Wairarapa District Health Board

Annual Report 2014

CONTENTS

FOREWORD

ABOUT WAIRARAPA DISTRICT HEALTH BOARD

Wairarapa District Health Board (DHB) works cooperatively with health professionals and the community to improve, promote and protect the health and wellbeing of the Wairarapa community, with a focus on reducing differences in health outcomes, particularly for Māori.

Wairarapa DHB operates hospital, health and disability support services and contracts independent community-based organisations to provide services, such as Compass Health, family doctors, pharmacists, Care NZ, disability support and Māori health organisations.

In population terms, Wairarapa DHB is the second smallest of the 20 DHBs, with a population of approximately 41,000 people. Whilst it has a small population base, this population is spread over a large geographic area. Its cover extends from the Rimutaka Hill and Ocean Beach in the south to Mount Bruce in the north, a total of 5,936 square kilometres. The Wairarapa district includes three Territorial Local Authorities: Masterton; Carterton and South Wairarapa. The area is characterised by urban clusters surrounded by sparsely populated rural areas. About half of the population lives in urban centres compared with the national average of 83% for all DHBs.

Masterton, the largest of these urban clusters, is located in the heart of the Wairarapa and has a population of 23,300. Masterton, separated geographically from the rest of the Wellington region by the Rimutaka Ranges, is about an hour and a half drive from both Wellington and Palmerston North. Carterton, located south of Masterton, has a population of just over 8,230. South Wairarapa, with a total population of nearly 9,500, includes the towns of Featherston, Greytown and Martinborough. Approximately 30 per cent of the properties in South Wairarapa are owned by absentee owners.

Rangitane O Wairarapa and Ngati Kahungunu Ki Wairarapa have manawhenua status within the district.

The Wairarapa population is slowly growing, with the fastest growth in Carterton. At the 2006 census the Wairarapa DHB had a total population of 38,610, projected to decrease by 4% between 2006 and 2026. However the 2013 census showed a growth of 6.5% since 2006, which is 0.8% higher than the national average.

Māori make up 16% of the total population, have a younger age profile and are projected to form an increasing proportion of the population. Pacific people make up 2% of the population.

Key demographic features of Wairarapa population include:

- Small population increase overall over the next 10 years
- Increasing Māori population (projected to increase 20% in next ten years)
- Older and rapidly aging population (over 55 population projected to grow 14.6% in the next 10 years)
- Very small Pacific population.

The population mix is predicted to change over the next few years, with increasing percentages of older people and increasing numbers of Māori. These are the groups that have the greatest needs for health and disability services.

OPERATING STRUCTURE

DHB Governance

Wairarapa DHB's Board is the Governance Arm which oversees DHB activities. It comprises 11 members (seven elected and four appointed by the Minister of Health) who set policy. Board elections were held in 2013, with three new members taking up roles from December. The Board is advised by several committees, which are increasingly operating in close collaboration with Hutt Valley and Capital & Coast DHB sub-committees. Board policies are implemented by the Chief Executive and members of the Executive Leadership Team, who are responsible for services provided across both Wairarapa and Hutt Valley DHBs.

Planning & Funding

The Planning & Funding arms of Wairarapa, Hutt Valley and Capital & Coast DHBs amalgamated to form the 3DHB Service Integration and Development Unit (SIDU). On behalf of the three DHBs they plan, contract, monitor and evaluate health and disability services run by the DHBs and their contractors. SIDU strives to maintain and improve the Wairarapa community's health within available funding. They also consult the community on significant changes to services and ensure any advice given to the Board is consistent with national strategies and Government policy.

Provider Arm

The Provider Arm manages Wairarapa Hospital and community-based services, and employs about 450 full-time equivalent staff. Services directly run by Wairarapa DHB are known collectively as the Provider Arm of the DHB and include:

- Wairarapa Hospital, including medical, surgical, paediatric, rehabilitation, maternity, and emergency services
- Mental Health
- Community Care, such as Community Nursing and Health Promotion
- Needs assessment and Disability Support Services

The Provider Arm no longer includes 'Ambulance' as this service was sold to Wellington Free Ambulance 1 March 2012.

Through SIDU the DHB also contracts many agencies and organisations to provide health services in the Wairarapa, including aged care, primary services, and community-based mental heath and maternity services.

Partnership with Iwi

Wairarapa DHB recognises and respects the Treaty of Waitangi, and the principles of partnership, participation and protection, in the context of the New Zealand Public Health and Disability Act 2000. Wairarapa DHB will continue to work with Te Oranga o te Iwi Kainga, our Māori Partnership Board to ensure

Māori participation at all levels of service planning, and service delivery for the protection and improvement of the health status of Māori.

VISION, MISSION & VALUES

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

Our Vision

Well Wairarapa –Better health for all

Wairarapa ora – Hauora pai mo te katoa

Our Mission

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

Our Values

The values that underpin all of our work are:

Respect – Whakamana Tangata

According respect, courtesy and support to all

Integrity – Mana Tu

Being inclusive, open, honest and ethical

Self Determination – Rangatiratanga

Determining and taking responsibility for ones actions

Cooperation – Whakawhanaungatanga

Working collaboratively with other individuals and organisation

Excellence – Taumatatanga

Striving for the highest standards in all that we do

FROM THE CHAIR AND CHIEF EXECUTIVE

This has been a strenuous year for Wairarapa DHB, as we have implemented more streamlined services across Wairarapa and Hutt Valley DHBs, within the context of 3DHB initiatives.

We ended the year on a high note, performing well against the national health targets and coming much closer to our budgeted deficit than has been achieved over previous years.

Our hospital services have continued to perform well against many indicators. We topped the country in two Hand Hygiene audits, which measure the compliance with the five opportunities for hand hygiene related to patient care, and scored very highly on measures to prevent surgical site infection.

A project to reduce average length of stay in our medical/surgical ward has resulted in a drop of up to .6 days, when comparing the first four months of each calendar year over the last 3 years, despite an overall increase in admissions.

FOCUS ON COMMUNITY CARE

Wairarapa medical practices are top achievers in New Zealand with their support for smokers to quit smoking. Since January 2013 Wairarapa medical practices have continually exceeded the primary health care target of offering smokers brief advice and support to quit smoking. In the April to June 2014 quarter, the practices achieved support to 98% of their patients who smoke. The target is 90%.

The 2013/14 year also saw developments to the Shared Care Record, first introduced into the Wairarapa in 2011. Six practices can now access the record, as can approved pharmacists and ED clinicians. Future developments are focused on refinement of the information available as part of the Shared Care Record, to included ECGs and contact people for any Enduring Power of Attorney agreements (EPOAs). Information for young people under the age of 18 will also become available on the Shared Care Record.

Mother and baby health has also been a focus in our community. The Maternity Quality and Safety programme guides the development and delivery of integrated maternity services and monitors agreed quality performance indicators to ensure effective service delivery and the best possible outcomes for women and their babies. As part of our programme DHB maternity staff visited all Wairarapa medical practices and provided them with new pregnancy information packs, giving women up-to-date information about being healthy in pregnancy, smokefree, how to find a midwife plus local midwives' leaflets. In addition, our partnership arrangement with Hutt Valley DHB enabled us to 'clone' their maternity information website, and customise it for Wairarapa parents. Across the sub-region, we ran a joint campaign promoting '5 things to do in the first 10 weeks' and in October 2013, Wairarapa DHB resumed the contract to deliver antenatal education, extending this to teen parent classes at the Teen Parent Unit in Feb 2014. During the year, we trialled 'drop-in' classes at the VLCA practice, Whaiora, and this will be evaluated and refined in the coming year, with a focus on rural satellite outreach. A future focus is improved integration between community midwives and medical practices.

In 2013, Carterton Medical Centre created an IFHC to meet the health needs of its community and deliver quality care services from its hub. This has resulted in a wide range of services such as laboratory, midwife,

physiotherapy, podiatry, counselling, audiology, mole map, optometry, DHB specialist diabetes and respiratory nurses, B4 School checks and Māori massage/Mirimiri services now able to be accessed in Carterton instead of travelling outside the district. Future integrated health centre developments are being planned for Masterton and the South Wairarapa.

At Wairarapa DHB, the Cancer Nurse Coordinator has been working with the clinicians who deliver oncology services to audit and review the DHB's performance against the draft national tumour standards. Two standards (bowel cancer and lung cancer) were completed in 2013/14. An important aspect of the Faster Cancer Treatment Programme is presenting cases diagnosed with cancer to multidisciplinary treatment planning meetings (MDMs). At Wairarapa DHB we introduced these early on in 2013. All patients with complex cancers are discussed at multidisciplinary forums often hosted by a DHB video conferencing link up between smaller DHBs and the larger DHB treatment teams. Colorectal cancer patients are brought to MDM clinical discussion typically within one week of a diagnosis and can be treated within 31 days. These patients are 6% more likely to receive timely treatment compared to the regional average.

Falls prevention spans both community and hospital care and concerted and sustained effort continues to improve patient safety. Working with the national HQSC campaign, Wairarapa DHB has introduced a 'traffic light' system to monitor and manage falls risk in patients. In the community, the Glenwood Residential Care facility has introduced a successful falls prevention programme.

Also spanning community and hospital services, clinicians can now access information from Regional Public Health related to individual patients through the patient management system Concerto. The School Public Health Nurses moved to using Concerto for personal health information in August 2013. The Disease Control Team moved to Concerto in June 2014 and is recording all communicable diseases, follow-up patient and contact information.

Primary mental health services have focused on 'any door is the right door' to improve access to services. A single brochure bringing all information about MHA services together has had good feedback from the community. Primary Mental Health Nurses work across six medical centres in Wairarapa providing mental health and addiction assessment and brief interventions as well as education/information for GPs and Practice Nurses. Te Hauora Runanga O Wairarapa - Kaupapa Māori Addictions and Mental Health Support services work collaboratively with Carterton Medical. This has increased access to information and treatment options for Māori patients.

The Suicide Prevention Group organised a high profile positive event with Pio Terei from the 'Parenting Place' speaking at Masterton Town Hall in June, reaching over 300 people. The 'Blokes Book' targeting men's wellbeing was redeveloped and distributed via rural networks, access to online tools improved, and the referral process to Child and Adolescent services streamlined.

Health Passports were introduced in December 2013, and are now available in all medical practices in the Wairarapa. A Health Passport contains information that a person wants a health professional or carer to know about how they can be supported.

On Tuesday 5th February 2014, Wairarapa's largest general practice, Masterton Medical, caught fire. There was significant damage resulting in a disaster situation that impacted the 23,000 enrolled patients and the Wairarapa after-hours service. A well-organised emergency response from Masterton Medical meant patients were being seen within 16 hours of the event. Subsequently, Masterton Medical has been rehoused on the Wairarapa Hospital complex, co-locating with the FOCUS Needs Assessment and Coordination Agency.

On the 28th June 2014, the first-ever Pacific Health Day was held collaboratively by Whaiora, Masterton Medical, the DHB, Compass Health and Medlab. The day was a huge success with over 100 people attending the day and many receiving free health checks.

INTEGRATION

A single Chief Executive was appointed across Wairarapa and Hutt Valley DHBs in December 2012, and a single Executive Leadership Team was largely in place by April 2013. Over the last year we have implemented a shared Directorate structure across Wairarapa and Hutt Valley DHBs, which closely mirrors the structure in Capital & Coast DHB. This has supported increased dialogue and clinical collaboration between services across our sub-region.

As part of this streamlining, we have included the Chair of Te Awakairangi Health Network (PHO) and the TeHei Wairarapa programme manager to be part of the single executive leadership team for the two DHBs. Their contribution has greatly strengthened the links between community and hospital based services, and encourages whole-of-system thinking preceding decision making.

While we have had a good track record for managing our resources well over recent years, our relatively small size accentuates vulnerabilities in cover for some specialist services, and creates clinical and administrative inefficiencies relative to the size of the population we serve. Therefore, the partnership model offered in the 3DHB Programme continues to offer the best viable solution to continued clinical and financial viability.

We recognise that our future lies in forging strong sub-regional and regional relationships and implementing sustainable arrangements to continue to deliver safe, high quality affordable services in the Wairarapa over the forthcoming years. We have materially benefitted from this partnership arrangement in the last year, as seen in the collaboration experienced when a fire disabled our Central Sterilising Unit in late 2013. Our Theatre services were superbly supported by the Central Sterile team at Hutt Valley DHB, while a team of clinical and operations experts from the 3 DHBs explored how standardisation and continued partnership could strengthen our local services.

This is not a one-way relationship, however – we have been able to share examples of efficient service models with our neighbours, for them to consider and adapt where relevant, including our community-based mental health services, our FOCUS (NASC) service, the relationship between the DHB and primary care providers and the way we support older people's independence.

Many of our successes have stemmed from staff making the shift in thinking and owning their contribution to improving the patient journey – right across the spectrum of health care from home, through hospital, and back out into the community.

We believe the best approach to continue this work is to design the way we want to deliver services in the future to guide further structural changes to our services. For the past two years, the sub-regional Clinical Leadership Group has progressed integrated activity in a number of specialties including Ear, Nose and Throat, Gastroenterology, Child Health and Palliative Care. We are also progressing partnership in a single Mental Health, Addictions and Intellectual Disability Directorate for the sub-region. At Kenepuru Community Hospital a new 24-chair purpose-built Satellite Dialysis Unit opened in March and will be used by patients from across the three DHBs, boosting capacity in the sub-region to meet the growing demand for this service.

Done right, all three Boards believe that greater integration will remove many of the artificial boundaries and barriers that hamper effective health care delivery that at times frustrates both patients and clinical staff alike. It will enable our experienced and capable staff to use their time and expertise to better meet the needs of our regions' population; and help ease the financial pressures we are all experiencing as we create services that are sustainable.

Most importantly, we believe this partnership approach will make a material difference to fundamentals such as reducing waiting times and providing better and equitable access to diagnostic and elective services.

INVESTING IN THE FUTURE

3DHealthPathways began this year and are designed to provide GPs with quick access to relevant information about how to manage common conditions and how and when to refer to hospital. This is another integrated project across the three DHBs and local pathways have already been developed for cellulitis, deep vein thrombosis, diabetes, nutrition, dementia, frailty, vulnerable pregnant women, and obesity. This is a significant piece of work will continue to be a priority for the coming year as we step up our exploration of new ways of shifting the healthcare emphasis towards prevention, empowerment and health maintenance services close to home.

Improved access to services and waiting times for patients has been a major focus for all staff with many successful results including elective surgery and orthopaedic service. The elective surgery team also delivered an additional 71 discharges in 2013/14, which again exceeded our elective surgery discharge target.

Our increased immunisation rates have remained consistently high over the past few years and as of July 1, 96% of 8 month old babies were fully immunised in our region. This achievement reflects effective collaboration between PHOs, primary health care/general practices, Plunket, Well Child/Tamariki providers and Regional Public Health, as well as local Lead Maternity Carer and Midwife teams. It also demonstrates an important investment in the future health of our children.

The increasing trend of 'never having smoked' reported by year 10 students in the Wairarapa also reflects a multi-agency approach to reducing the harm caused by tobacco.

For our older service users, Wairarapa reports a reduction in the rate of acute readmissions and acute medical admissions; and an increase in the average age of entry into residential care, reflecting both the work put in by FOCUS around Ageing in Place and multidisciplinary clinical meetings to review patients experiencing multiple ED presentations or admissions.

As we work towards a healthier population, our staff are critical to successfully achieving our outcomes. Over the 2013/14 year we have worked with our neighbouring DHBs to formulate consistent policy and practice that will support the concept of a positive work environment for our staff, many of whom work between DHBs. The resulting 3DHB plan draws together actions that will support this goal.

Finally, we would like to thank the Board and the staff for their continued support and commitment to the people of the region. We recognise that all these achievements are part of a wider change in our approach that is also seeing us working more collaboratively to change the way we do things to optimise the use of our resources to ensure a more sustainable, safer and more convenient patient journey for the people of our region.

We expect the achievements of this year to be a firm foundation for the 2014/15 year, as we move from a 2DHB to an increasingly 3DHB model for service planning and delivery.

Derek Milne
Board Chair

Graham Dyer
Chief Executive

FROM THE CLINICAL LEADERS

We have written this annual report together as part of our vision of inter-professional collaboration driving continuous quality improvement for the people and families that we work with. We are passionate about improving and leading the way we deliver health care, so that it is truly patient-centred and meets the needs of communities. We realise for patients it is about receiving the right care, at the right time and in the right place.

In striving to provide seamless care, we recognise that patients today require support from a multitude of different services and health professionals. Improving the patient journey, and partnering with our primary care colleagues so that we can look holistically at the care we provide, is helping to help reduce treatment delays and length of hospital admission overall. We recognise that shorter patient journeys are safer, as well as being more convenient for our patients.

WHOLE OF SYSTEM THINKING

An important initiative we have begun this year with our primary care partners and Capital & Coast DHB has been the 3DHealthPathways project. 3DHealthPathways is a collection of online 'care pathways' which describe the best agreed-upon route for the patient to take as they move from primary care through the health system. By standardising clinical practice and the best way to access it, we expect to see significant gains for the patient and health organisations alike. We have already finished 48 pathways with many more in the development phase.

Similarly, the Alliance Leadership Teams consisting of Primary Health Organisations (PHOs) and DHB staff have also embedded a 'whole of system' approach to health across the lower North Island.

Evidence of this approach in action includes the way in which Hutt Valley DHB specialist nurses and Nurse Practitioners are working alongside and mentoring nurses in the community. Examples include a case review mentoring programme established across a number of facilities in aged residential care; DHB-employed Clinical Nurse Specialists (CNS) Diabetes mentoring and coaching nurses in primary care to upskill and enable them to provide a greater range of services in primary care; and Te Omanga Hospice specialist nurses providing mentoring, consultation as well as a clinical load for patients needing end of life care, enabling 'on the spot' teaching for nurses working in aged residential care.

Wairarapa examples of 'whole of system' thinking include the introduction of mental health specialist clinics and nurses in the community, extension of the availability of the primary Shared Care record for Emergency Department clinicians, collaborative work around maternal and child health, allied health services being made available at Integrated Family Health Centres, and falls prevention initiatives spanning secondary and aged care facilities.

Across the two DHBs we have increased the number of new graduate nurses employed from 26 to 39, compared to the previous year. This includes 11 nurses employed in primary and aged residential care, but supported by the DHB-provided Nursing Entry to Practice programme. This increase met the required

financial modelling criteria, while recognising the importance of developing our next generation of nurses across the sector.

FOCUS ON QUALITY AND SAFETY

We are working together to ensure that change initiatives are focused on quality and safety, so that we can measure the impact of change through variables like readmission rates, surgical harm or reported medication incidents.

We continue to support and promote the Health Quality & Safety Commission campaigns, which have targeted key areas including inpatient falls, healthcare-associated infections and hand hygiene compliance as well as surgical safety checks.

Acknowledging the value of improvement work by individuals and teams is important and alongside our annual local Nursing and Midwifery Awards, this year we launched the inaugural 3DHB Allied Health, Technical & Scientific Awards. The awards recognise the key role Allied Health professions play in healthcare delivery. This year we are also launching the 3DHB Quality Awards.

The ongoing commitment to training our workforce; both present and future, remains a key driver to our success. This year we have opened our multidisciplinary Xcel8 training programme to Capital & Coast DHB colleagues so that we continue to encourage innovation and practice improvement to benefit our combined populations.

As teaching hospitals, our commitment to research and to training a wealth of undergraduate and post graduate students is well-established and we work closely with the Wellington universities and polytechnics, as well as across New Zealand.

We value and appreciate the array of involvement from clinical staff at all levels across the DHBs and primary and community care to ensure we all practice safe, high-quality and effective healthcare.

INTEGRATED SERVICES

Through the sub-regional (3DHB) programme, Service Level Alliances have been set up in areas such as Child Health and Health of the Older Person where we have identified that by working collaboratively, we can deliver better services more quickly to our patients.

This year has also seen the coming together over the three DHBs of the Māori Health Service and Mental Health, Addictions and Intellectual Disability Service directorates, respectively.

With all this activity underway, we must acknowledge the commitment and professionalism of our staff and those of other DHBs and primary and community settings who have developed partnerships across teams and services, to enable gains for patients.

Iwona Stolarek
Chief Medical Officer

Helen Pocknall
Executive Director,
Nursing and Midwifery

Russell Simpson
Executive Director, Allied Health,
Scientific and Technical

COLLABORATION HIGHLIGHTS

3DHB INTEGRATION PROGRAMME

The past year has seen a continued commitment to partnership between Wairarapa, Hutt Valley and Capital & Coast DHBs as we focus on providing sustainable services, both clinically and financially. The three DHBs believe that the best health gains for patients can be achieved through a joined-up approach to service delivery across the sub-region, and that by removing artificial boundaries decisions can be made in the collective interest of the sub-region's population. This includes improving equity of access to services for the combined population.

