TE WAIORA Nelson Marlborough Health

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Presented to the House of Representatives pursuant to sections 150 of the Crown Entities Act 2004

Annual Report 2020/21

Contents

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 and community 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.

The 2020/21 financial year is another year that is unlike any other we have experienced since the establishment of DHBs back on 1 January 2001. The continued impact of the Covid-19 pandemic that started for us in early 2020 continued to be felt through the 2020/21 year and as we write this report we are seeing the public of New Zealand health system respond to the delta variant into late 2021. The announcement by the Government of the significant overhaul of the health system early in 2021 also creates new opportunities for the future.

Through these and the other events that have occurred during this last financial year, one thing has stayed the same – the effort and energy that everyone at NMH has brought to work has stayed grounded in our values and our dedicated teams have continued to provide the best possible care for our community. There have been numerous innovations, initiatives and investments that have been made through the financial year that have strengthened our health system and sought to make it more accessible and equitable for everyone in our region. We will continue to push the Ki Te Pae Ora programme of work as it remains crucial to ensuring our health system is sustainable and fit for the future.

A strong focus has been on establishing the Covid-19 vaccination programme as we strive to achieve the 90% target by the end of 2021. By the end of the 2020/21 financial year we had undertaken first doses on 32,179 people and second doses on 22,531 people – that's 24% and 17% of the population eligible for the vaccine at 30 June 2021 respectively and we are on track to achieve the 90% second dose target by the end of the 2021 year.

We have also continued to progress the Nelson Hospital Redevelopment project with work underway to complete the detailed business case in conjunction with the Health Infrastructure Unit. Alongside this, we have continued our focus on key areas within an interim facilities programme of work including a new purpose-built dialysis building, relocation of the ophthalmology service and extensions for the emergency department. This interim programme is essential to ensure we can meet the growing demand for health services until the completion of the Nelson Hospital rebuild.

Health is never delivered by one person, but by a team of people working in partnership underpinned by respect and compassion. Thank you to everyone for your contribution to the NMH healthcare system during 2020/21.

Jenny Black
Board Chair

Lexie O'Shea
Chief Executive

A day in the life of NMH

In 24 hours across our district

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 processes 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 2019 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, the Board has formed the Audit and Risk Committee.

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.

The following table shows the Board members through the year:

Name	Appointment	
Jenny Margery Black	Elected	Chair
Craig Dennis	Appointed	Deputy Chair
Brigid Forrest	Elected	
Olivia Hall	Appointed	
Gerald Hope	Elected	
Jill Kersey	Appointed	
Dawn McConnell	Appointed	
Paul Matheson	Elected	
Jacinta Newport	Elected	
Allan Panting	Elected	
Stephen Vallance	Elected	

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 2020/21 was as follows:

Board Member	Board		Advisory Committees		A&RC	
Name	Held	Attended	Held	Attended	Held	Attended
Jenny Black	11	11	10	10	4	3
Craig Dennis	11	11	10	10	4	4
Brigid Forrest	11	11	10	10	4	4
Olivia Hall	11	11	10	8		
Gerald Hope	11	8	10	7	4	4
Jill Kersey	11	7	10	6		
Dawn McConnell	11	10	10	9		
Paul Matheson	11	8	10	7		
Jacinta Newport	11	9	10	8		
Allan Panting	11	10	10	9	4	3
Stephen Vallance	11	11	10	10		

Key: Advisory Committee: The three NMH statutory committees consisting of Hospital Advisory Committee (HAC), Community & Public Health Advisory Committee (CPHAC) and Disability Support Advisory Committee (DiSAC)
A&RC: Audit & Risk Committee

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 2021 $000	Actual 2020 $000
Value of Board member remuneration		
Jenny Black (Chair)	47	42
Craig Dennis	30	26
Brigid Forrest	24	23
Olivia Hall	24	13
Gerald Hope	24	22
Jill Kersey	25	13
Dawn McConnell	26	22
Paul Matheson	23	13
Jacinta Newport	23	13
Allan Panting	24	23
Stephen Vallance	23	22
Alan Hinton	-	12
Jenny Margaret Black	-	10
Judy Crowe	-	9
Patrick Smith	-	10
Total remuneration	**293**	**273**

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 2021:

Board members

Name	Interest
Jenny Black *(Chair)*	▪ Chair, South Island Alliance Board ▪ Chair, National DHB Chairs group ▪ Director of Central Region Technical Advisory Services Ltd ▪ Chair, Te Hiringa Hauora
Craig Dennis *(Deputy Chair)*	▪ Director, Taylors Contracting Co Ltd ▪ Director of CD & Associates Ltd ▪ Director of KHC Dennis Enterprises Ltd ▪ Director of 295 Trafalgar Street Ltd ▪ Director of Scott Syndicate Development Company Ltd ▪ Director of Malthouse Investment Properties Ltd
Brigid Forrest	▪ Doctor, Hospice Marlborough (employed by Salvation Army) ▪ Locum GP in Marlborough (not a member of PHO) ▪ Daughter-in-law employed by Nelson Bays Primary Health as a Community Dietician ▪ Small Shareholder and Director on the Board of Marlborough Vintners Hotel ▪ Joint owner, Forrest Wines Ltd
Gerald Hope	▪ Chief Executive, Marlborough Research Centre ▪ Director, Maryport Investments Ltd ▪ Councillor Marlborough District Council (Wairau Awatere Ward)
Jill Kersey	▪ Board Member, Nelson Brain Injury Association
Olivia Hall	▪ Chair of parent organisation of Te Hauroa o Ngāti Rārua ▪ Employee of NMIT ▪ Chair of Te Rūnanga o Ngāti Rārua ▪ Chair, Tasman Bays Heritage Trust (Nelson Provincial Museum)
Dawn McConnell	▪ Te Ātiawa representative and Chair Iwi Health Board ▪ Director, To Hauora O Ngāti Rārua ▪ Trustee, Waikawa Marae ▪ Regional Iwi representative, Department of Internal Affairs
Paul Matheson	▪ Chair, Top of the South Regional Committee, NZ Community Trust
Jacinta Newport	▪ Employee of West Coast DHB as rural nurse specialist ▪ Trustee of Medical Cannabis Awareness NZ ▪ Owner/Director of Helibike Nelson

Name	Interest
Allan Panting	▪ Chair General Surgery Prioritisation Working Group ▪ Chair Ophthalmology Service Improvement Advisory Group ▪ Chair Maternal Foetal Medicine Service Improvement Advisory Group ▪ Chair National Orthopaedic Sector Group
Stephen Vallance	▪ Chairman, Crossroads Trust Marlborough

Executive leadership team

Name	Interest
Lexie O'Shea *Interim Chief Executive*	▪ Board Member, Health Roundtable ▪ Trustee, Churchill Hospital
Nick Baker *Chief Medical Officer*	▪ Senior Clinical Lecturer, Community Child Health, University of Otago Wellington School of Medicine ▪ Member Steering Group NZ Child and Youth Epidemiology Service ▪ Member of Paediatric Society of NZ ▪ Fellow Royal Australian College of Physicians ▪ Occasional Expert Witness Work – Ministry of Justice ▪ Technical Expert DHB Accreditation for the Ministry of Health ▪ Associate Fellow Royal Australian College of Medical Administrators ▪ Fellow Royal Meteorological Society ▪ Member, NZ Digital Investment Board, Ministry of Health ▪ Member of Dunedin Hospital Executive Steering Group
Hilary Exton *GM Allied Health*	▪ Member of the Nelson Marlborough Cardiology Trust ▪ Member of Physiotherapy New Zealand
Pam Kiesanowski *Director of Nursing & Midwifery*	▪ Chair SI NENZ Group
Jane Kinsey *GM MH & Addictions & DSS*	▪ Husband works for NMH in AT&R as a Physiotherapist ▪ Board member for Distance Running Academy
Kirsty Martin *GM Information Technology*	▪ Nil
Cathy O'Malley *GM Strategy Primary & Community*	▪ Daughter employed by NMH within Pharmacy service ▪ Sister employed by Marlborough PHO
Pat Davidsen *Interim GM Clinical Services*	▪ Chair, Nayland College ▪ Brother undertakes some graphic design work for NMH ▪ Brother employed by Medical & Injury Centre
Eric Sinclair *GM Finance, Performance & Facilities*	▪ Trustee of Golden Bay Community Health Trust ▪ Wife is a Registered Nurse working in General Practice
Ditre Tamatea *GM Māori Health & Vulnerable Populations*	▪ Partner is an Obstetric and Gynaecological Consultant working in other DHBs.

Name	Interest
Trish Casey *General Manager People & Capability*	▪ Husband is shift manager of St John Ambulance ▪ Trustee, Empowerment Trust
Dr Elizabeth Wood *Chair, Clinical Governance Committee*	▪ General practitioner Mapua Health Centre ▪ MCNZ Performance Assessment Committee Member ▪ PCM trainer and licensee

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 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 December 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, 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
- the direction to act consistently with the national-level plans and policies related to the Government response to the COVID-19 pandemic
- the direction to specify the persons who are eligible to receive the publicly funded Covid-19 vaccination.

Our people

Our people are the key to ensuring NMH can sustainably respond to increasing demands for services across our district.

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

A skilled, supported, responsive and diverse workforce is essential for sustainable service delivery. NMH needs the right mix of people in sufficient supply working in partnership with each other and 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 must take responsibility and make improvements to continually develop and support our people so that our workforce culture is inclusive and empowering. 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.

Health, safety and wellbeing

All NZ workforces are covered by the *Health and Safety at Work Act 2015* and regulations made under the Act (unless specifically excluded), and are 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
- a culture where our staff are encouraged to take ownership of safety, speak up and be heard
- emergency procedures support, and supportive debriefs for our staff
- hazard/risk reporting, monitoring and management systems, tools and resources
- adequate training and 'work site' specific induction processes
- document and data control
- workplace health and 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 – both lag and lead indicators.

Good employer

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

- NMH values – Integrity, Respect, Innovation and Team Work
- leadership, accountability and culture
- health, safety and wellbeing
- equal employment opportunities
- recruitment, selection and induction
- remuneration, recognition and conditions
- a programme to increase the participation of Māori in our workforce
- recognition of the aims and cultural differences of ethnic and minority groups, and building of cultural competence
- 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 highly contestable recruitment and selection procedure is followed to ensure fairness and equity in employment opportunities.

Learning, 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.

