Wairarapa District Health Board

Annual Report 2016

CONTENTS

VISION, MISSION & VALUES

The following vision, mission and values govern the planning and activity of Wairarapa District Health Board (DHB) and contribute to 3DHB planning, alongside the highly congruent vision, mission and values of Hutt Valley and Capital & Coast DHBs.

Our Vision

Well Wairarapa – Better health for all.

Wairarapa ora – Hauora pai mo te katoa.

Our Mission

To improve, promote and protect the health status of the people of the Wairarapa, and the independent living of those with disabilities, by supporting and encouraging healthy choices.

Our Values

The values that underpin all of our work are:

Respect – Whakamana Tangata

According respect, courtesy and support to all.

Integrity – Mana Tu

Being inclusive, open, honest and ethical.

Self Determination – Rangatiratanga

Determining and taking responsibility for one's actions.

Cooperation – Whakawhānaungatanga

Working collaboratively with other individuals and organisations.

Excellence – Taumatatanga

Striving for the highest standards in all that we do.

CHAIR & CHIEF EXECUTIVE'S FOREWORD

It is our pleasure to present the Annual Report for the Wairarapa District Health Board (WDHB) and, in doing so, to state our belief that the core role of the DHB is to apply the revenue that it receives to provide the best health service to our Wairarapa people as we can.

2015/2016 has been a year of significant change throughout the Wairarapa health sector. The district health board has given the future provision of health services across the district the highest level of importance, setting the direction of operations in collaboration with Iwi Kainga, and investing in local leadership.

The renewed vigour applied to our relationship with our Iwi partnership board has emphasized strategic planning and the investment needed to improve outcomes for our Maori populations, focusing on reducing disparities.

Financially we are working towards "living within our means". The teams are focusing on efficiencies which has resulted in an improved fiscal position, and we are now aligned with our budgeted deficit. This highlights the commitment of our staff to work together towards savings which result in better resource for patient care. The organisational drive towards a healthy budget and the considerable achievements made are clearly reflected in the financial results over the past year. Our emphasis on delivering quality service within budget will remain strong as we continue towards the ultimate goal of operating within a surplus environment.

We continue to work with our neighbouring DHBs, Hutt Valley and Capital & Coast. This 3DHB collaboration ensures shared services that influence the best possible patient/client care across the sub region. We are pleased with the quality of our shared services, which provide our region with the capability to best serve our laboratory, mental health, radiology and ICT needs. We are thankful we have Capital & Coast DHB delivering tertiary services for our population.

Clinical governance and clinically led services will influence better outcomes. To this end, we are pleased to have employed Dr Tom Gibson as the DHB's Chief Medical Officer. Our CMO is dedicated to clinical outcomes with patient safety and quality at the forefront of decision making. This focus will drive service initiatives and provide the best guidance for workforce development which we are committed to. Continuing the development of models of care and enabling our clinicians to work to the top of their scope will influence better patient outcomes.

Renewed clinical governance has instigated learning together to add value to the services we provide for the people we serve. An example of this is the primary and community health service integration programme. Driven by Tehei Wairarapa, the Alliance commenced phase one of the programme which focused on delivering care closer to home. This will only be achieved by taking a 'one team' approach to the delivery of services to people in the community through the integration of general practice, community nursing, allied health and needs assessment services. By working as a multidisciplinary team and improving communication between the services, people are receiving more proactive care, reducing their need to access health services in the hospital setting.

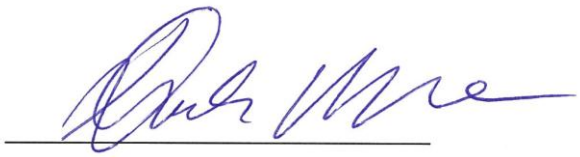
The DHB has again met and exceeded nationwide standards in the majority of our health targets. This success is the result of our deliberate approach to continued quality improvement processes and outcomes. Of particular note is the positive six hour wait time results in the fourth quarter. Reduced wait time provides for greater patient safety and comfort and this was achieved through the establishment of a short-stay process, changing accountabilities for patient flow and additional initiatives that all staff were actively engaged in. We were also very pleased to have achieved our elective surgery volumes and targets, greatly assisted over the winter months by a MOU with Selina Sutherland Hospital Trust to board or outsource patients at times of bed pressure. Where we have not achieved our target, we have made good progress to determine the barriers to success and take remedial action, often in conjunction with our neighbouring DHBs on whom we rely for some services not provided in the Wairarapa. Our community providers have made impressive gains on the cardiac and diabetes measures.

We also continue to make a difference with some of the new initiatives that we have developed and implemented. In the hospital, theatre efficiency has improved and health recovery programmes are emphasized. An extensive public awareness campaign continues to ensure the Wairarapa community is informed about where to present with their health complaints, lessening the load on the emergency department. With an average of eight babies born each week in Wairarapa, our maternity services and supports are a key focus. Wairarapa DHB's new primary birthing room, Tūranga Matua, promotes safe comfortable normal birthing and a record 113 women participated in the Big Latch event, celebrating breastfeeding. The highly successful Ha Ngawari Breathe Easy programme was rolled out with excellent measurable outcomes. This culturally safe workshop is aimed at reducing avoidable hospital admissions by increasing heath literacy and empowering whānau to self manage the family's mild to moderate asthma. These are just a few of the many initiatives we promote throughout the district to improve the health and wellbeing of our local population.

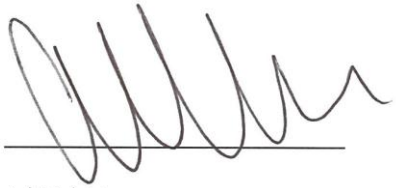
The Pacific Work Plan was launched in late July and continues to reach our Pacific population and gain better outcomes for our people.

Our hospital services have benefited from generous donations from The Wairarapa Community Health Trust. Thank you, these donations have meant that in a fiscally constrained environment we have been able to replace significant items of equipment which had reached end-of-life simultaneously, having been purchased when Wairarapa Hospital was built 10 years ago. Most notably, the Trust funded the replacement of the Cardiac Monitoring System in our High Dependency Unit, Emergency Department and Medical Surgical Ward, as well as other items to support diagnostics and patient comfort.

Finally, we wish to thank all our people, our clinicians, our staff, our DHB partners. Without you we would not be able to achieve the vision we work towards of "better health for all".



Dr Derek Milne
Board Chair



Adri Isbister
Chief Executive

STRATEGIC DIRECTION

Wairarapa DHB aspires to be a respected provider of health services, to have staff who are engaged towards our vision and take ownership of the services they provide. We are working towards strong local leadership at every level, driving our goals of a healthier public, cohesive primary and secondary care teams, innovative quality care and an integrated health environment.

Wairarapa DHB is motivated to build an organisation of people that focuses on the best interests of our community, and this is enabled by nurturing leadership capability. To support this direction, we are investing in the sub regional leadership programme to develop current and future leaders by establishing our expectations and developing the skills to meet those expectations. In addition, we will re-establish the employee engagement survey which will help to identify the areas and aspects of leadership we need to focus on.

The work initiated this year will be an important focus for the coming year. Our priorities focus on clinical governance; living within our means; the national health targets, including the new obesity management target; integration of services and improved health information technology.

We were delighted to be informed that, along with Hutt Valley DHB, we have been chosen to extend the bowel screening pilot that was initiated at Waitemata DHB five years ago. The project is well underway and on target for rollout in July 2017. This project builds on the excellent work done in achieving both quality of service indicators and colonoscopy wait times.

In March, the board of directors decided to push the go button on the investment for a central region patient administration system, the Regional Health Informatics Programme (RHIP). This programme will centralise and store patient information and bring us closer to the long term vision of a patient record shared across the central region.

Financially, we strive for an operating environment without deficit constraints. A strong focus on efficiencies and accountable leadership will walk alongside our delivery of quality patient care, with an aim to not just operate within budget but build a robust and sustainable financial future.

We are committed to a healthier population, with reduced disparities in respect to both access and outcomes. We aspire to a vibrant, strong, confident and well Wairarapa. We want to develop health resilience within the community that is built upon strong health literacy and personal health responsibility as much as it is on the provision of an effective and integrated system of delivery across primary and hospital care.

As a health system we are taking responsibility. We are accountable and we are committed. Our multi agency, collaborative approach is for the benefit of the people and communities we serve, and will reap its rewards in the years ahead.

GOVERNANCE REPORT

ROLE OF THE BOARD

The Board's governance responsibilities include:

Communicating with the Minister and other stakeholders to ensure their views are reflected in the DHB's planning.

- Delegating responsibility for achievement of specific objectives to the Chief Executive.
- Monitoring organisational performance towards achieving objectives.
- Reporting to stakeholders on plans and progress against them.
- Maintaining effective systems of internal control.

STRUCTURE OF THE DHB

DHB Operations

The Board appointed the Chief Executive to manage all DHB operations. All other employees of the DHB have been appointed by the Chief Executive either directly or via the Chief Executive's delegated authority. The Board directs the Chief Executive by delegating responsibility and authority for the achievement of objectives through setting policy.

Quality assurance

Wairarapa District Health Board (WDHB) has numerous processes to ensure the quality of the governance, funder and provider outputs.

GOVERNANCE PHILOSOPHY

Over the past few years the three DHBS have taken a 'whole-of-health system' approach, including integrating clinical and support services where this provides benefits across the system.

Each Board continues to provide governance of local services and all three Boards provide collective governance over services that are shared or integrated, ensuring local accountability.

Integrated service approaches are intended to deliver:

- preventative health and empowered self-care
- provision of relevant services close to home
- quality hospital care, including highly complex care for those who need it.

This requires a strong focus on relationships with primary and community care and working closely with staff and communities as we progress service design. The Boards believe this gives us the best opportunity to address the challenges of balancing quality, cost and access.

Board membership

The elected and appointed Board members have diverse skills and experience in order to bring a wide range of thought to bear on policy issues. All members are required to act in the best interests of the DHB. Members are encouraged to contribute to Board decision-making processes, acknowledging that the Board must stand unified behind its decisions once made; individual members have no separate governing role outside the boardroom. The Board acknowledges its responsibility to maintain communication with stakeholders and in particular remain cognisant of the Minister's expectations.

The members of the Board at 30 June 2016 are as follows. Board members commenced their term on 6 December 2010 except as noted.

- Derek Milne (Chair) – commenced December 2013
- Leanne Southey (Deputy Chair)
- Liz Falkner
- Rob Irwin
- Ronald Karaitiana – commenced December 2013
- Helen Kjestrup
- Rick Long
- Alan Shirley – commenced December 2013
- Fiona Samuel
- Janine Vollebregt
- Jane Hopkirk – commenced August 2015

Disclosure of interest

The Board maintains an interests' register. Board members are aware of their obligations to declare any potential conflicts of interests to ensure transparency in the decision making process.

Name	Interest
Mr Derek Milne *Chair*	• Chair, Wairarapa District Health Board • Deputy Chair, Capital & Coast District Health Board • Deputy Chair, Wairarapa, Hutt Valley and CCDHB Hospital Advisory Committees • Member, Hutt Valley and CCDHB Finance Risk & Audit Committees • Ex Officio Member, WDHB Finance Risk & Audit Committee *(30 March 2016)* • Ex Officio Member, WDHB Hospital Advisory Committee *(30 March 2016)* • Member, WDHB CPHAC/DSAC *(30 March 2016)* • Brother-in-law is on the Board of Healthcare Ltd
Mrs Leanne Southey *Deputy Chair*	• Chair, Wairarapa District Health Board, Finance Risk & Audit Committee • Deputy Chair, Wairarapa District Health Board • Chair of Lands Trust Masterton *(15 February 2016)* • Member, Wairarapa, Hutt Valley and CCDHB, Community Public Health Advisory Committees & Disability Support Advisory Committees • Director, Southey Sayer Limited • Chartered Accountant to Health Professionals including Selina Sutherland Hospital and Selina Sutherland Trust • Trustee, Wairarapa Community Health Trust • Sister-in-Law is employed by WDHB • Shareholder of Mangan Graphics Ltd • Member of UCOL Council
Dr Liz Falkner *Member*	• Member, Wairarapa District Health Board • Member, WDHB Hospital Advisory Committee (30 March 2016) • Retired General Practitioner with Masterton Medical Limited • Medical Advisor – Post Polio Support Society NZ Inc • Sister in Law works part time at Wairarapa District Health Board *(23 February 2016)*
Dr Rob Irwin *Member*	• Member, Wairarapa District Health Board • Member, WDHB Hospital Advisory Committee *(30 March 2016)* • Trustee Wairarapa Community Health Trust • Member, South Masterton Rotary • Chair, Wairarapa Trails Trust *(30 March 2016)*
Ms Helen Kjestrup *Member*	• Member, Wairarapa District Health Board • Member, WDHB Finance Risk and Audit Committee *(30 March 2016)* • Works for Central TAS as an Auditor • Shareholder, Property Investment Company – Kjestrup Properties • Assessor for Royal College of GPs for Cornerstones Programme
Mr Rick Long m*ember*	• Member, Wairarapa District Health Board • Member, Wairarapa District Health Board, Finance Risk & Audit Committee • Chairman of Wairarapa Community Transport Services Inc • Chairman of Tolley Educational Trust • Trustee for Sport and Vintage Aviation Society • Biomedical Services New Zealand Limited • Member of Masterton Lands Trust

	• Director, Longs Properties Limited (*1 February 2016)*
Mr Alan Shirley *Member*	• Member, Wairarapa District Health Board • Member, Wairarapa, Hutt Valley and CCDHB Hospital Advisory Committees • Surgeon at Wairarapa Hospital • Technical Advisory for Ministry of Health • Wairarapa Community Health Board Member • Technical Expert Advisor • Subregional Endoscopy Steering Group • Member, Wairarapa, Hutt Valley and CCDHB, Community Public Health Advisory Committees & Disability Support Advisory Committees *(30 March 2016)*
Ms Fiona Samuel *Member*	• Member, Wairarapa District Health Board • Member, Wairarapa, Hutt Valley and CCDHB Hospital Advisory Committees • Member, WDHB Hospital Advisory Committee *(30 March 2016)* • Casual Nurse, at Wairarapa Hospital • Duty Nurse Manager, at Wairarapa Hospital • Contractor Auditor for TAS • Member of Clinical Board Wairarapa District Health Board
Ms Janine Vollebregt *Member*	• Member, Wairarapa District Health Board • Chair, WDHB Hospital Advisory Committee *(30 March 2016)* • DHB Nurse Educator for the UCOL Undergraduate Maori Students. This 0.4 FTE position is effective from 30 April 2008 to 30 June 2010. • Community Health Clinic establishment • Sister in Law works part time at Wairarapa District Health Board *(23 February 2016)*
Mr Ronald Karaitiana *Member*	• Member, Wairarapa District Health Board • Member, Wairarapa Te Iwi Kainga Committee • Member, Wairarapa District Health Board, Finance Risk & Audit Committee • ACC Manager in Claims Management • Wife Kylie Smith is currently the DHB liaison from Child Youth & Family • Maori relationships with staff vary from a number of cousins working at DHB • Occasionally plays in a band (potential no risk to the board) • Trust Chairman Akura Lands Trust • Advisory Committee for Diabetes New Zealand
Ms Jane Hopkirk *Member*	• Member, Wairarapa District Health Board • Member, Wairarapa, Hutt Valley and CCDHB, Community Public Health Advisory Committees & Disability Support Advisory Committees *(30 March 2016)* • Member, Wairarapa Te Iwi Kainga Committee • Kaiarahi, Takiri Mai Te Ata, Kokiri Hauora • Member, Occupational Therapy Board of New Zealand (*23 February 2016)*

Division of responsibility between the Board and management

Key to the efficient running of the DHB is that there is a clear division between the roles of the Board and management. The Board concentrates on setting policy, approving strategy and monitoring progress toward meeting objectives. Management is concerned with implementing policy and strategy.

Delegations

The Board has an approved delegation policy in accordance with clause 39 Schedule 3 of the New Zealand Public Health and Disability Act 2000. This Act requires (s26 (3)), and the policy allows the Board to delegate management matters of the WDHB to the Chief Executive.

Accountability

The Board holds monthly meetings to monitor progress toward its strategic objectives and to ensure that the affairs of the DHB and its subsidiaries are being conducted in accordance with the DHB's policies.

Internal audit

While many of the Board's functions have been delegated, the overall responsibility for maintaining effective systems of internal control ultimately rests with the Board.

The DHB uses external resources through the TAS regional internal audit programme to maintain an internal audit function which is responsible for monitoring its systems of internal control and the quality and reliability of financial and non-financial information reported to the Board. Internal Audit reports its findings directly to the Audit and Risk Committee established by the Board.

Risk management

The Board acknowledges that it is ultimately responsible for the management of risks to the DHB. The Board has charged the Chief Executive through its risk management policy with establishing and operating a risk management programme in accordance with the Joint Australian/New Zealand Standard guideline requirements on risk management.

Legislative compliance

The Board acknowledges its responsibility to ensure the organisation complies with all relevant legislation.

DISCLOSURE OF ULTRA VIRES TRANSACTIONS

Wairarapa DHB has not entered any transactions during the year that have been enforced under section 20(3) of the Crown Entities Act 2004.

PERMISSION TO ACT DESPITE BEING INTERESTED IN A MATTER

A member who is interested in a matter relating to a DHB must not vote or take part in any discussion or decision of the Board or any committee relating to that matter under section 66 of the Crown Entities Act 2004. However, under section 68 of the Crown Entities Act 2004, the Chair of the DHB may exempt one or more Board members from this requirement if it is in the public interest to do so. Where such an

exemption is given, this must be disclosed in the annual report. No permissions were provided under section 68 during the 2015-16 year.

BOARD MEMBERS' MEETING ATTENDANCE

The table shows the attendance of Board members at Board and committee meetings during the financial year. The numbers in brackets below shows the total meetings of the Board/Committee during the member's Board or Committee membership.

The references to the committees listed in the table are as follows:
The references to the committees listed in the table are as follows:
CPHAC: Community & Public Health Advisory Committee
FRAC: Finance, Risk and Audit Committee
CPHAC/DSAC 3DHB – Wairarapa/Hutt/Capital & Coast combined

	Board (11)	3DHB CHPAC/ DSAC (6)	HAC (6)	FRAC (6)
Derek Milne	10	6	5	6
Leanne Southey	11	5	n/a	6
Rob Irwin	11	n/a	6	2
Rick Long	11	n/a	n/a	5
Janine Vollebregt	10	2	2	n/a
Fiona Samuel	10	n/a	3	n/a
Ron Karaitiana	10	n/a	1	5
Liz Falkner	9	1	2	n/a
Alan Shirley	9	2	5	n/a
Jane Hopkirk	8	3	n/a	n/a
Helen Kjestrup	7	1	1	4

Board members' remuneration

Board members' remuneration received or receivable for the year ended 30 June 2016 are shown in the table below. In addition, Board members are able to claim reimbursement for out of pocket expenses.

	2016 Board Fee	2016 Committees Fees	2016 Total Fees	2015 Total Fees
Derek Milne (Chairman)	33,600	2,015	35,615	37,043
Leanne Southey (Deputy Chair)	20,400	3,075	23,475	23,638
Rob Irwin	16,320	2,000	18,320	19,320
Helen Kjestrup	16,320	1,350	17,670	18,070
Janine Vollebregt	16,320	1,325	17,645	18,070
Rick Long	16,320	1,250	17,570	18,070
Ronald Karaitiana	16,320	1,250	17,570	17,820
Fiona Samuel	16,320	1,000	17,320	17,820
Alan Shirley	16,320	750	17,070	18,070
Jane Hopkirk	13,181	500	13,681	0
Liz Falkner	10,880	1,100	11,980	16,392
Hoani Paku	0	2,750	2,750	500
Yvette Grace	0	2,625	2,625	1,250
Kim Smith	0	2,063	2,063	2,188
Mike Kawana	0	2,000	2,000	1,250
Mihi Namana	0	1,750	1,750	1,750
Hariata Tahana	0	1,750	1,750	1,000
Kristina Perry	0	750	750	0
Antonia Aporo	0	750	750	0
Ron Mark (Resigned)	0	0	0	2,919
Mary Kerehi	0	0	0	250
TOTAL	**192,301**	**30,053**	**222,354**	**215,420**

OUR PEOPLE

A skilled, supported and responsive workforce is essential for sustainable service delivery. The DHB needs the right mix of trained and qualified people in sufficient supply and working in partnership with each other. Trusting, valuing and fully engaging health professionals improves patient care and job satisfaction and will assist in recruitment and retention. Focusing on improving clinical workforce retention and fostering clinical leadership continues to be a key priority for the DHB.

The DHB supports clinical governance based on the following six principles:

Quality and safety will be the goal of every clinical and administrative initiative.
The most effective use of resources occurs when clinical leadership is embedded at every level of the system.
Clinical decisions at the closest point of contact will be encouraged.
Clinical review of administrative decisions will be enabled.
Clinical governance will build on successful initiatives, and embed a transformative new partnership which will be an enabler for better outcomes for patients.

Wairarapa DHB is committed to continuing to support and grow clinical leadership by supporting clinical governance of the patient journey across primary and secondary services.

Identifying more efficient and effective ways to deliver services at a regional, sub-regional and local level, controlling the growth of hospital labour costs, maintaining and where possible improving hospital productivity, and achieving better integration of local primary and secondary services all require support, active involvement and leadership by clinicians.

The DHB continues to ensure local clinicians take a lead role in the establishment of regional clinical networks, local and regional clinical pathways, and optimal clinical arrangements for securing specialised hospital capacity with neighbouring DHBs. Strengthened clinical leadership is achieved through the Alliance Leadership Team, the Clinical Board and involvement of clinicians in the development of collaborative service models at a sub-regional and regional level.

The Clinical Board is responsible for providing clinical leadership, leading the development of clinical governance across all of the services provided by the DHB, overseeing the quality and safety of services delivered by DHB providers and the clinical quality programme, and providing advice and recommendations to the DHB Board, Chief Executive and management.

The Alliance Executive Team has provided leadership to support the collaboration and integration occurring across our local system and the implementation of this work programme.

The DHB focuses on the needs of each employee through individual performance planning and development. This ensures all staff have performance objectives that align to the DHB's strategy, goals and values. A new performance appraisal system that focuses on a common approach to the performance conversation across workforces is being consulted on and implemented.

GOOD EMPLOYER OBLIGATIONS REPORT

A key value of Wairarapa DHB is to be a good employer. Wairarapa DHB embraces the '7 key elements of being a good employer' as prescribed by the Equal Employment Opportunities Commissioner. These elements are:

- leadership, accountability and culture
- recruitment, selection and induction
- employee development, promotion and exit
- flexibility and work design
- remuneration, recognition and conditions
- harassment and bullying prevention
- safe and healthy environment.

Wairarapa DHB has an equal employment opportunities focus within the relevant policies. A rigorous recruiting and selection procedure is followed to ensure fairness and equal opportunity. Training and development opportunities are offered to all staff, and personal performance and development plans are a requisite for all employees.

Several forums are in place comprising a selection of employees from across Wairarapa DHB to discuss workplace practices, systems and environment. Flexibility and work design are among the many topics these forums consider as well as health and safety and professional practices.

Wairarapa DHB has a zero tolerance policy to bullying and harassment; this is supported by our Workplace Bullying, Discrimination, Harassment and Victimisation Prevention Policy. On going training is planned for this year to support managers, team leaders and union delegates to address inappropriate behaviour as it is identified.

Approximately 92 per cent of employees are covered by collective employment agreements (CEA). All the CEAs have prescribed remuneration, recognition and conditions clauses. Wairarapa DHB has a dedicated approach to employees on true individual employment agreements to ensure to the review of remuneration is consistent and in line with Ministry expectations.

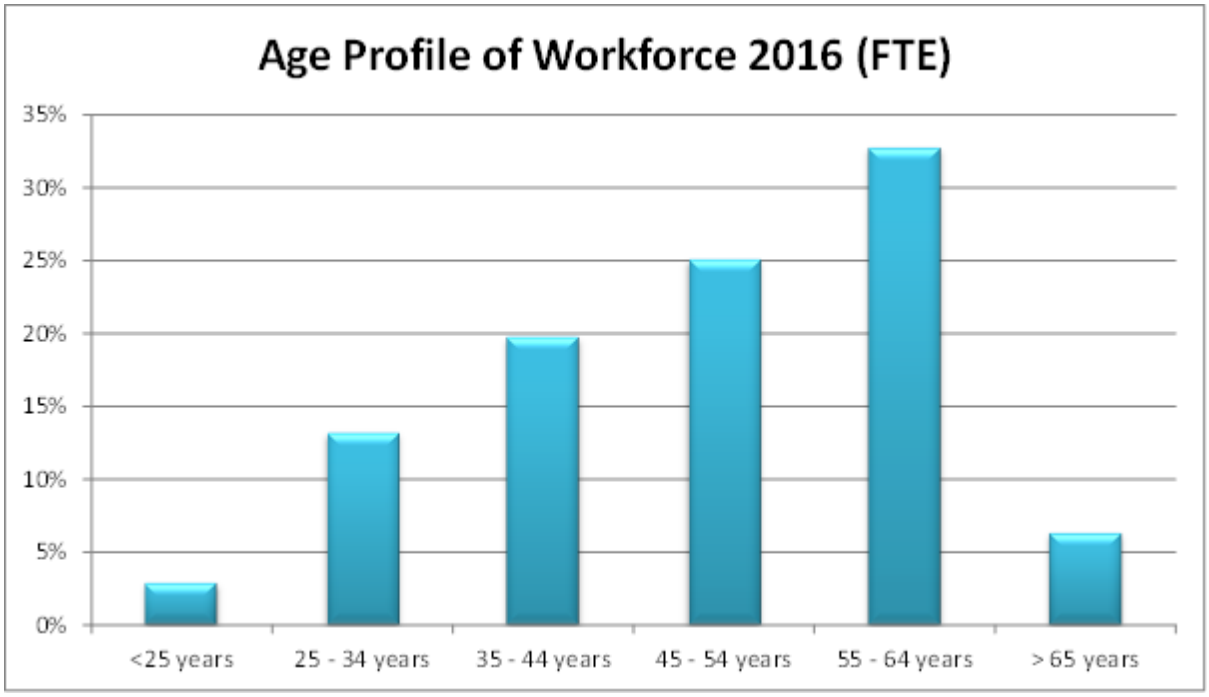
The Protected Disclosure Act 2000 and the Board's related policy protects the right of employees to raise matters of public concern in a safe and appropriate manner. Where an individual may feel personally disadvantaged there are established grievance procedures available including external mediation or the mechanisms covered by the Employment Relations Act 2000. Employees also have 'no questions asked' access to the Employee Assistance Programme.

