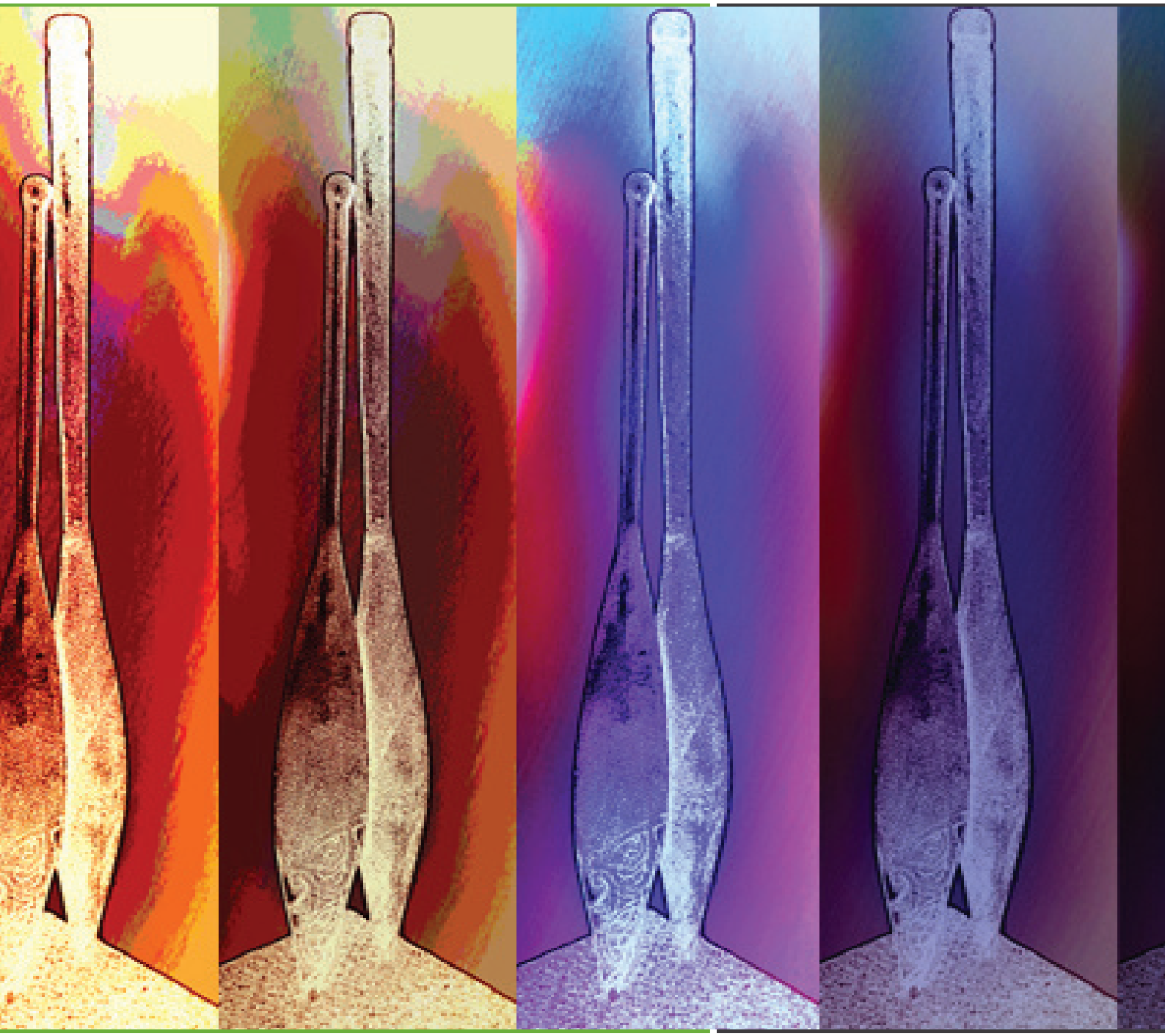
2021 / 2022

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



KAUA E RANGIRUATIA TE HĀPAI O TE HOE,
E KORE TO TĀTOU WAKA E Ū KI UTA

DO NOT LIFT THE PADDLE OUT OF UNISON OR OUR CANOE WILL NEVER REACH THE SHORE

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 & VALUES

HE HAPORI ORA - THRIVING COMMUNITIES

OUR VISION: *He Hapori 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 hapori i tōna ake tino rangatiratanga*

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

NGĀ UARATANGA - 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.

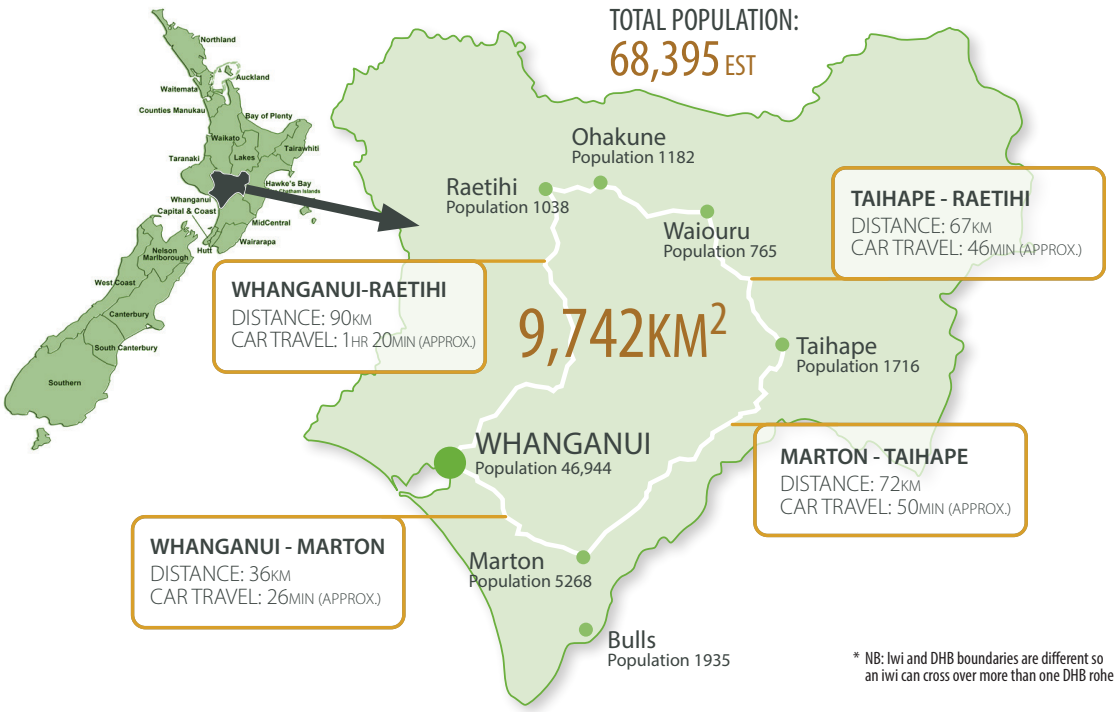
THE POPULATION WE SERVE

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

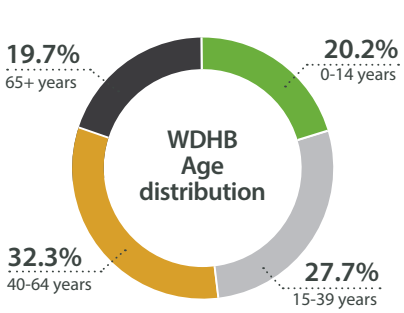

Ngaa Rauru Kiitahi

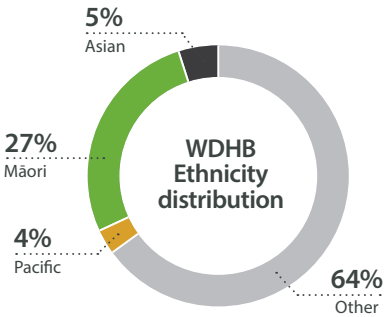

Ngāti Hauiti

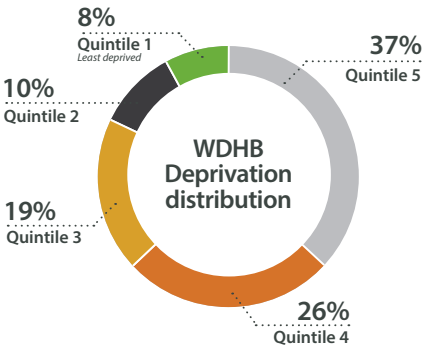

Ngā Wairiki Ngāti Apa


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.

HE HAPORI 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 Hapori 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 hapori 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 HAPORI **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 UARATANGA - OUR VALUES
AROHA | KOTAHITANGA | 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

There is a long whakapapa of relationship between the community and Whanganui hospitals and health service management. In the recent 21 years of district health boards those relationships have further evolved and developed. Whanganui District Health Board guided by Kaumātua and Kuia has had a joint board partnership relationship with Hauora ā Iwi. A close working relationship with Ngā Kaitātaki Hauora (Māori Health Outcomes Advisory Group (MHOAG)), the executive leaders of Iwi health provider organisations. Also working with Whanganui Regional Health Network, the National Hauora Coalition PHO, general practice services and community providers.

The 2021-2022 year was a time of planning and preparation for the major reform of the health system announced in April 2021 and culminating in the formal disestablishment of district health boards on 1 July 2022 and the formation of Te Whatu Ora Health New Zealand and Te Aka Whai Ora the Māori Health Authority.

At the same time Whanganui District Health Board continued the COVID response and vaccination programme. Primary care and Māori health services joined together to form and led community hubs that have been very successful in addressing the health and social needs of our communities during the COVID surge. Coordinating with local government agencies and sector services. Iwi resourced local COVID response teams, and linked into Māori communities with messaging and welfare packages and support. The Hub concept is ongoing as providers work with communities to address childhood immunisations and screening services that require some 'catch up' now that COVID levels are starting to reduce.

Another focus at a district level, has been the development of a localities prototype – a place-based approach to improving the health of populations. An initial proposal led by Hauora a Iwi, Ngā Kaitātaki Hauora and the Whanganui Regional Health Network, supported by the Whanganui District Health Board has been selected nationally as one of nine prototypes for further development as part of the roll out of the Health Reforms 2022.

Across its 21-year history, 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'. The aim has been to address inequities in service provisions, resources, capability and capacity. Over time the partnering with Iwi and Iwi health organisations has strengthened and has created a foundation for the transition to the new system.

Mauri Ora Clinic

With COVID causing increased pressure in the community in early 2022, with Omicron's arrival in our district, the Mauri Ora whare was temporarily re-purposed as a community COVID Clinic. Mauri Ora whare is usually run by Te Hau Ranga Ora/Māori Health Services for emergency and temporary accommodation for out-of-town whānau, was converted into a clinic space.

The change was to meet the need in the community and better support access to in-person assessment and intervention for those with COVID. Clinicians working in ED, WAM and providing COVID care in the community such as GPs and others could refer or redirect people to the clinic. Self-referrals were also accepted.

The Mauri Ora whare has had significant roles in the history of health services in the district. It previously housed Te Korimako, which was the first tangata whenua provider in Aotearoa to secure funding for community health services from an Area Health Board. Te Korimako later amalgamated with Te Waipuna o te Awa resulting in establishment of Te Oranganui Iwi Health Authority.

Mauri Ora means alive or life force and in temporarily re-purposing it, the DHB aimed to improve support for the community and our partners in primary care as well as our own staff - as everyone worked to provide quality health services to people with COVID.

Waka Hauora – a health bus for the community

In 2021 Whanganui District Health Board working with the Rob Bartley Foundation launched Waka Hauora, a new Health Bus for the district. Donated by the Rob Bartley Foundation and inspired by Whanganui businessman Rob Bartley, who died in March 2021, the bus is a multi-purpose mobile health clinic. During the COVID vaccination drive, the bus joined the campaign with staff holding pop-up clinics at workplaces and community hubs. Waka Hauora was a useful asset in supporting health services reach to those more isolated and rural communities.

The late Rob Bartley with kaihautū hauora chief executive Russell Simpson at the inauguration of the Health Bus in 2021

Kāwanatanga Hapori – Social Governance

- Whanganui District Health Board commissioned Te Oranganui Trust as lead agent for Healthy Families Whanganui, to undertake a 'whole of community, whole of systems approach to prevention focus. These insights will be used to shift the pendulum from reactive to proactive, informing the co-design of a regional strategic approach and traction plan. "Our people are enjoying high levels of wellbeing, our approach and impact is about sustainability.
- The COVID-19 Hub response demonstrates a well functioning social governance model (see page 56).
- The Impact Collective sought and managed, to achieve a level of community intelligence that was a 'first of its kind' in both scale and complexity in Aotearoa New Zealand. In doing so, we enabled community services, organisations, Iwi and central and local government agencies to be better informed, aligned and united over community priorities. Enabling them to identify areas where they could collectively create positive impact in the Whanganui community. At the heart of this, is ensuring they were enabled to create equitable and accessible services and initiatives for all. To do this, it was important to first build an in depth understanding of the Whanganui community and the people who live here. We chose to leverage existing data insights that had previously been collected, as well as gathering our own lived experience or people insights through speaking directly to members of the community. This was achieved by working with our data partners DOT Loves Data, to build our Equity and Wellbeing Dashboard. The dashboard aimed to bring together data insights from over 150 data indicators covering the breadth of areas of equity and wellbeing across our framework. Whilst our Systems Strategists also simultaneously ran workshops and interviews with community groups and organisations, to gather the lived experience narratives.

  Following an extensive process of synthesis and thematic analysis to bring existing data insights together with the fresh narratives from the Whanganui community, our team were able to present 44 themes that are related to a persons' journey through their life, from infancy to elderly, and a further 13 themes that cross the timespan of our lives. In addition, a series of enablers and barriers were articulated which outlined some of the issues we continue to face in engaging with our communities alongside the positives of moving forward, in a way which is connected to and focused on the needs of the community. Across the Whanganui Region, areas of strength were characterised as being within the following areas of the United Nations 17 SDGS in order of significance; Sustainable Cities and Communities, Quality Education, Good Health and Wellbeing, Reduced Inequalities, Life on Land, Decent Work and Economic Growth, Responsible Consumption and Zero Hunger. Interestingly, areas where barriers were identified were often found in the same areas as the community strengths, with the following areas having the most prevalent barriers identified in the Whanganui community; Good Health and Wellbeing, Sustainable Cities and Communities, Quality Education, Decent Work and Economic Growth, No Poverty, Reduced Inequalities, and Peace, Justice and Strong Institutions. The final section in the profile, the summary of findings, gave the reader, the ability to pick up the strengths, barriers and opportunities in an easily digested format. It was designed to facilitate our communities being able to use the pages as a guide to develop services and traction plans.

  The hope is that the intelligence provided in the report achieves a number of outcomes. These include; being representative of the voice of the Whanganui community, aligning the lived experiences with the data insights to tell a fuller story, capturing and highlighting the complexity of the system and showing that agencies cannot address a single need in isolation, and showcasing some of the incredible individuals, groups and organisations doing good mahi in the Whanganui community. Ultimately, we sought to highlight and present the biggest strengths and opportunities of the Whanganui community and act as the springboard to inspire collective action to either enhance existing strengths, or overcome existing barriers.

  As the team now move into the Rangitīkei, the insights we are capturing are very different to those contained in the Whanganui profile. The differences due to the Rural vs Urban population, and access to services is clearly articulated with this information being captured then demonstrated and highlighted in the Rangitīkei Wellbeing and Equity Profile. Before the end of 2022 we will move into the Ruapehu district, following completion of that district we will move across to South Taranaki in early 2023.

  In conclusion, the Impact Collective team acknowledge and thank the members of our community who shared the taonga of their stories. This cooperation enabled us to prepare the profile of intelligence and insights for the Whanganui community. It was a truly humbling experience and one that we will revere into the future. You can locate the full profile at ***impactcollective.org.nz***.

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 district health boards such as Waikato and is part of national planned care conversations.
- Whanganui District Health Board has partnered with the Robert Bartley Foundation (RBF) to deliver primary/preventative services across the Whanganui rohe. Through this partnership a Mobile Community Clinic (health bus) will be operationalised 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.
- The COVID-19 Hub response provided both social, health and welfare provisions closer to home (see page 56).

MAHI WHAKARITERITE

OUR OVERVIEW OF PERFORMANCE

BOARD CHAIR'S REPORT

The Whanganui District Health Boards' Annual Report for 2021/2022 showcases the achievements delivered against the strategic direction implemented through He Hapori Ora Thriving Communities, the vision for Whanganui District Health Board.

With additional pressure placed upon our community and our hospital due to COVID-19, our Board has had to navigate a different healthcare environment than we are used to. A task that was tackled with the health of our community forefront of all our minds, the Board came together through this turbulent and busy time, in a remarkable way and with successful outcomes for implementing change.

I would like to acknowledge the losses we as a Board have had over this period. With the passing of Alisa Stewart QSO, former Principal Nurse, District Health Board member, District Council member and a supporter of many community organisations, in August 2021 and, more recently, Auntie Gina Mahi in August 2022. Auntie Gina Mahi was the highly respected wife of our Whanganui District Health Board kaumātua Uncle John Mahi. To lose two, such highly valued members of our organisation is a tremendous loss that I know is felt deeply by us all on a personal and professional level.

On 1 July we saw the disestablishment of District Health Boards, as the transition to a new national healthcare system, Te Whatu Ora Health New Zealand commenced. Moving forward, the next two years will look different for us, and for some, there will be the challenge of change.

Te Whatu Ora Health New Zealand remodels healthcare and its delivery in a new way, unlike any that has been delivered before. Established to create one equitable health system across Aotearoa, functions will now be delivered at local, district, regional and national levels. It is an exciting time to be involved with health.

I want to extend my thanks to my fellow Board members, their tireless dedication to our hospital governance during trying times is a testament to their sense of community spirit and values. Russell Simpson, kaihautū hauora chief executive, your leadership and drive across the organisation has been crucial to getting us to where we are.

As always, to our staff, you have all worked extremely hard through incredibly difficult circumstances, I want to thank you for all the hard work and efforts over the last year.

As I sign off on my last board report for Whanganui District Health Board, I wish you all well and hope to work with many of you again in my new role at Te Whatu Ora as independent chair of the Hospital & Specialist Services Workstream.

Ngā mihi

Ken Whelan
Toihau - Whanganui District Health Board Chair

CHIEF EXECUTIVE'S REPORT

Tēnā koutou katoa

The last two years have seen our healthcare settings challenged in ways I have never experienced, and for many of us this is the first time in living memory we have managed through a pandemic. While COVID-19 is not over, it has become endemic in our lives and has led to the development of many new models of care, and engagement with our communities that have brought about a localised response to meeting the needs of our community.

I have relished the opportunity to engage and work alongside many community providers, government agencies, iwi and support services to ensure our people had access to all they needed to self-isolate and manage in an environment where the looming threat of a pandemic dominated our headlines.

Whanganui District Health Board supported the delivery of the largest vaccination and COVID-19 testing programme in a generation, across our region over the past 12 months. Frequent visits around the rohe to connect with those on the ground, including our rural communities at Marton, Taihape and Waimarino were a highlight. COVID-19 vaccination and testing has continued to provide us with the opportunity to build and expand on existing strong community relationships within primary care and Iwi/whānau for the benefit of our regions 69,000 residents. The strength in the quality of these relationships across the rohe with our partners in care, preparing and partnering closely with our communities, ensured that together, we continued to build a resilient Whanganui community, empowering whānau and individuals to determine their own wellbeing – one of the mainstays of care that I strove for as chief executive.

The Integrated Recovery Team utilised their learnings, implementing insights from the successful model undertaken for the growing collective Wellbeing Insight Report to capture a community wide, co-design led response. A partnership was formed between Whanganui District Health Board and the then newly formed, Impact Collective – a resource started during my tenure and driven by using local research to capture local data and insights that accurately reflected our community. Through this initiative we were part of extensive engagement work undertaken with community focus groups. This research was vital in understanding what health and wellbeing meant to our communities. This engagement model has progressed into longer term programmes of work such as the Impact Collective, who provide data and analytics for our rohe of Rangitīkei, Ruapehu, South Taranaki and Whanganui. I'm incredibly proud to have been part of a solution that combines local government supporting local solutions to local issues.