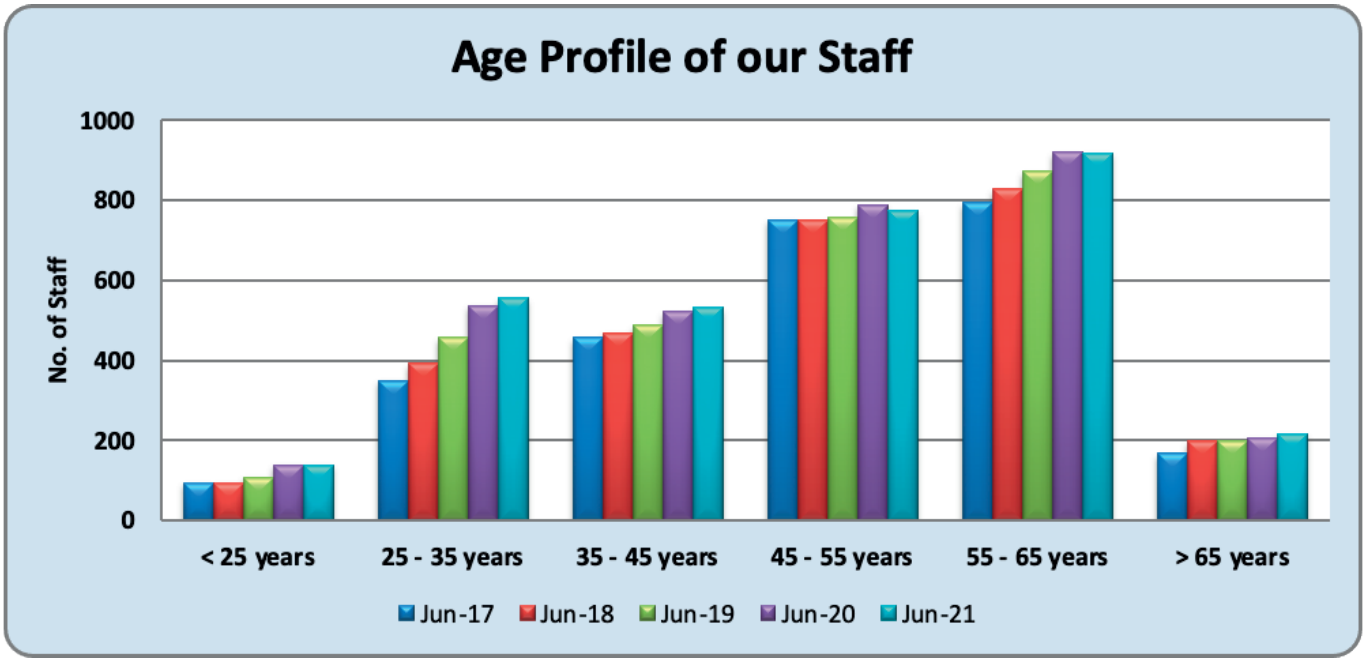
Employee by gender	Jun-17	Jun-18	Jun-19	Jun-20	Jun-21
Female	2,177	2,281	2,393	2,547	2,559
Male	474	481	522	599	612
Undefined					1
Total staff (headcount)	**2,651**	**2,762**	**2,915**	**3,146**	**3,172**

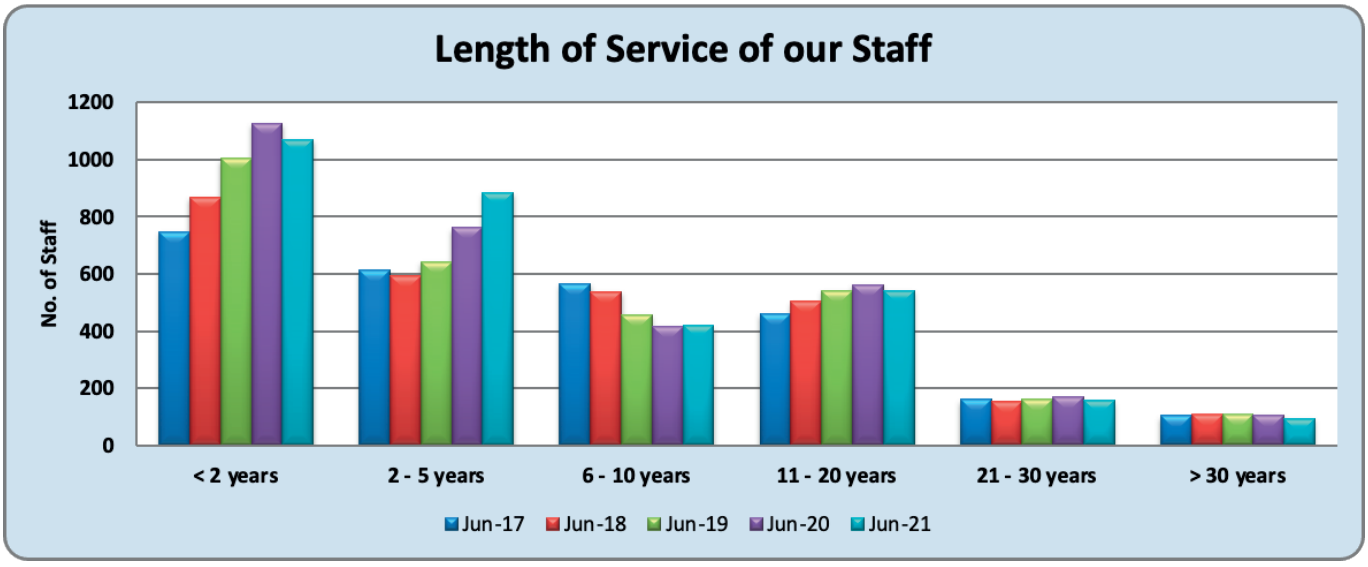
Employee by employment grouping	Jun-17	Jun-18	Jun-19	Jun-20	Jun-21
Medical	198	212	213	227	231
Nursing	678	691	709	762	788
Allied health	319	321	339	368	381
Disability support services	255	273	266	269	281
Hotel and support	103	114	124	129	134
Management and administration	352	356	383	410	423
Total FTEs	**1,905**	**1,967**	**2,034**	**2,165**	**2,238**

Employee by ethnicity	Jun-17	Jun-18	Jun-19	Jun-20	Jun-21
Asian	75	84	117	182	256
Australian	37	39	35	40	51
European	256	251	259	280	311
Māori	88	97	116	117	213
NZ European/Pākehā	1,634	1,696	1,727	1,807	2,128
Other	53	56	57	71	85
Pacific peoples	11	13	15	15	18
Unknown/unspecified	497	526	589	634	110
Total staff (headcount)	**2,651**	**2,762**	**2,915**	**3,146**	**3,172**

Gender pay Equity by employment grouping	Jun-18	Jun-19	Jun-20	Jun-21
Senior medical officers	0.0%	-2.8%	-4.9%	5.4%
Resident medical officers	9.9%	7.6%	7.7%	0.0%
Nursing	-22.2%	-18.8%	-20.0%	-13.2%
Allied health	-2.2%	-3.6%	-3.3%	-5.6%
Hotel and support	-18.7%	-10.9%	-13.1%	-17.3%
Management and administration	19.6%	22.4%	21.2%	17.5%

The table above shows the calculation of the difference in remuneration between females and males across the various employment groupings using the calculation of median as promulgated by Statistics NZ. A negative percentage means the median for the female is higher by the stated percentage than the median for a male in that employment grouping. Conversely, a positive percentage means the median for a male is higher than the median for a female.


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-17
Jun-18
Jun-19
Jun-20
Jun-21


Length of Service of our Staff
No. of Staff
1200
1000
800
600
400
200
0
< 2 years
2 - 5 years
6 - 10 years
11 - 20 years
21 - 30 years
> 30 years
Jun-17
Jun-18
Jun-19
Jun-20
Jun-21

Employee remuneration

The number of employees earning more than $100,000 is listed in the table below. Of the 462 (2019/20: 390) employees shown, 309 (2019/20: 333) are or were medical, dental, nursing or allied health employees.

Salary band ($000)	2021	2020
100 – 110	127	97
110 – 120	79	65
120 – 130	34	38
130 – 140	27	17
140 – 150	18	17
150 – 160	12	8
160 – 170	7	7
170 – 180	11	10
180 – 190	4	12
190 – 200	11	3
200 – 210	7	9
210 – 220	9	15
220 – 230	7	6
230 – 240	11	9
240 – 250	7	8
250 – 260	8	4
260 – 270	9	7
270 – 280	5	8
280 – 290	5	10
290 – 300	11	3
300 – 310	9	6
310 – 320	6	8
320 – 330	3	8
330 – 340	6	6
340 – 350	10	0
350 – 360	7	4
360 – 370	3	3
370 – 380	4	0
380 – 390	1	0
390 – 400	2	0
410 – 420	1	0
420 – 430	1	0
400 – 410	0	1
440 – 450	0	1
Total employees	**462**	**390**

Termination payments

During the 2020/21 year, NMH paid $15,812 for one employee upon termination of their employment with NMH (2019/20: nil).

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 2021 fairly reflect the financial position and operations of the Nelson Marlborough District Health Board.

Jenny Black
Board Chair

Craig Dennis
Board Member

Lexie O'Shea
Chief Executive

Eric Sinclair
Chief Financial Officer

21 March 2022

Statement of performance

As part of evaluating the effectiveness of the decisions made on behalf of our community, we provide a forecast of the services ('outputs') to be funded and provided within the financial year. To do this we identify a range of performance measures and targets that reflect quantity, quality, timeliness, and service coverage for the outputs within our *NMH Annual Plan and NMH 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 *2020/21 NMH Annual Plan*, published online at www.nmdhb.govt.nz.

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

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

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

Under the *Public Finance Act*, NMH 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 2020/21 financial year is $517,054,000 (2019/20: $462,233,000) 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 17 to 32.

Note that the financial results presented by output class in this statement of service performance do not include the allocation of the Holidays Act remediation implications. Refer to Note 27 for further information.

Impact of COVID-19

The performance of a number of the performance measures included in the Statement of Performance have been impacted by the national and local response to the COVID-19 pandemic. NMH has not sought to differentiate the performance excluding COVID-19 impacts within this Statement of Performance.

A system view

The Statement of Intent for 2019/20 to 2022/23 articulates Nelson Marlborough Health's strategic intentions and priorities for the next three-four years. As per sections 139 and 141 of the *Crown Entities Act 2004*, the Statement of Intent explains (the sections referenced in the following are the sections within the Statement of Intent):

a) the nature and scope of Nelson Marlborough Health's functions and intended operations (see section 1.3 – Introducing Nelson Marlborough Health)

b) how the entity intends to manage its functions and operations to meet its strategic intentions (section 1.3 – Our strategic priorities; Our key areas of focus; Appendix A: Priorities Matrix)

c) how the entity proposes to manage its organisational health and capability (section 2 – Managing our Business)

d) how the entity proposes to assess its performance (sections 1.4 Making a Difference – A System View and section 3 – Statement of Performance Expectations).

Our strategic priorities

NMH also have a number of strategic priorities. To meet both the current and future needs of the Nelson Marlborough region, NMH needs to consider how health services are provided to ensure transparency and efficiency while providing patient-centred care.

NMH has identified six priorities to guide action across our health system over the next few years:

1. **Achieve health equity** – Improve health status of those currently disadvantaged, particularly Māori
2. **Drive efficient, effective and safe healthcare** – support clinical governance, innovation and invest to improve
3. **One team** – to achieve joined-up care within health and across local authority and social services
4. **Workforce** – develop the right workforce capacity, capability and configuration
5. **Technology** – digital enablement to allow better information sharing, more efficient health care delivery and better personal outcomes
6. **Facilities Development** – planning for a redevelopment of Nelson Hospital.

These priorities were selected based on evidence about needs, current performance, and future gains. We referenced local and national health and social sector strategies, reviewed the data and listened to feedback from key internal and external stakeholders.

The six priorities are supported by targeted actions in key focus areas, many of which emphasise building capacity and capability in primary and community settings and concentrate on integrating service models.

Making a difference – a system view

To achieve equity by meeting the health needs of everyone in our community, and do so in a way that is clinically and financially sustainable, requires collaboration across our local health system and joint working with other sectors such as welfare, justice and local government.

Working with our Alliance partners, we have jointly developed a plan to improve our performance (System Level Measures Improvement Plan 2019/20) and understand where we are making a difference as measured by the following System Level Outcome Measures.

Keeping children out of hospital

Why is this a priority?

Ambulatory Sensitive Hospitalisations (ASH) refer to mostly acute admissions regarded as avoidable if treated earlier in a primary care setting. Prevention of avoidable admissions can be extended to include housing, health literacy, urban design, welfare and education – the social determinants of health.

The ASH rate for children aged 0–4 years in Nelson Marlborough is lower than the national average, which is positive. However, analysis of the overall rate has revealed that the ASH rate for Māori children is significantly higher than for other children in our region.

The top conditions that contribute to the higher ASH rate for Māori children are dental conditions, asthma, respiratory infections and gastroenteritis. Consumption of sugary drinks, poor access to oral health care and primary care, exposure to second-hand smoke, and poor housing are known drivers associated with these conditions. Activities which address these drivers will be important for reducing inequity within our ASH rates.