The 3DHB Health Service Delivery programme has continued to focus on specific clinical service projects identified as critical services for integration along with the key enablers required to support these. Service design has been clinically led, with representation from across the individual sub-regional services as appropriate.

To enable our progress towards fully integrated sub-regional services, we developed a clear framework that identified the stages of integration for this programme. This included the definition of the agreed sub-regional approach at each integration stage for governance, clinical leadership, management, responsibility, accountability, funding, service delivery, operational activity and employment.

A report outlining the considerations needed to progress service design was informed by the outcome of sub-regional workshops with clinical and management representation from services across the DHBs. These workshops gave many staff the opportunity to see the benefits of integration provides and for them to influence areas where they felt careful consideration is needed.

Information from this report and framework is now used by all services progressing sub-regional integration design.

Integrated service design continues with Child Health, Radiology and Gastroenterology services, linking directly into local primary secondary integration where appropriate through Primary Care Alliance Leadership Teams.

A PATHWAY TO GOOD HEALTH

The 3DHealthPathways project was launched in February 2014. This collaboration between General Practice and DHBs sees care pathways developed to take the uncertainty out of patient care by ensuring a clear and consistent treatment regime for patients to be referred along.

In doing so, health professionals from across different sectors and organisations must agree upon best practice treatment guidelines, and discuss any existing barriers to implementation.

The implementation team includes sub-regional specialists, SIDU programme manager, and five general practitioners as clinical editors. A further editor with a dedicated focus on faster cancer treatment is

currently being finalised. The governance group comprises clinical and corporate members from the Wairarapa, Hutt Valley and Capital & Coast DHB executive teams and primary care across the sub-region.

There are currently 95 pathways on the work programme. An example of the co-design approach is the pathway under development to treat carpal tunnel syndrome, a disabling condition that causes wrist pain and numbness. CCDHB's orthopaedic department has agreed to accept surgical treatment referrals directly from GPs, provided the treatment steps outlined in the pathway are first followed. This means patients can go to their GP, who will perform the appropriate treatment steps, and if surgical treatment is necessary, give certainty that they will receive it.

"That's a really powerful thing to say 'I'm referring you for an operation', not 'I'm referring you to see a specialist first'," said Lower Hutt GP Dr Chris Masters, who is one of five 'clinical editors' who have been appointed to work with hospital and community-based specialists as part of the integrated approach.

"While hospital treatment may be necessary for some complex conditions, people don't want to go to hospital when they can come and see their local family doctor or medical centre to get treatment that is closer to home and more convenient," Dr Masters said.

The new general practice model recognises that long-term conditions require coordinated care from different health services. Practice nurses and community health providers such as physiotherapists are seen as key to this.

While the project is still in its initial stages it is seen as a priority for the coming year. Pathways in development include: diabetes nutrition, frail elderly patients, gastroenterology, cellulitis, older persons health, orthopaedics, haematology, general surgery and rheumatic fever.

APPOINTMENTS

In the past year new joint appointments have been created that will continue to build on the work of the integration programme. To date these positions have been for corporate service delivery. We are excited to report the development of the first 3D clinical service position with the agreement to progress a 3DHB General Manager of Mental Health and Addiction Services. The appointment of this position will enable the general manager to lead the staff involved in the delivery of Mental Health and Addictions Services across the sub-region to develop a single approach to service design and delivery.

Corporate Service appointments have progressed with the appointment of a 3DHB Executive Director Corporate Services Group, a 3DHB Chief Information Officer and a 3DHB Facilities Management structure. The focus of these positions in the short-term is to support the 3DHB development to keep us on the pathway toward sustainability and strengthening the back office systems and functions that underpin the way we do business.

These positions will provide strategic advice and direction for Wairarapa, Hutt Valley and Capital & Coast DHBs in relation to financial management, information communications technology, facilities management and payroll and to ensure that the strategic direction translates into tactical and operational activity supporting all DHBs' wider goals as well as individual service goals.

MĀORI HEALTH

There are different views on what a 3DHB Māori health approach will look like, but the focus remains on improving each DHB's performance against the national Māori health targets. Having a collaborative approach will provide the framework for the wider teams to learn from each other.

The 3DHB sub-region is home to 438,345 people, equivalent to nearly 11% of New Zealanders in 2013. The Māori populations of the Wairarapa and Hutt Valley districts are higher than the 15% national average, at 16% and 18% respectively, while 11% of people in the Capital & Coast district identify as Māori.

Additionally, the Māori population of all three DHBs is expected to grow within an overall sub-regional growth rate projected at 0.6% per year to 2026.

Each of the three DHB Māori health teams is unique and has strengths that we can collectively learn from. For example, Wairarapa leads the country for screening 80% of Māori women for cervical cancer checks.

LABORATORY

Hutt Valley and Capital & Coast DHB's laboratories combined into a single service, OneLab, in March 2014 with a Laboratory Manager appointed across the sites. Work is underway to align processes and protocols as far as possible and to utilise opportunities as they present in order to continuously improve service delivery for patients.

The combined laboratories installed a new combined laboratory information system, Sysmex Delphic, across both DHBs. The implementation was completed in November 2013 in Capital & Coast and April 2014 in Hutt Valley. The project required the two laboratory teams and ICT to work closely together to create a single system that could be used by both DHB laboratories. This has successfully occurred and, except where required for technical reasons, the system is configured the same in both laboratories.

The Anatomic Pathology portion of the system is ahead of the rest of the DHB laboratories in the country. At least four other laboratories have been to visit the system and Canterbury DHB laboratory has just gone live with a similar system with many of the configurations learnt from our system.

NEW SATELLITE DIALYSIS UNIT

Based on current and projected demand in the sub-region, a new satellite dialysis unit was built at Kenepuru Hospital and officially opened by Minister of Health Tony Ryall on 20 March 2014. The unit provides services for patients from Wairarapa, Hutt Valley and Capital & Coast DHBs.

The new purpose built unit is more accessible and spacious and has plenty of natural light. Feedback received from patients has been overwhelmingly positive with everyone appreciating the state-of-the-art facility that is not just aesthetically pleasing but also comfortable.

The unit is operational seven days a week with up to 32 patients receiving treatment each day. In addition to the patients who attended the previous Porirua satellite unit, a significant number of patients have transferred from the Wellington Hospital unit out to Kenepuru. Patients have adapted well to the change in environment with many patients embracing the opportunity to become more actively involved in aspects of

their treatment. Feedback from patients includes one saying: “I enjoy being able to do things for myself – learning is good for me.”

The opening of the new larger unit has given the renal service the capacity to provide patients with dialysis treatment in the most appropriate facility based on the level of care they require. With 16 of the available 24 dialysis stations currently commissioned for use, the unit will be able to cope with additional demand over the coming years.

OPHTHALMOLOGY

This year Capital & Coast started an opthalmologists’ minor operations session each week at Hutt Hospital, meaning patients from the Hutt and Wairarapa no longer have to travel to Wellington for minor surgical procedures.

The plan is to extend this to a full day outpatient department session at Hutt Hospital, so staff can continue to help clear the backlog of children awaiting operations for squints. This will mean that paediatric patients who live in the Hutt and Wairarapa will no longer have to travel to Wellington for outpatient appointments.

EAR, NOSE & THROAT (ENT)

The sub-regional ENT steering group formally disbanded during 2013/14 following completion of its work programme, which included the development and implementation of management and referral pathways and agreement on workforce strategies. The members of the group continue to take a sub-regional approach to achieving targets and developing the workforce.

DISABILITY SERVICES

Great progress has been made during 2013/14 in improving health services for people who experience long-term impairments/disability in the wider Wellington region.

In December 2013 the first sub-regional New Zealand Disability Service Implementation Plan was agreed by the Wairarapa, Hutt Valley and Capital & Coast Boards at their first combined meeting. To support the roll out and to provide a voice at governance level the Sub-Regional Disability Advisory Group was formed.

The group produced its first newsletter in May 2014 providing a means to enable a mechanism for community engagement across all sectors, including mental health, older people, primary care and young peoples’ networks.

A sub-regional Disability Forum was held, which provided an opportunity for people with disabilities to give their feedback on the implementation of the sub-regional disability plan. The key themes that arose from the forum correspond with the determinants of the Triple Aim approach which, in relation to disability, means the need to balance patient experience; visibility of disability (within population health initiatives) through more robust data collection; and through efficient and financially sustainable systems that enable all to access services they need.

Other Disability Service highlights include:

- The launch of the Health Passport in Wairarapa, Hutt Valley and Capital & Coast DHBs. The Health Passport will assist health providers to better understand the care and communication needs of people who experience long-term impairments/disability.
- The Disability Alert Icon was launched at Capital & Coast and Hutt Valley. The icon will alert staff to patients' particular needs when using health services, including what they need to be kept safe.
- An eLearning module for all Capital & Coast staff was launched. This gives basic education and specific instructions on the use of the Disability Alert Icon, and the link to the Health Passport.
- A disability champion/facilitator network made up of staff across all three Sub-Regional District Health Boards and community services was launched to help improve services and information to health staff and people with disabilities.

RHEUMATIC FEVER PREVENTION

In 2013/14 a sub-regional rheumatic fever plan was developed that built on the Rheumatic Fever Prevention Programme operating in Porirua. The aim of the sub-regional plan is to reduce the incidence of rheumatic fever in the region through a programme of work focussed on prevention, treatment and follow-up of rheumatic fever. The plan is part of the Government's Rheumatic Fever Prevention Programme which is working to improve outcomes for vulnerable children and achieve the goal of reducing the incidence of rheumatic fever in New Zealand by two thirds to a rate of 1.4 cases per 100,000 people by June 2017.

The plan's goals are to prevent the transmission of Group A streptococcal throat infections in the Wairarapa, Hutt Valley and Capital & Coast DHB region.

This will be achieved through:

- The development and implementation of a pathway to identify and refer high-risk children to comprehensive housing, health assessment and referrals services, in 2014/15
- The development of the Housing and Health Capability Building Programme and implementation of insulation referral process for high-risk patients, in 2014/15
- Raising community awareness.

To ensure Group A streptococcal infections are treated quickly and effectively there has been increased training and information for primary care providers and an algorithm tool for the treatment of sore throats in primary care has been developed. A review of the sore throat swabbing in schools model will happen in the coming year. In 2013/14 the total number of throat swabs was 7,180, with 11.2% positive swabs.

Results for 12/13 and 13/14 for Porirua, 4-19 year olds:

	2013/14	2012/13
Positive	802	791
Negative	6378	5890
Total swabs	7180	6681
% positive	11.2%	11.8%

Hutt Valley and Capital & Coast are steadily reducing the rate of first episode rheumatic fever hospitalisation (per 100,000 total population), with Capital & Coast achieving 1.7 (per 100,000 total population) in 2013/14, which is better than the target for the year.

Rapid response clinics were opened in Porirua, with ongoing review and refinement of the services as required. Engagement with the Pacific Health and Wellbeing Collective continued to ensure key messages are reaching Pacific families. This collaborative approach will continue with ongoing engagement with local providers in Porirua East through the Porirua Kids Group and Porirua Social Sector Trial.

At Hutt Valley, walk-in sore throat treatments clinics were commenced from June 2014 at three pharmacies, three general practices and one after-hours medical centre.

INFORMATION, COMMUNICATION & TECHNOLOGY (ICT)

ICT has had a significant year of achievements as we continue to enhance the 3DHB ICT integration. The three pillars of work being progressed are:

- Convergence of platforms, systems and processes
- One approach in areas of commonality
- Intellectual property sharing.

This collaborative approach was formalised in May 2013 with the development of a 3DHB ICT service. A senior management structure and 3DHB ICT Governance Group was implemented to drive and support the next level of changes to occur over the coming financial year.

The area of security will continue to be a key focus for the organisation and the formation of the Information, Privacy and Security Group has provided structure and support to the management of key security matters.

During the past year a number of ICT projects have been completed to support the Minister's initiative of 'Better, Sooner, More Convenient' healthcare delivery, including significant input in supporting the Central Region Information Systems Plan (CRISP). The key projects include:

- Electronic results sign-off
- Occupancy at a glance
- Clinical audit tool
- Laboratory system upgrade
- The Referral Management Module for Outpatients and Allied Health which offers a number of benefits including more accurate data capture and reporting, ability to view and better manage a patient's full episode of care and management of referrals in real time.

During the past year the Department of Internal Affairs (Government Chief Information Officer) released the Whole of Government Direction for ICT Functional Leadership of District Health Boards in respect of:

- ICT strategic planning and investment
- ICT procurement
- ICT assurance

These directives are to be effective from 1 July 2014. As a result of this initiative there are a number of 3DHB ICT activities planned to align current processes to this approach.

A number of Ministry of Health (National Health IT Board) projects, including National Patient Flow, Maternity and e-Pharmacy have either been implemented or are underway in conjunction with other projects.

Sub-regionally a number of activities are underway to integrate IT systems across the three DHBs. Convergence work completed includes the implementation of a Microsoft 3DHB Outlook service, enabling all staff to electronically communicate with ease.

The Common Operating Environment Programme of work, which included the migration of XP Microsoft to Windows 7, is well underway. This significant activity has been a driver in progressing and engaging the teams across the 3DHBs and will result in having the sub-region under the Citrix environment, providing the platform for other convergence work.

Other collaborative work includes:

- A standardised single time sheeting process for projects across the 3DHBs has been implemented. This has enabled more accurate and timely reporting to support the financial and resource management of projects and business-as-usual activities.
- Work to collaboratively manage risk across the three DHBs is underway. In support, Audit NZ has been engaged in a common audit review process across the sub-region.
- Building on the existing quality control and compliance activities, ICT have commenced a programme of independent quality audits on key projects which will continue through the next financial year.
- Wairarapa District Health Board service calls are now managed by the Capital & Coast Service Desk. This enhances the capture of data and enables the Wairarapa ICT team to focus on project and business as usual activities.
- The establishment of a single 3DHB ICT structure is to commence in the first quarter of 2014/15. This will support integration activities and enable both effectiveness and efficiency gains across the three DHBs.

GOVERNANCE REPORT

ROLE OF THE BOARD

The Board's governance responsibilities include:

- Communicating with the Minister and other stakeholders to ensure their views are reflected in the DHB's planning
- Delegating responsibility for achievement of specific objectives to the Chief Executive
- Monitoring organisational performance towards achieving objectives
- Reporting to stakeholders on plans and progress against them
- Maintaining effective systems of internal control.

STRUCTURE OF THE DHB

DHB Operations

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

Quality Assurance

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

GOVERNANCE PHILOSOPHY

In December 2013, all three Boards endorsed a statement agreeing to support a whole of health system approach, by working towards operating as one organisation, as one team over multiple sites.

They agreed that the three Boards will continue to provide governance, ensuring local accountability.

The shared goal is to develop integrated service approaches to improve

- Preventative health and empowered self-care
- Provision of relevant services close to home; and
- 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 2014 are as follows. Board members commenced their term on 6 December 2010 except as noted. See the Directory at the back of this report for members whose term expired in December 2013.

- Derek Milne (Chair) – commenced December 2013
- Leanne Southey (Deputy Chair)
- Liz Falkner
- Ron Mark – commenced December 2013
- Rob Irwin
- Helen Kjestrup
- Rick Long
- Alan Shirley – commenced December 2013
- Fiona Samuel
- Ronald Karaitiana – commenced December 2013

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.

Board member	Interests declared
Derek Milne (Chair)	Chair, Wairarapa District Health Board Chair, Wairarapa, Hutt Valley and CCDHB, Community Public Health Advisory Committee & Disability Support Advisory Committees Deputy Chair, Capital & Coast District Health Board Deputy Chair, Capital & Coast District Health Board, Finance Risk & Audit Committee Deputy Chair, Wairarapa, Hutt Valley and CCDHB Hospital Advisory Committees Member, Wairarapa, Hutt Valley and CCDHB Finance Risk & Audit Committee Member, Wairarapa District Health Board, Finance Risk & Audit Committee Brother-in-law is on the Board of Healthcare Ltd Daughter is a Doctor at Auckland Hospital
Bob Francis (Chair until Dec 2013)	Chairman, Pukaha Mount Bruce Chairman, Wairarapa Healthy Homes Trustee, Wairarapa Community Transport Trust Chairman, Aratoi Foundation Board member, Capital & Coast DHB Member, Audit & Risk Committee Member, Hospital Advisory Committee Chair, Community and Public Health Advisory Committee

	Chair, Disability Support Advisory Committee
Leanne Southey (Deputy Chair)	Chair, Wairarapa District Health Board, Finance Risk & Audit Committee Deputy Chair, Wairarapa District Health Board Member, Wairarapa, Hutt Valley and CCDHB, Community Public Health Advisory Committee & Disability Support Advisory Committees Member, Wairarapa, Hutt Valley and CCDHB Finance Risk & Audit Committee Director, Southey Sayer Limited Chartered Accountant to Health Professionals including Selina Sutherland Hospital and Selina Sutherland Trust Trustee, Wairarapa Community Health Trust Sister-in-Law is employed by WDHB Trustee of Masterton Trust Lands Trust Director and part owner of Mangan Graphics Ltd Member of UCOL Council
Dr Liz Falkner	Member, Wairarapa District Health Board Member, Wairarapa, Hutt Valley and CCDHB, Community Public Health Advisory Committee & Disability Support Advisory Committees Salaried General Practitioner with Masterton Medical Limited General Medical Practice in which Doctor Falkner works is a member of the Wairarapa Community PHO. Medical Advisor – Post Polio Support Society NZ Inc
Charles Grant	Te Iwi Kainga
Rob Irwin	Member, Wairarapa District Health Board Member, Wairarapa, Hutt Valley and CCDHB Hospital Advisory Committees Member, Wairarapa District Health Board, Finance Risk & Audit Committee Member, Wairarapa, Hutt Valley and CCDHB Finance Risk & Audit Committee Trustee Wairarapa Community Health Trust Member, South Masterton Rotary
Ronald Karaitiana	Member, Wairarapa District Health Board Member, Wairarapa Te Iwi Kainga Committee Member, Wairarapa District Health Board, Finance Risk & Audit Committee Member, Wairarapa, Hutt Valley and CCDHB, Finance Risk & Audit Committee ACC Manager in Claims Management Wife Kylie Smith is currently the DHB liaison from Child Youth & Family Māori relationships with staff vary from a number of cousins working at DHB Occasionally plays in a band (potential no risk to the board) Trust Chairman Akura Lands Trust Rangitane o Wairarapa Board Director
Helen Kjestrup	Member, Wairarapa District Health Board Member, Wairarapa, Hutt Valley and CCDHB, Community Public Health Advisory Committee & Disability Support Advisory Committees Works for Central Tas as an Auditor Shareholder, Property Investment Company – Kjestrup Properties Assessor for Royal College of GPs for Cornerstones Programme Member of Compass Quality Board Clinical Project Facilitator of TeAHN Contract Auditor for TAS
Rick Long	Member, Wairarapa District Health Board Member, Wairarapa District Health Board, Finance Risk & Audit Committee Member, Wairarapa, Hutt Valley and CCDHB Finance Risk & Audit Committee Chairman of Wairarapa Community Transport Services Inc

	Chairman of Tolley Educational Trust Trustee for Sport and Vintage Aviation Society Biomedical Services New Zealand Limited Clinical Board
Ron Mark	Member, Hutt Valley District Health Board Member, Wairarapa District Health Board Member, Wairarapa Te Iwi Kainga Committee Mayor for Carterton District Council Patron, Te Awa Ora a Māori Mental Health Service Provider in Christchurch Trustee & Lead Negotiator, Ngati Kahungunu ki Wairarapa Tamaki Nui A Rua (Treaty Settlement) Trust
Vivien Napier	Member, RNZ Plunket Society South Wairarapa District Council Deputy Mayor Director, Katson Developments (importing of farm machinery) Vice President of the Wairarapa Branch Plunket Society Hospital Advisory Committee (Chair) Audit and Risk Committee
Fiona Samuel	Member, Wairarapa District Health Board Member, Wairarapa, Hutt Valley and CCDHB Hospital Advisory Committees Registered Nurse, Acute Services at Wairarapa Hospital Contractor Auditor for TAS
Alan Shirley	Member, Wairarapa District Health Board Member, Wairarapa, Hutt Valley and CCDHB Hospital Advisory Committees Surgeon at Wairarapa Hospital Technical Advisory for Ministry of Health Wairarapa Community Health Board Member Technical Expert Advisor
Janine Vollebregt	Member, Wairarapa District Health Board DHB Nurse Educator for the UCOL Undergraduate Māori Students. This 0.4 FTE position is effective from 30 April 2008 to 30 June 2010. Member, Wairarapa, Hutt Valley and CCDHB, Community Public Health Advisory Committee & Disability Support Advisory Committees

Division of responsibility between the Board and Management

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

Delegations

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

Accountability

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

Internal audit

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

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

Risk management

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

Legislative compliance

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

DISCLOSURE OF ULTRA VIRES TRANSACTIONS

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

PERMISSION TO ACT DESPITE BEING INTERESTED IN A MATTER

A member who is interested in a matter relating to a DHB must not vote or take part in any discussion or decision of the board or any committee relating to that matter under section 66 of the Crown Entities Act 2004. However, under section 68 of the Crown Entities Act 2004, the Chair of the DHB may exempt one or more Board Members from this requirement if it is in the public interest to do so. Where such an exemption is given, this must be disclosed in the annual report.
No permissions were provided under section 68.

