Wairarapa District Health Board 2016/2017
Annual Report

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

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It is our pleasure to present the Annual Report for the Wairarapa District Health Board (WrDHB) and, in doing so, state our belief that the core role of the DHB is to improve, promote and protect the health of our populations; to reduce health disparities; and to apply the revenue received to provide the best health service for our Wairarapa people that we can.

Sir Paul Collins, Board Chair

Adri Isbister, Chief Executive

2016/2017 has been a year of significant change for WrDHB. December 2016 brought a change in governance with both the local election and government appointed board members.

WrDHB has given the future provision of health services across the district the highest level of importance; setting the strategic direction of operations in collaboration with Iwi Kainga, ensuring long term planning 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.

We are thankful to have a strong relationship with Selina Sutherland Hospital Trust. The private hospital facility on site provides for collaborative working to ensure the best surgical care for our community.

Financially extraordinary Inter District Flows (IDF's) have been a challenge. Without these IDF's WrDHB's financial result would be under the approved budget deficit of $1.5m. Supplementary to budget, the IDF's incurred costs relating to care resulting in a budget deficit of $2.8m. IDF's ensure our Wairarapa population receives the specialist health care provided in other regions when necessary.

Our emphasis on delivering quality service within budget will remain strong as we continue towards the ultimate goal of operating within a surplus environment which will enable us to invest in key strategic initiatives.

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. Patient safety and quality is at the forefront of decision making, driving the development of models of care and enabling our clinicians to work to the top of their scope to influence better patient outcomes.

We value

Respect – Whakamana Tangata
Integrity – Mana Tu
Self Determination – Rangatiratanga
Cooperation - Whakawhānaungatanga
Excellence – Taumatatanga

Our Mission

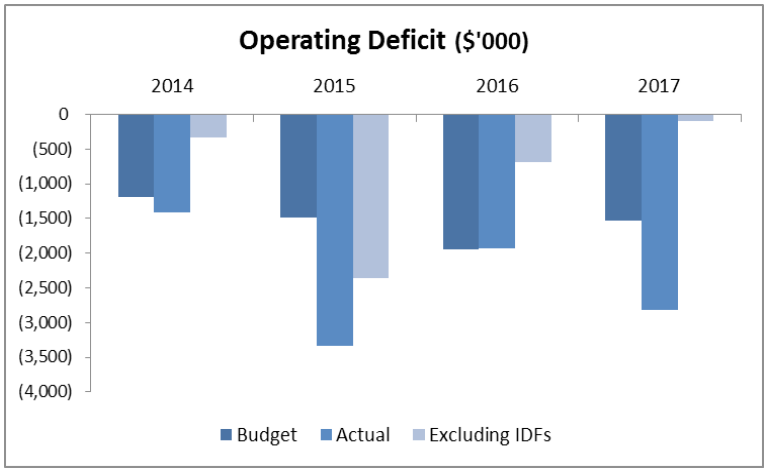
To improve, promote and protect the health status of the people of the Wairarapa, and the independent living of those with disabilities, by supporting and encouraging healthy choices.

Financial summary

A plain English summary of our accounts - the detail of which can be found in the financial statements (from page 58 of this report).

We receive revenue and funding from:	2017 $'000	2016 $'000
Crown revenue	138,177	135,408
Care we provide for patients from other DHBs	3,246	3,320
ACC contract revenue	2,453	2,338
Donations and bequests	476	518
Other revenue	6,254	5,906

Our costs to operate are primarily:		
Wages and salaries	46,426	45,420
Other operating expenses	23,889	23,095
External providers of health care	43,986	43,679
Cost of other DHBs caring for our population	36,443	34,166
Depreciation, interest and capital charge	2,677	3,058



Note: Excluding IDFs = Operating Deficit excluding the value of the top 10 cases treated by other DHBs.

So what is the DHB worth?	As at June 2017 $'000	As at June 2016 $'000
We have total assets of	54,060	53,199
We have total liabilities of	22,614	45,684
So our equity is	31,445	7,515

Contents

Working with our community

The DHB has again met and exceeded nationwide standards in the majority of our health targets.

This is the result of our deliberate approach to continued quality improvement processes and outcomes, and the work of general practice and the PHO. We are also very pleased to have achieved our elective surgery volumes and targets.

Delivering better services closer to home

We are privileged to have the medical, allied health, nursing, care assistant and administration staff not only in our hospital, but in our community and in general practice, keeping us well and ensuring good care intervention. We warmly thank you for that commitment to the health of our region. We also thank our partners, the PHO, local NGOs, and community funders - without which we would not be able to achieve our vision of better health for all.

	25,431 outpatient appointments
	3,845 operations and procedures
	9,100 hospital admissions
	32,903 x-rays and scans

Whānau centred care

Community, family and whānau are at the centre of our approach to care.

We fund various services through Wairarapa's health and community providers, including many in primary care.

We have a positive relationship with Compass Health, the Primary Health organisation (PHO), and through the PHO have a number of community programmes that enable people to access better services within their GP practices. We know that our general practices are the cornerstone of health provision.

Health promotion, engagement and influencing healthy lifestyles is a key part of this strategy.

	240,526 GP visits
	7,242 over 65 years flu vaccinations
	14,579 school dental checks
	434 babies born in Wairarapa Hospital
	3,147 patients with E-health access

Mental health, addictions and intellectual disability services (MHAIDs)

WrDHB provides a comprehensive mental health service in partnership with Capital Coast DHB and Hutt Valley DHB (3DHB). MHAIDs leads services driven by local teams. MHAIDs 3DHB offers a number of services from crisis, acute inpatient care, intensive psychiatric care, services for the elderly, psychology, alcohol and drug services, and also specialist services for children and young people; including early intervention, personality disorder and maternal mental health support. This year, we are pleased to have relocated the child and adolescent mental health service team to premises in Lincoln Road. Formally opened, this new environment is warm and friendly and is co-located with other sector services delivering family and whanau support.

Working with our partners

Intersectorial collaboration

An intersectoral project launched this year recognises the many social determinants of people's health, wellbeing and resilience; and the many agencies who play a part in enabling our community to be 'well'. By working together on shared priorities, we can make a positive difference. Following wide consultation to determine the key intersectoral priorities, an intersectoral forum of decision makers will be established to ensure both collaboration and progress against strategic goals.

Iwi kainga

We work closely with our Māori Relationship Board, Te Oranga O Te Iwi Kainga, and this both steers and supports the work we are doing to improve the health of our Wairarapa community. Equitable health outcomes continues as a key focus for the District Health Board.

Disability strategy introduced

We are delighted to have introduced our Disability Strategy this year; Enabling Partnerships: Collaboration for effective access to health services.

This strategy was developed together with our fellow DHBs in the Sub Region. Our Tihei Wairarapa Primary and Community Alliance programme continues to focus on delivering integrated care models closer to home and ensuring a multi disciplinary team approach.

Consumer council

Wairarapa DHB plans to have a Consumer Council in place by November 2017. The Council is designed to enhance consumer experience and service integration across the sector, promote equity of outcomes and ensure that services are organised around the needs of people and their family/ whānau. It will provide a consumer perspective and advice to both board and management through recommendations and co-design experience, so that services are better aligned with the needs of the community.

Community support

This year we have invested in a new CT scanner, bringing state of the art intelligence into our imaging service and enhancing the quality of care and wait times.

Chaplain, Lizzie Snowsill blesses the new CT scanner
November 2016

As much as we are publicly funded we do rely on the support we receive from individual entities, community trusts and organisations, such as the Wairarapa Community Health Trust (WCHT) and Rotary. Wairarapa people are very supportive of their health services, generously contributing to maintaining and developing them over and above what can be provided through national funding.

The DHB signed a Memorandum of Understanding this year with its designated charity, the Wairarapa Community Health Trust, to create a better process for people to donate funds to health services in the Wairarapa.

WCHT has provided over $100,000 in equipment, diagnostic and therapeutic aids in the last 12 months, all with funding from our community. Collectively, The Rotary Clubs of Masterton have constructed an enclosed 'delirium courtyard', and are designing and building a 'therapeutic courtyard' in 2017/18.

Our sincere thanks to both these organisations for their invaluable contibutions. These considerable donations have meant that, in a fiscally constrained environment, we have been able to improve our services for the Wairarapa region.

Looking forward

Wairarapa DHB aspires to be a respected provider of health services, to have staff that are engaged with our vision and that 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.

NZ Health Strategy

The New Zealand Health Strategy defines the future direction of healthcare in this country, describing an environment where Kiwis can live well, stay well and get well. The themes of this are embedded in the work that we do; people powered, care closer to home, value and high performance, one team and smart systems are all key drivers. The ultimate goal of Wairarapa DHB is for greater system integration that puts the patient and their whānau at the core of every decision that is made.

Iwi Kainga relationship

We are committed to a partnership with our district Iwi Rangitāne and Kahungunu. Iwi Kainga is a signatory to our annual plan and has provided the DHB with advice and support towards equity of outcomes. This will continue.

Our Maori Services Directorate also plays an enormous part in contributing to our strategic planning. All service deliverables within our annual plan have an equity focus.

Workforce is a priority for Māori Health, in particular attracting strong Māori clinical applicants and investing into and growing the Māori workforce. Ensuring better access to oral health: deteriorating oral health across all ages for Māori remains a major issue. Māori Men's Health is an area highlighted by Iwi Kainga; new thinking needs to take place to address health issues for Maori men.

Quality and Safety

The people we serve are at the heart of what we do. We have invested in co-design for services to ensure proper representation and influence that is meaningful. We intend to improve performance year on year.

Community Focus

The focus of the board and senior management is to invest in models of care and opportunities of service development that meet the objectives of the NZ Health and Disability Strategy. The programmes of work already underway and the new opportunities such as iMoko will make a positive difference to the health outcomes we seek. Our strategy requires a strong focus on relationships with NGO's, primary and community care. We will work 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.

Priorities

Our board prioritises our resource to respond to pressures such as ageing populations, increasingly expensive medical technology, a growing burden of chronic lifestyle-related disease and emerging and re-emerging infectious diseases; we need to take action and take this seriously. A discussion is being had with the PHO on urgent care and where best to place this service to reduce the increasing demand on hospital services, particularly the emergency department. A particular focus on ensuring quality is embedded in all service development with the triple aim as a guide is paramount to success.

Our people

We are investing in quality and safety and promoting professional and accountability programmes. Our people are our greatest assets and we need to invest in people to ensure the best outcomes.

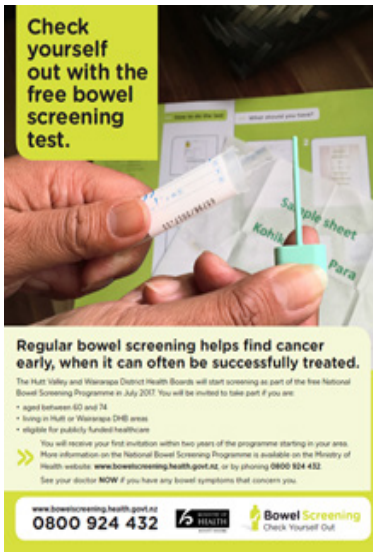
SMART systems

The implementation of the new patient management system part of the Regional Health Informatics Programme (RHIP is on track to "go live" in November 2017). 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. Further investment is needed to complete the whole programme with clinical portal, e prescription and a regional radiology information system planned.

Looking forward

Bowel Screening

We were delighted to be informed that, along with Hutt Valley DHB, we had been chosen to extend the bowel screening pilot that was initiated at Waitemata DHB five years ago. The programme is well underway as being business as usual following its launch in July 2017.



Top: messages to the public include how simple the bowel screening test kit is to use; Left: Nicola Giblett, Programme Manager and Fiona Cundy, Wairarapa Project Lead celebrate the launch

A series of hui held with Wairarapa stakeholders, health professionals, participants and their family/whānau ensured that the key messages about the bowel screening programme were well presented before, during and following the launch date. Equity remains a strong focus of the programme.

Special note of thanks from the Wairarapa District Health Board

Wairarapa District Health Board wishes to thank Derek Milne for his chairmanship over the past three years, and was pleased to see Derek being elected to the board for this term.

Thank you, farewell and congratulations were extended to Rob Irwin, Helen Kjestrup and Janine Vollebregt; all valued board members who have stood down after many years of service.

Accountability

Financially, we strive for an operating environment without deficit constraints. A strong focus on efficiencies, effectiveness and strong 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.

Equity

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.

Intersectoral

As a health system we are taking responsibility. We are accountable and we are committed.

Our multi agency, collaborative approach, and partnership with the PHO and general practice is for the benefit of the people and communities we serve, and will reap its rewards in the years ahead. We strive for a healthier population, reduction of health disparities, and improvement in Māori health.

The intersectoral work and our partnership with other sectors in service development and implementation will eliminate the duplication of scarce resource and provide the community with the leadership needed to work in collaboration. We are working intersectorally on adequate housing, as ASH rates linked to respiratory issues is a major concern.

Ministerial directions

Section 151(1)(f) of the Crown Entities Act 2004 requires information on any new direction given to all DHBs by a Minister in writing under any enactment during that financial year, as well as other such directions that remain current. The following have been identified as Ministerial Directions:

- The 2011 Eligibility Direction issued under s.32 of the NZ Public Health and Disability Act 2000;
- The requirement to implement the New Zealand Business Number (NZBN) in key systems by December 2018, issued in May 2016 under s.107 of the Crown Entities Act;
- The direction to support a whole of government approach issued in April 2014 under s.107 of the Crown Entities Act. The three directions cover Procurement , ICT and Property and the former two apply to DHBs;
- The direction on the use of authentication services issued in July 2008, which continues to apply to all Crown agencies apart from those with sizeable ICT business transactions and investment specifically listed within the 2014 direction.

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 (WrDHB) 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.

Governance report

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 2017 are as follows:

Sir Paul Collins (Chair) – commenced December 2016

Leanne Southey (Deputy Chair) – commenced December 2010

Liz Falkner – commenced December 2010

Rick Long – commenced December 2010

Fiona Samuel – commenced December 2010

Derek Milne – commenced December 2013

Ronald Karaitiana – commenced December 2013

Alan Shirley – commenced December 2013

Jane Hopkirk – commenced August 2015

Nicolas Crozier – commenced December 2016

Adrienne Staples – commenced December 2016

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.

