2012/13



Nelson Marlborough District Health Board Annual Report

TE WAI ORA
Nelson Marlborough District Health Board


NMDHB VALUES


Leading Towards Health Conscious Families

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 CHIEF EXECUTIVE

It is with pleasure that we present the annual report for 2012/13. The report consists of two parts; the year in review and the statements of service performance and financial accounts.

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

In reviewing the 2012/13 year we have continued 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. During the year the Board and the Iwi Health Board put in place a 30 year vision in the Maori Health Outcomes Framework for our district. This Framework focuses on self management and a redesigned service delivery model.

REGIONAL COLLABORATION

We continue to participate in the South Island Alliance activities to achieve the vision of a clinically and fiscally sustainable health system focused on keeping people well and providing equitable, and timely, access to safe, effective, high-quality services as close to people's homes as possible for the South Island.

During the 2012-13 year the South Island Alliance continued to develop it's relationships and activities within the 'best for patients, best for system' framework. The South Island Alliance Leadership Team recognises it needs to continue to build on the achievements to date and to negotiate a way into the future. The Alliance framework is creating an environment where it's easier for changes to be made to the way we have traditionally interacted and delivered services. The Alliance's ability to achieve through this approach is demonstrated by the outcomes achieved to date.

COLLABORATION WITH PRIMARY HEALTH

We commenced a process to refocus and reshape the existing Nelson Marlborough Health Alliance towards a Virtual Primary Health Environment. This will see the Primary and Community Services that we as a District Health Board operate, and other Primary and Community Services that we fund through the Primary Health Organisations become a single virtual environment, focussing on streamling services as opposed to organisational structures and boundaries. This approach is consistent with the Ministry of Health expectations in terms of service development and direction particularly pertaining to primary care development and integration.
The work involves the two Chief Executives of the Primary Health Organisations, the Service Director of Community Based Services, and the General Manager Strategy & Planning.

FUTURE PLANNING

In January 2013 a discussion was commenced with staff regarding the services currently provided at Wairau Hospital.

The discussion document arose out of concerns being raised by clinical staff both in Wairau and Nelson around the quality and safety of services in Wairau. Concerns were also being brought to the Board table by Board members, including representatives from Wairau.

The review was being driven by quality and safety issues and clinical sustainability which were unlikely to be addressed by simply adding more resources to strengthen the viability of Wairau Hospital. Such an approach was not feasible without reducing costs elsewhere within the Nelson Marlborough health system, or attracting alternative income sources.

The Board has made:

- A commitment to the provision of 24/7 acute, and elective services in both Nelson and Wairau Hospitals
- An agreement to involve the wider community in the process to consider the future, address the issues and develop solutions, that are sustainable from both a clinical and financial perspective

Solutions proposed must meet three hurdles:

- High quality safe service provision
- Clinically and financially sustainable
- Community acceptance

The integration of services across the Top of the South needs to generate a true service culture that recognises the principle of collective responsibility for service delivery which will attract future workforce.

We see that addressing quality and safety concerns for the "Top of the South" Services will through the principle of one service two sites that optimises care for all patients in the district. The pathway will however be challenging and will take a considerable period of time to implement. The key component however is having a clear direction and holding each other to account to ensure that we progress along the pathway.

REVIEW OF OPERATIONS

Given the position the Board found itself in late 2012 the outturn for the 2012/13 financial year is ahead of the forecast we committed to as part of the Intensive Monitoring Review process with the NHB. The year concluded with a loss of $2.930 million (0.7% of revenue) against a budgeted surplus of $55,000.

We met the Elective Surgical Performance Indicator targets of having no patients waiting for either a First Specialist Assessment Appointment, or for Surgery for longer than 5 months. The challenge will now be to head towards the 4 month target by the end of 2014.
During the year we met all expectations in respect to elective surgery with 6,054 procedures being completed. Achieving the 5 month waiting target has resulted in us receiving an incentive payment from the Ministry of Health.

The National Health Board continues to meet with the Board subcommittee and the Chief Executive on a monthly basis. The feedback from the NHB was that they were comfortable with the progress that NMDHB had made. Controls that have been put in place have been effective to see the fiscal deterioration reversed, however it will be essential that once on a sound footing these controls are able to be released as they are having some adverse impacts on the morale of the workforce which should not be continued over any extended period of time.

The Golden Bay IFHC development continues to proceed. Challenges remain, however the DHB, PHO, and Property Trust are working through all of the issues. Some expectations in terms of the community need to be managed.

QUALITY

A separate Quality Report is being issued that sets out a summary of the quality indicators used to reflect service provision across NMDHB. This follows the introduction of a regular quality and safety report to the Board commenced in May 2013 and is intended to maintain a balanced perspective of overall performance at the Organisational Governance level. The report includes a dashboard from which the Board can monitor progress on an ongoing basis and ensuring that the organisation responds in the event that performance issues emerge.

Using a 'drill down' capability, trends and issues can be investigated and reported on at various levels of the organisation. It is aligned with the Health Quality and Safety Commission (HQSC) set of national health quality and safety indicators.

During a certification visit the calibration and testing of clinical equipment was identified as an issue. Steps have been taken to check all equipment and to put in place a regular testing regime.

CAPITAL DEVELOPMENTS

The business case for the redevelopment of the Nelson Hospital site remains suspended while investigations continue on the remedial work to improve the compliance ratings for key buildings on both sites. We will also need to take a cautious approach as every $1 million spent on capital development requires an operational efficiency of at least $100k to be found. Many examples across the sector demonstrate business cases which promised much but delivered little in terms of operational efficiency. Those organisations then face challenging and painful decisions as they determine how to live within their means. This is a trap that NMDHB wishes to avoid.

A contract for the demolition of Dalton House on the Nelson Hospital campus has been let following an approval under the Resource Management Act. It is planned that in due course this site will be used to accommodate a learning centre, after hours facility and potentially other services, however innovative funding opportunities will need to be found..

With the completion of the new Churchill Trust building at Wairau Hospital the areas formally occupied by them and the Marlborough Orthopaedic Centre are now available. Discussions are underway on possible integration of Kimi Hauora Wairau into the Hospital campus.

A significant priority for the next year will be the redevelopment of facilities for Psychogeriatric patients currently housed at Alexandra Hospital in Richmond. These facilities are not fit for purpose and need significant attention.

OUTLOOK

The fiscal challenge will remain tough in 2013/14 and plans are in place which manage the financial challenges while minimising any affect on service delivery as far as possible.

We are taking all necessary steps to ensure that we optimise performance against the 2014/15 budget. We are forecasting a break even position, however this requires delivery of $6 to $8 million of initiatives. Every area of the Nelson Marlborough Health System has been asked to contribute towards these savings initiatives in order to return us back to a position where we will be able to invest in innovation moving forward.

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 would like to acknowledge the contributions to Maori health in Te Tau Ihu of Tahi Takao as a member of the Iwi Health Board and as Kaumatua to the Board.

During the 2012/13 John Peters advised the Board of his intention to retire in December 2012. John was Chief Executive from November 2004 and during his time there have been a number of milestones for the organisation. The Board wishes John and Lorell all the best for the future.

Staff need to be congratulated for how they have managed what has been a very challenging year. Planning for 2013/14 is now well in place. With the formal sign off of the Annual Plan we are progressing with all actions required to meet the plan.

Jenny Black
BOARD CHAIR

Chris Fleming
CHIEF EXECUTIVE

BOARD AND COMMITTEES

The Board meets monthly while the advisory committees meetings rotate over a three monthly cycle with individual committee meetings followed by a combined workshop. Since 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 is 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:

Community and Public Health Advisory Committee/Disability Support Advisory Committee (CPHAC/DiSAC)		**Hospital Advisory Committee (HAC)**	
Gerald Hope (Chair)	Judith Holmes	Judy Crowe (Chair)	Jane Anderson-Bay
John Moore (Deputy Chair)	Jennifer M Black	Russell Wilson	Dawn McConnell
Fleur Hansby	Jos Van der Pol	Roma Hippolite	
Gordon Currie	Mabel Grennell	Ian MacLennan	
Patrick Smith	Glenys MacLellan	John Inder	
Sonny Alesana	George Truman	Francis Gargiulo	

Note: as Chair of NMDHB Jenny Black is ex-officio of both Advisory Committees

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

2012/13 was a year for opportunity and change. The Iwi Health Board remains committed to working with the Nelson Marlborough District Health Board (NMDHB) to support the Treaty of Waitangi obligations set out in the NZ Public Health and Disability Act 2000.

NATIONAL MAORI HEALTH TARGETS

Achieved breast screening (50-69yr) target

Within 10% of target for ASH (45-64yr), cessation advice (hosp) and immunisation (8m)

Within 20% of target for PHO enrolment, ASH (0-4yr), ASH (0-74yr), full & exclusive breast feeding (6w), and influenza Immunisations

Greater than 20% or non-compliance to target for full & exclusive feeding (3m and 6m), CVRA rate, cervical screening (25-69yr) & cessation advice (primary care).

KEY MESSAGES

Strengthening Maori leadership

Greater focus on Maori health outcomes

Better positioning of Maori health to meet tomorrow's generation

The Iwi Health Board members derive from the eight Iwi who make up the Manawhenua O Te Tau Ihu and Maataa Waka: Ngati Apa, Rangitane, Ngati Koata, Ngati Kuia, Ngati Rarua, Ngati Tama, Ngati Toarangatira, Te Atiawa and Maataa Waka.

Changes in the Iwi Health Board included the retirement of Kaumatua Tahi Takao, a long serving member for Maataa Waka and resignation of long term chairperson Joe Puketapu to take up an opportunity with Ngati Rarua Iwi Trust. New members include Ngawai Webber representing Ngati Koata, Luke Katu for Ngati Toa Rangatira, Lee Luke for Ngati Rarua and Josephine Faragher who is the Ngati Kuia representative.

IHB have continued in it's proactive role of supporting the DHB with advice through representation on the DHB Board sub-committee meetings as well as the twice yearly Board to Board meetings. These provide an excellent opportunity for both boards to focus on key issues and agree a direction and approach in areas such as the Maori health provider coalition and the Maori health action plan.

During the year the development and formation of the Maori health provider coalition known as Te Taumata Hauora O Te Aroha continued. The group has been preparing a Whanau Ora framework for the top of the south island, exploring options and governance arrangements for a new entity and working with the community to establish a set of Maori health priorities that will form the basis for future services. This is a major change management programme with the aim of meeting the needs of future generations who access Maori health. A challenging process which is progressing towards delivering the benefits and achievements set out in our 30 year Maori health vision for Nelson Marlborough.

Maori health planning continues to be an important focus for IHB. The Maori health action plan for 2012/13 shows Nelson Marlborough DHB is placed at the mid-range of district health boards in achieving the national targets. For example, the DHB exceeded its breast screening target at 82% (national target 70%) and there were three targets within 10% of the national target. They include ASH (45 – 64yrs) at 2320 (National target 1661), Cessation advice (hospital) at 94% (National target 95%, and immunisation at 81% (national target 90%). Overall, there is room for improvement by NMDHB.

The IHB is concerned at the lack of ethnicity data collection nationally and supports better reporting of this data at a local level. Improving the collection of this information will continue to support the way the IHB and the DHB Board respond to the growing needs.

The IHB are committed to a strategy for improving Maori clinical workforce, and to growing the regulated and non-regulated workforce. They are keen to understand what the workforce looks like and the capacity issues that might arise to meet the changing needs of future generations. They continuously monitor progress towards the Maori health workforce action plan including the development of one-off scholarships and future strategic relationships with tertiary institutions like Nelson Marlborough Institute of Technology, Christchurch Polytechnic Institute of Technology, Careerforce NZ and other institutions.

During the year IHB started reviewing the work to form a South Island Iwi Health accord with all nine iwi. This will see a joint approach to Maori health planning and accountability covering all district health boards within Te Waipounamu. Discussion between IHB and Te Runanga O Ngai Tahu are planned to advance this further in 2013/14.

For 2013/14 the IHB wants to continue to strengthen Maori leadership in health, have greater focus on Maori health outcomes, and better position Maori health to meet tomorrow's generation. It will continue to closely monitor the DHB through the Maori health targets, review the 30 year Maori health & wellness strategic framework and further support and offer direction on Maori health to the Nelson Marlborough DHB board.

OUR COMMUNITY AND ITS HEALTH AND DISABILITY NEEDS

Since 1 July 2011Nelson and Tasman has 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 2012/13 year, and is expected to continue through the 2013/14 year. The population has predominantly increased in the over 45 year age group, resulting in increased demand.

NMDHB HAS	COMPARED TO THE REST OF NEW ZEALAND NMDHB HAS
» a population >141,465 (32.4% Marlborough, 33.3% Nelson, 34.3% Tasman)	» a high incidence of chronic lung disease, chronic pain and dementia, intellectual and physical disability
» a challenging terrain and distance frequently isolates our communities	» a high incidence of obesity in Maori men, but fewer people overall classified as overweight and obese
» a population density of six people per square kilometre	» high rates of breast and prostate cancer, and associated high death rates
» two secondary hospitals	» a high personal injury and accident rate
» two rural hospitals	» more people > 65; fastest growing > 85
» New Zealand's only DHB owned Intellectual Disability Support Service (IDSS)	» more births; fewer young adults (18-30)
» 2,176 staff (1,689 full time equivalents)	» one of the lowest 'amenable mortality'1[1] rates
» 126 GPs with 37 locums and 29 contracted dentists	» one of the longest 'life expectancy at birth' rates
» 29 dispensing pharmacies (including one in Nelson hospital and one in Wairau Hospital)	» one of the 'most active' populations in NZ
» 40 NGO providers	» access to good public health, community, general practice and secondary services.
» two PHOs	
» 28 aged residential care facilities	
» five home based support agencies.	

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 dollar so that services were delivered in better, sooner and more convenient ways to our communities.

The Nelson Marlborough District Health Board (NMDHB) under our Chief Executive and Board have every intention to fund, deliver and provide healthcare and support care services that address the ongoing health and support needs of the Nelson, Tasman and Marlborough populations within the funding provided by the taxpayer.[1]

In September 2012 the Board endorsed our overarching strategy for the 'Top of the South' known as HEALTH 2030[2]. This Annual Plan and Statement of Intent 2013/14 progresses the implementation of the HEALTH 2030 Strategy Action Plan. It lays out what we intend to do locally, regionally and nationally and how we expect our established partnerships both locally and regionally to work with us to support this work. It also demonstrates progress on our obligations under the Treaty of Waitangi.

In early 2013, NMDHB initiated a major review of 'Top of the South' services based on 'best for patient, best for system' with the key principle being 'one service two sites' particularly for hospital services. This aligns to our strategic direction as set out in HEALTH 2030, the Annual Plan 2013/14 (AP) signals the implementation of the agreed recommendations from this review to ensure high quality and safe services are consistently and sustainably accessed and delivered to patients according to need.

1 An overview of the Nelson Marlborough population can be found at: http://www.health.govt.nz/new-zealand-health-system/my-dhb/nelson-marlborough-dhb

2 The Board's HEALTH 2030 strategy is expected to be refined with both PHOs and the IHB during the 2013/14 year

To achieve the South Island regional goals for 2012/13, 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 2012/13 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).

THE YEAR IN REVIEW

NMDHB SIGNIFICANT SERVICE CHANGE INITIATIVES FOR 2012/13

NATIONAL PHARMACY SERVICES PATIENT-CENTRED MODEL OF CARE IMPLEMENTATION

This is a new model aligned to a national agreement between community pharmacies and DHBs to ensure that patients receive different levels of care dependent on their need. Under the new model, the funding for community pharmacies is aligned to the patient service, not just to the dispensed item. This service transition will be implemented over the next three years.

TRANSFORMATIONAL SERVICE CHANGE ACROSS DISTRICT SPECIALIST HEALTH SERVICES

NMDHB supports the need for transformational service change across district specialist health services. The clinically-led review of the services, the new clinically-designed service model and the consultation and implementation is being addressed. NMDHB anticipates that the outcome improves productivity, effectiveness and efficiency by delivering new service models with clinicians working across the district in an integrated system of care. This will involve reconfiguring service delivery to ensure that services are delivered within our means and will require new ways of doing things:

SERVICE CHANGE INITIATIVES	ACHIEVED
Active Care Approach • Improved Active Care of older people through case management • Introducing single point of contact with older people requiring support services • Implementing wrap-around services that address long-term conditions • Implementing a collaborative model of care across services for older people.	NMDHB has the fourth best readmission rate of any DHB, although it has increased slightly in the last year though there has been variability over 5 years. The DHB has had several projects aimed to improve readmission rates. The Community Care Coordination Centre (CCCC) has become operative and aims to ensure appropriate care in the community post-discharge and development of appropriate care plans. The CCCC is also involved in discharge letters, which provide a better summary to GPs and patients. IV therapies are provided in Nelson/Tasman by GPs. TPOT (Productive Operating Theatre) has a recovery aspect and the preadmissions project ensures patients are ready for surgery. Work on orthopaedic pathways is progressing and this specialty has been involved in the ERAS and preadmissions project. NMDHB currently has the lowest length of stay of any DHB in New Zealand. Projects that have contributed to this are the Enhanced Recovery After Surgery project which has shown reduced LoS for patients it has involved, TPOT (Productive Operating Theatre) which involves work on recovery and patient preparation), it is also linked with work involved in establishing the CCCC which ensures appropriate community care for discharged patients. Multiple other projects are also correlated with this success. ED attendances have decreased by over 1,500 from 2011/12 to - 2012/13. Some likely reasons for the decrease include providing IV therapies and pain services in the Community, the opening of the Medical and Injury Centre beside Nelson ED, Allied Health involvement in ED (which was undertaken in Nelson but a project brief is being developed for Wairua). An ongoing oversight group has been working on reducing ED volumes in Wairau and has increased community communication, introduced a voucher system and undertaking liaison with St Johns. Community management of heart failure has been strengthened to prevent readmissions.
Acute Demand Management This involved: • Acute care delivery across the district – orthopaedics • Reducing readmissions • Specialists at the front line • Reducing long-stay patients • Improved discharge letters/care plans • Reducing inappropriate admissions • Reducing ED presentations • Allied health team in ED.	Case management is currently completed between Support Works and Home Based Support Providers. Expansion of case management to include other Primary Care providers is planned for stage two of the CCCC implementation process. CCCC has been implemented in collaboration with Kimi Hauora Wairau & Nelson Bays PHO s. Evaluation of the CCCC is currently underway and will contribute informing future service direction, location and resource allocation decisions. The Falls Prevention programme has been developed with a strong cross sectorial / primary & secondary interface approach. Positive outcomes from this activity include early enrolment in falls prevention programmes at the CCCC and following activation of personal alarms in the home setting following St John ambulance response. ACC representation on the working group has resulted in expansion of funding for falls prevention programmes in Nelson and Marlborough for 3 years (funding was to cease this year in Nelson and had ceased in Blenheim). The stroke workstream has seen implementation of a standardised best practice pathway for the acute management and care of acute stroke. Thrombolysis targets are being met. Auditing has identified areas for future activity within the DHB.

SERVICE IMPROVEMENTS

HEALTH TARGETS

Since 2007/08 DHBs have been measured on a quarterly basis against a number of health targets. 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 2012/13 was:

Target Area		2012/13		2011/12		2010/11	
	National goal	NMDHB	National	NMDHB	National	NMDHB	National
Shorter stays in Emergency Departments	95%	97%	93%	98%	93%	97%	92%
Improved access to elective surgery	100%	100%	107%	103%	105%	100%	104%
Shorter waits for cancer treatment	100%	100%	100%	100%	100%	100%	100%
Increased immunisation	85%	87%	90%	87%	92%	87%	90%
Better help for smokers to quit				96%	91%	90%	85%
Primary care	90%	48%	57%				
Hospital	95%	95%	96%				
More heart and diabetes checks	60%	57%	67%	50%	46%	69%	72%

SERVICES PROVIDED BY NMDHB KEY ACHIEVEMENTS

COMMUNITY BASED

1) NEW BORN ENROLMENT

Connecting babies to health services in our region is a whole lot easier now with the introduction of a Newborn Enrolment Programme. Every baby is entitled to free health services, but rather than having to enrol in each one individually, parents are now able to fill out one form that enrols their child with five services at once: their GP, the National Immunisation Register (NIR), the Community Oral Health Service, the Universal Newborn Hearing Screening Programme, and a Well Child Tamariki Ora provider, such as Plunket or Te Korowai Trust. Ideally the form is filled out before mother and baby leave hospital, or in the case of home births, the Lead Maternity Carer ensures the form is sent to the NIR coordinator for action. Once it's filled out each service gets a copy - they contact the family to welcome them and let them know what the service is all about. The development of the form and the process has been a collaborative initiative between Nelson Bays Primary Health, Kimi Hauora Wairau Marlborough PHO, midwives and other health services, because previously, very few babies were registered with their GP by six weeks and less than half were enrolled by 12 weeks. It also provides an opportunity for midwives to talk to the mums about the various health services available and the options they have. The midwives can talk about the benefits of each service and support new parents to fill the form out correctly. Now GPs and other essential health services have all the correct information they need and can link in with families much earlier than in the past, which is better for picking up on health issues or concerns a lot sooner.

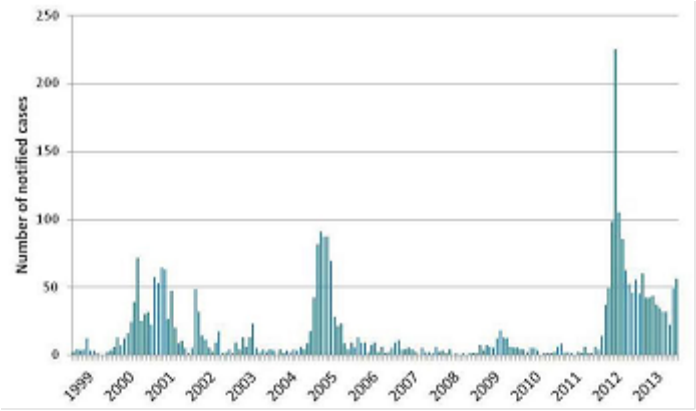
2) INCREASED IMMUNISATION – AT 8 MONTHS

In order to achieve maximum protection for children against potentially serious communicable diseases, we aim to have as many babies as possible fully immunised by the time they are eight-months old. This means that they would have their three necessary immunisations, at six-weeks, three-months and five-months of age. The target for the whole country is for 85% of eight-month old babies to be fully immunised by June 2013; this target will increase to 90% by June 2014, and 95% by December 2014. There are a number of health services involved in giving immunisations, so, in September 2012, an immunisation 'think tank' workshop with these services was held to make sure that families can easily access the immunisation services they need. As a result, we have been:

- Rolling-out the Newborn Enrolment process to Marlborough so that all newborns get enrolled with the five free services to which they are entitled;
- Working with GPs so they know the 'timeline' for eight-month olds immunisations
- Publishing an information leaflet with important for parents who consider declining immunisation for their children
- Maintaining the Outreach Immunisation Service, which is an intensive approach to reach children who do not access primary care for immunisations, it works in the community to locate families and provide a mobile immunisation service, vaccinating in homes or other community locations.
- In the past year, there were 1,567 babies eligible for their immunisations and 1,360 of these were fully immunised; we met the target by achieving an average of 87% coverage for our eight-month olds (Maori children 84%, Pacific 93%, Asian 93%, NZ European 88% and other ethnicities 81%). There were 118 babies (7.5%) for whom their families declined full immunisation.

3) PERTUSSIS

The Public Health Service (PHS) has been active over the year in responding to the outbreak of Pertussis (whooping cough) that has continued with a recent upsurge in cases again associated with the winter months. This district was one of the earliest parts of the country to be affected with the outbreak, which then extended nationwide. The public health response to Pertussis cases starts with assessment and management by GPs of suspect cases and then notification through to the PHS. Pertussis is a 'notifiable disease' under the Health Act, which means doctors have to report it. A key reason for such notification is to try and minimise its spread in the community, as this disease is highly communicable between people, and can be very serious especially for babies. On receiving the notification, a Public Health Nurse follows up with the family concerned to see if there are others at risk and to advise on ways of preventing further spread of the infection to others. Graph shows this districts Pertussis notifications of cases per month.



In addition to promoting vaccinations for infants and children, early in the 2012 outbreak we offered free vaccination to hospital staff as an extra precaution, and later made a submission to the Ministry of Health in support of extending free vaccination to pregnant women. Free vaccination for pregnant women started January 2013. On-time immunisation support includes the National Immunisation Register that keeps track of what vaccinations children have had; this helps the parent as well as the health care professional ensue children get the best protection by keeping an accurate and permanent record of vaccinations. We give updates to health care professionals, the education sector, and the public on a regular basis during an outbreak with advice on how they can help reduce transmission of the disease.

Public Health staff have collected and analysed information that has helped shape the response for this outbreak and will also inform strategies to reduce the frequency and severity of future outbreaks. Some outbreaks are inevitable, but with GPs and the PHS managing notifications vigilantly and educating families and schools, we limit the damage that this disease could potentially do in the community.

4) TARGETED YOUTH HEALTH SERVICE (TYHS)

The TYHS is a nursing service provided by a registered nurse who is skilled in youth health and development. Experience shows us that providing youth specific health services are effective in connecting young people to health care and enhances wellbeing. The service is provided in conjunction with other community and hospital services. The service is provided by Nelson Bays Primary Health (NBPH) and provides nursing services delivered in Nelson and Marlborough. The service provides students in low socio-demographic circumstances with the opportunity to access a youth health nurse; to support early detection and treatment of problems related to vision, hearing, behaviour and development, and other health and disability conditions, in order to support learning and school performance. The main elements include co-ordinating health services so they link up and better support youth, promotional campaigns and youth-friendly information, referral to other services, e.g. oral health services, and Individual health services when sought by student or by nurse contacting a student. In 2012 a total of 104 young people were seen for the first time to complete a youth health assessment, a total of 1,222 follow ups were recorded; key support needed for youth related to mental health and alcohol and other drugs. TYHS is meeting the needs of the young people and they are satisfied with the service provided. Communication and engagement with young people are very important in building a trusting relationship that, in turn, contributes to the effectiveness of working with the young person to address their concerns and health issues.

MEDICAL SURGICAL SERVICES (INCLUDING CLINICAL SUPPORT SERVICES)

ACHIEVEMENTS

- Exceeded elective surgical discharge target of 6,029 by 25 resulting in end year result of 6054 for 100.4%.
- Achieved the five month wait for procedures and FSA.
- Production overall was constrained resulting in end year CWDs of 1405 CWD above plan. Intervention rates continue to be high.
- Cardiology discharges full year were 103% with acute delivery under plan and elective delivery above plan. Acute delivery was 86 discharges below plan, whilst elective delivery was 124 discharges above plan. This resulted in elective discharges being 136%.
- Cardiology CWDs were 105% with acute CWDs being 98% and elective CWDs being 124%.
- A move away from active review by using GPs to monitor those patients
- District wide single points of entry for the receiving of referrals from general practice to DHB services has commenced with the Vascular Service. In addition the Community Care Coordination Centre has been established to connect DHB community and Primary Care Services.
- Wairau and Nelson Emergency Departments (ED) have consistently exceeded the national target of 95% of patients admitted, discharged or transferred to a hospital ward within six hours. NMDHB continued to maintain lowest average Length of Stay nationally.
- Appointment of a Service Manager Clinical Administration and Chief Pharmacist
- Commencement of the Electronic Referral Management System (ERMS) Project
- Commencement of Health Pathways Project lead
- Roll out of the Community Pharmacy Agreement
- Completion of the MOH Violence Intervention Programme self audit
- Successful introduction and implementation of pilot programme for permanent Social Worker and Physiotherapist appointed and based in Nelson Emergency Department
- Single Point of Entry as part of the Nelson Marlborough Alliance Health of Older People (Community Care Co-ordination Centre CCCC)
- Establishment of a NM Falls Alliance project
- Air ambulance contract successfully renegotiated
- Completion of the Nelson Allied Health Store
- Appointment of a district wide social work and speech therapy team leader

CHALLENGES

- Needed trade-offs to balance activity to funding so that the service can live within its means.
- Acute demand for the year ending 12/13 was 101% which was 110 more discharges against plan.
- Management of IDFs including eligibility, clinical appropriateness and direct referrals.

- Rising costs especially for clinical supplies in a period when the exchange rate have been favourable.
- Use of outsourced staff.
- Clinical Administration challenges and resources
- The Intele PACS/RIS integration
- Maintaining current Patient Management System
- High demands for clinical supplies

CONTINUED PROJECTS

- The Productive Operating Theatre (TPOT)
  - Key areas of theatre procedures were examined, including scheduling, consultations, preadmission, and data capture.
  - Since the introduction of this project theatre utilisation has increased, a positive trend in session start times has prevailed and changed scheduling has allowed for better acute and elective demand management.
  - This initiative finishes in August 2013.

- Preadmission Redesign Project
  - This project focuses on the improvement of patient safety through a systematic approach to peri-operative assessment, identifying, quantifying and managing risk. It enables post operative care planning prior to the patient's admission to hospital and is aimed at increasing the patient's commitment to their pathway, providing opportunity for explanations and discussions. It focuses clinician resource where it is most needed and contributes to improving elective surgery productivity.
  - All services are now using the process district wide.
  - All patients have an opportunity to complete their Health Questionnaire on the day of their FSA.
  - The Pre Admission Hub is now fully operational supporting pre admission patients and the surgical speciality departments.

- Care Capacity Demand Management (CCDM)
  - This process was designed to match clinical demand to available resources and the capacity to deliver care.
  - CCDM was piloted in Ward 9 from November 2012 to August 2013. A report will be produced from this project.
  - The use of a hospital operations centre has improved resource utlisation and reduced the use of casual nursing staff.

- Endoscopy
  - This project has improved variance in wait times through the use of a general scoping list; revised referral processes; and a single triage point with the intention of producing an annual appointment list.
  - With all administrative pathways, protocols and documents in place, patient focused booking will be introduced in August 2013.

- Enhanced Recovery After Surgery (ERAS)
  - This programme takes a multi disciplinary approach to elective colorectal surgery to ensure that patients receive optimal preparation pre-operatively (both physiologically and psychologically) so that they present for surgery well informed and at their fittest.
  - Protocols and processes were successfully implemented into Colorectal Surgical Services.
  - This project has reduced the average length of stay for patients and improved patient satisfaction considerably.

- Faster Cancer Treatment
  - NMDHB has established multi disciplinary teams, and revised administrative pressures.
  - The Multi Disciplinary Model Project has been approved by the South Island Alliance Leadership Team, costings and site plans are to be confirmed.

» Shifting Services

  ➤ Four medical/surgical services have been shifted out of the hospital and into the community – Skin Lesions; Pain Service; IV Therapies; and Cardiac Rehabilitation and Education.

» Electronic Referrals Management System (ERMS)

  ➤ NMDHB, Marlborough PHO (Kimi Hauora Wairau) and Nelson Bays Primary Health worked together on this project to improve outpatient referrals.

  ➤ There are two key work streams in this project, the first being the development of an electronic referrals system between General Practitioners and the DHB. The second is the development within the DHB of more robust and consistent district-wide business processes to receive, track and process referrals through to triage; and a patent focused booking system, including improved communication between referrers and the DHB.

  ➤ ERMS is due to be introduced into Wairau in July 2013, and Nelson in September 2013.

» Community Pharmacy Agreement

  ➤ The introduction of the national community pharmacy agreement.

» Health Pathways

  ➤ Progress continues with the development and localisation of the NM health pathways

» Clinical Administration

  ➤ A review of the administration service resulting in the development of a proposed model

The Medical Surgical Services Directorate is continuing to make improvements on Health Pathways, Community Care Co-ordination Centre and replacement of the Patient Management System.

CHALLENGES FOR 2013/2014

» Achieving the 4 month target for ESPI

» Capturing the savings initiatives

» Top of the South Services Review including radiology

» Need to meet new targets for MRI wait times

» Prescribing patterns for pharmaceuticals

» Clinical administration review

» Centralised rostering

» Aligning the SMO workforce including use of non clinical time

» Improving Transport across district

Acutal to Planned 2012/2013				
	2012/13 Planned	2012/13 Actual	% Difference	Total difference above (+ve) below (-ve)
Case-weighted inpatient discharges				
Maternity	**1,860**	**1,750**	**-5.9%**	**-110**
Medical	**7,530**	**7,559**	**0.4%**	**29**
Medical electives	469	575	22.6%	106
Medical acute	7,061	6,984	-1.1%	-77
Surgical	**12,228**	**12,026**	**-1.7%**	**-202**
Surgical electives	7,122	6,623	-7.0%	-499
Surgical acute	5,106	5,403	5.8%	297
Total case-weighted inpatient discharges				
Total	21,618	21,335	**-1.3%**	**-283**
Outpatient services				
ED (non-admitted)	35,000	32,391	**-7.5%**	**-2,609**
Medical first	8,836	7,987	**-9.6%**	**-849**
Medical follow up	15,850	15,234	**-3.9%**	**-616**
Chemotherapy	2,300	2,431	**5.7%**	**131**
Renal	1,700	1,161	**-31.7%**	**-539**
Scope	2,270	2,292	**1.0%**	**22**
Surgical first	12,320	13,448	**9.2%**	**1,128**
Surgical follow up	21,425	21,636	**1.0%**	**211**
Other services				
Maternity	1,350	1,318	**-2.4%**	**-32**
Medical	7,643	8,055	**5.4%**	**412**
Surgical	6,795	7,283	**7.2%**	**488**
Health of Older People	20,100	14,807	**-26.3%**	**-5,293**
Miscellaneous	237,414	217,279	**-8.5%**	**-20,135**

NB. Medical & Surgical Other Services have moved over years as Purchase Units have been redefined over combined specialties
Health of Older People = sum of HOP PUC's

MENTAL HEALTH

For Mental Health the 20012/13 year has been busy, productive and effective, not only in consolidating relationships but in extending systems Directorate-wide, reviewing those current Specialist systems and processes, as well as accomplishing the planned service developments, all of which serve to stand it in good stead with energy and enthusiasm for the forthcoming year.

Building on the strong relationship base developed across the continuum of services has been through key groups whose role include consultation and advice in our decision making (Stakeholders Reference Group), provision of consumer advice through a Consumer Collective forum and the Specialist Service Consumer Advisor. Using a collaborative approach these groups promote greater integration and contribute to annual planning, service development, service delivery, and workforce training.

We continue to meet key performance indicators (access to services has improved 4%) which is in line with the regional integration objective of alignment and support set out in the South Island Mental Health Alliance's workplan. The Intellectual Disability/Mental Health Regional Service Project is of particular importance to the District.

Financial sustainability remained a key focus. Stringent monitoring of expenditure enabled the Directorate to remain within budget, whilst achieving it's 2012/13 objectives and positioning itself for the 2013/14 priorities.

The Directorate continues to participate in the National Mental Health KPI project which has now been extended to CAMHS. Benchmark data, used in service planning and review, indicates the District to be performing well.

A joint venture by NBPH and DHB Specialist Service using a web-based referral system has improved stepped care and established a Single Point of triage for all referrals to Nelson Adult Mental Health services by streamlining access for consumers and simplifying the referral process for clinicians, consumers and families. This will be extended to Wairau in the 2013/14 year and will include NGOs including Kaupapa Maori.

Primary Mental Health Initiative funding was increased (and ringfenced) for youth (12-19 years) in Nelson and Wairau and the NBPH Youth Addictions pilot extended as a contract for a further two years.
As dictated by the MOH funding the contract with NBPH for the Suicide Prevention Coordinator was extended to July 2013. The role of the Coordinator was revamped to include a clinical focus working closely with the Mobile Community Team on postvention with clients and families, as well as suicide prevention activities.

NBPH, Specialist Service and MSD commenced an inter-agency project trialling increasing therapeutic supports for those with depression to assist work ready skills and gain employment.

There were a number of changes in Kaupapa Maori Services. Following the decision of Te Rapuora to close Te Kahui Hauora o Ngati Koata extended their services in Wairau to cover most of the contracted services. This involved them working from the Specialist Service Witherlea House and AOD in Wairau to facilitate service delivery commencement. The work of the Coalition will inform further contracts and service delivery.

The Specialist Service has focused on service reconfiguration and systems review to improve access and early response as well as ensure multi-disciplinary input and timely consumer reviews. Changes were made to Consultant Psychiatrists, inpatient services and the Kawai Clinic to ensure cover, enhanced continuity of care and updated, multi-disciplinary input Risk and Recovery Plans (MOH target) for continuing care clients.

Further work is required for a dedicated service for those under 65 with neurological disorders and challenging behaviour, and those with dual disability (intellectual disability and mental health) currently provided at Alexandra Hospital for a small number of clients. This would limit extended inappropriate admissions to the Inpatient Unit. An extensive Staff Safety Review was completed and recommendations actioned following an increasing number of reportable assaultative events.

Other developments are community liaison in Older Persons Mental Health with nurses providing early intervention and accessible expertise and the Dementia Educator position teaching the "Walking in Another Shoes" programme to service providers to support residential placement.

Nikau House provides day services to clients in the Nelson district with a range of activities, some collaborative with NGO while others are competitive eg " the Great Cake Bake Off" or are within the mainstream community e.g. the Incredibles soccer team, promoted above the lower grade for the first time in 5 years!

Addictions continues to develop services to meet a growing demand Drink Driving Groups (more than one D.I.C); a new Youth Counsellor employed for Wairau and a new Counsellor role working with pregnant women with addictions and mothers of small children in line with COPMIA service development. An enhanced local network amongst GPs, Pharmacies and other Medics has been developed to limit drug seeking behaviour.

CAMHS has seen new services introduced for Youth Forensic and Community Liaison (bridging with CAMHS, Schools and Primary Health). With this growth Wairau facilities have become cramped which is being addressed. To foster integration with personal health CAMHS is working more closely with Paediatrics.

Challenges for 2013/14 include continuing to build on the current plans while meeting
the Prime Minister's Youth Mental Health Project and Youth Forensic, the National Mental Health and Addictions Service Development Plan, "Rising to the Challenge", the Suicide Prevention Plan, and Drivers of Crime.

DSS

The 2012-2013 year has been a very difficult one for DSS. It was identified that there were concerns regarding the management culture and staff understanding of their obligations in regards to the issue of potential abuse and neglect within the service. NMDHB engaged to experts (external) to complete a review of circumstances relating to the care and support provided to one of the service users and the overall management culture within the service.

The review found that there were some significant issues that needed resolution and made a number of recommendations (34) covering the following areas.

- Management
- Working relationships with external groups
- Staff training and policies in relation to abuse and neglect
- Health and safety
- Incident and accident system
- Workforce
- Complaints

Work has commenced on implementing the recommendations, the implementation phase should be completed by the end of 13/14 year, however the required cultural changes will take considerably longer to implement. All staff especially those staff with management roles will be and are expected to walk the talk. It is only through role modelling to the required standards and encouraging the same from all staff that the culture will truly develop into a continuous quality improvement culture that fully reflects the values of the organisation.

The focus on implementing the recommendations made by the Rutherford review has been maintained with those recommendations able to be implemented being completed. The Rutherford review made recommendations in three areas:

1) Governance and ownership. Work has commenced on preparing DSS for the potential transfer to a newly established Trust for future ownership. A steering group was established to oversee this project, the draft Trust Deed has been completed and the pathway to financial viability established.
2) Financial viability. This work stream is closely related to one above, the service has now achieved financial breakeven and has established that to be fully financially viable a minimum of $600k further savings are to made. A plan to achieve this has been established.
3) Day service model. This work stream proposes a more individually focussed service model that is provided in a variety of setting including the individuals own home. A pilot trial has commenced.

Overall the service has successfully maintained certification with only two issues to be resolved, this is attributable to the team as a whole and a credit to everyone involved.

DSS has met all of its financial targets.

INFRASTRUCTURE

NMDHB has joined the Demand Response Trial with Transpower to run the emergency generators at Nelson Hospital when demand on the national grid peaks.

The business case for the redevelopment of the Nelson Hospital site remains suspended while investigations continue on the remedial work to improve the compliance ratings for key buildings on both sites.

A contract for the demolition of Dalton House on the Nelson Hospital campus has been let following an approval under the Resource Management Act. It is planned that in due course this site will be used to accommodate a learning centre, after hours facility and potentially other services, however innovative funding opportunities will need to be found.

With the completion of the new Churchill Trust building at Wairau Hospital the areas formally occupied by them and the Marlborough Orthopaedic Centre are now available. Discussions are underway on possible integration of Kimi Hauora Wairau into the Hospital campus.

ORGANISATIONAL STRUCTURE

The current proposal for change is centred around:

- Having a strong operational leadership team focused on the effective and efficient provision of services within the hospital and community services we operate. This team will be a partnership between management, doctors, nursing and allied health
- A separate Clinical Governance Group which will champion the environment in which quality and safety of services, as well as an environment of continuous quality improvement, will flourish. This group, reporting to both the Chief Executive and the Board, will include health professionals, and will also bring a stronger consumer perspective to what we are doing.
- Rebuilding the Nelson Marlborough Health Alliance to have oversight for both strategic and operational planning, funding and the provision of primary and community care services across the region. This will include the DHB and the two PHOs initially, but may well grow to engage other parts of the Nelson Marlborough Health System

The proposed structure requires each of these three components to be strong. One of the early pieces of feedback has been the challenge of "if it is not broken don't change it," however given the overall organisational performance it is fair to recognise that there are actually things that are broken, and as such we need to adjust it. The issues include fiscal performance, but also links very clearly into the fact that we do not have "One Service Two Sites" embedded in everything we do. There is duplication of roles within the existing structures, and our relationship and partnership with primary care, PHOs and NGOs could improve further. The future is exciting, however the current period of change is very challenging and destabilising for all. The review will progress in a fair and transparent manner.

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.

NMDHB along with all other DHBs released the 2011-12 Serious and Sentinel Events on the 21st November. NMDHB reported six events for the year. The events included the death of a patient in surgery which is under police investigation, death as a result of a presumed hospital-acquired infection, and a serious medication error which occurred prior to, but is considered unlikely to have caused the death of a patient; this is before the Coroner. Three falls resulting in serious injury to the patient were reported compared to six from the 2010-11 year.

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 entered into as Nelson Marlborough Health Alliance as set out on page 24.

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 owns 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 the Nelson and Wairau hospitals
- Nelson Marlborough Health Alliance
- Nelson Bays Primary Health for the delivery of health services at Golden Bay.

NELSON MARLBOROUGH HEALTH ALLIANCE

Following the development the new PHO Agreement which makes it a requirement for PHOs to be a part of an Alliance with its District Health Board we have taken an approach of entering into a renewed Alliance structure with a view towards the Alliance becoming a critical part of the Nelson Marlborough Health System.

Over the next few months we will work with our PHOs to reform the scope of the NMHA to encapsulate the following:

> *A joint oversight responsibility for strategic, and operational planning, funding and provision of Primary & Community Services across the Nelson Marlborough Health System.*

It is envisaged that the Alliance's interest will be primarily in areas where significant or transformational changes may be anticipated. A key difference, however, within the Alliance model is that once we agree on specific areas, and the parameters to operate within, the Alliance Leadership Team will establish Service Level Alliance Teams who will then be tasked with leading the changes within the scope and parameters that they have been given.

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 continue to be 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. 2012/13 has seen continued 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 2012/13, with all sessions being over-subscribed.

The Board is an active participant in the South Island Regional Training Hub (SIRTH).

QUALITY AND COMMUNICATION

The Quality and Safety Governance Committee (Q&SGC) maintains the overview of quality and safety in the organisation. Its focus in 2012/13 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 Q&SGC initiated the inaugural NMDHB Quality Report (Accounts) during the year with a goal of publishing the document in the first quarter of 2013/14. The approach taken to the style of the Quality Report has been influenced by the inclusion of consumer representatives on the group charged with its development.

The Executive Leadership Team (ELT) considered the outcome of the Report into care at Mid Staffordshire Trust during the year. Mid Staffordshire Trust is an English health care provider who was subject to a number of investigations into the care provided in its hospital. Multi systems failure was identified by the various investigations. ELT considered the Report with a view to relevant recommendations being considered and included in NMDHBs quality planning.

A full Certification audit was undertaken in March 2013. Certification was again confirmed by the Ministry of Health.

The Care Capacity Demand Programme continues within the organisation. Changes to staffing and the model of nursing care delivery in the medical unit in Nelson Hospital have been maintained and the process has been extended to a mixed surgical ward at Nelson Hospital. 2012/13 saw the implementation of the implementation of 'Capacity at a Glance' screens throughout both Nelson and Wairau Hospitals. The next stage of the programme 'Variance at a Glance' was trialed during the year and will go live in early 2013/14.
The Chief Executive continues to hold quarterly staff forums in both Nelson and Wairau. 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-Partnership Forum continued to meet quarterly during the year and discuss and consider issues relevant across all union groups and NMDHB.

STAFF WELLBEING

The 'Wellness at Work' focus has seen a 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 continued 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 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 eleventh 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 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 (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. In April 2013 the Advisory Committees met in a combined workshop to discuss mutual issues for health and disability services in the district. Membership of each of the committees is set out in the Board and Committees section.

MEETING ATTENDANCE

	BOARD MEETINGS	CPHAC/ DiSAC	HAC	COMBINED COMMITTEE
BOARD MEMBERS				
Jenny Black	12	4	5	1
Ian MacLennan	12		5	1
Judy Crowe	12		5	1
Gordon Currie	9	2		1
Fleur Hansby	11	4		1
Roma Hippolite	11		4	1
Gerald Hope	11	3		1
John Inder	12		5	1
John Moore	10	3		1
Patrick Smith	11	2		1
Russell Wilson	12		4	1
COMMUNITY REPRESENTATIVES				
Jennifer Black		4		
Judith Holmes		4		
George Truman		4		1
Jos Van Der Pol		4		
Glenys MacLellan		3		1
Mabel Grennell		1		1
Sonny Alesana				1
Jane Anderson-Bay			5	
Francis Gargiulo			3	1
Dawn McConnell			2	
Total Meetings	**12**	**4**	**5**	**1**

PAYMENTS IN RESPECT OF TERMINATION

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 $874,006 (2011/12 – 38 payments totaling $1,145,303).

Number of employees | 37 Total $874,006

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.

EMPLOYEE REMUNERATION

The number of employees earning more than $100,000 is detailed in the table below. Of the 208 employees shown, 174 are or were medical, dental, nursing or allied health employees (162 in 2011/12).

Salary	2012	2013
100000 - 109999	33	29
110000 - 119999	18	34
120000 - 129999	7	8
130000 - 139999	7	7
140000 - 149999	3	1
150000 - 159999	5	6
160000 - 169999	3	3
170000 - 179999	6	10
180000 - 189999	9	9
190000 - 199999	10	4
200000 - 209999	10	5
210000 - 219999	9	16
220000 - 229999	9	6
230000 - 239999	12	6
240000 - 249999	6	8

Salary	2012	2013
250000 - 259999	6	12
260000 - 269999	7	9
270000 - 279999	2	4
280000 - 289999	4	9
290000 - 299999	8	4
300000 - 309999	5	6
310000 - 319999	2	2
320000 - 329999	4	1
330000 - 339999	1	3
340000 - 349999	1	3
360000 – 369999	1	
380000 - 389999		2
400000 - 410000	1	1
410000 - 420000	1	
Grand Total	**191**	**208**

GOVERNANCE PHILOSOPHY

CLINICAL GOVERNANCE

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.

The Board has acknowledged that its risk tolerance[3] varies depending on the area of impact if an identified risk is realised. It has recognizes that there are circumstances in which it seeks to engage actively with risk in order to achieve innovation and realise improvement opportunities.

When the Board is considering a decision which will expose the DHB to new risks, the decisions will be based on an assessment of the risks against the potential benefits and will keep in mind the Board's articulated risk tolerance as set out in the Code of Conduct Handbook 2013.

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.

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3 Risk Tolerance is defined as "the amount of loss the entity is willing to bear should a risk materialise" which is different to the concept of Risk Appetite or "the amount of risk the DHB is prepared to take in pursuit of its objectives".

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 will be jointly reviewed by NMDHB and the participating Unions in 2013-14.

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 2013 fairly reflect the financial position and operations of NMDHB.

Jenny Black
BOARD CHAIR

Rusell Wilson
CHAIR, AUDIT & RISK COMMITTEE

Chris Fleming
CHIEF EXECUTIVE

Eric Sinclair
GM FINANCE & PERFORMANCE

AUDIT OFFICE OPINION

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

TO THE READERS OF NELSON MARLBOROUGH DISTRICT HEALTH BOARD'S AND GROUP'S FINANCIAL STATEMENTS AND NON-FINANCIAL PERFORMANCE INFORMATION FOR THE YEAR ENDED 30 JUNE 2013

The Auditor General is the auditor of Nelson Marlborough District Health Board (the Health Board) and group. The Auditor General has appointed me, John Mackey, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and non financial performance information of the Health Board and group on her behalf.
We have audited:

- The financial statements of the Health Board and group on pages 29 to 67, that comprise the statement of financial position as at 30 June 2013, the statement of financial performance, statement of comprehensive income, statement of movements 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 non financial performance information of the Health Board the on pages 68 to 92 that comprises the output classes and performance measures, and which includes outcomes.

UNMODIFIED OPINION ON THE FINANCIAL STATEMENTS

In our opinion the financial statements of the Health Board and group on pages 29 to 67:
- comply with generally accepted accounting practice in New Zealand; and
- fairly reflect the Health Board and group's:
  - financial position as at 30 June 2013; and
  - financial performance and cash flows for the year ended on that date.

QUALIFIED OPINION ON THE PERFORMANCE INFORMATION

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

Except for the effect of the matters described in the above paragraph, the performance information of the Health Board and group on pages 68 to 92:
- complies with generally accepted accounting practice in New Zealand; and
- fairly reflects the Health Board's and group's service performance and outcomes for the year ended 30 June 2013, including for each class of outputs:
  - the service performance compared with forecasts in the statement of forecast service performance at the start of the financial year; and
  - the actual revenue and output expenses compared with the forecasts in the statement of forecast service performance at the start of the financial year.

Our audit was completed on 22 October 2013. 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 non financial performance information are free from material misstatement.

Material misstatements are differences or omissions of amounts and disclosures that, in our judgement, are likely to influence readers' overall understanding of the financial statements and non financial performance information. If we had found material misstatements that were not corrected, we would have referred to them in our opinion.

AUDIT OFFICE OPINION

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

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

An audit also involves evaluating:

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

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

We obtained all the information and explanations we required about the financial statements. However, as referred in our opinion, we did not obtain all the information and explanations we required about the performance information. We believe we have obtained sufficient and appropriate audit evidence to provide a basis for our audit opinions.

RESPONSIBILITIES OF THE BOARD

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

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

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

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 an independent opinion on the financial statements and non financial performance information 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 External Reporting Board.

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

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

Financial Statements

NELSON MARLBOROUGH DISTRICT HEALTH BOARD
CONSOLIDATED STATEMENT OF FINANCIAL PERFORMANCE
FOR THE YEAR ENDED 30 JUNE 2013

in thousands of New Zealand Dollars

	NOTE	PARENT & GROUP 2013 Budget $000	2013 Actual $000	2012 Actual $000
Income				
Revenue	**4**	411,642	414,933	400,723
Other Operating income	**5**	3,354	3,736	5,958
Finance income	**6**	1,415	1,767	1,609
Total Income		416,411	420,436	408,290
Expenses				
Personnel Costs	**7**	154,796	153,206	152,238
Outsourced Services		9,850	11,788	11,932
Clinical Supplies		29,357	31,741	30,710
Infrastructure & Non-Clinical Expenses		21,656	22,989	22,306
Payments to non-Health Board Providers		174,700	179,313	172,024
Other Operating Expenses	**8**	3,009	2,568	2,645
Depreciation and amortisation expense	**16,17**	13,210	11,404	12,071
Finance Costs	**6**	2,608	2,926	2,800
Capital Charge	**9**	7,170	7,430	6,792
Total Expenses		416,356	423,366	413,518
Net Surplus/(Deficit)		**55**	**(2,930)**	**(5,228)**

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.

NELSON MARLBOROUGH DISTRICT HEALTH BOARD
CONSOLIDATED STATEMENT OF COMPREHENSIVE INCOME
FOR THE YEAR ENDED 30 JUNE 2013

in thousands of New Zealand Dollars

	NOTE	PARENT & GROUP 2013 Budget $000	2013 Actual $000	2012 Actual $000
Net Surplus/(Deficit)		**55**	**(2,930)**	**(5,228)**
Other Comprehensive Income				
(Impairment)/Revaluation of Property, Plant and Equipment	22	-	(3,565)	9,380
Total Comprehensive Income		**55**	**(6,495)**	**4,152**

NELSON MARLBOROUGH DISTRICT HEALTH BOARD
CONSOLIDATED STATEMENT OF MOVEMENTS IN EQUITY
FOR THE YEAR ENDED 30 JUNE 2013
in thousands of New Zealand Dollars

	NOTE	PARENT & GROUP 2013 Budget $000	2013 Actual $000	2012 Actual $000
Equity at Beginning of the Year		**96,247**	**93,888**	**89,805**
Comprehensive Income				
Net Surplus/(Deficit)		55	(2,930)	(5,228)
Other Comprehensive Income		-	(3,565)	9,380
Total Comprehensive Income		**55**	**(6,495)**	**4,152**
Owner Transactions				
Equity Injections		-	-	478
Equity Repayments		(547)	(547)	(547)
Total Equity at the End of the Year	**22**	**95,755**	**86,846**	**93,888**

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.

NELSON MARLBOROUGH DISTRICT HEALTH BOARD
CONSOLIDATED STATEMENT OF FINANCIAL POSITION
FOR THE YEAR ENDED 30 JUNE 2013

in thousands of New Zealand Dollars

	NOTE	PARENT & GROUP 2013 Budget $000	2013 Actual $000	2012 Actual $000
ASSETS				
CURRENT ASSETS				
Cash and Cash Equivalents	**10**	19,253	30,445	4,800
Debtors and Other Receivables	**11**	23,136	10,970	12,813
Investments	**12**	-	-	25,282
Inventories	**13**	2,125	2,048	2,246
Prepayments		418	411	448
Non-current Assets Held for Sale	**14**	-	4,131	2,045
TOTAL CURRENT ASSETS		**44,932**	**48,005**	**47,634**
NON CURRENT ASSETS				
Prepayments		42	130	1
Other Financial Assets	**15**	7	3	7
Property, Plant and Equipment	**16**	164,554	157,272	166,425
Intangible Assets	**17**	5,264	3,602	1,840
TOTAL NON CURRENT ASSETS		**169,867**	**161,007**	**168,273**
TOTAL ASSETS		**214,799**	**209,012**	**215,907**
LIABILITIES				
CURRENT LIABILITIES				
Creditors & Other Payables	**18**	22,931	23,175	22,351
Loans & Borrowings	**19**	3,695	11,141	1,045
Employee Entitlements	**20**	32,518	29,707	29,570
Provisions	**21**	388	1,430	388
TOTAL CURRENT LIABILITIES		**59,532**	**65,453**	**53,354**
NON CURRENT LIABILITIES				
Loans & Borrowings	**19**	46,696	45,252	56,369
Employee Entitlements	**20**	12,816	11,461	12,296
TOTAL NON CURRENT LIABILITIES		**59,512**	**56,713**	**68,665**
TOTAL LIABILITIES		**119,044**	**122,166**	**122,019**
NET ASSETS		**95,755**	**86,846**	**93,888**
EQUITY				
Crown Equity	**22**	29,675	29,134	29,681
Other Reserves	**22**	49,220	47,423	50,988
Retained Earnings/(Losses)	**22**	16,860	10,289	13,219
TOTAL EQUITY		**95,755**	**86,846**	**93,888**

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.

NELSON MARLBOROUGH DISTRICT HEALTH BOARD
CONSOLIDATED STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED 30 JUNE 2013
in thousands of New Zealand Dollars

	NOTE	PARENT & GROUP 2013 Budget $000	2013 Actual $000	2012 Actual $000
CASH FLOWS FROM OPERATING ACTIVITIES				
Cash was provided from:				
Receipts from Ministry of Health and patients		414,746	421,138	405,522
Interest received		1,415	1,767	1,620
		416,161	422,905	407,142
Cash was disbursed to:				
Payments to employees		153,906	152,944	151,548
Payments to suppliers		238,081	250,672	236,635
Capital Charge		7,099	7,430	7,508
Interest paid		2,816	2,926	2,800
Net GST paid/(refunded)		(37)	(2,649)	2,054
		401,865	411,323	400,545
Net cash inflow/(outflow) from operating activities	**23**	**14,296**	**11,582**	**6,597**
CASHFLOWS FROM INVESTING ACTIVITIES				
Cash was provided from:				
Sale of property, plant & equipment		3,000	40	1,413
Cash inflow on maturity of investments		-	25,285	-
Cash was applied to:				
Acquisition of property, plant & equipment		13,555	6,219	8,798
Acquisition of intangible assets		5,200	2,431	196
Acquisition of investments		-	-	13,175
		18,755	8,650	22,169
Net cash inflow/(outflow) from investment activities		**(15,755)**	**16,675**	**(20,756)**
CASHFLOWS FROM FINANCING ACTIVITIES				
Cash was provided from:				
Loans Raised		-	-	8,000
Finance Leases Raised		56	-	392
Equity Injections		-	-	478
Cash was applied to:				
Equity Repaid		547	547	547
Repayment of Borrowings		-	1,020	-
Payment of Finance Lease Liabilities		1,045	1,045	1,159
Net cash inflow /(outflow) from financing activities		**(1,536)**	**(2,612)**	**7,164**
Net increase/(decrease) in cash and cash equivalents		(2,995)	25,645	(6,995)
Add Cash and cash equivalents at 1 July		22,248	4,800	11,795
Adjustment to Opening Balance due to reclassification of				
Cash and cash equivalents as at 30 June		**19,253**	**30,445**	**4,800**

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 and to be consistent with the presentation basis of the other primary financial statements.

Equipment totalling $577,633 (2012: $255,000) was acquired by means of finance leases during the year. Interest received and interest paid have been reclassified within the 2013 Budget to be reflected as operating activities. In the Annual Plan they were classified as investing activities and financing activities respectively.

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.

NELSON MARLBOROUGH DISTRICT HEALTH BOARD
CONSOLIDATED STATEMENT OF COMMITMENTS
FOR THE YEAR ENDED 30 JUNE 2013

in thousands of New Zealand Dollars

	PARENT & GROUP	
	2013 Actual $000	**2012 Actual $000**
Capital Commitments		
Property, Plant & Equipment	555	1,380
Intangible Assets	37	232
Total capital commitments	**592**	**1,612**
Non-cancellable commitments - Provider Commitments		
Not later than one year	13,029	6,077
Later than one year and not later than two years	2,341	909
Later than two years and not later than five years	4,082	307
Later than five years	10,193	-
	29,645	**7,293**
Non-cancellable commitments - Operating Lease Commitments		
Not later than one year	653	663
Later than one year and not later than two years	498	631
Later than two years and not later than five years	1,228	1,279
Later than five years	1,693	1,491
	4,072	**4,064**
Non-cancellable commitments - Finance Lease Commitments		
Not later than one year	672	1,123
Later than one year and not later than two years	260	640
Later than two years and not later than five years	-	199
Later than five years	-	-
	932	**1,962**
Non-cancellable commitments - Other		
Not later than one year	1,214	1,088
Later than one year and not later than two years	299	23
Later than two years and not later than five years	23	-
Later than five years	-	-
	1,536	**1,111**
Total Commitments	**36,777**	**16,042**

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

The Provider Commitments disclosed in this note include committed obligations for health purchasing expenditure with NGOs.The Board is also obligated to funding significant streams of 'demand driven' health purchasing expenditure. Commitments of this nature are in place for the purchase of pharmacy, laboratory and GP services. Because this expenditure is 'demand driven' it is not possible to quantify the obligation in this note.

Expenditure of this nature in the 2013 year totalled $115.0 million (2012: $115.4 million).

NELSON MARLBOROUGH DISTRICT HEALTH BOARD
CONSOLIDATED STATEMENT OF CONTINGENT ASSETS AND LIABILITIES
FOR THE YEAR ENDED 30 JUNE 2013

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 $0.3m (2012: up to $0.02m) for disputes and legal proceedings by 1 client.

CONTINGENT ASSETS

Nelson Marlborough DHB is seeking legal redress against a third party for overexpenditure and has recorded a contingent asset of $1.78m (2012: $1.78m).

NELSON MARLBOROUGH DISTRICT HEALTH BOARD
NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2013

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 2013. The financial statements were approved by the Board on 22 October 2013.

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 2013 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.

The Minister of Commerce has approved a new Accounting Standards Framework (incorporating a Tier Strategy) developed by the External Reporting Board (XRB). Under this Accounting Standards Framework, the DHB is classified as a Tier 1 reporting entity and it will be required to apply full public sector Public Benefit Entity Accounting Standards (PAS). These standards are being developed by the XRB and are mainly based on current International Public Sector Accounting Standards. The effective date for the new standards for public sector entities is expected to be for reporting periods beginning on or after 1 July 2014. This means the DHB expects to transition to the new standards in preparing its 30 June 2015 financial statements. As the PAS are still under development, the DHB is unable to assess the implications of the new Accounting Standards Framework at this time.
Due to the change in the Accounting Standards Framework for public benefit entities, it is expected that all new NZ IFRS and amendments to existing NZ IFRS will not be applicable to public benefit entities. Therefore,the XRB has effectively frozen the financial reporting requirements for public benefit entities up until the new Accounting Standards Framework is effective. Accordingly, no disclosure has been made about new or amended NZ IFRS that exclude public benefit entities from their scope.

(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 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	***Estimated Life***	***Amortisation Rate***
Software	3 - 10 years	10 - 34 %

INVENTORIES HELD FOR DISTRIBUTION

Inventories classified as held for distribution are stated at cost (calculated using the weighted average cost method) adjusted, where applicable, for any loss of service potential. 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, or for a nominal cost, it is recognised at fair value when control over the asset is obtained.

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

(c) Subsequent Costs

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

(d) Revaluation of land and buildings

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

Additions between revaluations are recorded at cost.

The results of revaluing land and buildings are credited or debited to an asset revaluation reserve for that class of asset and other comprehensive income. Where a revaluation results in a debit balance in the asset revaluation reserve, the debit balance will be expensed in the surplus or deficit. Any decreases in value relating to a class of land and 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	
	2013 Actual $000	**2012 Actual $000**
Health and Disability Services (MOH contracted revenue)	395,504	381,596
Inter District Patient Inflows	8,259	7,996
ACC	4,133	4,044
Patient/Consumer Sourced Revenue	5,767	5,822
Other Government and DHB's	1,270	1,265
	414,933	**400,723**

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 (2012: $Nil).

5) OTHER OPERATING INCOME

	PARENT & GROUP	
	2013 Actual $000	2012 Actual $000
Donated Property, Plant & Equipment	46	103
Rental income	1,155	1,070
Gain on Disposal of Property, Plant & Equipment	13	296
Other income	2,522	4,489
	3,736	**5,958**

6) FINANCE INCOME & COSTS

	PARENT & GROUP	
	2013 Actual $000	2012 Actual $000
Interest income	1,767	1,609
Finance Income	**1,767**	**1,609**
Interest on finance lease	82	141
Interest on loans	2,844	2,659
Interest on overdraft	-	-
Finance costs	**2,926**	**2,800**

7) PERSONNEL COSTS

	PARENT & GROUP	
	2013 Actual $000	2012 Actual $000
Wages and salaries	142,298	142,169
Contributions to defined contribution plans	3,587	3,276
Other personnel costs	7,321	6,793
	153,206	**152,238**

8) OTHER OPERATING EXPENSES

	PARENT & GROUP	
	2013 Actual $000	2012 Actual $000
Audit fees - Annual Audit	147	147
Donations made	-	-
Koha	1	2
Impairment loss on property, plant and equipment	-	-
Impairment of receivables (bad and doubtful debts)	107	165
Loss on disposal of property, plant and equipment	1	163
Rental and operating lease costs	2,111	2,061
Restructuring expenses	201	107
	2,568	**2,645**

During the year, Nelson Marlborough Hospitals Charitable Trust paid audit fees of $3,559 (2012: $3,340).

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 2013 was 8% (2012: 8%).

10) CASH AND CASH EQUIVALENTS

	PARENT & GROUP	
	2013 Actual $000	**2012 Actual $000**
Bank Balances & cash on hand	(7)	145
Funds advanced to HBL	30,452	-
Call Deposits	-	4,655
Term Deposits with original maturities less than 3 months	-	-
Bank Overdraft	-	-
Cash and cash equivalents in the Statement of Cash Flows	**30,445**	**4,800**

Nelson Marlborough DHB is a party to the "DHB Treasury Services Agreement" between Health Benefits Limited (HBL) and the participating DHBs. This Agreement enables HBL to "sweep" DHB bank accounts and invest surplus funds. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with HBL, which will incur interest at the credit interest rate received by HBL plus an administrative margin. The maximum debit balance that is available to any DHB is the value of provider arm's planned monthly Crown revenue, used in determining working capital limits, is defined as one-12th of the annual planned revenue paid by the funder arm to the provider arm as denoted in the most recently agreed Annual Plan inclusive of GST. For Nelson Marlborough DHB that equates to $19M.

The balance held by NMDHB within this Agreement is shown within the table above.

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

As at 30 June 2013, Nelson Marlborough DHB did not have any call deposits.
At 30 June 2012, the interest rate on Nelson Marlborough DHB's call deposits was 2.00%.
Interest rates on term deposits in 2012 ranged from 3.66% to 4.40%.

11) DEBTORS AND OTHER RECEIVABLES

	PARENT & GROUP	
	2013 Actual $000	2012 Actual $000
Trade receivables due from non-related parties	1,329	1,874
Ministry of Health receivables	3,615	4,156
Gross trade receivables	4,944	6,030
Less Provision for impairment	(420)	(421)
Net trade receivables	4,524	5,609
Accrued Income	6,422	7,182
Other Receivables	24	22
Total debtors and other receivables	**10,970**	**12,813**

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 2013 and 2012, all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below:

	PARENT & GROUP			
	Gross Receivable 2,013 $000	Impairment 2,013 $000	Gross Receivable 2012 $000	Impairment 2012 $000
Trade Receivables				
Current	3,571	(14)	4,498	(19)
31-60 days	239	(1)	504	(5)
61-90 days	375	(8)	148	(6)
Over 90 days	759	(397)	880	(391)
Total	**4,944**	**(420)**	**6,030**	**(421)**

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	
	2013 Actual $000	2012 Actual $000
Gross trade receivables	4,944	6,030
Individual impairment	-	-
Collective impairment	(420)	(421)
Net trade receivables	**4,524**	**5,609**

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

	PARENT & GROUP	
	2013 Actual $000	2012 Actual $000
Provision for impairment at 1 July	421	411
Additional provisions made during the year	107	164
Provisions used during the year	(108)	(154)
Provisions reversed during the period	-	-
Provision for impairment at 30 June	**420**	**421**

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	
	2013 Actual $000	2012 Actual $000
Current		
Term deposits with original maturities greater than 3 months and remaining duration less than 12 months	-	25,282
	-	25,282

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%.

13) INVENTORIES

	PARENT & GROUP	
	2013 Actual $000	2012 Actual $000
Inventories held for distribution		
Pharmaceuticals	341	270
Other Supplies net of provision for obsolete stock.	1,707	1,976
	2,048	2,246

In 2013, the value of inventories distributed and recognised as an expense in the clinical supplies expense included in the deficit was $17.7 million (2012 $16.8 million).

The carrying amount of inventories held for distribution carried at current replacement cost at 30 June 2013 is $Nil (2012 $Nil). The write-down of inventories held for distribution amounted to $Nil for 2013 (2012 $Nil). There have been no reversals of write-downs (2012: $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	
	2013 Actual $000	2012 Actual $000
Non-current assets held for sale include:		
Land	958	1,126
Buildings	3,173	919
	4,131	2,045

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 $1,612,000

15) OTHER FINANCIAL ASSETS

	PARENT & GROUP	
	2013 Actual $000	2012 Actual $000
Shares in South Island Shared Services Agency Limited	**3**	**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 sold 65 of the 130 shares owned back to SISSAL during the year.
There are no impairment provisions for other financial assets (2012: $Nil).

16) PROPERTY, PLANT & EQUIPMENT

Cost or Valuation	PARENT & GROUP						
	Land $000	Buildings $000	Plant & Equipment $000	Motor Vehicles $000	Leased Assets $000	Work in Progress $000	Total $000
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**
Balance at 1 July 12 - at Valuation	12,416	130,587	-	-	-	-	143,003
Balance at 1 July 12 - at Cost	-	3,155	46,510	5,296	9,646	2,311	66,918
Additions	140	2,688	2,789	316	578	5,901	12,412
Revaluation increase/(decrease)	-	233	-	-	-	-	233
Impairment Loss	-	(3,773)	-	-	-	-	(3,773)
Disposals/transfers	55	(1,189)	(4,986)	(174)	(41)	(6,537)	(12,872)
Balance at 30 June 13 - at Valuation	**12,471**	**127,047**	**-**	**-**	**-**	**-**	**139,518**
Balance at 30 June 13 - at Cost	**140**	**4,654**	**44,313**	**5,438**	**10,182**	**1,676**	**66,403**
Accumulated Depreciation & Impairment Losses							
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**
Balance at 1 July 13	-	324	31,958	3,444	7,770	-	43,496
Depreciation for the year	-	5,569	3,524	485	1,128	-	10,706
Revaluations / Impairment Loss	-	25	-	-	-	-	25
Disposals/transfers	-	(328)	(5,067)	(144)	(40)	-	(5,579)
Balance at 30 June 13	**-**	**5,591**	**30,415**	**3,785**	**8,858**	**-**	**48,649**
Carrying Amounts							
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**
At 1 July 12	12,416	133,418	14,552	1,852	1,876	2,311	166,425
At 30 June 13	**12,611**	**126,110**	**13,898**	**1,653**	**1,324**	**1,676**	**157,272**

IMPAIRMENT
An impairment loss of $3.8m been recognised for 2013 (2012: $6.4m). This arose primarily due to modifications required to buildings to meet earthquake standards ($2.5m), reduction in Golden Bay Hospital asset ($0.3m) and roof repair ($1.0m).

REVALUATION
The most recent 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 that 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 revaluation 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 2013, the net carrying amount of leased IT and clinical equipment was $1,324,235 (2012: $1,875,952).

WORK IN PROGRESS
The total amount of property, plant, and equipment in the course of construction is $1.68m (2012: $2.31m).

17) INTANGIBLE ASSETS

(a) Software

	PARENT & GROUP			
	Owned $000	Leased $000	Work in Progress $000	Total $000
Balance at 1 July 11	6,646	330	76	7,052
Additions	192	1	200	393
Disposals	-	-	(193)	(193)
Balance at 30 June 12 - at Cost	**6,838**	**331**	**83**	**7,252**
Balance at 1 July 12 - at Cost	6,838	331	83	7,252
Additions	1,372	-	1,525	2,897
Disposals/transfers	(224)	(65)	(1,343)	(1,632)
Balance at 30 June 13 - at Cost	**7,985**	**266**	**265**	**8,516**
Accumulated Amortisation & Impairment Losses				
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**
Balance at 1 July 12	5,082	330	-	5,412
Amortisation for the year	698	-	-	698
Impairment Loss	-	-	-	-
Disposals	(224)	(65)	-	(289)
Balance at 30 June 13	**5,556**	**265**	**-**	**5,821**
Carrying Amounts				
At 1 July 11	2,392	28	76	2,496
At 30 June 12	**1,756**	**1**	**83**	**1,840**
At 1 July 12	1,756	1	83	1,840
At 30 June 13	**2,430**	**1**	**265**	**2,696**

(b) Health Benefits Limited Finance, Procurement and Supply

	PARENT & GROUP	
	2013 Actual $000	2012 Actual $000
Balance at 1 July 12 - at Cost	-	-
Additions	906	-
Balance at 30 June 13 - at Cost	**906**	

During the year shares were purchased in Health Benefits Limited (HBL). HBL is an agency set up by all the Ministry of Health to provide shared services for District Health Boards. The investment was made to fund the establishment of a shared service arrangement to support the delivery of Finance, Procurement and Supply Chain services.

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

Total Intangible Assets	PARENT & GROUP	
	2013 Actual $000	2012 Actual $000
Carrying Amounts		
(a) Software	1,840	2,496
(b) Health Benefits Limited Finance, Procurement and Supply Chain Investment	-	-
Total Intangible Asset Balance at 1 July - at carrying value	**1,840**	**2,496**
(a) Software	2,696	1,840
(b) Health Benefits Limited Finance, Procurement and Supply Chain Investment	906	-
Total Intangible Asset Balance at 30 June - at carrying value	**3,602**	**1,840**

IMPAIRMENT

No impairment losses have been recognised (2012: $Nil).

LEASED INTANGIBLES

Nelson Marlborough DHB leases IT software under a number of finance lease agreements.
At 30 June 2013, the net carrying amount of leased intangibles was $342 (2012: $577).

18) CREDITORS AND OTHER PAYABLES

	PARENT & GROUP	
	2013 Actual $000	2012 Actual $000
Trade payables	2,587	5,358
Revenue in advance	802	142
Capital Charge payable	-	-
GST, PAYE & FBT payable	4,006	3,514
Other non-trade payables and accrued expenses	15,781	13,337
	23,175	**22,351**

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 & BORROWINGS

	PARENT & GROUP	
	2013 Actual $000	2012 Actual $000
Current		
Current portion of Debt Management Office fixed interest loans	10,500	-
Current portion of finance lease liabilities	641	1,045
	11,141	**1,045**
Non-Current		
Debt Management Office fixed interest loans	45,000	55,500
Finance lease liabilities	252	869
	45,252	**56,369**

(a) Debt Management Office fixed Interest Loans

Nelson Marlborough District Health Board has ten loans with the Debt Management Office. The terms and conditions are as follows:

Interest rate summary	**PARENT & GROUP**	
	2013 Actual $000	**2012 Actual $000**
Debt Management Office (%)	2.91% - 6.535%	2.91% - 6.535%

The interest rates on the seven loans are fixed.

Loans are repayable as follows	**Parent & Group**	
	2013 Actual $000	**2012 Actual $000**
Within next 12 months	10,500	-
One to two years	8,000	10,500
Two to five years	21,000	14,000
Beyond five years	16,000	31,000
	55,500	**55,500**

Term Loan Facility Limits	**PARENT & GROUP**	
	2013 Actual $000	**2012 Actual $000**
Debt Management Office	**55,500**	**55,500**

SECURITY AND TERMS

Theses loans were previously provided by the Crown Health funding Authority however this entity no longer exists. The loan facility is now provided by the Debt Management Office, which is part of the Treasury and administered by the Ministry of Health. The Debt Management Office term liabilities are secured by a negative pledge.

Without the Debt Management Office'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.

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 2013 $000	**Interest 2013 $000**	**Principal 2013 $000**	**Minimum lease payments 2012 $000**	**Interest 2012 $000**	**Principal 2012 $000**
Within next 12 months	672	31	641	1,123	78	1,045
One to two years	223	6	216	640	27	613
Two to five years	37	1	36	260	4	256
Beyond five years	-	-	-	-	-	-
	932	**39**	**893**	**2,023**	**109**	**1,914**

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.

20) EMPLOYEE ENTITLEMENTS

	PARENT & GROUP	
	2013 Actual $000	2012 Actual $000
Current liabilities		
Sabbatical leave	196	179
Retirement Gratuities	1,537	1,901
Long service leave	558	569
Annual leave	15,704	15,762
Sick Leave	444	395
Continuing medical education	7,014	6,453
Salary and wages accrued	4,254	4,311
	29,707	**29,570**
Non-current liabilities		
Sick Leave	763	1,099
Sabbatical leave	1,374	1,269
Retirement Gratuities	6,653	7,196
Long service leave	2,671	2,732
	11,461	**12,296**

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

LONG SERVICE LEAVE, RETIREMENT GRATUITIES, AND SABBATICAL LEAVE

The discount rates used are the risk free rates as determined by the NZ Treasury and published on its website. Discount rates used range from 2.53% to 6.00% (2012: 2.43-6.00%), with an average of 4.57% (2012: 4.82%). For SMOs, a salary inflation factor of 3.0% (2012: 2.5%) has been used in year 1 and 3.0% thereafter (2012: 2.5%). For non-SMOs, a salary inflation factor of 3.0% has been used in all years (2012: 2.5%). The take-up rate used for sabbatical leave is 25% (2012: 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 $706,000 increase/$642,000 decrease in the long service leave, retirement gratuities and sabbatical leave liability (2012: $815,000 increase / $741,000 decrease).

SICK LEAVE

The discount rates used in the valuation are the risk free rates as determined by the NZ Treasury and published on its website. The average discount rate is 3.6% (2012: 3.4%). Average future salary growth has been assumed to be 3% per annum, plus a salary scale of 1% per annum.

21) PROVISIONS

Current Provisions	PARENT & GROUP	
	2013 Actual $000	2012 Actual $000
Restructuring	1,067	25
ACC Partnership Programme	363	363
	1,430	388
Total Provisions	**1,430**	**388**

Movements in Provisions	PARENT & GROUP		
	Restructuring $000	ACC Partnership Programme $000	Total $000
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**
2013			
Balance at 1 July 2012	25	363	388
Additional provisions made during the year	1,067	-	1,067
Provisions used during the year	(25)	-	(25)
Provisions reversed during the period	-	-	-
Balance at 30 June 2013	**1,067**	**363**	**1,430**

RESTRUCTURING PROVISIONS

An amount of $0.03m 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 last valuation was effective at 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 (2012: 3.5%).

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 160% of the industry premium and a stop loss limit of $250,000 for any high cost claim.

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	
	2013 Actual $000	**2012 Actual $000**
(a) Crown Equity		
Balance at 1 July	29,681	29,750
Equity Injections	-	478
Equity Repayments	(547)	(547)
Balance at 30 June	**29,134**	**29,681**
(b) Retained Earnings		
Balance at 1 July	13,219	18,335
Net (deficit)/surplus	(2,930)	(5,228)
Transfer from property, plant and equipment revaluation reserve on classification as held for sale	-	112
Transfer from property, plant and equipment revaluation reserve on disposal	-	-
Retained Earnings at 30 June	**10,289**	**13,219**
(c) Revaluation Reserve		
Opening Balance at 1 July	50,988	41,720
Revaluations of Land and Buildings	-	9,380
Impairment Charge	(3,565)	-
Transfer to Retained Earnings on classification as held for sale	-	(112)
Transfer to Retained Earnings on disposal of property, plant and equipment	-	-
Balance at 30 June	**47,423**	**50,988**
Revaluation reserves consist of:		
Land	9,004	8,928
Buildings	38,419	42,060
Total Revaluation Reserves	**47,423**	**50,988**
Total Equity at 30 June	**86,846**	**93,888**

Retained earnings includes accumulated surpluses/deficits of unspent mental health ring fenced funding as detailed in note 31.

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

	PARENT & GROUP	
	2013 Actual $000	2012 Actual $000
Reported surplus/(deficit)	(2,930)	(5,228)
Add back non-cash items:		
Depreciation and amortisation expense	11,404	12,071
Impairment losses	-	-
Add back items classified as investing activities:		
Net Loss/(Gain) on disposal of Property, Plant & Equipment	(12)	(133)
Movements in working capital:		
(Increase)/Decrease in debtors and other receivables	1,843	(188)
(Increase)/Decrease in prepayments	(92)	(7)
(Increase)/Decrease in inventories	198	(203)
Increase/(Decrease) in creditors and other payables	824	(1,322)
Increase/(Decrease) in employee entitlements	(698)	2,651
Increase/(Decrease) in provisions	1,042	(1,132)
Movements in working capital disclosed as investing activities		
(Increase)/Decrease in creditors relating to purchase of Property, Plant & Equipment	2	88
(Increase)/Decrease in Deferred Gain on sale and leaseback of Property, Plant & Equipment		
Net cash (outflow)/inflow from operating activities	**11,582**	**6,597**

24) OPERATING LEASES

(a) Leases as Lessee

	PARENT & GROUP	
	2013 Actual $000	2012 Actual $000
The future aggregate minimum lease payments to be paid under non-cancellable operating leases are as follows:		
Less than one year	701	663
Between one and five years	1,725	1,910
More than five years	1,693	1,491
Total non-cancellable operating leases	**4,119**	**4,064**

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 2013, $2,110,926 was recognised as an expense in the surplus or deficit in respect of operating leases (2012: $2,061,000).

(b) Leases as Lessor

Nelson Marlborough DHB leases owned properties to third parties under operating leases resulting in revenue of $1.0m (2012: $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.

	PARENT & GROUP	
	2013 Actual $000	2012 Actual $000
The future minimum lease payments under non-cancellable operating leases in the aggregate and for each of the following periods:		
Not later than one year	770	994
Later than one year and not later than five years	1,364	2,083
Later than five years	-	51
	2,133	**3,127**

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.

From 1 July 2012 Health Benefits Limited (HBL) assumed responsibility for the investment of all the Nelson Marlborough DHB's surplus funds. The policies risk mamagement policies HBL have adopted are consistent with the those that follow.

(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 for 2012 were:

	PARENT & GROUP	
	2013	2012
Call Deposits	-	2.00%
Term Deposits with maturity less than 3 months	-	3.66-4.40%
Term Deposits with maturity greater than 3 months but less than 12 months	-	4.40-4.66%

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 2013 (2012: $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.

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	
	2013 Actual $000	2012 Actual $000
Counterparties with Credit Ratings		
Cash and Cash Equivalents		
AA	-	4,800
	-	4,800
Investments		
AA	-	25,282
	-	25,282
Counterparties without Credit Ratings		
Cash and Cash Equivalents		
Cash on Hand	30,445	-
	30,445	-
Debtors and Other Receivables		
Existing Counterparty with no defaults in the past	10,707	12,677
Existing Counterparty with defaults in the past	263	136
Total Debtors and Other Receivables	**10,970**	**12,813**

(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 2013. 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.

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

	PARENT & GROUP						
2013	**Balance Sheet $000**	**Contractual cash flow $000**	**6 mths or less $000**	**6-12 mths $000**	**1-2 years $000**	**2-5 years $000**	**More than 5 years $000**
DMO loans	55,500	55,500	-	10,500	8,000	21,000	16,000
Finance lease liabilities	893	932	672	223	37	-	-
Creditors and other payables	18,368	18,368	18,368	-	-	-	-
Total	**74,761**	**74,800**	**19,040**	**10,723**	**8,037**	**21,000**	**16,000**

2012	**Balance Sheet $000**	**Contractual cash flow $000**	**6 mths or less $000**	**6-12 mths $000**	**1-2 years $000**	**2-5 years $000**	**More than 5 years $000**
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**

(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 2013, it is estimated that a general increase of one percentage point in interest rates would decrease Nelson Marlborough DHB's deficit by approximately $302,000 (2012: $265,000).

(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				
2013	**Note**	**Loans and receivables**	**Available for sale**	**Other - Amortised Cost**	**Carrying amount**	**Fair value**
Assets		**$000**	**$000**	**$000**	**$000**	**$000**
Cash and cash equivalents	**10**	30,445	-	-	30,445	30,445
Debtors and other receivables	**11**	10,970	-	-	10,970	10,970
Investments	**12**	-	-	-	-	-
Total Current assets		41,415	-	-	41,415	41,415
Other Financial Assets	**15**	-	3	-	3	3
Total Non-current assets		-	3	-	3	3
Total Assets		**41,415**	**3**	**-**	**41,418**	**41,418**
Liabilities						
Creditors and other payables	**18**	-	-	18,368	18,368	18,368
Finance lease liabilities	**19**	-	-	641	641	641
Secured loans	**19**	-	-	10,500	10,500	10,675
Total current liabilities		**-**	**-**	**29,509**	**29,509**	**29,684**
Finance lease liabilities	**19**	-	-	252	252	252
Secured loans	**19**	-	-	45,000	45,000	48,470
Total Non-current liabilities		**-**	**-**	**45,252**	**45,252**	**48,722**
Total Liabilities		**-**	**-**	**74,761**	**74,761**	**78,406**
2012	**Note**	**Loans and receivables**	**Available for sale**	**Other - Amortised Cost**	**Carrying amount**	**Fair value**
Assets		**$000**	**$000**	**$000**	**$000**	**$000**
Cash and cash equivalents	**10**	4,800	-	-	4,800	4,800
Debtors and other receivables	**11**	12,813	-	-	12,813	12,813
Investments		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**

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 $399.8m (2012: $385.7m) to provide health services in the Nelson Marlborough area for the year ended 30 June 2013.

Revenue earned from other DHBs for the care of patients outside Nelson Marlborough DHB's district amount to $8.3m (2012: $8.0m) for the year ended 30 June 2013. Expenditure to other DHBs for their care of patients from Nelson Marlborough DHB's district amounted to $40.2m (2012: $38.4m) for the year ended 30 June 2013.

(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 2013 totalled $2.3m (2012: $2.5m). These purchases included the purchase of electricity from Meridian Energy, air travel from Air New Zealand, and energy from Solid Energy.

(c) Transactions with subsidiaries

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

	PARENT & GROUP	
	2013 Actual $000	**2012 Actual $000**
Donations from NMHCT	138	74
	138	**74**

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.

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

South Island Shared Services Agency Limited (SISSAL) has been set up by all South Island DHBs to provide shared support services to funder operations. Nelson Marlborough DHB paid South Island Shared Services Agency Limited $0 for support with Funder operations during the period (2012: $100,000). The balance outstanding at year end was Nil (2012: Nil).

During the year SISSAL brought back 50% of the shares held by each of the South Island DHBs. This equates to 65 shares for Nelson Marlborough DHB. Nelson Marlborough DHB continues to hold 65 shares (which equates to 13% of the total share capital issued) at a value of $3,250.

(e) Transactions with Key Management Personnel

	PARENT & GROUP	
	2013 Actual $000	**2012 Actual $000**
Salaries and other short-term employee benefits	4,456	5,131
Post-employment benefits	168	-
Other long-term benefits	-	-
Termination benefits	-	-
Total key management personnel remuneration	**4,624**	**5,131**

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 2012/13 until April 2013. The value of expenditure totalled $943,743 and was on normal commercial terms. There are no outstanding balance 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 2012/13 until April 2013. The value of expenditure totalled $1,321,329 and was on normal commercial terms. There is a balance of $16,138 outstanding for unpaid invoices at year end.

During the year, Nelson Marlborough DHB purchased servies from the St Marks Society in Blenheim of which J Inder is a Board Member. The value of expenditure totalled $592,710 and was on normal commercial terms. There are no outstanding balance 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 2013, the Trust had total revenue of $119,210 (2012: $111,000), and a net surplus of $109,551 (2012: $101,000). The Trust had assets of $3,116,259 (2012: $2,994,000), and liabilities of $Nil (2012: $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 $4.0m. This was mainly due to increased revenue from:

- Increased population based funding (PBFF) for vaccines, long term support – chronic health conditions (LTS-CHC) and primary mental health $1.7m.
- Capital charge adjustment for the 2012/13 property revaluation $0.7m.
- ACC revenue due to better capture of data and higher volume of ACC cases $0.6m
- Interest received $0.4m
- Programme funding not included in the Annual Plan plus Elective Service Patient Flow (ESPI) incentive $0.3m.
- Elective programmes not included in the Annual Plan $0.3m

Expenditure
Overall the level of Acute surgery was well above what was expected, given the region's population and demographics.

Personnel costs are $1.6m favourable to budget. As part of the DHB savings plan control over replacing staff has resulted in vacancies in various departments reducing staff costs. Some of these savings have been offset by increased outsourcing and recruitment expenses largely related to critical clinical appointments. The favourable variance in personnel includes a reduction through the statistical revaluation of personnel liabilities of $0.6m which has been offset by the recognition of a provision for restructuring of $1M. Outsourced services are $1.9m unfavourable to budget.

Clinical supplies are unfavourable to budget by $2.4m. This largely reflects increased caseweight volumes in cardiology, orthopaedics and vascular procedures. The spend is 7% over budget.

Infrastructure & Non-Clinical Expenses are favourable to budget by $0.3m. Increased costs occurred in Insurances $0.5m, were offset by an underspend in corporate training $0.4m, the budget for pandemics and emergencies not being utilised $0.4m, and depreciation $1.2m less than budgeted due to assets not purchased during the year.

Payments to Providers are unfavourable to budget by $4.6m. Pharmaceuticals are $2m unfavourable to budget, however, this is partially offset by additional funding for vaccines of $1.2m and the reimbursement of influenza vaccine costs of $0.25m. Aged Related Residential Care (ARRC) costs are $0.9m unfavourable to budget. The increase is demand driven expenditure, including demographic changes. NMDHB has the lowest ARRC bed usage rate in the South Island and the growth trend is being managed through appropriate use of home based services. Inter-district Outflows are $2m unfavourable to budget. This includes a final unfavourable wash-up for 2011/12 of $0.5m. The balance is due to a significant increase in volumes over plan. The level of increase reduced over the second six months of the year.

(b) Statement of Changes in Equity

The net deficit was $2.9m less than budgeted surplus due to the explanations provided in Note 30(a), Statement of Comprehensive Income.

Other Comprehensive income was $3.6m unfavourable to budget due to the impairment of Land and Buildings as at 30 June 2013.

Equity injections and repayments were in line with budget.

(c) Statement of Financial Position

Current Assets
Current assets are $3.1m more than budgeted. Cash & cash equivalents are $11.2m more than budget and Debtors & Other receivables are $12.2m less than budget. The budget included $10m of short term investment in Debtors and Other receivables, however all deposits are now held by HBL and included in Cash and cash equivalents. Non-current assets held for sale are $4.1m greater than budget, the budget assumed these propertises would be sold by 30 June 2013.

Non Current Assets
Non-current assets are $8.9m more than budget. The variance reflects the deferred purchase of budgeted assets.

Current Liabilities
Current liabilities are $5.9m more than budget in total. Short term loans and borrowings are $7.4m more than budget, the budget classified $8m of term loan as long term rather than current. Provisions are $1.0m more than budgeted due to a $1.0m provision for restructuring.

Non Current Liabilities
Non-current liabilities are $2.8m less than budget. The variance is made up of $1.4m Loans & Borrowings with a reduction in the use of Finance leases, and $1.3m Employee Entitlements with a reduction in retirment gratuity liability.

Equity
Equity is $8.9m less than budget due to the variances as described in Note 30(b), Statement of Changes in Equity.

(d) Statement of Cash Flows

Cash inflows from Operating Activities were $1.3m less than budget. Receipts from Ministry of Health and patients were $6.4m more than budget and payments to suppliers were $11.1m more than budget for various reasons outlined in Note 30 (a). GST refund of $2.6m was not accounted for in the budget.
Cash inflows from Investing Activities were $32.4m favourable to budget. Sale of Assets was lower than budget by $3.0m. Investment in Property, Plant, and Equipment was $7.3m less than budgeted, with many budgeted projects deferred. Investment in intangible assets has also been deferred leaving $2.8m less than budgeted. $25.3m of short term loans matured and were re-invested with HBL and re-clasified as cash and cash equivalents.

Cash outflows from Financing Activities were $1.0m more than budget. The liability for finance leases has decreased by $1.0m.

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	
	2013 $000	**2012 $000**
Opening balance of mental health funds	417	109
Excess/(Shortfall) of funding for mental health services over payments	17	308
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	**434**	**417**

32) SEVERANCE PAYMENTS

Nelson Marlborough DHB has not made any severance payments other than in accordance with relevant employee contractual obligations. There have been payments to 5 employees totalling $39,837 made in the year ended 30 June 2013.

33) SUMMARY OF REVENUE AND EXPENSES BY OUTPUT CLASS

	PARENT & GROUP		
	2012/13 Budget $000	2012/13 Actual $000	2011/12 Actual $000
Income			
Prevention Services	$7,537	$7,563	9,150
Early Detection and Management Services	$111,214	$112,258	109,848
Intensive Assessment and Treatment Services	$211,233	$213,903	204,257
Support Services	$86,427	$86,711	85,035
Total Revenue	**416,410**	**420,435**	**408,290**
Expenditure			
Prevention Services	$6,584	$6,370	7,325
Early Detection and Management Services	$109,603	$108,799	110,035
Intensive Assessment and Treatment Services	$211,643	$219,176	208,984
Support Services	$88,525	$89,020	87,174
Total Expenses	**416,355**	**423,366**	**413,518**
Surplus/(Deficit)			
Prevention Services	952	1,193	1,825
Early Detection and Management Services	1,611	3,459	(187)
Intensive Assessment and Treatment Services	(410)	(5,273)	(4,727)
Support Services	(2,098)	(2,309)	(2,139)
Total Surplus/(Deficit)	**55**	**(2,930)**	**(5,228)**

34) BOARD MEMBERS' REMUNERATION

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

	PARENT & GROUP	
	2013 Actual $000	2012 Actual $000
Jenny Black	40	40
Judy Crowe	21	21
Ian MacLennan	26	26
John Moore	21	21
Gordon Currie	21	22
Fleur Hansby	24	20
Roma Hippolite	21	24
Gerald Hope	22	22
John Inder	21	21
Patrick Smith	23	22
Russell Wilson	22	22
	262	**261**

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

Committee Members (Community Representatives)		
Hospital Advisory Committee		
Jane Anderson-Bay	1	1
Francis Gargiulo	1	2
Tahi Takao	-	1
Hinekehu Nga McConnell	1	-
Community and Public Health Advisory Committee/Disability Support Advisory Committee		
Sonny Alesana	1	1
Mabel Grennell	1	1
Judith Holmes	1	1
Glenys MacLellan	2	1
Jos van der Pol	1	1
George Truman	1	1
Jennifer M Black	1	
	11	10

Output Classes and Performance Measures 2012/13

PREVENTION SERVICES

OUTPUT CLASS DESCRIPTION[4,5]

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.[6]

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:** Health promotion has been defined by the World Health Organisation's 2005 Bangkok Charter for Health Promotion in a Globalized World as 'the process of enabling people to increase control over their health and its determinants, and thereby improve their health'. The primary means of health promotion occur through developing healthy public policy that addresses the prerequisites of health, such as income, housing, food security, employment, and quality working conditions. Health Education services 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.

4 For a full definition of the output classes refer to 2012/2013 Annual Plan.
5 This SFSP uses 2009/10 data as our baseline and compares with expected performance in 2012/13 to provide the trend and progress for increasing the level of service delivery.
6 A full description of NMDHB Prevention Services are contained in the Public Health Service Draft Annual Plan for July 2012 to June 2013.

» **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 wellbeing; 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.

OUTPUT CLASS: PREVENTION SERVICES

Output Subset: Health Promotion and Education Services

Health promotion services work to develop public policy that addresses the prerequisites of health such as income, housing, food security, employment, and quality working conditions. Health Education services inform people about the risks and support them to be healthy. Success begins with awareness and engagement, reinforced by programmes that support people to maintain wellness or assist them to make healthier choice. Change is indicated by rates of positive or negative behaviours (such as smoking rates).

Measures Quality (Q) – Quantity (V) – Coverage (C) – Timeliness (T)	Notes	Actual 2009/10	Target 2012/13	Current National Average	2012/13 Achieved	Comments on 2012/13 Performance
Number of submissions and Health Impact Assessments completed	V	5	5	N/A	5 submissions	**ACHIEVED** Five submissions were made including local authority draft annual plans. In addition, we collaborated with community organisations to prepare a further 7 submissions.
Number of people in NMDHB Quit Coach smoking cessation programmes (Total and Maori).	V	790	600 *(Change in practice since 2009/12, so ED referrals go to Quitline rather than to the hospital Quit Coaches.*	N/A	Total =448 Maori =91 (20%)	**NOT ACHIEVED** All patients in hospital who are current smokers are offered support to quit and a variety of support services are available to them. As well as the hospital-based quit service support can also be given through general practice, Aukati Kaipaipa, or the Quitline. There are other community-based services that also have staff trained in giving quit support. The number of people able to be given support by the NMDHB Quit Coach smoking cessation programme is fewer than target and also a reduction compared to 2011/12 when there were 492 referrals. This is due to: • reduced numbers of referrals from the Emergency Departments. Quitline report 224 referrals for the period from all NMDHB Emergency Departments, • staff resignations in both Quit Coaching and Smokefree Coordinator, resulting in vacancies and thus less availability of Quit Coach time. Changes in practice have been implemented to respond to this so that in the latter part of the year, the Nelson Quit Coach service is restricted to providing a single bedside consult for inpatients and referring all patients who want follow up support onward to other quit support service options. Pre-operative patients and pregnant women and their whanau are still offered multi-session support through the hospital. This will be reviewed when staff appointments are able to be made.
Proportion of hospitalised smokers who are provided with advice and support to quit in hospital settings	C	52%	95%	88% (Q1 2011/12)	95% (Q4 2012/13)	**ACHIEVED** Maintenance of this level of achievement against the target has been challenging and takes a combined approach from clinical and support staff to deliver: staff education and support, feedback on results, auditing to ensure accurate data capture orientation and an ongoing commitment to clinical best practice.

Measures Quality (Q) – Quantity (V) – Coverage (C) – Timeliness (T)	Notes	Actual 2009/10	Target 2012/13	Current National Average	2012/13 Achieved	Comments on 2012/13 Performance
Proportion of enrolled patients who smoke & are seen in General Practice who are provided with advice and help to quit	C	36% (June 2011)	90%	National coverage has increased to 56.9% as at Quarter 4 2012/13	48.14%	**NOT ACHIEVED** This is a relatively new target and with a variety of different general practice settings and the large number of patients involved, it is taking time to develop and embed the systems that enable achievement of the target. It involves education in clinical practice and in utilising the systems for ensuring the activity is accurately recorded and collated to measure the achievement. There has been steady improvement over the year.
Proportion of babies are breast-fed (exclusive and full) in the district at six weeks of age	Q,C	72%	75%	74% (national target) 66% (Jul-Dec 2012)	72% (Plunket data Jul-Dec 2012)	**PARTIALLY ACHIEVED** Breastfeeding rates have been maintained and are above the national rates, but are still 3% below the target.
Proportion of babies are breast-fed (exclusive and full) in the district at three months of age	Q,C	60%	62%	57% (national target) 55% (Jul-Dec 2012)	63% (Plunket data Jul-Dec 2012)	**ACHIEVED**
Proportion of babies are breast-fed (exclusive and full) in the district at six months of age	C	26%	29%	27% (national target) 25% (Jul-Dec 2012)	28% (Plunket data Jul-Dec 2012)	**PARTIALLY ACHIEVED** Rates have increased over the baseline and are above the national rates, but are 1% below the target.
Proportion of maternity facilities who have Baby Friendly Hospital Accreditation	Q	100%	100%	N/A	100%	**ACHIEVED** All four maternity facilities in Nelson Marlborough have maintained Baby Friendly Hospital Accreditation.
Number of NMDHB staff trained in Family Violence intervention	V	100	100	N/A	100%	**ACHIEVED** Staff were trained in all designated services. Designated services are the core service identified by the Ministry of Health and part of the contract with NMBHB to implement the VIP programme. These are: • Mental health • Alcohol and Drug • Child Health (including school, home visiting services and tertiary paediatric services) • Maternity • Sexual Health • Emergency department
Provision of a consistent, quality FVIP that achieves above the national benchmark score of 70 on the FVIP Evaluation Audit of hospital responsiveness for child abuse.	Q	80%	85%	71%	81%	**NOT ACHIEVED** The VIP service undertook a self audit this year and though evidence was present to score the criteria it was agreed with the VIP Team that further improvements / evidence could be achieved. As a result the score on self audit appears slightly lower. With the quality plans put in place this will be addressed within the next quarter and a full self audit is expected to results in an increase in the overall score.
NMDHB provides a consistent, quality FVIP and achieves above the national benchmark score of 70 on the FVIP Evaluation Audit of hospital responsiveness for partner abuse.	Q	78%	81%	67%	80%	**PARTIALLY ACHIEVED** Performance was within 1% of the 2012/13 target.
Proportion of priority services that are screening more than half of eligible women, aged 16 years and over	C	N/A	60%	N/A	75%	**ACHIEVED** Services are screening eligible women for family violence. A random audit is taken of records and these are audited for screening rates.

OUTPUT CLASS: PREVENTION SERVICES

Output Subset: Statutory Regulation

These services sustainably manage environments to support people and communities to make healthier choices and maintain health and safety. They include compliance monitoring with liquor licensing and smoke environment legislation, assurance of safe drinking water, proper management of hazardous substances and effective quarantine and bio-security procedures.

Measures Quality (Q) – Quantity (V) – Coverage (C) – Timeliness (T)	Notes	Actual 2009/10	Target 2012/13	Current National Average	2012/13 Achieved	Comments on 2012/13 Performance
Implement the Health (Drinking Water) Amendment Act 2007 by providing IANZ endorsed reports within 20 working days of assessments for Public Health Risk Management Plans (PHRMP's)	V	10	10	N/A	11 PHRMP Adequacy reports were processed.	**ACHIEVED** Drinking Water Assessors (a statutory officer in the Health Act, employed by the public health service) are statutorily responsible for assessing Public Health Risk Management plans of water suppliers. DWA's have a 20 working day period to approve or disapprove the plan (section 69Z (1) (5) Health Act 1956). To be approved the plans must meet minimum criteria as stipulated under the Act. Two of the Public Health Risk Management plans were not approved as they did not meet the minimum criteria under the Health Act 1956. In one instance the plan was amended to ensure compliance whilst the second PHRMP is being re-written
Number of mosquito surveillance visits (weekly in summer and fortnightly in winter at Port Nelson [8 sites] and Port Marlborough [5 sites])	V	507	507	N/A	586 surveillance visits	**ACHIEVED** There were no exotic species of interest found during this period. 240,586 samples taken were all identified as native species. The most abundant and widespread native mosquito found was the Ochlerotatus notoscriptus. Species / Total O. cantipodeus: 1 Oc.notoscriptus: 147 Cx. pervigilans: 77 Cx. quinquefasciatus: 15 Total: 240
Controlled purchase operations (CPOs) to audit for sales of tobacco to people under 18 years	V	2 (120 premises)	2	N/A	Two CPOs were undertaken across the district resulting in 89 premises being subjected to control purchase operations	**ACHIEVED** An emerging area of work is CPO's to address the sale of "legal highs" to under 18 year olds. One CPO (involving 6 premises) was undertaken in Nelson and Tasman. No sales were made to the 16 year old volunteer.
Incidence of non-compliance during CPOs	Q	0	0	N/A	3	**NOT ACHIEVED** Three sales were made to our under 18 year old volunteer – the new regulatory procedure of processing incidence of non-compliance has worked well in that it has simplified the process, reduced processing costs and shortened the time it takes for the regulatory requirement to runs it's course.
Audits of retailers for compliance with the Smokefree Environments Act	V	60	60	N/A	141	Achieved All tobacco retailers were visited to check compliance with the display ban. All retailers were compliant. There was some debate about acceptable signage which has since been resolved.

OUTPUT CLASS: PREVENTION SERVICES

Output Subset: Population Based Screening

These services are mostly funded and provided through the National Screening Unit and help to identify people at risk of illness and pick up conditions earlier. They include breast and cervical cancer screening and antenatal HIV screening. The DHB's role is to encourage uptake, as indicated by high coverage rates.

Measures Quality (Q) – Quantity (V) – Coverage (C) – Timeliness (T)	Notes	Actual 2009/10	Target 2012/13	Current National Average	2012/13 Achieved	Comments on 2012/13 Performance
Percentage of enrolled women aged 20-69 who have had a cervical screen at least once in the last three years - Marlborough	C	72.4%	73.1%	74.41% (June11)	75.4% (March 2013)	**ACHIEVED**
Percentage of enrolled women aged 20-69 who have had a cervical screen at least once in the last three years – Nelson Bays	C	80.6%	≥75% *(75% is the national maximum target for the PHO Performance Programme – NBPH consistently achieves above this target).*	74.41% (June11)	83.2% (March 2013)	**ACHIEVED**
Percentage of high needs enrolled women aged 20-69 who have had a cervical screen at least once in the last three years – Marlborough	C	64.2%	66.09%	66.56% (June11)	68.8% (March 2013)	**ACHIEVED**
Percentage of high needs enrolled women aged 20-69 who have had a cervical screen at least once in the last three years – Nelson Bays	C	77.3%	≥75%	66.56% (June11)	79.5 (March 2013)	**ACHIEVED**
Percentage of high needs women aged 45-65 who have participated in the mammography screening programme – Marlborough	C	66.4%	≥70%	62.8% (June11)	72% (March 2013)	**ACHIEVED**
Percentage of high needs women aged 45-65 who have participated in the mammography screening programme – Nelson Bays	C	76.5%	≥70%	62.8% (June11)	77.8% (March 2013)	**ACHIEVED**
Percentage of newborn hearing screening programme (consents for screening compared to live births)	C	94.8% (Apr-Sep 2010)	97%	77.8%	99.5% (NSU report for Oct11-Mar12)	**ACHIEVED** The most recent results released by the Ministry of Health (as reported here) are for the 6 months to March 2012. The Ministry has advised that the next period results are being worked on, although no specific date for release has been advised.
Completed screening to consents for screening	Q	97.4%	99%	98.6%	99.5%	**ACHIEVED**
Percentage of newborn screening completed within 1 month of birth	Q	90.9%	95%	94.0%	95.1%	**ACHIEVED**

OUTPUT CLASS: PREVENTION SERVICES

Output Subset: Immunisation Services

These services reduce the transmission and impact of vaccine-preventable diseases. 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 service.

Measures Quality (Q) – Quantity (V) – Coverage (C) – Timeliness (T)	Notes	Actual 2009/10	Target 2012/13	Current National Average	2012/13 Achieved	Comments on 2012/13 Performance
Percentage of two-year-olds fully vaccinated	C	89%	95%	91% (12 months to June 2013)	87% over the 12 month period	**NOT ACHIEVED** Nelson Marlborough has difficulty in achieving this target. While we endeavour to have good systems and services in place to facilitate access to immunisation and thus high coverage, there are a significant number of parents in this district who choose not to immunise. For this 12 month period, the decline rate for immunisation was 8.4%. There was another 1% who opted-off the NIR (the information system that records the immunisations that individual receive), so that their immunisation status is unknown. From the 1709 children eligible (i.e. turning 2 years in this period), 1493 were fully immunised, 144 declined and 19 opted off, leaving 163 who were not fully immunised by the time they turned 2.
Percentage of 8 month old children who have completed their scheduled immunisations	C	Baseline being established in 2012/13	85% *(New Health Target: The first stage is 85% by July 2013 and the second stage is 90% by July 2014).*	89% (12 months to June 2013)	87%	**ACHIEVED** This is a new target, promoting timeliness of immunisation for young babies. Nelson Marlborough has put in place support systems and resources to assist providers to achieve high coverage. We anticipate that this will lay a good foundation to increase coverage in line with the increased target for 2013/14.d the target for this period.
Number of schools with year 7 & 8 students who are offered vaccination programmes	V	100%	100%	N/A	100%	**ACHIEVED** All schools with Year 7&8 students are offered the vaccination programmes. A few schools choose to have the programmes available through the school.
Percentage of Year 8 girls who are vaccinated against Human Papillomavirus	C	40%	60%	N/A	For the birth cohort year 1999 (the percentages vaccinated are: Total: 54% Maori: 61% Pacific: 45%	**PARTIALLY ACHIEVED** The target has been met for Maori but not for other ethnicities. The programme has not had high uptake across the country. Girls in Year 8 can be vaccinated in Nelson Marlborough through the school-based programme or in general practice. The birth cohort 1999 has been reported as this is the age group that would all have had complete access to the school programme.
Over 65-year-olds vaccinated for seasonal influenza – Marlborough	C	59.8%	60%	65%	59% (December 2012)	**PARTIALLY ACHIEVED** Vaccinations for over 65 years Marlborough were just 1 percentage point below target.
Over 65-year-olds vaccinated for seasonal influenza – Nelson Bays	C	67.11%	68.1%	65%	67.2% (December 2012)	**PARTIALLY ACHIEVED** Vaccinations for over 65 years Nelson Bays were just 1 percentage point below target.

OUTPUT CLASS: PREVENTION SERVICES

Output Subset: Well Child Tamariki Ora Services

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. Well Child services delivered locally by Public Health services and Maori Health providers. Public Health Services under the Community-Based Services Directorate will deliver B4 School Checks to all children in their fourth year of age.

Measures Quality (Q) – Quantity (V) – Coverage (C) – Timeliness (T)	Notes	Actual 2009/10	Target 2012/13	Current National Average	2012/13 Achieved	Comments on 2012/13 Performance
Number of new baby cases seen by services contracted by NMDHB	V *(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).*	125	300	N/A	269 (approx)	**ACHIEVEMENT IS DEMAND DRIVEN** Lower than predicted. There were fewer babies born in Nelson Marlborough in 2012 than the year before, so this would also have an impact of the Well Child Tamariki Ora service provision as well. Services funded through NMDHB enrol approximately 17-18% of new babies
Number of Before (B4) School Checks	V	1,021	1,462	N/A	1492	**ACHIEVED**
Number of Before (B4) School Checks – high deprivation	V	165	145	N/A	140	**ACHIEVED**
Services delivered by providers in accordance with the Well Child Framework	Q	100%	100%	N/A	100%	**ACHIEVED** All the services funded through NMDHB provide the services in accordance with the Well Child Tamariki Ora framework and schedule.
Percentage of eligible children receiving Before (B4) School Checks	C	62%	80%	73.8%	83%	**ACHIEVED**

OUTPUT CLASS: PREVENTION SERVICES

Output Subset: Mental Health Promotion

The Children of Parents with Mental Illness service is targeted to intervene earlier and facilitate access to community, primary and specialist health supports. The service is aimed at building resilience and averting future adverse outcomes for infants, children and youth.

Measures Quality (Q) – Quantity (V) – Coverage (C) – Timeliness (T)	Notes	Actual 2009/10	Target 2012/13	Current National Average	2012/13 Achieved	Comments on 2012/13 Performance
Number of COPMI identified.	V	N/A	Establish Services by June 2013, baseline reporting	N/A	26	**ACHIEVED** Working with South Island Alliance on planning around COPMI services.
Number of COPMI referrals to specialist services.	V	N/A	Establish Services by June 2013, baseline reporting	N/A	8	**ACHIEVED** Working with SI Alliance on planning around COPMI services.

Forecast Prevention services Output Class Statement of Financial Performance

$000s	2012/2013 Actual	2012/2013 Plan	Variance
Revenue	7,563	7,537	27
Expenditure			
Personnel costs	3,733	4,165	432
Outsourced services	117	139	22
Clinical supplies	79	4	(75)
Infrastructure	426	420	(5)
Provider payments	2,016	1,856	(160)
Total expenditure	6,370	6,584	214
Net surplus/(loss)	**1,193**	**952**	**241**

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
- diagnostic imaging services
- 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. Below is the 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.
- Programmes of Integrated Care. Components of programmes integrated care[7] include:
  - Self-management support and patient education: Self-management support involves collaboratively helping patients and their families acquire the skills and knowledge to manage their own illness, providing self-management tools and routinely assessing problems and accomplishments. Education is giving the patients information (materials and/or instructions) regarding their condition and possible management.
  - Clinical follow-up: This means monitoring the patient after or during treatment on a close regular base. This is often done by a nurse case manager who uses a phone, mailings, or visits. Clinical follow-up can be seen as part of self-management support.

7 See "Integrated Care Programmes for Chronically Ill patients: a review of systematic reviews. Marielle Ouwens, Hub Wollersheim, Rosella Hermens, Marlies Hulscher Richard Grol. Int J Qual Health Care (2005) 17 (2): 141-146. doi: 10.1093/intqhc/mzi016 First published online: January 21, 2005

- Case management: This means explicit allocation of coordination tasks to an appointed individual (a case manager) or a small team who may or may not be responsible for the direct provision of care. The case manager or team takes responsibility for guiding the patient through the complex care process in the most efficient, effective and acceptable way.
- A multidisciplinary patient care team: This is composed of a group of professionals who communicate with each other regularly about the care of a defined group of patients and participate in that care.
- Multidisciplinary clinical pathway: Clinical pathways or integrated care pathways are structured multidisciplinary care plans which detail essential steps in the care of patients with a specific clinical problem and describe the patient's expected clinical course. Clinical pathways should be derived from evidence-based guidelines translated into practice.
- Feedback, reminders, and education for professionals: The aim of feedback, reminders, and education is to provide health care providers with information regarding appropriate care for patients. This information can come from clinical pathways, medical records, computerised databases, patients, or audits by colleagues. Feedback is given after the consultation; education is given before consultation; reminders are given before or during consultation.
- Additional requirements: (i) Supportive clinical information system; (ii) specialised clinics or centres; (iii) shared mission on integrated care; (iv) leaders with a clear vision on integrated care; (v) finances for implementation and maintenance; (vi) management commitment and support; (vii) patients capable and motivated for self-management; (viii) culture of quality improvement.

» **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 Diagnostic Imaging Services** are services[8] 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, we will target an increase in the number of community referred radiological images (MRI, CT, Coronary angiography, Ultrasound), as an indication of improved primary care access to diagnostics, without the need for a hospital appointment.

» **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.

OUTPUT CLASS: EARLY DETECTION AND MANAGEMENT

Output Subset: Primary Health Care (GP) Services

These services are offered in local community settings by teams of 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.

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.

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

Measures Quality (Q) – Quantity (V) – Coverage (C) – Timeliness (T)	Notes	Actual 2009/10	Target 2012/13	Current National Average	2012/13 Achieved	Comments on 2012/13 Performance
Percentage of people in the district enrolled with a PHO - Nelson	C	>99%	>99%	96%	99%	**ACHIEVED** The projected DHB population for July 2013 is 141,248. There are 97.6% of this figure enrolled with a PHO and 98.3% if the DHB owned service at Murchison is included. Although exact regional projections are difficult to determine it would appear that Nelson Bays Primary Health has enrolled over 99% of the population. Since it has been a long time since the last census both figures may be misleading. However it is known that Marlborough does have a large transient working age population that is difficult to enrol.
Percentage of people in the district enrolled with a PHO - Marlborough	C	>98%	>98%	96%	93% approximately	**PARTIALLY ACHIEVED** The projected DHB population for July 2013 is 141,248. There are 97.6% of this figure enrolled with a PHO and 98.3% if the DHB owned service at Murchison is included. Although exact regional projections are difficult to determine it would appear that Nelson Bays Primary Health has enrolled over 99% of the population whereas Marlborough is around 93%. Since it has been a long time since the last census both figures may be misleading. However it is known that Marlborough does have a large transient working age population that is difficult to enrol.
Percentage of people with diabetes who have had Annual Reviews	V	72%	87.5%	N/A	73.82%	**NOT ACHIEVED** Kimi Hauora Wairau Marlborough PHO continues to have issues with incomplete datasets and data issues. This is in the process of being resolved.
Number of people enrolled in the Care Plus programme each quarter:	V	6,364	80% of available places	N/A	91% (7,476)	Achieved
Ambulatory Sensitive Hospitalisation rates for children age 0 – 4 are reduced – Total Population	Q *Ratio of actual to expected ASH hospitalisations. The expected rate is the national average and a ratio greater than 100 indicates performance worse than the national average. Baseline being established 2012/13*	95	<90	100	92%	**NOT ACHIEVED** Ambulatory Sensitive Hospitalisation rates for children age 0 – 4 were 2% higher than the 2012/13 target. Dental conditions continue to be high, at least in part due to unfluoridated Nelson water. Asthma, upper respiratory and ENT are also contributing to elevated rates.
Integrated patient pathways are established across primary/secondary care	V *Number of patient pathways localised through NMHA in 2012/13*	N/A	>100	N/A	152	**ACHIEVED** Completed Health Pathways are published on the Health Pathways website and use of the website has grown significantly over the past year with an increase of over 150% in use year on year. Feedback from GPs on the pathways continues to be positive, and there is increased use and engagement from secondary care clinicians. Development work continues to focus on clinical areas with high levels of patient demand such as orthopaedics examining increased opportunities for patients to be supported by primary care, encouraging more appropriate referrals to secondary services, and more integrated working across the whole health system.
Percentage of newborns enrolled with a PHO by four weeks	T	25%	95%	N/A	60%	**NOT ACHIEVED** While the target for new born enrolments of 95% was not achieved there has been an improvement in the number of newborns enrolling earlier with general practice from 25% in 2009/10 to 60 in 2012/13 since the introduction of the newborn enrolment form and process (In Nelson Bays in April 2012 and in Marlborough in November 2012). It is expected that the percentage of new born enrolments will increase in 2013/14.

OUTPUT CLASS: EARLY DETECTION AND MANAGEMENT

Output Subset: Oral Health Services

These services are provided by registered oral health professionals to assist people in maintaining healthy teeth and gums. High enrolments are indicative of engagement, while more timely examination and treatment indicates a well-functioning and efficient service. We are 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

We maintain utilisation of dental service for adolescents through maintaining access to services and ensuring dental service providers operate effective recall systems. We are improving access to dental services for low income adults.

Measures Quality (Q) – Quantity (V) – Coverage (C) – Timeliness (T)	Notes	Actual 2009/10	Target 2012/13	Current National Average	2012/13 Achieved	Comments on 2012/13 Performance
Number of children under five enrolled in DHB funded dental services	C	3,500	2012 – 5000 2013 – 5750	Not yet available	2012: 5054	**ACHIEVED** The latest data is for the 2012 calendar year.
Proportion of children caries free at 5 years of age – Maori	Q	61%	2012 – 70% 2013 – 70%	38% (2010)	2012: 40%	**NOT ACHIEVED** A new Model of Care was introduced in 2011 focusing on prevention and engaging whanau/caregivers in their children's oral health. The increase in the number of X-rays taken will initially show an increase in caries (hidden caries). However, with early prevention measures in place, e.g. 6-monthly fluoride applications for high risk patients and 12-monthly for low risk, we anticipate an improvement in the caries rate. We also expect improvements will flow from increasing whanau/caregivers awareness of their children's oral health through attendance at the appointments and through encouraging use of full strength fluoride toothpaste twice daily. The Oral Health Educator focuses on engaging with the Maori Community to increase awareness and enrolment. The latest data is for the 2012 calendar year.
Proportion of children caries free at 5 years of age – Total	Q	61%	2012 – 70% 2013 – 70%	57% (2010)	2012: 64	**NOT ACHIEVED** A new Model of Care was introduced as described above. Fluoridation of water supplies contributes to better oral health status, particularly for vulnerable populations. It is notable that although NMDHB district water supplies are not fluoridated, the caries and DMFT rates are relatively good here and are comparable with areas where there is fluoridated water. The latest data is for the 2012 calendar year.
Decayed, Missing, Filled, Teeth (DMFT) at year 8 (around age 12 years) – Maori	Q	1.16	2012 – 1:10 2013 – 1:10	1.89	2012: 1.23	**NOT ACHIEVED** A new Model of Care was introduced in 2011 focusing on prevention and engaging whanau/caregivers in their children's oral health. The increase in the number of X-rays taken will initially show an increase in caries (hidden caries). However, with early prevention measures in place, e.g. 6-monthly fluoride applications for high risk patients and 12-monthly for low risk, we anticipate an improvement in the caries rate. We also expect improvements will flow from increasing whanau/caregivers awareness of their children's oral health through attendance at the appointments and through encouraging use of full strength fluoride toothpaste twice daily. The Oral Health Educator focuses on engaging with the Maori Community to increase awareness and enrolment. The latest data is for the 2012 calendar year.
DMFT at year 8 (around age 12 years) – Total	Q	1.16	2012 – 1:10 2013 – 1:10	1.23	2012: 0.92	**ACHIEVED** The latest data is for the 2012 calendar year.

Measures Quality (Q) – Quantity (V) – Coverage (C) – Timeliness (T)	Notes	Actual 2009/10	Target 2012/13	Current National Average	2012/13 Achieved	Comments on 2012/13 Performance
Utilisation of adolescent oral health services	C	80.4%	2012 – 85% 2013 – 85%	National coverage has increased to 70.1% for 2012	2012/13: 85.2%	**ACHIEVED** Nelson Marlborough has consistently high coverage and in 2012 had the second highest coverage of all DHBs. We continue to encourage children's enrolment with the adolescent oral health service on transition to secondary school and work with dentists, schools and other youth providers to encourage utilisation. The latest data is for the 2012 calendar year.

OUTPUT CLASS: EARLY DETECTION AND MANAGEMENT

Output Subset: Primary and Community Programmes of Care

These services are targeted at people with high health need due to long-term conditions and aim to reduce deterioration, crises and complications. Success is demonstrated through identification of need, regular monitoring and outcomes that demonstrate successful management of conditions. A focus on early intervention strategies and additional services available in the community will help to reduce the need for hospital appointments. The services provide:

» community programmes that support keeping people well and address inequalities

» 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.

Measures Quality (Q) – Quantity (V) – Coverage (C) – Timeliness (T)	Notes	Actual 2009/10	Target 2012/13	Current National Average	2012/13 Achieved	Comments on 2012/13 Performance
Impacts are measured by maintaining our Ambulatory Sensitive Hospitalisation (ASH) indirectly standardised discharge ratio (ISDR) for asthma acute admissions per annum	V *Note: this relates to population 'other [0-74 years]'*	<100	<100	100	ASH rates ranged form 46% Maori 45 – 64 years to 131% Non-Maori 0 – 4 years (note the percentages for NMDHB are assessed against the national rates and therefore higher than 100%).	**NOT ACHIEVED** Rates are above the National Average by 15% for Maori and by 31% for Non-Maori. The ASH indirect standardised rates for children 0-4 years are: At March 2012 Maori 82.2, Other 81.5 At March 2013 Maori 68.1, Other 81.5.
Number of patients receiving asthma/COPD services – Nelson	V	443	443	N/A	362 unique individuals, 165 follow ups	**ACHIEVED** A resignation saw the service with only one Nurse Educator for a period of three months impacting on volumes. Volumes however are above expected numbers.
Number of patients receiving asthma/COPD services - Wairau	V	156	156	N/A	87	**NOT ACHIEVED** The number presented was to ensure at least 156 patients received asthma/COPD services. However in the course of the year a new pulmonary rehabilitation course has meant that patients that would otherwise have required this service have been receiving information that allows for self-management and support that has reduced the need for the provision of these services. This is a positive step that means we have had to redevelop the expectations of the asthma/COPD service in Wairau.
Number of patients receiving podiatry services - Nelson *Primary care delivery of podiatry only. Note that this is a community demand driven service.*	V	2,475	2475	N/A	2431	**PARTIALLY ACHIEVED** The target was under by 44 or 1.7%. Did not attends were an issue earlier in the period, but a DNA policy is now limiting the impact.
Number of patients receiving podiatry services - Wairau	V	1,526	1526	N/A	1009	**NOT ACHIEVED** A streamlining of the referral process has allowed for demand for the service to be met and allowed the resultant podiatry time to be used for working with a specialist nurse, assistance to Diabetes Marlborough and educational sessions for nurses.

OUTPUT CLASS: EARLY DETECTION AND MANAGEMENT

Output Subset: Pharmacy Services

These services include provision and dispensing of medicines and are demand-driven. As long-term conditions become more prevalent, we are likely to see an increased dispensing of pharmaceutical items. To improve service quality we will introduce medication management for people on multiple medications to reduce potential negative interactive effects. We are:

- implementing safe and effective pharmacy services across settings of care (hospital and community) assisted by the Rutherford Performance Programme.
- implementing the first phase of the new community pharmacy service model
- working with PHO and NMDHB hospital prescribers on chronic non-malignant pain pharmacological best practice approaches.

Measures Quality (Q) – Quantity (V) – Coverage (C) – Timeliness (T)	Notes	Actual 2009/10	Target 2012/13	Current National Average	2012/13 Achieved	Comments on 2012/13 Performance
Percentage of patients whose medicines are reconciled within 24 hours of admission, transfer or discharge	V,Q	15%	60%	N/A	27%	**NOT ACHIEVED** This is based on medicines reconciled within 24 hours for admissions.
Total number of dispensed items	V	1,782,771	1,854,738	N/A	2,125,134	**ACHIEVED** The increase in dispensed items is due to recent changes in implementing the Community Pharmacy Service Agreement. The trend of higher than forecast dispensed items is expected to moderate and reduce in future years as improved dispensing practices are put in place.
Percentage of pharmacies on new contract	V *On implementation of new National Pharmacy Service Agreement*	95%	100%	N/A	100%	**ACHIEVED**
Percentage of pharmacies offering new community pharmacist long-term condition service	C *On implementation of new National Pharmacy Service Agreement*	50%	100%	N/A	100%	**ACHIEVED**
Average number of adverse events (ADE) each quarter which may cause patient harm	Q	30	<20	N/A	-	Unable to report on this measure in 2012/13.The measure will be amended for future Statements of Service Performance.
Percentage reduction in community pharmaceutical costs	Q	0	<3%	N/A	2.7%	**ACHIEVED** This was 2.7% above budget which is under the target of keeping dispensing costs to less than a 3% increase for 2012/13. This was in part due to revised Pharmac rebate forecasting.

OUTPUT CLASS: EARLY DETECTION AND MANAGEMENT

Output Subset: Community Referred Testing and Diagnostics

These are services 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. To improve performance, we will target improved primary care access to imaging diagnostics to improve clinical referral processes and decision making.

We are further maximising utilisation of diagnostic tests and procedures to ensure early detection and diagnosis of a patient condition and to assist effective assessment and treatment of a patient condition under treatment.

Measures Quality (Q) – Quantity (V) – Coverage (C) – Timeliness (T)	Notes	Actual 2009/10	Target 2012/13	Current National Average	2012/13 Achieved	Comments on 2012/13 Performance
Number of medical laboratory diagnostic tests	V	1,610,213	1,610,213	N/A	1,245,666	**NOT ACHIEVED** A focus has been placed on improving laboratory data quality. Laboratory services are being delivered by a new provider who has been revising the test format. Improved data procedures have resulted in a decrease in test volumes due to changes in the method for counting the number of laboratory tests.
Number Medical Imaging examinations	V	90,446	90,446	N/A	89,305	**PARTIALLY ACHIEVED**
Number Cardiac procedures	V	N/A	960	N/A	1228	**ACHIEVED** NMDHB's cardiac intervention rates are in the top three highest rates in New Zealand.
Number of respiratory procedures	V	N/A	180	N/A	180	**ACHIEVED**
Number of Audiology procedures	V	3,949	4,400	N/A	2,630	**NOT ACHIEVED** NMDHB has had a review of the service as a result of resource issues and were able to determine that our service delivery was out of alignment with the Service Coverage Schedule and the Service Specifications. A re-alignment of our delivery was made to meet the policy and as a result there was a reduction of procedure volumes.
Percentage of facilities with TELARC accreditation where applicable	Q	100%	100%	N/A	100%	**ACHIEVED**
Percentage of urgent tests completed within 3 hours on receipt of sample at the lab	T	80%	90%	N/A	85%+	**PARTIALLY ACHIEVED**
Reduce the days for availability of histology results - community	T	5 days	4 days	N/A	91% within 4 days	**PARTIALLY ACHIEVED**
Reduce the days for availability of histology results – hospital	T	5 days	3 days	N/A	91% within 3 days	**PARTIALLY ACHIEVED**
Percentage of routine laboratory test results available to referrers within 48 hours from time of receipt	T	80%	85%	N/A	88%+	**ACHIEVED**
Percentage of Medical Imaging reports meeting 14-day-availability to referrer	T	100%	100%	N/A	95%	**PARTIALLY ACHIEVED**
Percentage of patients waiting time target for Medical Imaging procedures - urgent	T	Within 24 hours	Within 24 hours	N/A	100%	**ACHIEVED**
Percentage of patients waiting time target for Medical Imaging procedures – semi-urgent	T	Within 14 days	Within 14 days	N/A	100%	**ACHIEVED**
Percentage of patients waiting time target for Medical Imaging procedures - routine	T	14 days and above	14 days and above	N/A	100%	**ACHIEVED**

OUTPUT CLASS: EARLY DETECTION AND MANAGEMENT

Output Subset: Infection Control

These services:

- minimise and manage the infection risks by incorporating measures and interventions required to prevent pathogen transfer between patients, staff and visitors
- monitor and refine systems used to manage the infection risks within NMDHB as per NZS 8134:2008
- safeguard patients from developing infections due to, or resulting from medical interventions
- participate in three national programmes including hand hygiene, central line associated blood stream infections, surgical site infection reduction

Measures Quality (Q) – Quantity (V) – Coverage (C) – Timeliness (T)	Notes	Actual 2009/10	Target 2012/13	Current National Average	2012/13 Achieved	Comments on 2012/13 Performance
Number of norovirus, and/or methicillin resistant staphylococcus aureus outbreaks	Q	0	0	N/A	1	**NOT ACHIEVED** Gastroenteritis outbreak DSS involving 4 clients and 4 staff
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	Q	<1	<1	N/A	0	**ACHIEVED** No known clusters or episodes of cross-infection
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	Q	0	0	N/A	16	**NOT ACHIEVED** Laboratory now reporting positive blood cultures electronically, rather than (unreliable) manual reporting. Dialysis patients now included.
Percentage of wounds that develop symptoms, signs and microbiological evidence of infection within 30 days of selected clean surgical procedures	Q	<4%	<4%	N/A	1.4%	**ACHIEVED** Surveillance programme and methodology changed March 2013 in line with national SSI Surveillance Programme. Now limited to hip and knee arthroplasty only
Cross infections (including outbreaks)	Q	<1	<1	N/A	1	**NOT ACHIEVED**
Hospital-acquired blood stream infections	Q	0	0	N/A	16	**NOT ACHIEVED**
Percentage of wounds with infections developing within 30 days of selected clean surgical procedures	Q	<4%	<4%	N/A	1.4%	**ACHIEVED**

OUTPUT CLASS: EARLY DETECTION AND MANAGEMENT

Output Subset: Primary Mental Health

These services are targeted to those general practice patients with mild to moderate mental health problems/ symptomology. Target populations are Maori, Pacific and lower socio economic incomes. A range of services are provided including extended general practice consultations, packages of care, brief intervention clinical services and an anxiety disorder programme. Outcomes expected are improved access and flow through community, primary and specialist mental health services; and improved mental health wellbeing.

Measures Quality (Q) – Quantity (V) – Coverage (C) – Timeliness (T)	Notes	Actual 2009/10	Target 2012/13	Current National Average	2012/13 Achieved	Comments on 2012/13 Performance
Number of Extended General Practice Consultations and Packages of Care available.	V	922	933	N/A	There were 1567 packages of care delivered in 2012/13.	**ACHIEVED**
Average PHQ -9[12] reductions	Q	7 points	7.5 points	N/A	9.5 points	**ACHIEVED** The average PHQ-9 reduction across NBPH and Kimi Hauora Wairau Marlborough PHO was 9.5 points.

Measures Quality (Q) – Quantity (V) – Coverage (C) – Timeliness (T)	Notes	Actual 2009/10	Target 2012/13	Current National Average	2012/13 Achieved	Comments on 2012/13 Performance
Completion of the 'Continuum Response' model (stepped care) for mild to severe mental health problems.	Q		Implement SPOE (Primary and Specialist MH Services) and Specialist to NGO standardised referral form by June 2013	N/A	Standardised referral form implemented	**PARTIALLY ACHIEVED** SPOE commenced in Nelson in February 2013. Plan to extend to Wairau in 13/14 year. Streamlined referral form in place with Gateway Housing Trust. Further extension of this will continue as part of SPOE development.

Forecast Early Detection and Management Services Output Class Statement of Financial Performance

$000s	2012/2013 Actual	2012/2013 Plan	Variance
Revenue	112,258	111,214	1,044
Expenditure			
Personnel costs	19,477	20,967	1,490
Outsourced services	1,530	1,964	433
Clinical supplies	1,393	1,435	41
Infrastructure	5,969	6,158	189
Provider payments	80,429	79,081	(1,349)
Total expenditure	108,799	109,603	804
Net surplus/(loss)	**3,459**	**1,611**	**1,848**

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 will 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.

OUTPUT CLASS: INTENSIVE ASSESSMENT AND TREATMENT SERVICES

Output Subset: Inpatient Planned (A – Elective) and Unplanned (B – Acute) Services including Mental Health

A - These are services for people who do not need immediate hospital treatment and are 'booked' or 'arranged' services. This includes elective surgery, but also non-surgical interventions and specialist assessments.

B - These are services for illnesses that have an abrupt onset, are often of short duration and rapidly progressive, for which the need for care is urgent. Hospital based acute services include emergency departments, short-stay acute assessments and intensive care services. There are also a number of community-based acute demand programmes and packages of care unique to Nelson Marlborough, established to reduce acute demand.

A - Patient Safety	Notes	Estimated 2011/12	Target 2012/13	Current National Average	2012/13 Achieved	Comments on 2012/13 Performance
Recommendations on NMDHB Serious and Sentinel Events 2010/11 are implemented within agreed timeframes	Q	100%	100%	N/A	100%	**ACHIEVED** An audit on implementation of sentinel events in 2013 for the period 1 July 2011 to 30 October 2012 confirms that recommendations have been actioned.
Patient Complaints: Number of complaints to NMDHB for the 12 months 1 July to 30 June:	Q	310	314	N/A	358	**ACHIEVED** An increase in complaints over this period should not necessarily be viewed as negative. NMDHB encourages patients and their whanau to raise concerns in order to improve the quality of services provided.

Complaints to NMDHB closed within 20 working days:	T	100%	100%	N/A	87%	**NOT ACHIEVED** NMDHB endeavours to respond to complaints within 20 working days. Responding within this timeframe is often reliant on staff availability and the increasing complexity of some complaints.
Health and Disability Commissioner complaints that results in a finding of breach of the Code of Rights	Q	0	1	N/A	1	**ACHIEVED** Breach related to a complaint dating back to 2009.
B – Scheduled Services (Inpatients and Outpatients)	**Notes**	**Estimated 2011/12**	**Target 2012/13**	**Current National Average**	**2012/13 Achieved**	**Comments on 2012/13 Performance**
Total elective caseweight (CWD) discharges provided	V *These elective surgery cwd volumes include elective cardiology and dental*	8,430	8,430 *Total CWDs as per internal DHB production plan*	N/A	9,092	**ACHIEVED**
Total number of elective surgical discharges provided	V	6,029	6,029 *There has not been an increase in elective surgery discharges in 2012/13 as NMDHB has been delivering at a level well above the standard discharge ratios for other DHBs when compared to per head of population*		6,054	**ACHIEVED**
Elective and arranged surgery is undertaken on a day case basis	Q *This measure is based on OS6 – Elective and arranged day surgery rate*	58.6%	60.5%	56%	66.97%	**ACHIEVED**
People receive their elective and arranged surgery on the day of admission	Q *This measure is based on OS7 – Elective and arranged day of surgery admission rate*	97%	97%	80%	96.4%	**PARTIALLY ACHIEVED** Performance in 2012/13 was 0.6% lower than the target.
Average elective and arranged inpatient length of stay (days) is maintained	Q *This measure is based on OS3 – Elective and arranged inpatient length of stay*	3.60	3.60	4.9	2.84	**ACHIEVED** NMDHB continues to place priority on achieving the target for elective and arranged inpatient length of stay. A positive result was achieved as our actual performance was lower than the target.
Total number of surgical First Assessments (FSA) provided	V *This measure is for DHB of Service and includes FSAs done for patient from outside of NMDHB*	22,426	21,856	N/A	22,182	**ACHIEVED**
ESPI overall flow indicators are met	T	100%	100%	N/A	100%	**ACHIEVED** Confirmed in MoH June 2013 report
C- Unscheduled Services (Inpatients and Outpatients)	**Notes**	**Estimated 2011/12**	**Target 2012/13**	**Current National Average**		
Total number of people presenting at hospital Emergency Departments (ED)	V	46,640	<46,000	N/A	45,419	**ACHIEVED**
People are assessed, treated or discharged from ED under six hours	T	95%	95%	N/A	96.53	**ACHIEVED**
GP practices provide patients access to telephone triage outside business hours	C	100%	100%	N/A	100%	**ACHIEVED**
Total acute inpatient average length of stay (days) is maintained	Q *This measure is based on OS4 – Acute inpatient length of stay*	3.44	3.44	4.09	3.48	**PARTIALLY ACHIEVED**

People receive radiation oncology treatment within 4 weeks of decision to treat	T	100%	100%	N/A	100%	**ACHIEVED** All patients were treated within required timeframes.
People receive medical oncology treatment within 4 weeks of decision to treat	T	100%	100%	N/A	90%	**PARTIALLY ACHIEVED** The outstanding 10% waited over 4 weeks due to clinical considerations.
Acute readmissions rate to hospital	Q *This measure is based on OS8 – Acute readmissions to hospital and is the standardised acute readmission rate for unplanned acute readmissions to hospital within 28 days of discharge*	9.11%	9.24%	N/A	9.74%	**NOT ACHIEVED**
Acute readmissions rate to hospital (over 65 years)	Q *This is a new measure for 2012/13 and is based on unstandardised data. NMDHB would like to set this target for 2013/14 on standardised data.*	11.55%	10.5%	N/A	9.74%	**NOT ACHIEVED** NMDHB has readmission rates that are in the bottom quartile of all DHBs. NMDHB is implementing a number of quality initiatives to reduce acute readmissions including Enhanced Recovery After Surgery, Pre operative and Intra-operative quality targets continue to be met overall. This target was later amended to 9.24% by the Ministry of Health.
Acute readmissions rate to hospital (over 75 years)	Q *This is a new measure for 2012/13 and is based on unstandardised data. NMDHB would like to set this target for 2013/14 on standardised data.*	12.37%	11.5%	N/A	13.69%	**NOT ACHIEVED** This target was later amended to 13.4% by the Ministry of Health.

OUTPUT CLASS: INTENSIVE ASSESSMENT AND TREATMENT

Output Subset: Maternity Services

These services are 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 will monitor volumes in this area to determine access and responsiveness of services.

Measures Quality (Q) – Quantity (V) – Coverage (C) – Timeliness (T)	Notes	Actual 2009/10	Target 2012/13	Current National Average	2012/13 Achieved	Comments on 2012/13 Performance
Total number of maternity deliveries in the NMDHB district	V *Number is approximate and includes births in primary maternity facilities*	1600	≥1600	N/A	1413	**ACHIEVEMENT IS DEMAND DRIVEN** NMDHB births in facilities (includes 8 from Golden Bay hospital and 56 from Motueka; excludes home births)
Proportion of total deliveries, made in primary birthing units	Q *Approximately 100 births per annum occur in Golden Bay and Motueka facilities*	6.2%	≥6.2%	N/A	4.3%	**NOT ACHIEVED**
Average post natal length of stay (days) is maintained	V *NMDHB offers longer stays for women who have a clinical need.*	3.00	3.00	N/A	2.02	**NOT ACHIEVED** This is the data for 2012/13 for Nelson Hospital only. Wairau Hospital combines antenatal admissions and post natal stays. In 2013/14 NMDHB will report post natal stay data for Nelson and Wairau Hospitals.
Caesarean rate	Q	28%	28%	N/A	29.4%	**NOT ACHIEVED** The Caesarean rate is just 1.4% above target, and is determined by clinical need.
Exclusive breast feeding at discharge from facility	Q	85.1%	86%	N/A	80% Nelson 90% Wairau. Combined rate is approximately 84%	**PARTIALLY ACHIEVED** Both maternity units are baby-friendly accredited and breastfeeding is encouraged and supported by all staff and Lead Maternity Carers as well as by specialist Lactation Consultant services when required.

Measures Quality (Q) – Quantity (V) – Coverage (C) – Timeliness (T)	Notes	Actual 2009/10	Target 2012/13	Current National Average	2012/13 Achieved	Comments on 2012/13 Performance
Neonatal inpatients DRGs	V *Volume growth here indicates NMDHB is growing capacity to help both local and national cases to support reduced infant mortality*	416	430	N/A	417	**ACHIEVEMENT IS DEMAND DRIVEN**
Perinatal infant mortality rate (per 1,000 births)	Q *Measure based on Perinatal and Maternal Mortality Review Committee (PMMRC) published data – baseline is 2009 at 7.79/1,000*	7.79	<7.79	10.6	6.03 (2011) 8.07 (2007-2011)	**ACHIEVED** These are the latest results for perinatal infant mortality.
Maternal mortality rate (per 100,000 maternities)	Q29 *Measure based on PMMRC published data – (pregnant up to 42 days post-birth or termination of pregnancy) – baseline is 19.2/100,000 over 2006-9 period*	0	0	19.2	0	**ACHIEVED**

OUTPUT CLASS: INTENSIVE ASSESSMENT AND TREATMENT

Output Subset: Assessment Treatment and Rehabilitation

These are services provided to restore functional ability and enable people 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 environments (where appropriate), is indicative of the responsiveness of services.

Establish a comprehensive Specialist Health Service for Older People (SHSOP) team, which consists of health professionals with geriatric and psycho-geriatric expertise, and which will use documented links and pathways with acute mental health, acute medical and surgical services and community providers who have an older persons' client base. The SHSOP service has inpatient as well as community teams.

Measures Quality (Q) – Quantity (V) – Coverage (C) – Timeliness (T)	Notes	Actual 2009/10	Target 2012/13	Current National Average	2012/13 Achieved	Comments on 2012/13 Performance
Total number of people (65+) accessing inpatient AT&R services	V	8,982	8,982 bed days	N/A	9,489 bed days , 654 inpatient discharges	**ACHIEVED**
Attendances/Visits	V	10,455	10,455	N/A	5,871	**NOT ACHIEVED** The target of 10,445 was over estimated and should have been revised to 7,942. The target for this measure will be reviewed.
Number of community events that have community rehabilitation directed/delivered by AT&R	V	2,064	2,064	N/A	3,186	**ACHIEVED**
Proportion of admissions into AT&R made by direct community referral	Q	80 cases,12.4%	26% *Based on 385 admissions*	N/A	50, 13%	**NOT ACHIEVED** This includes those cases admitted first to another ward before being moved to ATR. This target will be revised.
AT&R patients (65+) are discharged into their own homes (not into ARRC)	Q	377, 62.2%	64%	N/A	369	**PARTIALLY ACHIEVED** 369 (56%), Patients over 65 years were discharged to their own homes from Nelson and Wairau against the target of 377.
Maintaining Bed Days Inpatient Geriatric ATR	V	5,955	7,906	N/A	7,261	**PARTIALLY ACHIEVED**
Maintaining Bed Days Inpatient MH-ATR	V	2,555	2,555	N/A	3,136	**ACHIEVED** Continue to experience high demand for this service.

Measures Quality (Q) – Quantity (V) – Coverage (C) – Timeliness (T)	Notes	Actual 2009/10	Target 2012/13	Current National Average	2012/13 Achieved	Comments on 2012/13 Performance
Number of community events that have community rehabilitation directed or delivered by Geriatric ATR	C	6,703	8,598	N/A	1,514	**NOT ACHIEVED** The target of 8,598 was over estimated and should have been revised to a lower figure. The target for this measure will be reviewed.
Number of community events that have community rehabilitation directed or delivered by MH-ATR	C	2,957	2,957	N/A	3,101	**ACHIEVED** Initiatives are planned to explore options for capturing more detailed information around community activities, potentially aligning to Mental Health data capture.

Forecast Intensive Assessment and Treatment Services Output Class Statement of Financial Performance

$000s	2012/2013 Actual	2012/2013 Plan	Variance
Revenue	213,903	211,233	2,671
Expenditure			
Personnel costs	108,548	108,381	(167)
Outsourced services	8,879	6,580	(2,299)
Clinical supplies	30,715	28,339	(2,376)
Infrastructure	32,091	31,839	(252)
Provider payments	38,942	36,504	(2,438)
Total expenditure	219,176	211,643	(7,533)
Net surplus/(loss)	**(5,273)**	**(410)**	**(4,862)**

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 NMDHB uses the InterRAI (International Residential Assessment Instrument) tool to ensure people receive support services that best meet their needs and, where possible, support them to regain maximum functional independence.

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 DHB will target an increase in the number of sites that support the 'Liverpool Care of the Dying' pathway 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.

OUTPUT CLASS: REHABILITATION AND SUPPORT SERVICES

Output Subset: Palliative Care Services

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 support services

» ensure people have timely access to quality, culturally appropriate palliative care services

» co-ordinate care across hospital, community and support services

» implement the 'Liverpool Care Pathway' for palliative care services

» deliver a responsive system that supports a person's choice to die at home.

Measures Quality (Q) – Quantity (V) – Coverage (C) – Timeliness (T)	Notes	Actual 2009/10	Target 2012/13	Current National Average	2012/13 Achieved	Comments on 2012/13 Performance
Number of hospice/palliative care patients receiving service delivered according to the service specification (national services framework)	V,T	451	461	N/A	458	**ACHIEVED** The expected number of patients in Nelson Marlborough received hospice care in 2012/13.
Average quarterly total of palliative care patient consultations	V	480	490	N/A	502	**ACHIEVED** There is a mix of medical and nursing consultations.
Percentage of provider settings delivering a Liverpool care pathway model of care	Q	70%	>75%	N/A	81%	**ACHIEVED**

OUTPUT CLASS: REHABILITATION AND SUPPORT SERVICES

Output Subset: Needs Assessment & Support Services – NASC, Age Residential Care, Respite, Carer Support, Day Programmes & Home Based Support, Intellectual Disability Support Services

InterRAI ensures that older people, who have an assessed need, receive support services in their homes whenever possible. NMDHB uses:

- » regionally agreed service specifications for HBSS
- » regionally agreed eligibility criteria and standardised approach to access
- » locally agreed and expanded options for respite and day programmes for older people and their family/carers.

Measures Quality (Q) – Quantity (V) – Coverage (C) – Timeliness (T)	Notes	Actual 2009/10	Target 2012/13	Current National Average	2012/13 Achieved	Comments on 2012/13 Performance
The percentage of older people living in ARRC	C	7.4%	7.0%	N/A	7.0%	**ACHIEVED**
Total number of InterRAI first assessment	Q, V	620	750	N/A	752	**ACHIEVED**
Total number of InterRAI reassessments *Includes LTC-CHC & Residential with paper tool*	Q, V	1,304	1,700	N/A	2,123	**ACHIEVED**
Total number of service co-ordination events	V	8,683	8,900	N/A	8,682	**PARTIALLY ACHIEVED**
Total number of Respite care bed days - allocated/used *total allocation (is different to what is utilised).*	V	5,268/2,796	5,428	N/A	4,825 days allocated, 2,581days used	**NOT ACHIEVED**
Total number of Respite care bed days – Carer Support Days – allocated/used	V	5,363/4,716	5,930/5,000	N/A	6,399 Respite care bed days, 4,811 Carer Support Days	**PARTIALLY ACHIEVED**
In-home respite support	V	Nil service	590 days	N/A	47 days	**NOT ACHIEVED** The low number of in-home respite days was due to difficulties in locating qualified providersdespite advertising for suitable providers on a number of occasions.
Total number of Day Programme days	V	12,355	16,956	N/A	17,967 days allocated, 13,469 used	**ACHIEVED**
Total number of funded ARRC bed nights *Note: 4.5% increase in utilisation for population growth, exclusive of transfers from Canterbury due to the earthquake*	V	346,718	378,570	N/A	362,683	**PARTIALLY ACHIEVED**
Client satisfaction on survey: high level of satisfaction with NASC service (measured by a client satisfaction rating above 95%)	Q	96%	97%	N/A	97%	**ACHIEVED**
NASC response time to assessment	T	87% within 20 days	90% within 20 days	N/A	87.8%	**PARTIALLY ACHIEVED**
The number of rest home new admissions *The number of rest home new admissions*	V	192	192	N/A	353	**ACHIEVED** The target originally set of 192 for 2012/13 is incorrect and should have been 343 which is the number of rest home admissions last financial year.
Total number of clients receiving home based support *Excludes short term & Meals on Wheels. Does include Continuing Care*	Q,V	2,599 (2010)	2,750	N/A	2,614	**PARTIALLY ACHIEVED**
Total number of clients receiving home based support with moderate & high complex needs	Q,V	425 (2010)	445	N/A	996	**ACHIEVED**
Total number of clients receiving home based support with very high & complex needs	Q,V	76 (2010)	80	N/A	25	**NOT ACHIEVED**

OUTPUT CLASS: REHABILITATION AND SUPPORT

Output Subset: Community Support Services – Mental Health

These services are targeted to improve service user recovery. Accessing specialist mental health and addiction services early prevents deterioration in mental health.

<table>
<tr><th>Measures Quality (Q) – Quantity (V) – Coverage (C) – Timeliness (T)</th><th>Notes</th><th>Actual 2009/10</th><th>Target 2012/13</th><th>Current National Average</th><th>2012/13 Achieved</th><th>Comments on 2012/13 Performance</th></tr>
<tr><td>Youth Addictions Forensic position established in Wairau Aug 12</td><td>C</td><td>Nil</td><td>50 Youth Addictions Referrals</td><td>N/A</td><td>82</td><td>ACHIEVED
Good volume of referrals accessing service.</td></tr>
<tr><td>Increase in improvement in National Consumer Satisfaction Survey (Q20 – Overall Service Satisfaction)</td><td>Q</td><td>83.7%</td><td>85%</td><td>81.3%</td><td>79.9%</td><td>NOT ACHIEVED</td></tr>
<tr><td>Mental Health Access Rates</td><td>V</td><td></td><td>Mental Health Provider Arm
<table>
<tr><th></th><th><= 3 weeks</th><th><= 3 weeks</th><th><=8 weeks</th><th><=8 weeks</th></tr>
<tr><td>Age</td><td>Proposed target (%)</td><td>Q4 Actual (%)</td><td>Proposed target (%)</td><td>Q4 Actual (%)</td></tr>
<tr><td>0-19</td><td>60%</td><td>59.9%</td><td>75%</td><td>88.7%</td></tr>
<tr><td>20-64</td><td>60%</td><td>64.8%</td><td>75%</td><td>90.4%</td></tr>
<tr><td>65+</td><td>60%</td><td>75%</td><td>75%</td><td>89.3%</td></tr>
<tr><td>Total</td><td>60%</td><td>63.2%</td><td>75%</td><td>89.6%</td></tr>
</table>
Addictions (Provider Arm and NGO)
<table>
<tr><th></th><th><= 3 weeks</th><th><= 3 weeks</th><th><=8 weeks</th><th><=8 weeks</th></tr>
<tr><td>Age</td><td>Proposed target (%)</td><td>Q4 Actual (%)</td><td>Proposed target (%)</td><td>Q4 Actual (%)</td></tr>
<tr><td>0-19</td><td>60%</td><td>73.2%</td><td>75%</td><td>89.6%</td></tr>
<tr><td>20-64</td><td>60%</td><td>62.8%</td><td>75%</td><td>91%</td></tr>
<tr><td>65+</td><td>60%</td><td>92.3%</td><td>75%</td><td>100%</td></tr>
<tr><td>Total</td><td>60%</td><td>73.1%</td><td>75%</td><td>91.1%</td></tr>
</table></td><td></td><td>Actual data in table to the left</td><td>ACHIEVED
There are still issues with how this report is calculating this data, particularly in the CAMHS area. These issues have been communicated to the Ministry by NMDHB and other DHBs.</td></tr>
<tr><td>NMDHB will benchmark its performance with DHBs nationally. The National Mental Health KPI Project is currently being rolled out across the country and data/definitions are still being tested. NMDHB will continue to participate in this process, and report on these measures once data is stabilised.</td><td>Q</td><td colspan="3">
<table>
<tr><th>KPI</th><th>NMDHB 2007/08</th><th>NMDHB 2008/09</th><th>NMDHB 2009/10</th><th>NMDHB 2010/11</th><th>NMDHB 2011/12</th><th>National 2008/9 test average</th></tr>
<tr><td>KPI 2 – 28 day acute inpatient readmission rate</td><td>16%</td><td>14%</td><td>22%</td><td>17%</td><td>23%</td><td>12%</td></tr>
<tr><td>KPI 8 – Average length of acute inpatient stay</td><td>18 days</td><td>14 days</td><td>13 days</td><td>14 days</td><td>13 days</td><td>22 days</td></tr>
<tr><td>KPI 10 – Weekly community treatment is per clinical FTE</td><td>12</td><td>12</td><td>13</td><td>13</td><td>13</td><td>12</td></tr>
<tr><td>KPI 12 – Community treatment days per service user</td><td>10</td><td>9</td><td>10</td><td>11</td><td>9</td><td>8.5</td></tr>
<tr><td>KPI 16 – NGO services investment</td><td>31%</td><td>29%</td><td>27%</td><td>25%</td><td>26%</td><td>27%</td></tr>
<tr><td>KPI 18 – Pre-admission community care</td><td>59%</td><td>61%</td><td>70%</td><td>68%</td><td>55%</td><td>56%</td></tr>
<tr><td>KPI 19 – Post-discharge community care</td><td>69%</td><td>70%</td><td>63%</td><td>68%</td><td>53%</td><td>66%</td></tr>
<tr><td>KPI28 – Total staff turnover</td><td>12%</td><td>8%</td><td>9%</td><td>8%</td><td>9%</td><td>12%</td></tr>
<tr><td>KPI 29 – Sick leave usage</td><td>4%</td><td>3.5%</td><td>3.3%</td><td>3.6</td><td>3.3%</td><td>3.3%</td></tr>
</table>
National KPI project includes Adult Services only (excludes CAMHS, Addictions, Forensic Services)</td><td>ACHIEVED</td></tr>
</table>

Forecast Support Services Output Class Statement of Financial Performance

$000s	2012/2013 Actual	2012/2013 Plan	Variance
Revenue	86,711	86,427	284
Expenditure			
Personnel costs	21,447	21,283	(164)
Outsourced services	1,262	1,168	(94)
Clinical supplies	2,995	3,009	15
Infrastructure	5,392	5,805	413
Provider payments	57,925	57,259	(666)
Total expenditure	89,020	88,525	(496)
Net surplus/(loss)	**(2,310)**	**(2,098)**	**(212)**

Registrations of Interest - Board Members

Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
Jenny Black (Chair)	Life member of Diabetes NZ. Chair of South Island Alliance Board			
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 employed by NMDHB as house surgeon at Wairau Hospital Son is a member of NZ Medical Council Disability Funding from ACC		Family member Self	
Gerald Hope		Executive Officer Marlborough Research Centre Director Maryport Investments Ltd	Landlord to Hills Laboratory Services Blenheim	
Gordon Currie	Member NZ Board 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 Shareholder, 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) Director, NZ Operations Press Ganey Pty Ltd (PG) Principal consultant at Mana Consulting Ltd Project Manager for Maori Providers Coalition	Board Member of Ngati Koata Trust Sister is a Senior Performance Auditor at the Office of Auditor-General	TRM contracts for services to NMDHB 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	

As at 11 June 2013

Registrations of Interest - Executive Leadership Team

Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
MEDICAL SURGICAL SERVICES DIRECTORATE				
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			
Hilary Exton	Nil			
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			

Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
CORPORATE SUPPORT				
Nick Lanigan		Partner works for NMDHB		
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 Independent Appointed Director St John Priory 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.	
DONM				
Robyn Henderson	Nil		Nil	
CMO				
Heather McPherson	Nil			
DMH & WHANAU ORA				
Harold Wereta	Ngati Toarangatira Connections		Tribal Interest	
CHIEF EXECUTIVE'S OFFICE				
Chris Fleming	Director of Health Benefits Limited Lead Chief Executive Health of Older People Services workstream for South Island DHBs Lead Chief Executive Health of Older People Services workstream nationwide DHBs Chair of South Island Alliance Leadership Team Trustee of Churchill Trust Trustee of NMHCT			
Keith Rusholme	Wife is a provider of complementary health services		Possible provision of services to DHB staff	Sister works for DSS.
Mike Cummins	Wife works for medical practice Trustee of Golden Bay Community Health Te Hauora o Mohua Trust		Board appointed representative	

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

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