2009/10

Nelson Marlborough District Health Board Annual Report

TE WAI ORA
Nelson Marlborough District Health Board

"Work with the people of our community to promote, encourage
and enable their health, wellbeing and independence."

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STATEMENT FROM THE CHAIRPERSON AND CEO

It is with pleasure that we present the annual report for 2009/10. NMDHB has in place the capability to carry out all of the functions required of it under the New Zealand Public Health and Disability Act (NZPH&D Act).

Our vision

Progress towards our mission to "work with the people of our community to promote, encourage and enable their health, wellbeing and independence" continues. Our vision of "leading the way to health-conscious families" reflects the Board's commitment to being a community leader with an emphasis on improving health status through prevention, health promotion and reducing health inequalities in this district.

Collaboration and Partnership

We continue to strengthen community linkages through a range of activities including consultation processes, intersectoral work and contacts with a significant number of health and disability providers and interested agencies.

We are building on strong partnerships to establish better integration of primary, community, secondary and tertiary services. The Māori Health and Wellness Strategic Framework put in place last year with the Iwi Health Board, sets out a vision to implement a co-ordinated response from all key agencies accepting responsibility for Māori health gain. Goodwill between the two Boards to increase the Iwi Health Board's advocacy role for Māori Health Strategy and issues is apparent.

Future Planning

NMDHB has a HEALTH2030 Strategic Plan that guides our medium term developments. HEALTH2030 is designed to place people and their families/whanau (consumers) at the centre of our local delivery system, in order to improve their care and support experiences and outcomes.

HEALTH2030 is focussed on improving access to quality care and support services for people living within the Nelson Marlborough area. It does this by making these services accessible and effective and through influencing the socio-economic and disparities that contribute to poor health outcomes, particularly for Maori.

HEALTH2030 links with current planning at the South Island Health Services level and at the national level with the National Health Board's Long-Term Services Plan.

For HEALTH2030, services that are consumer-centred are:

- delivered through expanded, networked providers (some for example include NGOs, GPs, Maori Providers, Pharmacists) in a Primary Care led system
- interfaced with accessible, appropriate, efficient and safe, local and regional hospital services
- aligned to Public Health services that work with our communities to create environments that support wellness and resilience
- co-delivered through access to allied health services and other clinical support services such as pharmacist services, community diagnostics, occupational physiotherapist and psychologist services.

Review of Operations

The DHB finished the year with a financial deficit of $5.389m against a budgeted deficit of $5.882m. This result is after a capital charge (an 8% charge on the Government's equity in the DHB) of $7.0m.

Revenue received to fund health and other services was $381.5m.

Expenditure by the Fund was higher in disability support services, personal health and mental health. This included higher expenditure on residential care, home based support, interdistrict flows, patient travel and GP services. Continuing fiscal constraint is placing additional pressure on our controls on expenditure.

Consistent with recent year's performance, the NMDHB Provider Division again delivered more elective services than contracted and planned for the year. While over delivery occurred in some service lines a reduction in the number of ED presentations reflects a number of steps taken to reduce hospital admissions. The DHB has continued its consistently high ratings in the national patient satisfaction surveys; something the Board is very proud of and thanks the staff for achieving this for the fifth consecutive year.

The roll out of Actor, NMDHB's rostering and time and attendance system, to all staff is nearing completion.

Work on the redevelopment of Wairau continued with the first two stages already in use. Post balance date NMDHB was made aware that there is a possibility that this project may overrun by $1.7 million. Actions are being taken that should avoid this situation.

The national process in place for the release of reports on serious and sentinel events from the previous year has enabled the public to be informed of the processes we have in place to report, review, follow up, learn and make adjustments from such events. This approach gives the public the knowledge whether or not an institution is safe and where necessary adjustments are made to clinical and management practices. This will preserve the position of clinicians and nurses involved so that disclosure is encouraged in all cases and that the result is not the development of a "blame and shame" culture, but rather the development of systemic improvements.

Collaboration with Primary Health

Work between NMDHB and Nelson Bays Primary Health and Kimi Hauora Wairau Marlborough PHOs has developed initiatives to reduce demand on secondary services through improved pathways involving providers working together across the health care continuum. Strong leadership from both the hospital and community based services is underpinning this work.

Collaboration has also enabled further capacity to be developed within the primary sector, including the business case for the integration of services in Golden Bay and implementing sustainable after hours services for the district.

Influenza Pandemic

The response by the PHOs, general practice and DHB staff to the AH1N1 influenza pandemic that started late April 2009 continued through until the end of August 2009. Despite a significant amount of staff sickness there has been minimal impact on elective services. Additional support was provided to the after hours clinics. The second wave, albeit milder than the first wave, did not commence until late July 2010 and did not have any further financial impact in the 2009/10 year. The cost to NMDHB during the financial year was $220,486.

Acknowledgements

We would like to record our appreciation for the guidance, direction and support on matters of tikanga Māori from our four Kaumatua, who continue to support the Board and staff on formal and other occasions.

We wish to pay tribute to all the staff in our organisation for their continuing efforts to provide excellent service in a demanding environment. The contribution of the community to the improvement of health and disability services through discussing issues with us and supporting services is also acknowledged.

Outlook

The DHB will continue to face a number of challenges in the years ahead. The Rutherford Initiative, which commenced last year, continues to identify a number of opportunities to assist in enabling financial sustainability in these times of severe fiscal constraint. Increasing and competing demand for services is also placing further pressure on the health services locally. The continued support of all stakeholders will be important in achieving the best outcomes.

Suzanne Win
CHAIRPERSON

John Peters
CHIEF EXECUTIVE

BOARD AND COMMITTEES

Board Members - Left to right:
Front Row – Judi Billens, Suzanne Win, Jenny Black, Liz Richards, Judy Crowe, Sharon Brinsdon, Ian MacLennan
Back Row – Joe Puketapu, Andy Joseph, Lynette Jones, Graeme Faulkner, John Moore

The Board met six-weekly with meetings in Nelson and Blenheim. From February 2010 the three statutory advisory committees met two monthly. An opportunity for the public to bring issues to the Board's attention was given in a public forum at the beginning of each Board and committee meeting. All meetings are advertised and open to the public to attend, except where business needs to be conducted in closed sessions in accordance with criteria set out in the legislation.

The three Advisory Committees have key aspects of governance that they oversee:

Hospital Advisory Committee (HAC)

Lynette Jones (Chair)
Ian MacLennan
Joanne Mickleson
Joe Puketapu
Rawenata (Lovey) Gieger
Janet Kelly
Suzanne Win

Hospital Advisory Committee - This committee monitors the financial and operational performance of the hospitals and assesses strategic issues relating to the provision of hospital-based services.

Community and Public Health Advisory Committee (CPHAC)

John Moore (Chair)
Jenny Black
Trisha Falleni (Until Oct 2009)
Sonny Alesana (From Dec 2009)
Judy Crowe (Deputy Chair)
Liz Richards
Judith Holmes
Lorraine McMath
Suzanne Win (ex-officio)

Community and Public Health Advisory Committee - The role of this committee is to provide the Board with advice on the health and disability needs of our district population. The committee reports on anything significant that may affect our population's health and it also advises our Board on which issues are most important.

Disability Support Advisory Committee (DiSAC)

Sharon Brinsdon (Chair)
Graeme Faulkner
Glenys MacLellan
Tahi Takao (From Aug 2009)
Judi Billens
George Truman
Fleur Hansby
Suzanne Win (ex-officio)

Disability Support Advisory Committee - The role of this committee is to support the DHB to address the New Zealand Disability Strategy, fulfil its obligations under the New Zealand Health and Disability Act 2000 and also to initiate planning and funding recommendations for disability support services for people over 65 years and the development of associated needs assessments, policy and processes.

The Board also has an Audit and Risk Committee to assist the Board in discharging its responsibilities relative to financial reporting, regulatory compliance and risk management (including clinical risk management). This committee meets quarterly.

IWI HEALTH BOARD

NMDHB is committed to a partnership relationship with Māori and to assisting the Crown to fulfil its obligations under the Treaty of Waitangi. It is guided in that responsibility by the NZ Public Health and Disability Act 2000 and other policy directions from the Crown.

NMDHB maintains the special relationship established with the Manawhenua O Te Tau Ihu and Maataa Waka: Ngati Apa, Rangitane, Ngati Koata, Ngati Kuia, Ngati Rarua, Ngati Tama, Ngati Toarangatira, Te Atiawa and Maataa Waka. The NMDHB Board remains committed to the relationship developed with Iwi through the Iwi Health Board. This is manifest through the appointments to the Board Statutory committees and the biannual event of joint meetings. Topics have included showcasing of Māori health providers, models of collaborations looking at Tui Ora Ltd's current best practice and Whanau Ora national developments.

The Iwi Health Board has:

- Reviewed, with the NMDHB Board, the Memorandum of Agreement. Amendments have been approved and the new name will be 'He Kawenata' which is in keeping with the Treaty of Waitangi;
- Actively participated in strategic planning projects that advance Māori health;
- Provided representation on District Health Board Statutory Committees;
- Provided advice to Nelson Bays Primary Health and Kimi Hauora Wairau Marlborough PHO on the replacement of Māori Board members;
- Worked with Māori health providers to strengthen the developments towards a district wide Māori health provider coalition;
- Supported the strengthening of relationships between Māori health providers and organisations such as the PHOs, Hospice and wider NGO sector;
- Coordinated meetings with governance members of Māori health providers and PHOs to build ongoing relationships;
- Coordinated the launch of Māori art work in Nelson Hospital foyer which was unveiled by the Hon. Tariana Turia; and
- Provided advice and leadership on the implementation of Whanau Ora locally and nationally.

The Māori health gains made in the previous year will continue with the Iwi Health Board providing leadership and guidance to NMDHB, which is key to achieving improved health outcomes in years to come.

OUR COMMUNITY AND ITS HEALTH AND DISABILITY NEEDS

Our District covers the top of the South Island and incorporates the three local authority areas of Marlborough District, Nelson City and Tasman district. There were no significant changes to our population and their health needs over the year.

Tasman	46,100	34%
Nelson	44,400	33%
Marlborough	44,000	33%

Our population has a slightly older age-structure compared with New Zealand's overall figures. While generally the population is in the middle of the socio-economic scale, there are significant pockets of deprivation.

Population projections show overall population of the Nelson Marlborough district is expected to increase by nearly 10% between 2006 and 2026. The greatest growth is expected to occur for people aged over 50.

There is a small population of Pacific people resident in the Nelson Marlborough district (about 1% of the total population), with an expected increase of about 3% per annum in the next decade.

The proportion of Māori comprise 8% of the Nelson Marlborough population which is less than the New Zealand average of 15%.

There is a significant visitor population (tourists and seasonal workers, both national and international) attracted by the natural features (coastline, national parks and the climate) and the industries of the area (fishing and fish processing, viticulture, arts and crafts, horticulture). Some of these people have relatively poor health and high need for health and support services.

The health of people in Nelson Marlborough is generally very similar to or better than that of people in the rest of New Zealand.

Based on NMDHB health needs assessments and "An Indication of New Zealanders Health 2007" we know that the health issues of particular importance for the Nelson Marlborough communities are:

- An ageing population – older people have higher utilisation of services; we need to invest in keeping people well, supporting them at home and minimising the need for residential services;
- Increasing prevalence of chronic conditions – cancer and cardiovascular conditions at same rate at rest of NZ;
- Poor overall oral health, especially for children – based on year 8 students, we need to put emphasis on fluoridation of our water supplies and improved access to child and adolescent oral health services;
- The high number of smokers – although overall prevalence of smoking is lower in Nelson Marlborough than in NZ as a whole (19.3% compared to NZ 20.7%), there are still a large number of regular smokers in the district and some population groups have much higher rates (Māori and Pacific rates are very high at 39.7% and 34.1% respectively – nationally 42.2% and 30.3%);
- Poor air quality and water quality, and access to water, in some parts of the district, both in urban and rural settings – contributing to respiratory, communicable and other diseases;
- Relative access to emerging technologies to improve health and support outcomes; and
- Our population has better overall health status than the NZ average; we eat more fruit and vegetables and are more physically active overall, which creates a higher than average injury rate.

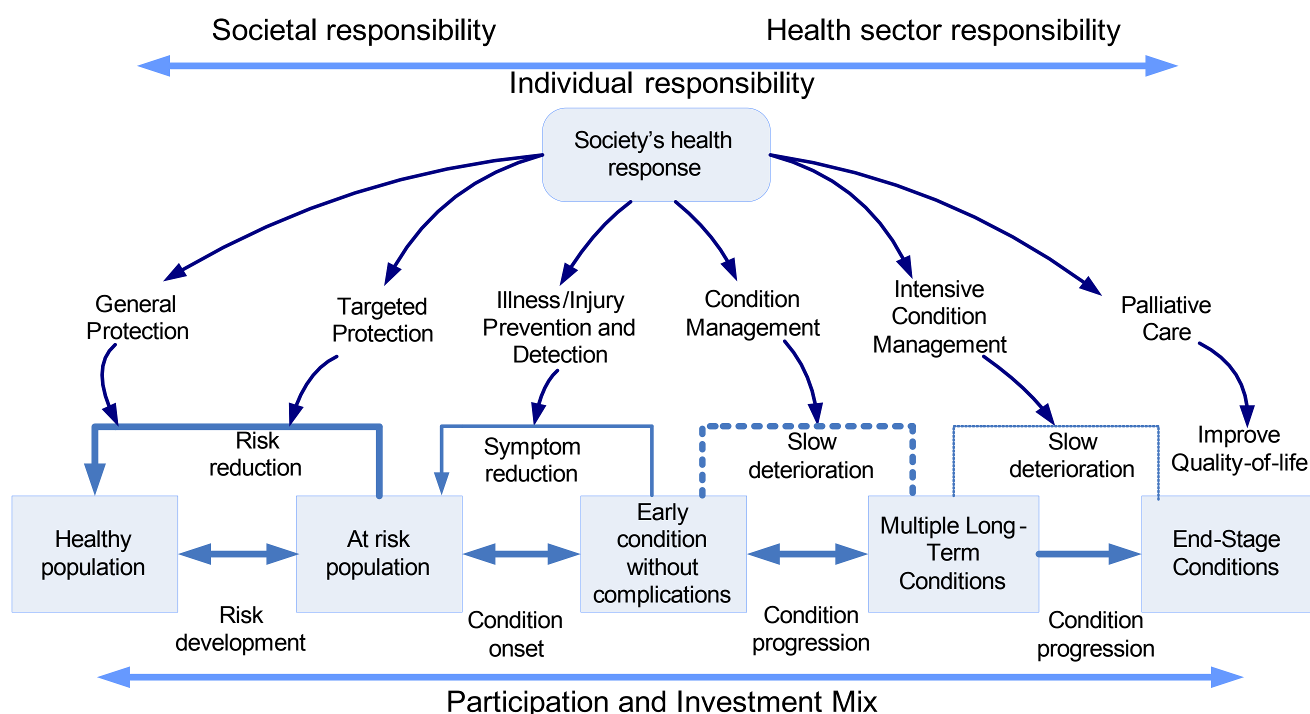
The key priorities are focused on:

- Better service quality and viable clinical delivery systems;
- Better performing organisations;
- Better access to healthcare and disability service;
- Effective partnership with Maori; and
- Better health for our communities.

Our key strategies were:

- Improve sustainability;
- Improve health and disability services;
- Improve long term condition management; and
- Improve wellness.

These are set out in the following:



Key Achievements (Interventions and Services):
During 2009/10 we achieved a number of key outcomes through our programmes, initiatives and other activities. These included (for full details refer page 55 onwards):

Output Class 1 - Public Health Initiatives

Nutrition and Physical Activity Programme
New services were funded as part of this programme through small grants to schools for edible gardens, community organisations for open orchards, to our PHOs for breastfeeding and peer counselling, Máori leadership, meal planning and physical activity programmes.

Working with other agencies
NMDHB actively participated in making submissions to a number of local and national policies including the sale of alcohol and the Long Term Council Community plans.

Output Class 2 – Primary and Community Services

Integrated Primary Health Care Centres
The business case for the redevelopment of health services in Golden Bay has been approved by the Board. Ministerial consent to the proposal is being sought.

Primary Care Capability and Capacity
Work is continuing on managing acute presentations to the ED at Nelson and Wairau Hospitals as well as access to diagnostics and revised clinical pathways for a range of treatments. It is gratifying to see the early results of such programmes resulting in reductions to hospital admissions and presentations to Emergency Departments.

Devolution of Services
NMDHB and the IHB recognised the value and significance of establishing a 'methodology for the Partnering Alliance' with Kimi Hauora Wairau Marlborough PHO, Nelson Bays Primary Health and NMDHB's Health Services providers. We believe that this alliance will further local ability to deliver on Government policy for 'Better Sooner More Convenient' (BSMC) Primary Health Care through ensuring coordination and management of care, particularly for Nelson Marlborough people who have multiple and/or complex long term conditions and those who have poorer health status.

The key purpose of coming together as an Alliance is "to develop health services around the patient as an integrated 'programme of care' unconstrained by organisational boundaries". This is seen as a methodology for the way we work together.

Primary Care Mental Health
With our PHOs, a stepped care model is being established to enable more people to be managed proactively in the community.

Output Class 3 – Hospital Services

Clinical Leadership

Through considerable consultation we are enhancing clinical engagement which will be further strengthened through the changes to the Executive Leadership Team to include strategic clinical representation in service delivery.

Devolution to Primary Care

By the use of pilot projects we are moving the setting of care to more relevant areas e.g. 'GP Access to Diagnostic Imaging'.

Working Collaboratively

We are actively involved in the South Island regional planning for

- better more convenient access to elective services to provide certainty for those requiring those services; and
- more robust hospital care delivery using regional solutions.

We are also working with other DHBs to better manage our Interdistrict flows and to ensure faster access to care when required particularly around the Government's Health Target for reduced waiting times for Cancer Radiotherapy Services.

Living within Funding

The Board is adamant that there will be no on-going cyclical deficits and that we must transform how, for whom, where and by whom we deliver services. This means we will not only be considering how we fund and deliver our services, but where services will be based. The core approach to this is through the Rutherford Initiative.

Steps have also been put in place to establish single wait lists, improve urgent after hours cover and re-configure services to enable acute presentations to be better managed.

Output Class 4 – Support Services

Health Services for Older People

Service changes to Health Services for Older People developed in 2008/09 were progressively implemented during 2009/10.

A revised home based support service specification, expected to commence 1 October 2009, was not fully implemented until January 2010. The new service facilitates ageing in place, improves the health of older people and reduces annual per capita costs of service. Assessment processes for older people have been reconfigured in line with the InterRAI comprehensive geriatric assessment tool and results of that assessment drive service allocation based on assessed need.

Expenditure on Aged Residential Care was higher than planned due to the increased number of beds available in the sector following the opening of two new facilities in our district. There was minimal decrease in the occupancy at other rest homes which indicates a level of unmet demand. NMDHB is rolling out education and training to this sector to assist in improving the supervision of quality and nursing provision.

Palliative Care

We have been working with our two palliative care providers to implement new specialist palliative care services, which ensure that services are coordinated to meet need.

Health and Disability Service Planning

Using the framework developed in 2008/09, we continued to build on the Board's conceptual approach to populations of need and proposes that services will be delivered through expanded, networked providers in a primary healthcare led system, including NGOs, GPs, Māori providers, pharmacists supported by local and regional hospital services.

Work included the Shifting Some Secondary Service project, a review of Acute Care services and the development of a Nelson Marlborough District Wide Clinical Services Plan.

Regional Collaboration

Management were involved in

- South Island Regional General Managers' Forum;
- South Island Elective Services;
- Long-term conditions management;
- South Island Health Service Plan developments; and
- South Island Asset Management Planning.

Health Targets

During 2009/10 DHBs were measured on a quarterly basis against a number of health targets first introduced in 2007/08. These targets are a set of national performance measures specifically designed to improve the performance of the health services. This can then be measured to see how they are improving health for all New Zealanders.

NMDHB has improved on all health targets since they were introduced. Our performance during 2009/10 was:

Target Area	National goal	NMDHB Q1	Q1National	Q4NMDHB	Q4 National
Shorter stays in Emergency Departments	95%	96%	80%	98%	87%
Improved access to elective surgery	100%	112%	98%	105%	105%
Shorter waits for cancer treatment	100%	96%	99%	97%	99%
Increased immunisation	85%	87%	81%	89%	87%
Better help for smokers to quit	80%	14%	17%	52%	57%
Better diabetes and cardiovascular services	N/A	63%	65%	66%	68%

Māori Health

Development of the Māori health provider coalition is moving ahead. The activity seeks to gain the support of the eight Māori health providers across Te Tau Ihu into forming a united group. Work has moved towards building the core principles, values and a business model that will support the coalition into the future.

Implementation of the Whanau Ora Pathfinder Service is completed. The service is supported by a network of providers working together and follows whanau who have members diagnosed with cancer and the ongoing support/management required for this condition.

Work has started on reviewing the newly established Whanau Ora services for Hauora Tane, Palliative Care and Kaumatua Services. The review is near completion and is about gathering information that will strengthen the way the services will be delivered into the future.

Te Hoe Nuku Roa, a longitudinal study of Nelson Marlborough Māori community's health, has entered into its second phase. The research will build on the baseline reporting done in 2008/09. The information is necessary (based on actual real time aspects of health and social context) to understand if health services have improved and how this knowledge can be utilised for future planning in the DHB for services to Māori.

The Māori and Pacific Health Reference Group has been operational for two years and has improved access to operational advice by the DHB and PHO staff. The group provides support and guidance to staff and management to ensure the needs of Māori and Pacific Island peoples are reflected appropriately. The group continues to provide advice to the Wairau Site Redevelopment Project as required.