Governance report

Name	Interest
Sir Paul Collins *Chair*	Director of: High Performance Sport NZ Limited (Chair) Active Equity Holdings Limited (Chair) Hurricanes GP Limited Ides Limited Chair, Sport New Zealand Director and shareholder of: AEL Managers Limited Beverage Holdings Limited Cohiba Traders Limited Ecopoint Limited Tofino Trustee Limited
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)* Director, Southey Sayer Limited Chartered Accountant to Health Professionals including Selina Sutherland Hospital and Selina Sutherland Trust Trustee, Wairarapa Community Health Trust Shareholder of Mangan Graphics Ltd Member of UCOL Council
Dr Nicholas Crozier *Member*	Board Member Compass Health Branch Medical Advisor ACC GP Masterton Medical Board Member Cancer Society
Dr Liz Falkner *Member*	Member, Wairarapa District Health Board Member, WRDHB 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)*
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)

Governance report

Mr Ronald Karaitiana *Member*	Member, Wairarapa District Health Board Member, Wairarapa Te Iwi Kainga Committee Member, Wairarapa District Health Board, Finance Risk & Audit Committee Wife Kylie Smith is currently the DHB liaison from Child Youth & Family Akura Lands Trust Chairman Advisory Committee for Diabetes New Zealand (24 August 2016) Contractor to Whaiora and Hauora as a Programme Manager Contractor to Rangitane as Transition Manager Director Rangitane ex Officio Extended family members work in varying roles at DHB Chair of WrDHB Hospital Advisory Committee
Mr Rick Long *Member*	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 Derek Milne *Member*	Member of 3DHB CPHAC/DSAC Brother-in-law is Chairman of Health Care NZ Daughter GP in Manurewa, Auckland
Ms Fiona Samuel Member	Member of Wairarapa District Health Board Casual Nurse at Wairarapa Hospital Duty Nurse Manager at Wairarapa Hospital (on a casual basis) Contractor Auditor for Central Technical Advisory Services Ltd Member of Clinical Board at Wairarapa District Health Board Violence Intervention Programme Clinical Co-ordinator from 22 August 2017
Mr Alan Shirley *Member*	Member, Wairarapa District Health Board Member, Wairarapa, Hutt Valley and CCDHB Hospital Advisory Committees Surgeon at Wairarapa Hospital Wairarapa Community Health Board Member Wairarapa Community Health Trust Trustee (*15 September 2016)*
Mrs Adrienne Staples *Member*	Councillor – Greater Wellington Regional Council Director – Sanctuary Hill Limited Trustee – Staples Property Trust Board Member – NZ Geographic Board

Governance report

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 WrDHB 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 2016-17 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:

FRAC:	Finance, Risk and Audit Committee
HAC:	Hospital Advisory Committee
CPHAC/DSAC	3DHB – Wairarapa/Hutt/Capital & Coast combined. During the financial period the 3DHB arrangement ceased.

	Board (10)	3DHB CHPAC/DSAC (2)	HAC (3)	FRAC (6)
Sir Paul Collins (Chairman)	6	0	0	1
Leanne Southey	10	3	0	4
Derek Milne	6	0	0	0
Derek Milne (Chair)	4	5	0	3
Rob Irwin	4	0	2	0
Helen Kjestrup	2	0	0	3
Janine Vollebregt	4	0	2	0
Rick Long	10	0	0	4
Ronald Karaitiana	6	0	4	3
Fiona Samuel	9	0	4	0
Alan Shirley	9	5	0	0
Jane Hopkirk	9	2	0	0
Adrienne Staples	6	0	0	2
Nick Crozier	5	0	3	0
Liz Falkner	10	0	5	0
Kim Smith	0	2	0	0
	100	**17**	**20**	**20**

Board members' remuneration

Board members' remuneration received or receivable for the year ended 30 June 2017 is shown in the table below. In addition, board members are able to claim reimbursement for out of pocket expenses.

	2017 Board Fee	2017 Committees Fees	2017 Total Fees	2016 Total Fees
Sir Paul Collins (Chairman)	19,600	250	19,850	0
Leanne Southey (Deputy Chair)	18,960	2,000	20,960	23,475
Derek Milne	24,960	1,000	25,960	35,615
Rob Irwin	7,532	500	8,032	18,320
Helen Kjestrup	7,532	250	7,782	17,670
Janine Vollebregt	7,532	625	8,157	17,645
Rick Long	16,320	1,000	17,320	17,570
Ronald Karaitiana	16,320	2,000	18,320	17,570
Fiona Samuel	16,320	1,188	17,507	17,320
Alan Shirley	16,320	750	17,070	17,070
Jane Hopkirk	16,320	250	16,570	13,681
Adrienne Staples	9,520	250	9,770	0
Nick Crozier	9,520	500	10,020	0
Liz Falkner	9,520	1,250	10,770	11,980
Hoani Paku	0	2,500	2,500	2,750
Yvette Grace	0	0	0	2,625
Kim Smith	0	2,750	2,750	2,063
Mike Kawana	0	500	500	2,000
Mihi Namana	0	1,750	1,750	1,750
Hariata Tahana	0	1,250	1,250	1,750
Kristina Perry	0	1,563	1,563	750
Antonia Aporo	0	2,000	2,000	750
TOTAL	196,277	24,125	220,402	222,354

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 Wairarapa 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 governance will build on successful initiatives and embed a transformative new partnership which will enabler for better outcomes for patients;
- Develop 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 Leadership 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 performance assessment system has been implemented for our people in non-clinical roles; with further development underway for a similar assessment system for clinical roles taking into account relevant registering body and employment agreement requirements.

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.

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.

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.

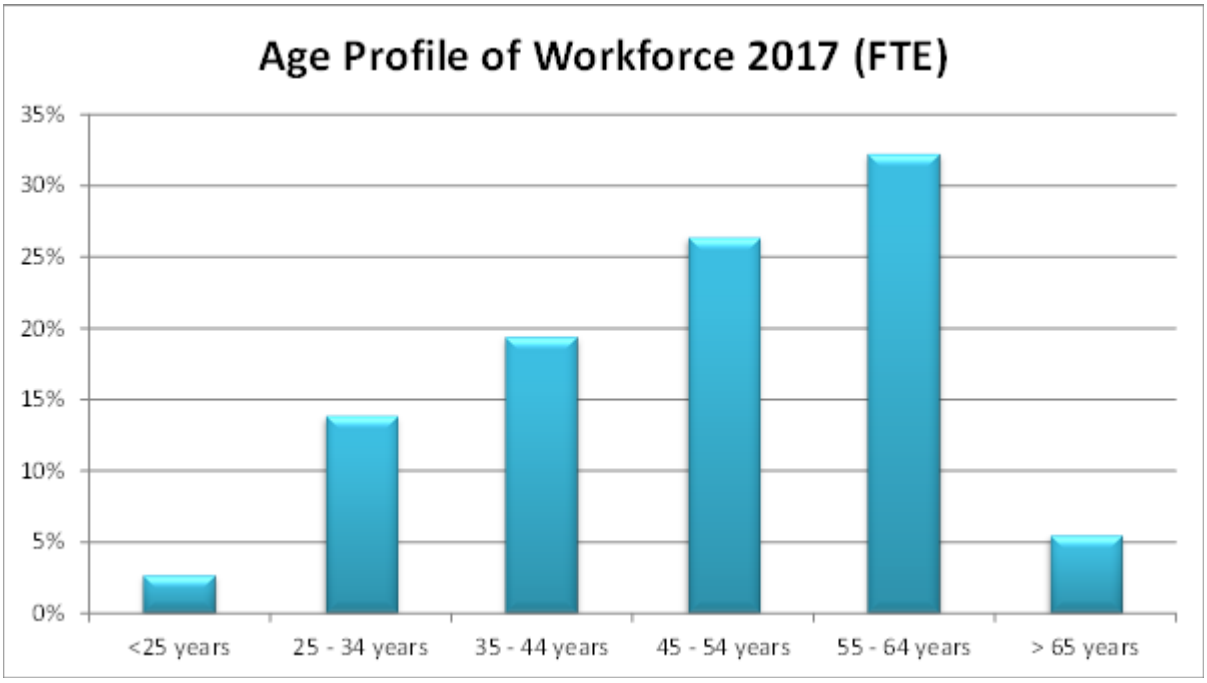
Wairarapa DHB has a zero tolerance policy to bullying and harassment; this is supported by our Workplace Bullying, Discrimination, Harassment and Victimisation Prevention Policy. On going focus will be provided to support managers, team leaders and union delegates to address inappropriate behaviour as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

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. To further support our people the DHB has in place an Employee Assistance Programme which can be accessed directly.

Full Time Equivalent staff numbers

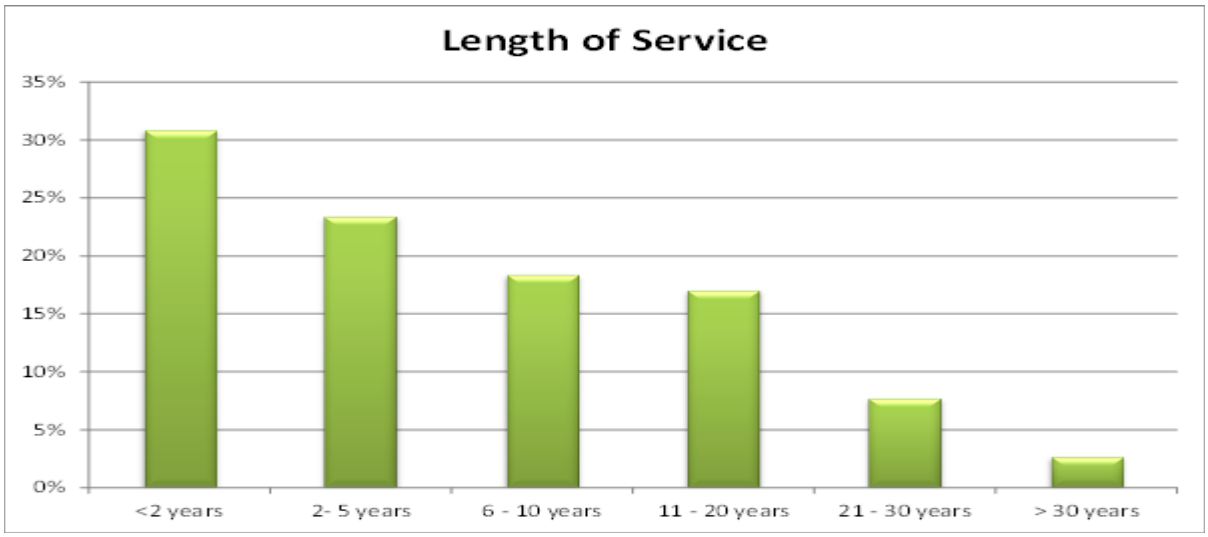
	2017	2016	2015	2014	2013	2012	2011	2010
Medical	44	42	40	36	39	38	36	33
Nursing	241	223	215	205	204	198	193	191
Allied Health	70	69	71	70	82	85	93	89
Other	116	108	102	106	101	120	119	125
Total	471	443	429	417	426	441	441	438

Age profile of workforce 2017 (FTE)

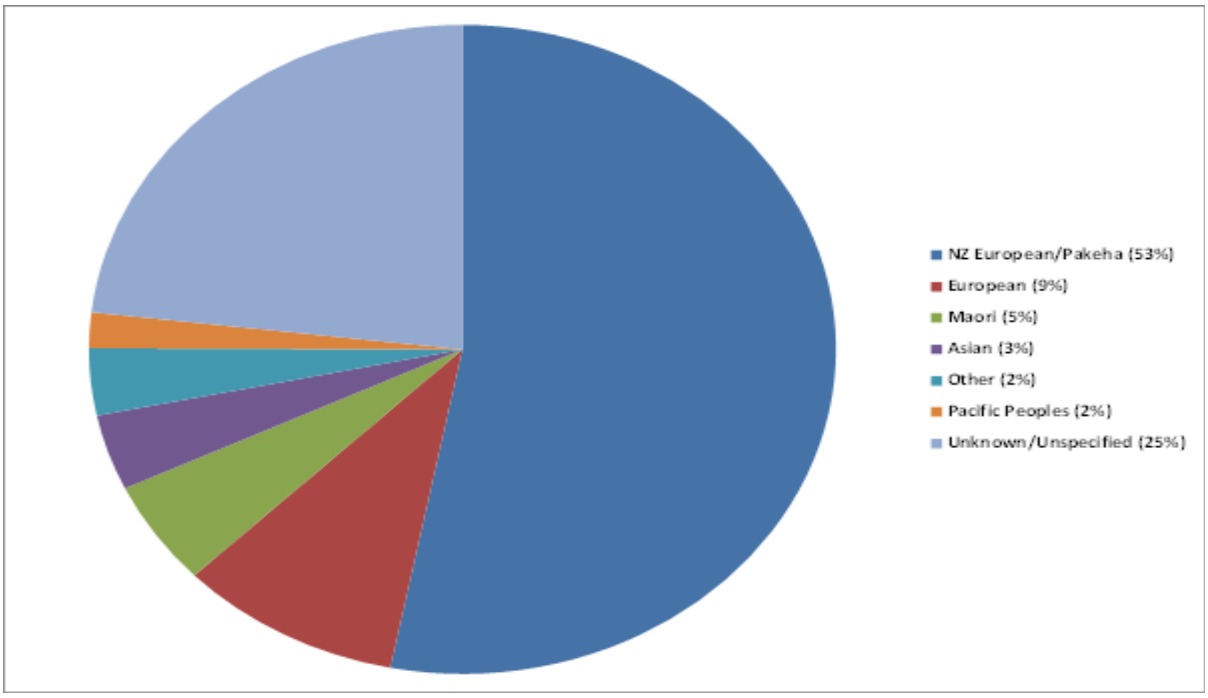


Workforce profile

Length of service



Statistics by ethnicity



Statistics by gender

	2017	2016	2015	2014	2013	2012	2011	2010
Female	81%	82%	82%	84%	82%	84%	83%	83%
Male	19%	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.

	2017 No. of Employees	2016 No. of Employees
$100,000 - $110,000	10	5
$110,001 - $120,000	6	7
$120,001 - $130,000	3	2
$130,001 - $140,000	4	5
$140,001 - $150,000	1	2
$150,001 - $160,000	1	1
$160,001 - $170,000	1	1
$170,001 - $180,000	2	3
$180,001 - $190,000	0	2
$190,001 - $200,000	0	0
$200,001 - $210,000	2	3
$210,001 - $220,000	1	0
$220,001 - $230,000	1	1
$230,001 - $240,000	2	2
$240,001 - $250,000	3	3
$250,001 - $260,000	3	3
$260,001 - $270,000	3	2
$270,001 - $280,000	2	2
$280,001 - $290,000	3	3
$290,001 - $300,000	0	0
$300,001 - $310,000	0	0
$310,001 - $320,000	2	1
$320,001 - $330,000	2	0
$330,001 - $340,000	1	0
$340,001 - $350,000	0	0
$350,001 - $360,000	0	1
$360,001 - $370,000	0	0
$370,001 - $380,000	0	1
	53	50

Of the employees shown above, 44 are clinical employees (2016: 42) and 9 are non-clinical employees (2016: 8). 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
2016/17 Tables

Revenue	2015/16 Actual	2016/17 Budget	2016/17 Actual
Prevention	1,193	1,236	1,098
Early Detection and Management	38,803	39,245	37,982
Intensive Assessment and Treatment	86,295	87,416	90,160
Rehabilitation and Support	20,063	20,879	20,133
Total	146,354	148,776	149,373

Expenditure	2015/16 Actual	2016/17 Budget	2016/17 Actual
Prevention	2,149	1,878	1,709
Early Detection and Management	40,300	40,387	40,250
Intensive Assessment and Treatment	85,666	87,082	89,569
Rehabilitation and Support	20,147	20,989	20,648
Total	148,262	150,336	152,176

Net deficit:	(1,908)	(1,560)	(2,803)

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. *(Quoted from the Ministry of Health, http://www.health.govt.nz/new-zealand-health-system/health-targets).*

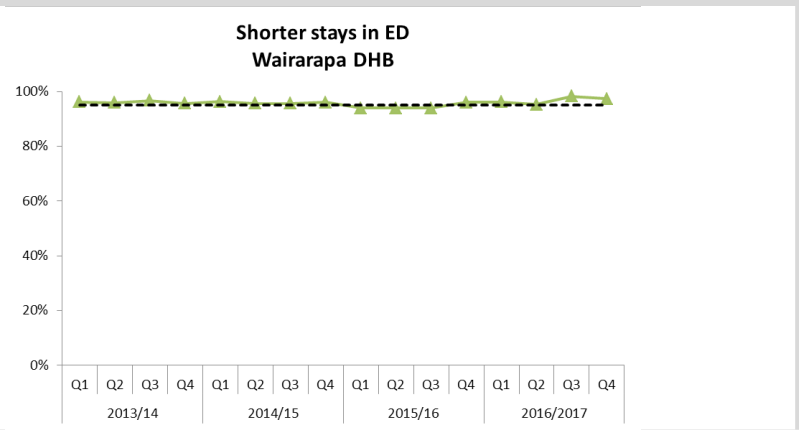
Note the changing vertical (y) axis between graphs.

