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TE WAIORA Nelson Marlborough Health

# Annual Report 2015/16

# Contents

# Report from the Board Chair and Chief Executive

Nelson Marlborough Health (NMH) has consistently delivered high quality health services in accordance with government expectations for the benefit of the population across the "Top of the South" within the Marlborough, Nelson and Tasman region. We are pleased to present the Annual Report for NMH for the 2015/16 year to highlight the consistently strong service and financial performance for our health service.

## Overview

With the end of the 2015/16 financial year comes the time to reflect on the overall performance of NMH. While there were some financial challenges during the year, one key indicator is the number of people in our communities who have received access to elective services. The results show we provided access to elective services to 7,814 people across the Top of the South which is 368, or 5 per cent, more patients than we expected. The additional volumes are a combination of services provided within our hospitals as well as some volume through Inter District Flows, where our people have received surgery in tertiary centres. In terms of financial value this is equivalent to $1.8 million of additional surgery, noting that our targets are amongst the highest in the country on a per capita basis. Within this additional volume we delivered 7 per cent more cataract surgeries than planned at 499 and 26 per cent more major joint (i.e. hip and knee) replacements at 566.

The ED 5000 project in Wairau is an initiative aiming to reduce the number of presentations to the Emergency Department in Wairau when the patient would be better suited to presenting to a GP. The Emergency Department in Nelson has seen an increase in presentations of 5.6 per cent while in Wairau there has been a decrease of 5.6 per cent. in previous years the growth has been higher in Wairau than in Nelson. Whilst the reduction in Wairau has been less than 5,000, we estimate that the reduction from the previous trend is 2,400. This is a great step forward but utilisation continues to be significantly higher in Wairau than in Nelson.

For us the enormous talent and commitment of our staff and the staff of the organisations we contract to provide health services has allowed us to continue to innovate and improve care for our patients. Some of our performance targets have been challenging but overall we are pleased with the performance of the DHB and the service improvements we have made over the last year.

Our primary care partners, Nelson Bays Primary Health and Kimi Hauroa Wairau, have both continued to make significant strides during the year on the key performance targets and are both ranked near the top performing Primary Health Organisations (PHOs) in the country.

The community health hubs, in partnership with the two PHOs in Richmond and in Blenheim, that opened last year have started to show the synergies in the integration of services provided that we envisaged when we established these hubs. It provides a great opportunity for the co-located services to further enhance planning and service development and delivery in a much more integrated manner and we look forward to seeing the benefits of this coming through even more over the coming years.

# Service planning

During the year we completed a three pronged process to inform us on the current state of health and wellbeing for our population and how to best reflect this in service priority areas and facilities going forward. This resulted in the development of three documents: a Health Needs and Service Profile; a Health Services Plan; and a Facilities Implications Report.

We undertook a number of staff and community engagement sessions on the first two of these documents in October 2015.

The Health Needs and Service Profile shows that Nelson Marlborough has relatively good health and good access to health and disability support services compared to others in New Zealand. Likewise, our health system performs well compared with other DHB areas.

The Health Services Plan outlines six key strategic elements and associated actions that, if undertaken, will assist to redesign the current models of care delivery across our system. These six key elements to service redesign are:

- Strengthen district wide integrated service planning and delivery;
- Implement new models of integrated primary and community healthcare;
- Extend the scope of care pathways and review tertiary service partnerships;
- Increase focus on health promotion and prevention and target resources to high needs populations;
- Achieve excellence in clinical care in NMH hospitals; and
- Prioritise service and capital investments and reinforce performance and accountability.

We commenced the development of the Primary and Community Health Strategy and consulted with our staff and communities in October 2016.

We have also started the process to develop the business cases required by the Treasury's Better Business Case process for the redevelopment of Nelson Hospital. The first of the four cases is the Strategic Assessment which we are expecting to complete by the end of 2016. This will provide key guidance on the service needs of a new hospital and what changes we may need to make to how services are delivered in the next 5–10 years.

# Health target performance

NMH continues to perform well against the health targets, the results of which can be seen later in this report. Overall we are consistently achieving on four of the health targets and are working hard on the other two. We remain concerned that the immunisation rates are holding relatively static below the target level and will continue to place emphasis on the teams to achieve the increase necessary to meet the target.

It is appropriate to acknowledge the work performed by our two primary health organisation partners, Nelson Bays Primary Health and Kimi Hauroa Wairau, on the gains they have made in the primary care target for better help for smokers to quit. Their performance has risen from amongst the lowest across the country two years ago to now consistently ranking in the top third.

Two other areas of emerging importance for the health sector are obesity and acute readmissions. Obesity is a common precursor for ill health so tackling obesity is a key focus area for 2016–17. We will continue to reduce the impact sugar is having on our health and have an action plan to prevent and manage obesity in children. Following the removal of sugar-sweetened beverages (SSBs) in March 2014, we have strengthened our policy and removed artificially-sweetened beverages (ASBs), juices, flavoured waters and pre-packaged 'smoothie' drinks from our hospitals. Public health and prevention services that support people to make healthy choices will help to decrease future demand for care and treatment and improve the quality of life and health status of

our population. Supporting our population to achieve healthier body weights through improved nutrition and physical activity levels is fundamental to improving their health and wellbeing and to preventing and better managing long-term conditions and disability at all ages. For children, we will embed referral processes to nutrition, activity and lifestyle interventions in the Before School Check (B4SC) programme to achieve a healthy weight for more children in Nelson Marlborough.

Our System Level Outcome Measures plan, jointly developed with the Nelson and Marlborough PHOs through the Top of the South Health Alliance, aims to reduce the rate of acute readmissions to maintain the best rate of acute hospital bed days of all DHBs. We will reduce acute unplanned readmissions by ensuring support for patients on early discharge and are finalising the protocol for Early Supported Discharge. We will also support patients to prevent illness through improved long term condition management and will continue to support and embed primary options for acute care.

## Financial performance

For the 2015/16 year we are reporting an operational surplus of $1.6 million which is lower than our planned $3.8 million surplus. This has primarily resulted from a significant adverse variance of $4.1 million in the payments for Inter District Flows of which $2.3 million related to vascular surgery where the loss of the vascular surgeon at the beginning of the financial year meant almost all vascular surgery needed to be provided from other centres. The total number of vascular surgeries provided was consistent with the previous year highlighting the impact a loss of specialist staff can have on the financial results.

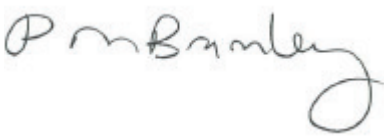
As we move into the new financial year we are confident in our ability to continue to maintain a strong financial performance and meet the challenging financial targets we have set.

## Acknowledgements

The achievements of 2015/16 have come about because of the dedication of the loyal workforce and our primary, community and other non-governmental providers we have in the Nelson, Marlborough and Tasman districts. We would like to take the opportunity to thank them for their continued commitment and support.

We would also like to acknowledge the contribution of Russell Wilson over a number of years to the Board. Russell was a Ministerial appointment to the Board and he was appointed as Deputy Chair in April 2015. Sadly, Russell passed away in February 2016. We miss his valued contribution and pass our best wishes and condolences to his family and friends.

Jenny Black
Board Chair



Peter Bramley
Acting Chief Executive

# A day in the life of Nelson Marlborough Health


**52** people receive support and advice to quit smoking

**33** women are screened for breast cancer

**1159** people visit a GP

**37** radiology tests are completed (CT and MRI)

**10** older people receive a comprehensive clinical assessment

**50** over 65 year-olds are vaccinated against influenza (during 'flu season)

**6** children receive a Before School Check

**5** babies complete their vaccinations for the eight-month-old age group

**35** people receive a cardiovascular risk assessment

**8** people receive a green prescription (a referral for increased physical activity)

**41** women are screened for cervical cancer

# Governance report

## Board objectives and functions

The Nelson Marlborough District Health Board (NMDHB) was established pursuant to section 19 of the New Zealand Public Health and Disability Act 2000. The NMDHB is a crown entity and is subject to the provisions of the Crown Entities Act 2004.

The objectives of the Board 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, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders
- To exhibit a sense of social responsibility by having regard to 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, and in planning for the provision of services and for significant changes to the provision of services
- To uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations
- To exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations
- To be a good employer

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

- To ensure the provision of services 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 the health of people

- To establish and maintain processes to enable Māori to participate in, and contribute to, strategies for Māori health improvement
- To continue to foster the development of Māori capacity for participating in the health and disability sector and for providing for the needs of Māori
- To regularly investigate, assess, and monitor the health status of its resident population, any factors that the DHB believes may adversely affect the health status of that population, and the needs of that population for services
- To promote the reduction of adverse social and environmental effects on the health of people and communities
- To monitor the delivery and performance of services by it and by persons engaged by it 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 Minister for the purposes of policy development, planning, and monitoring in relation to the performance of the DHB 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 pre-schools and schools within its geographical area on the fostering of health promotion and on disease prevention programmes
- To perform any other functions it is for the time being given by or under any enactment, or authorised to perform by the Minister by written notice to the board of the DHB after consultation with it

## Accountability and communication

Under the New Zealand Public Health and Disability Act 2000, the Nelson Marlborough District Health Board is accountable to the responsible 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 Nelson Marlborough Health's website.

# Board structure and membership

In accordance with the New Zealand Public Health and Disability Act 2000, Nelson Marlborough District Health Board comprised eleven members. Seven members were elected in the October 2013 triennial elections for local government and four members are appointed by the Minister of Health. The Minister of Health appoints the Chair and Deputy Chair from these eleven 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, the Nelson Marlborough District Health Board has four committees as follows:

- Statutory committees:
  - Community and Public Health Advisory Committee
  - Disability Support Advisory Committee
  - Hospital Advisory Committee
  - 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.

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 during 2015/16 were:

| Name | Appointment | |
|---|---|---|
| Jenny Margery Black | Elected | Chair |
| Alan Hinton | Appointed *2 | Deputy Chair<br>Chair, Audit & Risk Committee |
| Russell Wilson | Appointed *1 | Deputy Chair<br>Chair, Audit & Risk Committee |
| Judy Crowe | Elected | Chair, Community and Public Health and Disability Support Advisory Committees |
| Gerald Hope | Elected | Chair, Hospital Advisory Committee |
| Jessica Bagge | Elected | |
| Jenny Margaret Black | Elected | |
| Brigid Forrest | Elected | |
| Pat Heaphy | Elected | |
| Dawn McConnell | Appointed | |
| Patrick Smith | Appointed | |

*1 Russell Wilson was Deputy Chair and Chair of the Audit & Risk Committee until January 2016.

*2 Alan Hinton was appointed as Deputy Chair and Chair of the Audit & Risk Committee from November 2015.

# Board and committee attendance

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 2015/16 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 | 11 | 5 | 5 | 5 | 5 | 4 | 4 |
| Russell Wilson | 6 | 3 | | | 2 | 1 | 1 | 1 |
| Judy Crowe | 11 | 10 | 5 | 4 | | | | |
| Gerald Hope | 11 | 10 | | | 5 | 5 | 4 | 4 |
| Jessica Bagge | 11 | 9 | | | 5 | 3 | | |
| Jenny Margaret Black | 11 | 10 | 5 | 5 | | | | |
| Brigid Forrest | 11 | 10 | 5 | 4 | | | 4 | 3 |
| Alan Hinton | 11 | 11 | | | 5 | 5 | 4 | 4 |
| Pat Heaphy | 11 | 10 | 5 | 4 | | | | |
| Dawn McConnell | 11 | 7 | | | 5 | 2 | | |
| Patrick Smith | 11 | 11 | 5 | 5 | | | | |

## Non-Board committee members

| Board Member | CPHAC/DSAC | | HAC | | A&RC | |
|---|---|---|---|---|---|---|
| Name | Held | Attended | Held | Attended | Held | Attended |
| Jenni Gane | 5 | 4 | | | | |
| Glenys MacLellan | 5 | 4 | | | | |
| Judith Holmes | 5 | 5 | | | | |
| Dana Wensley | | | 5 | 5 | | |
| Patricia O'Brien | | | 5 | 5 | | |
| Luke Katu (IHB) | 5 | 4 | | | | |
| Sonny Alesana (IHB) | 5 | 2 | | | | |
| Dave Ashcroft | | | | | 2 | 2 |

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. Other Board members are welcome to attend committee meetings and a number do take this opportunity to keep themselves fully informed.

# Board and committee fees

NMDHB 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*. NMDHB members' fees were set within the maximum levels established for district health boards by the Minister of Health.

| | Actual 2016 $000 | Actual 2015 $000 |
|---|---|---|
| ***Value of Board member remuneration*** | | |
| Jennifer Margery Black (Chairperson) | 44 | 44 |
| Russell Wilson | 19 | 24 |
| Jessica Bagge | 21 | 22 |
| Jennifer Margaret Black | 22 | 22 |
| Judy Crowe | 21 | 23 |
| Brigid Forrest | 21 | 23 |
| Patrick Heaphy | 21 | 22 |
| Alan Hinton | 25 | 7 |
| Gerald Hope | 22 | 22 |
| Dawn McConnell | 24 | 29 |
| Patrick Smith | 23 | 24 |
| Ian MacLennan | - | 12 |
| **Total remuneration** | **263** | **274** |

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

| | Actual 2016 $000 | Actual 2015 $000 |
|---|---|---|
| ***Hospital Advisory Committee*** | | |
| Patricia O'Brien | 1 | 2 |
| Dana Wensley | 2 | 2 |
| **Total remuneration** | **3** | **4** |
| ***Community and Public Health Advisory Committee /Disability Support Advisory Committee*** | | |
| Sonny Alesana | 2 | 3 |
| Jennifer Gane | 1 | 1 |
| Judith Holmes | 2 | 2 |
| Luke Katu | 3 | |
| Glenys MacLellan | - | 1 |
| **Total remuneration** | **8** | **7** |

# Board register of interests

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 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 Board member and Executive Leadership Team, interests were declared in the Interest Register as at 30 June 2016:

## Board members

| Name | Interest |
|---|---|
| Jenny Margery Black *(Chair)* | ▪ Life member, Diabetes NZ<br>▪ Chair, South Island Alliance Board<br>▪ Chair, National DHB Chairs group |
| Alan Hinton *(Deputy Chair)* | ▪ Trustee, Richmond Rotary Charitable Trust<br>▪ Trustee, Natureland Wildlife Trust<br>▪ Trustee, Nelson Bays Community Foundation<br>▪ Trustee, Hoddy Estuary Park Trust<br>▪ Trustee, Garin College Education Trust<br>▪ Trustee, Nelson Christian Trust<br>▪ Director, Solutions Plus Tasman Ltd<br>▪ General Manager, Azwood Ltd<br>▪ Secretary, McKee Charitable Trust |
| Judy Crowe | ▪ Daughter employed by Capital and Coast DHB |
| Gerald Hope | ▪ Chief Executive, Marlborough Research Centre<br>▪ Director, Maryport Investments Ltd |
| Jessica Bagge | ▪ Councillor, Marlborough District Council<br>▪ Director, Marlborough Signs & Designs Ltd<br>▪ Spokesperson and Co-Leader, Save our Services/Hands Off Wairau |
| Jenny Margaret Black | ▪ Part-time employee, NMDHB<br>▪ ACP Practitioner |
| Brigid Forrest | ▪ Doctor, Hospice Marlborough (employed by Salvation Army)<br>▪ Locum GP in Marlborough<br>▪ Base Medical Officer, RNZAF Woodbourne (employed by Picton Medical Centre)<br>▪ Member, South Island Alliance palliative Care Workstream<br>▪ Contractor to NMDHB |
| Pat Heaphy | ▪ Spokesperson, Knights of Southern Cross<br>▪ National Spokesperson, Opposing Euthanasia<br>▪ Relative of NMDHB employee<br>▪ Relative of Cameron Gibson Wells employee |
| Dawn McConnell | ▪ Chair and Te Atiawa representative, Iwi Health Board<br>▪ Director, To Hauora O Ngati Rarua<br>▪ Trustee, Waikawa Marae<br>▪ Regional Iwi representative, Department of Internal Affairs |
| Patrick Smith | ▪ Member, Iwi Health Board<br>▪ Managing Director, Patrick Smith HR Ltd<br>▪ Member, Nelson Tasman Chamber of Commerce |

# Executive Leadership Team

| Name | Interest |
|---|---|
| Chris Fleming<br>*Chief Executive* | ▪ Trustee, The Churchill Private Hospital Trust<br>▪ Trustee, Nelson-Marlborough Hospitals Charitable Trust |
| Nick Baker<br>*Chief Medical Officer* | ▪ Senior Clinical Lecturer, Community Child Health, University of Otago, Wellington School of Medicine<br>▪ Member, Steering Group NZ Child and Youth Epidemiology Service<br>▪ Instructor, Advanced Paediatric Life Support NZ<br>▪ Technical Advisor, Whakawhetu National SUDI prevention for Māori<br>▪ Fellow, RACOP |
| Peter Bramley<br>*General Manager Clinical Services* | ▪ Nil |
| Robyn Byers<br>*General Manager Mental Health* | ▪ Nil |
| Hilary Exton<br>*Director, Allied Health* | ▪ Member, Nelson Marlborough Cardiology Trust<br>▪ Member, Physiotherapy New Zealand<br>▪ Member, New Zealand Paediatric Group |
| Ros Gellatly<br>*Chief Medical Advisor Primary* | ▪ GP, Scott Street Health<br>▪ RNZCGP representative, National IT Clinical Leadership Group<br>▪ Member, Southlink Health |
| Pam Kiesanowski<br>*Director of Nursing* | ▪ Nil |
| Patrick Ng<br>*General Manager IT & Infrastructure* | ▪ Nil |
| Keith Rusholme<br>*General Manager Disability Support Services* | ▪ Wife is a provider of complementary health services<br>▪ Sister works within the Disability Support Services |
| Eric Sinclair<br>*General Manager Finance & Performance* | ▪ Trustee, Golden Bay Community Health Trust |
| Harold Wereta<br>*General Manager Māori Health Whanau Ora* | ▪ Ngati Toarangatira connections<br>▪ Ngati Koata<br>▪ Member, Maitahi Outrigger Club |

Note the Executive Leadership Team interest 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.