Demonstrating success

National measure	Ambulatory Sensitive Hospitalisations (ASH) rate per 100,000 population, for 0–4 year olds	
Local milestone	ASH rates for Māori children aged 0–4 years fall 15% by 30 June 2021 (from 6,087 in December 2019 to 5,174 by 30 June 2021)	
Base 2019/20	**Target 2020/21**	**Actual 2020/21**
6,087	5,174	3,602

Comment

The milestone of reducing the ASH rate for Māori children aged 0–4 years from 6,087 to 5,174 by June 2021 has been met. In the 12 months to March 2021, the rate for Māori children fell from 5,925 in March 2020 to 3,602 in March 2021. While initially we assumed this trend was driven by a reduction in admissions for asthma (as a result of border closures and reduced circulation of winter viruses), a closer looks shows that admissions for dental conditions for Māori children has also decreased significantly. After rising steadily since March 2017, dental condition ASH rates for Māori children are at the lowest they've been in more than four years. This may reflect the impact of NMH's prevention efforts in the areas of fluoride, stainless steel crowns, water only policies and partnership with Te Piki Oranga.

Using health resources effectively

Why is this a priority?

Acute hospital bed days per capita measures the use of hospital resources, predominantly relating to adults and older people. Effective management of long-term illnesses and disease prevention in primary care prior to hospitalisation and the provision of effective care in the community after discharge have the potential to reduce hospital bed days. For example, access to primary care, streamlined diagnostic and treatment processes, discharge planning and community based health and restorative care. Good communication between clinicians across the health care continuum is vital.

Nelson Marlborough Health has the best rate of acute hospital bed days for all DHBs. However, rates remain higher for Māori and Pacific peoples than for non-Māori and non-Pacific, and for those aged over 75 years. The main drivers of overall acute hospital bed days in Nelson Marlborough are events associated with stroke and other cerebrovascular conditions and respiratory infections/inflammations. For Māori, the conditions driving the acute hospital bed days rate also include heart failure and shock, and cellulitis (bacterial skin infections). Nelson

Marlborough Health's Models of Care Programme, and in particular the development of shared care planning and Health Care Homes in primary care are some of the activities planned to address these rates.

Demonstrating success

National measure	Acute hospital bed days rate per 1,000 population domiciled within a DH	
Local milestone	Reduce the age standardised acute hospital bed days rate for Māori by 15% from 335.3 per 1,000 population to 285.0 per 1,000 population by 30 June 2021	
Base 2019/20	**Target 2020/21**	**Actual 2020/21**
335.3	285.0	306.0

Comment

The age-standardised acute hospital bed days (by DHB of domicile) rate for Māori decreased from 332.0 per 1,000 population in March 2020 to 306.0 per 1,000 population by March 2021. In 2020–21, 'Stroke and cerebrovascular conditions' and 'respiratory conditions' were the largest drivers of the acute hospital bed day rate among Māori. However, the latest data shows that 'Heart Failure and Shock', 'Major Affective Disorders', and 'Tracheostomy' are now the main drivers. For most DRGs, the Māori acute hospital bed day rates in NMH are lower than their counterparts in other DHBs, with the exception of Major Affective Disorders, Caesarean Delivery, and Oesophagitis and Gastroenteritis, which are higher than NZ rates.

Person-centred care

Why is this a priority?

The patient experience of care measurement tools in primary and secondary care give insight into how patients experience the health care system, and how integrated their care was. Evidence suggests that patient experience is positively associated with adherence to recommended medication and treatments, engagement in preventive care such as screening services and immunisations and ability to use the health resources available effectively.

This measure provides information about how people experience health care and may highlight areas that Nelson Marlborough Health needs to have a greater focus on, such as health literacy and communication.

Primary care: n the twelve months prior to the survey, 14.1% of respondents in Nelson Marlborough indicated there was a time when they wanted health care from a GP or nurse but could not get it. Similarly, 18.5% of patients indicated that there was a time they did not visit a GP or nurse because of cost, with Māori (34.5%) more likely to report this than the 'other' ethnic group (17.4%). Responses to these questions were explored further:

- Could you tell us why cost stopped you from seeing a GP or nurse? – Māori were more likely than other ethnic groups to report that the appointment was too expensive (92.6%), they couldn't take time off work (27.8%) or the cost of travel was too great (13.0%)
- Has cost stopped you from picking up a prescription? – Māori were more likely than other ethnic groups to answer 'yes' (16.8%)
- Have you been involved in decisions about your care and treatment as much as you wanted to be? Māori were less likely than other ethnic groups to answer 'yes' (68.2%).

The activities to improve patient experience in primary care therefore focus on addressing these barriers.

Secondary care: With respect to secondary care, and the inpatient survey, Nelson Marlborough Health has identified communication and coordination as domains in which we could improve. In particular, patients have

indicated that they could be better informed about medication side-effects upon discharge and receive more information from the hospital on how to manage their condition after discharge. This corresponds to the responses received to the survey questions:

- Did a member of staff tell you about medication side effects to watch for when you went home?
- And do you feel you received enough information from the hospital on how to manage your condition after your discharge?

The response rate for the inpatient hospital survey in the last quarter of 2019 was around 24%. The results from this survey showed that 54% of patients reported receiving enough information on medication side-effects to watch for when they went home from hospital. For the same quarter, 66% of patients responded receiving enough information from the hospital on how to manage their condition after discharge. These results are comparable with the New Zealand average but Nelson Marlborough Health have a number of activities planned to improve them.

Demonstrating success

National measure	Primary care survey responses for four domains: Communication, Partnership, Coordination, Physical and Emotional needs	
Local milestone	5% reduction in Māori reporting barriers to accessing primary care and pharmaceuticals by 30 June 2021	
Base 2019/20	**Target 2020/21**	**Actual 2020/21**
34.5%	<34.5%	29.5%

National measure	Hospital inpatient survey scores for four domains: Communication, Partnership, Coordination, Physical and Emotional needs	
Local milestone	70% of respondents report receiving enough information on medication side effects and condition management upon discharge from hospital by 30 June 2021	
Base 2019/20	**Target 2020/21**	**Actual 2020/21**
61%	70%	62.5%

Comment

The proportion of Māori reporting being unable to access health care from a GP or nurse when they wanted it increased from 23.5% in November 2020 to 29.5% in May 2021. The most common reasons given were that the waiting time was too long (70.6%), with some mentioning 'fear of the GP', 'difficulty taking time off work', 'and not wishing to make the health care providers too busy'.

NMH exceeded our local milestone for a 5% reduction in Māori reporting barriers to accessing pharmaceuticals. The proportion of Māori reporting that cost stopped them from picking up a prescription reduced from 21.1% in November 2020, to 15.8% in May 2021.

The proportion of Māori reporting that they had received as much information about how to manage their condition or recovery after they left hospital increased from 40.0%(n=5) in November 2020 to 62.5% (n=16) in February 2021. The proportion of Māori reporting that they were told the possible side effects of the medicine they left hospital with increased from 40% (n=5) in November 2020 to 60% (n=10) in February 2021.

Prevention and early detection

Why is this a priority?

Amenable mortality is a measure of the effectiveness of health care-based prevention programmes, early detection of illnesses, effective management of long-term conditions and equitable access to health care. It is a measure of premature deaths that could have been avoided through effective health interventions at an individual or population level. Health care service improvement across the system, including access to diagnostic and secondary care services, may lead to a reduction in amenable mortality.

Nationally, amenable mortality rates for Māori and Pacific peoples tend to be higher than for other population groups. We can assume this is the case for Nelson Marlborough also, even though we are unable to confirm this due to small numbers. In Nelson Marlborough Health the overall amenable mortality rate in 2015 was 67.7 per 100,000, with the main contributing conditions being coronary artery disease (43 deaths), COPD (21 deaths) and suicide (19 deaths).

Coronary artery disease is thought to begin with damage or injury to the inner layer of a coronary artery, sometimes as early as childhood. The damage may be caused by various factors, including:

- Smoking
- High blood pressure
- High cholesterol
- Diabetes or insulin resistance
- Sedentary lifestyle.

In order to address amenable mortality, and specifically amenable mortality from coronary artery disease, it will be important to implement activities that address the above risk factors.

The rate for Māori is not available because rates are suppressed where there are less than 30 deaths. However, in 2015 ten Māori people died from a potentially preventable condition. These numbers are disproportionately high for the size of the population. Therefore the focus is on reducing inequity within our amenable mortality rate by targeting actions towards Māori premature deaths.

Demonstrating success

National measure	Deaths under age 75 from causes classified as amenable to health care	
Local milestone	Reduce equity gaps in amenable mortality rates for Māori by 30% by 30 June 2023	
Base 2016	**Target 2022/23**	**Actual 2020/21**
23	6	Not measured

Comment

In 2016 the main conditions responsible for amenable mortality in Māori were coronary disease, chronic obstructive pulmonary disease (COPD), and suicide. While the System Level Measure Plan 2020-21 was fully implemented, ambulatory sensitive hospitalisations for 45–64 year olds for angina/chest pain, COPD and congestive heart failure among Māori suggest that the further work planned by the South Island Alliance in the System Level Measure Plan 2021–22 is justified.

Healthy start

Why is this a priority?

Good child health is important not only for children and families now, but also for good health later in adulthood. It is important that child health is a priority because children do not make their own lifestyle decisions and are vulnerable to the situation into which they are born.

Smoking during pregnancy and exposure to smoking in early childhood strongly influence pregnancy and early childhood health outcomes. This measure promotes the roles which collectively service providers play in the infants' life and the many opportunities for smoking interventions to occur. It also enables the health sector to connect infants and their family/whanau with maternity and childhood health care such as immunisation.

Babies living in smokefree homes aims to reduce the rate of infant exposure to cigarette smoke by focussing attention beyond maternal smoking to the home and family/whanau environment (ie, a healthy start). The measure aligns with the first core contact which is when the handover from maternity to Well Child Tamariki Ora (WCTO) providers and general practitioners occurs.

This measure was revised by the Ministry of Health on 31 October 2018 (numerator and denominator definitions changed). The result is that all registered births are recorded in the denominator, not just those enrolled with/contacted by the Well Child Tamariki Ora Provider. This means that the proportion of babies living in "smoking" houses according to the new measure could be due to **either**:

- living in a household where someone smokes **or**
- having not received a WCTO provider visit/enrolment.

Therefore, to increase the proportion of babies recorded as living in smokefree homes, we also need to increase the proportion of registered births enrolled with WCTO providers (and ensure this data is being captured or reported to the Ministry of Health). In Nelson Marlborough for the year to December 2017, only 66.9 percent of registered births were enrolled with a WCTO provider and only 53.4 percent of newborns in Nelson Marlborough could be confirmed as living in smokefree households at six weeks postnatal. The rate for Māori is a lot lower; only 40.1 percent of newborn Māori were enrolled with a WCTO provider and only 21.7 percent of Māori newborns in Nelson Marlborough could be confirmed as living in smokefree households at six weeks postnatal. This is lower than the national rate for Māori which is 34.4 percent.

Demonstrating success

National measure	Babies living in a smokefree households at six weeks post-natal (up to 56 days of age)	
Local milestone	At least 34.4% of Māori newborns in Nelson Marlborough Health live in a smokefree household at six weeks postnatal by 30 June 2021	
Base 2019/20	**Target 2020/21**	**Actual 2020/21**
21.7%	>34.4%	47.7%

Comment

From January 2019 to June 2019, in Nelson Marlborough only 40.1% of newborn Māori were enrolled with a WCTO provider and only 21.7% of Māori newborns in Nelson Marlborough could be confirmed as living in a smoke free household at six weeks postnatal. From July 2020 to December 2020, 71.8 % of newborn Māori were enrolled with a WCTO provider and 47.7% of Māori newborns could be confirmed as living in a smokefree household at six weeks postnatal. However, the proportion of babies in living in a smokefree home six weeks postnatal still remains lower than for non-Māori ethnic groups.

Youth are healthy, safe and supported

Why is this a priority?