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%

2016/17 Performance: 97.3%

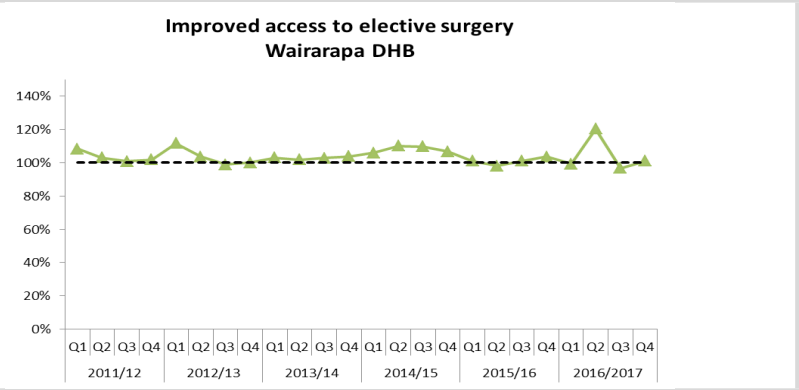


Improved access to elective surgery

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

Target: 2,417

2016/17 Performance: 2,459

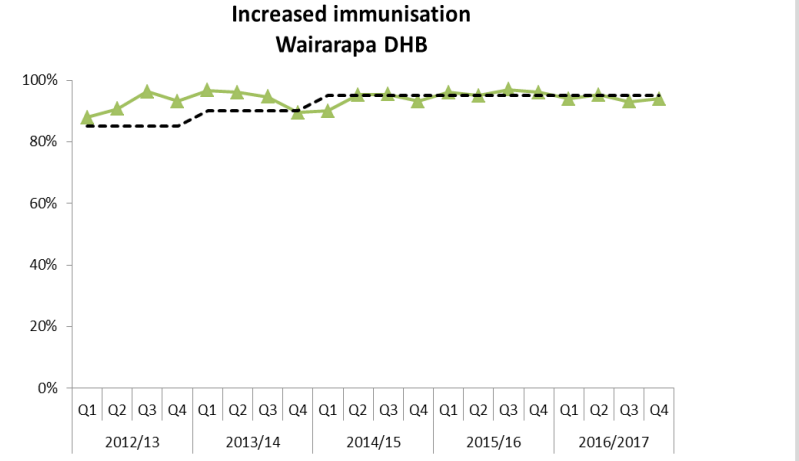


Increased immunisation

95 percent of eight month olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time.

Target: 95%

2016/17 Performance: 94%



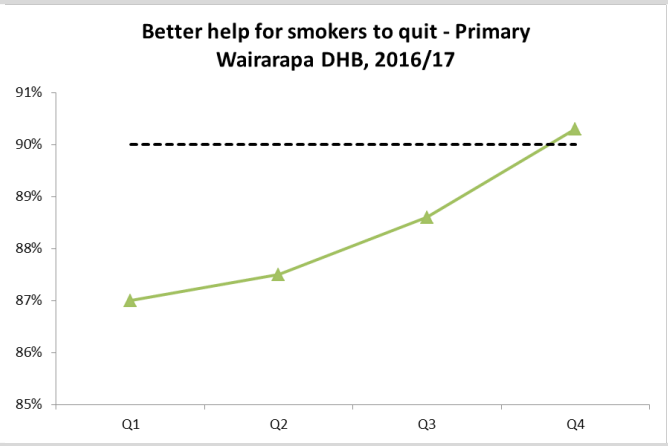
Minister's health targets

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.[1]

Target: 90%

2016/17 Performance: 90%

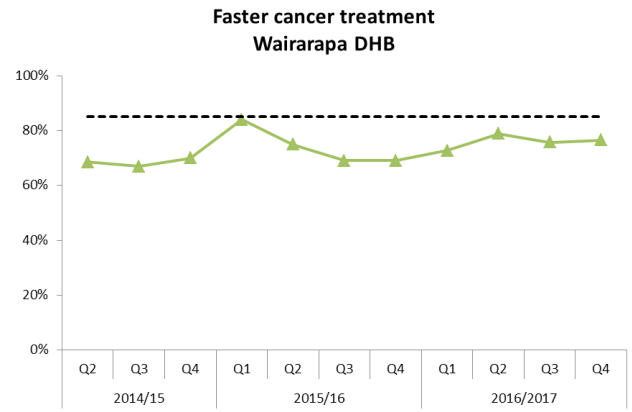


Faster cancer treatment

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.

Target: 85%

2016/17 Performance: 77%

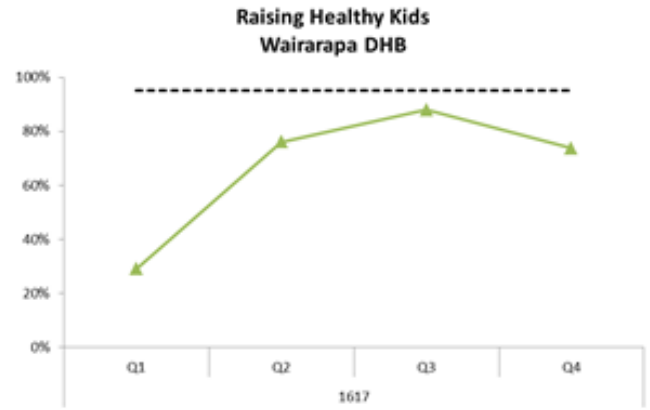


Raising Healthy Kids

By December 2017, 95% of obese children (BMI>98th percentile) identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.

Target: 95%

2016/17 Performance: 74%



This Health Target was introduced in 2016/17 so there is no data for previous years.

1 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.

Performance highlights

Wairarapa DHB continues to provide high quality and timely services for our population. In 2016/17:

- Wairarapa DHB achieved the Shorter Stays in Emergency Departments Health Target of 95% of patients presenting at an ED being admitted, discharged or transferred within six hours.
- Wairarapa DHB achieved the Improved Access to Elective Surgery Health Target, achieving 2459 surgical elective discharges against a plan of 2417.
- In Wairarapa DHB, the standardised inpatient ALOS (Electives) was below target.
- Wairarapa DHB achieved the Better Help for Smokers to Quit Health Target, with 90% of patients who smoke and were seen by a health practitioner in primary care being offered brief advice and support to quit smoking.
- The targets for the percentage of hospitalised smokers (95%) and the percentage of pregnant women who smoke (90%) receiving advice and help to quit were also exceeded.
- Wairarapa DHB continues to meet the Before School Check screening target for both the total population and the high need population, with 90.6% high need children and 93.8% of all children receiving a check.
- Compass PHO – Wairarapa achieved 100% of the DHB-domiciled population being enrolled with a PHO.
- 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 continues to achieve the 70% target for the percentage of eligible women having breast screening in the last 2 years.
- Regional Public Health exceeded the target for the percentage of school children receiving Boostrix vaccination in schools.
- 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 inpatient Patient Experience Survey.
- In Wairarapa DHB, the percentage of people 65 years of age and over receiving DHB-funded HOP services who are being supported to live at home continued to increase.
- At Wairarapa DHB, 100% of older people with long-term support needs received an InterRAI assessment and completed care plan.

Impacts and 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 our population's health. They also contribute to the effectiveness of the health system as a whole.

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 highlight the areas in which we are making a positive impact, and those in which we could seek to improve. These outcomes are progressed not just through the work of DHBs, but through the work of all 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 measure: A reduction in Ambulatory Sensitive Hospitalisation (ASH) rates[1]

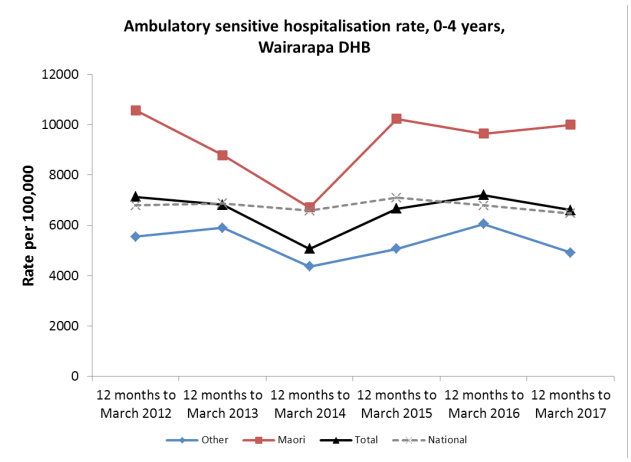
Ambulatory sensitive hospitalisations (ASH) are admissions to hospital for conditions that could have been prevented or treated by appropriate interventions in a primary care or community setting. These conditions include, for example, skin infections, dental conditions, asthma, pneumonia, cardiovascular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

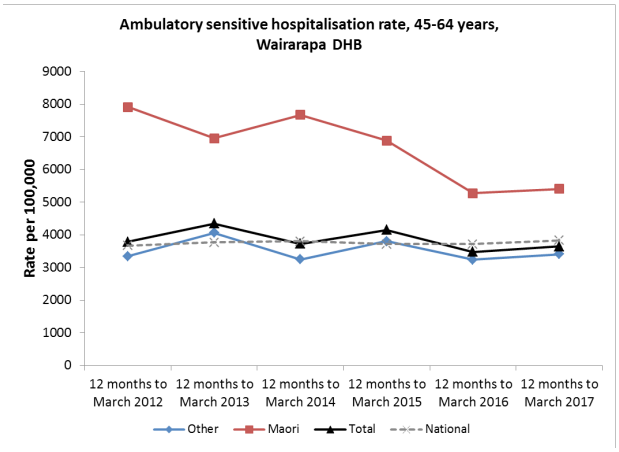
ASH rates also highlight opportunities to better support people to seek intervention early and to manage their long-term conditions. A reduction in ASH admissions will reflect better management and treatment across the whole health system.

Over the last five years, the ASH rate for Māori in Wairarapa DHB has decreased. However, it remains higher than the ASH rate for other ethnicities. This will continue to be a focus for the 2017/18 year.

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

[1]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.





Source: Ministry of Health

Impact measure: A reduction in amenable mortality rates

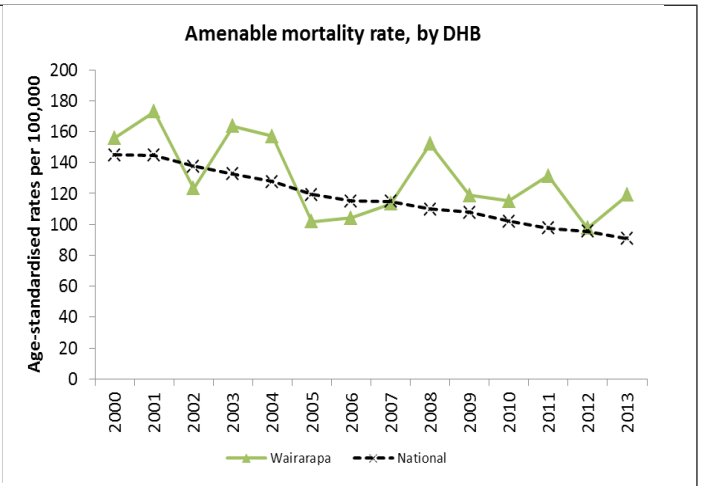
'Amenable mortality' is defined as premature deaths from conditions that were potentially avoidable through health care.

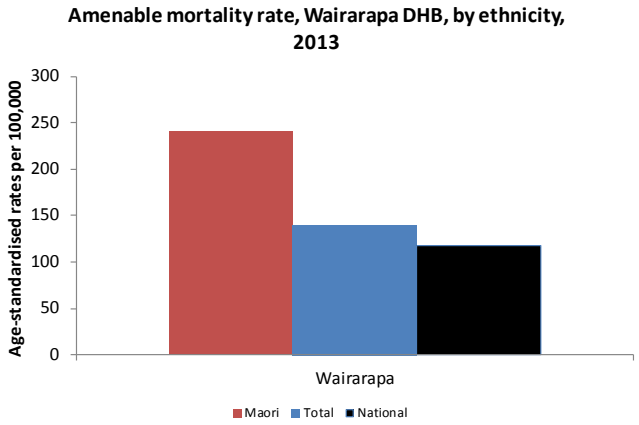
Differences in amenable mortality rates for different population groups reflect variation in the coverage, accessibility and quality of health care received by them.

Māori have higher amenable mortality rather compared to other ethnicities, indicating that this population is not receiving equitable access coverage or quality.

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

The graphs show the most recent data available from the Ministry of Health.





Source: Ministry of Health

Population health outcome: Improved environmental health and disease hazard management

What difference will we make for our population?

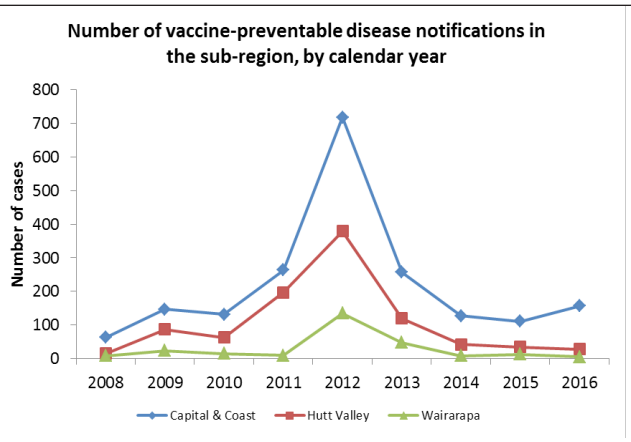
Through effective public health disease surveillance, investigation and control, the impacts of communicable, waterborne and foodborne diseases can be minimised. Public health actions are aimed at reducing the levels of harm from alcohol and drug use in the greater Wellington region. To achieve this 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[1]

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 returned to previous levels in 2014. 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

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

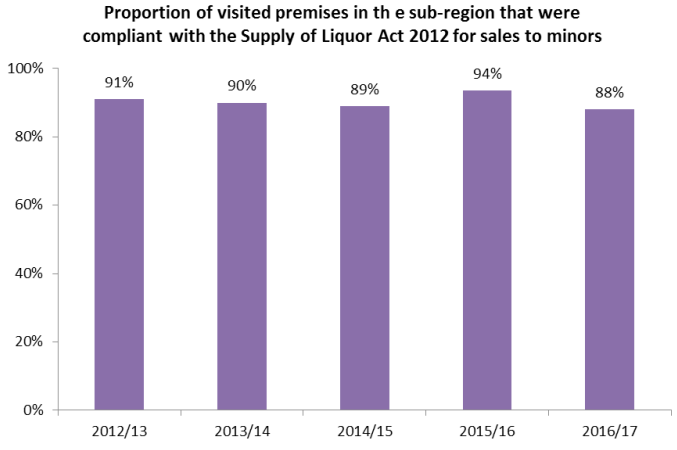
Impact measure: An increase in the percentage of premises visited that are compliant with Supply of Liquor Act 2012, for sales to minors (in the sub-region)

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.

Young people, Maori, Pacific peoples and those living in areas of higher socioeconomic deprivation are at greater risk of experiencing harm 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 2016/17, 88% of premises visited in the sub-region were compliant with the Supply of Liquor Act 2012 for sales to minors.



