%			
	Non-Māori	86.7%	83.8%			
	3-8 weeks					
	Total	97.3%	98.3%	≥ 95.0%		
	Māori	96.5%	98.2%			
	Non-Māori	98.0%	98.4%			
	>8 weeks					
	Total	100%	100%	100%		
Ambulatory Sensitive Hospitalisations (ASH) rates for 45-64 years of age relative to national rate *12 months to March 2020	All	162.6%	162.9%	≤ 170.0%		
	Māori	297.4%	265.3%	≤ 151.0%		
	Non-Māori	131.5%	137.4%	≤ 166.0%		
Proportion of patients with good or acceptable glycaemic control (HbA1C < 64 mmol/mol) *(2019-20 estimate as at Q2)*	All	61.3%	55.3%	≥ 60.0%		
	Māori	51.0%	48.4%	≥ 60.0%		
	Non-Māori	66.3%	58.8%	≥ 60.0%		
Percentage of people accepted for an urgent diagnostic colonoscopy received their procedure within two weeks	All	91.3%	93.5%	≥ 90.0%		
Percentage of long-term clients with mental illness who have an up-to-date relapse prevention plan	Child	89.4%	100%	≥ 95.0%		
	Adult	92.2%	98.9%	≥ 95.0%		

OUTPUT CLASS 3: INTENSIVE ASSESSMENT AND TREATMENT

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

Whanganui District Health Board provides a wide range of intensive assessment and treatment services to its population. The district health board also funds some intensive assessment and treatment services for its population that are provided by other district health boards.

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

Why is this output class significant?

Equitable, timely access to intensive assessment and treatment can significantly improve people's quality of life with early intervention.

Responsive services and timely treatment support improvements across the whole system, can give people confidence that complex intervention is available when needed.

Quality improvement in service delivery, systems and processes will improve the effectiveness of clinical practices and patient safety, reduce the number of events causing injury or harm and provide improved outcomes for people in our services.

What outcomes are we contributing to?

- Health and disability services are accessible and delivered to those most in need.
- The health and wellbeing of Māori is improved.
- The quality of life is enhanced for people with diabetes, cancer, respiratory illness, cardiovascular disease and other chronic (long duration) conditions.
- People experiencing a mental illness received care that maximises their independence and wellbeing.

2019/20 Performance overview

Planned care

The Ministry of Health has completed a review of the elective services programme. A major part of this review was to develop a permissive framework whereby the sector was able to schedule services in a variety of settings. To recognise this change in emphasis the electives programme was replaced by the planned care programme.

An internal review of the process used to allocate operating times for surgeons is on track. This will assist in list planning as one component of improving service delivery.

Acute demand

Whanganui District Health Board are committed to delivering service improvements to acute patient flow across primary and community care, and emergency care in secondary services. Our alliance leadership team and primary providers are developing services which provide care in the right place at the right time and reduces the need to seek care from a hospital provider unless clinically appropriate.

The year ended 30 June 2020 saw around 11,400 inpatients admitted acutely, using over 24,300 bed days. On average, these patients stay 2.30 days, a little over our target of 2.20. A very small cohort of unwell patients each required over 100 days in hospital. The length of stay of these episodes has a relatively strong effect on the overall average.

Unplanned readmissions within 28 days of a previous discharge have increased slightly beyond the optimum, again influenced by a small cohort of unwell patients with complex medical and social issues. Several of these have been admitted acutely more than 10 times in the year.

Cancer services

Whanganui District Health Board is committed to delivering sustainable service improvement activities to improve equity, access, timeliness and quality of cancer services. This includes addressing the equity issues at population health level, for example, late presentation and increased mortality rates for Māori. We engage with Māori communities to identify and implement strategies to support the achievement of equity in screening rates for Māori.

We achieved our Faster Cancer Treatment (62 days) measure comfortably this year, improving 9% on last year. Improving data capture will now involve including ethnicity details so that equity can be assured between Māori and non-Māori. Our Diagnostic services have achieved their targets of 95%, however as with Faster Cancer Treatment statistics, availability of ethnicity data has made accurate reporting on these measures for equity assurance difficult.

Surgical interventions

Standardised intervention rates for cataracts and major joints are slightly below target, in the case of cataracts, these have been impacted by Whanganui District Health Board having access to just one eye surgeon for most of the year under review. Interventions for major joints reflect the case need locally.

Cardiac and angiography services are provided by Capital & Coast and MidCentral DHBs, and while we continue to advocate for our patients, access to these specialties are managed within a greater regional caseload.

Mental health

The rate per 100,000 population who are committed to compulsory mental health treatment continues to be a significant challenge. It is a long-standing area of significant inequity, and while we are very close to target (and achieving our target for Māori) we are still lagging behind some DHBs. It is a highlight, however, that Māori have seen a large reduction this year.

The percentage of service users receiving community care within seven days following their discharge (KPI 19) has improved from last year and is approaching target. Work continues to make improvements in this area.

Table 6 | 2019/20 FINANCIAL PERFORMANCE: INTENSIVE ASSESSMENT & TREATMENT

Output Class 3 - INTENSIVE ASSESSMENT & TREATMENT	2019/20 Actual
Revenue	
Crown	170, 446
Other Income	1, 325
Inter-district Inflows	5, 053
Total revenue	**176, 824**
Expenditure	
Personnel costs	(85, 461)
Capital charge	(2, 648)
Depreciation	(5, 302)
Other	(39, 228)
Other Provider Payments	(12, 820)
Inter-district Outflows	(38, 614)
Overheads	-
Total expenditure	**(184, 073)**
(Deficit) / Surplus	**(7, 249)**

in thousands of New Zealand dollars

Table 7 provides the results for all the measures in this output class and includes a visual marker (green, orange, red) for the target and the trend. We are now reporting as many measures as we can by ethnicity – this reflects our commitment to equity for Māori and continues to show where Māori are disadvantaged.

Table 7 | NON-FINANCIAL PERFORMANCE: INTENSIVE ASSESSMENT & TREATMENT

Measures description	Ethnicity	2018/19 Actual	2019/20 Actual	2019/20 Target	A Achievement	C Change
Inpatient length of stay - **Acute** (days) *12 months to March 2020	All	2.24	2.30	≤2.2	orange	orange
Unplanned re-admission rate at 28 days *12 months to March 2020	All Māori Non-Māori	13.2% 13.0% 14.6%	14.0% 13.8% 14.1%	≤12.1% ≤12.1% ≤12.1%	red red red	orange orange green
Faster Cancer Treatment (62-day indicator)	All	83.0%	91.4%	≥90.0%	green	green
Improving waiting times for diagnostic services - **Computed Tomography (CT)** *Patients waiting for or receiving CT scan and report in 42 days or less* *Ethnicity data not available for these measures in 2019/20	All Māori Non-Māori	97.8% 98.2% 97.8%	91.0% N/A N/A	≥95.0% ≥95.0% ≥95.0%	orange	red
Improving waiting times for diagnostic services - **Magnetic Resonance Imaging (MRI)** *Patients waiting for or receiving MRI scan and report in 42 days or less* *Ethnicity data not available for these measures in 2019/20	All Māori Non-Māori	98.1% 96.1% 98.4%	95.9% N/A N/A	≥90.0% ≥90.0% ≥90.0%	green	orange
Percentage of service users receiving community care within seven days following their discharge (KPI 19) *12 months to December 2019	All Māori Non-Māori	N/A 50.0% 42.5%	62.0% 60.4% 63.8%	≥75.0% ≥75.0% ≥75.0%	red red red	green green green
Rate per 100,000 population committed to compulsory mental health treatment *12 months to March 2020	All Māori Non-Māori	174 307 121	138 256 100	≤135 ≤250 ≤100	orange green orange	green green green
Standardised intervention rates **Cardiac surgery and angioplasty/angiography** *12 months to March 2020	Cardiac (all) Angioplasty (all) Angiography (all)	5.5 11.8 30.3	4.5 13.7 31.2	≥6.5 ≥12.5 ≥34.7	red green red	red green green
Standardised intervention rates - **Cataracts and major joints** *12 months to March 2020	Cataracts (all) Major joints (all)	26.3 26.3	21.5 22.4	≥27.0 ≤28.5	red red	orange orange
Hospital acquired complications per 10,000 inpatient episodes	This measure is no longer available and cannot be reported					

OUTPUT CLASS 4: REHABILITATION AND SUPPORT

Rehabilitation and support services are delivered following a needs assessment process and coordination input by Needs Assessment and Service Coordination (NASC) services for a range of care such as home-based support services and residential care services for older people. This output class also includes palliative care services for people with end-stage conditions and services that support people with a disability.

Whanganui District Health Board contracts for the provision of these services from a wide range of providers, including specialist palliative carers, rest homes and home-based support agencies. These services are focused on, and delivered to, individuals.

Why is this output class significant?

Older people (aged 65+ years) have higher rates of mortality and hospitalisations for most chronic conditions, some infectious diseases and injuries (often from falls). These factors have a significant impact on the individual and their whānau/family, and also on the capacity of health and social services to respond to the need.

For people living with a disability or age-related illness, it is important they are supported to maintain their best possible functional independence and quality of life. It is also important that people who have end-stage conditions and their families are appropriately supported by palliative care services, so the person is able to live comfortably, have their needs met in a holistic and respectful way, and die without undue pain and suffering.

Whanganui District Health Board continues to place an emphasis on an increased proportion of older people living in their own home with their natural support system. This can be supplemented, where necessary, by subsidised home-based support services, before aged residential care is required.

What outcomes are we contributing to?

- The needs of specific age-related groups, including older people, vulnerable children and youth, people with chronic conditions are addressed.
- The wider community and whanau/family support - and enable older people and the disabled to participate fully in society and enjoy maximum independence.

2019/20 Performance overview

This output class is mostly focused on adults and healthy ageing. The recommendations of the Intermediate Care review have been fully implemented and are now operational.

Whanganui District Health Board worked in partnership with ACC to progress pressure injury prevention and management programme across the Whanganui District Health Board rohe. The initiative included links with aged residential care, general practice and community providers. Key staff have been appointed and the Pressure Injury Prevention Team is now operational.

Whanganui District Health Board is committed to ensuring mechanisms and processes are in place to support people with a disability when they interact with our services. All work in this area will be conducted applying the pro-equity for Māori framework, as we continue to develop a better understanding of the issues for Māori whānau with disabilities and develop services and systems that support their access and engagement with health services.

A whole of organisation review of consumer engagement has been completed to strengthen the participation of people with a disability in advisory roles particularly for Māori whānau with a disability. Seventy (70) staff have so far completed the e-learning module for disability responsiveness. Other activities have suffered a delay due to COVID-19 response.

Many of the indicators, apart from low-risk interRAI assessment times, are either achieving or almost achieving the targets. In nearly all cases, the results are comparable or improved on last year.

Mental health

The percentage of service users receiving community care within seven days following their discharge (KPI 19) has improved from last year and is approaching target. Work continues to make improvements in this area.

Needs assessments

InterRAI assessments within 230 days are in line with last year, however work is still required in this area to bring the rates completed within the expected timeframe up to target.

In-home strength & balance

The number of people receiving in-home strength and balance programmes within their home has exceeded the target which goes well towards helping older people remain independent in their own homes with improved quality of life.

Stroke services

Measures relating to the delivery of stroke services are exceeding targets which indicates that the stroke service is operating well and the 'code stroke' initiative is becoming embedded within our systems.

Polypharmacy

The proportion of over 64 year olds who are prescribed 11 or more medications is showing a slight increase. This reflects the increasingly complex health status of the elderly as people live longer. However, work needs to continue to minimise the number of medications people are taking.

Aged care

The proportion of the population over 65 in DHB funded aged residential care has declined. This does not reflect a decline in the number of people being supported, but more reflects the growing aged population in the Whanganui District Health Board area, both from natural ageing and through additional people moving into the area.

Colonoscopies

After being consistently achieved in quarters 1, 2 and 3, the urgent colonoscopy target result decreased in quarter 4 to 84%, below the 90% target. The non-urgent annual target was achieved (target 70%) with the overall result being 74.7%. Unfortunately the surveillance target of 70% was not achieved, with a result of 57.7% for the year. The decline in performance for urgent and surveillance colonoscopies is the result of significantly lower volumes being performed during the COVID-19 lockdown period.

Table 8 | 2019/20 FINANCIAL PERFORMANCE: REHABILITATION AND SUPPORT

Output Class 4 - REHABILITATION & SUPPORT	2019/20 Actual
Revenue	
Crown	36, 989
Other Income	18
Inter-district Inflows	1, 211
Total revenue	**38, 218**
Expenditure	
Personnel costs	(2, 684)
Capital charge	(285)
Depreciation	(36)
Other	(1, 768)
Other Provider Payments	(32, 167)
Inter-district Outflows	(3, 067)
Overheads	-
Total expenditure	**(40,007)**
(Deficit) / Surplus	**(1, 789)**

Table 9 provides the results for all the measures in this output class and includes a visual marker (green, orange, red) for the target and the trend. We are now reporting as many measures as we can by ethnicity. This reflects our commitment to equity for Māori and continues to show where Māori are disadvantaged.

