

Wairarapa District Health Board
Annual Report
2011



Wairarapa DHB

Wairarapa District Health Board

Te Poari Hauora a-rohe o Wairarapa

CONTENTS

FOREWORD	1
CHAIRMAN'S REVIEW	3
CHIEF EXECUTIVE'S REVIEW	5
GOVERNANCE REPORT	11
OUR PEOPLE	17
STATEMENT OF SERVICE PERFORMANCE	21
FINANCIAL STATEMENTS	32
STATEMENT OF ACCOUNTING POLICIES	41
NOTES TO THE FINANCIAL STATEMENTS	50
STATEMENT OF RESPONSIBILITY	85
AUDITOR'S REPORT	86
DIRECTORY	88

FOREWORD

This Annual Report is a summary of the Wairarapa District Health Board's performance during the year 1 July 2010 to 30 June 2011. 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

On behalf of the Board, I am pleased to present the 2010/11 Annual Report for the Wairarapa District Health Board (WDHB).

WDHB strives to fulfil its vision of a *Well Wairarapa - Better Health For All* by taking a leadership role and innovative approach to the provision of high quality health care, which places the person at the centre of their care.

RESULTS

The achievements of WDHB in pursuit of excellence and leading practice are recognised in the strong results in the six National Health Targets, where WDHB is consistently ranked in the top quarter of DHBs. The details of this performance are shown on page 5.

Fiscally, the WDHB has reported a deficit of \$3.6 million which although adverse to the planned deficit of \$2.2 million this is \$1.1 million better than for the preceding year. WDHB continues to face ongoing fiscal pressures to meet increasing demand for services, increasing costs of new technologies and treatments and the recruitment and retention of the workforce required to continue services. The DHB is committed to achieving a financial sustainable position over the next 2-3 years.

GROWING WITH OUR COMMUNITY

The Clinical Services Action Plan (CSAP) and Tihei Wairarapa ensure that we will continue to grow with our community, continuing to meet their needs now and well into the future. They are also about ensuring a strong foundation so we can adapt flexibly and innovatively to unexpected changes.

Our thinking has been shaped by the strategic environment within which we operate, which is characterised by: the ageing of our population, with increasing demand for health care services; government health reforms; and a continuing need for efficiency, adaptation, innovation and investment in resources and people.

We wish to continue playing a role in supporting our various partners and stakeholders through the various initiatives outlined in the CSAP and Tihei Wairarapa. We also want to continue to focus on improving access to health services for those who do not currently have equity of access to health services, attracting and retaining staff at a time of skilled workforce shortages, and investing in information technology to further enable the seamless transfer of patient information between providers.

WORKING WITH OUR NEIGHBOURS

A key area to ensure the ongoing provision of services in the Wairarapa is the work programme underway with our neighbouring DHBs.

A significant amount of time has been invested by senior management and clinicians in recent months progressing a number of collaborative efforts between WDHB and our neighbouring DHBs: Capital & Coast and Hutt Valley. This work, under the banner of the 3 DHB Health Service Development, is vital to ensure clinically sustainable services across the three DHBs.

WDHB continues to be strongly represented on a number of other regional and national groups. This includes the programme that developed the Regional Services Plan (RSP), a new requirement of legislation introduced during the last year. This work will continue and a revised and improved RSP will be produced early in the 2012 year to further drive the sustainability of services, clinically and financially, into the future.

A HEALTHY FUTURE

The future ahead promises to be one of continued rapid development with the progression of Tihei Wairarapa, the Regional Services Plan, the 3 DHB Health Service Development and the Central Region Information Systems Plan.

These programmes of work, along with further enhancements driven by the Ministry of Health, National Health Board and Health Benefits Limited, will provide us with many opportunities and challenges to keep WDHB at the forefront of national, regional and local health service delivery.

ACKNOWLEDGEMENTS

The support received from many individuals, Iwi, local government, businesses, support groups and volunteers is outstanding. Their support is greatly valued and appreciated as it is critical to our ongoing success and development as a District Health Board.

I also recognise the outstanding contribution of our Board Members, staff and health service providers in continuing the strong legacy of superb health care for the Wairarapa community.

I would also like to acknowledge the contribution over the previous three years of the four Board members whose term on the Board ended following the October 2010 DHB election process: Trish Taylor, Pamela Jefferies, Liz Mellish and Perry Cameron. I would also like to welcome the new members of the Board whose terms commenced in December 2010: Leanne Southey, Janice Wenn, Rob Irwin and Rick Long.



Bob Francis
Board Chairman

CHIEF EXECUTIVE'S REVIEW

The last year has been one of advancing local, sub regional and regional collaborative initiatives with a focus on supporting the delivery of the 'triple aim' of improving the patient experience, improving the health of our population, and making wise use health resources.

THE CHALLENGE

The challenge in achieving the 'triple aim' is made easier when we focus on delivering services to our community that achieve the seven parameters of quality: they are accessible, appropriate, effective, efficient, responsive, safe and provided in continuity. When we assess our service delivery, from a patients perspective, against these quality parameters, there is inevitable opportunities for improvement.

THE FRAMEWORK

Four major planning documents were completed this year. They build on the Clinical Services Action Plan that was developed in 2009. They put forward a vision that supports strategies to improve health outcomes in the Wairarapa, as part of the Central Region. These include the Maori Health Plan, Regional Services Plan, Annual Plan and our Statement of Intent.

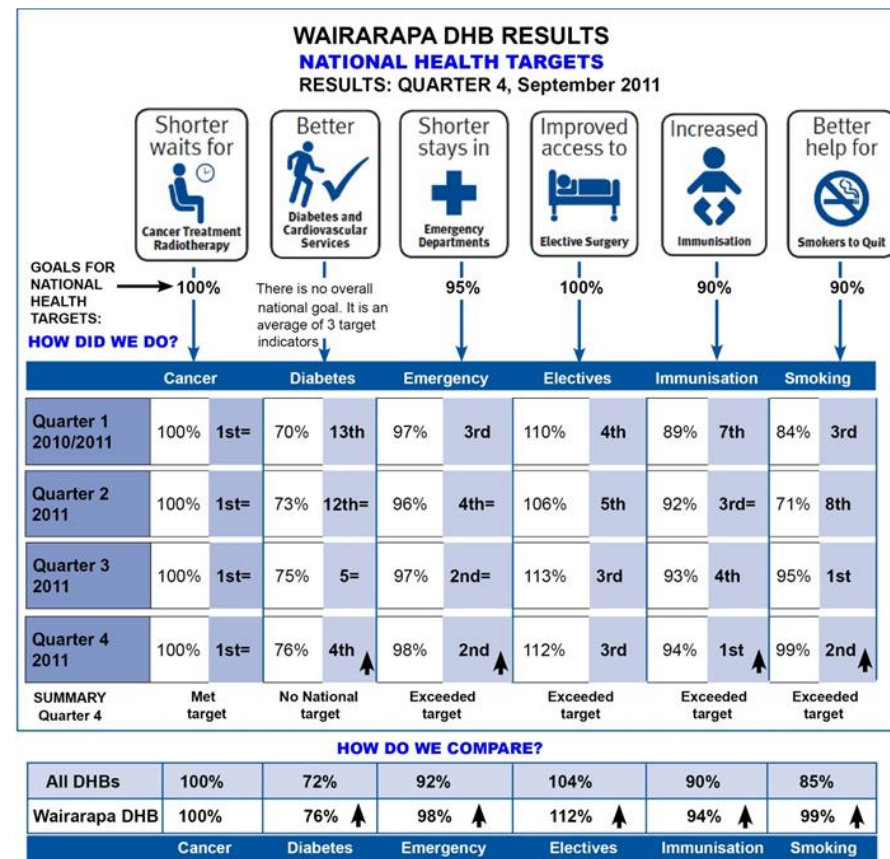
Tihei Wairarapa and the 3 DHB Health Service Development Programme are the strategies that the Wairarapa DHB have adopted to implement our vision for a sustainable future for health service delivery in the Wairarapa.

SERVICE DELIVERY IMPROVEMENT

HEALTH TARGETS

We have done superbly nationally and regionally. We have consistently outperformed many of the larger DHBs and have met or exceeded all our

targets. We have made considerable progress over the course of the year and this diagram shows our steady progress at a glance. This is a great achievement and a credit to all our staff and partners in the community.



CLINICAL SERVICES ACTION PLAN & TIHEI WAIRARAPA: YEAR ONE

Clinical Services Action Plan

In 2009/10 the DHB worked very closely with clinicians and health service providers to build a vision for a sustainable future for health service delivery in the Wairarapa. This close collaboration with clinicians resulted in the development of our Wairarapa Clinical Services Action Plan (CSAP).

CSAP identifies the changes necessary to put WDHB back onto a sustainable pathway.

There are six key strategies in the plan, and under each there is a description of what has been achieved, and what we are bringing forward into the next year.

Strategy 1: Focus on individuals and whanau/ family

'Whanau Ora' is a way of working that recognises each patient in the context of their family/ wider support network. While particularly relevant to helping improve the health of Maori, the principles have the potential to benefit the way we all manage our health.

Using this way of thinking, the DHB's staff orientation has been adapted to make sure the information and activities are 'patient and family' focused, rather than organisation focussed. The same focus has been applied to staff workshops and training activity.

An ongoing stream of work related to this is around 'advanced care planning' which helps individuals and families identify in advance what is important to them in end-of-life care.

Strategy 2: Redesign and coordinate the patient's journey

Every person's 'health journey' is different, but many have much in common. These common factors are often called 'care pathways', and there has been a lot of work in the last year to trace these, particularly for people who have long-term conditions, to help us reorganise resources and reduce duplication for patients.

This process has been helped through the establishment of an Alliance Leadership Team, a joint clinical and management forum from

representatives across the health system which governs the implementation of the Tihei Wairarapa programme of work.

Developments have included an advisory nurse to support ARC facilities and ARC nurse training programme, and developing designated GP support and supervision for ARC facilities.

The CRISP (Central Region Information System Plan) Phase 1 Business Case, was developed in 2010/11. The programme has just been approved for commencement. This regional wide initiative, along with the local ManageMyHealth implementation, will significantly enhance the communication about patients care between clinicians and providers.

Strategy 3: Develop Primary Care Services

Tihei Wairarapa

Tihei Wairarapa is a plan to help us better integrate health services in the Wairarapa, focussed initially on care which happens in the community. The first year of implementation is now completed, with most project milestones achieved. There has been an increased focus on 'patient-centric and whānau-centric' care across the Wairarapa health system and sub-regionally.

Some of our achievements over the past year include the development of more integrated models of care, including pathways and protocols for the frail elderly, common long term conditions and mental health. We have improved acute care arrangements through better understanding of ED and admission patterns. There is now a more systematic multi-disciplinary team approach to caring for people who are frequent users of Emergency Department services and families suffering from persistent serious skin infections. A review of outreach and whanau ora services is underway, with analysis of outreach data completed.

To be successful, change takes time, as much of it revolves around learning to work together differently. The team working on Tihei Wairarapa have taken the time necessary to build relationships and make necessary connections. The priority activities for the second year of the implementation plan have been agreed, with an emphasis on implementing the models of care and pathways the working groups have developed over the past twelve months.

The first priority is the transition in practices from Care Plus to the new Guided Care programme. Care Plus was a 'blue-print' that enabled GPs and practice nurses to more closely monitor people who had chronic conditions. The Guided Care Programme builds on this, but brings in a new tool that will make sure everyone eligible gets a consistent, comprehensive assessment, enabling referral to the most appropriate services to meet their needs.