Youth have their own specific health needs as they transition from childhood to adulthood. Evidence shows that youth are not in the habit of seeking the services or advice of a registered health practitioners when unwell. Generally they cope with illness with advice from friends and whānau as they see fit. Attending a health clinic is often viewed as a last resort instead of a reasonable first choice.

Research shows that youth whose healthcare needs are unmet can lead to increased risk for poor health as adults and overall poor life outcomes through disengagement and isolation from society and riskier behaviours in terms of drug and alcohol abuse and criminal activities. It is therefore a priority of Nelson Marlborough Health to increase youth access to primary and preventive health care services. To do this we will work further with local youth to understand what health services they need and the barriers to accessing services.

Nelson Marlborough Health has chosen to specifically focus on supporting young people to manage their sexual and reproductive health safely and receive youth friendly care.

It is common practice to offer sexually active youth STI testing upon visiting a general practice or a sexual health clinic. Chlamydia is one of the infections that is screened for as part of this testing. In this way, chlamydia testing coverage for 15–24 year olds not only indicates coverage of STI testing, but can also be used as an indicator of the ability of young people to receive youth-friendly care and manage their sexual and reproductive health safely.

In 2016, a substantially higher proportion females aged 20–24 years in Nelson Marlborough were likely to have been tested (35.7%) than males (9.1%). Coverage rates for Māori youth of all ages are comparable, or greater than Pacific peoples and youth identifying as European or other. Meanwhile, Asian youth experience the lowest coverage rates (only 3.4% of males and 14.3% of females aged 20–24 years had been tested).

Demonstrating success

National measure	Young people manage their sexual and reproductive health safely and receive youth friendly care – Chlamydia testing coverage for 15–24 year olds	
Local milestone	Increase the percentage of males aged 20–24 years being tested for Chlamydia from 9.1% in 2016 to at least 35.7% (ie, bring male rates in line with female rates) by 30 June 2021	
Base 2019/20	**Target 2020/21**	**Actual 2020/21**
9.1%	35.7%	8.7%

Comment

In 2019, the chlamydia testing coverage for males aged 20–24 years old decreased from 10.0% to 8.7% while testing coverage continues to increase for females, from 35.7% in 2018 to 37.3% in 2019. Rates also continue to remain higher for European/other ethnic groups than other ethnic groups.

Output class 1: Preventative services

Descrption

Preventative services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations comprising of services designed to enhance the health status of the population as distinct from treatment services which repair/support health and disability dysfunction.

Preventative services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing.

Preventative services include health promotion to ensure that illness is prevented and unequal outcomes are reduced; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and, population health protection services such as immunisation and screening services.

On a continuum of care these services are public wide preventative services.

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, drug and alcohol misuse, inactivity, poor nutrition, and rising obesity rates are major and common contributors to a number of the most prevalent long-term conditions. These risk factors are preventable through a supportive environment, improved awareness and greater personal responsibility for health and wellbeing. Prevention services support people to address any risk factors that contribute to both acute events (e.g. alcohol-related injury), as well as long-term conditions development (e.g. obesity, diabetes).

High health need and at-risk population groups (Māori, low socio-economic, 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	2018/19 *1	2019/20 *1	2020/21	Target
Percentage of enrolled women (20–69) who had a cervical smear in the last 3 years	V	80%	74%	73%	>85%
Percentage of enrolled high-needs *2 women (20–69) who had a cervical smear in the last 3 years	V	73%	66%	61%	>85%
Percentage of enrolled women (45–65) having mammography within 2 years	V	79%	77% *3	76%	>80%
Percentage of newborn hearing screening completed within one month of birth	V	99%	98%	100%	>95%

Performance Measures	Code	2018/19 *1	2019/20 *1	2020/21	Target
Percentage of eight month old that have their primary course of immunization at 6 weeks, 3 months, and 5 months on time	T	89%	91%	88%	95%
Percentage of two year old children fully vaccinated	C	87%	88%	88%	>95%
Percentage of over 65 year olds vaccinated for seasonal influenza	V	60%	73%	65%	>75%
Percentage of eligible children receiving Before (B4) School Checks	V	104%	92%	95%	100%
Number of clients seen by the primary mental health service – youth	Q	NEW	1060	619	>580
Number of clients seen by the primary mental health service – adults	Q	NEW	4,552	3379	>3,300
Shorter waits for non-urgent mental health services for 0–19 year olds: 80% of people seen within 3 weeks (PP8)	T	47%	67%	79%	>80%
Shorter waits for non-urgent addiction services for 0–19 year olds: 80% of people seen within 3 weeks	T	64%	N/A *3	N/A *3	>80%
Number (and percentage of the eligible population) of first does of vaccination for Covid-19	V	N/A	N/A	32,161 (24%)	N/A
Number (and percentage of the eligible population) of second does of vaccination for Covid-19	V	N/A	N/A	22,527 (17%)	N/A

*1 Previous years' figures have been calculated using Statistics New Zealand Population Projections. Using current projections means previous years' data may differ to previous reports. The eligible population (the 'denominator') is the projected population for the end-point of the monitoring period (June of each year reported). Source data minhealthnz.shinyapps.io/nsu-ncsp-coverage

*2 High needs refers to Māori, Pacific and quintile 5.

*3 Changes to the information system used to collect the data for this measure resulted in NMH being unable to report the results for this measure for the 2019/20 and 2020/21 years.

*4 Reporting from the Breast Screening Aotearoa service e within the MOH is only available to March 2020 due to disruptions caused by the response to the COVID-19 pandemic.

Financial results

	Budget 2021 $000	Actual 2021 $000	Actual 2020 $000
Revenue	**8,993**	**14,583**	**9,018**
Expenditure			
Workforce costs	5,044	8,660	5,556
Other operating costs	1,333	2,872	961
External providers and inter district flows	2,521	2,443	2,558
Total expenditure	**8,898**	**13,974**	**9,075**
Total surplus/(deficit)	**95**	**608**	**(56)**

Output class 2: Early detection and management services

Description

Early detection and management services are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. Include general practice, community and Māori health services, pharmacist services, Community Pharmaceuticals (the Schedule) and child and adolescent oral health and dental services.

These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB.

On a continuum of care these services are preventative and treatment services focused on individuals and smaller groups of individuals.

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	2018/19	2019/20	2020/21	Target
Percentage of people in the district enrolled with PHO – Nelson	C	99%	100%	95% *1	100%
Percentage of people in the district enrolled with PHO – Marlborough	C	98%	99%	91% *1	>99%
Utilisation of DHB-funded dental services by adolescents (School Year 9 up to and including age 17 years)	C, V	82%	81%	71%	>85%
Percentage of children <5 years enrolled in DHB funded dental services	C	94%	95%	93%	>=95%
Percentage of secondary care patients whose medicines are reconciled on admission	C, Q	78%	78%	93%	>50%
Percentage of people provided with a CT scan within 42 days of referral	T	96%	97%	93%	95%
Percentage of people provided with an MRI scan within 42 days of referral	T	32% *2	62% *2	73%	95%
Supporting Parents; Healthy Children: Information about parenting and children's needs is included in the initial assessment and wellbeing plan for adults with a mental health and/or addiction issue as applicable.	C	58%	58% *3	58%	100%
Post-discharge community care for mental health inpatients: Follow-up within 7 days	Q, T	55%	23% *4	62%	100%

*1 Denominator is subnational population estimates at 30 June 2021 – www.stats.govt.nz/information-releases/subnational-population-estimates-at-30-june-2021-provisional accessed 2/11/21

*2 NMH was replacing the MRI scanner in Nelson Hospital resulting in some delays in providing patients with this modality.

*3 The capture of this measure, introduced in 2018/19, is in development. The Dynamic Patient Summary in its "requirements definition phase" of development and build. Once developed this measure will be reported on.

*4 Changes to the information system used to collect the data for this measure resulted in NMH being unable to report the results for this measure for the 2017/18 year. We are continuing to refine the collection of this measure and the results for 2019/20 exclude the Mental Health outpatients data.

Financial results

	Budget 2021 $000	Actual 2021 $000	Actual 2020 $000
Revenue	**135,070**	**150,652**	**150,990**
Expenditure			
Workforce costs	24,803	27,828	28,592
Other operating costs	12,273	10,026	11,020
External providers and inter district flows	96,014	109,267	111,870
Total expenditure	**133,090**	**147,120**	**151,482**
Total surplus/(deficit)	**1,980**	**3,531**	**(492)**

Output class 3: Intensive assessment and treatment services

Description

Intensive assessment and treatment services are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are usually integrated into facilities that enable co-location of clinical expertise and specialized equipment such as a 'hospital'. These services are generally complex and provided by health care professionals that work closely together. They include:

- Ambulatory services (including outpatient, district nursing and day services) across the range of secondary preventive, diagnostic, therapeutic, and rehabilitative services
- Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services
- Emergency Department services including triage, diagnostic, therapeutic and disposition services.

On a continuum of care these services are at the complex end of treatment services and focussed on individuals.

Significance

Equitable, timely access to intensive assessment and treatment can significantly improve people's quality of life either through early intervention (e.g. removal of an obstructed gallbladder to prevent repeat attacks of abdominal pain) or through corrective action (i.e. major joint replacements to relieve pain and improve activity). Responsive services and timely treatment services also support improvements across the whole system and give people confidence that complex intervention will be available when needed. As an owner and provider of these services, the DHB is also concerned with the quality of the services being provided. Quality improvement in service delivery, systems and processes will improve patient safety, reduce the number of events causing injury or harm, and provide improved outcomes for people in our services. Adverse events and delays in treatment, as well as causing harm to patients, drive unnecessary costs and redirect resources away from other services. Quality improvement in service delivery, systems and processes will improve patient safety, reduce readmission rates, and better support people to recover from complex illness and / or maximise their quality of life.

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

Performance measures

Performance Measures	Code	2018/19	2019/20	2020/21	Target
Acute inpatient average length of stay (days)	Q	2.37	1.95	2	2.3
Percentage of elective and arranged surgery undertaken on a day case basis	Q	65%	65%	64%	>68%
Percentage of people receiving their elective and arranged surgery on day of admission	Q	93%	98%	98%	>99%
Women registering with an LMC by week 12 of their pregnancy	T	77%	79%	82%	>80%
Percentage of total deliveries in primary birthing units	Q, V	8%	10%	3%	>7.0%
Standardised Intervention Rate for major joint replacement	V	24 per 10,000	20 per 10,000	24 per 10,000	>21 per 10,000
Standardised Intervention Rate for cataract procedures	V	22 per 10,000	24 per 10,000	32 per 10,000	>27 per 10,000
95% of patients will be admitted, discharged, or transferred from an emergency department (ED) within six hours	Q	93%	92%	91%	95%
The percentage of elective surgery delivered against the agreed target	V, T	92%	110%	120%	100%
Non-Standardised Ambulatory Sensitive Hospitalisation Rate per 100,000 Population for adults	Q	2658	2771	2877	2465
Standardised Readmission Rate	Q	11.8%	11.5%	12.3%	11.4%
The percentage of patients that 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.	V, T	90%	81%	91%	90%
Reduce seclusion events per month	Q, V	34	10	12	<4

Financial results

	Budget 2021 $000	Actual 2021 $000	Actual 2020 $000
Revenue	**338,027**	**333,352**	**285,739**
Expenditure			
Workforce costs	177,036	176,603	163,064
Other operating costs	104,274	116,394	91,437
External providers and inter district flows	58,880	53,471	48,288
Total expenditure	**340,190**	**346,467**	**302,789**
Total surplus/(deficit)	**(2,163)**	**(13,115)**	**(17,050)**

Output class 4: Rehabilitation and support services

Description

Rehabilitation and support services are delivered following a 'needs assessment' process and co-ordination input by NASC Services for a range of services including palliative care, home-based support and residential care services. On a continuum of care these services will provide support for individuals.

