Wairarapa DHB Annual Report 2020/21

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

Contents

Chair & Chief Executive's Foreword

As I gather my thoughts to introduce this year's annual report I remember doing the same last year, and I recall my opening statement that it had been a year like no other. Today, the challenges that I reflected on then have only amplified and so, once again, I introduce our 'year like no other.'

I am proud to deliver this Annual Report. I am proud of the achievements we have made, of the people that have engineered them, and of those that bring our service improvements to life on a daily basis in the course of their work.

The word 'resilient' is often used today, but it seems to me the most appropriate way to describe the indomitable workforce that powers the Wairarapa District Health Board machine. In the thick of pandemic resurgence planning and response, rolling out a significant two-dose vaccination campaign, and managing through service constraints and industrial activity, we have continued to maintain a tightly controlled financial position and, on top of it all, provide excellent care for our community.

There is transformational change ahead. From 1 July 2022 Health New Zealand will take on the responsibilities of the 20 DHBs in New Zealand. While Health New Zealand is a national entity it will operate through four regions with the Wairarapa being in the Central region. The "win win" for us will be a continuation of the high standard of services we currently enjoy in the Wairarapa coupled with benefits from a focus on a strong joined up regional approach. What I can say, with the utmost confidence, is that we have the right team on board to bring those benefits to the fore.

Sir Paul Collins, Board Chair

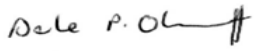
At Wairarapa DHB, we have remained steadfast on our quality improvement journey, despite the distractions of the COVID-19 response. We worked hard to catch up on our surgeries after the initial pandemic induced backlog, and succeeded. We are committed to putting our patients at the centre of all we do, and we are agile. We can work at pace. We can work together. We do not get distracted and we bounce back. I call it our 'can do' attitude, and it serves us well.

The COVID-19 vaccination programme rollout is a priority for the DHB. Being vaccinated is the one thing we can all do to gain more protection against the virus, which will lead to more certainty for the future. We established our COVID-19 vaccination clinics in April 2021 and by the end of June 12,069 vaccine doses had been delivered. We have a great team continuing to work hard to increase coverage levels across the Wairarapa.

Our planning focuses on collaboration which, in a small DHB, is critical to our success. We continue to work closely with our regional neighbouring DHBs – enabling better access to all the services our population needs and also aligning with the new direction of Health New Zealand and its focus on planning and delivery at a regional and locality level.

To be responsive and effective, and achieve the equitable health outcomes our community needs, we have to work by engaging the whole of health system. To some degree, the pandemic has lent a hand in ensuring that good collaboration takes place. It has required us all, across all sectors, to band together with the one aim – to protect the health of our people.

Within our DHB team, we continue on our own quality journey, with refreshed values that clearly describe the way we want to work and who we want to be. We are resolute in our aim to always make a difference in all that we do, and I am grateful to lead an organisation that demonstrates that every single day.
Looking back on the 2020/21 year, I see all the silver linings. Our commitment to our community has not wavered and we continue to prove that we can deliver what is required, and do it with pride.



Dale Oliff, Chief Executive

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
Together we MAKE a difference
Manaakitanga - Respect We care for each other, showing kindness and empathy in all that we do
Auaha - Innovation We are committed to finding future focused solutions and take personal responsibility to be better every day
Kotahitanga - Relationships Our diversity is our strength, we back each other and work together in partnership
Eke Taumatua - Equity We are committed to doing the right thing by ensuring equity and Hauora are at the heart of everything we do

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 2021.

	4,001 hospital operations and procedures
	10,346 patients with E-health access
	273,983 GP visits
	35,330 hospital outpatient appointments
	6,131 attended ambulance jobs in the Wairarapa
	492 babies were born in Wairarapa Hospital
	35,753 xrays and scans
	10,284 hospital admissions

Our future

COVID-19

COVID-19 has, in many respects, changed the landscape for health. The COVID-19 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 have 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-19, 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-19 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 2021 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.

Name	Appointment Date	Health Sector Interests Disclosed	Other Interests Disclosed
Board Member			
Sir Paul Collins *Board Chair*	December 2019	• Director, 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) • Director of Technical Advisory Services Limited (TAS)	• Director of: Active Equity Holdings Limited (Chair) Hurricanes GP Limited Ides Limited Shott Beverages Limited • Director and shareholder of: AEL Managers Limited Beverage Holdings Limited Cohiba Traders Limited Ecopoint Limited Tofino Trustee Limited
Dr Tony Becker *Deputy Chair*	December 2019	• Shareholder and Director (Clinical) Masterton Medical Limited • Shareholder and Director Wairarapa Skin Clinic • Wairarapa GP Trustee Tū Ora Compass Health	• 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
Helen Pocknall *Member*	December 2019	• Contractor with Ministry of Health	• Nil Interests declared
Ryan Soriano *Member*	December 2019	• Clinical Services Manager, HealthCare NZ	• Member, Board Trustee for Saint Patrick School Board, Masterton • Wife Employed as Senior Caregiver at Lansdowne Park Aged Care Facility
Joy Cooper *Member*	December 2019	• Nil Interests declared	• Chairperson Wharekaka Trust Board Incorporated
Jill Stringer *Member*	December 2019	• Nil Interests declared	• Director, Touchwood Services Limited • Husband employed by Rigg-Zschokke Ltd • Trustee, Wellington Welfare Guardian Trust
Jill Pettis *Member*	December 2019	• Nil Interests declared	• Nil Interests declared

Name	Appointment Date	Health Sector Interests Disclosed	Other Interests Disclosed
Board Member			
Yvette Grace *Member*	December 2019	• Member, Hutt Valley District Health Board • Member Concurrent FRAC Hutt Valley and Capital and Coast DHBs • Member 3DHB Disabilities Committee for Hutt Valley DHB • Member Wairarapa CPHAC Committee • He Kāhui Wairarapa, Board member • Te Hauora Rūnanga o Wairarapa, Board member • Wairarapa Child and Youth Mortality Review Committee, Local Review member	• 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 • Trustee House of Science Wairarapa • Trustee Equippers Church and Oasis Trust • House of Science, Wairarapa Trustee
Leanne Southey *Board Member*	December 2019	• Chair, Wairarapa District Health Board, Finance Risk & Audit Committee • Chartered Accountant to Health Professionals including Selina Sutherland Hospital and Selina Sutherland Trust • Trustee, Wairarapa Community Health Trust • Board Member, Wellington Free Ambulance	• Chair of Lands Trust Masterton *(15 February 2016)* • Director, Southey Sayer Limited • Shareholder of Mangan Graphics Ltd • Director of Wellington Water Ltd
Ronald Karaitiana *Board Member*	December 2019	• Member, Wairarapa District Health Board • Member, Wairarapa Te Iwi Kainga Committee • Member, Wairarapa District Health Board, Finance Risk & Audit Committee • Extended family members work in varying roles at DHB • Chief Executive, Te Hauora Runanga o Wairarapa • Whanau ora Collective Member Te Hauora and Whaiora via Te Pou Matakana • Board Director from Presbytarian Support Central	• Akura Lands Trust Chairman • RK Consulting Ltd, Business owner
Dr Norman Gray *Board Member*	December 2019	• Association of Salaried Medical Specialists (ASMS) Branch Representative for Wairarapa • Emergency Consultant and Clinical Lead, Wairarapa DHB • Board member MidCentral DHB	• 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 2020-21 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 2021

Board Members from July 2020 to June 2021	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 and committee meeting attendances for the year ended 30 June 2021

Board Members from July 2020 to June 2021	Board (11)	CPHAC (10)	DSAC (3)	FRAC (11)
Paul Collins (Chairperson)	11	0	0	11
Tony Becker (Deputy Chair & CPHAC Chair)	10	8	0	0
Joy Cooper	11	10	0	0
Norman Gray	9	0	0	8
Helen Pocknall	10	8	0	0
Ryan Soriano	11	0	3	0
Leanne Southey (FRAC Chair)	10	0	0	11
Jill Stringer	10	10	3	0
Yvette Grace	9	10	3	0
Ron Karaitiana	10	0	0	11
Jill Pettis	11	0	3	0

Our People

In the last 12 months the DHB has continued its journey to reshape how health care is delivered across the Wairarapa. The primary objective, which is also echoed in the wider NZ Health Reforms, is to move away from a hospital centric model to an across-system health service that delivers care to where the patient is.

A key enabler to achieving this are our organisational values and the culture they build. We have taken the opportunity to refresh the values for the Wairarapa District Health Board to align with our Strategic Direction - Hauora Mō Tātou. This ensures the 'what' we do and 'how' we do it are intrinsicly linked to maximize outcomes for our community.

COVID-19 has continued to have a significant presence over 20/21 in terms of our ongoing COVID-19 response and standing up a regional vaccination programme. This has seen us place an increased emphasis on staff wellbeing and building resilience to ensure staff have the resources, training and support to navigate the challenges and changes to the ways we work.

Inclusion and Diversity

We want the Wairarapa DHB to be a safe and inclusive place to work, where people have a strong sense of belonging, are comfortable bringing their whole selves to work, feel safe to raise concerns around non-inclusive behavior and are supported in their opportunities for growth. We are committed to being a good employer that provides equal employment opportunities and creates an environment where employees feel valued and respected, and where difference is celebrated and diversity encouraged.

Organisational Capability

As part of setting our people and the DHB up for success we have actively worked to get the People and Capability foundations in place. This has included updating all people related policies and enhancing the recruitment and on-boarding processes. We have refreshed key documents and artifacts to integrate our values, ensure we welcome new staff well and provide clarity around roles, including setting expectations, measuring performance and developing capability.

With the changes of the NZ Health Reforms coming into effect from July 2022, we have been working with the Executive Leadership Team to strengthen our capability to effectively lead change while maintaining a focus on the wellbeing of staff. This programme will be rolled out to all People Leaders over the coming year, supported by the introduction of a Wellbeing Survey that will inform individual, team and DHB wide wellbeing initiatives.

We have also continued to work on significant national projects around the Holidays Act and Pay Equity ensuring the supporting systems and processes are developed and implemented for Wairarapa DHB.

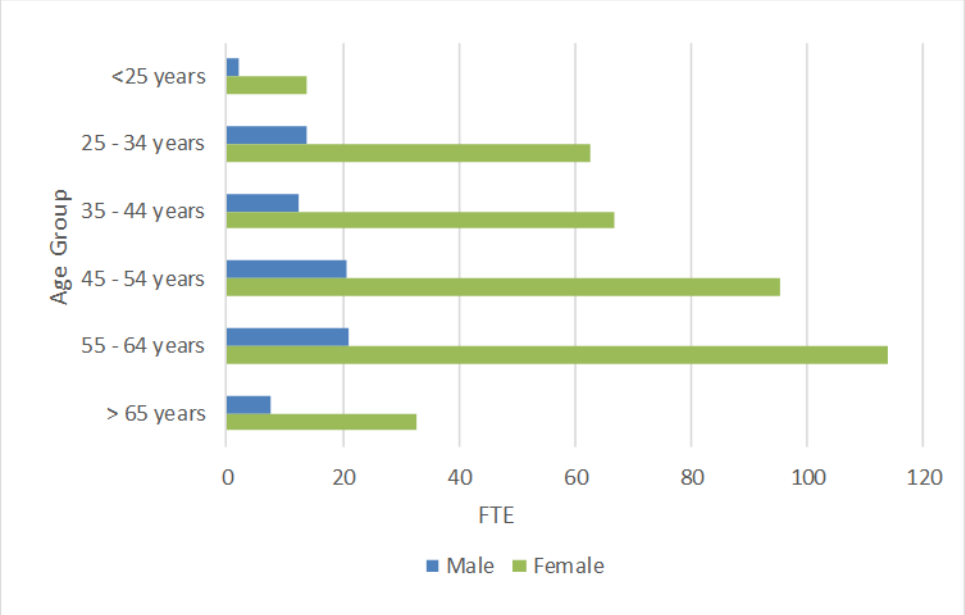
Workforce 2021

Full Time Equivalent staff numbers 2012-2021

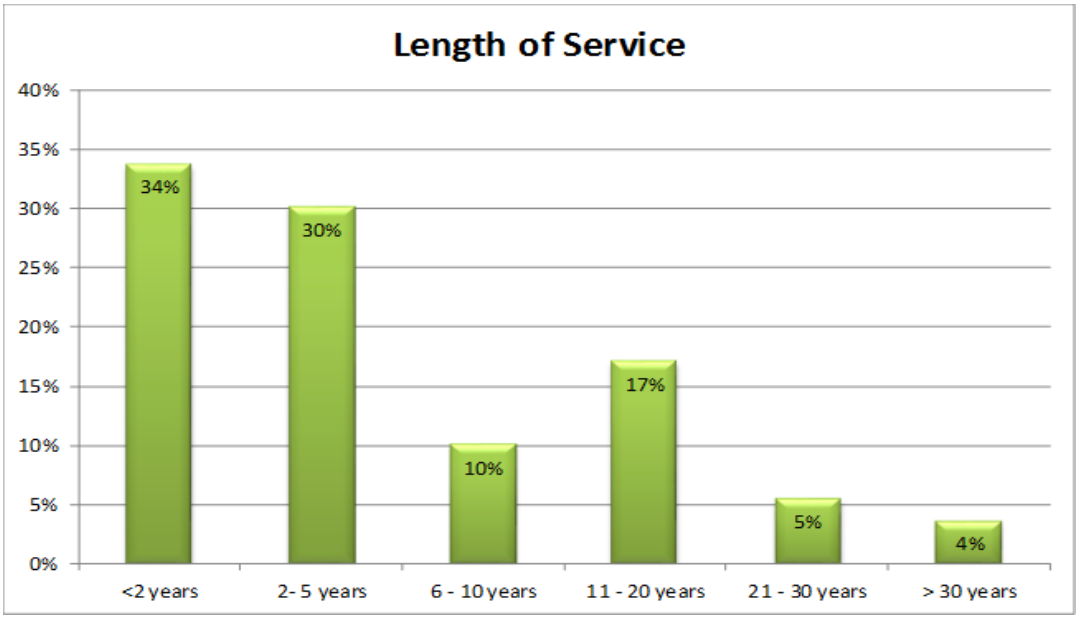
Full Time Equivalent Staff Numbers

	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012
Medical	40	42	45	46	43	42	40	36	39	38
Nursing	239	253	253	243	236	223	215	205	204	198
Allied Health	67	75	73	71	69	69	71	70	82	85
Other	119	124	125	126	111	108	102	106	101	120
Total	466	494	496	486	458	443	429	417	426	441

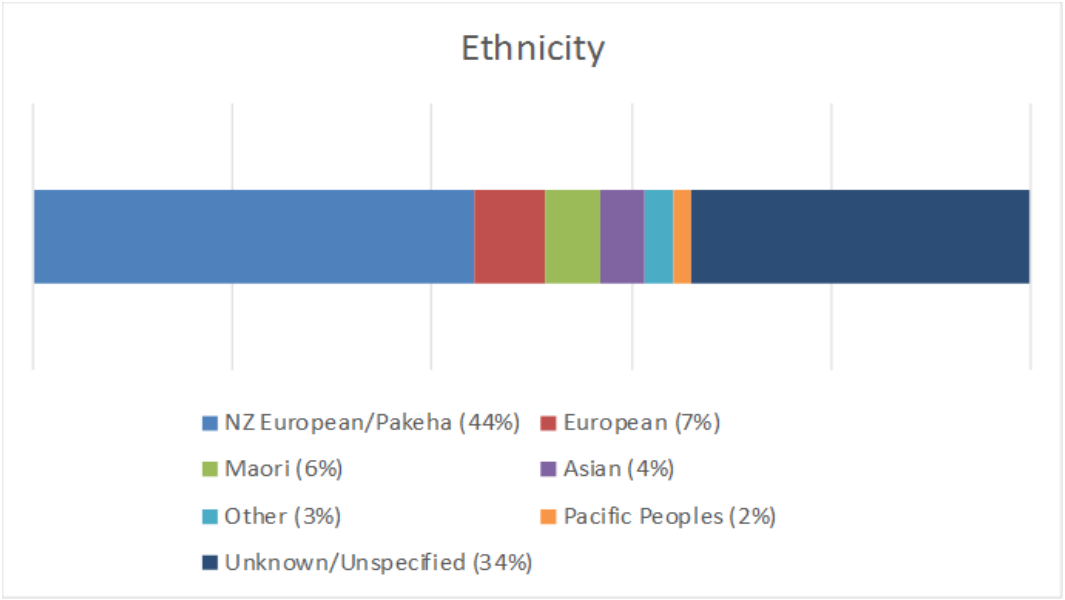
Our Age and Gender Profile



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 2020/21 year.