WORKFORCE PROFILE

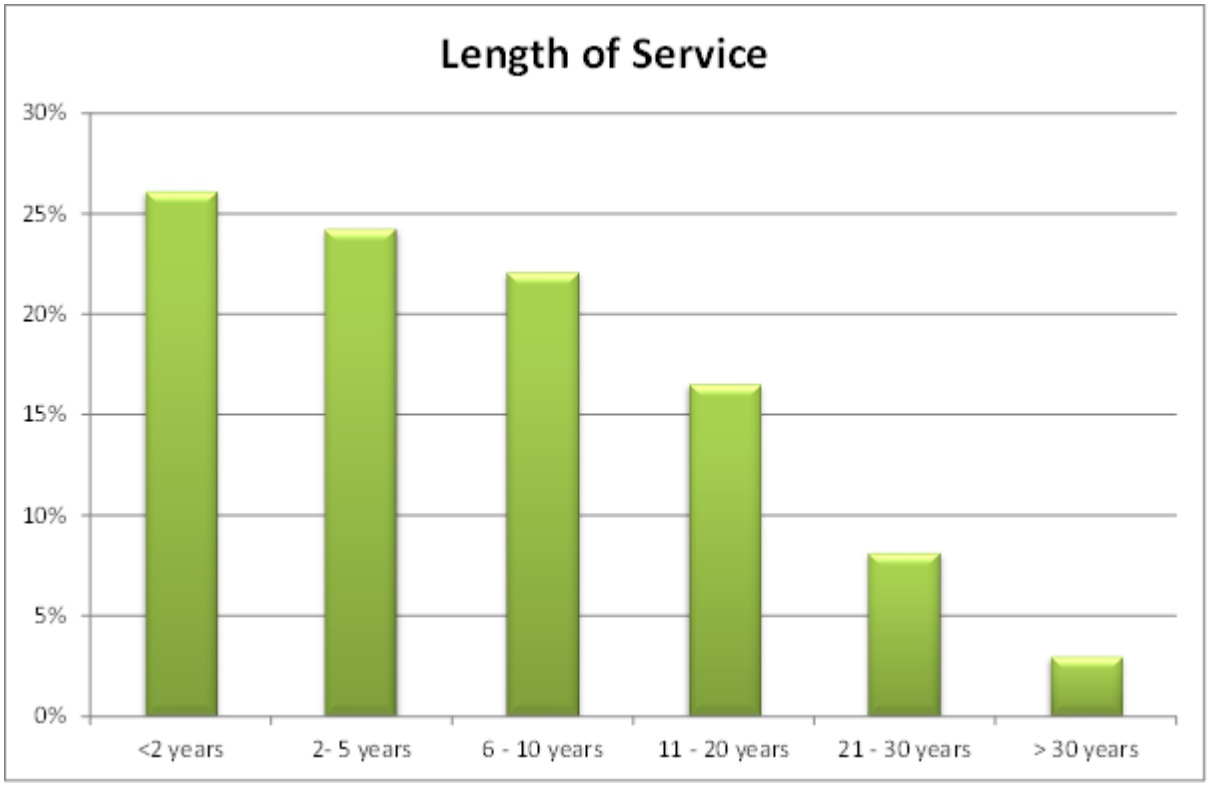
Full Time Equivalent staff numbers

	2016	2015	2014	2013	2012	2011	2010	2009
Medical	42	40	36	39	38	36	33	33
Nursing	223	215	205	204	198	193	191	183
Allied Health	69	71	70	82	85	93	89	90
Other	108	102	106	101	120	119	125	127
Total	443	429	417	426	441	441	438	433

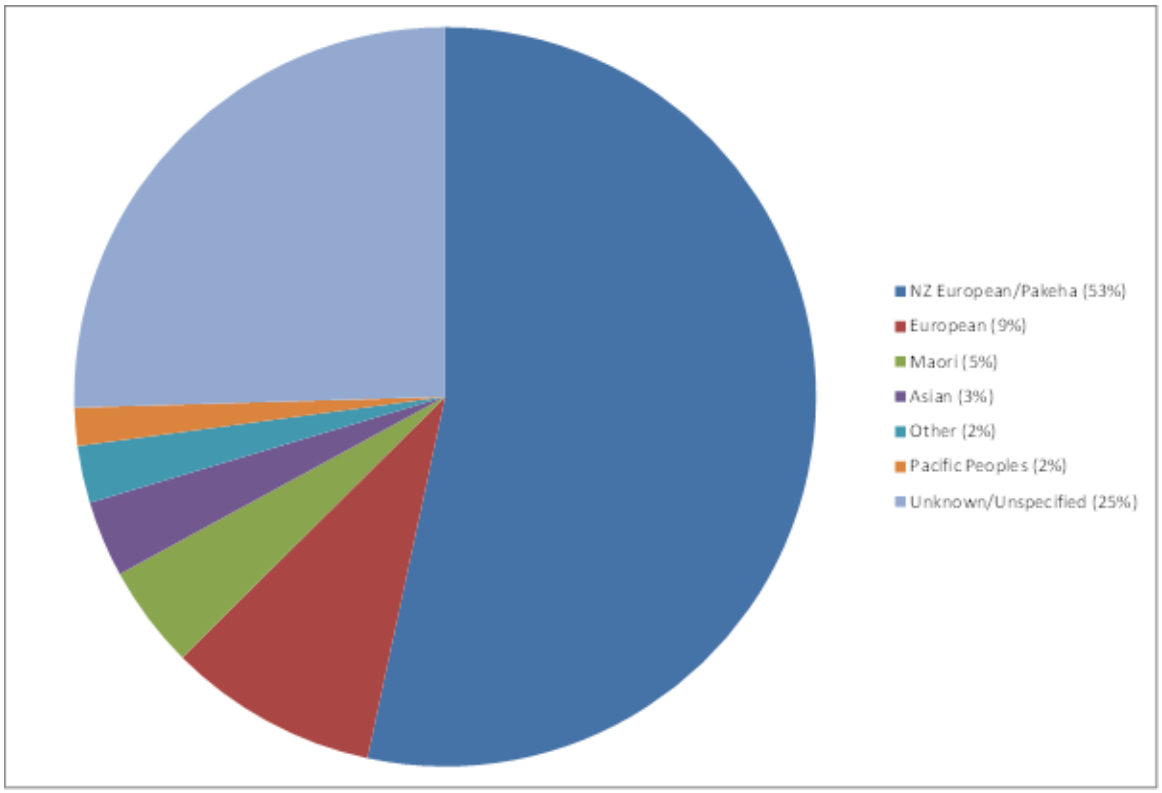
Age profile of workforce 2015 (FTE)



Length of service



Statistics by ethnicity



Statistics by gender

	2016	2015	2014	2013	2012	2011	2010
Female	82%	82%	84%	82%	84%	83%	83%
Male	18%	18%	16%	18%	16%	17%	17%

REMUNERATION OF EMPLOYEES

Employees (excluding Board members) including management and medical staff receiving remuneration in excess of $100,000 per annum are shown in the table below.

	2016 No. of Employees	2015 No. of Employees
$100,000 - $110,000	5	6
$110,001 - $120,000	7	6
$120,001 - $130,000	2	6
$130,001 - $140,000	5	2
$140,001 - $150,000	2	4
$150,001 - $160,000	1	3
$160,001 - $170,000	1	1
$170,001 - $180,000	3	1
$180,001 - $190,000	2	0
$190,001 - $200,000	0	1
$200,001 - $210,000	3	2
$210,001 - $220,000	0	2
$220,001 - $230,000	1	2
$230,001 - $240,000	2	2
$240,001 - $250,000	3	3
$250,001 - $260,000	3	3
$260,001 - $270,000	2	2
$270,001 - $280,000	2	3
$280,001 - $290,000	3	1
$290,001 - $300,000	0	0
$310,001 - $320,000	1	1
$350,001 - $360,000	1	0
$370,001 - $380,000	1	0
	50	**51**

Of the employees shown above, 42 are clinical employees (2015: 44) and 8 are non-clinical employees (2015: 3). Only staff on the Wairarapa payroll are included in the table above.

TERMINATION PAYMENTS

During the year the DHB made no payments to former employees in respect of the termination of the employment (either as redundancy compensation or in equalisation payments upon completion of a service review) with the DHB (2015: nil).

OUTPUT CLASSES: FINANCIAL PERFORMANCE ($000S)

Output Class Tables for Annual Report
2015/16 Tables

Revenue	2014/15 Actual	2015/16 Budget	2015/16 Actual
Prevention	1,225	1,207	1,193
Early Detection and Management	40,519	41,167	38,803
Intensive Assessment and Treatment	78,318	82,113	86,295
Rehabilitation and Support	18,997	19,600	20,063
Total	139,059	144,087	146,354

Expenditure	2014/15 Actual	2015/16 Budget	2015/16 Actual
Prevention	2,382	2,300	2,149
Early Detection and Management	42,199	43,010	40,300
Intensive Assessment and Treatment	78,642	80,835	85,666
Rehabilitation and Support	19,191	19,901	20,147
Total	142,414	146,046	148,262

Net deficit:	(3,355)	(1,959)	(1,908)

MINISTER'S HEALTH TARGETS

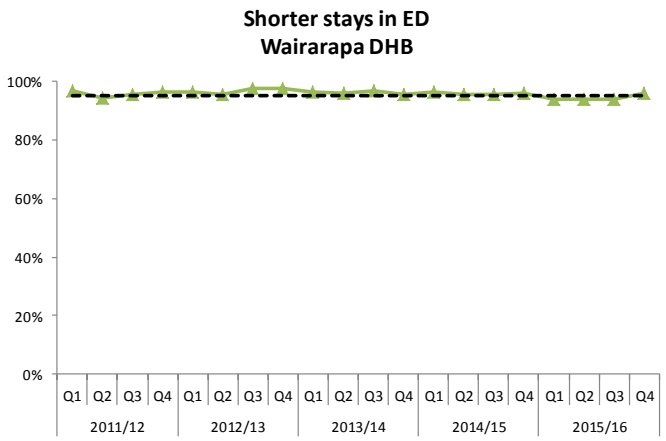
Health targets are a set of national performance measures specifically designed to improve the performance of health services that reflect significant public and government priorities. They provide a focus for action.[1] Note the changing vertical (y) axis between graphs.

Shorter stays in Emergency Departments

95 percent of patients presenting at an Emergency Department (ED) will be admitted, discharged or transferred within six hours.

Target: 95%

2015/16 Performance: 96%

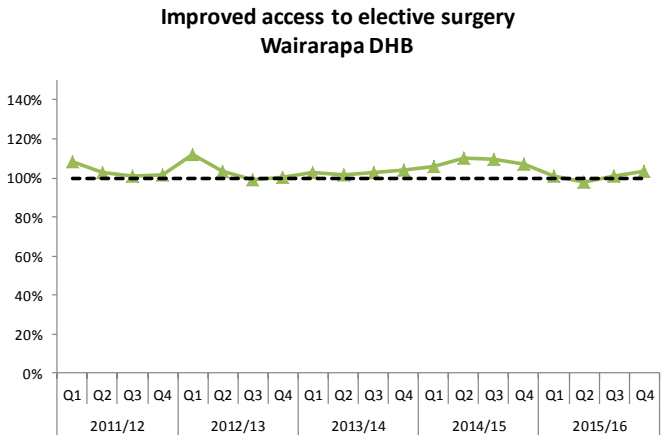


Improved access to elective surgery

More New Zealanders have access to elective surgical services with at least 4,000 additional discharges nationally every year.

Target: 2,395 (graph - 100%)

2015/16 Performance: 2,480



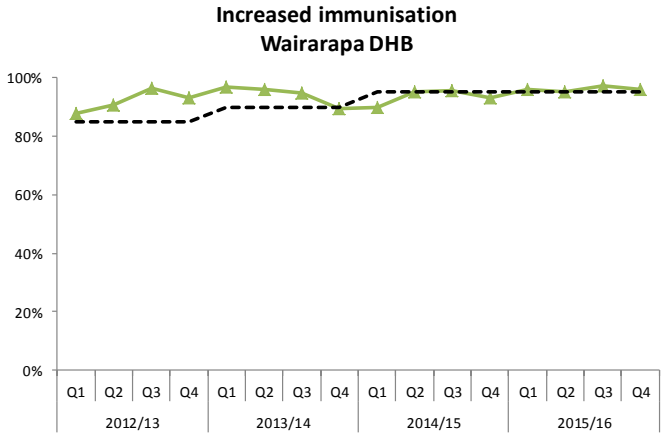
[1] Quoted from the Ministry of Health, http://www.health.govt.nz/new-zealand-health-system/health-targets

Increased immunisation

85 percent of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time by July 2013, 90 percent by July 2014 and 95 percent from December 2014.

Target: 95%

2015/16 Performance: 96%

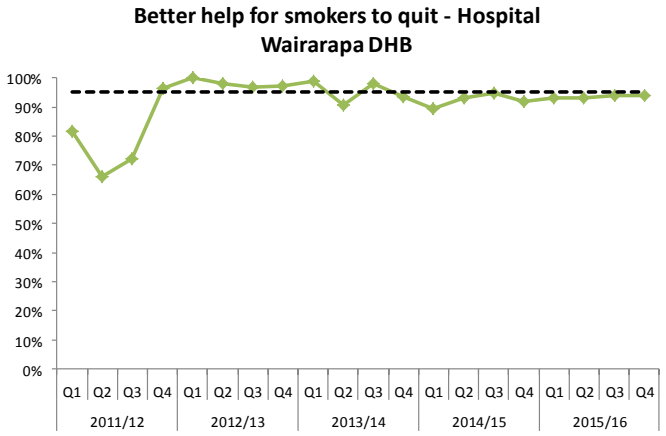


Better help for smokers to quit – Hospital

95 percent of patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking.

Target: 95%

2015/16 Performance: 94%

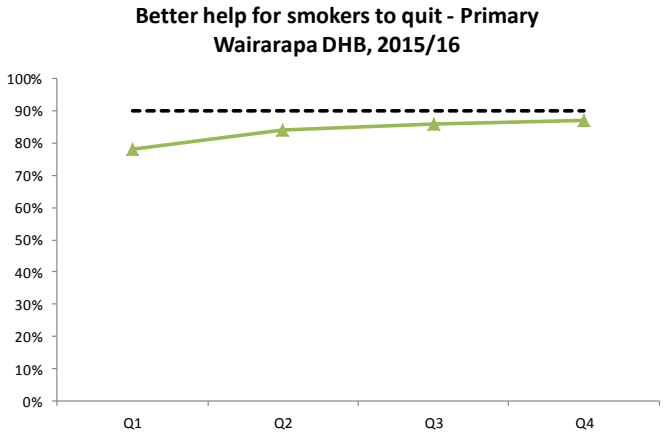


Better help for smokers to quit – Primary care

90 percent of patients who smoke and are seen by a health practitioner in primary care are offered brief advice and support to quit smoking.[2]

Target: 90%

2015/16 Performance: 87%



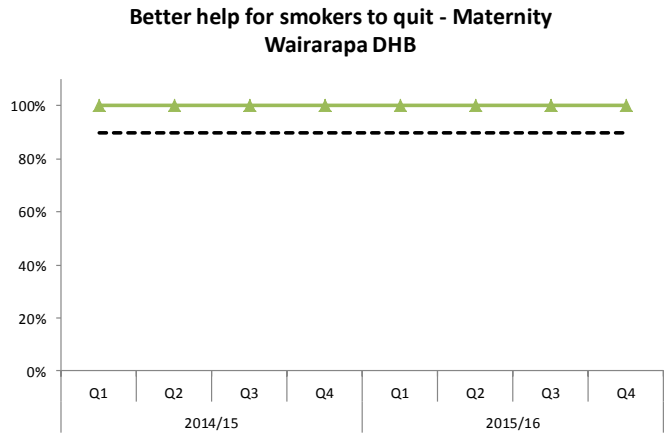
[2] From 2015/16, all smokers enrolled in a primary care practice are required to be given brief advice and support to quit smoking, regardless of whether they were seen or not by a general practitioner. Previously, only smokers who were seen by a general practitioner in the last 12 months were required to be given brief advice and support to quit smoking.

Better help for smokers to quit – Maternity

90% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking

Target: 90%

2015/16 Performance: 100%

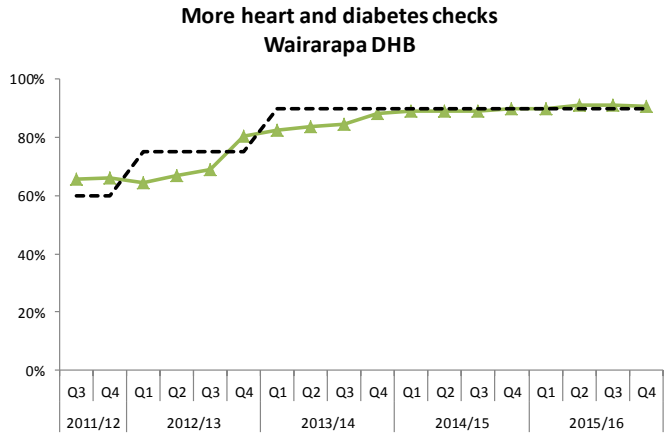


More heart and diabetes checks

90 percent of the eligible population[3] will have had their cardiovascular risk assessed in the last five years.

Target: 90%

2015/16 Performance: 91%

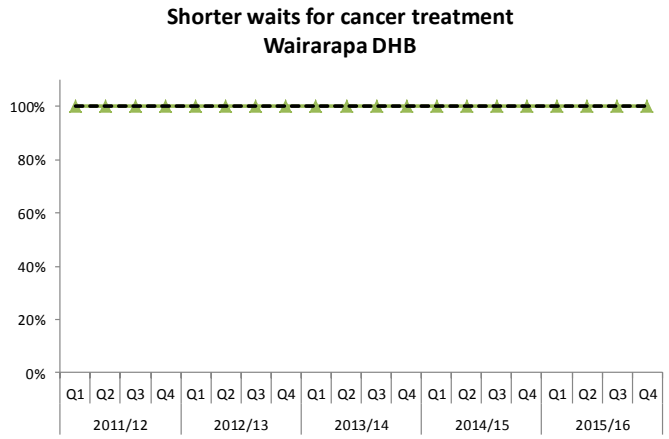


Shorter waits for cancer treatment

All patients, ready for treatment, wait less than four weeks for radiotherapy or chemotherapy. The Ministry of Health has transitioned from this target to the 'Faster cancer treatment' health target.

Target: 100%

2015/16 Performance: 100%



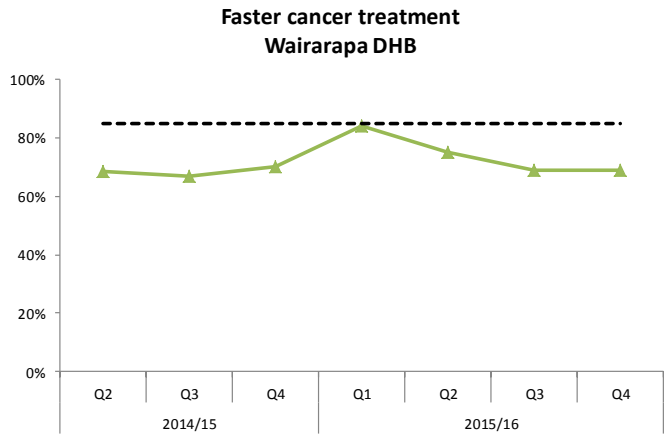
[3] Males of Māori, Pacific or Indian ethnicity aged 35-74 years at then end of the reporting period and enrolled with a PHO; Females of Māori, Pacific or Indian ethnicity aged 45-74 years at the end of the reporting period and enrolled with a PHO; Males of any other ethnicity aged 45-74 years at the end of the reporting period and enrolled with a PHO; Females of any other ethnicity aged 55-74 years at the end of the reporting period and enrolled with a PHO.

Faster cancer treatment

85 percent of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July 2016, increasing to 90 percent by June 2017[4].

Target: 85%

2015/16 Performance: 69%



[4] Faster cancer treatment is an area of focus for Wairarapa DHB, as we work with our neighbouring DHBs to streamline access to services that are not provided in Wairarapa.

PERFORMANCE HIGHLIGHTS

Wairarapa DHB continues to provide high quality and timely services for our population. In 2015/16:

- Wairarapa DHB achieved the immunisation Health Target of 95% of eight month olds having their primary course of immunisations on time.
- Compass PHO achieved the *CVD risk assessment* Health Target with 91% of eligible people enrolled in 2015/16 having received an assessment in the last 5 years.
- In Wairarapa DHB, there has been a substantial decrease in the burden of tooth decay (mean DMFT) in the 12 year olds. This decrease has also been substantial amongst Māori 12 year olds.
- In Wairarapa DHB, the average age of entry into residential care continues to increase and is the highest within the sub-region indicating that high-quality health services for older people are being provided in a timely manner for those who need them. These services are supporting older people to remain independent at home for longer.
- Regional Public Health exceeded the target for the percentage of school children receiving Boostrix vaccination and HPV vaccinations in schools.
- Wairarapa DHB continues to meet the Before School Check screening target for both the total population and the high need population, with 98% high need children and 95% of all children receiving a check.
- Wairarapa DHB continues to achieve the 70% target for the percentage of eligible women having breast screening in the last 2 years. The target was also achieved for eligible Māori women.
- All general practices in the Wairarapa have a diabetes care improvement plan. These plans include regular monitoring of diabetes care and outline strategies that will improve diabetes care in the practice.
- Wairarapa DHB achieved the 85% target for the percentage of children under 5 years of age enrolled in DHB-funded dental services.
- Wairarapa DHB exceeded the *Improved access to elective surgery* Health Target with 2,480 elective surgeries delivered.
- Wairarapa DHB met targets set for the number of inpatient falls causing harm and acquired pressure injuries. Wairarapa DHB also exceeded the target for each dimension of the Patient Experience Survey.
- In Wairarapa DHB, the target for the number of people accessing secondary mental health services was achieved.
- Wairarapa DHB made significant progress on providing comprehensive clinical (InterRAI) assessments and care plan to older people with long-term support needs. In 2015/16, 100% of people with long-term support needs received an InterRAI assessment.

IMPACTS & OUTCOMES

As the major funder and provider of health, wellbeing and disability services in our district, we work to make and maintain positive changes in the health of our population. Our decisions about which services to fund and deliver have a significant impact on the health of our population and contribute to the effectiveness of our entire health system.

In the following section, we present our intended outcomes and their associated impact measures. Although we do not have a specific target for our selected impact measures, trends in these measures can indicate in which areas our DHB is making a positive difference and in which areas our DHB should seek to improve. It is important to note that these outcomes are progressed not just through the work of DHBs, but also through the work of all of those across the health system and wider health and social services.

POPULATION HEALTH OUTCOME: IMPROVED HEALTH EQUITY

What difference will we make for our population?

There are recognised health disparities for several population groups due to accessibility, social determinants of health, cultural responsiveness, and current models of care. Patients can find it hard to access services or to know how to manage their health if services are not culturally competent. We acknowledge our responsibility to design and deliver services that are accessible and responsive to our population's needs.

Impact measures – The DHB measures progress through:

Impact measure: A reduction in amenable mortality rates

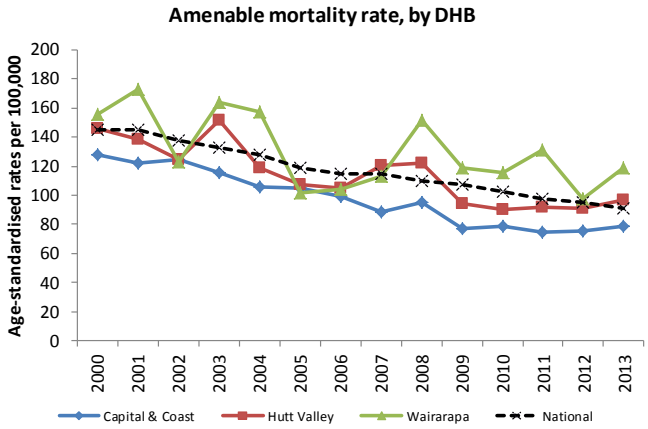
'Amenable mortality' is defined as premature deaths from conditions that were potentially avoidable through health care.

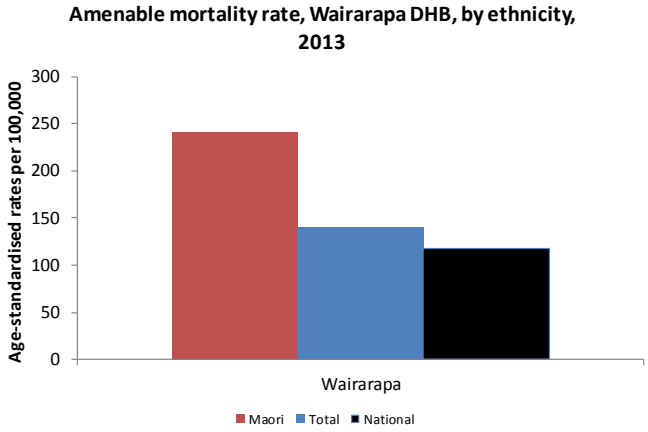
Differences in amenable mortality rates for different population groups reflect variation in the coverage and quality of health care received by them.

Amenable mortality is highest in the sub-region. Māori have higher amenable mortality rather compared to other ethnicities, indicating that this population is not receiving equitable coverage or quality.

This is an area of focus in the 2016/17 Maori Health Plan.