Significance

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

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

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

Performance measures

Performance Measures	Code	2018/19	2019/20	2020/21	Target
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	90%	86%	93%	>86%
Percentage of older people living in ARC	C	3.7%	3.6%	3.8%	<4%
Improving Mental Health Services using transition (discharge) planning and employment: Child and Youth with a transition (discharge) date.	Q	50% *6	51% *6	N/A *6	>95%

*1 Changes to the information system used to collect the data for this affect the results from the 2018/19 year with no result attainable for the 2020/21 year. Further work is required to ensure alignment of the target and results.

Financial results

	Budget 2021 $000	Actual 2021 $000	Actual 2020 $000
Revenue	**115,137**	**112,196**	**113,891**
Expenditure			
Workforce costs	28,140	26,892	29,074
Other operating costs	11,913	8,868	12,453
External providers and inter district flows	74,996	73,443	71,143
Total expenditure	**115,049**	**109,202**	**112,670**
Total surplus/(deficit)	**88**	**2,993**	**1,221**

Implementing the COVID-19 Vaccine Strategy

Vaccine doses administered by DHB **DHB of service**	**Dose 1**	**Dose 2**	**Total**
Nelson Marlborough	32,161	22,527	**54,688**

By DHB: Eligible population fully vaccinated by DHB of residence (note 1) (note 5) **DHB of residence**	**Proportion fully vaccinated** (note 1)
Nelson Marlborough	**17.78%**

Vaccine doses administered by age group (note 4) **Age range (years)**	**Dose 1**	**Dose 2**	**Total**
12 to 15	0	0	0
16 to 19	253	148	401
20 to 24	582	370	952
25 to 29	884	622	1,506
30 to 34	943	645	1,588
35 to 39	968	691	1,659
40 to 44	1,049	795	1,844
45 to 49	1,337	1,079	2,416
50 to 54	1,715	1,353	3,068
55 to 59	2,221	1,734	3,955
60 to 64	2,485	1,894	4,379
65 to 69	5,302	3,406	8,708
70 to 74	5,696	3,674	9,370
75 to 79	3,980	2,755	6,735
80 to 84	2,576	1,760	4,336
85 to 89	1,349	956	2,305
90+	821	645	1,466
Total	**32,161**	**22,527**	**54,688**

Eligible population fully vaccinated by age group (note 5) **Age range (years)**	**Proportion fully vaccinated** (note 1)
12 to 15	–
16 to 19	2.71%
20 to 24	5.98%
25 to 29	8.16%
30 to 34	7.53%
35 to 39	8.24%
40 to 44	9.21%
45 to 49	10.34%
50 to 54	12.42%
55 to 59	14.65%
60 to 64	16.97%
65 to 69	32.96%
70 to 74	37.85%
75 to 79	42.55%
80 to 84	43.84%
85 to 89	41.36%
90+	50.28%
Total	**17.78%**

Vaccine doses administered by ethnicity (note 4) **Ethnicity**	**Dose 1**	**Dose 2**	**Total**
Asian	1,404	905	2,309
European or other	27,979	19,845	47,824
Māori	1,793	1,353	3,146
Pacific peoples	735	265	1,000
Unknown	250	159	409
Total	**32,161**	**22,527**	**54,688**

Eligible population fully vaccinated by ethnicity (note 5) **Ethnicity**	**Proportion fully vaccinated** (note 1)
Asian	17.67%
European or other	18.18%
Māori	13.79%
Pacific peoples	13.93%
Unknown	23.09%
Total	**17.78%**

Vaccine doses administered by sequencing group (note 4) **Ethnicity**	**Dose 1**	**Dose 2**	**Total**
Group 1	1,141	1,078	2,219
Group 2	11,078	9,473	20,551
Group 3	19,778	11,857	31,635
Group 4	164	119	283
Total	**32,161**	**22,527**	**54,688**

Note 1

Fully vaccinated means two doses have been administered to an individual.

Note 2

The health service user (HSU) population used for COVID-19 vaccine coverage reporting provides information about the number of people in New Zealand who used health services in 2020. People are included if they were alive as at 30 June 2020, were 12 years of age as of 30 June 2020, (note that this was initially 16 years but was reduced to 12 years when the eligibility criteria changed), and if they were enrolled with a primary health organisation or received health services in the 2020 calendar year. There are other data sets that estimate the total number of people in New Zealand.

These include three datasets produced by Stats NZ: Estimated Resident Population (produced every five years, following each Census), Subnational Population Estimates (produced every year), and non-official population projections produced by Stats NZ for the Ministry of Health (produced every year).

The Stats NZ population estimates are based on Census data adjusted for the number of people who are born, who have died, and who have migrated to or from New Zealand. The Stats NZ population estimates and projections are of people usually resident in New Zealand, including those usually resident who are temporarily overseas, while the HSU includes everyone in New Zealand who used health services in a given period.

The HSU was chosen by the Ministry of Health as the denominator for COVID-19 vaccine coverage reporting because it allows for the assignment of the same demographics (eg, location and ethnicity) to people in the numerator (the number of people vaccinated) as the denominator (reference population). The HSU is available for every demographic contained in health data including age, ethnicity, DHB, and gender, separately or in combination. Other information such as neighbourhood deprivation, Statistical Area 2, or territorial local authority can also be added. It is possible to generate flags for health-related information on the HSU, for

example, those who are likely to have a long-term condition. Official Stats NZ estimates are not as flexible. For example, Stats NZ estimates by age, gender and Statistical Area 2/Territorial Authority/DHB are produced every year, but estimates that also include ethnicity are only produced every five years, the most recent being estimates for 2018. The projections Stats NZ produces for the Ministry every year do provide information by age, gender and broad ethnic group, but are only available at the DHB level.

The total population estimate based on HSU as at 30 June 2020 is 157,534. This is 3,776 below the Stats NZ total projected population of 161,310 (from the non-official population projections Stats NZ produced in 2020). When classifying the population into ethnicity, age and DHB there are further differences. For example, a summary of the differences by ethnicity are summarised in the table below. These differences arise as the populations are derived from different sources. For example, an individual may identify as one ethnicity when registering with a health service and a different ethnicity when completing a census declaration.

By definition, the HSU is not a total population estimate and is likely to miss highly marginalised groups. For example, analysis suggests that groups under-represented in the HSU include young people aged 15–45 years (men in particular), and people of Asian and Middle Eastern, Latin American and African ethnicity.

The HSU is considered by the Ministry of Health to be the best option for estimates of vaccine coverage, as it removes bias from calculated rates by ensuring demographic information in the numerator and denominator is consistent. For example, the ethnic group(s) with which someone identifies, and their location.

Total Population	HSU	Stats NZ	Difference
Māori	15,451	18,100	(2,649)
Pacific	2,844	3,280	(436)
Asian	7,096	9,030	(1,934)
Other	132,143	130,900	1,243
Total	**157,534**	**161,310**	**(3,776)**

Note 3

Group 1 includes border and managed isolation and quarantine employees and the people they live with. Group 2 includes high-risk frontline health care workforces; workers and residents in long-term residential environments; older Māori and Pacific peoples cared for by whānau, the people they live with, and their carers; people aged 65 years and older; people with relevant underlying health conditions. Group 3 includes people aged 65 years and older; people with relevant underlying health conditions; disabled people; and adults in custodial settings. Group 4 includes people aged 16 years and over. These definitions and population groups were occasionally updated based on operational and Cabinet decisions or updated estimates of the sizes of each group.

Note 4

The data in this table is based on the DHB of service (where the vaccine dose was administered).

Note 5

The data in this table is based on the DHB of residence of the individual receiving the vaccines. Ethnicity is based on the prioritised ethnicity classification system which allocates each person to a single ethnic group, based on the ethnic groups they identify with. Where people identify with more than one group, they are assigned in this order of priority: Māori, Pacific peoples, Asian, and European/Other. So, if a person identifies as being Māori and New Zealand European, the person is counted as Māori.

Financial statements

Statement of comprehensive revenue and expense

For the year ended 30 June 2021

	Note	Budget 2021 $000	Actual 2021 $000	Actual 2020 $000
Revenue				
Revenue	1	591,398	604,831	553,602
Interest revenue	5	1,250	483	974
Other revenue	2	4,579	5,467	5,427
Total revenue		**597,227**	**610,781**	**560,003**
Expenditure				
Employed Workforce	3	233,047	227,487	218,849
Outsourced Workforce	6	1,976	7,699	7,853
Total Workforce		235,023	235,186	226,702
Outsourced services		19,825	23,869	19,226
Clinical supplies		45,625	53,401	42,968
Infrastructure and non-clinical expenses		33,392	37,642	26,311
Payments to non-Health Board providers		232,411	238,623	233,859
Depreciation and amortisation expense	12,13	15,056	13,716	13,308
Capital charge	4	9,860	4,826	9,709
Finance costs	5	436	383	376
Other expenses	6	5,599	4,278	3,921
Total expenditure		**597,227**	**611,924**	**576,381**
Operating surplus/(deficit)		**0**	**(1,143)**	**(16,378)**
Impairment of intangible assets		-	-	-
Holiday's Act Remediation Provision		-	(4,840)	(46,082)
Net surplus/(deficit)		**0**	**(5,983)**	**(62,460)**
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		-	29,433	-
Impairment of property assets		-	-	-
Total other comprehensive revenue or expenses		-	**29,433**	-
Total comprehensive revenue and expense		**0**	**23,450**	**(62,460)**

The accompanying notes form part of these financial statements. Explanations of major variances against budget are provided in note 25.

Statement of financial position

As at 30 June 2021

	Note	Budget 2021 $000	Actual 2021 $000	Actual 2020 $000
Assets				
Current assets				
Cash and cash equivalents	7	8,410	19,415	9,134
Receivables	8	19,221	23,248	17,124
Inventories	9	2,742	3,387	2,900
Prepayments		1,188	1,760	386
Non-current assets held for sale	10	465	2,105	2,105
Other financial assets	11	21,284	21,300	21,298
Total current assets		**53,310**	**71,215**	**52,946**
Non-current assets				
Prepayments		36	695	521
Other financial assets	11	1,715	1,732	1,723
Property, plant and equipment	12	193,555	217,453	192,047
Intangible assets	13	11,973	11,873	12,086
Total non-current assets		**207,279**	**231,753**	**206,377**
Total assets		**260,589**	**302,968**	**259,323**
Liabilities				
Current liabilities				
Payables	14	60,151	59,544	45,598
Borrowings	15	501	737	632
Employee entitlements	16	29,330	101,813	92,904
Provisions	17	450	491	481
Total current liabilities		**90,432**	**162,585**	**139,615**
Non-current liabilities				
Borrowings	15	7,664	7,819	8,473
Employee entitlements	16	9,870	9,256	10,829
Total non-current liabilities		**17,534**	**17,075**	**19,302**
Total Liabilities		**107,966**	**179,660**	**158,917**
Net assets		**152,623**	**123,309**	**100,406**
Equity				
Crown equity	18	80,826	80,259	80,806
Other reserves	18	86,476	112,914	83,481
Accumulated comprehensive revenue and expense	18	(14,679)	(69,864)	(63,881)
Total equity		**152,623**	**123,309**	**100,406**

The accompanying notes form part of these financial statements. Explanations of major variances against budget are provided in note 25.

Statement of changes in net assets/equity

For the year ended 30 June 2021

	Note	Budget 2021 $000	Actual 2021 $000	Actual 2020 $000
Balance at 1 July		153,170	100,406	166,406
Total comprehensive revenue and expense for the year		0	23,450	(62,460)
Owner transactions				
Capital contribution	15,18	-	-	(2,994)
Repayment of capital		(547)	(547)	(547)
Balance at 30 June	18	**152,623**	**123,309**	**100,406**

The accompanying notes form part of these financial statements. Explanations of major variances against budget are provided in note 25.