Wairarapa DHB continues to provide high quality and timely services for our population. In 2020/21:

- 2020/21 saw the launch of Wairarapa's Strategic Plan – Hauora Mō Tātou.
- The COVID-19 lockdown period and overall response had a significant impact on our population's ability to access services. Despite this we still achieved many of our targets.
- The Wairarapa DHB set up its COVID-19 vaccination clinics in April 2021. By the end of June 7,957 people had had their first vaccination and 12,061 vaccine doses had been delivered.
- 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 (ALOS) for Elective events is lower than the target of 3.29 days (1.31 days in 2020/21).
- Wairarapa DHB achieved the Improved Access to Elective Surgery Health Target, achieving 4,181 surgical elective discharges against a plan of 3,404.
- We achieved the target for 2020/21 year with 60.1% of our babies living in smokefree homes six weeks postnatal.
- 92.2% of our children received their B4 school check.
- Newborn enrolment within general practice at 95.6% exceeded our target of 90%.
- We achieved our Ambulatory Sensitive Hospital admissions (ASH) rates target for 0-4 year olds (4,488 per 100,000 compared with target of less than or equal to 5,000 per 100,000).
- All of our 0-19 years referred to non-urgent child and adolescent addiction services were seen within the targeted 8 weeks.
- Wairarapa DHB continues to work to reduce the number of inpatient falls causing harm. In the last year this was 0.19 per 1,000 bed days against a target of 0.50 per 1,000 bed days.
- The percentage of patients receiving their first cancer treatment within 31 days from date of decision to treat was 88.3% which was higher than the 85.9% target.
- Medication errors causing harm have reduced from 0.09 per 1,000 bed days in 2019/20 to 0.05 per 1,000 bed days in 2020/21.
- We achieved our target for Did Not Attend (DNA) rates follow-up specialist appointments at 4.5% against a target of less than or equal to 6%.
- 98% people residing in Aged Residential Care facilities received InterRAI Long Term Care Facility (LTCF) assessments within timeframes (20/21 Target was 75%).

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 should 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?

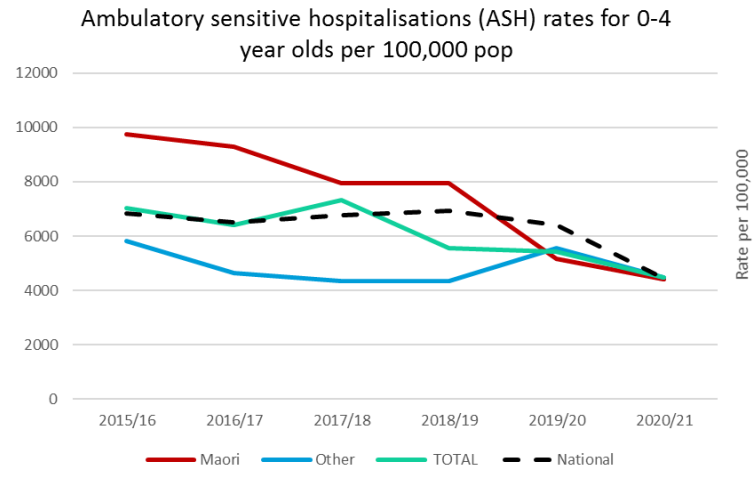
There are recognised health disparities for several population groups due to accessibility, social determinants of health, cultural responsiveness, and current models of care. Patients can find it hard to access services or to know how to manage their health if services are not culturally competent.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

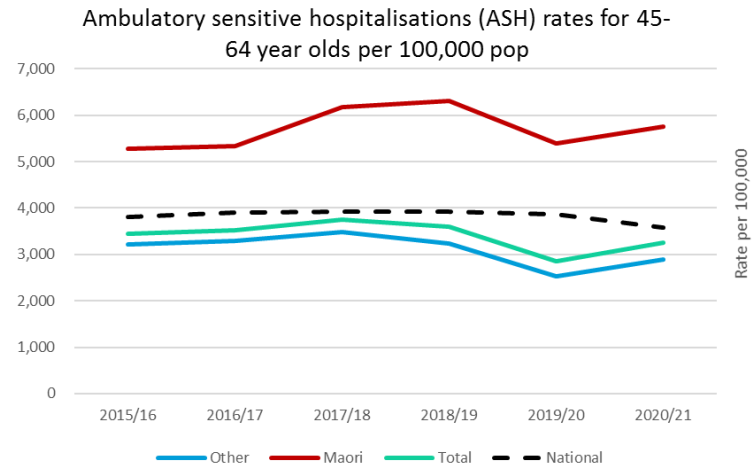
Impact measure: A reduction in Ambulatory Sensitive Hospitalisation (ASH) rates

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.

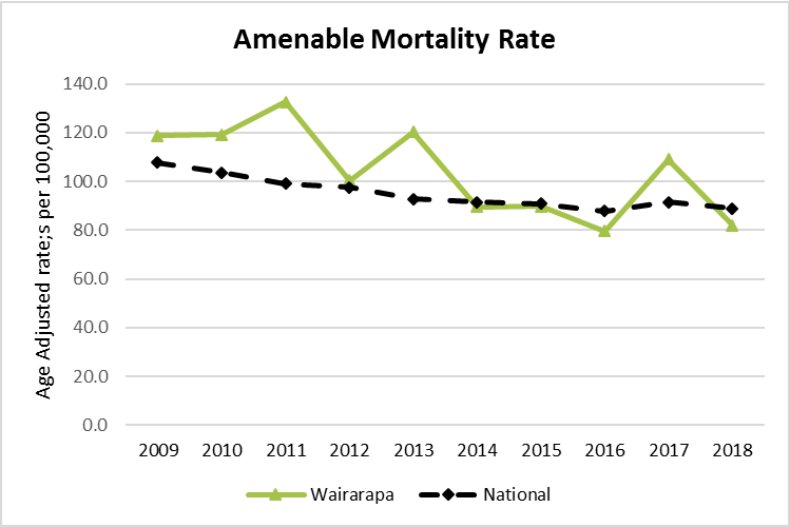
Over the last six years, the ASH rate for Māori 0-4 in Wairarapa DHB has decreased, with significant improvement over the last two years such that it is now in line with other ethnicities.

The Non-standardised ASH rate for Māori 45-64 has increased only slightly since December 2019. Closing the equity gap by improving the rate for Māori will continue to be a focus for the 2021/22 year. System Level Measures (SLMs) continue to drive clinically led system integration, focused on equity with a quality improvement process.





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 2018. The graphs show the most recent data available from the Ministry of Health which is for the twelve months ended 31 December 2018. The Wairarapa DHB amenable mortality rate for Māori at 156.7 (age standardised rate per 100,000) is lower than national (197.0) but for other population the rate is 80.0 compared with the national rate at 73.1 per 100,000. There is no new data set for this measure beyond 2018, however, we know anecdotally and from other measures of inequity that the Māori rate is more than twice the rate of others in our district. This measure alone provides rationale to focus on Māori specific service provision in order to target and tailor services to achieve better outcomes. The focus areas for 20/21 have been to build on the Health Care Home model of long-term condition management with a focus on diabetes, gout and respiratory disease.	 Source: Ministry of Health

Population health outcome: Improved environmental health and disease hazard management

What difference will we make for our population?

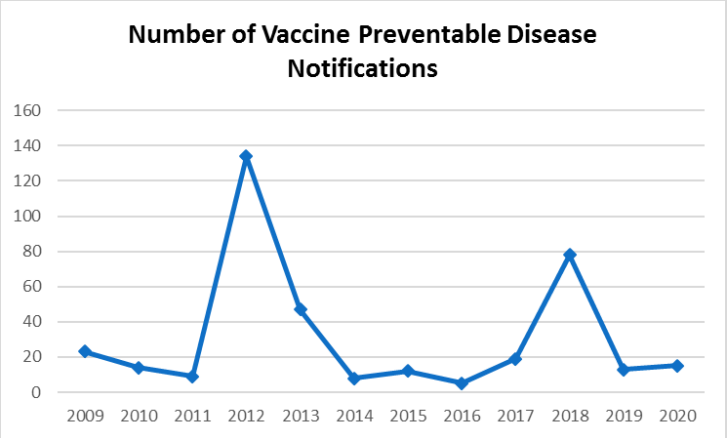
Through effective public health disease surveillance, investigation and control, the impacts of communicable, waterborne and foodborne diseases can be minimised. Public health actions are aimed at reducing the levels of harm from alcohol and drug use in the greater Wellington region. To achieve this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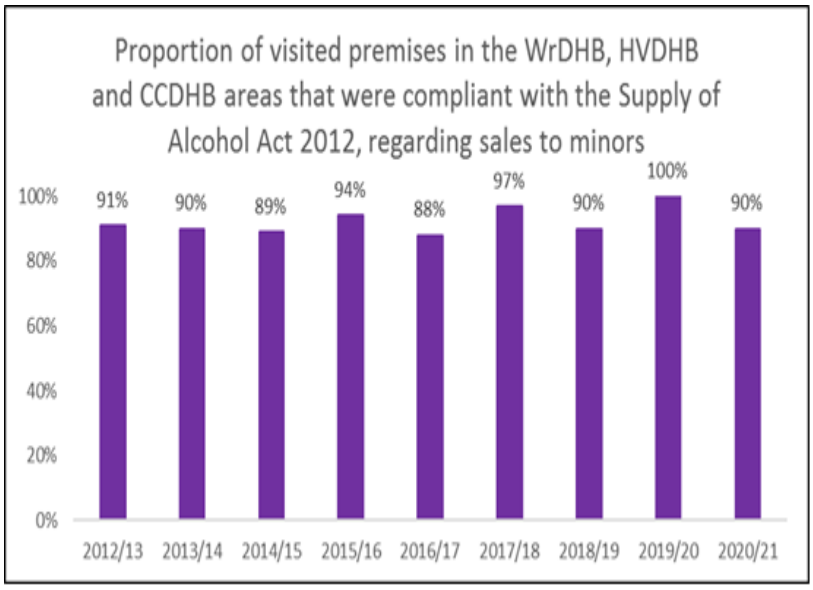


Source: Regional Public Health

In 2020/21, 90% of premises visited in the sub-region were compliant with the Supply of Liquor Act 2012 for sales to minors. All alcohol Controlled Purchase Op[erations (CPOs) were carried out under the authority of the Police, as per the Sale and Supply of Alcohol Act 2012. Due to COVID-19 response, RPH was not present for some CPOs.

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)

The data has not been updated from our previous report as the survey was disrupted by COVID-19.

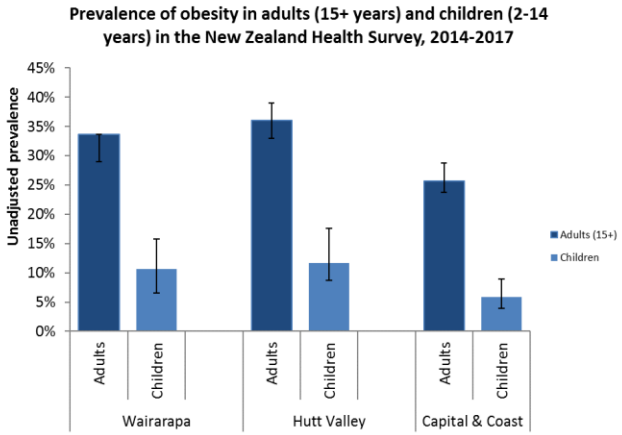
Obesity is one of the most important modifiable risk factors for a number of major diseases, including type 2 diabetes, ischaemic heart disease, ischaemic stroke, and several common cancers. In the last two decades, the prevalence of obesity in developed countries has increased so quickly that is has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

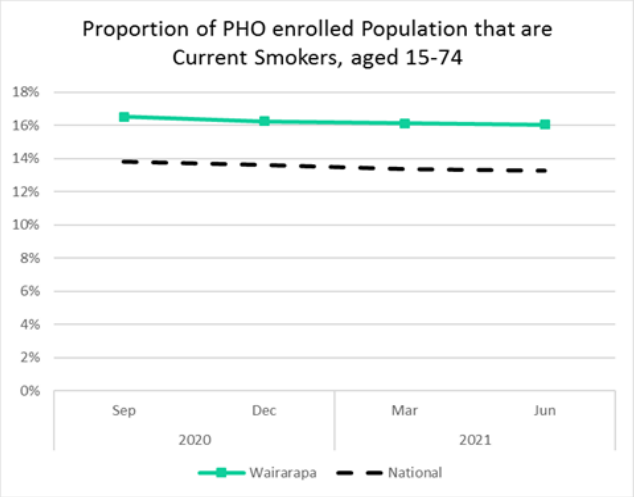
Our three focus areas in Tapu Te Hā are:

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.

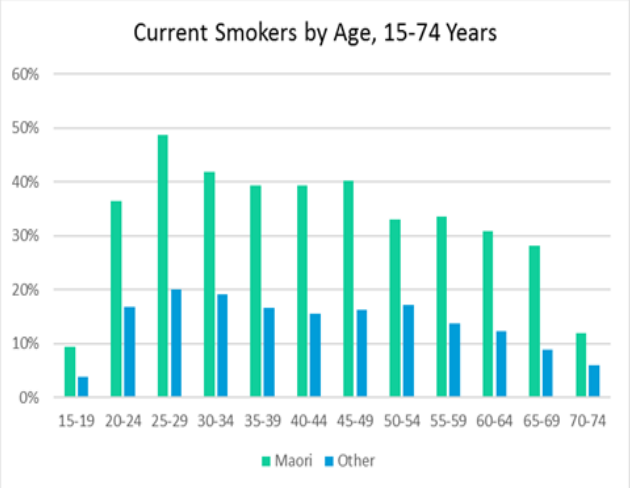
Māori Health Promotion – Māori health is about shared leadership with health, community and iwi.

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.

