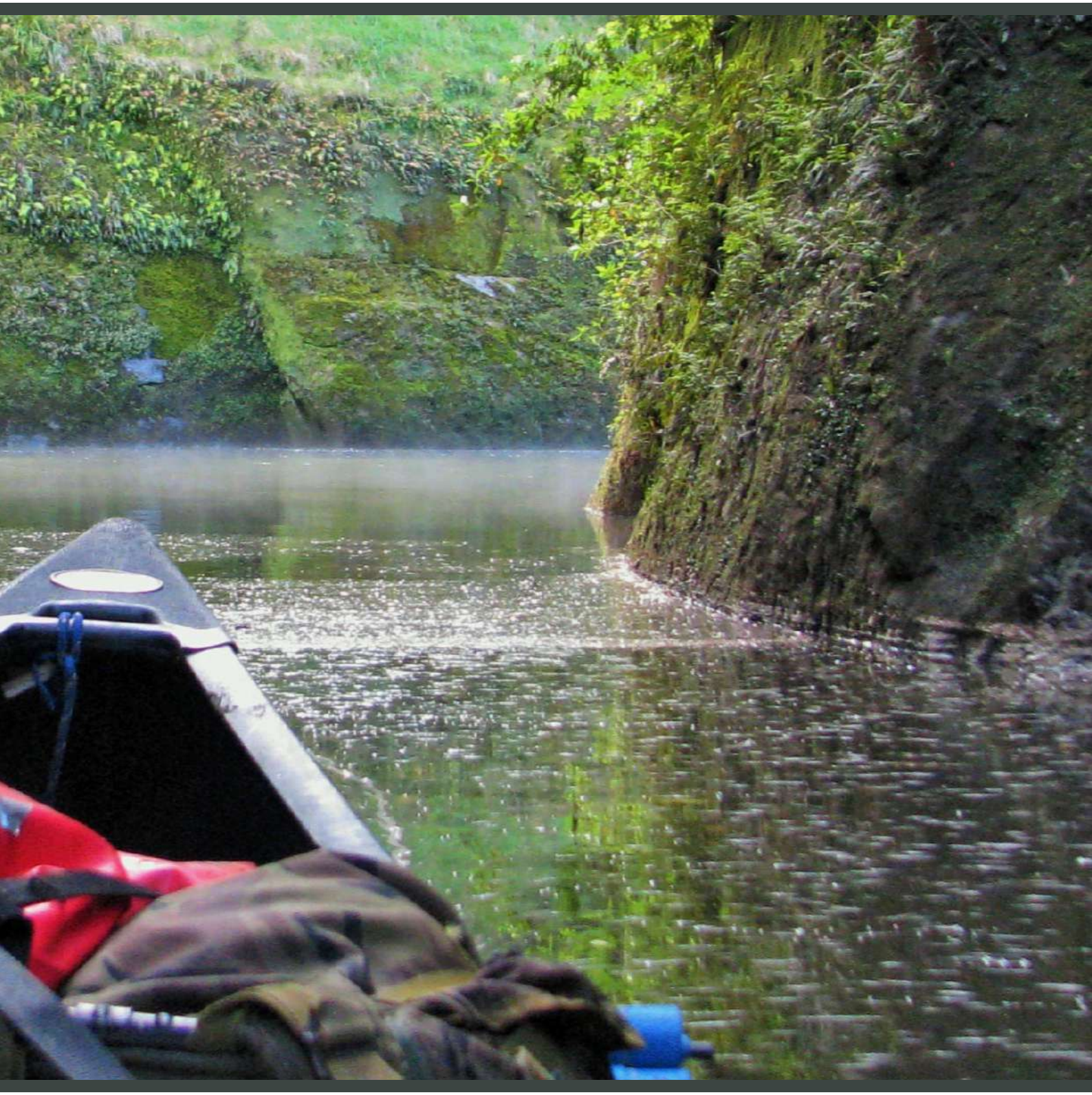
2018 / 2019

ANNUAL REPORT

TE PŪRONGO A-TAU

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

WHANGANUI
DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui



Early morning at Te Mangawa Iti | *Charles Ranginui*

MIHI

HE HONORE HE KORORIA HE MAUNGARONGO
KI RUNGA KI TE WHENUA HE WHAKAARO PAI
KI NGA TANGATA 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

CONTENTS

OUR VISION & VALUES

NGA MOEMOEĀ, NGA KAUPAPA

Our vision: *Better health and independence | He hauora pai ake, he rangatiratanga*

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.

Nothing about me without me, and my whānau/family
Ko au ko tōku whānau, ko tōku whānau ko au

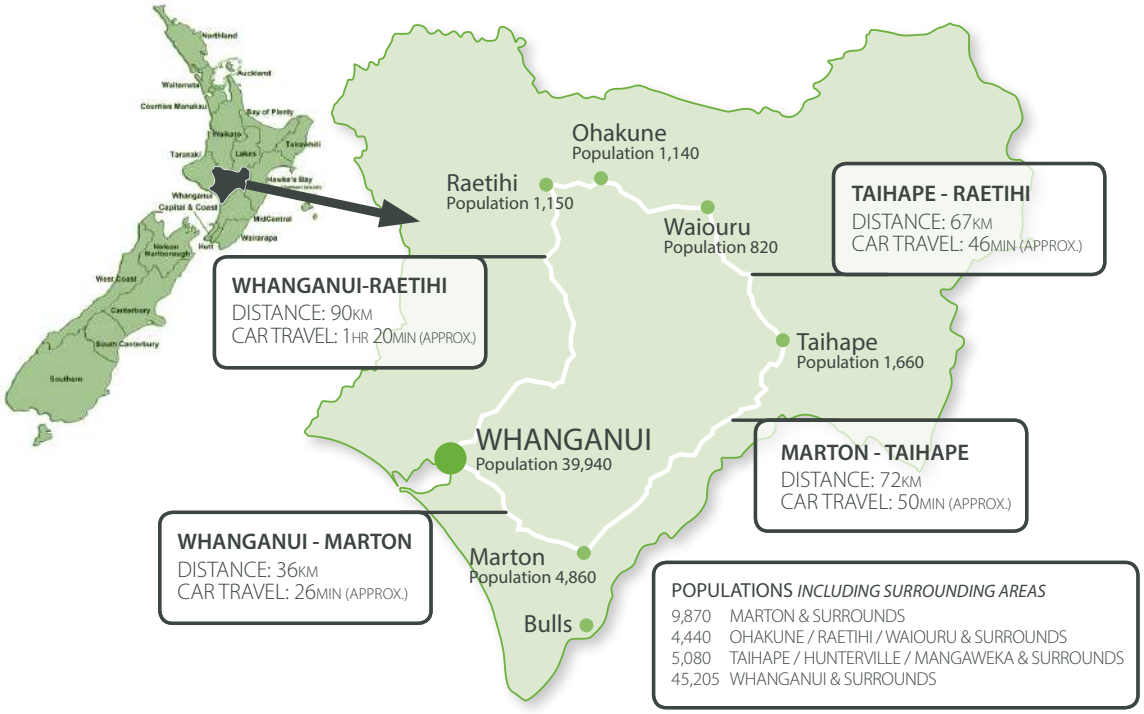
THE POPULATION WE SERVE

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: 64,595 estimate | 9,742KM²

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




Whanganui

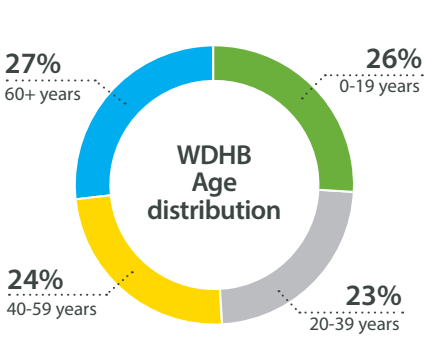

Ngā Rauru Kītahi

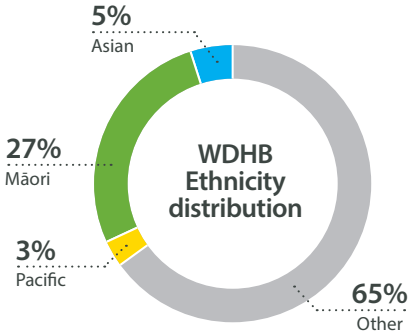

Ngāti Hauiti

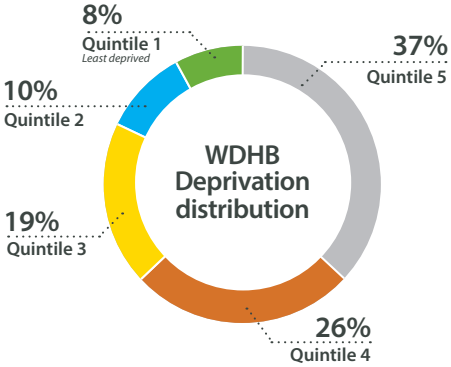

Ngā Wairiki Ngāti Apa


Mōkai Pātea


Ngāti Rangi







POPULATION AGE DISTRIBUTION - ALL NZ

0-19 years	25%
20-39 years	28%
40-59 years	25%
60+ years	21%

ETHNICITY DISTRIBUTION - ALL NZ

Māori	16%
Pacific	6%
Asian	16%
Other	62%

OUR DHB'S POPULATION

Whanganui District Health Board is responsible for ensuring the 64,595 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 five priority outcomes are aligned to the five themes and associated actions of the New Zealand Health Strategy.

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

Kia ora

I am proud to have been the chair of the Whanganui District Health Board this past six years. New Zealand has one of the best public health systems in the world and while Whanganui is one of the smaller district health boards, it punches well above its weight in the provision of health and wellbeing services for our population.

This year, our board has focused on leadership, a revised strategy, an equity lens on all our services and a more outward-looking community focus.

More and more, we are working with our community partners to provide better health services for our people. We all can take more responsibility for our own health and wellbeing - we must enable people and their whānau to access the community health services - and we must have a strong and relevant hospital setting for those whose needs cannot be met in primary care.

In addition to delivering our core services and commitments in 2018/19, we have embedded in our mahi the Minister of Health's expectations and a commitment to wellbeing. This means focusing our services and funding on those who need it most – improving mental wellbeing, child wellbeing, producing better health outcomes through working with other social sectors and providing more planned care for those who have knee, hip and other such surgical needs.

Our pro-equity stance gives us a platform to work alongside Māori, and enable them to develop their own ways to improve their population's health and give effect to the third article of the Treaty of Waitangi – the same rights and privileges for all.

We have delivered many significant milestones during the past year and had many successes. The "Fit For Surgery, Fit For Life" programme is a spectacular example of our staff going above and beyond expectations to improve health outcomes. The Ruapehu Whānau Transformation project is another illustration of a successful programme in which people work together to improve their own communities' lives.

Yet we have so much more to do. We must provide a more flexible system in which to meet the changing health and wellbeing needs of our people. We must do more with our community partners – the Ministry of Social Development, education, territorial authorities, NGOs, Police and our primary health organisations, to name a few.

We must continue to engage with new technology to improve our systems and processes. We need more people trained in health – technicians, sonography, radiology, midwifery – not just doctors and nurses.

We need our staff to embrace rather than fear the changes we will be going through to ensure sustainability. It is an ongoing challenge.

Over the past two years, we have moved into a deficit financial position. The impost of new technologies, an increasing complexity of demand for urgent care, innovations which help (such as Avastin injections) but which bring many more to our front door, a growing need for more surgery and increased demand for mental health care and more health care overall – these factors all mean we struggle to meet our budgets.

The Minister of Health is well aware of the issues all district health boards face in meeting the wider population needs. It is not easy. The revitalised ministry is also alongside us, guiding us through our decision-making, and we will continue to keep a sharp focus on all expenditure and continue to innovate to enable better, less expensive ways to meet our patients' health and wellbeing needs.

My thanks to our chief executive, Russell Simpson, who has championed so many causes and taken us away from a hospital-centric focus to a more community/team focus.

Well done to our team of clinicians, allied staff, administrators, haumoana, contractors, community partners and all deliverers of health care in our region. Work well done over a challenging year!

I thank my board colleagues for their frank discussions, their bravery in making the hard decisions, and their dedication to our population's health.

D McKinnon

Dot McKinnon, QSM
WDHB Board Chair

CHIEF EXECUTIVE'S REPORT

The 2018/19 year has been an exciting one for Whanganui District Health Board as we have moved our focus from a hospital-centric organisation towards an organisation that is more outwardly community facing.

The great work we have achieved has been done in collaboration with many other community agencies, such as the Police, Ministry of Social Development, Oranga Tamariki, non-government organisations, kaupapa Māori providers, iwi, primary health organisations and local territorial authorities. Overall, we have seen a significant improvement in the way agencies work together for the betterment of our community.

Our commitment to local iwi has strengthened over the past 12 months, with numerous examples of the strong relationships we have collectively built for a common purpose. That purpose is captured by the new Whanganui District Health Board vision of working towards "Thriving Communities" and promoting equity, particularly with the intention of reducing the gap between Māori and non-Māori. This joint approach has been a real highlight of our efforts over the past 12 months.

There is great work occurring every day, but we appreciate there is also much that needs to be done to ensure we can provide our people with the best possible outcomes.

The voice of our consumers has remained strong, and the input of clinical staff in the operation of our organisation is a key strength for our district health board.

The challenge of our population profile has not changed. An influx of people moving into our district, poor housing and the lack of suitable housing stock, and significant social deprivation all lead invariably to reduced health outcomes and increased demand on our services.

The importance of working with multiple agencies is borne out by the fact poor health outcomes result from many other societal factors, and that we who work in the health sector cannot solve the challenges on our own.

The ever-increasing demand on our health services is stretching us financially, while deprivation remains one of our greatest challenges with many unable to afford basic healthcare.

Our board and Hauora ā Iwi have continued to provide guidance to us on the importance of working with our local iwi, and ensuring that we put a spotlight on both health and social determinants.

I am thankful to our board chair Dot McKinnon, board members, the chair of Hauora ā Iwi, Mary Bennett, our various committees and our consumers for providing guidance and overseeing our programme of work.

A special mention needs to be made of our 1100 staff and contractors. Our staff are dedicated and truly make a difference in the lives of many on a daily basis, often without thanks. They are humble, pragmatic and I am proud to acknowledge their efforts.

It has been a privilege to serve this community over the past 12 months. While the 2019/20 year will not be any easier, I believe we are suitably placed as a Crown agency to lead a transformation across our community, for our community and with our community.

Kia kaha!

Russell Simpson
WDHB Chief Executive

HAUORA A 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 2019, the members of Hauora ā Iwi are:

- Tupoho/Whanganui: Sharlene Tapa-Mosen
- Ngā Wairiki Ngāti Apa: James Allen - Grace Taiaroa (deputy chair)
- Ngāti Hauiti: Heather Gifford
- Ngāti Rangi: Valanique Callaghan
- Ngarauru Kītahi: Hayden Potaka - Mary Bennett (chair)
- Mokai Patea: Barbara Ball - Maraea Bellamy
- Tamaupoko Whanganui: Te Aroha McDonnell

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 A IWI REPORT

E te Poari, 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.

Hauora ā Iwi has had another year of change and growth.

This year we welcomed Valanique Callaghan from Ngāti Rangi to our table. Valanique brought a strong rural focus to our conversations, reiterating the need for oral health initiatives that cater for the whole whānau, from pepe to kaumatua.

Valanique has since left and Hauora ā Iwi is grateful for her contribution. Ngāti Rangi are in the process of confirming their new representative.

Hauora ā Iwi congratulated Maraea Bellamy on her ministerial appointment to the Whanganui District Health Board. Maraea has a wealth of experience in the health sector ranging from a hands-on health practitioner career through to policy development and implementation with the Ministry of Health.

The next election of board members to Whanganui District Health Board takes place in October 2019. We will support Maraea's reappointment into the role in late 2019.

In 2018, the Whanganui District Health Board embarked on two significant pieces of work - a board strategy and an equity review. There have been numerous occasions where Hauora ā Iwi has been involved in the development of the strategy which has finally been endorsed by the board and is due for release in 2019.

The equity review commissioned by the Whanganui District Health Board was completed in late 2018. Both boards have had time to reflect on the findings and recommendations, and a comprehensive work plan has been developed and Hauora ā Iwi are monitoring progress against that plan.

Together these two documents provide the foundation for an accountability framework to measure Whanganui District Health Board performance on achieving health equity for Māori and the community as a whole.

