2020 / 2021
TE PŪRONGO A-TAU
ANNUAL REPORT

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

HE MIHI WHAKATAU

OUR STORY

Tihei mauri ora. Nei rā Ko Te Pōari o Whanganui e tuku mihi atu ki ngā uri o te rohe nei ki a koutou o Whanganui, Ngā Wairiki, Ngāti Apa, Ngāti Hauiti, Ngaa Rauru Kiitahi, Mōkai Pātea me koutou o Ngāti Rangi.

Mai i ngā matapihi taku titiro atu ki te awa o Waitōtara, ki te mana o Ngaa Rauru Kiitahi, ka huri au ki a koe e te Awa Tipua e rere kau ana i runga anō i ngā kōrero 'Ko au te awa, ko te awa ko au.'

E rere kau atu te wai ki ngā ngaru e aki ana ki a Whangaehu heke atu ki a Turakina awa me ngā whenua o Ngā Wairiki me Ngāti Apa.

Ka huri taku kanohi kia whaia e au i a Rangitikei awa ki ngā whānau o Ngāti Hauiti me Mōkai Pātea. Ko te kāhui maunga e tū mai rā me ōna kauae kōrero hei māharatanga ki ngā uri kei ōna rekereke.

Ngāti Rangi koutou ko Ngāti Uenuku, tēnā koutou.

Huri noa ki tēnei rohe o Te Pōari o Whanganui, tēnā koutou, tēnā koutou, tēnā tātou katoa.

We of the Whanganui District Health Board make acknowledgments to the descendants of Whanganui, Ngā Wairiki, Ngāti Apa, Ngāti Hauiti, Ngaa Rauru Kiitahi, Mōkai Pātea and Ngāti Rangi.

From our window we watch as the Waitōtara flows through the majestic Ngaa Rauru Kiitahi district. I turn to you the great river of Whanganui that flows with all its grace and acknowledge that 'I am the river, and the river is me.'

The river continues to flow and the waves break at Whangaehu and Turakina through the lands of Ngā Wairiki and Ngāti Apa.

I turn to follow the Rangitikei to the families of Ngāti Hauiti and Mōkai Pātea. From here we have a clear view of the stunning mountain clan, a reminder of those residing at its feet.

Ngāti Rangi and Ngāti Uenuku, we greet you.

To all of you within the district of the Whanganui District Health Board, we greet and acknowledge you all.

RĀRANGI KIKO

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OUR VISION: *He Hāpori Ora - Thriving Communities*

The people in Whanganui District Health Board rohe live their healthiest lives possible in thriving communities.

OUR MISSION: *Kia tāea e te whānau me te hāpori i tōna ake tino rangatiratanga*

Together we build resilient communities, empowering whānau and individuals to determine their own wellbeing.

NGĀ UARĀTANGA - OUR VALUES

Aroha

The value of love, respect and empathy, demonstrating compassionate and non-judgemental relationships.

Closely interlinked with: **Rangimārie** – humility, maintaining composure, peace, accountability and responsibility
Mauri – life's essence and balance.

Kotahitanga

The value of unity and vision sharing where we demonstrate trust and collaboration.

Closely interlinked with: **Whanaungatanga** – spiritual wellness, relationships, beliefs, knowing who you are and what to do
Mana tangata – dignity, respect, protections, safety and acceptance.

Manaakitanga

The value of respect, support and caring where we demonstrate doing our very best for others.

Closely interlinked with: **Kaitiakitanga** – protection, maintaining values and taking care of people and things
Tikanga Māori – guiding protocols and principles for how we do things.

Tino Rangatiratanga

The value of self-determination where we empower individual/whānau choice.

Closely interlinked with: **Wairuatanga** – spiritual wellness, relationships and beliefs
Whakapapa – whānau-centred approach which achieves equity in health outcomes for Māori.

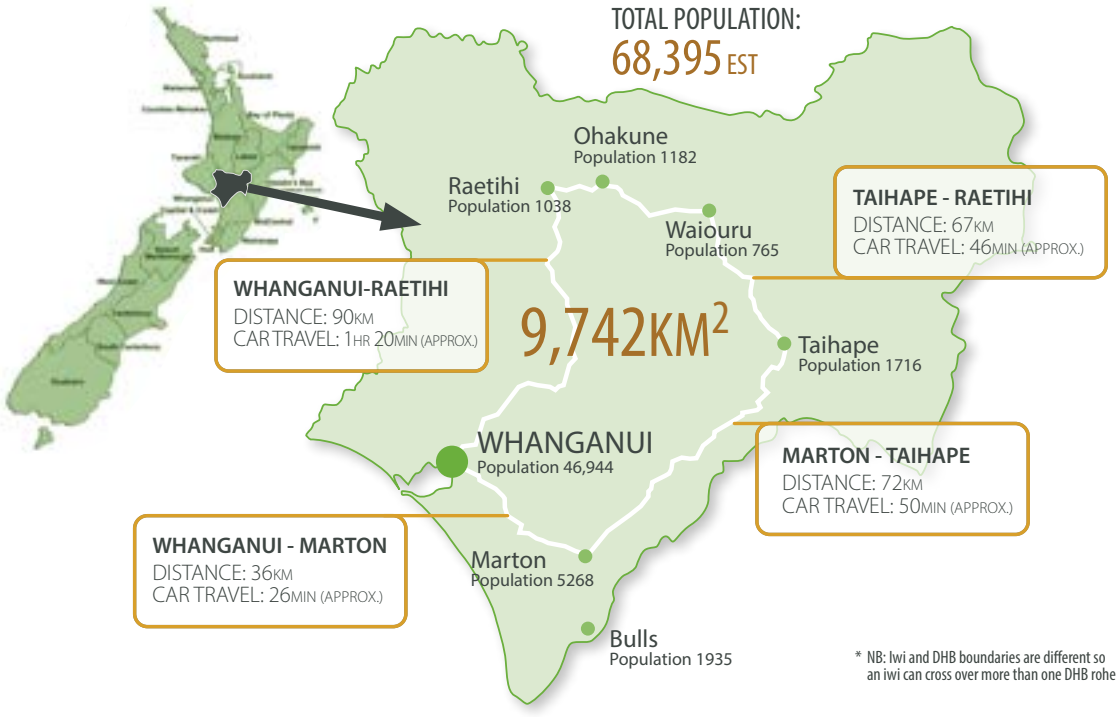
THE POPULATION WE SERVE

HE TĀNGATA, HE TĀNGATA, HE TĀNGATA

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

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

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



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

IWI IN THE ROHE*


Whanganui

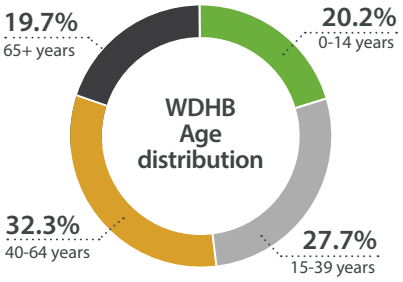

Ngaa Rauru Kiitahi

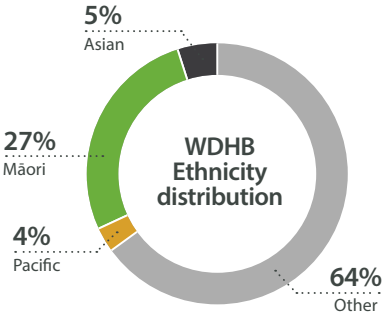

Ngāti Hauiti

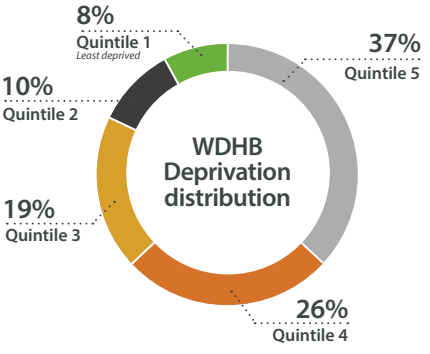

Ngā Wairiki Ngāti Apa


Mōkai Pātea


Ngāti Rangi







POPULATION AGE DISTRIBUTION - ALL NZ

0-19 years	25%
20-39 years	28%
40-59 years	25%
60-79 years	18%
80+	4%

ETHNICITY DISTRIBUTION - ALL NZ

Māori	17%
Other	59%
Asian	17%
Pacific	7%

NOTE: Information based on 2019 Statistics New Zealand population projections which use 2013 census as the base year for projections

OUR DHB'S POPULATION

Our region covers a total land area of 9,742 square kilometres, much of which is sparsely populated. The terrain is mountainous with two major centres - Whanganui city with a population of 46,944 and Marton with a population of 5,268. The major centres are supported by five smaller towns with a population less than 2000 - Waiouru 765, Taihape 1,716, Bulls 1,935, Ohakune 1,182 and Raetihi 1,038.

The population of Whanganui is characterised by a large percentage of Māori at 27 percent of our population (compared to the New Zealand average of 15.7 percent) and small but growing populations of Pasifika and Asian people at four and five percent respectively.

Compared to New Zealand's 19.6 percent, our district is home to a higher percentage of children and young people, with 20.2 percent under 15 years of age, of which 43 percent are of Māori ethnicity. Whanganui has a higher than average population of older aged citizens – with 19.7 percent older than 65 years of age (compared to 15.7 percent for the rest of the country in 2018). As older people, like young people, are high healthcare users, this demographic has significant implications for future provision of health services. Whanganui has a significantly higher percentage of our population living in the most highly deprived conditions with 63 percent in Quintile 4 & 5 compared to 40 percent nationally.

NEW ZEALAND HEALTH STRATEGY: *The Five Strategic Themes*

GUIDING PRINCIPLES FOR THE SYSTEM

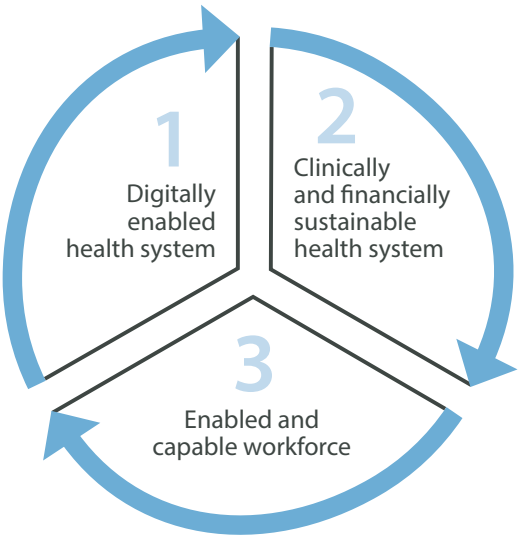
1. Acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi
2. The best health and wellbeing possible for all New Zealanders throughout their lives
3. An improvement in health status of those currently disadvantaged
4. Collaborative health promotion, rehabilitation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

CENTRAL REGION

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

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

Central Region Strategic Objectives



HE HĀPORI ORA

THRIVING COMMUNITIES

The New Zealand Health and Disability System Review, which was released in full in June 2020, suggests the overall health system requires changes to deliver equity, wellness and access to services.

We are in a good place to think about how these nationwide changes will influence our rohe and how we can lead by example as a model for social governance, pro-equity and services delivered closer to the home and in communities.

We are committed to pro-equity for Māori and to ensure everyone in the health sector is accountable for meaningful services and interventions to support Māori self-determination and Whānau Ora.

We are incredibly proud of what can be achieved in the Whanganui rohe – we already have the passion and knowledge in our communities which is the foundation for building stronger, more resilient and healthier communities. Whanganui District Health Board and Hauora ā Iwi are committed to building stronger, more resilient and healthier communities and we will continue to work side-by-side to make this strategy come to life for everyone in our rohe.

We are pleased to present the He Hāpori Ora Thriving Communities strategy to our rohe. We are looking forward to what we can achieve in the future.

Kia tāea e te whānau me te hāpori i tōna ake tino rangatiratanga

Together we build resilient communities,
empowering whānau and individuals to determine their own wellbeing

STRATEGIC FOCUS AREA	PRIORITY AREAS
MANA TAURITE **PRO-EQUITY**	1. Strengthen leadership and accountability for equity 2. Build Māori workforce and Māori health and equity capability 3. Improve transparency in data and decision making 4. Support more authentic partnership with Māori
KĀWANATANGA HĀPORI **SOCIAL GOVERNANCE**	1. Addressing social determinants of health 2. Collective action and shared intelligence 3. Authentic partnerships and connections 4. Strengthening integrated social governance leadership
NOHO ORA PAI I TŌU AKE KĀINGA **HEALTHY AT HOME: EVERY BED MATTERS**	1. Empowering whānau-centred care 2. Empowering consumer engagement 3. Communities have input into how services are funded to address their needs 4. Informed communities

NGĀ UARĀTANGA - OUR VALUES
AROHA | KŌTAHITANGA | MANAAKITANGA | TINO RANGATIRATANGA

UNDERPINNED BY TE TIRITI O WAITANGI PRINCIPLES:
GUARANTEE OF TINO RANGATIRATANGA | EQUITY | ACTIVE PROTECTION | OPTIONS | PARTNERSHIP

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

OUR RELATIONSHIPS IN THE COMMUNITY

Recently, health providers and Māori/Iwi partnership boards across the country were requested to provide information pertaining to existing health service provisions and enablers that could support population-based approaches to localities. Whanganui District Health Board in conjunction with Hauora ā Iwi, the Whanganui Regional Health Network, Māori/Iwi Health providers and community providers were pleased to provide a document which outlined the partnership approach to health provision in the Whanganui District Health Board rohe in response to these requests.

Whanganui District Health Board has sought to work in a manner consistent with 'serving all people within the porous boundaries of wider rohe of Whanganui, Rangitīkei, Ruapehu and South Taranaki'. It aims to address inequities in service provisions, resources, capability and capacity. Dependent on the approach, partnering with Māori may include the Whanganui District Health Board Iwi Māori Partnership Board (IMPB) - Hauora ā Iwi, Māori Health Outcomes Advisory Group (MHOAG), Māori health service providers, Kaumātua Kaunihera o Whanganui, Māori community leaders or all the above.

As a result of this collaborative piece of work, we are privileged to be able to present a few of these responses in the Whanganui District Health Board Annual Report 2020-21 which occurred over the past 12 months, with links to our He Hāpori Ora Thriving Communities strategic direction 2020-23.

Mana Taurite - Pro Equity

- Whanganui District Health Board has a mature relationship with Hauora ā Iwi (Iwi Māori Partnership Board) committed to improving equity in health outcomes for Māori people residing in the Whanganui District Health Board's region in a Memorandum of Understanding (MoU). A variation to the MoU has been agreed for 2020-22, amending the name to Mana Whenua Agreement and confirming ongoing commitment to the principles and intent of the MoU.
- Hauora ā Iwi commissioned a piece of research to better understand the impacts of COVID-19 lockdown on our communities. Some key findings told us that:
  - "It's not over yet" and "safe practices" must continue
  - Equity remains high on the agenda and we must continue to work with others to jointly address this issue
  - Iwi leadership is critical, and that leadership is trusted by our people
  - Relationships allowed us to be flexible, agile and proactive in addressing issues.

  Relationships and collaboration were key, from the partnership with Whanganui District Health Board to working alongside Police and Councils, and liaising with local social service providers.
- Through our Whanganui Alliance Leadership Team (WALT) and others have formed a primary care research collaborative and were funded by the Health Research Council of New Zealand. Recently an equity snapshot for primary healthcare was presented to WALT and further research commissioned with the Whakauae Research services who are an iwi-based Health Research group.
- The He Puna Ora service where Whanganui District Health Board worked in partnership with the Māori Health Outcomes Advisory Group (MHOAG) to commission the design, development and implementation of a Pregnancy and Parenting Service – He Puna Ora.

Kāwanatanga Hāpori – Social Governance

- Whanganui District Health Board commissioned Te Oranganui Trust as lead agent for Healthy Families Whanganui, Rangitīkei and Ruapehu to undertake a 'whole of community, whole of systems approach to the prevention of Suicide (2020/2021) report. These insights will be used to shift the pendulum on suicide from reactive to proactive, informing the co-design of a regional strategic approach and traction plan. This has resulted in an insights report, rangatahi report and a "growing collective wellbeing strategy" to ensure "Our people are enjoying high levels of wellbeing. This is evidenced by the reduction in suicides and suicidal behaviours. Our system of support for those at risk is joined up, responsive, accessible, and highly effective." Our approach and impact are sustainable.
- Whanganui District Health Board has taken guidance from the mahi of the Ruapehu Whānau Transformation Plan. "Informed through our statistics and stories, the Ruapehu Whānau Transformation Plan launched in 2013 containing solutions for how we, as a collective community, could enable positive transformation for all families in the communities of Raetihi, Ohakune and Waiouru". Since 2018 we set to partner with the RWT team to support the realisation of the Wellness Centre solution in the Ruapehu Whānau Transformation Plan 2020.
- A strategic leadership group led by Police and Iwi, supported by Whanganui Regional Health Network, Whanganui District Health Board and Te Oranganui, has been set up to provide courageous and connected strategic leadership to build safe, resilient, strong and connected communities that enable whānau to thrive. Leaders are to support and connect initiatives across government, non-government, Iwi and service providers building collective impact and recognising whānau as the building block of our community.
- The Impact Collective - Rangitīkei, Ruapehu, South Taranaki and Whanganui has created an 'Impact Collective Operational Team' to work with our communities, to baseline a rohe wide 'Community Wellbeing and Equity Profile' report. Involved in the mahi are the Ministry of Social Development, Te Puni Kōkiri, Whanganui District Health Board, Ruapehu District Council, Rangitīkei District Council, South Taranaki District Council and the NZ Police. The team continue to work with iwi who seek

to participate on enabling involvement with the individual iwi. This baselining is being conducted by DOT loves Data and will bring together the community statistics which are aligned to the 17 United Nations Sustainable Development Goals (thinking Global), Treasury's Living Standards Framework (aligning Nationally) and to a localised Whānau Ora framework (acting regionally/locally), alongside the 'stories and narratives' which are collated during community wide engagement. Collating the 'Stats and the Stories' for the communities, we are able to present a holistic wellness picture of the communities to the membership of the Impact Collective - Rangitīkei, Ruapehu, South Taranaki and Whanganui, the New Zealand Government, and most importantly, the communities. This aligns to a wider representation of wellness rather than just health, spanning social, environmental and economic factors.

Noho Ora Pai i Tōu Ake Kāinga – Healthy at Home: Every Bed Matters (69,000 beds)

- Fit for Surgery, Fit for Life is an integrated community provided service, with patients accessing services from a number of providers as needed, with navigation provided by Sport Whanganui. This programme is designed to work with patients whose weight places them at risk for surgery, to improve health and wellbeing prior to surgery. The initial trials have shown great success with some people not requiring surgery anymore. This model has been taken up by other DHBs such as Waikato and is part of national planned care conversations.
- The Conversation Café is a collaborative including the iwi-led health organisation Te Oranganui, Whanganui District Health Board MHA service, the peer-led MHA non-governmental organisation (NGO) Balance Aotearoa, and the family and whānau organisation Mental Health & Wellbeing Support. Support has also recently come from another peer-led NGO, Changing Minds. It brings people together to relax and chat about some of the region's important challenges and changes
- In the post Level 4 lockdown, Whanganui District Health Board in conjunction with the district councils, the Integrated Recovery Team undertook a series of community engagements that led to the development of six thematic analysis COVID-19 reports - ***wdhb.org.nz/media/key-documents/***.
- Whanganui District Health Board has partnered with the Robert Bartley Foundation (RBF) to deliver primary/preventative services across the wider Whanganui rohe. Through this partnership Whanganui District Health Board and the Robert Bartley Foundation will operationalise a Mobile Community Clinic (health bus) to enable immunisation, screening, vaccination, health checkups and health promotion activities to be conducted in our hard to reach (geographical) areas and support reducing inequities in health.
- Community Funded Options for Primary Care is an initiative led by the Whanganui Regional Health Network to deliver clinical services in primary care that might ordinarily require ED or hospital treatment. These services are provided in Primary Care, free to the patient, reducing barriers to access and improving experience of care. This currently includes some IV therapies and deep vein thrombosis, with potential to expand the menu of available services.

Robert Bartley's (QSM) wife Anne (centre) and family honour his legacy at the launch of the Robert Bartley Foundation Health Bus in October 2021

MAHI WHAKARITERITE

OUR OVERVIEW OF PERFORMANCE

BOARD CHAIR'S REPORT

Tēnā koutou katoa.

This 2020/21 Annual Report sets out the achievements of the Whanganui District Health Board on delivering against its strategic direction of He Hāpori Ora Thriving Communities. The past year has not been without its challenges with the continued pressures from COVID-19, the increasing financial pressures on district health boards and the Health and Disability System reform changes. It has been pleasing to work with the board and the executive of Whanganui District Health Board to ensure that despite these challenges, we have been able to continue service delivery, come in on the agreed budget and strengthening our community relationships to support the delivery of He Hāpori Ora Thriving Communities.

I would like to firstly acknowledge some of the losses the team have endured this year with the passing of both Paul Malan and Mal Rerekura. I know the team truly valued their input into the organisation, and I applaud the way in which the organisation pulled together to support one another through those periods of grief.

Moving forward in the 2021/22 year, we will be impacted by the reform changes announced this year by the Honourable Minister Little. These changes are set to create a new model for healthcare delivery that has not been presented with such wide-ranging changes in a generation. This gives us the opportunity to shift the pendulum of health and illness to health and wellness. A shift to more prevention models, working closer with our partners in care and more especially our people, and working together to ensure our services are provided in an equitable manner. It is about shifting the balance from focusing on equitable distribution of services to equitable outcomes from delivery. It is no longer acceptable to have a post-code system and the reforms are set to challenge and change this.

However, this is not new to Whanganui District Health Board, and embedding of the 'He Hāpori Ora Thriving Communities' strategic direction set by the Board has enabled our district health board to be on the recommended path towards Pro-Equity, Social Governance and Healthy at Home – Every Bed Matters (69,000 beds) for the past two years. This direction continues to be the guiding light for decision making and has enabled programmes of work such as the Waka Hauora, the Impact Collective - Rangitikei, Ruapehu, South Taranaki and Whanganui, the Ruapehu Wellness Centre, Te Rito Vaccination and Wellbeing Centre and cross-sector collaboration enabling the best flu vaccination delivery (particularly for Māori) in the country, to become achievable service delivery models.

This year we have reflected upon the importance of relationships in ensuring Whanganui District Health Board is placing our communities in the best position in the post reform environment. We have recommitted our relationship with our Māori/Iwi relationship board Hauora ā Iwi and have had an opportunity to collate the various partnered programmes of work we have worked on as a rohe to present to the Department of Prime Minister and Cabinet. This exercise truly emphasised that addressing health in the wider Whanganui District Health Board rohe is only achieved through the collective efforts of many.

I was pleased to be able to welcome Mary Bennett to the Board this year as its final appointed member. Mary sat as the Chair of Hauora ā Iwi through this year, and although is stepping aside from this role, is able to bring a unique perspective to the board which is certainly valuable in these times of change.