The Joint Agency Māori Health and Wellness Strategic Action Plan, by the name of 'Wassup!!!', was released in March 2010 to participating organisations. This plan sees a number of different health organisations working together to deliver coordinated actions to support Māori health. Project planning with participating parties has started to establish a baseline to measure and monitor the action plan implementation.

Work continues to roll out He Taura Tieke, the Māori Health responsiveness framework to hospital services, the primary health care sector and regional hospices. This follows the roll out in 2008 to the hospital services and the public health groups. These groups have now completed the baseline review on their services.

The Pukenga Hauora Service (Māori Health) continues to advance positive health outcomes for the Māori community and this year achieved a milestone by reviewing key Māori service policies including He Oranga Māori Best Practice and development of the Māori Bi-lingual Signage Policy. The year has been one of change with Pukenga Hauora Service focusing more on working closely with hospital services to improve Māori health understanding and the patient care journey for Māori.

The NMDHB Kaumatua Group continues to advance positive leadership to the Iwi Health Board, NMDHB Board and staff. This year it has achieved an important milestone supporting a number of key Māori policies including an update to He Oranga Māori Best Practice and cultural supervision. Throughout the year, this group has been active in supporting the Wairau Hospital Site Redevelopment, leading karakia or Māori prayers for the decommissioning of buildings and greeting the Hon. Tariana Turia with the formal unveiling of art works in the Nelson Hospital foyer.

SERVICES PROVIDED BY NMDHB

Primary and Community Division

Access to services/reducing inequalities – key achievements
A key area of focus this year has been on working with Nelson Bays Primary Health in supporting the development of an integrated community health centre for Golden Bay. This concept came from thinking about how to sustain the current high standard of care for residents into the future, and brings together the services provided by Nelson Bays Primary Health through the Golden Bay Medical Centre general practice; the Joan Whiting Memorial Trust who provide aged residential care; and NMDHB through the Golden Bay Community Hospital. This development has received broad support from the people of Golden Bay, and the agreement of the three providers to merge their services into an extended primary care service. The service will be operated by Nelson Bays Primary Health from the community hospital which will be extended and upgraded to accommodate the broader range of services, in a community owned facility.

We have worked with Nelson Bays Primary Health and Kimi Hauora Wairau Marlborough Primary Health Organisation to develop initiatives to reduce demand on secondary services. This work also aims to improve the service to patients through the development of improved pathways involving providers working together across the health care continuum.

This has seen new guidelines developed, and underway, for treating conditions such as suspected deep vein thrombosis, soft tissue infection, transient ischaemic attack, and improving access to x-rays for minor fractures. Strong clinical leadership from both the hospital and community based services is underpinning this work.

As part of ensuring our public health actions deliver the best possible value for money we have been going through an extensive developmental process, looking at realigning our health promotion activities against the greatest health needs of our communities. This has also prompted a study of our infrastructure needs and planning processes. We have worked on our annual planning process for improved health promotion delivery across the district, which also lays the foundation for future development of this work with other agencies in the community and the primary health organisations, and for an integrated South Island approach to optimising public health delivery.

Our response to the AH1N1 pandemic in 2009 included the setting up of and logistics surrounding CBACs (Community-Based Assessment Centres). Although use of these facilities were not required last year as numbers affected remained low, this essential preventative service remains ready to be rapidly activated should the need arise. We also provided an Influenza Road Show for general practitioners to ensure that they were up-to-date with what to expect and how to respond most effectively with their patients.

Public Health Service Key Achievements

This year we continued increasing immunisation rates for 2-year-olds, and have now reached 89%, exceeding the national target. This is due to a whole of sector approach to improving the rate, through collaborative information sharing, and an immunisation facilitation partnership with our two Primary Health Organisations.

Every year around 5,000 New Zealanders are killed by smoking. Our work continues towards providing better help for smokers to quit with the introduction of the evidence-based 'ABC approach' (**A**sk if a patient smokes, give **B**rief advice, offer **C**essation support) to our hospitals. The 'ABC approach' for all patients has been developed over the past year, and has been operational in the hospital since May.

In collaboration with our primary health organisations and general practices, we have exceeded the total population target for B4 School Checks, due to our ability to identify more local children that were eligible for this check but not previously identified.

The final report into the Fruit Growers Chemical Company site contamination in Mapua was completed for the Ministry of Health. The Ministry of Health accepted our report and is now working through the relevant health issues with the community.

Our work towards ensuring that adolescents get the dental treatments they are eligible for has seen another successful year. We have exceeded the national target, with 85% of our local teenagers accessing free dental services.

We have continued to work on improving the wider determinants of health and working intersectorally by advising councils on how to actively promote physical and social wellbeing, and submitting our expert opinion on such topics as the review of national environmental standards for air quality; the Southern Marlborough urban growth strategy; and, the Nelson City, Tasman District, and Marlborough district council's long term council community plans. This type of work ensures that agencies that sit outside of the health sector understand the health implications of their planned environmental changes.

Nutrition and Physical Activity Programme Key Achievements

As nutrition is a most important element in decreasing the growth in obesity, cardiovascular disease and diabetes, we have been working with the primary health care sector to improve nutrition awareness through the Community Nutrition Service. Nelson Bays Primary Health received the NMDHB Health Quality and Innovation Award for providing this service, which gave over 70 nutrition education sessions to 1,400 participants, as well as 480 individual nutrition consultations to those with specific needs.

We are getting closer to achieving our breastfeeding target for all new mothers, with 69% fully and exclusively breastfeeding their babies at six weeks. Work continues to keep this number high through to the key milestone of six months. We have supported training of 15 women as 'Mum4Mum' peer supporters in the community to work with new mums. We are furthermore working with businesses to create breastfeeding-friendly spaces.

Because maintaining good levels of physical activity is an investment in health for all ages we have continued to grow the 'Way 2 Go' Hubs through Nelson and Tasman and most recently Marlborough, with 16 of these community-based recreation hubs now operating, built up from only three, five years ago. These hubs work with an average 1,000 number of people a week, people who would otherwise be physically inactive.

SERVICES PROVIDED BY NMDHB - Continued over page

Hospital Health and Disability Services Key Achievements

PROVIDER DIVISION

The 2009/10 year has been another busy year for service development; however, demand for Medical and Surgical inpatient beds was within expected levels. Once again a high level of commitment from our staff has been evident, particularly as we have worked to contain cost growth whilst developing our services.

A highlight for the year has been the ongoing development of Wairau Hospital in Blenheim. This is a credit to our staff involved in the planning and implementation and to the community who have been so supportive throughout the development process.

A number of initiatives have been instrumental in the provider division meeting or exceeding 66% of its targets, for the remaining targets there has been improvement. Of note was the significant drop in numbers of patients failing to turn up for their appointments, helped by the implementation of text messaging and the gradual implementation of a patient focussed booking system where a patient chooses their appointment time.

	Nelson			Wairau			Total		
Target Area	**07/08 FY**	**08/09 FY**	**09/10 FY**	**07/08 FY**	**08/09 FY**	**09/10 FY**	**07/08 FY**	**08/09 FY**	**09/10 FY**
Admissions	16,958	17,989	17,174	8,841	9,017	8,619	25,799	27,006	25,793
Discharges	16,965	17,975	17,199	8,829	9,016	8,618	25,794	26,991	25,817
Daycases	7,024	7,460	7,049	3,695	3,818	3,482	10,719	11,278	10,531
DHB funded caseweights (CWD) - Acute CWD									
- Medicine	3,482	3,790	3,435	2,009	1,999	1,779	5,491	5,789	5,214
- Surgical	3,036	2,970	3,185	1,342	1,331	1,482	4,378	4,301	4,667
- Women, Child & Oral Health	840	880	1,696	323	315	835	1,163	1,195	2,531
Total Acute	**7,358**	**7,640**	**8,316**	**3,674**	**3,645**	**4,096**	**11,032**	**11,285**	**12,412**
Elective CWD -									
- Medicine	347	580	420	2	6	34	349	586	454
- Surgical	2,977	3,950	4,180	1,397	1,567	1,632	4,374	5,517	5,812
- Women, Child & Oral Health	646	655	670	324	320	283	970	975	953
Total Elective	**3,970**	**5,185**	**5,270**	**1,723**	**1,893**	**1,949**	**5,693**	**7,078**	**7,219**
Total CWDs	**11,328**	**12,825**	**13,586**	**5,397**	**5,538**	**6,045**	**16,725**	**18,363**	**19,631**
First Specialist Assessments	12,433	13,658	14,780	5,587	6,042	6,319	18,020	19,700	21,099
Follow ups	24,204	25,403	26,503	12,357	12,171	12,599	36,561	37,574	39,102
Minor procedures	7,824	9,430	10,721	3,393	3,771	4,112	11,217	13,201	14,833
In-Patient (IP) Patient Days	39,934	39,748	38,220	19,849	18,798	18,190	59,783	58,546	56,410
IP average length of stay	4.02	3.78	3.77	3.87	3.62	3.54	3.97	3.73	3.69
IP average occupancy	74.9%	75.1%	72.2%	74.6%	72.5%	70.2%	74.8%	74.3%	71.5%
Non DHB-funded caseweights	236	272	241	10	37	19	246	309	260
Discharges to other hospital or DHB	543	374	322	346	337	329	889	711	651
Deaths	180	180	169	75	73	78	255	253	247
Births	1,046	995	978	515	530	515	1,561	1,525	1,493
ED Presentations	25,053	26,479	25,800	11,503	18,124	17,733	36,556	44,603	43,533

Emergency Departments (Nelson and Wairau)

There have been many initiatives carried out over the past year in the Emergency Departments focussing on reducing the number of patient presentations whose needs could have been dealt with in primary care. An effective advertising campaign over Christmas using newspapers and movie theatre advertising plus new signage at entrance ways and on adjacent roadways was instrumental in informing the public and redirecting patients. The NMDHB website has been made more user friendly with specific information about when people should attend the ED and when they should visit their GP.

Patient care pathways have been trialled focussing on the areas of deep vain thrombosis, cellulitis and eye care follow up. Patients more appropriately managed in primary care are being redirected to their GPs on a daily basis with more timely appointments being recommended with their local after hours duty doctor or their own GP.

A telephone hot line was introduced between ED and the after hours duty doctors enhancing communication between the two, avoiding wrong number delays and providing timelier responses to the enquiries. The ED team has initiated a PHO subsidy for people without a GP and on low incomes to have one free visit to the after hours duty doctor. Letters were sent to GPs and nursing homes encouraging a 'culture change' in referrals going to GPs rather than ED for ongoing patient care. There is continuous communication with nursing homes around improving referral pathways for their patients and suggestions around having GP gatekeepers for every nursing home available twenty four hours of the day, seven days a week. Consideration is being given to patients who have been discharged from wards being provided with a GP follow up appointment before they leave hospital.

In the 2009/10 reporting year there has been an overall reduction in ED presentations of 2.4% for the region. This is in contrast to increases being experienced by other DHBs.

Elective Services

Standardised intervention rates show that we have outperformed many other DHBs in achieving the 'outstanding' status for Improved Access to the Elective Surgery Health Target set by the Ministry of Health.

Through He Taura Tieke Māori Health Strategies being implemented, we now have a more responsive and effective service provision for Māori.

Equipment has been purchased and training is almost complete for the provision of a Sentinel Node Biopsy Service which will result in an improvement in service to women with breast cancer.

In March this year our first endovascular aneurysm repair was performed which is a milestone in repairing abdominal aortic aneurysms for the Nelson Marlborough district and provides a second, less invasive option for suitable patients.

With the opening of the new integrated operating theatre at Wairau, surgeons are now able to undertake more complex, minimally invasive surgery. Wairau Hospital's digital operating theatre is the second true high definition/fully integrated operating theatre in New Zealand (the only public one), and utilises the most advanced technology available in the world today.

Mental Health

The Mental Health Team has had another round of successes this year with several of their local initiatives being taken up by the Ministry of Health or other DHBs throughout New Zealand. These include the Client Pathway model, which has been used as a model for the National Services Framework; the Addictions Service, which has been noted by the Ministry as a national model for Addictions/MH Integration; a Co-Existing Disorder (MH/Addictions) Service, which has been set up and is now heralded by the Ministry; and a Clinical Outcome Measurement, which was set up throughout Mental Health to measure client/clinician alliance, and which has been adopted by the Ministry via Te Pou.

Other notable Mental Health achievements include national recognition as one of the first Mental Health Services in New Zealand to implement 'Smokefree' across the entire service; and our initial 'Wazup programme', a pilot for high risk suicidality patients, which has been recognised and used for research by Otago Medical School and Yale University.

We have increased our designated Māori FTE in the Admission and Forensic Units and we have developed a 'Family Pathway' to align to our 'Client Pathway', which has been made possible by a Family Commission research grant. Our Opioid Substitution Programme has been extended and we have a new Biofeedback Programme for outpatients in Wairau and Nelson treating anxiety based disorders.

A new model has been instigated for triggering after hours calls district-wide which utilises Mental Health staff and produces further efficiencies for the service. The Intensive Patient Care Unit (IPC) has been commissioned, resulting in a reduction in the rates of seclusion for patients.

An outpatient clinic in Motueka has extended our rural service in Child and Adolescent Mental Health, Adult Mental Health, Opioid, Addictions, and Primary Care Liaison.

We have achieved excellence (100% compliance) in mandatory data reporting requirements and we have met cost saving targets set for the service. Furthermore, our Child and Adolescent Mental Health Service have been highly commended by the NMDHB Quality and Innovation Awards for its therapeutic model on Dialectical Behaviour Therapy.

SERVICES PROVIDED BY NMDHB - Continued over page

Intellectual Disability Support Services (IDSS)

Maintaining quality and establishing financial sustainability into the future have been the primary focus of the service this year.

To achieve this quality, systems and processes have been used to make changes to how we operate. In particular, there has been a focus on occupancy and development of a reputation in the community to enhance the capacity for growth.

We were successful with two training grant applications which has helped sustain a sound training programme. Staff rostering has been reviewed and other resource efficiencies across the service have been made.

From June 2009 to June 2010 IDSS client numbers have increased from 213 to 220.

The service achieved good feedback from audits.

Infrastructure Changes

WAIRAU HOSPITAL REDEVELOPMENT

The completion of the construction of the second stage of the Wairau Hospital Redevelopment Project in February 2010 was another significant milestone achievement. The first department to occupy the new stage two facilities was Medical Records, closely followed by Laboratory, Support Services, Emergency Department, Acute Assessment Unit/High Dependency Unit and finally the Radiology Department. The completion of the construction of the new operating theatre in June 2010 was also a significant milestone for the NMDHB.

Twelve months have now passed since the occupation of the new wards and allied health facilities which were completed in stage one of the development.

Positive feedback continues to flow from staff and patients, as the new systems and facilities become utilised, with particular praise falling on the new Emergency Department.

The pressure has continued throughout the year with the construction progress and to remain within budget. Cooperation from the public and patients has enabled an efficient construction work programme minimising any significant impact or disruptions being incurred by hospital services.

We look forward to the completion of the whole redevelopment of the hospital campus in 2011 when all services will be located in their new premises and the community of Marlborough will continue to enjoy the highest level of care in newly constructed and contemporary healthcare facilities.

Measuring Performance Against Strategy

The Balanced Scorecard (BSC) reporting package was used to monitor performance to our strategy throughout the year. Produced monthly, the BSC consisted of a strategy map, snapshot and trends report, as well as an exception report. The reports focused on decision-making around strategic issues as opposed to tactical issues, implications and reviewing past performance.

In reviewing the strategic purpose of the BSC, the Board recognised that due to a number of changes required by Government and the new Health Services Planning frameworks as well as the local changes to the organisational leadership approach, there is a need to revisit the BSC strategy map, the BSC process and align the initiatives from our District Annual Plan to the BSC.

The BSC methodology is now being incorporated as part of a whole 'Strategy Management System' for NMDHB. Since the introduction of the original BSC strategy map, a number of key developments have resulted, including:

1. Improved articulation of our values;
2. Better clarity around Government direction and expectations with regards to Health Targets and Better, Sooner, More convenient;
3. Requirements to deliver services within constrained resources;
4. Better clarity around national and regional planning objectives;
5. New organisational leadership structure and mandate;
6. The emerging implementation of key Rutherford Initiative recommendations;
7. Recovery planning and other centrally developed reporting processes (Health Targets, Performance Action Plans, and Indicators of DHB Performance);
8. Better understanding of the 'BSC' methodology and approach; and
9. Development of 'multiple bottom lines' (economic and service, cultural, sustainability and social) that align to the Board's strategy.

The new 'Strategy Management System' approach will critically connect strategic planning with tactical and operational planning at all levels within the organisation and utilise a set of performance measures that can be reflected at both the strategic and operational levels. A number of the measures we have been using for the current BSC will be appropriate for the new programme; however, it is planned to also incorporate national and regional measures that we are currently required to report.

COLLABORATION AND RELATIONSHIPS

Key relationships with district, regional and national interests are essential to maintaining the planning, funding and provision aspects of our role. We have relationships with other DHBs (particularly those within NMDHB's regional collective interests as well as those addressing national collective DHB interests) together with other agencies such as the Ministry of Social Development, the ACC, Justice, Police, Housing, Education, territorial authorities and a range of other NGOs.

These relationships allow for:

- Sharing knowledge around the forces for change which influence planning and provision of health and disability services;
- Ensuring access to a broad range of services across different settings now and into the future for those in the population who need these services;
- The exchange of knowledge around demographic drivers and community and provider themes to assist with planning;
- Planning South Island Shared Services back office functions related to Information Systems and Human Resources;
- Better knowledge and understanding of current and projected gaps in health status and service provision within our population and communities;
- Opportunities to target resources to maximise healthcare and health outcomes for the district's population utilising the knowledge gained through these relationships;
- Sustainability of the health and disability system at all levels over time;
- Delivering the assessment of individual patient/client need for, and the coordination of, a range of services through Support Works (district needs assessment and coordination service); and
- District-wide specialists' working relationships being developed in obstetrics and gynaecology, general surgery, paediatrics, ED and orthopaedics.

ORGANISATIONAL STRUCTURE

During the year our organisational structure underwent a number of changes that were aimed to enhance the special partnership arrangement with the Iwi Health Board (IHB) and the linkages with the statutory advisory committees and the Chief Executive (CE).

At a governance level, these included changes to the frequency of committee meetings and a joint revision with the IHB of the Memorandum of Agreement which, in keeping with the Treaty of Waitangi, is now known as 'He Kawenata'.

In April 2010 the CE commenced a review of the Strategic Leadership Team (SLT). A new structure, to be known as the Executive Leadership Team (ELT), seeks to create a new environment in which joint leadership between clinicians, management and providers across the continuum of care can be engaged to achieve the best care possible within the district's finite resources.

The intent is that this will bring those who are concerned with district-wide delivery of services into the senior team and increases the input of clinicians. It is also intended to achieve greater clarity and accountability across both operational and support functions.

The structure allows that service governance across primary and secondary care will be simplified, clinicians can be involved together with management at all levels of decision making, the 'line of sight' from proposal through to delivery will be clarified and opportunities for integration and efficiencies of both sustainable services and viable financial performance can be improved.

Structural change is, however, only part of the solution. The major ingredients are that the people involved in the leadership positions are competent as leaders, and committed to working collaboratively and for the benefit of the greater objective – the best and most effective services possible to the residents of Nelson, Tasman and Marlborough.

The objectives for the new structure are to:

- Take the work done in the Primary and Community Division to the next level by consolidating the accountability for integration of patient services across the continuum to better achieve health services that support the patient journey;
- Allow greater clinical engagement in leadership;
- Provide structural support for clinical accountability;
- Provide a single point of accountability for service delivery, across the service continuum;
- Clarify roles and responsibilities;
- Provide a single point of accountability for provision of business system support, information and operational analysis;
- Greater focus on quality, safety and risk management;
- Build on the work done on 'Optimising the Patient Journey' and gives greater focus on continuous operational improvement;
- Improvement in the accountability for financial management and delivery of results by budget holders;
- A committed focus on developing the strategic direction and accountability documents, with separation from provider contracting; and
- Allowing the senior managers the time needed to drive improvement and strategic intent versus reacting to operational issues.

KEY ALLIANCES

NMDHB has close relationships with the following entities:

Governance:

- The Iwi Health Board, with whom the Board has signed a Memorandum of Agreement, establishing a partnership based on the Treaty of Waitangi to improve Māori health outcomes; and
- The two Nelson Marlborough Primary Health Organisations with whom the Board has signed a Memorandum of Understanding.

Trusts:

- Nelson Marlborough Hospitals' Charitable Trust, which holds trust funds for the benefit of public hospitals;
- Marlborough Hospital Equipment Trust, which provides equipment and other items from public donations raised by the trust; and
- Hospice Nelson – Cooperative relationship.

Charitable Providers - from DHB sites:

- Churchill Private Hospital Trust, which provides private medical and surgical services in Marlborough; and
- Hospice Nelson Marlborough – Cooperative relationship for palliative care.

Cooperative Arrangements:

- South Island Shared Services Agency Ltd, which supports the activities of the South Island DHBs by providing services, such as planning and funding audit, analysis and advice and contract management, as determined by the participating DHBs;
- Other DHBs for collaborative purchasing of supplies and other services, including using utilities such as the Southern Alliance;
- NMDHB has an agreement with Nelson Radiology Ltd which covers a joint Magnetic Resonance Imaging (MRI) service with them;
- Golden Bay Integrated Health Services with whom NMDHB is working on a project to integrate health services providers;
- District Health Boards New Zealand which exists to support DHBs and provide co-ordination of activity at the national level;
- Top of the South Cardiology Ltd, which provides private cardiology services from Nelson Hospital; and
- The two PHOs and GPs for the provision of GP services from facilities leased from NMDHB on or adjacent to the Nelson and Wairau hospitals.