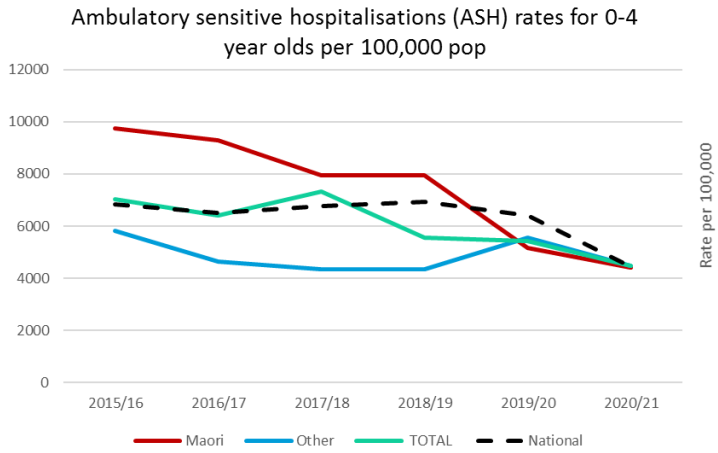
Measures – The DHB measures progress through:

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.

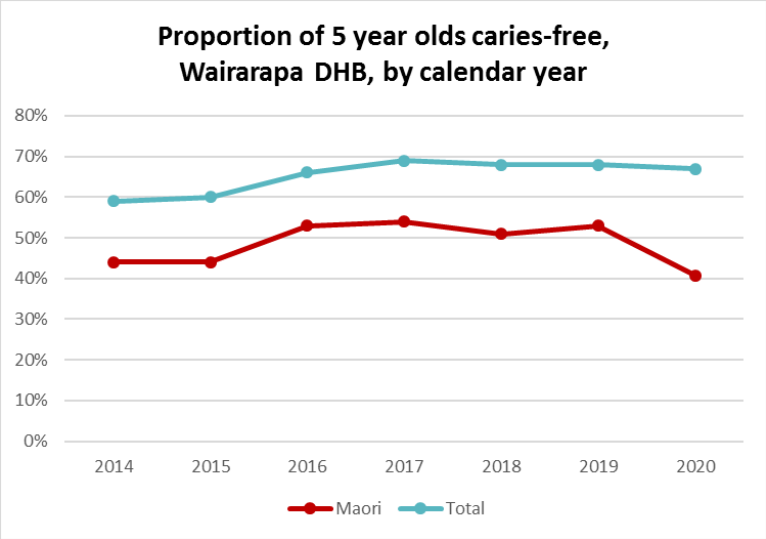
By ensuring that every child has access to and is receiving oral health services, we expect that the proportion of five year olds with no caries will increase.

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 2020, as has the proportion of Māori children who are caries free however it has seen a notable decrease this year.

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 16 weeks. Following the arrival of COVID-19 the oral health service has introduced the option for telephone baby consults

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.

In term two 2021 the service introduced fluoride applications in early childhood centres. With the recent COVID-19 outbreak this is in hiatus but if the cross infection regulations allow this will be re-introduced when appropriate. Level one under the old rules allowed this but the current level two rules are more stringent than the previous level two so we will wait and see when we can re-start this programme.



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

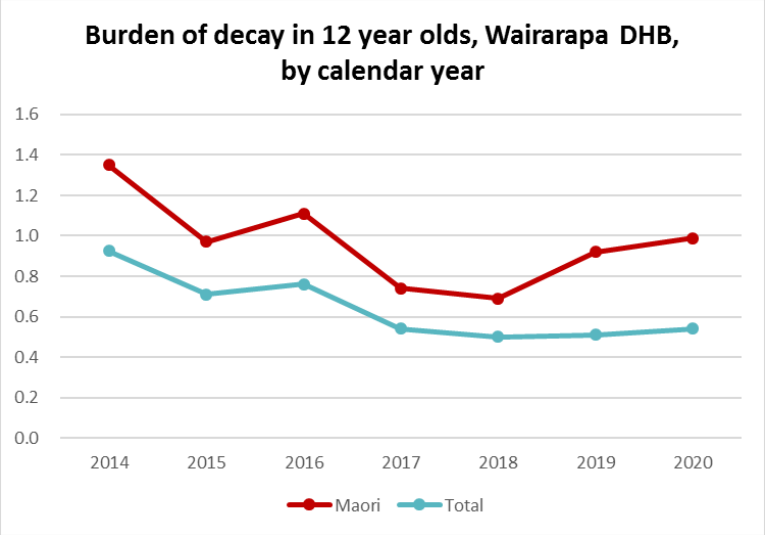
Impact measure: A decrease in the burden of tooth decay at Year 8

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 in the last two years 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.

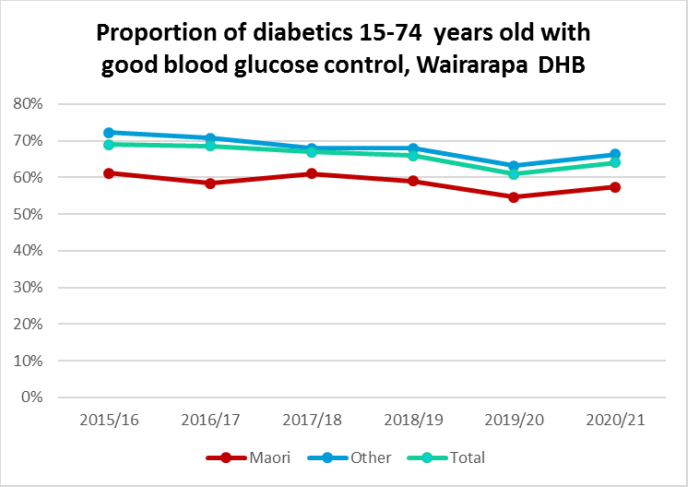
Measures – The DHB measures progress through:

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

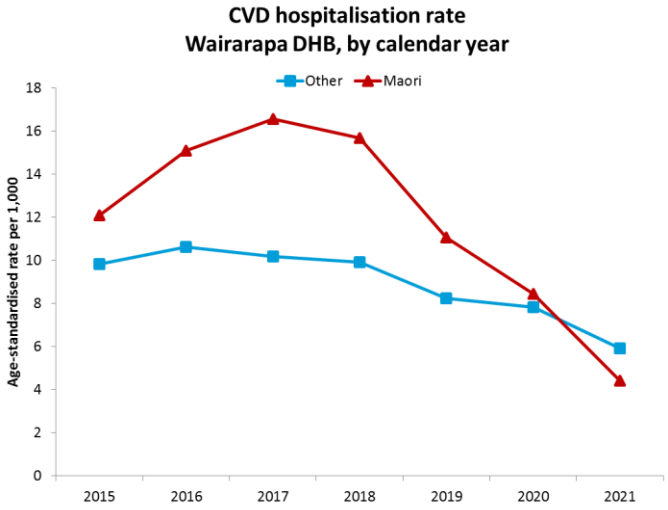
Cardiovascular diseases (CVD) are diseases that affect the heart and circulatory system. They include ischaemic heart disease, rheumatic heart disease, cerebrovascular disease and other forms of vascular and heart disease. Cardiovascular disease is the leading cause of death in the subregion. Overall, 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 intervention 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.

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.

The PHO has incentivised CVRA no cost screening for 30-40yr old Māori, Pacific and eligible South East Asian men and improved onsite practice access to diabetes and lipid blood screening to maximise opportunistic contacts for the hard to reach. Practice recalls target patients who meet set criteria for new diabetes medications. Self-management courses for Māori have been redesigned to be sustainable and maintain momentum if COVID-19 alert levels change.

For the first time Māori rates are lower than other populations.



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

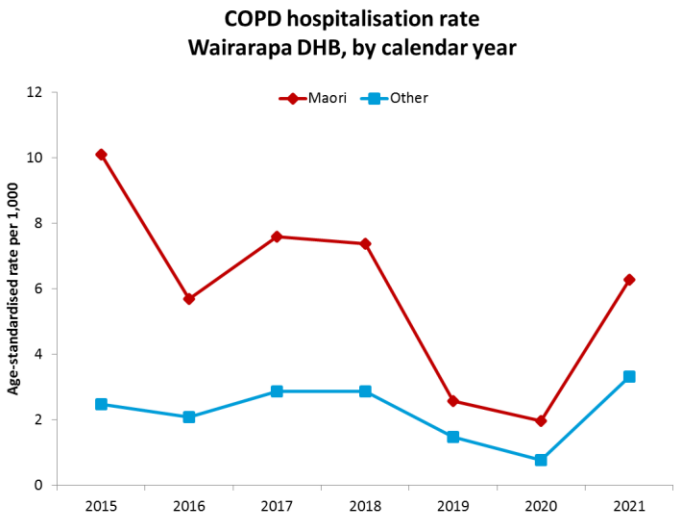
Impact measure: A decrease in the hospitalisation rate for chronic obstructive pulmonary disease

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.

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. There has been a significant spike in COPD admissions this year likely as a result of Respiratory Syncytial Virus (RSV).

SLM actions support a particular focus on Māori and Pasifika (30+ years) with COPD identification, assessment and management pathways. An enhanced COPD programme in primary healthcare is in progress with some delays in Spirometry clinics commencing linked to COVID-19 level 3 lockdowns.



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?

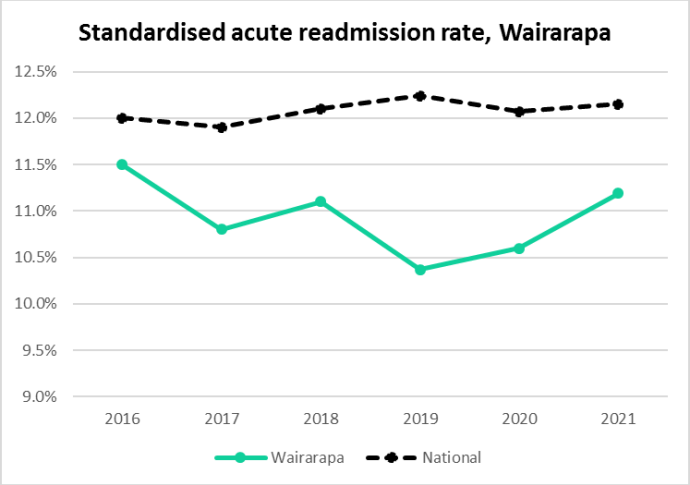
Equitable and timely access to intensive assessment and treatment can significantly improve people's quality of life, either through early intervention, or through corrective action (i.e. major joint replacements to relieve pain and improve activity). Improving our service delivery, systems, and processes 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 increased to 11.2% for Wairarapa DHB over the last year but continues to be below the national average.



Source: Ministry of Health.

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

Impact measure: Maintain or reduce the age standardised[1] cancer mortality rate

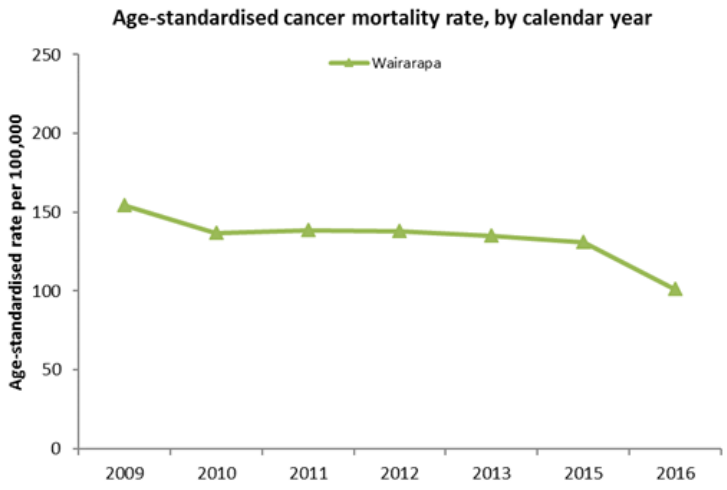
More people are developing cancer, mainly because the population is growing and getting older.

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

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

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

The Ministry of Health's Mortality Collection data up to 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?

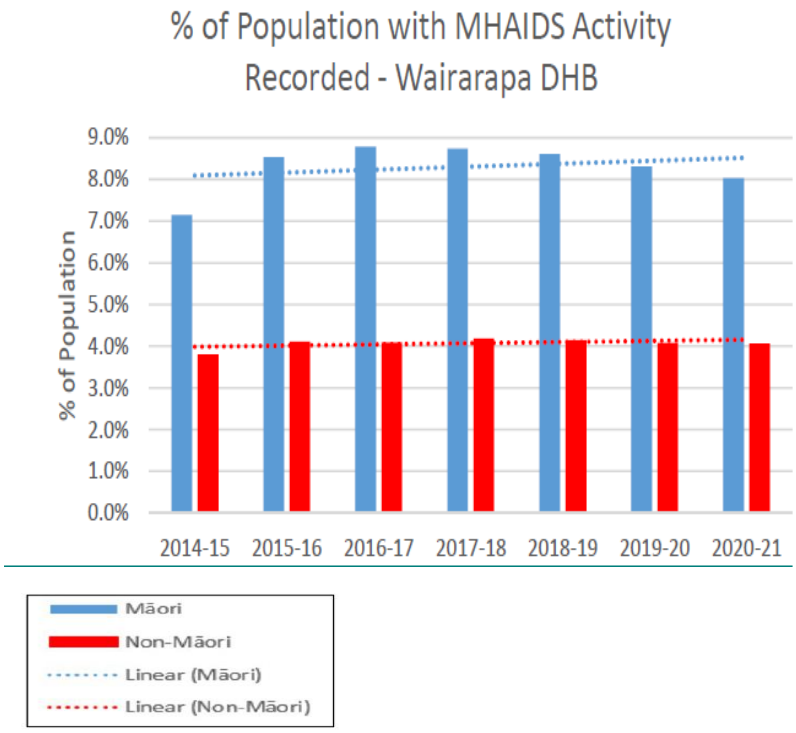
Specialist Mental Health Services are services for people who are most severely affected by mental illness or addictions and include assessment, diagnosis, treatment and rehabilitation, as well as crisis response when needed, and as required under the Mental Health Act.

Measures – The DHB measures progress through:

Impact measure: The percentage of the population with Mental Health and Addiction and Intellectual Disability Services (MHAIDS) Activity recorded over time.

This measure indicates the level of access to secondary mental health services to people who require secondary mental health care.

In Wairarapa DHB, the proportion of Māori recording MHAIDS activity has been trending upwards over time despite falling slightly in recent years. The rate for non-Māori is lower and comparatively stable over time.



Source: MHAIDS

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.

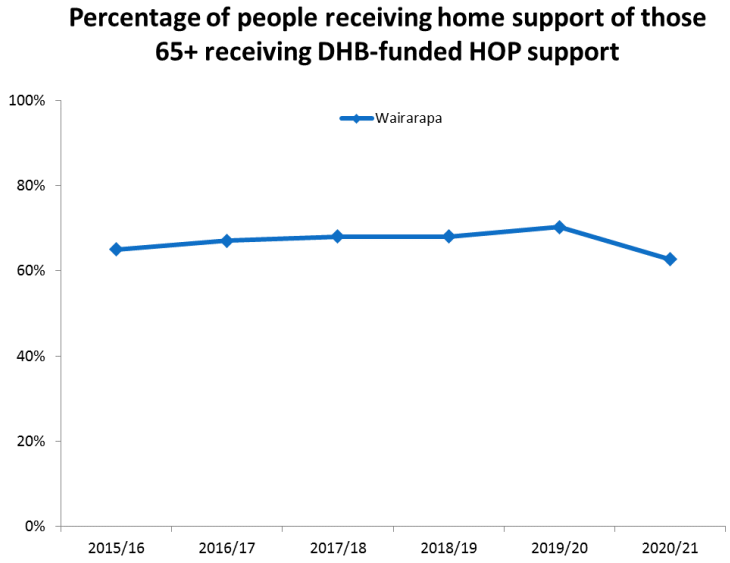
Measures – The DHB measures progress through:

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.