The Ministry of Health's Mortality Collection data up to year end 2013 was released in June 2016





Source: Ministry of Health

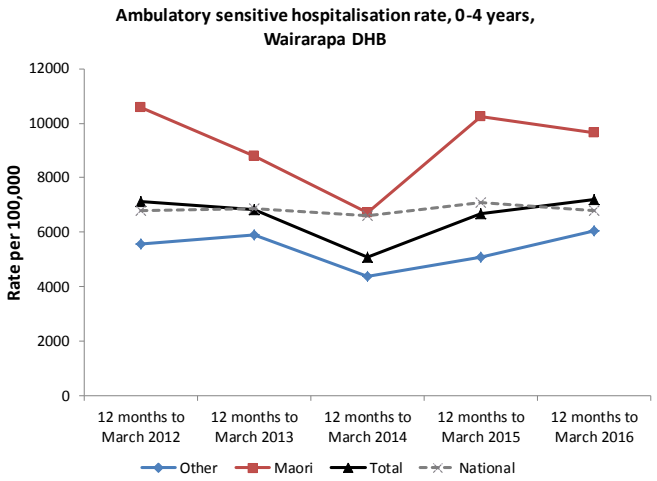
Impact measure: A reduction in Ambulatory Sensitive Hospitalisation (ASH) rates[5]

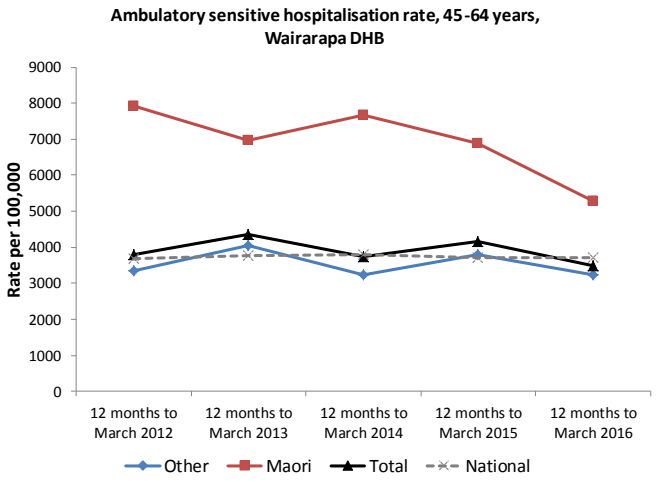
Ambulatory sensitive hospitalisations (ASH) are admissions to hospital for conditions that could have been prevented or treated by appropriate interventions in a primary care or community setting. These conditions include, for example, skin infections, dental conditions, asthma, pneumonia, cardiovascular disease and diabetes.

ASH rates also highlight opportunities to better support people to seek intervention early and to manage their long-term conditions. A reduction in ASH admissions will reflect better management and treatment across the whole health system.

Over the last five years, the ASH rate for Māori in Wairarapa DHB has decreased. However, it remains approximately 1.5 times higher than the ASH rate for other ethnicities.

Note that the methodology for this measure was revised by the Ministry of Health in 2015/16. This figure uses the revised methodology.





Source: Ministry of Health

[5] ASH rate for 0-74 years as published in the Annual Plan is no longer available. ASH rates are now calculated for the 0-4 and 45-64 years age groups only.

POPULATION HEALTH OUTCOME: IMPROVED ENVIRONMENTAL HEALTH AND DISEASE HAZARD MANAGEMENT

What difference will we make for our population?

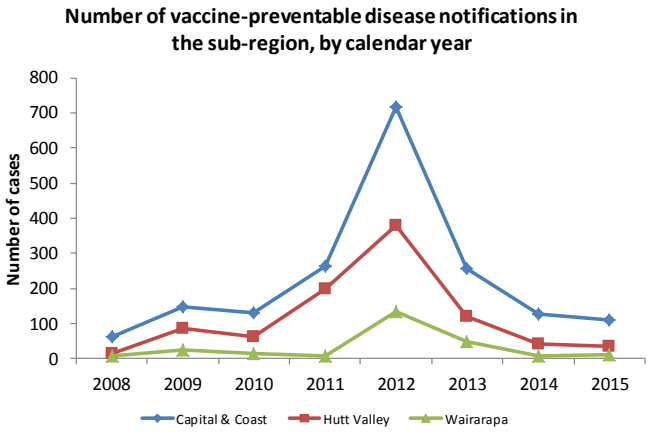
Through effective public health disease surveillance, investigation and control, the impacts of communicable, waterborne and foodborne diseases can be minimised. Public health actions are aimed at reducing the levels of harm from alcohol and drug use in the greater Wellington region. To achieve this Regional Public Health works with Police, councils, and community agencies to understand and address the issues driving the harmful consumption of alcohol and drug use.

Measures – The DHB measures progress through:

Impact measure: A decrease in vaccine-preventable disease notifications[6]

In addition to protecting an individual from disease, immunisation can also provide population-wide protection by reducing the incidence of infectious diseases and preventing the spread of these diseases to vulnerable people.

The peak in 2012 was due to Pertussis (whooping cough) outbreaks in the region, which caused an increase in vaccine preventable disease notifications. The number of notifications has returned to previous levels in 2014. In Wairarapa DHB, the number of vaccine-preventable disease notifications increased from 8 cases in 2014 to 12 in 2015. In the longer term, with increased immunisation, we expect that the number of vaccine-preventable disease notifications will continue to decrease.



Source: Institute of Environmental Science and Research

[6] Includes the following notifiable diseases: Haemophilus influenzae type B, Hepatitis B, Invasive pneumoccocal disease, Measles, Mumps, Pertussis, and Rubella.

Impact measure: An increase in the percentage of premises visited that are compliant with Supply of Liquor Act 2012, for sales to minors (in the sub-region)

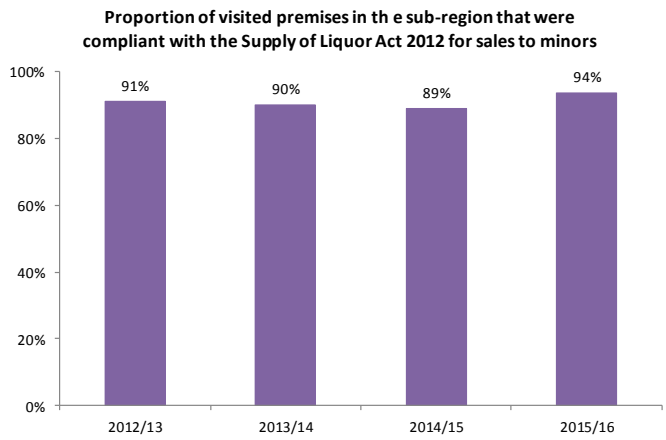
Alcohol is a significant contributor to disease and injury for New Zealanders. Alcohol is causally related to more than 60 health conditions and is a significant contributor to injury, road trauma, alcohol poisoning and crime.

In 2007 alcohol consumption was attributed to 5.4% of all deaths for those under 80 years old. In 2004 alcohol accounted for 28,403 years of life lost (disability-adjusted life years – DALYs) representing 6.5% of all DALYs for those under 80 years[7]. Young people, Maori, Pacific peoples and those living in areas of higher socioeconomic deprivation are at greater risk of experiencing harms from alcohol.

Harm reduction strategies include changing both physical and social environments. Effective interventions include regulating the availability of alcohol through minimum legal age of purchase, hours and days of sale restrictions and restriction on the density of outlets.

Controlled purchase operations (CPOs) have been an effective compliance tool over the last ten years, with the national incidence of premises selling to minors declining during this time. Regional Public Health works with Police, volunteers aged 15-17 and the District Licensing Committee to carry out CPOs.

In 2015/16, 94% of premises visited in the sub-region were compliant with the Supply of Liquor Act 2012 for sales to minors.



Source: Regional Public Health

[7] Ministry of Health (2013). Health loss in New Zealand: A report from the New Zealand Burden of Diseases, Injuries and Risk Factors Study, 2006–2016. Wellington: Ministry of Health.

POPULATION HEALTH OUTCOME: IMPROVED MANAGEMENT OF LIFESTYLE FACTORS THAT AFFECT HEALTH

What difference will we make for our population?

Lifestyle factors have a significant impact on overall health and well-being and are key contributors to cancer, obesity, cardiovascular disease and diabetes, which are major causes of death and poor health in our population. The Ministry of Health has estimated the burden of disease across New Zealand using 'disability-adjusted life years' (DALYs) that include both burden from early death and from lives led with disability. There are four key lifestyle factors that drive health loss: smoking (9.1% of health loss), obesity (7.9%), physical inactivity (4.2%) and poor diet (3.3%). Reducing the incidence of these negative lifestyle factors will improve the health of our population.

Measures – The DHB measures progress through:

Impact measures: A decrease in the obesity prevalence in adults and children (adults 15+ years and children 0-14 years)

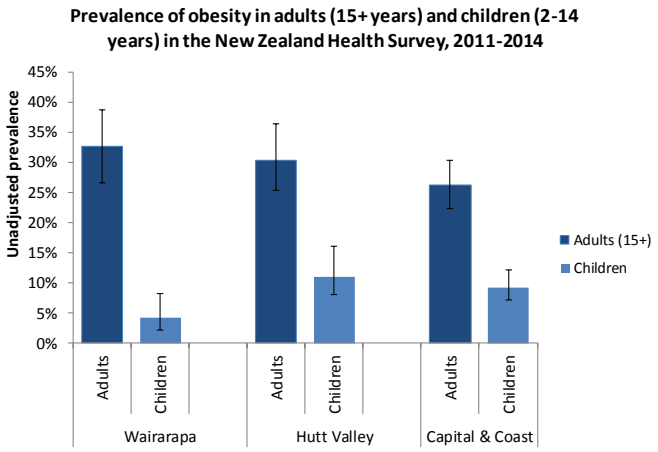
Obesity is one of the most important modifiable risk factors for a number of major diseases, including type 2 diabetes, ischaemic heart disease, ischaemic stroke, and several common cancers. In the last two decades, the prevalence of overweight and obesity in developed countries has increased so quickly that is has been described as an epidemic[8].

The most recent NZ Health Survey shows that there is no significant difference in obesity rates across the sub-region. Adults have a much higher obesity rate than children in all three.

By providing education and support for people to live healthily, we expect that the prevalence of obesity will decrease.

The DHB is establishing an inter-sectorial approach to tackling obesity. Obesity is not solely a health issue. There are many social determinants which require collective and coordinated action.

The programme is likely to use dental health as the vehicle for initiating conversations with children and families.



Source: New Zealand Health Survey, 2011-14. Error bars represent 95% confidence interval.

[8] Ministry of Health. 2004. *Tracking the Obesity Epidemic: New Zealand 1977–2003.* Wellington: Ministry of Health.

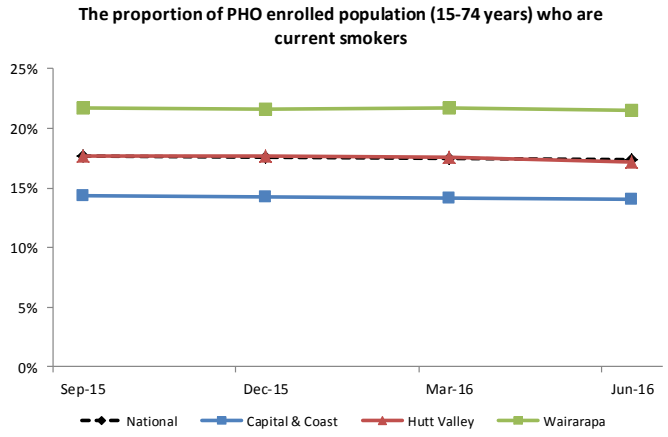
Impact measure: A decrease in the proportion of the PHO-enrolled population that is recorded as a 'current smoker'

Cigarette smoking has serious consequences for health. It is estimated that smoking kills 5,000 New Zealanders a year. Ministry of Health has set a goal that New Zealand will be smoke free by 2025. Our DHB is working towards this goal by providing smoking advice and cessation support to patients when they visit their general practice or visit the hospital.

In Wairarapa DHB, 22% of the PHO enrolled population are recorded as a 'current smoker'.

By continuing to provide smoking cessation advice and support, we expect that the percentage of people who smoke will continue to decrease.

Reducing harm caused by tobacco is a focus of the 2016/17 Maori Health Plan.



Source: Ministry of Health

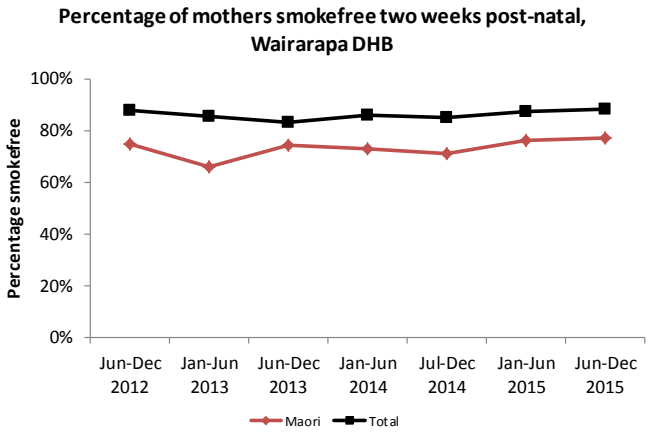
Impact measure: An increase in the proportion of mothers who are smokefree two weeks post-natal

Maternal smoking, both during and after pregnancy, can negatively impact a child's health. Infants are more at risk of sudden infant death syndrome, respiratory conditions, and tooth decay if they are exposed to cigarette smoke.

Mothers are given smoking cessation advice in hospital, and lead maternity carers provide information about the risks associated with smoking and referrals to smoking cessation providers. By continuing to provide cessation advice and support, we expect that the percentage of mothers who are smokefree two weeks post-natal will increase.

In Wairarapa DHB, Māori mothers were less likely to be smokefree compared to other ethnicities.

Data for January to June 2016 was not available at time of publication.



Source: WCTO Quality Indicators, Ministry of Health via Trendly

POPULATION HEALTH OUTCOME: CHILDREN HAVE A HEALTHY START IN LIFE

What difference will we make for our population?

A child's circumstances and health can have a lasting effect on their life. Poor health as a child predicts self-rated health and the development of chronic conditions as an adult[9].

For this reason, it important that the DHB provides children and their whānau with high-quality, equitable, and accessible services.

Measures – The DHB measures progress through:

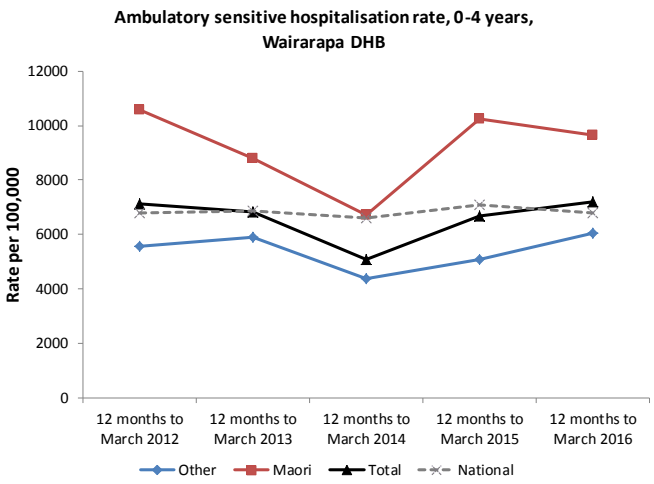
Impact measure: A reduction in Ambulatory Sensitive Hospitalisation (ASH) rates for 0-4 year olds

Ambulatory sensitive hospitalisations (ASH) are admissions to hospital for conditions that could have been prevented or treated by appropriate interventions in a primary care or community setting. For children, these conditions include skin infections, dental conditions, asthma, respiratory infections, and gastroenteritis.

ASH rates also highlight opportunities to better support people to seek intervention early and to manage their long-term conditions. A reduction in ASH admissions will reflect better management and treatment across the whole health system.

In Wairarapa DHB, ASH rates amongst Māori children are 1.6 times higher compared to Other children.

Note that the methodology for this measure was revised by the Ministry of Health in 2015/16. This figure uses the revised methodology.



Source: Ministry of Health

[9] Haas, H. A. (2007). The long-term effects of poor childhood health: An assessment and application of retrospective reports. *Demography, 44*(1), 113-135.

Impact measure: An increase in the proportion of children caries-free at 5 years

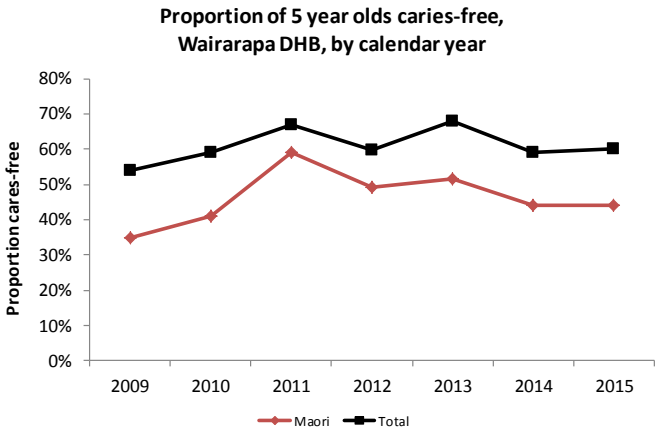
Regular dental care has lifelong benefits for health. Improved oral health is also an indicator of the equity of access to services and the effectiveness of mainstream services at targeting those most in need. Māori and Pacific children have worse oral health outcomes than other ethnicities.

The DHB is undertaking a number of activities to improve oral health outcomes for children. A new sub-regional enrolment system has recently been established, and its aim is to enrol every infant with community oral health services. In addition, Before School Checks include a 'Lift the Lip' oral health examination, through which children with poor oral health are referred to community oral health services.

By ensuring that every child has access to and is receiving oral health services, we expect that the proportion of five year olds with no caries will increase.

In Wairarapa DHB, the proportion of 5 year olds who are caries free has declined from 2013. The proportion of Māori children who are caries free has also declined since 2013.

For the previous 12 months, all babies born in Wairarapa DHB have been enrolled with an oral health service and mothers have been invited to attend health education sessions with their babies at around 8 weeks.



Source: Ministry of Health, Bee Healthy Dental Service

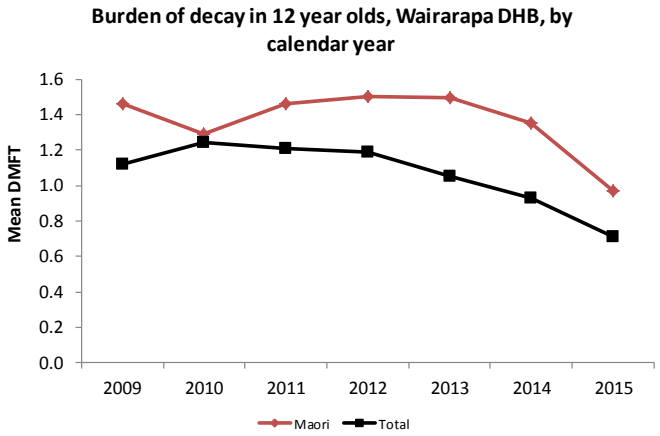
Impact measure: A decrease in the burden of tooth decay at Year 8

The burden of tooth decay is measured by the mean number of decayed, missing or filled teeth (DMFT) in twelve year old children. Māori and Pacific children have a higher burden of decay than other ethnicities.

By ensuring that every child has access to and is receiving oral health services, we expect that the burden of decay in twelve year olds will decrease.

In Wairarapa DHB, the mean DMFT amongst 12 year olds continues to decrease. Māori children have a higher burden of decay than other ethnicities. However the burden of decay has substantially declined over the last two years.

This outcome is the result of routine x-rays starting at aged 4There is evidence that decay is being picked up earlier and interventions implemented.



Source: Bee Healthy Dental Service

HEALTH SERVICES OUTCOME: LONG-TERM CONDITIONS ARE WELL-MANAGED

What difference will we make for our population?

The New Zealand Burden of Disease Study[10] suggest that over the next decade people will be living longer with more long-term conditions and consequent disability. In response, our health system needs to increasingly focus on the prevention and on-going management of long-term conditions, and enhance wellbeing in the presence of illness.

[10] Ministry of Health

Measures – The DHB measures progress through:

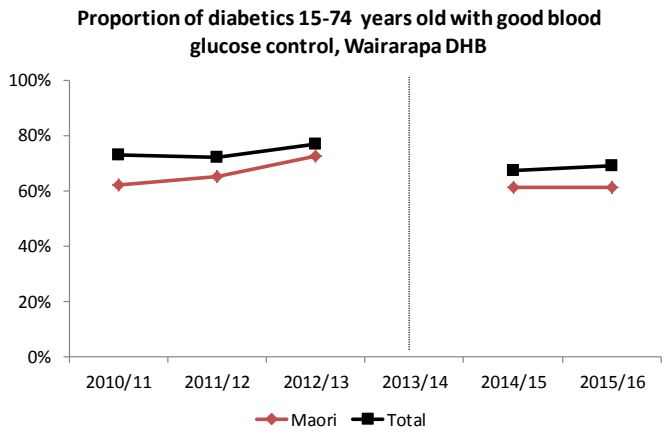
Impact measure: An increase in the proportion of diabetics with satisfactory blood glucose control (HbA1c less than 64 mmol/mol)

Diabetes is a long-term condition that is caused by the body not being able to control its blood sugar levels properly. Diabetes is associated with kidney failure, eyesight problems, foot ulcers, and cardiovascular disease. However, with good diet and exercise, diabetes can be controlled and the risks associated with diabetes minimised. A lower level of HbA1c in the blood indicates that a person's diabetes is being well-managed.

General Practices in our sub-region are required to have a 'Practice Population Plan' that outlines the services and support that they will provide to diabetics. By improving the quality of care and empowering people with diabetes to look after their health, we expect to see an increase in the proportion of diabetics with good blood glucose control.

In Wairarapa DHB, the proportion of Māori who have good blood glucose control is lower than other ethnicities.

Results from 2010/11 through to 2012/13 are as a proportion of diabetics who had an HbA1c tests. The methodology was revised in 2013/14 to be a proportion if all enrolled diabetics. Due to a delay in developing the new methodology, 2013/14 results are unavailable.

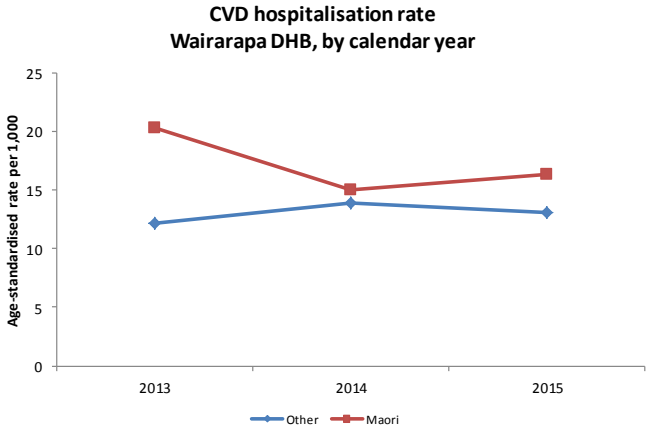


Impact measure: A decrease in the hospitalisation rate for cardiovascular disease

Cardiovascular diseases (CVD) are diseases that affect the heart and circulatory system. They include ischaemic heart disease, rheumatic heart disease, cerebrovascular disease and other forms of vascular and heart disease. Cardiovascular disease is the leading cause of death in the sub-region. Overall, around 70% of the burden of cardiovascular disease is attributed to modifiable risk factors. CVD is preventable through adopting a healthy lifestyle, and can be managed with lifestyle change, early intervention and effective management.

One of the Health Targets is to provide CVD risk checks for the eligible population. By identifying those at risk of CVD early, we can help them to change their lifestyle to improve their health, and reduce the chance that they develop a serious health condition. We expect that this intervention will lead to a decrease in the rate of CVD-related hospitalisations for our population.

In Wairarapa DHB, Maori have a higher rate of CVD hospitalisation than other ethnicities. The CVD hospitalisation rate for Māori has decreased since 2013.



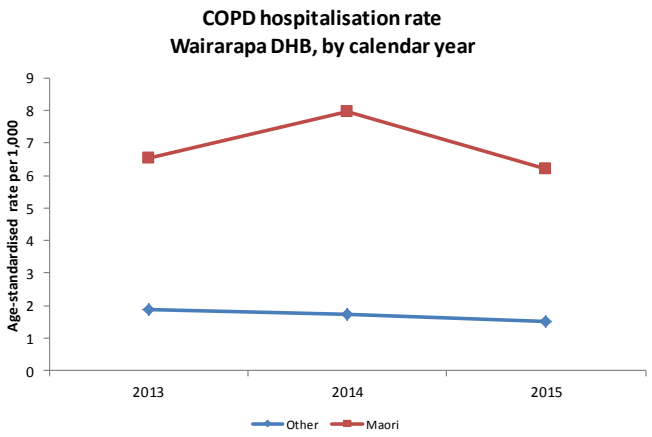
Source: National Minimum Dataset, ICD codes I00-I99, 15+ year olds

Impact measure: A decrease in the hospitalisation rate for chronic obstructive pulmonary disease

Chronic obstructive pulmonary disease (COPD) is the result of damage to the lungs. COPD is most commonly associated with smoking, and although lung damage is permanent, quitting smoking can help to improve COPD symptoms and prevent further damage.

By providing cessation support for people who smoke, improving access to primary care, and helping people to take their medication regularly, we expect that the rate of COPD hospitalisations for our population will decrease.

In Wairarapa DHB, the COPD hospitalisation rate for Māori is higher than the rate for other ethnicities. The COPD hospitalisation rate for Māori decreased during 2015.