BOARD MEMBERS' MEETING ATTENDANCE

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

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

Member	Board held*	Board attended	FRAC held*	FRAC attended	3DHB CPHAC/ DSAC held*	3DHB DSAC/ CPHAC attended	HAC held*	HAC attended
Derek Milne	(4)	4	(4)	3	(4)	4	(3)	3
Leanne Southey	(10)	10	(7)	7	(9)	8	n/a	n/a
Bob Francis	(6)	6	(3)	2	(5)	5	(5)	4
Liz Falkner	(10)	7	n/a	n/a	(4)	2	n/a	n/a
Ron Mark	(4)	4	n/a	n/a	(4)	1	n/a	n/a
Rob Irwin	(10)	9	(7)	6	n/a	n/a	(3)	2
Helen Kjestrup	(10)	5	n/a	n/a	(4)	4	n/a	n/a
Rick Long	(10)	10	(7)	5	n/a	n/a	n/a	n/a
Alan Shirley	(4)	4	n/a	n/a	n/a	n/a	(3)	3
Fiona Samuel	(10)	9	n/a	n/a	n/a	n/a	(8)	7
Janine Vollebregt	(10)	9	n/a	n/a	(9)	9	n/a	n/a
Charles Grant	(6)	4	n/a	n/a	n/a	n/a	n/a	n/a
Viv Napier	(6)	4	(3)	3	n/a	n/a	(5)	4
Ron Karaitiana	(10)	8	(4)	4	n/a	n/a	n/a	n/a

**There were changes to the membership of the Board and Committees in December 2013. This column reflects the total number of meetings held within the duration of the member's Board/Committee membership.*

Board Members' ReMUNeration

Board members' remuneration received or receivable for the year ended 30 June 2014 are shown in the table below. In addition Board members are able to claim reimbursement for out of pocket expenses.

	2014 Board Fee	2014 Committee Fees	2014 Total Fees	2013 Total Fees
Bob Francis (Outgoing Chairman)	15,231	2,375	17,606	36,094
Leanne Southey (Deputy Chair)	20,400	4,075	24,475	22,188
Rick Long	16,320	2,500	18,820	18,250
Derek Milne (Incoming Chairman)	18,092	1,766	19,858	0
Fiona Samuel	16,320	1,500	17,820	17,750
Janine Vollebregt	16,320	2,300	18,620	18,375
Rob Irwin	16,320	2,750	19,070	19,500
Helen Kjestrup	16,320	1,550	17,870	18,250
Ronald Karaitiana	16,320	1,250	17,570	0
Liz Falkner	16,320	350	16,670	16,500
Vivien Napier	7,712	1,750	9,462	19,750
Alan Shirley	8,653	750	9,403	0
Ron Mark	8,788	175	8,963	0
Charles Grant	7,532	0	7,532	16,500
Janice Wenn (Resigned March 2013)	0	0	0	12,077
Kim Smith	0	1,875	1,875	250
Yvette Grace	0	1,500	1,500	0
Mike Kawana	0	1,500	1,500	0
Mihi Namana	0	1,250	1,250	0
Hariata Tahana	0	1,000	1,000	0
Mary Kerehi	0	1,000	1,000	0
Taiawhio Gemmell	0	0	0	500
Ruth Carter	0	0	0	500
Lyn Olds	0	0	0	500
TOTAL	**200,648**	**31,216**	**231,864**	**216,984**

OUR PEOPLE

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

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

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

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

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

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

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

Meanwhile, the Alliance Leadership Team has clinical representation from across the Wairarapa health system and was the key driver in the development of Tihei Wairarapa and the implementation of the work programme.

The DHB focuses on the needs of each employee through individual performance planning and development. This ensures all staff have performance objectives that align to the DHB's strategy, goals and

values. This individualised performance development framework will reduce staff turnover and improve staff retention.

GOOD EMPLOYER

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

- Leadership, accountability and culture
- Recruitment, selection and induction
- Employee development, promotion and exit
- Flexibility and work design
- Remuneration, recognition and conditions
- Harassment and bullying prevention
- Safe and healthy environment

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

Several forums are in place comprising a selection of employees from across Wairarapa DHB. These forums meet to consider workplace practices. Flexibility and work design are among the many topics these forums consider. Other topics include health and safety, and professional practices, for example nursing, clerical and administration.

Wairarapa DHB has a zero tolerance policy to bullying and harassment. This is supported by a Harassment and Bullying Policy and frequent training sessions for all employees on dealing with bullying and harassment.

Approximately 92 per cent of employees are covered by collective employment agreements (CEA). All the CEAs have prescribed remuneration, recognition and conditions clauses. Wairarapa DHB has a similar approach for those employees on individual employment agreements to ensure fairness and equity in remuneration, recognition and conditions across the DHB.

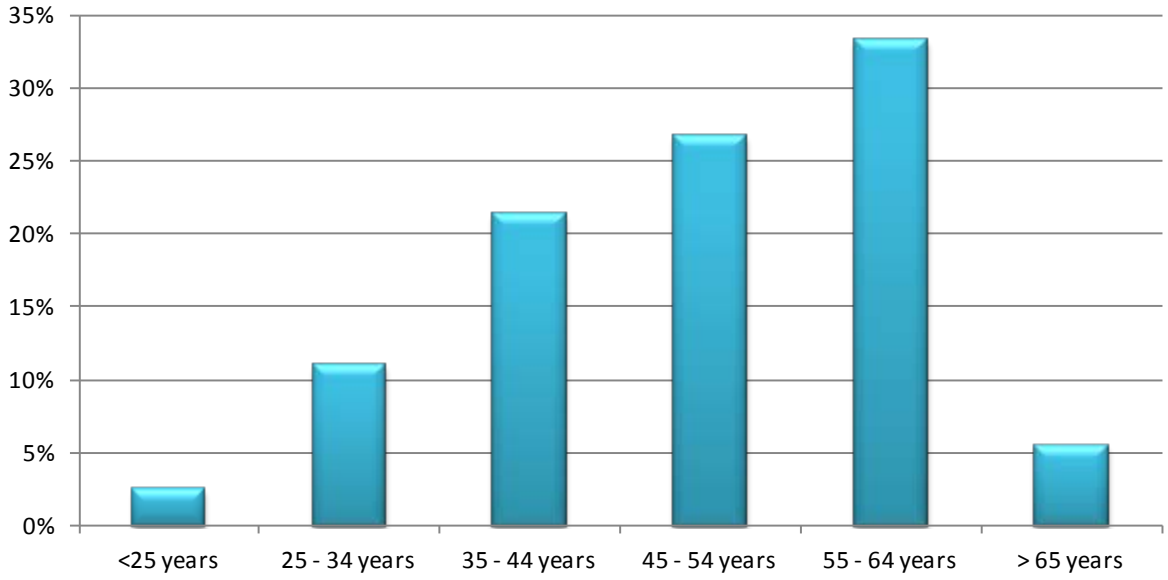
The Protected Disclosure Act 2000 and the Board's related policy, protects the right of employees to raise matters of public concern in a safe and appropriate manner. Where an individual may feel personally disadvantaged there are established grievance procedures available including external mediation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

WORKFORCE PROFILE

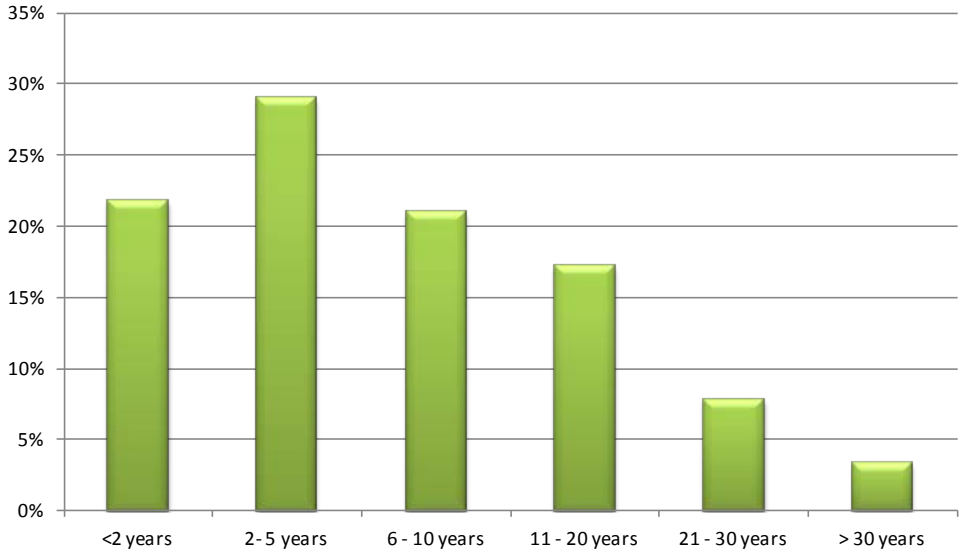
Full Time Equivalent Staff Numbers

	2014	2013	2012	2011	2010	2009
Medical	36	39	38	36	33	33
Nursing	205	204	198	193	191	183
Allied Health	70	82	85	93	89	90
Other	106	101	120	119	125	127
Total	417	426	441	441	438	433

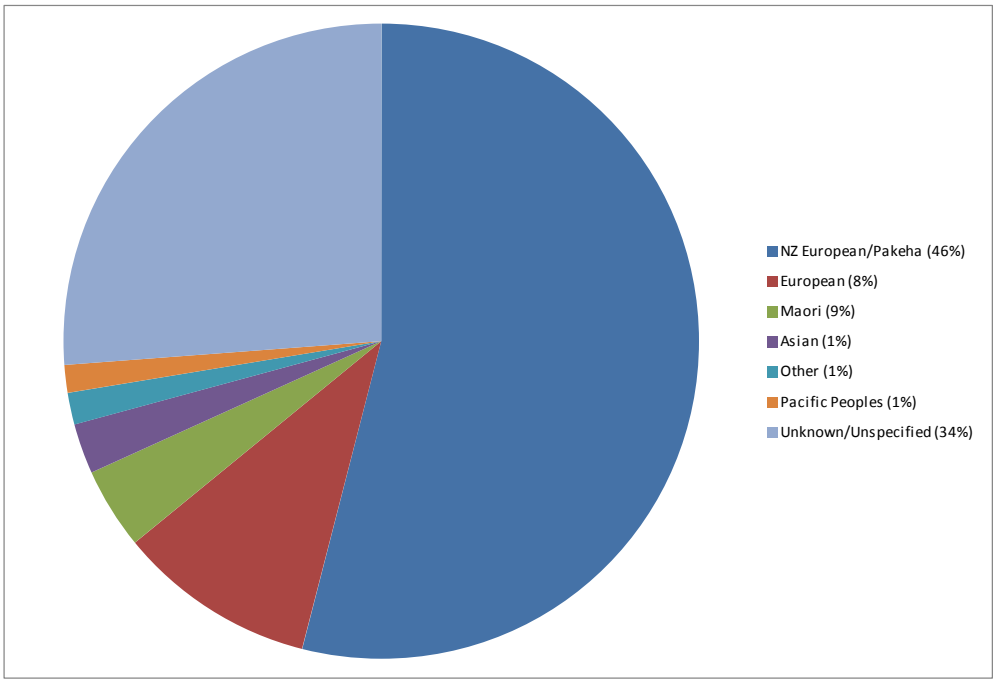
Age Profile of Workforce 2014 (FTE)



Length of Service



Statistics by Ethnicity



Statistics by Gender

	2014	2013	2012	2011	2010	2009
Female	84%	82%	84%	83%	83%	83%
Male	16%	18%	16%	17%	17%	17%

REMUNERATION OF EMPLOYEES

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

EMPLOYEE REMUNERATION	2014	2013
	No. of Employees	No. of Employees
$100,000 – $110,000	4	5
$110,001 – $120,000	6	6
$120,001 – $130,000	3	4
$130,001 – $140,000	5	7
$140,001 – $150,000	4	4
$150,001 – $160,000	6	2
$160,001 – $170,000	2	0
$170,001 – $180,000	1	2
$180,001 – $190,000	1	0
$190,001 – $200,000	0	0
$200,001 – $210,000	0	3
$210,001 – $220,000	2	0
$220,001 – $230,000	1	1
$230,001 – $240,000	1	3
$240,001 – $250,000	1	6
$250,001 – $260,000	3	2
$260,001 – $270,000	0	1
$270,001 – $280,000	3	1
$280,001 – $290,000	3	2
$290,001 – $300,000	1	1
$300,001 – $310,000	2	2
$310,001 – $320,000	0	1
$350,001 – $360,000	0	1
	49	55

Of the employees shown above, 38 are clinical employees (2013: 39) and 11 are non-clinical employees (2012: 15).Only staff on the Wairarapa payroll are included in the table above.

TERMINATION PAYMENTS

During the year the Board made the following payments to former employees in respect of the termination of the employment (either as redundancy compensation or in equalisation payments upon completion of a service review) with the Board. The total paid during the 2013/14 year was $56,854 (2013: $234,749) to 2 staff (2013: 6).

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 the health of our population and contribute to the effectiveness of our entire health system.

We can measure our progress toward improving the health of our population on three different timescales: long-term outcomes (5-10 years), medium-term impacts (3-5 years), and shorter-term outputs (1 year). When we make progress on our short-term outputs (described in the following Statement of Service Performance), over time we can expect to see improvement in our medium-term impacts, which in the long term will lead to progress toward our outcomes.

In 2013/14, the three sub-regional DHBs agreed to focus on four long-term outcomes:

- Reduction of health disparities/improved health equity
- People are healthier and taker greater responsibility for their own health
- Improving the health and wellbeing of our region's children
- Optimising the health, wellbeing, and independence of our region's older people.

We can measure our progress toward these outcomes by monitoring our population's health status and the environment in which they live. As such, in our 2013/14 Statement of Forecast Service Performance we identified impact measures related to each outcome, and we now report against these below. Although we do not have a specific target for our selected impact measures, trends in these measures can indicate in which areas the DHB is making a positive difference and in which areas the DHB should seek to improve.

It is important to note that these outcomes are progressed not just through the work of the DHBs, but also through the work of all of those across the health system and wider health and social services.

Measures that also appear in the Māori Health Plans for the sub-regional DHBs are denoted with a [†].

Population health outcome: Reduction of health disparities/improved health equity

There are recognised health disparities for several population groups due to accessibility, social determinants of health, cultural responsiveness, and the current models of care. Māori and Pacific have consistently worse health outcomes, and 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.

Patients experiencing disability can also have trouble finding services that are accessible and responsive to their needs. With an ageing population, the number of patients experiencing disability will increase and we need to deliver services that meet patients' needs. Low income and poor housing also contribute to poor health outcomes, so those living in deprived areas require services that are low-cost and easily accessible.

Measures – The DHB measures progress through:

A reduction in ambulatory sensitive hospitalisations (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 skin infections, dental conditions, asthma, pneumonia, cardiovascular disease, and diabetes.

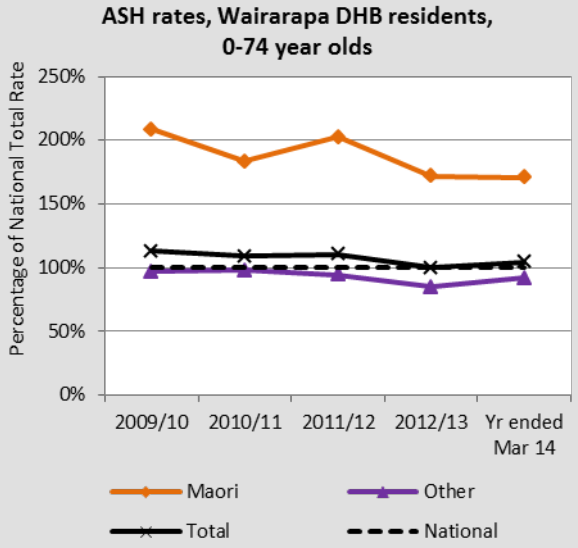
ASH rates also highlight opportunities to better support people to seek intervention early and to manage their long-term conditions. A reduction in ASH admissions will reflect better management and treatment across the whole health system.

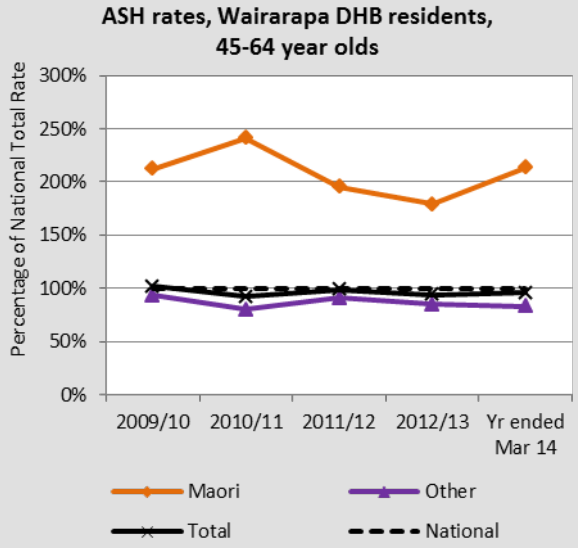
Our overall ASH rate is about the same as the national average. However, Māori continue to have higher ASH rates than other ethnicities.

ASH rates are affected by a wide range of services and programmes in the social sector, including housing and education. In addition to the outputs described in the following Statement of Service Performance, recent initiatives in the sub-region that will reduce ASH rates include:

- A sub-regional equity report, which contains a suite of equity indicators, including ASH rates. By improving our monitoring of disparities, we will be able to more effectively plan activities and reduce existing disparities.
- A project that aims to reduce the number of people who do not attend (DNA) outpatient appointments, as Māori and Pacific have higher DNA rates than other ethnicities.

This measure links to the Prevention Services and Early Detection & Management output classes.





Population health outcome: People are healthier and taker greater responsibility for their own health

What difference have we made for our population?

Wairarapa DHB and our partners, including Regional Public Health and local PHOs, continue to advocate for healthy lifestyles. By investing in preventative measures and promoting positive health choices, we expect that people's health will improve over time, which will reduce pressure on healthcare services and reduce hospital admissions.

Measures – The DHB measures progress through:

An increase in the proportion of "Never Smoked" responses from Year 10 students

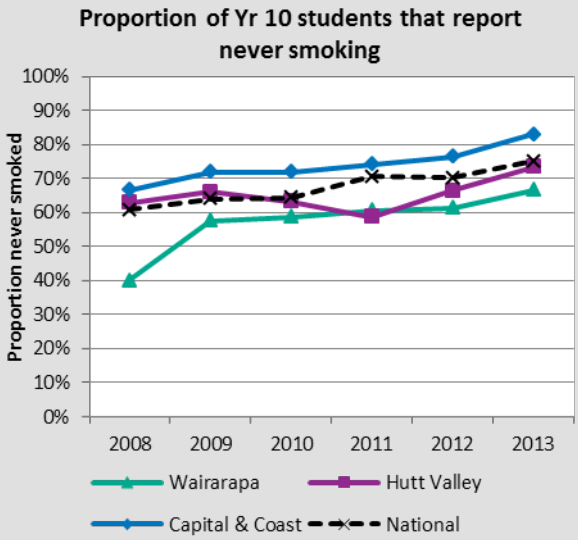
Over 95% of smokers have started smoking by 18 years of age, so reducing the number of young people taking up smoking will greatly reduce smoking rates in the future.

A reduction in the uptake of smoking is a good proxy measure of successful engagement and a change in the social and environmental factors that influence risky behaviour.

Nationally, the number of Year 10 students who report never smoking has increased. This rate has similarly increased in Wairarapa DHB, although the number of Year 10 students who report never smoking is lower than the national average.

The smoking cessation advice provided in primary care and hospitals helps to reduce smoking rates. Smoking education in RPH's school visits can increase the number of young people who have never smoked.

This measure links to the Prevention Services output class.