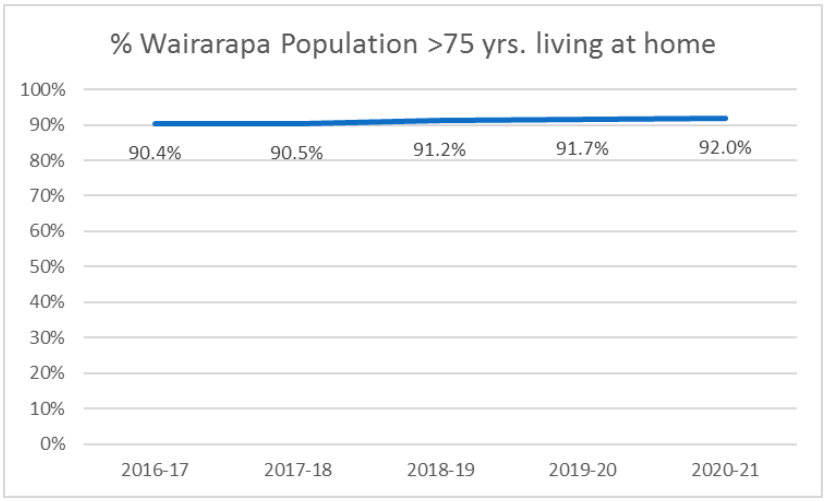
By providing comprehensive and high-quality home support services, we expect that the proportion of people receiving home support rather than in residential care will be increased or maintained.

In Wairarapa DHB, the proportion of older people receiving home based support services has been maintained over recent yers and dipped slightly in the past twelve months.



Source: NASC Data (20/21 Data only until March 2021)

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

Impact measure: Maintain or increase the 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 a 92.0% average over the year. For Māori, the rate is at 97.0%.	 Source: NASC Data

Implementing the COVID-19 vaccine strategy

Vaccine doses administered & eligible population vaccinated – by DHB of service / residence (note 1, 5)	Dose 1	Dose 2	Total	Proportion fully vaccinated
Wairarapa	7,957	4,104	12,061	11.21%

Vaccine doses administered & eligible population vaccinated – by age group (note 4)	Dose 1	Dose 2	Total	Proportion fully vaccinated
12 to 15	2	0	2	_
16 to 19	31	18	49	1.29%
20 to 24	97	73	170	4.14%
25 to 29	165	124	289	5.27%
30 to 34	169	115	284	4.87%
35 to 39	183	129	312	5.48%
40 to 44	239	188	427	7.57%
45 to 49	259	191	450	7.08%
50 to 54	346	260	606	9.13%
55 to 59	428	278	706	9.84%
60 to 64	553	372	925	11.74%
65 to 69	1,087	505	1,592	15.73%
70 to 74	1,585	619	2,204	20.87%
75 to 79	1,259	475	1,734	23.99%
80 to 84	878	375	1,253	29.63%
85 to 89	419	223	642	31.06%
90+	257	159	416	37.26%
Total	**7,957**	**4,104**	**12,061**	**11.21%**

Vaccine doses administered & eligible population vaccinated – by ethnicity (note 4)	Dose 1	Dose 2	Total	Proportion fully vaccinated
Asian	208	139	347	12.01%
European or other	7,002	3,526	10,528	11.94%
Māori	587	355	942	7.02%
Pacific peoples	108	61	169	9.93%
Unknown	52	23	75	16.57%
Total	**7,957**	**4,104**	**12,061**	**11.21%**

Vaccine doses administered by sequencing group (note 3, 4)	Dose 1	Dose 2	Total
Group 1	14	13	27
Group 2	4,168	2,591	6,759
Group 3	3,532	1,438	4,970
Group 4	243	62	305
Total	**7,957**	**4,104**	**12,061**

Note 1:

Fully vaccinated means two doses have been administered to an individual.

Note 2:

The health service user (HSU) population used for COVID-19 vaccine coverage reporting provides information about the number of people in New Zealand who used health services in 2020. People are included if they were alive as at 30 June 2020, were 12 years of age as of 30 June 2020, (note that this was initially 16 years but was reduced to 12 years when the eligibility criteria changed), and if they were enrolled with a primary health organisation or received health services in the 2020 calendar year. There are other data sets that estimate the total number of people in New Zealand.

These include three datasets produced by StatsNZ: Estimated Resident Population (produced every 5 years, following each Census), Subnational Population Estimates (produced every year), and non-official population projections produced by StatsNZ for the Ministry of Health (produced every year).

The Stats NZ population estimates are based on Census data adjusted for the number of people who are born, who have died, and who have migrated to or from New Zealand. The Stats NZ population estimates and projections are of people usually resident in New Zealand, including those usually resident who are temporarily overseas, while the HSU includes everyone in New Zealand who used health services in a given period.

The HSU was chosen by the Ministry of Health as the denominator for COVID-19 vaccine coverage reporting because it allows for the assignment of the same demographics (eg, location and ethnicity) to people in the numerator (the number of people vaccinated) as the denominator (reference population). The HSU is available for every demographic contained in health data including age, ethnicity, DHB, and gender, separately or in combination. Other information such as neighbourhood deprivation, Statistical Area 2, or territorial local authority can also be added. It is possible to generate flags for health-related information on the HSU, for example, those who are likely to have a long-term condition. Official Stats NZ estimates are not as flexible. For example, StatsNZ estimates by age, sex and Statistical Area 2/Territorial Authority/DHB are produced every year, but estimates that also include ethnicity are only produced every 5 years, the most recent being estimates for 2018. The projections StatsNZ produces for the Ministry every year do provide information by age, sex and broad ethnic group, but are only available at the DHB level.

The Total population estimate based on HSU as at 30 June 2020 is 48,618. This is 332 below the Stats NZ total projected population of 48,950 (from the non-official population projections StatsNZ produced in 2020). When classifying the population into ethnicity, age and DHB there are further differences. For example, a summary of the differences by ethnicity are summarised in the table below. These differences arise as the populations are derived from different sources. For example, an individual may identify as one ethnicity when registering with a health service and a different ethnicity when completing a census declaration.

By definition, the HSU is not a total population estimate and is likely to miss highly marginalised groups. For example, analysis suggests that groups underrepresented in the HSU include young people aged 15-45 years (men in particular), and people of Asian and Middle Eastern, Latin American and African ethnicity.

The HSU is considered by the Ministry of Health to be the best option for estimates of vaccine coverage, as it removes bias from calculated rates by ensuring demographic information in the numerator and denominator is consistent. For example, the ethnic group(s) with which someone identifies, and their location.

Total population	HSU	Stats NZ	Difference
Māori	8,587	8,940	(353)
Pacific	1,065	1,060	5
Asian	1,530	1,750	(220)
Other	37,436	37,200	236
Total	**48,618**	**48,950**	**(332)**

Note 3:

Group 1 includes border and managed isolation and quarantine employees and the people they live with. Group 2 includes high-risk frontline health care workforces; workers and residents in long-term residential environments; older Māori and Pacific peoples cared for by whānau, the people they live with, and their carers; people aged 65 years and older; people with relevant underlying health conditions. Group 3 includes people aged 65 years and older; people with relevant underlying health conditions; disabled people; and adults in custodial settings. Group 4 includes people aged 16 years and over. These definitions and population groups were occasionally updated based on operational and Cabinet decisions or updated estimates of the sizes of each group.

Note 4:

The data in this table is based on the DHB of service (where the vaccine dose was administered).

Note 5:

The data in this table is based on the DHB of residence of the individual receiving the vaccines. Ethnicity is based on the prioritised ethnicity classification system which allocates each person to a single ethnic group, based on the ethnic groups they identify with. Where people identify with more than one group, they are assigned in this order of priority: Māori, Pacific peoples, Asian, and European/Other. So, if a person identifies as being Māori and New Zealand European, the person is counted as Māori.

Statement of Performance

For the year ended 30 June 2021

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 2020/21 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 and also by the *MOH indicator* - these indicators being part of the MOH National non-financial Performance monitoring framework except for those marked "WPI" which are local Wairarapa DHB Performance indicators. 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 2020/21 performance (indicated with 'Est.'), based on historical and population trends.

Appropriation reporting

	Budget 2021 $000	Actual 2021 $000	Actual 2020 $000
Appropriation revenue	166,653	166,563	149,100

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.

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	Target/Est. 2020/21	Baseline	Baseline data date	2019/20 Performance	2020/21 Performance	Achievement
Health promotion and education								
Number of referrals to the Green Prescription program.	V	WPI	≥ 250	243	2019/20 Q4	243	167	Not 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	≥90%	89.30%	2019/20 Q3	89.9%	65.70%	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	PH04 (CW09)	≥90%	100%	2019/20 Q2	100%	100%	Achieved
Babies living in Smokefree Homes at 6 weeks post-natal	Q	SLM	Total ≥60%	Total 57.2%	2018/19 Q4	62.5%	Total 60%	Achieved
			Māori ≥60%	Māori 41.4%		41.6%	Māori 45%	Not Achieved
			Pacific ≥60%	Pacific 45.5%		Not reported	Pacific 43%	Not Achieved
			Other ≥60%	Other 67.9%		73.9%	Other 70%	Achieved
Immunisation								
Percentage of 8-month olds fully vaccinated	C	CW05 (FA1)	≥95%	Total 88.8%	2019/20 Q4	92.2%	Total 90.1%	Not Achieved
				Māori 86.0%		93.9%	Māori 85.6%	
				Pacific 100%		100%	Pacific 86.7%	
				Other 85.7%		90.8%	Other 92.6%	
Percentage of 5-year olds fully immunised	C	CW05 (FA2)	≥95%	Total 95.1%	2019/20 Q4	93.6%	Total 89.8%	Not Achieved
				Māori 93.0%		95.0%	Māori 90.2%	
				Pacific 100%		100%	Pacific 88.2%	
				Other 100%		90.2%	Other 89.6%	

Outputs measured by	Type of measure	MOH indicator	Target/Est. 2020/21	Baseline	Baseline data date	2019/20 Performance	2020/21 Performance	Achievement
Immunisation contd.								
Percentage of eligible girls and boys fully immunised with HPV vaccine.	C	CW05 (FA3)	≥75%	Total 66%	2019/20 Q4	66%	Total 70.7%	Only Achieved for Pacific
				Māori 67%		67%	Māori 66.2%	
				Pacific 76%		76%	Pacific 77.3%	
				Other 66%		66%	Other 70.7%	
Percentage of people aged 65+yrs who have completed their annual influenza immunisation.	C	CW05 (FA4)	≥75%	Total 75%	2019/20 Q4	75%	Total 72.0%	Not Achieved
				Māori 60%		60%	Māori 57.5%	
				Other 77%		77%	Other 73.0%	
Breastfeeding								
Percentage of infants fully or exclusively breastfed at 3-months.	Q	CW06	≥70%	30.70%	2018/19 Q1	27.3%	59.00%	Not Achieved
Population based screening services								
Percentage of eligible children receiving a B4 School Check.	C	WPI	≥90%	Total 100%	2019/20 Q4	71%	92.20%	Achieved
Percentage of eligible women (25-69 years) having cervical screening in last 3 years.	C	PV02	>80%	Total 73.9%	2019/20 Q3	74.2%	Total 72.1%	Not Achieved
				Māori 74.9%		74.1%	Māori 69.9%	
				Pacific 82.2%		80.9%	Pacific 77.4%	
				Other 74.3%		74.8%	Other 72.7%	
Percentage of eligible women (50-69 years) having breast screening in the last 2 years.	C	PV01	>70%	Total 68.2%	2019/20 Q3	71.10%	Total 65.9%	Not Achieved
				Māori 65.6%		66.72%	Māori 59.6%	
				Pacific 55.1%		57.19%	Pacific 55.7%	
				Other 68.6%		71.69%	Other 66.9	

Commentary

Public health protection and regulatory services

COVID-19 has had a significant impact on service delivery by Regional Pubic Health in Wairarapa. The response to the COVID-19 pandemic remains an ongoing work pressure for Public Health Units around the country who have been responding to COVID-19 since January 2020. RPH is intrinsic to the public health response in the greater Wellington region, coordinating and leading case and contact management, contributing to programmes at the border, and providing a conduit between national policy and local practice. In addition, RPH is part of the national network of Public Health Units that collectively respond, in the current distributed model, to community resurgence occurring anywhere in the country. As one of the larger public health units we carry a proportionately large share of the workload.

In response to community clusters in Auckland region in February and July 2021, RPH activated a seven day per week roster of dedicated COVID-19 staff, took on responsibility for investigation and managing cases occurring in Auckland managed isolation facilities, to lift the burden on Auckland Regional Public Health Service (ARPHS) and provided data management services on Auckland close contacts, using the national case and contact management system (NCTS).

In the Wairarapa in the year ended 30 June 2021, RPH continued to provide drinking water services directly for Carterton, Masterton, Tinui, Opaki, Fernridge and Wainuioru water supplies. These services have subsequently been transfered to Taumata Arowhai as a result of the passing of the Water Services Bill in September 2021. Currently there are a number of small supplies in the Wairarapa (Fernridge, Wainuioru, Mauriceville) without permanent chlorination that due to recurrent episodes of contamination remain on ongoing boil water notices to manage residual risk. Although this is not a permanent solution, it provides the time to consider how to improve the management of the residual risk. This type of residual risk is the focus of the current reforms in the Drinking Water regulation that happened following the water contamination in Havelock North. RPH works with these supplies to support the development of Water Safety Plans that will help to identify and manage risks.

A RPH Public Health Advisor and a Masterton District Council Licensing Inspector jointly completed alcohol retailer compliance visits for thirteen premises. A number of the premises needed to update their Duty Manager Register, otherwise the inspections were pleasing. RPH has lodged an opposition to the renewal of the alcohol licence for Thirsty Liquor (Masterton) and is seeking a reduction in hours on Friday and Saturday Nights. A hearing date has been set for mid-June by the District Licensing Committee.

Health promotion and preventive intervention services

Despite complexities of staff rostering due to RPH public health nurses working in COVID-19 teams, the School Based Immunisation Programme (HPV and Boostrix immunisations) was successfully implemented.

RPH is working towards a 'Smokefree Aotearoa New Zealand 2025 with Kapua O Te Rangi, Wāhi Reka and O Ngati Hamu Kohanga Reo, and Te Kura Kaupapa Māori O Wairarapa supporting changes in kohangareo and kura environments, staff and whanau. Health promotion activities were being planned to coincide with the celebration of Matariki. Activities will also included a review of smokefree/vapefree policies and signage, and promotion of the 'Drive Smokefree for Tamariki campaign. The campaign prepares whanau for the 'Smokefree and Vapefree Motor Vehicles Carrying Children Under the Age of 18 Years Law' which will be enforced from 28 November 2021.

In collaboration with Tu Ora Compass Health, RPH facilitated a whānau hui at Te Pa to share nutritional key messages and finalise the Healthy Pouaka kai recipes which were introduced at Wahi Reka Kohanga Reo.

Evaluation of the Pēpe Ora Expo estimated between 250 and 300 attended the Expo. Of the registrations, 13% were current smokers, with six referred to Stop Smoking Services; nine of the eleven registered pregnant women were referred to Pepe Ora Parenting Support programme.