Source: National Minimum Dataset, ICD codes J40-J44, 15+ year olds

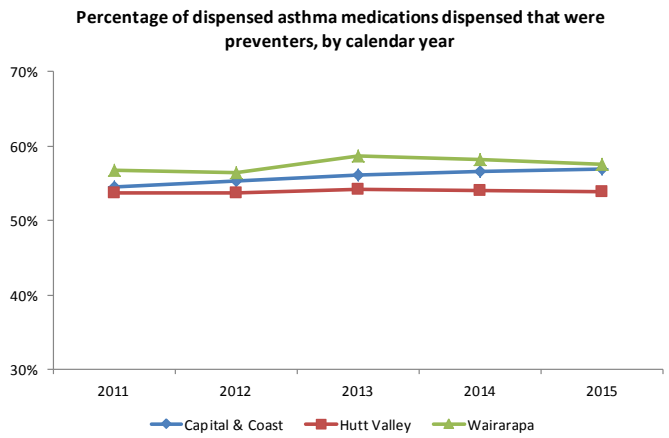
Impact measure: An increase in the proportion of dispensed asthma medications that were preventers rather than relievers

Asthma occurs when a person's airways tighten and produce more mucous, making it difficult to breathe. It is often caused by pollen, cold air, or respiratory infections. People with on-going asthma generally use a preventer, which reduces the chance that their asthma will be triggered. They can also use a reliever, which they take to reduce their symptoms if they have trouble breathing.

If a person's asthma is well-managed, they should be using their preventer more frequently than their reliever.

A higher percentage of preventers dispensed indicate that asthma is being well-managed. By improving access to primary care, and supporting people to take their long term medications, we expect that people will use more preventers and less relievers.

In Wairarapa DHB, the proportion of asthma medication dispensed which were preventers has remained at 58% over the last two years. [11]



Source: Pharmaceutical Claims Data Mart

[11] Earlier figures published in the Annual Plan were based on an incorrect methodology supplied by HQSC. This figure presents revised calculations of the above impact measure.

HEALTH SERVICES OUTCOME: PEOPLE RECEIVE HIGH QUALITY HOPSITAL AND SPECIALIST HEALTH SERVICES WHEN THEY NEED THEM

What difference will we make for our population?

Equitable and timely access to intensive assessment and treatment can significantly improve people's quality of life, either through early intervention, or through corrective action (i.e., major joint replacements to relieve pain and improve activity). Improving our service delivery, systems, and processes will improve patient safety, reduce the number of hospital events causing harm, and improve outcomes for people using our services.

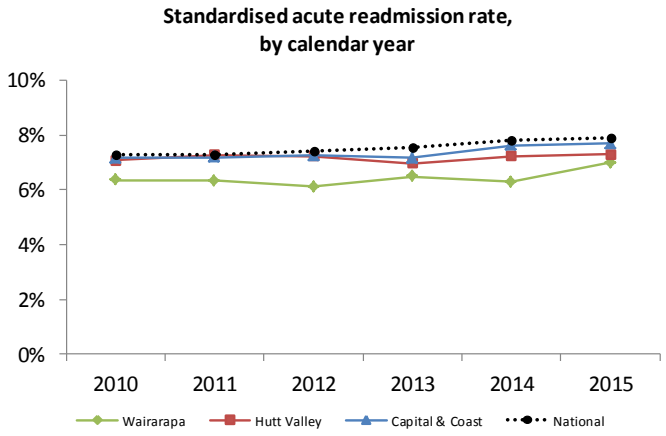
Measures – The DHB measures progress through:

Impact measure: A reduction in the standardised[12] rate of acute readmissions to hospital within 28 days

A decrease in the rate of acute readmissions shows that people are receiving high-quality care in hospital, that they are being appropriately discharged (i.e., not leaving hospital too early or too late), and that they are being well-supported by primary and community care once they are out of hospital.

The standardised acute readmission rate has remained at about 6.5% for Wairarapa DHB over the last five years. Although the acute readmission rate has remained the same, the average length of stay in our hospital facilities has decreased (see Section 3.3.3), which shows that the effectiveness and efficiency of treatment in hospital has improved.

Note that the methodology for this measure is being revised by Ministry of Health in 2015/16.



Source: Ministry of Health

[12] The standardised acute readmission rate accounts for casemix and population differences between DHBs, in order to improve the comparability of the measure across the sector. Refer to the Ministry of Health website (www.moh.govt.nz) for more information on how this measure is calculated.

Impact measure: Maintain or reduce the age-standardised[13] cancer mortality rate

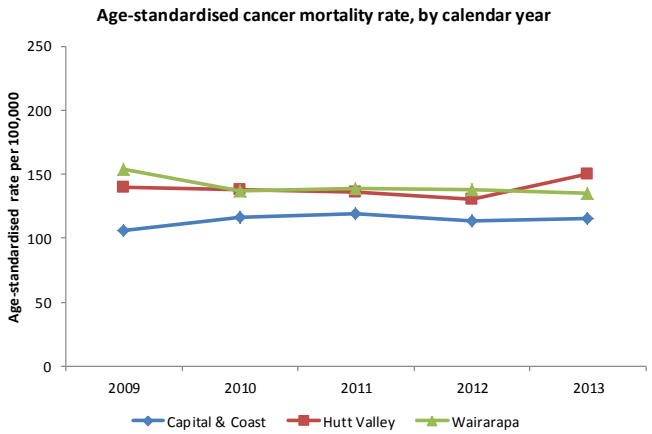
More people are developing cancer, mainly because the population is growing and getting older.

Many cancers can be cured if they're found and treated in time. It is estimated that in New Zealand, about one person in every three who gets cancer is cured.

By screening women for breast and cervical cancer, and providing timely cancer treatment, we expect that the cancer mortality rate will decrease.

In Wairarapa DHB, the age-standardised cancer mortality rate has declined over time suggesting that people are accessing timely cancer treatment.

The Ministry of Health's Mortality Collection data up to year end 2013 was released in June 2016



Source: Ministry of Health Mortality dataset

[13] Age-standardisation accounts for differences in the age structure between populations and changes in the age structure over time. The age-standardised rate estimates what the rate would be if the age structures were the same. See also Section 3.2.2.

HEALTH SERVICES OUTCOME: PEOPLE RECEIVE HIGH QUALITY MENTAL HEALTH SERVICES WHEN THEY NEED THEM

What difference will we make for our population?

Specialist Mental Health Services are services for people who are most severely affected by mental illness or addictions and include assessment, diagnosis, treatment and rehabilitation, as well as crisis response when needed, and as required under the Mental Health Act.

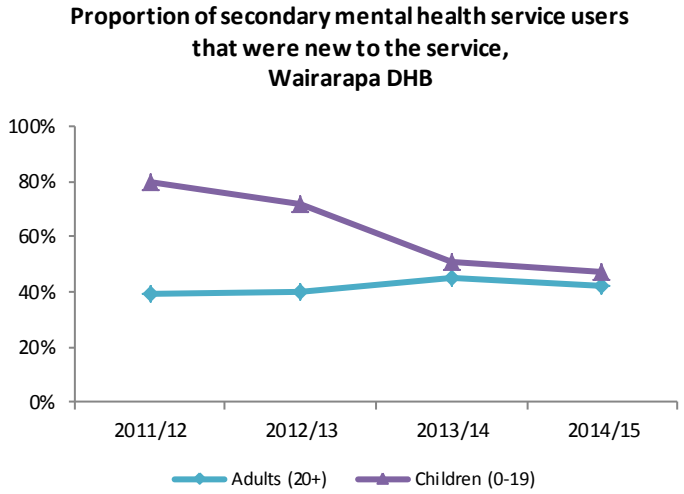
Measures – The DHB measures progress through:

Impact measure: An increase in the percentage of new service users accessing secondary mental health services (of all people accessing secondary mental health services. New service users are those who have not used mental health services in the last five years)

This measure indicates the responsiveness of secondary mental health services to people who require secondary mental health care for the first time.

By ensuring that existing users of secondary mental health services only receive these services for as long as they need them, we can increase our capacity and remove access barriers for new service users. As a result, we expect that the proportion of service users that are new will increase.

In Wairarapa DHB, the proportion of children who are new users of secondary mental health continues to decrease while the proportion of adults has remained comparatively stable.



Source: Ministry of Health

HEALTH SERVICES OUTCOME: RESPONSIVE HEALTH SERVICES FOR PEOPLE WITH DISABILITIES

What difference will we make for our population?

Disability is defined as long-term limitation (resulting from impairment) in a person's ability to carry out daily activities. In 2013, an estimated 24% of people living in New Zealand were identified as disabled. National estimates by age and gender applied to the sub-region indicate a disabled population of approximately 109,000 people: 11,000 in Wairarapa (27%), 33,000 in Hutt Valley (24%) and 65,000 in CCDHB (23%). The DHB has a responsibility to provide responsive and appropriate health services to people with disabilities.

Measures – The DHB measures progress through:

Impact measure: An increase in the proportion of patients and clinicians that found the Health Passport useful (as a percentage of patients and clinicians that responded to an evaluation survey and reported using the Health Passport) The Health Passport is a document that a person takes with them when they use medical services. The Health Passport contains information about the person that they would like hospital staff to know. For example, a Health Passport includes how a person would like to be communicated with, their medical conditions, what medications they are allergic to, and their religious/spiritual preferences. An increase in the proportion of people that find the Health Passport useful will indicate that the Health Passport is achieving its aims and improving the quality of care of patients when they are in hospital.	Measure to be developed

HEALTH SERVICES OUTCOME: IMPROVE THE HEALTH, WELL-BEING AND INDEPENDENCE OF OUR REGION'S OLDER PEOPLE

What difference will we make for our population?

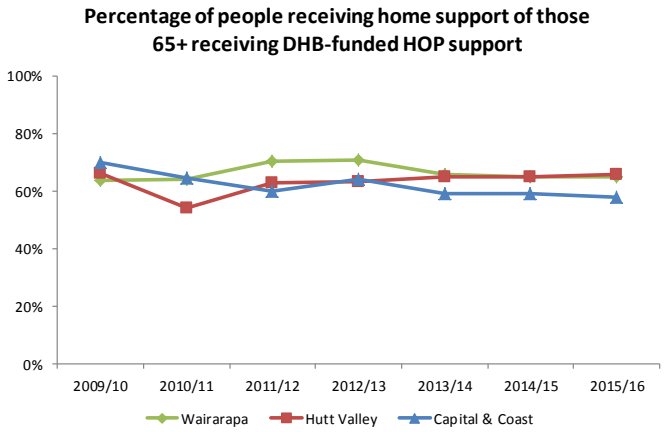
Our ageing population will increase pressure on the health system. National estimates suggest that the increase in health expectancy over the period 2006–2016 will be less than the corresponding increase in life expectancy. In other words, people will live longer, and they will live longer in good health, but they will also live longer in poor health, with multiple comorbidities, functional impairments and frailty. The DHB has a responsibility to provide appropriate services to improve the health, wellbeing, and independence of our older population.Measures – The DHB measures progress through:

Impact measure: Maintain or increase the proportion of patients receiving home based support services (of those 65+ who receive DHB funded home based support or aged residential care services)

With an ageing population, it is important that services are effective and efficient for people who wish to remain in their own homes. A 2008 study[14] found that "…home support plays an important and effective role in enhancing quality of life and the experience of ageing in place for older people in New Zealand, earning the retention of its place on the continuum of care, and should be acknowledged and valued as a critical ageing in place strategy." This shows the importance of helping older people to maintain their independence.

By providing comprehensive and high-quality home-support services, we expect that there will be an increase in the proportion of people receiving home support rather than in residential care.

In Wairarapa DHB, the proportion of patients receiving home based support services has been maintained.



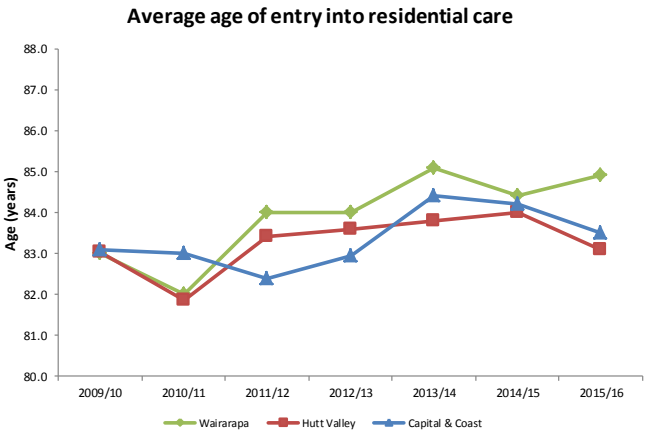
Source: Health of Older People regional benchmarking

[14] Hambleton, P., Keeling, S., & McKenzie, M. (2008). Quality of life is ... : The views of older recipients of low-level home support. *Social Policy Journal of New Zealand, 33*, 146-162.

Impact measure: Maintain or increase the average age of entry into residential care

An increase in the average age of entry into residential care would indicate that older people are remaining independent and staying at home for longer. By providing quality home support services to those who need them and high-quality and timely health services for older people to help them maintain their health, we expect that the average age of entry into residential care will increase.

In Wairarapa DHB, the average age of entry into residential care is 85 years.



Source: Health of Older People regional benchmarking

STATEMENT OF PERFORMANCE

For the year ended 30 June 2016

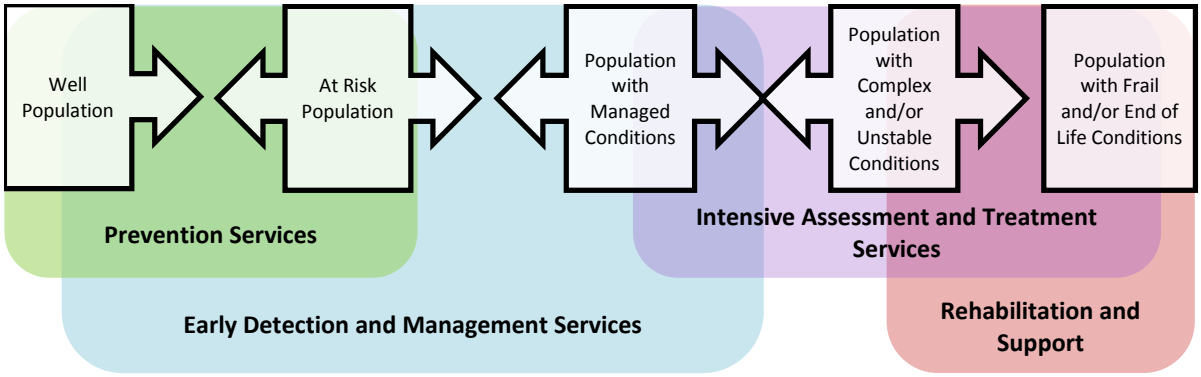
OUTPUT CLASSES CONTRIBUTING TO DESIRED OUTCOMES

One of the functions of this Annual Report is to evaluate the effectiveness of the decisions we make on behalf of our population, we do this by evaluating the services ('outputs') funded and provided in 2015/16.

Our four Output Classes and their related services are:

1. Prevention Services
   - Health protection and monitoring services
   - Health promotion services
   - Immunisation services
   - Smoking cessation services
   - Screening services
2. Early Detection and Management Services
   - Primary care (GP) services
   - Oral health services
   - Pharmacy services
3. Intensive Treatment and Assessment Services
   - Medical and surgical services
   - Cancer services
   - Mental health and addictions services
4. Rehabilitation and Support Services
   - Disability services
   - Health of older people services

Scope of DHB Operations – Output Classes in the Continuum of Care



The outputs reflect a picture of health service activity across the whole of the Wairarapa health system. We choose outputs that make the greatest contribution to the wellbeing of our population in the shorter term, and to the health outcomes that we are seeking to achieve over the longer term. These outputs also cover

areas in which we are developing new services and therefore expect to see a change in activity levels or settings in the current year. To give a representative picture of our performance, the outputs have been grouped into four 'output classes' that are a logical fit with the stages spanning the continuum of care and are applicable to all DHBs.

INTERPRETING OUR PERFORMANCE

Types of measures

Identifying appropriate measures for each output class is difficult as it is important to do more than measure just the volumes of patients and consumers through our system. The number of services delivered or the number of people who receive a service is often less important than whether the right person or enough of the right people received the right service, and whether the service was delivered at the right time. Because of this complexity, in addition to volume, we report on a mix of output measures to help us to evaluate different aspects of our performance. The outputs are categorised by type of measure, which shows whether the output is targeting coverage, quality, quantity (volume), or timeliness. When possible and relevant, we have also broken our performance down by ethnicity.

Type of Measure	Abbreviation
Coverage	C
Quality	Q
Volume	V
Timeliness	T
DHB of Domicile	DoD
DHB of Service	DoS

Ethnicity	Abbreviation
Māori	M
Pacific	P
Total (all ethnicities)	T

We have identified new measures in 2015/16 with a † symbol. These measures were introduced in the 2015/16 Annual Plan and did not appear in the 2014/15 Annual Report. Our 2014/15 performance has therefore not been audited by Audit New Zealand.

Standardisation

Different populations have different characteristics, and these different population characteristics can lead to different rates between populations. One such characteristic is the age structure of a population. It would be unreasonable to compare the hospital average length of stay in Wairarapa, which has a large proportion of elderly, directly to Capital & Coast, which has a smaller proportion of elderly. But, by standardising for age, we can see what the rates would have been if the two populations had the same proportion of people in each age group, and therefore draw comparisons. In the following outputs, if

measures have been standardised (often by the Ministry of Health to allow comparison between DHBs), we have noted why and how.

Targets and Estimates

Some of our performance measures are demand-based, and are included to show a picture of the services that the DHB funds and provides. For these measures, no specific targets are set because there are no assumptions about whether an increase or decrease is desirable. For performance measures that are demand-based, under the heading of "target", we have provided an estimate of our 2015/16 performance (indicated with 'Est.'), based on historical and population trends.

Appropriation Reporting

	Budget 2016 $000	Actual 2016 $000	Actual 2015 $000
Appropriation revenue *	128,179	128,179	122,511

What has been achieved with the appropriation is included in the Statement of Performance on pages 51 to 73.

*The appropriation revenue received by the DHB equals the Government's actual expenses incurred in relation to the appropriation, which is a required disclosure from the Public Finance Act.

OUTPUTS BY CLASS

3.3.1 Output class: Prevention Services

Description

'Preventative' health services promote and protect the health of the whole population, or identifiable sub-populations, and influence individual behaviours by targeting population-wide changes to physical and social environments to influence and support people to make healthier choices.

Context

New Zealand is experiencing a growing prevalence of long-term conditions such as diabetes and cardiovascular disease, which are major causes of poor health and morbidity and account for a significant number of presentations in primary care and admissions to hospital and specialist services. With an ageing population, the burden of long-term conditions will increase. It has been estimated that 70% of health funding is spent on long-term conditions. Two in every three New Zealand adults have been diagnosed with at least one long-term condition and long-term conditions are the leading driver of health inequalities. The majority of chronic conditions are preventable or could be better managed. Tobacco smoking, inactivity, poor nutrition, and rising obesity rates are major and common contributors to a number of the most prevalent long-term conditions and are avoidable risk factors, preventable through a supportive environment, improved awareness and personal responsibility for health and wellbeing.

These prevention services also support people to address any risk factors that contribute to both acute events (e.g., alcohol-related injury) and the development of long-term conditions (e.g., obesity or diabetes). High health need and at-risk population groups (low socio-economic, Māori, and Pacific) who are more likely to be exposed to environments less conducive to making healthier choices are a focus. Preventative services are our best opportunity to target improvements in the health of these high need populations to reduce inequalities in health status and improve population health outcomes. These services also ensure that threats to the health of the community such as communicable disease, water quality, imported disease-carrying pests, are detected early and prevented, and ensure our ability to respond to emergency events such as pandemics or earthquakes.

Outputs

Health protection and monitoring services: enable people to increase control over their health and its determinants, and thereby improve their health through developing healthy public policy that addresses the prerequisites of health, such as income, housing, food security, employment, and quality working conditions. Health protection activity is enacted through a range of platforms, as described by the Ottawa Charter: public policy, reorienting the health system, environments, community action, and supporting individual personal skills. While health has a significant role here, some outcomes such as obesity require a whole of sector approach; our DHB and RPH work with other sectors (housing, justice, education) to enable this.

Health promotion services: inform people about health matters and health risks, and support people to be healthy. Success begins with awareness and engagement, reinforced by community health programmes that support people to maintain wellness or assist them to make healthier choice.

Immunisation services: work to prevent the outbreak of vaccine-preventable diseases and unnecessary hospitalisations. The work spans primary and community care and allied health services to optimise provision of immunisations across all age groups, both routinely and in response to specific risk. A high coverage rate is indicative of a well-coordinated, successful service.

Smoking cessation services: are provided by clinical staff to smokers to help smokers quit. Clinicians follow the ABC process[15]: **A**sk all patients whether they smoke and document their response; if the patient smokes, provide **B**rief advice to quit smoking; and if patient agrees, provide **C**essation support (e.g., a prescription for nicotine gum or a referral to a provider like Quitline).

Screening services: encourage uptake of services predominately funded and provided through the National Screening Unit that help early identification of breast and cervical cancer, and carry out newborn hearing testing, and antenatal HIV screening.

15 ABC for Smoking Cessation Quick Reference Card, PHARMAC

How we measure performance of our Prevention Services:

Outputs	Measure	Type of Measure	2014/15 Performance	2015/16 Target	2015/16 Performance	2015/16 Achievement
Public health protection and regulatory services	The number of disease notifications investigated in the sub-region[16]	V	1,955	Est. 1,797	1,692	Not achieved
	The number of environmental health investigations in the sub-region	V	562	Est. 684	988	Achieved
	The number of premises visited for alcohol controlled purchase operations in the sub-region	V	354	Est. 277	142	Not achieved
Health promotion and preventive intervention services	Number of submissions providing strategic public health input and expert advice to inform policy and public health programming in the sub-region	V	29	Est. 25	30	Achieved
	The percentage of infants fully or exclusively breastfed at 3 months[†17]	C	54%	≥60%	52%	Not achieved
	Number of new referrals to Public Health Nurses in primary/intermediate schools[18]	V, DoS	2014: 136	Est. Total: 178	185	Achieved

16 This measure and the following 'Health promotion and preventive intervention services' measures are part of RPH's statutory activity and cover the sub-region (Wairarapa, Hutt Valley, and Capital & Coast DHBs).
17 This measure is based on all WCTO providers (not just Plunket).
18 This target is an estimated volume, rather than an aspirational target.

Outputs	Measure	Type of Measure	2014/15 Performance	2015/16 Target	2015/16 Performance	2015/16 Achievement
	The number of adult referrals to the Green Prescription programme in the sub-region†	V, DoS		Est. 3,904	3,734	Not achieved
Immunisations Services	**Integrated Performance & Incentive Framework (IPIF) Health Start:** The percentage of two year olds fully immunised *2014/15 - Unaudited	C	97%*	≥95%	94%	Not achieved
	Health Target: The percentage of eight month olds fully vaccinated	C	93%	≥95%	96%	Achieved
	The percentage of Yr 7 children provided Boosterix vaccination in the schools in the DHB[19]	C, DoS	80%	2015: ≥70% 2016: ≥70%	83%	Achieved
	The percentage of Yr 8 girls vaccinated against HPV (final dose) in schools in the DHB	C, DoS	60%	≥65%[20]	75%	Achieved
Smoking cessation services	**Health Target:** The percentage of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months	C	New methodology	≥90%	87%	Not achieved

19 Targets and performance are for the calendar year to align with school year.
20 Target aligned to national target.

Outputs	Measure	Type of Measure	2014/15 Performance	2015/16 Target	2015/16 Performance	2015/16 Achievement
	Health Target: The percentage of hospitalised smokers receiving advice and help to quit	C	92%	≥95%	94%	Not achieved
	Health Target: The percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer being offered brief advice and support to quit smoking[†]	C,DoS		≥90%	100%	Achieved
Screening services	The percentage of eligible children receiving a B4 School Check	C	High dep[21]: 107%[22]	≥90%	High dep: 98%	Achieved
			T: 87%		T: 95%	Achieved
	IPIF Health Adult: The percentage of eligible women (25-69 yrs) having cervical screening in the last 3 years	C	M: 68%	≥80%	M: 71%[23]	Not achieved
			T: 74%		T: 74%	Not achieved
	The percentage of eligible women (50-69 yrs) having breast screening in the last 2 years	C	M: 66%	≥70%	M: 75%	Achieved
			T: 72%		T: 77%	Achieved

21 'High dep' refers to children living in high deprivation areas: See Atkinson, J., Salmond, S., & Crampton, P. (2014). NZDep2013 Index of Deprivation, Wellington: Department of Public Health, University of Otago.
22 This rate is higher than 100% because the number of children that received screening was greater than the count of eligible children provided by Ministry of Health.
23 Data from National Screening Unit. Note that coverage rates in 2013/14 are based on population projections derived from Census 2006, whilst rates in 2014/15 are based on population projections derived from Census 2013.

Commentary

Public health protection and regulatory services

The target for the number of disease notifications investigated in the sub-region is an estimate based on the two previous years' disease notification/investigation data (across Wairarapa, Hutt Valley and Capital & Coast DHBs). In 2015/16, there was a decrease in the number of notified communicable diseases (1,692) based on the number of investigations in the previous year. The primary purpose of notification is to trigger an appropriate public health response to prevent further illness. The secondary purpose is for disease surveillance, to predict, observe and minimise the harm caused by an outbreak or epidemic/pandemic situation.

In 2015/16, fewer control purchase operations were conducted this year principally to reduce the financial cost of conducting control purchase operations outside of normal business hours.

Health promotion and preventive intervention services

In the sub-region, the Capital & Coast DHB Public Health Nurse (PHN) new referrals were achieved. However, this target does not include the throat swabbing work the PHNs in Porirua undertake. Some of the throat swabbing work had been moved to community health workers (CHWs) and this reverted back to PHNs when the CHWs resigned and we knew the programme was ending in 30 June 2016. The PHNs in Porirua have also carried out the supply of antibiotics for GAS+ patients; this does not occur at Wairarapa and Hutt Valley DHBs.

Breastfeeding Wairarapa is a community driven network working to support breastfeeding mums and their families. The organisations involved in Breastfeeding Wairarapa are Wairarapa DHB Maternity Services, Plunket, Whaiora, Parents as First Teachers (PAFT), Parents Centre, Regional Public Health – Wairarapa and Lead Maternity Carers (LMCs). The aim is to "Promote, increase and maintain high breastfeeding rates for all and encourage greater public awareness and community engagement in supporting families to breastfeed for at least six months." Regular drop in clinics are held across the Wairarapa on a weekly basis.

