WHANGANUI
DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

Tōna Tākune
Me Te Tauākī Mahi o te Pūtanga

2019/20 - 2022/23 Statement of Intent

incorporating the 2019/20 Statement of Performance Expectations

Presented to the House of Representatives pursuant to sections 149 and 149(L) of the Crown Entities Act 2004

Whanganui District Health Board Statement of Intent

(Issued under Section 139 of the
Crown Entities Act 2004)

‘I rere kau mai te awanui mai i te kāhui maunga ki Tangaroa.
Ko au te awa, ko te awa ko au.’

The river flows from the mountain to the sea. I am the river and the river is me.

Rārangi Kiko

Table of Contents

Statement of Responsibility

Whanganui District Health Board is governed by a board consisting of eleven members, seven of whom are elected triennially and four of whom are appointed by the Minister of Health.

The board has a Memorandum of Understanding with Hauora A Iwi. Representatives of the Iwi (tribal entities whose area of influence and obligations falls within or partly within the Whanganui District Health Board district) and their organisations who represent Tangata Whenua (members of tribal entities whose area of influence and obligations falls within or partly within the Whanganui District Health Board district). Hauora A Iwi members are committed to upholding their responsibilities to manaaki (care and support) and kaitiaki (protect) for all people who reside within their tribal areas that are also within the area of the Whanganui District Health Board. The Iwi are Whanganui; Ngā Rauru Kītahi; Ngā Wairiki Ngāti Apa; Mōkai Pātea; Ngāti Hauiti and Ngāti Rangi.

The board is advised by a Risk and Audit Committee and a Combined Statutory Advisory Committee fulfilling the statutory committee functions required under the New Zealand Public Health and Disability Act (2000).

This Statement of Intent for Whanganui District Health Board has been prepared in accordance with Part 4 of the Crown Entities Act 2004. It covers the period 1 July 2019 to 30 June 2022. It provides an overview of our strategic intentions to show how we will fulfil our statutory obligations over the next three years.

Signed, on behalf of the Whanganui District Health Board this 20th day of September 2019:

Board Member

Board Member

Wāhanga 1:
Te Kitenga Whānui o Ngā Rautaki-Matua

Section 1:
Overview of strategic priorities

1.1 Strategic intentions

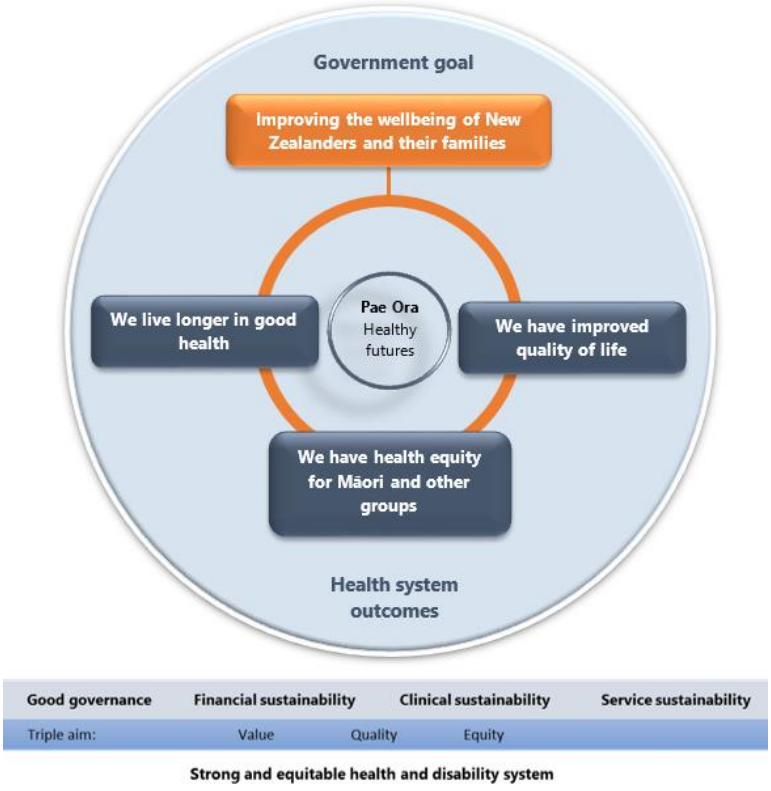
Whanganui is one of 20 district health boards (DHBs) in New Zealand established under the New Zealand Public Health and Disability Act 2000. The Act sets out the roles and functions of DHBs.

District health boards, as Crown agents, are also considered Crown entities, and covered by the Crown Entities Act 2004.

The statutory objectives of Whanganui DHB include:
- improving, promoting and protecting the health of communities
- promoting the integration of health services, especially primary and secondary care services
- promoting effective care or support of those in need of personal health services or disability support
- funding and providing public health services.

We align our intentions to our statutory objectives and to the Government's key goal of *Improving the wellbeing of New Zealanders and their families,* recognising the connections to the priority outcomes as set out in Figure 1.

Figure 1: Connection between Government priority outcomes and health system outcomes



Our activities are carried out within the context of an outcomes framework (refer to Figure 3 on page 7) that aligns our activities with relevant international and national obligations, regional and national direction. These include the following.

Te Tiriti o Waitangi

Commitment to the principles of partnership, participation and protection that underpin the relationship between the Government and Māori under Te Tiriti o Waitangi:

- **Partnership** involves working together with Iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services.
- **Participation** requires Māori to be involved at all levels of the health and disability sector, including in decision-making, planning, development and delivery of health and disability services.
- **Protection** involves the Government working to ensure Māori have equitable health outcomes, and safeguarding Māori cultural concepts, values and practices.

He Korowai Ōranga 2014 – Commitment to Māori Health Strategy: He Korowai Ōranga 2014, with the overall aim of **Pae ora** – healthy futures, which incorporates three interconnected elements:

- **Whānau ora** – healthy families – whānau wellbeing and support, participation in Māori culture and Te Reo.
- **Wai ora** – healthy environments – education, work, income, housing and deprivation.
- **Mauri ora** – healthy individuals – life stage from pepi/tamariki to rangatahi then pakeke and a section that includes individuals of all ages.

He Korowai Ōranga incorporates four pathways of action that are not mutually exclusive and are intended to work as an integrated whole:

Te Ara Tuatahi	Pathway One	Development of whānau, hapū, Iwi and Māori communities.
Te Ara Tuarua	Pathway Two	Māori participation in the health and disability sector.
Te Ara Tuatoru	Pathway Three	Effective health and disability services.
Te Ara Tuawhā	Pathway Four	Working across sectors.

We endorse the seven principles of Whānau Ora - that whānau are:
1. self-managing and empowered leaders
2. leading healthy lifestyles
3. confidently participating in te ao Māori (the Māori world)
4. participating fully in society
5. economically secure and successfully involved in wealth creation
6. cohesive, resilient and nurturing
7. responsible stewards of their living and natural environment.

The New Zealand Health Strategy – incorporating five strategic themes (people-powered, care closer to home, high value and performance, one team, smart system).

The Healthy Ageing Strategy – commitment to the vision that 'Older people live well, age well, and have a respectful end of life in age-friendly communities'.

The United Nations Convention on the Rights of Persons with Disabilities – commitment to the aim of 'promoting, protecting and ensuring the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity'.

Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014-2018 – commitment to facilitate the delivery of high quality health services that meet the needs of Pacific peoples.

Annual strategic discussions – we hold annual discussions with the Ministry of Health to confirm our planning intentions and to agree on the context of our focus areas.