Table 9 | NON-FINANCIAL PERFORMANCE: REHABILITATION AND SUPPORT SERVICES

Measures description	Ethnicity	2018/19 Actual	2019/20 Actual	2019/20 Target	A Achievement	C Change
Percentage of service users receiving community care within seven days following their discharge (KPI 19) *12 months to December 2019	All Māori Non-Māori	N/A 50.0% 42.5%	62.0% 60.4% 63.8%	≥75.0% ≥75.0% ≥75.0%		
Percentage of older people in aged residential care by facility who have a second InterRAI Long-Term Conditions Facilities (LTCF) assessment completed 230 days after admission	All	91.2%	89.6%	≥95.0%		
Number of older people receiving in-home strength and balance programmes	All	N/A	220	199		N/A
Percentage of potentially eligible stroke patients thrombolysed (ind 2)	All Māori Non-Māori	11.5% N/A N/A	17.0% 25.0% 16.3%	≥10.0% ≥10.0% ≥10.0%		
Percentage of stroke patients admitted to a stroke unit/organised stroke service with demonstrated stroke pathway (Ind. 1)	All Māori Non-Māori	98.3% N/A N/A	95.3% 76.9% 97.8%	>80.0% >80.0% >80.0%		
Percentage of people waiting for a surveillance or follow-up colonoscopy that wait no longer than 12 weeks (84 days) beyond the planned date	All	75.2%	57.7%	≥70.0%		
Proportion of over 64 year olds who are prescribed 11 or more medications	All Māori Non-Māori	2.2% 2.7% 2.1%	2.3% 2.9% 2.3%	≤2.0% ≤2.0% ≤2.0%		
Proportion of population aged 65+ years receiving DHB funded support in ARC facilities over the year *There is no target appropriate for this measure, figures given are presented as a guide*	All Māori Non-Māori	4.9% 3.3% 5.1%	4.3% 2.9% 4.5%	4.4% 3.0% 4.5%		

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INDEPENDENT AUDITOR'S REPORT

TO THE READERS OF WHANGANUI DISTRICT HEALTH BOARD'S FINANCIAL STATEMENTS AND PERFORMANCE INFORMATION FOR THE YEAR ENDED 30 JUNE 2020

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

We have audited:

- the financial statements of the Health Board on pages 52 to 85, that comprise the statement of financial position as at 30 June 2020, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and

- the performance information of the Health Board on pages 34 to 45.

Qualified opinion on the financial statements

In our opinion, except for the possible effects of the matter described in the Basis for our qualified opinion section of our report, the financial statements of the Health Board on pages 52 to 85:

- present fairly, in all material respects:
  - its financial position as at 30 June 2020; and
  - its financial performance and cash flows for the year then ended;
- comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards.

Unmodified opinion on the performance information

In our opinion, the performance information of the Health Board on pages 34 to 45:

- presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2020, 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;
  - what has been achieved with the appropriations; and
  - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure;
- complies with generally accepted accounting practice in New Zealand.
-

Our audit of the financial statements and the performance information was completed on 16 December 2020. This is the date at which our opinion is expressed.

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

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Basis for our qualified opinion on the financial statements and unmodified opinion on the performance information

As outlined in note 15 on page 76, 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 $7.0 million for the estimated amounts owed to current and past employees. Due to the complex nature of health sector employment arrangements, the Health Board's process is ongoing, and there is a high level of uncertainty over the amount of the provision. Because of the work that is yet to be completed, we have been unable to obtain sufficient appropriate audit evidence to determine if the amount of the provision is reasonable.

We were also unable to obtain sufficient appropriate audit evidence of the $4.2 million provision as at 30 June 2019. We accordingly expressed a qualified opinion on the financial statements for the year ended 30 June 2019.

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

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

We believe that the audit evidence we have obtained is sufficient and appropriate to provide the basis for our qualified opinion on the financial statements and the basis for our opinion on the performance information.

Emphasis of matters

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

The Health Board is reliant on financial support from the Crown

Without further modifying our opinion, we draw attention to the disclosures made in note 1 on page 57 that summarises the Board's use of the going concern assumption in preparing the financial statements. The Board has considered the circumstances which could affect the validity of the going concern assumption, including its responsibility to settle the estimated historical Holidays Act 2003 liability. There is uncertainty whether the Health Board will be able to settle this liability, if it becomes due within one year from approving the financial statements. To support the Board's going concern assumption, a letter of comfort was obtained from the Ministers of Health and Finance. The letter outlines that the Crown is committed to working with the Health Board over the medium term to maintain its financial viability. The Crown acknowledges that equity support may need to be provided, where necessary, to maintain viability.

Impact of COVID-19

Note 24 on pages 84 to 85 outlines the impact of COVID-19 on the Health Board.

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

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

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

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

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

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

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

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

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

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

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

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

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

Our responsibilities arise from the Public Audit Act 2001.

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Other Information

The Board is responsible for the other information. The other information comprises the information included on pages 4 to 33, but does not include the financial statements and the performance information, and our auditor's report thereon.

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

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

Independence

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

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

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

STATEMENT OF RESPONSIBILITY

For the year ended 30 June 2020

The board and management of Whanganui District Health Board are responsible for the preparation of the financial statements and statement of performance and for the judgements made in them.

The board and management of Whanganui District Health Board are responsible for any end-of-year performance information provided by Whanganui District Health Board under section 19A of the Public Finance Act 1989.

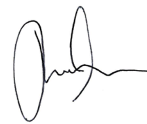
The board and management of Whanganui District Health Board are responsible for establishing and maintaining a system of internal controls designed to provide reasonable assurance as to the integrity and reliability of financial and non-financial reporting.

In the opinion of the board and management of Whanganui District Health Board, the financial statements and statement of performance for the year ended 30 June 2020, fairly reflect the financial position and operations of Whanganui District Health Board.

Signed on behalf of the board and management by:

Kenneth (Ken) Whelan
Toihau - Board Chair

Talia Anderson-Town
Finance, Risk and Audit Chair



Russell Simpson
Kaihautū Hauora - Chief Executive

Andrew McKinnon
General Manager Corporate (Chief Financial Officer)

Dated: 16 December 2020

STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSE

For the year ended 30 June 2020

in thousands of New Zealand dollars

	Note	2020 Actual	2020 Budget	2019 Actual
Revenue				
Revenue from non-exchange transactions	1a	245, 835	241, 436	232, 616
Revenue from exchange transactions	1b	33, 522	33, 990	32, 811
Other revenue	1c	322	340	372
Total revenue		**279, 679**	**275, 766**	**265, 799**
Expenses				
Personnel costs	2	(97, 994)	(97, 409)	(94, 090)
Outsourced services		(16, 753)	(14, 360)	(15, 122)
Depreciation and amortisation expense		(5, 565)	(5, 858)	(5, 417)
Capital charge	3	(3, 507)	(3, 534)	(4, 401)
Finance costs	4	(19)	(56)	(22)
Other expenses	5	(171, 353)	(167, 241)	(160, 496)
Total expenses		**(295, 191)**	**(288, 458)**	**(279, 548)**
Share of profit of associate	11	108	95	95
(Deficit) / Surplus		**(15, 404)**	**(12, 597)**	**(13, 654)**
Other comprehensive revenue and expense				
Gain on property revaluation	9	6, 670	-	-
Total other comprehensive revenue and expense		**6, 670**	**-**	**-**
Total comprehensive revenue and expense		**(8, 734)**	**(12, 597)**	**(13, 654)**

Explanations of major variances against budget are provided in Note 21.
The notes and statement of accounting policies form part of, and should be read in conjunction with these financial statements.

STATEMENT OF FINANCIAL POSITION

As at 30 June 2020

in thousands of New Zealand dollars

	Note	2020 Actual	2020 Budget	2019 Actual
Assets				
Current assets				
Cash and cash equivalents	6	3, 813	5	3, 020
Receivables from non-exchange transactions	7	566	160	352
Receivables from exchange transactions	7	5, 709	6, 741	5, 897
Prepayments		-	13	41
Inventories	8	1, 617	1, 437	1, 427
Trust / special funds		190	180	181
Patient and restricted trust funds		4	4	4
Total current assets		**11, 899**	**8, 540**	**10, 922**
Non-current assets				
Property, plant and equipment	9	79, 602	76, 138	75, 230
Intangible assets	10	11, 741	12, 366	11, 777
Investments in associates	11	1, 185	1, 171	1, 146
Total non-current assets		**92, 528**	**89, 675**	**88, 153**
Total assets		**104, 427**	**98, 215**	**99, 075**
Liabilities				
Current liabilities				
Bank overdraft		-	6, 918	-
Payables under non-exchange transactions	13	3, 297	2, 182	2, 092
Payables under exchange transactions	13	17, 238	13, 722	16, 142
Borrowings	14	198	198	230
Employee entitlements	15	21, 920	18, 181	16, 713
Total current liabilities		**42, 653**	**41, 201**	**35, 177**
Non-current liabilities				
Borrowings	14	486	486	684
Employee entitlements	15	839	942	873
Total non-current liabilities		**1, 325**	**1, 428**	**1, 557**
Total liabilities		**43, 978**	**42, 629**	**36, 734**
Net assets		**60, 449**	**55, 586**	**62, 341**
Equity				
Contributed capital		112, 409	111, 409	105, 567
Accumulated surplus / (deficit)		(82, 698)	(79, 884)	(67, 287)
Property revaluation reserve		30, 551	23, 881	23, 881
Hospital special funds		187	180	180
Total equity		**60, 449**	**55, 586**	**62, 341**

Explanations of major variances against budget are provided in Note 21.

The notes and statement of accounting policies form part of, and should be read in conjunction with these financial statements.

STATEMENT OF CHANGES IN EQUITY

For the year ended 30 June 2020

in thousands of New Zealand dollars

	2020 Actual	2019 Actual
Contributed capital		
Balance at 1 July	105, 567	105, 725
Crown equity	7, 000	-
Repayment of capital	(158)	(158)
Balance at 30 June	**112, 409**	**105, 567**
Accumulated (deficit)		
Balance at 1 July	(67, 287)	(53, 594)
Other reserved movements	(7)	(39)
Surplus / (Deficit) for the year	(15, 404)	(13, 654)
Balance at 30 June	**(82, 698)**	**(67, 287)**
Property revaluation reserves		
Balance at 1 July	23, 881	23, 881
Revaluation	6, 670	-
Balance at 30 June	**30, 551**	**23, 881**
Property revaluation reserves consist of:		
Land	1, 800	1, 093
Buildings	28, 751	22, 788
Total property revaluation reserves	**30, 551**	**23, 881**
Hospital special funds		
Balance at 1 July	180	141
Transfer from retained earnings in respect of:		3
Interest	3	40
Donations and funds received	4	
Transfer from retained earnings in respect of:		
Funds spent	-	(4)
Balance at 30 June	**187**	**180**
Total equity	**60, 449**	**62, 341**

Explanations of major variances against budget are provided in Note 21.
The notes and statement of accounting policies form part of, and should be read in conjunction with these financial statements.

STATEMENT OF CASH FLOWS

For the year ended 30 June 2020

in thousands of New Zealand dollars

	Note	2020 Actual	2020 Budget	2019 Actual
Cash flows from operating activities				
Receipts from the Crown		279, 252	273, 684	266, 128
Interest received		108	57	321
Receipt from other revenue		1, 318	1, 110	1, 655
Payment to suppliers		(187, 172)	(183, 571)	(169, 917)
Payment to employees		(92, 821)	(95, 854)	(90, 183)
Interest paid		(19)	(24)	(22)
Payment of capital charge		(3, 507)	(3, 534)	(4, 401)
GST (net)		179	110	177
Net cash inflow / (outflow) from operating activities		**(2, 662)**	**(8, 022)**	**3, 758**
Cash flows from investing activities				
Purchase of property, plant and equipment		(2, 271)	(5, 869)	(3, 262)
Purchase of intangible assets		(838)	(1, 630)	(1, 310)
Receipts from maturity of investments		(39)	(25)	2, 975
Net appropriation from trust funds		(9)	1	(40)
Net cash inflow / (outflow) from investing activities		**(3, 157)**	**(7, 523)**	**(1, 637)**
Cash flows from financing activities				
Capital contribution		7, 000	6, 000	-
Payment of finance lease		(95)	(95)	(92)
Repayment of capital		(158)	(158)	(158)
Payment of loans		(135)	(135)	(135)
Net cash inflow / (outflow) from financing activities		**6, 612**	**5, 612**	**(385)**
Net (decrease) / increase in cash and cash equivalents		793	(9, 933)	1, 736
Cash and cash equivalents at beginning of year		3, 020	3, 020	1, 284
Cash and cash equivalents at end of year	6	**3, 813**	**(6, 913)**	**3, 020**

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

	2020 Actual	2019 Actual
Net surplus / (deficit)	**(15, 404)**	**(13, 654)**
Add / (less) non-cash items		
Depreciation and amortisation expense	5, 565	5, 417
Impairment on intangible assets (NOS)	-	1, 048
Total non-cash items	**5, 565**	**6, 465**
Add / (less) items classified as investing or financing activities		
(Gains) / losses on disposal of property, plant and equipment	5	15
Surplus / (deficit) from associates	(108)	(95)
Payable movements attributed to capital purchase	(127)	268
Total items classified as investing or financing activities	**(230)**	**188**
Add / (less) movements in statement of financial position items		
Receivables	123	2, 555
Inventories	(190)	(15)
Payables	2, 301	4, 312
Employee entitlements	5, 173	3, 907
Net movements in working capital items	**7, 407**	**10, 759**
Net cash flow from operating activities	**(2, 662)**	**3, 758**

Explanations of major variances against budget are provided in Note 21.
The notes and statement of accounting policies form part of, and should be read in conjunction with these financial statements.

STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES

For the year ended 30 June 2020

REPORTING ENTITY

Whanganui District Health Board is a Crown entity as defined by the Crown Entities Act 2004 and is domiciled and operates in New Zealand. Whanganui District Health Board's ultimate parent is the New Zealand Crown. Whanganui District Health Board is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000, the Financial Reporting Act 2013, the Public Finance Act 1989 and the Crown Entities Act 2004.

Whanganui District Health Board's primary objective is to provide health, disability and mental health services to the New Zealand public. Whanganui District Health Board does not operate to make a financial return.

Whanganui District Health Board has designated itself as a public benefit entity (PBE) for financial reporting purposes. The group consists of Whanganui District Health Board and its associated entity Allied Laundry Services Limited (16.67%) owned, 2019: 16.67% owned), as disclosed in Note 11.

There is also an investment in Technical Advisory Services Limited (TAS) (16.7% owned), as disclosed in Note 12. In addition, funds administered on behalf of patients have been reported within the Statement of Changes in Equity.

The financial statements for Whanganui District Health Board are for year ended 30 June 2020, and were authorised by the board on 16 December 2020.

BASIS OF PREPARATION

The financial statements have been prepared on a going concern basis, and the accounting policies have been applied consistently throughout the period.

Statement of compliance

The financial statements of Whanganui District Health Board have been prepared in accordance with the requirements of the Crown Entities Act 2004, which includes the requirement to comply with generally accepted accounting practice in New Zealand (NZ GAAP).

The financial statements have been prepared in accordance with Tier 1 Public Benefit Entity (PBE) accounting standards.

Presentation currency and rounding

The financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars ($000).

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

Service performance reporting

PBE FRS 48 is effective for financial years beginning on or after 1 January 2022, with earlier application permitted.

The standard applies to all Tier 1 and Tier 2 not-for profit public benefit entities and Tier 1 and Tier 2 public sector public benefit entities required by legislation to provide information in respect of service performance in accordance with NZ GAAP.

The standard will provide users with sufficient contextual information to understand why the entity exists, what it intends to achieve in broad terms over medium to long term and how it goes about it, and provide users with information about what the entity has done during the reporting period in working towards its broader aims and objective.

Whanganui District Health Board has not yet determined how application of PBE FRS 48 will affect its performance reporting.

STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES

For the year ended 30 June 2020

GOING CONCERN

The going concern principle has been adopted in the preparation of these financial statements. The Whanganui District Health Board, after making enquiries, has a reasonable expectation that it has adequate resources to continue operations for the foreseeable future. The board has reached this conclusion having regard to circumstances which it considers likely to affect the district health board for the foreseeable future from the date of signing the 2019/20 financial statements, and to circumstances which it knows will occur after that date which could affect the validity of the going concern assumption (as set out in its current Annual Plan). The key considerations are set out below.

LETTER OF COMFORT

The board has received a Letter of Comfort dated 25 September 2020 from the Ministers of Health and Finance which states that deficit support will be provided where necessary to maintain viability.

OPERATING AND CASH FLOW FORECASTS

Operating and cash flow forecasts show that there will be operating cash flow deficit for the 2020/21 year. Whanganui District Health Board forecasts indicate that it will be reliant on accessing its overdraft facility with NZHPL to meet its operating cash flow deficit and to meet the investing cash flow requirements of the DHB for the 2020/21 financial year.

SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

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

COMPARATIVE FIGURES

Comparative figures in the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows are presented for the 12 months' operations from 1 July 2018 to 30 June 2019. The comparative figures in the Statement of Financial Position are presented as at 30 June 2019.

BUDGET FIGURES

The budget figures are those approved by the Whanganui District Health Board in its Annual Plan and included in the statement of performance tabled in Parliament. The budget figures have been prepared in accordance with NZ GAAP.

GOODS AND SERVICES TAX

All amounts are shown exclusive of Goods and Services Tax (GST), except for receivables and payables which are stated inclusive of GST. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

The net amount of GST recoverable from, or payable to, the IRD is included as part of receivables from non-exchange or exchange transactions or payables under non-exchange or exchange transactions in the Statement of Financial Position.

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

Commitments and contingencies are disclosed exclusive of GST.

INCOME TAX

Whanganui District Health Board 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 2007. The associate company Allied Laundry Services Limited, is exempt from income tax under section CW31 (2) of the Income Tax Act 2007.

FOREIGN CURRENCY TRANSACTIONS

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

STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES

For the year ended 30 June 2020

FINANCIAL INSTRUMENTS

Non-derivative financial instruments

Non-derivative financial instruments comprise receivables from exchange and non-exchange transactions, cash and cash equivalents, other investments, interest-bearing loans and borrowings, and payables under exchange and nonexchange transactions. Non-derivative financial assets are recognised initially at fair value plus transaction costs except for those financial assets classified as fair value through other comprehensive revenue and expense. Non-derivative financial liabilities are recognised initially at fair value plus transaction costs. Subsequent to initial recognition non-derivative financial instruments are measured as described in Note 20.

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

CHANGE IN ACCOUNTING POLICIES

The accounting policies adopted in these financial statements are consistent with those of the previous financial year, unless otherwise stated.

PROVISIONS

A provision is recognised when Whanganui District Health Board 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 that obligation. 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.

EQUITY

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

- Contributed capital
- Accumulated surplus/(deficit)
- Property revaluation reserves
- Hospital special funds.

Property revaluation reserve

This reserve relates to the revaluation of land and buildings to fair value.

Hospital special funds

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 recognised 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 retained earnings to Trust funds.

All hospital special funds (Trust) are held in bank accounts that are separate from Whanganui District Health Board's normal banking facilities.

COST OF SERVICE (Statement of Performance)

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

Cost allocation

Whanganui District Health Board has arrived at the net cost of service for each significant activity using the cost allocation system outlined below.

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.

Criteria for direct and indirect costs

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.

Cost drivers for allocation of direct and indirect costs

Direct costs are charged directly to outputs. Depreciation is charged on the basis of asset utilisation. Personnel costs are charged on the basis of actual time incurred. Property and other premises costs, such as maintenance, are charged on the basis of floor area occupied for the production of each output. The cost of indirect costs (internal services) not directly charged to outputs is attached as overheads using appropriate cost drivers such as actual usage, staff numbers and floor areas.

There have been no changes to the cost allocation methodology since the date of the last audited financial statements.

CRITICAL ACCOUNTING ESTIMATES AND ASSUMPTIONS

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

STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES

For the year ended 30 June 2020

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

- revenue recognised and income in advance - refer Note 1.
- useful lives and residual values of property, plant, and equipment – refer Note 9.
- fair value of land and buildings – refer Note 9.
- useful lives of software assets – refer Note 10.
- retirement and long service leave – refer Note 15
- Holidays Act compliance - refer Note 15.

1 REVENUE

ACCOUNTING POLICIES

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

Revenue is measured at the fair value of consideration received or receivable.

Crown funding

Whanganui District Health Board is primarily funded through revenue received from the Crown under a Crown Funding Agreement, which is based on population levels within the Whanganui District Health Board district. This funding is restricted in its use for the purpose of Whanganui District Health Board meeting the objectives specified in its founding legislation and the scope of the relevant appropriations of the funder.

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

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

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

The fair value of revenue from the Crown has been determined to be equivalent to the amounts due in the funding arrangements.

Inter-district inflows

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

ACC contract revenue

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

Goods sold and services rendered

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

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

Donated assets

Where a physical asset is gifted to or acquired by Whanganui District Health Board for nil consideration or at a subsidised cost, the asset is recognised at fair value and the difference between the consideration provided and fair value of the asset is recognised as revenue. The fair value of donated assets is determined as follows:

- For new assets, fair value is usually determined by reference to the retail price of the same or similar assets at the time the asset was received.
- For used assets, fair value is usually determined by reference to market information for assets of a similar type, condition, and age.

Donated services

Certain operations of Whanganui District Health Board are reliant on services provided by volunteers. Volunteer services received are not recognised as revenue or expenditure by Whanganui District Health Board.

Interest revenue

Interest received and receivable on funds invested, are calculated using the effective interest rate method, and are recognised as a revenue in the financial year in which they are incurred.

Revenue recognition and income advance

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

1 REVENUE (continued)

BREAKDOWN OF REVENUE AND FURTHER INFORMATION

1a. REVENUE FROM NON-EXCHANGE TRANSACTIONS	2020 Actual	2019 Actual
Health and disability services (Crown appropriation revenue)*	230, 812	223, 885
Ministry of Health other revenue	15, 008	8, 649
Other revenue	15	82
Total revenue from non-exchange transactions	**245, 835**	**232, 616**

1b. REVENUE FROM EXCHANGE TRANSACTIONS	2020 Actual	2019 Actual
Ministry of Health other revenue	17, 084	15, 597
ACC contract	6, 680	7, 641
Inter District Patient Inflows	8, 376	7, 637
Other Government	145	270
Other revenue	1, 129	1, 345
Finance income	108	321
Total revenue from exchange transactions	**33, 522**	**32, 811**

1c. OTHER REVENUE	2020 Actual	2019 Actual
Rental revenue	322	372
Total other revenue	**322**	**372**

* Performance against this appropriation is reported in the Statement of Performance on pages 34-45. The appropriation revenue received by Whanganui District Health Board equals the Government's actual expenses incurred in relation to the appropriation, which is a required disclosure from the Public Finance Act.

2 PERSONNEL COSTS

ACCOUNTING POLICIES

Salaries and wages

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

Superannuation schemes - Defined contribution schemes

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

BREAKDOWN OF PERSONNEL COSTS AND FURTHER INFORMATION

	2020 Actual	2019 Actual
Salaries and wages	93, 405	90, 161
Defined contribution scheme employer contributions	2, 873	2, 562
Increase / (decrease) in employee entitlements	1, 716	1, 367
Total personnel costs	**97, 994**	**94, 090**

EMPLOYEE REMUNERATION (over $100,000)

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

	Number of employees	
	2020 Actual	2019 Actual
100, 000 - 109, 999	60	49
110, 000 - 119, 999	39	15
120, 000 - 129, 999	12	13
130, 000 - 139, 999	9	7
140, 000 - 149, 999	4	3
150, 000 - 159, 999	4	3
160, 000 - 169, 999	2	3
170, 000 - 179, 999	3	2
180, 000 - 189, 999	2	1
190, 000 - 199, 999	2	2
200, 000 - 209, 999	2	1
210, 000 - 219, 999	3	3
220, 000 - 229, 999	2	4
230, 000 - 239, 999	1	3
240, 000 - 249, 999	3	3
250, 000 - 259, 999	3	2
260, 000 - 269, 999	1	-
270, 000 - 279, 999	1	-
280, 000 - 289, 999	2	4
290, 000 - 299, 999	3	2
300, 000 - 309, 999	2	3
310, 000 - 319, 999	-	4
320, 000 - 329, 999	1	1
330, 000 - 339, 999	2	4
340, 000 - 349, 999	-	4
350, 000 - 359, 999	4	3
360, 000 - 369, 999	4	2
370, 000 - 379, 999	1	1
380, 000 - 389, 999	3	2
390, 000 - 399, 999	2	1
400, 000 - 409, 999	1	-
420, 000 - 429, 999	2	1
430, 000 - 439, 999	1	-
450, 000 - 459, 999	2	-
730, 000 - 739, 999	-	1
820, 000 - 829, 999	1	-
Total employees	**184**	**147**

Of the 184 (2019:147) employees shown above, 156 (2019:125) were predominantly clinical employees and 28 (2019:22) were management/administrative employees. If the remuneration of the part-time employees were grossed up to a fulltime equivalent (FTE) basis, the total number of employees with FTE salaries of $100,000 or more would be 189 (2019: 150) compared with the actual number of employees of 184 (2019: 147).

The chief executive's remuneration is in the $390,000 to $399,999 band (2019: $390,000 to $399,999). This includes the value of the district health board's contribution to Kiwi-Saver and car allowance. Non-cash benefits are not included in the salary data for other employees.

Severance payments

One employee received a severance payment in 2020 (2019: 1). Employees received compensation and other benefits in relation to termination of their employment or change in contractual conditions totalling $19k (2019: $16k).

3 CAPITAL CHARGE

ACCOUNTING POLICIES

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

Further information

The district health board pays a capital charge to the Crown on its equity (adjusted for memorandum accounts) as at 30 June and 31 December each year. The capital charge rate for the year ended 30 June 2020 was 6% (2019: 6%).

4 FINANCE COSTS

ACCOUNTING POLICIES

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

BREAKDOWN OF BORROWING / FINANCING COSTS	2020 Actual	2019 Actual
Interest on finance lease	19	22
Total finance costs	**19**	**22**

5 OTHER EXPENSES

ACCOUNTING POLICIES

Operating lease

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

Lease payments made under an operating lease are recognised as an expenditure 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 on a straight-line basis as well as an integral part of the total lease expense.

BREAKDOWN OF OTHER EXPENSES AND FURTHER INFORMATION	2020 Actual	2019 Actual
Fees to Auditors		
Fees for audit of financial statements	195*	179
Audit related fee internal (for assurance related services)	133	136
Board members fees	202	205
Board member expenses	3	3
Operating lease expenses	547	523
(Reversal of) / impairment of receivables	28	(75)
Loss on disposal of property, plant and equipment	5	15
National Oracle Solution (NOS) impairment	-	1, 048
Inventories consumed	9, 002	8, 192
Clinical & infrastructure and non-clinical expenses	23, 368	21, 022
Inter district outflow	45, 247	43, 778
Payments to non-health board providers	92, 623	85, 470
Total other expenses	**171, 353**	**160,496**

* The audit fee includes a scope extension of 18k for year ended 30 June 2019.