The Green Prescription (GRx) referral target was increased by approximately 25% from the 2014/15 year and 96% of the new referral target was achieved. Increased promotion of the GRx programme is indicated. Within this result 91% (453/500) of the GRxPlus referral target for the year was achieved.

Smoking Cessation Services

From 2015/16, all smokers enrolled in a primary care practice are required to be given brief advice and support to quit smoking, regardless of whether they were seen or not by a general practitioner. Previously, only smokers who were seen by a general practitioner in the last 12 months were required to be given brief advice and support to quit smoking. This change in the measure requires more pro-active follow-up and advice for all people, rather than opportunistic interventions when patients are attending an appointment. Compass Health Wairarapa has made steady progress since the target definition changed improving from 78% in Quarter 1 to 87% in Quarter 4 2015/16.

An audit of those who have completed ABC training has been completed in the Emergency Department. Monthly reports with a breakdown of patients who have missed their brief advice will continue to be sent until the target has been met and sustained.

Immunisation services

In Wairarapa DHB, there were 123 children aged 24 months eligible for immunisation in the most recent quarter, with 116 fully immunised. There were six children for whom immunisation was declined. This results in only one child not fully immunised for this age group. There were also 116 eligible 8 month olds this quarter, with 111 fully immunised. There were three 8 month olds for whom immunisation was declined. This results in only two children not fully immunised for this age group. There is regular contact between DIF, NIR and OIS to discuss emergent issues relating to the delivery of service to overdue children/ whānau.

Screening services

The Wairarapa team have met both Before School Check targets for this financial year. The overall target has been met and the DHB has over performed in terms of the high deprivation target. New promotional material and tools have been received from the Ministry of Health and have been distributed to all medical centres. In the reporting quarter, there have been no workforce issues in terms of sickness or unexpected leave.

Wairarapa DHB has not achieved the percentage of eligible women aged 25 – 69 having had a cervical smear in the last 3 years for Maori women, however it has increased on the prior year. They have however achieved the target for breast screening for Maori women with more work being done to increase the percentage of Pacific Island women. Work is being done with PHOs and the community to positively influence this percentage for the next financial year.

Mobile rosters have changed so that screening is more accessible for priority women with the mobile now going annually to the Wairarapa.

3.3.2 Output Class: Early Detection & Management Services

Description

Early detection and management services cover a broad scope and scale of services provided across the continuum of care activities to maintain, improve and restore people's health. These services include detection of people at risk and with early disease and more effective management and coordination of people with long-term conditions. These services are by nature more generalist, usually accessible from multiple providers, and at a number of different locations.

Context

New Zealand is experiencing an increasing prevalence rate of long-term conditions such as diabetes and cardiovascular disease, and some population groups suffer from these conditions more than others, for example, Māori and Pacific people, older people and those on lower incomes. The health system is also experiencing increasing demand for acute and urgent care services. For our DHB, diabetes, COPD, asthma, and chronic respiratory conditions are significant long-term conditions that are prevalent in our population. Early detection and management services based in the community deliver earlier identification of risk, provide opportunity to intervene in less invasive and more cost-effective ways, and reduce the burden of long-term conditions through supported self-management (avoidance of complications, acute illness and crises). These services deliver coordination of care, ultimately supporting people to maintain good health.

Outputs

Primary care services: are offered in local community settings by teams of general practitioners (GPs), registered nurses, nurse practitioners, and other primary health care professionals; aimed at improving, maintaining, or restoring health. High numbers of enrolment with general practice are indicative of engagement, accessibility, and responsiveness of primary care services. These services keep people well by: intervening early to detect, manage, and treat health conditions (e.g., health checks); providing education and advice so people can manage their own health; and, reaching those at risk of developing long-term or acute conditions. Oral health services: are provided by registered oral health professionals to assist people in maintaining healthy teeth and gums. A reduction in the number of young children requiring invasive complex oral health treatment (under general anaesthetic) is indicative of the quality of early intervention and of public health education and messages regarding the importance of good oral health. High enrolment indicates engagement, while timely examination and treatment indicates a well-functioning, efficient service. Pharmacy services: Include provision and dispensing of medicines and are demand-driven. As long-term conditions become more prevalent, we are likely to see an increased dispensing of pharmaceutical items. To improve service quality are introducing medication management for people on multiple medications to reduce potential negative interactive effects. We are implementing safe and effective pharmacy services across settings of care (hospital and community).

How we measure the performance of our Prevention Services:

Outputs	Measure	Type of Measure	2014/15 Performance	2015/16 Target	2015/16 Performance	2015/16 Achievement
Primary care services	The percentage of the DHB-domiciled population that is enrolled in a PHO	C, DoD	M: 7,060 T: 42,471	≥99%	98%	Not achieved
	The rate ratio of nurse and GP visits by high need patients versus non high need patients[24]	C, DoS	1.13	≥1.12	1.13	Achieved
	The percentage of practices with a current Diabetes Practice Population Plan†	Q, DoS		100%	100%	Achieved
	Health Target: The percentage of the eligible population assessed for CVD risk in the last five years	C, DoS	90%	≥90%	90%	Achieved
	The number of new and localised Health Pathways in the sub-region†	Q		≥150	172	Achieved
	The average number of users (per month) of the Health Pathways website†	V		≥1,000	1,375	Achieved
Oral health	The percentage of children under 5	C, DoD	2014: 82%	2015: ≥85%	2015: 91%	Achieved

24 The ratio (high need: non high need) of standardised GP and nurse utilisation rate. This measures equity of access, as those with high needs are likely to require more visits.

Outputs	Measure	Type of Measure	2014/15 Performance	2015/16 Target	2015/16 Performance	2015/16 Achievement
services	years enrolled in DHB-funded dental services[25]			2016: ≥85%		
	The percentage of adolescents accessing DHB-funded dental services	C, DoD	2014: 67%	2015: ≥85% 2016: ≥85%	2015: 67%	Not achieved
Pharmacy services	The number of initial prescription items dispensed†	V, DoS		Est. 432,000	444,603	Achieved
	The percentage of the DHB-domiciled population that were dispensed at least one prescription item†	C, DoD		Est. 80%	80%	Achieved
	The number of people registered with a Long Term Conditions programme in a pharmacy†	V, DoS		Est. 2,100	1,997	Not achieved
	The number of people participating in a Community Pharmacy Anticoagulant Management service in a pharmacy†	V, DoS		Est. 35	43	Achieved

25 As oral health measures are reported on a calendar year the Ministry of Health requests targets be specified for each year.

Commentary

Primary Care Services

All seven practices in the Wairarapa have completed annual practice plans. As part of this process, practices are allocated funding for long term condition management and working with high needs populations. There is a specific Māori and Pacific section in these plans in which practices identify how they will make improvements to outcomes. During 2015/2016, the DHB, Compass Health Wairarapa and Masterton Medical introduced a new youth clinic for the region, Youth Kinex.

The acute demand group working for the Tihei Alliance Leadership Team is developing a longer term community communications strategy on the appropriate place for people to access health services.

All general practices in Wairarapa DHB have implemented diabetes care improvement plans. These plans are developed and implemented by general practices to provide quality care and management for enrolled patients with diabetes. The plans have all been reviewed and approved during the year by Compass Health Wairarapa.

Wairarapa DHB has achieved the *CVD risk assessment* Health Target. The PHO has continued to support general practices to achieve the target by providing feedback on performance and IT support to ensure that all eligible individuals are encouraged to get a check when due.

The target for the number of new and localised Health Pathways in the sub-region was achieved. More established pathway localisation and development processes, as well as a continually expanding network of engaged collaborators across primary and secondary care has contributed to exceeding the target.

The 2015/16 average number of users per month of the Health Pathways website exceeded the target. Although not formally assessed, the assumption is that the information offered by Health Pathways meets the needs of primary care practitioners and that their use help clinicians be more effective during consultations and when making referrals.

Oral Health Services

All new born babies are now enrolled with the oral health service and parents are invited to come into the clinic for group visits when the babies are around 2-3 months of age (before teething). As this continues the percentages will continue to increase.

To improve the percentage of adolescents accessing DHB-funded dental services, we work closely with all practices within the Wairarapa, including the new practice in Greytown. This practice is close to the college in South Wairarapa. We are also working with Māori health providers to encourage Māori adolescents to attend. Practices have told us they do not understand this result as they do not have a high rate of non-attendees and at year 8 all students from the oral health service are transferred to them. We are investigating this further with the practices.

Pharmacy Services

The number of people in this service reflects a national trend. Improved access to primary and secondary care information about patient conditions will enable pharmacies to more easily assess risk and select patients needing the higher level of care that this service would provide.

There has been steady uptake in the number of people participating in the Community Pharmacy Anticoagulant Management (CPAM) service and some pharmacies are now at their maximum contracted volume. The DHB continues to encourage pharmacies to work with GPs to carefully select the patients who will benefit most from this higher cost service. Some pharmacies are at their maximum contracted volume. The DHB continues to encourage pharmacies to work with GPs to carefully select the patients who will benefit most from this higher cost service.

3.3.3 Output Class: Intensive Assessment & Treatment Services

Description

Intensive assessment and treatment services are complex hospital services. They are provided by specialists and other health care professionals in a hospital setting. Hospitals often provide these services because clinical expertise (across a range of areas) and specialist equipment need to be located in the same place. These services include inpatient, outpatient, emergency and urgent care services. Our DHB provides an extensive range of intensive treatment and complex specialist services to our population. Our DHB also funds some tertiary and quaternary services that are provided by other DHBs, private hospitals, and private providers for our population. A proportion of these services are driven by demand, such as unplanned (acute) and maternity services. For planned (elective) services, access is determined by capability, capacity, resources, clinical triage, national service coverage agreements, and treatment thresholds.

Context

Equitable and timely access to intensive assessment and treatment can significantly improve people's quality of life, either through early intervention (e.g. removal of an obstructed gallbladder to prevent repeat attacks of abdominal pain/colic, and to reduce the risk of cancer and infection) or through corrective action (e.g. major joint replacements to relieve pain and improve activity). Flexible and responsive assessment and treatment services also support improvements across the whole system, so that people can receive support in the community with confidence that complex intervention is available if needed. As an owner and provider of these services, the DHB is also concerned with the quality of the services being provided. Adverse events in hospital cause harm to patients, drive unnecessary costs, and shift resources away from other services. Improving our service delivery, systems, and processes will improve patient safety, reduce the number of hospital events causing harm, and improve outcomes for people using our services. There are expectations for the delivery of increased elective surgical volumes, a reduction in waiting times for treatments, and increased clinical leadership around improving service delivery and safety to improve the quality and efficiency of care being delivered. The changes being made to meet expectations are providing opportunities to introduce innovative clinically led service delivery models and improve productivity within our hospital services.

Outputs

Medical and surgical services: Unplanned hospital services (Acute services) are for illnesses that have an abrupt onset and are often of short duration and rapidly progressive, creating an urgent need for care. Hospital-based acute services include emergency departments, short-stay acute assessments and intensive care services. Planned Services (Elective surgery) are services for people who do not need immediate hospital treatment and are 'booked' services. This also includes non-medical interventions (coronary angioplasty) and specialist assessments (first assessments, follow-ups, or preadmission assessments). National Elective Services Patient Flow Indicators (ESPIs) are indicative of a successful and responsive service; addressing increasing needs and matching commitments to capacity. Cancer services: Cancer services include diagnosis and treatment services. Cancer treatment in the sub-region is delivered by the Wellington Blood and Cancer Centre. Mental health and addictions services: Specialist Mental Health Services are services for people who are most severely affected by mental illness or addictions and include

assessment, diagnosis, treatment and rehabilitation, as well as crisis response when needed, and as required under the Mental Health Act. Currently the expectation established in the National Mental Health Strategy is that specialist services (including psychiatric disability services) will be available to 3% of the population. Utilisation rates will be monitored across age groups and ethnicities to ensure service levels are maintained and to demonstrate responsiveness.

How we measure performance of our Intensive Assessment & Treatment Services

Outputs	Measure	Type of Measure	2014/15 Performance	2015/16 Target	2015/16 Performance	2015/16 Achievement
Medical and surgical services	**Health Target:** The percentage of patients admitted, discharged or transferred from ED within six hours	T, DoS	96%	≥95%	96%	Achieved
	Health Target: The number of surgical elective discharges	V, DoD	1,966	2,395	2,480	Achieved
	The standardised[26] inpatient average length of stay (ALOS) in days, Acute[27]	T, DoS	3.47	≤2.41	2.37	Achieved
	The standardised inpatient average length of stay (ALOS) in days, Elective	T, DoS	2.92	≤1.57	1.47	Achieved
	The rate of inpatient falls causing harm, per 1,000 bed days	Q, DoS	0.4	≤1.95	1.15	Achieved
	The rate of Hospital Acquired Pressure Injuries, per 1,000 bed days	Q, DoS	7[28]	<0.65	0.65	Achieved
	The rate of identified medication errors causing harm, per 1,000 bed days	Q, DoS	0.4	<0.71	0.90	Not achieved

26 Standardised to diagnosis-related group (DRG) and co-morbidity/complication codes. See the Ministry of Health website (www.moh.govt.nz) for more information about how this is calculated.
27 This measure is provided by the Ministry of Health one quarter in arrears, so performance is for 12 months ending March 2014 (2013/14 baseline) and 12 months ending March 2016 (2015/16 performance).
28 This measure was not reported as a rate per 1,000 in the previous annual report.

Outputs	Measure	Type of Measure	2014/15 Performance	2015/16 Target	2015/16 Performance	2015/16 Achievement
	The weighted average score in the Patient Experience Survey[29†]	Q, DoS		>8.0	Communication: 8.8 Coordination: 8.8 Partnership: 9.4 Physical and emotional needs: 9.4	Achieved
	The percentage of "DNA" (did not attend) appointments for outpatient *first* specialist assessments	Q, DoS	7%	≤8.0%	7.3%	Achieved
	The percentage of "DNA" (did not attend) appointments for outpatient *follow-up* specialist appointments[†]	Q, DoS		≤6.4%	6.9%	Not achieved
Cancer services	The percentage of patients, ready for treatment, who waited less than four weeks for radiotherapy or chemotherapy	T, DoD	100%	100%	99.3%	Not achieved

29 In this measure, patients rate aspects of their hospital visit, with 10 being the best possible score. A person's age and gender affects how they respond in the Patient Experience Survey. The weighted score accounts for differences in the age and gender structure between DHBs to allow comparison.

Outputs	Measure	Type of Measure	2014/15 Performance	2015/16 Target	2015/16 Performance	2015/16 Achievement
	Health Target: The percentage of patients with a high suspicion of cancer and a need to be seen within two weeks that received their first cancer treatment (or other management) within 62 days of being referred[30]	T, DoD	68%	≥85%	69%	Not achieved
Mental health and addiction services	The number of people accessing secondary mental health services	V	1,915	Est. Total: 2,060	2,082	Achieved
	The percentage of people accessing secondary mental health services[†]	C		≥4.7%	4.8%	Achieved
	The percentage of patients 0-19 referred to non-urgent child & adolescent mental health services that were seen within eight weeks[31]	T, DoS	95%	≥95%	85%	Not achieved
	The percentage of patients 0-19 referred to non-urgent child & adolescent addictions services that were seen within eight weeks	T, DoS	89%	≥95%	97%	Achieved

30 This is a new measure that replaced the 'Shorter Waits for Cancer Treatment' Health Target from 1 October 2014.
31 This measure is provided by the Ministry of Health one quarter in arrears, so performance is for 12 months ending March 2014 (2013/14 baseline) and 12 months ending March 2016 (2015/16 performance).

Commentary

Medical and surgical services

The short stays in emergency departments Health Target has been achieved for 2015/16, with detailed analysis of ED breaches and CNM leadership to improve processes around patient flow.

The average length of stay for patients in our Medical-Surgical Ward is still a priority, with active 'pulling' of patients to rehab and early discharge planning. Excellent leadership and team work has meant this measure has been consistently achieved

The falls prevention working group continues to actively introduce and monitor falls prevention improvements to reduce patient harm from falls in the hospital.

The Guideline Implementation Pressure Injury Group continues to develop and monitor pressure injury prevention initiatives in order to prevent pressure injuries developing for patients whilst in hospital care.

Wairarapa DHB actively encourages reporting of medication errors as an active way of identifying focus areas for improvement. An increase in reporting of medication errors has been noted. The Medicines Committee reviews medication errors on a monthly basis and follows up any identified trends or 'one offs'. A new Medication Management Policy has been introduced alongside education as one way of reducing harm form medication error related events.

Understanding and enhancing the experience of patients in our hospital is a priority, the National Patient Experience survey is one way that helps us review our performance in this area.

Cancer services

The outcome for the percentage of patients ready for treatment who waited less than four weeks for radiotherapy or chemotherapy is a combination of delivery at either Capital & Coast DHB or Mid Central DHB. There has been a slight drop in performance and represents not only complex patients but also the volume of patients being treated.

To achieve the *faster cancer treatment* Health Target, the team are breaking down the pathways and identifying where the delays are. A large number of Wairarapa patients are dependent on other DHBs to deliver their cancer services, and sub-regional meetings are held quarterly to discuss cases that breach.

The new CMO and the Nursing Director are working alongside the Faster Cancer Treatment team at Wairarapa DHB and they are meeting weekly to try and effect change at SMO level. MRI delays had significant impact on the pathway flow of patients in the last quarter but that issue has now been resolved.

Mental health and addiction services

The 3DHB Mental Health, Addictions & Intellectual Disability's Child and Adolescent Mental Health service in Wairarapa have had difficulties recruiting to a senior clinical position and has not had the capacity to meet the demand during this period.

Wairarapa DHB met the target number of people accessing secondary mental health services. Wairarapa DHB met the target percentage of people accessing secondary mental health services including access for Maori population group.

Wairarapa DHB achieved 85% (target 95%) for the number of patients 0-19 referred to non-urgent child & adolescent mental health services within eight weeks. This was a drop in performance from 2014/15 and was largely driven by the unexpected departure of 50% of the service's SMO provision and subsequent difficulty in recruiting. Recruitment to cover this role for 12 months has now been successful and local data shows the service currently achieving the 96% on this target.

Wairarapa DHB met the target number of patients 0-19 referred to non-urgent child & adolescent addictions services within eight weeks. However, data issues have been identified during 2015/16. Wairarapa DHB is working with the Ministry of Health and non-governmental organisations to rectify data issues reported in 2015/16.

3.3.4 Output Class: Rehabilitation & Support Services

Description

Rehabilitation and support services provide people with the support that they need to maintain their independence, either temporarily while recovering from illness or disability, or over the rest of their lives. Rehabilitation and support services are provided mostly for older people, mental health clients, and clients with complex health conditions. A 'needs assessment', coordinated by Needs Assessment and Service Coordination (NASC), determines which services a person may require. These services may be provided at home, as personal care, community nursing, or community services. Alternatively, people may require long- or short-term residential care, respite, or day services. Support services also include palliative care services for people who have end-stage conditions. It is important that they and their families are supported so that the person can live comfortably, have their needs met in a holistic and respectful way, and die without undue pain and suffering. Rehabilitation and support services may be delivered in coordination with other organisations and agencies, and may include public, private, and part-funding arrangements.

Context

Services that support people to manage their needs and live well, safely and independently in their own homes are considered to provide a much higher quality of life, as a result of staying active and positively connected to their communities. People whose needs are adequately met by these support services are less dependent on hospital and residential services and less likely to experience acute illness or deterioration of their conditions. As a result, effective support services will help to reduce demand for acute services and improve access to other services and interventions. Support services will have a major impact on the sustainability of hospital and specialist services and on the wider health system in general. It will also free up resources for investment into early intervention, health promotion, and prevention services that will help people stay healthier for longer. Our DHB has taken a restorative approach and has introduced individual packages of care to better meet people's needs, including complex packages of care for people assessed as eligible for residential care who would rather remain in their own homes. With an ageing population, it is vital that we ascertain the effectiveness of services in this area and that our DHB uses the InterRAI (International Residential Assessment Instrument) tool to ensure people receive support services that best meet their needs and, where possible, support them to regain maximum functional independence.

Outputs

Disability services: Many disability services are accessed through a Needs Assessment and Service Co-ordination (NASC) service. NASCs are organisations contracted to the DSS, which work with disabled people to help identify their needs and to outline what disability support services are available. They allocate Ministry-funded support services and assist with accessing other supports. Health of older people services: These are services provided to enable people to live as independently as possible and to restore functional ability. Services are delivered in specialist inpatient units, outpatient clinics and also in home and work environments. Specialist geriatric and allied health expertise and advice is also provided to general practitioners, home and community care providers, residential care facilities and voluntary groups.

How we measure performance of our Rehabilitation & Support Services

Outputs	Measure	Type of Measure	2014/15 Performance	2015/16 Target	2015/16 Performance	2015/16 Achievement
Disability services	The number of Disability Forums	V	4	WRDHB: 1 3DHB: 1	WRDHB: 1 3DHB: 1	Achieved
	The number of sub-regional Disability Newsletters†	V		6	8[32]	Achieved
	The total number of hospital staff that have completed the Disability Responsiveness eLearning Module†	Q		200	0	Not Achieved
	The total number of Disability Alert registrations[33†]	Q		500	0	Not Achieved
Health of older people services	The percentage of people 65+ who have received long term home support services in the last three months who have had a comprehensive clinical [InterRAI] assessment and a completed care plan	C, DoS	97%	100%	100%	Achieved
	The total number of InterRAI assessments	V, DoS	494	Est. 1,782[34]	655[35]	Not achieved

32 The form of communication has changed and is equivalent to a newsletter.
33 It is estimated that 23% of the DHB's population has a disability. Disability Alerts help clinicians to identify and respond to the needs of the patients with disabilities. By increasing the number of Disability Alerts, we can improve the quality of care for our patients with disabilities. In addition, Disability Alerts allow us to track outcomes (e.g., length of stay) for patients with disabilities so that we can identify areas in which we need to focus or improve.
34 This is a descriptive measure of volumes only and is not the focus for service improvement or improving health status.
35 Note that there have been changes in the recording and reporting of the number of InterRAI assessments. The methodology for 2014/15 gives an underestimate of performance compared to the methodology for the target.

Outputs	Measure	Type of Measure	2014/15 Performance	2015/16 Target	2015/16 Performance	2015/16 Achievement
	The number of people 65+ who are being supported to live at home	V, DoS	655	Est. 636[36]	653	Achieved
	The percentage of people 65+ receiving DHB-funded HOP support who are being supported to live at home	C, DoS	65%	≥ 66%	65%	Not achieved
	The number of subsidised aged residential care bed days[37]	V, DoS	127,675	Est. 126,250[38]	129,953	Achieved
	The percentage of residential care providers meeting three or more year certification standards	Q, DoS	92%	100%	82%	Not achieved

Commentary

Disability services

Good progress has been made in raising awareness of disability issues and services in the Wairarapa, and it was pleasing that one of our Health Passport volunteers achieved a Prime Minister's award this year for her services in promoting Health Passports.

Wairarapa DHB achieved the output measures related to Disability Forums and Newsletters but it has not achieved the other two output measures yet. The DHB is currently developing a Disability Responsiveness eLearning tool, which will be made available to staff as soon as it is ready. Regarding Disability Alert registrations, the DHB has 98 completed Disability Support Needs forms ready to create alerts when the system is ready but this is unlikely to be before September 2017, when the legacy Patient Management System is scheduled for replacement.

36 This is a descriptive measure of volumes only and is not the focus for service improvement or improving health status.
37 Subsidised bed days are any DHB-funded bed days including top-up clients and people paying less than the maximum client contribution.
38 This is a descriptive measure of volumes only and is not the focus for service improvement or improving health status.

Health of older people services

The 100% target for the percentage of people 65+ who have received long term home support services in the last three months who have had a comprehensive clinical [InterRAI] assessment and a completed care plan is now being achieved.

The total number of InterRAI assessments is a descriptive measure of volumes only and is not the focus for service improvement or improving health status. The DHB is satisfied that all people being referred for an interRAI assessments are receiving them and that these assessments are informing their care plans.

Note that the 2015/16 result shows the total assessments completed in the national interRAI data warehouse. These include RAI-HC & Contact assessments, created in each DHB's office including assessments transferred out of office. The result for 2015/16 is lower than the target because the method of measuring the number of assessments also included reviews and reassessments which are not recorded in the national data warehouse.

There are increased numbers of older people who are being supported to live at home, which is in line with our strategy.

The number of aged subsidised resident care bed days: The DHB aims to support older people to live as independently as possible. This target is therefore not aspirational. Although the target has been achieved, it is closely linked to the measure above.

If a three or more year certification status is not met, Residential facilities may receive a two-year certification period. The two Age Residential Care providers with two-year certification account for 18% of Wairarapa ARC providers. Since there are only a small number of facilities, a small number of facilities with only 2 year certification can change the percentage result dramatically. Reporting in percentages for small numbers can give a distorted result.

FINANCIAL STATEMENTS

CONTENTS

STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSE

For the year ended 30 June 2016

	Note	Group Budget 2016 $000	Group Actual 2016 $000	Group Actual 2015 $000	Parent Actual 2016 $000	Parent Actual 2015 $000
Revenue						
Operating revenue	1	145,076	147,483	139,968	146,245	138,855
Finance revenue	2	6	7	176	109	199
Total revenue		**145,082**	**147,490**	**140,144**	**146,354**	**139,054**
Expenditure						
Workforce costs	3	40,047	45,420	41,610	45,420	41,610
Other operating expenses	4a	26,015	23,095	22,793	22,007	21,807
External providers	4b	46,553	43,679	45,705	43,679	45,705
Inter district flows	4b	30,636	34,166	29,819	34,166	29,819
Total operating expenditure		**143,251**	**146,360**	**139,927**	**145,272**	**138,941**
Operating result before Interest, Depreciation & Capital Charge		**1,831**	**1,130**	**217**	**1,082**	**113**
Interest, Depreciation & Capital Charge						
Interest expense	5	1,539	1,029	1,187	1,029	1,187
Capital charge	5	469	342	629	342	629
Depreciation & amortisation expense	7,8	1,764	1,686	1,737	1,619	1,652
Total Interest, Depreciation & Capital Charge		**3,772**	**3,057**	**3,553**	**2,990**	**3,468**
Surplus/(Deficit)		**(1,940)**	**(1,927)**	**(3,336)**	**(1,908)**	**(3,355)**
Total comprehensive revenue and expense		(1,940)	(1,927)	(3,336)	(1,908)	(3,355)

The accompanying notes form part of the financial statements. Explanations of major variances against budget are provided in note 22.