I would like to take the time to thank the Board for providing continued governance to the Whanganui District Health Board and to Russell Simpson Kaihautū Hauora Chief Executive for providing strong leadership to the organisation to enable it to support the delivery of our He Hāpori Ora Thriving Communities strategic direction. Finally, to all of our staff, thank you all for the tremendous effort you put into your work on a daily basis. Without each one of you contributing to the whole, we would not be able to function in the way that we do – with strength in numbers and a commitment to our communities.

Ngā Mihi,

Ken Whelan
Toihau - Whanganui District Health Board Chair

CHIEF EXECUTIVE'S REPORT

Tēnā koutou katoa

The 2020-21 year provided a number of challenges for Whanganui District Health Board as a result of local health, social, financial and political systems being tested by the COVID-19 pandemic. We have supported delivery of the largest vaccination programme in a generation across our rohe, ensuring our frontline teams and our most vulnerable populations are vaccinated. The COVID-19 vaccination rollout afforded the opportunity for Whanganui District Health Board to lean into our existing strong community relationships with our primary care and Māori/iwi health providers to deliver and lead the country in the vaccination programme. This is a testament to the quality of the relationships across the rohe with our partners in care, preparing and partnering closely with our communities to ensure that together we can build resilient communities, empowering whānau and individuals to determine their own wellbeing.

While COVID-19 remains a threat, we have embedded the learnings from our response to COVID-19. The Integrated Recovery Team used the successful model undertaken for our growing collective wellbeing insight report to capture a community-wide co-design approach. We undertook a series of more than 150 community focus group engagements to understand what health and wellbeing meant to our communities. Through this engagement, we have transitioned these into longer term programmes of work – such as the formation of the Impact Collective - Rangitīkei, Ruapehu, South Taranaki and Whanganui, where local governance support local solutions to local issues. This collective governance team is a clear example of how crown agencies, communities and providers can work together to ensure their communities thrive – focused on addressing social, economic and environmental factors that contribute to an individuals, whānau, hapū and community wellbeing. This type of collective solutions focus has enabled the opening of our Te Rito Vaccination and Wellbeing Centre in Whanganui, which is providing vaccination roll-outs as well as community wellness clinics (such as catch up MMR immunisations).

The release of the Health and Disability Systems Review decision by the Honourable Minister Little has provided a look into the future of healthcare in Aotearoa New Zealand. The decision document identified that a greater focus on the communities, more equitable service delivery and working together across the system is required in the delivery of the new operating model for health in the future. As Kaihautū Hauora of the Whanganui District Health Board, it is pleasing to note the alignment of our He Hāpori Ora Thriving Communities strategic direction set by the Board with the review decisions, has enabled our district health board to be on the recommended path towards Pro-Equity, Social Governance and Healthy at Home – Every Bed Matters (69,000 beds) for the past two years and we have embedded collective practices, with our partners in care, to support delivering on these strategic focus areas alongside our communities.

Whanganui District Health Board unfortunately lost a valued member of our executive team, Paul Malan, who died suddenly during the year. Paul's contribution to the District Health Board and its community cannot be understated and has left us with a void where Paul once stood. Furthermore, our team sadly lost a pillar of our Te Hau Ranga Ora team with the passing of Mal Rerekura in May. Mal had been an integral part of teaching all new employees about Whanganui tanga and supported the organisation through educating and participating in tikanga and reo. Mal's contributions to his iwi and his work at the Whanganui District Health Board are truly missed. Through these challenging times, it is important to acknowledge those that supported the teams and continued the work on behalf of the District Health Board – it is truly appreciated.

Along with Paul's and Mal's passing, we also sadly lost an esteemed community member this year, with Robert Bartley losing his battle with cancer in March. Whanganui District Health Board, alongside his foundation (the Robert Bartley Foundation) continues to help establish health initiatives he identified to enable Whanganui and the wider community access to healthcare services. The first initiative under development is the Waka Hauora – Mobile Health Clinic. Through the donation of a library bus by Whanganui District Council, the team have supported the foundation to retrofit the bus to enable delivery of vaccination, immunisation and screening programmes, as well as general health check-ups, to our most remote and vulnerable communities.

In a year where we have had increased pressures on our hospital system as a result of increased patient volumes, undertaking additional planned care commitments as a result of the COVID-19 period and greater seasonal demand, it was pleasing to see that through the contributions of the team, Whanganui District Health Board was able to finish the financial year within our agreed budget, excluding Holiday Act compliance costs.

I would like to thank Board chair, Ken Whelan, for his continued leadership, direction and sound judgment, navigating a period of uncertainty with the reform announcements and the efforts in addressing COVID-19. To the current Board members, thank you for your continued support. I would like to thank Mary Bennett for her support this year and as she stands down from the Hauora ā Iwi chairperson position, we welcome Sharlene Tapa-Mosen as our new chairperson. To all of the members of Hauora ā Iwi, thank you for your commitment to improving the health outcomes for Māori across our rohe and for your partnership as we progress as a pro-equity organisation. To our primary health organisations, the Whanganui Regional Health Network and National Hauora Coalition, the leadership and partnership that has been shown from your teams in the response to COVID-19, the vaccination roll-out and the proposed functional changes as a result of reforms is greatly appreciated.

Finally, a special thanks to my executive leadership team and the wider Whanganui District Health Board team. The 2020-21 period has shown the strength of leadership required by health to continue to address the impacts of COVID-19 and maintain high quality health services to our community. The 2021-22 year is going to present its own challenges and opportunities with the implementation of the Health and Disability Systems transition stages, continued pressures on the Whanganui District Health Board in terms of volumes and financial pressures, however, through our ongoing commitment to supporting He Hāpori Ora Thriving Communities, working with our partners in care and strengthening our community and iwi/Māori relationships, we will together, put the communities within the Whanganui District Health Board rohe in the best position for the future.

Ngā Mihi

Russell Simpson
Kaihautū Hauora - Whanganui District Health Board Chief Executive

HAUORA Ā IWI - MĀORI RELATIONSHIP BOARD

Our relationship with iwi is strong and continues to grow through the partnership board, Hauora ā Iwi, which has advised and worked with the Whanganui District Health Board and committee members contributing to strategic development, annual and regional planning, performance monitoring, quality and risk 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 2021, the members of Hauora ā Iwi are:

- **Whanganui:** Te Aroha McDonnell Tamaūpoko and Sharlene Tapa-Mosen ,Tūpoho
- **Ngaa Rauru Kiitahi:** Mary Bennett (Chair) and Wheturangi Walsh-Tapiata
- **Ngā Wairiki Ngāti Apa:** James Allen and (Dr) Cherryl Smith
- **Mōkai Pātea:** Barbara Ball and Maraea Bellamy
- **Ngāti Hauiti:** (Dr) Heather Gifford
- **Ngāti Rangi:** Hayley Robinson

'Ohinepani landing. Above the silence' - Charles Ranginui

HAUORA Ā 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.

We have had a period of stability around our Hauora ā Iwi table with all Iwi representatives holding office for the full year. Pro-equity remains top priority for us and we continue to challenge the Whanganui District Health Board to ensure a fair and just health service and response for our people.

COVID-19 impacts and lessons learned
Last year Hauora ā Iwi commissioned a piece of research to better understand the impacts of the COVID-19 lockdown on our communities. Some key findings told us that:

- "It's not over yet" and "safe practices" must continue
- Equity remains high on the agenda, and we must continue to work with others to jointly address this issue
- Iwi leadership is critical, and that leadership is trusted by our people
- Relationships allowed us to be flexible, agile and proactive in addressing issues
- Relationships and collaboration were key, from our partnership with Whanganui District Health Board to working alongside Police and Councils, and liaising with local social service providers.

Covid-19 vaccine rollout
Hauora ā Iwi has continued to join forces with Whanganui District Health Board as part of the Covid Vaccination roll-out project, advocating for priority to be given to our most vulnerable; kaumātua living alone or with whānau; Māori aged 50 years and over; Iwi led vaccination clinics; with delivery being based on a whānau centred approach that reaches all those over 16 in the same household rather than just the person who meets the criteria defined for the Groups set by the Ministry of Health. Iwi Provider led COVID Vaccination clinics are operating successfully and further site specific COVID clinics are planned. Negotiation on location of pop-up clinics is underway to ensure easy access to vaccinations and immunisations for our rural and remote communities.

Appointment to Whanganui District Health Board
Hauora ā Iwi congratulate Mary Bennett on her Ministerial appointment as the second Māori representative on the Board of Whanganui District Health Board. Mary accepted her appointment on the eve of the announcement of the health reforms. She has been our Hauora ā Iwi Chair for the past five years and during that time she has led and represented Hauora ā Iwi with strengthening our relationship with the Board and executives of Whanganui District Health Board, renegotiations of the Memorandum of Understanding, development of He Hāpori Ora Thriving Communities Strategy Document 2021-2023, presentation of numerous annual plans and reports; and engagement with the Emergency Operations Centre during and post COVID-19 lockdown 2020. Hauora ā Iwi wish to acknowledge and thank Mary for her significant contribution as chair.

In order to reduce any conflict between roles, Hauora ā Iwi has recently appointed Sharlene Tapa-Mosen as Chair. We congratulate Sharlene on her appointment and look forward to supporting her in her role over the next year. This will be a time of challenge and opportunities as we transition to a new mode of governance and service delivery.

Health Reforms and He Hāpori Ora - Thriving Communities Strategy Document 2021-2023
The He Hāpori Ora Thriving Communities strategy was launched in 2020. For Hauora ā Iwi, He Hāpori Ora is one of the foundations for the local level transformational change contemplated in the recently announced Health Reforms.

The strategy allows some flexibility in the creation and implementation of community led solutions and models of care that better meet the needs of our people.

We are excited about the proposed extended role of the Iwi Māori Relationship Boards and will work to ensure all our Iwi continue to be represented at a local and regional level.

Iwi Health Providers
In closing another year Hauora ā Iwi wish to acknowledge the hard work and commitment from our Iwi Health Providers. It has been a busy year and our kaimahi have been tireless in their dedication to serving our people. Regardless of where you work within the health system, Hauora ā Iwi offers thanks and gratitude for all that you do for the wellbeing of our people and the wider community.

Nā,
Hauora ā Iwi

Whanganui District Health Board
Annual Report 2020 / 21 | 13

CHIEF FINANCIAL OFFICER'S REPORT

Whanganui District Health Board recorded a deficit of $4.8 million in 2020/21, an improvement of $10.6 million compared to the 2019/20 deficit of $15.4 million. The 2020/21 result does include $2.03 million of Holiday Act Compliance costs (2020: $2.8 million). The total provision for the remediation of the Holiday Act now stands at $8.9 million which is now expected to start to be paid out to employees (current and past) in 2022.

Compared to budget, the deficit is higher by $1.6 million against budgeted deficit of $3.3 million. Excluding the movement in the Holiday Act remediation costs, the Whanganui District Health Board achieved its operating budget - an excellent result given the exceptional circumstance the health service had to face during the COVID-19 pandemic. Whanganui District Health Board also completed a number of initiatives during the year to control costs and thus achieve a significantly improved deficit in 2020/21.

Compared to 2019/20, actual revenue grew by $24.9 million (8.9%) to $304.6 million, enabled the continued delivery of much-needed services to our community. Population-based finding increases is due to population growth and additional funding for underline costs pressure.

Actual costs grew by $14.4 million (4.9%) to $309.5 million. In a year with continued pressure to meet the service demand, it was pleasing to limit the increase in operating costs to 4.9%. The main increase was in personnel costs due to growth in acute inpatient activity and the impact of the national multi-employer collective agreement wage settlements and inter-district outflow inpatient service price uplift.

Investment in regional health information systems projects has slowed, with the regional network now operationally focused and maintaining existing regional systems. A further $0.4 million (2020: $2.2 million) was invested in clinical equipment and facilities.

Cash position at year-end was $1.4 million overdraft, which is $5.2 million less than the 30 June 2020 cash position of to $3.8 million. The decline in the cash position was due increased investment in property, plant, equipment and intangible assets of $3.6 million and the prior year IDF wash-up payment of $1.6 million.

To maintain financial viability in 2020/21, the Board will need to access its available bank overdraft facility funding of up to $13 million.

An independent revaluation of land and buildings was completed at 30 June 2021. This has resulted in a $1.0 million (40.98%) increase in the carrying land value and a $7.68 million (11.69%) increase in the carrying value of buildings. The building carrying value increases have added $0.3 million in additional depreciation expenses to 2021-22 financial year.

Andrew McKinnon
General Manager Corporate (Chief Financial Officer)

	2021 Actual	2021 Budget	2020 Actual
Revenue			
Revenue	304, 613	298, 972	279, 679
Expenses			
Personnel costs (including outsourced, excluding Holiday Act remediation costs)	(109, 163)	(106, 182)	(104, 425)
Outsourced service	(7, 854)	(7, 779)	(7, 502)
Clinical and infrastructure & non-clinical supplies	(45, 201)	(43, 612)	(42, 466)
Other health provider	(98, 225)	(96, 460)	(92, 623)
Inter-district outflow	(46, 989)	(48, 189)	(45, 247)
Expenses (excluding Holiday Act remediation costs)	**(307, 432)**	**(302, 222)**	**(292, 263)**
Deficit before Holiday Act remediation expense	**(2, 819)**	**(3, 250)**	**(12,584)**
Expense - Holiday Act remediation costs	(2, 028)	-	(2, 820)
Deficit	**(4, 847)**	**(3, 250)**	**(15, 404)**

FINANCIAL SUMMARY

The 2020/21 financial result of $2.8 million deficit before considering Holiday Act Compliance costs is in line with the budgeted deficit of $3.3 million. Including Holiday Act Compliance costs the result is $1.6 million adverse to budget. Explanations of major variances against budget are provided in Note 21.

Revenue breakdown

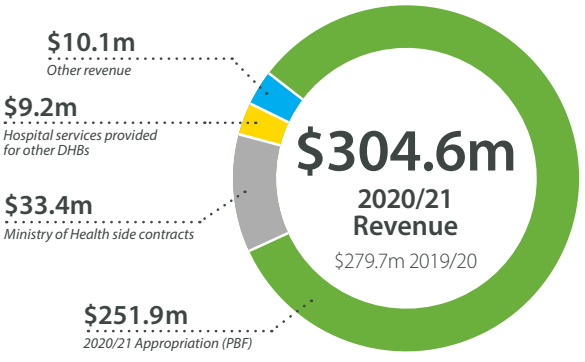
Revenue for the year of $304.6 million was $24.9 million or 8.9% higher, when compared with prior year revenue of $279.7 million.

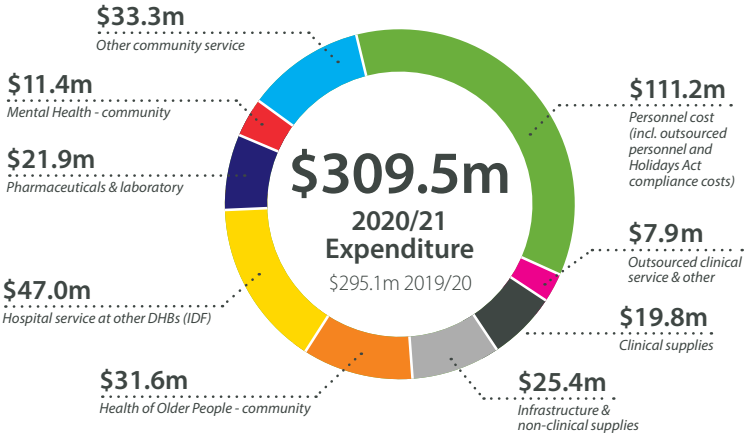
- Population-based funding was $21.1 million or 9.1 % higher than the prior year.
- Ministry of Health side contracts were $1.3 million higher than prior year, this higher revenue was passed on to other health providers.
- Elective initiative funding was $0.6 million higher than the prior year due to an increase in annual funding to improve access to care.
- COVID-19 pandemic funding was $1.6 million lower, due to prior year funding for Clinical base assessment centre (CBAC), suitability funding for Maori health, health of older people, General practice (GP) and primary care.
- Accident Compensation (ACC) revenue was $1.3 million higher than the prior year due to the adverse impact of COVID-19 pandemic on prior year ACC revenue.
- Other District Health Board was $0.8 million higher than prior year due to adverse impact of COVID-19 pandemic on prior year revenue.

Expenditure breakdown

Expenditure for the year of $309.5 million was $14.4 million or 4.9% higher, when compared with the prior year expense of $295.1 million.

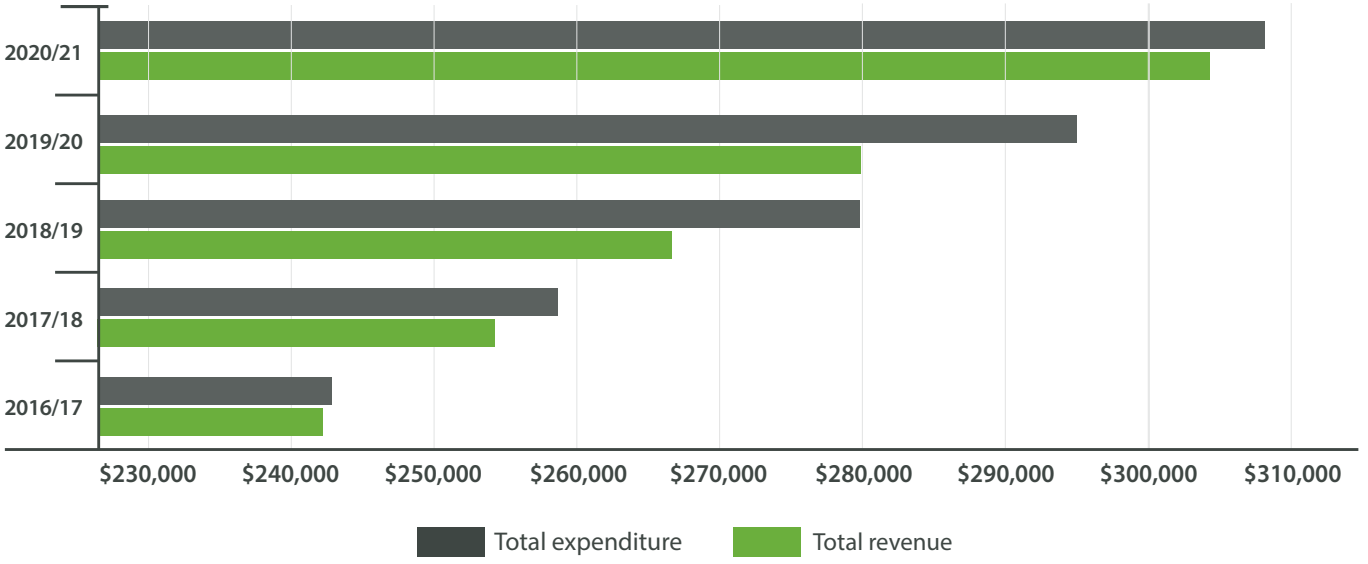
- Personnel costs (including outsourced and excluding Holiday Act costs) were $4.7 million or 4.5% higher than the prior year, due to growth in acute inpatient activity, increases in the multi-employer collective agreement and additional fulltime equivalents recruited for COVID-19 vaccination programme.
- Outsourced service costs were $0.4 million or 4.7% higher, than the prior year, due to high ACC contracted expenditure (offset by higher ACC revenue).
- Clinical supplies, infrastructure and non-clinical supplies were $2.7 million or 6.4% higher than the prior year, due to prior year lockdown has impact on cancellation of the some of the service resulted in lower theatre consumables, wards consumables and patient travel costs. A rise in wage rate increases the costs of renewal of facility contract.
- The purchase of services from other health board providers was $5.6 million or 6.0% higher than the prior year, due to increased spend on pharmaceutical, health of older people, mental health additional contracted service, primary care capitation and price uplifts - this was partly offset by additional funding received for primary care capitation and mental health.
- Inter-district outflow to other district health boards were $1.7 million or 5.2% higher than the prior year, primarily due to price uplifts inpatient service by 6.3%.
- Holiday Act compliance - Refer to Note 15 in the financial statements.



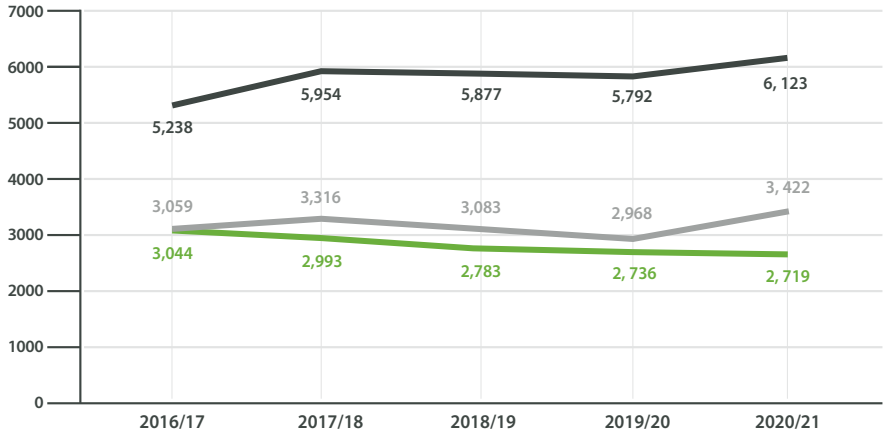


Total revenue & expenditure

(in thousands of New Zealand dollars)



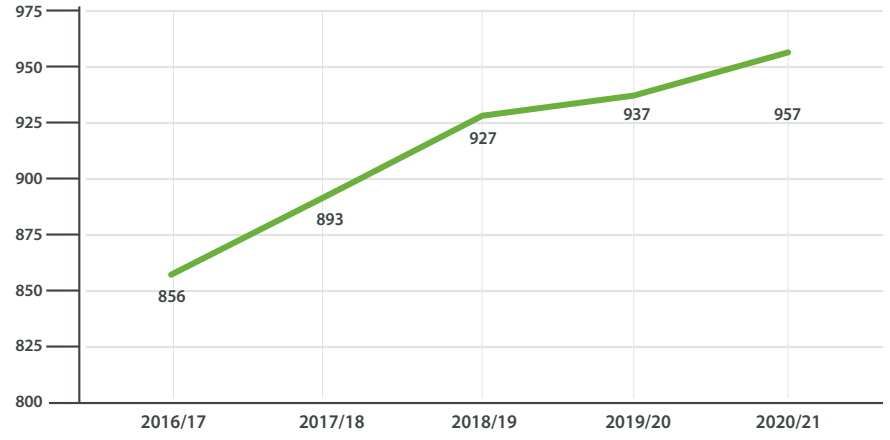
Inpatient Caseweight volume - Elective & Acute



Overall inpatient case-weight volume was 6.7% higher than compared to prior year volume, mainly due to impact of COVID-19 pandemic outbreak on prior year service. Acute medical volumes increased by 5.7% and Elective Surgery volumes increased by 15.3%.

Acute Medical
Acute surgical
Elective surgical

Full time Equivalents (FTE) trend



Fulltime equivalents (FTE) were 2.1% higher when compared to prior year. Nursing FTE increased due to additional FTE recruited for COVID-19 vaccination programme and to meeting the care capacity and demand management (CCDM) of high clinical need, medical personnel is due to recruitment of the vacant positions. Compared to prior year and the vaccination programme has added six additional FTE.