5 OTHER EXPENSES (continued)

BOARD MEMBER REMUNERATION	2020 Actual	2019 Actual
Mr Ken Whelan *(Board chair from Dec 19)*	19	-
Ms Annette Main *(Deputy Board chair from Dec 19)*	19	17
Mrs Dot McKinnon *(Board chair to Dec 19)*	15	34
Mr Stuart Hylton *(Deputy Board chair to Dec 19)*	19	21
Mrs Philippa Baker-Hogan	17	17
Mrs Judith MacDonald	17	17
Mr Graham Adams	17	17
Mr Charlie Anderson	17	17
Ms Talia Anderson-Town *(from Dec 19)*	8	-
Ms Materoa Mar *(from Dec 19)*	4	-
Mr Josh Chandulal-Mackay *(from Dec 19)*	9	-
Ms Soraya Peke-Mason *(from Dec 19)*	9	-
Hon Dame Tariana Turia *(to Dec 19)*	8	17
Mr Darren Hull *(to Dec 19)*	8	17
Ms Maraea Bellamy *(to Dec 19)*	8	14
Ms Jenny Duncan *(to Dec 19)*	8	17
Total board member remuneration	**202**	**205**

Whanganui District Health Board provides a deed of indemnity to directors for certain activities undertaken in the performance of the Whanganui District Health Board's functions.

No board members received compensation or other benefits in relation to cessation (2019: nil).

Payments made to committee members appointed by the board totalled $28k (2019: $28k).

Operating leases as lessee

THE FUTURE AGGREGATE MINIMUM LEASE PAYMENTS TO BE PAID UNDER NON-CANCELLABLE OPERATING LEASES ARE AS FOLLOWS	2020 Actual	2019 Actual
Non-cancellable operating leases		
Less than one year	-	34
One to two years	-	-
Two to three years	-	-
Total	**-**	**34**

6 CASH AND CASH EQUIVALENTS

ACCOUNTING POLICIES

Cash and cash equivalents comprise cash on hand, a demand fund held with NZ Health Partnerships (NZHP) and other highly liquid investments with maturity of no more than three months from the date of acquisition.

NZHP overdrafts that are part of the Whanganui District Health Board's cash management are included as a component of cash and cash equivalents for the purpose of the Statement of Cash Flow.

Bank overdrafts are shown in current liabilities in the Statement of Financial Position.

BREAKDOWN OF CASH AND CASH EQUIVALENTS AND FURTHER INFORMATION	2020 Actual	2019 Actual
Cash on hand	5	5
Demand funds held with NZHP	3, 808	3, 015
Total cash and cash equivalents	**3, 813**	**3, 020**

While cash and cash equivalents at 30 June 2020 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 not significant.

Working capital facility

Whanganui District Health Board is a party to the 'DHB Treasury Services Agreement' between NZ Health Partnerships (NZHP) and the participating district health boards. This agreement enables NZHP to 'sweep' district health board bank accounts and invest surplus funds. The 'DHB Treasury Services Agreement' provides for individual district health boards to have a debit balance with NZHP, which will incur interest at the credit interest rate received by NZHP plus an administrative margin.

The maximum debit balance that is available to any district health board is the value of provider division's planned monthly Crown revenue, used in determining working capital limits which is defined as one-12th of the annual planned revenue paid by the funder division to the provider division as denoted in the most recently agreed annual plan inclusive of GST.
As at 30 June 2020, this limit was $12.24m (2019: $11.51m).

7 RECEIVABLES

ACCOUNTING POLICIES

Short-term receivables are recorded at the amount due, less an allowance for credit losses. In measuring expected credit losses, short-term receivables have been assessed on a collective basis as they possess shared credit risk characteristics. They have been grouped based on the days past due.

Receivables are written off when there is no reasonable expectation of recovery. Indicators that there is no reasonable expectation of recovery include the debtor being in liquidation.

BREAKDOWN OF RECEIVABLES AND OTHER INFORMATION	2020 Actual	2019 Actual
Receivables - Other (gross)	2, 672	3, 644
Ministry of Health (gross)	3, 808	2, 782
Less: Life time expected credit loss	(205)	(177)
Total receivables	**6, 275**	**6, 249**
Total receivables comprises:		
Receivable from non-exchange transactions	566	352
Receivable from exchange transactions	5, 709	5, 897

The expected credit loss rates for receivables are based on the payment profile of revenue on credit at the measurement date and the corresponding historical credit losses experienced for that period. The historical loss rates are adjusted for current and forwardlooking macro-economic factors that might affect the recoverability of receivables. Given the short period of credit risk exposure, the impact of macro-economic factors is not considered to be significant.

There have been no changes during the reporting period in the estimation techniques or significant assumptions used in measuring the loss allowance.

7 RECEIVABLES (continued)

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

	Gross	Expected Credit Loss	Net	Gross	Expected Credit Loss	Net
	2020			2019		
Not past due	5, 301	(5)	5, 296	6, 131	(17)	6, 114
Past due 1 - 30 days	69	(19)	50	57	(10)	47
Past due 31 - 120 days	886	(15)	871	109	(21)	88
Past due 121 - 360 days	136	(78)	58	55	(55)	-
Past due over 360 days	88	(88)	-	74	(74)	-
Total	**6, 480**	**(205)**	**6, 275**	**6, 426**	**(177)**	**6, 249**

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

MOVEMENTS IN THE PROVISION FOR IMPAIRMENT OF RECEIVABLES ARE AS FOLLOWS:	2020 Actual	2019 Actual
Balance as at 1 July	177	252
Additional provisions made during the year	106	94
Receivables written off during the year	(2)	(96)
Receivables reversal & recovered during the year	(76)	(73)
Total	**205**	**177**

8 INVENTORIES

ACCOUNTING POLICIES

Inventories held for distribution in the provision of services that are not supplied on a commercial basis are stated at cost, adjusted where applicable for any loss of service potential. Cost is based on weighted average cost.

Inventories are held for the district health board's own use and are not supplied on a commercial basis. Inventories are stated at cost and adjusted where applicable for any loss of service potential. The amount of any write-down for the loss of service potential or from cost to net realisable value is recognised in surplus or deficit in the period of the write-down.

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

BREAKDOWN OF INVENTORIES AND FURTHER INFORMATION	2020 Actual	2019 Actual
Held for distribution inventories		
Central stores	504	351
Pharmaceuticals	392	355
Theatre supplies	476	476
Other supplies	245	245
	1, 617	**1, 427**

Write-down of inventories amounted to $36k (2019: $54k). There have been no reversals of write-downs.

No inventories are pledged as security for liabilities (2019: nil) but some inventories are subject to retention of title clauses (Romalpa clauses). The value of stocks subject to such clauses cannot be quantified due to the inherent difficulties in identifying the specific inventories affected at year-end.

The amount of inventories recognised as an expense during the year was $9.00 million (2019: $8.19 million), which is included in the Other Expenses line item of the Statement of Comprehensive Revenue and Expense.

9 PROPERTY, PLANT AND EQUIPMENT

ACCOUNTING POLICIES

Classes of property, plant and equipment

The major classes of property, plant and equipment are as follows:

- Land, at fair value.
- Buildings and improvements, at fair value less accumulated depreciation.
- Plant and equipment, at cost less accumulated depreciation and impairment losses.
- Vehicles, cost less accumulated depreciation and impairment losses.
- Leased assets, cost less accumulated depreciation and impairment losses.

Revaluations

Land and buildings are revalued, with sufficient regularity to ensure the carrying amount is not materially different to fair value, and at least every three years.

The carrying values of revalued assets are assessed annually to ensure that they do not differ materially from fair value. If there is evidence supporting a material difference, then the off-cycle asset classes are revalued.

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

The net revaluation results are credited or debited to other comprehensive revenue and expense and are accumulated to an asset revaluation reserve in equity for that class of asset. Where this would result in a debit balance in the asset revaluation reserve, this balance is recognised in the surplus or deficit. Any subsequent increase on revaluation that reverses a previous decrease in value recognised in the surplus or deficit will be recognised first in the surplus or deficit up to the amount previously expensed, and then recognised in other comprehensive revenue and expense.

Additions

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

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

Work in progress is recognised at cost less impairment and is not depreciated. Work in progress includes the cost of direct materials, direct labour and an appropriate share of overheads.

Disposal

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

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 Whanganui District Health Board and the cost of items can be measured reliably.

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

Depreciation

Depreciation is charged to surplus or deficit. Depreciation is provided on a straight-line basis on all property, plant and equipment other than land and motor vehicles. Land is not depreciated. Motor vehicles are depreciated using diminishing value basis. 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 major classes of estimated useful lives are as follows:

Class of asset	Estimated life	Depreciation rate
Land	Indefinite	N/A
Buildings & improvements	1 - 80 years	1.25% - 33%
Plant & equipment	3 - 40 years	2.5% - 33%
Vehicles	8 - 14.3 years	7% - 12.5%
Leased assets	7 - 8 years	12.5% - 14.3%

The residual value and useful lives of assets is reassessed annually. Work in progress is not depreciated. The total cost of a project is transferred to the appropriate class of asset on its completion and then depreciated.

Impairment of property, plant and equipment

Whanganui District Health Board does not hold any cash-generating assets. Assets are considered cash-generating where their primary objective is to generate a commercial return.

Non-cash-generating assets
Property, plant and equipment held at cost that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. If any such indication exists, the assets recoverable amounts are estimated. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable service amount. The recoverable service amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use of non-cash generating assets is determined as the present value of the remaining service potential using either the depreciated replacement cost approach, the restoration cost approach or the service units approach. The most appropriate approach used to measure value in use depends on the nature of the assets instead of impairment and availability of information.

If an asset's carrying amount exceeds its recoverable service amount, the asset is regarded as impaired and the carrying amount is written down to the recoverable service amount. For revalued assets, the impairment loss is recognised against the revaluation reserve for that 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 total impairment loss is recognised in the surplus or deficit. The reversal of an impairment loss on a revalued asset is credited to other comprehensive revenue and expense and increases the asset revaluation reserve for that class of asset. However, to the extent that an impairment loss for that class of asset was previously recognised in the surplus or deficit, a reversal of the impairment loss is also recognised in the surplus or deficit.

KEY ACCOUNTING ASSUMPTIONS AND ESTIMATES

Estimated useful lives of property, plant and equipment
At each balance date, Whanganui District Health Board reviews the useful lives and residual values of its property, plant and equipment. Assessing the appropriateness of useful life and residual value estimates of property, plant and equipment requires a number of factors to be considered such as the physical condition of the asset, expected period of use of the asset by Whanganui District Health Board, and expected disposal proceeds from the future sale of the asset.

Whanganui District Health Board has not made significant changes to past assumptions concerning useful lives and residual values.

Estimating the fair value of land and buildings

Valuation
Land and building valuation was performed by management utilising data provided by Evan Gamby (M Prop Stud Distn, Dip UV, FNZIV (Life), LPINZ, FRICS) and Logan Holyoake (B Prop; MPINZ) of Telfer Young. The valuation was completed as at 30 June 2020.

Land
Land is valued at its fair value using market-based evidence based on its highest and best use with reference to comparable land value.

Buildings and improvements
Specialised buildings are valued at fair value using depreciated replacement cost 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.
- Whanganui District Health Board's 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 replacement cost is derived from recent construction contracts of similar assets and Rider Levett Bucknall (RLB) New Zealand cost information. Construction costs range from $562 to $7,504 per square metre, depending on the nature of the specific asset valued.
- The remaining useful life of assets is estimated considering factors such as the condition of the asset, district health board's future maintenance and replacement plans, and experience with similar buildings.
- Straight-line depreciation has been applied in determining the depreciated replacement cost value of the asset.

Non-specialised buildings (for example, residential buildings) are valued at fair value using market-based evidence. Market rents and capitalisation rates were applied to reflect market value.

The recent revaluation of land and buildings resulted in a $0.7 million (41%) increase in the carrying value of land and $6 million (9.3%) increase in the carrying value of buildings and improvements. The revaluation resulted in a $6.7 million increase in property and plant revaluation reserve and a $6.7 million gain on property valuation in other comprehensive revenue and expense.

Restrictions on title
Whanganui District Health Board 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 Whanganui District Health Board 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.