Immunisation services

COVID-19 has had an impact on our local immunisation programme. 90.1% of all children aged 8 months and 85.6% of Māori and 86.7% of Pacific children were fully immunised, falling short of the target of 95%. In the twelve months 1 July 2020 – 30 June 2021 90% of all children aged twenty four months were fully immunised, 87.5% of Māori and 91.2% of Pacific Island two year olds were also fully immunised. The low percentage for Pasifika relates to small numbers within the cohort, so when 1 or 2 children are not fully immunised, this can equate to a high percentage. Multiple processes are in place to ensure those not fully immunised are identified and followed up within a timely manner. There is regular contact between the District Immunisation Co-ordinator, National Immunisation Register and Outreach Immunisation Service to discuss emergent issues relating to the delivery of service to overdue children/whānau, as well as good relationships with all of the immunisation providers within the Wairarapa.

The measures for all ethnicities were not met for 65+ influenza vaccination, with a number of variables impacting this, such as limited vaccine supply and COVID-19 levels. Lessons learnt during alert changes from COVID-19 were around stakeholder engagement, collaboration and tailoring an approach. The DHB, Māori Health team, Tū Ora Compass Health, Outreach Immunisation Co-ordination, Primary Care and Pharmacies worked together to provide the influenza vaccine to the community with a specific emphasis on whanau, Māori and Pasifika. One major learning was embedded in the quality of our communication with whānau and individuals, the telephonists and those working in clinics to ensure we cater for the needs of whanau, Māori and Pasifika.

Despite the challenges of delivering the School Based Immunisation Programme in an uncertain and ever changing environment, the programme has remained on track. Regional Public Health maintains regular communication with schools in the programme to reschedule immunisation clinics as required, and increasing the number of catch-up clinics to support access to vaccination. Regional Public Health works closely with whānau to support referral to primary care when needed.

Before Schools Check clinics for 4 year olds are held across all seven Wairarapa medical centres. An annual roster is followed to allow for the different caseloads of 4-year-olds in the practices. 2020/21 data demonstrates Wairarapa achieved an overall performance rate of 92.2% in relation to the total number of children eligible in the region for checks. Wairarapa performed well in relation to our high deprivation population exceeding target with a performance of 116.8%. An area for focus remains on our Māori and Pasifika populations where we achieved targets of 85.3% and 83.3% respectively. Over the last quarter of the year there was a strong commitment to strengthen the service delivered in the Wairarapa. As such Tū Ora Compass Health has developed a Wairarapa Child Health Coordinator role to ensure access and quality of the service improves. This role commenced in June 2021 and the initial primary focus will be to lead service development. This includes addressing equity and access, addressing any identified gaps in referral management, strengthening provider and referral networks, improve provider's paper-based administration systems and reinvigorate education and training for the Registered Nurses.

COVID-19 Vaccination

The Government has instigated a staged rollout of the COVID-19 Vaccine, vaccinating people in “Groups” based on various criteria. Wairarapa has no border facilities (Group 1) and therefore started its vaccination programme of delivery to Group 2 which includes health workers, frontline emergency service workers and people living in long term residential care.

Our COVID-19 vaccination programme delivered its first vaccination in early April 2021. In April, May and June we delivered vaccinations to Group 2 and our older population over 65 years.

By the end of June 2021, Wairarapa DHB had delivered 12,061 vaccine doses and 7,957 people had had their first dose. This represented 33% of the estimated population in Group 2 and Group 3 (which includes all people aged over 65, disabled people, those with existing health conditions etc) being actively engaged in their vaccination journey.

Smoking cessation services

Better Help for Smokers to Quit 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 2020/21 was 65.7% of smokers offered help to quit against the 90% target. For Māori the result was 63.1% and for Pasifika it was 66.2%. The PHO have put a new focus on stop smoking since March 2021. This has meant that dedicated resource has been directed to providing cessation support to Māori and Pacific smokers, in an attempt to refocus on equity. All those responsible for smoking cessation are meeting in Q1 2021/22 with the aim of furthering the kaupapa of meaningful action to address smoking and supporting practices to do so. The Wairarapa Smokefree Coordinator has been working closely with the Wairarapa Stop Smoking Service to help increase referrals to the service and to develop a programme that will assist Māori women to quit smoking. A Pēpe Ora Collective has been established and resourced to ensure the inclusion of the Hapū Māmā incentivised programme.

Maternity Health Target – The Wairarapa DHB regularly exceeds the health target of 90%. During 2020/21 100% of all pregnant smokers, including Māori pregnant smokers, were offered support to quit. Pēpe Ora has a kaiāwhina supporting the Pēpe Ora Parenting Support group and proactively refers to smoking cessation services or provide vapes as an alternative. Lead Maternity Carers continue to be supported to refer wahine and whanau to the Hapū Māmā programme and vapes are provided as well.

Screening services

Population based screening services in the Wairarapa remain a challenge reaching the overall coverage target of 80% for cervical screening, 70% for breast screening and specific targeted rates for priority populations. In order to improve equity for priority women, cervical screening is funding four 'Free Cervical Screening Clinics' per annum in the Wairarapa, two at Masterton Hospital and two at South Wairarapa. With the introduction of these clinics we are seeing priority women coverage increasing. With the introduction of the full time Health Navigator role in the Wairarapa funded by Regional Screening Services and Tū Ora Compass Health, a focus has been put on engaging eligible Māori and Pacific women into the screening pathway and or to Colposcopy Services. Clear referral processes are established along with increased collaboration with General Practices and stakeholders within the Wairarapa region. There is an increase in enrolments into the Breastscreen Aotearoa (BSA) program as a result of the PHO data matching. Referrals for DNA priority women are sent to the Health Navigator in the Wairarapa for engagement into the screening program.

The COVID-19 response during the year impacted overall Wairarapa coverage. The mobile screening unit and cervical clinics which were rostered to visit Wairarapa during this time were deferred.

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	Target/Est. 2020/21	Baseline	Baseline data date	2019/20 Performance	2020/21 Performance	Achievement
Primary Care services / Long term conditions management								
Newborn enrolment with General Practice	C	CW07	≥90%	Total 93.6% Māori 83.9% Pacific N/A Other 96.7%	Jun-20	Total 96.7% Māori 86.9% Pacific N/A Other 102.5%	Total 95.6% Māori 90.0% Pacific N/A Other 98.2%	Achieved
Percentage of DHB-domiciled population enrolled in a PHO.	C	PH03	≥99%	Total 98.1% Māori 96.6% Pacific 100% Asian 87% Other 98.8%	Apr-20	Total 97.29% Māori 95.60% Pacific 98.81% Asian 84.77% Other 98.18%	Total 97.3% Māori 92.1% Pacific 96.2% Asian 88.9% Other 98.6%	Not Achieved
ASH Rates (avoidable hospitalisations) for 0-4 years (rate per 100,000)	V	SLM	Total ≤ 5,000 Māori ≤ 5,000 Pacific N/A Other ≤5,000	Total 5,415 Māori 5,161 Pacific N/A Other 5,543	12 months to Mar 2020	Total 5,415 Māori 5,161 Pacific N/A Other 5,543	Total 4,488 Māori 4,421 Pacific N/A Other 4,488	Achieved
ASH Rates (avoidable hospitalisations) for 45-64 years	V	SS05	Total ≤ 2,500 Māori ≤ 5,000 Pacific N/A Other ≤2,500	Total 2,858 Māori 5,381 Pacific N/A Other 2,529	12 months to Mar 2020	Total 2,858 Māori 5,381 Pacific N/A Other 2,529	Total 3,347 Māori 5,756 Pacific N/A Other 2,994	Not Achieved
Percentage of DHB-domiciled population (15-74 yrs) enrolled in a PHO with well managed diabetes (HbA1c ≤ 64 mmol/mol)	C	SS13 (Focus Area 2)	≥70%	Total 56.7% Māori 51.3% Pacific 54.1% Other 58.5%	Dec-19	Total 60.9% Māori 54.7% Pacific 55.7% Other 63.1%	Total 64.0% Māori 57.4% Pacific 60.9% Other 66.3%	Not Achieved

Outputs measured by	Type of measure	MOH indicator	Target/Est. 2020/21	Baseline	Baseline data date	2019/20 Performance	2020/21 Performance	Achievement
Oral health								
Percentage of children under 5 years enrolled in DHB-funded dental services.	C	CW03	≥91%	Total 88.6%	2019/20 Q3	Total 88.6%	Total 92.2%	Achieved
				Māori 79.1%		Māori 79.1%	Māori 83.3%	Not Achieved
				Pacific 70.5%		Pacific 70.5%	Pacific 81.1%	Not Achieved
				Other 91.7%		Other 91.7%	Other 97.6%	Achieved
Percentage of children Carries Free at 5 years	Q	CW01	Total ≥71%	Total 68%	2019/20 Q2	Total 68%	Total 66.9%	Not Achieved
			Māori≥54%	Māori 53%		Māori 53%	Māori 40.8%	Not Achieved
			Pacific ≥60%	Pacific 50%		Pacific 50%	Pacific 45.5%	Not Achieved
			Other≥76%	Other 75%		Other 75%	Other 76.9%	Achieved
Percentage of children with Decayed, Missing, Filled Teeth-DMFT in year 8 kids	Q	CW02	Total ≤77%	Total 77%	2019/20 Q2	Total 77%	Total 73.9%	Achieved
			Māori≤61%	Māori 61%		Māori 61%	Māori 62.9%	Not Achieved
			Pacific ≤75%	Pacific 75%		Pacific 75%	Pacific 91.7%	Not Achieved
			Other≤83%	Other 83%		Other 83%	Other 77.6%	Achieved

Commentary

Primary Care Services / Long term conditions management

COVID-19

COVID-19 has had an impact on service delivery by Primary Care Services across the Wairarapa over the past 12 months. All of the Wairarapa practices provided COVID-19 assessment and swabbing throughout the year, with swabbing at weekends being offered from the Wairarapa After Hours Service. A total of 7097 COVID-19 tests were completed by Primary Care in this period. During 2020/21 the COVID-19 lockdowns ranged from Level 1 to Level 3, and providers have worked hard on catching up on screenings and other services with the backlog from previous lockdowns, as well as continuing to deliver their normal activities. The 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. Workforce shortages exacerbated by the border closure placed additional pressure on already busy teams. It is envisaged this will continue to have impacts on service delivery into 2021/22.

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 an 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. Although the percentage of patients with well managed diabetes falls below the target for all ethnicities, 91.1% of the total eligible population have had a HbA1c measurement in the past year, with 88.3% completion for Māori and 84.3% completion for Pacific populations. COVID-19 restrictions and workforce challenges in primary care affected the long term conditions programme during this 12 month period.

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

'What about you?' is a Wairarapa community-based communications and engagement campaign focused on addressing alcohol and drug-related issues and promoting mental wellbeing in Wairarapa. Seventeen network member organisations are actively involved in the campaign. Launched in October 2018, the campaign has been implemented in phases to maintain momentum and make it sustainable in the longer term. Tū Ora staff work with all partner agencies to review and plan direction each year to keep the campaign relevant for partner agencies and the community. A new implementation plan has been developed over the last year for implementation 2021-22. The 'Watch out for your Mates' campaign works with Wairarapa Rugby has been particularly successful over the last year and continues to be supported. Due to it's success linkages are being made with other sports codes. The collaborative and co-design approach for the campaign continues to make the 'What about you?' campaign effective with key activities and resources driven by input from network members and end target stakeholders. Ongoing monitoring and evaluation activities are used to identify opportunities for enhancements and new activities to include in the campaign. The focus for campaign activities has continued to be on building initiatives and use of resources into existing operational activities and communications programmes.

Self-Management Courses

Due to disruptions in organising and facilitating group courses due to COVID-19 over the last year Tū Ora Wairarapa has altered the delivery of Piki Te Ora and Self-Management courses for long term chronic health conditions to enable courses to be held within a COVID-19 environment. In an effort to address this issue during 2021, smaller group courses and two variations of on-line courses were trialled. The small group courses were the most successful and continue to be offered. The content, cultural appropriateness and delivery of the self-management courses is being evaluated and improved.

Tobacco Control

Activities during the 2020-21 period was again disrupted by COVID-19 lockdowns. The Wairarapa Smokefree Coordinator(SFC) and a Regional Public Health Advisor completed a project with Wāhi Reka Kohanga which focused on implementing a smokefree policy, quit smoking and making healthy kai and exercise choices. The focus around helping wahine Māori to quit smoking has changed to re-branding and re-vitalising the Hapū Māmā programme, to be completed in Quarter 2 2021-22. Training sessions with LMCs, Well Child Providers, Family Start and the Wairarapa Stop Smoking Service to help support the Hapū Māmā programmed have been provided. This training focused on a new approach to smoking cessation which will help increase the referrals to the Hapū Māma programme.

Palliative Care

The Wairarapa Palliative Care service is based on the 3DHB "Living Well, Dying Well" strategy. The plan is aimed at all people who would benefit from a palliative approach. Our approach is person centred and embraces the person, the family, whanau and other groups who may be involved in the person's journey. The care providers and partners in care are committed to maintaining the person at the centre of the service, linking in specialists, nursing and care support, allied health providers, pastoral care, and family support when it is needed. The service adjusts to the needs of the person.

In the last year, improvements in the Palliative Care service have included;

- increased hours for a GP specialist, in the role of Primary Care Liaison GP.
- Palliative Care Management meetings have become more inclusive, linking the Tū Ora Compass Health, GP liaison, and palliative care team.
- GP education around the Living Well Dying Well strategy, the gold standard (a system of needs based for prioritising and anticipatory planning) and medical care
- Clinical palliative care meetings and peer review have focussed on challenging issues in palliative care and linking to Te Omanga Hospice
- A clinical coach has been established to work alongside ARC providers to strengthen knowledge and skills- this role has been accepted very well by care teams.

Oral Health Services

All new-born babies are enrolled at birth and offered either a telephone 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 follow up with private practices to ensure the attendance of adolescents.

Pharmacy Services

The 2020/21 year continued to prove challenging for community pharmacies in responding to the many supply chain disruptions brought about by COVID-19. That meant extra work from having to dispense more frequently than usual to safeguard patient access to medication, and obtaining appropriate medications for patients when their usual medication was not available. The year was made even busier by pharmacies providing three times the amount of flu vaccinations in 2020 compared to 2019. Many pharmacists are also now trained to provide the COVID-19 vaccinations.

Aside from the outstanding response by community pharmacies to the challenges that COVID-19 brought, there were some other highlights. Access to fully funded emergency contraception through community pharmacies has now been extended to the 25-29 year olds, the age group that tends to have the highest number of terminations of pregnancy.

Use of cloud based medication charts was also extended to palliative care patients in the community. All relevant care providers including pharmacies, GPs, hospital and palliative care specialists and community palliative care nurses have access to the unique chart for each patient. These charting tools improve management for care providers involved in the care of a group of patients with often complex medication needs.

