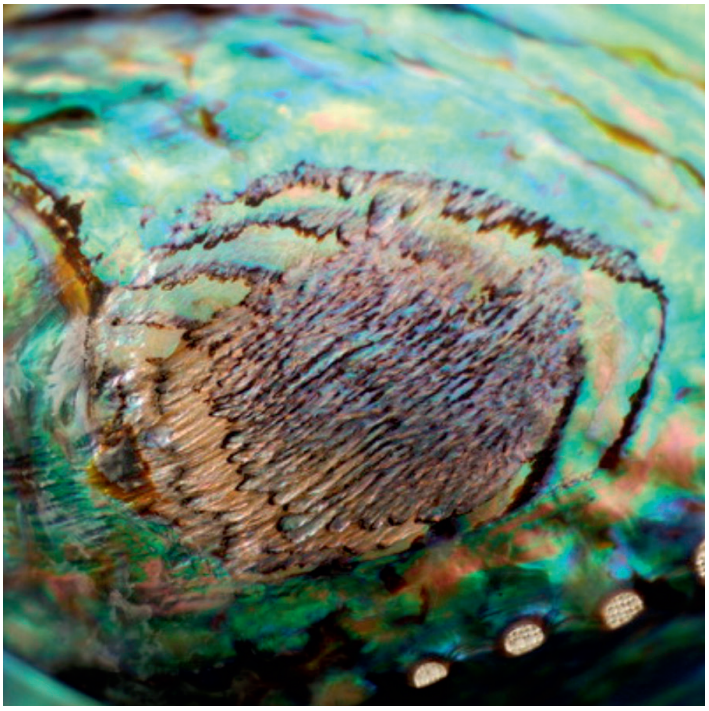
TE WAIORA Nelson Marlborough Health

E87

Presented to the House of Representatives pursuant to section 150 of the Crown Entities Act 2004

Annual Report 2017/18



Contents

Preface: A note about our name

'Nelson Marlborough Health' is the trading name of the Nelson Marlborough District Health Board.

In the first part of this annual report 'Nelson Marlborough Health (NMH) refers to our organisation and 'Nelson Marlborough District Health Board' or 'the board' refers to our 11-member governance group.

The second half of this report, from page 28, includes the financial and non-financial performance reporting that is subject to audit and in some places features our full legal name as 'Nelson Marlborough District Health Board (NMDHB)'.

Report from the Board Chair and Chief Executive

As we reflect on our major achievements, challenges and milestones during the past 12 months, we are proud of the continued organisation and community focus on Nelson Marlborough Health's mission to "work with the people of our community to promote, encourage and enable their health, wellbeing and independence" and our capacity to respond to ever-increasing demand for our services.

Overview

We are pleased to present this Annual Report for the year ended 30 June 2018.

Health services around New Zealand, and the world, continue to wrestle with an increasing demand for services, an ageing population, a range of increasing chronic conditions whilst striving to deliver good-quality and safe care across the health continuum within a fiscally -constrained environment. We believe Nelson Marlborough Health has a solid foundation in place to help us meet these challenges head on and while it will not be easy we are proud to lead a committed team to improve the health of our community.

We have seen an increase in the use of health services over the last 12 months with increases in the number of consultations with GPs, more pharmaceuticals provided across our community and increases in hospital services. This has placed increasing pressure on our health system and we have commenced two key programmes of work.

The first is the Models of Care Programme which will help us define how health services are provided to Marlborough, Nelson and Tasman communities in the future. The programme is developing a number of workstreams and will start trialling options during the coming 12 months. The second programme of work is the completion of an indicative business case as the start of a process to secure funding to develop Nelson Hospital to be better equipped to meet capacity pressures, and resolve seismic issues with the current buildings.

The replacement of our outdated patient administration system in May 2018 with a new platform, the South Island Patient Information Care System (SIPICS), enables us to more seamlessly connect patient information across all NMH health services but will also allow clinicians at other district health boards across the South Island to access information for any patients from our region who require treatment in other districts.

Successful cross-sector and agency partnerships are needed to meet community needs and achieve equity. Nelson Marlborough Health has worked strongly through the last year to develop the following partnerships:

- the South Island Alliance, comprising all five South Island district health boards
- the Top of the South Impact Forum, comprising district councils, primary health organisations, police and several government agencies who collectively work to improve housing, reduce methamphetamine harm, engage young people and reduce family harm
- the Regional Iwi Forum, comprising government agencies and representatives from the eight local iwi, who work collectively to improve outcomes for Māori
- the Top of the South Health Alliance, comprising the Nelson and Marlborough primary health organisations, Te Piki Oranga and NMH who work to improve capacity and capability in primary care.

Financial performance

For the 2017/18 year we are reporting an operational surplus of $223,000. Although this is lower than our planned $3.5 million surplus we remain in a sound financial position while continuing to invest in community healthcare, mental health services and secondary hospital care.

Acknowledgements

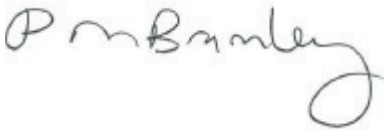
As we move into the next financial year it is important to acknowledge all the fantastic work that has happened over the previous year.

We have a health system to be proud of. We have so many dedicated and talented staff committed to delivering the best care we can, often under considerable financial constraint. We should pause and celebrate the day to day care delivered, from the safe arrival of little ones, to the improvements in supporting end of life care.

We acknowledge the kindness and compassion that leads to a better patient experience. We appreciate the year's innovations and change programmes – all of which intend to improve the quality of care.

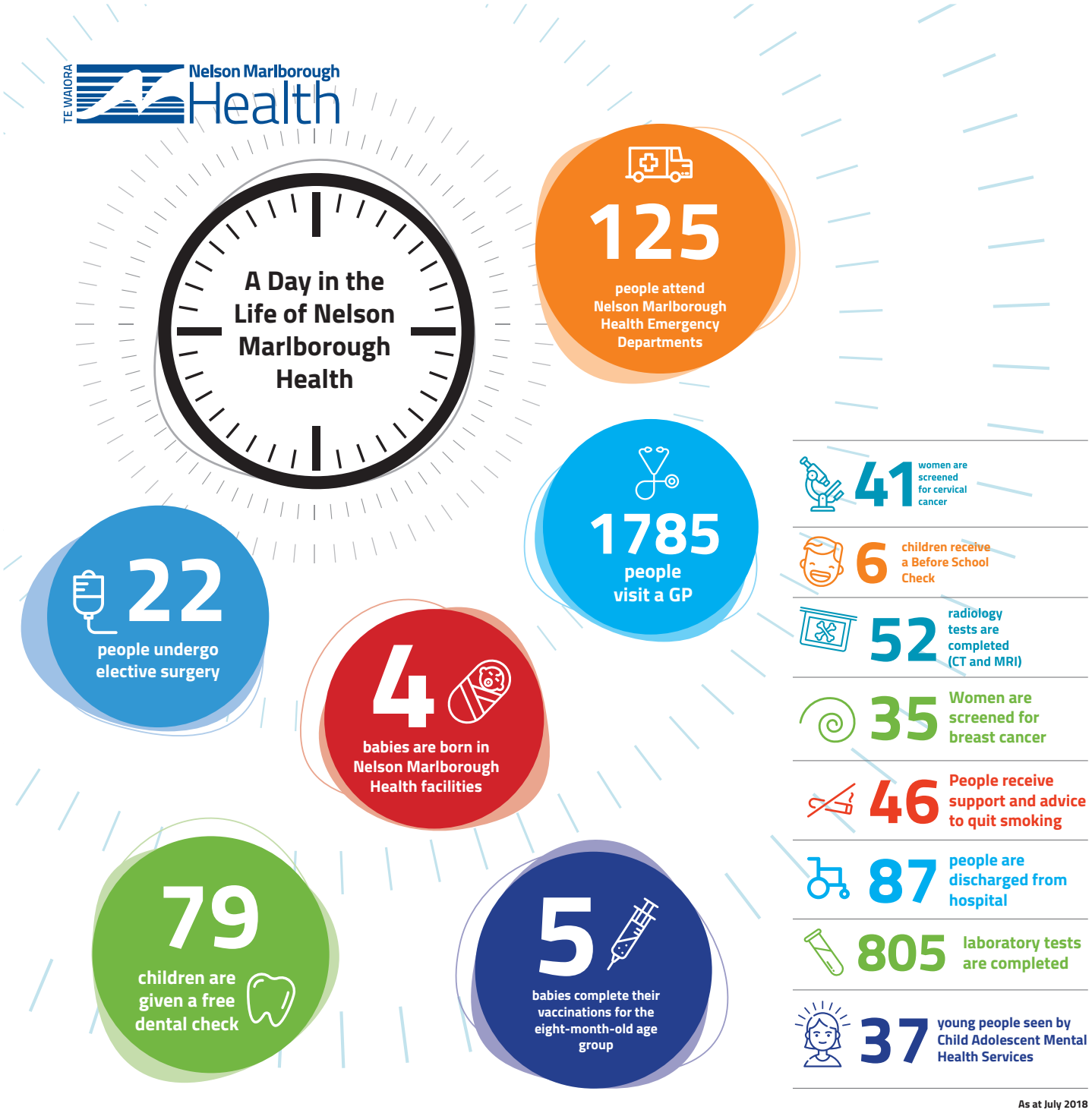
Thank you to all who are involved in the health system – whether in the frontline delivery of care, or in roles supporting the teams and infrastructure that contributes to the provision of great care.

Jenny Black
Board Chair



Peter Bramley
Chief Executive

A day in the life of Nelson Marlborough Health



Governance report

Board objectives and functions

The Nelson Marlborough District Health Board, known by its trading name as Nelson Marlborough Health (NMH) was established pursuant to section 19 of the *New Zealand Public Health and Disability Act 2000*. NMH is a Crown entity and is subject to the provisions of the Crown Entities Act 2004.

The objectives of NMH are:

- to improve, promote, and protect the health of people and communities
- to promote the integration of health services, especially primary and secondary health services
- to seek the optimum arrangement for the most effective and efficient delivery of health services in order to meet local, regional, and national needs
- to promote effective care or support for those in need of personal health services or disability support services
- to promote the inclusion and participation in society and independence of people with disabilities
- to reduce health disparities by improving health outcomes for Māori and other population groups
- to reduce, with a view to eliminating, inequity (health outcome disparities) between different population groups by implementing, in consultation with these groups, services and programmes designed to raise their health outcomes to those of other New Zealanders
- to exhibit social responsibility by regarding the interests of the people to whom it provides, or for whom it arranges the provision of, services
- to foster community participation in health improvement, in service planning and in significant changes to services
- to uphold the ethical and quality standards commonly expected of service providers and of public sector organisations
- to exhibit environmental responsibility by regarding the environmental implications of its operations
- to be a good employer.

For the purpose of pursuing and demonstrating its objectives, NMH has the following functions:

- to ensure service provision for its resident population and for other people as specified in its Crown funding agreement
- to actively investigate, facilitate, sponsor, and develop co-operative and collaborative arrangements with persons in the health and disability sector or in any other sector to improve, promote, and protect the health of people, and to promote the inclusion and participation in society and independence of people with disabilities
- to collaborate with relevant organisations to plan and co-ordinate at local, regional, and national levels for the most effective and efficient delivery of health services
- to issue relevant information to the resident population, persons in the health and disability sector, and persons in any other sector working to improve, promote, and protect people's health

- to establish and maintain processes to enable Māori to participate in, and contribute to, strategies for Māori health improvement
- to foster the development of Māori capacity for participating in the health and disability sector and for providing for Māori needs
- to regularly investigate, assess, and monitor the health status of its resident population, any factors that NMH believes may adversely affect the health status of that population, and the service needs of that population
- to promote the reduction of adverse social and environmental effects on the health of people and communities
- to monitor the delivery and performance of its services, and by the people it engages to provide or arrange for the provision of services
- to participate, where appropriate, in the training of health practitioners and other workers in the health and disability sector
- to provide information to the responsible Minister for the purposes of policy development, planning, and monitoring in relation to the performance of NMH and to the health and disability support needs of New Zealanders
- to provide, or arrange for the provision of, services on behalf of the Crown or any Crown entity within the meaning of the *Crown Entities Act 2004*
- to collaborate with preschools and schools within its geographical area on the fostering of health promotion and on disease prevention programmes
- to perform any other functions given by, or under, any enactment, or authorised to perform by the responsible minister by written notice to the board of NMH after due consultation.

Accountability and communication

Under the *New Zealand Public Health and Disability Act 2000*, NMH is accountable to the responsible government minister and provides regular reports and other informal communication. In addition, transparency of decision making and process is maintained by conducting open meetings, and by making minutes, papers and other publications available on the NMH website.

Board structure and membership

In accordance with the *New Zealand Public Health and Disability Act 2000*, the Nelson Marlborough District Health Board (the board) comprises 11 members. Seven members were elected in the October 2016 triennial elections for local government and four members are appointed by the Minister of Health. The minister then appoints the chair and deputy chair from these 11 members.

In accordance with sections 34-36 of the *New Zealand Public Health and Disability Act 2000*, the board is required to form three committees to enable it to perform its functions efficiently and effectively. The board also has the authority to form other committees as it deems necessary to fulfil its functions.

Accordingly, there are four committees:

- Statutory committees:
  - The Community and Public Health Advisory Committee
  - The Disability Support Advisory Committee
  - The Hospital Advisory Committee
- The Audit and Risk Committee

Since April 2011 the Community and Public Health Advisory Committee and the Disability Support Advisory Committee have met together in a single meeting.

From January 2017 the board determined that all board members would be members of the combined Community and Public Health Advisory Committee and the Disability Support Advisory Committee and of the Hospital Advisory Committee. The board also determined that there would be no non-board members on these committees.

The Nelson Marlborough District Health Board is also advised by the Iwi Health Board on all issues affecting Māori.

Members of the Nelson Marlborough District Health Board at 30 June 2018 were:

Name	Appointment	
Jenny Margery Black	Elected	Chair
Alan Hinton	Appointed	Deputy Chair Chair, Audit & Risk Committee
Gerald Hope	Elected	Chair, Hospital Advisory Committee
Patrick Smith	Appointed	Chair, Community and Public Health and Disability Support Advisory Committees
Jenny Margaret Black	Elected	
Judy Crowe	Elected	
Craig Dennis	Appointed	
Brigid Forrest	Elected	
Dawn McConnell	Appointed	
Alan Panting	Elected	
Stephen Vallance	Elected	

Board and committee attendance

The Nelson Marlborough District Health Board (the board) meets on a monthly basis. The board holds extra meetings when required for strategic planning or other specific issues. Attendance at board and committee meetings during 2017/18 was as follows:

Board members

Board Member	Board		CPHAC/DSAC		HAC		A&RC	
Name	Held	Attended	Held	Attended	Held	Attended	Held	Attended
Jenny Margery Black	11	8	5	4	5	3	4	3
Alan Hinton	11	10	5	4	5	5	4	4
Gerald Hope	11	11	5	5	5	5	4	3
Patrick Smith	11	10	5	5	5	4	0	0
Jenny Margaret Black	11	10	5	5	5	5	0	0
Judy Crowe	11	10	5	5	5	4	0	0
Craig Dennis	11	10	5	5	5	4	4	4
Brigid Forrest	11	9	5	5	5	3	4	3
Dawn McConnell	11	10	5	4	5	5	0	0
Alan Panting	11	11	5	5	5	5	0	0
Stephen Vallance	11	10	5	4	5	5	0	0

Key: CPHAC/DSAC: Community and Public Health and Disability Support Advisory Committees
HAC: Hospital Advisory Committee
A&RC: Audit & Risk Committee

The above tables record attendance of those board members who are members of relevant committees and are recorded as being present.

Board and committee fees

Board members are paid fees in accordance with the Cabinet Office Circular CO (12) 6 *Fees framework for members appointed to bodies in which the Crown has an interest*. Board members' fees were set within the maximum levels established for district health boards by the Minister of Health.

	Actual 2018 $000	Actual 2017 $000
Value of Board member remuneration		
Jennifer Margery Black (Chairperson)	42	41
Jessica Bagge	-	9
Jennifer Margaret Black	21	20
Judy Crowe	20	20
Brigid Forrest	21	21
Patrick Heaphy	-	9
Alan Hinton	26	25
Gerald Hope	20	20
Dawn McConnell	24	20
Patrick Smith	21	20
Allan Panting	20	11
Stephen Vallance	20	11
Craig Dennis	21	11
Total remuneration	**256**	**238**

Board register of interests

The Nelson Marlborough District Health Board (the board) maintains an interest register and ensures members are aware of their obligations to declare conflicts of interest. The register identifies areas where a board member, or a member of the NMH executive leadership team, has an interest that could lead to a potential conflict. In addition to the register, members are invited to declare any specific conflicts at the commencement of each meeting.