Between October 2021 and February 2022 I was seconded to a role with the Ministry of Health to lead a change in the care model for the management of COVID-19 with the emergence of new variants of the virus in late 2021. While this secondment took me out of the Whanganui region for almost six months the opportunity to implement at a national level the care in the community model was a real privilege. The model served our communities well across New Zealand and enabled people who contracted COVID-19 to isolate at home in familiar surroundings with their loved ones, rather than being moved to another facility. The care in the community model aligned well with the He Hapori Ora strategy "every bed matters", where the best bed for a person is their own one.

The disestablishment of District Health Boards across the motu and implementation of a national health service in July 2022 is a welcome move for those accessing health care services in New Zealand. We have pro-actively led in this area with the He Hapori Ora Thriving Communities strategic direction. Over the past four and a half years I have been at the helm of this strategy with the Board that has seen healthcare in our region deliver on Pro-Equity, Social Governance and Healthy at Home - Every Bed Matters. Through collective practices with our partners in care, Whanganui District Health Board has supported delivering these strategic focus areas to those in our communities.

With COVID-19 adding additional pressures we witnessed a significant increase in patient volumes, staffing shortages and disruption to planned care. Our level of care has maintained its exceptional standard and I can confirm Whanganui District Health Board was able to finish the financial year better than budget by $2 million, excluding Holiday Act Remediation costs and nursing pay equity settlement.

I am saddened to report our hospital whānau suffered the loss of two stalwarts of Whanganui District Health Board during the past year. Ailsa Crawford Stewart QSO, former Principal Nurse, District Health Board member, District Council member and a community supporter of numerous organisations, passing away on 25 August 2021. This happened at the height of our lockdowns so there was no public funeral for this treasured member of our team. However, Ailsa received a fitting tribute as staff formed a guard of honour as she was taken away from Whanganui Hospital for the last time. Ailsa's loss will be felt by many in our community as well as our team at Whanganui District Health Board.

Another blow to our team was the passing in August 2022 of much loved Auntie Gina Maihi. Auntie Gina was the wife of our hospital kaumātua Uncle John Maihi and incredibly respected by myself, our Board and our Whanganui District Health Board team. I extend my sincerest condolences to the whānau for their loss.

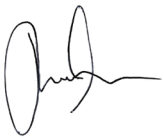
With our transition to Te Whatu Ora and Te Aka Whai Ora, one of my last tasks as chief executive is extending my gratitude for the dedication, leadership and focus over the year made by our Board members. I would particularly like to highlight the mahi of our Board Chair - Ken Whelan, whose direction and dedication to our community through his service has been strong and never faltered, no matter the challenges faced. Ken, I thank you for your steadfast support of me in my role as chief executive and your commitment to service for our rohe. I wish you well in your new role with Te Whatu Ora as the Independent Chair of the Hospital & Specialist Services Workstream.

Hauora ā Iwi has continued to work with myself and Whanganui District Health Board to advance Māori health outcomes in our district and I am thankful for their continued support and guidance while we continue to do the work to ensure health equity for all. Our Primary Health Organisations, the Whanganui Regional Health Network and National Hauora Coalition, have all been instrumental in our health care successes across our rohe. Their partnership, dedication and contributions during this year with COVID-19 and in our communities have been greatly appreciated by myself and all, as they helped us to serve here in Whanganui.

To my executive leadership team (ELT) and every team member both on campus and in our wider Whanganui District Health Board rohe. This year has tested, challenged, and confronted myself, and our team, in ways we could not have predicted. While we were well prepared with workflows, case modelling and care models having been completed last year, it was a demanding environment to navigate. COVID-19 and what it demanded of us as healthcare professionals has meant that our work environment be ever-changing and we are capable of remaining flexible as a healthcare service. Resources and team members have been stretched to capability at many times - when we asked more of our people they responded. Without the stellar leadership of ELT, and the resilience from our clinical and support team of 1200 staff, it would have been a much more challenging time. Thank you all, your dedication to our community and our health system has not gone unnoticed and has been a remarkable end to my tenure here as chief executive.

As we move into this new vision of health with strong partnerships, accessible healthcare, and equity for all, I encourage you to embrace the change. To continue to be the integral part of change that will see our national healthcare system develop and evolve into a formidable force delivering quality health care to our communities. I will end by saying thank you all for the privilege of being your leader over the past several years. I have enjoyed my mahi and will always fondly look back at my time here at Whanganui District Health Board. With the many challenges and as many successes, I am proud of the work we achieved here and look forward to challenges to come in my new role as interim regional director for the Central District as we forge a new health care system.

Ngā mihi nui



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.

Sharlene Tapa-Mosen is chair of Hauora ā Iwi and we acknowledge Sharlene's commitment and leadership.

As at 30 June 2022, the members of Hauora ā Iwi are:

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

HAUORA Ā IWI REPORT

Toituu te kupu, toituu te mana, toituu te whenua

Without language, without mana and without land, the essence of who we are will be lost.

Tēnā tātou e ngā tini ahuatanga o te wā, e ngā mate i runga rawa hāere, hāere, oti atu.

E te Poari matua o Whanganui, ko tenei te purongo o Hauora ā Iwi mo te tau nei 2021-2022

This year has been an active year which has been strongly influenced by the health reforms. The whakatauki above reminds us of who and what we are striving to acheive for whānau, hapu, iwi.

Hauora ā Iwi has had a working relationship with the Whanganui DHB since 2001. This relationship has gathered strength as priorities for Iwi have been defined.

There have been successes this year within our Iwi Provider Services, Te Puna Ora (mothers and babies), collaborative development of the Taihape Health Centre, Saliva Testing with Tupoho Services, and the significant mahi undertaken regarding COVID vaccine uptake and supporting whānau in isolation led by Iwi. This mahi has been well supported by Whagnaui District Health Board.

Hauora ā Iwi support the Whanganui District Health Board Annual Plan 2021–2022 our focus is primary care and improving community services. We acknowledge the relationships developed over a 20-year period, we value the espertise, guidance and knowledge of the board.

Hauora ā Iwi have also played a key role in ensuring the voice of Iwi is recognised in advancing Māori Health. This history and experience have placed Hauora ā Iwi in a position of responsibility for establishing a new Iwi Māori Partnership Board, which will replace the Hauora ā Iwi forum. The change will also bring a legislative change.

What is an Iwi Māori Partnership Board?

Under the health reforms the Iwi Māori Partnership Board is a new governance board currently under establishment and is the next step forward for Māori Health in New Zealand. The health system has undergone several health transformations, each bringing with it a new set of organisations and structures to fund and deliver health services to the community. The Health Reforms offer an opportunity to re-think and re-design the way Iwi are cared for.

The purpose of Iwi-Māori Partnership Boards is to represent local Māori perspectives on:

(a) the needs and aspirations of Māori in relation to hauora Māori outcomes; and

(b) how the health system is performing in relation to those needs and aspiration; and

(c) the design and delivery of services and public health interventions within localities.

The Iwi Māori Partnership Board will have decision-making power within the Whanganui rohe and will jointly agree local priorities and delivery of services with the Māori Health Authority and Health New Zealand. They will also be the primary source of whānau voice in the system.

The Iwi Māori Partnership board is to be established after 1 July 2022 to coincide with the implementation of the Pae Ora (Healthy Futures) Act.

The system is in change and as the journey continues, we wish our colleagues of the Whanganui District Health Board a positive and successful future.

Nāku noa

Sharlene Tapa-Mosen
Chair - Hauora ā Iwi

CHIEF FINANCIAL OFFICER'S REPORT

Whanganui District Health Board recorded a deficit of $9.9 million in 2021/22, an increase of $5.1 million compared to the 2020/21 deficit of $4.8 million. The 2021/22 result does include $4.5 million for Holiday Act Compliance costs (2021: $2 million). The total provision for the remediation of the Holiday Act now stands at $13.4 million which is expected to begin being paid out to employees (current and past) in 2023.

Compared to budget, the deficit is higher by $5.0 million against a budgeted deficit of $4.9 million. Excluding the movement in the Holiday Act remediation costs, operating result was adversed to budget by $1.0 million - 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 2021/22.

Compared to 2020/21, actual revenue grew by $47.3 million (15.5%) to $351.9 million, which enabled the continued delivery of much-needed services to our community. Population-based funding increases are due to population growth and additional funding for underlying costs pressure. Revenue growth also included COVID funding of $24.8 million (offset by costs).

Actual costs grew by $52.4 million (16.9%) to $361.8 million, including Holiday Act remedation expense, in a year with continued pressure to meet the service demand.

Personnel costs were the main increase, 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.

An upgrade of WebPAS (web-based Patient Administration System) is required as the current Oracle database is soon to be unsupported, thus increasing the risk of unplanned outages and failure of WebPAS, which will impact on the delivery of key clinical services. As a result it has been agreed with the Ministry of Health to migrate WebPAS to a cloud based, vendor-managed platform. The Software as Service (SaaS) model will ensure that webPAS is appropriately maintained and supported, avoiding future capital investment.

As at 30 June 2022, Whanganui District Health Board has recognised an impairment of $3.5 million (2021: nil) for WebPAS.

The cash position at year-end was $0.9 million, which is $2.3 million better than the 30 June 2021 cash position of $1.4 million overdraft. The improvement in the cash position was due to building projects, clinical equipment and IT projects running behind schedule. As at 30 June 2022, commitments of $6.9 million were carried forward in 2022-23 relating to 2021-22 capital expenditure.

To maintain financial viability in 2022/23, Te Whatu Ora - Health New Zealand Whanganui will need to access its available bank overdraft facility funding of up to $13.9 million.

An independent re-valuation of land and buildings was completed on 30 June 2022. This resulted in a $2.5 million (73.5%) increase in the carrying value of land and a $23 million (31.1%) increase in the carrying value of buildings and improvements. The revaluation resulted in a $25.5 million increase in the property revaluation reserve. This will increase depreciation in 2022/23 by $1 million and capital charge by $1.3 million.

Andrew McKinnon
General Manager Corporate (Chief Financial Officer)

	2022 Actual	2022 Budget	2021 Actual
Revenue			
Revenue	351, 948	319, 293	304, 613
Total revenue	**351, 948**	**319, 293**	**304, 613**
Expenses			
Personnel costs (including outsourced, excluding Holiday Act remediation costs)	(126, 430)	(109, 868)	(109, 163)
Outsourced clinical services	(8, 219)	(8, 105)	(7, 854)
Clinical and infrastructure & non-clinical supplies	(55, 461)	(50, 213)	(45, 201)
Impairment	(3, 540)	-	-
Other health provider	(112, 010)	(103, 403)	(98, 225)
Inter-district outflow	(51, 625)	(52, 005)	(46, 989)
Total expenses	**(357, 285)**	**(323, 594)**	**(307, 432)**
Deficit before Holiday Act remediation expense	**(5, 337)**	**(4, 301)**	**(2, 819)**
Holiday Act remediation expense	(4, 528)	(644)	(2, 028)
Deficit	**(9, 865)**	**(4, 945)**	**(4, 847)**

FINANCIAL SUMMARY

The 2021/22 financial result of $5.3 million deficit (2021: $2.8 million), before considering Holiday Act Compliance costs is $1 million adverse to budgeted deficit of $4.3 million. Including Holiday Act Compliance costs the result is $4.9 million adverse to budget. Explanations of major variances against budget are provided in Note 21.

Revenue breakdown

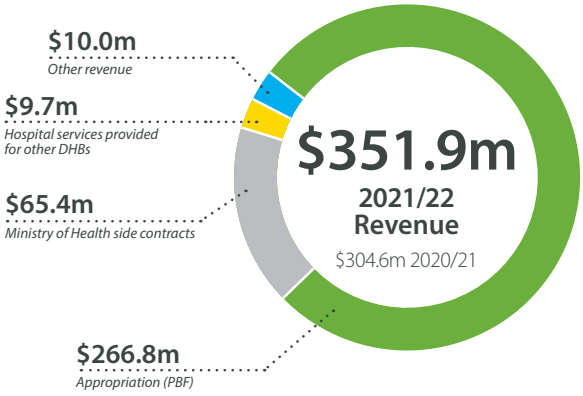
The revenue for the year of $351.9 million was $47.3 million or 15.5% higher, when compared with prior year revenue of $304.6 million.

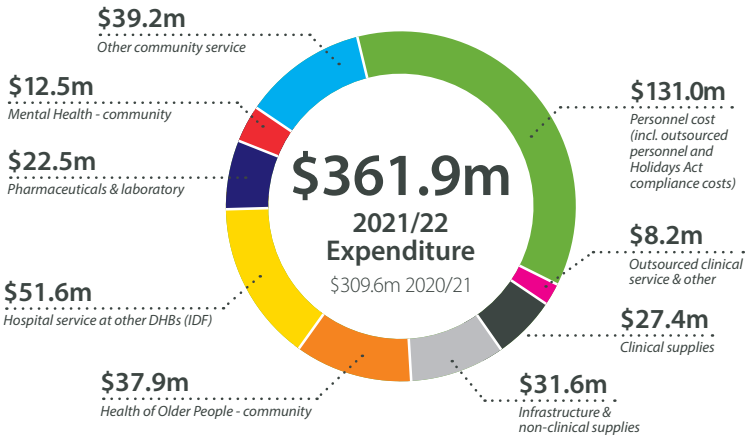
- Ministry of Health funding was $14.9 million higher than the prior year.
- Ministry of Health side contracts were $8.7 million higher than prior year, this higher revenue was passed on to other health providers.
- Ministry of Health planned care initiative funding was $0.9 million higher than the prior year due to an increase in annual funding to improve access to care.
- COVID-19 pandemic funding was $22.4 million higher, due to vaccination programme, community testing, public health, General Practice (GP) based assessment, Māori Health support, PCR and rapid antigen testing, Whānau engagement, community pharmacy care support, care in community, support isolation facility (SIQ) and MOH.
- Inter district inflow was $0.4 million higher than prior year due to price uplifts for inpatient service.

Expenditure breakdown

Expenditure for the year of $361.9 million was $52.3 million or 16.9% higher, when compared with the prior year expense of $309.6 million.

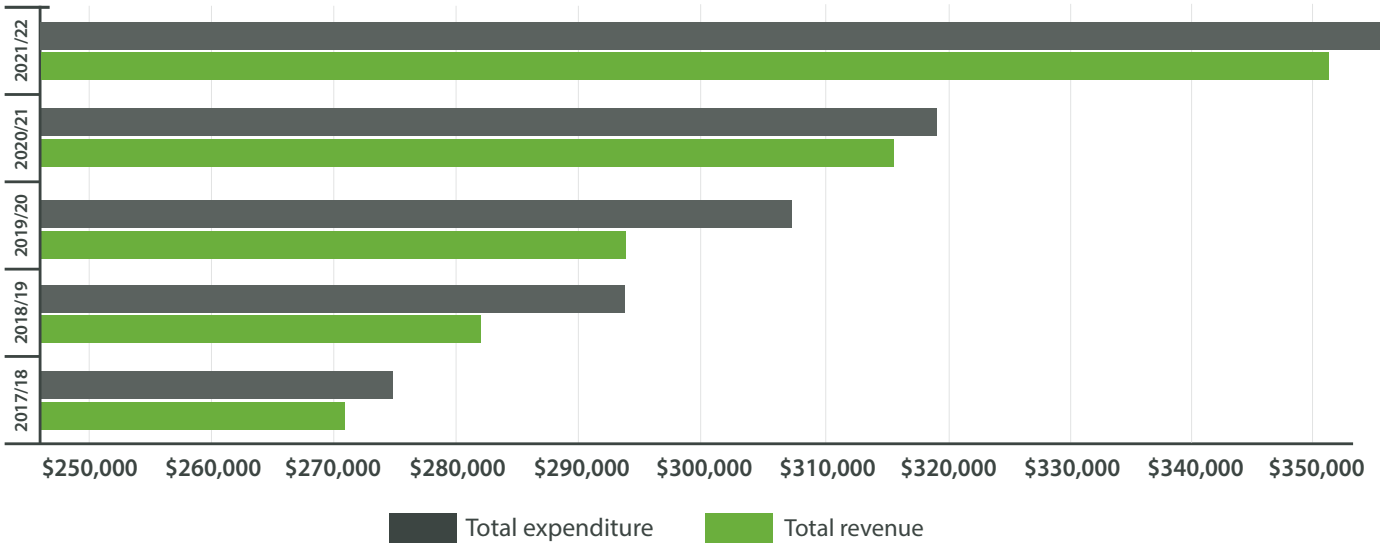
- Personnel costs (including outsourced but excluding Holiday Act costs) were $17.3 million or 15.8% higher than the prior year, due to growth in acute inpatient activity, increases in the multi-employer collective agreement and additional fulltime equivalents recruited for COVID-19 vaccination programme.
- Outsourced service costs were $0.4 million or 4.6% higher, than the prior year, due to high radiology and laboratory service expenditure. These were partly offset by a lower ACC contracted expenditure (offset by lower ACC revenue).
- Clinical supplies, infrastructure and non-clinical supplies were $10.3 million or 22.7% higher than the prior year mainly due to the inflation increase impact on supplies, district nursing dressing consumables, wards consumables, pharmaceuticals eye treatment drug costs, COVID costs, radiology consumable, blood products costs, pandenmic consumables and Microsoft licence fees. These were partly offset by lower theatre consumable relating to lower elective output.
- Impairment of WebPAS of $3.5 million due to service moving to the cloud under a SaaS model.
- The purchase of services from other health board providers was $13.8 million or 14.0% higher than the prior year, due to increased spend on COVID $8.7 million, pharmaceutical, primary care capitation and price uplifts, laboratory costs, health of older people mainly increase in home base support and residential care hospital, mental health additional contracted service. This was partly offset by additional funding received for primary care capitation and mental health.
- Inter-district outflow to other district health boards were $4.6 million or 9.9% higher than the prior year, primarily due to price uplifts inpatient service by 10%.
- Holiday Act compliance costs were $4.5 million compared with $2.0 million in the previous year - Refer to Note 15 in the financial statements.



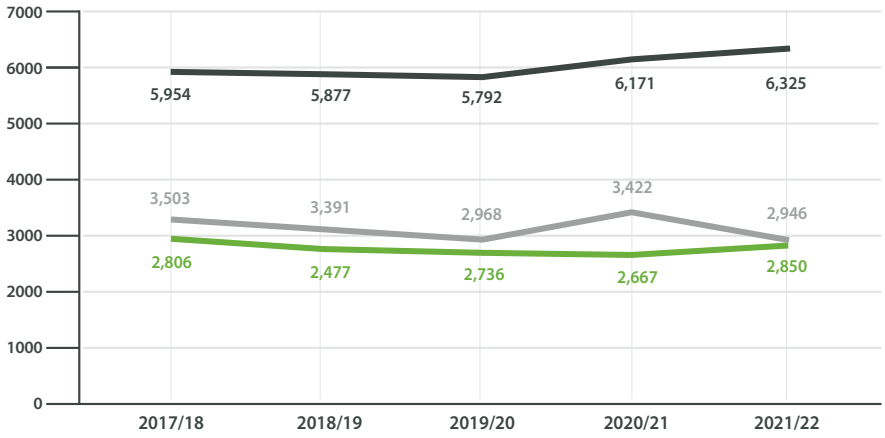


Total revenue & expenditure

(in thousands of New Zealand dollars)



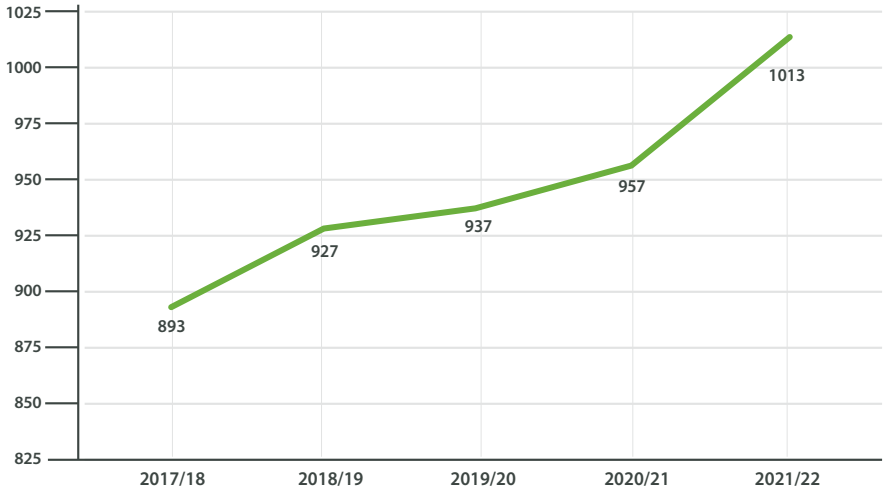
Inpatient Caseweight volume - Elective & Acute



Overall inpatient case-weight volume was 1.1% lower when compared to prior year volume, mainly due to cancellation of surgeries due COVID-19 pandemic. Acute medical volumes increased by 2.5%, acute surgical increased by 6.9% and elective surgery volumes decreased by 13.9%.