Source: Regional Public 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. There are four key lifestyle factors that drive health loss: smoking, obesity, physical inactivity and poor diet. Reducing the incidence of these negative lifestyle factors will improve the health of our population.

Measures – The DHB measures progress through:

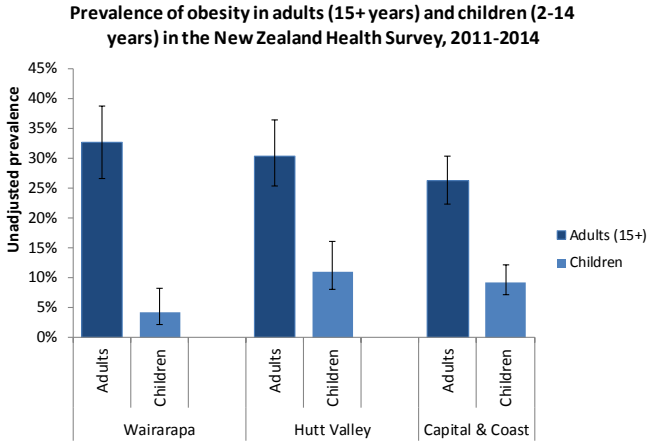
Impact measure: A decrease in the obesity prevalence in adults and children (adults 15+ years and children 0-14 years)

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 obesity in developed countries has increased so quickly that is has been described as an epidemic[1].

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.



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

1 Ministry of Health. 2004. *Tracking the Obesity Epidemic: New Zealand 1977–2003.* Wellington: Ministry of Health. The graph shows the most recent data available from the Ministry of Health.

Impacts and outcomes

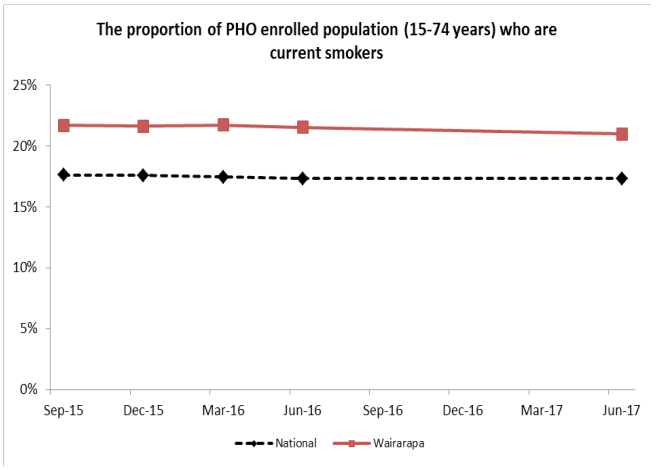
Impact measure: A decrease in the proportion of the PHO-enrolled population that is recorded as a 'current smoker'

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, 21% 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 has been a focus of the 2016/17 Maori Health Plan.



Source: Ministry of Health

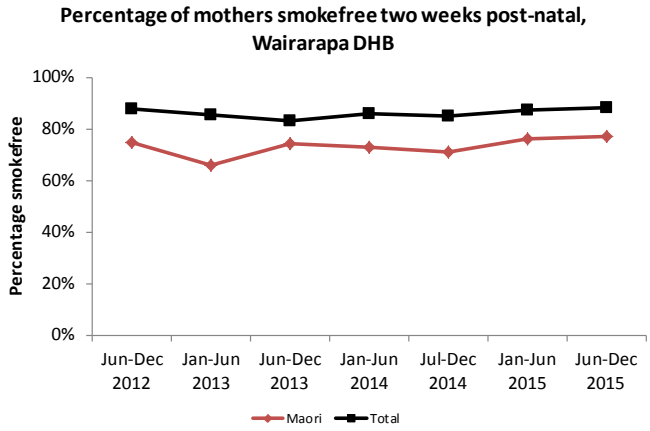
Impact measure: An increase in the proportion of mothers who are smokefree two weeks post-natal

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.

The graphs show the most recent data available from the Ministry of Health. Data for 2016/2017 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[1].

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:

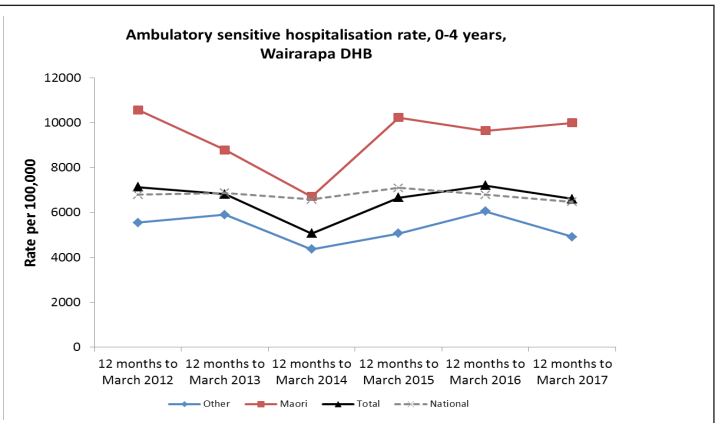
Impact measure: A reduction in Ambulatory Sensitive Hospitalisation (ASH) rates for 0-4 year olds

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

1 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

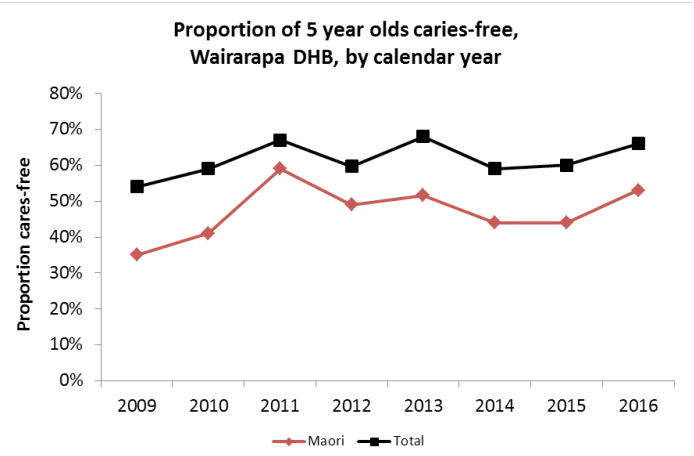
Regular dental care has lifelong benefits for health. Improved oral health is also an indicator of the equity of access to services and the effectiveness of mainstream services at targeting those most in need. Māori and Pacific children have worse oral health outcomes than other ethnicities.

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 increased from 2015 to 2016, as has the proportion of Māori children who are caries free.

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.



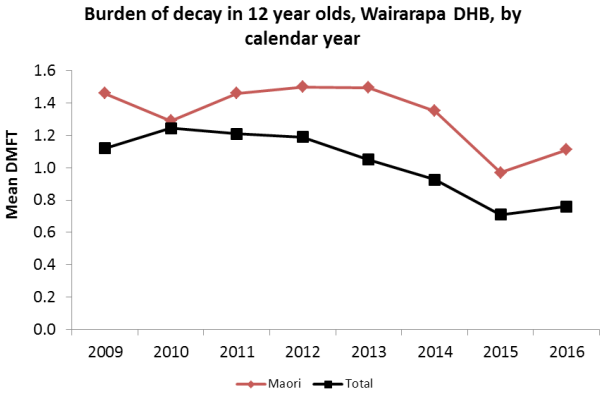
Source: Ministry of Health, Bee Healthy Dental Service

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 has increased in 2015/16, following decreases in recent years. Māori children have a higher burden of decay than other ethnicities.



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[1] 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.

Measures – The DHB measures progress through:

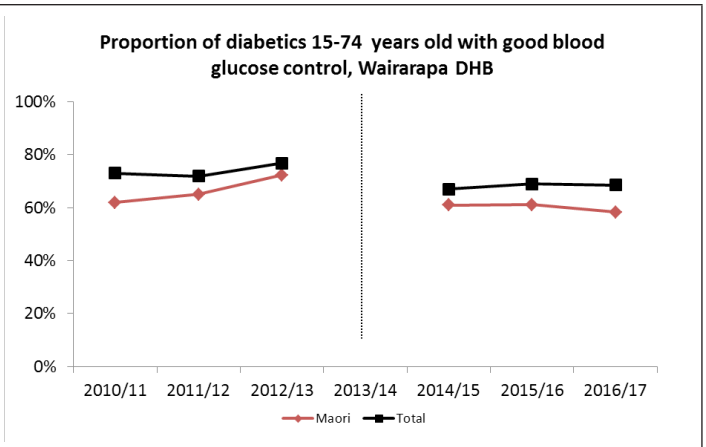
Impact measure: An increase in the proportion of diabetics with satisfactory blood glucose control (HbA1c less than 64 mmol/mol)

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.



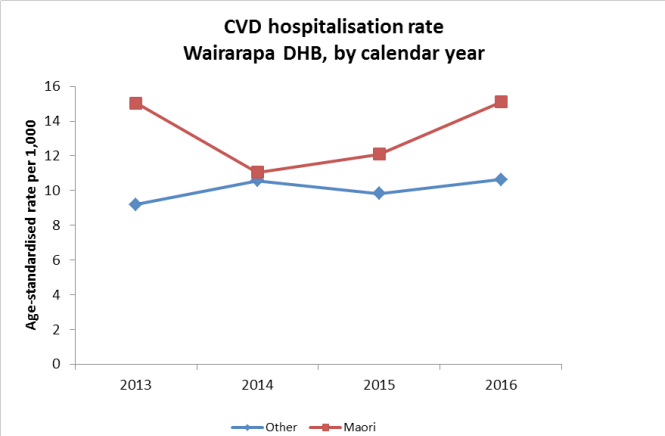
1 Ministry of Health

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 increased since 2014.



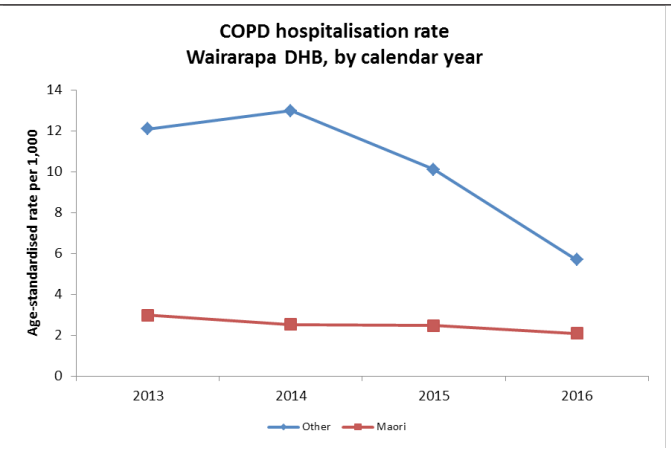
Source: National Minimum Dataset, ICD codes I00-I99, 15+ year olds

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

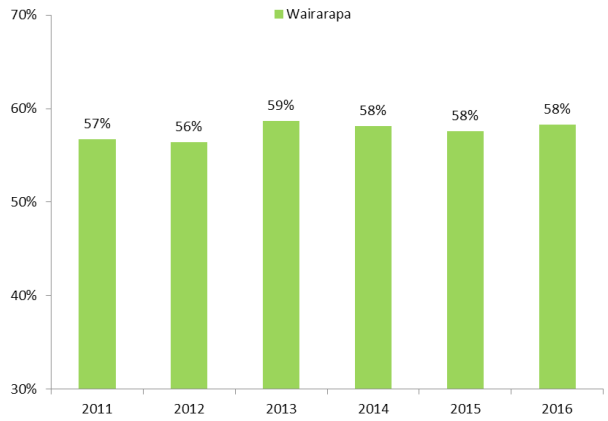
Impact measure: An increase in the proportion of dispensed asthma medications that were preventers rather than relievers

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. [1]



Source: Pharmaceutical Claims Data Mart

1 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 hospital and specialist health services when they need them

What difference will we make for our population?

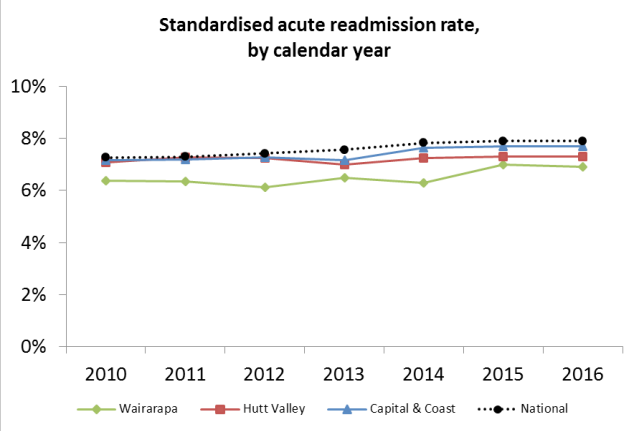
Equitable and timely access to intensive assessment and treatment can significantly improve people's quality of life, either through early intervention, or through corrective action (ie. major joint replacements to relieve pain and improve activity). Improving our service delivery, systems, and processes 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[1] 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 (ie. 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 7% for Wairarapa DHB over the last two years. Although the acute readmission rate has remained the same, the average length of stay in our hospital facilities has decreased, which shows that the effectiveness and efficiency of treatment in hospital has improved.



Source: Ministry of Health

1 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[1] cancer mortality rate

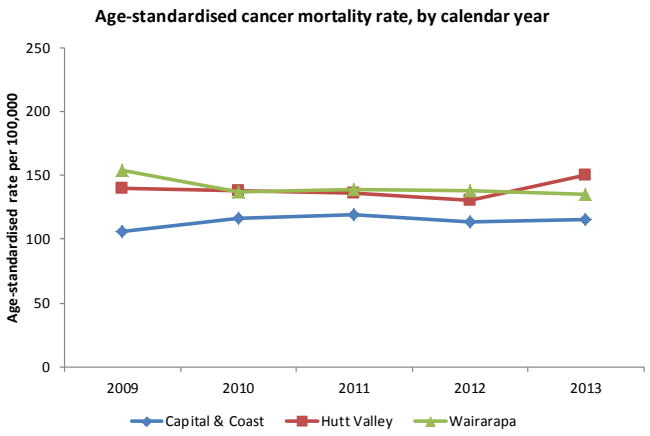
More people are developing cancer, mainly because the population is growing and getting older.

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

The Ministry of Health had not released updated data by the time of publication.

1 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.

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.

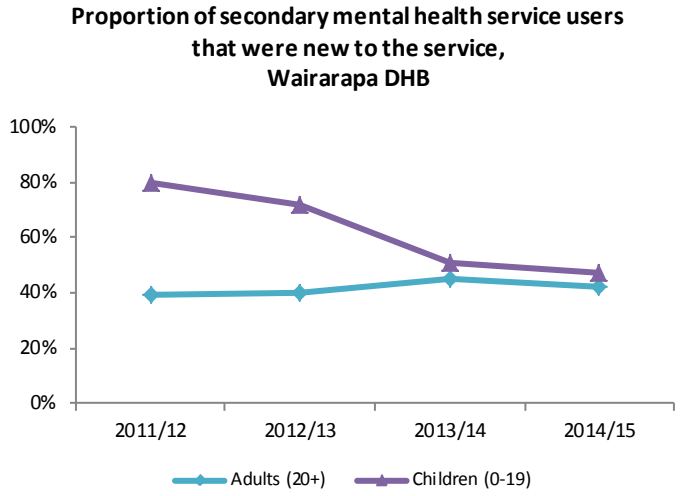
Measures – The DHB measures progress through:

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

Due to the provider of the national KPI data migrating to an online dashboard, 2016/17 data is not yet available.

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.	Note this measure is under-development with a review of the Health Passport.