The following interests were declared as at 30 June 2018:

Board members

Name	Interest
Jenny Margery *Black(Chair)*	▪ Chair, South Island Alliance Board ▪ Chair, National DHB Chairs group ▪ Chair of West Coast DHB ▪ Member of West Coast Partnership Group
Alan Hinton *(Deputy Chair)*	▪ Trustee, Richmond Rotary Charitable Trust ▪ Trustee, Natureland Wildlife Trust ▪ Trustee, Nelson Christian Trust ▪ Director, Solutions Plus Tasman Ltd ▪ General Manager, Azwood Ltd ▪ Secretary, McKee Charitable Trust
Judy Crowe	▪ Nil
Gerald Hope	▪ Chief Executive, Marlborough Research Centre ▪ Director, Maryport Investments Ltd ▪ Councillor Marlborough District Council (Wairau Awatere Ward)
Jenny Margaret Black (Marlborough)	▪ ACP Practitioner
Brigid Forrest	▪ Doctor, Hospice Marlborough (employed by Salvation Army) ▪ Locum GP in Marlborough (not a member of PHO) ▪ Member, South Island Alliance Palliative Care Workstream ▪ Daughter-in-law employed by Nelson Bays Primary Health as a Community Dietician. ▪ Small Shareholder and Director on the Board of Marlborough Vintners Hotel.
Dawn McConnell	▪ Director, To Hauora O Ngati Rarua ▪ Trustee, Waikawa Marae ▪ Regional Iwi representative, Department of Internal Affairs
Patrick Smith	▪ Managing Director, Patrick Smith HR Ltd
Craig Dennis	▪ Trustee of Nelson Region Hospice Investment Trust ▪ Partner of CFO on Call ▪ Business consultancy Director of CD & Associates ▪ Business consultancy Director of Scott Syndicate Development Company Ltd ▪ Property Developer Director of 295 Trafalgar Street Ltd ▪ Director of KHC Dennis Enterprises Ltd ▪ Chair of Progress Nelson Tasman ▪ Director, Taylors Contracting Co Ltd
Stephen Vallance	▪ Chairman, Marlborough Centre of the Cancer Society ▪ Chairman, Crossroads Trust Marlborough

Name	Interest
Allan Panting	▪ Chair Orthopaedic Prioritisation Working Group ▪ Chair General Surgery Prioritisation Working Group ▪ Chair Vascular Services Tier Two Specification Group ▪ Panel member to review Auckland DHB Orthopaedic Service ▪ Chair Ophthalmology Service Improvement Advisory Group

Executive leadership team

Name	Interest
Peter Bramley *Chief Executive*	▪ Brother has been engaged by NMDHB to explore options for NMHCT ▪ Daughter employed by NMH as a registered nurse
Nick Baker *Chief Medical Officer*	▪ Senior Clinical Lecturer, Community Child Health, University of Otago Wellington School of Medicine ▪ Member Steering Group NZ Child and Youth Epidemiology Service (previously Chair of and co-founder of the service) ▪ Instructor for Advanced Paediatric Life Support NZ ▪ Technical Advisor Whakawhetu National SUDI prevention for Māori ▪ Member of Paediatric Society of NZ ▪ Fellow RACOP ▪ Occasional Expert Witness Work – Ministry of Justice
Hilary Exton *GM Allied Health*	▪ Member of the Nelson Marlborough Cardiology Trust ▪ Member of Physiotherapy New Zealand ▪ Member of the New Zealand Paediatric Group ▪ President of the Nelson Marlborough Physiotherapy Branch
Pam Kiesanowski *Director of Nursing& Midwifery*	▪ Chair SI NENZ Group
Jane Kinsey *GM MH &Addictions &DSS*	▪ Husband works for NMH in AT&R as a Physiotherapist
Kirsty Martin *GM Information Technology*	▪ Nil
Cathy O'Malley *GM Strategy Primary & Community*	▪ Daughter employed by NMH within Pharmacy service
Lexie O'Shea *GM Clinical Services*	▪ Nil
Eric Sinclair *GM Finance, Performance & Facilities*	▪ Trustee of Golden Bay Community Health Trust ▪ Wife is a Registered Nurse working in General Practice on a casual basis
Ditre Tamatea *GM Māori Health & Vulnerable Populations*	▪ Partner is an Obstetric and Gynaecological Consultant working in other DHBs

Name	Interest
Rachel Wells *General Manager People & Capability*	▪ Husband employed by NMH in Facilities service
Dr Elizabeth Wood *Chair, Clinical Governance Committee*	▪ General practitioner Mapua Health Centre ▪ MCNZ Performance Assessment Committee Member

Note the executive leadership team interests recorded in the table above do not include their membership or roles within nationwide or regional executive or work groups that they hold as a result of their employment.

Ministerial Directions

Section 151(1)(f) of the *Crown Entities Act 2004* (the Act) states that the annual report must contain information on any new direction given to NMH by a minister in writing under any enactment during that financial year, as well as other such directions that remain current.

'Direction' is defined in the Act as "a direction given by a minister under this Act or the entity's Act to an entity or to a member or employee or office holder of an entity (for example, a direction on government policy, a direction to perform an additional function [issued under section 112 of the Act], or a direction relating to the entity's statement of intent)".

The following have been identified as ministerial directions and although referred to in the singular the direction was issued to all DHBs:

- the 2011 Eligibility Direction issued under s.32 of the *NZ Public Health and Disability Act 2000*
- the requirement to implement the New Zealand Business Number (NZBN) in key systems by Dec 2018, issued in May 2016 under s.107 of the *Crown Entities Act*
- the direction to support a whole of government approach issued in April 2014 under s.107 of the *Crown Entities Act*. The three directions cover procurement, ICT and property and the former two apply to DHBs
- the direction on the use of authentication services issued in July 2008, which continues to apply to all Crown agencies apart from those with sizeable ICT business transactions and investment specifically listed within the 2014 direction

Service updates

Māori health & vulnerable populations

Nelson Marlborough Health (NMH) is committed to reducing health inequities for Māori and other vulnerable population groups within its district. Our commitment is to build a centre of excellence for Māori health and work towards equity for the most disadvantaged people in our region.

The Nelson Marlborough District Health Board and its Treaty partner the Iwi Health Board continue to progress their working relationship, with more regular joint meetings in the 2017/18 year.

Whare Ora: Healthy Homes

NMH continued to support the Healthy Homes initiative that has insulated over 1000 homes across the district, benefiting almost 4000 high-needs individuals.

The new Whare Ora service was launched as a pilot project for 40 homes with the intent to reduce hospitalisations for tamariki with respiratory problems resulting from living in cold, damp homes. Data shows the ambulatory sensitive hospitalisation rates for Māori children are significantly related to respiratory problems – the result of living in unhealthy homes.

More than 50 per cent Māori in the Nelson Marlborough region live in the four most-deprived deciles and one in three tamariki live in a household that earns under $17,000 per annum.

Hauora Direct: a 360 degree health assessment

Hauora Direct is a 360 degree health assessment conducted in multiple settings including homes and workplaces.

The health assessment aligns to health priority indicator areas for Māori and is designed to accelerate sector performance against national Māori health priority areas.

In 2017/18 Hauora Direct was successfully conducted for Franklyn Village residents and for Golden Bay Fruit employees. Almost 90 per cent of adults and 86 per cent of children screened at Franklyn Village were found to have a health issue.

In 2017/18 Hauora Direct was integrated into Victory Community Centre and Tahuna Community Centre practices, with steps taken to introduce the system to hospital paediatric and mental health and addictions units.

Steps have also been taken to integrate Hauora Direct into NMH's IT system. The aim is to have portable technology to facilitate the delivery of Hauora Direct, to enable:

- health equity for high-needs population groups
- onsite enrolment for individuals
- automatic text reminders for appointments
- data entry as the assessment takes place
- immediate electronic referrals and appointments
- rapid collation of assessment summaries
- a shared view of assessment information and recommended interventions
- quantifiable Hauora Direct performance tracking.

Mokopuna Ora: Sudden unexpected death in infancy prevention (SUDI)

The redevelopment of the NMH safe sleep device (SSD) programme in 2017/18 saw the purchase of pēpi pods and wahakura, a system to distribute SSDs and SSD training for 34 new distributors.

The SSD distributor network has expanded beyond traditional maternal health settings in order to reach more vulnerable whānau and hapū mama throughout our community. This expanded reach has also provided opportunity to raise awareness of SUDI risk factors, safe sleep practices and services like Pēpi First, NMH's incentivised quit smoking service for hapū wāhine and their whānau.

In addition to the SSD programme, the Māori Health and Vulnerable Populations team Te Waka Hauora supported community events such as the Big Latch On (breastfeeding) and wahakura weaving wānanga.

In 2017/18 Te Waka Hauora made progress towards the future launch of Hapū Wānanga, a kaupapa Māori pregnancy and parenting education programme.

Wai Māori Fresh: Healthy environments

Wai Māori Fresh is a joint initiative between Māori Health and Vulnerable Populations and NMH Public Health Service staff who worked with Te Awhina Marae representatives in Motueka to install a water filtration system for the marae, benefiting participants in the marae's kohanga reo and resident kaumatua.

Māori Cancer Pathways Project: He Mate Pukupuku

Completed this year, the Māori Cancer Pathways Project He Mate Pukupuku project sought to improve the Māori cancer pathway, particularly by increasing Māori health literacy for cancer and increasing the cultural competence of healthcare professionals.

Project findings were shared with South Island DHBs and the decision made to continue project initiatives such as health literacy work.

Investment in Te Piki Oranga

NMH acknowledges the importance of a kaupapa Māori approach to mitigate Māori health inequities.

Accordingly, local Māori health provider Te Piki Oranga was awarded an 'evergreen' contract which brings a greater degree of certainty to its relationship with NMH and a more flexible funding approach. NMH funding was also granted to Te Piki Oranga for:

- the kaumatua day programme, a unique service provided by Te Piki Oranga, where navigation support is offered to local kaumatua
- the establishment of a kaupapa Māori oral health service which helps connect tamariki and whānau with oral health services
- the establishment of the first kaupapa Māori lactation service in the South Island.

Poutama: An integrated Māori model of care for mental health and addictions services

In 2017/18 NMH continued to progress the Poutama model of care by:

- increasing the cultural competency of mental health and addictions service staff
- increasing the number of Māori health positions within the service
- planning to introduce the Hauora Direct assessment process to the service
- educating staff and whānau about services users' preferences for their care and rehabilitation, as part of their advance care planning.

Community services

Primary care & community care

The Strategy, Primary and Community team aims to improve health outcomes for everyone in Nelson Marlborough by developing strategies and implementing plans to ensure the local health system is fit for the future, and by funding or delivering primary and community health services.

Making a health system that is fit for the future

NMH wants to improve and transform the way healthcare is provided in Nelson Marlborough. Our health services need to address the needs of our community, especially Māori and vulnerable populations, and cope with increased demand. We need health services that are safe, high-quality, and that take advantage of new technology.

Initiated in 2017/18, the Models of Care Programme encourages us consider how the various parts of our health system could work together better to improve communities' health outcomes. The programme will support innovation to deliver a more connected and networked health system that feels seamless.

A key component of this is designing and testing improvements and changes to the way health and healthcare are provided. The programme aims to build on the positive changes and projects that are already underway.

A clinical working group was appointed to the programme, to ensure proposed models of care align to Nelson Marlborough Health needs and promote the transformation of the total health system. Group members were selected for being innovative thinkers, with a health system view, who connect well with their clinical peers and colleagues. They are not representatives of a particular profession, care setting or organisation – but these aspects were considered when they were selected.

In 2017/18 the initial workstreams commenced, and a large number of people (including consumers) participated in workshops to share their thoughts about improving healthcare.

Community feedback

Each year Nelson Marlborough Health holds community engagement meetings to provide an update on health initiatives and obtain feedback from the community about issues that matter to them.

In 2017/18 these meetings targeted specific population groups. They were held at Whakatu Marae (reaching Māori health providers and consumers), the Stoke Community Centre (reaching older people), Murchison and Takaka (reaching rural and older persons), Nelson (reaching youth and older persons) and Seddon (reaching a rural and post-earthquake community).

The communities, particularly small rural communities, expressed a strong desire for telehealth. Telehealth is the use of information and communication technologies to deliver healthcare when patients and care providers are not in the same physical location. Telehealth examples include conducting follow-up specialist appointments over the phone, and the diagnosis and treatment of illness via secure video conference.

Telehealth is seen by these communities as a way to improve their access to health services by reducing travelling and waiting time, particularly for those who find it difficult to take time off work. In response, Nelson Marlborough Health is running telehealth pilots to understand the associated benefits and barriers, before it is implemented more widely.

Pharmacy and medication management

Pharmacists already contribute substantially to the effectiveness of the health system. Pharmacists are an integral part of most people's experience of healthcare, both in the community and in hospitals. However, the current system does not make the best use of pharmacists' unique skills.

Successful negotiations were completed for the Integrated Community Pharmacy Services Agreement (ICPSA), to take effect on 1 October 2018. The agreement is evergreen (it has no end-date) and allows for greater localisation of targeted services.

The new contract covers professional advisory services and supports the skilled role of pharmacists in medicines management. It will ensure future funding for professional advisory services provided by pharmacists does not depend on dispensing a pharmaceutical product.

Home and community support services

The people in our district are generally healthier than many others in New Zealand. Although we have the highest proportion of older people in the country, they have comparatively good health and are in a 'younger' demographic (ie, expenditure for older persons is largely for people aged 75+).

While living in aged residential care facilities is appropriate for a small proportion of our population, studies have shown a higher level of satisfaction and better long-term outcomes for people who remain in their own homes and positively connected to their communities.

To prepare for future demand, and better meet the need of older persons and those with chronic health conditions, we changed the home and community support service model.

The new model aims to achieve greater independence and improved quality of life for older people by achieving the following objectives:

- client-focused, high-quality services, that support maximisation of client independence
- integrated services that proactively respond to client needs, and are co-ordinated to meet client goals
- equity of access and service allocation across the district based on client needs
- clear eligibility criteria, streamlined referral processes and responsive service provision
- effective partnerships between contracted providers and the planning and funding department
- consistent and robust approach to managing quality with clear accountabilities for service provision
- fair and consistent funding structures which support the flexible, innovative and efficient use of resources to meet the needs and goals of clients.

Implementation of the new model in 2017/18 was mostly smooth, with a small number of issues resolved.

The Pepi First quit-smoking service

Pepi First is an incentivised quit-smoking service designed to support pregnant/hapū wāhine to give up smoking and avoid the negative effects of smoking on both themselves and their baby.

The programme uses carbon monoxide monitors to graphically show mothers the danger of smoking to an unborn baby. It also provides one-on-one support from a quit coach, nicotine replacement therapy and awards vouchers for remaining smoke-free.

Such programmes have been shown to improve quit rates for Māori and other high-need population groups. By the end of the 2017/18 year Pepi First had been running for one year; quit-smoking success rates were approximately 43 per cent which compares favourably to previous rate of 15 per cent or less.

Clinical governance

Clinical governance structures are now well established with clinical heads of department and clinical directors bringing together groups of departments. 2017/18 saw increased reporting to the Nelson Marlborough District Health Board (the board) about clinical issues.

Progress towards achieving clinical governance goals includes:

- analysis of patient experience survey data to find specific groups of patients who were dissatisfied with the information they were given at their time of discharge from hospital.
- positive results arising from local tests of change to assess dissatisfaction with medication information at discharge.

A local survey of patients was not implemented as the national patient survey rates for Nelson Marlborough are reliably above the national average. However, patient survey data is being used to support projects underway in surgical, endoscopy and orthopaedic pre-admission wards.

The Consumer Council was established in April 2017 and in the 2017/18 year completed its first year of operation, reporting to the board each month.

All of Nelson Marlborough GP practices contribute to the primary care patient experience survey.

Clinical services

NMH clinical services in 2017/18 provided an extensive range of elective and acute services for the Nelson Marlborough district – under a 'one service, two sites' operating model.

As is the trend nationally, the increase in chronic conditions and the aging population within the district was reflected in the increased complexity of presentations to our emergency departments – with subsequent increased admissions to our hospitals.

While this caused significant workload pressures on all NMH staff, our clinical and support teams continued to offer a high values-based professional service with care and compassion.

In 2017/18 we:

- achieved our elective surgeries discharge target of 7533
- provided 18,283 first specialist assessments and 37,601 follow-up appointments with specialist services
- delivered 16,392 medical and surgical procedures
- met the revised target requiring 90 per cent of cancer patients to receive treatment within 62 days after a referral for potential cancer
- assessed and provided care for 45,573 people who presented to hospital emergency departments
- noted the time people spent in emergency departments increased by eight per cent, indicative of higher acuity and case complexity.

The opening of the Marlborough Urgent Care Centre in November 2017 was a highlight – a collaborative effort between NMH and the Marlborough Primary Health Organisation. The availability of the centre, adjacent to Wairau Hospital's emergency department (ED), resulted in a reduced number of presentations (to approximately 200 per month) to the ED, particularly among lower-acuity patients.

The Motueka maternity unit external contract provider ceased service in September 2017. NMH stepped in to run the service for a six-month period; a favourable evaluation of the service in this time led to the decision to continue the primary maternity service for the foreseeable future.

In 2017/18 the service was developed to focus on health outcome measures within the 'first 1000 days' national project. These include: Enrolling with a lead maternity carer (LMC) by the time a woman is 12 weeks pregnant, smoking cessation in pregnancy, normal birth, family-focussed care, breastfeeding, maternal and infant mental health and bonding, parenting and pregnancy education, safe sleep and integrated care.

Antenatal, birth and postnatal care service use significantly increased at the Motueka maternity unit and the unit's service model supports the sustainable availability of LMCs to the local community.

At Wairau Hospital, a modified maternity service model was implemented in December 2017, taking into account recommendations from an external review and also informed by the evaluation of the Motueka maternity unit. The Wairau maternity service model was modified to:

- adequately respond to acuity and periods of increased activity in a safe and timely way
- find ways to retain a safe LMC service for the Marlborough community amid a regional shortage of community LMCs, which increases workload pressure on Wairau Hospital's core maternity service.

Other highlights for 2017/18 include:

- full compliance with the multi-employer collective agreement for registered medical officers
- the start of tele-radiology reporting for after-hours medical imaging at Nelson Hospital, allowing us to reduce the level of after-hours work for the MRT team and offer them a better work-life balance
- a review of the model of care for the intensive care and coronary unit and subsequent increase in nursing staff.

Disability support services

Enabling good lives

In 2017/18 the disability sector prepared for transformational change, led by the *Enabling Good Lives Strategy*, a partnership between the disability sector and government agencies.

This strategy recognises that disabled children are growing up wanting the same things as non-disabled children, and the expectations of disabled adults have changed and grown. There is also increasing recognition that disabled people are experts in their own lives, and our support needs to ensure and facilitate their right to be involved in the decisions that affect them which will then, in turn, lead to better outcomes.

In 2017/18 we began to emphasise the importance of future change with our staff, by introducing a self-assessment tool to stimulate reflections and learnings from the way we work.

In 2017/18, in consultation with service users, we started a process to re-name Disability Support Services (DSS).

The start of a new monthly information evening in 2017/18 is proving useful for recruitment; people are shown a presentation and videos of service users and support workers. This is an innovative approach and we remain focused on ensuring that we employ the right staff, with the right mind-set and attitude to ensure we optimise the wellbeing of the people we support.

Overview of our services

In 2017/18 Disability Support Services provided the following services:

- community residential homes
- day activities and vocations support
- respite care and carer support
- day services for adults with intellectual and physical disabilities.

Approximately 239 people accessed our services and were supported by 370 staff. There are 53 homes across the district providing either residential, respite and supported living services.

Investments and achievements in 2017/18

NMH was asked by the Ministry of Health to hold the contract for regional child respite services following the exit of the previous provider.

We have been running this service for one year and referrals for child respite care are increasing, prompting us to explore options to expand. NMH recognises the importance of access to respite care, for both the child and their whānau.

Another highlight was a stronger relationship with landlords, such as Housing NZ, to ensure our residential homes and facilities are fit for purpose. NMH contracted an experienced health and safety expert to review some of our houses, especially those for residents with challenging behaviours, and developed a work programme to implement the review recommendations.

Recommendations from two service audits were incorporated into this programme, for which the key aspects are:

- engagement of people and whānau
- improved incident investigation and improvement
- staff training, support, engagement and participation
- improved management and use of facilities and equipment
- better management of challenging behaviour and aggression in the workplace.

Because new referrals to residential homes in 2017/18 were mostly for services users with complex behaviour, NMH appointed two new group leaders to support staff who work with these people and their families and with our partner agencies.

Mental Health and Addiction Services

Service integration programme

NMH Mental Health and Addiction Services underwent significant change in 2017/18, as in the previous year.

The changes were prompted by existing service review recommendations and aim to ensure NMH can respond to current and anticipated future service demand and community need.

In particular, reviews found the need for NMH services to be better integrated with primary and community services, physical health services, and with cross-sector partners.

Service integration was also emphasised by the Government Inquiry into Mental Health and Addiction panel members who visited NMH in April 2018.

The panel held a public forum attended by approximately 120 people, and met with NMH leaders and staff, local non-government organisations, NMH partner agencies, consumer groups and young people. All were encouraged to provide written submissions to the panel.

Service models of care were examined through a series of five workshops for each model of care theme. The workshops applied quality-improvement methodology that focussed on a person's transition through the service, including Māori health, immediate support, intense support, integrated community support, independent living, quality improvement processes and workforce development.

The workshops also applied a person/whānau-centred approach, with an emphasis on early intervention, responsiveness and accessibility. The process ensured a good understanding of what was working well, and identified opportunities for improvement – resulting in a plan to integrate change and new initiatives into mental health and addiction services over the next two to three years.

The workshops involved more than 100 primary and secondary healthcare professionals, community and non-government organisation representatives, service users and whānau members.

NMH Mental Health and Addiction Services will continue to drive change through the health system-wide NMH Models of Care programme that started in 2017/18.

Primary and community partnerships

In 2017/18 we continued to strengthen roles for our primary and non-government organisation (NGO) partners who provide critical early intervention, thus ensuring people get the help they need earlier and reducing their need for secondary care.

All NGO contracts were adjusted after a stocktake of NGO activities to identify opportunities for improvement. Examples of contract changes include:

- increasing the contract term to three years
- filling gaps in service support (eg postnatal depression support)
- commencing a new pilot programme in Blenheim to strengthen employment support services.

We also started reviewing contract arrangements for our housing and recovery support services.

22 nurses completed the inaugural mental health credentialing programme for primary care and plans were made to repeat the programme.

We continued to work with our primary care partners to provide psychosocial support after emergency events. For example, in 2017/18 we continued to support earthquake-affected residents in Ward and Seddon, and cyclone-affected Tasman residents.

NMH completed its psychosocial response business plan and committed to facilitating biannual psychosocial response training and workforce development for agencies and our communities.

Secondary service enhancements

Investments and improvements were made to address the increasing demand on our secondary (hospital) services, including:

- providing training for staff, such as motivational interviewing and de-escalation and communication training
- employing new patient support security personnel in the Wāhi Oranga inpatient ward
- reducing levels of seclusion, with the safety and wellbeing of staff and patients in mind
- employing a mental health and addictions pharmacist
- introducing clinical co-ordinators to support clinical teams
- contracting Home Care Medical to provide 24/7 triage and phone support for referrals to our services
- establishing an after-hours roster for community assessment and treatment team members in the emergency department where they are ready to respond to urgent calls
- relocating our Māori mental health team to join the Maori Health and Vulnerable Populations team (Te Waka Hauora) to enable better collaboration
- working with physical health and disability support service staff to ensure a coordinated response to people with complex needs who may have previously struggled to have their needs met by a single service. This aligns with our commitment to an 'equally well' approach for service users and examples include providing influenza immunisation and metabolic monitoring for service users.
- adopting Health Connect South and SI PICS information technology platforms across our services and planning to make mental health and addictions service client records more accessible to hospital clinicians to enable better, safer patient care.

Information technology and infrastructure

SI PICS

A major milestone was reached in 2017/18 with replacement of the 20-year old patient administration system with a shared regional system called SI PICS (South Island Patient Information Care System) that seamlessly connects patient information across all NMH health services.

NMH was the first district health board (DHB) to introduce SI PICS to all sites and services and the second DHB to introduce SI PICS to its hospitals.

The move is part of a South Island Alliance initiative to replace nine different administration systems with a single regional patient administration system.

HealthOne

Also in 2017/18, hospitals, GPs and pharmacies in the Nelson Marlborough region started using the new HealthOne shared patient records system, following the introduction of Health Connect South (HCS) the previous year. NMH's use of these regional systems enables us to share critical patient information (with appropriate permissions) where and when it's needed, wherever a patient is in the South Island.

eRecords

The digitalisation of paper records commenced in 2017/18, moving them into the HCS system, and this has many benefits to both patients and clinicians, including:

- better clinical decision-making as a result of clinicians being able to search and find information more easily
- the ability for more than one person to view a record at the same time
- reduced need for physical records storage space
- improved privacy safeguards
- productivity gains for the medical records team and administrators who have historically spent a lot of time handling paper records.

eObservations

In 2017/18 planning started towards the introduction of eObservations, a nursing tool that improves patient safety by automatically calculating early warning scores and sending alerts as required. The new tool will also contribute to the NMH 'Paper-lite' strategy by replacing paper charts with a digital record.

IT system upgrades

The underlying infrastructure and security of NMH IT systems was strengthened by upgrading supporting systems (eg Microsoft Office) and adopting Infrastructure as a Service (IaaS) platform.

Our people

NMH's local health services must cope sustainably with increasing demand for services across our district.

NMH has local alliances where we partner with primary care and other stakeholders to provide and improve local health service integration. This partnership model approach assists in attracting and retaining qualified and trained staff within the NMH workforce.

A skilled, supported, responsive and diverse workforce is essential for sustainable service delivery. NMH needs the right mix of people in sufficient supply working in partnership with each other and taking a 'whole of team' approach which has been shown to deliver safer and more effective healthcare.

There is stability and experience in our wider district health and disability workforce. This workforce provides a significant opportunity for Nelson Marlborough to be a training/mentoring hub for the entry-level health and disability workforce in New Zealand.

We must take responsibility and make improvements to continually develop and support our people so that our workforce culture is inclusive and empowering. By trusting, valuing and fully-engaging health professionals we can improve patient care, job satisfaction, recruitment and retention. Focusing on improving clinical workforce retention and fostering clinical leadership continues as a key NMH priority.

Staff engagement

The Staff Engagement: Working Together partnership group continues to prioritise improvements in staff engagement and organisational culture. Key focus areas for the partnership have been around the launch of the Building Respect program in 2017/18, and providing a forum to discuss issues and opportunities that affect our staff.

In 2017/18 NMH, in conjunction with other district health boards, planned to adopt the State Services Commission's leadership framework that familiarises NMH people leaders with leadership and management capabilities.

Workforce development

NMH supports innovative workforce development ensuring health professionals work to their full scope of practice in the new and emerging models of patient care, with the support of an appropriately trained kaiawhina (unregulated) workforce.

In 2017/18 NMH improved its workforce development, education and training across the district by:

- building and aligning the capability and capacity of the health workforce to deliver new models of care
- improving the retention and sustainability of our vulnerable workforces
- growing the capacity and capability of Māori in our health workforce
- developing a health workforce that is representative of the community in which it delivers services to (
- strengthening health leadership, and management capability sector-wide
- developing an agile, change-ready and responsive workforce that will prepare us for change.

Health, safety and wellbeing

All NZ workforces are covered by the Health and Safety at Work Act 2015 and regulations made under the Act (unless specifically excluded), and are regulated by WorkSafe NZ.

NMH is committed to ensuring the health, safety and wellbeing of its employees, contractors and volunteers who work on or visit an NMH-owned or operated site. NMH also has responsibilities to patients, service users and others.

We do this by providing or ensuring:

- a safe work environment, safe plant and equipment, and adequate facilities
- a culture where our staff are encouraged to speak up and be heard
- emergency procedures support, and supportive debriefs for our staff
- hazard/risk reporting, monitoring and management systems, tools and resources
- adequate training and worksite-specific induction processes
- document and data control
- workplace health and wellbeing initiatives
- injury management, rehabilitation and return to work processes
- worker consultation and participation
- recognition of safety champions
- competent health and safety representatives
- measurement and evaluation processes – both lag and lead indicators.

Good employer

NMH aspires to be a 'good employer' by applying the following elements:

- NMH Values: Integrity, Respect, Innovation and Team Work
- leadership, accountability and culture
- health, safety and wellbeing
- equal employment opportunities
- recruitment, selection and induction
- remuneration, recognition and conditions
- recognition of the aims and employment needs of Māori and Pacifica
- recognition of the aims and cultural differences of ethnic and minority groups, and building of cultural competence
- recognition of the employment needs of people with disabilities
- harassment and bullying prevention.

NMH has an equal employment opportunities focus within the relevant policies. A highly contestable recruitment and selection procedure is followed to ensure fairness and equal opportunity.

Learning, training and development opportunities are offered to all staff, and personal performance and development plans are a mandatory requirement for all employees.

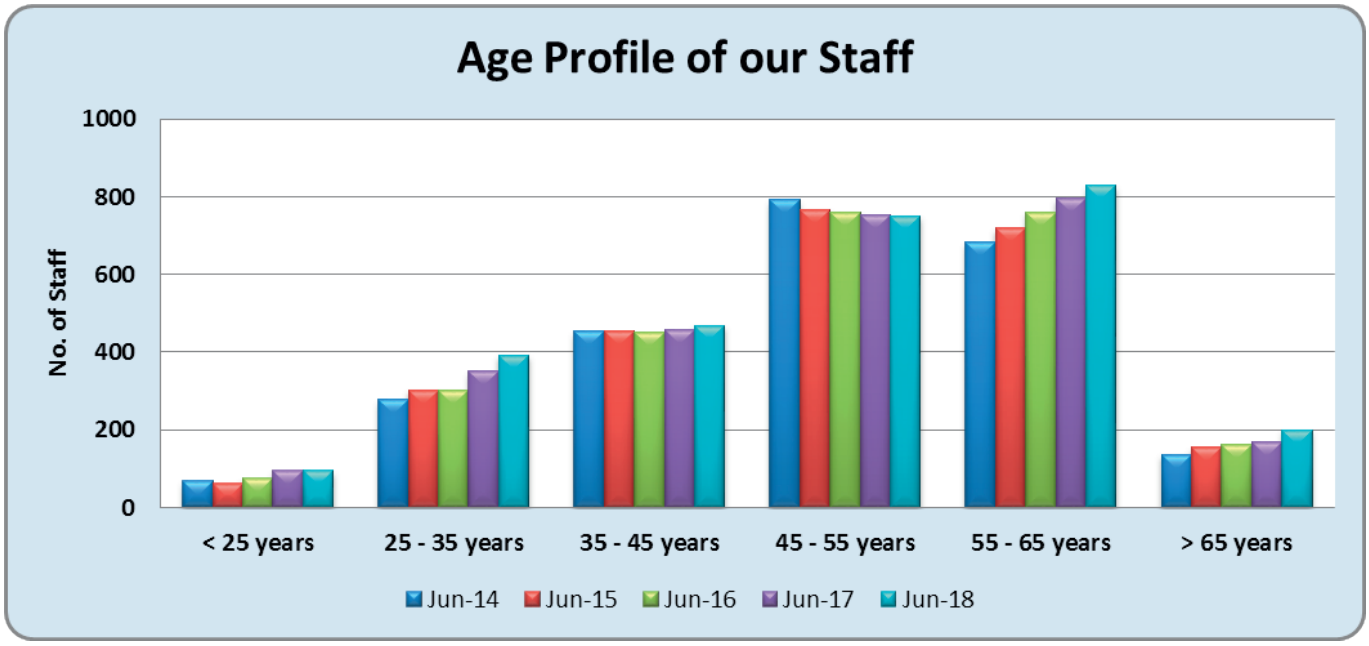
Workforce profile

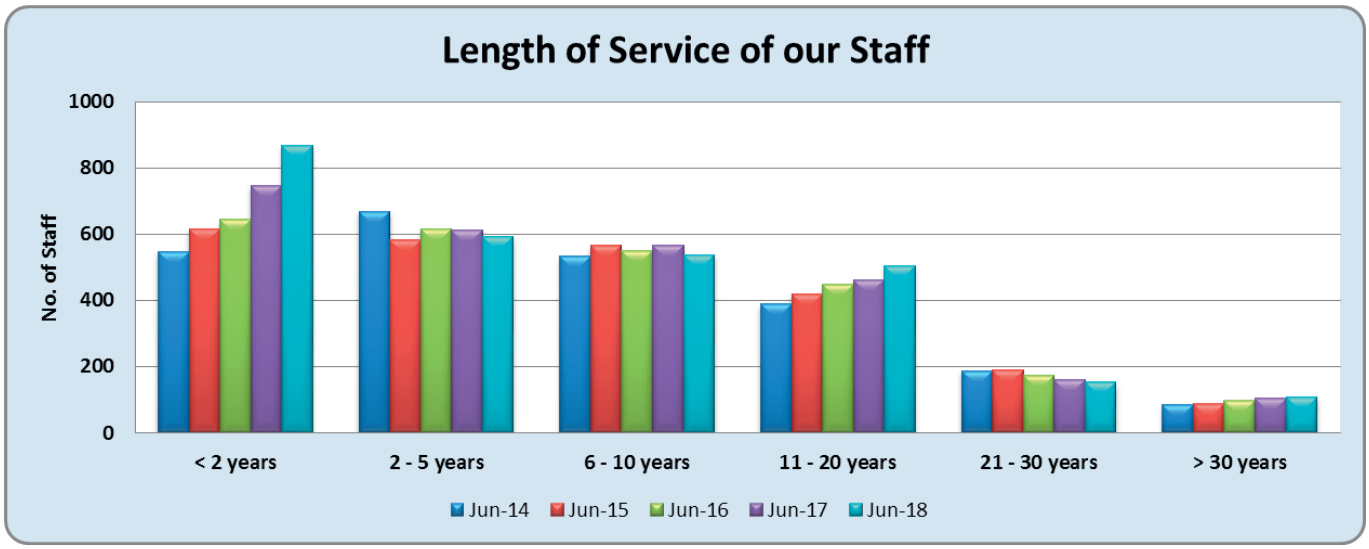
The table below provides a profile of the NMH workforce.

Employee by gender	Jun-14	Jun-15	Jun-16	Jun-17	Jun-18
Female	1,970	2,031	2,086	2,177	2,281
Male	441	429	442	474	481
Total staff (headcount)	**2,411**	**2,460**	**2,528**	**2,651**	**2,762**

Employee by employment grouping	Jun-14	Jun-15	Jun-16	Jun-17	Jun-18
Medical	183	189	190	198	212
Nursing	642	655	663	678	691
Allied health	303	316	319	319	321
Disability support services	265	263	257	255	273
Hotel and support	97	103	103	103	114
Management and administration	325	332	350	352	356
Total FTEs	**1,815**	**1,858**	**1,882**	**1,905**	**1,967**

Employee by ethnicity	Jun-14	Jun-15	Jun-16	Jun-17	Jun-18
Asian	34	50	51	75	84
Australian	30	36	37	37	39
European	231	240	256	256	251
Māori	80	77	91	88	97
NZ European/Pakeha	1,579	1,638	1,669	1,634	1,696
Other	53	52	53	53	56
Pacific peoples	3	7	7	11	13
Unknown/unspecified	401	360	364	497	526
Total staff (headcount)	**2,411**	**2,460**	**2,528**	**2,651**	**2,762**


Age Profile of our Staff
1000
800
600
400
200
0
No. of Staff
< 25 years
25 - 35 years
35 - 45 years
45 - 55 years
55 - 65 years
> 65 years
Jun-14
Jun-15
Jun-16
Jun-17
Jun-18


Length of Service of our Staff
1000
800
600
400
200
0
No. of Staff
< 2 years
2 - 5 years
6 - 10 years
11 - 20 years
21 - 30 years
> 30 years
Jun-14
Jun-15
Jun-16
Jun-17
Jun-18

Employee remuneration

The number of employees earning more than $100,000 is listed in the table below. Of the 288 employees shown, 240 are or were medical, dental, nursing or allied health employees. In the previous financial year (2016/17) there were 255 employees earning more than $100,000.

Salary band ($000)	2018	2017
100 – 110	58	59
110 – 120	31	27
120 – 130	21	18
130 – 140	15	11
140 – 150	14	8
150 – 160	10	7
160 – 170	9	6
170 – 180	8	4
180 – 190	14	10
190 – 200	6	9
200 – 210	13	4
210 – 220	7	9
220 – 230	5	9
230 – 240	13	8
240 – 250	6	14
250 – 260	6	10
260 – 270	9	6
270 – 280	7	4
280 – 290	5	8
290 – 300	16	9
300 – 310	3	2
310 – 320	4	0
320 – 330	1	5
330 – 340	2	5
340 – 350	1	1
360 – 370	0	2
400 – 410	1	0
420 – 430	1	0
Total	**288**	**255**

Termination payments

During the 2017/18 year, NMH paid $355,860 to 10 employees upon termination of their employment with NMH.

These payments include amounts required to be paid pursuant to employment agreements in place, with the majority of payments being redundancy payments.

In the previous financial year (2016/17) nine payments totalling $285,411 were made.

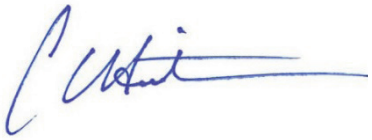
Statement of responsibility

The Board and management of the Nelson Marlborough District Health Board accept responsibility for the preparation of the financial statements and statement of performance, and for the judgments made in them.

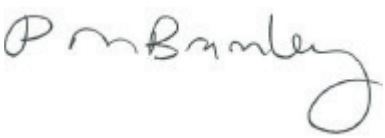
The Board and management of the Nelson Marlborough District Health Board accept responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting.

In the opinion of the Board and management of the Nelson Marlborough District Health Board the financial statements and statement of performance for the twelve months ended 30 June 2018 fairly reflect the financial position and operations of the Nelson Marlborough District Health Board.

Jenny Black
Board Chair



Alan Hilton
Board Member



Peter Bramley
Chief Executive

Eric Sinclair
GM Finance and Performance

30 October 2018

Statement of performance

Health targets

The following table shows the performance of Nelson Marlborough Health (the trading name of Nelson Marlborough District Health Board) against Ministry of Health targets for each of the quarters within the financial year. More information on these targets and the performance of other DHBs can be found on the Ministry of Health website.

Health Target		Q1	Q2	Q3	Q4
	95% of patients will be admitted, discharged, or transferred from an emergency department (ED) within six hours.	94%	95% ✓	95% ✓	95% ✓
	The volume of elective surgery will be increased by an average of 4,000 discharges per year across the country.	106% ✓	97%	95%	100% ✓
	90 per cent of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.	96% ✓	90% ✓	86%	87%
	95% of 8-month-olds have their primary course of immunisation at 6 weeks, 3 months and 5 months on time.	88%	91%	87%	90%
	90% of PHO enrolled patients who smoke have been offered help to quit smoking by a healthcare practitioner in the last 15 months.	85%	85%	87%	87%
	The target is that by December 2017, 95 per cent of obese children identified in the B4 School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.	61%	79%	87%	94%

Report against statement of performance expectations

As part of evaluating the effectiveness of the decisions made on behalf of our community, we provide a forecast of the services ('outputs') to be funded and provided within the financial year. To do this we identify a range of performance measures and targets that reflect quantity, quality, timeliness, and service coverage for the outputs within our *NMH Annual Plan and NMH Statement of Intent*.

We have structured the outputs, consistent with other district health boards across New Zealand into four output classes described in this section. Further detail on each of the output classes and the various services within each can be read in the *2017/18 NMH Annual Plan*, published online at www.nmdhb.govt.nz.

The performance measures for each output are also classified into one of the four output classes and the results shown in the following pages.

Our measure for the outputs cover four elements of performance with the element shown in the column headed 'code' in the tables for each output class. The four elements with the code shown are as follows:

- **V** – Volume: to demonstrate volumes of services delivered
- **Q** – Quality: to demonstrate safety, effectiveness and acceptability
- **T** – Timeliness: to demonstrate responsive access to services
- **C** – Coverage: to demonstrate the scope and scale of services provided

For each performance measure we show whether the target has been achieved or not through the following key and comment has been made for any measures where we did not achieve the target:

- Achieved
- Partially achieved
- Not achieved

Under the *Public Finance Act*, NMDHB is required to disclose the revenue appropriation provided to it by the government for the year, the equivalent expense against that appropriation and the service performance measures that report against the use of that funding. The appropriation revenue received by NMH for the 2017/18 financial year is $418,304,000 which equals the government's actual expenses incurred in relation to the appropriation. The performance measures are set out in the statement of service performance on pages 28 to 37.

Output class 1: Prevention services

Description

Preventative health services promote and protect the health of the whole population, or identifiable sub-populations, and influence individual behaviours by targeting population-wide changes to physical and social environments that engage, influence and support people to make healthier choices. These services include education programmes and services to raise awareness of risk behaviours and healthy choices, the use of legislation and policy to protect the public from environmental risks and communicable diseases, and individual health protection services such as immunisation and screening programmes that support early intervention to modify lifestyles and maintain good health.

Significance

New Zealand is experiencing a growing prevalence of long-term conditions such as diabetes and cardiovascular disease, which are major causes of poor health and account for a significant number of presentations in primary care and admissions to hospital and specialist services. With an aging population, the burden of long-term conditions will increase.

By improving environments and raising awareness, these prevention services support people to make healthier choices, reducing major risk factors that contribute to long-term conditions and delaying or reducing the impact of these conditions. Tobacco smoking, inactivity, poor nutrition, and rising obesity rates are major and common contributors to a number of the most prevalent long-term conditions. These risk factors are preventable through a supportive environment, improved awareness and greater personal responsibility for health and wellbeing. Prevention services support people to address any risk factors that contribute to both acute events (e.g. alcohol-related injury), as well as long-term conditions development (e.g. obesity, diabetes).

High health need and at-risk population groups (low socio-economic, Māori, disabled people and those with mental health issues) who are more likely to be exposed to environments less conducive to making healthier choices are a focus. Preventative services are our best opportunity to target improvements in the health of these high need populations to reduce inequalities in health status and improve population health outcomes.

Performance measures

Performance measures	Code	2015/16	2016/17	2017/18	Target	Performance
Percentage of enrolled women (20-69) who had a cervical smear in the last 3 years	V	80%	81%	81%	85%	🟠
Percentage of enrolled high-needs women (20-69) who had a cervical smear in the last 3 years	V	67%	68%	71%	90%	🔴
Percentage of enrolled women (45-65) having mammography within 2 years	V	72%	80%	80%	80%	🟢
Percentage of newborn hearing screening completed within one month of birth	V	95%	93%	99%	95%	🟢
Percentage of two year old children fully vaccinated	C	90%	91%	89%	95%	🟠
Percentage of over 65 year olds vaccinated for seasonal influenza	V	69%	61%	61%	75%	🔴

Performance measures	Code	2015/16	2016/17	2017/18	Target	Perfor-mance
Percentage of eligible children receiving Before (B4) School Checks	V	101%	104%	103%	100%	●
Reduction in alcohol related harm measure – Implementation of the Alcohol Related Harm Reduction Strategy	T,Q	-	-	Yes	NEW	●
Number of clients seen by the primary mental health service – youth	Q	N/A	494	579	460	●
Number of clients seen by the primary mental health service - adults	Q	N/A	2615	3231	2200	●

Financial results

	Budget 2018 $000	Actual 2018 $000	Actual 2017 $000
Revenue	**8,647**	**8,226**	**7,758**
Expenditure			
Workforce costs	4,315	4,438	4,193
Other operating costs	1,330	971	849
External providers and inter district fows	2,515	2,343	1,989
Total expenditure	**8,160**	**7,752**	**7,031**
Total surplus/(deficit)	**487**	**474**	**727**

Output class 2: Early detection and management services

Description

Early detection and management services maintain, improve and restore people's health. These services include detection of people at risk, and identification of disease, and well as more effective management and coordination of people with long-term conditions. These services are by nature more generalist, usually accessible from multiple providers, and at a number of different locations. Providers include general practice, community services, personal and mental health services, Māori and Pacific health services, pharmacy services, diagnostic imaging and laboratory services, and child and youth oral health services.

Primary healthcare services are offered in local community settings by teams of general practitioners (GPs), registered nurses, nurse practitioners, and other primary healthcare professionals, and are aimed at improving, maintaining, or restoring health. High numbers of enrolment with general practice are indicative of engagement, accessibility, and responsiveness of primary care services. These services keep people well by:

a) intervening early to detect, manage, and treat health conditions (e.g. health checks)

b) providing education and advice so people can manage their own health

c) reaching those at risk of developing long-term or acute conditions.

Significance

New Zealand is experiencing an increasing rate of long-term conditions, (meaning that once diagnosed, people usually have these conditions for the rest of their lives). Examples include diabetes and cardiovascular disease, and some population groups suffer from these conditions more than others.

By promoting regular engagement with health services we support people to maintain good health through earlier detection and management services based in the community. These services provide an opportunity to intervene in less invasive and more cost-effective ways, and reduce the burden of long-term conditions through supported self- management (avoidance of complications, acute illness and crises). These services deliver coordination of care, ultimately supporting people to maintain good health.

Performance measures

Performance measures	Code	2015/16	2016/17	2017/18	Target	Performance
Percentage of people in the district enrolled with PHO – Nelson	C	98%	98%	99%	99%	●
Percentage of people in the district enrolled with PHO – Marlborough	C	95%	97%	97%	99%	●
Percentage of children <5 years enrolled in DHB funded dental services	C	82%	83%	86%	85%	●
Percentage of secondary care patients whose medicines are reconciled on admission	C,Q	24%	30%	48%	>22%	●
Percentage of people provided with a CT scan within 42 days of referral	T	79%	98%	81%	100%	●
Percentage of people provided with an MRI scan within 42 days of referral	T	79%	59%	48%	100%	●

Financial results

	Budget 2018 $000	Actual 2018 $000	Actual 2017 $000
Revenue	**122,815**	**123,542**	**123,372**
Expenditure			
Workforce costs	21,909	21,823	20,600
Other operating costs	8,555	8,477	7,876
External providers and inter district fows	89,202	89,244	91,025
Total expenditure	**119,666**	**119,544**	**119,501**
Total surplus/(deficit)	**3,149**	**3,998**	**3,871**

Output class 3: Intensive assessment and treatment services

Description

Intensive assessment and treatment services are usually complex services provided by specialists and other healthcare professionals working closely together. These services are usually (but not always) provided in hospital settings which enable the co-location of clinical expertise and specialist equipment. These services include ambulatory services, inpatient and outpatient services, and emergency or urgent care services.

As the local provider of hospital and specialist services, NMDHB provides an extensive range of intensive treatment and complex specialist services to our population. We also fund some intensive assessment and treatment services for our population provided by other DHBs, private hospitals, and private providers. A proportion of these services are driven by demand, such as unplanned (acute) and maternity services. However, others are planned (elective) services and access is determined by capacity, clinical triage, national service coverage agreements, and treatment thresholds.

Significance

Equitable, timely access to intensive assessment and treatment can significantly improve people's quality of life either through early intervention (e.g. removal of an obstructed gallbladder to prevent repeat attacks of abdominal pain) or through corrective action (i.e. major joint replacements to relieve pain and improve activity).

Responsive services and timely treatment services also support improvements across the whole system and give people confidence that complex intervention will be available when needed. As an owner and provider of these services, NMDHB is also concerned with the quality of the services being provided.

Quality improvement in service delivery, systems and processes will improve patient safety, reduce the number of events causing injury or harm, and provide improved outcomes for people in our services. Adverse events and delays in treatment, as well as causing harm to patients, drive unnecessary costs and redirect resources away from other services.

Quality improvement in service delivery, systems and processes will improve patient safety, reduce readmission rates, and better support people to recover from complex illness and / or maximise their quality of life.

Government has set clear expectations for the delivery of elective service volumes, a reduction in waiting times for treatments, and increased clinical leadership to improve the quality of care. To meet these expectations we are introducing innovative clinically led service delivery models and reducing waiting time within our hospital services.

Performance measures

Performance measures	Code	2015/16	2016/17	2017/18	Target	Performance
Acute inpatient average length of stay (days)	Q	2.23	2.3	2.3	3.47	●
Percentage of elective and arranged surgery undertaken on a day case basis	Q	66%	65%	66%	61%	●
Percentage of people receiving their elective & arranged surgery on day of admission	Q	98%	98%	99%	97%	●
Women registering with an LMC by week 12 of their pregnancy	T	81%	80%	80%	80%	●
Percentage of total deliveries in primary birthing units	Q V	7%	5%	5%	7%	●
Standardised Intervention Rate for major joint replacement	V	27 per 10,000	23 per 10,000	26 per 10,000	21 per 10,000	●
Standardised Intervention Rate for cataract procedures	V	27 per 10,000	31 per 10,000	29 per 10,000	27 per 10,000	●

Financial results

	Budget 2018 $000	Actual 2018 $000	Actual 2017 $000
Revenue	**266,397**	**261,177**	**245,297**
Expenditure			
Workforce costs	135,193	137,678	129,129
Other operating costs	82,666	82,766	74,533
External providers and inter district fows	48,052	44,270	42,666
Total expenditure	**265,911**	**264,714**	**246,328**
Total surplus/(deficit)	**486**	**(3,537)**	**(1,031)**

Output class 4: Rehabilitation and support services

Description

Rehabilitation and support services provide people with the support and assistance they need to maintain or regain maximum functional independence, either temporarily while they recover from illness or disability, or over the rest of their lives.

These services are delivered following a clinical 'needs assessment' process coordinated by needs assessment and service coordination services and include: domestic support, personal care, community nursing and community services provided in people's own homes and places of residence including day care, respite and residential care services. Services are mostly for older people, mental health clients, and for personal health clients with complex health conditions.

Support services also include palliative care services for people who have end-stage conditions. It is important that they and their families are appropriately supported, so that the person is able to live comfortably, have their needs met in a holistic and respectful way, and die without undue pain and suffering. Delivery of these services may require coordination with other organisations and agencies, and may include public, private, and part-funding arrangements.

Significance

Services that support people to manage their needs and live well, safely and independently in their own homes are considered to provide a much higher quality of life. As a result, people stay active and positively connected to their communities. People whose needs are adequately met will also be less dependent on hospital and residential services and less likely to experience acute illness, crisis or deterioration of their conditions. Even when returning to full health is not possible, timely access to responsive support services enables people to maximise function and independence.

In preventing deterioration and acute illness or crisis, these services have a major impact on the sustainability of hospital and specialist services and on the wider health system in general by reducing acute demand, unnecessary ED presentation, and the need for more complex intervention. These services also support the flow of patients and improved recovery after an acute illness or hospital admission – helping to reduce readmission rates and supporting people to recover from complex illness and/or maximise their quality of life.

Living in aged residential care has been associated with more rapid functional decline than 'ageing in place' and is a more expensive option. Resources can be better utilised providing appropriate levels of support to people to help them stay in their own homes and to moderate the need for residential care and hospital services.

NMDHB has taken a restorative approach and has introduced individual packages of care to better meet people's needs, including complex packages of care for people assessed as eligible for residential care who would rather remain in their own homes. With an ageing population, it is vital that we ascertain the effectiveness of services in this area and we use the InterRAI (international residential assessment instrument) tool to ensure people receive support services that best meet their needs and, where possible, support them to regain maximum functional independence.

Performance measures

Performance measures	Code	2015/16	2016/17	2017/18	Target	Performance
The percentage of people in aged residential care by facility and by DHB who have a subsequent interRAI long term care facility (LTCF) assessment completed within 230 days of the previous assessment.	Q	75%	81%	86%	80%	●
Percentage of older people living in ARRC.	C	5%	5%	4%	5%	●
Improving Mental Health Services using transition (discharge) planning and employment: Child and Youth with a transition (discharge) date.	Q	100%	91%	90%	95%	●

Financial results

	Budget 2018 $000	Actual 2018 $000	Actual 2017 $000
Revenue	**95,906**	**105,309**	**91,810**
Expenditure			
Workforce costs	22,672	24,759	21,398
Other operating costs	10,441	11,554	9,608
External providers and inter district fows	63,415	69,708	61,143
Total expenditure	**96,528**	**106,021**	**92,148**
Total surplus/(deficit)	**(622)**	**(712)**	**(338)**

Financial statements

Statement of comprehensive revenue and expense

For the year ended 30 June 2018

	Note	Budget 2018 $000	Actual 2018 $000	Actual 2017 $000
Revenue				
Revenue	1	487,908	490,461	462,339
Interest revenue	5	2,000	1,745	1,849
Other revenue	2	3,857	6,048	4,049
Total revenue		**493,765**	**498,254**	**468,237**
Expenditure				
Personnel costs	3	184,089	184,567	171,259
Outsourced services		15,875	20,482	14,621
Clinical supplies		33,878	38,606	35,623
Infrastructure and non-clinical expenses		27,622	25,600	24,140
Payments to non-Health Board providers		203,184	205,567	196,822
Depreciation and amortisation expense	12,13	12,907	10,598	10,415
Capital charge	4	9,355	9,376	6,418
Finance costs	5	252	346	1,914
Other expenses	6	3,103	2,888	3,796
Total expenditure		**490,265**	**498,030**	**465,008**
Operating surplus/(deficit)		**3,500**	**224**	**3,229**
Impairment of intangible assets		-	(2,255)	-
Net surplus/(deficit)		**3,500**	**(2,031)**	**3,229**
Other comprehensive revenue or expenses				
Item that will be reclassified to surplus/(deficit):				
Financial assets at fair value through other comprehensive revenue and expense		-	-	-
Item that will not be reclassified to surplus(deficit):				
Gain/(Loss) on property revaluations		-	33,262	-
Impairment of property assets		-	-	-
Total other comprehensive revenue or expenses		-	**33,262**	-
Total comprehensive revenue and expense		**3,500**	**31,231**	**3,229**

The accompanying notes form part of these financial statements. Explanations of major variances against budget are provided in note 25.

Statement of financial position

As at 30 June 2018

	Note	Budget 2018 $000	Actual 2018 $000	Actual 2017 $000
Assets				
Current assets				
Cash and cash equivalents	7	49,105	18,468	21,561
Receivables	8	14,402	18,017	16,001
Inventories	9	2,770	2,715	2,700
Prepayments		600	414	2,139
Non-current assets held for sale	10	465	465	464
Other financial assets	11	-	19,950	12,351
Total current assets		**67,342**	**60,029**	**55,216**
Non-current assets				
Prepayments		50	55	(260)
Other financial assets	11	1,693	1,707	8,576
Property, plant and equipment	12	164,999	196,453	163,600
Intangible assets	13	5,484	11,810	10,245
Total non-current assets		**172,226**	**210,025**	**182,161**
Total assets		**239,568**	**270,055**	**237,377**
Liabilities				
Current liabilities				
Payables	14	35,252	30,139	30,831
Borrowings	15	500	490	477
Employee entitlements	16	26,553	33,851	30,188
Provisions	17	-	474	455
Total current liabilities		**62,305**	**64,954**	**61,951**
Non-current liabilities				
Borrowings	15	7,300	8,172	8,663
Employee entitlements	16	10,200	9,406	9,923
Total non-current liabilities		**17,500**	**17,578**	**18,586**
Total Liabilities		**79,805**	**82,532**	**80,537**
Net assets		**159,763**	**187,523**	**156,840**
Equity				
Crown equity	18	82,468	81,899	82,446
Other reserves	18	53,213	86,475	53,213
Accumulated comprehensive revenue and expense	18	24,082	19,149	21,181
Total equity		**159,763**	**187,523**	**156,840**

The accompanying notes form part of these financial statements. Explanations of major variances against budget are provided in note 25.

Statement of changes in net assets/equity

For the year ended 30 June 2018

	Note	Budget 2018 $000	Actual 2018 $000	Actual 2017 $000
Balance at 1 July		156,810	156,840	98,658
Total comprehensive revenue and expense for the year		3,500	31,231	3,229
Owner transactions				
Capital contribution	15,18	-	-	55,500
Repayment of capital		(547)	(547)	(547)
Balance at 30 June	18	**159,763**	**187,524**	**156,840**

The accompanying notes form part of these financial statements. Explanations of major variances against budget are provided in note 25.

Statement of cash flows

For the year ended 30 June 2018

	Note	Budget 2018 $000	Actual 2018 $000	Actual 2017 $000
Cash flows from operating activities				
Receipts from the Ministry of Health and patients		485,385	492,924	466,600
Interest received		2,000	1,745	1,849
Payments to employees		(181,277)	(179,243)	(169,886)
Payments to suppliers		(276,178)	(293,187)	(282,579)
Capital charge		(9,355)	(9,376)	(6,418)
Interest paid		(252)	(435)	(2,246)
GST (net)		-	584	(245)
Net cash flow from operating activities	19	**20,323**	**13,012**	**7,075**
Cash flows from investing activities				
Receipts from sale of property, plant and equipment		-	107	273
Receipts from maturity of investments		-	351	351
Purchase of property, plant and equipment		(17,050)	(13,114)	(6,976)
Purchase of intangible assets		(500)	(2,012)	(2,012)
Acquisition of investments		-	585	(351)
Net cash flow from investing activities		**(17,550)**	**(14,083)**	**(8,715)**
Cash flows from financing activities				
Borrowings withdrawn		-	-	-
Finance leases raised		-	(1,475)	1,713
Capital contribution		-	-	-
Repayment of capital		(547)	(547)	(547)
Repayment of borrowings		-	-	-
Payment of finance lease liabilities		(240)	-	(2,739)
Net cash flow from financing activities		**(787)**	**(2,022)**	**(1,573)**
Net increase/(decrease) in cash and cash equivalents		**1,986**	**(3,093)**	**(3,213)**
Cash and cash equivalents at the beginning of the year		47,119	21,561	24,774
Cash and cash equivalents at the end of the year		**49,105**	**18,468**	**21,561**

The accompanying notes form part of these financial statements. Explanations of major variances against budget are provided in note 25.

Reconciliation of net surpluses to net cash flow from operating activities

For the year ended 30 June 2018

	Actual 2018 $000	Actual 2017 $000
Net surplus/(deficit)	(2,031)	3,229
Add/(less) non-cash items		
Depreciation and amortisation expense	10,598	10,415
Impairment losses	2,255	-
Total non-cash items	**12,853**	**10,415**
Add/(less) items classified as investing or financing activities		
Fair value movement on loans and receivables	(81)	(77)
(Gains)/losses on disposal of property, plant and equipment	(110)	(27)
Total items classified as investing or financing activities	**(192)**	**(104)**
Add/(less) movements in statement of financial position items		
(Increase)/Decrease in receivables	(2,016)	(1,849)
(Increase)/Decrease in prepayments	1,410	(1,508)
(Increase)/Decrease in inventories	(15)	23
Increase/(Decrease) in payables	(692)	(3,491)
Increase/(Decrease) in employee entitlements	3,146	1,373
Increase/(Decrease) in provisions	19	(867)
(Increase)/Decrease in payables relating to purchase of property, plant and equipment	531	(146)
Net movements in statement of financial position items	**2,382**	**(6,465)**
Net cash flow from operating activities	**13,012**	**7,075**

Statement of accounting policies

For the year ended 30 June 2018

Reporting entity

Nelson Marlborough District Health Board (NMDHB) is a Crown entity as defined by the Crown Entities Act 2004 and is domiciled and operates in New Zealand. The relevant legislation governing NMDHB's operations includes the Crown Entities Act 2004 and the New Zealand Public Health and Disability Act 2000. NMDHB's ultimate controlling entity is the New Zealand Crown.

NMDHB's primary objective is to provide health, disability and mental health services to the New Zealand public. NMDHB does not operate to make a financial return.

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

The financial statements for NMDHB are for the year ended 30 June 2018, and were approved by the Board on 30 October 2018.

Basis of preparation

The financial statements have been prepared on a going concern basis, and the accounting policies have been applied consistently throughout the period.

Statement of compliance

The financial statements of NMDHB have been prepared in accordance with the requirements of the Crown Entities Act 2004, and the New Zealand Public Health and Disability Act 2000, which includes the requirement to comply with generally accepted accounting practice in New Zealand (NZ GAAP).

The financial statements have been prepared in accordance with and comply with PBE Accounting Standards.

Presentation currency and rounding

The financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars ($000).

Changes in accounting policies

There have been no changes in the group's accounting policies since the date of the last audited financial statements.

Standards issued and not yet effective and not early adopted

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

Impairment of revalued assets

In April 2017, the XRB issued Impairment of Revalued Assets, which now clearly scopes revalued property, plant, and equipment into the impairment accounting standards. Previously, only property, plant, and equipment measured at cost were scoped into the impairment accounting standards.

Under the amendment, a revalued asset can be impaired without having to revalue the entire class-of-asset to which the asset belongs. This amendment is effective for the 30 June 2020 financial statements, with early adoption permitted. The timing of the DHB adopting this amendment will be guided by the Treasury's decision on when the Financial Statements of the Government will adopt the amendment.

Financial instruments

In January 2017, the XRB issued PBE IFRS 9 Financial Instruments. This replaces PBE IPSAS 29 Financial Instruments: Recognition and Measurement. PBE IFRS 9 is effective for financial years beginning on or after 1 January 2021, with earlier application permitted. The main changes under the standard relevant to the DHB are:

- New financial asset classification requirements for determining whether an asset is measured at fair value or amortised cost
- A new impairment model for financial assets based on expected losses, which might result in the earlier recognition of impairment losses.

The Treasury has decided that the Financial Statements of the Government will early adopt PBE IFRS 9 for the 30 June 2019 financial year. The DHB will also early adopt PBE IFRS 9 for the 30 June 2019 financial year to be consistent with Crown's accounting policy for financial instruments. The DHB has not yet assessed in detail the impact of the new standard. Based on an initial assessment, the DHB anticipates that the standard will not have a material effect on the DHB's financial statements.

Interests in other entities

In January 2017, the XRB issued new standards for interests in other entities (PBE IPSAS 34 - 38). These new standards replace the existing standards for interests in other entities (PBE IPSAS 6 - 8). The new standards are effective for annual periods beginning on or after 1 January 2019, with early application permitted.

The DHB plans to apply the new standards in preparing the 30 June 2020 financial statements. The DHB has not yet assessed the effects of these new standards.

Summary of significant accounting policies

Significant accounting policies are included in the notes to which they relate.

Significant accounting policies that do not relate to a specific note are outlined below.

Grant expenditure

Non-discretionary grants are those grants awarded if the grant application meets the specified criteria and are recognised as expenditure when an application that meets the specified criteria for the grant has been received.

Discretionary grants are those grants where NMDHB has no obligation to award on receipt of the grant application and are recognised as expenditure when approved by the Grants Approval Committee and the approval has been communicated to the applicant. NMDHB's grants awarded have no substantive conditions attached.

Foreign currency transactions

Foreign currency transactions are translated into NZ$ (the functional currency) using the exchange rates prevailing at the dates of the transactions. Foreign exchange gains and losses resulting from the settlement of such transactions and from the translation at year-end exchange rates of monetary assets and liabilities denominated in foreign currencies are recognised in the surplus or deficit.

Goods and services tax

All items in the financial statements are presented exclusive of GST, except for receivables and payables, which are presented on a GST-inclusive basis. Where GST is not recoverable as input tax, 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 a net operating cash flow in the statement of cash flows.

Commitments and contingencies are disclosed exclusive of GST.

Income tax

NMDHB is a public authority and consequently is exempt from the payment of income tax. Accordingly, no provision has been made for income tax.

Budget figures

The budget figures are derived from the statement of performance expectations as approved by the Board at the beginning of the financial year. The budget figures have been prepared in accordance with NZ GAAP, using accounting policies that are consistent with those adopted by the Board in preparing these financial statements.

Cost allocation

NMDHB has determined the cost of outputs using the cost allocation system outlined below.

Direct costs are those costs directly attributed to an output. Indirect costs are those costs that cannot be identified in an economically feasible manner with a specific output.

Direct costs are charged directly to outputs. Indirect costs are charged to outputs based on cost drivers and related activity or usage information. Depreciation is charged on the basis of asset utilisation.

Personnel costs are charged on the basis of actual time incurred. Property and other premises costs, such as maintenance, are charged on the basis of floor area occupied for the production of each output.

Other indirect costs are assigned to outputs based on the proportion of direct staff costs for each output.

There have been no changes to the cost allocation methodology since the date of the last audited financial statements.

Critical accounting estimates and assumptions

In preparing these financial statements, NMDHB has made estimates and assumptions concerning the future. These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. The estimates and assumptions 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.

Estimating the fair value of land and buildings

The significant assumptions applied in determining the fair value of land and buildings are disclosed in the notes.

Retirement and long service leave

The Notes provide an analysis of the exposure in relation to estimates and uncertainties surrounding retirement and long service leave liabilities.

Critical judgements in applying accounting policies

Management has exercised the following critical judgements in applying accounting policies:

Grants received

NMDHB must exercise judgement when recognising grant revenue to determine if conditions of the grant contract have been satisfied. This judgement will be based on the facts and circumstances that are evident for each grant contract.

Notes to the financial statements

For the year ended 30 June 2018

1. Revenue

Accounting policy

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

MOH population-based revenue

The DHB receives annual funding from the MOH, which is based on population levels within the NMDHB region. MOH population-based revenue for the financial year is recognised based on the funding entitlement for that year.

MOH contract revenue

The revenue recognition approach for MOH contract revenue depends on the contract terms. Those contracts where the amount of revenue is substantively linked to the provision of quantifiable units of service are treated as exchange contracts and revenue is recognised as the DHB provides the services. For example, where funding varies based on the quantity of services delivered, such as number of screening tests or heart checks.

Other contracts are treated as non-exchange and the total funding receivable under the contract is recognised as revenue immediately, unless there are substantive conditions in the contract. If there are substantive conditions, revenue is recognised when the conditions are satisfied. A condition could include the requirement to provide services to the satisfaction of the funder to receive or retain funding. Revenue for future periods is not recognised where the contract contains substantive termination provisions for failure to comply with the service requirements of the contract. Conditions and termination provisions need to be substantive, which is assessed by considering factors such as the past practice of the funder. Judgement is often required in determining the timing of revenue recognition for contracts that span a balance date and multi-year funding arrangements.

Inter-district flows

Inter-district patient inflow revenue occurs when a patient treated within the DHB's district is domiciled outside of the district. Inter-district patient inflow revenue is recognised when eligible services are provided.

ACC contract revenue

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

Grants received

Grants are recognised as revenue when they become receivable unless there is an obligation in substance to return the funds if conditions of the grant are not met. If there is such an obligation, the grants are initially recorded as grants received in advance and recognised as revenue when conditions of the grant are satisfied.

Provision of services

Certain operations of NMDHB are reliant on services provided by volunteers. Volunteer services received are not recognised as revenue or expenditure by NMDHB due to the difficulty of measuring their fair value with reliability.

Breakdown of patient care revenue

	Actual 2018 $000	Actual 2017 $000
Health and disability services (MOH contracted revenue)	467,689	440,560
Inter-district patient inflows	9,190	8,740
ACC	5,264	5,237
Patient/consumer sourced revenue	6,663	6,535
Other government and DHB's	1,655	1,267
Total revenue	**490,461**	**462,339**

NMDHB 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 (2017: $Nil).

2. Other revenue

Accounting policy

Donated assets

Where a physical asset is gifted to or acquired by NMDHB for nil consideration or at a subsidised cost, the asset is recognised at fair value and the difference between the consideration provided and fair value of the asset is recognised as revenue unless there is a use or return condition attached to the asset. The fair value of donated assets is determined as follows:

- For new assets, fair value is usually determined by reference to the retail price of the same or similar assets at the time the asset was received
- For used assets, fair value is usually determined by reference to market information for assets of a similar type, condition, and age.

Donated services

Volunteer services received are not recognised as revenue or expenses by NMDHB.

Rental revenue

Lease receipts under an operating sublease are recognised as revenue on a straight-line basis over the lease term.

	Actual 2018 $000	Actual 2017 $000
Donated property, plant and equipment	2,164	163
Rental revenue	1,324	1,327
Gain on disposal of property, plant and equipment	110	27
Other	2,450	2,532
Total other revenue	**6,048**	**4,049**

3. Personnel costs

Accounting policy

Salaries and wages

Salaries and wages are recognised as an expense as employees provide services.

Superannuation schemes

Defined contribution schemes

Employer contributions to KiwiSaver, the Government Superannuation Fund, and the State Sector Retirement Savings Scheme are accounted for as defined contribution schemes and are recognised as an expense in the surplus or deficit as incurred.

Defined benefit schemes

The DHB makes employer contributions to the DBP Contributors Scheme (the scheme), which is managed by the Board of Trustees of the National Provident Fund. The scheme is a multi-employer defined benefit scheme.

Insufficient information is available to use defined benefit accounting, as it is not possible to determine from the terms of the scheme the extent to which the surplus/deficit will affect future contributions by individual employers, as there is no prescribed basis for allocation. The scheme is therefore accounted for as a defined contribution scheme. Further information on this scheme is disclosed in Note 16.

	Actual 2018 $000	Actual 2017 $000
Salaries and wages	170,900	159,044
Defined contribution plan employer contributions	5,557	5,233
Other personnel costs	8,110	6,982
Total personnel costs	**184,567**	**171,259**

4. Capital charge

Accounting policy

Capital charge

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

NMDHB pays a capital charge to the Crown based on its liable net assets as at 30 June and 31 December each year. The capital charge rate for the period ended 30 June 2018 was 6% (2017: 7% for six months to 31 December 2016; 6% for six months to 30 June 2017).

5. Finance revenue and costs

Accounting policy

Interest revenue

Interest revenue is recognised using the effective interest method.

Borrowing costs

Borrowing costs are recognised as an expense in the financial year in which they are incurred.

	Actual 2018 $000	Actual 2017 $000
Finance costs		
Interest on secured loans	-	1,633
Interest on finance lease	346	281
Total finance costs	**346**	**1,914**
Finance revenue		
Interest revenue	**1,745**	1,849
Total finance revenue	**1,745**	**1,849**

6. Other expenses

Accounting policy

Other expenses

	Actual 2018 $000	Actual 2017 $000
Audit fees	185	177
Donations made	-	-
Koha	-	-
Impairment of property, plant and equipment	-	-
Impairment of receivables	(37)	175
Loss on disposal of property, plant and equipment	18	71
Write down to Fair Value on Loans provided to Golden Bay Health Trust	(81)	(77)
Rental and operating lease costs	2,818	2,951
Restructuring expenses	(15)	499
Total other expenses	**2,888**	**3,796**

7. Cash and cash equivalents

Accounting policy

Cash and cash equivalents includes cash on hand, deposits held on call with banks, and other short-term highly liquid investments with original maturities of three months or less, and bank overdrafts. Bank overdrafts are presented within borrowings in current liabilities in the statement of financial position.

		Actual 2018 $000	Actual 2017 $000
Cash at bank and on hand	-	2	7
Cash advanced to NZHPL		18,470	21,554
Total cash and cash equivalents		**18,468**	**21,561**

NMDHB is a party to the DHB Treasury Services Agreement between NZ Health Partnerships Limited (NZHP) and participating DHBs. This agreement enables NZHPL to "sweep" DHB bank accounts and invest surplus funds. The agreement provides for individual DHBs to have a debit balance with NZHP, which will incur interest at the credit interest rate received by NZHP plus an administrative margin. The maximum debit balance that is available to any DHB is the value of provider arm's planned monthly Crown revenue, used in determining working capital limits, is defined as one-12th of the annual planned revenue paid by the funder arm to the provider arm as denoted in the most recently agreed Annual Plan, inclusive of GST. For NMDHB, that equates to $18.95 million.

8. Receivables

Accounting policy

Short-term receivables are recorded at their face value, less any provision for impairment.

A receivable is considered impaired when there is evidence that NMDHB will not be able to collect the amount due. The amount of the impairment is the difference between the carrying amount of the receivable and the present value of the amounts expected to be collected.

	Actual 2018 $000	Actual 2017 $000
Gross receivables	18,512	16,773
Less: provision for impairment	(495)	(772)
Total receivables	**18,017**	**16,001**
Gross receivables comprises of:		
Receivables from the Ministry of Health	2,937	3,421
Receivables from non-related parties	1,631	2,184
Accrued revenue	13,917	10,973
Other receivables	27	195
Total gross receivables	**18,512**	**16,773**

Ageing profile of receivables

	2018		2017	
	Gross	Impairment	Gross	Impairment
	$000	$000	$000	$000
Not past due	13,945	(0)	11,167	33
Past due 1 - 30 days	3,935	(16)	3,402	(45)
Past due 31 - 60 days	77	(13)	1,293	(41)
Past due 61 - 90 days	123	(86)	151	(45)
Past due over 90 days	432	(380)	760	(674)
Total	**18,512**	**(495)**	**16,773**	**(772)**

All receivables greater than 30 days in age are considered to be past due.

Due to the large number of receivables, the impairment assessment is generally performed on a collective basis, based on an analysis of past collection history and write offs.

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

	Actual 2018 $000	Actual 2017 $000
Provision for impairment at 1 July	772	677
Additional provisions made during the year	(38)	175
Receivables written off during the year	(239)	(80)
Provision for impairment at 30 June	**495**	**772**

9. Inventories

Accounting policy

Inventories held for distribution in the provision of services that are not supplied on a commercial basis are measured at cost (using the weighted average cost method), adjusted, when applicable, for any loss of service potential.

Inventories acquired through non-exchange transactions are measured at fair value at the date of acquisition.

The amount of any write-down for the loss of service potential or from cost to net realisable value is recognised in surplus or deficit in the period of the write-down.

	Actual 2018 $000	Actual 2017 $000
Held for distribution inventories		
Pharmaceuticals	426	390
Other supplies	2,519	2,540
Provision for obsolete stock	(230)	(230)
Total inventories	**2,715**	**2,700**

Inventories are measured at the lower of cost and net realisable value.

In 2018, the value of inventories distributed and recognised as an expense in the clinical supplies expense included in the deficit was $22.4 million (2017: $24.1 million).

There have been no write-downs or reversals of write-downs of inventories during the period.

No inventories are pledged as security for liabilities.

10. Non-current assets being held and prepared for sale

Accounting policy

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

Any impairment losses for write-downs of non-current assets held for sale are recognised in the surplus or deficit.

Any increases in fair value (less costs to sell) are recognised up to the level of any impairment losses that have been previously recognised.

Non-current assets held for sale are not depreciated or amortised while they are classified as held for sale.

	Actual 2018 $000	Actual 2017 $000
Non-current assets held for sale include:		
Land	-	-
Buildings	-	-
Total non-current assets held for sale	-	-
Non-current assets being prepared for sale include:		
Land	259	259
Buildings	206	206
Total non-current assets being prepared for sale	**465**	**465**

NMDHB classifies properties in either "being held for sale" where the DHB has formally declared the properties as surplus or "being prepared for sale" where the DHB is working through the formal processes required to declare the property surplus.

NMDHB owns 2 properties one in Tapawera and one in Songer St, Nelson which have been classified as being prepared for sale following the Board approval to sell the properties, as they will provide no future use to NMDHB.

The accumulated property revaluation reserve recognised in equity in relation to these properties is $546k.

11. Other financial assets

Accounting policy

Investments

Bank term deposits

Bank term deposits are initially measured at the amount invested. Interest is subsequently accrued and added to the investment balance.

Equity investments

NMDHB designates equity investments at fair value through other comprehensive revenue and expense, which are initially measured at fair value plus transaction costs.

After initial recognition, these investments are measured at their fair value with gains and losses recognised in other comprehensive revenue and expense, except for impairment losses that are recognised in the surplus or deficit.

On de-recognition, the cumulative gain or loss previously recognised in other comprehensive revenue and expense is reclassified to the surplus or deficit.

A significant or prolonged decline in the fair value of the investment below its cost is considered objective evidence of impairment. If impairment evidence exists, the cumulative loss recognised in other comprehensive revenue and expense is reclassified from equity to the surplus or deficit.

Impairment losses recognised in the surplus or deficit are not reversed through the surplus or deficit.

	Actual 2018 $000	Actual 2017 $000
Current Portion		
Westpac Short Term Investment	6,950	12,351
BNZ Term Deposit <12 Months	13,000	-
Total Current Financial Assets	19,950	12,351
Non-current Portion		
Equity investments	3	3
Loans receivable	1,704	1,623
Westpac Long Term Investment	-	6,950
Total Non-Current Financial Assets	1,707	8,576
Total Financial Assets	**21,657**	**20,927**

NMDHB 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.

In September 2013, NMDHB provided two loans to Golden Bay Integrated Health Centre (GBIFHC). The first loan is for $1,560,000, repayable over 25 years, interest free for 5 years. As at 1/7/18 the interest on this loan was deferred for a further year. The second loan is for $778,000, repayable over 35 years but not before 25 years and is interest free.

The loans receivable from GBIFHC have been measured at fair value through surplus or deficit.

12. Property, plant and equipment

Accounting policy

Property, plant, and equipment consists of the following asset classes: land, buildings, clinical equipment, fixtures and fittings, and other equipment and motor vehicles.

Land is measured at fair value, and buildings are measured at fair value less accumulated depreciation. All other assets classes are measured at cost, less accumulated depreciation and impairment losses.

Revaluations

Land and buildings are revalued with sufficient regularity to ensure that the carrying amount does not differ materially from fair value and at least every five years.

The carrying values of revalued assets are assessed annually to ensure that they do not differ materially from fair value. If there is evidence supporting a material difference, then the off-cycle asset classes are revalued.

Land and building revaluation movements are accounted for on a class-of-asset basis.

The net revaluation results are credited or debited to other comprehensive revenue and expense and are accumulated to an asset revaluation reserve in equity for that class of asset. Where this would result in a debit balance in the asset revaluation reserve, this balance is not recognised in other comprehensive revenue and expense but is recognised in the surplus or deficit. Any subsequent increase on revaluation that reverses a previous decrease in value recognised in the surplus or deficit will be recognised first in the surplus or deficit up to the amount previously expensed, and then recognised in other comprehensive revenue and expense.

Additions

The cost of an item of property, plant, and equipment is recognised as an asset only when it is probable that future economic benefits or service potential associated with the item will flow to NMDHB and the cost of the item can be measured reliably.

Work in progress is recognised at cost less impairment and is not depreciated.

In most instances, an item of property, plant, and equipment is initially recognised at its cost. Where an asset is acquired through a non-exchange transaction, it is recognised at its fair value as at the date of acquisition.

Disposals

Gains and losses on disposals are determined by comparing the proceeds with the carrying amount of the asset. Gains and losses on disposals are reported net in the surplus or deficit. When revalued assets are sold, the amounts included in revaluation reserves in respect of those assets are transferred to accumulated surpluses or deficits in equity.

Subsequent costs

Costs incurred subsequent to initial acquisition are capitalised only when it is probable that future economic benefits or service potential associated with the item will flow to NMDHB and the cost of the item can be measured reliably.

The costs of day-to-day servicing of property, plant, and equipment are recognised in the surplus or deficit as they are incurred.

Depreciation

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

Asset	Useful Life (Years)	Depreciation Rate
Buildings & fit-out	5 – 76	1.3% – 20%
Plant & equipment	2 – 20	5% – 50%
Motor vehicles	5 – 16	6.25% – 20%
Leased assets	2 – 7.25	13.8% – 50%

Leasehold improvements are depreciated over the unexpired period of the lease or the estimated remaining useful lives of the improvements, whichever is the shorter.

The residual value and useful life of an asset is reviewed, and adjusted if applicable, at each financial year end.

Impairment of property, plant, and equipment and intangible assets

NMDHB does not hold any cash-generating assets. Assets are considered cash-generating where their primary objective is to generate a commercial return.

Non-cash-generating assets

Property, plant, equipment and intangible assets held at cost that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable service amount. The recoverable service amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is determined using an approach based on either a depreciated replacement cost approach, restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and availability of information.

If an asset's carrying amount exceeds its recoverable service amount, the asset is regarded as impaired and the carrying amount is written-down to the recoverable amount. The total impairment loss is recognised in the surplus or deficit.

The reversal of an impairment loss is recognised in the surplus or deficit.

Critical accounting estimates and assumptions

Estimating the fair value of land and buildings

The most recent valuation of land and buildings was performed by an independent registered valuer,

Marvin Clough, ANZIV of BECA Limited. The valuation is effective as at 30 June 2018. A depreciated replacement cost methodology has been used. The revaluation excluded buildings purchased during that year. The next revaluation will be completed by 30 June 2023.

Buildings

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

Depreciated replacement cost is determined using a number of significant assumptions, including:

- The replacement asset is based on the replacement with modern equivalent assets, with adjustments where appropriate for optimisation due to over-design or surplus capacity. There has been no optimisation adjustments for the most recent valuation.
- The replacement cost is derived from recent construction contracts of similar assets and Property Institute of New Zealand cost information.
- The remaining useful life of assets is estimated using recent asset management information.
- Straight-line depreciation has been applied in determining the depreciated replacement cost value of the asset.

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.

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

At each balance date, the useful lives and residual values of property, plant, and equipment are reviewed. Assessing the appropriateness of useful life and residual value estimates of property, plant, and equipment

requires a number of factors to be considered such as the physical condition of the asset, expected period of use of the asset by NMDHB, and expected disposal proceeds from the future sale of the asset.

An incorrect estimate of the useful life or residual value will affect the depreciation expense recognised in the surplus or deficit, and carrying amount of the asset in the statement of financial position. NMDHB minimises the risk of this estimation uncertainty by:

- physical inspection of assets;
- asset replacement programs;
- review of second hand market prices for similar assets; and
- analysis of prior asset sales.

NMDHB has not made significant changes to past assumptions concerning useful lives and residual values.

	Land	Buildings	Plant and Equipment	Motor Vehicles	Leased Assets	Work in Progress	Total
	$000	$000	$000	$000	$000	$000	$000
Cost or valuation							
Balance at 1 July 2016	11,620	127,275	55,934	5,956	19,621	4,935	225,341
Additions	-	1,305	5,189	412	1,193	10,300	18,399
Revaluations	-	-	-	-	-	-	-
Disposals	(157)	(157)	(851)	(51)	(57)	(8,100)	(9,373)
Balance at 30 June 2017	**11,463**	**128,423**	**60,272**	**6,317**	**20,757**	**7,135**	**234,367**
Balance at 1 July 2017	11,463	128,423	60,272	6,317	20,757	7,135	234,367
Additions	-	8,603	6,252	495	521	11,166	27,037
Revaluations	17,175	(311)	-	-	-	-	16,864
Disposals	-	(19)	(20,647)	(520)	(10,504)	(15,870)	(47,560)
Balance at 30 Jun 2018	**28,638**	**136,696**	**45,877**	**6,292**	**10,774**	**2,431**	**230,708**
Accumulated depreciation and impairment losses							
Balance at 1 July 2016	-	5,045	40,860	3,538	11,754	-	61,197
Depreciation expense	-	5,610	2,940	463	557	-	9,570
Revaluations/Impairment	-	-	-	-	-	-	-
Disposals	-	-	-	-	-	-	-
Balance at 30 Jun 2017	**-**	**10,655**	**43,800**	**4,001**	**12,311**	**-**	**70,767**
Balance at 1 July 2017	-	10,655	43,800	4,001	12,311	-	70,767
Depreciation expense	-	5,762	3,164	540	374	-	9,840
Revaluations/Impairment	-	(16,398)	-	-	-	-	(16,398)
Disposals	-	(19)	(19,091)	(503)	(10,341)	-	(29,954)
Balance at 30 Jun 2018	**-**	**-**	**27,873**	**4,038**	**2,344**	**-**	**34,255**
Carrying Amounts							
At 1 July 2016	11,620	122,230	15,074	2,418	7,867	4,935	164,144
At 30 Jun/1 Jul 2017	11,463	117,768	16,472	2,316	8,446	7,135	163,600
At 30 June 2018	**28,638**	**136,696**	**18,004**	**2,254**	**8,430**	**2,431**	**196,453**

No impairment loss of has been recognised in 2018, (2017: Nil).

Restrictions on title

NMDHB 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 NMDHB 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.

NMDHB leases clinical and IT equipment under a number of finance lease agreements. At 30 June 2018, the net carrying amount of leased IT and clinical equipment was $1.00 million (2017: $1.26 million).

The total amount of property, plant, and equipment in the course of construction 2018 is $3.87 million (2017: $7.84 million).

13. Intangible assets

Accounting policy

Software acquisition and development

Acquired computer software licenses 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 are recognised as an intangible asset. Direct costs include 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 development and maintenance of NMDHB's website are recognised as an expense when incurred.

Amortisation

The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life. Amortisation begins when the asset is available for use and ceases at the date that the asset is derecognised. The amortisation charge for each financial year is recognised in the surplus or deficit.

The useful lives and associated amortisation rates of major classes of intangible assets have been estimated as follows:

Asset	Useful Life (Years)	Depreciation Rate
Software	3 – 10	10% – 33.3%

Finance Procurement Supply Chain, including National Oracle Solution

The Finance Procurement Supply Chain (FPSC), which includes the National Oracle Solution (NOS), is a national initiative funded by DHBs and facilitated by NZ Health Partnerships Limited (NZHPL) to deliver sector wide benefits. NZHPL holds an intangible asset recognised at the capital cost of development relating to this programme. NMDHB holds an asset at cost of capital invested by NMDHB in the FPSC programme less any impairment applied. This investment represents the right to access the FPSC assets and are considered to have an indefinite life. DHBs have the ability and intention to review the service level agreement indefinitely and the fund established by NZHPL through the on-charging of depreciation and amortisation on the assets to the DHBs will be used to, and is sufficient to, maintain the assets standard of performance or service potential indefinitely. As the rights are considered to have an indefinite life, the intangible asset is not amortised and will be tested for impairment annually.

Impairment of intangible assets

Refer to the policy for impairment of property, plant, and equipment in Note 12. The same approach applies to the impairment of intangible assets, except for intangible assets that are still under development.

Intangible assets that are under development and not yet ready for use are tested for impairment annually, irrespective of whether there is any indication of impairment.

Breakdown of intangible assets and further information

	NZHPL	Acquired Software	Internally Generated Software	Total
	$000	$000	$000	$000
Movements for each class of intangible asset				
Balance at 1 July 2016	2,255	13,282	1,982	17,519
Additions	-	3,750	104	3,854
Disposals	-	(2,179)	-	(2,179)
Balance at 30 June 2017	**2,255**	**14,853**	**2,086**	**19,194**
Balance at 1 July 2017	2,255	14,853	2,086	19,194
Additions	-	12,759	535	13,294
Disposals	(2,255)	(10,643)	-	(12,898)
Balance at 30 June 2018	**-**	**16,969**	**2,621**	**19,590**
Accumulated amortisation and impairment losses				
Balance at 1 July 2016	-	7,911	193	8,104
Amortisation expense	-	785	60	845
Disposals	-	-	-	-
Impairment losses	-	-	-	-
Balance at 30 June 2017	**-**	**8,696**	**253**	**8,948**
Balance at 1 July 2017	-	8,696	253	8,948
Amortisation expense	-	425	333	758
Disposals	-	(1,927)	-	(1,927)
Impairment losses	-	-	-	-
Balance at 30 June 2018	**-**	**7,194**	**586**	**7,779**
Carrying amounts				
At 1 July 2016	2,255	5,371	1,789	9,415
At 30 June / 1 July 2017	2,255	6,157	1,833	10,246
At 30 June 2018	**-**	**9,775**	**2,035**	**11,810**

Included in the Internally Generated Software is a total of $0.05 million (2017: $0.81 million) which is work in progress.

NZ Health Partnerships Limited (NZHPL) was established on 1 July 2015 taking on the assets and liabilities of Health Benefits Limited (HBL). HBL was an agency set up by all the Ministry of Health to provide shared services for District Health Boards. The investment was made to fund the establishment of a shared service arrangement to support the delivery of Finance, Procurement and Supply Chain services. NZHPL is owned by the 20 district health boards with each of the district health boards owning five (5) "A" Class shares. The A class shares have been issued for a nil consideration. All district health boards also own "B" Class shares in NZHPL

reflecting the level of investment in the FPSC Programme. The NMDHB holding of B class shares is 2,255,000 shares of the total B Class shares issued of 68,333,000.

At 30 June 2017, NMDHB had made payments totalling $2.255 million (2016: $2.255 million) in relation to the Finance, Procurement and Supply Chain (FPSC) programme. This is a national initiative and is managed on behalf of DHBs by NZ Health Partnerships Limited (NZHP).

In return for these payments, NMDHB gained rights to access the FPSC asset, which includes National Oracle Solution (NOS) programme. In the event of liquidation or dissolution of NZHP, NMDHB shall be entitled to be paid from the surplus assets, an amount equal to their proportionate share of the liquidation value based on its proportional share of the total FPSC/NOS rights that have been issued.

The FPSC/NOS rights have been tested for impairment by comparing the carrying amount of the intangible asset to its depreciated replacement cost (DRC), which is considered to equate to NMDHB share of the DRC of the underlying FPSC/NOS assets.

The Government has requested that an updated business case be developed before there is further work on the FPSC/NOS programme and the programme has consequently been paused indefinitely. Given the inherent uncertainty this creates regarding the future of the FPSC/NOS programme NMDHB has determined that the full value should be impaired in the 30 June 2018 financial statements. This has resulted in impairment losses of $2.255 million (2017: Nil) being recognised within the Statement of Comprehensive Revenue and Expenses.

14. Payables

Accounting policy

Short-term payables are recorded at their face value.

	Actual 2018 $000	Actual 2017 $000
Payables under exchange transactions		
Creditors	4,868	5,271
Revenue in advance	1,206	3,814
Capital charge payable	-	-
Other	19,165	17,804
Total payables under exchange transactions	**25,238**	**26,889**
Payables under non-exchange transactions		
Capital charge payable	-	-
Taxes payable (GST, Employer Deductions & FBT)	4,214	3,591
Other	687	351
Total payables under non-exchange transactions	4,901	3,942
Total Payables	**30,139**	**30,831**

15. Borrowings

Accounting policy

Overdraft facility

Amounts drawn under the NZHPL banking facility are recorded at the amount payable plus accrued interest.

Finance leases

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

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

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

Critical judgements in applying accounting policies

Leases 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 the group.

Judgement is required on various aspects that include, but are not limited to, 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.

Management has exercised its judgement on the appropriate classification of leases, and has determined that a number of lease arrangements are finance leases.

	Actual 2018 $000	Actual 2017 $000
Current portion		
Finance leases	490	477
Total current portion	**490**	**477**
Non-current portion		
Finance leases	8,172	8,663
Total non-current portion	**8,172**	**8,663**
Total borrowings	**8,662**	**9,140**

Fair value

The fair value of finance leases is $8.7 million (2017: $9.1). Fair value has been determined using contractual cash flows discounted using a rate based on market borrowing rates at balance date ranging from 4.8% to 7.0% (2017: 4.8% to 7.0%).

Analysis of Finance leases

	Actual 2018 $000	Actual 2017 $000
Minimum lease payments payable:		
Not later than one year	824	824
Later than one year and not later than five years	3,154	3,278
Later than five years	12,497	13,238
Total minimum lease payments	**16,475**	**17,340**
Future finance charges	(7,831)	(6,704)
Present value of minimum lease payments	**8,643**	**10,636**
Present value of minimum lease payments payable:		
Not later than one year	492	477
Later than one year and not later than five years	1,989	2,049
Later than five years	6,163	8,110
Total present value of minimum lease payments	**8,643**	**10,636**

Description of Material Leasing Arrangements

NMDHB has entered into finance leases primarily for 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 12 & 13.

In September 2013 NMDHB set up a finance lease to account for the lease of the completed Golden Bay Integrated Health Centre facilities to the Golden Bay Community Health Trust. The initial terms had a Net Present Value of $8,386,915, a discount rate of 4.75% and a term of 35 years. At 30 June 2017, Golden Bay Community Health Trust had an outstanding lease liability with a present value of $7.2M (2016: $7.5M). NMDHB does not have the option to purchase the asset at the end of the lease term.

There are no restrictions placed on NMDHB by any of the finance leasing arrangements.

16. Employee entitlements

Accounting policy

Short-term employee entitlements

Employee entitlements that are due to be settled within 12 months after the end of the period in which the employee renders the related service are measured based on accrued entitlements at current rates of pay.

These include salaries and wages accrued up to balance date, annual leave earned but not yet taken at balance date, sick leave, conference leave and medical education leave.

A liability for sick leave is recognised to the extent that absences in the coming year are expected to be greater than the sick leave entitlements earned in the coming year. The amount is calculated based on the unused sick leave entitlement that can be carried forward at balance date, to the extent that it will be used by staff to cover those future absences.

A liability and an expense are recognised for bonuses where there is a contractual obligation or where there is a past practice that has created a constructive obligation and a reliable estimate of the obligation can be made.

Long-term employee entitlements

Employee benefits that are due to be settled beyond 12 months after the end of period in which the employee renders the related service, such as long service leave and retirement gratuities, have been calculated on an actuarial basis. The calculations are based on:

- likely future entitlements accruing to staff, based on years of service, years to entitlement, the likelihood that staff will reach the point of entitlement, and contractual entitlement information; and
- the present value of the estimated future cash flows.

Presentation of employee entitlements

Sick leave, annual leave, and vested long service leave are classified as a current liability. Non-vested long service leave and retirement gratuities expected to be settled within 12 months of balance date are classified as a current liability. All other employee entitlements are classified as a non-current liability.

Defined contribution schemes

Obligations for contributions to KiwiSaver, the Government Superannuation Fund, and the State Sector Retirement Savings Scheme are accounted for as defined contribution superannuation schemes and are recognised as an expense in the surplus or deficit as incurred.

Critical accounting estimates and assumptions

Sabbatical leave, long service leave, and retirement gratuities

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

Expected future payments are discounted using discount rates derived from the yield curve of New Zealand government bonds. The discount rates used have maturities that match, as closely as possible, the estimated future cash outflows. The salary inflation factor has been determined after considering historical salary inflation patterns and after obtaining advice from an independent actuary. A weighted average discount rate of 2.91% (2017: 2.87%) and an inflation factor of 2.0% (2017: 2.0%) were used. The discount rates used are those advised by the Treasury. The salary inflation factor is the group's best estimate forecast of salary increments. The take-up rate used for sabbatical leave is 16% (2017: 16%).

If the discount rate were to differ by 1% from that used, with all other factors held constant, the carrying amount of the sabbatical, long service leave, and retirement gratuities obligations would be an estimated $0.5 million higher/lower.

If the salary inflation factor were to differ by 1% from that used, with all other factors held constant, the carrying amount of the sabbatical, long service leave, and retirement gratuities obligations would be an estimated $0.5 million higher/lower.

Sick leave

The discount rates used in the valuation are the risk free rates as determined by the NZ Treasury and published on its website. The average discount rate is 2.9% (2017: 2.9%). Average future salary growth has been assumed to be 2.0% per annum, plus a salary scale of 1% per annum.

Breakdown of employee entitlements

	Actual 2018 $000	Actual 2017 $000
Current Portion		
Accrued salaries & wages	7,173	4,743
Annual leave	19,504	18,224
Sick leave	502	601
Sabbatical leave	218	210
Retirement gratuities	2,181	2,147
Long service leave	546	637
Continuing medical education	3,727	3,626
Total current portion	**33,851**	**30,188**
Non-current portion		
Sick leave	816	770
Sabbatical leave	854	793
Retirement gratuities	5,460	5,793
Long service leave	2,276	2,567
Total non-current portion	**9,406**	**9,923**
Total employee entitlements	**43,257**	**40,111**

Annual leave

Many public and private sector entities, including NMDHB, are continuing to investigate historic underpayment of holiday entitlements.

For employers such as NMDHB that have workforces that include differential occupational groups with complex entitlements, non-standard hours, allowances and/or overtime, the process of assessing compliance with the Act and determining the underpayment is time consuming and complicated.

DHBs have decided to take a national approach and have been working with key stakeholders to define a baseline interpretation document for the health sector. This is substantially agreed, but there are some remaining issues which are in the process of being resolved. The intention is that, once the baseline document is agreed, this would be used by each DHB to systematically assess their liability.

NMDHB has estimated its liability as at 30 June 2018 to be $1.4 million (2017: $1.0 million).

This estimate is based on the best information available to the DHB at balance date but, due to the uncertainties involved, the actual liability could be different.

17. Provisions

Accounting policy

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

Provisions are measured at the present value of the expenditure expected to be required to settle the obligation using a pre-tax discount rate that reflects current market assessments of the time value of money and the risks specific to the obligation. The increase in the provision due to the passage of time is recognised as an interest expense and is included in "finance costs".

Restructuring

A provision for restructuring is recognised when an approved detailed formal plan for the restructuring has either been announced publicly to those affected, or for which implementation has already commenced.

Onerous contracts

A provision for onerous contracts is recognised when the expected benefits or service potential to be derived from a contract are lower than the unavoidable cost of meeting the obligations under the contract.

The provision is measured at the present value of the lower of the expected cost of terminating the contract and the expected net cost of continuing with the contract.

ACC Partnership Programme

NMDHB belongs to the ACC Partnership Programme (the "Full Self Cover Plan") whereby NMDHB accepts the management and financial responsibility for employee work-related illnesses and accidents. Under the programme, NMDHB is liable for all claims costs for a period of four years up to a specified maximum. At the end of the four-year period, NMDHB 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 using market yields on government bonds at balance date with terms to maturity that match, as closely to possible, the estimated future cash outflows.

Breakdown of provisions and further information

	Actual 2018 $000	Actual 2017 $000
Current portion		
Restructuring	48	48
ACC Partnership Programme	426	407
Total current portion	**474**	**455**
Total provisions	**474**	**455**

Movements for each class of provision are as follows:

	Restructures $000	*ACC* $000	*Total* $000
Balance at 1 July 2016	836	486	1,322
Additional provisions made	257	-	257
Amounts used	(463)	-	(463)
Unused amounts reversed	(582)	(79)	(661)
Balance at 30 June 2017	**48**	**407**	**455**
Balance at 1 July 2017	48	407	455
Additional provisions made	-	19	19
Amounts used	-	-	-
Unused amounts reversed	-	-	-
Balance at 30 June 2018	**48**	**426**	**474**

ACC partnership programme

Exposures arising from the programme are managed by promoting a safe and healthy working environment by:

- implementing and monitoring health and safety policies;
- induction training on health and safety;
- actively managing workplace injuries to ensure that employees return to work as soon as practical;
- recording and monitoring workplace injuries and near misses to identify risk areas and implementing mitigating actions; and
- identifying workplace hazards and implementation of appropriate safety procedures.

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 last valuation was effective at 30 June 2018. 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.

A risk margin of 11% has been included to allow for the inherent uncertainty in the central estimate of the claims liability. This is the rate used by ACC.

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

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.

NMDHB has chosen a stop loss limit of 160% of the industry premium and a stop loss limit of $250,000 for any high cost claim. If the claims for a year exceed the stop loss limit, NMDHB will continue to meet the costs of claims and will be reimbursed by ACC for the costs that exceed the stop loss limit.

NMDHB 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.

Average inflation has been assumed as 2.5% for the years' ending 30 June 2019 and 30 June 2020. A discount rate of 3.8 % has been used for the year ending 30 June 2019 and 3.9% for the year ending 30 June 2020.

Any changes in liability valuation assumptions will not have a material effect on the financial statements.

18. Equity

Accounting policy

Equity is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified into the following components.

- contributed capital;
- accumulated surplus/(deficit);
- property revaluation reserves; and
- fair value through other comprehensive revenue and expense reserves.

Property revaluation reserve

This reserve relates to the revaluation of property, plant, and equipment to fair value.

Breakdown of equity and further information

	Actual 2018 $000	Actual 2017 $000
Crown equity		
Balance at 1 July	82,446	27,493
Capital contribution	-	-
Conversion of Loans to Equity	-	55,500
Repayment of capital	(547)	(547)
Balance at 30 June	**81,899**	**82,446**
Accumulated surplus/(deficit)		
Balance at 1 July	21,181	17,952
Surplus/(deficit) for the year	(2,031)	3,229
Property revaluation reserve transfer on disposal	-	-
Balance at 30 June	**19,149**	**21,181**
Revaluation reserves		
Balance at 1 July	53,213	53,213
Revaluations	33,262	-
Impairment charge	-	-
Transfer to accumulated surplus/(deficit) on disposal	-	-
Balance at 30 June	**86,475**	**53,213**
Revaluation reserves consist of		
Land	25,300	8,125
Buildings	61,175	45,088
Total revaluation reserves	**86,475**	**53,213**
Financial assets at fair value through other comprehensive revenue and expense reserves		
Balance at 1 July	-	-
Net change in fair value	-	-
Transfer to surplus/(deficit) on disposal	-	-
Balance at 30 June	-	-
Total Equity	**187,523**	**156,840**

Capital management

The group's capital is its equity, which consists of Crown equity, accumulated surpluses or deficits, property revaluation reserves, and trust funds. Equity is represented by net assets.

The group 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.

The group manages its equity as a by-product of prudently managing revenues, expenses, assets, liabilities, investments, and general financial dealings to ensure that it effectively achieves its objectives and purposes while remaining a going concern.

Accumulated comprehensive revenue and expense includes accumulated surpluses/deficits of unspent mental health ring fenced funding as detailed in note 26.

19. Capital commitments and operating leases

Accounting policy

Operating leases as lessee

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset to the lessee. Lease payments under an operating lease are recognised as an expense on a straight-line basis over the lease term. Lease incentives received are recognised in the surplus or deficit as a reduction of rental expense over the lease term. The DHB leases a number of buildings, vehicles, and office equipment (mainly photocopiers) under operating leases.

	Actual 2018 $000	Actual 2017 $000
Capital commitments		
Property, plant and equipment	1,766	2,089
Intangible assets	515	241
Total capital commitments	**2,281**	**2,330**
Non-cancellable Provider commitments		
Not later than one year	21,630	16,559
Later than one year and not later than five years	13,687	18,134
Later than five years	-	2,282
Total non-cancellable Provider commitments	**35,317**	**36,975**
Non-cancellable operating lease commitments		
Not later than one year	1,275	970
Later than one year and not later than five years	4,024	2,541
Later than five years	1,334	1,575
Total non-cancellable operating lease commitments	**6,633**	**5,086**
Non-cancellable finance lease commitments		
Not later than one year	824	824
Later than one year and not later than five years	3,154	3,278
Later than five years	12,497	13,238
Total non-cancellable finance lease commitments	**16,475**	**17,340**
Non-cancellable other commitments		
Not later than one year	625	1,560
Later than one year and not later than five years	150	150
Later than five years	-	151
Total non-cancellable other lease commitments	**775**	**1,861**
Total commitments	**61,481**	**63,592**

Capital commitments represent capital expenditure contracted for at balance date but not yet incurred.

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, GP services and for Health of Older People residential and community based services. Because this expenditure is 'demand driven' it is not possible to quantify the obligation in this note. Expenditure of this nature in the 2018 year totalled $134.5 million (2017: $126.6 million).

Other commitments include non-cancellable contracts for the provision of services.

Leases as lessee

Total future minimum lease payments to be paid under non-cancellable operating leases at balance date as a lessee are $6,633 million, (2017, $5,085 million).

NMDHB leases several buildings under operating leases. The leases are for periods ranging from 1 to 20 years initially, with rights of renewal ranging from 1 to 11 years.

NMDHB also leases clinical equipment under operating leases. The lease terms are for periods ranging from 16 months to 4 years.

During the year ended 30 June 2018, $2,889,482 was recognised as an expense in the surplus or deficit in respect of operating leases (2017: $2,947,062)

Leases as lessor

NMDHB leases owned properties to third parties under operating leases resulting in revenue of $1.3 million (2017: $1.3 million). These leases are for periods ranging initially from 2 to 99 years. In some cases, rights of renewal for one or more terms ranging from 2 to 5 years are provided. Some leases are subject to the terms of service contracts.

The total future minimum lease payments under non-cancellable operating leases as a lessor at balance date are $5.120 million (2017: $5.214 million).

NMDHB have entered into a sub-lease with Nelson Bays Primary Health Organisation for the Golden Bay Integrated Health Centre buildings. The sub lease is for an initial amount of $492,000 plus GST per annum, commencing 16 September 2013, for a term of 10 years with a two yearly rent review.

20. Contingencies

Accounting policy

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.

NMDHB has no other contingent liabilities as at 30 June 2018 (2017: $0m).

Contingent assets

NMDHB has no contingent assets as at 30 June 2018 (2017: $0m).

21. Related party transactions

Accounting policy

Government-related entities

NMDHB is a wholly-owned entity of the Crown.

Related party disclosures have not been made for transactions with related parties, including associates that are:

- within a normal supplier or client/recipient relationship; and
- on terms and conditions no more or less favourable than those that it is reasonable to expect that NMDHB would have adopted in dealing with the party at arm's length in the same circumstances.

Further, transactions with other government agencies (for example, government departments and Crown entities) are not disclosed as related party transactions when they are consistent with the normal operating arrangements between government agencies

Significant transactions with government-related entities

NMH has received funding from the Crown and ACC of $474.4 million (2017: $446.9 million) to provide health services in the Nelson Marlborough area for the year ended 30 June 2018.

Revenue earned from other DHBs for the care of patients outside NMDHB's district amounted to $9.4 million (2017: $8.9 million) for the year ended 30 June 2018. Expenditure to other DHBs for their care of patients from NMDHB's district amounted to $45.3 million (2017: $43.0 million) for the year ended 30 June 2018.

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

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

NMH also purchases goods and services from entities controlled, significantly influenced, or jointly controlled by the Crown. Purchases from these government-related entities for the year ended 30 June 2018 totalled $2.1 million (2017: $2.1 million). These purchases included the purchase of electricity from Genesis Energy, air travel from Air New Zealand, and energy from Solid Energy.

Transactions with key management personnel

Key management personnel includes all Board members, the Chief Executive, and members of the Leadership Team & their close family members.

	Actual 2018 $000	Actual 2017 $000
Board Members		
Remuneration	256	238
Full-time equivalent members	11	11
Leadership Team		
Remuneration	2,784	2,894
Full-time equivalent members	11	12
Total key management personnel remuneration	3,040	3,132
Total fill time equivalent personnel	**22**	**23**

Due to the difficulty in determining the full-time equivalent of Board Members, the full-time equivalent figure is taken as the number of Board Members.

NMDHB entered into a variety of transactions with Golden Bay Community Health Trust during the financial year. NMDHB's General Manager, Finance, Performance & Facilities, Eric Sinclair, is a Trustee of the Golden Bay Community Health Trust. The NMDHB has a loan with present value of $1.6 million to the Golden Bay Community Health Trust and has an outstanding lease liability with a present value of $7.23 million (Discount rate: 4.75%) at the end of the financial year. Lease payments to the Golden Bay Community Health Trust are expected to cease in the year 2048. The relationship of the lease and liability has been disclosed in Note 15. There are no outstanding balances for unpaid invoices at year end.

NMH purchased services from the Marlborough District Council during the financial year. Gerald Hope, an NMDHB Board Member is a District Councillor of Marlborough District Council. Payments to Marlborough District Council during the Financial Year totalled $0.04 million. The services provided for and from Marlborough District Council were on normal commercial terms. There are no outstanding unpaid invoices at year end.

The NMDHB purchased and received services from the West Coast DHB (WCDHB) during the financial year. NMDHB's Board Chair, Jenny Black, is also the Board Chair of the WCDHB. Revenue in the form of Inter District Flows (IDFs) from the WCDHB totalled $1.1 million during the financial year, while payments in the form of IDFs totalled $0.3 million. The services provided for and from the WCDHB were on normal commercial terms. There is no amounts outstanding for outstanding receipts at year end.

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

22. Events after the balance date

Board members are not aware of any 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.

23. Financial instruments

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

NMDHB 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.

From 1 July 2012 Health Benefits Limited (HBL), and from 1 July 2015 NZ Health Partnerships Limited (NZHP) assumed responsibility for the investment of all the NMDHB's surplus funds. The risk management policies HBL and NZHP have adopted are consistent with those that follow.

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 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 15.

There are no interest rate options or interest swap agreements in place as at 30 June 2018 (2017: $Nil).

Credit rate risk

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

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

Concentrations of credit risk from accounts receivable are high due to the reliance on the Ministry of Health for approximately 94% of NMDHB'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.

NMDHB is a party to the "DHB Treasury Services Agreement" between NZ Health Partnerships Limited (NZHP) and the participating DHBs. NZHP is an entity owned 100% by the 20 District Health Boards and in this capacity is assessed to be a low risk high-quality entity.

At balance 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 7), and debtors and other receivables (note 8).

The credit quality of financial assets that are neither past due nor impaired can be assessed by reference to Standard and Poor's credit ratings (if available) or to historical information about counterparty default rates:

	2018 $000	2017 $000
Counterparties with credit ratings:		
Cash and cash equivalents		
AA	-	-
Investments		
AA	-	-
Total counterparties with credit ratings	-	-
Counterparties without credit ratings		
Cash on hand	(2)	7
Funds advanced to NZHP	18,470	21,554
Total counterparties without credit ratings	**18,468**	**21,561**
Receivables		
Existing counterparties with no defaults in the past	17,922	15,921
Existing counterparty with defaults in the past	95	80
Total receivables	**18,017**	**16,001**

Currency risk

Currency risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate due to changes in foreign exchange rates.

NMDHB had no foreign currency assets or liabilities as at 30 June 2018 (2017: Nil). 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.

Liquidity risk

Liquidity risk represents NMDHB's ability to meet its contractual obligations. NMDHB evaluates its liquidity requirements on an ongoing basis by continuously monitoring forecast and actual cash flow requirements.

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

2018	Balance Sheet $000	Contractual Cash $000	6 mths or less $000	6-12 mths $000	1-2 years $000	2-5 years $000	More than 5 years $000
DMO Loans	-	-	-	-	-	-	-
Finance lease liabilities	8,662	15,480	-	824	824	2,454	11,379
Creditors and other payables	30,139	30,139	30,139	-	-	-	-
Total current assets	38,801	45,619	30,139	824	824	2,454	11,379

2017	Balance Sheet $000	Contractual Cash $000	6 mths or less $000	6-12 mths $000	1-2 years $000	2-5 years $000	More than 5 years $000
DMO Loans	-	-	-	-	-	-	-
Finance lease liabilities	9,140	15,480	-	824	824	2,454	11,379
Creditors and other payables	30,831	30,830	30,830	-	-	-	-
Total current assets	39,971	46,310	30,830	824	824	2,454	11,379

Sensitivity analysis

In managing interest rate risk, NMDHB 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 2018, it is estimated that a general increase of one percentage point in interest rates would decrease NMDHB's deficit by approximately $465,810 (2017: $400,562).

Market risk

NMDHB does not have any significant market risk and has not entered into any derivative financial instruments.

Classification and fair values

	Note	Loans and receivables	Available for sale	Amortised cost	Carrying amount	Fair value
		$000	$000	$000	$000	$000
30 June 2018						
Current assets						
Cash and cash equivalents	7	18,468	-	-	18,468	18,468
Receivables	8	18,017	-	-	18,017	18,017
Other financial assets	11	19,950	-	-	19,950	19,950
Total current assets		**56,435**	-	-	**56,435**	**56,435**
Non-current assets						
Other financial assets	11	1,704	3		1,707	1,707
Total non-current assets		**1,704**	**3**	-	**1,707**	**1,707**
Total assets		**58,139**	**3**	-	**58,142**	**58,142**
Current liabilities						
Payables	14	-	-	24,719	24,719	24,719
Finance leases	15	-	-	490	490	490
Total current liabilities		-	-	**25,209**	**25,209**	**25,209**
Non-current liabilities						
Finance leases	15			8,172	8,172	8,172
Total non-current liabilities		-	-	**8,172**	**8,172**	**8,172**
Total liabilities		-	-	**33,381**	**33,381**	**33,381**
30 June 2017						
Current assets						
Cash and cash equivalents	7	21,561	-	-	21,561	21,561
Receivables	8	16,001	-	-	16,001	16,001
Other financial assets	11	12,351	-	-	12,351	12,351
Total current assets		**49,913**	-	-	**49,913**	**49,913**
Non-current assets						
Other financial assets	11	8,573	3		8,576	8,576
Total non-current assets		**8,573**	**3**	-	**8,576**	**8,576**
Total assets		**58,486**	**3**	-	**58,489**	**58,489**
Current liabilities						
Payables	14	-	-	23,686	23,686	23,686
Finance leases	15	-	-	477	477	477
NZDMO loans	15			-	-	-
Total current liabilities		-	-	**24,163**	**24,163**	**24,163**
Non-current liabilities						
Finance leases	15			8,663	8,663	8,663
NZDMO loans	15			-	-	-
Total non-current liabilities		-	-	**8,663**	**8,663**	**8,663**
Total liabilities		-	-	**32,826**	**32,826**	**32,826**

24. Capital Management

NMDHB's capital is its equity, which comprises Crown equity, reserves and accumulated comprehensive revenue and expense. Equity is represented by net assets.

NMDHB 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.

NMDHB 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 NMDHB's management of capital during the year (2017: Nil).

25. Explanation of major variances against budget

Statement of comprehensive revenue and expense

Revenue

Additional funding contracts for a range of services was received from the Ministry of Health totalling $2.1 million. Churchill Trust donated $1.8M towards the Post Anaesthetic Care Unit (PACU) portion of the re-constructed Theatre area in Wairau.

Expenditure

Volume driven clinical supplies especially in the areas of Pharmaceuticals, radiology and lab testing and other associated expenses contributed to variance to budget in expenses. The impairment of the National Oracle System asset (refer note 13) was not expected when the budgets were developed and shows as a variance in the statement of comprehensive revenue and expenses.

Statement of financial position

The projections in the 2017/18 Annual Plan was based on forecasts prepared well before the end of the 2016/17 year. A comparison of the actual balances with the plan would include amounts reflecting differences between the forecast and reported 2016/17 balances. These amounts comprised increases of $38.0 million in assets, $34 million in liabilities and $34 million in equity. This includes a $33M Revaluation in Land and Buildings.

Statement of cash flows

Net cash flows from Operating Activities was lower than expected mainly due to lower payments due to supplies at balance date.

26. Mental health ring-fenced accounts

NMDHB is required to abide by the restrictions on the use of funding supplied for mental health purposes. Surplus mental health funds at the end of the financial year are made available for future mental health services.

	$000	$000
Mental health funds		
Opening balance	1,762	889
Excess/(shortfall) of funding over payments	(610)	873
Adjustments to funds available		-
Total mental health funds	**1,152**	**1,762**

27. Summary of revenue and expenditure by output class

	Budget 2018 $000	Actual 2018 $000	Actual 2017 $000
Revenue			
Prevention services	8,647	8,226	7,758
Early detection and management services	122,815	123,542	123,372
Intensive assessment and treatment services	266,397	261,177	245,297
Support services	95,906	105,309	91,810
Total revenue	**493,765**	**498,254**	**468,237**
Expenditure			
Prevention services	8,160	7,752	7,031
Early detection and management services	119,666	119,544	119,501
Intensive assessment and treatment services	265,911	264,714	246,328
Support services	96,528	106,021	92,148
Total expenditure	**490,265**	**498,031**	**465,008**
Surplus/(deficit)			
Prevention services	487	474	727
Early detection and management services	3,149	3,998	3,871
Intensive assessment and treatment services	486	(3,537)	(1,031)
Support services	(622)	(712)	(338)
Total surplus/(deficit)	**3,500**	**223**	**3,229**

28. Statement of performance expectations legislative breach

Under section 149C of the Crown Entities Act 2004, NMDHB is required to deliver a completed Statement of Performance Expectations to the Minister of Health on or before 30 June of each year. NMDHB has not complied with this requirement for the Statement of Performance Expectations for the 2018/19 financial year which was submitted on 16 October 2018.

Audit report

To the readers of Nelson Marlborough District Health Board's financial statements and performance information for the year ended 30 June 2018

The Auditor-General is the auditor of Nelson Marlborough District Health Board (the Health Board). The Auditor-General has appointed me, Jacques Coetzee, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and the performance information, including the performance information for an appropriation, of the Health Board on his behalf.

We have audited:

- the financial statements of the Health Board on pages 38 to 75, that comprise the statement of financial position as at 30 June 2018, the statement of comprehensive revenue and expense, statement of changes in net assets/equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Health Board on pages 28 to 37.

Opinion

Unmodified opinion on the financial statements

In our opinion, the financial statements of the Health Board on pages 38 to 75:

- present fairly, in all material respects:
    - its financial position as at 30 June 2018; and
    - its financial performance and cash flows for the year then ended; and
- comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Standards.

Qualified opinion on the performance information because of limited controls on information from third party health providers

Some significant performance measures of the Health Board, (including some of the national health targets, rely on information from third-party health providers, such as primary health organisations. The Health Board's control over much of this information is limited, and there are no practical audit procedures to determine the effect of this limited control. For example, the primary care measure that includes advising smokers to quit relies on information from general practitioners that we are unable to independently test.

Our audit opinion on the performance information of the Health Board for the period ended 30 June 2017 was modified for the same reason.

In our opinion, except for the matters described above, the performance information of the Health Board on pages 28 to 37:

- presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2018, including:
  - for each class of reportable outputs:
    - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
    - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
  - what has been achieved with the appropriation; and
  - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and
- complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 30 October 2018. This is the date at which our opinion is expressed.

The basis for our opinion is explained below and we draw attention to a matter in relation to compliance with the Holidays Act 2003. In addition, we outline the responsibilities of the Board and our responsibilities relating to the financial statements and the performance information, and we explain our independence.

Compliance with the Holidays Act 2003

District Health Boards (DHBs) have been investigating issues associated with the calculation of employee entitlements under the Holidays Act 2003. A national approach is being taken to remediate these issues. Due to the nature of DHB employment arrangements, this is a complex and time consuming process. This matter may result in significant liabilities for some DHBs. The Health Board has provided further disclosure about this matter in note 16 on page 63. Our opinion is not modified in respect of this matter.

Basis for our opinion

We carried out our audit in accordance with the Auditor General's Auditing Standards, which incorporate the Professional and Ethical Standards and the International Standards on Auditing (New Zealand) issued by the New Zealand Auditing and Assurance Standards Board. Our responsibilities under those standards are further described in the Responsibilities of the Auditor section of our report.

We have fulfilled our responsibilities in accordance with the Auditor General's Auditing Standards.

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

Responsibilities of the Board for the financial statements and the performance information

The Board is responsible on behalf of the Health Board for preparing financial statements and performance information that are fairly presented and comply with generally accepted accounting practice in New Zealand.

The Board is responsible for such internal control as it determine is necessary to enable it to prepare financial statements and performance information that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements and the performance information, the Board is responsible on behalf of the Health Board for assessing the Health Board's ability to continue as a going concern. The Board is also responsible for disclosing, as applicable, matters related to going concern and using the going concern basis of accounting, unless there is an intention to liquidate the Health Board or there is no realistic alternative but to do so.

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

Responsibilities of the auditor for the financial statements and the performance information

Our objectives are to obtain reasonable assurance about whether the financial statements and the performance information, as a whole, are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit carried out in accordance with the Auditor General's Auditing Standards will always detect a material misstatement when it exists. Misstatements are differences or omissions of amounts or disclosures, and can arise from fraud or error. Misstatements are considered material if, individually or in the aggregate, they could reasonably be expected to influence the decisions of readers, taken on the basis of these financial statements and the performance information. We were unable to determine whether there are material misstatements in the statement of performance because the scope of our work was limited, as we referred to in our opinion.

For the budget information reported in the financial statements and the performance information, our procedures were limited to checking that the information agreed to the Health Board's statement of performance expectations.

We did not evaluate the security and controls over the electronic publication of the financial statements and the performance information.

As part of an audit in accordance with the Auditor General's Auditing Standards, we exercise professional judgement and maintain professional scepticism throughout the audit. Also:

- We identify and assess the risks of material misstatement of the financial statements and the performance information, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- We obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Health Board's internal control.
- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board.
- We evaluate the appropriateness of the reported performance information within the Health Board's framework for reporting its performance.
- We conclude on the appropriateness of the use of the going concern basis of accounting by the Board and, based on the audit evidence obtained, whether a material uncertainty exists related to events or

conditions that may cast a significant doubt on the Health Board's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements and the performance information or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Health Board to cease to continue as a going concern.

- We evaluate the overall presentation, structure and content of the financial statements and the performance information, including the disclosures, and whether the financial statements and the performance information represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with the Board regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Our responsibilities arise from the Public Audit Act 2001.

Other Information

The Board is responsible for the other information. The other information comprises the information included on pages 1 to 27, but does not include the financial statements and the performance information, and our auditor's report thereon.

Our opinion on the financial statements and the performance information does not cover the other information and we do not express any form of audit opinion or assurance conclusion thereon.

In connection with our audit of the financial statements and the performance information, our responsibility is to read the other information. In doing so, we consider whether the other information is materially inconsistent with the financial statements and the performance information or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on our work, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Independence

We are independent of the Health Board in accordance with the independence requirements of the Auditor General's Auditing Standards, which incorporate the independence requirements of Professional and Ethical Standard 1 (Revised): Code of Ethics for Assurance Practitioners issued by the New Zealand Auditing and Assurance Standards Board.

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

Jacques Coetzee
Audit New Zealand

On behalf of the Auditor General
Wellington, New Zealand

TE WAIORA Nelson Marlborough Health

www.nmdhb.govt.nz

Annual Report 2017/18
Nelson Marlborough District Health Board