Full time equivalents (FTE)

WHAT WE PROVIDED IN 2020/21

PROVIDER DIVISION (Whanganui Hospital and Waimarino and Rangitikei Rural Health Centres)

22,417
PATIENTS THROUGH EMERGENCY DEPARTMENT
2019/20: 21,163

8,742
INPATIENT STAYS
2019/20: 8,356

3,887
OPERATIONS
2019/20: 3,558

52,560
RADIOLOGY TESTS
2019/20: 54,688

957
FULL TIME EQUIVALENT (FTE) STAFF
2019/20: 937

254
NEW INPATIENT ADMISSIONS TO MENTAL HEALTH
2019/20: 257

50,678
SPECIALIST OUTPATIENT APPOINTMENTS*
2019/20: 45,558

$101m
TOTAL WAGE BILL
2019/20: $98m

732
BIRTHS IN WHANGANUI HOSPITAL/RURAL HEALTH SERVICE
2019/20: 705

SUPPORTED **170**
PEOPLE WHO DIED IN HOSPITAL
2019/20: 185

2,931
ALL ELECTIVE SURGICAL OPERATIONS*
(WITH ANAESTHETIC)
2019/20: 2,681

956
ALL ACUTE EMERGENCY OPERATIONS*
(WITH ANAESTHETIC)
2019/20: 877

217
PEOPLE HAVING MORE THAN 3 ACUTE ADMISSIONS
2019/20: 184

COVID-19 PANDEMIC

7,689
ATTENDANCE
AT ASSESSMENT CENTRE
2019/20: 6,069

8,365
SWABS TAKEN
2019/20: 4,724

0
POSITIVE CASES
ALL RECOVERED
2019/20: 9

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

TE RŌPŪ WHAKAHAERE

OUR ORGANISATION

PURPOSE & OBJECTIVES

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

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

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

ii. Funding and purchasing health and disability services

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

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

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

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

SERVICE AND BUSINESS PLANNING DIVISION

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

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

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

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

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

PROVIDER DIVISION (Whanganui Hospital/Rural Health Centres)

The Provider Division provides secondary and community specialist health services. These secondary level services include:

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

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

CORPORATE SERVICES DIVISION

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

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

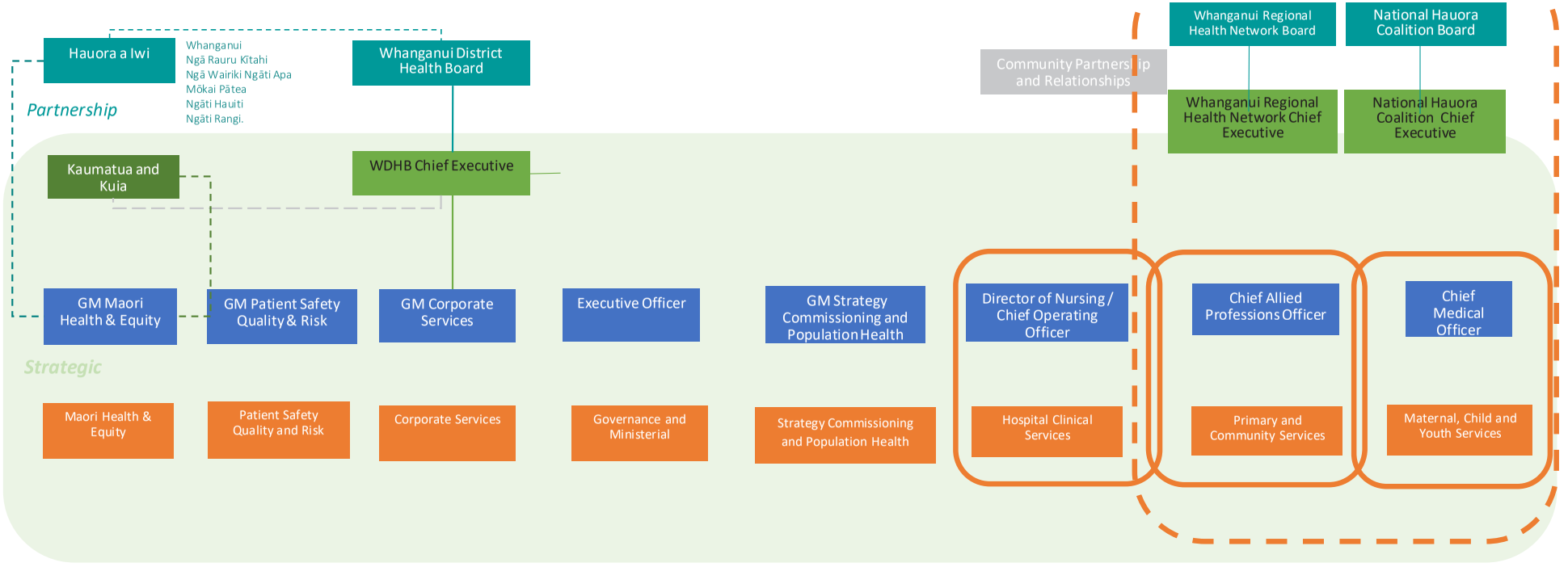
There are a number of other functions that are directly responsible to the chief executive officer and provide a service across both the Strategy Commission and Public Health divisions. These include media and communications, human resources and industrial relations.

CORPORATE GOVERNANCE

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

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

WHANGANUI DISTRICT HEALTH BOARD ORGANISATIONAL STRUCTURE as at 30 June 2021



KEY

- Chief Executive
- Executive
- Senior Clinical
- Senior Manager
- Executive Assistant
- Personal assistant
- Responsibility area

Coloured solid is direct reporting line

Coloured dotted is professional reporting line

Grey dash is functional relationship

COMMUNITY PARTNRESHIP RELATIONSHIPS

- District Councils
- Regional Councils
- Te Puni Kokiri
- Office of Treaty Settlements
- Iwi/Maori Provider Organisations
- Healthy Families
- Safer Whanganui
- Ruapehu Whanau Transformation
- Oranga Tamariki
- FLOW

ROLE OF THE BOARD

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

THE BOARD

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

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

BOARD COMPOSITION AND SIZE

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

HAUORA Ā IWI

Whanganui District Health Board has a legislative requirement to build and maintain relationships with iwi Māori under section 4 of the New Zealand Public Health and Disability Act 2000. Hauora ā Iwi has been established by Whanganui District Health Board to contribute to advancement of Māori health outcomes and 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 function 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 2020/21 financial year.

The iwi represented on Hauora ā Iwi are:

- Tūpoho/Whanganui
- Ngā Wairiki Ngāti Apa
- Ngāti Hauiti
- Ngāti Rangi
- Ngaa Rauru Kiitahi
- Mōkai Pātea
- Tamaūpoko Whanganui

The Mana Whenua Agreement between Hauora ā Iwi and Whanganui District Health Board 2020-22 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.

Hauora ā Iwi partnered with the Board to develop and agree the strategy document He Hāpori Ora Thriving Communities 2020-23. The aims and objectives of the strategy extend the overarching aims of the Mana Whenua Agreement 2020-22.

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

CONDUCT OF BOARD BUSINESS

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

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

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

CONFLICT OF INTEREST

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

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

ACCESS TO INFORMATION

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

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

CORPORATE ASSURANCE

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

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

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

RISK MANAGEMENT

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

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

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

Key areas of focus for the committee include:

Risk framework and monitoring risk

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

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

Monitoring health and safety

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

External and internal audit assurance programme, internal control systems

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

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

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

Monitoring clinical governance, patient safety and privacy

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

Monitoring external provider performance

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

Emergency management readiness and business continuity

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

Monitoring fraud and corruption

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

THE COMMITTEES

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

There are two standing committees:

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

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

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

The structure and membership of the Board and its committees is summarised in the following tables.

Committees of the Whanganui District Health Board as at 30 June 2021

Chair	Board members	External members	Functions
Combined Statutory Advisory Committee			
Annette Main	Charlie Anderson Graham Adams Phillipa Baker-Hogan Josh Chandulal-Mackay Ken Whelan Soraya Peke-Mason	Frank Bristol Heather Gifford Te Aroha McDonnell Maraea Bellamy Deborah Smith Christie Teki Hayley Robinson	Assess health needs, disability support needs and health status of the resident population. Advise the board on health funding priorities and promote policy that maximises gains, and improves equity, in health outcomes. Annual purchasing plan and framework as part of business planning. Monitor financial and operational performance of the hospital and related services. Assess strategic issues and governance policy relating to provision of hospital services.
Finance, Risk and Audit Committee			
Talia Anderson-Town	Stuart Hylton Judith MacDonald Ken Whelan	Anne Kolbe Matthew Doyle Mary Bennett	Clinical and business risk management framework including compliance and internal controls. Integrity of Financial Statements and Statement of Performance. Relationship with external auditor.

BOARD & COMMITTEE MEMBER ATTENDANCE RECORD

1 July 2020 to 30 June 2021

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

	Board	Combined WDHB & HAI	Combined Statutory Advisory Committee	Finance, Risk and Audit Committee
Number of meetings held	**6**	**2**	**4**	**6**
Board members				
Mr Ken Whelan (Board Chair)	**5**	**1**	N/A	**5**
Annette Main (Deputy Board Chair)	**6**	**1**	**4**	N/A
Stuart Hylton	**6**	**1**	N/A	**4**
Philippa Baker-Hogan	**4**	**1**	**3**	N/A
Judith MacDonald	**3**	**1**	N/A	**6**
Graham Adams	**6**	**2**	**4**	N/A
Charlie Anderson	**5**	**2**	**3**	N/A
Talia Anderson-Town (FRAC Chair)	**5**	**1**	N/A	**6**
Josh Chandulal-Mackay	**6**	**0**	**4**	N/A
Soraya Peke-Mason	**2**	**0**	**3**	N/A
Mary Bennett (from April 2021)	**2**	**2**	N/A	**5**
External committee members				
Anne Kolbe			N/A	**2**
Matthew Doyle			N/A	**5**
Maraea Bellamy			**1**	N/A
Frank Bristol			**1**	N/A
Heather Gifford			**3**	N/A
Christie Teki			**4**	N/A
Te Aroha McDonnell			**4**	N/A
Deborah Smith			**4**	N/A

	Hauora ā Iwi
Hauora ā Iwi	**9**
James Allen	**7**
Barbara Ball	**8**
Maraea Bellamy	**8**
Mary Bennett	**9**
Heather Gifford	**9**
Te Aroha McDonnell	**9**
Hayley Robinson	**9**
Cherryl Smith	**8**
Sharlene Tapa-Mosen	**6**
Wheturangi Walsh-Tapiata	**7**

OUR BOARD

KEN WHELAN | *Toihau - Board chair*

"My clinical background is in nursing but I've been in executive management for more than 25 years. Overall, I have had more than 40 year's experience in both the New Zealand and Australian health sectors.

"Currently I'm Crown Monitor Waikato District Health Board and am on a couple of other boards. I am also part of the lead faculty providing health executive leadership programmes in Australia. Previously I was chief executive of Northland and Capital Coast District Health Boards and deputy director general of health performance and purchasing in New South Wales. In Queensland I was chief executive of the Townsville health district, a large tertiary facility in north Queensland where the population was spread over a large geographical area which meant equity of access to care was a significant challenge.

"Prior to returning to New Zealand, I was chief executive of Metro North in Brisbane which is the largest provider Health service in Australia with an annual budget of $3.5 Billion."

ANNETTE MAIN | *Deputy board chair*

"Joining the Whanganui District Health Board in October 2017 has given me the opportunity to share the knowledge and understanding of our community gained during my six years as Whanganui's mayor.

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

GRAHAM ADAMS

"I was first elected to the district health board in 2004 and served 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 the Chair of Trustees of the Akoranga Education Trust whose "raison-d'etre" is to provide scholarships for students of the Whanganui district who are studying at UCOL."

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 second-term district health board member, I am also a third-term district councillor."

TALIA TIORI ANDERSON-TOWN

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

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

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

PHILIPPA BAKER-HOGAN

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

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

MARY BENNETT

"Ko Ngaa Rauru Kiitahi, Ngāti Tuwharetoa me Te Atihaunui-a-Pāpārangi nga Iwi. Ko Mary Bennett tōku ingoa.

"My career spans over 20 years experience in the Pubic sector. I became involved in Iwi governance in 2014 and hold positions on the Paepae (Board) of Te Kaahui o Rauru, Board of Te Oranganui Trust and Hauora ā Iwi, the Iwi Relationship Board to the Whanganui District Health Board. It is these connections and conversations I bring to the Board table.

"I was appointed to the Board on the eve of the health reforms announcement which signalled the introduction of significant changes in the health sector. I am excited by the challenges and opportunities the health reforms offer, and to be a part of leading system changes which better meet the needs of our people; quality health services that are both easy to access and affordable '...having the right people, providing the right services, in the right place, at the right time, and in the right way...' "

JOSH CHANDULAL-MACKAY

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

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

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

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 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, and Gonville Health Ltd. My family and I have lived in this district all our lives and it is important to me that we have a range of quality health services for our people."

SORAYA PEKE-MASON

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

It was humbling to be appointed to the Board in December 2019. I come from many years' experience in politics, private enterprise, Iwi, community and land development. As Māori this appointment is timely as we move through health reforms and health outcome inequities. Health services are critical to the social wellbeing, strength and harmony of any community. This includes meeting and addressing the health needs of our communities.

Sitting on Whanganui District Health Board provides a pathway where life experiences can contribute towards advocating for best practice health services and future of our communities. We need good policies and programmes that meet and address their needs. Programmes that reduce disparities and inequality, are accessible and inclusive particularly for Māori. At the same time, we can foster and learn from places that are healthy and vibrant.

I spent many years working in Australia returning home in 2000. I gravitated towards local and central government politics spending 12 years elected member of Rangitikei District Council. Work takes me across Whanganui, Ruapēhu and Rangitīkei regions.I want our communities to be strong and vibrant that live in harmony with each other, where diversity is celebrated, people feel safe, valued and know where to go for good health services.

OUR EXECUTIVE LEADERSHIP TEAM

RUSSELL SIMPSON | *Kaihautū Hauora - Chief Executive*

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

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

NADINE MACKINTOSH | *Executive Officer*

"I am of Ngāti Hineuru, Ngaa Rauru Kiitahi and Ngāti Ruanui decent, and am a highly accomplished and experienced executive officer with more than 10 years experience supporting chief executives, boards, chairpersons, and high-level leaders within the health sector. I have been supporting the office of the chief executive at the Whanganui District Health Board since 2018, having previously served as the board secretary across the Wairarapa, Hutt Valley and Capital and Coast District Health Boards.

"Having previously worked across the private sector with experience in the agriculture, education, professional services and investment banking sectors, my role contributes to the successful operations and governance of the Chief Executive's Office and the Whanganui District Health Board."

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

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

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

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

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

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

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

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

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

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

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

ALEX KEMP | *Director Allied Health Scientific and Technical*

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

"My passion is to ensure Whanganui District Health Board continues to work with the community and within the community to empower people to take charge of their own health. DHBs are part of a wider health system and we need to work with others to ensure we give the greatest benefit to its users. I am passionate about reducing inequity for Māori and ensuring we honour Te Tiriti o Waitangi in all we do."

ROWENA KUI | *Kaiuringi Māori Health and Equity*

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

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

IAN MURPHY | *Chief Medical Officer*

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

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

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

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

PAUL MALAN (Deceased) | *General Manager Service and Business Planning*

Paul Malan was General Manager Service and Business Planning from September 2018 until his untimely death in April 2021.

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

Paul's academic training was in economics and public health which complemented his interest in the public sector role in a well-functioning, developed economy. Paul was 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.

Paul grew up in a rural community in Zimbabwe and always admired the ingenuity evident in small communities with a strong identity – he felt a sense of those factors in Whanganui. Paul's wife grew up in Hastings and they returned to Aotearoa New Zealand with their two sons in 2001.

TE HUNGA ORA

OUR PEOPLE

WORKFORCE PROFILE

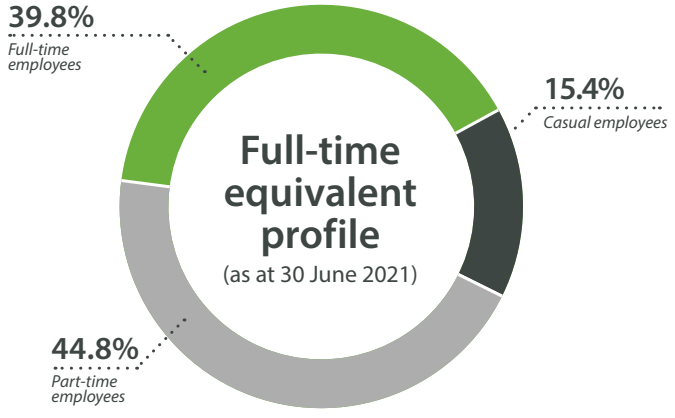
Whanganui District Health Board's workforce is made up of Medical (9.9%), Nursing & Midwifery (52.6%), Allied Health (17.7%), Administration/Management (18.5%) and Support (1.9%) employees.

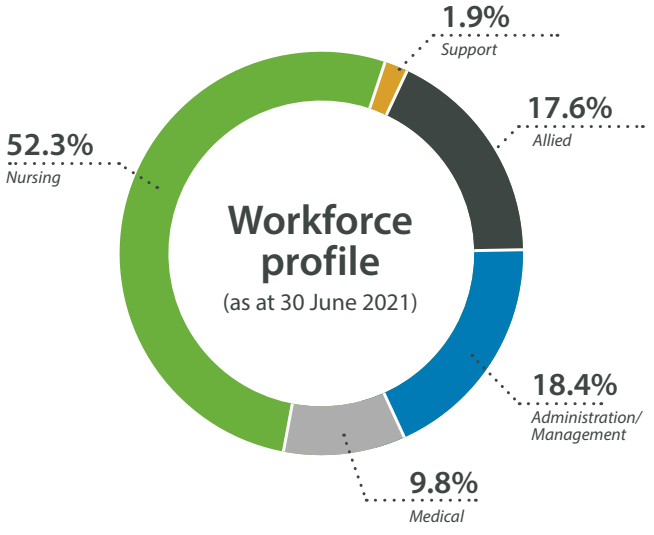
Whanganui District Health Board enjoys a stable employee complement with an average length of employee service of 9.74 years. The organisational employee turnover was 7.8 % for the financial year.

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

Notes:

- Report includes: permanent and temporary employees
- Report excludes: Casual employees
- Full-time Equivalent (FTE) = 875.28
- Headcount = 1044





AGE PROFILE

Age band	Count	Percentage
20-29	140	13.4%
30-39	184	17.7%
40-49	225	21.6%
50-59	283	27.2%
60-69	199	19.1%
70+	10	1.0%

MEDIAN AGE PROFILE

Median female age	48 years
Median male age	51 years

GENDER PROFILE

Gender	Count	Percentage
F	847	81.4%
G	1	0.1%
M	193	18.5%

ETHNICITY PROFILE

NZ European/Pakeha	49.4%
European	16.0%
Māori	12.7%
Asian	10.3%
Other	7.4%
African	2.3%
Pacific	1.0%
Middle Eastern	0.2%
Latin American	0.3%
Not stated	0.5%

DISABILITY PROFILE

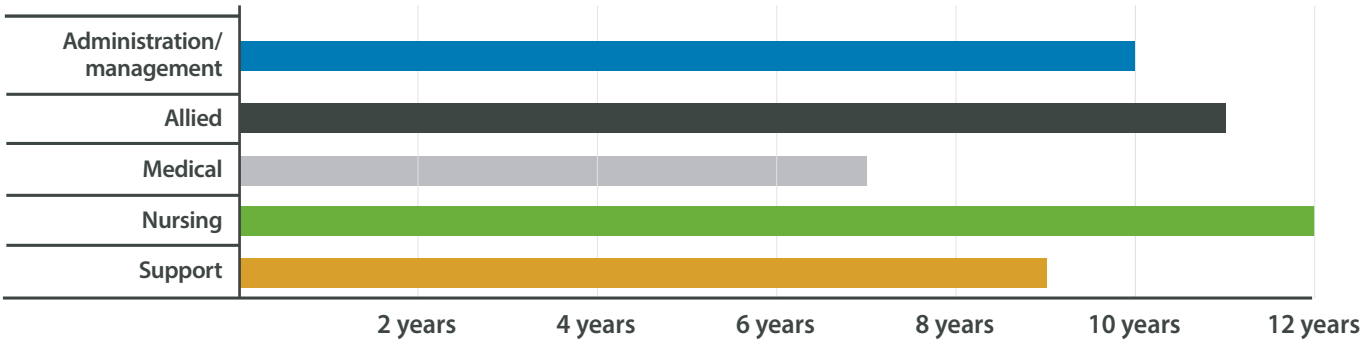
Employees	Percentage
12	1.2%

GENDER BY OCCUPATIONAL CATEGORY

Occupational category	F	G	M
Administration/ Management	161	-	30
Allied	158	-	24
Medical	41	-	62
Midwifery	22	-	-
Nursing	451	1	71
Support	15	-	6

Service profile

(as at 30 June 2021) - Total Average Service 9.80 years



ETHNICITY PROFILE BY OCCUPATIONAL CATEGORY

Occupational category	African	Asian	European	Latin American	Māori	Middle Eastern	NZ European	Pacific	Other	Not stated
Administration /Management	5	8	27	-	23	-	109	2	17	-
Allied	3	9	25	2	25	-	105	2	10	1
Medical	10	24	40	1	-	2	8	1	13	4
Midwifery	-	-	8	-	2	-	11	-	1	-
Nursing	6	65	66	-	77	-	269	5	35	-
Support	-	1	1	-	5	-	12	-	1	-

GENDER PAY GAP

	Female	Male
Median	$77,386	$85,375
Gender pay gap	9.36%	

ETHNICITY PAY GAP

	Asian	Māori	Pacific	Other
Median	$77, 636	$65, 652	$76, 259	$77, 386
Pay gap	-0.32%	15.16%	1.46%	

NATIONALLY & REGIONALLY

Whanganui District Health Board works collaboratively with the five other District Health Boards in the Central Region (MidCentral, Capital & Coast, Hawkes 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. As a DHB, the greatest percentage of our operational costs relate to our workforce. Investing time and resources in our people, collectively and individually is a priority.

COVID continued to disrupt some of the 2020/21 year's planned activities, however a collective national District Health Board response and local district integrated social governance framework minimised the impact on service delivery that results from matters such as pandemics.

We are committed to working with Māori/iwi and our community and the Impact Collective Rangitīkei, Ruapehu, South Taranaki and Whanganui supports Whanganui District Health Board's Social Governance strategic focus area. The governance of the Impact Collective comes from across the rohe, and from both iwi and mainstream partners such as Ngā Wairiki Ngāti Apa, Ngaa Rauru Kiitahi, Ministry of Social Development, Te Puni Kōkiri, local district councils, NZ Police and the Whanganui District Health Board. The Impact Collective is to be governed in a co-chair manner with one Māori and one mainstream chair.

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.

