ANNUAL REPORT

NELSON MARLBOROUGH DHB

2014/2015

TE WAI ORA

Nelson Marlborough
District Health Board

Contents

Report from the Board Chair and Chief Executive

OVERVIEW

It is with pleasure that we present the annual report for Nelson Marlborough District Health Board for the 2014/15 year. This report describes how the DHB has performed over the last year and how we account for the public money spent by the DHB over this period. We will publish our Quality Accounts separately, which is a report outlining our activities and priorities to improve quality of care and outcomes for patients and clients who use our services.

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.

Attendances to our Emergency Departments in Nelson and Wairau were 47,338 during the year, down by 464 from the previous year and we have a focus in the coming year to further reduce the attendances to ensure that care is provided in the right location. Planned treatments and operations have continued around previous year levels within our two facilities and our staff have worked hard to maintain and improve the quality of our services in the face of an ageing population, increasing demand and a challenging financial environment.

Despite the pressures, we continue to evolve and improve our services through innovation and technology, and there have been many notable successes. We replaced the CT (computed tomography) scanners in both Nelson and Wairau during the year and have now implemented an MRI (magnetic resonance imaging) in Wairau in conjunction with Pacific Radiology. We have continued our investment in information technology and are moving towards the implementation of PICS (patient information care system) as the patient administration system across the South Island, due to go live in November 2016.

Our primary care partners, Nelson Bays Primary Health and Kimi Hauroa Wairau, have both made 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.

It is pleasing that we have now opened community health hubs, in partnership with the two PHOs in Richmond and in Blenheim. This provides a great opportunity for the co-located services to enhance planning and service development/delivery in a much more integrated manner and we are starting to see the benefits of this coming through.

We invested significant effort and energies to strengthen our clinical leadership and clinical governance ensuring this is integrated at all levels of the organisation, and across the Nelson Marlborough health system. We are creating an environment where clinical excellence will flourish. The Clinical Governance Group has created vision and a Clinical Governance Framework which lists the four key areas the committee and clinical leadership will focus on over the next year. These four areas are: Will to Act; Tools to Measure; Tools for Change; and Harm Free Care.

SERVICE PLANNING

During the year we commenced 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 two documents: a Health Needs and Service Profile; and a Health Services Plan.

A Facilities Implications Report is also under development and is expected to be complete in October 2015. We are planning 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 health care;
- 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 NMDHB hospitals; and
- Prioritise service and capital investments and reinforce performance and accountability.

HEALTH TARGET PERFORMANCE

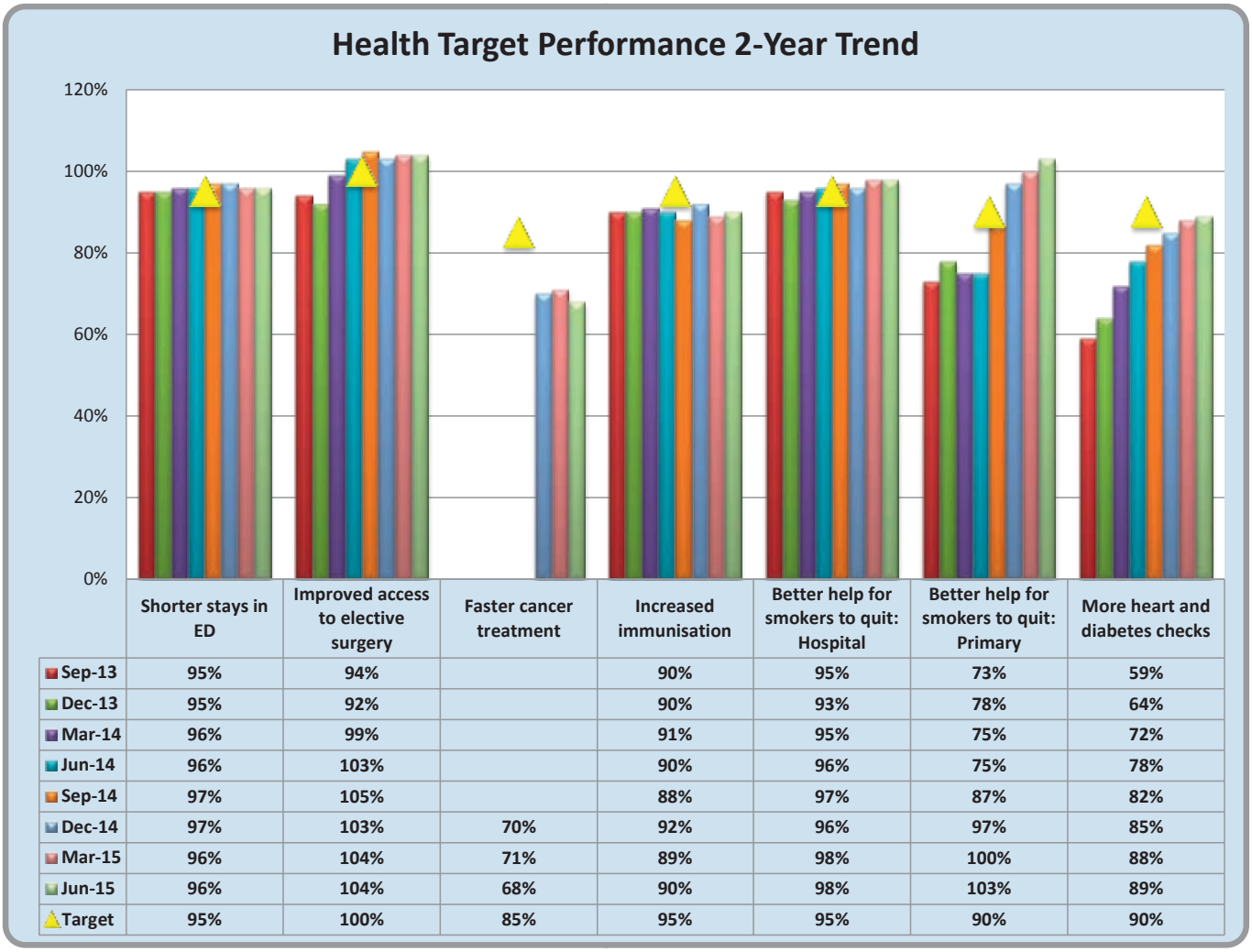
Our DHB continues to perform well against the health targets as seen in the graph below which shows the performance across each quarter for the 2013/14 and 2014/15 years. Overall three of the health targets are now achieved with good progress on two of the others.

The faster cancer treatment target was introduced on 1 October 2014 and currently no district health board has achieved the national target. We will continue to be vigilant in our work towards delivering to the national target level and rely on other district health boards to assist us in meeting the level expected.

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 to now in the top third.

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.

The rate of progress over the last two years on the heart and diabetes checks is particularly pleasing and we expect to see the health target reached early in the 2015/16 year.



	Shorter stays in ED	Improved access to elective surgery	Faster cancer treatment	Increased immunisation	Better help for smokers to quit: Hospital	Better help for smokers to quit: Primary	More heart and diabetes checks
Sep-13	95%	94%		90%	95%	73%	59%
Dec-13	95%	92%		90%	93%	78%	64%
Mar-14	96%	99%		91%	95%	75%	72%
Jun-14	96%	103%		90%	96%	75%	78%
Sep-14	97%	105%		88%	97%	87%	82%
Dec-14	97%	103%	70%	92%	96%	97%	85%
Mar-15	96%	104%	71%	89%	98%	100%	88%
Jun-15	96%	104%	68%	90%	98%	103%	89%
Target	95%	100%	85%	95%	95%	90%	90%

WORKFORCE PLANNING

A key development during the year was the development of a Workforce Strategy and Action Plan. A number of workshops were held with representatives from all disciplines across the primary and secondary health workforce. The outcome from these workshops was a Plan containing nine strategies with actions associated to each strategy. We are now moving into the implementation of the Plan's nine strategies and actions over a three year period.

This Plan is an exciting development for our DHB and provides an impetus to continue to grow and development the workforce across the whole health system.

FINANCIAL PERFORMANCE

The previous 24 months was a challenging time for the DHB in moving to a sustainable financial position and transitioning to achieving increasing surpluses that allow us to progress towards the redevelopment of the Nelson hospital. We are now on a steady financial footing and are able to progress with new investments in workforce, integration and infrastructure.

For the 2014/15 year we are reporting an operational surplus of $1.7 million which is slightly ahead of the planned $1.5 million surplus. 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.

THE YEAR AHEAD

Our DHB, like the other DHBs in our country, continues to face pressures and challenges in delivering timely, appropriate and accessible health care in a financially constrained environment. We have, and will continue to take steps to meet these challenges and look to further opportunities as they arise to improve the health of our population. It is pleasing that our 2015/16 Annual Plan sets out a number of areas where we are able to invest in our future. This includes:

- We will strive to better integrate the health care services across the continuum and aim to better link primary and secondary services with patients and their families through investment in initiatives that provide the opportunity to enhance integration of primary, community and secondary services under the umbrella of the Top of the South / Te Tau Ihu o Te Waka a Maui Health Alliance (TOSHA).
- We have committed to significant investment in initiatives through the Information Services Alliance under the South island Alliance umbrella that make significant inroads in enhancing the integration of clinical information both across our district and regionally.
- The Learning and Development Centre on the Nelson Hospital site has been discussed for a long time and we now have underway the planning to start the development during the 2015/16 year. We will also commence the planning work required for the redevelopment of the Nelson hospital during the year ahead and expect the redevelopment to be complete in around five years time.
- Specific initiatives within the Workforce Strategy and Action Plan will get underway as we seek to further grow and develop our workforce.
- We are aiming to invest more into public health initiatives such as pushing for a reduction in sugar consumption and targeting the territorial local authorities to undertake fluoridation of the drinking water. These initiatives are seen as key in the overall improvement in the health and well being of our community.
- Continuing to invest in improving the clinical leadership and clinical governance across the Nelson Marlborough health system to ensure the highest possible standards of safe and affordable health care is provided.

ACKNOWLEDGEMENTS

The achievements of 2014/15 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.

Jenny Black
Board Chair

Chris Fleming
Chief Executive

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 Maori 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 Maori to participate in, and contribute to, strategies for Maori health improvement

- To continue to foster the development of Maori capacity for participating in the health and disability sector and for providing for the needs of Maori
- 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 the Board'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 Maori.

Members of the Nelson Marlborough District Health Board during 2014/15 were:

NAME	APPOINTMENT	
Jenny Margery Black	Elected	Chair
Russell Wilson	Appointed *1	Deputy Chair Chair, Audit & Risk Committee
Ian MacLennan	Appointed *2	Deputy Chair
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	
Alan Hinton	Appointed *3	
Pat Heaphy	Elected	
Dawn McConnell	Appointed	
Patrick Smith	Appointed	

*1 Russell Wilson was appointed Deputy Chair on 2 April 2015.

*2 Ian MacLennan completed his term as an appointed member on 25 November 2014.

*3 Alan Hinton was appointed to the Board on 16 December 2014. Prior to his appointment Alan was co-opted as a member of the Audit & Risk Committee.

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 2014/15 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	12	11	3	2	4	4	4	4
Russell Wilson	12	12			4	4	4	4
Ian MacLennan	4	4					2	2
Judy Crowe	12	11	3	3				
Gerald Hope	12	12			4	4	4	2
Jessica Bagge	12	12			4	4		
Jenny Margaret Black	12	12	3	3				
Brigid Forrest	12	12	3	3			4	3
Alan Hinton	7	7			3	3	4	4
Pat Heaphy	12	11	3	3				
Dawn McConnell	12	11			4	4		
Patrick Smith	12	10	3	3				

Non-Board committee members

BOARD MEMBER	CPHAC/DSAC		HAC		A&RC	
NAME	HELD	ATTENDED	HELD	ATTENDED	HELD	ATTENDED
Jenni Gane	3	2				
Glenys MacLellan	3	3				
Judith Holmes	3	3				
Dana Wensley			4	3		
Patricia O'Brien			4	3		
Luke Katu (IHB)	3	2	4	2		
Sonny Alesana (IHB)	3	3				

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. Members of the Board also attended five workshops during the year including a strategic planning meeting.

BOARD AND COMMITTEE FEES

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

	Actual 2015 $000	Actual 2014 $000
Value of Board member remuneration		
Jennifer Margery Black (Chairperson)	44	55
Russell Wilson	24	23
Jessica Bagge	22	12
Jenifer Margaret Black	22	13
Judy Crowe	23	22
Brigid Forrest	23	13
Patrick Heaphy	22	12
Alan Hinton	7	
Gerald Hope	22	24
Dawn McConnell	29	6
Patrick Smith	24	23
Ian MacLennan	12	29
Gordon Currie		10
Fleur Hansby		10
Roma Hippolite		20
John Inder		10
John Moore		11
Total remuneration	**274**	**293**

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

	Actual 2015 $000	Actual 2014 $000
Hospital Advisory Committee		
Patricia O'Brien	2	1
Dana Wensley	2	1
Jane Anderson-Bay		1
Francis Gargiulo		1
Total remuneration	**4**	**4**
Community and Public Health Advisory Committee/Disability Support Advisory Committee		
Sonny Alesana	3	4
Jennifer Gane	1	
Judith Holmes	2	1
Hughes Katu		4
Glenys MacLellan	1	1
George Truman		1
Jos van der Pol		1
Total remuneration	**7**	**12**

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 2015:

Board members

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

Executive Leadership Team

NAME	INTEREST
Chris Fleming *Chief Executive*	• Director and Chair of Audit & Risk Committee, Health Benefits Ltd • Trustee, The Churchill Private Hospital Trust • Trustee, Nelson-Marlborough Hospitals Charitable Trust
Nick Baker *Chief Medical Officer*	• Senior Clinical Lecturer, Community Child Health, University of Otago Wellington School of Medicine • Member, Steering Group NZ Child and Youth Epidemiology Service • Instructor, Advanced Paediatric Life Support NZ • Technical Advisor, Whakawhetu National SUDI prevention for Maori • Fellow, RACOP
Peter Bramley *General Manager Clinical Services*	• Nil
Robyn Byers *General Manager Mental Health*	• Nil
Hilary Exton *Director, Allied Health*	• Member, Nelson Marlborough Cardiology Trust • Member, Physiotherapy New Zealand • Member, New Zealand Paediatric Group
Ros Gellatly *Chief Medical Advisor Primary*	• GP, Scott Street Health • RNZCGP representative, National IT Clinical Leadership Group • Member, Southlink Health
Pam Kiesanowski *Director of Nursing*	• Nil
Andrew Lesperance *General Manager Strategy, Planning and Alliance Support*	• Member, National Pharmacy Audit Sub Committee
Patrick Ng *General Manager IT & Infrastructure*	• Nil
Keith Rusholme *General Manager Disability Support Services*	• Wife is a provider of complementary health services • Sister works within the Disability Support Services
Eric Sinclair *General Manager Finance & Performance*	• Trustee, Golden Bay Community Health Trust
Karen Vaughan *General Manager Clinical Governance Support*	• Nil
Harold Wereta *General Manager Maori Health Whanau Ora*	• Ngati Toarangatira connections • Ngati Koata • 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

Implementing the 30-year vision for Māori health and the NMDHBs vision Health 2030 continues to be the main focus for the Iwi Health Board as it continues to strengthen the relationship they have with Nelson Marlborough DHB Board. The partnership formed in 2004 represents the responsibilities both have to fulfilling the obligations under the Treaty of Waitangi and the expected requirements as set out in the NZ Public Health and Disability Act 2000.

Ngāti Āpa, Rangitāne, Ngāti Koata, Ngāti Kuia, Ngāti Rārua, Ngāti Tama, Ngāti Toarangatira and Te Āti Awa make up Manawhenua ō Te Tau Ihu also known as the Iwi Health Board. In addition, there are appointed representatives from Pasifika and Mātā Waka (or Maori who are not affiliated with local Iwi) their combined presence ensures there is collective ownership to creating changes that will improve Māori and Pacific health into the future.

Representation on the NMDHB Board statutory sub-committees continues to be important to the Iwi Health Board. There are members on all three DHB appointed statutory committees. Alongside these committees, both the NMDHB board and Iwi Health Board meet twice a year and this has created an important forum where strategic issues like Maori health planning and measurement of Maori health outcomes are discussed and agreed to.

The Iwi Health Board continues to show strong interest and determination to improving Maori health across the district. The year usually starts with DHB planning. This includes advising on the Whānau Ora sections in the Annual Plan and then guiding the development to the Māori Health Plan.

Key Messages

- Strengthening Maori leadership
- Greater focus on Maori health outcomes
- Better positioning of Maori health to meet tomorrow's generation

National Maori Health Targets for NMDHB

- Angiogram in high risk patients at 100% (Target 70%)
- Breast screening hosp (50 – 69y) 76% (Target 70%)
- Smoking Cessation Primary at 104% (Target 90%)
- Smoking Cessation Hospital at 98% (Target 95%)
- Breastfeeding (6mths) at 50% (Target 59%),
- Cardiovascular Risk Assessment at 80% (Target 90%)
- Immunisations (8mths) at 84% (Target 95%).

An important focus for Iwi Health Board has been strengthening the Maori health plan (2014/15) reporting dashboard. The dashboard developed locally and nationally now allows the group to effectively seek information from the DHB on why services are not meeting their targets and advice on where opportunities might exist to address these. Overall, the DHB exceeded the Angiogram in high risk patient target at 100% (National Target 70%), 76% for the Breast screening Hospital 50 – 69yr (National target 70%, Smoking Cessation Hospital target was achieved at 98% (National target 90%), and Smoking Cessation Primary target at 104% (National target 90%). Other results within ten percent of the national target include breastfeeding at six months (National target 59%), Cardiovascular Risk Assessment (National target 80%) and immunisations at 8 months (National target 95%). There were three failed targets - Breastfeeding at 6 wks, Breastfeeding at 3 months and Post Angio data collection. The Iwi Health Board will be working hard in 2015/16 to improve the level of performance across all parts of the health system.

One of the main roles of the Iwi Health Board is to guide and advise the NMDHB board on matters of strategy. Key areas of focus covering 2014/15 have included the design/ development of the Maori health monitoring framework to measure overall performance against the Maori health vision, reviewing and strengthening Iwi Mandate for appointed Iwi Health Board representatives, establishing guidelines for

Iwi Health Board to direct decision making when wider Iwi engagement is required versus when they can make decisions that are within their mandate and complete a stocktake review on the Maori Health Workforce Action Plan (2011 – 2015). Iwi Health Board have also been actively engaged with advising on Oral Health, support the discussion on Sugary foods and early engagement about fluoridation, guiding the Iwi engagement discussion covering the Regional Inter-sector Forum (Government Agencies) and development of their 2015/16 work plan and communication strategy.

The year has ended with a positive feeling that Maori health across the district is improving and recognises that more work is needed before health inequalities between populations has been eliminated.

For 2015/16 the Iwi Health Board will continue to strengthen Maori leadership in health, have greater focus on Maori health outcomes, and focus strongly on how they can guide with improving the level of advice/direction they give to the NMDHB Board and wider Maori community. Close monitor of the health sector against the Maori health targets and reviewing the 30 year Maori health & wellness strategic framework will be their primary focus.

Service updates

COMMUNITY SERVICES

Primary Care - Health Target Success

During the year a key area of focus was improving results in the primary care component of the Better Help for Smokers to Quit target, and the More Heart and Diabetes Checks target.

The 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.

Achievement of these targets is an excellent indicator of the continued advancement in the provision of health services by primary care in the Nelson Marlborough region.

The target for Better Help for Smokers to Quit is for 90 percent of patients who smoke and are seen by a health practitioner in primary care to be offered brief advice and support to quit smoking. Steady improvement was made towards achieving this target during the year, and by June 2015 Nelson Marlborough District and PHOs were the highest performing of any region with a full 100 percent of smokers being offered advice and support to quit during the last quarter of June 2015.

The target for More Heart and Diabetes Checks is for 90 percent of the eligible population to have have had their cardiovascular risk assessed in the last five years. Again, steady improvement was made toward achieving this target during the year and these gains will be built on in the coming year.

Primary Care – Integration Success

Primary care is the first point of contact for access to the health system and the gateway to hospital-based care. Primary care is vital to the success of the health system, both in ensuring equity of outcomes for the Nelson Marlborough population, the delivery of patient centred care across the traditional community, primary and secondary service boundaries, and in managing health service costs.

Our ability to move towards a single, integrated health service for our community has been supported with increased co-location of hospital and primary care based services. In the Nelson area, the NMDHB's public health service staff and the Nelson Bays PHO's staff now operate from a single shared facility in Richmond. Prime Minister John Key opened the new Marlborough Community Health Hub in April 2015, which focuses on integrated services and preventive health care. Both facilities provide us with the opportunity to create a community-facing service, and also support greater collaboration on common objectives such as improving immunisation coverage and helping people to quit smoking.

The Top of the South Health Alliance (ToSHA) partnership between Nelson Marlborough DHB and the two Primary Health Organisations in the region is our key vehicle for achieving integration of our community, primary and secondary providers to enable high quality, safe, patient-centred care delivery. During the year ToSHA has invested in initiatives that enhance integration and improve patient care.

Strong progress has been made towards improving access to diagnostics. General Practitioners in Nelson Bays now have the technical ability to view images and reports online as they are performed in Nelson Marlborough DHB. A successful trial has also been completed for GPs to directly refer patients for an x-ray out-of-hours in the Nelson region.

A project to provide more integrated and coordinated care in rural areas is progressing well. Areas of duplication and fragmentation have been investigated and a model for allocation of rural funding has been agreed by stakeholders through the Top of the South Health Alliance. The model will see funding

channelled to 'rural with low urban influence' practices, and has allowed for the establishment of a 'rural flexible fund' for rural services delivered by primary care health providers.

Managing acute (unplanned) demand is an ongoing challenge. Research shows the vast majority of people (about 90 per cent) only present once or twice to the Emergency Department (ED) during the year, but about one percent of presentations were by people coming six times or more. To improve patient care and reduce unnecessary visits to the ED, detailed individual plans were developed for those people who frequently come to ED in Nelson. Research was also completed with GPs to learn more about why patients come to ED rather than see their GP, and to understand the potential capacity of GPs to take on some services that have traditionally been provided in a hospital environment. A working group is assessing hospital based services to identify what services may be suitable for transfer to the community, so patients can access services closer to home in a more cost effective way.

CLINICAL GOVERNANCE

The Clinical Governance systems within Nelson Marlborough District Health Board (NMDHB), continue to develop and strengthen, attempting to set in place an environment where clinical excellence will flourish. Foundation documents for this process have been developed by the Clinical Governance Group. They have created a Clinical Governance Framework which lists the four key areas the committee and clinical leadership will focus on over the next year.

Key areas planned and identified within the 2014/15 Annual Plan have been achieved. Some elements remain work in progress, however there have been significant achievements in establishing the foundations and increasing capacity and capability to deliver quality safe care sustainably across the organisation.

The Clinical Governance Committee has established principles upon which Clinical Governance within NMDHB will function. These are:

1. Patients at the absolute centre of our considerations – consumers engaged at every level, learning from patient stories, cultural practices supporting Maori patients and people of diverse cultural backgrounds.
2. Clinical staff who have a focus on caring for the wider health system as well as the patient in front of them.
3. Partnerships between clinicians (nursing, medical and allied health) and management embedded at every level of the organisation.
4. Robust employment, orientation, training, supervision, mentoring, performance appraisal, maintenance of skills, processes.
5. Patient care and system function enabled by clinically focused information systems.
6. Learning from adverse events and complaints to improve systems of care – an "intelligent system" that learns from experience - serious event process, complaints, no blame systems focus, systems ready to change and improve.
7. Information about clinical performance and quality - collected, analysed, shared and used to improve the system.
8. Financial and clinical systems linked – so we know where we spend our money, what we get for the money and what clinical outcomes change because of what we spend.
9. Communication across the whole health system so the right people know the right things – two way information flow avoiding over and under communication.

National Targets of the Health Safety Quality Commission (HSQC)

NMDHB is performing well for most of the HQSC targets, with substantial improvement over the last 12 months in many areas. Ongoing effort to maintain and achieve good results continues. Work on the new initiatives is well underway for the Opiate Project and to explore local Surgical Mortality Review Group development. NMDHB achieves good results on the National Patient Experience survey.

Improving consumer engagement is seen as an important focus. Work has started with the development of a position statement and there is already strong consumer engagement in Mental Health and within Maternity and Child Services integration work.

The vision statement of Clinical Governance is: "Systems and processes are in place to support us to do the right thing so we achieve the highest possible standard of health, safe care and support for the Top of the South."

Clinical Governance across the organisation will continue to evolve in the coming year with the four key areas of focus:

1. Leadership and Culture (will to act). This focuses on clinical leadership development across all disciplines; building a strong culture with solid foundations based on a Just Culture principle; working with consumers as partners across all levels within the organisation.
2. Measurement (tools to measure). This focus will be producing data for improvement and the development of measures which reflect the Triple Aim for Healthcare. Key to the success of this is understanding the data we produce and ensuring we measure and report the right things to support decision making at all levels within the organisation.
3. Workforce (tools for change). The development and implementation of criteria for a healthy well functioning department, that ensures the patient/client /service user is at the centre. Creating a sustainable system with care delivered by the right person with the right skills, and growing capacity and capability to deliver services in a safe harm free way.
4. Quality Initiatives (harm free care). This area continues to focus on the national entity measures, as well as key organisational projects. This includes using information from events to improve systems and design our systems with human fallibility in mind.

Specific issues for action in 2015/16 are:

a. Reportable event management, ensuring timely collection of information using a "Just Culture" view point which leads to system improvement.

b. Infrastructure and capability for change and transformation.

c. Consumer involvement at all levels.

NMDHB CLINICAL GOVERNANCE FRAMEWORK

Vision

Systems and processes are in place to support us to do the right thing so we achieve the highest possible standard of health, safe care and support for the Top of the South.

Themes

Will to Act	Tools to Measure	Tools for Change	Harm- free Care
Leadership and Culture	*Measurement*	*Workforce*	*Quality Initiatives*

Components

Will to Act	Tools to Measure	Tools for Change	Harm- free Care
People centred care	Knowing how we are doing locally, nationally and internationally	Noticing , celebrating and appreciating success	Participate in National safety initiatives
Clinical leadership development	Knowing we are safe	Continuous professional development	Using what we learn to drive harm free care
Fair and Just Culture fostered	Knowing we are improving	Having tools for change	Integrating IT changes
Excellent communication			
Evidence based practice			
Serious event management			

Outcomes

Will to Act	Tools to Measure	Tools for Change	Harm- free Care
Improved experience of care	Excellent use of information to guide decisions and improve care	Workforce skilled and confident to both provide care and bring about beneficial change	National exemplar of best practice
Improved workplace safety culture	Information feeds into short feedback loops to accelerate improvement	Healthy Departments and Teams	Excellent performance on national quality and safety markers
Safe care for all patients, clients and service users	Agreed ranking system and clinician input into budget allocation for best value.		
Foster clinical governance with other health organisations			

CLINICAL SERVICES

Clinical Services in 2014/15 has provided for the community of NMDHB 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 225 the 6,029 elective 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 464 cataract procedures were delivered, and there were 520 hip and knee replacements completed.

We also made progress in improving the waiting times for Angiography, CT and MRI. A new MRI was installed at Wairau Hospital in June of 2015. This will improve the access for patients to MRI across the district.

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 2014/15, 47,888 people presented to our emergency departments. NMDHB continued to meet the national health target that at least 95% of people presenting to an Emergency Department are either discharged or admitted to hospital within 6 hours.

In Nelson Hospital 40,278 bed nights for patient care were provided, and 16,517 were provided in Wairau Hospital.

The clinical services team provided 21,671 first specialist assessments over the year, and 39,873 follow up appointments with specialist services. In addition a further 16,765 medical and surgical procedures were delivered.

Many initiatives were undertaken over the year to improve both the quality and efficiency of our service provision.

We have seen a significant improvement in a number of areas including a reduced number of falls in a hospital setting, reduced cancellations on day of surgery, and reduced rates of infection and pressure related injuries.

An improved pathway of care, in conjunction with St John, has been put in place for patients with a STEMI (cardiac) condition. Two other new projects have been initiated, one related to the safer user of pain medication, and the other focussed to improved discharge processes from hospital to primary care.

In General Surgery and Orthopaedics programmes were successfully undertaken to improve care and recovery for patients following surgery.

We continue to drive improvement in the Did Not Attend rate for children attending community dental clinics.

The Maternal and Child Integration Programme which brings together community agencies to improve the health and support of mothers and children has continued with a number of initiatives. These have included the development of a Child Health calendar, a smart phone app to assist with the coordination and scheduling of care for mothers and children, and in this coming year will see the establishment of resources centres.

Our Public Health Service continues to support a healthy population with a focus to Health Promotion, a Smokefree DHB, and completion of Before Schools Checks and Childhood Immunisation Programmes.

During the year there was a focus to improving services across our two hospital sites as part of the Top of the South Service plan. Clinical teams have worked closely together to ensure services are supported and strengthened at both sites. Ear Nose & Throat services began delivering surgery at Wairau Hospital as well as Nelson Hospital. More surgeons are now operating at both sites, meaning more patients can be treated closer to home. A new daily ambulance service has been introduced to better support the transfer of patients between the two hospitals.

We have continued to support and promote the delivery or clinical services "closer to home" by supporting patients to have their care provided in the context of their General Practitioner. More skin lesion removals are now being done in primary care rather than in hospital, along with IV treatments preventing a visit unnecessarily to a hospital. Better access to radiology through the After Hours Medical and Injury Centre is being supported preventing unnecessary presentation to the Emergency Department. One of the exciting initiatives has been the development of a Rheumatology service that is multidisciplinary using specialist nursing and GP resources but based in the community. We are looking to extend this approach to the management of other chronic conditions in the following year.

MENTAL HEALTH SERVICES

Building on the past three years of establishing and consolidating the Mental Health Service as a functional, effective entity for the organisation: business as usual is now ensuring financial sustainability and effective resource utilization, systems review, quality improvement activities, performance monitoring and regional participation. In addition each year has a particular focus which for 2014/15 was the responsiveness and accessibility of Specialist Services, following the preceding years' focus on NGOs, then Primary Mental Health.

The model of care and client pathway of the Nelson Community team and Inpatient Services have been reviewed with particular consideration of equity of access, caseloads, transition to primary care, access to multi-disciplinary team review, roster sustainability (particularly from a Health and Safety perspective), resource utilization, the case management model and continuum of care. A revised pathway will be implemented in 2015/16 following consultation. Seclusion minimization remains a key project in the Inpatient service, and Advanced Care Directives promoted for clients to specify treatment preferences when acutely unwell.

Some examples of other quality improvement activities are:

- Wairau Residential Review (extended to Nelson in 2015/16).
- Rural Services Review – Te Whare Mahana's scope of services was re-aligned, with MOH funding the dialectical behaviour therapy residential programme and continuing to fund increased outreach services (additional FTE and increasing Adult, Youth and AOD Specialist Service input).
- Consult Liaison extended in Clinical Services.
- A paediatric psychology collaborative with Clinical Services.
- Passed certification and opioid substitution treatment audit.
- Nikau House and Wairau's Get Active programme extended aligning to "Equally Well" imperatives to improve physical health and social inclusion. This involved increasing exercise, nutrition and sugar free initiatives including advancing smoke-free activities, and increased participation in community activities.
- Child and Adolescent Mental Health Service ("CAMHS") new Community Liaison role was reviewed receiving high commendations for the role itself and the many collaborative inter-agency initiatives introduced.
- Youth forensic role integrated into youth justice and a client pathway formalised.
- Nikau's Wellness Clinic extended checking physical status and metabolic monitoring (to address physical health risk and comorbidity).

- Single referral triage process extended to CAMHS and Wairau.
- He Taura Tieke (a self-audit tool that measures how effective our service is for Maori and their Whanau) update completed.
- A very successful health promotion activity, the musical "Next to Normal" supported by the NMDHB, Nelson Bay Primary Health and Health Action Trust.
- Mental Health of the Older Person facility renovated with resultant increase in reportable events from challenging behaviour but exemplary client management by staff for the several months of very noisy disruptive building work.
- The Nelson/Wairau Mental Health of the Older Person Liaison roles established in 2013/14 were reviewed and shown to be very successful in maintaining clients with their Providers, averting behavioural deterioration and re-admissions.
- Respite extended in Wairau (Hapai Toi Ora) and Nelson (Tipahi).
- The NGO Residential Providers and Specialist Service Governance Group found to be very effective to manage and improve efficacy of client flow.

Workforce training continues service-wide inclusive of clients and families, and where relevant this has also included the colleges, and other government departments and agencies. Also successful inter-service collaboration of placements and supervision. In particular, since its inception in October 2014, Te Piki Oranga staff have been working in the Specialist Community and CAMHS teams and collaboratively with Addictions.

Across the service it has been another busy year of focused, data informed, best practice activity guided by the Directorate Reference Group. The aim, consistent with "Rising to the Challenge", being effective resource utilization, improving integration across services, increasing access, cementing resilience and recovery gains, and well supported knowledgeable workforce.

DISABILITY SUPPORT SERVICES

The key priorities for DSS in the 2014/15 year were:

- Continuing the development of a new culture within the service.
- Continuing the development of service provision in line with Government strategies.
- Maintaining financial viability.
- Embedding the new management structure.
- Training of all staff to better meet the needs of the people we support.

The annual work plan for the year was divided into four performance/work areas:

- *Person centred:* The people we support are at the centre of DSS service provision.
- *Staff supported:* For staff to be valued, supported and trained to achieve the best outcomes for the people we support
- *Systems:* To make DSS systems more efficient and effective
- *Financial viability:* DSS to maintain an overall 7% contribution to indirect and overhead costs.

The highlights for 2014/15 were:

- A positive behaviour support training package has been developed for staff so that a person centred support approach can be taken for people who communicate through challenging behaviour. This approach is also proving to be a major contributor to the redevelopment of the new culture within the service.

- The customer survey has been redeveloped. Once staff have been selected they will be trained in its use and then we will commence using the new survey tool.
- The follow up external review of culture within DSS has been completed. It acknowledged that all previous recommendations have been implemented and that progress has been made. However the review found that we still have some way to go. 28 recommendations were made to help DSS achieve the right culture.
- DSS met and exceeded its target to maintain financial viability.
- A District Health Board staff survey was completed which also identified that DSS was making good progress towards making DSS a good place for staff to work. A work programme is being developed to ensure that the areas needing the most work are focussed on.
- Computers are installed in the houses to allow more efficient and effective systems (payroll, incident reporting, communication). The first wave of training is due to be completed by the end of September 2015.
- Despite the loss of some of the people we support through natural attrition, we have had sufficient referrals to keep our overall occupancy at 96% - 97%. This has allowed us to meet our financial targets.
- A review of staff rosters has been completed and initial consultation with staff has been completed. The accepted recommendations will be implemented over the 2015/16 financial year.
- The new senior management team is in place and having a very positive impact on services.
- The PDSS review has taken place and there is an action plan in place.
- Monthly combined Team Leader forum has been reconfigured to ensure an opportunity to value and empower Team Leaders through offering an inclusive, safe environment.
- Opportunities are developing to work with private property investors to "future proof" residential property options.
- Laying the groundwork to build on new service models – active model, social model.
- The Health and Safety Committee has a full contingent of Reps who are currently being trained.
- The first issue of the DSS newsletter has been released.
- Regular meetings have been established with both Rescare and the Unions.
- Development of the 2015/16 Work Plan in an easy read format.
- The transport project is making progress towards stream-lining usage of vehicles to ensure better sharing of vehicles.

INFORMATION TECHNOLOGY AND INFRASTRUCTURE

Information Technology

During the year two regional technology initiatives were initiated to modernise our core hospital management and clinical record platforms. The Patient Information and Care System (PICS) project was approved and the project was established. The PICS project will provide a regional patient management platform across the South Island and Nelson Marlborough will be the second release onto the platform, which is due to go live at Nelson Marlborough in November 2016. The Health Connect South (HCS) project was also approved and implementation was well underway by the end of the financial year. We anticipate that Health Connect South will go live at Nelson Marlborough in December 2015. Both of these initiatives are core to replacing beyond end of life, legacy applications and provide core infrastructure that supports our region's strategic priorities.

The first stage of the electronic referrals management system, ERMS, was also implemented at Nelson Marlborough, and 90% of referrals from general practice are now transmitted electronically. Work is underway to establish a case for the implementation of the next phases of this project which will eventually see referrals received, triaged and managed electronically.

During the year, Nelson Marlborough developed a technology strategy. The strategy focuses on systematically replacing paper-based processes with electronic processes over the next 5 years and will then shift its focus to systematically digitising all patient care related data capture and transactional processing with the intention of becoming a digital hospital and a digital local health system. A number of initiatives have subsequently been approved in the capital plan to initiate the strategy. These initiatives will start us on our journey towards paper-lite and will further inform our detailed plan for the remainder of the initial five year paper-lite programme.

Hospital Facilities

During the year a detailed design was completed for the strengthening of our Arthur Wicks building at Wairau hospital and to improve the layout of the 1st floor of the building. We are currently in the process of tendering the construction work and anticipate that strengthening work will be underway by January of 2016, with a completion date of 6-8 months from there. We also received detailed earthquake assessments for our other main hospital buildings – the George Manson Building and the Percy Brunette Building in Nelson. These assessments will be incorporated into our planning for the re-development of the Nelson Hospital site. We anticipate commencing the Treasury Better Business Case process for re-developing the Nelson Hospital site in early 2016.

Work is underway to complete a proposal for the replacement of the primary boiler and its controllers at the Nelson site. The existing boiler is more than 30 years old. As well as managing risks associated with the reliability of the existing boilers, the replacement boiler will also consume less fuel.

A multi-year motor vehicle replacement programme was agreed to by the Board. The programme will allow us to systematically reduce the age of our fleet to six years or below within the next six years. The first year of the programme has seen the 30 oldest of an approximate fleet of 200 cars and vans replaced with new Toyota vehicles using the price advantage provided to us by the All of Government agreement with Toyota.

Our people

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

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/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 the DHB.

STAFF ENGAGEMENT

A Staff Engagement Survey has recently been undertaken within NMDHB. The information provided in this survey has helped to identify what is important to the people working at NMDHB, highlight where areas of concern are and where we can improve. It also identified the things we do well.

Following the results of the survey, the Chief Executive and the Board have 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.

This work is to commence with some urgency and accordingly, the CE has allocated each of these issues to a nominated ELT member to address, with the outcome communicated to staff in due course.

The results of this survey were also presented to the staff via the CE staff forums in July 2015 and are also available to staff via the NMDHB Intranet. Unions were also provided with the information. The results also align with some action points identified in the Workforce Plan.

WORKFORCE DEVELOPMENT

In late 2014, a Workforce Planning Group was initiated, bringing together a representative working group from all disciplines across the primary and secondary health workforce in Nelson Marlborough District Health Board and the Primary Health Organisation. The group was tasked with developing a whole of service Workforce Strategy and Action Plan for the Nelson Marlborough District Wide Health & Disability Service.

As an outcome of the workshops, a total of 9 strategies were identified (each with a number of actions attached to them) and these have been allocated to an Executive Sponsor.

The implementation of the Workforce Plan's nine strategies and the individual action points identified under each strategy will be undertaken in three phases. This will be staged over a period of three years effective from 1 July 2015, with the final phase to be completed by 30 June 2018. Stage one of the Action Plan is to be completed in the 2015/16 financial year.

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

NMDHB is committed to ensuring the health, safety and wellbeing of workers, contracted services and volunteers who work on or visit an NMDHB owned or operated site. NMDHB also have responsibilities to patients, service users and others.

The NMDHB Workplace Health, Safety and 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

Over the last 18 months there has been increased interest and exposure of the Health, Safety and Wellbeing of NMDHB workers. 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 and Safety at Work HSW 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 Workplace Health and Safety Management System.

GOOD EMPLOYER

A key value of Nelson Marlborough District Health Board 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 Maori.
- 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

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

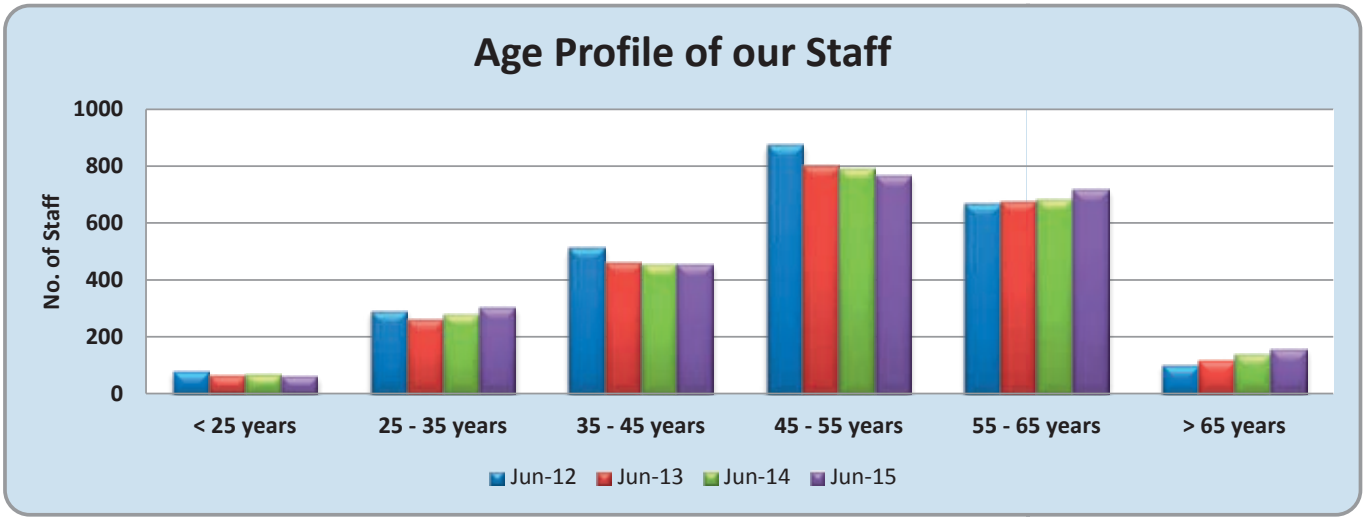
Training and Development opportunities are offered to all staff, and personal performance and development plans are a mandatory requirement for all employees.

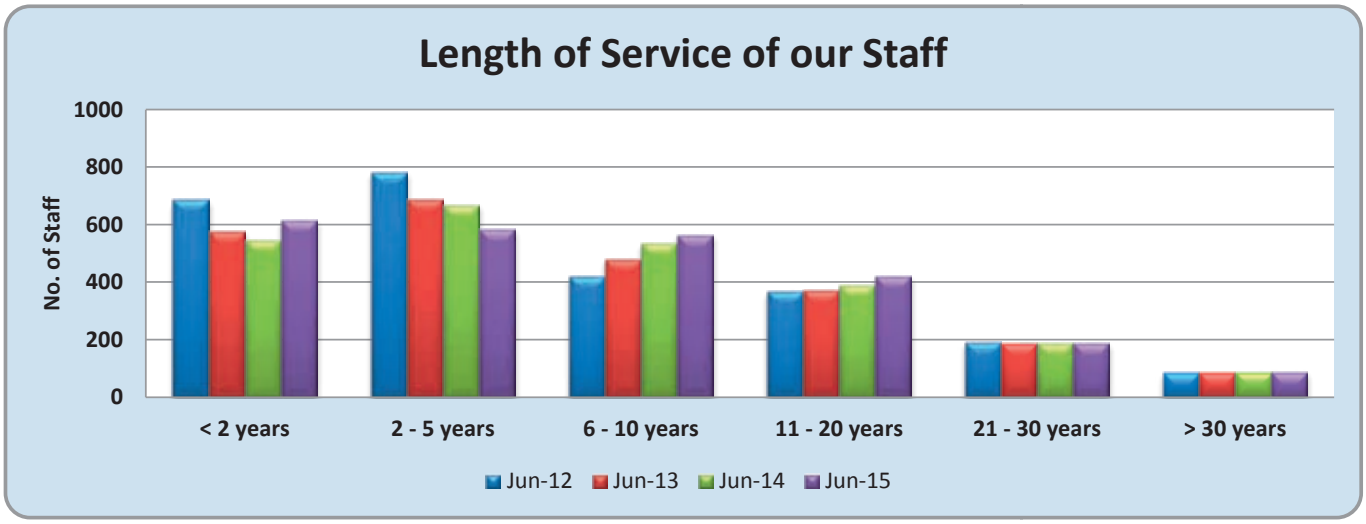
WORKFORCE PROFILE

The following provides a profile of the Nelson Marlborough DHB workforce.

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

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


Age Profile of our Staff
No. of Staff
1000
800
600
400
200
0
< 25 years
25 - 35 years
35 - 45 years
45 - 55 years
55 - 65 years
> 65 years
Jun-12
Jun-13
Jun-14
Jun-15


Length of Service of our Staff
No. of Staff
1000
800
600
400
200
0
< 2 years
2 - 5 years
6 - 10 years
11 - 20 years
21 - 30 years
> 30 years
Jun-12
Jun-13
Jun-14
Jun-15

EMPLOYEE REMUNERATION

The number of employees earning more than $100,000 is detailed in the table below. Of the 215 employees shown, 181 are or were medical, dental, nursing or allied health employees (2013/14: 177).

Salary Band ($000)	2014	2015
100 – 110	29	49
110 – 120	34	16
120 – 130	8	13
130 – 140	7	9
140 – 150	1	7
150 – 160	6	6
160 – 170	3	5
170 – 180	10	5
180 – 190	9	5
190 – 200	4	6
200 – 210	5	2
210 – 220	16	5
220 – 230	6	13
230 – 240	6	7
240 – 250	8	7
250 – 260	12	16
260 – 270	9	8
270 – 280	4	7
280 – 290	9	8
290 – 300	4	5
300 – 310	6	3
310 – 320	2	3
320 – 330	1	3
330 – 340	3	2
340 – 350	3	2
350 – 360	0	1
360 – 370	0	0
370 – 380	0	1
380 – 390	2	0
390 – 400	0	0
400 – 410	1	1
Total	**217**	**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 $115,923 to 7 employees (2013/14: 23 payments totalling $768,990).

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 judgements 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 20 June 2015 fairly reflect the financial position and operations of the Nelson Marlborough District Health Board.

Jenny Black
Board Chair

Alan Hinton
Board Member

Chris Fleming
Chief Executive

Eric Sinclair
GM Finance and Performance

Statement of service performance

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 of 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:

●	Achieved
●	Partially Achieved
●	Not Achieved

In this report we have also separately shown the performance of the DHB against the six health targets identified by the Government and for which the results are reported publicly each quarter. Our DHB's performance is shown on the following page.

The 2014/15 Vote Health Estimates of Appropriations noted that performance information for selected Non-departmental Appropriations (Health Workforce Training and Development, National Child health Services, National Contracted Services, National Disability Support Services, National Elective Services, National Emergency Services, National Health Information Systems, National Maternity Services, National Mental health Services, National Personal Health Services, and Primary Health Care Strategy) would be reported in part through DHBs 2014/15 Annual Reports. The Ministry of Health has advised DHBs that the Minister of Health will report this information instead of DHBs. Readers wishing to view the overall budget and performance information for these selected Non-departmental Appropriations will be able to refer to the Minister of Health's 2014/15 Vote Health Non-Departmental Expenditure report. This report will be made available on the Ministry of Health's website.

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.

On 1 October 2014 the Shorter Waits For Cancer Treatment health target was replaced by the Faster Cancer Treatment target. No DHB is yet to reach the 85% target for the Faster Cancer Treatment measure.

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	97% ✓	97% ✓	96% ✓	96% ✓
Improved access to Elective Surgery	The national volume of elective surgery by at least 4000 discharges per year	105% ✓	103% ✓	104% ✓	104% ✓
Shorter waits for Cancer Treatment	All patients, ready for treatment, will wait less than four weeks for radiotherapy or chemotherapy	100% ✓			
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		70%	71%	68%
Increased Immunisation	95% of 8-month-olds have their primary course of immunisation at 6 weeks, 3 months and 5 months on time	88%	92%	89%	90%
Better help for Smokers to Quit	95% of patients who smoke and are seen by a health practitioner in public hospitals, and 90% of patients who smoke and are seen by a health practitioner in primary care, are offered brief advice and support to quit smoking	97% ✓ 87%	96% ✓ 97% ✓	98% ✓ 100% ✓	98% ✓ 103%*1 ✓
More Heart and Diabetes Checks	90% of the eligible population will have had their cardiovascular risk assessed in the last 5 years	82%	85%	88%	89%

*1 The performance in quarter 4 for the primary care better help for smokers to quit is higher than 100% because in addition to offering advice in primary care settings, patients were contacted who had not recently attended their general practice to offer them brief advice and support to quit smoking.

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 morbidity 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. It has been estimated that 70% of health funding is spent on long-term conditions . Two in every three New Zealand adults have been diagnosed with at least one long-term condition and long-term conditions are the leading driver of health inequalities . A majority of chronic conditions are preventable or could be better managed . Tobacco smoking, inactivity, poor nutrition, and rising obesity rates are major and common contributors to a number of the most prevalent long-term conditions and are avoidable risk factors, preventable through a supportive environment, improved awareness and personal responsibility for health and wellbeing.

These prevention services also support people to address any risk factors that contribute to both acute events (e.g. alcohol-related injury) long-term conditions development (e.g. obesity, diabetes). High health need and at-risk population groups (low socio-economic, Maori, and Pacific) 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. These services also ensure that threats to the health of the community such as communicable disease, water quality, imported disease-carrying pests, are detected early and prevented, and ensure our ability to respond to emergency events such as pandemics or earthquakes.

Performance measures

	PERFORMANCE MEASURES	CODE	2012/13	2013/14	2014/15	TARGET	TREND	PERFOR-MANCE
HEALTH PROMOTION AND EDUCATION SERVICES	No of health impact assessments/submissions	V	5	9	8	5	↓	●
	% hospitalised smokers given advice	C	95	95	98	95	↑	●
	% smokers given advice in primary care	C	48	75	100	90	↑	●
	% babies breastfed at 3 months old	C	63	62	62	65	↔	●
	Family Violence IP responsiveness audit - child abuse	Q	81	91	90	90	↓	●
	Family Violence IP responsiveness audit - partner abuse	Q	80	82	84	85	↑	●
	% of DHB services implementing child protection policies	Q	na	na	100	100	↓	●

	PERFORMANCE MEASURES		CODE	2012/13	2013/14	2014/15	TARGET	TREND	PERFOR-MANCE
STATUTORY REGULATION	No of Public health risk management plans - drinking water		V	11	11	10	10	↓	●
	No of Mosquito surveillance visits		V	586	631	555	507	↓	●
	Controlled purchase operations: sale of tobacco to minors		V	89	61	93	90	↑	●
	Smokefree environment audits of retailer compliance		V Q	141	115	139	140	↑	●
	Controlled purchase operations: sale of alcohol to minors		V	60	172	166	160	↓	●
	% of reported communicable disease followed up		Q	60	92	100	100	↑	●

	PERFORMANCE MEASURES		CODE	2012/13	2013/14	2014/15	TARGET	TREND	PERFOR-MANCE
POPULATION BASED SCREENING SERVICEST	% Enrolled women 20-69 having a cervical smear within the last three years	Marlborough	C	75	78	79	80	↑	●
		Nelson	C	83	85	86	80	↑	●
	% High needs women having had a cervical smear within the last three years	Marlborough	C	69	72	73	80	↑	●
		Nelson	C	80	81	82	80	↑	●
	% Enrolled high needs women having mammography within two years	Marlborough	C	72	72	80	>70	↑	●
		Nelson	C	78	76	80	>70	↑	●
	% Newborn hearing screening consents		C	100	95	99	95	↑	●
	% Newborn screening completed within one month of birth		T Q	95	95	94	95	↓	●
IMMUNISATION	% Two year olds fully vaccinated		C	87	88	93	95	↑	●
	% babies fully vaccinated at eight months		C	87	90	90	95	↔	●
	% Schools with vaccination programmes for year 7&8 children		V	100	100	100	100	↔	●
	% Over 65s vacinated for seasonal influenza	Marlborough	C	59	64	62	75	↓	●
		Nelson	C	67	70	68	75	↓	●
TAMARIKI ORA	No of Before (B4) School checks delivered		V	1,492	1,637	1,563	1,533	↓	●
	% eligible children receiving B4 School checks		C	83	102	102	90	↔	●
	No of B4 School checks - high deprivation		V	140	113	159	158	↑	●
MENTAL HEALTH	Parent and or student resilience sessions delivered in schools		V	na	na	15	6		●
	No of rural Mental Health promotion seminars delivered		V	na	na	8	3		●
	Mental Health Awareness week promotions delivered		T	na	na	3	unspecified		●

Commentary

Overall performance in the Prevention Services output class has been with most measures achieved. Comment on significant variances within each of the components within this output class follows:

Health promotion and education

- The performance on the smoking advice continues to significantly exceed the targets. The benefits for smoking cessation are well documented and it is pleasing that all general practise now have robust systems to achieve this target along with the continued performance in the hospital inpatient setting.
- The DHB has a highly efficient Public Health team who have continued to exceed the target for submissions and health impact assessments. The team responds to local demand as necessary.

Population based screening

- The targets for mammography screening in both Nelson and Marlborough continue to exceed the target with pleasing numbers attending screening. The establishment of Te Piki Oranga has assisted in targeting high needs patients and the DHB is pleased with the improvements in equitable access being achieved.

Immunisation services

- The immunisation targets are generally not being achieved despite more effort being placed on this area. We are continuing to work with our PHO partners to meet the targets.
- There was a late start to the influenza vaccination season due to the late arrival of the vaccine. Due to this the vaccinations were given later in the year and the season was extended so the full results will not be known until the first quarter results for 2015/16 are produced.

Financial performance

	Budget 2015 $000	Actual 2015 $000	Actual 2014 $000
Revenue	**7,548**	**7,877**	**7,448**
Expenditure			
Workforce costs	4,036	3,679	3,419
Other operating costs	962	985	1,001
External providers and inter district fows	1,860	2,284	2,320
Total expenditure	**6,858**	**6,948**	**6,740**
Total surplus/(deficit)	**690**	**929**	**708**

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
- Maori 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 prevalence rate of long-term conditions such as diabetes and cardiovascular disease, and some population groups suffer from these conditions more than others, for example, Maori and Pacific people, older people and those on lower incomes. The health system is also experiencing increasing demand for acute and urgent care services. For NMDHB, cancer, respiratory disease, chronic pain, and dementia are significant long-term conditions that are prevalent in our population. Early detection and management services based in the community deliver earlier identification of risk, provide 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	2012/13	2013/14	2014/15	TARGET	TREND	PERFOR-MANCE
PRIMARY HEALTH	% of people in the disrict enrolled with PHO	Nelson	C	99	99	98	>99	↓	🟡
		Marlborough	C	93	98	96	>96	↓	🟡
	ASH rates (avoidable hospital admissions) children 0-4 years		Q	92	79	80	93	↑	🔴
	% of newborns PHO enrolled by four weeks of age		T	60	72	78	95	↑	🔴
ORAL HEALTH	No of children <5 years enrolled in DHB funded dental services		C	5,054	6,103	6,745	6,816	↑	🟡
	% of children caries free at 5yrs		Q	64	55	61	60	↑	🟢
	Decayed, Missing, Filled Teeth (DMFT) score at year 8		Q	0.9	1.0	0.9	1.0	↓	🟡
	Use of adolescent oral health services % year 9 to Age 17		C	85	85	79	85	↓	🔴

	PERFORMANCE MEASURES	CODE	2012/13	2013/14	2014/15	TARGET	TREND	PERFOR-MANCE
COMMUNITY PROGRAMMES	No of patients receiving asthma/COPD services - Nelson	V	362	381	310	443	↓	🔴
	No of patients receiving asthma/COPD services - Marlborough	V	87	121	190	156	↑	🟢
	No of patients receiving non-malignant pain services - Nelson	V	na	115	68	200	↓	🔴
	No of patients receiving non-malignant pain services - Marlborough	V	na	121	53	100	↓	🔴
	% of patients having a CVD assessment in the last five years	V	57.3	77.8	89.2	90.0	↑	🟡

	PERFORMANCE MEASURES	CODE	2012/13	2013/14	2014/15	TARGET	TREND	PERFOR-MANCE
PHARMACY SERVICES	% of patients whose medicines are reconciled within 24 hrs of admission, transfer or discharge	V Q	27	27	28	40	↑	🔴
	Standardised % rate of patients with long term conditions (LTC) registered with community pharmacists for the LTC programme	V Q	na	na		90		🔴
	No of prescribing errors by hopital practitioners on community prescriptions	Q	1,160	1,259	1,048	<1000	↓	🟡
	No of community pharmacies delivering anticoagulant management services (CPAMS)	V C	2	na	7	6	↓	🟢
INFECTION CONTROL	No of norovirus and /or MRSA outbreaks	Q	1	0	1	0	↑	🟡
	Episodes of patient infection involving 2 or more patients with the same micro-organism in the same time period and linked by location or procedure	Q	0	0	0	0	↔	🟢
	No of positive blood tests for hospital aquired infections	Q	16	18	18	0	↔	🔴
	% of infected wounds within 90 days of selected surgical procedures	Q	1.4	1.7	1.1	<4	↓	🟢
	Hand hygiene compliance rates	Q	na	69.7%	79.7%	75.0%	↑	🟢
PRIMARY MENTAL HEALTH	No of extended GP consultations and care packages available	V	1,567	2,642	3,249	2,100	↑	🟢
	% PMHI extended GP consults and care packages accessed by young people 12-19 yrs	Q	na	11	15	15	↑	🟢
	No of young people supported by primary youth intensive AOD service	V	na	29	31	30	↑	🟢
COMMUNITY REFERRED TESTING AND DIAGNOSTICS	No of medical laboratory diagnostic tests	V	1,245,666	1,091,335	1,012,532	1,208,128	↓	🟡
	No of medical imaging examinations	V	89,305	87,087	145,076	91,086	↑	🟢
	% of urgent patients seen within target waiting time (24hrs) for medical imaging	T	100	100	85	98	↓	🔴
	% routine laboratory test results available to referers within 48 hours from time of receipt	T C	88	100	98	85	↓	🟢
	% of medical imaging reports meeting 14 day availability to referer	T	95	100	80	100	↓	🔴
	% of urgent lab tests completed within 3hrs of receipt of sample	T	85	90	93	90	↑	🟢

Commentary

We note significant performance improvement in many of the metrics for this output class, with primary health, oral health and community programmes recording noteworthy momentum and progress toward better overall achievement. It is expected that further progress and achievement will be facilitated in the 2015/16 year, as the Top of the South Health Alliance imbeds systems and processes across primary care and district wide. Comment on significant variances within each of the components within this output class follows:

Primary health

- Three recent initiatives should start beginning to have an impact on the 0-4 year ASH rate: early enrolment in the Community Oral Health Service and hiring of Oral Health Educators; work within the Top of the South Health Alliance has lead to a newborn enrolment initiative which sees newborns connected with general practice from the first weeks of life; and free after hours funding for under sixes was implemented later in 2012. These initiatives have some lead time before influencing ASH rates, but should start influencing the rates going forward.
- There is a disparity between the 'official' result recorded by the Ministry of Health shown for the percentage of newborns enrolled with a PHO by four weeks of age and the data held by our PHO partners. This appears to be caused by a coding issue and work is continuing to try to resolve this. The DHB has chosen to report the MOH figures. Initiatives to improve newborn enrolment have been implemented in the year, but take some time to fully bed in.

Oral health

- Oral health targets are set on a calendar year rather than the financial year given this best fits within the school age population covered by this target. The target set is the target for the 2014 calendar year which was missed by a small margin. The target for the number of children enrolled for the 2015 calendar year is 7,242.

Community programmes

- The number of patients receiving asthma/COPD services was not achieved in Nelson but over achieved in Marlborough. The over achievement in Marlborough is very pleasing with the high demand for services being acknowledged and prioritised by Kimi Hauroa Wairau. The Nelson under delivery has reduced from the previous year, where it was trending upwards, due to a decline in referrals for the service along with some resource constraints that occurred during the year.
- The target for the number of patients receiving non-malignant pain services has not been achieved in Nelson or Marlborough which is disappointing. In Nelson, a focus has been on developing GP capacity to manage pain within the medical home. Now over 60% of referrals are maintained with the General Practice after assessment but with support from the pain multidisciplinary team. However, Marlborough has seen a significant drop in referral numbers from General Practice. This appears to have arisen from the higher needs and longer term patients referred but the service hasn't been considered for those who have had chronic pain for shorter periods at risk of longer term pain. Work to encourage these referrals is being undertaken. There has also been a high number (34%) of patients who have declined referral as they don't want the non-medical model or commitments have meant they could not attend. Work is being done around understanding how to cater for these patients. There are a significant number engaged in the programme that have yet completed it.

Pharmacy services

- The percentage of patients who have their medicines reconciled within 24 hours of admission, transfer or discharge has risen marginally from the previous year however it fell well below the target set. The DHB has prioritised additional pharmacy technician resource in the 2015/16 year with the intent to increase our performance against this target.

» The results for the standardised percentage rate of patients with long term conditions were compiled by our shared service agency, but capacity and priority issues has meant that they will are no longer able to report this information. Although NMDHB has found this measure a useful understanding of whether the appropriate cohort are being serviced by the programme, we are now moving to enhance our understanding through raw numbers and history of enrolment.

Infection control

» Hospital-acquired bloodstream infections are defined as a positive blood culture result where the blood sample was taken at least 48 hours after admission. There may a number of contributing factors including patient co-morbidity and immunosuppression. NMDHB follows best-practice guidelines for insertion and maintenance of invasive devices to minimise the risk of bloodstream infections resulting from healthcare intervention. All hospital-acquired bloodstream infections are investigated by the infection prevention service and the source of infection is identified in conjunction with the treating medical team. Whilst the DHB has set a target of zero for and we aim to achieve that, it is reasonable to expect that some hospital-acquired bloodstream infections will occur.

Community referred testing and diagnostics

» The Clinical Laboratory Oversight Group has ben tasked with a gate-keeping role over the appropriateness of all laboratory testing. This gate-keeping role is attributed to why the target for the number of laboratory diagnostic tests completed was significantly lower than the target.

» 100% of urgent inpatient referrals for medical imaging were seen within target time. However, urgent community referrals are not always triaged to be seen within 24 hours. The service has been limited by radiologist vacancies which the DHB continues to recruit. The new MRI scanner installed in Wairau in June 2015, has eased the situation considerably, however recruiting to vacant positions remains a key issue to meet the target in the future.

» The vacant radiologist positions in Nelson also impacted the DHB's ability to meet the percentage of medical imaging reports being available within 14 days.

Financial performance

	Budget 2015 $000	Actual 2015 $000	Actual 2014 $000
Revenue	**114,505**	**115,006**	**111,870**
Expenditure			
Workforce costs	21,084	19,870	20,444
Other operating costs	9,027	7,991	9,105
External providers and inter district fows	82,892	83,033	81,467
Total expenditure	**113,003**	**110,894**	**111,016**
Total surplus/(deficit)	**1,502**	**4,112**	**854**

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 health care 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, NMDHB provides an extensive range of intensive treatment and complex specialist services to our population. NMDHB 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 and timely access to intensive assessment and treatment can significantly improve people's quality of life, either through early intervention (i.e. removal of an obstructed gallbladder to prevent repeat attacks of abdominal pain/ colic, increased risk of cancer and/or infection) or through corrective action (i.e. major joint replacements to relieve pain and improve activity). Flexible and responsive assessment and treatment services also support improvements across the whole system, enabling people to be supported in the community with 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. Adverse events in hospital, 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 the number of events causing injury, and provide improved outcomes for people in our services. There are expectations for the delivery of increased elective surgical volumes, a reduction in waiting times for treatments, and increased clinical leadership around improving service delivery and safety to improve the quality and efficiency of care being delivered. The changes being made to meet expectations are providing opportunities to introduce innovative clinically led service delivery models and improve productivity within our hospital services.

Performance measures

	PERFORMANCE MEASURES	CODE	2012/13	2013/14	2014/15	TARGET	TREND	PERFOR-MANCE
PATIENT SAFETY	% of recommendations on serious and sentinel events implemented within agreed timeframe	Q T	100	100	100	100	↔	🟢
	% of complaints closed within 20 days	Q	87	84	79	100	↓	🔴
	No of patient falls per 1000 inpatient bed days	Q V	0.006	0.008	0.005	0.007	↓	🟢
SCHEDULED SERVICES	Total elective caseweight (CWD) discharges	V	9,092	8,400	7,303	7,400	↓	🟡
	No of elective surgical discharges	V	6,054	6,197	6,254	6,029	↑	🟢
	% of elective and arranged surgery undertaken as day care cases	Q	67.0	67.1	65.4	60.5	↓	🟢
	% of people receiving elective and arranged surgery on day of admission	Q	96	97	97	97	↑	🟢
	Elective and arranged inpatient average length of stay (days)	Q	2.84	2.86	2.85	3.10	↓	🟢
UNSCHEDULED SERVICES	No of people presenting at ED (emergency departments)	V	45,419	47,802	47,338	<35,000	↓	🔴
	% of people assessed, treated or dishcarged from ED within 6hrs	T	97	96	96	95	↑	🟢
	Acute inpatient average length of stay (days)	Q	3.48	3.50	3.57	3.47	↑	🟡
	% of people receiving cancer treatment within 4 weeks of decision to treat	T	100	100	100	100	↔	🟢
	Acute readmissions to hospital within 30 days	Q	9.7	6.8	7.5	7.0	↑	🟡
	Acute readmissions to hospital within 30 days - 75 yrs and over	Q	13.7	9.4	10.3	10.3	↑	🟢

	PERFORMANCE MEASURES	CODE	2012/13	2013/14	2014/15	TARGET	TREND	PERFOR-MANCE
MATERNITY SERVICES	No of maternity deliveries in the NMDHB district	V	1,413	1,544	1,500	est.1,600	↓	🟡
	% of total deliveries in primary birthing units	Q V	4.3	3.7	7.0	7.0	↑	🟢
	Average postnatal length of stay (days)	V	2.0	2.2	2.4	2.0	↑	🟡
	Average postnatal length of stay (days) - cesarean delivery	V	3.9	4.2	4.0	4.0	↓	🟢
	% newborn babies fully breastfed on discharge from facility	Q V	84	87	89	84	↑	🟢
	Perinatal infant mortality rate per 1,000 births		6.03	7.92	4.2	8	↓	🟢
	Maternal mortality rate per 100,000 live births		0	1	0	1	↓	🟢
ASSESSMENT, TREATMENT & REHABILITATION	No of people (65+) accessing inpatient AT&R services	V	9,489	8,897	7,738	9,000	↓	🔴
	No of packages of community rehabilitation directed/delivered by AT&R	V	3,186	2,549	1,838	2,064	↓	🔴
	% of AT&R patients (65+) discharged into their own homes	Q	56	65	62	65	↓	🟡
	% AT&R patients (65+) discharged back to their original setting	Q	56	65	69	64	↑	🟢

Commentary

The results for the Intensive Assessment and Treatment Services output class are pleasing with most measures either achieved or partially achieved. Comment on significant variances within each of the components within this output class follows:

Patient safety

» The DHB is working hard to triage and clear the backlog of complaints as quickly as possible, and anticipate that once additional administrative support is in place in 2015/16 that this will create the capacity to respond more quickly and efficiently to complaints.

Unscheduled services

» On review the target set for emergency department attendances was too ambitious and was not appropriately managed and resourced. The DHB has put in place a specific project to target Wairau emergency department attendances in 2015/16 and has allocated budget to work to achieve a reduction.

Assessment, treatment and rehabilitation

» The measure reporting the number of people over 65 years of age accessing inpatient AT&R services does not necessarily portray the result intended. In 2013/14 the DHB showed the number of bed days utilised rather than the number of patients and inadvertently carried this through to the target set. Bed days utilised is a more accurate portrayal of the service performance. If the 2014/15 results were on bed days then the actual result would show 8,663 bed days were utilised.

» The number of packages of community rehabilitation delivered/directed by the AT&R service is significantly lower than the target. This has resulted in difficulties in attracting suitable applicants for the clinical teams, particularly in Wairau. The DHB is continuing to explore ways to recruit to these teams and enhance the community rehabilitation programme.

Financial performance

	Budget 2015 $000	Actual 2015 $000	Actual 2014 $000
Revenue	**226,890**	**228,877**	**222,735**
Expenditure			
Workforce costs	115,312	115,071	111,386
Other operating costs	71,116	76,369	72,569
External providers and inter district fows	40,527	41,025	37,997
Total expenditure	**226,955**	**232,465**	**221,952**
Total surplus/(deficit)	**(65)**	**(3,588)**	**783**

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 of staying 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, or maintaining full health is not possible, timely access to responsive support services enables people to maximise function with the greatest 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. Effective and responsive delivery of support services will help to reduce demand for acute services and improve access to other services and interventions. It will also free up resources for investment into early intervention, health promotion and prevention services that will help people stay healthier for longer. NMDHB has taken a restorative approach and has introduced individual packages of care to better meet people's needs, including complex packages of care for people assessed as eligible for residential care who would rather remain in their own homes. With an ageing population, it is vital that we ascertain the effectiveness of services in this area and that NMDHB uses 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	2012/13	2013/14	2014/15	TARGET	TREND	PERFORMANCE
PALLIATIVE CARE	No of hospice patients receiving service according to service specification (National Service Framework)	V T	458	423	754	670	↑	●
	No of primary and secondary facilities receiving palliative care education	V T	39	35	35	92	↔	●
	No of hospice inpatients Nelson and Blenheim	V	505	524	523	520	↓	●

	PERFORMANCE MEASURES	CODE	2012/13	2013/14	2014/15	TARGET	TREND	PERFOR-MANCE
NEEDS ASSESSMENT AND SUPPORT SERVICES	% of older people living in ARRC	C	7	7	4	7	↓	●
	Total number of respite care bed days allocated/ used	V	4825/2581	5075/3100	5667/3570	4900/3350	↑	●
	Total number of carer support allocated/used	T	6399/4811	6857/3690	6917/3131	6450/5050	↑	●
	% Client satisfaction survey rating >95%	Q	97	na	100	>97	↓	●
	Total number of funded ARRC bed nights	V	362,683	357,700	364,423	365,000	↑	●
	Total number of clients receiving home based support services	V	2,614	2,552	2,447	2,883	↓	●
	% NASC response time to assessment within 14 working days	T	88	90	99	>80	↑	●
	% of audited InterRAI care plans meet the assessed needs of the client	Q	na	na	100	95	↓	●

	PERFORMANCE MEASURES	CODE	2012/13	2013/14	2014/15	TARGET	TREND	PERFOR-MANCE
COMMUNITY MENTAL HEALTH OLDER PERSONS	% Increase in overall service satisfaction in the National Consumer Satisfaction survey	Q	80	78	100	>80	↑	●
	No of completed needs assessments for those with complex needs	V			344	>200		●
COMMUNITY SUPPORT SERVICES MENTAL HEALTH	No of training sessions provided to primary care and /or ARRC providers (Walking in anothers shoes and Community Liason)	Q V	na	41	28	24	↓	●
	No of liaison contacts - one to one advice/ education with primary care and/or ARRC providers	Q V	na	904	882	550	↓	●
GERIATRIC AT&R	No of group education sessions provided to primary care and/or ARRC providers	Q V	na	61	24	10	↓	●
	Specialist Nursing Education in ARRC - FTE	V	0.8	na	1.4	1.4		●

Commentary

Performance within the Rehabilitation and Support Services output class is very pleasing with all but one measures successfully achieved or partially achieved. Comment on significant variances within each of the components within this output class follows:

Palliative care

» Palliative education has not increased as expected and will form an important part of the business case as a bid for the new MOH funding in 2015/16. The increased volume for palliative care also has an impact on the ability to provide education.

Needs assessment and support services

» Although the percentage of people living in ARRC is lower than target this is expected to rise in the coming years. The result for 2014/15 reflects the wider strategy to support people to live within their own homes.

» The number of respite beds is client demand driven. The number of bed days allocated relates to the overall strategy of keeping clients supported in the community for as long as possible. The allocation is often high as "emergency allocation" is used as a principle, i.e. if the main carer becomes unwell

the client can go into respite without delay. Over the winter months respite beds were used to support lower acuity patients who required some further care while the hospital was full.

» Like respite beds, carer support is also demand driven. Allocation usage relates to the overall strategy of supporting patients to live at home safely and with supported carers. This strategy reduces the volume of patients entering ARRC. The responsibility of finding a carer to take on the responsibility for the nominal sum can be challenging therefore it is not uncommon for the allocation to go unutilised. NMDHB has recently offered a contract specifically to find carers for people to use to avoid this scenario.

» The percentage of NASC response times has continued to improve as more efficient processes have been developed to ensure response times are exceeded.

Community support services

» Staff have worked hard to provide a number of training sessions and one-on-one / education sessions to ARRC providers and primary care, building close relationships which provide meaningful dialogue.

Financial performance

	Budget 2015 $000	Actual 2015 $000	Actual 2014 $000
Revenue	**90,661**	**91,494**	**92,123**
Expenditure			
Workforce costs	20,989	20,809	20,855
Other operating costs	10,679	9,983	10,439
External providers and inter district fows	59,620	60,438	58,780
Total expenditure	**91,288**	**91,230**	**90,074**
Total surplus/(deficit)	**(627)**	**264**	**2,049**

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STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSE

For the year ended 30 June 2015

	Note	Budget 2015 $000	Actual 2015 $000	Actual 2014 $000
Revenue				
Revenue	1	434,898	436,024	427,360
Interest revenue	5	1,500	2,689	2,180
Other revenue	2	3,206	4,540	4,634
Total revenue		**439,604**	**443,253**	**434,174**
Expenditure				
Personnel costs	3	161,378	159,428	156,105
Outsourced services		11,861	14,357	14,374
Clinical supplies		31,726	32,785	31,630
Infrastructure and non-clinical expenses		24,187	22,946	23,341
Payments to non-Health Board providers		184,943	186,780	180,564
Depreciation and amortisation expense	12,13	11,742	11,139	11,193
Capital charge	4	7,190	7,252	6,974
Finance costs	5	3,048	3,225	3,131
Other expenses	6	2,029	3,624	2,470
Total expenditure		**438,104**	**441,536**	**429,782**
Surplus/(Deficit)		**1,500**	**1,717**	**4,392**
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	(449)
Impairment of property assets		-	-	-
Total other comprehensive revenue or expenses		**-**	**6,239**	**(449)**
Total comprehensive revenue and expense		**1,500**	**7,956**	**3,943**

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 2015

	Note	Budget 2015 $000	Actual 2015 $000	Actual 2014 $000
Assets				
Current assets				
Cash and cash equivalents	7	16,742	43,712	45,450
Receivables	8	10,970	10,781	11,056
Inventories	9	2,048	2,703	2,171
Prepayments		411	387	328
Non-current assets held for sale	10	2,182	750	751
Total current assets		**32,353**	**58,333**	**59,756**
Non-current assets				
Prepayments		130	107	182
Financial assets	11	3	1,475	2,341
Property, plant and equipment	12	178,113	165,091	158,378
Intangible assets	13	7,278	7,182	4,693
Total non-current assets		**185,524**	**173,855**	**165,593**
Total assets		**217,877**	**232,187**	**225,349**
Liabilities				
Current liabilities				
Payables	14	24,481	28,996	27,841
Borrowings	15	6,506	6,668	8,765
Employee entitlements	16	26,534	29,643	30,895
Provisions	17	1,430	1,164	1,054
Total current liabilities		**58,951**	**66,470**	**68,556**
Non-current liabilities				
Borrowings	15	56,713	57,214	55,645
Employee entitlements	16	11,461	10,852	10,907
Total non-current liabilities		**68,174**	**68,065**	**66,552**
Total Liabilities		**127,125**	**134,536**	**135,108**
Net assets		**90,752**	**97,651**	**90,242**
Equity				
Crown equity	18	28,040	28,040	28,587
Other reserves	18	47,423	53,213	46,974
Accumulated comprehensive revenue and expense	18	15,289	16,398	14,681
Total equity		**90,752**	**97,651**	**90,242**

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 2015

	Note	Budget 2015 $000	Actual 2015 $000	Actual 2014 $000
Balance at 1 July		89,799	90,242	86,846
Total comprehensive revenue and expense for the year		1,500	7,956	3,943
Owner transactions				
Capital contribution		-	-	-
Repayment of capital		(547)	(547)	(547)
Balance at 30 June	**18**	**90,752**	**97,651**	**90,242**

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 2015

	Note	Budget 2015 $000	Actual 2015 $000	Actual 2014 $000
Cash flows from operating activities				
Receipts from the Ministry of Health and patients		438,385	440,792	431,621
Interest received		1,500	2,689	2,180
Payments to employees		(159,611)	(158,571)	(155,704)
Payments to suppliers		(257,399)	(260,574)	(247,476)
Capital charge		(7,475)	(7,252)	(6,974)
Interest paid		(3,048)	(3,225)	(3,131)
GST (net)		-	(534)	(184)
Net cash flow from operating activities	**19**	**12,352**	**13,325**	**20,332**
Cash flows from investing activities				
Receipts from sale of property, plant and equipment		301	183	2,065
Receipts from maturity of investments		-	-	-
Purchase of property, plant and equipment		(18,800)	(11,696)	(4,502)
Purchase of intangible assets		(5,577)	(2,474)	(1,352)
Acquisition of investments		-	-	-
Net cash flow from investing activities		**(24,076)**	**(13,987)**	**(3,789)**
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		(245)	(529)	(991)
Net cash flow from financing activities		**(792)**	**(1,076)**	**(1,538)**
Net increase/(decrease) in cash and cash equivalents		**(12,516)**	**(1,738)**	**15,005**
Cash and cash equivalents at the beginning of the year		29,258	45,450	30,445
		-	-	-
Cash and cash equivalents at the end of the year		**16,742**	**43,712**	**45,450**

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 2015

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 2015, and were approved by the Board on 27 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).

Standards Issues and not yet effective and not early adopted

In May 2013, the External Reporting Board issued a new suite of PBE accounting standards for application by public sector entities for reporting periods beginning on or after 1 July 2014. NMDHB has applied these standards in preparing the 30 June 2015 financial statements.

In October 2014, the PBE suite of accounting standards was updated to incorporate requirements and guidance for the not-for-profit sector. These updated standards apply to PBEs with reporting periods beginning on or after 1 April 2015. NMDHB will apply these updated standards in preparing its 30 June 2016 financial statements. NMDHB expects there will be minimal or no change in applying these updated accounting standards.

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 derecognition, 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:

Buildings and fitout 10 to 76 years 1.3%-10%

Plant and equipment 2 to 20 years 5%-50%

Motor vehicles 5 to 16 years 6.25%-20%

Leased assets 2 to 7.25 years 13.8%-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:

Software	3 to 10 years	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 2015

1. REVENUE

	Actual 2015 $000	Actual 2014 $000
Health and disability services (MOH contracted revenue)	415,590	407,185
Inter-district patient inflows	7,483	7,818
ACC	4,842	4,820
Patient/consumer sourced revenue	6,224	6,155
Other government and DHB's	1,884	1,383
Total revenue	**436,024**	**427,360**

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 (2014: $Nil).

2. OTHER REVENUE

	Actual 2015 $000	Actual 2014 $000
Donated property, plant and equipment	62	200
Rental revenue	1,377	1,440
Gain on disposal of property, plant and equipment	131	235
Other	2,970	2,759
Total other revenue	**4,540**	**4,634**

3. PERSONNEL COSTS

	Actual 2015 $000	Actual 2014 $000
Salaries and wages	147,349	144,959
Defined contribution plan employer contributions	4,691	4,425
Increase in employee entitlements	7,388	6,721
Total personnel costs	**159,428**	**156,105**

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 2015 was 8% (2014 8%).

5. FINANCE REVENUE AND COSTS

	Actual 2015 $000	Actual 2014 $000
Finance costs		
Interest on secured loans	2,942	2,876
Interest on finance lease	283	255
Total finance costs	**3,225**	**3,131**
Finance revenue		
Interest revenue	2,689	2,180
Total finance revenue	**2,689**	**2,180**

6. OTHER EXPENSES

	Actual 2015 $000	Actual 2014 $000
Audit fees	177	165
Donations made	-	-
Koha	0	0
Impairment of property, plant and equipment	-	-
Impairment of receivables	168	91
Loss on disposal of property, plant and equipment	2	136
Write down to Fair Value on Loans provided to Golden Bay Health Trust	866	-
Rental and operating lease costs	2,410	2,164
Restructuring expenses	-	(86)
Total other expenses	**3,624**	**2,470**

7. CASH AND CASH EQUIVALENTS

	Actual 2015 $000	Actual 2014 $000
Cash at bank and on hand	-0	7
Cash advanced to HBL	43,712	45,443
Total cash and cash equivalents	**43,712**	**45,450**

NMDHB is a party to the DHB Treasury Services Agreement between Health Benefits Limited (HBL) and participating DHBs. This agreement enables HBL to "sweep" DHB bank accounts and invest surplus funds. The agreement provides for individual DHBs to have a debit balance with HBL, which will incur interest at the credit interest rate received by HBL 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 $20M.

8. RECEIVABLES

	Actual 2015 $000	Actual 2014 $000
Gross receivables	11,239	11,443
Less: provision for impairment	(458)	(387)
Total receivables	**10,781**	**11,056**

Gross receivables comprises of:		
Receivables from the Ministry of Health	2,230	1,761
Receivables from non-related parties	1,844	3,346
Accrued revenue	7,139	6,299
Other receivables	26	38
Total gross receivables	**11,239**	**11,443**

Ageing profile of receivables

	2015		2014	
	Gross $000	Impairment $000	Gross $000	Impairment $000
Not past due	6,235	-	6,336	-
Past due 1 - 30 days	3,377	(15)	4,112	(18)
Past due 31 - 60 days	436	(10)	244	(4)
Past due 61 - 90 days	55	(6)	155	(3)
Past due over 90 days	1,136	(427)	596	(362)
Total	**11,239**	**(458)**	**11,443**	**(387)**

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

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

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

	Actual 2015 $000	Actual 2014 $000
Provision for impairment at 1 July	387	420
Additional provisions made during the year	169	91
Receivables written off during the year	(98)	(124)
Provision for impairment at 30 June	**458**	**387**

9. INVENTORIES

	Actual 2015 $000	Actual 2014 $000
Held for distribution inventories		
Pharmaceuticals	409	402
Other supplies	2,524	1,999
Provision for obsolete stock	(230)	(230)
Total inventories	**2,703**	**2,171**

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

In 2015, the value of inventories distributed and recognised as an expense in the clinical supplies expense included in the deficit was $19.1 million (2014 $17.9 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 2015 $000	Actual 2014 $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	418
Buildings	165	333
Total non-current assets being prepared for sale	**487**	**751**

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 4 properties in Nelson and Murchison which have been classified as held 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 $323,373.

11. OTHER FINANCIAL ASSETS

	Actual 2015 $000	Actual 2014 $000
Non-current Portion		
Equity investments	3	3
Loans receivable	1,472	2,338
Total non-current portion	**1,475**	**2,341**

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 2013	12,611	131,701	44,313	5,438	10,182	1,676	205,921
Additions	-	1,214	1,687	244	9,008	12,493	24,646
Revaluations	-	-	-	-	-	-	-
Disposals	(690)	(294)	(114)	(209)	(5)	(12,151)	(13,463)
Balance at 30 June 2014	**11,921**	**132,621**	**45,886**	**5,473**	**19,185**	**2,018**	**217,104**
Balance at 1 July 2014	11,921	132,621	45,886	5,473	19,185	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 Jun 2015	**11,620**	**125,532**	**51,461**	**5,685**	**19,185**	**3,511**	**216,996**
Accumulated depreciation and impairment losses							
Balance at 1 July 2013	-	5,591	30,415	3,785	8,858	-	48,649
Depreciation expense	-	5,553	3,377	422	1,058	-	10,410
Revaluations/Impairment	-	-	-	-	-	-	-
Disposals	-	(34)	(113)	(181)	(5)	-	(333)
Balance at 30 Jun 2014	**-**	**11,110**	**33,679**	**4,026**	**9,911**	**-**	**58,726**
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/Impairment	-	(16,577)	-	-	-	-	(16,577)
Disposals	-	-	-	(702)	-	-	(702)
Balance at 30 Jun 2015	**-**	**68**	**37,203**	**3,710**	**10,924**	**-**	**51,905**
Carrying Amounts							
At 1 July 2013	12,611	126,110	13,898	1,653	1,324	1,676	157,272
At 30 Jun/1 Jul 2014	11,921	121,511	12,207	1,447	9,274	2,018	158,378
At 30 June 2015	**11,620**	**125,464**	**14,258**	**1,976**	**8,261**	**3,511**	**165,091**

No impairment loss of has been recognised in 2015, (2014: 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. An 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 2015, the net carrying amount of leased IT and clinical equipment was $ 654,502 (2014: $1,075,698).

The total amount of property, plant, and equipment in the course of construction is $4.21m (2014: $2.02m).

13. INTANGIBLE ASSETS

	HBL	Acquired Software	Internally Generated Software	Total
	$000	$000	$000	$000
Movements for each class of intangible asset				
Balance at 1 July 2013	906	8,274	242	9,422
Additions	546	1,624	38	2,208
Disposals	-	(334)	-	(334)
Balance at 30 June 2014	**1,452**	**9,564**	**280**	**11,296**
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**

	HBL	Acquired Software	Internally Generated Software	Total
	$000	$000	$000	$000
Accumulated amortisation and impairment losses				
Balance at 1 July 2013		5,678	143	5,821
Amortisation expense		765	18	783
Disposals		-	-	-
Impairment losses		-		-
Balance at 30 June 2014	**-**	**6,443**	**160**	**6,604**
Balance at 1 July 2014	-	6,443	160	6,604
Amortisation expense	-	675	6	681
Disposals	-	1	-	1
Impairment losses		-	-	-
Balance at 30 June 2015	**-**	**7,120**	**166**	**7,286**
Carrying amounts				
At 1 July 2013	906	2,596	100	3,602
At 30 June / 1 July 2014	1,452	3,121	120	4,693
At 30 June 2015	**2,255**	**3,353**	**1,574**	**7,182**

Included in the Internally Generated Software additions for the year is a total of $699,000 which is work in progress.

During the year shares were purchased in Health Benefits Limited (HBL). HBL is 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.

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.

At 30 June 2015, the DHB had made payments totalling $2,255,274 (2014: $1,452,420) to HBL in relation to the FPSC Programme, which was in progress at year end. This is a national initiative facilitated by HBL. In return for these payments, the DHB gains FPSC rights. In the event of liquidation or dissolution of HBL, the DHB shall be entitled to be paid from the surplus assets, an amount equal to, the DHB's proportionate share of the liquidation value based on its proportional share of the total FPSC rights that have been issued.

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

In April 2015, all District Health Boards considered a National Case for Change which modified the scope of the FPSC Programme. This change of scope recognised two key changes:

- That the national procurement service provided by healthAlliance FPSC Ltd (a company owned by healthAlliance NZ Ltd which in turn is owned by the four northern region District Health Boards and HBL) was operational from 1 July 2014; and
- That the programme needed to complete the national financial management information system build.

In this regard the DRC of the FPSC assets was considered to equate, in all material respects, to the the costs capitalised to date such that the FPSC rights are not impaired.

No impairment losses have been recognised (2014: $Nil).

14. PAYABLES

	Actual 2015 $000	Actual 2014 $000
Payables under exchange transactions		
Creditors	3,745	5,114
Revenue in advance	735	651
Capital charge payable	-	-
Other	18,311	17,393
Total payables under exchange transactions	**22,792**	**23,158**
Payables under non-exchange transactions		
Capital charge payable	-	-
Taxes payable (GST, Employer Deductions & FBT)	5,208	3,818
Other	997	865
Total payables under non-exchange transactions	**6,205**	**4,683**
Total Payables	**28,996**	**27,841**

15. BORROWINGS

	Actual 2015 $000	Actual 2014 $000
Current portion		
NZDMO Loans	6,000	8,000
Finance leases	668	765
Total current portion	**6,668**	**8,765**
Non-current portion		
NZDMO loans	49,500	47,500
Finance leases	7,714	8,145
Total non-current portion	**57,214**	**55,645**
Total borrowings	**63,881**	**64,410**

NZDMO loans

	Actual 2015 $000	Actual 2014 $000
Loans are repayable as follows:		
Not later than one year	6,000	8,000
Later than one year and not later than five years	35,500	31,000
Later than five years	14,000	16,500
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 as at the 30/06/2015 range from 3.34% to 6.54% (2014, 4.13% - 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 $55.5m (2014, $55.5m). The term loans are not guaranteed by the Government of New Zealand.

Finance leases

	Actual 2015 $000	Actual 2014 $000
Minimum lease payments payable:		
Not later than one year	929	1,043
Later than one year and not later than five years	1,974	2,169
Later than five years	13,858	14,350
Total minimum lease payments	**16,761**	**17,562**
Future finance charges	(8,380)	(8,652)
Present value of minimum lease payments	**8,381**	**8,910**
Present value of minimum lease payments payable:		
Not later than one year	668	764
Later than one year and not later than five years	964	1,156
Later than five years	6,749	6,990
Total present value of minimum lease payments	**8,381**	**8,910**

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. As at 30 June 2015, Golden Bay Community Health Trust had an outstanding lease liability with a present value of $7,947,600 (2014 $8,187,227). 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 2015 $000	Actual 2014 $000
Current Portion		
Accrued salaries & wages	5,492	4,833
Annual leave	16,683	16,415
Sick leave	574	383
Sabbatical leave	198	196
Retirement gratuities	1,633	1,588
Long service leave	544	576
Continuing medical education	4,519	6,904
Total current portion	**29,643**	**30,895**
Non-current portion		
Sick leave	746	705
Sabbatical leave	887	1,353
Retirement gratuities	6,493	6,306
Long service leave	2,726	2,543
Total non-current portion	**10,852**	**10,907**
Total employee entitlements	**40,494**	**41,802**

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 2.97% to 5.50% (2014: 3.42% to 5.50%), with an average of 4.57% (2014: 4.85%). A salary inflation factor of 3.5% (2014: 3.5%) has been used per year. The take-up rate used for sabbatical leave is 16% (2014: 25%).

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 3.6% (2014: 4.3%). Average future salary growth has been assumed to be 3.5% per annum, plus a salary scale of 1% per annum.

17. PROVISIONS

	Actual 2015 $000	Actual 2014 $000
Current portion		
Restructuring	805	691
ACC Partnership Programme	359	363
Total current portion	**1,164**	**1,054**
Total provisions	**1,164**	**1,054**

Movements for each class of provision are as follows:

	Restructures $000	ACC $000	Total $000
Balance at 1 July 2013	1,067	363	1,430
Additional provisions made	500	-	500
Amounts used	(736)	-	(735)
Unused amounts reversed	(141)	-	(141)
Balance at 30 June 2014	**690**	**363**	**1,054**
Balance at 1 July 2014	690	363	1,054
Additional provisions made	679	(5)	674
Amounts used	(41)	-	(41)
Unused amounts reversed	(523)	-	(523)
Balance at 30 June 2015	**805**	**358**	**1,164**

Restructuring provisions

An amount of $0.04m has been released from the provision in relation to completed restructuring initiatives, and revisions to the estimated redundancy costs for initiatives not yet completed. (2014: $0.74m)

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 2015. 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 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 2.1% per annum. The discount rate used is 3.0% per annum (2014: 4.3%).

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 2015 $000	Actual 2014 $000
Crown equity		
Balance at 1 July	28,587	29,134
Capital contribution	-	-
Repayment of capital	(547)	(547)
Balance at 30 June	**28,040**	**28,587**
Accumulated surplus/(deficit)		
Balance at 1 July	14,681	10,289
Surplus/(deficit) for the year	1,717	4,392
Property revaluation reserve transfer on disposal	-	-
Balance at 30 June	**16,398**	**14,681**
Revaluation reserves		
Balance at 1 July	46,974	47,423
Revaluations	6,239	-
Impairment charge	-	-
Transfer to accumulated surplus/(deficit) on disposal	-	(449)
Balance at 30 June	**53,213**	**46,974**
Revaluation reserves consist of		
Land	8,125	8,928
Buildings	45,088	38,046
Total revaluation reserves	**53,213**	**46,974**

	Actual 2015 $000	Actual 2014 $000
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	**97,651**	**90,242**

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 2015 $000	Actual 2014 $000
Net surplus/(deficit)	1,717	4,392
Add/(less) non-cash items		
Depreciation and amortisation expense	11,139	11,193
Impairment losses	-	-
Total non-cash items	**11,139**	**11,193**
Add/(less) items classified as investing or financing activities		
Fair value movement on loans and receivables	866	-
(Gains)/losses on disposal of property, plant and equipment	(132)	(100)
Total items classified as investing or financing activities	**734**	**(100)**
Add/(less) movements in statement of financial position items		
(Increase)/Decrease in receivables	275	(86)
(Increase)/Decrease in prepayments	17	32
(Increase)/Decrease in inventories	(532)	(123)
Increase/(Decrease) in payables	859	4,666
Increase/(Decrease) in employee entitlements	(1,308)	634
Increase/(Decrease) in provisions	(110)	(376)
(Increase)/Decrease in payables relating to purchase of property, plant and equipment	534	99
Net movements in statement of financial position items	**(265)**	**4,846**
Net cash flow from operating activities	**13,325**	**20,332**

20. CAPITAL COMMITMENTS AND OPERATING LEASES

	Actual 2015 $000	Actual 2014 $000
Capital commitments		
Property, plant and equipment	1,495	1,783
Intangible assets	191	79
Total capital commitments	**1,686**	**1,862**
Non-cancellable Provider commitments		
Not later than one year	13,293	13,136
Later than one year and not later than five years	12,789	12,144
Later than five years	4,395	10,347
Total non-cancellable Provider commitments	**30,477**	**35,627**
Non-cancellable operating lease commitments		
Not later than one year	917	653
Later than one year and not later than five years	2,709	1,802
Later than five years	2,223	1,393
Total non-cancellable operating lease commitments	**5,849**	**3,848**
Non-cancellable finance lease commitments		
Not later than one year	929	1,043
Later than one year and not later than five years	1,974	2,170
Later than five years	13,858	14,350
Total non-cancellable finance lease commitments	**16,761**	**17,563**
Non-cancellable other commitments		
Not later than one year	1,559	3,681
Later than one year and not later than five years	-	23
Later than five years	-	-
Total non-cancellable other lease commitments	**1,559**	**3,704**
Total commitments	**56,332**	**62,604**

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 2015 year totalled $117.8 million (2014: $116.0 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 $5.848m, (2014, $3.848m).

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 18 months to 2 years.

During the year ended 30 June 2015, $2,409,998 was recognised as an expense in the surplus or deficit in respect of operating leases (2014: $2,163,713)

Leases as lessor

NMDHB leases owned properties to third parties under operating leases resulting in revenue of $1.3m (2014: $1.3m). 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 $7.023m (2014, 7.523m).

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 2015 (2014: $0.0m).

Contingent assets

NMDHB is seeking legal redress against a third party for over expenditure and has recorded a contingent asset of $1.78m (2014, $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 $421.9m (2014: $412.0m) to provide health services in the Nelson Marlborough area for the year ended 30 June 2015.

Revenue earned from other DHBs for the care of patients outside NMDHB's district amounted to $7.8m (2014: $8.1m) for the year ended 30 June 2015. Expenditure to other DHBs for their care of patients from NMDHB's district amounted to $41.4m (2014: $37.8m) for the year ended 30 June 2015.

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 2014 totalled $2.8m (2014: $2.8m). 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 $0.062m (2014, $0.046m).

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

	Actual 2015 $000	Actual 2014 $000
Board Members		
Remuneration	276	293
Full-time equivalent members	11	11
Leadership Team		
Remuneration	2,715	2,948
Full-time equivalent members	13	16
Total key management personnel remuneration	**2,991**	**3,241**
Total fill time equivalent personnel	**24**	**27**

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

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 $7.95m (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 $2.3m. The services provided for and from Marlborough District Council were on normal commercial terms. There are no outstanding unpaid invoices at year end.

Over the financial year, the NMDHB had a variety of financial transactions with Health Benefits Limited. NMDHB's Chief Executive Chris Fleming, is a Director of Health Benefits Limited. Payments to Health Benefits Limited totalled $1.8m while receipts from Health Benefits Limited totalled $0.04m. The NMDHB purchased $0.8m worth of FPSC rights during the financial year, totalling the NMDHB's shareholding to $2.3m which reflects a 3.3% shareholding of Health Benefits Limited. The transactions during the financial year are consistent with the transition of Health Benefits Limited taking over New Zealand's DHB finance and procurement departments. There are no significant outstanding balances for 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 $3.4m during the financial year, while payments to the Churchill Trust totalled $0.1m. The services provided for and from the Churchill Trust were on normal commercial terms. There is a balance of $0.1m 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

NZ Health Partnerships Limited (NZHPL) was established on 1 July 2015 taking on the assets and liabilities of Health Benefits Limited. 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 (refer to note 13). The NMDHB holding of B class shares is 2,255,000 shares of the total B Class shares issued of 68,333,000.

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

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) assumed responsibility for the investment of all the NMDHB's surplus funds. The risk management policies HBL 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 2015 (2014: $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 Health Benefits Limited (HBL) and the participating DHBs. HBL is a crown owned entity 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:

	Actual 2015 $000	Actual 2014 $000
Counterparties with credit ratings:		
Cash and cash equivalents		
AA	-	-
Investments		
AA	-	-
Total counterparties with credit ratings	**-**	**-**
Counterparties without credit ratings		
Cash on hand	(0)	7
Funds advanced to HBL	43,712	45,443
Total counterparties without credit ratings	**43,712**	**45,450**
Receivables		
Existing counterparties with no defaults in the past	10,714	10,921
Existing counterparty with defaults in the past	67	135
Total receivables	**10,781**	**11,056**

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 2015. 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.

2015	Balance Sheet	Contract-ual Cash	6 mths or less	6-12 mths	1-2 years	2-5 years	More than 5 years
	$000	$000	$000	$000	$000	$000	$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**

2014	Balance Sheet	Contract-ual Cash	6 mths or less	6-12 mths	1-2 years	2-5 years	More than 5 years
	$000	$000	$000	$000	$000	$000	$000
DMO Loans	55,500	55,500	-	8,000	6,000	25,000	16,500
Finance lease liabilities	8,910	17,563	600	443	688	1,482	14,350
Creditors and other payables	23,372	23,372	23,372	-	-	-	-
Total current assets	**87,782**	**96,435**	**23,972**	**8,443**	**6,688**	**26,482**	**30,850**

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 2015, it is estimated that a general increase of one percentage point in interest rates would decrease NMDHB's deficit by approximately $437,000 (2014: $454,000).

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 $000	Available for sale $000	Amortised cost $000	Carrying amount $000	Fair value $000
30 June 2015						
Current assets						
Cash and cash equivalents	7	43,712	-	-	43,712	43,712
Receivables	8	10,781	-	-	10,781	10,781
Total current assets		**54,493**	**-**	**-**	**54,493**	**54,493**
Non-current assets						
Other financial assets	11	1,472	3		1,475	1,475
Total non-current assets		**1,472**	**3**	**-**	**1,475**	**1,475**
Total assets		**55,964**	**3**	**-**	**55,968**	**55,968**
Current liabilities						
Payables	14	-	-	23,053	23,053	23,053
Finance leases	15	-	-	668	668	668
NZDMO loans	15			6,000	6,000	6,147
Total current liabilities		**-**	**-**	**29,721**	**29,721**	**29,868**
Non-current liabilities						
Finance leases	15			7,714	7,714	7,714
NZDMO loans	15			49,500	49,500	52,635
Total non-current liabilities		**-**	**-**	**57,214**	**57,214**	**60,349**
Total liabilities		**-**	**-**	**86,935**	**86,935**	**90,217**
30 June 2014						
Current assets						
Cash and cash equivalents		45,450	-	-	45,450	45,450
Receivables		11,056	-	-	11,056	11,056
Total current assets		**56,506**	**-**	**-**	**56,506**	**56,506**
Non-current assets						
Other financial assets		2,338	3	-	2,341	2,341
Total non-current assets		**2,338**	**3**	**-**	**2,341**	**2,341**
Total assets		**58,844**	**3**	**-**	**58,847**	**58,847**
Current liabilities						
Payables		-	-	23,372	23,372	23,372
Finance leases		-	-	765	765	765
NZDMO loans		-	-	8,000	8,000	8,269
Total current liabilities		**-**	**-**	**32,137**	**32,137**	**32,406**
Non-current liabilities						
Finance leases		-	-	8,145	8,145	8,145
NZDMO loans		-	-	47,500	47,500	49,440
Total non-current liabilities		**-**	**-**	**55,645**	**55,645**	**57,585**
Total liabilities		**-**	**-**	**87,782**	**87,782**	**89,991**

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.

26. EXPLANATION OF MAJOR VARIANCES AGAINST BUDGET

Statement of comprehensive revenue and expense

Revenue

Revenue was favourable to plan by $3.6m:

- Additional revenue received for 2013/14 PHO performance management costs and the recognition of additional 2013/14 discharge funding, has resulted in a $0.2m additional revenue.
- Additional revenue for a 5% increase in Rest Home price has contributed $0.4m in PBFF Adjustments.
- One-off funding of $0.1m was received for implementation of patient portals in general practice.
- Funding for Phase two of the National Patient Flow programme has contributed $0.2m additional revenue.
- One-off sustainability funding of $0.1m for Wakefield Health Centre.
- Termination of the Suicide Prevention Coordination Pilot resulted in $0.1m less revenue.
- An unfavourable final washup for 2013/14 IDF Inflows has contributed a $0.1m unfavourable variance and unfavourable forecast washup for 2014/15 has contributed $0.1m unfavourable variance.
- Interest income is $1.2m favourable. Lower Capex spending during 2013/14 and 2014/15 has allowed the continued growth of the cash balance held with HBL.
- Rental for GB Integrated Health Facility was not budgeted for and has been recognised as income totalling $0.5m for the year. This has been offset by an increase in depreciation and finance lease charge.
- Other Income is favourable to Plan by $0.3m. $0.1m Pharmac rebate, $0.1m Blood rebate, and $0.1m recognition of the balance of revenue for TPOT and ERAS have all contributed to this favourable variance.

Expenditure

Expenditure was $3.4m unfavourable to plan. This was due to:

- Workforce Costs (Including Personnel and Outsourced Workforce) are $0.1m unfavourable to Plan. Working beyond contracted FTE spread over several areas including HDU Wairau, Theatre Wairau, Hospital Management and Medical Unit Nelson has contributed to an unfavourable variance in Nursing. Vacancies in General Surgery Wairau, Paediatrics, Nelson Radiology, Hospital Management,

Community Oral Health, Health Promotion, General Surgery Wairau, Paediatrics, Nelson Radiology, Hospital Management, Community Oral and Health Promotion all contribute to the favourable variance.

- Outsourced services are $2.2m unfavourable to Plan. This is largely driven by the cover for some of the medical vacancies across a number of specialties in Nelson and Wairau including physicians, general surgery and obstetrics & gynaecology.
- Clinical supplies are $1.1m unfavourable to Plan. This largely reflects increased case weight volumes in emergency medicine, ear nose and throat, vascular, gynaecology, urology and dental procedures.
- Infrastructure & Non-Clinical Expenses are on Plan. Increased costs occurred in Software maintenance $0.1m, general maintenance $0.3m and the $0.9m Golden Bay loan write down. These were offset by an under spend in HBL funding for FPSC project fees $0.5m, national DHB Insurance savings $0.1m, telecommunications $0.1m and depreciation $0.6m less than budgeted due to assets not purchased during the year.
- Payments to Providers are $1.4m unfavourable to Plan. Expenditure on Hospital Level Care and Rest Home level care continues to increase and is 5 % higher than budget resulting in a $0.7m unfavourable variance. Home Based Support is $0.3m unfavourable. Rest Home Aged Residential care is due to a 5% rest home price increase resulting in a $0.3m unfavourable variance to plan.

Statement of financial position

Current assets

Current assets are $26m more than Plan. Cash & cash equivalents are $27m more than Plan and Debtors & Other receivables are $0.2m more than Plan. All deposits are now held by HBL and included in Cash and cash equivalents. Non-current assets held for sale are $1.4m less than Plan. Deferred purchase of budgeted non-current assets has contributed to the budget cash surplus.

Non-current assets

Non-current assets are $11.7m less than Plan. Delays in the capital expenditure programme has resulted in this variance however this is partially offset by an increase in Land and Buildings resulting from the revaluation of these assets.

Current liabilities

Current liabilities are $7.5m higher than Plan in total. Creditors and Other payables are $4.5m more than Plan reflecting the higher expenditure for the year and Employee Entitlements are $3.1m higher than Plan with the increasing valuations of leave and other entitlements from salary/wage rises.

Non-current liabilities

Non-current liabilities are $0.1m less than Plan. The variance is made up of $0.5m Loans & Borrowings, and $0.6m less than Plan in Employee Entitlements with a reduction in non-current personnel liabilities.

Equity

Equity is $6.9m more than Plan due to the revaluation of land and buildings and the variances described below.

Statement of changes in net assets/equity

The net surplus was $0.2m more than Plan due to the explanations provided in above, Statement of Comprehensive Revenue and Expense. Other Comprehensive revenue or expenses was $6.4m favourable to Plan due to the $6.2m revaluation of Land and Buildings.

Equity injections and repayments were in line with Plan.

Statement of cash flows

Cash inflows from Operating Activities were $1.0m more than Plan. Receipts from Ministry of Health and patients were $2.4m more than Plan and payments to suppliers were $3.2m more 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 $7.0m less than Plan, with many planned projects deferred. Investment in intangible assets has also been deferred leaving $3m less than Plan.

Cash outflows from Financing Activities were $0.3m more than Plan. The payment of finance leases liability has increased by $0.3m.

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 2015, the Trust had total revenue of $610,122 (2014: $270,998), and a net surplus of $290,278 (2014: Surplus $95,347). The Trust had assets of $3,286,656 (2014: $3,025,768), and liabilities of $Nil (2014: $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 2015 $000	Actual 2014 $000
Mental health funds		
Opening balance	642	434
Excess/(shortfall) of funding over payments	(378)	208
Adjustments to funds available		-
Total mental health funds	**264**	**642**

29. SUMMARY OF REVENUE AND EXPENDITURE BY OUTPUT CLASS

	Budget 2015 $000	Actual 2015 $000	Actual 2014 $000
Revenue			
Prevention services	7,548	7,877	7,448
Early detection and management services	114,505	115,006	111,870
Intensive assessment and treatment services	226,890	228,876	222,736
Support services	90,661	91,494	92,123
Total revenue	**439,604**	**443,253**	**434,177**
Expenditure			
Prevention services	6,858	6,948	6,740
Early detection and management services	113,003	110,893	111,016
Intensive assessment and treatment services	226,955	232,466	221,953
Support services	91,288	91,229	90,075
Total expenditure	**438,104**	**441,536**	**429,784**
Surplus/(deficit)			
Prevention services	690	929	708
Early detection and management services	1,502	4,113	854
Intensive assessment and treatment services	(65)	(3,590)	783
Support services	(627)	265	2,049
Total surplus/(deficit)	**1,500**	**1,717**	**4,394**

30. ADJUSTMENTS ARISING ON TRANSITION TO THE NEW PBE ACCOUNTING STANDARDS

Reclassification adjustments

There have been no reclassifications on the face of the financial statements in adopting the new PBE accounting standards.

Recognition and measurement adjustments

There have been no recognition and measurement adjustments to the 30 June 2014 comparative information resulting from the transition to the new PBE accounting standards.

Audit report

TO THE READERS OF NELSON MARLBOROUGH DISTRICT HEALTH BOARD'S FINANCIAL STATEMENTS AND PERFORMANCE INFORMATION FOR THE YEAR ENDED 30 JUNE 2015

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 46 to 84, that comprise the statement of financial position as at 30 June 2015, the statement of comprehensive revenue and expense, statement of changes in net asset/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 31 to 45.

Unmodified opinion on the financial statements

In our opinion the financial statements of the Health Board:

- present fairly, in all material respects:
  - its financial position as at 30 June 2015; 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 performance information of the Health Board for the period ended 30 June 2014, 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 31 to 45:

- presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2015, 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 28 October 2015. 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 or its subsidiary.

Ian Lothian
Audit New Zealand
On behalf of the Auditor General
Christchurch, New Zealand

ANNUAL REPORT

NELSON MARLBOROUGH DHB

2014/2015

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Nelson Marlborough
District Health Board