A VIBRANT ORGANISATION WITH A LEARNING CULTURE

Learning Environment:
Learning and development opportunities provided for staff included competency, professional, practice and organisation development aspects. 90 nurses from across the district were supported through Clinical Training Agency funded programmes to complete post graduate nursing studies with an increasing number going on to complete Masters' degrees.

The NMDHB Management Series continued in 2009/10 with 150 clinical and non-clinical managers having completed the programme since its inception three years ago. Modules on risk management, process improvement and IT time efficiency were added during the year.

Clinical Assessment Skills workshops for nurses were held in both Nelson and Wairau during the year with 74 nurses attending and providing positive feedback.

Intellectual Disability Support Services (IDSS) continued the development programme for service leaders this year with specific development in change and project management.

An Allied Health Training Strategy was finalised in the 2009/10 year. The strategy combines and streamlines training for all allied health staff and is designed to ensure competence and continued development to meet the requirements of the Health Practitioners Competence Assurance Act as well as utilise the latest best practice available.

IT training has been refocused during the year with most training now being delivered in-house. This has resulted in support and coaching being closer at hand for staff.

A strategy for the introduction of e-learning has been developed with a pilot programme underway within the reporting period. Initially focused on e-assessments of staff knowledge and learning around the Code of Consumer Rights, it will extend to areas such as informed consent and restraint in the 2010/11 year.

NMDHB has continued providing components of its Learning and Development programme to support skill development in the Mental Health NGO sector in the district.

The Treaty of Waitangi workshops continued in 2009/10, with all sessions being over-subscribed.

A new orientation programme for clerical/administration staff was launched during the year and is being rolled out to all new and existing staff.

The Family Violence Intervention Programme training for staff in priority areas continued and was almost complete by year-end. Now built into the orientation for new staff in these areas, a refocus of the training effort has been completed with a focus on shorter but more frequent in-service training.

Communication and Quality:
The formal partnership agreement formed during the 2008/09 year with NZNO and the PSA, who represent a significant proportion of our workforce, has continued. The Partnership Group was responsible for a separate section on bullying being part of the 2009/10 Workplace Audit (climate survey).

As a result of that feedback, the Partnership Group has reviewed and suggested changes to the organisational policy and process around the management of these situations. Consultation with other unions and groups was underway at year end with an expectation that the revised policy and new process would be confirmed in August 2010 and progressively implemented within the organisation during the 2010/11 year.

The Chief Executive holds quarterly staff forums in both Nelson and Wairau and six monthly in the rural areas. In addition to the Chief Executive's written update published monthly, a quarterly in-house magazine titled "DHB Connections" is published regularly.

The revamped NMDHB quality awards were presented at a ceremony in September 2009. Attracting a wide range of impressive entries from across the district the supreme winner was a community dietetics programme run out of Nelson Bays Primary Health organisation.

All NMDHB specific collective agreements were settled without industrial action. Industrial action was experienced within the context of national multi employer collective negotiations.

NMDHB underwent a Periodic Review for Accreditation and a Surveillance visit for Certification in April 2010. Both Accreditation and Certification were confirmed by the relevant authorities.

The national 'Optimising the Patient Journey' (OPJ) programme came to an end in February 2010. However, the local roll out has continued with the methodologies now rolled out to 13 clinical environments across the DHB. The OPJ team presented their learnings at national collaborative events, and contributed to the Quality Improvement Toolkit for New Zealand Health Services. Relationships are being cultivated with International areas of best practice in healthcare improvement.

The development of new strategies for moving continuous quality improvement forward is part of the team's ongoing work. The team have created process improvement modules, which now form part of the management series for the DHB, and over 20 improvement projects were facilitated by this process alone in the last six months. Clinical environments and hospital teams have supported projects surrounding patient focused booking, just-in-time stores systems (Kanban), medication standardisation, patient flow initiatives theatre utilisation and service redesign, to name but a few.

Staff Wellbeing:
The 'Wellness at Work' focus has seen a wide variety of opportunities provided for staff in the physical activity area. Taking a 'try before you buy' approach, we sponsored staff to participate in yoga and tai chi classes. Successful staff health fairs were held in Wairau and Nelson in November 2009, offering staff access to a wide variety of health and nutrition and physical activity information.

NMDHB has power-assisted bicycles for staff to use around Nelson on organisational business. Located with services whose business is mainly carried out in the community, the bikes are a quick means of travel within the city confines and role model healthy physical activity to other staff and the public.

NMDHB continues to have recreational bikes available for staff to loan on a three-week basis for personal use. Aimed at encouraging staff to take up recreational cycling the bikes have proved popular with staff, a number have gone on to purchase their own.

The organisation retained its tertiary status with the ACC Partnership Programme for the eighth consecutive year. Furthermore, the organisation has an active district-wide Occupational Health and Safety team who provide support for staff when they are ill or injured.

Governance Structure

The Board, comprising seven elected and four appointed members, provides governance of Nelson Marlborough District Health Board (NMDHB). The actual meetings dates being:

2009: 11 August, 22 September, 3 November, 15 December

2010: 26 January, 2 March, 13 April, 25 May

Board members act in the best interests of NMDHB. The Board concentrates on setting policy and strategy and monitoring its achievement and appoints the CE to manage the implementation of this policy and strategy. All other employees are appointed by the CE.

The Board maintains open communication with the Minister of Health to ensure recognition of the Government's expectations and to report on the organisation's plans and progress.

In accordance with the Act, the Board constituted three Advisory Committees (meet eight-weekly; each comprising a mix of Board members and community members), the Audit and Risk Committee (meets quarterly) and the Remuneration Committee (meets at least six-monthly). Membership of each of the committees is set out on page 3.

Clinical Governance
NMDHB has a philosophy of involving and taking advice from clinical staff in making decisions on key issues. This is achieved as outlined below:

- The Clinical Quality Improvement Council has links to the Audit and Risk Committee and quarterly to the Board via the Hospital Advisory Committee, covering clinical quality matters related mainly to the Provider Division.
- The Clinical Advisory Committee reports to the Chief Executive and provides leadership advice and direction for clinical service delivery.
- The Director of Nursing and Midwifery and the Chief Medical Adviser are members of both the above committees and the Strategic Leadership Team.
- NMDHB operates a robust credentialing process for Senior Medical Officers.
- Establishment of the Executive Leadership Team will enhance the involvement of clinical staff in decision making and strategic direction.

INTERESTS REGISTER

The Board maintains an interest register and ensures Board members are aware of their obligations to declare interests.

All relevant and required disclosures relating to Board members' interests were affected during the year, including where an interest relates to transactions of the Board that any Board member has or may have had an interest in.

NMDHB and its Board members have taken out Directors' and Officers' Liability Insurance, providing cover against particular liabilities.

There were no notices from Board members requesting to use NMDHB information, received in their capacity as Board members, which would not otherwise have been available to them.

EMPLOYEE REMUNERATION

The number of employees earning more than $100,000 is detailed in the table below. Of the 178 employees shown, 148 are or were medical, dental, nursing or allied health employees.

Total Remuneration and Other Benefits ($000s)	Employees Whose Actual Remuneration Falls in the Band
100-110	26
110-120	17
120-130	8
130-140	10
140-150	4
150-160	7
160-170	9
170-180	7
180-190	1
190-200	10
200-210	4
210-220	14
220-230	9
230-240	7
240-250	7
250-260	5
260-270	5
270-280	9
280-290	4
290-300	2
300-310	1
320-330	1
340-350	1
350-360	1
370-380	1
380-390	2
390-400	1
420-430	1
430-440	1
440-450	2
450-460	1
	178

Table Continued...

PAYMENTS IN RESPECT OF TERMINATION OF EMPLOYMENT

During the year, the Board made the following payments to former employees in respect of the termination of their employment with the organisation. These payments include amounts required to be paid pursuant to employment agreements in place, with the majority of payments being either redundancy or retirement gratuities. The total payments made by NMDHB were $1,081,111 (2008/09 - 15 payments totaling $683,172).

Number of employees: **54** | Total: **$1,081,111**

AUDITORS

The Auditor-General is appointed under Crown Entities Act 2004. Audit New Zealand is contracted to provide audit services.

The audit fees payable were $134,000 for the fiscal year 2009/10.

GOVERNANCE PHILOSOPHY

Internal Control

The Board maintains policies, systems and procedures of internal control. The effectiveness of internal control is monitored through the internal audit function which operates independently of management, reporting directly to the Audit and Risk Committee and liaising with the external auditors.

Risk Management

The Board acknowledges that it is ultimately responsible for the management of risks to the organisation. NMDHB has established a risk management programme to complement existing risk management strategies, ensuring that NMDHB is in line with the Australia/NZ Standard 4360:2004 Risk Management.

Clinical Governance

NMDHB has a philosophy of involving and taking advice from clinical staff in making decisions on key issues. The Clinical Quality Improvement Council reports to the Chief Executive and has links to the Audit and Risk Committee. The Chief Medical Advisor is also a member of the Strategic Leadership Team and has an organisation-wide responsibility for medical leadership. NMDHB operates a robust credentialing process for Senior Medical Officers.

Legislative Compliance

The Board acknowledges it is ultimately responsible to ensure the organisation complies with all relevant legislation. The Board delegated responsibility to the CE for the development and operation of a programme to systematically identify compliance issues and ensure that all staff are aware of legislative requirements relevant to them. A Corporate Quality Improvement Council was established during the year to review all non-clinical policies and procedures. It includes several representatives of the Strategic Leadership Team with links to the Audit and Risk Committee.

Ethics

The Board has a code of conduct for staff and also has policies and procedures to ensure that staff maintain high standards of ethical behaviour. Monitoring compliance with ethical standards is done through such means as monitoring complaints, customer satisfaction survey feedback, internal audit reports and performance appraisals.

Good Employer Policies

NMDHB has a number of human resource management policies in place that contribute to it being a good employer:

NMDHB is firmly committed to ensuring equality of employment opportunities for all employees regardless of gender, race, colour, religious or ethical belief, disability, marital status, family responsibilities, age, sexual orientation and ethnic origin. The principle of appointment on merit (which includes experience, skills and personal qualities as well as formal qualifications) will be upheld and staff will be selected in an open and non-discriminatory manner.

All appointments are made with the aim of recruiting the person best suited for the position and are in accordance with relevant legislation (Human Rights Act 1993, Privacy Act 1993, Employment Relations Act 2000) and the organisation's policies (Equal Employment Opportunities Policy).

NMDHB provides confidential assistance and ongoing support to staff involved in a critical incident, and provides a confidential Employee Assistance Programme available to all staff free of charge; NMDHB has a patient chaplaincy service provided in its two larger facilities, staff can and do access that service.

It is the Board's policy to have regard in disciplinary matters to the principle of both fairness to every individual employee and the effective management of the services of the organisation.

NMDHB encourages the assistance of staff to an early and safe return to meaningful and productive work following illness or injury. The Board also undertakes to provide a supportive climate in which those with chronic health conditions may maintain their work performance.

Sexual harassment and bullying will not be tolerated or condoned by NMDHB. The organisation will take disciplinary action where investigation shows a complaint of sexual harassment/bullying is justified. The organisation is working with unions and their members to revise the organisation's policy and process in relation to bullying and harassment.

NMDHB is committed to providing a healthy and safe workplace for its staff. Hazard identification and control, accident prevention and rehabilitation will be addressed as priorities. Health and safety promotion including Fitness to Work and wellness programmes, have high priority.

NMDHB has a commitment to the progressive development of its employees. The Board encourages employees to access and participate effectively in any education and development offered which is relevant to their work needs and the Board's strategic direction, supported by an in-house Learning and Development Service.

The Board is a party to and a participant in the National District Health Board's Future Workforce Strategy 2005-2010 which is guiding workforce development in the organisation and acknowledges the recent establishment of Health Workforce New Zealand and the strategic direction they will set for health workforce development in the future.

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Audit Report

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

The Auditor General is the auditor of Nelson Marlborough District Health Board (the Health Board) and group. The Auditor General has appointed me, John Mackey, using the staff and resources of Audit New Zealand, to carry out the audit on her behalf. The audit covers the financial statements and statement of service performance included in the annual report of the Health Board and group for the year ended 30 June 2010.

Unqualified Opinion

In our opinion:

- The financial statements of the Health Board and group on pages 21 to 52:
  - comply with generally accepted accounting practice in New Zealand; and
  - fairly reflect:
    - The Health Board and group's financial position as at 30 June 2010; and
    - The results of its operations and cash flows for the year ended on that date.
- The statement of service performance of the Health Board and group on pages 55 to 66:
  - complies with generally accepted accounting practice in New Zealand; and
  - fairly reflects for each class of outputs:
    - its standards of delivery performance achieved, as compared with the forecast standards included in the statement of forecast service performance at the start of the financial year; and
    - its actual revenue earned and output expenses incurred, as compared with the expected revenues and proposed output expenses included in the statement of forecast service performance at the start of the financial year.

The audit was completed on 21 September 2010, and 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 the Auditor, and explain our independence.

Basis of opinion

We carried out the audit in accordance with the Auditor General's Auditing Standards, which incorporate the New Zealand Auditing Standards.
We planned and performed the audit to obtain all the information and explanations we considered necessary in order to obtain reasonable assurance that the financial statements and statement of service performance did not have material misstatements, whether caused by fraud or error.

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

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

Audit procedures generally include:

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

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

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

Responsibilities of the Board and the Auditor

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

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

Independence

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

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

John Mackey
Audit New Zealand
On behalf of the Auditor General
Christchurch, New Zealand

STATEMENT OF RESPONSIBILITY

The Board and management of Nelson Marlborough District Health Board (NMDHB) accept responsibility for the preparation of the Annual Financial Statements and the judgements used in them.

The Board and management of NMDHB accepts 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 NMDHB the Annual Financial Statements for the twelve months ended 30 June 2010 fairly reflect the financial position and operations of NMDHB.

Suzanne Win
Chairperson
21 September 2010

Ian MacLennan
Board Member
21 September 2010

John Peters
Chief Executive
21 September 2010

Mike Cummins
Acting CFO
21 September 2010

CONSOLIDATED STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 30 JUNE 2010 (in thousands of New Zealand Dollars)

	Note	2010 Budget $000	Parent & Group 2010 Actual $000	2009 Actual $000
Revenue	**4**	372,487	375,498	365,588
Other Operating income	**5**	3,065	4,563	4,390
Finance income	**6**	3,302	1,487	3,966
TOTAL INCOME		378,854	381,548	373,944
Expenses				
Personnel Costs	**7**	142,632	141,988	140,074
Outsourced Services		11,646	11,384	15,226
Clinical Supplies		27,751	28,376	28,593
Infrastructure & Non-Clinical Expenses		20,656	20,125	22,007
Payments to non-Health Board Providers		159,202	160,409	150,850
Other Operating Expenses	**8**	2,317	3,581	2,597
Depreciation and amortisation expense	**9,10**	11,521	11,685	10,210
Finance Costs	**6**	2,669	2,352	2,560
Capital Charge	**11**	6,342	7,037	6,579
TOTAL EXPENSES		384,736	386,937	378,696
NET SURPLUS/(DEFICIT)		**(5,882)**	**(5,389)**	**(4,752)**
Other Comprehensive Income				
Revaluation of Property, Plant and Equipment	**16**	-	-	**10,768**
Total Comprehensive Income		**(5,882)**	**(5,389)**	**6,016**

Explanations of significant variances against budget are detailed in note 28.

CONSOLIDATED STATEMENT OF MOVEMENTS IN EQUITY FOR THE YEAR ENDED 30 JUNE 2010 (in thousands of New Zealand Dollars)

	Note	2010 Budget $000	Parent & Group 2010 Actual $000	2009 Actual $000
Equity at Beginning of the Year		84,769	93,113	87,603
Total Comprehensive Income for the Year		(5,882)	(5,389)	6,016
Equity Injections		-	41	41
Equity Repayments		529	547	547
TOTAL EQUITY AT THE END OF THE YEAR		**78,358**	**87,218**	**93,113**

The accompanying notes form part of and are to be read in conjunction with these financial statements

CONSOLIDATED STATEMENT OF FINANCIAL POSITION AS AT 30 JUNE 2010 (in thousands of New Zealand Dollars)

	Note	Parent & Group		
		2010	2010	2009
		Budget	Actual	Actual
		$000	$000	$000
Assets				
Non Current Assets				
Property, Plant and Equipment	**9**	153,186	153,929	138,465
Intangible Assets	**10**	-	3,072	3,302
Prepayments		-	111	96
Other Financial Assets	**12**	7	7	7
TOTAL NON CURRENT ASSETS		**153,193**	**157,119**	**141,870**
Current Assets				
Cash and Cash Equivalents	**13**	16,650	22,920	37,524
Debtors and Other Receivables	**14**	12,733	9,177	16,668
Prepayments		418	469	281
Inventories	**15**	2,378	2,016	2,318
TOTAL CURRENT ASSETS		**32,179**	**34,582**	**56,791**
TOTAL ASSETS		**185,372**	**191,701**	**198,661**
Equity				
Crown Equity	**16**	27,294	26,772	27,278
Other Reserves	**16**	33,661	44,591	44,429
Retained Earnings/(Losses)	**16**	17,403	15,855	21,406
TOTAL EQUITY		**78,358**	**87,218**	**93,113**
Non Current Liabilities				
Loans & Borrowings	**17**	42,599	37,540	26,073
Employee Entitlements	**18**	10,772	10,858	11,470
TOTAL NON CURRENT LIABILITIES		**53,371**	**48,398**	**37,543**
Current Liabilities				
Bank Overdraft	**13**	-	-	-
Loans & Borrowings	**17**	2,670	1,580	13,556
Creditors & Other Payables	**20**	24,700	25,736	27,270
Employee Entitlements	**18**	26,273	25,925	25,601
Provisions	**19**	-	2,844	1,578
TOTAL CURRENT LIABILITIES		**53,643**	**56,085**	**68,005**
TOTAL LIABILITIES		**107,014**	**104,483**	**105,548**
TOTAL EQUITY & LIABILITIES		**185,372**	**191,701**	**198,661**

For and on behalf of the Board

Suzanne Win - 21-September 2010

Ian MacLennan - 21-September-2010

The accompanying notes form part of and are to be read in conjunction with these financial statements

CONSOLIDATED STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 30 JUNE 2010 (in thousands of New Zealand Dollars)

	Note	Parent & Group		
		2010	2010	2009
		Budget	Actual	Actual
CASHFLOWS FROM OPERATING ACTIVITIES		**$000**	**$000**	**$000**
Cash was provided from:				
Receipts from Ministry of Health and patients		375,426	388,306	365,784
Interest received		3,302	1,487	3,966
		378,728	389,793	369,750
Cash was disbursed to:				
Payments to employees		141,499	141,963	135,065
Payments to suppliers		220,862	227,087	218,904
Capital Charge		6,364	6,939	7,310
Interest paid		2,669	2,292	2,557
Net GST paid/(refunded)		72	(999)	(223)
		371,466	377,282	363,613
Net cash inflow/(outflow) from operating activities	**21**	7,262	12,511	6,137
CASHFLOWS FROM INVESTING ACTIVITIES				
Cash was provided from:				
Sale of property, plant & equipment		4,085	747	78
Cash was applied to:				
Acquisition of property, plant & equipment		30,257	24,633	24,183
Acquisition of intangible assets		-	944	2,029
		30,257	25,577	26,212
Net cash inflow/(outflow) from investment activities		(26,172)	(24,830)	(26,134)
CASHFLOWS FROM FINANCING ACTIVITIES				
Cash was provided from:				
Loans Raised		-	12,000	-
Equity Injections		-	41	41
Cash was applied to:				
Equity Repaid		530	547	547
Repayments of Borrowings		-	12,000	-
Payment of Finance Lease Liabilities		1,341	1,779	1,605
Net cash inflow /(outflow) from financing activities		(1,871)	(2,285)	(2,111)
Net increase/(decrease) in cash and cash equivalents		(20,781)	(14,604)	(22,108)
Add Cash and cash equivalents at 1 July		37,431	37,524	59,632
CASH AND CASH EQUIVALENTS AS AT 30 JUNE		**16,650**	**22,920**	**37,524**

The GST component 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 statement purposes.

The accompanying notes form part of and are to be read in conjunction with these financial statements

STATEMENT OF COMMITMENTS AS AT 30 JUNE 2010 (in thousands of New Zealand Dollars)

	Parent & Group	
	2010	2009
	Actual	Actual
	$000	$000
Capital Commitments		
Property, Plant & Equipment	12,798	21,302
Intangible Assets	257	806
Total capital commitments	13,055	22,108
Non-cancellable commitments - Provider Commitments		
Not later than one year	11,379	11,480
Later than one year and not later than two years	2,216	3,114
Later than two years and not later than five years	662	1,579
Later than five years	-	-
	14,257	16,173
Non-cancellable commitments - Operating Lease Commitments		
Not later than one year	900	919
Later than one year and not later than two years	796	615
Later than two years and not later than five years	1,710	1,653
Later than five years	2,304	1,655
	5,710	4,842
Non-cancellable commitments - Finance Lease Commitments		
Not later than one year	1,792	1,805
Later than one year and not later than two years	1,212	1,367
Later than two years and not later than five years	1,545	1,912
Later than five years	-	128
	4,549	5,212
Non-cancellable commitments - Other		
Nelson Marlborough DHB has entered into non-cancellable contracts for the provision of services.		
Not later than one year	929	878
Later than one year and not later than two years	66	-
Later than two years and not later than five years	-	-
Later than five years	-	-
	995	878
TOTAL COMMITMENTS	**38,566**	**49,213**

The Provider Commitments disclosed in this note include committed obligations for health purchasing expenditure with NGOs. The Board is also obligated to funding significant streams of 'demand driven' health purchasing expenditure. Commitments of this nature are in place for the purchase of pharmacy, laboratory and GP services. Because this expenditure is 'demand driven' it is not possible to quantify the obligation in this note. Expenditure of this nature in the 2010 year totalled $103.5 million (2009: $94.1 million).