Key workforce measures are closely monitored, reported and acted upon. One such key measure of workforce success is a place where staff want to work, and where they want their whānau and themselves to receive treatment when needed. Staff retention figures provides an indication of being a good employer. The average length of service (retention) of Whanganui District Health Board employees is 9.74 years.

As a District Health Board we work in partnership with our various unions and contractors to continue to improve our environment.

OUR LEGAL RESPONSIBILITIES

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

- 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).

Our organisation is guided by four core values. These values come from Whanganui District Health Board's 'waka model' and represent the four corner panels of our tukutuku panel. Our values/ngā uarātanga are: Aroha, Kōtahitanga, Manaakitanga and Tino Rangatiratanga.

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

We are committed to:

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

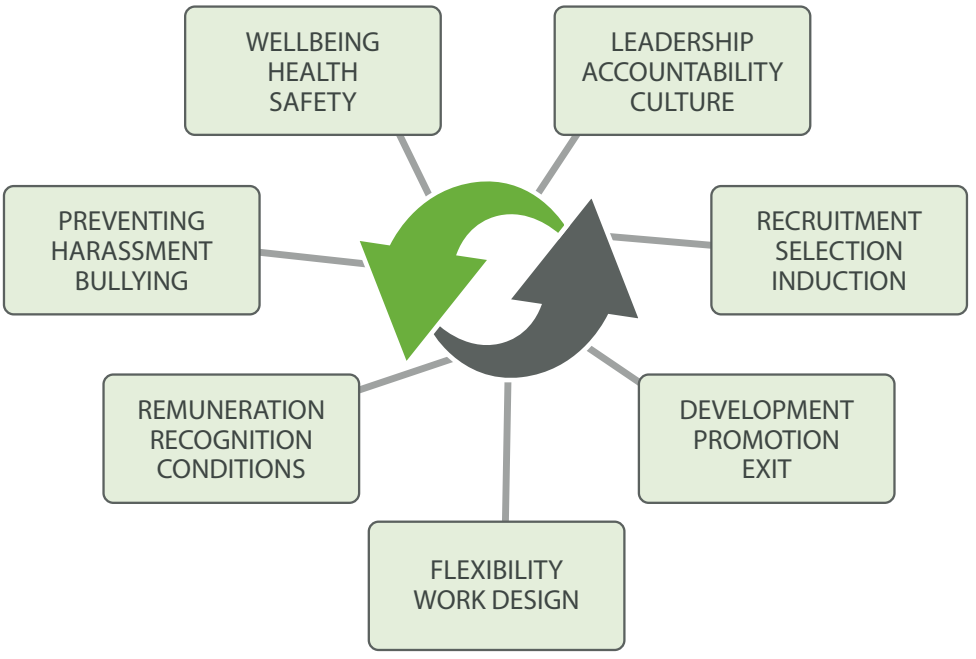
We want all our staff to be able to make a personal commitment to delivering He Hāpori Ora - Thriving Communities (our strategy) and practice in a truly patient and whānau-centred, rather than provider or management-centred way, and to:

- have an organisation and rohe-wide goal of health equity and really listens to the voice of patients and their whānau
- work in partnership for community wellbeing and 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
- investigating and implementing new ways of delivering services to enable consumer choice

- give a high level of understanding and support to team members and health partners 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 incivility.

GOOD EMPLOYER: THE SEVEN KEY ELEMENTS

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



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

Leadership, accountability and culture

OUR AMBITIONS

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

OUR ACTIONS

- Reporting culture – we actively encourage patients to complain and staff to report all accidents, incidents and near misses in order to learn and improve our practices, processes and systems.
- During 2020/21 we implemented C-Gov as our new safety management tool.
- Open disclosure conversations with whānau following adverse outcomes.
- Engaged Board and executive leadership team.
- Leaders visible in the organisation and district.
- Visibility of key organisational activities at executive and governance level i.e. people matters, health and safety, patient care, service delivery, system improvement, risks, etc.
- Strategy, vision and values articulated in the annual plan and endorsed by the Board.
- Whanganui District Health Board whānau ora philosophy, cultural competencies, Te Tiriti o Waitangi and our waka values are socialised at Hāpai te Hoe (organisational orientation programme) with all new staff.
- Development of He Waka Hourua as the next step in Whanganui District Health Board's cultural training programme focussing on equity, pro-equity and health literacy.
- Appropriate appointments at all levels. Recruitment panels for leadership roles include a member of the Te Hau Ranga Ora team. Recruitment panels for executive roles include a member of the Hauora ā Iwi Board.
- Clinical leadership across medical, nursing and allied health, scientific and technical workforces.
- Supporting restorative practices and remedy problems as soon as possible, respectful of the individual and as efficiently as possible for Whanganui District Health Board.
- Speaking up for Safety programme contributing to preventing unintended patient harm. Speaking up for Safety™ encourage and enable all staff to feel comfortable in speaking up about safety and quality issues. This fits with our organisation's commitment to achieving the safest and best care for our patients, and providing a safe environment for our staff.

- Use of Te Reo Māori across the system – greetings, signage, information to whānau and improved pronunciation through Te Reo Māori sessions onsite.
- Build Māori workforce and Māori health equity and equity capability. Improving capability and building Māori leadership capacity across the health system alongside our commitment to pro-equity for Māori and whānau ora.
- Agreed equity framework and targets for the Central region.
- Regional ethnicity data collection and reporting.
- All staff, Board, management and leadership continue to demonstrate participation in cultural competence training.
- Initiated action focussing on an increased focus on inclusivity and diversity in our workplace culture and employment practices.

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.
- Appointment based on values, fit, whānau ora and pro-equity with the Whanganui District Health Board
- Not compromising appointment decisions just for the sake of having someone in the role.
- Agreed equity targets to proactively grow Māori workforce across the health district that reflects proportionally for our Māori population by 2030.
- Grow Māori workforce across the health district – implementation of Whanganui District Health Board Māori workforce pipeline and the Ministry of Health Raranga Tupuake – Māori Workforce Development Plan.
- Māori applicants represented the majority of nursing staff employed via the Nurse Entry to Practice (NETP) and New Entry to Specialised Practice - Mental Health (NESP) programmes.
- Proactively promote training and development 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.
- Robust policies and procedures (developed in consultation with unions) to support recruitment and retention of staff and especially Māori and Pacifica staff. Our turnover for Māori staff is lower than the turnover for other staff.
- Monitoring key employment data (dashboards) on the recruitment and retention of Māori and Pacifica in the " Central Region and District Health Boards.
- Disability training programme for all staff.

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.
- Increased online training opportunities for staff.
- Various MECA clauses supporting professional development.
- Encouraging and supporting formal and informal growth and development opportunities.
- A focus on growing our own workforce.
- Career development and growth opportunities for staff.
- Support programme in place for all new graduate Māori nurses - tuakana taina.
- Reviewed and implemented the Whanganui District Health Board continuing education/professional development policy and procedure in consultation with unions.
- The final phase of Te Whare Toi, Whanganui District Health Board's education centre development is nearing completion to support our growing focus on workforce development.
- As a regional organisation we experience lower levels of turnover than organisations located in most major cities. Our average turnover for the previous four years was 7.45 percent.
- Feedback processes for all exiting staff with more than sixty percent of leavers participating in the Whanganui District Health Board exit survey.
- Support the further development of skill sharing in the region by developing the Calderdale infrastructure and project support tools and resources.
- Include health literacy as core component of staff training.
- Education committee actively leads training at all levels within the organisation.
- All new graduate Māori nurses receive formal support - provide tuakana taina support for new graduate Māori nurses through Te Uru Pounamu Programme.

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

- Whanganui District Health Board provides a 24/7 365 service with the majority of staff working rostered and rotated shifts. Fifty-nine percent of our permanent employees work part-time and this provides opportunity for flexible working arrangements.
- Actively using safer staffing and rostering principles and tools (Care Capacity Demand Management - CCDM and TrendCare) to determine FTE staffing requirements. The principles were nationally agreed and a governance group consisting of management, staff and union representation oversees this arrangement.
- Dashboards (Hospital At A Glance - HAAG) 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.
- During 2020 Whanganui District Health Board introduced a working from home policy and procedure to support flexibility. The use of Telehealth tools for patient contact also increased significantly.
- Workforce planning data informing business and investment decisions.
- During December 2020/January 2021 Whanganui District Health Board reduced non-essential services delivered over the holiday period and actively encouraged staff to take leave resulting in many staff optimising the opportunity to take at least two weeks or more continued annual leave.

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 collective agreements.
- More than 80% of staff are union members.
- Staff benefits exceeding the minimum legislative requirements e.g. annual and sick leave.
- Additional staff benefits provided to assist in the national pandemic approach.
- Working towards all staff earning more than the living wage.
- Participation in national programmes of work to review pay equity claims for various staffing groups.
- Whanganui District Health Board supports and actively promotes professional work days recognition such as International Nurses' Day, International Social Workers' Day, World Physiotherapy Day, Administrative Professionals Day.
- Non-financial staff recognition include team functions, awards, and letters of thanks, compliments from patients and visitors, and visibility in newsletters.
- Gender pay equity negotiations underway for PSA administrative staff.
- Supporting the government's direction for pay restraint in the public sector.
- Implemented accrual of annual leave approach for all casual employees.
- Implement equity and pay parity agreements as per the agreed settlement timeframes.

Harrassment & bullying prevention

OUR AMBITIONS

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

OUR ACTIONS

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

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 Whanganui District Health Board does.
- Management and disclosure of adverse events to ensure a safe quality working environment.
- Ongoing training for managers and team leaders regarding their health and safety and injury management responsibilities.
- Executive leadership team visibility of long-term absences and injury management activities, progress and support.
- Staff reporting injuries and incidents on our C-Gov incident database. Investigation of all injuries/incidents.
- Whanganui District Health Board remains a tertiary-level ACC accredited employer programme (AEP) member following the 2021 audit.
- Staff returning to work from 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 and purchasing more and new manual handling equipment resulting in a reduction of manual handling incidents and injuries.
- Wellbeing resources available for all health employees at: ***https://wellbeingforhealth.co.nz/***, the national wellbeing group (Kāhui Oranga) website supporting compassionate leadership, positive mental health and wellbeing.
- Promoting the positive drivers of workplace wellbeing is a key priority for district health boards and our union partners. These are what enable our people to do and be their very best and respond to the challenges of wellbeing. We have a collective commitment to create environments in which all our people can thrive at work.
- Working nationally with MBIE to further improve the guidelines for violence in the health and disability sector.
- Create environments where our people are well supported and enabled to thrive and deliver the best care to our patients, whānau and communities.
- Use of Te Reo Māori reflected in all Whanganui District Health Board communication, formal interactions and site naming conventions.
- Continued site maintenance and development that support patient care, service delivery, safety and general aesthetics.
- Undertaken various pulse surveys with staff or sub-sets of staff to identify key themes and priority areas for focus.
- Whanganui District Health Board actively promotes the Employee Assistance Programme (EAP) and the 1737 text/phone line to all staff for proactive assistance in dealing with personal and/or work related concerns. The service is free of charge and confidential and staff are able to self-refer or can be referred by a manager.

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 Whanganui District Health Board's health and safety systems are audited biennially and injury management systems annually by an accredited ACC auditor.

High-risk hazards

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

Manual handling

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

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

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

Continuous improvement includes:

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

Management of aggression

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

Currently in place:

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

Continuous improvement includes:

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

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

PŪRONGO MAHI WHAKARITERITE

STATEMENT OF PERFORMANCE

The Statement of Service Performance for the year ended 30 June 2021 shows how the Whanganui District Health Board has performed when compared with the Statement of Performance Expectations that we published for 2020/21.

WHANGANUI DISTRICT HEALTH BOARD'S INTERVENTION LOGIC:

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

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

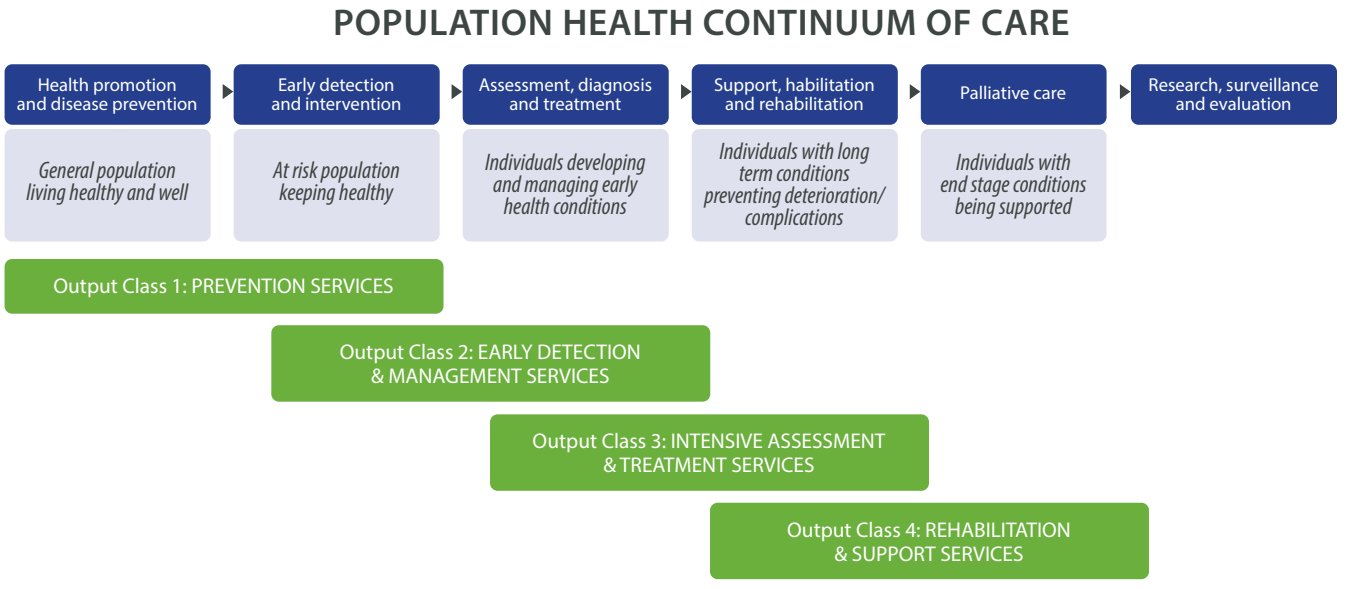
On a continuum of care, our work covers the whole population, from the many who are living healthy and well, through to the few who need support for end stage conditions. For reporting purposes we group our work into four output classes:

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

POPULATION HEALTH CONTINUUM OF CARE

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

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



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

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

The following sections are arranged by Output Class and provide an overview across a range of measures within each, making reference to the focus areas above. The measures discussed do not cover everything we do, but are designed to give an idea of the breadth of our services and how we have performed against our expectations in the 2020/21 financial year.

A summary of 2020/21 financial performance is also included for each Output Class.

HOW TO READ THE FOLLOWING TABLES

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

In the non-financial performance tables 3, 5, 7 and 9, where the measure description includes a "*" followed by a date period, this refers to the period covered by the reported 2020/21 actual results.

ACHIEVEMENT COLUMN

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

CHANGE COLUMN

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

COVID comment

Whanganui District Health Board COVID-19 Vaccination programme commenced on 31 March 2021 and as of year-end 30 June 2021 we had delivered 18,775 Pfizer BioNTech doses to 10,631 people, including 8,144 second doses, through 11 vaccination clinics in Whanganui City and rural surrounds.

In the same period, we provided 8,365 swab tests via CBAC centres, GP clinics and through the DHB provider.

IMPLEMENTING THE COVID-19 VACCINE STRATEGY

Source of information: Ministry of Health

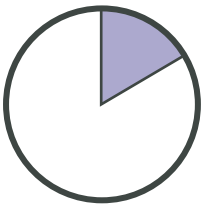
VACCINE DOSES ADMINISTERED BY WHANGANUI DISTRICT HEALTH BOARD

10,631
DOSE 1

8,144
DOSE 2

18,775
TOTAL

ELIGIBLE POPULATION FULLY VACCINATED BY DHB OF RESIDENCE (WHANGANUI)
(Note 1, Note 4)



16.60%
PROPORTION FULLY VACCINATED
(Note 1)

VACCINE DOSES ADMINISTERED BY AGE GROUP (Note 4)

Age range (years)	Dose 1	Dose 2	Dose 3
12 - 15	0	0	0
16 - 19	91	69	160
20 - 24	176	144	320
25 - 29	307	262	569
30 - 34	324	270	594
35 - 39	315	274	589
40 - 44	358	297	655
45 - 49	549	454	1, 003
50 - 54	683	587	1, 270
55 - 59	874	699	1, 573
60 - 64	975	777	1, 752
65 - 69	1, 476	1, 045	2, 521
70 - 74	1, 586	1, 134	2, 720
75 - 79	1, 247	889	2, 136
80 - 84	868	624	1, 492
85 - 89	474	348	822
90+	328	271	599
TOTAL	10, 631	8, 144	18, 775

ELIGIBLE POPULATION FULLY VACCINATED BY AGE GROUP (Note 4)

Age range (years)	Proportion fully vaccinated (Note 1)
12 - 15	-
16 - 19	4.49%
20 - 24	7.05%
25 - 29	9.47%
30 - 34	8.64%
35 - 39	9.60%
40 - 44	10.42%
45 - 49	12.61%
50 - 54	15.24%
55 - 59	15.91%
60 - 64	18.04%
65 - 69	25.85%
70 - 74	29.87%
75 - 79	35.77%
80 - 84	35.17%
85 - 89	36.21%
90+	47.66%
TOTAL	16.6%

ELIGIBLE POPULATION FULLY VACCINATED BY ETHNICY (Note 4)

Ethnicity	Proportion fully vaccinated (Note 1)
Asian	22.94%
European or other	18.57%
Māori	9.87%
Pacific peoples	10.00%
Unknown	36.57%
TOTAL	16.6%

VACCINE DOSES ADMINISTERED BY ETHNICITY (Note 4)

Ethnicity	Dose 1	Dose 2	Dose 3
Asian	436	387	823
European or other	8, 637	6, 602	15, 239
Māori	1, 369	1, 015	2, 384
Pacific peoples	127	91	218
Unknown	62	49	111
TOTAL	10, 631	8, 144	18, 775

VACCINE DOSES ADMINISTERED BY SEQUENCING GROUP (Note 4)

Sequencing group (Note 3)	Dose 1	Dose 2	Dose 3
Group 1	56	56	112
Group 2	4, 479	4, 137	8, 616
Group 3	5, 833	3, 739	9, 572
Group 4	263	212	475
TOTAL	10, 631	8, 144	18, 775

Note 1: Fully vaccinated means two doses have been administered to an individual.

Note 2: The health service user (HSU) population used for COVID-19 vaccine coverage reporting provides information about the number of people in New Zealand who used health services in 2020. People are included if they were alive as at 30 June 2020, were 12 years of age as of 30 June 2020, (note that this was initially 16 years but was reduced to 12 years when the eligibility criteria changed), and if they were enrolled with a primary health organisation or received health services in the 2020 calendar year. There are other data sets that estimate the total number of people in New Zealand.

These include three datasets produced by Stats NZ: Estimated Resident Population (produced every 5 years, following each Census), Subnational Population Estimates (produced every year), and non-official population projections produced by Stats NZ for the Ministry of Health (produced every year).

The StatsNZ population estimates are based on Census data adjusted for the number of people who are born, who have died, and who have migrated to or from New Zealand. The Stats NZ population estimates and projections are of people usually resident in New Zealand, including those usually resident who are temporarily overseas, while the HSU includes everyone in New Zealand who used health services in a given period.

The HSU was chosen by the Ministry of Health as the denominator for COVID-19 vaccine coverage reporting because it allows for the assignment of the same demographics (eg, location and ethnicity) to people in the numerator (the number of people vaccinated) as the denominator (reference population). The HSU is available for every demographic contained in health data including age, ethnicity, DHB, and gender, separately or in combination. Other information such as neighbourhood deprivation, Statistical Area 2, or territorial local authority can also be added. It is possible to generate flags for health-related information on the HSU, for example, those who are likely to have a long-term condition. Official Stats NZ estimates are not as flexible. For example, StatsNZ estimates by age, sex and Statistical Area 2/Territorial Authority/DHB are produced every year, but estimates that also include ethnicity are only produced every 5 years, the most recent being estimates for 2018. The projections Stats)NZ produces for the Ministry every year do provide information by age, sex and broad ethnic group, but are only available at the DHB level.

The Total population estimate based on HSU as at 30 June 2020 is 68,242. This is 248 below the Stats NZ total projected population of 68,490 (from the non-official population projections Stats NZ produced in 2020). When classifying the population into ethnicity, age and DHB there are further differences. For example, a summary of the differences by ethnicity are summarised in the table below. These differences arise as the populations are derived from different sources. For example, an individual may identify as one ethnicity when registering with a health service and a different ethnicity when completing a census declaration.

By definition, the HSU is not a total population estimate and is likely to miss highly marginalised groups. For example, analysis suggests that groups underrepresented in the HSU include young people aged 15-45 years (men in particular), and people of Asian and Middle Eastern, Latin American and African ethnicity.

The HSU is considered by the Ministry of Health to be the best option for estimates of vaccine coverage, as it removes bias from calculated rates by ensuring demographic information in the numerator and denominator is consistent. For example, the ethnic group(s) with which someone identifies, and their location.

VACCINE DOSES ADMINISTERED BY ETHNICITY (Note 4)

Total population	HSU	Stats NZ	Difference
Māori	**18, 185**	**19, 200**	**(1, 015)**
Pacific	**1, 873**	**1, 980**	**(107)**
Asian	**2, 397**	**2, 810**	**(413)**
Other	**45, 787**	**44, 500**	**1, 287**

Note 3: Group 1 includes border and managed isolation and quarantine employees and the people they live with. Group 2 includes high-risk frontline health care workforces; workers and residents in long-term residential environments; older Māori and Pacific peoples cared for by whānau, the people they live with, and their carers; people aged 65 years and older; people with relevant underlying health conditions. Group 3 includes people aged 65 years and older; people with relevant underlying health conditions; disabled people; and adults in custodial settings. Group 4 includes people aged 16 years and over. These definitions and population groups were occasionally updated based on operational and Cabinet decisions or updated estimates of the sizes of each group.

Note 4: The data in this table is based on the DHB of residence of the individual receiving the vaccines. Ethnicity is based on the prioritised ethnicity classification system which allocates each person to a single ethnic group, based on the ethnic groups they identify with. Where people identify with more than one group, they are assigned in this order of priority: Māori, Pacific peoples, Asian, and European/Other. So, if a person identifies as being Māori and New Zealand European, the person is counted as Māori.