STATEMENT OF FINANCIAL POSITION

As at 30 June 2016

	Note	Group Budget 2016 $000	Group Actual 2016 $000	Group Actual 2015 $000	Parent Actual 2016 $000	Parent Actual 2015 $000
Assets						
Property, plant & equipment	7a	45,169	40,380	40,838	40,200	40,712
Intangible assets	8	2,902	6,202	4,456	6,087	4,442
Investments	9	806	815	807	918	910
Total non-current assets		**48,877**	**47,397**	**46,101**	**47,205**	**46,064**
Cash & cash equivalents	10	133	191	334	7	11
Inventories	11	797	902	797	902	797
Trade & other receivables	12	3,534	4,659	3,511	4,498	3,349
Assets classified as held for sale	7b	0	50	0	50	0
Total current assets		**4,464**	**5,802**	**4,642**	**5,457**	**4,157**
Total assets		**53,341**	**53,198**	**50,743**	**52,662**	**50,221**

	Note	Group Budget 2016 $000	Group Actual 2016 $000	Group Actual 2015 $000	Parent Actual 2016 $000	Parent Actual 2015 $000
Equity						
Crown equity	13	42,037	42,034	39,037	42,034	39,037
Revaluation reserve	13	5,558	5,558	5,558	5,558	5,558
Retained earnings	13	(40,105)	(40,077)	(38,150)	(40,430)	(38,522)
Total equity		**7,490**	**7,515**	**6,445**	**7,162**	**6,073**
Liabilities						
Interest-bearing loans & borrowings	14	24,803	19,802	21,126	19,802	21,126
Employee benefits	15	563	620	563	620	563
Restricted Funds	16	266	274	266	274	266
Total non-current liabilities		**25,632**	**20,696**	**21,955**	**20,696**	**21,955**
Cash & cash equivalents - overdraft	10	2,190	1,412	1,510	1,412	1,510
Interest-bearing loans & borrowings	14	1,324	6,324	5,069	6,324	5,069
Payables & accruals	17	9,982	9,749	9,882	9,674	9,812
Employee benefits	15	6,723	7,504	5,882	7,393	5,801
Total current liabilities		**20,219**	**24,989**	**22,343**	**24,803**	**22,192**
Total liabilities		**45,851**	**45,685**	**44,298**	**45,499**	**44,147**
Total equity & liabilities		**53,341**	**53,198**	**50,743**	**52,662**	**50,221**

The accompanying notes form part of the financial statements. Explanations of major variances against budget are provided in note 22.

STATEMENT OF CHANGES IN EQUITY

For the year ended 30 June 2016

	Note	Group Budget 2016	Group Actual 2016 $000	Group Actual 2015 $000	Parent Actual 2016 $000	Parent Actual 2015 $000
Balance at 1 July		**6,430**	**6,445**	**9,784**	**6,073**	**9,431**
Net surplus / (deficit) for the year		(1,940)	(1,927)	(3,336)	(1,908)	(3,355)
Other comprehensive revenue and expense		0	0	0	0	0
Total comprehensive revenue and expense		(1,940)	(1,927)	(3,336)	(1,908)	(3,355)
Equity injection from the Crown		3,000	3,000	0	3,000	0
Repayment of equity to the Crown		0	(3)	(3)	(3)	(3)
Movements in equity for the year		3,000	2,997	**(3)**	2,997	**(3)**
Balance at 30 June	13	**7,490**	**7,515**	**6,445**	**7,162**	**6,073**

The accompanying notes form part of the financial statements. Explanations of major variances against budget are provided in note 22.

STATEMENT OF CASH FLOWS

For the year ended 30 June 2016

	Note	Group Budget 2016 $000	Group Actual 2016 $000	Group Actual 2015 $000	Parent Actual 2016 $000	Parent Actual 2015 $000
Cash flows from operating activities						
Operating receipts:						
Government & crown agency revenue		141,625	139,918	139,912	138,502	138,656
Other		3,503	6,417	3,962	6,417	3,937
Interest received		130	51	181	50	179
Payments to suppliers & employees		(143,538)	(144,985)	(141,385)	(143,732)	(140,218)
Capital charge paid		(469)	(226)	(629)	(226)	(629)
Interest paid		(1,070)	(1,032)	(1,187)	(1,032)	(1,187)
Goods and Services Tax (net)		0	(61)	(44)	(61)	(44)
Net cash flows from operating activities	10	**181**	**82**	**810**	**(82)**	**694**
Cash flows from investing activities						
Proceeds from sale of property, plant & equipment		0	0	0	0	0
Dividends received		0	0	0	107	25
Investment in joint venture		0	0	(752)	0	(752)
Acquisition of property, plant & equipment		(1,904)	(1,108)	(394)	(1,020)	(331)
Acquisition of intangible assets		(2,071)	(1,942)	(283)	(1,834)	(265)
Net cash flows from investing activities		**(3,975)**	**(3,050)**	**(1,429)**	**(2,747)**	**(1,323)**

The accompanying notes form part of the financial statements. Explanations of major variances against budget are provided in note 22.

STATEMENT OF CASH FLOWS (CONTINUED)

For the year ended 30 June 2016

	Note	Group Budget 2016 $000	Group Actual 2016 $000	Group Actual 2015 $000	Parent Actual 2016 $000	Parent Actual 2015 $000
Cash flows from financing activities						
Equity injected		3,000	3,000	0	3,000	0
Repayments of loans		(68)	(74)	(60)	(74)	(60)
Repayment of equity		0	(3)	(3)	(3)	(3)
Net cash flows from financing activities		2,932	**2,923**	(63)	**2,923**	(63)
Net increase / (decrease) in cash & cash equivalents		**(862)**	**(45)**	**(682)**	**94**	**(692)**
Cash & cash equivalents at beginning of year		(1,195)	(1,176)	(494)	(1,499)	(807)
Cash & cash equivalents at end of year	**10**	**(2,057)**	**(1,221)**	**(1,176)**	**(1,405)**	**(1,499)**

The accompanying notes form part of the financial statements. Explanations of major variances against budget are provided in note 22.

STATEMENT OF CONTINGENCIES

As at 30 June 2016

	Group Actual 2016 $000	Group Actual 2015 $000	Parent Actual 2016 $000	Parent Actual 2015 $000
Legal proceedings and obligations	0	0	0	0
Total contingent liabilities	**0**	**0**	**0**	**0**
Total contingent assets	**0**	**0**	**0**	**0**

STATEMENT OF COMMITMENTS

As at 30 June 2016

	Group Actual 2016 $000	Group Actual 2015 $000	Parent Actual 2016 $000	Parent Actual 2015 $000
Capital Commitments				
Buildings	11	0	11	0
Clnical equipment	429	86	429	86
Other equipment	48	8	48	8
Intangible assets	853	3	827	3
Total capital commitments	**1,341**	**97**	**1,315**	**97**
Operating Lease Commitments:				
Less than one year	770	741	770	741
One to two years	635	356	635	356
Two to five years	958	461	958	461
Five years	160	207	160	207
	2,523	**1,765**	**2,523**	**1,765**
Total Commitments	**3,864**	**1,862**	**3,838**	**1,862**

The accompanying notes form part of the financial statements. Explanations of major variances against budget are provided in note 22.

STATEMENT OF ACCOUNTING POLICIES

Reporting entity

Wairarapa District Health Board ("DHB") is a Health Board established by the New Zealand Public Health and Disability Act 2000. Wairarapa DHB is a crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand. Wairarapa DHB is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000, the Financial Reporting Act 1993, the Public Finance Act 1989 and the Crown Entities Act 2004.

Wairarapa DHB has designated itself as a public benefit entity (PBE) for financial reporting purposes.

The consolidated financial statements of Wairarapa DHB for the year ended 30 June 2016 comprise Wairarapa DHB and its subsidiary Biomedical Services New Zealand Limited (together referred to as "WDHB") and joint venture the Central Region Technical Advisory Service Limited (CRTAS) which is one sixth owned. The financial statements were authorised for issue by the Wairarapa District Health Board on 31 October 2016.

Wairarapa DHB's primary objective is to deliver health, disability and mental health services to the community within its district.

Statement of compliance

The consolidated financial statements have been prepared in accordance with Generally Accepted Accounting Practice in New Zealand (NZGAAP) as appropriate for Public Benefit Entities.

The financial statements have been prepared in accordance with Tier 1 PBE accounting standards.

Basis of preparation

Functional and presentation currency

The financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars ($000). The functional currency of the DHB and its subsidiaries and joint venture is New Zealand dollars.

Measurement base

The financial statements have been prepared on the historical cost basis except where modified by the revaluation of land, buildings and forward exchange contracts at fair value. The following assets and liabilities are stated at their fair value: derivative financial instruments (foreign exchange and interest rate swap contracts), financial instruments classified as available-for-sale, land and buildings, and investment property.

Non-current assets held for sale and disposal groups held for sale are stated at the lower of carrying amount and fair value less costs to sell.

Critical accounting estimates and assumptions

The preparation of financial statements in conformity with PBE Accounting standards requires management to make judgements, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, income and expenses. The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances, the results of which form the basis of making the judgements about carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Going concern

The going concern principle has been adopted in the preparation of these financial statements. The Board, after making enquiries, has a reasonable expectation that the DHB has adequate resources to continue operations for the foreseeable future based on current trading terms and legislative requirements. The Board has reached this conclusion having regard to circumstances which it considers likely to affect the DHB during the period of one year from the date of signing the 2015/16 financial statements, and to circumstances which it knows will occur after that date which could affect the validity of the going concern assumption (as set out in its current Statement of Intent). The key considerations are set out below.

Letter of comfort

The Board has received a letter of comfort dated 26 September 2016 from the Ministers of Health and Finance which states that deficit support will be provided where necessary to maintain viability.

Operating and cash flow forecasts

The Board has considered forecast information relating to operational viability and cash flow requirements. The Board is satisfied that there will be sufficient cash flows generated from operating activities to meet the investing and financing cashflow requirements of the DHB as set out in its current Statement of Intent and based on current trading terms and legislative requirements.

Borrowing covenants and forecast borrowing requirements

The forecasts for the next three years prepared by the DHB show that the peak borrowing requirement will not exceed the available borrowing facilities. Furthermore, the forecast borrowing requirements can be met without breaching covenants or other borrowing restrictions.

While the Board is confident in the ability of the DHB to continue as a going concern, if the forecast information relating to operational viability and cash flow requirements is not achieved there would be significant uncertainty as to whether the DHB would be able to continue as a going concern based on current trading terms and legislative requirements.

If the DHB was unable to continue as a going concern adjustments may have to be made to reflect the situation that assets may have to be realised and liabilities extinguished other than in the normal course of business and at amounts which could differ significantly from the amounts at which they are currently reported in the statement of financial position.

Changes in accounting policies

There have been no changes in accounting policies during the financial year.

Standards issued and not yet effective and not early adopted

In 2015, the External Reporting Board issued Disclosure Initiative (Amendments to PBE IPSAS 1), 2015 Omnibus Amendments to PBE Standards, and Amendments to PBE Standards and Authoritative Notices as a Consequence of XRB A1 and Other Amendments. These amendments apply to PBEs with reporting periods beginning on or after 1 January 2016. WDHB will apply these amendments in preparing its 30 June 2017 financial statements. WDHB expects there will be not effect in applying these amendments.

Basis for consolidation

Subsidiaries

Subsidiaries are entities controlled by WDHB. Control exists when WDHB has the power, directly or indirectly, to govern the financial and operating policies of an entity so as to obtain benefits from its activities. In assessing control, potential voting rights that presently are exercisable or convertible are taken into account. The financial statements of subsidiaries are included in the consolidated financial statements from the date that control commences until the date that control ceases.

Joint ventures

Joint ventures are those entities over whose activities WDHB has joint control, established by contractual agreement. The consolidated financial statements include WDHB's interest in joint ventures, using the equity method, from the date that joint control commences until the date that joint control ceases.

Transactions eliminated on consolidation

Intra-group balances and any unrealised gains and losses or revenue and expenses arising from intra-group transactions are eliminated in preparing the consolidated financial statements. Unrealised gains arising from transactions with associates and jointly controlled entities are eliminated to the extent of WDHB's interest in the entity. Unrealised losses are eliminated in the same way as unrealised gains but only to the extent that there is no evidence of impairment.

Budget figures

The budget figures are those approved by the DHB in its Annual Plan and included in the Statement of Intent and Statement of Performance Expectations tabled in Parliament.

The budget figures have been prepared in accordance with NZGAAP. Those standards are consistent with the accounting policies adopted by WDHB for the preparation of these financial statements.

Goods and services tax

All amounts are shown exclusive of Goods and Services Tax (GST), except for receivables and payables that 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 or payables 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

Commitments and Contingencies are disclosed exclusive of GST.

Revenue

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

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

Crown funding

The vast majority of revenue is provided through an appropriation in association with a Crown Funding Agreement. Revenue received is restricted in its use for the purpose of the DHB meeting its objectives. Revenue is recognised monthly in accordance with the Crown Funding Agreement payment schedule, which allocates the appropriation equally throughout the year.

ACC contracted revenue

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

Revenue for other DHBs

Inter district patient inflow revenue occurs when a patient treated within the WDHB region is domiciled outside of Wairarapa. The MoH credits WDHB with a monthly amount based on estimated patient treatment for non-Wairarapa residents within Wairarapa. An annual wash up occurs at year end to reflect the actual non-Wairarapa patients treated at Wairarapa DHB.

Interest Revenue

Interest revenue is recognised using the effective interest method.

Revenue relating to service contracts

WDHB is required to expend all monies appropriated within certain contracts during the year in which it is appropriated. Should this not be done, the contract may require repayment of the money or WDHB, with the agreement of the Ministry of Health, may be required to expend it on specific services in subsequent years. The amount unexpended is recognised as a liability.

Goods sold and services rendered

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

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

Rental Revenue

Rental revenue from investment property is recognised in the statement of comprehensive revenue and expense on a straight-line basis over the term of the lease. Lease incentives granted are recognised as an integral part of the total rental revenue over the lease term.

Expenses

Capital charge

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

Interest expense

The DHB has elected to defer the adoption of the revised NZ IAS 23 Borrowing Costs (Revised 2007) in accordance with the transitional provisions of NZ IAS 23 that are applicable to public benefit entities. Therefore, all borrowing costs are recognised as an expense in the financial year in which they are incurred.

Operating lease payments

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

Payments made under operating leases are recognised in the statement of comprehensive revenue and expense in the periods in which they are incurred. Lease incentives received are recognised in the surplus or deficit over the lease term as an integral part of the total lease expense.

Finance lease payments

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

At the commencement of the lease term, finance leases 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 amount recognised as an asset is depreciated over its useful life. If there is no certainty as to whether the DHB 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.

Minimum lease payments are apportioned between the finance charge and the reduction of the outstanding liability. The finance charge is allocated to each period during the lease term on an effective interest basis.

Net financing costs

Net financing costs comprise interest paid and payable on borrowings calculated using the effective interest rate method, interest received and receivable on funds invested calculated using the effective interest rate method, dividend income and gains and losses on hedging instruments that are recognised in the statement of comprehensive revenue and expense.

The interest expense component of finance lease payments is recognised in the statement of comprehensive revenue and expense using the effective interest rate method.

Dividend income is recognised in the statement of comprehensive revenue and expense when the shareholder's right to receive payment is established.

Non-current assets held for sale

Non-current assets held for sale are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. Immediately before the classification of assets as held for sale, the measurement of the assets (and all assets and liabilities in a disposal group) is brought up-to-date in accordance with applicable PBE Accounting standards. Then, on initial classification as held for sale, a non-current asset and/or a disposal group is recognised at the lower of its carrying amount and its fair value less costs to sell.

Impairment losses on initial classification as held for sale are included in the statement of comprehensive income, even when the asset was previously revalued. The same applies to gains and losses on subsequent re-measurement.

Non-current assets held for sale (including those that are part of the disposal group) are not depreciated or amortised while they are classified as held for sale.

Income tax

WDHB is a crown entity under the New Zealand Public Health and Disability Act 2000, section 169 of the Crown Entities Act 2004 and is exempt from income tax under section CW38 of the Income Tax Act 2007.

Foreign currency

Foreign currency transactions

Transactions in foreign currencies are translated at the foreign exchange rate ruling at the date of the transaction. Monetary assets and liabilities denominated in foreign currencies at the balance date are translated to NZD at the foreign exchange rate ruling at that date. Foreign exchange differences arising on translation are recognised in the statement of comprehensive revenue and expense. Non-monetary assets and liabilities that are measured in terms of historical cost in a foreign currency are translated using the exchange rate at the date of the transaction. Non-monetary assets and liabilities denominated in foreign currencies that are stated at fair value are translated to NZD at foreign exchange rates ruling at the dates the fair value was determined.

Property, plant and equipment

Classes of property, plant and equipment

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

land
buildings
clinical equipment
information technology
motor vehicles
other plant and equipment
work in progress.

Owned assets

Revaluation

Except for land and buildings and the assets vested from the hospital and health service (see below), items of property, plant and equipment are stated at cost, less accumulated depreciation and impairment losses. The cost of self-constructed assets includes the cost of materials, direct labour, the initial estimate, where relevant, of the costs of dismantling and removing the items and restoring the site on which they are located, and an appropriate proportion of direct overheads.

Land and buildings are revalued to fair value as determined by an independent registered valuer with sufficient regularity to ensure the carrying amount is not materially different to fair value, and at least every five years. Any increase in value of a class of land and buildings is recognised directly to equity unless it offsets a previous decrease in value recognised in the statement of comprehensive revenue and expense. Any decreases in value relating to a class of land and buildings are debited directly to the revaluation reserve, to the extent that they reverse previous surpluses and are otherwise recognised as an expense in the statement of comprehensive revenue and expense.

Revaluation movements are accounted for on a class-of-asset basis.

Additions

The cost of an item of property, plant, and equipment is recognised as an asset only when it is probable that service potential associated with the item will flow to the DHB and the cost of the item can be measured reliably. Additions to property, plant and equipment between valuations are recorded at cost.

Where material parts of an item of property, plant and equipment have different useful lives, they are accounted for as separate components of property, plant and equipment.

Property, plant and equipment vested from the hospital and health service

Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets of Wairarapa Health Limited (a hospital and health service company) vested in WDHB on 1 January 2001. Accordingly, assets were transferred to WDHB at their net book values as recorded in the books of the hospital and health service. In effecting this transfer, the health board has recognised the cost (or in the case of land and

buildings – the valuation) and accumulated depreciation amounts from the records of the hospital and health service. The vested assets will continue to be depreciated over their remaining useful lives.

Disposal of property, plant and equipment

Where an item of plant and equipment is disposed of, the gain or loss recognised in the statement of comprehensive revenue and expense is calculated as the difference between the net sales price and the carrying amount of the asset. When revalued assets are sold, the amounts included in revaluation reserves in respect of those assets are transferred to accumulated surpluses.

Properties intended for sale

Properties intended for sale are valued at the lower of cost or net realisable value.

Leased assets

Leases where WDHB assumes substantially all the risks and rewards of ownership, whether or not title is eventually transferred are classified as finance leases. The assets acquired by way of finance lease are stated at an amount equal to the lower of their fair value and the present value of the minimum lease payments at inception of the lease, less accumulated depreciation and impairment losses.

The property held under finance leases and leased out under operating lease is classified as investment property and stated at fair value. Property held under operating leases that would otherwise meet the definition of investment property may be classified as investment property on a property-by-property basis.

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 WDHB. All other costs are recognised in the statement of comprehensive revenue and expense as an expense as incurred.

Depreciation

Depreciation is provided on a straight line basis on all property, plant and equipment other than land at rates that will write off the cost (or valuation) of the assets to their estimated residual values over their useful lives. The useful lives and associated depreciation rates of major classes of assets have been estimated as follows:

Class of asset	Estimated life	Depreciation Rates
Buildings (including components)	2 to 50 years	2% - 50%
Clinical equipment	2.5 to 15 years	6.67% - 40%
Information technology	2.5 to 15 years	6.67% - 40%
Motor vehicles	5 to 12.5 years	8% - 20%
Other plant and equipment	2.5 to 15 years	6.67% - 40%

The residual value of assets is reassessed annually.

Work in progress is recognised at cost, less impairment, and is not depreciated. The total cost of a project is transferred to the appropriate class of asset on its completion and then depreciated.

Intangible assets

Intangible assets comprise computer software products acquired by WDHB and are stated at cost less accumulated amortisation and impairment losses.

Subsequent expenditure

Subsequent expenditure on intangible assets is capitalised only when it increases the service potential or future economic benefits embodied in the specific asset to which it relates. All other expenditure is expensed as incurred.

Amortisation

Amortisation is provided on a straight-line basis over the estimated useful lives of intangible assets unless such lives are indefinite. Intangible assets with an indefinite useful life are tested for impairment at each balance sheet date. Other intangible assets are amortised from the date they are available for use. The estimated useful lives are as follows:

Type of asset	Estimated life	Depreciation Rates
Software	2 to 10 years	10% - 50%

The amortisation charge for each year is recognised in the surplus or deficit.

Impairment

The carrying amounts of WDHB's assets, inventories and inventories held for distribution are reviewed at each balance date to determine whether there is any indication of impairment. If any such indication exists, the assets' recoverable amounts are estimated.

For intangible assets that have an indefinite useful life and intangible assets that are not yet available for use, the recoverable amount is estimated at each balance sheet date and was estimated at the date of transition.

If the estimated recoverable amount of an asset is less than its carrying amount, the asset is written down to its estimated recoverable amount and an impairment loss is recognised in the surplus or deficit.

An impairment loss on property, plant and equipment revalued on a class of asset basis is recognised directly against any revaluation reserve in respect of the same class of asset to the extent that the impairment loss does not exceed the amount in the revaluation reserve for the same class of asset.

When a decline in the fair value of an available-for-sale financial asset has been recognised directly in equity and there is objective evidence that the asset is impaired, the cumulative loss that had been recognised directly in equity is recognised in the statement of comprehensive revenue and expense even though the financial asset has not been derecognised. The amount of the cumulative loss that is recognised in the statement of comprehensive revenue and expense is the difference between the acquisition cost and

current fair value, less any impairment loss on that financial asset previously recognised in the statement of comprehensive revenue and expense.

Calculation of recoverable amount

The estimated recoverable amount of receivables carried at amortised cost is calculated as the present value of estimated future cash flows, discounted at their original effective interest rate. Receivables with a short duration are not discounted.

Estimated recoverable amount of other assets is the greater of their fair value less costs to sell and value in use. Value in use is calculated differently depending on whether an asset generates cash or not. For an asset that does not generate largely independent cash inflows, the recoverable amount is determined for the cash-generating unit to which the asset belongs.

For non-cash generating assets that are not part of a cash generating unit value in use is based on depreciated replacement cost (DRC). For cash generating assets value in use is determined by estimating future cash flows from the use and ultimate disposal of the asset and discounting these to their present value using a pre-tax discount rate that reflects current market rates and the risks specific to the asset.

Impairment gains and losses for items of property, plant and equipment that are revalued on a class of assets basis are also recognised on a class basis.

Reversals of impairment

Impairment losses are reversed when there is a change in the estimates used to determine the recoverable amount.

An impairment loss on an equity instrument investment classified as available-for-sale or on items of property, plant and equipment carried at fair value is reversed through the relevant reserve. All other impairment losses are reversed through the surplus or deficit.

An impairment loss is reversed only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised.

Investments

Investments, including those in subsidiary and associated companies, are stated at the lower of cost and net realisable value. Any decreases are recognised in the surplus or deficit.

Debtors and other receivables

Trade and other receivables are initially recognised at fair value and subsequently stated at amortised cost less impairment losses. Bad debts are written off during the period in which they are identified.

Inventories

Inventories are stated at the lower of cost and net realisable value. Net realisable value is the estimated selling price in the ordinary course of business, less the estimated costs of completion and selling expenses.

Cost is based on weighted average cost.

Inventories held for distribution

Inventories held for distribution are stated at the lower of cost and current replacement cost.

The amount of any write-down for the loss of service potential is recognised in surplus or deficit in the period of the write-down.

Cash and cash equivalents

Cash and cash equivalents includes cash balances, deposits held at call with banks, other highly liquid investments with original maturities of three months or less, and bank overdrafts. Bank overdrafts are repayable on demand and form an integral part of WDHB's cash management and are included as a component of cash and cash equivalents for the purpose of the statement of cash flows.

Bank overdrafts are shown within borrowings in current liabilities in the statement of financial position.

Interest-bearing borrowings

Interest-bearing borrowings are recognised initially at fair value less attributable transaction costs. Subsequent to initial recognition, interest-bearing 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.

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

Employee benefits

Defined contribution schemes

Obligations for contributions to defined contribution schemes including Kiwisaver are recognised as an expense in the statement of comprehensive revenue and expense as incurred.

Defined benefit schemes

WDHB's net obligation in respect of defined benefit pension schemes is calculated separately for each scheme by estimating the amount of future benefit that employees have earned in return for their service in the current and prior periods; that benefit is discounted to determine its present value, and the fair value of any plan assets is deducted. The discount rate is the yield at the balance sheet date on New Zealand government bonds that have maturity dates approximating to the terms of WDHB's obligations. The calculation is performed by a qualified actuary using the projected unit credit method.

When the benefits of a scheme are improved, the portion of the increased benefit relating to past service by employees is recognised as an expense in the statement of comprehensive income on a straight-line basis over the average period until the benefits become vested. To the extent that the benefits vest immediately, the expense is recognised immediately in the surplus or deficit.

All actuarial gains and losses as at 1 July 2006, the date of transition to NZIFRSs, were recognised. Likewise, all actuarial gains and losses that arise subsequent to the transition date in calculating WDHB's obligation in respect of a scheme are recognised in the surplus or deficit.