STATEMENT OF CONTINGENT ASSETS AND LIABILITIES AS AT 30 JUNE 2010 (in thousands of New Zealand Dollars)

Contingent Liabilities

A contingent liability not recognised in these financial statements is for the removal of asbestos from some of the Board's buildings. The amount of this liability cannot be reliably calculated.

Nelson Marlborough DHB has a contingent liability for the back payment of IDSS sleepover allowances. The liability cannot be accurately quantified, but is estimated to be in the range $4.7m - $7.9m.

Nelson Marlborough DHB also has two contingent liabilities for legal proceedings and disputes by third parties.

Contingent Liabilities

Nelson Marlborough DHB has no contingent assets (2009 $Nil).

NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2010 (in thousands of New Zealand Dollars)

1. REPORTING ENTITY

Nelson Marlborough District Health Board ("Nelson Marlborough DHB") is a Health Board established by the New Zealand Public Health and Disability Act 2000. Nelson Marlborough DHB is a Crown Entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand. Nelson Marlborough 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.

The Group consists of NMDHB and its subsidiary, Nelson Marlborough Hospitals Charitable Trust.

Nelson Marlborough DHB's activities involve the delivery of health and disability services and mental health services in a variety of ways to the community. Therefore, Nelson Marlborough DHB has designated itself and its subsidiaries as public benefit entities, for the purposes of the New Zealand equivalents to International Financial Reporting Standards (NZ IFRS).

The financial statements of Nelson Marlborough DHB and group are for the year ended 30 June 2010. The financial statements were approved by the Board on 21 September 2010.

2. BASIS OF PREPARATION

(a) Statement of Compliance

The consolidated financial statements have been prepared in accordance with the requirements of the Crown Entities Act 2004, which includes the requirement to comply with Generally Accepted Accounting Practice in New Zealand (NZ GAAP). They comply with New Zealand equivalents to International Financial Reporting Standards (NZ IFRS), and other applicable Financial Reporting Standards, as appropriate for public benefit entities.

(b) Measurement Base

The financial statements are prepared on the historical cost basis modified by the revaluation of certain assets and liabilities as identified in the statement of accounting policies.

(c) Functional and presentation currency

The financial statements are presented in New Zealand Dollars (NZD), rounded to the nearest thousand. The functional currency of Nelson Marlborough DHB is New Zealand dollars.

(d) Management Judgements, Estimates & Assumptions

The preparation of financial statements in conformity with NZ IFRS 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 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.

Judgements made by management in the application of NZ IFRS that have a significant effect on the financial statements and estimates with a significant risk of material adjustment in the next year are discussed in note 27.

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

Certain new standards, amendments and interpretations to existing standards have been published that are not effective for the year ended 30 June 2010 and have not been applied in preparing these financial statements. The following standards, amendments and interpretations which are relevant to Nelson Marlborough DHB are:

- NZ IFRS 9
  NZ IFRS 9 Financial Instruments will eventually replace NZ IAS 39 Financial Instruments: Recognition and Measurement. NZIAS 39 is being replaced in three main phases. The first phase 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 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. Nelson Marlborough DHB has not yet assessed the effect of the new standard and does not expect to early adopt it.

- NZ IAS 24
  NZ IAS 24 Related Party Disclosures (Revised 2009) replaces NZ IAS 24 Related Party Disclosures (Issued 2004) and is effective for reporting periods beginning on or after 1 January 2011. The revised standard simplifies the definition of a related party, clarifying its intended meaning and eliminating inconsistencies from the definition. Nelson Marlborough DHB intends to adopt this standard for the year ended 30 June 2012 and has not yet assessed the impact of this standard.

(f) Changes in Accounting Policies
There have been no changes in accounting policies during the financial year.

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

- NZ IAS 1
  NZ IAS 1 Presentation of Financial Statements (Revised 2007) replaces NZ IAS 1 Presentation of Financial Statements (Issued 2004). The revised standard requires information in financial statements to be aggregated on the basis of shared characteristics and introduces a statement of comprehensive income. The statement of comprehensive income will enable readers to analyse changes in equity resulting from non-owner changes separately from transactions with owners. Nelson Marlborough DHB has decided to prepare a single statement of comprehensive income for the year ended 30 June 2010 under the revised standard. Financial statement information for the year ended 30 June 2009 has been restated accordingly. Items of other comprehensive income presented in the statement of comprehensive income were previously recognised directly in the statement of changes in equity.

3. ACCOUNTING POLICIES

Basis of Consolidation

Subsidiaries
Subsidiaries are those entities controlled by Nelson Marlborough DHB. Control exists when Nelson Marlborough DHB has the power, directly or indirectly, to govern the financial and operating policies of an entity so as to obtain benefits from its activities. Nelson Marlborough Hospitals Charitable Trust is a subsidiary of Nelson Marlborough DHB. The financial results of the Trust are not material and have not been consolidated. Therefore, the financial results disclosed for both the parent and group are the same. Information relating to the Trust is separately disclosed in the notes to the financial statements.

Budget Figures
The budget figures were approved by the Board at the beginning of the year in its District Annual Plan and included in the Statement of Intent tabled in parliament. The budget figures have been prepared in accordance with NZ GAAP. They comply with NZ IFRS and other applicable Financial Reporting Standards as appropriate for public benefit entities. Those standards are consistent with the accounting policies adopted by Nelson Marlborough DHB for the preparation of the financial statements.

Borrowing Costs
Nelson Marlborough DHB has elected to defer the adoption of NZ IAS 23 Borrowing Costs (Revised 2007) in accordance with its transitional provisions that are applicable to public benefit entities. Consequently, all Borrowing costs are recognised as an expense in the period in which they are incurred.

Capital Charge
The capital charge is recognised as an expense in the period to which the charge relates.

Cash and Cash Equivalents
Cash and cash equivalents means cash on hand, call deposits held with banks, short term deposits that have maturities of three months or less, and bank overdrafts.

Creditors and other payables
Creditors and other payables are initially measured at fair value and subsequently measured at amortised cost using the effective interest method. Payables of short duration are not discounted.

Debtors and other receivables
Debtors and other receivables are initially measured at fair value and subsequently measured at amortised cost using the effective interest method, less any provision for impairment. Receivables of short duration are not discounted. Impairment of a receivable is established when there is objective evidence that Nelson Marlborough DHB will not be able to collect amounts due according to the original terms of the receivable. Significant financial difficulties of the debtor, probability that the debtor will enter into bankruptcy, and default in payments are considered indicators that the debtor is impaired. The amount of the impairment is the difference between the asset's carrying amount and the estimated recoverable amount. The carrying amount of the asset is reduced through the use of an allowance account, and the amount of the loss is recognised in the surplus or deficit. When the receivable is uncollectable, it is written off and the allowance reversed.

Employee Entitlements

(a) Defined Contribution Plans
Obligations for contributions to defined contribution pension plans, such as Kiwisaver and the State Sector Retirement Savings Scheme, are recognised as an expense in the surplus or deficit when they are incurred.

(b) Defined Benefit Plans
NMDHB does not make contributions to defined benefit pension plans.

(c) Long Service Leave, Sabbatical Leave, Sick Leave, and Retirement Gratuities
NMDHB's net obligation in respect of long service leave, sabbatical leave, sick leave and retirement leave is the amount of future benefit that employees have earned in return for their service in the current and prior periods. The obligation is valued on an actuarial basis. Those entitlements expected to be settled within 12 months of balance date are classified as a current liability. Where settlement is expected more than 12 months after balance date, the entitlements are classified as non-current liabilities.

(d) Annual Leave, Conference Leave and Medical Education leave
Annual leave, conference and medical education leave are short-term obligations and are calculated on an actual entitlement basis at current rates of pay.

NMDHB accrues the obligation for paid absences when the obligation both relates to employees' past services and it accumulates.

Financial Instruments

Non-derivative financial instruments

Non-derivative financial instruments comprise investments in equity securities, debtors and other receivables, cash and cash equivalents, loans and borrowings, and creditors and other payables.

(a) Recognition

A financial instrument is recognised if Nelson Marlborough DHB becomes a party to the contractual provisions of the instrument. Non-derivative financial instruments are initially recognised at fair value plus transaction costs unless they are carried at fair value through other comprehensive income in which case the transaction costs are recognised in the surplus or deficit. Subsequent to initial recognition, non-derivative financial instruments are measured as described below.

Purchases and sales of financial assets are recognised on trade-date, the date on which Nelson Marlborough DHB commits to purchase or sell the asset. Financial assets are derecognised when Nelson Marlborough DHB's rights to receive cash flows from the financial assets have expired or if the DHB transfers the financial asset to another party without retaining control or substantially all risks and rewards of ownership. Financial liabilities are derecognised if Nelson Marlborough DHB's obligations specified in the contract expire or are discharged.

Cash and cash equivalents comprise cash balances, call deposits, and other deposits with original maturities of no more than three months. Bank overdrafts that are repayable on demand and form an integral part of Nelson Marlborough DHB's cash management are included as a component of cash and cash equivalents for the purpose of the Statement of Cash Flows.

Nelson Marlborough DHB classifies its financial assets into the following categories: Fair Value through other comprehensive income, loans and receivables, fair value through profit and loss, and amortised cost.

(b) Measurement

Fair Value through other comprehensive income

Nelson Marlborough DHB's investments in equity securities are classified as fair value through other comprehensive income. Subsequent to initial recognition, they are measured at fair value and changes therein, other than impairment losses, and foreign exchange gains and losses are recognised in other comprehensive income. When an investment is derecognised, the cumulative gain or loss in equity is transferred to surplus or deficit.

The fair value of financial instruments traded in active markets is based on quoted market prices at balance date. The quoted market price used is the current bid price.

Nelson Marlborough DHB classifies its investment in equity securities as fair value through other comprehensive income. However, the shares have been recorded at cost as they do not have a quoted price in an active market and their fair value cannot be reliably measured.

Loans and Receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. They are included in current assets, except for maturities greater than 12 months after balance date, which are included in non-current assets. After initial recognition they are measured at amortised cost using the effective interest method less impairment. Receivables of short duration are not discounted. Gains and losses when the asset is impaired or derecognised are recognised in the surplus or deficit.

Nelson Marlborough DHB classifies debtors and other receivables, and cash and cash equivalents as Loans and Receivables.

Instruments at fair value through surplus or deficit

An instrument is classified at fair value through surplus or deficit if it is held for trading or is designated as such upon initial recognition. Nelson Marlborough DHB does not have any financial instruments classified at fair value through other comprehensive income.

Other Financial Instruments

Financial instruments that are not classified as fair value through other comprehensive income, or fair value through surplus or deficit are measured at amortised cost using the effective interest method, less any impairment losses.

Nelson Marlborough DHB classifies creditors and other payables, finance leases, and secured loans as Other Financial Instruments.

Derivative financial instruments

Nelson Marlborough DHB does not have any derivative financial instruments.

Goods and Services Tax

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

The net amount of GST recoverable from, or payable to, the Inland Revenue Department (IRD) is included as part of receivables or payables in the Statement of Financial Position.

The net GST paid to, or received from the IRD, including the GST relating to investing and financing activities, is classified as an operating cash flow in the Statement of Cash Flows.

Commitments and contingencies are disclosed exclusive of GST.

Impairment

(a) Recognition

NMDHB considers at each balance date whether there is any indication that its assets other than investment property, inventories and inventories held for distribution may be impaired. If any such indication exists, the asset's recoverable amount is estimated. Given that the future economic benefits of the DHB's assets are not directly related to the ability to generate net cash flows, the value in use of these assets is measured on the basis of depreciated replacement cost.

If an asset's carrying amount exceeds its recoverable amount, the asset is impaired and the carrying amount is written down to the recoverable amount. For revalued assets the impairment loss is recognised against the revaluation reserve for that class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised in the surplus or deficit. For assets not carried at a revalued amount, the total impairment loss is recognised in the surplus or deficit.

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 date and was estimated at the date of transition.

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

Impairment losses on an individual basis are determined by an evaluation of the exposures on an instrument by instrument basis. All individual trade receivables that are considered significant are subject to this approach. For trade receivables which are not significant on an individual basis, collective impairment is assessed on a portfolio basis based on number of days overdue, and taking into account the historical loss experience.

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.

(b) 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.

The estimated recoverable amount of other assets is the greater of their fair value less costs to sell and value in use. Given that the future economic benefits of the DHB's assets are not directly related to the ability to generate net cash flows, the value in use of these assets is measured on the basis of depreciated replacement cost.

(c) Reversals of Impairment
Impairment losses are reversed when there is a change in the estimates used to determine the recoverable amount.

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.

An impairment loss on an equity instrument investment classified as fair value through other comprehensive income 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.

The reversal of an impairment loss on a revalued asset is credited to the revaluation reserve. However, to the extent that an impairment loss for that class of asset was previously recognised in the surplus or deficit, a reversal of the impairment loss is also recognised in the surplus or deficit. For assets not carried at a revalued amount the reversal of an impairment loss is recognised in the surplus or deficit.

Income Tax
Nelson Marlborough DHB is a Crown Entity under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under section CW38 of the Income Tax Act 2007. Accordingly, no charge of income tax has been provided for.

Intangible Assets
(a) Software acquisition and development
Computer software licenses acquired by Nelson Marlborough DHB are capitalised on the basis of the costs incurred to acquire and bring to use the specific software.

Costs that are directly associated with the development of software for internal use by Nelson Marlborough DHB are recognised as an intangible asset. Direct costs include the software development, employee costs and an appropriate portion of relevant overheads.

Staff training costs are recognised as an expense when incurred.

Costs associated with maintaining computer software are recognised as an expense when incurred.

Costs associated with the development and maintenance of Nelson Marlborough DHB's website are recognised as an expense when incurred.

(b) Amortisation
Amortisation is recognised in the surplus or deficit 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	Amortisation Rate
Software	3 - 10 years	10 - 34 %

Inventories held for distribution
Inventories classified as held for distribution are stated at cost (calculated using the weighted average cost method) adjusted, where applicable, for any loss of service potential. Where inventories are acquired at no cost or for nominal consideration, the cost is the current replacement cost at the date of acquisition.

Any write-down from cost to current replacement cost is recognised in the surplus or deficit in the period when the write-down occurs.

Investments
At each balance date, NMDHB assesses whether there is any objective evidence that an investment is impaired.

Leases

(a) Finance Leases

Leases which effectively transfer to Nelson Marlborough DHB substantially all the risks and benefits incident to ownership of the leased asset are classified as finance leases. At the commencement of the lease, Nelson Marlborough DHB recognises finance leases as assets and liabilities in the Statement of Financial Position at the lower of the fair value of the leased asset or the present value of the minimum lease payments.

The finance charge is charged to the surplus or deficit over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability.

The amount recognised as an asset is depreciated over the shorter of its useful life and the lease term.

(b) Operating Leases

Leases where the lessor effectively retains substantially all the risks and benefits of ownership of the leased items are classified as operating leases. Payments under these leases are recognised as expenses in the periods in which they are incurred.

Loans and borrowings

Loans and borrowings are recognised initially at fair value less attributable transactions costs. Subsequent to initial recognition, loans and 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.

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.

NMDHB does not have any non-current assets that meet the definition of held for sale.

Property, Plant and Equipment

(a) Classes of property, plant and equipment

The major classes of property, plant and equipment are as follows:
- Freehold Land
- Freehold Buildings
- Plant and Equipment
- Motor Vehicles
- Work in Progress

(b) Recognition and Measurement

Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets of Nelson Marlborough Health Services Limited (a Hospital and Health Service) vested in Nelson Marlborough District Health Board on 1 January 2001. Accordingly, assets were transferred to Nelson Marlborough DHB and their net book values recorded in the books of the Hospital and Health Service. In effecting this transfer, the health board has recognised the cost and accumulated depreciation amounts from the records of the Hospital and Health Service. The vested assets have since been revalued and are depreciated over their remaining useful lives.

Except for land and buildings and the assets vested from the Hospital and Health Service (see above), items of property, plant and equipment are stated at cost, less accumulated depreciation and impairment losses.

Cost includes expenditures that are directly attributable to the acquisition of the asset. The cost of self-constructed assets includes the cost of materials and direct labour, any other costs directly attributable to bringing the asset to a working condition for its intended use, and the costs of dismantling and removing the items and restoring the site on which they are located. Purchased software that is integral to the functionality of the related equipment is capitalised as part of that equipment.

Where an asset is acquired at no cost, or for a nominal cost, it is recognised at fair value when control over the asset is obtained.

When parts of an item of property, plant and equipment have different useful lives, they are accounted for as separate items (major components) of property, plant and equipment.

(c) 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 Nelson Marlborough DHB and the cost of the item can be reliably measured. All other costs are recognised in the surplus or deficit as an expense as incurred.

(d) Revaluation of land and buildings

Land and buildings are revalued every three years to fair value as determined by an independent registered valuer by reference to the highest and best use. Assets for which no open market evidence exists are revalued on an Optimised Depreciated Replacement Cost basis.

Additions between revaluations are recorded at cost.

The results of revaluing land and buildings are credited or debited to an asset revaluation reserve for that class of asset and other comprehensive income. Where a revaluation results in a debit balance in the asset revaluation reserve, the debit balance will be expensed in the surplus or deficit. Any decreases in value relating to a class of land and buidlings are debited directly to other comprehensive income and the revaluation reserve, to the extent that they reverse previous surpluses and are otherwise recognised as an expense in the surplus or deficit.

The carrying values of revalued assets are reviewed annually to ensure that those values are not materially different to fair value.

(e) Depreciation

Depreciation is provided on a straight-line basis on all Property, Plant and Equipment other than freehold land, at rates which will write off the cost (or valuation) of the assets to their estimated residual values over their useful lives.

The estimated useful lives of major classes of assets and resulting rates are as follows:

Type of Asset	Estimated Life	Depreciation Rate
Buildings and Building Fitout	10 to 76 years	1.3 - 10%
Plant and equipment	2 to 20 years	5 - 50%
Motor vehicles	5 to 16 years	6.25 - 20%
Leased Assets	2 to 7.25 years	13.79- 50%

The residual values and useful lives of property, plant and equipment are reassessed annually at financial year end.

(f) Capital Work in Progress
Capital work in progress is not depreciated. The total cost of a project is transferred to buildings, building fitout and/or plant and equipment on its completion and then depreciated.

(g) Leased Assets
Leases where Nelson Marlborough DHB assumes substantially all the risks and rewards of ownership are classified as finance leases. The assets acquired by way of finance lease are stated at an amount equal to the lower of their fair value or the present value of minimum lease payments.

(h) Disposal of Property, Plant and Equipment
When Property, Plant and Equipment is disposed of, any gain or loss is recognised in the surplus or deficit and is calculated as the difference between the net sale price and the carrying value of the asset.

When revalued assets are sold, the amounts included in revaluation reserves in respect of those assets are transferred to general funds.

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

Provisions are measured at the present value of the expenditures expected to be required to settle the obligation. Provisions are not discounted if the effect of the time value of money is not material.

(a) Restructuring
A provision for restructuring is recognised when Nelson Marlborough DHB 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.

(b) ACC Partnership Programme
Nelson Marlborough DHB belongs to the ACC Partnership Programme under which it accepts the management and financial responsibility for employee work-related illnesses and accidents. Under the programme, Nelson Marlborough DHB is liable for all its claims costs for a period of four years up to a specified maximum. At the end of the four year period, Nelson Marlborough DHB pays a premium to ACC for the value of residual claims, and from that point the liability for ongoing claims passes to ACC.

The liability for the ACC Partnership Programme is measured using actuarial techniques at the present value of expected future payments to be made in respect of the employee injuries and claims up to balance date. Consideration is given to anticipated future wage and salary levels and experience of employee claims and injuries.

Expected future payments are discounted at a rate that approximates the average gross yield on Government Bonds of short to medium term durations consistent with the duration of the liabilities.

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

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

(b) Goods Sold
Revenue from goods sold is recognised when Nelson Marlborough DHB has transferred to the buyer the significant risks and rewards of ownership of the goods and Nelson Marlborough DHB does not retain either continuing managerial involvement to the degree usually associated with ownership or effective control over the goods sold.

(c) Provision of Services
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 Nelson Marlborough DHB and that payment can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied by Nelson Marlborough DHB.

(d) Interest Income
Interest income is recognised using the effective interest method.

(e) Donated Assets
Where a physical asset is gifted to or acquired by Nelson Marlborough DHB for nil or nominal cost, the fair value of the asset received is recognised as income. Such assets are recognised as income when control over the asset is obtained.

Trust and Bequest Funds
Donations and bequests are made for specific purposes. The use of these funds must comply with the specific terms of the sources from which the funds were derived.

All donations and bequests are assigned to and managed by the Nelson Marlborough Hospitals Charitable Trust (NMHCT) which has an independent Board of Trustees. The funds are held separately by NMHCT and not included in NMDHB's Statement of Financial Position. The revenue and expenditure in respect of these funds are also excluded from NMDHB 's surplus or deficit.

Donations and bequest to the Nelson Marlborough DHB from the NMHCT are recognised as income when received, or entitlement to receive money is established. Expenditure subsequently incurred in respect of these funds is recognised as an expense in the surplus or deficit.

4. REVENUE

	Parent & Group	
	2010	2009
	Actual	Actual
	$000	$000
Health and Disability Services (MOH contracted revenue)	360,269	350,156
Inter District Patient Flows	6,595	6,211
ACC	3,447	3,992
Patient/Consumer Sourced Revenue	4,079	3,586
Other Government and DHB's	1,108	1,643
	375,498	**365,588**

Nelson Marlborough DHB has been provided with funding from the Crown for specific purposes of the DHB as set out in its founding legislation and the scope of the relevant government appropriations. Apart from these general restrictions, there are no unfulfilled conditions or contingencies attached to government funding (2009: $Nil).

