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# About the Wairarapa District Health Board

The Wairarapa District Health Board (Wairarapa DHB) was established under the New Zealand Public Health and Disability Act 2000. Wairarapa DHB is responsible for the local planning of healthcare services, setting priorities, allocating funds, managing service provision for greater effectiveness and achieving an improved health status within the framework of the New Zealand Health Strategy.

The Wairarapa district encompasses a large geographic area characterised by relative isolation and a mainly low-density resident population of around 38,000. The Wairarapa DHB provider arm provides services at and from Masterton Hospital, Buchanan House in Greytown and Choice Health (Public Health) in downtown Masterton. Services provided include medical, surgical, women's health, child health, elderly, disability support, mental health, intellectual disability, public health and related support services. Wairarapa DHB also provides biomedical equipment servicing through its wholly owned subsidiary Biomedical Services New Zealand Limited, and has a one-sixth ownership of a joint venture the Central Region Technical Advisory Service Limited (TAS).

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## Community

**Maori**

**Patients / Service Users**

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**Caregivers**

**Health and Disability Service Providers**

**Community and Consumer Groups**

**Local and Central Government Agencies**

**General Public**

**Experts**

## Governance

**Mana Whenua Caucus** — **DHB Board**

- **Disability Support Advisory Committee**
- **Community and Public Health Advisory Committee**
- **Hospital Advisory Committee**
- **Audit and Risk**

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

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**The Chief Executive Officer**
**Maori Health**

**Planning and Funding Division**
Health Planning
Contracting
Monitoring

**Hospital, Health and Disability Services Division**
Community Health
Secondary Personal Health
Mental Health
Disability

**Corporate Services**
Internal Audit
Finance
Asset Mgmt
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IT/ IS

# About the Wairarapa District Health Board

## Population

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- Maori population expected to grow 10.7% in the next 10 years.
- Over 55 Maori population expected to grow 41.4% in the next 10 years.
- Total over 65 population expected to grow 20.1% in the next 10 years.
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## Strategic Health Goals

1. Improving child, family and youth health.
2. Better mental health.
3. Reducing the incidence and impact of diabetes.
4. Reducing the incidence and impact of respiratory disease.

## Key Strategies for Achieving these Health Goals

- Reduce inequalities in access to services, with particular regard to inequalities between Maori and others.
- Increasing collaboration and co-operation with other agencies and sectors.
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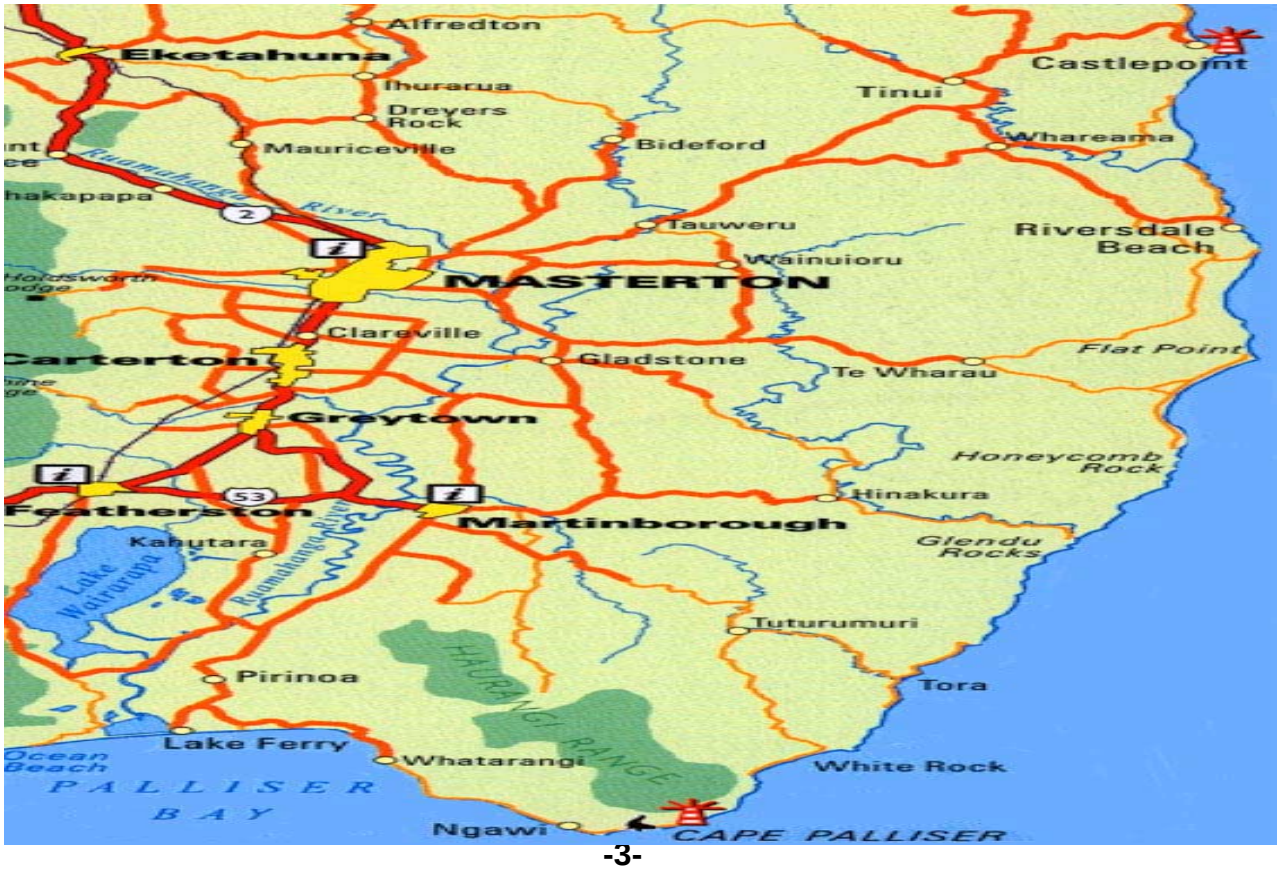
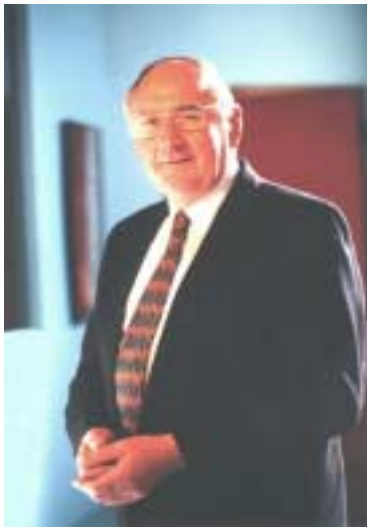


# Chairman's Report



It is my pleasure to present the Annual Report of the Wairarapa DHB for 2002/2003. I am particularly pleased to report that we continue to make steady progress in further building the capacity of the Wairarapa DHB, while continuing to provide the same range and volume of services as in previous years. This report outlines the Board's performance in meeting its objectives under the New Zealand Public Health and Disability Act 2000.

The year to June 2003 has seen further development of the Board's systems for managing the funding of all health and disability services. More recently, the Board's focus has shifted to its statutory objective of promoting the integration of health services, with particular focus on implementing the Government's Primary Health Strategy.

The Board has taken very seriously the right of communities to understand the health issues facing the region and for them to have an opportunity to be involved. When formulating the first District Strategic Plan, the District Health Board sought community feedback on the local issues that need addressing within the guidelines of the NZ Health and NZ Disability strategies. Through this consultation process, the community has made it very clear that self determination and community driven initiatives will pave the way for effective healthcare provision in the Wairarapa.

PHO development in the Wairarapa has had communities of interest actively engaged in looking at issues and solutions that enable collaboration and inclusiveness. This has led to agreement for there to be only one PHO for the Wairarapa with a proposed establishment target of 1 January 2004. It is exciting to see providers and communities actively grasping the concepts and talking about how to deliver better primary health care to our communities in a manner that the community feel best serves them.

Of particular significance over the past 12 months has been the signing of the partnership agreement between the Wairarapa DHB and the Mana Whenua. This agreement has been critical in cementing a constructive and positive relationship. The year has seen significant interaction, participation and engagement occur between Maori and the DHB on multiple levels particularly through the Maori Health Committee.

The Provider arm has faced many challenges through the year particularly with regard to recruitment and retention and issues related to compliance with health service standards. Despite these challenges, the provider arm has delivered services in line with contract expectations. Furthermore, the Wairarapa DHB once again achieved tertiary status for its ACC Safety Management Practices Programme.

Legislatively, the Board is required to act with fiscal probity. The Board accepts its responsibility to optimise all the vote-Health dollars coming into the Wairarapa to enable maximum health gains to be delivered. It is pleasing that the DHB finished the year within $237,000 of its $49 million budget. The unfavourable variance was largely due to a delay in the disposal of Greytown Hospital property that had been planned in the financial year.

The Board continues to face a range of issues with regard to sustainable standards of care both at Masterton Hospital as well as across the Wairarapa. While the environment is fraught with challenges the District Health Board recognises that there are many opportunities and that through ongoing constructive engagement of the community, neighbouring DHBs and the MOH, innovative partnerships will continue to be developed that will ensure that a comprehensive range of services will continue to be delivered locally.

The year saw a change in CEO, with Joel George moving onto other challenges after seven successful years with the DHB. I would like to acknowledge Joel's contribution to the health of the Wairarapa throughout this period. The Board was fortunate in the appointment of David Meates as Chief Executive in April. David brings an extensive background in health service delivery and a record of leadership that will take the Wairarapa DHB forward in new ways and address the historical issues that must be resolved for the long term clinical and financial sustainability of many of the hospital services in the Wairarapa.

The rapid development of planning and funding functions within the DHB and the continued provision of hospital and health services, are the result of the commitment and dedication of our management and staff. It is a credit to management and staff that they have been able to maintain standards and levels of care while coping with these ongoing changes, new roles and associated pressures. All staff can be justifiably proud of this achievement. With the help of such committed professional people, together we can look forward to strengthening our relationships and activities with communities, providers and other agencies for the benefit of all people within the Wairarapa.

I should like to thank all DHB staff and my fellow Board Members for their support during what was a challenging but successful year for the Wairarapa DHB. We are all confident we are on the right track for the future.

Doug Matheson
**Chairman**

# Chief Executive's Report

The Wairarapa DHB is pleased to present its second Annual Report, which outlines achievements in the past year and identifies how the organisation will continue to meet the health and disability challenges of the people of the Wairarapa.

This has been a challenging year for the organisation with a change of CEO, the development of our capability and capacity of the planning and funding functions and recruitment and retention and service delivery issues within the provider arm.

Despite these challenges the commitment and dedication of staff has remained paramount. I am pleased to report that the Wairarapa DHB has had another solid performance with a range of quality achievements across a range of services.

The strategic focus remains on the facilitation of access to services, emphasis on collaboration and integration not only within the health and disability sectors but also with the housing, police, councils and education sectors. There has been increased focus on community involvement and improving health outcomes for Maori. Over the past year there has also been a considerable amount of collaborative work completed moving towards the development of a single PHO within the Wairarapa. In particular, I would like to thank kaumatua and kuia for their support of the Wairarapa DHB and its activities.

At the provider level it has been another challenging year, particularly with regard to recruitment and retention and the delivery of sustainable health services to the Wairarapa. Despite these challenges the provider arm delivered services in line with contractual expectations. However, the cost of delivering these services was substantially greater than funded and the DHB was able to deliver a near breakeven result only through the release of revenue provisions and the non-investment in areas such as Information Technology.

Advancements have continued to be made in terms of workforce development (local DHB / UCOL Bachelor of Nursing Programme due to commence 2004), clinical governance (the establishment of a Clinical Board) and improved service efficiencies (reductions in waiting times for elective services).

The future holds some uncertainty as to the sustainability of the current service configuration within the Wairarapa. The future industrial relations issues particularly Multi Employer Collective Agreements (MECAs), and risks around demand driven expenditure such as pharmaceuticals, laboratory and GMS will put added pressure on what are scarce resources.

There are many challenges to face in the coming year. However, significant progress has been made towards the completion of a Business Case supporting the redevelopment of Masterton Hospital and ensuring that services will remain clinical viable and affordable. Optimism is building among DHB staff, community groups and providers as new developments

emerge. A smoother and improved co-ordination of functions is placing the Wairarapa DHB in good stead to take advantage of the opportunities that lie ahead. With the move to population based funding and the devolution of further health services to the DHB, it is time to modify capabilities, open avenues and allow more flexibility.

I would like to thank the Board and all staff of the Wairarapa DHB who have continued to cope under pressure, maintain standards and deliver levels of care to a very high standard. In the short time that I have been here I have been impressed by the commitment and passion for effective health service delivery. I look forward to working with you to fulfill our future goals in what deems to be an exciting and innovative period.

David Meates
**Chief Executive**

# Report on Governance and Accountability

## Role of the Board

The Board concentrates on setting policy, approving strategy, and monitoring progress toward meeting objectives.

The Board's governance responsibilities include:

- Setting policy.
- Approving strategy.
- Planning.
- Communicating with the Minister and other stakeholders to ensure their views are reflected in the District Health Board's planning.
- Delegating responsibility for achievement of specific objectives to the Chief Executive.
- Reporting to stakeholders on plans and progress against them.
- Maintaining effective systems of internal control.
- Monitoring organisational performance towards achieving objectives.
- Funding.
- Compliance and other statuary requirements.

## Structure of Wairarapa DHB

## DHB Operations

The Board has appointed a single employee – the Chief Executive – to manage all Wairarapa DHB operations. The Chief Executive has appointed all other employees of Wairarapa DHB. The Board directs the Chief Executive by delegating responsibility, accountability and authority for the achievement of objectives through setting policy, strategic goals, performance objectives and plans.

## Board Committees

The Board has set up committees to provide a more detailed level of focus on particular issues. Each committee has been delegated responsibility for governance – that is advising the Board on policies and monitoring of the organisation's progress towards meeting the District Health Board's objectives. Committees do not involve themselves in operational matters. The Board's standing committees (including the statutory advisory committees) are:

*Back left to right: Martin Easthope, George Makaera, Janice Wenn, Michael Hullah, Doug Matheson, Piri Tetau, Bobby Paurini*
*Front: Taka Parere, Kuki Rimene*

The Community and Public Health Advisory Committee – meets monthly.

The Disability Support Advisory Committee – meets monthly.

The Hospital Advisory Committee – meets monthly.

The Audit Committee – generally meets quarterly.

## Subsidiaries and Joint Ventures

Biomedical Services New Zealand Limited is a wholly owned subsidiary of Wairarapa DHB. Biomedical Services New Zealand Limited's principal activities during the year were testing, calibration and maintenance of biomedical equipment throughout New Zealand.

Wairarapa DHB has one-sixth ownership of a joint venture called the Central Region Technical Advisory Service Limited (TAS). This company was established to provide the six central region district health boards with applied analysis, service planning and external quality audit services in order to inform local funding and planning decisions.

## Partnership with Iwi

2003 has been a year of great significance for Wairarapa DHB and Maori. The DHB has strengthened it relationship with local Iwi and has built on discussions with Iwi during 2002.

The commitment of parties to work together has been consolidated and resulted in the signing of a relationship agreement in March of this year.