SUMMARY OF 2020-21 FINANCIAL PERFORMANCE BY OUTPUT CLASS

Table 1 | SUMMARY OF FINANCIAL PERFORMANCE BY OUTPUT CLASS

Consolidated	Prevention	Early detection & management	Intensive Assessment & Treatment	Support & Rehabilitation	Total
Revenue					
Crown	6, 843	59, 653	186, 145	41, 099	293, 740
Other Income	42	87	1, 485	33	1, 647
Inter-district Inflows	76	2, 531	5,427	1, 192	9, 226
Total revenue	**6,961**	**62, 271**	**193, 057**	**42, 324**	**304, 613**
Expenditure					
Personnel costs	(2, 347)	(8, 725)	(87, 729)	(2, 463)	(101, 264)
Capital charge	(155)	(315)	(2, 221)	(240)	(2, 931)
Depreciation	(12)	(228)	(6, 079)	(47)	(6, 366)
Other	(723)	(7, 894)	(43, 060)	(2, 008)	(53, 685)
Other Provider Payments	(4, 107)	(44, 949)	(14, 956)	(34, 213)	(98, 225)
Inter-district Outflows	(45)	(4, 321)	(39, 196)	(3, 427)	(46, 989)
Total expenditure	**(7, 389)**	**(66, 432)**	**(193, 241)**	**(42, 398)**	**(309, 460)**
(Deficit) / Surplus	**(428)**	**(4, 161)**	**(184)**	**(74)**	**(4, 847)**

in thousands of New Zealand dollars

OUTPUT CLASS 1: PREVENTION

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

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

Why is this output class significant?

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

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

What outcomes are we contributing to?

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

2020/21 performance overview

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

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

Immunisation

Despite the prolonged efforts of the Immunisation Outreach team, numbers of parents declining to have their children vaccinated, or opting-off the programme continues to adversely impact our ability to achieve success against the 8 month immunisation measure.

Decline rates account for almost 10% of children creating major challenges in achieving a 95% target, and in the case of Māori, this rate was over 11% recently. As these children age they create a dampening effect on achieving target in older cohorts.

Overall, we achieved immunisation on time for 81.6%, and 70.5% for Māori. Improving immunisation rates continues to be a focus as does finding innovative ways to reach our target populations.

Māori continue to be over-represented in the overdue/decliners of immunisation outreach service numbers. Outreach is working with Iwi/Māori health providers to find solutions. Focus on increasing Māori immunisation forms part of a several prong approach: continued awareness within general practice by Immunisation coordination services, within WCTO providers, at pregnancy and parenting education sessions, when tamariki present at ED, paediatrics (ward, Gateway, child development) and at Whanganui Accident and Medical. Parents declining to immunise their tamariki is a national issue and needs to be addressed nationally.

Feedback from general practices has been that they are struggling to get families to come in early for their second MMR dose. It is also a busy space for whānau, trying to understand all of the vaccine programmes and how it pertains to them.

For the second year in a row, Immunisation week and all of its promotion has been put on hold.

HPV vaccination

Vaccination rates have been impacted adversely by COVID-19 with a further decline in vaccination rates compared to last year. 687 of the eligible 976 (70.4%) boys and girls received at least one dose. The figure for Māori was 68.3%.

Work progressed to develop a joint health promotion and communication plan with Whanganui District Health Board and the Whanganui Regional Health Network that covers Immunisation week and a long lead in time using various channels to reach priority populations.

Influenza vaccinations

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

A dual-purpose clinic deals with all influenza-like illness as a pre-urgent care and pre-emergency department pathway.

In the COVID-prone environment we will continue to run an "influenza" clinic/workstream at the hospital front-door. This is based on the CBAC model that existed through alert levels 2 – 4 and ensures better streaming of patients, isolation of winter ills and the ability to re-establish a swabbing regime if necessary.

Smokefree

Whanganui District Health Board is committed to the government's goal of Smokefree 2025. We work across the system to lead on health promotion activity and to collaborate with all providers on other tobacco control and smokefree activity. The prevalence of smoking in our district continues to be higher than the national average which is reflective of our profile of increased overall population, a high and growing population of Māori and high levels of deprivation.

Our work continues to develop a whānau ora concept to shift focus from smoking cessation to providing a person-centered pathway to smokefree focused on addressing barriers to quit developed through learnings from the Kaiwhakatere Ōranga initiative.

An outreach approach implemented across primary care programmes through a kaiawhina role connects with whānau identified through general practice or primary settings to the right resources, linkages and support with an absolute emphasis on smokefree homes.

Support for our enrolled Māori who are registered as smokers has been better from an equity perspective, with a greater percentage of Māori than non-Māori being provided with advice and referral to stop smoking services. The focus is on increasing service utilisation via enhanced social media outreach. This is proving successful, as well as establishing new and increasing previous networks including with hapū māmā and rangatahi groups.

Our Hapū Māmā programme continues to evolve along kaupapa Māori based offerings including hapū māmā and whānau individualised opportunities to participate in weaving their own wahakura. This engagement promotes korero around health messaging in particular lifestyle choices such as smoking, drugs, alcohol, and their impact on the wellbeing of pēpē.

Cervical screening

In the three years to March 31, we completed 151 screens less (12,049 compared to 12,200) than that same period to last year, among a larger population of eligible women (17,283 compared with 16,369). We completed 2,804 cervical smears for Māori women, down from 2,881 in the previous period. COVID-19 impacted on cervical screening with a backlog that required proactive support to re-engage and provide reassurance for wahine that patient safety is paramount.

Targeted approaches continue to ensure wāhine are offered multiple choices of where they can go to have their smear done including outreach, after hours and iwi-led events. A survey approach undertaken upon screening has provided valuable feedback which has led to changes in how wāhine are contacted and how information is delivered including the role of social media networks.

Ambulatory sensitive hospitalisations

Children under four attending hospital for preventable causes continue to achieve target, with Māori childrens' result improving 18 percent on last year. There remains a considerable inequity however, and work continues to address this. Dental admissions for Māori children, while consistently at around 35-40 per year, account for around 70% of total dental admissions by children from a cohort population of just 40%. Admissions for asthma have consistently declined this year, from 25 last year for Māori to just 11, and just 20 overall, down from 36 previously. Most other ASH conditions remain relatively stable over the past five years or have improved slightly.

Dental

Children reach five years of age caries free in greater numbers than before (68.9%), and although Māori lag behind (41.4%) there has been a slight improvement compared to last year's rates. Of the 725 children examined in the calendar year 2020, 429 were caries free (Māori 256 examined /106 caries free).

Table 2 | 2020/21 FINANCIAL PERFORMANCE: PREVENTION SERVICES

Output Class 1 - PREVENTION	2020/21 Actual
Revenue	
Crown	6, 843
Other Income	42
Inter-district Inflows	76
Total revenue	**6, 961**
Expenditure	
Personnel	(2, 347)
Capital charge	(155)
Depreciation	(12)
Other	(723)
Other Provider Payments	(4, 107)
Inter-district Outflows	(45)
Total expenditure	**(7, 389)**
(Deficit) / Surplus	**(428)**

in thousands of New Zealand dollars

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

Table 3 | NON-FINANCIAL PERFORMANCE: PREVENTION SERVICES

Measures description	Ethnicity	2019/20 Actual	2020/21 Actual	2020/21 Target	A Achievement	C Change
Ambulatory Sensitive Hospitalisations (ASH) rates for children 0-4 years of age (compared to the national rate) *12 months to March 2021	All Māori Non-Māori	93.8% 125.5% 67.1%	87.0% 106.0% 72.0%	≤110.0% ≤115.0% ≤110.0%	🟢 🟢 🟢	🟢 🟢 🟢
Children caries-free at five years of age *12 months to December 2020	All Māori Non-Māori	58.6% 40.9% 64.8%	59.2% 41.4% 68.9%	≥58.0% ≥58.0% ≥58.0%	🟢 🔴 🟢	🟢 🟢 🟢
Immunisation coverage rates at milestone at eight months of age	All Māori Non-Māori	85.8% 79.4% 91.2%	81.6% 70.5% 90.6%	≥95.0% ≥95.0% ≥95.0%	🔴 🔴 🟠	🟠 🔴 🟠
Babies in a smokefree household at six weeks of age *July to December 2020	All Māori Non-Māori	48.1% 32.9% 60.3%	48.6% 31.4% 61.7%	≥38.0% ≥28.0% ≥58.0%	🟢 🟢 🟢	🟢 🟠 🟢
Proportion of youth who have received the HPV vaccine *2007 cohort to 30 June 2021	All Māori Non-Māori	69.5% 68.1% 70.5%	70.4% 68.3% 77.9%	≥75.0% ≥75.0% ≥75.0%	🟠 🟠 🟢	🟢 🟢 🟢
Cervical screening three-year coverage rate for women aged 25-69 years *12 months to March 2021	All Māori Non-Māori	74.5% 73.9% 74.7%	69.7% 65.5% 71.1%	≥80.0% ≥80.0% ≥80.0%	🔴 🔴 🟠	🟠 🔴 🟠
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	88.3% 88.2% 88.3%	76.8% 78.7% 75.4%	≥95.0% ≥95.0% ≥95.0%	🔴 🔴 🔴	🔴 🔴 🔴
Number of extended consults delivered by a GP or practice nurse	Total Youth Adult	1290 152 (11.8%) 1138 (88.2%)	1150 151 (13%) 1000 (87%)	2228 446 (20%) 1782 (80%)	 🔴 🔴	 🟠 🟠
Proportion of enrolled population aged 65+ years who have received flu vaccination *Non-Māori volume estimated	All Māori Non-Māori	77.6% 84.7% 76.9%	72.0% 76.3% 73.5%	≥75.0% ≥75.0% ≥75.0%	🟠 🟢 🟠	🟠 🔴 🟠

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 whānau/families.

What outcomes are we contributing to?

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

2020/21 performance overview

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

Midwifery

The development of the midwifery workforce plan in 2019/20 was delayed due to several factors relating to the Whanganui District Health Board restructure, however five new graduate midwives are now working in the Whanganui rohe. Two are Lead Maternity Carers (LMC), both Māori and of three core midwives, one is Māori. Ongoing work with Otago Polytechnic to support midwifery students (50% of 2021 third year students are Māori) continues. A new director of midwifery (DOM) was appointed on 20 July and is now in position.

Whanganui District Health Board managed a small primary midwifery service throughout the year (between five to 10 women). However, with the expected Christmas/holiday season shortfall of LMCs this number has grown significantly (now 32 women) and has warranted an increase in FTE to manage this growing caseload. Local LMCs are agreeable to picking up the postnatal modules for these women.

The proportion of pregnant women completing (over 75% of programme) Whanganui District Health Board funded pregnancy and parenting education was disappointing this year. Just 18% of mothers attended, with only 14% of Māori mothers. Last year we committed to increase our focus on first time mothers, and of the 218 attendees, 90% were first time Mums, including 76% of Māori attendees.

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

The organisational restructure saw the establishment of the Maternal Child and Youth health service group that enabled increased integration across the continuum. We have embedded a wellbeing and equity focus in implementing 'Supporting Parents, Healthy children' to support early intervention in the life course.

School-based Health Services (SBHS)

This year we promoted health messages and awareness of health services available to youth, inclusive of where to access emergency contraception, after hour's medical care and surrounding agencies and networks. Posters and brochures for local and rural areas were designed for students and disseminated to students, teachers, parents/caregivers, other agencies. We contribute to the rohe wide youth services networks by attending and collaborating at a multidisciplinary level to ensure that health of our youth population is at the centre of their care.

Increased appointment attendance rates for students, in particular Māori students attending appointments at Maternal, Infant, Child and adolescent Mental Health and Addiction Service (MICAMHAS) and Youth Services Trust.

Increased service access to students using Telehealth. Lessons learned from COVID-19, the nurses now work alongside students to get their views on expanding service delivery and engagement via Telehealth.

Youth Service Level Alliance Team to be incorporated into new Maternal Child and Youth service level alliance. Terms of reference developed and recruitment of members in process, youth population priorities identified.

Dental (calendar year 2020)

It was disappointing to see the low proportion of adolescents using Whanganui District Health Board funded dental services this year (71.7%), with the first half of the year significantly impacted by COVID lockdown, reducing the number seen from 1,874 (Jan-Jun 2019) to just 869 for the same period in 2020. Conversely, in the latter half of 2020, 1,957 adolescents have been seen, compared to 1,184 in the second half of 2019.

Population mental health

The proportion of youth aged 12-19 years seen each quarter in primary care for mental health has remains relatively steady, however Māori youth rates have dropped below target to 1.6%. Although achievement rates have dropped slightly, it is important to note that numbers of youth seen have risen, as part of an increased population pool.

Shorter waits for non-urgent mental health and addiction services (0-19 yrs) have achieved all targets, a considerable improvement on last year. 86% of youth received services within three weeks (89.2% Māori), and 98.6% within eight weeks (99.4% Māori).

The rate of persons committed to compulsory mental health treatment continues to rise year on year.

The percentage of long-term clients with mental illness who have an up-to-date relapse prevention plan remains at 100%.

Ambulatory sensitive hospitalisations (ASH)
We have achieved our target overall, and rates for Māori have improved slightly compared to last year, however 45-64 year olds in our district are hospitalised for preventable illness at 157% of the national rate (Māori 250%). Improvement is required in our ability to prevent deteriorating long-term conditions resulting in hospitalisation.

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

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

The proportion of patients with good or acceptable glycaemic control (HbA1C < 64 mmol/mol) has risen slightly compared to last year from 55.3% to 56.7%, (47.2% Māori).

We are developing pathways that address health conditions significant for Māori, or where standardised management will deliver health gains, including the local roll-out of Best start, Community Funding Options Programme, Gout, Diabetes, Congestive Heart Failure. COPD is in development.

Colonoscopies
The percentage of people accepted for an urgent diagnostic colonoscopy that received their procedure within two weeks (14 days) has fallen significantly, from 93.5% last year to just 79.6% against a target of 90.0%.

We developed a policy for management of endoscopy waiting list that includes an escalation process for patients at risk of exceeding maximum wait time, and developed reporting that identifies all patients that are waiting for colonoscopy by ethnicity and triage category. The report also includes an acuity index calculation, so that patients at risk of exceeding maximum wait time can be easily identified.

Following commencement of bowel screening in our region, we now ensure that 95% of bowel screening participants who return a positive FIT have a first offered diagnostic date that is within 45 working days of their result being recorded in the NBSP IT system, with no equity gap for Māori and Pacific populations. We work hard to ensure at least 60% of our eligible bowel screening population participate in the programme, again with no equity gap for Māori and Pacific Island populations.

Bowel screening participation rates and bowel screening colonoscopy wait time results by ethnicity (Māori, Pacific Island, Asian, Other) are reviewed monthly at bowel screening equity working group meetings.

Table 4 | 2020/21 FINANCIAL PERFORMANCE: EARLY DETECTION & MANAGEMENT

Output Class 2 - EARLY DETECTION & MANAGEMENT	2020/21 **Actual**
Revenue	
Crown	59, 653
Other Income	87
Inter-district Inflows	2, 531
Total revenue	**62, 271**
Expenditure	
Personnel	(8, 725)
Capital charge	(315)
Depreciation	(228)
Other	(7, 894)
Other Provider Payments	(44, 949)
Inter-district Outflows	(4, 321)
Total expenditure	**(66, 432)**
(Deficit) / Surplus	**(4, 161)**

in thousands of New Zealand dollars

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

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

Measures description	Ethnicity	2019/20 Actual	2020/21 Actual	2020/21 Target	A Achievement	C Change
Proportion of pregnant women accessing DHB funded pregnancy and parenting education	All Māori Non-Māori	19.6% 13.3% 24.7%	18.0% 14.0% 20.8%	≥ 40.0% ≥ 40.0% ≥ 40.0%	🔴 🔴 🔴	🟠 🟢 🔴
Proportion of adolescent population utilising DHB funded dental service *12 months to December 2020	All	77.0%	71.7%	≥ 85.0%	🔴	🟠
Proportion of children enrolled in the Community Oral Health Service who have treatment according to plan *12 months to December 2020	All Māori Non-Māori	94.3% 93.3% 95.0%	94.6% 93.9% 95.1%	≥ 90.0% ≥ 90.0% ≥ 90.0%	🟢 🟢 🟢	🟢 🟢 🟢
Proportion of youth (12-19 years old) seen each quarter by primary mental health services *12 months to December 2020	All Māori Non-Māori	1.4% 2.0% 1.1%	1.2% 1.6% 1.0%	≥ 2.0% ≥ 2.0% ≥ 2.0%	🔴 🔴 🔴	🔴 🔴 🟠
Shorter waits for non-urgent mental health and addiction services (0-19 years old) *12 months to March 2021 We no longer report results for those seen after more than eight weeks as everybody is seen after eight weeks and therefore the results are always 100%.	**< 3 weeks** Total Māori Non-Māori **< 8 weeks** Total Māori Non-Māori	 81.6% 78.2% 83.8% 98.3% 98.2% 98.4%	 86.3% 89.2% 84.6% 98.6% 99.4% 98.1%	 ≥ 80.0% ≥ 95.0%	 🟢 🟢 🟢 🟢 🟢 🟢	 🟢 🟢 🟢 🟢 🟢 🟠
Ambulatory Sensitive Hospitalisations (ASH) rates for 45-64 years of age relative to national rate *12 months to March 2021	All Māori Non-Māori	162.9% 265.3% 137.4%	157.1% 250.0% 132.5%	≤ 170.0% ≤ 151.0% ≤ 166.0%	🟢 🔴 🟢	🟢 🟢 🟢
Proportion of patients with good or acceptable glycaemic control (HbA1C < 64 mmol/mol)	All Māori Non-Māori	55.3% 48.4% 58.8%	56.7% 47.2% 61.6%	≥ 60.0% ≥ 60.0% ≥ 60.0%	🟠 🔴 🟢	🟢 🟠 🟢
Percentage of people accepted for an urgent diagnostic colonoscopy received their procedure within two weeks	All	93.5%	79.6%	≥ 90.0%	🔴	🔴
Percentage of long-term clients with mental illness who have an up-to-date relapse prevention plan	Child Adult	100% 98.9%	100% 100%	≥ 95.0% ≥ 95.0%	🟢 🟢	🟢 🟢

OUTPUT CLASS 3: INTENSIVE ASSESSMENT AND TREATMENT

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

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

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

Why is this output class significant?

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

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

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

What outcomes are we contributing to?

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

2020/21 performance overview

Planned care

The Ministry of Health completed a review of the elective services programme in 2019/20. A major part of this review was to develop a permissive framework whereby the sector was able to schedule services in a variety of settings. To recognise this change in emphasis the electives programme was replaced by the planned care programme.

Improve understanding of local health needs:
To understand the health needs of our population, and a comparison of what is or has been provided and the health aspirations of our community, a Gap analysis of where we need to implement service and model of care change has been developed, in conjunction with our Community Strategy team. Whanganui District Health Board is a pro-equity district health board and service design with a focus on equity for Māori is a key underpinning of our planning function.

Balancing national consistency and local context:
Engagement with MidCentral and Wairarapa District Health Boards on identification of vulnerable services and potential sub-regional arrangements. This is both on a formal forum basis and informal communications between service team.

Support consumers to navigate their health journeys:
Introduction of appointment related communication in modes that suit patients eg email, text, letter. We have upgraded "text to remind" services for appointments.

Optimising sector capacity and capability:
Significant work underway with theatre service delivery to optimise capacity, and gain a clear understanding of capacity and mapping against service delivery requirements.

Acute demand

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

The year ended 30 June 2021 saw around 12,011 inpatients admitted acutely (2019/20: 11,400), using over 25,489 bed days (2019/20: 24,300). On average, these patients stay 2.53 days, a little over our target of 2.20. A very small cohort of unwell patients (5) each required over 100 days in hospital. The length of stay of these episodes has a relatively strong effect on the overall average.

Unplanned readmissions within 28 days of a previous discharge have increased slightly beyond the optimum, again influenced by a small cohort (21) of unwell patients with complex medical and social issues requiring more than 10 admissions each.

A significant amount of acute demand was responded to through virtual consultations – Whanganui District Health Board have increased the ability for clinicians to safely deliver virtual consultations through a Telehealth rollout across all services.

Cancer services

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

We narrowly missed our Faster Cancer Treatment (62 days) target of 90% this year (89.9%). Availability of ethnicity data has made accurate reporting on these measures for equity assurance difficult.

Surgical interventions

Standardised intervention ratios for cataracts have been impacted by reduced ophthalmology resource for the past three years. Rates for major joint surgery are significantly above the national rate, and have been at this level for several years and indicate that our population is receiving equitable levels of care.

Whanganui District Health Board cardiac procedure rates remain close to national intervention ratios, with the target significantly higher that nationally achieved. This is also true for angioplasty and angiography. Cardiac services are provided by our tertiary partners and we continue to work with them to advocate for the care of our patients.

Mental health

The rate per 100,000 population who are treated under compulsory community mental health orders continues to be a significant challenge. In this rohe these include a sizeable group of chronically unwell service users who transition between inpatient stay, community service, and prison. Attempts to change our practice to a more proactive model failed, resulting in those who were made informal being again sectioned. Whanganui has experienced an influx of unwell service users since last lockdown, some returning from overseas, who are having a real effect on service pressures. Lack of local whanau support limits their ability to function independent of services. Kaupapa Māori services are however endeavouring to fill this gap.

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

Table 6 | 2020/21 FINANCIAL PERFORMANCE: INTENSIVE ASSESSMENT & TREATMENT

Output Class 3 - INTENSIVE ASSESSMENT & TREATMENT	2020/21 **Actual**
Revenue	
Crown	186, 145
Other Income	1, 485
Inter-district Inflows	5, 427
Total revenue	**193, 057**
Expenditure	
Personnel	(87, 729)
Capital charge	(2, 221)
Depreciation	(6, 079)
Other	(43, 060)
Other Provider Payments	(14, 956)
Inter-district Outflows	(39, 196)
Total expenditure	**(193, 241)**
(Deficit) / Surplus	**(184)**

in thousands of New Zealand dollars

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

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

Measures description	Ethnicity	2019/20 Actual	2020/21 Actual	2020/21 Target	A Achievement	C Change
Inpatient length of stay - **Acute** (days) *12 months to March 2021	All	2.26	2.53	≤2.2	🔴	🔴
Unplanned re-admission rate at 28 days *12 months to March 2021	All Māori Non-Māori	14.0% 13.8% 14.1%	14.1% 12.8% 14.6%	≤12.1% ≤12.1% ≤12.1%	🟠 🟠 🟠	🟠 🟢 🟠
Faster Cancer Treatment (62-day indicator)	All	91.4%	89.9%	≥90.0%	🟠	🟠
Improving waiting times for diagnostic services - **Computed Tomography (CT)** *Patients waiting for or receiving CT scan and report in 42 days or less* *Ethnicity data not available for these measures in 2020/21	All Māori Non-Māori	91.0% N/A N/A	92.8% N/A N/A	≥95.0% ≥95.0% ≥95.0%	🟠	🟢
Improving waiting times for diagnostic services - **Magnetic Resonance Imaging (MRI)** *Patients waiting for or receiving MRI scan and report in 42 days or less* *Ethnicity data not available for these measures in 2020/21	All Māori Non-Māori	95.9% N/A N/A	61.2% N/A N/A	≥90.0% ≥90.0% ≥90.0%	🔴 🔴 🔴	🔴
Percentage of service users receiving community care within seven days following their discharge (KPI 19)	All Māori Non-Māori	62.0% 60.4% 63.8%	74.8% 75.0% 74.6%	≥75.0% ≥75.0% ≥75.0%	🟠 🟢 🟠	🟢 🟢 🟢
Rate per 100,000 population committed to compulsory mental health treatment *12 months to March 2021	All Māori Non-Māori	138 256 100	200 355 143	≤135 ≤250 ≤100	🔴 🔴 🔴	🔴 🔴 🔴
Standardised intervention rates **Cardiac surgery and angioplasty/angiography**	Cardiac (all) Angioplasty (all) Angiography (all)	4.5 13.7 31.2	4.5 12.0 28.9	≥6.5 ≥12.5 ≥34.7	🔴 🟠 🔴	🟢 🔴 🟠
Standardised intervention rates - **Cataracts and major joints** *12 months to March 2021	Cataracts (all) Major joints (all)	21.5 22.4	23.7 25.0	≥27.0 ≤28.5	🔴 🔴	🟢 🟢

OUTPUT CLASS 4: REHABILITATION AND SUPPORT

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

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

Why is this output class significant?