A strong and equitable health and disability system is delivered through good governance and sustainability – clinical, financial and service sustainability. Whanganui DHB is guided by the New Zealand triple aim in our prioritisation processes, keeping us focused on all these aspects. The triple aim has been developed by the Health Quality and Safety Commission as a framework for quality improvement – it includes three dimensions:

1. improved quality, safety and experience of care (individual and whānau dimension)
2. improved health and equity for all populations (population dimension)
3. best value for public health & disability system resources (system dimension).

The triple aim is depicted in Figure 2 below and the way we manage our work within this framework is further outlined in Section 2.

Figure 2: The New Zealand Triple Aim

1.2 The population we serve

Our district is home to just under 65,000 people and we need to ensure they have access to a wide range of health and disability support services. We aim to meet our statutory objectives by engaging with our communities to assess health status and need, and to determine what resources should be directed to preventing illness, to detecting and managing illness, to providing intensive assessment and treatment, and to providing rehabilitation and support.

The infographic on the next page is an overview of our district and the population that we serve.

Our population has a unique profile compared to the rest of New Zealand:

- modest growth overall, impacting on the share of funding received
- high rates of relative deprivation, which correlates to poor health status and high health need
- a higher proportion of Māori
- a higher proportion of people aged over 65
- a relatively large geographical area with some pockets of isolated, small rural populations
- a small hospital servicing a widely dispersed population base
- significant travel distances to the bigger hospitals.

Whanganui DHB aims to eliminate inequity, integrate care, partner for community wellbeing and empower whānau and individuals to make healthy choices. We are accountable for public health services delivered to the population of the Whanganui district as defined by the NZ Public Health and Disability Act.

Whanganui DHB works with many other organisations and communities inside and outside the health sector, to deliver on local, regional and national health priorities.

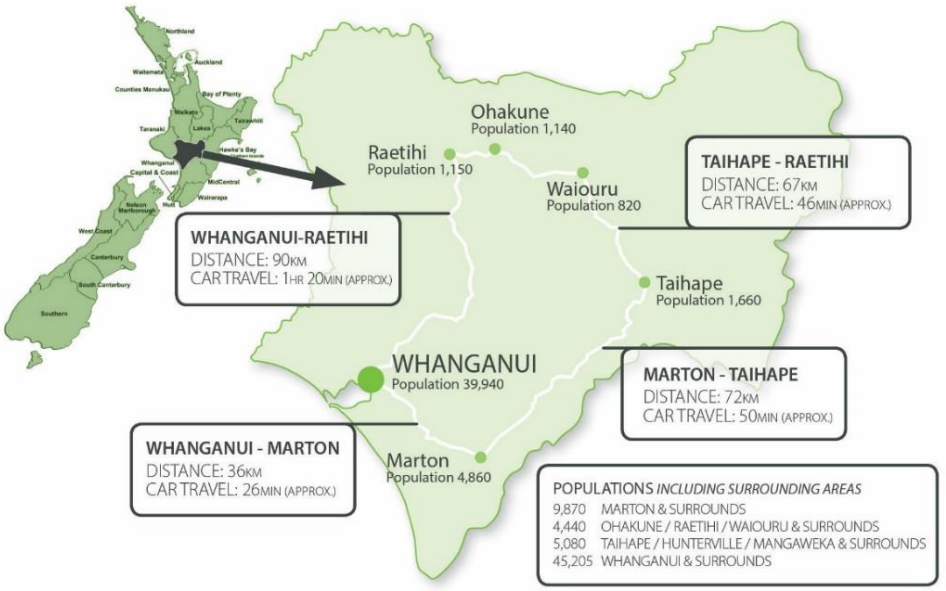
THE POPULATION WE SERVE

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 DHBs.

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

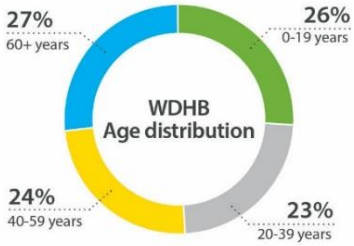

Ngā Rauru Kītahi

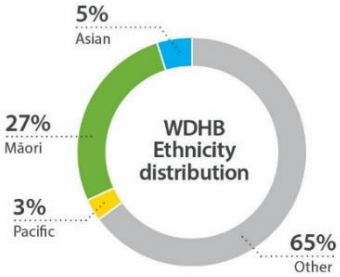

Ngāti Hauiti

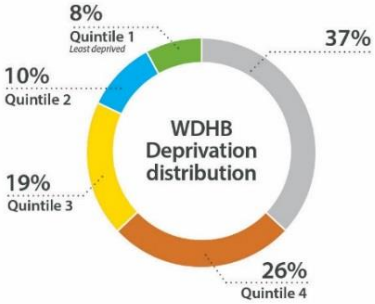

Ngā Wairiki Ngāti Apa


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%

DEPRIVATION DISTRIBUTION - ALL NZ	
Quintile 1	20%
Quintile 2	20%
Quintile 3	20%
Quintile 4	20%
Quintile 5	20%

1.3 Linking the Government Priorities to our population needs

Our vision is *He Hāpori Ora - Thriving Communities*.

We aim to deliver our vision by focusing on four key strategic drivers:

- Eliminating inequity – by targeting vulnerability, understanding need and measuring what matters, and focusing on access.
- Integrating care – by shifting to community and primary health care, reducing hospitalisation, and focusing on public health, health promotion, protection and prevention.
- Partnering for community wellbeing – by broad, integrated social mobilisation across all communities; good communication to keep the population engaged with the health sector.
- Empowering whānau and individuals to make healthy choices – by supporting wellness through Whānau Ora; promoting the '65,000 beds' campaign, and using helpful planning and case management tools.

Figure 3: Our Outcomes Framework

Our way of working

As outlined in the framework, we are committed to achieving equity in health outcomes for Māori and improving the health of our community. This influences what we do and more importantly, how we do it, including:

- applying the philosophy of Whānau Ora as a key principle in how we partner with all health consumers and their families/whānau and how we understand and acknowledge their cultural values and beliefs.
- applying the equity lens and Whānau Ora philosophy ensures that governance, leadership and our wider workforce understand their responsibilities and are culturally aware and supported in their cultural practice.
    - Whānau-centred care guides our view of best practice.

- Applied to planning and service improvement, the equity lens and whānau-centredness requires whānau, clinicians and the community to work together to build an understanding of what is happening and what needs to be done differently. This requires working across systems to support whānau goals and aspirations and building resilience in whānau and the community.

- investing in sustainable kaupapa Māori services, to provide whānau choice and support the building of the capacity and capability of the Māori workforce cross our system.

Equity in health outcomes

In December 2018 we completed a 'Pro-equity check-up' to identify actions that we can take as an organisation to create a strong foundation for the work that must happen as we work to eliminate inequity. The check-up provided us with an independent, unbiased view of where we were at, to inform our implementation work plan. The work plan outlines actions to focus efforts for the most sustained impact.

Hauora A Iwi (Māori relationship board) was engaged in the check-up process and has endorsed the recommendations in the report.

The report identified 11 findings under four themes: Organisational leadership and accountability for equity; Māori workforce and Māori health and workforce capability; transparency in data and decision-making; and authentic partnership with Māori.