## Treaty of Waitangi Policy

As part of the agreement the Board and Mana Whenua have worked together to develop a Treaty of Waitangi Policy. The Treaty Policy will umbrella all DHB activity. It is envisaged that Treaty based guidelines for DHB activity will follow.

The Board and Mana Whenua have now shifted their attention to the development of a joint action plan and monitoring framework.

# Governance Philosophy

*Back row, left to right: Dr Rob Tuckett, Doug Matheson (Chair), Lyn Patterson, David Meates (CEO), Martin Easthope.*
*Front row: Cheryl-Ann Broughton-Kurei, Janine Vollebregt, Janice Wenn, Dr Liz Falkner, Linda Nelson. Absent: Robyn Daglish and Vivien Napier*

## Board Membership

The Board members bring diverse skill and backgrounds experience to the governance of the Wairarapa DHB.

All members are required to act in the best interests of the District Health Board. Board members accept the principal of collective accountability, individual members have no separate governing role outside the boardroom.

## Relationship with Stakeholders

The Board is committed to a strong relationship with all stakeholders. Board members take every opportunity to meet with relevant groups to ensure open two-way communication is maintained.

## Division of Responsibility Between the Board and Management

To ensure the efficient running of the District Health Board there is a clear division between the roles of the Board and management. The Board concentrates on setting policy, reviewing and approving strategy and plans, and monitoring progress towards meeting objectives.

Management is concerned with implementing policy and strategy and managing the organisation to meet the goals and objectives. The Board has clearly distinguished these roles by ensuring that the delegation of responsibility, accountability and authority to the chief executive is concise and complete. The Board sets annual performance criteria against which the performance of the chief executive is measured.

## Accountability

The Board and its committees holds regular meetings to ensure that the affairs of the District Health Board and its subsidiaries are being conducted in accordance with Wairarapa DHB's policies, strategies, plans and performance goals ensuring compliance with statutory and other requirements.

## Conflicts of interest

The Board maintains a member's interests register and at each meeting ensures Board members are aware of their obligations to declare any potential conflicts of interests.

## 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. Internal controls include the policies, systems and procedures established to provide assurance that specific objectives of the Board will be achieved. The Board and management have acknowledged their responsibility by signing the statement of responsibility on page 22 of this report.

Wairarapa DHB has an internal audit function that 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 auditor reports directly to the Chief Executive and reports its findings to the Audit Committee. Internal audit liases closely with the external auditors, who review the systems of internal control to the extent necessary to support their audit opinion.

The Auditor-General is the appointed external auditor of the District Health Board. The appointment is made under section 14 of the Public Audit Act 2001, section 43(1) of the Public Finance Act 1989 and section 43 of the New Zealand Public Health and Disability Act 2000. The Auditor-General has appointed Audit New Zealand as the audit provider to Wairarapa DHB.

The audit system is built into the overall organisation through committees and management objectives to ensure that there is a continuing commitment to evaluation and improvement of standards and performance, and audit provider service quality. In this way, it contributes to the continuous quality improvement model.

# Governance Philosophy Continued

## Risk Management

The Board is committed to sound risk management practices through an established risk management programme in accordance with the 'Guidelines for Managing Risk in the Australian and New Zealand Public Sector AS/NZS 4360:1999.

Risk management processes involve identification, analysis and evaluation of risks before deciding to accept or treat. Risks are identified, monitored and reported to the Audit Committee and the Board.

## Legislative Compliance

The Board acknowledges its responsibility to ensure the organisation complies with all legislation and regulations. The Board has delegated responsibility to the chief executive for the development and operation of a programme to systematically identify compliance issues, and for ensuring that all staff are aware of legislative and regulatory requirements that are particularly relevant to them.

## Ethics

The Board acknowledges a variety of codes of professional ethics, and monitors whether staff maintain high standards of ethical behaviour and practice the principles of 'good corporate citizenship'.

Monitoring compliance with ethical codes is done through such means as monitoring trends in complaints and disciplinary actions; internal audit reports; or any reports or indications that show non-conformance with the principles espoused in the code of ethics.

Good corporate citizenship involves this entity, including its employees, acknowledging that it is a member of one or more communities outside of itself, and making a commitment to act in a manner consistent with the social moves and accepted rights and responsibilities of all citizens of those communities.

# Planning and Funding

In 2002/03 the planning and funding team continued to build capacity to manage its planning and funding responsibilities. Key activities and achievements during the year included:

- Approval and publication of the DHB's Strategic Plan for the next five to ten years.
- Establishment of service advisory groups to progress implementation of the four priority areas identified in the Strategic Plan. Each group has wide stakeholder representation.
- Completion of two surveys of Wairarapa disability agencies. Information from these surveys provided a good base for our preparations to take on responsibility for funding of disability services for older people.
- Completion of an establishment plan for services for Health of Older People.
- Analysis of population based funding allocations and inter-district flows.
- Participation in joint project work with other DHBs, both regionally and nationally, including projects related to:
  - Regional mental health services planning and funding.
  - Management of community referred services.
  - Preparation for devolution of DSS for older people.
- Support and facilitation of the Wairarapa PHO Steering Committee, and community and provider communication and liaison in relation to PHO development.
- Development of relationships with providers of services for older people.
- Establishment of a local DHB project to promote management of demand driven pharmaceutical expenditure growth.
- Development of provider monitoring and audits systems and processes. A rolling programme of routine provider audits has been instituted and three providers were audited during the year.
- Participation in Masterton Hospital Site Development project planning.
- Other important planning and funding activity has related to further identification, under-standing and management of risks. The Wairarapa faces considerable risks related to its small size/population and to the open ended nature of some of the funding arrangements that have been devolved to it.

## New Initiatives Developed and Funded During 2002/03

**1. Kura Kaupapa Maori Clinic**

A weekly primary health clinic has been established at the Te Kura Kaupapa in Masterton - Wairarapa's lowest decile primary school – from July 2002. The clinic provides free general practitioner services to children enrolled at the Kura and their whanau. Prior to establishment of the Kura Clinic, this group showed very low uptake of primary health services, other than presenting to the Hospital Emergency Department.

During the year the clinic has been in operation many individuals have been treated for a wide range of conditions, and there has been growing awareness of health issues and choices among the Kura community. The clinic operates for four hours each week and sees an average of 15 patients at each session. However, the impact of the clinic on the whole school community is much greater than the sum of its impacts on individual patients. A new 'health confidence' has emerged. The Kura lunch menus have changed to incorporate healthy eating. Healthy lifestyle awareness and prevention have become prominent concepts in this community.

**2. Additional Outreach Clinics for Asthma and Diabetes**

Following the success of the outreach clinics established at Papawai Marae in previous years, increased funding was provided in 2002/03 to enable further clinics to be established. The diabetes and asthma nurse educators provide the clinics, and have been joined more recently by the cardiac outreach nurse. They monitor and advise a group of patients who otherwise do not usually access primary health care. Most patients attending the monthly clinics say that they cannot afford to visit a general practitioner.

The outreach nurse clinics work in close liaison with Whaiora Whanui. Whaiora Whanui provide whanua ora services that support people to follow the advice they receive at the clinics.

During 2002/03 new clinics have commenced at two other locations - Pirinoa Marae and at the Cameron Community Centre in Masterton. The Cameron Centre Clinic attracts urban Maori and Pacific people. A specialist physician from the hospital is now seeing some patients at the outreach clinics. This has improved linkages between primary and secondary care, and increased retention in health care programmes.

In a further development during 2002/03, the asthma and diabetes nurse educators have also established regular sessions at general practices throughout the district. This is proving very beneficial. Referrals to doctors for specific assessments, treatments, or medication changes, can now be made and usually implemented within the same session. Fewer people are lost to follow-up, and nurse educators' notes and advice can be integrated with general practice records. Some people who previously would not access a general practice are now beginning to see their nurse educator in a general practice setting.

Together the kura general practitioner clinic and outreach nurse clinics are changing the face of primary care for Maori. Maori are becoming more aware of their primary health needs and issues, and of what they should be able to expect from general practitioners and other primary health workers. This has been reflected during 2002/03, in the PHO Steering Committee. Maori on the PHO Steering Committee have provided strong input.

**3. Maori Health Developments**

Over the past twelve months a Maori Health Development Action Plan for the next three years has been developed. A key feature of the Plan is the development of a Treaty of Waitangi Policy framework within the DHB.

This Plan has been developed with the local Maori community and will guide our Maori health development work program for the next two years. In particular, the plan will ensure we continue to:

- enable Maori participation in all DHB activities
- foster Maori development
- and work in partnership with Maori.

**Communication**

We continue to proactively keep Maori informed about the DHB and its activities. To progress this we have sent to all Marae and Maori community groups an information booklet, outlining the activities the DHB has progressed with Mana Whenua and the Wairarapa Maori Health Committee.

**Maori Provider Development**

During 2003 the Wairarapa DHB has worked with Maori providers and supported Wairarapa Maori providers to form a working collective. This has resulted in the Maori provider collective successfully applying for development funding from the Ministry of Health. The collective is currently developing a joint strategic plan to progress the delivery of Maori provider services within the Wairarapa.

**Maori Focus Groups**

A number of Hui a Iwi and Maori focus groups have been implemented this year. A specific focus group was held with Maori who frequently utilise inpatient services to get their feedback on how our facilities might be improved. They told us that as a general principle the DHB needed to be developing facilities that would better enable culturally effective practice.

Maori also implemented their own focus groups to review each strategic priority area and provided the DHB with feedback and input on how we might improve the way we

effect positive changes in Maori health.

**Maori Workforce Development**

An exciting community initiative has been the news that UCOL will provide its bachelor of nurse training at its Masterton campus in 2004. The DHB has worked hard to encourage potential Maori students to enrol in the programme. One positive result related to this matter has been that nine Maori students have enrolled in UCOLs nursing precourse in 2003 in preparation for 2004.

**Maori Representation**

Excellent Maori representation has been achieved on all of the Wairarapa DHB's advisory and project groups. This includes such groups as the Clinical Board, PHO Steering Group and the DHB's strategic priority advisory groups.

**The Future**

In the coming year we will continue to make good progress. Some of the initiatives we plan to advance are: the establishment of a PHO that has

significant Maori representation at a governance level; implementation of the Maori Health Development Action Plan; implementation of the Treaty of Waitangi Policy and relevant guidelines; support for Maori nurses enrolled in UCOLs Bachelor of Nursing programme locally; and to implement a comprehensive cultural training framework for staff within our district.

## PHO Developments

Support for progress towards establishment of a PHO has been a key focus in 2002/03. In July 2002 the DHB held a one-day public workshop to discuss PHO concepts. About 120 people, representing all parts of the Wairarapa, attended.

The workshop demonstrated widespread enthusiasm for the development of a single PHO for the Wairarapa, and gave the DHB the mandate to move this forward. Following the workshop the DHB advertised widely for registrations of interest in working with the DHB to design and establish a PHO. Again there was a very large response. A PHO steering committee was then set up and began meeting in November 2002. The steering committee continued to meet through to June 2003. Mana Whenua, Maori providers, general practitioners, practice nurses, pharmacists, practice managers, mental health providers, older people, and the general community were all represented on the steering committee.

At 30 June the steering committee disbanded as a PHO Trust was then established with an interim trust board. The PHO is expected to become operational on 1 January 2004.

The PHO Steering Committee's significant achievements included: securing agreement from all general practices that they would participate in a single Wairarapa-wide PHO; and

ensuring that the PHO trust board has 50% Maori membership.

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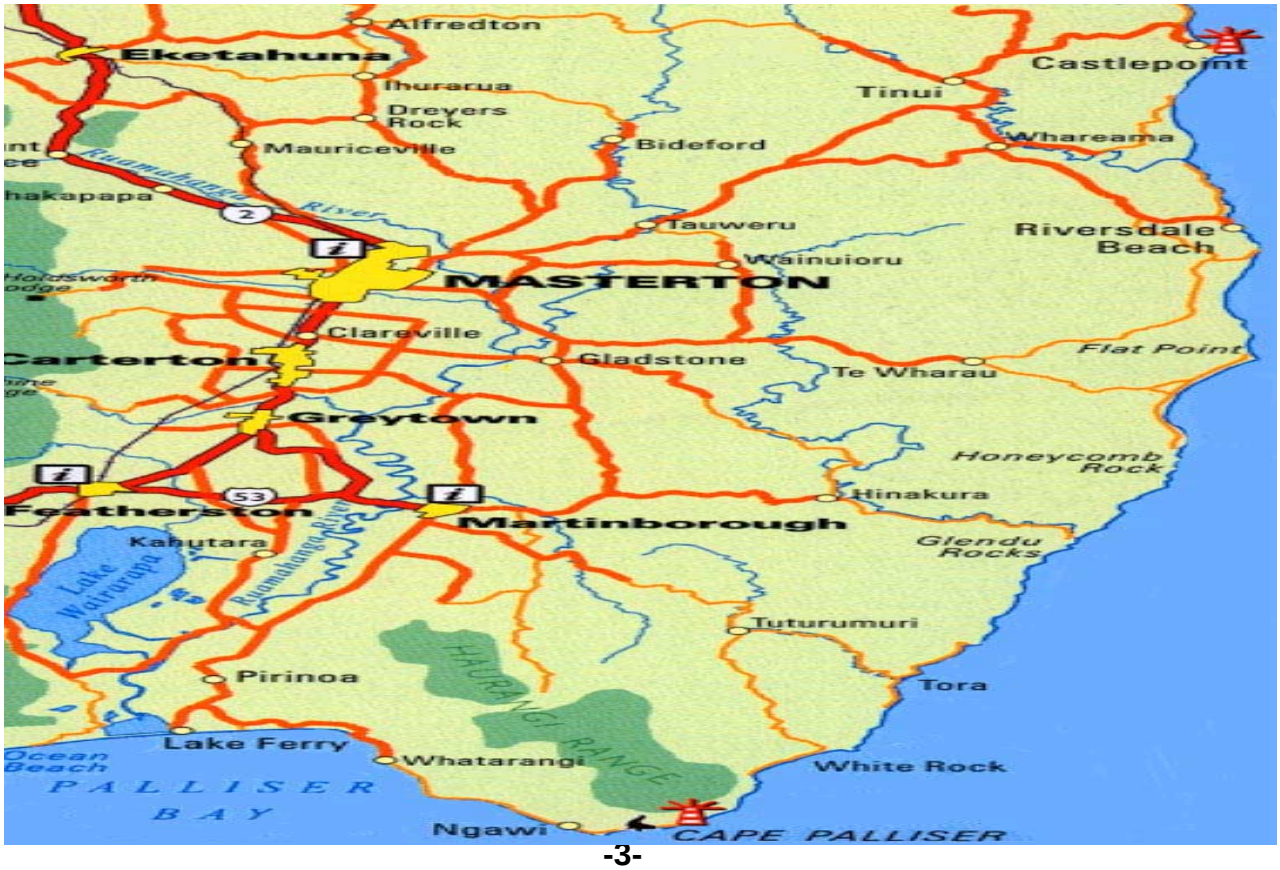
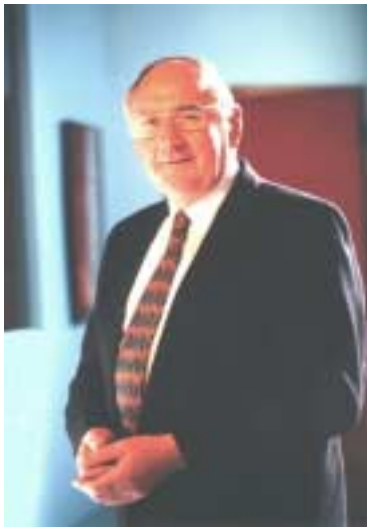


# Chairman's Report



It is my pleasure to present the Annual Report of the Wairarapa DHB for 2002/2003. I am particularly pleased to report that we continue to make steady progress in further building the capacity of the Wairarapa DHB, while continuing to provide the same range and volume of services as in previous years. This report outlines the Board's performance in meeting its objectives under the New Zealand Public Health and Disability Act 2000.

The year to June 2003 has seen further development of the Board's systems for managing the funding of all health and disability services. More recently, the Board's focus has shifted to its statutory objective of promoting the integration of health services, with particular focus on implementing the Government's Primary Health Strategy.

The Board has taken very seriously the right of communities to understand the health issues facing the region and for them to have an opportunity to be involved. When formulating the first District Strategic Plan, the District Health Board sought community feedback on the local issues that need addressing within the guidelines of the NZ Health and NZ Disability strategies. Through this consultation process, the community has made it very clear that self determination and community driven initiatives will pave the way for effective healthcare provision in the Wairarapa.

PHO development in the Wairarapa has had communities of interest actively engaged in looking at issues and solutions that enable collaboration and inclusiveness. This has led to agreement for there to be only one PHO for the Wairarapa with a proposed establishment target of 1 January 2004. It is exciting to see providers and communities actively grasping the concepts and talking about how to deliver better primary health care to our communities in a manner that the community feel best serves them.

Of particular significance over the past 12 months has been the signing of the partnership agreement between the Wairarapa DHB and the Mana Whenua. This agreement has been critical in cementing a constructive and positive relationship. The year has seen significant interaction, participation and engagement occur between Maori and the DHB on multiple levels particularly through the Maori Health Committee.

The Provider arm has faced many challenges through the year particularly with regard to recruitment and retention and issues related to compliance with health service standards. Despite these challenges, the provider arm has delivered services in line with contract expectations. Furthermore, the Wairarapa DHB once again achieved tertiary status for its ACC Safety Management Practices Programme.

Legislatively, the Board is required to act with fiscal probity. The Board accepts its responsibility to optimise all the vote-Health dollars coming into the Wairarapa to enable maximum health gains to be delivered. It is pleasing that the DHB finished the year within $237,000 of its $49 million budget. The unfavourable variance was largely due to a delay in the disposal of Greytown Hospital property that had been planned in the financial year.

The Board continues to face a range of issues with regard to sustainable standards of care both at Masterton Hospital as well as across the Wairarapa. While the environment is fraught with challenges the District Health Board recognises that there are many opportunities and that through ongoing constructive engagement of the community, neighbouring DHBs and the MOH, innovative partnerships will continue to be developed that will ensure that a comprehensive range of services will continue to be delivered locally.

The year saw a change in CEO, with Joel George moving onto other challenges after seven successful years with the DHB. I would like to acknowledge Joel's contribution to the health of the Wairarapa throughout this period. The Board was fortunate in the appointment of David Meates as Chief Executive in April. David brings an extensive background in health service delivery and a record of leadership that will take the Wairarapa DHB forward in new ways and address the historical issues that must be resolved for the long term clinical and financial sustainability of many of the hospital services in the Wairarapa.

The rapid development of planning and funding functions within the DHB and the continued provision of hospital and health services, are the result of the commitment and dedication of our management and staff. It is a credit to management and staff that they have been able to maintain standards and levels of care while coping with these ongoing changes, new roles and associated pressures. All staff can be justifiably proud of this achievement. With the help of such committed professional people, together we can look forward to strengthening our relationships and activities with communities, providers and other agencies for the benefit of all people within the Wairarapa.

I should like to thank all DHB staff and my fellow Board Members for their support during what was a challenging but successful year for the Wairarapa DHB. We are all confident we are on the right track for the future.

Doug Matheson
**Chairman**

# Chief Executive's Report

The Wairarapa DHB is pleased to present its second Annual Report, which outlines achievements in the past year and identifies how the organisation will continue to meet the health and disability challenges of the people of the Wairarapa.

This has been a challenging year for the organisation with a change of CEO, the development of our capability and capacity of the planning and funding functions and recruitment and retention and service delivery issues within the provider arm.

Despite these challenges the commitment and dedication of staff has remained paramount. I am pleased to report that the Wairarapa DHB has had another solid performance with a range of quality achievements across a range of services.

The strategic focus remains on the facilitation of access to services, emphasis on collaboration and integration not only within the health and disability sectors but also with the housing, police, councils and education sectors. There has been increased focus on community involvement and improving health outcomes for Maori. Over the past year there has also been a considerable amount of collaborative work completed moving towards the development of a single PHO within the Wairarapa. In particular, I would like to thank kaumatua and kuia for their support of the Wairarapa DHB and its activities.

At the provider level it has been another challenging year, particularly with regard to recruitment and retention and the delivery of sustainable health services to the Wairarapa. Despite these challenges the provider arm delivered services in line with contractual expectations. However, the cost of delivering these services was substantially greater than funded and the DHB was able to deliver a near breakeven result only through the release of revenue provisions and the non-investment in areas such as Information Technology.

Advancements have continued to be made in terms of workforce development (local DHB / UCOL Bachelor of Nursing Programme due to commence 2004), clinical governance (the establishment of a Clinical Board) and improved service efficiencies (reductions in waiting times for elective services).

The future holds some uncertainty as to the sustainability of the current service configuration within the Wairarapa. The future industrial relations issues particularly Multi Employer Collective Agreements (MECAs), and risks around demand driven expenditure such as pharmaceuticals, laboratory and GMS will put added pressure on what are scarce resources.

There are many challenges to face in the coming year. However, significant progress has been made towards the completion of a Business Case supporting the redevelopment of Masterton Hospital and ensuring that services will remain clinical viable and affordable. Optimism is building among DHB staff, community groups and providers as new developments

emerge. A smoother and improved co-ordination of functions is placing the Wairarapa DHB in good stead to take advantage of the opportunities that lie ahead. With the move to population based funding and the devolution of further health services to the DHB, it is time to modify capabilities, open avenues and allow more flexibility.

I would like to thank the Board and all staff of the Wairarapa DHB who have continued to cope under pressure, maintain standards and deliver levels of care to a very high standard. In the short time that I have been here I have been impressed by the commitment and passion for effective health service delivery. I look forward to working with you to fulfill our future goals in what deems to be an exciting and innovative period.

David Meates
**Chief Executive**

# Report on Governance and Accountability

## Role of the Board

The Board concentrates on setting policy, approving strategy, and monitoring progress toward meeting objectives.

The Board's governance responsibilities include:

- Setting policy.
- Approving strategy.
- Planning.
- Communicating with the Minister and other stakeholders to ensure their views are reflected in the District Health Board's planning.
- Delegating responsibility for achievement of specific objectives to the Chief Executive.
- Reporting to stakeholders on plans and progress against them.
- Maintaining effective systems of internal control.
- Monitoring organisational performance towards achieving objectives.
- Funding.
- Compliance and other statuary requirements.

## Structure of Wairarapa DHB

## DHB Operations

The Board has appointed a single employee – the Chief Executive – to manage all Wairarapa DHB operations. The Chief Executive has appointed all other employees of Wairarapa DHB. The Board directs the Chief Executive by delegating responsibility, accountability and authority for the achievement of objectives through setting policy, strategic goals, performance objectives and plans.

## Board Committees

The Board has set up committees to provide a more detailed level of focus on particular issues. Each committee has been delegated responsibility for governance – that is advising the Board on policies and monitoring of the organisation's progress towards meeting the District Health Board's objectives. Committees do not involve themselves in operational matters. The Board's standing committees (including the statutory advisory committees) are:

*Back left to right: Martin Easthope, George Makaera, Janice Wenn, Michael Hullah, Doug Matheson, Piri Tetau, Bobby Paurini*
*Front: Taka Parere, Kuki Rimene*

The Community and Public Health Advisory Committee – meets monthly.

The Disability Support Advisory Committee – meets monthly.

The Hospital Advisory Committee – meets monthly.

The Audit Committee – generally meets quarterly.

## Subsidiaries and Joint Ventures

Biomedical Services New Zealand Limited is a wholly owned subsidiary of Wairarapa DHB. Biomedical Services New Zealand Limited's principal activities during the year were testing, calibration and maintenance of biomedical equipment throughout New Zealand.

Wairarapa DHB has one-sixth ownership of a joint venture called the Central Region Technical Advisory Service Limited (TAS). This company was established to provide the six central region district health boards with applied analysis, service planning and external quality audit services in order to inform local funding and planning decisions.

## Partnership with Iwi

2003 has been a year of great significance for Wairarapa DHB and Maori. The DHB has strengthened it relationship with local Iwi and has built on discussions with Iwi during 2002.

The commitment of parties to work together has been consolidated and resulted in the signing of a relationship agreement in March of this year.

## Treaty of Waitangi Policy

As part of the agreement the Board and Mana Whenua have worked together to develop a Treaty of Waitangi Policy. The Treaty Policy will umbrella all DHB activity. It is envisaged that Treaty based guidelines for DHB activity will follow.

The Board and Mana Whenua have now shifted their attention to the development of a joint action plan and monitoring framework.

# Governance Philosophy

*Back row, left to right: Dr Rob Tuckett, Doug Matheson (Chair), Lyn Patterson, David Meates (CEO), Martin Easthope.*
*Front row: Cheryl-Ann Broughton-Kurei, Janine Vollebregt, Janice Wenn, Dr Liz Falkner, Linda Nelson. Absent: Robyn Daglish and Vivien Napier*

## Board Membership

The Board members bring diverse skill and backgrounds experience to the governance of the Wairarapa DHB.

All members are required to act in the best interests of the District Health Board. Board members accept the principal of collective accountability, individual members have no separate governing role outside the boardroom.

## Relationship with Stakeholders

The Board is committed to a strong relationship with all stakeholders. Board members take every opportunity to meet with relevant groups to ensure open two-way communication is maintained.

## Division of Responsibility Between the Board and Management

To ensure the efficient running of the District Health Board there is a clear division between the roles of the Board and management. The Board concentrates on setting policy, reviewing and approving strategy and plans, and monitoring progress towards meeting objectives.

Management is concerned with implementing policy and strategy and managing the organisation to meet the goals and objectives. The Board has clearly distinguished these roles by ensuring that the delegation of responsibility, accountability and authority to the chief executive is concise and complete. The Board sets annual performance criteria against which the performance of the chief executive is measured.

## Accountability

The Board and its committees holds regular meetings to ensure that the affairs of the District Health Board and its subsidiaries are being conducted in accordance with Wairarapa DHB's policies, strategies, plans and performance goals ensuring compliance with statutory and other requirements.

## Conflicts of interest

The Board maintains a member's interests register and at each meeting ensures Board members are aware of their obligations to declare any potential conflicts of interests.

## 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. Internal controls include the policies, systems and procedures established to provide assurance that specific objectives of the Board will be achieved. The Board and management have acknowledged their responsibility by signing the statement of responsibility on page 22 of this report.

Wairarapa DHB has an internal audit function that 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 auditor reports directly to the Chief Executive and reports its findings to the Audit Committee. Internal audit liases closely with the external auditors, who review the systems of internal control to the extent necessary to support their audit opinion.

The Auditor-General is the appointed external auditor of the District Health Board. The appointment is made under section 14 of the Public Audit Act 2001, section 43(1) of the Public Finance Act 1989 and section 43 of the New Zealand Public Health and Disability Act 2000. The Auditor-General has appointed Audit New Zealand as the audit provider to Wairarapa DHB.

The audit system is built into the overall organisation through committees and management objectives to ensure that there is a continuing commitment to evaluation and improvement of standards and performance, and audit provider service quality. In this way, it contributes to the continuous quality improvement model.

# Governance Philosophy Continued

## Risk Management

The Board is committed to sound risk management practices through an established risk management programme in accordance with the 'Guidelines for Managing Risk in the Australian and New Zealand Public Sector AS/NZS 4360:1999.

Risk management processes involve identification, analysis and evaluation of risks before deciding to accept or treat. Risks are identified, monitored and reported to the Audit Committee and the Board.

## Legislative Compliance

The Board acknowledges its responsibility to ensure the organisation complies with all legislation and regulations. The Board has delegated responsibility to the chief executive for the development and operation of a programme to systematically identify compliance issues, and for ensuring that all staff are aware of legislative and regulatory requirements that are particularly relevant to them.

## Ethics

The Board acknowledges a variety of codes of professional ethics, and monitors whether staff maintain high standards of ethical behaviour and practice the principles of 'good corporate citizenship'.

Monitoring compliance with ethical codes is done through such means as monitoring trends in complaints and disciplinary actions; internal audit reports; or any reports or indications that show non-conformance with the principles espoused in the code of ethics.

Good corporate citizenship involves this entity, including its employees, acknowledging that it is a member of one or more communities outside of itself, and making a commitment to act in a manner consistent with the social moves and accepted rights and responsibilities of all citizens of those communities.

# Planning and Funding

In 2002/03 the planning and funding team continued to build capacity to manage its planning and funding responsibilities. Key activities and achievements during the year included:

- Approval and publication of the DHB's Strategic Plan for the next five to ten years.
- Establishment of service advisory groups to progress implementation of the four priority areas identified in the Strategic Plan. Each group has wide stakeholder representation.
- Completion of two surveys of Wairarapa disability agencies. Information from these surveys provided a good base for our preparations to take on responsibility for funding of disability services for older people.
- Completion of an establishment plan for services for Health of Older People.
- Analysis of population based funding allocations and inter-district flows.
- Participation in joint project work with other DHBs, both regionally and nationally, including projects related to:
  - Regional mental health services planning and funding.
  - Management of community referred services.
  - Preparation for devolution of DSS for older people.
- Support and facilitation of the Wairarapa PHO Steering Committee, and community and provider communication and liaison in relation to PHO development.
- Development of relationships with providers of services for older people.
- Establishment of a local DHB project to promote management of demand driven pharmaceutical expenditure growth.
- Development of provider monitoring and audits systems and processes. A rolling programme of routine provider audits has been instituted and three providers were audited during the year.
- Participation in Masterton Hospital Site Development project planning.
- Other important planning and funding activity has related to further identification, under-standing and management of risks. The Wairarapa faces considerable risks related to its small size/population and to the open ended nature of some of the funding arrangements that have been devolved to it.

## New Initiatives Developed and Funded During 2002/03

**1. Kura Kaupapa Maori Clinic**

A weekly primary health clinic has been established at the Te Kura Kaupapa in Masterton - Wairarapa's lowest decile primary school – from July 2002. The clinic provides free general practitioner services to children enrolled at the Kura and their whanau. Prior to establishment of the Kura Clinic, this group showed very low uptake of primary health services, other than presenting to the Hospital Emergency Department.

During the year the clinic has been in operation many individuals have been treated for a wide range of conditions, and there has been growing awareness of health issues and choices among the Kura community. The clinic operates for four hours each week and sees an average of 15 patients at each session. However, the impact of the clinic on the whole school community is much greater than the sum of its impacts on individual patients. A new 'health confidence' has emerged. The Kura lunch menus have changed to incorporate healthy eating. Healthy lifestyle awareness and prevention have become prominent concepts in this community.

**2. Additional Outreach Clinics for Asthma and Diabetes**

Following the success of the outreach clinics established at Papawai Marae in previous years, increased funding was provided in 2002/03 to enable further clinics to be established. The diabetes and asthma nurse educators provide the clinics, and have been joined more recently by the cardiac outreach nurse. They monitor and advise a group of patients who otherwise do not usually access primary health care. Most patients attending the monthly clinics say that they cannot afford to visit a general practitioner.

The outreach nurse clinics work in close liaison with Whaiora Whanui. Whaiora Whanui provide whanua ora services that support people to follow the advice they receive at the clinics.

During 2002/03 new clinics have commenced at two other locations - Pirinoa Marae and at the Cameron Community Centre in Masterton. The Cameron Centre Clinic attracts urban Maori and Pacific people. A specialist physician from the hospital is now seeing some patients at the outreach clinics. This has improved linkages between primary and secondary care, and increased retention in health care programmes.

In a further development during 2002/03, the asthma and diabetes nurse educators have also established regular sessions at general practices throughout the district. This is proving very beneficial. Referrals to doctors for specific assessments, treatments, or medication changes, can now be made and usually implemented within the same session. Fewer people are lost to follow-up, and nurse educators' notes and advice can be integrated with general practice records. Some people who previously would not access a general practice are now beginning to see their nurse educator in a general practice setting.

Together the kura general practitioner clinic and outreach nurse clinics are changing the face of primary care for Maori. Maori are becoming more aware of their primary health needs and issues, and of what they should be able to expect from general practitioners and other primary health workers. This has been reflected during 2002/03, in the PHO Steering Committee. Maori on the PHO Steering Committee have provided strong input.

**3. Maori Health Developments**

Over the past twelve months a Maori Health Development Action Plan for the next three years has been developed. A key feature of the Plan is the development of a Treaty of Waitangi Policy framework within the DHB.

This Plan has been developed with the local Maori community and will guide our Maori health development work program for the next two years. In particular, the plan will ensure we continue to:

- enable Maori participation in all DHB activities
- foster Maori development
- and work in partnership with Maori.

**Communication**

We continue to proactively keep Maori informed about the DHB and its activities. To progress this we have sent to all Marae and Maori community groups an information booklet, outlining the activities the DHB has progressed with Mana Whenua and the Wairarapa Maori Health Committee.

**Maori Provider Development**

During 2003 the Wairarapa DHB has worked with Maori providers and supported Wairarapa Maori providers to form a working collective. This has resulted in the Maori provider collective successfully applying for development funding from the Ministry of Health. The collective is currently developing a joint strategic plan to progress the delivery of Maori provider services within the Wairarapa.

**Maori Focus Groups**

A number of Hui a Iwi and Maori focus groups have been implemented this year. A specific focus group was held with Maori who frequently utilise inpatient services to get their feedback on how our facilities might be improved. They told us that as a general principle the DHB needed to be developing facilities that would better enable culturally effective practice.

Maori also implemented their own focus groups to review each strategic priority area and provided the DHB with feedback and input on how we might improve the way we

effect positive changes in Maori health.

**Maori Workforce Development**

An exciting community initiative has been the news that UCOL will provide its bachelor of nurse training at its Masterton campus in 2004. The DHB has worked hard to encourage potential Maori students to enrol in the programme. One positive result related to this matter has been that nine Maori students have enrolled in UCOLs nursing precourse in 2003 in preparation for 2004.

**Maori Representation**

Excellent Maori representation has been achieved on all of the Wairarapa DHB's advisory and project groups. This includes such groups as the Clinical Board, PHO Steering Group and the DHB's strategic priority advisory groups.

**The Future**

In the coming year we will continue to make good progress. Some of the initiatives we plan to advance are: the establishment of a PHO that has

significant Maori representation at a governance level; implementation of the Maori Health Development Action Plan; implementation of the Treaty of Waitangi Policy and relevant guidelines; support for Maori nurses enrolled in UCOLs Bachelor of Nursing programme locally; and to implement a comprehensive cultural training framework for staff within our district.

## PHO Developments

Support for progress towards establishment of a PHO has been a key focus in 2002/03. In July 2002 the DHB held a one-day public workshop to discuss PHO concepts. About 120 people, representing all parts of the Wairarapa, attended.

The workshop demonstrated widespread enthusiasm for the development of a single PHO for the Wairarapa, and gave the DHB the mandate to move this forward. Following the workshop the DHB advertised widely for registrations of interest in working with the DHB to design and establish a PHO. Again there was a very large response. A PHO steering committee was then set up and began meeting in November 2002. The steering committee continued to meet through to June 2003. Mana Whenua, Maori providers, general practitioners, practice nurses, pharmacists, practice managers, mental health providers, older people, and the general community were all represented on the steering committee.

At 30 June the steering committee disbanded as a PHO Trust was then established with an interim trust board. The PHO is expected to become operational on 1 January 2004.

The PHO Steering Committee's significant achievements included: securing agreement from all general practices that they would participate in a single Wairarapa-wide PHO; and

ensuring that the PHO trust board has 50% Maori membership.

# Financial Statements

# Statement of Accounting Policies

## Reporting Entity

Wairarapa DHB is a Crown entity in terms of the Public Finance Act 1989.

The group consists of Wairarapa DHB, its subsidiary Biomedical Services New Zealand Limited (100% owned) and joint venture the Central Region Technical Advisory Service Limited (TAS) which is one sixth owned.

The financial statements and group financial statements of Wairarapa DHB have been prepared in accordance with the requirements of the Public Health and Disability Act 2000 and the Public Finance Act 1989.

In addition, funds administered on behalf of patients have been reported as a note to the financial statements.

## Measurement Base

The financial statements have been prepared on an historical cost basis.

## Accounting Policies

The following particular accounting policies, which materially affect the measurement of results and financial position, have been applied:

### 1. Basis of Consolidation – Purchase Method

The consolidated financial statements include the parent DHB and its subsidiary. The subsidiary is accounted for using the purchase method which involves adding together corresponding assets, liabilities, revenues and expenses on a line-by-line basis.

All significant inter-entity transactions are eliminated on consolidation.

### 2. Budget Figures

The budget figures are those approved by the Board and published in its Annual Plan. The budget figures have been prepared in accordance with generally accepted account practice and are consistent with the accounting policies adopted by the Board for the preparation of these financial statements.

### 3. Goods and Services Tax

All items in the financial statements are exclusive of goods and services tax (GST) with the exception of receivables and payables, which are stated with GST included. Where GST is irrecoverable as an input tax then it is recognised as part of the related asset or expense.

### 4. Taxation

Wairarapa DHB is a public authority under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under Section CB3 of the Income Tax Act 1994.

The wholly owned subsidiary company, Biomedical Services New Zealand Limited, is subject to income tax. Income tax expense is charged in the group statement of financial performance in respect of its current year's earnings after allowing for permanent differences. Deferred taxation is determined on a comprehensive basis using the liability method. Deferred tax assets attributable to timing differences or tax bases are only recognized where there is virtual certainty of realisation.

### 5. Trust and Bequest Funds

Donations and bequests to Wairarapa DHB are recognised as revenue when control over assets is obtained. A liability, rather than revenue, is recognised where fulfilment of any restrictions attached to those assets is not probable. Those donations and

bequests with restrictive conditions are appropriated from retained earnings to the trust funds component of equity. When expenditure is subsequently incurred in respect of these funds it is recognised in the statement of financial performance and an equivalent amount is transferred from the trust funds component of equity to retained earnings.

## 6. Accounts Receivable

Accounts receivable are stated at expected realisable value after providing for doubtful and uncollectible debts.

## 7. Inventories

Inventories are valued at the lower of cost, determined on a weighted average basis, and net realisable value after allowing for slow moving and obsolete items.

## 8. 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 statement of financial performance.

## 9. Fixed Assets

**Fixed Assets 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) were vested in Wairarapa DHB on 1 January 2001. Accordingly, assets were transferred to Wairarapa DHB at their net book values as recorded in the books of the Hospital and Health Service. In effecting this transfer, the 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.

**Fixed assets acquired since the establishment of the Wairarapa DHB**
Assets, other than land and buildings, acquired by the Board since its establishment, and other than those vested from the Hospital and Health Service, are recorded at cost less accumulated depreciation. Cost includes all appropriate costs of acquisition and installation, including materials, labour, direct overheads, financing and transport costs.

**Revaluation of Land and Buildings**
Land and buildings have been revalued in the year ending 30 June 2003, and will be every three years following, to their fair value as determined by an independent registered valuer by reference to their highest and best use. Additions between revaluations are recorded at cost. The results of revaluing land and buildings are credited or debited to an asset revaluation reserve for that class of asset. Where a revaluation results in a debit balance in the asset revaluation reserve, the debit balance is expensed in the statement of financial performance.

**Disposal of Fixed Assets**
When a fixed asset is disposed of, any gain or loss is recognised in the statement of financial performance and is calculated as the difference between the sale price and the carrying value of the fixed asset.

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

## 10. Depreciation

Depreciation is provided on a straight line basis on all fixed assets other than freehold land, at rates that will write off the cost 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:

| | | |
|---|---|---|
| Buildings and fit out | 2 to 50 years | (2%–50%) |
| Plant and equipment | 2.5 to 15 years | (6.5%–40%) |
| Motor vehicles | 5 to 12.5 years | (8%–20%) |
| Leased assets | 2.5 to 15 years | (6.5%–40%) |

Capital work in progress is not depreciated. The total cost of a project is transferred to freehold buildings/building fit-out and/or plant and equipment on its completion and then depreciated.

## 11. Employee Entitlements

Provision is made in respect of the Wairarapa DHB's liability for annual leave, long service leave, retirement gratuities, parental leave and conference leave. Annual leave, parental leave and conference leave have been calculated on an actual entitlement basis at current rates of pay whilst the other provisions have been calculated on an actuarial basis.

## 12. Leases

**Finance Leases**
Leases which effectively transfer to Wairarapa DHB substantially all the risks and benefits incident to ownership of the leased items are classified as finance leases. These are capitalised at the lower of the fair value of the asset or the present value of the minimum lease payments. The leased assets and corresponding lease liabilities are recognised in the statement of financial position. The leased assets are depreciated over the period Wairarapa DHB is expected to benefit from their use.

**Operating Leases**
Leases where the lessor effectively retains substantially all the risks and benefits of ownership of the leased items are classified as operating leases. Operating lease expenses are recognised on a systematic basis over the period of the lease.

## 13. Financial Instruments

Wairarapa DHB seeks to minimise exposure arising from its treasury activity. The District Health Board is not authorised by its treasury policy to enter any transactions that are speculative in nature.

Wairarapa DHB (and group) is party to financial instruments as part of its normal operations. These financial instruments include bank accounts, short-term deposits, investments, debtors, creditors and loans. All financial instruments are recognised in the statement of financial position and all revenue and expenses in relation to financial instruments are recognised in the statement of financial performance.

Except for loans, which are recorded at cost, and those items covered by a separate accounting policy, all financial instruments are shown at their estimated fair value.

## 14. Statement of Cash flows

***Cash*** means cash balances on hand, held in bank accounts, bank overdrafts, demand deposits and other highly liquid investments in which Wairarapa DHB invests as part of its day-to-day cash management.

***Operating activities*** include all transactions that are not investing or financing activities. Cash inflows include all receipts from the sale of goods and services and other sources of revenue which supports the Board's operating activities. Cash outflows include payments made to employees, suppliers and for taxes.

***Investing activities*** are those activities relating to the acquisition and disposal of current and non-current securities and advances and any other non-current assets.

***Financing activities*** comprise the change in equity and debt capital structure of Wairarapa DHB.

## 15. Foreign Currency Translations

Transactions denominated in foreign currencies (other than forward exchange contracts) are translated at the rate of exchange ruling at the transaction date. Short term transactions covered by forward exchange contracts are measured and reported at the forward rates specified in the contracts.

At balance date foreign monetary assets and liabilities are translated at the closing rate and exchange differences arising from the transactions are recognised in the statement of financial performance.

## 16. Cost of Service Statements

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

## 17. Cost Allocation

Wairarapa DHB 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 board activity.
***Indirect*** *costs* are those costs which cannot be identified in an economically feasible manner with a specific Board 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 actual usage, staff numbers and floor area. For the year ended 30 June 2003, indirect costs accounted for 38% of Wairarapa DHB's total costs.

## 18. Changes in Accounting Policies

There have been no changes from the accounting policies adopted in the last audited financial statements. All policies have been applied on a basis consistent with the previous period.

## Consolidated Statement of Financial Performance

### For the year ended 30 June 2003

| | Note | Group Budget 2003 $000 | Group Actual 2003 $000 | Group Actual 2002 $000 | Parent Actual 2003 $000 | Parent Actual 2002 $000 |
|---|---|---|---|---|---|---|
| Revenue | | 49,498 | 51,033 | 45,143 | 50,345 | 44,457 |
| Expenses | | 49,299 | 51,085 | 46,252 | 50,441 | 45,606 |
| Capital Charge | 19 | 636 | 616 | 640 | 616 | 640 |
| Operating Surplus/(Deficit) before Taxation | 1 | (437) | (668) | (1,749) | (712) | (1,789) |
| Tax Expense | 2 | 8 | 14 | 17 | 0 | 0 |
| Operating Surplus/(Deficit) after Taxation | | (445) | (682) | (1,766) | (712) | (1,789) |
| **Net Surplus / (Deficit)** | | **(445)** | **(682)** | **(1,766)** | **(712)** | **(1,789)** |

## Consolidated Statement of Movements in Equity

### For the year ended 30 June 2003

| | Group Budget 2003 $000 | Group Actual 2003 $000 | Group Actual 2002 $000 | Parent Actual 2003 $000 | Parent Actual 2002 $000 |
|---|---|---|---|---|---|
| **Net Surplus / Deficit for the Year** | **(445)** | **(682)** | **(1,766)** | **(712)** | **(1,789)** |
| Other Recognised Revenue and Expenses | | | | | |
| Increase in Revaluation Reserve | 0 | 3,445 | 0 | 3,445 | 0 |
| **Total Recognised Revenue and Expenses** | **(445)** | **2,763** | **(1,766)** | **2,733** | **(1,789)** |
| Contribution from Owners | 0 | 1,500 | 500 | 1,500 | 500 |
| **Movements in Equity for the Period** | **(445)** | **4,263** | **(1,266)** | **4,233** | **(1,289)** |
| Equity at Start of the Period | 6,009 | 6,065 | 7,331 | 5,950 | 7,239 |
| **Equity at End of the Period** | **5,564** | **10,328** | **6,065** | **10,183** | **5,950** |

**The accompanying accounting policies and notes form part of these financial statements**

# Consolidated Statement of Financial Position

**As at 30 June 2003**

| | Note | Group Budget 2003 $000 | Group Actual 2003 $000 | Group Actual 2002 $000 | Parent Actual 2003 $000 | Parent Actual 2002 $000 |
|---|---|---|---|---|---|---|
| **EQUITY** | | | | | | |
| General Funds | 3a | 7,370 | 12,320 | 7,375 | 12,320 | 7,375 |
| Retained Earnings/(Accumulated Deficit) | 3b | (2,014) | (2,213) | (1,524) | (2,358) | (1,639) |
| Trust Funds | 4 | 208 | 221 | 214 | 221 | 214 |
| **Total Equity** | | **5,564** | **10,328** | **6,065** | **10,183** | **5,950** |
| **Represented by:** | | | | | | |
| **ASSETS** | | | | | | |
| **Current Assets** | | | | | | |
| Cash | | 108 | 138 | 490 | 0 | 399 |
| Receivables and Prepayments | 5 | 4,807 | 5,068 | 4,561 | 4,982 | 4,491 |
| Inventories | 6 | 420 | 499 | 472 | 499 | 472 |
| Properties Intended for Sale | | 0 | 125 | 203 | 125 | 203 |
| **Total Current Assets** | | **5,335** | **5,830** | **5,726** | **5,606** | **5,565** |
| **Non Current Assets:** | | | | | | |
| Trust Funds | 7 | 208 | 221 | 214 | 221 | 214 |
| Fixed Assets | 8 | 16,996 | 17,617 | 14,494 | 17,494 | 14,342 |
| Investments | 9 | 0 | 0 | 0 | 103 | 103 |
| **Total Non-Current Assets** | | **17,204** | **17,838** | **14,708** | **17,818** | **14,659** |
| **Total Assets** | | **22,539** | **23,668** | **20,434** | **23,424** | **20,224** |
| **LIABILITIES** | | | | | | |
| **Current Liabilities:** | | | | | | |
| Bank Overdraft | 11 | 968 | 159 | 0 | 159 | 0 |
| Payables and Accruals | 12 | 6,110 | 4,299 | 5,608 | 4,218 | 5,542 |
| Employee Entitlements | 13 | 2,479 | 2,479 | 2,273 | 2,463 | 2,246 |
| Current Portion of Term Loans | 14 | 32 | 32 | 94 | 32 | 94 |
| **Total Current Liabilities** | | **9,589** | **6,969** | **7,975** | **6,872** | **7,882** |
| **NON-CURRENT LIABILITIES:** | | | | | | |
| Employee Entitlements | 13 | 386 | 371 | 362 | 369 | 360 |
| Term Loans | 14 | 7,000 | 6,000 | 6,032 | 6,000 | 6,032 |
| **Total Non-Current Liabilities** | | **7,386** | **6,371** | **6,394** | **6,369** | **6,392** |
| **TOTAL LIABILITIES** | | **16,975** | **13,340** | **14,369** | **13,241** | **14,274** |
| **NET ASSETS** | | **5,564** | **10,328** | **6,065** | **10,183** | **5,950** |

**For and on behalf of the Board:**

_____ **Board Member** _____ **Board Member**

**Date**_____ **Date** _____

**The accompanying accounting policies and notes form part of these financial statements.**

# Consolidated Statement of Cash Flows

## For the year ended 30 June 2003

| | Note | Group Budget 2003 $000 | Group Actual 2003 $000 | Group Actual 2002 $000 | Parent Actual 2003 $000 | Parent Actual 2002 $000 |
|---|---|---|---|---|---|---|
| **CASH FLOWS FROM OPERATING ACTIVITIES** | | | | | | |
| **Cash was provided from:** | | | | | | |
| Receipts from Ministry of Health and Patients | | 48,827 | 50,301 | 44,052 | 49,611 | 43,363 |
| Interest Received | | 42 | 93 | 82 | 91 | 81 |
| | | **48,869** | **50,394** | **44,134** | **49,702** | **43,444** |
| **Cash was distributed to:** | | | | | | |
| Payments to Suppliers | | 24,092 | 27,170 | 22,071 | 26,866 | 21,741 |
| Payments to Employees | | 22,259 | 23,077 | 21,177 | 22,776 | 20,888 |
| Capital Charge | | 644 | 616 | 640 | 616 | 640 |
| Interest Paid | | 518 | 500 | 287 | 500 | 287 |
| Goods and Services Tax (net) | | 46 | 243 | (105) | 247 | (126) |
| | | **47,559** | **51,606** | **44,070** | **51,005** | **43,430** |
| **Net Cash Inflow/(Outflow) from Operating Activities** | 15 | **1,310** | **(1,212)** | **64** | **(1,303)** | **14** |
| **CASH FLOWS FROM INVESTING ACTIVITES** | | | | | | |
| **Cash was provided from:** | | | | | | |
| Proceeds from Sale of Fixed Assets | | 750 | 222 | 140 | 222 | 140 |
| **Cash was applied to:** | | | | | | |
| Purchase of Fixed Assets | | (3,568) | 920 | 1,449 | 876 | 1,353 |
| **Net Cash Inflow / (Outflow) from Investment Activities** | | **(2,818)** | **(698)** | **(1,309)** | **(654)** | **(1,213)** |
| **CASH FLOWS FROM FINANCING ACTIVIES** | | | | | | |
| **Cash was provided from:** | | | | | | |
| Proceeds from Crown Financing Agency | | 1,000 | 0 | 6,000 | 0 | 6,000 |
| Capital Introduced | | 0 | 1,500 | 500 | 1,500 | 500 |
| | | **1,000** | **1,500** | **6,500** | **1,500** | **6,500** |
| **Cash was applied to:** | | | | | | |
| Repayments of loans | | 93 | 94 | 5,669 | 94 | 5,669 |
| Restricted Fund Movement | | 0 | 7 | 6 | 7 | 6 |
| **Net Cash Inflow/(Outflow) from Financing Activities** | | **907** | **1,399** | **825** | **1,399** | **825** |
| **Net Increase in Cash Held** | | **(601)** | **(511)** | **(420)** | **(558)** | **(374)** |
| Add Opening Cash | | (259) | 490 | 910 | 399 | 773 |
| **CLOSING CASH BALANCE** | | **(860)** | **21** | **490** | **(159)** | **399** |
| Made up of: Cash | | 108 | 85 | 447 | 0 | 399 |
| Bank Overdraft | | (968) | (159) | 0 | (159) | 0 |
| Short Term Deposits | | 0 | 53 | 43 | 0 | 0 |
| **CLOSING CASH BALANCE** | | **(860)** | **21** | **490** | **(159)** | **399** |

**The accompanying accounting policies and notes form part of these financial statements.**

## Consolidated Statement of Contingent Liabilities

**As at 30 June 2003**

| | Group | | Parent | |
|---|---|---|---|---|
| | 2003 $000 | 2002 $000 | 2003 $000 | 2002 $000 |
| Legal Proceedings and Disputes by Third Parties | 205 | 233 | 205 | 233 |

## Consolidated Statement of Commitments

**As at 30 June 2003**

| | Group | | Parent | |
|---|---|---|---|---|
| | 2003 $000 | 2002 $000 | 2003 $000 | 2002 $000 |
| **Capital Commitments** | **193** | **54** | **193** | **54** |
| **Non-Cancellable Operating Lease Commitments:** | | | | |
| Less than One Year: | 1,031 | 1,319 | 1,009 | 1,303 |
| One to Two Years | 865 | 1,036 | 830 | 1,028 |
| Two to Five Years | 374 | 1,525 | 351 | 1,502 |
| Five Years | 0 | 10 | 0 | 9 |
| **Total Operating Lease Commitments** | **2,270** | **3,890** | **2,190** | **3,842** |
| **Non-cancellable Contracts for the Provision of Services** | | | | |
| Not Later Than One Year | | | | |
| Non Funder | 1,602 | 1,402 | 1,602 | 1,402 |
| Funder | 3,083 | 1,652 | 3,083 | 1,652 |
| Later Than One Year and Not Later Than Two Years | | | | |
| Non Funder | 449 | 976 | 449 | 976 |
| Funder | 687 | 534 | 687 | 534 |
| Later Than Two Years and Not Later Than Five Years | | | | |
| Non Funder | 74 | 417 | 74 | 417 |
| Funder | 368 | 0 | 368 | 0 |
| Over Five Years | | | | |
| Non Funder | 0 | 0 | 0 | 0 |
| Funder | 0 | 0 | 0 | 0 |
| **Total Non-Cancellable Contracts** | **6,263** | **4,981** | **6,263** | **4,981** |
| **TOTAL COMMITMENTS** | **8,726** | **8,925** | **8,646** | **8,877** |

**The accompanying accounting policies and notes form part of these financial statements.**

# Notes to the Consolidated Financial Statements

## For the year ended 30 June 2003

## 1. Net Operating Surplus / (Deficit) Before Taxation

| | | Group | | Parent | |
|---|---|---|---|---|---|
| | | 2003 $000 | 2002 $000 | 2003 $000 | 2002 $000 |
| **After Charging:** | | | | | |
| Audit Fees | | 50 | 45 | 43 | 38 |
| Deprecation Total | | 1,495 | 1,484 | 1,438 | 1,440 |
| Made up of: | Buildings | 792 | 804 | 792 | 804 |
| | Plant and Equipment | 622 | 594 | 576 | 555 |
| | Motor Vehicles | 81 | 86 | 70 | 81 |
| Net Gain on Sale of Fixed Assets | | (112) | (97) | (115) | (97) |
| Impairment Losses on Fixed Assets | | 0 | 59 | 0 | 59 |
| Board Member's Fees | | 230 | 207 | 228 | 202 |
| Interest Expense | | 440 | 347 | 440 | 347 |
| Finance Charge on Leased Assets | | 1 | 12 | 1 | 12 |
| Rental and Operating Lease Costs | | 1,610 | 1,060 | 1,586 | 1,039 |
| Bad Debts Written Off | | 13 | 11 | 13 | 11 |
| Changes in Provision for Bad Debts | | 48 | (4) | 48 | (4) |
| **After Crediting:** | Donations | 37 | 54 | 37 | 54 |
| | Interest Income | 94 | 82 | 91 | 81 |

## 2. Tax Expense

In accordance with the New Zealand Public Health and Disability Act 2000, the parent (Wairarapa DHB) is a public authority and is exempt from income tax. The following taxation relates to the subsidy company Biomedical New Zealand Limited.

| | Group | |
|---|---|---|
| | 2003 $000 | 2002 $000 |
| Profit / (Loss) before Taxation | 42 | 39 |
| Prima Facie Taxation of 33% on Subsidiary | 14 | 13 |
| **Plus / (Less) Taxation Effect On:** | | |
| Prior Period Adjustment | 0 | 4 |
| Permanent Differences | 0 | 0 |
| Timing Differences Not Recognised | 0 | 0 |
| Taxation Charge | **14** | **17** |

Biomedical Services New Zealand Limited has not recognised deferred tax asset accumulative timing differences of $124,170 (June 2002: $121,291) as these are not expected to reverse in the foreseeable future. The tax effect of the

timing differences not recognised is $40,976 (June 2002: $40,026). At balance date there were imputation credits of $14,830 available to shareholders.

## 3. Equity

| | Group | | Parent | |
|---|---|---|---|---|
| **(a) General Funds** | **2003 $000** | **2002 $000** | **2003 $000** | **2002 $000** |
| **Opening Balance** | 7,375 | 6,875 | 7,375 | 6,875 |
| Movement in Revaluation Reserve | 3,445 | 0 | 3,445 | 0 |
| Issued During the Year | 1,500 | 500 | 1,500 | 500 |
| **Balance At 30 June** | **12,320** | **7,375** | **12,320** | **7,375** |
| | | | | |
| **(b) Retained Earnings** | | | | |
| Retained Earnings at 1 July 2002 | (1,524) | 248 | (1,639) | 156 |
| Operating Surplus / (Deficit) | (682) | (1,766) | (712) | (1,789) |
| Transfers from Trust Funds (note 4) | 8 | 8 | 8 | 8 |
| Transfer to Trust Funds (note 4) | (15) | (14) | (15) | (14) |
| **RETAINED EARNINGS AT 30 JUNE** | **(2,213)** | **(1,524)** | **(2,358)** | **(1,639)** |

## 4. Trust Funds

Trust assets are funds donated or bequeathed for a specific purpose. The use of these assets must comply with the specific terms of the sources from which the funds were derived.

Revenue and expenditure in respect of these trusts is recognised in the statement of financial performance. An amount equal to the expenditure is transferred from the Trust Fund component of equity to retained earnings. An amount equivalent to the revenue is transferred from retained earnings to the Trust Fund.

| | Group | | Parent | |
|---|---|---|---|---|
| | **2003 $000** | **2002 $000** | **2003 $000** | **2002 $000** |
| **Opening Balance** | 214 | 208 | 214 | 208 |
| Transfer From Retained Earnings in Respect of: | | | | |
| Funds Received | 5 | 4 | 5 | 4 |
| Interest Received | 10 | 10 | 10 | 10 |
| **Total Receipts** | **15** | **14** | **15** | **14** |
| Transfer to retained earnings in respect of: | | | | |
| Funds Spent | **8** | **8** | **8** | **8** |
| **BALANCE AT 30 JUNE** | **221** | **214** | **221** | **214** |

Trust funds were classified as non-current liabilities within the Statement of Intent but have been classified as equity for this report.

The following funds are held as investments of Wairarapa DHB.

| | 2003 $000 | 2002 $000 |
|---|---|---|
| Brownette Bequest | 19 | 18 |
| Cameron Bequest | 2 | 1 |
| Greytown Hospital Patient Comfort Fund | 94 | 90 |
| Macintosh Bequest | 3 | 3 |
| Mason Bequest | 6 | 6 |
| Masterton Hospital Patient Comfort Fund | 32 | 30 |
| Ross Bequest | 17 | 17 |
| Toogood Bequest | 5 | 5 |
| Tyacke Bequest | 20 | 19 |
| Funds Donated to Specific Departments | 23 | 25 |
| **TOTAL** | **221** | **214** |

## 5. Receivables and Prepayments

| | Group | | Parent | |
|---|---|---|---|---|
| | 2003 $000 | 2002 $000 | 2003 $000 | 2002 $000 |
| Trade Debtors | 1,134 | 1,001 | 1,046 | 919 |
| Provision for Doubtful Debts | (87) | (40) | (87) | (40) |
| Accrued Income | 3,779 | 3,388 | 3,779 | 3,388 |
| Prepayments | 238 | 140 | 236 | 140 |
| Sundry | 4 | 72 | 1 | 72 |
| Receivables and Prepayments Excluding Owing by Subsidiary | **5,068** | **4,561** | **4,975** | **4,479** |
| Amount Owing by Subsidiary | 0 | 0 | 7 | 12 |
| **RECEIVABLES AND PREPAYMENTS INCLUDING OWING BY SUBSIDIARY** | **5,068** | **4,561** | **4,982** | **4,491** |

## 6. Inventories

| | Group | | Parent | |
|---|---|---|---|---|
| | 2003 $000 | 2002 $000 | 2003 $000 | 2002 $000 |
| Pharmaceuticals | 70 | 64 | 70 | 64 |
| Surgical and Medical Supplies | 135 | 126 | 135 | 126 |
| Theatre Supplies | 232 | 217 | 232 | 217 |
| Other Supplies | 62 | 65 | 62 | 65 |
| **TOTAL INVENTORY** | **499** | **472** | **499** | **472** |

No inventories are pledged as security for liabilities but some inventories are subject to Retention of Title clauses under the Personal Property Securities Act 1999. 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.

## 7. Investments

| | Group | | Parent | |
|---|---|---|---|---|
| | 2003 $000 | 2002 $000 | 2003 $000 | 2002 $000 |
| Money Market and other Trading Banks | 221 | 214 | 221 | 214 |

These investments are all held as trust funds.

## 8. Fixed Assets

| | Group | | Parent | |
|---|---|---|---|---|
| | 2003 $000 | 2002 $000 | 2003 $000 | 2002 $000 |
| **Land** | | | | |
| At Valuation | 690 | 644 | 690 | 644 |
| Land– Net Book Value | 690 | 644 | 690 | 644 |
| **Buildings** | | | | |
| At Valuation | 13,664 | 0 | 13,664 | 0 |
| At Cost | 24 | 15,549 | 24 | 15,549 |
| Accumulated Depreciation | 15 | 4,968 | 15 | 4,968 |
| Buildings – Net Book Value | 13,673 | 10,581 | 13,673 | 10,581 |
| **Plant and Equipment** | | | | |
| At Cost | 9,492 | 8,925 | 9,042 | 8,480 |
| Accumulated Depreciation | 6,868 | 6,390 | 6,517 | 6,062 |
| Plant and Equipment – Net Book Value | 2,624 | 2,535 | 2,525 | 2,418 |
| **Motor Vehicles:** | | | | |
| At Cost | 225 | 244 | 183 | 244 |
| Accumulated Depreciation | 136 | 142 | 118 | 142 |
| Motor Vehicles – Net Book Value | 89 | 102 | 65 | 102 |
| **Capital Work in Progress** | | | | |
| At Cost | 302 | 336 | 302 | 336 |
| **Capitalised Finance Leases** | | | | |
| Motor Vehicles: | | | | |
| At Cost | 570 | 570 | 570 | 528 |
| Accumulated Depreciation | 331 | 274 | 331 | 267 |
| Motor Vehicle – Net Book Value | 239 | 296 | 239 | 261 |
| **Total Fixed Assets** | | | | |
| At Cost and Valuation | 24,967 | 26,268 | 24,475 | 25,781 |
| Accumulated Depreciation | 7,350 | 11,774 | 6,981 | 11,439 |
| **TOTAL CARRYING AMOUNT OF FIXED ASSETS** | **17,617** | **14,494** | **17,494** | **14,342** |

### Land and Buildings

Revalued freehold land and buildings are stated at fair value as determined by CB Richard Ellis (Registered Valuers), as at 30 June 2003.

### Restrictions

Wairarapa DHB does not have full title to Crown land it occupies but transfer is arranged if and when land is sold. Some of the District Health Board's land is subject to Waitangi Tribunal claims. The disposal of certain properties may be subject to the provisions of s40 of the Public Works Act 1981.

Titles to land transferred from the Crown to Wairarapa DHB are subject to a memorial in terms of the Treaty of Waitangi Act 1975 (as amended by Treaty of Waitangi (State Enterprises) Act 1988). The effect on the value of assets resulting from potential claims under the Treaty of Waitangi Act 1975 cannot be quantified.

Proceeds from the sale of Board assets are used to purchase new assets as specified under Clause 43, Schedule 3 New Zealand Public Health and Disability Act 2000.

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

## 9. Investment in Subsidiaries

| | Parent | |
|---|---|---|
| | **2003** | **2002** |
| | **$000** | **$000** |
| Share in subsidiaries (non current) | 103 | 103 |
| Advances to subsidiaries (current) | 0 | 0 |
| **TOTAL INVESTMENTS** | **103** | **103** |

Biomedical Services New Zealand Limited is 100% owned by Wairarapa DHB. 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.

## 10. Investment in Joint Venture

Wairarapa DHB has a 16.7% share holding in Central Region's Technical Advisory Services limited (TAS). TAS was incorporated on 6 June 2001. TAS has a total share capital of $600 of which Wairarapa DHB's share is $100. At 30 June 2003 all share capital remains uncalled.

The balance date of TAS is 30 June.

## 11. Bank Overdraft

The bank overdraft is secured by a negative pledge which requires the Board to comply with certain covenants such as limitations on borrowings, interest cover and working capital ratio. The Board and group complied with all covenants for the 2003 financial year. The facility available totals $2,500,000. The current interest rate on the group's bank overdraft is 9.85% per annum (2002 - 11.10%).

## 12. Payables and Accruals

| | Group | | Parent | |
|---|---|---|---|---|
| | **2003** | **2002** | **2003** | **2002** |
| | **$000** | **$000** | **$000** | **$000** |
| Trade Creditors and Accruals | 3,825 | 4,696 | 3,747 | 4,624 |
| Capital Charge Due to the Crown | 159 | 137 | 159 | 137 |
| GST / FBT Payable | 315 | 346 | 302 | 343 |
| Directors Fees Payable | 0 | 3 | 0 | 3 |
| Income Received in Advance | 0 | 426 | 0 | 426 |
| Amount Owing to Subsidiaries | 0 | 0 | 10 | 9 |
| **TOTAL PAYABLES AND ACCRUALS** | **4,299** | **5,608** | **4,218** | **5,542** |

## 13. Employee Entitlements

| | Group | | Parent | |
|---|---|---|---|---|
| | 2003 $000 | 2002 $000 | 2003 $000 | 2002 $000 |
| Accrued Pay | 588 | 516 | 591 | 507 |
| Annual Leave | 1,396 | 1,346 | 1,377 | 1,329 |
| Retirement Leave | 298 | 271 | 296 | 269 |
| Long Service Leave | 254 | 241 | 254 | 241 |
| Maternity Grant | 8 | 1 | 8 | 1 |
| Course and Conference Leave | 306 | 259 | 306 | 259 |
| Total Employee Entitlements | 2,850 | 2,635 | 2,832 | 2,606 |
| Made up of: | | | | |
| Current | 2,479 | 2,273 | 2,463 | 2,246 |
| Non-current | 371 | 362 | 369 | 360 |
| **TOTAL EMPLOYEE ENTITLEMENTS** | **2,850** | **2,635** | **2,832** | **2,606** |

## 14. Term Loans (Secured)

| | Group | | Parent | |
|---|---|---|---|---|
| | 2003 $000 | 2002 $000 | 2003 $000 | 2002 $000 |
| Crown Funding Agency | 6,000 | 6,000 | 6,000 | 6,000 |
| Finance Leases | 32 | 126 | 32 | 126 |
| **TOTAL** | **6,032** | **6,126** | **6.032** | **6,126** |
| **Made up of:** | | | | |
| Current Portion | 32 | 94 | 32 | 94 |
| Non-current Portion | 6,000 | 6,032 | 6,000 | 6,032 |
| **Repayable as follows:** | | | | |
| Less Than One Year | 32 | 94 | 32 | 94 |
| One To Two Years | 6,000 | 32 | 6,000 | 32 |
| Two to Five Years | 0 | 6,000 | 0 | 6,000 |
| **TOTAL** | **6,032** | **6,126** | **6,032** | **6,126** |
| **Interest Rates Summary:** | | | | |
| Crown Financing Agency | 7.09% | 7.09% | 7.09% | 7.09% |
| Finance leases: | | | | |
| Minimum | 0.00% | 7.49% | 0.00% | 7.49% |
| Maximum | 9.74% | 9.74% | 9.74% | 9.74% |

A $6 million term loan was raised with the Crown Financing Agency on 12 April 2002. The Crown Financing Agency term liabilities are secured by a negative pledge. Without the Crown Financing Agency's prior written consent Wairarapa District Health Board cannot perform the following actions in the following areas:

- Security interest: Create any security interest over its assets except in certain defined circumstances.
- Loans and Guarantees: Lend money to another person or give a guarantee.
- Change of Business: Make a substantial change in the nature of business.
- Disposals: Dispose of all or substantial part of its assets except in certain defined circumstances.
- Provide Services: Provide services to or accept services from a person other than for proper value and on reasonable commercial terms.

Term liabilities owed to the Wairarapa Community Health Trust and UDC Finance Limited are secured by the assets purchased.

## Analysis of Finance Lease Liabilities

| | Group | | Parent | |
|---|---|---|---|---|
| | 2003 $000 | 2002 $000 | 2003 $000 | 2002 $000 |
| Payable no Later than One Year | 32 | 94 | 32 | 94 |
| Later than One, not Later Than Two Years | 0 | 32 | 0 | 32 |
| Later than two, not later than five years | 0 | 0 | 0 | 0 |
| **TOTAL** | **32** | **126** | **32** | **126** |
| **Representing lease liabilities**: | | | | |
| Current | 32 | 94 | 32 | 94 |
| Non-current | 0 | 32 | 0 | 32 |

## 15. Reconciliation of Net Surplus/(Deficit) After Taxation with Cash flow from Operating Activities

| | Group | | Parent | |
|---|---|---|---|---|
| | 2003 $000 | 2002 $000 | 2003 $000 | 2002 $000 |
| **Net Surplus/(Deficit) After Tax** | **(682)** | **(1,766)** | **(712)** | **(1,789)** |
| Depreciation | 1,495 | 1,543 | 1,439 | 1,499 |
| Increase/(Decrease) Employee Entitlements | 9 | (37) | 9 | (38) |
| Net Loss/(Gain) on Sale of Fixed Assets | (112) | (97) | (115) | (97) |
| **Total non-Cash Items** | **1,392** | **1,409** | **1,333** | **1,364** |
| **Movements in Working Capital Items** | | | | |
| (Increase)/Decrease in Receivables and Prepayments | (599) | (1,028) | (589) | (1,030) |
| (Increase)/Decrease in Inventories | (24) | (53) | (24) | (53) |
| Increase/(Decrease) in Payables and Accruals | (1,305) | 1,413 | (1,311) | 1,433 |
| Increase/(Decrease) in Taxation | 6 | 89 | 0 | 89 |
| **Working Capital Movement – Net** | **(1,922)** | **421** | **(1,924)** | **439** |
| **Net cash (Outflow)/inflow from Operating Activities** | **(1,212)** | **64** | **(1,303)** | **14** |

## 16. Related Party Disclosure

Wairarapa DHB is a wholly owned entity of the Crown. The Government significantly influences the role of the Board as well as being its major source of revenue.

The group enters into numerous transactions with government departments and other Crown agencies on an arm's length basis. Where those parties are acting in the course of their normal dealings with the group, these transactions are not considered to be related party transactions.

### Related Party Transactions and Balances

### (a) Funding

Wairarapa DHB received $50 million from the Ministry of Health to provide health services to the Wairarapa area in the year ended 30 June 2003.

The amount outstanding at year end was $4 million.

### (b) Inter- group Transactions and Balances

**Biomedical Services New Zealand Limited**

Wairarapa DHB purchased from Biomedical Services New Zealand Limited biomedical servicing of patient related equipment. The purchases account for less than 1% of total purchases by Wairarapa DHB.

These transactions were carried out under the terms of the Letter of Agreement between Wairarapa DHB and Biomedical Services New Zealand Limited dated 24 June 1996, effective from 1 February 1996.

| | 2003 $000 | 2002 $000 |
|---|---|---|
| Purchases | 94 | 88 |
| Management Fee | 30 | 30 |
| Insurance Cover | 4 | 7 |

The following balances as at 30 June 2003 resulted from the above transactions and are payable on normal trading terms:

| | 2003 $000 | 2002 $000 |
|---|---|---|
| Accounts Payable | 10 | 9 |
| Accounts Receivable | 7 | 12 |

Doug Matheson (Chairperson, Wairarapa DHB) and David Meates (Chief Executive, Wairarapa DHB) are Directors of Biomedical Services New Zealand Ltd. Joel George was a Director of Biomedical Services New Zealand Ltd until 4 March 2003. Maureen Breukers was a Director of Biomedical Services New Zealand Ltd from 4 March 2003 to 1 August 2003.

**(c) Key Management and Board Members**
There were no transactions between the Board members and senior management with Wairarapa DHB in any capacity other than that for which they are employed, except for those Board members listed below:

| | |
|---|---|
| Cheryl-Ann Broughton-Kurei | Executive Director, Whaiora Whanui Trust Incorporated |
| Doctor Liz Falkner | General Practitioner, The Doctors (Masterton) |
| Vivien Napier | Board Member, Te Mauri a Iwi (Family Start) |

All transactions were carried out on an arm's length basis and amounted to $1,247,000.

**(d) Other Related Parties**
Payments to the Central Region Technical Advisory Service Limited in the year ending 30 June 2003 totalled $56,941.

## 17. Financial Instruments

The group has a series of policies providing risk management for interest rates, operating and capital expenditures denominated in a foreign currency Wairarapa DHB is a party to financial instruments as part of its everyday operations. These include instruments such as bank balances, investments, accounts receivable, trade creditors and loans.

The group is risk averse and seeks to minimise exposure from its treasury activities. Its policies do not allow any transactions that are speculative in nature to be entered into.

**Interest Rate Risk**
Interest rate risk is the risk that the value of a financial instrument will fluctuate due to changes in market interest rates. This could particularly impact on the cost of borrowing or the return from investments. The Board members do not consider there is any significant exposure to interest rate risk on its investments.

The interest rates on the group's borrowings are disclosed in Notes 11 and 14. There was no interest rate swap agreement in place as at 30 June 2003. (There was no interest rate swap in place at June 2002). Interest rates on investments and credit funds range from 1.75% to 5.25%.

**Currency Risk**
Currency risk is the risk that the value of a financial instrument will fluctuate due to changes in foreign exchange rates. Foreign currency forward exchange contracts (and option agreements) can be used to manage foreign currency exposure. There were no foreign currency forward exchange contracts in place as at 30 June 2003 (June 2002 nil).

**Credit Risk**
Credit risk is the risk that a third party will default on its obligations to Wairarapa DHB or the group, causing the Wairarapa DHB or group to incur a loss.

Financial instruments that potentially subject Wairarapa DHB to risk consist principally of cash and short-term investments, trade receivables and various off-balance sheet instruments.

Wairarapa DHB invests in short-term investments with high credit quality financial institutions and sovereign bodies and limits the amount of credit exposure to any one financial institution. Accordingly Wairarapa District Health Board does not require any collateral or security to support financial instruments with organisations it deals with.

The Board receives 92% (June 2002 92%) of its revenue from the Crown through the Ministry of Health. Accordingly, the Board does not consider there is any risk arising from the concentration of credit with respect to accounts receivable.

**Fair Value**
The fair value of financial instruments is approximated by the carrying amount disclosed in the statement of financial position.

## 18. Patient Funds

Wairarapa DHB administers certain funds on behalf of patients. These funds are held in a separate bank account and any interest earned is allocated to the individual patient balances. Therefore, the transactions during the year and the balance at 30 June are not recognised in the statements of financial performance, financial position or cash flows of Wairarapa DHB.

| | 2003<br>$ | 2002<br>$ |
|---|---|---|
| OpeningBalance | 664 | 649 |
| Monies Received | 0 | 0 |
| Interest Earned | 13 | 15 |
| Payments Made | 0 | 0 |
| **CLOSING BALANCE** | **677** | **664** |

## 19. Capital Charge

Wairarapa DHB pays a capital charge quarterly to the crown based on the greater of its actual or budgeted closing equity balance for the month. The capital charge rate for the year ended 30 June 2003 was 11% (June 2002 11%).

## 20. Board Members' Remuneration

Board members' remuneration, including reimbursements, received or receivable for the year ended 30 June 2003:

| | 2003 $000 | 2002 $000 |
|---|---|---|
| Doug Matheson - Chariperson | 36 | 37 |
| Doctor Rob Tuckett | 19 | 20 |
| Janice Wenn | 18 | 17 |
| Robyn Daglish | 19 | 18 |
| Cheryl-Ann Broughton-Kurei | 18 | 10 |
| Martin Easthope | 24 | 13 |
| Doctor Liz Falkner | 18 | 10 |
| Linda Nelson | 20 | 11 |
| Janine Vollebregt | 19 | 11 |
| Vivienne Napier | 19 | 11 |
| Lyn Patterson | 18 | 9 |
| Alan Stewart | 0 | 11 |
| Dave Morgan | 0 | 8 |
| Colleen Pringle | 0 | 8 |
| Des Ratima | 0 | 8 |
| **TOTAL** | **228** | **202** |

## 21. Employee Remuneration

The number of employees and former employees who received remuneration and other benefits of $100,000 or more per annum during the year.

| Total Annual Remuneration and Other Benefits $ | Number of Employees 2003 | Number of Employees 2002 |
|---|---|---|
| 100,000–110,000 | 3 | 4 |
| 110,001–120,000 | 3 | 0 |
| 120,001–130,000 | 5 | 1 |
| 130,001–140,000 | 1 | 0 |
| 140,001–150,000 | 4 | 3 |
| 150,001–160,000 | 2 | 5 |
| 160,001–170,000 | 1 | 1 |
| 170,001–180,000 | 1 | 2 |
| 180,001–190,000 | 2 | 0 |
| 190,001–200,000 | 0 | 0 |
| 200,001–210,000 | 0 | 2 |
| 210,001–220,000 | 0 | 1 |
| 230,001-240,000 | 1 | 0 |

The former chief executive's total annual remuneration and other benefits falls in the $140,001 to $150,000 band shown above and he was employed until 18 March 2003. The new chief executive commenced employment in April 2003.

Of the 23 employees shown above, 19 are medical employees.

If the remuneration of part-time employees were grossed-up to an FTE basis, the total number of employees with FTE salaries of $100,000 or more would be 27, compared with the actual total number of employees of 23.

**Termination Payments**
During the year the Board made one payment to a former employee in respect of the termination of the employment with the Board. The payment was $11,461.

## 22. Vesting of Assets

Wairarapa DHB was established on 1 January 2001 under the New Zealand Public Health and Disability Act 2000. On that date the assets and liabilities of Wairarapa Health Limited were vested in Wairarapa District Health Board at their carrying values as recorded in the books of the Hospital and Health Service. The net value of the assets vested is recognised as a capital contribution by the Crown, the owner of both the Hospital and Health Service and the District Health Board.

## 23. Post Balance Date Events

There were no significant events between the year end and the signing of the financial statements.

## 24. Explanation of Major Variations

Revenue was $1.5 million higher than planned resulting from Third Order in Council contracts devolved from the Ministry of Health after the budget was completed and the write back of revenue provisions totalling $1.1m. The Revenue write-backs were unbudgeted and were made up of $586,000 for Disability Support, $101,000 for Maternity Services and $426,000 for Personal Health catch-up work from previous years.

Operating expenditure was $1.8m higher than planned due to expenses relating to the Third Order in Council contracts, higher personnel and outsourced services costs. The personnel budget was based on the premise that there would be a number of vacancies in medical staff early in the year. However, this did not eventuate because the opportunity was taken to appoint senior medical staff to positions that had been vacant for some time. Higher than planned recruitment costs and the costs of locum doctors are also reflected in the over spend. This was balanced by cost containment strategies for infrastructure and non-clinical supplies.

In June 2003 the Wairarapa DHB received $1.5m of crown equity to support the deficit. The plan included a draw down of $1m additional term debt for major capital expenditure related to the site redevelopment. The plan also assumed $2.5m of capital expenditure for site redevelopment much of which was expected to be in year end payables. Site redevelopment was delayed while a Business Case was prepared seeking funding from the Ministry of Health. This Business Case has subsequently been completed and support will not be known until November 2003. As a consequence, payables are $1.8m less than planned.

The revaluation of land and buildings effective 30 June 2003 resulted in an increase in the value of Fixed Assets of $3.4m. This is also reflected in the Revaluation Reserve in General Funds.

# Statement of Objectives and Service Performance

## for the year ended June 2003

The Minister of Health purchased personal health and disability support services from Wairarapa DHB during the year ended 30 June 2003. The DHB sets objectives with key deliverables as specified in the Statement of Intent for each of the three activity classes as follows:

- Funding and delivery of health and disability support services
- Provision of hospital and health services
- Governance and administration

This section of the report describes the achievement against each objective to demonstrate the Wairarapa DHB's performance for the year and show how the overarching goals are met.

| **Goal** | **Improvement of Health and Disability Services** | |
|---|---|---|
| **Objective** | **To implement the Primary Healthcare Strategy** | |
| **Output Class** | **Deliverables** | **Achievements** |
| **Funder** | To manage a programme leading to the introduction of a Primary Health Organisation (PHO) structure for the Wairarapa. | Wairarapa DHB funder developed and managed a comprehensive programme that included information sharing, a public workshop in July 2002, registration of interest process and establishment of a PHO steering committee in November 2002. |
| **Provider** | To contribute to the development of PHO structure. | Provider services contributed to the development by having a representative on the PHO Steering committee. |
| **Governance** | To monitor progress against the work programme to develop a PHO structure, and instruct on corrective or amended actions as necessary | The Board received and reviewed monthly reports on PHO establishment and other primary health care issues. |

| **Objective** | **To establish a Child Health Register or Database** | |
|---|---|---|
| **Output Class** | **Deliverables** | **Achievements** |
| **Funder** | To have a reliable population wide register in place by 31 March 2003. This requires identification of the status of the current national systems development and establishing links to the national systems. | Current national systems development is at the pilot stage, this has delayed the implementation in the Wairarapa. |
| **Provider** | Work towards the establishment of a reliable register. | Hospital birth data is collected and available for populating the register when it becomes operational. |
| **Governance** | To monitor progress against the work programme to establish a child health register, and instruct on corrective or amended actions as necessary. | The Board reviewed progress reports each month. |

| Objective | To establish a Chronic Disease Register | |
|---|---|---|
| **Output Class** | **Deliverables** | **Achievements** |
| **Funder** | To have a reliable population wide chronic disease register in place by 30 June 2003 that enables the reporting of indicators of people with asthma , chronic obstructive pulmonary disease (COPD) and diabetes. | A diabetes database, a register of oxygen users and a register of clients of the asthma service are in place. These records will be further developed to establish a comprehensive chronic disease register. |
| **Provider** | To develop the secondary service components of the chronic disease register and care plans by 30 June 2003. | Information on services are captured in the DHB patient management system and in the future this will be incorporated into the chronic disease register. |
| **Governance** | To monitor progress against the work programme to develop a chronic disease register, and instruct on corrective or amended actions as necessary. | The Board reviewed progress reports quarterly. |

| Objective | To reduce avoidable Hospital admissions | |
|---|---|---|
| **Output Class** | **Deliverables** | **Achievements** |
| **Funder** | To co-ordinate with the provider services a work programme with action plans and timetables to reduce avoidable hospital admissions. | Information was collected relating to avoidable hospital admissions and two reports have been completed this year. |
| **Provider** | Develop and provide reports in conjunction with the funder staff on long-term trends for avoidable admissions. Work with primary care to identify service developments in the community that assists in avoiding such admissions. | Service developments include working closely with Maori providers, the appointment of a cardiac outreach nurse, continued support of the diabetes and asthma outreach nurses and planning for an outreach respiratory nurse position. The employment of GPs in the emergency department has assisted in reducing the referral rate and avoidable admissions. |
| **Governance** | To monitor progress against the work programme to reduce avoidable hospital admissions, and instruct on corrective or amended actions as necessary. | The Board reviewed progress reports each quarter. |

| Objective | To reduce waiting times for Public Hospital elective services | |
|---|---|---|
| **Output Class** | **Deliverables** | **Achievements** |
| **Funder** | To work towards the implementation of referral guidelines in primary care for the five most commonly referred conditions by 30 June 2003. | See comments below. |
| **Provider** | Provider to develop, funder to monitor, a system of setting financially sustainable thresholds for commonly accessed elective surgery by December 2002.<br>Targets are as follows:<br>1. Booked surgery to be completed within six months of the first assessment.<br>2. 100% of referred patients to wait no longer than six months for their first assessment.<br>3. 100% of patients in active care and review have an assessment at least six monthly<br>4. Number of patients on active care and review kept below 10% of total surgical discharges.<br>5. All contracted elective (arranged) work is completed. | The five most common orthopaedic referrals were identified and referral guidelines implemented. This process has commenced with the Gynaecology referrals. The financially sustainable thresholds has been reviewed quarterly and waiting times have improved.<br><br>Of the targets stated above 3, 4 and 5 were achieved. Work is ongoing to achieve the remaining targets. |

| | | |
|---|---|---|
| **Governance** | To monitor progress against the work programme to reduce waiting times for public hospital elective services, and instruct on corrective or amended actions as necessary | Waiting times, numbers of people waiting and referrals were reported to the Board each month by the provider and quarterly by the funder. |

| **Objective** | **To further develop the Mental Health workforce** | |
|---|---|---|
| **Output Class** | **Deliverables** | **Achievements** |
| **Funder** | To work with the Regional Mental Health Network and local providers to complete a district-wide mental health workforce development plan, as a component of the regional mental health workforce development plan, by 31 March 2003. | The project was postponed pending progress in development of the regional mental health workforce plan. |
| **Provider** | To complete a review of clinical accountability and supervision arrangements by 31 March 2003. | This goal has been moved out to December 2003 and is included as part of the MHS Professional Development Framework. |
| **Governance** | To monitor progress against the work programme and instruct on corrective or amended actions as necessary. | Reports are reviewed by Hospital Advisory Committee each month. |

| **Objective** | **To ensure all providers comply with the mental health information national collection (MHINC) data requirements.** | |
|---|---|---|
| **Output Class** | **Deliverables** | **Achievements** |
| **Funder** | To develop a plan for all mental health providers to report service utilisation data to the mental health information national collection (MHINC) program by 30 June 2003. | Plan development postponed pending completion of software developments at national level. |
| **Provider** | To provide data to the MHINC by 31 December 2002. | Data sent monthly to MHINC database, reports analysed against original data. |
| **Governance** | To monitor progress against the work programme to ensure all providers comply with data collection requirements. | Board receives quarterly reports and monitors progress. |

| **Objective** | **To improve Maori access to Mental Health Services** | |
|---|---|---|
| **Output Class** | **Deliverables** | **Achievements** |
| **Funder** | To implement the Maori mental health strategy to improve the effectiveness of mainstream services for Maori including building the capability of Kaupapa Maori services.<br>The following targets for access to treatment are included in The New Zealand Mental Health Strategy: 0-9 years 0.5%, 10-14years 1.6%,15-19 years 1.4%,20-64years 0.9%, 65 plus years 0.25%. | To improve the delivery of mental health services in the Wairarapa there was participation in local and regional forums, relationship building with local providers and collaboration with other DHBs.<br><br>Performance against targets for access to treatment as follows: 0-9 years 0.23%, 10-14 years 1.72%, 15-19 years 4.66%, 20-64 years 3.36%, 65 plus years 1.72%. This shows a high number of clients between the ages of 15 to 64 using the service. |

| Objective | To improve Child Health Services | |
|---|---|---|
| **Output Class** | **Deliverables** | **Achievements** |
| **Funder** | To provide a report to the Ministry of Health that includes vaccination rates, an analysis of the differences between the local rates and the sector targets, reasons for the variance with proposed strategies including the timeline to close the gap. | Information has been collected and the report to be completed. The immunisation co-ordinator has started to audit GP practices. The information collected has been useful in encouraging practices to vaccinate children who are overdue for their vaccination. |
| **Funder** | To monitor statistics for school entry children passing a hearing screening test to ensure that children who have hearing loss when they start school are identified and referred for appropriate treatment. The Ministry of Health set a target of 92% of school entrants passing a hearing screening test. | The Public Health services of the DHB reported information monthly to Planning and Funding. 97% of new school entrants passed the hearing screening first test. Those that failed were retested within 12 weeks. |
| **Funder** | To provide information to the Ministry of Health for the calculation of readmission for asthma rates in children under 5 and children 5 to 14. The Ministry of Health has set a target rate per 100 discharges of 5.8% (Maori 5.9%, Pacific 5.5%, Other 5.3%) for children under 5 and 6.2% (Maori 6.6%, Pacific 6.4%) for children 5 to 14.<br><br>(A readmission within a month indicates whether appropriate education and treatment occurred at the initial admission and/or whether support exists in the community). | Information was provided to the Ministry of Health during the year. The actual rates achieved during the year for children under 5 were 4.3% ( Maori 7.7%, Pacific 0%). These were in the top eight best rates nationally and represented only one readmission.<br><br>For children between 5 to 14 there were no readmissions. |
| **Funder** | To provide information to the Ministry of Health for the calculation of the percentage of babies born in public hospitals with a birth weight under 2500 grams. The Ministry target rate per 100 discharges was 4.8% (Maori 4.9%,Pacific 4.9%, Other 4.9% `).<br><br>(This is an important statistic. Infants born under 2500 gm are more likely to have poor health outcomes and increased disabilities). | Information was provided to the Ministry of Health throughout the year for the calculation of the rate. The actual rates during the year were 6.1% overall (Maori 9%, Pacific 0%, Other 5.2%). |
| **Funder** | To provide information to the Ministry of Health regarding exclusive and full breastfeeding rates at six weeks and three months. To monitor and put in place strategies to improve the rates.<br>The target rates were as follows:<br>• Six weeks - greater than 60%<br>• Three months - greater than 46%<br>(This is a key statistic because breastfeeding provides immunological advantages to the infant and provides an optimal combination of nutrients for growth and development). | Information was provided to the Ministry of Health during the year.<br><br>The actual rate for six weeks was 68% and for three months was 60%. |
| **Funder** | To provide information to the Ministry of Health regarding hospital admission that could reasonably be expected to be dealt with in primary care or on an outpatient basis.<br>The target rates were as follows:<br>• 9.3% of the Wairarapa population between 0 and 4.<br>• 1.9% of the Wairarapa population between 5 and 14.<br>• 1.4% of the Wairarapa population between 15 and 25. | The information was provided to the Ministry of Health. The actual rates were as follows:<br>• 12.1% for ages 0 to 5 (national average 7.9%)<br>% for ages 5 to 14 (national average 1.85%).<br>• 1.7 % for ages 15 to 25 (national average (1.4%)<br><br>All of the actual rates were slightly higher than the target rates. |

| Objective | To reduce the incidence and impact of Diabetes | |
|---|---|---|
| **Output Class** | **Deliverables** | **Achievements** |
| **Funder** | To implement the minimum diabetes dataset.<br><br>(This measure will enable the population with diabetes to be identified and monitored) | Wairarapa DHB contracts the management of the minimum diabetes data set to the Wellington regional Diabetes Trust through capital and Coast DHB. Data was reported in the Trust's annual report to Wairarapa DHB and the DHB then reported the data to the Ministry by the due date. |
| **Funder** | To monitor the diabetes case detection rate The target rate was that greater than 40% of people with diabetes to be recorded on the diabetes register. (This measure will enable the population with diabetes to be identified and monitored). | Overall the number of people with diabetes registered on the database increased from 28% in 2001 to 34% in 2002. |
| **Funder** | To monitor the number of people with diabetes who are being case managed by measuring HBA 1c blood test results. The target percentage is that less than 30% of people with type 1 or type 2 diabetes that are on the register to have a HBA1c test result of more than 8%.<br><br>(HBA1c is the most common predictor of micro vascular complications and diabetes control. A test result of more than 8% shows poor diabetes control. | The actual result was 26.5% of people with type 1 of 2 diabetes on the register had a HBA 1c result of more than 8%. This was better than the target. Initiatives including providing newly diagnosed people with personalised diabetes education packs and holding Maori and urban outreach clinics continue to improve the results. |
| **Funder** | To monitor the percentage of people on the diabetes register who have had a retinal screening test within the last two years. The target percentage is that greater than 70% of people with type 1 or type 2 diabetes that are on the register have had a retinal screening or an ophthalmologist examination in the last 2 years.<br><br>(A major potential impact of diabetes is blindness. Testing can prevent this). | The actual result was 88% of people with type 1 or type 2 diabetes that are on the register have had a retinal screening or an ophthalmologist examination in the last 2 years. This was better than the target. |

| Objective | To reduce the rate of suicide and suicide attempts. | |
|---|---|---|
| **Output Class** | **Deliverables** | **Achievements** |
| **Funder** | To promote and encourage the use of the guidelines for suicide prevention by contracted providers. | Suicide prevention objectives has been included as a requirement for the PHO Business Plan. |

| Objective | To promote the inclusion and participation in society and independence of people with disabilities. | |
|---|---|---|
| **Output Class** | **To develop capability to undertake planning and funding responsibilities for health and disability services for older people by 30 June 2003.** | |
| **Output Class** | **Deliverables** | **Achievements** |
| **Funder** | To complete a disability needs assessment by 30 June 203 and to develop a strategy for consultation with key stakeholders on disability support services and related matters by 31 October 2003.<br><br>Develop a plan to establish capability and capacity to operate as funder of health and disability services for older people within a timeframe agreed with the Ministry of Health. | A disability needs assessment was completed and a strategy on disability support services for older people developed and consulted on. An older people's forum was established and meets regularly.<br><br>An establishment plan to operate as a funder of health and disability services for older people was completed and delivered to the Ministry in the agreed timeframe. |

| Objective | To promote the inclusion and participation in society and independence of people with disabilities Continued. | |
|---|---|---|
| **Output Class** | **Deliverables** | **Achievements** |
| **Provider** | Ensure that future provider property developments occur in consultation with disability advocates to ensure accessibility to facilities.<br><br>\Ensure that information about the rights of the disabled is accessible to the public.<br><br>Develop a plan for delivery of services so as to ensure provision of an integrated continuum of care for older people, by 30 June 2003. | Facility development guidelines include consultation with disability advocates.<br><br>Pamphlets on the rights of disabled are available to patients and family.<br><br>A plan to ensure an integrated continuum of care for older people was completed during the year. |
| **Governance** | To monitor progress against the work programmes to develop capability and implement Wairarapa DHB's Disability Strategy action plan and instruct on corrective or amended actions as necessary.<br>Hold not less than six meetings of the Disability Services Advisory Committee. | The Board receives monthly reports on the capability work programme.<br><br>Seven meetings of the Disability Support Advisory Committee were held during the year. |

| Objective | To reduce health disparities by improving health outcomes for Maori and other population groups | |
|---|---|---|
| **Objective** | **To further develop the relationship between Wairarapa DHB and Ngati Kahunga ki Wairarapa and Rangitane o Wairarapa** | |
| **Output Class** | **Deliverables** | **Achievements** |
| **Funder** | To develop Maori heath strategy by 30 June 2003, in conjunction with the Maori health committee, that will sit alongside the main strategies contained within the District Strategic Plan.<br><br>To ensure that processes for participation, engagement an input by iwi/Maori are in place for health needs assessment, prioritisation, planning, service delivery and monitoring and evaluating services | Maori health development action plan developed and implementation commenced.<br><br>The Maori Health Committee continue provide input into a range of operational matters when proactively engaged. Through these mechanisms and other forums Maori are being enabled to provide input into Wairarapa DHB matters at all levels.<br><br>We are currently progressing the development of a Maori workforce development strategy and a Maori provider development strategy. |
| **Provider** | Increase the responsiveness for Maori by ensuring that service participation in the Maori "Enabling Framework" and that the number of Maori on staff increase by more than 10 by 30 June 2003. | A Maori staff group meets monthly. Maori staff numbers increased by six during the year. |
| **Governance** | To continue to develop the partnership agreement.<br>To monitor progress against the Maori health strategy actions and instruct on corrective or amended actions as necessary. | The Board and Mana Whenua are working together at a governance level to ensure Maori input is being achieved in strategic matters of the Board<br><br>The Board receives monthly reports on the implementation of the Maori health strategy. |

| Objective | To improve ethnicity data collection in all systems | |
|---|---|---|
| **Output Class** | **Deliverables** | **Achievements** |
| **Funder** | Develop a work programme by 30 November 2002, including action plans and timelines to ensure all contracts for provision of services include ethnicity data collection requirements, promote awareness, develop capability and monitor compliance in ethnicity data collection across all contracted providers. | Work programme developed. All new contracts include the requirement to report ethnicity data. Awareness has been promoted at regular meetings with providers. |
| **Provider** | Meet the contract requirements for collection of ethnicity data, and ensure that all relevant databases contain ethnicity data or are capable of linking to other systems containing ethnicity data. Further develop procedures to ensure that ethnicity data is updated and as complete and accurate as possible in all systems. | Ethnicity data is collected and recorded in the Patient Management System, this can be accessed by other systems.<br><br>All referral forms request ethnicity data, so our systems can be kept up to date. |
| **Governance** | To monitor progress against the work programme and instruct on corrective or amended actions as necessary. | Management reports to the Board include progress on this work programme. |

| Goal | Community participation | |
|---|---|---|
| **Objective** | **To ensure that the Wairarapa community and key stakeholders are engaged and participating in the planning for the provision of health services in the Wairarapa.** | |
| **Output Class** | **Deliverables** | **Achievements** |
| **Funder** | To engage with the community regarding the development of PHO's , health needs assessment, review of the strategic and annual plans and the implementation of service development plans. | There was extensive engagement with the community and stakeholders through workshops and reference and advisory group meetings. These included the PHO steering group, the mental health advisory group, diabetes team and 5 reference groups, respiratory service advisory group, health of older persons advisory group and forum, pharmaceutical advisory group and the immunisation outreach advisory group. |
| **Provider** | Ensure that there is consumer participation regarding service developments in mental health and maternity services. | Maternity services met with Te Roopu Tautoko Whanua and various consumer focus group. Mental health services also met with various consumer focus groups during the year. |
| **Governance** | Measured by the number of meetings with stakeholders, number of submissions received, the number of open Board and committee meetings and the number of proactive press releases. | During the period 1 July 2002 to 30 June 2003 the following open public meetings of the Wairarapa DHB were held:<br>• twelve Board Meetings, along with one Special Board Meeting in October 2002.<br>• ten Community and Public Health Advisory Committee Meetings.<br>• eight Disability Support Advisory Committee Meetings.<br>• eleven Hospital Advisory Committee Meetings.<br><br>The following consultation meetings were held in May 2003 to consult on the Wairarapa DHB's Site Development Business Case proposal:<br>• two public meetings.<br>• one Maori Health Provider hui.<br><br>Remaining consultation meetings were held in July 2003. Five written submissions were received from stakeholders in respect of the Masterton Hospital Site Development proposal. Other feedback was received |

| | | |
|---|---|---|
| | | verbally at meetings. |

| **Goal** | **Quality of services** | |
|---|---|---|
| **Objective** | **To maximise the quality of all services provided and/or funded by Wairarapa DHB, including their cultural appropriateness, through effective monitoring and audit and the promotion of an organisational culture, which is supportive of quality initiatives.** | |
| **Output Class** | **Deliverables** | **Achievements** |
| **Funder** | Provide a report annually on the extent to which service agreements are consistent with quality requirements. | All contracts are consistent with the quality requirements contained within the national policy frameworks. |
| **Provider** | Provide a report annually on the annual audit programme. | A report was completed and sent to the Audit Committee describing the audits completed during the year. |
| **Governance** | Monitor progress against the quality improvement and audit work programme of the funder and provider, and instruct on correctable or amended actions as required. | The Board through the Audit Committee receives regular reports on quality and audit issues and monitors progress. |

| **Objective** | **To ensure mental health services are delivered that: improve the health status of people with severe mental illness ,and actively involve consumers and communities at all levels.** | |
|---|---|---|
| **Output Class** | **Deliverables** | **Achievements** |
| **Funder** | To work with providers of mental health services to assist them to develop their capability and capacity to measure and report mental health outcomes achieved, also ensuring they can access training and support from the regional network. Provide progress reports quarterly on the use of outcome measures<br><br>Ensure that there is consumer input into all mental health service planning by supporting advisory groups. | A national outcome measurement programme is in the planning stage. Regional workshops to inform Providers of national developments were held in March 2003.<br><br>Advisory groups were supported and continued to meet regularly during the year. |
| **Provider** | Provide quarterly progress reports on the use of outcome measures, consumer input to service development, implementation of national strategies regarding youth and children and a list of key quality improvement initiatives. | Quarterly progress reports were completed. A quality project group is developing the key quality improvement initiatives. |
| **Governance** | To monitor progress against the funder and provider deliverables and instruct on corrective or amended actions as necessary. | The Board receives regular reports and monitors progress. |

| **Objective** | **To demonstrate a culture of continuous quality improvement** | |
|---|---|---|
| **Output Class** | **Deliverables** | **Achievements** |
| **Funder** | To develop an action plan by 30 June 2003 to support providers to meet the requirements of the Health and Disability Services (Safety) Act over the next two planning cycles.<br><br>Ensure there is a quality component in all contracts and that new and renewed contracts are consistent with requirements in applicable national service frameworks. | An action plan was developed. All contracts have quality components and the new or renewed contracts have reference to the national service specification requirements.<br><br>All contracts include quality requirements that are consistent with national service frameworks. |
| **Provider** | Achieve hospital accreditation through Quality Health | The provider continued to work towards accreditation |

| | | |
|---|---|---|
| | New Zealand by 30 June 2003.<br>Further progress credentialing of senior medical staff by self –assessment process by 30 November 2002, a gap analysis completed by 31 March 2003 and action plans finalised by 30 April 2003. | during the year however due conflicting priorities and the level of work still to be done the timeframe for accreditation was extended to mid-year 2004.<br><br>The credentialing committee was established and the process commenced with three groups of specialist being credentialed. |
| **Governance** | To ensure that a Clinical Board is in place and functioning by 30 June 2003.<br><br>Monitor progress against funder and provider deliverables, and instruct on corrective or amended actions as necessary. | A Clinical Board was appointed and functioning as at 30 June 2003.<br>The Board receives regular reports and monitors progress. |

| **Goal** | **Financial responsibility** | |
|---|---|---|
| **Objective** | **To operate in a financially responsible manner as per section 41 of the New Zealand Public Health and Disability Act 2000.** | |
| **Output Class** | **Deliverables** | **Achievements** |
| **Funder** | Breakeven operating result | Operating deficit of $60,122<br>This result was $60,122 worse than the target |
| **Provider** | Operating deficit not exceeding $252,000 | Operating deficit of $350,054<br>This result was $98,054 worse than the target |
| **Governance** | Operating deficit not exceeding $211,000 | Operating deficit of $301,444<br>This was $90,444 worse than the target. |
| **Consolidated** | Return on net funds employed 5.28%<br>Operating margin to revenue 1.33%<br>Revenue to net funds 3.96<br>Debt to debt plus equity 59.4% | Return on net funds employed 1.6%<br>Operating margin to revenue 0.5%<br>Revenue to net funds 3.11<br>Debt to debt plus equity 36.9% |

## Summary of Revenues and Expenses by Output Class

A key aspect of performance that needs to be reported for each output class is the related revenue and expenditure. This is shown below as well as a reconciliation of the accumulated funds to show the cumulative impact of the net surplus/(deficit) for each output class over time.

| | Funder $000 | Governance and Administration $000 | Provision of Hospital and Health Services $000 | Eliminations $000 | Consolidated $000 |
|---|---|---|---|---|---|
| **Revenue** | | | | | |
| Crown | 42,814 | 996 | 35,358 | 30,358 | 48,810 |
| Other | 11 | 1 | 1,548 | 25 | 1,535 |
| **Total Revenue** | **42,825** | **997** | **36,906** | **30,383** | **50,345** |
| **Expenditure** | | | | | |
| Personnel | 0 | 695 | 22,276 | 0 | 22,971 |
| Depreciation | 0 | 58 | 1,380 | 0 | 1,438 |
| Capital Charge | 0 | 56 | 560 | 0 | 616 |
| Other | 42,885 | 489 | 13,041 | 30,383 | 26,032 |
| **Total expenditure** | **42,885** | **1,298** | **37,257** | **30,383** | **51,057** |
| **Net surplus/(deficit)** | **(60)** | **(301)** | **(351)** | **0** | **(712)** |

### Reconciliation of Equity

| | Funder $000 | Governance and Administration $000 | Provision of Hospital and Health Services $000 | Eliminations $000 | Consolidated $000 |
|---|---|---|---|---|---|
| Opening equity | 0 | 8 | 5,942 | 0 | 5,950 |
| Plus/(less) surplus/(loss) for period | (60) | (301) | (351) | 0 | (712) |
| Other movements | 0 | 0 | 4,945 | 0 | 4,945 |
| **Closing equity** | **(60)** | **(293)** | **10,536** | **0** | **10,183** |

# Directory

| | | |
|---|---|---|
| **Board Office** | **Wairarapa DHB** | |
| | **PO Box 96** | |
| | **Masterton** | |
| | **Telephone:** | **(06) 946-9800** |
| | **Fax:** | **(06) 946-9801** |
| **Website** | **www.wairarapa.dhb.org.nz** | |
| **Board Members:** | **Doug Matheson** | **Chairperson** |
| | **Martin Easthope** | **Deputy Chairperson** |
| | **Cheryl-Ann Broughton-Kurei** | |
| | **Doctor Liz Falkner** | |
| | **Vivien Napier** | |
| | **Linda Nelson** | |
| | **Robyn Daglish** | |
| | **Lyn Patterson** | |
| | **Doctor Rob Tuckett** | |
| | **Janine Vollebregt** | |
| | **Janice Wenn** | |
| **Chief Executive** | **David Meates *1** | |
| **Executive Managers** | **Tom Babe** | **Audit and Risk Manager** |
| | **Joy Cooper** | **Director Planning and Funding** |
| | **Joe Howells** | **General Manager Healthcare Services** |
| | **Anne McLean** | **Quality Manager** |
| | **Riki Niania** | **Director Maori Health** |
| | **Helen Pocknall** | **Director of Nursing** |
| | **Alan Shirley** | **Chief Medical Advisor** |
| | **Eric Sinclair *2** | **Chief Financial Officer and General Manager Corporate Services** |
| | **Jill Stringer** | **Communications Advisor** |
| **Auditor** | **Audit New Zealand on behalf of the Office of the Controller and Auditor-General** | |
| **Bankers** | **ANZ Banking Group (New Zealand) Ltd** | |
| | **Crown Financing Agency** | |
| **Solicitors** | **Impact Legal** | |
| | **Broadmore Barnett** | |

**Footnotes**

***1** **Replaced Joel George during the year. Note: John Peters was Acting Chief Executive for a period during the year**

***2** **Replaced Maureen Breukers subsequent to the end of the year.**