5. OTHER OPERATING INCOME

	Parent & Group	
	2010	2009
	Actual	Actual
	$000	$000
Donations and bequests received	198	78
Rental income	920	836
Gain on Disposal of Property, Plant & Equipment	38	29
Other income	3,407	3,447
	4,563	**4,390**

During the period, Nelson Marlborough DHB disposed of four motor vehicles for a net gain of $15,000 (2009: one motor vehicle for $3,000). Surplus items of equipment were disposed of for a net gain of $23,000 (2009: $26,000).

6. FINANCE INCOME & COSTS

	Parent & Group	
	2010	2009
	Actual	Actual
	$000	$000
Interest income	1,487	3,966
Finance Income	**1,487**	**3,966**
Interest on finance lease	286	319
Interest on loans	2,053	2,241
Insert on overdraft	13	-
Finance costs	**2,352**	**2,560**

7. PERSONNEL COSTS

	Parent & Group	
	2010	**2009**
	Actual	**Actual**
	$000	**$000**
Wages and salaries	132,611	126,980
Contributions to defined contribution plans	2,718	2,229
Other personnel costs	6,659	10,865
	141,988	**140,074**

8. OTHER OPERATING EXPENSES

		Parent & Group	
	Note	**2010**	**2009**
		Actual	**Actual**
		$000	**$000**
Audit fees - Annual Audit		130	140
Audit fees - Other Services		4	-
Donations made		-	-
Koha		-	1
Impairment loss on property, plant and equipment	**9, 10**	-	130
Impairment of receivables (bad and doubtful debts)		1	315
Loss on disposal of property, plant and equipment		17	49
Rental and operating lease costs		1,555	1,683
Restructuring expenses		1,874	279
		3,581	**2,597**

During the year, Nelson Marlborough DHB disposed of property, plant and equipment at a net loss of $17,000 (2009: $49,000). The Board disposed of 4 motor vehicles at a net loss of $9,000 (2009: 3 motor vehicles at a net loss of $24,000). Clinical equipment was disposed of at a net loss of $7,000 (2009: $17,000) and other non-clinical equipment at a net loss of $1,000 (2009: $4,000). No IT hardware was disposed of at a loss (2009: $3,000). No loss on disposal of buildings was incurred ($2009: $1,000).

During the year, Nelson Marlborough Hospitals Charitable Trust paid audit fees of $3,949 (2009: $3,111).

9. PROPERTY, PLANT & EQUIPMENT

	Parent & Group						
Cost or Valuation	**Land**	**Buildings**	**Plant & Equipment**	**Motor Vehicles**	**Leased Assets**	**Work in Progress**	**Total**
	$000	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**
Balance at 1 July 08 - at Valuation	11,532	84,213	-	-	-	-	95,745
Balance at 1 July 08 - at Cost	30	5,242	31,827	3,929	7,488	2,520	51,036
Additions	-	16,322	5,871	513	787	1,736	25,229
Revaluations	2,881	(1,577)	-	-	-	-	1,304
Disposals	-	-	(1,237)	(97)	(96)	-	(1,430)
Balance at 30 June 09 - at Valuation	14,443	89,108	-	-	-	-	103,551
Balance at 30 June 09 - at Cost	-	15,092	36,461	4,345	8,179	4,256	68,333
Balance at 1 July 09 - at Valuation	14,443	89,108	-	-	-	-	103,551
Balance at 1 July 09 - at Cost	-	15,092	36,461	4,345	8,179	4,256	68,333
Additions	-	14,169	3,318	290	1,349	7,692	26,818
Revaluations	-	-	-	-	-	-	-
Disposals	-	(174)	(1,202)	(171)	(97)	-	(1,644)
Balance at 30 June 10 - at Valuation	14,443	89,108	-	-	-	-	103,551
Balance at 30 June 10 - at Cost	-	29,087	38,577	4,464	9,431	11,948	93,507
Accumulated Depreciation & Impairment Losses							
Balance at 1 July 08	-	9,175	21,899	1,180	2,352	-	34,606
Depreciation for the year	-	4,285	2,878	604	1,713	-	9,480
Impairment Loss	-	-	130	-	-	-	130
Disposals	-	-	(1,215)	(23)	(95)	-	(1,333)
Revaluations	-	(9,464)	-	-	-	-	(9,464)
Balance at 30 June 09	-	3,996	23,692	1,761	3,970	-	33,419
Balance at 1 July 09	-	3,996	23,692	1,761	3,970	-	33,419
Depreciation for the year	-	5,257	2,971	676	1,790	-	10,694
Impairment Loss	-	-	-	-	-	-	-
Disposals	-	(173)	(606)	(108)	(97)	-	(984)
Revaluations	-	-	-	-	-	-	-
Balance at 30 June 10	-	9,080	26,057	2,329	5,663	-	43,129
Carrying Amounts							
At 1 July 08	11,562	80,280	9,928	2,749	5,136	2,520	112,175
At 30 June 09	14,443	100,204	12,769	2,584	4,209	4,256	138,465
At 1 July 09	14,443	100,204	12,769	2,584	4,209	4,256	138,465
At 30 June 10	14,443	109,115	12,520	2,135	3,768	11,948	153,929

Impairment

No impairment losses have been recognised for 2010 (2009: $130,000).

Revaluation

The revaluation of land and buildings was carried out as at 30 June 2009 by M Lauchlan, a registered valuer with Duke & Cooke Limited. An optimised depreciated replacement cost methodology has been used. The revaluation excluded buildings at Wairau which are recorded at their 2006 revaluation less subsequent depreciation for existing buildings or at cost for additions since the June 2006 revaluation as the redevelopment is still to be completed. The next valuation will be completed by 30 June 2012, or earlier, if the estimated fair value is materially different from the carrying value.

All other items of property, plant and equipment are recorded on a historical cost basis. The carrying amount of property, plant and equipment is not materially different to its fair value.

Restrictions

Nelson Marlborough DHB does not have full title to Crown land it occupies but transfer is arranged if and when land is sold. Some of the land is subject to Waitangi Tribunal claims. The disposal of certain properties may be subject to the provisions of section 40 of the Public Works Act 1981. Titles to land transferred from the Crown to Nelson Marlborough DHB are subject to a memorial in terms of the Treaty of Waitangi Act 1975 (as amended by the Treaty of Waitangi (State Enterprises) Act 1998). The effect on the value of assets resulting from potential claims under the Treaty of Waitangi Act 1975 cannot be quantified.

Leased Assets

Nelson Marlborough DHB leases clinical and IT equipment under a number of finance lease agreements. At 30 June 2010, the net carrying amount of leased IT and clinical equipment was $3,768,000 (2009: $4,209,000).

10. INTANGIBLE ASSETS

(a) Software

	Parent & Group			
	Owned	**Leased**	**Work in Progress**	**Total**
	$000	**$000**	**$000**	**$000**
Balance at 1 July 08	3,169	146	282	3,597
Additions	1,262	154	796	2,212
Disposals	-	-	-	-
Balance at 30 June 09 - at Cost	4,431	300	1,078	5,809
Balance at 1 July 09 - at Cost	4,431	300	1,078	5,809
Additions	1,474	16	(729)	761
Disposals	-	-	-	-
Balance at 30 June 10 - at Cost	5,905	316	349	6,570
Accumulated Amortisation & Impairment Losses				
Balance at 1 July 08	1,755	22	-	1,777
Amortisation for the year	652	78	-	730
Impairment Loss	-	-	-	-
Disposals	-	-	-	-
Balance at 30 June 09	2,407	100	-	2,507
Balance at 1 July 09	2,407	100	-	2,507
Amortisation for the year	886	105	-	991
Impairment Loss	-	-	-	-
Disposals	-	-	-	-
Balance at 30 June 10	3,293	205	-	3,498
Carrying Amounts				
At 1 July 08	1,414	124	282	1,820
At 30 June 09	2,024	200	1,078	3,302
At 1 July 09	2,024	200	1,078	3,302
At 30 June 10	2,612	111	349	3,072

Impairment

No impairment losses have been recognised (2009: $Nil).

Leased Intangibles

Nelson Marlborough DHB leases IT software under a number of finance lease agreements. At 30 June 2010, the net carrying amount of leased intangibles was $111,000 (2009: $200,000).

11. CAPITAL CHARGE

Nelson Marlborough DHB pays a monthly Capital Charge to the Crown based on the greater of its actual or budgeted closing equity balance for the month.

The capital charge rate for the year ended 30 June 2010 was 8% (2009: 8%).

12. OTHER FINANCIAL ASSETS

	Parent & Group	
	2010	2009
	Actual	Actual
	$000	$000
Shares in South Island Shared Services Agency Limited	**7**	**7**

Nelson Marlborough District Health Board owns shares in the South Island Shared Services Agency Limited (SISSAL). SISSAL is an agency set up by all South Island DHBs to provide shared support services.

The shares have been recorded at cost as they do not have a quoted price in an active market and their fair value cannot be reliably measured.

The Board has no intention of disposing of its investment.

There are no impairment provisions for other financial assets (2009: $Nil).

13. CASH & CASH EQUIVALENTS

	Parent & Group	
	2010	2009
	Actual	Actual
	$000	$000
Bank Balances & cash on hand	190	352
Call Deposits	8,683	7,092
Term Deposits with original maturities less than 3 months	14,047	30,080
Bank Overdraft	-	-
Cash and cash equivalents in the Statement of Cash Flows	**22,920**	**37,524**

The carrying value of bank balances and cash on hand, call deposits, and term deposits with maturities less than three months approximate their fair value.

At 30 June 2010, the interest rate on Nelson Marlborough DHB's call deposits was 3.4% (2009: 2.50%).
Interest rates on term deposits ranged from 3.82% to 4.79% (2009: 3.60% to 4.60%).

Nelson Marlborough DHB has a bank overdraft facility with Westpac Banking Corporation Limited. The overdraft facility has a limit of $8,000,000.
The facility was unused at 30 June 2010.

The bank overdraft is secured by a negative pledge. Without Westpac's prior written consent, Nelson Marlborough DHB cannot perform the following actions:
- create any security over its assets except in certain circumstances,
- lend money to another person or entity (except in the ordinary course of business and then only on commercial terms) or give a guarantee,
- make a substantial change in the nature or scope of its business as presently conducted or undertake any business or activity unrelated to health; and
- dispose of any assets except disposals at full value in the ordinary course of business.

Nelson Marlborough DHB must also meet a cash flow cover covenant, under which earnings will be not less than two times interest and financing costs.

The current interest rate on Nelson Marlborough DHB's bank overdraft is 8.75% per annum. (2009: 8.75%)

14. DEBTORS AND OTHER RECEIVABLES

	Parent & Group	
	2010	2009
	Actual	Actual
	$000	$000
Trade receivables due from non-related parties	1,352	1,774
Ministry of Health receivables	3,500	3,585
Gross trade receivables	4,852	5,359
Less Provision for impairment	(348)	(626)
Net trade receivables	4,504	4,733
Accrued Income	4,581	11,909
Other Receivables	92	26
Total debtors and other receivables	**9,177**	**16,668**

Fair Value

Trade and other receivables are non-interest bearing and receipt is normally on 30-day terms, therefore the carrying value of trade and other receivables approximates their fair value.

Impairment

As at 30 June 2010 and 2009, all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below:

	Parent & Group			
	Gross Receivable	Impairment	Gross Receivable	Impairment
Trade Receivables	**2010**	**2010**	**2009**	**2009**
Current	3,956	(10)	2,826	(16)
31-60 days	179	(4)	1,975	(6)
61-90 days	77	(4)	205	(1)
Over 90 days	640	(330)	353	(603)
Total	**4,852**	**(348)**	**5,359**	**(626)**

The impairment provision has been calculated based on expected losses. Expected losses are determined by specific review of Ministry of Health receivables, and based on an analysis of NMDHB's losses during previous periods for other trade receivables.

In summary, trade receivables are determined to be impaired as follows:

	Parent & Group	
	2010	2009
	Actual	Actual
Gross trade receivables	4,852	5,359
Individual impairment	-	-
Collective impairment	(348)	(626)
Net trade receivables	**4,504**	**4,733**

Movements in the provision for impairment of receivables are as follows:	Parent & Group	
	2010	2009
	Actual	Actual
Provision for impairment at 1 July	626	402
Additional provisions made during the year	228	224
Provisions used during the year	(278)	-
Provisions reversed during the period	(228)	-
Provision for impairment at 30 June	**348**	**626**

Nelson Marlborough DHB does not hold any collateral as security or other credit enhancements over receivables that are either past due or impaired.

15. INVENTORIES

	Parent & Group	
	2010	**2009**
	Actual	**Actual**
	$000	**$000**
Inventories held for distribution		
- Pharmaceuticals	254	292
- Surgical and medical supplies	1,762	2,026
	2,016	**2,318**

In 2010, the value of inventories distributed and recognised as an expense in the surplus or deficit was $15.6 million (2009 $13.9 million).

The carrying amount of inventories held for distribution carried at current replacement cost at 30 June 2010 is $Nil (2009 $Nil). The write-down of inventories held for distribution amounted to $Nil for 2010 (2009 $Nil). There have been no reversals of write-downs (2009: $Nil).

No inventories are pledged as security for liabilities nor are any inventories subject to retention of title clauses.

16. CAPITAL AND RESERVES

	Parent & Group	
	2010	**2009**
	Actual	**Actual**
	$000	**$000**
(a) Crown Equity		
Balance at 1 July	27,278	27,784
Equity Injections	41	41
Equity Repayments	(547)	(547)
Balance at 30 June	**26,772**	**27,278**
(b) Retained Earnings		
Balance at 1 July	21,406	26,158
Net (deficit)/surplus	(5,389)	(4,752)
Transfer from property, plant and equipment revaluation reserve on disposal	(162)	-
Retained Earnings at 30 June	**15,855**	**21,406**
(c) Revaluation Reserve		
Opening Balance at 1 July	44,429	33,661
Revaluations	-	10,768
Transfer to Retained Earnings on disposal	162	-
Balance at 30 June	**44,591**	**44,429**
Total Equity at 30 June	**87,218**	**93,113**

Revaluation Reserve

The revaluation reserve relates to the revaluation of land and buildings.

17. LOANS & BORROWINGS

	Parent & Group	
	2010	2009
	Actual	Actual
	$000	$000
Non-current		
Secured loans	35,000	23,000
Finance lease liabilities	2,540	3,073
	37,540	**26,073**
Current		
Current portion of secured loans	-	12,000
Current portion of finance lease liabilities	1,580	1,556
	1,580	**13,556**

(a) Secured loans

Nelson Marlborough District Health Board has three secured loans with the Crown Health Financing Agency. The terms and conditions are as follows:

	Parent & Group	
Interest rate summary	2010	2009
	Actual	Actual
Crown Health Financing Agency	4.2% - 6.535%	6.28% - 6.535%

The interest rates on the three loans are fixed.

	Parent & Group	
Loans are repayable as follows	2010	2009
	Actual	Actual
	$000	$000
Within next 12 months	-	12,000
One to two years	12,000	-
Two to five years	8,000	-
Beyond five years	15,000	23,000
	35,000	**35,000**

	Parent & Group	
Term Loan Facility Limits	2010	2009
	Actual	Actual
	$000	$000
Crown Health Financing Agency	55,500	43,000

Security and terms

The loan facility is provided by the Crown Health Financing Agency, which is part of the Treasury. The Crown Health Financing Agency term liabilities are secured by a negative pledge. Without the Crown Health Financing Agency's prior written consent Nelson Marlborough DHB cannot perform the following actions:

a) Create any security interest over its assets except in certain defined circumstances; or

b) Lend money to another person or entity (except in the ordinary course of business and then only on commercial terms) or give a guarantee; or

c) Make a substantial change in the nature or scope of its business as presently conducted or undertake any business or activity unrelated to health; or

d) Dispose of any of its assets except at full value in the ordinary course of business.

Nelson Marlborough DHB must also meet the following covenants:

a) Interest Cover: Earnings before interest and depreciation must not be less than three times interest and financing costs.

b) Debt to Debt Plus Equity: Interest bearing debt is less than 65 per cent of the total of interest bearing debt plus equity.

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

Term loans are not guaranteed by the Government of New Zealand.

(b) Finance Lease Liabilities

Finance Leases are repayable as follows:

	Parent & Group					
	Minimum lease payments	**Interest**	**Principal**	**Minimum lease payments**	**Interest**	**Principal**
	2010	**2010**	**2010**	**2009**	**2009**	**2009**
	$000	**$000**	**$000**	**$000**	**$000**	**$000**
Within next 12 months	1,792	212	1,580	1,805	249	1,556
One to two years	1,212	127	1,085	1,367	158	1,209
Two to five years	1,546	91	1,455	1,912	174	1,738
Beyond five years	-	-	-	128	2	126
	4,550	430	4,120	5,212	583	4,629

Description of Material Leasing Arrangements

Nelson Marlborough DHB has entered into finance leases primarily for IT equipment, and for certain items of clinical equipment. The net carrying amount of the leased items within each class of property, plant and equipment, and intangible assets is shown in notes 9 and 10.

Nelson Marlborough DHB does not have the option to purchase the asset at the end of the lease term.

There are no restrictions placed on Nelson Marlborough DHB by any of the finance leasing arrangements.

18. EMPLOYEE ENTITLEMENTS

	Parent & Group	
	2010	**2009**
	Actual	**Actual**
	$000	**$000**
Non-current liabilities		
Sabbatical leave	1,016	942
Retirement Gratuities	7,754	8,657
Long service leave	2,088	1,871
	10,858	**11,470**
Current liabilities		
Sabbatical leave	161	160
Retirement Gratuities	1,395	1,328
Long service leave	457	334
Annual leave	13,738	12,795
Sick Leave	1,303	1,334
Continuing medical education	5,215	4,420
Salary and wages accrued	3,656	5,230
	25,925	**25,601**

The present value of the long service leave, retirement gratuities, sabbatical leave, and sick leave obligations depend on a number of factors that are determined on an actuarial basis. The key assumptions used in calculating these liabilities are the discount rate, salary inflation factor, resignation rate, and take-up rate (for sabbatical leave). Any changes in these assumptions will impact on the carrying amount of the liability.

Long Service Leave, Retirement Gratuities, and Sabbatical Leave

The discount rates used are the weighted averages of returns on New Zealand government stock with terms to maturity that match, as closely as possible, the estimated future cash outflows. Discount rates used range from 3.48% to 6.21% (2009: 3.77%-6.47%), with an average of 5.51% (2009: 5.15%). A salary inflation factor of 4.5% (2009: 4.5%) has been used, except in year 1, when a salary inflation of 7% (2009: 7%) has been used for SMOs and 4.5% for non-SMOs. The take-up rate used for sabbatical leave is 25% (2009: 25%). The valuation is most sensitive to changes in the assumed discount rate, salary inflation factor, and resignation rates. A 1% increase/decrease in the salary inflation factor would, leaving all other assumptions unaltered, result in an $805,000 increase/$712,000 decrease in the long service leave, retirement gratuities and sabbatical leave liability (2009: $880,000 increase / $795,000 decrease). An increase in the take-up rate of sabbatical leave to 50% would result in a $1.2 million increase in the liability (2009: $1.1 million).

Sick Leave

The discount rate used is the weighted average of gross redemption yields on NZ Government stock. The average discount rate is 5.3% (2009: 5.1%). Average future salary growth has been assumed to be 3% per annum, plus a salary scale of 1% per annum.

19. PROVISIONS

	Parent & Group	
	2010	2009
	Actual	Actual
Current Provisions	$000	$000
Restructuring	2,386	1,182
ACC Partnership Programme	458	396
	2,844	**1,578**
Non-current Provisions	$000	$000
Restructuring	-	-
ACC Partnership Programme	-	-
	-	-
Total Provisions	**2,844**	**1,578**

Movements in Provisions		Parent & Group	
	Restructuring	ACC Partnership Programme	Total
2009	$000	$000	$000
Balance at 1 July 2008	1,292	536	1,828
Additional provisions made during the year	221	-	221
Provisions used during the year	(331)	-	(331)
Provisions reversed during the period	-	(140)	(140)
Balance at 30 June 2009	**1,182**	**396**	**1,578**
2010			
Balance at 1 July 2009	1,182	396	1,578
Additional provisions made during the year	2,386	62	2,448
Provisions used during the year	(627)	-	(627)
Provisions reversed during the period	(555)	-	(555)
Balance at 30 June 2010	**2,386**	**458**	**2,844**

Restructuring Provisions

During the year ended 30 June 2010, Nelson Marlborough DHB completed transferral of the provision of health services at Motueka Hospital to the Friends of Motueka Hospital Trust Incorporated. Costs of $627,000 were charged against the provision brought forward from 30 June 2009. The remainder of the provision was reversed. During the year, the CE of Nelson Marlborough DHB has undertaken a review of the management structure. As a result of the review, changes to that structure are being implemented. The restructuring plan and any associated payments are expected to be completed by October 2010. Provision has been made for the expected redundancy costs under various employment agreements. During the year the Rutherford Initiative has identified a number of possible changes as to how psychogeriatric services may be provided in the future. NMDHB has a number of obligations to undertake consultation with key stakeholders. Provision has been made for possible costs arising as a result of such consultation, the planning for which has commenced.

ACC Partnership Programme

The liability for the ACC Partnership Programme is measured at the present value of anticipated future payments to be made in respect of the employee injuries and claims up to the reporting date using actuarial techniques. Consideration is given to expected future wage and salary levels, and experience of employee claims and injuries.

Expected future payments are discounted using a rate that approximates the average gross yield on Government Bonds of short to medium term durations consistent with the duration of the liabilities.