A major milestone was achieved in early August 2011 when the rollout of the Shared Care Record (SCR) started. This means that a summary of the latest information held by your GP on your diagnosis and medications will be available to clinicians in a range of settings, including after hours care, Emergency Department, Aged Residential Care, and for emergency paramedics. Four practices, covering nearly 75% of the Wairarapa population, are participating in the SCR at this point, and it is heralded by clinicians as a big improvement in the quality of care, with the potential to save lives. Note that patients can choose to 'opt off' the SCR by contacting their General Practice.

Strategy 4: Reorganise and develop the healthcare workforce

The healthcare workforce is facing huge challenges in the years ahead as our population and our workforce ages, technology changes, and our expectations change. As part of our longer term strategy, this year we have implemented "The Productive Ward", a programme that allows clinical staff to spend more time with patients through better organisation of the environment, and processes.

We have also recognised the need for senior Wairarapa clinical staff to be better connected and supported within the region, and have encouraged links with our like staff in our neighbouring DHBs

Ongoing development for all our staff is important, and we have developed an annual calendar of training programmes to better enable us to release staff for ongoing education.

Another significant milestone has been the progressive implementation of the cultural competency framework, Te Arawhata Totika and the work with unions to encourage staff to take annual leave entitlements.

In partnership with clinical staff across the maternity 'spectrum' we are reviewing how maternity services are provided. I want to acknowledge

all the staff that has been involved in this review and thank them for going the extra mile whilst we have a number of vacant midwife positions.

The Board also took a decision to exit the provision of ambulance services. It was acknowledged that the WDHB could not currently, or into the future, meet its obligations as a good employer over such a small and specialised workforce, within the current arrangement.

Strategy 5: Public Health interventions

Creating an overarching public health plan was a priority this year, enabling us to embed Keeping Well (the regional public health plan) priorities into planning and contracting. Elements of our Public Health plan included support for the Masterton East project, continuation of the Healthy Eating Healthy Action programme, and further development of tobacco control and smoking cessation programmes.

This involved a review of the actions and functions of the Healthy Lifestyles groups and clarification and streamlining of health promotion actions. It also enabled us to provide targeted programmes in high needs communities.

Strategy 6: Control costs and maximise revenue

We take 'making best use of resources' seriously, and have an ongoing programme of process improvements to control our costs, and bring in all the revenue due to us for the work we do. Process improvements include improving address coding for Inter-District Flows (IDFs). This is the way our DHB pays for procedures on Wairarapa patients carried out in another DHB, or procedures we provide for out-of-region patients in the Wairarapa. We have also improved coding and ACC claiming processes, enabling us to more accurately claim for the work we do.

To reduce our IDF costs, we have worked on processes to reduce referrals to other DHBs when the procedure can be safely and appropriately performed at Wairarapa Hospital.

A highly successful project has been the roll-out of the pharmacy synchronisation pilot. This has allowed pharmacists to work with patients and their general practitioners to have their prescriptions synchronized, so all their medications are reviewed and re-prescribed in

one visit. This has significantly reduced both cost and waste of prescribing medicines.

There are several projects underway that will be carried forward into the next year, including rationalisation of the use of diagnostics, sharing back office functions between DHBs (e.g. Hutt Valley DHB now manages the WDHB payroll functions), access to elective services and IDF referral patterns. We have also started to introduce hospital capacity planning and developing new ways of funding services to provide new models of care.

FINANCIAL SUSTAINABILITY

It gets harder in a climate of financial restraints and rising costs to balance the budget. At the end of the financial year we had a deficit of \$3.62 million against a budgeted deficit of \$2.19 million. This unfavourable variance of \$1.43 million is 1.16% of total turnover.

A revised forecast (a deficit of \$3.95 million) was agreed with the Board in January 2011. The actual result was favourable to forecast by \$0.33 million. We have contained cost growth below national averages and the annual deficit position is reducing (2009/10 deficit was \$4.68 million).

Wairarapa DHB faces the continuing challenge of increasing demand, increasing costs of new technologies and treatments, providing services within the available funding, compliance with legislation, and recruiting and maintaining the workforce it requires. The cost of inter-district flows continues to rise.

Our staffing numbers decreased slightly. Full Time Equivalent staff numbers across the DHB were budgeted at 452.9, with an actual result of 438.2, favourable against budget by 14.7 FTEs.

Our goal is to achieve financial security by ensuring delivery on Minister-of Health agreed financial forecasts within available funding, through active cost management and achieving planned productivity savings.

Good To Great

A range of service and workforce initiatives under the Good to Great programme had a target of \$2.35 million in for 2010/11. \$1.39 million was achieved (59.1%).

This programme was reviewed at the end of June and DHB staff were asked to complete a survey to gauge the success of Good to Great. 159 staff (approximately 25%) completed the questionnaire giving their opinion about the success of the programme and identifying the issues, barriers, opportunities facing our organisation. It was important to gather ideas and comments from staff - it is part of building our future together.

ORGANISATIONAL SUSTAINABILITY

WORKING WITH OUR NEIGHBOURS

We have been working in partnership with our neighbouring DHBs and other health providers to develop clinically sustainable services. There are various collaborative initiatives on the drawing board, particularly at a sub-regional level, both between DHBs and between clinicians and managers.

The Sub-Regional Clinical Leadership Group (SRCLG)

This group which was established in early 2010, has proved a valuable forum. Senior clinicians and managers from the three DHBs have met regularly throughout the year and this is helping cement new relationships and new ways of thinking. They have commissioned a series of service reviews, focusing first on vulnerable services or services which will most benefit from a sub-regional approach.

The sub-regional workstreams led by the SRCLG are developing into concrete programmes, under the banner of the '3D' initiative (3 DHB Health Service Development). Care is being taken to align work with regional initiatives, particularly those contained in the Regional Services Plan (an plan agreed between the six lower North Island DHBs).

Examples of Collaborative initiatives:

- WDHB payroll is now managed by Hutt Valley DHB
- A joint surgical initiative between Hutt Valley DHB and WDHB sees Wairarapa surgeon, Bertrand Jauffret, operating on his more complex Wairarapa patients at Hutt Hospital where there is full ICU back-up. In return, some Hutt Valley patients who have been on the waiting list for some time for minor surgery are offered surgery sooner at Wairarapa Hospital.
- Wairarapa women get faster surgery in Hutt Hospital with Wairarapa specialist, Dr Maha Jaber. She sees women in a Masterton clinic and if they require an operation that can't be done in Wairarapa she can offer them surgery in the Hutt. After surgery, they have their follow-up clinics at Wairarapa Hospital. It means more patient continuity and satisfaction.
- MidCentral DHB does excellent work on our behalf to meet the cancer waiting times health target. Through their efforts we consistently achieve 100% of the national health target.
- We have entered a joint contract with the other DHBs in our region for the provision of uniforms. Not only does it save cost, it also makes it easier for staff to transfer between DHBs.

Other sub-regional approaches being explored include the sharing of Planning and Funding services, regional cover for speech language therapy services, the development of a regional ENT service, a joint undertaking for the regional DHBs to consult with each other when appointing senior staff so we better support each other, and a sub-regional look at capacity planning to make best use of staff and facility resources.

WAIRARAPA DHB: COMMUNITY PERCEPTION

The achievement and improvement in health targets, the ongoing work around the Clinical Services Action Plan, no Health and Disability Commissioner cases and the improvement in relations with neighbouring DHBs continues to put the WDHB in a positive light.

Local and regional media coverage has been generally positive throughout the year and reflective of the excellent work and achievements of WDHB.

WDHB has built sound collaborative relationships with local government and key community groups. We have strong relationships with the three territorial local authorities and the regional council and contribute to some joint planning processes with them.

WDHB works with Work and Income, the Ministry of Social Development, Accident Compensation Corporation (ACC), Te Puni Kokiri and the education sector to identify and use opportunities for shared approaches to common problems. This is particularly important in progressing implementation of 'whole of government' strategies such as the National Suicide Prevention Strategy, and the New Zealand Disability Strategy.

MAORI PARTNERSHIP

The Maori Health Plan was completed in September 2010, and this is now driving the work and monitoring programme for the Maori Health Directorate and the Senior Leadership Team (SLT) in regards to improving the health of Maori in our region. The Maori Health Plan outlines the concerns regarding the health of Maori within Wairarapa and the need to ensure our workforce can address these needs.

A Maori Health Workforce Development Plan is under development as part of the broader DHB workforce plan. It will contain strategies for recruitment and retention of a local and regional Maori workforce.

SLT completed Waiata and Te Reo education sessions and support is being provided for increased education opportunities for cultural training

across the DHB. The Maori Health team offer regular Te Reo and waiata classes for staff who are encouraged to attend.

The improvement of health outcomes for Maori is a strategic priority for WDHB. Maori participation in the provision and development of health services in Wairarapa will continue to be underpinned at the governance level by the relationship between the Board and Te Iwi Kainga.

QUALITY OF SERVICE DELIVERY

The midterm certification audit against the Health and Disability Sector Standards found that progress had been made against all of the 12 recommendations, however medication management still required improvements. We have established a pharmaceutical work stream, led by the Chief Medical Officer and Director of Nursing and Midwifery, for zero tolerance of prescribing errors.

We have had no cases considered for investigation by the Health and Disability Commission. Complaints management processes are improving and compliments still outnumber complaints. Clinical quality indicators are stable, with recent improvements in Occupational Health and Safety due to some particular initiatives related to equipment management. Opportunities exist for enhancing engagement around quality frameworks with Primary Care and reducing the incidence of falls and infections acquired in the community.

There is increasing focus nationally and internationally on the quality and safety of health services, with recent legislation requiring certification, credentialing and audit, and reports of the Health and Disability Commissioner placing increasing demands and expectations on the provision of care. Added to this are the statutory requirements on DHBs to improve health outcomes and reduce inequalities.

Wairarapa Hospital consistently has high levels of patient satisfaction recorded in patient feedback. A new quality initiative was the

appointment of quality leaders, a team made up of representatives from key clinical areas, who focus on quality-based issues such as falls, audits, documentation, reportable events and outcomes. This has resulted in a greatly improved culture of quality awareness amongst clinical staff, who continue to develop innovative new quality initiatives.

CONCLUSION

Overall, it has been a challenging year, marked by a consistent effort to improve the quality of care and live within our means. By most national measures we are 'punching well above our weight' by coming in or at the top of the measure, thanks largely to the dedication of our staff and their innovative approach to problem solving.

Thanks must also go to our community partners who helped shape the future vision of integrated healthcare in the Wairarapa through the Tihei Wairarapa plan, and to our Board, who have the courage and foresight to enable bold measures to enable us to meet the 'Triple Aim'.



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.

The membership of the Board at 30 June 2011 is:

- Bob Francis (Chair)
- Leanne Southey (Deputy Chair)
- Dr. Liz Falkner
- Rob Irwin
- Helen Kjestrup
- Rick Long
- Mavis Mullins (subsequently resigned from Board - August 2011)
- Vivien Napier
- Fiona Samuel
- Janine Vollebregt
- Janice Wenn

BOARD ELECTIONS

Board elections occur every 3 years with the latest elections completed in October 2010. The new Board took office on 6 December 2010.

