Wairarapa District Health Board

Annual Report

2010

Wairarapa DHB

Wairarapa District Health Board

Te Poari Hauora a-rohe o Wairarapa

CONTENTS

FOREWORD

This Annual Report is a summary of the Wairarapa District Health Board's performance during the year 1 July 2009 to 30 June 2010. The Report covers progress the WDHB made towards goals set in its Statement of Intent, District Annual Plan and District Strategic Plan.

ABOUT THE WAIRARAPA DISTRICT HEALTH BOARD

The Wairarapa District Health Board (WDHB) works co-operatively with health professionals and the community to improve, promote and protect the health and well-being of the Wairarapa community, with a focus on reducing differences in health outcomes, particularly for Maori.

The WDHB operates hospital, health and disability support services and contracts independent community-based organisations to provide services, such as the Wairarapa Community Primary Health Organisation, family doctors, pharmacists and mental health, disability support and Maori health organisations.

In population terms, WDHB is the second smallest of the twenty-one DHBs, with a population of nearly 40,000. Whilst it has a small population base, this population is spread over a large geographic area. Its cover extends from the Rimutaka Hill and Ocean Beach in the south to Mount Bruce in the north, a total of 5,936 square kilometres. The Wairarapa district includes three Territorial Local Authorities: Masterton; Carterton and South Wairarapa. The area is characterised by urban clusters surrounded by sparsely populated rural areas. About half of the population lives in urban centres compared with the national average of 83% for all DHBs.

Masterton, the largest of these urban clusters, is located in the heart of the Wairarapa and has a population of 18,000. Masterton, separated geographically from the rest of the Wellington region by the Rimutaka Ranges, is about an hour and a half drive from both Wellington and Palmerston North. Carterton, located south of Masterton, has a population of just over 7,000. South Wairarapa, with a total population of nearly 9,000, includes the towns of Featherston, Greytown and Martinborough. Approximately 30 percent of the properties in South Wairarapa are owned by absentee owners.

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

The Wairarapa population is static and aging. At the 2006 census the Wairarapa DHB is estimated to have a total population of 38,610. The Wairarapa population is projected to decrease by 4% between 2006 and 2026, compared to New Zealand which is projected to increase by 15% for the same period.

Maori make up 14% of the total population, have a younger age profile and are projected to form an increasing proportion of the population. Pacific people make up 2% of the population.

Key demographic features of Wairarapa population include:

- Declining population overall (projected to decline 4% in next ten years)
- Increasing Maori population (projected to increase 20% in next ten years).
- Older and rapidly aging population (over 55 population projected to grow 14.6% in the next 10 years)
- Very small Pacific population.

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

OPERATING STRUCTURE

DHB Governance

The WDHB Board is the Governance Arm which oversees DHB activities. Its 11 members, seven elected and four appointed by the Minister of Health, set policy. The Board is advised by several committees and its policies are implemented by the Chief Executive and members of the Senior Leadership Team.

Funder Arm

The WDHB Planning and Funding arm plans, contracts, monitors and evaluates health and disability services run by the WDHB and contractors. When funding the services, Planning and Funding strives to maintain and improve the Wairarapa community's health within available funding. Planning and Funding also consults the community on significant changes to services and ensures any advice given to the Board is consistent with national strategies and Government policy.

Provider Arm

WDHB run services are known collectively as the Provider Arm of the WDHB and include:

- Medical and Surgical Services
- Mental Health
- Community Care, such as Community Nursing and Health Promotion activities
- Aged Care
- Disability Support Services
- Ambulance

The Provider Arm manages Wairarapa Hospital, and employs about 450 full-time equivalent staff.

Partnership with Iwi

The WDHB recognises and respects the Treaty of Waitangi, and the principles of partnership, participation and protection, in the context of the New Zealand Public Health and Disability Act 2000. The WDHB will continue to work with the Te Oranga o te Iwi Kainga to ensure Maori participation at all levels of service planning, and service delivery for the protection and improvement of the health status of Maori.

VISION, MISSION & VALUES

Our Vision

Well Wairarapa –Better health for all
Wairarapa ora – Hauora pai mo te katoa

Our Mission

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

Our Values

The values that underpin all of our work are:

- **Respect – Whakamana Tangata**

  According respect, courtesy and support to all
- **Integrity – Mana Tu**

  Being inclusive, open, honest and ethical
- **Self Determination - Rangatiratanga**

  Determining and taking responsibility for ones actions
- **Co-operation - Whakawhanaungatanga**

  Working collaboratively with other individuals and organisations
- **Excellence – Taumatatanga**

  Striving for the highest standards in all that we do

CHAIRMAN'S REVIEW

It is my pleasure to present the Wairarapa District Health Board's Annual Report for the year ended 30 June 2010 on behalf of the Board.

The 2009/10 year was a very challenging year for business generally and the Wairarapa District Health Board has not been immune to the effects the global recession has had on NZ business.

RESULTS

The Wairarapa DHB has posted a net deficit of $4.7 million, which was significantly above the budgeted deficit. The primary driver behind this adverse result is the continued growth of inter district flows (IDFs) – those payments made by Wairarapa DHB to other DHBs to treat people domiciled within the Wairarapa. IDFs were $3.4 million higher than the previous year and $3.0 million higher than budgeted. While the IDF funding mechanism operates in its current format the DHB will continue to experience pressure on that part of its budget.

Although the overall financial result is disappointing a total of $4.0 million in efficiencies and cost savings were made during the year, short of the targeted $4.6 million. However, the effort put in to achieving this level is remarkable and represented the largest efficiency and cost saving programme, as a percentage of total revenue, in the country.

The DHB has continued to see increasing number of patients in both the hospital and community settings.

Some of the key achievements through the year include:

- Standardised access rates to both primary and secondary services are well above the NZ average
- Wairarapa residents access to elective services is above the national average
- Reduced the gap between Maori and others accessing annual diabetes checks and also those with satisfactory control of their diabetes
- Continued to support family carers by guaranteeing access to respite care
- Increased the number of older people supported to live in the community
- Improved access to elective surgery

For the first time the Minister of Health released the "league tables" which showed the performance of all DHBs across six key health targets. The Wairarapa DHB has ranked consistently at the forefront across all measures for each of the four quarters. Although these national health targets are primarily focused on the hospital sector the DHB has continued to see significant gains in primary health and community health within our district.

Over the past year, clinicians in the hospital and in the community have worked closely with management to build a sustainable future for health service delivery in the Wairarapa. This close collaboration resulted in the development of our Wairarapa Clinical Services Action Plan and the establishment of a Joint Clinical Forum to support its implementation.

Our Clinical Services Action Plan identifies actions the DHB must take to ensure services are clinically and financially sustainable. The actions recognise we are operating within a difficult financial environment where we must reduce and control our costs.

Balanced against the need to control our costs, we also want to improve the health of our population and improve the patient's experience.

OUTLOOK

In 2010/11, we need to make changes to the way we work. We will focus on the continued development of patient centred models of care and the redesign of patient pathways to better manage acute demand and the burden of long-term conditions. We will be looking at key aspects of our business to determine how we can be more cost effective.

This will involve discussions with other DHBs in the Central region as we work to implement the Regional Clinical Services Plan, involving the most efficient and effective way to fund and deliver services across the region. Our regional collaborative efforts include a focus on opportunities with neighbouring DHBs, in particular Hutt Valley DHB and Capital and Coast DHB. Together, the three DHBs will be exploring new opportunities for clinical and corporate service collaboration in 2010/11, resulting in greater clinical and corporate convergence.

There is also closer collaboration between primary and secondary health care services in the Wairarapa consistent with our successful proposal Tihei Wairarapa to develop an Integrated Family Health Model of Care in the district.

Lastly, I would like to acknowledge the contribution of the Board, management and staff and the various health providers in the Wairarapa who have worked tremendously hard during the year to improve the health of our community. While the past year has been testing, our people have risen to the challenge, reviewing and testing business assumptions and priorities and implementing different and smarter ways to deliver health care. We expect this to continue out into the future.

Bob Francis
Board Chairman

CHIEF EXECUTIVE'S REVIEW

The last year has been exciting and challenging with a huge range of issues and developments to get on top of. The DHB continues to have strong support from the staff and community in so many ways.

We can look back with pride over the last year because we have achieved so much. We had three main aims:

- reduce and control costs;
- improve the patient experience
- improve the health of the whole population.

There have been substantial changes to help us achieve these aims. Under the umbrella of the Good to Great programme we have made many efficiencies, taken huge steps forward with primary care, punched above our weight with health targets and forged relationships with neighbouring DHBs. It was quickly becoming obvious that if we continued to operate as we had always done we would no longer be financially or clinically sustainable. We had to do things differently.

REDUCING AND CONTROLLING COSTS

Our budgeted deficit was close to a million dollars but the end of the year result was actually $4.7 million. $3.1 million of that deficit was the result of adverse IDFs (87% of the deficit). There were other cost pressures as well, such as annual leave adjustments.

We launched the Good to Great programme of initiatives and efficiencies. We needed a $4.6million efficiency programme to achieve the $1million deficit and we achieved $4million. Realising these savings involved a line-by-line analysis of all of the DHB's Provider and Funder Services and various initiatives to control costs. The $4million we achieved was the largest in percentage terms in the country. We made savings of 3.3% of total revenue.

We made gains in many areas.

- Under the Good to Great umbrella we had a target of $4.6 million and $4million (87%) was achieved.
- We reduced the costs of outsourced services as well as clinical and non-clincal supplies.
- FTEs were budgeted at 461.7 but the actual result was 436.7 – favourable against budget by 24.9 FTE staff.

FROM GOOD TO GREAT

These cost savings cannot be sustained without 'transformational organisational change' and The Good to Great programme was designed to foster a critical analysis of our present clinical and business practice and make positive change that would support us into the future.

The Good to Great programme of initiatives and efficiencies is now embedded into the organisation's culture and the need for further direct cost reductions and revenue improvement strategies is widely recognised.

A range of service and workforce initiatives, under the Good to Great programme were completed and they achieved not only an improvement in the financial position, but also an improvement in clinical sustainability as well as the patient and staff experience.

Service Reviews

These areas were reviewed and in some cases changes were made; for others it was business as usual:

- Perioperative service
- Pharmacy costs
- Transport review
- Ambulance service

Workforce reviews and other staff initiatives

The reviews listed below created substantial improvements and efficiencies.

Nursing workforce review	Partially implemented
Corporate services review	Findings incorporated into other reviews e.g. HR and P&F
Senior Leadership Team	Implemented
Hospital management team / Tier 3	Implemented
Clinical administration support	Spilt into two phases – phase 1 complete
FOCUS	Implemented
Community Nursing	Implemented
Maori Health Unit	Completed – no changes recommended
Outpatients / ambulatory care	Partially implemented
Human Resource Review	Completed. HR Manager appointed
PA / Corporate administration review	Partially implemented – pending appointments

Helping staff do their jobs

Enabling strategies to help staff do their jobs well were introduced as part of the Good to Great Programme.

- Revised performance development framework and policy has been implemented. This is being used to guide training investment and performance-based remuneration reviews
- An organizational training calendar has been established, as part of a review of in-house training and development activities. This review has resulted in a revised orientation programme being implemented and also finance training for 47 managers.
- Capacity planning
- Releasing time to care
- Project training
- IT prioritisation and implementation project
- Facility developments

Information Technology Improvements

- Strategic Information Group established, 50/50 clinicians and managers
- Prioritised list of Information Technology projects
- Implementation of e-referrals from primary to secondary care
- Advancement of ED discharge summary and Oral Health planning / design
- Active participation in development of Central Regional Information Strategic Plan (CRISP)
- Significant number of staff attended in-house IT training run in partnership with UCOL
- Planning and development of new intranet

Thanking our staff

Long service awards were given to staff with continuous service for 30+years and for 25+ years. A special morning tea was held to celebrate their contribution and to thank each staff member personally. We also held morning teas to thank the Flower Ladies and the Volunteers for the marvellous work they do supporting staff and patients.

Leadership

Management roles

The Senior Leadership Team was restructured as part of the Good to Great programme to align accountabilities with integrated care service development.

A new Senior Leadership Team and Tier Three structure has been implemented and all positions are now confirmed with people in their posts.

Clinical leadership

A range of clinical leadership initiatives have been initiated over the last 15 months in response to the document 'In Good Hands'.

- Senior Medical Staff now have allotted time for their monthly meeting. This provides a forum for management discussion and initiatives fundamental to improve patient care
- Joint Consultative meetings have been established with ASMS
- There was enthusiastic clinical participation in the development of the Wairarapa Clinical Services Plan
- Numerous clinicians were involved in the EOI for Better, Sooner, More Convenient Primary Health Care, and the development of the business case Tihei Wairarapa
- Clinical staff are actively encouraged to be involved in sub-regional and regional discussions
- A new organizational structure incorporates 'clinical director' positions, an Associate Director of Nursing and a joint appointment with Hutt Valley DHB of a Director Allied Health

MAORI HEALTH

Our efforts to control and reduce costs must happen in a way that protects and promotes the health of those people in our community with poorer health status. These efforts must give special consideration to the needs of Maori given that health outcomes for Maori are typically poorer than other population groups within our district. We need to avoid increasing inequalities within our community. Instead, we must direct our spending more towards those with the greatest needs, including the frail elderly, those with long term conditions, and population groups with poorer health outcomes.

Achievements

- We have had particular success in exceeding targets for immunisation of Maori under two years.
- There has also been a range of cultural competency initiatives undertaken in Mental Health, Maternity and Allied Health – this was on the back of the launch of Te Arawhata Totika.
- The Maori Health Plan has been developed in partnership with Te Iwi Kainga and it sets guidelines for action from 2010 – 2015. The final draft is being considered at the September Board meeting.

QUALITY OF SERVICE DELIVERY

The audit against the Health and Disability Sector Standards for certification found no significant areas of concern, with 12 areas for improvement. All 12 have been acted upon. Achievement against the Quality Improvement Plan key objectives includes:

Quality leaders in 12 clinical departments	Achieved
Medicine reconciliation process implemented	Achieved
Frontline staff trained in adverse event management and open disclosure	Achieved
Optimising the patient journey	"Put it Back jack" and "Sort it Out Jack"
Implement DHB infection prevention and control plan	Revised & implemented
Report mortality reviews to Clinical Board	Range of quality indicators now being reported
Review and revise policy and procedures – 575 controlled documents – 257 policies to review (will be significantly culled)	In progress

WORKING WITH OUR NEIGHBOURS

Working in partnership with our neighbouring DHBs and other health providers in the Wairarapa to ensure clinically sustainable services is essential.

Central Region

We are working closely with other DHBs in the Central Region to determine the most efficient and effective way to fund and deliver services that are both clinically and financially sustainable on behalf of our population. This may require changes to the way services are currently organised in the Central region. Specific projects we are discussing at a regional level include:

- Implementing the Regional Elective Surgery Plan
- Progressing clinical pathway development for key procedures across the region
- Undertaking the Strengthening Hospital Services Projects in Radiology, Women's Services and Older Adults.

Our work with other DHBs will also involve exploring opportunities for joint procurement and sharing support and administrative services. It will also ensure standardised prioritisation tools and processes are used to inform access to regional services and review access to elective services to ensure equity with other DHBs. This may result in changes in some procedures that are performed regionally (and locally) given that Wairarapa is providing higher intervention levels for its population than the national average.

Sub-regional collaboration

Significant progress has been made to advance cooperative, clinically led discussions with Hutt Valley and Capital Coast DHBs. A Memorandum of Understanding has been agreed between the three Chairs and a Clinical Leadership Forum established. The clinical leadership forum is focusing on four specialties and discussing regional approaches in these areas:

- Paediatrics
- Mental Health
- ENT
- Health of Older Persons

We will seek further benefits through collaborative clinical and corporate arrangements.