Both boards have agreed to work closely together to understand the true nature of our relationship and what it means and looks like to work in partnership with each other. The full Whanganui District Health Board Pro-equity checkup can be found at: tinyurl.com/y4x5crmv

He Ara Oranga: Report of the Government Inquiry into Mental Health and Addictions was released in November 2018 and is available at: https://mentalhealth.inquiry.govt.nz/assets/Summary-reports/He-Ara-Oranga.pdf.

As part of the national consultation on the New Zealand Health and Disability System Review, Hauora ā Iwi and others were invited to meet with the review chair, Heather Simpson.

Heather was genuinely interested in everyone's views on the constraints and issues within the current system. She challenged and encouraged deep kōrero on what a future health system might look like and indicated she is keen to return to Whanganui for more kōrero.

We look forward to further discussion and debate with Heather.

At an operational level we are witnessing a change in the way the Whanganui District Health Board operational team is engaging with iwi and the wider community. The chief executive is more visible on the street and is constantly seeking opportunities to partner on initiatives such as oral health and suicide prevention - strategies that will result in better health outcomes for all.

We will continue to encourage partnership engagement, particularly with our Māori health providers and iwi.

Once again Hauora ā Iwi acknowledge and give thanks to all our Māori health providers for the ongoing support and manaaki you give to our whānau.

We acknowledge and commend your dedication and commitment to Whānau Ora, the work you do at the coalface, the impact you have on the lives of our people and, in many cases, on non-Māori members of the wider community.

Hauora ā Iwi also wish to acknowledge the kaimahi in the Whanganui District Health Board Te Hau Ranga Ora Haumoana Service. Thank you for your continued support to whānau in hospital and the educational support to your work colleagues as they journey through your Hāpai Te Hoe programme.

Hauora ā Iwi will continue to monitor progress on accelerating health gain and achieving health equity for Māori. We look forward to working with and supporting the new board to achieve these goals in the 2019/20 year.

Nā
Hauora ā Iwi

CHIEF FINANCIAL OFFICER'S REPORT

There was an overall 4.2% reduction in inpatient services at Whanganui Hospital – mostly from acute and elective surgical services. However, there was a 6.4% increase in the number of patients requiring more complex services who were transferred to other district health boards.

The deficit has increased from $4.179m in 2017/18 to $13.654m in 2018/19, including $4.68m of one-off costs. The budgeted deficit for 2018/19 was $7.89m, and the underlying operating deficit, excluding the one-off items, was $9m.

Compared to 2017/18, revenue increased by $11.7m (4.6%) to $265.8m. Costs increased by $21.2m (8.2%) to $279.5m. The underlying population-based funding increase in 2018/19 was 3.24%, which was then topped up to cover higher than anticipated wage settlements. The cost increase of $21.2m included one-off costs of $1.0m due to software write down, and $3.7m Holidays Act remediation provision. The remaining $16.5m increase included staff costs of $10.6m due to significant national multi-employer collective agreement wage settlements and an increase in staff numbers. This increase was partly driven by the need to meet roster requirements in the multi-employer collective agreement and patient acuity. Other cost increases include $0.7m for depreciation, $0.6m for clinical supplies, $1.5m for mental health – mainly due to funded pay equity payments and price increases.

In 2017/18, it was noted that costs related to patients being sent to other district health boards for more complex services increased by $2.8m (7%). This trend has continued in 2018/19, with a further $2.6m (6.4%) increase in services. The growth has been due to cardiology, cardiothoracic and vascular surgery, neurology and haematology.

Expenditure in community aged care increased by $0.3m or 1.3% (excluding pay equity), which is less than the 2.0% price increase awarded to aged care and home support providers in 2018/19. The trend of largely neutral costs growth in aged care which started in 2016/17 has continued.

The deficit position is not expected to improve in 2019/20, as population-based funding increases are unable to keep pace with the demand for health services and increased costs. The board is adopting a number of initiatives to reduce the demand for hospital services, including an acute demand management project involving primary health organisations, general practitioners, residential care facilities and St John Ambulance. Benchmarking work has commenced with similar-sized district health boards as a basis for examining cost structures and operating models to find more efficient ways of working.

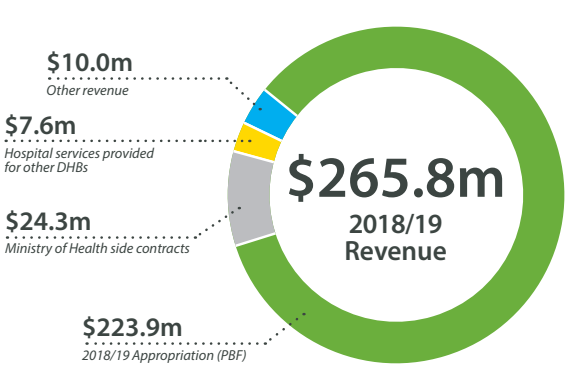
Investment in regional health information systems projects has slowed, with the regional network now operationally-focused. An investment of $1.167m has been applied to enhancing and maintaining existing regional systems.

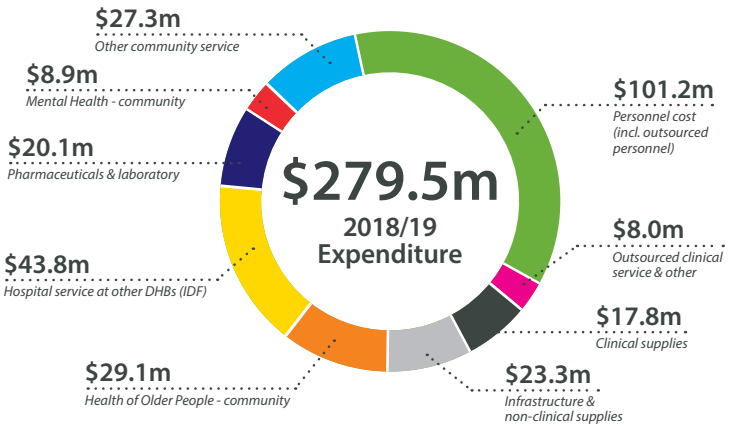
A further $3.137m was invested in clinical equipment and facilities.

Cash and investments has declined by $1.264m – from $4.284m at 30 June 2018 to $3.02m at June 2019. The operating deficit of $13.65m, whilst significant, has not had a similar cash impact due to depreciation and other non-cash items of $6.47m and a $10.76m reduction in working capital. The resulting net cash flow from operations was a positive of $3.76m. Investment in property, plant, equipment and intangible assets was $4.57m.

To maintain financial viability in 2019/20, the board will need to access its available bank overdraft funding of up to $12m, as well as deficit support through shareholder equity of $6m in the fourth quarter.

Brian Walden
General Manager Corporate
(Chief Financial Officer)





WHAT WE PROVIDED IN 2018/19

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

21,697
PATIENTS THROUGH EMERGENCY DEPARTMENT
2017/18: 23,705

8,604
INPATIENT STAYS
2017/18: 9,464

4,274
OPERATIONS
2017/18: 4,076

54,899
RADIOLOGY TESTS
2017/18: 53,244

927
FULL TIME EQUIVALENT (FTE) STAFF
2017/18: 893

249
NEW INPATIENT ADMISSIONS TO MENTAL HEALTH
2017/18: 260

45,658
SPECIALIST OUTPATIENT APPOINTMENTS*
2017/18: 45,587

$94.1m
TOTAL WAGE BILL
2017/18: $83.5m

728
BIRTHS
IN WHANGANUI HOSPITAL/RURAL HEALTH SERVICE
2017/18: 743

SUPPORTED
160
PEOPLE WHO DIED IN HOSPITAL
2017/18: 199

3,337
ALL ELECTIVE SURGICAL OPERATIONS*
(WITH ANAESTHESTIC)
2017/18: 3,070

937
ALL ACUTE EMERGENCY OPERATIONS*
(WITH ANAESTHESTIC)
2017/18: 1,006

192
PEOPLE HAVING MORE THAN 3 ACUTE ADMISSIONS
2017/18: 294

* 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 DHB 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 Service and Business Planning and Provider 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 Service and Business Planning and Provider divisions. These include media and communications, human resources and industrial relations.

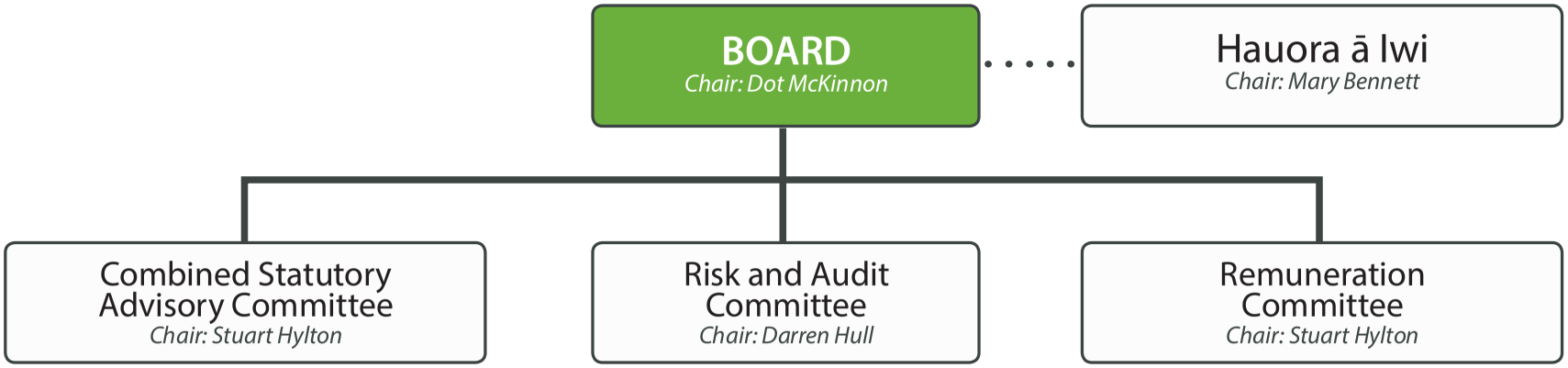
CORPORATE GOVERNANCE

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

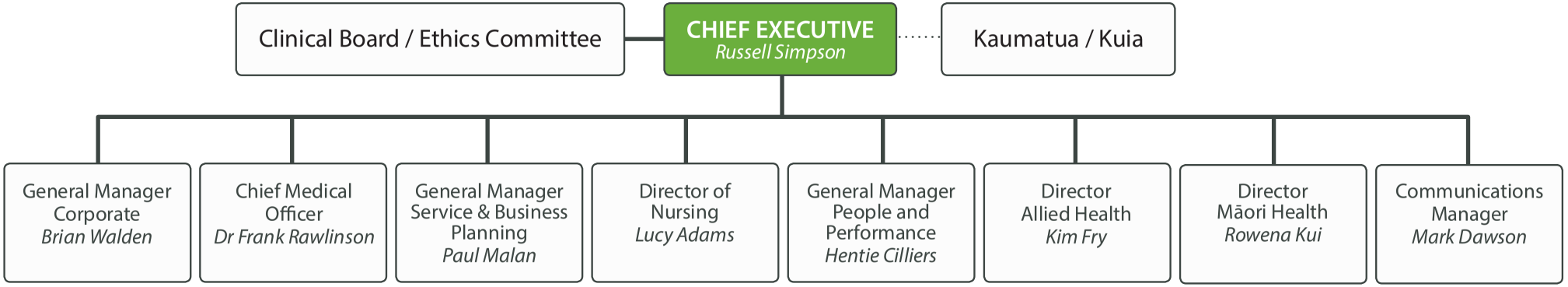
The board places great importance in the highest standards of governance and continually reviews its governance practices to address Whanganui District Health Board's obligations as a responsible corporate citizen.

WHANGANUI DISTRICT HEALTH BOARD ORGANISATIONAL STRUCTURE as at 30 June 2019

GOVERNANCE



MANAGEMENT



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 management 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
- providing advice and counsel to management
- 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 A 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 2018/19 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 normally holds 11 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 canvass 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 management 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 Risk and Audit Committee made up of four board members and two independent members.

The committee meets six times a year. The 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 systems 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 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 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 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 three standing committees:

- Combined Statutory Advisory Committee*
- Risk and Audit Committee
- Remuneration 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 2019

Chair	Board members	External members	Functions
Combined Statutory Advisory Committee			
Stuart Hylton	Jenny Duncan Judith MacDonald Dot McKinnon Philippa Baker-Hogan Darren Hull Dame Tariana Turia Annette Main Charlie Anderson Graham Adams Maraea Bellamy	Frank Bristol Matthew Rayner Dr Andrew Brown Leslie Gilsenan Grace Taiaroa Heather Gifford	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.
Risk and Audit Committee			
Darren Hull	Jenny Duncan Dot McKinnon Dame Tariana Turia Annette Main	Anne Kolbe Malcolm Inglis	Clinical and business risk management framework including compliance and internal controls. Integrity of Financial Statements and Statement of Performance. Relationship with external auditor.
Executive Employment Remuneration Committee			
Stuart Hylton	Dot McKinnon		Effectiveness, integrity and legal compliance of remuneration programmes. Annual review and recommendation of chief executive's remuneration package.

BOARD & COMMITTEE MEMBER ATTENDANCE RECORD

1 July 2018 to 30 June 2019

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 Advisory Committee	Risk and Audit Committee
Number of meetings held	**11**	**3**	**7**	**5**
Board members				
Dot McKinnon *(chair)*	**9**	**3**	**5**	**2**
Stuart Hylton *(deputy chair)*	**11**	**2**	**7**	N/A
Philippa Baker-Hogan	**7**	**1**	**7**	N/A
Judith MacDonald	**9**	**0**	**5**	N/A
Jenny Duncan	**8**	**2**	**7**	**4**
Graham Adams	**8**	**3**	**5**	N/A
Charlie Anderson	**9**	**1**	**5**	N/A
Annette Main	**7**	**1**	**6**	**5**
Dame Tariana Turia	**8**	**1**	**4**	**2**
Darren Hull	**9**	**2**	**4**	**4**
Maraea Bellamy	**8**	**3**	**6**	N/A
External committee members				
Frank Bristol			**5**	N/A
Matthew Rayner			**5**	N/A
Dr Anne Kolbe			N/A	**5**
Dr Andrew Brown			**5**	N/A
Leslie Gilsenan			**5**	N/A
Malcolm Inglis			N/A	**5**
Heather Gifford			**3**	N/A
Grace Taiaroa			**5**	N/A
Hauora ā Iwi				
Mary Bennett		**3**		
Barbara Ball		**3**		
Maraea Bellamy		**3**		
Te Aroha McDonnell		**0**		
Hayden Potaka		**0**		
James Allen		**3**		
Heather Gifford		**2**		
Grace Taiaroa		**2**		
Sharlene Tapa-Mosen		**0**		
Valanique Callaghan		**0**		

OUR BOARD

DOT McKINNON QSM | *Board chair*

"I was appointed to chair Whanganui District Health Board in December 2013 and in December 2016, was also appointed to chair MidCentral District Health Board. My roles include being an associate in the legal firm, Moore Law, chair of the Four Regions Trust (formerly Wanganui Powerco Trust), a member of the Health Practitioner's Disciplinary Tribunal, member of the Health Sector Relationship Agreement committee, member of the district health board national executive, member of the Health Workforce Group. My career has spanned both public and private sectors including being Whanganui's deputy mayor for six years, the managing director of Kingsgate Hotel for 13 years, and a polytechnic lecturer. I have been a director or trustee of a number of companies, boards or trusts including Wanganui District Council Holdings Ltd, Aubert Home of Compassion, Whanganui College Board of Trustees, Whanganui Community Foundation, NZ Masters Games, Rotary NZ World Community Service, , UCOL Transition Committee plus various other governance roles in the arts, sport and economic development units."

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 Wanganui."

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."

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."

MARAEA BELLAMY

I te taha o toku matua – ngā iwi me ngā hapū o Mōkai Pātea; Ngāti Uenuku; Te Atihaunui-a-Pāpārangi, and Te Aitanga a Māhaki are my primary affiliations.

I te taha o toku whaea – Te Atiawa, Toa Rangatira, Ngāti Tama are my primary affiliations.

I was appointed to the district health board in July 2018 and currently sit on six iwi and health rūnanga/boards.

I have worked in four fields: health, education, central government policy, organisation planning & performance. I began as a clinician from 1976-1983 at Taihape Hospital, before moving to Auckland and working at first Middlemore Hospital and then the Auckland Nursing Bureau while training as a primary school teacher. I taught in South Auckland for five years before shifting to Wellington and returning to health. I have held senior management roles since the 1990s, firstly at Hutt Valley Health CHE; the Ministry of Health and Te Puni Kokiri, and the Maori Fisheries Commission, Te Ohu Kaimoana.

My whānau, whānau whānui, and my upbringing in Taihape, provide me with a strong set of values, and the passion and commitment to iwi Māori, and rural communities. I am very pleased to be able to contribute to the governance of the Whanganui District Health Board. My goal is to ensure that the Whanganui health system provides equitable outcomes for Māori and for our rural communities.

JENNY DUNCAN

"As a second term board member, I was elected to the Whanganui District Health Board and the Whanganui District Council in 2013. I am an accountant and business coach with wide experience in business and community organisations.

"A robust and accessible health service is essential to a thriving and equitable community and it is my commitment to the Whanganui region that we retain the best service this community can afford."

DARREN HULL

"I was appointed to the Whanganui District Health Board in December 2016 following a three-year term on the district health board's Risk & Audit Committee, including over two years as chair.

"My background includes 14 years in the commercial corporate sector and the same period as a director in public practice with local business advisory firm, Venter & Hull Chartered Accountants Ltd.

"As a passionate local who has raised a family in our wonderful city, it's a pleasure to assist with governance of our district health board, with the constant challenge to maximise health outcomes and equity for our population."

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."

ANNETTE MAIN

"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."

DAME TARIANA TURIA

Dame Tariana entered the New Zealand Parliament in the 1996 election as a list MP for the Labour Party and was a list MP again in 1999. In 2002, she contested the Te Tai Hauauru Māori electorate, winning the seat. She held a number of non-Cabinet ministerial roles.

In 2004, she resigned from Parliament over the foreshore and seabed legislation and was a key figure in the formation of the Māori Party, winning Te Tai Hauauru in a by-election. She held the seat for the Māori Party at the 2005, 2008 and 2011 general elections, serving as a minister and bringing in Whānau Ora.

She retired from Parliament in 2014 and was made a Dame Companion of the New Zealand Order of Merit a year later.

OUR EXECUTIVE MANAGEMENT TEAM

RUSSELL SIMPSON | *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."

BRIAN WALDEN | *General Manager, Corporate & Chief Financial Officer*

"As a chartered accountant in private sector finance and business roles, I joined the board in 1995 as general manager, finance and planning.

"I was the general manager, hospital and health services from 1998 to 2004 and then, as general manager, strategic developments I led the redevelopment of hospital facilities, including Taihape Hospital and implementation of the community oral health project, from 2005 through to 2011. In 2011, as general manager, corporate, I assumed the responsibilities of chief financial officer, information technology, procurement, supply and non-clinical support service functions.

"I have been the central region CFO representative on national projects - Finance Procurement Supply Chain; National Food Services project; National Linen and Laundry Service; banking and insurance – and am a director of Allied Laundry Limited. I am also the lead CFO supporting the Central Region Health Informatics Project. Whanganui led the central region district health boards' implementation of the regional Clinical Portal and Radiology Information systems. Continuing transformation of information systems remains a key focus."

LUCY ADAMS | *Director of Nursing*

"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."

HENTIE CILLIERS | *General Manager People and Performance*

"My professional qualifications and work experience is in human resources and includes management and leadership roles in public, non-profit and private organisations in South Africa and New Zealand.

"I joined Whanganui District Health Board in 2008 and I am passionate about health and wellbeing and building a representative workforce to deliver safe quality care for our community."

MARK DAWSON | *Communications Manager*

"I have been a journalist for 47 years, working across print and online in Britain and New Zealand. Born in Leeds, Yorkshire, in the north of England, I moved to New Zealand in 1999, working at The Southland Times in Invercargill and the Dominion and Dominion Post in Wellington before becoming editor of the Whakatane Beacon and Opotiki News in the eastern Bay of Plenty.

"In April 2013, I was appointed editor of New Zealand's oldest newspaper, the Whanganui Chronicle, where I enjoyed a six-year tenure before joining the Whanganui District Health Board.

"In my work in both newspapers and with the district health board, I have appreciated the importance of building open and strong relationships with individuals, agencies, iwi, territorial authorities, businesses and many more."

KIM FRY | *Director Allied Health*

"My professional qualification and work experience is in social work, working in both physical and mental health settings as well as social service organisations in New Zealand and London. I have a Bachelor of Social Work and completed a Masters of Social Work after several years of work. My experience also includes management, leadership and coordination roles."

ROWENA KUI | *Director Māori Health*

"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."

DR FRANK RAWLINSON | *Chief Medical Officer*

"I completed medical training at Groote Schuur Hospital in Cape Town gaining MB.ChB. in 1980 and psychiatric training in the United Kingdom, gaining MRC.Psych, in 1987. I'm married to Rozanna with two daughters, Danya and Zara. Arrived in New Zealand and Whanganui on 8 February 1988 and have lived here since.

"I view a health literate, activated and engaged patient/community as necessary to enabling ongoing improvements in individual and population health.

"I'm an active mountain bike track builder promoting development of critical skills, intergenerational social engagement and healthy lifestyle."

OUR PEOPLE

TE HUNGA ORA

WORKFORCE PROFILE

The Whanganui District Health Board workforce is made up of Medical (8.9%), Nursing/Midwifery (51.1%), Allied Health (18.8%), Administration/Management (20.61%) and Support (0.6%) employees.

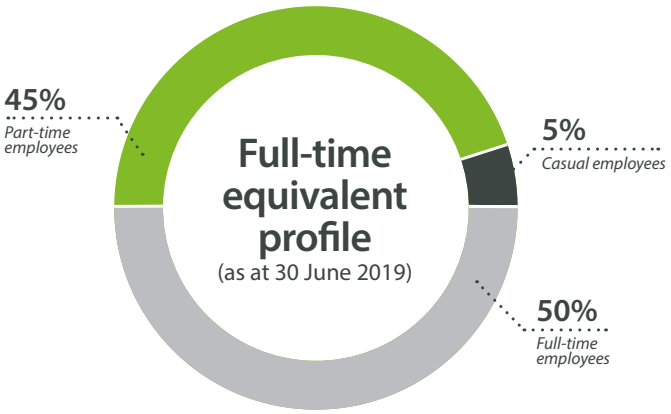
Whanganui District Health Board enjoys a stable employee complement with an average length of employee service of 9.47 years. The organisational employee turnover was 8.8% for the financial year.

Employee gender, age, ethnicity and disability information are provided on a voluntary basis. The tables on this page depict the Whanganui District Health Board's gender, ethnicity and age profile of participating employees, including permanent and of temporary employees and excluding casual staff.

NATIONALLY & REGIONALLY

Whanganui District Health Board works collaboratively with the six district health boards in the Central Region (MidCentral, Capital and Coast, Hawke's Bay, Hutt Valley and Wairarapa) on regional and vulnerable services, including workforce matters.

All 20 district health boards support a strong national workforce and work collaboratively supporting national programmes and policies and promoting health as a career of choice.



AGE PROFILE

Age band	Count	Percentage
20-29	130	12.4%
30-39	191	18.2%
40-49	224	21.4%
50-59	304	29.0%
60-69	188	18.0%
70+	10	1.0%

GENDER PROFILE

Gender	Count	Percentage
F	846	80.8%
M	201	19.2%

ETHNICITY PROFILE

NZ European/Pakeha	52.3%
European	15.7%
Maori	11.2%
Asian	8.5%
Other	8.1%
African	2.7%
Pacific Peoples	1.3%
Middle Eastern	0.2%

The therapies team with their new uniforms

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 family/whānau and themselves to receive treatment when needed.

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 management team 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 management 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 family/whānau-centred, rather than provider or management-centred way, and to:

- be part of an organisation that really listens to the voice of patients and their family/whānau
- put themselves in the shoes of the patient and whānau and want for them what we would want for our own family
- 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, families and staff is considered
- have the personal courage to stand up and speak out against workplace bullying.

GOOD EMPLOYER: THE SEVEN KEY ELEMENTS

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

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

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.
- 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 staff.
- Support programme for new graduate Māori nurses - tuākana tāina.
- Retention of staff low turnover compared with other organisations.
- Increased number of applicants for jobs advertised.
- Feedback processes for all exiting staff. Implementing suggestions for improvement.

Leadership, Accountability & 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.
- Listening to the voice of our patients and family.
- Open disclosure conversations with whānau following adverse outcomes.
- Engaged board and executive management team.
- Leaders visible in the organisation.
- 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 Whanganui District Health Board.
- Whānau ora philosophy and cultural competencies socialised at organisational orientation for all new staff.
- Appropriate appointments at all levels.
- Clinical leadership across medical, nursing and allied health.
- Remedy mistakes/problems as soon as possible, respectful of the individual and as efficiently as possible for the Whanganui District Health Board.
- Speaking up for Safety programme to further contribute 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, improved pronunciation through Te Reo Māori sessions onsite.

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

- Headcount - forty-six percent of employees work fulltime, 32 percent work part-time, 14 percent casual staff are employed, five percent were temporary employed and two percent of staff were on paid parental leave during the financial year.
- 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.

Harassment & bullying prevention

OUR AMBITIONS

- Zero tolerance approach.
- No harassment or bullying.
- Employee confidence in commitment and actions.

OUR ACTIONS

- Zero-tolerance of all forms of harassment and bullying.
- Train managers and employees on their rights and responsibilities, specific policies and procedures in place for dealing with harassment and/or bullying complaints and acts quickly to address complaints.
- 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.

Wellbeing, healthy & safe environment

OUR AMBITIONS

- Proactive 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.
- The 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 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.
- Whanganui District Health Board remains a tertiary level ACC accredited employer programme member.
- Staff returning to work from either a work/non-work injury or a medical condition are given the same support in their return to work.
- Updated hazard management registers.
- Ongoing manual handling training.
- Purchasing more and new manual handling equipment.
- Achieved bronze accreditation for our wellbeing programme (WorkWell). Staff identified three key priorities: physical activity, healthy eating and mental health and wellbeing.

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 percent 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.
- Support and actively promote professional work day's recognition such as International Nurses' Day, International Social Workers' Day, World Physiotherapy Day, National Anaesthesia Day.
- Non-financial staff recognition including team functions, awards, and letters of thanks, compliments from patients and visitors, and visibility in newsletters.

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 plan and the Ministry of Health Raranga Tupuake – Māori Workforce Development Plan.
- Proactively promote 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.
- Develop proactive recruitment policy and process to increase Māori staff.

Moko learning gardening - Ako i te Mara | *Brenda Nelson*

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 our 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.

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, online 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 added to its manual handling equipment; including all size slings, HoverMatts and pumps, bariatric equipment; patient beds, high back chairs, wheelchairs, slings, walking pants and weighing scales. An equipment review and maintenance programme is in place.

Continuous improvement includes:

- exploring further improving physiotherapy and occupational therapy input into patient care.
- 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 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 that when people are unwell their behaviour may change. Patients may be 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:

- Aggression workgroup established.
- Trained health and safety representatives.
- Safe rostering practices.
- Reporting on the incident management system.
- Ongoing training e.g. staff working on wards are trained in managing patients with dementia and de-escalating challenging situations.
- Broset violence checklist which assess confusion, irritability, verbal and physical threats – this enables improved pre-emption of potential changes in behaviour.
- 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.
- 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:

- Participation in a national district health board security review with union partners.
- Working with WorkSafe in developing good practice guidance for managing the risk of violence in the health and disability sector.
- An independent audit of the WDHB's management of risks related to aggression.
- Further improve data collection and intelligence.
- Strengthening the governance group's action plan, monitoring incidents/trends and reporting back to management, the board and Risk & Audit Committee.
- Ongoing education and development of specific training for reception and administrative staff.
- Rolling out an agreed behaviour-response approach to challenging situations.
- 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 WDHB alarm systems across the DHB.
- Trialling of personal alarms.
- 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 DHB – staff, managers, board members and union partners.

STATEMENT OF PERFORMANCE

For the year ended 30 June 2019

The Statement of Service Performance shows how the district health board has performed when compared with the Statement of Performance Expectations that we published for 2018/19.

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, families and whānau 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, the decisions the district health board makes have a significant impact on its population and, if well planned and coordinated, will contribute to an improved, effective and efficient healthcare system.

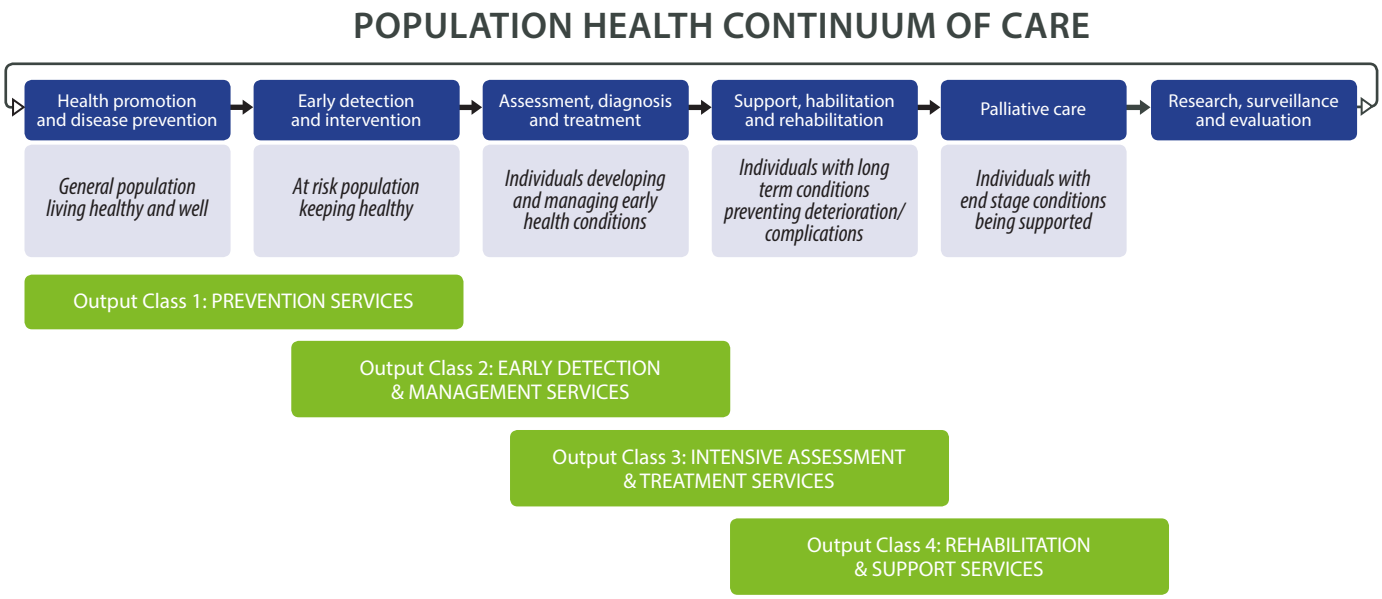
On a continuum of care, our work covers the whole population, from the many who are living healthy and well through to the few who need support for end stage conditions. For reporting purposes we group our work into four output classes:

- **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 the 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 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.

FOCUS AREAS

For the 2018/19 year, we signalled three key focus areas in our Statement of Performance Expectations:

- Pregnancy, early years and adolescence
- Adulthood and healthy ageing
- Equitable access to clinical services.

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 that 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 2018/19 financial year.

A summary of 2018/19 financial performance is also included for each Output Class.

SUMMARY OF 2018-19 FINANCIAL PERFORMANCE BY OUTPUT CLASS

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 will support 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, low levels of physical activity 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.

2018/19 Performance overview

Across our focus area of pregnancy, early years and adolescence, there were a number of highlights for the year. Our before schools checks (B4SC) continues to perform very well and is ranked second in New Zealand for 2018/19. Although we surpassed all the targets and had an equitable outcome for Māori tamariki, we had a slight decline in the achievement for children in high deprivation areas. Ambulatory sensitive hospitalisations (ASH) for asthma and wheeze were also a highlight – having recognised the significant contribution that this category of ASH makes to overall ASH results for the 0-4 age group, we focused on updating the pathway and working closely with our primary care partners to provide better care in the community for these conditions. We are pleased to have met the primary care targets for providing brief advice and support for quitting to pregnant women who are smokers but disappointed by the declining trend. Unfortunately we did not meet the targets within the hospital and our efforts will be renewed in this important area. Some of the other indicators relating to the impact of second hand smoke on babies and children, have changed in the current reporting period – this has made some of our targets unreportable.

From the 2019/20 year the focus will be on "babies in smokefree homes" – recognising that it is the environment babies and young children are in that is the greatest concern. This is a challenging area to effect change because a whānau approach is needed but often the mother accessess care or support alone. In 2019/20 smokefree homes will continue to be a priority for 'Well Child Tamariki Ora' services supported by a regional and national service improvement initiative.

An area which did not meet the targets and had a declining trend across all ethnicities was the referral requirements for children identified as obese during the B4SC. Next year we will intensify efforts to refer children to general practice for growth monitoring, as this is becoming more acceptable to parents. We will also work with Sport Whanganui to develop a broader approach to reducing childhood obesity.

Our other focus area was adulthood and healthy ageing and, although a number of the targets were not quite met, there is an improving trend across most.

Across all age groups, enrolments in a primary health organisation (PHO) is still high. However, we set a target of 100% as we believe that everyone being enrolled (and attending primary care when necessary) does contribute positively to efforts in prevention services.

In terms of equity, we still see persistent disadvantage for Māori children in breastfeeding rates, immunisation and ASH. Māori rates for ASH for asthma and wheeze are improving but are declining for dental (see Output Class 3). Breastfeeding remains a strong focus amongst our Lead Maternity Carer (LMC) partners and for all pregnancy support services.

Outreach immunisation services report declines and 'opt off' continues to be an issue. This is a national issue with people hesitant to immunise, continued anti-vax coverage in the media and social media causing some people to question the value of immunisation. Although many of our unvaccinated children are transient, the outreach services continue to try innovative approaches, working with the community to improve coverage and equity.

Our rheumatic fever rates are unreportable – there have been only two new cases in the last five years and there are eight patients in total known to the services.

For older people there are continuing inequities in screening rates. However, when we look at the trends, Māori rates are improving for cervical screening and breast screening so, with more focus and targeting, we anticipate equity will be achieved.

Table 1 provides the results for all the measures in this output class and includes a visual marker (green, yellow, 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.

2018/19 FINANCIAL PERFORMANCE: PREVENTION SERVICES

Output Class 1 - PREVENTION	2017/18 Actual	2018/19 Actual	2018/19 Budget
Revenue			
Crown	4,769	5,099	5,152
Other Income	77	45	43
Inter-district Inflows	44	39	39
Total revenue	**4,890**	**5,183**	**5,234**
Expenditure			
Personnel costs	(2,834)	(2,943)	(3,392)
Capital charge	(110)	(229)	(237)
Depreciation	(21)	(13)	(13)
Other	(846)	(373)	(388)
Other Provider Payments	(2,509)	(2,881)	(3,051)
Inter-district Outflows	(54)	(50)	(50)
Overheads	-	-	-
Total expenditure	**(6,374)**	**(6,489)**	**(7,131)**
(Deficit) / Surplus	**(1,484)**	**(1,306)**	**(1,897)**

HOW TO READ THE FOLLOWING GRAPHS

Symbols used

N/A	Not applicable - may be due to small numbers or unavailability of data
Δ	The measure/method of calculation changed during the period - result unavailable
Base	New measure introduced - baseline to be established
*	Previous year result has changed due to policy changes affecting the calculation
#	Previous year result has changed due to better data becoming available
^	Previous year result has changed due to an identified error

Colour coding

- Target met or exceeded
- Target missed by less than 10 basis points
- Target missed by more than 10 basis points
- Trend improving
- Trend slightly declining
- Trend declining

Table 1 | NON-FINANCIAL PERFORMANCE: PREVENTION SERVICES

Measures description	Ethnicity	2017/18 Actual	2018/19 Actual	2018/19 Target	Target	Trend
Percent of target population of children who have received Before School Checks (B4SC)	All Māori High Deprivation	92.9% 92.0% 94.1%	97.0% 95.6% 90.9%	≥90.0% ≥90.0% ≥90.0%	🟢 🟢 🟢	🟩 🟩 🟨
Percentage of obese children identified in the Before School Check (B4SC) programme will be referred to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions	All Māori Non-Māori	100.0% 100.0% 100.0%	86.7% 86.1% 87.5%	≥95.0% ≥95.0% ≥95.0%	🟡 🟡 🟡	🟥 🟥 🟥
Proportion of infants exclusively or fully breastfed at six weeks old	All Māori	70.5% 64.0%	66.3% 64.3%	≥75.0% ≥75.0%	🟡 🔴	🟥 🟩
Proportion of infants exclusively or fully breastfed at three months old	All Māori	56.0% 48.8%	51.2% 50.4%	≥70.0% ≥70.0%	🟡 🔴	🟥 🟩
Rheumatic fever rates per 100,000 total population	All	0.0%	N/A	<1.1		
Four-year old children living in smokefree homes	All	N/A	Δ	No target		
Immunisation coverage rates at milestone (eight months old)	Māori Non-Māori	87.0% 89.2%	81.5% 91.6%	≥95.0% ≥95.0%	🔴 🟡	🟥 🟩
Immunisation coverage rates at milestone (two years old)	Māori Non-Māori	90.9% 91.8%	83.8% 90.9%	≥95.0% ≥95.0%	🔴 🟡	🟥 🟨
Immunisation coverage rates at milestone (five years old)	Māori Non-Māori	87.4% 89.1%	85.0% 90.6%	≥95.0% ≥95.0%	🟡 🟡	🟨 🟩
Ambulatory Sensitive Hospitalisations (ASH) rates for children 0-4 years of age relative to the national rate	All Māori Non-Māori	119.4% 140.2% 102.7%	104.1% 142.4% 73.1%	≤100.0% ≤100.0% ≤100.0%	🟡 🔴 🟢	🟩 🟨 🟩
Ambulatory Sensitive Hospitalisations (ASH) rates for asthma and wheeze admission for children 0-4 years relative to the national rate	All Māori Non-Māori	138.3% 193.7% 93.8%	100.0% 144.6% 64.0%	≤107.5% ≤138.3% ≤76.5%	🟢 🔴 🟢	🟩 🟩 🟩
Percentage of youth who have received HPV vaccine	Māori Non-Māori	96.0% 66.7%	72.5% 81.0%	≥ 75.0% ≥ 75.0%	🟡 🟢	🟥 🟩
Percentage of pregnant women (who identify as smokers at confirmation of pregnancy in general practice or booking with a LMC) will be offered advice and support to quit smoking	All Māori Non-Māori	97.3% 96.0% 100.0%	92.0% 90.8% 94.3%	≥90.0% ≥90.0% ≥90.0%	🟢 🟢 🟢	🟥 🟥 🟥
Percentage of all pregnant women smoke-free at two weeks post-natal	All	79.0%	Δ	≥95.0%		
Percentage of patients who smoke and are seen by a health practitioner in public hospitals will be offered brief advice and support to quit smoking	Māori Non-Māori	94.1% * 94.7% *	86.9% 84.2%	≥95.0% ≥95.0%	🟡 🔴	🟥 🟥
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	92.0%	90.3% 89.6% 90.9%	≥90.0% ≥90.0% ≥90.0%	🟢 🟡 🟢	🟨
Percentage of pregnant women who identify as smokers upon registration with a DHB employed midwife or Lead Maternity Carer (LMC) are offered advice and support to quit smoking	Māori Non-Māori	100.0% 100.0%	90.8% 94.3%	≥90.0% ≥90.0%	🟢 🟢	🟥 🟥
Proportion of enrolled population aged 65+ years who have received flu vaccination	All Māori Non-Māori	63.1% 59.5% 63.4% ^	70.3% 73.1% 70.0%	≥75.0% ≥75.0% ≥75.0%	🟡 🟡 🟡	🟩 🟩 🟩
Cervical screening three-year coverage rate for women aged 25-69 years	Māori Non-Māori	71.9% 77.6%	72.3% 77.4%	≥ 80.0% ≥ 80.0%	🟡 🟡	🟩 🟨
Breast screening two-year coverage rate for eligible women aged 50-69 years	Māori Non-Māori	72.8% # 79.9%	73.1% 80.7%	≥ 70.0% ≥ 70.0%	🟢 🟢	🟩 🟩
Percentage of WDHB population enrolled in a Primary Health Organisation	All Māori Non-Māori	99.0% 96.3% 100.0% ^	98.5% 97.8% 98.8%	100.0% 100.0% 100.0%	🟡 🟡 🟡	🟨 🟩 🟨

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 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.

2018/19 Performance overview

For pregnancy, early years and adolescence the highlight has been the continuing growth of enrolments of 0-4 year old children in district health board funded dental services. Over a number of years there has been a specific initiative to enrol children in oral health services at the same time as other enrolments, rather than having a separate process.

Results in this and other output classes show that the oral health results for older children (ASH for dental conditions – Output Class 3) and adolescents continues to not meet targets and so getting the enrolments and ensuring access in the very early years is vital. Mean score of decayed, missing and filled teeth of year eight children is an important indicator.

The rate for non-Māori shows real improvement, and is considerably better than our target of < 0.83. The rate for Māori on the other hand is still outside the target, and the equity gap is not closing. Preventive measures are constantly being applied to permanent teeth to try and improve this mean score.

The number of adolescents accessing oral health care in the district has dropped from 3,040 in 2017/18 to 2,630 in 2018/19. The district health board provider arm has become the largest provider of adolescent oral health services in the area due to shrinking provision by other contracted providers. This is not ideal but, to improve coverage, we have been taking these services on-site in secondary schools, and this is proving to be an ideal way for Māori to receive this service, and is improving equity in this regard.

Although we have not quite achieved the target yet for pregnant women accessing district health board funded pregnancy and parenting education, it is pleasing to see the trend continues to improve.

Whanganui district, like many across New Zealand, has been impacted by the reducing number of Lead Maternity Carers contracted by the Ministry of Health and so some women have not been able to engage ante-natal support as early as recommended. However, this remains a focus for improvement as education helps to deliver important health messages along with preparation for birth and parenthood.

Our results for youth accessing primary mental health services is concerning as the target has not been met and the trend is unfavourable. Less than 60% of the number of Māori youth were reported to have been seen in general practice compared to the year before but we know that our youth community provider has seen a significant increase in numbers. Anecdotally we believe that rangatahi prefer to access a youth-specific service for some of their issues and so we need to ensure that access is available wherever it is sought. We also know the demand for mental health and addictions services by young people has increased significantly and that secondary services are under pressure (see Output Class 3) – with the 2019 wellbeing budget, we anticipate being able to review our primary mental health models of care for young people.

In terms of adulthood and healthy ageing, most indicators are favourable. The improvements in colonoscopy diagnostics results is significant as Whanganui District Health Board prepares for the local rollout of the national bowel screening programme (expected to be in October 2019). A considerable amount of effort has been made to ensure that diagnostic colonoscopy service is not negatively impacted by the new programme and the 12 month totals for urgent diagnostic colonoscopy and surveillance colonoscopy are now above the target levels. While the 12 month total for the non-urgent diagnostic colonoscopy target result is slightly below the 70% target, we note that it was above target level in all months from February to June 2019.

Cardiovascular (CVD) risk assessment rates appear to have remained fairly static although the target group of Māori men is still below the target and had an adverse trend in this financial year. We have previously signalled an intention to focus on cardiovascular health for Māori as there is a known inequity in this area. The system level measures programme will focus attention on this area again in 2019/20 in order to improve this result. Despite the unfavourable CVD results, disease management for diabetics has made some gains and this is an important contributor. There is still some inequity, in that the target has not quite been met (for good control) for Māori, but there is a positive trend for all groups.

Table 2 provides the results for all the measures in this output class and includes a visual marker (green, yellow, 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.

2018/19 FINANCIAL PERFORMANCE: EARLY DETECTION & MANAGEMENT

Output Class 2 - EARLY DETECTION & MANAGEMENT	2017/18 Actual	2018/19 Actual	2018/19 Budget
Revenue			
Crown	52,021	54,999	54,133
Other Income	553	322	436
Inter-district Inflows	1,453	1,507	1,752
Total revenue	**54,027**	**56,828**	**56,321**
Expenditure			
Personnel costs	(8,969)	(9,765)	(10,745)
Capital charge	(476)	(564)	(567)
Depreciation	(422)	(459)	(485)
Other	(7,676)	(8,120)	(8,270)
Other Provider Payments	(36,954)	(39,157)	(38,066)
Inter-district Outflows	(3,258)	(3,328)	(3,305)
Overheads	-	-	-
Total expenditure	**(57,755)**	**(61,393)**	**(61,438)**
(Deficit) / Surplus	**(3,728)**	**(4,565)**	**(5,117)**

Table 2 | NON-FINANCIAL PERFORMANCE: EARLY DETECTION & MANAGEMENT

Measures description	Ethnicity	2017/18 Actual	2018/19 Actual	2018/19 Target	Target	Trend
Newborns are enrolled with a Primary Health Organisation (PHO) by three-months	Māori Non-Māori	83.5% 69.4%	60.6% 71.2%	≥85.0% ≥85.0%	🔴 🔴	🟩 🟥
Number of 0-4 year old children enrolled in DHB funded dental service	All Māori Non-Māori	5,477 2,438 3,039	5,601 2,437 3,164	4,450 1,940 2,510	🟢 🟢 🟢	
Percentage of under 14 years able to access free primary care within 60 minutes including after hours	All	N/A *	N/A	≥95.0%		
Proportion of adolescent population utilising DHB funded dental services	All	79.8% #	69.2%	≥85.0%	🔴	🟥
Proportion of youth (12-19 years old) seen each quarter by primary mental health services	Māori Non-Māori	2.4% 1.4%	1.4% 1.0%	≥3.0% ≥3.0%	🔴 🔴	🟥 🟨
Mean score of decayed, missing and filled teeth of year eight children	Māori Non-Māori	1.16 0.74	1.21 0.67	≤ 0.83 ≤ 0.83	🔴 🟢	🟨 🟩
Proportion of pregnant women accessing DHB funded pregnancy and parenting education	All	23.6%	24.7%	≥ 30.0%	🟡	🟩
Improve the proportion of patients with good or acceptable glycaemic control (HbA1C < 64 mmol/mol)	Māori Non-Māori	51.0% 65.5%	51.0% 66.3%	≥53.0% ≥53.0%	🟡 🟢	🟩 🟩
Percentage of eligible Māori men in the PHO aged 35-44 who have had a CVD risk recorded within the past five years	Māori	68.0% #	61.8%	≥ 90.0%	🔴	🟥
Proportion of eligible population who have had their cardiovascular risk assessed in the last five years	All Māori Non-Māori	89.1% 87.5% 89.0%	87.6% 84.8% 88.4%	≥ 90.0% ≥ 90.0% ≥ 90.0%	🟡 🟡 🟡	🟨 🟨 🟨
Ambulatory Sensitive Hospitalisations (ASH) rates for 45-64 years of age relative to national rate	All Māori Non-Māori	161.4% 252.3% # 127.6% #	162.5% 298.5% 131.1%	< 150.0% < 268.4% < 130.1%	🔴 🔴 🟡	🟨 🟥 🟨
Proportion of over 64 year olds who are prescribed 11 or more medications	All	1.6%	2.0%	< 2.0%	🟢	🟨
Percentage of people accepted for an urgent diagnostic colonoscopy received their procedure within two weeks	All	89.9%	91.3%	≥ 90.0%	🟢	🟩
Percentage of people accepted for a non-urgent diagnostic colonoscopy received their procedure within (42 days)	All	56.3%	64.1%	≥ 70.0%	🟡	🟩
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	55.9%	75.2%	≥ 70.0%	🟢	🟩

OUTPUT CLASS 3: INTENSIVE ASSESSMENT & 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 focused 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 either through 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.

2018/19 Performance overview

We have had a significant and sustained reduction in the number of 0-5 year olds presenting to the emergency department overnight. This is very encouraging and will be due to a number of factors including better access to primary care through reduced fees as well as the improvements in the national HealthLine services. As mentioned previously (Output Class 2), we have seen an increase in the volumes of young people seeking secondary mental health services and it is good to see that we are meeting the target waiting time and that the trend shows some improvement. Ongoing focus will be needed in ensuring that access is equitable and that people get the level of help needed as quickly as possible. As reported under Output Class 2, we will seek to continue encouraging youth to access services in alternative community-based settings.

Another area of reduced hospital utilisation has been in paediatric admissions, where the total number is down. This is a good trend as it indicates that paediatric issues are being dealt with better in primary and community settings. This reflects the efforts of Paediatrics to provide better and more responsive support in out-of-hospital settings.

Ambulatory Sensitive Hospitalisation (ASH) rates for 0-4 children for dental conditions have worsened and we are approaching the worst levels since 2015. This may be related to the rising enrolments discovering concerns earlier in an increasing population – but we are aware of the significant attention needed in this area and will continue to focus here in 2019/20, including further development of a kaupapa approach that has been trialled.

There are good results around hospital utilisation for acute surgical discharges (reduced) and for inpatient length of stay for acute and elective patients. Unfortunately the results for acute medical discharge numbers is not favourable.

The surging demand for acute medical services has been recognised for some time and may be reflected in the emergency department (ED) results, which have not met targets and have mostly declining trends. We do have concerns about this data, however, as we introduced new technology in 2018 and the timing of transitions in ED required manual administrative interventions which may not have been prioritised in a busy ED. In addition (although not reported in district health board results) we know that volumes at Whanganui Accident and Medical (WAM) continue to grow too. Our "front door" services have undergone some change and we have a system-wide focus on acute demand (through the Whanganui Alliance) – these initiatives should help to provide improvements that will change the results for acute and medical patients over time.

For the ageing population, standardised intervention rates are showing favourable trends. Our intervention rate for major joint surgery is coming closer to the national average, which is releasing some resource to increase some of those areas where we were not faring so well – cardiac surgery, cataracts, angioplasty and angiography are all improving and are now only slightly below the target.

As mentioned above, inpatient length of stay continues to improve (reduce) as people are supported to go home sooner and the unplanned readmissions, although not yet at target, are improving too. This would indicate that earlier discharges are taking place with appropriate support and follow-up.

For cancer services, the target for those referred with a high suspicion of cancer has not yet been achieved, although the trend is favourable. There is significant effort in this area although the result is impacted by small numbers. The target for cancer treatment within 31 days of diagnosis for all cancer patients was achieved again this year. This means that once a decision to treat has been agreed and accepted, the treatment is commencing within expected timeframes.

A number of process indicators around secondary mental health services are unfavourable this year and there is a growing inequity in the use of compulsory treatment orders (CTOs). This is an unresolved issue. We were able to keep the rate lower comparatively to other district health boards, initially due mainly to the good work of Māori providers in the community. But, overall, the rate has gone up steadily in the past two years and this appears to be in line with the increase in acute demand. The intention to reduce CTOs is well socialised among 'responsible clinicians' but is difficult in times of needing to deal with acute presentations safely and effectively. For Māori who have been subject to indefinite CTOs for long periods we make a commitment to challenge responsible clinicians on a case-by-case basis. Overall mental

health and addictions services have experienced significant overutilisation this year and we are continuing with a focused effort to bring these indictors back in line, including engaging support from our Māori provider partners in the process. A new position has been created to assist with transitions along with more integrated processes with community providers pending transition. The community contact before and after admission will improve as a result.

Markers of patient safety, such as surgical procedures and surgical infections, continue to perform satisfactorily. Where the targets have not been met, the margin is narrow and within the range of expectations.

Table 3 provides the results for all the measures in this output class and includes a visual marker (green, yellow, 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.

2018/19 FINANCIAL PERFORMANCE: INTENSIVE ASSESSMENT & TREATMENT

Output Class 3 - INTENSIVE ASSESSMENT & TREATMENT	2017/18 **Actual**	2018/19 **Actual**	2018/19 **Budget**
Revenue			
Crown	147,562	156,356	154,790
Other Income	1,706	1,542	1,392
Inter-district Inflows	4,824	4,341	4,573
Total revenue	**154,092**	**162,239**	**160,755**
Expenditure			
Personnel costs	(67,875)	(76,756)	(73,786)
Capital charge	(3,489)	(3,365)	(3,367)
Depreciation	(4,173)	(4,809)	(4,893)
Other	(32,538)	(34,155)	(32,528)
Other Provider Payments	(10,288)	(12,525)	(11,887)
Inter-district Outflows	(34,551)	(37,457)	(34,905)
Overheads	-	-	-
Total expenditure	**(152,914)**	**(169,067)**	**(161,366)**
(Deficit) / Surplus	**(1,178)**	**(6,828)**	**(611)**

Table 3 | NON-FINANCIAL PERFORMANCE: INTENSIVE ASSESSMENT & TREATMENT

Measures description	Ethnicity	2017/18 Actual	2018/19 Actual	2018/19 Target	Target	Trend
Ambulatory Sensitive Hospitalisations (ASH) rate for dental in children 0-4 years compared with national rates	All Māori Non-Māori	165.1% 228.4% 114.4%	209.6% 280.1% 152.6%	≤180.5% ≤243.9% ≤118.2%	🔴 🔴 🔴	🟥 🟥 🟥
Proportion of 0 -19 year olds referred for non-urgent mental health and addiction services seen within three weeks (all services)	All	80.0%	80.2%	≥80.0%	🟢	🟩
Percentage of long-term (under 19 years) clients with mental illness who have an up-to-date relapse prevention plan	All	100.0%	89.4%	≥ 95.0%	🔴	🟥
Number of Paediatric Department admissions	Māori Non-Māori	367 482	351 313	No target No target		🟩 🟩
Percentage of long-term adult clients with mental illness who have an up-to-date relapse prevention plan	All	96.0%	92.2%	≥ 95.0%	🟡	🟥
Percentage of service users receiving community care within seven days prior to an admission (KPI 18)	Māori Non-Māori	41.5% 53.7%	39.0% 50.3%	≥ 75.0% ≥ 75.0%	🔴 🔴	🟥 🟨
Percentage of service users receiving community care within seven days following their discharge (KPI 19)	Māori Non-Māori	N/A N/A	50.0% 42.5%	≥ 75.0% ≥ 75.0%	🔴 🔴	
Rate per 100,000 population Māori are committed to compulsory treatment relative to non-Māori	Māori Non-Māori	209 101	307 121	No target No target		🟥 🟥
Percentage of patients will be admitted, discharged, or transferred from an Emergency Department within six hours	Māori Non-Māori	92.8% ^ 90.7% ^	92.0% 89.7%	≥ 95.0% ≥ 95.0%	🟡 🟡	🟨 🟨
The number of people identified as having fragility fractures and the proportion who avoid a secondary fracture	All	(222) 46.0%	(258) 55.0%	No target		🟩
Percentage of older patients given a falls risk assessment	All	93.0%	N/A	> 90.0%		
Percentage of category one patients seen immediately (resuscitation)	Māori Non-Māori	95.1% 75.9%	96.4% 87.7%	100.0% 100.0%	🟡 🔴	🟩 🟩
Percentage of category three patients seen within 30 minutes (urgent)	Māori Non-Māori	91.5% 90.2%	46.2% 46.8%	≥ 75.0% ≥ 75.0%	🔴 🔴	🟥 🟥
Percentage of category two patients seen within 10 minutes (emergency)	Māori Non-Māori	92.6% 85.9%	26.2% 25.6%	≥ 80.0% ≥ 80.0%	🔴 🔴	🟥 🟥
Number of Emergency Department attendances	Māori Non-Māori	5,956 ^ 17,749 ^	6,220 15,477	No target No target		🟥 🟩
Percentage of admission through Emergency Department	Māori Non-Māori	N/A N/A	44.6% 51.8%	Base Base		
Number of acute surgical inpatient discharges (excluding emergency medicine)	Māori Non-Māori	549 1,901	503 1,515	No target No target		🟩 🟩
Number of acute medical inpatient discharges (excluding emergency medicine)	Māori Non-Māori	1,058 3,595	1,130 3,311	No target No target		🟥 🟩
Percentage of patients waiting less the maximum waiting time for first specialist assessment and treatment	All	99.0%	99.6%	≥ 100.0%	🟢	🟩
Unplanned readmission rate at 28 days	Māori Non-Māori	13.8% 15.4%	13.0% 14.6%	<11.8% <11.8%	🟡 🔴	🟩 🟩
Number of presentations by 0-5 years to the Emergency Department between 2100 and 0800	All	886	837	3,509	🟢	🟩
Standardised Intervention Rate - Elective services	Major joints Cataracts Cardiac surgery Angioplasty Angiography	35.2 18.2 4.8 11.2 28.0	26.3 26.3 5.5 11.8 30.3	>21.0 >27.0 >6.5 >12.5 >34.7	🟢 🟡 🟡 🟡 🟡	🟩 🟩 🟩 🟩 🟩

Measures description	Ethnicity	2017/18 Actual	2018/19 Actual	2018/19 Target	Target	Trend
Inpatient Length of Stay - Acute	All	2.29	2.24	< 2.30	●	■
Inpatient Length of Stay - Elective	All	1.47	1.44	< 1.45	●	■
Improving the quality of identity data within the National Health Index: Indicator 2: Recording of non-specific ethnicity in new NHI registration		N/A	N/A	≤ 0.5%		
Indicator 3: Update of specific ethnicity value in existing NHI record with a non-specific value		N/A	N/A	≤ 0.5%		
Percentage of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks	All	82.0%	83.0%	> 85.0%	●	■
Proportion of patients with a confirmed diagnosis of cancer who receive their first cancer treatment (or other management) within 31 days of the decision to treat	All	91.0%	90.1%	> 85.0%	●	■
Number of cardiac surgery discharges for the local population	All	41	43	> 52	●	■
Percentage of acute cardiac services patients who receive an angiogram within three days of admission	All Māori Non-Māori	67.8% # 91.7% # 61.7% #	57.0% 52.4% 57.9%	> 70.0% > 70.0% > 70.0%	● ● ●	■ ■ ■
Percentage compliance with good hand hygiene practice	All	86.0%	85.0%	> 80.0%	●	■
Percentage of surgical procedures where the level of team engagement with the surgical safety checklist were at five or above	Sign in Time out Sign out	92.0% 100.0% 97.0%	99.0% 92.0% 95.0%	> 95.0% > 95.0% > 95.0%	● ● ●	■ ■ ■
Surgical site infection 'Process Marker 1': Percentage of primary hip and knee replacement patients receiving prophylactic antibiotics 0-60 minutes before incision	All	100.0%	98.0% (est)	100.0%	●	■
Surgical site infection 'Process Marker 2': Percentage of hip and knee replacement patients receiving 2.0g or more of cefazolin or 1.5g or more cefuroxime	All	100.0%	100.0% (est)	> 95.0%	●	■

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 Hospice Whanganui, 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 family/whānau, 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 that 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 family support and enable older people and the disabled to participate fully in society and enjoy maximum independence.

2018/19 Performance overview

This output class is mostly focused on adults and healthy ageing. All indicators, apart from low-risk interRAI assessment times, are either achieving or almost-achieving the targets. In nearly all cases, the trends are favourable – showing improvement.

There has been a reduction in the proportion of the population who have been assessed with a home support service coordination outcome.

Clinicians report that the number of referrals for interRAI home care assessments continues to be at a very high level so this is a positive trend. It may also indicate that more of the people who are being assessed are able to self-care and maintain independence without support.

Over the past few years there have been more programmes aimed at supporting older people to overcome mobility issues – for example, falls risk assessments are now well-embedded in practice and can lead to falls prevention exercise classes being advised. In addition, we are encouraging early assessments so that baseline functionality can be evaluated well before any decline requires an intervention.

For older people, the actual numbers needing support at higher levels of care has not increased at the same rate as the population increase – this is testament to the efficacy of our focus on supporting people to maintain independence in their own homes.

The number of people dying in acute settings has not reduced for non-Māori and the acute demand work (mentioned previously) will have a focus on improving palliative support in community settings.

The number of people seen by the cardiac rehabilitation team whilst in hospital has reduced – although this is shown as a declining trend, it may be due to less total numbers of people appropriate for the cardiac rehabilitation team being in hospital as they are being discharged to community setting sooner than before.

We have a comprehensive acute stroke and Assessment Treatment and Rehabilitation (ATR) ward. All acute stroke patients receive a multi-disciplinary treatment rehabilitation approach from their first day of admission and this does improve outcomes. We have developed a best practice stroke pathway that supports our patients being directly admitted from ED to the acute stroke unit (ASU). We utilise telestroke with oversight from Wellington for after-hours thrombolysis and this has improved our thrombolysis rate. This is a good result for our community as quicker thrombolysis leads to reduced risk of disability following stroke.

We recently implemented 'code stroke' in business hours and this is seeing us streamline our service further with improved door to needle times consistently under 30 minutes. We are aiming to extend code stroke through the evenings as well. We also work regionally with Capital and Coast District Health Board on other aspects of stroke management for the benefit of Whanganui district patients.

Table 4 provides the results for all the measures in this output class and includes a visual marker (green, yellow, 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.

2018/19 FINANCIAL PERFORMANCE: REHABILITATION AND SUPPORT

Output Class 4 - REHABILITATION & SUPPORT	2017/18 Actual	2018/19 Actual	2018/19 Budget
Revenue			
Crown	40,103	40,385	39,798
Other Income	102	67	80
Inter-district Inflows	992	1,097	1,097
Total revenue	**41,197**	**41,549**	**40,975**
Expenditure			
Personnel costs	(3,778)	(4,626)	(4,193)
Capital charge	(282)	(243)	(242)
Depreciation	(104)	(136)	(137)
Other	(2,925)	(3,649)	(3,101)
Other Provider Payments	(30,982)	(30,907)	(30,634)
Inter-district Outflows	(3,271)	(2,943)	(2,929)
Overheads	-	-	-
Total expenditure	**(41,342)**	**(42,504)**	**(41,236)**
(Deficit) / Surplus	**(145)**	**(955)**	**(261)**

Table 4 | NON-FINANCIAL PERFORMANCE: REHABILITATION AND SUPPORT SERVICES

Measures description	Ethnicity	2017/18 Actual	2018/19 Actual	2018/19 Target	Target	Trend
Percentage of referrals for an InterRAI assessment that are completed within national guidelines - low risk 15 days	All	51.0%	77.5%	>95.0%	🔴	🟩
Percentage of referrals for an InterRAI assessment that are completed within national guidelines - crisis within 48 hours	All	100.0%	100.0%	>95.0%	🟢	🟩
Percentage of referrals for an InterRAI assessment that are completed within national guidelines - high risk as soon as possible	All	87.0%	93.8%	>95.0%	🟡	🟩
Percentage of referrals for an InterRAI assessment that are completed within national guidelines - medium risk 10 days	All	76.0%	87.2%	>95.0%	🟡	🟩
Proportion of population aged 65+ years who have been assessed with a home support service coordination outcome	Māori Non-Māori	8.5% 7.4%	6.1% 6.4%	No target No target		🟩 🟩
Percentage of aged residential facilities in DHB area using, or training their nurses to use, the InterRAI Long-Term Conditions Facilities (LTCF) assessment tool	All	100.0%	100.0%	100.0%	🟢	🟩
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	90.0%	91.2%	100.0%	🟡	🟩
Proportion of population aged 65+ years receiving DHB funded support in ARC facilities over the year	Māori Non-Māori	3.6% 5.6%	3.0% 5.1%	No target No target		🟩 🟩
Number of long-term residents living in aged residential care facilities who die in acute settings	Māori Non-Māori	2 20	0 20	No target No target		🟩 🟩
Number of patients seen by cardiac rehabilitation and education team while in hospital	All	326	304	No target		🟨
Percentage of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within seven days of acute admission (Ind. 3)	All	79.0%	85.2%	>80.0%	🟢	🟩
Percentage of stroke patients admitted to a stroke unit/organised stroke service with demonstrated stroke pathway (Ind. 1)	All	97.0%	98.3%	>80.0%	🟢	🟩
Percentage of potentially eligible stroke patients thrombolysed (Ind. 2)	All	8.4%	11.5%	>10.0%	🟢	🟩

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Deloitte.

INDEPENDENT AUDITOR'S REPORT

TO THE READERS OF THE WHANGANUI DISTRICT HEALTH BOARD'S FINANCIAL STATEMENTS AND PERFORMANCE INFORMATION FOR THE YEAR ENDED 30 JUNE 2019

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 50 to 84 that comprise the statement of financial position as at 30 June 2019, 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 30 to 41.

Qualified opinion – Our audit was limited due to the uncertainties associated with the calculation of employee entitlements under the Holidays Act 2003

In our opinion, except for the matters described in the *Basis for our qualified opinion* section of our report:

- the financial statements of the Health Board on pages 50 to 84:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2019; and
        - its financial performance and cash flows for the year then ended; and
    - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards; and
- the performance information of the Health Board on pages 30 to 41:
    - presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2019, including:
        - for each class of reportable outputs:
            - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
            - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
        - what has been achieved with the appropriation; and
        -
        - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and
    - complies with generally accepted accounting practice in New Zealand.

Deloitte.

Our audit of the financial statements and the performance information was completed on 31 October 2019. This is the date at which our qualified opinion is expressed.

The basis for our qualified opinion is explained below, and we draw your attention to the matter of the Health Board being reliant on financial support from the Crown. In addition, we outline the responsibilities of the Board and our responsibilities relating to the financial statements and the performance information, we comment on other information, and we explain our independence.

Basis for our qualified opinion

As outlined in note 16 on page 75 and 76, the Health Board has been investigating issues associated with the calculation of employee entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues. Due to the nature of health sector employment arrangements, this is a complex and time consuming process and is yet to be completed. The Health Board has estimated a provision as at 30 June 2019 of $4.2 million to remediate these issues. However, until further work is undertaken by the Health Board, there are substantial uncertainties surrounding the amount of its liability. Because of the work that has yet to be completed to remediate these issues, we have been unable to obtain sufficient audit evidence to determine the appropriateness of the amount of the provision.

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

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

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

The Health Board is reliant on financial support from the Crown

Without further modifying our opinion, we draw attention to the disclosures made in the Statement of Significant Accounting Policies on page 55 that outline the financial difficulties being experienced by the Health Board in relation to operating and cashflow forecasts.The Health Board has determined that it is a going concern, because it has obtained a letter of comfort from the Ministers of Health and Finance. The letter confirms that the Crown will provide the Health Board with equity support, should it be necessary, to maintain viability. We consider these disclosures to be adequate.

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 they determine is necessary to enable them 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 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 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.

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Our responsibilities arise from the Public Audit Act 2001.

Other Information

The Board is responsible for the other information. The other information comprises the information included on pages 4 to 29, 47 to 49 and 85 to 91, 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(Revised): *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
for Deloitte Limited
On behalf of the Auditor-General
Hamilton, New Zealand

FINANCIAL SUMMARY

The 2018/19 financial result of a $13.7m deficit, compared to the 2017/18 deficit of $4.2m was due to significant growth in expenditure to meet the increasing demand and provision for Holidays Act compliance. Whanganui District Health Board region has a high proportion of older people who are living longer, and this contributes to a greater level of frailty in the community. The impact of this increasing frailty put pressure on services in the community, with flow-on effects of increased demand for hospital-based services.

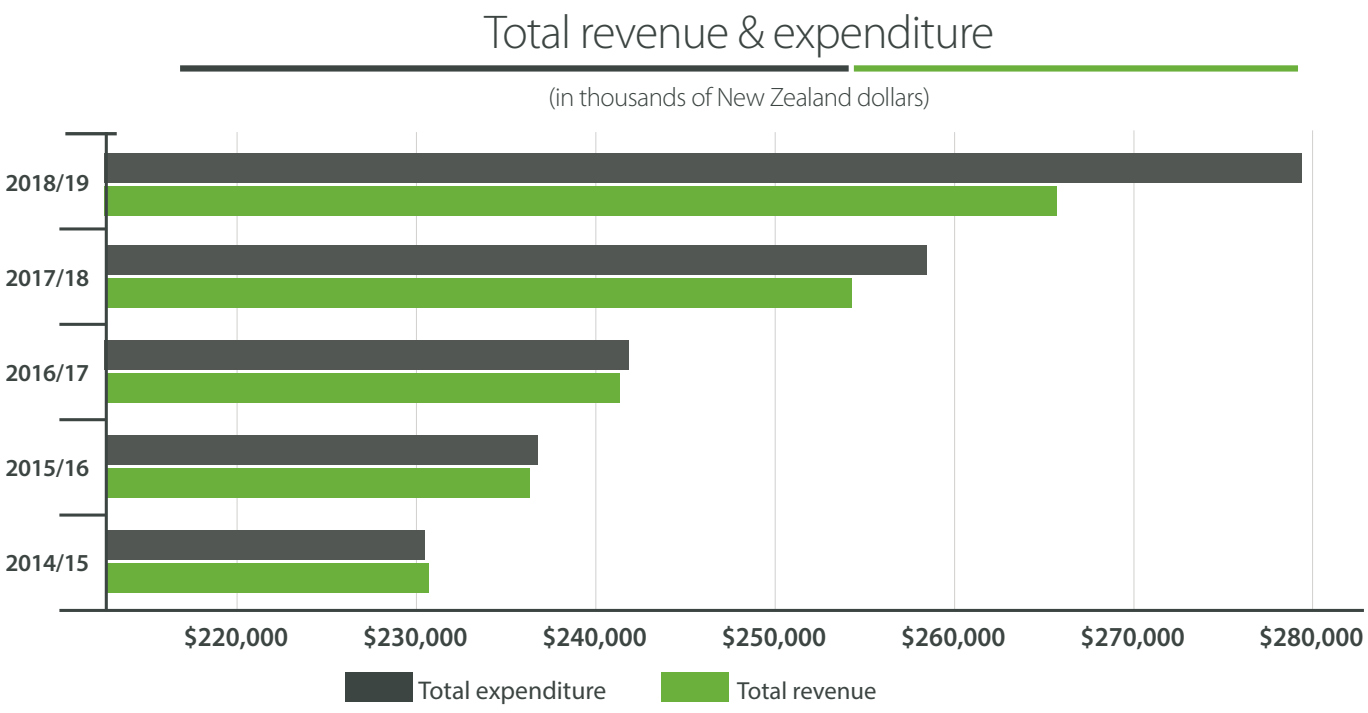
To meet the increased demand, additional resources in both hospital and community settings have been required. This has meant increased levels of clinical staffing and supplies. Patient acuity and complexity has increased, partly due to more patients having dementia. A greater number of patients have needed to be transferred to receive services from other district health boards.

Revenue breakdown

In 2018/19, revenue increased by $11.7m (4.6%), compared to an $11.8m (4.9%) increase in 2017/18. Ninety-six percent of revenue was received from the Crown – unchanged from 2017/18.

The increases are due to following factors:

- An increase in population based funding of $7.9m
- In-between travel settlement funding of $0.6m
- Primary care funding for Community Services Card holders, CarePlus and Very Low Cost Access for under-6s and under-14s of $1m. This revenue was passed on to primary care providers
- Home and community support (care and support workers) pay equity settlement of $1m. This revenue was passed on to home and community support providers.
- Care Capacity and Demand Management (CCDM) funding for implementing a programme to align patient demand with staff resourcing – one-off funding of $0.7m.
- Bowel screening project and school based health $0.1m.

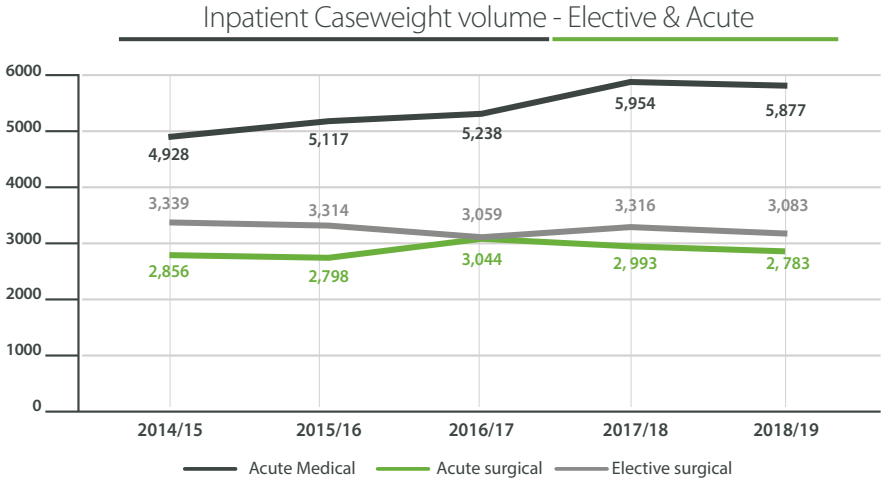


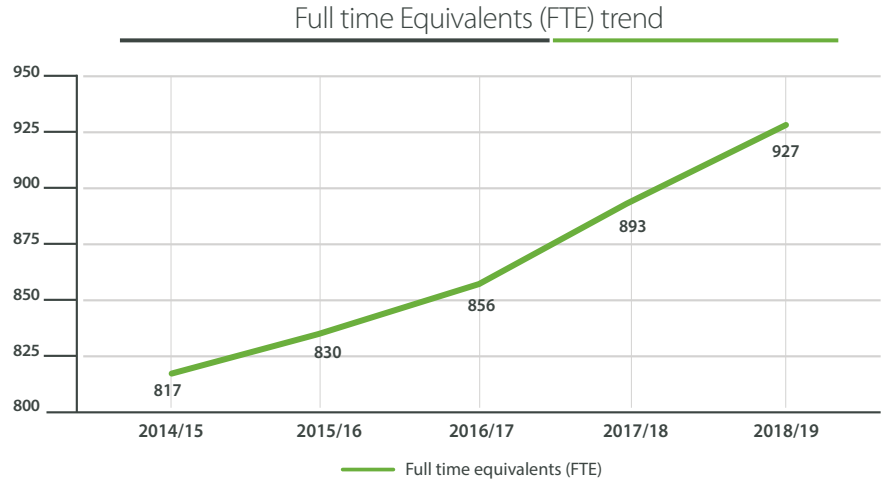
Expenditure breakdown

In 2018/19, expenditure increased by $21.2m (8.2%). This is significantly greater than the $15.4m (6.4%) increase experienced in 2017/18. The most significant increases have resulted from increased demand for services.

The main increases have been:

- Personnel costs (including outsourced) increased by $10.9m (12.7%) due to increased service volume, patient acuity requiring more clinical staff, implementation of safer rosters model (CCDM), increase in one-on-one care for patients, increases multiemployer collective agreement and increases the provision of $3.6m for Holidays Act compliance.
- Outsourced services costs increased by $0.5m due to high demand for radiology services and rest home convalescence.
- Depreciation costs increased by $0.7m as a result of increased building valuation (30 June 2018) and capitalisation of the completed Regional Health Informatics Programme.
- Clinical supplies, infrastructure and non-clinical supplies increased by $0.6m due to high patient acuity impacting on ward supplies costs, patient travel and pharmaceuticals. This expense excludes inter-district outflows and payments to non-health board providers included in Note 5.
- Payments to other district health boards increased by $2.6m (6.4%) due to demand for cardiology, cardiothoracic, vascular surgery and necrology at Capital and Coast District Health Board; and for general surgery, haematology, urology and ENT at MidCentral District Health Board.





- Other health provider costs increased by $4.7m (5.9%) due to price uplifts, health of older people, primary care capitation, and mental health services. This was partly offset by additional funding received for pay equity and primary health care.
- Finance, Procurement and Information Management (FPIM) write-off of $1m – refer Note 11.

Assets

Total assets increased by $5.8m which relates to the gap between additions and accumulated depreciation and the FPIM write-off.

Liabilities

Total liabilities increased by $8m. Employee entitlements contributed $3.9m which relates to provision for Holidays Act compliance, provision for the expiry of multi-employer collective agreements. Provision for inter-district flows, pharmacy discretionary top up and in-between travel wash up contributed $4.1m increase.

STATEMENT OF RESPONSIBILITY

For the year ended 30 June 2019

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.

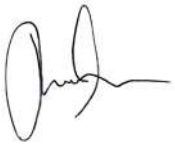
The board and management of Whanganui District Health Board are responsible for any end-of-year performance information provided by Whanganui District Health Board under section 19A of the Public Finance Act 1989.

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 the Whanganui District Health Board, the financial statements and statement of performance for the year ended 30 June 2019, fairly reflect the financial position and operations of the Whanganui District Health Board.

Signed on behalf of the board and management by:

Dot McKinnon
Board Chair



Chief Executive

Brian Walden
General Manager Corporate

Darren Hull
Board member

Dated: 31 October 2019

STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSE

For the year ended 30 June 2019

in thousands of New Zealand dollars

	Note	2019 Actual	2019 Budget	2018 Actual
Revenue				
Revenue from non-exchange transactions	1a	232, 616	230, 901	222, 111
Revenue from exchange transactions	1b	32, 811	31, 950	31, 627
Other revenue	1c	372	339	339
Total revenue		**265, 799**	**263, 190**	**254, 077**
Expenses				
Personnel costs	2	(94, 090)	(92, 116)	(83, 456)
Outsourced services		(15, 122)	(13, 635)	(14, 397)
Depreciation and amortisation expense		(5, 417)	(5, 528)	(4, 720)
Capital charge	3	(4, 401)	(4, 413)	(4, 357)
Finance costs	4	(22)	(22)	(10)
Other expenses	5	(160, 496)	(155, 457)	(151, 445)
Total expenses		**(279, 548)**	**(271, 171)**	**(258, 385)**
Share of profit of associate	12	95	95	129
(Deficit) / Surplus		**(13, 654)**	**(7, 886)**	**(4, 179)**
Other comprehensive revenue and expense				
Gain on property revaluation		-	-	7, 024
Total other comprehensive revenue and expense		**-**	**-**	**7, 024**
Total comprehensive revenue and expense		**(13, 654)**	**(7, 886)**	**2, 845**

Explanations of major variances against budget are provided in Note 22.
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 2019

in thousands of New Zealand dollars

	Note	2019 Actual	2019 Budget	2018 Actual
Assets				
Current assets				
Cash and cash equivalents	6	3, 020	5	1, 284
Receivables from non-exchange transactions	7	352	169	223
Receivables from exchange transactions	7	5, 897	7, 313	8, 514
Prepayments		41	13	13
Investments	8	-	-	3, 000
Inventories	9	1, 427	1, 412	1, 412
Trust / special funds		181	141	141
Patient and restricted trust funds		4	4	4
Total current assets		**10, 922**	**9, 057**	**14, 591**
Non-current assets				
Property, plant and equipment	10	75, 230	77, 361	76, 766
Intangible assets	11	11, 777	13, 251	12, 417
Investments in associates	12	1, 146	1, 167	1, 121
Total non-current assets		**88, 153**	**91, 779**	**90, 304**
Total assets		**99, 075**	**100, 836**	**104, 895**
Liabilities				
Current liabilities				
Bank overdraft		-	5, 038	-
Payables under non-exchange transactions	14	2, 092	2, 720	2, 179
Payables under exchange transactions	14	16, 142	11, 420	11, 743
Borrowings	15	230	23	227
Employee entitlements	16	16, 713	11, 827	12, 874
Total current liabilities		**35, 177**	**31, 235**	**27, 023**
Non-current liabilities				
Borrowings	15	684	684	914
Employee entitlements	16	873	808	805
Total non-current liabilities		**1, 557**	**1, 492**	**1, 719**
Total liabilities		**36, 734**	**32, 727**	**28, 742**
Net assets		**62, 341**	**68, 109**	**76, 153**
Equity				
Contributed capital		105, 567	105, 567	105, 725
Accumulated surplus / (deficit)		(67, 287)	(61, 480)	(53, 594)
Property revaluation reserve		23, 881	23, 881	23, 881
Hospital special funds		180	141	141
Total equity		**62, 341**	**68, 109**	**76, 153**

Explanations of major variances against budget are provided in Note 22.
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 2019

in thousands of New Zealand dollars

	2019 Actual	2018 Actual
Contributed capital		
Balance at 1 July	105, 725	105, 884
Conversion of Crown loan to equity	-	-
Repayment of capital	(158)	(159)
Balance at 30 June	**105, 567**	**105, 725**
Accumulated (deficit)		
Balance at 1 July	(53, 594)	(49, 409)
Other reserved movements	(39)	(6)
Surplus / (Deficit) for the year	(13, 654)	(4, 179)
Balance at 30 June	**(67, 287)**	**(53, 594)**
Property revaluation reserves		
Balance at 1 July	23, 881	16, 857
Revaluation	-	7, 024
Balance at 30 June	**23, 881**	**23, 881**
Property revaluation reserves consist of:		
Land	1, 093	1, 093
Buildings	22, 788	22, 788
Total property revaluation reserves	**23, 881**	**23, 881**
Hospital special funds		
Balance at 1 July	141	135
Transfer from retained earnings in respect of:		
Interest	3	4
Donations and funds received	40	4
Transfer from retained earnings in respect of:		
Funds spent	(4)	(2)
Balance at 30 June	**180**	**141**
Total equity	**62, 341**	**76, 153**

Explanations of major variances against budget are provided in Note 22.
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 2019

in thousands of New Zealand dollars

	Note	2019 Actual	2018 Budget	2018 Actual
Cash flows from operating activities				
Receipts from the Crown		266, 128	262, 703	248, 493
Interest received		321	410	509
Receipt from other revenue		1, 655	1, 495	1, 934
Payment to suppliers		(169, 917)	(168, 577)	(164, 496)
Payment to employees		(90, 183)	(93, 196)	(81, 344)
Interest paid		(22)	(22)	(10)
Payment of capital charge		(4, 401)	(4, 413)	(4, 357)
GST (net)		177	37	(91)
Net cash inflow / (outflow) from operating activities		**3, 758**	**(1, 563)**	**638**
Cash flows from investing activities				
Receipts from sale of property, plant and equipment		-	-	38
Purchase of property, plant and equipment		(3, 262)	(5, 572)	(2, 457)
Purchase of intangible assets		(1, 310)	(1, 797)	(3, 983)
Receipts from maturity of investments		2, 975	3, 000	-
Net appropriation from trust funds		(40)	-	(7)
Net cash inflow / (outflow) from investing activities		**(1, 637)**	**(4, 369)**	**(6, 409)**
Cash flows from financing activities				
Capital contribution		-	-	-
Payment of finance lease		(92)	(92)	(57)
Repayment of capital		(158)	(158)	(159)
Payment of loans		(135)	(135)	(135)
Net cash inflow / (outflow) from financing activities		**(385)**	**(385)**	**(351)**
Net (decrease) / increase in cash and cash equivalents		1, 736	(6, 317)	(6, 122)
Cash and cash equivalents at beginning of year		1, 284	1, 284	7, 406
Cash and cash equivalents at end of year	6	**3, 020**	**(5, 033)**	**1, 284**

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

	2019 Actual	2018 Actual
Net surplus / (deficit)	**(13, 654)**	**(4, 179)**
Add / (less) non-cash items		
Depreciation and amortisation expense	5, 417	4, 720
Impairment on intangible assets (NOS)	1, 048	83
Total non-cash items	**6, 465**	**4, 803**
Add / (less) items classified as investing or financing activities		
(Gains) / losses on disposal of property, plant and equipment	15	16
Surplus / (deficit) from associates	(95)	(129)
Payable movements attributed to capital purchase	268	64
Total items classified as investing or financing activities	**188**	**(49)**
Add / (less) movements in statement of financial position items		
Receivables	2, 555	(1, 091)
Inventories	(15)	(85)
Payables	4, 312	(873)
Employee entitlements	3, 907	2, 112
Net movements in working capital items	**10, 759**	**63**
Net cash flow from operating activities	**3, 758**	**638**

Explanations of major variances against budget are provided in Note 22.
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 2019

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, 2018: 17.64% owned), as disclosed in Note 12.

There is also an investment in Technical Advisory Services Limited (TAS) (16.7% owned), as disclosed in Note 13. 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 2019, and were authorised by the board on 31 October 2019.

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 been early adopted

Whanganui District Health Board elected to early adopt PBE IFRS 9 Financial Instruments. PBE IFRS 9 replaces PBE IPSAS 29 Financial Instruments: Recognition and Measurement. Information about the adoption of PBE IFRS 9 is provided in Note 23.

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

Impairment of revalued assets

In April 2017, the XRB issued Impairment of Revalued Assets, which now clearly scopes revalued property, plant, and equipment into the impairment accounting standards. Previously, only property, plant, and equipment measured at cost were scoped into the impairment accounting standards.

Under the amendment, a revalued asset can be impaired without having to revalue the entire class of asset to which the asset belongs. This amendment is effective for the 30 June 2020 financial statements, with early adoption permitted. The timing of Whanganui District Health Board adopting this amendment will be guided by the Treasury's decision on when the Financial Statements of the Government will adopt the amendment.

Interests in other entities

In January 2017, the XRB issued new standards for interests in other entities (PBE IPSAS 34 - 38). These new standards replace the existing standards for interests in other entities (PBE IPSAS 6 - 8). The new standards are effective for annual periods beginning on or after 1 January 2019.

Whanganui District Health Board will apply these new standards in preparing the 30 June 2020 Financial Statements. No effect is expected as a result of this change.

Service performance reporting

In November 2017, the XRB issued new standards for service performance reporting. PBE FRS 48 is effective for financial years beginning on or after 1 January 2021, 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 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 Statement of Performance.

Whanganui District Health Board will apply these new standards in preparing the 30 June 2022 service performance reporting.

STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES

For the year ended 30 June 2019

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 2018/19 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 21 October 2019 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 significant operating cash flow deficit for the 2019/20 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 2019/20 financial year.

EQUITY SUPPORT

Whanganui District Health Board has requested deficit support from the Ministry of Health of $6m in the 2019-20 financial year due to deteriorating financial performance that has resulted in increasing deficits over the past two financial years. Cash resources have declined and financial support will be required to meet the financial obligations of Whanganui District Health Board.

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 2017 to 30 June 2018. The comparative figures in the Statement of Financial Position are presented as at 30 June 2018.

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 NZGAAP.

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 2019

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 non-exchange 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 21.

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 2019

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 10.
- fair value of land and buildings – refer Note 10.
- useful lives of software assets – refer Note 11.
- retirement and long service leave – refer Note 16
- Holidays Act compliance - refer Note 16.

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.

in thousands of New Zealand dollars

1 REVENUE (continued)

BREAKDOWN OF REVENUE AND FURTHER INFORMATION

1a. REVENUE FROM NON-EXCHANGE TRANSACTIONS	2019 Actual	2018 Actual
Health and disability services (Crown appropriation revenue)*	223, 885	216, 181
Ministry of Health other revenue	8, 649	5, 922
Other revenue	82	8
Total revenue from non-exchange transactions	**232, 616**	**222, 111**

1b. REVENUE FROM EXCHANGE TRANSACTIONS	2019 Actual	2018 Actual
Ministry of Health other revenue	15, 597	14, 692
ACC contract	7, 641	6, 935
Inter District Patient Inflows	7, 637	7, 666
Other Government	270	247
Other revenue	1, 345	1, 578
Finance income	321	509
Total revenue from exchange transactions	**32, 811**	**31, 627**

1c. OTHER REVENUE	2019 Actual	2018 Actual
Rental revenue	372	339
Total other revenue	**372**	**339**

* Performance against this appropriation is reported in the Statement of Performance on pages 30-41. 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

	2019 Actual	2018 Actual
Salaries and wages	90, 161	80, 497
Defined contribution scheme employer contributions	2, 562	2, 327
Increase / (decrease) in employee entitlements	1, 367	632
Total personnel costs	**94, 090**	**83, 456**

in thousands of New Zealand dollars

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	
	2019 Actual	2018 Actual
100, 000 - 109, 999	49	30
110, 000 - 119, 999	15	13
120, 000 - 129, 999	13	20
130, 000 - 139, 999	7	8
140, 000 - 149, 999	3	3
150, 000 - 159, 999	3	-
160, 000 - 169, 999	3	2
170, 000 - 179, 999	2	2
180, 000 - 189, 999	1	2
190, 000 - 199, 999	2	2
200, 000 - 209, 999	1	1
210, 000 - 219, 999	3	1
220, 000 - 229, 999	4	1
230, 000 - 239, 999	3	2
240, 000 - 249, 999	3	4
250, 000 - 259, 999	2	4
260, 000 - 269, 999	-	3
270, 000 - 279, 999	-	2
280, 000 - 289, 999	4	2
290, 000 - 299, 999	2	3
300, 000 - 309, 999	3	2
310, 000 - 319, 999	4	2
320, 000 - 329, 999	1	2
330, 000 - 339, 999	4	2
340, 000 - 349, 999	4	3
350, 000 - 359, 999	3	2
360, 000 - 369, 999	2	-
370, 000 - 379, 999	1	2
380, 000 - 389, 999	2	3
390, 000 - 399, 999	1	1
400, 000 - 409, 999	-	1
410, 000 - 419, 999	-	1
420, 000 - 429, 999	1	-
440, 000 - 449, 999	-	1
620, 000 - 629, 999	-	-
640, 000 - 649, 999	-	-
660, 000 - 669, 999	-	1
730, 000 - 739, 999	1	-
Total employees	**147**	**128**

Medical staff make up 71 (2018: 77) of the 147 (2018: 128) people in these bands.

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 150 (2018: 133) compared with the actual number of employees of 147 (2018: 128). The chief executive's remuneration is in the $390,000 to $399,999 band (2018: $310,000 to $319,999). Due to the timing of recruitment of the new chief executive, the salary band for the 2017/18 year is based on part year only. If calculated on a full year, the salary band would be $390,000 to $399,999.). This includes the value of the district health board's contribution to KiwiSaver 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 2019 (2018: 1). Employees received compensation and other benefits in relation to termination of their employment or change in contractual conditions totalling $16k (2018: $11k).

in thousands of New Zealand dollars

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 2019 was 6% (2018: 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	2019 Actual	2018 Actual
Interest on finance lease	22	10
Total finance costs	**22**	**10**

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	2019 Actual	2018 Actual
Fees to Auditors		
Fees for audit of financial statements	179	180
Audit related fee internal (for assurance related services)	136	96
Board members fees	205	190
Board member expenses	3	6
Operating lease expenses	523	501
(Reversal of) / impairment of receivables	(75)	(95)
Loss on disposal of property, plant and equipment	15	16
National Oracle Solution (NOS) impairment	1, 048	83
Inventories consumed	8, 192	7, 563
Clinical & infrastructure and non-clinical expenses	21, 022	21, 038
Inter district outflow	43, 778	41, 134
Payments to non-health board providers	85, 470	80, 733
Total other expenses	**160, 496**	**151, 445**

in thousands of New Zealand dollars

5 OTHER EXPENSES (continued)

BOARD MEMBER REMUNERATION	2019 Actual	2018 Actual
Mrs Dot McKinnon *(Board chair)*	34	33
Mr Stuart Hylton *(Deputy Board chair)*	21	21
Mrs Philippa Baker-Hogan	17	17
Mrs Judith MacDonald	17	17
Ms Jenny Duncan	17	17
Mr Graham Adams	17	17
Mr Charlie Anderson	17	17
Ms Annette Main	17	17
Hon Dame Tariana Turia	17	17
Mr Darren Hull	17	17
Ms Maraea Bellamy *(from July 2018)*	14	-
Total board member remuneration	**205**	**190**

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 (2018: nil).

Payments made to committee members appointed by the board totalled $28k (2018: $32k).

Operating leases as lessee

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

There are no restrictions placed on Whanganui District Health Board by any of its leasing arrangements. Whanganui District Health Board leases a number of vehicles, clinical and office equipment (mainly photocopiers and printers) under operating leases. The leases typically run for a period of three to five years with an option to renew the lease after that date. None of the leases include contingent rentals.

THE FUTURE AGGREGATE MINIMUM LEASE PAYMENTS TO BE PAID UNDER NON-CANCELLABLE OPERATING LEASES ARE AS FOLLOWS	2019 Actual	2018 Actual
Non-cancellable operating leases		
Less than one year	34	189
One to two years	-	-
Two to three years	-	-
Total	**34**	**189**

in thousands of New Zealand dollars

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	2019 Actual	2018 Actual
Cash on hand	5	5
Demand funds held with NZHP	3, 015	1, 279
Total cash and cash equivalents	**3, 020**	**1, 284**

While cash and cash equivalents at 30 June 2019 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 2019, this limit was $11.505m (2018: $11.158m).

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	2019 Actual	2018 Actual
Receivables - Other (gross)	3, 644	4, 616
Ministry of Health (gross)	2, 782	4, 373
Less: Life time expected credit loss	(177)	(252)
Total receivables	**6, 249**	**8, 737**
Total receivables comprises:		
Receivable from non-exchange transactions	352	223
Receivable from exchange transactions	5, 897	8, 514

The expected credit loss rates for receivables at 30 June 2019 and 1 July 2018 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 forward-looking 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.

in thousands of New Zealand dollars

7 RECEIVABLES (continued)

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

	Gross	Expected Credit Loss	Net	Gross	Expected Credit Loss	Net
	2019			2018		
Not past due	6, 131	(17)	6, 114	8, 676	(32)	8, 644
Past due 1 - 30 days	57	(10)	47	21	(19)	2
Past due 31 - 120 days	109	(21)	88	109	(25)	84
Past due 121 - 360 days	55	(55)	-	69	(63)	6
Past due over 360 days	74	(74)	-	114	(113)	1
Total	**6, 426**	**(177)**	**6, 249**	**8, 989**	**(252)**	**8, 737**

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:	2019 Actual	2018 Actual
Balance as at 1 July	252	347
Additional provisions made during the year	94	209
Receivables written off during the year	(96)	(73)
Receivables reversal & recovered during the year	(73)	(231)
Total	**177**	**252**

8 INVESTMENTS

ACCOUNTING POLICIES

Bank term deposits

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

BREAKDOWN OF INVESTMENT AND FURTHER INFORMATION	2019 Actual	2018 Actual
Current portion		
Term deposit	-	3, 000
Total current portion	**-**	**3, 000**
Non-current portion		
Term deposit	-	-
Total non-current portion	**-**	**-**
Total investment	**-**	**3, 000**

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

A loss allowance for expected credit losses is recognised if the estimated loss allowance is significant.

in thousands of New Zealand dollars

9 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	2019 Actual	2018 Actual
Held for distribution inventories		
Central stores	351	313
Pharmaceuticals	355	357
Theatre supplies	476	476
Other supplies	245	266
Total inventories	**1, 427**	**1, 412**

Write-down of inventories amounted to $54k (2018: $42k). There have been no reversals of write-downs.

No inventories are pledged as security for liabilities (2018: 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 $8.19m (2018: $7.56m), which is included in the Other Expenses line item of the Statement of Comprehensive Revenue and Expense.

in thousands of New Zealand dollars

10 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, the useful lives and residual values of property, plant, and equipment are reviewed. 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 DHB, 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
The most recent valuation of land and buildings was performed by an independent registered valuer, Telfer Young Limited. The valuation was completed as at 30 June 2018.

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.
- The replacement cost is derived from recent construction contracts of similar assets and Property Institute of New Zealand cost information. Construction costs range from $511 to $6,822 per square metre, depending on the nature of the specific asset valued.
- For 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 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.

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.

Work in progress
Building refurbishment in progress for construction of a new clinical training/education centre totalling nil (2018: $52k).

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 2018	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 2017										30 June 2018		
Land	1,560	-	1,560	-	-	-	161	-	-	-	1,721	-	1,721
Buildings & improvements	68,083	(6,804)	61,279	753	-	-	(273)	(2,513)	-	7,094	68,563	(2,223)	66,340
Plant & equipment	23,326	(17,409)	5,917	1,761	-	(529)	(15)	(1,470)	519	56	24,543	(18,304)	6,239
Leased assets	120	(71)	49	807	-	-	-	(60)	-	-	927	(131)	796
Motor vehicles	2,915	(1,096)	1,819	64	-	(102)	-	(221)	58	-	2,877	(1,259)	1,618
	96,004	**(25,380)**	**70,624**	**3,385**	**-**	**(631)**	**(127)**	**(4,264)**	**577**	**7,150**	**98,631**	**(21,917)**	**76,714**
Work in progress													
Buildings & improvements	-	-	-	52	-	-	-	-	-	-	52	-	52
	-	**-**	**-**	**52**	**-**	**-**	**-**	**-**	**-**	**-**	**52**	**-**	**52**
Total	**96,004**	**(25,380)**	**70,624**	**3,437**	**-**	**(631)**	**(127)**	**(4,264)**	**577**	**7,150**	**98,683**	**(21,917)**	**76,766**

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**

in thousands of New Zealand dollars

11 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

The amortisation policy for RHIP software estimated useful life has increased to 13 years however, this has not had a material impact on the amortisation of the software.

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 10. 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.

During the year the business case for the project was reviewed and it was decided that the 10 district health boards already using Oracle finance systems would continue to implement FPIM, and the other 10 district health boards not using FPIM would not implement it.

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

As at 30 June 2019, Whanganui District Health Board has recognised an impairment of $1,048k (2018: $83k) for FPIM shared service rights for NOS.

Regional Health Informatics Programme (RHIP)

RHIP is a programme to move the central region district health boards from a current state of disparate, fragmented and, in some cases obsolescent, clinical and administrative information systems to a future state of 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 2019, Whanganui District Health Board had invested a total of $11.6m (2018: $10.7m) in RHIP. Of this investment, $5.4m has been recognised as work in progress and $6.2m 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.

Tamatea Cave with students | *Charles Ranginui*

in thousands of New Zealand dollars

BREAKDOWN OF INTANGIBLE ASSETS AND FURTHER INFORMATION

Movements for each class of intangible assets are as follows:

30 June 2018	Cost / valuation	Accumulated amortisation	Carrying amounts	Additions	Transfer	Disposals	Impairment	Amortisation	Elimination on disposal	Cost / valuation	Accumulated amortisation	Carrying amounts
	1 July 2017									30 June 2018		
Software	4,961	(3,735)	1,226	228	-	(649)	-	(225)	649	4,540	(3,311)	1,229
Regional Health Informatics Programme (RHIP)	491	(196)	295	1,617	1,383	-	-	(125)	-	3,491	(321)	3,170
Regional Health Informatics Programme (RHIP) - local	595	-	543	1,023	770	-	-	(106)	-	2,388	(158)	2,230
	6,047	**(3,983)**	**2,064**	**2,868**	**2,153**	**(649)**	**-**	**(456)**	**649**	**10,419**	**(3,790)**	**6,629**
Work in progress												
Regional Health Informatics Programme (RHIP)	6,162	-	6,162	763	(2,153)	-	-	-	-	4,772	-	4,772
FPIM (NOS)	983	-	983	116	-	-	(83)	-	-	1,016	-	1,016
	7,145	**-**	**7,145**	**879**	**(2,153)**	**-**	**(83)**	**-**	**-**	**5,788**	**-**	**5,788**
Total	**13,192**	**(3,983)**	**9,209**	**3,747**	**-**	**(649)**	**(83)**	**(456)**	**649**	**16,207**	**(3,790)**	**12,417**

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) & Local	4,772	-	4,772	988	(332)	-	-	-	-	5,428	-	5,428
FPSC rights	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**

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

in thousands of New Zealand dollars

12 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.