There are no other restrictions on property, plant and equipment.

in thousands of New Zealand dollars

BREAKDOWN OF PROPERTY, PLANT AND EQUIPMENT AND FURTHER INFORMATION

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

30 June 2019	Cost / valuation	Accumulated depreciation	Carrying amounts	Additions	Transfer	Disposals	Revaluation increase	Depreciation expenses	Elimination on disposal	Elimination on revaluation	Cost / valuation	Accumulated depreciation	Carrying amounts
	1 July 2018										30 June 2019		
Land	1,721	-	1,721	-	-	-	-	-	-	-	1,721	-	1,721
Buildings & improvements	68,563	(2,223)	66,340	556	52	-	-	(2,816)	-	-	69,171	(5,039)	64,132
Plant & equipment	24,543	(18,304)	6,239	2,469	-	(863)	-	(1,502)	848	-	26,149	(18,958)	7,191
Leased assets	927	(131)	796	39	-	-	-	(119)	-	-	966	(250)	716
Motor vehicles	2,877	(1,259)	1,618	73	-	-	-	(221)	-	-	2,950	(1,480)	1,470
	98,631	**(21,917)**	**76,714**	**3,137**	**52**	**(863)**	**-**	**(4,658)**	**848**	**-**	**100,957**	**(25,727)**	**75,230**
Work in progress										-			
Buildings & improvements	52	-	52	-	(52)	-	-	-	-	-	-	-	-
	52	**-**	**52**	**-**	**(52)**	**-**	**-**	**-**	**-**		**-**	**-**	**-**
Total	**98,683**	**(21,917)**	**76,766**	**3,137**	**-**	**(863)**	**-**	**(4,658)**	**848**		**100,957**	**(25,727)**	**75,230**

30 June 2020	Cost / valuation	Accumulated depreciation	Carrying amounts	Additions	Transfer	Disposals	Revaluation increase	Depreciation expenses	Elimination on disposal	Elimination on revaluation	Cost / valuation	Accumulated depreciation	Carrying amounts
	1 July 2019										30 June 2020		
Land	1,721	-	1,721	-	-	-	707	-	-	-	2,428	-	2,428
Buildings & improvements	69,171	(5,039)	64,132	696	-	-	705	(2,646)	-	5,258	70,572	(2,427)	68,145
Plant & equipment	26,149	(18,958)	7,191	1,535	-	(93)	-	(1,569)	89	-	27,591	(20,438)	7,153
Leased assets	966	(250)	716	-	-	-	-	(120)	-	-	966	(370)	596
Motor vehicles	2,950	(1,480)	1,470	38	-	-	-	(228)	-	-	2,988	(1,708)	1,280
	100,957	**(25,727)**	**75,230**	**2,269**	**-**	**(93)**	**1,412**	**(4,563)**	**89**	**5,258**	**104,545**	**(24,943)**	**79,602**
Work in progress													
Buildings & improvements	-	-	-	-	-	-	-	-	-	-	-	-	-
	-	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Total	**100,957**	**(25,727)**	**75,230**	**2,269**	**-**	**(93)**	**1,412**	**(4,563)**	**89**	**5,258**	**104,545**	**(24,943)**	**79,602**

10 INTANGIBLE ASSETS

ACCOUNTING POLICIES

Initial recognition

Intangible assets that are acquired by Whanganui District Health Board are stated at cost less accumulated amortisation and impairment losses. Work in progress is disclosed separately where the software development or project has not been completed at balance date.

Software acquisition and development

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

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

Costs associated with maintaining computer software are recognised as an expense when incurred.

Amortisation

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

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

Type of asset	Estimated life	Amortisation rate
Software	4 - 10 years	10 - 25%
RHIP	Work in progress	Nil
RHIP local & regional cost	10 to 20 years	7.7 - 20%
FPIM	Written-off	Nil

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

Impairment of intangible assets

Refer to the policy for impairment of property, plant and equipment in Note 9. The same approach applies to the impairment of intangible assets.

KEY ACCOUNTING ASSUMPTIONS AND ESTIMATES

Estimating useful lives of software assets

Whanganui District Health Board's internally generated software largely arises from local development of regional clinical systems for radiology, clinical support (Clinical Portal) and patient administration (webPAS) as part of Whanganui District Health Board's regulatory functions.

Internally generated software has a finite life, which requires Whanganui District Health Board to estimate the useful life of software assets.

In assessing the useful lives of software assets, a number of factors are considered, including:

- the period of time the software is intended to be in use
- the effect of technological change on systems and platforms
- the expected timeframe for the development of replacement systems and platforms.

An incorrect estimate of the useful lives of software assets will affect the amortisation expense recognised in the surplus or deficit, and the carrying amount of the software assets in the Statement of Financial Position.

FPIM (NZ Health Partnerships Limited)

Whanganui District Health Board has invested in the Finance, Procurement and Information Management (FPIM) project, formerly known as the National Oracle Solution (NOS).

NZ Health Partnerships Ltd, a company collectively owned by the 20 district health boards, facilitates this project.

Whanganui District Health Board is not currently using FPIM and, as a result, the investment in FPIM was impaired in 2018.

Regional Health Informatics Programme (RHIP)

RHIP is a programme to move the Central Region district health boards from disparate, fragmented and, in some cases obsolescent, clinical and administrative information systems to a shared, standardised and fully integrated information systems that will enhance clinical practice, drive administrative efficiencies, enable regionalisation of services and reduce current operational risks.

It was originally agreed that Technical Advisory Services Limited (TAS) would create the RHIP assets and provide services in relation to those assets to the district health boards. Each district health board would provide funding to TAS and in return for the funding relating to capital items, the district health boards would be provided with Class B Redeemable Shares in TAS. The agreement to provide the RHIP assets and services was amended on 1 December 2014 to transfer the ownership of RHIP assets to district health boards jointly.

As at 30 June 2020, Whanganui District Health Board had invested a total of $12.27m (2019: $11.6m) in RHIP. Of this investment, $4k has been recognised as work in progress and $12.27m has been capitalised for the patient administration system (webPAS), regional radiology system (RIS) and Clinical Portal (CP) in respect of intangible assets. The investment has been tested for impairment during the year by the district health board, however, based on the information available, no impairment is required at this point.

BREAKDOWN OF INTANGIBLE ASSETS AND FURTHER INFORMATION

Movements for each class of intangible assets are as follows:

30 June 2019	Cost / valuation	Accumulated amortisation	Carrying amounts	Additions	Transfer	Disposals	Impairment	Amortisation	Elimination on disposal	Cost / valuation	Accumulated amortisation	Carrying amounts
	1 July 2018									30 June 2019		
Software	4,540	(3,311)	1,229	138	-	(5)	-	(241)	5	4,673	(3,547)	1,126
Regional Health Informatics Programme (RHIP)	3,491	(321)	3,170	-	326	-	-	(320)	-	3,817	(641)	3,176
Regional Health Informatics Programme (RHIP) - local	2,338	(158)	2,230	9	6	-	-	(198)	-	2,403	(356)	2,047
	10,419	**(3,790)**	**6,629**	**147**	**332**	**(5)**	**-**	**(759)**	**5**	**10,893**	**(4,544)**	**6,349**
Work in progress												
Regional Health Informatics Programme (RHIP)	4,772	-	4,772	988	(332)	-	-	-	-	5,428	-	5,428
FPIM (NOS)	1,016	-	1,016	32	-	-	(1,048)	-	-	-	-	-
	5,788	**-**	**5,788**	**1,020**	**(332)**	**-**	**(1,048)**	**-**	**-**	**5,428**	**-**	**5,428**
Total	**16,207**	**(3,790)**	**12,417**	**1,167**	**-**	**(5)**	**(1,048)**	**(759)**	**5**	**16,321**	**(4,544)**	**11,777**

30 June 2020	Cost / valuation	Accumulated amortisation	Carrying amounts	Additions	Transfer	Disposals	Impairment	Amortisation	Elimination on disposal	Cost / valuation	Accumulated amortisation	Carrying amounts
	1 July 2019									30 June 2020		
Software	4,673	(3,547)	1,126	345	-	-	-	(238)	-	5,018	(3,785)	1,233
Regional Health Informatics Programme (RHIP)	3,817	(641)	3,176	-	5,615	-	-	(536)	-	9,432	(1,177)	8,255
Regional Health Informatics Programme (RHIP) - local	2,403	(356)	2,047	156	274	-	-	(228)	-	2,833	(584)	2,249
	10,893	**(4,544)**	**6,349**	**501**	**5,889**	**-**	**-**	**(1,002)**	**-**	**17,283**	**(5,546)**	**11,737**
Work in progress												
Regional Health Informatics Programme (RHIP) & Local	5,428	-	5,428	465	(5,889)	-	-	-	-	4	-	4
FPSC rights	-	-	-	-	-	-	-	-	-	-	-	-
	5,428	**-**	**5,428**	**465**	**(5,889)**	**-**	**-**	**-**	**-**	**4**	**-**	**4**
Total	**16,321**	**(4,544)**	**11,777**	**966**	**-**	**-**	**-**	**(1,002)**	**-**	**17,287**	**(5,546)**	**11,741**

There are no restrictions over the title of Whanganui District Health Board intangible assets, nor are any intangible assets pledged as security for liabilities.

11 INVESTMENT IN ASSOCIATES

Associates are those entities in which Whanganui District Health Board has significant influence, but not control, over the financial and operating policies. Whanganui District Health Board has shareholdings in an associate Allied Laundry Services Limited, and participates in commercial and financial policy decisions of that company. The accounts of the associate company are audited.

Allied Laundry Services Limited principal activities are the provision of laundry and linen services. Allied Laundry Services Limited is a profit-oriented company incorporated and domiciled in New Zealand.

Whanganui District Health Board associate investment is accounted for using the equity method. The investment in an associate is initially recognised at cost and the carrying amount in the financial statements is increased or decreased to recognise the district health board's share of the surplus or deficit of the associate after the date of acquisition. Distributions received from an associate reduce the carrying amount of the investment in the group financial statements.

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

On derecognition, the cumulative gain or loss previously recognised in other comprehensive revenue and expense is reclassified to the surplus or deficit.

If Whanganui District Health Board's share of losses exceeds its interest in an associate, its carrying amount is reduced to nil and recognition of further losses is discontinued except to the extent that Whanganui District Health Board has incurred legal or constructive obligations or made payments on behalf of an associate.

Where the group transacts with an associate, surplus or deficits are eliminated to the extent of the interest in the associate.

BREAKDOWN OF INVESTMENT IN ASSOCIATE AND FURTHER INFORMATION	2020 Actual	2019 Actual
***Summary of financial information on associate entities** (100 percent)*		
Assets	9, 867	9, 918
Liabilities	(2, 232)	(2, 544)
Equity	(7, 635)	(7, 374)
Revenue	(11, 759)	(10, 916)
Expense	10, 995	10, 268
Surplus / (deficit)	764	648
Allied Laundry Services Limited	16.67%	16.67%
Investment in associates		
Balance as at 1 July	1, 146	1, 121
Dividends	(69)	(70)
Share of profit	108	95
Total investment in associates	**1, 185**	**1, 146**

12 OTHER FINANCIAL ASSETS

Whanganui District Health Board holds a 16.7 percent (2019: 16.7%) shareholding in Technical Advisory Services Limited (TAS) and participates in its commercial and financial policy decisions. The five other district health boards in the central region each hold 16.7 percent (2019: 16.7%) of the shares. Technical Advisory Services Limited was incorporated on 6 June 2001. The total share capital of $600 remains uncalled and as a result no investment has been recorded in the Statement of Financial Position for this investment.

13 PAYABLES

ACCOUNTING POLICIES

Trade and other payables are generally settled within 30 days so are recorded at their face value.

BREAKDOWN OF PAYABLES UNDER NON-EXCHANGE AND EXCHANGE TRANSACTIONS	2020 Actual	2019 Actual
Payables under non-exchange transaction		
Creditors	-	38
Tax payables (GST, PAYE)	1, 861	1, 669
ACC levy	151	139
Income in advance	994	-
Other	291	246
Total payables under non-exchange transaction	**3, 297**	**2, 092**
Payables under exchange transaction		
Creditors	2, 388	2, 841
Income in advance	294	263
Accrued expense	14, 556	13, 038
Total payables under exchange transaction	**17, 238**	**16, 142**
Total payables	**20, 535**	**18, 234**

14 BORROWINGS

ACCOUNTING POLICIES

Borrowings are initially measured at fair value, plus transaction costs. Subsequent to initial recognition, all 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. Interest due on the borrowings is subsequently accrued and added to the accrued expense.

Borrowings are classified as current liabilities unless Whanganui District Health Board has an unconditional right to defer settlement of the liability for at least 12 months after balance date.

Finance lease

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 whereby Whanganui District Health Board 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.

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

CRITICAL JUDGEMENTS IN APPLYING ACCOUNTING POLICIES

Leases classification

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

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

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

BREAKDOWN OF BORROWINGS AND FURTHER INFORMATION

	2020 Actual	2019 Actual
Current portion		
The Energy Efficiency and Conservation Authority	101	135
Finance lease	97	95
Total current portion	**198**	**230**
Non-current portion		
The Energy Efficiency and Conservation Authority	-	101
Finance lease	486	583
Total non-current portion	**486**	**684**
Total borrowings	**684**	**914**

NZ Health Partnerships overdraft facility

Whanganui District Health Board has a maximum borrowing limit of $12.24m (2019: $11.51m) as at 30 June 2020. Refer to Note 6 for further information.

Interest rates

NZ Health Partnerships borrowings has on-call interest rate plus an administrative margin. This is disclosed in note 20C.

ENERGY EFFICIENCY & CONSERVATION AUTHORITY LOAN PAYABLE AS FOLLOWS:

	2020 Actual	2019 Actual
Less than one year	101	135
One to two years	-	101
Two to three years	-	-
Three to four years	-	-
Four to five years	-	-
Over five years	-	-
Total	**101**	**236**

Whanganui District Heath Board received an interest-free loan of $642k in January 2016 from the Energy Efficiency and Conservation Authority to upgrade infrastructure for energy efficiency.

ANALYSIS OF FINANCE LEASE AS FOLLOWS:

	2020 Actual	2019 Actual
Minimum lease payments payables		
Less than one year	114	114
Between one and five years	455	455
More than five years	65	179
Total minimum lease payments	**634**	**748**
Less: Future finance charges	(51)	(70)
Present value of minimum lease payments	**583**	**678**

PRESENT VALUE OF MINIMUM LEASE PAYMENTS PAYABLE:

	2020 Actual	2019 Actual
Minimum lease payments payables		
Less than one year	97	95
Between one and five years	421	408
More than five years	65	175
Total minimum lease payments	**583**	**678**
Less: Future finance charges	-	-
Present value of minimum lease payments	**583**	**678**

Whanganui District Health Board finance lease liabilities are effectively secured as the rights to the leased asset revert to the lessor in the event of default.