The DHB election process elects 7 members of the Board with a further 4 members appointed by the Minister of Health, who also appoints the Chair and Deputy Chair. The appointed members for the Board following the election are:

- Bob Francis (Chair)
- Leanne Southey (Deputy Chair from 6 December 2010)
- Mavis Mullins
- Janice Wenn (from 6 December 2010)
- Pamela Jefferies (to 5 December 2010)
- Liz Mellish (to 5 December 2010)

The members were elected:

- Dr. Liz Falkner
- Helen Kjestrup
- Vivien Napier
- Fiona Samuel
- Janine Vollebregt (Deputy Chair until 5 December 2010)
- Rob Irwin (from 6 December 2010)
- Rick Long (from 6 December 2010)
- Perry Cameron (to 5 December 2010)
- Trish Taylor (to 5 December 2010)

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 (Chair)	<ul style="list-style-type: none"> • 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
Leanne Southey (Deputy Chair)	<ul style="list-style-type: none"> • Director, Sadler Oakley Newman Ltd • Chartered Accountant to health professionals including Selina Sutherland Hospital and Selina Sutherland Trust • Trustee, Wairarapa Community Health Trust • Trustee, Masterton Trust Lands Trust • Sister-in-law employed by WDHB
Dr. Liz Falkner	<ul style="list-style-type: none"> • 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
Rob Irwin	<ul style="list-style-type: none"> • Trustee, Wairarapa Community Health Trust

Member	Interests Declared
Rick Long	<ul style="list-style-type: none"> • Half owner of the Sign Factory • Chairman, Wairarapa Community transport Services Inc.
Helen Kjestrup	<ul style="list-style-type: none"> • Clinical Services Manager, Masterton Medical Ltd • Shareholder, Property Investment Company - Kjestrup Properties • Assessor for Royal College of GPs for Cornerstone Programme • Member, Long Term Conditions Steering Group • Member, Wairarapa Nurses Advisory Group • Member, WDHB Clinical Forum • Member, Tihei Wairarapa Elderly Care and Long Term Conditions Workstreams
Vivien Napier	<ul style="list-style-type: none"> • RNZ Plunket Society Member • South Wairarapa District Council Deputy Mayor • Director Katson Developments • Vice President of the Wairarapa Branch Plunket Society
Fiona Samuel	<ul style="list-style-type: none"> • Member of Wairarapa DHB Clinical Forum • Kaitataki Whanau Ora - Whanau Ora Manager Whaioara • Member of Child Health Advisory Strategy Group • MOH Expert Advisory Group for Maori Diabetes and Cardiovascular Disease • Member, Tihei Wairarapa Acute Workstream

Member	Interests Declared
Janine Vollebregt	<ul style="list-style-type: none"> • Part-time Academic Nurse Lecturer at UCOL (May 2010 - November 2010 based at Wairarapa Hospital) • Clinical Nurse Manager, Glenwood Masonic
Janice Wenn	<ul style="list-style-type: none"> • Iwi member, PHO Alliance Leadership Team • Member, PHO Whanau Ora Reference group • Director, Tu Tama Wahine o Taranaki • Lead researcher for Tu Tama Wahine domestic violence and Youth Resiliency HRC funded research programmes • Collaborator with Te Hauke o Wanganui for Whanau Ora Action Research contract Te Puni Kokiri • Senior Researcher Pumanawa Hauora, massey University • Member, Cancer, Comorbidity and Care, Interventions to Reduce Inequalities Advisory Group
Mavis Mullins	<ul style="list-style-type: none"> • Chair Aohanga Incorporation • Chair Poutama Trust • Chair Te Huarahi Tika Trust • Director Hautaki Limited • Director Landcorp Farming Limited
Perry Cameron	<ul style="list-style-type: none"> • Executive Director of Perry Cameron & Associates Ltd (PCA), a professional consultancy firm.

Member	Interests Declared
Liz Mellish	<ul style="list-style-type: none"> • Trustee Palmerston North Maori Reserve • Executive Officer Wellington Tenth Trust • Trustee Wellington Tenth Development Trust • Member Capital and Coast DHB DSAC • Chair Card Reserve Surface Trust, Featherston • Consultant for Maori Business
Pamela Jefferies	<ul style="list-style-type: none"> • 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
Trish Taylor	<ul style="list-style-type: none"> • 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 2011 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

	2011 Board Fee	2011 CPHAC	2011 HAC	2011 DSAC	2011 ARC	2011 Total Fees	2010 Total Fees
Bob Francis (Chairman)	32,000	1,563	1,000		1,000	35,563	37,313
Leanne Southey (Deputy Chair)	11,538	500			938	12,976	0
Janine Vollebregt	17,693	500	1,000	1,250	500	20,943	25,938
Vivien Napier	16,000	1,250	1,125	250		18,625	21,188
Fiona Samuel	16,000	1,500		1,000		18,500	19,250
Liz Falkner	16,000	750		1,000		17,750	19,000
Helen Kjestrup	16,000	500	500		500	17,500	18,500
Mavis Mullins	16,000		500		500	17,000	11,827
Rob Irwin	9,231		500	500	500	10,731	0
Rick Long	9,231	750			500	10,481	0
Janice Wenn	9,231		500	500		10,231	0
Perry Cameron	6,769	750			313	7,832	20,375
Trish Taylor	6,769	750		250		7,769	20,000
Pamela Jefferies	6,769		625			7,394	19,250
Liz Mellish	6,769	500				7,269	18,250
Taiawhio Gemmell		1,500				1,500	500
Ruth Carter				1,000		1,000	750
Lyn Olds				1,000		1,000	750
Yvette Grace						0	2,096
TOTAL	196,000	10,813	5,750	6,750	4,751	224,064	234,987

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 Alliance Leadership Team, the Clinical Board and involvement of clinicians in the development of collaborative service models at a sub-regional and regional level.

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

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

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 policies. A rigorous recruiting and selection procedure is followed to ensure fairness and equal opportunity. Training and Development opportunities are offered to all staff, and personal performance and development plans are a requisite for all employees.

Several forums are in place comprising a selection of employees from across 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 CEAs 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.

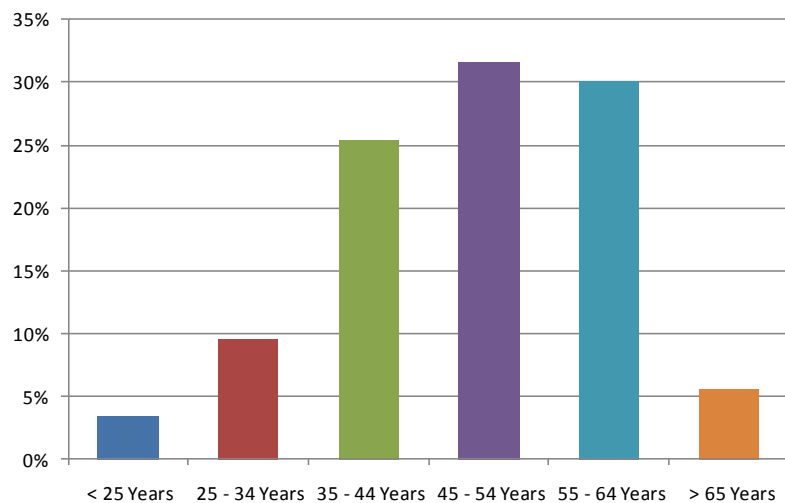
The Protected Disclosure Act 2000 and the Board’s related policy, protects the right of employees to raise matters of public concern in a safe and appropriate manner. Where an individual may feel personally disadvantaged there are established grievance procedures available including external mediation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

WORKFORCE PROFILE

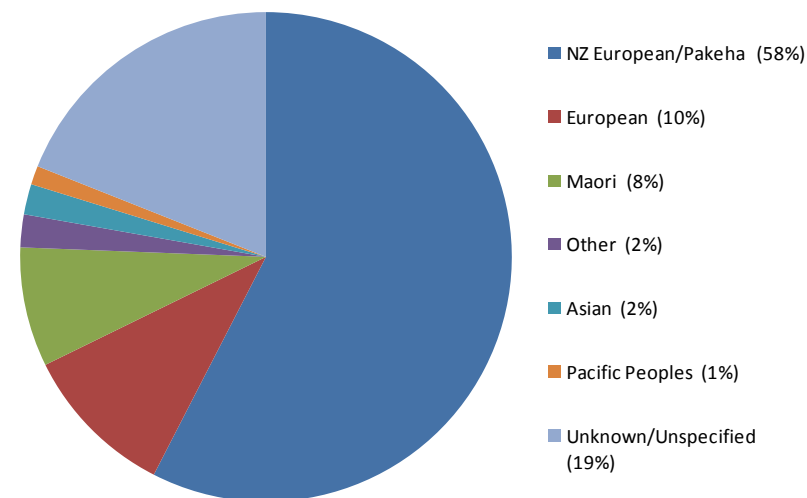
FULL TIME EQUIVALENT STAFF NUMBERS

	2007	2008	2009	2010	2011
Medical	26	30	33	33	36
Nursing	164	168	183	191	193
Allied Health	89	88	90	89	93
Other	121	121	127	125	119
Total	400	407	433	438	441

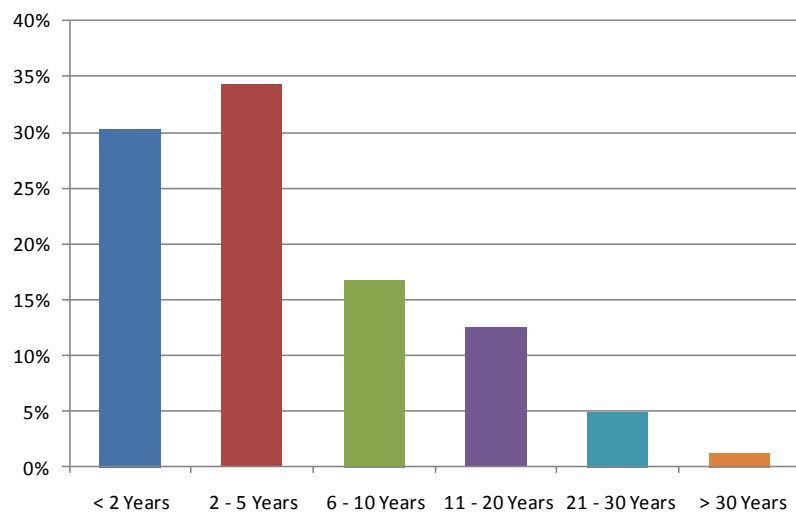
AGE PROFILE OF WORKFORCE



STATISTICS BY ETHNICITY



LENGTH OF SERVICE



STATISTICS BY GENDER

	2007	2008	2009	2010	2011
Female	85%	83%	83%	83%	83%
Male	15%	17%	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, 37 are clinical employees (2010: 35) and 10 are non-clinical employees (2010: 8).

TERMINATION PAYMENTS

During the year the Board made the following payments to former employees in respect of the termination of the employment (either as redundancy compensation or in equalisation payments upon completion of a service review) with the Board. The total paid during the 2010/11 year was \$187,393 (2010: \$140,670) to 13 staff (2010: 10).

	2011 No. of Employees	2010 No. of Employees
\$100,000 - \$110,000	9	6
\$110,001 - \$120,000	5	4
\$120,001 - \$130,000	4	4
\$130,001 - \$140,000	3	3
\$140,001 - \$150,000	3	1
\$150,001 - \$160,000	2	3
\$160,001 - \$170,000	0	0
\$170,001 - \$180,000	0	2
\$180,001 - \$190,000	0	4
\$190,001 - \$200,000	6	4
\$200,001 - \$210,000	1	2
\$210,001 - \$220,000	3	0
\$220,001 - \$230,000	3	3
\$230,001 - \$240,000	3	2
\$240,001 - \$250,000	2	1
\$250,001 - \$260,000	2	3
\$260,001 - \$270,000	0	1
\$270,001 - \$280,000	1	0
	47	43

STATEMENT OF SERVICE PERFORMANCE

The Statement of Service Performance describes the WDHB's non-financial performance under each output class and provides an indication of how well activity over the past year contributed to improving the health and well-being of the Wairarapa population. The Statement of Service Performance also measures operational performance, ensuring the WDHB is delivering sustainable and quality services effectively and efficiently.

The performance measures include national measures, which are consistent across all 20 DHBs, along with local measures and associated targets. The measures presented are intended to provide a picture of access to services, timeliness of service provision and the quality of care being provided, in order to enable evaluation of performance over time. In determining the set of performance measures, we have focused on our identified health gain priorities, the transformation we are seeking to achieve and the expectations of the Minister of Health. The national 'Health Targets' are the measures that reflect the Minister of Health's expectations for 2010/11, and these are mixed through the Statement of Service Performance.

