2011/12



Nelson Marlborough District Health Board Annual Report

TE WAI ORA
Nelson Marlborough District Health Board


NMDHB VALUES


To work with people of our community to promote, encourage and enable their health, well-being and independence.

VALUES *What we value*	ATTRIBUTES *What you would see us 'being'*	BEHAVIOURS *What you would see us 'doing'*
Respect We care about and will be responsive to the needs of our diverse people, communities and staff.	• caring for others • understanding • patient • committed • courteous • compassionate • enabling • culturally sensitive	• taking the time • engaging-working together • listening and acting • advocating • acknowledge the individuals situation • putting aside personal preferences or ways of doing • heeding verbal and non verbal messages • valuing diversity
Innovation We will provide an environment where people can challenge current processes and generate new ways of working and learning.	• challenging the status quo • enquiring • seeking out new information • researching • having a can do attitude • embracing change • an enabling environment • reflective • seeking constant improvement	• generating and supporting new ways of working and learning • evaluating and learning from our actions • external evidence and local learning guide our direction • utilising the best from wherever and making it work for us • benchmarking to improve
Teamwork We create an environment where teams flourish and connect across the organisation for the best possible outcome.	• cooperative • problem solving • creative • energetic • enthusiastic • clear of purpose – team and individual • supportive	• communicating effectively • sharing resources and knowledge • utilising strengths of individual team members • providing seamless service from consumers perspective • all staff actively contributing to decision making • achieving effective outcomes • acknowledging and valuing diverse skills and contributions
Integrity We support an environment which expects openness and honesty in all our dealings and maintains the highest integrity at all times.	• accountable • personally and collectively responsible • culturally responsive • being true to oneself • open, fair and reasonable	• taking personal responsibility for actions and outcomes • telling the truth • challenge, question and address appropriately • honouring commitments • walking the talk • striving to be open, fair and reasonable

Nelson Marlborough District Health Board

CONTENTS

STATEMENT FROM THE CHAIRPERSON AND CEO

It is with pleasure that we present the annual report for 2011/12. Nelson Marlborough District Health Board (NMDHB) has in place the capability to carry out all of the functions required of it under the New Zealand Public Health and Disability Act (NZPH&D Act).

OUR VISION

We continue to progress towards our mission to 'work with the people of our community to promote, encourage and enable their health, wellbeing and independence'. This progress is in conjunction with the Government's objectives for improved patient and population health outcomes. The Board's commitment to being a community leader is reflected through our vision of 'leading the way to health-conscious families.' We have an emphasis on a more responsive, interconnected system of health, disability and support care through prevention, health promotion and reducing health inequalities in this district.

This commitment is reflected in the values adopted by the Board:

- Respect
- Innovation
- Teamwork
- Integrity.

PARTNERSHIP WITH IWI

We continue to build on strong partnerships by establishing better integration of primary, community, secondary and tertiary services. In 2009 the Iwi Health Board put in place the Maori Health and Wellness Strategic Framework which provides a co-ordinated response from all key agencies that accept a responsibility for Maori health gain. A high level of good will between the two Boards reinforces the Iwi Health Board's advocacy role for Maori Health Strategy.

REGIONAL COLLABORATION

We continue to be actively involved in supporting and implementing regional collaboration through the South Island DHB Alliance, National 20-DHB Collective and tertiary services providers located at Capital & Coast DHB, Canterbury DHB, Hutt Valley DHB and Auckland DHB. We consider regional collaboration to be an essential part of the future direction of both Nelson Marlborough and the South Island to ensure the sustainability of health and disability services for our region.

COLLABORATION WITH PRIMARY HEALTH

The Nelson Marlborough Health Alliance (NMHA) has been formed to achieve the Government policy of better, sooner, more convenient health care through an integrated and coordinated environment. Nelson Bays Primary Health, Kimi Hauora Wairau Marlborough PHO organisation and Nelson Marlborough District Health Board formed the NMHA with the goal to improve health and disability outcomes for the people of Nelson, Tasman and Marlborough.

These goals will be achieved through clinically-led service development and its implementation through a 'best for patient, best for system' framework. The NMHA enables our organisations to work effectively together, utilising our combined resources to jointly solve problems, develop innovations in health care delivery to meet health care challenges.

Primary care networks, through effective partnership with DHBs, play a critical role in supporting the Government to achieve its priorities. Successful primary care networks deliver patient-centred services that are clinically led, management supported, and community engaged.

Collaboration has already enabled development of further capacity in the primary health care sector, including the integration of services in Golden Bay and the development of sustainable after hours services for the district.

Other community activities include consultation processes, intersectoral work and contracts with a significant number of health and disability providers and interested agencies.

FUTURE PLANNING

Our medium-term developments are being guided by our HEALTH2030 Strategic Plan. HEALTH2030 is designed to transform models of care by placing people and their families/whanau at the centre of our local delivery system, in order to improve their care and support experiences and outcomes.

This vision is being continually refined to ensure it encompasses and, where appropriate, leads changes in the models of care for health and disability services across our district and region.

HEALTH2030 is focussed on improving access to quality health care and support services for people living within the Nelson Marlborough district. It does this by making high quality services accessible and effective, and through influencing the broader determinants of health that contribute to poor health outcomes. HEALTH 2030 plans for the majority of health care to be delivered through a Primary Care led system using expanded networks of providers. These networks would be interfaced with hospital services and a broad range of clinical support services such as pharmacist services, community diagnostics, occupational therapist, physiotherapist and psychologist services.

HEALTH2030 links with current strategic planning at the South Island Health Services level and at the national level with the Ministry of Health's direction for the long-term development of services.

REVIEW OF OPERATIONS

NMDHB finished the year with a financial deficit of $5.228m against a budgeted surplus of $0.110m. This result is after a capital charge (an 8% charge on the Government's equity in the DHB) of $6,792m.

This result reflects a number of factors including a concerted effort to reduce waiting times for elective surgery, a significant increase in acute cases, particularly cardiac and surgery which combined was 11% over the planned volume and the costs for Christchurch people who relocated to Nelson and Marlborough after the 2010 and 2011 earthquakes.

Revenue was $3.0m higher than budget due to a series of factors including the devolution of funding for long-term support services for clients with chronic health conditions, reimbursement by Canterbury DHB for Christchurch evacuees in age related residential care, and funding for new programmes and initiatives.

There has been a range of unplanned costs including the impact of the Canterbury earthquake on costs such as insurances, the Disability Support Services (DSS) Sleepover allowance, an adverse shift in the net Inter-District Flows (IDF), costs and adjustments to Pharmac funding relating to both the 2010/11 and the 2011/12 years. The annual revaluation of employee liabilities increased costs by $876,000 due to a substantial reduction late in the year in discount rates in the Treasury Model used for that valuation.

Our achievement of reducing waiting times for surgery increased our costs higher than planned. Medical and nursing costs and expenditure on clinical supplies were $2.0m over budget.

We have continued to participate in the national process for the release of reports on serious and sentinel events. The intent was to inform the public of the processes we have in place to report, review, follow up, learn and improve care outcomes from such events. This preserves the position of clinical staff involved so that open disclosure is encouraged in all cases and promotes a systems improvement culture rather than a 'blame and shame' culture.

The Rutherford Performance Programme continued to identify a number of opportunities to assist in enabling financial sustainability. Increasing and competing demand for services is also placing further pressure on the health services locally. The ongoing support of all stakeholders is important in achieving the best outcomes.

CLINICAL GOVERNANCE

Within NMDHB's Executive Leadership Team (ELT), Service Directorates hold responsibility for both the purchasing of services and the delivery of DHB-owned services. General Managers support the Service Directorates in achieving their operational activities. This model ensures frontline clinicians (predominantly medical) are actively engaged as members of that team in determining the direction and management of the organisation. NMDHB's Executive Leadership Team represents broad clinical and management expertise.

The ELT creates joint leadership amongst medical, nursing and allied health clinicians, management and providers across the continuum of care activities for patients. Clinicians are increasingly engaged at all levels of decision-making.
The focus of the ELT is on common care platforms through district-wide delivery of services along with increased input from clinicians and greater clarity and accountability across both operational and support services functions. This is accomplished within the district's finite resources.

CANTERBURY EARTHQUAKES

The Canterbury earthquakes of September 2010 and February 2011 have had an ongoing impact on NMDHB. The numbers of people relocating from Christchurch and the surrounding area has seen increases in demand for services by people in the older age groups, e.g. age related residential care, home based support. The impact has resulted in Health of Older People (HOP) expenditure and is continuing to grow.

CAPITAL DEVELOPMENTS

Following the Canterbury earthquakes we have taken the opportunity to have all our buildings assessed by engineers to determine their compliance to building standards. Two buildings have been vacated due to the low ratings while two others will require remedial work to improve their compliance ratings.

With the new knowledge of the status of the buildings on the Nelson site, the business case for the site redevelopment is being restarted and the proposed interim upgrade of Nelson Hospital suspended. Much has changed; in particular, the new process required extensive use of Investment Logic Mapping as required by Treasury's Better Business Case guidelines.

OUTLOOK

With the continuing fiscal constraints and the ageing population the DHB will continue to face a number of challenges in the years ahead. The focus for the next year is to 'accelerate the pace of change' in achieving the Government's objectives for improved patient and population health outcomes and a more responsive, interconnected system of health, disability and support care, while living within our means.

ACKNOWLEDGEMENTS

We would like to record our appreciation for the guidance, direction and support on matters of tikanga Maori from our four Kaumatua, who continue to support the Board and staff on formal and other occasions. We wish to pay tribute to Rangi Joseph and Wilmarae Rodrigues who died during the year. Their contributions as a Kaumatua and Iwi Health Board Member to the Board and Maori health in this district were invaluable.

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

Jenny Black
Chairman

John Peters
Chief Executive

BOARD AND COMMITTEES

Board Members: Left to Right
Front row: Jenny Black, Fleur Hansby, Judy Crowe
Back row: Andy Joseph, Ian MacLennan, Roma Hippolite, Gerald Hope, John Inder, Russell Wilson, John Moore
Photos right: Patrick Smith (top), Gordon Currie (bottom)

The Board meets monthly while the advisory committees meet alternately every two months. From April 2011 the Community and Public Health Advisory Committee and the Disability Support Advisory Committee have met together in a single meeting.

An opportunity for the public to bring issues to the Board's attention was given in a public forum at the beginning of each Board and Committee meeting. All meetings are advertised and open to the public to attend, except where business needs to be conducted in closed sessions in accordance with criteria set out in the legislation.

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

HOSPITAL ADVISORY COMMITTEE (HAC)

Judy Crowe (Chair)
Russell Wilson
Roma Hippolite
Francis Garguilo
Ian MacLennan
John Inder
Tahi Takao (to September 2011)
Trisha Falleni (to May 2012)
Jane Anderson-Bay

COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE

DISABILITY SUPPORT ADVISORY COMMITTEE (CPHAC/DISAC)

Gerald Hope (Chair)
John Moore (Deputy Chair)
Fleur Hansby
Gordon Currie
Patrick Smith
Glenys MacLellan
Sonny Alesana
Judith Holmes
Jennifer M Black
Jos Van der Pol
Mabel Grennell
George Truman

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

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

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

The Board also has an Audit and Risk Committee to assist in discharging the Board's responsibilities relative to financial reporting, regulatory compliance and risk management (including clinical risk management). This Committee meets quarterly.
The Remuneration Committee meets six-monthly to review the performance of the Chief Executive.

IWI HEALTH BOARD

The Iwi Health Board (IHB) works in partnership with the Nelson Marlborough District Health Board (NMDHB) to fulfil its obligations under the Treaty of Waitangi. It is guided in that responsibility by the NZ Public Health and Disability Act 2000 and other policy directions from the Crown. This special relationship includes the Manawhenua O Te Tau Ihu and Maataa Waka: Ngati Apa, Rangitane, Ngati Koata, Ngati Kuia, Ngati Rarua, Ngati Tama, Ngati Toarangatira and Te Atiawa.

2011/12 was a year of challenges while offering excitement with the ongoing developments and formation of the Maori health provider Coalition and Whanau Ora nationally. The Coalition has made very good progress with the appointment of a Project Manager. Four options have been developed and these are being consulted on with local Maori health provider boards. The IHB has a particular interest in Whanau Ora nationally and has been monitoring developments to ensure Te Tau Ihu is prepared and ready. Nelson Marlborough has three providers who are part of Te Waipounamu Whanau Ora Collective. One local Maori health provider has been placed onto an integrated contract.

Nine Iwi from Te Waipounamu started a journey in March 2012 to develop a strategic relationship that would advance Maori health in the South Island. The Iwi include Ngai Tahu, Te Atiawa, Ngati Tama, Ngati Rarua, Ngati Koata, Ngati Toarangatira, Ngati Kuia, Ngati Apa, and Rangitane. Iwi in Te Tau Ihu o te Waka a Maui hosted the first hui in March 2012 with Ngai Tahu facilitating the second workshop in May 2012. The focus was to develop a strategic approach to Maori health planning and to hold district health boards accountable for sector performance. These discussions will continue into 2012/13.

The IHB has also been actively involved in the NMDHB's Annual Plan and were pleased to approve the NMDHB Maori Health Action Plan for 2011/12. The IHB would like to acknowledge the work completed by the Maori Health Directorate. More significantly, the IHB recognises that the new Maori Health Action Plan approach enables the sector to more effectively monitor and track progress and improvements in Maori health status. The IHB has now endorsed a set of national Maori health targets that will measure the same rates for Maori and non-Maori. More work is needed to improve the rate of coverage for cardiovascular risk assessments.

The national target for Maori was set at 60% for 2011/12 and our target for Maori was 48.5%.

During the course of the year, the IHB and NMDHB held two joint meetings to progress key strategic points that could inform district planning. Hosted at local marae, questions asked by each board included:

1. How do we get people to be responsible for their health?
2. How do we learn from these messages to get people responsible?
3. What do we need to do differently that will allow this to happen (e.g. obesity)?
4. What policies do we need to put in place to make this happen?

These questions were key to shaping IHB input into the annual plan and the Maori health action plan for 2012/13. It also signalled willingness between IHB and NMDHB to look at the strategic picture and work more openly and collaboratively towards improving the health status of Maori across Nelson Marlborough.

The He Taura Tieke service audit framework has proved itself valuable for NMDHB in determining its success in providing culturally appropriate services to Maori. NMDHB continues to lead this development for the Nelson Marlborough district and is pleased to see Nelson Bays and Kimi Hauora Marlborough Primary Health Organisations implementing the tool.

Now that NMDHB is being measured against national targets, we have seen marked improvements for Maori health. For example, Maori children (two-year-olds) immunisation rates at 91% compared to the national target of 95%. This is a marked improvement to the previous year's result. Smoking cessation programmes have seen improved coverage with 92% of hospitalised smokers being provided advice compared to the national target of 90%. One area of challenge to the DHB are the diabetes annual review checks. In this period NMDHB achieved 68% for Maori when compared to the national target 82%. The NMDHB is working with both primary health organisations and Maori health providers to improve this position. The DHB will start producing quarterly reports on the Maori Health National Targets in 2012/13.

There was also a note of deep sadness with the passing of IHB member Wilmarae Rodrigues and local DHB and Marlborough Kaumatua Joseph Rangi. Both had been ill for some time and their loss will be felt forever by local Iwi and NMDHB. E moe, e takato nei ra e korua i te moengaroa o o matua tupuna.

OUR COMMUNITY AND ITS HEALTH AND DISABILITY NEEDS

As of 1 July 2011, probably related to the Canterbury earthquakes, Nelson and Tasman had above average population growth, amounting to a doubling of the usual population growth. This has created challenges for the ongoing delivery of needed health services across settings of care through the 2011/12 year, and is expected to continue through the 2012/13 year. The population has predominantly increased in the over 45 year age group, resulting in increased demand.

NMDHB HAS
A population >139,900 (33% Marlborough, 33% Nelson, 34% Tasman)
A challenging terrain and distance frequently isolates our communities
A population density of six people per square kilometre
Two secondary hospitals
Two rural hospitals
New Zealand's only DHB owned Intellectual Disability Support Service (IDSS)
2,176 staff (1,689 full time equivalents)
138 GPs with 21 locums and 29 dentists
29 dispensing pharmacies (including one in Nelson hospital and one in Wairau Hospital)
40 NGO providers
Two PHOs
28 aged related residential care facilities
Five home based support agencies

COMPARED TO THE REST OF NEW ZEALAND NMDHB HAS
A high incidence of chronic lung disease, chronic pain and dementia, intellectual and physical disability
A high incidence of obesity in Maori men, but fewer people overall classified as overweight and obese
High rates of breast and prostate cancer, and associated high death rates
A high personal injury and accident rate
More people > 65; fastest growing > 85
More births; fewer young adults (18-30)
One of the lowest 'amenable mortality'[1] rates
One of the longest 'life expectancy at birth' rates
One of the 'most active' populations in NZ
Access to good public health, community, general practice and secondary services.

1 A rate that measures premature mortality according to access to health services.

Our focus for the year, and for the next three years, was to ensure viability of our services within our allocated funding path while maintaining productive (efficient and high quality), health and disability services delivery to people in the Nelson Marlborough district.

Our priority for the year was to achieve the best and smartest use of constrained resources across the whole district. This required a transformational shift in thinking and operating to deliver maximum value for our health care dollars so that services were delivered in better, sooner and more convenient ways to our communities.

To achieve the South Island regional goals for 2011/12, our focus was on three overarching priorities that are underpinned by a range of strategically relevant key themes and initiatives. Our three overarching priorities for 2011/12 were:

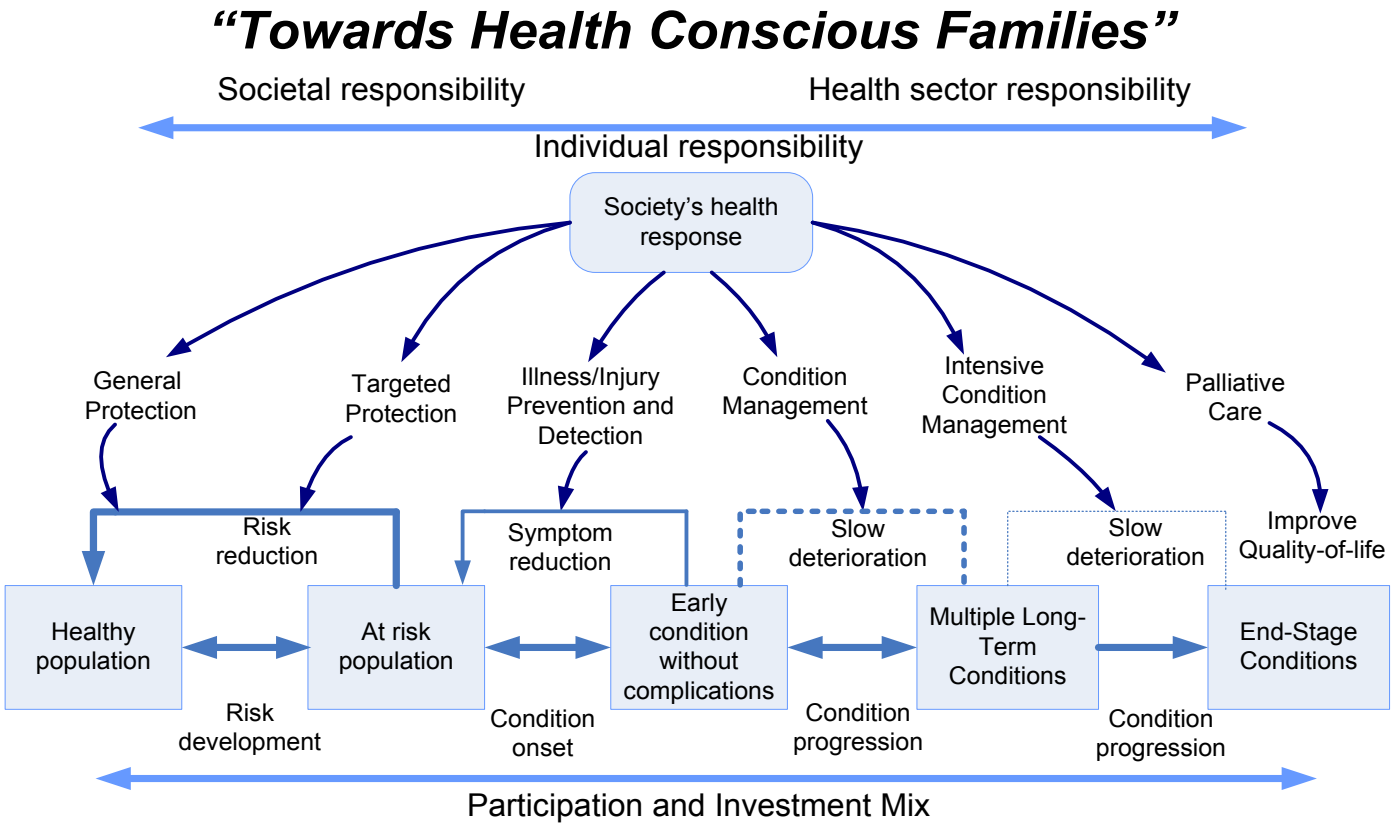
1. Improving the health and wellbeing of people in our district
2. Increasing the sustainability of health and disability services in our district
3. Improving the management of demand and the delivery of services.

The changes put in place to enable us to live within our means and to be viable required new ways of working across the district to be developed. These included:

- implementing an effective district-wide approach to all service delivery so that we make the very best use of resources, capital (buildings and equipment) and skilled people. We can no longer run separate systems, with significant extra costs, that have developed over many years
- implementing a new 'capacity-based' funding approach for our hospital provider that enables clinical leaders to be significantly more engaged in key decisions around service provision
- accelerating our collaborative partnerships with Iwi and the two PHOs
- aligning Nelson Marlborough service transformation to the broader South Island collective service delivery model
- working with our PHOs, Mental Health providers and Iwi providers to achieve greater collaboration and work within 'integrated family health systems'.

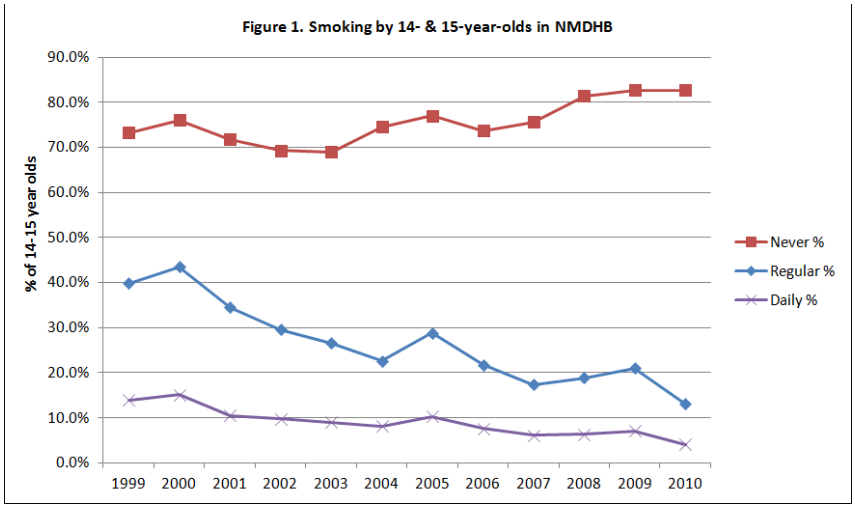
Four strategies were put in place to achieve this local transformation. All four were underpinned by our Maori Health Strategy and included:

1. Regain viability (financial and workforce)
2. Increase productivity (value for money) and responsiveness (quality and collaboration)
3. Manage infrastructure (facilities, systems and equipment)
4. Improve health and independence (level, equity, well-being and participation).

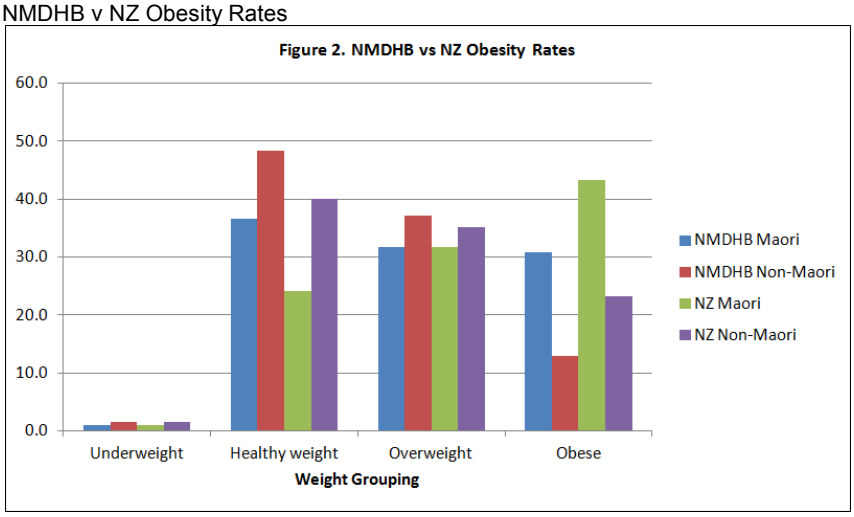


PEOPLE TAKING GREATER RESPONSIBILITY FOR THEIR HEALTH

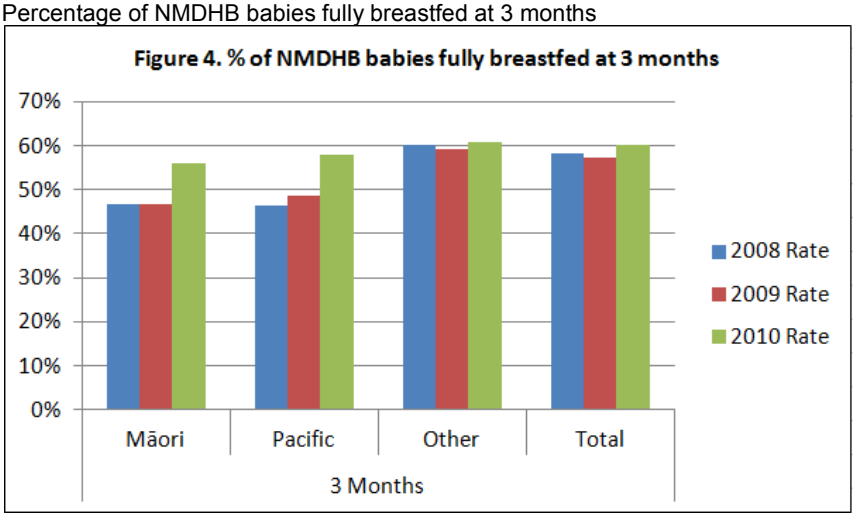
Key indicators continue to show we are achieving results from the various programmes we have in place.



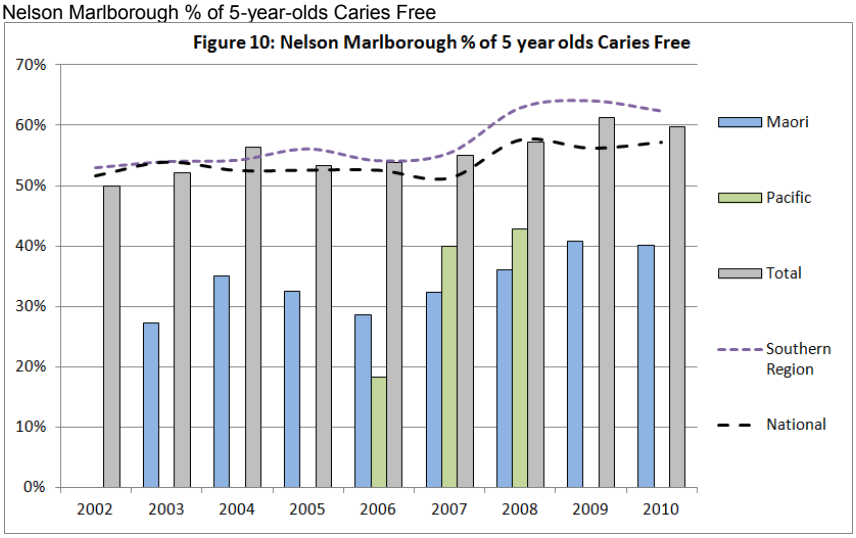
NMDHB v NZ Obesity Rates



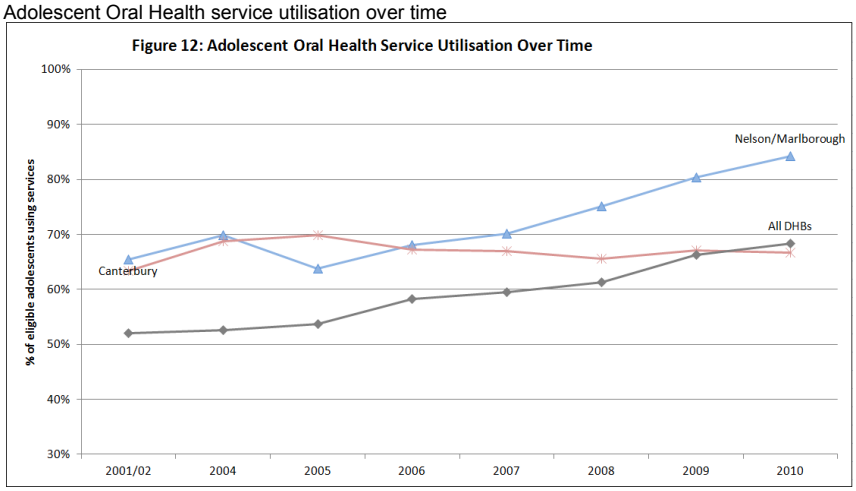
Percentage of NMDHB babies fully breastfed at 3 months



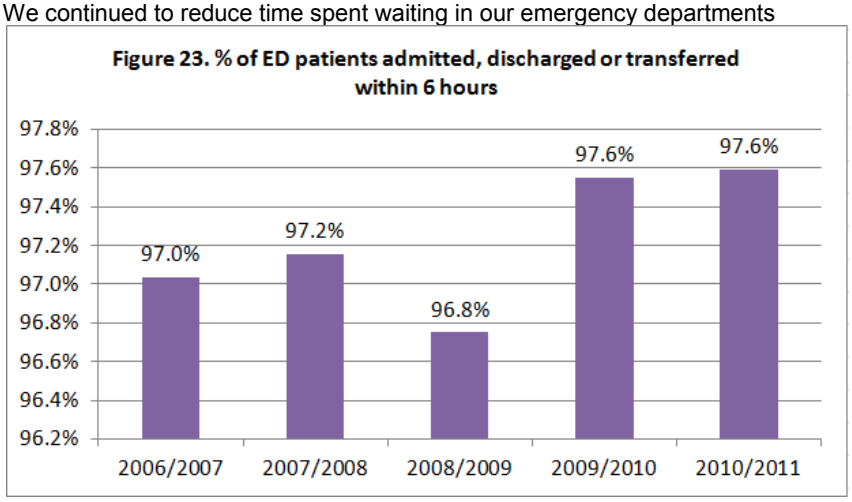
Nelson Marlborough % of 5-year-olds Caries Free



Adolescent Oral Health service utilisation over time



We continued to reduce time spent waiting in our emergency departments



SIGNIFICANT SERVICE CHANGE

During 2011/12 we planned to make a number of significant service changes or improvements. As the following records there has been progress on all of the planned changes and this work will be continuing in 2012/13 as we work towards our vision.

COMMUNITY BASED SERVICE DIRECTORATE PROPOSED SIGNIFICANT CHANGE

COMMUNITY BASED SERVICE DIRECTORATE PROPOSED SIGNIFICANT SERVICE CHANGE	REASON/RATIONALE FOR CHANGE	HOW WILL IMPROVED PERFORMANCE AND/OR BENEFITS BE MEASURED?	TIMEFRAMES FOR SIGNIFICANT SERVICE CHANGE • DEVELOPMENT • CONSULTATION • IMPLEMENTATION	PARTIALLY ACHIEVED	ACHIEVED
Maori Health Provider service change: Options (preference in order) if non compliance with audit recommendations: • Separation of health services from wider provider commercial, cultural and social activities (set up of legal entity specifically centred on health service delivery) • Exit of service, and enter Request for Proposal process to deliver existing services • Statutory management	Sustainability Cost Effectiveness Maximising resources.	Tracking of overhead costs through provider financial reports. Reduced number of complaints being received by NMDHB. Governance management of contractual risk (inclusive of the processes in relation to this) well documented (evidence supplied to NMDHB).	If a satisfactory outcome is not reached by the 31st March 2011 it is envisaged that consultation with the Provider will occur in April 2011 (re the three proposed options identified previously) and processes agreed for timeframes and implementation.	This is a multi-year project started in 2010. Whanau Ora nationally caused a separation between Maori health providers where three joined the He Oranga Pounamu Whanau Ora Collective based in Christchurch. Nonetheless, the DHB has been engaging with all eight Maori health providers to create changes for the future. In July 2011 five Maori health providers signed a Memorandum of Agreement and formed the Coalition. The group formally established a work plan in November 2011. A project manager was engaged in March 2012 to work towards a Coalition of those providers. NMDHB has engaged all eight boards of the Maori health provider over options being proposed for a future new entity. The options include status quo or do nothing, admin-hub, service delivery-hub, and one entity and amalgamate all services. Decision on new entity to be made by the Coalition by December 2012.	
Rutherford Review for Intellectual Disability Support Services (IDSS) future strategic direction may create public interest, and may result in a change in governance and ownership of this service.	Sustainability Quality Cost Effectiveness Maximisation of limited resources.	To be identified in the review.	To be identified in the review.		Completed consultation on the future governance structure for the DSS in August 2011 with 104 submissions. In September 2011 the Board resolved to establish a steering group to oversee the development of a business case for the establishment of an independent trust for the NMDHB to transfer service to.

MEDICAL SURGICAL SERVICE DIRECTORATE PROPOSED SIGNIFICANT SERVICE CHANGE

MEDICAL SURGICAL SERVICE DIRECTORATE PROPOSED SIGNIFICANT SERVICE CHANGE	SERVICE CHANGE CRITERIA	HOW WILL IMPROVED PERFORMANCE AND/OR BENEFITS BE MEASURED?	TIMEFRAMES FOR SIGNIFICANT SERVICE CHANGE • DEVELOPMENT • CONSULTATION • IMPLEMENTATION	PARTIALLY ACHIEVED	ACHIEVED
Ophthalmology Rutherford review may result in significant changes to the model of delivery of our eye services	Sustainability Quality Equity	Wait time ESPI Clinical activity parameters Service quality reports Patient satisfaction survey Patient reported outcome measures to be developed.	Consultation closed 28/11/10 Final decision 31/03/11 Implementation April 2011	In process of change CAPEX purchases approved to effect increased cost effective output at Wairau Diabetic retinal Screening model of care under review. Developing capacity of RN staff District wide processes initiated	
Rutherford Review for O&G and Maternity services likely to create considerable public interest, and may result in significant alteration of service delivery	Sustainability Quality Access Cost-Effectiveness Maximisation of limited resources	To be identified in the review.	To be identified in the review. This review is likely to be consulted on in the 2011/12 year with implementation planned for 2012/13 year.	Established Maternity Quality and Safety group. Moving to more clinic based procedures Developing district wide guidelines Process of moving Lactation Services and Parental Education to community in final stages	

MENTAL HEALTH SERVICE DIRECTORATE PROPOSED SIGNIFICANT SERVICE CHANGE

MENTAL HEALTH SERVICE DIRECTORATE PROPOSED SIGNIFICANT SERVICE CHANGE	SERVICE CHANGE CRITERIA	HOW WILL IMPROVED PERFORMANCE AND/OR BENEFITS BE MEASURED?	TIMEFRAMES FOR SIGNIFICANT SERVICE CHANGE • DEVELOPMENT • CONSULTATION • IMPLEMENTATION	PARTIALLY ACHIEVED	ACHIEVED
Maori Health Provider service change: Options and recommendations: 1. Separation of health services from wider provider commercial, cultural and social activities (set up of legal entity specifically centred on health service delivery) 2. Exit of service, and enter Request for Proposal process to deliver existing services 3. Statutory management.	Sustainability Cost-Effectiveness Maximisation of limited resources Equity	Tracking of overhead costs through provider financial reports. Reduced number of complaints being received by NMDHB. Governance management of contractual risk (inclusive of the processes in relation to this) well documented (evidence supplied to NMDHB).	If a satisfactory outcome is not reached by the 31 March 2011 it is envisaged that consultation with the Provider will occur in April 2011 and processes agreed for timeframes and implementation.	The DHB is working with all three Kaupapa Maori mental health providers. The Coalition has endorsed this workstream	
Psychiatry of Old Age Services – (post Rutherford/ Psycho-geriatric Services) as follows: Current Psycho geriatric community team becomes a sub specialty based in Mental Health community team and works in conjunction with Geriatric SHSHOP team. Seven specialist Psycho-geriatric ATR beds be relocated to the Mental Health Admissions Unit. (The number of specialist psychogeriatric beds is estimated at seven to date, but yet to be confirmed) Long term psychogeriatric continuing care is to be contracted to a community provider (in line with other DHBs)	Sustainability Quality Access Cost-Effectiveness Maximisation of limited resources	Sustainable service in line with SHSOP Guideline. InterRai assessments. HoNOS 65+ health outcome measures in an acute mental health setting.	Consultation process has been implemented as per Rutherford process. Development Group and subsidiary working party currently overseeing Needs Assessment and Clinical Assessment of remaining patients at Alexandra to determine pathway forward. A Request for Proposal in relation to Long Term Continuing Care is currently in progress. Clinical discussions in progress around model of care. Envisaged that full implementation will commence in the 2011/2012 financial year.		The re-integration of 8.5 admission beds and the community team Psychogeriatrics into Mental Health. Transferred 17 clients requiring residential care to community providers.
South Island Mental Health Regional Models of Care Review. NMDHB access a range of tertiary level mental health and addiction services e.g. forensic acute inpatient; mothers and babies; eating disorders; child and youth inpatient. NMDHB access to these services doesn't necessarily equate to our entitlement or the financial resources we pay to CDHB or ODHB through Inter District Flows (e.g. NMDHB do not use the Mothers and Babies Service, but fully utilise the Eating Disorders service). NMDHB is supporting reviewing the models of care and the funding model associated to regional services. The aim is to improve existing services, and free up resources for investment in other key priority areas for NMDHB.	Sustainability Quality Access Cost-Effectiveness Maximisation of limited resources	Sustainability of regional services to ensure continued access for all District Health Boards. Increased service provision in: Children of Parents with Mental Illness (COPMI). Addiction Services. Co-Existing Disorders, Mental Health and Intellectual Disability (Dual Disability).	Models of Care to be completed third quarter 2010/2011. Regional discussion on funding models commence fourth quarter 2010/2011. Preparation for IDF budget allocations by October 2011.		As a member of the South Island Mental Health Alliance NMDHB was involved in the region achieving the Ministry's regional integration objective. Reviewing of the models of care, access, mechanisms of regional service delivery, volumes and funding have been foci.

SERVICE IMPROVEMENTS

COMMUNITY BASED SERVICE DIRECTORATE PROPOSED SERVICE IMPROVEMENTS

COMMUNITY BASED SERVICE DIRECTORATE PROPOSED SERVICE IMPROVEMENTS	REASON/RATIONALE FOR IMPROVEMENT	HOW WILL IMPROVED PERFORMANCE AND/OR BENEFITS BE MEASURED?	TIMEFRAMES FOR SIGNIFICANT SERVICE CHANGE • DEVELOPMENT • CONSULTATION • IMPLEMENTATION	PARTIALLY ACHIEVED	ACHIEVED
Variation to Whanau Ora (WO) Heads of Agreement to align with Maori Provider Coalition establishment.	Quality Consistency of service Access Maximisation of limited resource Equity.	Via reporting mechanisms as stipulated in the revised service specification. Evidence of improved financial maximisation via financial reporting.	Consultation continuing with a 3 month exit period stipulated. Expected start date of new variation on 1st May 2011.	Whanau Ora nationally caused a separation between Maori health providers within this district where three joined the He Oranga Pounamu Whanau Ora Collective based in Christchurch. All eight Maori health provider boards have now been engaged to examine options for future provision of Maori services.	
Implementation of a Maori health service framework in Te Tau Ihu through: Establishment of the Maori Health provider Coalition & Collective Implementation of new services across eight Maori health providers	Quality Consistency of service Access Maximisation of limited resource Sustainability Cost-Effectiveness Equity	Via reporting mechanisms as stipulated in the revised service specification. Evidence of improved financial maximisation via financial reporting.	Consultation continuing with Maori health providers who are in the Coalition and part of the He Oranga Pounamu Whanau Ora EOI collective. Tentative timeframes include: March 2011 – Coalition MOA agreed to by provider boards August 2011, new service framework agreed to by Coalition & Collective November 2011, new service specs and pricing framework agreed to by Coalition & Collective January 2012 starting phased implementation of new service framework for Maori health.	See under service change above.	
Whanau Ora Pathfinder Service reallocation	Maximisation of limited resource	As per current service specifications and reporting requirements stipulated.	Three months exit notification and to start date of service (by July 1 2011).		Integrated with palliative care funding with three Maori Health providers.
After Hours Primary Care provision – service relocation and expansion	Quality Consistency of service Access Maximisation of limited resource Equity.	Viability of After Hours services (financial, clinical). # of patients seen In ED (reduce rate of growth). # of services shifted from a secondary care setting to primary care.	Would look to get facility established in the 2011/12 year.	Following the review of the scope of the service provision in Nelson the approval to lease land to a GP owned Company was obtained in November 2011. Decision was made in October 2011 to increase the budget for the building of a facility adjacent to the ED at Nelson Hospital for future use by the Orthopaedic Service. This interim arrangement is to enable investigations to continue on options for an integrated health learning centre.	

COMMUNITY BASED SERVICE DIRECTORATE PROPOSED SERVICE IMPROVEMENTS (C0NTINUED)

COMMUNITY BASED SERVICE DIRECTORATE PROPOSED SERVICE IMPROVEMENTS	REASON/RATIONALE FOR IMPROVEMENT	HOW WILL IMPROVED PERFORMANCE AND/OR BENEFITS BE MEASURED?	TIMEFRAMES FOR SIGNIFICANT SERVICE CHANGE • DEVELOPMENT • CONSULTATION • IMPLEMENTATION	PARTIALLY ACHIEVED	ACHIEVED
The establishment of an integrated family health centre in Golden Bay through merging the services of the Community Hospital, the Joan Whiting Memorial Trust Rest Home and the GP practice. This service will be operated by NBPH from a Community owned facility.	Quality Consistency of service Access Maximisation of limited resource Sustainability Cost-Effectiveness Equity	Integrated services are delivered and sufficient efficiencies are delivered through integration to ensure ongoing service viability.	Timetable estimate – April/ May 2012 for new facility to be completed and all services operating from it.	Ministerial approval was obtained on 17 November 2011 to enable the Golden Bay Community Hospital Te Hauora o Mohua Trust to establish an IFHC. That approval also agreed to a change in service provider from NMDHB to NBPH for the services provided through the existing community hospital, district and public health nursing services. This change over was effected from 21 May 2012. The Trust tendered the construction of the facility in April 2012 however due to a variety of factors work is continuing on changes to specifications and funding options.	
Health of Older People (HOP) Aged Residential Care for psycho-geriatrics (to be led by Mental Health Service Directorate)	Sustainability Cost-Effectiveness	National Service framework.	Envisaged that full implementation will commence in the 2011/12 financial year.		See significant service changes under Mental Health
Oral Health – completion of community oral health service model	Quality Consistency of service Access Maximisation of limited resource Equity	Improvement in oral health status indicators Improved recruitment and retention / Staff satisfaction. Facilities comply with standards and legislation Efficient service delivery Timely and accurate information reporting	Fixed clinics built by 30 June 2011 and first mobile commences mid-2011		Introduction of the new Community Oral Health Service and clinics was completed in June 2012 with the second mobile becoming operational. The service has five district-wide clinics based in the community and two mobile treatment buses that service rural areas in Tasman and Marlborough.
'Better Sooner More Convenient' Strategy 1. Shift medical & surgical services from hospital settings to community & primary health care settings safely & as appropriate. 2. Enable organisational development of new Family Health Centres supported by community providers. 3. Facilitate improved clinical pathways including, e.g.: • Diabetes • Access to diagnostics • Surgical pre-admissions • Endoscopy • Child health continuum	Quality Consistency of service Access Maximisation of limited resource Sustainability Cost-Effectiveness Equity	NMHA Agreement in place incorporating commitment for services based on multidisciplinary, whole of system approach. NMHA annual work plan developed, clinically led outlining service changes through implementation of clinical pathways processes. At least two community based Integrated Family Health Centres support new clinical models of care & reduce acute demand. Development of clinical pathways for specific services as agreed with NMHA. Reduces acute demand.			MSSD is leading a number of initiatives to shift services from a hospital setting to a community setting, with the focus on delivering a service that is better, sooner and more convenient for the patient. Services include delivery of IV treatments, skins lesion removal in a community setting and follow-up appointments with General Practitioners with special interests. The Directorate is seeking the support of the PHOs in the management of IV treatments in a primary care setting. A proposal has been submitted to the MoH seeking funding to support post-operative care. A Clinical Nurse Specialist in Acute Pain Management is providing this service in Nelson Hospital PHOs are overseeing the management of IV treatments in community settings where previously they were delivered in a hospital setting

MEDICAL SURGICAL SERVICE DIRECTORATE PROPOSED SERVICE IMPROVEMENTS

MEDICAL SURGICAL SERVICE DIRECTORATE PROPOSED SERVICE IMPROVEMENTS	REASON/RATIONALE FOR IMPROVEMENT	HOW WILL IMPROVED PERFORMANCE AND/OR BENEFITS BE MEASURED?	TIMEFRAMES FOR SIGNIFICANT SERVICE CHANGE • DEVELOPMENT • CONSULTATION • IMPLEMENTATION	PARTIALLY ACHIEVED
Endoscopy Review One point of entry, consistent prioritisation, one waiting list, capacity planning, clear pathway	Sustainability Access Equity	Waiting times reduced. Improved throughput. Improved efficiency – better use of existing resource	Review began March 2011 Successful application for funding confirmed June 2012 Project Implementation August 2012	A district clinical lead for the Endoscopy Service to be appointed.
Theatre Productivity Improving 1st case starts, reduced turnover time & overruns	Consistency of Service Access Cost-effectiveness	Number patients receiving surgery, less cancelled patients, waiting time for acute surgery. Less overtime costs. More elective throughput.	Building Teams for Safer Care – The Productive Operating Theatre project began January 2012.	Theatres teams at both sites are moving through the TPOT framework. Significant progress with the foundation and enabling modules. A fortnightly meeting is held by The Productive Operating Theatre (TPOT) team with regular updates to the Steering Group and wider organisation from the TPOT Programme Facilitator.
Surgical Preadmission Reducing points of entry. Improving the quality of the surgical workup. Simplifying the patient pathway Nurse led process	Quality Consistency of service Access	Less cancelled patients due to better workup. Fewer clinics. More elective throughput Release of House surgeon time.	Related to site redevelopment of outpatient area Initiatives begin May 2011	Pre-admissions is now operating five days a week in Nelson. The Pre-Admission Coordinator has been appointed along with a Programme Facilitator. Pre-admission Clinic in Nelson Hospital was moved to the surgical outpatients area in June supporting the pre-admission pathway. Piloting newly developed pathway. Documentation condensed into one booklet to follow patient journey.
Minor Skin Lesions Review of skin lesions pathway and repositioning of minor skin lesion removal in community setting	Consistency of service Access Cost-effectiveness	Number of procedures performed away from hospital. Reduction in theatre sessions dedicated to removal of skin lesions	Consultation began March 2011 Implementation in October 2012	Following a tender process the selection of providers to manage skin lesion removal in community settings will be completed by first quarter of 2012/13
District wide Interventional Cardiology Better provision of service across the district Improved SMO Leave - Improve leave notice and approval process Leave planning by service	Sustainability Quality Sustainability Quality	Improved patient outcomes Time of leave notice Reduced cancellations Less outsourced costs Improved clinical outputs from locums – More clinical delivery, less locum cost, reduced leave balances	Implementation July 2011 Implementation May 2011	Third cardiologist commenced May 2012
Improved SMO Leave Improve leave notice and approval process Leave planning by service	Sustainability Quality	Time of leave notice Reduced cancellations Less outsourced costs Improved clinical outputs from locums – More clinical delivery, less locum cost, reduced leave balances.	Implementation May 2011	The investment in clinical leadership is with the purpose of strengthening clinical engagement in service leadership and improvement. Strengthening DHB leave policy Developing leave approval/notification logarithm Standardising process for locum engagement.

MENTAL HEALTH SERVICE DIRECTORATE PROPOSED SERVICE IMPROVEMENTS

MENTAL HEALTH SERVICE DIRECTORATE PROPOSED SERVICE IMPROVEMENTS	REASON/RATIONALE FOR IMPROVEMENT	HOW WILL IMPROVED PERFORMANCE AND/OR BENEFITS BE MEASURED?	TIMEFRAMES FOR SIGNIFICANT SERVICE CHANGE • DEVELOPMENT • CONSULTATION • IMPLEMENTATION	ACHIEVED
Directorate Funding, Performance and Reporting Review	Quality Access Consistency of service Cost-effectiveness Maximisation of limited resource	Collective NGO and DHB owned service mental health reports by NHI & KPI outcome data (where applicable). Implementation of standardized referral, assessment and recovery plans. Agreed client pathways across specialist mental health service providers. All NGO providers aligned to new mental health service specifications. Implementation of Rutherford Initiative recommendations in relation to mental health. DHB owned service multidisciplinary team review.	Consultation completed around Rutherford Initiative recommendations. Mental Health Service Directorate to further develop project plan inclusive of timeframes.	Worked with Providers to ensure alignment to MOH new service specifications, reporting requirements; monitored performance to contract; modified contracting provisions to allow flexibility for responsive purchasing and more relevant provider specific terms.
Implementation of the national Key Performance Indicator project.	Quality Sustainability Consistency of service Access	Benchmarked across DHBs nationally, which will indicate areas that require further investigation of service enhancement.	Full implementation commencing 1 July 2011.	Participated in the National Mental Health KPI project. Benchmark data indicates the District to be performing well.
Development of Stepped Care Model (as agreed with the NMHA)	Access Maximising limited resources Consistency of service Equity Quality	Stepped Care Model agreed by the Mental Health Service Directorate, Community Based Services Directorate and the Nelson Marlborough Health Alliance.	Development of Stepped Care Model by 31 March 2012 (inclusive of consultation). Implementation commences 1 May 2012.	A client pathway proposal for tangata whaiora (stepped care). This extends the Specialist Service Client Pathway with a Single Point of Entry across primary and specialist services and standardised referral documentation including NGO referrals.
Children of Parents with Mental Illness (COPMI). Taking an integrated approach with community.	Quality	Agreed pathways across services.	Discussions have commenced with Strengthening Families. By 30 September 2011 first meeting of key stakeholders held to discuss COPMI report and seek agreement on collaboration and pathways.	A review of Specialist Services for COPMIA was completed and will be extended in 2012/13 to Primary Services. The community team in Nelson has developed a service for Mothers and Babies to respond to the complex needs of mentally unwell mothers with young children (home-based treatment).
Development of Addictions Youth Co-existing service.	Access Equity	Service model of care agreed and operational by 1 July 2011.	Service operational 1st July 2011.	A Youth Addictions pilot in Nelson was extended to Wairau with community support work hours increased to support the role.
Rural Mental Health Service Provision	Access Equity	Improved understanding of the needs of two rural communities.	High level review completed by 31st March 2011.	Completed clinical review of Golden Bay and Motueka to ensure ongoing Consultant Psychiatry input in these areas. Extended CAMHS in Motueka.

CLINICAL SUPPORT SERVICE DIRECTORATE PROPOSED SERVICE IMPROVEMENTS

CLINICAL SUPPORT SERVICE DIRECTORATE PROPOSED SERVICE IMPROVEMENTS	REASON/RATIONALE FOR IMPROVEMENT	HOW WILL IMPROVED PERFORMANCE AND/OR BENEFITS BE MEASURED?	TIMEFRAMES FOR SIGNIFICANT SERVICE CHANGE • DEVELOPMENT • CONSULTATION • IMPLEMENTATION	PARTIALLY ACHIEVED
Review current **Medical Laboratory service referral patterns** regarding quantity and quality to ensure discretionary ordering patterns are widely practiced	Sustainability Quality Consistency of service Access Equity Cost-effectiveness Maximisation of limited resource	Reduction in total number of tests & reduction in unnecessary tests. Contract price maintained.	1 month to develop best practice test referral educational strategies. 2 months for consultation. 3 months for implementation Completion by 31 December 2011.	Following a change in ownership of the current Medical Laboratory discussions continue with the Senior Management of Southern Community Laboratories on strategies to improve referral patterns. Contract was renewed for a further five years.
Review current number of **community and hospital radiology examinations** (appropriateness of type of examination requested) to reduce the number of unnecessary referrals	Sustainability Quality Consistency of service Access Equity Cost-effectiveness Maximisation of limited resource	Tracking actual against budget monthly volume of examinations. By comparing actual against budget forecasts for radiology examinations.	Modified radiology access criteria will be in place by 1 October 2011 allowing for development, consultation and implementation.	Work in progress on Radiology Clinical Pathways, which has created much discussion between Radiology and Community referrers around the appropriateness of referrals.
Establish clinical pathways to improve GP access to diagnostic services	Sustainability Quality Consistency of service Access Equity Cost-effectiveness Maximisation of limited resource	Monitoring waiting times for designated diagnostic procedures. Customer satisfaction surveys re: access to diagnostics.	Consultation & implementation by 1 January 2012.	As above. Working towards new criteria for access to CT and MRI within 42 days for all community and Outpatient referrals
Introduce additional initiatives to reduce **community and hospital pharmaceutical expenditure**	Sustainability Quality Consistency of service Access Equity Cost-effectiveness Maximisation of limited resource	Monthly analysis of community and hospital dispensing volumes. Monthly analysis of drug costs. Monthly comparisons of actual with budget forecasts.	Appointment of Chief Pharmacist Agree initiatives to constrain community & hospital pharmaceutical costs. Completion by 1 Oct 2011.	Appointment of a Chief Pharmacist in June 2012 has enabled work on an implementation plan for the initiatives to constrain expenditure on pharmaceuticals to commence. Education to Community Pharmacists on Long Term Condition implementation under new Community Pharmacy Service Agreement
Implement the **Hospital Medicine Reconciliation Service**	Quality Consistency of service Access Equity Cost-effectiveness Maximisation of limited resource	Monitoring medication error rate. Monitor hospital readmissions due to medication adverse reactions.	Implementation to commence 1 April 2011 and completion by 30 June 2012.	Following the appointment of a Chief Pharmacist plans for developing a single health community for pharmaceuticals in NM have been commenced. The plan is to examine the management of risks for patients using tools such as medicines reconciliation, information technology e.g. e-prescribing/e-medicines.
Review Allied Health services to improve access and reduce waiting times: • District consistency • Accreditation and consistency • Single point of entry • Discharge planning process • Manage waitlist within available resources.	Sustainability Quality Consistency of service Access Equity Cost-effectiveness Maximisation of limited resource	Consumer, referrer & staff feedback. Reduction in length of wait for first assessment. Reduction in 'Did Not Attend' rates. Reduction in client assessments. Reduction in length of wait for low cost, high volume equipment. Reduction in LOS	Pilot projects initiated, evaluation and implementation will occur on 1 January 2012	The referral and Booking process, currently auditing by Specialty against expected pathways to see where the issues are. Gap analysis. An ED 6 month pilot in Nelson has commenced on 16 April involving Social Workers and Physiotherapy. A policy has been developed and approved allowing delegations to Allied Health Assistants to do duties that would otherwise have been done by a Therapist. Work is being conducted on working with other disciplines across the DHB for a community referral single point of entry.

CLINICAL SUPPORT SERVICE DIRECTORATE PROPOSED SERVICE IMPROVEMENTS (CONTINUED)

CLINICAL SUPPORT SERVICE DIRECTORATE PROPOSED SERVICE IMPROVEMENTS	REASON/RATIONALE FOR IMPROVEMENT	HOW WILL IMPROVED PERFORMANCE AND/OR BENEFITS BE MEASURED?	TIMEFRAMES FOR SIGNIFICANT SERVICE CHANGE • DEVELOPMENT • CONSULTATION • IMPLEMENTATION	ACHIEVED
Review Allied Health services to improve access and reduce waiting times: • District consistency • Accreditation and consistency • Single point of entry • Discharge planning process • Manage waitlist within available resources.	Sustainability Quality Consistency of service Access Equity Cost-effectiveness Maximisation of limited resource	Consumer, referrer & staff feedback. Reduction in length of wait for first assessment. Reduction in 'Did Not Attend' rates. Reduction in client assessments. Reduction in length of wait for low cost, high volume equipment. Reduction in LOS	Pilot projects initiated, evaluation and implementation will occur on 1 January 2012	The referral and Booking process, currently auditing by Specialty against expected pathways to see where the issues are. Gap analysis. An ED 6 month pilot in Nelson has commenced on 16 April involving Social Workers and Physiotherapy, A policy has been developed and approved allowing delegations to Allied Health Assistants to do duties that would otherwise have been done by a Therapist. Work is being conducted on working with other disciplines across the DHB for a community referral single point of entry.
Review **Support Works assessment processes:** • Improve dementia client pathways • Review HBSS contracts • Improve palliative care access • Extend InterRAI programme • Review assessment criteria for access to paediatrics • Review short-term discharge care & support • Review strategic plan for high & complex needs for child & youth • Review access criteria for meals on wheels service.	Quality Access Equity Cost-effectiveness Maximisation of limited resources Consistency of service	Meet needs of client groups in community setting. Reduction in entry to age residential care Reduced ALOS in hospital setting. Maintain budget for home based support services. Maintain budget for palliative care. Reduction in duplication of assessment information. Use of electronic patient information.	Development to be completed by1 July 2011. Implementation completed by 30 June 2012.	Dementia pathway for Primary Care implemented for both clinical and support services available.GP's are using the pathway. To be reviewed against the Minister's expectations for 2012/2013 for Dementia pathways. Reporting has been developed on a quarterly basis to review HBSS service spec and contract. This will be used to inform work for 2012/2013 regarding contracting and pricing options going forward. InterRAI has been extended into palliative care based at the hospices. 'Read only' users have been increased to clinical staff within the DHB. Access criteria reviewed with paediatricians and child and youth service manager. Current process working well. Report provided regarding use of support services for this group. Short term support deferred to 2012/2013 as part of other planning on discharges. High and complex needs for youth has been included in community base workstream for youth services. Clients receiving MOW have been data matched with Support Works supports further work required on this for 2012/2013.
Introduce improved systems to identify residency of all patients	Sustainability Quality Consistency of service Cost-effectiveness Maximisation of limited resource	Monitor IDF numbers on a monthly basis. Analyse external IDF reports monthly.	Implementation scheduled for 1 July 2011	Education and training programme put in place for clerical staff to better identify residency of patients
Review the appropriateness of current protocols for the transfer of patients for treatment out of district Develop clearer guidelines/protocols to ensure all NMDHB Senior Medical staff are familiar and aware of NMDHB policies for patient referrals to other DHBs.	Sustainability Quality Consistency of service Access Equity Cost-effectiveness Maximisation of limited resource	Monitoring IDF data. Monitor patient travel costs Retrospective audit on patients sent to other DHBs for treatment	Estimate 6 months to develop policies (or update existing policies), consult and implement. Target date 1 October 2011.	Clinical review group of unscheduled flights has been put in place to review transfers
Review patient travel in general in response to Rutherford Initiative requirement	Sustainability Quality Consistency of service Access Equity Cost-effectiveness Maximisation of limited resource	Monitor patient travel records Monitor actual against budget for patient travel monthly	All aspects of policy review can be accomplished within 3 months. Implemented by 1 October 2011.	Trialled a pilot service for a Patient Shuttle between Blenheim and Nelson between October 2011 and March 2012. Due to low utilisation the decision was not to proceed beyond the end of the pilot. Patient travel in both scheduled and unscheduled flights have exceeded budget due to significant cost of one off expensive evacs to Auckland, as well as higher number of unscheduled flight movements than last year, as well as trends over the past 9 months showing more patients travelling to Wellington by air instead of Christchurch.

HEALTH TARGETS

During 2011/12 DHBs have been measured on a quarterly basis against a number of health targets first introduced in 2007/08. These targets are a set of national performance measures specifically designed to improve the performance for three prevention services and three hospital services.

NMDHB has improved on all health targets since they were introduced. Our performance during 2010/11 was:

	2011/12			2010/11		2009/10	
Target Area	**National goal**	**NMDHB**	**National**	**NMDHB**	**National**	**NMDHB**	**National**
Shorter stays in Emergency Departments	95%	98%	93%	97%	92%	98%	87%
Improved access to elective surgery	100%	103%	105%	100%	104%	105%	105%
Shorter waits for cancer treatment	100%	100%	100%	100%	100%	97%	99%
Increased immunisation	95%	87%	92%	87%	90%	89%	87%
Better help for smokers to quit	95%	96%	91%	90%	85%	52%	57%
More heart and diabetes checks	60%	50%	46%	69%	72%	66%	68%

COMMUNITY BASED SERVICE DIRECTORATE

MAORI HEALTH

2011/12 saw many projects for Maori health started and showed early results for future success. A key development started in 2010 and continued in 2011/ 12 is the development of the Maori health provider Coalition. In July 2011 a key milestone was achieved with five of the eight Maori health providers contracted to deliver Maori health services formalising their relationship with the signing of the Memorandum of Agreement. By so doing, these providers have agreed to work as a team and to explore future change to Maori health service delivery in Nelson Marlborough. This was followed up in March 2012 with the appointment of a project manager to review the Coalition Work Plan. This plan now approves the direction for the Coalition and what shape it will take in the near future. This project will cover multiple years with it coming to fruition in 2013/14.

Te Pumanawa Hauora, Research Centre for Maori Health and Development at Massey University has started the final stages of the Te Hoe Nuku Roa, a longitudinal study of Nelson Marlborough Maori community's health. A project team was appointed in October 2011 with surveying of 120 Maori families (out of 150) being completed in May 2012. The project had some problems as whanau had either moved or did not want to participate in the project. This has caused some delays in the final analysis, as new whanau had to be recruited to the project. NMDHB is now awaiting a final report which will be reading in 2012/13.

Te Rau Matatini was re-engaged to complete an extended pilot on the Maori cultural competency project. Project planning and preparation started in March 2012 with the pilot going live in June 2012. This pilot includes non-Maori DHB staff. It was extended based on a recommendation made by Te Rau Matatini to include non-Maori DHB staff in future programmes. There are ten participants on the programme. Each person is supported by mentors identified by Te Rau Matatini. The pilot will not be completed until September 2012 with a final report being presented to NMDHB.

Work has started on the development of a long-term Maori health outcomes framework for Nelson Marlborough. This project is led by the Iwi Health Board. The outcome is to develop a framework that will measure progress towards the achievement of the 30-year Maori health vision. Early developments include a literature review and interviews with key stakeholders.

They include NMDHB Service Directorates, Kimi Hauora Wairau Marlborough and Nelson Bays PHO, and Maori health providers. The project will continue in 2011/12.

He Pukenga Hauora Service (Maori Health) continues to advance positive health outcomes for the Maori community. There has been the continued roll out of He Taura Tieke, complete DNA or Did Not Attend audits, and support for the ongoing function and establishment of the Maori chaplaincy service. In addition, the team continues to provide cultural support to service departments and guidance to whanau accessing NMDHB hospital services.

NMDHB's Kaumatua Group continues with its role in advancing positive leadership to the Iwi Health Board, NMDHB Board and DHB staff. This year the group has been instrumental in guiding the Maori and non-Maori DHB staff with Marae protocols, support with the Maori chaplaincy service, and looking a succession planning and workforce development for Kaumatua within the Maori community.

ACHIEVEMENTS FOR MAORI IN NELSON MARLBOROUGH

72% of Maori diabetes checks achieved to our target benchmark of 60%.

94% of Maori under 2-year-olds fully immunised year to date (note this is against a current 95% target rate).

98% of Maori hospitalised were offered smoking cessation advice and support to quit (this is higher than the rate for 'other people' of 96%).

ADOLESCENT ORAL HEALTH (PUBLIC HEALTH)

The adolescents in our district have some of the best access to free dental service in the country, and are taking up the opportunity in large numbers. This is largely thanks to dentists being engaged and committed to the health of our young people; they ensure that they stay in contact and get recalled for regular checkups. Our Adolescent Oral Health Coordinators also contribute to this high use of the service by ensuring that as many children as possible transfer to the dental services as they leave Year 8 at school. Over the last five years adolescent use of our oral health service has been amongst the highest in the country. Last year, 86% of adolescents in Nelson Marlborough attended the dentist. There are 28 dentists across Nelson Tasman and Marlborough run a high quality service for the adolescents. Oral Health services are free for 0 to 17-year-olds; our new Community Oral Health Clinics see children from birth until they finish their intermediate schooling in Year 8, then private dentists treat adolescents from Year 9 until they turn 18 years of age for free, under a contract with the DHB. This high use of our oral health services means our children's teeth will be kept healthy through timely treatment and the promotion of healthy teeth practices, and will serve them well in their adult years.

COMMUNITY ORAL HEALTH SERVICE MOBILE TREATMENT UNIT (ORAL HEALTH)

Introduction of the new Community Oral Health Service and clinics was completed in June. The service has five district-wide clinics based in the community and two mobile treatment buses that service rural areas in Tasman and Marlborough. The Marlborough Mobile allows around 2,000 children from Havelock, Renwick, Seddon, Ward, Picton and Murchison to have easy access to oral health care, and the Tasman Mobile sees around 4,000 children at Upper and Lower Moutere, Collingwood, Takaka, Tapawera, Wakefield, and Mapua. Parents and caregivers have overwhelmingly praised the new clinics and the mobiles for being bright, inviting, and very child-friendly, and have valued the opportunity to stand beside the Therapists and Assistants, ask questions, and learn about their children's oral health needs as the examinations and treatments are carried out. This new approach is calming and reassuring, for children and adults alike.

SMOKING CESSATION (PUBLIC HEALTH)

We know that around two people in ten admitted to hospital currently smoke, and that half of the people who currently smoke want to quit. The DHB's clinical staff, in and around the hospital, talk to almost all these smokers about their options for giving up smoking if they choose to do so; in 2011/12 this amounted to around 3,800 people. NMDHB's Public Health Service supports this work with the 'Smoking Cessation ABC' Programme (Asking about and recording smoking status, giving Brief advice and making an offer of Cessation support) and also provides 'Quit Support' Coaches who provide individual help or offer confidential support to hospital patients and outpatients, parents of admitted children, and pregnant women and their whanau who would like support to stop smoking. Support is user-friendly and can be by TXT, telephone, email or face-to-face. Smoking is still the leading cause of preventable death in New Zealand and increases the risk of developing heart disease, lower respiratory infections, and lung diseases, including cancer, so we will continue our efforts to support the people of our district to be 'smokefree'.

PERTUSSIS OUTBREAK (PUBLIC HEALTH)

An outbreak of Pertussis has been in progress since August 2011 with a total of 839 cases notified to the end of June 2012, and with Nelson Marlborough recording the highest number of reported cases amongst all DHBs in New Zealand. The Public Health Service set up an incident management system (CIMS) to provide outbreak control over busiest part of the outbreak; the most affected group were school children in the Tasman area. Our work involved following-up and monitoring infected people, data collection, providing advice to doctors and health professionals, and information to schools and the public. The outbreak has continued at a moderate level during 2012, with a more even mix of cases from Nelson and Tasman emerging and relatively few cases in Marlborough. From the data collected we are looking at the factors underlying the local clustering and severity of the outbreak in order to work towards minimising such an outbreak in future.

SAFE COMMUNITY DESIGNATION (PUBLIC HEALTH)

Nelson/Tasman was officially designated and commended as an 'International Safe Community' in August 2011 by the World Health Organisation (WHO). This is a concept that recognises safety as 'a universal concern and a responsibility for all', an approach to community safety that encourages greater cooperation and collaboration between non-government organisations, the business sector, local, and government agencies. Our local programme is called 'Safe at the Top' and has the support of over 80 community organisations. It is led by NMDHB, NZ Police, Accident Compensation Corporation, Nelson City Council, Tasman District Council, the Ministry of Social Development, and Fulton Hogan. Achieving the 'International Safe Community' status is the first milestone on a continuing journey of improving safety for everyone in our district. The future direction will be to address some of our more important community safety issues and to begin the accreditation process in Marlborough.

NEWBORN ENROLMENT (CHILD AND YOUTH)

A new programme to progress newborn enrolment with general practice was introduced to ensure all the babies in our district are connected to health services in order that their health needs can be met in a timely way and parents can be supported to keep their children well. Early enrolment of newborns supports the babies to get four free health services to which they are entitled. Parents fill out just one form that then enrols their baby with four services: a general practitioner, the National Immunisation Register (NIR), a Well Child Tamariki Ora provider and the Community Oral Health Service.

GATEWAY ASSESSMENTS (CHILD AND YOUTH)

Gateway Assessments for children is a new service implemented with the Ministry of Social Development to assist some of New Zealand's most vulnerable children who have often become disconnected from regular health and support services. Referrals are made by Child Youth and Family (CYF) to the Health Coordinators who arrange for a health assessment by paediatricians and/or other appropriate services and, together with CYF, agree a plan and co-ordinate the access to whatever services are needed for the child. The assessments are health and education focussed for children in the care of CYF, with the aim of identifying and addressing health and education needs to ensure these children have the best possible opportunities for growth and learning development.

NEW PAIN SERVICE (PRIMARY CARE)

A new community-based Persistent Non-Malignant Pain Service (PNMP) was introduced, delivered by clinicians specialising in pain management, including physiotherapists and psychologist. It will be provided in Nelson/Tasman by Nelson Bays Primary Health and in Marlborough by Kimi Hauora Wairau Marlborough Primary Health Organisation. Persistent (or chronic) pain is pain that has lasted for a long time (minimum three months) as opposed to acute pain which is immediate and short lasting. In order to be referred to the new service, people suffering persistent pain will have tried all specific curative treatment options aimed at the condition underlying the pain. This service is designed to be more accessible and comfortable for the patient, and will enable people with this type of pain to regain function, manage their pain and reduce their need for emergency temporary relief, and improve their quality of life.

GOLDEN BAY (PRIMARY CARE)

NMDHB, together with Nelson Bays Primary Health and Golden Bay Community Health 'Te Hauora o Mohua', continued work to finalise the set up of an Integrated Family Health Centre in Golden Bay. This new approach to health services will bring together Primary Care and general practice, Rest Home, and the Community Hospital to provide health services 24 hours a day in a modern, purpose-designed setting. Doctors and nurses will be able to work as a team, making the best use of specialist skills and providing clients with better comfort and amenities. The estimated completion date for the health centre is mid 2013.

HOSPITAL AND COMMUNITY INTEGRATION AND COLLABORATION - IMPROVING THE CO-ORDINATION OF CARE

Work has started on the building of a new orthopaedics and GP after-hours and duty-doctor facility on the corner of Franklyn Street and Waimea Road in Nelson. The new Medical and Injury Centre (MIC) will provide out of hours, duty doctor, and enhanced General Practice services. MIC complements and supports our Nelson General Practices by providing urgent and unplanned medical care as well as innovative generalist services. In addition, MIC is a low cost access General Practice striving to improve access for underserved patients and reduce inequalities. MIC will promote extended care in all of our General Practices recognising the importance of continuity and the value of your General Practice medical home. The facility is due for completion in late 2012.

REST HOME SUBSIDIES IN A LICENCE TO OCCUPY VILLA, APARTMENT OR UNIT (HEALTH OF OLDER PEOPLE)

During the year NMDHB facilitated national guidelines for DHBs and Age Related Residential Care providers where clients receive rest home services while they remain in their own serviced villas, apartments or unit under a Licence to Occupy (LTO). This followed an approach on behalf of a Marlborough resident.

The guidelines now require ARRC Providers to inform and negotiate with residents eligible for subsidised care, who remain in their own units, a level of reimbursement for weekly service fees.

Where negotiations on behalf of affected residents are not resolved, DHBs are now expected to pursue such breaches.

MEDICAL SURGICAL SERVICE DIRECTORATE

On 29 June 2012 the Medical Surgical Team achieved the target of no patient waiting for either a FSA or elective procedure more than six months by treating all patients placed on a waiting list on or before 2 January 2012. This ensured NMDHB was ESPI compliant in accordance with the targets set by the Ministry of Health.

This was achieved through a high level of commitment from our staff and was in a year where demand for Medical and Surgical inpatient beds continued to grow. Acute caseweight activity was 112% of plan for the year and elective caseweights 110% of plan. Overall 21,493 caseweights were delivered against a plan of 19,329.

The complexity of patients grew during the year which had a flow-on effect into costs, particularly for patient consumables.

The Medical Surgical Directorate continues to perform well in the national targets:

- Achieved the elective surgical discharges required by the Ministry of Health for our population: 6,029. Standardised intervention rates show that we continue to outperform many other DHBs in terms of access to elective surgery
- Achieved for 97% of those that presented to our Emergency Departments a waiting time of less than six hours before discharge or admission to the hospital
- Provided for patients more first specialist assessments by consultants than planned.

The Medical Surgical Directorate continued with a focus to improving quality healthcare in the following areas:

- **Quality Framework.** The quality framework through the Quality and Safety Governance Committee continues to improve our processes around reportable and sentinel events.
- **Theatre Productivity.** Building on the work of the previous year, a number of initiatives are underway to improve theatre quality and efficiency. These are being overseen by The Productive Operating Theatre project team.
- **Surgical Pre-Admission Redesign.** Changes have been made to implement the redesigned preadmission process that leads up to patients having elective surgery. The focus is on improving the quality of surgical and anaesthetic assessment and simplifying the pathway a patient takes, with a view to reducing the number of cancellations on the day of surgery.
- **Shifting services.** The management of IV treatments in community settings previously delivered in a hospital setting was taken over by the PHOs. Evaluation of proposals to manage skin lesion removal in community settings is currently being finalised. These moves are in keeping with the Better, Sooner, More Convenient framework of care for patients.
- **Care Capacity Demand Management Programme.** This programme started in 2010 and focuses on better matching nursing resources to the varying demands of patient care. It is assisting us to ensure we have the necessary resources to deliver quality care and help us as an organisation to respond effectively when demand for care rises.
- **Acute demand in a Hospital Setting.** Hospital at a Glance has been launched, enabling visibility of hospital capacity to aid coordination of resources across the hospital. Standard operating procedures for each clinical area are being developed.

EMERGENCY DEPARTMENTS (NELSON AND WAIRAU)

The trend in presentations to our Emergency Departments over the 2011/12 year has been different from previous years. Initiatives commenced in 2009/10 that focused on reducing the number of patient presentations whose needs could have been dealt with in primary care have continued to be effective in Nelson. In Marlborough, due to constraints in primary care, numbers of presentations continued to grow as a trend. A new general practice opened by Kimi Hauora Wairau Marlborough PHO in April 2012 is expected to help reduce the trend.

NMDHB continued to reinforce the message 'ED for emergencies only, advertising campaigns, particularly over Christmas, newspapers and movie theatre advertising for visitors to the district, signage at entranceways and on adjacent roadways and specific information on our website about when people should attend the ED and when they should visit their GP.

Work across directorates has commenced on a series of initiatives to reduce the number of presentations including single point of entry, rapid response teams and data sharing with providers such as St John. It is anticipated these initiatives will commence in the first quarter of 2012/13.
Work on health pathways, see page 30, is also intended to contribute to the reduction in the number of presentations.

2011/2012 ACTUAL TO PLANNED				
	2011/12 Actual to Planned		% Difference	Total Difference above (+ve)/below(-ve)
	2011/12 Planned	2011/12 Actual Estimate		
CASE-WEIGHTED INPATIENT DISCHARGES				
Maternity	**1,761**	**1,773**	**0.68%**	**12**
Medical	**6,625**	**6,734**	**1.65%**	**109**
Medical electives	480	516	7.48%	36
Medical acute	6,145	6,218	1.19%	73
Medical other	-	-	0.00%	0
Surgical	**11,288**	**11,728**	**3.90%**	**440**
Surgical electives	6,692	6,606	-1.28%	-86
Surgical acute	4,596	5,122	11.44%	526
Surgical other	-	-	0.00%	0
Total	**19,674**	**20,235**	**2.85%**	**561**
OUTPATIENT SERVICES (EXPRESSED AS EVENTS)				
ED	30,000	34,548	15.16%	4,548
Medical first	9,005	7,604	-15.56%	-1,401
Medical follow up	16,351	15,904	-2.73%	-447
Oncology	1,900	2,286	20.32%	386
Renal	1,750	1,416	-19.09%	-334
Scope	3,687	1,416	-61.59%	-2,271
Surgical first	12,053	12,476	3.51%	423
Surgical follow up	21,717	21,904	0.86%	187
OTHER SERVICES (EXPRESSED AS EVENTS)				
Maternity	1,446	1,388	-3.99%	-58
Medical	10,019	5,532	-44.78%	-4,487
Surgical	6,610	3,405	-48.49%	-3,205
Health of Older People	24,777	20,822	-15.96%	-3,955
Miscellaneous	212,863	215,662	1.32%	2,799
ALL NON-INPATIENT SERVICES (EXPRESSED AS CASE-WEIGHTED OUTPUTS)				
Total	**13,488**			
Total volume growth	**33,162**			

MENTAL HEALTH SERVICE DIRECTORATE

The Mental Health Directorate has had a productive year embedding the Directorate and building on relationships across the continuum of services. The Directorate model is well suited to Mental Health and in itself an applauded innovation. A Reference Group was set up with relevant Provider Stakeholders to function as the consultation domain and assist with decision-making. This has been very effective, described recently by an NGO member (and agreed unanimously by the Group) as 'useful, productive, important and progressive'.

The structure successfully supports greater integration and collaboration in service delivery, combined view and review of contracts based on district needs, reporting data and performance, and shared training across the Directorate, thus improving access to services (3% increase), value on investment and supporting workforce, and thereby addressing Ministry targets.

Further, it supports and is supported by the regional service focus of the South Island Mental Health Alliance of which the Service Director is a member, and in this achieves the Ministry's regional integration objective. Reviewing the models of care, access, mechanisms of regional service delivery, volumes and funding have been foci.

Financial sustainability remained a key focus in 2011/12. By stringently monitoring expenditure the Directorate has remained within budget, whilst achieving Annual Plan 2011/12 objectives and positioning for the 2012/13 Annual Plan priorities.

The Significant Service Change in Psycho-geriatrics went according to plan with the successful re-integration of 8.5 admission beds and the community team into Mental Health. Those requiring residential care (17) were appropriately transferred to community providers. The process was well supported by family and also attracted commendation as change management example from the Minister of Health. Acknowledgement also goes to staff for their professionalism and care during the process, as for many their own positions were disestablished. A business case was developed for the design of future inpatient facility.

Planned Service Improvements were achieved and some extend into 2012/13. For the improvement around 'Directorate funding, Performance and Reporting Review', the Directorate focussed primarily on NGO contracts and performance. Working together with providers to ensure alignment to Ministry new service specifications; for more informative, aligned reporting requirement (NHIs and KPI outcome data); performance to contract; standardising prices; extending tenure; negotiated flexibility (to ensure responsive purchasing); reviewing and re-writing contracts generic clauses and more relevant provider-specific terms.

The Directorate completed participation in the National Mental Health KPI project and benchmark data indicates the District to be performing well. The data is very useful in service planning and review.

A directorate-wide client pathway proposal has been agreed to develop a continuum of response for the tangata whaiora (stepped care). This extends the Specialist Service Client Pathway with a single point of entry across primary and specialist services and standardised referral documentation within this, including NGO referral documentation. There are a number of clinical pathways within this:

- Services for children with parents who have mental illness or addiction was a focus and a review Specialist Services for COPMIA was completed, to be extended 2012/13 to Primary Services. The community team in Nelson has progressed Mothers and Babies services, developing a responsiveness to the complex needs of mentally unwell mothers with young children (home-based treatment).
- Youth Addiction Services: A Youth Addictions pilot in Nelson was extended to Wairau and community support work hours increased to support the role. The staff work closely with youth justice, schools, police and probation. This too will be extended in 2012/13.
- Rural Services had a preliminary clinical review of Golden Bay and Motueka to ensure ongoing Consultant Psychiatry input and extended CAMHS in Motueka. Also to continue in 2012/13.
- Access and delivery of brief intervention clinical services and extended GP consultations was considered (focus for 2012/13), as was the utility and utilisation of e-therapy self-help tools (Beating the Blues, John Kirwan's Depression Helpline, the Lowdown).

The Specialist Service initiatives are many:

- Addictions are running more district-wide groups (Nelson, Motueka, Wairau) to deal with increased workload (recovery, relapse prevention, anxiety and drink driving); Koru Clinic (drop in for Opioid Substitute Treatment [OST] clients) extended to Wairau; more GPs involved in OST client care; a new triage where clients/ family have immediate access to brief intervention

- Multidisciplinary input (clinical psychology and NASC) have increased across teams and will extend with other disciplines 2012/13.
- In Witherlea Marlborough group work has increased (mindfulness, depression, initiatives, healthy living for those with chronic conditions) and the Dialectical Behaviour Therapy initiative refreshed in its 8th year of delivery. The team is also extending their rehabilitative focus and working on a partnership with Hapai Te Ora.
- Nikau House Nelson continues to share activities with NGOs (the Quadrangular Indoor Sports Tournament, Beach Sculpture Day, Cooking with Gateway Housing, and the Great Cake Bakeoff won by The Whitehouse). Other successful activities have been Safe Cycling with Sports Tasman and police, Quit Smoking, weekly Kick Start Breakfast promoting nutrition and healthy eating, weight management support groups (PHO Dietician). After hours activities have increased within budget.
- The Continuing Care team has challenged the 'lifetime users' mindset and successfully discharged into the community.
- The Admission Unit has developed sensory modulation as a treatment modality to minimise admission trauma and to maximise de-escalation in intensive care.
- The CAMHS team have upgraded facilities in Nelson and Wairau; a new initiative based at a local college on early intervention for emotional distress (a suicide prevention approach); increased child psychiatry hours in Wairau; increased liaison with Paeds and Child Development team and NGOs which improves access for children and families; a core team was trained in the Maudsley approach to Eating Disorders; improved triage; re-started Dialectical Behaviour Therapy groups for children.

The first year of the Directorate has been a busy time, not only in consolidating relationships but also a mixture of establishing systems and processes as well as clinical developments, all of which serve to stand it in good stead for the forthcoming year.

DISABILITY SUPPORT SERVICES (DSS)

The service was reviewed as part of the NMDHB Rutherford Performance Programme and has commenced planning and acting in response to 17 initiatives identified in the report. The most significant of these has been to consult on the future governance structure for the DSS and to establish a steering group to oversee the development of a business case for the establishment of an independent trust for the NMDHB to transfer service to.

The service has continued to develop internal systems to create role and values clarity, this has been communicated through wide circulation of the DSS quality and work plan as well as the development of an operations manual, specific to how the service achieves the health and disability sector standards.

The service continues to improve its financial performance and efficiency. Sleepover Wages Act and variance between wage inflation and fund increase have impacted on final results in the financial year. Service user numbers have been stable throughout the year. The service achieved good feedback from audits.

CANTERBURY EARTHQUAKES

As noted in our 2011/12 Annual Plan, due to the emergent nature of the effects of the 22 February 2011 earthquake in Canterbury, we identified areas such as age related residential care, GP visits and pharmaceuticals where we expected impacts to be reflected in our results. Population estimates by Statistics NZ show Nelson and Tasman territorial districts to have some of the highest increases over that year.

The impacts of the earthquakes are expected to be ongoing over at least the next five years. Media reports of future migration of people from Canterbury indicate that our district is the most preferred location for those considering moving.[6]

INFRASTRUCTURE CHANGES

Following the Canterbury earthquakes we have taken the opportunity to have all our buildings assessed by engineers to determine their compliance to building standards. Two buildings have been vacated due to the low ratings (the former nurses homes at both Nelson and Wairau Hospitals) while two others will require remedial work to improve their compliance ratings (George Manson and Percy Brunette at Nelson).

With the new knowledge of the status of the buildings on the Nelson site, the business case for the site redevelopment is being restarted and the proposed interim upgrade of Nelson Hospital suspended. Changes to the process introduced by the Better Business Case guidelines require extensive use of investment logic mapping and preliminary workshops have been held.

Work is also under way on a number of remedial actions at Wairau Hospital following a post project compliance review. We are working with the Project Managers and Contractors to address the items identified in the review.

6 The Press 1 June 2012 "Survey picks quake exodus"

HEALTH PATHWAYS

In June 2011, Nelson Marlborough joined the health pathways initiative developed in Canterbury. This has been an important joint working approach between primary and secondary care clinicians in our district.

The pathways process is a collaborative approach where clinicians get together to develop pathways of care which are agreed, evidence-based and able to be implemented across the district. A leadership group (pathways support group) provides the support for pathway development and the systems to connect NMDHB directorates to implement service changes identified. Pathways are disseminated on the easily accessible Health Pathways website. We have been fortunate in that a lot of work has been done by Canterbury clinicians and many pathways will be relatively easy to adjust for the Nelson Marlborough context.

There have been some pathways developed entirely in Nelson Marlborough, including Measles, Weight Management in Adults, Persistent Non-malignant Pain Management and Cognitive Impairment. However, the largest proportion of work has been in localising the existing Canterbury pathways.

The groups of pathways chosen to localise have been identified as a result of service pressures, or clinical interest. Groups of pathways underway include:
Paediatric, Cardiology, Pregnancy, Radiology, Rheumatology, Allied Health, District Nursing and many individual pathways.

There are more than 150 pathways that are either live or underway. The pathways group has an objective to move rapidly to a point where a majority of pathways are relevant to clinicians in Nelson Marlborough, but at the same time balance the need to engage the services and clinicians in the opportunity for change.

By enhancing general practice access to services, simplifying the transfer of care between settings and providing access to specialist advice without the need for a hospital appointment, services traditionally provided in hospitals can increasingly be provided in the community.

By supporting the provision of less complex services in community settings, we are freeing up our secondary care capacity to cope with growing and increasingly complex demand.

NMDHB continues to work with the South Island IT Alliance to collectively implement the e-referrals and patient administration systems. This implementation is expected to be completed over the next three years.

REGIONAL COLLABORATION

Nelson Marlborough is part of the South Island (SI) region along with Canterbury, West Coast, South Canterbury and Southern DHBs. Each SI DHB individually ensures the provision of health and disability services for its population and faces similar challenges in delivering high quality services, ensuring the future sustainability of those services and achieving Government priorities. All South Island DHBs are changing the way they work within their local districts to meet these challenges and alleviate the pressures they face. However, as individual DHBs we cannot make a large enough impact to ensure the future sustainability of SI services, particularly regarding more highly specialised and complex services.

With a relatively small total SI population (1,038,843 people, 24% percent of the total New Zealand population), implementing diverse but similar individual responses duplicates effort and investment and leads to service and access inequalities. Regional collaboration is an essential part of our future direction. In agreeing a collaborative regional direction, the SI DHBs have committed to a 'best for patient, best for system' alliance framework that aligns with national policy. The SI's Regional Health Services Plan articulates the regional direction and the key principles that will inform regional service development, service configuration and infrastructure requirements over the next several years.[6]

The regional direction, which is closely aligned to the national approach, is based on the following concepts:

- More health care will be provided at home and in community and primary care settings
- Secondary and tertiary services will be provided across DHB boundaries
- Flexible models of care and new technologies will support service delivery in different environments from those traditionally recognised
- Health professionals will work differently to coordinate a smooth transition for patients between services and providers
- Clinical networks and multidisciplinary alliances will support the delivery of quality health services across the health continuum.

These concepts emphasise a significant step change in the way we design and deliver services. Through regional service planning, traditional DHB boundaries and patient flows are being challenged to ensure that services are supported in a sustainable manner.

While regional planning initially focused on the sustainability of vulnerable hospital and specialist services, the emerging 'whole of system'[7] approach, recognises primary and community services as essential to future sustainability.

NATIONAL COLLABORATION

At a national level, we work with the education, social development and justice sectors to improve outcomes for the Nelson Marlborough population through training, health, nutrition, physical activity, alcohol and other drug and mental health initiatives – crossing sectors in an effort to meet shared goals.

Similarly, we are committed to implementing a number of national programmes which will improve the health of our community, including B4 School Checks, the Human Papilloma Virus (HPV) Immunisation Programme and rollout of the InterRAI assessment tool for which NMDHB is taking a lead in the South Island.

NMDHB also participates in the national workstreams being developed and led by the National Health Board, National IT Board, Health Quality and Safety Commission and Health Workforce New Zealand. By clearly establishing strategic direction, these workstreams will support common platforms, reduce duplication and variation and minimise inequalities between DHBs – all of which will free up resources and create additional capacity in the health sector.

While the conceptual framework was initially focused largely on the sustainability of vulnerable hospital and specialist services, the emerging 'whole of system' approach recognises the development of primary and community services as essential to future sustainability and is aligned to the national direction. These relationships allow for:

- Sharing knowledge around the forces for change which influence planning and provision of health and disability services
- Ensuring access to a broad range of services across different settings now and into the future for those in the population who need these services

6 South Island Regional Health Services Plan 2012/13 – available from www.nmdhb.govt.nz.

7 This model moves from the current 'silo-like, fragmented approach' characteristic to most health care delivery to an approach that involves every service, every organisation, across all settings of care and all levels in optimising the quality and safe delivery of patient-centred care.

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

We have relationships with other agencies such as the Ministry of Social Development, the ACC, Justice, Police, Housing, Education, territorial authorities and a range of other NGOs.

NELSON MARLBOROUGH HEALTH ALLIANCE

During 2011/12 representatives from the boards of both PHOs and NMDHB developed a charter and supporting expectations, roles, powers and duties for the Nelson Marlborough Health Alliance (NMHA). The Chairs of each organisation provide governance to the NMHA; the respective CEs provide leadership to the NMHA.

The intent of the NMHA is to use a collaborative approach to complex health projects or initiatives for the benefit of the district, where the organisations agree to work together in an open and co-operative manner:

- Sharing the risk and rewards of managing the project or initiative
- Giving access to the expertise and skills of all of the parties
- Developing and applying innovative solutions
- Giving greater opportunity to effectively use assets.

Working within the Better, Sooner, More Convenient Government policy and the NMDHB Board's HEALTH2030 strategy, the NMHA works together to plan and provide integrated and co-ordinated health services through clinically-led service development and its implementation within a 'best for patient, best for system' framework.

The expectations from developing the NMHA are that:

- health disparities in the district are addressed
- health services are better, sooner and more convenient for the people of Nelson Bays, Tasman, Golden Bay, Murchison and Marlborough.

CROSS-SECTORAL

NMDHB works with three unitary local authorities (Nelson City, Tasman and Marlborough districts) through a variety of mechanisms including membership of key committees (civil defence, transport, disability access), environmental safety and sustainability (air, water, built environment, footpaths, cycle ways etc.) and undertakes 'Health Impact Assessments' collaboratively with other agencies. We contribute to the 'Safe at the Top' initiative.[6] Led by the Ministry of Social Development, NMDHB continues to be a member of the Strong Families Regional Governance Group and the Family Violence Intervention Programme. NMDHB is a partner in the Talking Heads initiative. This brings together the three district Mayors and heads of Government departments on local initiatives related to community well being, and includes governance of the WHO sponsored Safer Communities project.

SENTINEL EVENTS

Sentinel Events are defined as any unexpected occurrence involving death or serious physical or psychological injury, including near-misses for which a recurrence would carry a significant chance of a serious adverse outcome. These are reported nationally in November for the previous year ending 30 June. During 2011 there were ten events with falls resulting in fractures being over-represented in that year and a project is well underway to address this ongoing risk, particularly with the frail elderly. Four reviews found appropriate care had been provided and there were no recommendations for improvement.

An audit of the recommendations prior to 1 July 2010 showed all of these have been completed.

6 Refer http://static.bewell.org.nz/gems/SafeAtTheTop.pdf

ORGANISATIONAL STRUCTURE

The changes that were made to our organisational structure in 2011 have enhanced the special partnership arrangement with the Iwi Health Board (IHB) and the linkages with the statutory advisory committees and the Chief Executive (CE).

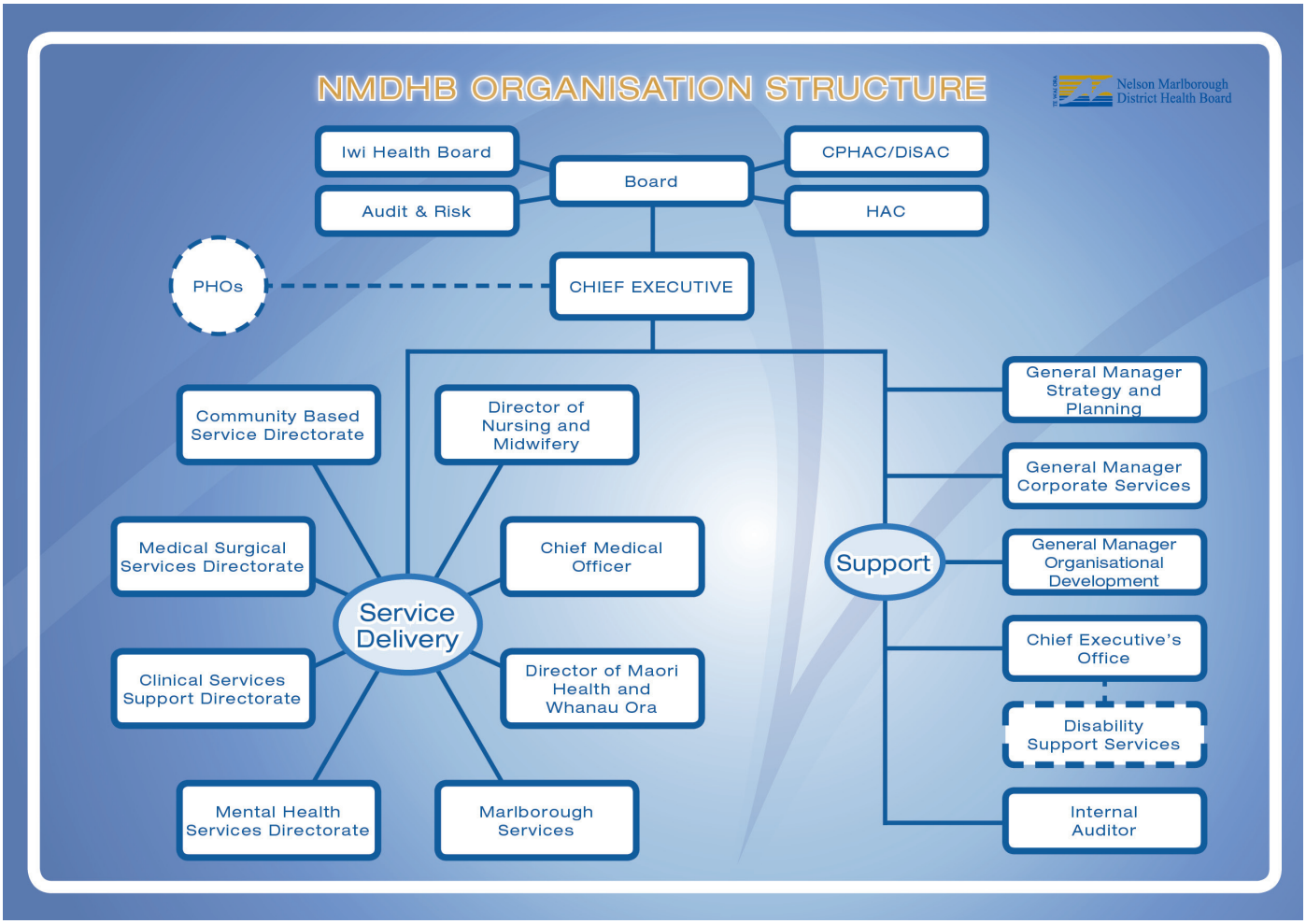
Following the joint revision with the IHB of the Memorandum of Agreement now known as 'He Kawenata', the two boards continue to meet to consider the Treaty of Waitangi and health and disability issues for local Maori.

NMDHB's Executive Leadership Team ensures primary and secondary clinicians are integral to determining the direction and management of the organisation. Chaired by the Chief Executive, the team consists of ten clinicians from both specialist (hospital) and community (GP) settings; the Directors of Nursing and Midwifery, Allied Health, Maori Health and Whanau Ora and the Chief Medical Officer. It also contains Executive Service Directors who are part of the service directorate triumvirates, supported by the General Managers Strategy and Planning, Corporate Services, Board Secretary and Organisational Development.

CLINICAL LEADERSHIP CAPABILITY

NMDHB's Executive Clinical Directors and appointed service line clinical heads of department, the Chief Medical Officer, the Director of Nursing and Midwifery and the Director of Allied Health are all leading various initiatives and processes that develop and strengthen clinical leadership, support the engagement of all health clinicians, ensure clinical competency, professional reaccreditation and new models of care delivery. Quality and Safety in NMDHB is overseen by the 'Quality and Safety Governance Committee', chaired by the Chief Medical Officer.

Clinicians take lead roles in service development, capability and capacity development and resource planning. This reflects the move of the Medical Surgical Services Directorate, funded through a capacity model to progress initiatives that deliver more care in community settings.



KEY ALLIANCES

GOVERNANCE

- The Iwi Health Board, with whom the Board has signed 'He Kawenata,' establishing a partnership based on the Treaty of Waitangi to improve Maori health outcomes
- The two Nelson Marlborough Primary Health Organisations with whom the Board has signed a Memorandum of Understanding or has entered into as Nelson Marlborough Health Alliance.

TRUSTS

- Nelson Marlborough Hospitals' Charitable Trust, which holds trust funds for the benefit of public hospitals
- Marlborough Hospital Equipment Trust, which provides equipment and other items from public donations raised by the trust
- Hospice Nelson – Cooperative relationship
- NMDHB has appointed a trustee to the Golden Bay Community Health Te Hauora o Mohua Trust which will own the buildings that comprise the Golden Bay Integrated Family Health Centre.

CHARITABLE PROVIDERS - FROM DHB SITES

- Churchill Private Hospital Trust, which provides private medical and surgical services in Marlborough
- Hospice Marlborough – Cooperative relationship for palliative care
- Nelson Bays Primary Health Trust which provides health services at the Golden Bay Integrated Family Health Centre.

COOPERATIVE ARRANGEMENTS

- South Island Alliance Programme Office which supports the activities of the South Island DHBs by providing services such as regional planning and funding, service development, information services, project management and other collaborative activities across the South Island, as determined by the participating DHBs
- Other DHBs for collaborative purchasing of supplies and other services, including using utilities such as the Southern Alliance
- NMDHB has an agreement with Nelson Radiology Ltd which covers a joint Magnetic Resonance Imaging (MRI) service with them
- Top of the South Cardiology Ltd, which provides private cardiology services from Nelson Hospital
- The two PHOs and GPs for the provision of GP services from facilities leased from NMDHB on or adjacent to the Nelson and Wairau hospitals
- Nelson Marlborough Health Alliance.

A VIBRANT ORGANISATION WITH A LEARNING CULTURE

LEARNING ENVIRONMENT

Learning and development opportunities provided for staff included competency, professional, practice and organisation development aspects. Nurses from across the district were supported through Health Workforce New Zealand (HWNZ) funded programmes to complete post graduate nursing studies with an increasing number going on to complete Masters' degrees. HWNZ funding is also received for Resident Medical Officers/Registrars and Maori Health initiatives. A wide range of core competency programmes are run for staff in different disciplines to meet their requirements under the Health Practitioners' Competence Assurance Act.

The organisation offers a range of in-house learning opportunities for staff. 2011/12 has seen considerable development in the e-learning programme with a wide range of self-learning packages now available to staff. Combined with face-to-face and practical learning opportunities, e-learning is continuing to enhance the learning environment within the organisation. The Treaty of Waitangi workshops continued in 2011/12, with all sessions being over-subscribed. The Board is a participant in the recently established South Island Regional Training Hub (SIRTH). Regional Hubs have been established by Health Workforce New Zealand to enable regional clinical education innovation.

QUALITY AND COMMUNICATION

The Quality and Safety Governance Committee (Q&SGC) maintains the overview of quality and safety in the organisation. Its focus in 2011/12 has been to ensure improved measurement, monitoring and reporting of quality and safety. Chaired by the Chief Medical Officer, the Committee reports to the Executive Leadership Team and through the Chief Executive to the Board's Audit and Risk Committee and to the Board.

The two-yearly NMDHB Health Quality & Innovation Awards were held in November 2011. Open to all providers funded by NMDHB, the awards attracted 14 entries from across the health spectrum. The supreme winner was a programme facilitated by the Marlborough Public Health Unit and run in conjunction with other local agencies called Marborough Clued-Up Kids Programme.

A Certification progress visit was undertaken in April 2012. Certification was again confirmed by the Ministry of Health.

The organisation has progressed the Care Capacity Demand Programme beyond the initial year of involvement with the national safe staffing unit support. Significant changes to staffing and the model of nursing care delivery in the medical unit in Nelson Hospital have resulted. Changes to other patient care areas within Nelson Hospital are pending.

The Chief Executive continues to hold quarterly staff forums in both Nelson and Wairau and six-monthly in the rural areas. In addition to the Chief Executive's written monthly update, an in-house magazine entitled 'DHB Connections' is published quarterly.

All NMDHB-specific collective agreements were settled without industrial action. The NMDHB Bipartite Forum was reviewed during the year in line with National Bipartite Action Group guidelines and continues to meet regularly considering cross organisational issues of interest to both staff/representative groups and NMDHB.

STAFF WELLBEING

The 'Wellness at Work' focus has seen a wide variety of opportunities provided for staff in the physical activity area. Taking a 'try before you buy' approach, we sponsored staff to participate in programmes such as yoga. Nelson and Wairau Hospitals have staff gymnasiums on site. Run by staff committees these facilities provide a wide variety of fitness/recreational opportunities.

A staff health screening programme called Well4Life was commenced during the year. A mobile service provided to staff in their place of work, the programme offers screening for basic health indicators. Staff are offered health information to aid their personal health decisions and if their health indicators warrant it, they are offered a subsidised visit to their general practitioner for follow up.

NMDHB has power-assisted bicycles for staff in mental health and public health services to use around Nelson on business. The bikes are a quick means of travel within the city confines and role model healthy physical activity to other staff and the public.

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

The organisation retained its tertiary status with the ACC Partnership Programme for the tenth consecutive year. Furthermore, the organisation has an active district-wide Health, Safety & Wellbeing team that provides support for staff when they are ill or injured and support well health initiatives.

GOVERNANCE STATEMENT

GOVERNANCE STRUCTURE

The Board, comprising seven elected and four appointed members, provides governance to Nelson Marlborough District Health Board (NMDHB). The Board met eleven times during the year on the following dates:

2011: 26 July; 23 August; 27 September; 25 October; 22 November; 20 December 2012; 24 January; 28 February; 27 March; 24 April; 22 May; 26 June

The Board concentrates on ensuring that it operates in a financially responsible manner by setting policy and strategy, monitoring its achievement and appointing the CE to manage the implementation of this policy and strategy. All other employees are appointed by the CE.

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

In accordance with the Act, the Board has constituted three Advisory Committees (meeting two-monthly; each comprising a mix of Board members and community members; the CPHAC and DiSAC meeting jointly), the Audit and Risk Committee (meets quarterly) and the Remuneration Committee. Membership of each of the committees is set out on page 7.

The Advisory Committees met five times each year and the Audit and Risk four times.

MEETING ATTENDANCE

The commitment of the Members of the Board and the Advisory Committees to the organisation is demonstrated through a high level of attendance at formal meetings and workshops:

	BOARD MEETINGS		COMMITTEE MEETINGS	
	Scheduled	Attended	Scheduled	Attended**
Jenny Black	12	11	15	14
Ian MacLennan	12	11	9	13
Judy Crowe	12	11	5	11
Gordon Currie	12	12	6	12
Fleur Hansby	12	11	6	5
Roma Hippolite	12	10	14	13
Gerald Hope	12	8	10	7
John Inder	12	12	5	10
John Moore	12	12	10	11
Patrick Smith	12	10	11	9
Russell Wilson	12	11	9	11
Community Representatives				
Jennifer Black			6	6
Judith Holmes			6	6
George Truman			6	6
Jos Van Der Pol			6	6
Glenys MacLellan			6	5
Jane Anderson-Bay			5	3
Francis Gargiulo			5	5
Kaumatua				
Mabel Grennell*		4	6	6
Tahi Takao*		1	5	6
Graeme Grennell		1		1
Andy Joseph		1		3
Iwi Health Board				
Joe Puketapu			5	5
Sonny Alesanna*			11	7
Trisha Falleni			5	4
Judi Billens			5	5
Wilmarae Rodrigues			5	3

* Also Iwi Health Board representative on an Advisory Committee

**Board members are appointed to one of the advisory committees. Some members also attend the meetings of the advisory committee of which they are not a member. Their attendance at those meetings has been counted in the above figures.

EMPLOYEE REMUNERATION

The number of employees earning more than $100,000 is detailed in the table below. Of the 191 employees shown, 162 are or were medical, dental, nursing or allied health employees (136 in 2010/11).

The increase in numbers has been principally in clinical areas. The slightly higher number of Management (5) reflects the transition to the new leadership team model.

TOTAL REMUNERATION AND OTHER BENEFITS ($000S)	EMPLOYEES WHOSE ACTUAL REMUNERATION FALLS IN THE BAND
100-110	33
110-120	18
120-130	7
130-140	7
140-150	3
150-160	5
160-170	3
170-180	6
180-190	9
190-200	10
200-210	10
210-220	9
220-230	9
230-240	12
240-250	6
250-260	6
260-270	7
270-280	2
280-290	4
290-300	8
300-310	5
310-320	2
320-330	4
330-340	1
340-350	1
360-370	1
380-390	1
400-410	1
410-420	1
Total	**191**

PAYMENTS IN RESPECT OF TERMINATION OF EMPLOYMENT

During the year, the Board made the following payments to former employees in respect of the termination of their employment with the organisation. These payments include amounts required to be paid pursuant to employment agreements in place, with the majority of payments being either redundancy or retirement gratuities. The total payments made by NMDHB were $1,145,303 (2010/11 – 41 payments totaling $1,063,755).

Number of employees: **38** | Total: **$1,145,303**

AUDITORS

The Auditor-General is appointed under Crown Entities Act 2004. Audit New Zealand is contracted to provide audit services. The audit fees payable were $142,000 for the fiscal year 2011/12.

INTERESTS REGISTER

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

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

NMDHB and its Board members have taken out directors' and officers' liability insurance, providing cover against particular liabilities.

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

GOVERNANCE PHILOSOPHY

CLINICAL GOVERNANCE

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

- Extensive involvement by clinicians in the Executive Leadership Team enhances the involvement of clinical staff in decision making and strategic direction
- Appointment of clinical heads of department for various specialty groups strengthens clinical engagement in service leadership and improvement
- The Quality and Safety Governance Committee has links to the Audit and Risk Committee covering clinical quality matters across the organisation
- The Director of Nursing and Midwifery, the Chief Medical Officer and Director of Allied Health are members of both the above committees and the Executive Leadership Team
- NMDHB operates a robust credentialing process for Senior Medical Officers.

INTERNAL CONTROL

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

RISK MANAGEMENT

The Board acknowledges that it is ultimately responsible for the management of risks to the organisation. NMDHB has established a risk management programme to complement existing risk management strategies, ensuring that NMDHB is in line with the AS/NZS ISO 31000:2009 Risk Management.

LEGISLATIVE COMPLIANCE

The Board acknowledges it is ultimately responsible to ensure the organisation complies with all relevant legislation. The Board delegated responsibility to the CE for the development and operation of a programme to systematically identify compliance issues and ensure that all staff are aware of legislative requirements relevant to them. During the year, the Corporate Quality Improvement Council reviewed key non-clinical policies and procedures. It had links to the Audit and Risk Committee through representatives of the Executive Leadership Team. Management have introduced a training session for senior staff and is working to further integrate regular reviews of compliance into business as usual.

ETHICS

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

GOOD EMPLOYER POLICIES

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

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

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

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

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

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

Sexual harassment and bullying will not be tolerated or condoned by NMDHB. The organisation will take disciplinary action where investigation shows a complaint of sexual harassment/bullying is justified. The organisation worked with unions and their members to revise the organisation's policy and process in relation to bullying and harassment. This was re-launched in November 2011.

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

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

STATEMENT OF RESPONSIBILITY

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

The Board and management of NMDHB 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 NMDHB the Annual Financial Statements for the twelve months ended 30 June 2012 fairly reflect the financial position and operations of NMDHB.

Jenny Black
Chairman

Russell Wilson
Chair of Audit and Risk Committee

John Peters
Chief Executive

Nick Lanigan
GM Corporate Services

INDEPENDENT AUDITOR'S REPORT

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

TO THE READERS OF
NELSON MARLBOROUGH DISTRICT HEALTH BOARD'S
FINANCIAL STATEMENTS AND STATEMENT OF SERVICE PERFORMANCE
FOR THE YEAR ENDED 30 JUNE 2012

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

We have audited:

- the financial statements of the Health Board on pages 42 to 81, that comprise the statement of financial position as at 30 June 2012, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the statement of service performance of the Health Board on pages 85 to 110.

Opinion

In our opinion:

- the financial statements of the Health Board on pages 42 to 81:
  - » comply with generally accepted accounting practice in New Zealand; and
  - » fairly reflect the Health Board's:
    - › financial position as at 30 June 2012; and
    - › financial performance and cash flows for the year ended on that date; and
- the statement of service performance of the Health Board on pages 85 to 110:
  - » complies with generally accepted accounting practice in New Zealand; and
  - » fairly reflects the Health Board's service performance for the year ended 30 June 2012, including:
    - › its performance achieved as compared with forecast targets specified in the statement of forecast service performance for the financial year; and
    - › its revenue earned and output expenses incurred, as compared with the forecast revenues and output expenses specified in the statement of forecast service performance for the financial year.

Our audit was completed on 11 September 2012. 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 we explain our independence.

Basis of opinion

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

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

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

An audit also involves evaluating:

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

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

Responsibilities of the Board

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

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

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

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

Responsibilities of the Auditor

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

Independence

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

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

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

CONSOLIDATED STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 30 JUNE 2012

(IN THOUSANDS OF NEW ZEALAND DOLLARS)

		Parent & Group		
	Note	2012	2012	2011
		Budget	Actual	Actual
		$000	$000	$000
Income				
Revenue	4	398,018	400,723	389,360
Other Operating income	5	4,161	5,958	4,917
Finance income	6	835	1,609	1,482
TOTAL INCOME		**403,014**	**408,290**	**395,759**
Expenses				
Personnel Costs	7	149,506	152,238	143,739
Outsourced Services		10,646	11,932	12,140
Clinical Supplies		27,886	30,710	30,653
Infrastructure & Non-Clinical Expenses		20,172	22,306	21,109
Payments to non-Health Board Providers		168,182	172,024	164,290
Other Operating Expenses	8	3,125	2,645	1,511
Depreciation and amortisation expense	16,17	13,203	12,071	12,410
Finance Costs	6	3,016	2,800	2,545
Capital Charge	9	7,170	6,792	7,139
TOTAL EXPENSES		**402,906**	**413,518**	**395,536**
NET SURPLUS/(DEFICIT)		**108**	**(5,228)**	**223**
Other Comprehensive Income				
Revaluation of Property, Plant and Equipment	22	-	9,380	(614)
Total Comprehensive Income		**108**	**4,152**	**(391)**

The revaluation of property, plant, and equipment represents the revaluation on Land and Buildings as at 30 June 2012.

The accompanying notes form part of and are to be read in conjunction with these financial statements.
Explanations of significant variances against budget are detailed in note 30.

CONSOLIDATED STATEMENT OF MOVEMENTS IN EQUITY FOR THE YEAR ENDED 30 JUNE 2012

(IN THOUSANDS OF NEW ZEALAND DOLLARS)

	Note	Parent & Group 2012 Budget $000	2012 Actual $000	2011 Actual $000
Equity at Beginning of the Year		**90,530**	**89,805**	**87,218**
Comprehensive Income				
Net Surplus/(Deficit)		108	(5,228)	223
Other Comprehensive Income		-	9,380	(614)
Total Comprehensive Income for the Year		**108**	**4,152**	**(391)**
Owner Transactions				
Equity Injections		508	478	3,525
Equity Repayments		(547)	(547)	(547)
TOTAL EQUITY AT THE END OF THE YEAR	**22**	**90,671**	**93,888**	**89,805**

Explanations of significant variances against budget are detailed in note 30.

The accompanying notes form part of and are to be read in conjunction with these financial statements.
Explanations of significant variances against budget are detailed in note 30.

CONSOLIDATED STATEMENT OF FINANCIAL POSITION AS AT 30 JUNE 2012 (IN THOUSANDS OF NEW ZEALAND DOLLARS)

	Note	Parent & Group 2012 Budget $000	2012 Actual $000	2011 Actual $000
Assets				
Current Assets				
Cash and Cash Equivalents	10	40,131	4,800	11,795
Debtors and Other Receivables	11	8,361	12,813	12,625
Investments	12	-	25,282	12,106
Inventories	13	2,318	2,246	2,043
Prepayments		590	448	402
Non-current Assets Held for Sale	14	-	2,045	2,712
TOTAL CURRENT ASSETS		**51,400**	**47,638**	**41,683**
Non Current Assets				
Property, Plant and Equipment	16	158,239	166,425	160,266
Intangible Assets	17	3,152	1,840	2,496
Prepayments		100	1	40
Other Financial Assets	15	7	7	7
TOTAL NON CURRENT ASSETS		**161,498**	**168,273**	**162,809**
TOTAL ASSETS		**212,898**	**215,907**	**204,492**
Liabilities				
Current Liabilities				
Creditors & Other Payables	18	33,204	22,351	23,673
Loans & Borrowings	19	1,750	1,045	13,159
Employee Entitlements	20	25,886	29,570	26,896
Provisions	21	760	388	1,520
TOTAL CURRENT LIABILITIES		**61,600**	**53,354**	**65,248**
Non Current Liabilities				
Loans & Borrowings	19	49,767	56,369	37,120
Employee Entitlements	20	10,858	12,296	12,319
TOTAL NON CURRENT LIABILITIES		**60,625**	**68,665**	**49,439**
TOTAL LIABILITIES		**122,225**	**122,019**	**114,687**
NET ASSETS		**90,673**	**93,888**	**89,805**
Equity				
Crown Equity	22	30,190	29,681	29,750
Other Reserves	22	44,591	50,988	41,720
Retained Earnings/(Losses)	22	15,892	13,219	18,335
TOTAL EQUITY		**90,673**	**93,888**	**89,805**

For and on behalf of the Board

Jenny Black
Board Member
11 September 2012

Russell Wilson
Board Member
11 September 2012

The accompanying notes form part of and are to be read in conjunction with these financial statements.
Explanations of significant variances against budget are detailed in note 30.

CONSOLIDATED STATEMENT OF CASH FLOWS YEAR ENDED 30 JUNE 2012 (IN THOUSANDS OF NEW ZEALAND DOLLARS)

	Note	Parent & Group 2012 Budget $000	2012 Actual $000	2011 Actual $000
CASHFLOWS FROM OPERATING ACTIVITIES				
Cash was provided from:				
Receipts from Ministry of Health and patients		402,334	405,522	390,725
Interest received		835	1,620	1,482
		403,169	407,142	392,207
Cash was disbursed to:				
Payments to employees		149,507	151,548	141,558
Payments to suppliers		229,454	236,635	232,826
Capital Charge		5,326	7,508	6,558
Interest paid		3,016	2,800	2,412
Net GST paid/(refunded)		1,519	2,054	(166)
		388,822	400,989	383,188
Net cash inflow/(outflow) from operating activities	**23**	**14,347**	**6,597**	**9,019**
CASHFLOWS FROM INVESTING ACTIVITIES				
Cash was provided from:				
Sale of property, plant & equipment		129	1,413	226
Cash was applied to:				
Acquisition of property, plant & equipment		6,611	8,798	21,888
Acquisition of intangible assets		410	196	467
Acquisition of investments		0	13,175	12,106
		7,021	22,169	34,461
Net cash inflow/(outflow) from investment activities		**(6,892)**	**(20,756)**	**(34,235)**
CASHFLOWS FROM FINANCING ACTIVITIES				
Cash was provided from:				
Loans Raised		0	8,000	12,500
Finance Leases Raised		1,184	(392)	231
Equity Injections		580	478	3,525
Cash was applied to:				
Equity Repaid		547	547	547
Repayments of Borrowings		0		0
Payment of Finance Lease Liabilities		932	1,159	1,618
Net cash inflow /(outflow) from financing activities		**285**	**7,164**	**14,091**
Net increase/(decrease) in cash and cash equivalents		7,740	(6,995)	(11,125)
Add Cash and cash equivalents at 1 July		22,830	11,795	22,920
CASH AND CASH EQUIVALENTS AS AT 30 JUNE		**30,570**	**4,800**	**11,795**

The GST component of operating activities reflects the net GST paid and received with the Inland Revenue Department. The GST component has been presented on a net basis, as the gross amounts do not provide meaningful information for financial statement purposes.

Equipment totalling $255,000 (2011: $406,000) was acquired by means of finance leases during the year.

The accompanying notes form part of and are to be read in conjunction with these financial statements.
Explanations of significant variances against budget are detailed in note 30.

CONSOLIDATED STATEMENT OF FINANCIAL COMMITMENTS AS AT 30 JUNE 2012 (IN THOUSANDS OF NEW ZEALAND DOLLARS)

	Parent & Group	
	2012 Actual $000	2011 Actual $000
Capital Commitments		
Property, Plant & Equipment	1,380	1,596
Intangible Assets	232	15
Total capital commitments	**1,612**	**1,611**
Non-cancellable commitments - Provider Commitments		
Not later than one year	6,077	2,653
Later than one year and not later than two years	909	998
Later than two years and not later than five years	307	130
Later than five years	-	-
	7,293	**3,781**
Non-cancellable commitments - Operating Lease Commitments		
Not later than one year	663	797
Later than one year and not later than two years	631	609
Later than two years and not later than five years	1,279	1,461
Later than five years	1,491	1,895
	4,064	4,762
Non-cancellable commitments - Finance Lease Commitments		
Not later than one year	1,123	1,295
Later than one year and not later than two years	640	1,005
Later than two years and not later than five years	199	715
Later than five years	-	-
	1,962	3,015
Non-cancellable commitments - Other		
Nelson Marlborough DHB has entered into non-cancellable contracts for the provision of services.		
Not later than one year	1,088	634
Later than one year and not later than two years	23	135
Later than two years and not later than five years	-	22
Later than five years	-	-
	1,111	791
TOTAL COMMITMENTS	**16,042**	**13,960**

The accompanying notes form part of and are to be read in conjunction with these financial statements.
Explanations of significant variances against budget are detailed in note 30.

STATEMENT OF CONTINGENT ASSETS AND LIABILITIES AS AT 30 JUNE 2012

CONTINGENT LIABILITIES

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

Nelson Marlborough DHB also has a contingent liability in the region of $0.02m (2011: $0.28m) for disputes and legal proceedings by three employees.

CONTINGENT ASSETS

Nelson Marlborough DHB is seeking legal redress against a third party for overexpenditure and has recorded a contingent asset of $1.78m (2011: $1.78m).

NOTES TO THE CONSOLODATED FINANCIAL STATEMENT FOR THE YEAR ENDED 30 JUNE 2012

1. REPORTING ENTITY

Nelson Marlborough District Health Board ("Nelson Marlborough DHB") is a Health Board established by the New Zealand Public Health and Disability Act 2000. Nelson Marlborough DHB is a Crown Entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand. Nelson Marlborough DHB is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000, the Financial Reporting Act 1993, the Public Finance Act 1989 and the Crown Entities Act 2004.

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

The financial statements of Nelson Marlborough DHB and group are for the year ended 30 June 2012. The financial statements were approved by the Board on 11 September 2012.

2. BASIS OF PREPARATION

(a) Statement of Compliance

The consolidated financial statements have been prepared in accordance with the requirements of the NZ Public Health & Disability Act 2000 and the Crown Entities Act 2004, which includes the requirement to comply with Generally Accepted Accounting Practice in New Zealand (NZ GAAP). They comply with New Zealand equivalents to International Financial Reporting Standards (NZ IFRS), and other applicable Financial Reporting Standards, as appropriate for public benefit entities.

(b) Measurement Base

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

(c) Functional and presentation currency.

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

(d) Management Judgements, Estimates & Assumptions

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

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

Judgements made by management in the application of NZ IFRS that have a significant effect on the financial statements and estimates with a significant risk of material adjustment in the next year are discussed in note 29.

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

Certain new standards, amendments and interpretations to existing standards have been published that are not effective for the year ended 30 June 2012 and have not been applied in preparing these financial statements. The following standards, amendments and interpretations which are relevant to Nelson Marlborough DHB are:

NZ IFRS 9

NZ IFRS 9 Financial Instruments will eventually replace NZ IAS 39 Financial Instruments: Recognition and Measurement. NZIAS 39 is being replaced in three main phases. The first phase on the classification and measurement of financial assets has been completed and has been published in the new financial instrument standard NZ IFRS 9. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39. The approach in NZ IFRS 9 is based on how an entity manages its financial instruments and the contractual cash flow characteristics of the financial assets. The financial liability requirements are the same as those of NZ IAS 39, except for when an entity elects to designate a financial liability at fair value through the surplus/deficit. The new standard is required to be adopted for the year ended 30 June 2014. Nelson Marlborough DHB has not yet assessed the effect of the new standard and does not expect to early adopt it.

(f) Changes in Accounting Policies

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

3. ACCOUNTING POLICIES

Basis of Consolidation

Subsidiaries

Subsidiaries are those entities controlled by Nelson Marlborough DHB. Control exists when Nelson Marlborough DHB has the power, directly or indirectly, to govern the financial and operating policies of an entity so as to obtain benefits from its activities.

Nelson Marlborough Hospitals Charitable Trust is a subsidiary of Nelson Marlborough DHB. The financial results of the Trust are not material and have not been consolidated. Therefore, the financial results disclosed for both the parent and group are the same. Information relating to the Trust is note 27.

Budget Figures

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

Borrowing Costs

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

Capital Charge

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

Cash and Cash Equivalents

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

Creditors and other payables

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

Debtors and other receivables

Debtors and other receivables are initially measured at fair value and subsequently measured at amortised cost using the effective interest method, less any provision for impairment. Receivables of short duration are not discounted.

Impairment of a receivable is established when there is objective evidence that Nelson Marlborough DHB will not be able to collect amounts due according to the original terms of the receivable. Significant financial difficulties of the debtor, probability that the debtor will enter into bankruptcy, and default in payments are considered indicators that the debtor is impaired. The amount of the impairment is the difference between the asset's carrying amount and the estimated recoverable amount. The carrying amount of the asset is reduced through the use of an allowance account, and the amount of the loss is recognised in the surplus or deficit. When the receivable is uncollectable, it is written off and the allowance reversed.

Employee Entitlements

(a) Defined Contribution Plans

Obligations for contributions to defined contribution pension plans, such as Kiwisaver and the State Sector Retirement Savings Scheme, are recognised as an expense when they are incurred.

(b) Defined Benefit Plans

Nelson Marlborough DHB does not make contributions to defined benefit pension plans.

(c) Long Service Leave, Sabbatical Leave, Sick Leave, and Retirement Gratuities.

Nelson Marlborough DHB's net obligation in respect of long service leave, sabbatical leave, sick leave and retirement leave is the amount of future benefit that employees have earned in return for their service in the current and prior periods. The obligation is valued on an actuarial basis.

Those entitlements expected to be settled within 12 months of balance date are classified as a current liability. Where settlement is expected more than 12 months after balance date, the entitlements are classified as non-current liabilities.

(d) Annual Leave, Conference Leave and Medical Education leave

Annual leave, conference and medical education leave are short-term obligations and are calculated on an actual entitlement basis at current rates of pay.

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

Equity

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

- Crown equity
- Retained earnings
- Revaluation reserves

Revaluation reserves are related to the revaluation of land and buildings to fair value.

Financial Instruments

Non-derivative financial instruments

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

(a) Recognition

A financial instrument is recognised if Nelson Marlborough DHB becomes a party to the contractual provisions of the instrument.

Non-derivative financial instruments are initially recognised at fair value plus transaction costs unless they are carried at fair value through other comprehensive income in which case the transaction costs are recognised in the surplus or deficit. Subsequent to initial recognition, non-derivative financial instruments are measured as described below.

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

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

Nelson Marlborough DHB classifies its financial instruments into the following categories: Fair Value through other comprehensive income, loans and receivables, fair value through surplus or deficit, and amortised cost.

(b) Measurement

Fair Value through other comprehensive income

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

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

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

Loans and Receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. They are included in current assets, except for maturities greater than 12 months after balance date, which are included in non-current assets.

After initial recognition they are measured at amortised cost using the effective interest method less impairment. Receivables of short duration are not discounted. Gains and losses when the asset is impaired or derecognised are recognised in the surplus or deficit.

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

Other Financial Instruments
Financial instruments that are not classified as fair value through other comprehensive income, or fair value through surplus or deficit are measured at amortised cost using the effective interest method, less any impairment losses. Nelson Marlborough DHB classifies creditors and other payables, finance leases, and secured loans as Other Financial Instruments.

Derivative Financial Instruments
Nelson Marlborough DHB does not have any derivative financial instruments.

Goods and Services Tax
All items in the financial statements are exclusive of goods and services tax (GST) with the exception of receivables and payables which are stated inclusive of GST. Where GST is irrecoverable as an input tax, then it is recognised as part of the related asset or expense. The net amount of GST recoverable from, or payable to, the Inland Revenue Department (IRD) is included as part of receivables or payables in the Statement of Financial Position. The net GST paid to, or received from the IRD, including the GST relating to investing and financing activities, is classified as an operating cash flow in the Statement of Cash Flows.

Commitments and contingencies are disclosed exclusive of GST.

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

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

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

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

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

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

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

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

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

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

An impairment loss on an equity instrument investment classified as fair value through other comprehensive income or on items of property, plant and equipment carried at fair value is reversed through the relevant reserve. All other impairment losses are reversed through the surplus or deficit.
The reversal of an impairment loss on a revalued asset is credited to the revaluation reserve. However, to the extent that an impairment loss for that class of asset was previously recognised in the surplus or deficit, a reversal of the impairment loss is also recognised in the surplus or deficit. For assets not carried at a revalued amount the reversal of an impairment loss is recognised in the surplus or deficit.

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

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

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

Staff training costs are recognised as an expense when incurred.

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

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

(b) Amortisation
Amortisation is recognised in the surplus or deficit on a straight line basis over the estimated useful lives of intangible assets unless such lives are indefinite. Other intangible assets are amortised from the date they are available for use. The estimated useful lives are as follows:

Type of Asset: Software
Estimated Life: 3 - 10 years
Amortisation Rate: 10 - 34 %

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

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

Investments

(a) Bank Deposits
Investments in bank deposits are initially measured at fair value plus transaction costs. After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest method, less any provision for impairment.

At each balance date, Nelson Marlborough DHB assesses whether there is any objective evidence that an investment is impaired.

Leases

(a) Finance Leases

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

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

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

(b) Operating Leases

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

Loans and borrowings

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

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

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.

For revalued assets, any impairment losses for write-downs of non-current assets held for sale are recognised in other comprehensive income to the extent the impairment loss does not exceed the amount in the revaluation reserve in equity for that same class of asset. For assets not carried at a revalued amount, the total impairment loss is 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 (including those that are part of a disposal group) are not depreciated or amortised while they are classified as held for sale.

Property, Plant and Equipment

(a) Classes of property, plant and equipment

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

- Freehold Land
- Freehold Buildings
- Plant and Equipment
- Motor Vehicles
- Work in Progress

(b) Recognition and Measurement

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

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

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

Where an asset is acquired at no cost, it is recognised at fair value when control over the asset is obtained. When parts of an item or property, plant and equipment have different useful lives, they are accounted for as separate items (major components) of property, plant and equipment.

(c) Subsequent Costs

Subsequent costs are added to the carrying amount of an item of property, plant and equipment when that cost is incurred if it is probable that the service potential or future economic benefits embodied within the new item will flow to Nelson Marlborough DHB and the cost of the item can be reliably measured. All other costs are recognised in the surplus or deficit as an expense as incurred.

(d) Revaluation of land and buildings

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

Additions between revaluations are recorded at cost.

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

The carrying values of revalued assets are reviewed annually to ensure that those values are not materially different to fair value. If there is evidence supporting a material difference, then the asset class will be revalued.

(e) Depreciation

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

TYPE OF ASSET	ESTIMATED LIFE	DEPRECIATION RATE
Buildings and Building Fitout	10 to 76 years	1.3 - 10%
Plant and equipment	2 to 20 years	5 - 50%
Motor vehicles	5 to 16 years	6.25 - 20%
Leased Assets	2 to 7.25 years	13.79% - 50%

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

(f) Capital Work in Progress

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

(g) Leased Assets

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

(h) Disposal of Property, Plant and Equipment

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

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

Provisions

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

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

(a) Restructuring

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

(b) ACC Partnership Programme

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

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

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

Revenue

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

(a) Crown Funding

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

(b) ACC Contracted Revenue

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

(c) Inter-District Patient Flows

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

(d) Rental Income

Lease income under an operating lease is recognised as revenue on a straight-line basis over the lease term.

(e) Goods Sold

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

(f) Provision of Services

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

(g) Interest Income

Interest income is recognised using the effective interest method.

(h) Donated Assets

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

(i) Volunteer Services

Certain operations of Nelson Marlborough DHB are reliant on services provided by volunteers. Volunteer services received are not recognised as revenue or expenditure by Nelson Marlborough DHB 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 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 the Nelson Marlborough DHB from the NMHCT are recognised as income when received, or entitlement to receive money is established. Expenditure subsequently incurred in respect of these funds is recognised as an expense in the surplus or deficit.

4. REVENUE

	Parent & Group	
	2012	**2011**
	Actual	**Actual**
	$000	**$000**
Health and Disability Services (MOH contracted revenue)	381,596	371,016
Inter District Patient Flows	7,996	8,067
ACC	4,044	3,197
Patient/Consumer Sourced Revenue	5,822	5,139
Other Government and DHB's	1,265	1,941
	400,723	**389,360**

Nelson Marlborough DHB has been provided with funding from the Crown for specific purposes of the DHB as set out in its founding legislation and the scope of the relevant government appropriations. Apart from these general restrictions, there are no unfulfilled conditions or contingencies attached to government funding (2011: $Nil).

5. OTHER OPERATING INCOME

	Parent & Group	
	2012	**2011**
	Actual	**Actual**
	$000	**$000**
Donations and bequests received	103	334
Rental income	1,070	1,054
Gain on Disposal of Property, Plant & Equipment	296	97
Other income	4,489	3,432
	5,958	**4,917**

6. FINANCE INCOME & COSTS

	Parent & Group	
	2012	2011
	Actual	Actual
	$000	$000
Interest income	1,609	1,482
Finance Income	**1,609**	**1,482**
Interest on finance lease	141	218
Interest on loans	2,659	2,327
Insert on overdraft	-	-
Finance costs	**2,800**	**2,545**

7. PERSONNEL COSTS

	Parent & Group	
	2012	2011
	Actual	Actual
	$000	$000
Wages and salaries	142,169	133,757
Contributions to defined contribution plans	3,276	3,061
Other personnel costs	6,793	6,921
	152,238	**143,739**

8. OTHER OPERATING EXPENSES

	Parent & Group	
	2012	2011
	Actual	Actual
	$000	$000
Audit fees - Annual Audit	147	135
Donations made	-	-
Koha	2	1
Impairment loss on property, plant and equipment	-	-
Impairment of receivables (bad and doubtful debts)	165	169
Loss on disposal of property, plant and equipment	163	69
Rental and operating lease costs	2,061	1,862
Restructuring expenses	107	(725)
	2,645	**1,511**

Audit fees - other services were for the audit of Nelson Marlborough DHB's FMIS implementation.

During the year, Nelson Marlborough Hospitals Charitable Trust paid audit fees of $3,340 (2011: $3,310).

9. CAPITAL CHARGE

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

The capital charge rate for the year ended 30 June 2012 was 8% (2011: 8%).

10. CASH & CASH EQUIVALENTS

	Parent & Group	
	2012 Actual $000	**2011 Actual $000**
Bank Balances & cash on hand	145	182
Call Deposits	4,655	5,590
Term Deposits with original maturities less than 3 months	-	6,023
Bank Overdraft	-	-
Cash and cash equivalents in the Statement of Cash Flows	**4,800**	**11,795**

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

At 30 June 2012, the interest rate on Nelson Marlborough DHB's call deposits was 2.0% (2011: 3.10%).
Interest rates on term deposits ranged from 3.66% to 4.40% (2011: 4.02% to 4.30%).

11. DEBTORS AND OTHER RECEIVABLES

	Parent & Group	
	2012 Actual $000	2011 Actual $000
Trade receivables due from non-related parties	1,874	1,416
Ministry of Health receivables	4,156	3,755
Gross trade receivables	6,030	5,171
Less Provision for impairment	(421)	(411)
Net trade receivables	5,609	4,760
Accrued Income	7,182	7,833
Other Receivables	22	32
Total debtors and other receivables	**12,813**	**12,625**

Fair Value

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

Impairment

As at 30 June 2012 and 2011, all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below:

	Parent & Group			
	Gross Receivable	Impairment	Gross Receivable	Impairment
Trade Receivables	**2012**	**2012**	**2011**	**2011**
Current	4,498	(19)	4,408	(7)
31-60 days	504	(4)	161	(2)
61-90 days	148	(6)	47	(4)
Over 90 days	880	(391)	555	(398)
Total	**6,030**	**(421)**	**5,171**	**(411)**

All receivables greater than 30 days in age are considered to be past due. The impairment provision has been calculated based on expected losses. Expected losses are determined by specific review of Ministry of Health receivables, and based on an analysis of Nelson Marlborough DHB's losses during previous periods for other trade receivables.

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

	Parent & Group	
	2012 Actual	2011 Actual
Gross trade receivables	6,030	5,171
Individual impairment	-	-
Collective impairment	(421)	(411)
Net trade receivables	**5,609**	**4,760**

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

	Parent & Group	
	2012 Actual	2011 Actual
Provision for impairment at 1 July	411	348
Additional provisions made during the year	164	170
Provisions used during the year	(154)	(107)
Provisions reversed during the period	-	-
Provision for impairment at 30 June	**421**	**411**

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

12. INVESTMENTS

	Parent & Group	
	2012	**2011**
	Actual	**Actual**
	$000	**$000**
Current		
Term deposits with original maturities greater than 3 months and remaining duration less than 12 months	25,282	12,106
	25,282	**12,106**
Non-current		
Term deposits with original maturities greater than 3 months and remaining duration greater than 12 months	-	-
	-	-

The carrying value of the current portion of investments approximates their fair value.

There is no impairment provision for investments.

At 30 June 2012, the interest rates on investments ranged from 4.40% to 4.66% (2011: 4.33% to 4.95%).

13. INVENTORIES

	Parent & Group	
	2012	**2011**
	Actual	**Actual**
	$000	**$000**
Inventories held for distribution		
Pharmaceuticals	270	315
Surgical and medical supplies	1,976	1,728
	2,246	**2,043**

In 2012, the value of inventories distributed and recognised as an expense in the clinical supplies expense in the Statement of Comprehensive Income was $16.8 million (2011 $16.3 million).

The carrying amount of inventories held for distribution carried at current replacement cost at 30 June 2012 is $Nil (2011 $Nil). The write-down of inventories held for distribution amounted to $Nil for 2012 (2011 $Nil). There have been no reversals of write-downs (2011: $Nil).

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

14. NON-CURRENT ASSETS HELD FOR SALE

	Parent & Group	
	2012 Actual $000	2011 Actual $000
Non-current assets held for sale include:		
Land	1,126	1,791
Buildings	919	921
	2,045	**2,712**

Nelson Marlborough DHB owns 9 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 Nelson Marlborough DHB.

The accumulated property revaluation reserve recognised in equity in relation to these properties is $1,285,000.

15. OTHER FINANCIAL ASSETS

	Parent & Group	
	2012 Actual $000	2011 Actual $000
Shares in South Island Shared Services Agency Limited	7	7

Nelson Marlborough District Health Board owns shares in the South Island Shared Services Agency Limited (SISSAL). SISSAL is an agency set up by all South Island DHBs to provide shared support services.
The shares have been recorded at cost as they do not have a quoted price in an active market and their fair value cannot be reliably measured.

The Board has no intention of disposing of its investment.
There are no impairment provisions for other financial assets (2011: $Nil).

16. PROPERTY, PLANT & EQUIPMENT

	Parent & Group						
Cost or Valuation	**Land**	**Buildings**	**Plant & Equipment**	**Motor Vehicles**	**Leased Assets**	**Work in Progress**	**Total**
	$000	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**
Balance at 1 July 10 - at Valuation	14,443	89,108	-	-	-	-	103,551
Balance at 1 July 10 - at Cost	-	29,087	38,577	4,464	9,431	11,948	93,507
Additions	-	24,795	5,427	174	406	21,333	52,135
Revaluation increase/(decrease)	(294)	(371)	-	-	-	-	665
Disposals/transfers	(1,791)	(1,840)	(66)	(212)	(542)	(30,897)	(35,348)
Balance at 30 June 11 - at Valuation	12,358	86,897	-	-	-	-	99,255
Balance at 30 June 11 - at Cost	-	53,882	43,938	4,426	9,295	2,384	113,925
Balance at 1 July 11 - at Valuation	12,358	86,897	-	-	-	-	99,255
Balance at 1 July 11 - at Cost	-	53,882	43,938	4,426	9,295	2,384	113,925
Additions	10	3,375	3,606	902	579	8,172	16,644
Revaluation increase/(decrease)	143	(3,792)					(3,649)
Impairment Loss		(6,400)					(6,400)
Disposals/transfers	(95)	(220)	(1,034)	(32)	(228)	(8,245)	(9,854)
Balance at 30 June 12 - at Valuation	12,416	130,587	-	-	-	-	143,003
Balance at 30 June 12 - at Cost	**-**	**3,155**	**46,510**	**5,296**	**9,646**	**2,311**	**66,918**
Accumulated Depreciation & Impairment Losses							
Balance at 1 July 10	-	9,080	26,057	2,329	5,663	-	43,129
Depreciation for the year	-	5,741	3,299	674	1,637	-	11,351
Impairment Loss	-	(51)	-	-	-	-	51
Disposals/transfers	-	(796)	(66)	(111)	(542)	-	(1,515)
Revaluations	-	-	-	-	-	-	-
Balance at 30 June 11	**-**	**13,974**	**29,290**	**2,892**	**6,758**	**-**	**52,914**
Balance at 1 July 11	-	13,974	29,290	2,892	6,758	-	52,914
Depreciation for the year	-	5,909	3,482	584	1,240	-	11,215
Revaluations / Impairment Loss	-	(19,431)				-	(19,431)
Disposals/transfers	-	(128)	(814)	(32)	(228)	-	(1,202)
Balance at 30 June 12	**-**	**324**	**31,958**	**3,444**	**7,770**	**-**	**43,496**
Carrying Amounts							
At 1 July 10	14,443	109,115	12,520	2,135	3,768	11,948	153,929
At 30 June 11	12,358	126,805	14,648	1,534	2,537	2,384	160,266
At 1 July 11	12,358	126,805	14,648	1,534	2,537	2,384	160,266
At 30 June 12	**12,416**	**133,418**	**14,552**	**1,852**	**1,876**	**2,311**	**166,425**

IMPAIRMENTS

An impairment loss of $6.4m been recognised for 2012 (2011: $0.6). This arose primarily due to modifications required to Buildings to meet Earthquake standards ($4.7m) and to rectify remedial actions in the construction of the Wairau redeveloped hospital ($1.7m).

REVALUATION

The revaluation of land and buildings was carried out as at 30 June 2012 by M Lauchlan, a registered valuer with Duke & Cooke Limited. An optimised depreciated replacement cost methodology has been used. The revaluation excluded buildings purchased during the year. 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.

The next valuation will be completed by 30 June 2015.

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

RESTRICTIONS

Nelson Marlborough DHB does not have full title to Crown land it occupies but transfer is arranged if and when land is sold. Some of the land is subject to Waitangi Tribunal claims. The disposal of certain properties may be subject to the provisions of section 40 of the Public Works Act 1981.

Titles to land transferred from the Crown to Nelson Marlborough DHB are subject to a memorial in terms of the Treaty of Waitangi Act 1975 (as amended by the Treaty of Waitangi (State Enterprises) Act 1998). The effect on the value of assets resulting from potential claims under the Treaty of Waitangi Act 1975 cannot be quantified.

LEASED ASSETS

Nelson Marlborough DHB leases clinical and IT equipment under a number of finance lease agreements. At 30 June 2012, the net carrying amount of leased IT and clinical equipment was $1,875,952 (2011: $2,537,000).
Work In Progress

The total amount of property, plant, and equipment in the course of construction is $2.31m (2011: $2.46m).

17. INTANGIBLE ASSETS

(a) Software	Parent & Group			
	Owned	Leased	Work in Progress	Total
	$000	$000	$000	$000
Balance at 1 July 10	5,905	316	349	6,570
Additions	742	14	432	1,188
Disposals	(1)	-	(705)	(706)
Balance at 30 June 11 - at Cost	6,646	330	76	7,052
Balance at 1 July 11 - at Cost	6,646	330	76	7,052
Additions	192	1	200	393
Disposals/transfers			(193)	(193)
Balance at 30 June 12 - at Cost	**6,838**	**331**	**83**	**7,252**
Accumulated Amortisation & Impairment Losses				
Balance at 1 July 10	3,293	205	-	3,498
Amortisation for the year	962	97	-	1,059
Impairment Loss	-	-	-	-
Disposals	(1)	-	-	(1)
Balance at 30 June 11	4,254	302	-	4,556
Balance at 1 July 11	4,254	302	-	4,556
Amortisation for the year	828	28		856
Impairment Loss				-
Disposals				-
Balance at 30 June 12	**5,082**	**330**	**-**	**5,412**
Carrying Amounts				
At 1 July 10	2,612	111	349	3,072
At 30 June 11	2,392	28	76	2,496
At 1 July 11	2,392	28	76	2,496
At 30 June 12	**1,756**	**1**	**83**	**1,840**

Impairment

No impairment losses have been recognised (2011: $Nil).

Leased Intangibles

Nelson Marlborough DHB leases IT software under a number of finance lease agreements.

At 30 June 2012, the net carrying amount of leased intangibles was $577 (2011: $28,000).

18. CREDITORS AND OTHER PAYABLES

	Parent & Group	
	2012	2011
	Actual	Actual
	$000	$000
Trade payables	5,358	6,263
Revenue in advance	142	763
Capital Charge payable	-	1,911
GST, PAYE & FBT payable	3,514	4,156
Other non-trade payables and accrued expenses	13,337	10,580
	22,351	**23,673**

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

19. LOANS AND BORROWINGS

	Parent & Group	
	2012	2011
	Actual	Actual
	$000	$000
Current		
Current portion of Crown Health Financing Agency fixed interest loans	-	12,000
Current portion of finance lease liabilities	1,045	1,159
	1,045	13,159
Non-current		
Crown Health Financing Agency fixed interest loans	55,500	35,500
Finance lease liabilities	869	1,620
	56,369	**37,120**

(a) Crown Health Financing Agency fixed interest loans

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

	Parent & Group	
Interest rate summary	2012	2011
	Actual	Actual
Crown Health Financing Agency	2.91% - 6.535%	3.71% - 6.535%

The interest rates on the seven loans are fixed.

Loans are repayable as follows	Parent & Group	
	2012	2011
	Actual	Actual
	$000	$000
Within next 12 months	-	12,000
One to two years	10,500	-
Two to five years	14,000	16,500
Beyond five years	31,000	19,000
	55,500	**47,500**

Term Loan Facility Limits	Parent & Group	
	2012	2011
	Actual	Actual
	$000	$000
	55,500	**55,500**

Crown Health Financing Agency

(a) Security and Terms

The loan facility is provided by the Crown Health Financing Agency, which is part of the Treasury. The Crown Health Financing Agency term liabilities are secured by a negative pledge.

Without the Crown Health Financing Agency's prior written consent Nelson Marlborough DHB cannot perform the following actions:

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

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

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

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

Nelson Marlborough DHB must also meet the following covenants:

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

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

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

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

(b) Finance Lease Liabilities

Finance Leases are repayable as follows:

	Parent & Group					
	Minimum lease payments	**Interest**	**Principal**	**Minimum Lease Payments**	**Interest**	**Principal**
	2012	**2012**	**2012**	**2011**	**2011**	**2011**
	$000	**$000**	**$000**	**$000**	**$000**	**$000**
Within next 12 months	1,123	78	1,045	1,295	136	1,159
One to two years	640	27	613	1,005	73	932
Two to five years	260	4	256	715	27	688
Beyond five years			-	-	-	-
	2,023	**109**	**1,914**	**3,015**	**236**	**2,779**

Description of Material Leasing Arrangements

Nelson Marlborough DHB has entered into finance leases primarily for IT equipment, and for certain items of clinical equipment. The net carrying amount of the leased items within each class of property, plant and equipment, and intangible assets is shown in notes 16 & 17.

Nelson Marlborough DHB does not have the option to purchase the asset at the end of the lease term. There are no restrictions placed on Nelson Marlborough DHB by any of the finance leasing arrangements.

(c) Overdraft Facility

Nelson Marlborough DHB has a bank overdraft facility with Westpac Banking Corporation Limited. The overdraft facility has a limit of $8,000,000. The facility was unused at 30 June 2011 and as of 1 July 2012 has been cancelled. The DHB has substantial cash and investments and no plans to utilise the facility in the future.

The bank overdraft is secured by a negative pledge. Without Westpac's prior written consent, Nelson Marlborough DHB cannot perform the following actions:

- create any security over its assets except in certain circumstances,
- lend money to another person or entity (except in the ordinary course of business and then only on commercial terms) or give a guarantee,
- make a substantial change in the nature or scope of its business as presently conducted or undertake any business or activity unrelated to health; and
- dispose of any assets except disposals at full value in the ordinary course of business.

Nelson Marlborough DHB must also meet a cash flow cover covenant, under which earnings will be not less than two times interest and financing costs. The current interest rate on Nelson Marlborough DHB's bank overdraft is 8.45% per annum (2011: 8.45%).

20. EMPLOYEE ENTITLEMENTS

	Parent & Group	
	2012	2011
	Actual	Actual
	$000	$000
Current liabilities		
Sabbatical leave	179	176
Retirement Gratuities	1,901	1,524
Long service leave	569	565
Annual leave	15,762	14,613
Sick Leave	395	356
Continuing medical education	6,453	5,905
Salary and wages accrued	4,311	3,757
	29,570	**26,896**
Non-current liabilities		
Sick Leave	1,099	1,016
Sabbatical leave	1,269	1,259
Retirement Gratuities	7,196	7,592
Long service leave	2,732	2,452
	12,296	**12,319**

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. They 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 2.43% to 6.00% (2011: 2.82-6.20%), with an average of 4.82% (2011: 5.35%). For SMOs, a salary inflation factor of 2.5% (2011: 7.5%) has been used in year 1 and 2.5% thereafter (2011: 5.0%). For non-SMOs, a salary inflation factor of 2.5% has been used in all years (2011: 4.5% year 1, 4.0 years 2 and 3 & 4.25% thereafter). The take-up rate used for sabbatical leave is 25% (2011: 25%).

The valuation is most sensitive to changes in the assumed interest rate, salary inflation factor, and resignation rates. A 1% increase/decrease in the salary inflation factor would, leaving all other assumptions unaltered, result in an $815,000 increase/$741,000 decrease in the long service leave, retirement gratuities and sabbatical leave liability (2011: $807,000 increase / $732,000 decrease).

An increase in the take-up rate of sabbatical leave to 50% would result in a $1.4 million increase in the liability (2011: $1.4 million).

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 3.4% (2011: 5.0%). Average future salary growth has been assumed to be 3% per annum, plus a salary scale of 1% per annum.

21. PROVISIONS

	Parent & Group	
	2012	2011
	Actual	Actual
Current Provisions	$000	$000
Restructuring	25	1,103
ACC Partnership Programme	363	417
	388	1,520
Total Provisions	**388**	**1,520**

Movements in Provisions	Parent & Group		
	Restructuring	ACC Partnership Programme	Total
2011	$000	$000	$000
Balance at 1 July 2010	2,386	458	2,844
Additional provisions made during the year	275	-	275
Provisions used during the year	(183)	-	(183)
Provisions reversed during the period	(1,375)	(41)	(1,416)
Balance at 30 June 2011	**1,103**	**417**	**1,520**
2012			
Balance at 1 July 2011	**1,103**	**417**	**1,520**
Additional provisions made during the year			-
Provisions used during the year	(828)		(828)
Provisions reversed during the period	(250)	(54)	(304)
Balance at 30 June 2012	25	363	388

Restructuring Provisions

An amount of $0.25m has been released from the provision in relation to completed restructuring initiatives, and revisions to the estimated redundancy costs for initiatives not yet completed.

ACC Partnership Programme

Liability Valuation

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 valuation is effective 30 June 2012. 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.

Risk Margin

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 3% per annum. The discount rate used is 3.5% per annum (2011: 3.8%). 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.

Insurance Risk

Nelson Marlborough DHB 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.

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

22. EQUITY

	Parent & Group	
	2012 Actual $000	**2011 Actual $000**
(a) Crown Equity		
Balance at 1 July	29,750	26,772
Equity Injections	478	3,525
Equity Repayments	(547)	(547)
Balance at 30 June	**29,681**	**29,750**
(b) Retained Earnings		
Balance at 1 July	18,335	15,855
Net (deficit)/surplus	(5,228)	223
Transfer from property, plant and equipment revaluation reserve on classification as held for sale	112	1,783
Transfer from property, plant and equipment revaluation reserve on disposal		474
Retained Earnings at 30 June	**13,219**	**18,335**
(c) Revaluation Reserve		
Opening Balance at 1 July	41,720	44,591
Revaluations of Land and Buildings	9,380	-
Impairment Charge		(614)
Transfer to Retained Earnings on classification as held for sale	(112)	(1,783)
Transfer to Retained Earnings on disposal of property, plant and equipment	-	(474)
Balance at 30 June	**50,988**	**41,720**
Revaluation reserves consist of:		
Land	9,004	8,862
Buildings	42,096	32,858
Total Revaluation Reserves	51,100	41,720
Total Equity at 30 June	**93,888**	**89,805**

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

	Parent & Group	
	2012 Actual $000	2011 Actual $000
Reported surplus/(deficit)	(5,228)	223
Add back non-cash items:		
Depreciation and amortisation expense	12,071	12,410
Impairment losses	-	-
Add back items classified as investing activities:		
Net Loss/(Gain) on disposal of Property, Plant & Equipment	(133)	(28)
Movements in working capital:		
(Increase)/Decrease in debtors and other receivables	(188)	(3,448)
(Increase)/Decrease in prepayments	(7)	138
(Increase)/Decrease in inventories	(203)	(27)
Increase/(Decrease) in creditors and other payables	(1,322)	(2,063)
Increase/(Decrease) in employee entitlements	2,651	2,432
Increase/(Decrease) in provisions	(1,132)	(1,324)
Movements in working capital disclosed as investing activities		
(Increase)/Decrease in creditors relating to purchase of Property, Plant & Equipment	(355)	679
(Increase)/Decrease in Deferred Gain on sale and leaseback of Property, Plant & Equipment		27
Net cash (outflow)/inflow from operating activities	**6,154**	**9,019**

24. OPERATING LEASES

(a) Leases as lessee	Parent & Group	
	2012 Actual $000	2011 Actual $000
The future aggregate minimum lease payments to be paid under non-cancellable operating leases are as follows:		
Less than one year	663	797
Between one and five years	1,910	2,070
More than five years	1,491	1,895
Total non-cancellable operating leases	**4,064**	**4,762**

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

The DHB also leases clinical equipment under operating leases. The lease terms are for periods ranging from 18 months to 2 years.
There are no restrictions placed on Nelson Marlborough DHB by any of its leasing arrangements. During the year ended 30 June 2012, $2,061,000 was recognised as an expense in the surplus or deficit in respect of operating leases (2011: $1,862,000)

(b) Leases as lessor
Nelson Marlborough DHB leases owned properties to third parties under operating leases resulting in revenue of $0.9m (2011: $0.9m). 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.

25. FINANCIAL INSTRUMENTS

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

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

(a) Interest rate risk

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

The interest rates on Nelson Marlborough DHB's investments are :	Parent & Group	
	2012	**2011**
Call Deposits	2.00%	3.10%
Term Deposits with maturity less than 3 months	3.66-4.40%	4.02-4.3%
Term Deposits with maturity greater than 3 months but less than 12 months	4.40-4.66%	4.33-4.95%

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 19.

There are no interest rate options or interest swap agreements in place as at 30 June 2012 (2011: $Nil).

(b) Credit Risk

Credit risk is the risk that a third party will default on its obligations to Nelson Marlborough DHB, causing the DHB to incur a loss. Financial instruments which potentially subject Nelson Marlborough DHB to credit risk principally consist of cash, short-term deposits and accounts receivable.

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

Concentrations of credit risk from accounts receivable are high due to the reliance on the Ministry of Health for approximately 94% of Nelson Marlborough DHB's revenue. However, the Ministry of Health is assessed to be a low risk and high-quality entity due to its nature as the government funded purchaser of health and disability support services.

At balance 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 10), debtors and other receivables (note 11) and investments (note 12).

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:

	Parent & Group 2012 Actual $000	2011 Actual $000
Counterparties with Credit Ratings		
Cash and Cash Equivalents		
AA	4,800	11,790
	4,800	11,790
Investments		
AA	25,282	12,106
	25,282	12,106
Counterparties without Credit Ratings		
Cash and Cash Equivalents		
Cash on Hand	-	5
	-	5
Debtors and Other Receivables		
Existing Counterparty with no defaults in the past	12,677	12,374
Existing Counterparty with defaults in the past	136	251
Total Debtors and Other Receivables	**12,813**	**12,625**

(c) 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.

Nelson Marlborough DHB had no foreign currency assets or liabilities as at 30 June 2012. During the year, expenditure invoiced in foreign currencies was recorded in NZD calculated with the same exchange rates as those used for the payments for those invoices. No exchange rate gains or losses were recorded.

(d) Liquidity Risk

Liquidity risk represents Nelson Marlborough DHB's ability to meet its contractual obligations. The DHB evaluates its liquidity requirements on an ongoing basis by continuously monitoring forecast and actual cash flow requirements and maintaining an overdraft facility. The following table sets out the contractual undiscounted cash flows for all financial liabilities.

			Parent & Group				
2012	**Balance Sheet**	**Contractual cash flow**	**6 mths or less**	**6-12 mths**	**1-2 years**	**2-5 years**	**More than 5 years**
CHFA loans	55,500	55,500	-	-	10,500	14,000	31,000
Finance lease liabilities	1,914	2,023	588	535	640	260	-
Creditors and other payables	18,695	18,695	18,695	-	-	-	-
Total	**76,109**	**76,218**	**19,283**	**535**	**11,140**	**14,260**	**31,000**
2011	**Balance Sheet**	**Contractual cash flow**	**6 mths or less**	**6-12 mths**	**1-2 years**	**2-5 years**	**More than 5 years**
CHFA loans	47,500	59,691	13,291	1,048	2,100	22,107	21,145
Finance lease liabilities	2,779	3,015	698	597	1,005	715	-
Creditors and other payables	16,843	16,843	16,843	-	-	-	-
Total	**67,122**	**79,549**	**30,832**	**1,645**	**3,105**	**22,822**	**21,145**

(e) Capital Management

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

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

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

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

(f) Sensitivity Analysis

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

At 30 June 2012, it is estimated that a general increase of one percentage point in interest rates would decrease Nelson Marlborough DHB's deficit by approximately $265,000 (2011: $241,000).

(g) Market Risk

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

(h) Classification and Fair Values

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

		Parent & Group				
2012	**Note**	**Loans and receivables**	**Available for sale**	**Other - Amortised Cost**	**Carrying amount**	**Fair value**
Assets						
Cash and cash equivalents	**10**	4,800	-	-	4,800	4,800
Debtors and other receivables	**11**	12,813	-	-	12,813	12,813
Investments	**12**	25,282	-	-	25,282	25,282
Total Current assets		**42,895**	**-**	**-**	**42,895**	**42,895**
Other Financial Assets	**15**	-	7	-	7	7
Total Non-current assets		**-**	**7**	**-**	**7**	**7**
Total Assets		**42,895**	**7**	**-**	**42,902**	**42,902**
Liabilities						
Creditors and other payables	**18**	-	-	18,695	18,695	18,695
Finance lease liabilities	**19**	-	-	1,045	1,045	1,045
Secured loans	**19**	-	-	-	-	-
Total current liabilities		**-**	**-**	**19,740**	**19,740**	**19,740**
Finance lease liabilities	**19**	-	-	869	869	869
Secured loans	**19**	-	-	55,500	55,500	61,296
Total Non-current liabilities		**-**	**-**	**56,369**	**56,369**	**62,165**
Total Liabilities		**-**	**-**	**76,109**	**76,109**	**81,905**

2011	Note	Loans and receivables	Available for sale	Other - Amortised Cost	Carrying amount	Fair value
Assets						
Cash and cash equivalents	10	11,795	-	-	11,795	11,795
Debtors and other receivables	11	12,625	-	-	12,625	12,625
Investments		12,106	-	-	12,106	12,106
Total Current assets		**36,526**	**-**	**-**	**36,526**	**36,526**
Other Financial Assets	15	-	7	-	7	7
Total Non-current assets		**-**	**7**	**-**	**7**	**7**
Total Assets		**36,526**	**7**	**-**	**36,533**	**36,533**
Liabilities						
Creditors and other payables	18	-	-	16,843	16,843	16,843
Finance lease liabilities	19	-	-	1,159	1,159	1,159
Secured loans		-	-	12,000	12,000	12,128
Total current liabilities		**-**	**-**	**30,002**	**30,002**	**30,130**
Finance lease liabilities	19	-	-	1,620	1,620	1,620
Secured loans	19	-	-	35,500	35,500	38,169
Total Non-current liabilities		-	-	37,120	37,120	39,789
Total Liabilities		**-**	**-**	**67,122**	**67,122**	**69,919**

26. RELATED PARTY TRANSACTIONS & KEY MANAGEMENT PERSONNEL

Nelson Marlborough DHB is a wholly-owned entity of the Crown.

(a) Significant transactions with government-related entities

The DHB has received funding from the Crown and ACC of $385.7m (2011: $374.1m) to provide health services in the Nelson Marlborough area for the year ended 30 June 2012.

Revenue earned from other DHBs for the care of patients outside Nelson Marlborough DHB's district amount to $8.0m (2011: $8.1m) for the year ended 30 June 2012. Expenditure to other DHBs for their care of patients from Nelson Marlborough DHB's district amounted to $38.4m (2011: $36.1m) for the year ended 30 June 2012.

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

In conducting its activities, Nelson Marlborough DHB 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.

Nelson Marlborough DHB 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 2012 totalled $2.5m (2011: $2.2m). These purchases included the purchase of electricity from Meridian Energy, air travel from Air New Zealand, and postal services from New Zealand Post. The 2010/2011 Annual Report reflected an incorrect amount for 2011 of $5.0m.

(c) Transactions with subsidiaries

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

	Note	Parent & Group	
		2012	2011
		Actual	Actual
		$000	$000
Donations from NMHCT		74	189
		74	189

Nelson Marlborough Hospitals Charitable Trust is recognised as a subsidiary of Nelson Marlborough DHB, however it's results are not deemed material and are not consolidated in these financial statements. **27**

(d) Transactions with related parties other than those described above

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

	Parent & Group	
	2012	2011
	Actual	Actual
	$000	$000
Services provided to the DHB	100	313
Payable for services provided to the DHB	-	-

(e) Transactions with Key Management Personnel

Key Management Personnel Remuneration

	Parent & Group	
	2012	2011
	Actual	Actual
	$000	$000
Salaries and other short-term employee benefits	5,131	4,777
Post-employment benefits	-	-
Other long-term benefits	-	-
Termination benefits	-	58
Total key management personnel remuneration	**5,131**	**4,835**

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

Related party transactions involving key management personnel (or their close family members).

During the year, Nelson Marlborough DHB purchased NIL services from Te Rau Matatini Limited of which Board member R Hippolite is a Director. During the year, Nelson Marlborough DHB purchased services from Te Hauora O Ngati Rarua Limited. J Puketapu ceased as a NMDHB Board Member on 6 December 2010 but remained a Board Member of the Iwi Health Board during 2011/12. The value of expenditure totalled $983,000 and was on normal commercial terms. There is a balance of $882 outstanding for unpaid invoices at year end.

During the year, Nelson Marlborough DHB purchased services from Kimi Hauora Wairau PHO. J Puketapu ceased as a NMDHB Board Member on 6 December 2010 but remained a Board Member of the Iwi Health Board during 2011/12. The value of expenditure totalled $1.16m and was on normal commercial terms. There is a balance of $26,242 outstanding for unpaid invoices at year end.

Remuneration paid to Board members is disclosed separately in Note 34. There are close family members of key management personnel employed by Nelson Marlborough DHB. The terms and conditions of those arrangements are no more favourable than the DHB would have adopted if there were no relationship to key management personnel.

27. NON CONSOLIDATION OF SUBSIDIARIES

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

For the year ended 30 June 2012, the Trust had total revenue of $111,000 (2010: $117,000), and a net surplus of $101,000 (2011: $104,000). The Trust had assets of $2,994,000 (2011: $2,702,000), and liabilities of $Nil (2011: $Nil) at that date.

28. SUBSEQUENT EVENTS

The impacts of the announcement by Health Benefits Limited on proposed changes affecting back office services for DHBs, has not been assessed at the time of the adoption of these accounts.

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.

29. ACCOUNTING ESTIMATES AND JUDGEMENTS

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

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

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

Nelson Marlborough DHB has not made any material changes to past assumptions concerning the useful lives and residual values of its property, plant and equipment. The carrying amounts of property, plant and equipment are disclosed in note 16.

(b) Employee Entitlements

Long service leave, retiring leave, sabbatical leave, and sick leave liabilities are calculated on an actuarial basis. The key assumptions adopted in calculating the value of these liabilities are disclosed in note 20. Changes in these assumptions will have an impact of the carrying value of the liabilities.

(c) Lease Classification

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

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

(d) Revenue Recognition

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

30. EXPLANATION OF SIGNIFICANT VARIANCES FROM BUDGET

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

(a) Statement of Comprehensive Income

Revenue

Revenue was higher than budget by $5.3m. This was mainly due to increased revenue from:

- Devolved funding for Long Term Support services for clients with chronic health conditions $1.1m.
- IDFs for Aged Residential Care services for displaced Canterbury DHB clients $0.8m
- Additional revenue in the Funder arm $0.9m, offset by increased expenditure.
- Other income was higher than budget by $1.8m. This included a Gain on Sale of Property of $0.3m and greater than budgeted revenues achieved from ACC, rebates, reimbursements, non residents, rentals, and donations.
- Additional interest received of $0.8m due to higher than budgeted interest rates and a focus on daily cash management.

Expenditure

Overall the level of Acute surgery was well above what was expected, given the region's population and demographics. Elective Surgery was also conducted at levels well above plan in a successful attempt to meet the DHB's targets to reduce waiting times. The final result was total Caseweights produced being 11% above Plan. This increased activity did result in over expenditure predominantly in Personnel, Outsourced Services and Clinical Supplies.

Personnel costs are $2.7m unfavourable to budget. The overspend was caused by the additional medical and surgical activity as above, a $0.9m unfavourable revaluation of employee liabilities caused by a substantial reduction in discount rates by the Treasury and one off MECA settlement payments of $0.6m which brought costs forward from the 2012/13 year.

Outsourced Services are $1.3m unfavourable to budget. $1.0m of this variance relates to the additional surgical activity as noted above.

Clinical supplies are unfavourable to budget by $2.8m. Over-delivery of caseweight volumes has driven demand based expenditure on Pharmaceuticals ($0.7m), Implants and Prostheses ($0.7m), and Treatment Disposables ($1.5m).

Infrastructure & Non-Clinical Expenses are unfavourable to budget by $2.1m. Increased costs occurred in Insurances $0.3m due to the Christchurch earthquake increasing premiums, Utility costs $0.4m due to increased usage and contract costs, Maintenance $0.3m and Affiliation costs of $0.6m.

Payments to Providers are unfavourable to budget by $3.8m. This is mainly due to Disability Support with increased Aged Residential Care costs associated with Christchurch earthquake evacuees $1.1m, Long Term Support Services $0.9m offset by increased funding, $0.3 for Rest Home Dementia, again offset by increased funding in revenue.

Other Operating Expenses are favourable to budget by $0.5m due largely to lower than anticipated restructuring costs. Refer to note 21.

Finance costs are favourable to budget by $0.2m due largely to lower than budgeted interest rates.
Capital Charge expense is unfavourable to budget by $0.3m due to a higher equity than budgeted.

(b) Statement of Changes in Equity.

The net deficit was $5.3m less than budgeted surplus due to the explanations provided in Note 30(a), Statement of Comprehensive Income.

Other Comprehensive income was $9.4m unfavourable to budget due to the revaluation of Land and Buildings as at 30 June 2012. Equity injections were on line with budget.

(c) Statement of Financial Position

Current Assets

Current assets are $3.8m less than budgeted. Cash & cash equivalents are $35.3m less than budget, due to the longer maturities of term investments. This is offset by higher than budgeted investments being $25.3m ahead of budget. Debtors & Other receivables are $4.4m higher than budget. Non-current assets held for sale are $2.0m greater than budget.

Non Current Assets

Non-current assets are $6.8m higher than budget . The increase relates to the revaluation of Land and Buildings.

Current Liabilities

Current liabilities are $8.2m less than budget in total. Creditors & Other Payables are $10.8m less than budget. Employee Entitlements are $3.7m greater than budget of which $0.9m relates to the annual revaluation exercise. Provisions are $0.4m less than budgeted due to a lower provision being required in 2010/11 for both the restructuring accrual and the ACC Partnership Programme.

Non Current Liabilities

Non-current liabilities are $8.0m higher than budget. The increase os due to Loans & Borrowings of $6.6m and Employee Entitlements of $1.4m, the latter being due to the annual employee liability revaluation.

Equity

Equity is $3.2m higher than budget due to the variances as described in Note 30(b), Statement of Changes in Equity.

(d) Statement of Cash Flows

Cash Outflows From Investing Activities were $13.4m favourable to budget. Investment in Property, Plant, and Equipment was $13.3m higher than budgeted, largely due to the completion of the Wairau site. Sale of Assets was higher than budget by $1.3m.

Cash Flows From Financing Activities were favourable to budget by $5.6m, largely due to an equity injection of $8m, however this was offset by a reduction in Finance Leases of $2.0m.

31. MENTAL HEALTH RINGFENCED ACCOUNTS

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

	Parent & Group	
	2012	**2011**
	$000	**$000**
Opening balance of mental health funds	109	15
Excess/(Shortfall) of funding for mental health services over payments	308	94
Adjustment to prior years mental health funds available	-	-
Surplus mental health funds at the end of the financial year which are available for future mental health services	**417**	**109**

32. SEVERANCE PAYMENTS

	Note
Nelson Marlborough DHB has not made any severance payments other than in accordance with relevant employee contractual obligations.	**26, 21**

33. SUMMARY OF REVENUE AND EXPENSES BY OUTPUT CLASS

	Parent & Group		
	2011/12 Actual $000	2011/12 Budget $000	2010/11 Actual $000
Income			
Public Health	9,150	8,799	9,560
Primary and Community Services	109,848	110,104	106,943
Hospital Services	204,257	201,010	198,806
Support Services	85,035	82,981	80,447
Total Revenue	**408,290**	**402,894**	**395,756**
Expenditure			
Public Health	7,325	7,848	8,368
Primary and Community Services	110,035	109,254	106,340
Hospital Services	208,984	200,848	198,795
Support Services	87,174	84,836	82,030
Total Expenses	**413,518**	**402,786**	**395,533**
Surplus/(Deficit)			
Public Health	1,825	951	1,192
Primary and Community Services	(187)	850	603
Hospital Services	(4,727)	162	11
Support Services	(2,139)	(1,855)	(1,583)
Total Surplus/(Deficit)	**(5,228)**	**108**	**223**

33. BOARD MEMBERS' REMUNERATION

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

	Parent & Group	
	2012	**2011**
	Actual	**Actual**
	$000	**$000**
Jenny Black (Chairperson from Dec 2010)	40	34
Judy Crowe	21	21
Ian MacLennan	26	26
John Moore	21	22
To December 2010		
Judith Billens	-	9
Sharon Brinsdon	-	10
Graeme Faulkner	-	9
Lynette Jones	-	10
Joe Puketapu	-	10
Liz Richards	-	12
Suzanne Win (Chairperson from Jan 06)	-	18
From December 2010		
Gordon Currie	22	12
Fleur Hansby	20	13
Roma Hippolite	24	15
Gerald Hope	22	13
John Inder	21	12
Patrick Smith	22	13
Russell Wilson	22	13
The total value of remuneration paid or payable to Committee members (excluding Board members) during the year was:	**261**	**272**
	261	**272**

Committee Members (Community Representatives)

Hospital Advisory Committee

To December 2010		
Janet Kelly	-	1
Joanne Mickleson	-	1
Rawenata Geiger (from Sep 09)	-	1
From December 2010		
Jane Anderson-Bay	1	1
Francis Gargiulo	2	1
Tahi Takao	1	1

Community and Public Health Advisory Committee /Disability Support Advisory Committee (combined committee from December 2010)

To December 2010		
Tahi Takao (From Aug 09)	-	1
Lorraine McMath (to Dec 09)	-	-
Trisha Filleni (to Oct 09)	-	-
From December 2010		
Sonny Alesana (from Dec 09)	1	1
Mabel Grennell	1	1
Judith Holmes	1	1
Glenys MacLellan	1	1
Jos van der Pol	1	1
George Truman	1	1
	10	**13**

REGISTRATIONS OF INTEREST - BOARD

NAME	EXISTING – HEALTH	EXISTING – OTHER	INTEREST RELATES TO	POSSIBLE FUTURE CONFLICTS
Jenny Black (Chair)	• Life member of Diabetes NZ.	• Member Nelson Regional Transport Committee • Trustee Top of the South Athletics Charitable Trust		
Ian MacLennan (Deputy Chair	• Honorary Treasurer of Nelson Centre of the Cancer Society of NZ	• Tenancy and IT hosting		• Accommodation for the Cancer Society
Fleur Hansby	• Son is 6th year medical student • Disability Funding from ACC		• Family member • Self	
Gerald Hope	• Chairman Marlborough Hospice Trust	• Executive Officer Marlborough Research Centre • Director Maryport Investments Ltd	• Landlord to Cawthron Laboratory Services Blenheim	
Gordon Currie	• President Nelson GreyPower	• Wife is Health Representative for Nelson Greypower	• Residents over 50 years	
John Inder	• Board Member St Mark's Society		• Alcohol and other drug residential treatment. NGO part funded by NMDHB	
John Moore	Nil.	• Member Nelson Regional Land Transport Committee • Trustee Top of the South Athletics Charitable Trust		
Judy Crowe	• Chairperson of Nelson Marlborough Hospitals' Charitable Trust	• Member of the Gladys Amelia Pascoe Trust	• Provision of trust funds towards equipment, training and patient support	
Patrick Smith	• Member of IHB • Chair of Hauora Tane Management Group	• Managing Director, Patrick Smith HR Ltd • Member on Board of Nelson Tasman Chamber of Commerce • Partner, Kimi Human Resources	• Consultancy services • Contracts held • HR business with a focus in primary industries and Maori Services	• Focus on primary sector and Maori Working with Maori Health Providers who hold contracts •
Roma Hippolite	• Chair, Te Rau Matatini Ltd (TRM) • Board Member of Ngati Koata Trust • Director, NZ Operations Press Ganey Pty Ltd (PG) • Principal consultant at Mana Consulting Ltd • Project Manager for Maori Providers Coalition	• Sister is a Senior Performance Auditor at the Office of Auditor-General	• TRM contracts for services to NMDHB • Ngati Koata representative on IHB • Provides survey and consulting services to the healthcare sector • Provides consulting, including facilitation services to the health sector • Contract is funded by NMDHB, administered by Te Hauora o Ngati Rarua • Non-financial interest	• NMDHB may continue to contract TRM for services • NMDHB may contract PG in future for survey or consulting services
Russell Wilson	• Sister in law is an employee of NMDHB	• Member of NZ National Party (Regional Office holder) • Managing Director of Carat Investments; • Principal Consultant at Wilson Consultants (HR and Business Management consultancy)	• NMDHB Board Office; • NZ National Party • Carat Investments • Wilson Consultants	

REGISTRATIONS OF INTEREST - EXECUTIVE LEADERSHIP TEAM

NAME	EXISTING – HEALTH	EXISTING – OTHER	INTEREST RELATES TO	POSSIBLE FUTURE CONFLICTS
MEDICAL SURGICAL SERVICES				
Dr Bruce King	Nil			
Dr Elizabeth Wood	• Self employed contractor at the Mapua Health Centre as a GP • Work at NRAHDD and a shareholder			
Dr Peter Bramley	Nil			
MENTAL HEALTH SERVICES DIRECTORATE				
Dr Heather McPherson	Nil			
Dr Jocy Wood	• Partner of Nelson East Family Medical Centre. Group GP practice • Shareholder – Nelson Regional After Hours			
Robyn Byers	Nil			
COMMUNITY BASED SERVICES DIRECTORATE				
Dr Nick Baker	• Sr Clinical Lecturer, Community Child Health, University of Otago Wellington School of Medicine • Member Steering Group NZ Child and Youth Epidemiology Service (previously Chair of and co-founder of the service) • Chair NZ Child and Youth Mortality Review Committee • Member Child and Youth Network Advisory Group – MOH/PSNZ/NHB • Member NZ Paediatric and Child Health Committee Royal Australasian College of Physicians • Instructor for Advanced Paediatric Life Support NZ	• Wife is a Graphic Artist who does some health related work.		
Dr Bev Nicholls	• Board of NRADD and Shareholder • Nelson Bays PHO Clinical Governance Group • GP and recipient of Nelson Bays PHO funds • Member of IT Development, National IT Board • Member National Information Clinical Leadership Group	• Wife and close friend GPs.		
Peter Burton	Nil	• NMDHB Representative on Tasman Council's Regional Land Transport Committee		
CLINICAL SERVICES SUPPORT DIRECTORATE				
Dr Stephen Busby	• Shareholder Director, Nelson Radiology Limited			
Dr Neil Whittaker	• General Practice owner • Contracted to RNZCGP Medical Educator		• Clinical Director Community	
Hilary Exton	Nil			
James Bowyer	• Trustee on the Nelson Medical Research and Education Trust • Trustee on the Nelson Marlborough Cardiology Trust	• Wife a nurse on Paediatric Ward Nelson Hospital		

NAME	EXISTING – HEALTH	EXISTING – OTHER	INTEREST RELATES TO	POSSIBLE FUTURE CONFLICTS
MARLBOROUGH SERVICES DIRECTORATE				
Dr Ros Gellatly	• Practice Partner Scott St Health • GP Liaison NMDHB • Executive Clinical Director Marlborough Services NMDHB • Clinical Advisor Electives, NHB, MOH • Kimi Hauora Wairau Marlborough PHO Clinical Governance Committee Chair • Representative, National Health IT Board Clinical Leadership Group RNZCGP • Advisory Group Member, Royal NZ College GPs Professional Practice Expert Advisory Group			
Carey Virtue		• Partner works in the Ministry of Health		
CORPORATE SUPPORT				
Nick Lanigan		• Wife consults for 2Degrees		
Denise Hutchins	Nil	• Board Member, Royal NZ Federation of Justice's Associations		
Dr Sharon Kletchko	• Member Exceptional Circumstances Panel – PHARMAC • Treasurer, International Society for Health Care Priorities • Member St John South Island Region Trust Board • Member RACP NZ Policy and Advocacy Committee • South Island Representative on RACP NZ Joint Executive • Member of the Medicine's Review Committee (Medicine's Act) MEDSAFE • Member DHBRF Governance	• Deputy Chair of the New Zealand Standards Council • Member of the Board – EVIDEM Collaboration.	• EVIDEM is a Not-for-Profit international research collaboration whose purpose is "To promote public health through transparent and efficient healthcare decision making via systematic assessment and dissemination of the evidence for and value of healthcare interventions."	
Robyn Henderson	• Undertaking research for doctoral thesis on Media, advertising and other influences on decision to enter aged care - to be undertaken in 2 Aged Care facilities		• Aged Care	
Heather McPherson	Nil			
Harold Wereta	• Ngati Toarangatira Connections		• Tribal Interest	
CHIEF EXECUTIVE'S OFFICE				
John Peters	• Director of SISSAL • Trustee of Nelson Marlborough Hospitals' Charitable Trust • Trustee Churchill Trust	• Director of Management and Industrial Services Ltd.	• Shared services provision, administration of trust funds for health purposes & provision of private health services at Wairau Hospital • MIS Ltd previously provided consultant services to other DHBs	
Keith Rusholme	• Wife provides first aid training and complementary help services		• Provision of services to DHB staff or contracted providers	• Sister works for IDSS
Mike Cummins	• Wife works for medical practice • Trustee of Golden Bay Community Health Te Hauora o Mohua Trust		• Board appointed representative to facility provider in Golden Bay	

OUTPUT CLASSES

PREVENTION SERVICES

OUTPUT CLASS 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.

These services include:

- education programmes and services that raise awareness of risk behaviours and healthier options
- legislation, regulation and policy that protects the public from toxic environmental risks and communicable diseases
- population-based immunisation and screening programmes that support early intervention to maintain good health.

Funding and delivery of these services are the responsibility of many organisations across the district including: the Ministry of Health; NMDHB Community Based Services Directorate Public Health Unit; primary care services and general practice; a number of non-government organisations; and local government. A mix of public and private funding is used to provide these services.

WHY IS THIS OUTPUT CLASS SIGNIFICANT FOR NMDHB?

These services support people to address any risk factors that contribute to long-term conditions development. They enable people to avoid, delay or reduce the impact of these conditions on their quality of life.

High health need and at-risk population groups (low socio-economic Maori and Pacific) who are more likely to engage in risky behaviours and to live in environments less conducive to making healthier choices are targeted. 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 ensure that threats to the health of the community are detected early and prevented. These services also respond to emergency events such as pandemics or earthquakes.

WHAT ARE THE OUTPUT CLASS MAJOR SUB-SETS AND HOW ARE THEY DESCRIBED?

- **Health Promotion and Education Services** are services that inform people about health matters and support them to be healthy. Success is measured by greater awareness, engagement and the volume of programmes that support people to maintain wellness, and assist them to change personal behaviours.
- **Statutory and Regulatory Services** are services which sustainably manage environmental elements and risks in a way that supports people and communities to make healthier choices and maintain their health and safety. These services are frequently delivered by public health units and include effective quarantine and bio-security procedures, proper management of hazardous substances, assurance of safe drinking water, and compliance monitoring with liquor licensing and smoke environment legislation.
- **Population Based Screening Services** are services mostly funded and provided through the National Screening Unit that help to identify people at risk of illness earlier including breast screening, cervical cancer screening, newborn hearing testing, antenatal HIV screening, etc. The DHB's role is to encourage uptake, as indicated by high coverage rates.
- **Immunisation Services** are services which prevent the outbreak of vaccine-preventable diseases and unnecessary hospitalisations. The DHB works with primary care and allied health professionals to improve the provision of immunisations across all age groups both routinely and in response to specific risk. A high coverage rate is indicative of a well-coordinated and successful approach to immunisation delivery for our region.
- **Well Child Tamariki Ora Services** are a screening, surveillance, education and support services offered to all New Zealand children and their family or whanau from birth to five years. It assists families and whanau to improve and protect their children's health. Services in our district are provided by Plunket, Maori Health Providers and the Public Health Service.
- **Mental Health Promotion** are services that promote a social and physical environment that enhances mental health and resiliency. These services promote mental well being; raise knowledge of mental illness including recognition of early warning signs and availability of appropriate interventions; and reduce stigma and discrimination towards people who experience mental illness.

OUTPUTS AND PERFORMANCE MEASURES 2011/12

*Items referred to as 'Partially Achieved' reflect the ratings given by the Ministry of Health or are within 10% of the target.

**A 'Not Achieved' rating is where actual performance did not meet the Ministry's definition or there is a substantial difference from the target.

Assessment of some measures is based on Ministry of Health ratings for their quarterly assessment of the MOH Performance Measures. A definition of performance for Outstanding, Achieved, Partially Achieved and Not Achieved is provided for each measure. Refer to pages 22- 23 for further details.

OUTPUT CLASS: PREVENTION SERVICES

OUTPUT SUBSET: HEALTH PROMOTION AND EDUCATION SERVICES

INITIATIVES/ACTIVITIES UNDERTAKEN	AND DELIVER THESE OUTPUTS	OUTPUTS MEASURED BY	2011/12 ACHIEVED	IMPACTS MEASURED BY	2011/12 ACHIEVED	COMMENTS ON 2011/12 PERFORMANCE
Smoking Cessation Fund and provide smoking cessation services to improve access. Identify and work with high priority populations (Maori, mental health, maternity) that have higher proportions of smokers – to encourage smokers to access support to quit smoking Work to reduce smoking initiation.	**Smoking cessation services.** Giving people who contact the health service better support to quit smoking.	**Quantity** 600 people in NMDHB Quit Coach smoking cessation programmes (Total and Maori). **Quality** NMDHB clinical staff are trained to give advice and support using the Ministry-approved training (the e-learning tool and Smokefree Basic Training) **Timeliness** Meeting our smoking cessation health target: 95% of people receive advice and support to quit in hospital settings and 90% in Primary Care by July 2012. **Coverage** Meeting our smoking cessation health targets: 95% of people receive advice and support to quit in hospital settings and 90% in Primary Care by July 2012. 90 percent of enrolled patients who smoke and are seen in General Practice, will be provided with advice and help to quit by July 2012	***Not Achieved*** **Quantity** 600 people were referred to the NMDHB Quit Coach services, of these about 12% (74) declined the service or were unable to be contacted after 3 attempts. ***Achieved*** **Quality** All medical, nursing and allied health staff have been trained in the ABC approach to smoking cessations and in using this within the hospital services. ***Achieved*** Timeliness/ Coverage Secondary Care: 95.71% ***Not Achieved***** 42%, NMDHB ranks fifth across all DHBs against this primary care Health Target. There is ongoing work with GP practices to improve systems and achievement	Percentage of Year 10 students who have never smoked: Baseline 2009 (www.ash.org.nz) / By July 2012 61.1% / 62% Detected incidence of population with lung cancer: Baseline 2007 / By July 2010 26.5/ 100,000 / 26/ 100,000 National rates. Source: Age standardised rates from NZ Cancer Registry	**Achieved** Percentage of Year 10 students who have never smoked: 2011: 71.4% for NMDHB. 2011 is most up-to-date result For NZ, between 1999 and 2009 male registration rates for LUNG cancer decreased by 15.3%, while female registration rates increased by 18.0%. In 2009 rates were 36.7 per 100,000 for males; 27.1/100,000 for females. For NZ, between 1999 and 2009 male mortality rates for LUNG cancer decreased by 25.2%, and female mortality rates decreased by 1.9%. NM rates of cancer registrations (ALL cancers) are not significantly different than for NZ overall for 2007-09.	Source: www.ash.org.nz This is from a document published in July 2012: Citation: Ministry of Health. 2012. Cancer: New Registrations and Deaths 2009. Wellington: Ministry of Health.

OUTPUT SUBSET: HEALTH PROMOTION AND EDUCATION SERVICES CONTINUED

INITIATIVES/ACTIVITIES UNDERTAKEN	AND DELIVER THESE OUTPUTS	OUTPUTS MEASURED BY	2011/12 ACHIEVED	IMPACTS MEASURED BY	2011/12 ACHIEVED	COMMENTS ON 2011/12 PERFORMANCE
Breastfeeding Encourage and support local providers to promote breastfeeding, particularly to prioritise promotion and education to sub-populations that have lower breastfeeding rates. Encourage providers to participate in the Baby Friendly Hospital Initiative and adopt the principles of the Baby Friendly Community Initiative.	**Breastfeeding education and promotion services.** Number of maternity facilities that are Baby Friendly Hospital Initiative (BFHI) accredited. Number of NGOs that are working on breastfeeding initiatives – target of 10.	**Quantity** 70 mothers educated through Mum4Mum training in breastfeeding. **Quality** All four Maternity facilities are BFHI accredited **Timeliness** Time from referral to delivery of lactation consultancy services *Note: this is a new measure and the target is 72 hours from referral.*	***Not Achieved***** **Quantity** Training scaled back as sustainability of services uncertain due to funding changes. ***Achieved*** **Quality** Nelson Hospital, Wairau Hospital, Motueka Maternity Unit and Golden Bay maternity unit are all baby-friendly accredited facilities. ***Partially y Achieved*** **Timeliness** Depending on the time of the referral and the nature of the referral up to 24 or 48 hours, although longer if over a weekend. All seen within a week.	Breastfeeding rates at six weeks: Baseline08/09 | By July 12 72% | 80% (74%) Breastfeeding rates at 3 months: Baseline09/10 | By July 12 60% | 70 % (57%) Breastfeeding rates at six months: Baseline09/10 | By July 2012 26% | 35% (27%) Breastfeeding baselines rates at December 2009 and are an amalgamation of Full and Exclusive figures. National target is in brackets	***Not Achieved***** **Impact** Target | Actual Jul-Dec11 6 wks 80% | 69% (66%) 3mths 70% | 59% (55%) 6mths 35% | 19% (26%) National achievement is in brackets. Only six months of data are available for these targets.	Breastfeeding rates in 2011/12 have not met NMDHB targets, except for Maori at three months (60% against target of 56%). Rates at earlier ages are generally above the national levels, but at six months the Nelson Marlborough rates are lower than the national. *Note: the rates reported are for the six months to December 2011. The data is provided six monthly. Mum4Mum was active in Nelson and Motueka with referrals to volunteers being made by Plunket, LMCs and other Midwives. Marlborough Mum4Mum is being delivered in a less formal environment with volunteers maintaining training as required.*
Family Violence Intervention Provide NMDHB staff with ongoing training in family violence intervention in order to better identify, assess and refer victims of domestic violence and abuse. Identify at-risk families through appropriate and timely screening. Support contracted service providers to better identify, assess and refer victims of domestic violence and abuse. Build more effective care pathways for family violence victims, including through intersectoral collaboration.	NMDHB maintains a Family Violence Intervention Programme (FVIP) which includes staff training, NGO service provider training and screening for partner abuse in priority services.	**Quantity** 100 staff are trained in FVI. NMDHB FVIP training provided to two NGO health service providers. **Quality** NMDHB provides a consistent, quality FVIP and achieves above the national benchmark score of 70 on the FVIP Evaluation Audit of hospital responsiveness for both child and partner abuse. **Coverage** 60% of priority services are screening more than half of eligible women, i.e. women aged 16+ yrs	***Achieved*** **Quantity** Number of staff trained: 344 Training provided to 5 NGO providers. ***Achieved*** **Quality** Audit score for child abuse was 90 and for partner abuse was 81 giving an overall score of 171. ***Achieved*** **Coverage** 80% of priority services are screening 50% or above of eligible women, i.e. aged 16 and over	Audit scores for child abuse: BaselineSept09 | 2011/12 80 | 80 Audit scores for partner abuse: BaselineSept09 | 2011/12 78 | 78	***Achieved*** Audit score for child abuse was 90 and for partner abuse was 81 giving an overall score of 171.	NMDHB received a Ministry of Health rating for Outstanding performer (an outstanding performer has combined audit scores of 170/200 or above). The audit scores measure DHB progress in developing and sustaining family violence prevention programmes in acute and community health services. An overall audit score and breakdown of scores across a series of categories is provided. Scores may range from 0 to 100, with higher numbers indicating greater system development.

OUTPUT SUBSET: STATUTORY REGULATION

<table>
<tr><th>WE WILL UNDERTAKE THESE INITIATIVES/ ACTIVITIES</th><th>AND DELIVER THESE OUTPUTS</th><th>OUTPUTS MEASURED BY</th><th>THAT WILL LEAD TO THESE IMPACTS</th><th>IMPACTS MEASURED BY</th><th>2011/12 ACHIEVED</th><th>COMMENTS ON 2011/12 PERFORMANCE</th></tr>
<tr><td>Border Health
Border Health Surveillance (carry out requirements under Health Act, Biosecurity Act and International Health Regulations 2005)</td><td>Undertake mosquito surveillance weekly (summer) and fortnightly (winter) at Port Nelson (8 sites) and Port Marlborough (5 sites)</td><td>Quantity
507 surveillance visits</td><td>Reduced risk of diseases from introduced mosquitoes across the NZ border</td><td>Presence of exotic or endemic mosquitoes, capable of being disease vectors, are detected early thereby enabling appropriate eradication responses.</td><td>Achieved
Quantity
619 surveillance visits</td><td>There were no exotic species of interest found during this period.
222/618 samples taken were all identified as native species.
The most abundant and widespread exotic mosquito found was the Ochlerotatus notoscriptus.

<table><tr><th>Species</th><th>Total</th></tr><tr><td>Oc.notoscriptus</td><td>180</td></tr><tr><td>Cx. pervigilans</td><td>25</td></tr><tr><td>Cx. quinquefasciatus</td><td>10</td></tr><tr><td>Other</td><td>07</td></tr><tr><td>Total</td><td>222</td></tr></table></td></tr>
<tr><td>Smokefree Environments
Enforcement of the Smokefree Environments Act</td><td>Controlled purchase operations (CPOs)
Audits of retailers for compliance with the Smokefree Environments Act</td><td>Quantity
2 CPOs are conducted (covering about 60 premises)
Quality
>60 retailers are audited</td><td>More tobacco retailers comply with the Act, reducing access to tobacco products for people under 18.</td><td>Incidence of non-compliance during CPOs
<table><tr><td>Baseline2009/10
Sept 2010</td><td>2011/12</td></tr><tr><td>No sales to under 18s</td><td>0 sales</td></tr></table></td><td>Achieved
Quantity
2 CPOs were conducted

Achieved
Quality
The CPOs covered about 60 retail premises</td><td>Quality
A sale was made during the CPO performed in October 2011. Case is currently waiting for court hearing.
<table><tr><td>Baseline2010/11
Sept 2010</td><td>2011/12</td></tr><tr><td>No sales to under 18s</td><td>1 sale</td></tr></table></td></tr>
</table>

OUTPUT SUBSET: POPULATION BASED SCREENING

<table>
<tr><th>WE WILL UNDERTAKE THESE INITIATIVES/ ACTIVITIES</th><th>AND DELIVER THESE OUTPUTS</th><th>OUTPUTS MEASURED BY</th><th>2011/12 ACHIEVED</th><th>THAT WILL LEAD TO THESE IMPACTS</th><th>IMPACTS MEASURED BY</th><th>COMMENTS ON 2011/12 PERFORMANCE</th></tr>
<tr>
<td>Maintain NZ screening programmes</td>
<td>Provision of appropriate population screening services:
Cervical screening
Breast screening
Antenatal HIV screening (Human Immunodeficiency virus)

Newborn Hearing screening
Newborn Metabolic Screening Programme (the ‘heel prick’ or ‘Guthrie’ test).</td>
<td>Quantity
Proportion of enrolled women aged 20-69 who have had a cervical screen at least once in the last three years:
<table><tr><td>Baseline 2009/10</td><td>2011/12</td></tr><tr><td>Nelson Bays 80.6</td><td>>75</td></tr><tr><td>Marlborough 72.4</td><td>73.4</td></tr></table>
72% of high needs enrolled women aged 20-69 who have had a cervical screen at least once in the last three years:
<table><tr><td>Baseline 2009/10</td><td>2011/12</td></tr><tr><td>Nelson Bays 77.3</td><td>>75</td></tr><tr><td>Marlborough 64.2</td><td>65</td></tr></table>
70% of women aged 45-65 who are enrolled in the national mammography screening programme:
<table><tr><td>Baseline 2009/10</td><td>2011/12</td></tr><tr><td>Nelson Bays 76.5</td><td>>70</td></tr><tr><td>Marlborough 66.4</td><td>67</td></tr></table>
Quality
100% of the PHO Performance Programme indicators (21 in total) are met to improve the health of this district’s population.

Coverage
78% of enrolled women aged 20-69 who have had a cervical screen in the last three years</td>
<td>Partially Achieved*
Quantity
For cervical screening total eligible population

Partially Achieved*
For cervical screen high needs

Achieved
for mammography screening

Partially Achieved*
Quality
The interim PHO results confirm that 10 Indicators were achieved

Partially Achieved*
Refer to detailed figures in comments column</td>
<td>Reduced deterioration and progression to more serious illness.
Babies with problems that could impact on their health and development are picked up early Nationally fewer women dying from cervical cancer.

Impact effects:
Approximately 64,000 babies born annually in New Zealand are screened, up to 1,200 babies will be referred for an audiological assessment, and of those babies 80 to 120 babies will be found to have moderate or more severe hearing loss requiring early health intervention and special education services.

Women who are found to have HIV can be offered treatment to reduce the chance that they will transmit the virus to the baby. Treatment works well by reducing the risk of the baby getting HIV from 31.5 percent to less than 1 percent.

Cervical Cancer
Both rates and counts are projected to continue to fall sharply, although exact estimates are imprecise because of relatively small numbers.
This is entirely due to the ongoing effect of the screening programme (insufficient time has elapsed for HPV immunisation to have had a measurable impact on incidence).[1]</td>
<td>Nationally fewer women dying from cervical cancer.
Nationally fewer women dying of breast cancer.
# of babies who have these problems and who have better health outcomes per annum</td>
<td>Proportion of enrolled women aged 20-69 who have had a cervical screen at least once in the last three years:

Nelson Bays PHO: 81.37
KHW (Marlborough) PHO 72.45
Nelson Marlborough Total = 78.62
Proportion of high needs enrolled women aged 20-69 who have had a cervical screen at least once in the last three years

Nelson Bays PHO: 77.06
KHW (Marlborough) PHO = 63.75
Nelson Marlborough Total = 73.42
70% of women aged 45-65 who are enrolled in the national mammography screening programme:

Nelson Bays PHO:= 77.07
KHW (Marlborough) PHO: 72.28
Nelson Marlborough Total = 75.73
Note: rates reported are from the PHO Performance Programme July-Dec2011. Reports are published six-monthly.</td>
</tr>
</table>

OUTPUT SUBSET: IMMUNISATION SERVICES

WE WILL UNDERTAKE THESE INITIATIVES/ ACTIVITIES	AND DELIVER THESE OUTPUTS	OUTPUTS MEASURED BY	2011/12 ACHIEVED	IMPACTS MEASURED BY	2011/12 ACHIEVED	COMMENTS ON 2011/12 PERFORMANCE
Ensure the provision of a range of immunisation services. Ensure the delivery of immunisation recall systems.	Immunisation services (through general practice, outreach, school and other community settings).	**Quantity** 1544 two-year-olds fully immunised for their age at 24 months. All schools with Year 7 children are provided with the dTap vaccination programme. All schools with Year 8 girls are provided with the Human Papillomavirus vaccination programme. Proportion of Over 65 year olds receiving the flu vaccination: Nelson/Tasman 69.74% Marlborough 60.0 %. **Quality** No avoidable cold chain failures Note: The 'cold chain' is maintenance of refrigerated storage of vaccines at appropriate temperatures to maintain vaccine effectiveness. Proportion of practice nurses who are currently Authorised Independent Vaccinators. **TIMELINESS** 80% of newborns are enrolled with a GP at four weeks of age.	***Achieved*** **Quantity** 1579 two year old children fully vaccinated at 24 months. ***Partially Achieved*** All schools, except one who declined, were provided with the dTap vaccination Programme Partially Achieved* All schools are offered the HPV Programme Partially Achieved* Over 65 year olds flu vaccinated: 64.6% (Jul-Dec 2011) ***Not Achieved***** **Quality** There was one avoidable cold chain failure. **Quality** 81% of practice nurses are authorised independent vaccinators (AIVs) as at 30 June 2012. ***Not Achieved***** Timeliness enrolment of new borns by four weeks with a GP is a priority for 2012/13	Increased percentage of population vaccinated to achieve herd immunity. Immunisation: Two-year-olds fully vaccinated: | Baseline Dec2010 | July 2012 | | --- | --- | | 89% | 95% | Year 7 children (birth cohort 1999) vaccinated DTap-IPV: | Baseline Dec 2010 | 2011/12 | | --- | --- | | 59.4% | 60% | (based on eligible children from the SBVS programme) Year 8 girls (birth cohort 1998) vaccinated against Human Papillomavirus: | Baseline Dose 3, birth cohort 1997 Dec 2010 | 31st December 2011 | | --- | --- | | 40% | 60% | Over 65 year olds flu vaccinated: | Baseline based on PHO enrolled population | MoH ongoing target | | --- | --- | | 65% | 75% | Nelson/Tasman 69.74% Marlborough 60.0 %	**Not Achieved**** Two-year-olds fully vaccinated for the 2011/12 year was 88% Year 7 children (birth cohort 1999) vaccinated DTap-IPV: Achieved 60.8% of the total eligible population **Not Achieved**** Year 8 girls (birth cohort 1998) vaccinated against Human Papillomavirus: 29% **Partially Achieved*** Over 65 year olds flu vaccinated: 64.6% (Jul-Dec 2011). Only six months of data are available from PHOs Nelson/Tasman: 67.12% Marlborough: 59.81%	The national target is 95% and the actual rate of NZ as a whole was 92%. Nelson Marlborough has a relatively high rate of families who decline to fully immunise their children. All schools with Yr 7 were offered the respective immunisation programmes There has not been high uptake of the HPV vaccination for a variety of reasons, e.g. it takes 3 doses to be fully immunised. All schools with Yr 8 were offered the respective immunisation programmes. 5 schools (of the 48 eligible) declined to host the Year 8 HPV programme Nelson Marlborough had a similar 'flu vaccination rate to NZ as a whole, (which was 65.5%) but this both rates are lower than target of 75%. Nelson Bays Primary Health experienced a decrease in the number of people aged 65 years and over, who had an influenza vaccination this year.

OUTPUT SUBSET: WELL CHILD TAMARIKI ORA SERVICES

WE WILL UNDERTAKE THESE INITIATIVES/ACTIVITIES	AND DELIVER THESE OUTPUTS	OUTPUTS MEASURED BY	2011/12 ACHIEVED	IMPACTS MEASURED BY	2011/12 ACHIEVED	COMMENTS ON 2011/12 PERFORMANCE
Work with Plunket as the national provider to ensure high coverage and quality of Well Child services in the district, in line with service specifications. Public Health Services under the Community Based Services Directorate will deliver B4 School Checks to all children in their 4th year of age.	Well Child services delivered locally by Public Health Service and Maori Health providers. Before (B4) School Checks delivered by Public Health Service and primary health care providers.	**Quantity** Number of new baby cases seen by services funded through NMDHB: Baseline 2009/10: 125; 2011/12: 125 Note: all children are entitled to the service; the majority of new babies are enrolled with Plunket; services funded through NMDHB are Maori Health providers and the Public Health Service. Number of Before (B4) School checks: Baseline 2009/10: 1,366; 2011/12: 1,462 **Quality** Services delivered by providers in accordance with the Well Child Framework	***Achieved*** **Quantity** NMDHB funded services saw 287 new babies during 2011/12 **Achieved** Number of Before (B4) School checks delivered: 1519 Achieved **Quality** Services were delivered to the Well Child Framework	Breastfeeding rates as above. Immunisation rates as above. 80% of eligible children receive Before (B4) School Checks.	***Achieved*** **Impacts** 82% of the eligible population received a B4 School Check in 2011/12	**Quality** Providers are legally bound by the Funding agreement with NMDHB to deliver services according to the Well Child Framework. Regular reporting and audit from time to time also confirms this.

OUTPUT SUBSET: MENTAL HEALTH PROMOTION

WE WILL UNDERTAKE THESE INITIATIVES/ACTIVITIES	AND DELIVER THESE OUTPUTS	OUTPUTS MEASURED BY	2011/12 ACHIEVED	IMPACTS MEASURED BY	2011/12 ACHIEVED	COMMENTS ON 2011/12 PERFORMANCE
Work with Te Tau Ihu Mental Health Promotion Network, Nelson Bays Primary Health, and Kimi Hauora Wairau to increase mental health promotion/ prevention activities within the service coverage area. Work intersectorally with key agencies involved in supporting Children of Parents with Mental Illness (COPMI). Focussed at improving communication and collaboration to better meet COPMI needs.	Mental Health Awareness Week programme. Development of a COPMI Reference Group to develop a COPMI support pathway.	**Quantity** In association with Te Tau Ihu Mental Health Promotion Network, a district wide programme is developed and implemented. COPMI pathway agreed across agencies. Quality COPMI pathway agreed between (at a minimum) Strengthening Families, Child Youth and Family, NBPH, KHW MPHO, DHB owned mental health service.	***Not Achieved***** Refer to next column ***Not Achieved***** Refer to next column	At least three mental health awareness week programmes held in three different locations: Baseline2009/10: 2 programmes; 2011/12: 3 programmes 11/12 Number of COPMI supported through pathway: Baseline 2009/10: No pathways developed; 2011/12: 5 pathways	***Achieved*** 2011/12 actual: 6 programmed ***Not Achieved***** Pathways are yet to be developed. The MHSD Reference Group, that includes the representatives listed in column three, is reviewing COPMI pathways.	Mental Health Awareness week 2011 activities occurred in six locations across the NMDHB district. A collaborative coordinated approach allowed for the delivery of mental wellbeing workshops in five locations involving the wider sector. These workshops were held in Nelson, Richmond, Tapawera, Motueka and Golden Bay. Packs of information relating to workplace wellbeing were delivered to many workplaces and a poster campaign was launched across Nelson city and Takaka. In Marlborough, a wellbeing walk with associated activities was delivered across the community.

PREVENTION SERVICES OUTPUT CLASS STATEMENT OF FINANCIAL PERFORMANCE

000s	2011/12 Actual	2011/12 Plan	2011/12 Variance
Revenue	**9,149**	**8,799**	**351**
Expenditure			
Personnel costs	3,887	4,203	316
Outsourced services	456	456	(1)
Clinical Supplies	177	508	331
Infrastructure	742	779	37
Provider payments	2,062	1,903	(159)
Total Expenditure	7,325	7,848	523
Net Surplus/(Loss)	**1,825**	**951**	**874**

EARLY DETECTION AND MANAGEMENT SERVICES

Output Class 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
- more effective management and coordination of people with long-term conditions.

These services are by nature more generalist, usually accessible from multiple providers and a number of different locations. Providers include:

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

A significant proportion of these services are demand driven, such as pharmacy, community radiology and diagnostic laboratory services. These services are provided with a mix of public and private funding and may include co-payments for general practice and pharmacy services.

WHY IS THIS OUTPUT CLASS SIGNIFICANT FOR NMDHB?

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 locally.

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, reduce the burden of long-term conditions through supported self- management (avoidance of complications, acute illness and crises). These services deliver coordination of care, supporting people to maintain good health.

Description of the sub-sets of services that make up this output class:

- **Primary Health Care (GP) Services** are services offered in local community settings by a primary care team including general practitioners (GPs), registered nurses, nurse practitioners and other primary health care professionals aimed at improving, maintaining or restoring people's health. High levels of enrolment with general practice are indicative of engagement, accessibility and responsiveness of primary care services.
- **Oral Health Services** are services provided to assist people in maintaining healthy teeth and oral tissues and are provided by approved registered oral health professionals. High enrolments are indicative of engagement, while more timely examination and treatment of children will indicate a well functioning and efficient approach to delivery.
- **Primary and Community Programmes of Care** are services, initiated and managed in primary care, and targeted at people with high health need due to long-term conditions such as diabetes, CVD or mental illness and provide identification, intervention and management to reduce deterioration, crises and complications. Success is demonstrated through identification of need, regular monitoring for improvement or deterioration, and clinical outcomes that demonstrate successful management of conditions. A focus on early intervention strategies and delivery of services closer to home will improve service availability in the community and is expected to decrease demand for specialist or hospital appointments.

- **Pharmacy Services** are services aligned to requirements of the Pharmaceutical Schedule including provision and dispensing of medicines. Pharmaceuticals are demand driven, and we are likely to see an increased dispensing of pharmaceutical items as more people engage with health services. To improve performance, NMDHB will target medication management for people on multiple medications to reduce potential negative interactive effects.
- **Community Referred Testing and Imaging Services** are services[6] to which a health professional may refer a person to help diagnose a health condition, or as part of treatment. They are provided by personnel such as laboratory technicians, medical radiation technologists and nurses. These services are demand driven and are likely to increase as more people engage with health services and respond to health promotion messages about early diagnosis. To improve performance there will be an increase in the number of community referred radiological images, as an indication of improved primary care access to diagnostics, without the need for a hospital appointment.

6 Laboratory, imaging procedures, cardiology/ physiological procedures, audiology services, neurology services, endocrinology services

- **Infection Control** are services that are committed to prevention of infections and occupational exposures throughout the healthcare continuum. The programme manages and minimises the infection risk by incorporating measures/ interventions that are required to prevent pathogen transfer between patients, staff and visitors and in safe-guarding patients from developing infections due to, or resulting from medical interventions.
- **Primary and Mental Health Services** are services that are delivered in a primary care setting for the assessment, treatment and when needed the ongoing management of people with mild to moderate mental health and/or addiction issues. This includes promotion, prevention, early intervention and ongoing treatment.

OUTPUTS AND PERFORMANCE MEASURES 2011/12

*Items referred to as 'Partially Achieved' reflect the ratings given by the Ministry of Health or are within 10% of the target.

**A 'Not Achieved' rating is where actual performance did not meet the Ministry's definition or there is a substantial difference from the target.

OUTPUT CLASS: EARLY DETECTION AND MANAGEMENT

WE WILL UNDERTAKE THESE INITIATIVES/ ACTIVITIES	AND DELIVER THESE OUTPUTS	OUTPUTS MEASURED BY	2011/12 ACHIEVED	IMPACTS MEASURED BY	2011/12 ACHIEVED	COMMENTS ON 2011/12 PERFORMANCE
Keep more people well by • Intervening early to detect, manage and treat existing health conditions • Better education and advice so people can manage their own health • Reaching those at risk of developing long-term or acute conditions	Provision of First contact services by GP or practice nurses. Enrolment of eligible people in the Care Plus Programme. Early detection of people with diabetes. Free diabetes checks to review and modify (if required) management of patients with diabetes. Enrolment of at risk people in the VRA programme.	**Quantity** % of people with diabetes who have had Annual Reviews Baseline2010/11: 72% | 2011/12: 76% 90% of adult population who have had CVD risk assessed in the last 5 years Number of people enrolled in the Care Plus programme each quarter: Baseline2010/11: 6,364 | 2011/12: 6,491 % of at risk people enrolled in the VRA programme: Baseline2010/11 | 2011/12 NBPH 50% | 50% KHW 26% | 30% **Quality** % of people with diabetes who have a laboratory test measure of good care(HB A1c equal to or less than 8%): *Note: Hba1c is a measure of diabetes control by reflecting the average blood glucose over the previous two to three months.* Baseline2010/11: 79% | 2011/12: 80% **Timeliness** People with diabetes with HbA1c over 8% who have had a free second visit within 12 months: Baseline2010/11: 85% | 2011/12: 85%	***Achieved**** **Quantity** 77% ***Not Achieved*** **Quantity** 49.9% ***Achieved*** 6,904 people enrolled in Care Plus ***Achieved*** NBPH: 75.4% of target KHW: 60% of target ***Partially Achieved**** 76% ***Partially Achieved**** 73%* Note further refinements will be made by Nelson Bays PHO to measure this in 2012/13	Number of acute admissions to hospital: Baseline2009/10: 11,967 | 2011/12: 12,206 % of people in the district enrolled with a PHO: Baseline2010 | 2011/12 N 93,331 (>99%) | >99% W 41,898 (>98%) | >98%	**Quantity** 13,603 acute admissions to hospital. This quantity is demand driven ***Partially Achieved**** Nelson PHO: 94,671, 99.5% KHW PHO: 42,388, 93% (Note an additional GP practice in Wairau that opened in 2012 will increase the number of people enrolled with a GP)	Source: Data from 2011/12 Nelson & Wairau. Admit Code

OUTPUT SUBSET: ORAL HEALTH

WE WILL UNDERTAKE THESE INITIATIVES/ ACTIVITIES	DELIVER THESE OUTPUTS	OUTPUTS MEASURED BY	2011/12 ACHIEVED	IMPACTS MEASURED BY	2011/12 ACHIEVED	COMMENTS ON 2011/12 PERFORMANCE
Influencing the oral health status of young children through: • Implementation of the new model of care for primary school and pre-school children through the Community Oral Health Hubs, including • Targeting children and adolescents living in disadvantaged areas with oral health promotion programmes • Work with Well Child Tamariki Ora providers to increase the enrolment of preschool children with the service Maintain utilisation of dental service for adolescents through maintaining access to services and ensuring dental service providers operate effective recall systems. Improving access to dental services for low income adults.	Enrolment in dental services at an earlier age. Oral examination of preschool and school children, with recall according to need. Adolescent oral health services contracts with dentists. Oral examination of adolescents. Low income adult attendance for examination.	**Quantity** Number of children under five enrolled in DHB funded dental services: Baseline2009/10: 3500 / 2011/12: 4500 **Quality** Proportion of children caries free at 5 years of age: Baseline2009/10: Maori 41%, Other 65%, Total 61% / 2011/12: 43%, 65%, 62% **Timeliness** Number and % of pre-school and primary school children who have been examined according to their planned recall.	***Not Achieved***** **Quantity** Number of children under five enrolled in DHB funded dental services: 4140 ***Achieved*** **Quality** Proportion of children caries free at 5 years of age Maori 50%; Other 70%; Total 67% ***Not Achieved***** **Timeliness** 9563 pre-school and primary school children (51%) have been examined according to their planned recall	Decayed Missing or Filled Teeth (DMFT) scores are a quality measure for oral health in children in this district. DMFT at year 8 (around age 12 years): Baseline2010: Maori 1.93, Other 1.00, All 1.16 / 2011/12: 1.55, 1.10, 1.15 Utilisation of adolescent oral health services: Baseline2009/10: 80.4% / 2011/12: 85%	***Achieved*** **Impacts** DMFT at year 8 (around age 12 years): Maori 1.38; Other 0.97; All 1.04 ***Achieved*** Utilisation of adolescent oral health services: 86.7%	*Note: all oral health data is measured for the 2011 calendar (school) year.*

OUTPUT SUBSET: PRIMARY AND COMMUNITY PROGRAMMES OF CARE

WE WILL UNDERTAKE THESE INITIATIVES/ ACTIVITIES	AND DELIVER THESE OUTPUTS	OUTPUTS MEASURED BY	2011/12 ACHIEVED	IMPACTS MEASURED BY	2011/12 ACHIEVED	COMMENTS ON 2011/12 PERFORMANCE
Provide community programmes that support keeping people well and address inequalities	Whanau Ora community services Maori Palliative Care support	**Quantity** Whanau Ora Plans achieved by provider service aggregated per annum. **Quality** % of Plans completed by provider service aggregated per annum. **Timeliness** Whanau Ora plans completed on an annual basis.	***Not Achieved***** Refer to comments in next column	Completion of community based Whanau Ora plans Baseline2009/10: 70% / 2011/12: 80%	***Not Achieved***	NMDHB has undertaken an independent review of Whanau Ora services across NGOs, and have established that although the service specification is standardised across all services, there is not a standardised approach to assessment for whanau plans. Therefore, this measure no longer forms an accurate basis for performance or improvement, and work is being progressed on standardising an input and output for services through the Hauora Coalition workstreams.
Provide targeted interventions for people to support areas of key inequality such as clinical interventions for people with asthma and other respiratory conditions, and podiatry services.	Asthma and COPD services Podiatry Services	**Quantity and Quality** Number of patients receiving asthma/COPD services: Baseline2009/10 / 2011/12: Nelson: 443 / 452; Wairau: 156 / 160 Number of patients receiving podiatry services: Baseline2009/10 / 2011/12: Nelson: 2,475 / 2,525; Wairau: 1,526 / 1,557	***Achieved for Nelson*** ***Not Achieved for Wairau***** Nelson: 684 Wairau: 86 ***Achieved*** Number of patients receiving podiatry services in 2011/12: Nelson: 2559 Wairau: 1521	Impacts are measured by maintaining our Ambulatory Sensitive Hospitalisation (ASH) indirectly standardised discharge ratio (ISDR) for asthma acute admissions per annum. Baseline2009/10: <100 / 2011/12: <100 *Note: this relates to population "other [0-74 years]"*	***Achieved*** ASH Indirect Standardised Ratio (ISDR) 81.5	NMDHB has achieved the target for 2011/12. The achievement denotes efficacy of NMDHB's continued reorientation of health services to meet the identified need. In addition, the establishment of the Hauora Provider Coalition as a Maori collaborative partner entity is realising benefit.

OUTPUT SUBSET: PHARMACY SERVICES

WE WILL UNDERTAKE THESE INITIATIVES/ACTIVITIES	AND DELIVER THESE OUTPUTS	OUTPUTS MEASURED BY	2011/12 ACHIEVED	IMPACTS MEASURED BY	2011/12 ACHIEVED	COMMENTS ON 2011/12 PERFORMANCE
Implement safe and effective pharmacy services across settings of care (hospital and community).	Hospital based pharmacy service. Community pharmacy services. Provision of a services for the collection of unused medicines (DUMP campaign)	**Quantity** % of patients whose medicines are initiated within 24 hours of admission, transfer or discharge: Baseline2010/11: 15%; 2011/12: 60% Total community dispensing volumes Baseline2009/10: 1,782,771; 2011/12: 1,818,371	***Achieved*** 60% ***Achieved*** 2,142,235	Average number of adverse events (ADE) each quarter which may cause patient harm Baseline March-May 2009: 30; 2011/12: 20 Hospital average length of stay: Baseline2009/10: Nelson:<3.51; Wairau:<3.21; 2011/12: Nelson:<3.51; Wairau:<3.21	***Achieved*** 12 adverse events ***Achieved*** Hospital average length of stay: 3.44 days 3.00 days	A reduced figure is positive as there are fewer adverse events Note that this excludes Day Cases

OUTPUT SUBSET: INFECTION CONTROL

WE WILL UNDERTAKE THESE INITIATIVES/ACTIVITIES	DELIVER THESE OUTPUTS	OUTPUTS MEASURED BY	2011/12 ACHIEVED	IMPACTS MEASURED BY	2011/12 ACHIEVED	COMMENTS ON 2011/12 PERFORMANCE
Monitor and refine systems used to manage the infection risks within the NMDHB as per NZS 8134:2008. Minimise and manage the infection risks by incorporating measures and interventions required to prevent pathogen transfer between patients, staff and visitors. Safeguard patients from developing infections due to, or resulting from medical interventions	Minimise episodes of epidemiologically linked patient infection Minimise infections that develop in hospital or associated with a hospital procedure that lead to positive blood cultures Minimise infections developing in wounds from operations undertaken in NMDHB	**Quantity** Number of norovirus, and/or methicillin resistant staphylococcus aureus infections in community facilities. Baseline 2010/11: 10; 2011/12: 6 Episodes of patient infection involving two or more patients with the same micro-organism, during the same time period and linked by location or procedure: Baseline 2010/11: <1; 2011/12: <1 **Quality** Positive blood cultures in inpatients who have been in hospital for more than 48 hours (not present or incubating at admission) or related to a hospital health-care associated device or procedure: Baseline 2009/10: Zero; 2011/12: Zero Percentage of wounds that develop symptoms, signs and microbiological evidence of infection within 30 days of selected clean surgical procedures: Baseline 2009/10: < 4%; 2011/12: < 4%	***Achieved*** **Quantity** 5: Number of norovirus, and/or methicillin resistant staphylococcus aureus infections ***Achieved*** <1 ***Achieved*** Zero ***Achieved*** 1.4% (refer to comment in next column)	Cross infections (including outbreaks) in NMDHB facilities: Baseline2010/11: <1; 2011/12: <1 Hospital-acquired blood stream (HABSI) infections: Baseline2009/10: Zero; 2011/12: Zero Percentage of wounds with infections developing within 30 days of selected clean surgical procedures: Baseline2009/10: < 4%; 2011/12: < 4%	***Achieved*** No confirmed outbreaks or cross infections in 2011/12 ***Not Achieved***** 25 HABSI reported for this period ***Achieved*** Sept/Oct 2011 surveillance period = 1.4% clean surgical site infections (SSI)	National 5 Moments Hand Hygiene programme implemented Surveillance project implemented for Central Line-associated BSI (CLABSI). Currently ad hoc manual Laboratory reporting of positive blood cultures Working party reviewed international best practice recommendations – no significant changes made

OUTPUT SUBSET: COMMUNITY REFERRED TESTING AND DIAGNOSTICS

<table>
<tr><th>WE WILL UNDERTAKE THESE INITIATIVES/ ACTIVITIES</th><th>DELIVER THESE OUTPUTS</th><th>OUTPUTS MEASURED BY</th><th>2011/12 ACHIEVED</th><th>IMPACTS MEASURED BY</th><th>2011/12 ACHIEVED</th><th>COMMENTS ON 2011/12 PERFORMANCE</th></tr>
<tr>
<td>Ensure timely referral and response to testing and diagnostic services.</td>
<td>Testing and diagnostics
1. Laboratory
2. Imaging procedures
3. Cardiology/ Physiological procedures
4. Audiology
5. Neurology
6. Endocrinology</td>
<td>
Quantity
Number laboratory tests:
<table>
<tr><td>Baseline 2009/10</td><td>2011/12</td></tr>
<tr><td>1,610,213</td><td>1,610,213</td></tr>
</table>
Number radiological examinations:
<table>
<tr><td>Baseline 2009/10</td><td>2011/12</td></tr>
<tr><td>90,446</td><td>90,446</td></tr>
</table>
Number of cardiology and physiology procedures:
<table>
<tr><td>Baseline 2009/10</td><td>2011/12</td></tr>
<tr><td>8,198</td><td>8,198</td></tr>
</table>
Number of Audiology procedures:
<table>
<tr><td>Baseline 2009/10</td><td>2011/12</td></tr>
<tr><td>3,698</td><td>3,698</td></tr>
</table>
Quality
100% of facilities have received TELARC accreditation where applicable.

Increase the percentage of urgent tests completed within 3 hours on receipt of sample at the lab:
<table>
<tr><td>Baseline 2009/10</td><td>2011/12</td></tr>
<tr><td>80%</td><td>85%</td></tr>
</table>
Reduce the days for availability of histology results:
<table>
<tr><td>Baseline 2009/10</td><td>2011/12</td></tr>
<tr><td>Community: 5 days</td><td>4 days</td></tr>
<tr><td>Hospital: 5 days</td><td>3 days</td></tr>
</table>
Timeliness
% of routine laboratory test results available to referrers within 48 hours from time of receipt:
<table>
<tr><td>Baseline 2009/10</td><td>2011/12</td></tr>
<tr><td>80%</td><td>80%</td></tr>
</table>
% of Radiological reports meeting 14 day availability to referrer:
<table>
<tr><td>Baseline/2009/10</td><td>2011/12</td></tr>
<tr><td>100%</td><td>100%</td></tr>
</table>
% of patients waiting time target for radiological examinations:
<table>
<tr><td>Baseline 2009/10</td><td>2011/12</td></tr>
<tr><td>Urgent – within 24 hrs</td><td>Within 24 hours</td></tr>
<tr><td>Semi-urgent – within 14 days</td><td>Within 14 days</td></tr>
<tr><td>Routine – 14 days and above</td><td>14 days and above</td></tr>
</table>
</td>
<td>
Achieved
Quantity
1,799,678 or 11.77% increase

Partially Achieved
88,914 radiological examinations

Achieved
9,341 (Note there has been change in data capture)

Not Achieved
Data capture change from NSF. 2011/12 data of 2,451 will now be baseline

Achieved
Quality
87%

Not Achieved**
5 days

4 days

Achieved
Timeliness
82%

Achieved

Achieved

Not Achieved
Within 30 days

Not Achieved
Within 30 days
</td>
<td>
Ambulatory Sensitive Hospitalisations:
<table>
<tr><td>Age</td><td>Baseline 2010/11 Quarter2</td><td>2011/ 12 target</td></tr>
<tr><td>0-4 Maori</td><td>92</td><td><95</td></tr>
<tr><td>0-4 Other</td><td>112</td><td><105</td></tr>
<tr><td>45-64 Maori</td><td>56</td><td><95</td></tr>
<tr><td>45-64 Other</td><td>80</td><td><95</td></tr>
<tr><td>0-74 Maori</td><td>76</td><td><95</td></tr>
<tr><td>0-74 Other</td><td>93</td><td><95</td></tr>
</table>
Average length of stay for acute inpatients:
<table>
<tr><td>Baseline 2009/10</td><td>2011/12</td></tr>
<tr><td>Nelson: <3.30</td><td><3.30</td></tr>
<tr><td>Wairau: <2.39</td><td><2.39</td></tr>
</table>
Reduction in mortality rates within 30 days:
<table>
<tr><td>Baseline 2009/10</td><td>2011/12</td></tr>
<tr><td>National benchmark</td><td>National benchmark</td></tr>
</table>
</td>
<td>
Achieved, except Maori 0-4
<table>
<tr><td>2011/ 12</td></tr>
<tr><td>107.2</td></tr>
<tr><td>94.6</td></tr>
<tr><td>63.5</td></tr>
<tr><td>73.2</td></tr>
<tr><td>78.1</td></tr>
<tr><td>82.4</td></tr>
</table>
Partially Achieved
3.68 days
2.95 days

Achieved
NMDHB standardised mortality rate for 2011/12 was below the average for the 20 DHBs
</td>
<td>
Source: Figures from MoH NMDHB ASH admissions for year ending 31 March 2012 ((Note: This is the latest period for reported data)

NMDHB has the lowest average length of stay for the 20 DHBs to 31 March 2012. Note that this excludes Day Cases

NMDHB standardised mortality was 1.46 compared to the DHB average of 1.50
</td>
</tr>
</table>

OUTPUT SUBSET: PRIMARY MENTAL HEALTH

WE WILL UNDERTAKE THESE INITIATIVES/ACTIVITIES	AND DELIVER THESE OUTPUTS	OUTPUTS MEASURED BY	2011/12 ACHIEVED	IMPACTS MEASURED BY	2011/12 ACHIEVED	COMMENTS ON 2011/12 PERFORMANCE
Work with the Nelson Marlborough Health Alliance to develop a Primary Stepped Care Model.	Primary mental health programmes including Brief Intervention Clinical Services, extended General Practice Consultations, Packages of Care. Workforce development initiatives that include the introduction of E therapy. An agreed Primary Stepped Care Model endorsed by the sector. Inclusive of a range of primary mental health services.	**Quantity** Total number of patients accessing the primary mental health programme. Baseline2009/10: 922 2011/12: 950 **Quality** Reduction in Mental Health Outcome Measures such as PHQ-9, Kessler 10 or GAD7 scores. Note: The PHQ9 has a scoring range of 0 to 27 (with 27 indicating extreme psychological distress). Currently the average drop in score (severity) is seven and the target drop for 2011/12 is 7.5 following participation in NMDHB primary mental health care programmes. Baseline2009/10: 7 points 2011/12: 7.5 points	***Achieved*** Refer to next column ***Partially Achieved**** Refer to next column	Increased number of general practice patients utilising the Primary Mental Health programme funding. Baseline2009/10: 922 2011/12: 950[2] Average PHQ-9 score reductions. Baseline2009/10: 7 points 2011/12: 7.5 points	***Achieved*** 2011/12 Actual: 1,113 patients utilising Primary Mental Health programme funding ***Partially Achieved**** 2011/12 Actual: 7.3: this is very close to the target across a higher than expected number accessing the services	Referrals to Brief Intervention continue to be steady, with referral numbers greater than programme funding availability at Nelson Bays PHO.

EARLY DETECTION AND MANAGEMENT SERVICES OUTPUT CLASS STATEMENT OF FINANCIAL PERFORMANCE

000s	2011/12 Actual	2011/12 Plan	2011/12 Variance
Revenue	109,847	110,104	(257)
Expenditure			
Personnel costs	22,473	22,082	(391)
Outsourced services	2,019	2,318	299
Clinical Supplies	1,543	1,714	171
Infrastructure	6,500	6,617	117
Provider payments	77,500	76,524	(976)
Total Expenditure	**110,034**	**109,254**	**(780)**
Net Surplus/(Loss)	**(187)**	**850**	**(1,036)**

INTENSIVE ASSESSMENT AND TREATMENT SERVICES

Output Class 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.

WHY IS THIS OUTPUT CLASS SIGNIFICANT FOR NMDHB?

Equitable 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 so that the patients does not have 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 can 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. It would then be expected that our population is able to establish greater lifestyle stability, based on improved public confidence in the health system and utilisation overall.

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.

Government has set clear expectations for the delivery of increased elective surgical volumes, a reduction in waiting times for treatments and increased clinical leadership to improve the quality of care being delivered. The changes being made to meet Government expectations are providing unique opportunities to introduce innovative clinically led service delivery models and improve productivity within our hospital services.

DESCRIPTION OF THE SUB-SETS OF SERVICES THAT MAKE UP THIS OUTPUT CLASS

Inpatient Planned and Unplanned Services are services that include:

- **Planned (Elective) Services** are services for people who do not need immediate hospital treatment and are 'booked' services. This includes elective surgery, but also non-medical interventions (such as coronary angioplasty) and specialist assessments (either first assessments, follow-ups or preadmission assessments). National Elective Services Patient Flow Indicators (ESPIs) are indicative of a successful and responsive service, addressing increasing needs and matching commitments to capacity.
- **Unplanned (Acute) Services** are services for illnesses that have an abrupt onset and are often of short duration and rapidly progressive, creating an urgent need of care (nb: they may or may not lead to a hospital admission). Hospital-based acute services include emergency departments, short-stay acute assessments and intensive care services. Performance against clinical triage guidelines is used to demonstrate the capacity and responsiveness of the system. Productivity measures such as length of stay rates are balanced with outcome measures such as readmission rates to indicate the quality of service provision.
- **Specialist Mental Health Services** are services for people who are most severely affected by mental illness or addictions and include assessment, diagnosis, treatment and rehabilitation, as well as crisis response when needed, and as required under the Mental Health Act. Currently the expectation established in the National Mental Health Strategy is that specialist services (including psychiatric disability services) will be available to 3% of the population. Utilisation rates will be monitored across age groups and ethnicities to ensure service levels are maintained and to demonstrate responsiveness.
- **Maternity Services** are services provided to women and their families through pre-conception, pregnancy, childbirth and for the first months of a baby's life. These services are provided in home, community and hospital settings by a range of health professionals, including midwives, GPs and obstetricians and include: specialist obstetric, lactation, anaesthetic, paediatric and radiology services. We monitor volumes in this area to determine access and responsiveness of services.

- **Specialist Assessment, Treatment and Rehabilitation Services** are services provided to people who experience disability or age-related disorders to restore people's functional ability and enable them to live as independently as possible. Services are delivered in specialist inpatient units, outpatient clinics and also in home and work environments. Specialist geriatric and allied health expertise and advice is also provided to general practitioners, home and community care providers, residential care facilities and voluntary groups. An increase in the rate of people discharged home with support, rather than to residential care or hospital environment (where appropriate) will be indicative of success and of the responsiveness of services.

OUTPUTS AND PERFORMANCE MEASURES 2011/12

*Items referred to as 'Partially Achieved' reflect the ratings given by the Ministry of Health or are within 10% of the target.

**A 'Not Achieved' rating is where actual performance did not meet the Ministry's definition or there is a substantial difference from the target.

OUTPUT CLASS: INTENSIVE ASSESSMENT AND TREATMENT SERVICES

OUTPUT SUBSET: INPATIENT PLANNED AND UNPLANNED SERVICES INCLUDING MENTAL HEALTH

WE WILL UNDERTAKE THESE INITIATIVES/ ACTIVITIES	AND DELIVER THESE OUTPUTS	OUTPUTS MEASURED BY	2011/12 ACHIEVED	IMPACTS MEASURED BY	2011/12 ACHIEVED	COMMENTS ON 2011/12 PERFORMANCE
Elective Services (inpatient, outpatient)	Provision of 24 hour inpatient and outpatient elective services (treatment after seven days) for surgical, paediatric, and oral health. People are assessed by a specialist following referral from their GP. People receive an elective intervention through admission and discharge on the day of the intervention. People requiring radiotherapy receive it within agreed National Target waiting times.	**Quantity** Number of elective (planned) caseweighted discharges (CWD) and number of people discharged: Baseline 2010/11 Forecast: 2011/12 CWDs 8564: >8,430 People discharged 6898: >6,930 Number of first specialist assessments (FSAs) delivered: Baseline 2010/11 Forecast: 2011/12 13,320: >12,695 Day-surgery as a % of all surgery: Baseline 2010/11 Forecast: 2011/12 60.5%: 60.5% **Quality** Day Surgery as a percentage of all elective surgery. No within Cancer treatment waiting times within target limits. Elective Services Patient flow indicators are met (ESPIs demonstrate that the DHB is managing patients in accordance with the three principles (clarity, timeliness and fairness), matching our commitments to capacity, and meeting the six month timeframe for provision of assessment and treatment).	***Partially Achieved**** **Quantity** Number of elective (planned) caseweighted discharges (CWD) and number of people discharged: Baseline 2010/11 Forecast: 2011/12 CWDs 8564: 7720 People discharged 6898: 6209 ***Achieved*** Number of first specialist assessments (FSAs) delivered: 15,813 ***Achieved*** Day-surgery as a % of all surgery: 86.6%	No within cancer treatment waiting times target: Baseline2010/11 Forecast: 2011/12 Within MoH target of four weeks: Within MoH target of four weeks ESPI overall flow indicators are met: Baseline 2010/11 Forecast: 2011/12 100%: 100%	**Achieved** All patients were treated within the cancer treatment waiting times target ***Achieved*** ESPI overall flow indicators are met: 100%	No patients waited outside of the four week period for chemotherapy apart from for a clinically valid reason, i.e. still recovering post surgery or delayed by the patient.

<table>
<tr><th>WE WILL UNDERTAKE THESE INITIATIVES/ ACTIVITIES</th><th>AND DELIVER THESE OUTPUTS</th><th>OUTPUTS MEASURED BY</th><th>2011/12 ACHIEVED</th><th>IMPACTS MEASURED BY</th><th>2011/12 ACHIEVED</th><th>COMMENTS ON 2011/12 PERFORMANCE</th></tr>
<tr>
<td>Acute Services (emergency department, inpatient, outpatient) continued</td>
<td>Provision of district wide medical services including assessment, diagnosis, treatment, management of medical conditions.
This includes provision of emergency services and intensive/ cardiac care supporting all other service streams, and the provision of diagnostic testing functions supporting all service streams.
People have efficient and effective care of their acute problem as measured through the ‘average length of stay’</td>
<td>Quality
% of people readmitted:<table><tr><td>Baseline 2010/11 Forecast</td><td>2011/12</td></tr><tr><td>< 3%</td><td>< 3%</td></tr></table>Average length of stay:<table><tr><td>Baseline 2010/11 Forecast</td><td>2011/12</td></tr><tr><td><4 days</td><td><4 days</td></tr></table></td>
<td>Not Achieved**
Standardised acute readmission: Percentage of people readmitted: 9.06%

Achieved
Average length of stay: 3.29 days</td>
<td>Percentage of total acute admissions that were treated as day stay cases. This indicator shows the proportion of all acute discharges which are the same day. Decrease in the % could indicate fewer inappropriate admissions.<table><tr><td>Baseline 2010/11 forecast</td><td>2011/12</td></tr><tr><td>25.7%</td><td>25%</td></tr></table></td>
<td>Not Achieved**
Percentage of total acute admissions that were treated as day stay cases: 30.9%</td>
<td>Source: Readmissions measured using Readmit Indicator recorded in Oracare</td>
</tr>
</table>

<table>
<tr><th>WE WILL UNDERTAKE THESE INITIATIVES/ ACTIVITIES</th><th>AND DELIVER THESE OUTPUTS</th><th>OUTPUTS MEASURED BY</th><th>2011/12 ACHIEVED</th><th>IMPACTS MEASURED BY</th><th>2011/12 ACHIEVED</th><th>COMMENTS ON 2011/12 PERFORMANCE</th></tr>
<tr>
<td>Timely access to acute care and appropriate timely discharge.
Improve Emergency Department capacity and services.
Timely transfer to appropriate services from Emergency Department service.
Ensure good access to support services in the community or primary care level to support patient recovery following an acute event.
Improve care pathways to ensure people receive the right treatment in the right place.
Ensure timely access to diagnostic services.</td>
<td>Acute services:
Provision of district wide medical services including assessment, diagnosis, treatment, management of medical conditions. This includes provision of emergency services and intensive/cardiac care supporting all other service streams, and the provision of diagnostic testing functions supporting all service streams.
People have efficient and effective care of their acute problem as measured through the ‘average length of stay’.</td>
<td>Quantity
Avoidable hospital admissions.

Quality
Reduced quality length of stay per acute patient.

Reduced numbers of people readmitted to hospital following acute admission.

Fewer people dying within 30 days of hospital admission.

A high level of patient satisfaction
Achievement of Ministry of Health Monitoring Framework Performance

Measures
Implementation of recommendations on NMDHB Serious and Sentinel

Events
Reduction in patient complaints
Overall Patient satisfaction on survey (NZ Patient Satisfaction Index, Health Services Consumer Research):
Proportion of patients whose satisfaction survey rating was good or very good:

<table>
<tr><td>2008/09 Baseline</td><td>2009/10</td><td>2011/12 Target</td></tr>
<tr><td>76%
DHB Average 68%</td><td>76%
DHB Average 68%</td><td>>70%</td></tr>
</table>
NMDHB will be a leading DHB for overall patient satisfaction:
<table>
<tr><td>2008/09 Baseline</td><td>2009/10</td><td>2011/12 Target</td></tr>
<tr><td>Ranked as the top DHB in 2008/09</td><td>Ranked as the first equal DHB in 2009/10</td><td>In the top 3 of DHBs for patient satisfaction</td></tr>
</table>
Timeliness
Reduced waiting times for patients discharged or transferred from the ED.</td>
<td>Quantity
Refer next column
Quality: Patient Satisfaction

Not Assessed
Proportion of patients whose satisfaction survey rating was good or very good: The Patient Satisfaction Survey conducted by the Ministry of Health ceased in the first quarter of 2011/12. NMDHB was the top ranked DHB for patient satisfaction when the final survey was conducted in December 2010

Achieved
Refer to next column</td>
<td>Ambulatory hospital admissions:
<table>
<tr><td>Age</td><td>Baseline Result 2010/11 Quarter 2</td><td>2011/12 Target</td></tr>
<tr><td>Maori 0-74</td><td>76</td><td><95</td></tr>
<tr><td>Other 0-74</td><td>93</td><td><95</td></tr>
<tr><td>Maori 0-4</td><td>92</td><td><95</td></tr>
<tr><td>Other 0-4</td><td>112</td><td><105</td></tr>
<tr><td>Maori 45-64</td><td>56</td><td><95</td></tr>
<tr><td>Other 45-64</td><td>80</td><td><95</td></tr>
</table>
Average length of stay for acute inpatients:
<table>
<tr><td>Baseline 2010/11 Forecast</td><td>2011/12</td></tr>
<tr><td>3.7 Days</td><td>3.44 Days</td></tr>
</table>
% of admitted patients discharged or transferred from the Emergency Department within six hours:
<table>
<tr><td>Baseline 2010/11 Forecast</td><td>2011/12</td></tr>
<tr><td>>95%</td><td>>95%</td></tr>
</table>
Reduced standardised readmission rate:
<table>
<tr><td>Baseline 2010/11 Forecast</td><td>2011/12</td></tr>
<tr><td><3%</td><td><3%</td></tr>
</table>
Reduction in 30-day-mortality rates:
<table>
<tr><td>Baseline 2010/11 Forecast</td><td>2011/12</td></tr>
<tr><td>8</td><td>6</td></tr>
</table></td>
<td>Achieved except Maori 0-4
Ambulatory hospital admissions:
<table>
<tr><td>Age</td><td>Baseline Result 2010/11 Quarter 2</td><td>2011/12 Result</td></tr>
<tr><td>Maori 0-74</td><td>76</td><td>78.1</td></tr>
<tr><td>Other 0-74</td><td>93</td><td>82.4</td></tr>
<tr><td>Maori 0-4</td><td>92</td><td>107.2</td></tr>
<tr><td>Other 0-4</td><td>112</td><td>94.6</td></tr>
<tr><td>Maori 45-64</td><td>56</td><td>63.5</td></tr>
<tr><td>Other 45-64</td><td>80</td><td>73.2</td></tr>
</table>
Achieved
Average length of stay for acute inpatients: 3.29 days
Achieved
97.4%
Percentage of patients admitted, discharged or transferred from the Emergency Department within six hours

Not Achieved**
Standardised acute readmission:
Percentage of people readmitted:
9.06%

Not Achieved**
NMDHB standardised mortality rate for 2011/12 increased from 279 deaths in 2010/11 to 300 in 2011/12 instead of achieving a reduction in mortality rates</td>
<td>Source: ASH figures are from MoH NMDHB Ash Report for year ending 31 March 2012

NMDHB is ranked 9th out of the 20 DHBs for standardised mortality in 2011/12</td>
</tr>
</table>

<table>
<tr><th>WE WILL UNDERTAKE THESE INITIATIVES/ ACTIVITIES</th><th>AND DELIVER THESE OUTPUTS</th><th>OUTPUTS MEASURED BY</th><th>2011/12 ACHIEVED</th><th>IMPACTS MEASURED BY</th><th>2011/12 ACHIEVED</th><th>COMMENTS ON 2011/12 PERFORMANCE</th></tr>
<tr>
<td>Acute Specialist Mental Health Inpatient Services</td>
<td>Development of Acute Inpatient Beds for Psychiatry of Old Age (Psycho-geriatric) as part of mental health and addiction services. This will include care pathways in association with NASC/ HOP clinical services.
Participation in the KPI Framework for Mental Health and Addiction Services inclusive of the sub domain ‘Inpatient Care’.</td>
<td>Quantity
Agreed reconfiguration of accommodate inpatient beds.

Quality
Agreed care pathways between for HOP and Mental Health, Addiction Services and other mental health supports.

Average length of acute inpatient stay.
Preadmission community care.</td>
<td>Partially Achieved*
Psychogeriatric Facilities Business Case has been completed with options being considered. Psychogeriatric Service moved under Mental Health Services Directorate on 1 July 2011 and is now part of the Mental Health Client Pathway.

Achieved
Quality
Pathways in place
Average length of acute inpatient stay is 10.5 days.
Preadmission community care: 60.2% (Final figure to come in Sept).</td>
<td>Patient Complaints
Number of complaints to NMDHB for the 12 months 1 July to 30 June:
<table>
<tr><td>2008/09 Baseline</td><td>2009/10</td><td>2011/12 Target</td></tr>
<tr><td>225</td><td>315</td><td>310</td></tr>
</table>
Complaints to NMDHB closed within 20 working days:
<table>
<tr><td>2008/09 Baseline</td><td>2009/10</td><td>2011/12 Target</td></tr>
<tr><td>84%</td><td>94%</td><td>100%</td></tr>
</table>
Health and Disability Commissioner complaints that results in a finding of breach of the Code of Rights
<table>
<tr><td>2008/09 Baseline</td><td>2009/10</td><td>2011/12 Target</td></tr>
<tr><td>0</td><td>1</td><td>0</td></tr>
</table>
Achievement of Ministry of Health Monitoring Framework Performance Measures*:
<table>
<tr><td>2008/09 Baseline</td><td>2009/10</td><td>2011/12 Target</td></tr>
<tr><td>76%</td><td>77%</td><td>>90%</td></tr>
</table>
*Achievement (outstanding, achieved, satisfactory ratings) for the 30 Monitoring Framework Performance Measures reported to the Ministry of Health in Appendix 2 including the:
16 measures for quality and output delivery for the Policy Priorities Dimension
6 measures for System Integration
8 measures for Ownership Dimension
100% of recommendations on NMDHB Serious and Sentinel Events 2009/10 are implemented within agreed timeframes
Average total length of adult acute mental health inpatient stay.
<table>
<tr><td>Baseline2009/10</td><td>2011/12</td></tr>
<tr><td>12</td><td>14</td></tr>
</table>
KPI Framework – Preadmission community care (percentage of people admitted who were seen within seven days prior to admission).
<table>
<tr><td>Baseline2009/10</td><td>2011/12</td></tr>
<tr><td>70%</td><td>75%</td></tr>
</table>
</td>
<td>Achieved
<table>
<tr><td>2011/12 Actual</td></tr>
<tr><td>286</td></tr>
</table>
Partially Achieved*
<table>
<tr><td>2011/12 Actual</td></tr>
<tr><td>95.5%</td></tr>
</table>
Achieved
<table>
<tr><td>2011/12 Actual
0</td></tr>
</table>
Not Achieved**
72%

Achieved
All recommendations were implemented within agreed timeframes

Achieved
<table>
<tr><td>2011/12 actual</td></tr>
<tr><td>10.5 days</td></tr>
</table>
Not Achieved**
Actual: 60.2% (partially achieved). This is based on data to 30 March 2012.</td>
<td>The trend of fewer patient complaints has continued in 2011/12 as NMDHB continues to place the highest priority on quality services and patient safety

The optimal length of stay for adult acute patients is 10-14 days

Full 2011/12 data will not be submitted and checked/cleaned for analysis until September 2012.</td>
</tr>
</table>

OUTPUT SUBSET: MATERNITY

WE WILL UNDERTAKE THESE INITIATIVES/ ACTIVITIES	DELIVER THESE OUTPUTS	OUTPUTS MEASURED BY	2011/12 ACHIEVED	IMPACTS MEASURED BY	2011/12 ACHIEVED	COMMENTS ON 2011/12 PERFORMANCE
Timely access to and appropriate timely discharge from maternity services (includes DHB non-specialist antenatal consults, post-natal stays in a primary maternity facility, specialist neo-natal services, labour and delivery services, first obstetric consults, subsequent obstetric consults, maternity inpatient DRGs, maternity outpatients first specialist appointments, maternity outpatient follow-up services, amniocentesis, foetal medicine/anomalies clinics).	Maternity services involve pre-natal and post-natal and birthing services as well as specialist obstetric care and neonatal special care bay unit services. Women receive evidence-based access to caesarean section births.	**Quantity** Number of deliveries in NMDHB funded facilities = 1500 approx Number of first obstetric consults = 830 Number of subsequent obstetric consults = 728 **Quality** Reduced caesarean section rate: Baseline2006-10: 28% / 2011/12: <28% Established breastfeeding at discharge. **Timeliness** Post natal average LOS: Baseline2010/11: 3.0 days / 2011/12: 3.0 days	**Quantity** These services are demand driven. Deliveries in NMDHB funded facilities: 1,458 Number of first obstetric consults: 705 Number of subsequent obstetric consults: 667 Not Achieved** **Quality** Reduced caesarean section rate: 29.8% ***Achieved*** Mothers who have established breastfeeding at discharge range from 70-99%. ***Partially Achieved*** Wairau Not Achieved Nelson **Timeliness** Post natal average Length of Stay: 2.07 days Nelson, Wairau: 2.76 days	Neonatal inpatients DRGs : Baseline2009/10: 388 / 2011/12: 416 Nationally, reduced infant mortality. Nationally, reduced maternal mortality. Impact effects: The infant mortality rate has shown a downward trend from 1942 to 2004 and then stabilised between 2005-2008. There are significant and relatively stable differences in infant mortality rates between Maori and Other (non Maori, non Pacific) from 1996 to 2008. In 2008 the Pacific fetal mortality rate is slightly higher than Maori and Other rates. This trend is generally consistent with previous years. Congenital abnormalities caused the highest number of infant deaths in 2008.[4]	***Achieved*** Neonatal inpatients Diagnosis Related Groups (DRGs) : 412 National maternal mortality reduced from 6 per 100,000 in 2006 to 1 in 2010 (Perinatal and Mortality Review committee, 2010)	We had slightly fewer than expected acute neonatal babies who needed treatment which is a positive result

OUTPUT SUBSET: ASSESSMENT TREATMENT AND REHABILITATION

WE WILL UNDERTAKE THESE INITIATIVES/ACTIVITIES	AND DELIVER THESE OUTPUTS	OUTPUTS MEASURED BY	2011/12 ACHIEVED	IMPACTS MEASURED BY	2011/12 ACHIEVED	COMMENTS ON 2011/12 PERFORMANCE
Establish Comprehensive Specialist Health Service for Older People team (SHSOP) which consists of health professionals with Geriatric and Psycho Geriatric expertise. The SHSOP service has inpatient and community teams. The SHSOP team use documented links and pathways with Acute Mental Health, Acute Medical and Surgical Services and community providers who have an older persons' client base.	Expertise to support providers across the continuum of services. Home visits. Community based/marae based clinics. Rapid response. Consultation/ Liaison. Case management for high needs co-morbidity. Rehabilitation episodes in the community. Documented dementia pathway which includes SHSOP, NASC, PHO Support Services, Hospital and community providers.	**Quantity** Maintaining Bed Days Inpatient Services: Baseline 2009/10: 8,982 / 2011/12: 8,982 Attendances/Visits: Baseline 2009/10: 10,455 / 2011/12: 10,455	***Not Achieved*** Quantity 2011/12: 7,457 days ***Not Achieved***** 6,725 The variance is due to an overestimation of the target (should have been 7,942).	Number of community events that have community rehabilitation directed/delivered by SHSOP ATR Baseline 2009/10: 2,064 / 2011/12: 2,064 Number of individuals who have community rehabilitation directed/ delivered by SHSOP MH-ATR Baseline 2009/10: 317 / 20101/12: 317	***Achieved*** 3,473 community events ***Partially Achieved**** 241 individuals	

INTENSIVE ASSESSMENT AND TREATMENT SERVICES OUTPUT CLASS STATEMENT OF FINANCIAL PERFORMANCE

000s	2011/12 Actual	2011/12 Plan	2011/12 Variance
Revenue	204,257	201,010	3,247
Expenditure			
Personnel costs	105,005	102,704	(2,301)
Outsourced services	8,153	6,569	(1,583)
Clinical Supplies	29,593	26,066	(3,527)
Infrastructure	29,438	28,984	(454)
Provider payments	36,796	36,526	(270)
Total Expenditure	**208,984**	**200,848**	**(8,136)**
Net Surplus/(Loss)	**(4,727)**	**163**	**(4,890)**

REHABILITATION AND SUPPORT SERVICES

Output Class 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.

WHY IS THIS OUTPUT CLASS SIGNIFICANT FOR NMDHB?

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 the DHB 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.

DESCRIPTION OF THE SUB-SETS OF SERVICES THAT MAKE UP THIS OUTPUT CLASS

- **Palliative Care Services** are services that improve the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early intervention, assessment, treatment of pain and other supports. The number of sites that support the "Liverpool Care of the Dying" pathway are expected to increase as this reflects best-practice care.
- **Support Services:**
  - ***Needs Assessment and Services Coordination Services*** are services that determine a person's eligibility and need for publicly funded support services and then assist the person to determine the best mix of supports based on their strengths, resources and goals. The supports are delivered by an integrated team in the person's own home or community. The number of assessments completed is indicative of access and responsiveness.

» ***Age Residential Care*** are services provided to meet the needs of a person who has been assessed as requiring long-term residential care in a hospital or rest home indefinitely. With an ageing population, a decrease in the number of subsidised bed days alongside an increase in the number of home-based support service hours is seen as indicative of more people being successfully supported to continue living at home.

» ***Respite, Carer Support and Day Programmes*** are services providing people with a break from a routine or regimented programme so that crisis can be averted or so that a specific health needs can be addressed. Services are provided by specialised organisations and are usually short-term or temporary in nature and may also include support and respite for families, caregivers and others affected. Services are expected to increase over time, as more people are supported to remain in their own homes.

» ***Home-Based Support Services*** are services designed to support people to continue living in their own homes and to restore functional independence. They may be short or longer-term in nature. Examples include domestic support, personal care and community nursing services. An increase in the number of people being supported is indicative of increased capacity in the system, and success is measured against a decreased or delayed entry into residential or hospital services.

» ***Community Support Services – Mental Health*** are services that support tangata whaiora/ service users' recovery journey. This includes a wide range of services such as Home Based Support, Residential Housing, Planned and Crisis Respite, Day Activity and Living Skills, Peer Support, Vocational Support and Community Support Work to tangata whaiora/ service users living in the community.

» ***Community Support Services – Intellectual Disability Support Services and Physical Disability Support Services*** are services that provide residential support in community home settings for people with intellectual and physical disability needs. This support is provided on a 24-hour-basis to support the person to maintain as ordinary life as possible to achieve their goals.

OUTPUTS AND PERFORMANCE MEASURES 2011/12

*Items referred to as 'Partially Achieved' reflect the ratings given by the Ministry of Health or are within 10% of the target.

**A 'Not Achieved' rating is where actual performance did not meet the Ministry's definition or there is a substantial difference from the target.

OUTPUT CLASS: REHABILITATION AND SUPPORT SERVICES

OUTPUT SUBSET: PALLIATIVE SERVICES

WE WILL UNDERTAKE THESE INITIATIVES/ ACTIVITIES	AND DELIVER THESE OUTPUTS	OUTPUTS MEASURED BY	2011/12 ACHIEVED	IMPACTS MEASURED BY	2011/12 ACHIEVED	COMMENTS ON 2011/12 PERFORMANCE
Ensure people have timely access to quality, culturally appropriate palliative care services. Co-ordinate care across hospital, community and support services. Implement the 'Liverpool Pathway' for palliative care services. Deliver a responsive system that supports person's choice to die at home	Specialist palliative inpatient care Nelson and Wairau. Specialist care for palliative care patients living in the community. Specialist palliative care advice& support for generalist palliative care providers caring for patients living in the community. Community based specialist palliative care teams across the district	**Quantity:** Total number of hospice palliative care patients Baseline 2009/10: 451; 2011/12: 461 Average quarterly total of palliative care patient consultations: Baseline 2009/10: 480; 2011/12: 490 **Quality:** % of provider settings delivering a Liverpool care pathway model of care Baseline 2009/10: 70%; 2011/12: 75%	***Achieved*** Nelson:326 Wairau: 226 ***Achieved*** Nelson: 399 Wairau: 198 ***Achieved*** 79%	The hospices will conduct patient and their whanau service satisfaction surveys	Achieved	Patient and their whanau service satisfaction surveys are conducted least once annually also as part of accreditation requirements

OUTPUT SUBSET: NEEDS ASSESSMENT & SUPPORT SERVICES – NASC, AGE RESIDENTIAL CARE, RESPITE, CARER SUPPORT, DAY PROGRAMMES & HOME BASED SUPPORT, INTELLECTUAL DISABILITY SUPPORT SERVICES

WE WILL UNDERTAKE THESE INITIATIVES/ ACTIVITIES	AND DELIVER THESE OUTPUTS	OUTPUTS MEASURED BY	2011/12 ACHIEVED	IMPACTS MEASURED BY	2011/12 ACHIEVED	COMMENTS ON 2011/12 PERFORMANCE
InterRAI will be used to ensure people who have a need receive appropriate support services. Use regionally agreed service specifications for HBSS. Use regionally agreed eligibility criteria and standardised approach to access. To increase the availability of respite and day programme options for Older People and their family/carers.	Comprehensive assessment to identify need. Restorative focused, goal based support services. Equitable access to services. A range of options for packages of support that will reduce carer stress. Continue to support older people to remain in their home environment.	**Quantity** Total number of InterRAI first assessment Baseline Jan-Dec2010: 620 / 2011/12: 640 Total number of InterRAI reassessments BaselineJan-Dec20101: 1,304 / 2011/12: 1,347 Includes CC & Residential with paper tool Total number of service co-ordination events Baseline 2009/10: 8,883 / 2011/12: 9,050 Total number of needs re-/assessments for Life-long Disability clients: Baseline Jan-Dec20101: 1,750 / 2011/12: 1,800 Total number of service coordination for Life-long Disability clients: Baseline Jan-Dec20101: 1,669 / 2011/12: 1,680 Total number of Respite care bed days: Baseline 2009/10: 2,796 / 2011/12: 3268 Carer Support Days Baseline 2009/10: 4716 / 2011/12: 5930 Day Programme days: Baseline 2009/10: 11830 / 2011/12: 13242 In home respite support: Baseline 2009/10: Nil service / 2011/12: 590 days Total number of funded ARC bed nights: Note: 4.5% increase in utilisation for population growth, exclusive of transfers from Canterbury due to the earthquake Baseline 2009/10: 346,718 / 2011/12: 362,190 Total number of IDSS clients: Baseline 2009/10: 210 / 2011/12: 210 Quality Client satisfaction on survey: high level of satisfaction with NASC service (measured by a client satisfaction rating above 95%) Baseline Jan-Dec 2010: 96% / 2011/12: 97% **Timeliness** NASC response time to assessment: Baseline Jan-Dec 2010: 87% within 20 days / 2011/12: 90% within 20 days	***Achieved*** 685 actual ***Achieved*** 1,795 actual ***Achieved*** 9,650 ***Not Achieved*** 765 MOH client management system does not capture information as previously. Reassessment for this group is every three years ***Achieved*** 1,786 service coordination activity has increased ***Achieved*** 4,674 days allocated ***Partially Achieved*** 5,612 carer support days allocated ***Achieved*** 18,544 day programme days allocated this is reflective of consumer and family needs to support a person at home Not Achieved** Service contract in place provider is still establishing the service ***Achieved*** 372,622 bed nights ***Achieved*** 228 Includes MOH and LTS-CHC clients ***Partially Achieved**** 96% ***Achieved*** 91.15%	The % of older people living in ARC: Baseline 2009/10: 7.4% / 2011/12: 7.0% The number of rest home new admissions: Baseline 2009/10: 192 / 2011/12: 192 Total number of clients receiving home based support: Baseline Jan-Dec 2010: 3,2221 / 2011/12: 3,322 1-Excludes short term & Meals on Wheels. Does include Continuing Care Total number of clients receiving home based support with high & complex needs Baseline Jan-Dec 2010: 425 / 2011/12: 445 Total number of clients receiving home based support with very high & complex needs: Baseline Jan-Dec 2010: 76 / 2011/12: 80	***Achieved*** 5.01% 329 Admissions: ***Not Achieved**** 2,572 349 Based on InterRAI assessment. 32 based on outcome of InterRAI Assessment	In 2011/12 there were 1219 people living in residential care compared to a population of people over 65 years of 23,987 This number is for fully subsidised and non subsidised residents it will also include residents in licensed to occupy units and some CHCH residents who moved post the earthquake as they had no accommodation options left in CHCH and entered residential care here. The 2009/2010 number included subsidised residents only. Target was developed as a predictive of clients receiving home based services and other services e.g. respite or carer support. Reflects more clients entering and exiting services based on restorative model. This number has decreased as more clients are being maintained in the moderate complex category. This a demand driven target.

OUTPUT SUBSET: COMMUNITY SUPPORT SERVICES – MENTAL HEALTH

<table>
<tr><th>WE WILL UNDERTAKE THESE INITIATIVES/ ACTIVITIES</th><th>AND DELIVER THESE OUTPUTS</th><th>OUTPUTS MEASURED BY</th><th>2011/12 ACHIEVED</th><th>IMPACTS MEASURED BY</th><th>2011/12 ACHIEVED</th><th>COMMENTS ON 2011/12 PERFORMANCE</th></tr>
<tr>
<td>Directorate Funding Performance and Reporting Review.</td>
<td>Consolidation of the NGO Sector, in preparation for the 2012/2013 financial year.

Standardising of referral, assessment and recovery plan processes, linked into agreed client pathways across specialist mental health services.

Review Models of Care inclusive of DHB Owned and NGO Sector (flow on approach).

Continuation of existing Community Support Services across the age continuum, including Child and Youth Mental Health Services, Kaupapa Maori Mental Health Services, Adult Services and Specialist Older Persons Mental Health Services.</td>
<td>Quantity
Number of service users in the NGO sector (by NGO service and unique total across all NGOs).
<table><tr><td>Baseline 2009/10</td><td>2011/12</td></tr><tr><td>505</td><td>510</td></tr></table>NMDHB agreed pathway of NGO consolidation sector by 31 December 2011.

Existing NGO service agreements extended to the 30 June 2012. NGO/DHB Owned Service total expenditure percentages remain the same as 2010/2011.

Quality
Robust, fair and equitable Request for Proposal processes for NGO consolidation aligned to Treasury Guidelines and NMDHB policies.
Models of Care and Client Pathways agreed at Mental Health Service Directorate level for implementation across the sector (note Specialist and Primary Care clinical input) for full implementation 2012/13.
Strengthen the service user experiences across mental health services.</td>
<td>Achieved
Quantity
An average of 910 clients were seen by NGO service providers in 2011/12

Not Achieved**
Pathway of NGO consolidation is still progressing
Partially Achieved*
Service agreements are in the process of being extended.

Achieved
NGO/Specialist total expenditure percentages remained the same in 2011/12

Achieved
Quality
The Maori hub process has been conducted within these guidelines and policies

Achieved
Standard referral, assessment and recovery plan in place in Specialist Services.
Process underway to develop standardised Specialist to NGO referral process.
Single Point of Entry (SPOE) process underway with input from PHO.

Achieved
84.1% overall satisfaction (National Mental Health Consumer Satisfaction Survey) above target (82%).</td>
<td>Accessing specialist mental health and addiction services early prevents deterioration in mental health.

Access rates to mental health services at NHI level:
<table><tr><td rowspan="3">Age 0-19</td><td>Maori</td><td>3.2%</td></tr><tr><td>Other</td><td>3.6%</td></tr><tr><td>Total</td><td>3.53%</td></tr><tr><td rowspan="3">Age 0-64</td><td>Maori</td><td>6.36%</td></tr><tr><td>Other</td><td>3.89%</td></tr><tr><td>Total</td><td>3.93%</td></tr><tr><td>Age 65</td><td>Total</td><td>0.73%</td></tr></table>Increase in improvement in National Consumer Satisfaction Survey measured by National Mental Health Key Performance Indicator 16 NGO Services investment.

<table><tr><td>Baseline 2009/10</td><td>2011/12</td></tr><tr><td>Overall consumer satisfaction: 80%</td><td>Overall consumer satisfaction: 82%</td></tr></table>NMDHB will benchmark its performance with DHBs nationally. The KPI indicator measures the total spending by NMDHB on NGO mental health and addiction services as a percentage of overall total spending on mental health services</td>
<td>Achieved
<table><tr><td>Actual</td></tr><tr><td>4.21% ▲</td></tr><tr><td>4.32% ▲</td></tr><tr><td>4.3% ▲</td></tr><tr><td>7.71% ▲</td></tr><tr><td>4.36% ▲</td></tr><tr><td>4.64% ▲</td></tr><tr><td>0.95% ▲</td></tr></table>Achieved
<table><tr><td>2011/12</td></tr><tr><td>84.1% ▲</td></tr></table>Benchmarking not yet completed for 2011/12 year. NMDHB continues to participate in this process.</td>
<td>Directorate Reference Group established and functioning well. This process has helped identify and address service gaps and capacity to assist across providers.

Standard referral, assessment and recovery plan in place in Specialist Services. Process underway to develop standardised Specialist to NGO referral process.

Single Point of Entry (SPOE) process underway with input from PHO.

NGO/Specialist total expenditure percentages remained the same in 2011/12</td>
</tr>
</table>

SUPPORT SERVICES OUTPUT CLASS STATEMENT OF FINANCIAL PERFORMANCE

000s	2011/12 Actual	2011/12 Plan	2011/12 Variance
Revenue	85,035	82,981	2,055
Expenditure			
Personnel costs	20,873	20,518	(355)
Outsourced services	1,305	1,303	(2)
Clinical Supplies	2,956	3,013	57
Infrastructure	6,376	6,772	396
Provider payments	55,664	53,230	(2,434)
Total Expenditure	**87,174**	**84,836**	**(2,338)**
Net Surplus/(Loss)	**(2,139)**	**(1,855)**	**(284)**

(Footnotes)

1. Cervical Cancer (Ministry of Health. 2010. Cancer Projections: Incidence 2004–08 to 2014–18. Wellington: Ministry of Health.)
2. 934 is the target as per SOI but this is an error and should have been 950
3. ESPIs demonstrate that the DHB is managing patients in accordance with the three principles (clarity, timeliness and fairness), matching our commitments to capacity, and meeting the six month timeframe for provision of assessment and treatment.
4. http://www.health.govt.nz/publication/fetal-and-infant-mortality-2006-2007-and-2008.

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Westpac Banking Corporation

Auditors
Audit New Zealand on behalf of the Auditor-General

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

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