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.

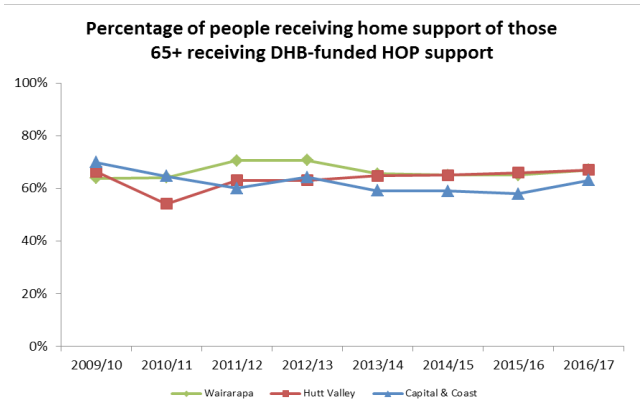
Measures – The DHB measures progress through:

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[1] 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 over the last three years.



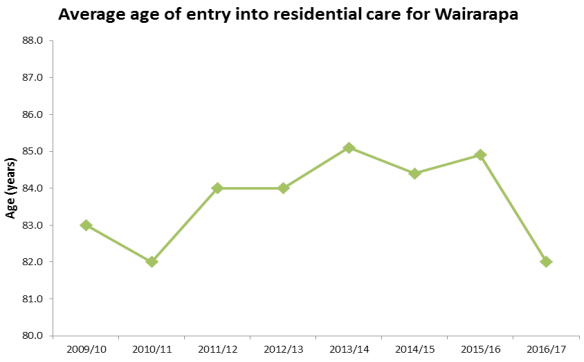
Source: Health of Older People regional benchmarking

1 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 82 years.



Source: Health of Older People regional benchmarking

Statement of performance

For the year ended 30 June 2017

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 (or outputs) that we funded and provided in the 2016/17 year.

Our four Output Classes and their related services are:

1. Prevention

Public Health Protection and Regulatory Services
Health Promotion and Preventative Intervention Services
Immunisation services
Smoking cessation services
Screening services

2. Early Detection and Management

Primary care (GP) services
Oral health services
Pharmacy

3. Intensive Assessment and Treatment

Medical and surgical services
Cancer services
Mental health and addictions services

4. Rehabilitation and Support

Disability services
Health of older people services

The outputs reflect 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 short term, and to the health outcomes that we are seeking to achieve over the longer term.

The outputs have been grouped into four 'output classes' that are a logical fit with the stages spanning the continuum of care.

Interpreting our performance

Types of measures

Identifying appropriate measures for each output class is important, as we wish 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, we report on a mix of output measures that help us to evaluate different aspects of our performance.

Outputs

The outputs are categorised by the 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 2016/17 with a † symbol. These measures were introduced in the 2016/17 Annual Plan and did not appear in the 2015/16 Annual Report. Our 2015/16 performance in these areas 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.

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 2016/17 performance (indicated with 'Est.'), based on historical and population trends.

Appropriation Reporting

	Budget 2017 $000	Actual 2017 $000	Actual 2016 $000
Appropriation revenue *	136,112	138,177	128,179

What has been achieved with the appropriation is included in the Statement of Performance section.

* 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.

3.3.1 Output class: Prevention

Description

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

These prevention services also support people to address any risk factors that contribute to both acute events (eg. alcohol-related injury) and the development of long-term conditions (eg. diabetes). A focus for these services is high health need and at-risk population groups (low socio-economic, Māori, and Pacific), who are more likely to be exposed to environments that are less conducive to making healthier choices.

Preventative services are our best opportunity to target improvements in the health of high need populations to reduce inequalities in health status and improve population health outcomes. These services ensure that threats to the health of the community such as communicable disease, water quality and imported disease-carrying pests are detected early and prevented. They also ensure we have the ability to respond to emergency events such as pandemics or earthquakes.

Outputs

Public Health Protection and Regulatory Services: enable people to increase control over their health and its determinants. This is done to address 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 the Health system has a significant role here, it requires a whole of sector approach and our DHB and Regional Public Health services work with other sectors (housing, justice, education) to enable this.

Health Promotion and Preventative Intervention 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 choices.

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[1]: **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: These services help to identify people at risk of ill-health and to pick up conditions earlier. They help early identification of breast and cervical cancer, and carry out newborn hearing testing, and antenatal HIV screening.

1 ABC for Smoking Cessation Quick Reference Card, PHARMAC

Outputs

How we measure performance of our Prevention Services:

Outputs	Measure	Type of Measure	2015/16 Performance	2016/17 Target	2016/17 Performance	2016/17 Achievement
Public health protection and regulatory services	The number of disease notifications investigated [1]	V	WDHB 134 Māori 20 Pacific 2	WDHB 134 Est. Māori 18 Est. Pacific 1 Est.	WDHB 154 Māori 15 Pacific 3	Refer to the narrative
	The number of environmental health investigations	V	92	73	90	Achieved
	The number of premises visited for alcohol controlled purchase operations	V	0	12 Est	19	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[2]	V	30	29	17	Not achieved
	The percentage of infants fully or exclusively breastfed at 3 months[3]	C	54%	≥60%	60%	Achieved
	Number of new referrals to Public Health Nurses in primary/intermediate schools[4]	V, DoS	WRDHB:185 Māori 100 Pacific 7	WDHB 178 Es.t Māori 119 Est. Pacific 8 Est.	WDHB 147	Not Achieved

1 This target is an estimated volume, as disease notification is not a response activity.

2 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).

3 This measure is based on all WCTO providers (not just Plunket).

4 This target is an estimated volume, rather than an aspirational target.

Outputs

Outputs	Measure	Type of measure	2015/16 performance	2016/17 target	2016/17 performance	2016/17 achievement
	The number of adult referrals to the Green Prescription programme	V, DoS	3,734 (in the sub-region)	≥406	124	Not achieved
Immunisation Services	The percentage of two year olds fully immunised	C	94%	≥95%	94.30%	Not achieved
	Health Target: The percentage of eight month olds fully vaccinated	C	96%	≥95%	94%	Not Achieved
	The percentage of Yr 7 children provided Boosterix vaccination in the schools in the DHB[1]	C, DoS	83%	≥70%	WDHB 81% Māori 85% Pacific 86%	Achieved
	The percentage of Yr 8 girls vaccinated against HPV (final dose) in schools in the DHB	C, DoS	75%	≥70%	WDHB 65.07% Māori 72.86% Pacific 64.29%	Partially 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	87%	≥90%	90.50%	Achieved
	The percentage of hospitalised smokers receiving advice and help to quit	C	94%	≥95%	92.2%	Not Achieved

1 Targets and performance are for the calendar year to align with school year.

Outputs

Outputs	Measure	Type of measure	2015/16 performance	2016/17 target	2016/17 performance	2016/17 achievement
	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	100%	≥90%	100%	Achieved
Screening services	The percentage of eligible children receiving a B4 School Check	C	High Dep: 98%	≥90%	High dep: 90.6%	Achieved
			T: 95%		T: 93.8%	Achieved
	The percentage of eligible women (25-69 yrs) having cervical screening in the last 3 years	C	M: 71%	≥80%	M: 72.4% P: 93.0%	Partially achieved
			T: 74%		T: 77.7%	Not achieved
	The percentage of eligible women (50-69 yrs) having breast screening in the last 2 years	C	M: 75%	≥70%	M: 69.1% P:72%	Partially Achieved
			T: 77%		T: 75.6%	Achieved

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 the Wairarapa health district). In 2016/17, there was an increase in the number of notified communicable diseases in the health district 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. For the 16/17 year there was an increase in the number of notified tuberculosis cases (no cases in 2015/16 and 6 cases in 2016/17) and associated cases of latent tuberculosis infection.

Regional Public Health responded to an increased number of Campylobacter notifications within the health district with enhanced surveillance to identify any linkages or common sources. No common sources were identified. For the period Campylobacter notifications were high across New Zealand.

At the start of the year RPH had put controlled purchase operations (CPOs) on hold while we addressed health and safety issues and the writing of the new operating procedures. This process has now been completed and staff are able to conduct CPOs with the Police in line with the new procedures. Since we have been available to assist the Police have been short staffed, and this has meant they had put CPOs on hold until they had staff capacity. This has again impacted on us being involved as alcohol CPOs require Police involvement and are led by them. We have however resumed the joint operations and have been involved in two CPOs this year across the sub regions, this included premises in the Wairarapa.

Health promotion and preventive intervention services

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).

Breastfeeding Wairarapa noted a decline in numbers of mothers attending the Breast Friends Drop in Centre and closed in February 2017. As Breastfeeding Wairarapa reviews this service, discussions have been held with other local service providers faced with similar challenges of declining numbers. As a collaborative approach to encourage participation and improve engagement, Breastfeeding Wairarapa is looking at a One-Stop-Shop model called Pepe Ora.

RPH have made fewer submissions during this period primarily due to capacity issues, and have prioritised the ones that would make the most improvements for our communities. We are currently gearing up for the three year Council Long Term Plans.

All low Decile schools have a designated Public Health Nurse to respond to referrals and there is a response model in place for all high Decile schools. The referrals relate to the schools and there is a PHN working in Early Childhood Centres who has completed 27 personal health referrals over the past year.

The Public Health Nurse(PHN) team is responsible for personal health referrals and HPV/Boostrix vaccinations in the Wairarapa. The PHNs deliver health promotion and education to the schools and ECCs with the aim to promote well-health and reduce the number of personal health referrals. The increased access to care through free under 12 year olds has contributed to children seeking early access to their GP practices.

Outputs

Green Prescription referral numbers are growing in the Wairarapa, but this is slower than anticipated. The Wairarapa based Healthy Lifestyle Co-ordinator continues to prioritise practice-based promotion and has recently linked in with secondary care based nurses and marae-based services. Compass Health – Wairarapa have been a supportive partner, sharing key messages on Sport Wellington's behalf during clinical visits.

Winter is typically quieter for the Green Prescription programme for prediabetes, GRxPlus, as Sport Wellington respond to the trends of their participants (ie. less likely to participate in group programmes, and less interested in getting out and about). However, Sport Wellington have increased their face-to-face delivery during this time. Permanent face-to-face locations have been expanded to the Wairarapa. In 2017/18, Sport Wellington expects to link more GRxPlus participants into group programmes across the DHB and planning for this is currently underway.

With Healthy Lifestyle Programmes funding renewed, there are new opportunities for collaboration to deliver group-based interventions in Wairarapa DHB. Co-delivery of programmes is currently underway with Te Rangimarie Marae in the Wairarapa.

Immunisation services

In Wairarapa DHB, for the year 1 July 2016 to 30 June 2017 there were 499 children aged 8 months eligible for immunisation, with 467 of these fully immunised. There were 22 infants for whom immunisation was declined, and 3 whom had opted off the National Immunisation Register, so immunisation status is unknown. This results in 7 infants not fully immunised for this age group over this 12 month period. In total, 94% of this milestone age group were fully immunised, with a total of 96% for Maori and 94% for Pacific Island populations.

There were also 527 children aged 24 months eligible for immunisation, with 497 of these fully immunised. There were 24 children for whom immunisation was declined, and 1 whom opted off NIR. This results in 5 children not fully immunised for this age group over this 12 month period. In total, 94% of this milestone age group were fully immunised, with a total of 94% for Maori and 100% for Pacific Island populations.

There is regular contact between District Immunisation Facilitator, National Immunisation Register and Outreach Immunisation Service to discuss emergent issues relating to the delivery of service to overdue children/whanau, as well as good relationships with all of the immunisation providers within the Wairarapa.

Smoking Cessation Services

Primary Care Health Target **-** The target for primary care is that 90% of enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15months.This target covers the entire population of people who smoke, regardless of whether or not they are seen in the practice. This means practices must be more pro-active with follow-up and advice for all people, rather than just opportunistic interventions when patients are attending an appointment. Compass Health Wairarapa have consistently achieved close to target for each quarter during 2016/17, Quarter one – 87%, Quarter two – 88%, Quarter three – 88.6% and Quarter four on 30 June 2017 achieving at 90.3%.

Secondary Care Health Target - During the year 2016/2017 the Wairarapa DHB has had a hospital wide focus to ensure the target of 95% was achieved and sustained. All ward managers reviewed their documentation and systems and made the necessary changes to ensure every patient who smoked was identified and received brief advice. Any patient who missed their brief advice was investigated and a report was sent by the Smokefree Coordinator to the appropriate manager to then follow up. Weekly reports on how the target is progressing is sent to all those involved in the health target. A new hospital Stop Smoking Clinic has been established with the Regional Stop Smoking Service to encourage hospital staff to refer patients for cessation support.

Maternity Health Target – The Wairarapa DHB regularly achieve the health target of 90%.The Lead Maternity Carers(LMC)consistently screen their clients for smoking and offer brief advice to those who do smoke. A pregnancy incentivised programme (Hapu Mama) has been developed by Regional Public Health and the Regional Stop Smoking Service to support the LMCs and their clients who smoke. The LMCs referral rate to the programme has increased during the 2016/17 year.

Screening services

The new model of care for the B4 School check was implemented for the 2016/17 year. The new model of care comprises of trained Practice nurses delivering the check in the Practice where the check takes place. Annual B4 School Check training is offered to Practices to maintain and improve skill. The whole B4 School Check also includes vision and hearing tests provided by Regional Public Health. Both the high needs target and the total target were achieved in Wairarapa.

Although Wairarapa DHB has not achieved the percentage of eligible women aged 25 – 69 having had a cervical smear in the last 3 years it has shown improvement during the reporting year. The total population courage has increased to 77.7% and Pacific coverage is 93%. Maori have increased to 72.4% and there is still an inequity issue with coverage. During the year Compass Health undertook and incentive pilot which helped increase the coverage rates. The system continues to work hard to promote cervical screening and improve recall processes however with the loss of the Mana Wahine Service maintaining and improving on current rates will be a challenge.

The Mobile Breast Screening bus is now rostered to visit Wairarapa annually. This will ensure that it is more accessible to priority women in Wairarapa.

3.3.2 Output Class: Early Detection & Management Services

Description

Early detection and management services are delivered by a range of health and allied health professionals in private, not-for-profit and government service settings. These services include general practice, community and Maori health services, Pharmacist services, Community Pharmaceuticals and child and adolescent oral health and dental services. These services are by nature more generalist,and are focused on individuals and smaller groups of individuals.

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. These services keep people well by intervening early to detect, manage, and treat health conditions (eg. 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 dental services provided to children (pre-school, primary school and intermediate school children) and adolescents (year 8 up to their 18th birthday) by registered oral health professionals to assist people in maintaining healthy teeth and gums.

Pharmacy services: Include the provision and dispensing of medicines, and are demand-driven. Community pharmacies provide medicine management to people living in the community. Medication management is particularly important for people on multiple medications to reduce potential negative interactive effects.