Whanganui District Health Board has entered into finance lease for clinical equipment, Computed Tomography (CT) scanner. The equipment lease is for an initial period of eight (8) years ending January 2026, with right of purchase any time within eight (8) years from the commission date.

15 EMPLOYEE BENEFITS

ACCOUNTING POLICIES

Short-term employee entitlements

Employee benefits that are due to be settled within 12 months after the end of the period 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 and annual leave earned but not yet taken at balance date and sick leave.

A liability for sick leave is recognised to the extent that absences in the coming year are expected to be greater than the sick leave entitlements earned in the coming year. The amount is calculated based on the unused sick leave entitlement that can be carried forward at balance date, to the extent that it will be used by staff to cover those future absences.

The liability and an expense are recognised for bonuses where it is a contractual obligation or where there is a past practice that has created a constructive obligation and reliable estimate of the obligation can be made.

Long-term employee entitlements

Employee benefits that are due to be settled beyond 12 months after the end of period in which the employee renders the related service, such as long service leave and retirement gratuities, have been calculated using projected unit credit method and discounted to its present value. 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, annual leave, continuing medical education leave, sabbatical and long service leave are classified as a current liability. Long service leave and retirement gratuities expected to be settled within 12 months of balance date are classified as a current liability. All other employee entitlements are classified as a non-current liability.

Key accounting assumptions in measuring retirement and long service leave obligations

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

Expected future payments are discounted using forward discount rates derived from the yield curve of New Zealand government bonds. The discount rates used have maturities that match, as closely as possible, the estimated future cash outflows. The salary inflation factor has been determined after considering historical salary inflation patterns. A weighted average discount rate range from 0.14% to 1.28% (2019: 1.35% to 2.24%) and an inflation factor of 3% (2019: 3%) were used.

BREAKDOWN OF EMPLOYEE ENTITLEMENTS

	2020 Actual	2019 Actual
Current portions		
Accrued salaries and wages	3, 040	2, 403
Annual leave	9, 746	8, 109
Sick leave	223	212
Retirement gratuities	637	604
Long service leave	960	893
Sabbatical leave	516	516
Other leave	4	2
Continuing medical education leave	27	27
Other entitlement	6, 767	3, 947
Total current portion	**21, 920**	**16, 713**
Non-current portions		
Retirement gratuities	713	766
Long service leave	126	107
Total non-current portion	**839**	**873**
Total employee entitlements	**22, 759**	**17, 586**

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 and the New Zealand Blood Service, with the Council of Trade Unions, health sector unions and Ministry of Business Innovation and Employment Labour Inspectorate for an agreed and national approach to identify, rectify and remediate any Holidays Act non-compliance. District health boards have agreed to a memorandum of understanding which contains a method for determination of individual employee earnings, for calculation of liability for any historical non-compliance.

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

The remediation project associated with the memorandum of understanding is a significant undertaking. There are three key phases to the process;

1. Review – Involves testing Whanganui District Health Board's payroll system against the memorandum of understanding to identify the extent of non-compliance.
2. Rectification – Fixing any identified issues of non-compliance in Whanganui District Health Board's holiday pay payments and applying processes to ensure future payment to employees comply with the Act.
3. Remediation - Calculating and paying any amount owing to current and non-current employees arising from any identified non-compliance. A national register will be developed to allow former employees of District Health Boards to register and provide up to date contact information. Former employees who worked for Whanganui District Health Board from 1 May 2010 will be able to register. The register will be available via a website which will be publicised and a link placed on Whanganui District Board's website as soon as available. Current Whanganui District Health Board employees do not need to register on the national website. Those registered will receive notifications and progress updates.

Whanganui District Health Board carried out and completed the review phase of process in the financial year ended 30 June 2020. The phase also involved an audit completed by Technical Advisory Services (TAS). The findings of this audit are currently being worked through with the relevant unions. Some issues have been escalated nationally for direction and clarification which may delay the completion of the remaining phases of the project. The outcome of the project and time line addressing any non-compliance will not be determined until the three phases of work are completed.

Notwithstanding, as at 30 June 2020, in preparing these financial statements, Whanganui District Health Board recognise it has an obligation to address any historical non-compliance 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 memorandum of understanding. This was based on a detailed analysis of current and former employees to calculate an indicative liability for those current and former employees.

Whanganui District Health Board has estimated its liability as at 30 June 2020 to be $7m (2019: $4.2m). This indicative liability amount is the best estimate at this stage. However, until the project has progressed further, there remain substantial uncertainties. The estimates and assumptions may differ to the subsequent actual results as further work is completed and result in further adjustment to the carrying amount of the provision liabilities within the next financial year.

16 CONTINGENT LIABILITIES AND CONTINGENT ASSETS

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.

Whanganui District Health Board has no contingent liabilities relating to legal action instigated by employees (2019: nil).

Contingent assets

Whanganui District Health Board has no contingent assets (2019: nil).

17 CAPITAL COMMITMENTS

	2020 Actual	2019 Actual
Capital commitments		
Buildings and improvements	83	448
Plant and equipment	1, 022	492
Intangible assets	581	749
Motor vehicles	-	38
Total	**1, 686**	**1, 727**

	2020 Actual	2019 Actual
Capital commitments		
Less than one year	1, 686	1, 727
One to two years	-	-
Total	**1, 686**	**1, 727**

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

18 RELATED PARTY TRANSACTION

Whanganui District Health Board is a wholly-owned entity of the Crown.

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

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

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

KEY MANAGEMENT PERSONNEL COMPENSATION	2020 Actual	2019 Actual
Board members		
Remuneration	202	205
Full-time equivalent members	0.78	0.95
Executive team		
Remuneration	1, 720	1, 789
Full-time equivalent members	7.51	7.74
Total key management personnel compensation	**1, 926**	**1, 994**
Total full time equivalent personnel	**8.29**	**8.69**

The full-time equivalent for board members has been determined based on the frequency and length of board meetings and the estimated time for board members to prepare for meetings. An analysis of board member remuneration is provided in Note 5.

19 EVENTS AFTER THE BALANCE DATE

There were no significant events after the balance date. The COVID-19 pandemic has not had any material impact after the balance date.

20 FINANCIAL INSTRUMENTS

Financial assets

Classification

Financial assets are divided into two classifications - those measured at amortised cost and those measured at fair value. The classification depends on the entity's business model for managing the financial assets and the contractual terms of the cash flows.

Whanganui District Health Board has no financial assets measured at fair value.

Recognition and derecognition

Regular way purchases and sales of financial assets are recognised on trade-date, the date on which Whanganui District Health Board commits to purchase or sell the asset. Financial assets are derecognised when the rights to receive cash flows from the financial assets have expired or have been transferred and Whanganui District Health Board has transferred substantially all the risks and rewards of ownership.

Measurement

At initial recognition, Whanganui District Health Board measures a financial asset at its fair value.

Subsequent measurement of the financial asset depends on Whanganui District Health Board's business model for managing the asset and the cash flow characteristics of the asset. Whanganui District Health Board has no financial assets measured at fair value and only has financial assets measured at amortised cost.

Amortised cost: Assets that are held for collection of contractual cash flows where those cash flows represent solely payments of principal and interest are measured at amortised cost. Interest income from these financial assets is included in finance income using the effective interest rate method. Any gain or loss arising on derecognition is recognised directly in surplus or deficit. Impairment losses are presented as separate line item in the statement of surplus or deficit.

Impairment

Whanganui District Health Board assesses on a forward looking basis the expected credit losses associated with its debt instruments carried at amortised cost. The impairment methodology applied depends on whether there has been a significant increase in credit risk. For trade receivables, the Whanganui District Health Board applies the simplified approach, which requires expected lifetime losses to be recognised from initial recognition of the receivables, see Note 7 for further details.

Financial liabilities and equity

Debt and equity instruments that are issued are classified as either financial liabilities or as equity in accordance with the substance of the contractual arrangement. A financial liability is a contractual obligation to deliver cash or another financial asset or to exchange financial assets or financial liabilities with another entity under conditions that are potentially unfavourable to Whanganui District Health Board or a contract that will or may be settled in the Whanganui District Health Board's own equity instruments and is a non-derivative contract for which it is or may be obliged to deliver a variable number of its own equity instruments, or a derivative contract over own equity that will or may be settled other than by the exchange of a fixed amount of cash (or another financial asset) for a fixed number of Whanganui District Health Board's own equity instruments

Equity instruments

An equity instrument is any contract that evidences a residual interest in the assets of an entity after deducting all of its liabilities. Equity instruments issued by Whanganui District Health Board are recognised at the proceeds received, net of direct issue costs. Repurchase of the district health board's own equity instruments is recognised and deducted directly in equity. No gain/loss is recognised in surplus or deficit on the purchase, sale, issue or cancellation of Whanganui District Health Board's own equity instruments.

Financial liabilities

Financial liabilities are classified as either financial liabilities at fair value through surplus or deficit or other financial liabilities. Whanganui District Health Board has no financial liabilities at fair value.

Other financial liabilities

Other financial liabilities, including trade and other payables, finance leases and borrowings, are initially measured at fair value, net of transaction costs. Other financial liabilities are subsequently measured at amortised cost using the effective interest method. The effective interest method is a method of calculating the amortised cost of a financial liability and of allocating interest expense over the relevant period. The effective interest method is the rate that exactly discounts estimated future cash payments through the expected life of the financial liability, or, where appropriate, a shorter period, to the net carrying amount on initial recognition.

Derecognition of financial liabilities

Whanganui District Health Board derecognises financial liabilities when, and only when, its obligations are discharged, cancelled or have expired. The difference between the carrying amount of the financial liability derecognised and the consideration paid and payable is recognised in surplus or deficit.

20a FINANCIAL INSTRUMENT CATEGORIES

	2020 Actual	2019 Actual
Financial assets measured at amortised cost (2018: Loans and receivables)		
Cash and cash equivalents	3, 813	3, 020
Receivables (Gross)	6, 480	6, 426
Total financial assets measured at amortised cost	**10, 293**	**9, 446**
Financial liabilities measured at amortised cost		
Payables *(excluding income in advance, taxes payable and grants received subject to conditions)*	17, 386	16, 302
Borrowings - Energy Efficiency and Conservation Authority	101	236
Finance leases	583	678
Total financial liabilities measured at amortised cost	**18, 070**	**17, 216**

20b FAIR VALUE

ESTIMATION OF FAIR VALUES ANALYSIS

The following summarises the major methods and assumptions used in estimating the fair values of financial instruments reflected in the table.

	Notes	Carrying amount	Fair value
30 June 2019			
Financial assets			
Cash and cash equivalents	6	3, 020	3, 020
Receivables (Gross)	7	6, 426	6, 426
Financial liabilities			
Payables *(excluding income in advance, taxes payable and grants received subject to conditions)*	13	16, 302	16, 302
Borrowings - Energy Efficiency and Conservation Authority	14	236	236
Finance lease liabilities	14	678	678
30 June 2020			
Financial assets			
Cash and cash equivalents	6	3, 813	3, 813
Receivables (Gross)	7	6, 480	6, 480
Financial liabilities			
Payables *(excluding income in advance, taxes payable, and grants received subject to conditions)*	13	17, 386	17, 386
Borrowings - The Energy Efficiency and Conservation Authority	14	101	101
Finance lease liabilities	14	583	583

Interest-bearing loans and borrowings

Fair value is calculated based on discounted expected future principal and interest cash flows.

Finance lease liabilities

The fair value is estimated as the present value of future cash flows, discounted at market interest rates for homogeneous lease agreements. The estimated fair values reflect change in interest rates.

Receivables/payables/cash and cash equivalents

For receivables/payables/cash and cash equivalents with a remaining life of less than one year, the notional amount is deemed to reflect the fair value. All other receivables/payables/cash and cash equivalents are discounted to determine the fair value.

Interest rates used for determining fair value

The calculation of fair market value of the loans is based on the government loan rate plus 15 basis points, which is based on mid-market pricing.

Investment

For short-term investments with a remaining life of less than one year, the notional amount is deemed to reflect fair value.

20c FINANCIAL INSTRUMENT RISK

Whanganui District Health Board's activities expose it to a variety of financial instrument risks, including market risk, credit risk, and liquidity risk. Whanganui District Health Board has a Finance, Risk and Audit Committee that provides oversight of risk management activities and also has a series of policies to manage the risks associated with financial instruments and seeks to minimise exposure. These policies do not allow any transactions that are speculative in nature to be entered into.

MARKET RISK

Fair value interest rate risk

Interest rate risk is the risk that a financial instrument will fluctuate, due to changes in market interest rates. Whanganui District Health Board's exposure to fair value interest rate risk is limited to its bank deposits which are held at fixed rates of interest. Whanganui District Health Board does not actively manage its exposure to fair value interest rate risk as investment and borrowings are generally held to maturity.

Cash flow interest rate risk

Cash flow interest rate risk is the risk that the cash flows from a financial instrument will fluctuate because of changes in market interest rates. Whanganui District Health Board's exposure to cash flow interest rate risk is limited to on-call deposits. This exposure is not considered significant and is not actively managed.

Whanganui District Health Board's investment policy requires a spread of investment maturity dates to limit exposure to short-term interest rate movements. Whanganui District Health Board currently has no variable interest rate investments.

The exposure to interest rate risk arises from NZ Health Partnerships sweep account facility which attracts an on-call interest rate. In respect of income-earning financial assets and interest-bearing financial liabilities, the table on the following page indicates their effective interest rates at the Statement of Financial Position date and the periods in which they reprise.