Source: Action on Smoking and Health Survey, www.ash.org.nz

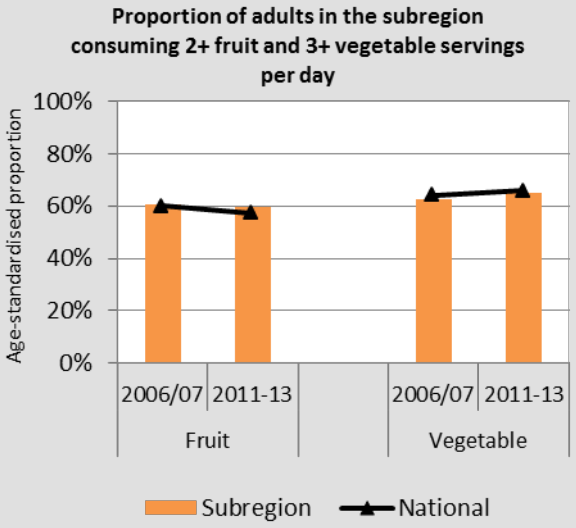
An increase in the percentage of adults consuming 2+ fruit and 3+ vegetable servings daily

Good nutrition is fundamental to health and the prevention of disease and disability. Appropriate fruit and vegetable consumption helps to protect people against and a number of risk factors and conditions, including high cholesterol, high blood pressure, obesity, CVD, and diabetes. These nutrition-related risk factors jointly contribute to about two in five deaths each year.

Fruit and vegetable intake in the sub-region is not significantly different from the national average, and has not significantly changed from 2006/07 to 2011-13.

Regional Public Health's school visits include nutrition education and RPH also runs a school vegetable garden programme. These initiatives will help to increase the consumption of fruit and vegetables in the sub-region.

This measure links to the Prevention Services output class.



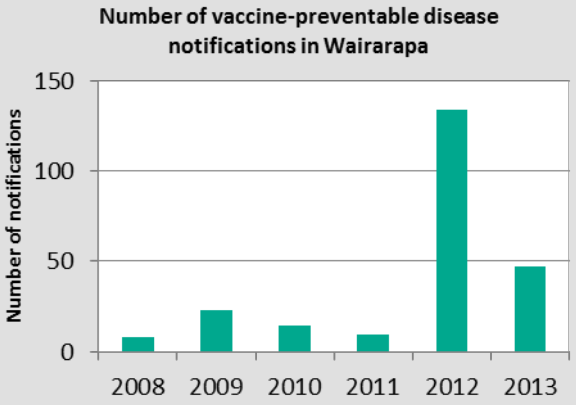
Source: NZ Health Survey

A decrease in the number of vaccine-preventable disease notifications

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.

Pertussis outbreaks in the region in recent years have caused an increase in vaccine preventable disease notifications. However, the number of notifications is beginning to return to previous levels in 2013. We expect that increased immunisation will lead to a decrease in the number of vaccine preventable disease notifications in the longer term.

This measure links to the Prevention Services output class.



Source: Environmental Science & Research, www.esr.cri.nz

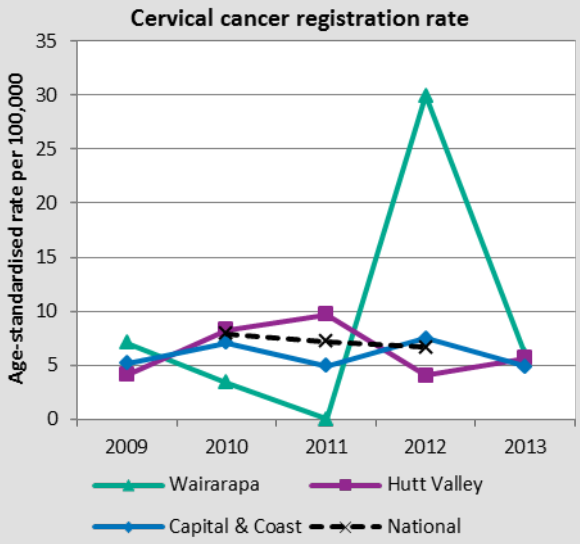
A decrease in the cancer registration rate (rate per 100,000)

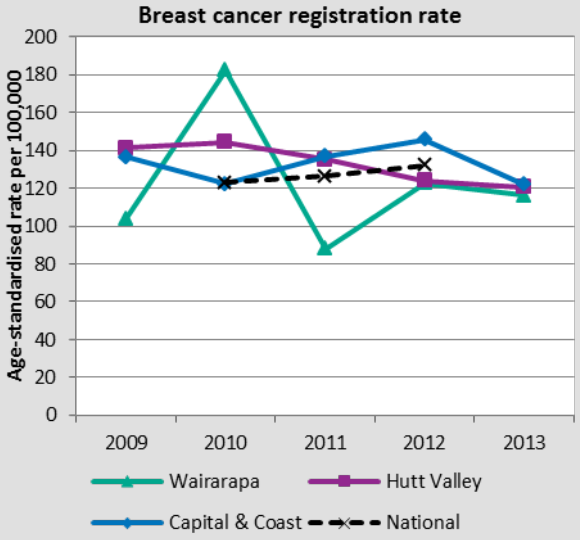
Breast screening for women over the age of 40 years significantly reduces their chance of dying from breast cancer[1]. Increased accessibility of breast screening services may increase breast cancer registration rates but will reduce breast cancer deaths.

Cervical screening reduces the chance of developing cervical cancer by about 90%. Increased accessibility of cervical screening services will reduce cervical cancer registration rates.

Note that Wairarapa DHB's rates are variable because they are affected by small changes in registrations. For example, in 2012 there were 6 cervical cancer registrations for Wairarapa residents, which resulted in a large increase in the rate that year.

This measure links to the Early Detection and Management output class.





Source: NZ Cancer Registry, provisional data.

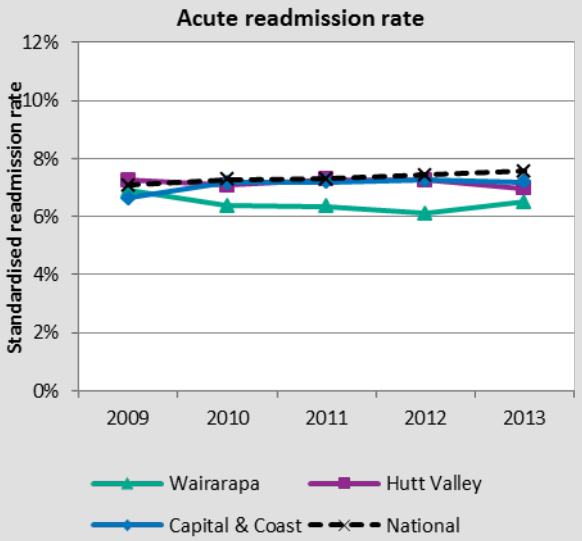
[1] Nelson HD, Tyne K, Naik A, et al. Screening for Breast Cancer: Systematic Evidence Review Update for the US Preventive Services Task Force. Rockville (MD): Agency for Healthcare Research and Quality (US); 2009 Nov. (Evidence Syntheses, No. 74.) Available from: http://www.ncbi.nlm.nih.gov/books/NBK36392/

A reduction in the rate of acute re-admissions, Total

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.

Nationally, there has been a reduction in the rate of acute re-admissions since 2011/12. Wairarapa residents have a lower rate of readmission than the national average. This result is in conjunction with the average length of stay in Wairarapa Hospital decreasing, which shows that the effectiveness and efficiency of hospital treatment is increasing.

This measure links to the Intensive Assessment and Treatment Services output class.



Population health outcome: Improving the health and wellbeing of our region's children

What difference have we made for our population?

Healthy behaviours in childhood and the teenage years can affect health outcomes in adulthood. Health promotion and prevention can be particularly focussed on children and youth to ensure long term health gains for our population.

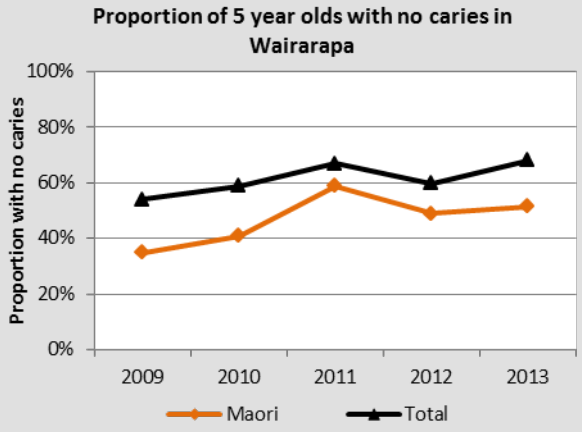
Measures – The DHB measures progress through:

Oral health measures:

- An increase in the proportion of children caries free at age 5
- A decrease in the mean number of decayed, missing, or filled teeth (DMFT) at age 12

Regular dental care has lifelong benefits for improved health. Māori and Pacific children are more likely to have decayed, missing, or filled teeth, and improved oral health is an indicator of the equity of access to services and the effectiveness of mainstream services at targeting those most in need.

Water fluoridation helps to maintain oral health, prevents tooth decay, and reduces health inequalities. There is evidence of this within our sub-region; Māori

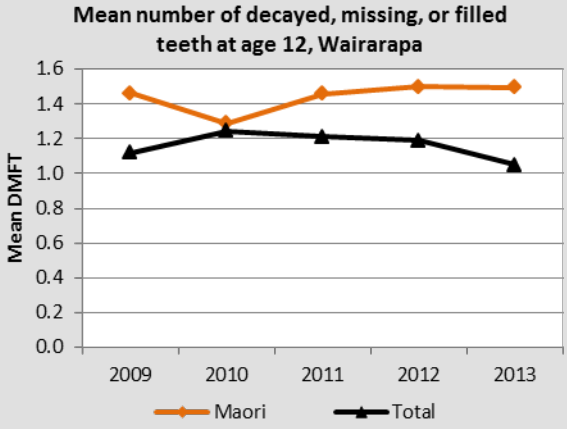


children in non-fluoridated areas of Kapiti have twice as many decayed, missing, or filled teeth, as Māori children living in areas with community water fluoridation. For this reason, the sub-regional DHBs and Regional Public Health supported community water fluoridation in 2013/14.

The mean number of decayed, missing or filled teeth is decreasing in Hutt Valley, which is good. However, disparities between Māori and Pacific and other ethnicities still exist.

The oral health team is working closely with early childhood services and medical centres to find and enrol children younger than five years to the school dental service, which should improve oral health outcomes.

This measure links to the Early Detection & Management output class.



An increase in the percentage of children immunised at 8 weeks

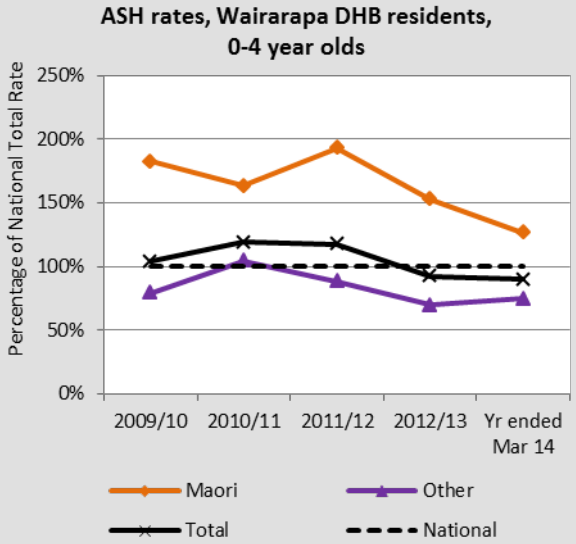
Immunisation rates for this age group are currently not reported by the National Immunisation Register.

A reduction in ambulatory sensitive hospitalisations (ASH) rates[†]

Wairarapa DHB's 0-4 year olds ASH rate is slightly lower than that of the national average. Although Māori have higher ASH rates than other ethnicities, it is promising that this disparity has decreased in 2013/14.

The local newborn enrolment project is currently developing a single system in each of the three DHBs that enables enrolment of newborns to primary care, oral health and Well Child Tamariki Ora services. The project also includes the development of information for parents and providers about the importance of newborn enrolment and the process for enrolling.

In addition, following the government policy to provide free after-hours care to children under six from July 2012, consultations for under-sixes across all general



practices in the sub-region have been made free.

This measure links to the Prevention Services and Early Detection & Management output classes.

Population health outcome: Optimising the health, wellbeing, and independence of our region's older people

What difference have we made for our population?

It is important to ensure that health services meet the increasing need of our ageing population. Currently, one in five people in the Wairarapa are over 65 years old, and this number is expected to increase to one in four by 2021. The largest need and the highest health care costs are amongst those over 85 years and the number of people aged 85+ in Wairarapa is expected to increase by 50% by 2026.

By ensuring that health services are responsive to the needs of our older population, we can help older people to maintain their independence and to remain at home for longer.

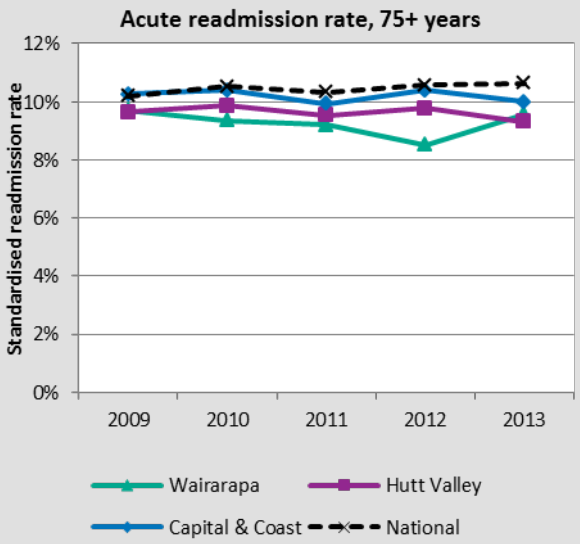
Measures – The DHB measures progress through:

A reduction in the rate of acute re-admissions, 75+

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 once they are out of hospital.

Nationally, there has been a slight increase in the rate of acute readmissions of people 75+ years over the past four years. Wairarapa DHB's has not increased over the last four years and is lower than the national average.

This measure links to the Intensive Assessment and Treatment Services output classes.



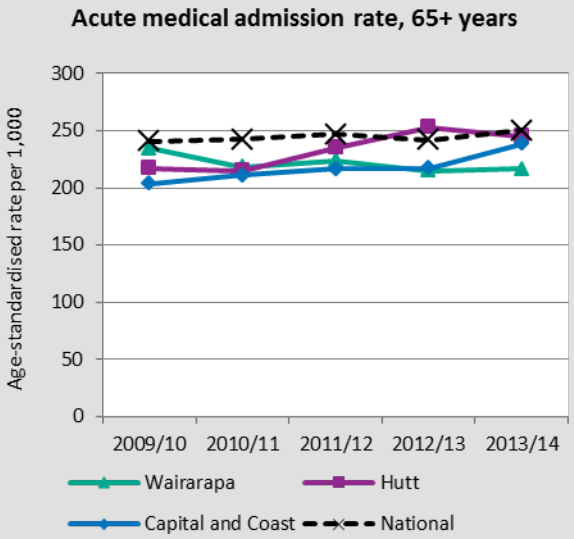
A reduction in the rate of acute medical admissions for 65+

Acute admission rates are influenced by a broad set of strategies, including prevention and treatment in primary care, and alternative models of care.

Unplanned acute admissions are an indicator of the quality of acute care (in the hospital and/or the community), and access to and the quality of health and disability services.

Wairarapa DHB's rate of acute medical admissions has decreased in recent years, and is lower than the national rate. The recent establishment of 3DHealthPathways, which describe the route a patient takes as they move through the health system and receive healthcare, should reduce the acute admission rate in future years. 3DHealthPathways will increase collaboration between health services which will result in better quality of care for our population.

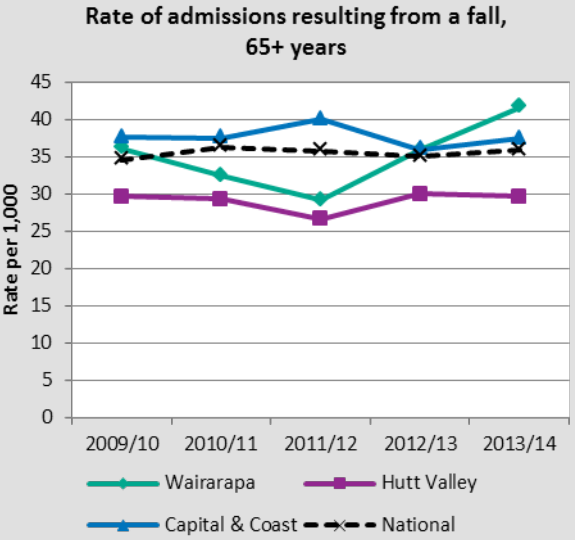
This measure links to the Early Detection & Management and Rehabilitation & Support output classes.



A reduction in the rate of admissions as a result of a fall, 65+

Falls are a common indicator in the health of older persons sector, both nationally and internationally. Reducing the rate of falls will promote and protect good health and independence, as older people will be able to do more things for themselves and remain in their own homes for longer. It will also reduce the demand on other services that provide treatment or interventions for falls.

The three DHBs joined with the Health and Safety Quality Commission in 2013/14 to implement a Falls Collaborative (as part of the Commission's Reducing Harm from Falls programme) with aged care facilities across the sub-region. This programme supported aged care to introduce and implement Quality Improvement



projects to reduce the incidence of falls within facilities. The formal programme has finished. It has been independently evaluated and as a result the Commission is developing a set of tools and templates to support best practice in falls risk assessment and individualised care planning. The three DHBs will be involved in the promotion of these resources.

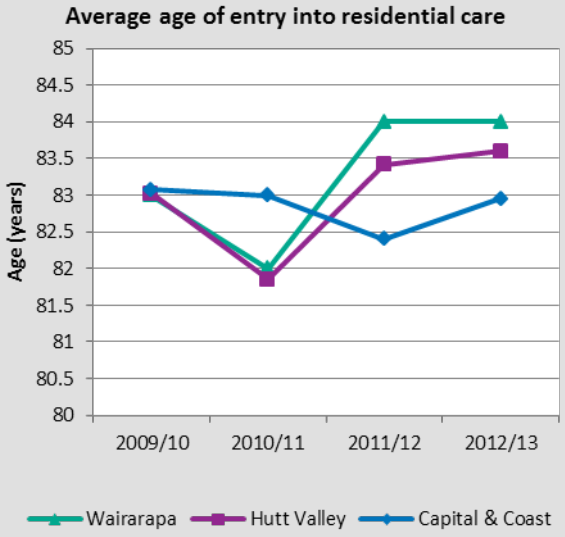
This measure links to the Rehabilitation & Support output class.

An increase in the average age of entry into residential care

With an ageing population, it is important that services are effective and efficient for people who wish to remain in their own homes. A 2008 study[2] 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.

Increasing the average age of entry into aged residential care indicates that our health services are providing for our older population's needs. There has been an increase in the age at which people are entering aged residential care in Wairarapa DHB.

This measure links to the Rehabilitation & Support output class.



Source: Regional Benchmarking. 2013/14 data not available at time of publication.

[2] Hambleton, Penny, Sally Keeling, & Margaret McKenzie (2008). "Quality of Life is…:The Views of Older Recipients of Low-Level Home Support." *Social Policy Journal of New Zealand (33).*

STATEMENT OF SERVICE PERFORMANCE

For the year ended 30 June 2014

In the Statement of Service Performance, we evaluate our performance (outputs) against the targets that we set in our 2013/14 Statement of Forecast Service Performance. We choose outputs that make the greatest contribution to the wellbeing of our population in the shorter term, and to the health outcomes that we are seeking to achieve over the longer term. These outputs also cover areas in which we are developing new services and therefore expect to see a change in activity levels or settings in the current year. They reflect a picture of health service activity across the whole of the Wairarapa health system.

To give a representative picture of our performance, the outputs have been grouped into four 'output classes' that are a logical fit with the stages spanning the continuum of care and are applicable to all DHBs:

1. Prevention Services;
2. Early Detection and Management Services;
3. Intensive Assessment and Treatment Services; and,
4. Rehabilitation and Support Services.

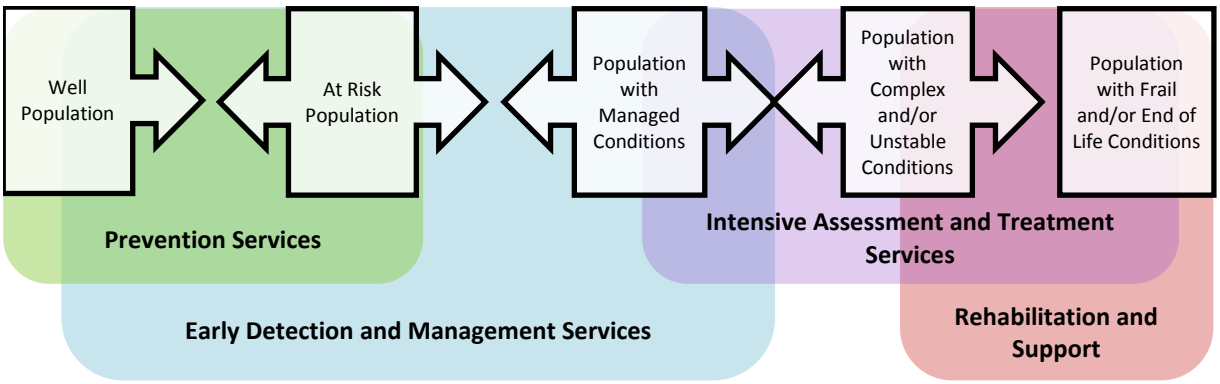


Figure 1: Scope of DHB Operations – Output Classes in the Continuum of Care

Prevention Services (Public Health Services)

Public health services are publicly funded to protect and promote the health of our population or of identifiable subpopulations (e.g., Māori, or children under 5). Public health services improve and maintain the health and wellbeing of the population through population-wide physical and social environment interventions, and enabling and empowering community resiliency. Notably, public health services are different to 'curative' services which repair health dysfunction and disability and support rehabilitation.