Outputs

How we measure the performance of our Prevention Services:

Outputs	Measure	Type of Measure	2015/16 Performance	2016/17 Target	2016/17 Performance	2016/17 Achievement
Primary care services	The percentage of the DHB-domiciled population that is enrolled in a PHO	C, DoD	98%	≥99%	100%	Achieved
	The percentage of practices with a current Diabetes Practice Population Plan	Q, DoS	100%	100%	100%	Achieved
	The percentage of the eligible population assessed for CVD risk in the last five years	C, DoS	90%	≥90%	89.20%	Not Achieved
	The number of new and localised Health Pathways in the sub-region	Q	68	≥250	320	Achieved
	The average number of users (per month) of the Health Pathways website	V	845	≥5750	1300	Not Achieved
Oral health services	The percentage of children under 5 years enrolled in DHB-funded dental services[1]	C, DoD	2015: 91%	95%	2016: 83%	Not Achieved
	The percentage of adolescents accessing DHB-funded dental services	C, DoD	2015: 67%	≥85%	2016: 64.2%	Not Achieved

Pharmacy services	The number of initial prescription items dispensed	V, DoS	444,603	436,515	457,278	Achieved
	The percentage of the DHB-domiciled population that were dispensed at least one prescription item	C, DoD	80%	≥80%	84%	Achieved
	The percentage of people registered with a Long Term Conditions programme in a pharmacy	V, DoS	7.8%	≥8.1%	9.7%	Achieved
	The number of people participating in a Community Pharmacy Anticoagulant Management service in a pharmacy	V, DoS	43	≥30	45	Achieved

1 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 expectation in these plans that activities to improve health outcomes for Māori and Pacific are identified.

All 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 are incorporated into the Practice's Annual plans.

89.2% of the eligible Wairarapa population have had a heart check (CVD risk assessment) just short of the target of 90%. 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 PHO has also provided funding for to enable practices to offer free checks for Maori, Pacific and low income people.

During 2016/2017, Compass Health, Masterton Medical and Connecting Communities continued to develop Youth Kinex, a youth centred health and wellbeing service to support improved access to services for young people.

The Tihei Alliance has continued to focus on better management of acute care. The 'Where should I be?' campaign aims to make it easier for people to know when and where to access healthcare services in the region, particularly for acute or after hours treatment. The campaign includes wellness promotions and injury prevention campaigns to help people avoid getting sick in the first place along with simple messaging about options for local healthcare advice and support.

The campaign has contributed to a reduction in people with minor injuries and illnesses accessing Wairarapa Hospital's Emergency Department and an increase in visits to local medical centres.

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

The 2016/17 average number of users per month of the Health Pathways website did not reach expectations. 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

Over the last two years, all newborn babies have been enrolled at birth and parents have been invited to attend information groups when the child is 2 – 3 months old. This has increased pre-school enrolments and we anticipate this will continue for the next three years, when all pre-schoolers will have been offered this service.

All (100%) of adolescents (Year 8) in the Wairarapa are transferred to private practitioners who operate within the Combined Dentral Agreement (CDA). The DHB meets regularly with the individual Dental Practices, and will continue to work to increase the percentage of adolescents accessing services. The DHB is also working with secondary schools to make sure that all new arrivals to the area have access to dental care.

Pharmacy Services

The number of dispensed items, and the percentage of people who were dispensed at least one item, reflect prescribing patterns and the consequent level of community pharmacy activity. The significant growth in people registered by the LTC pharmacy programme occurred in two Wairarapa pharmacies, against a national trend of flat or little growth in this service. Some Wairarapa pharmacies have high levels of patients in this service.

The number of people participating in the Community Pharmacy Anticoagulant Management Service is now at or close to the maximum contracted level for this service. 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 delivered by a range of secondary, tertiary and quarternary providers using public funds. These services are usually integrated into facilities that enable co-location of clinical expertise and specialised equipment, such as a hospital. These services are generally complex and provided by health care professionals that work closely together. On a continuum of care, these services are at the complex end of treatment services and focused on individuals.

They include:

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

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).

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 are monitored across age groups and ethnicities to ensure service levels are maintained and to demonstrate responsiveness.

Outputs

How we measure performance of our Intensive Assessment & Treatment Services

Outputs	Measure	Type of measure	2015/16 performance	2016/17 target	2016/17 performance	2016/17 target
Medical and surgical services	**Health Target:** The percentage of patients admitted, discharged or transferred from ED within 6 hours	T,DoS	96%	≥95%	97.30%	Achieved
	Health Target: The number of surgical elective discharges	V, DoD	2,480	≥2417	2,459	Achieved
	The standardised[1] inpatient average length of stay (ALOS) in days, Acute[2]	T, DoS	2.37	≤2.35	2.36	Not Achieved
	The standardised inpatient average length of stay (ALOS) in days, Elective	T, DoS	1.47	≤1.55	1.36	Achieved
	The rate of inpatient falls causing harm, per 1,000 bed days	Q, DoS	1.15	≤1.3	1.07	Achieved
	The rate of Hospital Acquired Pressure Injuries, per 1,000 bed days	Q, DoS	0.65	≤0.50	0.43	Achieved
	The rate of identified medication errors causing harm, per 1,000 bed days	Q, DoS	0.90	≤0.65	1.7	Not Achieved

1 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.

2 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).

Outputs

Outputs	Measure	Type of measure	2015/16 performance	2016/17 target	2016/17 performance	2016/17 achievement
	The weighted average score in the Patient Experience Survey[1]	Q, DoS	Communication: 8.8 Coordination: 8.8 Partnership: 9.4 Physical and emotional needs: 9.4	>8.0	Communication: 8.5 Coordination: 8.7 Partnership: 8.5 Physical and emotional needs: 8.8	Achieved
	The percentage of "DNA" (did not attend) appointments for outpatient *first* specialist assessments	Q, DoS	7.30%	≤8%	6.98%	Achieved
	The percentage of "DNA" (did not attend) appointments for outpatient *follow-up* specialist appointments	Q, DoS	6.90%	≤6%	7.30%	Not Achieved
Cancer services	The percentage of patients, ready for treatment, who waited less than four weeks for radiotherapy or chemotherapy	T, DoD	99.3%	100%	100%	Achieved

1 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

Outputs	Measure	Type of measure	2015/16 performance	2016/17 target	2016/17 performance	2016/17 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[1]	T, DoD	68%	≥95%	75.8%	Not achieved
Mental health and addiction services	The number of people accessing secondary mental health services	V	M:616 T: 2,082	M:535 T: 1,891	M: 622 T: 2,048	Achieved
	The percentage of patients 0-19 referred to non-urgent child & adolescent mental health services that were seen within eight weeks[2]	T, DoS	85%	≥95%	93%	Not achieved
	The percentage of patients 0-19 referred to non-urgent child & adolescent addictions services that were seen within eight weeks	T, DoS	97%	≥95%	98%	Achieved

1 This is a new measure that replaced the 'Shorter Waits for Cancer Treatment' Health Target from 1 October 2014.

2 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

ED wait times have maintained high performance throughout the year, meeting the 6 hour target with an improvement on the previous year. Weekly review of breaches with the director of Nursing and CNM Acute care seeks to identify reasons for breaches, and develop means to mitigate these. The use of short stay beds has been beneficial, as has staff training.

Average length of stay for electives remains on target in spite of a very busy year. Regular review of patient flow and identification of barriers has contributed to this good performance. The performance for acutes is slightly below target, due to the complex co-morbidities of many elderly patients. On-going work around patient flow is focused on improving length of stay.

Medication errors remain a cause for concern. Regular education of medical and nursing staff has occurred. Work is in progress towards moving to an electronic prescribing and dispensing system that, it is believed, will significantly reduce medication error compared with the current handwritten process. The Clinical Board continues to monitor medication errors.

Focussing on consumer value encourages our DHB to involve our communities in improving current performance and planning for the future – receiving feedback via the National Patient Experience survey is one way that we can gain insight into the experience of patients in our hospital and identify how we can improve.

Cancer services

The percentage of people waiting longer than 4 weeks for chemotherapy and radiotherapy is below target at 99.3%. In real terms this may represent one or at most two patients when measured against the total number of patients being treated. Regular communication with medical oncology and radiotherapy services in neighboring DHBs providing these services has kept delay to a minimum.

The 31 and 62 day targets remain a challenge for this DHB. This is due in part to the reliance on neighboring DHBs for many cancer services. Cancer patients on these lists are case managed by weekly review by the cancer care nurse and the chief medical officer. Each patient journey is explored, and any blocks to the flow of treatment identified and where possible addressed. One of the most frequent causes of breach relates to prostate cancer, for patients who opt for surgery. As the urology team visit only monthly, it is difficult to ensure surgery is provided within the required time frame. Part of this process is administrative, with some debate about the date on which 'Decision to treats' should be recorded.

Mental health and addiction services

Maori access rates (as a percentage of all patients seen by secondary mental health services) have increased from 33.7% to 35.3% over the past two years, and achieved the performance target.

During this period the service experienced a deficit in SMO resource (employed FTE) in addition to a deficit in registered clinician resource.

The service successfully increased the employed clinical FTE, which may have had a positive impact on the management of new referrals.

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. Rehabilitation and support services may be delivered in coordination with other organisations and agencies, and may include public, private, and part-funding arrangements.

Outputs

Disability services: Many disability services are accessed through a Needs Assessment and Service Co-ordination (NASC) service. NASCs are organisations contracted to the Disability Support Services, 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 older 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	2015/16 Performance	2016/17 Target	2016/17 Performance	2016/17 Achievement
Disability services	The number of Disability Forums	V	1	≥1	1	Achieved
	The number of sub-regional Disability Newsletters	V	8	≥2	12	Achieved
	The total number of Disability Alert registrations[1†]	Q	N/A	≥324	N/A	N/A
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	100%	100%	100%	Achieved
	The percentage of people 65+ receiving DHB-funded HOP support who are being supported to live at home	C, DoS	65%	≥ 65%	67%	Achieved
	The percentage of the population aged 75+ who are in Aged Residential Care (including private payers)	C, DoS	12.2%	≤12.2%	9.7%	Achieved
	The number of subsidised aged residential care bed days[2]	V.DoS	127.675	Est. 126.250[3]	130,396	Achieved
	The percentage of residential care providers meeting three or more year certification standards	Q, DoS	82%	≥83%	85%	Achieved

1 Disability Alerts help clinicians to identify and respond to the needs of the patients with disabilities. Disability Alerts are scheduled to be introduced in the Wairarapa from March 2018. In the meantime, Wairarapa clients are registering their interest in the alert and preparing for its introduction.

2 Subsidised bed days are any DHB-funded bed days, including top-up clients and people paying less than the maximum client contribution.

3 This is a descriptive measure of volumes only and is not the focus for service improvement or improving health status

Commentary

Disability services

Two key events occurred during the 2016/17 year. International disability week led to a significant celebration locally and sub-regionally. Twelve Wairarapa DHB staff were awarded a champions gift at a December celebration for services to support staff and patients with disabilities. A 3DHB event launching a video and education package for the sub-region was attended by Wairarapa DHB staff and consumers. The second event was the co-production of the sub-regional disability strategy 2017-2022. The Chair of the SRDAG led a public launch attended by intersectoral partners and co-writers of the Plan.

The Disability Team now releases regular community bulletins of events and updates on local forums, and events. This has led to a more informed and united community.

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 consistently achieved.

There is an increased proportion of older people who are being supported to live at home, which is in line with the DHB's strategy.

Reporting in percentages for small numbers can give a distorted result. In 2016-17 Wairarapa had thirteen facilities and two of these (15%) have two year certification rather than three. There is therefore likely to be a time-lag for this measure as recertification of these facilities won't be due until 2018.

A smaller proportion of the population over 75 years were in residential care at the end of June than the year before.

Financial statements

Contents

Statement of comprehensive revenue and expense

For the year ended 30 June 2017

	Note	Group Budget 2017 $000	Group Actual 2017 $000	Group Actual 2016 $000	Parent Actual 2017 $000	Parent Actual 2016 $000
Revenue						
Operating revenue	1	149,964	150,577	147,483	149,308	146,245
Finance revenue	2	80	29	7	66	109
Total revenue		**150,044**	**150,606**	**147,490**	**149,374**	**146,354**
Expenditure						
Workforce costs	3	41,571	46,426	45,420	46,426	45,420
Other operating expenses	4a	27,795	23,889	23,095	22,753	22,007
External providers	4b	44,861	43,986	43,679	43,986	43,679
Inter district flows	4b	33,969	36,443	34,166	36,443	34,166
Total operating expenditure		**148,196**	**150,744**	**146,360**	**149,608**	**145,272**
Operating result before Interest, Depreciation & Capital Charge		**1,849**	**(138)**	**1,130**	**(234)**	**1,082**
Interest, Depreciation & Capital Charge						
Interest expense	5	970	576	1,029	576	1,029
Capital charge	5	560	381	342	381	342
Depreciation & amortisation expense	7,8	1,856	1,720	1,686	1,612	1,619
Total Interest, Depreciation & Capital Charge		**3,386**	**2,677**	**3,057**	**2,569**	**2,990**
Surplus/(Deficit)		**(1,537)**	**(2,815)**	**(1,927)**	**(2,803)**	**(1,908)**
Total comprehensive revenue and expense		(1,537)	(2,815)	(1,927)	(2,803)	(1,908)

The accompanying notes form part of the financial statements. Major variances against budget are explained in note 22.

Statement of financial position

As at 30 June 2017

	Note	Group Budget 2017 $000	Group Actual 2017 $000	Group Actual 2016 $000	Parent Actual 2017 $000	Parent Actual 2016 $000
Assets						
Property, plant & equipment	7a	44,011	39,555	40,380	39,408	40,200
Intangible assets	8	3,512	7,772	6,202	7,661	6,087
Investments	9	814	323	815	426	918
Total non-current assets		**48,337**	**47,650**	**47,397**	**47,495**	**47,205**
Cash & cash equivalents	10	130	177	191	3	7
Inventories	11	903	1,016	902	1,016	902
Trade & other receivables	12	4,682	5,167	4,659	5,001	4,498
Assets classified as held for sale	7b	0	50	50	50	50
Total current assets		**5,715**	**6,410**	**5,802**	**6,070**	**5,457**
Total assets		**54,052**	**54,060**	**53,199**	**53,565**	**52,662**

	Note	Group Budget 2017 $000	Group Actual 2017 $000	Group Actual 2016 $000	Parent Actual 2017 $000	Parent Actual 2016 $000
Equity						
Crown equity	13	45,037	68,778	42,034	68,778	42,034
Revaluation reserve	13	5,558	5,558	5,558	5,558	5,558
Retained earnings	13	(40,464)	(42,892)	(40,077)	(43,233)	(40,430)
Total equity		**10,131**	**31,444**	**7,515**	**31,103**	**7,162**
Liabilities						
Interest-bearing loans & borrowings	14	15,474	223	19,802	223	19,802
Employee benefits	15	620	607	620	607	620
Restricted Funds	16	274	332	274	332	274
Total non-current liabilities		**16,368**	**1,162**	**20,696**	**1,162**	**20,696**
Cash & cash equivalents - overdraft	10	669	3,183	1,412	3,183	1,412
Interest-bearing loans & borrowings	14	10,579	79	6,324	79	6,324
Payables & accruals	17	9,065	10,283	9,749	10,227	9,674
Employee benefits	15	7,240	7,909	7,504	7,811	7,393
Total current liabilities		**27,553**	**21,454**	**24,989**	**21,300**	**24,803**
Total liabilities		**43,921**	**22,616**	**45,684**	**22,462**	**45,499**
Total equity & liabilities		**54,052**	**54,060**	**53,199**	**53,565**	**52,662**

The accompanying notes form part of the financial statements. Major variances against budget are explained in note 22.