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	Target/Est. 2020/21	Baseline	Baseline data date	2019/20 Performance	2020/21 Performance	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	≥95%	84.60%	2019/20 Q2	84.80%	85.4%	Not Achieved
Percentage of patients 0-19 years referred to non-urgent child & adolescent Addiction services & seen within 8 weeks.	T	MH03	≥95%	87.10%	2019/20 Q2	100%	100.0%	Achieved
Percentage of clients with transition (discharge) plan	3DHB	MH02	≥95%	67%	2019/20 Q2	48%	51.0%	Not Achieved
Elective and Acute (Emergency Dept.) inpatient/outpatient								
Number of surgical elective discharges. (including minor procedures & non-surgical interventions)	V	SS07 (PC1)	≥3,404	3,232	2019/20 Q4	2,541	4,181	Achieved
Percentage of patients admitted, discharged or transferred from ED within 6 hours.	T	SS10	≥95%	91.80%	2019/20 Q4	91.8%	90.7%	Not Achieved
Inpatient average length of stay ALOS (Acute).	T	WPI	≤3.50	3.5	2019/20 Q4	2.66	2.43	Achieved
Inpatient average length of stay ALOS (Planned).	T	WPI	≤3.29	3.29	2019/20 Q4	1.47	1.31	Achieved
Standardised Acute Readmissions	Q	SS07 (PC6)	Total ≤11%	Total 10.6%	2019/20 Q4	10.3%	Total 11.2%	Not Achieved
				Māori 9.5%		8.5%	Māori 11.9%	
				75+Total 11.5%		15.0%	75+Total 17.7%	
				75+Māori 7.0%		9.1%	75+Māori 14.1%	

Outputs measured by	Type of measure	MOH indicator	Target/Est. 2020/21	Baseline	Baseline data date	2019/20 Performance	2020/21 Performance	Achievement
Quality and safety								
Rate of inpatient falls causing harm per 1,000 bed days.	Q	WPI	≤0.50	0.14	2019/20 Q4	0.14	0.19	Achieved
Rate of hospital acquired pressure injuries per 1,000 bed days.	Q	WPI	≤0.50	0.23	2019/20 Q4	0.23	0.62	Not Achieved
Rate of identified medication errors causing harm per 1,000 bed days.	Q	WPI	≤0.50	0.09	2019/20 Q4	0.09	0.05	Achieved
Percentage Did Not Attend (DNA) appointments for outpatient First Specialist assessments.	Q	SS07 (PC7)	≤8%	7.80%	2019/20 Q4	8.20%	6.6%	Achieved
Percentage DNA appointment for follow-up Specialist appointments.	Q	WPI	≤6%	5.90%	2019/20 Q4	6.50%	4.5%	Achieved
Patient experience (Note: the Patient Experience Survey format changed during the year meaning the original planned measures no longer exist. The following is an extract from the System Level Measures Performance Dashboard which replaced the original Patient Experience Survey)								
Did the GP or nurse involve you as much as you wanted to be in making decisions about your treatment and care?	Q	WPI	80.6%	78.6%	August 2020	Not reported	85.9%	Achieved
Were you involved as much as you wanted to be in making decisions about your treatment and care?	Q	WPI	79.1%	77.1%	August 2020	Not reported	81.4%	Achieved
Did hospital staff include your family/whanau or someone close to you in discussions about the care you received during your stay?	Q	WPI	82.0%	80.0%	August 2020	Not reported	84.8%	Achieved
Did you have enough information about how to manage your condition or recovery after you left hospital?	Q	WPI	65.8%	63.8%	August 2020	Not reported	80.0%	Achieved
Were you told the possible side-effects of the medicine (or prescription for medicine) you left the hospital with, in a way you could understand?	Q	WPI	67.8%	65.8%	August 2020	Not reported	75.0%	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	≥85%	94.10%	2019/20 Q2	91.40%	88.30%	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	≥90%	97.50%	2019/20 Q2	90.20%	88.60%	Not Achieved

Commentary

Quality

Inpatient Falls (causing harm Severity Assessment Code or 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 not achieved. WrDHB is actively participating in the new HQSC Pressure Injury Quality Safety Marker Programme. The combined Pressure Injury and Falls Prevention Committee has multi-disciplinary membership and meets quarterly to provide oversight and governance of the prevention programmes. Trends form part of pre reading data for the Committee quarterly meetings which report through to the Clinical Board. Additionally WrDHB has sign up to the ACC funded pressure injury prevention project with the aim to achieve significant positive outcomes.

Medication Errors (causing harm Severity Assessment Code or 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

Waiting times for youth has improved further during the last quarter of the year, with 100% of those referred to Addiction services being seen within 8 weeks, and almost 90% within 3 weeks. The NGO sector has been notable in their achievement of this target.

The Wairarapa MHS across all age groups continues to experience vacancies within a number of roles across adult and child/youth service, despite an energised effort to recruit. Location and local available workforce with appropriate skills appears to be the main contributor to this, but we have started investigating some permanent solutions utilising digital communication and supporting growth of this workforce through education in work programmes, both of which will be developed more extensively in 21/22. This factor has had an impact on meeting waiting time targets, particularly within the CAMHS team.

Primary Mental Health – Access and Choice programme continues to show successful and developing engagement with the local community

With the re-introduction of a single MH&A service development manager role supporting the mental health and addiction portfolio within the Wairarapa, there has been a great deal of opportunity to consider the current service provision and engage with providers regarding potentials for service development. We have been able to identify areas in youth, older persons and addiction services in particular that have had investment in order to improve outcomes in the local community.

We are working closely with the school based health programme to encourage investment in MH&A support for those in secondary education, and look to 21/22 for continued growth in this area amongst the NGO providers.

Finally, we have commenced work on collaborative co-design process funded by MoH to support transformational development of MHS across the Wairarapa. Formation of consumer groups across all age groups is key to this and we have some improved involvement to support this activity.

Medical and surgical services

2020/21 Emergency Department presentations increased by 6% on the previous 12 months in volumes with the most notable rises in triage 3 and 4 presentations the latter of which increased by over 11% . Inpatient

discharges at 10,284 were up 8% on the previous year having surpassed 10,000 for the first time since 2018. General Medicine and General Surgical discharges were the main contributors to admissions growth. Overall acute contract volumes delivery was up by 8% and Planned care/Elective volumes by 6%. Notable exceptions were seen in Orthopaedics where volumes have dropped comparatively due to challenges with surgeon recruitment. Overall for the same period the bed day numbers actually reduced by 2% for the year resulting from reductions to the ALOS between years as a result of targeted flow efficiency projects for inpatient care.

Waiting times for planned care saw Wairarapa achieve significantly positive performance results when compared to the overall national position in both procedures and specialist assessment activity. ESPI compliance was achieved across the majority of the year and we have been one of the only DHBs to have achieved this. Diagnostics wait times have however remained a challenge, in particular in those modalities where imaging is not available in the Wairarapa and services are delivered by other DHBs or providers (MRI). For locally delivered imaging the third quarter saw a period of pressure on CT wait times which were recovered and remained on track for the remainder of the year. Our performance in endoscopy waiting time and screening programmes remains strong.

Cancer services

The DHB overall average performance against the 62 day target of 90% for the 2020/21 year was slightly below target at 88.6%. The service has achieved the 31 day target with an annual performance of 88.3% compliance against the target of 85%. Performance in both measures has been impacted by the COVID-19 response however it was pleasing to exceed one target and be very close to the other over the course of the year. 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	Target/Est 2020/21	Baseline	Baseline data date	2019/20 Performance	2020/21 Performance	Achievement
% People > 75 living in their own home	C	SS04	Total ≥91.75%	91.26%	30/06/2019	Not reported	92.0%	Achieved
			Māori ≥93.75%	93.66%	30/06/2019	Not reported	97.0%	Achieved
Acute average length of stay in hospital for people >75 years of age	C	SS04	Total ≤5.5	5.6	30/06/2019	Not reported	4.7	Achieved
			Māori ≤4.5	4.1	30/06/2019	Not reported	7.3	Not Achieved
Standardised acute readmission rate for people >75 years of age	C	SS04	Total ≤11%	12%	30/06/2019	Not reported	12.6%	Not Achieved
			Māori ≤11%	11.20%	30/06/2019	Not reported	14.1%	Not Achieved
Rate of hip (neck of femur) fractures due to an out of hospital fall per 1,000 people >50 years of age	C	WPI	Total ≤0.7500	0.8675 per 1,000 population	30/06/2019	Not reported	0.8447 per 1,000 population	Not Achieved
% of residential care providers being awarded 3-year (or more) certification in the planned year	Q	WPI	100%	100%	30/06/2019	Not reported	100%	Achieved

Commentary

Disability care services

E-Learning: E-learning is now well established at Wairarapa DHB and all employees are able to access on-line training at any time.

Disability Alerts: The disability alert framework has migrated to become an initiative led out of the MOH and is being implemented on a national basis.

Health of older people services

Based on June 2021 data, 7.6 % of the older population received funded Home and Community Support 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.

Older people may enter residential care following an interRAI assessment by FOCUS and 3.7% of the Wairarapa population of people over 65 years are living in residential care. During 2020/2021, entry has increased to 211 people. This is an increase on previous years and reflects the growing older population in the Wairarapa. The percentage of the total 65+ population entering ARC is remaining stable.

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 Wairarapa 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 for the year ended 30 June 2021.

Signed on behalf of the Board:

Board member
17 December 2021

Board member
17 December 2021

Independent Auditor's Report

To the readers of Wairarapa District Health Board's financial statements and performance information for the year ended 30 June 2021

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 of the District Health Board, on his behalf.

We have audited:

- the financial statements of the District Health Board on pages 67 to 102, that comprise the statement of financial position as at 30 June 2021, 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 accounting policies and other explanatory information; and
- the performance information of the District Health Board on pages 19 to 59.

Opinion

In our opinion:

- the financial statements of the District Health Board on pages 67 to 102, which have been prepared on a disestablishment basis:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2021; and
        - its financial performance and cash flows for the year then ended; and
    - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards; and
- the performance information of the District Health Board on pages 19 to 59:
    - presents fairly, in all material respects, the District Health Board's performance for the year ended 30 June 2021, 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 2021. 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.

Emphasis of matters

Without modifying our opinion, we draw attention to the following disclosures.

The financial statements have been appropriately prepared on a disestablishment basis

Note 1 on page 72 outlines the health sector reforms announced by the Minister of Health on 21 April 2021. Legislation to disestablish all District Health Boards and establish a new Crown entity, is expected to come into effect on 1 July 2022. The District Health Board therefore prepared its financial statements on a disestablishment basis. The values of assets and liabilities have not changed because these will be transferred to the new Crown entity.

Uncertainties in estimating the holiday pay provision under the Holidays Act 2003

Note 14 on page 92 to 94 outlines that 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. The District Health Board has estimated a provision of $10.4 million, as at 30 June 2021 to remediate these issues. However, until the process is completed, there are uncertainties surrounding the amount of this provision.

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

Note 1 on page 72 outlines the District Health Board's financial performance difficulties. There is uncertainty whether the District Health Board will be able to settle its liabilities, including the estimated historical Holidays Act 2003 liability, if they were to become due prior to disestablishment. The District Health Board therefore obtained a letter of comfort from the Ministers of Health and Finance, which confirms that the Crown will provide the District Health Board with financial support, where necessary.

Seismic status of main hospital building

Note 10 on pages 84 to 88 outlines 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 101 of the financial statements and page 40 of the performance information outlines the impact of Covid-19 on the District Health Board.

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

Note 2 on page 36 and 37 outlines the information used by the District Health Board to report on its Covid-19 vaccine coverage. The District Health Board uses the Health Service User (HSU) population data rather than the population data provided by Statistics New Zealand (Stats NZ), for the reasons set out in Note 2. The note outlines that there would be differences in the reported results for the overall population if the Stats NZ population data was used. There would be further differences in the reported results of vaccination coverage if the Stats NZ population data is classified by ethnicity and age. The District Health Board has provided a table that highlights the differences in the ethnicity groupings between the HSU population data and the Stats NZ population data.

Basis for our opinion

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

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

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

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 liquidate 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 disestablishment basis of accounting by the Board.

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

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

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

Our responsibilities arise from the Public Audit Act 2001.

Other Information

The Board is responsible for the other information. The other information comprises the information included on pages 1 to 102 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 2021

	Note	Budget 2021 $000	Actual 2021 $000	Actual 2020 $000
Revenue				
Patient care revenue	2	187,011	191,613	174,524
Interest revenue		24	62	69
Other revenue	2	5,382	5,297	4,630
Total revenue		**192,417**	**196,972**	**179,223**
Expenditure				
Personnel costs	3	56,011	50,722	56,147
Outsourced services		8,266	15,909	10,519
Clinical supplies		12,278	12,591	12,035
Infrastructure and non-clinical expenses		8,791	9,260	9,590
External providers		59,169	61,111	57,446
Inter district flows		44,494	45,151	41,404
Capital charge	4	2,251	1,424	1,958
Interest expense		10	0	9
Depreciation and amortisation expense	10, 11	2,319	2,564	2,509
Impairment expense	10, 11	0	1,494	4,223
Other expenses	5	1,828	1,852	1,750
Total expenses		**195,417**	**202,078**	**197,590**
Surplus/(deficit)		**(3,000)**	**(5,106)**	**(18,367)**
Other comprehensive revenue and expense				
Item that will not be reclassified to surplus/(deficit)				
Revaluation of land and building	16	0	0	0
Total other comprehensive revenue and expense		**0**	**0**	**0**
Total comprehensive revenue and expense		**(3,000)**	**(5,106)**	**(18,367)**

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 2021

	Note	Budget 2021 $000	Actual 2021 $000	Actual 2020 $000
Assets				
Current assets				
Cash & cash equivalents	6	10	4,750	5,920
Receivables	7	6,439	6,473	5,694
Prepayments		370	260	228
Investments	8	185	84	85
Inventories	9	1,040	993	1,082
Total current assets		8,044	**12,560**	**13,009**
Non-current assets				
Property, plant & equipment	10	46,258	45,290	44,976
Intangible assets	11	12,833	4,794	6,521
Total non-current assets		**59,091**	**50,084**	**51,497**
Total assets		**67,135**	**62,644**	**64,506**
Liabilities				
Current liabilities				
Cash & cash equivalents - overdraft	6	1,041	0	0
Payables and deferred revenue	12	11,725	18,382	15,441
Borrowings	13	0	0	0
Employee entitlements	14	13,160	18,646	18,311
Total current liabilities		**25,926**	**37,028**	**33,752**
Non-current liabilities				
Borrowings	13	0	0	0
Employee entitlements	14	639	531	566
Restricted Funds	15	185	91	85
Total non-current liabilities		**824**	**622**	**651**
Total liabilities		**26,750**	**37,650**	**34,403**
Net assets		**40,385**	**24,994**	**30,103**
Equity				
Crown equity	16	106,575	103,569	103,572
Revaluation reserve	16	11,234	11,234	11,234
Retained earnings	16	(77,424)	(89,809)	(84,703)
Total equity		**40,385**	**24,994**	**30,103**

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 2021

	Note	Budget 2021 $000	Actual 2021 $000	Actual 2020 $000
Balance at 1 July		**40,385**	**30,103**	**35,473**
Net surplus / (deficit) for the year		(3,000)	(5,106)	(18,367)
Other comprehensive revenue and expense		0	0	0
Total comprehensive revenue and expense		(3,000)	(5,106)	(18,367)
Equity injection from the Crown		3,000	0	13,000
Repayment of equity to the Crown		0	(3)	(3)
Movements in equity for the year		3,000	(3)	**12,997**
Balance at 30 June	16	**40,385**	**24,994**	**30,103**

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 2021

	Budget 2021 $000	Actual 2021 $000	Actual 2020 $000
Cash flows from operating activities			
Operating receipts:			
Government & crown agency revenue	186,770	191,461	175,294
Other	5,214	5,281	4,684
Interest received	24	61	68
Payments to suppliers & employees	(191,527)	(194,334)	(180,434)
Capital charge paid	(2,251)	(1,424)	(1,958)
Interest paid	(10)	0	(9)
Goods and Services Tax (net)	(400)	144	184
Net cash flows from operating activities	**(2,180)**	**1,189**	**(2,171)**
Cash flows from investing activities			
Increase in investment	0	7	0
Proceeds from sale of property, plant & equipment	220	60	0
Acquisition of property, plant & equipment	(3,560)	(1,789)	(1,687)
Acquisition of intangible assets	(2,269)	(634)	(1,291)
Net cash flows from investing activities	**(5,609)**	**(2,356)**	**(2,978)**
Cash flows from financing activities			
Equity injected	3,000	0	13,000
Repayments of loans	0	0	(139)
Repayment of equity	0	(3)	(3)
Net cash flows from financing activities	**3,000**	**(3)**	**12,858**
Net increase / (decrease) in cash & cash equivalents	**(4,789)**	**(1,170)**	**7,709**
Cash & cash equivalents at beginning of year	3,758	5,920	(1,789)
Cash & cash equivalents at end of year	**(1,031)**	**4,750**	**5,920**

Reconciliation of net deficit to net cash flow from operating activities

	Actual 2021 $000	Actual 2020 $000
Net surplus / (deficit)	**(5,106)**	**(18,367)**
Add/(less) non-cash items		
Depreciation and amortisation expense	2,564	2,509
Impairment of Intangibles	1,494	4,223
Net movement in non-cash items	**4,058**	**6,732**
Add/(less)items classified as investing or financing activities		
Net (gains)/losses on disposal of property, plant & equipment	(60)	0
Net movement in investing or financing activities	**(60)**	**0**
Add/(less) movements in statement of financial position items		
(Increase)/decrease in receivables	(779)	741
(Increase)/decrease in inventories	89	(43)
(Increase)/decrease in payables	2,719	2,944
Increase/(decrease) in prepayments	(32)	92
Increase/(decrease) in provisions	300	5,730
Net movement in working capital items	**2,297**	**9,464**
Net cash flow from operating activities	**1,189**	**(2,171)**

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 2021

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 and operates 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 DHB 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 2021 and were approved for issue by the Board on 17 December 2021.