Nelson Marlborough DHB manages has exposure arising from the Programme by promoting a safe and healthy working environment by:
- *implementing and monitoring health and safety policies;*
- *induction training on health and safety;*
- *actively managing work place injuries to ensure employees return to work as soon as practical;*
- *recording and monitoring work place injuries and near misses to identify risk areas and implementing mitigating actions; and*
- *identification of work place hazards and implementation of appropriate safety procedures.*

Nelson Marlborough DHB has chosen a stop loss limit of 200% of the industry premium. The stop loss limit means Nelson Marlborough DHB will only carry the total cost of claims up to $1m.
Nelson Marlborough DHB is not exposed to any significant concentrations of insurance risk as work related injuries are generally the result of an isolated event to an individual employee.

An external independent actuarial valuer, Marcelo Lardies (BSc (Hons), Fellow of the NZ Society of Actuaries) from Aon New Zealand Limited, has calculated the DHB's liability, and the valuation is effective 30 June 2010. The valuer has attested he is satisfied as to the completeness and accuracy of the data used to determine the outstanding claims liability. There are no qualifications contained in the actuarial valuer's report. Pre valuation date claim inflation has been taken as 50% of movements in the Consumer Price Index and 50% of the movements in the Average Wage Earnings index. Post valuation date claim inflation has been taken as 4% per annum. The discount rate used is 4.5% per annum (2009: 4.0%).

The value of the liability is not material for the DHB's financial statements. Therefore, any changes in the assumptions will not have a material impact on the financial statements.

20. CREDITORS AND OTHER PAYABLES

	Parent & Group	
	2010	2009
	Actual	Actual
	$000	$000
Trade payables	4,348	3,338
Revenue in advance	707	193
Capital Charge payable	1,332	1,234
GST, PAYE & FBT payable	4,005	2,878
Other non-trade payables and accrued expenses	15,344	19,627
	25,736	**27,270**

Trade and other payables are non-interest bearing and are normally settled on 30-day terms, therefore the carrying value of trade and other payables approximates their fair value.

21. RECONCILIATION OF NET SURPLUS/(DEFICIT) WITH NET CASH FLOW FROM OPERATING ACTIVITIES

		Parent & Group	
	Note	2010	2009
		Actual	Actual
		$000	$000
Reported surplus/(deficit)	**16**	(5,389)	(4,752)
Add back non-cash items:			
Depreciation and amortisation expense		11,685	10,210
Impairment losses		-	130
Add back items classified as investing activities:			
Net Loss/(Gain) on disposal of Property, Plant & Equipment		(21)	20
Movements in working capital:			
(Increase)/Decrease in debtors and other receivables		7,491	(3,955)
(Increase)/Decrease in prepayments		(203)	41
(Increase)/Decrease in inventories		302	61
Increase/(Decrease) in creditors and other payables		(1,534)	345
Increase/(Decrease) in employee entitlements		(288)	4,678
Increase/(Decrease) in provisions		1,266	(250)
Movements in working capital disclosed as investing activities			
(Increase)/Decrease in creditors relating to purchase of Property, Plant & Equipment		(728)	(391)
(Increase)/Decrease in Deferred Gain on sale and leaseback of Property, Plant & Equipment		(70)	-
Net cash (outflow)/inflow from operating activities		**12,511**	**6,137**

22. OPERATING LEASES

(a) Leases as lessee

	Parent & Group	
	2010	2009
	Actual	Actual
	$000	$000
The future aggregate minimum lease payments to be paid under non-cancellable operating leases are as follows:		
Less than one year	900	919
Between one and five years	2,506	2,268
More than five years	2,304	1,655
Total non-cancellable operating leases	**5,710**	**4,842**

Nelson Marlborough DHB leases several buildings under operating leases. The leases are for periods ranging from 1 to 7 years initially, with rights of renewal ranging from 1 to 6 years.

The DHB also leases motor vehicles and clinical equipment under operating leases. The leases terms are typically 3 years for vehicles, and for periods ranging from 1 to 5 years for clinical equipment.

There are no restrictions placed on Nelson Marlborough DHB by any of its leasing arrangements.

During the year ended 30 June 2010, $1,555,000 was recognised as an expense in the surplus or deficit in respect of operating leases (2009: $1,683,000)

(b) Leases as lessor

	Parent & Group	
	2010	2009
	Actual	Actual
	$000	$000
The future aggregate minimum lease payments receivable under non-cancellable operating leases are as follows:		
Less than one year	35	35
Between one and five years	140	140
More than five years	291	326
Total non-cancellable operating leases receivable	**466**	**501**

Nelson Marlborough DHB leases land to the Friends of Motueka Hospital Trust Incorporated. The lease has a term of 20 years, with annual rental of $20,000, and rental review dates two yearly from commencement date.

The DHB has also entered into an agreement commencing 1 August 2008, to sublet premises for a period of 5 years, with two further rights of renewal of two years each. Total future minimum sublease payments to be received under this agreement are $105,365.

23. FINANCIAL INSTRUMENTS

Nelson Marlborough DHB is party to financial instruments as part of its everyday operations. These include instruments such as bank balances, investments, accounts receivable, trade creditors and loans.

Nelson Marlborough DHB has a series of policies providing risk management for interest rates and the concentration of credit. The policies do not allow any transactions which are speculative in nature to be entered into.

(a) Interest rate risk

Interest rate risk is the risk that the interest component of a financial instrument will fluctuate due to changes in market rates.
This could particularly impact on the costs of borrowing or the return from investments.

The interest rates on Nelson Marlborough District Health Board's investments are:	Parent & Group	
	2010	2009
Call Deposits	3.40%	2.50%
Term Deposits with maturity less than 3 months	3.82-4.79%	3.6%-4.6%

The Board does not consider there is any significant exposure to interest rate risk on its investments.

The interest rates on the Board's borrowings are disclosed in Note 17.

There are no interest rate options or interest swap agreements in place as at 30 June 2010 (2009: $Nil).

(b) Credit Risk

Credit risk is the risk that a third party will default on its obligations to Nelson Marlborough DHB, causing the DHB to incur a loss.

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

Due to the timing of its cash inflows and outflows, the Health Board places its surplus cash and short-term deposits with high-quality financial institutions and limits the amount of credit exposure to any one financial institution.

Concentrations of credit risk from accounts receivable are high due to the reliance on the Ministry of Health for approximately 94% of the DHB's revenue. However, the Ministry of Health 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.

At balance sheet date there were no significant other concentrations of credit risk. The maximum exposure to credit risk is represented by the carrying amount of cash and cash equivalents (note 13), and debtors and other receivables (note 14).

(c) Currency Risk

Nelson Marlborough DHB had no foreign currency assets or liabilities as at 30 June 2010. During the year, expenditure invoiced in foreign currencies was recorded in NZD calculated with the same exchange rates as those used for the payments for those invoices. No exchange rate gains or losses were recorded.

(d) Liquidity Risk

Liquidity risk represents Nelson Marlborough DHB's ability to meet its contractual obligations. The DHB evaluates its liquidity requirements on an ongoing basis. In general, Nelson Marlborough 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.

The following table sets out the contractual undiscounted cash flows for all financial liabilities.

			Parent & Group				
2010	**Balance Sheet**	**Contractual cash flow**	**6 mths or less**	**6-12 mths**	**1-2 years**	**2-5 years**	**More than 5 years**
Secured loans	35,000	45,645	997	992	13,743	12,461	17,452
Finance lease liabilities	4,120	4,550	969	823	1,212	1,546	-
Creditors and other payables	19,692	19,692	19,692	-	-	-	-
Total	**58,812**	**69,887**	**21,658**	**1,815**	**14,955**	**14,007**	**17,452**

2009	**Balance Sheet**	**Contractual cash flow**	**6 mths or less**	**6-12 mths**	**1-2 years**	**2-5 years**	**More than 5 years**
Secured loans	35,000	45,588	12,936	741	509	4,717	26,685
Finance lease liabilities	4,629	5,212	943	862	1,367	1,912	128
Creditors and other payables	22,965	22,965	22,965	-	-	-	-
Total	**62,594**	**73,765**	**36,844**	**1,603**	**1,876**	**6,629**	**26,813**

(e) Capital Management

Nelson Marlborough DHB's capital is its equity, which comprises Crown equity, reserves and retained earnings. Equity is represented by net assets.

Nelson Marlborough DHB is subject to the financial management and accountability provisions of the Crown Entities Act 2004, which impose restrictions in relation to borrowings, acquisition of securities, issuing guarantees and indemnities and the use of derivatives.

Nelson Marlborough DHB manages its equity as a by-product of prudently managing revenues, expenses, assets, liabilities and general financial dealings to ensure that it effectively achieves its objectives and purpose, whilst remaining a going concern.

There have been no material changes in Nelson Marlborough DHB's management of capital during the year.

(f) Sensitivity Analysis

In managing interest rate risk, Nelson Marlborough DHB aims to reduce the impact of short-term fluctuations on its earnings. Over the longer term, however, permanent changes in interest rates would have an impact on earnings.

At 30 June 2010, it is estimated that a general increase of one percentage point in interest rates would decrease Nelson Marlborough DHB's deficit by approximately $309,000 (2009: $540,000).

(g) Market Risk

Nelson Marlborough DHB does not have any significant market risk as it does not enter into derivative financial instruments.

(h) Classification and Fair Values

The classification and fair values together with the carrying amounts shown in the Statement of Financial Position are as follows:

		Parent & Group				
2010	**Note**	**Loans and receivables**	**Available for sale**	**Other - Amortised Cost**	**Carrying amount**	**Fair value**
Assets						
Other Financial Assets	**12**	-	7	-	7	7
Total Non-current assets		-	7	-	7	7
Debtors and other receivables	**14**	9,177	-	-	9,177	9,177
Cash and cash equivalents	**13**	22,920	-	-	22,920	22,920
Total Current assets		32,097	-	-	32,097	32,097
Total Assets		**32,097**	**7**	**-**	**32,104**	**32,104**
Liabilities						
Secured loans	**17**	-	-	35,000	35,000	36,966
Finance lease liabilities	**17**	-	-	2,540	2,540	2,540
Other loans	**17**	-	-	-	-	-
Total Non-current liabilities		-	-	37,540	37,540	39,506
Finance lease liabilities	**17**	-	-	1,580	1,580	1,580
Creditors and other payables	**20**	-	-	19,692	19,692	19,692
Total current liabilities		-	-	21,272	21,272	21,272
Total Liabilities		**-**	**-**	**58,812**	**58,812**	**60,778**

2009	**Note**	**Loans and receivables**	**Available for sale**	**Other - Amortised Cost**	**Carrying amount**	**Fair value**
Assets						
Other Investments	**12**	-	7	-	7	7
Total Non-current assets		-	7	-	7	7
Debtors and other receivables	**14**	16,668	-	-	16,668	16,668
Cash and cash equivalents	**13**	37,524	-	-	37,524	37,524
Total Current assets		54,192	-	-	54,192	54,192
Total Assets		**54,192**	**7**	**-**	**54,199**	**54,199**
Liabilities						
Secured loans	**17**	-	-	35,000	35,000	36,048
Finance lease liabilities	**17**	-	-	3,073	3,073	3,073
Total Non-current liabilities		-	-	38,073	38,073	39,121
Finance lease liabilities	**17**	-	-	1,556	1,556	1,556
Creditors and other payables	**20**	-	-	22,965	22,965	22,965
Total current liabilities		-	-	24,521	24,521	24,521
Total Liabilities		**-**	**-**	**62,594**	**62,594**	**63,642**

24. RELATED PARTY TRANSACTIONS & KEY MANAGEMENT PERSONNEL

(a) Ownership

Nelson Marlborough DHB is a crown entity in terms of the Crown Entities Act 2004, and is owned by the Crown. The Government significantly influences the role of the DHB as well as being its major source of revenue. The funding received from the Government and the related amounts outstanding at year end are shown below.

	Parent & Group	
	2010	2009
	Actual	Actual
Percentage of total revenue received from the Government, through the Ministry of Health	94%	96%
Total amount outstanding at 30 June	**3,499,565**	**3,584,609**

(b) Transactions with other entities controlled by the Crown

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

(c) Transactions with subsidiaries

Nelson Marlborough DHB entered into transactions with the Nelson Marlborough Hospitals' Charitable Trust in the receipt of donations which are recognised as income when received, or an entitlement to receive money is established

	Parent & Group	
	2010	2009
	Actual	Actual
	$000	$000
Donations from NMHCT	179	78
	179	**78**

(d) Identity of related parties other than those described above

Nelson Marlborough DHB has a related party relationship with its board members.

During the year, Nelson Marlborough DHB did not enter into any transactions with entities over which Board members have control or significant influence.

Nelson Marlborough DHB entered into transactions with South Island Shared Services Agency Limited (SISSAL). SISSAL was set up by all South Island DHBs to provide shared support services to funder operations. The six South Island DHBs hold shares in the company in proportion to their respective populations. NMDHB has 130 shares valued at $6,500 representing 13% of the shareholding.

(e) Revenue from related parties

During the year, Nelson Marlborough DHB did not receive any revenue from non-Crown related parties other than the Nelson Marlborough Hospitals Charitable Trust.

(f) Purchases from related parties

	Parent & Group	
	2010	2009
	Actual	Actual
	$000	$000
South Island Shared Services Agency Limited	**333**	**523**
	333	**523**

All transactions with related parties are entered into on a normal commercial basis.

(g) Outstanding Balances owing to related parties

	Parent & Group	
	2010	2009
	Actual	Actual
	$000	$000
South Island Shared Services Agency Limited	92	57
	92	**57**

(h) Outstanding Balances owing from related parties

There are no amounts owing from related parties (2009: $Nil).

No related party debts have been written off or forgiven during the year.

(i) Key Management Personnel Remuneration

The key management personnel remuneration is as follows:

	Parent & Group	
	2010	**2009**
	Actual	**Actual**
	$000	**$000**
Salaries and other short-term employee benefits	2,296	2,301
Post-employment benefits	-	-
Other long-term benefits	-	-
Termination benefits	-	-
Total key management personnel remuneration	**2,296**	**2,301**

Key management personnel includes all board members, the Chief Executive, and members of the Strategic Leadership Team.

Remuneration paid to Board members is disclosed separately in Note 32.

There are close family members of key management personnel employed by Nelson Marlborough DHB. The terms and conditions of those arrangements are no more favourable than NMDHB would have adopted if there were no relationship to key management personnel.

25. NON CONSOLIDATION OF SUBSIDIARIES

Nelson Marlborough Hospitals Charitable Trust (the "Charitable Trust") provides health related services, projects, research, and education to the residents of the Nelson Marlborough District Health Board (the "DHB") catchment area. The Charitable Trust is controlled by the DHB in accordance with NZ IAS 27.

For the year ended 30 June 2010, the Trust had total revenue of $91,000 (2009: $125,000), and a net surplus of $77,000 (2009: $115,000). The Trust had assets of $2,776,000 (2009: $1,896,000), and liabilities of $Nil (2009: $Nil) at that date.

26. SUBSEQUENT EVENTS

Board members are not aware of any other matter or circumstance, since the end of the financial year (not otherwise dealt with in this report or in the Board's financial statements), that may significantly affect the operation of the organisation, the results of its operations, or the state of affairs of the board.

27. ACCOUNTING ESTIMATES AND JUDGEMENTS

The estimates and judgements that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed below:

(a) Property, plant and equipment useful lives and residual values

Nelson Marlborough DHB depreciates its property, plant and equipment over its useful life to its estimated residual value. An incorrect estimate of the useful life or residual value of an item of property, plant and equipment will impact the depreciation expense recognised in the surplus or deficit, and carrying amount of the asset in the Statement of Financial Position.

Nelson Marlborough DHB has not made any material changes to past assumptions concerning the useful lives and residual values of its property, plant and equipment. The carrying amounts of property, plant and equipment are disclosed in note 9.

(b) Employee Entitlements

Long service leave, retiring leave, sabbatical leave, and sick leave liabilities are calculated on an actuarial basis. The key assumptions adopted in calculating the value of these liabilities are disclosed in note 18. Changes in these assumptions will have an impact of the carrying value of the liabilities.

(c) Lease Classification

Determining whether a lease agreement is a finance lease or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to Nelson Marlborough DHB. Judgement is required on various aspects that include the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term and determining an appropriate discount rate to calculate the present value of the minimum lease payments. Classification as a finance lease means the asset is recognised in the Statement of Financial Position as property, plant and equipment, whereas for an operating lease no such asset is recognised.

Nelson Marlborough DHB has exercised its judgement on the appropriate classification of equipment leases and has determined that a number of lease arrangements are finance leases.

(d) Revenue Recognition

Nelson Marlborough DHB must exercise judgement where recognising revenue to determine if conditions of the contract have been satisfied. This judgement is based on the facts and circumstances that are evident for each grant contract.

28. EXPLANATION OF FINANCIAL VARIANCES FROM BUDGET

Significant variances from budget figures per the Statement of Intent are explained below:

(a) Statement of Comprehensive Income

Revenue

Revenue was higher than budget by $2.69m. This was mainly due to increased revenue from:
- *Funding for prior year wash-ups for Herceptin ($0.5m)*
- *Funding increases to cover increased costs for Oral Health and InterRai ($0.4m)*
- *Funding increases/additions that are offset by increased expenditure, notably Primary Mental Health ($0.6m), PHO Performance Management ($0.5m), Rural After Hours Premium ($0.5m), Hospice ($0.4m),*

Travel Assistance ($0.3m), Nicotine replacement Therapy ($0.3m).
- *Kiwisaver tax credits to offset employer contributions ($1.1m)*

Offset by decreased revenue from Interest Received ($1.8m) due to interest rates having fallen since the budget was set, and average cash balances over the year were less than budgeted.

Expenditure

Personnel costs are $0.6m under budget. This is a combined effect of staff mix and control of non-contractual costs.

Clinical supplies are over budget by $0.6m. Over-delivery of volumes has driven demand based expenditure on Patient Appliances ($0.2m), Implants and Prostheses ($0.6m), and Treatment Disposables ($0.3m). This is offset by an underspend in Haemophilia Blood Products related to a revision of the purchasing process.

Payments to Providers are over budget by $1.2m. The main contributors to this negative variance are:

Favourable variances:
- *School Dental (0.3m) due to less demand than budgeted.*

- *A provision in the budget for demand driven services of $1.9m has no direct spend against it. It is offset by unfavourable variances on demand driven expenditure lines such as:*
  - *Aged Residential Care Services ($0.9m). Due to the increased number of beds available in the sector.*
  - *Home Based Support Services ($0.3m)*
  - *Palliative Care ($0.4m) for Hospice Services*

Other Unfavourable provider Payment Variances:

- *Pharmaceutical ($0.4m) due to unexpectedly high growth in demand for community pharmaceuticals, particularly from non-PHO prescribers.*
- *Patient travel and accommodation ($0.5m) . A dual effect of an increase in the subsidy plus an increase in patients travelling for specialist treatment.*
- *GP Services ($1.0m) including PHO programmes and Primary Mental Health initiatives. Offset by increased funding.*

Other Operating Expenses are over budget by $1.3m:

- *This is entirely due to a larger provision made for Restructuring expenses than had been anticipated. See note 19.*

Capital Charge expense is over budget by $0.7m due to the effect of the revaluation of fixed assets at the end of June 2009.

(b) Statement of Financial Position

Equity

Equity is $8.9 m higher than budget. $8.3m relates to the difference in brought forward balance resulting from Fixed Asset revaluation, and the remainder is due to the lower than budgeted deficit.

Current Assets

Current assets are $2.4m higher than budget. Cash and cash equivalents are $6.3m higher than budget due largely to the timing of the purchase and sale of capital items, along with the settlement of the higher than anticipated year end 08/09 receivables. Receivables and accrued revenue are less than budget by $3.5m.

Non Current Assets

Non-current assets are $3.9m above budget. The delayed timing of capex purchases has resulted in lower than budget net asset values overall. However a greater than budget balance in WIP ($6.7m variance related mostly to Wairau Stage 3 redevelopment) more than offsets that, creating the higher than budget Non-Current Asset balance.

Current Liabilities

Current liabilities are $2.4m higher than budgeted largely due to the effect of the increased restructuring provision and a higher than anticipated movement in the ACC liability.

Non Current Liabilities

Non-current liabilities are $5.0m lower than budget. This variance is due to non-current finance leases which started the financial year $3.0m lower than budget due to the brought forward position that was assumed when the budget was set; this was then compounded by lower than budgeted finance leases raised in the current financial year. Clinical equipment budgeted to be leased in particular was either deferred until 2010/11, or analysis proved that buying outright was the better option at the time.

(c) Statement of Cash Flows

Cash Flows From Operating Activities were favourable to budget by $5.2m. Cash inflows were greater than budget by $11.1m due to the favourable consolidated revenue variance and the settlement of the 08/09 electives wash-up. Offset by cash outflows unfavourable to budget $5.2m, resulting mainly from the payment of Inter District Flows accrued in June 2009 ($3.3m), and payment to other providers for higher than budgeted demand driven costs such as Aged Residential Care, Homes Based Support, and Palliative care ($1.6m negative variance in total).

Cash Flows From Investing Activities were $1.3m favourable to budget due to lower than budgeted capital expenditure.

Cash Flows From Financing Activities were unfavourable to budget by $0.4m, due to greater than budgeted repayment of Finance Lease Liabilities.

(d) District Strategic Plan

Section 38(1)(c) of the New Zealand Public Health and Disability Act 2000 requires the District Strategic Plan (DSP) to be reviewed every three years. DHB DSPs in the sector are due for their 3-yearly review and are in the process of being reviewed.

The New Zealand Public Health and Disability Amendment Bill (currently before Parliament) include proposed amendments to planning requirements for DHB's. The amendments will provide for a planning and accountability framework that takes account of national, regional and local requirements, including the preparation of regional plans.