- Acute Medical
- Acute surgical
- Elective surgical

Full time Equivalents (FTE) trend



Fulltime equivalents were 56, 5.9% higher when compared to the prior year.

The COVID-19 prevention programme has contributed 54 FTE out of 56. This was made up of nursing FTE 28, management & administration 25 and other 1 FTE.

- Full time equivalents (FTE)

WHAT WE PROVIDED IN 2021/22

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

22,531
PATIENTS THROUGH EMERGENCY DEPARTMENT
2020/21: 22,417

8,418
INPATIENT STAYS
2020/21: 8,742

3,714
OPERATIONS
2020/21: 3,887

56,049
RADIOLOGY TESTS
2020/21: 52,560

1,013
FULL TIME EQUIVALENT (FTE) STAFF
2020/21: 957

235
NEW INPATIENT ADMISSIONS TO MENTAL HEALTH
2020/21: 254

50,685
SPECIALIST OUTPATIENT APPOINTMENTS*
2020/21: 50,678

$120m
TOTAL WAGE BILL
2020/21: $101m

725
BIRTHS
IN WHANGANUI HOSPITAL/RURAL HEALTH SERVICE
2020/21: 732

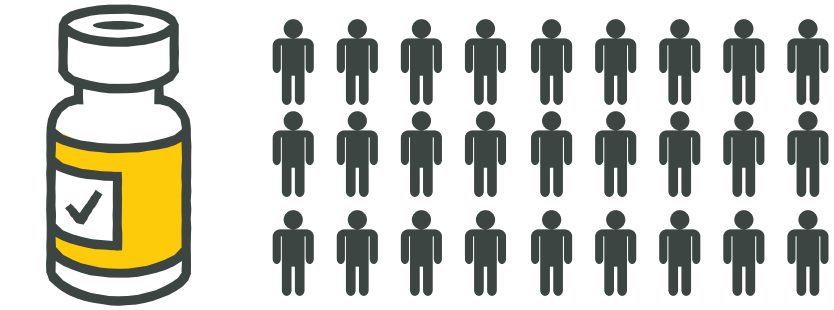
SUPPORTED **177** PEOPLE WHO DIED IN HOSPITAL
2020/21: 170

2,658
ALL ELECTIVE SURGICAL OPERATIONS
(WITH ANAESTHETIC)
2020/21: 2,931

1,056
ALL ACUTE EMERGENCY OPERATIONS
(WITH ANAESTHETIC)
2020/21: 956

206
PEOPLE HAVING MORE THAN 3 ACUTE ADMISSIONS
2020/21: 217

WHAT WE PROVIDED IN 2021/22 (COVID)



123, 281
2020/21: 20,234

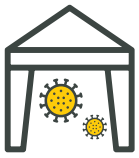
27,556
DOSES GIVEN TO MĀORI

95,725
DOSES GIVEN TO NON-MĀORI

44,066
DOSE 1
(VACCINATED)

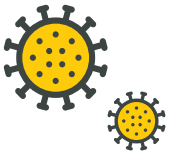
44,238
DOSE 2
(IMMUNISED)

34,977
BOOSTER/FINAL DOSE
(IMMUNISED & BOOSTED)



15,250
ATTENDANCE
AT ASSESSMENT CENTRE
2020/21: 7,689

16,792
SWABS TAKEN
2020/21: 8,635



17, 064
POSITIVE CASES
ALL RECOVERED
2020/21: 0

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.

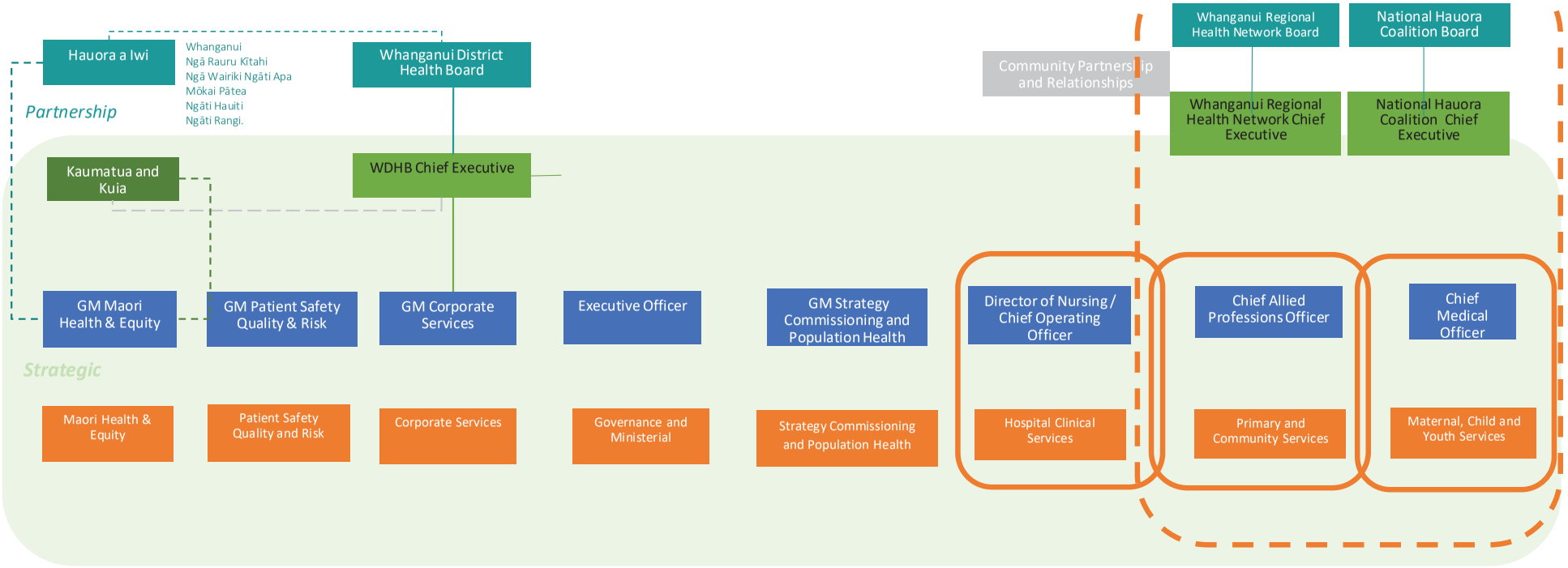
There are a number of other functions that are directly responsible to the chief executive officer and provide a service across both the Strategy Commission and Public Health divisions. These include media and communications, human resources and industrial relations.

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 2022



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 2021/22 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, Matt Laing from 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 2022

Chair	Board members	External members	Functions
Combined Statutory Advisory Committee			
Annette Main	Charlie Anderson Graham Adams Phillipa Baker-Hogan Josh Chandulal-Mackay 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 *(until Oct 2021)* 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 2021 to 30 June 2022

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

	Board	Combined WDHB & HAI	Finance, Risk and Audit Committee
Number of meetings held	**7**	**3**	**6**
Board members			
Mr Ken Whelan (Board Chair)	**4**	**1**	**3**
Annette Main (Deputy Board Chair)	**7**	**3**	N/A
Stuart Hylton	**7**	**3**	**6**
Philippa Baker-Hogan	**7**	**1**	N/A
Judith MacDonald	**5**	**1**	**6**
Graham Adams	**7**	**1**	N/A
Charlie Anderson	**5**	**1**	N/A
Talia Anderson-Town (FRAC Chair)	**6**	**3**	**6**
Josh Chandulal-Mackay	**1**	**0**	N/A
Soraya Peke-Mason	**7**	**2**	N/A
Mary Bennett (from April 2021)	**6**	**0**	**6**
External committee members			
Anne Kolbe			**4**
Matthew Doyle (until October 2021)			**0/1**
Maraea Bellamy			N/A
Frank Bristol			N/A
Heather Gifford			N/A
Christie Teki			N/A
Te Aroha McDonnell			N/A
Deborah Smith			N/A

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.

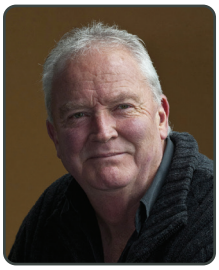
"This followed 12 years as an elected member on the Manawatu Whanganui Regional Council which provided me with the wider regional view needed. I have a balanced perspective on the intersect between the health sector and wider aspirations for the wellbeing of our communities."

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 an accomplished 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 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.

Since October 2021 I have represented Whanganui District Health Board as the central region resilience lead for the COVID response and Care in the Community Hubs as well as being the Whanganui locality prototype project manager.

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.

"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 to achieve our vision of He Hāpori Ora Thriving Communities."

LUCY ADAMS | *Director of Nursing and Chief Operating Officer (until 14 January 2022)*

"I took up the role of director of nursing 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, specialising in neurosurgery and neurointensive care before transferring to emergency nursing. I was then appointed to St John as a health emergency manager where I implemented the Ministry of Health 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."

MAURICE CHAMBERLAIN | *Acting Director of Nursing (from 20 December 2021)*

"My wife and I were born in Whanganui; we both have very strong whānau connections here. I moved to Palmerston North where I completed my nursing training in the 1990s, then on to Bay of Plenty where I progressed my career, returning home in 2019 closing the loop. I have a strong clinical, leadership and academic background by my primary value remains patient-centred. If you put the patient at the centre correct decisions/outcomes follow."

RON DUNHAM | *General Manager Strategy Commissioning and Population Health (from 5 January 2022)*

I was formerly the Chief Executive (CE) of the Lakes District Health Board for over six years. Before this, I was Chief Executive of the Western New South Wales Local Health District in Australia, an extensive outback health system with 41 hospitals in some very remote areas. Previously I was the Chief Operating Officer at Middlemore Hospital and then Chief Executive of the Bay of Plenty DHB.

I have a clinical background (nursing) and started my nursing career in Tauranga. I have always been passionate about improving the health of communities and interested in addressing the broader influences of health status, particularly for disadvantaged communities. I had 54 years working in health before finally retiring in late 2022.

GRAHAM DYER | *General Manager Strategy Commissioning and Population Health*

17 July 2021- 28 January 2022) Acting Chief Executive (4 October 2021 - 28 January 2022)

I have over twenty five year's experience in the health sector, with twenty of these being in executive management or CEO roles. I came to Whanganui after a period of consulting work, including the Ministry of Health, the Office of the Auditor General, and Southern Cross Insurance. Before this, I led the Provider Services team at ACC, responsible for commissioning over $3bn of services across the country.

I was the CEO of Hutt Valley District Health Board for five years, three of these years being CEO for both the Wairarapa and Hutt Valley District Health Boards. I have experience as a Director of several companies and trusts in the public and private sectors, the most recent being the CEO representative on the Health Workforce New Zealand board.

JENNIE FOWLER | *Acting Chief Allied Professions Officer (from 30 May 2022)*

I am of Ngati Maniapota descent. As a child I shifted to various towns across the North Island due to my father's career. I first trained as a comprehensive Nurse then as a Social Worker. I arrived in Whanganui as a Social Worker and then stepped up into leadership roles. The Whanganui rohe has become my home.

I have worked in rural, urban and hospital settings, and have been actively involved with regional and national work. My passion is inter-disciplinary teams working in partnership with the hospital, community and primary care that is patient/whānau centred.

KATHERINE FRASER-CHAPPLE | *Chief Operating Officer (from 20 December 2021)*

I grew up in the Rangitīkei, and with my parents and grandparents born in the Whanganui rohe I have strong connections to our district. My partner and I came home to the Rangitīkei in 2017.

I have worked in health since 1999 prior to the establishment of District Health Boards and have been in roles across Funder, Corporate and Provider divisions of Taranaki and Whanganui District Health Boards. I have a strong focus on ensuring service delivery meets our expectations of equity and whānau centred care, and making the best use of our resources to support the health needs of our community.

ALEX KEMP | *Director Allied Health Scientific and Technical (until 21 June 2022)*

"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.

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 the Māori concept of whānau ora provides the perfect framework for the district health board and community providers to deliver services in 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, in Auckland followed by a stint in Australia where I began a long involvement with professional team sport.
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 employed as a principal clinical adviser with ACC."

TE HUNGA ORA

OUR PEOPLE

WORKFORCE PROFILE

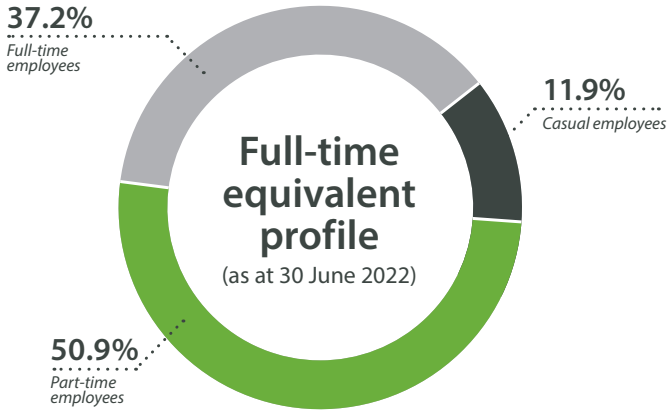
Whanganui District Health Board's workforce is made up of Medical (9.3.%), Nursing & Midwifery (51.7%), Allied Health (20.4%), Administration/Management (20.4%) and Support (2.1%) employees.

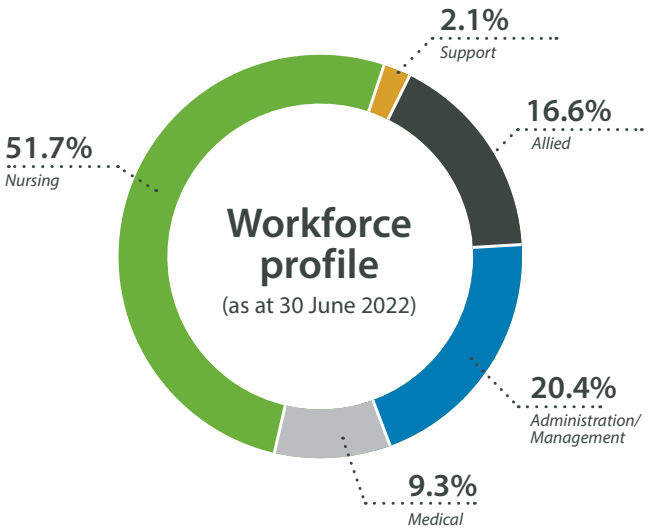
Whanganui District Health Board enjoys a stable employee complement with an average length of employee service of 9.2 years. The organisational employee turnover was 13.3% for the financial year.

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

Notes:

- Report includes: permanent and temporary employees
- Report excludes: casual employees
- Full-time equivalent (Contracted FTE) = 919.82
- Headcount = 1120





AGE PROFILE

Age band	Count	Percentage
20-29	154	13.8%
30-39	200	17.9%
40-49	236	21.1%
50-59	312	27.9%
60-69	202	18.1%
70+	15	1.3%

MEDIAN AGE PROFILE

Median female age	48 years
Median male age	50 years

GENDER PROFILE

Gender	Count	Percentage
F	919	82.1%
G	1	0.1%
M	199	17.8%

ETHNICITY PROFILE

Gender	Count	Percentage
NZ European/Pakeha	546	48.8%
European	175	15.6%
Māori	143	12.8%
Asian	125	11.2%
Other	77	6.9%
African	27	2.4%
Pacific	15	1.3%
Middle Eastern	7	0.6%
Latin American	2	0.2%
Not stated	2	0.2%

DISABILITY PROFILE

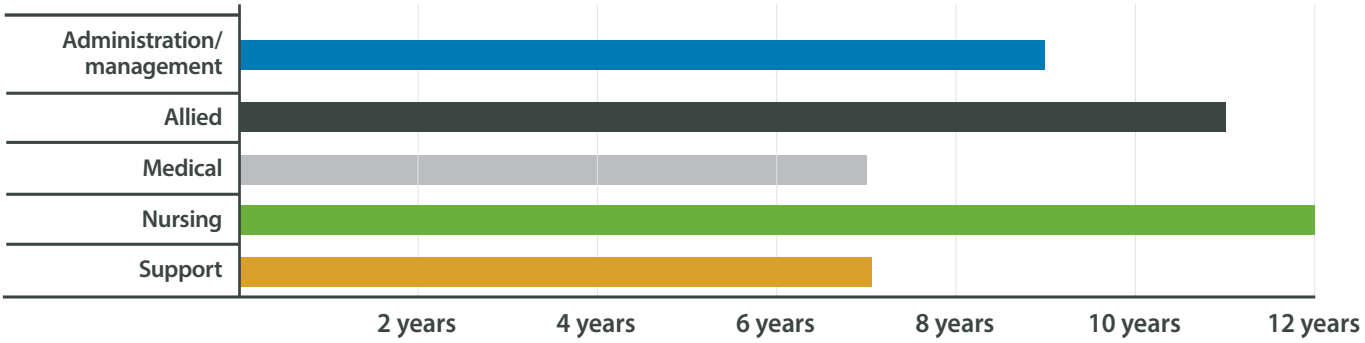
Employees	Percentage
11	1.0%

GENDER BY OCCUPATIONAL CATEGORY

Category	F	G	M
Administration/ Management	193	-	35
Allied	157	1	28
Medical	41	-	63
Midwifery	23	-	-
Nursing	488	-	67
Support	18	-	6

Service profile

(as at 30 June 2022) - Total Average Service 9.20 years



ETHNICITY PROFILE BY OCCUPATIONAL CATEGORY

Occupational category	African	Asian	European	Latin American	Māori	Middle Eastern	NZ European	Pacific	Other
Administration /Management	6	11	28	-	36	-	127	5	15
Allied	6	9	24	1	28	1	104	2	11
Medical	11	22	43	1	2	2	10	2	11
Midwifery	-	-	9	-	2	-	9	-	3
Nursing	5	83	71	-	71	-	283	7	35
Support	-	2	2	-	4	-	14	-	2

GENDER PAY GAP

	Female	Male
Median	$82, 299	$90,000
Gender pay gap	8.56%	

ETHNICITY PAY GAP

	Asian	Māori	Pacific	Other
Median	$83,186	$72,005	$64,903	$83,186
Pay gap	0.00%	13.44%	21.98%	

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.

Commenced a national review in conjunction with unions regarding restorative practices application in District Health Boards with an aim to implement consistent national processes and practices.

COVID-19 continued to disrupt some of the 2021/22 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.

Nationally the 20 DHBs in consultation with unions developed frequently asked questions (FAQs) to guide managers and employees in the COVID-19 response. The DHBs' approach to COVID-19 provided guidance regarding working with COVID-19 patients, deployment of staff, protecting vulnerable staff, special leave provisions for employees isolating or ill with COVID-19 as well as national arrangements with education provides (schools and childcare).

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 9.2 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 uaratanga are: Aroha, Kotahitanga, 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.