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

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

Whanganui District Health Board continues to place an emphasis on an increased proportion of older people living in their own home with their natural support system. This can be supplemented, where necessary, by funded 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 whānau/family support - and enable older people and the disabled to participate fully in society and enjoy maximum independence.

2020/21 Performance overview

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

Mental health

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

Needs assessments

InterRAI facility assessments are expected to be completed by an ARC provider within 230 days and generally there is good compliance.

In-home strength & balance

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

Stroke services

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

Polypharmacy

The proportion of over 64 year olds who are prescribed 11 or more medications is showing a slight increase again this year, with 3.2% of elder Māori. This reflects the increasingly complex health status of the elderly as people live longer. However, work needs to continue to minimise the number of medications people are taking.

Aged care

The proportion of the population over 65 in DHB funded aged residential care has declined, with 2.1% of Māori and 4.3% non-Māori being supported in aged residential care facilities. This does not reflect a decline in the number of people being supported, but more reflects the growing aged population in the Whanganui District Health Board area, both from natural ageing and through additional people moving into the area.

Table 8 | 2020/21 FINANCIAL PERFORMANCE: REHABILITATION AND SUPPORT

Output Class 4 - REHABILITATION & SUPPORT	2020/21 Actual
Revenue	
Crown	41,099
Other Income	33
Inter-district Inflows	1 192
Total revenue	**42, 324**
Expenditure	
Personnel	(2, 463)
Capital charge	(240)
Depreciation	(47)
Other	(2, 008)
Other Provider Payments	(34, 213)
Inter-district Outflows	(3, 427)
Total expenditure	**(42, 398)**
(Deficit) / Surplus	**(74)**

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

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

Measures description	Ethnicity	2019/20 Actual	2020/21 Actual	2020/21 Target	A Achievement	C Change
Percentage of mental health and addictions service users receiving community care within seven days following their discharge (KPI 19)	All Māori Non-Māori	62.0% 60.4% 63.8%	74.8% 75.0% 74.6%	≥75.0% ≥75.0% ≥75.0%	🟠 🟢 🟠	🟢 🟢 🟢
Percentage of older people in aged residential care by facility who have a second InterRAI Long-Term Conditions Facilities (LTCF) assessment completed 230 days after admission	All	89.6%	87.5%	≥95.0%	🟠	🟠
Number of older people receiving in-home strength and balance programmes	All	220	217	>199	🟢	🟠
Percentage of potentially eligible stroke patients thrombolysed (ind 2)	All Māori Non-Māori	17.0% 25.0% 16.3%	20.3% 26.7% 15.0%	≥10.0% ≥10.0% ≥10.0%	🟢 🟢 🟢	🟢 🔴 🟠
Percentage of stroke patients admitted to a stroke unit/organised stroke service with demonstrated stroke pathway (Ind. 1) *12 months to March 2021	All Māori Non-Māori	95.3% 76.9% 97.8%	94.5% 87.5% 95.5%	>80.0% >80.0% >80.0%	🟢 🟢 🟢	🟠 🟢 🟠
Percentage of people waiting for a surveillance or follow-up colonoscopy that wait no longer than 12 weeks (84 days) beyond the planned date	All	57.7%	52.1%	≥70.0%	🔴	🔴
Proportion of over 64 year olds who are prescribed 11 or more medications	All Māori Non-Māori	2.3% 2.9% 2.3%	2.3% 3.2% 2.2%	≤2.0% ≤2.0% ≤2.0%	🟠 🟠 🟠	🟢 🟠 🟠
Proportion of population aged 65+ years receiving DHB funded support in ARC facilities over the year There is no target appropriate for this measure, figures given are presented as a guide	All Māori Non-Māori	4.3% 2.9% 4.5%	4.1% 2.1% 4.3%	N/A N/A N/A		

PŪRONGO PŪTEA

FINANCIAL STATEMENTS

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INDEPENDENT AUDITOR'S REPORT

TO THE READERS OF WHANGANUI DISTRICT HEALTH BOARD'S FINANCIAL STATEMENTS AND PERFORMANCE INFORMATION FOR THE YEAR ENDED 30 JUNE 2021

The Auditor-General is the auditor of Whanganui District Health Board (the Health Board). The Auditor-General has appointed me, Matt Laing, 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 57 to 88, that comprise the statement of financial position as at 30 June 2021, 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 36 to 50.

Opinion

In our opinion:

- the financial statements of the Health Board on pages 57 to 88:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2021; 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.
- the performance information of the Health Board on pages 36 to 50:
    - presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2021, including:
        - for each class of reportable outputs:
            - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
            - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
        - what has been achieved with the appropriations; and
        - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and
    - complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 21 December 2021. This is the date at which our opinion is expressed.

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

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Basis for our opinion

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

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

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

Emphasis of matters

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

Emphasis of matter – Uncertainties in estimating the holiday pay provision under the Holidays Act 2003

Note 15 on pages 79 to 80, outlines that the Health Board has been investigating issues with the way it calculates holiday pay entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues. The Health Board has estimated a provision of $8.88 million, as at 30 June 2021 to remediate these issues. However, until the process is completed, there are uncertainties surrounding the amount of this provision.

The financial statements have been appropriately prepared on a disestablishment basis

Basis of preparation section on page 61, which outlines the health sector reforms announced by the Minister of Health on 21 April 2021. Legislation to disestablish all District Health Boards and establish a new Crown entity, is expected to come into effect on 1 July 2022. The Health Board therefore prepared its financial statements on a disestablishment basis. The values of assets and liabilities have not changed because these will be transferred to the new Crown entity.

The Health Board is reliant on financial support from the Crown because it has financial difficulties

Basis of preparation section on page 62, which outlines that Crown support would be required if the Health Board was required to settle the estimated historical Holidays Act 2003 liability within the period of one year from approving these financial statements. The Health Board therefore obtained a letter of comfort from the Ministers of Health and Finance, which confirms that the Crown will provide the Health Board with financial support, where necessary.

Impact of Covid-19

Note 24 on page 87 to the financial statements, which outlines the ongoing impact of Covid-19 on the Health Board.

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

Covid-19 vaccine dose information on pages 37 to 39 outlines the information used by the DHB to report on its Covid-19 vaccine coverage. The DHB uses the Health Service User (HSU) population data rather than the population data provided by Statistics New Zealand (Stats NZ), for the reasons set out in page 38. The note outlines that there would be differences in the reported results for the overall population if the Stats NZ population data was used. There would be further differences in the reported results of vaccination coverage if the Stats NZ population data is classified by ethnicity and age. The DHB has provided a table that highlights the differences in the ethnicity groupings between the HSU population data and the Stats NZ population data.

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

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

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

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

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

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.

Our responsibilities arise from the Public Audit Act 2001.

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Other Information

The Board is responsible for the other information. The other information comprises the information included on pages 4 to 35 and pages 89 to 96, but does not include the financial statements and the performance information, and our auditor's report thereon.

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

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

Independence

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

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

Matt Laing
Partner
for Deloitte Limited on behalf of the Auditor-General
Hamilton, New Zealand

STATEMENT OF RESPONSIBILITY

For the year ended 30 June 2021

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

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

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

In the opinion of the Board and management of Whanganui District Health Board, the financial statements and statement of performance for the year ended 30 June 2021, fairly reflect the financial position and operations of Whanganui District Health Board.

Signed on behalf of the Board and management by:

Kenneth (Ken) Whelan
Toihau - Board Chair

Talia Anderson-Town
Finance - Risk and Audit Chair

Russell Simpson
Kaihautū Hauora - Chief Executive

Andrew McKinnon
General Manager Corporate - Chief Financial Officer

21 December 2021

STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSE

For the year ended 30 June 2021

in thousands of New Zealand dollars

	Note	2021 Actual	2021 Budget	2020 Actual
Revenue				
Revenue from non-exchange transactions	1a	272, 044	268, 056	245, 835
Revenue from exchange transactions	1b	32, 268	30, 571	33, 522
Other revenue	1c	301	345	322
Total revenue		**304, 613**	**298, 972**	**279, 679**
Expenses				
Personnel costs	2	(101, 264)	(99, 522)	(97, 994)
Outsourced services		(17, 693)	(14, 439)	(16, 753)
Depreciation and amortisation expense		(6, 366)	(6, 201)	(5, 565)
Capital charge	3	(2, 931)	(3, 133)	(3, 507)
Finance costs	4	(16)	(16)	(19)
Other expenses	5	(181, 316)	(178, 996)	(171, 353)
Total expenses		**(309, 586)**	**(302, 307)**	**(295, 191)**
Share of profit of associate	11	126	85	108
(Deficit) / Surplus		**(4, 847)**	**(3, 250)**	**(15, 404)**
Other comprehensive revenue and expense				
Gain on property revaluation	9	8, 679	-	6, 670
Total other comprehensive revenue and expense		**8, 679**	**-**	6, 670
Total comprehensive revenue and expense		**3, 832**	**(3, 250)**	**(8, 734)**

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

Whanganui District Health Board
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STATEMENT OF FINANCIAL POSITION

As at 30 June 2021

in thousands of New Zealand dollars

	Note	2021 Actual	2021 Budget	2020 Actual
Assets				
Current assets				
Cash and cash equivalents	6	-	5	3, 813
Receivables from non-exchange transactions	7	469	160	566
Receivables from exchange transactions	7	10, 244	5, 319	5, 709
Prepayments		176	13	-
Inventories	8	1, 495	1, 617	1, 617
Trust/special funds		198	189	190
Patient and restricted trust funds		6	4	4
Total current assets		**12, 588**	**7, 307**	**11, 899**
Non-current assets				
Property, plant and equipment	9	88, 851	78, 310	79, 602
Intangible assets	10	11, 210	12, 640	11, 741
Investments in associates	11	1, 173	1, 102	1, 185
Total non-current assets		**101, 234**	**92, 052**	**92, 528**
Total assets		**113, 822**	**99, 359**	**104, 427**
Liabilities				
Current liabilities				
Cash and cash equivalents	6	1, 355	9, 199	-
Payables under non-exchange transactions	13	2, 522	2, 135	3, 297
Payables under exchange transactions	13	18, 134	15, 061	17, 238
Borrowings	14	100	100	198
Employee entitlements	15	26, 435	19, 304	21, 920
Total current liabilities		**48, 546**	**45, 799**	**42, 653**
Non-current liabilities				
Borrowings	14	385	385	486
Employee entitlements	15	768	805	839
Total non-current liabilities		**1, 153**	**1, 190**	**1, 325**
Total liabilities		**49, 699**	**46, 989**	**43, 978**
Net assets		**64, 123**	**52, 370**	**60, 449**
Equity				
Contributed capital		112, 251	114, 651	112, 409
Accumulated (deficit) / surplus		(87, 556)	(86, 349)	(82, 698)
Property revaluation reserve		39, 230	23, 881	30, 551
Hospital special funds		198	187	187
Total equity		**64, 123**	**52, 370**	**60, 449**

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

STATEMENT OF CHANGES IN EQUITY

For the year ended 30 June 2021

in thousands of New Zealand dollars

	2021 Actual	2020 Actual
Crown equity		
Balance at 1 July	112, 409	105, 567
Capital contribution from the Crown	-	7, 000
Repayment of capital to the Crown	(158)	(158)
Balance at 30 June	**112, 251**	**112, 409**
Accumulated (deficit)		
Balance at 1 July	(82, 698)	(67, 287)
Other reserved movements	(11)	(7)
Deficit for the year	(4, 847)	(15, 404)
Balance at 30 June	**(87, 556)**	**(82, 698)**
Property revaluation reserves		
Balance at 1 July	30, 551	23, 881
Revaluation	8, 679	6, 670
Balance at 30 June	**39, 230**	**30, 551**
Property revaluation reserves consist of:		
Land	2, 795	1, 800
Buildings	36, 435	28, 751
Total property revaluation reserves	**39, 230**	**30, 551**
Hospital special funds		
Balance at 1 July	187	180
Transfer from retained earnings in respect of:		
Interest	1	3
Donations and funds received	13	4
Transfer from retained earnings in respect of:		
Funds spent	(3)	-
Balance at 30 June	**198**	**187**
Total equity	**64, 123**	**60, 449**

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

STATEMENT OF CASH FLOWS

For the year ended 30 June 2021

in thousands of New Zealand dollars

	Note	2021 Actual	2021 Budget	2020 Actual
Cash flows from operating activities				
Receipts from the Crown		299, 460	297, 302	279, 252
Interest received		57	266	108
Receipt from other revenue		1, 550	1, 305	1, 318
Payment to suppliers		(199, 485)	(195, 835)	(187, 172)
Payment to employees		(96, 820)	(102, 185)	(92, 821)
Interest paid		(16)	(16)	(19)
Payment of capital charge		(2, 931)	(3, 133)	(3, 507)
GST (net)		128	(159)	179
Net cash inflow / (outflow) from operating activities		**1, 943**	**(2, 455)**	**(2, 662)**
Cash flows from investing activities				
Purchase of property, plant and equipment		(5, 570)	(7, 802)	(2, 271)
Purchase of intangible assets		(1, 186)	(1, 895)	(838)
Receipts from maturity of investments		12	(25)	(39)
Net appropriation from trust funds		(10)	1	(9)
Net cash inflow / (outflow) from investing activities		**(6, 754)**	**(9, 721)**	**(3, 157)**
Cash flows from financing activities				
Capital contribution		-	2, 400	7, 000
Payment of finance lease		(98)	(98)	(95)
Repayment of capital		(158)	(158)	(158)
Payment of loans		(101)	(101)	(135)
Net cash inflow / (outflow) from financing activities		**(357)**	**2, 043**	**6, 612**
Net (decrease) / increase in cash and cash equivalents		(5, 168)	(10, 133)	793
Cash and cash equivalents at beginning of year		3, 813	939	3, 020
Cash and cash equivalents at end of year	**6**	**(1, 355)**	**(9, 194)**	**3, 813**

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

	2021 Actual	2020 Actual
Net surplus / (deficit)	**(4, 847)**	**(15, 404)**
Add / (less) non-cash items		
Depreciation and amortisation expense	6, 366	5, 565
Total non-cash items	**6, 366**	**5, 565**
Add / (less) items classified as investing or financing activities		
Losses / (gains) on disposal of property, plant and equipment	80	5
(Deficit) / surplus from associates	(126)	(108)
Payable movements attributed to capital purchase	271	(127)
Total items classified as investing or financing activities	**225**	**(230)**
Add / (less) movements in statement of financial position items		
Receivables	(4, 488)	123
Inventories	122	(190)
Payables	121	2, 301
Employee entitlements	4, 444	5, 173
Net movements in working capital items	**199**	**7, 407**
Net cash flow from operating activities	**1943**	**(2, 662)**

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

STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES

For the year ended 30 June 2021

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, (2020: 16.67% owned), as disclosed in Note 11.

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

The financial statements for Whanganui District Health Board are for year ended 30 June 2021, and were authorised by the Board on 21 December 2021.

BASIS OF PREPARATION

Health Sector Reforms

On 21 April 2021, the Minister of Health announced the health sector reforms in response to the Health and Disability System Review.

The reforms will replace all 20 DHBs with a new Crown entity, Health New Zealand, which will be responsible for running hospitals and commissioning primary and community health services. It will have four regional divisions.

As a result of the reforms, responsibility for public health issues will rest with a new Public Health Authority. A new Māori Health Authority will monitor the state of Māori health and commission services directly.

Legislation to establish the new entities and disestablish DHBs is scheduled to come into effect on 1 July 2022. Because of the expected date of these reforms the financial statements of the Whanganui District Health Board have been prepared on a disestablishment basis. No changes have been made to the recognition and measurement, or presentation in these financial statements, because all assets, liabilities, functions and staff of the DHBs and shared services agencies will transfer to Health New Zealand.

Statement of compliance

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

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

Presentation currency and rounding

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

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

Standards and amendments, issued but not yet effective that have not been early adopted, and which are relevant to the Whanganui District Health Board are:

Amendment to Cash Flow Statement

An amendment to PBE IPSAS 2 requires entities to provide disclosures that enable users of financial statements to evaluate changes in liabilities arising from financing activities, including both changes arising from cash flows and non-cash changes. This amendment is effective for the year ending 30 June 2022, with early application permitted. This amendment will result in additional disclosures. The Whanganui District Health Board does not intend to early adopt the amendment.

Financial instruments

PBE IPSAS 41 replaces PBE IFRS 9 Financial Instruments and is effective for the year ending 30 June 2023, with earlier adoption permitted. The Whanganui District Health Board has assessed that there will be little change as a result of adopting the new standard as the requirements are similar to those contained in PBE IFRS 9. The Whanganui District Health Board does not intend to early adopt the standard.

Service Performance Reporting

PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 Presentation of Financial Statements and is effective for the year ending 30 June 2023, with earlier adoption permitted.

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

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

Whanganui District Health Board has not yet determined how application PBE FRS 48 will affect its statement of performance. Whanganui District Health Board does not plan to early adopt the standard.

STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES

For the year ended 30 June 2021

LETTER OF COMFORT

The Board has received a Letter of Comfort dated 13 October 2021 from the Ministers of Health and Finance. All assets, liabilities, functions and staff of the Whanganui District Health Board will transfer to Health New Zealand (HNZ) from 1 July 2022. Financial support will be provided until Whanganui District Health Board is disestablished.

OPERATING AND CASH FLOW FORECASTS

Operating and cash flow forecasts show there will be operating cash flow deficit for the 2021/22 year. Whanganui District Health Board forecasts indicate it will be reliant on accessing its overdraft facility with NZ Health Partnerships to meet its operating cash flow deficit and to meet the investing cash flow requirements of the Whanganui District Health Board for the 2021/22 financial year.

SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

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

COMPARATIVE FIGURES

Comparative figures in the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows are presented for the 12 month's operations from 1 July 2019 to 30 June 2020. The comparative figures in the Statement of Financial Position are presented as at 30 June 2020.

BUDGET FIGURES

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

GOODS AND SERVICES TAX

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

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

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

INCOME TAX

Whanganui District Health Board is a Crown entity under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under section CB3 of the Income Tax Act 2007. The associate company Allied Laundry Services Limited, is exempt from income tax under section CW31 (2) of the Income Tax Act 2007.

FOREIGN CURRENCY TRANSACTIONS

Foreign currency transactions (including those subject to forward foreign exchange contracts) are translated into NZ dollars (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.

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 20.

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

CHANGE IN ACCOUNTING POLICIES

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

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

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

1 REVENUE

ACCOUNTING POLICIES

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

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

Crown funding

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

The revenue recognition approach for Crown contract revenue depends on the contract terms. Those contracts where the amount of revenue is substantively linked to the provision of quantifiable units of service are treated as exchange contracts and revenue is recognised as Whanganui District Health Board 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	2021 Actual	2020 Actual
Health and disability services (Crown appropriation revenue)*	251, 927	230, 812
Ministry of Health other revenue	20, 033	15, 008
Other revenue	84	15
Total revenue from non-exchange transactions	**272, 044**	**245, 835**

1b. REVENUE FROM EXCHANGE TRANSACTIONS	2021 Actual	2020 Actual
Ministry of Health other revenue	13, 377	17, 084
ACC contract	7, 981	6, 680
Inter District Patient Inflows	9, 226	8, 376
Other Government	276	145
Other revenue	1, 351	1,129
Finance income	57	108
Total revenue from exchange transactions	**32, 268**	**33, 522**

1c. OTHER REVENUE	2021 Actual	2020 Actual
Rental revenue	301	322
Total other revenue	**301**	**322**

* Performance against this appropriation is reported in the Statement of Performance on pages 36-50. 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

	2021 Actual	2020 Actual
Salaries and wages	95, 469	93, 405
Defined contribution scheme employer contributions	2, 843	2, 873
Increase / (decrease) in employee entitlements	2, 952	1, 716
Total personnel costs	**101, 264**	**97, 994**

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	
	2021 Actual	2020 Actual
100, 000 - 109, 999	43	60
110, 000 - 119, 999	46	39
120, 000 - 129, 999	18	12
130, 000 - 139, 999	11	9
140, 000 - 149, 999	7	4
150, 000 - 159, 999	4	4
160, 000 - 169, 999	1	2
170, 000 - 179, 999	2	3
180, 000 - 189, 999	2	2
190, 000 - 199, 999	3	2
200, 000 - 209, 999	3	2
210, 000 - 219, 999	2	3
220, 000 - 229, 999	4	2
230, 000 - 239, 999	2	1
240, 000 - 249, 999	2	3
250, 000 - 259, 999	3	3
260, 000 - 269, 999	3	1
270, 000 - 279, 999	1	1
280, 000 - 289, 999	2	2
290, 000 - 299, 999	1	3
300, 000 - 309, 999	1	2
310, 000 - 319, 999	3	-
320, 000 - 329, 999	5	1
330, 000 - 339, 999	-	2
350, 000 - 359, 999	1	4
360, 000 - 369, 999	1	4
370, 000 - 379, 999	4	1
380, 000 - 389, 999	2	3
390, 000 - 399, 999	1	2
400, 000 - 409, 999	3	1
410, 000 - 419, 999	3	-
420, 000 - 429, 999	4	2
430, 000 - 439, 999	-	1
440, 000 - 449, 999	-	-
450, 000 - 459, 999	-	2
460, 000 - 469, 999	1	-
490, 000 - 499, 999	1	-
820, 000 - 829, 999	-	1
920, 000 - 929, 999	1	-
Total employees	**191**	**184**

Of the 191 (2020:184) employees shown above, 168 (2020:156) were predominantly clinical employees and 23 (2020:28) were management/administrative employees. If the remuneration of the part-time employees were grossed up to a fulltime equivalent (FTE) basis, the total number of employees with FTE salaries of $100,000 or more would be 203 (2020: 189) compared with the actual number of employees of 191 (2020: 184).

The chief executive's remuneration is in the $390,000 to $399,999 band (2020: $390,000 to $399,999). This includes the value of the Whanganui District Health Board's contribution to Kiwi-Saver and car allowance. Non-cash benefits are not included in the salary data for other employees.

Severance payments

No employee received a severance payment in 2021 (2020: 1). No employees received compensation and other benefits in relation to termination of their employment or change in contractual conditions in 2021 (2020: $19k).