Statement of cash flows

For the year ended 30 June 2021

	Note	Budget 2021 $000	Actual 2021 $000	Actual 2020 $000
Cash flows from operating activities				
Receipts from the Ministry of Health and patients		597,222	603,047	561,979
Interest received		1,250	483	974
Payments to employees		(233,016)	(225,809)	(212,876)
Payments to suppliers		(339,110)	(352,053)	(324,844)
Capital charge		(9,860)	(4,826)	(9,709)
Interest paid		-	-	-
GST (net)		-	272	69
Net cash flow from operating activities		**16,486**	**21,115**	**15,592**
Cash flows from investing activities				
Receipts from sale of property, plant and equipment		-	106	29
Receipts from maturity of investments		-	-	-
Purchase of property, plant and equipment		(7,000)	(7,884)	(10,865)
Purchase of intangible assets		(2,000)	(1,573)	(1,940)
Acquisition of investments		-	(0)	(14)
Net cash flow from investing activities		**(9,000)**	**(9,351)**	**(12,790)**
Cash flows from financing activities				
Borrowings withdrawn		-	-	-
Finance leases raised		(436)	(935)	565
Capital contribution		-	-	-
Repayment of capital		(547)	(547)	(547)
Repayment of borrowings		-	-	-
Payment of finance lease liabilities		-	-	-
Net cash flow from financing activities		**(983)**	**(1,482)**	**17**
Net increase/(decrease) in cash and cash equivalents		**6,503**	**10,282**	**2,820**
Cash and cash equivalents at the beginning of the year		1,907	9,134	6,315
Cash and cash equivalents at the end of the year		**8,410**	**19,416**	**9,134**

The accompanying notes form part of these financial statements. Explanations of major variances against budget are provided in note 25.

Reconciliation of net surpluses to net cash flow from operating activities

For the year ended 30 June 2021

	Actual 2021 $000	Actual 2020 $000
Net surplus/(deficit)	(5,983)	(62,460)
Add/(less) non-cash items		
Depreciation and amortisation expense	13,716	13,308
Impairment losses	-	-
Total non-cash items	**13,716**	**13,308**
Add/(less) items classified as investing or financing activities		
Fair value movement on loans and receivables	(8)	(8)
(Gains)/losses on disposal of property, plant and equipment	(32)	(32)
Total items classified as investing or financing activities	**(41)**	**(41)**
Add/(less) movements in statement of financial position items		
(Increase)/Decrease in receivables	(6,125)	2,093
(Increase)/Decrease in prepayments	(1,549)	318
(Increase)/Decrease in inventories	(487)	(158)
Increase/(Decrease) in payables	13,946	11,512
Increase/(Decrease) in employee entitlements	7,336	50,673
Increase/(Decrease) in provisions	10	45
(Increase)/Decrease in payables relating to purchase of property, plant and equipment	291	302
Net movements in statement of financial position items	**13,423**	**64,785**
Net cash flow from operating activities	**21,115**	**15,592**

Statement of accounting policies

For the year ended 30 June 2021

Reporting entity

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

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

NMH has designated itself as a public benefit entity (PBE) for the purposes of complying with generally accepted accounting practice (GAAP).

The financial statements for NMH are for the year ended 30 June 2021, and were approved by the Board on 21 March 2022.

The *Crown Entities Act 2004* requires that before the start of each financial year, the DHB must prepare a Statement of Performance Expectations (SPE) for that financial year. NMDHB approved its SPE for the financial year 2021–22 after the specified deadline of 30 June 2021.

Basis of preparation

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

Statement of going concern

Health Sector Reforms

On 21 April 2021 the Minister of Health announced the health sector reforms in response to the Health and Disability System Review.

The reforms will replace all 20 District Health Boards (DHBs) with a new Crown entity, Health New Zealand, that will be responsible for running hospitals and commissioning primary and community health services. It will have four regional divisions. As a result of the reforms, responsibility for public health issues will rest with a new Public Health Authority. A new Māori Health Authority will monitor the state of Māori health and commission services directly. Legislation to establish the new entities and disestablish DHBs is scheduled to come into effect on 1 July 2022.

Because of the expected date of these reforms the financial statements of the DHB have been prepared on a disestablishment basis. No changes have been made to the recognition and measurement, or presentation in these financial statements, because all assets, liabilities, functions and staff of the DHBs and shared services agencies will transfer to Health New Zealand.

Operating and cash flow forecasts

Operating and cash flow forecasts indicate that the DHB will have sufficient funds (including equity funding from the Crown for approved capital projects) to meet the forecast operating and investing cash flow requirements of the DHB for the 2021/22 financial year. However, if the DHB was required to settle the holiday pay liability disclosed in note 16 prior to 1 July 2022, additional financial support would be needed from the Crown.

NMH has received a letter of comfort, dated 21 February 2022 from the Ministers of Health and Finance which states that equity support will be provided if required to settle the estimated holiday pay liability to maintain viability.

Statement of compliance

The financial statements of NMH have been prepared in accordance with the requirements of the Crown Entities Act 2004, and the New Zealand Public Health and Disability Act 2000, which includes the requirement to comply with generally accepted accounting practice in New Zealand (NZ GAAP).

The financial statements have been prepared in accordance with and comply with PBE Accounting Standards.

NMH was required under section 156(3)(a) of the *Crown Entities Act 2004* to complete the audited financial statements and statements of performance by 31 December 2021. The timeframe was not met because Audit New Zealand was unable to compete the audit within this timeframe due to an auditor shortage and the consequential effects of COVID-19 including lockdowns.

Presentation currency and rounding

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

Changes in accounting policies

There have been no changes in the group's accounting policies since the date of the last audited financial statements.

Standards issued and not yet effective and not early adopted

Standards and amendments, issued but not yet effective that have not been early adopted, and which are relevant to the DHB are:

Amendment to PBE IPSAS 2 Statement of Cash Flows

An amendment to PBE IPSAS 2 Statement of Cash Flows requires entities to provide disclosures that enable users of financial statements to evaluate changes in liabilities arising from financing activities, including both changes arising from cash flows and non-cash changes. This amendment is effective for annual periods beginning on or after 1 January 2021, with early application permitted. This amendment will result in additional disclosures. NMH does not intend to early adopt the amendment.

PBE IPSAS 41 Financial Instruments

The XRB issued PBE IPSAS 41 *Financial Instruments* in March 2019. This standard supersedes PBE IFRS 9 Financial Instruments, which was issued as an interim standard. It is effective for the year ending 30 June 2023. Although NMH has not assessed the effect of the new standard, it does not expect any significant changes as the requirements are similar to PBE IFRS 9.

PBE FRS 48 Service Performance Reporting

PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 and is effective for the year ending 30 June 2023, with earlier adoption permitted. NMH has not yet determined how application of PBE FRS 48 will affect its statement of performance.

Summary of significant accounting policies

Significant accounting policies are included in the notes to which they relate. Significant accounting policies that do not relate to a specific note are outlined below.

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 NMH 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. NMH'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 prevailing 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.

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 Inland Revenue Department (IRD) is included as part of receivables or payables in the statement of financial position.

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

Commitments and contingencies are disclosed exclusive of GST.

Income tax

NMH 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

NMH 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, NMH 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.

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:

Grants received

NMH 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 2021

1. Revenue

Accounting policy

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 NMH 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.

Provision of services

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

Breakdown of patient care revenue

	Actual 2021 $000	Actual 2020 $000
Health and disability services (MOH contracted revenue)	577,865	530,572
Inter-district patient inflows	9,450	8,956
ACC	7,877	6,773
Patient/consumer sourced revenue	6,835	5,887
Other government and DHB's	2,804	1,414
Total revenue	**604,831**	**553,602**

NMH 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 (2020: Nil).

2. Other revenue

Accounting policy

Donated assets

Where a physical asset is gifted to or acquired by NMH 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.

Donated services

Volunteer services received are not recognised as revenue or expenses by NMH.

Rental revenue

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

	Actual 2021 $000	Actual 2020 $000
Donated property, plant and equipment	1,045	544
Rental revenue	1,445	1,363
Gain on disposal of property, plant and equipment	106	32
Other	2,871	3,488
Total other revenue	**5,467**	**5,427**

3. Personnel costs

Salaries and wages

Salaries and wages are recognised as an expense as employees provide services.

Superannuation schemes

Defined contribution schemes

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

Defined benefit schemes

The DHB makes employer contributions to the DBP Contributors Scheme (the scheme), which is managed by the Board of Trustees of the National Provident Fund. The scheme is a multi-employer defined benefit scheme.

Insufficient information is available to use defined benefit accounting, as it is not possible to determine from the terms of the scheme the extent to which the surplus/deficit will affect future contributions by individual employers, as there is no prescribed basis for allocation. The scheme is therefore accounted for as a defined contribution scheme. Further information on this scheme is disclosed in Note 16.

	Actual 2021 $000	Actual 2020 $000
Salaries and wages	211,829	202,969
Defined contribution plan employer contributions	7,110	6,608
Other personnel costs	8,548	9,272
Total personnel costs	**227,487**	**218,849**

4. Capital charge

Capital charge

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

NMH 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 June 2021 was 5% (2020: 6%).

5. Finance revenue and costs

Accounting policy

Interest revenue

Interest revenue is recognised using the effective interest method.

Borrowing costs

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

	Actual 2021 $000	Actual 2020 $000
Finance costs		
Interest on finance lease	383	376
Total finance costs	**383**	**376**
Finance revenue		
Interest revenue	483	**974**
Total finance revenue	**483**	**974**

6. Other expenses

Accounting policy

Other expenses

Expenses are recognised as soon as they are incurred.

	Actual 2021 $000	Actual 2020 $000
Audit fees	230	214
Impairment of receivables	(66)	-
Loss on disposal of property, plant and equipment	29	3
Write down to Fair Value on Loans provided to Golden Bay Health Trust	(9)	(8)
Rental and operating lease costs	3,215	3,075
Restructuring expenses	879	637
Total other expenses	**4,278**	**3,921**

Contractors and consultants

NMH uses contractors and consultants to provide backfill for vacant positions or cover short-term demand, where specialist skills or independent external advice are needed (such as for specific programmes or projects), and in periods of peak demand.

A contractor is a person who is not considered an employee, providing backfill or extra capacity in a role that exists within NMH or acts as an additional resource for a time-limited piece of work.

A consultant is a person or firm who is not considered a contractor or employee, engaged to perform a piece of work with a clearly defined scope and provide expertise, in a particular field, not readily available from within NMH.

For transparency reasons NMH has elected to disclose contractors and consultants information seperately as below:

	Actual 2021 $000	Actual 2020 $000
Medical Locums	7,006	7,148
Other Contractors	693	705
Consulting Services	1,375	707
Total Contractors and Consultants - Operating	9,074	8,560
Contractors capitalised to assets	251	460
Consulting services capitalised to assets	627	3,824
Total contractors and consultants - Capital	878	4,284
Total contractors and consultants	**9,952**	**12,844**

7. Cash and cash equivalents

Accounting policy

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, and bank overdrafts. Bank overdrafts are presented within borrowings in current liabilities in the statement of financial position.

	Actual 2021 $000	Actual 2020 $000
Cash at bank and on hand	7	(34)
Cash advanced to NZHPL	19,409	9,168
Total cash and cash equivalents	**19,415**	**9,134**

While cash and cash equivalents at 30 June 2021 are subject to the expected credit loss requirements of PBE IFRS 9, no loss allowance has been recognised because the estimated loss allowance for credit losses is trivial.

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

8. Receivables

Accounting policy

Short-term receivables are recorded at the amount due, less an allowance for credit losses. NMH applies the simplified expected credit loss model of recognising lifetime expected credit losses for receivables.

A receivable is considered impaired when there is evidence that NMH 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.