Long service leave, sabbatical leave and retirement gratuities

WDHB's net obligation in respect of long service leave, sabbatical leave and retirement gratuities is the amount of future benefit that employees have earned in return for their service in the current and prior periods. The obligation is calculated using the projected unit credit method and is discounted to its present value. The discount rates used for the 2016 valuation are based on the weighted average of bond yields such that the estimated term of the bonds is consistent with the estimated term of the liabilities. This approach is consistent with the requirements of PBE IPSAS 25.

Annual leave, conference leave, sick leave and medical education leave

Annual leave, sick leave and medical education leave are short-term obligations and are calculated on an actual basis at the amount WDHB expects to pay. WDHB accrues the obligation for paid absences when the obligation both relates to employees' past services and it accumulates.

Provisions

A provision is recognised for future expenditure of uncertain amount or timing when there is a present obligation (either legal or constructive) as a result of a past event, it is probable that an outflow of future economic benefits will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation.

A provision is recognised when WDHB 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 the 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.

Restructuring

A provision for restructuring is recognised when WDHB has approved a detailed and formal restructuring plan, and the restructuring has either commenced or has been announced publicly. Future operating costs are not provided for.

Creditors and other payables

Trade and other payables are stated at amortised cost using the effective interest rate. Short term payables are recorded at their face value.

Cost of service statements

The cost of service statements, as reported in the Statement of Performance, report the net cost of services for the outputs of WDHB and are represented by the cost of providing the output less all the revenue that can be allocated to these activities.

Cost allocation

WDHB 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 major board activities. Indirect costs are charged to major board activities based on cost drivers and related activity/usage information.

Criteria for direct and indirect costs - Direct costs are those costs directly attributable to a specific WDHB activity. Indirect costs are those costs which cannot be identified in an economically feasible manner with a specific WDHB activity.

Cost drivers for allocation of indirect costs - The cost of internal services not directly charged to board activities is allocated as overheads using appropriate cost drivers such as direct cost ratios, actual usage, staff numbers and floor area.

NOTES TO THE FINANCIAL STATEMENTS

1 OPERATING REVENUE

	Group Actual 2016 $000	Group Actual 2015 $000	Parent Actual 2016 $000	Parent Actual 2015 $000
Health & disability services (Crown appropriation revenue)*	128,179	122,511	128,179	122,511
Other MOH revenue	7,229	7,079	7,229	7,079
Inter district patient inflows	3,320	3,343	3,320	3,343
ACC contract	2,338	2,063	2,338	2,063
Donations & bequests	518	151	518	151
Other revenue	5,899	4,820	4,661	3,707
Total operating revenue	**147,483**	**139,968**	**146,245**	**138,855**

* The appropriation revenue received by the DHB equals the Government's actual expenses incurred in relation to the appropriation, which is a required disclosure from the Public Finance Act

2 FINANCE REVENUE

	Group Actual 2016 $000	Group Actual 2015 $000	Parent Actual 2016 $000	Parent Actual 2015 $000
Interest revenue	55	181	54	179
Dividend revenue	0	0	106	25
Gain/(Loss) on disposal of property, plant & equipment	(48)	(5)	(51)	(5)
Total finance revenue	**7**	**176**	**109**	**199**

3 WORKFORCE COSTS

	Group Actual 2016 $000	Group Actual 2015 $000	Parent Actual 2016 $000	Parent Actual 2015 $000
Wages & salaries	39,540	36,855	39,540	36,855
Payments to contracted workforce	4,231	4,326	4,231	4,326
Increase/(decrease) in liability for employee entitlements	1,649	429	1,649	429
Total workforce costs	**45,420**	**41,610**	**45,420**	**41,610**

4 OTHER EXPENSES

4a Other operating costs

Operating lease expenses

Wairarapa DHB leases property, plant & equipment in the normal course of its business. The majority of these leases have a non-cancellable term of between 12 and 36 months. The future minimum lease payments payable are disclosed in the Statement of Commitments.

Leases can be renewed at the Wairarapa DHB's option, with rents set by reference to current market rates for items of equivalent age & condition. Wairarapa DHB has, in some cases, the option to purchase the asset at the end of the lease term.

There are no restrictions placed on Wairarapa DHB by any of the leasing arrangements.

	Group Actual 2016 $000	Group Actual 2015 $000	Parent Actual 2016 $000	Parent Actual 2015 $000
Outsourced services	3,825	4,305	3,825	4,305
Clinical supplies	9,852	9,013	9,852	9,013
Operating lease expenses	1,192	1,448	1,158	1,414
Audit fees (for the audit of the financial statements)	110	114	108	112
Audit fees (for other assurance services)	88	48	88	48
Impairment of trade receivables (bad & doubtful debts)	(19)	(5)	(19)	(5)
Board member fees & expenses	227	231	221	225
Other operating expenses	7,820	7,639	6,774	6,695
Total other operating expenses	**23,095**	**22,793**	**22,007**	**21,807**

4b Payments to external health providers

Wairarapa DHB makes payments to a number of non-government organisations (NGOs) through its funder arm for health services provided by those NGOs. These services include payments to the Primary Health Organisation (PHO), general practitioners, community pharmacies, aged care providers, home and community support providers, Māori health providers and a number of other organisations.

Additionally the Wairarapa DHB pays other district health boards for services those district health boards provide for Wairarapa residents either for an acute episode or for a range of elective and outpatient services not provided within Wairarapa Hospital. This payment mechanism is called inter district flows (IDFs).

	Group Actual 2016 $000	Group Actual 2015 $000	Parent Actual 2016 $000	Parent Actual 2015 $000
Payments to non-health board providers	43,679	45,705	43,679	45,705
Inter-District Flow payments to other DHBs	34,166	29,819	34,166	29,819

5 FINANCE COSTS

	Group Actual 2016 $000	Group Actual 2015 $000	Parent Actual 2016 $000	Parent Actual 2015 $000
Interest expense	1,029	1,187	1,029	1,187
Capital charge	342	629	342	629
Total finance costs	**1,371**	**1,816**	**1,371**	**1,816**

Wairarapa DHB pays a capital charge to the Crown based on the greater of its actual or budgeted closing equity balance, adjusted for equity contributions or repayment of equity, for the year. The capital charge rate for the period ended 30 June 2016 was 8% (2015 – 8%).

6 INCOME TAX

In accordance with the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004, the group (Wairarapa DHB and its 100% owned subsidiary Biomedical Services New Zealand Limited) is a public authority and is exempt from income tax.

7 PROPERTY, PLANT & EQUIPMENT

7a Non-current assets

Group	Land (at valuation)	Buildings (at valuation)	Clinical equipment	Other equipment	Information technology	Motor vehicles	Work in progress	Total
	$000	$000	$000	$000	$000	$000	$000	$000
Cost / valuation								
Balance at 1 July 2014	2,435	37,430	6,847	2,523	922	857	28	51,042
Additions	0	16	249	90	36	10	22	423
Disposals	0	0	(40)	(10)	0	(23)	(50)	(123)
Revaluation increase	0	0	0	0	0	0	0	0
Balance at 30 June 2015	**2,435**	**37,446**	**7,056**	**2,603**	**958**	**844**	**0**	**51,342**
Balance at 1 July 2015	2,435	37,446	7,056	2,603	958	844	0	51,342
Additions	0	1	925	136	44	42	0	1,148
Disposals	0	0	(74)	0	(13)	(25)	0	(112)
Transfer to assets held for resale	(40)	(60)	0	0	0	0	0	(100)
Revaluation increase	0	0	0	0	0	0	0	0
Balance at 30 June 2016	**2,395**	**37,387**	**7,907**	**2,739**	**989**	**861**	**0**	**52,278**

(Note: An amount for disposal shown in the work in progress category represents amounts transferred to the appropriate asset category)

Group	Buildings (at valuation)	Clinical equipment	Other equipment	Information technology	Motor vehicles	Work in progress	Total
Accumulated Depreciation & impairment losses							
Balance at 1 July 2014	784	5,017	2,062	772	404	0	9,039
Depreciation charge for the year	784	448	182	49	71	0	1,534
Elimination on disposal	0	(35)	(10)	(1)	(23)	0	(69)
Elimination on revaluation	0	0	0	0	0	0	0
Balance at 30 June 2015	**1,568**	**5,430**	**2,234**	**820**	**452**	**0**	**10,504**
Balance at 1 July 2015	1,568	5,430	2,234	820	452	0	10,504
Depreciation charge for the year	786	432	152	51	71	0	1,492
Elimination on disposal	0	(68)	0	0	(25)	0	(93)
Transfer to assets held for resale	(5)	0	0	0	0	0	(5)
Elimination on revaluation	0	0	0	0	0	0	0
Balance at 30 June 2016	**2,349**	**5,794**	**2,386**	**871**	**498**	**0**	**11,898**

Group	Land (at valuation)	Buildings (at valuation)	Clinical equipment	Other equipment	Information technology	Motor vehicles	Work in progress	Total
Carrying amounts								
At 1 July 2014	2,435	36,646	1,830	461	150	453	28	42,003
At 30 June 2015	**2,435**	**35,878**	**1,626**	**369**	**139**	**392**	**0**	**40,838**
At 1 July 2015	2,435	35,878	1,626	369	139	392	0	40,838
At 30 June 2016	**2,395**	**35,038**	**2,113**	**353**	**119**	**363**	**0**	**40,380**

(Note: An amount for disposal shown in the work in progress category represents amounts transferred to the appropriate asset category)

Parent	Land (at valuation) $000	Buildings (at valuation) $000	Clinical equipment $000	Other equipment $000	Information technology $000	Motor vehicles $000	Work in progress $000	Total $000
Cost / valuation								
Balance at 1 July 2014	2,435	37,430	6,847	1,784	885	758	28	50,167
Additions	0	16	249	49	21	0	22	357
Disposals	0	0	(40)	(2)	0	(9)	(50)	(101)
Revaluation increase	0	0	0	0	0	0	0	0
Balance at 30 June 2015	**2,435**	**37,446**	**7,056**	**1,831**	**906**	**749**	**0**	**50,423**
Balance at 1 July 2015	2,435	37,446	7,056	1,831	906	749	0	50,423
Additions	0	1	925	52	42	0	0	1,020
Disposals	0	0	(74)	0	0	0	0	(74)
Transfer to assets held for resale	(40)	(60)	0	0	0	0	0	(100)
Revaluation increase	0	0	0	0	0	0	0	0
Balance at 30 June 2016	**2,395**	**37,387**	**7,907**	**1,883**	**948**	**749**	**0**	**51,269**

Parent	Buildings (at valuation)	Clinical equipment	Other equipment	Information technology	Motor vehicles	Work in progress	Total
Accumulated Depreciation & impairment losses							
Balance at 1 July 2014	784	5,017	1,440	737	320	0	8,298
Depreciation charge for the year	784	448	119	48	60	0	1,459
Depreciation charge discontinued operations	0	0	0	0	0	0	0
Impairment losses	0	0	0	0	0	0	0
Elimination on disposal	0	(35)	(2)	0	(9)	0	(46)
Elimination on revaluation	0	0	0	0	0	0	0
Balance at 30 June 2015	**1,568**	**5,430**	**1,557**	**785**	**371**	**0**	**9,711**
Balance at 1 July 2015	1,568	5,430	1,557	785	371	0	9,711
Depreciation charge for the year	786	432	103	50	60	0	1,431
Impairment losses	0	0	0	0	0	0	0
Elimination on disposal	0	(68)	0	0	0	0	(68)
Transfer to assets held for resale	(5)	0	0	0	0	0	(5)
Elimination on revaluation	0	0	0	0	0	0	0
Balance at 30 June 2016	**2,349**	**5,794**	**1,660**	**835**	**431**	**0**	**11,069**

Parent	Land (at valuation)	Buildings (at valuation)	Clinical equipment	Other equipment	Information technology	Motor vehicles	Work in progress	Total
Carrying amounts								
At 1 July 2014	2,435	36,646	1,830	344	148	438	28	41,869
At 30 June 2015	**2,435**	**35,878**	**1,626**	**274**	**121**	**378**	**0**	**40,712**
At 1 July 2015	2,435	35,878	1,626	274	121	378	0	40,712
At 30 June 2016	**2,395**	**35,038**	**2,113**	**223**	**113**	**318**	**0**	**40,200**

Revaluation

The most recent revaluation was performed by CB Richard Ellis and the valuation is effective as at 30 June 2013.

Land

Land is valued at fair value using market-based evidence based on its highest and best use with reference to comparable land values. Adjustments have been made to the "unencumbered" land value for land where there is a designation against the land or the use of the land is restricted. These adjustments are intended to reflect the negative effect on the value of the land where an owner is unable to use the land more intensely.

Restrictions on the DHB's ability to sell land would normally not impair the value of the land because it has operational use of the land for the foreseeable future and will receive substantially the full benefits of outright ownership.

Buildings

Specialised hospital buildings are valued at fair value using depreciated replacement cost because no reliable market data is available for such buildings.

Depreciated replacement cost is determined using a number of significant assumptions. Significant assumptions include:

The replacement asset is based on the reproduction cost of the specific assets with adjustments where appropriate for optimisation due to over-design or surplus capacity.
The replacement cost is derived from recent construction contracts of similar assets and Property Institute of New Zealand cost information.
The remaining useful life of assets is estimated.
Straight-line deprecation has been applied in determining the depreciated replacement cost value of the asset.

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

Restrictions

The disposal of certain properties may be subject to the provisions of s40 of the Public Works Act 1981. Proceeds from the sale of Wairarapa DHB assets are used to purchase new assets as specified under Clause 43, Schedule 3 New Zealand Public Health and Disability Act 2000.

7b Assets classified as held for sale

Wairarapa DHB has decided to sell the residential property at Tinui. Permission is being sought from the Minister of Health to sell this property.

8 INTANGIBLE ASSETS

Group	Intangible Assets $000	Work in progress $000	Total $000
Cost			
Balance at 1 July 2014	2,182	557	2,739
Additions	42	2,921	2,963
Disposals	0	(27)	(27)
Balance at 30 June 2015	**2,224**	**3,451**	**5,675**
Balance at 1 July 2015	2,224	3,451	5,675
Additions	289	1,938	2,227
Disposals	0	(286)	(286)
Balance at 30 June 2016	**2,513**	**5,103**	**7,616**

Group	Intangible Assets	Work in progress	Total
Accumulated amortisation & impairment losses			
Balance at 1 July 2014	1,017	0	1,017
Amortisation charge for the year	203	0	203
Impairment losses	0	0	0
Disposals	0	0	0
Balance at 30 June 2015	**1,220**	**0**	**1,220**
Balance at 1 July 2015	1,220	0	1,220
Amortisation charge for the year	194	0	194
Impairment losses	0	0	0
Elimination on disposal	0	0	0
Balance at 30 June 2016	**1,414**	**0**	**1,414**

Group	Intangible Assets	Work in progress	Total
Carrying amounts			
At 1 July 2014	1,165	557	1,722
At 30 June 2015	**1,004**	**3,451**	**4,456**
At 1 July 2015	1,004	3,451	4,456
At 30 June 2016	**1,099**	**5,103**	**6,202**

Parent	Intangible Assets $000	Work in progress $000	Total $000
Cost			
Balance at 1 July 2014	2,136	557	2,693
Additions	28	2,921	2,949
Disposals	0	(27)	(27)
Balance at 30 June 2015	**2,164**	**3,451**	**5,615**
Balance at 1 July 2015	2,164	3,451	5,615
Additions	286	1,833	2,119
Disposals	0	(286)	(286)
Balance at 30 June 2016	**2,450**	**4,998**	**7,448**

Parent	Intangible Assets	Work in progress	Total
Accumulated amortisation & impairment losses			
Balance at 1 July 2014	980	0	980
Amortisation charge for the year	193	0	193
Impairment losses	0	0	0
Disposals	0	0	0
Balance at 30 June 2015	**1,173**	**0**	**1,173**
Balance at 1 July 2015	1,173	0	1,173
Amortisation charge for the year	188	0	188
Impairment losses	0	0	0
Disposals	0	0	0
Balance at 30 June 2016	**1,361**	**0**	**1,361**

Parent	Intangible Assets	Work in progress	Total
Carrying amounts			
At 1 July 2014	1,156	557	1,713
At 30 June 2015	**991**	**3,451**	**4,442**
At 1 July 2015	991	3,451	4,442
At 30 June 2016	**1,089**	**4,998**	**6,087**

(Note: An amount for disposal shown in the work in progress category represents amounts transferred to the appropriate asset category)

Impairment

No impairment losses have been recognised during the period.

9 INVESTMENT

Investment in subsidiary

Biomedical Services New Zealand Limited is 100% owned by WDHB (2015 – 100%). The principal activity of the subsidiary is the testing and maintenance of biomedical equipment. The year ended 30 June 2016 financial statements were used as the basis for consolidation. The balance date of Biomedical Services New Zealand Ltd is 30 June.

	Group Actual 2016 $000	Group Actual 2015 $000	Parent Actual 2016 $000	Parent Actual 2015 $000
Investment in subsidiary	0	0	103	103
Investment in joint ventures	541	541	541	541
Trust funds invested	274	266	274	266
Total investments	**815**	**807**	**918**	**910**

Investment in joint ventures

Central Region's Technical Advisory Services Limited (CRTAS)

WDHB, in conjunction with the five other district health boards in the central region (Capital & Coast DHB, Hutt DHB, MidCentral DHB, Whanganui DHB and Hawkes Bay DHB), have embarked on a collaborative effort to implement the Regional Health Informatics Programme (RHIP), (formally Central Region Information Systems Programme (CRISP)). This programme will provide a single instance of a range of clinical information systems across the region.

During 2015 Wairarapa DHB and the other DHBs involved in the RHIP project signed a variation to the original agreement regarding investment in RHIP. It was agreed that investments in CRTAS would no longer be for the acquisition of Class B Redeemable Preference Shares. The capital payments to CRTAS for the RHIP project have been reclassified as Work in Progress as at 30 June 2015 as all partners in the RHIP project are to share ownership of the intangible assets resulting from RHIP. WDHB had treated the initial contributions as Investments in the financial statements to 30 June 2014. These have now been reclassified as Work in Progress.

New Zealand Health Parternships Limited

At 1 July 2015, the DHB had made payments totalling $541,000 (2014: Nil) to New Zealand Health Partnerships Limited (NZHPL) in relation to the National Oracle Solutions ("NOS") programme, (formally Finance, Procurement and Supply Chain ("FPSC")) which was in progress at year end. This is a national initiative facilitated by NZHPL. In return for these payments, the DHB gains NOS rights. These NOS rights have been tested for impairment by comparing the carrying amount of the intangible asset to its depreciated replacement cost (DRC), which is considered to equate to the DHB's share of the DRC of the underlying NOS assets.

It is expected that the final costs of the NOS programme will exceed the original budget. NZHP is undertaking an exercise to determine the revised costs of the programme and following this, formal approval to proceed will be required from the DHBs. The current expectation of the Board is that the NOS programme will proceed as originally planned. In this scenario, the DRC of the NOS rights is considered to equate, in all material respects, to the costs capitalised to date such that the NOS rights are not impaired. However, the future of the NOS programme is uncertain and any future decision to re-scope or discontinue the NOS programme will require a reassessment of the recoverable amount (ie DRC) of the NOS rights.

10 CASH & CASH EQUIVALENTS

	Group Actual 2016 $000	Group Actual 2015 $000	Parent Actual 2016 $000	Parent Actual 2015 $000
Short term deposits	75	124	0	0
Cash & cash equivalents	116	210	7	11
Bank overdraft	(1,412)	(1,510)	(1,412)	(1,510)
Total cash & cash equivalents	**(1,221)**	**(1,176)**	**(1,405)**	**(1,499)**

WDHB is a party to the "DHB Treasury Services Agreement" between New Zealand Health Partnerships Limited (NZHP) and the participating DHBs. This Agreement enables NZHP to "sweep" DHB bank accounts and invest surplus funds on their behalf. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with NZHP, which will incur interest at the on-call interest rate received by NZHP plus an administrative margin of 0.5%.

The balance held by WDHB within this Agreement is shown as bank overdraft within the table above.

The carrying value of cash and cash equivalents and term deposits with maturities less than three months approximates their fair value.

Reconciliation of net deficit to net operating cash flows

	Group Actual 2016 $000	Group Actual 2015 $000	Parent Actual 2016 $000	Parent Actual 2015 $000
Net surplus/(deficit)	**(1,927)**	**(3,336)**	**(1,908)**	**(3,355)**
Add/(less) non-cash items:				
Depreciation & amortisation	1,686	1,737	1,619	1,652
Increase/(decrease) employee benefits (non-current)	57	82	57	82
Add/(less) items classified as investment activity:				
Net loss/(gain) on sale of property, plant & equipment	53	6	50	5
Dividends received	0	0	(106)	(25)
Add/(less) movements in working capital items:				
(Increase)/decrease in receivables	(1,151)	1,899	(1,149)	1,968
(Increase) / decrease in inventories	(105)	(53)	(105)	(53)
(Decrease) in payables & accruals	1,469	475	1,460	420
Net cash flow from operating activities	**82**	**810**	**(82)**	**694**

11 INVENTORIES

	Group Actual 2016 $000	Group Actual 2015 $000	Parent Actual 2016 $000	Parent Actual 2015 $000
Central stores	262	217	262	217
Pharmaceuticals	88	108	88	108
Theatre supplies	332	301	332	301
Other supplies	220	171	220	171
Total inventories	**902**	**797**	**902**	**797**

Write-down of inventories amounted to nil for 2016 (2015 – nil). The amount of inventories recognised as an expense during the year ended 30 June 2016 was nil (2015 – nil). No inventories are pledged as security for liabilities 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.

12 TRADE & OTHER RECEIVABLES

	Group Actual 2016 $000	Group Actual 2015 $000	Parent Actual 2016 $000	Parent Actual 2015 $000
Trade debtors	4,469	3,330	4,306	3,166
Provision for doubtful debts	(56)	(78)	(56)	(78)
Prepayments	246	259	246	259
Amount owing by subsidiary	0	0	2	2
Total trade & other receivables	**4,659**	**3,511**	**4,498**	**3,349**
Receivables from the sale of goods and services (exchange transactions)	1,140	602	977	438
Receivables from non- exchange transactions	3,519	2,910	3,521	2,911
Total trade & other receivables	**4,659**	**3,511**	**4,498**	**3,349**

The carrying value of debtors and other receivables approximates their fair value.

13 EQUITY

Group	Crown equity $000	Property revaluation reserve $000	Retained earnings $000	Total $000
Balance at 1 July 2014	39,040	5,558	(34,814)	9,784
Total recognised revenue & expenses	0	0	(3,336)	(3,336)
Contribution (net) from the Crown	(3)	0	0	(3)
Movement in revaluation of land & buildings	0	0	0	0
Balance at 30 June 2015	**39,037**	**5,558**	**(38,150)**	**6,445**
Balance at 1 July 2015	39,037	5,558	(38,150)	6,445
Total recognised revenue & expenses	0	0	(1,927)	(1,927)
Contribution from the Crown	3,000	0	0	3,000
Repayment to Crown	(3)	0	0	(3)
Movement in revaluation of land & buildings	0	0	0	0
Balance at 30 June 2016	**42,034**	**5,558**	**(40,077)**	**7,515**

Parent	Crown equity $000	Property revaluation reserve $000	Retained earnings $000	Total $000
Balance at 1 July 2014	39,040	5,558	(35,167)	9,431
Total recognised revenue & expenses	0	0	(3,355)	(3,355)
Contribution (net) from the Crown	(3)	0	0	(3)
Movement in revaluation of land & buildings	0	0	0	0
Balance at 30 June 2015	**39,037**	**5,558**	**(38,522)**	**6,073**
Balance at 1 July 2015	39,037	5,558	(38,522)	6,073
Total recognised revenue & expenses	0	0	(1,908)	(1,908)
Contribution from the Crown	3,000	0	0	3,000
Repayment to Crown	(3)	0	0	(3)
Movement in revaluation of land & buildings	0	0	0	0
Balance at 30 June 2016	**42,034**	**5,558**	**(40,430)**	**7,162**

Revaluation reserve

The revaluation reserve relates to land and buildings. Where buildings are reclassified as investment property, the cumulative increase in the fair value of the buildings at the date of reclassification in excess of any previous impairment losses is included in the revaluation reserve.

14 INTEREST-BEARING LOANS & BORROWINGS

	Group Actual 2016 $000	Group Actual 2015 $000	Parent Actual 2016 $000	Parent Actual 2015 $000
Non current liabilities				
Privately sourced loans	302	376	302	376
Crown sourced loans	19,500	20,750	19,500	20,750
Total non current interest-bearing loans & borrowings	**19,802**	**21,126**	**19,802**	**21,126**
Current liabilities				
Privately sourced loans	74	69	74	69
Crown sourced loans	6,250	5,000	6,250	5,000
Total current interest-bearing loans & borrowings	**6,324**	**5,069**	**6,324**	**5,069**

Crown loans

The crown loans are secured by a negative pledge. The Ministry of Health (MoH) and the DHB have agreed a debt facility of $25,750,000 of which $25,750,000 was drawn at 30 June 2016. The MoH term borrowings are secured by a negative pledge. The CHFA was disbanded on 1 July 2012 and the lending functions previously performed by the CHFA have been transferred to the Ministry of Health.

Included in the non-current Crown sourced loans above is a tranche of the debt totalling $5,000,000 that was refinanced on 15 April 2016.

Without the MoH's prior written consent the DHB cannot perform the following actions:

create any security interest over its assets except in certain defined circumstances
lend money to another person or entity (except in the ordinary course of business and then only on commercial terms) or give a guarantee
make a substantial change in the nature or scope of its business as presently conducted
dispose of any of its assets except disposals in the ordinary course of business or disposal for full fair value
provide or accept services other than for proper value and on reasonable commercial terms.

The DHB must also meet the following covenants which have been complied with at all times during the year.

Interest-bearing debt divided by interest-bearing debt plus equity is less than 65 per cent.
A cash flow covenant, under which the accumulated annual cash flow must be greater than zero.

The fair value of the Crown loan borrowings is $26,590,000.

The Government of New Zealand does not guarantee term loans.

Private loans

The Selina Sutherland Hospital Trust has provided privately funded financing arrangements for the DHB to extend the Selina Sutherland private hospital. The private hospital wing is part of the Wairarapa Hospital.