Statement of changes in equity

For the year ended 30 June 2017

	Note	Group Budget 2017	Group Actual 2017 $000	Group Actual 2016 $000	Parent Actual 2017 $000	Parent Actual 2016 $000
Balance at 1 July		**8,668**	**7,515**	**6,445**	**7,162**	**6,073**
Net surplus / (deficit) for the year		(1,537)	(2,815)	(1,927)	(2,803)	(1,908)
Other comprehensive revenue and expense		0	0	0	0	0
Total comprehensive revenue and expense		(1,537)	(2,815)	(1,927)	(2,803)	(1,908)
Equity injection from the Crown	14	3,000	26,750	3,000	26,750	3,000
Repayment of equity to the Crown		0	(6)	(3)	(6)	(3)
Movements in equity for the year		3,000	26,744	**2,997**	26,744	**2,997**
Balance at 30 June	13	**10,131**	**31,444**	**7,515**	**31,103**	**7,162**

Statement of cash flows

For the year ended 30 June 2017

	Note	Group Budget 2017 $000	Group Actual 2017 $000	Group Actual 2016 $000	Parent Actual 2017 $000	Parent Actual 2016 $000
Cash flows from operating activities						
Operating receipts:						
Government & crown agency revenue		149,964	143,368	139,918	143,368	138,502
Other		0	6,701	6,417	5,432	6,417
Interest received		81	55	51	55	50
Payments to suppliers & employees		(148,013)	(149,882)	(144,985)	(148,643)	(143,732)
Capital charge paid		(560)	(381)	(226)	(381)	(226)
Interest paid		(970)	(576)	(1,032)	(576)	(1,032)
Goods and Services Tax (net)		0	(95)	(61)	(95)	(61)
Net cash flows from operating activities	10	**502**	**(810)**	**82**	**(840)**	**(82)**
Cash flows from investing activities						
Proceeds from sale of property, plant & equipment		0	5	0	5	0
Dividends received		0	(31)	0	(31)	107
Acquisition of property, plant & equipment		(984)	(686)	(1,108)	(670)	(1,020)
Acquisition of intangible assets		(1,764)	(1,183)	(1,942)	(1,159)	(1,834)
Net cash flows from investing activities		**(2,748)**	**(1,895)**	**(3,050)**	**(1,855)**	**(1,323)**

The accompanying notes form part of the financial statements. Major variances against budget are explained in note 22.

Statement of cash flows

For the year ended 30 June 2017

	Note	Group Budget 2017 $000	Group Actual 2017 $000	Group Actual 2016 $000	Parent Actual 2017 $000	Parent Actual 2016 $000
Cash flows from financing activities						
Equity injected		3,000	1,000	3,000	1,000	3,000
Repayments of loans		(73)	(74)	(74)	(74)	(74)
Repayment of equity		0	(6)	(3)	(6)	(3)
Net cash flows from financing activities		2,927	**920**	2,923	**920**	2,923
Net increase / (decrease) in cash & cash equivalents		**682**	**(1,785)**	**(45)**	**(1,775)**	**94**
Cash & cash equivalents at beginning of year		(1,220)	(1,221)	(1,176)	(1,405)	(1,499)
Cash & cash equivalents at end of year	10	**(539)**	**(3,006)**	**(1,221)**	**(3,180)**	**(1,405)**

During the reporting period there was a one-off non-cash transaction of Capital Contribution from the Crown.

Statement of contingencies

As at 30 June 2017

	Group Actual 2017 $000	Group Actual 2016 $000	Parent Actual 2017 $000	Parent Actual 2016 $000
Legal proceedings and obligations	0	0	0	0
Total contingent liabilities	**0**	**0**	**0**	**0**
Total contingent assets	**0**	**0**	**0**	**0**

The accompanying notes form part of the financial statements. Major variances against budget are explained in note 22.

Statement of commitments

As at 30 June 2017

	Group Actual 2017 $000	Group Actual 2016 $000	Parent Actual 2017 $000	Parent Actual 2016 $000
Capital Commitments				
Buildings	0	11	0	11
Clnical equipment	16	429	16	429
Other equipment	14	48	14	48
Intangible assets	3,432	853	3,429	827
Total capital commitments	**3,462**	**1,341**	**3,459**	**1,315**
Operating Lease Commitments:				
Less than one year	720	770	720	770
One to two years	520	635	520	635
Two to five years	573	958	573	958
Five years	104	160	104	160
	1,917	**2,523**	**1,917**	**2,523**
Total Commitments	**5,379**	**3,864**	**5,376**	**3,838**

The accompanying notes form part of the financial statements. Major variances against budget are explained 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 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 2017 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 24 October 2017.

Wairarapa DHBs 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 the requirements of the Crown Entities Act 2004 and the New Zealand Public Health and Disability Act 2000, which includes the requirement to comply with Generally Accepted Accounting Practice in New Zealand (NZGAAP).

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 derivative financial instruments. 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. The accounting estimates and judgements being applied are disclosed in Note 21.

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 2016/17 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 21 September 2017 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.

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 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

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.

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.

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. The DHB does not have investment property.

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. Intangible Assets for the year now includes RHIP, and NOS which is an Indefinite Life Intangible Asset to be tested for impairment annually.

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 cost less any impairments in the parent entity financial statements, otherwise these are to be accounted for as financial instruments recognised at Fair Value.

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 WDHBs obligation in respect of a scheme are recognised in the surplus or deficit.

Long service leave, sabbatical leave and retirement gratuities

WDHBs 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 2017 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.

1. OPERATING REVENUE

	Group Actual 2017 $000	Group Actual 2016 $000	Parent Actual 2017 $000	Parent Actual 2016 $000
Health & disability services (Crown appropriation revenue)*	130,431	128,179	130,431	128,179
Other MOH revenue	7,746	7,229	7,746	7,229
Inter district patient inflows	3,246	3,320	3,246	3,320
ACC contract	2,453	2,338	2,453	2,338
Donations & bequests	476	518	476	518
Other revenue	6,225	5,899	4,956	4,661
Total operating revenue	**150,577**	**147,483**	**149,308**	**146,245**

* 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 2017 $000	Group Actual 2016 $000	Parent Actual 2017 $000	Parent Actual 2016 $000
Interest revenue	55	55	55	54
Dividend revenue	(31)	0	6	106
Gain/(Loss) on disposal of property, plant & equipment	5	(48)	5	(51)
Total finance revenue	**29**	**7**	**66**	**109**

The DHB received a dividend payment that related to a prior period. The dividend of $37k paid by subsidiary to the parent on 31 October 2016 was recognized in the prior year.

3. WORKFORCE COSTS

	Group Actual 2017 $000	Group Actual 2016 $000	Parent Actual 2017 $000	Parent Actual 2016 $000
Wages & salaries	41,937	39,540	41,937	39,540
Payments to contracted workforce	4,084	4,231	4,084	4,231
Increase/(decrease) in liability for employee entitlements	405	1,649	405	1,649
Total workforce costs	**46,426**	**45,420**	**46,426**	**45,420**

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 2017 $000	Group Actual 2016 $000	Parent Actual 2017 $000	Parent Actual 2016 $000
Outsourced services	4,614	3,825	4,614	3,825
Clinical supplies	9,723	9,852	9,723	9,852
Operating lease expenses	1,287	1,192	1,253	1,158
Audit fees (financial statements, Audit NZ)	113	110	111	108
Audit fees (for other assurance services, TAS)	61	88	61	88
Impairment of trade receivables (bad & doubtful debts)	19	(19)	19	(19)
Board member fees & expenses	239	227	233	221
Other operating expenses	7,833	7,820	6,739	6,774
Total other operating expenses	**23,889**	**23,095**	**22,753**	**22,007**

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 2017 $000	Group Actual 2016 $000	Parent Actual 2017 $000	Parent Actual 2016 $000
Payments to non-health board providers	43,986	43,679	43,986	43,679
Inter-District Flow payments to other DHBs	36,443	34,166	36,443	34,166

5. FINANCE COSTS

	Group Actual 2017 $000	Group Actual 2016 $000	Parent Actual 2017 $000	Parent Actual 2016 $000
Interest expense	576	1,029	576	1,029
Capital charge	381	342	381	342
Total finance costs	**957**	**1,371**	**957**	**1,371**

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. There was a reduction in the capital charge rate from 7% to 6% on the 1 January 2017 for the period ended 30 June 2017 (2016 – 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 cost) $000	Buildings (at cost) $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 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)
Balance at 30 June 2016	**2,395**	**37,387**	**7,907**	**2,739**	**989**	**861**	**0**	**52,278**
Balance at 1 July 2016	2,395	37,387	7,907	2,739	989	861	0	52,278
Additions	0	41	445	102	36	0	46	670
Disposals	0	0	0	0	(585)	0	0	(585)
Balance at 30 June 2017	**2,395**	**37,428**	**8,352**	**2,841**	**440**	**861**	**46**	**52,363**

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

Group	Buildings (at cost)	Clinical equipment	Other equipment	Information technology	Motor vehicles	Work in progress	Total
Accumulated Depreciation & impairment losses							
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)
Balance at 30 June 2016	**2,349**	**5,794**	**2,386**	**871**	**498**	**0**	**11,898**
Balance at 1 July 2016	2,349	5,794	2,386	871	498	0	11,898
Depreciation charge for the year	785	451	123	50	74	0	1,483
Impairment losses	0	0	0	(585)	0	0	(585)
Elimination on disposal	0	12	0	0	0	0	12
Balance at 30 June 2017	**3,134**	**6,257**	**2,509**	**336**	**572**	**0**	**12,808**

Group	Land (at cost)	Buildings (at cost)	Clinical equipment	Other equipment	Information technology	Motor vehicles	Work in progress	Total
Carrying amounts								
At 1 July 2015	2,435	35,878	1,626	369	139	392	0	40,839
At 30 June 2016	**2,395**	**35,038**	**2,113**	**353**	**118**	**363**	**0**	**40,380**
At 1 July 2016	2,395	35,038	2,113	353	118	363	0	40,380
At 30 June 2017	**2,395**	**34,294**	**2,095**	**332**	**104**	**289**	**46**	**39,555**

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

Parent	Land (at cost) $000	Buildings (at cost) $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 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)
Balance at 30 June 2016	**2,395**	**37,387**	**7,907**	**1,883**	**948**	**749**	**0**	**51,269**
Balance at 1 July 2016	2,395	37,387	7,907	1,883	948	749	0	51,269
Additions	0	41	445	68	30	0	46	630
Disposals	0	0	0	0	(585)	0	0	(585)
Balance at 30 June 2017	**2,395**	**37,428**	**8,352**	**1,951**	**393**	**749**	**46**	**51,314**

Parent	Buildings (at cost)	Clinical equipment	Other equipment	Information technology	Motor vehicles	Work in progress	Total
Accumulated Depreciation & impairment losses							
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)
Balance at 30 June 2016	**2,349**	**5,794**	**1,660**	**835**	**431**	**0**	**11,069**
Balance at 1 July 2016	2,349	5,794	1,660	835	431	0	11,069
Depreciation charge for the year	785	451	65	49	60	0	1,410
Impairment losses	0	0	0	(585)	0	0	(585)
Elimination on disposal	0	12	0	0	0	0	12
Balance at 30 June 2017	**3,134**	**6,257**	**1,725**	**299**	**491**	**0**	**11,906**

Parent	Land (at cost)	Buildings (at cost)	Clinical equipment	Other equipment	Information technology	Motor vehicles	Work in progress	Total
Carrying amounts								
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**
At 1 July 2016	2,395	35,038	2,113	223	113	318	0	40,200
At 30 June 2017	**2,395**	**34,294**	**2,095**	**226**	**94**	**258**	**46**	**39,408**

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 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**
Balance at 1 July 2016	2,513	5,103	7,616
Additions	135	1,251	1,386
Additions (transfer)	541	0	541
Disposals	(38)	(133)	(171)
Balance at 30 June 2017	**3,151**	**6,221**	**9,372**

Group	Intangible Assets	Work in progress	Total
Accumulated amortisation & impairment losses			
Balance at 1 July 2015	1,220	0	1,220
Amortisation charge for the year	194	0	194
Balance at 30 June 2016	**1,414**	**0**	**1,414**
Balance at 1 July 2016	1,414	0	1,414
Amortisation charge for the year	225	0	225
Impairment losses	(39)	0	(39)
Balance at 30 June 2017	**1,600**	**0**	**1,600**

Group	Intangible Assets	Work in progress	Total
Carrying amounts			
At 1 July 2015	1,004	3,451	4,455
At 30 June 2016	**1,099**	**5,103**	**6,202**
At 1 July 2016	1,099	5,103	6,202
At 30 June 2017	**1,551**	**6,221**	**7,772**

Parent	Intangible Assets $000	Work in progress $000	Total $000
Cost			
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**
Balance at 1 July 2016	2,450	4,998	7,448
Additions	0	1,223	1,223
Additions (transfer)	541	0	541
Balance at 30 June 2017	**2,991**	**6,221**	**9,212**

Parent	Intangible Assets	Work in progress	Total
Accumulated amortisation & impairment losses			
Balance at 1 July 2015	1,173	0	1,173
Elimination on revaluation	0	0	0
Balance at 30 June 2016	**1,361**	**0**	**1,361**
Balance at 1 July 2016	1,361	0	1,361
Amortisation charge for the year	190	0	190
Balance at 30 June 2017	**1,551**	**0**	**1,551**

Parent	Intangible Assets	Work in progress	Total
Carrying amounts			
At 1 July 2015	991	3,451	4,442
At 30 June 2016	**1,089**	**4,998**	**6,087**
At 1 July 2016	1,089	4,998	6,087
At 30 June 2017	**1,440**	**6,221**	**7,661**

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

The DHB has identified the intangible assets as having an indefinite life span based on the assumption that the software is able to be updated. The DHB has identified that the intangible work in progress will also have an indefinite life span upon completion, but will be assessed for impairment every financial period.

There is no intangible asset whose title is restricted and no intangible asset pledged as security for liabilities.

9. INVESTMENT

Investment in subsidiary

Biomedical Services New Zealand Limited is 100% owned by WDHB (2016 – 100%). The principal activity of the subsidiary is the testing and maintenance of biomedical equipment. The year ended 30 June 2017 financial statements were used as the basis for consolidation. The balance date of Biomedical Services New Zealand Ltd is 30 June.

	Group Actual 2017 $000	Group Actual 2016 $000	Parent Actual 2017 $000	Parent Actual 2016 $000
Investment in subsidiary	0	0	103	103
Investment in joint ventures	0	541	0	541
Trust funds invested	323	274	323	274
Total investments	**323**	**815**	**426**	**918**

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 Partnerships Limited - NOS Reclassification

The asset was reclassified as an intangible in the 2017 financial period. The reclassification is aligned with PBEIPSAS standards. The asset conveys a property right to the DHB. No impairments are applicable in this period.

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. Commitments to this Joint Venture: $1.46 million.