	Actual 2021 $000	Actual 2020 $000
Gross receivables	23,484	17,538
Less: Allowance for credit losses	(236)	(414)
Total receivables	**23,248**	**17,124**
Gross receivables comprises of:		
Receivables from the Ministry of Health	4,039	1,514
Receivables from non-related parties	2,335	3,273
Accrued revenue	17,059	12,718
Other receivables	51	33
Total gross receivables	**23,484**	**17,538**

Ageing profile of receivables

	2021		2020	
	Gross	Impairment	Gross	Impairment
	$000	$000	$000	$000
Not past due	17,141	-	12,899	-
Past due 1-30 days	5,292	(24)	3,974	(15)
Past due 31-180 days	761	(40)	251	(52)
Past due 181 days - One Year	85	(36)	157	(111)
Past due One Year - Two Years	75	(60)	174	(44)
Past due Greater than Two Years	130	(76)	83	(192)
Total	**23,484**	**(236)**	**17,538**	**(414)**

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 2021	Actual 2020
	$000	$000
Opening allowance for credit losses as at 1 July	414	497
Increase in loss allowance made during the year	(66)	(2)
Receivables written off during the year	(112)	(81)
Balance at 30 June	**236**	**414**

9. Inventories

Accounting policy

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.

	Actual 2021	Actual 2020
	$000	$000
Held for distribution inventories		
Pharmaceuticals	840	496
Other supplies	2,777	2,634
Provision for obsolete stock	(230)	(230)
Total inventories	**3,387**	**2,900**

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

In 2021, the value of inventories distributed and recognised as an expense in the clinical supplies expense included in the deficit was $39.7 million (2020 $27.5 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

Accounting policy

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.

	Actual 2021 $000	Actual 2020 $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	1,899	1,899
Buildings	206	206
Total non-current assets being prepared for sale	**2,105**	**2,105**

NMH 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.

Surplus land has been determined to the east of Wairau Hospital which has been declared surplus and in September 2021 a sale and purchase agreement for this land has been entered with Kainga Ora. Settlement on this land occurred on 3 February 2022 at a sale price of $4m.

NMH 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 NMH.

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

11. Other financial assets

Accounting policy

Investments

Bank term deposits

Bank term deposits are initially measured at the amount invested. Interest is subsequently accrued and added to the investment balance. A loss allowance for expected credit losses is recognised if the estimated loss allowance is not trivial.

Equity investments

NMH 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.

When sold, the cumulative gain or loss previously recognised in other comprehensive revenue and expense is transferred within equity to accumulated surplus/deficit.

	Actual 2021 $000	Actual 2020 $000
Current Portion		
BNZ Short Term Investment	21,300	21,298
BNZ Term Deposit <12 Months	-	-
Total Current Financial Assets	21,300	21,298
Non-current Portion		
Equity investments	3	3
Loans receivable	1,729	1,720
BNZ Long Term Investment	-	-
Total Non-Current Financial Assets	1,732	1,723
Total Financial Assets	**23,032**	**23,021**

NMH 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, NMH 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 interest on this loan was deferred for three years then on 1/7/21 the interest on this loan was deferred for a further year. 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

Accounting policy

Property, plant, and equipment consists of the following asset classes: land, buildings, clinical equipment, fixtures and fittings, other 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 NMH 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 accumulated surpluses/(deficits) in equity.

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 NMH 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	3–89	0.95%–33.3%
Plant & equipment	3–50	2.0%–33.3%
Motor vehicles	5–15.5	6.45%–20.0%
Leased assets	5–35	2.9%–20.0%

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.

Impairment of property, plant, and equipment and intangible assets

NMH 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, 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.

Critical accounting estimates and assumptions

Estimating the fair value of land and buildings

The most recent valuation of land and buildings was performed by an independent registered Valuer.

Marvin Clough, ANZIV of BECA Limited. The valuation is effective as at 30 June 2021. 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 2024.

Buildings

Specialised hospital buildings are valued at fair value using depreciated replacement cost because no reliable market data is available for such buildings.

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. There has been no optimisation adjustments for the most recent valuation.
- 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.

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 NMH, 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. NMH 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.

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

	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 2019	28,638	140,413	33,586	6,369	10,192	6,701	225,899
Additions	240	1,562	6,451	439	-	10,947	19,639
Revaluations	-	(2,993)	-	-	-	-	(2,993)
Disposals	(1,640)	(5)	(1,784)	(177)	1,549	(8,692)	(10,749)
Balance at 30 June 2020	**27,238**	**138,977**	**38,253**	**6,631**	**11,741**	**8,956**	**231,796**
Balance at 1 July 2020	27,238	138,977	38,253	6,631	11,741	8,956	231,796
Additions	-	1,778	5,533	669	-	7,877	15,857
Revaluations	15,330	(3,155)	-	-	-	-	12,175
Disposals	-	-	(456)	(458)	-	(7,972)	(8,886)
Balance at 30 Jun 2021	**42,568**	**137,600**	**43,330**	**6,842**	**11,741**	**8,861**	**250,942**
Accumulated depreciation and impairment losses							
Balance at 1 July 2019	-	5,733	16,347	4,066	2,299	-	28,445
Depreciation expense	-	5,819	4,607	672	640	-	11,738
Revaluations/Impairment	-	-	-	-	-	-	-
Disposals	-	-	(260)	(174)	-	-	(434)
Balance at 30 Jun 2020	**-**	**11,552**	**20,694**	**4,564**	**2,939**	**-**	**39,749**
Balance at 1 July 2020	-	11,552	20,694	4,564	2,939	-	39,749
Depreciation expense	-	5,893	4,754	672	612	-	11,931
Revaluations/Impairment	-	(17,258)	-	-	-	-	(17,258)
Disposals	-	-	(428)	(505)	-	-	(933)
Balance at 30 Jun 2021	**-**	**187**	**25,020**	**4,731**	**3,551**	**-**	**33,489**
Carrying Amounts							
At 1 July 2019	28,638	134,680	17,239	2,303	7,893	6,701	197,454
At 30 Jun 2020	27,238	127,425	17,559	2,067	8,802	8,956	192,047
At 30 June 2021	**42,568**	**137,413**	**18,310**	**2,111**	**8,190**	**8,861**	**217,453**

During the 19/20 year a building within the Nelson hospital complex was identified as requiring further seismic strengthening. The estimated cost of strengthening exceeds the current carrying value $2,993k, therefore the asset was impaired to a nil value. Impairment in 2021: Nil, (2020 $2,993k).

Restrictions on title

NMH 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 NMH 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.

NMH leases clinical and IT equipment under a number of finance lease agreements. At 30 June 2021, the net carrying amount of leased IT and clinical equipment was $1.78 million (2020: $2.15 million).

The total amount of property, plant, and equipment in the course of construction 2021 is $9.67 million (2020: $10.18 million).

13. Intangible assets

Accounting policy

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 NMH'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	4–10	3.33%–25%

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. NMH holds an asset at cost of capital invested by NMH in the FPSC programme less any impairment applied. 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.

Impairment of intangible assets

Refer to the policy for impairment of property, plant, and equipment in Note 12. The same approach applies to the impairment of intangible assets, except for intangible assets that are still under development.

Intangible assets that are under development and not yet ready for use are tested for impairment annually, irrespective of whether there is any indication of impairment.

Breakdown of intangible assets and further information

	Acquired Software	Internally Generated Software	Total
	$000	$000	$000
Movements for each class of intangible asset			
Balance at 1 July 2019	14,078	2,328	16,406
Additions	3,109	-	3,109
Disposals/Impairments	(1,372)	(43)	(1,415)
Balance at 30 June 2020	**15,815**	**2,285**	**18,100**
Balance at 1 July 2020	15,815	2,285	18,100
Additions	3,189	151	3,340
Disposals/Impairments	(1,768)	-	(1,768)
Balance at 30 June 2021	**17,236**	**2,436**	**19,672**
Accumulated amortisation and impairment losses			
Balance at 1 July 2019	4,156	513	4,669
Amortisation expense	1,448	122	1,570
Disposals	(225)	-	(225)
Impairment losses	-	-	-
Balance at 30 June 2020	**5,379**	**635**	**6,014**
Balance at 1 July 2020	5,379	635	6,014
Amortisation expense	1,614	171	1,785
Disposals	-	-	-
Impairment losses	-	-	-
Balance at 30 June 2021	**6,993**	**806**	**7,799**
Carrying amounts			
At 1 July 2019	9,922	1,815	11,737
At 30 June / 1 July 2020	10,436	1,650	12,086
At 30 June 2021	**10,243**	**1,630**	**11,873**

Included in the Internally Generated Software is a total of $0.05 million (2020: $0.05 million) which is work in progress.

NZ Health Partnerships Limited (NZHPL) was established on 1 July 2015 taking on the assets and liabilities of Health Benefits Limited (HBL). HBL was an agency set up by all the Ministry of Health to provide shared services for District Health Boards. The investment was made to fund the establishment of a shared service arrangement to support the delivery of Finance, Procurement and Supply Chain services. NZHPL is owned by the 20 district health boards with each of the district health boards owning five (5) "A" Class shares. The A class

shares have been issued for a nil consideration. All district health boards also own "B" Class shares in NZHPL reflecting the level of investment in the FPSC Programme. The NMH 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, NMH had made payments totalling $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, NMH gained rights to access the FPSC asset, which includes National Oracle Solution (NOS) programme. In the event of liquidation or dissolution of NZHP, NMH 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 NMH share of the DRC of the underlying FPSC/NOS assets.

In 2018 the Government requested that an updated business case be developed before further work was undertaken on the FPSC/NOS programme and the programme was consequently paused. Given the inherent uncertainty this created regarding the future of the FPSC/NOS programme, NMH determined that the full value of $2.255 million would be impaired in the 30 June 2018 financial statements.

In September 2018 NZHPL made a Capital Call to NMH for NOS Revised Business Case of $301,926. Once again given the inherent uncertainty regarding the future of the FPSC/NOS programme, NMH determined that the full value of $0.302 million would be impaired in the 30 June 2019 financial statements. This has resulted in impairment losses of $0.302 million (2018: $2.255m) being recognised within the Statement of Comprehensive Revenue and Expenses.

14. Payables

Accounting policy

Short-term payables are recorded at the amount payable.

	Actual 2021 $000	Actual 2020 $000
Payables under exchange transactions		
Creditors	5,294	7,081
Revenue in advance	1,490	2,510
Capital charge payable	-	-
Other	47,303	29,994
Total payables under exchange transactions	**54,087**	**39,585**
Payables under non-exchange transactions		
Capital charge payable	-	-
Taxes payable (GST, Employer Deductions & FBT)	5,176	4,618
Other	281	1,395
Total payables under non-exchange transactions	5,457	6,013
Total Payables	**59,544**	**45,598**

15. Borrowings

Accounting policy

Overdraft facility

Amounts drawn under the NZHPL banking facility are recorded at the amount payable plus accrued interest.

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 NMH 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 NMH 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.

Critical judgements in applying accounting policies

Leases classifications

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 the group.

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.

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

	Actual 2021 $000	Actual 2020 $000
Current portion		
Finance leases	737	632
Total current portion	**737**	**632**
Non-current portion		
Finance leases	7,819	8,473
Total non-current portion	**7,819**	**8,473**
Total borrowings	**8,556**	**9,105**

Fair value

The fair value of finance leases is $8.6 million (2020: $9.1m). Fair value has been determined using contractual cash flows discounted using a rate based on market borrowing rates at balance date ranging from 4.8% to 6.0% (2020: 4.8% to 6.0%).

Analysis of finance leases

	Actual 2021 $000	Actual 2020 $000
Minimum lease payments payable:		
Not later than one year	1,029	1,029
Later than one year and not later than five years	3,277	3,485
Later than five years	11,573	12,425
Total minimum lease payments	**15,879**	**16,939**
Future finance charges	(7,405)	(7,819)
Present value of minimum lease payments	**8,474**	**9,120**
Present value of minimum lease payments payable:		
Not later than one year	654	645
Later than one year and not later than five years	2,045	2,155
Later than five years	5,775	6,320
Total present value of minimum lease payments	**8,474**	**9,120**

Description of material leasing arrangements

NMH has entered into finance leases primarily for 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 NMH 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 2021, Golden Bay Community Health Trust had an outstanding lease liability with a present value of $6.5M (2020: $6.7M). NMH does not have the option to purchase the asset at the end of the lease term.