Public health services include:

- Health promotion to prevent illness and to achieve equity in health status;
- Statutorily-mandated health protection services to protect the public from toxic environmental risks and communicable diseases; and,
- Individual health protection services, including immunisation and screening services.

Early Detection and Management (Primary and Community Health Services)

Primary and community healthcare services are delivered by a range of health and allied-health professionals in various private, not-for-profit, and government service settings. These services include general practice, community, and Māori and Pacific health services, community pharmacy services, and child and adolescent dental and oral health services. These services are usually accessible from multiple health providers and from a number of different locations within the district.

Intensive Assessment and Treatment (Hospital Services)

Hospital services are publicly funded and are delivered by a range of secondary, tertiary, and quaternary providers. These services are usually integrated with 'facilities' (hospitals) so that specialised clinical expertise and equipment are conveniently provided in the same place, as hospital services are usually highly complex and provided by a variety of health care professionals that work closely together.

Hospital services 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 streams) including diagnostic, therapeutic, and rehabilitative services
- Emergency Department services including triage, diagnostic, therapeutic, and disposition services.

Rehabilitation and Support (Support Services)

Support services are delivered following a 'needs assessment' process and coordination input by Needs Assessment Service Co-ordination Services for a range of services including palliative care services, home-based support services, and residential care services.

Interpreting our Performance

Identifying appropriate measures for each output class is difficult as it is important to do more than measure just the volumes of patients and consumers through our system. The number of services delivered or the number of people who receive a service is often less important than whether the right person or enough of the right people received the right service, and whether the service was delivered at the right time.

Because of this complexity, in addition to volume, we have added a mix of output measures to help us to evaluate different aspects of our performance. The outputs are categorised by type of measure, which shows whether the output is targeting coverage, quality, quantity (volume), or timeliness.

Type of Measure	**Abbreviation**
Coverage	C
Quality	Q
Volume	V
Timeliness	T

The tables on the following pages show our performance against our targets. Our performance has been categorised according to the table below:

Performance	Definition
Achieved	Target has been achieved.
Partially Achieved	For targets with multiple components, some targets have been met but not all.
Not Achieved	Target has not been met.

In addition, we've used the following superscript symbols:

Symbol	Definition
†	Appears in the Māori Health Plan for Wairarapa DHB.
*	New measure in 2013/14. Our 2012/13 performance has therefore not been audited by Audit New Zealand.

Financial Performance ($000s)

Revenue	2012/13	2013/14 Budget	2013/14 Actual
Prevention	2,412	2,507	2,303
Early Detection and Management	40,530	42,069	39,832
Intensive Assessment and Treatment	71,001	70,391	75,063
Rehabilitation and Support	18,163	20,095	19,273
Total	132,106	135,062	136,471

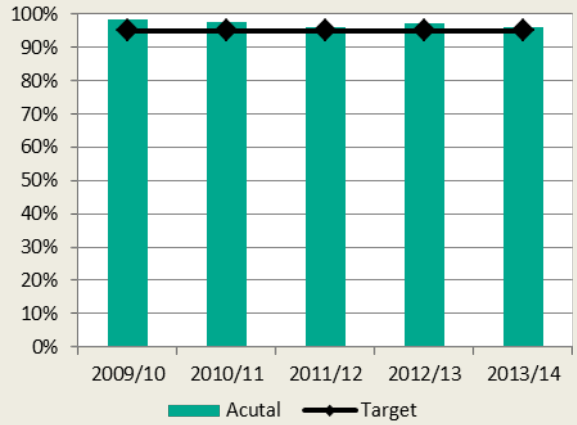
Expenditure	2012/13	2013/14 Budget	2013/14 Actual
Prevention	3,213	3,145	3,036
Early Detection and Management	42,053	41,195	41,352
Intensive Assessment and Treatment	71,832	73,024	74,226
Rehabilitation and Support	18,344	18,898	19,445
Total	135,442	136,262	138,059

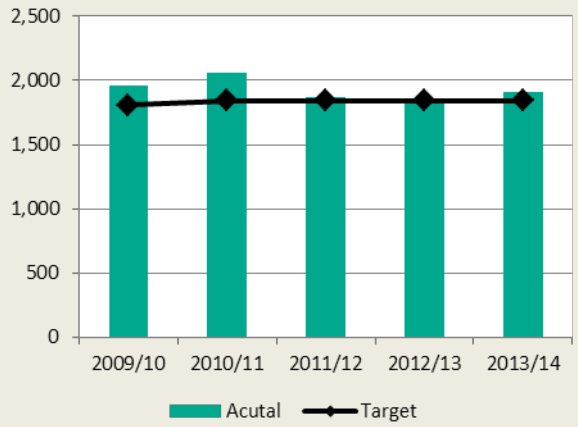
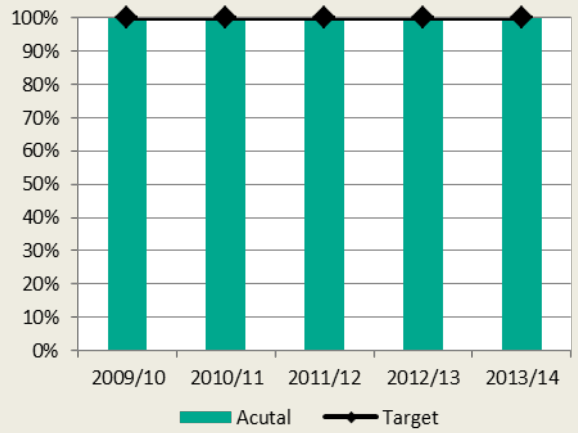
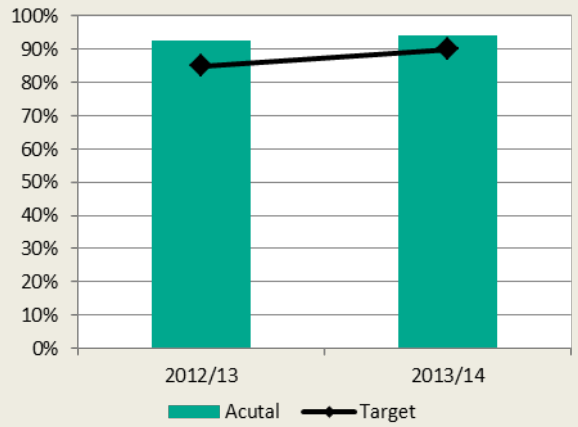
PERFORMANCE HIGHLIGHTS

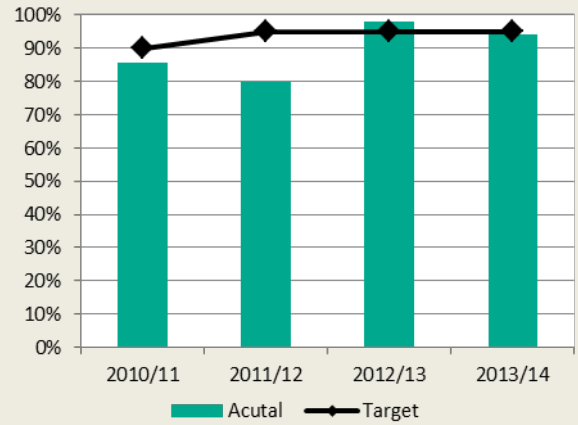
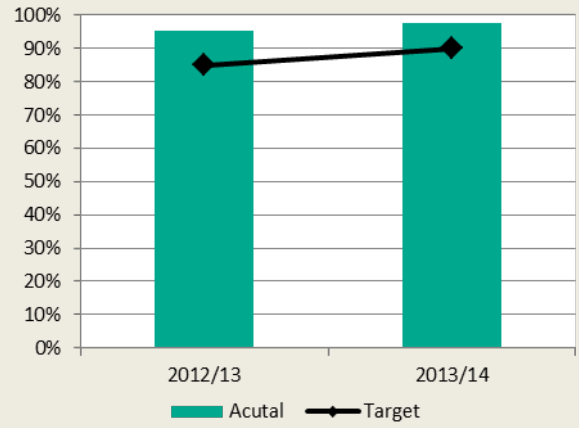
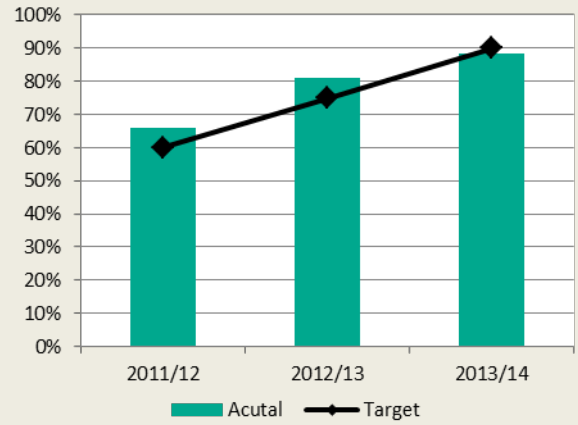
Wairarapa DHB continues to provide high quality and timely services for our population. In 2013/14:

- Compass Health PHO exceeded the Better help for smokers to quit primary care health target, with 98% of smokers visiting their GP receiving advice to quit. In quarter four, Wairarapa DHB was ranked fourth out of 20 DHBs on this target.
- All general practices in the Wairarapa now have a diabetes care improvement plan. These plans include regular monitoring of diabetes care and outline strategies and services that will improve diabetes care in the practice.
- Wairarapa DHB and PHOs met all of the Before School Checks, cervical screening, and breast screening targets. Notably, these targets were met for both the total population and for the Māori/high need populations, showing equity in access to screening services.
- Wairarapa DHB exceeded the elective surgery health target with 1,912 elective surgeries delivered to the DHB population.
- The average length of stay for both acute and elective admissions to Wairarapa Hospital continues to decrease.
- The Wairarapa population's access to secondary mental health services continues to increase.
- All of the aged residential care providers in Wairarapa DHB continue to meet three year certification standards.

Minister's Health targets

Health target	Description and 2013/14 Result	Trend
Shorter stays in Emergency Departments	95 percent of patients presenting at an Emergency Department (ED) will be admitted, discharged or transferred within six hours. 2013/14 Result: 96% **Output Class: Intensive Assessment and Treatment**	

Health target	Description and 2013/14 Result	Trend
Improved access to elective surgery	More New Zealanders have access to elective surgical services with at least 4,000 additional discharges nationally every year. Target was 1,841 discharges in 2013/14. 2013/14 Result: 1,912 **Output Class: Intensive Assessment and Treatment**	
Shorter waits for cancer treatment	All patients, ready for treatment, wait less than four weeks for radiotherapy or chemotherapy. 2013/14 Result: 100% **Output Class: Intensive Assessment and Treatment**	
Increased immunisation	90 percent of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time by July 2013, 90 percent by July 2014 and 95 percent by December 2014. 2013/14 Result: 96% **Output Class: Prevention Services**	
Better help for smokers to quit	95 percent of patients who smoke and are seen by a health practitioner in public hospitals and 90 percent of patients who smoke and are seen by a health practitioner in primary care are offered	Hospital:

Health target	Description and 2013/14 Result	Trend
	brief advice and support to quit smoking. 2013/14 Result: Hospital: 95% Primary Care: 98% **Output Class: Prevention Services**	 Primary Care: 
Better diabetes and cardiovascular services More heart and diabetes checks	90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years. 2013/14 Result: 88% **Output Class: Early Detection and Management**	

PREVENTION SERVICES

Health Promotion Services

Measure	Type of Measure	2012/13 Performance	Target 2013/14	2013/14 Performance	Achievement
The number of schools and early childhood services receiving health promotion visits[3]	V	32	**45**	36	Not Achieved
The number of new client referrals to school health nurses[4]	V	210	**550**[5]	171	Not Achieved
The percentage of infants exclusively and fully breastfed at 6 months[6]	C	27%	**27%**	30%	Achieved

Health promotion visits to schools and early childhood services includes education on leading preventable conditions, including skin infection, dental, vision and hearing, hygiene, nutrition and behavioural concerns. The number of new referrals to school nurses is expected to decrease as health promotion activity increases.

Immunisation Services

Measure	Type of Measure	2012/13 Performance	Target 2013/14	2013/14 Performance	Achievement
Health target: The percentage of eight month olds fully vaccinated[†]	C	92%	**90%**	96%	Achieved
The percentage of Yr 7 children vaccinated in schools[7]	C	84%*	**85%**	74%	Not Achieved
The percentage of Yr 8 girls vaccinated against HPV[8]	C	66%*[9]	**68%**	64%	Not Achieved
The percentage of enrolled people over 65 years vaccinated against flu[10†]	C	70%	**69%**	68%	Not Achieved
High Need		69%	**69%**	66%	Achieved

[3] Including health promotion to alternative education providers.
[4] This measure was originally "The number of new client referrals *by* school health nurses". This wording has since been revised as we are measuring referrals to the public health nursing service, not volume of referrals by the nursing service to other providers.
[5] This target was set on an erroneous baseline of 549 referrals in 2011/12.
[6] Plunket data.
[7] Performance aligned to school year: January to December 2012 (2012/13) and January to December 2013 (2013/14).
[8] Ibid.
[9] Fully vaccinated Dose 3.
[10] As flu vaccinations are seasonal, result is as at July 2013 (for 2012/13) and July 2014 (for 2013/14)

Wairarapa DHB continues to achieve the eight-month old immunisation health target. The results for Year 7 and Year 8 vaccinations in schools do not include the children who were vaccinated in primary care.

Smoking Cessation Services

Measure	Type of Measure	2012/13 Performance	Target 2013/14	2013/14 Performance	Achievement
Health target: The percentage of hospitalised smokers receiving advice and help to quit†	C	98%	**95%**	95%	
Health target: The percentage of enrolled patients who smoke and are seen in General Practice who are offered brief advice and support to quit smoking†	C	96%	**90%**	98%	Achieved

Wairarapa DHB records show that we have met the hospital health target in 2013/14. However, an audit at the end of 2013/14 found discrepancies in our smoking cessation data collection. We have consequently put stronger processes in place, including regular audits of discharged patient notes. Compass Health Wairarapa continues to meet the general practice health target.

EARLY DETECTION AND MANAGEMENT

Primary Care Services

Measure	Type of Measure	2012/13 Performance	Target 2013/14	2013/14 Performance	Achievement
The number of DHB domiciled population enrolled in a PHO[11]	V	41,762*	**41,823**	42,052	Achieved
Māori†		6,575*	**6,511**	6,807	Achieved
The ratio (high need: non high need) of standardised GP and nurse utilisation rate	V	1.16*	**>1.16**	1.12	Not Achieved
Health target: The percentage of the eligible population assessed for CVD risk in the last five years†	C	81%	**90%**	88%	Not Achieved
The percentage of diabetics receiving an annual check	C	85%*	**90%**	83%	Not Achieved
The percentage of practices with a diabetes care improvement plan	Q	Measure established 13/14	**100%**	100%	Achieved

Although the CVD risk assessment health target was not met, a 7% increase equates to an additional 1,300 people receiving an assessment. Wairarapa DHB was on track to achieve this health target for the first three

[11] PHO enrolment as at 1 July 2013 (for 2012/13) and 1 July 2014 (for 2013/14).

quarters and was the leading DHB for the first two quarters of the year, with results improving each quarter. However, in the final quarter a fire at the Masterton Medical Centre meant that PHO and practice resources needed to be redeployed and this may have impacted our final result.

The way that diabetics receive all the health checks they need has moved away from a one-off formal check (as measured above) to reviews that may be spread over a number of visits. This is part of a more flexible diabetes care plan, but results in the number of annual reviews being undercounted.

Screening Services

Measure	Type of Measure	2012/13 Performance	Target 2013/14	2013/14 Performance	Achievement
The percentage of eligible children receiving a Before School Check	C	81%	**≥90%**	93%	Achieved
High need		84%	**≥90%**	98%	Achieved
The percentage of eligible women (25-69) having cervical screening in the last 3 years[12†]	C	82%	**≥80%**	81%	Achieved
Māori		80%*	**80%**	80%	Achieved
The percentage of eligible women (50-69 yrs) having breast screening in the last 2 years[†]	C	72%*	**≥70%**	75%	Achieved
Māori		71%*	**≥70%**	74%	Achieved

Wairarapa DHB has met all of its screening services targets in 2013/14, including the targets for high need and Māori, showing equity in access to our screening services.

Oral Health Services

Measure	Type of Measure	2012 Performance	Target[13]		2013 Performance	Achievement
			2013	2014		
The percentage of children under 5 years enrolled in DHB funded dental services	C	78%*	**85%**	**85%**	78%	Not Achieved
The percentage of adolescents accessing DHB funded dental services	C	70%	**85%**	**85%**	64%	Not Achieved

[12] National Screening Unit data. Note that in 2013/14 the National Screening Unit revised the original measure from 20-69 year olds to 25-69 years old to align with international best practice. The national targets (to which our targets are aligned) have remained the same.

[13] Oral health measures are reported on a calendar year, so the Ministry of Health requests that we specify targets for each year.

Although Wairarapa DHB has not met the under-five enrolment target, the dental service is enrolling between 30 and 40 pre-schoolers each month, which is consistent with the birth rate in the Wairarapa. The enrolment coverage is expected to increase once the dental service begins to receive referrals for newborns from lead maternity carers in October 2014 (in addition to the referrals from Well Child/Tamariki Ora providers that are currently received).

The local PHO medical centre recently set up an adolescent clinic to improve adolescent access rates. In addition, two low-decile colleges now have a nurse who is working closely with the adolescent oral health co-ordinator. Annual meetings are held with the dentists, the clinical team leader, and the adolescent co-ordinator to facilitate increased access and to identify barriers to access.

INTENSIVE ASSESSMENT AND TREATMENT

Medical and Surgical Services

Measure	Type of Measure	2012/13 Performance	Target 2013/14	2013/14 Performance	Achievement
Health target: The percentage of patients admitted, discharged or transferred from ED within six hours	T	97%	**95%**	96%	Achieved
Health target: The number of surgical elective discharges	V	1,842	**1,841**	1,912	Achieved
The average length of stay for inpatients (days) [14] - Acute	T	3.69*	**4.22**	3.56	Achieved
Elective		3.45*	**3.48**	3.22	Achieved

Wairarapa DHB has met all of our medical and surgical services targets in 2013/14, with 96% of patients admitted, discharged or transferred from ED within six hours, and 1,912 elective surgery discharges. The average length of stay for both acute and elective admissions continues to decrease, showing improvements in the efficiency of the patient journey through hospital.

[14] Ministry of Health reporting is a quarter in arrears, so data is for 12 months ending March 2013 (for 2012/13) and March 2014 (for 2013/14).

Quality Measures

Measure	Type of Measure	2012/13 Performance	Target 2013/14	2013/14 Performance	Achievement
The percentage of "DNA" (did not attend) appointments for outpatients	Q	9%	**7%**	8%	Not Achieved
Māori		20%*	**17%**	18%	Achieved
The ratio of first specialists assessments (medical & surgical) to follow up appointments	Q	1:1.5*	**<1:1.7**	1:1.5	Achieved
The rate of falls per 1000 bed days causing patient harm[15]	Q	1.9*	**<4.5**	2.2	Achieved
The rate of medication errors per 1000 bed days	Q	2.7*	**<2.9**	3.3	Not Achieved

Although the DNA rate for Māori has decreased in 2013/14, there is still inequity between Māori and other ethnicities. Māori and Pacific teams are using a range of culturally specific approaches including engagement with patients and whanau prior to appointments, coordinating appointments, providing assistance to attend or linking with community services and responding to referrals from clinics following a DNA.

Wairarapa DHB continues to provide high quality and timely care to patients. In 2013 the Health Quality & Safety Commission (HQSC) introduced a campaign that focusses on improving patient safety in medications, falls, health acquired infections, and perioperative harm. Our fall rates are now substantially lower than they were in 2011/12.

Cancer Services

Measure	Type of Measure	2012/13 Performance	Target 2013/14	2013/14 Performance	Achievement
Health target: The percentage of patients, ready for treatment, who wait less than four weeks for radiotherapy or chemotherapy	T	100%	**100%**	**100%**	Achieved

[15] This measure was originally "The rate of falls per 1,000 bed days" in the 2013/14 Annual Plan and has since been revised.