OTHER LOCAL ACHIEVEMENTS

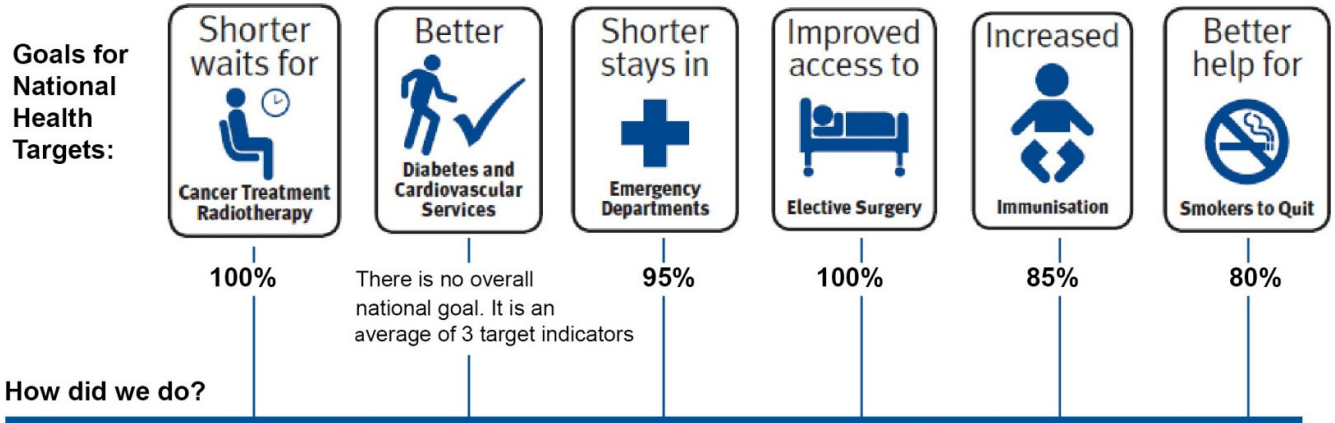
Improving the patient experience and the health of the population was a key achievement locally through:

- We have standardised access rates to both primary and secondary services are well above the NZ average
- Wairarapa residents' access to elective services is above the national average
- We have reduced the gap between Maori and others accessing annual diabetes checks and also those with satisfactory control of their diabetes
- We have continued to support family carers by guaranteeing access to respite care
- Nursing staff from aged residential care providers have enrolled in the DHB Professional Development Recognition Programme (PDRP)

The number of older people supported to live in the community has increased.

NATIONAL HEALTH TARGETS

We have consistently outperformed some of the larger DHBs and have done superbly over all four quarters.



How did we do?

	Cancer		Diabetes		Emergency		Electives		Immunisation		Smoking	
Quarter 1	100%	**1st=**	77%	**2nd**	98.3%	**2nd**	104%	**5th**	89%	**4th**	86%	**1st**
Quarter 2	100%	**1st=**	76%	**1st**	97%	**3rd**	95%	**17th**	87%	**7th**	80%	**1st**
Quarter 3	100%	**1st=**	76%	**1st**	98%	**2nd**	103%	**11th**	92%	**3rd**	87%	**1st**
Quarter 4	100%	**1st=**	75%	**1st**	97%	**3rd**	108%	**4th**	94%	**2nd**	87%	**1st**

TIHEI WAIRARAPA

A significant development during 2009/10 was the successful expression of interest, and subsequent business case, around Better, Sooner More Convenient Primary Health Care. The business case, Tihei Wairarapa sets the foundation for a co-operative working arrangement with primary care providers to implement whanau ora/patient centric services. The signing of the alliance leadership charter and Schedule X of the PHO agreement is the culmination of these efforts to date.

Tihei Wairarapa, is the master plan for integrating the patient journey across primary and secondary care. It grew out of the Wairarapa Clinical Services Action Plan (CSAP) which was the product of much discussion and planning by clinicians in the community and within the DHB. It identifies how we must change the way we deliver services so that we can provide safe, sustainable, value for money healthcare services well into the future. Tihei Wairarapa includes plans to develop an Integrated Family Health Network in the Wairarapa.

It will also involve working more closely with other DHBs in the Central region as we determine the most efficient and effective way to fund and deliver services on behalf of our population.

CONCLUSION

We have done superbly and made huge progress over the last 12 months. There are many more challenges ahead but that's what makes it all so interesting.

I have really enjoyed my first 18 months at Wairarapa DHB - meeting a large number of the Wairarapa community and the Wairarapa DHB staff. It has been a pleasure to work alongside the staff at the DHB to achieve our goals. I believe there is now a strong and capable team in place – able to take on the challenges of the next 12 – 24 months.

Tracey Adamson
Chief Executive

GOVERNANCE REPORT

ROLE OF THE BOARD

The Board's governance responsibilities include:

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

STRUCTURE OF THE DHB

DHB OPERATIONS

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

QUALITY ASSURANCE

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

GOVERNANCE PHILOSOPHY

BOARD MEMBERSHIP

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

Board elections occur every 3 years with the latest elections completed in October 2010. The new Board will take office in December 2010. The membership of the Board and its Committees as at 30 June 2010 is:

- Bob Francis – Chair
- Janine Vollebregt – Deputy Chair
- Perry Cameron
- Dr. Liz Falkner
- Pamela Jefferies
- Helen Kjestrup
- Liz Mellish
- Mavis Mullins
- Vivien Napier
- Fiona Samuel
- Trish Taylor

DISCLOSURE OF INTEREST

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

Member	Interests Declared
Bob Francis	• Chairman - Pukaha Mount Bruce • Board Member - New Zealand Fire Commission • Chairman - Wairarapa Sports Education Trust • Chariman - Wairarapa Healthy Homes • Trustee – Wairarapa Community Transport Trust • Chairman – Aratoi Foundation
Janine Vollebregt	• Self employed Registered Nurse who is providing occasional relief for the Wairarapa Community PHO Contracted Nursing Outreach Clinics. • DHB Nurse Educator for the UCOL Undergraduate Maori Students. This 0.4 FTE position is effective from the 30 April 2008 to 30 June 2010. • Part-time Nursing Lecturer at UCOL (one day per week) until 1 December 2009. • Part-time Academic Nurse Lecturer at UCOL from 24 may 2010 until November 2010 (based at Wairarapa Hospital).
Perry Cameron	• Executive Director of Perry Cameron & Associates Ltd (PCA), a professional consultancy firm.
Dr. Liz Falkner	• Salaried General Practitioner with Masterton Medical Ltd (MML). MML is a member of the Wairarapa Community PHO. • Medical Advisor – Post Polio Support Society NZ Inc
Pamela Jefferies	• Trustee and Treasurer - We the People Foundation • Chairman of Biomedical Services NZ Ltd (subsidiary 100% owned by the Wairarapa DHB) • Member of Care Plus Scheme, provided through the Wairarapa Community PHO • Trustee Greytown District Trust Lands Trust • Board Member, Wairarapa Organisation for Older People • Trustee Toi Wairarapa • Board Member, New Zealand Blood • Board Member, UCOL
Helen Kjestrup	• Clinical Services Manager at Masterton Medical Ltd. • Shareholder, Property Investment Company – Kjestrup Properties • Assessor for Royal College of GPs for Cornerstones Programme • Member, Long term Conditions Steering Group • Member, Wairarapa Nurses Advisory Group • Member Wairarapa DHB Clinical Forum

Member	Interests Declared
Liz Mellish	• Trustee Palmerston North Maori Reserve • Executive Officer Wellington Tenths Trust • Trustee Wellington Tenths Development Trust • Member Capital and Coast DHB DSAC • Chair Card Reserve Surface Trust, Featherston • Consultant for Maori Business
Mavis Mullins	• Chair Aohanga Incorporation • Chair Poutama Trust • Chair Te Huarahi Tika Trust • Director Hautaki Limited • Director Landcorp Farming Limited
Vivien Napier	• RNZ Plunket Society Member • South Wairarapa District Council Deputy Mayor • Director Katson Developments (importing of farm machinery) • Vice President of the Wairarapa Branch Plunket Society
Fiona Samuel	• Member of Wairarapa DHB Clinical Forum • Kaitataki Whanau Ora – Whanau Ora Manager Whaiora. • Member of Child Health Advisory Strategy Group • MOH Expert Advisory Group for Maori Diabetes and Cardiovascular Disease
Trish Taylor	• Family member is a staff member of Wairarapa DHB. • Patron of the Wairarapa Addiction Service

DIVISION OF RESPONSIBILITY BETWEEN THE BOARD AND MANAGEMENT

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

DELEGATIONS

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

ACCOUNTABILITY

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

INTERNAL AUDIT

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

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

RISK MANAGEMENT

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

LEGISLATIVE COMPLIANCE

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

DISCLOSURE OF ULTRA VIRES TRANSACTIONS

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

PERMISSION TO ACT DESPITE BEING INTERESTED IN A MATTER

A member who is interested in a matter relating to a DHB must not vote or take part in any discussion or decision of the board or any committee relating to that matter under section 66 of the Crown Entities Act 2004. However, under section 68 of the Crown Entities Act 2004, the chair of the DHB may exempt one or more board members from this requirement if it is in the public interest to do so. Where such an exemption is given, this must be disclosed in the annual report.

No permissions were provided under section 68.

BOARD MEMBERS' REMUNERATION

Board members' remuneration received or receivable for the year ended 30 June 2010 are shown in the table on the following page. In addition Board members are able to claim reimbursement for out of pocket expenses.

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

- CPHAC: Community & Public Health Advisory Committee
- HAC: Hospital Advisory Committee
- DSAC: Disability Support Advisory Committee
- ARC: Audit & Risk Committee

	2010 Board Fee	2010 CPHAC	2010 HAC	2010 DSAC	2010 ARC	2010 Total Fees	2009 Total Fees
Bob Francis – Chairman	32,000	2,813	1,250		1,250	37,313	36,813
Janine Vollebregt – Deputy Chair	20,000	2,250	2,000	938	750	25,938	25,375
Pamela Jefferies	16,000		2,750		1,250	20,000	20,500
Vivien Napier	16,000	2,313	2,375	500		21,188	20,500
Perry Cameron	16,000	2,500			1,875	20,375	19,688
Liz Falkner	16,000		2,250	250		18,500	18,250
Trish Taylor	16,000	2,500		750		19,250	19,000
Helen Kjestrup	16,000		2,250		1,000	19,250	18,500
Fiona Samuel	16,000	2,500		500		19,000	19,000
Liz Mellish	16,000	2,250				18,250	16,750
Mavis Mullins	11,077		500	250		11,827	0
Yvette Grace	1,846		250			2,096	19,250
Ruth Carter				750		750	500
Lyn Olds				750		750	250
Taiawhio Gemmell		500				500	0
TOTAL	**192,923**	**17,626**	**13,625**	**4,688**	**6,125**	**234,987**	**234,376**

OUR PEOPLE

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

The DHB supports the In Good Hands task force report. This report identified qualities of the New Zealand healthcare system in regards to clinical governance based on the following six principles:

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

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

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

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

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

Meanwhile, the Clinical Forum has clinical representation from across the Wairarapa health system and was the key driver in the development of Tihei Wairarapa. In the future, the Clinical Forum will focus on the wider strategy for the regionalisation of care and developing specific actions within the CSAP.

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

GOOD EMPLOYER

A key value of the WDHB is to be a good employer. The WDHB embraces the 7 Key Elements of "the Good Employer' as prescribed by the EEO Commissioner. The elements are:

- Leadership, Accountability and Culture
- Recruitment, selection and Induction
- Employee Development, Promotion and Exit
- Flexibility and Work Design
- Remuneration, Recognition and Conditions
- Harassment and Bullying Prevention
- Safe and Healthy Environment

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

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

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

Approximately 92 per cent of employees are covered by collective employment agreements (CEA). All the CEA's have prescribed Remuneration, Recognition and conditions clauses. The WDHB has a similar approach for those employees on individual employment agreements to ensure fairness and equity in Remuneration, Recognition and Conditions across the WDHB.

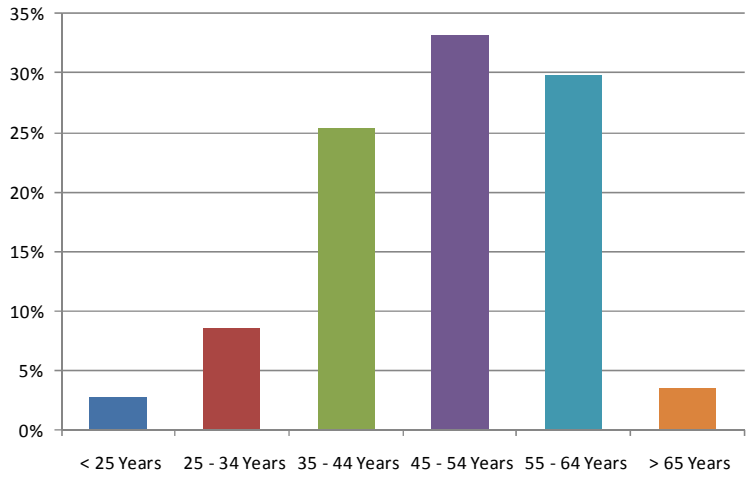
The Protected Disclosure Act 2000 and the Board's related policy, protects the right of employees to raise matters of public concern in a safe and appropriate manner. Where an individual may feel personally disadvantaged there are established grievance procedures available including external mediation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

WORKFORCE PROFILE

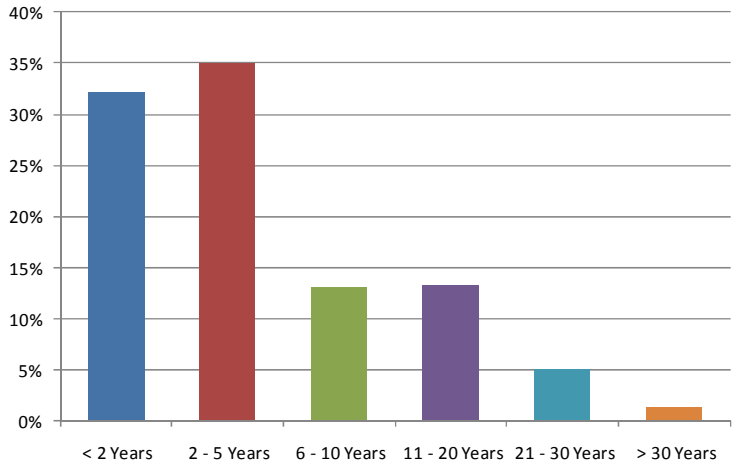
FULL TIME EQUIVALENT STAFF NUMBERS

	2006	2007	2008	2009	2010
Medical	27	26	30	33	33
Nursing	162	164	168	183	191
Allied Health	108	89	88	90	89
Other	120	121	121	127	125
Total	**417**	**400**	**407**	**433**	**438**

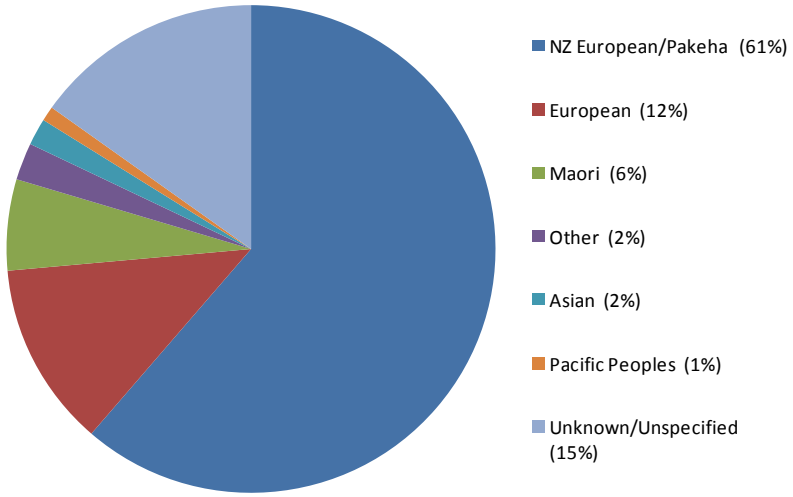
AGE PROFILE OF WORKFORCE



LENGTH OF SERVICE



STATISTICS BY ETHNICITY



STATISTICS BY GENDER

	2006	2007	2008	2009	2010
Female	85%	85%	83%	83%	83%
Male	15%	15%	17%	17%	17%

REMUNERATION OF EMPLOYEES

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

Of the employees shown above, 35 were or are clinical employees (2009: 39) and 8 were neither medical nor dental employees (2009: 8).

	2010 No. of Employees	2009 No. of Employees
$100,000 – $110,000	6	10
$110,001 – $120,000	4	5
$120,001 – $130,000	4	1
$130,001 – $140,000	3	5
$140,001 – $150,000	1	2
$150,001 – $160,000	3	1
$160,001 – $170,000	0	1
$170,001 – $180,000	2	4
$180,001 – $190,000	4	4
$190,001 – $200,000	4	3
$200,001 – $210,000	2	2
$210,001 – $220,000	0	3
$220,001 – $230,000	3	4
$230,001 – $240,000	2	1
$240,001 – $250,000	1	1
$250,001 – $260,000	3	0
$260,001 – $270,000	1	0
	43	**47**

TERMINATION PAYMENTS

During the year the Board made the following payments to former employees in respect of the termination of the employment with the Board. The total paid during the 2009/10 year was $140,670 (2009: 66,704) to 10 staff (2009: 2).

STATEMENT OF SERVICE PERFORMANCE

Wairarapa District Health Board's (WDHB) business is the funding and provision of health services to meet the needs of its resident population, improve health outcomes and reduce inequalities in health between population groups, and particularly between Maori and non Maori.

WDHB is guided by its District Strategic (2005) Plan which set four population health priorities and three disease priorities to be addressed through a mix of population, service and disease based approaches. These represent areas where WDHB believes there is potential to make improvements in the health status of its population and in the delivery and effectiveness of the services provided.

The priorities selected were:

- Improving the health of Maori – reducing disparities
- Improving the health of people in low socio-economic groups
- Improving the health of older people
- Improving children and youth health
- To reducing the incidence and impact of chronic conditions
- Mental health and addictions
- To reducing the incidence and impact of cancer

In its 2009/10 Statement of Intent WDHB set out objectives, measures and targets to reflect the activity it expected to achieve in each of these priority areas. Additional performance measures and targets were included regarding:

- Improve hospital services and productivity
- Improving workforce retention

This section of the annual report describes achievement against each objective to demonstrate WDHB's performance during the year and show how progress is made towards the WDHB's strategic priorities.

The measures indicated in this section are not a comprehensive list but reflect activity in the seven priority areas of the DSP and priorities identified by the Minister of Health. This activity requires the Wairarapa DHB to work collaboratively and develop more holistic approaches; promote healthier lifestyles; improve the quality and safety of services and increase efficiency and value for money.

The Ministry of Health has identified a set of national health targets to encourage rapid progress on key national priority areas. The output relating to each Health target measure is shown in *italics* ion the tables on the following pages.

The performance objectives and measures shown here include several measures over which the WDHB does not have direct control, for example reduction in smoking. These measures are included as they are important determinants of health status and the ability of the WDHB is limited to one of influencing the behaviour of the community. By including these measures WDHB is acknowledging that it cannot achieve its purpose by its own actions alone. WDHB continues to work with other providers, national and local external agencies and community groups to collectively improve the health of its community.

The WDHB is required to disclose the actual revenue earned and output expenses incurred for each of the output classes. The WDHB, consistent with the other district health boards in New Zealand has three output classes specified by the government: Funds, Governance and Provider. The financial information is disclosed in Note 21 on page 86.

IMPROVING THE HEALTH OF MAORI - REDUCING DISPARITIES

He Korowai Oranga: the Maori Health Strategy sets the national direction for Maori health development. The overall aim is whanau ora, whereby Maori families are supported to achieve their maximum health and wellbeing. He Korowai Oranga sets out four pathways for action which determines the priorities, objectives, and actions being undertaken by Wairarapa DHB at a local level. In 2008 Wairarapa DHB completed the development of Te Arawhata Totika - a cultural competency framework. This is a significant achievement for Wairarapa as the framework articulates the values relating to hauora that Wairarapa tangata whenua have identified. Te Arawhata Totika will be used to support, strengthen and increase responsiveness to Maori across all Wairarapa DHB services. The framework also provides the structure for the Wairarapa DHB Maori Health Action Plan 2009-2012.

Improving Maori health is both a national and local priority. The Wairarapa health status report 2008 indicates that Maori have a worse health status than non-Maori across nearly all indicators. Disparities in health outcome are greater between Maori and non-Maori than between any other population groups. Maori have much higher rates of admission to hospital than non-Maori and make less use of primary care services. Key actions to improve Maori health in 2009/10 include:

- Improved targeting of health promotion & prevention of chronic conditions
- Screening for cancer and other chronic conditions
- Increasing access to primary health care services
- Improved integration of primary care and Maori Health Provider services
- Implementation of the Wairarapa DHB wide Cultural Competency Framework – Te Arawhata Totika.

OUTPUT CLASS	OUTPUT	MEASURE	TARGET	ACHIEVEMENT
Funder: Primary & Community	Diabetic annual reviews	Percentage of Maori with diabetes receiving annual reviews	72%	69%
Funder: Primary & Community	Primary care consultations for CVD risk	Cardiovascular risk assessment completed - % of Maori target groups	73%	59%
Funder: Primary & Community	Vaccinations	Immunisation of 2 year old Maori children	85%	92%
		Influenza vaccinations for Maori aged 65 years or older	48%	71%
Provider: Hospital Services	Hospital admissions	Rates of ambulatory sensitive admissions of Maori aged 0-4 years not to exceed more than 20% above national average	120	125

OUTPUT CLASS	OUTPUT	MEASURE	TARGET	ACHIEVEMENT
		Rates of ambulatory sensitive admissions of Maori aged 45-64 years not to exceed more than 29% above national average	129	102
		Rates of ambulatory sensitive admissions of Maori aged 0-74 years not to exceed more than 40% above national average	140	119

COMMENTARY

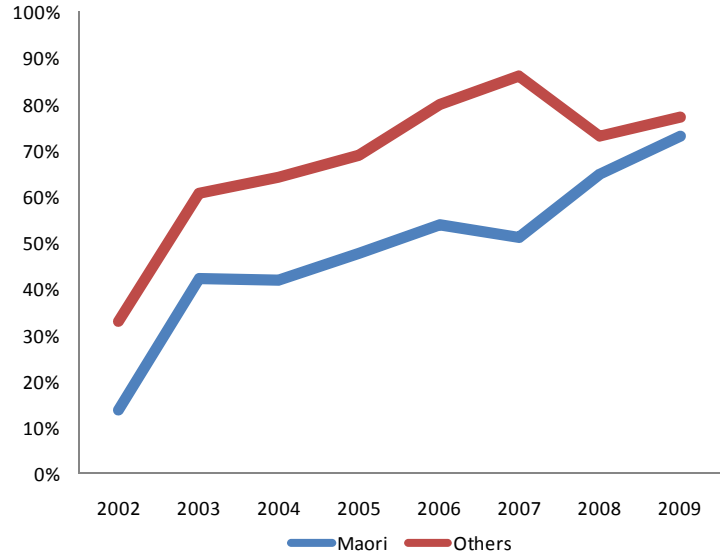
Excellent results have been achieved in the rates of childhood immunisation and influenza vaccinations for Maori. Both of these are as a result of concerted efforts and collaboration between providers. Outreach immunisation services have been effectively utilised for both these groups.

While the target for ambulatory sensitive hospitalisations for children under 5 was not quite achieved, this is not statistically significant. ASH rates for Maori of other age groups were better than the annual target.

The target for Maori receiving diabetes annual reviews has not been met. This result is in direct contrast to the trend of improved results and reduction of the gap between Maori and others as shown in the graph at right.

This continuing improvement was evident in the first half of 2009/10, with the DHB on track to reach the target. Unfortunately, this was not sustained for the second half of the year. The dominant reason for this has been major changes in the provision of primary care during the first half of 2010. These changes included the closure of a major GP practice in Masterton and the subsequent merging of patients into another practice, which has greatly disrupted business as usual.

Fortunately, other changes that occurred in this period included the establishment of a Very Low Cost Access GP service with a Maori Provider and the redefinition of the practice nurse's role in the major GP practices. Further developments in integrated health services are expected with the implementation of the Wairarapa Clinical Services Action Plan (WCSAP) and Tihei Wairarapa, the primary care business case.



Although the impact of the negative changes has been immediate, the impact of the positive changes that have and are occurring will take longer to become apparent.

Cardio vascular risk data is taken from the DHB Performance Scorecard Report for the first half of the 2009-10 year. While the target was not achieved, this is a new indicator and Wairarapa compares well against the national average result.

IMPROVING THE HEALTH OF PEOPLE IN LOWER SOCIO ECONOMIC GROUPS

Inequalities can be found in almost all aspects of health and disability services provision, including access to services, utilisation of services, incidence of health risk factors and disease, and clinical interventions provided. People who live in relatively deprived areas (the highest deciles as measured by the NZ Index of Deprivation) are twice as likely to die early from avoidable diseases. They are admitted to hospital more often for diabetes, asthma and other chronic conditions, compared with the rest of the population. They face greater barriers to accessing health services (user charges and transport pose greater difficulties) than for people in better off groups; and are more likely to live in poorly insulated homes than are detrimental to good health. About 12% of the total Wairarapa population lives in the most deprived areas (Deciles 9 and 10).

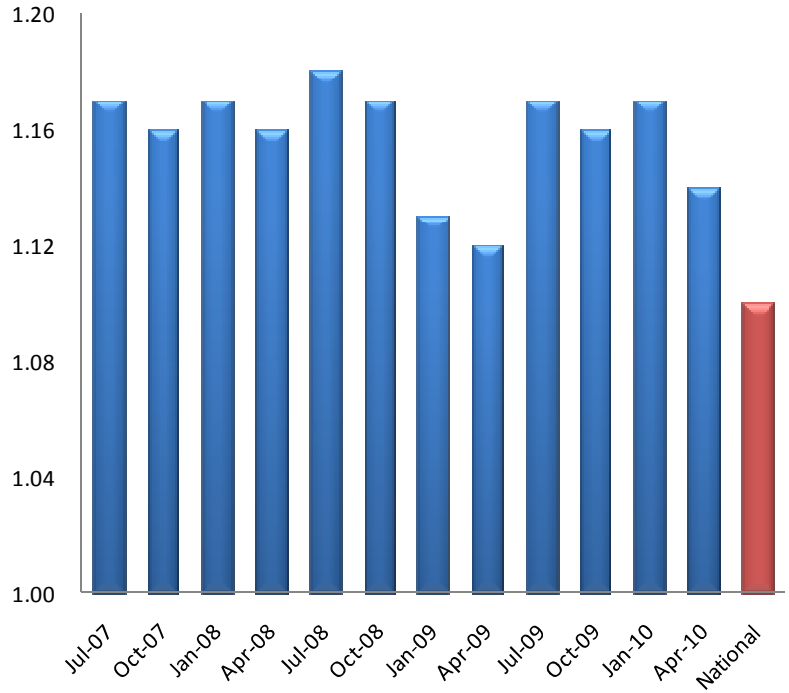
Efforts to ensure increasing access to health services and improve the health status of people in the lower socio-economic groups will continue, including focusing the PHO to more closely target high needs groups, increased collaboration between child health providers to ensure children from low income families are receiving the health services they require and the alignment of health promotion activities to the Keeping Well strategic goals.

OUTPUT CLASS	OUTPUT	MEASURE	TARGET	ACHIEVEMENT
Funder: Primary & Community	Primary care consultations	The ratio of primary care consultations by high needs people to primary care consultations by all people	>1.18	1.14
Funder: Primary & Community	B4 school checks	The proportion of 4 year olds from deprivation quintile 5 receiving a B4 school check	80%	85%

COMMENTARY

A very good result was achieved in the provision of B4 School checks for four year olds living in Deprivation quintile 5 areas. This was the result of on-going collaboration between child health providers.

In the latter half of the year there has been a reduction in the ratio of primary care consultations by high needs people, as shown in the graph to the right. This may be due to a period of reconfiguration of General Practices in Masterton. The DHB and PHO continue to support free outreach services and a new Very Low Cost Access practice opened in April 2010. This is expected to reverse the trend seen in the latest period.



IMPROVING THE HEALTH OF OLDER PEOPLE

The Wairarapa DHB has prioritised implementation of the Health of Older People Strategy through its DSP and the principles of this strategy have been incorporated into the Wairarapa Elder Local Links (W.E.L.L.) plan which describes the direction the Wairarapa DHB is taking to implement the Strategy.

As people age their health needs usually increase, they are also more likely to be complex with longer and more severe impact, and they are more likely to suffer from chronic conditions. Wairarapa has a proportionally large population of older people. Increasing access to primary and preventive care (such as flu vaccination) improves health outcomes, and reduces avoidable admissions to hospital for older people.

Some frail older people require disability support services on a daily basis. Usually they prefer to receive these services in their own homes where this is possible, rather than entering residential care. Research evidence shows people supported in their own homes have better health outcomes that those admitted to residential care. During 2009/10 Wairarapa DHB will continue to expand service options to enable more people to remain in their own homes if they wish.

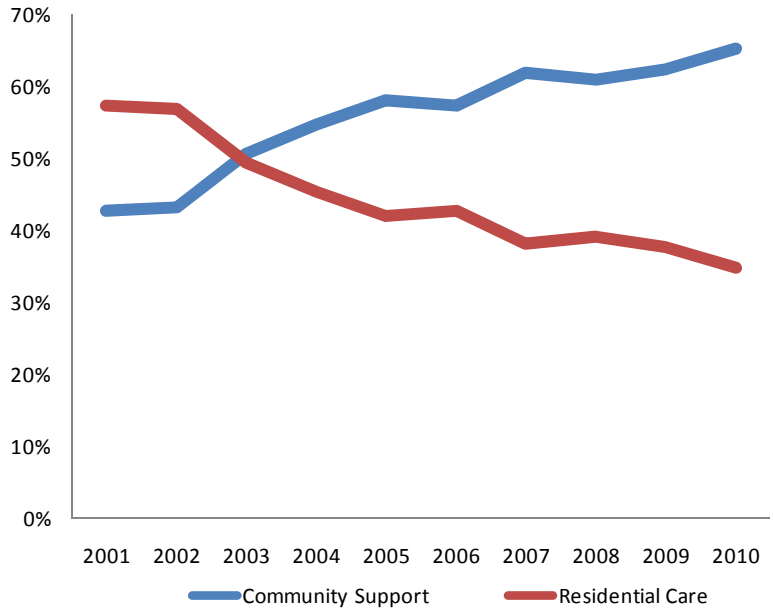
Implementing an integrated continuum of care for older people will continue through a range of service developments across the Health and Disability sector. These developments will be aligned with ensuring a smooth transition between services (e.g. hospital, community and other agencies). The single point of entry for universal access to community nursing and support services will be extended to incorporate services for psychiatric disability in 2009/10.

OUTPUT CLASS	OUTPUT	MEASURE	TARGET	ACHIEVEMENT
Funder: Primary & Community	Influenza vaccinations	Percentage of people aged 65 years and above vaccinated against influenza	69%	69.4%
Funder: Support Services	Home based support services	Percentage of people aged 65 years and above, receiving disability support services, supported in their own homes, rather than in residential care	65%	62%
Provider: Hospital Services	Assessment, treatment and rehabilitation	Number of people who have suffered a stroke event, who have been admitted to organized stroke services and remain there	78%	77%
Funder: Primary & Community	Residential care support services	Percentage of people entering residential care under the health recovery programme who return to their own homes	77%	86%

COMMENTARY

Wairarapa DHB has continued to provide support for older people which meets their assessed support needs. To achieve this, the DHB has ensured that a wide range of services are available that can be targeted to provide the most cost-effective support to enable independence of older people and assist them to live safely at home.

As evident in the table below, the percentage of older people being supported at home compared to the percentage in residential care appears to have plateaued over the past few years and it is difficult to know whether the plateau is the optimal situation or not. There will always be some older people who cannot feasibly be supported to safely live at home.



Although the proportion of older people being supported to live at home has not increased, the actual number has increased and the level of support needed appears higher. Of all older people who meet the criteria for entering residential care, 38% are being supported in the community. The Health Recovery Programme is now well established and was reviewed again during 2009. This review identified a high rate of return home and a sustainable outcome. From July to December 2009, no patients were readmitted over this time for the same diagnosis.

There has been a steady increase in the number of people being admitted to hospital with a stroke who have been on the stroke pathway. Wairarapa DHB has contributed to the development of a regional thrombolysis protocol. It has also developed close links with Hutt Valley DHB Stroke Services and benefits from Hutt Valley DHB's medical advice and special educational opportunities for rehabilitation nurses.

Care planning and goal setting documentation has been further modified to meet the Ministry of Health, ACC, and Specialist Health Services for Older People (SHSOP) guidelines. There has been increasing consultation and collaboration between the Clinical Nurse Specialist Gerontology/Rehabilitation (CNS), residential care providers and GPs. The CNS facilitates Older Persons Health Study days which are open to residential care providers. In addition, the Rehabilitation Service is providing registered nurse mentoring to a sole charge registered nurse in an ARC facility.

IMPROVING CHILD AND YOUTH HEALTH

The childhood years set the foundation for health in later life, with both risk and protective factors established for many diseases that affect adult health. In the context of an aging society, children and young people are also the future social and economic capital, the taonga. The effectiveness of health and social services in promoting their well-being has a direct consequence for the Wairarapa DHB future.

During the 2008/09 year the Wairarapa DHB completed a Child Health Strategy to provide a framework for the on-going review and development of child health services. The high level goal or outcome that the Wairarapa DHB is working towards is that all children in Wairarapa have equal opportunity to a long and healthy life.

The Child Health Strategy acknowledges that the most important and direct influence on the health and well-being of children are their parents, with the role of health services being to support families through education and advice, to screen for illness and disability and to provide affordable and accessible clinical services as required.

Key actions planned to address child and youth needs in 2009/10 include:

- Better prevention and early detection of health issues in children aged 0-5 years through collaboration of Well Child, Public Health and Primary Care Services
- Development of a multidisciplinary approach to child health development services and services for children with complex needs
- Complete local and national processes to build and procure dental facilities
- Increase training of hospital and primary care practitioners in the identification of oral health need.

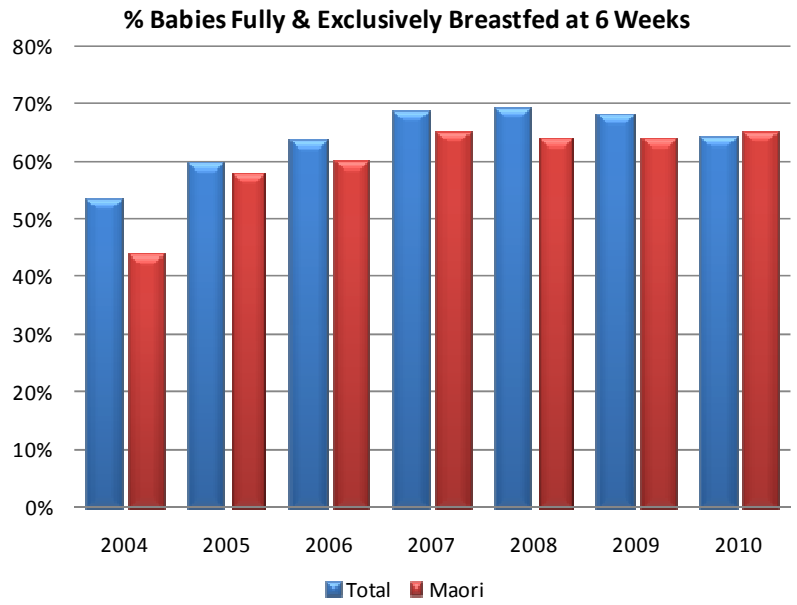
OUTPUT CLASS	OUTPUT	MEASURE	TARGET	ACHIEVEMENT
Funder: Primary & Community	Completion of a vaccination	Progress towards the national target of 95% of 2 year olds fully immunised	Maori: 85% Total: 85%	Maori: 92% Total: 91%
Provider: Hospital Services	Hospitalisation	Rates of ambulatory sensitive hospitalisations of children aged 0–4 years, not to exceed target level above the national average	Maori: 120 Total: 120	Maori: 125 Total: 109
Funder: Primary & Community	Dental consultations	Progress towards the national target of 85% of adolescents having oral health treatment completed each year	78%	77%
Funder: Primary & Community	B4 school checks	Progress towards ensuring all 4 year olds receive a full health check	70%	90%

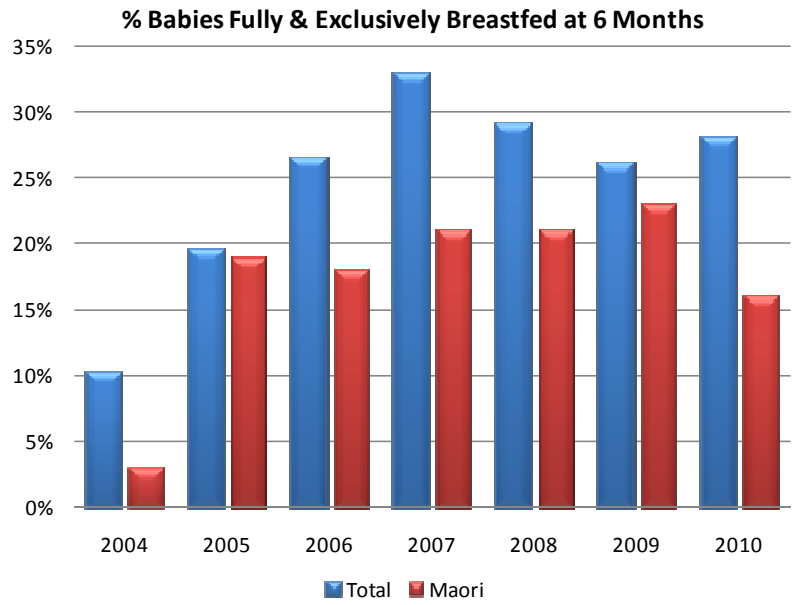
OUTPUT CLASS	OUTPUT	MEASURE	TARGET	ACHIEVEMENT
Provider: Public Health	HEADSS assessments	Number of HEADSS assessments completed	120	131
Funder: Public Health	Post natal maternity care	Percentage of women full and exclusively breastfeeding – total population	6 weeks: 74% 3 months: 62% 6 months: 29%	6 weeks: 64% 3 months: 54% 6 months: 28%
		Percentage of women full and exclusively breastfeeding – Maori population	6 weeks: 74% 3 months: 60% 6 months: 30%	6 weeks: 65% 3 months: 52% 6 months: 16%

COMMENTARY

Some excellent results were achieved for child and youth health indicators, particularly for immunisation, and delivery of B4 School and HEADSS checks. Targets for oral health treatment completion and Ambulatory Sensitive Hospitalisations for Maori children were very nearly reached.

Increasing breastfeeding rates has been a priority for WDHB for several years, therefore the current trend, illustrated in the graphs on the following page, is disappointing. Anecdotal reports from Well Child providers suggest that the economic downturn may have caused new mothers to return to work earlier than in past years. Encouraging breast feeding among working mothers will be a future focus for the DHB.


% Babies Fully & Exclusively Breastfed at 6 Weeks
80%
70%
60%
50%
40%
30%
20%
10%
0%
2004
2005
2006
2007
2008
2009
2010
Total
Maori


% Babies Fully & Exclusively Breastfed at 6 Months
35%
30%
25%
20%
15%
10%
5%
0%
2004
2005
2006
2007
2008
2009
2010
Total
Maori

TO REDUCE THE INCIDENCE AND IMPACTS OF CHRONIC CONDITIONS

The social and economic costs of chronic conditions are high and affect all New Zealanders directly or indirectly. People with chronic conditions use a wide range of services repeatedly and often do so frequently. Changes to the health system that make it easier for people with chronic conditions to use these services are expected to benefit all people who use these services as well as for those who care for them.

The incidence of chronic conditions is increasing. This group of conditions is the leading cause of morbidity in New Zealand, and disproportionately affects Māori and Pacific peoples. Reducing inequalities by orienting the system to meet the needs of those at greatest risk of poor outcomes' is one of the essential principles underpinning the approach being taken by Wairarapa DHB in reducing the incidence and impact of long term conditions.

In line with the Wairarapa DHB Strategic Plan, activity related to long term conditions will focus on healthier lifestyles (reducing smoking, improving nutrition and exercise), increased access to primary care, increased early intervention and improved disease management. Further developments in these areas will be within a multi-sectoral approach and will build on the achievements of the past year.

OUTPUT CLASS	OUTPUT	MEASURE	TARGET	ACHIEVEMENT
Funder: Primary & Community	Diabetic annual reviews	Proportion estimated to have diabetes accessing free annual checks (all ethnicities)	75%	75%
Funder: Primary & Community	Diabetes consultations	Proportion on the diabetes register who have good diabetes management (HbA1C + or< 8%) - all ethnicities	75%	77%
Funder: Primary & Community	Care Plus consultations	Percentage of expected Care Plus population enrolled in the programme	100%	111%
Funder: Primary & Community / Hospital Services	Integrated palliative care service	Number of patients who have received integrated palliative care service	230	194

COMMENTARY

Reducing the incidence and impact of long term conditions continues to be a DHB priority, and over the past year much effort has been directed towards this strategy. The results of 2009/10 are encouraging given the effort that has been expended by a range of agencies and health professionals in managing a range of long term conditions (e.g. CVD risk and management and diabetes detection and management). Considerable effort has been made by the PHO to reach Maori, especially through links with Maori Health providers.

Specific achievements in 2009/10 include:

- A focus on prevention of long term conditions through a range of intersectoral health promotion and Healthy Eating, Healthy Action (HEHA) programmes, enabling access for people with low socio-economic status.
- Increased links between DHB Clinical Nurse Specialists and Primary Care Nurses (e.g. increased training, consultation, information sharing and patient management).
- Increased number of people attending annual reviews and GP appointments through Maori Health provider support. Follow-up of non-attendees, support to attend appointments and promotion of self management.
- Continuing emphasis on CVD risk assessments in primary health, targeted at specific population risk groups.
- Implementation of the Heart Health project to improve outcomes for people suffering from acute coronary syndrome by identifying and implementing improvements to services and systems in across the primary and secondary sectors in Wairarapa.
- Completion of the pilot for improving systems and processes for generic treatment and management of long term conditions at primary health care level, which includes three strands:
    - System design and change management at individual practice level
    - Improved prescribing and medication management – for patients in the community and Wairarapa hospital
    - Targeted multi-disciplinary case management for 'frequent flyers' and support for them to better self-manage.
- Successful expression of interest in the "Better, Sooner, More Convenient" pilot for transformation of primary care, development of the business case (Tihei Wairarapa) and action plan. Tihei Wairarapa includes a specific strand for long term conditions which encompasses the development of self management systems for early stages of long term conditions and 'guided care' for those needing a case management approach.

While fewer people than anticipated required palliative care services during the year, all those assessed as requiring care received these services.

MENTAL HEALTH AND ADDICTIONS

This year's Te Kokiri Implementation plan reflects a wide range of activities that all Wairarapa DHB funded Mental Health and Addiction services plan to undertake. The common theme throughout this is 'more and better, collaboratively'. The plan identifies few new initiatives but rather builds on the achievements of previous years and looks to ensure that the maximum gain for service users is achieved through providers and service users working more closely together.

About 3% of the population has serious ongoing mental illness that requires specialist care and treatment from mental health services, about 12% experience moderate/mild mental illness and problems that require primary health services treatment and care.

OUTPUT CLASS	OUTPUT	MEASURE	TARGET	ACHIEVEMENT
Provider: Primary & Community	Mental health and addiction services	Percentage of the population accessing mental health and addiction services – Child & Youth	2.8%	2.1%
		Percentage of the population accessing mental health and addiction services – Adult	3%	2.7%
Provider: Primary & Community	Mental health services	Percentage of mental health service users who have up to date relapse prevention plans	100%	90%

COMMENTARY

Access rates

Access rates to mental health services continue to fall below target but conversely, trend slowly upwards. While there are some reasons for this linked to data collection and reporting, overall, access is improving and will continue to do so in the year ahead as linkages with primary care and community health and social services improves through the Tihei Wairarapa business case projects.

The year has seen improvements in a number of areas that ensure that people most in need of mental health and addiction services get the help that they require. Clinical and managerial staff has worked collectively on a number of projects including:

- Development and implementation of processes that support Wairarapa Hospital Mental Health Crisis response teams and the Emergency Department to work together to help patients who present in ED with injuries resulting from self harm or attempted suicide.
- Development and implementation of processes between Wairarapa Hospital paediatric services and the child and adolescent mental health service to improve the diagnosis and care coordination for young people living with high and complex needs including diagnoses such as autism spectrum disorders, ADHD and chronic conditions such as diabetes that impact on the mental wellbeing of the youngster
- Shared care and multi disciplinary approaches between NGO addiction services, Wairarapa Hospital staff and Mental Health Services to contribute to a more comprehensive and holistic approach to caring for patients who have co existing mental health and addiction problems and specific diagnoses such as Hepatitis C.

While access rates fall below target, there are no significant waiting times for any mental health or addiction service and all services are committed to maintaining excellent working relationships with primary care, community and social services. For the DHBs Child and Adolescents Mental Health Service (CAMHS) an important relationship exists between schools CYFs and Education support services and ensures that referrals are appropriately managed and responded to in a timely manner.

Relapse Prevention Plans

This target requires all patients who have been engaged with mental health and addiction services for over 2 years to have relapse prevention plans in place.

In the Wairarapa there are 81 addiction and 102 mental health clients who have been engaged with the services for over two years. Of these, at the end of the last quarter there were 2 addiction clients and 6 mental health clients who did not have current relapse prevention plans. This is due to the nature of their contact with the service. While the target of 100% has not been achieved, through internal file audits and quarterly multi disciplinary reviews of all cases, the DHB is confident that this does not reflect negatively on the outcomes for this client group.

REDUCE THE INCIDENCE AND IMPACT OF CANCER

The Wairarapa Cancer Control Action Plan, 2007 aims to improve all services across the continuum of care for cancer. The priority actions identified in the Plan require ongoing commitment in order to achieve long term reductions in the incidence of cancer and improve outcomes for those living with cancer.

Cancer covers a very large number of different diseases many of which are increasing as the population ages. While success rates for cancer treatments are improving, the numbers dying from cancer are still increasing as cancer affects growing numbers of people. Cancer is a leading cause of hospitalisation and death – the second highest cause of death in Wairarapa. The incidence of cancer is increasing, but cancer survival rates are improving.

Many cancers are potentially preventable, and with more health promotion and prevention the rates can be reduced. More screening, and early treatment can reduce the numbers of people who are affected by cancer for and the length of time that they are affected, while more co-coordinated and accessible treatment, support and palliative care services can greatly reduce the impacts of cancer on patients and their families. Key actions planned for 2009/10 include:

- Implement the Primary Care Smoke Free Plan focusing on screening and brief intervention
- Improved screening and early detection rates for breast and cervical cancer
- Meeting radiation oncology and chemotherapy waiting time targets
- Exploring opportunity for a local chemotherapy service

OUTPUT CLASS	OUTPUT	MEASURE	TARGET	ACHIEVEMENT
Funder: Hospital Services	Cancer treatment services	Percentage of patients who receive radiation oncology treatment within 6 weeks of the first specialist assessment	100%	95%
Funder: Public Health	Population screening services	Percentage of high needs woman aged 45 -69 who have had mammograms in the last two years	65%	61.2%
		Percentage of woman aged 20-69 who have had a cervical smear over the previous three years (high needs)	>70%	70.4%
Funder: Hospital Services	Smoking Cessation Services	Percentage of hospitalised smokers are provided with advice to help to quit	80%	87%

COMMENTARY

Smoking Cessation Services

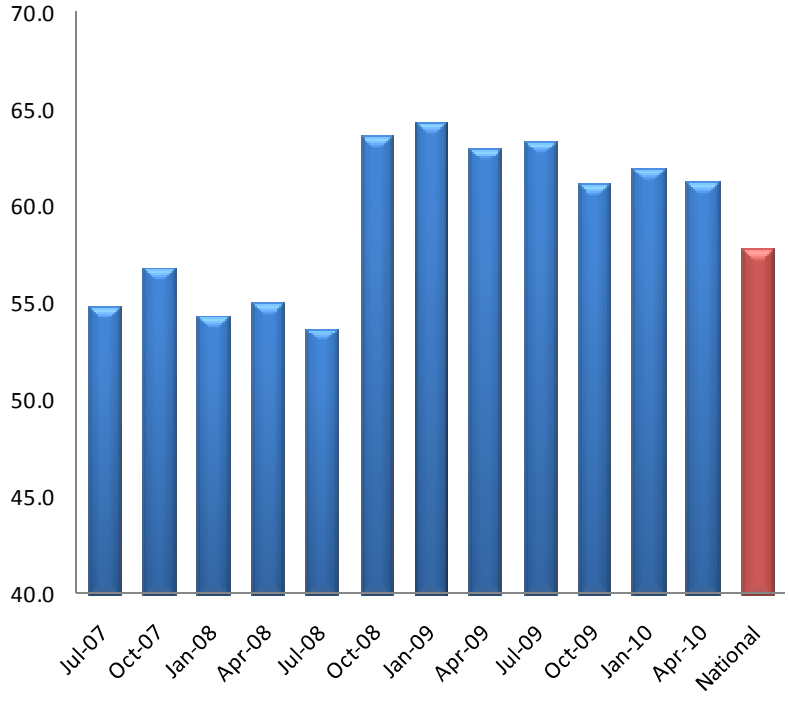
This target has been consistently achieved throughout the year as a result of it being maintained as a high priority across all levels of the District Health Board. Ongoing internal audits of admission and discharge planners, training of clinical staff in smoking cessation programmes, and communication of progress reports and results across all staff through the DHBs internal newsletter "Insite" ensures an ongoing focus is maintained.

Breast Cancer Screening Services

All breast screening in Wairarapa is done at a mobile screening unit which visits the district every two years as shown in the graph (at right). Progress against this target is therefore evident every eighth quarter. While screening was undertaken in early 2010, this data is not available until October 2010. Providers continue to work together to increase the proportion of high needs women screened for breast cancer.

Cancer Treatment Services

Overall, waiting times for radiation oncology treatment are kept to a minimum with on average 98% of people receiving treatment within 6 weeks of their first specialist assessment (across both the Capital and Coast and Mid Central treatment centres). Waiting times outside of this have been reported by the treatment centres as being predominantly due to clinical reasons with only two cases waiting longer than 6 weeks.



IMPROVE HOSPITAL SERVICES AND PRODUCTIVITY

Wairarapa Hospital is the major provider of health services in the Wairarapa. To remain a clinically and financially sustainable provider, it must ensure that it continues to improve its operating efficiency and effectiveness and that it is able to attract and retain appropriate numbers of suitably qualified staff.

Wairarapa DHB faces a growing challenge to fund and provide increasing access to the required range of safe, high quality services at levels that will deliver the best value for money within its fiscal envelope.

In 2009/10 and outyears, growth in the Wairarapa DHB's funding envelope will be less than in previous years, while demand for services and operating costs are rising faster. Managing in this environment requires the Wairarapa DHB to make the best possible prioritisation and allocative decisions and to focus on cost reduction, and cost containment.

Key actions for 2009/10 include:

- Further streamlining hospital operations to maximize flow of the patient from primary care through the hospital and back to primary care
- Continuing to monitor ambulatory sensitive admissions, analyse data, and identify and implement system changes to reduce these admissions
- Improving Day of Surgery and Day Case rates
- Delivering increasing numbers of elective discharges while meeting all Electives targets and maintaining Green ESPIs for all specialties
- Optimizing the Patient Journey.

OUTPUT CLASS	OUTPUT	MEASURE	TARGET	ACHIEVEMENT
Provider: Hospital Services	Surgical CWDs	Percentage of people admitted for surgery whose surgery is performed on the day of admission (DOSA)	92%	98%
Provider: Hospital Services	Elective CWDs	Percentage of people receiving elective operations whose operation is performed as a day case	75%	70%
Provider: Hospital Services	Acute CWDs	Proportion of inpatients admitted that had previously been admitted in the past 30 days and were readmitted to the same specialty	<10%	4.7%
Provider: Hospital Services	Elective CWDs	Electives discharges	1,809	1,961
Provider: Hospital Services	Emergency department attendances	Number of people whose emergency department length of stay is less than 6 hours	>95%	97%

OUTPUT CLASS	OUTPUT	MEASURE	TARGET	ACHIEVEMENT
Provider: Hospital Services	Outpatient attendances	Reduction in the number of Do Not Attends (DNA) in outpatients	7.5%	6.6%

COMMENTARY

Throughout 2009/10 we have continued to work with Primary Care to provide easier access to health services for patients. Using tools to focus on advance planning for patients and new initiatives such as the introduction of antibiotic services in the home and in Primary Care practices has enabled patients to receive care at home or at their GP practice without the need for hospital admission, or to enable patients to leave hospital sooner following admission. We have achieved a significant reduction (surpassing the target set by more than half) in the number of re – admissions within 30 days for patients into the same service. Targets for reducing the need for patients to need to come into hospital the day before their surgery have also been exceeded. However a slight under achievement in the number of patients who went home on the same day as their surgery points to further improvements which will need to be achieved in this regard.

Just over 19,500 patients attended our emergency department with 19,002 of these treated within 6 hours (97.4%). The national health target for waiting set by the government is 95%. The DHB has also delivered above the target number of planned surgical discharges and has achieved the measures (ESPI's) set by the Ministry of Health to ensure patients receiving planned care (electives) are treated with clarity and in a timely way. This year we have also looked to introduce new ways of planning services that give patients more choice how these services are delivered. An example of this is the U-Book system whereby patients who are planning to attend a specialist appointment at the hospital can select dates for these appointments that are more convenient for them. Pleasingly this has helped to reduce the number of people who miss their appointments and exceeded the target we had set for this. The improvements to how we plan and facilitate the patient in accessing care in the hospital and closer working relationships with Primary Care will continue to be a focus for 2010/11.

IMPROVING WORKFORCE RETENTION

Sustaining a skilled, supported and responsive health workforce is a key requirement to delivering effective health care and improving health outcomes. A successful functioning health system relies on having the right balance of trained and qualified people in sufficient supply and working in partnership with each other – from medical and nursing staff and allied health professionals, to management and administrative teams.

Trusting, valuing and fully engaging health professionals improves patient care and job satisfaction and will assist in recruitment and retention. Focusing on improving clinical workforce retention and fostering clinical leadership has been identified by the Minister of Health as a key priority for 2009/10.

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

We will demonstrate our commitment to fostering clinical leadership by:

- Supporting clinicians on the Wairarapa DHB's senior leadership team to be active participants in all decision making
- Developing partnerships between clinicians and management at all levels of the organisation with shared decision making, responsibility and accountability
- Supporting the Wairarapa DHB's Clinical Board and the advice and recommendations they give to the DHB Board on the quality and safety of services delivered by the Hospital
- Devolving decisions and accountability to the most appropriate clinical units or teams (which may include clinics, wards or departments) across the DHB
- Ensuring strong clinical leadership and governance of the Wairarapa Clinical Services Action Plan (25 clinicians from across the health system were members of the steering group)

OUTPUT CLASS	OUTPUT	MEASURE	TARGET	ACHIEVEMENT
Governance: Hospital Services	Performance planning and development	Reduced number of resignations due to dissatisfaction as a percentage of total annual resignations	15%	1.6%
Governance: Hospital Services	Organisational culture survey	Number of organisational culture initiatives completed each year	4	Data not captured
Governance: Hospital Services	Professional managers development seminars	Number of professional managers development seminars completed annually	12	Data not captured
Governance: Hospital Services	Clinical leadership training seminars	Number of clinical leadership training seminars completed for senior clinical staff	4	Data not captured

COMMENTARY

Resignations

When an employee resigns the employee is requested to provide a reason for their resignation from a list provided. In the 2009/10 year there were a total of 119 resignations of which the vast majority (104) identified the prime reason for their resignation was for personal/family/whanau reasons. Only 2 specifically list lack of job satisfaction as their prime reason for resigning. This is compared to the 2008/09 year where there were 109 resignations of which 79 listed personal/family/whanau as the prime reason for their resignation and 0 listed lack of job satisfaction.

When an employee resigns, they are invited to provide feedback on their experience of working for the DHB and their reasons for leaving the employment of the DHB. A small proportion of those who resign choose to complete an exit interview, however the majority of those who do complete a interview state their reason for leaving was attributed to dissatisfaction with their role. The number of exit interviews has not increased over the last year. This is viewed as a positive result given the Wairarapa DHB has gone through significant change over the last 12 months.

Organisational Culture Initiatives

Due to the dramatic change in New Zealand's financial and economic climate, the Wairarapa DHBs focus has been on ensuring that they are a sustainable organisation. Given the level of change required it was identified that it was not appropriate to commit to an organisational culture survey in this year.

Given the degree of change within the Health Sector Wairarapa DHB has focused on involving staff in decision making processes and engaging staff. The Chief Executive has held staff presentations to introduce a programme of work titled 'Good to Great'. This programme of work was focused on reviewing services to achieve sustainability, improving the overall health of the Wairarapa population while also improving the patient journey. Additional presentations have been held to provide staff with progress updates on the 'Good to Great' project.

The organisation has been introduced to the work of John Kotter detailed in his book titled 'Our Ice Iceberg is Melting'. The themes of the book are being integrated into the workforce slowly. A number of books have been circulated through the organisation and staff have been invited to read the books. At the staff presentations (undertaken by the CE) staff were requested to complete a survey to provide the DHB with a indication if 'a sense of urgency had been adequately set' and therefore indicating that staff understand the reasons for change.

Management Development and Leadership

Management Development and Leadership within the DHB is under review, both at a local and regional level. The Wairarapa DHB is developing a structured programme that links to regional initiatives, which focuses on developing the Leadership competence of our clinicians and managers.

Specific management training on financial management was undertaken during the year with 2 sessions covering a total of 42 people.

No clinical leadership training seminars were completed during the year. The time and efforts of the senior clinical staff were concentrated in a wide series of discussions leading to the development of the Clinical Services Action Plan and the Clinical Forum which brings clinical staff from both primary and secondary care together.

FINANCIAL STATEMENTS

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STATEMENT OF COMPREHENSIVE INCOME

For the year ended 30 June 2010

	Note	Group Budget 2010 $000	Group Actual 2010 $000	Group Actual 2009 $000	Parent Actual 2010 $000	Parent Actual 2009 $000
Income						
Operating income	1	120,748	123,246	118,919	122,166	117,625
Finance income	2	170	105	424	152	396
Total income		**120,918**	**123,351**	**119,343**	**122,318**	**118,021**
Expenditure						
Employee benefits	3	36,531	35,331	34,111	35,331	34,111
Other operating expenses	4	80,206	88,553	84,703	87,542	83,463
Depreciation & amortisation expense	7,8	2,546	2,085	2,008	2,004	1,911
Finance costs	5	2,493	2,116	2,643	2,116	2,643
Tax expense	6	0	0	(123)	0	0
Total expenses		**121,776**	**128,085**	**123,342**	**126,993**	**122,128**
Net surplus/(deficit)		**(858)**	**(4,734)**	**(3,999)**	**(4,675)**	**(4,107)**
Other comprehensive income						
Gain / (loss) on property revaluations		0	0	0	0	0
Total other comprehensive income		**0**	**0**	**0**	**0**	**0**
Total comprehensive income		**(858)**	**(4,734)**	**(3,999)**	**(4,675)**	**(4,107)**
Total comprehensive income attributable to:						
Wairarapa District Health Board		(858)	(4,734)	(3,999)	(4,675)	(4,107)
Non-controlling interest		0	0	0	0	0

STATEMENT OF FINANCIAL POSITION

For the year ended 30 June 2010

	Note	Group Budget 2010 $000	Group Actual 2010 $000	Group Actual 2009 $000	Parent Actual 2010 $000	Parent Actual 2009 $000
Assets						
Property, plant & equipment	7	42,340	41,641	42,011	41,555	41,872
Intangible assets	8	1,139	1,308	942	1,290	913
Investments	9	0	0	0	103	103
Trust fund assets	16	55	160	61	160	61
Total non-current assets		**43,534**	**43,109**	**43,014**	**43,108**	**42,949**
Cash & cash equivalents	10	359	406	(984)	109	(1,260)
Inventories	11	702	679	698	679	698
Trade & other receivables	12	4,103	3,698	4,111	3,591	3,998
Assets classified as held for sale	7	0	2,300	2,300	2,300	2,300
Total current assets		**5,164**	**7,083**	**6,125**	**6,679**	**5,736**
Total assets		**48,698**	**50,192**	**49,139**	**49,787**	**48,685**

STATEMENT OF FINANCIAL POSITION

For the year ended 30 June 2010

	Note	Group Budget 2010 $000	Group Actual 2010 $000	Group Actual 2009 $000	Parent Actual 2010 $000	Parent Actual 2009 $000
Equity						
Crown equity	13	20,787	25,484	18,854	25,484	18,854
Revaluation reserve	13	1,479	1,479	1,479	1,479	1,479
Retained earnings	13	(13,696)	(19,631)	(14,897)	(19,922)	(15,247)
Total equity		**8,570**	**7,332**	**5,436**	**7,041**	**5,086**
Liabilities						
Interest-bearing loans & borrowings	14	25,000	20,199	20,208	20,199	20,208
Employee benefits	15	880	533	520	533	520
Trust funds	16	55	160	61	160	61
Total non-current liabilities		**25,935**	**20,892**	**20,789**	**20,892**	**20,789**
Interest-bearing loans & borrowings	14	0	5,302	5,558	5,302	5,558
Payables & accruals	17	8,193	11,320	11,334	11,267	11,286
Employee benefits	15	6,000	5,346	6,022	5,285	5,966
Total current liabilities		**14,193**	**21,968**	**22,914**	**21,854**	**22,810**
Total liabilities		**40,128**	**42,860**	**43,703**	**42,746**	**43,599**
Total equity & liabilities		**48,698**	**50,192**	**49,139**	**49,787**	**48,685**

STATEMENT OF CHANGES IN EQUITY

For the year ended 30 June 2010

	Note	Group Budget 2010 $000	Group Actual 2010 $000	Group Actual 2009 $000	Parent Actual 2010 $000	Parent Actual 2009 $000
Balance at 1 July		**8,431**	**5,436**	**8,845**	**5,086**	**8,603**
Total comprehensive income previously reported		(858)	(4,734)	(3,999)	(4,675)	(4,107)
Effect on retained earnings of restatement		0	0	0	0	0
Total comprehensive income as restated		**(858)**	**(4,734)**	**(3,999)**	**(4,675)**	**(4,107)**
Equity injection from the Crown		1,000	6,633	593	6,633	593
Repayment of equity to the Crown		(3)	(3)	(3)	(3)	(3)
Movements in equity for the year		**997**	**6,630**	**590**	**6,630**	**590**
Balance at 30 June		**8,570**	**7,332**	**5,436**	**7,041**	**5,086**
Total comprehensive income attributable to:						
Wairarapa District Health Board		(858)	(4,734)	(3,999)	(4,675)	(4,107)
Non-controlling interest		0	0	0	0	0
Total comprehensive income		**(858)**	**(4,734)**	**(3,999)**	**(4,675)**	**(4,107)**

STATEMENT OF CASH FLOWS

For the year ended 30 June 2010

	Note	Group Budget 2010 $000	Group Actual 2010 $000	Group Actual 2009 $000	Parent Actual 2010 $000	Parent Actual 2009 $000
Cash flows from operating activities						
Operating receipts		121,066	123,399	118,509	122,178	117,202
Interest received		170	98	388	91	360
Payments to suppliers & employees		(116,676)	(124,696)	(117,500)	(123,560)	(116,254)
Capital charge paid		(560)	(405)	(811)	(405)	(811)
Interest paid		(1,933)	(1,860)	(1,958)	(1,860)	(1,958)
Income tax paid		0	1	123	0	0
Goods and Services Tax (net)		0	326	46	327	66
Net cash flows from operating activities	10	**2,067**	**(3,137)**	**(1,203)**	**(3,229)**	**(1,395)**
Cash flows from investing activities						
Proceeds from sale of property, plant & equipment		0	121	0	121	0
Dividends received		0	0	0	54	17
Acquisition of property, plant & equipment		(1,221)	(1,005)	(1,905)	(993)	(1,834)
Acquisition of intangible assets		(1,010)	(1,192)	(383)	(1,187)	(378)
Net cash flows from investing activities		**(2,231)**	**(2,076)**	**(2,288)**	**(2,005)**	**(2,195)**

STATEMENT OF CASH FLOWS

For the year ended 30 June 2010

	Note	Group Budget 2010 $000	Group Actual 2010 $000	Group Actual 2009 $000	Parent Actual 2010 $000	Parent Actual 2009 $000
Cash flows from financing activities						
Loans drawn down		120	120	120	120	120
Equity injected		1,000	6,764	590	6,764	590
Repayments of loans		(582)	(377)	(358)	(377)	(358)
Repayment of equity		(3)	(3)	(3)	(3)	(3)
Restricted fund movement		0	99	7	99	7
Net cash flows from financing activities		**535**	**6,603**	**356**	**6,603**	**356**
Net increase / (decrease) in cash held		**371**	**1,390**	**(3,135)**	**1,369**	**(3,234)**
Cash & cash equivalents at beginning of year		(12)	(984)	2,151	(1,260)	1,974
Cash & cash equivalents at end of year	10	**359**	**406**	**(984)**	**109**	**(1,260)**

The Goods and Services Tax (net) component (GST) of operating activities reflects the net GST paid and received with the Inland Revenue Department. The GST component has been presented on a net basis as the gross amounts do not provide meaningful information for financial statements purposes.

STATEMENT OF CONTINGENCIES

For the year ended 30 June 2010

	Group Actual 2010 $000	Group Actual 2009 $000	Parent Actual 2010 $000	Parent Actual 2009 $000
Legal proceedings and obligations	0	0	0	0
Uncalled shares in Central Region Technical Advisory Services Ltd	0	0	0	0
Total contingent liabilities	**0**	**0**	**0**	**0**

STATEMENT OF COMMITMENTS

For the year ended 30 June 2010

	Group Actual 2010 $000	Group Actual 2009 $000	Parent Actual 2010 $000	Parent Actual 2009 $000
Capital Commitments	**15**	**11**	**15**	**11**
Operating Lease Commitments:				
Less than One Year:	707	940	647	880
One to Two Years	383	349	342	306
Two to Five Years	95	153	45	100
Five Years	0	0	0	0
	1,185	**1,442**	**1,034**	**1,286**
Non-cancellable contracts for the provision of services				
Not later than one year				
Non funder	1,817	2,839	1,817	2,839
Funder	8,235	7,869	8,235	7,869
Later than one year & not later than two years				
Non funder	710	160	710	160
Funder	4,306	7,325	4,306	7,325
Later than two years & not later than five years				
Non funder	819	0	819	0
Funder	329	4,134	329	4,134
Over five years				
Non funder	0	0	0	0
Funder	0	0	0	0
	16,216	**22,327**	**16,216**	**22,327**
Total Commitments	**17,416**	**23,780**	**17,265**	**23,624**

STATEMENT OF ACCOUNTING POLICIES

REPORTING ENTITY

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

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

The consolidated financial statements of Wairarapa DHB for the year ended 30 June 2010 comprise Wairarapa DHB and its subsidiary Biomedical Services New Zealand Limited (together referred to as "WDHB") and joint venture the Central Region Technical Advisory Service Limited (TAS) which is one sixth owned. The financial statements were authorised for issue by the Board on 26 october 2010.

Wairarapa DHB's activities involve delivering health and disability services and mental health services in a variety of ways to the community.

STATEMENT OF COMPLIANCE

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

BASIS OF PREPARATION

Functional and presentation currency

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

Measurement base

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

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

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

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

Changes in accounting policies

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

The Wairarapa DHB and group has adopted the following revisions to accounting standards during the financial year, which have had only a presentational or disclosure effect:

- NZ IAS 1 Presentation of Financial Statements (Revised 2007) replaces NZ IAS 1 Presentation of Financial Statements (Issued 2004). The revised standard requires information in financial statements to be aggregated on the basis of shared characteristics and introduces a statement of comprehensive income. The statement of comprehensive income will enable readers to analyse changes in equity resulting from non-owner changes separately from transactions with owners. The Wairarapa DHB and group has decided to prepare a single statement of comprehensive income for the year ended 30 June 2010 under the revised standard. Financial statement information for the year ended 30 June 2009 has been restated accordingly. Items of other comprehensive income presented in the statement of comprehensive income were previously recognised directly in the statement of changes in equity.
- Amendments to NZ IFRS 7 Financial Instruments: Disclosures. The amendments introduce a three-level fair value disclosure hierarchy that distinguishes fair value measurements by the significance of valuation inputs used. A maturity analysis of financial assets is also required to be prepared if this information is necessary to enable users of the financial statements to evaluate the nature and extent of liquidity risk. The transitional provisions of the amendment do not require disclosure of comparative information in the first year of application. The Council and group has elected to disclose comparative information.
- NZ IAS 24 Related Party Disclosures (Revised 2009) replaces NZ IAS 24 Related Party Disclosures (Issued 2004). The revised standard simplifies the definition of a related party, clarifying its intended meaning and eliminating inconsistencies from the definition. The Wairarapa DHB and group has elected to early adopt the revised standard and its effect has been to disclose further information about commitments between related parties

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

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

- NZ IFRS 9 Financial Instruments will eventually replace NZ IAS 39 Financial Instruments: Recognition and Measurement. NZ IAS 39 is being replaced through the following 3 main phases: Phase 1 Classification and Measurement, Phase 2 Impairment Methodology, and Phase 3 Hedge Accounting. Phase 1 on the classification and measurement of financial assets has been completed and has been published in the new financial instrument standard NZ IFRS 9. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39. The approach in NZ IFRS 9 is based on how an entity manages its financial instruments (its business model) and the contractual cash flow characteristics of the financial assets. The new standard also requires a single impairment method to be used, replacing the many different impairment methods in NZ IAS 39. The new standard is required to be adopted for the year ended 30 June 2014. The Wairarapa DHB has not yet assessed the effect of the new standard and expects it will not be early adopted.

BASIS FOR CONSOLIDATION

Subsidiaries

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

Joint ventures

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

Transactions eliminated on consolidation

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

BUDGET FIGURES

The budget figures are those approved by the health board in its District Annual Plan and included in the Statement of Intent tabled in parliament. The budget figures have been prepared in accordance with NZGAAP. They comply with NZIFRS and other applicable Financial Reporting Standards as appropriate for public benefit entities. Those standards are consistent with the accounting policies adopted by WDHB for the preparation of these financial statements.

GOODS AND SERVICES TAX

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

REVENUE

Crown funding

The majority of revenue is provided through an appropriation in association with a Crown Funding Agreement. Revenue is recognised monthly in accordance with the Crown Funding Agreement payment schedule, which allocates the appropriation equally throughout the year.

Revenue relating to service contracts

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

Goods sold and services rendered

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

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

Rental income

Rental income from investment property is recognised in the statement of comprehensive income on a straight-line basis over the term of the

lease. Lease incentives granted are recognised as an integral part of the total rental income over the lease term.

EXPENSES

Operating lease payments

Payments made under operating leases are recognised in the statement of comprehensive income in the periods in which they are incurred.

Finance lease payments

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

Net financing costs

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

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

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

Non-current assets held for sale

Immediately before the classification of assets as held for sale, the measurement of the assets (and all assets and liabilities in a disposal group) is brought up-to-date in accordance with applicable NZIFRSs. Then, on initial classification as held for sale, a non-current asset and/or a disposal group is recognised at the lower of its carrying amount and its fair value less costs to sell.

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

Business combinations involving entities under common control

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

WDHB applies the book value measurement method to all common control transactions.

INCOME TAX

WDHB is a crown entity under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under section CB3 of the Income Tax Act 1994.

FOREIGN CURRENCY

Foreign currency transactions

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

PROPERTY, PLANT AND EQUIPMENT

Classes of property, plant and equipment

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

- freehold land
- freehold buildings
- medical equipment
- information technology
- motor vehicles
- other plant and equipment
- work in progress.

Owned assets

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

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

Additions to property, plant and equipment between valuations are recorded at cost.

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

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

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

Disposal of Property, Plant and Equipment

Where an item of plant and equipment is disposed of, the gain or loss recognised in the statement of comprehensive income is calculated as the difference between the net sales price and the carrying amount of the asset.

Properties Intended for Sale

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

Leased assets

Leases where WDHB assumes substantially all the risks and rewards of ownership are classified as finance leases. The assets acquired by way of finance lease are stated at an amount equal to the lower of their fair value and the present value of the minimum lease payments at inception of the lease, less accumulated depreciation and impairment losses.

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

Subsequent costs

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

Depreciation

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

Class of Asset	Estimated Life
• Freehold buildings	2 to 50 years
• Medical equipment	2.5 to 15 years
• Information technology	2.5 to 15 years
• Motor vehicles	5 to 12.5 years
• Other plant and equipment	2.5 to 15 years

The residual value of assets is reassessed annually.

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

INTANGIBLE ASSETS

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

Subsequent expenditure

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

Amortisation

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

Type of asset	Estimated life
• Software	2 to 5 years

IMPAIRMENT

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

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

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

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

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

Calculation of recoverable amount

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

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

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

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

Reversals of impairment

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

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

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

INVESTMENTS

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

TRADE AND OTHER RECEIVABLES

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

INVENTORIES

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

Cost is based on weighted average cost.

Inventories held for distribution

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

CASH AND CASH EQUIVALENTS

Cash and cash equivalents comprises cash balances, call deposits and deposits with a maturity of no more than twelve months from the date of acquisition. Bank overdrafts that are repayable on demand and form an integral part of WDHB's cash management are included as a component of cash and cash equivalents for the purpose of the statement of cash flows.

INTEREST-BEARING BORROWINGS

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

EMPLOYEE BENEFITS

Defined contribution plans

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

Defined benefit plan

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

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

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

Long service leave, sabbatical leave and retirement gratuities

WDHB's net obligation in respect of long service leave, sabbatical leave and retirement gratuities is the amount of future benefit that employees have earned in return for their service in the current and prior periods. The obligation is calculated using the projected unit credit method and is discounted to its present value. The discount rate is the market yield on relevant New Zealand government bonds at the balance sheet date.

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

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

PROVISIONS

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

Restructuring

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

TRADE & OTHER PAYABLES

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

NOTES TO THE FINANCIAL STATEMENTS

1. OPERATING INCOME

	Group Actual 2010 $000	Group Actual 2009 $000	Parent Actual 2010 $000	Parent Actual 2009 $000
Health & disability services (MOH contracted revenue)	113,094	109,842	113,094	109,842
Inter district patient inflows	3,290	2,915	3,290	2,915
ACC contract	2,055	2,273	2,055	2,273
Donations & bequests	585	7	585	7
Other income	4,222	3,882	3,142	2,588
Total operating income	**123,246**	**118,919**	**122,166**	**117,625**

2. FINANCE INCOME

	Group Actual 2010 $000	Group Actual 2009 $000	Parent Actual 2010 $000	Parent Actual 2009 $000
Interest income	98	388	91	360
Dividend income	0	17	54	17
Gain on disposal of property, plant & equipment	7	19	7	19
Total finance income	**105**	**424**	**152**	**396**

3. EMPLOYEE BENEFITS

	Group Actual 2010 $000	Group Actual 2009 $000	Parent Actual 2010 $000	Parent Actual 2009 $000
Wages & salaries	35,331	34,111	35,331	34,111
Contributions to defined benefit plans	0	0	0	0
Increase / decrease in employee benefit provisions	0	0	0	0
Total employee benefits	**35,331**	**34,111**	**35,331**	**34,111**

4. OTHER OPERATING EXPENSES

	Group Actual 2010 $000	Group Actual 2009 $000	Parent Actual 2010 $000	Parent Actual 2009 $000
Other operating expenses	19,734	20,475	18,802	19,324
Payments to non-health board providers	66,657	61,884	66,657	61,884
Operating lease expenses	1,753	1,873	1,691	1,798
Audit fees (for the audit of the financial statements)	105	93	94	82
Audit fees (for other assurance work)	0	0	0	0
Impairment of trade receivables (bad & doubtful debts)	40	78	40	78
Board member fees & expenses	254	262	248	259
Loss / (gain) on disposal of property, plant & equipment	10	38	10	38
Impairment loss on property, plant & equipment	0	0	0	0
Total other operating expenses	**88,553**	**84,703**	**87,542**	**83,463**

Operating lease expenses

Wairarapa DHB leases property, plant & equipment in the normal course of its business. The majority of these leases have a non-cancellable term of between 24 and 36 months. The future minimum lease payments payable are disclosed in the Statement of Commitments.

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

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

5. FINANCE COSTS

	Group Actual 2010 $000	Group Actual 2009 $000	Parent Actual 2010 $000	Parent Actual 2009 $000
Interest expense	1,858	1,958	1,858	1,958
Capital charge	258	685	258	685
Total finance costs	**2,116**	**2,643**	**2,116**	**2,643**

Wairarapa DHB pays a capital charge to the Crown based on the greater of its actual or budgeted closing equity balance, adjusted for equity contributions or repayment of equity, for the year. The capital charge rate for the period ended 30 June 2010 was 8% (2009 – 8%).

6. INCOME TAX

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.

Biomedical Services New Zealand Limited successfully applied to the Inland Revenue Department to be acknowledged as a public authority in terms of the Income Tax Act 1993. This has resulted in the company being exempt from income tax.

The date of effect for the public authority status is 1 January 2001 being the day that the parent of Biomedical Services New Zealand Limited, Wairarapa District Health Board came into existence. The Wairarapa District Health Board is a public authority in terms of the New Zealand Public Health and Disability Act 2000.

The Inland Revenue Department has confirmed Biomedical Services New Zealand Limited as a public authority and tax payments made by the company since 1 January 2001 were refunded by the Inland Revenue Department. The amount of the refund was $1,000 (2009: $124,921). This amount has been recognised within the financial statements contained herein.

7. PROPERTY, PLANT & EQUIPMENT

Group	Freehold land (at valuation) $000	Freehold buildings (at valuation) $000	Clinical equipment $000	Other equipment $000	Information technology $000	Motor vehicles $000	Work in progress $000	Total $000
Cost / valuation								
Balance at 1 July 2008	2,165	36,508	5,839	2,312	735	919	307	48,785
Additions	0	337	337	131	38	215	809	1,867
Disposals	0	0	(169)	(65)	(1)	(559)	0	(794)
Revaluations	0	0	0	0	0	0	0	0
Balance at 30 June 2009	**2,165**	**36,845**	**6,007**	**2,378**	**772**	**575**	**1,116**	**49,858**
Balance at 1 July 2009	2,165	36,845	6,007	2,378	772	575	1,116	49,858
Additions	0	51	703	49	86	1,030	792	2,711
Disposals	0	(1)	(200)	(59)	0	0	(1,023)	(1,283)
Revaluations	0	0	0	0	0	0	0	0
Balance at 30 June 2010	**2,165**	**36,895**	**6,510**	**2,368**	**858**	**1,605**	**885**	**51,286**

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

Group	Freehold land (at valuation)	Freehold buildings (at valuation)	Clinical equipment	Other equipment	Information technology	Motor vehicles	Work in progress	Total
Depreciation & impairment losses								
Balance at 1 July 2008		1,051	2,945	1,325	669	631		6,621
Depreciation charge for the year		1,076	557	199	15	91		1,938
Impairment losses		0	0	0	0	0		0
Disposals		(15)	(149)	(9)	(1)	(538)		(712)
Revaluations		0	0	0	0	0		0
Balance at 30 June 2009		**2,112**	**3,353**	**1,515**	**683**	**184**		**7,847**
Balance at 1 July 2009		2,112	3,353	1,515	683	184		7,847
Depreciation charge for the year		1,074	557	174	16	152		1,973
Impairment losses		0	0	0	0	0		0
Disposals		0	(132)	(42)	(1)	0		(175)
Revaluations		0	0	0	0	0		0
Balance at 30 June 2010		**3,186**	**3,778**	**1,647**	**698**	**336**		**9,645**

Group	Freehold land (at valuation)	Freehold buildings (at valuation)	Clinical equipment	Other equipment	Information technology	Motor vehicles	Work in progress	Total
Carrying amounts								
At 1 July 2008	2,165	35,457	2,894	987	66	288	307	42,164
At 30 June 2009	**2,165**	**34,733**	**2,654**	**863**	**89**	**391**	**1,116**	**42,011**
At 1 July 2009	2,165	34,733	2,654	863	89	391	1,116	42,011
At 30 June 2010	**2,165**	**33,709**	**2,732**	**721**	**160**	**1,269**	**885**	**41,641**

Parent	Freehold land (at valuation) $000	Freehold buildings (at valuation) $000	Clinical equipment $000	Other equipment $000	Information technology $000	Motor vehicles $000	Work in progress $000	Total $000
Cost / valuation								
Balance at 1 July 2008	2,165	36,508	5,839	1,736	613	862	307	48,030
Additions	0	337	337	105	37	171	809	1,796
Disposals	0	0	(169)	(2)	0	(545)	0	(716)
Revaluations	0	0	0	0	0	0	0	0
Balance at 30 June 2009	**2,165**	**36,845**	**6,007**	**1,839**	**650**	**488**	**1,116**	**49,110**
Balance at 1 July 2009	2,165	36,845	6,007	1,839	650	488	1,116	49,110
Additions	0	51	703	40	83	1,030	792	2,699
Disposals	0	(1)	(200)	(53)	0	0	(1,023)	(1,277)
Revaluations	0	0	0	0	0	0	0	0
Balance at 30 June 2010	**2,165**	**36,895**	**6,510**	**1,826**	**733**	**1,518**	**885**	**50,532**

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

Parent	Freehold land (at valuation)	Freehold buildings (at valuation)	Clinical equipment	Other equipment	Information technology	Motor vehicles	Work in progress	Total
Depreciation & impairment losses								
Balance at 1 July 2008		1,051	2,945	886	597	596		6,075
Depreciation charge for the year		1,076	557	138	7	76		1,854
Impairment losses		0	0	0	0	0		0
Disposals		(15)	(149)	(3)	0	(524)		(691)
Revaluations		0	0	0	0	0		0
Balance at 30 June 2009		**2,112**	**3,353**	**1,021**	**604**	**148**		**7,238**
Balance at 1 July 2009		2,112	3,353	1,021	604	148		7,238
Depreciation charge for the year		1,074	557	131	11	134		1,907
Impairment losses		0	0	0	0	0		0
Disposals		0	(132)	(35)	(1)	0		(168)
Revaluations		0	0	0	0	0		0
Balance at 30 June 2010		**3,186**	**3,778**	**1,117**	**614**	**282**		**8,977**

Parent	Freehold land (at valuation)	Freehold buildings (at valuation)	Clinical equipment	Other equipment	Information technology	Motor vehicles	Work in progress	Total
Carrying amounts								
At 1 July 2008	2,165	35,457	2,894	850	16	266	307	41,955
At 30 June 2009	**2,165**	**34,733**	**2,654**	**818**	**46**	**340**	**1,116**	**41,872**
At 1 July 2009	2,165	34,733	2,654	818	46	340	1,116	41,872
At 30 June 2010	**2,165**	**33,709**	**2,732**	**709**	**119**	**1,236**	**885**	**41,555**

Impairment

No impairment losses have been recognised during the period.

Revaluation

Current Crown accounting policies require all crown entities to revalue land and buildings in accordance with NZIAS 16, Property, Plant and Equipment. Current valuation standards and guidance notes have been developed in association with the treasury for the valuation of hospitals and tertiary institutions. The most recent revaluation was performed by CB Richard Ellis and the valuation is effective as at 30 June 2006.

Restrictions

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

ASSETS CLASSIFIED AS HELD FOR SALE

Wairarapa DHB revalued the buildings and associated land under a Statement of Standard Accounting Practice No. 17 (SSAP-17) methodology to the lower of cost and net realisable value. The valuation was completed by CB Richard Ellis as at 30 June 2006. The Wairarapa DHB considers this value to be materially correct as at 30 June 2010.

Wairarapa DHB is awaiting a decision from the Office of Treaty Settlements on whether the property classified as held for sale will be landbanked, and therefore sold to the Office of Treaty Settlements, or whether the property will receive clearance for private sale. Wairarapa DHB expects that the decision and subsequent sale will occur within 12 months of balance date.

8. INTANGIBLE ASSETS

Group	Software $000	Work in progress $000	Total $000
Cost / valuation			
Balance at 1 July 2008	726	163	889
Additions	174	234	408
Disposals	0	0	0
Revaluations	0	0	0
Balance at 30 June 2009	**900**	**397**	**1,297**
Balance at 1 July 2009	900	397	1,297
Additions	269	462	731
Disposals	0	(253)	(253)
Revaluations	0	0	0
Balance at 30 June 2010	**1,169**	**606**	**1,775**

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

Group	Software	Work in progress	Total
Depreciation & impairment losses			
Balance at 1 July 2008	285		285
Amortisation charge for the year	70		70
Impairment losses	0		0
Disposals	0		0
Revaluations	0		0
Balance at 30 June 2009	**355**		**355**
Balance at 1 July 2009	355		355
Amortisation charge for the year	112		112
Impairment losses	0		0
Disposals	0		0
Revaluations	0		0
Balance at 30 June 2010	**467**		**467**

Group	Software	Work in progress	Total
Carrying amounts			
At 1 July 2008	441	163	604
At 30 June 2009	**545**	**397**	**942**
At 1 July 2009	545	397	942
At 30 June 2010	**702**	**606**	**1,308**

Parent	Software $000	Work in progress $000	Total $000
Cost / valuation			
Balance at 1 July 2008	656	163	819
Additions	169	234	403
Disposals	0	0	0
Revaluations	0	0	0
Balance at 30 June 2009	**825**	**397**	**1,222**
Balance at 1 July 2009	825	397	1,222
Additions	265	462	727
Disposals	0	(253)	(253)
Revaluations	0	0	0
Balance at 30 June 2010	**1,090**	**606**	**1,696**

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

Parent	Software	Work in progress	Total
Depreciation & impairment losses			
Balance at 1 July 2008	252		252
Amortisation charge for the year	57		57
Impairment losses	0		0
Disposals	0		0
Revaluations	0		0
Balance at 30 June 2009	**309**		**309**
Balance at 1 July 2009	309		309
Amortisation charge for the year	97		97
Impairment losses	0		0
Disposals	0		0
Revaluations	0		0
Balance at 30 June 2010	**406**		**406**

Parent	Software	Work in progress	Total
Carrying amounts			
At 1 July 2008	404	163	567
At 30 June 2009	**516**	**397**	**913**
At 1 July 2009	516	397	913
At 30 June 2010	**684**	**606**	**1,290**

Impairment

No impairment losses have been recognised during the period.

9. INVESTMENTS

	Group Actual 2010 $000	Group Actual 2009 $000	Parent Actual 2010 $000	Parent Actual 2009 $000
Investment in subsidiary	0	0	103	103

Investment in Subsidiary

Biomedical Services New Zealand Limited is 100% owned by Wairarapa DHB (2008 – 100%). The principal activity of the subsidiary is the testing and maintenance of biomedical equipment. The latest audited financial statements were used as the basis for consolidation. The balance date of Biomedical Services New Zealand Ltd is 30 June.

Investment in Associate

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 2010 all share capital remains uncalled. The balance date of TAS is 30 June.

10. CASH & CASH EQUIVALENTS

	Group Actual 2010 $000	Group Actual 2009 $000	Parent Actual 2010 $000	Parent Actual 2009 $000
Short term deposits	2,197	2,190	2,000	2,000
Cash & cash equivalents	5	4	5	4
Bank overdraft	(1,796)	(3,178)	(1,896)	(3,264)
Total cash & cash equivalents	**406**	**(984)**	**109**	**(1,260)**

The bank overdraft is secured by a negative pledge which requires the Wairarapa DHB to operate within its approved overdraft facility. The facility available totals $6,000,000. The current interest rate on the group's bank overdraft is 10.55% per annum (2009 – 10.55%).

Reconciliation of Net Deficit to Net Operating Cash Flows

	Group Actual 2010 $000	Group Actual 2009 $000	Parent Actual 2010 $000	Parent Actual 2009 $000
Net surplus	(4,734)	(3,999)	(4,675)	(4,107)
Add/(less) Non-cash items:				
Depreciation & amortisation	2,085	2,008	2,004	1,911
Increase/(decrease) employee benefits (non-current)	0	0	13	(6)
Add/(less) Items classified as investment activity:				
Net loss/(gain) on sale of property, plant & equipment	3	19	3	19
Dividends received	0	0	(54)	(17)
Add/(less) movements in working capital items:				
(Increase)/decrease in receivables	413	(331)	407	(282)
(Increase) in inventories	19	(26)	19	(26)
(Decrease) in payables & accruals	(923)	1,126	(946)	1,113
Increase/(decrease) in taxation	0	0	0	0
Net cash flow from operating activities	(3,137)	(1,203)	(3,229)	(1,395)

11. INVENTORIES

	Group Actual 2010 $000	Group Actual 2009 $000	Parent Actual 2010 $000	Parent Actual 2009 $000
Central stores	210	243	210	243
Pharmaceuticals	83	84	83	84
Theatre supplies	249	228	249	228
Other supplies	137	143	137	143
Total inventories	**679**	**698**	**679**	**698**

Write-down of inventories amounted to nil for 2010 (2009 – nil). The amount of inventories recognised as an expense during the year ended 30 June 2010 was nil (2009 – nil).

No inventories are pledged as security for liabilities but some inventories are subject to retention of title clauses (Romalpa clauses). The value of stocks subject to such clauses cannot be quantified due to the inherent difficulties in identifying the specific inventories affected at year-end.

12. TRADE & OTHER RECEIVABLES

	Group Actual 2010 $000	Group Actual 2009 $000	Parent Actual 2010 $000	Parent Actual 2009 $000
Trade Debtors	3,548	3,990	3,440	3,872
Provision for Doubtful Debts	(109)	(82)	(109)	(82)
Prepayments	259	203	259	202
Amount Owing by Subsidiary	0	0	1	6
Total trade & other receivables	**3,698**	**4,111**	**3,591**	**3,998**

13. EQUITY

Group	Crown equity $000	Property revaluation reserve $000	Retained earnings $000	Total $000
Balance at 1 July 2008	18,264	1,479	(10,898)	8,845
Total recognised income & expenses	0	0	(3,999)	(3,999)
Contribution (net) from the Crown	590	0	0	590
Movement in revaluation of land & buildings	0	0	0	0
Balance at 30 June 2009	**18,854**	**1,479**	**(14,897)**	**5,436**
Balance at 1 July 2009	18,854	1,479	(14,897)	5,436
Total recognised income & expenses	0	0	(4,734)	(4,734)
Contribution (net) from the Crown	6,630	0	0	6,630
Movement in revaluation of land & buildings	0	0	0	0
Balance at 30 June 2010	**25,484**	**1,479**	**(19,631)**	**7,332**

Parent	Crown equity $000	Property revaluation reserve $000	Retained earnings $000	Total $000
Balance at 1 July 2008	18,264	1,479	(11,140)	8,603
Total recognised income & expenses	0	0	(4,107)	(4,107)
Contribution (net) from the Crown	590	0	0	590
Movement in revaluation of land & buildings	0	0	0	0
Balance at 30 June 2009	**18,854**	**1,479**	**(15,247)**	**5,086**
Balance at 1 July 2009	18,854	1,479	(15,247)	5,086
Total recognised income & expenses	0	0	(4,675)	(4,675)
Contribution (net) from the Crown	6,630	0	0	6,630
Movement in revaluation of land & buildings	0	0	0	0
Balance at 30 June 2010	**25,484**	**1,479**	**(19,922)**	**7,041**

Revaluation reserve

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

14. INTEREST-BEARING LOANS & BORROWINGS

	Group Actual 2010 $000	Group Actual 2009 $000	Parent Actual 2010 $000	Parent Actual 2009 $000
Non current liabilities				
Privately sourced loans	199	208	199	208
Crown sourced loans	20,000	20,000	20,000	20,000
Total non current interest-bearing loans & borrowings	**20,199**	**20,208**	**20,199**	**20,208**
Current liabilities				
Privately sourced loans	114	120	114	120
Crown sourced loans	5,188	5,438	5,188	5,438
Total current interest-bearing loans & borrowings	**5,302**	**5,558**	**5,302**	**5,558**

The Crown Health Financing Agency (CHFA) and the DHB have agreed a debt facility of $25,750,000 of which $25,187,500 was drawn at 30 June 2010. The CHFA term borrowings are secured by a negative pledge. Without the CHFA's prior written consent the DHB cannot perform the following actions:

- create any security interest over its assets except in certain defined circumstances;
- lend money to another person or entity (except in the ordinary course of business and then only on commercial terms) or give a guarantee;
- make a substantial change in the nature or scope of its business as presently conducted or undertake any business or activity unrelated to health; and
- dispose of any of its assets except disposals at full value in the ordinary course of business.

Wairarapa DHB must meet agreed covenants for the CHFA term borrowing. These covenants have been complied with since the facility was established. The Government of New Zealand does not guarantee term loans.

The Wairarapa Community Health Trust has provided privately funded financing arrangements for the DHB to acquire the ambulance vehicle fleet & ophthalmic instruments & equipment. Wairarapa DHB has no other privately funded financing arrangements.

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

	Group Actual 2010 $000	Group Actual 2009 $000	Parent Actual 2010 $000	Parent Actual 2009 $000
Crown Health Financing Agency				
Interest rate summary	5.92%	5.92%	5.92%	5.92%
Repayable as follows:				
Less than one year	5,188	5,438	5,188	5,438
One to two years	5,000	5,000	5,000	5,000
Two to five years	15,000	15,000	15,000	15,000
	25,188	**25,438**	**25,188**	**25,438**
Privately sourced loans				
Interest rate summary	4.60%	4.60%	4.60%	4.60%
Repayable as follows:				
Less than one year	114	120	114	120
One to two years	133	133	133	133
Two to five years	66	75	66	75
	313	**328**	**313**	**328**

15. EMPLOYEE BENEFITS

	Group Actual 2010 $000	Group Actual 2009 $000	Parent Actual 2010 $000	Parent Actual 2009 $000
Non current liabilities				
Liability for long service leave	227	234	227	234
Liability for retirement gratuities	306	286	306	286
Total non current employee benefits	**533**	**520**	**533**	**520**
Current liabilities				
Liability for long service leave	363	433	363	433
Liability for retirement gratuities	95	87	93	85
Liability for sabbatical leave	50	50	50	50
Liability for continuing medical education leave	452	580	452	580
Liability for maternity grant	7	10	7	10
Liability for annual leave	2,962	2,637	2,923	2,603
Liability for sick leave	134	402	134	402
Provision for restructuring	61	0	61	0
Salary & wages accrual	1,222	1,823	1,202	1,803
Total current employee benefits	**5,346**	**6,022**	**5,285**	**5,966**

Defined Benefit Plans

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

16. TRUST FUNDS

	Group Actual 2010 $000	Group Actual 2009 $000	Parent Actual 2010 $000	Parent Actual 2009 $000
Balance at beginning of year	61	54	61	54
Funds received	99	7	99	7
Interest received		0		0
Funds spent		0		0
Balance at end of year	**160**	**61**	**160**	**61**

Wairarapa DHB receives donations and bequests for specific purposes. If for any reason Wairarapa DHB is not able to use the funds as specified, then Wairarapa DHB is obligated to return the donation to the donor. Funds are held in a separate bank account and any interest earned is allocated to the individual trust balances.

17. PAYABLES & ACCRUALS

	Group Actual 2010 $000	Group Actual 2009 $000	Parent Actual 2010 $000	Parent Actual 2009 $000
Trade creditors & accruals	9,786	9,770	9,692	9,692
Capital charge payable	53	173	53	173
GST & other taxes payable	1,481	1,107	1,500	1,125
Income received in advance	0	284	0	284
Amount owing to subsidiary	0	0	22	12
Total payables & accruals	**11,320**	**11,334**	**11,267**	**11,286**

18. FINANCIAL INSTRUMENTS

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

Credit Risk

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

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

Concentrations of credit risk from accounts receivable are limited due to the large number and variety of customers. The Ministry of Health is the largest single debtor (approximately 60 per cent). It is assessed to be a low risk and high-quality entity due to its nature as the government funded purchaser of health and disability support services.

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

Group	Actual 2010 $000 Gross	Actual 2010 $000 Impairment	Actual 2010 $000 Net	Actual 2009 $000 Gross	Actual 2009 $000 Impairment	Actual 2009 $000 Net
Not past due	2,285	0	2,285	2,229	0	2,229
Past due 1-30 days	720	0	720	1,300	0	1,300
Past due 31-60 days	168	0	168	323	(2)	321
Past due 61-90 days	23	0	23	54	(16)	38
Past due > 91 days	352	(109)	243	91	(64)	27
Total	**3,548**	**(109)**	**3,439**	**3,997**	**(82)**	**3,915**

Parent	Actual 2010 $000 Gross	Actual 2010 $000 Impairment	Actual 2010 $000 Net	Actual 2009 $000 Gross	Actual 2009 $000 Impairment	Actual 2009 $000 Net
Not past due	2,285	0	2,285	2,229	0	2,229
Past due 1-30 days	613	0	613	1,175	0	1,175
Past due 31-60 days	167	0	167	323	(2)	321
Past due 61-90 days	23	0	23	54	(16)	38
Past due > 91 days	352	(109)	243	91	(64)	27
Total	**3,440**	**(109)**	**3,331**	**3,872**	**(82)**	**3,790**

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

Liquidity Risk

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

Interest Rate Risk

Interest rate risk is the risk that the fair value of a financial instrument will fluctuate or, the cash flows from a financial instrument will fluctuate, due to changes in market interest rates.

The DHB adopts a policy of ensuring that greater than 75% of its exposure to changes in interest rates on borrowings is on a fixed rate basis. No interest rate swaps are deemed necessary.

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

Foreign Currency Risk

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

The DHB has deemed that hedging will only occur for significant, generally in excess of $50,000, transactions sourced directly from overseas. The DHB has not entered any hedge contracts for foreign exchange transactions during the year.

Capital Management

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

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

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

Sensitivity Analysis

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

At 30 June 2010, it is estimated that a general increase of one percentage point in interest rates would increase Wairarapa DHB's deficit before tax by approximately $252,000 (2009: $275,000).

Fair Value Analysis

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

Group	Held for trading	Designated at fair value through profit & loss	Loans and receivables	Available for sale	Other amortised cost	Carrying amount	Fair value
	2010	2010	2010	2010	2010	2010	2010
	$000	$000	$000	$000	$000	$000	$000
Investments					0	0	0
Trade and other receivables			3,698			3,698	3,698
Cash and cash equivalents			406			406	406
Crown sourced loans					25,188	25,188	26,366
Privately sourced loans					313	313	313
Trade and other payables					11,320	11,320	11,320

Group	Held for trading	Designated at fair value through profit & loss	Loans and receivables	Available for sale	Other amortised cost	Carrying amount	Fair value
	2009	2009	2009	2009	2009	2009	2009
	$000	$000	$000	$000	$000	$000	$000
Investments					0	0	0
Trade and other receivables			4,111			4,111	4,111
Cash and cash equivalents			(984)			(984)	(984)
Crown sourced loans					25,438	25,438	25,438
Privately sourced loans					328	328	328
Trade and other payables					11,334	11,334	11,334

Parent	Held for trading	Designated at fair value through profit & loss	Loans and receivables	Available for sale	Other amortised cost	Carrying amount	Fair value
	2010	2010	2010	2010	2010	2010	2010
	$000	$000	$000	$000	$000	$000	$000
Investments					103	103	103
Trade and other receivables			3,591			3,591	3,591
Cash and cash equivalents			109			109	109
Crown sourced loans					25,188	25,188	26,366
Finance lease liabilities					313	313	313
Trade and other payables					11,267	11,267	11,267

Parent	Held for trading	Designated at fair value through profit & loss	Loans and receivables	Available for sale	Other amortised cost	Carrying amount	Fair value
	2009	2009	2009	2009	2009	2009	2009
	$000	$000	$000	$000	$000	$000	$000
Investments					103	103	103
Trade and other receivables			3,998			3,998	3,998
Cash and cash equivalents			(1,260)			(1,260)	(1,260)
Crown sourced loans					25,438	25,438	25,438
Finance lease liabilities					328	328	328
Trade and other payables					11,286	11,286	11,286

19. RELATED PARTIES

Identity of Related Parties

Wairarapa DHB has a related party relationship with its subsidiaries, associates, joint venture and with its board members and executive officers.

Remuneration of key management personnel

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

	Group Actual 2010 $000	Group Actual 2009 $000	Parent Actual 2010 $000	Parent Actual 2009 $000
Key management remuneration	1,822	1,890	1,661	1,661

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

There were no loans to board members or executive officers for the year ended 30 June 2009 (2008 – nil).

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

Transactions with related parties

Wairarapa DHB has a 100% shareholding in Biomedical Services New Zealand Limited. Biomedical Services New Zealand Limited has a balance date of 30 June and was incorporated in New Zealand. The directors of Biomedical Services New Zealand Limited are Pamela Jefferies (Wairarapa DHB Board member) and Tracey Adamson (Wairarapa DHB Chief Executive). The total value of transactions between Wairarapa DHB and Biomedical Services New Zealand Limited was $169,000 (2009: $165,000). The amount outstanding at balance date is $23,000 (2009: $19,000).

Wairarapa DHB has a 16.7% shareholding in Central Region Technical Advisory Services Limited (2008 – 16.7%) and participates in its commercial and financial policy decisions. The total value of transactions between Wairarapa DHB and Central Region Technical Advisory Services Limited was $142,000 (2009: $165,000). No amounts are outstanding at balance date.

Ownership

Wairarapa DHB is a wholly owned entity of the Crown and is a crown entity in terms of the Crown Entities Act 2004. The Government significantly influences the role of the Wairarapa DHB as well as being its major source of revenue.

Transaction with other entities owned by the Crown

There have been transactions with other entities controlled by the Crown that have not been separately disclosed because the transactions have been carried out on the same terms as if the transactions had been carried out at arms length.

Inter District Flows

Wairarapa DHB purchases services from other DHBs for its community. The process for this purchasing arrangement is inter district flows. For the period the following transactions were incurred by the DHB.

	2010 $000	2009 $000
Revenue	3,290	2,915
Expenditure	24,289	20,890
Receivable at 30 June	112	166
Payable at 30 June	3,851	2,025

20. SUBSEQUENT EVENTS

There are no significant events subsequent to balance date.

21. SEGMENTAL REPORTING

Wairarapa DHB operates in three segments:

- Funds – the funding of health and disability service providers, including the DHB's own provider arm. This output was previously provided by the Health Funding Authority and the Ministry of Health. It is effectively the flow of funds between the Crown and the DHB and onto the providers.
- Provider – the provision of health and disability services through the DHB's provider arm.
- Governance – the governance of the DHB, the Office of the Chief Executive and the administration of the funding activity.

The summary financial information below shows the total equity position and the revenue and expenditure for the financial year by segment for the parent DHB as required by the Operating Policy Framework.

	Parent Budget 2010 $000	Parent Actual 2010 $000	Parent Actual 2009 $000
Equity Position			
Funds	760	(1,934)	1,718
Provider	4,088	10,114	4,088
Governance	(720)	(1,139)	(720)
Total equity	**4,128**	**7,041**	**5,086**

	Parent Budget 2010 $000	Parent Actual 2010 $000	Parent Actual 2009 $000
Revenue			
Funds	112,192	113,875	111,314
Provider	54,991	56,157	54,991
Governance	1,785	3,215	2,053
Eliminations	(49,875)	(50,929)	(50,337)
Total revenue	**119,093**	**122,318**	**118,021**
Expenditure			
Funds	113,150	117,527	112,066
Provider	54,991	56,761	58,204
Governance	1,785	3,634	2,195
Eliminations	(49,875)	(50,929)	(50,337)
Total expenditure	**120,051**	**126,993**	**122,128**
Net Surplus / (Deficit)	**(958)**	**(4,675)**	**(4,107)**

22. ACCOUNTING ESTIMATES & JUDGEMENTS

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

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

Investment property

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

Finance and operating leases

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

23. EXPLANATION OF FINANCIAL VARIANCES FROM BUDGET

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

Revenue

- Additional revenue has recognised during the year over the budgeted amount primarily relating to additional funding for various initiatives funded by the Ministry of Health. These initiatives also attract additional expenditure.
- During the year the Shamrock trust donated $500,000 for the purchase of a new ambulance and other ambulance equipment. This donation was not budgeted.

Expenditure

- Additional expenditure has also arisen due to the higher than planned inter district flows for people Wairarapa community treated at other DHBs.
- Costs incurred in the settling of multi-employer collective agreements and in the payments for short-term contracted staff were lower than budgeted.
- Activity occurred at significantly higher than planned levels within Wairarapa Hospital resulting in increased clinical consumable costs.
- Depreciation & amortisation costs were lower than planned reflecting a delay in the acquisition of some capital asset items and technological enhancements resulting in longer useful lives, for certain categories of asset & therefore lower depreciation charges.

Assets

- Property, plant & equipment was lower than planned reflecting delays in the national procurement project for oral health and the late delivery of the mobile units.
- Trade & other receivables are higher than budget due to the additional funding streams from the Ministry of Health as noted in the revenue commentary above.
- The budget assumed that the old Masterton Hospital campus would be sold during the financial year and the proceeds used to repay equity in line with the Minister of Health approval of the Wairarapa Hospital business case. This sale did not proceed as planned and the asset remains on the books

Liabilities

- Trade & other payables are higher than planned reflecting the amount outstanding for inter district flows payable to other DHBs.

Equity

- As noted above the Masterton Hospital campus was expected to be sold during the financial year and the proceeds to repay equity. This did not occur.
- The Wairarapa DHB received a one-off equity injection from the Government totalling $5.1 million on 29 June that was not planned. This equity injection reflected unfunded deficits in prior years and other one-off adjustments made through changes to government policy in prior years.

STATEMENT OF RESPONSIBILITY

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

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

In the opinion of the Board and management of Wairarapa District Health Board the financial statements and the statement of service performance for the year ended 30 June 2010 fairly reflect the financial position and operations of Wairarapa District Health Board.

Chair
Bob Francis

Board Member & Chair, Audit & Risk Committee
Perry Cameron

Chief Executive
Tracey Adamson

General Manager Finance & Information
Eric Sinclair

AUDITOR'S REPORT

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

TO THE READERS OF WAIRARAPA DISTRICT HEALTH BOARD AND GROUP'S FINANCIAL STATEMENTS AND STATEMENT OF SERVICE PERFORMANCE FOR THE YEAR ENDED 30 JUNE 2010

The Auditor-General is the auditor of the Wairarapa District Health Board (the Health Board) and group. The Auditor-General has appointed me, Leon Pieterse, using the staff and resources of Audit New Zealand, to carry out the audit on her behalf. The audit covers the financial statements and statement of service performance of the Health Board and group for the year ended 30 June 2010.

Unqualified Opinion

In our opinion:

- The financial statements of the Health Board and group on pages 42 to 91:
  - comply with generally accepted accounting practice in New Zealand; and
  - fairly reflect:
    - the Health Board and group's financial position as at 30 June 2010; and
    - the results of operations and cash flows for the year ended on that date.
- The statement of service performance of the Health Board and group on pages 21 to 40:
  - complies with generally accepted accounting practice in New Zealand; and
  - fairly reflects for each class of outputs:
    - its standards of delivery performance achieved, as compared with the forecast standards included in the statement of forecast service performance at the start of the financial year; and
    - its actual revenue earned and output expenses incurred, as compared with the expected revenues and proposed output expenses included in the statement of forecast service performance at the start of the financial year.

The audit was completed on 28 October 2010, and is the date at which our opinion is expressed.

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

Basis of Opinion

We carried out the audit in accordance with the Auditor-General's Auditing Standards, which incorporate the New Zealand Auditing Standards.

We planned and performed the audit to obtain all the information and explanations we considered necessary in order to obtain reasonable assurance that the financial statements and statement of service performance did not have material misstatements, whether caused by fraud or error.

Material misstatements are differences or omissions of amounts and disclosures that would affect a reader's overall understanding of the financial statements and statement of service performance. If we had found material misstatements that were not corrected, we would have referred to them in our opinion.

The audit involved performing procedures to test the information presented in the financial statements and statement of service performance. We assessed the results of those procedures in forming our opinion.

Audit procedures generally include:

- determining whether significant financial and management controls are working and can be relied on to produce complete and accurate data;
- verifying samples of transactions and account balances;
- performing analyses to identify anomalies in the reported data;
- reviewing significant estimates and judgements made by the Board;
- confirming year-end balances;
- determining whether accounting policies are appropriate and consistently applied; and
- determining whether all financial statement and statement of service performance disclosures are adequate.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements and statement of service performance.

We evaluated the overall adequacy of the presentation of information in the financial statements and statement of service performance. We obtained all the information and explanations we required to support our opinion above.

Responsibilities of the Board and the Auditor

The Board is responsible for preparing the financial statements and statement of service performance in accordance with generally accepted accounting practice in New Zealand. The financial statements must fairly reflect the financial position of the Health Board and group as at 30 June 2010 and the results of operations and cash flows for the year ended on that date. The statement of service performance must fairly reflect, for each class of outputs, the Health Board and group's standards of delivery performance achieved and revenue earned and expenses incurred, as compared with the forecast standards, revenue and expenses at the start of the financial year. The Board's responsibilities arise from the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004.

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

Independence

When carrying out the audit we followed the independence requirements of the Auditor-General, which incorporate the independence requirements of the Institute of Chartered Accountants of New Zealand.

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

Leon Pieterse

Audit New Zealand

On behalf of the Auditor General

Wellington, New Zealand

DIRECTORY

Board Office	Wairarapa DHB P O Box 96 Masterton 5888 Telephone: 06 946 9880 Website: www.wairarapa.dhb.org.nz	
Board Members	Bob Francis Janine Vollebregt Perry Cameron Liz Falkner Pamela Jefferies Helen Kjestrup Liz Mellish Mavis Mullins Vivien Napier Fiona Samuel Trish Taylor	Chairman Deputy Chairman
Chief Executive	Tracey Adamson	
Executive Managers	Eric Sinclair Simon Everitt Kieran McCann Robyn Brady Helen Pocknall Alan Shirley Cate Tyrer Stephanie Turner Gretchen Dean	General Manager Finance & Information General Manager Strategic Development and Population Health General Manager Clinical Services General Manager Service Improvement and Clinical Support Director of Nursing, Midwifery and Allied Health Chief Medical Officer Director, Quality, Safety and Risk Director of Maori Health Human Resources Manager
Auditor	Audit New Zealand on behalf of the Office of the Controller and Auditor-General	
Bankers	ANZ Banking Group (New Zealand) Ltd Crown Health Financing Agency	