Due to these proposed changes within the sector, the DHB is unable to make the changes to the DSP that may be necessary. Consequently, the DHB is in breach of section 38(1)(c) of the New Zealand Public Health and Disability Act 2000.

The Minister of Health last consented to NMDHB's DSP for the period 2005-2015 in December 2005. The DSP was reviewed in 2008 and the Board confirmed that no substantive changes were required.
A Health Services Plan for South Island DHBs is also being developed.

29. MENTAL HEALTH RINGFENCED ACCOUNTS

Nelson Marlborough DHB is required to abide by the restrictions on the use of funding supplied for mental health purposes.

	Parent & Group	
	2010	**2009**
	$000	**$000**
Opening balance of mental health funds	352	939
Excess/(Shortfall) of funding for mental health services over payments	(461)	(587)
Adjustment to prior years mental health funds available	124	-
Surplus mental health funds at the end of the financial year which are available for future mental health services	**15**	**352**

30. SEVERANCE PAYMENTS

Nelson Marlborough DHB has not made any severance payments other than in accordance with relevant employee contractual obligations.

Termination payments are disclosed on page 17.

31. SUMMARY OF REVENUE AND EXPENSES BY OUTPUT CLASS

	Parent & Group				
	Funding	Governance and Funding Administration	Hospital Provider	Eliminations	Total Board
	Actual	Actual	Actual	Actual	Actual
	$000	$000	$000	$000	$000
Revenue					
Revenue	345,879	5,267	214,902	190,550	375,498
Other Operating Income	-	12	4,551	-	4,563
Finance Income	846	-	641	-	1,487
Total Revenue	**346,725**	**5,279**	**220,094**	**190,550**	**381,548**
Expenses					
Personnel Costs	-	1,682	140,306		141,988
Outsourced Services	5,165	403	10,981	5,165	11,384
Clinical Supplies	-	-	28,376	-	28,376
Infrastructure & Non-Clinical Supplies	-	1,300	18,814	-	20,114
Payments to non-Health Board Providers	345,794	-	-	185,385	160,409
Other Operating Expenses	-	13	3,579	-	3,592
Depreciation and amortisation expense	-	4	11,681	-	11,685
Finance Costs	-	-	2,352	-	2,352
Capital Charge	-	1,877	5,160	-	7,037
Total Expenses	**350,959**	**5,279**	**221,249**	**190,550**	**386,937**
Net Surplus/(Deficit)	**(4,234)**	**-**	**(1,155)**	**-**	**(5,389)**
Reconciliation to Retained Earnings					
Opening Retained Earnings	27,705	354	(6,653)	-	21,406
Plus/(less) Transfer from Property Plant & Equipment Revaluation Reserve on disposal	-	-	(162)	-	(162)
Plus/(less) Surplus/(Deficit) for the year	(4,234)	-	(1,155)	-	(5,389)
Closing Retained Earnings	**23,471**	**354**	**(7,970)**	**-**	**15,855**

31. SUMMARY OF REVENUE AND EXPENSES BY OUTPUT CLASS (continued)

	Parent & Group				
	Funding	Governance and Funding Administration	Hospital Provider	Eliminations	Total Board
	Budget	Budget	Budget	Budget	Budget
	$000	$000	$000	$000	$000
Revenue					
Revenue	342,776	5,801	213,950	190,040	372,487
Other Operating Income	-	-	3,065	-	3,065
Finance Income	1,502	-	1,800	-	3,302
Total Revenue	**344,278**	**5,801**	**218,815**	**190,040**	**378,854**
Expenses					
Personnel Costs	-	1,931	140,701	-	142,632
Outsourced Services	5,661	503	11,143	5,661	11,646
Clinical Supplies	-	-	27,751	-	27,751
Infrastructure & Non-Clinical Supplies	-	1,488	19,168	-	20,656
Payments to non-Health Board Providers	343,581	-	-	184,379	159,202
Other Operating Expenses	-	4	2,313	-	2,317
Depreciation and amortisation expense	-	-	11,521	-	11,521
Finance Costs	-	-	2,669	-	2,669
Capital Charge	-	1,875	4,467	-	6,342
Total Expenses	**349,242**	**5,801**	**219,733**	**190,040**	**384,736**
Net Surplus/(Deficit)	**(4,964)**	**-**	**(918)**	**-**	**(5,882)**
Reconciliation to Retained Earnings					
Opening Retained Earnings	28,394	203	(5,313)	-	23,284
Plus/(less) Transfer from Property Plant & Equipment Revaluation Reserve on disposal	-	-	-	-	-
Plus/(less) Surplus/(Deficit) for the year	(4,964)	-	(918)	-	(5,882)
Closing Retained Earnings	**23,430**	**203**	**(6,231)**	**-**	**17,402**

2009-12 Statement of Intent

Nelson Marlborough DHB 2009-12 Statement of Intent did not fully comply with the requirements of the Crown Entities Act 2004. Sections 142 (2) (b) and (c) of the Crown Entities Act 2004 require for each output class adopted, that the Statement of Intent:

- identify the expected revenue to be earned, and proposed expenses to be incurred, for each class of outputs; and

- comply with generally accepted accounting practice.

At the time the 2009-12 Statement of Intent was adopted, Nelson Marlborough DHB were unable to reliably identify the expected revenue and proposed expenses for each class of outputs. As a result Nelson Marlborough DHB breached sections 142 (2) (b) and (c) of the Crown Entities Act 2004.

The breaches occurred because Nelson Marlborough DHB decided to adopt more relevant output classes, but they were not able to allocate the underlying budget information to the new output classes. The allocation process requires a substantial amount of work and there was insufficient time for it to be carried out between the time the new output classes were adopted and the time the Statement of Intent was adopted.

The new output classes will enable Nelson Marlborough DHB to more meaningfully report service performance for the year ending 30 June 2011.

32. BOARD MEMBERS REMUNERATION

The total value of remuneration paid or payable to each Board member during the year was:

	Parent & Group	
	2010	**2009**
	Actual	**Actual**
	$000	**$000**
Judith Billens	23	23
Jenny Black	21	21
Sharon Brinsdon	21	20
Judy Crowe	21	20
Graeme Faulkner	21	21
Lynette Jones	21	21
Ian MacLennan	22	21
John Moore	21	20
Joe Puketapu	22	22
Liz Richards	26	29
Suzanne Win (Chairperson from Jan 06)	41	41
	260	**259**

32. BOARD MEMBERS REMUNERATION (continued)

The total value of remuneration paid or payable to Committee members (excluding Board members) during the year was:

	Parent & Group	
	2010	2009
	Actual	Actual
	$000	$000
Committee Members (Community Representatives)		
Hospital Advisory Committee		
Graeme Grennell	-	2
Janet Kelly	1	2
Joanne Mickleson	2	2
Rawenata Geiger (from Sep 09)	1	-
Community and Public Health Advisory Committee		
Judith Holmes	1	2
Lorraine McMath	1	2
Sonny Alesana (from Dec 09)	1	-
Trisha Filleni (To Oct 09)	1	-
Disability Support Advisory Committee		
Rawenata (Lovey) Geiger	-	2
Glenys MacLellan	1	2
Kim Robinson	-	1
George Truman	1	2
Viveyan Tuhimata (Weke)	-	1
Tahi Takao (From Aug 09)	1	-
Fleur Hansby	1	-
	12	**18**

REGISTRATION OF INTEREST

NMDHB BOARD MEMBERS

NAME	EXISTING – HEALTH	EXISTING – OTHER
John Moore	• Nil	• Member Nelson Regional Transport Committee • Trustee Top of the South Athletics Charitable Trust
Judy Crowe	• Chairperson of Nelson Marlborough Hospitals' Charitable Trust.	• Member of the Gladys Amelia Pascoe Trust.
Liz Richards	• Member of Nelson Community Health Links Group • Chair of the Upper South A Regional Ethics Committee	• Deputy Chair Canterbury Community Trust • Member of Nelson Labour Electorate Committee • Appointed as Trustee Tasman Bay Heritage Trust.
Lynette Jones	• Convenor of 'Friends of Marlborough Hospice' • Patron of Marlborough Red Cross.	
Sharon Brinsdon	• Financial interest in husband's GP practice • Husband is employed one-tenth at Nelson Hospital (Eye Department) • Financial interest through husband's shareholding in Nelson Medical Limited (1/6 share) which owns the Health @132 medical centre • Financial interest through husband's shareholding in different companies undertaking medical developments in Collingwood St, Nelson (1/60 share) and Queen Street, Richmond (1/10 share).	
Suzanne Win	• Director of Split Ridge Associates Ltd that provides consultancy services to health and disability organisations • Trustee of Gracelands Group • Member of DHBNZ Chairs Executive with lead responsibility for workforce and participant on Tripartite Forum • Partner is a part-time employee of NMDHB Provider Division.	• Trustee of Donald Beasley Institute Career Force Board Member (Currently on leave).
Ian MacLennan	• Treasurer of Nelson Centre of the Cancer Society of NZ.	
Jennifer Black	• Life member of Diabetes NZ.	
Graeme Faulkner	• Provision of rental premises to DHB clinic • Employee of medical practice.	
Judi Billens	• Board Member Age Concern • Member Barnardos Advocacy for Children & Young People • NZ Pelim Practitioners Nelson (Kaumatua) • NM Iwi Health Board • Healthcare New Zealand Advisory Committee Member • Committee Member of St John Nelson Bays Area • CYFS Care and Protection Group.	• Member Ngati Tama Iwi Trust Board • Board of Governance Te Rito Family Violence • Shareholder and owner in Wakatu Inc.
Joe Puketapu	• Member IHB Executive Committee • Chair IHB • Chairperson Waikawa Marae Committee • Employee, Te Hauora O Ngati Rarua Ltd • Trustee on the Board of Kimi Hauora Wairau PHO.	• Trustee Te Atiawa Manawhenua Trust • Former Director Tainui Taranaki Ki Te Tau Ihu.

30 June 2010

INTEREST RELATES TO	POSSIBLE FUTURE CONFLICTS
• Provision of trust funds towards equipment, training and patient support.	
• Advocacy and Health Issues • Health Research • Donations to community health groups.	
• The provision of health and disability services in the Nelson-Marlborough District.	• Husband is a member of executive of Southlink Health (IPA) • Sister is staff nurse at Wairau Hospital. (A & E OPD).
• Provision of consultancy services to health and disability organisations for DHBs or Ministry of Health.	Partner is • Member on PHO Alliance Executive • Chair of West Coast PHO contracted to MOH to coordinate the implementation of the Cardiac Network • Chair of the Board of Access Home Health Ltd • Director on Management Board of Jack Inglis Friendship Hospital.
	• Accommodation for the Cancer Society.
• District Nurse clinics • Picton Medical Centre a contracted GP service.	• Negotiating DHB contracts for practice.
• Health Services	

NMDHB OUTPUTS CLASSES and STATEMENTS OF SERVICE PERFORMANCE

Output Class 1: Public Health Services

Public Health Services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations comprising services designed to enhance the health status of the population as distinct from the 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 unequal outcomes are reduced; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and, individual health protections services such as immunisation and screening services.

Public Health Services Statement of Service Performance

The following table outlines the Public Health services we delivered to our population. These outputs are aggregated into the following sub-classes: Health Protection services; Health Promotion services; Population Screening services; Immunisation services.

Table 1: Public Health services delivered in 2009-2010 (table continued over next page):

Outputs	Measures	2008/09 Actual	2009/10 Target	2009/10 Achieved	Comments
Health Protection Services	1. Number of Controlled Purchase Operations carried out with Tobacco retailers	2	3	Not Achieved 1	Number of CPO required for district was reviewed and one was considered to be appropriate with current level of resourcing. Extra resources were allocated to the AH1N1 Pandemic Response.
	2. Proportion of Environmental Health complaints that are investigated, out of those notified and that require investigation	100%	100%	100%	
	3. Number of Communicable Disease investigations completed (24 hour service) per annum	Approx. 450	450	Achieved 784	Seasonal variation always makes accurate predictions for communicable disease outbreaks difficult; numbers increased last year due largely to AH1N1, and also an increase in general flu incidences and a spike in one particular disease related to swimming pools.
Health Promotion Services	1. Achieving the national target for hospitalised smokers to be provided with advice and help to quit by July 2010	-	80%	Partially Achieved 52%	Significant work is under way to train staff and improve data collection procedures.[1]
	2. Number of Controlled Purchase Operations carried out with alcohol retailers	3	4	Achieved 6	CPOs attended with Police and Licensing Inspectors.
	3. Implementing school/ECC nutrition food & beverage classification system	10% of schools	20% of schools	Not Achieved	NMDHB is no longer funded to undertake this work.
	4. Provision of Public Health Policy Advice	Input into 4 Council plans	Input into 4 Council plans	Achieved 6	Submissions made by NMDHB on Long Term Council Community Plans and various policies.
	5. Provision of Public Health training to health professions on nutrition policy and practice	10% of Practice / PHC Nurses trained	20% of Practice / PHC Nurses trained	Achieved 40%	The Community Nutrition Service has provided nutrition policy and practice training to health professionals; more health professionals have attended these training sessions than previously anticipated.

[1] Although the target was introduced in July 2009, NMDHB's service was not properly established and staffed until early 2010. Progress from quarter to quarter has been significant (from Q1 to Q3: 16%, 43%, 47%) and up to 52% in the month of June

Table 1: Public Health services delivered in 2009-2010 (continued):

Outputs	Measures	2008/09 Actual	2009/10 Target	2009/10 Achieved	Comments
Population Screening Services	1. Percentage of eligible women 'registered' on the National Cervical Screening Programme (NCSP), 20-69 years	75%	75%	Achieved 75.4%	
	2. Percentage of enrolled women completing free breast screening, in line with programme criteria)	70%	Other 75% Maori 70% PI 70%	Achieved Other 82% Maori 73% PI 86%	
	3. B4 School Checks carried out	300	837	Achieved 1071	There were more children identified locally as eligible than identified by the Ministry.
Immunisation Services (these are subject to Ministry of Health funded levels)	1. Achieving the national immunisation target for two year olds to be fully immunised by July 2010	-	85%	Achieved (89%)	The MOH National Immunisation Target was achieved for 2009/10.
	2. The percentage of age-appropriate immunisation for two-year olds, as per the National Immunisation Register (NIR)	79%	81%	Achieved (88%)	
	3. The percentage of children completing the year 7 vaccination, of those eligible and who have consented	90%	90%	Achieved (90%)	
	4. The rate of immunisation for year 8 girls for the HPV vaccine	85%	85%	Achieved (48%)	Locally we have been addressing this with increased communications to schools and taking opportunities for promotion. However, for girls aged 10-11 years this will fall under the normal immunisation schedule for Year 8 girls and will therefore be managed in line with this system.

How we Organised Ourselves to Achieve these Results

The key public health initiatives (our enablers) that we completed in 2009/10 are:

Action	2009/10 Achieved	Comment
• Implementing new services as part of our Nutrition and Physical Activity Programme. This is a core component of our strategy to improve wellness and encourage our community to take individual responsibility for their health. This will reduce the demand for acute services and enable us to put further investment into primary care services for our communities	Achieved	New initiatives funded through Small grants - 60+ schools, ECE services and community organisations supported to establish nutrition and/or physical activity initiatives; - 8 school edible gardens; 14 Open Orchards; - Breastfeeding Coordinator positions within two Primary Health Organisations; Peer Counselling Administrator roles in Nelson/Tasman and Marlborough; - Maori Leadership programme within local marae; - 'Trolley Tips' – web-based meal planning resource; - 'Seasonal Challenge' social marketing programme - nutrition, and physical activity for children and parents; - 'Active8' programme in Kimi Hauora Wairau PHO.
• Working closely with other agencies that have a major impact on the major determinants of heath for improved community well-being. Examples include disability-friendly, healthy and accessible housing; and impact assessment on Local Authority policies and Council plans	Achieved	- 11 submissions to local and national policies; - Currently engaged in writing a Health Impact Assessment for the Nelson Arterial flow study in a partnership arrangement with Nelson City Council. This will not be completed until September 2010; - Worked closely with a number of government departments, the Local Authorities and the Parliamentary Commissioner for the Environment to complete a report into the health effects of the remediation process for a contaminated site at Mapua. The health report was received favourably by the Mapua community and the Ministries of Health and Environment. The Ministry of Health is continuing to work with the community to address their health concerns; - A submission was made to ERMA on the reclassification (by ERMA) of Methyl Bromide for use in New Zealand. We are awaiting results of that hearing;
• Strengthening: - preventing and reducing family violence and improving the mental wellbeing of communities - using Impact Assessment (IA) in the development of key policies such as: ✓ increasing the uptake of fluoridation of public water supplies for improved oral health ✓ addressing with Local Authorities: air and water quality, tobacco smoking in open places, cycle and walking pathways, contaminated sites restoration, housing insulation/solar heating/ sustainable energy sources; sale of alcohol issues; urban design; safe environments.	Achieved	A submission was made to the Law Commission on the sale of alcohol in New Zealand. The submission represented a whole of DHB response. We await the outcome of this process; The three local authority Long Term Council Community Plans were submitted on during this period, with favourable responses received for our constructive approach for a way forward, leading directly to a new partnering relationship with Nelson City Council and the Ministry of Social Development.

Contribution to Outcomes

These outputs contribute to the outcomes of:

- People are healthy, able to self mange and live longer, and
- People who are at risk of illness and/or injury are diagnosed and managed earlier.

Our performance is also reflected in the monitoring undertaken in the NMDHB Balanced Scorecard. The Scorecard Report for the period to 30 June 2010 notes that there has been an increase in life expectancy for males from 74.4 years in 1995-97 to 78.0 years in 2005-07. For women there was an increase from 79.7 years in 1995-97 to 82.2 years in 2005-07. Patient and consumer satisfaction with NMDHB's services is also very high. For quarter three: 1 January to 31 March 2010 NMDHB was ranked number two of all DHBs (92.43%) in overall patient satisfaction in the Patient Satisfaction Index complied by the Ministry of Health. NMDHB's inpatient patient satisfaction was the second highest of all DHBs at 91.20% and second highest for outpatient patient satisfaction at 96.96%.

Output Class 2: Primary and Community Services

Primary Health and Community Services Output Class services are focused on achieving all four 'JUMBO' objectives: Improving Wellness, Improving Long Term Condition Management, Improving Health & Disability Services and Improving Sustainability. Some of these services are provided by the Hospital division of the DHB while others are funded by the DHB, through a range of contracts and provided by PHOs and other, mainly local community based NGOs. These outputs are aggregated into the following sub-classes: personal health services, mental health services, Maori and Pacific health services and disability services.

Public Health Services Statement of Service Performance

The table below outlines the Primary and Community Services we delivered to our population. These outputs are aggregated into: Supported Self-Management, Provision of Primary Care Services for Enrolled People (Access and First Point of Contact Services), and Provision of Services for people with Long-Term (chronic) Conditions.

Table 2: Primary and Community Services Statement of Service Performance (table continued over next page):

Outputs	Measures	2008/09 Actual	2009/10 Target	2009/10 Achieved	Comments
Supported Self-Management	Number of Primary Care practitioners trained to deliver Self-Management	-	10	Not Achieved 2	Kimi Hauora Wairau (KHW) PHO has only recently commenced the Long Term Chronic Conditions programme and the Coordinator will start training for the 2010-11 year. Nelson Bays Primary Health (NBPH) PHO has one person (Chronic Care Coordinator) trained and the Professional Nurse Advisor has delivered dedicated courses. There are currently 20 in total who have been trained since 2006.
Provision of primary care services for Enrolled People	**Access** • Enrolment of the resident and eligible population	92%	94%	Achieved 98.3%	There were 134,950 PHO enrolments in the NM District Eligible population is based on Statistics NZ 2009 estimates.
	• very low cost access (note Murchison included in this)	3 services	4 services	Achieved 4 services	Includes Murchison.
	• urgent after-hours Primary Care Services	5 services	5 services	Achieved 5 services	The OAG Audit published 10 July 2010 shows that NMDHB has provided good access to GP After-hours services.
	First point of contact services (reducing Triage 4&5 attendance levels to Nelson Marlborough EDs)	2008/09 ED triage 4 & 5 levels	10 % reduction on base: Triage 4 – 18,145 Triage 5 – 7,375	Partially Achieved Triage 4 – 18,220 Triage 5 – 5,795	Each PHO has been provided with weekly data regarding attendance to ED of patients who meet Triage 4 & 5 criteria and have used this information to make a significant impact on the numbers presenting for Triage 5.
	Number of patients completing vascular risk assessment (VRA)	1,500	7,139	Not achieved 5,549	There was a delay in implementing the KHW programme. KHW PHO - 470 NBPH PHO - 5,079.
Provision of services for people with Long Term (chronic) conditions care	Proportion people on the diabetes register who have good diabetes management (HBA1c ≤ 8.0%)	Maori 68%; PI 62%; Other 79%	Maori >70%; PI >65%; Other >75%	Partially Achieved Maori 63.9% PI 71% Other 78.5%	NMDHB continues to work with NBPHO and KHW PHO to improve the number of Maori with good diabetes management. This includes greater efforts to arrange follow up interventions to ensure diabetes management plans are being followed. It also includes initiatives to capture interventions by Maori Health providers, especially in Marlborough, which are currently not recorded and contribute to current under reporting of the performance indicator.