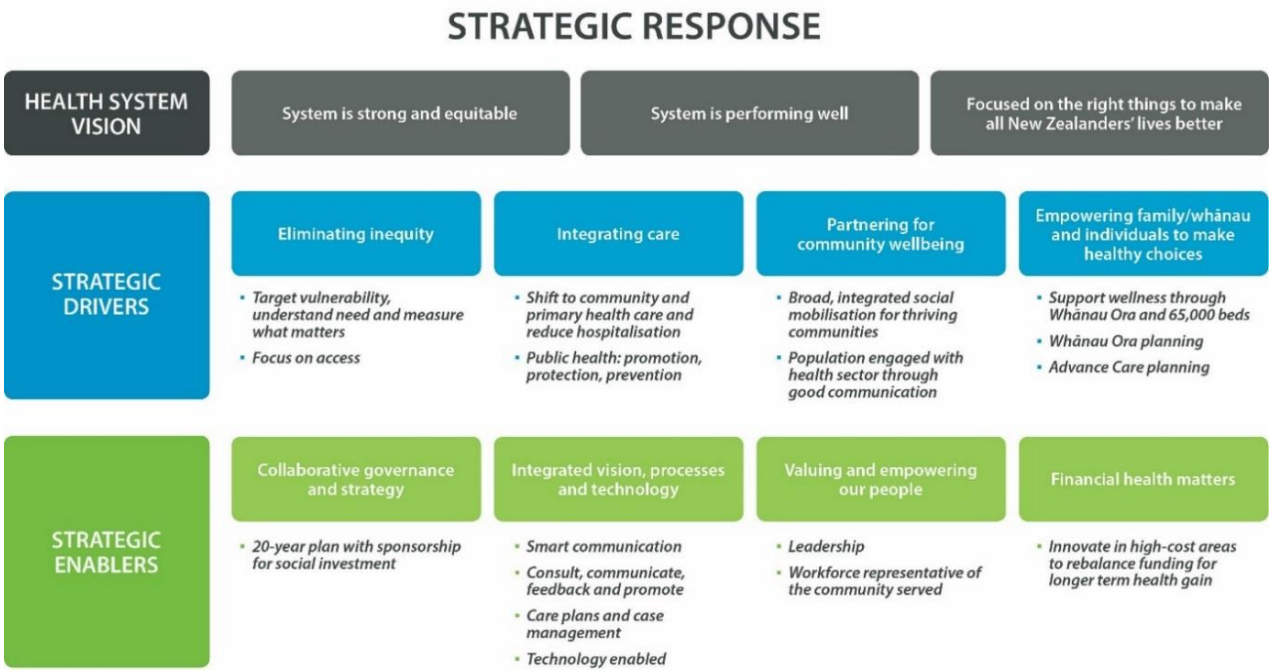
Acknowledging our population demographics, improving Māori health is our primary equity challenge.

WĀHANGA 2: Kaitiakitanga

SECTION 2: Stewardship

To be effective, the New Zealand health system must be strong and equitable, perform well and be focused on the right things to make all New Zealanders' lives better. Strategic enablers that underpin our approach to stewardship and support our strategic drivers, are depicted in Figure 4.

Figure 4:

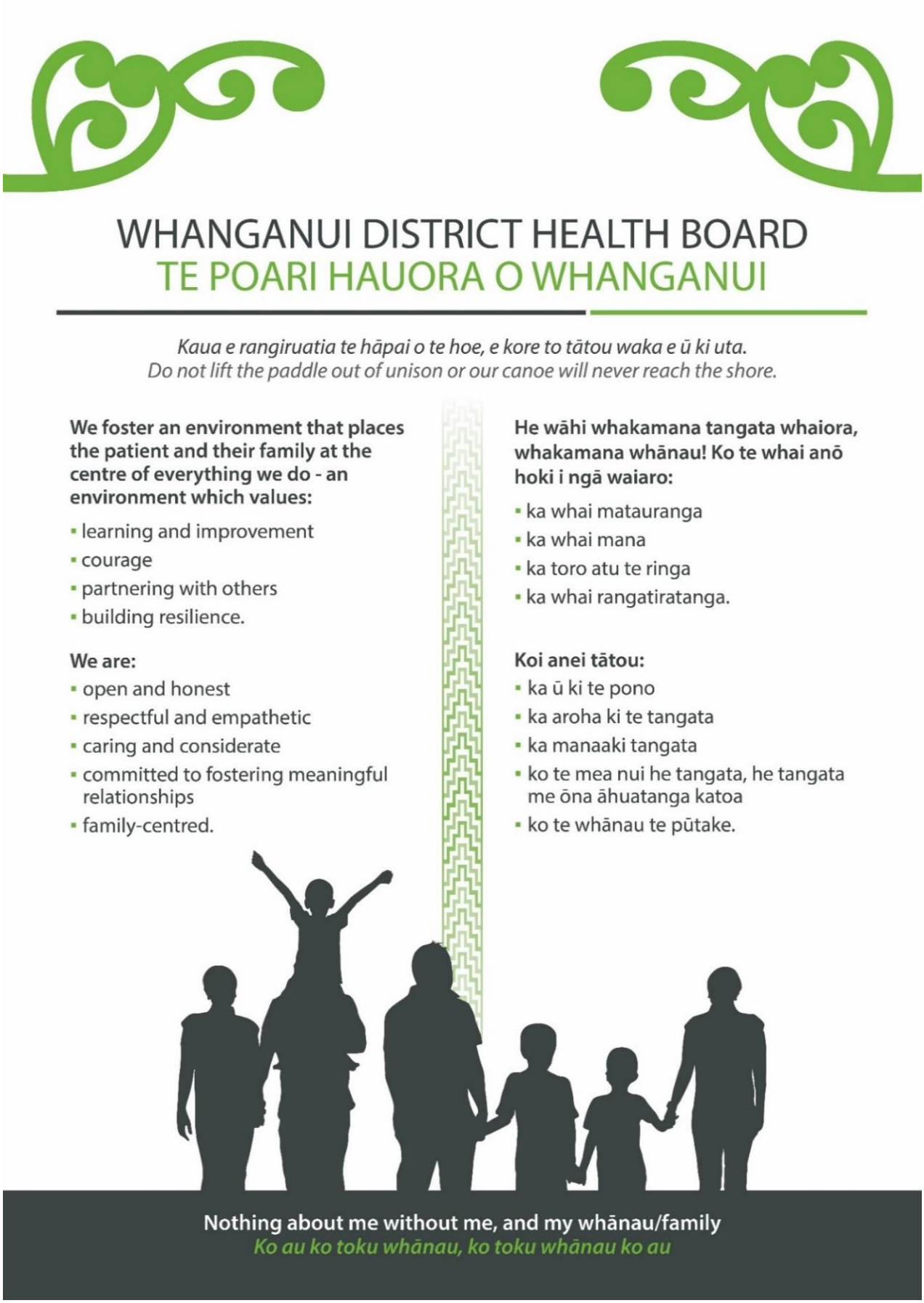


An effective national health system is crucial in our mission to eliminate inequity, integrate care, partner for community wellbeing and empower whānau and individuals to make healthy choices. Locally, to improve system effectiveness over the next three years, we are focused on the following system enablers:

- Collaborative governance and strategy – we are supporting local efforts to develop a 20-year plan with sponsorship for social investment in our community.
- Integrated vision, processes and technology – through smart communication; a commitment to consult, communicate, feedback and promote; comprehensive care plans and case management; and technology enablement.
- Valuing and empowering our people – through leadership and a workforce that is representative of the community served.
- Financial health – innovation in high cost areas to rebalance funding for longer term health gain.

Our values

As a pro-equity organisation, committed to whānau-based care and support, our vision inspires and guides us and our values underpin everything we do. Our values are depicted in the following infographic.



2.1 Managing our business

Funding and financial management
Whanganui DHB's key financial indicators are reported through Whanganui DHB's performance management process to governance and management leaders on a regular basis. Further information about Whanganui DHB's planned financial position for 2019/20 and out years is contained in the financial performance summary of our Annual Plan (section 2.2), and in our Statement of Performance Expectations.

Investment and asset management
All DHBs are required to complete a stand-alone Long Term Investment Plan (LTIP) covering at least 10 years. LTIPs are part of the new Treasury system for monitoring investments across government, the Investment Management and Asset Management Performance (IMAP) system. Whanganui DHB's LTIP is available on our website at www.wdhb.org.nz.

