Wairarapa DHB
Wairarapa District Health Board
Te Poari Hauora a-rohe o Wairarapa

E94

Wairarapa Ora
Hauora pai mo te katoa
Well Wairarapa – better health for all

Wairarapa District Health Board

Annual Report 2018

Presented to the House of Respresentatives pursuant to section 150 of the Crown Entities Act 2004

Contents

Chair & Chief Executive's Foreword

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 population; 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**

2017/2018 has been a year of significant challenge and change for WrDHB. Significantly, the new leadership team is in place, plus work on the new patient administration system, which was implemented in February 2018.

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 Māori populations, focusing on reducing disparities. Equity remains a high strategic priority.

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 private surgical care for our community.

The growth of the older population has influenced primary care, community and hospital services. The year has had higher than usual patients being admitted to hospital wards and the utilization of primary care per 1000 population remains the highest in New Zealand.

WrDHB continues to have financial challenges however not withstanding these challenges we have made headway with the iMOKO programme and implemented an intersectoral group working across sectors, learning and focusing on how we create innovation and less duplication.

The Bowel Screening programme rolled out to the people of Wairarapa has been and will continue to be a success. WrDHB are meeting our KPI's and I am thankful for such dedicated "coal face "teams.

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

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.

Working with our community

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.

	249,539 GP visits		29,095 outpatient appointments
	5,839 over 65 years flu vaccinations		3,875 operations and procedures
	13,538 school dental checks		10,440 hospital admissions
	446 babies born in Wairarapa Hospital		34,290 x-rays and scans
	4,068 patients with E-health access		

Whanau 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.

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.

Working with our partners

Intersectoral 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

With the introduction our Disability Strategy last year; Enabling Partnerships: Collaboration for effective access to health services, we continue to identify improved access to services for disabled people as an operational priority.

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 Consumer Council was established in 2017. The Council works in partnership with the DHB as an advisory body, enabling those who use health services to offer their collective perspective into health services planning, delivery and evaluation at all levels of the organisation. The Council provides a strong and viable voice for the community and consumers of health services, with the aim of enhancing the Wairarapa community's experience of health services and service integration, promoting equitable outcomes and ensuring services are organised around the needs of people.

The Council identifies and advises on issues requiring consumer and community participation; participates, reviews and advises on reports, developments and initiatives relating to health service delivery and the availability and/or distribution of health-related information; and ensures regular communication and networking takes place with the community and relevant consumer groups.

Community support

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 has a Memorandum of Understanding 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.

Our sincere thanks to the whole community for their ongoing invaluable contributions to the DHB. These donations have meant that, in a fiscally constrained environment, we have been able to improve our services for the Wairarapa region.

Strategic direction

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 have 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 for the Wairarapa DHB continues to be 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 Māori Health 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, investing into, and growing the Māori workforce.

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 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 Board 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. Accessing where best to place our services 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 new patient management system part of the Regional Health Informatics Programme was implemented this year. This programme centralises, stores 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.

Bowel Screening

The bowel screening programme is now business as usual following its launch in July 2017. We have topped 70% for overall participation for bowel screening up until the end of July 2018, which is over and above the target of 60%. This is excellent for a screening programme and we are pleased to see participation from Asian community has improved. Opportunistic screening for Māori has made it easier to engage in primary care and highlights the WrDHB improved focus on equity.

Accountability

Financially, we operate in an environment with deficit constraints. A strong focus on efficiencies, effectiveness and strong leadership walks alongside our delivery of quality patient care, with an aim to not just operate within budget but to 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 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.

Governance

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.

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 2007

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.

Name	Interest
Sir Paul Collins *Chair*	• Director of: Active Equity Holdings Limited (Chair) Hurricanes GP Limited Ides Limited Shott Beverages Limited • 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 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)
Mr Ronald Karaitiana *Member*	• Member, Wairarapa District Health Board • Member, Wairarapa Te Iwi Kainga Committee • Member, Wairarapa District Health Board, Finance Risk & Audit Committee • Akura Lands Trust Chairman • Contractor to Whaiora and Hauora as a Programme Manager • Masterton District Council on behalf of Rangitane • Director Rangitane ex Officio • Extended family members work in varying roles at DHB • Chair of WrDHB Hospital Advisory Committee

Name	Interest
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 • Member of Masterton Lands Trust • Director, Longs Properties Limited (*1 February 2016)*
Mr Derek Milne *Member*	• Member of 3DHB DSAC • Brother-in-law is Chairman of Health Care NZ • Daughter GP in Green Cross Health Onehunga, 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 • Partner in Primary Care Development
Mr Alan Shirley *Member*	• Member, Wairarapa District Health Board • Member, Wairarapa, Hutt Valley and CCDHB DSAC • 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

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 Disclosure Ultra Vires Transactions

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

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 2017-18 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.

	Board (11)	**3DHB CPHAC/ DSAC (5)**	**HAC (6)**	**FRAC (7)**
Sir Paul Collins (Chairman)	11	n/a	n/a	7
Leanne Southey (Deputy Chair)	11	n/a	n/a	6
Ronald Karaitiana (HAC Chair)	10	n/a	6	7
Nick Crozier	10	n/a	5	n/a
Liz Falkner	9	n/a	5	n/a
Jane Hopkirk	10	2	n/a	n/a
Rick Long	10	0	n/a	6
Derek Milne	11	4	n/a	n/a
Fiona Samuel	9	n/a	5	n/a
Alan Shirley	9	2	n/a	n/a
Adrienne Staples	10	n/a	n/a	6

Our People

The role our DHB plays and how our healthcare is delivered in the future is changing and there a need to have a workforce that has leaders and teams who are ready and skilled for this changing environment.

The DHB has been focusing on looking at what the needs of our teams are and where the workforce is heading in the future. This is about having the right mix of people from a technical perspective in conjunction with having people who understand and reflect our community.

The development of the DHB's strategic priorities has seen the focus in two areas from a people perspective:

- We have the best people, places and tools to support what we do;
- High performing teams driving organisational success

These strategic priorities are the pillars in determining the focus for the organisation in regards to what needs to be in place to support the strategic direction and operational deliverables for our workforce.

The first steps in focusing on our people has been the results of a staff survey, which have highlighted the following areas to focus on and develop:

- Leadership
- Culture
- Behaviour
- Wellbeing
- Communication
- Environment
- Systems

As part of our commitment to our workforce, we engaging in a number of conversations about how we can put people at the core of what we do and reviewing our HR processes and systems.

Organisational Capability

The DHB is committed to being a good employer. We promote equity, fairness and a safe and healthy workplace, and have a clear set of organisational values. These are supported by core operational policies, including a Code of Conduct, Workplace Bullying, Discrimination, Harassment and Victimisation Policy and Employee Assistance Programme.

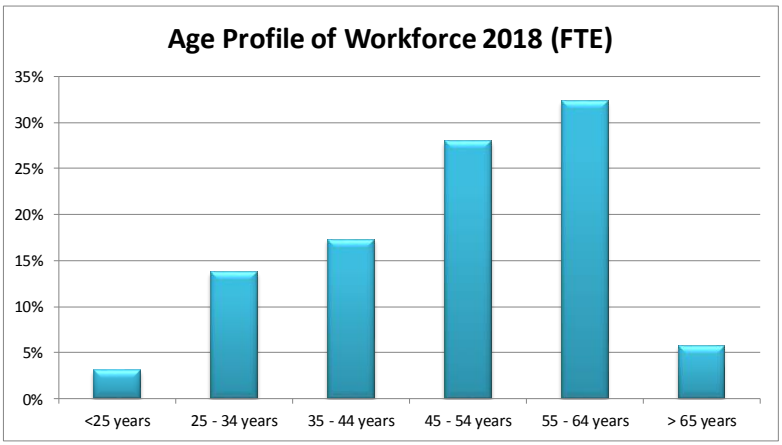
Workforce

Full Time Equivalent staff numbers

Full Time Equivalent Staff Numbers

	2018	2017	2016	2015	2014	2013	2012	2011	2010	2009
Medical	46	43	42	40	36	39	38	36	33	33
Nursing	243	236	223	215	205	204	198	193	191	183
Allied Health	71	69	69	71	70	82	85	93	89	90
Other	126	111	108	102	106	101	120	119	125	127
Total	486	458	443	429	417	426	441	441	438	433

Age profile of workforce 2018 (FTE)

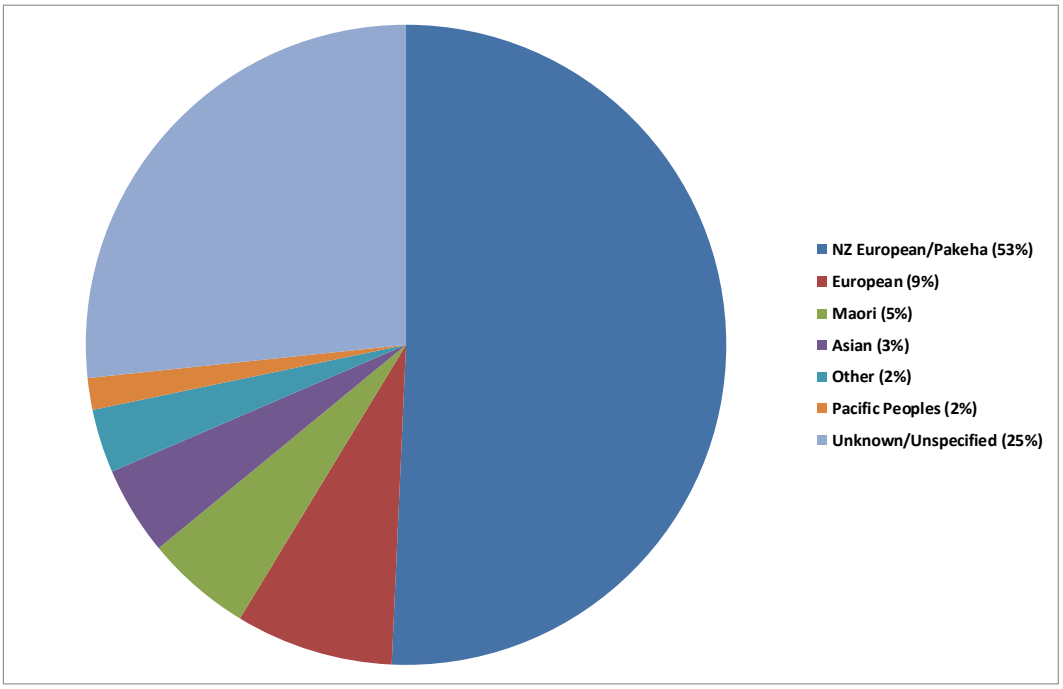


*excludes casual employees

Length of service

- Excludes RMO's

Statistics by ethnicity



Statistics by gender

	2018	2017	2016	2015	2014	2013	2012	2011	2010
Female	83%	81%	82%	82%	84%	82%	84%	83%	83%
Male	17%	19%	18%	18%	16%	18%	16%	17%	17%

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).*

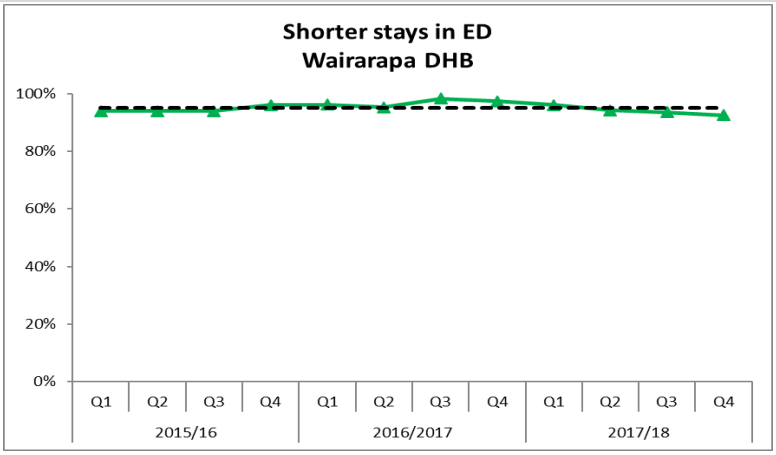
Note the changing vertical (y) axis between graphs.