BASIS OF PREPARATION

Health Sector Reforms

On 21 April 2021, the Minister of Health announced the health sector reforms in response to the Health and Disability System Review.

The reforms will replace all 20 DHBs with a new Crown Entity, Health New Zealand, that will be responsible for running hospitals and commissioning primary and community health services. It will have four regional divisions.

As a result of the reforms, responsibility for public health issues will rest with a new Public Health Authority. A new Maori Health Authority will monitor the state of Maori health and commission service directly.

Legislation to establish the new entities and disestablish DHBs is scheduled to come into effect on 1 July 2022.

Because of the expected date of these reforms the financial statements of the DHB have been prepared on a disestablishment basis. No changes have been made to the recognition and measurement, or presentation in these financial statements, because all assets, liabilities, functions and staff of the DHBs and shared services agencies will transfer to Health New Zealand.

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 2021/22, 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.

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 generally accepted accounting practice (GAAP).

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

Presentation currency and rounding

The financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars ($000), other than remuneration disclosed in accordance with section 152 of the Crown Entities Act 2004 in Note 3 and the related party transaction disclosures in Note 18, which are rounded to the nearest dollar.

Changes in accounting policies

There have been no changes in the DHB's accounting policies since the date of the last audited 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 the year ended 30 June 2022, with early application permitted. This amendments will result in additional disclosures. The DHB does not intend to early adopt the amendment.

PBE IPSAS 41 Financial Instruments

PBE IPSAS 41 replaces PBE IFRS *Financial Instruments* and is effective for the year ended 30 June 2023, with earlier adoption permitted. The DHB has assessed that there will be little change as a result of adopting the new standard as the requirements are similar to those contained in PBE IFRS 9. The DHB does not intend to early adopt the standard.

PBE FRS 48 Service Performance Reporting

PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 *Presentation of Financial Statements* and is effective for the year ending 30 June 2023, with earlier adoption permitted. The DHB has not yet determined how application of PBE FRS 48 will affect its statement of performance. It does not plan to early adopt the standard.

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

Goods and services tax

All items in the financial statements are presented exclusive of goods and services tax (GST), except for receivables and payables, 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 (IR) is included as part of receivables or payables in the statement of financial position.

The net GST paid to, or received from the IR, including the GST relating to investing and financing activities is classified as a net operating cash flow in the statement of cash flows.

Commitments and contingencies are disclosed exclusive of GST.

Income tax

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

Budget figures

The budget figures are derived from the 2020/21 Statement of Performance Expectations. The budget has been prepared in accordance with GAAP, using accounting policies that are consistent with those adopted by the Board in preparing these 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.
- 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 or heart checks.

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

	Actual 2021 $000	Actual 2020 $000
MoH population-based funding	166,653	149,100
MoH other contracts	15,218	17,185
Inter-district flows	4,852	4,563
ACC contract revenue	2,680	2,489
Other patient care related revenue	2,210	1,187
Total patient care revenue	**191,613**	**174,524**

ii. Other revenue

	Actual 2021 $000	Actual 2020 $000
Gain on sale of property, plant and equipment	60	4
Cash donations and bequests received	56	189
Rental revenue	1,471	1,241
Other revenue	3,710	3,196
Total other revenue	**5,297**	**4,630**

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

	Actual 2021 $000	Actual 2020 $000
Salaries and wages	48,956	48,900
Defined contributions plan employer contributions	1,466	1,517
Increase/(decrease) in liability for employee entitlements	300	5,730
Total personnel costs	**50,722**	**56,147**

Employee remuneration

The number of employees or former employees who received remuneration and other benefits of $100,000 or more within specified $10,000 bands were as follows:

	2021		2020	
	Number of Clinical Staff	Number of Non-Clinical Staff	Number of Clinical Staff	Number of Non-Clinical Staff
$100,000 - $109,999	18	3	22	8
$110,000 - $119,999	7	4	15	4
$120,000 - $129,999	6	1	3	4
$130,000 - $139,999	2	2	4	2
$140,000 - $149,999	4		1	
$150,000 - $159,999		2	2	2
$160,000 - $169,999	1		1	
$170,000 - $179,999	1		2	
$180,000 - $189,999		1		2
$190,000 - $199,999			2	
$200,000 - $209,999	2	1		
$210,000 - $219,999	1			
$220,000 - $229,999	1	1	1	
$230,000 - $239,999			3	
$240,000 - $249,999	6		1	
$260,000 - $269,999			1	
$270,000 - $279,999	2			
$280,000 - $289,999	1		1	
$300,000 - $309,999	2		2	
$310,000 - $319,999			1	
$320,000 - $329,999	1	1	3	1
$330,000 - $339,999	2		3	
$340,000 - $349,999	2		1	
$350,000 - $359,999	1		1	
$370,000 - $379,999			1	
$380,000 - $389,999	1			
$390,000 - $399,999			1	
$400,000 - $409,999	1		1	
$420,000 - $429,999	1		1	
$450,000 - $459,999			1	
$490,000 - $499,999	1			
$500,000 - $509,999			1	
$530,000 - $539,999	1			
	65	**16**	**76**	**23**

The reduced number of staff included in this analysis has been impacted by the transfer to CCDHB of all IT and Mental Health staff (17 staff removed).

During the year no payments, either as redundancy compensation or in equalisation payments upon completion of a service review, were paid by the DHB (2020: nil).

Board member remuneration

The total value of remuneration paid or payable to each Board member during the year was:

	2021 Board Fee	2021 Committees	2021 Total Fees	2020 Total Fees
Sir Paul Collins (Chairman)	33,059	2,750	35,809	33,816
Dr Tony Becker (Deputy Chair)	20,086	2,771	22,857	11,696
Leanne Southey (FRAC Chair)	16,320	3,063	19,383	20,857
Ronald Karaitiana (HAC Chair)	16,069	2,500	18,569	18,068
Joy Cooper	16,069	2,500	18,569	9,599
Yvette Grace	16,320	2,500	18,820	9,852
Dr Norman Gray	16,320	2,250	18,570	10,102
Jill Pettis	16,069	250	16,319	8,599
Helen Pocknall	16,320	2,000	18,320	10,102
Ryan Soriano	16,069	250	16,319	8,599
Jill Stringer	16,069	2,500	18,569	9,599
Derek Milne	0	0	0	7,718
Nick Crozier	0	0	0	7,405
Liz Falkner	0	0	0	6,905
Jane Hopkirk	0	0	0	7,655
Rick Long	0	0	0	8,155
Fiona Samuel	0	0	0	6,905
Alan Shirley	0	0	0	7,405
Adrienne Staples	0	0	0	7,655
TOTAL	**198,769**	**23,334**	**222,103**	**210,692**

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 (2020:$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 DHB 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 2021 was 5% (2020: 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

	Actual 2021 $000	Actual 2020 $000
Operating lease and rental expenses	1,436	1,315
Audit fees (Audit NZ for annual financial statements)	139	144
Audit fees (CRTAS for other assurance services)	64	45
Impairment of receivables (bad & doubtful debts)	(39)	24
Board member fees & expenses	252	222
Loss on disposal of property, plant and equipment	0	0
Total other expenses	**1,852**	**1,750**

Operating leases as lessee

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

	Actual 2021 $000	Actual 2020 $000
Not later than one year	572	881
Later than one year and not later than five years	699	947
Later than five years	20	58
Total non-cancellable operating leases	**1,291**	**1,886**

The DHB leases a number of buildings, vehicles and clinical equipment under operating leases.

6. Cash and cash equivalents

Accounting policy

Cash and cash equivalents includes cash on hand, deposits held at call with banks, and other short-term highly liquid investments with original maturities of three months or less, 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 2021 $000	Actual 2020 $000
Current Assets:		
Cash on hand	4	2
Westpac account	(4)	1
Bank - BNZ / NZHP Sweep	4,750	5,917
Current Liabilities:		
Bank overdraft - BNZ / NZHP Sweep	0	0
Total cash and cash equivalents	**4,750**	**5,920**

The DHB is party to a DHB Treasury Services Agreement between New Zealand Health Partnerships Limited (NZHPL) and participating DHBs. This Agreement enables NZHPL to "sweep" DHB bank accounts and invest surplus funds on their behalf. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with NZHPL, which will incur interest at the credit interest rate received by NZHPL plus an administrative margin. The balance held by the DHB within this Agreement is shown as bank overdraft within the table above. The maximum borrowing facility available to any DHB is the value of one month's Provider Arm funding inclusive of GST. As at 30 June 2021 this limit was $7.19m (2020:$5.642 million).

While cash and cash equivalents at 30 June 2021 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.

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 or a failure to make contractual payments for a period of greater than 90 days past due.

Breakdown of receivables and further information

	Actual 2021 $000	Actual 2020 $000
Gross receivables	6,502	5,763
Less: Allowance for credit losses	(29)	(69)
Total receivables	**6,473**	**5,694**
Receivables consist of		
Receivables from MoH	3,814	2,295
Other receivables	1,086	705
Other accrued revenue	1,602	2,763
Less: Allowance for credit losses	(29)	(69)
Total receivables	**6,473**	**5,694**

	Receivables days past due				
30 June 2021	Current	1-30 days	31-90 days	More than 90 days	Total
Expected credit loss rate	0.0%	0.0%	13.3%	18.6%	
Gross carrying amount ($000)	6,231	87	90	94	**6,502**
Lifetime expected credit loss ($000)	-	-	12	17	**29**

	Receivables days past due				
30 June 2020	Current	1-30 days	31-90 days	More than 90 days	Total
Expected credit loss rate	0.0%	0.0%	9.5%	31.6%	
Gross carrying amount ($000)	5,225	13	438	87	**5,763**
Lifetime expected credit loss ($000)	-	-	42	27	**69**

The expected credit loss rates for receivable as at 30 June 2021 and 30 June 2020 are based on the payment profile of revenue on credit over the previous two years at the measurement date and the corresponding historical credit losses experience for that period. Given the short period of credit risk exposure, the impact of macroeconomic factors is not considered significant.

There have been no material changes during the reporting period in the estimation techniques or assumptions used in measuring the loss allowance.

The movement in the allowance for credit losses is as follows:

	Actual 2021 $000s	Actual 2020 $000s
Balance at 1 July	69	46
Additional provisions made/(provisions released)	(33)	25
Receivables written off during the year	(7)	(2)
Balance at 30 June	**29**	**69**

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

	Actual 2021 $000	Actual 2020 $000
Current Portion		
Term deposits with maturites less than 3 months	84	85
Term deposits with maturites less than 12 months	0	0
Total investments	**84**	**85**

The DHB considers there has not been a significant increase in credit risk for investments in term deposits because the issuer of the investment continues to have low credit risk at balance date. Term deposits are held with banks that have a long-term AA- investment grade credit rating, which indicates that the bank has a strong capacity to meet its financial commitments.

No loss allowance for expected credit losses has been recognised because the estimated 12-month expected loss allowance for credit losses is trivial.

The carrying amounts of term deposits with maturities less than 12 months approximate their fair value.

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

	Actual 2021 $000	Actual 2020 $000
Central Warehouse	614	533
Pharmaceuticals	205	135
Surgical and medical supplies (held in Theatre and Wards)	274	474
Less: provision for obsolete stock	(100)	(60)
Total trade inventories	**993**	**1,082**

The amount of inventories recognised as an expense during the year was $2.74m (2020:$2.65m), which is included in the clinical supplies line item of the statement of comprehensive revenue and expense.

The write-down of inventories held for distribution amounted to $100k (2020:$60k). There have been no reversals of write-downs.

No inventories are pledged as security for liabilities (2020:$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, information technology, motor vehicles and other plant and equipment.

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 reverses a previous decrease in value recognised in the surplus or deficit will be recognised first in the surplus or deficit up to the amount previously expensed, and then recognised in other comprehensive revenue and expense.

Additions

The cost of an item of property, plant, and equipment is recognised as an asset only when it is probable that future economic benefits or service potential associated with the item will flow to the DHB 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 cost. 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 DHB and the cost 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 disposals are determined by comparing the proceeds with the carrying amount of the asset. Net gains or 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 surplus or deficit 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

Property, plant, and equipment 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. For revalued assets, the impairment loss is recognised in other comprehensive revenue and expense and decreases the revaluation reserve for that class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised in the surplus or deficit.

For assets not carried at a revalued amount, the total impairment loss is recognised in the surplus or deficit.

The reversal of an impairment loss on a revalued asset is recognised in other comprehensive revenue and expense and increases the asset revaluation reserve for the class of asset. However, to the extent that an impairment loss for the class of asset was previously recognised in the surplus or deficit, a reversal of an impairment loss is also recognised in the surplus or deficit.

For assets not carried at a revalued amount, the reversal of an impairment loss is recognised in the surplus or deficit.

Critical accounting estimates and assumptions

Estimating the fair value of land and buildings

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.