While the WDHB is a provider of hospital and specialist services, we are also the funder of services for our community and work in partnership with other health and disability service providers, external agencies and organisations to collectively improve the health of our community. As the funder, we are often reliant on a third party to deliver the outputs needed to achieve the desired outcomes or objective, and our role is in influencing and enabling change through partnership, leadership and supportive contracting. A number of the associated performance measures in the 2010/11 Statement of Service Performance were chosen to provide an indication of the success of that collective and collaborative approach.

This Statement of Service Performance has been grouped into four output classes. These groupings enable us to provide an overview of the services that the WDHB is responsible or accountable for. The four output classes chosen across all 20 DHBs are outlined below. The DHB sector has revised the naming of these subsequent to the completion of the 2010/11 Statement of Intent (the new names have been used through this Statement of Service Performance, the names utilised in the 2010/11 Statement of Intent are shown in brackets).

Prevention Services (Public Health Services)

Public health services are publicly funded services that protect and promote population health or identifiable subpopulations, comprising services designed to enhance the health status of the population as distinct from curative services which repair/support health and disability dysfunction.

Public health services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing. Public health services include health promotion to ensure that illness is prevented and equality in health status is achieved; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and, individual health protection services such as immunisation and screening services.

Early Detection and Management (Primary and Community Health Services)

Primary and community health care services comprise services that are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. It includes general practice, community and Māori health services, pharmacist services, community pharmaceuticals and child and adolescent oral health and dental services. These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB.

Intensive Assessment and Treatment (Hospital Services)

The hospital services output class comprises services that are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are usually integrated with 'facilities' classified as hospitals to enable collocation of clinical expertise and specialised equipment. These services are generally complex and provided by health care professionals that work closely together. They include:

- Ambulatory services (including outpatient, district nursing and day services) across the range of secondary preventive, diagnostic, therapeutic and rehabilitative services
- Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services
- Emergency Department services including triage, diagnostic, therapeutic and disposition services.

Rehabilitation and Support (Support Services)

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

Performance Interpretation

The tables on the following pages have the achievements against targets for each of these output classes. The column for the achievement has been colour coded with those shaded green indicating that performance has met or been better than the target and those shaded red indicating that performance has not met the target.

Cost of Service Statement Budget Figures

The budget figures showing in the cost of service statements on the following pages differs from that shown in the Statement of Intent. This change has occurred because of the maturation of the direct and indirect cost allocation process employed through the year. This maturation process occurred given the new structure for the statement of service performance as outlined on the previous page.

The current year, budget and prior year figures shown in these cost of service statements have all been prepared on a consistent basis.

PREVENTION SERVICES

OUTPUT	MEASURE	TARGET	ACHIEVEMENT
Health Promotion Services: Smoking Cessation	% of hospitalised smokers are provided with advice to help to quit	90%	Qtr 1: 84% Qtr 2: 71% Qtr 3: 95% Qtr 4: 99%
	% of patients attending primary care provided with advice to help to quit	80%	21%
Health Promotion Services: HEHA	% of all women full and exclusively breastfeeding at 6 weeks	74%	67%
	% of all women full and exclusively breastfeeding at 3 months	57%	55%
	% of all women full and exclusively breastfeeding at 6 months	27%	25%
	% of Maori women full and exclusively breastfeeding at 6 weeks	74%	70%
	% of Maori women full and exclusively breastfeeding at 3 months	57%	54%
	% of Maori women full and exclusively breastfeeding at 6 months	27%	16%
Population Screening Services: Cancer	Percentage of high needs woman aged 45 -69 who have had mammograms in the last two years.	63%	71%
	Percentage of woman aged 20-69 who have had a cervical smear over the previous three years (high needs)	69%	79%
Health Protection: Immunisation Services	Progress towards the national target of 95% of 2 yr olds fully immunised (Maori)	91%	94%
	Progress towards the national target of 95% of 2 yr olds fully immunised (Total)	90%	94%

COMMENTARY

The priority for the year was creating an overarching public health plan that enabled the DHB to embed keeping Well (the regional public health plan) priorities into planning and contracting. Elements of the public health plan included a continuation of the Health Eating Health Action programme and further development of the tobacco control and smoking cessation programmes.

Clarification and streamlining the health promotion actions within the functioning of the Healthy Lifestyles groups was key because this enabled high needs communities or population groups to have better targeted programmes.

Overall performance was positive for the year with a sound improvement in the Health target for smoking cessation for inpatient services with the DHB having the best results in the country for the third quarter and the second best for the fourth quarter while achieving 95% and 99% for these quarters respectively. The WDHB will continue to focus with our primary care providers on improving the smoking cessation advice provision through the coming years - this will be particularly important given primary care smoking cessation advice is now part of the national Health Targets.

The breastfeeding results although below the targets are pleasing in that they show an improvement across all measures from the previous year except for the six month target for all women which has dropped from 28% in 2009/10 to 25% for this year. The benefits of breastfeeding are well publicised and the WDHB is committed to continuing to improve these results in the 2011/12 year.

COST OF SERVICE STATEMENT: PREVENTION SERVICES

	2011 Actual \$000	2011 Budget \$000	2010 Actual \$000
Operating Expenditure			
Workforce costs	1,096	1,183	1,347
Treatment related costs	415	371	422
External providers	784	743	933
Inter district flows	0	0	0
Depreciation & amortisation	98	50	60
Total Operating Expenditure	2,393	2,347	2,762
Allocation of corporate costs	1,095	753	823
Total Cost of Services	3,488	3,100	3,585
Revenue	2,944	2,979	3,622
Net Result of Service	(544)	(121)	37

EARLY DETECTION AND MANAGEMENT

OUTPUT	MEASURE	TARGET	ACHIEVEMENT
PHO (Other Services): CVD risk assessment	Increased percent of the eligible adult population have had their CVD risk assessed in the last five years (Maori)	75%	75%
	Increased percent of the eligible adult population have had their CVD risk assessed in the last five years (Other)	82%	81%
PHO (Other Services): Diabetic Annual Reviews (DAR)	Proportion estimated to have diabetes accessing free annual checks (Maori)	73%	73%
	Proportion estimated to have diabetes accessing free annual checks (Other)	77%	76%
PHO (Other Services): Diabetes management	Proportion of Maori on the diabetes register who have good diabetes management (HbA1C + or< 8%)	72%	61%
	Proportion of non-Maori on the diabetes register who have good diabetes management (HbA1C + or< 8%)	80%	73%
Oral Health Services	Children caries free at 5 years of age (fluoridated)	63%	51%
	Adolescent oral health utilisation rates	79%	82%

COMMENTARY

Primary and community health care services continue to deliver a strong performance against the range of targets. It is disappointing that the overall percentage of people under good diabetic management has decreased from the 2009/10 year (77%) to 73% in the 2010/11 year while the proportion having free annual checks has increased from 75% to 76%. This continues to be an area of focus in 2011/12 through the Tihei Wairarapa work programme.

WDHB has however consistently out performed many of the larger DHBs in meeting the health target for CVD risk and diabetes management. For the 2010-2011 year Wairarapa's performance improved in the first quarter from 70% (13th in the country) to 76% in the fourth quarter (4th in the country) for the diabetes and cardiovascular health target.

WDHB has 100% enrolment in the adolescent oral health service and has exceeded achievement of its target in 2010/11. Contributing to this has been a public awareness campaign to encourage adolescents to attend visits to their dentists and the DHB has also used a dedicated oral health promoter to visits colleges and other educational providers throughout the Wairarapa. All non attending adolescents are also being followed up by the Adolescent Coordinator overseeing the programme.

COST OF SERVICE STATEMENT: EARLY DETECTION AND MANAGEMENT

	2011 Actual \$000	2011 Budget \$000	2010 Actual \$000
Operating Expenditure			
Workforce costs	6,574	6,113	6,549
Treatment related costs	2,216	1,909	2,046
External providers	28,302	27,760	28,314
Inter district flows	1,941	1,934	1,922
Depreciation & amortisation	165	124	142
Total Operating Expenditure	39,198	37,840	38,973
Allocation of corporate costs	4,077	3,401	3,459
Total Cost of Services	43,275	41,241	42,432
Revenue	42,921	41,224	42,144
Net Result of Service	(354)	(17)	(288)

INTENSIVE ASSESSMENT AND TREATMENT

OUTPUT	MEASURE	TARGET	ACHIEVEMENT
ED attendances	% of patients will be admitted, discharged or transferred from the Emergency Department within 6 hours.	95%	97%
Elective CWDs	Electives discharges	1,841	2,059
Cancer treatment services	% of patients who receive radiation oncology treatment within 6 weeks by the end of July 2010 (and within 4 weeks by December 2010) of the first specialist assessment	100%	100%
Length of Stay	Elective and Arranged Inpatient Length of Stay	3.92	3.52
Medical CWDs	Acute Inpatient Length of Stay	3.55	3.48
Elective CWDs	Percentage of people receiving elective operations whose operation is performed as a day case	62%	75%
	Elective Services Performance Indicators (ESPI) compliant for all specialties	100%	98%
Surgical CWDs	Percentage of people admitted for surgery whose surgery is performed on the day of admission (DOSA)	98%	98%
Acute CWDs	The proportion of inpatients admitted that had previously been admitted in the past 30 days and were readmitted to the same specialty.	< / = 10.3%	8.3%
Hospitalisation	Rates of ambulatory sensitive hospitalisations (ASH) for Maori (0-74 yrs) (expressed as the ratio of actual to expected ASH hospitalisations)	125	112
	Rates of ambulatory sensitive hospitalisations (ASH) for other (0-74 yrs) (expressed as the ratio of actual to expected ASH hospitalisations)	134	125
Ambulance Response Times	Priority 1 Ambulance response time from receipt of call to arrival at a Masterton location	< / = 8 minutes	76% < / = 8 minutes
ED Triage Wait times	% of patients are seen within ED triage waiting times for Triages 1 - 3	100%	100%

OUTPUT	MEASURE	TARGET	ACHIEVEMENT
Blood Stream Infections (BSI)	Hospital Acquired BSI's per 1000 bed days	< 3.5	0.4

COMMENTARY

WDHB has continued to see strong demand for hospital services within the emergency department, outpatient services and inpatient beds. The emergency department performance against the health target has been at the top of the country across the year with 98% of patients seen within 6 hours.

With some of the lowest length of stay for medical and surgical events in the country and the strong demand for acute hospital services the lower than targeted rates of ambulatory sensitive hospitalisations, which normally increase with high acute demand, is very pleasing. A continued focus within the acute workstream of the Tihei Wairarapa programme is expected to improve the integration of ambulatory services which should show further improvement in these results over the next 2-3 years.

Inpatient services have continued to achieve outstanding results. The number of elective case-weighted discharges is higher than planned whilst maintaining a low level of acute readmissions. These results are particularly pleasing given the various quality and efficiency indicators, such as length of stay, DOSA and blood stream infections have all bettered the targeted levels.

The achievement of the ESPIs was creating a level of pressure during the year with waiting times for outpatient appointments exceeding thresholds. However a focus on increased clinics and communication with community practices saw the wait times were reduced resulting in no significant reduction in patients waiting longer than 6 months at 30 June 2011 and regaining compliance against MOH targets for this ESPI. It is planned to continue to improve to have no patients waiting longer than six months for access to treatment and assessments for elective services within the first half of the 2011/12 year.