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 Whanganui 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 2021 was 5% (2020: 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	2021 Actual	2020 Actual
Interest on finance lease	16	19
Total finance costs	**16**	**19**

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	2021 Actual	2020 Actual
Fees to Auditors		
Fees for audit of financial statements	211*	195*
Audit related fee internal (for assurance related services)	118	133
Board members fees	187	202
Board member expenses	2	3
Operating lease expenses	454	547
(Reversal of) / impairment of receivables	70	28
Loss on disposal of property, plant and equipment	80	5
Inventories consumed	8, 969	9, 002
Clinical & infrastructure and non-clinical expenses	26, 011	23, 368
Inter district outflow	46, 989	45, 247
Payments to non-health board providers	98, 225	92, 623
Total other expenses	**181, 316**	**171, 353**

* The audit fee includes a scope extension of $25k for year ended 30 June 2021 (2020: $18k).

in thousands of New Zealand dollars

5 OTHER EXPENSES (continued)

BOARD MEMBER REMUNERATION	2021 Actual	2020 Actual
Mr Ken Whelan *(Board chair from Dec 19)*	33	19
Ms Annette Main *(Deputy Board chair from Dec 19)*	21	19
Mrs Dot McKinnon *(Board chair to Dec 19)*	-	15
Mr Stuart Hylton *(Deputy Board chair to Dec 19)*	17	19
Mrs Philippa Baker-Hogan	17	17
Mrs Judith MacDonald	17	17
Mr Graham Adams	17	17
Mr Charlie Anderson	17	17
Mrs Talia Anderson-Town *(from Dec 19)*	17	8
Ms Materoa Mar *(from Dec 19)*	-	4
Mr Josh Chandulal-Mackay *(from Dec 19)*	17	9
Mrs Soraya Peke-Mason *(from Dec 19)*	11	9
Hon Dame Tariana Turia *(to Dec 19)*	-	8
Mr Darren Hull *(to Dec 19)*	-	8
Ms Maraea Bellamy *(to Dec 19)*	-	8
Ms Jenny Duncan *(to Dec 19)*	-	8
Mrs Mary Bennett *(from April 21)*	3	-
	187	**202**

Whanganui District Health Board provides a deed of indemnity to Board members 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 (2020: nil).

Payments made to committee members appointed by the Board totalled $18k (2020: $28k).

Operating leases as lessee

THE FUTURE AGGREGATE MINIMUM LEASE PAYMENTS TO BE PAID UNDER NON-CANCELLABLE OPERATING LEASES ARE AS FOLLOWS	2021 Actual	2020 Actual
Non-cancellable operating leases		
Less than one year	103	-
One to two years	103	-
Two to three years	103	-
Total	**309**	**-**

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	2021 Actual	2020 Actual
Cash on hand	5	5
Demand funds held with NZHP	(1, 360)	3, 808
Total cash and cash equivalents	**(1, 355)**	**3, 813**

While cash and cash equivalents at 30 June 2021 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.

NZ Health Partnerships overdraft facility

The maximum debit balance 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 twelfth 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 2021, this limit was $12.97m (2020: $12.24m).

Interest rates

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

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	2021 Actual	2020 Actual
Receivables - Other (gross)	6, 844	2, 672
Ministry of Health (gross)	4, 144	3, 808
Less: provision for impairments	(275)	(205)
Total receivables	**10, 713**	**6, 275**
Total receivables comprises:		
Receivable from non-exchange transactions	469	566
Receivable from exchange transactions	10, 244	5, 709

The expected credit loss rates for receivables are based on the payment profile of revenue on credit at the measurement date and the corresponding historical credit losses experienced for that period. The historical loss rates are adjusted for current and 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
	2021			2020		
Not past due	10, 161	(24)	10, 137	5, 301	(5)	5, 296
Past due 1 - 30 days	168	(15)	153	69	(19)	50
Past due 31 - 120 days	183	(46)	137	886	(15)	871
Past due 121 - 360 days	278	(47)	231	136	(78)	58
Past due over 360 days	198	(143)	55	88	(88)	-
Total	**10, 988**	**(275)**	**10, 713**	**6, 480**	**(205)**	**6, 275**

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:	2021 Actual	2020 Actual
Balance as at 1 July	205	177
Additional provisions made during the year	138	106
Receivables written off during the year	-	(2)
Receivables reversal & recovered during the year	(68)	(76)
Total	**275**	**205**

8 INVENTORIES

ACCOUNTING POLICIES

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

Inventories are held for Whanganui 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	2021 Actual	2020 Actual
Held for distribution inventories		
Central stores	438	504
Pharmaceuticals	319	392
Theatre supplies	476	476
Other supplies	262	245
Total inventories	**1, 495**	**1, 617**

Write-down of inventories amounted to $71k (2020: $36k). There have been no reversals of write-downs.

No inventories are pledged as security for liabilities (2020: 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 value of inventories recognised as an expense during the year was $9 million (2020: $9 million), which is included in the Other Expenses line item of the Statement of Comprehensive Revenue and Expense.

in thousands of New Zealand dollars

9 PROPERTY, PLANT AND EQUIPMENT

ACCOUNTING POLICIES

Classes of property, plant and equipment

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

- Land, at fair value.
- Buildings and improvements, at fair value less accumulated depreciation.
- Clinical and other equipment, at cost less accumulated depreciation and impairment losses.
- Vehicles, at cost less accumulated depreciation and impairment losses.
- Leased assets, at 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 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%
Clinical & other equipment	3 - 40 years	2.5% - 33%
Vehicles	8 - 14.3 years	7% - 12.5%
Leased assets	7 - 8 years	12.5% - 14.3%

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

Impairment of property, plant and equipment

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

Non-cash generating assets

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

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

If an asset's carrying amount exceeds its recoverable service amount, the asset is regarded as impaired and the carrying amount is written down to the recoverable service amount. For revalued assets, the impairment loss is recognised against the revaluation reserve for that class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised in the surplus or deficit.

For assets not carried at a revalued amount, the total impairment loss is recognised in the surplus or deficit. The reversal of an impairment loss on a revalued asset is credited to other comprehensive revenue and expense and increases the asset revaluation reserve for that class of asset. However, to the extent that an impairment loss for that class of asset was previously recognised in the surplus or deficit, a reversal of the impairment loss is also recognised in the surplus or deficit.

KEY ACCOUNTING ASSUMPTIONS AND ESTIMATES

Estimated useful lives of property, plant and equipment

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

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

Estimating the fair value of land and buildings

Valuation

The most recent valuation of land and buildings was performed by an independent registered valuer Evan Gamby (M Prop Stud Distn, Dip UV, FNZIV (Life), LPINZ, FRICS) and Logan Holyoake (B Prop; MPINZ) of Telfer Young Limited. The valuation is effective as at 30 June 2021.

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 used in the 30 June 2021 valuation 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. Optimisation has been undertaken in line with Treasury Guideline.
- Whanganui District Health Board's earthquake prone buildings that are expected to be strengthened; the estimated earthquake-strengthening costs have been deducted off the depreciated replacement cost in estimating fair value.
- The replacement cost is derived from recent construction contracts of similar assets and Property Institute of New Zealand cost information. Construction costs range from $575 to $7,675 per square meter, depending on the nature of the specific asset valued.
- The remaining useful life of assets is estimated considering factors such as the condition of the asset, district health board's future maintenance and replacement plans, and experience with similar buildings.
- Straight-line depreciation has been applied in determining the depreciated replacement cost value of the asset.

Non-specialised buildings (for example, residential buildings) are valued at fair value using market-based evidence.

Market rents and capitalisation rates were applied to reflect market value.

The recent revaluation of land and buildings resulted in a $1.0 million - 40.98% increase in the carrying value of land and $7.68 million - 11.69% increase in the carrying value of buildings and improvements. The revaluation resulted in a $8.68 million increase in property revaluation reserve and a $8.68 million gain on property revaluation in other comprehensive revenue and expense.

Restrictions on title

Whanganui District Health Board does not have full title to Crown land it occupies, but transfer is arranged 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 in course of refurbishment and construction total $45k (2020: nil).

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 2020	Cost / valuation	Accumulated depreciation	Carrying amounts	Additions	Disposals	Revaluation increase	Depreciation expenses	Elimination on disposal	Elimination on revaluation	Cost / valuation	Accumulated depreciation	Carrying amounts
	1 July 2019									30 June 2020		
Land	1,721	-	1,721	-	-	707	-	-	-	2,428	-	2,428
Buildings & improvements	69,874	(5,207)	64,667	696	-	705	(2,699)	-	5,258	71,275	(2,648)	68,627
Clinical & other equipment	25,446	(18,790)	6,656	1,535	(93)	-	(1,516)	89	-	26,888	(20,217)	6,671
Leased assets	966	(250)	716	-	-	-	(120)	-	-	966	(370)	596
Motor vehicles	2,950	(1,480)	1,470	38	-	-	(228)	-	-	2,988	(1,708)	1,280
	100,957	**(25,727)**	**75,230**	**2,269**	**(93)**	**1,412**	**(4,563)**	**89**	**5,258**	**104,545**	**(24,943)**	**79,602**
Work in progress												
Buildings & improvements	-	-	-	-	-	-	-	-	-	-	-	-
	-	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Total	**100,957**	**(25,727)**	**75,230**	**2,269**	**(93)**	**1,412**	**(4,563)**	**89**	**5,258**	**104,545**	**(24,943)**	**79,602**

30 June 2021	Cost / valuation	Accumulated depreciation	Carrying amounts	Additions	Disposals	Revaluation increase	Depreciation expenses	Elimination on disposal	Elimination on revaluation	Cost / valuation	Accumulated depreciation	Carrying amounts
	1 July 2020									30 June 2021		
Land	2,428	-	2,428	-	-	995	-	-	-	3,423	-	3,423
Buildings & improvements	71,275	(2,648)	68,627	1,798	-	4,983	(2,789)	-	2,701	78,056	(2,736)	75,320
Clinical & other equipment	26,888	(20,217)	6,671	3,681	(278)	-	(1,829)	273	-	30,291	(21,773)	8,518
Leased assets	966	(370)	596	-	-	-	(105)	-	-	966	(475)	491
Motor vehicles	2,988	(1,708)	1,280	-	-	-	(226)	-	-	2,988	(1,934)	1,054
	104,545	**(24,943)**	**79,602**	**5,479**	**(278)**	**5,978**	**(4,949)**	**273**	**2,701**	**115,724**	**(26,918)**	**88,806**
Work in progress												
Buildings & improvements	-	-	-	45	-	-	-	-	-	45	-	45
	-	**-**	**-**	**45**	**-**	**-**	**-**	**-**	**-**	**45**	**-**	**45**
Total	**104,545**	**(24,943)**	**79,602**	**5,524**	**(278)**	**5,978**	**(4,949)**	**273**	**2,701**	**115,769**	**(26,918)**	**88,851**

Whanganui District Health Board has restated comparative information for prior period with respect to reclassification of plant to buildings and improvements from clinical and other equipment

in thousands of New Zealand dollars

10 INTANGIBLE ASSETS

ACCOUNTING POLICIES

Initial recognition

Intangible assets 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 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.

Information technology shared services rights

Whanganui District Health Board has provided funding for the development of information technology (IT) shared services across the DHB sector and the rights to the shared services is recognised as an intangible asset at the cost of the group's capital investment.

Amortisation

The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life 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%

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

Impairment of intangible assets

Refer to the policy for impairment of property, plant and equipment in Note 9. The same approach applies to the impairment of intangible assets, except for intangible assets that are still under development.

Intangible assets that are under development and not yet ready for use are tested for impairment annually, irrespective of whether there is any indication of impairment.

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.

Regional Health Informatics Programme (RHIP)

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

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

As at 30 June 2021, Whanganui District Health Board had invested a total of $12.62 million (2020: $12.27 million) in RHIP. Of this investment, $44k (2020: $4K) has been recognised as work in progress.

The investment has been tested for impairment during the year by Whanganui District Health Board. However, based on the information available, no impairment is required at this point.

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 2020	Cost / valuation	Accumulated amortisation	Carrying amounts	Additions	Transfer	Disposals	Impairment	Amortisation	Elimination on disposal	Cost / valuation	Accumulated amortisation	Carrying amounts
	1 July 2019									30 June 2020		
Software	4,673	(3,547)	1,126	345	-	-	-	(238)	-	5,018	(3,785)	1,233
Regional Health Informatics Programme (RHIP)	3,817	(641)	3,176	-	5,615	-	-	(536)	-	9,432	(1,177)	8,255
Regional Health Informatics Programme (RHIP) - local	2,403	(356)	2,047	156	274	-	-	(228)	-	2,833	(584)	2,249
	10,893	**(4,544)**	**6,349**	**501**	**5,889**	**-**	**-**	**(1,002)**	**-**	**17,283**	**(5,546)**	**11,737**
Work in progress												
Regional Health Informatics Programme (RHIP)	5,428	-	5,428	465	(5,889)	-	-	-	-	4	-	4
	5,428	**-**	**5,428**	**465**	**(5,889)**	**-**	**-**	**-**	**-**	**4**	**-**	**4**
Total	**16,321**	**(4,544)**	**11,777**	**966**	**-**	**-**		**(1002)**	**-**	**17,287**	**(5,546)**	**11,741**

30 June 2021	Cost / valuation	Accumulated amortisation	Carrying amounts	Additions	Transfer	Disposals	Impairment	Amortisation	Elimination on disposal	Cost / valuation	Accumulated amortisation	Carrying amounts
	1 July 2020									30 June 2021		
Software	5,018	(3,785)	1,233	568	-	(96)	-	(264)	19	5,490	(4,030)	1,460
Regional Health Informatics Programme (RHIP)	9,432	(1,177)	8,255	353	-	-	-	(909)	-	9,785	(2,086)	7,699
Regional Health Informatics Programme (RHIP) - local	2,833	(584)	2,249	-	-	-	-	(242)	-	2,833	(826)	2,007
	17,283	**(5,546)**	**11,737**	**921**	**-**	**(96)**	**-**	**(1,415)**	**19**	**18,108**	**(6,942)**	**11,166**
Work in progress												
Regional Health Informatics Programme (RHIP) & Local	4	-	4	40	-	-	-	-	-	44	-	44
	4	**-**	**4**	**40**	**-**	**-**	**-**	**-**	**-**	**44**	**-**	**44**
Total	**17,287**	**(5,546)**	**11,741**	**961**	**-**	**(96)**	**-**	**(1,415)**	**19**	**18,152**	**(6,942)**	**11,210**

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

11 INVESTMENT IN ASSOCIATES

ACCOUNTING POLICIES

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

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

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

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

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

If Whanganui District Health Board's share of deficit 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	2021 Actual	2020 Actual
Summary of financial information on associate entities *(100 percent)*		
Assets	11, 899	9, 867
Liabilities	(4, 151)	(2, 232)
Equity	(7, 748)	(7, 635)
Revenue	(11, 761)	(11, 759)
Expense	11, 008	10, 995
Surplus / (deficit)	753	764
Allied Laundry Services Limited	16.67%	16.67%
Investment in associates		
Balance as at 1 July	1, 185	1, 146
Dividends	(138)	(69)
Share of profit	126	108
Total investment in associates	**1, 173**	**1, 185**

12 OTHER FINANCIAL ASSETS

Whanganui District Health Board holds a 16.7% (2020: 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 % (2020: 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

13 PAYABLES

ACCOUNTING POLICIES

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

BREAKDOWN OF PAYABLES UNDER NON-EXCHANGE AND EXCHANGE TRANSACTIONS

	2021 Actual	2020 Actual
Payables under non-exchange transaction		
Creditors	33	-
Tax payables (GST, PAYE)	2, 061	1, 861
ACC levy	155	151
Income in advance	-	994
Other	273	291
Total payables under non-exchange transaction	**2, 522**	**3, 297**
Payables under exchange transaction		
Creditors	2, 842	2, 388
Income in advance	2, 180	294
Accrued expense	13, 112	14, 556
Total payables under exchange transaction	**18, 134**	**17, 238**
Total payables	**20, 656**	**20, 535**

14 BORROWINGS

ACCOUNTING POLICIES

Borrowings are initially measured at fair value, plus transaction costs. Subsequent to initial recognition, all borrowings are stated at amortised cost with any difference between cost and redemption value being recognised in the surplus or deficit over the period of the borrowings on an effective interest basis. Interest due on the borrowings is subsequently accrued and added to the accrued expense.

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

Finance lease

A finance lease is a lease that transfers to the lessee substantially all the risks and rewards incidental to ownership of an asset, whether or not title is eventually transferred.

At the commencement of the lease term, finance leases whereby Whanganui District Health Board is the lessee are recognised as assets and liabilities in the Statement of Financial Position at the lower of the fair value of the leased item or the present value of the minimum lease payments.

The finance charge is charged to the surplus or deficit over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability.

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

CRITICAL JUDGEMENTS IN APPLYING ACCOUNTING POLICIES

Leases classification

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

Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term and determining an appropriate discount rate to calculate the present value of the minimum lease payments.

Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant and equipment, whereas for an operating lease no such asset is recognised.

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

in thousands of New Zealand dollars

BREAKDOWN OF BORROWINGS AND FURTHER INFORMATION

	2021 Actual	2020 Actual
Current portion		
The Energy Efficiency and Conservation Authority	-	101
Finance lease	100	97
Total current portion	**100**	**198**
Non-current portion		
Finance lease	385	486
Total non-current portion	**385**	**486**
Total borrowings	**485**	**684**

ENERGY EFFICIENCY & CONSERVATION AUTHORITY LOAN PAYABLE AS FOLLOWS:

	2021 Actual	2020 Actual
Less than one year	-	101
Total	**-**	**101**

ANALYSIS OF FINANCE LEASE AS FOLLOWS:

	2021 Actual	2020 Actual
Minimum lease payments payables		
Less than one year	114	114
Between one and five years	406	455
More than five years	-	65
Total minimum lease payments	**520**	**634**
Less: Future finance charges	(35)	(51)
Total borrowings	**485**	**583**

PRESENT VALUE OF MINIMUM LEASE PAYMENTS PAYABLE:

	2021 Actual	2020 Actual
Minimum lease payments payables		
Less than one year	100	97
Between one and five years	385	421
More than five years	-	65
Present value of minimum lease payments	**485**	**583**

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

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

15 EMPLOYEE BENEFITS

ACCOUNTING POLICIES

Short-term employee entitlements

Employee benefits that are due to be settled within 12 months after the end of the period in which the employee renders the related service are measured based on accrued entitlements at current rates of pay.

These include salaries and wages accrued up to balance date and annual leave earned but not yet taken at balance date and sick leave.

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

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

Long-term employee entitlements

Employee benefits that are due to be settled beyond 12 months after the end of period in which the employee renders the related service, such as long service leave and retirement gratuities, have been calculated using projected unit credit method and discounted to its present value. The calculations are based on:

- likely future entitlements accruing to staff, based on years of service, years to entitlement, the likelihood that staff will reach the point of entitlement, and contractual entitlement information; and
- the present value of the estimated future cash flows.

Presentation of employee entitlements

Sick leave, annual leave, continuing medical education leave, sabbatical and long service leave are classified as a current liability. Long service leaves 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 ranges from 0.21% to 2.79% (2020: 0.14 to 1.28%) and an inflation factor of 3% (2020: 3%) were used.

The discount rates used are those advised by the Treasury. The salary inflation factor is Whanganui District Health Board's best estimate forecast of salary increment.

Continuing medical education leave

The continuing medical education leave liability assumes that the utilisation of the annual entitlement, which can be accumulated for up to three years. The liability has not been calculated on an actuarial basis because the present value effect is trivial.

Holidays Act 2003 remediation

Several 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 (NZBS), with the Council of Trade Unions (CTU), health sector unions and Ministry of Business Innovation and Employment (MBIE) Labour Inspectorate for an agreed and national approach to identify, rectify and remediate any Holidays Act non-compliance. DHBs 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 DHBs that have workforces that include differential occupational groups with complex entitlements, non-standard hours, allowances and/or overtime, the process of assessing non-compliance with the Act and determining any additional payment is time consuming and complicated.

This has led to a memorandum of understanding (MOU) being agreed which (along with a Baseline Document and Framework) outlines the actions DHB's will take to assess compliance with the Act, sets out the interpretations and methods that have been agreed for calculating individual payments to employees, and sets out the agreed review process for assessing each DHB's compliance with the Baseline Document.

The review process agreed as part of the MOU commenced in 2019 and will rollout in tranches to the DHB's and NZBS, Whanganui District Health Board believes it can make a reliable estimate of their obligation to address historic non-compliance under the MOU.

The remediation project associated with the MOU is a significant undertaking and work to assess all non-compliance will continue into the 2021/22 financial year. The outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed.

Notwithstanding this, as at 30 June 2021, in preparing these financial statements, Whanganui District Health Board recognises it has an obligation to address any historical non-compliance under the MOU and has made an estimate of its liability by undertaking its own review of its payroll processes based on the requirements of the MOU. A copy of the payroll system was created, modifications made to the system configuration and scripts run to recalculate what the value of the liability on an individual employee basis was estimated to be.

in thousands of New Zealand dollars

Whanganui District Health Board has estimated its liability as at 30 June 2021 to be $8.9 million (2020: $7 million) and is included in the Liability for Other Entitlement. WDHB is confident that the provision represents with reasonable certainty its liability. The liability may change over time as the agreed process set out in the Framework continues including national agreement being reached by DHBs on matters of interpretation to ensure national consistency. Payments are expected to be ready to be made in 2022.

BREAKDOWN OF EMPLOYEE ENTITLEMENTS	2021 Actual	2020 Actual
Current portions		
Accrued salaries and wages	4, 532	3, 040
Annual leave	10, 916	9, 746
Sick leave	173	223
Retirement gratuities	653	637
Long service leave	801	960
Sabbatical leave	449	516
Other leave	3	4
Continuing medical education leave	27	27
Other entitlement	8, 881	6, 767
Total current portion	**26, 435**	**21, 920**
Non-current portions		
Retirement gratuities	630	713
Long service leave	138	126
Total non-current portion	**768**	**839**
Total employee entitlements	**27, 203**	**22, 759**

16 CONTINGENT LIABILITIES AND CONTINGENT ASSETS

Contingent liabilities

Contingent liabilities are disclosed if the possibility that they will crystallise is not remote.

Whanganui District Health Board has one legal claim against it, relating to an outsourced contract dispute. Whanganui District Health Board is vigorously contesting the claims and there is uncertainty as to what the legal outcome might be. (2020: nil).

Contingent assets

Whanganui District Health Board has no contingent assets (2020: nil).

in thousands of New Zealand dollars

17 CAPITAL COMMITMENTS

	2021 Actual	2020 Actual
Capital commitments		
Buildings and improvements	13	83
Plant and equipment	1, 155	1, 022
Intangible assets	549	581
Total capital commitments	**1, 717**	**1, 686**

	2021 Actual	2020 Actual
Capital commitments		
Less than one year	1, 717	1, 686
One to two years	-	-
Total	**1, 717**	**1, 686**

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

18 RELATED PARTY TRANSACTIONS

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	2021 Actual	2020 Actual
Board members		
Remuneration	187	202
Full-time equivalent members	0.86	0.78
Executive team		
Remuneration	1, 872	1, 720
Full-time equivalent members	7.85	7.51
Total key management personnel compensation	**2, 059**	**1, 922**
Total full time equivalent personnel	**8.71**	**8.29**

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

19 EVENTS AFTER THE BALANCE DATE

There were no significant events after the balance date.