# Iwi Health Board

Māori health inequity and achievement of the 30-year Māori Health vision provide the main focus for the Iwi Health Board as it continues to strengthen the direction and approach for Māori living across Nelson Marlborough. The partnership with the Nelson Marlborough District Health Board (NMDHB) is of key importance to the success and more importantly how both parties fulfil their obligations under the Treaty of Waitangi and NZ Public Health and Disability Act 2000.

Representation on the Iwi Health Board (IHB) is drawn from Ngāti Apa, Rangitane, Ngāti Koata, Ngāti Kuia, Ngāti Rarua, Ngāti Tama, Ngāti Toarangātira and Te Ati Awa and make up Manawhenua o Te Tau Ihu. In addition, there are appointed members from Pasifika and Maata Waka (or Māori with tribal affiliations to other regions). This combined presence and energy ensures health planning takes a collective view to health improvement.

### National Target Achievements

Angiogram in high risk patients at 100% (70%)

Post Angio data collection at 100% (95%)

Breast screening for 50–69 years at 73% (70%)

### Areas for Improvement

Cardio vascular risk assessment for males 35–44 years at 65% (90%)

Mental health: rates of compulsory community treatment at 301 (2015/16 target <180)

Preschool enrolment in Oral health service 56% (95%)

Mothers Smokefree 2 week postnatal at 66% (95%)

Notes: (x%) = National Target

## Achieving the treaty partnership

The IHB and the Board meet twice a year and this has been an important forum for both parties to advance strategic issues. The Boards are exploring collectively how the present partnership model could be strengthened and what mechanism could be implemented so that the DHB management are able to have direct access to the IHB's influence for decisions that would shape service delivery geared to the Māori population.

## Board appointments/statutory committees

As part of the DHB election process there are two Māori representatives appointed by the Minister of Health. This appointment process is completed every three years in line with DHB elections.

IHB enjoys strong representation on three statutory sub-committees. They are viewed as key contributors to raising the profile of Māori health and health inequalities at sub-committee level. During their term on the Board at least one member is seconded to the IHB. This helps to support a flow of communication up to the Board.

### Areas of focus

IHB has continued its focus on strengthening the Māori Health Plan 2015/16 and exploring pathways that support Māori workforce recruitment. The group was pleased to see NMH had achieved three national Māori health targets. One area of concern raised by the IHB to the Board and Ministry of Health was the changes

being made to the national targets. Three new targets not achieved were cardio vascular risk assessment (35 – 44 years), oral health and smokefree two week postnatal that were introduced midway through the year.

Making a submission to the NZ Health Strategy was strategic for the IHB. The group were able to highlight the need to improve the recognition and presence of the Treaty of Waitangi, the connectivity between stated Māori health statements to actions, and the importance of Māori leadership throughout the document.

Another significant contribution made by IHB was to the Nelson Marlborough Population Health Profile and the Health Services Plan. Both documents were viewed by the IHB as critical steps in the future planning for Māori health in the region. During the consultation phase the IHB stressed the importance of addressing health inequities being embedded as a key priority and the need to be able to measure health gain for Māori against the life of the 2030 vision for the district.

Supporting the ongoing development and operation of the Māori health provider Te Piki Oranga continues as an important focus for IHB. Regular six month meetings are held between the two boards to align activity and strategic planning. The meetings are useful in that it allows the two boards to have free conversations about areas of opportunities.

## Key achievements

The year has had its challenges. Amongst all of the developments reported to date there have been successes. Here are some key highlights:

- Implementing a project with the Southern Cancer Network to improve the Cancer Pathway for Māori with a focus on enhancing cultural competency in delivering services across the cancer continuum and increasing health literacy in cancer for Māori communities.
- Forty Nelson Marlborough Health services/departments participating in He Taura Tieke, a self-audit tool through which to review and improve delivery of service to Māori.
- Development of the Māori Health Monitoring Framework aligned to the refreshed He Korowai Oranga strategy to monitor the health status of the Māori population.

For 2016/17 the Iwi Health Board will continue to strengthen the advice given to its partner NMDHB Board. It will have as its key focus Māori health inequities and the measurement of these through the Māori health reporting framework. Working with NMH and sector management will be another area IHB will have a focus on. With the emergence of Oranga Māori Komiti, a sub-committee of the Te Tau Ihu Iwi leaders forum, this opportunity will enable the IHB to focus on how it can become an effective advisor to NMH's operations and the sector as a whole. Strong Māori leadership and advice remain at the forefront for future direction.

# Service updates

## Community services

### Primary care – Health Target success

Health targets are a set of national performance measures specifically designed to improve the performance of health services that reflect significant public and government priorities.

For Nelson Marlborough Health the targets provide a focus for action and drive continual performance improvement. The people of Nelson Marlborough generally have good health compared to others in New Zealand, with a higher life expectancy than the New Zealand average and lower amenable mortality.

The more heart and diabetes checks target is particularly important for the people of Nelson Marlborough because although the incidence of coronary heart disease is falling it remains the single largest cause of health loss. We met the target with a result of 91 per cent in Quarter 4.

Nelson Marlborough people continue to have good access to elective surgery with the elective surgery target surpassed by 5 per cent. Nelson Marlborough has continued to meet the shorter stays in ED target with 96 per cent of people being admitted, discharged, or transferred from the emergency department within six hours.

Further progress is needed on immunisation coverage for eight month olds. It is difficult to reach the 95 per cent immunisation target as there are a lot of "decliners" in the region, that is those who decide not to immunise their children. The focus will be on understanding why people are choosing to decline, providing tools for health professionals working with parents choosing to decline or delay immunisation and training to participate in difficult conversations.

Although the Nelson Marlborough population ranks relatively low on most risk factors we still have 15,000 smokers. So it is important that we provide smokers with better help to quit. Overall for the year we achieved a result of 90 per cent of smokers who were offered help to quit by a health professional. Māori adults are much more likely to be current smokers than non-Māori and we will continue to work with Māori and Pacific leadership to support people becoming smokefree with a specific emphasis on pregnant women.

Faster Cancer Treatment was a new target introduced in 2015/16. Cancer is a leading cause of morbidity and mortality in New Zealand, accounting for nearly one third of all deaths. Although no DHB has yet met the target we are making progress and achieved a result of 76 per cent for the year.

The achievement of these results is a good indicator of the continual improvement in healthcare in our region and the results are a credit to the health professionals in Nelson Marlborough.

### Primary Care – integration services

The Nelson Marlborough health system is made up of interconnected and interdependent organisations and practitioners who work together to meet the population health, personal health and disability support needs of our district as a whole and our local communities. A strong primary healthcare system is central to improving the health of people in our region and, in particular, tackling inequalities in health.

The Te Tau Ihu Top of the South Alliance (ToSHA) leads a work programme of population health improvement and service transformation that will contribute to the DHB's overall goals.

ToSHA led the development of a Nelson Marlborough Primary & Community Health Strategy, which includes an integrated model with general practice at the core, multi-disciplinary teams with personnel working at the top of their scopes and alignment of primary and community services with specialist support. This new model will be shared with the community for their feedback in October 2016.

The prevalence of long-term conditions (LTCs) is rising in New Zealand and many people have several LTCs. ToSHA has led the development and implementation of culturally appropriate self-management programmes for people living with LTC's that better meet the needs of individuals, that are close to people's home and have a consistent approach throughout the Nelson Marlborough district. Supporting self-management involves educating people about their condition and care and motivating them to care for themselves better.

All Nelson Marlborough women can now pick up the emergency contraceptive pill free of charge as part of a new initiative introduced in October 2015. As well as receiving the pill, women are given an information pack and a supply of free condoms while longer term contraceptive choices are considered. Pharmacies supplying the pill also hand out vouchers for a free sexual health check-up and consultation to find out about contraceptive options. Providing free access to the contraceptive pill may reduce the number of terminated pregnancies in the region, the number of teen pregnancies and associated health issues and raise awareness of sexually transmitted diseases.

Chronic obstructive pulmonary disease (COPD) is a progressive lung disease. Marlborough residents have higher COPD mortality and hospitalisation rates than residents of the other localities, which can contribute to the high rate of ED presentations. A programme has been introduced for management of COPD acute exacerbation in primary care. A spirometry service has also been introduced in primary care to support the diagnosis and management of COPD by measuring lung function.

Children aged under 13 in Nelson Marlborough now receive free GP visits and prescriptions. The changes are designed to improve access to healthcare for primary and intermediate school children, ensuring they can get the care they need when they need it and avoid possible complications and visits to the hospital Emergency Department.

Regular cervical screening is important to pick up on the increased risk of developing cervical cancer well before any actual danger manifests. Overall Nelson Marlborough Health achieves the 80 per cent screening coverage target for all eligible women. However lower rates of screening coverage for Māori contributes to a higher incidence of cervical cancer among Māori women compared with European and other ethnicities. To increase screening coverage a new cervical screening invitation and recall service has been established in Nelson Marlborough.

# Clinical governance

Clinical governance systems within NMH continue to develop and embed with the intention of achieving an environment where clinical excellence will flourish. A positive, safe environment for everyone is known to be associated with better healthcare outcomes, kinder and safer patient care.

Key areas in the 2015-16 Annual Plan have been largely achieved. Some areas not consistently achieved throughout the year remain works in progress, for example hand hygiene. Our other planned outcome goals around response rate to the patient experience survey and percentage of patients having trust and confidence in the staff treating them were achieved. We can be proud of the fact that this figure was 88 per cent in the final quarter patient experience survey.

During this year the Clinical Governance Committee has settled on three words to describe and encapsulate our efforts over the next few years. We intend to be 'safe, skilled and compassionate'.

- Safe refers to work such as ensuring our systems are safe, that we learn from adverse events and complaints and that we are capturing information in a way that gives us confidence that our healthcare is safe.

- Skilled covers ensuring that we have the right skills for the job, that departments are credentialed and that we are compliant as a training organisation.
- Compassionate speaks for itself. Following the results of our staff survey and in line with national developments such as the Royal Australasian College of Surgeons very public commitment to reducing bullying amongst surgical trainees, we will be developing systems to address these issues for all staff. We intend to operate using the principles of 'Just Culture' and this will link with a drive to increasing our public transparency at all levels.

# Clinical services

Clinical Services in 2015/16 has provided for the community of NMH a wide range of acute and elective services. In an environment of increasing numbers with chronic diseases, an ageing population and rising complexity of treatment the clinical teams have delivered exceptional care with some of the best health metrics for the country.

The team exceeded by 355 the 7,445 electives surgeries required to meet our expected surgical discharges. We also achieved the new four month target that no one waits longer than four months for either a first specialist assessment or an elective procedure once someone is accepted to the surgical waiting list. In particular 499 cataract procedures were delivered and there were 566 hip and knee replacements completed.

We also made progress in improving the waiting times for Angiography, CT and MRI. With the installation of a new MRI in Wairau Hospital better access for patients to MRI across the district was achieved.

Cancer waiting times decreased compared to the previous year, with significantly more people receiving treatment within 62 days of a referral for suspicion of cancer. Wait times for endoscopy also improved with less people on the waiting list and people receiving their procedure in a more timely manner.

Our Emergency Departments at both Nelson and Wairau Hospitals experienced increasing pressure from presentations with rising complexity reflected in increasing rates of admission to hospital. In 2015/16, 48,216 people presented to our Emergency Departments. NMH continued to meet the national health target that at least 95 per cent of people presenting to an emergency department are either discharged or admitted to hospital within 6 hours.

In Nelson Hospital 39,102 bed nights for patient care were provided and 16,342 were provided in Wairau Hospital.

The Clinical Services team provided 20,208 first specialist assessments over the year and 36,469 follow up appointments with specialist services. In addition 18,478 medical and surgical procedures were delivered.

# Mental health services

The Mental Health and Addictions Directorate continues to demonstrate its effectiveness in addressing local, regional and national priorities across the continuum. The Directorate has remained within budget while implementing service development and quality improvements within NMH services across the wider health sector and with other agencies.

Workforce development continues as a priority for specialist, NGO and primary mental health services including consumer and whanau education. Government and community agencies are also offered the opportunity to participate in relevant sessions. A major focus has been providing training in peer-led recovery models.

An external review of the Directorate was completed resulting in a number of recommendations for service reconfiguration and development. This supported and built on the direction of travel commenced through the Service Integration, Residential and Addictions Reviews. In its conclusion the review found that "the standard

of services across the continuum of Mental Health and Addictions need provided to the Nelson Marlborough population is above the New Zealand average and much better than many. A number of "exemplars" exist. The review team see Nelson Marlborough Health as having a strong foundation to move into the future and become a world class service".

# Disability support services

During the past year the following notable items occurred:

- Offer of a contract from the Ministry of Health to offer supported living services to existing customers
- Establishment of DSS as a business unit within NMH
- Confirmation of the 2nd tier management structure within DSS as meeting service need
- A higher than expected rate of service user attrition mostly due to more deaths than anticipated
- An increase in the number of referrals to the service for younger people
- Senior management restructure that disestablished the role of General Manager DSS and contributed to Keith Rusholme deciding to resign after 43 years of service with NMH.

Plans for 2016/17:

- Implementing changes that arise from the senior management restructure
- Some people being referred to the service have needs that are quite complex and requires specific and deliberate decisions about the way support is provided and the skill-set sought in staff
- Consolidating housing stock to minimise vacancies and exit lease of properties that are no longer meeting need
- Introduction of e-learning for Health and Wellbeing students.

# Information technology and infrastructure

## Information technology

The paper-lite strategy remains our key area of focus for Nelson and Marlborough. A series of proposals has been business cased and approved for the first round of paper-lite gains. These include electronic laboratory sign-off, electronic radiology ordering, electronic radiology sign-off and electronic referral triaging. These initiatives are all dependent on the implementation of the regional clinical solution known as Health Connect South. We are therefore working closely with the regional implementation team to get Health Connect South implemented by late 2016. Once this solution is implemented these initial paper-lite initiatives will get underway. To further our paper-lite agenda we are also anticipating making successful cases for digitising early warning scores and bedside care, implementing Health One (a solution built on Health Connect South, whereby General Practitioners, pharmacies and secondary care clinicians can access key patient information from each others' systems) and we hope to start MedChart, the first of the electronic medicine management initiatives.

We remain conscious that a transformation is required from the current paper medical charts to a future where the information in these charts can be found in the electronic health record in Health Connect South. To this end we are developing a case around the creation of a document management solution which would be accessible

from Health Connect South, and which would index, store and enable quick searching on the information currently captured in the paper medical charts. Once in place we would then undertake a bulk scanning process to get the paper medical records into an electronic state. Whilst we envisage that this will be a multi-year initiative, at the conclusion of this programme substantial progress will have been made towards making the local hospital system paper-lite.

Delays have occurred in the regional Patient Administration System (PICS) being made available for implementation in Nelson Marlborough. However, the software vendor and regional implementation team have now indicated that we will have the software made available to us by August 2017. We are planning a rapid implementation that would see us on the new patient administration system by November of 2017 with a fall back date of February 2018 if unforeseen events delay the initial implementation and go-live.

## Hospital facilities

A conceptual design exercise is underway to identify the short term clinical needs for the hospital and to build these in conjunction with a Learning & Development Centre. We plan to put conceptual plans to our Board in October/November of 2016, and if approved, detailed design would occur prior to the possible commencement of construction towards the start of the 2017/18 financial year.

We have initiated the Treasury Better Business Case approach for the re-development of Nelson Hospital. As well as being earthquake prone our main buildings (George Manson and Percy Brunette) are now 50-60 years old and are struggling to cope with the demands of contemporary hospital care delivery. Furthermore, there is currently insufficient capacity to cope with projected demand over the next 20 years. We have completed initial investment logic mapping and benefits mapping work and are underway with our Strategic Assessment. We are working closely with the Ministry of Health and are observing the business case development process at Canterbury and Southern District Health Boards prior to commencing with hospital services re-design work and the next stages of business case development.

# Our people

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

Being a smaller region Nelson Marlborough is well positioned to develop "true partnership", where staff of both public and private services work together to provide an integrated service to the community. This may also assist in attracting and retaining qualified and trained staff within the Nelson Marlborough health workforce.

Nelson Marlborough has stability and experience in the district wide health and disability workforce. This workforce resource provides a significant opportunity for Nelson Marlborough to be a training or mentoring hub for the entry level health and disability workforce in New Zealand.

We need to work on the development of staff so our workforce culture is inclusive and empowering and we must take responsibility and make improvements. Trusting, valuing and fully engaging health professionals improves patient care and job satisfaction and will assist in recruitment and retention. Focusing on improving clinical workforce retention and fostering clinical leadership continues as a key priority for NMH.

## Staff engagement

A Staff Engagement Survey was completed by NMH last year. The information provided in the survey helped to identify what is important to the people working at NMH and it highlights areas of concern that we are working to improve. The survey also identified the things we do well. It is our intention to complete a further survey in May 2017.

The Chief Executive and the Board made a commitment to address the following top four issues (most negative):

- I feel appreciated for the contribution I make
- I feel happy with my career development options within this health service
- I have not felt bullied by other team members in the last 12 months
- I have opportunities to contribute to important decisions that affect my work.

The organisation in partnership with the unions setup a "Staff Engagement Working Together" group. This group's agenda is to address the top four issues for the organisation including, but not limited to, changing the organisation's culture.

A large piece of work currently being reviewed by the group is the 'Building Respect' programme modelled on the Vanderbilt Principles from the Vanderbilt Hospital in the USA. A decision by NMH on the potential for a similar programme to be introduced is expected in the next few weeks.

# Workforce development

In late 2014, a Workforce Planning Group was initiated, bringing together a representative working group.

The implementation of the NMH & Disability Workforce Plan's nine strategies and the individual action points identified under each strategy was to be undertaken in three phases and to be completed by June 2018.

Stage one of the action plan that was to be completed in the 2015/16 financial year is still being implemented.