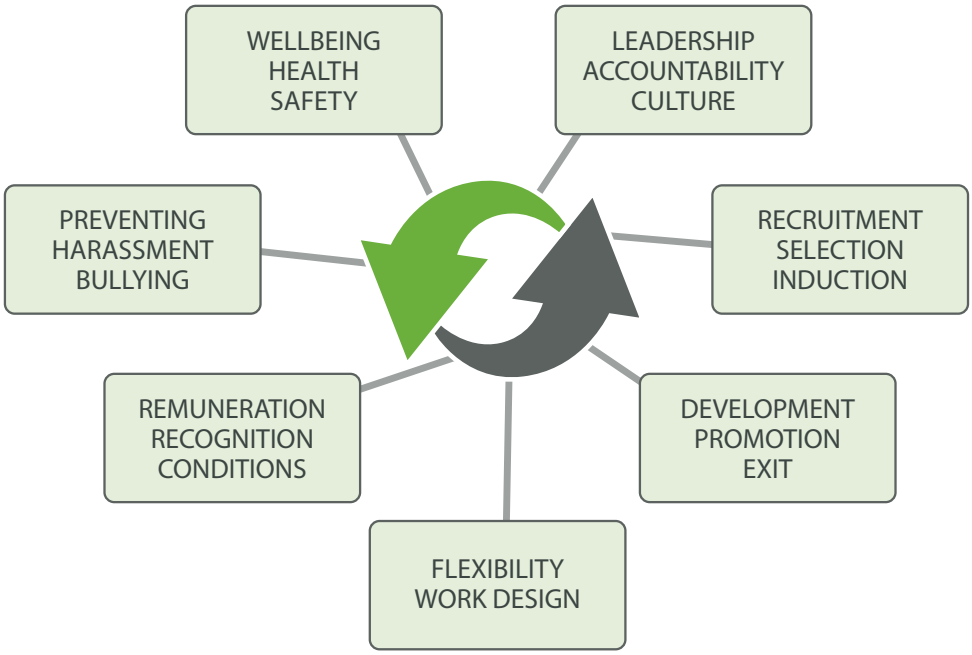
We want all our staff to be able to make a personal commitment to delivering He Hāpori Ora Thriving Communities (our strategy) and practice in a truly patient and whānau-centred, rather than provider or management-centred way, and to:

- 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.
- Safety management tool C-Gov.
- 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.
- He Waka Hourua Whanganui District Health Board's cultural training programme focussing on equity, pro-equity and health literacy implemented.
- 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.
- 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.
- Executive oversight of vacancies, recruitment and internal staff movement
- 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.
- Māori applicants who meet the minimum eligibility criteria for a role are shortlisted for interview
- All locally trained Registered Nurses offered employment in the district.
- 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. Due to COVID-19 this did not go ahead in 2021/22 and will be resumed in 2022/23.
- Recruitment and retention is aligned with Kia Ora Hauora, YES Kaupapa, Rangatahi focused pathways – Ara ki te mahi Hauora
- 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.
- Participated in various local, regional and national recruitment campaigns to recruit 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.
- Te Whare Toi, Whanganui District Health Board's education centre officially opened.
- 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 9.38 percent.
- Feedback processes for all exiting staff with more than sixty percent of leavers participating in the exit survey.

- 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.
- NETP/NESP continue to use an accelerated approach to employment of Māori nursing staff

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. Participation in a national fatigue study led in association with unions.
- Working from home policy and procedure to support flexibility.
- The use of Telehealth tools for patient contact.
- Workforce planning data informing business and investment decisions.
- Whanganui District Health Board actively encourages all staff to take leave during December/January. Non-essential services are reduced where possible during the period to enable staff to optimise the opportunity.

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. At the conclusion of the gender equity pay negotiations most if not all employees will be paid a living wage.
- Participation in national programmes of work to review pay equity claims for various staffing groups.
- Gender pay equity negotiations with the PSA administrative staff has been concluded and equity pay implementation was completed in 2022/23.
- Gender pay equity negotiations with various unions representing nursing, midwifery, allied health, and technical staff are underway.
- 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. During 2021/22 Whanganui District Health Board increased the number and type of non-financial recognitions to acknowledge the important and difficult work of healthcare employees and frontline workers.
- Supporting the government's direction for pay restraint in the public sector.

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. Trained first responders.
- 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 and management refresher training delivered in 2021/22.
- 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.
- 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.
- 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.
- Appointment of a psychosocial wellbeing support coordinator.

HEALTH & SAFETY

Accredited Employer Programme (AEP)

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

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

High-risk hazards

Whanganui District Health Board has two high-risk hazards (aggression and manual handling) that require managing closely. 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

Manual handling remains a high risk hazard at Whanganui Hospital.

We manage manual handling risk by creating a culture where staff understand the risks and how to work safely. This is enabled by employing a dedicated manual handling trainer and purchasing specialised manual handling equipment.

Currently we have engaged an external contractor for manual handling, offering weekly training. The plan is to employ a person for this position to commence in 2023.

This role will be responsible for:

- One-on-one training with ward champions to develop sustainable area specific training.
- Continue with manual handling training and purchasing/managing equipment.
- Continue to roll-out the "Get up get dressed keep moving" campaign.
- Accountable for care sensitive indicator training.
- Producing monthly reports.

Management of aggression

Our services are places 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.

We currently have the following measures in place:

- Trained health and safety representatives.
- Reporting on the incident management system.
- Ongoing training for mental health staff
- 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.

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.
- Staff and union engagement in addressing concerns and developing solutions.

Areas for further development in 2022/23:

- Further improve data collection and intelligence.
- Strengthen health and safety monitoring of staff working in the community.
- Review of all alarm systems.
- Further strengthen aggression training.
- Implement debrief procedures identified by the workgroup.
- Further strengthen links with the police and other social agencies.
- Violence and aggression towards staff review undertaken by an external provider TAS (this programme of work is underway).

PŪRONGO MAHI WHAKARITERITE

STATEMENT OF PERFORMANCE

The Statement of Service Performance for the year ended 30 June 2022 shows how the Whanganui District Health Board has performed when compared with the Statement of Performance Expectations that we published for 2021/22.

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.

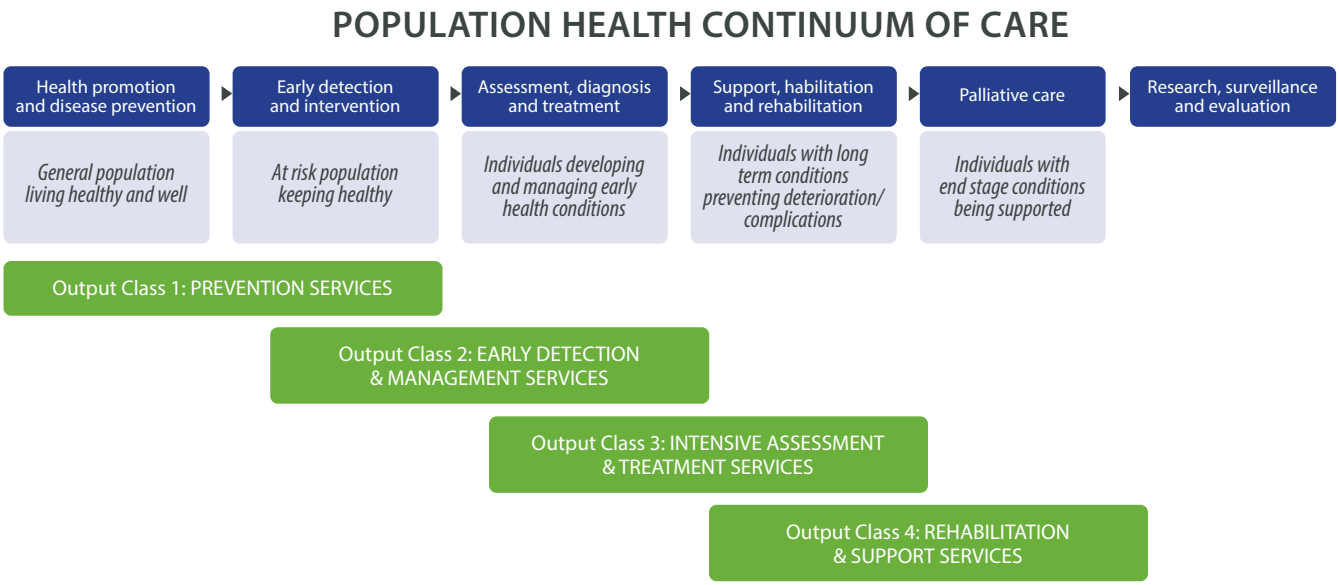
On a continuum of care, our work covers the whole population, from the many who are living healthy and well, through to the few who need support for end stage conditions. For reporting purposes we group our work into four output classes:

- **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 2021/22 financial year.

A summary of 2021/22 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 2021/22 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

Whanganui District Health Board has a projected population of 69,120. Māori account for 19,800, Pacifica and Asian for 4,990, and Others for 44,330.

Whanganui District Health Board has seen its population rise over 10% (20% Māori) in the last five years, from 62,445 (2016/17) to 69,120 in the current year. In the over 65s group, this rise has been 19% (Māori 50%) resulting in increasing need for resources to be directed towards this vulnerable population.

Over 40% of our population live in the most deprived quintile, with 65% living in the lower two quintiles (4 & 5), and with our rising population numbers this represents more people living in the most deprived areas.

SUMMARY OF 2021-22 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	14, 002	72, 998	201, 909	44, 548	333, 457
Other Income	7, 090	155	1, 512	66	8, 823
Inter-district Inflows	157	2, 600	5, 836	1, 075	9, 668
Total revenue	**21,249**	**75, 753**	**209, 257**	**45, 689**	**351, 948**
Expenditure					
Personnel costs	(7, 536)	(9, 711)	(100, 040)	(3, 111)	(120, 398)
Capital charge	(210)	(412)	(2, 146)	(326)	(3, 094)
Depreciation	(33)	(281)	(6, 848)	(174)	(7, 336)
Other	(9, 410)	(8, 887)	(46, 857)	(2, 196)	(67, 350)
Other Provider Payments	(3, 780)	(57, 351)	(14, 302)	(36, 577)	(112, 010)
Inter-district Outflows	(47)	(4, 199)	(43, 980)	(3, 399)	(51, 625)
Total expenditure	**(21, 016)**	**(80, 841)**	**(214, 173)**	**(45, 783)**	**(361, 813)**
(Deficit) / Surplus	**233**	**(5, 088)**	**(4, 916)**	**(94)**	**(9, 865)**

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. They comprise 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 prevalence and impact of long-term illness or disease.

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.

2021/22 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 ongoing 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 of 7.3% of children create major challenges in achieving a 95% target, and in the case of Māori, this rate was 9.1% recently. As these children age they create a dampening effect on achieving target in older cohorts.

Overall, we achieved immunisation on time for 81.2%, and 73.4% for Māori (an improvement from 70.5% in the preceding year).
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 pronged approach: continued awareness within general practice by Immunisation coordination services, within WCTO providers, at pregnancy and parenting education sessions, when tamariki present at the Emergency Department, 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.

Collaboration continues with Iwi providers to improve coverage and create joint work plans.

The local Youth One Stop Shop (YOSS) has been supported to the point of now being able to provide immunisations across the national schedule, in particular MMR. The YOSS is ideally placed within the student precinct of the local polytech.

HPV vaccination

Vaccination rates have been impacted adversely for a second year by COVID-19 with a further decline in vaccination rates compared to last year. In the 2021/22 period 607 of the eligible 984 (61.7%) boys and girls received at least one dose. The figure for Māori was 59.9%. Slightly more boys than girls were vaccinated this year

2020-21 Result: 687 of the eligible 976 (70.4%) boys and girls received at least one dose. The figure for Māori was 68.3%.

Work continues alongside schools to do catch up programmes.

Influenza vaccinations

Influenza vaccinations among the over 65s have seen a significant decrease (63.2% down from 72%), particularly for Māori (61% down from 76.3%). 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.

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 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 smoke free 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 Mama and Rangataahi groups.

Our Hapū Mama Programme continues to evolve as more Kaupapa Māori based and is offering hapū mama and whānau individualised opportunities to participate in weaving their own wahakura. This engagement promotes kōrero around health messaging in particular lifestyle choices such as smoking, drugs, alcohol, and their impact on the wellbeing of pēpē.

Smokefree coordinator has provided education to Lead Maternity Carers (LMCs) Well child Tamariki Ora providers, whānau ora and family start kaimahi. Relating specifically to hapū māmā, it involves a vape to quit programme.

Babies Living in Smokefree Homes
COVID-19 has had an impact in terms of reaching people and connecting them to stop smoking services. Whanganui District Health Board along with contracted partners have undertaken several specific activities in response to this measure and we envision these will provide the foundation for improved rates over the coming years. The activities included: smokefree training with Well Child Tamariki Ora, lead maternity carers and other community providers, system wide engagement that will provide local insights and recommendations for intervention, advancement of smokefree wānanga for hapū māmā in conjunction with National Sudden Unexplained Death in Infancy (SUDI) programme.

Cervical screening
In the three years to 31 March, we completed 237 screens less (11,812 compared to 12,049) than that same period to last year, among a similar population of eligible women (17,442 compared with 17,283). We completed 2,760 cervical smears for Māori women, down from 2,804 in the previous period. This is a year on year decline caused by COVID-19 impacting on cervical screening with a backlog that required proactive support to re-engage and provide reassurance for wahine that patient safety is paramount. Just 59.3% of eligible Māori wahine were screened, and 67.7% overall, against a target of 80%.

Targeted approaches continue to ensure wahine 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 wahine 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, but Māori children's results remain 13% above the national average. This represents a considerable inequity however, and work continues to address this. Dental admissions for Māori children, while consistently at around 35-40 per year, now account for 80% of total dental admissions by children from a cohort population of just 40%. Admissions for asthma have significantly reversed earlier improvements, from just 11 last year for Māori to 34 this year. Overall, there were 48 admissions this year, compared to just 20 last year. While other ASH conditions have remained relatively stable over the past five years, the last 12 months have seen increases across most condition types.

Dental
Children reach five years of age caries free in greater numbers than before (59.2%), and although Māori continue to lag behind there has been a slight improvement (44.1%) compared to last year's rates (41.4%). This year, more children (811) were examined than in the calendar year 2020 (725), with 480 being caries free (Māori 290 examined/128 caries free).

in thousands of New Zealand dollars

Table 2 | 2021/22 FINANCIAL PERFORMANCE: PREVENTION SERVICES

Output Class 1 - PREVENTION	2022 Actual	2021 Actual
Revenue		
Crown	14, 002	6, 843
Other Income	7, 090	42
Inter-district Inflows	157	76
Total revenue	**21, 249**	**6, 961**
Expenditure		
Personnel	(7, 536)	(2, 347)
Capital charge	(210)	(155)
Depreciation	(33)	(12)
Other	(9, 410)	(723)
Other Provider Payments	(3, 780)	(4, 107)
Inter-district Outflows	(47)	(45)
Total expenditure	**(21, 016)**	**(7, 389)**
(Deficit) / Surplus	**(233)**	**(428)**

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	2020/21 Actual	2021/22 Actual	2021/22 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 2022	All Māori Non-Māori	87.0% 106.0% 72.0%	92.0% 113.0% 74.0%	≤110.0% ≤115.0% ≤110.0%	🟢 🟢 🟢	🟠 🟠 🟠
Children caries-free at five years of age *Calendar 2021	All Māori Non-Māori	59.2% 41.4% 68.9%	59.2% 44.1% 67.6%	≥58.0% ≥58.0% ≥58.0%	🟢 🔴 🟢	🟢 🟢 🟠
Immunisation coverage rates at milestone at eight months of age *CW05	All Māori Non-Māori	81.6% 70.5% 90.6%	81.2% 73.4% 87.4%	≥95.0% ≥95.0% ≥95.0%	🔴 🔴 🟠	🟠 🟢 🟠
Babies in a smokefree household at six weeks of age *SLM data - July to December 2021	All Māori Non-Māori	48.6% 31.4% 61.7%	39.6% 24.6% 50.4%	≥38.0% ≥28.0% ≥58.0%	🟢 🔴 🔴	🔴 🔴 🔴
Proportion of youth who have received the HPV vaccine *2008 cohort - 12 months to July 2022	All Māori Non-Māori	70.4% 68.3% 77.9%	61.7% 59.9% 62.8%	≥75.0% ≥75.0% ≥75.0%	🔴 🔴 🔴	🔴 🔴 🔴
Cervical screening three-year coverage rate for women aged 25-69 years *3 years to 31 March 2021	All Māori Non-Māori	69.7% 65.5% 71.1%	67.7% 59.3% 70.8%	≥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	76.8% 78.7% 75.4%	71.3% 73.6% 69.5%	≥95.0% ≥95.0% ≥95.0%	🔴 🔴 🔴	🟠 🟠 🟠
Number of extended consults delivered by a GP or practice nurse *MH 04 FA1	Total Youth Adult	1150 151 (13.0%) 1000 (87.0%)	1111 154 (13.9%) 957 (86.1%)	2228 446 (20.0%) 1782 (80.0%)	 🔴 🟠	 🟢 🟠
Proportion of enrolled population aged 65+ years who have received flu vaccination	All Māori Non-Māori	72.0% 76.3% 73.5%	63.2% 61.0% 63.4%	≥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.

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.

2021/22 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.

Parenting classes

The proportion of pregnant women completing (over 75% of programme) district health board funded pregnancy and parenting education this year was just 26%, (Māori 20%). 45 Māori mothers of 219 (who delivered in the year) attended the programme, with 44 of them being first time mothers.

Working with Iwi health provider to provide regular wahakura wananga that includes rural provision.

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 hours 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 and 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.

There were 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.

There was 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.

Dental (calendar year 2021)

The proportion of adolescents using district health board funded dental services this year (73.9%) is a slight increase on last year 71.7%. The number of adolescents seen (2,954) slightly increased from (2,826) for the same period last year. Rates for Māori, first published this period, are significantly worse, at 62.3%, with non-Māori (81.5%) almost achieving target of 85%.

Population mental health

The proportion of youth aged 12-19 years seen each quarter in primary care for mental health remains relatively steady (1.3%) but below target (2.0%). Our teams see more youth each year, but the population growth for this age group has grown faster than the service's ability to respond. Rates for Māori have risen slightly to 1.7% while non-Māori rates are 1.0%.

Shorter waits for non-urgent mental health and addiction services (0-19 yrs) have achieved most targets, but our ability to see patients within three weeks is down around 5.7% on last year, and for Māori this is down 9.3%. Overall, 81% of youth received services within three weeks (79.9% Māori), and 97.9% within eight weeks (96.9% Māori).

This year we enhanced the range of health services offered by Youth One Stop Shop (YOSS) to meets the needs of our diverse community - including Māori, Pasifika and Rainbow communities - by partnering with other providers including Iwi and kaupapa providers and specialist mental health and addiction services.

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 however 45-64 year olds in our district are hospitalised for preventable illness at 161% of the national rate (Māori 280%). Angina and chest pain, chronic obstructive pulmonary disease and myocardial infarct continue to hospitalise Māori at a rate greatly disproportionate to their population.

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 significantly compared to last year from 56.7% to 64.2%, (Māori – 50.9%, up from 47.2%).

We have improved the management of people with long term conditions through actions such as those provided by multi-disciplinary teams (including allied health and kaiawhina) to support improved service delivery in primary care, with self-management, equitable access, identification and prioritisation of high-risk groups, support and education.

Ongoing focus and support for the GoutStop Programme ensured the programme is embedded across the region including: Monitoring of general practice data to enable iterative changes to improve the number of Māori males receiving regular uric acid testing; monitoring of TUKU data (patients enrolled in the programme by pharmacists and referrals to kaiawhina) to enable improvements of process/patient journey to support patients and to achieve target uric acid levels; implementation of a district-wide community education, communications plan and resources; establishment of a gout consumer group to inform any changes to current programme and resources.

Better data helps Whanganui District Health Board on improving health pathways for long term conditions e.g. diabetes, respiratory conditions that could be managed in the community with a focus on equity. We continued to develop plans with MidCentral and Waiarapa District Health Boards and will introduce Systemised Nomenclature of Medicine (SNOMED) standards with careful planning and change management.

Colonoscopies

The percentage of people accepted for an urgent diagnostic colonoscopy that received their procedure within two weeks (14 days) has risen slightly from 79.6% last year to 83.9% against a target of 90.0%.

Colonoscopy wait time results are discussed at monthly endoscopy user group meetings. Our policy for management of the endoscopy waiting list continues to be used to support achievement of wait time targets and management of patients at risk of exceeding recommended and maximum wait times.