Table 2: Primary and Community Services Statement of Service Performance (continued):

Outputs	Measures	2008/09 Actual	2009/10 Target	2009/10 Achieved	Comments
Provision of services for people with Long Term (chronic) conditions care	**GP Diagnostics Imaging Access** (No of Diagnostic Images)	500	500	Achieved 1,619	NMDHB was a pilot for this access however an evaluation showed that the majority of tests did not meet cost-benefit criteria.
	Number of patients received GP supported palliative care	14	18	Achieved 274	KHW PHO – 107 patients, NBPH PHO 167 patients. The original target measures were incorrectly set, hence, the higher number of patients that have been treated.
	Primary mental health services: • GP extended consultations • Packages of care	795 573	834 834	Achieved 1,488 1,441	Note that these are the number of Packages of Care (including number of counselling sessions) made available to patients. Not all patients use their full allocation of counselling sessions. The volumes are higher than expected due to NMDHB entering into a service agreement with the Ministry of Health in December 2009 who provided additional funding for both sustainable and non/sustainable PMHI volumes.
	• Primary mental health brief intervention clinical service: Counselling sessions provided	100 (partial year)	1,500	Achieved 1,548	KHW PHO has solidified their model of care in the last year around meeting 'moderate' mental health need with the provision of psychological assessment and counselling, and Anxiety Disorder group work. These services are outsourced. NBPH PHO directly employ 3.0 FTE Brief Intervention Clinical Workers, one based at a Motueka GP practice, the other two are based in the Nelson Central Business District and they provide up to four sessions for those patients with moderate mental health need. Both PHO's collect data and every quarter both PHOs can demonstrate an improvement in the patients' wellbeing. Depending on the quarter Maori referrals are between 0 – 20%. General practice feedback is positive.

How we Organised Ourselves to Achieve these Results

The key Primary and Community initiatives (our enablers) that we achieved in 2009/10 are:

Action	2009/10 Achieved	Comment
• Scoping the development and implementation for 'Integrated Primary Health Care Centres' to incorporate a full range of service providers and services	Achieved	The Business Case for the Golden Bay Integrated Health Service has been approved.
• Expansion of Primary Care capability and capacity to include management of acute patients who would normally be referred and managed by secondary services through realignment of existing service lines and contracts (within current resource investment)	Partially Achieved	Work is in progress to better manage acute presentations. This is primarily based on working with Nelson Region After Hours & Duty Doctors and Wairau GP After Hours services to reduce triage 4 & 5 patients attending the Emergency Departments. It includes Access to Diagnostics initiatives and the drafting of revised clinical pathways for services including Deep Vein Thrombosis, Intravenous Cellulitis Treatment, Transient Ischemic Attack and Sleep Studies. These will be subject to a business case value for money assessment before any service changes are finalised for Minister of Health approval as per the OPF.
• Extending 'Optimising the Patient Journey' to cover the full continuum of care	Achieved	We have achieved the extension of Optimising the Patient Journey processes into some across continuum processes e.g. diabetes. This is an ongoing process.
• Implementing the devolution of hospital provided service, DHB owned community services and community contracted services to Primary Care according to the plan agreed between the PHOs and NMDHB (within current resource investment and at no charge to patients)	Partially Achieved	Development of a 'Patient Care Alliance Memorandum of Understanding' and identify the services which would best fit a "shared service" arrangement is under way with NMDHB secondary services and KHW PHOs.
• Supporting PHOs to implement the remaining 4 community hubs under the Urgent After Hours Primary Health Care Strategy (within current resource investment)	Achieved	Implementation of After-Hours service initiatives by KHW and NBPH PHOs to establish 4 community hubs. Long term sustainability of Urgent After Hours services is being progressed.
• Improving access to Primary Care Mental Health Services to enable more people to be managed proactively by their Primary Care Practice Team.	Achieved	In 2009/10 NMDHB contracted with the Ministry of Health to increase primary mental health services, including a 0.5 FTE Youth AOD Worker, and increased volumes for extended consultations and packages of care. NMDHB is in the process of establishing a Stepped Care model alongside KHW and NBPH PHOs.

Contribution to Outcomes

These outputs contribute to the outcomes of:

- People who are at risk of illness and/or injury are diagnosed and managed earlier
- People with early conditions are treated and managed earlier and illness progression is reduced
- People with long term conditions have their care coordinated across a range of service providers leading to reduced premature disability and death.

Our performance is also reflected in the monitoring undertaken in the NMDHB Balanced Scorecard. The Scorecard Report for the period to 30 June 2010 notes that there has been an increase in the number of people now receiving annual diabetes health checks from 2749 in 2008 to 3343 in 2009. In addition for Māori there was an increase in diabetes health checks from 173 in 2008 to 223 in 200910. For the 12 months 30 June 2010 our Ambulatory Sensitive Hospitalisations were stable at 12.0% against our target of 12.7%. Our focus will need to be on treating angina and chest pain at PHO/community level to respond to the increase in the number of angina/chest pain discharges which in May 2010 increased to 81 from an average of 54 over the last 16 months.

Output Class 3: Hospital Services

Hospital Services are focused on achieving three of 'JUMBO' strategic objectives: Improving Long Term Condition Management, Improving Health and Disability Support Services and Improving Sustainability. This section outlines the hospital-based services we intend to deliver. It also outlines those hospital services we funded others to provide for our population. Hospital services include all personal health services, mental health services, Maori health services and services for older people provided through our hospital provider and through other DHBs via inter-district flows (IDFs).

Hospital Services Statement of Service Performance

For the purposes of this SOI these outputs are aggregated into: Acute (those services that are unscheduled) and Elective (those services that are scheduled) inpatient caseweights[2]; and, 'Non-admitted patient caseweights, Emergency Department Attendances[3], Assessment, Treatment and Rehabilitation Episodes and Maternity Patients. In the future we will be recording these as 'discharges' to better reflect the output as an individual receipt of service. The table below outlines some of the outputs and measures we delivered over the next three years.

Table 3: Hospital Services Outputs Class Statement of Service Performance (table continued over next page):

Outputs	Measures	2008/09 Actual	2009/10 Target	2009/10 Achieved	Comments
Acute Inpatient Caseweights	Caseweights: Acute Inpatients	12,950	13,300	Achieved 12,412 (includes maternity)	While we did not achieve the target number of acute admissions this is a good result as it means that fewer people needed urgent admission to hospital and this reflects better primary care management in the community. This is consistent with our long term population health strategy.
Elective Inpatient Caseweights	Caseweights: Elective Inpatients Procedures: Elective Inpatients	8,130 125	7,635 145	Achieved 8,614 158	Elective services to patients were over delivered by 17% by the DHB's Provider and 21% for Inter District Flows for patients treated by other DHBs.
	Increase in elective discharges to reach the target set by the Ministry of Health	-	5,968	Achieved 6,247	Elective discharges were 5% above the MOH target.
	Cancer Waiting Times (weeks to treatment)	90% within 6 weeks	100% within 6 weeks	Partially Achieved 97% of patients receive treatment within 6 weeks	97% of patients from Nelson Marlborough DHB were treated within the MOH target of having treatment within six weeks of their First Specialist Assessment.
Mental Health Acute Inpatient outputs	Number of acute inpatient bed nights occupied on a per annum basis.	8,541	8,711	Achieved 6,051	Fewer acute inpatient bed nights occupied is a goal of the health sector and reflects improved community care.
	Number of service users with a 50% improvement change in HONOS[4] from admission to discharge.	New measure	70% of admissions	Achieved: 92% of service users	
Non-admitted Patient Visits	First Specialist Attendances Follow Ups Procedures	8,247 38,475 13,802	18,475 38,875 13,952	Achieved 21,099 39,102 14,833	Demonstrates improved overall care access and reflected in lower acute inpatient occupancy

[2] New Zealand Caseweights or Weighted Inpatient Stays (WIESNZ09) is a standard classification method for all inpatient activity in NZ hospitals. Caseweights define complexity of care and are different from inpatient discharges (numbers of people treated) which will also be reported against.

[3] For more detail, please refer to Appendix 1, our 2009/2010 Price-Volume Schedule (PVS) in the 2009-10 Statement of Intent.

[4] HONOS: Health of the Nation Outcome Scales.

Table 3: Hospital Services Outputs Class Statement of Service Performance (continued):

Outputs	Measures	2008/09 Actual	2009/10 Target	2009/10 Achieved	Comments
Mental Health Follow up Face to Face contacts (excludes addictions)	Monthly number of direct client contacts to support achievement of service user/tangata whaiora recovery plans[1]	3,834	3,836	Achieved 4,787	Nelson Marlborough benchmarks amongst the top 10% of DHB mental health services providers nationally.
	Number of service users with a 10% improvement change in HONOS from admission to discharge.	New Measure	70% of service users	Achieved 96% of service users	
Number of people supported within Mental Health	Number of people accessing mental health services on a monthly basis[2] (excludes addictions)	1,013	1,015	Achieved 1,260	This reflects increased population growth and the economic situation.
Emergency Department Attendances	Number of attendances	25,295	24,295	Achieved 25,214 Nelson ED 17,594 Wairau ED	The target of 24,295 attendances in 2009/10 was just for Nelson ED. It should have also included attendances for Wairau ED.
	Percentage of people waiting more than 6 hours for treatment	-	<5%	2%	In 2009/10 2% of patients waited more than 6 hours for ED treatments which was well within the target of less than 5% of people waiting more than 6 hours. Further improvements are being made to our ED procedures to reduce the waiting time.
Assessment, Rehabilitation & Treatment (AT&R) Episodes	Bed Days: Inpatient Services Attendances/Visits:	10,571 11,570	10,873 11,920	Achieved 8,982 10,455	There were fewer patients requiring AT&R services due to improved community care. While we did not achieve the target number of AT&R bed days this is a good result as it means that fewer people needed to be cared for in aged residential care facilities. This reflects better processes to support aged people to live independently in their own homes. This is consistent with our aged care health strategy.
Maternity Services	Deliveries in facility	1,610	1,625	Partially Achieved 1,487	Fewer deliveries occurred than expected (demand driven). A health priority is to offer women who meet clinical criteria a longer post natal stay in hospital.
	Post Natal Stays	1,512	1,650	Not Measured	The original measure of bed days for Post Natal Stays has changed due to coding changes. However, we can measure the average length of Post Natal Stays by the increase in the average length of stay in 2009/10. Systems are being reviewed for 2010/11.
			Average Length of Post Natal Stays for Nelson Hospital increased from 1.96 days in 2008/09 to 2.02 days in 2009/10. Average Length of Post Natal Stays for Wairau Hospital increased from 1.92 days in 2008/09 to 2.30 days in 2009/10.		

[1] (Calculated by July, September, October, November, December 08 Follow up Face to Face contacts 19,172 divided by 5 months to average it out.).

[2] Calculated by July, September, October, November and December 08 data divided by 5 to get an average).

NMDHB OUTPUTS CLASSES and STATEMENTS OF SERVICE PERFORMANCE - Continued over page

How we Organised Ourselves to Achieve these Results

The key Hospital Services Initiatives (our enablers) that we achieved in 2009/10 are:

Action	2009/10 Achieved	Comment
• Enhanced clinical leadership to continue to engage our clinicians in all levels of planning through a participatory approach as outlined in the 'In Good Hands' Ministerial Task Group Report 2009	Partially achieved	Considerable consultation with clinical groups is underway on enhancing clinical engagement, delivering elective services and leadership. Executive Leadership Team restructured to include active service delivery strategic clinical representation.
• Continuing the devolution to Primary Care settings of relevant hospital services as illustrated by our 'GP Access to Diagnostic Imaging Pilot' initiated in the 2008/2009 year	Achieved	A GP access to Diagnostic Imaging Pilot initiated in 2008/09 remains in place and accessible to GPs for designated Diagnostic Imaging procedures, mainly CT procedures. Access is based on priority and provided within a set annual budget which is based on a designated number of Relative Value Units. New procedures have been implemented for patients five years after treatment for breast cancer (DCIS)[5] to undergo direct access to mammography rather than seeing general surgeon for access to mammography.
• Providing certainty for better more convenient access to elective services through a collective South Island Elective Services Planning (SI ESP) approach	Partially Achieved	Elective services workstream for South Island regional planning is developing common tools, processes and production methodologies which will support whole of region electives purchasing initiatives and optimal utilisation of existing resources. Addressing this aspect is essential in order to develop a regional 'common platform' through which all DHBs can enable equitable access for their populations to elective services. This supports Government policy objectives.
• Reviewing current services provision across the District to live within funding	• Partially Achieved	Good progress is being achieved in responding to the significant fiscal pressure in 2009/10 that will continue for the next three years and onward. We have been working very hard to bring our deficit in 2009/10 back into line with the position forecast in our 2009/10 DAP. The Board is adamant that there will be no on-going cyclical deficits and that we must transform how, for whom, where and by whom we deliver services. This means we will not only be considering how we fund and deliver our services, but where services will be based. The core approach NMDHB has taken to achieving smarter ways of working and identifying efficiencies is through the Rutherford Initiative. Our objective last year was to find $10M over three years. However, because of the service needs outlined above we now must find closer to $20M over the next three years. Six Rutherford reviews are now in the implementation stage. In addition a review of Home Based Support Services was completed in 2009/10.[6]
• Establishing single waitlists	Partially achieved	Work commencing with ENT and urology. Patient's currently moving between two sites but IT system changes are to be implemented to make the process more achievable and efficient. Urologists now triage all district wide referrals on one site (Nelson).
• Improving urgent after hours cover	Achieved	Additional after hours services implemented in Nelson and Wairau.
• Re-configuring primary care services, acute Emergency Department (ED) and acute inpatient services using information from the Acute Care Review (April 2009)	Partially achieved	Work is in progress to better manage acute presentations. This is primarily based on working with Nelson Region After Hours & Duty Doctors and Wairau GP After Hours services to reduce triage 4 &5 patients attending ED. It includes Access to Diagnostics initiatives with the drafting of revised clinical pathways for services including Deep Vein Thrombosis, Intravenous Cellulitis Treatment, Transient Ischemic Attack and Sleep Studies. The business case must meet value for money criteria before any service changes are signalled as per the OPF.
• Working collaboratively with South Island DHBs to plan and implement regional solutions to more, better, higher quality, more robust hospital care delivery through the South Island Heath Services Plan (SI HSP).	Partially Achieved	Good progress is being made on the comprehensive programme development that is under way with South Island DHBs on a regional strategic plan to be completed by 30 September 2010. This plan focuses on the viability (financial and clinical) of specialist hospital services. The planning (using clinical engagement) is assessing how services could be best delivered to meet objectives for equity of access, clinical responsibility, quality and safety, clinical sustainability, Maori health needs, community engagement, continuum of care and fiscal sustainability.

[5] DCIS: Ductal Carcinoma In Situ.

[6] Rutherford Initiative recommendations have resulted in budget adjustments of $13,543,151 as at 28 January 2010.

Contribution to Outcomes

These outputs contribute to the outcomes of:

- People who are at risk of illness and/or injury are diagnosed and managed earlier
- People with early conditions are treated and managed earlier and illness progression is reduced
- People with long term conditions have their care coordinated across a range of service providers leading to reduced premature disability and death.

Our performance on Hospital Services is also reflected in the monitoring undertaken in the NMDHB Balanced Scorecard. Two of the measures in the Scorecard Report for the period to 30 June 2010 notes that the unplanned hospital re-admission rate was 0.4% against a target of less than 1.6%. The average hospital length of stay was 3.21 days against a combined target for Surgical and Medicine of 3.75 days. These measures of our performance are reported and monitored each month by the Senior Management Team.

Output Class 4: Support Services

Support Services are those services that assist people with maintaining functional independence and/or support for daily living as well as palliative care support. Support services activities are focused on achieving three NMDHB strategic objectives: Improving Long Term Condition Management, Improving Health & Disability Support Services and Improving Sustainability. This section outlines the Support services we delivered to our population.

Support Services Statement of Service Performance

For the purposes of this SOI these outputs are aggregated into: Home-based support services; Residential Care support services; Day Services; Palliative Care services. The table below outlines some of the outputs and measures we delivered in the 2009/10 year.

Table 4: Support Services Output Class Statement of Service Performance (table continued over next page):

Outputs	Measures	2008/09 Actual	2009/10 Target	2009/10 Achieved	Comments
Assessments	Community Based Assessments - HOP	1,850	1,905	Achieved 2,355	Rest home residential assessments were done in the absence of a current assessment. This number will increase due to change in practice of reassessing immediately prior to residential entry.
	Residential Based Assessments - HOP	585	602	Not Achieved 131	
Life Long Disability ASC	Number of Individual Contacts[7]	1,777	1,830	Not Achieved 622	The overall number of contacts has increased from 2008/09, however, there have been changes to the MOH database as it no longer records all contacts, only assessments and reassessments.
	Number of Coordination Services	2,035	2,096	Partially Achieved 1,754	
Home-Based Support Services (per month)	Number of Non Complex Packages Units utilised pm	7,193	7,711	Achieved 14,991	The number of Complex Packages Units over the twelve months has varied due to a change in practice six months into the year. The non-complex group includes household management.
	Number of Intermediate Package Units utilised pm	-	5,839	Achieved 10,927	
	Number of Complex Packages Units utilised pm	21,787	17,518	Partially Achieved 8,813	

[7] Includes new assessment, reassessments and reviews.

Table 4: Support Services Output Class Statement of Service Performance (continued):

Outputs	Measures	2008/09 Actual	2009/10 Target	2009/10 Achieved	Comments
Residential Care Support Services				Achieved four of five targets	The continuing care bed days target was partially achieved. The increase in Dementia Care Bed Days was due to an increase of 29 additional dementia care beds in 2009/10.
	Rest Home Bed Days	152,610	152,763	165,461	
	Dementia Care Bed Days	43,145	43,999	54,624	
	Continuing Care Bed Days	118,891	122,183	117,299	
	Psychogeriatric Bed Days	7,784	5,862	7,739	
	Respite Care Bed Days	2,760	2,790	3,370	
Day Services				Achieved	
	Day Care Days	10,382	10,691	10,934	
	Respite Care Days	2,760	2,790	3,370	
Palliative Care Services				Achieved	
	Palliative Care Bed Days	401	410 clients 3,628 Bed Days	441 Clients 4,000 Bed Days	
	Home Based Support Packages	431	451	518	

How we Organised Ourselves to Achieve these Results

The key Support Services Initiatives (our enablers) that we achieved in 2009/10 are:

Action	2009/10 Achieved	Comment
• Ensuring improvement in the supervision of quality and nursing provision with the Aged Residential Care sector and contributing to the completion of the national review of Aged Residential Care services through the existing national shared DHB processes	Achieved	The Nursing Team at NMDHB are rolling out Education and Training to the sector. A programme integrating ARC providers into the DHB nursing programme has commenced and evaluation will take place annually. A regular forum meets quarterly to network and identify nursing issues and agree service development across the nursing continuum for older people.
• Having already developed a local dedicated respite bed service with a number of contracted providers we will ensure that our approach is aligned with agreed national approach and service specifications	Achieved	Our approach is in line with national service specifications and has been well communicated to the Ministry of Health.
• Ensuring funding for Home-Based Support Services (HBSS) is invested in those who are most in need and could achieve most benefit	Achieved	NMDHB has reconfigured its assessment processes for older people in line with the interRAI comprehensive geriatric assessment tool and results of assessment drive service allocation based on assessed need.
• Implementing the criteria for access to the 'interim funding pool' (IFP) to enable this client group with disabling chronic health conditions to have appropriate access to restorative support services that meet their needs	Achieved for people meeting the access criteria	There is still a service gap as some people do not meet the IFP criteria. NMDHB endeavours to meet this gap, however, there are still people we cannot provide support to as they do not meet any funding stream access criteria.
• Working collaboratively with SI DHBs to implement the InterRAI tool for the purposes of needs-assessment, coordination of care plans and delivery, improvements in quality of care and better understanding of the costs of care	Achieved	A South Island Health of Older People's Portfolio Manager's Network has been established and a work plan to 30th June 2011 has been signed off by South Island CEOs. The work plan includes roll out of interRAI across the South Island DHB, working towards common service specifications and access/eligibility criteria to services for older people and developing a common funding model across the South Island DHBs.
• Working with our two palliative care providers (hospices) to continue to implement the new specialist palliative care service specification across Nelson Marlborough.	Achieved	We now have an assessment process and client pathway to access services. NMDHB has regular meetings with the hospices. There is a needs assessor assigned to each hospice to help coordinate services to meet need.

Contribution to Outcomes

These outputs contribute to the outcomes of:

- People and their whanau with end stage conditions are supported to live and die well
- People with early conditions are treated and managed earlier and illness progression is reduced
- People with long term conditions have their care coordinated across a range of service providers leading to reduced premature disability and death.

Our performance is also reflected in the monitoring undertaken in the NMDHB Balanced Scorecard. The Scorecard Report for the period to 30 June 2010 notes that 87.6% of Support Works Needs Assessments were completed within the target of 20 working days to provide support for people with disabilities to assist in maintaining their goal of achieving an ordinary life.

EXECUTIVES

Strategic Leadership Team - Left to right:
Front Row – Robyn Henderson, Denise Hutchins, Andre Nel, Nigel Trainor, Sharon Kletchko, Peter Burton
Back Row – Nicola Ehau, Mike Cummins, Keith Rusholme, Nick Lanigan, John Peters, Harold Wereta

EXECUTIVES

John Peters, *Chief Executive*
Andre Nel, *Chief Medical Advisor*
Denise Hutchins, *General Manager Organisational Development*
Keith Rusholme, *Chief Operating Officer*
Mike Cummins, *Board Secretary*
Nick Lanigan, *Chief Information Officer*
Nicola Ehau, *Director of Māori Health (July 2009 – September 2009)*
Harold Wereta, *Director of Māori Health (beginning November 2009)*
Nigel Trainor, *General Manager Finance and Commercial*
Peter Burton, *General Manager Primary and Community*
Brenda Bruning, *Acting Director of Nursing (June 2009-February 2010)*
Robyn Henderson, *Director of Nursing and Midwifery (beginning February 2010)*
Sharon Kletchko, *General Manager Planning and Funding*

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