The Workforce Plan is the first step in a process that signals proactive thinking for the whole of Nelson Marlborough district wide health services' most valuable resource—the health and disability workforce.

# Health, safety and wellbeing

New Zealand's key work health and safety legislation is the Health and Safety at Work Act 2015 (HSWA) and regulations made under that Act. All work and workplaces are covered by HSWA unless specifically excluded. WorkSafe is the government agency that is the work health and safety regulator.

Further to legislative changes in the Health & Safety at Work Act 2015, NMH is committed to ensuring the health, safety and wellbeing of employees, contractors and volunteers who work on or visit an NMH owned or operated site. NMH also have responsibilities to patients, service users and others.

The NMH Workplace Health, Safety & Wellbeing Management is a systematic approach to:

- Providing a safe work environment and adequate facilities
- Ensuring any plant or equipment used is designed and made safe for the employee to use and is properly maintained
- Provide emergency procedures
- Hazard/risk management system and tools and resources
- Adequate training and refresher training including induction and orientation
- Document and data control
- Injury management
- Worker consultation and participation
- Rehabilitation and return to work.

Led by the Board and Executive Leadership team the risk profile and monitoring of high risk hazards is being driven by executive management. The introduction of new initiatives, management systems, resources and worker/management education has allowed for the dissemination of Health and Safety information; preparation for the new Health & Safety at Work Legislation; recognition of safety champions, development of safe work procedures and tools to assist our competent Health and Safety Representatives. Measurement and evaluation ensures the effectiveness and continual improvement of the Workplace Health & Safety Management System.

# Good employer

A key value of Nelson Marlborough Health is to be a good employer. This is demonstrated by the following elements:

- Leadership, accountability and culture
- A Health and Safety programme
- An Equal Employment Opportunities programme
- Recruitment, selection and induction
- Remuneration, recognition and conditions
- Recognition of the aims and employment needs of Māori
- Recognition of the aims and cultural differences of ethnic and minority groups
- Recognition of the employment needs of people with disabilities
- Harassment and bullying prevention.

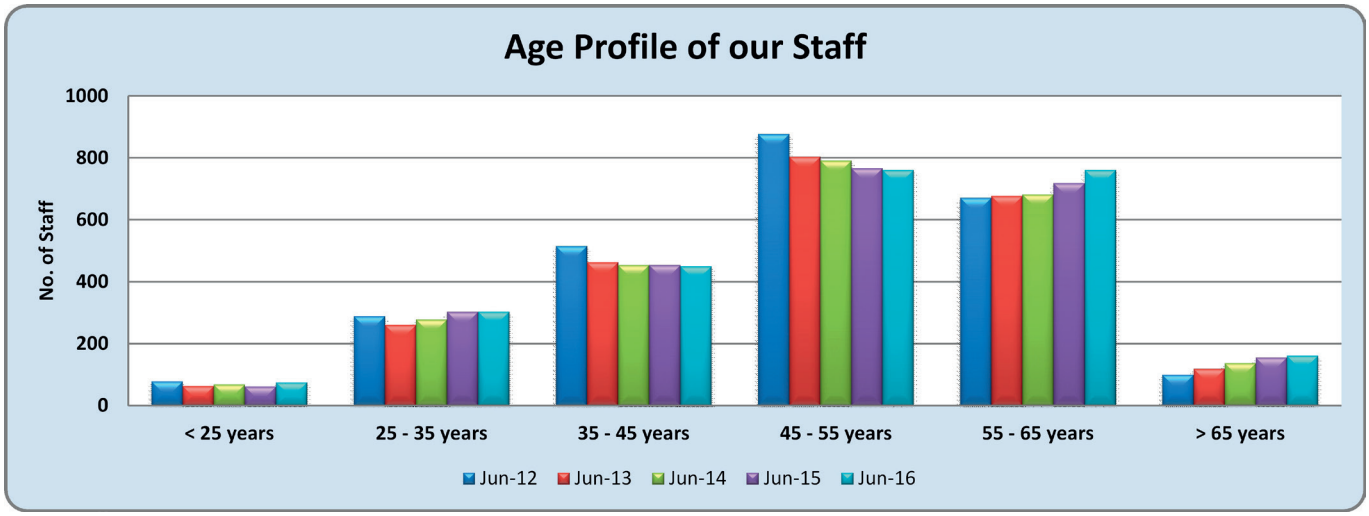
NMH has an equal employment opportunities focus within the relevant polices. A rigorous recruiting and selection procedure is followed to ensure fairness and equal opportunity.

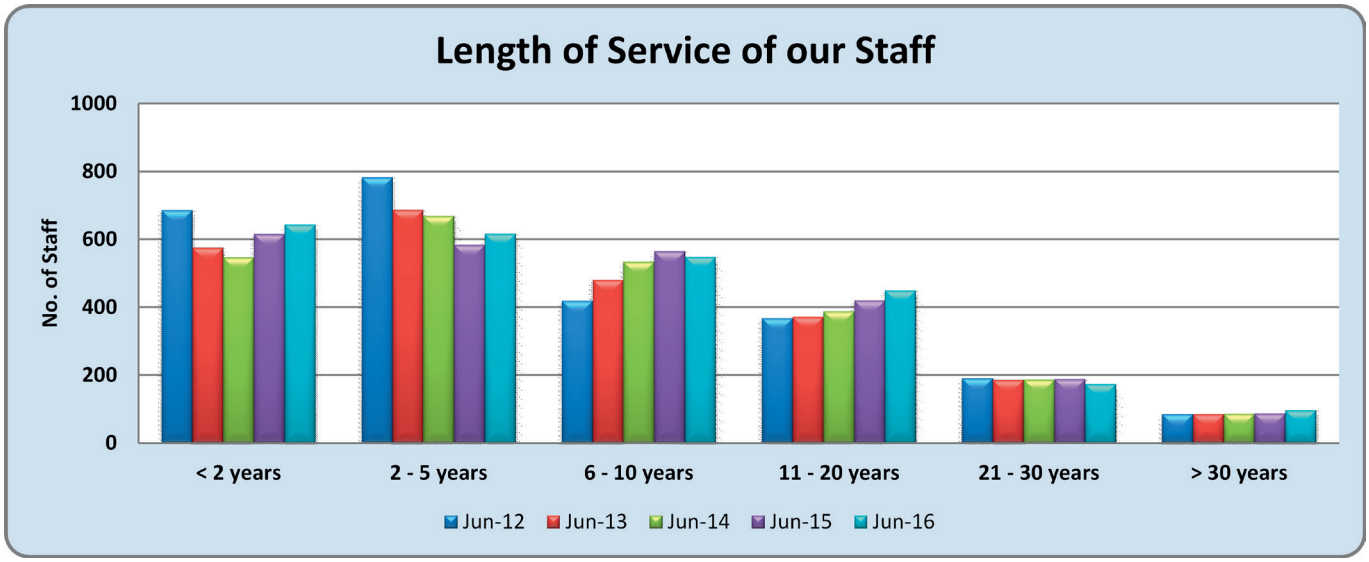
Training and development opportunities are offered to all staff and personal performance and development plans are a mandatory requirement for all employees.

# Workforce profile

| Employee Grouping | Jun-12 | Jun-13 | Jun-14 | Jun-15 | Jun-16 |
|---|---|---|---|---|---|
| Medical | 181 | 180 | 183 | 189 | 190 |
| Nursing | 652 | 640 | 642 | 655 | 663 |
| Allied Health | 310 | 312 | 303 | 316 | 319 |
| Disability Support Services | 273 | 270 | 265 | 263 | 257 |
| Hotel and Support | 99 | 95 | 97 | 103 | 103 |
| Management and Administration | 338 | 340 | 325 | 332 | 350 |
| **Total FTEs** | **1,853** | **1,838** | **1,815** | **1,858** | **1,882** |

| Ethnicity | Jun-12 | Jun-13 | Jun-14 | Jun-15 | Jun-16 |
|---|---|---|---|---|---|
| Asian | 29 | 28 | 34 | 50 | 51 |
| Australian | 33 | 31 | 30 | 36 | 37 |
| European | 209 | 217 | 231 | 240 | 256 |
| Māori | 82 | 85 | 80 | 77 | 91 |
| NZ European/Pakeha | 1,674 | 1,562 | 1,579 | 1,638 | 1,669 |
| Other | 51 | 47 | 53 | 52 | 53 |
| Pacific Peoples | 4 | 3 | 3 | 7 | 7 |
| Unknown/Unspecified | 450 | 414 | 401 | 360 | 364 |
| **Total Staff (Headcount)** | **2,532** | **2,387** | **2,411** | **2,460** | **2,528** |


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-12
Jun-13
Jun-14
Jun-15
Jun-16


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-12
Jun-13
Jun-14
Jun-15
Jun-16

# Employee remuneration

The number of employees earning more than $100,000 is detailed in the table below. Of the 256 employees shown, 216 are or were medical, dental, nursing or allied health employees (2014/15: 181).

| Salary Band ($000) | 2016 | 2015 |
|---|---|---|
| 100–110 | 50 | 49 |
| 110–120 | 25 | 16 |
| 120–130 | 17 | 13 |
| 130–140 | 20 | 9 |
| 140–150 | 13 | 7 |
| 150–160 | 4 | 6 |
| 160–170 | 4 | 5 |
| 170–180 | 7 | 5 |
| 180–190 | 11 | 5 |
| 190–200 | 5 | 6 |
| 200–210 | 5 | 2 |
| 210–220 | 7 | 5 |
| 220–230 | 5 | 13 |
| 230–240 | 12 | 7 |
| 240–250 | 10 | 7 |
| 250–260 | 7 | 16 |
| 260–270 | 10 | 8 |
| 270–280 | 3 | 7 |
| 280–290 | 9 | 8 |
| 290–300 | 5 | 5 |
| 300–310 | 10 | 3 |
| 310–320 | 4 | 3 |
| 320–330 | 4 | 3 |
| 330–340 | 3 | 2 |
| 340–350 | 0 | 2 |
| 350–360 | 3 | 1 |
| 360–370 | 1 | 0 |
| 370–380 | 0 | 1 |
| 400–410 | 0 | 1 |
| 420–430 | 1 | 0 |
| 440–450 | 1 | 0 |
| **Total** | **256** | **215** |

# Termination payments

During the year the DHB made the following payments to former employees in respect of the termination of their employment with the organisation. These payments include amounts required to be paid pursuant to employment agreements in place, with the majority of payments being redundancy payments. The payments made by the DHB during the year totalled $140,898 to 5 employees (2015/16: 7 payments totalling $115,923).

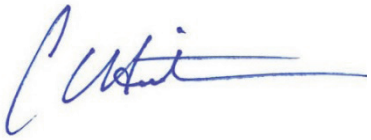
# Statement of responsibility

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.

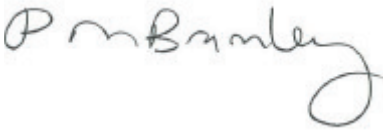
The Board and management of the Nelson Marlborough District Health Board accept responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting.

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 2016 fairly reflect the financial position and operations of the Nelson Marlborough District Health Board.

Jenny Black
**Board Chair**



Alan Hilton
**Board Member**



Peter Bramley
**Acting Chief Executive**

Eric Sinclair
**GM Finance and Performance**

# Statement of performance

## Strategic outcomes

Nelson Marlborough Health is the largest funder and provider of health and disability services across the top of the South Island comprising the Marlborough, Nelson and Tasman region. The actions we take in terms of which services to fund and the level at which we invest has a significant impact on the health of the 144,500 people who live in our district. In achieving our vision of "Towards Healthy Families" it is important that we understand the level of need within our population, as well as the current and future drivers of service demand. We strive to take a long term view, and shift resources to where we believe they are most needed, in order to make a positive change to the health of our population whilst ensuring that the health system is sustainable.

This section provides an overview of our outcomes framework, which is designed to align to the strategic direction of the Ministry of Health and the Government. Our strategy identifies three Outcome Goals which demonstrate success over time. These are long-term indicators and, as such the aim is for measureable change in health status over time rather than a fixed target. The indicators are noted below and are measured from the NZ Health Survey undertaken by the Ministry of Health. The Health Survey has not been updated to include results for 2015/16 and other periods since the Health Survey was completed and consequently we are unable to report achievement against these.

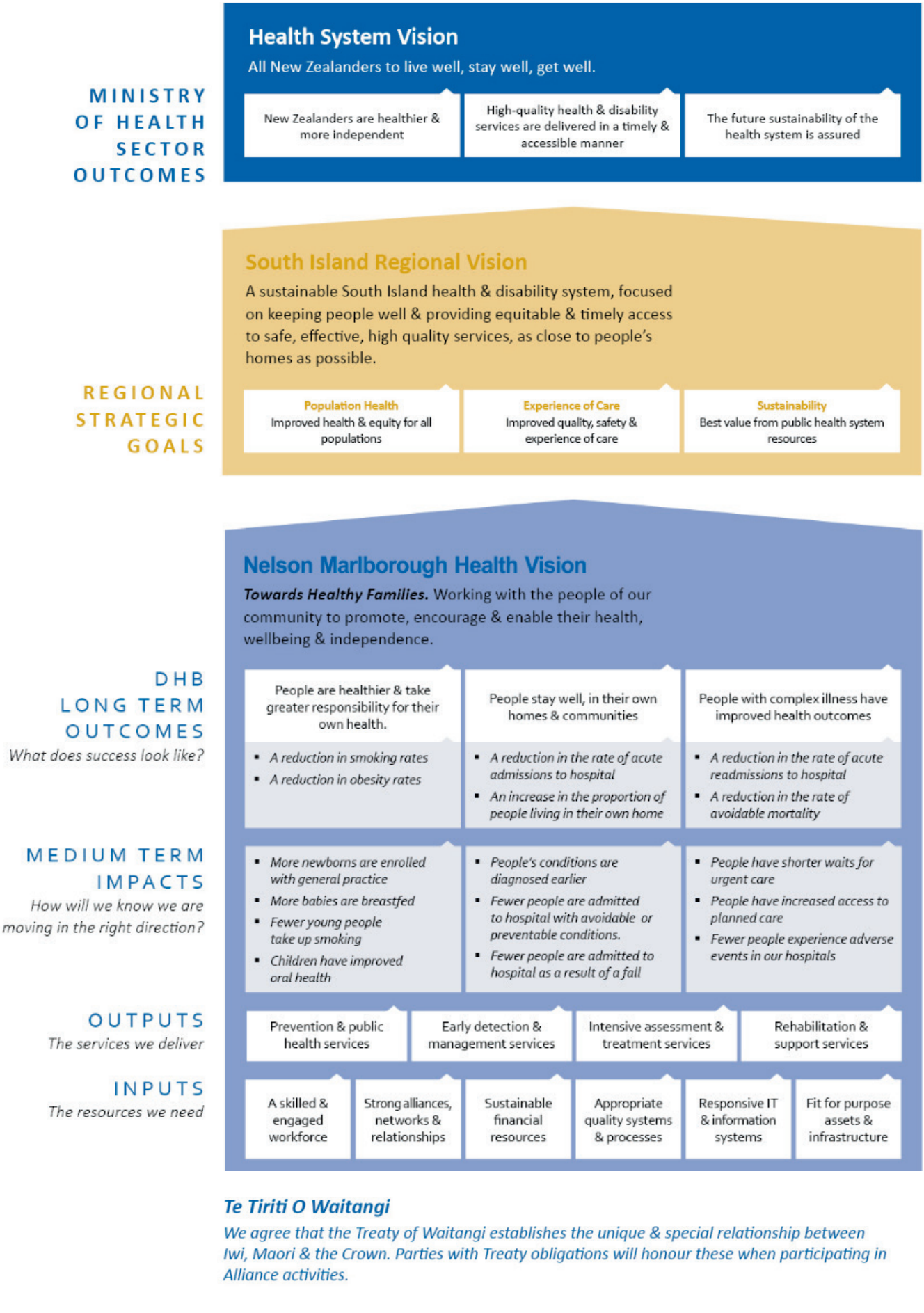
- **Strategic Outcome 1: People are healthier and take greater responsibility for their own health**
  - A reduction in smoking rates
  - A reduction in obesity rates
- **Strategic Outcome 2: People stay well, in their own homes and communities**
  - A reduction in the rate of acute medical admissions
  - An increase in the proportion of people living in their own homes
- **Strategic Outcome 3: People with complex illness have improved health outcomes**
  - A reduction in the rate of acute readmissions to hospital
  - A reduction in the rate of avoidable mortality

The South Island DHBs have also identified a core set of associated medium-term indicators. Because change will be evident over a shorter period of time these indicators have been identified as the headline or main measures of performance. Each DHB has set local targets in order to evaluate their performance over the following four years and determine whether they are moving in the right direction.

The outcome and impact indicators were specifically chosen from existing data sources and reporting frameworks. This approach enables regular monitoring and comparison without placing additional reporting burden on the DHBs or other providers.

As part of our obligations as a DHB we must also work towards achieving equity and to promote this the targets for each of the impact indicators are the same across all ethnic groups.

The following intervention logic diagram demonstrates the value chain: how the services that an individual DHB chooses to fund or provide (outputs) will have an impact on the health of their population and ultimately result in achievement of the desired longer-term outcomes and the expectations and priorities of Government.




### *Te Tiriti O Waitangi*

*We agree that the Treaty of Waitangi establishes the unique & special relationship between Iwi, Maori & the Crown. Parties with Treaty obligations will honour these when participating in Alliance activities.*

# Strategic outcome 1: People are healthier and take greater responsibility for their own health

## Why is this a priority?

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 hospital and specialist services. The likelihood of developing long-term conditions increases with age, and with an ageing population the burden of long-term conditions will grow. The World Health Organisation (WHO) estimates more than 70 per cent of all health funding is spent on managing long-term conditions. These conditions are also more prevalent amongst Māori and Pacific Islanders and are closely associated with significant disparities in health outcomes across population groups.