Wairarapa DHB has no other privately funded financing arrangements.

Details of the interest rates and repayment schedule applicable to the interest-bearing loans & borrowings are shown below.

	Group Actual 2016 $000	Group Actual 2015 $000	Parent Actual 2016 $000	Parent Actual 2015 $000
Ministry of Health				
Interest rate summary	3.50%	4.00%	3.50%	4.00%
Repayable as follows:				
Less than one year	6,250	5,000	6,250	5,000
One to two years	5,500	1,250	5,500	1,250
Greater than two years	14,000	19,500	14,000	19,500
	25,750	**25,750**	**25,750**	**25,750**
Privately sourced loans				
Interest rate summary	7.00%	7.00%	7.00%	7.00%
Repayable as follows:				
Less than one year	74	69	74	69
One to two years	74	74	74	74
Greater than two years	228	302	228	302
	376	**445**	**376**	**445**

15 EMPLOYEE BENEFITS

	Group Actual 2016 $000	Group Actual 2015 $000	Parent Actual 2016 $000	Parent Actual 2015 $000
Non current liabilities				
Liability for long service leave	274	244	274	244
Liability for retirement gratuities	346	319	346	319
Total non current employee benefits	**620**	**563**	**620**	**563**
Current liabilities				
Liability for long service leave	434	420	434	420
Liability for retirement gratuities	246	170	244	168
Liability for sabbatical leave	50	50	50	50
Liability for continuing medical education leave	295	225	295	225
Liability for maternity grant	12	39	12	39
Liability for annual leave	4,130	3,671	4,050	3,605
Liability for sick leave	82	93	82	93
Salary & wages accrual	2,255	1,214	2,226	1,201
Total current employee benefits	**7,504**	**5,882**	**7,393**	**5,801**

The present value of long service leave, and retirement gratuities 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 and after obtaining advice from an independent actuary. Weighted average discount rates of 2.3 % for long service leave (2015: 3.1%) and2.4% for retirement gratuities (2015: 3.2%) and a salary increase assumption of 2% (2015: 1%) were used.

Defined benefit plans

Wairarapa DHB does not make any contributions to a defined benefit plan other than KiwiSaver and has no defined benefit obligations.

16 RESTRICTED FUNDS

	Group Actual 2016 $000	Group Actual 2015 $000	Parent Actual 2016 $000	Parent Actual 2015 $000
Balance at beginning of year	266	258	266	258
Funds received	87	59	87	59
Interest received	3	6	3	6
Funds spent	(82)	(57)	(82)	(57)
Balance at end of year	**274**	**266**	**274**	**266**

Wairarapa DHB receives donations and bequests for specific purposes. If for any reason Wairarapa DHB is not able to use the funds as specified, then Wairarapa DHB is obligated to return the donation to the donor. Funds are held in a separate bank account and any interest earned is allocated to the individual restricted fund balances.

17 PAYABLES & ACCRUALS

Payables under exchange transactions

	Group Actual 2016 $000	Group Actual 2015 $000	Parent Actual 2016 $000	Parent Actual 2015 $000
Trade creditors & accruals	3,718	3,564	3,627	3,478
Capital charge payable	0	0	0	0
Revenue received in advance	17	13	17	13
Amount owing to subsidiary	0	0	16	17
Total payables & accruals	**3,735**	**3,577**	**3,660**	**3,508**

Payables under non-exchange transactions

	Group Actual 2016 $000	Group Actual 2015 $000	Parent Actual 2016 $000	Parent Actual 2015 $000
Trade creditors & accruals	4,952	5,247	4,952	5,248
Capital charge payable	0	0	0	0
GST & other taxes payable	1,061	992	1,061	992
Revenue received in advance	1	66	1	66
Amount owing to subsidiary	0	0	0	0
Total payables & accruals	**6,014**	**6,305**	**6,014**	**6,305**
Total payables & accruals	**9,749**	**9,882**	**9,674**	**9,812**

Creditors and other payables are non-interest bearing and are normally settled on 30 day terms. Therefore, the carrying value of creditors and other payables approximates their fair values.

18 FINANCIAL INSTRUMENTS

Exposure to credit, interest rate and currency risks arise in the normal course of Wairarapa DHB's operations. The DHB does not utilise derivative financial instruments to hedge exposure to fluctuations in foreign exchange rates and interest rates.

Liquidity risk

Liquidity risk represents the DHB's ability to meet its contractual obligations as they fall due. The DHB evaluates its liquidity requirements on an ongoing basis. In general, the DHB generates sufficient cash flows from its operating activities to meet its obligations arising from its financial liabilities and has credit lines in place to cover potential shortfalls.

Cash flow interest rate risk

Interest rate risk is the risk that the fair value of a financial instrument will fluctuate or the cash flows from a financial instrument will fluctuate due to changes in market interest rates. The DHB adopts a policy of ensuring that greater than 75% of its exposure to changes in interest rates on borrowings is on a fixed rate basis. No interest rate swaps are deemed necessary.

The interest rates applicable to the DHB have been disclosed in note 14.

Currency risk

Currency risk is the risk that the fair value of future cash flows of a financial instrument will fluctuate because of changes in foreign exchange rates. The DHB is exposed to foreign currency risk on sales and purchases that are denominated in a currency other than NZD. The currencies giving rise to this risk are primarily Australian Dollars, US Dollars and Japanese Yen.

Forward foreign exchange contracts

Forward foreign exchange contracts are used to manage exposure to foreign exchange risk arising from the purchase of equipment denominated in a foreign currency. The DHB does not hold these contracts for trading purposes. The DHB has not entered into any hedge contracts for foreign exchange transactions during the year as it has deemed that hedging will only occur for significant, generally in excess of $50,000, transactions sourced directly from overseas.

Price risk

Price risk is the risk that the value of a financial instrument will fluctuate as a result of changes in market prices. The DHB has no financial instruments that give rise to price risk.

Fair value interest rate risk

Fair value interest rate risk is the risk that the fair value of a financial instrument will fluctuate due to changes in market interest rates. The DHB's exposure to fair value interest rate risk arises from bank deposits and bank loans that are at fixed rates of interest. The exposure to fair value interest rate risk is not actively managed by the DHB as investments and borrowings are generally held to maturity.

Credit risk

Credit risk is the risk that a third party will default on its obligation to WDHB causing it to incur a loss. Due to the timing of its cash inflows and cash outflows, WDHB invests surplus cash with registered banks.

Financial instruments, which potentially subject the DHB to concentrations of risk, consist principally of cash, short-term deposits and accounts receivable.

The status of trade receivables at the reporting date is as follows:

Group	Actual 2016 $000 Gross	Actual 2016 $000 Impairment	Actual 2016 $000 Net	Actual 2015 $000 Gross	Actual 2015 $000 Impairment	Actual 2015 $000 Net
Not past due	4,325	0	4,325	3,077	0	3,077
Past due 1-30 days	69	0	69	100	0	100
Past due 31-60 days	7	0	7	24	(10)	14
Past due 61-90 days	0	(3)	(3)	0	0	0
Past due > 90 days	68	(53)	15	114	(68)	46
Total	**4,469**	**(56)**	**4,413**	**3,315**	**(78)**	**3,237**

Parent	Actual 2016 $000 Gross	Actual 2016 $000 Impairment	Actual 2016 $000 Net	Actual 2015 $000 Gross	Actual 2015 $000 Impairment	Actual 2015 $000 Net
Not past due	4,162	0	4,162	2,928	0	2,928
Past due 1-30 days	69	0	69	100	0	100
Past due 31-60 days	7	0	7	24	(10)	14
Past due 61-90 days	0	(3)	-3	0	0	0
Past due > 90 days	68	(53)	15	114	(68)	46
Total	**4,306**	**(56)**	**4,250**	**3,166**	**(78)**	**3,088**

The maximum exposure to credit risk is represented by the carrying amount of each financial asset in the statement of financial position.

The provision for impairment has been calculated based on the monthly review of debtor balances ageing and the likelihood of overdue amounts being recovered.

Movements in the provision for impairment of receivables are as follows:

	Actual 2016 $000	Actual 2015 $000
Balance at 1 July	78	89
Additional provisions made/(provisions released)	(24)	(15)
Receivables written off	2	4
Total	**56**	**78**

The DHB places its cash and short-term deposits with high-quality financial institutions and the DHB has a policy that limits the amount of credit exposure to any one financial institution.

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. It 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.

No collateral or other credit enhancements are held for financial instruments that give rise to credit risk.

The carrying amounts of financial assets and liabilities in each of the categories are as follows:

	Actual 2016 $000	Actual 2015 $000
Fair value through surplus or deficit - Held for trading		
Forward foreign exchange contracts in a liability position	0	0
Loans and receivables:		
Cash and cash equivalents	191	334
Trade and other receivables	4,659	3,510
Investments	815	807
Total loans and receivables	**5,665**	**4,651**
Financial liabilities measured at amortised cost:		
Payable & accruals (excluding revenue in advance and GST)	8,670	8,811
Borrowings - MOH loans	25,750	25,750
Borrowings - Privately sourced loans	376	445
Total financial liabilities measured at amortised cost	**34,796**	**35,006**

Capital management

The DHB's capital is its equity, which comprises Crown equity, reserves and retained earnings. Equity is represented by net assets. The DHB manages its revenues, expenses, assets, liabilities and general financial dealings prudently in compliance with the budgetary processes.

The DHB's policy and objectives of managing the equity is to ensure the DHB effectively achieves its goals and objectives, whilst maintaining a strong capital base. The DHB policies in respect of capital management are reviewed regularly by the governing Board.

There have been no material changes in the Group DHB's management of capital during the period.

Sensitivity analysis

In managing interest rate and currency risks the DHB aims to reduce the impact of short-term fluctuations on the DHB's earnings. Over the longer-term, however, permanent changes in foreign exchange and interest rates would have an impact on consolidated earnings.

If the interest base rate change by plus or minus 0.5% (2015 0.5%) the effect would have been to increase/(decrease) other comprehensive revenue and expense by $7,000 (2015 $20,000)

Credit quality of financial assets

The credit quality of financial assets that are neither past due nor impaired can be assessed by reference to Standard and Poor's credit ratings.

Wairarapa DHB credit quality information follows:

	Actual 2016 $000	Actual 2015 $000
Counterparties with credit ratings		
Cash and cash equivalents and trust fund assets:		
AA	(947)	(910)
AA-	0	0
Total cash and cash equivalents and trust fund assets	**(947)**	**(910)**
Counterparties without credit ratings		
Debtors and other receivables:		
Existing counterparty with no defaults in the past	4,659	3,511
Existing counterparty with defaults in the past	0	0
Total debtors and other receivables	**4,659**	**3,511**

Group	Loans and receivables	Other amortised cost	Carrying amount	Fair value
	2016 $000	2016 $000	2016 $000	2016 $000
Investments	0	815	815	815
Trade and other receivables	4,659	0	4,659	4,659
Cash and cash equivalents	191	0	191	191
Crown sourced loans	0	25,750	25,750	26,590
Privately sourced loans	0	376	376	376
Trade and other payables	0	9,749	9,749	9,749

Group	Loans and receivables	Other amortised cost	Carrying amount	Fair value
	2015 $000	2015 $000	2015 $000	2015 $000
Investments	0	807	807	807
Trade and other receivables	3,511	0	3,511	3,511
Cash and cash equivalents	334	0	334	334
Crown sourced loans	0	25,750	25,750	26,474
Privately sourced loans	0	445	445	445
Trade and other payables	0	9,792	9,792	9,792

Parent	Loans and receivables	Other amortised cost	Carrying amount	Fair value
	2016 $000	2016 $000	2016 $000	2016 $000
Investments	0	918	918	918
Trade and other receivables	4,554	0	4,554	4,554
Cash and cash equivalents	7	0	7	7
Crown sourced loans	0	25,750	25,750	26,590
Finance lease liabilities	0	376	376	376
Trade and other payables	0	9,674	9,674	9,674

Parent	Loans and receivables	Other amortised cost	Carrying amount	Fair value
	2015 $000	2015 $000	2015 $000	2015 $000
Investments	0	910	910	910
Trade and other receivables	3,427	0	3,427	3,427
Cash and cash equivalents	11	0	11	11
Crown sourced loans	0	25,750	25,750	26,474
Finance lease liabilities	0	445	445	445
Trade and other payables	0	9,813	9,813	9,813

19 RELATED PARTIES

Related party disclosures have not been made for transactions with related parties 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 WDHB would have adopted in dealing with the party at an arms' 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.

WDHB is a wholly-owned entity of the Crown.

Inter district flows

WDHB earns revenue from other DHBs for the care of patients domiciled outside the DHB's district where the service is provided by WDHB. WDHB incurs expenditure to other DHBs for the care of Wairarapa domiciled patients where the care is provided outside the DHB's district. The process for this purchasing arrangement is inter-district flows. For the period the following transactions were incurred by WDHB.

	2016 $000	2015 $000
Revenue	3,320	3,343
Expenditure	34,166	29,819
Receivable at 30 June	58	1,119
Payable at 30 June	1,618	2,659

Collectively, but not individually, significant transactions with government-related entities

In conducting its activities, WDHB is required to pay various taxes and levies (such as GST, FBT, PAYE and ACC levies) to the Crown and entities related to the Crown. The payment of these taxes and levies, other than income tax, is based on the standard terms and conditions that apply to all tax and levy payers. The WDHB is exempt from paying income tax.

WDHB also purchases goods and services from entities controlled, significantly influenced, or jointly controlled by the Crown. Purchases from these government-related entities for the year ended 30 June 2016 totalled $803,000 (2015: $879,000). These purchases included the purchase of energy from Genesis Power New Zealand Ltd as well as postal services from New Zealand Post.

Remuneration of key management personnel

Key management personnel are defined as those persons having authority and responsibility for planning, directing and controlling the activities of the entity, directly or indirectly of that entity. This includes the senior leadership team and the Board members.

The remuneration paid to the key management personnel is:

	Group Actual 2016 $000	Group Actual 2015 $000	Parent Actual 2016 $000	Parent Actual 2015 $000
Board Members				
Remuneration	214	193	208	187
Full-time equivalent members	1	1	1	1
Leadership Team				
Remuneration	1,159	1,297	944	1,105
Full-time equivalent personnel	8	8	6	6
Total key management personnel remuneration	**1,373**	**1,490**	**1,152**	**1,292**
Full-time equivalent personnel	**9**	**9**	**7**	**7**

During the year Wairarapa DHB transacted with Hutt Valley DHB on normal inter-DHB terms. In addition the DHBs share an executive management team and also hold combined Community Public Health Advisory Committee meetings.

All payments included in the remuneration total are classified as "short term benefits". Wairarapa DHB does not have any compensation arrangements for key management personnel of the nature of post-employment benefits, other long term benefits or termination benefits.

There were no loans to board members or executive officers for the year ended 30 June 2016 (2015 – nil).

Wairarapa DHB does not provide non-cash benefits to board members or executive officers.

20 SUBSEQUENT EVENTS

There are no significant events subsequent to balance date.

21 ACCOUNTING ESTIMATES & JUDGEMENTS

Management discussed with the Audit & Risk Committee the development, selection and disclosure of WDHB's critical accounting policies and estimates and the application of these policies and estimates.

Certain critical accounting judgments in applying WDHB's accounting policies are described below.

Investment property

WDHB has sublet various areas within the Wairarapa Hospital facility but has decided not to treat those particular areas as an investment property because it is not WDHB's intention to hold this for capital appreciation or rental. Accordingly, this is still treated as a lease of property, plant and equipment.

Finance and operating leases

The inception of the property leases of WDHB has taken place over a number of years. They are combined leases of land and buildings. It is not possible to obtain a reliable estimate of the split of the fair values of the lease interest between land and buildings at inception. Therefore, in determining lease classification WDHB evaluated whether both parts are clearly operating leases or finance leases. Firstly, land title does not pass. Secondly, because the rent paid to the landlord for the building is able to be increased to market rent at regular intervals and WDHB does not participate in the residual value of the building, it is judged that substantially all the risks and rewards of the building are with the landlord. Based on these qualitative factors it is concluded that the leases are operating leases.

Estimating useful lives and residual values of property, plant, and equipment

The useful lives and residual values of property, plant, and equipment are reviewed at each balance date. Assessing the appropriateness of useful life and residual value estimates requires the WDHB to consider a number of factors such as the physical condition of the asset, advances in medical technology, expected period of use of the asset by the WDHB, and expected disposal proceeds (if any) from the future sale of the asset. An incorrect estimate of the useful life or residual value will affect the depreciable amount of an asset, therefore affecting the depreciation expense recognised in the surplus or deficit and the asset's carrying amount. The WDHB minimises the risk of this estimation uncertainty by:

physical inspection of the assets
asset replacement programs.

In the year to 30 June 2016, the WDHB has not made changes to past assumptions concerning useful lives and residual values of assets.

22 EXPLANATION OF FINANCIAL VARIANCES FROM BUDGET

The significant variances between the actual reported financial results and those budgeted are as follows.

Revenue

- Additional revenue has been recognised during the year over the budgeted amount primarily relating to additional funding for initiatives funded by the Ministry of Health. These initiatives attract additional expenditure.
- In addition, the DHB received Donations totalling $518, 000 which is considerably more than in previous years. The majority of donations were received from Wairarapa Community Health Trust.

Expenditure

- Additional expenditure has arisen due to higher than planned medical workforce expenses. The adverse workforce variance reflects the costs of locums engaged to provide necessary cover at various times throughout the year. Other operating expenses were higher than planned as a result of not fully achieving planned savings and efficiencies targets set at the beginning of the year.

Assets

- The balance of property, plant and equipment is lower than planned. This is due to delays in various IT projects including RHIP and NOS.

Liabilities

- Trade creditors are lower than planned primarily due to savings made throughout the year .

Equity

- The higher than planned closing equity position relates to the lower than budgeted loss for the financial year.

STATEMENT OF RESPONSIBILITY

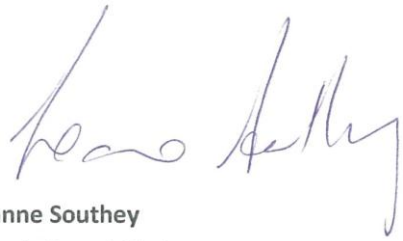
We are responsible for the preparation of the Wairarapa District Health Board group's financial statements and the statement of performance and for the judgements made in them.

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

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 Wairarapa District Health Board for the year ended 30 June 2016.

Dr Derek Milne
Board Chair
31 October 2016



Leanne Southey
Deputy Board Chair
31 October 2016

Independent Auditor's Report

To the readers of Wairarapa District Health Board's financial statements and performance information for the year ended 30 June 2016

The Auditor-General is the auditor of Wairarapa District Health Board Group (the Group). The Auditor-General has appointed me, Kelly Rushton, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and the performance information, including the performance information for an appropriation, of the Group, consisting of Wairarapa District Health Board and its subsidiaries, on her behalf.

We have audited:

- the financial statements of the Group on pages 73 to 121, that comprise the statement of financial position, statement of contingencies, and statement of commitments as at 30 June 2016, 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 Group on pages 21 to 72.

Unmodified opinion on the financial statements

In our opinion:

- the financial statements of the Health Board on pages 73 to 121:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2016; and
        - its financial performance and cash flows for the year then ended;
    - comply with generally accepted accounting practice in New Zealand and have been prepared in accordance with Public Benefit Entity Reporting Standards.

Qualified opinion on the performance information because of limited controls on information from third-party health providers in the prior year

In respect of the 30 June 2015 comparative information only, some significant performance measures of the Group, (including some of the national health targets), relied on information from third-party health providers, such as primary health organisations. The Group's control over much

of this information was limited, and there were no practical audit procedures to determine the effect of this limited control.

The limited control over information from third-party health providers meant that our work on the affected performance information contained in the statement of performance for the comparative year was limited, and our audit opinion on the statement of performance for the year ended 30 June 2015 was modified accordingly.

The limited control over information from third parties has been resolved for the 30 June 2016 year, however, the limitation cannot be resolved for the 30 June 2015 year, which means that the Group's performance information reported in the statement of performance for the 30 June 2016 year, may not be directly comparable to the 30 June 2015 performance information.

In our opinion, except for the effect of the matters described above, the performance information of the Group on pages 21 to 72:

- presents fairly, in all material respects, the Group's performance for the year ended 30 June 2016, including:
    - for each class of reportable outputs:
        - its standards of performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
        - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year.
    - what has been achieved with the appropriation; and
    - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure.
- complies with generally accepted accounting practice in New Zealand.

Our audit was completed 31 October 2016. This is the date at which our opinion is expressed.

The basis of our opinion is explained below. In addition, we outline the responsibilities of the Board and our responsibilities, and explain our independence.

Basis of opinion

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the International Standards on Auditing (New Zealand). Those standards require that we comply with ethical requirements and plan and carry out our audit to obtain reasonable assurance about whether the financial statements and the performance information are free from material misstatement.

Material misstatements are differences or omissions of amounts and disclosures that, in our judgement, are likely to influence readers' overall understanding of the financial statements and the performance information. We were unable to determine whether there are material misstatements in the statement of performance because the scope of our work was limited, as we referred to in our opinion.

An audit involves carrying out procedures to obtain audit evidence about the amounts and disclosures in the financial statements and the performance information. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and the performance information, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the preparation of the Group's financial statements and performance information 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 Group's internal control.

An audit also involves evaluating:

- the appropriateness of accounting policies used and whether they have been consistently applied;
- the reasonableness of the significant accounting estimates and judgements made by the Board;
- the appropriateness of the reported performance information within the Health Board's framework for reporting performance;
- the adequacy of the disclosures in the financial statements and the performance information; and
- the overall presentation of the financial statements and the performance information.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements and the performance information. Also, we did not evaluate the security and controls over the electronic publication of the financial statements and the performance information.

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

Responsibilities of the Board

The Board is responsible for preparing financial statements and performance information that:

- comply with generally accepted accounting practice in New Zealand and Public Benefit Entity Standards;
- present fairly the Group's financial position, financial performance and cash flows; and
- present fairly the Group's performance.

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

The Board is responsible for such internal control as it determines is necessary to enable the preparation of financial statements and performance information that are free from material misstatement, whether due to fraud or error. The Board is also responsible for the publication of the financial statements and the performance information, whether in printed or electronic form.

Responsibilities of the Auditor

We are responsible for expressing an independent opinion on the financial statements and the performance information and reporting that opinion to you based on our audit. Our responsibility arises from the Public Audit Act 2001.

Independence

When carrying out the audit, we followed the independence requirements of the Auditor-General, which incorporate the independence requirements of the External Reporting Board.

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

Kelly Rushton
Audit New Zealand
On behalf of the Auditor-General
Wellington, New Zealand

DIRECTORY

Board Office	Wairarapa DHB P O Box 96 Masterton, 5840 06 946 9800 www.wairarapa.dhb.org.nz	
Board Members	**Derek Milne (Chair from Dec 2013)**	
	Leanne Southey (Deputy Chair)	**Fiona Samuel**
	Dr Liz Falkner	**Alan Shirley**
	Dr Rob Irwin	**Janine Vollebregt**
	Ronald Karaitiana	**Helen Kjestrup**
	Rick Long	**Jane Hopkirk**

Executive Leadership Team for Wairarapa DHB (as at 30 June 2016)			
Adri Isbister	Chief Executive Wairarapa District Health Board	**Amber O'Callaghan**	Executive Director, Quality & Risk
Tom Gibson	Chief Medical Officer	**Andy Harris**	Acting Executive Director, Allied Health, Scientific & Technical
Helen Pocknall	Executive Director of Nursing & Midwifery	**Jill Stringer**	Interim Director Wairarapa Health Services
Shayne Hunter	Acting 3DHB Executive Director Corporate	**Jason Kerehi**	Director, Māori Health Directorate
Donna Hickey	Acting Executive Director, People & Culture 3DHB	**Tofa Suafole Gush**	Director of Pacific People's Health
Justine Thorpe	Programme Director, Tihei Wairarapa	**Sandra Williams**	Director, Service Integration & Development Unit 3DHB (SIDU)
Nigel Fairley	General Manager Mental Health Addictions & Intellectual CCDHB	**Catherine Sheridan**	Senior Finance Manager

Community & Public Health Advisory Committee / Disability Support Advisory Committee			
The Community & Public Health Advisory Committee advises the board on the health needs and status of our population. This is a joint committee with Wairarapa, Hutt Valley and Capital & Coast District Health Boards.			
Dr Derek Milne	Wairarapa	**Tom Gibson**	Wairarapa
Leanne Southey	Wairarapa	**Liz Falkner**	Wairarapa
Alan Shirley	Wairarapa	**Nick Leggett (Chair)**	CCDHB
Jane Hopkirk	Wairarapa	**Virginia Hope (Joint Chair)**	CCDHB

Chris Laidlaw	CCDHB	**Helen Ritchie**	CCDHB
Peter Douglas	CCDHB	**David Choat**	CCDHB
Margaret Faulkner	CCDHB	**Tino Pereiro**	CCDHB
Kim Smith	CCDHB	**Dr Tristram Ingham**	CCDHB
Sandra Grieg	Hutt Valley	**Katy Austin**	Hutt Valley
Wayne Guppy	Hutt Valley		
Hospital Advisory Committee			
The Hospital Advisory Committee (HAC) monitors the financial and operational performance of Wairarapa Hospital and its services.			
Janine Vollebregt (Chair)	Wairarapa	**Dr Rob Irwin**	Wairarapa
Dr Derek Milne (Ex Officio)	Wairarapa	**Ronald Karaitiana**	Wairarapa
Dr Liz Falkner	Wairarapa	**Tom Gibson**	Wairarapa
Fiona Samuel	Wairarapa	**Jill Stringer**	Wairarapa
Financial Audit & Risk Committee			
The Financial Audit & Risk Committee (FRAC) provides advice and recommendations to assist the Board in the proper auditory and scrutiny of its financial affairs and risk management issues.			
Leanne Southey (Chair)	Wairarapa	**Derek Milne (Ex Officio)**	Wairarapa
Helen Kjestrup	Wairarapa	**Rick Long**	Wairarapa
Ronald Karaitiana	Wairarapa		