Shared service arrangements and ownership interests
Whanganui DHB has a part ownership interest in Technical Advisory Services (TAS) and Allied Laundry Services Limited. Whanganui DHB does not intend to acquire shares or interests in other companies, trusts or partnerships at this time. Should it decide to do so, it would first consult with the Minister of Health.

Risk management
Whanganui DHB has a formal risk management and reporting system, which incorporates a process to regularly identify risks – both current and emerging – in order to implement strategies to minimise those risks. The DHB is committed to managing risk in accordance with the process set out in the Australian/New Zealand Joint Standard on Risk Management (AS/NZS ISO 31000:2009).

Quality assurance and improvement
Whanganui DHB's approach to quality assurance and improvement is in line with the New Zealand Triple Aim: Improved quality, safety and experience of care, improved health and equity for all populations, and best value for public health system resources. Contracted services are aligned with national quality standards and auditing of contracted providers includes quality audits.

2.2 Building capability

Capital and infrastructure development
After heavy investment in building redevelopment in five out of the last six years, a reduction in capital expenditure might have been expected, however the Regional Digital Health Strategy (formerly the Regional Health Informatics Programme) requires significant information technology investment over the next three years. The scale of the expenditure will put pressure on all other aspects of the budget spend, however, this is manageable over this timeframe. The increased depreciation cost as a result of high investment in information technology will have a significant impact on the bottom line over the term of this plan. All investment into Regional Digital Health Strategy projects will be subject to normal business approval processes with the Ministry of Health.

Information technology and communication systems
Whanganui DHB's information technology (IT) and communication systems goals align with the national and regional strategic direction for IT. Further detail about Whanganui DHB's current IT initiatives are contained annually in the Central Region's Regional Service Plan.

Workforce

Whanganui DHB, as an equal employment opportunity (EEO) employer, is committed to increasing and developing an inclusive workforce that continues to embrace diversity. Below is a short summary of Whanganui DHB's organisational culture, leadership and workforce development initiatives:

- Continue to grow clinical leadership across medical, nursing and allied health.

- Proactively grow the Māori workforce across the health district that proportionally reflects the Whanganui DHB district Māori population:
  - Determine targets and action plans
  - Maintain focus on Kia Ora Hauora
  - Expand the existing cultural safety programmes
  - Continue Te Reo Māori programmes for staff on site
  - Foster a working environment that attracts and values Māori staff
  - Contracted providers – contract clause to enable reporting on Māori workforce capacity and capability introduced at time of review
  - Whanganui DHB Speaking Up for Safety programme includes action on racism and institutional bias.

- Deliver on the Whanganui DHB pro-equity plan
  - Build Māori workforce and Māori health equity and equity capability.

- Be guided by the Ministry of Health Rāranga Tupuake – Māori Workforce Development Plan.

- Provide tuakana/taina support for new graduate Māori nurses through Te Uru Pounamu programme.

- Expand Te Uru Pounamu to encourage connection between Māori health professionals.

- Proactively promote HWNZ funding for Māori particularly in kura kaupapa settings.

- Growing a future-proof workforce.

- Meet all of our training and facility accreditation requirements from regulatory bodies, including New Zealand Nursing Council, Medical Council of New Zealand, New Zealand Dental Council, and Pharmacy Council.

- Improve the learning culture within the DHB through cementing the new relationship with the University of Otago Wellington for training interns.

- Establish an education centre to support our growing focus on workforce development.

- Community-based attachments are an important part of Whanganui DHB's training towards our future medical workforce. We currently have two community-based attachments with a further one required over the next two years, in line with MCNZ requirements for general registration.

- Implement equity and pay parity agreements.

- Identify areas of staff development to align with health gain areas for the district.

- Work closely with regional DHB shared services continuing to identify the workforce requirements around the service delivery needs for services to older people and their family/whānau.

- Build on current data collection processes and continues within the context of existing sub-regional service developments and national workforce programmes.

Further detail about the region's approach to workforce is contained in the Central Region's Regional Services Plan.

Co-operative Developments

We recognise that to improve health and equity we need to work with other government and non-government partners. We know that health and wellbeing in the broader context is determined by income, employment, education, housing, culture and ethnicity, social cohesion, resilience and hope for the future. Examples of our work with other agencies includes:

- children and families at risk
- nutrition and physical activity
- smokefree environments
- family violence prevention
- safer communities
- healthy homes
- pathways to employment.

We also have formal contractual and funding arrangements with a range of health providers including general practice services, community pharmacies, rest homes, and community health providers. We are aware of, and make integral in our planning, the fact that the number of people who require hospital treatment is very small, compared to the number of individual interactions with health services in the community.

In all our work we are committed to partnering with individuals, their whānau, and broader communities, to fulfil our role and responsibilities, both as a DHB, and as members of our community.

- Partnership with Iwi and relationships with Māori: We recognise and respect the principles of the Treaty of Waitangi in accordance with the New Zealand Public Health and Disability Act 2000 and are committed to the advancement of Māori health priorities. The board recognises that partnership and participation are essential to enable Iwi to participate and contribute to strategies for Māori health improvement and to foster the development of Māori capacity to participate in the health and disability sector.

  The board's Memorandum of Understanding with Hauora A Iwi recognises this commitment. Hauora A Iwi, as the inter-tribal forum established by a confederation of six Iwi, is the highest-level strategic partner with the DHB.

- Community engagement: We are committed to working with local communities through an open and transparent planning and decision-making process. We aim to keep the community informed at all times through consultation, communication, public board and committee meetings and the regular release of information.

- Partnership with public health services: We recognise our statutory responsibilities to improve, promote and protect the health of people and communities. Our planning and provision of public health services is integrated with and informed by local population health priorities in addition to national and regional direction. The regulatory function of public health is provided to Whanganui DHB by MidCentral District Health Board through their Health Protection Service.

- Cross-DHB cooperation: We work closely with other DHBs in the region so the most effective and efficient configuration of services is achieved across the region. The 2019/20 Regional Service Plan sets out the vision and actions proposed for regional service development. In addition, we have a foundation agreement with MidCentral DHB (centralAlliance) that outlines mechanisms for the two DHBs to collaborate on planning and delivery of services, to support the long-term clinical and financial sustainability of both DHBs.

- Public sector cooperation: We recognise the importance of alliances with other agencies outside health and the crucial role other agencies play in assisting the board to address and improve the determinants of health.

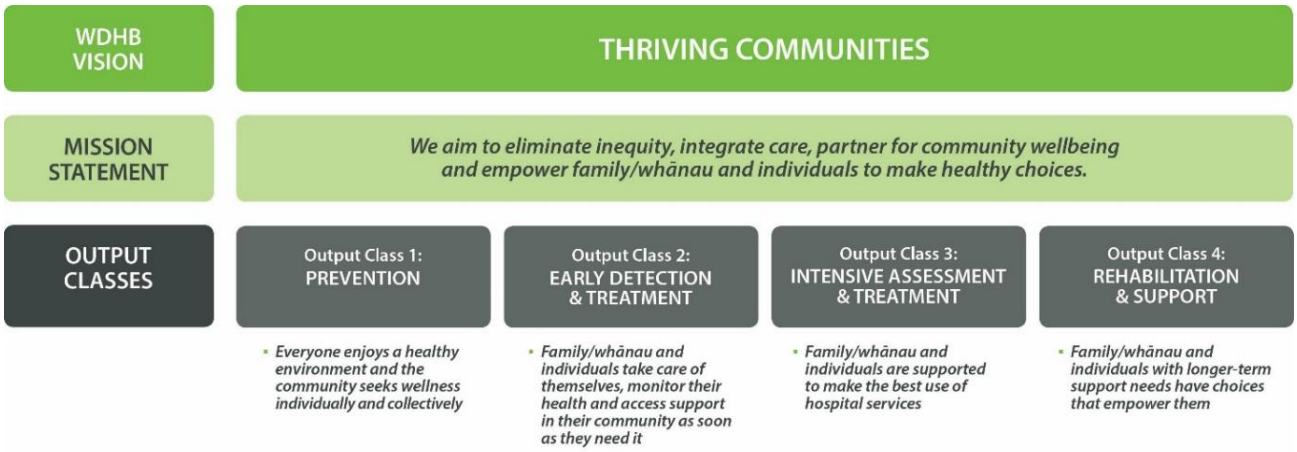
- Private sector cooperation: We work with a range of private sector providers to deliver and coordinate services to the community. The majority of health and disability providers contracted are private providers and we ensure we meet the requirements of the Operational Policy Framework when entering into contractual arrangements with private providers.