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 National Bowel Screening Programme (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 | 2021/22 FINANCIAL PERFORMANCE: EARLY DETECTION & MANAGEMENT

Output Class 2 - EARLY DETECTION & MANAGEMENT	2022 Actual	2021 Actual
Revenue		
Crown	72, 998	59, 653
Other Income	155	87
Inter-district Inflows	2, 600	2, 531
Total revenue	**75, 753**	**62, 271**
Expenditure		
Personnel	(9, 711)	(8, 725)
Capital charge	(412)	(315)
Depreciation	(281)	(228)
Other	(8, 887)	(7, 894)
Other Provider Payments	(57, 351)	(44, 949)
Inter-district Outflows	(4, 199)	(4, 321)
Total expenditure	**(80, 841)**	**(66, 432)**
(Deficit) / Surplus	**(5, 088)**	**(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	2020/21 Actual	2021/22 Actual	2021/22 Target	A Achievement	C Change
Proportion of pregnant women accessing DHB funded pregnancy and parenting education	All Māori Non-Māori	18.0% 14.0% 20.8%	26.1% 20.5% 29.3%	≥ 40.0% ≥ 40.0% ≥ 40.0%	🔴 🔴 🔴	🟢 🟢 🟢
Proportion of adolescent population utilising DHB funded dental service *12 months to December 2021	All Māori Non-Māori	71.7% N/A N/A	73.9% 62.3% 81.5%	≥ 85.0% ≥ 85.0% ≥ 85.0%	🔴 🔴 🟠	🟢
Proportion of children enrolled in the Community Oral Health Service who have treatment according to plan *12 months to December 2021 (Q4 CW04)	All Māori Non-Māori	94.6% 93.9% 95.1%	92.2% 92.2% 92.2%	≥ 90.0% ≥ 90.0% ≥ 90.0%	🟢 🟢 🟢	🟠 🟠 🟠
Proportion of youth (12-19 years old) seen each quarter by primary mental health services	All Māori Non-Māori	1.2% 1.6% 1.0%	1.3% 1.7% 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 2022	**< 3 weeks** Total Māori Non-Māori **< 8 weeks** Total Māori Non-Māori	 86.3% 89.2% 84.6% 98.6% 99.4% 98.1%	 80.6% 79.9% 81.0% 97.9% 96.9% 98.5%	 ≥ 80.0% ≥ 80.0% ≥ 80.0% ≥ 95.0% ≥ 95.0% ≥ 95.0%	 🟢 🟠 🟢 🟢 🟢 🟢	 🟠 🔴 🟠 🟠 🟠 🟢
Ambulatory Sensitive Hospitalisations (ASH) rates for 45-64 years of age relative to national rate *12 months to March 2022	All Māori Non-Māori	157.1% 250.0% 132.5%	160.9% 280.4% 127.4%	≤ 170.0% ≤ 151.0% ≤ 166.0%	🟢 🔴 🟢	🟢 🔴 🟢
Proportion of patients with good or acceptable glycaemic control (HbA1C < 64 mmol/mol) *SS13 FA2 Diabetes Q4	All Māori Non-Māori	56.7% 47.2% 61.6%	64.2% 50.9% 64.2%	≥ 60.0% ≥ 60.0% ≥ 60.0%	🟢 🔴 🟢	🟢 🟢 🟢
Percentage of people accepted for an urgent diagnostic colonoscopy received their procedure within two weeks *12 months to May 2022	All	79.6%	83.9%	≥ 90.0%	🔴	🟢
Percentage of long-term clients with mental illness who have an up-to-date relapse prevention plan	Child Adult	100% 100%	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 receive care that maximises their independence and wellbeing.

2021/22 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. Enhancement of telehealth options for outpatient appointments has been essential in delivery of care through COVID environments.

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 2022 saw around 15,000 acute admissions to Whanganui Hospital. These included 7,000 day cases and temporary admissions through the Emergency Department.

On average, overnight patients stay 2.45 days, a little over our target of 2.20, but a further decrease on last year (2.53). A very small cohort of unwell patients (50) accounted for over 800 admissions, while ten patients alone stayed for almost 1,400 bed nights (over about 50 admissions).

Unplanned readmissions within 28 days of a previous discharge have again increased slightly beyond the optimum, from 14.1% last year to 14.5% (Māori 13.0%).

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 roll-out 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 missed our Faster Cancer Treatment (62 days) target of 90% this year (84.9%), down slightly on previous year reported (89.95%).

Surgical interventions

Standardised intervention ratios for cataracts have significantly improved from for the past three years. 375 procedures were carried out this year (ratio: 40.58) compared with 219 last year (ratio: 23.7). This is significantly above the national average. Rates for major joint surgery are also significantly above the national rate, and have been at this level for several years which indicate that our population is receiving equitable levels of care.

Whanganui District Health Board Cardiac procedure rates have dropped below national intervention ratios, while angioplasty and angiography have remained stable. 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, with Māori being almost three times more likely to be treated under section 29 compulsory treatment.

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 lockdown, some returning from overseas, who are having a real effect on service pressures. Lack of local whānau 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 year on year and is now achieving target for both Māori and non-Māori. Of the 221 clients discharged from mental health and addictions inpatient services, 178 were followed up within 7 days (80.5%). For Māori, 65 of 84 clients discharged were followed up within 7 days (77.4%), against a target of >75%.

Table 6 | 2021/22 FINANCIAL PERFORMANCE: INTENSIVE ASSESSMENT & TREATMENT

Output Class 3 - INTENSIVE ASSESSMENT & TREATMENT	2022 Actual	2021 Actual
Revenue		
Crown	201, 909	186, 145
Other Income	1, 512	1, 485
Inter-district Inflows	5, 836	5, 427
Total revenue	**209, 257**	**193, 057**
Expenditure		
Personnel	(100, 040)	(87, 729)
Capital charge	(2, 146)	(2, 221)
Depreciation	(6, 848)	(6, 079)
Other	(46, 857)	(43, 060)
Other Provider Payments	(14, 302)	(14, 956)
Inter-district Outflows	(43, 980)	(39, 196)
Total expenditure	**(214, 173)**	**(193, 241)**
(Deficit) / Surplus	**(4, 916)**	**(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	2020/21 Actual	2021/22 Actual	2021/22 Target	A Achievement	C Change
Inpatient length of stay - **Acute** (days) *12 months to March 2022	All	2.53	2.45	≤2.2	🔴	🟢
Unplanned re-admission rate at 28 days *12 months to March 2022 (14 July)	All Māori Non-Māori	14.1% 12.8% 14.6%	14.5% 13.0% 14.9%	≤12.1% ≤12.1% ≤12.1%	🔴 🟠 🔴	🟠 🟠 🟠
Faster Cancer Treatment (62-day indicator)	All	89.9%	84.9%	≥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* *12 months to May 2022,	All Māori Non-Māori	92.8% * *	91.7% * *	≥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* *12 months to May 2022	All Māori* Non-Māori*	61.2% * *	55.2% * *	≥90.0% ≥90.0% ≥90.0%	🔴	🔴
Percentage of service users receiving community care within seven days following their discharge (KPI 19) *12 months to March 2022	All Māori Non-Māori	74.8% 75.0% 74.6%	78.3% 77.4% 78.8%	≥75.0% ≥75.0% ≥75.0%	🟢 🟢 🟢	🟢 🟢 🟢
Rate per 100,000 population committed to compulsory mental health treatment *12 months to March 2022	All Māori Non-Māori	200 355 143	188 348 127	≤135 ≤250 ≤100	🔴 🔴 🔴	🟢 🟢 🟢
Standardised intervention rates **Cardiac surgery and angioplasty/angiography** *12 months to March 2022 (due to COVID staff shortages at MoH)	Cardiac (all) Angioplasty (all) Angiography (all)	4.5 12.1 28.9	2.7 13.2 26.2	≥6.5 ≥12.5 ≥34.7	🔴 🟢 🔴	🔴 🟢 🔴
Standardised intervention rates - **Cataracts and major joints** *12 months to March 2022 (due to COVID staff shortages at MoH)	Cataracts (all) Major joints (all)	23.7 25.0	40.6 23.9	≥27.0 ≤28.0	🟢 🔴	🟢 🟠

** Ethnicity data was not collected for this measure*

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 support - and enabling older people and the disabled to participate fully in society and enjoy maximum independence.

2021/22 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 year on year and is now achieving target for both Māori and non-Māori. Of the 221 clients discharged from mental health and addictions inpatient services, 173 were followed up within 7 days (78.3%). For Māori, 65 of 84 clients discharged were followed up within 7 days (77.4%), against a target of >75%.

Needs assessments

InterRAI facility assessments are expected to be completed by an ARC provider within 230 days and generally there is good compliance. This year, 91.4% were assessed within the target timeframe, a slight increase on the previous year (87.5%).

Stroke services

Measures relating to the delivery of stroke services are exceeding (23%) targets (>10%) which indicates that the stroke service is operating well and the 'code stroke' initiative is embedded within our systems. Virtually all patients (99.2%) are admitted to our organised stroke service under a demonstrated stroke pathway.

Polypharmacy

The proportion of over 64 year olds who are prescribed 11 or more medications is showing a slight increase again this year, with 3.4% of elder Māori and 2.4% overall. 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 2.5% of Māori and 4.5% non-Māori being supported in aged residential care facilities. More clients were funded for aged residential care this year (616, including 41 Māori) than last year (583, including 34 Māori).

Table 8 | 2021/22 FINANCIAL PERFORMANCE: REHABILITATION AND SUPPORT

Output Class 4 - REHABILITATION & SUPPORT	2022 Actual	2021 Actual
Revenue		
Crown	44, 548	41, 099
Other Income	66	33
Inter-district Inflows	1, 075	1, 192
Total revenue	**45, 689**	**42, 324**
Expenditure		
Personnel	(3, 111)	(2, 463)
Capital charge	(326)	(240)
Depreciation	(174)	(47)
Other	(2, 196)	(2, 008)
Other Provider Payments	(36, 577)	(34, 213)
Inter-district Outflows	(3, 399)	(3, 427)
Total expenditure	**(45, 783)**	**(42, 398)**
(Deficit) / Surplus	**(94)**	**(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	2020/21 Actual	2021/22 Actual	2021/22 Target	A Achievement	C Change
Percentage of mental health and addictions service users receiving community care within seven days following their discharge (KPI 19) *12 months to March 2022	All Māori Non-Māori	74.8% 75.0% 74.6%	78.3% 77.4% 78.8%	≥75.0% ≥75.0% ≥75.0%	🟢 🟢 🟢	🟢 🟢 🟢
Percentage of older people in aged residential care by facility who have a second InterRAI Long-Term Conditions Facilities (LTCF) assessment completed 230 days after admission	All	87.5%	91.4%	≥95.0%	🟠	🟢
Number of older people receiving in-home strength and balance programmes	All	217	103	>199	🔴	🔴
Percentage of potentially eligible stroke patients thrombolysed (ind 2)	All Māori Non-Māori	20.3% 26.7% 15.0%	23.0% 28.6% 22.6%	≥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 2022	All Māori Non-Māori	94.5% 87.5% 95.5%	99.2% 94.1% 100.0%	>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 *12 months to May 2022	All	52.1%	65.1%	≥70.0%	🟠	🟢
Proportion of over 64 year olds who are prescribed 11 or more medications	All Māori Non-Māori	2.3% 3.2% 2.2%	2.4% 3.4% 2.3%	≤2.0% ≤2.0% ≤2.0%	🔴 🔴 🔴	🟠 🟠 🟠
Proportion of population aged 65+ years receiving DHB funded support in ARC facilities over the year There is no target appropriate for this measure, figures given are presented as a guide	All Māori Non-Māori	4.1% 2.1% 4.3%	4.3% 2.5% 4.5%	4.4% 3.0% 4.5%	🟠 🔴 🟢	🟢 🟢 🟢

COVID-19 REPORT

Late 2021 saw the secondment of Russell Simpson to the Ministry of Health to lead the introduction of the Covid-19 Care in the Community Programme. The programme provides a holistic model of care from prevention to treatment and includes a welfare component (see model on page 56). The four components are:

- Public Health
- Community Care - Welfare and Wellbeing
- Primary Care - Clinical Support
- Secondary Care

The Public Health and Secondary Care components are led by Whanganui District Health Board whereas the other two components are led by community partners, organised into regional hubs.

Public Health

Public health includes measures for protecting people and whānau in the community and at home. This means ensuring having people at home with COVID-19 does not increase spread in the community. Our public health response is critical in supporting this approach, from identifying people and tracking the path to infection, to preventing further spread.

Public health measures include:

- Isolation and quarantine (MIQ or SIQ)
- Testing
- Genome sequencing
- Vaccination
- Contact tracing
- Clearance/assessment of end of infectious period.

Vaccination

The act of being vaccinated and immunised has been a form of protection against infections and diseases since modern medicinal history. For the beginning of all life, vaccinations are available from birth and continue throughout important stages of their life. For the period 1 July 2021 through 30 June 2022 Whanganui District Health Board provided 123,281 doses of Covid-19 vaccinations. (refer pages 50-55 for more detail)

The immunisation roll-out in the rohe has been administered by the shared efforts of the Whanganui District Health Board, General Practices, Māori Providers, Pacifica Leaders, governmental agencies and many more networks that had the shared vision of protecting the communities.

Testing

Throughout the phases of COVID testing, people presenting with COVID-19 symptoms initiate a test to know their status. The result of their COVID test confirmed positive case or not.

In the event of positive, Ministry of Health guidelines issued a standard isolation period of seven days. The rampant spread of COVID-19 in communities ushered Polymerase Chain Reaction (PCR) testing aside and Rapid Antigen Testing (RATs) to be the norm. Within the Whanganui rohe over 900,000 RAT tests have been distributed. The high number reflects on the recommendation to take a test every time you feel unwell and test every day if you are a household contact.

Supported isolation and quarantine

Supported isolation and quarantine (SIQ) facilities have been set up across the Whanganui District Health Board geographical area, including Ohakune, Taihape and Whanganui. SIQ facilities are used for those who don't have a safe place to quarantine at home, including people who are homeless, living with large extended whānau and critical workers.

Whanganui does not have a formal MIQ facility; these are generally based in large centers such as Auckland or Wellington.

Secondary services

Secondary services have been impacted through both staff absence (up to 62 patient-facing staff per day) and increased occupancy. In order to maintain patient safety, some elective cases have needed to be postponed.

Sadly, five people died in Whanganui Hospital, and one person from the Whanganui district died in Auckland Hospital with COVID-19 during this period.

ADDITIONAL PERFORMANCE INFORMATION: COVID-19 VACCINATIONS AND MORTALITY

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

COVID-19 Vaccinations

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

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

HSU 2021
People are included if they were:
- alive on 31 December 2021
- enrolled with a primary health organisation or received health services in the 2021 calendar year.

HSU 2020
People are included if they were:
- alive on 1 July 2020,
- enrolled with a primary health organisation or received health services in the 2020 calendar year.

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

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

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

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

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

To determine the coverage of the COVID-19 vaccine across the population of Whanganui DHB we have used the HSU 2021 data as the denominator (the figure which the total eligible population vaccinated is divided by). The suitability of the HSU for this purpose was reviewed by Stats NZ, with their findings and recommendations published on 4 August 2022[1].

Percentages over 100% occur where there are more vaccinated persons than was expected in the HSU 2021 data. This is mostly seen in small populations. As the HSU is a point in time denominator, any movement of persons into or out of an area are not captured and percentages above 100% can occur. Percentage of the eligible population who have completed their primary COVID-19 vaccination course[2] (HSU 2021 vs HSU 2020)

Year[3]	HSU 2021 Percentage of the eligible population who have completed their primary course	HSU 2020 Percentage of the eligible population who have completed their primary course
2020/2021	14.77%	15.26%
2021/2022	72.9%	75.36%
Total	**87.71%**	**90.62%**

Using HSU 2021 to determine the percentage of the eligible population who have completed their primary course, the coverage is calculated to be 87.7%, compared with 90.62% using HSU 2020 as at 30 June 2022.

The difference in the percentage of the eligible population vaccinated using HSU 2021, compared with using HSU 2020, reflects an increase in the number of individuals interacting with the health system during the 2021 calendar year compared with 2020.

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

COVID-19 VACCINE DOSES ADMINISTERED BY DOSE TYPE AND YEAR

The counts in the table below measure the number of COVID-19 vaccination doses administered in Whanganui DHB during 2021/22 and the prior financial year (2020/21). This information was obtained from the COVID-19 Vaccination and Immunisation Programme (CVIP) database.

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

Year[4]	Dose 1	Dose 2	Booster 1	Booster 2	Total[5]
2020/2021	11, 387	8, 847	0	0	20, 234
2021/2022	44, 066	44, 238	34, 549	428	123, 281
Total	**55, 453**	**53, 085**	**34, 549**	**428**	**143, 515**

By 30 June 2022, a total of 143,515 vaccinations had been administered of which 86% were administered in 2021/22

[1] https://www.stats.govt.nz/reports/review-of-health-service-user-population-methodology
[2] Individuals who have received dose 1 and dose 2 of the COVID-19 vaccine are considered to have completed their primary course. This definition supersedes the term 'fully vaccinated' reported in our 2020/21 annual report.
[3] Data as at 30 June 2021 for 2020/21 and 30 June 2022 for 2021/22.
[4] Data as at 30 June for each financial year, and respectively covers all vaccination doses administered between 1July-30 June.
[5] Excludes third primary doses administered and any subsequent boosters a person may have received after the second booster vaccination.

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

COVID-19 VACCINE DOSES ADMINISTERED BY AGE GROUP

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

COVID-19 vaccine doses administered by age group[6]

Age group (years)[7]	Dose 1	Dose 2	Booster 1	Booster 2	Total[8]
0 to 11	2,782	1,243	0	0	4,025
12 to 15	3,294	3,137	0	0	6,431
16 to 19	2,713	2,652	690	0	6,055
20 to 24	2,946	2,898	1,273	3	7,120
25 to 29	3,165	3,126	1,584	6	7,881
30 to 34	3,304	3,287	1,939	6	8,536
35 to 39	2,871	2,871	1,946	9	7,697
40 to 44	2,615	2,614	1,907	9	7,145
45 to 49	2,983	3,026	2,441	9	8,459
50 to 54	3,256	3,339	3,068	16	9,679
55 to 59	3,456	3,600	3,541	21	10,618
60 to 64	3,398	3,547	3,776	44	10,765
65 to 69	2,513	2,920	3,606	62	9,101
70 to 74	2,012	2,456	3,323	96	7,887
75 to 79	1,193	1,544	2,365	82	5,184
80 to 84	891	1,126	1,701	44	3,762
85 to 89	460	591	891	19	1,961
90+	214	261	498	2	975
Total	**44, 066**	**44, 238**	**34, 549**	**428**	**123, 281**

Note 1: Some demographic breakdowns appear to show more doses administered for Dose 2 compared to Dose 1. This is due to COVID-19 vaccination doses being administered in the previous financial year (2020/21).

[6] Data as at 30 June 2022 and covers all vaccination doses administered between 1 July 2021-30 June 2022.
[7] Age groupings in this table reflect the age of the person at the time of the vaccination being administered.
[8] Excludes third primary doses administered to individuals and any subsequent boosters which may have been administered after the second booster vaccination.

COVID-19 PEOPLE VACCINATED BY AGE GROUP

The counts and the percentages in the table below measure the number of people who received COVID-19 vaccination doses during 2021/22. This data was obtained from the CVIP database (broken down by age group), and the percentages calculated using HSU 2021 as the denominator.

Please note, as this table refers to people vaccinated (and the respective percentage of a given demographic per row), it is not comparable to the table above (COVID-19 doses administered by age group).

COVID-19 people vaccinated by age group during 2021/22[9]

Age group (years)[10]	Partially Vaccinated[11]	Partially Vaccinated percentage of HSU2021[11]	Completed Primary Course[12]	Completed Primary Course percentage of HSU2021[12]	Received First Booster	Received First Booster percentage of Eligible	Received Second Booster	Received Second Booster percentage of Eligible
0 to 11	2,331	21%	1,065	10%	0	0%	0	0%
12 to 15	2,822	74%	2,483	65%	0	0%	0	0%
16 to 19	2,886	85%	2,812	83%	377	37%	0	0%
20 to 24	3,035	80%	2,986	78%	1,297	40%	0	0%
25 to 29	3,071	72%	3,050	72%	1,485	44%	0	0%
30 to 34	3,332	76%	3,316	75%	1,900	52%	0	0%
35 to 39	2,971	77%	2,971	77%	1,956	59%	0	0%
40 to 44	2,689	77%	2,699	77%	1,909	63%	0	0%
45 to 49	2,763	69%	2,820	71%	2,267	69%	0	0%
50 to 54	3,259	73%	3,336	75%	3,022	76%	12	3%
55 to 59	3,327	70%	3,454	73%	3,400	81%	25	5%
60 to 64	3,499	73%	3,653	76%	3,792	85%	42	7%
65 to 69	2,742	64%	3,082	72%	3,637	91%	57	8%
70 to 74	2,042	54%	2,452	65%	3,290	94%	90	12%
75 to 79	1,396	53%	1,785	68%	2,608	96%	89	14%
80 to 84	956	51%	1,218	65%	1,774	98%	46	11%
85 to 89	538	55%	687	71%	1,006	102%	21	9%
90+	275	49%	337	60%	563	108%	3	2%
Total	**43, 934**	**63%**	**44, 206**	**63%**	**34, 283**	**73%**	**385**	**9%**

[9] *Data as at 30 June 2022 and includes all people who received COVID-19 vaccinations between 1 July 2021– 30 June 2022.*
[10] *Age groupings in this table reflect age of the persons at end of financial year.*
[11] *Partial vaccination refers to individuals who had received a single one dose of the COVID-19 vaccination (as at 30 June 2022).*
[12] *Primary course refers to the first two doses of the COVID-19 vaccine (dose 1 and dose 2).*

COVID-19 VACCINE DOSES ADMINISTERED BY ETHNICITY

The counts in the table below measure the number of COVID-19 vaccine doses administered by the ethnicity of the individual who received the dose. This information was obtained from the COVID-19 Vaccination Immunisation Programme database.

