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Wairarapa DHB
2019/20
Annual Report

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

Contents

Chair & Chief Executive's Foreword

Ki te kōtahi te kākaho ka whati, ki te kāpuia e kore e whati
A reed that stands alone is easily broken, many bound together are unbreakable

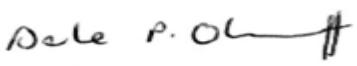
Reading through this Annual Report for the Wairarapa District Health Board, I proudly acknowledge the quantity and quality of the work produced in what has been a truly challenging year. To deliver a health system that meets the needs of our communities in the most effective manner and within the resources available to us requires significant and dedicated commitment. To manage it successfully in the midst of a pandemic is highly commendable. I am encouraged by the focus this year on improvement and change, and I am looking forward in anticipation of an exceptional year ahead. In this regard the platform for higher quality and sustainable services outlined by Dale Oliff places us in a strong position for 2020 and beyond.

Sir Paul Collins, Board Chair

This has been a year internationally coined 'unprecedented' and we can certainly attest to that here at Wairarapa DHB. Not only have we had to absorb the new ways of working that COVID 19 has introduced, we have challenged ourselves to work at the top of our scope and invest in outcomes that make a difference. We have a hard working and dedicated team that is continually seeking to work smarter, to be more integrated and to work at pace to collectively make a significant and quantifiable difference.
Key initiatives to grow on this platform for the future include:

- a sound plan developed in our Wairarapa 2020/30 strategy;
- the implementation of a long term sustainability plan that will result in better clinical and community outcomes, including a target of a break even financial outcome within two years;
- increased resources in our hospital resulting in a marked reduction in waiting times in important areas, such as orthopaedic surgery;
- an increased focus on Māori health and equitable access, including a refresh of our Māori Relationship Board, Te Oranga o Te Iwi Kainga; and
- an enhanced relationship with our community and our PHO, Tū Ora Compass Health.

I'd like to take this opportunity to thank all those in the community that assist us in achieving our vision of a well Wairarapa. It really does take a village.



Dale Oliff, Chief Executive

Wairarapa DHB operates in a fiscally challenging environment. We are tasked with providing excellent, quality care and improving the health of our population while managing our deficit and ensuring that every decision is financially viable. To achieve this we plan well, evaluate often, and measure our success against outcomes at every opportunity.

We have successfully managed our financial position such that our operating deficit before extraordinary items was $2.284m favourable to budget - this result being achieved whilst at the same time continuing to deliver high quality health care to our Wairarapa community. There has been significant one-off costs regarding Holidays Act compliance and impairment of regional software projects that have impacted our year end result. Our financial result is summarised in the table below:

Results for year ended 30 June 2020	**Actual $m**	**Budget $m**	**Variance $m**
Surplus / (deficit) excluding Holiday Pay and Impairment	**(8.927)**	**(10.723)**	**2.284**
Increase in Holiday Pay Provision	(5.214)		(5.214)
Impairment of Intangible Assets	(4.226)		(4.226)
Sub total	**(9.440)**	**-**	**(9.440)**
Surplus / (deficit) for the year	**(18.367)**	**(10.723)**	**(7.644)**
Total Comprehensive Revenue & Expense	**(18.367)**	**(10.723)**	**(7.644)**

Our vision
Hauora pai mo te katoa Well Wairarapa - better health for all

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

Our Values
Whakaoranga – Wellness Finding ways to create a healthier community
Eke Taumata - Equity Acting to support equity across our community
Manaakitanga - Respect Caring and empathy in all that we do
Ngā rautaki ki mua - Innovation Finding future-focused solutions
Arotahitanga - Relationships Working together with people as partners

Our why

It is important to look to the past and learn from it, but not live in the past. Our nation, as we know it today, was built on two sets of traditions. Te Tiriti o Waitangi was the agreement which bound those traditions together and formed what we now call Aotearoa-New Zealand.

We are responsible for improving, promoting and protecting the health of people and communities, and reducing health disparities by improving health outcomes and reducing inequities. These expectations are reflected in our vision, mission and values and are at the heart of all we do.

We are serious about our role as a healthcare funder and provider and as public servants we are here to serve. We know that working alongside our people is critical to achieving our collective aims. We continue to see gaps in our delivery of services to the community and we are focussed on ways we can continually improve, and find equitable outcomes for those most at risk of experiencing poor health.

Our ‘why’ is our commitment to empower and enable whānau to take the lead in managing their own health and wellbeing, and to enjoy their best life for all of their life.

Our what

A snapshot of some of the activities undertaken across Wairarapa DHB in the year ended 30 June 2020.

	3,670 hospital operations and procedures
	7,800 patients with E-health access
	268,246 GP visits
	32,797 hospital outpatient appointments
	5,846 attended ambulance jobs in the Wairarapa
	484 babies were born in Wairarapa Hospital
	30,944 xrays and scans
	9,539 hospital admissions

Our future

Our year

2020 has, in many respects, changed the landscape for health. The COVID pandemic has reminded us of our vulnerability but also identified our strengths and allowed new ways of working to emerge that we can maximise for ongoing advantage.

Tele-health has entered the everyday realm of care and is becoming accepted as a convenient face-to-face alternative, saving patients' time and money. An enhanced focus on mental health, self awareness and compassion for others has surfaced, and we have a better understanding of the deep impact social determinants has on our health and wellbeing. Simple healthcare measures, like effective handwashing and staying home when

you are sick, have been emphasised and become a core requirement in the everyday workplace. We have a better understanding of the challenges our elderly and our most vulnerable face, and we have learned to think of and plan for those that need the most assistance. Connectivity has improved with strengthened community watch groups and networks, and 'being kind' has become a universal key code of conduct.

With all that has been lost to COVID, it is critically important that the gains are captured and used to our best advantage. We are richer for the learnings of the global COVID crisis, and we are weaving our insights into the fabric of our forward planning.

Our path forward

The Health and Disability System Review proposes changes that may reshape the way our healthcare service is structured. We expect these changes will soon start to be effected and we hope that they will serve to improve the consumer experience, support effective staffing and decision making, and ensure an integrated system that is best placed to bridge the equity gaps and improve health and wellbeing for all our communities.

However the review serves to alter the mechanics of this District Health Board, we will keep our promise to put people at the heart of healthcare and ensure that service design and delivery keeps the patient and their whānau front and centre. While our DHB might align itself alongside others in a refreshed regional system, the needs of our local community will be championed and Wairarapa will continue to be well served as a region in its own right.

We expect to be challenged and to be held accountable, and we welcome the opportunity to implement the improvements ahead of us collaboratively with the engagement of our confident and agile staff, and our close community partners.

Our community

Wairarapa District Health Board serves to support our whānau to enjoy a good life from their first to their last days. This requires an inclusive approach to providing opportunities for the people of Wairarapa, empowering support within the community and better navigation to cross-sector services.

Persistent inequities in health outcomes tells us that we need to do things differently. The social determinants of health are the conditions in which people are born, grow, live, work and age. We know the solutions for better health and wellbeing are much more complex than what the DHB alone can deliver through traditional health services. Broadly speaking, improving the social landscape for our community will reduce the health inequities that challenge our region, and this will require a collaborative approach across all sectors.

We need to integrate health and social services. Working in partnership we can grow a more confident, vibrant community and improve health outcomes for our people. We support a well Wairarapa at every level, with closely aligned and cohesive services that empower our community to achieve a healthier, happier and satisfying life.

Our priorities

In order to shift to a responsive, effective health system that achieves equitable outcomes for all people in our communities, we need to effect change in eight key areas:

- Integrating health and social services
- Strengthening primary care
- Excellence in older persons' services
- Improving access to health and disability services

- Close connections between primary and secondary care
- Creating a fit-for-purpose hospital
- Building a sustainable workforce
- Tamariki-Mokopuna, our children and young people are our future

Our improvement focus in each of these areas will ensure we place the value of our service to the people front and centre of our thinking, design and delivery.

Our team

With strong leadership and an excellent organisational culture we can support positive, long lasting, improved service that will grow community wellbeing and achieve more equitable outcomes.

Our staff and our healthcare partners are our greatest asset. As one team, our staff and our community partners can make a valuable difference and be proud of the service we provide. Confident and accountable for our actions, we can move forward decisively into a future that Wairarapa will be proud to share. To ensure we do this well, we will continue to invest in our culture and our values and grow an integrated workforce that shares a passion for quality improvement and gold standard service.

Our commitment

We will keep healthcare real. We will continue to hold ourselves to account – to identify and address disparities and to acknowledge where there are gaps. We will invest where it is most needed and save where it is not, in order to improve health outcomes for our people.

We will plan in order to improve, and we will improve in order to change outcomes. We will work smarter, we will work hard to keep healthcare simple, seamless and easy to navigate, and we will keep the patient and their whānau at the centre of everything we do.

Above all, we will communicate and collaborate, and we will keep our community informed.

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, we have taken a 'whole-of-health system' approach, including integrating clinical and support services where this provides benefits across the system.

We also continue to work closely with our neighbouring DHBs – Capital and Coast and Hutt Valley. While each Board continues to provide governance of local services ensuring local accountability, all three Boards provide collective governance over services that are shared or integrated.

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 2020 are as follows:

Sir Paul Collins (Chair) – commenced December 2016

Leanne Southey – commenced December 2010

Ronald Karaitiana – commenced December 2013

Dr Tony Becker (Deputy Chair) – commenced December 2019

Joy Cooper – commenced December 2019

Dr Norman Gray – commenced December 2019

Helen Pocknall – commenced December 2019

Ryan Soriano – commenced December 2019

Yvette Grace – commenced December 2019

Jill Pettis – commenced December 2019

Jill Stringer – commenced December 2019

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.

Wairarapa District Health Board INTEREST REGISTER	
Name	**Interest**
Sir Paul Collins *Chair*	• Director of: Active Equity Holdings Limited (Chair) Hurricanes GP Limited Ides Limited Shott Beverages Limited Technical Advisory Services Limited • Director and shareholder of: AEL Managers Limited Beverage Holdings Limited Cohiba Traders Limited Ecopoint Limited Tofino Trustee Limited • Director of New Zealand Health Partnerships Limited • Trustee of the Malaghan Institute of Medical Research • Member to Governance Board for Health Finance, Procurement & information Management System Programme (FPIM)
Dr Tony Becker *Deputy Chair*	• Shareholder and Director (Clinical) Masterton Medical Limited • Shareholder and Director Wairarapa Skin Clinic • Wife contracts to Wairarapa District Health Board • Trustee, Hau Kainga • Sister in law is an Associate Director of Nursing at Surgery Women's and Children's Directorate at CCDHB
Mrs Leanne Southey *Member*	• Chair, Wairarapa District Health Board, Finance Risk & Audit Committee • 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
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 • Extended family members work in varying roles at DHB • CE Te Hauora Runanga o Wairarapa • RK Consulting Ltd, Business owner • Whanau ora Collective Member Te Hauora and Whaiora via Te Pou Matakana • Member, Presbyterian Support Services Board includes Age Residential Services of Enliven and Community Social Services of Family Works
Helen Pocknall *Member*	• Contractor with Ministry of Health
Ryan Soriano *Member*	• Clinical Services Manager, HealthCare NZ • Member, Board Trustee for Saint Patricks School Board, Masterton • Wife Employed as Senior Caregiver at Lansdowne Park Aged Care Facility

Name	Interest
Joy Cooper *Member*	• Chairperson Wharekaka Trust Board Incorporated
Norman Gray *Member*	• Association of Salaried Medical Specialists (ASMS) Branch Representative for Wairarapa • Emergency Consultant and Clinical Lead, Wairarapa DHB • Member, Mid Central DHB
Jill Stringer *Member*	• Director, Touchwood Services Limited • Husband employed by Rigg-Zschokke Ltd • Trustee, Wellington Welfare Guardian Trust
Yvette Grace *Member*	• General Manager, Rangitāne Tu Mai Rā Treaty Settlement Trust • Member, Hutt Valley District Health Board • Husband is a Family Violence Intervention Coordinator at Wairarapa District Health Board • Sister-in-law is a Nurse at Hutt Hospital • Sister-in-law is a Private Physiotherapist in Upper Hutt • Member Concurrent FRAC Hutt Valley and Capital and Coast DHBs • Member 3DHB Disabilities Committee for Hutt Valley DHB • Member Wairarapa CPHAC Committee • Trustee House of Science Wairarapa • Trustee Equippers Church and Oasis Trust
Jill Pettis *Member*	• Nil Interests declared

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 Finance, Risk and Audit 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 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 2019-20 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. In 2019/20 a voluntary reduction in board fees was taken by some members.

The references to the committees listed in the table are as follows:

FRAC	Finance, Risk and Audit Committee
CPHAC	Community and Public Health Advisory Committee
DSAC	Disability Services Advisory Committee 3DHB – Wairarapa/Hutt/Capital & Coast combined
HAC	Hospital Advisory Committee (this is incorporated into the Board meeting).

Board and committee memberships for the year ended 30 June 2020

Board Members from December 2019 to June 2020	Board	CPHAC	DSAC	FRAC
Paul Collins (Chairperson)	Chair			Member
Tony Becker (Deputy Chair & CPHAC Chair)	Deputy Chair	Chair		
Joy Cooper	Member	Member		
Norman Gray	Member			Member
Helen Pocknall	Member	Deputy Chair		
Ryan Soriano	Member		Member	
Leanne Southey (FRAC Chair)	Member			Chair
Jill Stringer	Member	Member	Member	
Yvette Grace	Member	Member	Member	
Ron Karaitiana	Member			Member
Jill Pettis	Member		Member	

Board Members from July 2019 to December 2019	Board	CPHAC	DSAC	FRAC
Paul Collins (Chairperson)	Chair			Member
Derek Milne (CPHAC Chair)	Member	Chair	Member	
Leanne Southey (Deputy Chair & FRAC Chair)	Deputy Chair			Chair
Adrienne Staples	Member			Member
Nick Crozier	Member	Member	Member	
Ron Karaitiana (HAC Chair)	Member			Member
Liz Falkner	Member			
Rick Long	Member			Member
Alan Shirley	Member	Member	Member	
Fiona Samuel	Member			
Jane Hopkirk	Member	Member	Member	

Board and committee meeting attendances for December 2019 – June 2020

Board Members from December 2019 to June 2020	Board (6)	CPHAC (4)	DSAC (1)	FRAC (5)
Paul Collins (Chairperson)	6			5
Tony Becker (Deputy Chair & CPHAC Chair)	6	3		
Joy Cooper	6	4		
Norman Gray	5			4
Helen Pocknall	6	4		
Ryan Soriano	6		1	
Leanne Southey (FRAC Chair)	6			5
Jill Stringer	6	4	1	
Yvette Grace	6	2	1	
Ron Karaitiana	6			5
Jill Pettis	6		1	

Board and committee meeting attendances for July 2019 – December 2019

Board Members from July 2019 to December 2019	Board (5)	CPHAC (2)	DSAC (1)	FRAC (5)
Paul Collins (Chairperson)	4			5
Derek Milne (CPHAC Chair)	4	2	1	
Leanne Southey (Deputy Chair & FRAC Chair)	5			5
Adrienne Staples	5			4
Nick Crozier	5	2	1	
Ron Karaitiana (HAC Chair)	5			4
Liz Falkner	5			
Rick Long	4			5
Alan Shirley	4	2	1	
Fiona Samuel	3			
Jane Hopkirk	5	1	1	

Our People

In the last 12 months the DHB has started its journey to reshape how health care is delivered across the Wairarapa. Our primary objective is to move away from a hospital centric model to an across-system health service that delivers care to where the patient is.