Sensitivity analysis

In managing interest rate risks Whanganui District Health Board aims to reduce the impact of short-term fluctuations on its earnings under their adopted Treasury Management Policy. Over the longer term, however, permanent changes in interest rates would have an impact on consolidated earnings.

At 30 June 2020, it is estimated that a general increase of one percentage point in interest rates would have minimal impact on earnings in 2019/20, as most of the district health board's term debt is at fixed rates. Only the net interest from cash holdings and the NZ Health Partnerships sweep would be affected.

Credit risk

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

In the normal course of business, Whanganui District Health Board is exposed to credit risk from cash and term deposits with banks, NZHP and receivables. For each of these, the maximum credit exposure is best represented by the carrying amount in the Statement of Financial Position.

Whanganui District Health Board's shared banking arrangement with NZHP results in credit risk exposure to the district health board. NZHP is indemnified by all district health boards for any default by banks holding cash on deposit from NZHP. NZHP will pass on any losses it incurs as a result of default by banks. NZHP manages credit risk by investing in NZ incorporated banks with a minimum credit rating of A+. Whanganui District Health Board has counter-party credit risk for foreign currency and interest rate derivatives as this transaction is undertaken by the bank. The money with NZHP is classified under "counterparties without credit rating".

Whanganui District Health Board has experienced no defaults of interest or principal payments for term deposits.

Concentrations of credit risk from accounts receivable are limited due to the large number and variety of customers. The Ministry of Health is the largest single debtor approximately at 59% (2019: 45%). The Ministry of Health 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.

At the Statement of Financial Position 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 thousands of New Zealand dollars

	Effective interest rate %	Total	1 - 12 months	1 - 2 years	2 - 5 years	More than 5 years
30 June 2019						
Cash on hand	-	5	5	-	-	-
NZ Health Partnerships Limited	-	3, 015	3, 015	-	-	-
Receivables (net)	-	6, 249	6, 249	-	-	-
Borrowings - Energy Efficiency & Conservation Authority	0.00%	236	135	101	-	-
Finance leases	3.00%	678	95	97	311	175
30 June 2020						
Cash on hand	-	5	5	-	-	-
NZ Health Partnerships Limited	-	3, 808	3, 808	-	-	-
Receivables (net)	-	6, 275	6, 275	-	-	-
Borrowings - Energy Efficiency & Conservation Authority	0.00%	101	101	-	-	-
Finance leases	3.00%	583	97	100	321	65

Liquidity risk

Management of liquidity risk

Liquidity risk is the risk that Whanganui District Health Board encounters 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.

Whanganui District Health Board mostly manages liquidity risk by continuously monitoring forecast and actual cash flow requirements, maintaining an overdraft facility.

Contractual maturity analysis of financial liabilities, excluding derivatives

The table below analyses Whanganui District Health Board's 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 on the instrument at balance date. The amounts disclosed are the contractual undiscounted cash flows and include interest payments.

	Carrying amount	Contractual cash flow	1 - 12 months	1 - 2 years	2 - 5 years	More than 5 years
30 June 2019						
Payables *(excluding income in advance, taxes payable & grants received subject to conditions)*	16, 302	16, 302	16, 302	-	-	-
Borrowings - Energy Efficiency & Conservation Authority	236	236	135	101	-	-
Finance leases	678	748	114	114	341	179
Total	**17, 216**	**17, 286**	**16, 551**	**215**	**341**	**179**
30 June 2020						
Payables *(excluding income in advance, taxes payable & grants received subject to conditions)*	17, 386	17, 386	17, 386	-	-	-
Borrowings - Energy Efficiency & Conservation Authority	101	101	101	-	-	-
Finance leases	583	634	114	114	341	65
Total	**18, 070**	**18, 121**	**17, 601**	**114**	**341**	**65**

Capital management

Whanganui District Health Board's capital is its equity, which comprises Crown equity, accumulated funds, property revaluation reserves and hospital special funds, as disclosed in the Statement of Financial Position. Equity is represented by net assets. Whanganui District Health Board is subject to the financial management and accountability provisions of the Crown Entities Act 2004, which impose restrictions in relation to borrowings, acquisition of securities, issuing guarantees and indemnities, and the use of derivatives.

Whanganui District Health Board has complied with the financial management requirements of the Crown Entities Act 2004 during the year.

Whanganui District Health Board manages its equity as a by-product of prudently managing revenues, expenses, assets, liabilities, investments, and general financial dealings to ensure that it effectively achieves its objectives and purpose, while remaining a going concern. Whanganui District Health Board policies in respect of capital management are reviewed regularly by the board.

There have been no material changes in Whanganui District Health Board's management of capital during the period.

21 EXPLANATION OF FINANCIAL VARIANCE AGAINST BUDGET

Statement of Comprehensive Revenue and Expense

- Exchange and non-exchange revenue exceeded budget by $3.9 million, due to additional revenue received for COVID-19 pandemic management and additional funding for side contracts (offset by equivalent costs). This was partly offset by lower Accidental Compensation revenue and inter-district inflow revenue due to COVID-19 impact on services.
- Personnel costs exceeded budget by $0.6 million due to an increase in the provision for Holidays Act compliance, this was party offset by lower medical personnel costs due to vacancies (offset by outsourced locum medical staff costs) and lower course and conference expenditure as a result of COVID-19 preventing attendance.
- Outsourced services exceeded budget by $2.4 million due to higher than anticipated use of locum medical staff to cover vacancies as well as outsourced clinical services to meet increased clinical demand.
- Depreciation is less than budget by $0.3 million due to the delay in implementing IT projects and completing clinical equipment purchases.
- Other expenses exceeded budget by $4.1 million due to increased COVID-19 costs ($4.7 million) and inter-district outflows ($2 million). This was partly offset by lower clinical supplies costs (0.7 million) as well as lower health older people and pharmaceutical costs ($1.9 million).

Statement of Financial Position

- Property, plant and equipment exceeded budget by $3.5 million due to revaluation uplift of $6.7 million. This was partly offset by the delay of capital expenditure relating to buildings, IT and clinical equipment.
- Intangible assets were $0.6 million less than budget due to delays in the Regional Health informatics Programme (RHIP).
- Payables under non-exchange and exchange transactions exceeded to budget by $4.6 million due to increased inter-district outflows, facility contract and COVID-19 costs.
- Employee entitlements exceeded budget by $3.7 million due to an increase in the provision of Holidays Act compliance and greater than expected leave entitlements owing at year-end.

Statement of Changes in Equity

- Statement of Changes in Equity exceeded budget by $4.9 million due to property, plant and equipment's valuation uplift of $6.7 million and additional deficit support received of $7 million against a budget of $6 million. This was partly offset by an increased deficit against budget by $2.8 million, largely due to Holidays Act compliance provision.

Statement of Cash Flows

- Cash and cash equivalents exceeded budget by $10.7 million (anticipated overdraft of $7 million) mainly due to delays in capital expenditure programme, addition deficit support received and movements in working capital.

22 COMPLIANCE WITH LEGISLATION

Crown Entities Act 2004

There were nil breaches noted of the Crown Entities Act in 2020 (2019: nil).

New Zealand Public Health and Disability Act 2000

There were nil breaches noted of the NZPHD Act in 2020 (2019: nil).

Ministerial Directions

Whanganui District Health Board complies with the following Ministerial directions:

- The 2011 Eligibility Direction issues under section 32 of the NZ Public Health and Disability Act 2000.
- The requirement to implement the New Zealand Business Number (NZBN) in key systems by December 2018, issued in May 2016 under section 107 of the Crown Entities Act.
- The direction 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. Procurement and ICT apply to Whanganui District Health Board.
- The direction on the use of authentication services issued in July 2008 which continues to apply to all Crown agencies apart from those with sizeable ICT business transactions and investment specifically listed within the 2014 direction.
- COVID-19 Health Response Act 2020.

23 SUMMARY COST OF SERVICES

	2020 Actual	2020 Budget	2019 Actual
Revenue			
Prevention services	9, 327	5, 581	5, 183
Early detection and management	55, 310	61, 524	56, 828
Intensive assessment and treatment	176, 824	168, 068	162, 239
Rehabilitation and support	38, 218	40, 593	41, 549
Total revenue	**279, 679**	**275, 766**	**265, 799**
Expenditure			
Prevention services	(10, 789)	(7, 226)	(6, 489)
Early detection and management	(60, 214)	(67, 449)	(61, 393)
Intensive assessment and treatment	(184, 073)	(170, 936)	(169, 067)
Rehabilitation and support	(40, 007)	(42, 752)	(42, 504)
Total expenditure	**(295, 083)**	**(288, 363)**	**(279, 453)**
(Deficit) / Surplus	**(15, 404)**	**(12, 597)**	**(13, 654)**

24 COVID-19

The coronavirus (COVID-19) outbreak is a serious threat to public health. It has interrupted the movement of people and goods throughout the world, and many levels of government and private sector organisations have taken significant measures to contain the virus, including quarantines, workplace shutdowns and border closures.

Consequences of the outbreak have also contributed to significant volatility in global markets since early February 2020.

The COVID-19 pandemic has developed rapidly in 2020, with a significant number of cases globally. The first cases were reported to the World Health Organization (WHO) on 29 December 2019, and the WHO declared a global health emergency on 30 January 2020 and then a global pandemic on 11 March 2020.

Measures taken to contain the virus have significantly affected economic activity which, in turn, has implications for financial reporting.

By early January, New Zealand's Ministry of Health was notifying district health boards about unusual cases of pneumonia. Whanganui DHB's Patient Safety & Quality department (which covers infection prevention and emergency management) was among those notified, and it maintained a watching brief on the developing situation.

Whanganui District Health Board already had a pandemic plan in place following past pandemics such as SARS, MERS, swine flu and ebola which had threatened but never really impacted New Zealand.

An Incident Management Team was set up to monitor the situation before the first New Zealand case, which came on 28 February.

On 16 March the chief executive opened the Emergency Operations Centre in the Whanganui District Health Board hospital boardroom. Three days later, the first community-based assessment centre (CBAC) was operational on the hospital campus and by the following week the Whanganui District Health Board had five further CBACs set up to test for COVID-19 – two in the city; and three in rural towns.

On 21 March, with 52 cases in the country, New Zealand was put on Alert Level 2. Two days later, with more than 100 cases, it was Alert Level 3 and on 25 March New Zealand had Alert Level 4 lockdown with more than 200 cases.

Whanganui District Health Board responded accordingly to the various alert levels with its public messaging; its practices around infection control; personal protective equipment; staff welfare; hospital access restrictions; deferment of some elective surgeries etc.

Whanganui's first COVID-19 cases were reported on 28 March – three men returning from a trip to Chicago. All three self-isolated, did not need hospital care and were managed by Public Health staff. Six other cases followed over the next three weeks – two returning from the Philippines; two from the UK; and two in the community where we could not establish a transmission link. All nine cases recovered without needing hospital care. Our last positive case was 17 April, 2020.

In April 2020, the Emergency Operations Centre moved to the Whanganui District Council building and integrated with the Civil Defence & Emergency Management team, with support from council staff. As well as this integration, emphasis was placed on developing existing relationships with iwi, who were very active in their rohe (territory) in terms of both protective measures and community welfare; other health providers and agencies; regional and territorial authorities; Police; Fire & Emergency NZ; and many other bodies.

At the hospital, the philosophy was to err on the side of caution and prepare for a possible surge of cases. The second-floor Surgical Ward was converted into an isolation ward for potential COVID-19 cases and the third floor became a blended Medical/Surgical ward. With the move to Alert Level 3 on 27 April, elective surgery and non-urgent specialist appointments were re-started. Whanganui District Health Board had approximately 130 deferred surgeries and this backlog was eliminated by August 2020.

A permanent switch of hospital wards was made on 30 April, with the Medical Ward moving to the second floor and the Surgical Ward to the third floor, while maintaining the capacity for an isolation area if needed. When New Zealand moved to Alert Level 2 on 13 May, visitor restrictions at the hospital were relaxed.

The Emergency Operations Centre was de-activated on 20 May, with a number of staff joining the wider-based Integrated Recovery Team. A public survey was undertaken on how people had coped with the lockdown, and a survey was also done of Whanganui District Health Board staff's responses to the lockdown and dealing with the pandemic in general.

On 8 June, New Zealand moved to Alert Level 1 and the DHB and hospital moved back to normal working arrangements, though with extra emphasis on good hygiene procedures. The CBAC on the hospital campus was kept in operation, while the others were closed down with swabbing reverting to GP practices.

Revenue	
Ministry of Health revenue	**3, 931**
Expense	
Personnel (including outsourced services)	(708)
Clinical & infrastructure & non-clinical expenses	(1, 198)
Payments to non-health board providers	(3, 524)
Total Expense	**(5, 430)**

The Ministry of Health provided funding to meet the increased costs associated with COVID-19, community based assessment centre (CBAC) establishment, General Practice based assessments, primary care response and virtual consultations, pharmaceutical, residential aged care and Māori Health services.

Due to the COVID-19 pandemic, there was an additional $0.7 million in personnel costs mainly driven by Emergency Operations Centre management, casual staff and staff self-isolation costs.

$1.2 million was spent on clinical and infrastructure and non-clinical supply costs mainly driven by personnel protective clothing, hygienic and sanitation supplies, pharmaceutical, patient transport, security management, advertising and building alteration costs to ensure safer access to the hospital site for community and staff.