COVID-19 vaccine doses[13] administered by ethnicity[14] (1 July 2021 – 30 June 2022)

Ethnicity (Note 1, 2)	Dose 1	Dose 2	Booster 1	Booster 2	Total
Asian	1,680	1,628	1,373	9	4,690
Other	29,886	30,687	26,718	389	87,680
Maori	11,192	10,673	5,664	27	27,556
Pacific Peoples	1,170	1,110	657	1	2,938
Unknown	138	140	137	2	417
Total	**44, 066**	**44, 328**	**34, 549**	**428**	**123, 281**

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

Note 2: Some demographic breakdowns appear to show more doses administered for Dose 2 compared to Dose 1. This is due to COVID-19 vaccination doses being administered in the previous financial year (2020/21).

COVID-19 PEOPLE VACCINATED BY ETHNICITY

The counts in the table below measure the number of people receiving doses (obtained from the COVID-19 Vaccination and Immunisation Programme database).

COVID-19 people vaccinated by ethnicity during 2021/22[15]

Ethnicity (Note 1)	Partially Vaccinated	Partially Vaccinated percentage of HSU2021	Completed Primary Course	Completed Primary Course percentage of HSU2021	Received First Booster	Received First Booster percentage of Eligible	Received Second Booster	Received Second Booster percentage of Eligible
Asian	1,514	69%	1,552	71%	1371	77%	4	5%
Māori	10,465	74%	10,409	73%	5615	56%	22	4%
European/other	28,392	69%	29,905	73%	26,505	78%	356	10%
Pacific peoples	1,086	75%	1,099	76%	654	61%	1	3%
Unknown	146	74%	176	90%	138	57%	2	13%
Total	**41, 603**	**70%**	**43, 141**	**73%**	**34, 283**	**73%**	**385**	**9%**

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

COVID-19 people vaccinated by ethnicity from 1 July 2020 to 30 June 2022

Ethnicity (Note 1, 2)	Partially Vaccinated	Partially Vaccinated percentage of HSU2021	Completed Primary Course	Completed Primary Course percentage of HSU2021	Received First Booster	Received First Booster percentage of Eligible	Received Second Booster	Received Second Booster percentage of Eligible
Asian	1,972	90%	1,960	89%	1,371	77%	4	5%
Māori	12,083	85%	11,606	82%	5,615	56%	22	4%
European/other	37,347	91%	36,826	90%	26,506	78%	356	10%
Pacific peoples	1,277	89%	1,233	86%	654	61%	1	3%
Unknown	255	130%	251	128%	138	57%	2	13%
Total	**52, 934**	**90%**	**51, 876**	**88%**	**34, 284**	**73%**	**385**	**9%**

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

Note 2: Partially Vaccinated counted for 12+ years old (age as at 30 June 2022)
Completed Primary Course counted for 12+ years old (age as at 30 June 2022)
Rec'd First Booster counted for 18+ years old (age as at 30 June 2022)
Rec'd Second Booster counted for 18+ years old (age as at 30 June 2022)
50+ age determined as at 30 June 2022
Basis of population is HSU2021 for 12+ years old
All counts exclude those who died prior to 30 June 2022

[13] *This excludes third primary doses administered and any subsequent boosters a person may have received after a second booster.*
[14] *Data as at 30 June 2022 and includes all vaccination doses being administered between 1 July 2021 – 30 June 2022.*
[15] *Data as at 30 June 2022 and includes all people who received COVID-19 vaccinations between 1 July 2021 – 30 June 2022.*

FURTHER NOTES ON THE HSU DATASET

While the health system uses the HSU to determine vaccination coverage within the eligible population, the HSU is not a total population estimate and it does not include people who do not use health services.

The HSU is an estimate of the number of people in New Zealand in a given 12-month period, based on information about who used health services in that period. The HSU 2020 was developed and used for the roll-out of the COVID-19 vaccine to calculate the proportion of the eligible population who were vaccinated against COVID-19.

While we use the HSU to determine vaccination coverage within the eligible population, the HSU is not a total population estimate and it is likely to miss highly marginalised groups.

For example, our analysis suggests that groups underrepresented in the HSU include young people aged 15-45 years (men in particular), and people of Asian and Middle Eastern, Latin American and African ethnicities.

There are other datasets that measure the number of people living in New Zealand produced by Stats NZ : [16]

1. Census counts produced every 5 years with a wide range of disaggregations
2. Population estimates (ERP) which include adjustments for people not counted by census:
   a. National population estimates (produced quarterly)
   b. Subnational population estimates (produced every year)
3. Population projections which give an indication of the future size and composition of the population:
   a. Official national and subnational projections
   b. Customised population projections (produced every year by Stats NZ for the Ministry of Health using requested ethnic groupings and DHB areas).

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

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

Stats NZ

'The ERP and HSU have different target populations. In principle, the ERP is an estimate of the population usually living (resident) in New Zealand at a point in time, and the HSU is a measure of the population in New Zealand using (or potentially using) the health system at a point in time. For both the ERP and HSU, mean populations over a period of time can be derived from the point in time estimates.' [17]

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

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

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

- age
- ethnicity
- DHB
- gender

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

Comparison of HSU 2021 to the Stats NZ projected resident population

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

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

	HSU 2021	Stats NZ PRP	Difference (Note 1)
Maori	18,903	19,700	797
Pacific Peoples	1,892	2,050	158
Asian	2,737	2,880	143
European or Other	46,324	44,400	-1,924
Missing	209	0	-209
Total (Note 1)	70,065	69,100	-965

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

Comparison of HSU 2020 to the Stats NZ PRP[18]

For reference, we have provided the HSU 2020 comparison

	HSU 2020	Stats NZ PRP	Difference
Maori	18,185	19,300	1,115
Pacific Peoples	1,873	2,010	137
Asian	2,397	2,840	443
European or Other	45,606	44,300	-1,306
Missing	181	0	-181
Total (Note 1)	68,242	68,400	158

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

COVID-19 MORTALITY RATES

The data used to determine deaths attributed to COVID-19 comes from EpiSurv[19] and the National Contact Tracing Solution (NCTS) databases. The data received through these systems is extensively checked for duplications using national health index (NHI) data.

The definition of COVID-19 deaths that the Ministry now uses in most situations, including in this section, is defined as 'deaths attributed to COVID-19'. *'Deaths attributed to COVID-19' include deaths where COVID-19 was the underlying cause of death, or a contributory cause of death. This is based on Cause of Death Certificates which are coded by the Mortality Coding Team within the Ministry.*

There can be delays processing the Cause of Death Certificates being updated in our systems. For example, where a paper-based death certificate is issued, the data will not be recorded as quickly as if it was submitted electronically.

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

COVID-19 Deaths by age group

Age group (years)	
<10	0
10 to 19	0
20 to 29	1
30 to 39	0
40 to 49	1
50 to 59	1
60 to 69	0
70 to 79	3
80 to 89	4
90+	6
Total	**16**

COVID-19 deaths by ethnicity

Ethnicity	
Asian	0
European/other	12
Māori	4
Pacific peoples	0
Unknown[20]	0
Total	**16**

[16] *https://www.stats.govt.nz/methods/population-statistics-user-guide.*

[17] *More information on the findings from the Stats NZ review of the HSU is available at: stats.govt.nz/reports/review-of-health- service-user-population-methodology/*

[18] *HSU 2020 data is as at 1 July 2020 and Stats NZ PRP data is as at 30 June 2020.*

[19] *EpiSurv is a secure national system used by Primary Health Units to report cases of notifiable diseases. It is operated by the Institute of Environmental Science and Research (ESR), on behalf of the Ministry of Health*

[20] *'Unknown' refers to individuals where no ethnicity can be satisactorily determined.*

COVID IN THE COMMUNITY

Whanganui District

The Care in the Community Team met with leaders from the Whanganui Regional Health Network and Te Oranganui. Whanganui Regional Health Network are the Primary Health Organisation for the Whanganui rohe, and they provide a wide range of community-based health services. Te Oranganui is an Iwi governed organisation that delivers a wide range of health and social services to all people throughout the Whanganui and neighbouring regions. Prior to the COVID-19 response, these organisations were already engaged with one another and working together on other strategies. Within the COVID-19 response, they were integral clinical and Iwi leads for the rohe.

Initially, in 2020, it was identified early on that the Whanganui region needed an Iwi-led response. This led to the ability to build on the partnerships that were already in place and "get on with it". There wasn't time to wait until funds were released – it was said "this has not been about the funding", in fact they began delivering care without the funding being in place. Rather than funding leading the response, it was the community need that led the response, we were told that "we're not always popular – but too bad, it is about our communities".

The Whanganui District rohe has both urban and rural areas, some very remote. This presents significant challenges for these geographically isolated communities to access care. Given this, the Whanganui District took advantage of many pre-existing networks and adopted a model with Hubs spread around its key region. Whanganui Regional Health Network already had clinics in some of these areas, which provided clear clinical care options, whilst the Iwi relationships in many of these areas were also already strongly established. This created a strong foundation from which to build the COVID-19 response.

Four Hubs were established, using Iwi boundaries, which had clinical and social/welfare leads to support a whānau ora approach for their COVID-19 response. These were the: Whanganui Hub (including South Taranaki), the South Rangitīkei (Marton) Hub, North Rangitīkei (Taihape) Hub, and the Waimarino (Ruapehu) Hub. A virtual hub was established for non-enrolled primary care patients and overflow for existing primary care providers. One key aspect of note is that many of the rural areas already had well established community forums – so a community led hub approach was not new.

Relationships

A hui held at Te Poho o Tuariki late in 2021 brought together a wide range of regional stakeholders. As the meeting was held at a Māori establishment, it naturally become an Iwi-led hui. This meeting was considered a catalyst to ensure the approach taken to the COVID-19 response in the District was Iwi-led and community driven.

One relationship which has grown substantially over the course of the COVID-19 response is that with the Ministry of Social Development. This collaborative relationship has led to each hub having a Kai COVID Hub and the funding of many Ministry of Social Development Community Connector roles to a plethora of community organisations. Bulk funding was received from Ministry of Social Development which was driven by clear metrics of COVID-19 positives in the rohe, thus easing the reporting pressure for accessing further funding as need dictated. Whanganui District Health Board provided access to a District funded initial 48-hours welfare support – a helpful safety net, which was only used in the very initial stages.

It was commented that there are many 'critical friends' within health that absolutely understand and are supportive of what Iwi and community providers are trying to achieve. Furthermore, the Iwi campervans and Waka Hauora Health bus both offer mobile services and must work together to coordinate services provided to the rural areas.

Wider relationships between various agencies and organisations have been developed and strengthened through the Hub and Regional Hui. These were online and held weekly to begin with and during the surge, regional huis were facilitated by Iwi. These huis would involve various members including representatives from Whanganui District Health Board, Ministry of Social Development, Ministry of Education, Civil Defence, Farmers Groups, other Non-Government Organisations, etc. These inter-disciplinary meetings were essential for building cross-sector relationships and ensuring knowledge sharing.

Community focused approaches

The Whanganui River community is one of the most isolated in the Whanganui District. The Whanganui based "triad" relationship of Te Oranganui, Whanganui Regional Health Network and Whanganui District Health Board, were able to vouch for this community to receive outcomes-based funding from the Ministry of Social Development – a new approach. This enabled two Iwi groups to receive putea from connector roles to provide for their own people in specific ways that their community needed, enabling them to have self-determination and paddle their own waka. This led to such initiatives as delivery of medications, lozenges, Pedialyte and ice blocks for sick children, as well as firewood to keep houses warm. This had led to Te Oranganui working with the region to help create a wellbeing plan.

Waimarino (Ruapehu) had some unique challenges presented by lower vaccination rates and the holiday homes in the area. However, the Waimarino rohe has a strong Iwi provider (Ngāti Rangi), a Māori provider (Te Puke Karanga Hauora), a Whanganui District Health Board Clinic and a Whanganui Regional Health Network owned general practice. The local holiday homes presented a challenge to the community as owners would sometimes leave their home regions and come to the area when lockdowns hit.

North Rangitīkei (Taihape) had a strong response due to the close relationship between Mōkai Pātea and Taihape Health Centre. We were told that the two organisations work well together, being very integrated in how they think and deliver services. This was demonstrated in their collaborative approaches on the COVID-19 and vaccination campaigns. Furthermore, by working together they were able to locate people within their communities that hadn't previously been reached. It was commented that these smaller rural communities are often better at working together and have less issues working together than larger urban areas.

South Rangitīkei (Marton) faced one of the earlier outbreaks in the region. This was a breakout from the works that spread predominantly throughout the Pasifika community in the region. The social/welfare and clinical leads worked well together provide a social and welfare approach that included assistance across the spectrum, including medication and poverty. Supported by the Whanganui Regional Health Network, public health nurses, Iwi providers and clinical teams, they were able to manage the outbreak well. Another unique challenge in this area was weather events, that further developed relationships between the hub and the emergency management staff at council, to develop plans for potential evacuation of COVID-19 positive cases.

The Whanganui Hub was effective due to the cohesion that developed that may not have been as strong previously. Specifically, collaboration between Iwi providers was strengthened. For example, Tupoho, an Iwi provider of predominantly social services, opened the regions first COVID-19 salivary testing clinic. Te Oranganui, had benefits and challenges from this, but ensured they "worked together wherever we could so that the community had options". The collaborative relationship involved use of resources (e.g., mobile van) and they were open to requests. They also ran a kai hub on behalf of Iwi and still have a distribution centre.

South Taranaki is a predominantly rural community with some significant businesses. This area had regular Sunday night meetings with members of the leaders from the Whanganui Hub. These meetings enabled regular contact, an ability to listen and respond to concerns. The Hub worked together with Ngā Rauru to meet the needs of the community. A mobile bus from the District was helpful for the community, allowing mobile services to be receptive to the needs of the community. This community was well supported by the Whanganui District Health Board leader.

Finally, the virtual clinic was available seven days a week, with the primary focus of this service being on COVID-19 positive people receiving a call and wraparound services as appropriate. It was an integrated workforce, including Whanganui District Health Board employees and Whanganui Regional Health Network employees working together.

Outcomes and frustrations

The outcomes of the above locally led and regionally supported initiatives proved to be effective as demonstrated by the data for the rohe. Specifically, during the first surge earlier in 2022 the modelling was met for the number of COVID-19 positive cases, but the hospitalisations tended to remain lower than predictions. Demonstrating that the regular contact with positive cases, wrap-around support and monitoring provided, was critical to ensuring people could be cared for in their homes.

One big success for the region, has been the establishment of the District Mauri Ora Clinic. The clinic was initially run by the Whanganui District Health Board, and passed to community providers. It is a clinic for any respiratory symptoms, it is free, and located on hospital grounds. It has a Whānau Ora model there are connections with mental health and addiction services, primary care, Iwi providers, as well as pharmacies, strengthening these wider networks. Based on recent data, service users were 30% Māori and 10% Pasifika, with a Pasifika translator having been involved in ensuring communications about the clinic are in the languages of Pasifika communities.

Looking ahead

The relationships established are valued by the various organisations involved in the Hubs. This is evidenced from the fact that the Hubs continue to meet fortnightly. When considering more infrequent meetings it was indicated by the majority that the connections are vital, and so these continue regularly even though COVID-19 positive cases may be dropping. These are still attended by most of the members, including District Health Board staff providing clinical input. This was emphasised by a comment that "90% of this is about relationships and communication".

One of the key aspects raised regarding the path forward was the need for more coordination. Confusion can arise from the many avenues and options for care. Hence, a path forward is to ensure clarity by having more streamlined services. This includes some of the mobile options becoming more in sync with their timings and offerings, as well as the number of venues available for similar services, such as testing, in one area.

The innovative approaches taken in the Whanganui region for the COVID-19 response have led to discussions regarding how this can be embedded in other areas. One interesting example was the two-hour trip some people must take to access GP services. How could mobile services provided during COVID-19 be utilised to overcome this access barrier for these remote communities?

PŪRONGO PŪTEA

FINANCIAL STATEMENTS

Deloitte.

TO THE READERS OF
WHANGANUI DISTRICT HEALTH BOARD'S FINANCIAL STATEMENTS AND PERFORMANCE INFORMATION FOR THE YEAR ENDED 30 JUNE 2022

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 65 to 96, that comprise the statement of financial position as at 30 June 2022, 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 55.

Opinion

Qualified opinion on the financial statements

In our opinion, except for the possible effects of the matter described in the Basis for our opinion section of our report, the financial statements of the Health Board on pages 65 to 96, which have been prepared on a disestablishment basis:

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

Unmodified opinion on the performance information

In our opinion, the performance information of the Health Board on pages 36 to 55:

- presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2022, including:
    - for each class of reportable outputs:
        - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
        - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
        - what has been achieved with the 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 08/05/2023. This is the date at which our opinion is expressed.

The basis for our opinion is explained below and we draw attention to other matters. In addition, we outline the responsibilities of the Board of Te Whatu Ora – Health New Zealand 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

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

As outlined in note 15 on pages 87 and 88, the Health Board has been investigating issues with the way it calculates holiday pay entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues.

The provision for employee entitlements includes a provision of $13.4 million for the estimated amounts owed to current and past employees as at 30 June 2022.

During December 2022, the sector received legal advice on how to decide whether a day is an 'otherwise working day' when calculating the provision for holiday pay entitlements. This provision has been amended to include this fact but the work and evidence to support this provision was still ongoing at the date of signing this report. We have therefore been unable to obtain adequate evidence to determine if the amount of this provision is reasonable.

As at 30 June 2021 the Health Board estimated a provision for holiday pay entitlements of $8.88 million. There were uncertainties in estimating this provision, and as a result an emphasis of matter was included in the unmodified opinion expressed on the financial statements for the year ended 30 June 2021.

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 in the financial statements.

The financial statements have been prepared on a disestablishment basis

The basis of preparation section on page 69 outlines that the Health Board has prepared its financial statements on a disestablishment basis because the Health Board was disestablished, and its functions transferred to Te Whatu Ora - Health New Zealand on 1 July 2022. There have been no changes to the values of the Health Board's assets and liabilities as a result of preparing the financial statements on a disestablishment basis.

Impact of Covid-19

Note 24 on page 96 to the financial statements, which outline(s) the ongoing impact of Covid-19 on the Health Board.

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

Page 50 to 55 outlines the information used by the Health Board to report on its Covid-19 vaccine coverage. The Health Board 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 on page 54 to 55. The notes 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 Health Board 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 of Te Whatu Ora – Health New Zealand for the financial statements and the performance information

The preparation of the final financial statements and performance information for the Health Board is the responsibility of the Board of Te Whatu Ora.

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

Up until 30 June 2022, the Health Board was responsible for such internal control as it determined necessary to enable it to prepare financial statements and performance information that were free from material misstatement, whether due to fraud or error. From 1 July 2022, the Board of Te Whatu Ora took over these responsibilities to enable the completion of the financial statements and performance information.

The responsibilities of the Board of Te Whatu Ora arise from the transition provisions in the Pae Ora (Healthy Futures) Act 2022.

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

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

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

For the budget information reported in the financial statements and the performance information, our procedures were limited to checking that the information agreed to the 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 of Te Whatu Ora.

- 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 disestablishment basis by the Board of Te Whatu Ora.

- We evaluate the overall presentation, structure and content of the financial statements and the performance information, including the disclosures, and whether the financial statements and the performance information represent the underlying transactions and events in a manner that achieves fair presentation.

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

Our responsibilities arise from the Public Audit Act 2001.

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Other Information

The Board of Te Whatu Ora is responsible for the other information. The other information comprises the information included on pages 2 to 35, 56 to 59, 64 and page 98 to 103, 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
for Deloitte Limited
On behalf of the Auditor-General
Hamilton, New Zealand

STATEMENT OF RESPONSIBILITY

For the year ended 30 June 2022

Te Whatu Ora – Health New Zealand was established on 1 July 2022 under the Pae Ora (Healthy Futures) Act 2022.