Mental Health and Addictions Services

Measure	Type of Measure	2012/13 Performance	Target 2013/14	2013/14 Performance	Achievement
The percentage of people accessing secondary mental health services [16]	C	4.02%*	**≥3.89%**	4.72%	Achieved
The percentage of people accessing secondary mental health services, 0-19[17]		4.77%	**≥4.71%**	5.54%	Achieved
Māori		5.69%*	**≥4.71%**	6.63%	Achieved
The percentage of people accessing secondary mental health services, 20-64 [18]		4.79%*	**≥4.57%**	5.69%	Achieved
Māori		9.24%*	**≥4.57%**	10.74%	Achieved
The percentage of long term clients who have up-to-date relapse prevention plans	Q	93%	**≥95%**	89%	Not Achieved
The percentage of patients referred to non-urgent mental health services who are seen within eight weeks	T	95.9%*	**≥95%**	97.5%	Achieved
The percentage of patients referred to non-urgent addictions services who are seen within eight weeks	T	91.5%*	**≥95%**	96.2%	Achieved

Wairarapa DHB has met all but one of the mental health targets in 13/14. There has been increasing collaboration between Wairarapa, Hutt Valley, and Capital & Coast DHB Mental Health and Addiction Services in 2013/14. Through recent strategic changes, access to the child, youth, and adult mental health services has improved considerably, and these services are now operating with a small or zero waitlist.

[16] Ministry of Health reporting is a quarter in arrears, so data is for 12 months ending March 2013 (for 2012/13) and March 2014 (for 2013/14).
[17] Ministry of Health reporting is a quarter in arrears, so data is for 12 months ending March 2013 (for 2012/13) and March 2014 (for 2013/14).
[18] Ministry of Health reporting is a quarter in arrears, so data is for 12 months ending March 2013 (for 2012/13) and March 2014 (for 2013/14).

REHABILITATION AND SUPPORT

Measure	Type of Measure	2012/13 Performance	Target 2013/14	2013/14 Performance	Achievement
The percentage of people 65+ who have received long term home support services in the last three months who have had a comprehensive clinical [InterRAI] assessment and a completed care plan	Q	49%[19]*	**>95%**	76%[20]	Not Achieved
The number of total assessments (including new and review)	V	1573*	**758**[21]	1749	Achieved
The number of people receiving home and community support services	V	754	**740**	780	Achieved
The number of home based support hours	V	91,497	**91,122**[22]	91,493	Achieved
The number of respite days[23]	V	2,455	**1,258**[24]	3,144	Achieved
The number of subsidised aged residential care bed days	V	119,566	**123,000**[25]	124,694	Achieved
The percentage of residential care providers meeting three year certification standards[26]	Q	100%	**100%**	100%	Achieved
The number of Disability Forum meetings (sub-regional and local)	V	2	**2**	2	Achieved

[19] Data for January to March 2013 quarter. Data for the full 2012/13 financial year is unavailable as data collection systems were established in 2012/13.

[20] Ministry of Health reporting is a quarter in arrears, so data is for 12 months ending March 2014 (for 2013/14).

21 The interRAI assessment tool rollout began in 2011. Assessment volumes have increased steadily since then.

[22] These targets are based on historical trends and are not aspirational. There are no assumptions around whether an increase/decrease is desirable or not. Performance on these targets will vary from year to year depending on a number of factors (e.g., socio-demographic and economic profiles).

[23] Excluding bulk-funded beds (3 beds).

[24] These targets are based on historical trends and are not aspirational. There are no assumptions around whether an increase/decrease is desirable or not. Performance on these targets will vary from year to year depending on a number of factors (e.g., socio-demographic and economic profiles).

[25] Ibid.

[26] Excluding new providers and facilities as these are required to have a one year certification.

Although Wairarapa DHB did not meet the InterRAI target, our performance has increased by 15%, which equates to approximately 300 more people receiving assessments. Wairarapa DHB has invested in additional staffing resources and continues to make steady progress towards achievement of this target.

The three sub-regional DHBs collaborated in a disability plan in 2013. As a result of this collaborative approach, the first 3DHB intersectoral forum around disability issues was held in 2013/14.

FINANCIAL STATEMENTS

CONTENTS

STATEMENT OF COMPREHENSIVE INCOME

For the year ended 30 June 2014

	Note	Group Budget 2014 $000	Group Actual 2014 $000	Group Actual 2013 $000	Parent Actual 2014 $000	Parent Actual 2013 $000
Income						
Operating income	1	135,020	137,628	132,583	136,471	131,337
Finance income	2	43	145	606	168	765
Total income		**135,063**	**137,773**	**133,189**	**136,639**	**132,102**
Expenditure						
Workforce costs	3	39,812	40,889	39,807	40,889	39,807
Other operating expenses	4a	20,984	22,507	21,689	21,470	20,618
External providers	4b	45,840	45,272	45,496	45,272	45,496
Inter district flows	4b	26,226	27,262	25,799	27,262	25,799
Total operating expenditure		**132,862**	**135,930**	**132,791**	**134,893**	**131,720**
Operating result before interest, depreciation & capital charge		**2,201**	**1,843**	**398**	**1,746**	**382**
Interest, Depreciation & Capital Charge						
Interest expense	5	1,175	1,169	1,334	1,169	1,334
Capital charge	5	482	297	685	297	685
Depreciation & amortisation expense	7,8	1,741	1,783	1,777	1,700	1,699
Net loss / (gain) on disposal of assets		0	0	0	0	0
Total interest, depreciation & capital charge		**3,398**	**3,249**	**3,796**	**3,166**	**3,718**
Net surplus/(deficit) from continuing operations		**(1,197)**	**(1,406)**	**(3,398)**	**(1,420)**	**(3,336)**

	Note	Group Budget 2014 $000	Group Actual 2014 $000	Group Actual 2013 $000	Parent Actual 2014 $000	Parent Actual 2013 $000
Net surplus/(deficit) from continuing operations		**(1,197)**	**(1,406)**	**(3,398)**	**(1,420)**	**(3,336)**
Net surplus/(deficit) from discontinued operations						
Ambulance services	23	0	0	0	0	0
Impairment on property valuation	7b	0	0	0	0	0
Net surplus/(deficit) from discontinued operations		**0**	**0**	**0**	**0**	**0**
Net surplus/(deficit) for the year		**(1,197)**	**(1,406)**	**(3,398)**	**(1,420)**	**(3,336)**
Other comprehensive income						
Gain / (loss) on property revaluations	7a	0	0	3,403	0	3,403
Total other comprehensive income		**0**	**0**	**3,403**	**0**	**3,403**
Total comprehensive income		**(1,197)**	**(1,406)**	**5**	**(1,420)**	**67**
Total comprehensive income attributable to:						
Wairarapa District Health Board		(1,197)	(1,406)	5	(1,420)	67
Non-controlling interest		0	0	0	0	0

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

STATEMENT OF FINANCIAL POSITION

As at 30 June 2014

	Note	Group Budget 2014 $000	Group Actual 2014 $000	Group Actual 2013 $000	Parent Actual 2014 $000	Parent Actual 2013 $000
Assets						
Property, plant & equipment	7a	38,825	42,003	43,402	41,869	43,251
Intangible assets	8	1,140	1,722	1,463	1,713	1,446
Investments	9	3,673	2,760	2,924	2,863	3,027
Total non-current assets		**43,637**	**46,485**	**47,789**	**46,445**	**47,724**
Cash & cash equivalents	10	4	318	300	5	4
Inventories	11	830	744	763	744	763
Trade & other receivables	12	5,080	5,444	4,247	5,317	4,076
Assets classified as held for sale	7b	0	0	0	0	0
Total current assets		**5,914**	**6,506**	**5,310**	**6,066**	**4,843**
Total assets		**49,551**	**52,991**	**53,099**	**52,511**	**52,567**

	Note	Group Budget 2014 $000	Group Actual 2014 $000	Group Actual 2013 $000	Parent Actual 2014 $000	Parent Actual 2013 $000

Equity						
Crown equity	13	37,227	39,040	39,043	39,040	39,043
Revaluation reserve	13	2,417	5,558	5,558	5,558	5,558
Retained earnings	13	(33,563)	(34,814)	(33,408)	(35,167)	(33,747)
Total equity		**6,081**	**9,784**	**11,193**	**9,431**	**10,854**
Liabilities						
Interest-bearing loans & borrowings	14	22,081	20,194	21,758	20,194	21,758
Employee benefits	15	697	481	551	481	551
Trust funds	16	310	258	259	258	259
Total non-current liabilities		**23,088**	**20,933**	**22,568**	**20,933**	**22,568**
Cash & cash equivalents - Overdraft	10	2,000	812	1,169	812	1,169
Interest-bearing loans & borrowings	14	4,575	6,064	4,560	6,064	4,560
Payables & accruals	17	8,170	9,888	8,177	9,817	8,080
Employee benefits	15	5,637	5,510	5,432	5,454	5,336
Total current liabilities		**20,382**	**22,274**	**19,338**	**22,147**	**19,145**
Total liabilities		**43,470**	**43,207**	**41,906**	**43,080**	**41,713**
Total equity & liabilities		**49,551**	**52,991**	**53,099**	**52,511**	**52,567**

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

STATEMENT OF CHANGES IN EQUITY

For the year ended 30 June 2014

	Note	Group Budget 2014	Group Actual 2014 $000	Group Actual 2013 $000	Parent Actual 2014 $000	Parent Actual 2013 $000
Balance at 1 July		**6,081**	**11,193**	**6,423**	**10,854**	**6,022**
Prior year equity closing balance correction		0	0	(31)	0	(31)
Net surplus / (deficit) for the year		(1,197)	(1,406)	(3,398)	(1,420)	(3,336)
Other comprehensive income		0	0	3,403	0	3,403
Total comprehensive income		**(1,197)**	**(1,406)**	**(26)**	**(1,420)**	**36**
Equity injection from the Crown		1,200	0	4,799	0	4,799
Repayment of equity to the Crown		(3)	(3)	(3)	(3)	(3)
Movements in equity for the year		**1,197**	**(3)**	**4,796**	**(3)**	**4,796**
Balance at 30 June	13	**6,081**	**9,784**	**11,193**	**9,431**	**10,854**
Total comprehensive income attributable to:						
Wairarapa District Health Board		(1,197)	(1,406)	5	(1,420)	67
Non-controlling interest		0	0	0	0	0
Total comprehensive income		**(1,197)**	**(1,406)**	**5**	**(1,420)**	**67**

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

STATEMENT OF CASH FLOWS

For the year ended 30 June 2014

	Note	Group Budget 2014 $000	Group Actual 2014 $000	Group Actual 2013 $000	Parent Actual 2014 $000	Parent Actual 2013 $000
Cash flows from operating activities						
Operating receipts:						
Government & crown agency revenue		125,386	132,110	122,871	132,110	122,871
Other		5,037	3,634	8,662	3,610	8,662
Interest received		72	150	76	150	76
Payments to suppliers & employees		(127,648)	(133,061)	(132,380)	(133,078)	(132,380)
Capital charge paid		(600)	(763)	(373)	(763)	(373)
Interest paid		(1,529)	(1,172)	(1,333)	(1,172)	(1,333)
Income tax paid		0	0	0	0	0
Goods and Services Tax (net)		0	29	(24)	29	(24)
Net cash flows from operating activities	10	**718**	**927**	**(2,501)**	**886**	**(2,501)**
Cash flows from investing activities						
Proceeds from sale of property, plant & equipment		0	25	1,674	25	1,674
Dividends received		0	0	160	24	160
Investment in joint venture		(2,640)	0	(2,371)	0	(2,371)
Acquisition of property, plant & equipment		(540)	(171)	(1,101)	(171)	(1,101)
Acquisition of intangible assets		(500)	(345)	(244)	(345)	(244)
Net cash flows from investing activities		**(3,680)**	**(491)**	**(1,882)**	**(467)**	**(1,882)**

	Note	Group Budget 2014 $000	Group Actual 2014 $000	Group Actual 2013 $000	Parent Actual 2014 $000	Parent Actual 2013 $000
Cash flows from financing activities						
Loans drawn down		0	0	0	0	0
Equity injected		3,100	0	4,797	0	4,797
Repayments of loans		(125)	(58)	(163)	(58)	(163)
Repayment of equity		(3)	(3)	(3)	(3)	(3)
Restricted fund movement		0	0	3	0	3
Net cash flows from financing activities		**2,972**	**(61)**	**4,634**	**(61)**	**4,634**
Net increase / (decrease) in cash held		**10**	**0**	**251**	**0**	**251**
Cash & cash equivalents at beginning of year		(2,006)	(869)	(1,120)	(1,165)	(1,416)
Cash & cash equivalents at end of year	**10**	**(1,996)**	**(494)**	**(869)**	**(807)**	**(1,165)**

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

STATEMENT OF CONTINGENCIES

As at 30 June 2014

	Group Actual 2014 $000	Group Actual 2013 $000	Parent Actual 2014 $000	Parent Actual 2013 $000
Legal proceedings and obligations	0	0	0	0
Uncalled shares in Central Region Technical Advisory Services Ltd	0	0	0	0
Total contingent liabilities	**0**	**0**	**0**	**0**
Total contingent assets	**0**	**0**	**0**	**0**

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

STATEMENT OF COMMITMENTS

As at 30 June 2013

	Group Actual 2014 $000	Group Actual 2013 $000	Parent Actual 2014 $000	Parent Actual 2013 $000
Capital Commitments	**225**	**94**	**225**	**94**
Operating Lease Commitments:				
Less than One Year:	902	640	902	640
One to Two Years	470	229	470	229
Two to Five Years	440	146	440	146
Five Years	259	0	259	0
	2,071	**1,015**	**2,071**	**1,015**
Total Commitments	**2,296**	**1,109**	**2,296**	**1,109**

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

STATEMENT OF ACCOUNTING POLICIES

Reporting entity

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

Wairarapa DHB is a public benefit entity, as defined under NZIAS 1.

The consolidated financial statements of Wairarapa DHB for the year ended 30 June 2014 comprise Wairarapa DHB and its subsidiary Biomedical Services New Zealand Limited (together referred to as "WDHB") and joint venture the Central Region Technical Advisory Service Limited (TAS) which is one sixth owned. The financial statements were authorised for issue by the Wairarapa District Health Board on 31 October 2014.

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

Statement of compliance

The consolidated financial statements have been prepared in accordance with Generally Accepted Accounting Practice in New Zealand (NZGAAP) as appropriate for Public Benefit Entities. They comply with New Zealand equivalents to International Financial Reporting Standards (NZIFRS), and other applicable Financial Reporting Standards, as appropriate for public benefit entities.

Basis of preparation

Functional and presentation currency

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

Measurement base

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

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

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

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

Going Concern

The going concern principle has been adopted in the preparation of these financial statements. The Board, after making enquiries, has a reasonable expectation that the DHB has adequate resources to continue operations for the foreseeable future based on current trading terms and legislative requirements. The Board has reached this conclusion having regard to circumstances which it considers likely to affect the DHB during the period of one year from the date of signing the 2013/14 financial statements, and to circumstances which it knows will occur after that date which could affect the validity of the going concern assumption (as set out in its current Statement of Intent). The key considerations are set out below.

Letter of comfort

The Board has received a letter of comfort, 28 August 2014 from the Ministers of Health and Finance which states that deficit support will be provided where necessary to maintain viability.

Operating and cash flow forecasts

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

Borrowing covenants and forecast borrowing requirements

The forecasts for the next 3 years prepared by the DHB show that the peak borrowing requirement will not exceed the available borrowing facilities. Furthermore, the forecast borrowing requirements can be met without breaching covenants or other borrowing restrictions.

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

If the DHB was unable to continue as a going concern adjustments may have to be made to reflect the situation that assets may have to be realised and liabilities extinguished other than in the normal course of

business and at amounts which could differ significantly from the amounts at which they are currently reported in the statement of financial position.

Changes in accounting policies

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

Standards, amendments, and interpretations issued that are not yet effective and have not been early adopted

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

NZ IFRS 9 Financial Instruments will eventually replace NZ IAS 39 Financial Instruments: Recognition and Measurement. NZ IAS 39 is being replaced through the following 3 main phases: Phase 1 Classification and Measurement, Phase 2 Impairment Methodology, and Phase 3 Hedge Accounting. Phase 1 has been completed and has been published in the new financial instrument standard NZ IFRS 9. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39. The approach in NZ IFRS 9 is based on how an entity manages its financial assets (its business model) and the contractual cash flow characteristics of the financial assets. The financial liability requirements are the same as those of NZ IAS 39, except for when an entity elects to designate a financial liability at fair value through the surplus/deficit. The new standard is required to be adopted for the year ended 30 June 2016. However, as a new Accounting Standards Framework will apply before this date, there is no certainty when an equivalent standard to NZ IFRS 9 will be applied by public benefit entities.

The Minister of Commerce has approved a new Accounting Standards Framework (incorporating a Tier Strategy) developed by the External Reporting Board (XRB). Under this Accounting Standards Framework, WDHB is classified as a Tier 1 reporting entity and it will be required to apply full Public Benefit Entity Accounting Standards (PAS). These standards are being developed by the XRB based on current International Public Sector Accounting Standards. The effective date for the new standards for public sector entities is expected to be for reporting periods beginning on or after 1 July 2014. This means WDHB expects to transition to the new standards in preparing its 30 June 2015 financial statements. As the PAS are still under development, WDHB is unable to assess the implications of the new Accounting Standards Framework at this time.

Due to the change in the Accounting Standards Framework for public benefit entities, it is expected that all new NZ IFRS and amendments to existing NZ IFRS will not be applicable to public benefit entities. Therefore, the XRB has effectively frozen the financial reporting requirements for public benefit entities up until the new Accounting Standard Framework is effective. Accordingly, no disclosure has been made about new or amended NZ IFRS that exclude public benefit entities from their scope.

Basis for consolidation

Subsidiaries

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

Joint ventures

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

Transactions eliminated on consolidation

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

Budget figures

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

The budget figures have been prepared in accordance with NZGAAP. They comply with NZIFRS and other applicable Financial Reporting Standards as appropriate for public benefit entities. Those standards are consistent with the accounting policies adopted by WDHB for the preparation of these financial statements.

Goods and services tax

All amounts are shown exclusive of Goods and Services Tax (GST), except for receivables and payables that are stated inclusive of GST. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

Commitments and Contingencies

Commitments and Contingencies are disclosed exclusive of GST.

Revenue

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

Crown funding

The vast majority of revenue is provided through an appropriation in association with a Crown Funding Agreement. Revenue received is restricted in its use for the purpose of the DHB meeting its objectives.

Revenue is recognised monthly in accordance with the Crown Funding Agreement payment schedule, which allocates the appropriation equally throughout the year.

ACC contracted revenue

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

Revenue for other DHBs

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

Interest Income

Interest income is recognised using the effective interest method.

Revenue relating to service contracts

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

Goods sold and services rendered

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

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

Rental income

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

Expenses

Capital Charge

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

Interest expense

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

Operating lease payments

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

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

Finance lease payments

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

At the commencement of the lease term, finance leases are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased item or the present value of the minimum lease payments.

The amount recognised as an asset is depreciated over its useful life. If there is no certainty as to whether the DHB will obtain ownership at the end of the lease term, the asset is fully depreciated over the shorter of the lease term and its useful life.

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

Net financing costs

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

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

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

Non-current assets held for sale

Non-current assets held for sale are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. Immediately before the classification of assets as held for sale, the measurement of the assets (and all assets and liabilities in a disposal group) is brought up-to-date in accordance with applicable NZIFRSs. Then, on initial classification as

held for sale, a non-current asset and/or a disposal group is recognised at the lower of its carrying amount and its fair value less costs to sell.

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

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

Business combinations involving entities under common control

A business combination involving entities or businesses under common control is a business combination in which all of the combining entities or businesses are ultimately controlled by the same party or parties both before and after the business combination, and that control is not transitory. WDHB applies the book value measurement method to all common control transactions.

Income tax

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

Foreign currency

Foreign currency transactions

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

Property, Plant & Equipment

Classes of property, plant and equipment

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

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

Owned assets

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

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

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

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

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

Property, Plant and Equipment Vested from the Hospital and Health Service

Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets of Wairarapa Health Limited (a hospital and health service company) vested in WDHB on 1 January 2001. Accordingly, assets were transferred to WDHB at their net book values as recorded in the books of the hospital and health service. In effecting this transfer, the health board has recognised the cost (or in the case of land and buildings – the valuation) and accumulated depreciation amounts from the records of the hospital and health service. The vested assets will continue to be depreciated over their remaining useful lives.

Disposal of Property, Plant and Equipment

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

Properties Intended for Sale

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

Leased assets

Leases where WDHB assumes substantially all the risks and rewards of ownership, whether or not title is eventually transferred are classified as finance leases. The assets acquired by way of finance lease are stated

at an amount equal to the lower of their fair value and the present value of the minimum lease payments at inception of the lease, less accumulated depreciation and impairment losses.

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

Subsequent costs

Subsequent costs are added to the carrying amount of an item of property, plant and equipment when that cost is incurred if it is probable that the service potential or future economic benefits embodied within the new item will flow to WDHB. All other costs are recognised in the statement of comprehensive income as an expense as incurred.

Depreciation

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

Class of Asset	Estimated life
Buildings (including components)	2 to 50 years
Clinical equipment	2.5 to 15 years
Information technology	2.5 to 15 years
Motor vehicles	5 to 12.5 years
Other plant and equipment	2.5 to 15 years

The residual value of assets is reassessed annually.

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

Intangible assets

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

Subsequent expenditure

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

Amortisation

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

Type of Asset	Estimated life
Software	2 to 10 years

Impairment

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

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

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

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

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

Calculation of recoverable amount

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

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

For non-cash generating assets that are not part of a cash generating unit value in use is based on depreciated replacement cost (DRC). For cash generating assets value in use is determined by estimating

future cash flows from the use and ultimate disposal of the asset and discounting these to their present value using a pre-tax discount rate that reflects current market rates and the risks specific to the asset.

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

Reversals of impairment

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

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

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

Investments

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

Debtors and other receivables

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

Inventories

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

Cost is based on weighted average cost.

Inventories held for distribution

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

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

Cash and cash equivalents

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

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

Interest-bearing borrowings

Interest-bearing borrowings are recognised initially at fair value less attributable transaction costs. Subsequent to initial recognition, interest-bearing borrowings are stated at amortised cost with any difference between cost and redemption value being recognised in the surplus or deficit over the period of the borrowings on an effective interest basis.

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

Employee benefits

Defined contribution schemes

Obligations for contributions to defined contribution schemes are recognised as an expense in the statement of comprehensive income as incurred.

Defined benefit schemes

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

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

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

Long service leave, sabbatical leave and retirement gratuities

WDHB's net obligation in respect of long service leave, sabbatical leave and retirement gratuities is the amount of future benefit that employees have earned in return for their service in the current and prior periods. The obligation is calculated using the projected unit credit method and is discounted to its present value. The discount rates used for the 2014 valuation are based on the weighted average of bond yields such that the estimated term of the bonds is consistent with the estimated term of the liabilities. This approach is consistent with the requirements of NZ IAS19.

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

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

Provisions

A provision is recognised when WDHB has a present legal or constructive obligation as a result of a past event, and it is probable that an outflow of economic benefits will be required to settle the obligation. If the effect is material, provisions are determined by discounting the expected future cash flows at a pre-tax rate that reflects current market rates and, where appropriate, the risks specific to the liability.

Restructuring

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

Creditors & other payables

Trade and other payables are stated at amortised cost using the effective interest rate.

Cost of Service Statements

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

Cost Allocation

WDHB has arrived at the net cost of service for each significant activity using the cost allocation system outlined below:

Cost Allocation Policy - Direct costs are charged directly to major board activities. Indirect costs are charged to major board activities based on cost drivers and related activity/usage information.

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

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

NOTES TO THE FINANCIAL STATEMENTS

1 OPERATING INCOME

	Group Actual 2014 $000	Group Actual 2013 $000	Parent Actual 2014 $000	Parent Actual 2013 $000
Health & disability services (MOH contracted revenue)	127,061	123,074	127,061	123,074
Inter district patient inflows	3,558	3,357	3,558	3,357
ACC contract	2,181	2,031	2,181	2,031
Donations & bequests	21	81	21	81
Other income	4,807	4,040	3,650	2,794
Total operating income	**137,628**	**132,583**	**136,471**	**131,337**

2 FINANCE INCOME

	Group Actual 2014 $000	Group Actual 2013 $000	Parent Actual 2014 $000	Parent Actual 2013 $000
Interest income	150	77	149	76
Dividend income	0	0	24	160
Gain/(Loss) on disposal of property, plant & equipment	(5)	529	(5)	529
Total finance income	**145**	**606**	**168**	**765**

3 WORKFORCE COSTS

	Group Actual 2014 $000	Group Actual 2013 $000	Parent Actual 2014 $000	Parent Actual 2013 $000
Wages & salaries	34,938	36,717	34,938	36,717
Payments to contracted workforce	5,903	3,576	5,903	3,576
Increase / (decrease) in liability for employee entitlements	48	(486)	48	(486)
Total workforce costs	**40,889**	**39,807**	**40,889**	**39,807**

4 OTHER EXPENSES

4a Other Operating Costs

	Group Actual 2014 $000	Group Actual 2013 $000	Parent Actual 2014 $000	Parent Actual 2013 $000
Other operating expenses	7,921	7,602	6,973	6,591
Outsourced Services	4,528	4,226	4,491	4,226
Clinical Supplies	8,286	7,929	8,286	7,929
Operating lease expenses	1,444	1,430	1,409	1,387
Audit fees (for the audit of the financial statements)	113	120	102	109
Audit fees (for other assurance services)	12	82	12	82
Impairment of trade receivables (bad & doubtful debts)	(46)	46	(46)	46
Board member fees & expenses	249	254	243	248
Total other operating expenses	**22,507**	**21,689**	**21,470**	**20,618**

Operating lease expenses

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

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

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

4b Payments to External Health Providers

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

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

	Group Actual 2014 $000	Group Actual 2013 $000	Parent Actual 2014 $000	Parent Actual 2013 $000
Payments to non-health board providers	45,272	45,496	45,272	45,496
Inter-District Flow payments to other DHBs	27,262	25,799	27,262	25,799

5 FINANCE COSTS

	Group Actual 2014 $000	Group Actual 2013 $000	Parent Actual 2014 $000	Parent Actual 2013 $000
Interest expense	1,169	1,334	1,169	1,334
Capital charge	297	685	297	685
Total finance costs	**1,466**	**2,019**	**1,466**	**2,019**

Wairarapa DHB pays a capital charge to the Crown based on the greater of its actual or budgeted closing equity balance, adjusted for equity contributions or repayment of equity, for the year. The capital charge rate for the period ended 30 June 2014 was 8% (2013 – 8%).

6 INCOME TAX

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

7 PROPERTY, PLANT & EQUIPMENT

7a Non-Current Assets

Group	Land (at valuation) $000	Buildings (at valuation) $000	Clinical equipment $000	Other equipment $000	Information technology $000	Motor vehicles $000	Work in progress $000	Total $000
Cost / valuation								
Balance at 1 July 2012	1,935	34,406	6,476	2,443	892	909	1,149	48,210
Additions	0	51	534	81	42	50	515	1,273
Disposals	0	0	(252)	(14)	(3)	(51)	(1,622)	(1,942)
Revaluations	500	2,903	0	0	0	0	0	3,403
Balance at 30 June 2013	**2,435**	**37,360**	**6,758**	**2,510**	**931**	**908**	**42**	**50,944**
Balance at 1 July 2013	2,435	37,360	6,758	2,510	931	908	42	50,944
Additions	0	70	93	68	0	0	326	557
Disposals	0	0	(4)	(55)	(9)	(51)	(340)	(459)
Revaluations	0	0	0	0	0	0	0	0
Balance at 30 June 2014	**2,435**	**37,430**	**6,847**	**2,523**	**922**	**857**	**28**	**51,042**

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

Group	Land (at valuation)	Buildings (at valuation)	Clinical equipment	Other equipment	Information technology	Motor vehicles	Work in progress	Total
Depreciation & impairment losses								
Balance at 1 July 2012		757	4,253	1,770	683	296		7,758
Depreciation charge for the year		768	528	174	57	86		1,613
Depreciation charge discontinued operations		0	0	0	0	0		0
Impairment losses		0	0	0	0	0		0
Disposals		0	(252)	(15)	(2)	(35)		(304)
Revaluations		(1,525)	0	0	0	0		(1,525)
Balance at 30 June 2013		**0**	**4,529**	**1,929**	**738**	**347**		**7,542**
Balance at 1 July 2013		0	4,529	1,929	724	347		7,529
Depreciation charge for the year		784	491	179	57	76		1,587
Impairment losses		0	0	0	0	0		0
Disposals		0	(3)	(46)	(9)	(19)		(77)
Revaluations		0	0	0	0	0		0
Balance at 30 June 2014		**784**	**5,017**	**2,062**	**773**	**404**		**9,039**

Group	Land (at valuation)	Buildings (at valuation)	Clinical equipment	Other equipment	Information technology	Motor vehicles	Work in progress	Total
Carrying amounts								
At 1 July 2012	1,935	33,649	2,223	673	209	613	1,149	40,452
At 30 June 2013	**2,435**	**37,360**	**2,229**	**581**	**193**	**561**	**42**	**43,402**
At 1 July 2013	2,435	37,360	2,229	581	193	561	42	43,402
At 30 June 2014	**2,435**	**36,646**	**1,830**	**461**	**150**	**453**	**28**	**42,003**

Parent	Land (at valuation)	Buildings (at valuation)	Clinical equipment	Other equipment	Information technology	Motor vehicles	Work in progress	Total
	$000	$000	$000	$000	$000	$000	$000	$000
Cost / valuation								
Balance at 1 July 2012	1,935	34,406	6,476	1,750	847	798	1,149	47,361
Additions	0	51	534	30	39	36	515	1,205
Disposals	0	0	(252)	0	(1)	(40)	(1,622)	(1,915)
Revaluations	500	2,903	0	0	0	0	0	3,403
Balance at 30 June 2013	**2,435**	**37,360**	**6,758**	**1,780**	**885**	**794**	**42**	**50,054**
Balance at 1 July 2013	2,435	37,360	6,758	1,780	885	794	42	50,054
Additions	0	70	93	6	0	0	326	495
Disposals	0	0	(4)	(2)	0	(36)	(340)	(382)
Revaluations	0	0	0	0	0	0	0	0
Balance at 30 June 2014	**2,435**	**37,430**	**6,847**	**1,784**	**885**	**758**	**28**	**50,167**

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

Parent	Land (at valuation)	Buildings (at valuation)	Clinical equipment	Other equipment	Information technology	Motor vehicles	Work in progress	Total
Depreciation & impairment losses								
Balance at 1 July 2012		757	4,253	1,195	644	221		7,070
Depreciation charge for the year		768	528	126	45	68		1,535
Depreciation charge discontinued operations		0	0	0	0	0		0
Impairment losses		0	0	0	0	0		0
Disposals		0	(252)	(1)	0	(24)		(277)
Revaluations		(1,525)	0	0	0	0		(1,525)
Balance at 30 June 2013		**0**	**4,529**	**1,320**	**689**	**265**		**6,803**
Balance at 1 July 2013		0	4,529	1,320	689	265		6,803
Depreciation charge for the year		784	491	122	48	60		1,505
Impairment losses		0	0	0	0	0		0
Disposals		0	(3)	(2)	0	(5)		(10)
Revaluations		0	0	0	0	0		0
Balance at 30 June 2014		**784**	**5,017**	**1,440**	**737**	**320**		**8,298**

Parent	Land (at valuation)	Buildings (at valuation)	Clinical equipment	Other equipment	Information technology	Motor vehicles	Work in progress	Total
Carrying amounts								
At 1 July 2012	1,935	33,649	2,223	555	203	577	1,149	40,291
At 30 June 2013	**2,435**	**37,360**	**2,229**	**460**	**196**	**529**	**42**	**43,251**
At 1 July 2013	2,435	37,360	2,229	460	196	529	42	43,251
At 30 June 2014	**2,435**	**36,646**	**1,830**	**344**	**148**	**438**	**28**	**41,869**

Revaluation

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

The total fair value of land and buildings was valued by CB Richard Ellis as at 30 June 2013 amounted to $39,795,520.

Land

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

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

Buildings

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

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

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

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

Restrictions

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

7b Assets Classified as Held for Sale

There are no assets held which are intended for sale at balance date.

8 INTANGIBLE ASSETS

Group	Intangible Assets $000	Work in progress $000	Total $000
Cost / valuation			
Balance at 1 July 2012	1,614	466	2,080
Additions	205	40	245
Disposals	0	0	0
Revaluations	0	0	0
Balance at 30 June 2013	**1,819**	**506**	**2,325**
Balance at 1 July 2013	1,811	506	2,317
Additions	414	51	465
Disposals	(43)	0	(43)
Revaluations	0	0	0
Balance at 30 June 2014	**2,182**	**557**	**2,739**

Group	Intangible Assets	Work in progress	Total
Depreciation & impairment losses			
Balance at 1 July 2012	698		698
Amortisation charge for the year	164		164
Impairment losses	0		0
Disposals	0		0
Revaluations	0		0
Balance at 30 June 2013	**862**		**862**
Balance at 1 July 2013	864		864
Amortisation charge for the year	196		196
Impairment losses	0		0
Disposals	(43)		(43)
Revaluations	0		0
Balance at 30 June 2014	**1,017**		**1,017**

Group	Intangible Assets	Work in progress	Total
Carrying amounts			
At 1 July 2012	916	466	1,382
At 30 June 2013	**957**	**506**	**1,462**
At 1 July 2013	947	506	1,453
At 30 June 2014	**1,165**	**557**	**1,722**

Parent	Intangible Assets $000	Work in progress $000	Total $000

Cost / valuation			
Balance at 1 July 2012	1,520	466	1,986
Additions	205	40	245
Disposals	0	0	0
Revaluations	0	0	0
Balance at 30 June 2013	**1,725**	**506**	**2,231**
Balance at 1 July 2013	1,725	506	2,231
Additions	411	51	462
Disposals	0	0	0
Revaluations	0	0	0
Balance at 30 June 2014	**2,136**	**557**	**2,693**

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

Parent	**Intangible Assets**	**Work in progress**	**Total**
Depreciation & impairment losses			
Balance at 1 July 2012	621		621
Amortisation charge for the year	164		164
Impairment losses	0		0
Disposals	0		0
Revaluations	0		0
Balance at 30 June 2013	**785**		**785**
Balance at 1 July 2013	785		785
Amortisation charge for the year	195		195
Impairment losses	0		0
Disposals	0		0
Revaluations	0		0
Balance at 30 June 2014	**980**		**980**

Parent	Intangible Assets	Work in progress	Total
Carrying amounts			
At 1 July 2012	899	466	1,365
At 30 June 2013	**940**	**506**	**1,446**
At 1 July 2013	940	506	1,446
At 30 June 2014	**1,156**	**557**	**1,713**

Impairment

No impairment losses have been recognised during the period.

9 INVESTMENT

Investment in Subsidiary

Biomedical Services New Zealand Limited is 100% owned by WDHB (2013 – 100%). The principal activity of the subsidiary is the testing and maintenance of biomedical equipment. The latest audited financial statements were used as the basis for consolidation. The balance date of Biomedical Services New Zealand Ltd is 30 June.

	Group Actual 2014 $000	Group Actual 2013 $000	Parent Actual 2014 $000	Parent Actual 2013 $000
Investment in subsidiary	0	0	103	103
Investment in joint venture	2,502	2,665	2,502	2,665
Trust funds invested	258	259	258	259
Total investments	**2,760**	**2,924**	**2,863**	**3,027**

Investment in Joint Venture

The investment in Central Region's Technical Advisory Services Limited (CRTAS) comprises 16.67% (2013: 16.67%) shareholding in CRTAS. CRTAS is a joint venture company incorporated on 6 June 2001 and owned by the six DHBs within the central region. CRTAS has a total share capital of $600 of which Wairarapa DHBs share is $100. At balance date all share capital remains uncalled.

During 2013 Wairarapa DHB made a further investment in CRTAS including an advance for the acquisition of Class B Redeemable Preference Shares. The advance will convert to Redeemable Preference Shares after all terms of the issue, compliance with the applicable law and requirements of the Ministry of Health have been met.

WDHB, in conjunction with the five other district health boards in the central region (Capital & Coast DHB, Hutt DHB, MidCentral DHB, Whanganui DHB and Hawkes Bay DHB), have embarked on a collaborative effort to implement the Central Region Information Systems Programme (CRISP) phase 1. This programme will provide a single instance of a range of clinical information systems across the region. TAS has been determined as the owner of the CRISP assets and will be funded by the issuance of "B class" shares to the value equivalent to each DHB's allocated contribution. The Memorandum of Agreement between the six DHBs and TAS has not yet been formally executed by all parties however the contributions to implementation have commenced. WDHB has treated the initial contributions, totalling $2,665,000 as a Joint Venture, in line with this plan.

10 CASH & CASH EQUIVALENTS

	Group Actual 2014 $000	Group Actual 2013 $000	Parent Actual 2014 $000	Parent Actual 2013 $000
Short term deposits	313	296	0	0
Cash & cash equivalents	5	4	5	4
Bank overdraft	(812)	(1,169)	(812)	(1,169)
Total cash & cash equivalents	**(494)**	**(869)**	**(807)**	**(1,165)**

WDHB is a party to the "DHB Treasury Services Agreement" between Health Benefits Limited (HBL) and the participating DHBs. This Agreement enables HBL 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 HBL, which will incur interest at the on-call interest rate received by HBL plus an administrative margin of 0.5%.

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

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

Reconciliation of Net Deficit to Net Operating Cash Flows

	Group Actual 2014 $000	Group Actual 2013 $000	Parent Actual 2014 $000	Parent Actual 2013 $000
Net surplus/(Deficit)	(1,406)	(3,398)	(1,420)	(3,336)
Add/(less) Non-cash items:				
Depreciation & amortisation	1,781	1,777	1,700	1,699
Impairment on property valuation	0	0	0	0
Increase/(decrease) employee benefits (non-current)	(70)	(146)	(70)	(146)
Add/(less) Items classified as investment activity:				
Net loss/(gain) on sale of property, plant & equipment	5	0	5	0
Dividends received	0	0	(24)	(160)
Add/(less) movements in working capital items:				
(Increase)/decrease in receivables	(1,197)	399	(1,241)	440
(Increase) / decrease in inventories	19	4	19	0
(Decrease) in payables & accruals	1,795	(1,137)	1,917	(1,002)
Increase/(decrease) in taxation	0	0	0	0
Net cash flow from operating activities	**927**	**(2,501)**	**886**	**(2,501)**

11 INVENTORIES

	Group Actual 2014 $000	Group Actual 2013 $000	Parent Actual 2014 $000	Parent Actual 2013 $000
Central stores	197	251	197	251
Pharmaceuticals	96	94	96	94
Theatre supplies	283	250	283	250
Other supplies	168	168	168	168
Total inventories	**744**	**763**	**744**	**763**

Write-down of inventories amounted to nil for 2014 (2013 – nil). The amount of inventories recognised as an expense during the year ended 30 June 2014 was nil (2013 – nil). No inventories are pledged as security for liabilities but some inventories are subject to retention of title clauses (Romalpa clauses). The value of stocks subject to such clauses cannot be quantified due to the inherent difficulties in identifying the specific inventories affected at year-end.

12 TRADE & OTHER RECEIVABLES

	Group Actual 2014 $000	Group Actual 2013 $000	Parent Actual 2014 $000	Parent Actual 2013 $000
Trade Debtors	5,290	4,179	5,155	4,001
Provision for Doubtful Debts	(89)	(141)	(89)	(141)
Prepayments	243	209	243	209
Amount Owing by Subsidiary	0	0	8	7
Total trade & other receivables	**5,444**	**4,247**	**5,317**	**4,076**

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

13 EQUITY

Group	Crown equity	Property revaluation reserve	Retained earnings	Total
	$000	$000	$000	$000
Balance at 1 July 2012	34,247	2,155	(29,979)	6,423
Total recognised income & expenses	0	0	(3,398)	(3,398)
Prior year equity closing balance correction			(31)	(31)
Contribution (net) from the Crown	4,796	0	0	4,796
Movement in revaluation of land & buildings	0	3,403	0	3,403
Balance at 30 June 2013	**39,043**	**5,558**	**(33,408)**	**11,193**
Balance at 1 July 2013	39,043	5,558	(33,408)	11,193
Total recognised income & expenses	0	0	(1,406)	(1,406)
Prior year equity closing balance correction			0	0
Contribution (net) from the Crown	(3)	0	0	(3)
Movement in revaluation of land & buildings	0	0	0	0
Balance at 30 June 2014	**39,040**	**5,558**	**(34,814)**	**9,784**

Parent	Crown equity	Property revaluation reserve	Retained earnings	Total
	$000	$000	$000	$000
Balance at 1 July 2012	34,247	2,155	(30,380)	6,022
Total recognised income & expenses	0	0	(3,336)	(3,336)
Prior year equity closing balance correction	0	0	(31)	(31)
Contribution (net) from the Crown	4,796	0	0	4,796
Movement in revaluation of land & buildings	0	3,403	0	3,403
Balance at 30 June 2013	**39,043**	**5,558**	**(33,747)**	**10,854**
Balance at 1 July 2013	39,043	5,558	(33,747)	10,854
Total recognised income & expenses	0	0	(1,420)	(1,420)
Prior year equity closing balance correction			0	0
Contribution (net) from the Crown	(3)	0	0	(3)
Movement in revaluation of land & buildings	0	0	0	0
Balance at 30 June 2014	**39,040**	**5,558**	**(35,167)**	**9,431**

Revaluation reserve

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

14 INTEREST-BEARING LOANS & BORROWINGS

	Group Actual 2014 $000	Group Actual 2013 $000	Parent Actual 2014 $000	Parent Actual 2013 $000
Non-current liabilities				
Privately sourced loans	444	508	444	508
Crown sourced loans	19,750	21,250	19,750	21,250
Total non-current interest-bearing loans & borrowings	**20,194**	**21,758**	**20,194**	**21,758**
Current liabilities				
Privately sourced loans	64	60	64	60
Crown sourced loans	6,000	4,500	6,000	4,500
Total current interest-bearing loans & borrowings	**6,064**	**4,560**	**6,064**	**4,560**

Crown Loans

The crown loans are secured by a negative pledge. The Ministry of Health (MoH) and the DHB have agreed a debt facility of $25,750,000 of which $25,750,000 was drawn at 30 June 2014. The MoH term borrowings are secured by a negative pledge. The CHFA was disbanded on 1 July 2012 and the lending functions previously performed by the CHFA have been transferred to the National Health Board Business Unit (NHB) within the Ministry of Health.