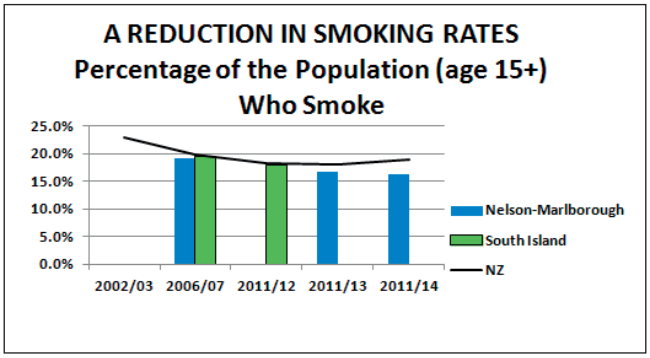
Tobacco smoking, inactivity, poor nutrition and rising obesity rates are major contributors to a number of the most prevalent long-term conditions. These are avoidable risk factors, preventable through a supportive environment, improved awareness and personal responsibility for health and wellbeing. Public health and prevention services that support people to make healthy choices will help to decrease future demand for care and treatment and improve the quality of life and health status of our population.

## Overarching Outcome Indicators

### *Smoking*

Tobacco smoking kills an estimated 5,000 people in NZ every year. Smoking is also a major contributor to preventable illness and long-term conditions, such as cancer, respiratory disease, heart disease and stroke and a risk factor for six of the eight leading causes of death worldwide.

In addition, tobacco and poverty are inextricably linked. In some communities, a sizeable portion of household income is spent on tobacco, meaning less money for necessities such as nutrition, education and health.




Supporting people to say 'no' to smoking is our foremost opportunity to not only improve overall health outcomes but also to reduce inequalities in the health of our population.

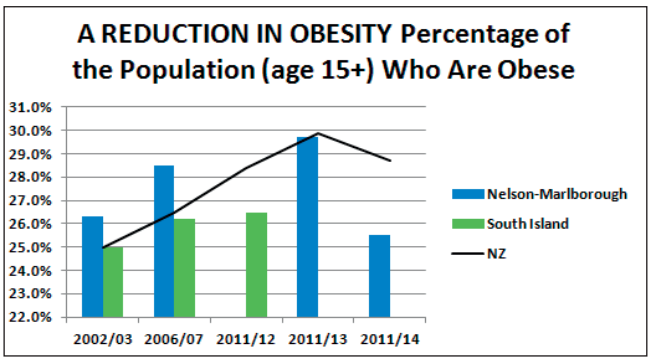
*Data Source: National Health Survey*

*The NZ Health Survey was completed by the Ministry of Health in 2002/03, 2006/07, 2011/12 and 2012/13. However the 2011/12 and 2012/13 surveys were combined in order to provide results for smaller DHBs—hence the different time periods presented. Results are unavailable by ethnicity. The 2013 Census results (while not directly comparable) indicate rates for Māori, while improving, are twice that of the total population—30.7% of Canterbury Māori are regular smokers in 2013 compared to 14.5% of the total population.*

### *Obesity*

There has been a rise in obesity rates in New Zealand in recent decades. The 2011/13 NZ Health Survey found that 30 per cent of adults and 10 per cent of children are now obese.

This has significant implications for rates of cardiovascular and respiratory disease, diabetes and some cancers, as well as poor psychosocial outcomes and reduced life expectancy.



Supporting our population to achieve healthier body weights through improved nutrition and physical activity levels is fundamental to improving their health and wellbeing and to preventing and better managing long-term conditions and disability at all ages.

*Data Source: National Health Survey*

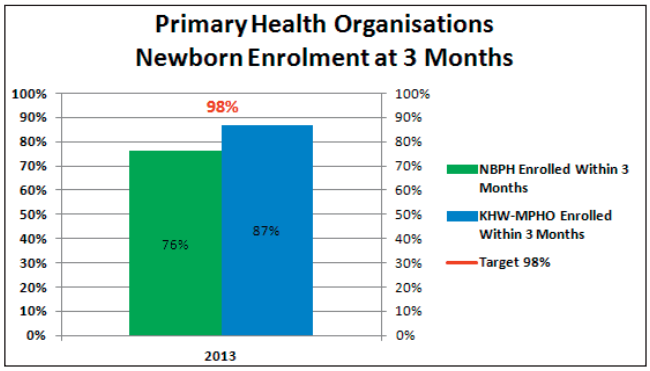
*The NZ Health Survey defines 'Obese' as having a Body Mass Index (BMI) of >30 or >32 for Māori and Pacific people.*

## Intermediate Impact Indicators

### *Newborn enrolment*

Enrolment of a newborn baby with their general practice soon after birth is important so they can receive essential healthcare, including immunisations, on time. Late enrolment means a baby may start their immunisations late exposing them to preventable diseases like whooping cough and measles. This could also lead to delays in receiving further immunisations. Earlier enrolment helps minimise this risk.

An increase in newborn enrolments is seen as an early indicator for immunisation rates, and overall general child health.



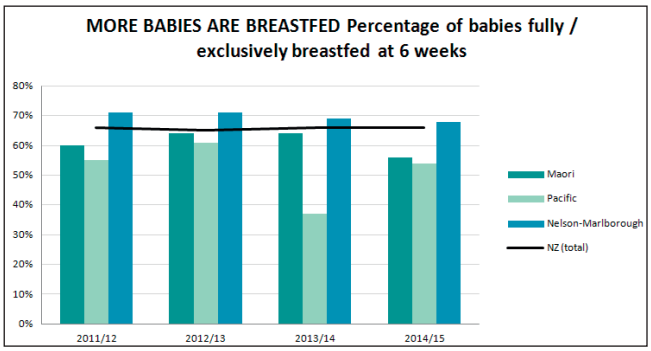

| 2014/15 Actual | 2015/16 Actual | 2015/16 Target | 2016/17 Target | 2017/18 Target |
|---|---|---|---|---|
| N/A | 78% | 98% | 98% | 98% |

### *Breastfeeding*

Breastfeeding helps lay the foundations for a healthy life contributing positively to infant health and wellbeing and potentially reducing the likelihood of obesity later in life.

Breastfeeding also contributes to the wider wellbeing of mothers and bonding between mother and baby.

An increase in breastfeeding rates is seen as a proxy indictor of the success of health promotion and engagement activity, appropriate access to support services and a change in both social and environmental factors influencing behaviour and support healthier lifestyle choices.




| 2014/15 Actual | 2015/16 Actual | 2015/16 Target | 2016/17 Target | 2017/18 Target |
|---|---|---|---|---|
| 68% | 69% | 75% | 75% | 75% |

*Data Source: Plunket via the Ministry of Health*

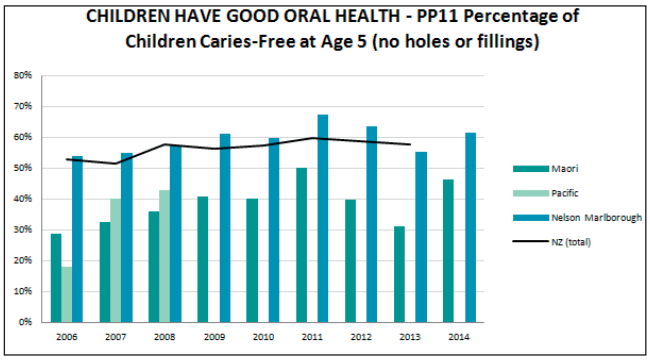
*Because provider data is currently not able to be combined performance data from the largest provider (Plunket) is therefore presented. While this covers the majority of children, because local WellChild/Tamariki Ora providers target Māori and Pacific mothers results for these ethnicities are likely to be under-stated.*

## *Oral health*

Oral health is an integral component of lifelong health and impacts a person's self-esteem and quality of life.

Good oral health not only reduces unnecessary hospital admissions but also signals a reduction in a number of risk factors, such as poor diet, which then has lasting benefits in terms of improved nutrition and health outcomes.

Māori and Pacific children are more likely to have decayed, missing or filled teeth. As such improved oral health is also a proxy indicator of equity of access and the effectiveness of services in targeting those most at risk.




| 2014/15 Actual | 2015/16 Actual | 2015/16 Target | 2016/17 Target | 2017/18 Target |
|---|---|---|---|---|
| 61% | 59% | 65% | 65% | 65% |

The target for this measure has been set to maintain the total population rate while placing particular emphasis on improving the rates for Māori and Pacific children.

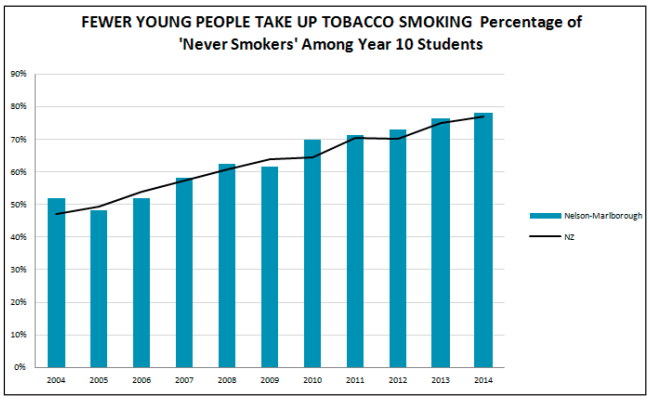
*Data Source: Ministry of Health Oral Health Team*

## *Smoking*

Most smokers begin smoking before 15 years of age with the highest prevalence of smoking amongst younger people. Reducing smoking prevalence across the total population is therefore largely dependent on preventing young people from taking up smoking.

A reduction in the uptake of smoking by young people is seen as a proxy indicator of the success of health promotion and engagement activity and a change in the social and environmental factors that influence risk behaviours and support healthier lifestyles.

Because Māori and Pacific have higher smoking rates reducing the uptake amongst Māori and Pacific youth provides significant opportunities to improve long-term health outcomes for these populations.




| 2014/15 Actual | 2015/16 Actual | 2015/16 Target | 2016/17 Target | 2017/18 Target |
|---|---|---|---|---|
| 78% | 80% | 82% | 84% | 86% |

*Data Source: National Year 10 ASH Snapshot Survey*

*The ASH Survey has been used to monitor student smoking since 1999 and is run by Action on Smoking and Health and provides an annual point preference snapshot of students aged 14 or 15 years at the time of the survey—see www.ash.org.nz.*

# Strategic outcome 2: People stay well, in their own homes and communities

## Why is this a priority?

When people are supported to stay well in the community they need fewer hospital-level or long-stay interventions. This is not only a better health outcome but it reduces the pressure on our hospitals and frees up health resources. Studies show countries with strong primary and community care systems have lower rates of death from heart disease, cancer and stroke and achieve better health outcomes at a lower cost than countries with systems that focus on specialist level care.

General practice can deliver services sooner and closer to home and through early detection, diagnosis and treatment, deliver improved health outcomes. The general practice team is also vital as a point of continuity, particularly in terms of improving the management of care for people with long-term conditions and reducing the likelihood of acute exacerbations of those conditions resulting in complications of injury and illness.

Health services also play an important role in supporting people to regain their functionality after illness and to remain healthy and independent. Supporting general practice are a range of other health professionals including midwives, community nurses, social workers, allied and personal health providers and pharmacists. These providers also have prevention, early intervention and restorative perspectives and link people with other social services that can further support them to stay well and out of hospital.

Even where returning to full health is not possible, access to responsive, needs-based pain management and palliative services (closer to home and families) can help to improve the quality of people's lives.

## Overarching Outcome Indicators

### *Acute hospital admissions*

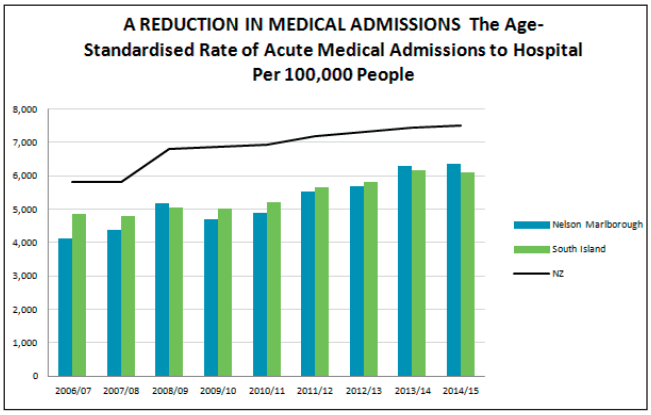
Long-term conditions (cardiovascular and respiratory disease, diabetes and mental illness) have a significant impact on the quality of a person's life.

However, with the right approach, people can live healthier lives and avoid the deterioration of their condition that leads to acute illness, hospital admission, complications and death.

Lower acute admission rates can be used as a proxy indicator of improved conditions management they can also be used to indicate the accessibility of timely and effective care and treatment in the community.

Reducing acute admissions also has a positive effect by enabling more efficient use of specialist resources that would otherwise be taken up by reacting to demand for urgent care.

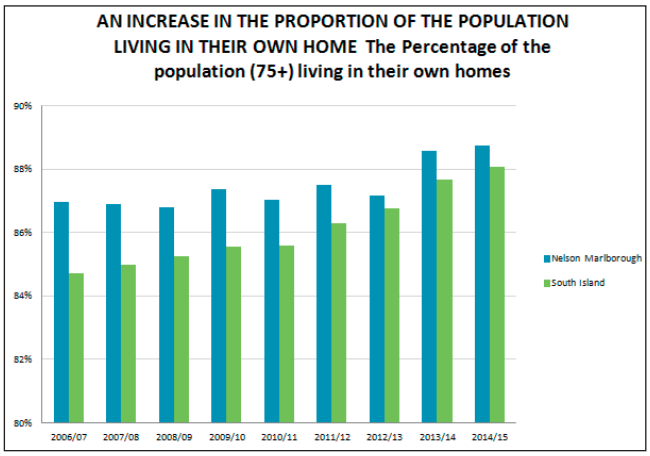
*Data Source: National Minimum Data Set*




The provisional result for Nelson Marlborough Health for 2015/16 is a readmission rate of 10.8 per cent

### *People living at home*

While living in Aged Residential Care (ARC) is appropriate for a small proportion of our population, studies have shown a higher level of satisfaction and better long-term outcomes where people remain in their own homes and positively connected to their communities.




Living in ARC is also a more expensive option and resources could be better spent providing appropriate levels of home-based support to help people stay well in their own homes.

An increase in the proportion of older people supported in their own homes can be used as a proxy indicator of how well the health system is managing age-related and long-term conditions and responding to the needs of our older population.

*Data Source: SIAPO Client Claims Payment System*

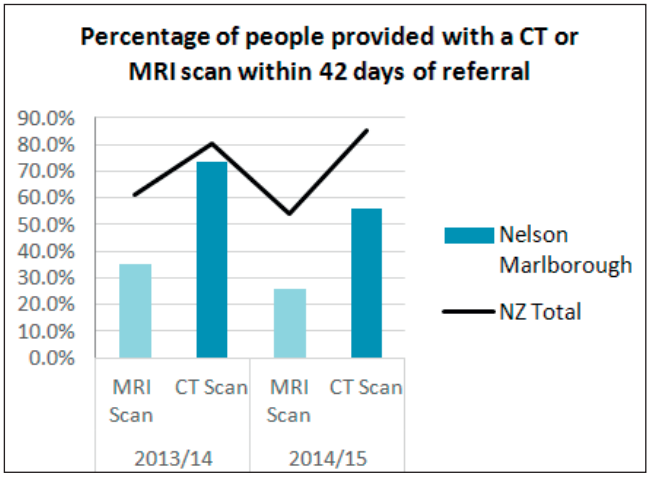
## Intermediate Impact Indicators

### *Earlier diagnosis*

Diagnostics are an important part of the healthcare system and timely access by improving clinical decision making enables early and appropriate intervention, improving quality of care and outcomes for our population.

Timely access to diagnostics can be seen as a proxy indicator of system effectiveness where effective use of resources is needed to minimise wait times while meeting increasing demand.

*Data Source: Individual DHB Patient Management Systems*



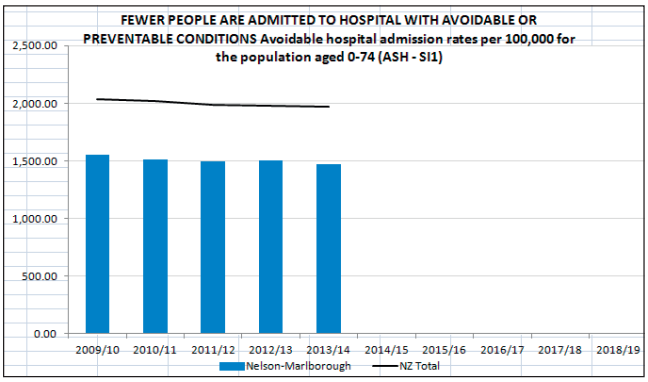

| 2014/15 Actual | 2015/16 Actual | 2015/16 Target | 2016/17 Target | 2017/18 Target |
|---|---|---|---|---|
| CT: 56% | 79% | 95% | 95% | 95% |
| MRI: 26% | 79% | 85% | 85% | 85% |

## *Avoidable hospital admissions*

Given the increasing prevalence of chronic conditions effective primary care provision is central to ensuring the long-term sustainability of our health system.

Keeping people well and supported to better manage their long-term conditions by providing appropriate and coordinated primary care should result in fewer hospital admissions - not only improving health outcomes for our population but also reducing unnecessary pressure on our hospital services.

Lower avoidable admission rates are therefore seen as a proxy indicator of the accessibility and quality of primary care services and mark a more integrated health system.




| 2014/15 Actual | 2015/16 Actual | 2015/16 Target | 2016/17 Target | 2017/18 Target |
|---|---|---|---|---|
| 1469 | 1537 | N/A | N/A | N/A |

*Data Source: Ministry of Health Performance Reporting SI1*

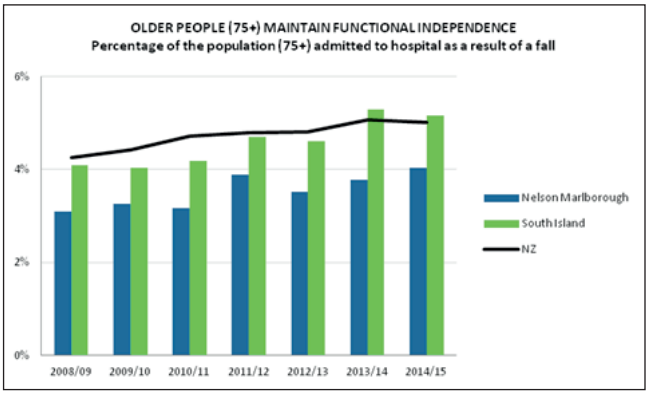
*This indicator is based on the national performance indicator SI1 and covers hospitalisations for 26 conditions which are considered preventable including: asthma, diabetes, angina, vaccine-preventable diseases, dental conditions and gastroenteritis. The target is set to maintain performance below the national rate, which reflects less people presenting. There is currently a definition issue with regards to the use of self-identified vs. prioritised ethnicity and while this has no impact on total population result it has significant implications for Māori and Pacific breakdowns against this measure. The DHB continues to communicate with the Ministry around resolving this issue.*

## *Falls preventions*

Approximately 22,000 New Zealanders (aged over 75) are hospitalised annually as a result of injury due to falls. Compared to people who do not fall, these people experience prolonged hospital stay, loss of confidence and independence and an increased risk of institutional care.

With an ageing population a focus on reducing falls will help people to stay well and independent and will reduce the demand on acute and aged residential care services.

Solutions to reducing falls span both the health and social service sectors and include appropriate medications use, improved physical activity and nutrition, appropriate support and a reduction in personal and environmental hazards.




| 2014/15 Actual | 2015/16 Actual | 2015/16 Target | 2016/17 Target | 2017/18 Target |
|---|---|---|---|---|
| 7.7% | 7.2% | N/A | N/A | N/A |

Lower falls rates can therefore be seen as a proxy indicator of the responsiveness of the whole of the health system to the needs of our older population as well as a measure of the quality of the individual services being provided.

*Data Source: National Minimum Data Set*

# Strategic outcome 3: People with complex illness have improved health outcomes

## Why is this a priority?

For people who do need a higher level of intervention timely access to quality specialist care and treatment is crucial in supporting recovery or slowing the progression of illness. This leads to improved health outcomes with restored functionality and a better the quality of life.

As providers of hospital and specialist services, DHBs are operating under growing demand and workforce pressures. At the same time Government is concerned that patients wait too long for specialist assessments, cancer treatment and elective surgery. Shorter waiting lists and wait times are seen as indicative of a well-functioning system that matches capacity to demand by managing the flow of patients through its services and reduces demand by moving the point of intervention earlier in the path of illness.

This goal reflects the importance of ensuring that hospital and specialist services are sustainable and that the South Island has the capacity to provide for the complex needs of its population into the future. It also reflects the importance of the quality of treatment. Adverse events, unnecessary waits or ineffective treatment can cause harm, resulting in longer hospital stays, readmissions and unnecessary complications that have a negative impact on the health of our population.

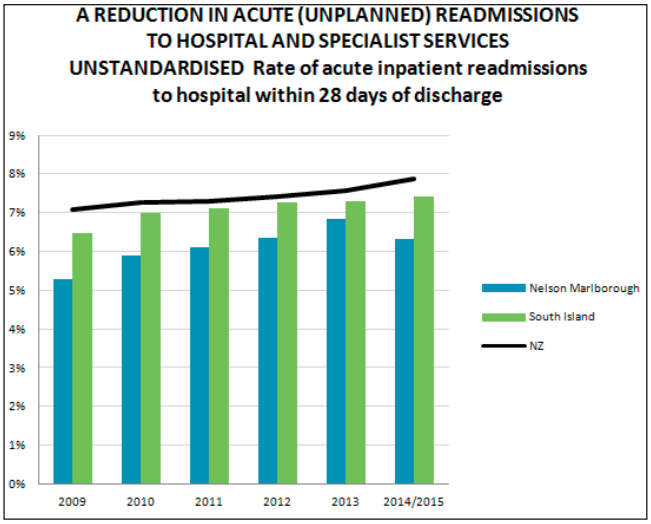
## Overarching Outcome Indicators

### *Acute readmissions*

Unplanned hospital readmissions are largely (though not always) related to the care provided to the patient.

As well as reducing public confidence and driving unnecessary costs - patients are more likely to experience negative longer-term outcomes and a loss of confidence in the system.

Because the key factors in reducing acute readmissions include safety and quality processes, effective treatment and appropriate support on discharge – they are a useful maker of the quality of care being provided and the level of integration between services.



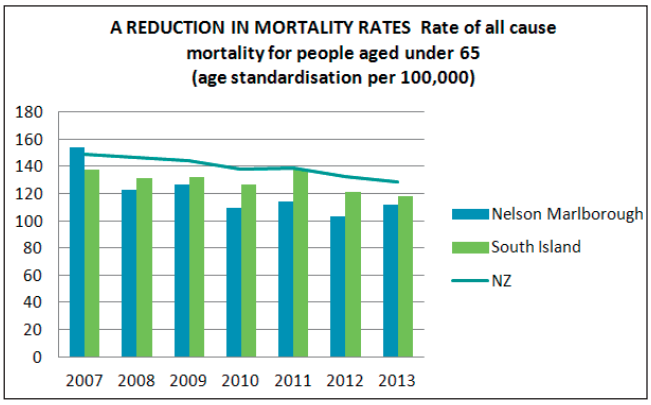

*Data Source: Ministry of Health Performance Data OS8*

*This indicator is based on the national performance indicator OS8. The DHB has identified a number of data inconsistencies with the when comparing local data, particularly where patients transferring between hospitals are coded as readmissions. The DHB continues to work with the Ministry to resolve this issue and is tracking trends internally to identify any performance issues.*

### *Avoidable mortality*

Timely and effective diagnosis and treatment are crucial factors in improving survival rates for complex illnesses such as cancer and cardiovascular disease. Early detection increases treatment options and the chances of survival.

Premature mortality (death before age 65) is largely preventable through lifestyle change, intervention and safe and effective treatment. By detecting people at risk and improving the treatment and management of their condition, the serious impacts and complications of a number of complex illnesses can be reduced.




A reduction in avoidable mortality rates can be used as a proxy indicator of responsive specialist care and improved access to treatment for people with complex illness.

*Data Source: National Mortality Collection - 2010 Update.*

*National Mortality Collection data is released four years in arrears and the data presented was released in 2014.*

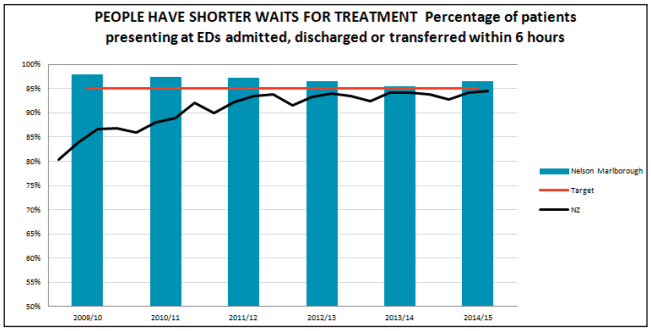
## Intermediate Impact Indicators

### *Waits for urgent care*

Emergency Departments (EDs) are important components of our health system and a barometer of the health of the hospital and the wider system.

Long waits in ED are linked to overcrowding, longer hospital stays and negative outcomes for patients. Enhanced performance will not only improve patient outcomes by providing early intervention and treatment but will improve public confidence and trust in health services.

Solutions to reducing ED wait times span not only the hospital but the whole health system. In this sense this indicator is a marker of how responsive the whole system is to the urgent care needs of the population.




| 2014/15 Actual | 2015/16 Actual | 2015/16 Target | 2016/17 Target | 2017/18 Target |
|---|---|---|---|---|
| 97% | 96 | 95% | 95% | 95% |

*Data Source: Individual DHB Patient Management Systems*

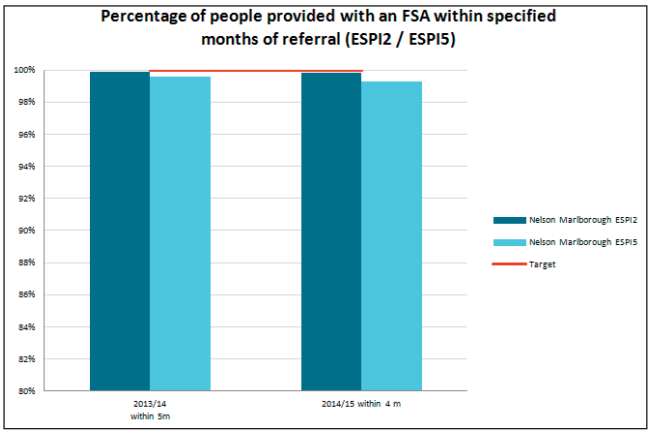
*This indicator is based on the national DHB Health Target 'Shorter Stays in ED' introduced in 2009—in line with the health target reporting the annual results presented are those from the final quarter of the year.*

## *Access to planned care*

Planned services (including specialist assessment and elective surgery) are an important part of the healthcare system and improve people's quality of life by reducing pain or discomfort and improving independence and wellbeing.

Timely access to assessment and treatment is considered a measure of health system effectiveness and improves health outcomes by slowing the progression of disease and maximising people's functional capacity.

Improved performance against this measure requires effective use of resources so wait times are minimised, while a year-on-year increase in volumes is delivered. In this sense this indicator is a marker of how responsive the system is to the needs of the population.




| 2014/15 Actual | 2015/16 Actual | 2015/16 Target | 2016/17 Target | 2017/18 Target |
|---|---|---|---|---|
| >99% | >95% | 100% | 100% | 100% |

*Data Source: Ministry of Health Quickplace Data Warehouse*

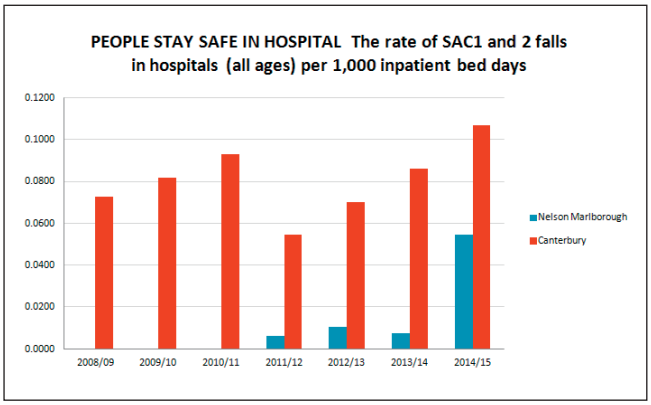
*The Elective Services Patient Flow Indicators (ESPIs) have been established nationally to track system performance and DHB are provided with individual performance reports from the Ministry of Health on a monthly basis. In line with the ESPIs target reporting the annual results presented are those from the final quarter of the year.*

## *Adverse events*

Adverse events in hospital, as well as causing avoidable harm to patients, reduce public confidence and drive unnecessary costs. Fewer adverse events provide an indication of the quality of services and systems and improve outcomes for patients in our services.

The rate of falls is particularly important as patients are more likely to have a prolonged hospital stay, loss of confidence, conditioning and independence and an increased risk of institutional care.

Achievement against this measure is also seen as a proxy indicator of the engagement of staff and clinical leaders in improving processes and championing quality.




| 2014/15 Actual | 2015/16 Actual | 2015/16 Target | 2016/17 Target | 2017/18 Target |
|---|---|---|---|---|
| 0.06% | 0.06% | N/A | N/A | N/A |

*Data Source: Individual DHB Quality Systems*

*The Severity Assessment Code (SAC) is a numerical score given to an incident based on the outcome of the incident and the likelihood that it will recur. Level 1 and 2 incidents are those with both the highest consequence and likelihood.*

# Health Targets

The following table shows the performance of the DHB against the Health Targets for each of the quarters within the financial year. More information on the Health Targets and the performance of other DHBs can be found at the Ministry of Health website (www.health.govt.nz/new-zealand-health-system/health-targets). The website includes a detailed description of the Health Target and why it is important.

| Health Target | | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|---|
| Shorter stays in Emergency Departments | 95% of patients will be admitted, discharged, or transferred from an emergency department (ED) within six hours | 95% | 97% | 96% | 96% |
| Improved access to Elective Surgery | The national volume of elective surgery by at least 4000 discharges per year | 101% | 102% | 102% | 105% |
| Faster Cancer Treatment | 85% of patients 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 by July 2016, increasing to 90% by June 2017 | 69% | 84% | 81% | 76% |
| Increased Immunisation | 95% of 8-month-olds have their primary course of immunisation at 6 weeks, 3 months and 5 months on time | 90% | 92% | 90% | 91% |
| Better help for Smokers to Quit | 90% of PHO enrolled patients who smoke have been offered help to quit smoking by a healthcare practitioner in the last 15 months | 91% | 92% | 88% | 90% |
| | 95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking. | 97% | 98% | 98% | 97% |
| | 90% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking | 98% | 94% | 97% | 100% |
| More Heart and Diabetes Checks | 90% of the eligible population will have had their cardiovascular risk assessed in the last 5 years | 90% | 91% | 91% | 91% |

# 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 Annual Plan and Statement of Intent.

We have structured the outputs, consistent with other district health boards across New Zealand into four output classes: Prevention Services; Early Detection and Management Services; Intensive Treatment and Assessment Services and Rehabilitation and Support Services. Further detail on each of the four output classes and the various services within each of the output classes can be obtained from the Annual Plan found on the DHB's website (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, the DHB 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 the DHB for the financial year 2015/16 is $394,740,000 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 25 to 39.

## 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 to influence and support people to make healthier choices.

### 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 ageing 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 | 2013/14 | 2014/15 | 2015/16 | Target | Performance |
|---|---|---|---|---|---|---|
| Percentage of enrolled women (20–69) who had a cervical smear in the last 3 years | V | 82% | 83% | 80% | 85% | 🟠 |
| Percentage of enrolled high-needs women (20–69) who had a cervical smear in the last 3 years | V | 78% | 78% | 67%[1] | 90% | 🔴 |
| Percentage of enrolled high-needs women (45–65) having mammography within 2 years | V | 75% | 80% | 72% | 70% | 🟢 |
| Percentage of newborn hearing screening completed within one month of birth | V | 95% | 94% | 95% | 95% | 🟢 |
| Percentage of two year old children fully vaccinated | C | 88% | 93% | 90% | 95% | 🟠 |
| Percentage of over 65-year-olds vaccinated for seasonal influenza | V | 67% | 65% | 69% | 75% | 🟠 |
| Percentage of eligible children receiving Before (B4) School Checks | V | 102% | 102% | 101% | 90% | 🟢 |
| Reduction in Alcohol related harm—Development of NMDHB alcohol strategy | T,Q | NA | NA | NA[2] | New | 🔴 |

[1] We increased the target to 90% from 80% in 2014/15 reflecting a desire to increase our performance which had stagnated. We maintained the level to the old target for the first six months however performance dipped in the second six months of the year due to a change in the service model to focus more on the more vulnerable populations comprising Māori, Pacific Peoples and Asian. The implementation of this model has taken longer to fully bed in that we had hoped for.

[2] A multi-sectorial approach to developing the measurement for the alcohol related harm was originally proposed. The first attempt at seeking commitment with proposed partners met with no success. This has delayed the development of the strategy. The decision was made to recommence with a health strategy however since then renewed interest from the wider sector has been received. Timeframes have been adjusted and it is now projected to have the strategy developed and signed off by NMH and partner agencies by the end of the 2016/17 year.

## Financial results

| | Budget 2016 $000 | Actual 2016 $000 | Actual 2015 $000 |
|---|---|---|---|
| **Revenue** | **7,697** | **8,295** | **7,877** |
| ***Expenditure*** | | | |
| Workforce costs | 4,097 | 4,068 | 3,679 |
| Other operating costs | 981 | 1,311 | 985 |
| External providers and inter district fows | 1,899 | 2,441 | 2,284 |
| **Total expenditure** | **6,977** | **7,820** | **6,948** |
| **Total surplus/(deficit)** | **720** | **475** | **929** |

# Output class 2: Early detection and management services

## Description

Early detection and management services cover a broad scope and scale of services provided across the continuum of care activities to maintain, improve and restore people's health. These services include detection of people at risk and with early disease and 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 that deliver these services across our district include:

- general practice services
- primary and community services
- personal and mental health services
- Māori and Pacific health services
- pharmacy services
- diagnostic imaging and laboratory services
- children and youth oral health and dental services.

## Significance

New Zealand is experiencing an increasing rate of long-term conditions, so called because once diagnosed people usually have them 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 | 2013/14 | 2014/15 | 2015/16 | Target | Performance |
|---|---|---|---|---|---|---|
| Percentage of people in the district enrolled with PHO—Nelson | C | 99% | 98% | 98% | 99% | ● |
| Percentage of people in the district enrolled with PHO—Marlborough | C | 98% | 96% | 95% | 99% | ● |
| Ambulatory Sensitive Hospitalisation (ASH) rates for children age 0–4 years | Q | 79% | 80% | 83% | 95% | ● |
| Percentage of children <5 years enrolled in DHB funded dental services | C | 72% | 79% | 82% | 80% | ● |
| Number of patients contacts receiving asthma/ COPD services—Nelson | V | 381 | 310 | 599 | 443 | ● |
| Number of patients contacts receiving asthma/ COPD services—Marlborough | V | 121 | 190 | 162 | 156 | ● |
| Percentage of secondary care patients whose medicines are reconciled on admission | C,Q | 27% | 28% | 24% | >22% | ● |
| Percentage of Medical Imaging reports meeting 14-day-availability to referrer | T | 100% | 80% | 97% | 100% | ● |
| Percentage of patients seen within waiting time target for urgent medical imaging procedures (within 24 hours) | T | 100% | 85% | 100% | 98% | ● |
| Percentage of PMHI extended GP consults and packages of care used by youth | Q | 11% | 15% | 23% | 15% | ● |

## Financial results

| | Budget 2016 $000 | Actual 2016 $000 | Actual 2015 $000 |
|---|---|---|---|
| **Revenue** | **116,761** | **117,809** | **115,006** |
| ***Expenditure*** | | | |
| Workforce costs | 21,400 | 20,653 | 19,870 |
| Other operating costs | 9,133 | 8,432 | 7,991 |
| External providers and inter district fows | 84,611 | 86,583 | 83,033 |
| **Total expenditure** | **115,144** | **115,668** | **110,894** |
| **Total surplus/(deficit)** | **1,617** | **2,141** | **4,112** |

# Output class 3: Intensive assessment and treatment services

## Description

Intensive assessment and treatment services are services that are complex and provided by specialists and other healthcare professionals working closely together in multi and interdisciplinary teams. These services are therefore usually (but not always) provided in hospital settings that 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, NMH provides an extensive range of intensive treatment and complex specialist services to our population. NMH also funds some tertiary and quaternary 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 for which access is determined by capability, capacity, resources, 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, the DHB 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 | 2013/14 | 2014/15 | 2015/16 | Target | Performance |
|---|---|---|---|---|---|---|
| Acute inpatient average length of stay (days) | Q | 3.5 | 3.57 | 2.23 | 3.47 | ● |
| Percentage of elective and arranged surgery undertaken on a day case basis | Q | 67% | 65% | 66% | 61% | ● |
| Percentage of people receiving their elective and arranged surgery on day of admission | Q | 97% | 97% | 98% | 97% | ● |
| Women registering with an LMC by week 12 of their pregnancy | T | NA | NA | 81% | 80% | ● |
| Percentage of total deliveries in primary birthing units | Q | 4% | 7% | 7% | 7% | ● |
| Average post natal length of stay (days)—Nelson | V | 2.2 | 2.4 | 2.5* | <2 | ● |
| Average post natal length of stay (days)—Wairau | V | 2.2 | 2.4 | 2.8* | <2 | ● |
| Average post natal length of stay (days)—caesarean | V | 4.2 | 4 | 3.7 | <4 | ● |
| Percentage of AT&R patients (65+) discharged back to their original setting | Q | 65% | 69% | 72% | 64% | ● |

* Post natal length of stay has increased in both Nelson and Wairau over a five year period. This is largely the result of a government initiative to increase the length of stay for mothers post natally which has not been reflected within our target which has remained constant for the same period.

## Financial results

| | Budget 2016 $000 | Actual 2016 $000 | Actual 2015 $000 |
|---|---|---|---|
| **Revenue** | **240,220** | **243,471** | **228,876** |
| ***Expenditure*** | | | |
| Workforce costs | 123,263 | 124,768 | 115,071 |
| Other operating costs | 72,321 | 74,151 | 76,369 |
| External providers and inter district fows | 42,707 | 44,396 | 41,025 |
| **Total expenditure** | **238,291** | **243,315** | **232,465** |
| **Total surplus/(deficit)** | **1,929** | **156** | **(3,589)** |

# Output class 4: Rehabilitation and support services

## Description

Rehabilitation and support services provide people with the support and assistance they need to maintain maximum functional independence, either temporarily while recovering from illness/disability, or over the rest of their lives. These services are delivered following a 'needs assessment' process coordinated by Needs Assessment and Service Coordination (NASC) services and include domestic support, personal care, community nursing and community services provided in people's own homes and places of residence and also long and short-term residential care, respite and day services. Services are provided 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, enabling the person 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 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.

Nelson Marlborough Health 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 | 2013/14 | 2014/15 | 2015/16 | Target | Performance |
|---|---|---|---|---|---|---|
| Percentage of NASC response time to assessment within 20 working days | T | 90% | 99% | 90% | >90% | ● |
| Percentage of audited InterRAI Care Plans meet the assessed needs of the client | Q | NA | 100% | 100% | 95% | ● |
| Percentage of older people living in ARRC | C | 7% | 4% | 5% | 7% | ● |
| Improving Mental Health services using transition (discharge) planning and employment | Q | NA | NA | 100% | 95% | ● |

## Financial results

| | Budget 2016 $000 | Actual 2016 $000 | Actual 2015 $000 |
|---|---|---|---|
| **Revenue** | **92,447** | **91,997** | **91,494** |
| ***Expenditure*** | | | |
| Workforce costs | 21,304 | 21,372 | 20,809 |
| Other operating costs | 10,697 | 10,290 | 9,983 |
| External providers and inter district fows | 60,856 | 61,553 | 60,438 |
| **Total expenditure** | **92,857** | **93,215** | **91,230** |
| **Total surplus/(deficit)** | **(410)** | **(1,218)** | **264** |

# Financial statements

## Statement of comprehensive revenue and expense

For the year ended 30 June 2016

| | Note | Budget 2016 $000 | Actual 2016 $000 | Actual 2015 $000 |
|---|---|---|---|---|
| ***Revenue*** | | | | |
| Revenue | 1 | 450,924 | 454,484 | 436,024 |
| Interest revenue | 5 | 2,250 | 2,157 | 2,689 |
| Other revenue | 2 | 3,961 | 4,930 | 4,540 |
| **Total revenue** | | **457,135** | **461,571** | **443,253** |
| | | | | |
| ***Expenditure*** | | | | |
| Personnel costs | 3 | 167,667 | 167,363 | 159,428 |
| Outsourced services | | 11,991 | 14,210 | 14,357 |
| Clinical supplies | | 31,862 | 35,180 | 32,785 |
| Infrastructure and non-clinical expenses | | 26,710 | 23,472 | 22,946 |
| Payments to non-Health Board providers | | 189,923 | 194,972 | 186,780 |
| Depreciation and amortisation expense | 12,13 | 11,053 | 10,812 | 11,139 |
| Capital charge | 4 | 7,310 | 7,801 | 7,252 |
| Finance costs | 5 | 3,187 | 3,005 | 3,225 |
| Other expenses | 6 | 3,576 | 3,202 | 3,624 |
| **Total expenditure** | | **453,279** | **460,017** | **441,536** |
| | | | | |
| **Surplus/(Deficit)** | | **3,856** | **1,554** | **1,717** |
| | | | | |
| **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 | | - | - | 6,239 |
| Impairment of property assets | | - | - | - |
| **Total other comprehensive revenue or expenses** | | - | - | **6,239** |
| | | | | |
| **Total comprehensive revenue and expense** | | **3,856** | **1,554** | **7,956** |

The accompanying notes form part of these financial statements. Explanations of major variances against budget are provided in note 26.

# Statement of financial position

For the year ended 30 June 2016

| | Note | Budget 2016 $000 | Actual 2016 $000 | Actual 2015 $000 |
|---|---|---|---|---|
| **Assets** | | | | |
| ***Current assets*** | | | | |
| Cash and cash equivalents | 7 | 26,055 | 24,774 | 43,712 |
| Receivables | 8 | 11,056 | 14,152 | 10,781 |
| Inventories | 9 | 2,171 | 2,723 | 2,703 |
| Prepayments | | 328 | 588 | 387 |
| Non-current assets held for sale | 10 | 750 | 487 | 750 |
| Current Financial Assets | 11 | - | 6,000 | - |
| **Total current assets** | | **40,360** | **48,724** | **58,333** |
| ***Non-current assets*** | | | | |
| Prepayments | | 182 | 43 | 107 |
| Non-CurrentFinancial assets | 11 | 1,405 | 14,498 | 1,475 |
| Property, plant and equipment | 12 | 178,653 | 164,144 | 165,091 |
| Intangible assets | 13 | 7,018 | 9,415 | 7,182 |
| **Total non-current assets** | | **187,258** | **188,100** | **173,855** |
| **Total assets** | | **227,618** | **236,824** | **232,188** |
| **Liabilities** | | | | |
| ***Current liabilities*** | | | | |
| Payables | 14 | 26,183 | 34,582 | 28,996 |
| Borrowings | 15 | 245 | 6,556 | 6,668 |
| Employee entitlements | 16 | 30,863 | 28,333 | 29,643 |
| Provisions | 17 | 1,950 | 1,322 | 1,164 |
| **Total current liabilities** | | **59,241** | **70,793** | **66,471** |
| ***Non-current liabilities*** | | | | |
| Borrowings | 15 | 62,968 | 56,968 | 57,214 |
| Employee entitlements | 16 | 10,907 | 10,405 | 10,852 |
| **Total non-current liabilities** | | **73,875** | **67,373** | **68,066** |
| **Total Liabilities** | | **133,116** | **138,166** | **134,537** |
| **Net assets** | | **94,502** | **98,658** | **97,651** |
| **Equity** | | | | |
| Crown equity | 18 | 28,062 | 27,493 | 28,040 |
| Other reserves | 18 | 46,974 | 53,213 | 53,213 |
| Accumulated comprehensive revenue and expense | 18 | 19,466 | 17,952 | 16,398 |
| **Total equity** | | **94,502** | **98,658** | **97,651** |

The accompanying notes form part of these financial statements. Explanations of major variances against budget are provided in note 26.

# Statement of changes in net assets/equity

For the year ended 30 June 2016

| | Note | Budget 2016 $000 | Actual 2016 $000 | Actual 2015 $000 |
|---|---|---|---|---|
| **Balance at 1 July** | | 91,193 | 97,651 | 90,242 |
| ***Total comprehensive revenue and expense for the year*** | | 3,856 | 1,554 | 7,956 |
| ***Owner transactions*** | | | | |
| Capital contribution | | - | - | - |
| Repayment of capital | | (547) | (547) | (547) |
| **Balance at 30 June** | 18 | **94,502** | **98,658** | **97,651** |

The accompanying notes form part of these financial statements. Explanations of major variances against budget are provided in note 26.

# Statement of cash flows

For the year ended 30 June 2016

| | Note | Budget 2016 $000 | Actual 2016 $000 | Actual 2015 $000 |
|---|---|---|---|---|
| ***Cash flows from operating activities*** | | | | |
| Receipts from the Ministry of Health and patients | | 454,870 | 456,611 | 440,792 |
| Interest received | | 2,250 | 2,157 | 2,689 |
| Payments to employees | | (173,784) | (169,767) | (158,571) |
| Payments to suppliers | | (263,422) | (265,997) | (260,574) |
| Capital charge | | (7,310) | (7,801) | (7,252) |
| Interest paid | | (3,187) | (3,005) | (3,225) |
| GST (net) | | - | (27) | (534) |
| **Net cash flow from operating activities** | 19 | **9,417** | **12,171** | **13,325** |
| ***Cash flows from investing activities*** | | | | |
| Receipts from sale of property, plant and equipment | | - | 293 | 183 |
| Receipts from maturity of investments | | - | - | - |
| Purchase of property, plant and equipment | | (18,250) | (8,671) | (11,696) |
| Purchase of intangible assets | | (3,000) | (2,951) | (2,474) |
| Acquisition of investments | | - | (18,950) | - |
| **Net cash flow from investing activities** | | **(21,250)** | **(30,279)** | **(13,987)** |
| ***Cash flows from financing activities*** | | | | |
| Borrowings withdrawn | | - | - | - |
| Finance leases raised | | - | - | - |
| Capital contribution | | - | - | - |
| Repayment of capital | | (547) | (547) | (547) |
| Repayment of borrowings | | - | - | - |
| Payment of finance lease liabilities | | (668) | (283) | (529) |
| **Net cash flow from financing activities** | | **(1,215)** | **(830)** | **(1,076)** |
| **Net increase/(decrease) in cash and cash equivalents** | | **(13,048)** | **(18,938)** | **(1,738)** |
| Cash and cash equivalents at the beginning of the year | | 39,103 | 43,712 | 45,450 |
| **Cash and cash equivalents at the end of the year** | | **26,055** | **24,774** | **43,712** |

The accompanying notes form part of these financial statements. Explanations of major variances against budget are provided in note 26.

# Statement of accounting policies

For the year ended 30 June 2016

## 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 and disability 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 2016, and were approved by the Board on 25 October 2015.

## 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, which includes the requirement to comply with generally accepted accounting practice in New Zealand (NZ GAAP).

These financial statements comply with PBE accounting standards and have been prepared in accordance with the Tier 1 PBE accounting standards.

These financial statements are the first financial statements presented in accordance with the new PBE accounting standards. There are no adjustments on transition to the 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).

# Summary of significant accounting policies

## Revenue

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 DHB 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.

### *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.

### *Rental revenue*

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

### *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.

### *Trust and bequest funds*

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

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

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

## Capital charge

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

## Borrowing costs

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

## 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 spot exchange rates 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.

## Leases

### *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.

### *Operating leases*

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.

## Cash and cash equivalents

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.

## Receivables

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.

## Investments

### *Bank term deposits*

Investments in bank term deposits are initially measured at the amount invested.

After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest method, less any provision for impairment.

### *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.

## Inventories

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.

## Non-current assets held for sale

Non-current assets held for sale are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. 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.

## Property, plant, and equipment

Property, plant, and equipment consists of the following asset classes: land, buildings and building fitout, plant and 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 general funds.

### *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 | 10–76 | 1.3%–10% |
| 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.

## Intangible assets

### *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% |

## 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, and 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.

## Payables

Short-term payables are recorded at their face value.

## Borrowings

Borrowings are initially recognised at their fair value plus transaction costs. After initial recognition, all borrowings are measured at amortised cost using the effective interest method.

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

## Employee entitlements

### *Short-term employee entitlements*

Employee benefits 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 to 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.

## Superannuation schemes

### *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.

## Provisions

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.

## Equity

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.

Fair value through other comprehensive revenue and expense reserves

This reserve comprises the cumulative net change of financial assets classified as fair value through other comprehensive revenue and expense.

## 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 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.

### *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.

### *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:

### *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 NMDHB.

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.

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

### *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 2016

## 1. Revenue

| | Actual 2016 $000 | Actual 2015 $000 |
|---|---|---|
| Health and disability services (MOH contracted revenue) | 432,377 | 415,591 |
| Inter-district patient inflows | 8,580 | 7,483 |
| ACC | 4,716 | 4,842 |
| Patient/consumer sourced revenue | 6,345 | 6,224 |
| Other government and DHB's | 2,466 | 1,884 |
| **Total revenue** | **454,484** | **436,024** |

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 (2015: $Nil).

## 2. Other revenue

| | Actual 2016 $000 | Actual 2015 $000 |
|---|---|---|
| Donated property, plant and equipment | 98 | 62 |
| Rental revenue | 1,336 | 1,377 |
| Gain on disposal of property, plant and equipment | 178 | 131 |
| Other | 3,318 | 2,970 |
| **Total other revenue** | **4,930** | **4,540** |

## 3. Personnel costs

| | Actual 2016 $000 | Actual 2015 $000 |
|---|---|---|
| Salaries and wages | 155,114 | 147,349 |
| Defined contribution plan employer contributions | 4,970 | 4,691 |
| Other personnel costs | 7,279 | 7,388 |
| **Total personnel costs** | **167,363** | **159,428** |

## 4. Capital charge

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 year ended 30 June 2016 was 8% (2015: 8%).

## 5. Finance revenue and costs

| | Actual 2016 $000 | Actual 2015 $000 |
|---|---|---|
| ***Finance costs*** | | |
| Interest on secured loans | 2,733 | 2,942 |
| Interest on finance lease | 272 | 283 |
| **Total finance costs** | **3,005** | **3,225** |
| ***Finance revenue*** | | |
| Interest revenue | **2,157** | 2,689 |
| **Total finance revenue** | **2,157** | **2,689** |

## 6. Other expenses

| | Actual 2016 $000 | Actual 2015 $000 |
|---|---|---|
| Audit fees | 160 | 177 |
| Donations made | - | - |
| Koha | - | - |
| Impairment of property, plant and equipment | - | - |
| Impairment of receivables | 283 | 169 |
| Loss on disposal of property, plant and equipment | 2 | 2 |
| Write down to Fair Value on Loans provided to Golden Bay Health Trust - | 74 | 866 |
| Rental and operating lease costs | 2,702 | 2,410 |
| Restructuring expenses | 129 | - |
| **Total other expenses** | **3,202** | **3,624** |

## 7. Cash and cash equivalents

| | Actual 2016 $000 | Actual 2015 $000 |
|---|---|---|
| Cash at bank and on hand | - | - |
| Cash advanced to NZHPL | 24,774 | 43,712 |
| **Total cash and cash equivalents** | **24,774** | **43,712** |

NMDHB is a party to the DHB Treasury Services Agreement between NZ Health Partnerships Limited (NZHP) and participating DHBs. This agreement enables NZHP 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

| | Actual 2016 $000 | Actual 2015 $000 |
|---|---|---|
| Gross receivables | 14,829 | 11,239 |
| Less: provision for impairment | (677) | (458) |
| **Total receivables** | **14,152** | **10,781** |
| ***Gross receivables comprises of:*** | | |
| Receivables from the Ministry of Health | 3,327 | 2,230 |
| Receivables from non-related parties | 1,701 | 1,844 |
| Accrued revenue | 9,769 | 7,139 |
| Other receivables | 32 | 26 |
| **Total gross receivables** | **14,829** | **11,239** |

## Ageing profile of receivables

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:

| | 2016 | | 2015 | |
|---|---|---|---|---|
| | Gross $000 | Impairment $000 | Gross $000 | Impairment $000 |
| Not past due | 10,435 | (26) | 6,235 | - |
| Past due 1 - 30 days | 2,957 | (19) | 3,377 | (15) |
| Past due 31 - 60 days | 637 | (21) | 436 | (10) |
| Past due 61 - 90 days | 103 | (75) | 55 | (6) |
| Past due over 90 days | 697 | (536) | 1,136 | (427) |
| **Total** | **14,829** | **(677)** | **11,239** | **(458)** |

# 9. Inventories

| | Actual 2016 $000 | Actual 2015 $000 |
|---|---|---|
| ***Held for distribution inventories*** | | |
| Pharmaceuticals | 406 | 409 |
| Other supplies | 2,547 | 2,524 |
| Provision for obsolete stock | (230) | (230) |
| **Total inventories** | **2,723** | **2,703** |

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

In 2016, the value of inventories distributed and recognised as an expense in the clinical supplies expense included in the deficit was $20.5 million (2015: $19.1 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

| | Actual 2016 $000 | Actual 2015 $000 |
|---|---|---|
| ***Non-current assets held for sale include:*** | | |
| Land | - | 96 |
| Buildings | - | 167 |
| **Total non-current assets held for sale** | **-** | **263** |
| ***Non-current assets being prepared for sale include:*** | | |
| Land | 322 | 322 |
| Buildings | 165 | 165 |
| **Total non-current assets being prepared for sale** | **487** | **487** |

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 in French Pass and Tapawera 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 $112,000.

## 11. Other financial assets

| | Actual 2016 $000 | Actual 2015 $000 |
|---|---|---|
| ***Current Portion*** | | |
| Westpac Short Term Investment | 6,000 | - |
| ***Total Current Financial Assets*** | 6,000 | - |
| ***Non-current Portion*** | | |
| Equity investments | 3 | 3 |
| Loans receivable | 1,545 | 1,472 |
| Westpac Long Term Investment | 12,950 | - |
| ***Total Non-Current Financial Assets*** | 14,498 | 1,475 |
| **Total Financial Assets** | **20,498** | **1,475** |

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. 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

| | 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 2014 | 11,921 | 132,622 | 45,886 | 5,473 | 19,186 | 2,018 | 217,106 |
| Additions | 502 | 2,445 | 5,575 | 982 | - | 10,997 | 20,501 |
| Revaluations | (803) | (9,534) | - | - | - | - | (10,337) |
| Disposals | - | - | - | (770) | - | (9,504) | (10,274) |
| **Balance at 30 June 2015** | **11,620** | **125,533** | **51,461** | **5,685** | **19,186** | **3,511** | **216,996** |
| Balance at 1 July 2015 | 11,620 | 125,533 | 51,461 | 5,685 | 19,186 | 3,511 | 216,996 |
| Additions | - | 1,742 | 4,487 | 893 | 435 | 8,981 | 16,538 |
| Revaluations | - | - | - | - | - | - | - |
| Disposals | - | - | (14) | (622) | - | (7,557) | (8,193) |
| **Balance at 30 Jun 2016** | **11,620** | **127,275** | **55,934** | **5,956** | **19,621** | **4,935** | **225,341** |
| ***Accumulated depreciation and impairment losses*** | | | | | | | |
| Balance at 1 July 2014 | - | 11,110 | 33,679 | 4,026 | 9,911 | - | 58,726 |
| Depreciation expense | - | 5,535 | 3,524 | 386 | 1,013 | - | 10,458 |
| Revaluations/Impairme | - | (16,577) | - | - | - | - | (16,577) |
| Disposals | - | - | - | (702) | - | - | (702) |
| **Balance at 30 Jun 2015** | **-** | **68** | **37,203** | **3,710** | **10,924** | **-** | **51,905** |
| Balance at 1 July 2015 | - | 68 | 37,203 | 3,710 | 10,924 | - | 51,905 |
| Depreciation expense | - | 4,977 | 3,657 | 530 | 830 | - | 9,994 |
| Revaluations/Impairme | - | - | - | - | - | - | - |
| Disposals | - | - | - | (702) | - | - | (702) |
| **Balance at 30 Jun 2016** | **-** | **5,045** | **40,860** | **3,538** | **11,754** | **-** | **61,197** |
| ***Carrying Amounts*** | | | | | | | |
| At 1 July 2014 | 11,921 | 121,512 | 12,207 | 1,447 | 9,275 | 2,018 | 158,380 |
| At 30 Jun/1 Jul 2015 | 11,620 | 125,465 | 14,258 | 1,975 | 8,262 | 3,511 | 165,091 |
| **At 30 June 2016** | **11,620** | **122,230** | **15,074** | **2,418** | **7,867** | **4,935** | **164,144** |

No impairment loss of has been recognised in 2016, (2015: Nil).

The most recent revaluation of land and buildings was carried out as at 30 June 2015 by M Lauchlan, a registered Valuer with Duke & Cooke Limited. 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 2020.

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.
- 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.

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 2016, the net carrying amount of leased IT and clinical equipment was $439,158 (2015: $654,502).

The total amount of property, plant, and equipment in the course of construction 2016 is $5.65 million (2015: $4.21 million).

## 13. Intangible assets

| | HPL | Acquired Software | Internally Generated Software | Total |
|---|---|---|---|---|
| | $000 | $000 | $000 | $000 |
| ***Movements for each class of intangible asset*** | | | | |
| Balance at 1 July 2014 | 1,452 | 9,564 | 280 | 11,296 |
| Additions | 803 | 1,774 | 1,460 | 4,037 |
| Disposals | - | (865) | - | (865) |
| **Balance at 30 June 2015** | **2,255** | **10,473** | **1,740** | **14,468** |
| Balance at 1 July 2015 | 2,255 | 10,473 | 1,740 | 14,468 |
| Additions | - | 3,404 | 242 | 3,646 |
| Disposals | | (595) | - | (595) |
| **Balance at 30 June 2016** | **2,255** | **13,282** | **1,982** | **17,519** |
| ***Accumulated amortisation and impairment losses*** | | | | |
| Balance at 1 July 2014 | | 6,444 | 160 | 6,604 |
| Amortisation expense | | 675 | 6 | 681 |
| Disposals | | 1 | - | 1 |
| Impairment losses | | - | - | - |
| **Balance at 30 June 2015** | **-** | **7,120** | **166** | **7,286** |
| Balance at 1 July 2015 | - | 7,120 | 166 | 7,286 |
| Amortisation expense | - | 791 | 27 | 818 |
| Disposals | - | - | - | - |
| Impairment losses | | - | - | - |
| **Balance at 30 June 2016** | **-** | **7,911** | **193** | **8,104** |
| ***Carrying amounts*** | | | | |
| At 1 July 2014 | 1,452 | 3,120 | 120 | 4,692 |
| At 30 June / 1 July 2015 | 2,255 | 3,353 | 1,574 | 7,182 |
| **At 30 June 2016** | **2,255** | **5,371** | **1,789** | **9,415** |

Included in the Internally Generated Software is a total of $799,031 (2015: $699,000) 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.

No impairment losses have been recognised (2015: $Nil).

# 14. Payables

| | Actual 2016 $000 | Actual 2015 $000 |
|---|---|---|
| ***Payables under exchange transactions*** | | |
| Creditors | 4,026 | 3,745 |
| Revenue in advance | 1,481 | 735 |
| Capital charge payable | - | - |
| Other | 22,412 | 18,311 |
| **Total payables under exchange transactions** | **27,919** | **22,791** |
| ***Payables under non-exchange transactions*** | | |
| Capital charge payable | - | - |
| Taxes payable (GST, Employer Deductions & FBT) | 5,585 | 5,208 |
| Other | 1,078 | 997 |
| **Total payables under non-exchange transactions** | 6,663 | 6,205 |
| **Total Payables** | **34,582** | **28,996** |

# 15. Borrowings

| | Actual 2016 $000 | Actual 2015 $000 |
|---|---|---|
| ***Current portion*** | | |
| NZDMO Loans | 6,000 | 6,000 |
| Finance leases | 556 | 668 |
| **Total current portion** | **6,556** | **6,668** |
| ***Non-current portion*** | | |
| NZDMO loans | 49,500 | 49,500 |
| Finance leases | 7,468 | 7,714 |
| **Total non-current portion** | **56,968** | **57,214** |
| **Total borrowings** | **63,524** | **63,882** |

## NZDMO loans

| | Actual 2016 $000 | Actual 2015 $000 |
|---|---|---|
| ***Loans are repayable as follows:*** | | |
| Not later than one year | 6,000 | 6,000 |
| Later than one year and not later than five years | 41,500 | 35,500 |
| Later than five years | 8,000 | 14,000 |
| **Total NZDMO loans** | **55,500** | **55,500** |

NMDHB has seven fixed interest term loans with the New Zealand Debt Management Office (NZDMO). The fixed interest rates at 30 June 2016 range from 2.21% to 6.54% (2015: 3.34% to 6.54%).

The NZDMO term loans are secured by a negative pledge. Without NZDMO's consent, NMDHB cannot:

- Create any security interest over its assets except in certain defined circumstances
- Lend money to another person or entity (except in the ordinary course of business and then only on commercial terms) or give a guarantee

- Make a substantial change in the nature or scope of its business as presently conducted or undertake any business activity unrelated to health
- Dispose of any of its assets except at full value in the ordinary course of business

The maximum loan facility from NZDMO available is $55.5 million (2015: $55.5 million). The term loans are not guaranteed by the Government of New Zealand.

## Finance leases

| | Actual 2016 $000 | Actual 2015 $000 |
|---|---|---|
| ***Minimum lease payments payable:*** | | |
| Not later than one year | 762 | 929 |
| Later than one year and not later than five years | 1,968 | 1,974 |
| Later than five years | 13,366 | 13,858 |
| **Total minimum lease payments** | **16,096** | **16,761** |
| Future finance charges | (8,072) | (8,380) |
| **Present value of minimum lease payments** | **8,024** | **8,381** |
| ***Present value of minimum lease payments payable:*** | | |
| Not later than one year | 500 | 668 |
| Later than one year and not later than five years | 959 | 964 |
| Later than five years | 6,565 | 6,749 |
| **Total present value of minimum lease payments** | **8,024** | **8,381** |

### *Description of Material Leasing Arrangements*

NMDHB has entered into finance leases primarily for IT equipment, and for certain items of clinical equipment. The net carrying amount of the leased items within each class of property, plant and equipment, and intangible assets is shown in notes 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 2016, Golden Bay Community Health Trust had an outstanding lease liability with a present value of $7,707,974 (2015: $7,947,600). 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

| | Actual 2016 $000 | Actual 2015 $000 |
|---|---|---|
| ***Current Portion*** | | |
| Accrued salaries & wages | 3,239 | 5,492 |
| Annual leave | 17,813 | 16,683 |
| Sick leave | 562 | 574 |
| Sabbatical leave | 196 | 198 |
| Retirement gratuities | 2,093 | 1,633 |
| Long service leave | 622 | 544 |
| Continuing medical education | 3,808 | 4,519 |
| **Total current portion** | **28,333** | **29,643** |
| ***Non-current portion*** | | |
| Sick leave | 729 | 746 |
| Sabbatical leave | 839 | 887 |
| Retirement gratuities | 6,215 | 6,493 |
| Long service leave | 2,622 | 2,726 |
| **Total non-current portion** | **10,405** | **10,852** |
| **Total employee entitlements** | **38,738** | **40,495** |

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

## Long Service Leave, Retirement Gratuities, and Sabbatical Leave

The discount rates used are the risk free rates as determined by the NZ Treasury and published on its website. Discount rates used range from 2.03% to 4.75% (2015: 2.97% to 5.50%), with an average of 3.79% (2015: 4.57%). A salary inflation factor of 2.0% (2015: 3.5%) has been used per year. The take-up rate used for sabbatical leave is 16% (2015: 16%).

## 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 2.5% (2015: 3.6%). Average future salary growth has been assumed to be 2.0% per annum, plus a salary scale of 1% per annum.

# 17. Provisions

| | Actual 2016 $000 | Actual 2015 $000 |
|---|---|---|
| ***Current portion*** | | |
| Restructuring | 836 | 805 |
| ACC Partnership Programme | 486 | 359 |
| **Total current portion** | **1,322** | **1,164** |
| **Total provisions** | **1,322** | **1,164** |

Movements for each class of provision are as follows:

| | *Restructures* $000 | *ACC* $000 | *Total* $000 |
|---|---|---|---|
| Balance at 1 July 2014 | 691 | 363 | 1,054 |
| Additional provisions made | 679 | (5) | 674 |
| Amounts used | (41) | - | (41) |
| Unused amounts reversed | (523) | - | (523) |
| **Balance at 30 June 2015** | **806** | **358** | **1,164** |
| Balance at 1 July 2015 | 806 | 358 | 1,164 |
| Additional provisions made | 759 | 128 | 887 |
| Amounts used | (495) | - | (495) |
| Unused amounts reversed | (234) | - | (234) |
| **Balance at 30 June 2016** | **836** | **486** | **1,322** |

## Restructuring provisions

An amount of $495,000 has been released from the provision in relation to completed restructuring initiatives, and revisions to the estimated redundancy costs for initiatives not yet completed. (2015: $41,000).

## ACC partnership programme

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

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

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 2016. 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. Post valuation date claim inflation has been taken as 1.7% per annum. The discount rate used is 4.2% per annum (2015: 3.0%).

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

NMDHB operates the Full Self Cover Plan. Under this plan, it assumes full financial and injury management responsibility for work-related injuries and illnesses for a selected management period and continuing financial liability for the life of the claim to a pre-selected limit.

The DHB is responsible for managing claims for a period of up to 48 months following the lodgement date. At the end of 48 months, if an injured employee is still receiving entitlements, the financial and management responsibility of the claim will be transferred to ACC for a price calculated on an actuarial valuation basis.

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.

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.

## 18. Equity

| | Actual 2016 $000 | Actual 2015 $000 |
|---|---|---|
| ***Crown equity*** | | |
| Balance at 1 July | 28,040 | 28,587 |
| Capital contribution | - | - |
| Repayment of capital | (547) | (547) |
| **Balance at 30 June** | **27,493** | **28,040** |
| ***Accumulated surplus/(deficit)*** | | |
| Balance at 1 July | 16,398 | 14,681 |
| Surplus/(deficit) for the year | 1,554 | 1,717 |
| Property revaluation reserve transfer on disposal | - | - |
| **Balance at 30 June** | **17,952** | **16,398** |
| ***Revaluation reserves*** | | |
| Balance at 1 July | 53,213 | 46,974 |
| Revaluations | - | 6,239 |
| Impairment charge | - | - |
| Transfer to accumulated surplus/(deficit) on disposal | - | - |
| **Balance at 30 June** | **53,213** | **53,213** |
| ***Revaluation reserves consist of*** | | |
| Land | 8,125 | 8,125 |
| Buildings | 45,088 | 45,088 |
| **Total revaluation reserves** | **53,213** | **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** | **98,658** | **97,651** |

Accumulated comprehensive revenue and expense includes accumulated surpluses/deficits of unspent mental health ring fenced funding as detailed in note 28.

# 19. Reconciliation of net surplus to net cash flow from operating activities

| | Actual 2016 $000 | Actual 2015 $000 |
|---|---|---|
| **Net surplus/(deficit)** | 1,554 | 1,717 |
| ***Add/(less) non-cash items*** | | |
| Depreciation and amortisation expense | 10,812 | 11,139 |
| Impairment losses | - | - |
| **Total non-cash items** | **10,812** | **11,139** |
| ***Add/(less) items classified as investing or financing activities*** | | |
| Fair value movement on loans and receivables | (74) | 866 |
| (Gains)/losses on disposal of property, plant and equipment | (178) | (132) |
| **Total items classified as investing or financing activities** | **(252)** | **734** |
| ***Add/(less) movements in statement of financial position items*** | | |
| (Increase)/Decrease in receivables | (3,371) | 275 |
| (Increase)/Decrease in prepayments | (137) | 17 |
| (Increase)/Decrease in inventories | (20) | (532) |
| Increase/(Decrease) in payables | 5,586 | 859 |
| Increase/(Decrease) in employee entitlements | (1,757) | (1,308) |
| Increase/(Decrease) in provisions | 158 | (110) |
| (Increase)/Decrease in payables relating to purchase of property, plant and equipment | (402) | 534 |
| **Net movements in statement of financial position items** | **57** | **(265)** |
| **Net cash flow from operating activities** | **12,171** | **13,325** |

# 20. Capital commitments and operating leases

| | Actual 2016 $000 | Actual 2015 $000 |
|---|---|---|
| ***Capital commitments*** | | |
| Property, plant and equipment | 1,937 | 1,495 |
| Intangible assets | 46 | 191 |
| **Total capital commitments** | **1,983** | **1,686** |
| ***Non-cancellable Provider commitments*** | | |
| Not later than one year | 9,041 | 13,293 |
| Later than one year and not later than five years | 18,083 | 12,789 |
| Later than five years | 4,417 | 4,395 |
| **Total non-cancellable Provider commitments** | **31,541** | **30,477** |
| ***Non-cancellable operating lease commitments*** | | |
| Not later than one year | 1,056 | 917 |
| Later than one year and not later than five years | 2,848 | 2,709 |
| Later than five years | 2,123 | 2,223 |
| **Total non-cancellable operating lease commitments** | **6,027** | **5,849** |
| ***Non-cancellable finance lease commitments*** | | |
| Not later than one year | 762 | 929 |
| Later than one year and not later than five years | 1,968 | 1,974 |
| Later than five years | 13,366 | 13,858 |
| **Total non-cancellable finance lease commitments** | **16,096** | **16,761** |
| ***Non-cancellable other commitments*** | | |
| Not later than one year | 669 | 1,559 |
| Later than one year and not later than five years | - | - |
| Later than five years | - | - |
| **Total non-cancellable other lease commitments** | **669** | **1,559** |
| **Total commitments** | **56,316** | **56,332** |

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 2016 year totalled $122.4 million (2015: $117.8 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 $6,028 million, (2015, $5.848 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 2016, $2,701,952 was recognised as an expense in the surplus or deficit in respect of operating leases (2015: $2,409,998)

### Leases as lessor

NMDHB leases owned properties to third parties under operating leases resulting in revenue of $1.3 million (2015: $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 $5.896 million (2015: 7.023 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.

## 21. Contingencies

### 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 2016 (2015: $0).

### Contingent assets

NMDHB has no contingent assets as at 30 June 2016 (2015: $1.78m).

## 22. Related party transactions

### Government-related entities

NMDHB is a wholly-owned entity of the Crown.

#### *Significant transactions with government related entities*

The DHB has received funding from the Crown and ACC of $439.3 million (2015: $421.9 million) to provide health services in the Nelson Marlborough area for the year ended 30 June 2016.

Revenue earned from other DHBs for the care of patients outside NMDHB's district amounted to $8.9 million (2015: $7.8 million) for the year ended 30 June 2016. Expenditure to other DHBs for their care of patients from NMDHB's district amounted to $45.0 million (2015: $41.4 million) for the year ended 30 June 2016.

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

In conducting its activities, NMDHB 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.

NMDHB 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 2016 totalled $3.1

million (2015: $2.8 million). These purchases included the purchase of electricity from Genesis Energy, air travel from Air New Zealand, and energy from Solid Energy.

## Transactions with subsidiaries

NMDHB entered into transactions with the Nelson Marlborough Hospitals Charitable Trust (NMCHT) in the receipt of donations which are recognised as revenue when received, or an entitlement to receive money is established.

Donations received from NMCHT for the financial year were $85,000 (2015: $62,000).

NMCHT is recognised as a subsidiary of NMDHB, however it's results are not deemed material and are not consolidated in these financial statements.

## 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 2016 $000 | Actual 2015 $000 |
|---|---|---|
| ***Board Members*** | | |
| Remuneration | 265 | 276 |
| Full-time equivalent members | 12 | 11 |
| ***Leadership Team*** | | |
| Remuneration | 2,850 | 2,715 |
| Full-time equivalent members | 13 | 13 |
| **Total key management personnel remuneration** | 3,115 | 2,991 |
| **Total fill time equivalent personnel** | **25** | **24** |

Key management personnel includes all Board members, the Chief Executive, and members of the Leadership Team & their close family members. 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 GM of Finance and Performance, Eric Sinclair, is a Trustees of the Golden Bay Community Health Trust. The NMDHB has a loan with present value of $1.5m to the Golden Bay Community Health Trust and has an outstanding lease liability with a present value of $7.71 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.

The NMDHB purchased services from the Marlborough District Council during the financial year. Jessica Bagge, an NMDHB Board Member is a District Councillor of Marlborough District Council. Payments to Marlborough District Council during the Financial Year totalled $0.08 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 Churchill Trust during the financial year. Chris Fleming, the NMDHB's Chief executive is a Trustee of the Churchill Trust. Revenue services from the Churchill Trust totalled $3.7 million during the financial year, while payments to the Churchill Trust totalled $0.1 million. The services provided for and from the Churchill Trust were on normal commercial terms. There is a balance of $0.2 million 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.

## 23. 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.

## 24. 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 2016 (2015: $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:

| | 2016 $000 | 2015 $000 |
|---|---|---|
| ***Counterparties with credit ratings:*** | | |
| Cash and cash equivalents | | |
| *AA* | - | - |
| Investments | | |
| *AA* | - | - |
| **Total counterparties with credit ratings** | - | - |
| ***Counterparties without credit ratings*** | | |
| Cash on hand | - | - |
| Funds advanced to NZHP | 24,774 | 43,712 |
| **Total counterparties without credit ratings** | **24,774** | **43,712** |
| ***Receivables*** | | |
| Existing counterparties with no defaults in the past | 14,049 | 10,714 |
| Existing counterparty with defaults in the past | 103 | 67 |
| **Total receivables** | **14,152** | **10,781** |

## 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 2016 (2015: 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.

| 2016 | 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 | 55,500 | 55,500 | - | 6,000 | 15,000 | 26,500 | 8,000 |
| Finance lease liabilities | 8,024 | 16,096 | - | 762 | 492 | 1,476 | 13,366 |
| Creditors and other payables | 27,516 | 27,516 | 27,516 | - | - | - | - |
| **Total current assets** | 91,040 | 99,112 | 27,516 | 6,762 | 15,492 | 27,976 | 21,366 |

| 2015 | 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 | 55,500 | 55,500 | - | 6,000 | - | 35,500 | 14,000 |
| Finance lease liabilities | 8,381 | 16,761 | - | 929 | 498 | 1,476 | 13,858 |
| Creditors and other payables | 23,052 | 23,052 | 23,052 | - | - | - | - |
| **Total current assets** | 86,933 | 95,313 | 23,052 | 6,929 | 498 | 36,976 | 27,858 |

## 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 2016, it is estimated that a general increase of one percentage point in interest rates would decrease NMDHB's deficit by approximately $247,000 (2015: $437,000).

## 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 2016** | | | | | | |
| ***Current assets*** | | | | | | |
| Cash and cash equivalents | 7 | 24,774 | - | - | 24,774 | 24,774 |
| Receivables | 8 | 14,152 | - | - | 14,152 | 14,152 |
| Other financial assets | 11 | 6,000 | - | - | 6,000 | 6,000 |
| **Total current assets** | | **44,926** | - | - | **44,926** | **44,926** |
| ***Non-current assets*** | | | | | | |
| Other financial assets | 11 | 14,495 | 3 | | 14,498 | 14,498 |
| **Total non-current assets** | | **14,495** | **3** | - | **14,498** | **14,498** |
| **Total assets** | | **59,421** | **3** | - | **59,424** | **59,424** |
| ***Current liabilities*** | | | | | | |
| Payables | 14 | - | - | 27,516 | 27,516 | 27,516 |
| Finance leases | 15 | - | - | 556 | 556 | 556 |
| NZDMO loans | 15 | | | 6,000 | 6,000 | 6,027 |
| **Total current liabilities** | | - | - | **34,072** | **34,072** | **34,099** |
| ***Non-current liabilities*** | | | | | | |
| Finance leases | 15 | | | 7,468 | 7,468 | 7,468 |
| NZDMO loans | 15 | | | 49,500 | 49,500 | 53,501 |
| **Total non-current liabilities** | | - | - | **56,968** | **56,968** | **60,969** |
| **Total liabilities** | | - | - | **91,040** | **91,040** | **95,068** |
| **30 June 2015** | | | | | | |
| ***Current assets*** | | | | | | |
| Cash and cash equivalents | | 43,712 | - | - | 43,712 | 43,712 |
| Receivables | | 10,781 | - | - | 10,781 | 10,781 |
| **Total current assets** | | **54,493** | - | - | **54,493** | **54,493** |
| ***Non-current assets*** | | | | | | |
| Other financial assets | | 1,472 | 3 | - | 1,475 | 1,475 |
| **Total non-current assets** | | **1,472** | **3** | - | **1,475** | **1,475** |
| **Total assets** | | **55,965** | **3** | - | **55,968** | **55,968** |
| ***Current liabilities*** | | | | | | |
| Payables | | - | - | 23,053 | 23,053 | 23,053 |
| Finance leases | | - | - | 668 | 668 | 668 |
| NZDMO loans | | - | - | 6,000 | 6,000 | 6,147 |
| **Total current liabilities** | | - | - | **29,721** | **29,721** | **29,868** |
| ***Non-current liabilities*** | | | | | | |
| Finance leases | | - | - | 7,714 | 7,714 | 7,714 |
| NZDMO loans | | - | - | 49,500 | 49,500 | 52,635 |
| **Total non-current liabilities** | | - | - | **57,214** | **57,214** | **60,349** |
| **Total liabilities** | | - | - | **86,935** | **86,935** | **90,217** |

# 25. 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 (2015: Nil).

# 26. Explanation of major variances against budget

## Statement of comprehensive revenue and expense

### *Revenue*

Revenue was favourable to plan by $4.4m:

- Unbudgeted funding received for the free under 13 GP visits, hospice sustainability and Youth Forensic and Primary Youth Mental Health services contributes $1,808k to the favourable variance. Revenue has also been received to offset additional orthopaedic procedures with a favourable variance of $318k YTD.
- This is offset by funding for various PHO programmes such as Careplus and VLCA (very low cost access) tracking $627k lower than budgeted levels.
- The results for June include $425k accrued relating to the funding to offset with the additional capital charge costs relating to the property revaluation that occurred at 30 June 2015. This was not budgeted however offsets the additional capital charge expenses.
- $407k new funding has been received in March to June to offset increased 'In Between Travel' (IBT) costs for Home Based Support providers.
- Additional Palliative care funding of $78k was received in June.
- A revenue reduction of $515 due to an unbudgeted adjustment for Pharmac savings in relation to hospital drugs over the 15/16 year has been recognised in June
- ACC revenue is ($103k) unfavourable to budget primarily in Non Acute Rehab and Surgical services.
- Clinical Training Agency is $94k favourable in June with invoicing for additional RMO places on the HWNZ Medical Contract.
- We have recognised the settlement, totalling $700k, relating to the claim for over expenditure on the Wairau Hospital rebuild.

### *Expenditure*

Expenditure was $6.7m unfavourable to plan. This was due to:

- Workforce Costs (Including Personnel and Outsourced Workforce) are $0.3m favourable to Plan. The favourable variance is predominantly within the medical workforce which contributes $771k to the

favourable YTD variance. This is driven by vacancies across a number of specialities, which are offset by higher outsourced costs. The other workforce groups of Nursing and Hotel Services are also favourable to plan for the YTD reflecting vacancies across these workforce groups.

The annual valuation of the employee entitlements, completed by an actuary, has been recognised in June. This was $532k higher than budgeted which was driven by a lower Treasury Bond rate at June. A provision, for expenses relating to the recent restructure, of $225k has been allowed for in June.

- Outsourced services are ($2.2m) unfavourable to Plan. The adverse variance is mainly within the outsourced Medical services, radiology and breast screening services. This can largely be attributed to the vacancy in Surgical, Medical, Radiology and Mammography meaning a much higher outsourced cost has been incurred.
- Clinical Supplies are ($3.3m) unfavourable to Plan reflecting the high clinical activity experienced over the year. Hip and knee replacements performed were 114 units over the production plan resulting in ($433k) unfavourable variance. This higher level of Orthopaedic work impacted on other clinical supply lines including Patient Consumables ($230k) unfavourable.

  Pharmaceuticals tracked adverse to Plan across most cost lines including musculosketal and joint ($338k), nutrition ($248k), eye ($317k), immunosuppression ($739k) and gastro-intestinal ($99k).

  Costs for the blood product Intragram were ($463k) unfavourable, this is a demand driven cost and reflects the patient volume in our district where a single patient can incur significant costs.
- Infrastructure & Non-Clinical Expenses are $3.2m favourable to Plan. The favourable variance for the year is largely driven by the new investments that were budgeted, but were held, given the fiscal performance through the year. If the new investments are excluded then the variance for the year is $317k which is across a number of lines.
- Payments to Providers are ($5.0m) unfavourable to Plan. Aged Residential Care ("ARC") costs are favourable by $621 YTD, with the total number of clients within ARC tracking below budget for the past nine months. Home Based Support (HBS) is unfavourable by ($154k) YTD. Respite Care is overspent by ($182k) YTD due to a combination of increased expenditure on demand driven services plus the additional cost of the capacity respite bed in Motueka not included in the Budget. Community Pharmacy expenditure is ($621k) unfavourable YTD in part due to the costs associated with the medicine optimisation programme with PHOs ($115k) as well as Community Pharmacy Anticoagulation Service ($65k). However, overall overspend is based on the latest February 16 Pharmac forecast with the adverse result primarily driven by expenditure on Immunosuppressant drugs. YTD PHO services are adverse to plan by ($467k) which relates to the free under 13 visits which is offset by additional revenue.

## Statement of financial position

### *Current assets*

Current assets are $8m more than Plan. Cash & cash equivalents are $1m less than Plan and Debtors & Other receivables are $3.0m more than Plan. Deposits are now held by HPNZL and are included in Cash and cash equivalents. Non-current assets held for sale are $0.3m less than Plan. Deferred purchase of budgeted non-current assets has contributed to the budget cash surplus.

### *Non-current assets*

Non-current assets are $0.8m more than Plan. Delays in the capital expenditure programme has resulted in a $15.0m favourable variance in PPE, however this is offset by an increase in Non-Current Financial Assets, this category includes Deposits of $12.95m made with Westpac NZ.

### *Current liabilities*

Current liabilities are $11.6m higher than Plan in total. Creditors and Other payables are $8.4m more than Plan reflecting the higher expenditure for the year. Borrowings are $6.3m higher than Plan this is offset by Non-Current Borrowings $6.0m lower than plan. Employee Entitlements are $2.5m lower than Plan.

### *Non-current liabilities*

Non-current liabilities are $6.5m less than Plan. The variance is made up of $6.0m Loans & Borrowings as discussed in Current Liabilities, and $0.5m less than Plan in Employee Entitlements with a reduction in non-current personnel liabilities.

### *Equity*

Equity is $4.2m more than Plan due to the $6.2m revaluation of land and buildings as at 30 June 2015 not quantified when the Annual Plan was set and the variances described below.

## Statement of changes in net assets/equity

The net surplus was $4.2m more than Plan due to the explanations provided in above, Statement of Comprehensive Revenue and Expense

Equity injections and repayments were in line with Plan.

## Statement of cash flows

Cash inflows from Operating Activities were $2.8m more than Plan. Receipts from Ministry of Health and patients were $7.7m more than Plan, payments to Employees were $4.0m more than Plan and payments to Suppliers were $8.6m less than Plan for various reasons outlined above.

Cash inflows from Investing Activities were $10.0m less than Plan for the year. Investment in Property, Plant, and Equipment was $10.0m less than Plan, with many planned projects deferred.

Cash outflows from Financing Activities were $18.6m more than Plan. Repayment of Capital is $19m higher than planned reflecting the transfer of funds from HPNZL to Westpac term deposits.

# 27. Non-consolidation of subsidiary

Nelson Marlborough Hospitals Charitable Trust (NMCHT) provides health related services, projects, research, and education to the residents of the NMDHB catchment area. NMCHT is controlled by NMDHB in accordance with PBE IPSAS 6.

For the year ended 30 June 2016, the Trust had total revenue of $126,331 (2015: $610,122), and a net surplus of $123,856 (2015: Surplus $290,278). The Trust had assets of $3,277,696 (2015: $3,286,656), and liabilities of $Nil (2015: $Nil) at that date.

## 28. 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.

| | Actual 2016 $000 | Actual 2015 $000 |
|---|---|---|
| ***Mental health funds*** | | |
| Opening balance | 264 | 642 |
| Excess/(shortfall) of funding over payments | 625 | (378) |
| Adjustments to funds available | | - |
| **Total mental health funds** | **889** | **264** |

## 29. Summary of revenue and expenditure by output class

| | Budget 2016 $000 | Actual 2016 $000 | Actual 2015 $000 |
|---|---|---|---|
| ***Revenue*** | | | |
| Prevention services | 7,697 | 8,295 | 7,877 |
| Early detection and management services | 116,761 | 117,809 | 115,006 |
| Intensive assessment and treatment services | 240,220 | 243,471 | 228,876 |
| Support services | 92,447 | 91,997 | 91,494 |
| **Total revenue** | **457,125** | **461,572** | **443,253** |
| ***Expenditure*** | | | |
| Prevention services | 6,977 | 7,820 | 6,948 |
| Early detection and management services | 115,144 | 115,668 | 110,893 |
| Intensive assessment and treatment services | 238,291 | 243,315 | 232,466 |
| Support services | 92,857 | 93,214 | 91,229 |
| **Total expenditure** | **453,269** | **460,017** | **441,536** |
| ***Surplus/(deficit)*** | | | |
| Prevention services | 720 | 475 | 929 |
| Early detection and management services | 1,617 | 2,141 | 4,113 |
| Intensive assessment and treatment services | 1,929 | 156 | (3,590) |
| Support services | (410) | (1,217) | 265 |
| **Total surplus/(deficit)** | **3,856** | **1,555** | **1,717** |

# Audit report

## To the readers of Nelson Marlborough District Health Board's financial statements and performance information for the year ended 30 June 2016

The Auditor General is the auditor of Nelson Marlborough District Health Board (the Health Board). The Auditor General has appointed me, Ian Lothian, 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 appropriations, of the Health Board on her behalf.

We have audited:

- the financial statements of the Health Board on pages 45 to 82, that comprise the statement of financial position as at 30 June 2016, 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 25 to 44.

## Unmodified opinion on the financial statements

In our opinion:

- the financial statements of the Health Board on pages 45 to 82:
  - present fairly, in all material respects:
    - its financial position as at 30 June 2016; and
    - its financial performance and cash flows for the year then ended; and
  - comply with generally accepted accounting practice in New Zealand and have been prepared in accordance with Public Benefit Entity Reporting 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 2015, which is reported as comparative information, was modified for the same reason.

In our opinion, except for the effect of the matters described above, the performance information of the Health Board on pages 25 to 44:

- presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2016, including:
    - for each class of reportable outputs:
        - its standards of performance achieved as compared with forecasts included in the statement of performance expectations for the financial year;
        - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year;
    - what has been achieved with the appropriations; and
    - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure.
- complies with generally accepted accounting practice in New Zealand.

Our audit was completed on 25 October 2016. This is the date at which our opinion is expressed.

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

## Basis of opinion

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

Material misstatements are differences or omissions of amounts and disclosures that, in our judgement, are likely to influence readers' overall understanding of the 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.

An audit involves carrying out procedures to obtain audit evidence about the amounts and disclosures in the financial statements and the performance information. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and the performance information, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the preparation of the Health Board's financial statements and performance information 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.

An audit also involves evaluating:

- the appropriateness of accounting policies used and whether they have been consistently applied;
- the reasonableness of the significant accounting estimates and judgements made by the Board;
- the appropriateness of the reported performance information within the Health Board's framework for reporting performance;
- the adequacy of the disclosures in the financial statements and the performance information; and
- the overall presentation of the financial statements and the performance information.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements and the performance information. Also, we did not evaluate the security and controls over the electronic publication of the financial statements and the performance information.

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

## Responsibilities of the Board

The Board is responsible for preparing financial statements and performance information that:

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

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.

The Board is responsible for such internal control as it determines is necessary to enable the preparation of financial statements and performance information that are free from material misstatement, whether due to fraud or error. The Board is also responsible for the publication of the financial statements and the performance information, whether in printed or electronic form.

## Responsibilities of the Auditor

We are responsible for expressing an independent opinion on the financial statements and the performance information and reporting that opinion to you based on our audit. Our responsibility arises from the Public Audit Act 2001.

## Independence

When carrying out the audit, we followed the independence requirements of the Auditor General, which incorporate the independence requirements of the External Reporting Board.

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

Ian Lothian
Audit New Zealand

On behalf of the Auditor General
Christchurch, New Zealand

TE WAIORA Nelson Marlborough Health

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