As a result of the transitional arrangements in the Pae Ora Act all assets and liabilities of the Whanganui District Health Board (the Health Board) were transferred to Te Whatu Ora. By Ministerial approval under s 45J of the Public Finance Act 1989, Te Whatu Ora now has responsibility for providing the final annual report of the Health Board, which was disestablished at the end of 30 June 2022.

The Board and Management of Te Whatu Ora take responsibility for the preparation of the Whangnaui District Health Board financial statements and statement of performance, and for the judgements made in them.

We are responsible for any end-of-year performance information provided by the Whangnaui District Health Board under section 19A of the Public Finance Act.

We are responsible for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting.

In our opinion, these financial statements and statement of performance fairly reflect the financial position and operations of the Whangnaui District Health Board for the year ended 30 June 2022.

Signed on behalf of the Te Whatu Ora Board:

Naomi Ferguson
Acting Chair

Hon Amy Adams
Board Member

STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSE

For the year ended 30 June 2022

in thousands of New Zealand dollars

	Note	2022 Actual	2022 Budget	2021 Actual
Revenue				
Revenue from non-exchange transactions	1a	316, 818	285, 685	272, 044
Revenue from exchange transactions	1b	34, 812	33, 262	32, 268
Other revenue	1c	318	346	301
Total revenue		**351, 948**	**319, 293**	**304, 613**
Expenses				
Personnel costs	2	(120, 398)	(102, 809)	(101, 264)
Outsourced services		(18, 779)	(15, 808)	(17, 693)
Depreciation and amortisation expense		(7, 336)	(7, 349)	(6, 366)
Capital charge	3	(3, 094)	(3, 126)	(2, 931)
Finance costs	4	(13)	(115)	(16)
Other expenses	5	(212, 283)	(195, 116)	(181, 316)
Total expenses		**(361, 903)**	**(324, 323)**	**(309, 586)**
Share of profit of associate	11	90	85	126
(Deficit) / Surplus		**(9, 865)**	**(4, 945)**	**(4, 847)**
Other comprehensive revenue and expense				
Gain on property revaluation	9	25, 496	-	8, 679
Total other comprehensive revenue and expense		**25, 496**	**-**	**8, 679**
Total comprehensive revenue and expense		**15, 631**	**(4, 945)**	**3, 832**

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

STATEMENT OF FINANCIAL POSITION

As at 30 June 2022

in thousands of New Zealand dollars

	Note	2022 Actual	2022 Budget	2021 Actual
Assets				
Current assets				
Cash and cash equivalents	6	911	5	-
Receivables from non-exchange transactions	7	3, 100	160	469
Receivables from exchange transactions	7	18, 227	6, 415	10, 244
Prepayments		659	-	176
Inventories	8	1, 695	1, 617	1, 495
Trust/special funds		196	189	198
Patient and restricted trust funds		6	4	6
Total current assets		**24, 794**	**8, 390**	**12, 588**
Non-current assets				
Property, plant and equipment	9	113, 864	96, 445	88, 851
Intangible assets	10	6, 718	13, 422	11, 210
Investments in associates	11	1, 401	1, 255	1, 173
Total non-current assets		**121, 983**	**111, 122**	**101, 234**
Total assets		**146, 777**	**119, 512**	**113, 822**
Liabilities				
Current liabilities				
Cash and cash equivalents	6	-	8, 577	1, 355
Payables under non-exchange transactions	13	6, 255	3, 426	2, 522
Payables under exchange transactions	13	23, 351	18, 100	18, 134
Borrowings	14	103	103	100
Employee entitlements	15	36, 516	27, 299	26, 435
Total current liabilities		**66, 225**	**57, 505**	**48, 546**
Non-current liabilities				
Borrowings	14	282	282	385
Employee entitlements	15	674	729	768
Total non-current liabilities		**956**	**1, 011**	**1, 153**
Total liabilities		**67, 181**	**58, 516**	**49, 699**
Net assets		**79, 596**	**60, 996**	**64, 123**
Equity				
Contributed capital		112, 093	113, 393	112, 251
Accumulated (deficit) / surplus		(97, 419)	(92, 169)	(87, 556)
Property revaluation reserve		64, 726	39, 577	39, 230
Hospital special funds		196	195	198
Total equity		**79, 596**	**60, 996**	**64, 123**

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 2022

in thousands of New Zealand dollars

	2022 Actual	2021 Actual
Crown equity		
Balance at 1 July	112, 251	112, 409
Capital contribution from the Crown	-	-
Repayment of capital to the Crown	(158)	(158)
Balance at 30 June	**112, 093**	**112, 251**
Accumulated (deficit)		
Balance at 1 July	(87, 556)	(82, 698)
Other reserved movements	2	(11)
Deficit for the year	(9, 865)	(4, 847)
Balance at 30 June	**(97, 419)**	**(87, 556)**
Property revaluation reserves		
Balance at 1 July	39, 230	30, 551
Revaluation	25, 496	8, 679
Balance at 30 June	**64, 726**	**39, 230**
Property revaluation reserves consist of:		
Land	5, 312	2, 795
Buildings	59, 414	36, 435
Total property revaluation reserves	**64, 726**	**39, 230**
Hospital special funds		
Balance at 1 July	198	187
Transfer from retained earnings in respect of:		
Interest	-	1
Donations and funds received	15	13
Transfer from retained earnings in respect of:		
Funds spent	(17)	(3)
Balance at 30 June	**196**	**198**
Total equity	**79, 596**	**64, 123**

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 2022

in thousands of New Zealand dollars	Note	2022 Actual	2022 Budget	2021 Actual
Cash flows from operating activities				
Receipts from the Crown		332, 359	315, 201	299, 460
Interest received		100	53	57
Receipt from other revenue		8, 473	3, 909	1, 550
Payment to suppliers		(218, 421)	(210, 611)	(199, 485)
Payment to employees		(110, 411)	(99, 004)	(96, 820)
Interest paid		(13)	(13)	(16)
Payment of capital charge		(3, 094)	(3, 126)	(2, 931)
GST (net)		(151)	-	128
Net cash inflow / (outflow) from operating activities		**8, 842**	**6, 409**	**1, 943**
Cash flows from investing activities				
Purchase of property, plant and equipment		(5, 621)	(11, 489)	(5, 570)
Purchase of intangible assets		(471)	(3, 273)	(1, 186)
Receipts from maturity of investments		(228)	(35)	12
Net appropriation from trust funds		2	1	(10)
Net cash inflow / (outflow) from investing activities		**(6, 318)**	**(14, 796)**	**(6, 754)**
Cash flows from financing activities				
Capital contribution		-	1, 300	-
Payment of finance lease		(100)	(100)	(98)
Repayment of capital		(158)	(158)	(158)
Payment of loans		-	-	(101)
Net cash inflow / (outflow) from financing activities		**(258)**	**1, 042**	**(357)**
Net (decrease) / increase in cash and cash equivalents		2, 266	(7, 345)	(5, 168)
Cash and cash equivalents at beginning of year		(1, 355)	(1, 227)	3, 813
Cash and cash equivalents at end of year	6	**911**	**(8, 572)**	**(1, 355)**

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

	2022 Actual	2021 Actual
Net (deficit)	**(9, 865)**	**(4, 847)**
Add / (less) non-cash items		
Depreciation and amortisation expense	7, 336	6, 366
Impairment on intangible assets	3, 540	-
Total non-cash items	**10, 876**	**6, 366**
Add / (less) items classified as investing or financing activities		
Losses / (gains) on disposal of property, plant and equipment	191	80
Surplus from associates	(90)	(126)
Payable movements attributed to capital purchase	-	271
Total items classified as investing or financing activities	**101**	**225**
Add / (less) movements in statement of financial position items		
Receivables	(11, 007)	(4, 488)
Inventories	(200)	122
Payables	8, 950	121
Employee entitlements	9, 987	4, 444
Net movements in working capital items	**7, 730**	**199**
Net cash flow from operating activities	**8, 842**	**1, 943**

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 2022

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, (2021: 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 2022 and were authorised by the Board on 8 May 2023.

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

The Act disestablished all DHBs and the Health Promotion Agency and transferred the Whanganui District Health Board's assets and liabilities to Te Whatu Ora on 1 July 2022. As a result, the financial statements have been prepared on a disestablishment basis.

However, because health services will continue to be provided through Te Whatu Ora, no changes have been made to the recognition and measurement basis, or presentation of assets and liabilities in these financial statements due to the disestablishment basis of preparation.

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 PBE IPSAS 2 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 did not result in additional disclosures.

Standards issued that are not yet effective and have not been early adopted

PBE IPSAS 41 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.

PBE FRS 48 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 Whanganui District Health Board has determined the main impact of the new standard is that additional information will need to be disclosed on those judgements that have the most significant effect on the selection, measurement, aggregation, and presentation of service performance information.

STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES

For the year ended 30 June 2022

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 2020 to 30 June 2021. The comparative figures in the Statement of Financial Position are presented as at 30 June 2022.

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

There have been no changes in accounting policies during the financial year apart from the application of IFRIC interpretation on software-as-a-service (SaaS).

IFRIC released an agenda decision in April 2021 in relation to accounting for configuration and customisation costs incurred in implementing SaaS arrangements. SaaS arrangements are service contracts providing the DHB with the right to access the cloud provider's application software over the contract period. The agenda decision clarifies how current accounting standards should be applied to these types of arrangements.

The Whanganui District Health Board's accounting policy has historically been to capitalise costs directly attributable to the configuration and customisation of SaaS arrangements as intangible assets in the Statement of Financial Position. Following the adoption of the above IFRIC agenda decision, current SaaS arrangements were identified and assessed to determine if the Whanganui District Health Board has control of the software. For those arrangements where the Whanganui District Health Board does not have control of the developed software, the configuration and customisation costs previously capitalised have been derecognised and prospectively these costs are now recognised as operating expenses when the services are received. Amounts paid to the supplier in advance of the commencement of the service period, including for configuration or customisation that are not distinct from the underlying SaaS, are treated as a prepayment. The impact on prior year has been considered to be not material and restatement of 2021 financial statements has not been made.

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 2003 remediation - refer Note 15.

Many public and private sector entities, including Whanganui District Health Board, are continuing to investigate historic underpayment of holiday entitlements. For employers such as the Whanganui District Health Board that have workforces that include differential occupational groups with complex entitlements, non-standard hours, allowances and/or overtime, the process of assessing compliance with the Act and determining the underpayment is time consuming and complicated.

District Health Boards have taken a national approach and over the past few years the District Health Board's have been working with key stakeholders to define a baseline interpretation which is in place for the health sector. In December 2022, there were some remaining issues which was being resolved through legal advice. In 2022 this interpretation has been used by each DHB to systematically assess their liability. Whanganui District Health Board has included an estimated liability. Refer to note 15 which outlines the detail associated the compliance with the Holidays Act 2003.

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

	2022 Actual	2021 Actual
Health and disability services (Crown appropriation revenue)*	266, 802	251, 927
Ministry of Health other revenue	49, 956	20, 033
Other revenue	60	84
Total revenue from non-exchange transactions	**316, 818**	**272, 044**

1b. REVENUE FROM EXCHANGE TRANSACTIONS

	2022 Actual	2021 Actual
Ministry of Health other revenue	15, 415	13, 377
ACC contract	7, 902	7, 981
Inter District Patient Inflows	9, 668	9, 226
Other Government	469	276
Other revenue	1, 259	1, 351
Finance income	99	57
Total revenue from exchange transactions	**34, 812**	**32, 268**

1c. OTHER REVENUE

	2022 Actual	2021 Actual
Rental revenue	318	301
Total other revenue	**318**	**301**

* Performance against this appropriation is reported in the Statement of Performance on pages 36-48. 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

	2022 Actual	2021 Actual
Salaries and wages	110, 731	95, 469
Defined contribution scheme employer contributions	3, 302	2, 843
Increase / (decrease) in employee entitlements	6, 365	2, 952
Total personnel costs	**120, 398**	**101, 264**

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	
	2022 Actual	2021 Actual
100, 000 - 109, 999	85	43
110, 000 - 119, 999	59	46
120, 000 - 129, 999	51	18
130, 000 - 139, 999	38	11
140, 000 - 149, 999	13	7
150, 000 - 159, 999	6	4
160, 000 - 169, 999	9	1
170, 000 - 179, 999	5	2
180, 000 - 189, 999	4	2
190, 000 - 199, 999	2	3
200, 000 - 209, 999	2	3
210, 000 - 219, 999	3	2
220, 000 - 229, 999	1	4
230, 000 - 239, 999	-	2
240, 000 - 249, 999	1	2
250, 000 - 259, 999	1	3
260, 000 - 269, 999	2	3
270, 000 - 279, 999	3	1
280, 000 - 289, 999	3	2
290, 000 - 299, 999	4	1
300, 000 - 309, 999	4	1
310, 000 - 319, 999	4	3
320, 000 - 329, 999	1	5
330, 000 - 339, 999	2	-
340, 000 - 349, 999	1	-
350, 000 - 359, 999	2	1
360, 000 - 369, 999	2	1
370, 000 - 379, 999	1	4
380, 000 - 389, 999	3	2
390, 000 - 399, 999	2	1
400, 000 - 409, 999	-	3
410, 000 - 419, 999	3	3
420, 000 - 429, 999	1	4
450, 000 - 459, 999	2	-
460, 000 - 469, 999	-	1
470, 000 - 479, 999	1	-
480, 000 - 489, 999	2	-
490, 000 - 499, 999	-	1
500, 000 - 509, 999	1	-
550, 000 - 559, 999	1	-
920, 000 - 929, 999	-	1
950, 000 - 959, 000	1	-
Total employees remuneration	**326**	**191**

Of the 326 (2021:191) employees shown above, 299 (2021:168) were predominantly clinical employees and 27 (2021:23) 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 348 (2021: 203) compared with the actual number of employees of 326 (2021: 191).

The chief executive's remuneration is in the $500,000 to $509,999 band (2021: $390,000 to $399,999). This includes the value of the district health board's contribution to Kiwi-Saver and car allowance. Non-cash benefits are not included in the salary data for other employees. Chief executive's position was secondment to the Ministry of Health and had a start date of 6 October 2021 and an end date of 28 January 2022. His secondment was to the position of Programme Director, Long Term Health System Resilience at the Ministry of Health.

Severance payments

No employee received a severance payment in 2022 (2021: nil). No employees received compensation and other benefits in relation to termination of their employment or change in contractual conditions in 2022 (2021: nil).

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 2022 was 5% (2021: 5%).

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	2022 Actual	2021 Actual
Interest on finance lease	13	16
Total finance costs	**13**	**16**

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	2022 Actual	2021 Actual
Fees to Auditors		
*Fees for audit of financial statements**	256*	211*
Audit related fee internal (for assurance related services)	114	118
Board members fees	207	187
Board members expenses	1	2
Operating lease expenses	345	454
(Reversal of) / impairment of receivables	(23)	70
Loss on disposal of property, plant and equipment	191	80
WebPas (patient management system) impairment	3, 540	-
Inventories consumed	16, 050**	8, 969
Clinical & infrastructure and non-clinical expenses	27, 967	26, 011
Inter district outflow	51, 625	46, 989
Payments to non-health board providers	112, 010	98, 225
Total other expenses	**212, 283**	**181, 316**

* The audit fee includes a scope extension of $20k for year ended 30 June 2022 (2021: $25k).
** Includes Rapid Antigen test of $6,445 for year ended 30 June 2022 (2021: nil)

in thousands of New Zealand dollars

5 OTHER EXPENSES (continued)

BOARD MEMBER REMUNERATION

	2022 Actual	2021 Actual
Mr Ken Whelan *(Board chair)*	35	33
Ms Annette Main *(Deputy Board chair)*	21	21
Mr Stuart Hylton	17	17
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	17	17
Mr Josh Chandulal-Mackay	17	17
Mrs Soraya Peke-Mason	16	11
Mrs Mary Bennett *(from April 2021)*	16	3
Total Board member remuneration	**207**	**187**

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 (2021: nil).

Payments made to committee members appointed by the Board totalled $11k (2021: $18k).

Operating leases as lessee

THE FUTURE AGGREGATE MINIMUM LEASE PAYMENTS TO BE PAID UNDER NON-CANCELLABLE OPERATING LEASES ARE AS FOLLOWS

	2022 Actual	2021 Actual
Non-cancellable operating leases		
Less than one year	103	103
One to two years	103	103
Two to three years	-	103
Total non-cancellable operating leases	**206**	**309**

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

	2022 Actual	2021 Actual
Cash on hand	5	5
Demand funds held with NZHP	906	(1, 360)
Total cash and cash equivalents	**911**	**(1, 355)**

While cash and cash equivalents at 30 June 2022 are subject to the expected credit loss requirements of PBE IFRS 9, no loss allowance has been recognised because the estimated loss allowance for credit losses is not significant.

in thousands of New Zealand dollars

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 2022, this limit was $13.85m (2021: $12.97m).

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	2022 Actual	2021 Actual
Receivables - Other (gross)	9, 341	6, 844
Ministry of Health (gross)	12, 238	4, 144
Less: provision for impairments	(252)	(275)
Total receivables	**21, 327**	**10, 713**
Total receivables comprises:		
Receivable from non-exchange transactions	3, 100	469
Receivable from exchange transactions	18, 227	10, 244

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
	2022			2021		
Not past due	19, 549	(23)	19, 526	10, 161	(24)	10, 137
Past due 1 - 30 days	498	(19)	479	168	(15)	153
Past due 31 - 120 days	1, 089	(33)	1, 056	183	(46)	137
Past due 121 - 360 days	255	(35)	220	278	(47)	231
Past due over 360 days	188	(142)	46	198	(143)	55
Total	**21, 579**	**(252)**	**21, 327**	**10, 988**	**(275)**	**10, 713**

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:

	2022 Actual	2021 Actual
Balance as at 1 July	275	205
Additional provisions made during the year	110	138
Receivables written off during the year	(32)	-
Receivables reversal & recovered during the year	(101)	(68)
Total	**252**	**275**

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

	2022 Actual	2021 Actual
Held for distribution inventories		
Central stores	548	438
Pharmaceuticals	281	319
Theatre supplies	476	476
Other supplies	390	262
Total inventories	**1, 695**	**1, 495**

Write-down of inventories amounted to $55k (2021: $71k). There have been no reversals of write-downs.

No inventories are pledged as security for liabilities (2021: 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 $16 million including $6.4 million Rapid Antigen test (2021: $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% - 50%
Clinical & other equipment	3 - 33.3 years	3% - 33%
Vehicles	3.8 - 14.3 years	7% - 26%
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 2022.

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 2022 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 $661 to $15,080 per square metre, depending on the nature of the specific asset valued.
- The remaining useful life of assets is estimated considering factors such as the condition of the asset, district health board's future maintenance and replacement plans, and experience with similar buildings.
- Straight-line depreciation has been applied in determining the depreciated replacement cost value of the asset.

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

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

The recent revaluation of land and buildings resulted in a $2.5 million (73.5%) increase in the carrying value of land and $23 million (31.1%) increase in the carrying value of buildings and improvements. The revaluation resulted in a $25.5 million increase in property revaluation reserve and a $25.5 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 $440k (2021: $45k).

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 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**

30 June 2022	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 2021									30 June 2022		
Land	3,423	-	3,423	-	-	2,517	-	-	-	5,940	-	5,940
Buildings & improvements	78,056	(2,736)	75,320	1,584	(24)	19,889	(3,127)	24	3,090	99,505	(2,749)	96,756
Clinical & other equipment	30,291	(21,773)	8,518	3,529	(4,950)	-	(2,282)	4,755	-	28,870	(19,300)	9,570
Leased assets	966	(475)	491	-	(120)	-	(106)	120	-	846	(461)	385
Motor vehicles	2,988	(1,934)	1,054	145	(59)	-	(398)	31	-	3,074	(2,301)	773
	115,724	**(26,918)**	**88,806**	**5,258**	**(5,153)**	**22,406**	**(5,913)**	**4,930**	**3,090**	**138,235**	**(24,811)**	**113,424**
Work in progress												
Buildings & improvements	45	-	45	395	-	-	-	-	-	440	-	440
	45	**-**	**45**	**395**	**-**	**-**	**-**	**-**	**-**	**440**	**-**	**440**
Total	**115,769**	**(26,918)**	**88,851**	**5,653**	**(5,153)**	**22,406**	**(5,913)**	**4,930**	**3,090**	**138,675**	**(24,811)**	**113,864**

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 District Health Board 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	5-13 years	7.7-20%
Software	Work in progress	Nil

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

Impairment of intangible assets

Refer to the policy for impairment of property, plant and equipment in Note 9. The same approach applies to the impairment of intangible assets, 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 2022, Whanganui District Health Board had invested a total of $12.88 million (2021: $12.62 million) in RHIP. Of this investment, nil (2021: $44K) has been recognised as work in progress.