WĀHANGA 3:
Te Tauākī o te Pūtanga Ake

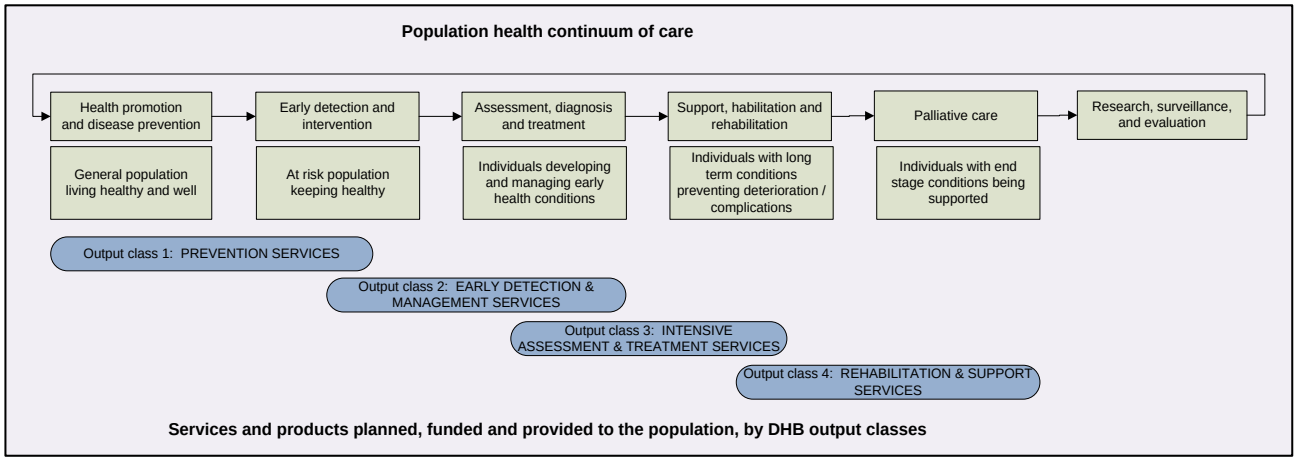
SECTION 3:
Statement of Performance Expectations

This section outlines our performance expectations for the first year of our Statement of Intent. In the 2019/20 financial year we will closely monitor the measures outlined in this section as we pursue the targets we have set.

The diagram below illustrates the link between our vision and the work that we do for the population of our district, grouped into output classes.



Further, there is a relationship between the population health continuum of care and outputs. Simply, this means that as care needs intensify, so too does the required response from the health and disability system. This is shown in the following diagram.



This shows that the DHB 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/whānau in end of life care. In doing so the DHB, as a Crown entity, must respond to the requirements of Parliament and the expectations and priorities of the Government for the public health sector.

Output Classes

Output classes cover the full range of the services that we provide. The following is a brief description of each output class and the performance measures within each output class that we will target in the 2019/20 financial year.

The performance measures chosen are not an exhaustive list of all our activity but provide a good representation of the performance in key focus areas for 2019/20 and include some volume targets and some quality indicators. This reflects our performance measurement philosophy that accounts for "How much did we do" as well as "How well did we do it". The overarching quality framework that is applied comes from the Institute of Health Innovation and includes six domains:

1. safety
2. timeliness
3. efficiency
4. effectiveness
5. equity
6. patient-centredness.

Activity not mentioned in this section continues to be funded and monitored.

Reducing inequities in health outcomes, in particular health inequities experienced by Māori, is a key priority identified in the National Health Strategy and a key priority for the Whanganui DHB. Our intervention logic follows the principle that equity of outcome will only follow equity of access and engagement – hence much of our improvement activity focuses on how to attain and promote access to services and how to truly engage our population of all age-groups to be empowered owners of their own wellbeing.

To help understand the inequity in health outcomes between Māori and non-Māori an equity ratio can be calculated. An equity ratio would illustrate the relative gap between the health outcomes measured for Māori and non-Māori. For example, a ratio of two for a disease state would show that Māori are twice as likely to have the disease. A ratio of two for a screening service would illustrates that non-Māori population are screened at twice the rate of Māori. A lower ratio would indicate lower inequity and a ratio of one would result where the health outcomes and services measures for Māori and non-Māori are the same.

3.1 Output Class 1: Prevention services

Preventative 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/support health and disability.

Preventative services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing. They include:

- Health promotion to ensure that illness is prevented and unequal outcomes are reduced.
- Statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases.
- Population health protection services such as immunisation and screening services.

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

Why is this output class significant?
The DHB 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, poor nutrition, low levels of physical activity and alcohol consumption together with health and environmental protection factors will contribute to an improved health status of our population overall and reduce the potential for untimely and avoidable death.

What outcomes are we contributing to?
- People/whānau 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.

Prevention	Plan 2019/20	Plan 2020/21	Plan 2021/22	Plan 2022/23
Revenue				
Crown	5,532	5,687	5,842	6,002
Other Income	6	5	5	5
Inter-district Inflows	43	44	45	46
Total Revenue	5,581	5,736	5,892	6,053
Expenditure				
Personnel	(3,331)	(3,449)	(3,571)	(3,698)
Capital charge	(240)	(258)	(239)	(221)
Depreciation	(14)	(15)	(16)	(16)
Other	(390)	(399)	(406)	(413)
Other Provider Payments	(3,197)	(3,288)	(3,384)	(3,482)
Inter-district Inflows	(54)	(56)	(58)	(60)
Overheads	0	0	0	0
Total Expenditure	(7,226)	(7,465)	(7,674)	(7,890)
Net Surplus (Deficit)	**(1,645)**	**(1,729)**	**(1,782)**	**(1,837)**