COST OF SERVICE STATEMENT: INTENSIVE ASSESSMENT AND TREATMENT

	2011 Actual \$000	2011 Budget \$000	2010 Actual \$000
Operating Expenditure			
Workforce costs	24,009	23,093	23,626
Treatment related costs	9,968	8,572	9,409
External providers	874	529	555
Inter district flows	21,464	20,869	20,697
Depreciation & amortisation	554	499	533
Total Operating Expenditure	56,869	53,562	54,820
Allocation of corporate costs	9,127	10,121	9,567
Total Cost of Services	65,996	63,683	64,387
Revenue	62,589	60,864	59,222
Net Result of Service	(3,407)	(2,819)	(5,165)

REHABILITATION AND SUPPORT

OUTPUT	MEASURE	TARGET	ACHIEVEMENT
Access to support services for Maori	The percentage of people over 65 years accessing support needs assessment who are Maori	4%	5%
Access to support for younger disabled Maori	The percentage of clients under 65 years receiving long term services to support them to live at home who are Maori	20%	18%
Quality of care as measured by skin condition	The number of people admitted to hospital from residential care who have a decubitus ulcer	5	3
Palliative Care Services	Number of patients who have received integrated palliative care service	230	161
Timeliness of Support needs assessment	Waiting time for routine >65 support needs assessments	3 weeks	75% within 3 weeks
Quality and patient centered care based on meeting patient's wishes	Percentage of patients in the palliative service who die in the place of their choosing	75%	100%
Aging in place	% people >65yrs receiving funded support who are living at home	63%	64%

COMMENTARY

A key project completed during the year was the implementation of InterRAI. InterRAI is an assessment tool being rolled out progressively throughout NZ that provides staff with a standard tool to assess the medical, rehabilitation and support requirements of the older person to enable them to remain in their home longer with an appropriate level of support provided. With the implementation of InterRAI now complete it is expected that improvements will be made in completing the needs assessments for people. This also enables a greater focus, through the various Whanau Ora programmes, for Maori to access the various support services.

5.5 percent of people over 65 years in the Wairarapa live in aged residential care facilities. The importance of quality care in residential care has been recognised by the DHB providing a number of initiatives which support providers in increasing their knowledge and skill base, particularly with regard to long term conditions and palliative care. These initiatives include dedicated DHB resource for Palliative Care, Gerontology and Infection Control. The DHB has also strongly promoted closer links between residential care facilities and primary care to strengthen residents' medical management. In addition, the newly adopted DHB role within the certification cycle for aged residential care facilities has ensured that the DHB is able to support providers to achieve their corrective actions and monitor their progress in doing so.

COST OF SERVICE STATEMENT: REHABILITATION AND SUPPORT

	2011 Actual \$000	2011 Budget \$000	2010 Actual \$000
Operating Expenditure			
Workforce costs	802	747	730
Treatment related costs	532	522	466
External providers	13,712	14,200	13,529
Inter district flows	1,252	1,252	1,189
Depreciation & amortisation	0	0	0
Total Operating Expenditure	16,298	16,721	15,914
Allocation of corporate costs	953	702	675
Total Cost of Services	17,251	17,423	16,589
Revenue	17,937	18,191	17,330
Net Result of Service	686	768	741

SUMMARY OF COST OF SERVICE STATEMENT

	2011 Actual \$000	2011 Budget \$000	2010 Actual \$000
Expenditure			
Prevention Services	3,488	3,100	3,585
Early Detection & Management Services	43,275	41,241	42,432
Intensive Assessment & Treatment Services	65,996	63,683	64,387
Rehabilitation & Support Services	17,251	17,423	16,589
Total Cost of Services	130,010	125,447	126,993
Revenue			
Prevention Services	2,944	2,979	3,622
Early Detection & Management Services	42,921	41,224	42,144
Intensive Assessment & Treatment Services	62,589	60,864	59,222
Rehabilitation & Support Services	17,937	18,191	17,330
Total Revenue	126,391	123,258	122,318
Net Surplus / (Deficit)	(3,619)	(2,189)	(4,675)

FINANCIAL STATEMENTS

CONTENTS

STATEMENT OF COMPREHENSIVE INCOME	33
STATEMENT OF FINANCIAL POSITION	34
STATEMENT OF CHANGES IN EQUITY	36
STATEMENT OF CASH FLOWS	37
STATEMENT OF CONTINGENT LIABILITIES	39
STATEMENT OF COMMITMENTS	40
STATEMENT OF ACCOUNTING POLICIES	41
NOTES TO THE FINANCIAL STATEMENTS	50

STATEMENT OF COMPREHENSIVE INCOME

For the year ended 30 June 2011

	Note	Group Budget 2011 \$000	Group Actual 2011 \$000	Group Actual 2010 \$000	Parent Actual 2011 \$000	Parent Actual 2010 \$000
Income						
Operating income	1	123,088	127,331	123,246	126,260	122,166
Finance income	2	170	110	105	131	152
Total income		123,258	127,441	123,351	126,391	122,318
Expenditure						
Employee benefits	3	36,999	35,712	35,331	35,712	35,331
Other operating expenses	4	84,087	91,246	88,553	90,291	87,542
Depreciation & amortisation expense	7,8	2,081	1,968	2,085	1,888	2,004
Finance costs	5	2,280	2,119	2,116	2,119	2,116
Tax expense	6	0	0	0	0	0
Total expenses		125,447	131,045	128,085	130,010	126,993
Net surplus/(deficit)		(2,189)	(3,604)	(4,734)	(3,619)	(4,675)
Other comprehensive income						
Gain / (loss) on property revaluations		0	676	0	676	0
Total other comprehensive income		0	676	0	676	0
Total comprehensive income		(2,189)	(2,928)	(4,734)	(2,943)	(4,675)
<i>Total comprehensive income attributable to:</i>						
Wairarapa District Health Board		(2,189)	(2,928)	(4,734)	(2,943)	(4,675)
Non-controlling interest		0	0	0	0	0

STATEMENT OF FINANCIAL POSITION

For the year ended 30 June 2011

	Note	Group Budget 2011 \$000	Group Actual 2011 \$000	Group Actual 2010 \$000	Parent Actual 2011 \$000	Parent Actual 2010 \$000
Assets						
Property, plant & equipment	7	40,194	41,773	41,641	41,689	41,555
Intangible assets	8	1,296	1,330	1,308	1,309	1,290
Investments	9	103	0	0	103	103
Trust fund assets	16	52	243	160	243	160
Total non-current assets		41,645	43,346	43,109	43,344	43,108
Cash & cash equivalents	10	77	(1,720)	406	(2,062)	109
Inventories	11	700	726	679	726	679
Trade & other receivables	12	3,962	5,022	3,698	4,906	3,591
Assets classified as held for sale	7	0	2,300	2,300	2,300	2,300
Total current assets		4,739	6,328	7,083	5,870	6,679
Total assets		46,384	49,674	50,192	49,214	49,787

STATEMENT OF FINANCIAL POSITION

For the year ended 30 June 2011

	Note	Group Budget 2011 \$000	Group Actual 2011 \$000	Group Actual 2010 \$000	Parent Actual 2011 \$000	Parent Actual 2010 \$000
Equity						
Crown equity	13	25,480	29,429	25,484	29,429	25,484
Revaluation reserve	13	1,479	2,155	1,479	2,155	1,479
Retained earnings	13	(21,636)	(23,235)	(19,631)	(23,541)	(19,922)
Total equity		5,323	8,349	7,332	8,043	7,041
Liabilities						
Interest-bearing loans & borrowings	14	20,925	25,239	20,199	25,239	20,199
Employee benefits	15	486	628	533	628	533
Trust funds	16	60	243	160	243	160
Total non-current liabilities		21,471	26,110	20,892	26,110	20,892
Interest-bearing loans & borrowings	14	5,057	573	5,302	573	5,302
Payables & accruals	17	8,461	9,027	11,320	8,951	11,267
Employee benefits	15	6,072	5,615	5,346	5,537	5,285
Total current liabilities		19,590	15,215	21,968	15,061	21,854
Total liabilities		41,061	41,325	42,860	41,171	42,746
Total equity & liabilities		46,384	49,674	50,192	49,214	49,787

STATEMENT OF CHANGES IN EQUITY

For the year ended 30 June 2011

Note	Group Budget 2011	Group Actual 2011 \$000	Group Actual 2010 \$000	Parent Actual 2011 \$000	Parent Actual 2010 \$000
Balance at 1 July	5,315	7,332	5,436	7,041	5,086
Net surplus / (deficit) for the year	(2,189)	(3,604)	(4,734)	(3,619)	(4,675)
Other comprehensive income	0	676	0	676	0
Total comprehensive income	(2,189)	(2,928)	(4,734)	(2,943)	(4,675)
Equity injection from the Crown	2,200	3,948	6,633	3,948	6,633
Repayment of equity to the Crown	(3)	(3)	(3)	(3)	(3)
Movements in equity for the year	2,197	3,945	6,630	3,945	6,630
Balance at 30 June	5,323	8,349	7,332	8,043	7,041
<i>Total comprehensive income attributable to:</i>					
Wairarapa District Health Board	(2,189)	(2,928)	(4,734)	(2,943)	(4,675)
Non-controlling interest	0	0	0	0	0
Total comprehensive income	(2,189)	(2,928)	(4,734)	(2,943)	(4,675)

STATEMENT OF CASH FLOWS

For the year ended 30 June 2011

	Note	Group Budget 2011 \$000	Group Actual 2011 \$000	Group Actual 2010 \$000	Parent Actual 2011 \$000	Parent Actual 2010 \$000
Cash flows from operating activities						
Operating receipts:						
Government & crown agency revenue		116,645	114,873	115,564	114,873	116,564
Other		6,613	10,918	9,835	9,697	5,614
Interest received		111	110	98	105	91
Payments to suppliers & employees		(122,625)	(128,589)	(126,696)	(127,502)	(123,560)
Capital charge paid		(480)	(305)	(405)	(305)	(405)
Interest paid		(1,440)	(1,713)	(1,860)	(1,713)	(1,860)
Income tax paid		0	0	1	0	0
Goods and Services Tax (net)		0	(175)	326	(174)	327
Net cash flows from operating activities	10	(1,176)	(4,881)	(3,137)	(5,019)	(3,229)
Cash flows from investing activities						
Proceeds from sale of property, plant & equipment		2,300	0	121	0	121
Dividends received		25	0	0	26	54
Acquisition of property, plant & equipment		(600)	(1,263)	(1,005)	(1,252)	(993)
Acquisition of intangible assets		(750)	(238)	(1,192)	(182)	(1,187)
Net cash flows from investing activities		975	(1,501)	(2,076)	(1,408)	(2,005)

STATEMENT OF CASH FLOWS

For the year ended 30 June 2011

	Note	Group Budget 2011 \$000	Group Actual 2011 \$000	Group Actual 2010 \$000	Parent Actual 2011 \$000	Parent Actual 2010 \$000
Cash flows from financing activities						
Loans drawn down		152	700	120	700	120
Equity injected		2,200	3,948	6,764	3,948	6,764
Repayments of loans		(373)	(390)	(377)	(390)	(377)
Repayment of equity		(3)	(3)	(3)	(3)	(3)
Restricted fund movement		0	1	99	1	99
Net cash flows from financing activities		1,976	4,256	6,603	4,256	6,603
Net increase / (decrease) in cash held		1,775	(2,126)	1,390	(2,171)	1,369
Cash & cash equivalents at beginning of year		(1,698)	406	(984)	109	(1,260)
Cash & cash equivalents at end of year	10	77	(1,720)	406	(2,062)	109

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 2011

	Group Actual 2011 \$000	Group Actual 2010 \$000	Parent Actual 2011 \$000	Parent Actual 2010 \$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 2011

	Group Actual 2011 \$000	Group Actual 2010 \$000	Parent Actual 2011 \$000	Parent Actual 2010 \$000
Capital Commitments	166	15	166	15
Operating Lease Commitments:				
Less than One Year:	801	707	752	647
One to Two Years	445	383	408	342
Two to Five Years	332	95	324	45
Five Years	0	0		0
	1,578	1,185	1,484	1,034
Non-cancellable contracts for the provision of services				
<i>Not later than one year</i>				
Non funder	2,591	1,817	2,591	1,817
Funder	4,745	8,235	4,745	8,235
<i>Later than one year & not later than two years</i>				
Non funder	647	710	647	710
Funder	359	4,306	359	4,306
<i>Later than two years & not later than five years</i>				
Non funder	353	819	353	819
Funder	0	329	0	329
<i>Over five years</i>				
Non funder	0	0	0	0
Funder	0	0	0	0
	8,695	16,216	8,695	16,216
Total Commitments	10,439	17,416	10,345	17,265

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 2011 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 27 October 2011.