10. CASH & CASH EQUIVALENTS

	Group Actual 2017 $000	Group Actual 2016 $000	Parent Actual 2017 $000	Parent Actual 2016 $000
Short term deposits	5	75	0	0
Cash & cash equivalents	172	116	3	7
Bank overdraft	(3,183)	(1,412)	(3,183)	(1,412)
Total cash & cash equivalents	**(3,006)**	**(1,221)**	**(3,180)**	**(1,405)**

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 2017 $000	Group Actual 2016 $000	Parent Actual 2017 $000	Parent Actual 2016 $000
Net surplus/(deficit)	**(2,815)**	**(1,927)**	**(2,803)**	**(1,908)**
Add/(less) non-cash items:				
Depreciation & amortisation	1,720	1,686	1,612	1,619
Add/(less) items classified as investment activity:				
Net loss/(gain) on sale of property, plant & equipment	5	53	5	50
Dividends received	(31)	0	6	(106)
Add/(less) movements in working capital items:				
Increase/(decrease) employee benefits (non-current)	(13)	57	(13)	57
(Increase)/decrease in receivables	(508)	(1,151)	(503)	(1,149)
(Increase) / decrease in inventories	(114)	(105)	(114)	(105)
(Decrease) in payables & accruals	946	1,469	970	1,460
Net cash flow from operating activities	**(810)**	**82**	**(840)**	**(82)**

11. INVENTORIES

	Group Actual 2017 $000	Group Actual 2016 $000	Parent Actual 2017 $000	Parent Actual 2016 $000
Central stores	863	262	863	262
Pharmaceuticals	153	88	153	88
Theatre supplies	0	332	0	332
Other supplies	0	220	0	220
Total inventories	**1,016**	**902**	**1,016**	**902**

Write-down of inventories amounted to nil for 2017 (2016 – nil). The amount of inventories recognised as a write-down during the year ended 30 June 2017 was nil (2016 – 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 2017 $000	Group Actual 2016 $000	Parent Actual 2017 $000	Parent Actual 2016 $000
Trade debtors	4,380	4,469	4,212	4,306
Provision for doubtful debts	(74)	(56)	(74)	(56)
Prepayments	861	246	861	246
Amount owing by subsidiary	0	0	2	2
Total trade & other receivables	**5,167**	**4,659**	**5,001**	**4,498**
Receivables from the sale of goods and services (exchange transactions)	1,251	1,140	1,085	977
Receivables from non- exchange transactions	3,916	3,519	3,916	3,521
Total trade & other receivables	**5,167**	**4,659**	**5,001**	**4,498**

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 2015	39,037	5,558	(38,150)	6,445
Total recognised revenue & expenses	0	0	(1,927)	(1,927)
Contribution (net) from the Crown	3,000	0	0	3,000
Repayment to Crown	(3)	0	0	(3)
Balance at 30 June 2016	**42,034**	**5,558**	**(40,077)**	**7,515**
Balance at 1 July 2016	42,034	5,558	(40,077)	7,515
Total recognised revenue & expenses	0	0	(2,815)	(2,815)
Contribution from the Crown	26,750	0	0	26,750
Repayment to Crown	(6)	0	0	(6)
Balance at 30 June 2017	**68,778**	**5,558**	**(42,892)**	**31,444**

Parent	Crown equity $000	Property revaluation reserve $000	Retained earnings $000	Total $000
Balance at 1 July 2015	39,037	5,558	(38,522)	6,073
Total recognised revenue & expenses	0	0	(1,908)	(1,908)
Contribution (net) from the Crown	3,000	0	0	3,000
Repayment to Crown	(3)	0	0	(3)
Balance at 30 June 2016	**42,034**	**5,558**	**(40,430)**	**7,162**
Balance at 1 July 2016	42,034	5,558	(40,430)	7,162
Total recognised revenue & expenses	0	0	(2,803)	(2,803)
Contribution from the Crown	26,750	0	0	26,750
Repayment to Crown	(6)	0	0	(6)
Balance at 30 June 2017	**68,778**	**5,558**	**(43,233)**	**31,103**

Revaluation reserve

The revaluation reserve relates to land and buildings. The DHB does not hold investment property.

14. INTEREST BEARING LOANS & BORROWINGS

	Group Actual 2017 $000	Group Actual 2016 $000	Parent Actual 2017 $000	Parent Actual 2016 $000
Non current liabilities				
Privately sourced loans	223	302	223	302
Crown sourced loans	0	19,500	0	19,500
Total non current interest-bearing loans & borrowings	**223**	**19,802**	**223**	**19,802**
Current liabilities				
Privately sourced loans	79	74	79	74
Crown sourced loans	0	6,250	0	6,250
Total current interest-bearing loans & borrowings	**79**	**6,324**	**79**	**6,324**

Crown loans

In September 2016 Cabinet agreed that the DHB sector should no longer access Crown debt and agreed to convert all existing DHB Crown debt into Crown equity.

On the 15 February 2017 all existing Crown loans were converted into Crown equity and from that day onward all Crown capital contributions would be made via Crown equity injections.

The termination of the loan agreement and the conversion of existing Crown loans to equity was completed by a non-cash transaction, other than for the interest due at conversion date.

As a consequence of the changes there has been a decrease in 2016/17 for the interest costs avoided from the conversion date until the end of the 2016/17 year and increasing DHB appropriations for the increased capital charge cost to the DHB thereafter.

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 2017 $000	Group Actual 2016 $000	Parent Actual 2017 $000	Parent Actual 2016 $000
Ministry of Health				
Interest rate summary	3.50%	3.50%	3.50%	3.50%
Repayable as follows:				
Less than one year	0	6,250	0	6,250
One to two years	0	5,500	0	5,500
Greater than two years	0	14,000	0	14,000
	0	**25,750**	**0**	**25,750**
Privately sourced loans				
Interest rate summary	7.00%	7.00%	7.00%	7.00%
Repayable as follows:				
Less than one year	79	74	79	74
One to two years	74	74	74	74
Greater than two years	149	228	149	228
	302	**376**	**302**	**376**

15. EMPLOYEE BENEFITS

	Group Actual 2017 $000	Group Actual 2016 $000	Parent Actual 2017 $000	Parent Actual 2016 $000
Non current liabilities				
Liability for long service leave	274	274	274	274
Liability for retirement gratuities	333	346	333	346
Total non current employee benefits	**607**	**620**	**607**	**620**
Current liabilities				
Liability for long service leave	452	434	452	434
Liability for retirement gratuities	230	246	228	244
Liability for sabbatical leave	0	50	0	50
Liability for continuing medical education leave	260	295	260	295
Liability for maternity grant	12	12	12	12
Liability for annual leave	4,336	4,130	4,262	4,050
Liability for sick leave	87	82	87	82
Salary & wages accrual	2,532	2,255	2,510	2,226
Total current employee benefits	**7,909**	**7,504**	**7,811**	**7,393**

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 2.5% for long service leave (2016: 2.3%) and 2.7% for retirement gratuities (2016: 2.4%) and a salary increase assumption of 2% (2016: 2%) were used.

The private and public sector have experienced widespread payroll issues relating to the Holiday's Act and employment agreements. This is particularly for a workforce with rostered employees working on varying work patterns. A proactive approach to finding a long term pay process solution is currently being undertaken by management to identify risk areas focusing on systems, reporting & analytics, people and processes.

Since the issues are currently being reviewed the holiday pay provision recognised is estimated based on the best information available at the date of this annual report. Once the issues have been resolved the actual liability may be different.

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 2017 $000	Group Actual 2016 $000	Parent Actual 2017 $000	Parent Actual 2016 $000
Balance at beginning of year	274	266	274	266
Funds received	91	87	91	87
Interest received	7	3	7	3
Funds spent	(40)	(82)	(40)	(82)
Balance at end of year	**332**	**274**	**332**	**274**

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 2017 $000	Group Actual 2016 $000	Parent Actual 2017 $000	Parent Actual 2016 $000
Trade creditors & accruals	2,013	3,718	1,944	3,627
Revenue received in advance	426	17	426	17
Amount owing to subsidiary	0	0	13	16
Total payables & accruals	**2,439**	**3,735**	**2,383**	**3,660**

Payables under non-exchange transactions	Group Actual 2017 $000	Group Actual 2016 $000	Parent Actual 2017 $000	Parent Actual 2016 $000
Trade creditors & accruals	6,239	4,952	6,239	4,952
GST & other taxes payable	966	1,061	966	1,061
Revenue received in advance	639	1	639	1
Total payables & accruals	**7,844**	**6,014**	**7,844**	**6,014**

Total payables & accruals	**10,283**	**9,749**	**10,227**	**9,674**

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 2017 $000 Gross	Actual 2017 $000 Impairment	Actual 2017 $000 Net	Actual 2016 $000 Gross	Actual 2016 $000 Impairment	Actual 2016 $000 Net
Not past due	168	0	168	4,325	0	4,325
Past due 1-30 days	3,866	0	3,866	69	0	69
Past due 31-60 days	223	0	223	7	0	7
Past due 61-90 days	48	0	48	0	(3)	(3)
Past due > 90 days	75	(74)	1	68	(53)	15
Total	**4,380**	**(74)**	**4,306**	**4,469**	**(56)**	**4,413**

Parent	Actual 2017 $000 Gross	Actual 2017 $000 Impairment	Actual 2017 $000 Net	Actual 2016 $000 Gross	Actual 2016 $000 Impairment	Actual 2016 $000 Net
Not past due	0	0	0	4,162	0	4,162
Past due 1-30 days	3,866	0	3,866	69	0	69
Past due 31-60 days	223	0	223	7	0	7
Past due 61-90 days	48	0	48	0	(3)	(3)
Past due > 90 days	75	(74)	1	68	(53)	15
Total	**4,212**	**(74)**	**4,138**	**4,306**	**(56)**	**4,250**

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 2017 $000	Actual 2016 $000
Balance at 1 July	56	78
Additional provisions made/(provisions released)	16	(24)
Receivables written off	2	2
Total	**74**	**56**

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 2017 $000	Actual 2016 $000
Fair value through surplus or deficit - Held for trading		
Loans and receivables:		
Cash and cash equivalents	177	191
Trade and other receivables (excluding prepayment)	4,306	4,413
Investments	323	815
Total loans and receivables	**4,806**	**5,419**
Financial liabilities measured at amortised cost:		
Payable & accruals (excluding revenue in advance and GST)	8,252	8,670
Cash and cash equivalents -Overdraft	3,183	1,412
Borrowings - MOH loans	0	25,750
Borrowings - Privately sourced loans	302	376
Total financial liabilities measured at amortised cost	**11,737**	**36,208**

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% (2016 0.5%) the effect would have been to increase/(decrease) other comprehensive revenue and expense by $11,000 (2016 $7,000).

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 2017 $000	Actual 2016 $000
Counterparties with credit ratings		
Cash and cash equivalents and trust fund assets:		
AA	323	274
Total cash and cash equivalents and trust fund assets	**323**	**274**
Counterparties without credit ratings		
Debtors and other receivables:		
Existing counterparty with no defaults in the past	4,306	4,413
Total debtors and other receivables	**4,306**	**4,413**

Group	**Loans and receivables**	**Other amortised cost**	**Carrying amount**	**Fair value**
	2017 $000	**2017 $000**	**2017 $000**	**2017 $000**
Investments	0	323	323	323
Trade and other receivables	5,167	0	5,167	5,167
Cash and cash equivalents	177	0	177	177
Crown sourced loans	0	0	0	0
Privately sourced loans	0	302	302	302
Trade and other payables	0	10,283	10,283	10,283

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	26,474
Privately sourced loans	0	376	376	376
Trade and other payables	0	9,749	9,749	9,749

Parent	Loans and receivables	Other amortised cost	Carrying amount	Fair value
	2017 $000	2017 $000	2017 $000	2017 $000
Investments	0	426	426	426
Trade and other receivables	5,075	0	5,075	5,075
Cash and cash equivalents	3	0	3	3
Crown sourced loans	0	0	0	0
Finance lease liabilities	0	302	302	302
Trade and other payables	0	10,227	10,227	10,227

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

19. RELATED PARTIES

WDHB is a wholly-owned entity of the Crown.

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.

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.

	2017 $000	2016 $000
Revenue	3,246	3,320
Expenditure	36,443	34,166
Receivable at 30 June	298	58
Payable at 30 June	740	1,618

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 2017 $000	Group Actual 2016 $000	Parent Actual 2017 $000	Parent Actual 2016 $000
Board Members				
Remuneration	226	214	220	208
Full-time equivalent members	0.7	0.6	0.7	0.6
Leadership Team				
Remuneration	1,337	1,159	1,132	944
Full-time equivalent personnel	9.0	8.0	7.0	6.0
Total key management personnel remuneration	**1,563**	**1,373**	**1,352**	**1,152**
Full-time equivalent personnel	**9.7**	**8.6**	**7.7**	**6.6**

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.

Board members Full-time equivalent members (FTE) is calculated on a formulae of time at and in preparation of meetings over the year.

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 2017 (2016 – 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.

Critical accounting estimates and assumptions were used in applying the accounting policies for the following:

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 2017, 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 $474,000 (2016:$518, 000) which is lower than in previous year, that year was above previous periods. 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 conversion of loans to equity during the year increased equity. This was then decreased by the higher than planned deficit.

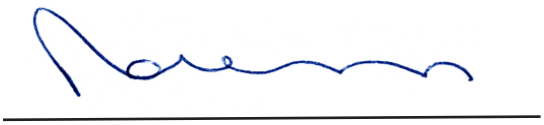
STATEMENT OF RESPONSIBILITY

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 2017.



Sir Paul Collins, Board Chair

Date: 31/10/17

Leanne Southey, Deputy Chair

Date: 31/10/17

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of Wairarapa District Health Board and group's financial statements and performance information for the year ended 30 June 2017

The Auditor-General is the auditor of Wairarapa District Health Board (the District Health Board) and group. The Auditor-General has appointed me, John Whittal, 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 Wairarapa District Health Board and group on his behalf.

We have audited:

- the financial statements of the District Health Board and group on pages 60 to 100, that comprise the statement of financial position, statement of contingencies and statement of commitments as at 30 June 2017, 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 including a summary of significant accounting policies and other explanatory information; and
- the performance information of the District Health Board and group on pages 21 to 58.

Opinion

- the financial statements of the District Health Board and group on pages 60 to 100:
    - present fairly, in all material respects:

        its financial position as at 30 June 2017; and

        its financial performance and cash flows for the year then ended; and
    - comply with generally accepted accounting practice in New Zealand in accordance with the Public Benefit Entity Reporting Standards.

- the performance information on pages 21 to 58:
    - presents fairly, in all material respects, the District Health Board and group's performance for the year ended 30 June 2017, including:

        for each class of reportable outputs:

            its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and

            its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and

            what has been achieved with the appropriation; and

            the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure.

    - complies with generally accepted accounting practice in New Zealand.

Our audit was completed on 31 October 2017. This is the date at which our opinion is expressed.

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

Basis for our opinion

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

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

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

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

The Board is responsible on behalf of the District Health Board and group for preparing financial statements and performance information that are fairly presented and comply with generally accepted accounting practice in New Zealand. The Board is responsible for such internal control as it determines is necessary to enable it to prepare

financial statements and performance information that are free from material misstatement, whether due to fraud or error.

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

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

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

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

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

For the budget information reported in the financial statements and the performance information, our procedures were limited to checking that the information agreed to the District Health Board and group's statement of performance expectations.

We did not evaluate the security and controls over the electronic publication of the financial statements and the performance information.

As part of an audit in accordance with the Auditor-General's Auditing Standards, we exercise professional judgement and maintain professional scepticism throughout the audit. Also:

- We identify and assess the risks of material misstatement of the financial statements and the performance information, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- We obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the District Health Board and group's internal control.

- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board.

- We evaluate the appropriateness of the reported performance information within the District Health Board and group's framework for reporting its performance.

- We conclude on the appropriateness of the use of the going concern basis of accounting by the Board and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the District Health Board and group's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements and the performance information or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the District Health Board and group to cease to continue as a going concern.

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

- We obtain sufficient appropriate evidence regarding the financial statements and the performance information of the entities or business activities within the group to express an opinion on the consolidated financial statements and the consolidated performance information. We are responsible for the direction, supervision and performance of the group audit. We remain solely responsible for our audit opinion.

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

Our responsibilities arise from the Public Audit Act 2001.

Other information

The Board is responsible for the other information. The other information comprises the information included on pages 1 to 20 and 101 but does not include the financial statements and the performance information, and our auditor's report thereon.

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

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

Independence

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

Other than in our capacity as auditor, we have no relationship with, or interests, in the group.

John Whittal
Audit New Zealand
On behalf of the Auditor-General
Wellington, New Zealand