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TE WAIORA Nelson Marlborough Health

Annual Report 2016/17

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Preface: A note about our name

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

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

The second half of this report, from page 27, includes the financial and non-financial performance reporting that is subject to audit and features our full legal name as 'Nelson Marlborough District Health Board (NMDHB)'.

Report from the Board Chair and Chief Executive

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

Overview

Health services around New Zealand, and around the world, are grappling with the challenges of an ageing population, rising demand for services and rising costs and Nelson Marlborough Health (NMH) is no exception.

Over this past year our hospital teams have delivered approximately 18,000 first specialist appointments, 36,000 follow-up appointments, 11,000 theatre operations, 16,000 procedures and we have seen more than 46,000 people present to our emergency departments. Over this last year Nelson Hospital has faced increasing pressure on bed capacity highlighting how crucial it is we progress in building a new hospital. This coming year will be key to shaping the models of care that will underpin our future healthcare delivery and help determine the design requirements of a new hospital.

As well as our hospital services, Nelson GPs completed nearly 295,000 consultations and Wairau GPs delivered 140,000 consultations. On top of this there were also nearly 95,000 nurse-led consultations for the year.

We have continued to focus on reducing the number of lower acuity (triage 4 and 5) presentations to the emergency department at Wairau Hospital. In 2016-17 there were 33 per cent less triage 4 and 5 presentations than in the year before and this work continues. As part of the ongoing strategy we are working with Marlborough Primary Health (Kimi Hauora Wairau) and Marlborough GPs to establish and run a primary urgent care service from a facility located near to Wairau Hospital's emergency department. The service will be open from 8am to 8pm daily and will assist with some of the capacity issues within primary care in Marlborough and the workload in the emergency department.

We have developed our Primary and Community Health Strategy, and as we move into the coming year our focus is to improve access and health outcomes for our most vulnerable people. We have embarked on transformative initiatives in our mental health services with the goal of providing greater support for those with mild to moderate mental health conditions.

We have invested significantly in our IT platforms. With Health Connect South we have connected our clinical teams to approximately 1 million health records across the South Island, and with the roll out of HealthOne our community and hospital teams will have access to shared records. In the 2017/18 financial year we look forward to a new patient management system, the digitisation of our medical records and the introduction of PatientTrack.

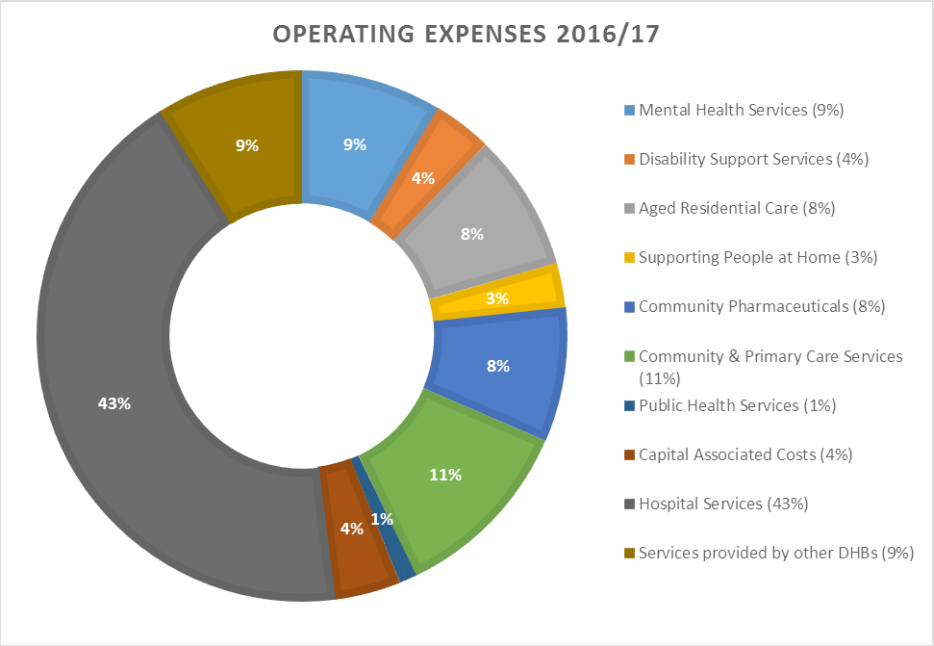
One of our most important gains over the last year was the strengthening of our clinical governance and quality teams and the formation of our Consumer Council. We can be proud of the way our teams are committed to delivering the best care they can, and enhancing the patient experience.

Financial performance

For the 2016/17 year we are reporting an operational surplus of $3.2 million. Although this is lower than our planned $4.0 million surplus, due mostly to the unexpected events of the Kaikoura earthquake and resident medical officer strikes, we remain one of the best financially-performing district health boards. This surplus represents a return on revenue of 0.7 per cent.

Planning and achieving a surplus allows us to plan for more investments into improved or new health services for the people in our community as well as providing a solid foundation for the rebuild of Nelson Hospital in the next few years.

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



Acknowledgements

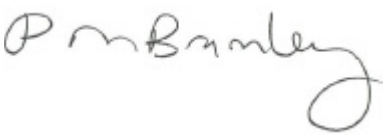
The triennial DHB elections were held in October 2016. While we were delighted to welcome three new members to the Nelson Marlborough District Health Board (the board) – Craig Dennis, Allan Panting and Stephen Vallance – we also farewelled two board members, Jessica Bagge and Pat Heaphy.

We would like to acknowledge Chris Fleming who resigned as chief executive in February to take up the role of chief executive at Southern DHB. We thank Chris for his leadership and commitment in the four years he was at NMH and wish him every success in his new role.

Peter Bramley was appointed chief executive in March 2017 after seven years as a general manager of clinical services.

Finally we would like to express our sincere thanks and gratitude to our board, executive leadership team, staff and volunteers who give so much every day and without whom, our story of growth, resilience and success would not be possible.

Jenny Black
Board Chair



Peter Bramley
Chief Executive

A day in the life of Nelson Marlborough Health

As at July 2017

Governance report

Board objectives and functions

- The Nelson Marlborough District Health Board, known by its trading name as Nelson Marlborough Health, (NMH) was established pursuant to section 19 of the *New Zealand Public Health and Disability Act 2000*. NMH is a Crown entity and is subject to the provisions of the *Crown Entities Act 2004*.
- The objectives of NMH are:
- to improve, promote, and protect the health of people and communities
- to promote the integration of health services, especially primary and secondary health services
- to seek the optimum arrangement for the most effective and efficient delivery of health services in order to meet local, regional, and national needs
- to promote effective care or support for those in need of personal health services or disability support services
- to promote the inclusion and participation in society and independence of people with disabilities
- to reduce health disparities by improving health outcomes for Māori and other population groups
- to reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders
- to exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges the provision of, services
- to foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services
- to uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations
- to exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations
- to be a good employer.

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

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

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

Accountability and communication

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

Board structure and membership

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

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

Accordingly, there are four committees:

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

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

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

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

Members of the Nelson Marlborough District Health Board at 30 June 2017 were:

Name	Appointment	
Jenny Margery Black	Elected *1	Chair
Alan Hinton	Appointed *2	Deputy Chair Chair, Audit & Risk Committee
Gerald Hope	Elected *1	Chair, Hospital Advisory Committee
Patrick Smith	Appointed *2	Chair, Community and Public Health and Disability Support Advisory Committees
Jenny Margaret Black	Elected *1	
Judy Crowe	Elected *1	
Craig Dennis	Appointed *4	
Brigid Forrest	Elected *1	
Dawn McConnell	Appointed *2	
Alan Panting	Elected *3	
Stephen Vallance	Elected *3	

*1 Board Members elected in October 2013 and were re-elected in October 2016.

*2 Board Members appointed during previous term and were reappointed following the October 2016 elections.

*3 Board Members elected in October 2016.

*4 Board Members appointed following the October 2016 elections.

Jessica Bagge and Pat Heaphy were elected (from the October 2013 elections) members of the Board until December 2016.

Board and committee attendance

The Nelson Marlborough District Health Board (the board) meets on a monthly basis. The board holds extra meetings when required for strategic planning or other specific issues. Attendance at board and committee meetings during 2016/17 was as follows:

Board members

Board Member	Board		CPHAC/DSAC		HAC		A&RC	
Name	Held	Attended	Held	Attended	Held	Attended	Held	Attended
Jenny Margery Black	11	11	4	4	3	3	4	4
Alan Hinton	11	11	2	2	3	3	4	4
Gerald Hope	11	9	3	1	3	3	4	3
Patrick Smith	11	11	4	4	2	2		
Jenny Margaret Black	11	10	4	4	2	2		
Judy Crowe	11	11	4	4	2	2		
Craig Dennis	6	6	2	2	2	2	2	2
Brigid Forrest	11	9	4	4	2	2	4	4
Dawn McConnell	11	11	2	1	3	3		
Alan Panting	6	6	2	2	2	2		
Stephen Vallance	6	5	2	2	2	1		
Jessica Bagge	5	4			1	1		
Pat Heaphy	5	3	2	1				

Non-Board committee members

Board Member	CPHAC/DSAC		HAC		A&RC	
Name	Held	Attended	Held	Attended	Held	Attended
Jenni Gane	2	1				
Glenys MacLellan	2	2				
Judith Holmes	2	2				
Dana Wensley	0	0	1			
Patricia O'Brien	0	0	1			
Luke Katu (IHB)	2	1	1	1		
Sonny Alesana (IHB)	1	1				
Dave Ashcroft					4	4

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

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

Board and committee fees

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

	Actual 2017 $000	Actual 2016 $000
Value of Board member remuneration		
Jennifer Margery Black (Chairperson)	41	44
Russell Wilson	-	19
Jessica Bagge	9	21
Jenifer Margaret Black	20	22
Judy Crowe	20	21
Brigid Forrest	21	21
Patrick Heaphy	9	21
Alan Hinton	25	25
Gerald Hope	20	22
Dawn McConnell	20	24
Patrick Smith	20	23
Allan Panting	11	-
Stephen Vallance	11	-
Craig Dennis	11	-
Total remuneration	**238**	**263**

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

	Actual 2017 $000	Actual 2016 $000
Hospital Advisory Committee		
Patricia O'Brien	-	1
Dana Wensley	-	2
Total remuneration	-	**3**
Community and Public Health Advisory Committee /Disability Support Advisory Committee		
Sonny Alesana	2	2
Jennifer Gane	-	1
Judith Holmes	1	2
Hughes Katu	3	3
Total remuneration	**6**	**8**

Board register of interests

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

The following interests were declared as at 30 June 2017:

Board members

Name	Interest
Jenny Margery Black *(Chair)*	▪ Chair, South Island Alliance Board ▪ Chair, National DHB Chairs group ▪ Chair of West Coast DHB ▪ Member of West Coast Partnership Group
Alan Hinton *(Deputy Chair)*	▪ Trustee, Richmond Rotary Charitable Trust ▪ Trustee, Natureland Wildlife Trust ▪ Trustee, Garin College Education Trust ▪ Trustee, Nelson Christian Trust ▪ Director, Solutions Plus Tasman Ltd ▪ General Manager, Azwood Ltd ▪ Secretary, McKee Charitable Trust
Judy Crowe	▪ Co Convenor of Educate Don't Fluoridate ▪ Friend is owner of Electric Bike Hub NZ
Gerald Hope	▪ Chief Executive, Marlborough Research Centre ▪ Director, Maryport Investments Ltd ▪ CE at MRC landlord to Hill laboratory services Blenheim ▪ Councillor Marlborough District Council (Wairau Awatere Ward)
Jenny Margaret Black (Marlborough)	▪ ACP Practitioner
Brigid Forrest	▪ Doctor, Hospice Marlborough (employed by Salvation Army) ▪ Locum GP in Marlborough (not a member of PHO) ▪ Member, South Island Alliance Palliative Care Workstream ▪ Daughter's partner owns a house rented by DSS ▪ Daughter-in-law employed by Nelson Bays Primary Health as a Community Dietician. ▪ Small Shareholder and Director on the Board of Marlborough Vintners Hotel
Dawn McConnell	▪ Director, To Hauora O Ngati Rarua ▪ Trustee, Waikawa Marae ▪ Regional Iwi representative, Department of Internal Affairs
Patrick Smith	▪ Managing Director, Patrick Smith HR Ltd ▪ Member, Nelson Tasman Chamber of Commerce

Name	Interest
Craig Dennis	▪ Trustee of Nelson Region Hospice Investment Trust ▪ Partner of CFO on Call ▪ Business consultancy Director of CD & Associates ▪ Business consultancy Director of Scott Syndicate Development Company Ltd ▪ Property Developer Director of 295 Trafalgar Street Ltd ▪ Director of KHC Dennis Enterprises Ltd ▪ Chair of Progress Nelson Tasman
Stephen Vallance	▪ Chairman, Marlborough Centre of the Cancer Society ▪ Chairman, Crossroads Trust Marlborough
Allan Panting	▪ Chair Orthopaedic Prioritisation Working Group ▪ Chair General Surgery Prioritisation Working Group ▪ Chair Vascular Services Tier Two Specification Group ▪ Panel member to review Auckland DHB Orthopaedic Service ▪ Chair Ophthalmology Service Improvement Advisory Group

Executive leadership team

Name	Interest
Peter Bramley *Chief Executive*	▪ Brother has been engaged by NMDHB to explore options for NMHCT
Nick Baker *Chief Medical Officer*	▪ 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) ▪ Instructor for Advanced Paediatric Life Support NZ ▪ Technical Advisor Whakawhetu National SUDI prevention for Māori ▪ Member of Paediatric Society of NZ ▪ Fellow RACOP ▪ Occasional Expert Witness Work—Ministry of Justice ▪ Technical Expert DHB Accreditation—MOH
Cathy O'Malley *GM Strategy Primary & Community*	▪ Nil
Hilary Exton *GM Allied Health*	▪ Member of the Nelson Marlborough Cardiology Trust ▪ Member of Physiotherapy New Zealand ▪ Member of the New Zealand Paediatric Group ▪ Secretary of the Nelson Marlborough Physiotherapy Branch
Ros Gellatly *Chief Medical Advisor Primary*	▪ GP, Scott Street Health ▪ RNZCGP representative, National IT Clinical Leadership Group ▪ Member, Southlink Health
Jane Kinsey *GM MH &Addictions & DSS*	▪ Husband works for NMH in AT&R as a Physiotherapist

Name	Interest
Pam Kiesanowski *Director of Nursing & Midwifery and Acting GM Clinical Services*	▪ Chair SI NENZ Group
Patrick Ng *General Manager IT & Infrastructure*	▪ Wife is a Senior Consultant for Computer Concepts Limited (CCL)
Heather Smith *GM Human Resources*	▪ Nil
Eric Sinclair *GM Finance & Performance*	▪ Trustee of Golden Bay Community Health Trust ▪ Wife is a Registered Nurse working in General Practice on a casual basis
Ditre Tamatea *GM Māori Health & Vulnerable Populations*	▪ Partner is an Obstetric and Gynaecological Consultant working in other DHBs
Dr Elizabeth Wood	▪ General practitioner Mapua Health Centre ▪ MCNZ Performance Assessment Committee Member

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

Ministerial Directions

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

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

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

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

Service updates

Māori health & vulnerable populations

Nelson Marlborough Health has committed itself to reducing health inequities for Māori and other vulnerable populations groups within its district.

The Nelson Marlborough District Health Board and its Treaty partner the Iwi Health Board continue to progress their working relationship, with more regular meetings between them and with senior management.

The Māori Health and Vulnerable Populations team, also known as Te Waka Hauora, is leading projects and programmes to reduce health inequity for Māori and to build a centre of excellence for Māori health.

The GM Māori Health and Vulnerable Populations is working with the NMH executive leadership team to develop programmes to lift performance against the 13 national *Māori Health Plan* indicators. As part of this commitment, NMH has created a strategic priorities decision-making matrix that aligns decisions around priorities with allocation of funding. Māori health equity and equity for other vulnerable population groups is the first priority within this matrix, making equity a key consideration when analysing proposals for new services or programmes, reporting requirements or general decision-making.

The Pepi First service

The Pepi First service was launched on 31 March 2017 to coincide with World Smokefree Day. Pepi First is a quit-smoking incentivisation programme for pregnant/hapu wahine.

The service provides carbon monoxide monitoring, quit coach support, nicotine replacement therapy and vouchers to reward smoke-free behaviour.

Incentivisation programmes are proven to improve quit rates for Māori and other high-need population groups. The service is free to all smokers in our district but targets Māori smokers and is on track with a 60 per cent success rate so far. The GM Māori Health and Vulnerable Populations is a champion for the programme.

Supporting safe sleep

NMH continued to invest in safe sleep devices (Pepi Pods/wahakura) and the promotion of these to reduce Māori sudden unexpected death in infancy (SUDI) rates.

NMH has also started to run wahakura wananga with hapu wahine and to distribute safe sleep devices to enable parental behaviour change that supports safe sleep.

Over 80 per cent of infants that die from SUDI in New Zealand are Māori and NMH's commitment to reducing this will be further strengthened with the purchase of more PepiPods and 'mini pods' (designed for use in maternity units) with the financial support of the Care Foundation and the Ministry of Health.

Improving the Māori cancer pathway

The He Huarahi Mate Pukupuku/Māori Cancer Pathway project continued to build momentum.

A South Island-wide project led by NMH, this initiative aims to improve the Māori cancer treatment pathway, and complements cancer prevention and detection initiatives. He Huarahi Mate Pukupuku highlights include:

- the establishment of a Māori cancer survivor group, Nga Morehu
- The appointment of a person to build cultural competence among cancer service staff
- the publication of a booklet to help whānau Māori whānau understand cancer and the support available to them
- seminars by Dr Lance O'Sullivan to share his views on cultural competency for health professionals
- plans for further public engagement by Māori Buck Shelford Māori

Taking a kaupapa Māori approach

NMH acknowledges the importance of a kaupapa Māori approach to address Māori health inequities. Accordingly, our local Māori health provider collective Te Piki Oranga was moved to an 'evergreen' contract, providing greater certainty to its relationship with NMH.

Another kaupapa Māori initiative to reduce health inequities for Māori was the integration of the Poutama model of care within NMH mental health and addictions services. Poutama will continue to build momentum over the coming year with a focus to:

- build Māori provider capacity for treating people with mild to moderate mental health conditions
- develop, enhance and support clinically and culturally responsive services

Future initiatives

Projects and programmes planned for the 2017/18 financial year include:

- Project 280 War against Poverty
- Whare Ora Healthy Homes initiative
- Wai-Māori Fresh – a safe drinking water on marae initiative
- Project Aroha for pepi, tamariki and rangatahi within the context of whānau
- HARTI Hauora Child Health Programme
- Hauora Direct 360 degree whānau assessment, referral and follow up (a pilot project with the Ministry of Social Development)
- Hapu Wānanga – kaupapa Māori pregnancy and parenting programme
- Recruit Me 'Double Up' – a breast and cervical screening initiative
- Miraka Direct – to promote and enable breastfeeding of Māori infants
- Piata 'Shine outreach programme' – an oral health outreach enrolment initiative

Also in 2017/18 the Iwi Health Board wants to meet with senior managers from different government departments to determine what work they are doing to improve the wellbeing of Māori.

Community services

Primary care & community care

The people in our district are generally healthier than many others in New Zealand. However, like many countries across the world, we face significant challenges which will place our health and care system under extreme pressure in the years to come.

The Primary & Community Health Strategy

We have completed a *Primary & Community Health Strategy* which outlines our direction for primary and community healthcare across the top of the South Island for the next 5-10 years. Keeping people well and in the community is a core feature of the strategy, and much of our activity supports this ambition, such as expanding the health hubs and community nursing roles.

Health hubs

We have two health hubs in our district – one in Queen Street Richmond, and one in Queen Street Blenheim – that continue to expand and provide a single site for multiple health-related organisations. Having multiple services at one site in the community, close to where people live and work, makes it easier for patients to get the care they need. It also enables greater team work across different organisations, which supports learning and better patient care.

Community nursing roles

Community nursing roles are essential to keeping people well in the community, and preventing them from becoming seriously unwell and requiring hospital care. This reduces the pressure on our hospital system.

People appointed to the new role of nurse practitioner for older persons use their advanced knowledge to deliver a large proportion of the services that an older person needs, and are based at a medical centre rather than a hospital.

Another achievement that highlights the importance of community nursing roles, and technology, is the introduction of a mobile scanning service. A nurse works district-wide to assess those at risk of, or with known, hepatitis C, and organises treatment. The nurse travels with a mobile scanner to test people who if have hepatitis C, may be able to undertake a new treatment that has a 95 per cent cure rate and minimal side effects.

Golden Bay Community Health investment

Golden Bay Community Health is an integrated rural health centre comprising general practice, a rural hospital and residential elderly care services. An additional $300k has been invested in Golden Bay services this year in sustainable, ongoing funding. Key achievements during the year are the expansion of the nursing staffing model and a haematology/chemotherapy service to patients within the community.

Health of older people

Care of the elderly will be an increasing proportion of NMH's work with the highest population growth expected in the older populations. Nelson Marlborough's 75+ population is projected to more than double, a slightly higher rate than for New Zealand as a whole. Tasman is projected to have the largest 75+ growth, and the largest percentage growth, nearly tripling by 2033.

To respond to these changes, and ensure the ongoing provision of quality care, NMH is adopting a restorative model of care across our home and community support services. The goal of the restorative care model is to increase independence, reduce acute demand and support hospital avoidance.

While living in aged residential care (ARC) facilities is appropriate for a small proportion of our population, studies have shown a higher level of satisfaction and better long-term outcomes where people remain in their own homes and positively connected to their communities. Living in ARC facilities is also a more expensive option, and resources could be better spent providing appropriate levels of home-based support to help people stay well in their own homes. NMH's low rate of people in ARC facilities is an indicator of how well the health system is managing age-related and long-term conditions and responding to the needs of our older population.

We use interRAI, a suite of assessment tools developed by international experts, to ensure all relevant health and wellbeing information about a person is gathered during one assessment process. A high-quality assessment process, followed by tailored care planning, provides better health outcomes for clients and reduced care costs for the health sector. InterRAI is now being used in 100 per cent of ARC facilities in Nelson Marlborough.

During the year we also implemented best practice pathways for dementia care, and continued the successful delivery of the 'walk in another's shoes' programme, which encourages a person-centred model of dementia care.

Pharmacy and medication management

Many health treatments include medication, and new medicines are being developed all the time. In New Zealand a range of medications are subsidised by the government, and there is continual pressure to provide timely access to new medicines, many of which are costly. When approving new medicines for use, Pharmac considers the clinical evidence using advice from expert clinical committees, undertakes an economic analysis and ranks the application relative to other medicines.

Keytruda is a new medicine which has proven more effective than chemotherapy in treating the most common type of lung cancer. Patients receiving the new treatment benefit from increased life expectancy. However, the medication does have a high cost.

Reducing error and harm from medicines through safe and quality use is an important element of healthcare. To achieve this, we have:

- reviewed and standardised prescribing advice given to resident medical officers across the district
- completed an audit of community pharmacy prescriptions errors to identify where the highest need for change is
- established a medicines safety committee to address prescribing issues in hospital services, in order of priority.

Earthquake response

The Nelson Marlborough Public Health Service had a significant role in response to the 14 November earthquake, specifically in the Ward and Seddon areas with the main focus being on water quality, sewage disposal and psychosocial support.

NMH received additional funding for earthquake support. We used this to fund health system navigators, more mental health brief intervention service, free GP consultations and outreach clinics in Ward, Seddon and Kekerengu, and additional shifts in ED to respond to increased demand.

The NMH Consumer Council

NMH appointed a consumer council to help shape and improve health services across the district. The council comprises seven members with diverse geographic and demographic backgrounds, who will strengthen consumer engagement and provide a strong consumer voice as an advisory group to the board.

NMH Consumer Council members (from left): Angelea Stanton, Diane Strong, Judith Holmes, Craig Vercoe, Kamaya Crawford, Philippa Hyndman and Pita Akauola.

Clinical governance

Clinical governance systems within NMH continue to develop in line with the national direction set by the Health Quality and Safety Commission (HQSC). The HQSC define clinical governance as "an organisation-wide approach to the continuous quality improvement of clinical services. It requires clinicians to be engaged in both the clinical and management structure of their health organisation to contribute to the mission, goals and values of that organisation."

There is now an established structure of clinical heads of department who work in partnership with their departmental managers to develop hospital services. Across the wider community, clinicians are involved in setting the direction of community health services provided by NMH. We are developing closer connections between the official clinical governance structures in the community setting (primary health organisations) and within the hospital setting. This is so that we can share what we are learning.

Our annual plan commitments for 2016-17 were all achieved with the exception of the HQSC Quality and Safety Marker for hand hygiene where we reached the target of 80 per cent compliance with all the five steps required for hand hygiene only during one quarter of this year, falling back to 78 per cent for the last quarter. We want to improve on this since we are one of only six other DHBs who also did not reach this target.

Otherwise we continue to work on our commitments to be 'safe, skilled and compassionate'. This involves an increasing openness around our adverse events in order to be able to share what we have learned. With the new consumer council we are including consumers in more meaningful ways as we review how we are doing and as we develop new services.

We also continue to work towards a positive, supportive culture in association with our new 'Building Respect' program and an agreement with the Royal Australasian College of Surgeons to 'Operate with Respect'. The importance of a safe culture in enabling a safe healthcare system cannot be underestimated and we are committed to achieving this.

Clinical services

NMH clinical services in 2016/17 continues to provide an extensive range of elective and acute services for the Nelson Marlborough district – under a 'one service, two sites' operating model.

As is the trend nationally the increase in chronic conditions and our aging population within the district is reflected in the increased complexity of presentations to our emergency departments. While this causes significant workload pressures, on all NMH staff, our clinical teams continue to offer a high values-based professional service with care and compassion.

We exceeded the elective surgeries target by 398, discharging 7843 people after elective surgery. Of these, 577 cataract procedures were delivered and 555 hip and knee replacements performed.

The clinical services team provided 18,478 first specialist assessments over the year and 36,688 follow-up appointments with specialist services. In addition 16,303 medical and surgical procedures were delivered.

We were delighted to meet the cancer treatment waiting time where 85 per cent of patients received treatment 62 days after a referral for potential cancer.

In 2016/17 46,798 people presented to our emergency departments and we continued to meet the national health target where 95 per cent of people presenting to an emergency department are either discharged or admitted to hospital within six hours.

In Nelson Hospital 39,345 bed nights for patient care were provided and 16,839 were provided in Wairau Hospital with an overall increase in presentations of five per cent across the year.

Our intensive coronary care service was reviewed this year with several recommendations to implement. The implementation is progressing in a phased approach with the first two of three phases nearing completion. This has seen the appointment of a director of intensive care, greater clinical oversight of inpatients, an increase to nursing staff within the department, and a change to a shared care model.

The *NZ Cardiac Networks recommendations for referral and access to secondary care* document written by the cardiology department was nationally endorsed and the STEMI heart attack treatment process was improved by implementing the timelines outlined in this document.

NMH's use of paramedic-mediated pre-hospital thrombolysis and transfer direct to PCI-capable hospitals proved successful in significantly reducing the time taken to treat people have had heart attacks. The STEMI pathway implemented here is now being introduced as the national STEMI pathway.

Our ophthalmology service has seen a dramatic growth in patients requiring treatment for eye disease with age-related macular degeneration driving changes to the way Avastin injections are delivered. A clinical nurse specialist was employed to deliver this treatment at Nelson Hospital, from a clinic rather than a surgical theatre. The appointment of the clinical nurse specialist has freed up both theatre space and our ophthalmologists to concentrate on more complex eye conditions.

This has resulted in better and timelier treatment for patients, preventing any adverse outcomes. The service is now looking into how this model can be applied at Wairau Hospital.

The He Huarahi Mate Pukupuku/Māori Cancer Pathway project progressed, to improve the cancer pathway for Māori to support equitable achievement of the Ministry of Health's 'Faster Cancer Treatment' target. The components of the project include education for health professionals about appropriate service delivery for Māori, and community education for Māori about cancer and the cancer treatment pathway.

Mental health and Addiction services

NMH finalised the executive leadership team restructure by combining the GM Disability Support Services and GM Mental Health and Addictions roles this year. The resulting GM Mental Health Addictions & Disability Support Services role is a comprehensive one responsible in partnership with community and secondary clinical directors for the direction, use of allocated funding and provision of mental health addictions and DSS across our district.

Disability support services

This year has seen significant changes within the disability sector. Service users and staff have had a very busy year with full programmes and activities. Some service changes have occurred in DSS houses to accommodate different service users' needs, and have been well-received. DSS management and administration staff relocated to offices closer to Nelson Hospital. Planning for a new district-wide child respite service started in 2016/17 and on track to start in the 2017/18 financial year.

The government's pay equity settlement for care and support workers was introduced for our DSS staff who appreciate the recognition this settlement gives.

The sector is also preparing for transformational change to come from implementation of the Enabling Good Lives strategy, a partnership between the disability sector and government agencies. This strategy recognises that disabled children are growing up wanting the same things as non-disabled children, and the expectations of disabled adults have changed and grown. There is also a growing recognition that disabled people are experts in their own lives, and our support needs to ensure and facilitate their right to be involved in the decisions that affect them which will then, in turn, lead to better outcomes.

Our DSS is at a stage where we need to prepare for the changing expectations of society. Our DSS mission is to 'support people to live the best possible life' and so our focus must be to help empower individuals and their families to make and influence decisions that affect their own lives.

Mental health and addictions services

This year has certainly been a year of change for the service. The year has focussed on implementation of the recommendations from several previous service reviews. The recommendations have largely begun to be addressed by the initiation of a quality improvement integration change programme led by the general manager.

Seven workstreams were formed, comprising people from specialist services, primary are, community and NGOs as well as service users and family members. The workstreams were a five-meeting process where change ideas were identified, trialled and then selected to guide the ongoing programme of change for the next 12 to 24 months.

All workstreams were person-centred with the aim to improve our model of care during a person's journey to be more integrated, responsive, effective, least-restrictive and recovery-focussed. We want to ensure services work together across the health system and with our cross-sector partners to improve access and support early intervention and recovery. We will achieve this by ensuring we invest and direct resources into the community to prevent admission or reliance on specialist services, and to provide services closer to home.

All services recently moved all mental health clinical information onto the same electronic system as our hospital clinical teams' system. This will improve information-sharing and communication between our clinical and mental health teams to ensure our clients receive the appropriate care when they need it.

Our community teams were rearranged; we now have distinct multi-disciplinary Marlborough, Nelson and Tasman teams. To support the teams we introduced a universal triage tool to assist with intake and service response consistency. Work is also underway to extend the single point of entry service district-wide.

Our mental health teams responded to community needs after the 14 November earthquake. Support was provided for primary care and community response and work continues to support and strengthen community resilience.

Health and safety has been a significant focus this year. There have been multiple facility modifications to ensure staff safety at work and resources have also been invested to recruit 'person support security personnel'. These staff will be employed by NMH and will be part of our emergency department and mental health unit teams, where they will help ensure safe and calm environments for staff, patients, service-users and visitors.

We have significantly reduced our use of seclusion, which is a credit to all involved. We have also invested in key roles including a nurse educator and a high and complex needs speciality nurse, to ensure a more coordinated and effective response and support for people and families who have needs that might fall between the gaps in services.

NMH would like to extend a 'thank you' in appreciation of the willingness and passion demonstrated by everyone who either participated or contributed to services and the changes that have occurred this year. This change programme relies on people's contribution and willingness to support change. Strong relationships and understanding of the role and contributions our colleagues make in clinical services, primary care, community agencies and cross-sector partners is critical if we are to sustainably improve the outcomes for people and families who require our support.

A special thank you must be extended to consumers and family members who participated and shared their experiences in order for us to learn and improve.

Information technology and infrastructure

Technology

Good progress was made with new 'paper-lite' initiatives during the year.

The regional electronic health record application (Health Connect South) and the electronic laboratory sign-off system were successfully implemented.

A regional application that allows health information to be shared between general practices, pharmacy and secondary care via the electronic health record (HealthOne) was well underway by the end of the financial year.

In addition to these initiatives, we made successful cases for our paper chart transformation initiative, district-wide referral centre model and pre-admissions hub, also in support of our paper-lite strategy. We anticipate these initiatives will get underway early in the 2017/18 financial year.

Infrastructure

Good progress has been made with the earthquake strengthening programme. We successfully strengthened and re-fitted the Arthur Wicks building at Wairau Hospital. This building was at 25 per cent of the national building standard for its respective rating. It is now at 100 per cent of the national building standard for its respective rating.

We made good progress on our Nelson Hospital redevelopment planning, with the first business case (a strategic assessment) completed. In the 2017/18 financial year we will progress with the next phase of business case development work.

Our people

NMH's local health services must cope sustainably with increasing demands for services to manage the flow of people across our district.

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

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

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

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

Staff engagement

The second NMH staff survey opened for participation on the last day of the 2016/17 financial year. The survey information will inform further improvements in staff engagement and organisational culture.

The Staff Engagement: Working Together partnership group continues to prioritise improvements in staff engagement and organisational culture, such as the Building Respect programme, designed to address inappropriate staff behaviour and starting in the 2017/18 financial year.

The Prevention of Workplace Aggression group has an executive lead and is supported by multi-disciplinary representatives across NMH and the district. The group has developed a strategic framework for the prevention of workplace aggression.

NMH, in conjunction with other DHBs, is adopting the State Services Commission's leadership framework that familiarises NMH people leaders with leadership and management capabilities.

Workforce development

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

NMH is improving its workforce development, education and training across the district by:

- building and aligning the capability and capacity of the health workforce to deliver new models of care
- improving the sustainability of our vulnerable workforces
- growing the capacity and capability of Māori in our health workforce
- strengthening health leadership.

Our workforce plan continues to be implemented across our health and disability workforce.

Health, safety and wellbeing

New Zealand's key work health and safety legislation is the *Health and Safety at Work Act 2015* and regulations made under that Act. All work and workplaces are covered by the Act unless specifically excluded, and regulated by WorkSafe NZ.

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

We do this by providing or ensuring:

- a safe work environment, safe plant and equipment, and adequate facilities
- emergency procedures
- hazard/risk monitoring and management systems, tools and resources
- adequate training and induction processes
- document and data control
- workplace wellbeing initiatives
- injury management, rehabilitation and return to work processes
- worker consultation and participation
- recognition of safety champions
- competent health and safety representatives
- measurement and evaluation processes

Good employer

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

- leadership, accountability and culture.
- health, safety and wellbeing
- equal employment opportunities
- recruitment, selection and induction
- remuneration, recognition and conditions
- recognition of the aims and employment needs of Māori
- recognition of the aims and cultural differences of ethnic and minority groups
- recognition of the employment needs of people with disabilities
- harassment and bullying prevention.

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

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

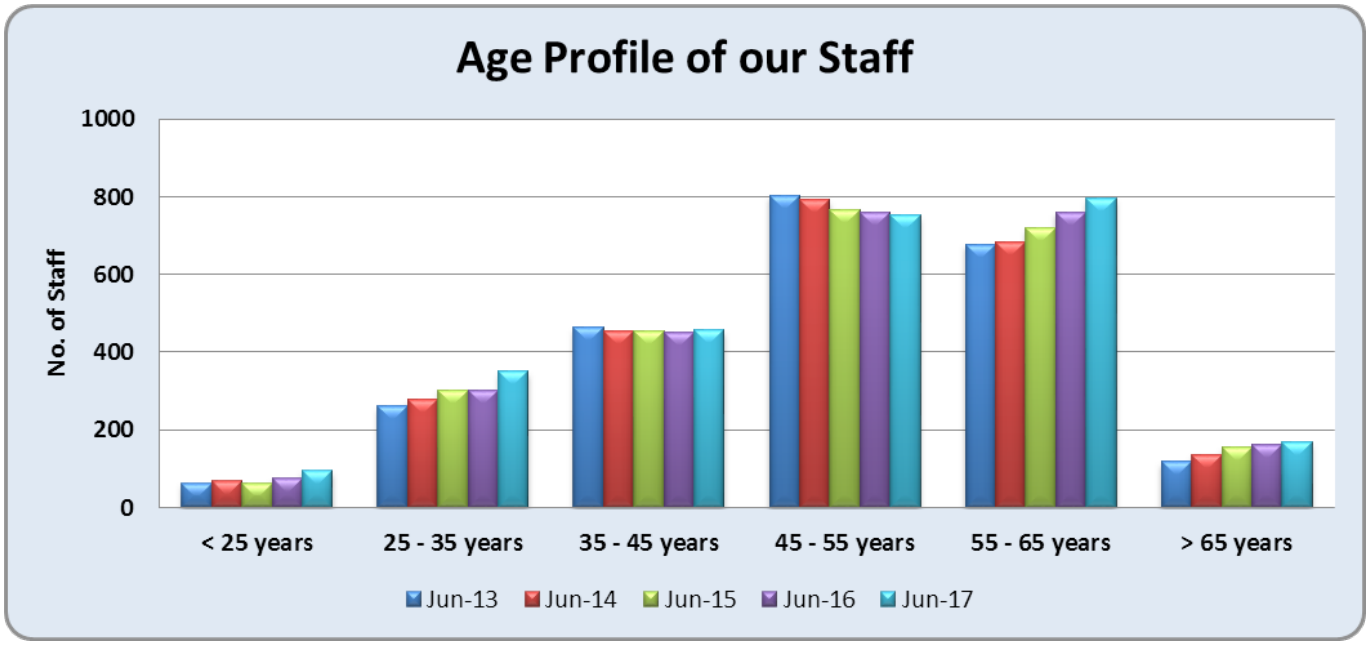
Workforce profile

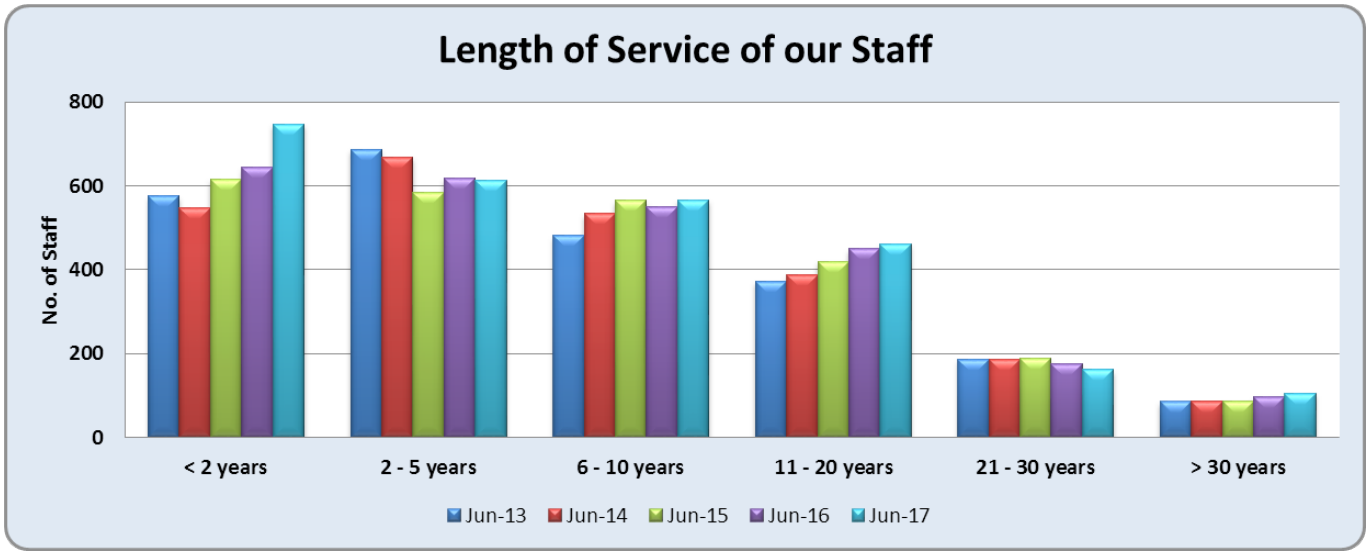
The table below provides a profile of the NMH workforce.

Employee by gender	Jun-13	Jun-14	Jun-15	Jun-16	Jun-17
Female	1,950	1,970	2,031	2,086	2,177
Male	437	441	429	442	474
Total staff (headcount)	**2,387**	**2,411**	**2,460**	**2,528**	**2,651**

Employee by employment grouping	Jun-13	Jun-14	Jun-15	Jun-16	Jun-17
Medical	180	183	189	190	198
Nursing	640	642	655	663	678
Allied health	312	303	316	319	319
Disability support services	270	265	263	257	255
Hotel and support	95	97	103	103	103
Management and administration	340	325	332	350	352
Total FTEs	**1,838**	**1,815**	**1,858**	**1,882**	**1,905**

Employee by ethnicity	Jun-13	Jun-14	Jun-15	Jun-16	Jun-17
Asian	28	34	50	51	75
Australian	31	30	36	37	37
European	217	231	240	256	256
Maori	85	80	77	91	88
NZ European/Pakeha	1,562	1,579	1,638	1,669	1,634
Other	47	53	52	53	53
Pacific peoples	3	3	7	7	11
Unknown/unspecified	414	401	360	364	497
Total staff (headcount)	**2,387**	**2,411**	**2,460**	**2,528**	**2,651**


Age Profile of our Staff
No. of Staff
1000
800
600
400
200
0
< 25 years
25 - 35 years
35 - 45 years
45 - 55 years
55 - 65 years
> 65 years
Jun-13
Jun-14
Jun-15
Jun-16
Jun-17


Length of Service of our Staff
No. of Staff
800
600
400
200
0
< 2 years
2 - 5 years
6 - 10 years
11 - 20 years
21 - 30 years
> 30 years
Jun-13
Jun-14
Jun-15
Jun-16
Jun-17

Employee remuneration

The number of employees earning more than $100,000 is listed in the table below. Of the 255 employees shown, 211 are or were medical, dental, nursing or allied health employees. In the previous financial year (2015/16) there were 216 employees earning more than $100,000.

Salary band ($000)	2017	2016
100–110	59	50
110–120	27	25
120–130	18	17
130–140	11	20
140–150	8	13
150–160	7	4
160–170	6	4
170–180	4	7
180–190	10	11
190–200	9	5
200–210	4	5
210–220	9	7
220–230	9	5
230–240	8	12
240–250	14	10
250–260	10	7
260–270	6	10
270–280	4	3
280–290	8	9
290–300	9	5
300–310	2	10
310–320	0	4
320–330	5	4
330–340	5	3
340–350	1	0
350–360	0	3
360–370	2	1
420–430	0	1
440–450	0	1
Total	**255**	**256**

Termination payments

During the 2016/17 year, NMH paid $285,411 to nine employees upon termination of their employment with NMH.

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

In the previous financial year (2015/16) five payments totalling $140,898 were made.

Statement of responsibility

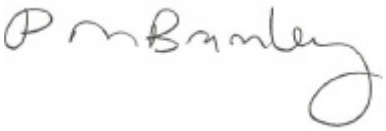
The Board and management of the Nelson Marlborough District Health Board accept responsibility for the preparation of the financial statements and statement of performance, and for the judgments made in them.

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

In the opinion of the Board and management of the Nelson Marlborough District Health Board the financial statements and statement of performance for the twelve months ended 30 June 2017 fairly reflect the financial position and operations of the Nelson Marlborough District Health Board.

Jenny Black
Board Chair

Alan Hilton
Board Member



Peter Bramley
Chief Executive

Eric Sinclair
GM Finance and Performance

30 October 2017

Statement of performance

Strategic outcomes

Nelson Marlborough Health is the largest funder and provider of health and disability services across the top of the South Island comprising the Marlborough, Nelson and Tasman districts. The actions we take in terms of which services to fund and the level at which we invest has a significant effect on the health of the 130,000 people who live here.

To achieve our vision where "All people live well, get well, stay well", we must understand the level of need within our population, as well as the current and future drivers of service demand. We strive to take a long-term view, and shift resources to where we believe they are most needed, in order to make a positive change to the health of our population, while ensuring that the health system is sustainable.

This section provides an overview of our outcomes framework, which is designed to align to the strategic direction of the Ministry of Health and the government. Our strategy identifies three outcome goals which demonstrate success over time. These are long-term indicators and, as such, the aim is for measureable change in health status over time, rather than a fixed target.

The indicators are noted below and are measured from the NZ Health Survey undertaken by the Ministry of Health. The survey has not been updated to include results for 2016/17 and other periods since the survey was completed; consequently we are unable to report achievement against these.

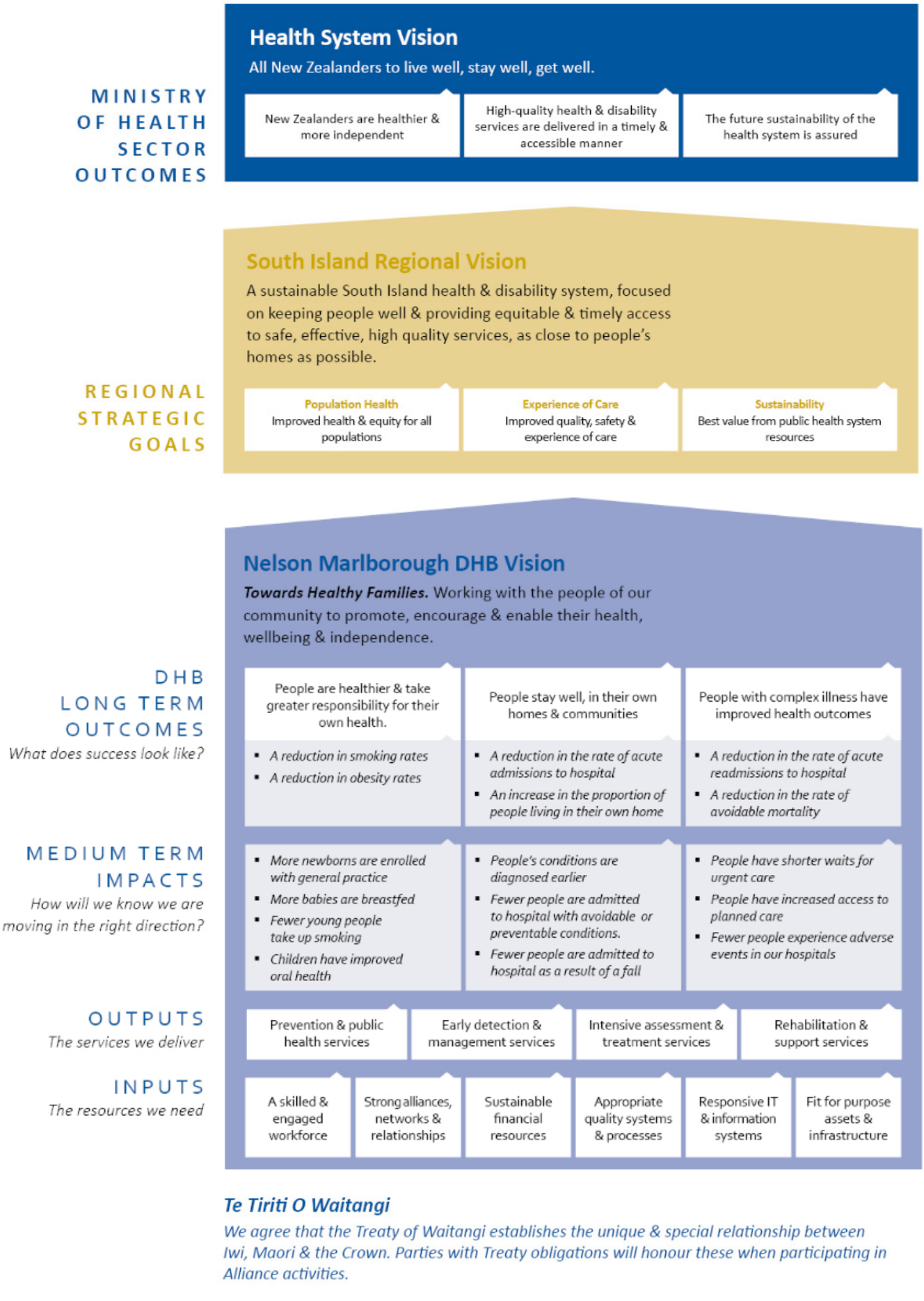
- ***Strategic Outcome 1: People are healthier and take greater responsibility for their own health***
  - a reduction in smoking rates
  - a reduction in obesity rates
- ***Strategic Outcome 2: People stay well, in their own homes and communities***
  - a reduction in the rate of acute medical admissions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

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

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

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

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



Te Tiriti O Waitangi

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

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

Why is this a priority?

New Zealand is experiencing a growing prevalence of long-term conditions such as diabetes and cardiovascular disease, which are major causes of poor health and account for a significant number of presentations in primary care and hospital and specialist services. The likelihood of developing long-term conditions increases with age, and with an ageing population, the burden of long-term conditions will grow. The World Health Organisation estimates more than 70 per cent of all health funding is spent on managing long-term conditions. These conditions are also more prevalent among Māori and Pacific Islanders and are closely associated with significant disparities in health outcomes across population groups.

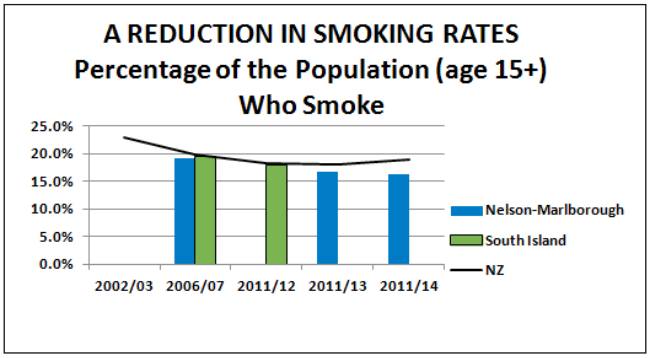
Tobacco smoking, inactivity, poor nutrition and rising obesity rates are major contributors to a number of the most prevalent long-term conditions. These are avoidable risk factors, preventable through a supportive environment, improved awareness and personal responsibility for health and wellbeing.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

Overarching Outcome Indicators

Smoking

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

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



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

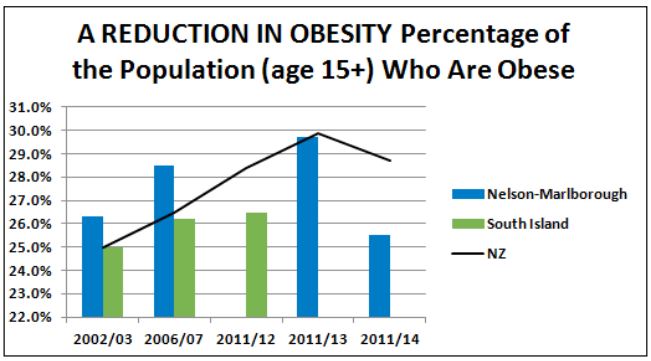
Data Source: National Health Survey.

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

Obesity

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

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



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

Data Source: National Health Survey.

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

Intermediate Impact Indicators

Newborn enrolment (at 3 months)

2015/16 Actual	2016/17 Actual	2016/17 Target	2017/18 Target	2018/19 Target
78%	78%	98%	98%	98%

Enrolment of a newborn baby with their general practice soon after birth is important so they can receive essential healthcare, including immunisations, on time. Late enrolment means a baby may start their immunisations late, exposing them to preventable diseases like whooping cough and measles. This could also lead to delays in receiving further immunisations. Earlier enrolment helps minimise this risk. An increase in newborn enrolments is seen as an early indicator for immunisation rates, and overall general child health.

Breastfeeding (Fully/exclusively breastfed at 6 weeks)

2015/16 Actual	2016/17 Actual	2016/17 Target	2017/18 Target	2018/19 Target
69%	74%	75%	75%	75%

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

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

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

Data Source: Plunket via the Ministry of Health.

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

Oral health (Caries-Free at age 5; no holes or fillings)

2015/16 Actual	2016/17 Actual	2016/17 Target	2017/18 Target	2018/19 Target
59%	60%	65%	65%	65%

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

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

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

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

Data Source: MOH Oral Health Team.

Smoking (Never Smokers among Year 10 Students)

2015/16 Actual	2016/17 Actual	2016/17 Target	2017/18 Target	2018/19 Target
80%	NA*	80%	82%	84%

* Snapshot survey by ASH was not available at time of completing report

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

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

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

Data Source: National Year 10 ASH Snapshot Survey.

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

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

Why is this a priority?

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

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

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

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

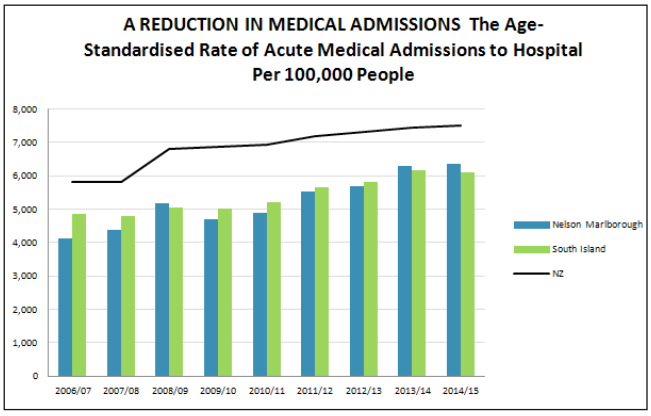
Overarching Outcome Indicators

Acute hospital admissions

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

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

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

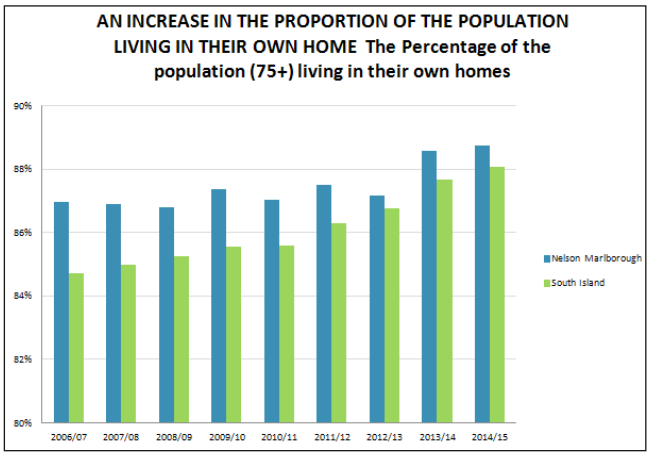


Reducing acute admissions also has a positive effect by enabling more efficient use of specialist resources that would otherwise be taken up by reacting to demand for urgent care.

Data Source: National Minimum Data Set.

People living at home

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



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

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

Data Source: SIAPO Client Claims Payment System.

Intermediate Impact Indicators

Earlier diagnosis

2015/16 Actual	2016/17 Actual	2016/17 Target	2017/18 Target	2018/19 Target
CT: 79%	98%	95%	95%	95%
MRI: 79%	59%	95%	85%	85%

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

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

Data Source: Individual DHB Patient Management Systems.

Avoidable hospital admissions (population aged 45–64)

2015/16 Actual	2016/17 Actual	2016/17 Target	2017/18 Target	2018/19 Target
2,555*	2,695*	N/A	N/A	N/A

* Please note the National Average was 2015/16—3,761 and 2016/17—3,811.

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

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

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

Data Source: Ministry of Health Performance Reporting SI1.

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

Falls preventions

2015/16 Actual	2016/17 Actual	2016/17 Target	2017/18 Target	2018/19 Target
7.2%	*	N/A	N/A	N/A

* Due to changes in the coding process being discussed nationally the results were not available at time of completing report.

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

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

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

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

Data Source: National Minimum Data Set.

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

Why is this a priority?

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

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

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

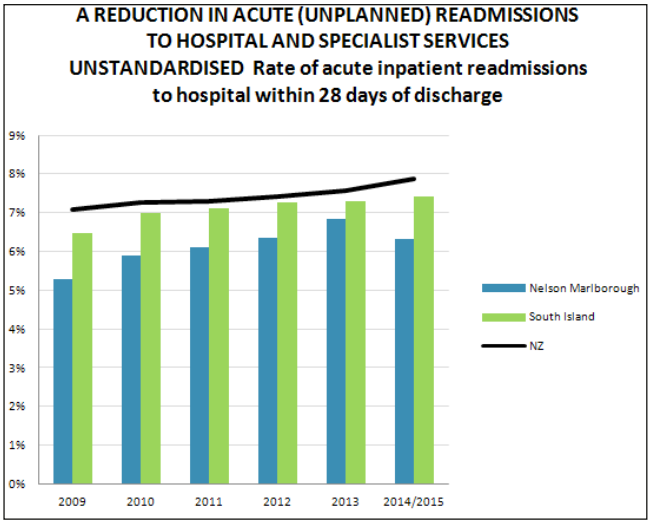
Overarching Outcome Indicators

Acute readmissions

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

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

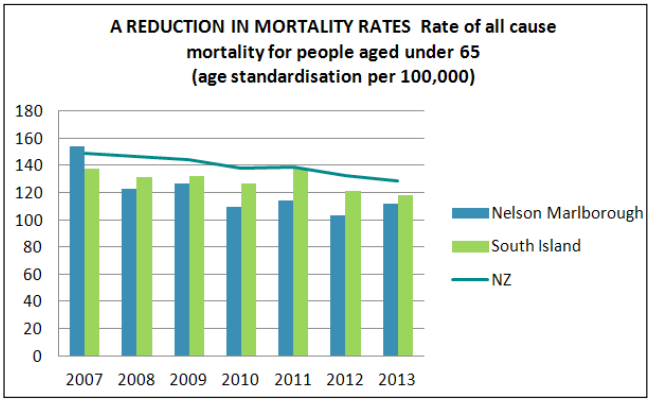
Because the key factors in reducing acute readmissions include safety and quality processes, effective treatment and appropriate support on discharge – they are a useful maker of the quality of care being provided and the level of integration between services.



Avoidable mortality

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

Premature mortality (death before age 65) is largely preventable through lifestyle change, intervention and safe and effective treatment. By detecting people at risk and improving the treatment and



management of their condition, the serious impacts and complications of a number of complex illnesses can be reduced.

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

Data Source: National Mortality Collection—2010 Update.

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

Intermediate Impact Indicators

Waits for urgent care

2015/16 Actual	2016/17 Actual	2016/17 Target	2017/18 Target	2018/19 Target
96%	96%	95%	95%	95%

Emergency departments (EDs) are important components of our health system and a barometer of the health of the hospital and the wider system. Long waits in ED are linked to overcrowding, longer hospital stays and negative outcomes for patients. Enhanced performance will not only improve patient outcomes by providing early intervention and treatment but will improve public confidence and trust in health services. Solutions to reducing ED wait times span not only the hospital but the whole health system. In this sense, this indicator is a marker of how responsive the whole system is to the urgent care needs of the population.

Data Source: Individual DHB Patient Management Systems

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

Access to planned care

2015/16 Actual	2016/17 Actual	2016/17 Target	2017/18 Target	2018/19 Target
>95%	>95%	100%	100%	100%

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

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

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

Data Source: Ministry of Health Quickplace Data Warehouse.

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

Adverse events

2015/16 Actual	2016/17 Actual	2016/17 Target	2017/18 Target	2018/19 Target
0.06%	0.15%	N/A	N/A	N/A

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

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

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

Data Source: Individual DHB Quality Systems.

Health targets

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

Health Target		Q1	Q2	Q3	Q4
	95% of patients will be admitted, discharged, or transferred from an emergency department (ED) within six hours.	96% ✓	96% ✓	95% ✓	95% ✓
	The national volume of elective surgery by at least 4000 discharges per year.	107% ✓	107% ✓	104% ✓	105% ✓
	85% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July 2016, increasing to 90% by June 2017.	83%	84%	85% ✓	85% ✓
	95% of 8-month-olds have their primary course of immunisation at 6 weeks, 3 months and 5 months on time.	89%	91%	89%	90%
	90% of PHO enrolled patients who smoke have been offered help to quit smoking by a healthcare practitioner in the last 15 months.	89%	87%	84%	89%
	95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking.	98% ✓	96% ✓	97% ✓	94%
	90% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.	100% ✓	95% ✓	98% ✓	100% ✓
	The target is that by December 2017, 95 percent of obese children identified in the B4 School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.	33%	39%	67%	74%

Report against statement of performance expectations

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

We have structured the outputs, consistent with other district health boards across New Zealand into four output classes described in this section. Further detail on each of the output classes and the various services within each can be read in the *2016/17 NMH Annual Plan*, published online (www.nmdhb.govt.nz).

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

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

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

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

- Achieved
- Partially achieved
- Not achieved

Under the *Public Finance Act*, NMDHB is required to disclose the revenue appropriation provided to it by the government for the year, the equivalent expense against that appropriation and the service performance measures that report against the use of that funding. The appropriation revenue received by NMH for the 2016/17 financial year is $399,273,000 which equals the government's actual expenses incurred in relation to the appropriation. The performance measures are set out in the statement of service performance on pages 27 to 47.

Output class 1: Prevention services

Description

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

Significance

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

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

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

Performance measures

Performance measures	Code	2014/15	2015/16	2016/17	Target	Performance
Percentage of enrolled women (25–69) who had a cervical smear in the last 3 years	V	83%	80%	81%	85%	●
Percentage of enrolled women (25–69) who had a cervical smear in the last 3 years – Māori only	V	78%	67%	68%	85%	●
Percentage of enrolled women (25–69) who had a cervical smear in the last 3 years – Pacific only	V	65.4%	85%	72%	85%	●
Percentage of enrolled women (45–65) having mammography within 2 years	V	80%	72%	80%	80%	●
Percentage of newborn hearing screening completed within one month of birth	V	94%	95%	93%	95%	●
Percentage of two year old children fully vaccinated	C	93%	90%	91%	95%	●

Performance measures	Code	2014/15	2015/16	2016/17	Target	Perfor-mance
Percentage of over 65 year olds vaccinated for seasonal influenza	V	65%	69%	61%	75%	●
Percentage of eligible children receiving Before (B4) School Checks	V	102%	101%	104%	100%	●
Reduction in Alcohol related harm measure – implementation of the Alcohol Related Harm Reduction Strategy	Q	N/A	N/A	N/A*	NEW	●
Number of clients seen by the primary mental health service – youth	Q	N/A	N/A	494	NEW	●
Number of clients seen by the primary mental health service – adults	Q	N/A	N/A	2,615	NEW	●

N/A* Agencies who previously indicated an interest and other identified agencies were invited to an alcohol harm reduction workshop hosted by Nelson Marlborough Public Health Service. The purpose of the workshop was to establish an action based approach to addressing alcohol harm within the Nelson, Marlborough and Tasman district. 18 attendees from eight different organisations attended the facilitated workshop and collectively agreed to a *Draft Alcohol Action Plan Framework*. Three priority action areas were identified. Expressions of interest were then sought for action group membership. Talking Heads members were informed (August 2017) of progress to date. To date there has been minimal interest in action group participation. Public Health is to initiate the first action group meetings to progress the three identified action areas.

Financial results

	Budget 2017 $000	Actual 2017 $000	Actual 2016 $000
Revenue	**8,364**	**7,758**	**8,295**
Expenditure			
Workforce costs	3,933	4,193	4,068
Other operating costs	1,023	849	1,311
External providers and inter district fows	2,410	1,989	2,441
Total expenditure	**7,366**	**7,031**	**7,820**
Total surplus/(deficit)	**998**	**727**	**475**

Output class 2: Early detection and management services

Description

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

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

a) intervening early to detect, manage, and treat health conditions (eg health checks)

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

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

Significance

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

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

Performance measures

Performance measures	Code	2014/15	2015/16	2016/17	Target	Performance
Percentage of people in the district enrolled with PHO – Nelson	C	98%	98%	98%	99%	●
Percentage of people in the district enrolled with PHO – Marlborough	C	96%	95%	97%	99%	●
Ambulatory Sensitive Hospitalisation (ASH) rates for children age 0–4 years	Q	80%	83%	88%	95%	●
Number of children <5 years enrolled in DHB funded dental services	C	6,745	6,521	6,585	7,242	●
Percentage of secondary care patients whose medicines are reconciled on admission	C,Q	28%	24%	30%	>22%	●
Percentage of people provided with a CT scan within 42 days of referral	T	56%	79%	98%	100%	●
Percentage of people provided with an MRI scan within 42 days of referral	T	26%	79%	59%	100%	●
Percentage of PMHI Extended GP consults and packages of care used by youth	Q	N/A	15%	16%	15%	●
Percentage of the eligible population who will have had their cardiovascular risk assessed in the last five years	C	89%	90%	91%	90%	●

Financial results

	Budget 2017 $000	Actual 2017 $000	Actual 2016 $000
Revenue	**122,121**	**123,372**	**117,809**
Expenditure			
Workforce costs	21,242	20,600	20,653
Other operating costs	8,302	7,876	8,432
External providers and inter district fows	87,614	91,025	86,583
Total expenditure	**117,158**	**119,501**	**115,668**
Total surplus/(deficit)	**4,963**	**3,871**	**2,141**

Output class 3: Intensive assessment and treatment services

Description

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

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

Significance

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

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

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

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

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

Performance measures

Performance measures	Code	2014/15	2015/16	2016/17	Target	Performance
Acute inpatient average length of stay (days)	Q	3.57	2.23	2.30	2.35	●
Percentage of elective and arranged surgery undertaken on a day case basis	Q	65%	66%	65%	68%	●
Percentage of people receiving their elective and arranged surgery on day of admission	Q	97%	98%	98%	97%	●
Women registering with an LMC by week 12 of their pregnancy	T	N/A	81%	80%	80%	●
Percentage of total deliveries in primary birthing units	Q	7%	7%	5%	7%	●
Ratio of patients assessed as triggering 'institutional risk' compared with ARC admissions' (Source: InterRAI)	Q	N/A	N/A	36%	25%	●
Standardised Intervention Rate for major joint replacement	V	N/A	27 per 10,000	23 per 10,000	21 per 10,000	●
Standardised Intervention Rate for cataract procedures	V	N/A	27 per 10,000	31 per 10,000	27 per 10,000	●

Financial results

	Budget 2017 $000	Actual 2017 $000	Actual 2016 $000
Revenue	**243,035**	**245,297**	**243,471**
Expenditure			
Workforce costs	127,140	129,129	124,768
Other operating costs	75,332	74,533	74,151
External providers and inter district fows	43,289	42,666	44,396
Total expenditure	**245,761**	**246,328**	**243,315**
Total surplus/(deficit)	**(2,726)**	**(1,031)**	**156**

Output class 4: Rehabilitation and support services

Description

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

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

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

Significance

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

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

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

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

Performance measures

Performance measures	Code	2014/15	2015/16	2016/17	Target	Performance
The percentage of people in aged residential care by facility and by DHB who have a subsequent interRAI long term care facility (LTCF) assessment completed within 230 days of the previous assessment	Q	NEW	75%	81%	80%	●
Percentage of older people living in ARRC	C	4%	5%	5%	4%	●
Improving Mental Health Services using transition (discharge) planning and employment: Child and Youth with a transition (discharge) date	Q	99%	100%	91%	95%	●

Financial results

	Budget 2017 $000	Actual 2017 $000	Actual 2016 $000
Revenue	**97,154**	**91,810**	**91,997**
Expenditure			
Workforce costs	22,246	21,398	21,372
Other operating costs	10,371	9,607	10,290
External providers and inter district fows	63,772	61,143	61,553
Total expenditure	**96,389**	**92,148**	**93,214**
Total surplus/(deficit)	**765**	**(338)**	**(1,217)**

Financial statements

Statement of comprehensive revenue and expense

For the year ended 30 June 2017

	Note	Budget 2017 $000	Actual 2017 $000	Actual 2016 $000
Revenue				
Revenue	1	466,995	462,339	454,484
Interest revenue	5	2,250	1,849	2,157
Other revenue	2	1,429	4,049	4,930
Total revenue		**470,674**	**468,237**	**461,571**
Expenditure				
Personnel costs	3	174,561	171,259	167,363
Outsourced services		10,186	14,621	14,210
Clinical supplies		34,081	35,623	35,180
Infrastructure and non-clinical expenses		23,638	24,140	23,472
Payments to non-Health Board providers		197,085	196,822	194,972
Depreciation and amortisation expense	12,13	12,517	10,415	10,812
Capital charge	4	7,937	6,418	7,801
Finance costs	5	2,986	1,914	3,005
Other expenses	6	3,683	3,796	3,202
Total expenditure		**466,674**	**465,008**	**460,017**
Surplus/(Deficit)		**4,000**	**3,229**	**1,554**
Other comprehensive revenue or expenses				
Item that will be reclassified to surplus/(deficit):				
Financial assets at fair value through other comprehensive revenue and expense		-	-	-
Item that will not be reclassified to surplus(deficit):				
Gain/(Loss) on property revaluations		-	-	-
Impairment of property assets		-	-	-
Total other comprehensive revenue or expenses		-	-	-
Total comprehensive revenue and expense		**4,000**	**3,229**	**1,554**

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

Statement of financial position

For the year ended 30 June 2017

	Note	Budget 2017 $000	Actual 2017 $000	Actual 2016 $000
Assets				
Current assets				
Cash and cash equivalents	7	49,464	21,561	24,774
Receivables	8	13,535	16,001	14,152
Inventories	9	2,723	2,700	2,723
Prepayments		588	2,139	588
Non-current assets held for sale	10	487	464	487
Current Financial Assets	11	-	12,351	6,000
Total current assets		**66,797**	**55,216**	**48,724**
Non-current assets				
Prepayments		43	-	43
Non-CurrentFinancial assets	11	2,106	8,576	14,498
Property, plant and equipment	12	161,597	163,600	164,144
Intangible assets	13	9,296	10,245	9,415
Total non-current assets		**173,042**	**182,421**	**188,100**
Total assets		**239,839**	**237,637**	**236,824**
Liabilities				
Current liabilities				
Payables	14	35,923	31,091	34,582
Borrowings	15	15,020	477	6,556
Employee entitlements	16	27,332	30,188	28,333
Provisions	17	1,322	455	1,322
Total current liabilities		**79,597**	**62,211**	**70,793**
Non-current liabilities				
Borrowings	15	47,728	8,663	56,968
Employee entitlements	16	10,405	9,923	10,405
Total non-current liabilities		**58,133**	**18,586**	**67,373**
Total Liabilities		**137,730**	**80,797**	**138,166**
Net assets		**102,109**	**156,840**	**98,658**
Equity				
Crown equity	18	26,946	82,446	27,493
Other reserves	18	53,213	53,213	53,213
Accumulated comprehensive revenue and expense	18	21,950	21,181	17,952
Total equity		**102,109**	**156,840**	**98,658**

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

Statement of changes in net assets/equity

For the year ended 30 June 2017

	Note	Budget 2017 $000	Actual 2017 $000	Actual 2016 $000
Balance at 1 July		98,656	98,658	97,651
Total comprehensive revenue and expense for the year		4,000	3,229	1,554
Owner transactions				
Capital contribution	15,18	-	55,500	-
Repayment of capital		(547)	(547)	(547)
Balance at 30 June	18	**102,109**	**156,840**	**98,658**

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

Statement of cash flows

For the year ended 30 June 2017

	Note	Budget 2017 $000	Actual 2017 $000	Actual 2016 $000
Cash flows from operating activities				
Receipts from the Ministry of Health and patients		470,520	466,600	456,611
Interest received		2,250	1,849	2,157
Payments to employees		(165,196)	(169,886)	(169,767)
Payments to suppliers		(279,947)	(282,579)	(265,997)
Capital charge		(7,937)	(6,418)	(7,801)
Interest paid		(2,986)	(2,246)	(3,005)
GST (net)		-	(245)	(27)
Net cash flow from operating activities	19	**16,704**	**7,075**	**12,171**
Cash flows from investing activities				
Receipts from sale of property, plant and equipment		150	273	293
Receipts from maturity of investments		-	351	-
Purchase of property, plant and equipment		(5,600)	(6,976)	(8,671)
Purchase of intangible assets		(4,250)	(2,012)	(2,951)
Acquisition of investments		-	(351)	(18,950)
Net cash flow from investing activities		**(9,700)**	**(8,715)**	**(30,279)**
Cash flows from financing activities				
Borrowings withdrawn		-	-	-
Finance leases raised		-	1,713	-
Capital contribution		-	-	-
Repayment of capital		(547)	(547)	(547)
Repayment of borrowings		-	-	-
Payment of finance lease liabilities		(776)	(2,739)	(283)
Net cash flow from financing activities		**(1,323)**	**(1,573)**	**(830)**
Net increase/(decrease) in cash and cash equivalents		**5,681**	**(3,213)**	**(18,938)**
Cash and cash equivalents at the beginning of the year		43,783	24,774	43,712
Cash and cash equivalents at the end of the year		**49,464**	**21,561**	**24,774**

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

Statement of accounting policies

For the year ended 30 June 2017

Reporting entity

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

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

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

The financial statements for NMDHB are for the year ended 30 June 2017, and were approved by the Board on 30 October 2017.

Basis of preparation

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

Statement of compliance

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

Presentation currency and rounding

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

Summary of significant accounting policies

Revenue

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

MOH population-based revenue

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

MOH contract revenue

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

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

Inter-district flows

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

ACC contract revenue

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

Grants received

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

Donated assets

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

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

Rental revenue

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

Provision of services

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

Capital charge

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

Borrowing costs

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

Grant expenditure

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

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

Foreign currency transactions

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

Leases

Finance leases

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

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

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

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

Operating leases

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset to the lessee.

Lease payments under an operating lease are recognised as an expense on a straight-line basis over the lease term.

Lease incentives received are recognised in the surplus or deficit as a reduction of rental expense over the lease term.

Cash and cash equivalents

Cash and cash equivalents includes cash on hand, deposits held on call with banks, and other short-term highly liquid investments with original maturities of three months or less.

Receivables

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

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

Investments

Bank term deposits

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

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

Equity investments

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

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

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

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

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

Inventories

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

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

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

Non-current assets held for sale

Non-current assets held for sale are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. Non-current assets held for sale are measured at the lower of their carrying amount and fair value less costs to sell.

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

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

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

Property, plant, and equipment

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

Land is measured at fair value, and buildings are measured at fair value less accumulated depreciation.

All other assets classes are measured at cost, less accumulated depreciation and impairment losses.

Revaluations

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

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

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

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

Additions

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

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

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

Disposals

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

Subsequent costs

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

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

Depreciation

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

Asset	Useful Life (Years)	Depreciation Rate
Buildings & fit-out	10–76	1.3%–10%
Plant & equipment	2–20	5%–50%
Motor vehicles	5–16	6.25%–20%
Leased assets	2–7.25	13.8%–50%

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

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

Intangible assets

Software acquisition and development

Acquired computer software licenses are capitalised on the basis of the costs incurred to acquire and bring to use the specific software.

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

Staff training costs are recognised as an expense when incurred.

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

Costs associated with development and maintenance of NMDHB's website are recognised as an expense when incurred.

Amortisation

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

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

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

Impairment of property, plant, and equipment and intangible assets

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

Non-cash-generating assets

Property, plant, and equipment and intangible assets held at cost that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its

recoverable service amount. The recoverable service amount is the higher of an asset's fair value less costs to sell and value in use.

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

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

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

Finance Procurement Supply Chain, including National Oracle Solution

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

Payables

Short-term payables are recorded at their face value.

Borrowings

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

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

Employee entitlements

Short-term employee entitlements

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

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

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

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

Long-term employee entitlements

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

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

Presentation of employee entitlements

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

Superannuation schemes

Defined contribution schemes

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

Provisions

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

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

Restructuring

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

Onerous contracts

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

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

ACC Partnership Programme

NMDHB belongs to the ACC Partnership Programme (the "Full Self Cover Plan") whereby NMDHB accepts the management and financial responsibility for employee work-related illnesses and accidents. Under the programme, NMDHB is liable for all claims costs for a period of four years up to a specified maximum. At the end of the four-year period, NMDHB pays a premium to ACC for the value of residual claims, and from that point the liability for ongoing claims passes to ACC.

The liability for the ACC Partnership Programme is measured using actuarial techniques at the present value of expected future payments to be made in respect of the employee injuries and claims up to balance date. Consideration is given to anticipated future wage and salary levels and experience of employee claims and injuries. Expected future payments are discounted using market yields on government bonds at balance date with terms to maturity that match, as closely to possible, the estimated future cash outflows.

Equity

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

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

Property revaluation reserve

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

Fair value through other comprehensive revenue and expense reserves

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

Goods and services tax

All items in the financial statements are presented exclusive of GST, except for receivables and payables, which are presented on a GST-inclusive basis. Where GST is not recoverable as input tax, it is recognised as part of the related asset or expense.

The net amount of GST recoverable from, or payable to, the IRD is included as part of receivables or payables in the statement of financial position.

The net GST paid to, or received from, the IRD, including the GST relating to investing and financing activities, is classified as a net operating cash flow in the statement of cash flows.

Commitments and contingencies are disclosed exclusive of GST.

Income tax

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

Budget figures

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

Cost allocation

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

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

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

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

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

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

Critical accounting estimates and assumptions

In preparing these financial statements, NMDHB has made estimates and assumptions concerning the future. These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed below.

Estimating the fair value of land and buildings

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

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

At each balance date, the useful lives and residual values of property, plant, and equipment are reviewed. Assessing the appropriateness of useful life and residual value estimates of property, plant, and equipment requires a number of factors to be considered such as the physical condition of the asset, expected period of use of the asset by NMDHB, and expected disposal proceeds from the future sale of the asset.

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

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

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

Retirement and long service leave

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

Critical judgements in applying accounting policies

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

Leases classification

Determining whether a lease agreement is a finance lease or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to NMDHB.

Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term, and determining an appropriate discount rate to calculate the present value of the minimum lease payments. Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant, and equipment, whereas for an operating lease no such asset is recognised.

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

Grants received

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

Notes to the financial statements

For the year ended 30 June 2017

1. Revenue

	Actual 2017 $000	Actual 2016 $000
Health and disability services (MOH contracted revenue)	440,560	432,377
Inter-district patient inflows	8,740	8,580
ACC	5,237	4,716
Patient/consumer sourced revenue	6,535	6,345
Other government and DHB's	1,267	2,466
Total revenue	**462,339**	**454,484**

NMDHB has been provided with funding from the Crown for specific purposes of the DHB as set out in its founding legislation and the scope of the relevant government appropriations. Apart from these general restrictions, there are no unfulfilled conditions or contingencies attached to government funding (2016: $Nil).

2. Other revenue

	Actual 2017 $000	Actual 2016 $000
Donated property, plant and equipment	163	98
Rental revenue	1,327	1,336
Gain on disposal of property, plant and equipment	27	178
Other	2,532	3,318
Total other revenue	**4,049**	**4,930**

3. Personnel costs

	Actual 2017 $000	Actual 2016 $000
Salaries and wages	159,044	155,114
Defined contribution plan employer contributions	5,233	4,970
Other personnel costs	6,982	7,279
Total personnel costs	**171,259**	**167,363**

4. Capital charge

NMDHB pays a capital charge to the Crown based on its liable net assets as at 30 June and 31 December each year. The capital charge rate for the period ended 30 December 2016 was 7% and the period ended 30 June 2017 was 6% (2016 8%).

5. Finance revenue and costs

	Actual 2017 $000	Actual 2016 $000
Finance costs		
Interest on secured loans	1,633	2,733
Interest on finance lease	281	272
Total finance costs	**1,914**	**3,005**
Finance revenue		
Interest revenue	**1,849**	2,157
Total finance revenue	**1,849**	**2,157**

6. Other expenses

	Actual 2017 $000	Actua 2016 $000
Audit fees	177	160
Donations made	-	-
Koha	-	-
Impairment of property, plant and equipment	-	-
Impairment of receivables	175	283
Loss on disposal of property, plant and equipment	71	2
Write down to Fair Value on Loans provided to Golden Bay Health Trust	(77)	(74)
Rental and operating lease costs	2,951	2,702
Restructuring expenses	499	129
Total other expenses	**3,796**	**3,202**

7. Cash and cash equivalents

	Actual 2017 $000	Actual 2016 $000
Cash at bank and on hand	7	-
Cash advanced to NZHPL	21,554	24,774
Total cash and cash equivalents	**21,561**	**24,774**

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

8. Receivables

	Actual 2017 $000	Actual 2016 $000
Gross receivables	16,773	14,829
Less: provision for impairment	(772)	(677)
Total receivables	**16,001**	**14,152**
Gross receivables comprises of:		
Receivables from the Ministry of Health	3,421	3,327
Receivables from non-related parties	2,184	1,701
Accrued revenue	10,973	9,769
Other receivables	195	32
Total gross receivables	**16,773**	**14,829**

Ageing profile of receivables

	2017		2016	
	Gross $000	Impairment $000	Gross $000	Impairment $000
Not past due	11,167	33	10,435	(26)
Past due 1 - 30 days	3,402	(45)	2,957	(19)
Past due 31 - 60 days	1,293	(41)	637	(21)
Past due 61 - 90 days	151	(45)	103	(75)
Past due over 90 days	760	(674)	697	(536)
Total	**16,773**	**(772)**	**14,829**	**(677)**

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

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

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

	Actual 2017 $000	Actual 2016 $000
Provision for impairment at 1 July	677	458
Additional provisions made during the year	175	282
Receivables written off during the year	(80)	(63)
Provision for impairment at 30 June	**772**	**677**

9. Inventories

	Actual 2017 $000	Actual 2016 $000
Held for distribution inventories		
Pharmaceuticals	390	406
Other supplies	2,540	2,547
Provision for obsolete stock	(230)	(230)
Total inventories	**2,700**	**2,723**

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

In 2017, the value of inventories distributed and recognised as an expense in the clinical supplies expense included in the deficit was $24.1 million (2016: $20.5 million).

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

No inventories are pledged as security for liabilities.

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

	Actual 2017 $000	Actual 2016 $000
Non-current assets held for sale include:		
Land	-	-
Buildings	-	-
Total non-current assets held for sale	-	-
Non-current assets being prepared for sale include:		
Land	259	322
Buildings	205	165
Total non-current assets being prepared for sale	**464**	**487**

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

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

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

11. Other financial assets

	Actual 2017 $000	Actual 2016 $000
Current Portion		
Westpac Short Term Investment	12,351	6,000
Total Current Financial Assets	12,351	6,000
Non-current Portion		
Equity investments	3	3
Loans receivable	1,623	1,545
Westpac Long Term Investment	6,950	12,950
Total Non-Current Financial Assets	8,576	14,498
Total Financial Assets	**20,927**	**20,498**

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

In September 2013, NMDHB provided two loans to Golden Bay Integrated Health Centre (GBIFHC). The first loan is for $1,560,000, repayable over 25 years, interest free for 5 years. The second loan is for $778,000, repayable over 35 years but not before 25 years and is interest free.

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

12. Property, plant and equipment

	Land	Buildings	Plant and Equipment	Motor Vehicles	Leased Assets	Work in Progress	Total
	$000	$000	$000	$000	$000	$000	$000
Cost or valuation							
Balance at 1 July 2015	11,620	125,533	51,461	5,685	19,186	3,511	216,996
Additions	-	1,742	4,487	893	435	8,981	16,538
Revaluations	-	-	-	-	-	-	-
Disposals	-	-	(14)	(622)	-	(7,557)	(8,193)
Balance at 30 June 2016	**11,620**	**127,275**	**55,934**	**5,956**	**19,621**	**4,935**	**225,341**
Balance at 1 July 2016	11,620	127,275	55,934	5,956	19,621	4,935	225,341
Additions	-	1,305	5,189	412	1,193	10,300	18,399
Revaluations	-	-	-	-	-	-	-
Disposals	(157)	(157)	(851)	(51)	(57)	(8,100)	(9,373)
Balance at 30 Jun 2017	**11,463**	**128,423**	**60,272**	**6,317**	**20,757**	**7,135**	**234,367**
Accumulated depreciation and impairment losses							
Balance at 1 July 2015	-	68	37,203	3,710	10,924	-	51,905
Depreciation expense	-	4,977	3,657	530	830	-	9,994
Revaluations/Impairment	-	-	-	-	-	-	-
Disposals	-	-	-	(702)	-	-	(702)
Balance at 30 Jun 2016	-	**5,045**	**40,860**	**3,538**	**11,754**	-	**61,197**
Balance at 1 July 2016	-	5,045	40,860	3,538	11,754	-	61,197
Depreciation expense	-	5,650	2,900	463	557	-	9,570
Revaluations/Impairment	-	-	-	-	-	-	-
Disposals	-	-	-	-	-	-	-
Balance at 30 Jun 2017	-	**10,695**	**43,760**	**4,001**	**12,311**	-	**70,767**
Carrying Amounts							
At 1 July 2015	11,620	125,465	14,258	1,975	8,262	3,511	165,091
At 30 Jun/1 Jul 2016	11,620	122,230	15,074	2,418	7,867	4,935	164,144
At 30 June 2017	**11,463**	**117,728**	**16,512**	**2,316**	**8,446**	**7,135**	**163,600**

No impairment loss of has been recognised in 2017, (2016: Nil).

The most recent revaluation of land and buildings was carried out as at 30 June 2015 by M Lauchlan, a registered Valuer with Duke & Cooke Limited. A depreciated replacement cost methodology has been used. The revaluation excluded buildings purchased during that year. The next revaluation will be completed by 30 June 2020.

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

- The replacement asset is based on the replacement with modern equivalent assets, with adjustments where appropriate for optimisation due to over-design or surplus capacity.
- The replacement cost is derived from recent construction contracts of similar assets and Property Institute of New Zealand cost information.
- The remaining useful life of assets is estimated using recent asset management information.
- Straight-line depreciation has been applied in determining the depreciated replacement cost value of the asset.

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

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

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

NMDHB leases clinical and IT equipment under a number of finance lease agreements. At 30 June 2017, the net carrying amount of leased IT and clinical equipment was $1.26 million (2016: $0.44 million).

The total amount of property, plant, and equipment in the course of construction 2017 is $7.84 million (2016: $5.65 million).

13. Intangible assets

	NZHP	Acquired Software	Internally Generated Software	Total
	$000	$000	$000	$000
Movements for each class of intangible asset				
Balance at 1 July 2015	2,255	10,473	1,740	14,468
Additions	-	3,404	242	3,646
Disposals		(595)	-	(595)
Balance at 30 June 2016	**2,255**	**13,282**	**1,982**	**17,519**
Balance at 1 July 2016	2,255	13,282	1,982	17,519
Additions	-	3,750	104	3,854
Disposals		(2,179)	-	(2,179)
Balance at 30 June 2017	**2,255**	**14,853**	**2,086**	**19,194**
Accumulated amortisation and impairment losses				
Balance at 1 July 2015	-	7,120	166	7,286
Amortisation expense	-	791	27	818
Disposals	-	-	-	-
Impairment losses		-	-	-
Balance at 30 June 2016	-	**7,911**	**193**	**8,104**
Balance at 1 July 2016	-	7,911	193	8,104
Amortisation expense	-	785	60	845
Disposals	-	-	-	-
Impairment losses		-	-	-
Balance at 30 June 2017	-	**8,696**	**253**	**8,949**
Carrying amounts				
At 1 July 2015	2,255	3,353	1,574	7,182
At 30 June / 1 July 2016	2,255	5,371	1,789	9,415
At 30 June 2017	**2,255**	**6,157**	**1,833**	**10,245**

Included in the Internally Generated Software is a total of $0.81 million (2016: $0.80 million) which is work in progress.

NZ Health Partnerships Limited (NZHP) was established on 1 July 2015 taking on the assets and liabilities of Health Benefits Limited (HBL). HBL was an agency set up by all the Ministry of Health to provide shared services for District Health Boards. The investment was made to fund the establishment of a shared service arrangement to support the delivery of Finance, Procurement and Supply Chain services. NZHP is owned by the 20 district health boards with each of the district health boards owning five (5) "A" Class shares. The A class shares have been issued for a nil consideration. All district health boards also own "B" Class shares in NZHP reflecting the level of investment in the FPSC Programme. The NMDHB holding of B class shares is 2,255,000 shares of the total B Class shares issued of 68,333,000.

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

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

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

The current expectation of the Board is that the FPSC/NOS programme will proceed as planned. In this scenario, the DRC of the FPSC/NOS rights is consider to equate to, in all material respects, to the costs capitalised to date such that the FPSC/NOS rights are not impaired.

No impairment losses have been recognised (2016: $Nil).

14. Payables

	Actual 2017 $000	Actual 2016 $000
Payables under exchange transactions		
Creditors	5,271	4,026
Revenue in advance	3,814	1,481
Capital charge payable	-	-
Other	18,064	22,412
Total payables under exchange transactions	**27,149**	**27,919**
Payables under non-exchange transactions		
Capital charge payable	-	-
Taxes payable (GST, Employer Deductions & FBT)	3,591	5,585
Other	351	1,078
Total payables under non-exchange transactions	3,942	6,663
Total Payables	**31,091**	**34,582**

15. Borrowings

	Actual 2017 $000	Actual 2016 $000
Current portion		
NZDMO Loans	-	6,000
Finance leases	477	556
Total current portion	**477**	**6,556**
Non-current portion		
NZDMO loans	-	49,500
Finance leases	8,663	7,468
Total non-current portion	**8,663**	**56,968**
Total borrowings	**9,140**	**63,524**

NZDMO loans

	Actual 2017 $000	Actual 2016 $000
Loans are repayable as follows:		
Not later than one year	-	6,000
Later than one year and not later than five years	-	41,500
Later than five years	-	8,000
Total NZDMO loans	-	**55,500**

Conversion of existing Crown loans to Crown equity

In September 2016 Cabinet agreed that the DHB sector should no longer access Crown debt and agreed to convert all existing DHB Crown debt into Crown equity.

On the 15 February 2017 all existing Crown loans were converted into Crown equity and from that day onward all Crown capital contributions would be made via Crown equity injections.

The termination of the loan agreement and the conversion of existing Crown loans to equity was completed by a non-cash transaction, other than for interest due at the conversion date.

As a consequence of the changes there has been a decrease in 2016/17 for the interest costs avoided from the conversion date until the end of the 2016/17 year and increasing DHB appropriations for the increased capital charge cost to the DHB thereafter.

Finance leases

	Actual 2017 $000	Actual 2016 $000
Minimum lease payments payable:		
Not later than one year	824	762
Later than one year and not later than five years	3,278	1,968
Later than five years	13,238	13,366
Total minimum lease payments	**17,340**	**16,096**
Future finance charges	(6,704)	(8,072)
Present value of minimum lease payments	**10,636**	**8,024**
Present value of minimum lease payments payable:		
Not later than one year	477	500
Later than one year and not later than five years	2,049	959
Later than five years	8,110	6,565
Total present value of minimum lease payments	**10,636**	**8,024**

Description of Material Leasing Arrangements

NMDHB has entered into finance leases primarily for IT equipment, and for certain items of clinical equipment. The net carrying amount of the leased items within each class of property, plant and equipment, and intangible assets is shown in notes 12 & 13.

In September 2013 NMDHB set up a finance lease to account for the lease of the completed Golden Bay Integrated Health Centre facilities to the Golden Bay Community Health Trust. The initial terms had a Net Present Value of $8,386,915, a discount rate of 4.75% and a term of 35 years. At 30 June 2017, Golden Bay Community Health Trust had an outstanding lease liability with a present value of $7,468,348 (2016: $7,707,974). NMDHB does not have the option to purchase the asset at the end of the lease term.

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

16. Employee entitlements

	Actual 2017 $000	Actual 2016 $000
Current Portion		
Accrued salaries & wages	4,743	3,239
Annual leave	18,224	17,813
Sick leave	601	562
Sabbatical leave	210	196
Retirement gratuities	2,147	2,093
Long service leave	637	622
Continuing medical education	3,626	3,808
Total current portion	**30,188**	**28,333**
Non-current portion		
Sick leave	770	729
Sabbatical leave	793	839
Retirement gratuities	5,793	6,215
Long service leave	2,567	2,622
Total non-current portion	**9,923**	**10,405**
Total employee entitlements	**40,111**	**38,738**

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.

Annual leave

The private and public sector have experienced widespread payroll issues relating to the Holiday's Act and employment agreements. This is particularly for a workforce with rostered employees working on varying work patterns. A proactive approach to finding a long term pay process solution is currently being undertaken by management to identify risk areas focusing on systems, reporting & analytics, people and processes.

Since the issues are currently being reviewed the holiday pay provision recognised is estimated based on the best information available at the date of this annual report. Once the issues have been resolved the actual liability may be different.

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 1.87% to 3.61% (2016: 2.03% to 4.75%), with an average of 2.87% (2016: 3.79%). A salary inflation factor of 2.0% (2016: 2.0%) has been used per year. The take-up rate used for sabbatical leave is 16% (2016: 16%).

Sick leave

The discount rates used in the valuation are the risk free rates as determined by the NZ Treasury and published on its website. The average discount rate is 2.9% (2016: 2.5%). Average future salary growth has been assumed to be 2.0% per annum, plus a salary scale of 1% per annum.

17. Provisions

	Actual 2017 $000	Actual 2016 $000
Current portion		
Restructuring	48	836
ACC Partnership Programme	407	486
Total current portion	**455**	**1,322**
Total provisions	**455**	**1,322**

Movements for each class of provision are as follows:

	Restructures $000	*ACC* $000	*Total* $000
Balance at 1 July 2015	806	358	1,164
Additional provisions made	759	128	887
Amounts used	(495)	-	(495)
Unused amounts reversed	(234)	-	(234)
Balance at 30 June 2016	**836**	**486**	**1,322**
Balance at 1 July 2016	836	486	1,322
Additional provisions made	257	-	257
Amounts used	(463)	-	(463)
Unused amounts reversed	(582)	(79)	(661)
Balance at 30 June 2017	**48**	**407**	**455**

Restructuring provisions

An amount of $0.458 million has been released from the provision in relation to completed restructuring initiatives, and revisions to the estimated redundancy costs for initiatives not yet completed. (2016: $0.495).

ACC partnership programme

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

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

An external independent Actuarial Valuer, Marcelo Lardies (BSc (Hons), Fellow of the NZ Society of Actuaries) from Aon New Zealand Limited, has calculated the DHB's liability, and the last valuation was effective at 30 June 2017. The valuer has attested he is satisfied as to the completeness and accuracy of the data used to determine the outstanding claims liability. There are no qualifications contained in the actuarial valuer's report.

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

Pre valuation date claim inflation has been taken as 50% of movements in the Consumer Price Index and 50% of the movements in the Average Wage Earnings index. Post valuation date claim inflation has been taken as 1.7% per annum. The discount rate used is the Treasury-issued future rates as at 31 March 17 (2016: 4.2%).

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

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

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

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

NMDHB is not exposed to any significant concentrations of insurance risk as work related injuries are generally the result of an isolated event to an individual employee.

18. Equity

	Actual 2017 $000	Actual 2016 $000
Crown equity		
Balance at 1 July	27,493	28,040
Capital contribution	-	-
Conversion of Loans to Equity	55,500	
Repayment of capital	(547)	(547)
Balance at 30 June	**82,446**	**27,493**
Accumulated surplus/(deficit)		
Balance at 1 July	17,952	16,398
Surplus/(deficit) for the year	3,229	1,554
Property revaluation reserve transfer on disposal	-	-
Balance at 30 June	**21,181**	**17,952**
Revaluation reserves		
Balance at 1 July	53,213	53,213
Revaluations	-	-
Impairment charge	-	-
Transfer to accumulated surplus/(deficit) on disposal	-	-
Balance at 30 June	**53,213**	**53,213**
Revaluation reserves consist of		
Land	8,125	8,125
Buildings	45,088	45,088
Total revaluation reserves	**53,213**	**53,213**
Financial assets at fair value through other comprehensive revenue and expense reserves		
Balance at 1 July	-	-
Net change in fair value	-	-
Transfer to surplus/(deficit) on disposal	-	-
Balance at 30 June	-	-
Total Equity	**156,840**	**98,658**

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

During the year all existing Crown loans were converted into Crown equity (refer Note 15 for more detail).

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

	Actual 2017 $000	Actual 2016 $000
Net surplus/(deficit)	3,229	1,554
Add/(less) non-cash items		
Depreciation and amortisation expense	10,415	10,812
Impairment losses	-	-
Total non-cash items	**10,415**	**10,812**
Add/(less) items classified as investing or financing activities		
Fair value movement on loans and receivables	(77)	(74)
(Gains)/losses on disposal of property, plant and equipment	(27)	(178)
Total items classified as investing or financing activities	**(104)**	**(252)**
Add/(less) movements in statement of financial position items		
(Increase)/Decrease in receivables	(1,849)	(3,371)
(Increase)/Decrease in prepayments	(1,508)	(137)
(Increase)/Decrease in inventories	23	(20)
Increase/(Decrease) in payables	(3,491)	5,586
Increase/(Decrease) in employee entitlements	1,373	(1,757)
Increase/(Decrease) in provisions	(867)	158
(Increase)/Decrease in payables relating to purchase of property, plant and equipment	(146)	(402)
Net movements in statement of financial position items	**(6,465)**	**57**
Net cash flow from operating activities	**7,075**	**12,171**

20. Capital commitments and operating leases

	Actual 2017 $000	Actual 2016 $000
Capital commitments		
Property, plant and equipment	2,089	1,937
Intangible assets	241	46
Total capital commitments	**2,330**	**1,983**
Non-cancellable Provider commitments		
Not later than one year	16,559	9,041
Later than one year and not later than five years	18,134	18,083
Later than five years	2,282	4,417
Total non-cancellable Provider commitments	**36,975**	**31,541**
Non-cancellable operating lease commitments		
Not later than one year	970	1,056
Later than one year and not later than five years	2,541	2,848
Later than five years	1,575	2,123
Total non-cancellable operating lease commitments	**5,086**	**6,027**
Non-cancellable finance lease commitments		
Not later than one year	824	762
Later than one year and not later than five years	3,278	1,968
Later than five years	13,238	13,366
Total non-cancellable finance lease commitments	**17,340**	**16,096**
Non-cancellable other commitments		
Not later than one year	1,560	669
Later than one year and not later than five years	150	-
Later than five years	151	-
Total non-cancellable other lease commitments	**1,861**	**669**
Total commitments	**63,592**	**56,316**

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

The provider commitments disclosed in this note include committed obligations for health purchasing expenditure with NGOs. The Board is also obligated to funding significant streams of 'demand driven' health purchasing expenditure. Commitments of this nature are in place for the purchase of pharmacy, GP services and for Health of Older People residential and community based services. Because this expenditure is 'demand driven' it is not possible to quantify the obligation in this note. Expenditure of this nature in the 2017 year totalled $126.6 million (2016: $122.4 million).

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

Leases as lessee

Total future minimum lease payments to be paid under non-cancellable operating leases at balance date as a lessee are $5,085 million, (2016, $6,028 million).

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

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

During the year ended 30 June 2017, $2,947,062 was recognised as an expense in the surplus or deficit in respect of operating leases (2016: $2,701,952).

Leases as lessor

NMDHB leases owned properties to third parties under operating leases resulting in revenue of $1.3 million (2016: $1.3 million). These leases are for periods ranging initially from 2 to 99 years. In some cases, rights of renewal for one or more terms ranging from 2 to 5 years are provided. Some leases are subject to the terms of service contracts.

The total future minimum lease payments under non-cancellable operating leases as a lessor at balance date are $5.214 million (2016: $5.896 million).

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

21. Contingencies

Contingent liabilities

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

NMDHB has no other contingent liabilities as at 30 June 2017 (2016: $0m).

Contingent assets

NMDHB has no contingent assets as at 30 June 2017 (2016: $0m).

22. Related party transactions

Government-related entities

NMDHB is a wholly-owned entity of the Crown.

Significant transactions with government related entities

The DHB has received funding from the Crown and ACC of $446.9 million (2016: $439.3 million) to provide health services in the Nelson Marlborough area for the year ended 30 June 2017.

Revenue earned from other DHBs for the care of patients outside NMDHB's district amounted to $8.9 million (2016: $8.9 million) for the year ended 30 June 2017. Expenditure to other DHBs for their care of patients from NMDHB's district amounted to $43.0 million (2016: $45.0 million) for the year ended 30 June 2017.

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

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

NMDHB also purchases goods and services from entities controlled, significantly influenced, or jointly controlled by the Crown. Purchases from these government-related entities for the year ended 30 June 2017 totalled

$2.1 million (2016: $3.1 million). These purchases included the purchase of electricity from Genesis Energy, air travel from Air New Zealand, and energy from Solid Energy.

Transactions with subsidiaries

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

Donations received from NMCHT for the financial year were $0 (2016: $85,000).

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

Transactions with key management personnel

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

	Actual 2017 $000	Actual 2016 $000
Board Members		
Remuneration	238	265
Full-time equivalent members	11	11
Leadership Team		
Remuneration	2,894	2,850
Full-time equivalent members	12	13
Total key management personnel remuneration	3,132	3,115
Total fill time equivalent personnel	**23**	**24**

Key management personnel includes all Board members, the Chief Executive, and members of the Leadership Team & their close family members. Due to the difficulty in determining the full-time equivalent of Board Members, the full-time equivalent figure is taken as the number of Board Members.

NMDHB entered into a variety of transactions with Golden Bay Community Health Trust during the financial year. NMDHB's General Manager, Finance and Performance, Eric Sinclair, is a Trustee of the Golden Bay Community Health Trust. The NMDHB has a loan with present value of $1.6 million to the Golden Bay Community Health Trust and has an outstanding lease liability with a present value of $7.47 million (Discount rate: 4.75%) at the end of the financial year. Lease payments to the Golden Bay Community Health Trust are expected to cease in the year 2048. The relationship of the lease and liability has been disclosed in Note 15. There are no outstanding balances for unpaid invoices at year end.

The NMDHB purchased services from the Marlborough District Council during the financial year. Gerald Hope, an NMDHB Board Member is a District Councillor of Marlborough District Council. Payments to Marlborough District Council during the Financial Year totalled $8,000. The services provided for and from Marlborough District Council were on normal commercial terms. There are no outstanding unpaid invoices at year end.

The NMDHB purchased and received services from the Churchill Trust during the financial year. The NMDHB's Chief executive is a Trustee of the Churchill Trust. Revenue services from the Churchill Trust totalled $3.6 million during the financial year. The services provided for and from the Churchill Trust were on normal commercial terms. There is a balance of $0.2 million outstanding for outstanding receipts at year end.

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

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

23. Events after the balance date

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

24. Financial instruments

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

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

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

Interest rate risk

Interest rate risk is the risk that the interest component of a financial instrument will fluctuate due to changes in market rates. This could particularly impact on the costs of borrowing or the return from investments. The Board does not consider there is any significant exposure to interest rate risk on its investments.

The interest rates on the Board's borrowings are disclosed in Note 15.

There are no interest rate options or interest swap agreements in place as at 30 June 2017 (2016: $Nil).

Credit rate risk

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

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

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

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

At balance date there were no significant other concentrations of credit risk. The maximum exposure to credit risk is represented by the carrying amount of cash and cash equivalents (note 7), and debtors and other receivables (note 8).

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

	2017 $000	2016 $000
Counterparties with credit ratings:		
Cash and cash equivalents		
AA	-	-
Investments		
AA	-	-
Total counterparties with credit ratings	-	-
Counterparties without credit ratings		
Cash on hand	7	-
Funds advanced to NZHP	21,554	24,774
Total counterparties without credit ratings	**21,561**	**24,774**
Receivables		
Existing counterparties with no defaults in the past	15,921	14,049
Existing counterparty with defaults in the past	80	103
Total receivables	**16,001**	**14,152**

Currency risk

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

NMDHB had no foreign currency assets or liabilities as at 30 June 2017 (2016: Nil). During the year, expenditure invoiced in foreign currencies was recorded in NZD calculated with the same exchange rates as those used for the payments for those invoices. No exchange rate gains or losses were recorded.

Liquidity risk

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

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

2017	Balance Sheet $000	Contractual Cash $000	6 mths or less $000	6-12 mths $000	1-2 years $000	2-5 years $000	More than 5 years $000
DMO Loans	-	-	-	-	-	-	-
Finance lease liabilities	10,636	17,340	-	824	824	2,454	13,238
Creditors and other payables	30,830	30,830	30,830	-	-	-	-
Total current assets	41,466	48,170	30,830	824	824	2,454	13,238

2016	Balance Sheet $000	Contractual Cash $000	6 mths or less $000	6-12 mths $000	1-2 years $000	2-5 years $000	More than 5 years $000
DMO Loans	55,500	55,500	-	6,000	15,000	26,500	8,000
Finance lease liabilities	8,024	16,096	-	762	492	1,476	13,366
Creditors and other payables	27,516	27,516	27,516	-	-	-	-
Total current assets	91,040	99,112	27,516	6,762	15,492	27,976	21,366

Sensitivity analysis

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

At 30 June 2017, it is estimated that a general increase of one percentage point in interest rates would decrease NMDHB's deficit by approximately $400,562 (2016: $247,000).

Market risk

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

Classification and fair values

	Note	Loans and receivables	Available for sale	Amortised cost	Carrying amount	Fair value
		$000	$000	$000	$000	$000
30 June 2017						
Current assets						
Cash and cash equivalents	7	21,561	-	-	21,561	21,561
Receivables	8	16,001	-	-	16,001	16,001
Other financial assets	11	12,351	-	-	12,351	12,351
Total current assets		**49,913**	-	-	**49,913**	**49,913**
Non-current assets						
Other financial assets	11	8,573	3		8,576	8,576
Total non-current assets		**8,573**	**3**	-	**8,576**	**8,576**
Total assets		**58,486**	**3**	-	**58,489**	**58,489**
Current liabilities						
Payables	14	-	-	23,686	23,686	23,686
Finance leases	15	-	-	477	477	477
NZDMO loans	15			-	-	-
Total current liabilities		-	-	**24,163**	**24,163**	**24,163**
Non-current liabilities						
Finance leases	15			8,663	8,663	8,663
NZDMO loans	15			-	-	-
Total non-current liabilities		-	-	**8,663**	**8,663**	**8,663**
Total liabilities		-	-	**32,826**	**32,826**	**32,826**
30 June 2016						
Current assets						
Cash and cash equivalents		24,774	-	-	24,774	24,774
Receivables		14,152	-	-	14,152	14,152
Other financial assets		6,000	-	-	6,000	6,000
Total current assets		**44,926**	-	-	**44,926**	**44,926**
Non-current assets						
Other financial assets		14,495	3		14,498	14,498
Total non-current assets		**14,495**	**3**	-	**14,498**	**14,498**
Total assets		**59,421**	**3**	-	**59,424**	**59,424**
Current liabilities						
Payables		-	-	27,516	27,516	27,516
Finance leases		-	-	556	556	556
NZDMO loans				-	-	6,027
Total current liabilities		-	-	**28,072**	**28,072**	**34,099**
Non-current liabilities						
Finance leases				7,468	7,468	7,468
NZDMO loans				-	-	53,501
Total non-current liabilities		-	-	**7,468**	**7,468**	**60,969**
Total liabilities		-	-	**35,540**	**35,540**	**95,068**

25. Capital Management

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

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

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

There have been no material changes in NMDHB's management of capital during the year (2016: Nil).

26. Explanation of major variances against budget

Statement of comprehensive revenue and expense

Revenue

An adjustment to the total revenue stream was made by the Ministry of Health to account for the changes in the capital charge rate (reduced from 8% to 6%) and the conversion of all Crown Loans to Crown Equity (refer Note 15):

Expenditure

As noted in the revenue comments above, the costs associated with Capital Charge and the Interest Expense changed during the year. Other expenses were higher than projected reflecting natural variation of activity across hospital, primary and community health activity.

Statement of financial position

The projections in the 2016/17 Annual Plan was based on forecasts prepared well before the end of the 2015/16 year. A comparison of the actual balances with the plan would include amounts reflecting differences between the forecast and reported 2015/16 balances. These amounts comprised increases of $3.0 million in assets, $0.4 million in liabilities and $3.4 million in equity, and explain most of the variances from budget except the conversion of $55.5 million from Crown Loans to Crown Equity.

Statement of cash flows

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

27. Non-consolidation of subsidiary

Nelson Marlborough Hospitals Charitable Trust (NMCHT) provides health related services, projects, research, and education to the residents of the NMDHB catchment area. In previous years NMCHT has been considered a subsidiary of NMDHB but has not been considered material to be consolidated within the NMDHB financial statements.

During 2016/17 changes were made to the governance structures of NMCHT that mean NMCHT is not controlled by NMDHB in accordance with PBE IPSAS 6 and therefore NMCHT is no longer considered a subsidiary of NMDHB.

28. Mental health ring-fenced accounts

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

	Actual 2017 $000	Actual 2016 $000
Mental health funds		
Opening balance	889	264
Excess/(shortfall) of funding over payments	873	625
Adjustments to funds available		-
Total mental health funds	**1,762**	**889**

29. Summary of revenue and expenditure by output class

	Budget 2017 $000	Actual 2017 $000	Actual 2016 $000
Revenue			
Prevention services	8,364	7,758	8,295
Early detection and management services	122,121	123,372	117,809
Intensive assessment and treatment services	243,035	245,297	243,471
Support services	97,154	91,810	91,997
Total revenue	**470,674**	**468,237**	**461,572**
Expenditure			
Prevention services	7,366	7,031	7,820
Early detection and management services	117,158	119,501	115,668
Intensive assessment and treatment services	245,761	246,328	243,315
Support services	96,389	92,148	93,214
Total expenditure	**466,674**	**465,008**	**460,017**
Surplus/(deficit)			
Prevention services	998	727	475
Early detection and management services	4,963	3,871	2,141
Intensive assessment and treatment services	(2,726)	(1,031)	156
Support services	765	(338)	(1,217)
Total surplus/(deficit)	**4,000**	**3,229**	**1,555**

Audit report

To the readers of Nelson Marlborough District Health Board's financial statements and performance information for the year ended 30 June 2017

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

We have audited:

- the financial statements of the Health Board on pages 48 to 83 that comprise the statement of financial position as at 30 June 2017, the statement of comprehensive revenue and expense, statement of changes in net assets/equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Health Board on pages 27 to 47.

Opinion

Unmodified opinion on the financial statements

In our opinion, the financial statements of the Health Board on pages 48 to 83:

- present fairly, in all material respects:
    - its financial position as at 30 June 2017; and
    - its financial performance and cash flows for the year then ended; and
- comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards.

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

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

Our audit opinion on the performance information of the Health Board for the period ended 30 June 2016, which is reported as comparative information, was modified for the same reason.

In our opinion, except for the matters described above, the performance information of the Health Board on pages 27 to 47:

- presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2017, including:
  - for each class of reportable outputs:
    - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
    - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year;
  - what has been achieved with the appropriation; and
  - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and
- complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 30 October 2017. This is the date at which our opinion is expressed.

The basis for our opinion is explained below. In addition, we outline the responsibilities of the Board and our responsibilities relating to the financial statements and the performance information, we comment on other information, and we explain our independence.

Basis for our opinion

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

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

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

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

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

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

In preparing the financial statements and the performance information, the Board is responsible on behalf of the Health Board for assessing the Health Board's ability to continue as a going concern. The Board is also responsible for disclosing, as applicable, matters related to going concern and using the going concern basis of

accounting, unless there is an intention to liquidate the Health Board or there is no realistic alternative but to do so.

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

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

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

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

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

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

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

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

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

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

Our responsibilities arise from the Public Audit Act 2001.

Other Information

The Board is responsible for the other information. The other information comprises the information included on pages 1 to 26 but does not include the financial statements and the performance information, and our auditor's report thereon.

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

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

Independence

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

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

Ian Lothian
Audit New Zealand

On behalf of the Auditor General
Christchurch, New Zealand

TE WAIORA Nelson Marlborough Health

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Nelson Marlborough District Health Board