Prevention Services					
Measure description	**Ethnicity**	**2017/18 Actual**	**2018/19 Forecast**	**2019/20 Target**	**2021/22 Outlook**
Ambulatory sensitive hospitalisations for children 0 – 4 years of age (compared with the national rate)					
	All	120%	110%	≤110%	≤100%
	Māori	141%	143%	≤115%	≤100%
	Non-Māori	103%	84%	≤110%	≤100%
Children caries free at 5 years of age					
	All	55%	57%	≥58%	≥60%
	Māori	35%	35%	≥58%	≥60%
	Non-Māori	66%	64%	≥58%	≥60%
Immunisation coverage rate at 8 months of age					
	All	88%	88%	≥95%	≥95%
	Māori	87%	88%	≥95%	≥95%
	Non-Māori	89%	91%	≥95%	≥95%
Babies in a Smokefree household at 6 weeks of age					
	All	55%	38%	≥38%	≥60%
	Māori	31%	14%	≥28%	≥60%
	Non-Māori	73%	58%	≥58%	≥60%
Proportion of infants exclusively or fully breastfed at six weeks					
	All	71%	67%	≥70%	≥70%
	Māori	64%	64%	≥70%	≥70%
	Non-Māori	76%	72%	≥70%	≥70%
Proportion of youth who have received HPV vaccine					
	All	78%	N/A	≥75%	≥75%
	Māori	96%	N/A	≥75%	≥75%
	Non-Māori	67%	N/A	≥75%	≥75%
Cervical screening three-year coverage rate for women aged 25-69 years					
	All	76%	76%	≥80%	≥80%
	Māori	72%	72%	≥80%	≥80%
	Non-Māori	78%	77%	≥80%	≥80%
Percentage of PHO enrolled patients who smoke have been offered help to quit smoking by a healthcare practitioner in the last 15 months					
	All	92%	90%	≥95%	≥95%
	Māori	N/A	90%	≥95%	≥95%
	Non-Māori	N/A	91%	≥95%	≥95%
Number of extended consults delivered by a GP or practice nurse					
	Total	1285	1964	2228	Target to be established: Youth 20% Adult 80%
	Youth	208	182	446	
	Adult	1077	1782	1782	
Percentage of enrolled population 65 years + who have the flu vaccination					
	All	63%	N/A	≥75%	≥75%
	Māori	59%	N/A	≥75%	≥75%
	Non-Māori	64%	N/A	≥75%	≥75%

3.2 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. Includes general practice, community and Māori health services, pharmacist services, community pharmaceuticals (the Schedule) and child and adolescent oral health and dental services.

These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB.

On a continuum of care these services are preventative and treatment services focused on 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 provider organisations 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 equitable with non-Māori.
- 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.

Early Detection & Management	Plan 2019/20	Plan 2020/21	Plan 2021/22	Plan 2022/23
Revenue				
Crown	59,962	61,782	63,453	65,213
Other Income	46	34	34	34
Inter-district Inflows	1,516	1,562	1,609	1,657
Total Revenue	61,524	63,378	65,096	66,904
Expenditure				
Personnel	(11,504)	(11,909)	(12,330)	(12,766)
Capital charge	(500)	(489)	(454)	(428)
Depreciation	(472)	(516)	(547)	(560)
Other	(9,151)	(9,364)	(9,548)	(9,717)
Other Provider Payments	(42,516)	(43,781)	(45,092)	(46,438)
Inter-district Inflows	(3,306)	(3,405)	(3,507)	(3,612)
Overheads	0	0	0	0
Total Expenditure	(67,449)	(69,464)	(71,478)	(73,521)
Net Surplus (Deficit)	**(5,925)**	**(6,086)**	**(6,382)**	**(6,617)**

Early Detection and Management					
Measure description	**Ethnicity**	**2017/18 Actual**	**2018/19 Forecast**	**2019/20 Target**	**2021/22 Outlook**
Proportion of pregnant women accessing DHB funded pregnancy and parenting education					
	All	24%	25% (est)	≥40.0%	≥40.0%
	Māori		Target to be established		
Proportion of adolescent population utilising DHB-funded dental services					
	All	79.4%	79.8%	≥85.0%	≥90%
	Māori		Target to be established		
Proportion of children enrolled in the community oral health service who have treatment according to plan					
	All	98%	97%	≥90%	≥90%
	Māori	98%	96%	≥90%	≥90%
	Non-Māori	98%	96%	≥90%	≥90%
Proportion of youth (12-19 years olds) seen each quarter by primary mental health services					
	All	1.8%	1.0%	≥2.0%	≥4.0%
	Māori	2.4%	0.8%	≥2.0%	≥4.0%
	Non-Māori	1.4%	1.1%	≥2.0%	≥4.0%
Shorter waits for non-urgent mental health and addiction services (0-19 yrs)					
	< 3 weeks	79.7%	84.2%	≥80%	≥80%
	3-8 weeks	19.9%	13.4%	≥95%	≥95%
	> 8 weeks	0.4%	2.4%	100%	100%
Ambulatory Sensitive Hospitalisations (ASH) rates for 45-64 years of age relative to national rate					
	All	161%	168%	≤170%	≤125%
	Māori	275%	295%	≤151%	≤125%
	Non-Māori	134%	138%	≤166%	≤125%
Proportion of patients with good or acceptable glycaemic control (HbA1C < 64 mmol/mol)					
	All	61%	61%	≥60%	≥60%
	Māori	51%	51%	≥60%	≥60%
	Non-Māori	65%	72%	≥60%	≥60%
Proportion of eligible population who have had their cardiovascular risk assessed in the last five-years					
	All	89%	89%	≥90%	≥90%
	Māori	88%	89% (est)	≥90%	≥90%
	Non-Māori	90%	89% (est)	≥90%	≥90%
Percentage of people accepted for an urgent diagnostic colonoscopy received their procedure within two-weeks (14 days)					
	All	90%	91%	≥90%	≥90%
Percentage of long term clients with mental illness who have an up-to-date relapse prevention plan					
	Child	100%	100% (est)	≥95%	≥95%
	Adult	96%	95%	≥95%	≥95%

3.3 Output Class 3: Intensive assessment and treatment

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

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

On a continuum of care these services are at the complex end of treatment services and focused on individuals.

Why is this output class significant?
Equitable, timely access to intensive assessment and treatment can significantly improve the quality of life for people through early intervention or through comprehensive, co-ordinated care.

Responsive services and timely treatment support improvements across the whole system and 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 equitable with non-Māori.
- 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 receive care that maximises their independence and wellbeing.

Intensive Assessment & Treatment	Plan 2019/20	Plan 2020/21	Plan 2021/22	Plan 2022/23
Revenue				
Crown	161,815	167,850	173,637	179,560
Other Income	1,095	1,063	1,064	1,064
Inter-district Inflows	5,158	5,313	5,472	5,637
Total Revenue	168,068	174,226	180,173	186,261
Expenditure				
Personnel	(78,914)	(81,708)	(84,607)	(87,612)
Capital charge	(2,605)	(2,682)	(2,493)	(2,323)
Depreciation	(5,229)	(5,723)	(6,071)	(6,221)
Other	(34,367)	(35,174)	(35,884)	(36,525)
Other Provider Payments	(12,835)	(13,221)	(13,619)	(14,028)
Inter-district Inflows	(36,986)	(38,096)	(39,239)	(40,416)
Overheads	-	-	-	-
Total Expenditure	(170,936)	(176,604)	(181,913)	(187,125)
Net Surplus (Deficit)	**(2,868)**	**(2,378)**	**(1,740)**	**(864)**

Intensive Assessment and Treatment					
Measure description	**Ethnicity**	**2017/18 Actual**	**2018/19 Forecast**	**2019/20 Target**	**2021/22 Outlook**
Inpatient length of stay – ACUTE					
	All	2.2	2.2	≤2.2	≤2.1
Unplanned readmission rate at 28 days					
	All	13.9%	13.9%	≤12.1%	≤12.0%
	Māori	13.8%	13.4%	≤12.1%	≤12.0%
	Non-Māori	14.0%	14.1%	≤12.1%	≤12.0%
Faster Cancer Treatment (62-day indicator)					
	All	95.2	87.3%	≥90%	≥90%
Improving waiting times for diagnostic services		Computed Tomography (CT)			
	All	98%	94%	≥95%	≥95%
	Māori	98%	95%	≥95%	≥95%
	Non-Māori	98%	94%	≥95%	≥95%
Improving waiting times for diagnostic services		Magnetic Resonance Imaging (MRI)			
	All	98%	74%	≥90%	≥90%
	Māori	96%	80%	≥90%	≥90%
	Non-Māori	98%	73%	≥90%	≥90%
Percentage of service users receiving community care within seven days following their discharge (KPI 19)					
	All	56%	50%	≥75%	≥90%
	Māori	56%	50%	≥75%	≥90%
	Non-Māori	57%	50%	≥75%	≥90%
Rate per 100,000 population are committed to compulsory mental health treatment					
	All	127	151	≤135	≤120
	Māori	211	278	≤250	≤225
	Non-Māori	101	111	≤100	≤90
Standardised intervention rates		(cardiac surgery and angioplasty/angiography)			
	Cardiac (All)	4.8	5.4	≥6.5	≥6.5
	Angioplasty (All)	11.2	11.3	≥12.5	≥12.5
	Angiography (All)	26.5	29.10	≥34.7	≥34.7
Standardised intervention rates		(cataracts and major joints)			
	Cataracts (All)	18.2	25.7	≥27.0	≥27.0
	Major joints (All)	35.2	30.2	≤28.0	≤21.0
Hospital acquired cardiac complications per 10,000 inpatient episodes					
	All	50.5	31 (est)	≤40.0	≤40.0