$3.5 million of additional costs were incurred for CBAC establishment, General Practice based COVID-19 assessments, primary care response, virtual consultations, Māori Health (Whanganui District Health Board was lead DHB for Māori health, therefore received additional funding and equivalent amounts of funding were passed on to district health boards and other providers), and aged residential care providers.

GLOSSARY

ACC
Accident Compensation Corporation

Acute
Acute care is a secondary healthcare service, where a patient receives active but short-term treatment for a severe injury or episode of illness, an urgent medical condition, or during recovery from surgery.

Admission
Admission to hospital services.

Ambulatory Sensitive Hospitalisation (ASH)
Acute admissions that are considered potentially reducible through interventions deliverable in a primary care setting.

Ambulatory services
Medical care provided on an outpatient basis, including diagnosis, observation, consultation, treatment, intervention and rehabilitation services.

Annual Report
Under section 150 of the Crown Entity Act, district health boards are obliged to prepared an annual report. Annual reports are prepared annually for each financial year ending 30 June. The purpose of the annual report is to compare activities performed with those intended in the annual plan.

ARC
Aged Residential Care

Aroha
Love, respect, empathy, protection, foundation, relationships, non-judging, unconditional, passion.

Assets
Resources owned by the district health board. Assets can be divided into categories such as current assets and non-current assets.

B4 School Check
The B4 School Check is a free health and development check for four-year-olds.

Balance date
A balance date is the end of an accounting (financial) year. The district health boards balance date is 30 June.

Bed days
The total number of bed days of all admitted patients during the reporting period. It is taken from the count of the number of inpatients at midnight (approximately) each day. Details for Same Day patients are also recorded as Occupied Bed Days where one Occupied Bed Day is counted for each Same Day patient.

Bed Occupancy
The available beds which have been occupied over the year. It is a measure of the intensity of the use of hospital resources by inpatients.

Capital charge
Capital charge is a fixed percentage charge on net assets. Charging this helps makes explicit the true costs of the taxpayers' investment in each of the district health boards and ensures that they make decisions based on the full cost of the services they provide. Also creates an incentive for district health boards to make the most efficient use of their working capital. Capital charge payments are payable to the Crown.

Capital expenditure (Capex)
Capital expenditure, or Capex, are funds used by an organisation to acquire or upgrade physical assets such as property, plants and equipment.

These used for more than one year in the operations of a business. Capital expenditures can be thought of as the amounts spent to acquire or improve an organisation's fixed assets.

Caries
Tooth decay or cavities.

Carrying Amount
The value at which an asset or liability is carried at on the balance date.

CCDM
Care Capacity and Demand Management Programme

centralAlliance
Collaborative agreement between Whanganui and MidCentral district health boards.

Chronic disease
A chronic disease is one lasting three months or more.

Communicable diseases
An infectious disease transmissible (as from person to person) by direct contact with an affected individual or the individual's discharges or by indirect means.

Community Services
Health services generally delivered in a community setting.

Comorbidities
The presence of one or more additional diseases or disorders co-occurring with a primary disease or disorder.

Crown Funding Agreement
The Crown Funding Agreement (CFA) is the agreement between the Minister of Health and district health boards. Through the CFA the Crown agrees to provide funding in return for service provision as specified in the CFA.

Crown-owned/Crown entity
A generic term for a diverse range of entities within one of the five categories referred to in section 7 of the CE Act, namely: statutory entities, Crown entity companies, Crown entity subsidiaries, school boards of trustees, and tertiary education institutions.

Current assets
An asset that can readily be converted to cash or will be used to repay a liability within 12 months of balance date.

Current liabilities
A liability that is required to be discharged/ settled within 12 months of balance date.

Depreciation (amortisation)
An expense charged each year to reflect the estimated cost of using assets over their lives. Amortisation relates to 'intangible' assets such as software (as distinct from physical assets, which are covered by depreciation).

Derivative financial instruments
Conventions, and rules accountants follow in recording and summarising transactions, and in the preparation of financial statements.

Discharge
Discharge from hospital services.

Dividends
Payment per share to shareholders as a return on their investment.

Elective surgery (service)
Elective surgery is a medical and surgical service for people who do not need to be treated right away.

Emergency Department
Medical treatment department specialising in emergency medicine, the acute care of patients who present without prior appointment; either by their own means or by that of an ambulance.

Employee Assistance Programme (EAP)
A programme available for Whanganui District Health Board employees which provides confidential support for both personal and work-related issues.

Whānau/family-centred
Refers to staff working alongside the patient and their whānau/family in a collaborative manner so that everyone understands the needs of the patient and whānau/family as self-determined by them to improve their health and overall wellbeing.

FSA
First Specialist Assessment

GAAP
Generally Accepted Accounting Principles. These include standards, conventions, and rules accountants follow in recording and summarising transactions, and in the preparation of financial statements.

General Practice
Medical profession, a general practitioner (GP) is a medical doctor who treats acute and chronic illnesses and provides preventive care and health education to patients.

Green Prescriptions
A health professional's written advice to become more physically active as part of their overall health management.

GST
Goods and service tax. In New Zealand the current GST rate is 15 percent.

Hāpai Te Hoe
Whanganui District Health Board cultural awareness programme.

Haumoana
Māori health worker. A member of the Te Hau Ranga Ora (Māori Health Services) - working with patients and their whānau/ families and colleagues as part of the health care team.

Hauora ā Iwi
Iwi Māori Relationship Board/Whanganui District Health Board governance partner.

Health care assistant
Heath care assistants work under the supervision of nurses and other health professionals to carry out a variety of tasks.

Health Promoting Schools
An approach where the whole school community works together to address the health and wellbeing of students, staff and their community.

Health protection
Health protection services work within the framework created by the various health-related Acts including the Health Act (1956), Food Act (1981), Sale and Supply of Alcohol Act (2012) and Smokefree Environments Act (1990) and their associated regulations.

Health Quality & Safety Commission
Crown entity, whose objective is to work with clinicians, providers and consumers to improve quality and safety across the health and disability sector.

HPV
Human Papilloma Virus

IEA
Individual Employment Agreement

Impairment
A reduction in the recoverable value of a non-current asset below its carrying value.

Inpatient services
The care of patients whose condition requires admission to a hospital.

Intangible assets
Intangible assets are those fixed assets that have no physical existence, such as software, patents, copyrights, goodwill, etc.

Inter-district Flow (IDF)
Health services provided by district health boards to patients domiciled to another district health board's population. Can result in either revenue inflow (health services delivered to patients domiciled at another district health board) or outflow (our population receiving health services at another district health board).

interRAI
interRAI is an electronic assessment tool used by health professionals working with older people.

Iwi
Tribe

Kaiāwhina
Māori health worker assistant; helper; advocate.

Kaitiakitanga
Protection, taking care of people, things, conflict resolution, environmental, maintain values, vision, understanding, keeping yourself and each other safe.

Kaupapa
Purpose; theme

Kohanga reo
Māori language nest - preschool.

Kotahitanga
Unity, cohesion, sharing vision, working together, trust, relationships, collaboration and integration.

LMC
Lead maternity carer

Length of stay
Length of stay (LOS) is a term to describe the duration of a single episode of hospitalisation. Inpatient days are calculated by subtracting day of admission from day of discharge.

Locum
A locum is someone who temporarily fulfils an employment role/duties of another. For example a locum doctor (medical personnel) works in the place of a regular/ permanent doctor when they are absent or when a district health board is short of staff. Whanganui District Health Board uses the term locum to refer to all arrangements of clinical personnel where we are invoiced for these services rather than a salary paid.

Long-term conditions
Long-term conditions account for a significant proportion of health care spend and hospitalisations, as well as being a barrier to full participation and independence in the workplace and society by affected individuals and their family/whānau.

Mahi whakariterite
Our priorities and performance.

Manaakitanga
Respect, support, helping, caring, non-judgemental, be of service to others.

Mana tangata
Our leadership; prestige, integrity, leadership.

Marae
Māori meeting place.

Mauri
Life essence, animate and inanimate objects have a mauri, tika, pono, balance and universe.

MECA
Multi Employer Collective Agreement

Mihi
Greeting, acknowledgement.

National Hauora Coalition
One of the two local primary health organisations (PHO).

Net assets
The value of a district health board's total assets less the value of its total liabilities

New Zealand Health Partnerships
Operates as a multi-parent crown subsidiary, created by the 20 district health boards. The aim of the entity is to work collaboratively to identify and build shared services for the benefit of the health sector.

Ngā moemoeā, ngā kaupapa
Our vision and purpose.

NGO
Non-government organisation

NIR
National Immunisation Register

Non-current assets
Non-current assets are assets which represent a longer-term investment and cannot be converted into cash quickly. They are likely to be held by a district health board for more than a year.

Non-current liabilities
A liability that is not required to be discharged/settled within 12 months of balance date.

NOS
National Oracle Solution

Output Class
Four output classes used by district health boards to reflect services provided. The output classes are Prevention; Early Detection and Management; Intensive Assessment and Treatment; Rehabilitation and Support.

Pepi-pod
Baby bassinet used to help reduce Sudden Unexpected Death in Infancy (SUDI).

Primary Health Organisation
Primary health organisations (PHOs) are funded by district health boards to support the provision of essential primary health care services through general practices to those people who are enrolled with the PHO.

Primary Services
Professional health care provided in the community.

Pūrongo arotake pūtea
Audit Report

Pūrongo mahi
Statement of Performance

Pūrongo pūtea
Financial Statements

Pūrongo ratonga
Statements of Service Quality

Rangimārie
Humility, maintaining one's composure, peace, accountability, responsibility, respect.

Regional Health Informatics Programme (RHIP)
Central Region clinical IT application programme of work.

RiskMan
Risk management reporting tool.

Screening services
Screening programmes can detect some conditions and reduce the chance of developing or dying from some conditions.

Secondary services
Medical care that is provided by a specialist or facility upon referral by a primary care physician and that requires more specialised knowledge, skill, or equipment.

Standardised Intervention Rate
A health intervention rate that has been standardised against a particular population.

Statement of Performance Expectations
A document that sets out the service performance expectaions for the upcoming year and provides a base for actual performance to be assessed.

SUDI
Sudden Unexpected Death in Infancy

Tamariki
Child/children

Tangata whenua
People of the land.

Te Hau Ranga Ora
Whanganui District Health Board's Māori Health Service.

Te Pōari o Whanganui
Whanganui District Health Board

Te Pūkaea
Whanganui District Health Board Consumer Advisory Group

Te Pūrongo a-tau
Annual Report

Te rōpū whakahaere
Our organisation

Te Tiriti o Waitangi
Treaty of Waitangi

Tertiary services
Consultative care, usually on referral from primary or secondary medical personnel, by specialists working in a centre with personnel and facilities for investigation and treatment.

Tikanga Māori
Right, honest, guiding principles, protocols, guidelines, actions, tapu, noa, tika, pono, accountability.

Tinorangatiratanga
Self-determining, empowering, respectful, proactive, solution-focused, choice, adaptability.

TrendCare
Patient acuity tool which helps inform the management of the clinical workforce.

Triage
The assignment of degrees of urgency to wounds or illnesses to decide the order of treatment of a large number of patients or casualties.

VLCA
Very Low Cost Access

Wairuatanga
Spiritual wellness, relationships, beliefs, karakia, whakamoemiti, ruruku, watea, blessings.

WALT
Whanganui Alliance Leadership Team

WDHB
Whanganui District Health Board

WDHB provider division
Whanganui District Health Board's service delivery division.

webPAS
Patient administration system.

Whakapapa
Relationships, Māori cultural foundation, service components, genealogy.

Whānau
Family

Whānaungatanga
Spiritual wellness, relationships, knowing who you are, identity, family, whānau, whānau kaupapa, social equity.

Whānau ora
Healthy family/families. An inclusive approach to providing services/opportunities for families, partnering with families, based on Māori concepts and values.

Whanganui Regional Health Network
One of the two local primary health organisations (PHO).

XRB
External Reporting Board

DIRECTORY

BOARD MEMBERS

Mr Kenneth (Ken) Whelan - **Toihau - Board chair**
Mrs Annette Main - **Deputy chair**
Mr Graham Adams
Mr Charlie Anderson
Mrs Philippa Baker-Hogan
Mr Stuart Hylton
Mr Josh Chandulal-Mackay
Ms Talia Anderson-Town
Mrs Judith MacDonald
Ms Soraya Peke-Mason

HAUORA A IWI MEMBERS

Mrs Mary Bennett - **Chair**
Mrs Grace Taiaroa - **Deputy Chair**
Mr James Allen
Mrs Barbara Ball
Mrs Maraea Bellamy
Mrs Heather Gifford
Mrs Te Aroha McDonnell
Mr Hayden Potaka
Mrs Sharlene Tapa-Mosen

OUR EXECUTIVE LEADERSHIP TEAM

Mr Russell Simpson	**Kaihautū Hauora - Chief Executive**
Mr Andrew McKinnon	**General Manager Corporate** (Chief Financial Officer)
Mrs Lucy Adams	**Director of Nursing**
Mrs Louise Allsopp	**General Manager Patient Safety Quality and Innovation**
Mrs Alex Forsyth	**Director Allied Health Scientific and Technical**
Mrs Rowena Kui	**Kaiuringi Māori Health and Equity**
Mr Paul Malan	**General Manager, Service and Business Planning**
Dr Ian Murphy	**Chief Medical Officer**

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on behalf of the Auditor-General

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Kia tāea e te whānau me te hāpori i tōna ake tino rangatiratanga

Together we build resilient communities, empowering whānau and individuals to determine their own wellbeing

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