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

STATEMENT OF COMPLIANCE

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

BASIS OF PREPARATION

Functional and presentation currency

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

Measurement base

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

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

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

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

Going Concern

Reliance is placed on the fact that WDHB is a going concern and will continue to receive revenue from the Ministry of Health and other sources sufficient to maintain its services beyond the year ended 30 June 2011. The Minister of Health and Minister of Finance have provided a letter of comfort thereby providing support to the Board to enable continuing supply of services. The Board places reliance on this support.

Changes in accounting policies

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

Early adopted amendments to standards

The following amendments to standards have been early adopted:

- NZ IFRS 7 Financial Instruments: Disclosures - The effect of early adopting these amendments is the following information is no longer disclosed:
 - the carrying amount of financial assets that would otherwise be past due or impaired whose terms have been renegotiated; and
 - the maximum exposure to credit risk by class of financial instrument if the maximum credit risk exposure is best represented by their carrying amount in the statement of financial position.
- NZ IAS 24 Related Party Disclosures (Revised 2009) - The effect of early adopting the revised NZ IAS 24 is:
 - more information is required to be disclosed about transactions between the WDHB and entities controlled, jointly controlled, or significantly influenced by the Crown;
 - commitments with related parties require disclosure; and
 - information is required to be disclosed about any related party transactions with Ministers of the Crown.

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.
- FRS-44 New Zealand Additional Disclosures and Amendments to NZ IFRS to harmonise with IFRS and Australian Accounting Standards (Harmonisation Amendments) - These were issued in May 2011 with the purpose of harmonising Australia and New Zealand's accounting standards with source IFRS and to eliminate many of the differences between the accounting standards in each jurisdiction. The amendments must first be adopted for the year ended 20 June 2012. The DHB has not yet assessed the effects of FRS-44 and the Harmonisation Amendments.

BASIS FOR CONSOLIDATION

Subsidiaries

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

Joint ventures

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

Transactions eliminated on consolidation

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

BUDGET FIGURES

The budget figures are those approved by the DHB in its Annual Plan and included in the Statement of Intent tabled in Parliament except as noted on page 22 regarding the cost of service statements.

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

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

Crown funding

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

ACC contracted revenue

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

Revenue for other DHBs

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

Interest Income

Interest income is recognised using the effective interest method.

Revenue relating to service contracts

WDHB is required to expend all monies appropriated within certain contracts during the year in which it is appropriated. Should this not be done, the contract may require repayment of the money or WDHB, with the agreement of the Ministry of Health, may be required to expend it on

specific services in subsequent years. The amount unexpended is recognised as a liability.

Goods sold and services rendered

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

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

Rental income

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

EXPENSES

Capital Charge

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

Interest expense

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

Operating lease payments

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

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

Finance lease payments

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

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

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

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

Net financing costs

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

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

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

Non-current assets held for sale

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

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

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

Business combinations involving entities under common control

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

INCOME TAX

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

FOREIGN CURRENCY***Foreign currency transactions***

Transactions in foreign currencies are translated at the foreign exchange rate ruling at the date of the transaction. Monetary assets and liabilities denominated in foreign currencies at the balance sheet date are

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

PROPERTY, PLANT AND EQUIPMENT***Classes of property, plant and equipment***

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

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

Owned assets

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

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

previous surpluses and are otherwise recognised as an expense in the statement of comprehensive income.

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

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

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

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

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

Disposal of Property, Plant and Equipment

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

Properties Intended for Sale

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

Leased assets

Leases where WDHB assumes substantially all the risks and rewards of ownership, whether or not title is eventually transferred are classified as finance leases. The assets acquired by way of finance lease are stated at an amount equal to the lower of their fair value and the present value of the minimum lease payments at inception of the lease, less accumulated depreciation and impairment losses.

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

Subsequent costs

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

Depreciation

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

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

The residual value of assets is reassessed annually.

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

INTANGIBLE ASSETS

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

Subsequent expenditure

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

Amortisation

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

Type of asset	Estimated life
• Software	2 to 10 years

IMPAIRMENT

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

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

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

An impairment loss on property, plant and equipment revalued on a class of asset basis is recognised directly against any revaluation reserve in respect of the same class of asset to the extent that the impairment loss

does not exceed the amount in the revaluation reserve for the same class of asset.

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

Calculation of recoverable amount

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

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

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

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

Reversals of impairment

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

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

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

INVESTMENTS

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

DEBTORS AND OTHER RECEIVABLES

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

INVENTORIES

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

Cost is based on weighted average cost.

Inventories held for distribution

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

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

CASH AND CASH EQUIVALENTS

Cash and cash equivalents includes cash balances, deposits held at call with banks, other highly liquid investments with original maturities of three months or less, and bank overdrafts. Bank overdrafts are repayable

on demand and form an integral part of WDHB's cash management and are included as a component of cash and cash equivalents for the purpose of the statement of cash flows.

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

INTEREST-BEARING BORROWINGS

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

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

EMPLOYEE BENEFITS

Defined contribution schemes

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

Defined benefit schemes

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

When the benefits of a scheme are improved, the portion of the increased benefit relating to past service by employees is recognised as an expense in the statement of comprehensive income on a straight-line

basis over the average period until the benefits become vested. To the extent that the benefits vest immediately, the expense is recognised immediately in the surplus or deficit.

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

Long service leave, sabbatical leave and retirement gratuities

WDHB's net obligation in respect of long service leave, sabbatical leave and retirement gratuities is the amount of future benefit that employees have earned in return for their service in the current and prior periods. The obligation is calculated using the projected unit credit method and is discounted to its present value. The approach used in 2011 to determine the discount rate has been refined. The 2010 valuation was based on the yield on 10 year government bonds. The discount rates used for the 2011 valuation are based on the weighted average of bond yields such that the estimated term of the bonds is consistent with the estimated term of the liabilities. This approach is consistent with the requirements of NZ IAS19.

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

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

PROVISIONS

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

Restructuring

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

CREDITORS & OTHER PAYABLES

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

COST OF SERVICE STATEMENTS

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

COST ALLOCATION

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

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

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

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

NOTES TO THE FINANCIAL STATEMENTS

1. OPERATING INCOME

	Group Actual 2011 \$000	Group Actual 2010 \$000	Parent Actual 2011 \$000	Parent Actual 2010 \$000
Health & disability services (MOH contracted revenue)	116,858	113,094	116,858	113,094
Inter district patient inflows	3,582	3,290	3,582	3,290
ACC contract	2,318	2,055	2,318	2,055
Donations & bequests	520	585	520	585
Other income	4,053	4,222	2,982	3,142
Total operating income	127,331	123,246	126,260	122,166

2. FINANCE INCOME

	Group Actual 2011 \$000	Group Actual 2010 \$000	Parent Actual 2011 \$000	Parent Actual 2010 \$000
Interest income	110	98	105	91
Dividend income	0	0	26	54
Gain on disposal of property, plant & equipment	0	7	0	7
Total finance income	110	105	131	152

3. EMPLOYEE BENEFITS

	Group Actual 2011 \$000	Group Actual 2010 \$000	Parent Actual 2011 \$000	Parent Actual 2010 \$000
Wages & salaries	35,365	35,938	35,365	35,938
Contributions to defined benefit plans	0	0	0	0
Increase / decrease in liability for employee entitlements	347	(668)	347	(668)
Restructuring provision for employee exit costs	0	61	0	61
Total employee benefits	35,712	35,331	35,712	35,331

4. OTHER OPERATING EXPENSES

	Group Actual 2011 \$000	Group Actual 2010 \$000	Parent Actual 2011 \$000	Parent Actual 2010 \$000
Other operating expenses	7,491	7,595	6,602	6,663
Outsourced Services	5,877	5,281	5,877	5,281
Clinical Supplies	7,412	6,858	7,412	6,858
Payments to non-health board providers	68,654	66,657	68,654	66,657
Operating lease expenses	1,265	1,753	1,217	1,691
Audit fees (for the audit of the financial statements)	112	105	100	94
Audit fees (for other assurance services)	116	0	116	0
Impairment of trade receivables (bad & doubtful debts)	28	40	28	40
Board member fees & expenses	257	254	251	248
Loss / (gain) on disposal of property, plant & equipment	34	10	34	10
Impairment loss on property, plant & equipment	0	0	0	0
Total other operating expenses	91,246	88,553	90,291	87,542

Operating lease expenses

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

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

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

5. FINANCE COSTS

	Group Actual 2011 \$000	Group Actual 2010 \$000	Parent Actual 2011 \$000	Parent Actual 2010 \$000
Interest expense	1,713	1,858	1,713	1,858
Capital charge	406	258	406	258
Total finance costs	2,119	2,116	2,119	2,116

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 2011 was 8% (2010 - 8%).

6. INCOME TAX

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

7. PROPERTY, PLANT & EQUIPMENT

Group	Land (at valuation) \$000	Buildings (at valuation) \$000	Clinical equipment \$000	Other equipment \$000	Information technology \$000	Motor vehicles \$000	Work in progress \$000	Total \$000
Cost / valuation								
Balance at 1 July 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
Balance at 1 July 2010	2,165	36,895	6,510	2,368	858	1,605	885	51,286
Additions	0	565	493	168	11	16	604	1,857
Disposals	0	0	(491)	(195)	(79)	0	(503)	(1,268)
Revaluations	(230)	(3,145)	0	0	0	0	0	(3,375)
Balance at 30 June 2011	1,935	34,315	6,512	2,341	790	1,621	986	48,500

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

NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS

Group	Land (at valuation)	Buildings (at valuation)	Clinical equipment	Other equipment	Information technology	Motor vehicles	Work in progress	Total
<u>Depreciation & impairment losses</u>								
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
Balance at 1 July 2010		3,186	3,778	1,647	698	336		9,645
Depreciation charge for the year		865	593	166	21	199		1,844
Impairment losses		0	0	0	0	0		0
Disposals		0	(458)	(196)	(43)	(14)		(711)
Revaluations		(4,051)	0	0	0	0		(4,051)
Balance at 30 June 2011		0	3,913	1,617	676	521		6,727
<u>Carrying amounts</u>								
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
At 1 July 2010	2,165	33,709	2,732	721	160	1,269	885	41,641
At 30 June 2011	1,935	34,315	2,599	724	114	1,100	986	41,773

NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS

Parent	Land (at valuation) \$000	Buildings (at valuation) \$000	Clinical equipment \$000	Other equipment \$000	Information technology \$000	Motor vehicles \$000	Work in progress \$000	Total \$000
Cost / valuation								
Balance at 1 July 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
Balance at 1 July 2010	2,165	36,895	6,510	1,826	733	1,518	885	50,532
Additions	0	565	493	96	0	4	604	1,762
Disposals	0	0	(491)	(171)	(1)	0	(503)	(1,166)
Revaluations	(230)	(3,145)	0	0	0	0	0	(3,375)
Balance at 30 June 2011	1,935	34,315	6,512	1,751	732	1,522	986	47,753

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

NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS

Parent	Land (at valuation)	Buildings (at valuation)	Clinical equipment	Other equipment	Information technology	Motor vehicles	Work in progress	Total
Depreciation & impairment losses								
Balance at 1 July 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
Balance at 1 July 2010		3,186	3,778	1,117	614	282		8,977
Depreciation charge for the year		865	593	127	7	176		1,768
Impairment losses		0	0	0	0	0		0
Disposals		0	(458)	(171)	(1)	0		(630)
Revaluations		(4,051)	0	0	0	0		(4,051)
Balance at 30 June 2011		0	3,913	1,073	620	458		6,064

Parent	Land (at valuation)	Buildings (at valuation)	Clinical equipment	Other equipment	Information technology	Motor vehicles	Work in progress	Total
<u>Carrying amounts</u>								
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
At 1 July 2010	2,165	33,709	2,732	709	119	1,236	885	41,555
At 30 June 2011	1,935	34,315	2,599	678	112	1,064	986	41,689

Impairment

No impairment losses have been recognised during the period.