To support our ambition we need to ensure we have the right leadership, capability, organisational structure and culture. While some work has commenced over the last year to build this, moving forward there will be an increased focus across these areas to ensure we deliver on our commitments. As part of this work we are developing our People Strategy which will set out in more detail the areas of focus and specific actions to be taken.

During 19/20 we undertook a reorganisation of our Operational and Professional Governance areas. This included the establishment of neighbourhood services to ensure better support of patients within our community. We also formed a Clinical Governance Board and implemented a new leadership model across our Clinical professions. These changes are aimed to provide a better aligned multi-disciplinary model of care.

The advent of COVID this year has also meant an increased focus on our workforce. This included the development of systems to better capture staff skill sets should they be needed to support COVID response work across the wider Health Sector. Alongside this, we have also had an increased emphasis on providing ongoing support around wellbeing and resilience.

Organisational Capability

The DHB is committed to being a good employer. We foster equal employment opportunities and promote equity, fairness and a safe and healthy workplace. Our organisational values are supported by core operational policies, including a Code of Conduct, Workplace Bullying, Discrimination, Harassment and Victimisation Policies and an Employee Assistance Programme.

During the year we continued to build on the work done to develop our values. This included the development of tools and resources to support a values based recruitment practice across the DHB. We also continue to work

on enhancing these practices to ensure that the DHB is attracting, appointing and retaining Māori staff. We are actively working toward having the diversity of our workforce reflect the community we serve.

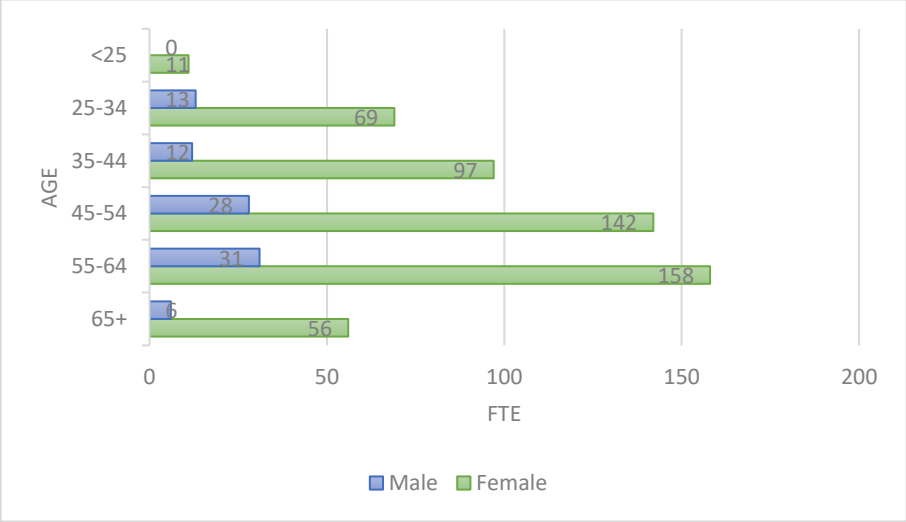
Work has also commenced on improving our workforce data collection and reporting. We have been successful in capturing ethnicity data and will continue to build on the data we collect and analyse to create more informative people dashboards for the business over the coming 12 months.

Workforce 2020

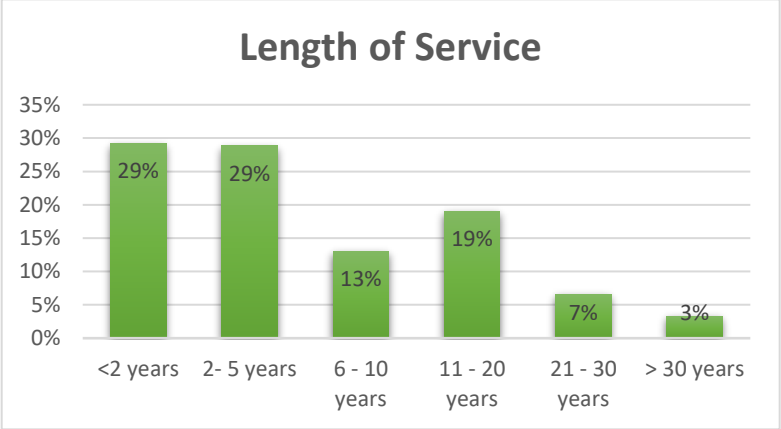
Full Time Equivalent staff numbers 2011-2020

	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011
Medical	42	45	46	43	42	40	36	39	38	36
Nursing	253	253	243	236	223	215	205	204	198	193
Allied Health	75	73	71	69	69	71	70	82	85	93
Other	124	125	126	111	108	102	106	101	120	119
Total	**494**	**496**	**486**	**458**	**443**	**429**	**417**	**426**	**441**	**441**

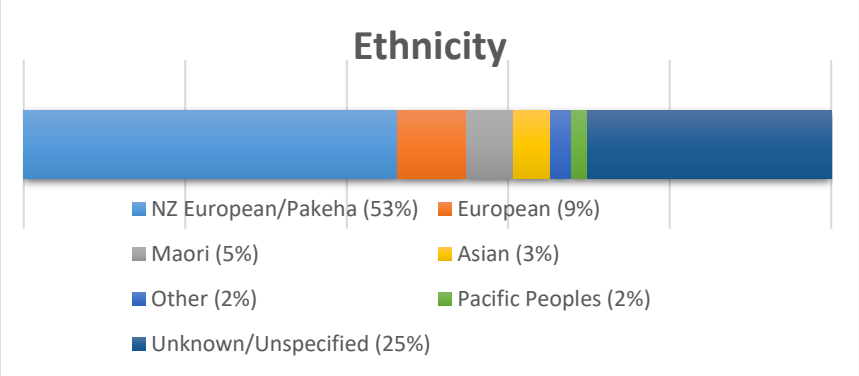
Our Age and Gender Profile



Length of service – excludes RMOs



Ethnicity



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 been met for the 2019/20 year.

Wairarapa DHB continues to provide high quality and timely services for our population. In 2019/20:

- The COVID-19 lockdown period had a significant impact on our population's ability to access services. Despite this we still achieved many of our targets.
- Wairarapa DHB exceeded its smoking cessation target for offering advice and/or help to quit to 90% of pregnant women who smoke (actual performance - 100%).
- In Wairarapa DHB, the standardised inpatient Average Length Of Stay for Elective events is lower than the target of 1.55 days (1.43 days in 2019/20).
- Wairarapa DHB achieved the Improved Access to Elective Surgery Health Target, achieving 2,541 surgical elective discharges against a plan of 2,417.
- Wairarapa DHB achieved the Shorter Stays in Emergency Departments Health Target of 90% of patients presenting at an ED being admitted, discharged or transferred within six hours.
- In the 2019/20 year, the percentage of babies living in smoke free homes in the Wairarapa at 6 weeks post natal has grown from 37.5% to 62.5%.
- Wairarapa DHB continues to achieve the 70% target for the percentage of eligible women having breast screening in the last 2 years.
- Wairarapa DHB continues to work to reduce the number of inpatient falls causing harm. In the last year this was 0.14 per 1,000 bed days against a target of 0.50 per 1,000 bed days.
- The rate of hospital acquired pressure injuries per 1,000 bed days has fallen from 1.39 to 0.23 per 1,000 bed days against a target of 1.4 per 1,000 bed days.
- Medication errors causing harm have reduced from 0.85 per 1,000 bed days in 2018/19 to 0.09 per 1,000 bed days in 2019/20.
- Wairarapa DHB has continued to meet or exceed the target for each dimension of the Inpatient Patient Experience Survey.
- We achieved our target for Did not attend (DNA) rates for follow-up specialist appointments to 6.5% against a target of less than or equal to 8%.
- Wairarapa DHB continued to meet the targets for the percentage of people 65 years of age and over receiving DHB-funded health of older people services (HOP) 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.
- 2019/20 saw the development of Wairarapa's Strategic Plan – Hauora Mō Tātou.
- 94% people residing in Aged Residential Care facilities received InterRAI Long Term Care Facility (LTCF) assessments within timeframes (19/20 Target is 75%).
- A smaller percentage of the population aged 75+ are in Aged Residential Care (8.3%) than expected.

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?

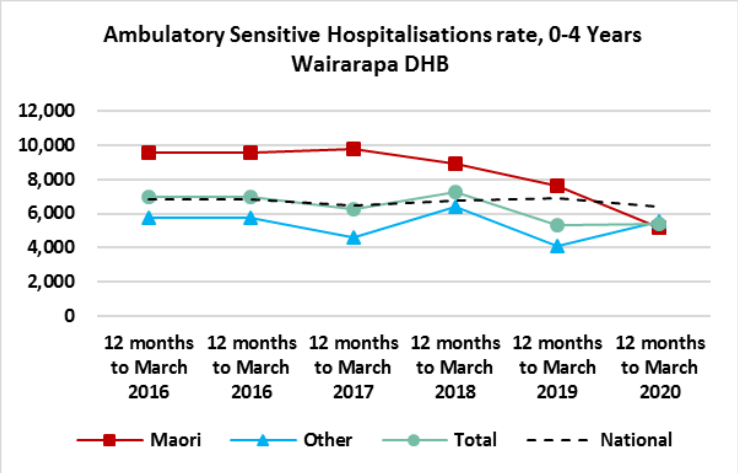
There are recognised health disparities for several population groups due to accessibility, social determinants of health, cultural responsiveness, and current models of care. Patients can find it hard to access services or to know how to manage their health if services are not culturally competent.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

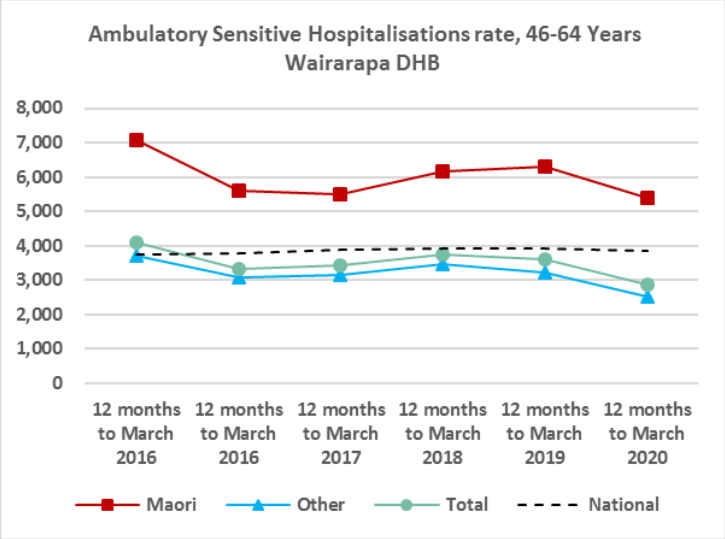
Impact measure: A reduction in Ambulatory Sensitive Hospitalisation (ASH) rates

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 six years, the ASH rate for Māori 0-4 in Wairarapa DHB has decreased, with significant improvement over the last two years such that it is now in line with other ethnicities.

The ASH rate for Māori 45-64 has reduced this year along with the rate for other ethnicities. Closing the gap by improving the rate for Māori will continue to be a focus for the 2020/21 year.





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.

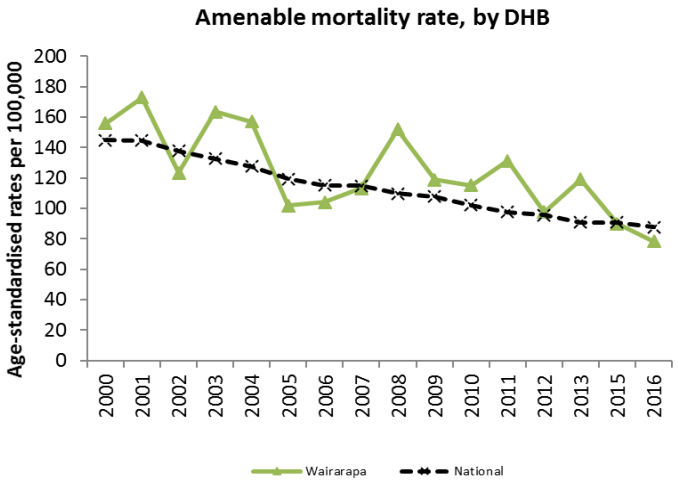
Differences in amenable mortality rates for different population groups reflect variation in the coverage, accessibility and quality of health care received by them.

The Amenable mortality rate for Wairarapa DHB is below the national rate as at 2016.

The graphs show the most recent data available from the Ministry of Health which is for the twelve months ended 31 December 2016.

The Wairarapa DHB amenable mortality rate for Māori at 188.0 (age standardised rate per 100,000) is lower than national (197.4) but for other population the rate is 85.0 compared with the national rate at 75.1 per 100,000.

There is no new data set for this measure beyond 2016, however, we know anecdotaly and from other measures of inequity that the Māori rate is more than twice the rate of others in our region. This measure alone provides rationale to focus,on Māori specific service provision in order to target and tailor services to achieve better outcomes.



Source: Ministry of Health

Population health outcome: Improved environmental health and disease hazard management

What difference will we make for our population?

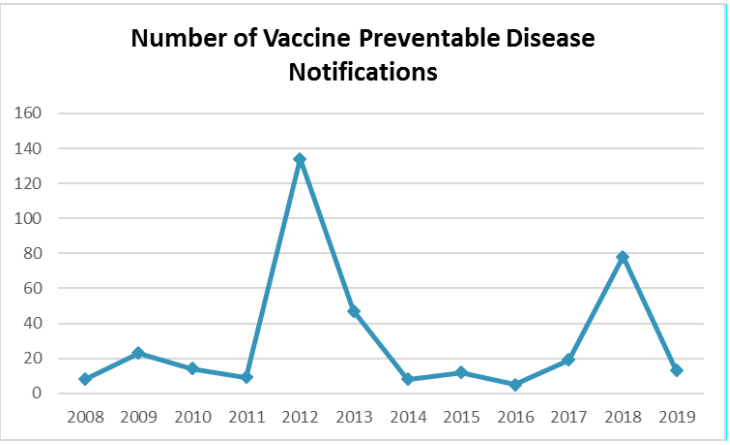
Through effective public health disease surveillance, investigation and control, the impacts of communicable, waterborne and foodborne diseases can be minimised. Public health actions are aimed at reducing the levels of harm from alcohol and drug use in the greater Wellington region. To achieve this 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 had increased from 2017 to 2018 but has decreased back down to slightly above previous levels.



Source: Institute of Environmental Science and Research. Data is for a calendar year.

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.

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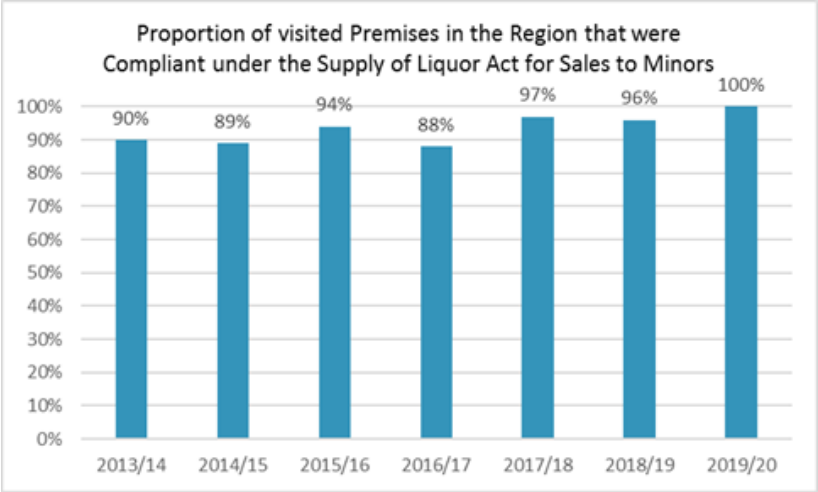


Source: Regional Public Health

In 2019/20, 100% of premises visited in the sub-region were compliant with the Supply of Liquor Act 2012 for sales to minors.