3.4 Output Class 4: Rehabilitation and support

Rehabilitation and support services are delivered following a 'needs assessment' process and co-ordination input by needs assessment and service coordination (NASC) services for a range of services including palliative care, home-based support and residential care services.

On a continuum of care these services will provide support for 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), all of which have a significant impact, not only for the individual and their family/whānau, but also on the capacity of health and social services to respond to the demands.

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 DHB is keen to place an emphasis on an increased proportion of older people living in their own home with their natural support system and if necessary supplemented by subsidised home-based support services, before aged residential care is pursued.

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/whānau support and enable older people and people with disabilities to participate fully in society and enjoy maximum independence.

Rehabilitation & Support	Plan 2019/20	Plan 2020/21	Plan 2021/22	Plan 2022/23
Revenue				
Crown	39,362	40,462	41,488	42,585
Other Income	20	12	11	11
Inter-district Inflows	1,211	1,247	1,285	1,323
Total Revenue	40,593	41,721	42,784	43,919
Expenditure				
Personnel	(3,660)	(3,788)	(3,920)	(4,058)
Capital charge	(189)	(169)	(156)	(150)
Depreciation	(143)	(155)	(164)	(168)
Other	(3,329)	(3,405)	(3,464)	(3,524)
Other Provider Payments	(32,487)	(33,453)	(34,454)	(35,482)
Inter-district Inflows	(2,944)	(3,032)	(3,123)	(3,217)
Overheads	0	0	0	0
Total Expenditure	(42,752)	(44,002)	(45,281)	(46,599)
Net Surplus (Deficit)	**(2,159)**	**(2,281)**	**(2,497)**	**(2,680)**

Rehabilitation and Support					
Measure description	**Ethnicity**	**2017/18 Actual**	**2018/19 Forecast**	**2019/20 Target**	**2021/22 Outlook**
Percentage of mental health & addictions service users receiving community care within seven days following their discharge (KPI 19)					
	All	56%	50%	≥75%	≥90%
	Māori	56%	50%	≥75%	≥90%
	Non-Māori	57%	50%	≥75%	≥90%
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%	91%	≥95%	≥95%
Number of older people receiving in-home strength and balance programmes					
	All	151	179	199	≥199
Percentage of potentially eligible stroke patients thrombolysed					
	All	8.4%	8.0%	≥10.0%	≥12.0%
Percentage of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway					
	All	97%	100%	≥80%	≥80%
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	56%	67%	≥70%	≥70%
Proportion of over 64 year olds who are prescribed 11 or more medications					
	All	1.6%	2.0%	≤2.0%	≤2.0%
	Māori	N/A	2.2%	≤2.0%	≤2.0%
	Non-Māori	N/A	2.0%	≤2.0%	≤2.0%
Proportion of population aged 65+ years receiving DHB funded support in ARC facilities over the year					
	All	5.4%	4.9%	4.4%	4.4%
	Māori	3.6%	3.0%	3.0%	3.0%
	Non-Māori	5.6%	5.1%	4.5%	4.5%

WĀHANGA 4: Ngā Ritenga Pūtea

SECTION 4: Financial Performance

4.1 Financial performance summary

Whanganui DHB remains committed to operating within annual funding over the long term, and to delivering on the agreed financial plan, supported by clinical and executive leadership.

The Whanganui DHB is planning a deficit of 12.6 million in 2019/20.

The financial plan for 2019/20 to 2022/23 is set out below:

Statement of prospective Financial Performance for the four years to 30 June 2023

	Actual 2017/18 $000	Forecast 2018/19 $000	Plan 2019/20 $000	Plan 2020/21 $000	Plan 2021/22 $000	Plan 2022/23 $000
Provider (deficit)	(4,314)	(12,958)	(9,702)	(11,039)	(11,694)	(11,962)
Governance and Funding Administration surplus/ (deficit)	501	457	-	-	-	-
Provider/Governance and funding (deficit)	**(3,813)**	**(12,501)**	**(9,702)**	**(11,039)**	**(11,694)**	**(11,962)**
Funder Arm surplus / (deficit)	(366)	(1,153)	(2,895)	(1,435)	(707)	(36)
Base net (deficit)	**(4,179)**	**(13,654)**	**(12,597)**	**(12,474)**	**(12,401)**	**(11,998)**
Mental Health Ring Fence expenditure from prior year	-	-	-	-	-	-
Asset write down & other	-	-	-	-	-	-
Consolidated net (deficit) for year	**(4,179)**	**(13,654)**	**(12,597)**	**(12,474)**	**(12,401)**	**(11,998)**

Funding increases

Whanganui DHB received a funding increase of 4.2% or $9.53m inclusive of $2.28m for MECA settlements.

The underlying funding increase for 2019/20 is 2.9% against last year 3.2%. The underlying funding increase has been impacted by a decrease of $0.76m in transitional funding due to a change in population growth patterns.

Whilst Whanganui has seen positive population growth the increase is still running lower than the national average resulting in our population based funding share dropping to 1.63%. Most provincial DHBs are similarly impacted and this trend is expected to continue due to higher population growth in major urban centres.

Budgeted revenue has increased over last year actuals by a net of 3.7%, which is less than the 4.2% stated above, due to non-recurring revenue items in 2018/19.

Key assumptions

For further detail on our annual planning assumptions and risk please refer to our Annual Plan.

Statement of prospective comprehensive revenue and expenses for the four years to 30 June 2023

	Actual 2017/18 000	Actual 2018/19 $000	Plan 2019/20 $000	Plan 2020/21 $000	Plan 2021/22 $000	Plan 2022/23 $000
Revenue						
Revenue from non-exchange transactions	222,111	232,616	241,436	250,443	258,978	267,813
Revenue from exchange transactions	31,627	32,811	33,990	34,278	34,627	34,984
Other Revenue	339	372	340	340	340	340
Total Revenue	**254,077**	**265,799**	**275,766**	**285,061**	**293,945**	**303,137**
Expenses						
Wages, salaries and employee benefit costs	(83,456)	(94,090)	(97,409)	(100,854)	(104,428)	(108,134)
Outsourced services	(14,397)	(15,122)	(14,360)	(14,768)	(15,195)	(15,636)
Depreciation and amortisation expense	(4,720)	(5,417)	(5,858)	(6,409)	(6,798)	(6,965)
Capital charge	(4,357)	(4,401)	(3,534)	(3,598)	(3,342)	(3,122)
Finance costs	(10)	(22)	(56)	(306)	(504)	(504)
Other expenses	(151,445)	(160,496)	(167,241)	(171,695)	(176,174)	(180,869)
Total expenses	**(258,385)**	**(279,548)**	**(288,458)**	**(297,630)**	**(306,441)**	**(315,230)**
Share of Profit of Associate	129	95	95	95	95	95
Surplus / (deficit)	**(4,179)**	**(13,654)**	**(12,597)**	**(12,474)**	**(12,401)**	**(11,998)**
Other Comprehensive revenue and expense						
Gain on property revaluation	**7,024**	**-**	**-**	**-**	**-**	**-**
Total other comprehensive revenue and expense	**7,024**	**-**	**-**	**-**	**-**	**-**
Total comprehensive revenue and expense	**2,845**	**(13,654)**	**(12,597)**	**(12,474)**	**(12,401)**	**(11,998)**