Revaluation

The total fair value of land and buildings valued by CB Richard Ellis as at 30 June 2011 amounted to \$36,250,000.

Land

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

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

The most recent revaluation was performed by CB Richard Ellis and the valuation is effective as at 30 June 2011.

Buildings

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

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

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

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

The most recent revaluation was performed by CB Richard Ellis and the valuation is effective as at 30 June 2011.

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 valued 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 2010. The Wairarapa DHB considers this value to be materially accurate as at 30 June 2011. A decision has been made by the Office of Treaty Settlements that the property classified as held for sale will be landbanked, and therefore sold to the Office of Treaty Settlements. Wairarapa DHB expects that the subsequent sale will occur within 12 months of balance date.

The accumulated property revaluation reserve recognised in equity for this property is nil.

8. INTANGIBLE ASSETS

Group	Intangible Assets \$000	Work in progress \$000	Total \$000
<u>Cost / valuation</u>			
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
Balance at 1 July 2010	1,169	606	1,775
Additions	468	96	564
Disposals	(69)	(412)	(481)
Revaluations	0	0	0
Balance at 30 June 2011	1,568	290	1,858

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

Group	Intangible Assets	Work in progress	Total
<u>Depreciation & impairment losses</u>			
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
Balance at 1 July 2010	467		467
Amortisation charge for the year	124		124
Impairment losses	(4)		(4)
Disposals	(59)		(59)
Revaluations	0		0
Balance at 30 June 2011	528		528

Group	Intangible Assets	Work in progress	Total
<u>Carrying amounts</u>			
At 1 July 2009	545	397	942
At 30 June 2010	702	606	1,308
At 1 July 2010	702	606	1,308
At 30 June 2011	1,040	290	1,330

Parent	Intangible Assets \$000	Work in progress \$000	Total \$000
<u>Cost / valuation</u>			
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
Balance at 1 July 2010	1,090	606	1,696
Additions	461	96	557
Disposals	(65)	(412)	(477)
Revaluations	0	0	0
Balance at 30 June 2011	1,486	290	1,776

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

Parent	Intangible Assets	Work in progress	Total
<u>Depreciation & impairment losses</u>			
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
Balance at 1 July 2010	406		406
Amortisation charge for the year	120		120
Impairment losses	0		0
Disposals	(59)		(59)
Revaluations	0		0
Balance at 30 June 2011	467		467
<u>Carrying amounts</u>			
At 1 July 2009	516	397	913
At 30 June 2010	684	606	1,290
At 1 July 2010	684	606	1,290
At 30 June 2011	1,019	290	1,309

Impairment

No impairment losses have been recognised during the period.

9. INVESTMENTS

	Group Actual 2011 \$000	Group Actual 2010 \$000	Parent Actual 2011 \$000	Parent Actual 2010 \$000
Investment in subsidiary	0	0	103	103

Investment in Subsidiary

Biomedical Services New Zealand Limited is 100% owned by WDHB (2010 - 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

WDHB 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 2011 all share capital remains uncalled. The balance date of TAS is 30 June.

10. CASH & CASH EQUIVALENTS

	Group Actual 2011 \$000	Group Actual 2010 \$000	Parent Actual 2011 \$000	Parent Actual 2010 \$000
Short term deposits	2,342	2,197	2,000	2,000
Cash & cash equivalents	6	5	6	5
Bank overdraft	(4,068)	(1,796)	(4,068)	(1,896)
Total cash & cash equivalents	(1,720)	406	(2,062)	109

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 11.05% per annum (2010 - 10.55%).

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

Reconciliation of Net Deficit to Net Operating Cash Flows

	Group Actual 2011 \$000	Group Actual 2010 \$000	Parent Actual 2011 \$000	Parent Actual 2010 \$000
Net surplus	(3,604)	(4,734)	(3,619)	(4,675)
Add/(less) Non-cash items:				
Depreciation & amortisation	1,968	2,085	1,888	2,004
Increase/(decrease) employee benefits (non-current)	0	0	95	13
Add/(less) Items classified as investment activity:				
Net loss/(gain) on sale of property, plant & equipment	34	3	34	3
Dividends received	0	0	(26)	(54)
Add/(less) movements in working capital items:				
(Increase)/decrease in receivables	(1,324)	413	(1,315)	407
(Increase) in inventories	(47)	19	(47)	19
(Decrease) in payables & accruals	(1,908)	(923)	(2,029)	(946)
Increase/(decrease) in taxation	0	0	0	0
Net cash flow from operating activities	(4,881)	(3,137)	(5,019)	(3,229)

11. INVENTORIES

	Group Actual 2011 \$000	Group Actual 2010 \$000	Parent Actual 2011 \$000	Parent Actual 2010 \$000
Central stores	222	210	222	210
Pharmaceuticals	81	83	81	83
Theatre supplies	249	249	249	249
Other supplies	174	137	174	137
Total inventories	726	679	726	679

Write-down of inventories amounted to nil for 2011 (2010 - nil). The amount of inventories recognised as an expense during the year ended 30 June 2011 was nil (2010 - 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 2011 \$000	Group Actual 2010 \$000	Parent Actual 2011 \$000	Parent Actual 2010 \$000
Trade Debtors	4,829	3,548	4,699	3,440
Provision for Doubtful Debts	(83)	(109)	(83)	(109)
Prepayments	276	259	276	259
Amount Owing by Subsidiary	0	0	14	1
Total trade & other receivables	5,022	3,698	4,906	3,591

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

13. EQUITY

Group	Crown equity \$000	Property revaluation reserve \$000	Retained earnings \$000	Total \$000
Balance at 1 July 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
Balance at 1 July 2010	25,484	1,479	(19,631)	7,332
Total recognised income & expenses	0	0	(3,604)	(3,604)
Contribution (net) from the Crown	3,945	0	0	3,945
Movement in revaluation of land & buildings	0	676	0	676
Balance at 30 June 2011	29,429	2,155	(23,235)	8,349

Parent	Crown equity \$000	Property revaluation reserve \$000	Retained earnings \$000	Total \$000
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
Balance at 1 July 2010	25,484	1,479	(19,922)	7,041
Total recognised income & expenses	0	0	(3,619)	(3,619)
Contribution (net) from the Crown	3,945	0	0	3,945
Movement in revaluation of land & buildings	0	676	0	676
Balance at 30 June 2011	29,429	2,155	(23,541)	8,043

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 2011 \$000	Group Actual 2010 \$000	Parent Actual 2011 \$000	Parent Actual 2010 \$000
Non current liabilities				
Privately sourced loans	739	199	739	199
Crown sourced loans	24,500	20,000	24,500	20,000
Total non current interest-bearing loans & borrowings	25,239	20,199	25,239	20,199
Current liabilities				
Privately sourced loans	135	114	135	114
Crown sourced loans	438	5,188	438	5,188
Total current interest-bearing loans & borrowings	573	5,302	573	5,302

The Crown Health Financing Agency (CHFA) and the DHB have agreed a debt facility of \$25,750,000 of which \$24,937,500 was drawn at 30 June 2011. 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;
- provide or accept services other than for proper value and on reasonable commercial terms; and
- dispose of any of its assets except disposals at full value in the ordinary course of business.

The covenants have been complied with at all times during the year.

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 ambulance fleet vehicles & ophthalmic instruments & equipment.

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

Wairarapa DHB has no other privately funded financing arrangements.

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

	Group Actual 2011 \$000	Group Actual 2010 \$000	Parent Actual 2011 \$000	Parent Actual 2010 \$000
Crown Health Financing Agency				
Interest rate summary	5.53%	5.92%	5.53%	5.92%
Repayable as follows:				
Less than one year	438	5,188	438	5,188
One to two years	10,500	5,000	10,500	5,000
Two to five years	14,000	15,000	14,000	15,000
	24,938	25,188	24,938	25,188
Privately sourced loans				
Interest rate summary	6.40%	4.60%	6.40%	4.60%
Repayable as follows:				
Less than one year	135	114	135	114
One to two years	349	133	349	133
Two to five years	390	66	390	66
	874	313	874	313

15. EMPLOYEE BENEFITS

	Group Actual 2011 \$000	Group Actual 2010 \$000	Parent Actual 2011 \$000	Parent Actual 2010 \$000
Non current liabilities				
Liability for long service leave	259	227	259	227
Liability for retirement gratuities	369	306	369	306
Total non current employee benefits	628	533	628	533
Current liabilities				
Liability for long service leave	366	363	366	363
Liability for retirement gratuities	101	95	99	93
Liability for sabbatical leave	50	50	50	50
Liability for continuing medical education leave	524	452	524	452
Liability for maternity grant	15	7	15	7
Liability for annual leave	2,785	2,962	2,731	2,923
Liability for sick leave	83	134	83	134
Provision for restructuring	0	61	0	61
Salary & wages accrual	1,691	1,222	1,669	1,202
Total current employee benefits	5,615	5,346	5,537	5,285

The present value of long service leave, and retirement gratuities obligations depend on a number of factors that are determined on an actuarial basis. Two key assumptions used in calculating this liability include the discount rate and the salary inflation factor. Any changes in these assumptions will affect the carrying amount of the liability.

Expected future payments are discounted using forward discount rates derived from the yield curve of New Zealand government bonds. The discount rates used have maturities that match, as closely as possible, the estimated future cash outflows. The salary inflation factor has been determined after considering historical salary inflation patterns and after obtaining advice from an independent actuary. Weighted average discount rates of 4.1% for long service leave (2010: 5.6%) and 4.4% for retirement gratuities (2010: 5.6%) and an inflation factor of 2% (2010: 2%) were used.

Defined Benefit Plans

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

16. TRUST FUNDS

	Group Actual 2011 \$000	Group Actual 2010 \$000	Parent Actual 2011 \$000	Parent Actual 2010 \$000
Balance at beginning of year	160	61	160	61
Funds received	83	99	83	99
Interest received	0	0	0	0
Funds spent	0	0	0	0
Balance at end of year	243	160	243	160

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 2011 \$000	Group Actual 2010 \$000	Parent Actual 2011 \$000	Parent Actual 2010 \$000
Trade creditors & accruals	7,608	9,786	7,498	9,692
Capital charge payable	154	53	154	53
GST & other taxes payable	1,229	1,481	1,249	1,500
Income received in advance	36	0	36	0
Amount owing to subsidiary	0	0	14	22
Total payables & accruals	9,027	11,320	8,951	11,267

18. FINANCIAL INSTRUMENTS

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

Credit Risk

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

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

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

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

NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS

Group	Actual			Actual		
	2011	2011	2011	2010	2010	2010
	\$000			\$000		
	Gross	Impairment	Net	Gross	Impairment	Net
Not past due	3,439	0	3,439	2,285	0	2,285
Past due 1-30 days	1,022	0	1,022	720	0	720
Past due 31-60 days	255	0	255	168	0	168
Past due 61-90 days	9	0	9	23	0	23
Past due > 91 days	90	(83)	7	352	(109)	243
Total	4,815	(83)	4,732	3,548	(109)	3,439

Parent	Actual			Actual		
	2011	2011	2011	2010	2010	2010
	\$000			\$000		
	Gross	Impairment	Net	Gross	Impairment	Net
Not past due	3,439	0	3,439	2,285	0	2,285
Past due 1-30 days	925	0	925	613	0	613
Past due 31-60 days	236	0	236	167	0	167
Past due 61-90 days	9	0	9	23	0	23
Past due > 91 days	90	(83)	7	352	(109)	243
Total	4,699	(83)	4,616	3,440	(109)	3,331

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

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

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

	Actual 2011 \$000	Actual 2010 \$000
Balance at 1 July	109	109
Additional Provisions made	83	0
Receivables written off	(109)	0
Total	83	109

Liquidity Risk

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

Cash flow interest Rate Risk

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

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

Foreign Currency Risk

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

Forward foreign exchange contracts

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

Price risk

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

Fair value interest rate risk

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

Credit risk

Credit risk is the risk that a third party will default on its obligation to the DHB, causing it to incur a loss. Due to the timing of its cash inflows and outflows, surplus cash is invested with registered banks. In the normal course of business, exposure to credit risk arises from cash and term deposits with banks, debtors and other receivables, and forward foreign exchange contracts (2011 - Nil) in an asset position. For each of these, the maximum credit risk exposure is best represented by the carrying amount in the statement of financial position.

Investments and forward foreign exchange contracts are entered into only with registered banks that have a Standard and Poors's credit rating of at least A2 for short term and A- for long term investments. WDHB has experienced no defaults of interest or principal payments for term deposits and forward foreign exchange contracts.

Concentrations of credit risk for debtors and other receivables are limited due to the large number and variety of customers. The MoH is the largest debtor. It is assessed as a low risk and high-quality entity due to being a government-funded purchaser of health and disability services.

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

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

	Actual 2011 \$000	Actual 2010 \$000
Fair value through surplus or deficit - Held for trading		
Forward foreign exchange contracts in a liability position	0	0
Loans and receivables:		
Cash and cash equivalents	(1,720)	406
Debtors and other receivables	5,022	3,698
Investments	0	0
Total loans and receivables	3,302	4,104
Financial liabilities measured at amortised cost:		
Creditors and other payables (excluding income in advance and GST)	7,762	9,839
Borrowings - CHFA loans	24,938	25,188
Borrowings - Privately sourced loans	874	313
Total financial liabilities measured at amortised cost	33,574	35,340

Capital Management

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

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

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

Sensitivity Analysis

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

At 30 June 2011, it is estimated that a general increase of one percentage point in interest rates would increase Wairarapa DHB’s deficit before tax by approximately \$18,000 (2010: \$252,000).

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

	2011 \$000	2010 \$000
Counterparties with credit ratings		
Cash and cash equivalents and trust fund assets:		
AA	(1,477)	566
AA-	0	0
Total Cash and cash equivalents and trust fund assets	(1,477)	566
Counterparties without credit ratings		
Debtors and other receivables:		
Existing counterparty with no defaults in the past	5,022	3,698
Existing counterparty with defaults in the past	0	0
Total debtors and other receivables	5,022	3,698

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.

NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS

Group	Held for trading	Designated at fair value through profit & loss	Loans and receivables	Available for sale	Other amortised cost	Carrying amount	Fair value
	2011	2011	2011	2011	2011	2011	2011
	\$000	\$000	\$000	\$000	\$000	\$000	\$000
Investments					0	0	0
Trade and other receivables			5,022			5,022	5,022
Cash and cash equivalents			(1,720)			(1,720)	(1,720)
Crown sourced loans					24,938	24,938	26,224
Privately sourced loans					874	874	874
Trade and other payables					9,027	9,027	9,027

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	25,188
Privately sourced loans					313	313	313
Trade and other payables					11,320	11,320	11,320

NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS

Parent	Held for trading	Designated at fair value through profit & loss	Loans and receivables	Available for sale	Other amortised cost	Carrying amount	Fair value
	2011	2011	2011	2011	2011	2011	2011
	\$000	\$000	\$000	\$000	\$000	\$000	\$000
Investments					103	103	103
Trade and other receivables			4,906			4,906	4,906
Cash and cash equivalents			(2,062)			(2,062)	(2,062)
Crown sourced loans					24,938	24,938	26,224
Finance lease liabilities					874	874	874
Trade and other payables					8,951	8,951	8,951
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

19. RELATED PARTIES

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

WDHB is a wholly-owned entity of the Crown.

Significant transactions with government-related entities

WDHB has received funding from the Crown and ACC of \$119.2 million (2010 \$115.1 million) to provide health services for the year ended 30 June 2011.

Inter District Flows

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

	2011 \$000	2010 \$000
Revenue	3,582	3,290
Expenditure	25,020	24,289
Receivable at 30 June	100	112
Payable at 30 June	4,766	3,851

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

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

WDHB also purchases goods and services from entities controlled, significantly influenced, or jointly controlled by the Crown. Purchases from these government-related entities for the year ended 30 June 2011 totalled \$748,000 (2010: \$702,000). These purchases included the purchase of energy from Meridian Power New Zealand Ltd, Solid Energy New Zealand Ltd and Genesis Power New Zealand Ltd as well as air travel from Air New Zealand, and postal services from New Zealand Post.

Transactions with related parties

Wairarapa DHB has a 100% shareholding in Biomedical Services New Zealand Limited. Biomedical Services New Zealand Limited has a balance date of 30 June and was incorporated in New Zealand. The directors of Biomedical Services New Zealand Limited are Pamela Jefferies (Wairarapa DHB Board member until 5 December 2011) and Tracey Adamson (Wairarapa DHB Chief Executive). The total value of transactions between Wairarapa DHB and Biomedical Services New Zealand Limited was \$127,000 (2010: \$169,000). The amount outstanding at balance date is \$12,000 (2010: \$23,000).

Wairarapa DHB has a 16.7% shareholding in Central Region Technical Advisory Services Limited (2010 - 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 \$259,101(2010: \$142,000). No amounts are outstanding at balance date.

Remuneration of key management personnel

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

	Group Actual 2011 \$000	Group Actual 2010 \$000	Parent Actual 2011 \$000	Parent Actual 2010 \$000
Key management remuneration	<u>1,720</u>	<u>1,822</u>	<u>1,550</u>	<u>1,661</u>

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 2011 (2010 - nil).

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

20. SUBSEQUENT EVENTS

There are no significant events subsequent to balance date.

21. ACCOUNTING ESTIMATES & JUDGEMENTS

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

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

Investment property

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

Finance and operating leases

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

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

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

- Physical inspection of the assets
- Asset replacement programs

In the year to 30 June 2011, the DHB has made changes to past assumptions concerning useful lives and residual values of assets.

22. EXPLANATION OF FINANCIAL VARIANCES FROM BUDGET

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

Revenue

- Additional revenue has recognised during the year over the budgeted amount primarily relating to additional funding for various initiatives funded by the Ministry of Health. These initiatives attract additional expenditure and this is reflected in Health Provider Payments being significantly higher than budgeted

Expenditure

- Additional expenditure has also arisen due to the higher than planned inter district flows for people Wairarapa community treated at other DHBs.
- Activity occurred at higher than planned levels within Wairarapa Hospital resulting in increased clinical supplies and outsourced clinical services costs.

Assets

- 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

- There were no material differences between what was planned and what was reported at balance date.

Equity

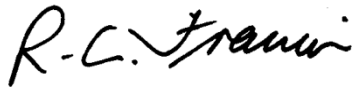
- As noted above the Masterton Hospital campus was expected to be sold during the financial year and the proceeds to repay equity. This did not occur.
- The Wairarapa DHB received a one-off equity injection from the Government totalling \$3.9 million on 21 April. This was higher than planned. The equity injection represented deficit support for losses incurred in the 2009/10 financial year.

STATEMENT OF RESPONSIBILITY

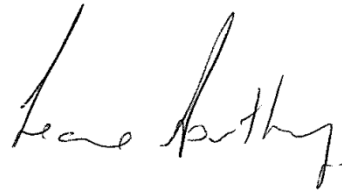
The Board and management of Wairarapa District Health Board accept responsibility for the preparation of the financial statements and the statement of service performance and judgements used in them.

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 2011 fairly reflect the financial position and operations of Wairarapa District Health Board.



Chair
Bob Francis



Board Member & Chair, Audit & Risk Committee
Leanne Southey



Chief Executive
Tracey Adamson



General Manager Finance & Information
Eric Sinclair

TO THE READERS OF THE WAIRARAPA DISTRICT HEALTH BOARD AND GROUP'S FINANCIAL STATEMENTS AND STATEMENT OF SERVICE PERFORMANCE FOR THE YEAR ENDED 30 JUNE 2011

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

We have audited:

- the financial statements of the Health Board and group on pages 33 to 84, that comprise the statement of financial position as at 30 June 2011, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the statement of service performance of the Health Board and group on pages 21 to 31.

Unqualified Opinion

In our opinion:

- The financial statements of the Health Board and group on pages 33 to 84:
 - comply with generally accepted accounting practice in New Zealand; and
 - fairly reflect the Health Board and group's:
 - financial position as at 30 June 2011; and
 - financial performance 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 31:
 - complies with generally accepted accounting practice in New Zealand; and
 - fairly reflects the Health Board and group's service performance for the year ended on 30 June 2011, including:
 - the performance achieved as compared with forecast targets specified in the statement of forecast service performance for the financial year; and
 - the revenue earned and output expenses incurred, as compared with the forecast revenues and output expenses specified in the statement of forecast service performance for the financial year.

The audit was completed on 27 October 2011. This is the date at which our opinion is expressed.

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

Basis of Opinion

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

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.

An audit involves carrying out procedures to obtain audit evidence about the amounts and disclosures in the financial statements and statement of service performance. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and statement of service performance, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the preparation of the Health Board and group's financial statements and statement of service performance that fairly reflect the matters to which they relate. We consider internal control in order to design audit procedures that are appropriate in the circumstances but not for the purpose of expressing an opinion on the effectiveness of the Health Board and group's internal control.

An audit also involves evaluating:

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

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements and statement of service performance. We have obtained all the information and explanations we have required and we believe we have obtained sufficient and appropriate audit evidence to provide a basis for our audit opinion.

Responsibilities of the Board

The Board is responsible for preparing financial statements and a statement of service performance that:

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

The Board is also responsible for such internal control as it determines is necessary to enable the preparation of financial statements and a statement of service performance that are free from material misstatement, whether due to fraud or error.

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

Responsibilities of the Auditor

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

Independence

When carrying out the audit, we followed the independence requirements of the Auditor General, which incorporate the independence requirements of the New Zealand Institute of Chartered Accountants. Other than the audit, we have no relationship with or interests in the Health Board or its subsidiary.



Stephen Lucy
Audit New Zealand
On behalf of the Auditor General
Wellington, New Zealand

DIRECTORY

Board Office	Wairarapa DHB P O Box 96 Masterton 5840 Telephone: 06 946 9880 Website: www.wairarapa.dhb.org.nz
Board Members	Bob Francis Chairman Leanne Southey Deputy Chairman Liz Falkner Rob Irwin Helen Kjestrup Rick Long Mavis Mullins Vivien Napier Fiona Samuel Janine Vollebregt Janice Wenn
Chief Executive	Tracey Adamson
Executive Managers	Eric Sinclair General Manager Finance & Information Simon Everitt General Manager Strategic Development and Population Health Kieran McCann General Manager Clinical Services Robyn Brady General Manager Service Improvement and Clinical Support Helen Pocknall Director of Nursing and Midwifery Alan Shirley Chief Medical Officer Cate Tyrer Director, Quality, Safety and Risk Stephanie Turner Director of Maori Health Gretchen Dean 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