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	2019 Actual	2018 Actual
Summary of financial information on associate entities *(100 percent)*		
Assets	9, 918	10, 014
Liabilities	(2, 544)	(3, 106)
Equity	(7, 374)	(6, 908)
Revenue	(10, 916)	(10, 590)
Expense	10,268	9,975
Surplus / (deficit)	648	615
Allied Laundry Services Limited	16.67%	17.64%
Investment in associates		
Balance as at 1 July	1, 121	1, 126
Dividends	(70)	(105)
Share of profit	95	129
Other movements	-	(29)
Total investment in associates	**1, 146**	**1, 121**

13 OTHER FINANCIAL ASSETS

Whanganui District Health Board holds a 16.7 percent (2018: 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 (2018: 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.

in thousands of New Zealand dollars

14 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

	2019 Actual	2018 Actual
Payables under non-exchange transaction		
Creditors	38	37
Tax payables (GST, PAYE)	1, 669	1, 380
ACC levy	139	105
Income in advance	-	446
Other	246	211
Total payables under non-exchange transaction	**2, 092**	**2, 179**
Payables under exchange transaction		
Creditors	2, 841	2, 972
Income in advance	263	-
Accrued expense	13, 038	8, 771
Total payables under exchange transaction	**16, 142**	**11, 743**
Total payables	**18, 234**	**13, 922**

15 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.

in thousands of New Zealand dollars

BREAKDOWN OF BORROWINGS AND FURTHER INFORMATION

	2019 Actual	2018 Actual
Current portion		
The Energy Efficiency and Conservation Authority	135	135
Finance lease	95	92
Total current portion	**230**	**227**
Non-current portion		
The Energy Efficiency and Conservation Authority	101	236
Finance lease	583	678
Total non-current portion	**684**	**914**
Total borrowings	**914**	**1, 141**

NZ Health Partnerships overdraft facility

Whanganui District Health Board has a maximum borrowing limit of $11.505m (2018: $11.158m) as at 30 June 2019. 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 21C.

ENERGY EFFICIENCY & CONSERVATION AUTHORITY LOAN PAYABLE AS FOLLOWS:

	2019 Actual	2018 Actual
Less than one year	135	135
One to two years	101	135
Two to three years	-	101
Three to four years	-	-
Four to five years	-	-
Over five years	-	-
Total	**236**	**371**

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

in thousands of New Zealand dollars

ANALYSIS OF FINANCE LEASE AS FOLLOWS:	2019 Actual	2018 Actual
Minimum lease payments payables		
Less than one year	114	114
Between one and five years	455	455
More than five years	179	293
Total minimum lease payments	**748**	**862**
Less: Future finance charges	(70)	(92)
Present value of minimum lease payments	**678**	**770**

PRESENT VALUE OF MINIMUM LEASE PAYMENTS PAYABLE:	2019 Actual	2018 Actual
Minimum lease payments payables		
Less than one year	95	92
Between one and five years	408	396
More than five years	175	282
Total minimum lease payments	**678**	**770**
Less: Future finance charges	-	-
Present value of minimum lease payments	**678**	**770**

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.

in thousands of New Zealand dollars

16 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 relatedservice 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.

The private and public sector have experienced widespread payroll issues relating to the Holidays Act and employment agreements. This is particularly so for a workforce with rostered employees working on varying work patterns. A proactive approach to finding a longterm pay process solution is currently being undertaken by management to identify risk areas focusing on systems, reporting and analytics, people and processes. Since the issues are currently being reviewed the holiday pay provision recognised is estimated based on the best information available at the date of this annual report. Once the issues have been resolved the actual liability may be different.

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 1.35% to 2.24% (2018: 1.77% to 3.41%) and an inflation factor of 3% (2018: 3%) were used.

BREAKDOWN OF EMPLOYEE ENTITLEMENTS	2019 Actual	2018 Actual
Current portions		
Accrued salaries and wages	6, 350	3, 810
Annual leave	8, 109	7, 074
Sick leave	212	197
Retirement gratuities	604	377
Long service leave	893	866
Sabbatical leave	516	516
Other leave	2	5
Continuing medical education leave	27	29
Total current portion	**16, 713**	**12, 874**
Non-current portions		
Retirement gratuities	766	723
Long service leave	107	82
Total non-current portion	**873**	**805**
Total employee entitlements	**17, 586**	**13, 679**

in thousands of New Zealand dollars

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 and work to assess all non-compliance will continue through the 2019/20 financial year. The agreed review process will roll-out in tranches, expected to be over 18 months although district health board readiness and availability of resources may determine when they can commence the process. The outcome of the project and timeline addressing any non-compliance will not be determined until this work is completed.

Notwithstanding, as at 30 June 2019, in preparing these financial statements, the Whanganui District Health Board recognises 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 details analysis of current and former employees; calculating an indicative liability for those current and former employees.

Whanganui District Health Board has estimated its liability as at 30 June 2019 to be $4.2m (2018: $0.55m). 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.

17 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 (2018: 4).

Contingent assets

Whanganui District Health Board has no contingent assets (2018: nil).

18 CAPITAL COMMITMENTS

	2019 Actual	2018 Actual
Capital commitments		
Buildings and improvements	448	244
Plant and equipment	492	373
Intangible assets	749	549
Motor vehicles	38	-
Total	**1, 727**	**1, 166**

	2019 Actual	2018 Actual
Capital commitments		
Less than one year	1, 727	1, 166
One to two years	-	-
Total	**1, 727**	**1, 166**

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

in thousands of New Zealand dollars

19 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	2019 Actual	2018 Actual
Board members		
Remuneration	205	190
Full-time equivalent members	0.95	1.00
Executive team		
Remuneration	1, 789	1, 873
Full-time equivalent members	7.74	7.47
Total key management personnel compensation	**1, 994**	**2, 063**
Total full time equivalent personnel	**8.69**	**8.47**

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.

20 EVENTS AFTER THE BALANCE DATE

There were no significant events after the balance date.

21 FINANCIAL INSTRUMENTS

Financial assets

Classification

PBE IFRS 9 divides all financial assets 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 applied the requirements of PBE IFRS 9 to instruments that continue to be recognised as at 1 July 2018. The transition from IAS 39 to IFRS 9 has not resulted in a change to the classifications of financial assets or liabilities for the entity.

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 DHB 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. Financial assets classified as held to maturity and loans and receivables under PBE IAS 39 that were measured at amortised cost continue to be measured at amortised cost under PBE IFRS 9 as they are held within a business model to collect contractual cash flows and these cash flows consist solely of payments of principal and interest on the principal amount outstanding.

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

From 1 July 2018, the 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 permitted by PBE IFRS 9, 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.

in thousands of New Zealand dollars

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 profit or loss 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.

21a FINANCIAL INSTRUMENT CATEGORIES

	2019 Actual	2018 Actual
Financial assets measured at amortised cost (2018: Loans and receivables)		
Cash and cash equivalents	3, 020	1, 284
Receivables (Gross)	6, 426	8, 989
Investment - term deposit	-	3, 000
Total financial assets measured at amortised cost	**9, 446**	**13, 273**
Financial liabilities measured at amortised cost		
Payables *(excluding income in advance, taxes payable and grants received subject to conditions)*	16, 302	12, 096
Borrowings - Energy Efficiency and Conservation Authority	236	371
Finance leases	678	770
Total financial liabilities measured at amortised cost	**17, 216**	**13, 237**

in thousands of New Zealand dollars

21b 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 2018			
Financial assets			
Cash and cash equivalents	6	1, 284	1, 284
Receivables (Gross)	7	8, 989	8, 989
Investment - term deposit	8	3, 000	3, 000
Financial liabilities			
Payables *(excluding income in advance, taxes payable and grants received subject to conditions)*	14	12, 096	12, 096
Borrowings - Ministry of Health	15	-	-
Borrowings - Energy Efficiency and Conservation Authority	15	371	371
Finance lease liabilities	15	770	770
30 June 2019			
Financial assets			
Cash and cash equivalents	6	3, 020	3, 020
Receivables (Gross)	7	6, 426	6, 426
Investment - term deposit	8	-	-
Financial liabilities			
Payables *(excluding income in advance, taxes payable, and grants received subject to conditions)*	14	16, 302	16, 302
Borrowings - Ministry of Health	15	-	-
Borrowings - The Energy Efficiency and Conservation Authority	15	236	236
Finance lease liabilities	15	678	678

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.

21c 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 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 2019, it is estimated that a general increase of one percentage point in interest rates would have minimal impact on earnings in 2018/19, 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 45% (2018: 50%). 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 2018						
Cash on hand	-	5	5	-	-	-
NZ Health Partnerships Limited	-	1, 279	1, 279	-	-	-
Investment - term deposit	3.50%	3, 000	3, 000	-	-	-
Receivables (net)	-	8, 737	8, 737	-	-	-
Borrowings - Energy Efficiency & Conservation Authority	0.00%	371	135	135	101	-
Finance leases	3.00%	770	92	95	301	282
30 June 2019						
Cash on hand	-	5	5	-	-	-
NZ Health Partnerships Limited	-	3, 015	3, 015	-	-	-
Investment - term deposit	-	-	-	-	-	-
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

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 2018						
Payables *(excluding income in advance, taxes payable & grants received subject to conditions)*	12, 096	12, 096	12, 096	-	-	-
Borrowings - Energy Efficiency & Conservation Authority	371	371	135	135	101	-
Finance leases	770	862	114	114	341	293
Total	**13, 237**	**13, 329**	**12, 345**	**249**	**442**	**293**
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**

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.

22 EXPLANATION OF FINANCIAL VARIANCE AGAINST BUDGET

Statement of Comprehensive Revenue and Expense

- Exchange and non-exchange revenue exceeded budget by $2.6m, due to additional revenue for in-between travel $0.6m, pay equity $0.8m, school-based health services top up of $0.2m, multi-employer collective agreement settlements $0.5m, primary care funding for Community Services Card holders, Care Plus and Very Low Cost Access for under-6s and under-14s $1.0m. There were also corresponding costs offsetting this revenue, partly offset by less inter-district inflow revenue of $0.5m.
- Personnel costs exceeded budget by $2.0m due to provision for Holidays Act compliance.
- Outsourced services exceeded budget by $1.5m due to higher than anticipated use of locum medical staff and outsourced clinical services to meet clinical demand.
- Depreciation is less than budget by $0.1m due to the timing of IT projects and clinical equipment purchases.
- Other expenses exceeded budget by $5.0m due to increased inter-district outflows $2.6m, FPIM write-off $1m, other health provider payment $1.8m offset by additional funding. This was partly offset by non-clinical supplies relating to IT $0.4m.

Statement of Financial Position

- Receivables were $1.2m less than budget due to in-between travel wash up funding received earlier than anticipated, and elective wash-up provision.
- Property, plant and equipment were $2.1m less than budget due to the timing delay of capital expenditure relating to buildings, IT and clinical equipment.
- Intangible assets were $1.5m less than budget due to delays in the Regional Health Informatics Programme (RHIP).
- Payables under non-exchange and exchange transactions were $4.1m more than budget due to inter-district outflows and demand-driven expenditure.
- Employee entitlements exceeded budget by $5.0m due to provision for Holidays Act compliance, expiring MECAs and greater than expected leave entitlements owing at year-end.

Statement of Changes in Equity

- Statement of Changes in Equity less than budget by $5.8m due a greater than planned deficit.

Statement of Cash Flows

- Cash and cash equivalents $8.1m more than budget (anticipated overdraft of $5m), which relates to movement in working capital. This comprises $3.9m increased payables provision relating to inter-district flows (anticipated to be paid in October 2019), $5m employee entitlements related to Holidays Act compliance and multi-employer collective agreements expiry, $3m delay in capital expenditure, $1.3m less trade and other receivables (related to in-between travel paid earlier than anticipated). This was partly offset by the operating deficit which was exceeded by $5.6m.

in thousands of New Zealand dollars

23 ADOPTION OF PBE IFRS 9 FINANCIAL INSTRUMENTS

In accordance with the transitional provisions of PBE IFRS 9, Whanganui District Health Board has elected not to restate the information for previous years to comply with PBE IFRS 9. Adjustments arising from the adoption of PBE IFRS 9 are recognised in opening equity at 1 July 2018.

Accounting policies have been updated to comply with PBE IFRS 9. The main updates are:

- Note 7 Receivables: This policy has been updated to reflect that the impairment of short-term receivables is now determined by applying an expected credit loss model.

- Note 9 Investment
  Term deposits: This policy has been updated to explain that a loss allowance for expected credit losses is recognised only if the estimated loss allowance significant.

On the date of initial application of PBE IFRS 9, being 1 July 2018, the classification of financial instruments under PBE IPSAS 29 and PBE IFRS 9 is as follows:

	CATEGORY		CARRYING AMOUNT		
	PBE IPSAS 29 (original)	IFRS 9 (new)	Closing balance 30 June 2018 (PBE IPSAS 29)	Adjustment PBE IFRS 9	Opening balance 1 July 2018 (IFRS 9)
30 June 2018					
Cash and cash equivalents	Loans and receivables	Amortised cost	1,284	-	1,284
Receivables	Loans and receivables	Amortised cost	8,737	-	8,737
Investment - term deposit	Loans and receivables	Amortised cost	3,000	-	3,000
Total financial assets			**13,021**	**-**	**13,021**

24 COMPLIANCE WITH LEGISLATION

Crown Entities Act 2004

There were no breaches noted of the Crown Entities Act in 2019 (2018: nil).

New Zealand Public Health and Disability Act 2000

There were no breaches noted of the NZPHD Act in 2019 (2018: nil).

25 SUMMARY COST OF SERVICES

	2018/19 **Actual**	2018/19 **Budget**	2017/18 **Actual**
Revenue			
Prevention services	5,183	5,234	4,890
Early detection and management	56,828	56,321	54,027
Intensive assessment and treatment	162,239	160,755	154,092
Rehabilitation and support	41,549	40,975	41,197
Total revenue	**265,799**	**263,285**	**254,206**
Expenditure			
Prevention services	(6,489)	(7,131)	(6,374)
Early detection and management	(61,393)	(61,438)	(57,755)
Intensive assessment and treatment	(169,067)	(161,366)	(152,914)
Rehabilitation and support	(42,504)	(41,236)	(41,342)
Total expenditure	**(279,453)**	**(271,171)**	**(258,385)**
(Deficit) / Surplus	**(13,654)**	**(7,886)**	**(4,179)**

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, plan 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.

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 l ives. 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.

Family/whānau-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.

Hapai 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 a 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, 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 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.

Nga moemoeā, nga 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

Rangimarie
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 Paori o Whanganui
Whanganui District Health Board

Te Pukaea
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

Mrs Dot McKinnon | **Chair**
Mr Stuart Hylton | **Deputy chair**
Mr Graham Adams
Mr Charlie Anderson
Mrs Philippa Baker-Hogan
Ms Maraea Bellamy
Mrs Jenny Duncan
Mr Darren Hull
Mrs Judith MacDonald
Mrs Annette Main
Dame Tariana Turia

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 MANAGEMENT TEAM

Mr Russell Simpson	**Chief Executive**
Mr Brian Walden	**General Manager Corporate** (Chief Financial Officer)
Mrs Lucy Adams	**Director of Nursing**
Mr Mark Dawson	**Communications Manager**
Mr Hentie Cilliers	**General Manager, Human Resources and Organisational Development**
Ms Kim Fry	**Director Allied Health**
Mrs Rowena Kui	**Director Māori Health**
Dr Francois Rawlinson	**Chief Medical Officer**
Mr Paul Malan	**General Manager, Service and Business Planning**

Fountain Fairies | *John van Dalen*

BANKERS

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Auckland 1010

Ministry of Health
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Wellington

AUDITOR

Melissa Youngson
Deloitte Limited
PO Box 17
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on behalf of the Auditor-General

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BOARD SECRETARY

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Whanganui

SOLICITORS

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Wellington

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Whanganui

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