Statement of prospective financial position as at year end for four years to 30 June 2023

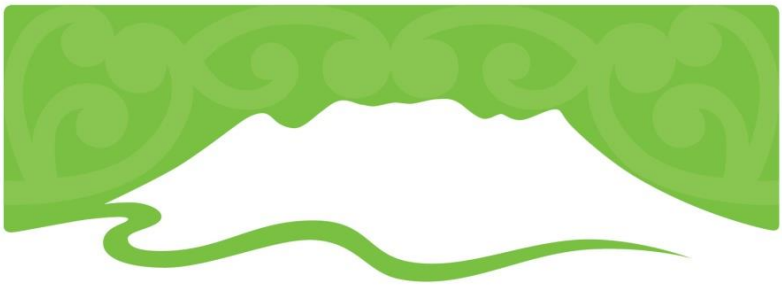
	Actual 2017/18 000	Actual 2018/19 $000	Plan 2019/20 $000	Plan 2020/21 $000	Plan 2021/22 $000	Plan 2022/23 $000
ASSETS						
Current assets						
Cash and cash equivalents	1,284	3,020	5	5	5	5
Receivables from non-exchange transactions	223	352	160	160	160	160
Receivables from exchange transactions	8,514	5,897	6,741	7,687	7,926	8,171
Prepayments	13	41	13	14	15	16
Investments	3,000	-	-	-	-	-
Inventories	1,412	1,427	1,437	1,390	1,390	1,390
Trust /special funds	141	181	180	180	180	180
Patient and restricted trust funds	4	4	4	4	4	4
Non- current assets held for sales	-	-	-	-	-	-
Total current assets	**14,591**	**10,922**	**8,540**	**9,440**	**9,680**	**9,926**
Non current assets						
Property, plant and equipment	76,766	75,230	76,138	78,208	79,523	78,318
Intangible assets	12,417	11,777	12,366	11,952	10,523	8,997
Investments in associates	1,121	1,146	1,171	1,196	1,221	1,246
Other financial assets	-	-	-	-	-	-
Total non current assets	**90,304**	**88,153**	**89,675**	**91,356**	**91,267**	**88,561**
Total assets	**104,895**	**99,075**	**98,215**	**100,796**	**100,947**	**98,487**
LIABILITIES						
Current Liabilities						
Bank Overdraft	-	-	6,918	8,826	12,291	12,604
Payables under non-exchange transitions	2,179	2,092	2,182	2,348	2,431	2,515
Payables under exchange transitions	11,743	16,142	13,722	12,802	13,201	13,614
Borrowings	227	230	198	100	103	107
Employee entitlements	12,874	16,713	18,181	15,370	15,933	16,422
Provisions	-	-	-	-	-	-
Total current liabilities	**27,023**	**35,177**	**41,201**	**39,446**	**43,959**	**45,262**
Non-current liabilities						
Borrowings	914	684	486	385	282	175
Employee entitlements	805	873	942	1,011	1,011	1,011
Provisions	-	-	-	-	-	-
Total non current liabilities	**1,719**	**1,557**	**1,428**	**1,396**	**1,293**	**1,186**
Total liabilities	**28,742**	**36,734**	**42,629**	**40,842**	**45,252**	**46,448**
Net Assets	**76,153**	**62,341**	**55,586**	**59,954**	**55,695**	**52,039**
EQUITY						
Equity						
Contributed Capital	105,725	105,567	111,409	128,251	136,393	144,735
Accumulated surplus / (deficit)	(53,594)	(67,287)	(79,884)	(92,358)	(104,759)	(116,757)
Property revaluation reserves	23,881	23,881	23,881	23,881	23,881	23,881
Hospital special funds	141	180	180	180	180	180
Total equity	**76,153**	**62,341**	**55,586**	**59,954**	**55,695**	**52,039**

Statement of prospective changes in equity for the year end for four years to 30 June 2023

	Actual 2017/18 000	Actual 2018/19 $000	Plan 2019/20 $000	Plan 2020/21 $000	Plan 2021/22 $000	Plan 2022/23 $000
Balance at 1 July	73,467	76,153	62,341	55,586	59,954	55,695
Total comprehensive revenue and expense for the year	2,845	(13,654)	(12,597)	(12,474)	(12,401)	(11,998)
Owners Transactions						
Capital contribution	-	-	6,000	17,000	8,300	8,500
Repayment of Capital	(159)	(158)	(158)	(158)	(158)	(158)
Balance at 30 June	**76,153**	**62,341**	**55,586**	**59,954**	**55,695**	**52,039**

Statement of prospective cash flows for the year end for four years to 30 June 2023

	Actual 2017/18 000	Actual 2018/19 000	Plan 2019/20 $000	Plan 2020/21 $000	Plan 2021/22 $000	Plan 2022/23 $000
Cash flows from Operating Activities						
Receipts from the Crown	248,493	266,128	273,684	283,001	292,592	301,778
Interest Received	509	321	57	4	4	4
Receipt from other revenue	1,934	1,655	1,110	1,110	1,110	1,110
Payment to Supplies	(164,496)	(169,917)	(183,571)	(187,498)	(191,313)	(196,434)
Payment to Employees	(81,344)	(90,183)	(95,854)	(103,596)	(103,865)	(107,645)
Interest Paid	(10)	(22)	(24)	(24)	(24)	(24)
Payment to capital charged	(4,357)	(4,401)	(3,534)	(3,598)	(3,342)	(3,122)
GST (net)	(91)	177	110	140	40	40
Net Cash inflow/(outflow) from operating activities	**638**	**3,758**	**(8,022)**	**(10,461)**	**(4,798)**	**(4,293)**
Cash flows from Investing Activities						
Receipts from sale of property, plant and equipment	38	-	-	-	-	-
Purchase of property, plant and equipment	(2,457)	(3,262)	(5,869)	(7,165)	(6,614)	(4,154)
Purchase of intangible assets	(3,983)	(1,310)	(1,630)	(900)	(70)	(80)
Receipts from maturity of investments	-	2,975	(25)	(25)	(25)	(25)
Net appropriation from trust funds	(7)	(40)	1	-	-	-
Net Cash inflow/(outflow) from investing activities	**(6,409)**	**(1,637)**	**(7,523)**	**(8,090)**	**(6,709)**	**(4,259)**
Cash flows from Financing Activities						
Capital contribution	-	-	6,000	17,000	8,300	8,500
Payment of finance lease	(57)	(92)	(95)	(98)	(100)	(103)
Repayment of Capital	(159)	(158)	(158)	(158)	(158)	(158)
Payment of loans	(135)	(135)	(135)	(101)	-	-
Net Cash inflow/(outflow) from financing activities	**(351)**	**(385)**	**5,612**	**16,643**	**8,042**	**8,239**
Net increase/(decreased) in cash and cash equivalents	(6,122)	1,736	(9,933)	(1,908)	(3,465)	(313)
Cash and cash equivalents at beginning of year	7,406	1,284	3,020	(6,913)	(8,821)	(12,286)
Cash and cash equivalents at end of year	**1,284**	**3,020**	**(6,913)**	**(8,821)**	**(12,286)**	**(12,599)**



WHANGANUI
DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui