Wairarapa District Health Board

Annual Report 2015

CONTENTS

VISION, MISSION & VALUES

The following vision, mission and values govern the planning and activity of Wairarapa District Health Board (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 one's actions.

Cooperation – Whakawhānaungatanga

Working collaboratively with other individuals and organisations.

Excellence – Taumatatanga

Striving for the highest standards in all that we do.

CHAIR & CHIEF EXECUTIVE'S FOREWORD

2014-15 has been a year of challenges and developments for the Wairarapa DHB. A shared management structure between Wairarapa and Hutt Valley DHBs created opportunities for sharing information and expertise. We also implemented many new initiatives within our 3DHB regional framework to improve patient services and broaden our scope of activity.

When the Chief Executive of Hutt Valley and Wairarapa DHBs left the position in April 2015, the Board decided to return to a single chief executive for each DHB. The position was widely advertised and a new chief executive starts in October.

Our commitment to taking an integrated approach to providing health care services to the people of the Wairarapa has seen us continue to work with a range of local and regional partner organisations towards developing seamless pathways of care.

Despite our relatively small size, we have continued to maintain our place alongside larger DHBs in our national health targets and patient satisfaction survey ratings.

We ended the year behind our forecast financial position but with a programme of work in place that is targeted at achieving a break-even position during the 2016-17 year.

3DHBs working together

Our focus on providing the right care in the right place has resulted in the introduction of new regional services delivered locally. Wairarapa, Hutt and Capital & Coast DHBs have worked closely together to improve services for both patients and staff.

An integrated 3DHB Mental Health, Addictions and Intellectual Disability Service was launched in early 2015. The new shared approach means Wairarapa psychologists now have access to Capital & Coast's library of psychometric tests. Dealing with one service instead of three will be of particular benefit for clients who live across DHBs, such as those who work in the Hutt but live in the Wairarapa.

February 2015 saw the introduction of a shared radiology service with Hutt Valley DHB, with both sites sharing radiologists, digital reporting systems and work stations. A specialist radiologist from the Hutt team is now on-site four days a week in the Wairarapa working alongside our Imaging team. The new service replaces the previously outsourced radiology service offered by a private provider and is designed to help manage ongoing increases in demand and cost for radiology services.

A new agreement with Capital & Coast DHB and Wellington Free Ambulance now provides improved cardiac care for Wairarapa patients. Local patients who suffer a significantly acute heart attack are treated by specially trained Wairarapa-based intensive-care paramedics and then flown directly to Wellington Hospital's specialist cardiac unit if necessary. The new service means local patients have the same access to specialised cardiac care as someone in Wellington.

The co-operative approach we share with our regional DHB partners was reflected when Hutt Central Sterile Supplies Department (CSSD) colleagues stepped in to support Wairarapa staff when new large surgical instrument washer-disinfectors were installed. They helped keep services functioning when issues occurred, options were analysed, and when the plan to install the new machines was implemented. The opportunity for cooperation between Wairarapa and the Hutt CSSD was realised and now illustrates a partnership between the two units.

The move to integrate services across the greater Wellington region was reflected in the decision to establish a regional integrated laboratory service. Southern Cross Laboratories has secured the contract for the new service which will see no change in the number or location of laboratory services in the region, whilst delivering better integrated services in a more cost effective and efficient way. Once introduced, health professionals across the region, including GPs and specialists, will be able to access lab results from the one system. The transition to the new service is scheduled for completion in November 2015, and will include upgrading equipment at the Wairarapa laboratory site located within the main hospital building.

A shared computer environment is the key to enabling staff to work together across the three DHBs. Hutt Valley and Capital & Coast have already implemented a Common Operating Environment (COE). Work towards integrating Wairarapa progressed through the year and implementation began in August 2015. The COE means the 3DHBs are using the same IT platforms and programmes, and our applications are aligned and up-to-date. Staff across the region are now able to access the same information regardless of where they are and what device they are using.

Integrated pathways between hospital and community

The 3DHB approach means that patients have increasingly seamless pathways between services delivered locally and more specialised treatment provided at other centres. The co-operative framework removes many of the artificial boundaries that hamper effective healthcare delivery and create stress and frustrations for patients and clinical staff alike.

The increased pace of integration can be seen not just with our neighbouring DHBs but also with local health providers. We work in partnership with medical practices, Compass Health, community health providers, support groups, aged residential care services, and NGOs to deliver high quality care. Tihei Wairarapa brings representatives from these sectors together to provide governance for initiatives to develop primary and secondary integration of health care. Key focus areas over past year have been on integrated maternity, child and youth services, respiratory and skin conditions, youth-friendly health services, and continuing care for the frail elderly.

A number of clinical pathways which guide staff through the diagnosis and treatment of various diseases have been developed and more are in progress. The ‘Health Pathways’ programme has seen best practice advice and treatment processes made available electronically so they can be easily accessed by medical staff no matter where they are located. In this way, everyone involved in the care of an individual has access to, and can update, these health and treatment records.

The integrated approach has also seen a heightened focus on providing care for people within their home or GP setting. This avoids the need, where appropriate, for unnecessary hospital visits and increases the likelihood that care is provided in best place first time. This approach includes looking at what traditional

outpatient services such as physiotherapy, phlebotomy and diabetes support could be incorporated into GP practices.

The approach also involves establishing a more integrated approach between community medical centres and acute services to help manage acute demand. During an upcoming pilot, patients coming to our Emergency Department (ED) with minor illnesses and injuries will be offered a referral to Masterton Medical Centre, located on the main hospital site. An appointment will be made for these patients and assistance provided for those who need transport to get to the centre. The pilot will be supported by communications aimed at encouraging people to see their GP or contact Healthline before turning up at ED. The aim of this collaborative approach is to improve patient care by directing specific patients to their GP where more timely care is available.

Our efforts to ensure people receive information and support to make positive choices about their health and wellbeing are evident in a number of campaigns run during the year targeting particular health areas. This included a maternity campaign to highlight the importance of monitoring baby movements, work with other health providers during the April Falls Awareness month, and our involvement in breastfeeding promotions including the Big Latch and Nurturing Baby events.

New initiatives making a difference

Among the highlights of the 2014-15 year, were a number of new initiatives that were launched within the DHB setting.

The appointment of three new staff in our Imaging Department has resulted in less waiting and fewer trips to other hospitals for local patients. The additional resources within the department have seen average waiting times for scans and non-urgent ultrasound reduce from four to five months to eight weeks. The change has been of particular benefit for pregnant Wairarapa women who previously have had to travel to Hutt Hospital for their 20week scans for the past five years.

Recent unanticipated population growth in the Wairarapa has resulted in increased demand for hospital services. The nursing team at Wairarapa Hospital was boosted with the approval for almost 10 new FTE (full time equivalent) roles to help address increased workload and target additional resources where they are required in response to this growth. The roles covered registered nursing, health care assistants, nurse educators and an additional weekend nursing co-ordinator.

After 14 years without a local neurology clinic, Wairarapa Hospital has a new service meaning that some people with neurological conditions may no longer need to travel to Wellington Hospital for the support they need. A consultant neurologist and registrar from Wellington Hospital now visit each month to diagnose, assess and support people with complex long term conditions such as Parkinsons, Motor Neurone Disease and Multiple Sclerosis. The new service means there are now 21 specialist services provided at Wairarapa Hospital.

A new Newborn Enrolment process was introduced in October. With the new process, a single multi-enrolment form replaces the need to complete seven separate forms for access to newborn health services. The new approach makes it quicker and simpler for new parents to gain access to core health services and increases the likelihood of enrolment.

Wairarapa patients with eye conditions benefited from the donation by two anonymous local benefactors of a new 3D optical coherence tomography (OCT) machine. The eye scanner, which helps diagnose and treat eye diseases, reduces the need for patients to travel to Wellington for scans. The new equipment will become increasingly useful in the future as our population gets older and the number of patients requiring eye treatment increases.

Our health services have benefited from other donations during the year. These have ranged from a donation from Wairarapa Rotary to purchase pepi-pods – a type of Moses basket designed to allow new babies to sleep safely beside their parents in bed – to knitted items to keep new babies warm when they leave hospital. The Wairarapa Community Health Trust donated new theatre equipment, new beds and paediatric equipment. These donations reflect the particularly close ties a smaller, rural DHB has with its community.

Our work with the Wairarapa's Pasifika community will culminate shortly in the launch of a Pacific Health Plan, due for release in late July 2015. Wairarapa is home to around 1100 Pacific people who are among the demographic groups in our region that have higher than average demands for healthcare.

During the year a number of specialised roles were introduced to the DHB, including a Colonoscopy Pre-assessment Nurse and a new clinical nurse specialist for diabetes who was appointed to assist in supporting the five per cent of people with diabetes within the region who have complex needs.

In early 2015, a new director of Māori Health was appointed for the DHB. This role replaced a 3DHB Māori Health Director position and reflected the Board's recognition that relationship with and for Māori of the Wairarapa is best based within our region, not as part of a wider regional approach. The role is the key interface with Te Iwi Kainga, the Māori Relationship Governance Board, which has representatives of Rangitane o Wairarapa and Kahungunu ki Wairarapa. Te Iwi Kainga provides input and advice on developing health strategies that work for Māori whānau, increase health service responsiveness to Māori, and reduce inequalities.

A new workshop and storage and cleaning area for Facilities, Maintenance and Occupational Therapy teams was opened in August 2014. The new base for equipment, offices and workshops was constructed with support from the Wairarapa Community Health Trust. The purpose-built facility provides a more effective work flow for dirty to clean equipment and an easily accessible location for patients to collect and return therapy equipment.

Reaching our health targets

The DHB has again achieved nationwide standards in reaching quarterly health targets set by the Ministry of Health. We consistently outperformed many of the larger DHBs and have met or exceeded most of our targets.

We exceeded both the national target of 95% for achieving shorter stays in the Hospital's Emergency Department in each quarter this year, and the target of 100% for improved access to elective surgery. There were 1,966 elective surgery procedures completed at Wairarapa Hospital during the year, 125 ahead of plan. Wairarapa Hospital surgeons did 137 hip and knee operations compared with 128 last year.

In Ophthalmology (including cataracts) where 270 procedures were completed compared with 231 last year, an increase of 39 discharges.

Immunisation rates remain high. In the last quarter, 115 out of the 124 local eight-month-olds were fully immunised. This is a great achievement and a credit to all of our staff and partners in the community. Work continues towards achieving the 'Better help for smokers to quit' target with staff in hospital departments and medical centres aware of the need to regularly encourage and assist smokers to quit.

Our work towards a new target for faster cancer treatment has been aided by a new online tracking system to help clinical staff identify and monitor where patients are on their cancer diagnosis and treatment pathway.

We are pleased with our results in the national patient satisfaction survey, with the DHB scoring in-line with the national average in many areas, and particularly highly in terms of patient confidence and trust in the doctor treating them.

Developing our people

Our commitment to continuous improvement includes providing opportunities for our people to engage in professional development to support their ability to perform to highest levels.

New roles were introduced to our nurse educator teams with the appointment of two clinically based nurse educators to assist staff in a clinical setting, a new dementia nurse educator, and the introduction of a Charge Nurse Manager for the Professional Development Unit.

A new online learning system became operational during the year. Ko Awatea LEARN allows staff to do training at a time and place that suits them best. Training modules are continuously added to the system and the system has had good uptake amongst staff.

A number of staff from across the DHB have enrolled in Te Tohu Whakawaiora, Certificate in Healthcare Capability: Raising Capability to Accelerate Māori Health Gain. The new level 3 NZQA accredited programme aims to help build a culturally responsive workforce and lift our level of competency in improving Māori health outcomes.

Professional development is not the sole domain of clinical staff. Our orderly team all completed the Certificate of Approval security training, which is part of a new NZQA qualification. As well as meeting the compliance standards for people working in a front-line security role, the training means the team is now better equipped to handle the range of situations they encounter every day.

In addition to formal programmes, ongoing professional development is a positive by-product of our 2DHB and 3DHB initiatives, providing opportunities for staff to engage with other health professionals and be involved in a wider programme of work than would normally be available in a DHB of our size. Having a broader range of services delivered locally creates a more interesting and stimulating working environment, provides opportunities to grow skills, and assists in attracting and retaining high quality staff to the DHB.

A change of leadership direction

In April 2015, the Chief Executive of Wairarapa and Hutt Valley DHBs Graham Dyer resigned. This decision caused the boards of both DHBs to consider the type of leadership the organisations needed going forward. These deliberations resulted in a decision to appoint separate chief executives for each DHB to help address the unique health challenges and requirements for each region.

This decision recognised the different pressures and demands in each DHB. The Wairarapa has a mostly rural population spread over a large geographical area, with a growing trend of older people. In contrast, the Hutt Valley's most urban population has not grown as quickly, with a rising number of younger people.

Despite the move to separate leadership and increased focus on local decision making, both DHBs remain committed to building on the collaborative gains of the last three years.

Interim leadership was provided initially by Dr Ian McPherson, and more recently by Craig Climo. Shortly after the end of this financial year, the Board appointed Adri Isbister to the role of Wairarapa DHB Chief Executive. The appointment will allow the organisation to refocus its efforts on the major challenges and opportunities facing the DHB.

Financial situation

The DHB ended the year with a deficit of $3.3m, against a forecast of $1.5m. This result reflected the challenges of the current operating environment, with increasing demands on the health dollar needing to be managed within a constrained funding setting.

A contributing factor to the year-end outcome is significant amount spent on 'inter-district flows' – the cost of Wairarapa patients receiving treatment at other centres.

While the overall financial result was disappointing, it needs to be considered within a wider context. The 2013 population census identified a turnaround in expected population numbers for the Wairarapa, with the region growing in size rather than decreasing as anticipated. The increased size will result in the DHB receiving additional population-based health funding, which is due to come onstream in the next financial year. Had the Board's request for this funding to be allocated in this financial year, the year-end outcome would have been more favourable.

Addressing the current financial situation will be a key focus for the Board over the coming year.

Recognising our team

The achievements of the 2014-15 year and the ability to take on the challenges of the year ahead would not be possible without a dedicated team of health professionals working within the organisation and the contribution of our regional, community and iwi partners.

The health sector attracts people committed to working to high professional standards and with a desire to make a difference to the people living within the communities they serve. This includes clinicians and support staff working within hospital and community settings, our partner organisations across the 3DHB and lower North Island regional network, and the other local health providers and community agencies we work alongside.

The calibre of our staff was aptly reflected at the inaugural 3DHB Quality Awards in December 2014, with a number of individuals and teams being nominated for awards and being amongst the winners on the night.

We would like to acknowledge the role and contribution of everyone involved in the delivery of health care and wellbeing services in the Wairarapa. Within the DHB, we would like to thank teams throughout the organisation at every level, the senior leadership team including former chief executive Graham Dyer and those that have managed the chief executive role on an interim basis, and the members of the DHB Board.

Dr Derek Milne
Board Chair

Adri Isbister
Chief Executive Officer

STRATEGIC DIRECTION

Moving forward, the Wairarapa DHB has three major areas of strategic focus and challenge.

Supporting our new leadership approach

The move to appoint a single chief executive signals the need for new management structure in line with this change in leadership approach. The new structure will reflect the need for increased focus on local demands and issues while continuing to be part of the wider regional context and 3DHB framework.

The objective of this approach is to increase dedicated time in operational areas while maintaining those aspects of the 2DHB and 3DHB structures that have benefited the Wairarapa in being part of a much larger grouping. It will also address some of the issues experienced by the current combined 2DHB management team in reporting to two separate legal entities with separate statutory responsibilities.

The move to the new structure does not mean the DHB will set about creating an isolated health empire. The need to look and think outwardly and be part of larger co-operative grouping will be imperative in ensuring our future viability and delivering on our vision of achieving the best possible health outcomes for the people in our region.

Ensuring financial viability

Achieving financial viability will require a dedicated focus on securing significant savings and efficiencies in our quest to reach our target of breaking even in the 2016-17 year. This will require the DHB to look closely at everything we do and ask ourselves the question of whether there are other, better ways of doing this that could provide efficiencies and deliver savings.

The focus for our savings programme is not on reducing services but on reviewing all other aspects of our operations. Securing savings involves ensuring we are not wasting money where this isn't contributing to our vision of better health for all. Savings are currently targeted at management and administrative functions and include areas such as building leases, fleet costs, outsourced services, and procurement processes.

We will also be looking closely at our inter-district flows to ensure services to our patients are being delivered in the best place and way possible. This involves looking at where it most makes sense to provide the service taking into account patient safety and needs, clinical appropriateness, equity of access, and financial viability. Central to this is reviewing the cost of services provided to our patients in other centres and whether it would be more cost effective as well as clinically viable and more patient friendly to deliver some of them locally.

The Board has targeted a $1.95m deficit for the 2015-16 year. This will be followed by a forecast $1m deficit for 2016-17 ahead of achieving a break even position for the 2017-18 year.

Providing sustainable services

With the best intentions for the people of our region, it isn't possible to provide every service from a DHB of our size. We need to be pragmatic about how we can best balance the needs of the population in our area within the resources we have and the access we can leverage through our 3DHB and lower North Island DHB partners.

An important aspect of this is looking ahead at the future needs of our population and taking into account changing demographics such as the increasing proportion of older people in our region and the requirements of groups that have particularly intensive health care needs.

Providing sustainable services isn't solely based on financial factors. Research and anecdotal evidence suggests that services are best delivered as close to home as possible, reducing the need for patients and their family members to travel and providing care in the setting where people are best placed to recover. Our quest will be to deliver as many services as possible from a local base, whether this is from standalone services or local services provided as part of a wider regional initiative.

This approach also addresses perceived and actual vulnerabilities in providing specialist services that are not viable for a DHB of our size. Sustainability comes from ensuring co-ordinated and equitable access to specialist care, even when this is delivered outside of our region. It also involves considering what management and administrative services are best housed locally or provided as part of the 2DHB, 3DHB or wider regional structure.

Being part of a wider grouping provides not only greater access to the care our patients need, whether in a local setting or after travelling to another centre. The 3DHB initiatives that have been introduced in recent years have provided development opportunities for our staff and contributed to creating a work environment which is professionally enriching and encourages them to perform to highest possible standards. Fostering a rewarding and motivating environment that helps to attract and retain high calibre staff is a contributing factor in establishing sustainable services.

Sustainability will also come from our continuing work with community, primary health and iwi partners to ensure we are collectively working in the best way to achieve the greatest health and wellbeing outcomes for the people of the Wairarapa. This includes ensuring healthcare in the community and primary settings increasingly reduces the number of people needing to be admitted to hospital for more complex treatment wherever this can be avoided.

Our work towards sustainable services, financial viability and administrative efficiency will be a driving focus for teams throughout the DHB in the year ahead.

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

Over the past few years the three DHBS have taken a 'whole-of-health system' approach, including integrating clinical and support services where this provides benefits across the system.

Each Board continues to provide governance of local services and all three Boards provide collective governance over services that are shared or integrated, ensuring local accountability.

Integrated service approaches are intended to deliver:

- preventative health and empowered self-care
- provision of relevant services close to home
- quality hospital care, including highly complex care for those who need it.

This requires a strong focus on relationships with primary and community care and working closely with staff and communities as we progress service design. The Boards believe this gives us the best opportunity to address the challenges of balancing quality, cost and access.

Board membership

The elected and appointed Board members have diverse skills and experience in order to bring a wide range of thought to bear on policy issues. All members are required to act in the best interests of the DHB. Members are encouraged to contribute to Board decision-making processes, acknowledging that the Board must stand unified behind its decisions once made; individual members have no separate governing role outside the boardroom. The Board acknowledges its responsibility to maintain communication with stakeholders and in particular remain cognisant of the Minister's expectations.

The members of the Board at 30 June 2015 are as follows. Board members commenced their term on 6 December 2010 except as noted.

- Derek Milne (Chair) – commenced December 2013
- Leanne Southey (Deputy Chair)
- Liz Falkner
- Rob Irwin
- Ronald Karaitiana – commenced December 2013
- Helen Kjestrup
- Rick Long
- Alan Shirley – commenced December 2013
- Fiona Samuel
- Ron Mark – commenced December 2013; resigned August 2014.

Disclosure of interest

The Board maintains an interests' register. Board members are aware of their obligations to declare any potential conflicts of interests to ensure transparency in the decision making process.

Name	Interest
Dr Derek Milne Chair	• Chair, Wairarapa District Health Board • Chair, Wairarapa, Hutt Valley and CCDHB Community Public Health Advisory Committees & Disability Support Advisory Committees • Deputy Chair, Capital & Coast District Health Board • Deputy Chair, Wairarapa, Hutt Valley and CCDHB Hospital Advisory Committees • Member, Hutt Valley and CCDHB Finance Risk & Audit Committees • Member, Wairarapa District Health Board, Finance Risk & Audit Committee • Brother-in-law is on the Board of Healthcare Ltd • Daughter is a GP at Masterton Medical Centre
Mrs 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 Committees & Disability Support Advisory Committees • 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
Ms Liz Falkner Member	• Member, Wairarapa District Health Board • Member, Wairarapa, Hutt Valley and CCDHB Community Public Health Advisory Committees & 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
Dr Rob Irwin Member	• Member, Wairarapa District Health Board • Member, Wairarapa, Hutt Valley and CCDHB Hospital Advisory Committees • Member, Wairarapa District Health Board Finance Risk & Audit Committee • Trustee Wairarapa Community Health Trust • Member, South Masterton Rotary
Ms Helen Kjestrup Member	• Member, Wairarapa District Health Board • Member, Wairarapa, Hutt Valley and CCDHB Community Public Health Advisory Committees & 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
Mr Rick Long Member	• Member, Wairarapa District Health Board • Member, Wairarapa District Health Board Finance Risk & Audit Committee • Chairman of Wairarapa Community Transport Services Inc

	• Chairman of Tolley Educational Trust • Trustee for Sport and Vintage Aviation Society • Biomedical Services New Zealand Limited • Member of Masterton Lands Trust
Mr Alan Shirley Member	• Member, Wairarapa District Health Board • Member, Wairarapa, Hutt Valley and CCDHB Hospital Advisory Committees • Surgeon at Wairarapa Hospital • Technical Expert Advisor Ministry of Health • Wairarapa Community Health Board Member • Technical Expert Advisor
Ms Fiona Samuel Member	• Member, Wairarapa District Health Board • Member, Wairarapa, Hutt Valley and CCDHB Hospital Advisory Committees • Casual Nurse, at Wairarapa Hospital • Duty Nurse Manager, at Wairarapa Hospital • Contractor Auditor for TAS • Member of Clinical Board Wairarapa District Health Board
Ms Janine Vollebregt *Member*	• 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 Committees & Disability Support Advisory Committees
Mr Ronald Karaitiana *Member*	• Member, Wairarapa District Health Board • Member, Wairarapa Te Iwi Kainga Committee • Member, Wairarapa District Health Board 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

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 through the TAS regional internal audit programme to maintain an internal audit function which is responsible for monitoring its systems of internal control and the quality and reliability of financial and non-financial information reported to the Board. Internal Audit reports its findings directly to the Audit and Risk Committee established by the Board.

Risk management

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

Legislative compliance

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

DISCLOSURE OF ULTRA VIRES TRANSACTIONS

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

PERMISSION TO ACT DESPITE BEING INTERESTED IN A MATTER

A member who is interested in a matter relating to a DHB must not vote or take part in any discussion or decision of the Board or any committee relating to that matter under section 66 of the Crown Entities Act 2004. However, under section 68 of the Crown Entities Act 2004, the Chair of the DHB may exempt one or more Board members from this requirement if it is in the public interest to do so. Where such an exemption is given, this must be disclosed in the annual report. No permissions were provided under section 68 during the 2014-15 year.

BOARD MEMBERS' MEETING ATTENDANCE

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

The references to the committees listed in the table are as follows:
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 attended (10)	FRAC attended (7)	3DHB DSAC/ CPHAC attended (6)	HAC attended (7)
Derek Milne	9	6	6	7
Leanne Southey	10	6	3	n/a
Liz Falkner	2	n/a	2	n/a
Rob Irwin	9	5	n/a	5
Ron Karaitiana	10	6	n/a	n/a
Helen Kjestrup	7	n/a	6	n/a
Rick Long	10	5	n/a	n/a
Fiona Samuel	7	n/a	n/a	6
Alan Shirley	9	3	2	7
Janine Vollebregt	9	n/a	6	n/a
Ron Mark	1	n/a	1	n/a

Board members' remuneration

Board members' remuneration received or receivable for the year ended 30 June 2015 are shown in the table below. In addition, Board members are able to claim reimbursement for out of pocket expenses.

BOARD & COMMITTEE FEES

	2015 Board Fee	2015 Committees Fees	2015 Total Fees	2014 Total Fees
Derek Milne (Chairman)	33,600	3,443	37,043	19,858
Leanne Southey (Deputy Chair)	20,400	3,238	23,638	24,475
Rob Irwin	16,320	3,000	19,320	19,070
Rick Long	16,320	1,750	18,070	18,820
Janine Vollebregt	16,320	1,750	18,070	18,620
Helen Kjestrup	16,320	1,750	18,070	17,870
Alan Shirley	16,320	1,750	18,070	9,403
Ronald Karaitiana	16,320	1,500	17,820	17,570
Fiona Samuel	16,320	1,500	17,820	17,820
Liz Falkner	15,692	700	16,392	16,670
Ron Mark (Resigned)	2,919	0	2,919	8,963
Kim Smith	0	2,188	2,188	1,875
Mihi Namana	0	1,750	1,750	1,250
Yvette Grace	0	1,250	1,250	1,500
Mike Kawana	0	1,250	1,250	1,500
Hariata Tahana	0	1,000	1,000	1,000
Hoani Paku	0	500	500	0
Mary Kerehi	0	250	250	1,000
Bob Francis (Previous Chairman)	0	0	0	17,606
Vivien Napier	0	0	0	9,462
Charles Grant	0	0	0	7,532
TOTAL	**186,851**	**28,569**	**215,420**	**231,864**

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. Strengthened clinical leadership is achieved through the Alliance Leadership Team, the Clinical Board and involvement of clinicians in the development of collaborative service models at a sub-regional and regional level.

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

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

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

GOOD EMPLOYER OBLIGATIONS REPORT

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

leadership, accountability and culture
recruitment, selection and induction
employee development, promotion and exit
flexibility and work design
remuneration, recognition and conditions
harassment and bullying prevention
safe and healthy environment.

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

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 the recently approved Workplace Bullying, Discrimination, Harassment and Victimisation Prevention Policy. This policy has been rolled out consistently across the three sub-regional DHBs and significant training has occurred to support the implementation of the policy.

Approximately 92 per cent of employees are covered by collective employment agreements (CEA). All the CEAs have prescribed remuneration, recognition and conditions clauses. Wairarapa DHB has a dedicated approach to employees on true individual employment agreements to ensure to the review of remuneration is consistent and in line with Ministry expectations.

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.

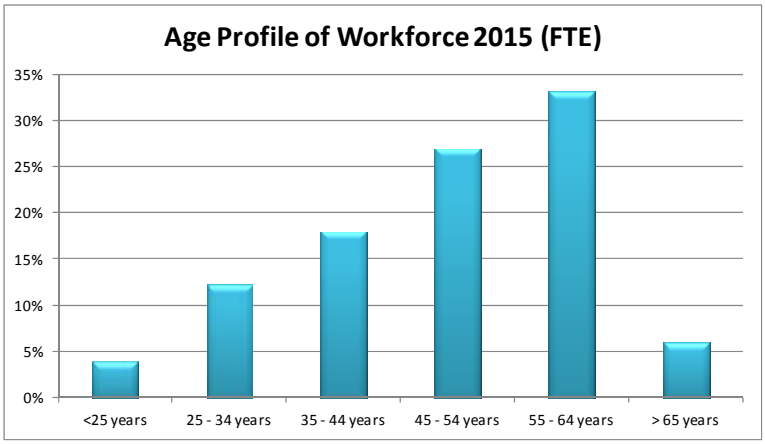
WORKFORCE PROFILE

Full Time Equivalent staff numbers

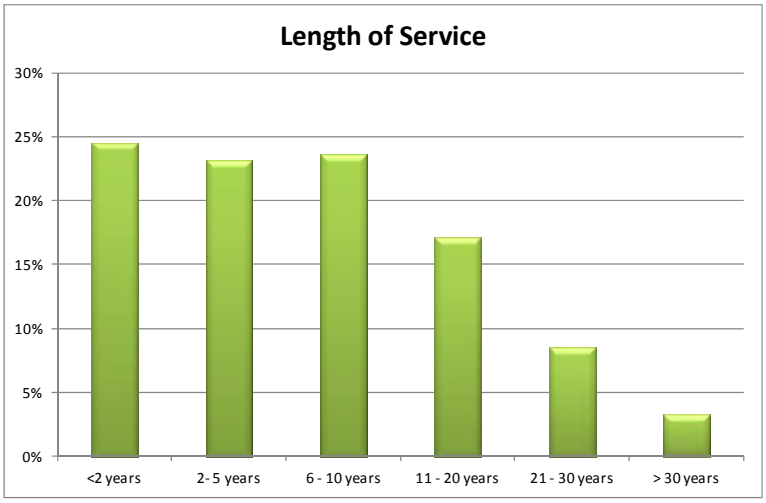
Full Time Equivalent Staff Numbers

	2015	2014	2013	2012	2011	2010	2009
Medical	40	36	39	38	36	35	33
Nursing	215	205	204	198	191	191	189
Allied Health	71	70	69	65	93	69	80
Other	102	106	101	120	119	126	127
Total	429	417	426	441	441	436	433

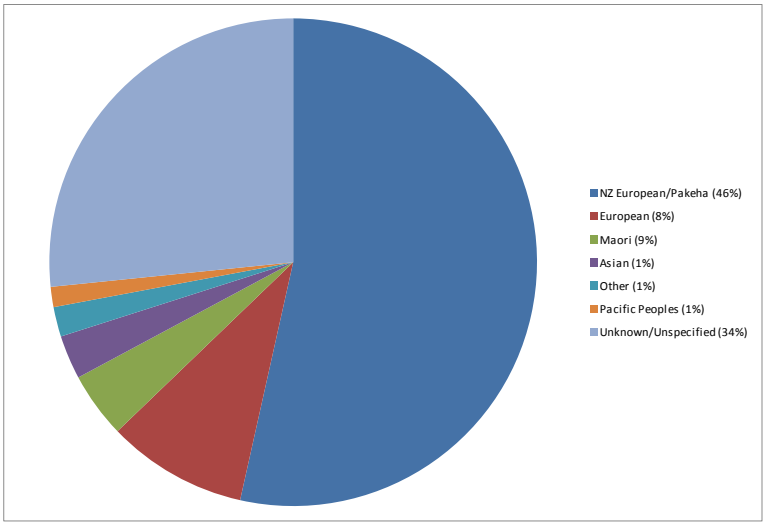
Age profile of workforce 2015 (FTE)



Length of service



Statistics by ethnicity



Statistics by gender

	2015	2014	2013	2012	2011	2010
Female	82%	84%	82%	84%	83%	83%
Male	18%	16%	18%	16%	17%	17%

REMUNERATION OF EMPLOYEES

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

	2015 No. of Employees	2014 No. of Employees
$100,000 – $110,000	5	4
$110,001 – $120,000	9	6
$120,001 – $130,000	5	3
$130,001 – $140,000	2	5
$140,001 – $150,000	2	4
$150,001 – $160,000	2	6
$160,001 – $170,000	2	2
$170,001 – $180,000	0	1
$180,001 – $190,000	2	1
$190,001 – $200,000	1	0
$200,001 – $210,000	2	0
$210,001 – $220,000	5	2
$220,001 – $230,000	3	1
$230,001 – $240,000	3	1
$240,001 – $250,000	4	1
$250,001 – $260,000	1	3
$260,001 – $270,000	0	0
$270,001 – $280,000	0	3
$280,001 – $290,000	0	3
$290,001 – $300,000	1	1
$300,001 – $310,000	0	2
	49	**49**

Of the employees shown above, 46 are clinical employees (2014: 38) and 3 are non-clinical employees (2014: 11). Only staff on the Wairarapa payroll are included in the table above.

TERMINATION PAYMENTS

During the year the Board made no payments to former employees in respect of the termination of the employment (either as redundancy compensation or in equalisation payments upon completion of a service review) with the Board (2014: $56,854 to 2 staff).

MINISTER'S HEALTH TARGETS

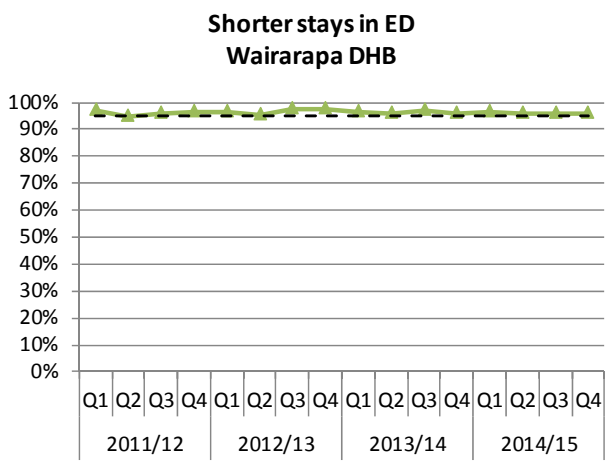
Health targets are a set of national performance measures specifically designed to improve the performance of health services that reflect significant public and government priorities. They provide a focus for action.[1] Note the changing vertical (y) axis between graphs.

Shorter stays in Emergency Departments

95 percent of patients presenting at an Emergency Department (ED) will be admitted, discharged or transferred within six hours.

Target: 95%

2014/15 Performance: 96%

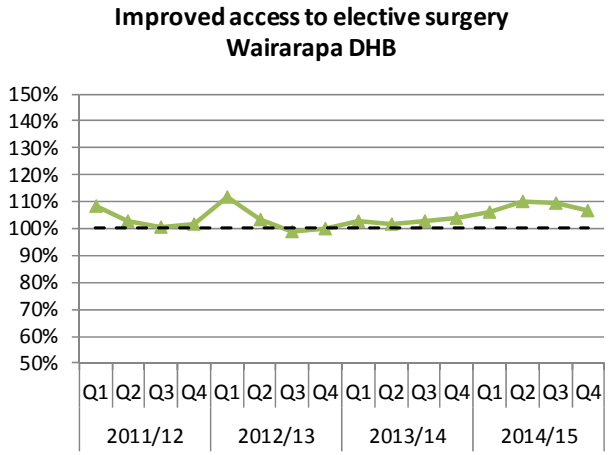


Improved access to elective surgery

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

Target: 1,841 (graph - 100%)

2014/15 Performance: 1,966



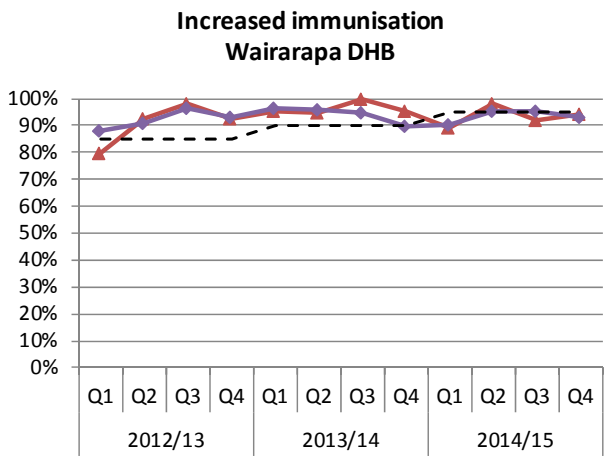
[1] Quoted from the Ministry of Health, http://www.health.govt.nz/new-zealand-health-system/health-targets

Increased immunisation

85 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.

Target: 95%

2014/15 Performance: 93%

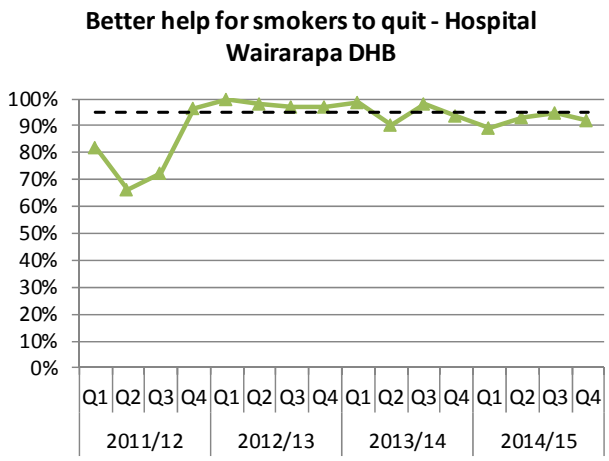


Better help for smokers to quit – Hospital

95 percent of patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking.

Target: 95%

2014/15 Performance: 92%

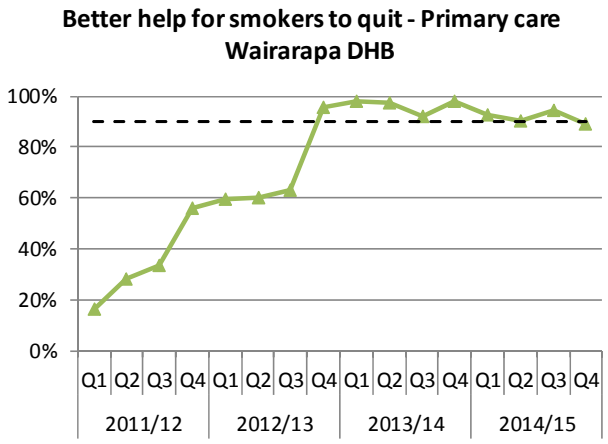


Better help for smokers to quit – Primary care

90 percent of patients who smoke and are seen by a health practitioner in primary care are offered brief advice and support to quit smoking.

Target: 90%

2014/15 Performance: 89%

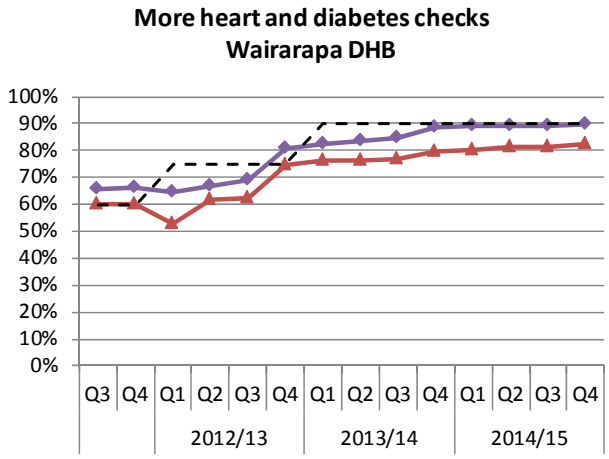


More heart and diabetes checks

90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years.

Target: 90%

2014/15 Performance: 90%

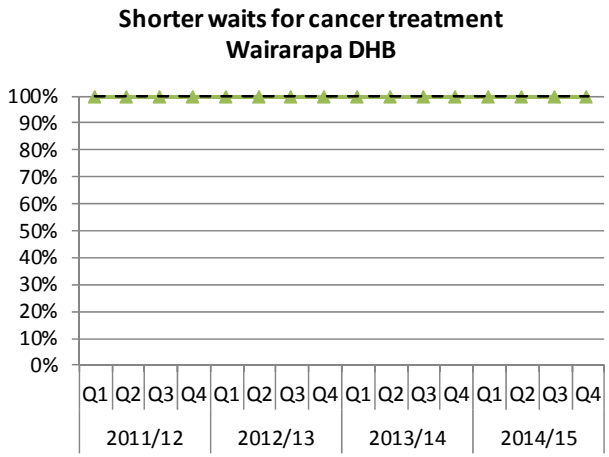


Shorter waits for cancer treatment

All patients, ready for treatment, wait less than four weeks for radiotherapy or chemotherapy. The Ministry of Health has transitioned from this target to the 'Faster cancer treatment' health target.

Target: 100%

2014/15 Performance: 100%

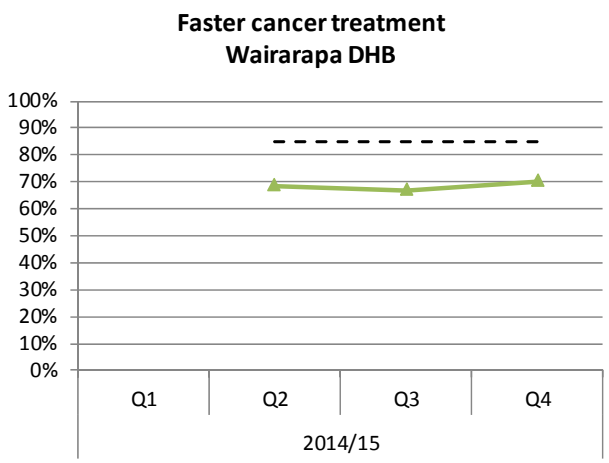


Faster cancer treatment

85 percent of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July 2016, increasing to 90 percent by June 2017.

Target: 85% by July 2016

2014/15 Performance: 69%



PERFORMANCE HIGHLIGHTS

Wairarapa DHB continues to provide high quality and timely services for our population. In 2014/15:

- Amenable (avoidable) mortality rates continue to decrease.
- The burden of tooth decay in 12 year olds has decreased over the last three years.
- Regional Public Health (RPH) achieved both of its immunisation targets – 80% of Yr 7 children received a Boostrix vaccination and 60% of Yr 8 girls received HPV vaccinations in schools.
- All general practices in the Wairarapa 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.
- Compass PHO achieved the *CVD risk assessment* health target, with 90% of eligible people receiving an assessment in 2014/15.
- Wairarapa DHB achieved the *Shorter stays in ED* health target; 96% of patients who presented to Masterton ED were admitted, discharged, or transferred from ED within six hours.
- Wairarapa DHB exceeded the *Improved access to elective surgery* health target with 1,966 elective surgeries delivered to the DHB population.
- The average length of stay for both acute and elective admissions to Masterton Hospital continues to decrease.
- The number of people who are seen within eight weeks for non-urgent mental health and addictions services in the Wairarapa DHB area continues to increase.
- Wairarapa DHB made significant progress on providing comprehensive clinical (InterRAI) and care plan assessments to older people with long-term support needs. In 2014/15, 97% of people with long-term support needs received an InterRAI assessment, an increase of 21% from the previous financial year.

IMPACTS & 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.

In the following section, we present our six intended outcomes and their associated impact measures. Although we do not have a specific target for our selected impact measures, trends in these measures can indicate in which areas our DHB is making a positive difference and in which areas our DHB should seek to improve. It is important to note that these outcomes are progressed not just through the work of DHBs, but also through the work of all of those across the health system and wider health and social services.

POPULATION HEALTH OUTCOME: IMPROVED HEALTH EQUITY

What difference will we make for our population?

Overarching across the three components of our strategy is a focus on patient-centred care. This incorporates an outcome of improved health equity, to ensure the gains in health of our population are across all groups. Inequalities in access to and decisions over resources are the primary cause of health inequalities. Differential access to health services – and in the quality of care provided to patients – also contribute to unequal health outcomes. These structural inequalities may explain more of ethnic inequalities in health than is often recognised.

Although the overall Wellington sub-region has a relatively affluent, healthy population, there are pockets of deprivation concentrated in parts of Porirua, the south eastern suburbs of Wellington, parts of the Hutt Valley such as Naenae and Wainuiomata, and parts of Masterton. Over half of the Pacific population and 29 per cent of Māori live in the most deprived areas.

Māori and Pacific peoples die on average 10 to 15 years earlier than non-Māori non-Pacific, and experience significantly higher acute admission and avoidable mortality rates. Although access to some health care services has improved, outcomes often remain worse for Māori and Pacific people.

We acknowledge our responsibility to design and deliver services that are accessible and responsive to all of our population’s needs.

Impact measures – The DHB measures progress through:

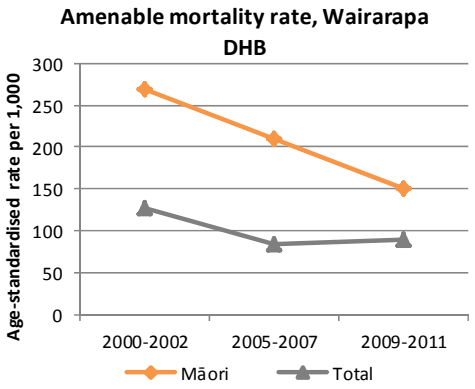
A reduction in amenable mortality rates for Māori & Pacific

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

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

Māori and Pacific amenable mortality rates are more than 2.5 times higher than other ethnicities, indicating that Māori and Pacific are not receiving equitable coverage or quality of healthcare.

This measure links to the Early Detection & Management and Intensive Assessment & Treatment output classes.



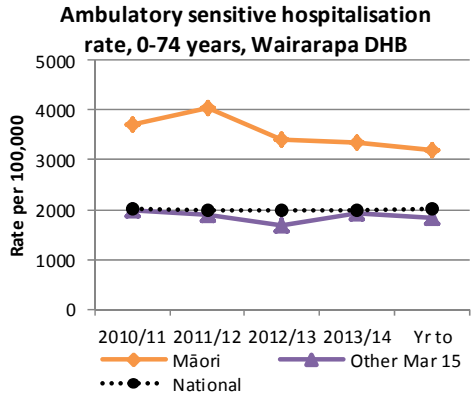
A reduction in the ambulatory sensitive hospitalisation (ASH) rates (0-74)

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.

In Wairarapa DHB, the ASH rate for Māori has decreased over the last four years, but is still more than one-and-a-half times greater than the rate for other ethnicities.

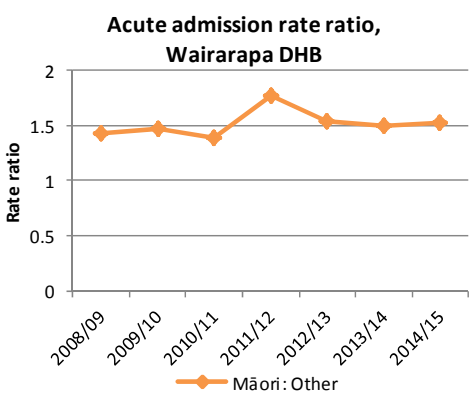
This measure links to the Prevention Services and Early Detection & Management output classes.



A reduction in the rate of acute admissions for Māori & Pacific compared to non-Māori non-Pacific

Māori and Pacific are at least one-and-a-half times more likely to be admitted acutely to hospital than non-Māori non-Pacific. This disparity reflects both social and economic inequities and inequities in access to health services.

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

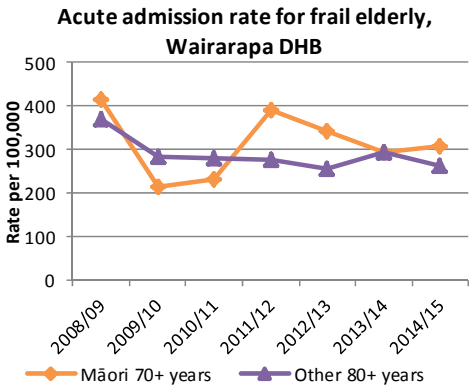


A reduction in acute medical admission rates for Māori and Pacific frail elderly[2]

Rates of acute medical admissions are high across all groups and particularly for Pacific people. Rates for Māori 70+ are declining, which is positive.

By improving the clinical management of frail elderly in the community, we expect that acute admission rates for frail elderly will decrease.

This measure links to the Rehabilitation & Support output class.



POPULATION HEALTH OUTCOME: PREVENTATIVE HEALTH

What difference will we make for our population?

Preventative health services provide the population with health literacy, or an understanding of how their daily choices affect their health, and protect the population to keep them healthy. Healthy eating, active living, and not smoking are some of the factors which can prevent diseases or poor health in the longer term.

Tobacco smoking kills an estimated 5,000 people in New Zealand every year, including deaths due to second-hand smoke exposure. Smoking is also a major contributor to preventable illness and long-term conditions. It is a major cause of lung and a variety of other cancers, as well as chronic obstructive pulmonary disorder, heart disease and strokes. Supporting the population to say no to tobacco smoking is an important opportunity to target improvements in the health of populations with high need and to improve Māori health.

[2] Age groups have been set based definitions used in current programmes of work for frail elderly.

Current trends indicate sustained increases in obesity in New Zealand's adult population. This has significant implications for rates of cardiovascular disease, diabetes, respiratory disease and some cancers, as well as poor psychosocial outcomes and reduced life expectancy. Supporting the population to maintain healthier body weight through improved nutrition and physical activity levels is fundamental to improving the health and wellbeing of the population and to the prevention of chronic conditions and disability at all ages.

Measures – The DHB measures progress through:

An increase in the percentage of adults 15+ consuming 2+ fruit and 3+ vegetable servings daily

Good nutrition is fundamental to health and the prevention of disease and disability.

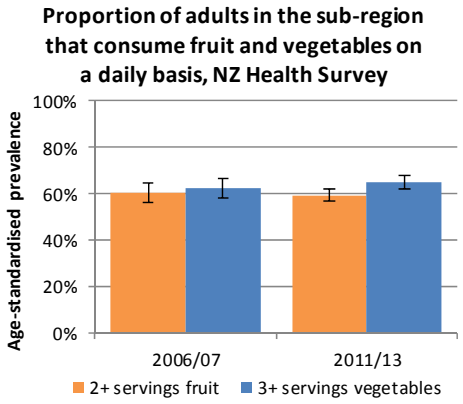
Appropriate fruit and vegetable consumption helps to protect people against obesity, CVD, diabetes and some common cancers and contributes to maintaining a healthy body weight.

Nutrition-related risk factors (such as high cholesterol, high blood pressure, obesity and inadequate fruit and vegetable intake) jointly contribute to two out of every five deaths each year.

By providing education and support for people to live healthily, we expect that the consumption of fruit and vegetables will increase.

The number of adults consuming fruit and vegetables on a daily basis has not changed significantly over the last five years.

This measure links to the Prevention Services output class.



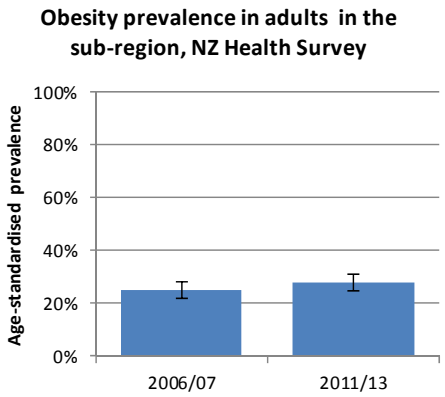
A reduction in obesity prevalence amongst the population 15+

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

The most recent NZ Health Survey shows that there is no significant difference in obesity rates between the three DHBs. Adults have a much higher obesity rate than children in all three.

By providing education and support for people to live healthily, we expect that the prevalence of obesity will decrease.

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



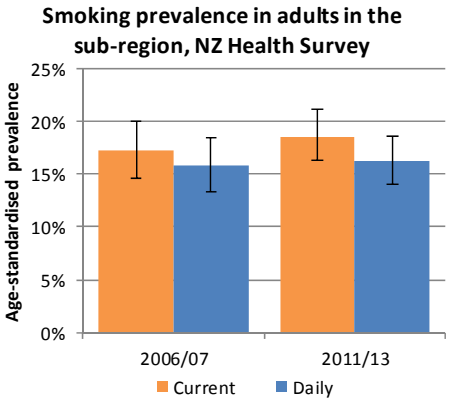
A reduction in smoking rates for the sub-region's 15+ population

Cigarette smoking has serious consequences for health. It is estimated that smoking kills 5,000 New Zealanders a year. Ministry of Health has set a goal that New Zealand will be smoke free by 2025. Our DHB is working towards this goal by providing smoking advice and cessation support to patients when they visit their general practice or visit the hospital.

Census 2013 data shows that in our sub-region, smoking prevalence in Māori (30%) and Pacific (24%) are higher than the average smoking prevalence (14%) in our sub-region.

By providing smoking cessation advice and support, we expect that the percentage of people who smoke will decrease.

This measure links to the Prevention Services output class.



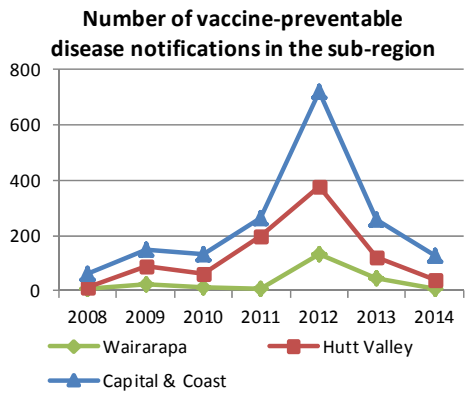
A decrease in the number of vaccine preventable disease notifications

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.

The peak in 2012 was due to Pertussis (whooping cough) outbreaks in the region, which caused an increase in vaccine preventable disease notifications. The number of notifications has returned to previous levels in 2014.

In the longer term, with increased immunisation, we expect that the number of vaccine-preventable disease notifications will decrease.

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



Source: Environmental Science & Research surveillance reports

POPULATION HEALTH OUTCOME: PREVENTATIVE HEALTH: IMPROVED CHILD AND YOUTH HEALTH

What difference will we make for our population?

Outcomes for the current generation of children and young people will determine the future success or failure of the community and society as a whole. The relatively short periods of time which gestation, infancy, childhood and adolescence occupy have more power to shape the individual than much longer periods of time later in life.

The health status of young people and expectant mothers is most strongly influenced by environmental determinants of health outside of the services the DHB provides. However the DHBs have a focus on influencing change that supports healthier environments; on ensuring younger populations have a healthy start to life; and on addressing the inequalities between population groups to improve overall population outcomes.

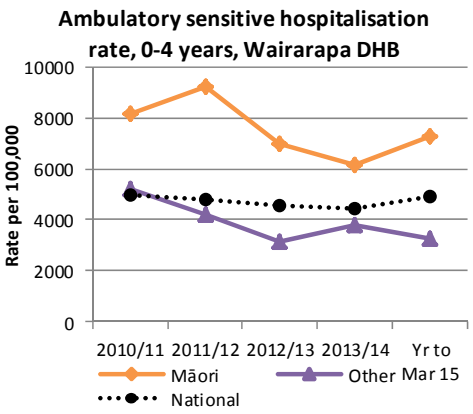
Measures – The DHB measures progress through:

A reduction in ambulatory sensitive hospitalisations of children (0-4)

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.

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



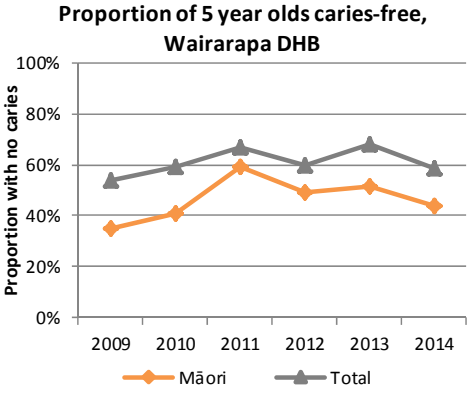
An increase in the proportion of children caries free at five years

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

The DHB is undertaking a number of activities to improve oral health outcomes for children. A new sub-regional enrolment system has recently been established, and its aim is to enrol every infant with community oral health services. In addition, Before School Checks include a 'Lift the Lip' oral health examination, through which children with poor oral health are referred to community oral health services.

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

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

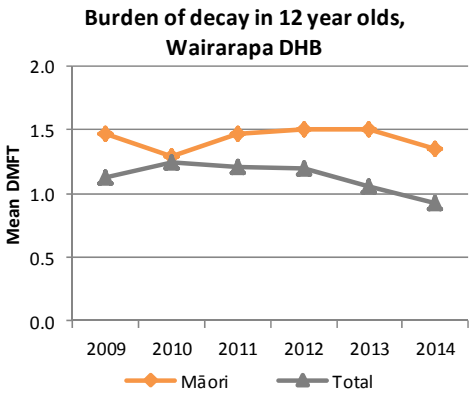


A decrease in the mean number of decayed, missing or filled teeth (DMFT) at Year 8

The burden of tooth decay is measured by the mean number of decayed, missing or filled teeth (DMFT) in twelve year old children. Māori and Pacific children have a higher burden of decay than other ethnicities.

By ensuring that every child has access to and is receiving oral health services, we expect that the burden of decay in twelve year olds will decrease.

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



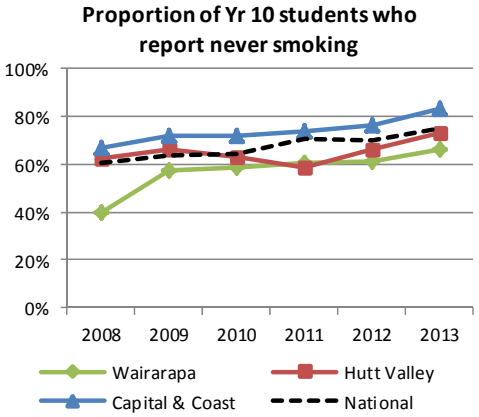
An increase in the proportion of year 10 students who report never smoking

Reducing smoking prevalence is dependent on smoking cessation and on preventing young people from taking up smoking. Over 95% of smokers have started smoking by 18 years of age.

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 risk behaviour.

The proportion of year 10 students who report never smoking has increased over the last five years across all three DHBs, which is positive.

This measure links to the Prevention Services output class.



POPULATION HEALTH OUTCOME: EMPOWERED SELF-CARE

What difference will we make for our population?

The impact of long-term conditions in terms of quality of life and cost to the health system is significant. Early diagnosis and intervention and improved disease management provide major opportunities for improving health outcomes; particularly for Māori and Pacific people, who have disproportionately higher rates of many long-term conditions.

Empowering people to manage their long-term conditions and seek appropriate intervention early will result in a reduction in the proportion of the population seeking urgent care or requiring acute admission to hospital. Improving access to alternative pathways of care will ensure people are being given the right treatment in the right place, improve health outcomes, reduce pressure on hospital resources and enable investment in other priority areas.

Measures – The DHB measures progress through:

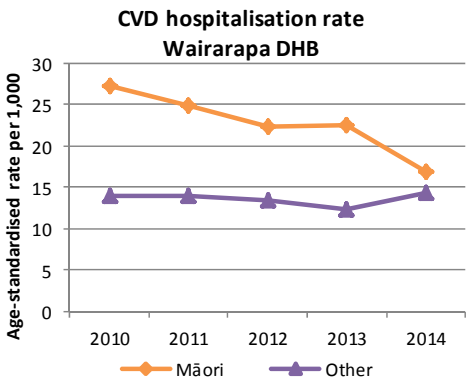
A reduction in the hospitalisation rate for cardiovascular disease (CVD)

Cardiovascular diseases (CVD) are diseases that affect the heart and circulatory system. They include ischaemic heart disease, rheumatic heart disease, cerebrovascular disease and other forms of vascular and heart disease. Cardiovascular disease is the leading cause of death in the sub-region. Overall, around 70% of the burden of cardiovascular disease is attributed to modifiable risk factors. CVD is preventable through adopting a healthy lifestyle, and can be managed with lifestyle change, early intervention and effective management.

One of the health targets is to provide CVD risk checks for the eligible population (65+ years). By identifying those at risk of CVD early, we can help them to change their lifestyle to improve their health, and reduce the chance that they develop a serious health condition. We expect that this intervention will lead to a decrease in the rate of CVD-related hospitalisations for our population.

In Wairarapa DHB, Māori have a higher rate of CVD hospitalisation than other ethnicities, but this inequity has decreased over the last four years.

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



A reduction in the hospitalisation rate for diabetes

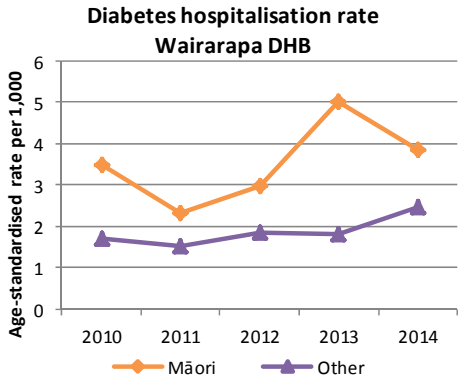
Diabetes is defined by the body's inability to control blood glucose. Diabetes is a chronic condition, which can cause kidney failure, eye disease, foot ulceration and a higher risk of heart disease if not well managed.

The New Zealand Health Survey found that the national prevalence of diagnosed diabetes increased from 5.1% in 2006-07 to 5.6% in 2011-14.

Supporting people to manage their diabetes well reduces acute admissions to hospital.

Diabetes admission rates increased for Māori between 2011 and 2013, but have decreased in 2014. The rate for other ethnicities continues to increase.

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

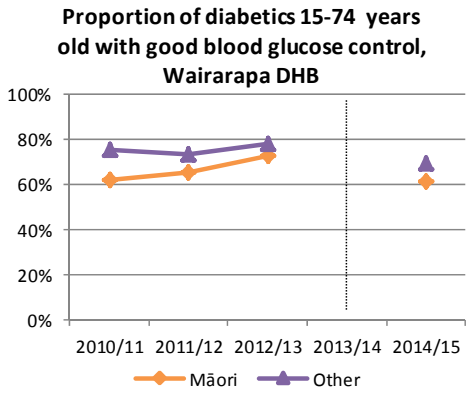


Increased proportion of diabetics checked with satisfactory or better blood glucose control (HbA1c less than or equal to 64 mmol/mol)

Diabetes is a significant cause of ill health and premature death. Improving the management of diabetes will reduce long-term avoidable complications which require hospital-level intervention, such as lower limb amputation, kidney failure and blindness, and will improve people's quality of life.

Fewer Māori and Pacific have good blood glucose control when compared to other ethnicities.

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



Results from 2010/11 to 2012/13 are presented as a rate of diabetics who had an HbA1c test. This measure was then revised from 2013/14 to be a rate of all enrolled diabetics, which resulted in a drop in reported performance. There was also a delay in developing reporting with the new methodology, so results for 2013/14 are not available.

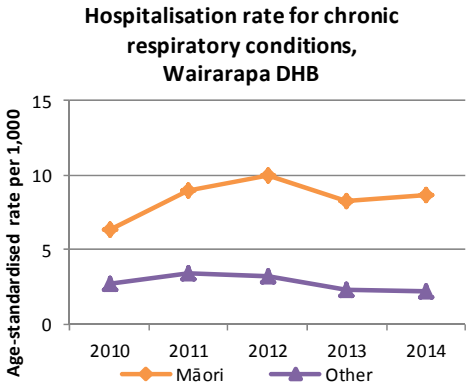
A reduction in the age standardised hospitalisation rate for chronic respiratory conditions

The most common chronic respiratory conditions include asthma and chronic obstructive pulmonary disorder (COPD).

By providing cessation support for people who smoke, improving access to primary care, and helping people to take their medication regularly, we expect that the rate of chronic respiratory hospitalisations for our population will decrease.

In Capital & Coast DHB, the rate of chronic respiratory hospitalisation for Māori has varied over the last five years. Rates for Māori and Pacific are approximately three times higher than the rate for other ethnicities.

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



HEALTH SERVICES OUTCOME: SERVICES CLOSER TO HOME

What difference will we make for our population?

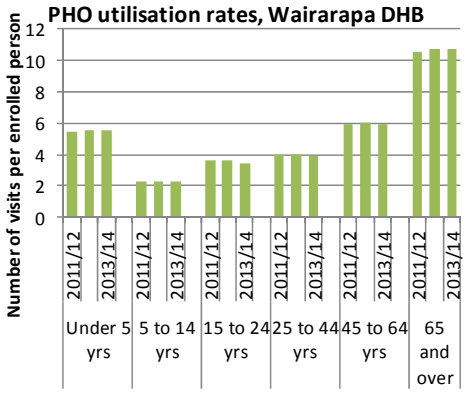
We are working to better integrate health services across the continuum to better provide the services patients require closer to their homes. When services are delivered closer to the patient's home they can better access services and have a relationship of trust with their regular GP, nurse or other clinician. This allows patients to use services when they need them and empowers them to manage their health.

Measures – The DHB measures progress through:

The utilisation rate of primary care by age group

When people are able to access primary care when they need it they can receive treatment earlier, have better continuity of care, and sometimes even prevent a hospital admission. Improved utilisation of primary care appropriate to the needs of the age group reflects patients' ability and willingness to visit their medical home of primary care for their medical treatment.

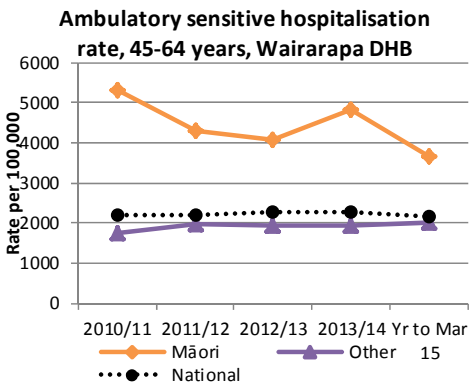
This measure links to the Early Detection & Management output class.



A reduction in ambulatory sensitive hospitalisations of adults (45-64)

Ambulatory sensitive hospital admissions are usually unplanned admissions that are potentially preventable by appropriate health services delivered in community settings, including through primary health care. They provide an indication of access to, and the effectiveness of, primary health care, as well as management of the interface between the primary and secondary health sectors.

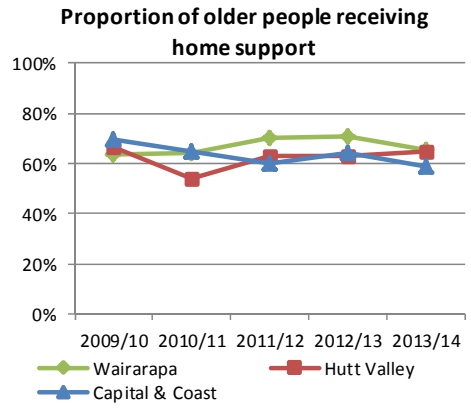
This measure links to the Prevention Services and Early Detection & Management output classes.



Maintain or increase the proportion of patients receiving home based support services of those 65+ who receive DHB funded home based support or aged residential care services

Services that support people to manage their needs and live well, safely and independently in their own homes provide a much higher quality of life, because people stay active and positively connected to their communities. People whose needs are met by these support services are less dependent on hospital and residential services and less likely to experience acute illness or deterioration of their conditions.

This measure links to the Rehabilitation & Support output class.



HEALTH SERVICES OUTCOME: QUALITY HOSPITAL CARE AND COMPLEX CARE FOR THOSE WHO NEED IT

What difference will we make for our population?

Improved patient-focused, clinically driven pathways will provide the flexibility for early intervention and planned readmission where clinically appropriate, and will support improvements in care across the whole continuum. Responsive intervention will also enable people, their families and caregivers to establish more stable lives.

Overseas experience shows that systemic changes to the way care is offered to patients can lead to measurable changes in patient morbidity and mortality. Examples are changes intended to reduce incidences of falls, pressure ulcers, pneumonia and hospital-acquired infections in patients.

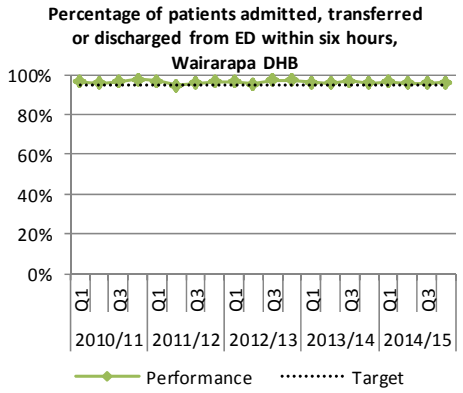
Measures – The DHB measures progress through:

The percentage of patients admitted, transferred or discharged from the Emergency Department within six hours

Timely access to treatment improves health outcomes and is indicative of increased capacity and improvements in the flow of patients through DHB services. It also demonstrates a commitment to addressing the needs of patients and valuing their time.

Timely acute care in ED is also a proxy measure for how well the whole system is working together to support people to stay well and to provide timely and appropriate complex care through management of acute demand in the community, improved capacity in ED and supported discharge into services in the community.

This measure links to the Intensive Assessment & Treatment output class.

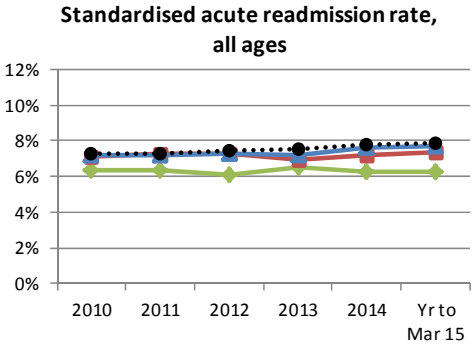


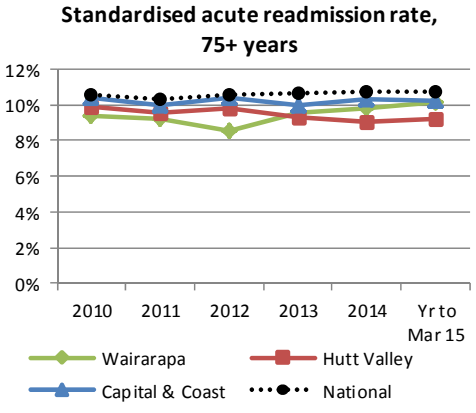
A reduction in the standardised rate of acute readmissions within 28 days, total & 75+ years

A decrease in the rate of acute readmissions shows that people are receiving high-quality care in hospital, that they are being appropriately discharged (ie not leaving hospital too early or too late), and that they are being well-supported by primary and community care once they are out of hospital.

The standardised acute readmission rate has remained at about 6.5% for Wairarapa and 7% for Hutt Valley and Capital & Coast over the last five years. Although the acute readmission rate has remained the same, the average length of stay in our hospital facilities has decreased (see Statement of Performance), which shows that the effectiveness and efficiency of treatment in hospital has improved.

This measure links to the Intensive Assessment & Treatment output class.



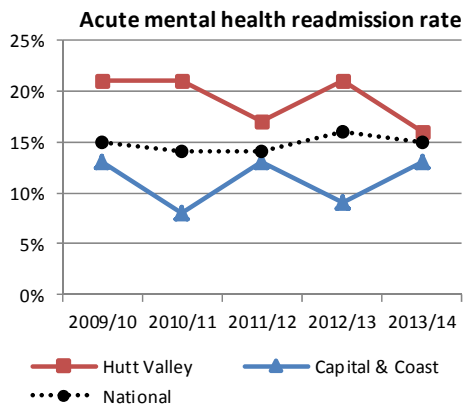


A reduction in the rate of acute readmissions within 28 days to Mental Health Services

Inpatient mental health services aim to provide treatment that enables individuals to return to the community as soon as possible. Unplanned readmissions to a psychiatric facility following a recent discharge may indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was inadequate to maintain the person out of hospital.

This indicator helps identify if investigation into the functioning of the system is needed to determine any areas in which it might be breaking down. Improved performance on this measure demonstrates better whole of system performance.

This measure links to the Intensive Assessment & Treatment output class.

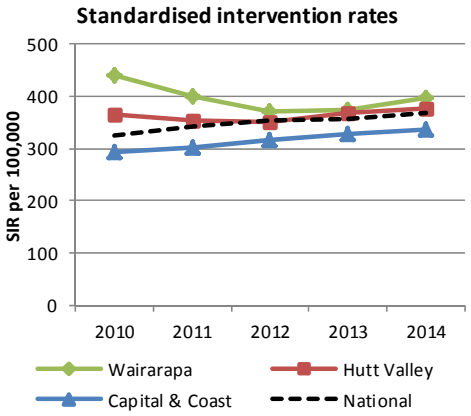


Maintain or increase standardised intervention rates (SIR) for elective services

One of the areas of focus for elective services is the level of service being provided to the DHB's population (as measured by Standardised Intervention Rates), and the level of service being provided for identified key conditions, including cardiac procedures, major joint replacement and cataract procedures.

As standardised intervention rates for the Wairarapa have been historically high, by more closely aligning to the national average the DHB is ensuring the sustainability of its services into the future.

This measure links to the Intensive Assessment & Treatment output class.



STATEMENT OF PERFORMANCE

For the year ended 30 June 2015

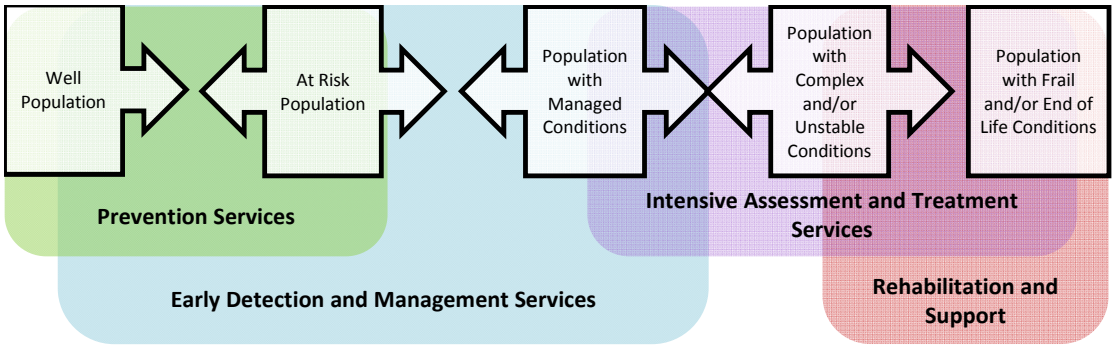
OUTPUT CLASSES CONTRIBUTING TO DESIRED OUTCOMES

In the Statement of Performance, we evaluate our performance (outputs) against the targets that we set in the Statement of Performance Expectations in our 2014/15 Annual Plan. We choose outputs that will make the greatest contribution to the wellbeing of our population in the shorter term, and to the health outcomes that we want 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. The outputs here provide a picture of the health service activity across the whole of the Wairarapa health system.

Our four Output Classes and their related services are:

1. Prevention Services
   - Health promotion and public health services
   - Immunisation services
   - Smoking cessation services
   - Screening services
2. Early Detection and Management Services
   - Primary care (GP) services
   - Oral health services
3. Intensive Treatment and Assessment Services
   - Medical and surgical services
   - Cancer services
   - Mental health and addictions services
4. Rehabilitation and Support Services
   - Disability services
   - Health of older people services.

Scope of DHB Operations – Output Classes in the Continuum of Care



VOTE HEALTH ESTIMATES OF APPROPRIATIONS

The 2014/15 Vote Health Estimates of Appropriations noted that performance information for selected Non-departmental Appropriations (Health Workforce Training and Development, National Child health Services, National Contracted Services, National Disability Support Services, National Elective Services, National Emergency Services, National Health Information Systems, National Maternity Services, National Mental health Services, National Personal Health Services, and Primary Health Care Strategy) would be reported in part through DHBs 2014/15 Annual Reports. The Ministry of Health has advised DHBs that the Minister of Health will report this information instead of DHBs. Readers wishing to view the overall budget and performance information for these selected Non-departmental Appropriations will be able to refer to the Minister of Health's 2014/15 Vote Health Non-Departmental Expenditure report. This report will be made available on the Ministry of Health's website.

INTERPRETING OUR PERFORMANCE

Types of measures

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 report on 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. Where possible and relevant, we have also broken our performance down by ethnicity.

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

We have identified new measures in 2014/15 with a † symbol. These measures were introduced in the 2014/15 Annual Plan and did not appear in the 2013/14 Annual Report. Our 2013/14 performance has therefore not been audited by Audit New Zealand.

Standardisation

Different populations have different characteristics, and these different population characteristics can lead to different rates between populations. One such characteristic is the age structure of a population. It would be unreasonable to compare the hospital average length of stay in Wairarapa, which has a large proportion of elderly, directly to Capital & Coast, which has a smaller proportion of elderly. But, by standardising for age, we can see what the rates would have been if the two populations had the same

proportion of people in each age group, and therefore draw comparisons. In the following outputs, if measures have been standardised (often by the Ministry of Health to allow comparison between DHBs), we have noted why and how.

OUTPUT CLASSES: FINANCIAL PERFORMANCE ($000S)

Revenue	2013/14	2014/15 Budget	2014/15 Actual
Prevention	2,303	1,671	1,225
Early Detection and Management	39,832	40,237	40,519
Intensive Assessment and Treatment	75,063	76,027	78,318
Rehabilitation and Support	19,273	19,478	18,997
Total	136,471	137,413	139,059

Expenditure	2013/14	2014/15 Budget	2014/15 Actual
Prevention	3,036	2,790	2,382
Early Detection and Management	41,352	41,061	42,199
Intensive Assessment and Treatment	74,226	75,563	78,642
Rehabilitation and Support	19,445	19,511	19,191
Total	138,059	138,925	142,414
Net deficit:	(1,588)	(1,512)	(3,355)

OUTPUT CLASS 1: PREVENTION SERVICES

Description

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

Context

The prevalence of long-term conditions in New Zealand is increasing. Long-term conditions include diabetes and cardiovascular disease, which are major causes of poor health and morbidity and account for a significant number of presentations in primary care and admissions to hospital and specialist services. With an ageing population, the burden of long-term conditions will increase. It is estimated that 70% of health funding is spent on long-term conditions. Two in every three New Zealand adults have been diagnosed with at least one long-term condition and long-term conditions are the leading driver of health inequalities. The majority of chronic conditions are preventable or could be better managed. Tobacco smoking, inactivity, poor nutrition, and rising obesity rates are major and common contributors to a number of the most

prevalent long-term conditions and are avoidable risk factors, preventable through a supportive environment, improved awareness and personal responsibility for health and wellbeing. These prevention services also support people to address any risk factors that contribute to both acute events (eg alcohol-related injury) and the development of long-term conditions (eg obesity or diabetes). High health need and at-risk population groups (low socio-economic, Māori, and Pacific) who are more likely to be exposed to environments less conducive to making healthier choices are a focus. Preventative services are our best opportunity to improve the health of these high need populations and to reduce inequalities in health status and improve population health outcomes. These services also ensure that threats to the health of the community such as communicable disease, water quality, imported disease-carrying pests, are detected early and prevented, and ensure our ability to respond to emergency events such as pandemics or earthquakes.

Outputs

Health promotion and public health services: inform people about health matters and health risks, and support people to be healthy. Success begins with awareness and engagement, reinforced by community health programmes that support people to maintain wellness or assist them to make healthier choices. Health promotion and public health services enable people to increase control over their health and its determinants, and thereby improve their health. A range of strategies are used, including those described by the Ottawa Charter: public policy, reorienting the health system, developing supportive environments, community action, and supporting individual personal skills. While health has a significant role here, some outcomes such as obesity require a joined-up approach to address determinants of health, such as income, housing, food security, employment, and quality working conditions. Our DHB and Regional Public Health (RPH) work with other sectors (eg housing, justice, education) to enable this.

Immunisation services: work to prevent the outbreak of vaccine-preventable diseases and unnecessary hospitalisations. The work spans primary and community care, allied health and public health services to optimise provision of immunisations across all age groups, both routinely and in response to specific risk. A high coverage rate is indicative of a well-coordinated, successful service.

Smoking cessation services: are provided by clinical staff to smokers to help smokers quit. Clinicians follow the ABC process[a]: Ask all patients whether they smoke and document their response; if the patient smokes, provide Brief advice to quit smoking; and if the patient agrees, provide **C**essation support (eg a prescription for nicotine gum or a referral to a provider like Quitline).

Screening services: encourage uptake of services predominately funded and provided through the National Screening Unit that help early identification of breast and cervical cancer, and carry out newborn hearing testing, and antenatal HIV screening.

How we measure the performance of our Prevention Services

Outputs	Measure	Type of Measure	2013/14 Performance	2014/15 Target	2014/15 Performance	2014/15 Achievement
Health promotion and public health services	The number of new referrals to public health nurses in primary/intermediate schools	V	2013: 171	**2014: 126**	2014: 136	Achieved
	The percentage of infants breastfed at 6 months[b]	C	68%[†]	**≥59%**[c]	70%	Achieved
Immunisation services	**Health target:** The percentage of eight month olds fully vaccinated	C	96%	**95%**	93%	Not Achieved
	The percentage of Yr 7 children provided Boostrix vaccination in schools [d]	C	2013: 74%	**2014: 70%**	2014: 80%	Achieved
	The percentage of Yr 8 girls vaccinated against HPV (final dose) [e]		2013: 64%	**2014: ≥60%**	2014: 60%	Achieved
	The percentage of enrolled people over 65 years vaccinated against flu	C	68%	**70%**	67%	Not Achieved
	High Needs		66%		66%	Not Achieved
Smoking cessation services	**Health target:** The percentage of hospitalised smokers receiving advice and help to quit	C	95%[f]	**95%**	92%	Not Achieved
	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	98%	**90%**	89%	Not Achieved
Screening services	The percentage of eligible children receiving a Before School Check	C	93%	**90%**	87%	Not Achieved
	High Need	C	98%		107%[g]	Achieved
	The percentage of eligible women (25-69) having cervical screening in the last 3 years[h]	C	81%	**≥80%**[c]	74%	Not Achieved
	Māori		80%		68%	Not Achieved
	The percentage of eligible women (50-69 yrs) having breast screening in the last 2 years[h]	C	75%	**≥70%**[c]	72%	Achieved
	Māori		74%		66%	Not Achieved

Comments on performance

Health promotion and public health services

Public health nurses continue to respond to the community's needs in primary and intermediate schools. Referrals to public health nurses are made by teachers, health professionals, social workers and caregivers. Wairarapa public health nurses work closely with the social workers in schools and vision hearing technicians. A number of referrals for behavioural, vision and hearing problems go directly to the relevant service. These services involve the public health nurse if the child or family require additional support.

Immunisation services

Wairarapa DHB did not achieve the eight month old immunisation health target. Performance on this measure dropped in 2014/15 because there were eight children for whom their caregivers declined immunisation. All other eligible children except one received their vaccinations on time. This result has been discussed with the Ministry of Health and is being monitored closely by the Immunisation Team.

Primary Health Organisations (PHOs) are being supported and encouraged to implement initiatives to increase immunisation coverage. Immunisation education is provided for primary health care nurses and hospital staff that have immunisation responsibilities. Primary healthcare providers also receive a list of children who are overdue for immunisation so that they can follow up to ensure that the children receive their immunisations.

Boostrix and HPV immunisation is carried out at the beginning of the year and involves the whole public health nurse team. This workplan causes less disruption for the schools and completes the main immunisation schedule by the end July. Minor catch up clinics are run if required. Wairarapa DHB did not achieve the overall population target but well exceeded the high deprivation target. This underachievement is due partly to smaller population numbers impacting on data fluctuations but also provider capacity in the final data input period.

The influenza vaccination period was extended by the Ministry of Health in 2014/15 due to a prolonged flu season. As a result, we expect the percentage of enrolled people over 65 years vaccinated against flu to increase over the next quarter (September 2015). Compass PHO continues to support practices to provide influenza vaccination for at-risk patients.

Smoking cessation services

Wairarapa DHB did not meet the smoking cessation advice provided in hospital health target. Performance on the target is being monitored closely by the Smokefree Coordinator, who reviews discharge summaries for patients who smoke and were not provided advice, and reports these to senior hospital managers. The Emergency Department (ED) Manager has been working closely with her staff to increase the number of smokers given cessation advice in ED, which should result in increased performance next quarter.

Compass Health PHO in Wairarapa is working with general practices to create sustainable systems to achieve the health target for smoking cessation advice in primary care.

Screening services

Wairarapa DHB achieved the target for cervical screening for the total population but Māori and Pacific cervical screening rates and breast screening rates did not meet the target. To improve screening rates, the screening service has implemented data matching with primary care, changed the mobile roster so that it visits Wairarapa annually, and is working with Whaiora Whanui to recruit and retain 'priority' women (Māori, Pacific, and those living in high deprivation areas) within screening services. Independent service providers, such as Whaiora Whanui, also work to locate and assist priority women to engage with screening services.

OUTPUT CLASS 2: EARLY DETECTION AND MANAGEMENT

Description

Early detection and management services include activities that maintain, improve and restore a person's health. These services cover a wide range of activities across the continuum of care. These services include detection of people at risk and with early disease and more effective management and coordination of people with long-term conditions. By nature, early detection and management services are more generalist, and are usually accessible from multiple providers at a number of different locations.

Context

The prevalence of long-term conditions in New Zealand is increasing. Maori and Pacific people, older people, and people with lower incomes often suffer from these conditions more than other population groups. There is also increasing demand for acute and urgent care services. For our DHB, long-term conditions with the highest prevalence include diabetes, chronic obstructive pulmonary disease (COPD), asthma, and chronic respiratory conditions. Early detection and management services based in the community can identify people at risk of developing a long-term condition, provide opportunity to intervene in less invasive and more cost-effective ways, and reduce the burden of long-term conditions through supported self-management (avoidance of complications, acute illness and crises). These services deliver coordination of care, and support people to maintain good health.

Outputs

Primary care services: are offered in local community settings by teams of general practitioners (GPs), registered nurses, nurse practitioners, and other primary health care professionals. Primary care services aim to improve, maintain, or restore health. High numbers of enrolment with general practice indicate that primary care services have high engagement, are easily accessible, and are responsive to the needs of the population. Primary care services keep people well by: intervening early to detect, manage, and treat health conditions (eg health checks); providing education and advice so people can manage their own health; and reaching those at risk of developing long-term or acute conditions.

Oral health services: are provided by registered oral health professionals to assist people to maintain healthy teeth and gums. A reduction in the number of young children requiring invasive complex oral health treatment (under general anaesthetic) is indicative of the quality of early intervention and of public health education and messages regarding the importance of good oral health. High enrolment indicates engagement, while timely examination and treatment indicates a well-functioning, efficient service.

How we measure the performance of our Early Detection & Management Services

Outputs	Measure	Type of Measure	2013/14 Performance	2014/15 Target	2014/15 Performance	2014/15 Achievement
Primary care services	The number of DHB domiciled population enrolled in a PHO[i]	V	42,052	**42,349**	42,471	Achieved
	Māori		6,807	**7,106**	7,060	Not Achieved
	The ratio of nurse and GP visits by high need patients versus non-high need patients[j]	V	1.12	**≥1.15**	1.13	Not Achieved
	Health target: The percentage of the eligible population assessed for CVD risk in the last five years	C	88%	**90%**	90%	Achieved
	The percentage of practices with a diabetes care improvement plan	Q	100%	**100%**	100%	Achieved
Oral health services	The percentage of children under 5 years enrolled in DHB funded dental services[k]	C	2013: 78%	**2014: 85% 2015: 87%**	2014: 82%	Not Achieved
	The percentage of adolescents accessing DHB funded dental services	C	2013: 64%	**2014: 85% 2015: 85%**	2014: 67%	Not Achieved

Comments on performance

Primary care services

Wairarapa DHB did not meet the target for the number of DHB-domiciled population enrolled in a PHO. However, enrolment rates are 98% for both the total and Māori population.

Although the target for the ratio of nurse and GP visits by high need patients versus non high need patients was not achieved, the ratio indicates that 'high need' patients (Māori, Pacific, and those living in the most deprived areas) are visiting primary care services more than non-high need patients, which is good. During 2014/2015, 'very low cost access' funding was provided to practices for which at least half of the enrolled population was identified as 'high need'. This funding allowed practices to have low consultation fees, which reduced the financial barriers to accessing primary health care for the 'high need' population.

Wairarapa DHB met the target for the percentage of practices with a diabetes care improvement plan. These plans are developed and implemented by general practices to provide quality care and management for enrolled patients with diabetes.

Oral health services

Since late 2014, all babies born within the Wairarapa are enrolled with the dental service. Enrolment rates should increase over the next few years as a result of this process. In future, we plan to data-match to primary care data to further improve enrolment rates.

The Oral Health Service is planning a number of new initiatives to improve adolescent utilisation. These initiatives include working closely with all contracted private dental practices. A new whānau-centred programme is being scoped with Te Hauora Runanga o Wairarapa and Whaiora Whanui. This programme will provide Māori adolescents with support to attend their oral health appointments. There are also sub-regional initiatives to raise awareness of 'FREE dental care for under 18 year olds'.

OUTPUT CLASS 3: INTENSIVE ASSESSMENT AND TREATMENT

Description

Intensive assessment and treatment services are complex hospital services. They are provided by specialists and other health care professionals in a hospital setting. Hospitals often provide these services because clinical expertise (across a range of areas) and specialist equipment need to be located in the same place. These services include inpatient, outpatient, emergency and urgent care services. Our DHB provides an extensive range of intensive treatment and complex specialist services to our population. Our DHB also funds some tertiary and quaternary services that are provided by other DHBs, private hospitals and private providers for our population. A proportion of these services are driven by demand, such as unplanned (acute) and maternity services. For planned (elective) services, access is determined by capability, capacity, resources, clinical triage, national service coverage agreements, and treatment thresholds.

Context

Equitable and timely access to intensive assessment and treatment can significantly improve people's quality of life, either through early intervention (ie removal of an obstructed gallbladder to prevent repeat attacks of abdominal pain/colic and to reduce the risk of cancer and infection) or through corrective action (ie major joint replacements to relieve pain and improve activity). Flexible and responsive assessment and treatment services also support improvements across the whole system, so that people can receive support in the community with confidence that complex intervention is available if needed. As an owner and provider of these services, the DHB is also concerned with the quality of the services being provided. Adverse events in hospital cause harm to patients, drive unnecessary costs, and shift resources away from other services. Improving our service delivery, systems and processes will improve patient safety, reduce the number of hospital events causing harm, and improve outcomes for people using our services. There are expectations for the delivery of increased elective surgical volumes, a reduction in waiting times for treatments, and increased clinical leadership around improving service delivery and safety to improve the quality and efficiency of care being delivered. The changes being made to meet expectations are providing opportunities to introduce innovative clinically led service delivery models and improve productivity within our hospital services.

Outputs

Medical and surgical services: Unplanned hospital services (acute services) are for illnesses that have an abrupt onset and are often of short duration and rapidly progressive, creating an urgent need for care. Hospital-based acute services include emergency departments, short-stay acute assessments and intensive care services. Planned services (elective surgery) are services for people who do not need immediate hospital treatment and are 'booked' services. Planned services also include non-medical interventions (coronary angioplasty) and specialist assessments (first assessments, follow-ups or preadmission assessments). National Elective Services Patient Flow Indicators (ESPIs) are indicative of a successful and responsive service, addressing increasing needs and matching commitments to capacity.

Cancer services: Cancer services include diagnosis and treatment services. Cancer treatment in the sub-region is delivered by the Wellington Blood and Cancer Centre.

Mental health and addictions services: Specialist Mental Health Services are services for people who are most severely affected by mental illness or addictions and include assessment, diagnosis, treatment and rehabilitation, as well as crisis response when needed, and as required under the Mental Health Act. Currently the expectation established in the National Mental Health Strategy is that specialist services (including psychiatric disability services) will be available to 3% of the population. Utilisation rates will be monitored across age groups and ethnicities to ensure service levels are maintained and to demonstrate responsiveness.

How we measure the performance of our Intensive Assessment & Treatment Services

Outputs	Measure	Type of Measure	2013/14 Performance	2014/15 Target	2014/15 Performance	2014/15 Achievement
Medical and surgical services	**Health target:** The percentage of patients admitted, discharged or transferred from ED within six hours	T	96%	**95%**	96%	Achieved
	Health target: The number of surgical elective discharges delivered by any DHB for the Wairarapa domiciled population	V	1,912	**1,841**	1,966	Achieved
	The standardised average length of stay for inpatients (days)[l m] - Acute	T	3.56	**3.66**	3.47	Achieved
	Elective		3.22	**3.18**	2.92	Achieved
Quality measures	The percentage of "DNA" (did not attend) appointments for outpatient first specialist assessments	Q	8%[†]	**6%[n]**	7%	Not Achieved
	Māori		18%[†]		14%	Not Achieved
	The number of hospital acquired pressure injuries[o]	Q	13[†]	**0**	7	Not Achieved

Outputs	Measure	Type of Measure	2013/14 Performance	2014/15 Target	2014/15 Performance	2014/15 Achievement
	The rate of falls causing harm per 1,000 bed days	Q	1.9[p]	**<4.8**	1.3	Achieved
	The rate of medication errors causing harm per 1,000 bed days	Q	0.7[q]	**<2.6**	0.4	Achieved
Cancer services	Shorter Waits for Cancer Treatment - The percentage of patients, ready for treatment, who wait less than four weeks for radiotherapy or chemotherapy	T	100%	**100%**	100%	Achieved
	Health target: Faster Cancer Treatment – The percentage of patients who receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks[r]	T	New measure	**85% by June 2016**	68%	Not Achieved
Mental health and addictions services	The number of people accessing secondary mental health services [l]	V	1,921[†]	**1,925**	1,915	Not Achieved
	Māori		535[†]	**545**	527	Not Achieved
	The percentage of patients 0-19 referred to non-urgent mental health services who are seen within eight weeks [l]	T	96%[†]	**95%**	95%	Achieved
	The percentage of patients 0-19 referred to non-urgent addictions services who are seen within eight weeks	T	91%[†]	**95%**	89%	Not Achieved

Comments on performance

Medical and surgical services

Wairarapa DHB has met both the 'Shorter stays in ED' and elective surgery health targets in 2014/15. In addition, the DHB has made significant gains in the average length of stay for both acute and elective admissions and achieved both targets.

Quality measures

Although the target 'Did not attend' (DNA) rates were not met, overall DNA rates for first specialist assessments have decreased by 1% and Māori DNA rates by 4% since 2013/14. The Outpatient services and Māori Health Unit staff are working together to continue the downward trend in DNAs. Initiatives include phone calls, texts and in some cases, transport for patients.

A Pressure Injuries Prevention Group reviews all hospital acquired pressure injuries. Staff are vigilant in reporting pressure areas on admission and during hospital stay. Upon admission, patients are assessed for risk of developing a pressure injury, and appropriate safeguards are put in place to reduce the risk.

To decrease the rate of falls in hospital, Wairarapa DHB uses a Mobility Alert system which identifies patients at risk of a fall. We are working with other DHBs in the Central Region to place mobility assessments on the patient management system.

Wairarapa DHB actively encourages reporting of medication errors as an active way of identifying focus for improvement. The Medicines Committee also reviews medication errors on a monthly basis and follows up any identified trends or 'one offs'. A new Wairarapa & Hutt Valley DHB Medication Management Policy is in draft form and due for release by the end of 2015.

Cancer services

Wairarapa DHB continues to meet the 'Shorter Waits for Cancer Treatment' health target. For the new Faster Cancer Treatment health target, we have an intensive work programme to understand and improve performance on this indicator.

Mental health and addictions services

Although Wairarapa DHB did not meet the target for the number people accessing secondary mental health services, the number of people accessing the service has remained stable from 2013/14 to 2014/15.

The mental health service model is stepped care which has clearer client pathways between and amongst the local services.

OUTPUT CLASS 4: REHABILITATION AND SUPPORT

Description

Rehabilitation and support services provide people with the support that they need to maintain their independence, either temporarily while recovering from illness or disability, or over the rest of their lives. Rehabilitation and support services are provided mostly for older people, mental health clients and clients with complex health conditions. A 'needs assessment', coordinated by Needs Assessment and Service Coordination (NASC), determines which services a person may require. These services may be provided at home as personal care, community nursing, or community services. Alternatively, people may require long- or short-term residential care, respite or day services. Support services also include palliative care services for people who have end-stage conditions. It is important that they and their families are supported so that the person can live comfortably, have their needs met in a holistic and respectful way, and die without undue pain and suffering. Rehabilitation and support services may be delivered in coordination with other organisations and agencies, and may include public, private and part-funding arrangements.

Context

Services that support people to manage their needs and live well, safely and independently in their own homes provide a much higher quality of life, because people stay active and positively connected to their communities. People whose needs are met by these support services are less dependent on hospital and residential services and less likely to experience acute illness or deterioration of their conditions. As a

result, effective support services will help to reduce demand for acute services and improve access to other services and interventions. Support services will have a major impact on the sustainability of hospital and specialist services and on the wider health system in general. It will also free up resources for investment into early intervention, health promotion, and prevention services that will help people stay healthier for longer. Our DHB has taken a restorative approach and has introduced individual packages of care to better meet people's needs, including complex packages of care for people assessed as eligible for residential care who would rather remain in their own homes. With an ageing population, it is vital that our rehabilitation and support services are effective, and that our DHB uses the InterRAI (International Residential Assessment Instrument) tool to ensure that people receive support services that best meet their needs and to support them to regain the most functional independence possible.

Outputs

Health of older people services: These services enable people to live as independently as possible and to restore functional ability. Services are delivered in specialist inpatient units, outpatient clinics and also in home and work environments. Specialist geriatric and allied health expertise and advice is also provided to general practitioners, home and community care providers, residential care facilities and voluntary groups.

Disability services: Many disability services are accessed through a Needs Assessment and Service Co-ordination (NASC) service. NASCs are organisations contracted to the Disability Support Services (DSS), which work with disabled people to identify their needs and to outline what disability support services are available. The DSS allocates Ministry-funded support services and helps people to access other support.

How we measure the performance of our Rehabilitation & Support Services

Outputs	Measure	Type of Measure	2013/14 Performance	2014/15 Target	2014/15 Performance	2014/15 Achievement
Health of older people services	The percentage of people 65+ who have received long term home support services in the last three months who have had a comprehensive clinical [InterRAI] assessment and a completed care plan	Q	76%	**≥95%**[c]	97%	Achieved
	The number of total InterRAI assessments	V	1,749	**850**[s]	494[t]	Not Achieved
	The number of people receiving home and community support services	V	780	**762**[s]	856	Achieved
	The number of days of Short-term Care (respite bed days, day respite, and community day activity support)[u]	V	9,370[†]	**8,073**[s]	9,383	Achieved
	The number of subsidised aged residential care bed days	V	124,694	**71,536**	127,675	Achieved
	The percentage of residential care providers meeting three year certification standards[v]	Q	100%	**100%**	92%	Not Achieved

Outputs	Measure	Type of Measure	2013/14 Performance	2014/15 Target	2014/15 Performance	2014/15 Achievement
Disability services	The number of Disability Forum meetings (sub-regional and local)	V	2	**2**	4	Achieved

Comments on performance

Health of older people services

The percentage of older people with long-term support needs who have had an interRAI assessment target was achieved, having increased by 21% between 2013/14 and 2014/15. The actual number of assessments is dependent on the needs of the older population so this measure is descriptive rather than aspirational.

While the number of subsidised bed days in long term care has risen (by 2%), so has the number of people receiving services supporting them to live at home (10%). The level of support for carers has remained constant.

There is one residential care provider in Wairarapa that has a two year certification. Two facilities (15%) have four year certification and the remaining have three year certification.

Disability services

Our priority in 2014/15 has been engagement with the local community. Wairarapa DHB was part of four sub-regional and local Disability Forum meetings in 2014/15. This engagement has helped us to improve the partnership between staff and communities in service development and planning.

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[a] ABC for Smoking Cessation Quick Reference Card, PHARMAC.

[b] Plunket data only for exclusive, full and partial breastfeeding.

[c] National target.

[d] Baselines (2013) and targets (2014) for Yr 7 Boostrix and Yr 8 HPV immunisations are for the calendar year to align with school year.

[e] New measure that was not in the Wairarapa DHB 2014/15 Annual Plan.

[f] Wairarapa DHB records show that we 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.

[g] This rate is higher than 100% because there were number of children that received screening was greater than the count of eligible children provided by Ministry of Health.

[h] Data from National Screening Unit for breast and cervical screening. Targets aligned to national targets. Baseline for cervical screening for 3 years to 30 June 2013.

[i] As at 1 July 2014 (2013/14 baseline) and 1 July 2015 (2014/15 performance).

[j] The ratio (high need: non-high need) of standardised GP and nurse utilisation rate. This measures equity of access, as those with high needs are likely to require more visits.

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

[l] This measure is provided by the Ministry of Health one quarter in arrears, so performance is for 12 months ending March 2014 (2013/14 baseline) and 12 months ending March 2015 (2014/15 performance).

[m] Standardised to diagnosis-related group (DRG) and co-morbidity/complication codes. See the Ministry of Health website (www.moh.govt.nz) for more information about how this is calculated.

[n] This is a long-term target.

[o] This measure has been updated from 'The number of hospital acquired pressure sores and ulcers' to reflect new terminology. The methodology for the measure remains the same.

[p] Performance on this measure was incorrectly reported as 2.2 per 1,000 bed days in the 2013/14 Annual Report. The 2013/14 Performance has been amended here.

[q] Performance on this measure was incorrectly reported as 3.3 per 1,000 bed days in the 2013/14 Annual Report. The 2013/14 Performance has been amended here.

[r] This is a new measure that replaced the 'Shorter Waits for Cancer Treatment' health target from 1 October 2014.

[s] This is a descriptive measure of volumes only and is not the focus for service improvement or improving health status.

[t] Note that there have been changes in the recording and reporting of the number of InterRAI assessments. The methodology for 2014/15 gives an underestimate of performance compared to the methodology for the target.

[u] Only includes volume paid as fee for service and excludes bulk-funded dedicated respite beds (2 beds in Wairarapa).

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

[†] These measures were introduced in 2014/15 and did not appear in the 2013/14 Annual Report. Our 2013/14 performance has therefore not been audited by Audit New Zealand.

FINANCIAL STATEMENTS

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STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSE

For the year ended 30 June 2015

	Note	Group Budget 2015 $000	Group Actual 2015 $000	Group Actual 2014 $000	Parent Actual 2015 $000	Parent Actual 2014 $000
Revenue						
Operating revenue	1	138,344	139,968	137,628	138,855	136,471
Finance revenue	2	106	176	145	199	168
Total revenue		**138,450**	**140,144**	**137,773**	**139,054**	**136,639**
Expenditure						
Workforce costs	3	36,649	41,610	40,889	41,610	40,889
Other operating expenses	4a	25,018	22,793	22,507	21,807	21,470
External providers	4b	46,854	45,705	45,272	45,705	45,272
Inter district flows	4b	27,795	29,819	27,262	29,819	27,262
Total operating expenditure		**136,316**	**139,927**	**135,930**	**138,941**	**134,893**
Operating result before Interest, Depreciation & Capital Charge		**2,134**	**217**	**1,843**	**113**	**1,746**
Interest, Depreciation & Capital Charge						
Interest expense	5	1,191	1,187	1,169	1,187	1,169
Capital charge	5	720	629	297	629	297
Depreciation & amortisation expense	7,8	1,714	1,737	1,783	1,652	1,700
Total Interest, Depreciation & Capital Charge		**3,625**	**3,553**	**3,249**	**3,468**	**3,166**
Surplus/(Deficit)		**(1,491)**	**(3,336)**	**(1,406)**	**(3,355)**	**(1,420)**
Total comprehensive revenue and expense		(1,491)	(3,336)	(1,406)	(3,355)	(1,420)

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 2015

	Note	Group Budget 2015 $000	Group Actual 2015 $000	Group Actual 2014 $000	Parent Actual 2015 $000	Parent Actual 2014 $000
Assets						
Property, plant & equipment	7a	43,751	40,838	42,003	40,712	41,869
Intangible assets	8	765	4,455	1,722	4,442	1,713
Investments	9	2,924	807	2,760	910	2,863
Total non-current assets		**47,440**	**46,100**	**46,485**	**46,064**	**46,445**
Cash & cash equivalents	10	296	334	318	11	5
Inventories	11	800	797	744	797	744
Trade & other receivables	12	4,583	3,511	5,444	3,349	5,317
Total current assets		**5,679**	**4,642**	**6,506**	**4,157**	**6,066**
Total assets		**53,119**	**50,743**	**52,991**	**50,221**	**52,511**

	Note	Group Budget 2015 $000	Group Actual 2015 $000	Group Actual 2014 $000	Parent Actual 2015 $000	Parent Actual 2014 $000
Equity						
Crown equity	13	39,030	39,037	39,040	39,037	39,040
Revaluation reserve	13	5,558	5,558	5,558	5,558	5,558
Retained earnings	13	(36,321)	(38,150)	(34,814)	(38,522)	(35,167)
Total equity		**8,267**	**6,445**	**9,784**	**6,073**	**9,431**
Liabilities						
Interest-bearing loans & borrowings	14	24,950	21,126	20,194	21,126	20,194
Employee benefits	15	650	563	481	563	481
Trust funds	16	260	266	258	266	258
Total non-current liabilities		**25,860**	**21,955**	**20,933**	**21,955**	**20,933**
Cash & cash equivalents - overdraft	10	4,583	1,510	812	1,510	812
Interest-bearing loans & borrowings	14	1,310	5,069	6,064	5,069	6,064
Payables & accruals	17	7,053	9,882	9,888	9,813	9,817
Employee benefits	15	6,046	5,882	5,510	5,801	5,454
Total current liabilities		**18,992**	**22,343**	**22,274**	**22,193**	**22,147**
Total liabilities		**44,852**	**44,298**	**43,207**	**44,148**	**43,080**
Total equity & liabilities		**53,119**	**50,743**	**52,991**	**50,221**	**52,511**

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 2015

	Note	Group Budget 2015	Group Actual 2015 $000	Group Actual 2014 $000	Parent Actual 2015 $000	Parent Actual 2014 $000
Balance at 1 July		**9,758**	**9,784**	**11,193**	**9,431**	**10,854**
Net surplus / (deficit) for the year		(1,491)	(3,336)	(1,406)	(3,355)	(1,420)
Other comprehensive revenue and expense		0	0	0	0	0
Total comprehensive revenue and expense		(1,491)	(3,336)	(1,406)	(3,355)	(1,420)
Repayment of equity to the Crown		0	(3)	(3)	(3)	(3)
Movements in equity for the year		0	**(3)**	**(3)**	**(3)**	**(3)**
Balance at 30 June	13	**8,267**	**6,445**	**9,784**	**6,073**	**9,431**

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 2015

	Note	Group Budget 2015 $000	Group Actual 2015 $000	Group Actual 2014 $000	Parent Actual 2015 $000	Parent Actual 2014 $000
Cash flows from operating activities						
Operating receipts:						
Government & crown agency revenue		127,786	139,912	132,110	138,656	132,110
Other		9,496	3,962	3,634	3,937	3,610
Interest received		107	181	150	179	150
Payments to suppliers & employees		(138,970)	(141,385)	(133,061)	(140,218)	(133,078)
Capital charge paid		(720)	(629)	(763)	(629)	(763)
Interest paid		(1,191)	(1,187)	(1,172)	(1,187)	(1,172)
Goods and Services Tax (net)		0	(44)	29	(44)	29
Net cash flows from operating activities	10	**(3,492)**	**810**	**927**	**694**	**886**
Cash flows from investing activities						
Proceeds from sale of property, plant & equipment		0	0	25	0	25
Dividends received		0	0	0	25	24
Investment in joint venture		(2,371)	(752)	0	(752)	0
Acquisition of property, plant & equipment		(1,001)	(394)	(171)	(331)	(171)
Acquisition of intangible assets		(244)	(283)	(345)	(265)	(345)
Net cash flows from investing activities		**(3,616)**	**(1,429)**	**(491)**	**(1,323)**	**(467)**

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

STATEMENT OF CASH FLOWS (CONTINUED)

For the year ended 30 June 2015

	Note	Group Budget 2015 $000	Group Actual 2015 $000	Group Actual 2014 $000	Parent Actual 2015 $000	Parent Actual 2014 $000
Cash flows from financing activities						
Equity injected		4,750	0	0	0	0
Repayments of loans		0	(60)	(58)	(60)	(58)
Repayment of equity		0	(3)	(3)	(3)	(3)
Net cash flows from financing activities		4,750	**(63)**	(61)	**(63)**	(61)
Net increase / (decrease) in cash held		**(896)**	**(682)**	**375**	**(692)**	**358**
Cash & cash equivalents at beginning of year		(3,682)	(494)	(869)	(807)	(1,165)
Cash & cash equivalents at end of year	**10**	**(4,578)**	**(1,176)**	**(494)**	**(1,499)**	**(807)**

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 2015

	Group Actual 2015 $000	Group Actual 2014 $000	Parent Actual 2015 $000	Parent Actual 2014 $000
Legal proceedings and obligations	0	0	0	0
Total contingent liabilities	**0**	**0**	**0**	**0**
Total contingent assets	**0**	**0**	**0**	**0**

STATEMENT OF COMMITMENTS

As at 30 June 2015

	Group Actual 2015 $000	Group Actual 2014 $000	Parent Actual 2015 $000	Parent Actual 2014 $000
Capital Commitments				
Buildings	0	211	0	211
Clnical equipment	86	0	86	0
Other equipment	8	0	8	0
Intangible assets	3	14	**3**	14
Total capital commitments	**97**	**225**	**97**	**225**
Operating Lease Commitments:				
Less than one year	741	902	741	902
One to two years	356	470	356	470
Two to five years	461	440	461	440
Five years	207	259	207	259
	1,765	**2,071**	**1,765**	**2,071**
Total Commitments	**1,862**	**2,296**	**1,862**	**2,296**

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 has designated itself as a public benefit entity (PBE) for financial reporting purposes.

The consolidated financial statements of Wairarapa DHB for the year ended 30 June 2015 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 30 October 2015.

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.

The financial statements have been prepared in accordance with Tier 1 PBE accounting standards.

These financial statements are the first financial statements arising on transition to the new PBE accounting standards. There are no material adjustments arising from this transition.

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.

Critical accounting estimates and assumptions

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 2014/15 financial statements, and to circumstances which it knows will occur after that date which could affect the validity of the going concern assumption (as set out in its current Statement of Intent). The key considerations are set out below.

Letter of comfort

The Board has received a letter of comfort dated 22 October 2015 from the Ministers of Health and Finance which states that deficit support will be provided where necessary to maintain viability.

Operating and cash flow forecasts

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

Borrowing covenants and forecast borrowing requirements

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

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

If the DHB was unable to continue as a going concern adjustments may have to be made to reflect the situation that assets may have to be realised and liabilities extinguished other than in the normal course of business and at amounts which could differ significantly from the amounts at which they are currently reported in the statement of financial position.

Changes in accounting policies

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

Standards issued and not yet effective and not early adopted

In May 2013, the External Reporting Board issued a new suite of PBE accounting standards for application by public sector entities for reporting periods beginning on or after 1 July 2014. WDHB has applied these standards in preparing the 30 June 2015 financial statements.

In October 2014, the PBE suite of accounting standards was updated to incorporate requirements and guidance for the not-for-profit sector. These updated standards apply to PBEs with reporting periods beginning on or after 1 April 2015. WDHB will apply these updated standards in preparing its 30 June 2016 financial statements. WDHB expects there will be minimal or no change in applying these updated accounting standards.

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 and Statement of Performance Expectations tabled in Parliament.

The budget figures have been prepared in accordance with NZGAAP. Those standards are consistent with the accounting policies adopted by WDHB for the preparation of these financial statements.

Goods and services tax

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

The net amount of GST recoverable from, or payable to, the IRD is included as part of receivables or payables in the statement of financial position.

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

Commitments and Contingencies

Commitments and Contingencies are disclosed exclusive of GST.

Revenue

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

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

Crown funding

The vast majority of revenue is provided through an appropriation in association with a Crown Funding Agreement. Revenue received is restricted in its use for the purpose of the DHB meeting its objectives. Revenue is recognised monthly in accordance with the Crown Funding Agreement payment schedule, which allocates the appropriation equally throughout the year.

ACC contracted revenue

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

Revenue for other DHBs

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

Interest 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.

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 and equipment

Classes of property, plant and equipment

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

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

Owned assets

Revaluation

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

Land and buildings are revalued to fair value as determined by an independent registered valuer with sufficient regularity to ensure the carrying amount is not materially different to fair value, and at least every five years. Any increase in value of a class of land and buildings is recognised directly to equity unless it offsets a previous decrease in value recognised in the statement of comprehensive 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 revenue and expense.

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

Additions

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

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

Property, plant and equipment vested from the hospital and health service

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

Disposal of property, plant and equipment

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

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 revenue and expense as an expense as incurred.

Depreciation

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

Class of asset	Estimated life	Depreciation Rates
Buildings (including components)	2 to 50 years	2% - 50%
Clinical equipment	2.5 to 15 years	6.67% - 40%
Information technology	2.5 to 15 years	6.67% - 40%
Motor vehicles	5 to 12.5 years	8% - 20%
Other plant and equipment	2.5 to 15 years	6.67% - 40%

The residual value of assets is reassessed annually.

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

Intangible assets

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

Subsequent expenditure

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

Amortisation

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

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

The amortisation charge for each year is recognised in the surplus or deficit.

Impairment

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

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

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

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

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

Calculation of recoverable amount

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

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

For non-cash generating assets that are not part of a cash generating unit value in use is based on depreciated replacement cost (DRC). For cash generating assets value in use is determined by estimating future cash flows from the use and ultimate disposal of the asset and discounting these to their present value using a pre-tax discount rate that reflects current market rates and the risks specific to the asset.

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

Reversals of impairment

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

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

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

Investments

Investments, including those in subsidiary and associated companies, are stated at 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 including Kiwisaver are recognised as an expense in the statement of comprehensive revenue and expense as incurred.

Defined benefit schemes

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

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

All actuarial gains and losses as at 1 July 2006, the date of transition to NZIFRSs, were recognised. Likewise, all actuarial gains and losses that arise subsequent to the transition date in calculating 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 2015 valuation are based on the weighted average of bond yields such that the estimated term of the bonds is consistent with the estimated term of the liabilities. This approach is consistent with the requirements of PBE IPSAS 25.

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

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

Provisions

A provision is recognised for future expenditure of uncertain amount or timing when there is a present obligation (either legal or constructive) as a result of a past event, it is probable that an outflow of future economic benefits will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation.

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

Restructuring

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

Creditors and other payables

Trade and other payables are stated at amortised cost using the effective interest rate. Short term payables are recorded at their face value.

Cost of service statements

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

Cost allocation

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

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

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

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

NOTES TO THE FINANCIAL STATEMENTS

1 OPERATING INCOME

	Group Actual 2015 $000	Group Actual 2014 $000	Parent Actual 2015 $000	Parent Actual 2014 $000
Health & disability services (MOH contracted revenue)	129,591	127,061	129,591	127,061
Inter district patient inflows	3,343	3,557	3,343	3,557
ACC contract	2,063	2,181	2,063	2,181
Donations & bequests	151	21	151	21
Other income	4,820	4,807	3,707	3,650
Total operating income	**139,968**	**137,628**	**138,855**	**136,471**

2 FINANCE INCOME

	Group Actual 2015 $000	Group Actual 2014 $000	Parent Actual 2015 $000	Parent Actual 2014 $000
Interest income	181	150	179	149
Dividend income	0	0	25	24
Gain/(Loss) on disposal of property, plant & equipment	(5)	(5)	(5)	(5)
Total finance income	**176**	**145**	**199**	**168**

3 WORKFORCE COSTS

	Group Actual 2015 $000	Group Actual 2014 $000	Parent Actual 2015 $000	Parent Actual 2014 $000
Wages & salaries	36,855	34,938	36,855	34,938
Payments to contracted workforce	4,326	5,903	4,326	5,903
Increase/(decrease) in liability for employee entitlements	429	48	429	48
Total workforce costs	**41,610**	**40,889**	**41,610**	**40,889**

4 OTHER EXPENSES

4a Other operating costs

Operating lease expenses

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

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

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

	Group Actual 2015 $000	Group Actual 2014 $000	Parent Actual 2015 $000	Parent Actual 2014 $000
Outsourced services	4,305	4,528	4,305	4,491
Clinical supplies	9,013	8,286	9,013	8,286
Operating lease expenses	1,448	1,444	1,414	1,409
Audit fees (for the audit of the financial statements)	114	113	112	102
Audit fees (for other assurance services)	48	12	48	12
Impairment of trade receivables (bad & doubtful debts)	(5)	(46)	(5)	(46)
Board member fees & expenses	231	249	225	243
Other operating expenses	7,639	7,921	6,695	6,973
Total other operating expenses	**22,793**	**22,507**	**21,807**	**21,470**

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 2015 $000	Group Actual 2014 $000	Parent Actual 2015 $000	Parent Actual 2014 $000
Payments to non-health board providers	45,705	45,272	45,705	45,272
Inter-District Flow payments to other DHBs	29,819	27,262	29,819	27,262

5 FINANCE COSTS

	Group Actual 2015 $000	Group Actual 2014 $000	Parent Actual 2015 $000	Parent Actual 2014 $000
Interest expense	1,187	1,169	1,187	1,169
Capital charge	629	297	629	297
Total finance costs	**1,816**	**1,466**	**1,816**	**1,466**

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 2015 was 8% (2014 – 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)	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 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)
Revaluation increase	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**
Balance at 1 July 2014	2,435	37,430	6,847	2,523	922	857	28	51,042
Additions	0	16	249	90	36	10	22	423
Disposals	0	0	(40)	(10)	0	(23)	(50)	(123)
Revaluation increase	0	0	0	0	0	0	0	0
Balance at 30 June 2015	**2,435**	**37,446**	**7,056**	**2,603**	**958**	**844**	**0**	**51,342**

(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
Accumulated Depreciation & impairment losses								
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
Elimination on disposal		0	(3)	(46)	(9)	(19)		(77)
Elimination on revaluation		0	0	0	0	0		0
Balance at 30 June 2014		**784**	**5,017**	**2,062**	**772**	**404**		**9,039**
Balance at 1 July 2014		784	5,017	2,062	772	404		9,039
Depreciation charge for the year		784	448	182	49	71		1,534
Elimination on disposal		0	(35)	(10)	(1)	(23)		(69)
Elimination on revaluation		0	0	0	0	0		0
Balance at 30 June 2015		**1,568**	**5,430**	**2,234**	**820**	**452**		**10,504**

Group

	Land (at valuation)	Buildings (at valuation)	Clinical equipment	Other equipment	Information technology	Motor vehicles	Work in progress	Total
Carrying amounts								
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**
At 1 July 2014	2,435	36,646	1,830	461	150	453	28	42,003
At 30 June 2015	**2,435**	**35,878**	**1,626**	**369**	**139**	**392**	**0**	**40,838**

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

Parent

	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 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)
Revaluation increase	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**
Balance at 1 July 2014	2,435	37,430	6,847	1,784	885	758	28	50,167
Additions	0	16	249	49	21	0	22	357
Disposals	0	0	(40)	(2)	0	(9)	(50)	(101)
Revaluation increase	0	0	0	0	0	0	0	0
Balance at 30 June 2015	**2,435**	**37,446**	**7,056**	**1,831**	**906**	**749**	**0**	**50,423**

Parent	Land (at valuation)	Buildings (at valuation)	Clinical equipment	Other equipment	Information technology	Motor vehicles	Work in progress	Total
Accumulated Depreciation & impairment losses								
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
Depreciation charge discontinued operat		0	0	0	0	0		0
Impairment losses		0	0	0	0	0		0
Elimination on disposal		0	(3)	(2)	0	(5)		(10)
Elimination on revaluation		0	0	0	0	0		0
Balance at 30 June 2014		**784**	**5,017**	**1,440**	**737**	**320**		**8,298**
Balance at 1 July 2014		784	5,017	1,440	737	320		8,298
Depreciation charge for the year		784	448	119	48	60		1,459
Impairment losses		0	0	0	0	0		0
Elimination on disposal		0	(35)	(2)	0	(9)		(46)
Elimination on revaluation		0	0	0	0	0		0
Balance at 30 June 2015		**1,568**	**5,430**	**1,557**	**785**	**371**		**9,711**

Parent	Land (at valuation)	Buildings (at valuation)	Clinical equipment	Other equipment	Information technology	Motor vehicles	Work in progress	Total
Carrying amounts								
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**
At 1 July 2014	2,435	36,646	1,830	344	148	438	28	41,869
At 30 June 2015	**2,435**	**35,878**	**1,626**	**274**	**121**	**378**	**0**	**40,712**

Revaluation

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

Land

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

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

Buildings

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

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

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

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

Restrictions

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

7b Assets classified as held for sale

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			
Balance at 1 July 2013	1,811	506	2,317
Additions	414	51	465
Disposals	(43)	0	(43)
Balance at 30 June 2014	**2,182**	**557**	**2,739**
Balance at 1 July 2014	2,182	557	2,739
Additions	42	2,921	2,963
Disposals	0	(27)	(27)
Balance at 30 June 2015	**2,224**	**3,451**	**5,675**

Group	Intangible Assets	Work in progress	Total
Accumulated amortisation & impairment losses			
Balance at 1 July 2013	864		864
Amortisation charge for the y	196		196
Impairment losses	0		0
Disposals	(43)		(43)
Balance at 30 June 2014	**1,017**		**1,017**
Balance at 1 July 2014	1,017		1,017
Amortisation charge for the y	203		203
Impairment losses	0		0
Elimiation on disposal	0		0
Balance at 30 June 2015	**1,220**		**1,220**

Group	Intangible Assets	Work in progress	Total
Carrying amounts			
At 1 July 2013	947	506	1,453
At 30 June 2014	**1,165**	**557**	**1,721**
At 1 July 2014	1,165	557	1,722
At 30 June 2015	**1,004**	**3,451**	**4,455**

Parent	Intangible Assets $000	Work in progress $000	Total $000
Cost			
Balance at 1 July 2013	1,725	506	2,231
Additions	411	51	462
Disposals	0	0	0
Balance at 30 June 2014	**2,136**	**557**	**2,693**
Balance at 1 July 2014	2,136	557	2,693
Additions	28	2,921	2,949
Disposals	0	(27)	(27)
Balance at 30 June 2015	**2,164**	**3,451**	**5,615**

Parent	Intangible Assets	Work in progress	Total
Accumulated amortisation & impairment losses			
Balance at 1 July 2013	785		785
Amortisation charge for the y	195		195
Impairment losses	0		0
Disposals	0		0
Balance at 30 June 2014	**980**		**980**
Balance at 1 July 2014	980		980
Amortisation charge for the y	193		193
Impairment losses	0		0
Disposals	0		0
Balance at 30 June 2015	**1,173**		**1,173**

Parent	Intangible Assets	Work in progress	Total
Carrying amounts			
At 1 July 2013	940	506	1,446
At 30 June 2014	**1,155**	**557**	**1,713**
At 1 July 2014	1,156	557	1,713
At 30 June 2015	**991**	**3,451**	**4,442**

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

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 (2014 – 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 2015 $000	Group Actual 2014 $000	Parent Actual 2015 $000	Parent Actual 2014 $000
Investment in subsidiary	0	0	103	103
Investment in joint ventures	541	2,502	541	2,502
Trust funds invested	266	258	266	258
Total investments	**807**	**2,760**	**910**	**2,863**

Investment in joint ventures

Central Region's Technical Advisory Services Limited (CRTAS)

WDHB, in conjunction with the five other district health boards in the central region (Capital & Coast DHB, Hutt DHB, MidCentral DHB, Whanganui DHB and Hawkes Bay DHB), have embarked on a collaborative effort to implement the 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

During 2015 Wairarapa DHB and the other DHBs involved in the CRISP project signed a variation to the original agreement regarding investment in CRISP. It was agreed that investments in CRTAS would no longer be for the acquisition of Class B Redeemable Preference Shares. The capital payments to TAS for the CRISP project have been reclassified as Work in Progress as at 30 June 2015 as all partners in the CRISP project are to share ownership of the intangible assets resulting from CRISP. WDHB had treated the initial contributions as Investments in the financial statements to 30 June 2014. These have now been reclassified as Work in Progress.

Health Benefits Limited

At 30 June 2015, the DHB had made payments totalling $541,000 (2014: Nil) to HBL in relation to the Finance, Procurement and Supply Chain ("FPSC") programme, which was in progress at year end. This is a national initiative facilitated by HBL. In return for these payments, the DHB gains FPSC rights. These FPSC rights have been tested for impairment by comparing the carrying amount of the intangible asset to its depreciated replacement cost (DRC), which is considered to equate to the DHB's share of the DRC of the underlying FPSC assets. HBL was wound up at 30 June 2015 and the roles and rights of this company were taken up by a new DHB controlled entity.

All assets and liabilities of HBL transferred on 1 July 2015, by way of an Order in Council pursuant to section 5 of the Health Sector (Transfers) Act 1993, to a new entity NZ Health Partnerships Limited (NZHP). NZHP is a multi-parent crown subsidiary owned by all 20 DHBs with equal Class A shareholding and voting rights.

The principle function of NZHP will be to continue the development and implementation of the four current business cases – Finance Procurement and Supply Chain, National Infrastructure Platform, Food Services and Linen and Laundry Services, as well as ongoing management of the shared banking and insurance arrangements.

It is expected that the final costs of the FPSC programme will exceed the original budget. HBL is undertaking an exercise to determine the revised costs of the programme and following this, formal approval to proceed will be required from the DHBs. The current expectation of the Board is that the FPSC programme will proceed as originally planned. In this scenario, the DRC of the FPSC rights is considered to equate, in all material respects, to the costs capitalised to date such that the FPSC rights are not impaired. However, the future of the FPSC programme is uncertain and any future decision to re-scope or discontinue the FPSC programme will require a reassessment of the recoverable amount (ie DRC) of the FPSC rights.

10 CASH & CASH EQUIVALENTS

	Group Actual 2015 $000	Group Actual 2014 $000	Parent Actual 2015 $000	Parent Actual 2014 $000
Short term deposits	124	313	0	0
Cash & cash equivalents	210	5	11	5
Bank overdraft	(1,510)	(812)	(1,510)	(812)
Total cash & cash equivalents	**(1,176)**	**(494)**	**(1,499)**	**(807)**

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 2015 $000	Group Actual 2014 $000	Parent Actual 2015 $000	Parent Actual 2014 $000
Net surplus/(deficit)	**(3,336)**	**(1,406)**	**(3,355)**	**(1,420)**
Add/(less) non-cash items:				
Depreciation & amortisation	1,732	1,781	1,652	1,700
Increase/(decrease) employee benefits (non-current)	82	(70)	82	(70)
Add/(less) items classified as investment activity:				
Net loss/(gain) on sale of property, plant & equipment	6	5	5	5
Dividends received	0	0	(25)	(24)
Add/(less) movements in working capital items:				
(Increase)/decrease in receivables	1,899	(1,197)	1,968	(1,241)
(Increase) / decrease in inventories	(53)	19	(53)	19
(Decrease) in payables & accruals	480	1,795	420	1,917
Net cash flow from operating activities	**810**	**927**	**694**	**886**

11 INVENTORIES

	Group Actual 2015 $000	Group Actual 2014 $000	Parent Actual 2015 $000	Parent Actual 2014 $000
Central stores	217	197	217	197
Pharmaceuticals	108	96	108	96
Theatre supplies	301	283	301	283
Other supplies	171	168	171	168
Total inventories	**797**	**744**	**797**	**744**

Write-down of inventories amounted to nil for 2015 (2014 – nil). The amount of inventories recognised as an expense during the year ended 30 June 2015 was nil (2014 – 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 2015 $000	Group Actual 2014 $000	Parent Actual 2015 $000	Parent Actual 2014 $000
Trade debtors	3,330	5,290	3,166	5,155
Provision for doubtful debts	(78)	(89)	(78)	(89)
Prepayments	259	243	259	243
Amount owing by subsidiary	0	0	2	8
Total trade & other receivables	**3,511**	**5,444**	**3,349**	**5,317**
Receivables from the sale of goods and services (exchange transactions)	602	965	438	838
Receivables from non- exchange transactions	2,910	4,479	2,911	4,479
Total trade & other receivables	**3,511**	**5,444**	**3,349**	**5,317**

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

13 EQUITY

Group	Crown equity $000	Property revaluation reserve $000	Retained earnings $000	Total $000
Balance at 1 July 2013	39,043	5,558	(33,408)	11,193
Total recognised income & expenses	0	0	(1,406)	(1,406)
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**
Balance at 1 July 2014	39,040	5,558	(34,814)	9,784
Total recognised income & expenses	0	0	(3,336)	(3,336)
Contribution (net) from the Crown	(3)	0	0	(3)
Movement in revaluation of land & buildings	0	0	0	0
Balance at 30 June 2015	**39,037**	**5,558**	**(38,150)**	**6,445**

Parent	Crown equity $000	Property revaluation reserve $000	Retained earnings $000	Total $000
Balance at 1 July 2013	39,043	5,558	(33,747)	10,854
Total recognised income & expenses	0	0	(1,420)	(1,420)
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**
Balance at 1 July 2014	39,040	5,558	(35,167)	9,431
Total recognised income & expenses	0	0	(3,355)	(3,355)
Contribution (net) from the Crown	(3)	0	0	(3)
Movement in revaluation of land & buildings	0	0	0	0
Balance at 30 June 2015	**39,037**	**5,558**	**(38,522)**	**6,073**

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 2015 $000	Group Actual 2014 $000	Parent Actual 2015 $000	Parent Actual 2014 $000
Non current liabilities				
Privately sourced loans	376	444	376	444
Crown sourced loans	20,750	19,750	20,750	19,750
Total non current interest-bearing loans & borrowing	**21,126**	**20,194**	**21,126**	**20,194**
Current liabilities				
Privately sourced loans	69	64	69	64
Crown sourced loans	5,000	6,000	5,000	6,000
Total current interest-bearing loans & borrowings	**5,069**	**6,064**	**5,069**	**6,064**

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 2015. 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 $5,000,000 that was refinanced with the NHB on 15 April 2016.

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
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 $26,340,000.

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 and repayment schedule applicable to the interest-bearing loans & borrowings are shown below.

	Group Actual 2015 $000	Group Actual 2014 $000	Parent Actual 2015 $000	Parent Actual 2014 $000
Ministry of Health				
Interest rate summary	4.00%	4.61%	4.00%	4.61%
Repayable as follows:				
Less than one year	5,000	6,000	5,000	6,000
One to two years	1,250	5,000	1,250	5,000
Greater than two years	19,500	14,750	19,500	14,750
	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	69	64	69	64
One to two years	74	69	74	69
Greater than two years	302	375	302	375
	445	**508**	**445**	**508**

15 EMPLOYEE BENEFITS

	Group Actual 2015 $000	Group Actual 2014 $000	Parent Actual 2015 $000	Parent Actual 2014 $000
Non current liabilities				
Liability for long service leave	244	223	244	223
Liability for retirement gratuities	319	258	319	258
Total non current employee benefits	**563**	**481**	**563**	**481**
Current liabilities				
Liability for long service leave	420	410	420	410
Liability for retirement gratuities	170	124	168	122
Liability for sabbatical leave	50	25	50	25
Liability for continuing medical education leave	225	200	225	200
Liability for maternity grant	39	13	39	13
Liability for annual leave	3,671	3,604	3,605	3,550
Liability for sick leave	93	80	93	80
Salary & wages accrual	1,214	1,054	1,201	1,054
Total current employee benefits	**5,882**	**5,510**	**5,801**	**5,454**

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 3.1% for long service leave (2014: 4.2%) and 3.2% for retirement gratuities (2014: 4.4%) and a salary increase assumption of 1% (2014: 1%) 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 2015 $000	Group Actual 2014 $000	Parent Actual 2015 $000	Parent Actual 2014 $000
Balance at beginning of year	258	259	258	259
Funds received	59	19	59	19
Interest received	6	5	6	5
Funds spent	(57)	(25)	(57)	(25)
Balance at end of year	**266**	**258**	**266**	**258**

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

Payables under exchange transactions

	Group Actual 2,015 $000	Group Actual 2,014 $000	Parent Actual 2,015 $000	Parent Actual 2,014 $000
Trade creditors & accruals	3,564	3,843	3,478	3,754
Capital charge payable	0	0	0	0
Income received in advance	13	0	13	0
Amount owing to subsidiary	0	0	17	18
Total payables & accruals	**3,577**	**3,843**	**3,508**	**3,772**

Payables under non-exchange transactions

	Group Actual 2015 $000	Group Actual 2014 $000	Parent Actual 2015 $000	Parent Actual 2014 $000
Trade creditors & accruals	5,247	5,113	5,248	5,113
Capital charge payable	0	0	0	0
GST & other taxes payable	992	932	992	932
Income received in advance	66	0	66	0
Amount owing to subsidiary	0	0	0	0
Total payables & accruals	**6,305**	**6,045**	**6,305**	**6,045**
Total payables & accruals	**9,882**	**9,888**	**9,814**	**9,817**

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

18 FINANCIAL INSTRUMENTS

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

Liquidity risk

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

Cash flow interest rate risk

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

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

Currency risk

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

Forward foreign exchange contracts

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

Price risk

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

Fair value interest rate risk

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

Credit risk

Credit risk is the risk that a third party will default on its obligation to WDHB causing it to incur a loss. Due to the timing of its cash inflows and cash outflows, WDHB invests surplus cash with registered banks.

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

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

Group	**Actual 2015 $000 Gross**	**Actual 2015 $000 Impairment**	**Actual 2015 $000 Net**	**Actual 2014 $000 Gross**	**Actual 2014 $000 Impairment**	**Actual 2014 $000 Net**
Not past due	3,077	0	3,077	5,029	0	5,029
Past due 1-30 days	100	0	100	(41)	5	(36)
Past due 31-60 days	24	(10)	14	136	(24)	112
Past due 61-90 days	0	0	0	0	0	0
Past due > 90 days	114	(68)	46	202	(70)	132
Total	**3,315**	**(78)**	**3,237**	**5,326**	**(89)**	**5,237**

Parent	**Actual 2015 $000 Gross**	**Actual 2015 $000 Impairment**	**Actual 2015 $000 Net**	**Actual 2014 $000 Gross**	**Actual 2014 $000 Impairment**	**Actual 2014 $000 Net**
Not past due	2,928	0	2,928	4,860	0	4,860
Past due 1-30 days	100	0	100	(41)	5	(36)
Past due 31-60 days	24	(10)	14	134	(24)	110
Past due 61-90 days	0	0	0	0	0	0
Past due > 90 days	114	(68)	46	202	(70)	132
Total	**3,166**	**(78)**	**3,088**	**5,155**	**(89)**	**5,066**

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 2015 $000	Actual 2014 $000
Balance at 1 July	89	141
Additional provisions made/(provisions released)	(15)	(58)
Receivables written off	4	6
Total	**78**	**89**

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

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

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

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

	Actual 2015 $000	Actual 2014 $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	334	318
Debtors and other receivables	3,512	5,444
Investments	807	2,760
Total loans and receivables	**4,653**	**8,522**
Financial liabilities measured at amortised cost:		
Creditors and other payables (excluding income in advance and GST)	3,564	9,033
Borrowings - MOH loans	25,750	25,750
Borrowings - Privately sourced loans	445	508
Total financial liabilities measured at amortised cost	**29,759**	**35,291**

Capital management

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

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

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

Sensitivity analysis

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

If the interest base rate change by plus or minus 0.5% (2014 0.5%) the effect would have been to increase/(decrease) other comprehensive revenue and expense by $20,000 (2014 $17,000)

Credit quality of financial assets

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

Wairarapa DHB credit quality information follows:

	Actual 2015 $000	Actual 2014 $000
Counterparties with credit ratings		
Cash and cash equivalents and trust fund assets:		
AA	(910)	(236)
AA-	0	0
Total cash and cash equivalents and trust fund assets	**(910)**	**(236)**
Counterparties without credit ratings		
Debtors and other receivables:		
Existing counterparty with no defaults in the past	3,511	5,444
Existing counterparty with defaults in the past	0	0
Total debtors and other receivables	**3,511**	**5,444**

Group	Held for trading	Designated at fair value through profit & loss	Loans and receivables	Available for sale	Other amortised cost	Carrying amount	Fair value
	2015 $000	2015 $000	2015 $000	2015 $000	2015 $000	2015 $000	2015 $000
Investments					807	807	807
Trade and other receivables			3,513			3,513	3,513
Cash and cash equivalents			334			334	334
Crown sourced loans					25,750	25,750	26,474
Privately sourced loans					445	445	445
Trade and other payables					9,792	9,792	9,792

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 $000	2014 $000	2014 $000	2014 $000	2014 $000	2014 $000	2014 $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					9,888	9,888	9,888

Parent	Held for trading	Designated at fair value through profit & loss	Loans and receivables	Available for sale	Other amortised cost	Carrying amount	Fair value
	2015 $000	2015 $000	2015 $000	2015 $000	2015 $000	2015 $000	2015 $000
Investments					910	910	910
Trade and other receivables			3,427			3,427	3,427
Cash and cash equivalents			11			11	11
Crown sourced loans					25,750	25,750	26,474
Finance lease liabilities					445	445	445
Trade and other payables					9,813	9,813	9,813

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 $000	2014 $000	2014 $000	2014 $000	2014 $000	2014 $000	2014 $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

19 RELATED PARTIES

Related party disclosures have not been made for transactions with related parties that are within a normal supplier or client/recipient relationship on terms and conditions no more or less favourable than those that it is reasonable to expect WDHB would have adopted in dealing with the party at an arms' length in the same circumstances. Further, transactions with other government agencies (for example, Government departments and Crown entities) are not disclosed as related party transactions when they are consistent with the normal operating arrangements between government agencies and undertaken on the normal terms and conditions for such transactions.

WDHB is a wholly-owned entity of the Crown.

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.

	2015 $000	2014 $000
Revenue	3,343	3,558
Expenditure	29,819	27,262
Receivable at 30 June	1,119	767
Payable at 30 June	2,659	1,714

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 2015 totalled $879,000 (2014: $726,000). These purchases included the purchase of energy from Meridian Power New Zealand Ltd and Genesis Power New Zealand Ltd as well as postal services from New Zealand Post.

Remuneration of key management personnel

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

The remuneration paid to the key management personnel is:

	Group Actual 2015 $000	Group Actual 2014 $000	Parent Actual 2015 $000	Parent Actual 2014 $000
Board Members				
Remuneration	193	207	187	201
Full-time equivalent members	12	12	10	10
Leadership Team				
Remuneration	1,297	1,296	1,105	1,114
Full-time equivalent personnel	8	8	6	6
Total key management personnel remuneration	**1,490**	**1,308**	**1,292**	**1,124**
Full-time equivalent personnel	**20**	**20**	**16**	**16**

Due to the difficulty in determining the full-time equivalent figure for Board members, the Headcount figure is taken for Board members

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 2015 (2014 – 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 2015, 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. The additional costs relating to locums have been reduced during 2015 compared to the 2014 financial year due to permanent recruitments to some previously vacant posts.
- Other ooperating 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 pproperty, plant and equipment is lower than planned. This is due to delays in various IT projects including CRISP and FPSC.

Liabilities

- Trade creditors are higher than planned primarily due to higher than usual accruals at year end due to some large items not being invoiced prior to 30 June 2015.

Equity

- The lower than planned closing equity position relates to the higher than budgeted loss for the financial year.

STATEMENT OF RESPONSIBILITY

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

We are responsible for any end-of-year performance information provided by the District Health Board under section 19A of the Public Finance Act 1989.

We are responsible for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting.

In our opinion, these financial statements and statement of performance fairly reflect the financial position and operations of Wairarapa District Health Board for the year ended 30 June 2015.

Dr Derek Milne
Board Chair

Leanne Southey
Deputy Board Chair

Independent Auditor's Report

To the readers of the Wairarapa District Health Board and Group's financial statements and performance information for the year ended 30 June 2015

The Auditor-General is the auditor of the Wairarapa District Health Board (the Health Board) and its subsidiary. 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 the performance information, including the performance information for an appropriation, of the Health Board and Group consisting of Wairarapa District Health Board and its subsidiary (collectively referred to as "Group"), on her behalf.

We have audited:

- the financial statements of the Health Board and Group on pages 58 to 105 that comprise the statement of financial position, statement of contingencies, and statement of commitments as at 30 June 2015, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and

- the performance information of the Health Board and Group on pages 24 to 56.

Unmodified opinion on the financial statements

In our opinion the financial statements of the Health Board and Group:

- present fairly, in all material respects the:
    - financial position as at 30 June 2015; and
    - financial performance and cash flows for the year then ended; and
- comply with generally accepted accounting practice in New Zealand and have been prepared in accordance with Public Benefit Entity Standards.

Qualified opinion on the performance information because of limited controls on 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.

Our audit opinion on the performance information of the Health Board and Group for the period ended 30 June 2014, which is reported as comparative information, was modified for the same reason.

Qualified opinion on the performance information about "better help for smokers to quit – hospital" in the prior year

In respect of the 30 June 2014 comparative information only, our audit of the reported performance for the national health target "better help for smokers to quit – hospital" on page 25 (which is also reported on page 46 as "the percentage of hospitalised smokers receiving advice and help to quit") identified errors which indicated that the report results for the year ended 30 June 2014 are likely to be materially overstated. We were unable to quantify the extent of any overstatement, and our audit opinion on the statement of service performance for the year ended 30 June 2014 was modified accordingly.

The issues which resulted in errors in the performance information for the above national health target have been resolved for the 30 June 2015 year. However, the issues cannot be resolved for the 30 June 2014 year, which means that the Health Board and Group's performance information reported in the statement of performance for the 30 June 2015 year, may not be directly comparable to the 30 June 2014 performance information.

In our opinion, except for the effect of the matters described above, the performance information of the Health Board and Group on pages 24 to 56:

- presents fairly, in all material respects, the Health Board and Group's performance for the year ended 30 June 2015, including:
    - for each class of reportable outputs:
        - its standards of performance achieved as compared with forecasts included in the statement of performance expectations for the financial year;
        - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year;
    - what has been achieved with the appropriation; and
    - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure.
- complies with generally accepted accounting practice in New Zealand.

Our audit was completed on 30 October 2015. 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 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 the 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 the performance information. We were unable to determine if there were 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 the performance information. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and the 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 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.

An audit also involves 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;
- the appropriateness of the reported performance information within the Health Board and Group's framework for reporting performance;
- the adequacy of the disclosures in the financial statements and the performance information; and
- the overall presentation of the financial statements and the performance information.

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

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

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;
- present fairly the Health Board and Group's financial position, financial performance and cash flows; and
- present fairly the Health Board and Group's performance.

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

The Board is 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 the performance information, whether in printed or electronic form.

Responsibilities of the Auditor

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

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 its subsidiary.

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 9800 www.wairarapa.dhb.org.nz	
Board Members	**Derek Milne (Chair from Dec 2013)**	
	Leanne Southey (Deputy Chair)	**Fiona Samuel**
	Liz Falkner	**Alan Shirley**
	Rob Irwin	**Janine Vollebregt**
	Ronald Karaitiana	**Helen Kjestrup**
	Rick Long	

Executive Leadership Team for Wairarapa and Hutt Valley DHBs (as at 30 June 2015)			
Craig Climo	Interim Chief Executive Officer	**Amber O'Callaghan**	Executive Director, Quality & Risk
Carolyn Cooper	Acting Chief Operating Officer	**Judith Parkinson**	Chief Financial Officer
Helen Pocknall	Executive Director of Nursing & Midwifery	**Jill Stringer**	Acting Director Wairarapa Health Services
Sisera Jayathissa & Rob Kusel	Acting Chief Medical Officer	**Jason Kerehi**	Director, Māori Health Directorate
Russell Simpson	Executive Director, Allied Health, Scientific & Technical	**Tofa Suafole Gush**	Director of Pacific People's Health
Donna Hickey	Acting Executive Director, People & Culture 3DHB	**Ashley Bloomfield**	Director, Service Integration & Development Unit 3DHB (SIDU)
Martin Hefford	Chief Executive, Te Awakairangi Health Network (PHO)	**Glen Willoughby**	Acting Chief Information Officer 3DHB
Justine Thorpe	Programme Director, Tihei Wairarapa	**Eng Chew**	Acting Executive Director, 3DHB Corporate Services

Community & Public Health Advisory Committee / Disability Support 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, Hutt Valley and Capital & Coast District Health Boards.			
Dr 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	**Peter Douglas**	Hutt Valley
Sandra Greig	Hutt Valley	**Katie Austin**	Hutt Valley

Liz Faulkner	Wairarapa	**Dr Tristram Ingham**	CCDHB Māori Partnership Board
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
Dr Derek Milne (Deputy)	Wairarapa	**John Terris**	Hutt Valley
Mr Alan Shirley	Wairarapa	**Sue Kedgley**	Capital & Coast
Fiona Samuel	Wairarapa	**Judith Aitkin**	Capital & Coast
Dr Rob Irwin	Wairarapa	**Ken Laban**	Capital & Coast
Dr Brian Betty	PHO Representative	**Dr Leo Buchanan**	Māori Health Representative