Included in the non-current Crown sourced loans above is a tranche of the debt totalling $4,500,000 that was refinanced with the NHB on 15 April 2014.

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

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

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

- Interest-bearing debt divided by interest-bearing debt plus equity is less than 65 per cent.

- A cash flow covenant, under which the accumulated annual cash flow must be greater than zero.

The fair value of the crown loan borrowings is $25,938,000.

The Government of New Zealand does not guarantee term loans.

Private Loans

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

Wairarapa DHB has no other privately funded financing arrangements.

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

	Group Actual 2014 $000	Group Actual 2013 $000	Parent Actual 2014 $000	Parent Actual 2013 $000
Ministry of Health				
Interest rate summary	4.61%	4.35%	4.61%	4.35%
Repayable as follows:				
Less than one year	6,000	4,500	6,000	4,500
One to two years	5,000	4,500	5,000	4,500
Greater than two years	14,750	16,750	14,750	16,750
	25,750	**25,750**	**25,750**	**25,750**
Privately sourced loans				
Interest rate summary	7.00%	7.00%	7.00%	7.00%
Repayable as follows:				
Less than one year	64	60	64	60
One to two years	69	64	69	64
Greater than two years	375	444	375	444
	508	**568**	**508**	**568**

15 EMPLOYEE BENEFITS

	Group Actual 2014 $000	Group Actual 2013 $000	Parent Actual 2014 $000	Parent Actual 2013 $000
Non-current liabilities				
Liability for long service leave	223	244	223	244
Liability for retirement gratuities	258	307	258	307
Total non-current employee benefits	**481**	**551**	**481**	**551**
Current liabilities				
Liability for long service leave	410	409	410	409
Liability for retirement gratuities	124	92	122	90
Liability for sabbatical leave	25	75	25	75
Liability for continuing medical education leave	200	228	200	228
Liability for maternity grant	13	8	13	8
Liability for annual leave	3,604	3,532	3,550	3,467
Liability for sick leave	80	86	80	86
Provision for restructuring	0	0	0	0
Salary & wages accrual	1,054	1,002	1,054	973
Total current employee benefits	**5,510**	**5,432**	**5,454**	**5,336**

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 4.2% for long service leave (2013: 3.4%) and 4.4% for retirement gratuities (2013: 3.9%) and a salary increase assumption of 1% (2013: 2%) were used.

Defined Benefit Plans

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

16 TRUST FUNDS

	Group Actual 2014 $000	Group Actual 2013 $000	Parent Actual 2014 $000	Parent Actual 2013 $000
Balance at beginning of year	259	247	259	247
Funds received	19	12	19	12
Interest received	5	0	5	0
Funds spent	(25)	0	(25)	0
Balance at end of year	**258**	**259**	**258**	**259**

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 trust balances.

17 PAYABLES & ACCRUALS

	Group Actual 2014 $000	Group Actual 2013 $000	Parent Actual 2014 $000	Parent Actual 2013 $000
Trade creditors & accruals	8,956	6,840	8,867	6,719
Capital charge payable	0	466	0	466
GST & other taxes payable	932	847	932	864
Income received in advance	0	24	0	24
Amount owing to subsidiary	0	0	18	7
Total payables & accruals	**9,888**	**8,177**	**9,817**	**8,080**

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

18 FINANCIAL INSTRUMENTS

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

Credit Risk

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

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

Concentrations of credit risk from accounts receivable are limited due to the large number and variety of customers. The Ministry of Health is the largest single debtor. It is assessed to be a low risk and high-quality entity due to its nature as the government funded purchaser of health and disability support services.

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

Group	Actual 2014 $000 Gross	Actual 2014 $000 Impairment	Actual 2014 $000 Net	Actual 2013 $000 Gross	Actual 2013 $000 Impairment	Actual 2013 $000 Net
Not past due	5,029	0	5,029	3,800	0	3,800
Past due 1-30 days	(41)	5	(36)	94	0	94
Past due 31-60 days	136	(24)	112	27	(8)	19
Past due 61-90 days	0	0	0	0	(53)	-53
Past due > 91 days	202	(70)	132	251	(80)	171
Total	**5,326**	**(89)**	**5,237**	**4,172**	**(141)**	**4,031**

Parent	Actual 2014 $000 Gross	Actual 2014 $000 Impairment	Actual 2014 $000 Net	Actual 2013 $000 Gross	Actual 2013 $000 Impairment	Actual 2013 $000 Net
Not past due	4,860	0	4,860	3,631	0	3,631
Past due 1-30 days	(41)	5	(36)	94	0	94
Past due 31-60 days	134	(24)	110	25	(8)	17
Past due 61-90 days	0	0	0	0	(53)	(53)
Past due > 91 days	202	(70)	132	251	(80)	171
Total	**5,155**	**(89)**	**5,066**	**4,001**	**(141)**	**3,860**

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

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

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

	Actual 2014 $000	Actual 2013 $000
Balance at 1 July	141	70
Additional Provisions made/(Provisions	(58)	141

released)		
Receivables written off	6	(70)
Total	**89**	**141**

Liquidity Risk

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

Cash flow interest Rate Risk

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

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

Foreign Currency Risk

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

Forward foreign exchange contracts

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

Price risk

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

Fair value interest rate risk

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

Credit risk

Credit risk is the risk that a third party will default on its obligation to the DHB, causing it to incur a loss. Due to the timing of its cash inflows and outflows, surplus cash is invested with registered banks. In the normal course of business, exposure to credit risk arises from cash and term deposits with banks, debtors and other receivables, and forward foreign exchange contracts (2013 – Nil) 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 Standard and Poors's credit rating of at least A2 for short term and A- for long term investments. WDHB has experienced no defaults of interest or principal payments for term deposits and forward foreign exchange contracts.

Concentrations of credit risk for debtors and other receivables are limited due to the large number and variety of customers. The MoH is the largest debtor. 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.

The carrying amounts of financial assets and liabilities in each of the NZ IAS 39 categories are as follows:

	Actual 2014 $000	Actual 2013 $000
Fair value through surplus or deficit - Held for trading		
Forward foreign exchange contracts in a liability position	0	0
Loans and receivables:		
Cash and cash equivalents	318	300
Debtors and other receivables	5,444	4,247
Investments	2,760	2,924
Total loans and receivables	**8,522**	**7,471**
Financial liabilities measured at amortised cost:		
Creditors and other payables (excluding income in advance and GST)	9,033	7,306
Borrowings - MOH loans	25,750	25,750
Borrowings - Privately sourced loans	508	568
Total financial liabilities measured at amortised cost	**35,291**	**33,624**

Capital Management

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

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

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

Sensitivity Analysis

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

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

Wairarapa DHB credit quality information follows:

	Actual 2014 $000	Actual 2013 $000
Counterparties with credit ratings		
Cash and cash equivalents and trust fund assets:		
AA	(236)	(610)
AA-	0	0
Total Cash and cash equivalents and trust fund assets	**(236)**	**(610)**
Counterparties without credit ratings		
Debtors and other receivables:		
Existing counterparty with no defaults in the past	5,444	4,247
Existing counterparty with defaults in the past	0	0
Total debtors and other receivables	**5,444**	**4,247**

Fair Value Analysis

The fair value of the financial instruments is considered equivalent to the carrying value recorded in the statement of financial position except for the Crown sourced loans which are based on the Government bond rate plus 15 basis points based on mid-market pricing, including accrued interest.

Group	Held for trading	Designated at fair value through profit & loss	Loans and receivables	Available for sale	Other amortised cost	Carrying amount	Fair value
	2014	2014	2014	2014	2014	2014	2014
	$000	$000	$000	$000	$000	$000	$000
Investments					2,760	2,760	2,760
Trade and other receivables			5,444			5,444	5,444
Cash and cash equivalents			318			318	318
Crown sourced loans					25,750	25,750	26,474
Privately sourced loans					508	508	508
Trade and other payables					9,948	9,948	9,948

Group	Held for trading	Designated at fair value through profit & loss	Loans and receivables	Available for sale	Other amortised cost	Carrying amount	Fair value
	2013	2013	2013	2013	2013	2013	2013
	$000	$000	$000	$000	$000	$000	$000
Investments					2,924	2,924	2,924
Trade and other receivables			4,076			4,076	4,076
Cash and cash equivalents			300			300	300
Crown sourced loans					25,750	25,750	26,474
Privately sourced loans					568	568	568
Trade and other payables					8,177	8,177	8,177

Parent	Held for trading	Designated at fair value through profit & loss	Loans and receivables	Available for sale	Other amortised cost	Carrying amount	Fair value
	2014	2014	2014	2014	2014	2014	2014
	$000	$000	$000	$000	$000	$000	$000
Investments					2,863	2,863	2,863
Trade and other receivables			5,406			5,406	5,406
Cash and cash equivalents			5			5	5
Crown sourced loans					25,750	25,750	26,474
Finance lease liabilities					508	508	508
Trade and other payables					9,817	9,817	9,817

Parent	Held for trading	Designated at fair value through profit & loss	Loans and receivables	Available for sale	Other amortised cost	Carrying amount	Fair value
	2013	2013	2013	2013	2013	2013	2013
	$000	$000	$000	$000	$000	$000	$000
Investments					3,027	3,027	3,027
Trade and other receivables			4,076			4,076	4,076
Cash and cash equivalents			4			4	4
Crown sourced loans					25,750	25,750	26,474
Finance lease liabilities					568	568	568
Trade and other payables					8,080	8,080	8,080

19 RELATED PARTIES

All related party transactions have been entered into on an arms' length basis.

WDHB is a wholly-owned entity of the Crown.

Significant transactions with government-related entities

WDHB has received funding from the Crown and ACC of $129.3 million (2013 $124.5 million) to provide health services for the year ended 30 June 2014.

Inter District Flows

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

	2014 $000	2013 $000
Revenue	3,558	3,357
Expenditure	27,262	25,799
Receivable at 30 June	767	100
Payable at 30 June	1,714	120

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

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

WDHB also purchases goods and services from entities controlled, significantly influenced, or jointly controlled by the Crown. Purchases from these government-related entities for the year ended 30 June 2014 totalled $726,000 (2013: $665,000). These purchases included the purchase of energy from Meridian Power New Zealand Ltd, Solid Energy New Zealand Ltd and Genesis Power New Zealand Ltd as well as postal services from New Zealand Post.

Transactions with related parties

Wairarapa DHB has a 100% shareholding in Biomedical Services New Zealand Limited. Biomedical Services New Zealand Limited has a balance date of 30 June and was incorporated in New Zealand. The directors of Biomedical Services New Zealand Limited are Rick Long (Wairarapa DHB Board member) and Bob Francis. The total value of transactions between Wairarapa DHB and Biomedical Services New Zealand Limited was $179,000 (2013: $209,000). The amount outstanding at balance date is $8,000 (Accounts Receivable) $18,000 (Accounts Payable) (2013: $17,000).

Wairarapa DHB has a 16.7% shareholding in Central Region Technical Advisory Services Limited (2013 – 16.7%) and participates in its commercial and financial policy decisions. The total value of transactions

between Wairarapa DHB and Central Region Technical Advisory Services Limited was $779,988 (2013: $2,451,734). The amount outstanding at balance date is $164,000 (2013: Nil).

Remuneration of key management personnel

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

The remuneration paid to the key management personnel is:

Group Actual 2014 $000	Group Actual 2013 $000	Parent Actual 2014 $000	Parent Actual 2013 $000
1,414	2,133	1,232	1,927

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

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

There were no loans to board members or executive officers for the year ended 30 June 2014 (2013 – nil).

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

20 SUBSEQUENT EVENTS

There are no significant events subsequent to balance date.

21 ACCOUNTING ESTIMATES & JUDGEMENTS

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

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

Investment property

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

Finance and operating leases

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

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

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

- Physical inspection of the assets
- Asset replacement programs

In the year to 30 June 2014, the WDHB has not made changes to past assumptions concerning useful lives and residual values of assets.

22 EXPLANATION OF FINANCIAL VARIANCES FROM BUDGET

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

Revenue

- Additional revenue has been recognised during the year over the budgeted amount primarily relating to additional funding for initiatives funded by the Ministry of Health. These initiatives attract additional expenditure.

Expenditure

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

Assets

- The balance of Property, Plant and equipment is higher than planned. This reflects the Property value increase that resulted from the Property revaluation as at 30 June 2013.

Liabilities

- Trade creditors are lower than planned primarily due to delays in the expected timing of expenditures in relation to the CRISP and FPSC programmes.

Equity

- The higher than planned closing equity position relates to the increase in the revaluation reserve resulting from the Property revaluation as at 30 June 2013.

STATEMENT OF RESPONSIBILITY

The Board and management of Wairarapa District Health Board accept responsibility for the preparation of the financial statements and the statement of service performance and judgements used in them.

The Board and management of Wairarapa District Health Board accept responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting.

In the opinion of the Board and management of Wairarapa District Health Board the financial statements and the statement of service performance for the year ended 30 June 2014 fairly reflect the financial position and operations of Wairarapa District Health Board.

Derek Milne
Board Chair

Leanne Southey
Board Member
Chair, Financial Risk and Audit Committee

Independent Auditor's Report

To the readers of Wairarapa District Health Board and group's financial statements and performance information for the year ended 30 June 2014

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

We have audited:

- the financial statements of the Health Board and group on pages 57 to 107, that comprise the statement of financial position as at 30 June 2014, the statement of comprehensive income, 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 Health Board and group that comprises the statement of service performance on pages 42 to 55 and the report about outcomes on pages 32 to 41.

Unmodified opinion on the financial statements

In our opinion the financial statements of the Health Board and group on pages 57 to 107:

- comply with generally accepted accounting practice in New Zealand; and
- fairly reflect the Health Board and group's:
  - financial position as at 30 June 2014; and
  - financial performance and cash flows for the year ended on that date.

Qualified opinion on the performance information

Reasons for our qualified opinion

Performance information from third party health providers

Some significant performance measures of the Health Board and group, (including some of the national health targets), rely on information from third-party health providers, such as primary health organisations. The Health Board and group's control over much of this information is limited, and there are no practical audit procedures to determine the effect of this limited control. For example, the primary care measure that includes advising smokers to quit relies on information from general practitioners that we are unable to independently test.

Performance information about smokers seen in hospital are offered advice and support to quit

Our audit of the reported performance for the national health target "smokers seen in hospital are offered advice and support to quit" identified errors which indicate that the reported results are likely to be materially overstated. We are unable to quantify the extent of any overstatement.

Comparative information

Our audit opinion on the performance information of the Health Board and group for the year ended 30 June 2013, which is reported as comparative information, was qualified for the same reasons.

Qualified opinion

In our opinion, except for the effect of the matters described in the "Reasons for our qualified opinion" above, the performance information of the Health Board and group on pages 42 to 55 and 32 to 41:

- complies with generally accepted accounting practice in New Zealand; and
- fairly reflects the Health Board and group's service performance and outcomes for the year ended 30 June 2014, including for each class of outputs:
    - its service performance compared with forecasts in the statement of forecast service performance at the start of the financial year; and
    - its actual revenue and output expenses compared with the forecasts in the statement of forecast service performance at the start of the financial year.

Our audit was completed on 31 October 2014. This is the date at which our opinion is expressed.

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

Basis of opinion

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

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

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

Board and group's financial statements and performance information that fairly reflect the matters to which they relate. We consider internal control 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 Health Board and group's internal control.

Our audit of the financial statements involved evaluating:

- the appropriateness of accounting policies used and whether they have been consistently applied;
- the reasonableness of the significant accounting estimates and judgements made by the Board; and
- the adequacy of disclosures in, and overall presentation of, the financial statements.

Our audit of the performance information involved evaluating:

- the appropriateness of the reported service performance within the Health Board and group's framework for reporting performance; and
- the adequacy of disclosures in, and overall presentation of, the performance information.

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

We have obtained all the information and explanations we have required about the financial statements. However, as referred to in our qualified opinion, we did not obtain all the information and explanations we required about the performance information of the Health Board and group. We believe we have obtained sufficient and appropriate audit evidence to provide a basis for our audit opinions.

Responsibilities of the Board

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

- comply with generally accepted accounting practice in New Zealand;
- fairly reflect the Health Board and group's financial position, financial performance and cash flows; and
- fairly reflect the Health Board and group's service performance achievements and outcomes.

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

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

Responsibilities of the Auditor

We are responsible for expressing an independent opinion on the financial statements and performance information and reporting that opinion to you based on our audit. Our responsibility arises from section 15 of the Public Audit Act 2001 and the Crown Entities Act 2004.

Independence

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

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

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

DIRECTORY

Board Office	Wairarapa DHB P O Box 96 Masterton, 5840 06 946 9880 www.wairarapa.dhb.org.nz	
Board Members	**Derek Milne (Chair from Dec 2013)**	**Ron Mark (from Dec 2013)**
	Leanne Southey (Deputy Chair)	**Fiona Samuel**
	Liz Falkner	**Alan Shirley (from Dec 2013)**
	Rob Irwin	**Janine Vollebregt**
	Ronald Karaitiana	**Bob Francis (Chair until Dec 2013)**
	Helen Kjestrup	**Charles Grant (until Dec 2013)**
	Rick Long	**Viv Napier (until Dec 2013)**

Executive Leadership Team for Wairarapa and Hutt Valley DHBs			
Graham Dyer	Chief Executive Officer	**Cate Tyrer**	General Manager, Quality & Risk
Pete Chandler	Chief Operating Officer	**Judith Parkinson**	Finance Manager
Helen Pocknall	Executive Director of Nursing & Midwifery	**Jill Stringer**	Communications Manager
Iwona Stolarek	Chief Medical Officer	**Kuini Puketapu**	Manager, Hutt Valley Māori Health Development Unit
Russell Simpson	Executive Director, Allied Health, Scientific & Technical	**Tofa Suafole Gush**	Director of Pacific People's Health
Carolyn Cooper	Executive Director, People & Culture 3DHB	**Ashley Bloomfield**	Director, Service Integration & Development Unit 3DHB (SIDU)
Bridget Allen (Hutt Valley)	Chief Executive, Te Awakairangi Health Network (PHO)	**Glen Willoughby**	Acting Chief Information Officer 3DHB
Justine Thorpe	Programme Director, TeHei Wairarapa	**John Ryan**	3DHB Corporate Services Manager

Community & Public Health Advisory Committee			
The Community & Public Health Advisory Committee advises the board on the health needs and status of our population. This is a joint committee with Wairarapa and Capital & Coast District Health Boards.			
Derek Milne (Chair)	Wairarapa	**Wayne Guppy**	Hutt Valley
Dr Virginia Hope (Deputy)	Capital & Coast	**David Choat**	Capital & Coast
Helen Kjestrup	Wairarapa	**Chris Laidlaw**	Capital & Coast
Janine Vollebregt	Wairarapa	**Helene Ritchie**	Capital & Coast
Leanne Southey	Wairarapa	**Keith Hindle (until Dec 2013)**	Hutt Valley
Liz Falkner	Wairarapa	**Iris Pahau (Until Dec 2013)**	Hutt Valley

Peter Douglas	Hutt Valley	**Bob Francis (Until Dec 2013)**	Wairarapa
Ron Mark	Wairarapa / Hutt Valley	**Ken Laban (Until Dec 2013)**	Hutt Valley
Sandra Greig	Hutt Valley		

Hospital Advisory Committee

The Hospital Advisory Committee (HAC) monitors the financial and operational performance of Hutt Hospital and its services. This was a joint committee with Wairarapa District Health Board until January 2014, when it became a 3DHB committee.

Dr Virginia Hope (Chair)	Hutt Valley / Capital & Coast	**Katy Austin**	Hutt Valley
Derek Milne (Deputy)	Wairarapa	**John Terris**	Hutt Valley
Alan Shirley	Wairarapa	**Sue Kedgley**	Capital & Coast
Fiona Samuel	Wairarapa	**Nick Leggett**	Capital & Coast
Rob Irwin	Wairarapa		