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%

2017/18 Performance: 94%

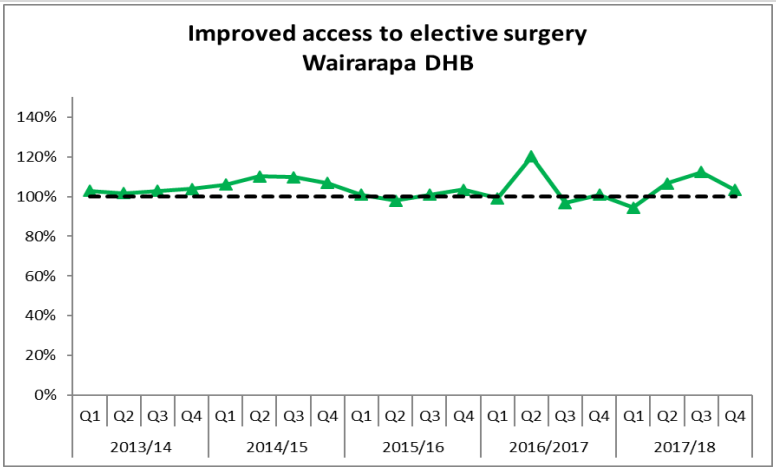


Improved access to elective surgery

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

Target: 2,417

2017/18 Performance: 2,495

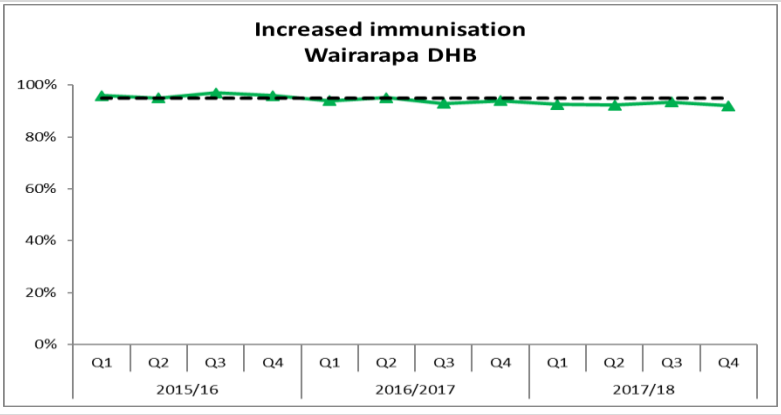


Increased immunisation

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%

2017/18 Performance: 92%

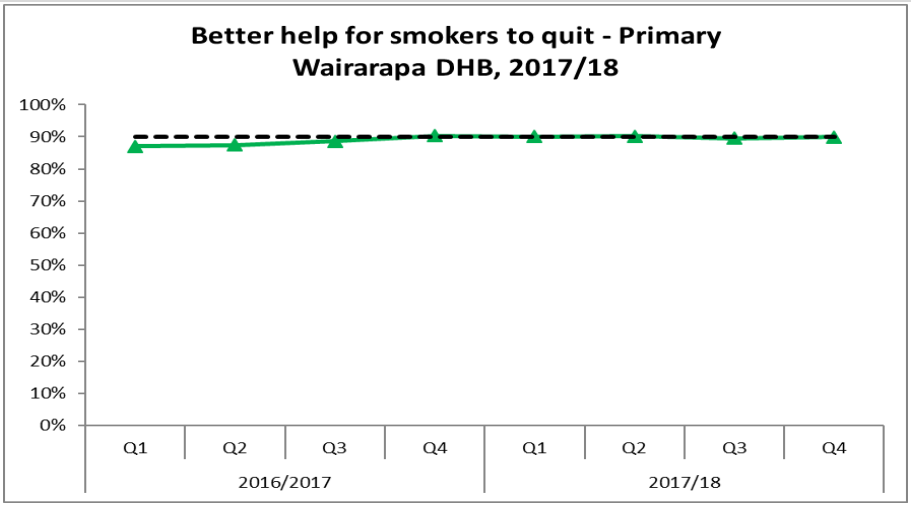


Better help for smokers to quit – Primary care

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%

2017/18 Performance: 90%

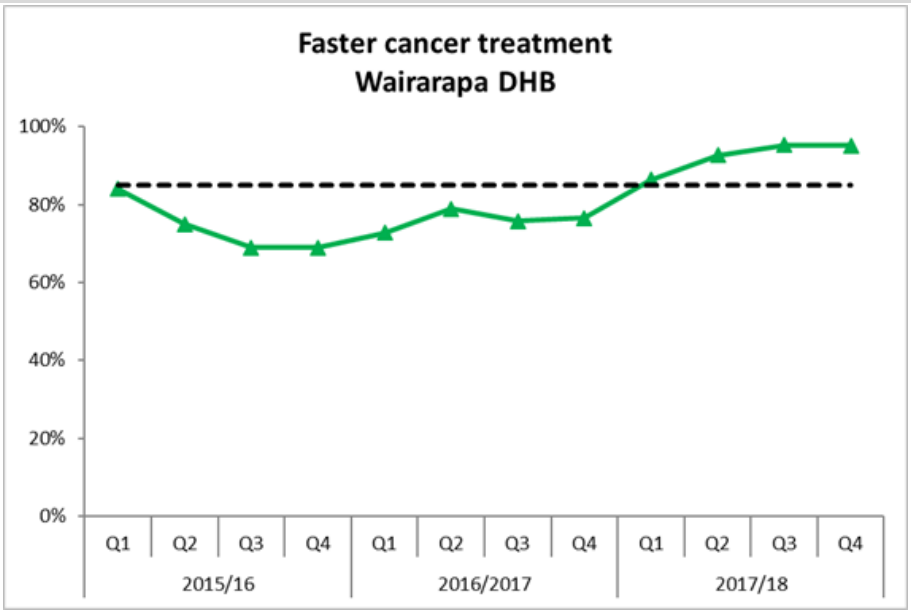


Faster cancer treatment

90 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: 90%

2017/18 Performance: 94%

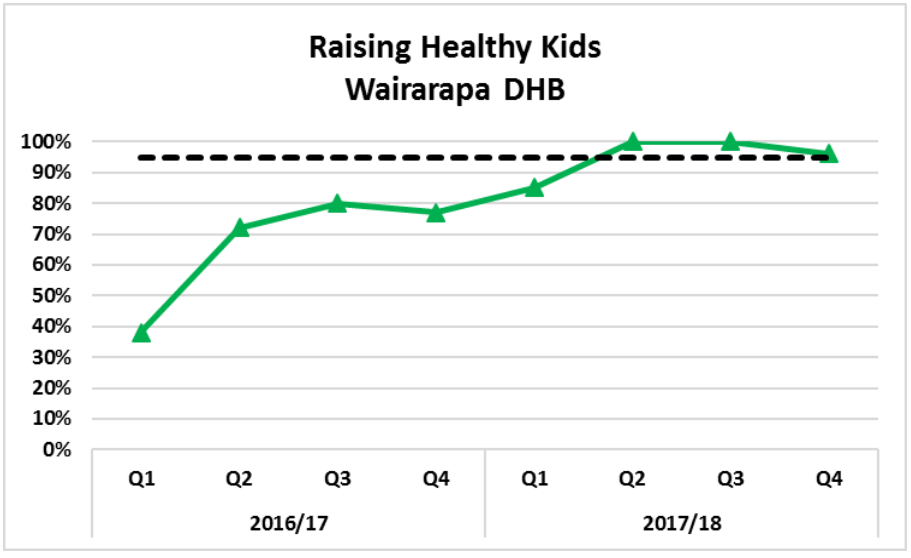


Raising Healthy Kids

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

Target: 95%

2017/18 Performance: 96%



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 is required to complete its Statement of Performance Expectations by the start of the financial year under section 149C of the Crown Entities Act 2004. This requirement has not been met for the 2018/19 year. The 2018/19 Statement of Performance Expectations was signed by the Board prior to 1 July 2018, but was not complete as it did not include forecast financial statements.

Wairarapa DHB continues to provide high quality and timely services for our population. In 2017/18:

- Wairarapa DHB achieved the Improved Access to Elective Surgery Health Target, achieving 2495 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 (96.5%) and the percentage of pregnant women who smoke (100%) 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 108.2% high need children and 93% of all children receiving a check.
- Compass PHO – Wairarapa achieved 100% of the DHB-domiciled population being enrolled with a PHO. 99% Māori were enrolled.
- 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.
- Wairarapa DHB also exceeded the target for each dimension of the inpatient Patient Experience Survey.
- Wairarapa DHB continued to meet the targets for the percentage of people 65 years of age and over receiving DHB-funded HOP services who are being supported to live at home.
- 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 also 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]

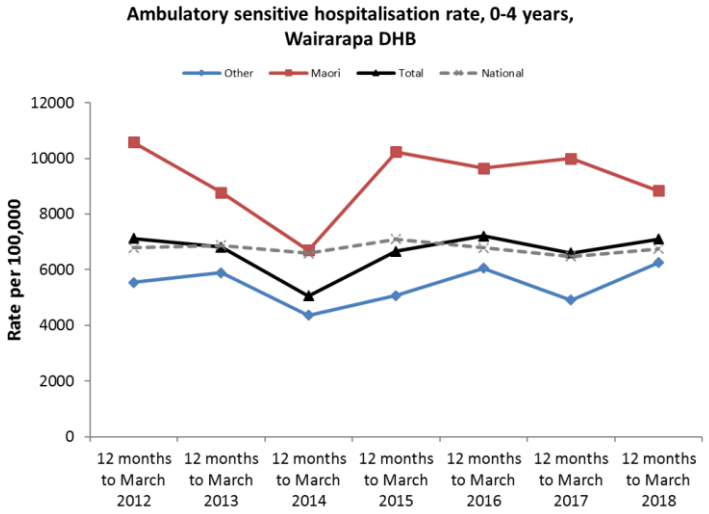
Ambulatory sensitive hospitalisations (ASH) are admissions to hospital for conditions that could have been prevented or treated by appropriate interventions in a primary care or community setting. These conditions include, for example, skin infections, dental conditions, asthma, pneumonia, cardiovascular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

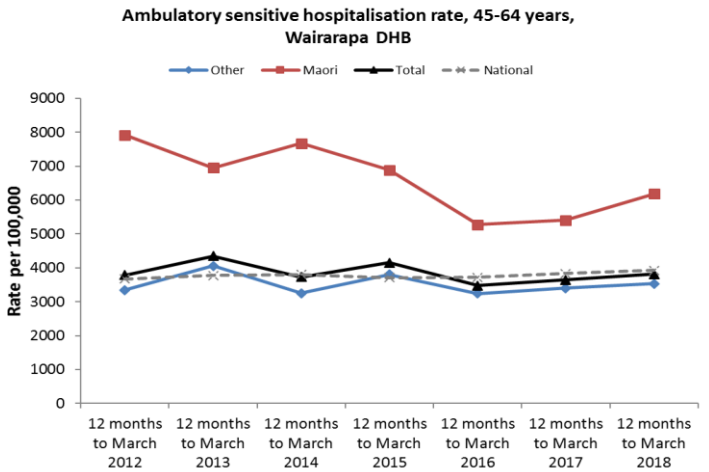
ASH rates also highlight opportunities to better support people to seek intervention early and to manage their long-term conditions. A reduction in ASH admissions will reflect better management and treatment across the whole health system.

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 2018/19 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

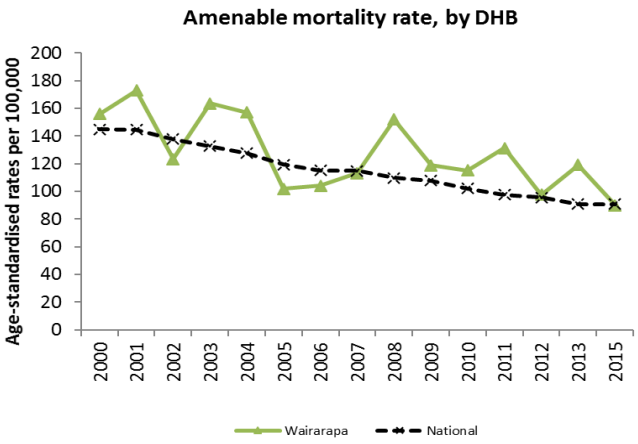
Impact measure: A reduction in amenable mortality rates

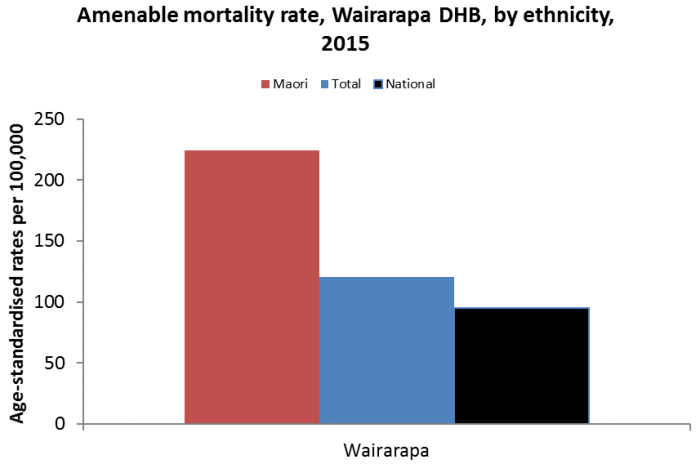
'Amenable mortality' is defined as premature deaths from conditions that were potentially avoidable through health care.

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.

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?

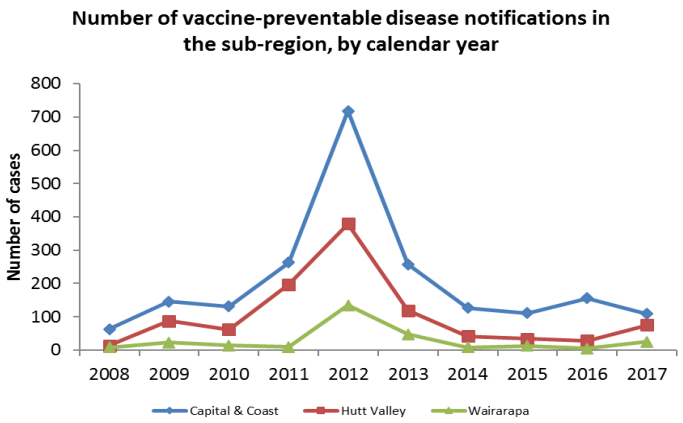
Through effective public health disease surveillance, investigation and control, the impacts of communicable, waterborne and foodborne diseases can be minimised. Public health actions are aimed at reducing the levels of harm from alcohol and drug use in the greater Wellington region. To achieve this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

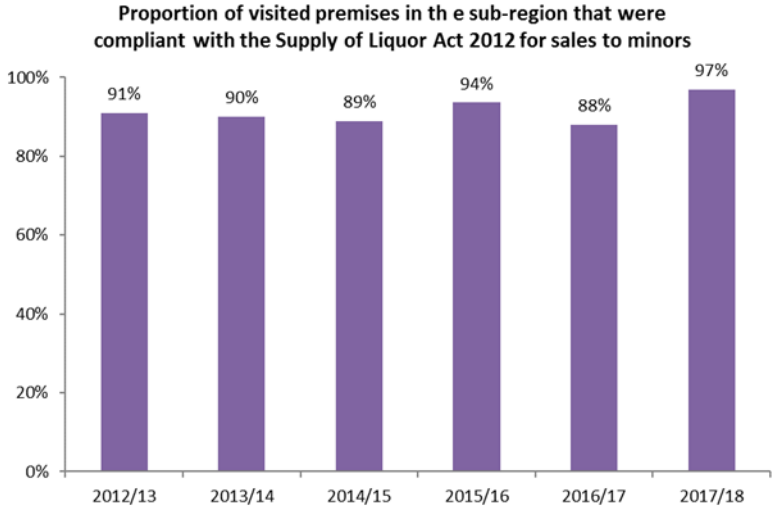
In addition to protecting an individual from disease, immunisation can also provide population-wide protection by reducing the incidence of infectious diseases and preventing the spread of these diseases to vulnerable people.

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. The number of notifications has increased from 2016 to 2017. 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 12 months report includes Jan 2018 data.

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, Māori , 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 2017/18, 97% 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:

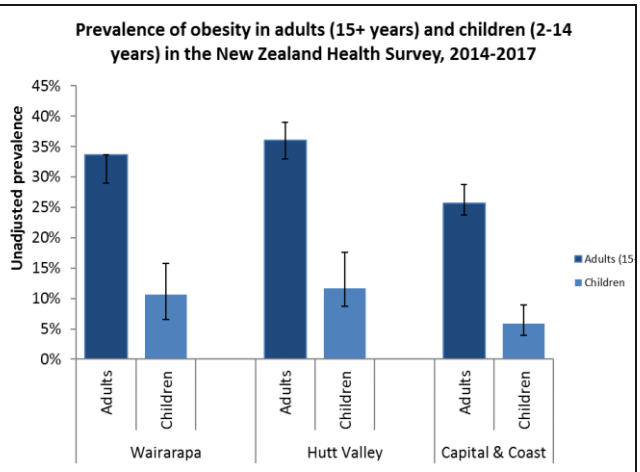
Impact measure: A decrease in the obesity prevalence in adults and children (adults 15+ years and children 0-14 years)

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, 2014-17. Error bars represent 95% confidence interval.

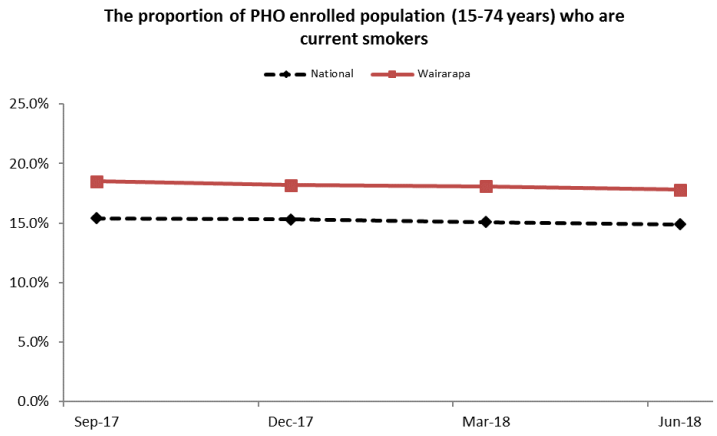
1 Ministry of Health. 2004. *Tracking the Obesity Epidemic: New Zealand 1977–2003.* Wellington: Ministry of Health. The graph shows the most recent data available from the Ministry of Health

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, 18% 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.



Source: Ministry of Health

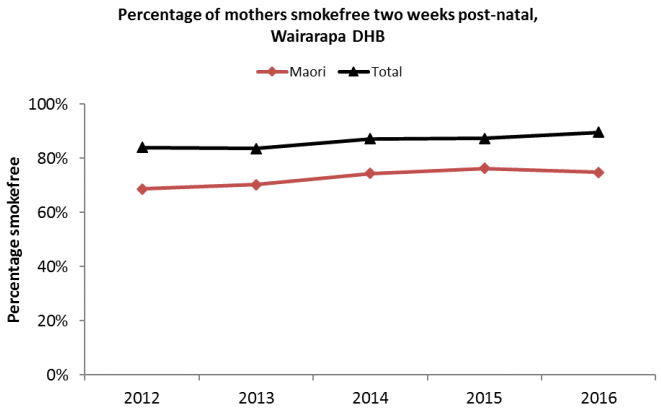
Impact measure: An increase in the proportion of mothers who are smoke-free two weeks postnatal

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 smoke-free two weeks postnatal will increase.

In Wairarapa DHB, Māori mothers were less likely to be smoke-free compared to other ethnicities.

The graphs show the most recent data available from the Ministry of Health. Data for 2017/2018 was not available at time of publication.



Source: Maternity clinical report published Dec 2017 as WCTO Quality Indicators, Ministry of Health via Trendly data quality was poor and unreliable.

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:

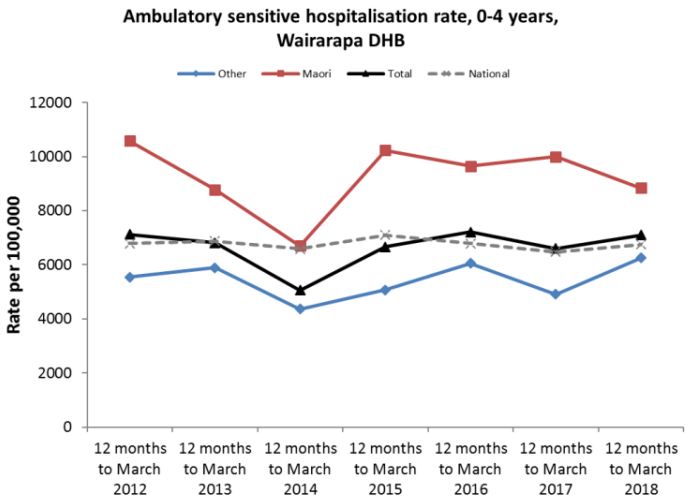
Impact measure: A reduction in Ambulatory Sensitive Hospitalisation (ASH) rates for 0-4 year olds

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 1.4 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

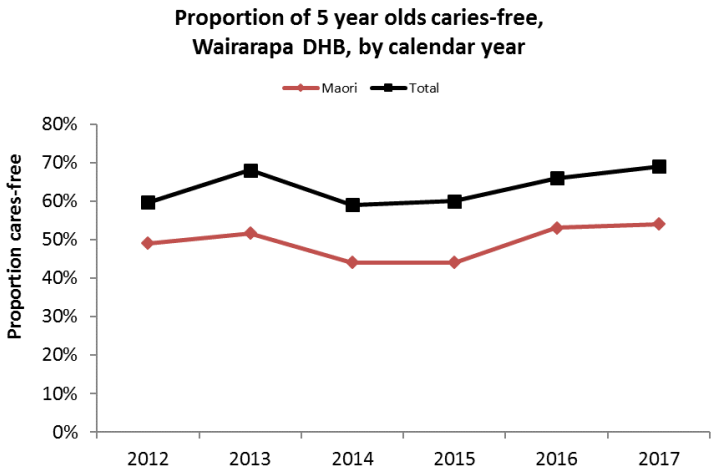
Regular dental care has lifelong benefits for health. Improved oral health is also an indicator of the equity of access to services and the effectiveness of mainstream services at targeting those most in need. Māori and Pacific children have worse oral health outcomes than other ethnicities.

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, however remains static from 2016 to 2017, 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.



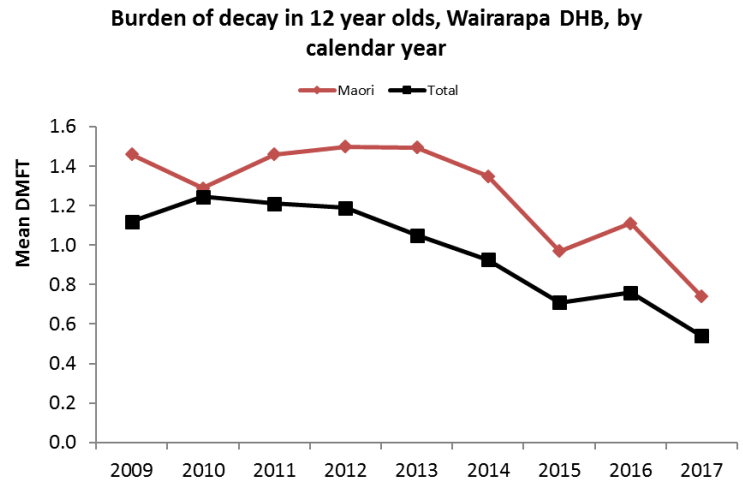
Source: Ministry of Health, Bee Healthy Dental Service

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:

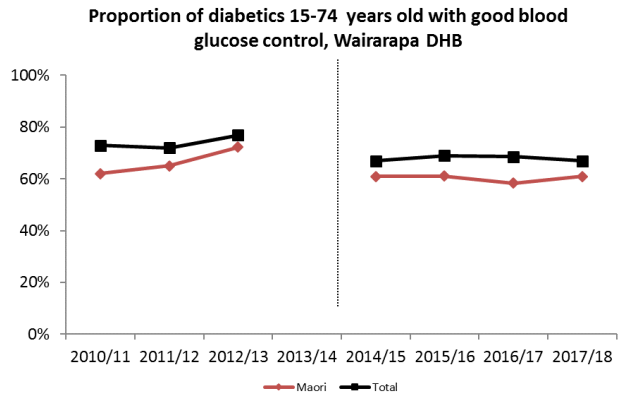
Impact measure: An increase in the proportion of diabetics with satisfactory blood glucose control (HbA1c less than 64 mmol/mol)

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. The result in the recent years had been very consistent with a slight increase in the trend for Māori population.



Source: PHO report

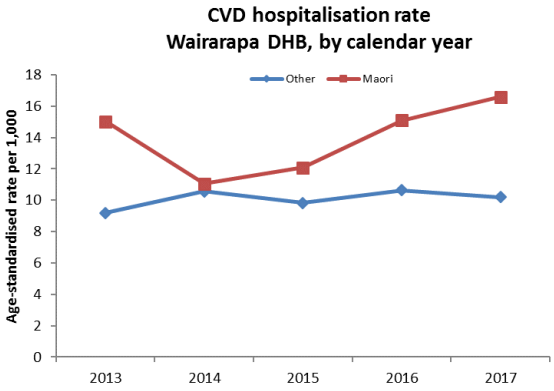
[1] Ministry of Health

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 subregion. 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.

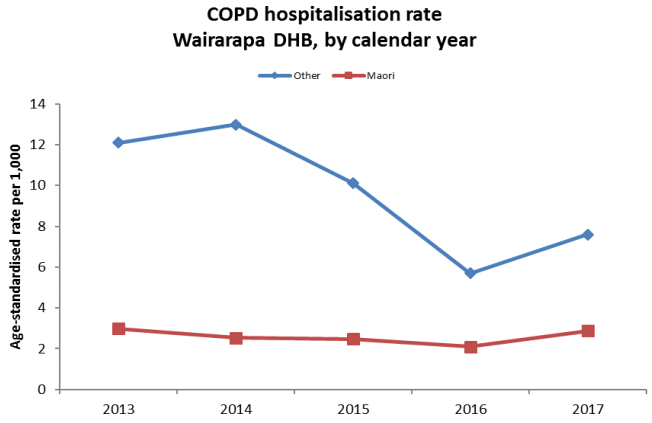
In Wairarapa DHB, Māori have a higher rate of CVD hospitalisation than other ethnicities. The CVD hospitalisation rate for Māori has increased since 2016.



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 lower than the rate for other ethnicities. The COPD hospitalisation rate for Māori and other decreased during 2016 however has slightly increased in 2017.



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

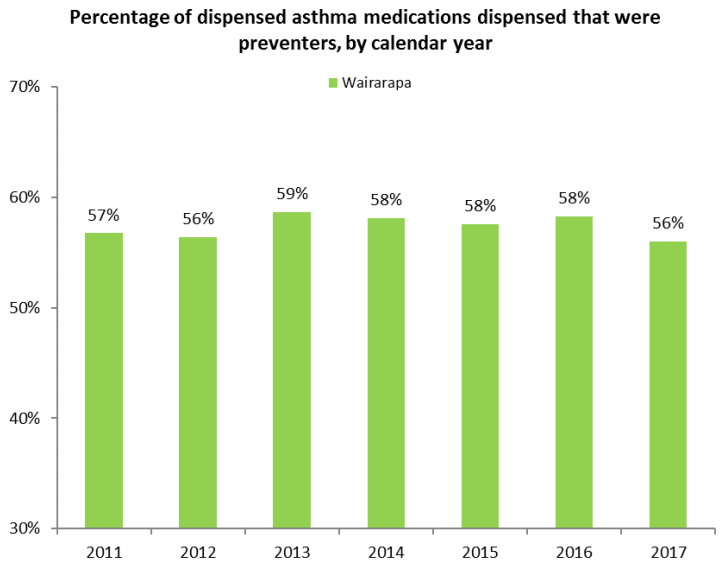
Impact measure: An increase in the proportion of dispensed asthma medications that were preventers rather than relievers

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 decreased at 56% over the last year. [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?

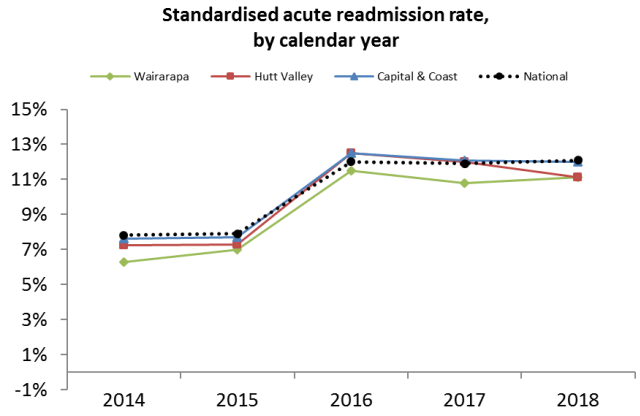
Equitable and timely access to intensive assessment and treatment can significantly improve people's quality of life, either through early intervention, or through corrective action (i.e. major joint replacements to relieve pain and improve activity). Improving our service delivery, systems, and processes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

Measures – The DHB measures progress through:

Impact measure: A reduction in the standardised[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 (i.e. not leaving hospital too early or too late), and that they are being well-supported by primary and community care once they are out of hospital.

The standardised acute readmission rate has remained at about 11% for Wairarapa DHB over the last two years. Although the acute readmission rate has remained about 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.

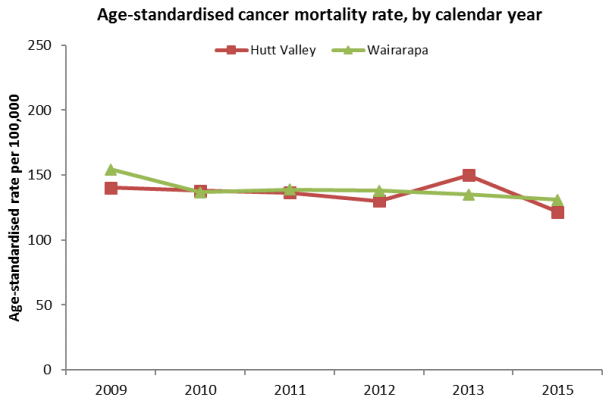


Source: Ministry of Health, have changed the methodology in 2016 for calculating the 28 days acute readmission rate and standardization

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 2015 was released in June 2017 and the data for 2017/2018 was not available at time of publication.



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:

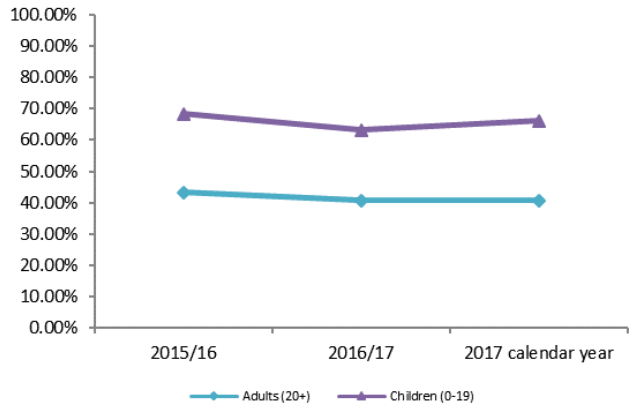
Impact measure: An increase in the percentage of new service users accessing secondary mental health services (of all people accessing secondary mental health services. New service users are those who have not used mental health services in the last five years)

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 and adults who are new users of secondary mental health has remained comparatively stable.

Proportion of secondary mental health service users that were new to the service, Wairarapa DHB



Source: PRIMHD

The most recent data available is for the 2017 calendar year due to a technical delay with the DHB sending data to the national PRIMHD data collection.

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.

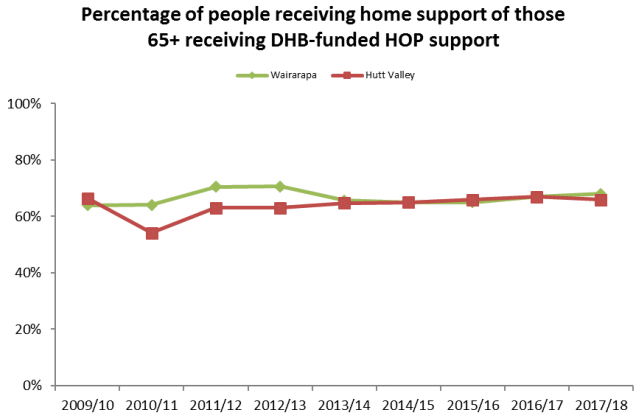
Measures – The DHB measures progress through:

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.



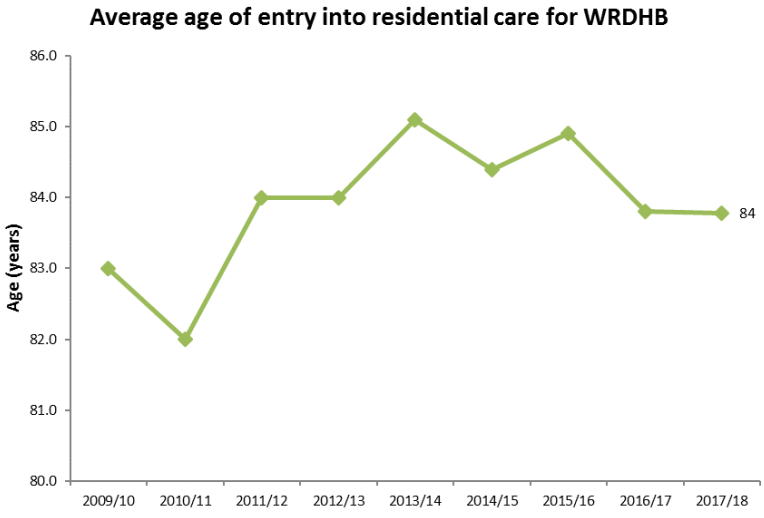
Source: Health of Older People regional benchmarking

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 84 years.



Source: Health of Older People regional benchmarking

Outputs

Statement of performance

For the year ended 30 June 2018

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 2017/18 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.

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 2017/18 with a † symbol. These measures were introduced in the 2017/18 Annual Plan and did not appear in the 2016/17 Annual Report. Our 2016/17 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 2017/18 performance (indicated with 'Est.'), based on historical and population trends.

Output class: Prevention Services

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 (e.g. alcohol-related injury) and the development of long-term conditions (e.g. 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]: Ask all patients whether they smoke and document their response; if the patient smokes, provide

[1] ABC for Smoking Cessation Quick Reference Card, PHARMAC

Brief 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.

How we measure performance of our Prevention Services:

Outputs	Measure	Type of Measure	2016/17 Performance	2017/18 Target	2017/18 Performance	2017/18 Achievement
Health protection and statutory regulation	The number of disease notifications investigated in the sub region.[1,4]	V	WDHB 154 Māori 15 Pacific 3	3DHB 1692	3DHB 2,127	3DHB Achieved
	The number of environmental health investigations in the sub region. [4]	V	90	3DHB 988	3DHB 779	3DHB Not Achieved
	The number of premises visited for alcohol controlled purchase operations in the sub region. [4]	V	19	3DHB 142	3DHB 122	3DHB Not Achieved
Health promotion and education	Number of adult referrals to the Green Prescription programme	V, DoS	124	300	308	Achieved
	Number of new referrals to Public Health Nurses in primary/intermediate schools[3]	V, DoS	WDHB 147	≥185	279	Achieved
Breastfeeding	Percentage of infants fully or exclusively breastfed at 3-months[2]	Q	60%	≥60%	56%	Not Achieved

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

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

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

4 17/18 Target and the performance are at the 3DHB Level and not comparable to 2016/17 performance.

Outputs	Measure	Type of measure	2016/17 Performance	2017/18 Target	2017/18 Performance	2017/18 Achievement
Immunisation	Percentage of 2-year olds fully immunised	C	94.30%	≥95%	94%	Not achieved
	Health Target: Percentage of 8-month olds fully vaccinated	C	94%	≥95%	92%	Not Achieved
	Percentage of year 7 children provided Boostrix vaccination in schools in Wairarapa district.[1]	C, DoS	WDHB 81% Māori 85% Pacific 86%	≥70%	77%	Achieved
	Percentage of Year 8 girls vaccinated against HPV (final dose) in schools in the DHB	C, DoS	WDHB 65.07% Māori 72.86% Pacific 64.29%	75%	67%	Not Achieved
Smoking cessation	**Health Target:** 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	90.50%	≥90%	90%	Achieved
	Percentage of hospitalised smokers receiving advice and help to quit	Q	92.2%	90%	97%	Achieved

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

Outputs	Measure	Type of measure	2016/17 Performance	2017/18 Target	2017/18 Performance	2017/18 Achievement
Smoking cessation services	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	Q,DoS	100%	≥90%	100%	Achieved
Population based Screening services	Percentage of eligible children receiving a B4 School Check	C	High Dep: 90.6% T: 93.8%	≥90%	93%	Achieved
	Percentage of eligible women (25-69 years) having cervical screening in the last 3 years	C	M: 72.4% P:93% T: 77.7%	>80%	78%	Not achieved
	Percentage of eligible women (50-69 yrs) having breast screening in the last 2 years	C	M: 69.1% P:72% T: 75.6%	>70%	75%	Achieved

Commentary

Public health protection and regulatory services

The number of environmental health investigations in the sub region have been fewer due to capacity issues and prioritising of other health protection areas of work (e.g. drinking water). However, there has been an increase in the number of investigations in the Wairarapa.

The number of Wairarapa disease notifications increased significantly. The main driver of this increase was an increase in pertussis notifications due to the national pertussis outbreak and an increase in campylobacter notifications. A change in laboratory testing methods has also increased the notifications of common enteric diseases such as cryptosporidium and giardia.

Although the target for the number of premises visited for alcohol controlled purchase operations in the sub region was not achieved, 26 premises visited in 2017/18 were in the WDHB area, up from 19 in 2016/17.

Health promotion and preventive intervention services

Although the target for the percentage of infants fully or exclusively breastfed at three months has not been achieved, the DHB and Regional Public Health continue to work with a range of stakeholders to support breastfeeding.

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, and Parents as First Teachers (PAFT), Parents Centre, Regional Public Health – Wairarapa and Lead Maternity Carers (LMCs).

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 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 wellhealth and reduce the number of personal health referrals. The increased access to care through free under 13 year olds has contributed to children seeking early access to their GP practices.

Wairarapa Green Prescription referral numbers have grown by around 25% per quarter over the period. The Wairarapa based Healthy Lifestyle Co-ordinator continues to prioritise practice-based promotion and also links with secondary care based nurses and marae-based services. Tū Ora Compass Health – Wairarapa have been a supportive partner, sharing key messages on Sport Wellington's behalf during clinical visits.

Delivery of group-based interventions in Wairarapa DHB has continued. Co-delivery of programmes is currently underway with Whaiora.

Immunisation services

In Wairarapa DHB, for the year 1 July 2017 to 30 June 2018 92% of children aged 8 months eligible for immunisation were fully immunised, falling short of the target of 95%. An increasing rate of parents declining immunisation (4.9%) has had a significant impact on the result Excluding those declining immunisation or opting off the register 19 children of this age were not fully immunised.

94% of children aged 24 months were fully immunised in the twelve month period. Excluding children for whom immunisation was declined or who opted off NIR only 6 children were not fully immunised for this age group over this 12 month period. 96% of Māori and 100% Pacific Island two year olds were fully immunised.

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.

Overall performance in the school based immunisation programme has been pleasing. 77% of year, 7 children received the Boosterix vaccination in the schools based programme. While only 67% of year 8 girls were vaccinated against HPV at school, Regional Public Health work closely with primary care in this programme. In total 80% of all year 8 girls and 95% of Māori year 8 girls received the vaccination. Since January 2017 HPV vaccination has also been offered for boys, however the measure includes girls only.

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. The target was achieved.

Secondary Care Health Target – During the year 2017/2018, the Wairarapa DHB has continued its hospital wide focus to ensure the target of 95% was achieved and sustained.

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 2017/18 year.

Screening services

In Wairarapa, the B4 School check is delivered by trained Practice nurses in the child's primary care practice. 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.

Maintaining and increasing cervical screening rates continues to be a challenge in Wairarapa since the loss of the Mana Wahine Service and there is still an inequity issue with coverage. The system continues to work hard to promote cervical screening and improve recall processes and an incentive system has had some limited success.

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.

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 Māori 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 (e.g. health checks), providing education and advice so people can manage their own health, and reaching those at risk of developing long-term or acute conditions.

Oral health services: are 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.

How we measure the performance of our Prevention Services:

Outputs	Measure	Type of Measure	2016/17 Performance	2017/18 Target	2017/18 Performance	2017/18 Achievement
Primary Care services / Long term conditions management	Percentage of the DHB-domiciled population enrolled in a PHO	C, DoD	100%	≥99%	100%	Achieved
	Percentage of practices with a current Diabetes Practice Population Plan (or LTC plan that includes diabetes)	C, DoS	100%	100%	100%	Achieved
	Percentage of the eligible population assessed for CVD risk in the last five years	C, DoS	89.20%	≥90%	86%	Not Achieved

	The number of new and localised Health Pathways in the sub-region[3]	V	320	3DHB 375	3DHB 390	Achieved
	The average number of users accessing the Health Pathways website in the last month of the financial year[2,3].	V	1,300	3DHB 2000	3DHB 2,103	Achieved
Oral health	Percentage of children under 5 years enrolled in DHB-funded dental services[1]	C, DoD	2016: 83%	≥95%	85%	Not Achieved
	Percentage of adolescents accessing DHB funded dental services	C, DoD	2016: 64.2%	≥85%	65%	Not Achieved
Pharmacy services	Number of initial prescription items dispensed	V, DoS	457,278	Est. ≥436,515	481,435	Achieved
	Percentage of the DHB-domiciled populations dispensed at least one prescription item	C, DoD	84%	Est≥80%	85%	Achieved
	Percentage of people registered with a Long Term Conditions programme in a pharmacy	C, DoS	9.7%	≥4%	6%	Achieved
	Number of people participating in a Community Pharmacy Anticoagulant Management service in a pharmacy	V, DoS	45	≥45	47	Achieved

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

2 This measure has changed in 17/18. The output measure in 16/17 was "The average number of users (per month) of the HealthPathways website.

3 Result for this measure is a total figure for the sub-regional DHBs: Wairarapa, Hutt Valley and Capital & Coast DHBs

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.

86% of the eligible Wairarapa population have had a heart check (CVD risk assessment) 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 Māori , Pacific and low income people.

The Tihei Alliance has continued to focus on better management of acute care, and has initiated planning for the introduction of the Health Care Home model across the Wairarapa practices. This model is evidenced to deliver improved quality of care through improved access and a focus on prevention and early intervention.

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 average number of users per month of the Health Pathways website increased in 2017/18. This indicates 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 three 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. The quadruple enrolment form has also been introduced for new-borns. This has increased pre-school enrolments and we anticipate this will continue for the next two years, when all pre-schoolers will have been offered these services.

All (100%) of adolescents (Year 8) in the Wairarapa are transferred to private practitioners who operate within the Combined Dental Agreement (CDA). Increasing the percentage of adolescents accessing dental services, especially Māori and Pacifica, is a priority in the DHB's 2018/19 System Level Measure Improvement Plan. 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. There was more moderate growth in the number of people registered in the LTC pharmacy programme, which appears to have stabilised,

but at a rate that is still significantly above other District Health Boards. 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.

There was significant work undertaken at a national level on a new pharmacy agreement in 2017/18. A new agreement is expected to be in place by 1 October 2018 that will pave the way for implementation of the Pharmacy Action Plan and more effective commissioning of pharmacy services.

Output Class: Intensive Assessment & Treatment Services

Description

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

How we measure performance of our Intensive Assessment & Treatment Services

Outputs	Measure	Type of measure	2016/17 Performance	2017/18 Target	2017/18 Performance	2017/18 Achievement
Elective and Acute (Emergency Dept.) inpatient/outpatient	**Health Target:** Percentage of patients admitted, discharged or transferred from ED within 6 hours	T,DoS	97.30%	95%	94%	Not Achieved
	Health Target: Number of surgical elective discharges	V, DoD	2,459	≥2417	2,495	Achieved
	Standardised[1] inpatient average length of stay ALOS (Acute)[2, 3]	T, DoS	2.36	≤2.35	2.41	Not Achieved
	Standardised inpatient average length of stay ALOS (Elective)[3]	T, DoS	1.36	≤1.55	1.37	Achieved
	Rate of inpatient falls causing harm, per 1,000 bed days	Q, DoS	1.07	≤1.3	0.27	Achieved
	Rate of hospital acquired pressure Injuries, per 1,000 bed days	Q, DoS	0.43	≤0.50	1.39	Not Achieved
	Rate of identified medication errors causing harm, per 1,000 bed days	Q, DoS	1.7	≤0.65	0.85	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 2017 (2016/17 baseline) and 12 months ending March 2018 (2017/18 performance).

3 This symbol of this target was reported incorrectly on the 17/18 Annual Plan as ≥. The correct symbol is ≤.

Outputs	Measure	Type of measure	2016/17 Performance	2017/18 Target	2017/18 Performance	2017/18 Achievement
	Weighted average score in Patient Experience Survey[1]	Q, DoS	Communication: 8.5 Coordination: 8.7 Partnership: 8.5 Physical and emotional needs: 8.8	≥8.3	Communication: 8.4 Coordination: 8.4 Partnership: 8.6 Physical and emotional needs: 8.5	Achieved
	Percentage Did Not Attend (DNA) appointments for outpatient First Specialist Assessments	Q, DoS	6.98%	≤8%	8%	Achieved
	Percentage of DNA appointments for follow-up Specialist appointments.	Q, DoS	7.30%	≤6%	8%	Not Achieved
Cancer services	Percentage of patients, ready for treatment, who waited less than 4 weeks for radiotherapy or chemotherapy[2]	T, DoD	100%	100%	N/A	N/A
	Percentage of patients receiving their first cancer treatment (or other management) within 31 days from date of decision-to-treat†.	T, DoD	New Measure	≥85%	94%	Achieved

Outputs	Measure	Type of measure	2016/17 Performance	2017/18 Target	2017/18 Performance	2017/18 Achievement
Cancer services	**Health Target**: Percentage of patients with a high suspicion of cancer and a need to be seen within 2 weeks that received their first cancer treatment (or other management) within 62 days of being referred[1]	T, DoD	75.8%	≥95%	94%	Not 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.
2. This measure is no longer required by the Ministry. This was reported on the 17/18 Annual Plan in error.

Outputs	Measure	Type of measure	2016/17 Performance	2017/18 Target	2017/18 Performance	2017/18 Achievement
Mental health and addiction services	Number of people accessing secondary mental health services[1]	V	M:622 T: 2,048	Māori : Est 535 Total: Est 1891	M: 718 T: 2206	Achieved
	Percentage of patients 0-19 referred to non-urgent child & adolescent mental health services & seen within 8 weeks[2]	T, DoS	93%	≥95%	55%	Not achieved
	Percentage of patients 0-19 referred to non-urgent child & adolescent addictions services & seen within 8 weeks[2]	T, DoS	98%	≥95%	68%	Not Achieved
	Percentage of people admitted to an acute mental health inpatient service that were seen by the mental health community team in the 7 days prior to admission[2†].	Q	New Measure	Local target: 50% (Nat'l ≥75%)	88%	Achieved
	Percentage of people discharged from an acute mental health inpatient service that were seen by the mental health community team in the 7 days following discharge[2†].	Q	New Measure	Local target: 65% (Nat'l ≥90%)	94%	Achieved

1 2017/18 Performance result is for 12 months ending Sep 2017 (PP6 Q2 1718 report) which is the most recent complete data available. Due to the DHB migration to a new patient management system, complete data for the full year is not available either locally or in PRIMHD national data Outputs

2 2017/18 Performance result is for the 5 months Feb-Jun 2018, which is the most recent data available. Due to the DHB migration to a new patient management system, complete data for the full year is not available either locally or in PRIMHD national data.

3 2017/18 Performance result is based on local internal data for Wairarapa residents admitted to inpatient service in Hutt Valley or Capital & Coast DHBs and seen by the Wairarapa community team

Commentary

Quality

Patient Falls (causing harm SAC 1-3) – Target was achieved. Patient Falls are acknowledged as a high area of harm and falls risk assessments remain a high priority within our organisation and individualized plans are put in place to meet the needs of patients. The Falls Prevention Committee meets bi-monthly with multidisciplinary team membership.

Pressure Injuries (Hospital acquired) – Target was not achieved. An increase in patient acuity and people living with comorbidities could be a cause of the rise in pressure injuries. 2018 sees the HQSC introduction of QSMs around pressure injuries currently in the implementation process within our organisation. Incorrect classification of pressure injuries could have impacted the data and plans are in place to mitigate this.

Medication Errors (causing harm SAC 1-3) – Target was not achieved. Encouragement to report errors continues. All nurses are required to complete online E-Learning module in this regard and auditing of prescribers has been initiated this year.

Medical and surgical services

A 4.6% increase in ED throughput has resulted in not achieving the ED Health target. Surge in demand at times has caused delays and on review of the data one of areas of delay is people being admitted to hospital. At times the AAU (Acute Assessment Unit) has been used but remains dependent on available staffing resource. Recent implementation of WebPas has impacted on processes and previous data entry errors are not being picked up and rectified as easily resulting in some patients being reported as a breach when they are not. Our future focus for next year will see ongoing work on assessing the feasibility of establishing an urgent care service in partnership with primary care. Recent investment for coming years in the Health Care Home programme is also predicated on realising better acute access and management in primary care leading to reductions in acute presentations. A flexible nursing team has recently been established to work across the hospital, assigned to areas of most pressure.

Outpatient DNA rates for follow-up appointments continue to be monitored. There is a significant equity challenge evident in relationship to DNA by ethnicity. The Māori Directorate and outpatients call and remind patients of upcoming appointments and reschedule if need be. Specific clinics with high DNA rates are targeted i.e. gynaecology, paediatrics and ENT. The coming year will see ongoing focus on these areas and opportunities for use of technology enabled by WebPAS to implement more patient centric scheduling systems as well as targeted engagement with Primary Care for patients who have multiple DNA who continue to be rescheduled despite missing several appointments.

The performance for acute average length of stay is slightly over the target. On-going work around patient flow including discharge planning is focused on improving length of stay. Targeted work on early planning and turnaround to prevent admission for avoidable cases will remain a key focus area. Recent investments in the Health Care Home are intended to see ongoing improvements in year of care planning for those patients who are high risk or complex/multiple co-morbidities, which should see reduced levels of acute admission reduced lengths of stay for those whose care is amenable to proactive intervention.

Ongoing education continues around medication and there has been an increased focus on auditing and quality improvement activities by the quality and pharmacy teams to improve medication error results. The Clinical Board continues to monitor medication errors.

Our local Consumer Council and central region quality alliance are focusing on person and whanau centred care, including a focus on communication and locally we are sharing the results of the National Adult In-Patient Experience survey more extensively to increase the visibility of our patients' experience of care.

Cancer services

The 62 day target has failed to reach target for only three months in the 2017-2018 year, and these three months were close to target. The overall annual result has achieved the target, and continuing regular case management is being undertaken. The 31 day target has achieved its annual target as well. Urology, and in particular prostate cancer treatment services remain the main area for concern within this target, due both to the delivery of the service and the nature of the disease.

Mental health and Addiction services

Māori access rates (as a percentage of total population) have increased from 7.86% to 9.22% over the past year, and achieved the performance target second year running.

Same as previous years during the year the service experienced a deficit in medical consultant resource (employed FTE) in addition to a deficit in registered clinician resource.

The service has increased accessed to acute inpatient resource contracted with Hutt valley DHB and this year has managed to increase clinical FTE, which has improved the management of new referrals.

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	2016/17 Performance	2017/18 Target	2017/18 Performance	2017/18 Achievement
Disability care services	Number of sub-regional and Wairarapa Disability forums.	V	1	≥1	1 Disability Action Group forum 1 Disability Champions forum	Achieved
	Number of sub-regional Disability newsletters published.	V	12	≥2	6 Disability information updates for the Sub-Regional Disability Advisory Group	Achieved
	Total number of hospital staff that have completed the Disability Responsiveness eLearning module†.	Q	New measure	50	162	Achieved
	Total number of Disability Alert registrations[1].	Q	N/A	≥324	N/A See comment	N/A

Outputs	Measure	Type of Measure	2016/17 Performance	2017/18 Target	2017/18 Performance	2017/18 Achievement
Health of older people (HOP) services	Percentage of people 65+ years who have received long term home support services in the last 3 months who have had comprehensive clinical [InterRAI] assessment and a completed care plan	C, DoS	100%	100%	100%	Achieved
	Percentage of people 65+ years receiving DHB funded HOP support, that are being supported to live at home	C, DoS	67%	≥ 65%	68%	Achieved
	Percentage of the population aged 75+ years that are in Aged Residential Care (including private payers)	C, DoS	9.7%	≤12.2%	9.3%	Achieved
	Percentage of residential care providers being awarded 3-year (or more) certification in the planned year.	Q, DoS	85%	≥83%	92%	Achieved

1 Disability Alerts help clinicians to identify and respond to the needs of the patients with disabilities. Disability Alerts were unable to be progressed due to difficulty with the implementation of Webpas into clinical areas at Wairarapa DHB. In the meantime, Wairarapa clients are registering their interest in the alert and preparing for its introduction.

Commentary

Disability services

A Disability meeting with members from the key groups, of Sub Regional Disability Advisory Group, Sub Regional Pacific Disability Steering Group and Sub regional Māori Disability Roopu is planned for November 2018. A Disability Forum will be held in 2019.

The Wairarapa has a newly developed web page with information. The page and its links will be further developed with support from the wider disability team/community. Communications through the "Daily Dose" has supported workforce and consumers with information about disability issues and events. The Sub Regional Disability Advisory Group has received Disability information updates of Wairarapa activity at each meeting.

IT alerts were unable to be progressed due to difficulty with the implementation of Webpas into clinical areas at Wairarapa DHB. A delay in implementation of the Disability Alerts was required until the electronic WebPas

patient information system was embedded and operating well. Progress is planned for 2018/19. Alert quality was reviewed by the 3DHB Disability team with good learning for planned Wairarapa implementation.

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 continues to be achieved.

There is an increased proportion of older people receiving DHB support funding who are being supported to live at home, which is in line with our strategy.

There are 12 ARC providers in Wairarapa and reporting in percentages for small numbers can give a distorted result. If a three or more year certification status is not met, Residential facilities may receive a two-year certification period. As at June 2018, there is one Age Residential Care provider with two-year certification. Their certification audit due in August 2018 is expected to result in 100% for this measure.

Although the actual numbers of older people entering residential care remains constant, the proportion of the population 65+ entering care has been steadily declining over the past 5 years. 368 people over 75+ are in residential care at the end of 2017-18 (pop 3,955).

Financial Statements

CONTENTS

Statement of Responsibility

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

We are responsible for any end-of-year performance information provided by the 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 the Wairarapa District Health Board group for the year ended 30 June 2018.

Signed on behalf of the Board:

Board member
30 October 2018

Board member
30 October 2018

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 2018

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 96, that comprise the statement of financial position as at 30 June 2018, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include significant accounting policies and other explanatory information; and
- the performance information of the District Health Board and group on pages 19 to 57.

Qualified opinion

Qualified opinion on the financial statements – Our work was limited over the carrying value of building assets

In our opinion, except for the possible effects of the matter described in the *Basis for our qualified opinion* section of our report:

- the financial statements of the District Health Board and group on pages 60 to 96
    - present fairly, in all material respects:
        - its financial position as at 30 June 2018; 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.

Unmodified opinion on the performance information

- the performance information of the District Health Board and group on pages 19 to 57 :
    - presents fairly, in all material respects, the District Health Board and group's performance for the year ended 30 June 2018, 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; and

- complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 31 October 2018. This is the date at which our qualified opinion is expressed.

The basis for our qualified opinion is explained below and we draw your attention to other matters. 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 qualified opinion

As disclosed in note 12, the District Health Board and group measures its building assets at fair value less accumulated depreciation, which have a reported carrying value as at 30 June 2018 of $33.54 million. Public Benefit Entity International Public Sector Accounting Standard 17 Property Plant and Equipment requires assets measured at fair value to be revalued with sufficient regularity to ensure that the carrying amount does not differ materially from its fair value. The last valuation accounted for was as at 30 June 2013.

The District Health Board has identified that the main hospital building requires seismic remediation to meet earthquake service and function requirements. The level of remediation work and the associated costs are not yet known. These costs could be substantial. The carrying value of the buildings as at 30 June 2018 does not reflect this required remediation work or other movements in fair value since the prior valuation. Consequently, we are unable to determine if the carrying value of buildings is materially different to their fair value and the amount of any fair value adjustment that would be recognised in the statement of comprehensive revenue and expense.

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 qualified opinion.

The Health Board is reliant on financial support from the Crown

We draw your attention to the disclosures made in note 1on page 65 that outline that the Board, in reaching the conclusion that the Health Board is a going concern, has taken into consideration the letter of support received from the Ministers' of Health and Finance. The letter confirms that the Crown will provide the Health

Board with financial support, should it be necessary, to maintain viability. We consider these disclosures to be adequate and our opinion is not modified in respect of this matter.

Compliance with the Holidays Act 2003

District Health Boards (DHBs) have been investigating issues associated with the calculation of employee entitlements under the Holidays Act 2003. A national approach is being taken to remediate these issues. Due to the nature of DHB employment arrangements, this is a complex and time consuming process. This matter may result in significant liabilities for some DHBs. The Health Board has provided further disclosure about this matter in note 16 on page 88 Our opinion is not modified in respect of this matter.

Failure to complete the statement of performance expectations for the reporting period beginning 1 July 2018

We draw your attention to the disclosures on page 21 about the failure to comply with section 149C of the Crown Entities Act 2004, which requires the DHB to complete its statement of performance expectations before the start of the financial year. We consider the disclosures to be appropriate and our opinion is not modified in respect to this matter.

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 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 Board is also responsible for disclosing, as applicable, matters related to going concern and using the going concern basis of accounting, unless there is an intention to liquidate the District Health Board and Group or there is no realistic alternative but to do so.

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

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

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

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

For the budget information reported in the financial statements and the performance information, our procedures were limited to checking that the information agreed to the 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 96 but does not include the financial statements and the performance information, and our auditor's report thereon.

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

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

Independence

We are independent of the 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 the audit, we have no relationship with, or interests, in the District Health Board or group.

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

Statement of Comprehensive Revenue and Expense

For the year ended 30 June 2018

	Note	Group Budget 2018 $000	Group Actual 2018 $000	Group Actual 2017 $000	Parent Actual 2018 $000	Parent Actual 2017 $000
Revenue						
Patient care revenue	2	151,232	152,037	144,719	152,037	144,719
Interest revenue		64	30	55	30	55
Other revenue	2	3,962	6,331	5,832	5,483	4,600
Total revenue		**155,258**	**158,398**	**150,606**	**157,550**	**149,374**
Expenditure						
Personnel costs	3	44,491	45,862	42,342	45,862	42,342
Outsourced services		6,782	8,474	9,834	7,439	8,698
Clinical supplies		9,663	11,456	9,723	11,456	9,723
Infrastructure and non-clinical expenses		7,810	7,323	6,694	7,323	6,736
External providers		47,308	48,850	43,986	48,850	43,986
Inter district flows		36,552	39,528	36,443	39,528	36,443
Capital charge	4	1,900	1,750	381	1,750	381
Interest expense		24	25	576	25	576
Depreciation and amortisation expense	12,13	1,994	1,682	1,710	1,572	1,602
Impairment expense	13	0	668	0	668	0
Other expenses	5	1,893	1,782	1,732	1,782	1,690
Total expenses		**158,417**	**167,400**	**153,421**	**166,255**	**152,177**
Share of associated surplus/(deficit)		**0**	**0**	**0**	**0**	**0**
Surplus/(deficit)		**(3,159)**	**(9,002)**	**(2,815)**	**(8,705)**	**(2,803)**
Other comprehensive revenue and expense						
Item that will not be reclassified to surplus/(deficit)						
Revaluation of land and building	18	0	0	0	0	0
Total other comprehensive revenue and expense		**0**	**0**	**0**	**0**	**0**
Total comprehensive revenue and expense		(3,159)	(9,002)	(2,815)	(8,705)	(2,803)

The accompanying notes form part of the financial statements. Explanations of major variances against budget are provided in note 23.

Statement of Financial Position

As at 30 June 2018

	Note	Group Budget 2018 $000	Group Actual 2018 $000	Group Actual 2017 $000	Parent Actual 2018 $000	Parent Actual 2017 $000
Assets						
Current assets						
Cash & cash equivalents	6	4	5	177	5	3
Receivables	7	4,226	3,902	4,306	3,902	4,140
Prepayments		314	312	861	312	861
Investments	8	306	343	323	343	323
Inventories	9	1,024	1,175	1,016	1,175	1,016
Non-current assets held for sale	10	0	0	50	0	50
Total current assets		5,874	**5,737**	**6,733**	**5,737**	**6,393**
Non-current assets						
Investments in subsidiary	11	643	-	-	-	103
Property, plant & equipment	12	39,190	38,821	39,555	38,821	39,408
Intangible assets	13	10,438	10,232	7,772	10,232	7,661
Total non-current assets		**50,271**	**49,053**	**47,327**	**49,053**	**47,172**
Total assets		**56,145**	**54,790**	**54,060**	**54,790**	**53,565**
Liabilities						
Current liabilities						
Cash & cash equivalents - overdraft	6	2,520	943	3,183	943	3,183
Payables and deferred revenue	14	10,530	10,400	10,283	10,400	10,227
Borrowings	15	79	85	79	85	79
Employee entitlements	16	8,041	9,030	7,909	9,030	7,811
Total current liabilities		**21,170**	**20,458**	**21,454**	**20,458**	**21,300**
Non-current liabilities						
Borrowings	15	152	138	223	138	223
Employee entitlements	16	619	653	607	653	607
Restricted Funds	8	318	343	332	343	332
Total non-current liabilities		**1,089**	**1,134**	**1,162**	**1,134**	**1,162**
Total liabilities		**22,259**	**21,592**	**22,616**	**21,592**	**22,462**
Net assets		**33,886**	**33,198**	**31,444**	**33,198**	**31,103**
Equity						
Crown equity	18	74,780	79,578	68,778	79,578	68,778
Revaluation reserve	18	5,558	5,558	5,558	5,558	5,558
Retained earnings	18	(46,452)	(51,938)	(42,892)	(51,938)	(43,233)
Total equity		**33,886**	**33,198**	**31,444**	**33,198**	**31,103**

The accompanying notes form part of the financial statements. Explanations of major variances against budget are provided in note 23.

Statement of Changes In Equity

For the year ended 30 June 2018

	Note	Group Budget 2018 $000	Group Actual 2018 $000	Group Actual 2017 $000	Parent Actual 2018 $000	Parent Actual 2017 $000
Balance at 1 July		**31,045**	**31,444**	**7,515**	**31,103**	**7,162**
Net surplus / (deficit) for the year		(3,159)	(9,002)	(2,815)	(8,705)	(2,803)
Other comprehensive revenue and expense		0	(44)	0	0	0
Total comprehensive revenue and expense		(3,159)	(9,046)	(2,815)	(8,705)	(2,803)
Equity injection from the Crown		6,000	10,800	26,750	10,800	26,750
Repayment of equity to the Crown		0	0	(6)	0	(6)
Movements in equity for the year		6,000	10,800	**26,744**	10,800	**26,744**
Balance at 30 June	18	**33,886**	**33,198**	**31,444**	**33,198**	**31,103**

The accompanying notes form part of the financial statements. Explanations of major variances against budget are provided in note 23.

Statement of Cash Flows

For the year ended 30 June 2018

	Group Budget 2018 $000	Group Actual 2018 $000	Group Actual 2017 $000	Parent Actual 2018 $000	Parent Actual 2017 $000
Cash flows from operating activities					
Operating receipts:					
Government & crown agency revenue	151,177	151,661	143,368	151,661	143,368
Other	3,998	4,893	6,701	4,710	5,432
Interest received	64	30	55	30	55
Payments to suppliers & employees	(154,421)	(160,159)	(149,882)	(160,090)	(148,643)
Capital charge paid	(2,179)	(1,750)	(381)	(1,750)	(381)
Interest paid	(24)	(25)	(576)	(25)	(576)
Goods and Services Tax (net)	0	(349)	(95)	(349)	(95)
Net cash flows from operating activities	**(1,385)**	**(5,699)**	**(810)**	**(5,813)**	**(840)**
Cash flows from investing activities					
Proceeds from sale of property, plant & equipment	50	132	5	132	5
Dividends received	24	0	(31)	26	(31)
Proceeds from sale of subsidiary	0	0	0	435	0
Increase in Investments	0	(9)	0	(9)	0
Acquisition of property, plant & equipment	(1,249)	(385)	(686)	(482)	(670)
Acquisition of intangible assets	(3,943)	(2,692)	(1,183)	(2,768)	(1,159)
Net cash flows from investing activities	**(5,118)**	**(2,954)**	**(1,895)**	**(2,666)**	**(1,855)**
Cash flows from financing activities					
Equity injected	6,000	10,800	1,000	10,800	1,000
Repayments of loans	(78)	(79)	(74)	(79)	(74)
Repayment of equity	0	0	(6)	0	(6)
Net cash flows from financing activities	**5,922**	**10,721**	**920**	**10,721**	**920**
Net increase / (decrease) in cash & cash equivalents	**(581)**	**2,068**	**(1,785)**	**2,242**	**(1,775)**
Cash & cash equivalents at beginning of year	(1,934)	(3,006)	(1,221)	(3,180)	(1,405)
Cash & cash equivalents at end of year	**(2,516)**	**(938)**	**(3,006)**	**(938)**	**(3,180)**

Reconciliation of net deficit to net cash flow from operating activities

	Group Budget 2018 $000	Group Actual 2018 $000	Group Actual 2017 $000	Parent Actual 2018 $000	Parent Actual 2017 $000
Net surplus / (deficit)	**(3,159)**	**(9,002)**	**(2,815)**	**(8,705)**	**(2,803)**
Add/(less) non-cash items					
Depreciation and amortisation expense	1,994	1,682	1,710	1,572	1,602
Donated Assets	0	(120)	0	(120)	0
Impairment of Intangibles	0	668	0	668	0
Net movement in non-cash items	1,994	2,230	1,710	2,120	1,602
Add/(less)items classified as investing or financing activities					
Net (gains)/losses on disposal of property, plant & equipment	0	(82)	15	(82)	15
Sale of investments	0	0	0	(435)	0
Dividends received	0	0	(31)	(26)	6
Repayment of loans	0	(85)	0	(85)	0
Net movement in investing or financing activities	**0**	(167)	**(16)**	(628)	21
Add/(less) movements in statement of financial position items					
Increase/decrease in receivables	0	404	(508)	238	(503)
Increase/decrease in inventories	0	(159)	(114)	(159)	(114)
Increase/decrease in payables	(220)	(721)	946	(493)	970
Increase/decrease in prepayments	0	549	0	549	0
Increase/decrease in provisions	0	1,167	(13)	1,265	(13)
Net movement in working capital items	(220)	1,240	311	1,400	340
Net cash flow from operating activities	**(1,385)**	**(5,699)**	**(810)**	**(5,813)**	**(840)**

The accompanying notes form part of the financial statements. Explanations of major variances against budget are provided in note 23.

Notes to the Financial Statements for the year ended 30 June 2018

Notes Index

1. Statement of Accounting Policies

Reporting Entity

Wairarapa District Health Board (the DHB) is a Crown Entity as defined by the Crown Entities Act 2004 and is domiciled in New Zealand. The relevant legislation governing the DHB's operations is the Crown Entities Act 2004 and the New Zealand Public Health and Disability Act 2000. The DHB's ultimate parent is the New Zealand Crown.

The consolidated financial statements of Wairarapa DHB for the year ended 30 June 2018 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 group's primary objective is to deliver health, disability and mental health services to the community within its district. The group does not operate to make a financial return.

The group is designated as a public benefit entity (PBE) for the purposes of complying with generally accepted accounting practice.

The financial statements for the group are for the year ended 30 June 2018 and were approved for issue by the Board on 25 October 2018.

Basis of Preparation

The financial statements have been prepared on a going concern basis, and the accounting policies have been applied consistently throughout the year.

Going Concern

Wairarapa DHB received a letter of support from the Ministers of Health and Finance that the Government is committed to working with the DHB over the medium term to maintain its financial viability. The DHB acknowledges that equity support will be required during 2018/19, due to population growth, continued national and regional cost pressures and increased demand placed on service delivery. The Crown will provide such support should it be necessary to maintain viability. The letter of support is considered critical to the going concern assumption underlying the preparation of the financial statements.

Statement of compliance

The financial statements of the group have been prepared in accordance with the requirements of the Crown Entities Act 2004 and the New Zealand Health and Disability Act 2000, which includes the requirement to comply with New Zealand generally accepted accounting practice (GAAP).

The financial statements have been prepared in accordance with and comply with PBE Accounting Standards.

Presentation currency and rounding

The financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars ($000), other than remuneration disclosed in Note 3, which is rounded to the nearest dollar.

Comparative Figures

Comparative figures have been adjusted where necessary to conform to the current year's presentation; this included some minor corrections to previously stated amounts.

Changes in accounting policies

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

Standards issued and not yet effective and not early adopted

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

Impairment of revalued assets

In April 2017, the XRB issued Impairment of Revalued Assets, which now clearly scopes revalued property, plant, and equipment into the impairment accounting standards. Previously, only property, plant, and equipment measured at cost were scoped into the impairment accounting standards.

Under the amendment, a revalued asset can be impaired without having to revalue the entire class-of-asset to which the asset belongs. This amendment is effective for the 30 June 2020 financial statements, with early adoption permitted. The timing of the DHB adopting this amendment will be guided by the Treasury's decision on when the Financial Statements of the Government will adopt the amendment.

Financial instruments

In January 2017, the XRB issued PBE IFRS 9 Financial Instruments. This replaces PBE ISAS 29 Financial Instruments: Recognition and Measurement. PBE IFRS 9 is effective for financial years beginning on or after 1 January 2021, with earlier application permitted. The main changes under the standard relevant to the DHB are:

- New financial asset classification requirements for determining whether an asset is measured at fair value or amortised cost.
- A new impairment model for financial assets based on expected losses, which might result in the earlier recognition of impairment losses.

The Treasury has decided that the Financial Statements of the Government will early adopt PBE IFRS 9 for the 30 June 2019 financial year. The DHB will also early adopt PBE IFRS 9 for the 30 June 2019 financial year to be consistent with the Crown's accounting policy for financial instruments. The DHB has not yet assessed in detail the impact of the new standard. Based on an initial assessment, the DHB anticipates that the standard will not have a material effect on the DHB's financial statements.

Interest in other entities

In January 2017, the XRB issued new standards for interest in other entities (PBE IPSAS 34 – 38). These new standards replace the existing standards for interest in other entities (PBE IPSAS 6 – 8). The new standards are effective for annual periods beginning on or after 1 January 2019, with early application permitted.

The DHB plans to apply the new standards in preparing the 30 June 2020 financial statements. The DHB has not yet assessed the effects of these new standards.

Summary of significant accounting policies

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

Foreign currency transactions

Foreign currency transactions are translated into NZ Dollars (the functional currency) using the exchange rates prevailing at the dates of the transactions.

Foreign exchange gains and losses resulting from the settlement of such transactions and from the transactions at year-end exchange rate of monetary assets and liabilities denominated in foreign currencies are recognised in the surplus or deficit.

Goods and services tax

All items in the financial statements are presented exclusive of goods and services tax (GST), except for receivables and payable, which are presented on a GST-inclusive basis. Where GST is not recoverable as input tax, it is recognised as part of the related asset or expense.

The net amount of GST recoverable from, or payable to, the Inland Revenue Department (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.

Income tax

The DHB is a public authority and consequently is exempt from the payment of income tax, as a result no provision has been made for income tax.

Budget figures

The budget figures are derived from the 2017/18 statement of performance expectations. The budget figures have been prepared in accordance with GAAP, using accounting policies that are consistent with those adopted by the Board in preparing these financial statements.

Cost allocation

The cost of outputs has been determined using the cost allocation system outlined below.

Direct costs are those directly attributed to an output. Indirect costs are those costs that cannot be identified in an economically feasible manner with a specific output.

Direct costs are charged directly to outputs. Indirect costs are charge to outputs based on cost drivers and related activity or usage information. Depreciation is charged on the basis of asset utilisation. Personnel costs are charged on the basis of actual time incurred. Property and other premises costs, such as maintenance, are charged on the basis of floor area occupied for the production of each output. Other indirect costs are assigned to outputs based on the proportion of direct staff costs for each output.

There have no changes to the cost allocation methodology since the date of the last audited financial statements.

Critical accounting estimates and assumptions

In preparing these financial statements, the Board has made estimates and assumptions concerning the future. These estimates and assumptions might differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectation of future events that are believed to be reasonable under the circumstances.

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

- Estimating the fair value of land and buildings – refer to Note 12.
- Measuring long service leave and retirement gratuities – refer to Note 16.

2. Revenue

Accounting policy

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

MoH population-based revenue
The DHB receives annual funding from the Ministry of Health (MoH), which is based on population levels within the Wairarapa DHB district.

MoH population-based revenue for the financial year is recognised based on the funding entitlement for that Year.

MoH contract revenue
The revenue recognition approach for MoH contract revenue depends on the contract terms. Those contracts where the amount of revenue is substantively linked to the provision of quantifiable units of service are treated as exchange contracts and revenue is recognised as the DHB provides the services. For example, where funding varies based on the quantity of services delivered, such as number of screening tests of heart checks.

Other contract are treated as non-exchange and the total funding receivable under the contract is recognised as revenue immediately, unless there are substantive conditions in the contract. If there are substantive conditions, revenue is recognised when the conditions are satisfied. A condition could include the requirement to provide services to the satisfaction of the funder to receive or retain funding. Revenue for future years is not recognised where the contract contains substantive termination provisions for failure to comply with the service requirements of the contract. Conditions and termination provisions need to be substantive, which is assessed by considering factors such as the past practice of the funder. Judgement is often required in determining the timing of revenue recognition for contracts that span a balance date and multi-year funding arrangements.

Inter-district flows
Inter district patient inflow revenue occurs when a patient treated within the DHB's district is domiciled outside of the Wairarapa. Inter-district patient inflow revenue is recognised when eligible services are provided.

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

Interest Revenue
Interest revenue is recognised using the effective interest method.

Rental Revenue
Rental revenue under an operating lease is recognised as revenue on a straight-line basis over the lease term.

Provision of other services
Revenue derived through the provision of other services to third parties is recognised in proportion to the stage of completion at balance date, based on the actual service provided as a percentage of the total services to be provided.

Donations and bequests
Donations and bequeathed financial assets are recognised as revenue, unless there are substantive use or return condition. A liability is recorded if there are substantive use or return conditions and the liability released to revenue as the conditions are met. For example, as the funds are spent for the nominated purpose.

Grants revenue

Grants are recognised as revenue when they become receivable unless there is an obligation in substance to return the funds if conditions of the grant are not met. If there is such an obligation, the grants are initially recorded as grants received in advance and recognised as revenue when conditions of the grant are satisfied.

Vested or donated physical assets

For assets received for no or nominal consideration, the asset is recognised at its fair value when the group obtains control of the asset. The fair value of the asset is recognised as revenue, unless there is a use or return condition attached to the asset.

The fair value of vested or donated assets is usually determined by reference to the cost of purchasing the asset if the asset is new, or reference to market information for assets of a similar type, condition, or age for used assets.

Donated services

Volunteer services received are recognised as revenue or expenses by the group.

Breakdown of patient care and other revenue

i. Patient care revenue

	Group Actual 2018 $000	Group Actual 2017 $000	Parent Actual 2018 $000	Parent Actual 2017 $000
MoH population-based funding	134,774	129,776	134,774	129,776
MoH other contracts	10,524	8,401	10,524	8,401
Inter-district flows	3,899	3,246	3,899	3,246
ACC contract revenue	2,205	2,453	2,205	2,453
Other patient care related revenue	635	843	635	843
Total patient care revenue	**152,037**	**144,719**	**152,037**	**144,719**

ii. Other revenue

	Group Actual 2018 $000	Group Actual 2017 $000	Parent Actual 2018 $000	Parent Actual 2017 $000
Gain on sale of property, plant and equipment	82	5	82	5
Gain on sale of investment	0	0	332	0
Donated equipment	120	14	120	14
Cash donations and bequests received	363	462	363	462
Dividend revenue	0	(31)	26	6
Rental revenue	1,234	1,172	1,234	1,172
Other revenue	4,532	4,210	3,326	2,941
Total other revenue	**6,331**	**5,832**	**5,483**	**4,600**

3. Personnel costs

Accounting policy

Salary and wages

Salary and wages are recognised as an expense as employees provide services.

Superannuation schemes

Defined contribution schemes

Employer contributions to Kiwisaver, the Government Superannuation Fund, and other State Sector Retirement Savings Scheme are accounted for as defined contribution schemes and are recognised as an expense in the surplus or deficit as incurred.

Breakdown of personnel costs and further information

	Group Actual 2018 $000	Group Actual 2017 $000	Parent Actual 2018 $000	Parent Actual 2017 $000
Salaries and wages	43,228	40,685	43,228	40,685
Defined contributions plan employer contributions	1,369	1,252	1,369	1,252
Increase/(decrease) in liability for employee entitlements	1,265	405	1,265	405
Total personnel costs	**45,862**	**42,342**	**45,862**	**42,342**

Employee remuneration

	2018 No. of Employees	2017 No. of Employees
$100,000 - $110,000	12	10
$110,001 - $120,000	5	6
$120,001 - $130,000	5	3
$130,001 - $140,000	1	4
$140,001 - $150,000	3	1
$150,001 - $160,000	1	1
$160,001 - $170,000	3	1
$170,001 - $180,000	1	2
$180,001 - $190,000	1	0
$190,001 - $200,000	0	0
$200,001 - $210,000	0	2
$210,001 - $220,000	2	1
$220,001 - $230,000	1	1
$230,001 - $240,000	1	2
$240,001 - $250,000	3	3
$250,001 - $260,000	1	3
$260,001 - $270,000	3	3
$270,001 - $280,000	1	2
$280,001 - $290,000	4	3
$290,001 - $300,000	4	0
$300,001 - $310,000	1	0
$310,001 - $320,000	2	2
$320,001 - $330,000	1	2
$330,001 - $340,000	1	1
$350,001 - $360,000	1	0
$380,001 - $390,000	1	0
$450,001 - $460,000	1	0
$460,001 - $470,000	2	0
	62	**53**

Termination payments

During the year, the DHB made one payment to a former employee 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 of $8,140 (for the 2017/18 period).

Board member remuneration

	2018 Board Fee	2018 Committees Fees	2018 Total Fees	2017 Total Fees
Sir Paul Collins (Chairman)	33,600	2,063	35,663	19,850
Leanne Southey (Deputy Chair)	20,400	2,125	22,525	20,960
Ronald Karaitiana	16,320	3,875	20,195	18,320
Nick Crozier	16,320	1,500	17,820	10,020
Liz Falkner	12,554	3,970	16,524	10,770
Jane Hopkirk	16,320	250	16,570	16,570
Rick Long	16,320	1,750	18,070	17,320
Derek Milne	16,320	250	16,570	25,960
Fiona Samuel	16,320	1,250	17,570	17,507
Alan Shirley	16,320	0	16,320	17,070
Adrienne Staples	16,320	1,750	18,070	9,770
Rob Irwin	0	0	0	8,032
Helen Kjestrup	0	0	0	7,782
Janine Vollebreght	0	0	0	8,157
TOTAL	**197,114**	**18,783**	**215,897**	**208,088**

There have been no payments made to committee members appointed by the Board who are not Board members during the financial year.

The DHB has provided a deed of indemnity to Board members for certain activities undertaken in the performance of the DHB's function.

The DHB has effected Directors' and Officers' Liability and Professional Indemnity insurance cover during the financial year in respect of the liability or costs of Board members and employees.

No Board members received compensation or other benefits in relation to cessation (2017:$nil).

4. Capital charge

Accounting policy

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

Further information

The group pays a capital charge every six months to the Crown. The charge is based on the previous six months actual closing equity balance at 31 December and 30 June. The capital charge rate for the year ended 30 June 2018 was 6% (2017: 7% for six months to 31 December 2016; 6% for six months to 30 June 2017).

5. Other expenses

Accounting policy

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.

Lease payments under an operating lease are recognised as an expense on a straight-line basis over the lease term.

Lease incentives received are recognised in the surplus or deficit as a reduction of lease expense over the lease term.

Breakdown of other expenses and further information

	Group Actual 2018 $000	Group Actual 2017 $000	Parent Actual 2018 $000	Parent Actual 2017 $000
Operating lease expenses	1,389	1,287	1,389	1,253
Audit fees (Audit NZ for annual financial statements)	114	113	114	111
Audit fees (CRTAS for other assurance services)	63	61	63	61
Impairment of receivables (bad & doubtful debts)	(11)	19	(11)	19
Board member fees & expenses	223	239	223	233
Loss on disposal of property, plant and equipment	4	13	4	13
Total other expenses	**1,782**	**1,732**	**1,782**	**1,690**

Operating leases as lessee

The future aggregate minimum lease payments to be paid under non-cancellable operating leases are as follows:

	Group Actual 2018 $000	Group Actual 2017 $000	Parent Actual 2018 $000	Parent Actual 2017 $000
Not later than one year	1,047	720	1,047	720
Later than one year and not later than five years	2,189	1,093	2,189	1,093
Later than five years	120	104	120	104
Non-cancellable operating leases	**3,355**	**1,917**	**3,355**	**1,917**

The groups leases a variety of clinical and IT equipment, a fleet of motor vehicles and a number of buildings.

6. Cash and cash equivalents

Accounting policy

Cash and cash equivalents includes cash on hand, deposits held at call with banks, other short-term liquid investments, and bank overdrafts. Bank overdrafts are shown within borrowings in current liabilities in the statement of financial position.

Breakdown of cash and cash equivalent and further information

	Group Actual 2018 $000	Group Actual 2017 $000	Parent Actual 2018 $000	Parent Actual 2017 $000
Cash at bank and on hand	4	177	4	3
Bank overdraft	(943)	(3,183)	(943)	(3,183)
New Zealand Health Partnerships Ltd	1	0	1	0
Total cash and cash equivalents	**(938)**	**(3,006)**	**(938)**	**(3,180)**

The DHB is party to a DHB Treasury Services Agreement between New Zealand Health Partnerships Limited (NZHPL) and the participating DHBs. This Agreement enables NZHPL 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 NZHPL, which will incur interest at the credit interest rate received by NZHPL plus an administrative margin. The balance held by the DHB within this Agreement is shown as bank overdraft within the table above. The maximum borrowing facility available to any DHB is the value of one month's Provider Arm funding inclusive of GST. As at 30 June 2018, this limit was $5m (2017:$5 million).

Financial assets recognised subject to restrictions

Included in cash and cash equivalents and investments (refer to Note 8) are unspent funds with restrictions that relate to the delivery of health service by the DHB. Other than for trust funds, it is not practicable for the DHB to provide further detailed information about the restrictions. Further information about trust funds is provided in Note 17.

The carrying value of cash and cash equivalents approximates their fair value.

7. Receivables

Accounting policy

Short-term receivables are recorded at the amount due, less any provision for not collectable.

A receivable is considered uncollectable when there is evidence that the group will not be able to collect the amount due. The amount that is uncollectable is the difference between the amount due of the receivable and the present value of the amounts expected to be collected.

Breakdown of receivables and further information

	Group Actual 2018 $000	Group Actual 2017 $000	Parent Actual 2018 $000	Parent Actual 2017 $000
Receivables from MoH	1,614	1,504	1,614	1,504
Other receivables	343	955	343	787
Other accrued revenue	2,008	1,921	2,008	1,921
Less: provision for uncollectability	(63)	(74)	(63)	(74)
Amount owing by subsidiary	0	0	0	2
Total receivables	**3,902**	**4,306**	**3,902**	**4,140**
Receivables from the sale of goods and services (exchange transactions)	62	312	62	146
Receivables from non- exchange transactions	3,840	3,994	3,840	3,994
Total receivables	**3,902**	**4,306**	**3,902**	**4,140**

The aging profile of receivables at year-end is detailed below:

	Actual 2018 $000s Gross	Actual 2018 $000s Impairment	Actual 2018 $000s Net	Actual 2017 $000s Gross	Actual 2017 $000s Impairment	Actual 2017 $000s Net
Group						
Not past due	3,829	0	3,829	4,034	0	4,034
Past due 1-30 days	27	0	27	223	(10)	213
Past due 31-60 days	7	(3)	4	48	(7)	41
Past due > 60 days	103	(60)	43	75	(57)	18
Total	**3,965**	**(63)**	**3,902**	**4,380**	**(74)**	**4,306**
Parent						
Not past due	3,829	0	3,829	3,868	0	3,868
Past due 1-30 days	27	0	27	223	(10)	213
Past due 31-60 days	7	(3)	4	48	(7)	41
Past due > 60 days	103	(60)	43	75	(57)	18
Total	**3,965**	**(63)**	**3,902**	**4,214**	**(74)**	**4,140**

All receivables greater than 30 days in age are considered to be past due.

Due to the large number of other receivables the assessment of the non-collectable amount is generally performed on a collective basis, based on an analysis of past collection history and write-offs.

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

	Actual 2018 $000s	Actual 2017 $000s
Balance at 1 July	74	56
Additional provisions made/(provisions released)	(5)	16
Receivables written off	(6)	2
Balance at 30 June	**63**	**74**

8. Investments

Accounting policy

Bank term deposits

Bank term deposits are initially measured at the amount invested. Interest is subsequently accrued and added to the investment balance.

Breakdown of investments and further information

	Group Actual 2018 $000	Group Actual 2017 $000	Parent Actual 2018 $000	Parent Actual 2017 $000
Current Portion				
Term deposits with maturites less than 3 months	99	87	99	87
Term deposits with maturites less than 12 months	244	236	244	236
Total investments	**343**	**323**	**343**	**323**

There is no impairment provision for investments.

9. Inventories

Accounting policy

Inventories held for distribution or consumption in the provision of service that are not supplied in a commercial basis are measured at cost (using the FIFO method), adjusted, when applicable, for any loss of service potential.

Inventories acquired through non-exchange transactions are measured at fair value at the date of acquisition. The amount of any write-down for the loss of service potential or from cost to net realisable value is recognised in the surplus or deficit in the year of the write-down.

Breakdown of inventories and further information

	Group Actual 2018 $000	Group Actual 2017 $000	Parent Actual 2018 $000	Parent Actual 2017 $000
Central stores	656	389	656	389
Pharmaceuticals	105	153	105	153
Theatre supplies	332	332	332	332
Other inventories	142	142	142	142
Less: provision for obsolete stock	(60)	0	(60)	0
Total trade inventories	**1,175**	**1,016**	**1,175**	**1,016**

The write-down of inventories held for distribution amounted to $60,000 (2017:$nil). There have been no reversals of write-downs.

No inventories are pledged as security for liabilities (2017:$nil), however, some inventories are subject to retention of title clauses.

10. Non-current assets held for sale

Accounting policy

A non-current asset is classified as held for sale of its carrying mount will be recovered principally through sale rather than through continued use. Non-current assets held for sale are measured at the lower of their carrying mount and fair value less costs to sell.

Any impairment losses for write-downs of non-current assets held for sale, while classified as held for sale, are recognised in the surplus or deficit.

Any increase in fair value (less costs to sell) are recognised up to the level of any impairment losses that have been previously recognised.

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

At 30 June 2017, residential property at Tinui was classified as held for sale. This property was sold during the year.

11. Investment in subsidiary

	Group Actual 2018 $000	Group Actual 2017 $000	Parent Actual 2018 $000	Parent Actual 2017 $000
Investment in subsidiaries	0	0	0	103

Biomedical Services New Zealand Limited is no longer owned by Wairarapa DHB (2017: 100%). The principal activity of the subsidiary was the testing and maintenance of biomedical equipment.

On 31 May 2018, the Wairarapa DHB (GROUP) disposed of its 100% equity interest in its subsidiary, Biomedical New Zealand Limited. The consideration was received fully in cash prior to the year ended 30 June 2018. There was no gain or loss on disposal.

12. Property, plant and equipment

Accounting policy

Property, plant and equipment consists of the following asset classes: land, buildings, clinical equipment, fixtures and fittings, and other equipment and motor vehicles.

Land is measured at fair value, and buildings are measured at fair value less accumulated depreciation. All other asset classes are measured at cost, less accumulated depreciation and impairment losses.

Revaluations

Land and buildings are revalued with sufficient regularity to ensure that the carrying amount does not differ materially from fair value and at least every five years.

The carrying values of land and buildings are regularly assessed by independent valuers to ensure that they do not differ materially from fair value. If there is evidence supporting a material difference, then the asset class will be revalued.

Land and building revaluation movements are accounted for on a class-of-asset basis.

The net revaluation results are credited or debited to other comprehensive revenue and expense and are accumulated to an asset revaluation reserve in equity for that class of asset. Where this would result in a debit balance in the asset revaluation reserve, this balance is not recognised in other comprehensive revenue and expense but is recognised in the surplus or deficit. Any subsequent increase on revaluation that reverse a previous decrease in value recognised in the surplus or deficit will be recognised first in the surplus or deficit up to the amount previously expensed, and then recognised in other comprehensive revenue and expense.

Additions

The cost of an item of property, plant, and equipment is recognised as an asset only when it is probable that future economic benefits or service potential associated with the item will flow to the group and the cost of the item can be measured reliably.

Work in progress is recognised at cost less impairment and is not depreciated.

In most instances, an item of property, plant and equipment is initially recognised at its costs. Where an asset is acquired through a non-exchange transaction, it is recognised at its fair value as at the date of acquisition.

Subsequent costs

Costs incurred subsequent to initial acquisition are capitalised only when it is probable that future economic benefits or service potential associated with the items will flow to the group and the costs of the item can be measured reliably.

The costs of day-to-day servicing of property, plant, and equipment are recognised in the surplus or deficit as they are incurred.

Disposals

Gains and losses on disposal are determined by comparing the proceeds with the carrying mount of the asset. Net gains and losses on disposals are reported in the surplus or deficit. When revalued assets are sold, the amounts included in revaluation reserves in respect of those assets are transferred to accumulated surpluses/(deficits) in equity.

Depreciation

Depreciation is provided in 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 property, plant, and equipment 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 and useful life of an asset is reviewed, and adjusted if applicable, at each financial year-end.

Impairment of property, plant and equipment

The group does not hold any cash-generating assets. Assets are considered cash generating where their primary objective is to generate a commercial return.

Non-cash-generating-assets

Property, plant, and equipment held at costs are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount might not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable service amount. The recoverable service amount is the higher of an asset's fair value less costs to sell and value in use. Value in use is determined using an approach based on either a depreciated replacement cost approach, a restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and availability of information/.

If an asset's carrying amount exceeds its recoverable service amount, the asset is regarded as impaired and the carrying mount is written down to its recoverable amount.

The total impairment loss is recognised in the surplus or deficit.

The reversal of an impairment loss is recognised in the surplus or deficit.

Group	Land (at cost)	Buildings (at cost)	Clinical equipment	Other equipment	Information technology	Motor vehicles	Work in progress	Total
	$000	$000	$000	$000	$000	$000	$000	$000
Cost / valuation								
Balance at 1 July 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**
Balance at 1 July 2017	2,395	37,428	8,352	2,841	440	861	46	52,363
Other Adjustment	0	0	(217)	0	0	0	0	(217)
Additions	0	34	530	157	84	0	9	814
Disposal of subsidiary	0	0	0	(890)	(47)	(112)	0	(1,049)
Disposals and Capitalisations	0	0	(41)	(2)	0	0	(24)	(67)
Balance at 30 June 2018	**2,395**	**37,462**	**8,624**	**2,106**	**477**	**749**	**31**	**51,844**
Accumulated Depreciation & impairment losses								
Balance at 1 July 2016		2,349	5,794	2,387	872	498	0	11,900
Depreciation charge for the year		785	451	122	49	74	0	1,481
Impairment losses		0	0	0	(585)	0	0	(585)
Elimination on disposal		0	12	0	0	0	0	0
Balance at 30 June 2017		**3,134**	**6,257**	**2,509**	**336**	**572**	**0**	**12,808**
Balance at 1 July 2017		3,134	6,257	2,509	336	572	0	12,808
Other Adjustment		0	(217)	0	0	0	0	(217)
Depreciation charge for the year		786	434	102	44	72	0	1,438
Disposal of subsidiary		0	0	(830)	(41)	(93)	0	(964)
Elimination on disposal		(2)	(39)	(1)	0	0	0	(42)
Balance at 30 June 2018		**3,918**	**6,435**	**1,780**	**339**	**551**	**0**	**13,023**
Carrying amounts								
At 1 July 2016	2,395	35,038	2,113	352	139	363	0	40,400
At 30 June 2017	**2,395**	**34,294**	**2,095**	**332**	**104**	**289**	**46**	**39,555**
At 1 July 2017	2,395	34,294	2,095	332	104	289	46	39,555
At 30 June 2018	**2,395**	**33,544**	**2,189**	**326**	**138**	**198**	**31**	**38,821**

(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 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**
Balance at 1 July 2017	2,395	37,428	8,352	1,951	393	749	46	51,314
Prior Period Adjustments	0	0	(217)	0	0	0	0	(217)
Additions	0	34	530	157	84	0	9	814
Disposals and Capitalisations	0	0	(41)	(2)	0	0	(24)	(67)
Balance at 30 June 2018	**2,395**	**37,462**	**8,624**	**2,106**	**477**	**749**	**31**	**51,844**
Accumulated Depreciation & impairment losses								
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**
Balance at 1 July 2017		3,134	6,257	1,725	299	491	0	11,906
Prior Period Adjustments		0	(217)	0	0	0	0	(217)
Depreciation charge for the year		786	434	56	40	60	0	1,376
Elimination on disposal		(2)	(39)	(1)	0	0	0	(42)
Balance at 30 June 2018		**3,918**	**6,435**	**1,780**	**339**	**551**	**0**	**13,023**
Carrying amounts								
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**
At 1 July 2017	2,395	34,294	2,095	226	94	258	46	39,408
At 30 June 2018	**2,395**	**33,544**	**2,189**	**326**	**138**	**198**	**31**	**38,821**

Wairarapa DHB engaged an Independent Registered Valuer (CBRE Limited) to revalue its land and buildings to fair value as at 30 June 2018.

Just prior to the release of the valuation report, the main hospital building was identified as requiring seismic remediation to meet its service and function requirements as an IL4 building. As at the date of these financial statements the level of remediation work and the associated costs are not yet known, but costs are expected to be substantial.

The fair value of the building for financial reporting purposes needs to take into consideration the condition (seismic rating) of the building. This cannot be performed because the costs are unknown.

Given the uncertainty over the appropriate fair value no revaluation adjustment has been made to the value of Wairarapa DHB's building asset values as at 30 June 2018. The building's current carrying value of $33.544m could be materially different from its fair value.

It is expected that costing information will be available and included in an updated valuation in the 2019 financial year.

Restrictions on title

The group does not have full legal title to the Crown land it occupies, but transfer is arranged if and when land is sold. Some of the group's land is subject to Treaty of Waitangi claims. The disposal of certain properties might be subject to the provisions of section 40 of the Public Works Act 1981.

Titles to land transferred from the Crown to the DHB are subject to a memorial in terms of the Treaty of Waitangi Act 1975. The effect on the value of assets resulting from potential Waitangi tribunal claims cannot be quantified and is therefore not reflected in the value of the Land

13. Intangible Assets

Accounting policy

Software acquisition and development

Acquired computer software licenses are capitalised in the basis of the costs incurred to acquire and bring to use the specific software.

Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include the costs of materials and services, employee costs, and other directly attributable overheads.

Staff training costs are recognised as an expense when incurred.

Costs of software updates or upgrades are capitalised only when they increase the usefulness or value of the asset.

Costs associated with the developing and maintaining the DHB's website are recognised as an expense when incurred.

Information technology shared service rights

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

Amortisation

The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life. Amortisation begins when the asset is available for use and ceases at the date that the asset is derecognised. The amortisation charge for each financial year is recognised in the surplus or deficit. The useful lives and associated amortisation rates of major classes of intangible assets have been estimated as follows:

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

Impairment of intangible assets

Refer to the policy for impairment of property, plant, and equipment in Note 12. The same approach applies to the impairment of intangible assets, except for intangible assets that are still under development.

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

Breakdown of intangible assets and further information

Group	Intangible Assets $000	Work in progress $000	Total $000
Cost			
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**
Balance at 1 July 2017	3,151	6,221	9,372
Additions	0	3,485	3,485
Additions (transfer)	63	(113)	(50)
Disposal of Subsidiary	(160)	0	(160)
Balance at 30 June 2018	**3,054**	**9,593**	**12,647**
Accumulated amortisation & impairment losses			
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**
Balance at 1 July 2017	1,600	0	1,600
Amortisation charge for the year	244	0	244
Disposal of Subsidiary	(97)	0	(97)
Impairment	85	583	668
Balance at 30 June 2018	**1,832**	**583**	**2,415**
Carrying amounts			
Balance at 1 July 2016	1,099	5,103	6,202
Balance at 30 June 2017	1,551	6,221	**7,772**
Balance at 1 July 2017	1,551	6,221	7,772
Balance at 30 June 2018	**1,222**	**9,010**	**10,232**

Parent	Intangible Assets $000	Work in progress $000	Total $000
Cost			
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**
Balance at 1 July 2017	2,991	6,221	9,212
Additions	0	3,485	3,485
Additions (transfer)	63	(113)	(50)
Balance at 30 June 2018	**3,054**	**9,593**	**12,647**
Accumulated amortisation & impairment losses			
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**
Balance at 1 July 2017	1,551	0	1,551
Amortisation charge for the year	196	0	196
Impairment	85	583	668
Balance at 30 June 2018	**1,832**	**583**	**2,415**
Carrying amounts			
Balance at 1 July 2016	1,089	4,998	6,087
Balance at 30 June 2017	1,440	6,221	**7,661**
Balance at 1 July 2017	1,440	6,221	7,661
Balance at 30 June 2018	**1,222**	**9,010**	**10,232**

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

There are no restrictions over the title of the group's intangible assets. No intangible assets are pledged as security for liabilities.

The DHB has contractual capital commitments of $1.018m (2017: $3.432m) in relation to intangible assets under development.

IT Shared services rights

The IT shared services project was undertaken for the purpose of reducing costs for the public health sector. The project is funded by the DHBs across the country. As at 30 June 2018, the group has paid $5.657 million as its share of the project funding, which represent its rights to use the systems when developed. These 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 group's share of the DRC of the underlying IT assets. At the 30 June 2018, an impairment of $0.668m was recognised (2017: Nil).

14. Payables and deferred revenue

Accounting policy

Short-term payables are recorded at the amount payable.

Breakdown of payables and deferred revenue

	Group Actual 2018 $000	Group Actual 2017 $000	Parent Actual 2018 $000	Parent Actual 2017 $000
Payables and deferred revenue under exchange transactions				
Trade creditors and accruals	3,922	2,013	3,922	1,944
Revenue received in advance	129	426	129	426
Amount owing to subsidiary	0	0	0	13
Total payables and deferred revenue under exchange transactions	4,051	2,439	4,051	2,383
Payables and deferred revenue under non-exchange transactions				
Trade creditors and accruals	5,622	6,239	5,622	6,239
GST and other taxes	617	966	617	966
Revenue received in advance	109	639	109	639
Total payables and deferred revenue under non-exchange transactions	6,349	7,844	6,349	7,844
Total payables and accruals	**10,400**	**10,283**	**10,400**	**10,227**

15. Borrowings

Accounting policy

Overdraft facility

Amounts drawn under the NZHPL banking facility are recorded at the amount payable plus accrued interest.

Breakdown of borrowings and further information

	Group Actual 2018 $000	Group Actual 2017 $000	Parent Actual 2018 $000	Parent Actual 2017 $000
Current portion				
Privately sourced loans	85	79	85	79
Non-current Portion				
Privately sourced loans	138	223	138	223
Total borrowings	**223**	**302**	**223**	**302**
Repayable as follows:				
Less than one year	85	79	85	79
One to two years	138	74	138	74
Greater than two years	0	149	0	149
Total borrowings	**223**	**302**	**223**	**302**

Conversion of Crown loans to equity

In September 2016 Cabinet agreed that the DHB sector should no longer access Crown debt and for existing DHB Crown debt to be converted to Crown equity. On 15 February 2017, the DHB Crown loans of $26.75million were converted into Crown equity. From that day onward, all Crown capital contributions to DHBs would be made via Crown equity injections. The termination of the Crown loan agreement and conversion of Crown loans to equity was completed by a non-cash transaction, other than for the interest due at conversion date.

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. The DHB has no other privately funded financing arrangements.

16. Employee entitlements

Accounting policy

Short-term employee entitlements

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

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

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

Long-term employee entitlements

Employee entitlements that are due to be settled beyond the 12 months after the end of the year in which the employee renders the related service, such as sabbatical leave, long service leave, and retirement gratuities, have been calculated on an actuarial basis. The calculations are based on:

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

Presentation of employee entitlement

Sick leave, continuing medical education costs, annul leave, long service leave that is available for use, and sabbatical leave that is available for use are classified as a current liability. Long service leave, sabbatical leave, and retirement gratuities expected to be settled within 12 months of balance date are also classified as a current liability. All other employee entitlements are classified as a non-current liability.

Critical accounting estimates and assumptions

Sabbatical leave, long service leave, and retirement provisions

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 2.2 % for long service leave (2017: 2.5%) and 2.5% for retirement gratuities (2017: 2.7%) and a salary increase assumption of 2% (2017: 2%) were used. The discount rates used are based on market yields at balance date. The salary inflation factor is the group's best estimate forecast of salary increments.

Continuing medical education costs

The continuing medical education liability assumes that the utilisation of the annual entitlement, which can be accumulated up to 3 years, will on average be 50% (2017: 50%) of the full entitlement. This utilisation assumption is based on recent experience.

Holiday pay provision

Many public and private sector entities, including the DHB, are continuing to investigate historic underpayment of holiday entitlements.

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

DHBs have decided to take a national approach and have been working with key stakeholders to define a baseline interpretation document for the health sector. This is substantially agreed, but there are some remaining issues which are in the process of being resolved. The intention is that, once the baseline document is agreed, this would be used by each DHB to systematically assess their liability.

The DHB has estimated its liability as $0.935m (2017: $0.935m). This estimate was based on a sample of staff and due to the uncertainties involved the actual liability may be different.

	Group Actual 2018 $000	Group Actual 2017 $000	Parent Actual 2018 $000	Parent Actual 2017 $000
Current portion				
Accrued salary and wages	2,335	1,612	2,335	1,590
Annual leave	4,605	4,336	4,605	4,262
Stat Days and Days in Lieu	1,000	920	1,000	920
Sick leave	98	87	98	87
Maternity grant	12	12	12	12
Continued medical education costs	334	260	334	260
Long service leave	410	452	410	452
Retirement gratuities	236	230	236	228
Total current portion	9,030	7,909	9,030	7,811
Non-current Portion				
Long service leave	272	274	272	274
Retirement gratuities	381	333	381	333
Total non-current portion	653	607	653	607
Total employee entitlements	**9,683**	**8,516**	**9,683**	**8,418**

17. Restricted Funds

	Group Actual 2018 $000	Group Actual 2017 $000	Parent Actual 2018 $000	Parent Actual 2017 $000
Balance at beginning of year	332	274	332	274
Funds received	13	91	13	91
Interest received	8	7	8	7
Funds spent	(10)	(40)	(10)	(40)
Balance at end of year	**343**	**332**	**343**	**332**

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. This balance is therefore offset by the balance in investments covered in Note 8 above.

18. Equity

Accounting policy

Equity is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified into the following components:

- Crown equity;
- accumulated surpluses/(deficits); and
- property revaluation reserves.

Property revaluation reserves

These reserves relate to the revaluation of property, plant, and equipment to fair value.

Group	Crown equity $000	Property revaluation reserve $000	Retained earnings $000	Total $000
Balance at 1 July 2016	42,034	5,558	(40,077)	7,515
Total recognised revenue & expenses	0	0	(2,815)	(2,815)
Contribution (net) 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**
Balance at 1 July 2017	68,778	5,558	(42,892)	31,444
Total recognised revenue & expenses	0	0	(8,419)	(8,419)
Removal of subsidiary	0	0	(44)	(44)
Contribution from the Crown	10,800	0	0	10,800
Repayment to Crown	0	0	0	0
Balance at 30 June 2018	**79,578**	**5,558**	**(51,355)**	**33,781**

Parent	Crown equity $000	Property revaluation reserve $000	Retained earnings $000	Total $000
Balance at 1 July 2016	42,034	5,558	(40,430)	7,162
Total recognised revenue & expenses	0	0	(2,803)	(2,803)
Contribution (net) from the Crown	26,750	0	0	26,750
Movement in revaluation of land & buildings	(6)	0	0	(6)
Balance at 30 June 2017	**68,778**	**5,558**	**(43,233)**	**31,103**
Balance at 1 July 2017	68,778	5,558	(43,233)	31,103
Total recognised revenue & expenses	0	0	(8,122)	(8,122)
Contribution (net) from the Crown	10,800	0	0	10,800
Movement in revaluation of land & buildings	0	0	0	0
Balance at 30 June 2018	**79,578**	**5,558**	**(51,355)**	**33,781**

Capital management

The group's capital is its equity, which consists of Crown equity, accumulates surpluses/(deficits) and property revaluation reserves. Equity is represented by net assets.

The group is subject to the financial management and accountability provisions of the Crown Entities Act 2004, which impose restrictions in relation to borrowings, acquisition of securities, issuing guarantees and indemnities, and the use of derivatives.

The group manages its equity as a by-product of prudently managing revenue, expenses, assets, liabilities, investments, and general financial dealings to ensure that it effectively achieves its objectives and purposes while remaining a going concern.

19. Contingences

Contingent liabilities and assets

The DHB currently has no legal claims against it and therefore assess that there is no contingent liabilities as at 30 June 2018 (2017: $nil). Likewise, the DHB has no contingent assets as 30 June 2018 (2017: $nil).

There is one employment related matter, which has the potential to become litigious in which case the potential outcome could be a liability of up to $200,000.

20. Related party transactions

The DHB is controlled by the Crown.

Related party disclosures have not been made for transactions with related parties, including associates that are:

- within a normal supplier or client/recipient relationship; and
- on terms and conditions no more or less favourable than those that it is reasonable to expect that the group would have adopted in dealing with the party at 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.

Key management personnel compensation:

	Group Actual 2018 $000	Group Actual 2017 $000	Parent Actual 2018 $000	Parent Actual 2017 $000
Board Members				
Remuneration	216	214	216	208
Full-time equivalent members	0.85	0.77	0.85	0.75
Leadership Team				
Remuneration	1,587	1,557	1,587	1,352
Full-time equivalent members	8.40	9.0	8.40	7.0
Total key personnel remuneration	**1,803**	**1,771**	**1,803**	**1,560**
Full-time equivalent personnel	**9.3**	**9.8**	**9.3**	**7.8**

The full-time equivalent for Board members has been determined based on the frequency and length of Board meetings and the estimated time for Board members to prepare for meetings.

An analysis of Board member remuneration is provided in Note 3.

21. Events after balance date

There were no significant events subsequent to balance date.

22. Financial Instruments

22A Financial instrument categories

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

	Actual 2018 $000s	Actual 2017 $000s
Fair value through surplus or deficit - Held for trading		
Cash and cash equivalents	5	177
Trade and other receivables	3,902	4,306
Investments	343	323
Total loans and receivables	**4,250**	**4,806**
Financial liabilities measured at amortised cost:		
Payable & accruals (excluding deferred revenue and taxes)	9,544	8,252
Cash and cash equivalents -Overdraft	943	3,183
Borrowings - Privately sourced loans	223	302
Total financial liabilities measured at amortised cost	**10,710**	**11,737**

22B Fair value hierarchy

The only financial instruments the group would measure at fair value in the statement of financial position would be forward foreign exchange contracts. At balance date the DHB does not hold any forward foreign exchange contracts (2017:$nil).

22C Financial instrument risks

The group's activities expose it to a variety of financial instrument risks, including market risk, credit risk, and liquidity risk. The group has a series of policies to manage the risks associated with financial instruments and seeks to minimise exposure from financial instruments. These policies do not allow any transactions that are speculative in nature to be entered into.

Market risk

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 group has no financial instruments that give risk 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 group's exposure to fair value interest rate risk arises from bank deposits that are at fixed rates of interest. The exposure to fair value interest rate risk is not actively managed by the group, as investments are generally held to maturity.

Cash flow interest rate risk

Cash flow interest rate risk is the risk that the cash flows from a financial instrument will fluctuate because of changes in market interest rates. The group's exposure to cash flow interest rate risk is limited to on-call deposits. This exposure is not considered significant and is not actively managed.

Currency risk

Currency risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate due to changes in foreign exchange rates.

The group purchases clinical equipment from overseas, which requires it to enter into transactions denominated in foreign currencies. As a result of these activities, exposure to currency risk arises. The total value of foreign transactions over the financial year was less than $280,000 so the group's foreign currency risk exposure is not considered significant and is not actively managed.

Credit risk

Credit risk is the risk that a third party will default on its obligations to the group, causing it to incur a loss. Due to the timing of the DHB's cash inflows and outflows, surplus cash is invested with registered banks or NZHPL.

In the normal course of business, exposure to credit risk arises from cash and term deposits with banks and NZHPL, receivables, and forward foreign exchange contracts in an asset position. For each of these, the maximum credit risk exposure is best represented by the carrying amount in the statement of financial position.

The amount of credit exposure to any one financial institution for term deposits is limited to no more than 25% of total investments held. Investments and forward foreign exchange contracts are entered into only with registered banks that have a Standard and Poor's credit rating of at least A2 for short-term investments and A- for long-term investments. The group has experience no default of interest or principal payments for term deposits and forward foreign exchange contracts.

Concentrations of credit risk for receivable are limited due to the large number and variety of customers. The MoH is the largest debtor (approximately 35%). It is assessed as a low-risk and high-quality entity due to being a government-funded purchaser of health and disability service.

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

Credit quality of financial assets

The credit quality of financial assets that ate neither past due nor impaired can be asses by reference to Standard and Poor's credit rating (if available) or to historical information about counterparty default rates.

	Actual 2018 $000s	Actual 2017 $000s
Counterparties with credit ratings		
Cash at bank and on hand, and investments		
AA-	348	500
Total cash at bank and on hand, and investments	**348**	**500**
Counterparties without credit ratings		
Cash and cash equivalents:		
NZ Health Partnerships Ltd - no defaults in the past	1	0
Receivables:		
Existing counterparty with no defaults in the past	3,902	4,306
Total loans and receivables	**3,902**	**4,306**

Liquidity Risk

Management of liquidity risk

Liquidity risk is the risk that the group will encounter difficulty raising liquid funds to meet commitments as they fall due. Prudent liquidity risk management implies maintain sufficient cash, availability of funding through an adequate amount of committed credit facilities, and the ability to close out market positions.

The group mostly manages liquidity risk by continuously monitoring forecast and actual cash flow requirements and maintain and overdraft facility.

Contractual maturity analysis of financial liabilities, excluding derivatives

The table below analyses financial liabilities (excluding derivatives) into relevant maturity groupings based on the remaining periods at balance date to the contractual maturity date. The amounts disclosed are the contractual undiscounted cash flows and include interest cash outflows.

Group	Loans and receivables	Other amortised cost	Carrying amount	Fair value
	2018	2018	2018	2018
	$000s	$000s	$000s	$000s
Privately sourced loans	0	223	223	223
Trade and other payables	0	10,400	10,400	10,400
	2017	2017	2017	2017
	$000s	$000s	$000s	$000s
Privately sourced loans	0	302	302	302
Trade and other payables	0	10,283	10,283	10,283

Parent	Loans and receivables	Other amortised cost	Carrying amount	Fair value
	2018	2018	2018	2018
	$000s	$000s	$000s	$000s
Privately sourced loans	0	223	223	223
Trade and other payables	0	10,400	10,400	10,400
	2017	2017	2017	2017
	$000s	$000s	$000s	$000s
Privately sourced loans	0	302	302	302
Trade and other payables	0	10,227	10,227	10,227

23. Explanation of major variances against budget

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

Revenue

- Overall revenue was $3.1 million favourable from additional revenue received from the Ministry for Health, donations and donated assets, revenue from the sale of an investment and higher Pharmac rebates.

Expenditure

- Overall expenditure was ($8.4m) more than budgeted including:
    - ($2.17m) higher personnel costs including outsourced with ($774k) higher medical staff costs because of the impact of job sizing and the costs of covering leave and vacancies; and ($1.43m) higher nursing costs (including health care assistants) required for increased demand an leave
    - ($1.79m) higher clinical supply costs, particularly implants and prostheses costs, pharmaceuticals, blood products and air ambulance costs
    - ($2.98m) additional IDF outflows payable to other DHBs for services received for our population

- ($1.54m) from other funder expenditure including higher costs for community pharmaceutical costs, home support and aged residential care services.

Assets

- The budgeted assets included investments in subsidiaries however; our investment in Biomedical Services NZ Ltd was sold during the year.

Liabilities

- The DHBs total liabilities were less than budgeted with a lower bank overdraft at balance date than expected.

Equity

- A higher deficit than expected was offset with a higher capital contribution from the Crown.

24. Summary cost of services

	Group Budget 2018 $000	Group Actual 2018 $000	Group Actual 2017 $000	Parent Actual 2018 $000	Parent Actual 2017 $000
Revenue					
Prevention services	1,068	1,231	1,098	1,231	1,098
Early detection and management services	41,044	38,401	37,982	38,401	37,982
Intensive assessment and treatment services	91,553	95,039	90,161	95,039	90,161
Rehabilitation and support services	21,593	22,880	20,133	22,880	20,133
Total revenue	155,258	157,551	149,374	157,551	149,374
Expenditure					
Prevention services	1,829	1,983	1,709	1,983	1,709
Early detection and management services	41,347	42,211	40,250	42,211	40,250
Intensive assessment and treatment services	91,431	97,643	89,570	97,643	89,570
Rehabilitation and support services	23,810	24,420	20,648	24,420	20,648
Total expenditure	158,417	166,257	152,177	166,257	152,177
Subsidiary not allocated	0	(297)	(12)	0	0
Suplus/(deficit)	**(3,159)**	**(9,003)**	**(2,815)**	**(8,706)**	**(2,803)**