An upgrade of WebPAS (web-based Patient Administration System) is required as the current Oracle database is soon to be unsupported, thus increasing the risk of unplanned outages and failure of WebPAS, which will impact on the delivery of key clinical services. As a result, it has been agreed with the Ministry of Health to migrate WebPAS to a cloud based, vendor-managed platform. The Software as Service (SaaS) model will ensure that webPAS is appropriately maintained and supported, avoiding future capital investment.

As at 30 June 2022, Whanganui District Health Board has recognised net impairment of $3.5 million (2021: nil) for WebPAS.

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 2021	Cost / valuation	Accumulated depreciation	Carrying amounts	Additions	Transfer	Disposals	Impairment	Amortisation	Elimination on disposal	Cost / valuation	Accumulated depreciation	Carrying amounts
	1 July 2020									30 June 2021		
Costs	17,283	(5,546)	11,737	921	-	(96)	-	(1,415)	19	18,108	(6,942)	11,166
	17,283	**(5,546)**	**11,737**	**921**	**-**	**(96)**	**-**	**(1,415)**	**19**	**18,108**	**(6,942)**	**11,166**
Work in progress												
Work in progress	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**

30 June 2022	Cost / valuation	Accumulated depreciation	Carrying amounts	Additions	Transfer	Disposals	Impairment	Amortisation	Elimination on impairment	Cost / valuation	Accumulated depreciation	Carrying amounts
	1 July 2021									30 June 2022		
Costs	18,108	(6,942)	11,166	471	44	-	(5,346)	(1,423)	1,806	13,277	(6,559)	6,718
	18,108	**(6,942)**	**11,166**	**471**	**44**	**-**	**(5,346)**	**(1,423)**	**1,806**	**13,277**	**(6,559)**	**6,718**
Work in progress												
Work in progress	44	-	44	-	(44)	-	-	-	-	-	-	-
	44	**-**	**44**	**-**	**(44)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Total	**18,152**	**(6,942)**	**11,210**	**471**	**-**	**-**	**(5,346)**	**(1,423)**	**1,806**	**13,277**	**(6,559)**	**6,718**

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	2022 Actual	2021 Actual
Summary of financial information on associate entities *(100 percent)*		
Assets	13,017	11, 899
Liabilities	(4, 612)	(4, 151)
Equity	(8, 405)	(7, 748)
Revenue	(13, 078)	(11, 761)
Expense	12, 422	11, 008
Surplus / (deficit)	656	753
Allied Laundry Services Limited	16.67%	16.67%
Investment in associates		
Balance as at 1 July	1, 173	1, 185
Dividends	138	(138)
Share of profit	90	126
Total Investment in associates	**1, 401**	**1, 173**

12 OTHER FINANCIAL ASSETS

Whanganui District Health Board holds a 16.7% (2021: 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 % (2021: 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 at the amount payable.

BREAKDOWN OF PAYABLES UNDER NON-EXCHANGE AND EXCHANGE TRANSACTIONS	2022 Actual	2021 Actual
Payables under non-exchange transaction		
Creditors	36	33
Tax payables (GST, PAYE)	3, 030	2, 061
ACC levy	190	155
Income in advance	189	-
Other	2, 810	273
Total payables under non-exchange transaction	**6, 255**	**2, 522**
Payables under exchange transaction		
Creditors	5, 194	2, 842
Income in advance	1, 589	2, 180
Accrued expense	16, 568	13, 112
Total payables under exchange transaction	**23, 351**	**18, 134**
Total payables	**29, 606**	**20, 656**

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

	2022 Actual	2021 Actual
Current portion		
Finance lease	103	100
Total current portion	**103**	**100**
Non-current portion		
Finance lease	282	385
Total non-current portion	**282**	**385**
Total borrowings	**385**	**485**

ANALYSIS OF FINANCE LEASE AS FOLLOWS:

	2022 Actual	2021 Actual
Minimum lease payments payables		
Less than one year	114	114
Between one and five years	293	406
More than five years	-	-
Total minimum lease payments	**407**	**520**
Less: Future finance charges	(22)	(35)
Total borrowings	**385**	**485**

PRESENT VALUE OF MINIMUM LEASE PAYMENTS PAYABLE:

	2022 Actual	2021 Actual
Minimum lease payments payables		
Less than one year	103	100
Between one and five years	282	385
More than five years	-	-
Total borrowings	**385**	**485**

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 3.34% to 4.19% (2021: 0.21 to 2.79%) and an inflation factor of 3% (2021: 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

A number of New Zealand's public and private organisations have identified issues with the calculation of leave entitlements under the Holidays Act 2003 ("the Act").

Work has been ongoing since 2016 on behalf of 20 District Health Boards (DHBs) and the New Zealand Blood Service (NZBS), with the Council of Trade Unions (CTU), health sector unions and Ministry of Business Innovation and Employment (MBIE) Labour Inspectorate, for an agreed and national approach to identify, rectify and remediate any Holidays Act non-compliance by DHBs. DHBs have agreed to a Memorandum of Understanding (MOU), which contains a method for determination of individual employee earnings, for calculation of liability for any historical non-compliance.

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

The remediation project associated with the MOU is a significant undertaking and work to assess all non-compliance will continue through the 2022/23 financial year.

As at 30 June 2022, 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 estimates and assumptions to determine a potential liability based on its own review of payroll processes which identified instances of non-compliance with the Act and the requirements of the MOU. Whanganui District Health Board has included an estimated liability of $13.4m (2021: $8.9m) within this note.

This indicative liability amount is the DHB's best estimate at this stage of the outcome from this project.

Notwithstanding this, as at 30 June 2022, 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 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 district health boards on matters of interpretation to ensure national consistency. Payments are expected to be ready to be made in 2023.

BREAKDOWN OF EMPLOYEE ENTITLEMENTS	2022 Actual	2021 Actual
Current portions		
Accrued salaries and wages	8, 154	4, 532
Annual leave	13, 052	10, 916
Sick leave	238	173
Retirement gratuities	192	653
Long service leave	993	801
Sabbatical leave	449	449
Other leave	2	3
Continuing medical education leave	27	27
Other entitlement	13, 409	8, 881
Total current portion	**36, 516**	**26, 435**
Non-current portions		
Retirement gratuities	552	630
Long service leave	122	138
Total non-current portion	**674**	**768**
Total employee entitlements	**37, 190**	**27, 203**

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 no legal claim against it (2021: one)

Contingent assets

Whanganui District Health Board has no contingent assets (2021: nil).

in thousands of New Zealand dollars

17 CAPITAL COMMITMENTS

	2022 Actual	2021 Actual
Capital commitments		
Buildings and improvements	4, 206	13
Plant and equipment	2, 685	1, 155
Intangible assets	532	549
Total capital commitments	**7, 423**	**1, 717**

	2022 Actual	2021 Actual
Capital commitments		
Less than one year	7, 423	1, 717
One to two years	-	-
Total	**7, 423**	**1, 717**

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	2022 Actual	2021Actual
Board members		
Remuneration	207	187
Full-time equivalent members	1.19	0.86
Executive team		
Remuneration	2, 170	1, 872
Full-time equivalent members	8.59	7.85
Total key management personnel compensation	**2, 377**	**2, 059**
Total full time equivalent personnel	**9.78**	**8.71**

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

Whanganui District Health Board has disestablished and is now part of Te Whatu Ora - Health New Zealand, effective from 1 July 2022.

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

	2022 Actual	2021 Actual
Financial assets measured at amortised costs		
Cash and cash equivalents	911	-
Receivables (Gross)	21, 579	10, 988
Total financial assets measured at amortised costs	**22, 490**	**10, 988**
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)*	24, 798	16, 415
Borrowings - Energy Efficiency and Conservation Authority	-	-
Finance leases	385	485
Total financial liabilities measured at amortised costs	**25, 183**	**18, 255**

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 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
Borrowings - Energy Efficiency and Conservation Authority	14	-	-
Finance lease liabilities	14	485	485
30 June 2022			
Financial assets			
Cash and cash equivalents	6	911	911
Receivables (Gross)	7	21, 579	21, 579
Financial liabilities			
Payables *(excluding income in advance, taxes payable, and grants received subject to conditions)*	13	24, 798	24, 798
Finance lease liabilities	14	385	385

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.

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 2022, it is estimated that a general increase of one percentage point in interest rates would have minimal impact on earnings in 2021-22, 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 57% (2021: 39%). 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 2021						
Receivables (net)	-	10, 173	10, 173	-	-	-
Financial liabilities						
NZ Health Partnerships Limited	-	1, 355	1, 355	-	-	-
Finance leases	3.00%	485	100	103	282	-
30 June 2022						
Cash and cash equivalents	-	5	5	-	-	-
NZ Health Partnerships Limited	-	906	906	-	-	-
Receivables (net)	-	21, 327	21, 327	-	-	-
Financial liabilities						
Finance leases	3.00%	385	103	107	175	-

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 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	-	-	-
Finance leases	485	520	114	114	292	-
Total	**18, 255**	**18, 290**	**17, 884**	**114**	**292**	-
30 June 2022						-
Payables *(excluding income in advance, taxes payable & grants received subject to conditions)*	24, 798	24, 798	24, 798	-	-	-
NZ Health Partnerships Limited	-	-	-	-	-	-
Finance leases	385	407	114	114	179	
Total	**25, 183**	**25, 205**	**24, 912**	**114**	**179**	-

Capital management

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

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

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

21 EXPLANATION OF FINANCIAL VARIANCE AGAINST BUDGET

Statement of Comprehensive Revenue and Expense

- Exchange and non-exchange revenue exceeded budget by $32.7 million, due to additional revenue received from MOH pandemic donated stock and pandemic management funding, MECA settlement Funding and additional funding for side contracts (offset by equivalent costs). This was partly offset by capturing surgical elective service revenue from other DHBs not eventuating.
- Personnel costs exceeded budget by $17.6 million due to an increase in the provision for Holidays Act compliance, additional costs relate to MECA settlement, COVID-19 programme costs, this was partly offset by lower allied health personnel costs due to vacancies and lower course and conference expenditure as a result of COVID-19 preventing attendance.
- Outsourced services exceeded budget by $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 and information technology (IT) outsourced staff costs to feel the vacancies and meet the demand of various IT project costs.
- Other expenses exceeded budget by $17.2 million due to increased COVID-19 costs being not budgeted $10 million, WebPAS impairment costs $3.5 million, RATS tests and pandemic consumables $6.4 million This was partly offset by lower inter-district outflows $0.4 million, lower other health provider costs $1.4 million, lower facility due to settlement of prior year claim $1.4 million.

Statement of Financial Position

- Receivable from Exchange and non-exchange exceeded budget by $14.8 million due to increases in receivables for inter district flow (IDF), pharmaceutical rebates and COVID-19 various funding programme.
- Property, plant and equipment exceeded budget by $17.4 million due to revaluation uplift of $20.1 million of land and building being not budgeted. This was partly offset by lower purchase of IT, clinical and other equipment.
- Intangible assets were $6.7 million less than budget due to delays in the Regional Health informatics Programme (RHIP) and impairment of WebPAS.
- Payables under non-exchange and exchange transactions exceeded to budget by $8.1 million due to COVID-19 payable for various programme and income in advance.
- Employee entitlements exceeded budget by $9.1 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 $18.6 million due to increases in revaluation of land and building being not budgeted for $25.1 million. This was partly offset by an increased deficit against budget by $5.2 million, largely due to Holidays Act compliance provision and budgeted equity support $1.3 million.

Statement of Cash Flows

- Cash and cash equivalents exceeded budget by $9.5 million 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 2022 (2021: nil).

New Zealand Public Health and Disability Act 2000

There were nil breaches noted of the NZPHD Act in 2022 (2021: 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.

Breach of statutory reporting deadline

The 2021/22 annual report of Whanganui District Health Board was not completed by 31 December 2022, as required by section 156 of the Crown Entities Act 2004 (as amended by the Annual Reporting and Audit Time Frames Extensions Legislation Act 2021 which extended the reporting timeframes in the Crown Entities Act 2004 by two months).

23 SUMMARY COST OF SERVICES

	2022 Actual	2022 Budget	2021 Actual
Revenue			
Prevention services	21, 249	7, 576	6, 961
Early detection and management	75, 753	69, 199	62, 271
Intensive assessment and treatment	209, 257	192, 510	193, 057
Rehabilitation and support	45, 689	50, 008	42, 324
Total revenue	**351, 948**	**319, 293**	**304, 613**
Expenditure			
Prevention services	(21, 016)	(8, 821)	(7, 389)
Early detection and management	(80, 841)	(72, 078)	(66, 432)
Intensive assessment and treatment	(214, 173)	(193, 690)	(193, 241)
Rehabilitation and support	(45,783)	(49, 649)	(42, 398)
Total expenditure	**(361, 813)**	**(324, 238)**	**(309, 460)**
(Deficit) / Surplus	**(9, 865)**	**(4, 945)**	**(4, 847)**

24 COVID-19

	2022 Actual	2021 Actual
Revenue		
Ministry of Health revenue	**24, 772**	**2, 367**
Expense		
Personnel (including outsourced services)	(6, 090)	(892)
Clinical & infrastracture & non-clinical expenses	(8, 602)	(231)
Payments to non-health board providers	(9, 979)	(1, 268)
Total Expense	**(24, 671)**	**(2, 391)**

Whanganui District health board received $24.8 million (2021: $2.4 million) funding to cover the cost of $24.8 million (2021: $2.4 million) in relation to COVID-19 pandemic, including MOH donated $6.4 million RATS tests and consumables.

There were an additional $6.1 million COVID-19 pandemic personnel costs mainly in vaccination programme, community testing, public health, general practice based assessment, Māori Health support, PCR and rapid antigen testing, whānau engagement, community pharmacy care support, care in community, support isolation facility (SIQ), hospital backfill and respiratory clinics to support general practice. (2021: $0.9 million)

Clinical infrastructure and non-clinical supplies to support vaccination and various programmes $8.6 million (2021: $0.2 million).

Payment to non-health provider costs of $10 million (2021:1.3 million) were incurred in vaccination programme, Māori Health support, community testing, general practice based assessment, whānau engagement, PCR and rapid antigen testing, community pharmacy support and care in community.

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 (up to 30 June 2022)

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

Mrs Sharlene Tapa-Mosen - **Chair** (Whanganui - Tūpoho)
Ms Mary Bennett - (Ngaa Rauru Kiitahi)
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)
Katarina Hina (Ngā Wairiki Ngāti Apa)
Mr James Allen (Ngā Wairiki Ngāti Apa)
Dr Heather Gifford (Ngāti Hauiti)
Mrs Hayley Robinson (Ngāti Rangi)
Ms Soraya Peke-Mason (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 *(until 14 January 2022)*
Mrs Louise Allsopp	General Manager Patient Safety Quality and Innovation
Mr Maurice Chamberlain	Acting Director of Nursing *(from 20 December 2021)*
Mr Ron Dunham	General Manager Strategy Commissioning and Population Health *(from 5 January 2022)*
Mr Graham Dyer	General Manager Commissioning and Population Health *(17 July 2021 - 28 January 2022)*
Mrs Jennie Fowler	Acting Chief Allied Professions Officer *(from 30 May 2022)*
Mrs Katherine Fraser-Chapple	Chief Operating Officer *(from 20 December 2021)*
Mrs Alex Kemp	Director Allied Health Scientific and Technical *(until 21 June 2022)*
Mrs Rowena Kui	Kaiuringi Māori Health and Equity
Dr Ian Murphy	Chief Medical Officer

BANKERS

Bank of New Zealand
80 Queen Street
Auckland 1010

Ministry of Health
No. 1 The Terrace
Wellington

AUDITOR

Matt Laing
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

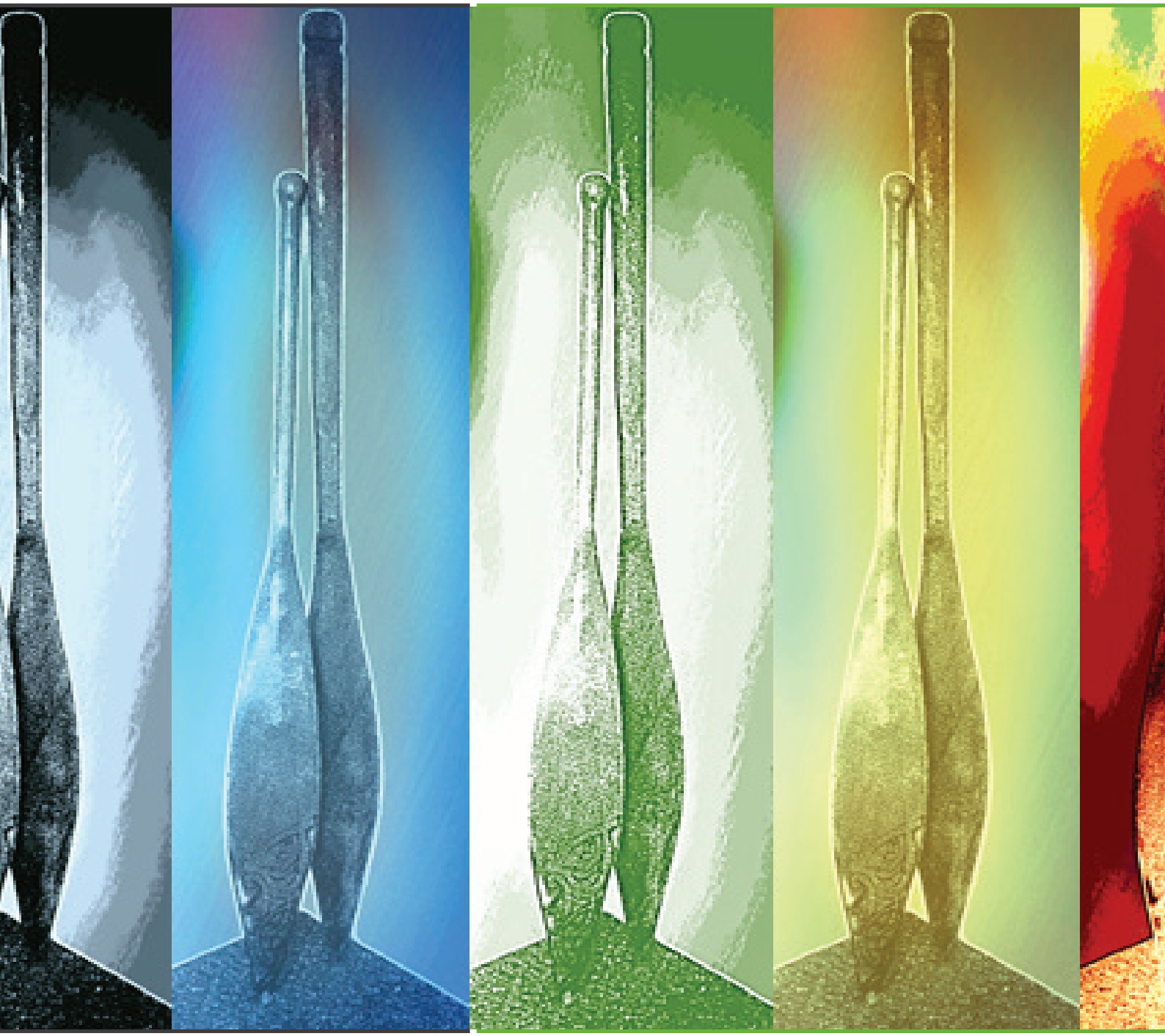
WHANGANUI
DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

2013 - 2022

This waitohu was gifted by kaumātua John Niko Maihi and iwi of
Whanganui, Ngaa Rauru Kiitahi, Ngā Wairiki Ngāti Apa, Mōkai Pātea, Ngāti Hauiti and Ngāti Rangi
and was borne with great honour by the Whanganui District Health Board

KIA TĀEA E TE WHĀNAU ME TE HAPORI 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