The Board has already requested additional seismic reports on the main hospital, including costs to remediate to higher levels of NBS. The outcome of this work may impact the carrying value of the buildings in coming years. Once the outcome is 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	IT, Motor vehicles and other plant and equipment	Total
	$000	$000	$000	$000	$000
Cost / valuation					
Balance at 1 July 2019	2,890	38,340	8,104	3,454	52,788
Additions	0	417	1,126	240	1,783
Balance at 30 June 2020	**2,890**	**38,757**	**9,230**	**3,694**	**54,571**
Balance at 1 July 2020	2,890	38,757	9,230	3,694	54,571
Additions	0	175	1,593	207	1,975
Disposals	0	0	(56)	0	(56)
Balance at 30 June 2021	**2,890**	**38,932**	**10,767**	**3,901**	**56,490**
Accumulated Depreciation & impairment losses					
Balance at 1 July 2019		11	5,579	2,487	8,077
Depreciation charge for the year		790	451	277	1,518
Balance at 30 June 2020		**801**	**6,030**	**2,764**	**9,595**
Balance at 1 July 2020		801	6,030	2,764	9,595
Depreciation charge for the year		788	596	277	1,661
Elimination on disposal		0	(56)	0	(56)
Balance at 30 June 2020		**1,589**	**6,570**	**3,041**	**11,200**
Carrying amounts					
At 1 July 2019	2,890	38,329	2,525	967	44,711
At 30 June 2020	**2,890**	**37,956**	**3,200**	**930**	**44,976**
At 30 June 2021	**2,890**	**37,343**	**4,197**	**860**	**45,290**

The DHB has contractual commitments at balance date of $0.416m (2020:$0.722m) in relation to clinical equipment.

Restrictions on title

The DHB does not have full legal title to the Crown land it occupies, but transfer is arranged if and when land is sold. 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 any 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 DHB'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%

No differentiation between acquired computer software or internally developed software is made.

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 any indication of impairment.

Breakdown of intangible assets and further information

	Software $000	Work in progress $000	Total $000
Cost			
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**
Balance at 1 July 2020	9,231	732	9,963
Additions	0	670	670
Additions (transfer)	(27)	27	0
Assets Impaired	(894)	(600)	(1,494)
Balance at 30 June 2021	**8,310**	**829**	**9,139**
Accumulated amortisation & impairment losses			
Balance at 1 July 2019	2,451	0	2,451
Amortisation charge for the year	991	0	991
Balance at 30 June 2020	**3,442**	**0**	**3,442**
Balance at 1 July 2020	3,442	0	3,442
Amortisation charge for the year	903	0	903
Impairment	0	0	0
Balance at 30 June 2021	**4,345**	**0**	**4,345**
Carrying amounts			
Balance at 1 July 2019	4,351	6,240	10,591
Balance at 30 June 2020	5,789	732	**6,521**
Balance at 1 July 2020	5,789	732	6,521
Balance at 30 June 2021	**3,965**	**829**	**4,794**

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

The DHB has contractual capital commitments of $1.748m (2020: $0.495m) 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 2021 the DHB has paid $5.657 million (2020: $5.657m) as its share of the project funding, which represent its rights to use the systems when developed.

Central Region IT Projects

In 2020 the software systems under development by Central Region's Technical Advisory Services Ltd (CRTAS) were assessed for impairment which resulted in an impairment being recognised of $4.223m. As at 30 June 2021 a further assessment was undertaken and a further impairment recognised in relation to software under-development of $0.955m.

12. Payables and deferred revenue

Accounting policy

Short-term payables are recorded at the amount payable.

Breakdown of payables and deferred revenue

	Actual 2021 $000	Actual 2020 $000
Payables and deferred revenue under exchange transactions		
Trade creditors and accruals	4,196	4,058
Revenue received in advance	9	9
Total payables and deferred revenue under exchange transactions	4,205	4,067
Payables and deferred revenue under non-exchange transactions		
Trade creditors and accruals	11,143	9,157
GST and other taxes	2,051	1,904
Revenue received in advance	983	313
Total payables and deferred revenue under non-exchange transactions	14,177	11,374
Total payables and accruals	**18,382**	**15,441**

13. Borrowings

Accounting policy

Overdraft facility

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

There were no borrowings as at 30 June 2021 or 2020.

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 2020 year.

14. Employee entitlements

Accounting policy

Short-term employee entitlements

Employee entitlements that are due to be settled wholly before 12 months after the end of the reporting period 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 not expected to be settled wholly before 12 months after the end of the reporting period 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 1.15% for long service leave (2020: 0.5%) and 1.6% for retirement gratuities (2020: 0.8%) and a salary increase assumption of 2% (2020: 2%) were used. The discount rates used are based on market yields at balance date. The salary inflation factor is the DHB'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 three years, will on average be 50% (2020: 50%) of the full entitlement. This utilisation assumption is based on recent experience. The liability has not been calculated on an actuarial basis because the present value effect is trivial.

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 Holidays Act).

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

For employers such as the DHBs that have workforces that include differential occupational groups with complex entitlements, non-standard hours, allowances and/or overtime, the process of assessing non-compliance with the Holidays 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 progressed during the 2019/20 and current financial years. The final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed.

As a result the 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 Holidays Act and the requirements of the MOU. The liability was estimated by:

- selecting a sample of current and former employees;
- calculating the underpayment for these employees over the full period of liability; and
- extrapolating the result.

The liability recognised 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 as to the actual amount the DHB will be required to pay to current and former employees.

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.

The estimates and assumptions may differ to the subsequent actual results as further work is completed. This may result in further adjustment to the carrying amount of the liability within the next financial year or payments to current and former employees that differ significantly from the estimation of the liability.

Breakdown of employee entitlements:

	Actual 2021 $000	Actual 2020 $000
Current portion		
Accrued salary and wages	1,495	2,068
Annual leave	4,480	4,263
Holidays Act 2003 remediation	10,388	9,675
Stat Days and Days in Lieu	1,080	1,101
Sick leave	87	95
Maternity grant	12	12
Continued medical education expenses	362	299
Long service leave	441	498
Retirement gratuities	301	300
Total current portion	18,646	18,311
Non-current Portion		
Long service leave	292	318
Retirement gratuities	239	248
Total non-current portion	531	566
Total employee entitlements	**19,177**	**18,877**

15. Restricted Funds

	Actual 2021 $000	Actual 2020 $000
Balance at beginning of year	85	185
Funds received	12	1
Interest received	0	3
Funds spent	(6)	(104)
Balance at end of year	**91**	**85**

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. As at the 30 June 2021 however there was a variance because of the delay in the transfer of funding between bank accounts.

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
- Property revaluation reserves and
- Retained earnings.

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 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**
Balance at 1 July 2020	103,572	11,234	(84,703)	30,103
Total recognised revenue & expenses	0	0	(5,106)	(5,106)
Contribution from the Crown	0	0	0	0
Repayment to the Crown	(3)	0	0	(3)
Movement in revaluation of land & buildings	0	0	0	0
Balance at 30 June 2021	**103,569**	**11,234**	**(89,809)**	**24,994**

Capital management

The DHB's capital is its equity, which consists of Crown equity, accumulates surpluses or 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 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 2021 (2020: $nil). Likewise, the DHB has no contingent assets as 30 June 2021 (2020: $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 DHB 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 2021 $000	Actual 2020 $000
Board Members		
Remuneration	222	211
Full-time equivalent members	1.0	0.9
Leadership Team		
Remuneration	1,968	2,040
Full-time equivalent members	8.4	8.4
Total key personnel remuneration	**2,190**	**2,251**
Full-time equivalent personnel	**9.4**	**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

After balance date, in August 2021 New Zealand moved into alert level 4 in response to Covid-19 and the Delta variant entering the country. This has not materially impacted on the actual results of the DHB that have occurred between year end and the signing of the financial statements.

The DHB is investigating options to strengthen and upgrade its current patient management system (webPAS). This may involve migrating to a vendor maintained cloud instance of WebPAS. The options are part of a regional project together with MidCentral DHB and Whanganui DHB. The outcome of this project may cause the (partial) impairment of the existing WebPAS assest. The net book value of the existing assets as at 30 June 2021 is $2.826m. The impact of any impairment is not yet known.

20. Financial Instruments

20A Financial instrument categories

The carrying amounts of financial assets and liabilities in each of the PBE IFRS 9 financial instrument categories are as follows:

	Note	Actual 2021 $000s	Actual 2020 $000s
Financial assets measured at amortised cost:			
Cash and cash equivalents	**6**	4,754	5,920
Trade and other receivables	**7**	6,473	5,694
Investments	**8**	84	85
Total financial assets measured at amoritised cost		**11,311**	**11,699**
Financial liabilities measured at amortised cost:			
Payable & accruals (excluding deferred revenue and taxes)	**12**	15,339	13,216
Cash and cash equivalents -Overdraft	**6**	4	0
Total financial liabilities measured at amortised cost		**15,343**	**13,216**

20B Fair value hierarchy

The only financial instruments the DHB 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 (2020:$nil).

20C Financial instrument risks

The DHB's activities expose it to a variety of financial instrument risks, including market risk, credit risk, and liquidity risk. The DHB 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 DHB 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 DHB'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 DHB, 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 DHB'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 DHB 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 $135k so the DHB's foreign currency risk exposure is not considered material and is not actively managed.

Credit risk

Credit risk is the risk that a third party will default on its obligations to the DHB, causing it to incur a loss.

Due to the timing of the DHB's cash inflows and outflows, surplus cash is invested with 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 (2021: 59% (2020:40%)). It is assessed as a low-risk and high-quality entity due to being a government-funded purchaser of health and disability services.

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

Credit risk exposure by credit risk grades, excluding receivables

The gross carrying amount of financial assets, excluding receivables, by credit rating is provided below by reference to Standard and Poor's credit rating (if available).

	Actual 2021 $000s	Actual 2020 $000s
COUNTERPARTIES WITH CREDIT RATINGS		
Cash at bank and investments		
AA-	84	86
Total cash at bank and investments - with credit ratings	84	86
COUNTERPARTIES WITHOUT CREDIT RATINGS		
Cash and cash equivalents		
NZ Health Partnerships Ltd	4,750	5,917

All instruments in this table have a loss allowance based on 12-month expected credit losses.

Liquidity Risk

Management of liquidity risk

Liquidity risk is the risk that the DHB 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 DHB 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.

30 June 2021	Carrying amount $000s	Contractual cash flows $000s	Less than 6 months $000s	6-12 months $000s	More than 1 year $000s
Payables & accruals (excluding deferred revenue and taxes)	15,339	15,339	15,339	0	0

30 June 2020	Carrying amount $000s	Contractual cash flows $000s	Less than 6 months $000s	6-12 months $000s	More than 1 year $000s
Payables & accruals (excluding deferred revenue and taxes)	13,216	13,216	13,216	0	0

21. Explanation of major variances against budget

Explanations for major variances from the DHB's budgeted figures in the statement of performance expectations are as follows:

Statement of comprehensive revenue and expense

Net Result

Overall the net result of ($5.106m) for WDHB was ($2.106m) adverse to budget. The net result was favourable by $0.154m prior to ($0.766m) of additional costs related to the Holidays Act and asset impairments of ($1.494m).

Revenue

Revenue was $4.555m favourable with $3.315m of additional revenue received from the Ministry of Health which included: $2.149m in relation to Covid-19 funding, $0.356m for Planned Care Services, $0.383m for mental health services and $0.243m for in-between travel, with revenue from other DHBs of an additional $1.125m and other sources of $0.115m.

Expenditure

Expenditure was ($6.661m) more than budgeted including:

- $5.289m lower personnel costs with the variance including:
  - $4.515m lower costs due to the transfer of mental health and IT staff to Capital and Coast DHB
  - $1.500m lower personnel costs because of medical staff vacancies which was partly offset by higher nursing costs
  - ($0.766m) as a further adjustment under the Holidays Act to recognise the remediation costs payable to employees.
- ($7.643m) higher outsourced costs including:
  - ($3.067m) higher outsourced personnel costs primarily for locum doctors to cover vacancies and leave but also includes ($0.774m) in relation to IT costs outsourced to CCDHB.
  - ($4.576m) higher other outsourced costs which is primarily from the Mental Health services costs now delivered by CCDHB.

- ($1.942m) higher funder expenditure including covid-19 related costs which was covered by additional funding and higher costs for community pharmaceuticals which was partly off-set by lower costs from lower than expected utilisation of Health Of Older People Services.
- ($0.657m) higher IDF outflows payable to other DHBs for services received for our population.
- ($1.494m) impairment of intangible assets to reflect the remaining useful life of some assets.

Statement of financial position

Assets

- The bank account was budgeted to be in overdraft but was actually in funds so was $5.781m favourable which was because of higher creditors and lower capital expenditure than budgeted.
- Property, plant and equipment was ($0.968m) lower than budget because of delays in the purchase of equipment. Total additions during the year was $1.975m compared to a budget of $3.560m.
- Intangible assets was ($8.039m) lower than budget which is mainly due to the total impairments actioned in 2019/20 and 2020/21 of $5.717m, and the planned expenditure on IT projects being deferred. Total additions during the year was $0.670m compared to a budget of $2.269m.

Liabilities

- Payables was $6.657m higher than budget and increased by $2.941m from last year end including $1.427m relating to the funder including $0.985m costs payable to other DHBs for IDFs and $0.442k relating to other funder expenditure; and $1.514m of other amounts payable to other DHBs primarilty payable to CCDHB for IT and Mental Health services provided following the transfer of staff.
- Employee entitlements was $5.378m higher than budget because of significant increase in the provision in 2019/20 which was not reflected in the budget.

Statement of changes in equity

- The opening balance was $10.282m below budget due to the higher deficit in 2019/20.
- The deficit for the current year was $2.106m higher than budgeted due to the statement of comprehensive revenue and expense explanations provide above.
- The planned equity injection of $3m was not required given the current bank balance and the NZHPL overdraft facility available.

Statement of cash flows

- The opening balance was $2.162m better than expected and together with the higher creditors at the end of the year and lower capital expenditure during the year resulted in the cash position at the end of the year being $5.781m favourable.
- As mentioned above the planned equity injection of $3m was not required.

22. Summary cost of services

Accounting policy

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.

	Budget 2021 $000	Actual 2021 $000	Actual 2020 $000
Revenue			
Prevention services	5,555	5,600	5,225
Early detection and management services	32,256	32,426	29,335
Intensive assessment and treatment services	122,560	126,291	113,801
Rehabilitation and support services	32,046	32,655	30,863
Total revenue	**192,417**	**196,972**	**179,224**
Expenditure			
Prevention services	6,251	6,092	5,756
Early detection and management services	32,007	32,680	29,767
Intensive assessment and treatment services	127,866	136,316	133,118
Rehabilitation and support services	29,293	26,990	28,950
Total expenditure	**195,417**	**202,078**	**197,591**
Land and Buldings revaluation not allocated	0	0	0
Total comprehensive revenue and expense	**(3,000)**	**(5,106)**	**(18,367)**

23. Impact of Covid-19 on the DHB

Wairarapa DHB is deemed an essential service and operations continued during the changes to COVID-19 alert levels.

Statement of Comprehensive Revenue and Expenses

Government funding

The MOH approved funding of $1.973m for the DHB to assist with the Covid-19 response and particularly for GP based assistance and Covid-19 vaccination costs. In addition, the MoH announced additional funding of $0.176m million to support community health providers impacted by the Covid-19 lockdown, and this

funding was paid to pharmacists, aged care providers and to support the digital enablement of PHO payments.

Personnel expenses

Personnel expenses have increase by $0.424m due to an increase in permanent and casual staff for the vaccination programme.

Other expenses

There was an increase in clinical and infrastructure and non-clinical supply costs of $0.155m, mainly driven by the administration of the Covid-19 vaccine roll-out such as leasing additional premises, hygienic and sanitation supplies, IT costs and advertising and signage costs.