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)

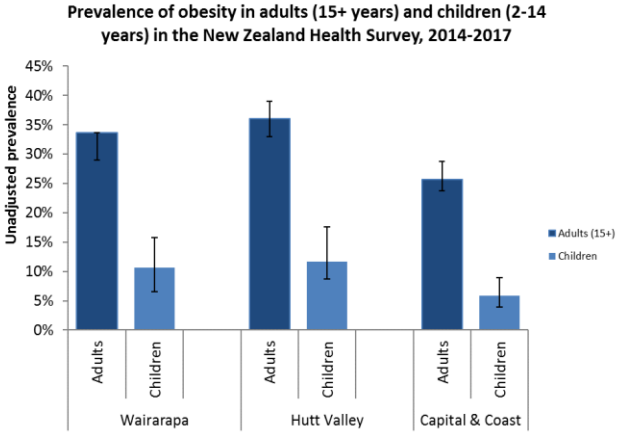
Obesity is one of the most important modifiable risk factors for a number of major diseases, including type 2 diabetes, ischaemic heart disease, ischaemic stroke, and several common cancers. In the last two decades, the prevalence of obesity in developed countries has increased so quickly that is has been described as an epidemic[1].

The Hapūtanga programme of work we are currently undertaking focuses in on whānau like never before. We know that breastfeeding, early nutrition, whānau eating habits are the key to long-term change. Co-ordinating and sharing our efforts across our community has a far reaching impact on whānau, the Sport Wellington team, the DHB, Oral Health, Regional Public Health, The PHO, Maternity Services, The Māori Womens Welfare League and Supporting Families all combine to ensure whānau get the best start in life.

Nationally, breastfeeding rates for Māori are lower than non-Māori . Well Child Tamariki Ora Quality Indicator Framework for WrDHB shows a significant inequity for Māori with 37% infants exclusively breastfed at three months compared to 66% for Non-Māori.

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.



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.

Tapu Te Hā (WrDHB Tobacco Control Plan 2019/20) is focused on improving the inequities created by smoking especially for Māori. In Wairarapa DHB, 16.7% of the PHO enrolled population are recorded as a 'current smoker'. Māori smokng rates are twice and three times that of others in Wairarapa in all age brackets 15-75 years.

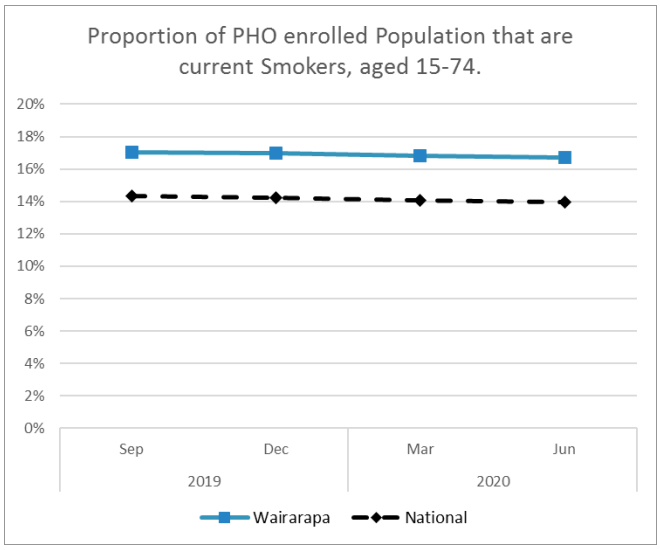
Our three focus areas in Tapu Te Hā are:

Kainga and Hapūtanga – building on the strong foundation provided by previous work such as Ka Tipu Ngā Mokopuna, Hapū Māmā, Hapūtanga, Pēpe Ora and Auahi Kore.

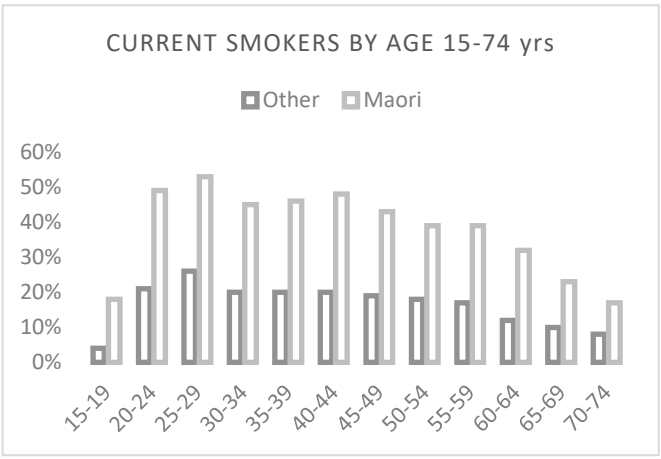
Māori Health Promotion – Māori health is about shared leadership with health, community and iwi.

The WrDHB works collaboratively with agencies in the Wairarapa that can affect change for whānau. Also acknowledging that Māori health is intimately connected to Māori culture.

Equity in Action – The WrDHB continues to take ownership of Tapu te Hā and endeavour to meet or exceed targets where possible.



Source: Ministry of Health



Source: Tu Ora Compass Health

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.

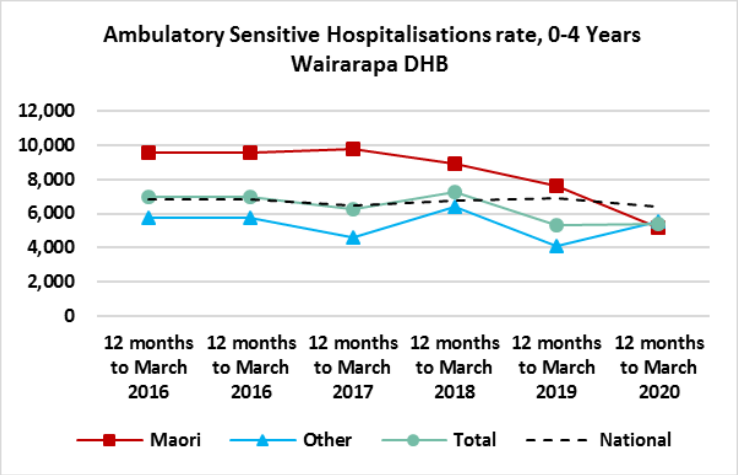
Measures – The DHB measures progress through:

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.

Over the last six years, the ASH rate for Māori 0-4 in Wairarapa DHB has decreased, with significant improvement over the last two years such that it is now inline with other ethnicities.



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.

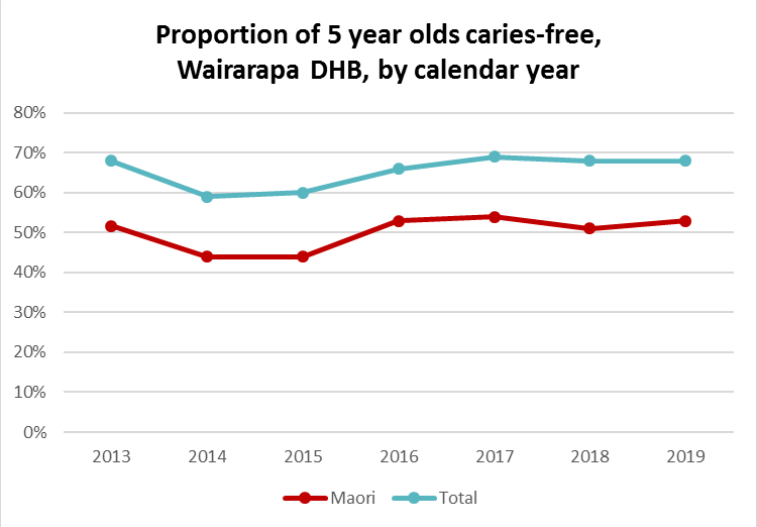
The DHB is undertaking a number of activities to improve oral health outcomes for children. A new sub-regional enrolment system has recently been established, and its aim is to enrol every infant with community oral health services. In addition, Before School Checks include a 'Lift the Lip' oral health 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 2019, as has the proportion of Māori children who are caries free which has seen a slight increase.

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 12 weeks. Following the arrival of COVID-19 the oral health service has introduced the option for telephone or zoom baby clincs . Phone consults have been well patronised.

A comprehensive programme of hauora Māori is being provided to all local Kohanga Reo to promote and celebrate hauora, by, with and for Māori. This programme sits under the Pae Ora banner and links with Smokefree, Oral Health, Breastfeeding, Mental Health and Wellbeing.



Source: Ministry of Health, Bee Healthy Dental Service (calendar year)

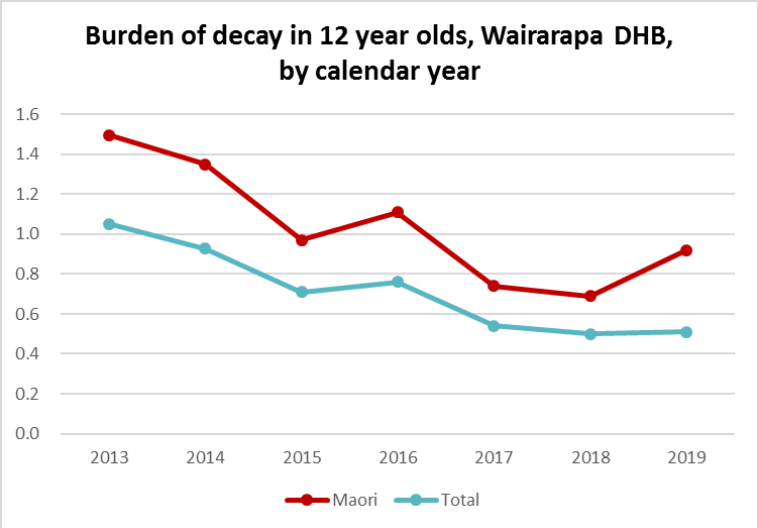
Impact measure: A decrease in the burden of tooth decay at Year 8

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 been decreasing from 2016, however there has been an increase this year in Māori children who continue to have a higher burden of decay than other ethnicities.

We have increased our preventative work with these children by routinely applying fluoride. In this time of COVID-19 we have also made sure that we are prioritising Māori , Pacific and low decile children.



Source: Bee Healthy Dental Service (calendar year)

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.

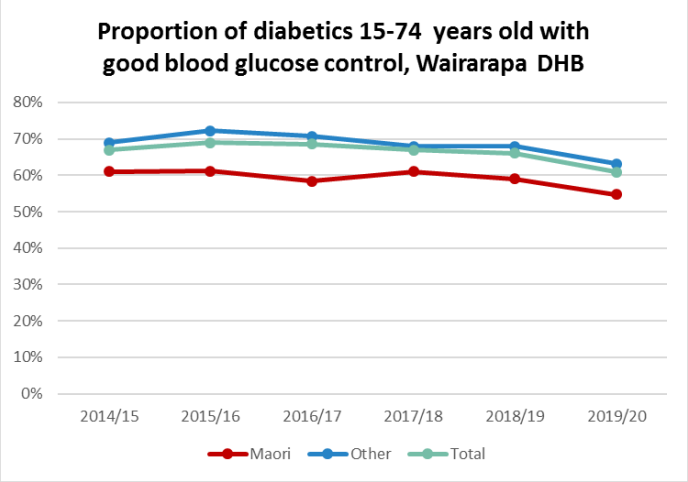
Measures – The DHB measures progress through:

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.



Source: PHO report

[1] Ministry of Health

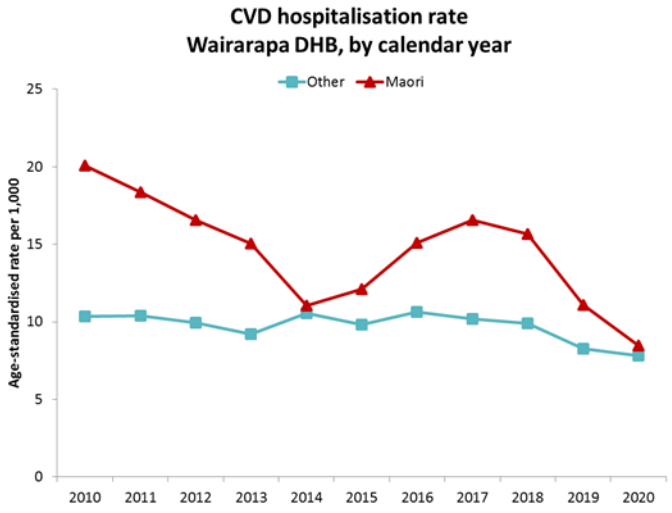
Impact measure: A decrease in the hospitalisation rate for cardiovascular disease

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.

The total cardiovascular disease mortality rate among Māori is more than twice as high as that among non-Māori.Māori are more than 1.5 times as likely as non-Māori to be hospitalised for cardiovascular disease. In Wairarapa DHB, Māori have a higher rate of CVD hospitalisation than other ethnicities.

A targeted and tailored programme of community based CVD risk assessment aimed at Māori and Pacific men aged 45-65 years to compliment General Practice, Cardiac Rehab and Green Prescription is currently being planned for implementation in the 2021 calendar year.



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

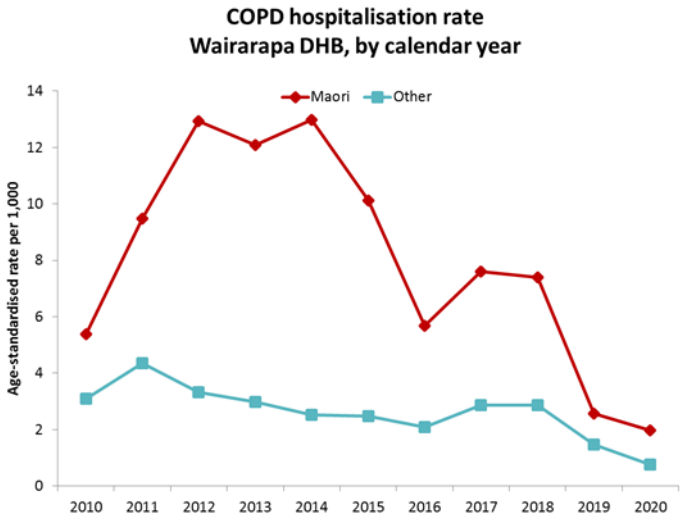
Impact measure: A decrease in the hospitalisation rate for chronic obstructive pulmonary disease

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.

The chronic obstructive pulmonary disease (COPD) mortality rate among Māori aged 45 and over is almost 3 times that of non-Māori in the same age group. The disparity was greater for females: Māori females had a COPD mortality rate almost 3.5 times that of non-Māori females.

Māori aged 45 and over had a COPD hospitalisation rate over 3.5 times that of non-Māori at the same age group. Again, the relative disparity was greater for females: Māori females had a COPD hospitalisation rate more than 4.5 times that of non-Māori females

In Wairarapa DHB, the COPD hospitalisations rate for Māori is higher when compared to other ethnicities. Rates had been falling for some years and the gap between Māori and other has reduced although a gap remains.



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

Health Services Outcome: People receive high quality hospital and specialist health services when they need them

What difference will we make for our population?

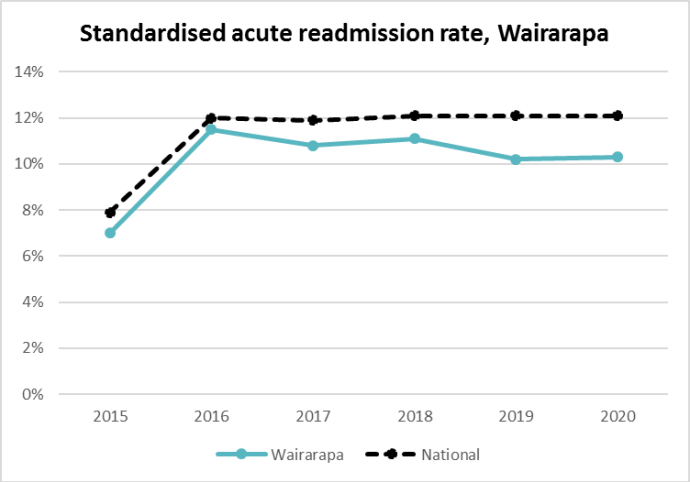
Equitable and timely access to intensive assessment and treatment can significantly improve people's quality of life, either through early intervention, or through corrective action (i.e. major joint replacements to relieve pain and improve activity). Improving our service delivery, systems, and processes 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 been maintained at 10.2% for Wairarapa DHB over the last year and continues to be below the national average.



Source: Ministry of Health.

Note: The methodology for calculating the 28 days acute readmission rate and standardisation changed in 2016.

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

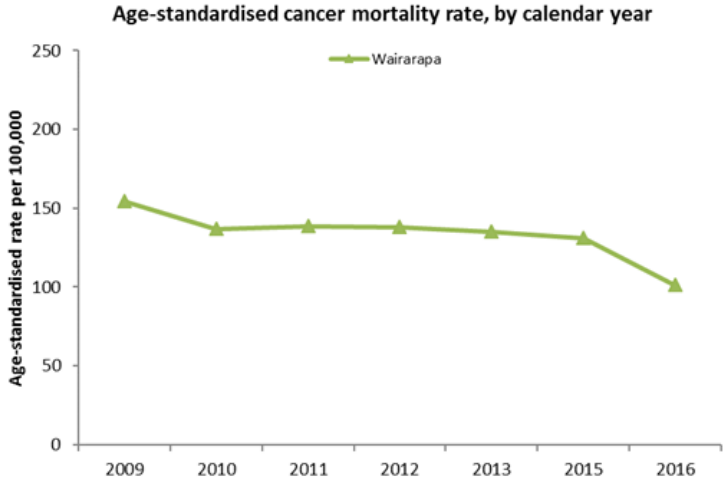
More people are developing cancer, mainly because the population is growing and getting older.

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 the calendar year-ended 2016 is the latest data available at time of publication.



Source: Ministry of Health Mortality dataset

Most recent available data is 2016 calendar year. The Ministry of Health had not released updated data at the time of publication.

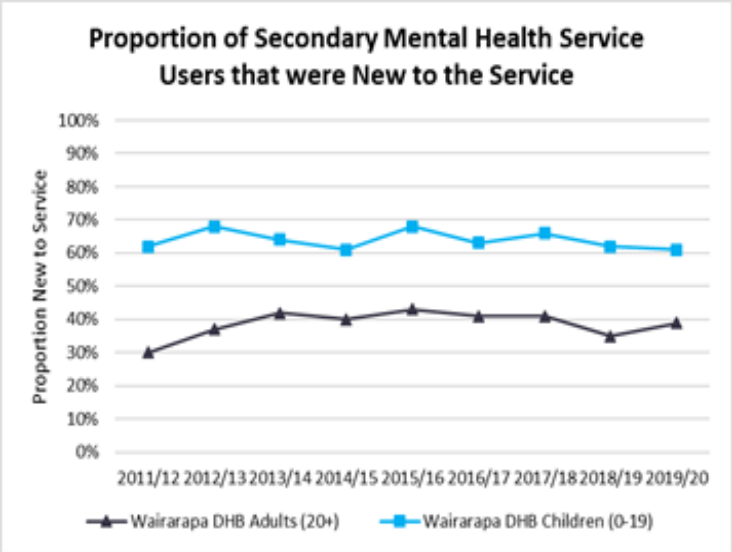
1 Age-standardisation accounts for differences in the age structure between populations and changes in the age structure over time. The age-standardised rate estimates what the rate would be if the age structures were the same.

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.	 Source: PRIMHD

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. Wairarapa DHB has one of the oldest populations in New Zealand. 22% of people are over 65 years compared to a national average of 16%. Over the next 40 years the national support ratio of people in the 50 to 74 age group to people over 85 years is expected to dramatically decrease from 15:1 to just under 5:1. For older women, this ratio drops even further to 2.4:1. The DHB has a responsibility to provide appropriate services to improve the health, wellbeing, and independence of our older population and will need to review its model of care to ensure it is fit for the future.

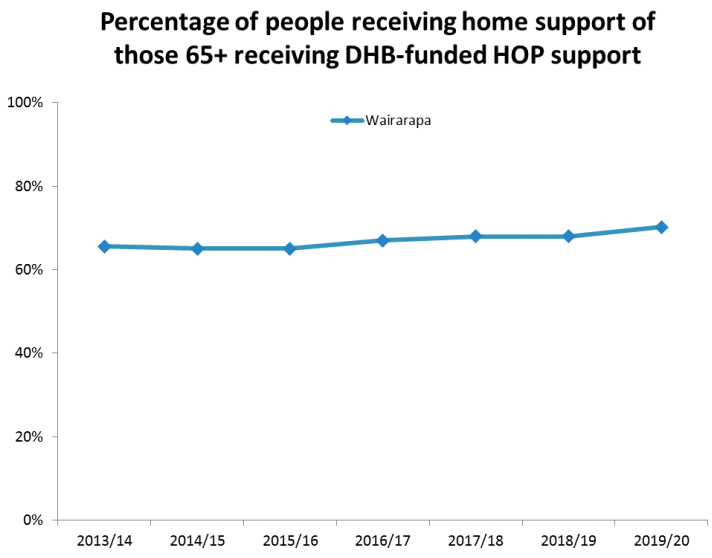
Measures – The DHB measures progress through:

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 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 the proportion of people receiving home support rather than in residential care will be increased or maintained.

In Wairarapa DHB, the proportion of older people receiving home based support services has been maintained over the last three years.

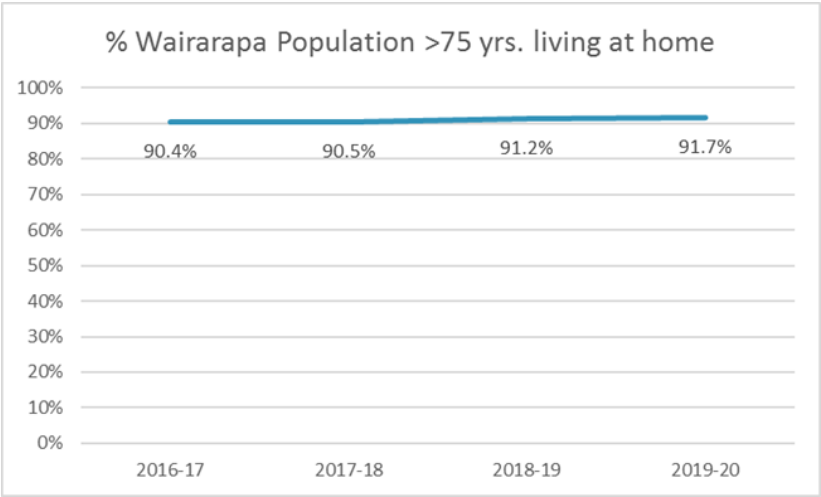


Source: NASC Data (19/20 Data only until March 2020)

Impact measure: Maintain or increase the proportion of the population 75 years and over who are living at home

Maintaining or increasing the proportion of older people living at home, reflects the wellbeing and resilience of older people (whether or not they are receiving support services). It is a measure which reflects how the whole health system enables older people to continue to live well in their community.

This well-being measure for people over 75 years old continues to increase, with 91.7% average over the year.



Source: NASC Data

[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

Statement of Performance

For the year ended 30 June 2020

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 2019/20 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 services

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. As such, 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

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

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 2019/20 performance (indicated with 'Est.'), based on historical and population trends.

Appropriation reporting

	Budget 2020 $000	**Actual 2020 $000**	**Actual 2019 $000**
Appropriation revenue	149,100	149,100	140,017

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

COVID-19

The COVID-19 pandemic did not reduce our ability to deliver key services, but did impact our hospital operations and limit our ability to achieve some of our targets this year. Where possible, the performance tables below try to show the performance before COVID-19, and during the pandemic response (April to June 2020) separately.

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]: **A**sk all patients whether they smoke and document their response; if the patient smokes, provide **B**rief advice to quit smoking; and if patient agrees, provide **C**essation support (e.g., a prescription for nicotine gum or a referral to a provider like Quitline).

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

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

How we measure the performance of our Prevention Services:

Outputs measured by	Type of measure	MOH indicator	2018/19 Baseline	Target/Est. 2019/20	Pre-COVID Performance July-Feb/ Q1-3	COVID Performance March-June/Q4	2019/20 Performance	2019/20 Pre COVID Achievement	COVID Achievement	Overall Achievement
Health promotion and education										
Number of adult referrals to the Green Prescription program.	V	WPI	224	≥ 224			243			Achieved
Smoking cessation										
Percentage of PHO enrolled patients who smoke and have been offered help to quit smoking by a health care practitioner in last 15 months.	C	PH04	91%	≥90%	90.0%	89.6%	89.9%	Achieved	Not Achieved	Not Achieved
Percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or LMC being offered brief advice and support to quit smoking.	Q	CW09	100%	≥90%	100%	100%	100%	Achieved	Achieved	Achieved
Babies living in Smokefree Homes at 6 weeks post-natal	Q	PH01	Total 37.5% Māori 18.5% Other 48.3%	Total ≥37.5% Māori ≥18.5% Other ≥48.3%			62.5% 41.6% 73.9%			Achieved
Immunisation										
Percentage of 2-year olds fully immunised.	C	CW05	Total 93.6% Māori 92.9% Pacific 100% Other 100%	≥95%	92.4% 95.7% 81.8% 91.8%	92.9% 95.3% 80.0% 92.4%	92.5% 95.6% 81.3% 91.9%	Achieved for Māori Only	Achieved for Māori Only	Achieved for Māori Only
Percentage of 8-month olds fully vaccinated	C	CW08	Total 92% Māori 95% Pacific 94% Other 77.8%	≥95%	93.4% 96.6% 100.0% 91.1%	88.8% 86.0% 100.0% 90.0%	92.2% 93.9% 100.0% 90.8%	Achieved for Māori and Pacific Only	Achieved for Pacific Only	Achieved for Pacific Only
Percentage of 5-year olds fully immunised	C	CW05	Total 91.1% Māori 91.5% Pacific 66.7% Other 87.5%	≥95%	93.1% 95.6% 100.0% 88.4%	95.1% 93.0% 100.0% 95.7%	93.6% 95.0% 100.0% 90.2%	Achieved for Māori and Pacific Only	Achieved for All Except Māori	Achieved for Māori and Pacific Only

Outputs measured by	Type of measure	MOH indicator	2018/19 Baseline	Target/Est. 2019/20	Pre-COVID Performance July-Feb/ Q1-3	COVID Performance March-June/Q4	2019/20 Performance	2019/20 Pre COVID Achievement	COVID Achievement	Overall Achievement
Percentage of year 7 children provided Boostrix vaccination in Wairarapa district.	C	WPI	Total 92%, Māori 94%, Pacific 113%, Other 90%	≥92%			69% 66% 70% 27%			Not Achieved
Percentage of year 8 girls and boys vaccinated against HPV (final dose) in Wairarapa district.	C	CW05	Total 89% Māori 118% Pacific 75% Other 85%	≥89%			66% 67% 76% 66%			Not Achieved
Percentage of people aged 65+yrs who have completed their annual influenza immunisation.	C	CW05	Total 65% Māori 57% Other 67%	≥75%			75% 60% 77%			Achieved for All Except Māori
Breastfeeding										
Percentage of infants fully or exclusively breastfed at 3-months.	Q	CW06	59%	≥70%			27.3%			Not Achieved
Population based screening services										
Percentage of eligible children receiving a B4 School Check.	C	CW10	Total 99.8%	≥90%	86%	71%	71%	Not Achieved	Not Achieved	Not Achieved
Percentage of eligible women (25-69 years) having cervical screening in last 3 years.	C	PV01	Total 79% Māori 69% Pacific 85% Other 79%	>80%	74.00% 74.23% 80.88% 74.69%	74.40% 73.98% 81.14% 73.54%	74.2% 74.1% 80.9% 74.8%	Achieved for Pacific Only	Achieved for Pacific Only	Achieved for Pacific Only
Percentage of eligible women (50-69 years) having breast screening in the last 2 years.	C	PV02	Total 77% Māori 70% Pacific 65% Other 78%	>70%	74.45% 68.34% 57.52% 75.30%	61.76% 62.13% 56.25% 61.68%	71.10% 66.72% 57.19% 71.69%	Achieved for Total and Other Only	Not Achieved	Achieved for Total and Other Only

Commentary

Public health protection and regulatory services

The number of disease notifications is demand driven and the expected volume is an estimate based on the total for the previous year. The total number of disease notifications has increased in the WrDHB area. Notifiable common gastric related illness dominate the notification volumes (e.g. campylobacter). In addition, pertussis has remained high across the 3DHB sub-region.

The number of environmental health investigations is demand driven and the expected volume is an estimate based on the total for the previous year. Whilst there has been a decrease in the total number of environmental investigations recorded, this does not represent the significant activity from Regional Public Health in responding to environmental health issues in the WrDHB. Examples include the 'hazardous substance' response in Carterton, from September 2018; the Martinborough drinking water transgressions , begun in February 2019; and the on-going work with drinking water supplies through the 2019/20 year.

The two Controlled Purchase Operations (CPOs) carried out with 26 premises being visited and resulted in no sales to a minor. All alcohol CPOs are carried out under the authority of the Police, as per the Sale and Supply of Alcohol Act 2012. (NB: the 2 CPOs were carried out in July & Nov of last year hence no effect in terms of COVID). The number of tobacco retailers visited during controlled purchase operations was lower than last year. The planned CPO that was set down for April 2020 was cancelled due to staff being deployed to support the Public Health response to COVID-19 and health and safety risks to our volunteers. A CPO is planned before the end of the 2020.

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, there has been a significant improvement in rates of breastfeeding amougst Māori women of 10% during the 19/20 year. 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).

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 wellbeing and reduce the number of personal health referrals. The increased access to care through free under 14 year olds has contributed to children seeking early access to their GP practices. The Boostrix vaccine that is given to Year 8 and some Year 9 students is delivered by Regional Public Health and a small amount administered through Primary Care. The low coverage rate for the 19/20 year is due to the fact that all schools were closed during the COVID-19 lockdown period. Regional Public Health were in the middle of their school based programme delivering Gardasil and Boostrix when the lockdown commenced, so these programmes were put on hold until schools returned as normal.

Wairarapa Green Prescription referral numbers have remained steady. The Wairarapa based Healthy Lifestyle Co-ordinator continues to prioritise practice-based promotion although a recent shift is increasing into community based 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.

Immunisation services

Inspite of the impact of COVID-19 on our local immunisation programme, 92% of all children aged 8 months and 94% of Māori infants eligible for immunisation were fully immunised, falling slightly short of the target of 95%. All eligible Pacific children aged 8 months were immunised during the period of 01 July 2019 – 30 June 2020. In the same twelve month period 93% of all children aged twenty four months were fully immunised, 96% of Māori and 81% Pacific Island two year olds were also fully immunised. The low percentage of Pacific relates to very low numbers and when 1 or 2 are missed this can constitute 10-20% points. There is regular contact between the 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. The measures for total and Pacifika were met for 65+ but not Māori, some lessons learnt during COVID-19 level 4 were around stakeholder enagagement, collaboration and tailoring an approach. The DHB, Māori Health team, Tū Ora Compass Health, Outreach Immunisation Co-ordination and Pharmacies worked together provide the flu vax to the community with a specific emphasis on whanau, Māori and Pacifika. One major learning was embedded in the quality of our communication with whānau and individuals, the telephonists and those manning the pop-up clinics needed to be able to cater to the needs of whanau, Māori and Pacifika.

Overall performance in the school based immunisation programme has been steady, the low coverage rate for this year is due to the fact that all schools were closed during the COVID-19 lockdown period. Regional Public Health were in the middle of their school based programme delivering Gardasil and Boostrix when the lockdown commenced, so these programmes were therefore put on hold until schools returned as normal. 69% of year 12 children received the Boostrix vaccination in the schools based programme. Regional Public Health work closely with primary care in the Year 8 HPV vaccination programme. In total 66% of all year 8 girls and boys received their final vaccination.

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. 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. Performance in 2019/20 was 89.9% of smokers offered help to quit against the 90% target.

Maternity Health Target – The Wairarapa DHB regularly exceeds the health target of 90%. During 2019/20 100% of all pregnant smokers, including Māori pregnant smokers, were offered support to quit. A pregnancy incentivised programme (Hapu Mama) has been developed to support the LMCs and their clients who smoke. The LMCs referral rate to the programme has increased during the 2019/20 year.

Screening services

In Wairarapa, the B4 School check service 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. This measure is constantly in 'catch-up' mode partly due to four year olds turning five but also struggling with DNA and reaching the 'hard to reach'. This propensity for 'catch-up' was and is accentuated by the level 4 lockdown and in the 2019/20 year, extra effort is going into providing these checks to those that were missed over the COVID-19 lockdown. In 2019/20 the 90% target was not achieved at 86% pre COVID-19 and 71% overall.

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 National Screening Unit (NSU), DHB and PHO have each part funded a full time equivalent co-ordinator in the Wairarapa to focus in on breast and cervical screening rates, specifically for eligible Māori and Pacific women. The target of 80% overall for 2019/20 was met by Pacific but not Māori or other both at 74% coverage across the last 3 years. The Mobile Breast Screening bus is now rostered to visit Wairarapa twice annually and will work in with the new local role developed to increase screening for Māori and Pacific women . A project is underway to look at a fixed site option in Wairarapa to provide year round access which may make breast screening more accessible to Wairarapa women. Wairarapa has met its overall target of 70% for the 19/20 year, but failed to meet this for Māori at 67% and Pacific women at 57% notwithstanding Pacific numbers are small and skew the data significantly when 1-5 women are not screened.

A priority group of interest for the 20/21 year for both cervical and breast screening are Asian women, like Pacific women the numbers are small but also like Pacific women, Asian women are not easy to find and we regularly do not meet our target for this group.

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 to ensure people are able to obtain optimal benefit from the medicines they have been prescribed.

How we measure the performance of our Early Detection and Management services:

Outputs measured by	Type of measure	MOH indicator	2018/19 Baseline	Target/Est. 2019/20	Pre-COVID Performance July-Feb/ Q1-3	COVID Performance March-June/Q4	2019/20 Performance	2019/20 Pre COVID Achievement	COVID Achievement	Overall Achievement
Primary Care services / Long term conditions management										
Newborn enrolment with General Practice	SI18	CW07	Total 82% Māori 88% Pacific NA Other 80%	≥80%	98.4% 88.0% 104.5%	91.8% 83.9% 96.7%	96.7% 86.9% 102.5%	Acheived	Achieved for All Except Māori	Acheived
Percentage of DHB-domiciled population enrolled in a PHO.	C	PH03	Total 99%, Māori 99% Pacific 107% Asian 76% Other 100%	All ethnicities ≥99%			97.29% 95.60% 98.81% 84.77% 98.18%			Not Achieved
ASH Rates (avoidable hospitalisations) for 0-4 years (rate per 100,000)	PP22	PH01	Total 6,452 Māori 9,318 Pacific NA Other 5,014	Total ≤ 6,300 Māori ≤ 9,000 Pacific NA Other ≤5,000	4,838 4,409 5,054	5,415 5,161 5,543	5,415 5,161 5,543	Achieved for All Except Other	Achieved for All Except Other	Achieved for All Except Other
ASH Rates (avoidable hospitalisations) for 45-64 years	SI1	SS	Total 3,756 Māori 5,935 Pacific NA Other 3,490	Total ≤ 3,500 Māori ≤ 5,500 Pacific NA Other ≤3,400	2,954 5,742 2,570	2,858 5,381 2,529	2,858 5,381 2,529	Achieved for All Except Māori	Achieved for All Except Māori	Achieved for All Except Māori
Percentage of DHB-domiciled population (15-74 yrs) enrolled in a PHO with well managed diabetes (HbA1c ≤ 64 mmol/mol)	PP20	SS13 FA2	Total 64% Māori 61% Pacific 56% Other 65%	≥70%			60.9% 54.7% 55.7% 63.1%	Not Achieved	Not Achieved	Not Achieved

Outputs measured by	Type of measure	MOH indicator	2018/19 Baseline	Target/Est. 2019/20	Pre-COVID Performance July-Feb/ Q1-3	COVID Performance March-June/Q4	2019/20 Performance	2019/20 Pre COVID Achievement	COVID Achievement	Overall Achievement
Oral health										
Percentage of children under 5 years enrolled in DHB-funded dental services.	C	CW04	Total 91.5% Māori 86.4% Pacific 71.4% Other 95.5%	≥91%			Total 88.6% Māori 79.1% Pacific 70.5% Other 91.7%			Achieved for Other Only
Percentage of children Carries Free at 5 years	Q	CW02	Total 67.87% Māori 51.2% Pacific 58.8% Other 75.3%	Total ≥68% Māori≥52% Pacific ≥60% Other≥76%			Total 68% Māori 53% Pacific 50% Other 75%			Achieved for Māori and Total Only
Percentage of children with Decayed, Missing, Filled Teeth-DMFT in year 8 kids	Q	CW01	Total 76% Māori 71.3% Pacific 80% Other 77.46%	Total ≤76% Māori≤72% Pacific ≤80% Other≤78%			Total 77% Māori 61% Pacific 75% Other 83%			Achieved for Māori and Pacificl Only

Commentary

Primary Care Services / Long term conditions management

COVID-19

COVID-19 has had a massive impact on service delivery by Primary Care Services across the Wairarapa. All of the Wairarapa practices apart from Kuripuni Medical Centre (their clients were swabbed at Masterton Medical Ltd) provided COVID-19 assessment and swabbing during the lockdown periods and have continued to do so, with swabbing at weekends being offered from the Wairarapa After Hours Service.

Staff from Masterton Medical Ltd and Tū Ora set up and ran the Community Testing Centre located at the Netball Courts, Colombo Road, Masterton during Alert level 4 & 3.

Due to the restrictions placed on Primary Care Providers during COVID-19 lockdowns, there are ongoing challenges for providers to catch up on screenings and other services that were unable to be delivered, and all teams are working very hard on catching up as well as continuing to deliver their normal activities.

The amazing response from Wairarapa Primary Care Teams to challenges posed by COVID-19 is acknowledged. As we moved in and out of Alert Levels Primary Care Teams continued to be responsive to the challenges. This provides additional pressure on already busy teams and will continue to have impacts on service delivery into 2020/21.

Long Term Conditions Management

All seven practices in the Wairarapa have completed their required annual practice plans. As part of this process, practices are allocated funding for long term conditions 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. The annual practice plans incorporate specific diabetes care improvement plans to provide quality care and management for enrolled patients with diabetes. 87% of the total eligible population have had a HbA1c measurement in the past year, with 84% completion for Māori and 87% completion for Pacific populations. To assist with better management of the eligible diabetes population in the Wairarapa 91% of the total Type 2 Diabetics have been prescribed Insulin during the past 12 months. With 88% of the Māori and 89% of the Pacific eligible population also being prescribed Insulin during this period.

87% of the total eligible Wairarapa population have had a heart check (CVD risk assessment) with 81% for the Māori eligible population and 80% for the Pacific eligible population. The total number of CVRA checks completed during the year was severely impacted by COVID-19 lockdowns and restrictions.

The PHO continues to support and work with all seven practices to ensure sustained progress is made to achieve the required targets, with feedback on performance and systems support to ensure that all eligible individuals are encouraged to get a check when due. The PHO has also provided funding to enable practices to offer free checks for Māori, Pacific and low-income people.

Health Care Home

Implementation of the Health Care Home model across all Wairarapa practices has continued through the year. Year of Care Planning is being implemented by all practices. All practices are making good use of telephone triage with their clients, and offering virtual consultations as required.

What About You – Alcohol Campaign

The What About You Alcohol campaign has continued to develop during the year. As well as continuing with the key message about the harm of misuse of alcohol the campaign also includes a focus on mental wellness.

There are now 16 health and social agencies in the Wairarapa Alcohol Network who continue to support and implement the What About You Campaign by integrating messages within their operational activities.

A brand new partnership has been developed this year with Wairarapa Bush Rugby Union, which is focused on working with 12 rugby clubs across the Wairarapa to set clear expectations about alcohol use and to support clubs to be safe, supportive and have successful environments for teams, players, administrators and wider communities.

Self-Management Courses
Self-Management Courses have continued during the year with interruptions to some courses because of COVID-19 lockdowns.

Our first Wairarapa "Piki Te Ora" self-management course was completed in June 2020. This course was our first course specifically focused on Māori participants. The course was held at Te Rangimarie Marae, in Masterton. The course content is the same as the "Take Control of Your Health" course, however it also incorporates kaupapa Māori principles. The course was led by a Māori facilitator. The first session to welcome everyone and outline the course began with a mihi whakatau followed by waiata. Each week sessions started and closed with a karakia. The course was a success. Participant evaluations were positive. Participants liked the size of the group which fluctuated from 6-10 weekly, and they felt comfortable on the marae and were complimentary of the course facilitation, content, and the respect for tikanga.

Tobacco Control
In December 2019, Wairarapa DHB contracted Tū Ora Compass Health to delivber the Tobacco Control Plan. The Smokefree Coordinator continues to work closely with Wairarapa DHB, Regional Public Health and Wairarapa Stop Smoking Service, with a focus to reduce the inequities created by smoking especially for Māori. Projects and activities planned for early 2020 were disrupted by COVID-19 lockdowns but will be implemented during 2020-21.

This year the Smokefree Coordinator has worked with the committee of Te Rangiura O Wairarapa to promote a smokefree Kapa Haka team. Eight of the kapa were smokefree by the day of the competition in February 2020.

The coordinator, working with Whaiora and the Wairarapa Stop Smoking team, support the kaimahi from Wahi Reka Kohanga to quit smoking and make health kai and exercise choices. A smokefree policy for the Kohanga was developed and implemented. As a result of this work, five kaimahi successfully stopped smoking as did some of the wider whanau members.

A focus group of young wahine was set up to help develop a strategy to support young wahine in the Wairarapa to stop smoking. This work will be undertaken during 2020-21.

Palliative Care
During the year there has been continued implementation of the `Living Well, Dying Well' strategy across the Wairarapa.

The Wairarapa GP Special Interest (GPSI) role has been re-purposed to become Palliative Care GP Liaison, which will provide wider support and education to Wairarapa General Practice Teams. This role will also work closely with specialists from Te Omanga Hospice and Secondary Care Specialist Teams at Wairarapa Hospital.

The Palliative Care Management Group and Palliative Care Reference Groups met regularly during the year to progress the Wairarapa Palliative Care Implementation Plan.

Implementation of the Palliative Care Register with the FOCUS team has meant that details of all palliative patients are now recorded centrally ensuring better support and management.

Oral Health Services

All newborn babies are enrolled at birth and offered either a telephone, zoom or physical group visit to the community dental clinic before their 5 month anniversary. We have noted an increase in those taking up remote appointments at this time. We are finding this increases the numbers availing themselves of the advice available.

We are routinely applying fluoride to children at each revision unless it is not appropriate or the parent wishes the child not to have it.

We have sought enduring consent for this from parents so that children at risk will be able to have two applications each year as clinical studies have shown this to reduce decay rates.

We are transferring all year 9 children to the Community Dental Agreement service providers and our adolescent co-ordinator actively followup with private practices to ensure the attendance of adolescents.

Pharmacy Services

The national pharmacy contract has now been bedded in and there is an annual review process to update prices and include any changes that are agreed by DHBs and pharmacy representatives.

DHBs continue to strive for a change to the structure of the payment mechanism to separate the advice and medication supply components of the dispensing process. The separation will not only enable pharmacies to focus on more specialised medication supply services, the funding could also then take account of equity factors so it more fairly reflects the populations served by each pharmacy. There are technical and regulatory challenges that also need to be addressed to enable the changes. In the meantime, the annual funding adjustment is provided to pharmacies for the advice they provide to patients.

Output Class: Intensive Assessment & Treatment Services

Description

Intensive assessment and treatment services are delivered by a range of secondary, tertiary providers using public funds. These services are usually integrated into facilities that enable co-location of clinical expertise and specialised equipment, such as a hospital. These services are generally complex and provided by health care professionals that work closely together. 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: include diagnosis and treatment services. Cancer treatment in the sub-region is delivered by the Wellington Blood and Cancer Centre.

Mental health and addiction 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 the performance of our Intensive Assessment & Treatment Services

Outputs measured by	Type of measure	MOH indicator	2018/19 Baseline	Target/Est. 2019/20	Pre-COVID Performance July-Feb/ Q1-3	COVID Performance March-June/Q4	2019/20 Performance	2019/20 Pre COVID Achievement	COVID Achievement	Overall Achievement
Mental Health and Addiction services										
Percentage of patients 0-19 yrs referred to non-urgent child & adolescent mental health services & seen within 8 weeks.	T	MH03	88%	≥95%	84.60%	84.80%	84.80%	Not Achieved	Not Achieved	Not Achieved
Percentage of patients 0-19 years referred to non-urgent child & adolescent Addiction services & seen within 8 weeks.	T	MH03	97.60%	≥95%	87.10%	100%	100%	Not Achieved	Achieved	Achieved
Percentage of clients with transition (discharge) plan	3DHB	MH02	44%	≥95%	50%	48%	48%	Not Achieved	Not Achieved	Not 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.	Q	WPI	92%	≥90%	85.7%	71.4%	81.6%	Not Achieved	Not Achieved	Not Achieved
Elective and Acute (Emergency Dept.) inpatient/outpatient										
Number of surgical elective discharges.	V	SS07	2,380	≥2,417			2,541			Achieved
Percentage of patients admitted, discharged or transferred from ED within 6 hours.	T	SS10	87%	≥90%	91%	93.2%	91.8%	Achieved	Achieved	Achieved
Standardised inpatient average length of stay ALOS (Acute).	T	WPI	2.36	≤2.35	2.66	2.65	2.66	Not Achieved	Not Achieved	Not Achieved
Standardised inpatient average length of stay ALOS (Elective).	T	WPI	1.45	≤1.55	1.49	1.43	1.47	Achieved	Achieved	Achieved
Standardised Acute Readmissions	Q	OS8	Total 11.2% Māori 12.2% 75+Total 11.4% 75+Māori 17.2%	Total ≤11%	10.60% 9.90% 11.00% 6.60%	10.3% 8.5% 15.0% 9.1%	10.3% 8.5% 15.0% 9.1%	Achieved	Achieved for All Except Total 75+	Achieved for All Except Total 75+

Outputs measured by	Note		Baseline	Target/Est. 2019/20	Pre-COVID Performance July-Feb/ Q1-3	COVID Performance March-June/Q4	2019/20 Performance	2019/20 Pre COVID Achievement	COVID Achievement	Overall Achievement
Rate of inpatient falls causing harm per 1,000 bed days.	Q	WPI	0.27	≤0.50	0.17	0.00	0.14	Achieved	Achieved	Achieved
Rate of hospital acquired pressure injuries per 1,000 bed days.	Q	WPI	1.39	≤1.40	0.17	0.41	0.23	Achieved	Achieved	Achieved
Rate of identified medication errors causing harm per 1,000 bed days.	Q	WPI	0.85	≤0.85	0.06	0.20	0.09	Achieved	Achieved	Achieved
Weighted average score in Patient Experience Survey	Q	SI8	Comms: 8.7 Co-ord: 8.5 P/ship: 8.7 Physical and emotional needs: 8.9	≥8.3			8.8 8.6 8.5 8.8			Achieved
Percentage Did Not Attend (DNA) appointments for outpatient first specialist assessments.	Q	WPI	8%	≤8%			8.20%			Not Achieved
Percentage DNA appointment for follow-up specialist appointments.	Q	WPI	8%	≤8%			6.50%			Achieved
Cancer services										
Percentage of patients receiving their first cancer treatment (or other management) within 31 days from date of decision-to-treat.	T	SS01	87.70%	≥85%	94.10%	91.40%	91.40%	Achieved	Achieved	Achieved
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.	T	SS11	88.90%	≥90%	97.50%	90.20%	90.20%	Achieved	Achieved	Achieved

Commentary

Quality

Patient Falls (causing harm SAC 1-3) – target was achieved. Patient falls are acknowledged as a high area of harm and falls reviews and risk assessments remain a high priority within our organisation and individualised plans are put in place to meet the needs of patients.

Pressure Injuries (Hospital acquired) – target was achieved. WrDHB is actively participating in the new HQSC Pressure Injury Quality Safety Marker Programme.

The combined Falls Prevention and Pressure Injury Committee has multi-disciplinary membership and meets quarterly to provide oversight and governance of the prevention programmes.

Medication Errors (causing harm SAC 1-3) – target was achieved. Encouragement to report errors continues to ensure learning occurs from events and auditing of prescribing continues.

Mental health and addiction services

Overall we have achieved 100% in waiting times target for adolescent Addiction services.

Wairarapa continues to carry vacancies for Clinical Psychology and this continues to be extremely difficult in a small community. We have recruited to the Team Leader role and believe this appointment will provide the leadership, and oversight required to maintain/ improve our performance on these measures.

Wait to treatment (post initial contact) remains a concern. We continue to focus on balancing wait to first contact and wait to treatment within our services.

Implementation of the new Primary Mental Health Access and Choice service commenced during 2019/20. This new service includes Health Improvement Practitioners, Health Coaches and Community Support workers working closely with General Practice Teams.

The Lead DHB proposal for the 3DHB MHAIDs service has been implemented since August 2020.

Medical and surgical services

Over the first half of the 2019/20 year Emergency Department presentations were similar to the previous 12 months in both volumes and triage streams. The COVID-19 response period between March and the end of May saw a significant reduction in attendances particulalry in April with almost a 20% reduction over the comparable 3 month period from the previous year. This period also saw a sharp rise in the percentage of those emergency presentations who were admitted which rose to over 45% at the peak of the COVID-19 outbreak. Across the whole year the result was consequently a 6% reduction compared to previous years activity. Given the increased vigilance and screening processes required for pandemic management, the waiting times for patients remained on average approximately 3% behind the 95% target which is consistent with previous years. Total inpatient discharges for the year was 9,540 which is broadly similar to last year with the average length of stay (ALOS) for all inpatients, both acute and planned, also broadly similar to previous years. Of all admissions, 5,330 were acute and 4,210 were arranged or planned.

For Planned Services the impact of COVID-19 was more pronounced with a sharp rise in the number of patients waiting for both appointments and surgery resulting form the required lockdown on non acute services. By the start of May this resulted in some 111 patients waiting longer than target for surgery and 200 for specialist assessment. Use of telehealth, flexible use of surgical capacity and additional work by staff meant a significant

proportion of this backlog was caught up by the final month of the year (June) By the end of June 2020, surgical waits behind target times halved to some 54 patients and all specialist appointmets waiting longer than planned were resolved.

Diagnostic waiting times were broadly achieved over the year for both CT and urgent colonoscopy. Semi urgent and surveillance colonoscopy were significantly disrupted in the later half of the year due to COVID as referenced earlier. Mitigation plans for these services are currently underway and will be addressed in the first half of the next financial year. MRI access and wait time remains significantly behind and has not been achieved at anytime over the year. This service is provided by a neighbouring DHB and the under achieved results are also reflected by the provider as well, being the result of significant capacity constraint at not only a local but a regional level for MRI imaging.

Cancer services

The DHB overall average performance against the 62 day target of 90% for the 2019/20 year was above target at 90.2%. The target was achieved for 3 of the 4 quarters. The service has also achieved the 31 day target with an annual performance of 91.4% compliance against the target of 85%. Those patients that did go over the target set by the MOH, had their treatment at other DHBs. Performance in both measures was reduced over the COVID reponse period however both targets were met looking at the year as a whole. The focus is to continue to fast track patients and to meet the MOH targets when capacity allows.

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 GPs, home and community care providers, residential care facilities and voluntary groups.

How we measure the performance of our Rehabilitation & Support services

Outputs measured by	Type of measure	MOH indicator	2018/19 Baseline	Target/Est. 2019/20	Pre-COVID Performance July-Feb/ Q1-3	COVID Performance March-June/Q4	2019/20 Performance	2019/20 Pre COVID Achievement	COVID Achievement	Overall Achievement
Disability care services										
Total number of hospital staff that have completed the Disability Responsiveness eLearning module.	Q	WPI	198	≥330			271			Not Achieved
Total number of Disability alert registrations	Q	WPI	0	≥100			0			Not Achieved
Health of Older People (HOP) services										
Percentage of people 65+years receiving DHB funded HOP support that are being supported to live at home.	C	WPI	69%	≥ 67%	69%	69%	69%	Achieved	Achieved	Achieved
Percentage of the population aged 75+ years that are in Aged Residential Care (including private payers).	C	WPI	14%	≤14%	8.25%	8.27%	8.27%	Achieved	Achieved	Achieved
% people who have received a LTCF residing in ARC or Residential Facilities within timeframes	Q	SS04	76%	≥ 75%	94%	n/a	94%	Achieved	Achieved	Achieved

Commentary

Disability care services

E-Learning: The effects of the response to COVID 19 impacted the ability to engage all of the workforce in e-learning activities. With the development of a revised e-learning module and the pending promotion of e-learning the response in the next reporting year will be improved.

Disability Alerts: The disability alert framework has been reviewed and the development of a second generation is underway. Until this is in place across the 3 DHB's within the region, disability alerts will not be established in the Wairarapa. There are ongoing infrastructure requirements to ensure the digital environment can support requirements. This is a work in progress.

Health of older people services

The proportion of older people receiving DHB support funding who are being supported to live at home is in line with our strategy and achieves the target. As at the end of 2019-20, 8.27% of people aged 75+ years in Wairarapa were in Aged Residential Care (including private payers) and this reducing proportion reflects the Wairarapa system approach to health of older people.

Financial Statements

CONTENTS

Statement of Responsibility

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

We are responsible for any end-of-year performance information provided by the 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 2020.

Signed on behalf of the Board:

Board member
17 December 2020

Board member
17 December 2020

Independent Auditor's Report

To the readers of Wairarapa District Health Board's financial statements and performance information for the year ended 30 June 2020

The Auditor-General is the auditor of Wairarapa District Health Board (the District Health Board). 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, on his behalf.

We have audited:

- the financial statements of the District Health Board on pages 63 to 96, that comprise the statement of financial position as at 30 June 2020, the statement of comprehensive revenue and expenses, 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 the statement of accounting policies and other explanatory information; and
- the performance information of the District Health Board on pages 19 to 55 and 96.

Qualified opinion on the financial statements

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 on pages 63 to 96:

- present fairly, in all material respects:
    - its financial position as at 30 June 2020; and
    - its financial performance and cash flows for the year then ended; and
- comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards.

Unmodified opinion on the performance information

In our opinion, the performance information of the District Health Board on pages 19 to 55 and 96:

- presents fairly, in all material respects, the District Health Board's performance for the year ended 30 June 2020, 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 17 December 2020. This is the date at which our opinion is expressed.

The basis for our opinion is explained below, and we draw attention to other matters. In addition, we outline the responsibilities of the Board 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 on the financial statements and unmodified opinion on the performance information

As outlined in Note 14 on pages 87 to 89, the District Health Board has been investigating issues with the way it calculates holiday pay entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues.

During the 2019 financial year-end audit, we were unable to obtain sufficient appropriate audit evidence to determine whether the amount of the District Health Board's provision of $4.4 million as at 30 June 2019 was reasonable, because of the work that was yet to be completed to remediate these issues. We accordingly expressed a qualified opinion on the financial statements for the year ended 30 June 2019.

The District Health Board made progress during the 30 June 2020 year in estimating the amount of the provision and we have been able to obtain sufficient appropriate audit evidence that the provision of $10.4 million as at 30 June 2020, is reasonable. However, until the process is completed, there are uncertainties surrounding the amount of the provision.

Our opinion on the current period's financial statements is qualified because of the possible effects of this matter on the comparability of the current period's provision and the 2019 provision.

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 the basis for our qualified opinion on the financial statements and the basis for our unmodified opinion on the performance information.

Emphasis of matters

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

The District Health Board is reliant on financial support from the Crown

Note 1 on page 68 summarises the Board's use of the going concern assumption in preparing the financial statements. The Board has considered the circumstances which could affect the validity of the going concern assumption, including its responsibility to settle the estimated historical Holidays Act 2003 liability. There is uncertainty whether the District Health Board will be able to settle this liability,

if it becomes due within one year from approving the financial statements. To support the Board's going concern assumption, a letter of comfort was obtained from the Ministers of Health and Finance. The letter outlines that the Crown is committed to working with the District Health Board over the medium term to maintain its financial viability. The Crown acknowledges that equity support may need to be provided, where necessary, to maintain viability.

Seismic status of main hospital building

Note 10 on pages 80 to 84 provides information about the seismic status of the District Health Board's main hospital building, the basis used to fair value the building at 30 June 2019, and future decisions about remediation to a higher level of New Build Standards that may impact the carrying value of the building in coming years.

Impact of Covid-19

Note 23 on page 96 of the financial statements and page 36 of the performance information outlines the impact of Covid-19 on the District Health Board.

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

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

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

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

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

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

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

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

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

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

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

- We identify and assess the risks of material misstatement of the financial statements and the performance information, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- We obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the District Health Board's internal control.

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

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

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

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

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

Our responsibilities arise from the Public Audit Act 2001.

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

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

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

Statement of Comprehensive Revenue and Expenses

For the year ended 30 June 2020

	Note	Budget 2020 $000	Actual 2020 $000	Actual 2019 $000
Revenue				
Patient care revenue	2	169,792	174,524	160,875
Interest revenue		24	69	47
Other revenue	2	4,450	4,630	4,853
Total revenue		**174,266**	**179,223**	**165,775**
Expenditure				
Personnel costs	3	52,343	56,147	53,093
Outsourced services		8,390	10,519	8,633
Clinical supplies		11,587	12,035	11,016
Infrastructure and non-clinical expenses		9,016	9,590	7,842
External providers		54,886	57,446	52,989
Inter district flows		42,242	41,404	39,724
Capital charge	4	1,941	1,958	1,776
Interest expense		7	9	14
Depreciation and amortisation expense	10, 11	2,771	2,509	2,092
Impairment expense	10, 11	0	4,223	1,188
Other expenses	5	1,806	1,750	1,806
Total expenses		**184,989**	**197,590**	**180,173**
Surplus/(deficit)		**(10,723)**	**(18,367)**	**(14,398)**
Other comprehensive revenue and expense				
Item that will not be reclassified to surplus/(deficit)				
Revaluation of land and building	16	0	0	5,676
Total other comprehensive revenue and expense		**0**	**0**	**5,676**
Total comprehensive revenue and expense		**(10,723)**	**(18,367)**	**(8,722)**

The accompanying notes form part of the financial statements. Explanations of major variances against budget are provided in note 21.

Statement of Financial Position

As at 30 June 2020

	Note	Budget 2020 $000	Actual 2020 $000	Actual 2019 $000
Assets				
Current assets				
Cash & cash equivalents	6	5	5,920	10
Receivables	7	5,290	5,694	6,435
Prepayments		370	228	320
Investments	8	140	85	185
Inventories	9	1,140	1,082	1,039
Total current assets		6,945	**13,009**	**7,989**
Non-current assets				
Property, plant & equipment	10	40,548	44,976	44,711
Intangible assets	11	10,661	6,521	10,591
Total non-current assets		**51,209**	**51,497**	**55,302**
Total assets		**58,154**	**64,506**	**63,291**
Liabilities				
Current liabilities				
Cash & cash equivalents - overdraft	6	1,341	0	1,799
Payables and deferred revenue	12	10,226	15,441	12,548
Borrowings	13	48	0	85
Employee entitlements	14	9,489	18,311	12,508
Total current liabilities		**21,104**	**33,752**	**26,940**
Non-current liabilities				
Borrowings	13	0	0	54
Employee entitlements	14	710	566	639
Restricted Funds	15	140	85	185
Total non-current liabilities		**850**	**651**	**878**
Total liabilities		**21,954**	**34,403**	**27,818**
Net assets		**36,200**	**30,103**	**35,473**
Equity				
Crown equity	16	104,578	103,572	90,575
Revaluation reserve	16	5,558	11,234	11,234
Retained earnings	16	(73,936)	(84,703)	(66,336)
Total equity		**36,200**	**30,103**	**35,473**

The accompanying notes form part of the financial statements. Explanations of major variances against budget are provided in note 21.

Statement of Changes In Equity

For the year ended 30 June 2020

	Note	Budget 2020 $000	Actual 2020 $000	Actual 2019 $000
Balance at 1 July		**32,923**	**35,473**	**33,198**
Net surplus / (deficit) for the year		(10,723)	(18,367)	(14,398)
Other comprehensive revenue and expense		0	0	5,676
Total comprehensive revenue and expense		(10,723)	(18,367)	(8,722)
Equity injection from the Crown		14,000	13,000	11,000
Repayment of equity to the Crown		0	(3)	(3)
Movements in equity for the year		14,000	12,997	**10,997**
Balance at 30 June	16	**36,200**	**30,103**	**35,473**

The accompanying notes form part of the financial statements. Explanations of major variances against budget are provided in note 21.

Statement of Cash Flows

For the year ended 30 June 2020

	Budget 2020 $000	Actual 2020 $000	Actual 2019 $000
Cash flows from operating activities			
Operating receipts:			
Government & crown agency revenue	170,239	175,294	158,095
Other	4,503	4,684	5,082
Interest received	24	68	55
Payments to suppliers & employees	(179,982)	(180,434)	(169,568)
Capital charge paid	(1,941)	(1,958)	(1,776)
Interest paid	(7)	(9)	(14)
Goods and Services Tax (net)	(400)	184	578
Net cash flows from operating activities	**(7,564)**	**(2,171)**	**(7,548)**
Cash flows from investing activities			
Proceeds from sale of property, plant & equipment	0	0	21
Acquisition of property, plant & equipment	(2,564)	(1,687)	(2,053)
Acquisition of intangible assets	(1,108)	(1,291)	(2,184)
Net cash flows from investing activities	**(3,672)**	**(2,978)**	**(4,216)**
Cash flows from financing activities			
Equity injected	14,000	13,000	11,000
Repayments of loans	(91)	(139)	(84)
Repayment of equity	0	(3)	(3)
Net cash flows from financing activities	**13,909**	**12,858**	**10,913**
Net increase / (decrease) in cash & cash equivalents	**2,673**	**7,709**	**(851)**
Cash & cash equivalents at beginning of year	(4,009)	(1,789)	(938)
Cash & cash equivalents at end of year	**(1,336)**	**5,920**	**(1,789)**

Reconciliation of net deficit to net cash flow from operating activities

	Actual 2020 $000	Actual 2019 $000
Net surplus / (deficit)	**(18,367)**	**(14,398)**
Add/(less) non-cash items		
Depreciation and amortisation expense	2,509	2,092
Donated Assets	0	(11)
Impairment of Intangibles	4,223	1,188
Net movement in non-cash items	**6,732**	**3,269**
Add/(less)items classified as investing or financing activities		
Net (gains)/losses on disposal of property, plant & equipment	0	8
Net movement in investing or financing activities	**0**	**8**
Add/(less) movements in statement of financial position items		
(Increase)/decrease in receivables	741	(2,533)
(Increase)/decrease in inventories	(43)	136
(Increase)/decrease in payables	2,944	2,514
Increase/(decrease) in prepayments	92	(8)
Increase/(decrease) in provisions	5,730	3,464
Net movement in working capital items	**9,464**	**3,573**
Net cash flow from operating activities	**(2,171)**	**(7,548)**

The accompanying notes form part of the financial statements. Explanations of major variances against budget are provided in note 21.

Notes to the Financial Statements for the year ended 30 June 2020

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

The financial statements for the DHB are for the year ended 30 June 2020 and were approved for issue by the Board on 17 December 2020.

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 may be required during 2020/21, 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 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 (NZGAAP).

The financial statements have also been prepared in accordance with and comply with Tier 1 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. The financial statements include the forecast financial statements as per the Statement of Intent 2019/2023 signed 24 June 2019, for comparison with the actual financial statements.

Changes in accounting policies

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

Standards issued and adopted early

Financial Instruments

In January 2017, the XRB issued PBE FRS 9 Financial Instruments. This replaces PBE IPSAS 29 Financial Instrument: 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 Crown's accounting policy for financial instruments. The standard has not had a material effect on the DHB's financial statements.

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:

Amendment to PBE IPSAS 2 Statement of Cash Flows

As an amendment to PBE IPSAS 2 Statement of Cash Flows required entities to provide disclosures that enable users of financial statements to evaluate changes in liabilities arising from financing activities, including both changes arising from cash flows and non-cash changes. This amendment is effective for annual periods beginning on or after 1 January 2021, with early application permitted. The DHB does not intend to early adopt the amendment.

PBE IPSAS 41 Financial Instruments

The XRB issued PBE IPSAS 41 Financial Instruments in March 2019. This standard supersedes PBE IFRS 9 Financial Instruments, which was issued as an interim standard. It is effective for reporting periods beginning on or after 1 January 2022. Although the DHB has not assessed the effect of the new standard, it does not expect any significant changes as the requirements are similar to PBE IFRS 9.

PBE FRS 48 Service Performance Reporting

PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 and is effective for reporting periods beginning on or after 1 January 2021. The DHB has not yet determined how application of PBE FRS 48 will affect its statement of performance.

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 as per the published 2019/20 Statement of Performance Expectations signed in June 2020. These budget figures are different from what was published in the Annual Plan. The budget has been prepared in accordance with NZGAAP, 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 10.
- Impairment of intangible assets – refer to Note 11.
- Measuring long service leave and retirement gratuities – refer to Note 14.
- Holidays Act liability – refer to Note 14.

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 contracts are treated as non-exchange and the total funding receivable under the contract is recognised as revenue immediately, unless there are substantive conditions in the contract. If there are substantive conditions, revenue is recognised when the conditions are satisfied. A condition could include the requirement to provide services to the satisfaction of the funder to receive or retain funding. Revenue for future years is not recognised where the contract contains substantive termination provisions for failure to comply with the service requirements of the contract. Conditions and termination provisions need to be substantive, which is assessed by considering factors such as the past practice of the funder. 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 DHB 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 not recognised as revenue or expenses by the DHB.

Breakdown of patient care and other revenue

i. Patient care revenue

	Budget 2020 $000	Actual 2020 $000	Actual 2019 $000
MoH population-based funding	149,100	149,100	140,017
MoH other contracts	12,880	17,185	13,721
Inter-district flows	4,572	4,563	3,552
ACC contract revenue	2,351	2,489	2,444
Other patient care related revenue	889	1,187	1,141
Total patient care revenue	**169,792**	**174,524**	**160,875**

ii. Other revenue

	Budget 2020 $000	Actual 2020 $000	Actual 2019 $000
Gain on sale of property, plant and equipment	0	4	0
Cash donations and bequests received	88	189	426
Rental revenue	1,275	1,241	1,330
Other revenue	3,087	3,196	3,097
Total other revenue	**4,450**	**4,630**	**4,853**

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

	Budget 2020 $000	Actual 2020 $000	Actual 2019 $000
Salaries and wages	50,898	48,900	48,142
Defined contributions plan employer contributions	1,445	1,517	1,487
Increase/(decrease) in liability for employee entitlements	0	5,730	3,464
Total personnel costs	**52,343**	**56,147**	**53,093**

Employee remuneration

	2020		2019	
	Number of Clinical Staff	Number of Non-Clinical Staff	Number of Clinical Staff	Number of Non-Clinical Staff
$100,000 - $109,999	22	8	16	4
$110,000 - $119,999	15	4	8	1
$120,000 - $129,999	3	4	4	4
$130,000 - $139,999	4	2	2	1
$140,000 - $149,999	1		1	
$150,000 - $159,999	2	2	2	1
$160,000 - $169,999	1		1	
$170,000 - $179,999	2			
$180,000 - $189,999		2	2	1
$190,000 - $199,999	2			
$200,000 - $209,999			1	
$210,000 - $219,999			1	
$220,000 - $229,999	1		2	
$230,000 - $239,999	3			
$240,000 - $249,999	1		3	
$250,000 - $259,999				
$260,000 - $269,999	1		1	1
$270,000 - $279,999				
$280,000 - $289,999	1		2	
$290,000 - $299,999			1	
$300,000 - $309,999	2		1	
$310,000 - $319,999	1		1	
$320,000 - $329,999	3	1	2	
$330,000 - $339,999	3		3	
$340,000 - $349,999	1		1	
$350,000 - $359,999	1		3	
$360,000 - $369,999			1	
$370,000 - $379,999	1			
$380,000 - $389,999			1	
$390,000 - $399,999	1		1	
$400,000 - $409,999	1			
$410,000 - $419,999			1	
$420,000 - $429,999	1		1	
$450,000 - $459,999	1			
$500,000 - $509,999	1			
	76	**23**	**63**	**13**

The impact of MECA changes has resulted in a number of nurses having their salaries increased from below $100 to over $100k, hence the increase in clinical staff in the $100k to $120k range increasing from 24 to 37.

In the case of non-clinical staff the impact of salary increases has also meant that staff have gone from below $100 to over $100k, some of these are normal increases and some have been as the result of changes to roles.

Termination payments

During the year ended 30 June 2020, four employees received compensation and other benefits in relation to cessation totalling $250,122 (2019: one employee received a total of $142,500).

Board member remuneration

	2020 Board Fee	2020 Committees	2020 Total Fees	2019 Total Fees
Sir Paul Collins (Chairman)	32,566	1,250	33,816	37,142
Dr Tony Becker (Deputy Chair from Dec)	10,749	947	11,696	0
Leanne Southey (FRAC Chair)	17,732	3,125	20,857	24,310
Ronald Karaitiana (HAC Chair)	15,818	2,250	18,068	21,011
Joy Cooper	8,599	1,000	9,599	0
Yvette Grace	9,102	750	9,852	0
Dr Norman Gray	9,102	1,000	10,102	0
Jill Pettis	8,599	0	8,599	0
Helen Pocknall	9,102	1,000	10,102	0
Ryan Soriano	8,599	0	8,599	0
Jill Stringer	8,599	1,000	9,599	0
Derek Milne	6,905	813	7,718	17,573
Nick Crozier	6,905	500	7,405	18,448
Liz Falkner	6,905	0	6,905	17,948
Jane Hopkirk	6,905	750	7,655	17,198
Rick Long	6,905	1,250	8,155	19,198
Fiona Samuel	6,905	0	6,905	17,948
Alan Shirley	6,905	500	7,405	17,448
Adrienne Staples	6,905	750	7,655	18,198
TOTAL	**193,807**	**16,885**	**210,692**	**226,422**

There have been no payments made to committee members appointed by the Board who are not Board members during the financial year. In 2019/20 a voluntary reduction in board fees was taken by some members.

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 (2019:$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 2020 was 6% (2019: 6%).

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

	Budget 2020 $000	Actual 2020 $000	Actual 2019 $000
Operating lease and rental expenses	1,368	1,315	1,388
Audit fees (Audit NZ for annual financial statements)	127	144	120
Audit fees (CRTAS for other assurance services)	65	45	49
Impairment of receivables (bad & doubtful debts)	0	24	10
Board member fees & expenses	246	222	231
Loss on disposal of property, plant and equipment	0	0	8
Total other expenses	**1,806**	**1,750**	**1,806**

Operating leases as lessee

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

	Actual 2020 $000	Actual 2019 $000
Not later than one year	881	976
Later than one year and not later than five years	947	1,334
Later than five years	58	53
Non-cancellable operating leases	**1,886**	**2,363**

The groups leases a variety of clinical 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

	Actual 2020 $000	Actual 2019 $000
Current Assets:		
Cash on hand	2	4
Westpac account	1	6
Bank - BNZ / NZHP Sweep	5,917	0
Current Liabilities:		
Bank overdraft - BNZ / NZHP Sweep	0	(1,799)
Total cash and cash equivalents	**5,920**	**(1,789)**

While cash and cash equivalents at 30 June 2020 are subject to the expected credit loss requirement of PBE IFRS 9, no loss allowance has been recognised because the estimated loss allowance or credit losses is trivial.

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 which for 2019/20 would have been $6.918m. As at 30 June 2020 the available overdraft limit remained as $5.642m with the overdraft limit not being updated with NZHPL during the year. (2019:$5.642 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 15.

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 an allowance for credit losses. The DHB applies the simplified expected credit loss model of recognising lifetime expected credit losses for receivables.

In measuring expected credit losses, short-term receivables have been assessed on a collective basis as they possess share credit risk characteristics. They have been grouped based on the days past due.
Short-term receivables are written off when there is no reasonable expectation of recovery. Indicators that there is no reasonable expectation of recovery include the debtor being in liquidation.

Previous accounting policy for impairment of receivables
In the previous year, the allowance for credit losses was based on the incurred credit loss model. An allowance for credit losses was recognised only when there was objective evidence that the amount due would not be fully collected.

Breakdown of receivables and further information

	Actual 2020 $000	Actual 2019 $000
Receivables from MoH	2,295	2,931
Other receivables	705	335
Other accrued revenue	2,763	3,215
Less: Allowance for credit losses	(69)	(46)
Total receivables	**5,694**	**6,435**
Receivables from the sale of goods and services (exchange transactions)	80	46
Receivables from non- exchange transactions	5,614	6,389
Total receivables	**5,694**	**6,435**

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

	Actual 2020 $000s Gross	Actual 2020 $000s Impairment	Actual 2020 $000s Net	Actual 2019 $000s Gross	Actual 2019 $000s Impairment	Actual 2019 $000s Net
Not past due	5,225	0	5,225	6,296	0	6,296
Past due 1-30 days	13	0	13	94	(7)	87
Past due 31-60 days	438	(42)	396	12	(2)	10
Past due > 60 days	87	(27)	60	79	(37)	42
Total	**5,763**	**(69)**	**5,694**	**6,481**	**(46)**	**6,435**

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 2020 $000s	Actual 2019 $000s
Balance at 1 July	46	63
Additional provisions made/(provisions released)	25	10
Receivables written off	(2)	(27)
Balance at 30 June	**69**	**46**

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

	Budget 2020 $000	Actual 2020 $000	Actual 2019 $000
Current Portion			
Term deposits with maturites less than 3 months	98	85	98
Term deposits with maturites less than 12 months	42	0	87
Total investments	**140**	**85**	**185**

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 average 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

	Budget 2020 $000	Actual 2020 $000	Actual 2019 $000
Central stores	468	533	467
Pharmaceuticals	158	135	158
Theatre supplies	332	332	332
Other inventories	142	142	142
Less: provision for obsolete stock	(60)	(60)	(60)
Total trade inventories	**1,140**	**1,082**	**1,039**

There was no write-down of inventories held for distribution (2019:$60k). There have been no reversals of write-downs.

No inventories are pledged as security for liabilities (2019:$nil), however, some inventories are subject to retention of title clauses.

10. 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)	1 to 50 years	1% - 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.

Wairarapa DHB engaged an Independent Registered Valuer (CBRE Limited) to revalue buildings to fair value as at 30 June 2019. The buildings are specialised and were valued using Optimised Depreciated Replacement Cost (ODRC). Optimisation is applied via replacement with modern equivalent material and construction techniques.

The valuation was completed on the basis that the main hospital building is 100% New Building Standard (NBS) on an Importance Level 4 (IL4) basis. Therefore the revalued amount represents the cost of replacing the existing the building with a modern day equivalent building of the same age.

The DHB also received a detailed seismic assessment on the 28 June 2019, which concludes that the main hospital (other than some peripheral structures that are planned to be strengthened) has met the minimum legal seismic requirements of NBS of 34%. However, it also concludes that the building would not meet its service requirements in the event of a 1 in 500 year earthquake.

The Board is confident that this issue does not affect the current operation and services provided by the Hospital, and it is considering what it can do to improve the building.

In 2019/20 the DHB attained further information on cost estimates to remediate (parts of the hospital) to higher levels of NBS. It requires further review and strategic planning to understand the impact, urgency and relevancy of any further seismic strengthening for the current and future service requirements. Pending the outcome of this review the DHB has not made any decisions that may impact the carrying value of the buildings in coming years. Once the outcome of this process known the Board will decide what, if any, additional remediation is required.

Land

The value of the land has been determined with reference to market data analysed to a rate per square metre. Factors taken into account when assessing the value include shape and size of the land blocks, zoning, title implications and subdivision/development potential.

Buildings

Specialised buildings have been valued using optimised depreciated replacement cost because no reliable market data is available for such buildings.

Depreciated replacement cost is determined using a number of significant assumptions, which include:

- The improvements are valued using the replacement cost. The notional replacement cost estimates reflect current materials and technology that provide the same level of utility as the present assets. Reference has been made to industry data and information regarding the original construction costs and component breakdowns.
- The replacement cost has been assessed based on current building costs in the local region, and also the national market. It has been derived from recent construction contracts of modern equivalent assets and Property Institute of New Zealand cost information. Construction costs for modern hospital buildings range from $4,500 to $5,000 per square metre excluding fees.
- Depreciation is then applied on a straight-line basis following the indicative life ranges as provided by independent advice, industry experience together with reference to the Treasury Guidelines. Where appropriate variance has been made for such factors as upgrading, level of maintenance, standard of construction and use.
- The depreciated replacement costs is componentised into building structure, services and in some circumstance's fit out. Services are further componentised into categories where appropriate.
- The remaining useful life of assets adopted in the valuation are a reflection of the indicative life adjusted for relevant factors as indicated. Building assets have been valued on a basis of the optional degree of componentisation being structure, services and fit-out.

The valuation of the buildings as at 30 June 2019 were impaired by $650k to recognise the estimated costs of doing further seismic strengthening work.

Non-specialised buildings, that is buildings at our Greytown site, have been valued using market-based evidence as this enables the value of the asset to be reliably determined. This has involved the comparison of land and buildings with sale of relevant property analysed to a rate per square metre.

Movements for each class of property, plant and equipment are as follows:

	Land	Buildings	Clinical equipment	Other equipment	Information technology (incl WIP)	Motor vehicles	Total
	$000	$000	$000	$000	$000	$000	$000
Cost / valuation							
Balance at 1 July 2018	2,395	37,462	8,624	2,106	508	749	51,844
Additions and Capitalisations	0	1,041	795	70	374	0	2,280
Revaluation increases	495	487	0	0	0	0	982
Asset Impairment	0	(650)	0	0	0	0	(650)
Disposals	0	0	(1,315)	(330)	(23)	0	(1,668)
Balance at 30 June 2019	**2,890**	**38,340**	**8,104**	**1,846**	**859**	**749**	**52,788**
Balance at 1 July 2019	2,890	38,340	8,104	1,846	859	749	52,788
Additions and Capitalisations	0	417	1,126	29	211	0	1,783
Asset Impairment	0	0	0	0	0	0	0
Balance at 30 June 2020	**2,890**	**38,757**	**9,230**	**1,875**	**1,070**	**749**	**54,571**
Accumulated Depreciation & impairment losses							
Balance at 1 July 2018		3,918	6,435	1,780	339	551	13,023
Depreciation charge for the year		787	431	53	56	61	1,388
Elimination on disposal		0	(1,287)	(330)	(23)	0	(1,640)
Elimination on revaluation		(4,694)	0	0	0	0	(4,694)
Balance at 30 June 2019		**11**	**5,579**	**1,503**	**372**	**612**	**8,077**
Balance at 1 July 2019		11	5,579	1,503	372	612	8,077
Depreciation charge for the year		790	451	55	162	60	1,518
Impairment		0	0	0	0	0	0
Balance at 30 June 2020		**801**	**6,030**	**1,558**	**534**	**672**	**9,595**
Carrying amounts							
At 1 July 2018	2,395	33,544	2,189	326	169	198	38,821
At 30 June 2019	**2,890**	**38,329**	**2,525**	**343**	**487**	**137**	**44,711**
At 1 July 2019	2,890	38,329	2,525	343	487	137	44,711
At 30 June 2020	**2,890**	**37,956**	**3,200**	**317**	**536**	**77**	**44,976**

The DHB has contractual commitments of $0.722m (2019:$nil) in relation to clinical equipment.

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.

11. 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 10. 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

	Intangible Assets $000	Work in progress $000	Total $000
Cost			
Balance at 1 July 2018	2,969	9,010	11,979
Additions	127	1,474	1,601
Assets Impaired	(538)	0	(538)
Additions (transfer)	4,244	(4,244)	0
Balance at 30 June 2019	**6,802**	**6,240**	**13,042**
Balance at 1 July 2019	6,802	6,240	13,042
Additions	0	1,144	1,144
Additions (transfer)	2,468	(2,468)	0
Assets Impaired	(39)	(4,184)	(4,223)
Balance at 30 June 2020	**9,231**	**732**	**9,963**
Accumulated amortisation & impairment losses			
Balance at 1 July 2018	1,747	0	1,747
Amortisation charge for the year	704	0	704
Balance at 30 June 2019	**2,451**	**0**	**2,451**
Balance at 1 July 2019	2,451	0	2,451
Amortisation charge for the year	991	0	991
Impairment	0	0	0
Balance at 30 June 2020	**3,442**	**0**	**3,442**
Carrying amounts			
Balance at 1 July 2018	1,222	9,010	10,232
Balance at 30 June 2019	4,351	6,240	**10,591**
Balance at 1 July 2019	4,351	6,240	10,591
Balance at 30 June 2020	**5,789**	**732**	**6,521**

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 $0.495m (2019: $0.921m) 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 2020 the group has paid $5.657 million (2019: $5.657m) 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 2020 no further impairment has been recognised (2019: $0.538 million).

Central Region IT Projects

An impairment of ($4.223m) (2019: nil) has been recognised in relation to intangible assets / work in progress in relation to Regional projects. This is to correct the remaining useful life of the assets based on information provided by Central Regional Technical Advisory Services.

12. Payables and deferred revenue

Accounting policy

Short-term payables are recorded at the amount payable.

Breakdown of payables and deferred revenue

	Actual 2020 $000	Actual 2019 $000
Payables and deferred revenue under exchange transactions		
Trade creditors and accruals	4,058	3,318
Revenue received in advance	9	9
Total payables and deferred revenue under exchange transactions	4,067	3,327
Payables and deferred revenue under non-exchange transactions		
Trade creditors and accruals	9,157	7,304
GST and other taxes	1,904	1,686
Revenue received in advance	313	231
Total payables and deferred revenue under non-exchange transactions	11,374	9,221
Total payables and accruals	**15,441**	**12,548**

13. 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

	Budget 2020 $000	Actual 2020 $000	Actual 2019 $000
Current portion			
Privately sourced loans	48	0	85
Non-current Portion			
Privately sourced loans	0	0	54
Total borrowings	**48**	**0**	**139**
Repayable as follows:			
Less than one year	48	0	85
One to two years	0	0	54
Greater than two years	0	0	0
Total borrowings	**48**	**0**	**139**

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 had 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 repaid the loan during the year.

14. 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, annual 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 0.5% for long service leave (2019: 1.3%) and 0.8% for retirement gratuities (2019: 1.5%) and a salary increase assumption of 2% (2019: 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% (2019: 50%) of the full entitlement. This utilisation assumption is based on recent experience.

Holiday pay provision

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

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

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

The remediation project associated with the MOU is a significant undertaking and work to assess all non-compliance will continue through the 2020/21 financial year. The review process agreed as part of the MOU will roll-out in tranches to the DHBs and NZBS, expected to be over 18 months although DHB readiness and availability of resources (internal and external to the DHB) may determine when a DHB can commence the process. The final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed.

Notwithstanding, as at 30 June 2020, in preparing these financial statements, the Wairarapa DHB recognises it has an obligation to address any historical non-compliance under the MOU and has made estimates and assumptions to determine a potential liability based on its own review of payroll processes which identified instances of non-compliance with the Act and the requirements of the MOU. This was based on selecting a sample of current and former employees; making a number of early assumptions; calculating an indicative liability for those current and former employees; and extrapolating the result. The provision was increased by a further $5.206m during the 2019/20 year.

This indicative liability amount is the DHB's best estimate at this stage of the outcome from this project. However, until the project has progressed further, there remain substantial uncertainties.

The estimates and assumptions may differ to the subsequent actual results as further work is completed and result in further adjustment to the carrying amount of the provision liabilities within the next financial year.

In addition to the provision for payments to current and former employees a provision has been made of $0.700m for the estimated costs for systems rectification and remediation, which is included under payables and deferred revenue.

	Actual 2020 $000	Actual 2019 $000
Current portion		
Accrued salary and wages	2,068	1,693
Annual leave	4,263	3,926
Provision under Holidays Act	9,675	4,469
Stat Days and Days in Lieu	1,101	1,124
Sick leave	95	109
Maternity grant	12	12
Continued medical education costs	299	358
Long service leave	498	449
Retirement gratuities	300	368
Total current portion	18,311	12,508
Non-current Portion		
Long service leave	318	310
Retirement gratuities	248	329
Total non-current portion	566	639
Total employee entitlements	**18,877**	**13,147**

15. Restricted Funds

	Actual 2020 $000	Actual 2019 $000
Balance at beginning of year	185	343
Funds received	1	3
Interest received	3	9
Funds spent	(104)	(170)
Balance at end of year	**85**	**185**

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.

16. 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.

	Crown equity $000	Property revaluation reserve $000	Retained earnings $000	Total $000
Balance at 1 July 2018	79,578	5,558	(51,938)	33,198
Total recognised revenue & expenses	0	0	(14,398)	(14,398)
Contribution from the Crown	11,000	0	0	11,000
Repayment to the Crown	(3)	0	0	(3)
Movement in revaluation of land & buildings	0	5,676	0	5,676
Balance at 30 June 2019	**90,575**	**11,234**	**(66,336)**	**35,473**
Balance at 1 July 2019	90,575	11,234	(66,336)	35,473
Total recognised revenue & expenses	0	0	(18,367)	(18,367)
Contribution from the Crown	13,000	0	0	13,000
Repayment to the Crown	(3)	0	0	(3)
Movement in revaluation of land & buildings	0	0	0	0
Balance at 30 June 2020	**103,572**	**11,234**	**(84,703)**	**30,103**

Capital management

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

The DHB 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 DHB has complied with the financial management requirement of the Crown Entities Act 2004 during the year.

The DHB 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.

17. Contingencies

Contingent liabilities and assets

The DHB currently has no legal claims against it and therefore assess that there are no contingent liabilities as at 30 June 2020 (2019: $nil). Likewise, the DHB has no contingent assets as 30 June 2020 (2019: $nil).

18. 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:

	Actual 2020 $000	Actual 2019 $000
Board Members		
Remuneration	211	226
Full-time equivalent members	0.89	0.89
Leadership Team		
Remuneration	2,040	1,751
Full-time equivalent members	8.4	8.4
Total key personnel remuneration	**2,251**	**1,977**
Full-time equivalent personnel	**9.3**	**9.3**

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.

19. Events after balance date

There were no significant events subsequent to balance date.

20. Financial Instruments

20A Financial instrument categories

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

	Actual 2020 $000s	Actual 2019 $000s
Financial assets measured at amortised cost:		
Cash and cash equivalents	5,919	10
Trade and other receivables	5,694	6,435
Investments	85	185
Total financial assets measured at amoritised cost	**11,698**	**6,630**
Financial liabilities measured at amortised cost:		
Payable & accruals (excluding deferred revenue and taxes)	13,216	10,622
Cash and cash equivalents -Overdraft	1	1,799
Borrowings - Privately sourced loans	0	139
Total financial liabilities measured at amortised cost	**13,217**	**12,560**

20B 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 (2019:$nil).

20C 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 $220k 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.

Investments and forward foreign exchange contracts are entered into only with registered banks that have a rating of at least AA- by Standard and Poor's.

Concentrations of credit risk for receivables are limited due to the large number and variety of customers. The Ministry of Health is the largest debtor (approximately 40%). 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 instruments that give rise to credit risk.

Credit quality of financial assets

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

	Actual 2020 $000s	Actual 2019 $000s
Counterparties with credit ratings		
Cash at bank and investments		
AA-	86	191
Total cash at bank and on hand, receivables and investments - with credit ratings	86	191
Counterparties without credit ratings		
Bank - BNZ / NZHP Sweep	5,917	0
Receivables		
Existing counterparty with no defaults in the past	5,694	6,435
Total cash at bank, receivables and investments - without credit ratings	**11,611**	**6,435**

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 an 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.

	Carrying amount $000s	Contractual cash flows $000s	Less than 6 months $000s	6-12 months $000s	More than 1 year $000s
2019					
Payables & accruals (excluding deferred revenue and taxes)	10,622	10,570	10,570	0	0
Borrowings - Privately sourced loans	139	146	49	49	48
Totals	**10,761**	**10,716**	**10,619**	**49**	**48**
2020					
Payables & accruals (excluding deferred revenue and taxes)	13,216	13,216	13,216	0	0
Totals	**13,216**	**13,216**	**13,216**	**0**	**0**

21. Explanation of major variances against budget

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

Net Result

Overall the net result of ($18.367m) for WDHB was ($7.644m) adverse to budget. The net result this year was heavily impacted by $5.706m of additional costs related to the Holidays Act and asset impairments of $4.223m.

Revenue

Revenue was $4.957m favourable with $4.305m of additional revenue received from the Ministry of Health which included: $1.453m in relation to Covid-19 funding; $0.340m additional funding for capital charge cost: $0.224m, for mental health services; $0.244m for in-between travel, with revenue from other sources including ACC revenue and other DHBs of an additional $0.652m.

Expenditure

Expenditure was ($12.601m) more than budgeted including:

- ($3.804m) higher personnel costs including:
    - $1.202m lower personnel costs because of medical staff vacancies which was partly offset by higher nursing costs
    - ($5.006m) as a further adjustment under the Holidays Act to recognise the remediation costs payable to employees.
- ($2.129m) higher outsourced costs which includes ($2.220m) of outsourced personnel costs for locum doctors to cover vacancies and leave.
- ($2.560m) higher funder expenditure including covid-19 related costs and mental health services which was covered by additional funding.
- $0.838m lower IDF outflows payable to other DHBs for services received for our population.
- ($4.223m) impairment of intangible assets to reflect the remaining useful life of some assets.
- ($0.700m) provision for systems rectification and remediation costs in relation to the Holidays Act.

Assets

- Receivables was $0.404m higher than budget but was $0.741m lower than last year because of lower amounts owing to us from the Ministry of Health and Pharmac.
- Property, plant and equipment was $4.428m higher than budget with a net increase from 2018/19 of $0.265m. Delays in the purchase of clinical equipment resulted in purchases for the year of $1.783m compared to a budget of $2.564m
- Intangible assets was ($5.111m) lower than budget due to planned expenditure on IT projects being deferred and the impairment of some assets. Total additions during the year was $1.144m compared to a budget of $1.108m.

Liabilities

- Payables was $5.215m higher than budget and increased by $2.893m from last year end including $0.744m costs relating to Covid-19 and $0.264m of other funder related cost, an increase of $0.623m payable to other DHBS for services received, and a new provision of $0.700m for system rectification costs in relation to payroll systems.
- The increase in employee entitlements of $5.730m from 2018/19 includes a further increase of $5.206m in the provision for costs payable under the Holidays Act.

22. Summary cost of services

	Budget 2020 $000	Actual 2020 $000	Actual 2019 $000
Revenue			
Prevention services	4,332	5,225	5,169
Early detection and management services	31,014	29,335	27,784
Intensive assessment and treatment services	106,208	113,801	102,989
Rehabilitation and support services	32,711	30,863	29,833
Total revenue	**174,265**	**179,224**	**165,775**
Expenditure			
Prevention services	4,626	5,756	5,203
Early detection and management services	30,169	29,767	28,107
Intensive assessment and treatment services	121,821	133,118	119,782
Rehabilitation and support services	28,372	28,950	27,081
Total expenditure	**184,988**	**197,591**	**180,173**
Land and Buldings revaluation not allocated	0	0	5,676
Total comprehensive revenue and expense	**(10,723)**	**(18,367)**	**(8,722)**

23. COVID-19

Wairarapa District Health Board is deemed an essential service and operations continued during the COVID-19 alert levels, including the full lockdown period. Safe working protocols were maintained with support staff working remotely where possible and frontline staff using personal protective equipment where appropriate.

Statement of Comprehensive Revenue and Expenses

COVID-19 has not materially impacted the net financial result of the DHB of COVID-19. Additional funding of $1.453m was received from the Ministry of Health to cover community related COVID-19 costs.

Expenses – The DHB incurred total costs of $2.286m costs in relation to COVID-19, however this total was not all additional costs as it includes the reallocation of personnel costs where staff were specifically allocated to COVID-19 work.

Statement of Financial Position

Wairarapa District Health Board has considered the impact of COVID-19 on the valuation of the Assets and Liabilities as at 30 June 2020. Based on the information available at the time of preparing these statements, COVID-19 has had no material impact on the Statement of Financial Position.

Capital spend – there was additional clinical equipment purchased of $0.233m to ensure adequate equipment was available.