20 FINANCIAL INSTRUMENTS

FINANCIAL ASSETS

Classification

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

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

Recognition and derecognition

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

Measurement

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

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

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

Impairment

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

Financial liabilities and equity

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

Equity instruments

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

Financial liabilities

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

Other financial liabilities

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

Derecognition of financial liabilities

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

in thousands of New Zealand dollars

20a FINANCIAL INSTRUMENT CATEGORIES

	2021 Actual	2020 Actual
Financial assets measured at amortised costs		
Cash and cash equivalents	-	3, 813
Receivables (Gross)	10, 988	6, 480
Total financial assets measured at amortised cost	**10, 988**	**10, 293**
Financial liabilities measured at amortised cost		
Cash and cash equivalents	1, 355	-
Payables *(excluding income in advance, taxes payable and grants received subject to conditions)*	16, 415	17, 386
Borrowings - Energy Efficiency and Conservation Authority	-	101
Finance leases	485	583
Total financial liabilities measured at amortised cost	**18, 255**	**18, 070**

20b FAIR VALUE

ESTIMATION OF FAIR VALUES ANALYSIS

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

	Notes	Carrying amount	Fair value
30 June 2020			
Financial assets			
Cash and cash equivalents	6	3, 813	3, 813
Receivables (Gross)	7	6, 480	6, 480
Financial liabilities			
Payables *(excluding income in advance, taxes payable and grants received subject to conditions)*	13	17, 386	17, 386
Borrowings - Energy Efficiency and Conservation Authority	14	101	101
Finance lease liabilities	14	583	583
30 June 2021			
Financial assets			
Cash and cash equivalents	6	-	-
Receivables (Gross)	7	10, 988	10, 988
Financial liabilities			
Cash and cash equivalents	6	1, 355	1, 355
Payables *(excluding income in advance, taxes payable, and grants received subject to conditions)*	13	16, 415	16, 415
Finance lease liabilities	14	485	485

Interest-bearing loans and borrowings
Fair value is calculated based on discounted expected future principal and interest cash flows.

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

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

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

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

20c FINANCIAL INSTRUMENT RISK

Whanganui District Health Board's activities expose it to a variety of financial instrument risks, including market risk, credit risk, and liquidity risk. Whanganui District Health Board has a Finance, Risk and Audit Committee that provides oversight of risk management activities and 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 2021, it is estimated that a general increase of one percentage point in interest rates would have minimal impact on earnings in 2020-21, 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 39% (2020: 59%). 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 2020						
Cash and cash equivalents	-	5	5	-	-	-
NZ Health Partnerships Limited	-	3, 808	3, 808	-	-	-
Receivables (net)	-	6, 275	6, 275	-	-	-
Financial liabilities						
Borrowings - Energy Efficiency & Conservation Authority	0.00%	101	101	-	-	-
Finance leases	3.00%	583	97	100	321	65
30 June 2021						
Receivables (net)	-	10, 713	10, 713	-	-	-
Financial liabilities						
NZ Health Partnerships Limited	0.00%	1, 355	1, 355	-	-	-
Finance leases	3.00%	485	100	103	282	-

Liquidity risk

Management of liquidity risk

Liquidity risk is the risk that Whanganui District Health Board encounters difficulty raising liquid funds to meet commitmentsas they fall due. Prudent liquidity risk management implies maintaining sufficient cash, the availability of funding through anadequate 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 2020						
Payables *(excluding income in advance, taxes payable & grants received subject to conditions)*	17, 386	17, 386	17, 386	-	-	-
Borrowings - Energy Efficiency & Conservation Authority	101	101	101	-	-	-
Finance leases	583	634	114	114	341	65
Total	**18, 070**	**18, 121**	**17, 601**	**114**	**341**	**65**
30 June 2021						
Payables *(excluding income in advance, taxes payable & grants received subject to conditions)*	16, 415	16, 415	16, 415	-	-	-
NZ Health Partnerships Limited	1, 355	1, 355	1, 355	-	-	-
Borrowings - Energy Efficiency & Conservation Authority	-	-	-	-	-	-
Finance leases	485	520	114	114	292	
Total	**18, 255**	**18, 290**	**17, 884**	**114**	**292**	**-**

Capital management

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

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

Whanganui District Health Board manages its equity as a by-product of prudently managing revenues, expenses, assets, liabilities, investments, and general financial dealings to ensure that it effectively achieves its objectives and purpose, while remaining a going concern. Whanganui District Health Board policies in respect of capital management are reviewed regularly by the board. There have been no material changes in Whanganui District Health Board's management of capital during the period.

21 EXPLANATION OF FINANCIAL VARIANCE AGAINST BUDGET

Statement of Comprehensive Revenue and Expense

- Exchange and non-exchange revenue exceeded budget by $5.7 million, due to additional revenue received for COVID-19 pandemic management and additional funding for side contracts (offset by equivalent costs), ACC revenue, inter-district inflow revenue. This was partly offset by lower interest income.
- Personnel costs exceeded budget by $1.7 million due to an increase in the provision for Holidays Act compliance, this was partly offset by lower medical personnel costs due to vacancies (offset by outsourced locum medical staff costs) and lower course and conference expenditure as a result of COVID-19 preventing attendance.
- Outsourced services exceeded budget by $3.3 million due to higher than anticipated use of locum medical staff to cover vacancies as well as outsourced clinical services to meet increased clinical demand.
- Depreciation exceeded to budget by $0.2 million due to the IT hardware and clinical equipment purchases.
- Other expenses exceeded budget by $2.3 million due to increased COVID-19 costs being not budgeted for $2.3 million and increase in facility contract value. This was partly offset by lower inter-district outflows.

Statement of Financial Position

- Receivables under non-exchange and exchange transactions exceeded to budget by $5.3 million due to increase in receivables for Inter-district flow (IDF), pharmaceutical rebate and COVID_19 vaccination programme.
- Property, plant and equipment exceeded budget by $10.5 million due to revaluation uplift of $8.8 million of land and building being not budgeted and purchase of IT and clinical equipment.
- Intangible assets were $1.4 million less than budget due to delays in the Regional Health informatics Programme (RHIP) and e-prescription administration project.
- Payables under non-exchange and exchange transactions exceeded to budget by $3.5 million due to facility contract price increased and income in advance.
- Employee entitlements exceeded budget by $7.1 million due to an unplanned increase in the provision of Holidays Act 2003 remediation liability and greater than expected leave entitlements owing at year-end.

Statement of Changes in Equity

- Statement of Changes in Equity exceeded budget by $11.8 million due to increases in revaluation of land and building being not budgeted for. This was partly offset by an increased deficit against budget by $1.6 million, largely due to Holidays Act compliance provision.

Statement of Cash Flows

- Cash and cash equivalents exceeded budget by $7.8 mainly due to delays in capital expenditure programme and movements in working capital.

22 COMPLIANCE WITH LEGISLATION

Crown Entities Act 2004

There were nil breaches noted of the Crown Entities Act in 2021 (2020: nil).

New Zealand Public Health and Disability Act 2000

There were nil breaches noted of the NZPHD Act in 2021 (2010: nil).

in thousands of New Zealand dollars

Ministerial Directions

Whanganui District Health Board complies with the following Ministerial directions:

- The 2011 Eligibility Direction issues under section 32 of the NZ Public Health and Disability Act 2000.
- The requirement to implement the New Zealand Business Number (NZBN) in key systems by December 2018, issued in May 2016 under section 107 of the Crown Entities Act.
- The direction to support a whole of Government approach issued in April 2014 under section 107 of the Crown Entities Act. The three directions cover Procurement, ICT and Property. Procurement and ICT apply to Whanganui District Health Board.
- The direction on the use of authentication services issued in July 2008 which continues to apply to all Crown agencies apart from those with sizeable ICT business transactions and investment specifically listed within the 2014 direction.
- COVID-19 Health Response Act 2020
- COVID-19 vaccination eligibility direction 2021.

23 SUMMARY COST OF SERVICES

	2021 Actual	2021 Budget	2020 Actual
Revenue			
Prevention services	6, 961	5, 287	9, 327
Early detection and management	62, 271	61, 299	55, 310
Intensive assessment and treatment	193, 057	186, 794	176, 824
Rehabilitation and support	42, 324	45, 592	38, 218
Total revenue	**304, 613**	**298, 972**	**279, 679**
Expenditure			
Prevention services	(7, 389)	(5, 340)	(10, 789)
Early detection and management	(66, 432)	(61, 488)	(60, 214)
Intensive assessment and treatment	(193, 241)	(189, 708)	(184, 073)
Rehabilitation and support	(42, 398)	(45, 686)	(40, 007)
Total expenditure	**(309, 460)**	**(302, 222)**	**(295, 083)**
(Deficit) / Surplus	**(4, 847)**	**(3, 250)**	**(15, 404)**

24 LIVING WITH COVID-19 FOLLOWING LOCKDOWN

The 12 months between 1 July 2020 and 30 June 2021 focused on health and community recovery, readiness planning and the vaccination roll-out.

Following the closure of the Emergency Operations Centre in May, Whanganui District Health Board staff and staff from a number of other organisations combined to form the integrated recovery team and this continued into the new financial year. The team produced a series of reports 'COVID-19; From Response to the Next Normal'.

The whole of New Zealand moved to alert level 1 on 8 June 2021, however the emergence of several cases in Auckland on 12 August 2021 triggered a return to alert level 3 for Auckland and alert level 2 for the rest of the country.

For Whanganui this meant an increase in the number of presentations at the CBAC for a short period of time and we also used the opportunity to finetune some of our procedures from stepping up from alert level 1 to 2.

On 22 September 2021 all regions except for Auckland returned to alert level 1.

Summer 2020 caused the Ministry of Health and DHBs across the country to do a substantial amount of work around preparing for a summer outbreak caused by increased movement around the country, festivals, large gatherings, etc Although the majority of summer passed without incident, an outbreak in Auckland in late February caused the country to fluctuate up and down levels for a short period of time before returning to alert level one in early March.

The central CBAC on the hospital grounds has remained open throughout this period, generally during business hours, but retaining the ability to rapidly flex up to meet increased demand for services – which generally occurred during community outbreaks in Auckland and alert level changes. In February 2021, responsibility for running this CBAC was transferred to the Whanganui District Health Board.

All of the hospital wards and a number of other departments participated in tabletop exercises between August and December. These exercises are an important part of the readiness phase and allow staff to familiarise themselves with the department plans developed earlier in the year.

The exercises involved nurse managers, clinical nurse managers, infection control, department staff, and emergency management.

Each exercise took the departments from a 'green hospital – alert level 1' phase where the focus was on getting the department ready, through to a 'red hospital – alert level 4' phase where staff had to working on functioning with reduced staff, large numbers of COVID-19 patients, etc

A significant EMERGO COVID-19 exercise is planned for December 2021 which will involve multiple Whanganui District Health Board staff and departments as well as our community partners.

In March 2021, Whanganui District Health Board hosted staff from Bay of Plenty District Health Board's acute mental health ward, who visited us to talk about their experience of COVID-19 on the ward during the initial lockdown in 2020. A number of staff from both the general side and mental health were fortunate enough to attend the two talks that they gave and to hear about the sobering reality around managing COVID-19 positive patients on the ward – it was a good reminder for everyone that the challenges of working with and caring for patients in a COVID-19 world on an acute mental health ward has vast differences – as well as many similarities – to those on the general side of hospitals.

Planning, preparing and managing the COVID-19 pandemic health response has been the focal point for Whanganui District Health Board throughout 2020/21. This year there were no COVID-19 cases detected in Whanganui District Health Board community, however Whanganui District Health Board have prepared and put in place plans to protect our community and avoid our health system getting overwhelmed by COVID-19.

Our staff have risen to the challenges. So many of our team dropped their regular work and put in hours and hours to ensure we could cope with what came our way. This has impacted the management of rosters and leave over the year, with increased discretionary sick leave/special leave as per national agreement. We have faced difficulty filling roles with reduced number of applicants for vacancies advertised. Annual leave balances have increased due to staff inability to travel and fear of COVID-19 lockdowns.

This year recovering the health system has challenges – especially the significant amount of deferred care resulting from the previous lockdown in March/April 2020 (compared to prior year acute and elective surgery are up by 6.7%). We also need to continue to support our community from a psychosocial perspective as we prepare to live with COVID-19 and deal with the economic fallout.

COVID-19 has had a significant impact on how we interact with others – including our staff, patients and their whanau and the wider community. The combination of stress and uncertainty can have significant and wide-reaching impacts on the mental wellbeing of people in Whanganui District health Boards community.

Whanganui District Health Board employed additional thirty full time equivalents staff between April 2021 and June 2021 to manage the COVID-19 vaccination and COVID-19 response programme.

	2021 Actual	2020 Actual
Revenue		
Ministry of Health revenue	**2, 367**	**3, 931**
Expense		
Personnel (including outsourced services)	(892)	(708)
Clinical & infrastracture & non-clinical expenses	(231)	(1, 198)
Payments to non-health board providers	(1, 268)	(3, 524)
Total Expense	**(2, 391)**	**(5, 430)**

Whanganui District Health Board received $2.4 million (2020: $3.9 million) funding to cover the cost of $2.4 million (2020: $5.4 million) in relation to COVID-19 pandemic.

There was an additional $0.9 million COVID-19 pandemic personnel costs mainly in Emergency Operation Centre management and vaccination programme, $0.2 million (2020: $1.2 million) costs incurred in clinical infrastructure and non-clinical supplies, $1.3 million (2020: $3.5 million) addition costs were incurred in pharmaceutical, aged residential care, Community Based Assessment Centre, assessments in General Practice, DHB and primary care digital enablement, Māori Health and vaccination programme.

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 prepare an annual report. Annual reports are prepared annually for each financial year ending 30 June. The purpose of the annual report is to compare activities performed with those intended in the annual plan.

ARC
Aged Residential Care

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

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

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

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

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

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

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

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

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

Caries
Tooth decay or cavities.

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

CCDM
Care Capacity and Demand Management Programme

centralAlliance
Collaborative agreement between Whanganui and MidCentral district health boards.

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

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

Community Services
Health services generally delivered in a community setting.

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

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

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

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

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

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

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

Discharge
Discharge from hospital services.

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

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

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

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

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

FSA
First Specialist Assessment

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

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

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

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

Hāpai Te Hoe
Whanganui District Health Board cultural awareness programme.

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

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

Health care assistant
Heath care assistants work under the supervision of nurses and other health professionals to carry out a variety of tasks.

Health Promoting Schools
An approach where the whole school community works together to address the health and wellbeing of students, staff and their community.

Health protection
Health protection services work within the framework created by the various health-related Acts including the Health Act (1956), Food Act (1981), Sale and Supply of Alcohol Act (2012) and Smokefree Environments Act (1990) and their associated regulations.

Health Quality & Safety Commission
Crown entity, whose objective is to work with clinicians, providers and consumers to improve quality and safety across the health and disability sector.

HPV
Human Papilloma Virus

IEA
Individual Employment Agreement

Impairment
A reduction in the recoverable value of a non-current asset below its carrying value.

Inpatient services
The care of patients whose condition requires admission to a hospital.

Intangible assets
Intangible assets are those fixed assets that have no physical existence, such as software, patents, copyrights, goodwill, etc.

Inter-district Flow (IDF)
Health services provided by district health boards to patients domiciled to another district health board's population. Can result in either revenue inflow (health services delivered to patients domiciled at another district health board) or outflow (our population receiving health services at another district health board).

interRAI
interRAI is an electronic assessment tool used by health professionals working with older people.

Iwi
Tribe

Kaiāwhina
Māori health worker assistant; helper; advocate.

Kaitiakitanga
Protection, taking care of people, things, conflict resolution, environmental, maintain values, vision, understanding, keeping yourself and each other safe.

Kaupapa
Purpose; theme

Kōhanga reo
Māori language nest - preschool.

Kotahitanga
Unity, cohesion, sharing vision, working together, trust, relationships, collaboration and integration.

LMC
Lead maternity carer

Length of stay
Length of stay (LOS) is a term to describe the duration of a single episode of hospitalisation. Inpatient days are calculated by subtracting day of admission from day of discharge.

Locum
A locum is someone who temporarily fulfils an employment role/duties of another. For example a locum doctor (medical personnel) works in the place of a regular/permanent doctor when they are absent or when a district health board is short of staff. Whanganui District Health Board uses the term locum to refer to all arrangements of clinical personnel where we are invoiced for these services rather than a salary paid.

Long-term conditions
Long-term conditions account for a significant proportion of health care spend and hospitalisations, as well as being a barrier to full participation and independence in the workplace and society by affected individuals and their family/whānau.

Mahi whakariterite
Our priorities and performance.

Manaakitanga
Respect, support, helping, caring, non-judgemental, be of service to others.

Mana tangata
Our leadership; prestige, integrity, leadership.

Marae
Māori meeting place.

Mauri
Life essence, animate and inanimate objects have a mauri, tika, pono, balance and universe.

MECA
Multi Employer Collective Agreement

Mihi
Greeting, acknowledgement.

National Hauora Coalition
One of the two local primary health organisations (PHO).

Net assets
The value of a district health board's total assets less the value of its total liabilities

New Zealand Health Partnerships
Operates as a multi-parent crown subsidiary, created by the 20 district health boards. The aim of the entity is to work collaboratively to identify and build shared services for the benefit of the health sector.

Ngā moemoeā, ngā kaupapa
Our vision and purpose.

NGO
Non-government organisation

NIR
National Immunisation Register

Non-current assets
Non-current assets are assets which represent a longer-term investment and cannot be converted into cash quickly. They are likely to be held by a district health board for more than a year.

Non-current liabilities
A liability that is not required to be discharged/settled within 12 months of balance date.

NOS
National Oracle Solution

Output Class
Four output classes used by district health boards to reflect services provided. The output classes are Prevention; Early Detection and Management; Intensive Assessment and Treatment; Rehabilitation and Support.

Pēpi-pod
Baby bassinet used to help reduce Sudden Unexpected Death in Infancy (SUDI).

Primary Health Organisation
Primary health organisations (PHOs) are funded by district health boards to support the provision of essential primary health care services through general practices to those people who are enrolled with the PHO.

Primary Services
Professional health care provided in the community.

Pūrongo arotake pūtea
Audit Report

Pūrongo mahi
Statement of Performance

Pūrongo pūtea
Financial Statements

Pūrongo ratonga
Statements of Service Quality

Rangimārie
Humility, maintaining one's composure, peace, accountability, responsibility, respect.

Regional Health Informatics Programme (RHIP)
Central Region clinical IT application programme of work.

Screening services
Screening programmes can detect some conditions and reduce the chance of developing or dying from some conditions.

Secondary services
Medical care that is provided by a specialist or facility upon referral by a primary care physician and that requires more specialised knowledge, skill, or equipment.

Standardised Intervention Rate
A health intervention rate that has been standardised against a particular population.

Statement of Performance Expectations
A document that sets out the service performance expectaions for the upcoming year and provides a base for actual performance to be assessed.

SUDI
Sudden Unexpected Death in Infancy

Tamariki
Child/children

Tangata whenua
People of the land.

Te Hau Ranga Ora
Whanganui District Health Board's Māori Health Service.

Te Pōari o Whanganui
Whanganui District Health Board

Te Pūkaea
Whanganui District Health Board Consumer Advisory Group

Te Pūrongo a-tau
Annual Report

Te rōpū whakahaere
Our organisation

Te Tiriti o Waitangi
Treaty of Waitangi

Tertiary services
Consultative care, usually on referral from primary or secondary medical personnel, by specialists working in a centre with personnel and facilities for investigation and treatment.

Tikanga Māori
Right, honest, guiding principles, protocols, guidelines, actions, tapu, noa, tika, pono, accountability.

Tino Rangatiratanga
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

Whanaungatanga
Spiritual wellness, relationships, knowing who you are, identity, family, whānau, whānau kaupapa, social equity.

Whānau ora
Healthy family/families. An inclusive approach to providing services/opportunities for families, partnering with families, based on Māori concepts and values.

Whanganui Regional Health Network
One of the two local primary health organisations (PHO).

XRB
External Reporting Board

DIRECTORY

BOARD MEMBERS

Mr Kenneth (Ken) Whelan - **Toihau - Board chair**
Mrs Annette Main - **Deputy chair**
Mr Graham Adams
Mr Charlie Anderson
Mrs Philippa Baker-Hogan
Mr Stuart Hylton
Mr Josh Chandulal-Mackay
Ms Talia Anderson-Town
Mrs Judith MacDonald
Ms Soraya Peke-Mason
Ms Mary Bennett

HAUORA A IWI MEMBERS

Ms Mary Bennett - **Chair to May 2021** (Ngaa Rauru Kiitahi)
Mrs Sharlene Tapa-Mosen - **Chair from May to June 2021** (Whanganui - Tūpoho)
Wheturangi Walsh-Tapiata (Ngaa Rauru Kiitahi)
Mrs Te Aroha McDonnell (Whanganui - Tamaupoko)
Mrs Barbara Ball (Mōkai Pātea)
Mrs Maraea Bellamy (Mōkai Pātea)
Dr Cherryl Smith (Ngā Wairiki Ngāti Apa)
Mr James Allen (Ngā Wairiki Ngāti Apa)
Dr Heather Gifford (Ngāti Hauiti)
Mrs Hayley Robinson (Ngāti Rangi)

OUR EXECUTIVE LEADERSHIP TEAM

Mr Russell Simpson	Kaihautū Hauora - Chief Executive
Mrs Nadine Mackintosh	Executive Officer
Mr Andrew McKinnon	General Manager Corporate (Chief Financial Officer)
Mrs Lucy Adams	Director of Nursing
Mrs Louise Allsopp	General Manager Patient Safety Quality and Innovation
Mrs Alex Kemp	Director Allied Health Scientific and Technical
Mrs Rowena Kui	Kaiuringi Māori Health and Equity
Dr Ian Murphy	Chief Medical Officer
Mr Paul Malan (deceased)	General Manager, Service and Business Planning

BANKERS

Bank of New Zealand
80 Queen Street
Auckland 1010

Ministry of Health
No. 1 The Terrace
Wellington

AUDITOR

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

REGISTERED OFFICE

Private Bag 3003
100 Heads Road
Whanganui
Phone 06 348 1234
Fax 06 345 9390

BOARD SECRETARY

Horsley Christie
14 Victoria Avenue
Whanganui

NZ BUSINESS NUMBER (NZBN)

9429000097970

SOLICITORS

Buddle Findlay
1 Willis Street
Wellington

Horsley Christie
14 Victoria Avenue
Whanganui

Kia tāea e te whānau me te hāpori i tōna ake tino rangatiratanga

Together we build resilient communities, empowering whānau and individuals to determine their own wellbeing

100 Heads Road, Private Bag 3003, Whanganui 4540, New Zealand

wdhb.org.nz

Cover photography by **Caleb Kingi**