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

16. Employee entitlements

Accounting policy

Short-term employee entitlements

Employee entitlements 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 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.

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.

Critical accounting estimates and assumptions

Sabbatical leave, long service leave, and retirement gratuities

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

Expected future payments are discounted using discount rates derived from the yield curve of New Zealand government bonds. The discount rates used have maturities that match, as closely as possible, the estimated future cash outflows. The salary inflation factor has been determined after considering historical salary inflation patterns and after obtaining advice from an independent actuary. A weighted average discount rate of 1.9% (2020: 0.8%) and an inflation factor of 1.5% (2020: 2.0%) were used. The discount rates used are those advised by the Treasury. The salary inflation factor is the group's best estimate forecast of salary increments. The take-up rate used for sabbatical leave is 16% (2020: 16%).

If the discount rate were to differ by 1% from that used, with all other factors held constant, the carrying amount of the sabbatical, long service leave, and retirement gratuities obligations would be an estimated $0.44 million higher/lower.

If the salary inflation factor were to differ by 1% from that used, with all other factors held constant, the carrying amount of the sabbatical, long service leave, and retirement gratuities obligations would be an estimated $0.44 million higher/lower.

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 1.9% (2020: 0.8%). Average future salary growth has been assumed to be 1.5% (2020: 2%) per annum, plus a salary scale of 1% (2020: 1%) per annum.

Breakdown of employee entitlements

	Actual 2021 $000	Actual 2020 $000
Current Portion		
Accrued salaries & wages	7,646	6,051
Annual leave	25,107	24,017
Holidays Act remediation	59,422	54,582
Sick leave	674	520
Sabbatical leave	220	229
Retirement gratuities	1,947	2,195
Long service leave	547	570
Continuing medical education	6,250	4,740
Total current portion	**101,813**	**92,904**
Non-current portion		
Sick leave	1,156	1,227
Sabbatical leave	1,039	1,061
Retirement gratuities	5,087	6,155
Long service leave	1,974	2,386
Total non-current portion	**9,256**	**10,829**
Total employee entitlements	**111,069**	**103,733**

Holidays Act remediation

A number of New Zealand's public and private organisations have identified issues with the calculation of leave entitlements under the Holidays Act 2003 ("the Act").

Work has been ongoing since 2016 on behalf of 20 District Health Boards (DHBs) and the New Zealand Blood Service (NZBS), with the Council of Trade Unions (CTU), health sector unions and Ministry of Business Innovation and Employment (MBIE) Labour Inspectorate, for an agreed and national approach to identify, rectify and remediate any Holidays Act non-compliance by DHBs. DHBs have agreed to a Memorandum of Understanding (MOU), which contains a method for determination of individual employee earnings, for calculation of liability for any historical non-compliance.

For employers such as the DHBs that have workforces that include differential occupational groups with complex entitlements, non-standard hours, allowances and/or overtime, the process of assessing non-compliance with the Act and determining the additional payment is time consuming and complicated.

The remediation project associated with the MOU is a significant undertaking and work to assess all non-compliance will continue through the 2020/21 financial year. The final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed.

However, during the 2019/20 financial year the review process agreed as part of the MOU has rolled out in tranches to the DHBs and NZBS. DHB readiness and availability of resources (internal and external to the DHB) has determined when a DHB can commence the process. NMH has made progress in its review and it now believes it can determine a reliable estimate of its obligation to address historic non-compliance under the MoU.

As a result, as at 30 June 2021, in preparing these financial statements, NMH recognises it has an obligation to address any historical non-compliance under the MOU. The DHB has made estimates and assumptions to determine a potential liability based on its review of payroll processes for instances of non-compliance with the Act and against the requirements of the MOU.

The liability has been estimated by

- selecting a sample of current and former employees;
- calculating the underpayment for these employees over the full period of liability; and
- extrapolating the result across all current and former employees.

This liability amount is the DHB's best estimate at this stage of the outcome from this project. However, until the project has progressed further, there remain significant uncertainties as to the actual amount the DHB will be required to pay to current and former employees.

The estimates and assumptions may differ to the subsequent actual results as further work is completed. This may result in further adjustment to the carrying amount of the provision within the next financial year or payments to employees that differ significantly from the estimation of liability.

NMH will be reliant on Crown support if it is to settle this liability within one year of the date of approving the financial statements. The Board has received a letter of comfort, dated 16 December 2020 from the Ministers of Health and Finance which states that equity support will be provided where necessary to maintain viability.

17. Provisions

Accounting policy

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

NMH belongs to the ACC Partnership Programme (the "Full Self Cover Plan") whereby NMH accepts the management and financial responsibility for employee work-related illnesses and accidents. Under the programme, NMH 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, NMH 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.

Breakdown of provisions and further information

	Actual 2021 $000	Actual 2020 $000
Current portion		
Restructuring	48	48
ACC Partnership Programme	443	433
Total current portion	**491**	**481**
Total provisions	**491**	**481**

Movements for each class of provision are as follows:

	Restructures $000	*ACC* $000	*Total* $000
Balance at 1 July 2019	48	388	436
Additional provisions made	-	-	-
Amounts used	-	-	-
Unused amounts reversed	-	45	45
Balance at 30 June 2020	**48**	**433**	**481**
Balance at 1 July 2020	48	433	481
Additional provisions made	-	-	-
Amounts used	-	-	-
Unused amounts reversed	-	10	10
Balance at 30 June 2021	**48**	**443**	**491**

Exposures arising from the programme are managed by promoting a safe and healthy working environment by:

- implementing and monitoring health and safety policies;
- induction training on health and safety;
- actively managing workplace injuries to ensure that employees return to work as soon as practical;
- recording and monitoring workplace injuries and near misses to identify risk areas and implementing mitigating actions; and
- identifying workplace hazards and implementation of appropriate safety procedures.

An external independent Actuarial Valuer, Simon Ferry (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 2021. 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 11.6% 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

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.

NMH 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. If the claims for a year exceed the stop loss limit, NMH will continue to meet the costs of claims and will be reimbursed by ACC for the costs that exceed the stop loss limit.

NMH 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.

Average inflation has been assumed as 1.85% for the next 5 years. A discount rate of 0.50% has been used for the next five years.

Any changes in liability valuation assumptions will not have a material effect on the financial statements.

18. Equity

Accounting policy

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.

Breakdown of equity and further information

	Actual 2021 $000	Actual 2020 $000
Crown equity		
Balance at 1 July	80,806	81,352
Capital contribution	-	-
Conversion of Loans to Equity	-	-
Repayment of capital	(547)	(547)
Balance at 30 June	**80,259**	**80,806**
Accumulated surplus/(deficit)		
Balance at 1 July	(63,881)	(1,421)
Surplus/(deficit) for the year	(5,983)	(62,460)
Property revaluation reserve transfer on disposal	-	-
Balance at 30 June	**(69,864)**	**(63,881)**
Revaluation reserves		
Balance at 1 July	83,481	86,475
Revaluations	29,433	-
Impairment charge	-	(2,975)
Transfer to accumulated surplus/(deficit) on disposal	-	(19)
Balance at 30 June	**112,914**	**83,481**
Revaluation reserves consist of		
Land	40,630	25,300
Buildings	72,284	58,181
Total revaluation reserves	**112,914**	**83,481**
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	**123,309**	**100,406**

Capital management

The group's capital is its equity, which consists of Crown equity, accumulated surpluses/(deficits), property revaluation reserves, and trust funds. Equity is represented by net assets.

The group 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.

The group manages its equity as a by-product of prudently managing revenues, expenses, assets, liabilities, investments, and general financial dealings to ensure that it effectively achieves its objectives and purposes while remaining a going concern.

Accumulated comprehensive revenue and expense includes accumulated surpluses/deficits of unspent mental health ring fenced funding as detailed in note 26.

19. Capital commitments and operating leases

Accounting policy

Operating leases as lessee

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. The DHB leases a number of buildings, vehicles, and office equipment (mainly photocopiers) under operating leases.

	Actual 2021 $000	Actual 2020 $000
Capital commitments		
Property, plant and equipment	3,468	1,788
Intangible assets	73	304
Total capital commitments	**3,541**	**2,092**
Non-cancellable operating lease commitments		
Not later than one year	1,391	1,295
Later than one year and not later than five years	3,673	4,065
Later than five years	823	1,380
Total non-cancellable operating lease commitments	**5,887**	**6,740**
Non-cancellable finance lease commitments		
Not later than one year	1,029	1,029
Later than one year and not later than five years	3,153	3,468
Later than five years	11,573	12,271
Total non-cancellable finance lease commitments	**15,755**	**16,768**
Total commitments	**25,183**	**25,600**

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

Leases as lessee

Total future minimum lease payments to be paid under non-cancellable operating leases at balance date as a lessee are $4.602 million, (2020, $6.740 million).

NMH 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.

NMH 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 2021, $3.084 million was recognised as an expense in the surplus or deficit in respect of operating leases (2020: $3.066 million).

Leases as lessor

NMH leases owned properties to third parties under operating leases resulting in revenue of $1.4 million (2020: $1.5 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 8 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 $5.887 million (2020: $6.740 million).

NMH 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.

20. 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.

NMH has no other contingent liabilities as at 30 June 2021 (2020: Nil).

Contingent assets

NMH has no contingent assets as at 30 June 2021 (2020: Nil).

21. Related party transactions

Accounting policy

Government-related entities

NMH is a wholly-owned entity of the Crown.

Related party disclosures have not been made for transactions with related parties, including associates that are:

- within a normal supplier or client/recipient relationship; and
- on terms and conditions no more or less favourable than those that it is reasonable to expect that NMH would have adopted in dealing with the party at arm's length in the same circumstances.

Further, transactions with other government agencies (for example, government departments and Crown entities) are not disclosed as related party transactions when they are consistent with the normal operating arrangements between government agencies.

Significant transactions with government-related entities

NMH has received funding from the Crown and ACC of $588.5 million (2020: $538.7 million) to provide health services in the Nelson Marlborough area for the year ended 30 June 2021.

Revenue earned from other DHBs for the care of patients outside NMH's district amounted to $9.5 million (2020: $9 million) for the year ended 30 June 2021. Expenditure to other DHBs for their care of patients from NMH's district amounted to $52.8 million (2020: $51.0 million) for the year ended 30 June 2021.

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

In conducting its activities, NMH 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.

NMH 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 2021 totalled $2.34 million (2020:$3.6 million). These purchases included the purchase of electricity from Meridian Energy and air travel from Air New Zealand.

Transactions with key management personnel

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

	Actual 2021 $000	Actual 2020 $000
Board Members		
Remuneration	293	273
Full-time equivalent members	11	11
Leadership Team		
Remuneration	3,160	2,894
Full-time equivalent members	12	12
Total key management personnel remuneration	3,453	3,167
Total fill time equivalent personnel	**23**	**23**

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.

The NMDHB purchased and received services from the Churchill Trust during the financial year. Peter Bramley, NMH's Chief Executive is a Trustee of the Churchill Trust. Revenue services from the Churchill Trust totalled $5.5 million during the financial year, while payments to the Churchill Trust totalled $0.3 million. The services provided for and from the Churchill Trust were on normal commercial terms. There is a balance of $0.3 million outstanding for outstanding receipts at year end.

NMH entered into a variety of transactions with Golden Bay Community Health Trust during the financial year. NMH's General Manager, Finance, Performance & Facilities, Eric Sinclair, is a Trustee of the Golden Bay Community Health Trust. The NMH 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 $6.5 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.

NMH purchased services from the Marlborough District Council during the financial year. Gerald Hope, an NMH Board Member is a District Councillor of Marlborough District Council. Payments to Marlborough District Council during the Financial Year totalled $0.054 million. The services provided for and from Marlborough District Council were on normal commercial terms. There are no outstanding unpaid invoices at year end.

The NMH purchased and received services from the West Coast DHB (WCDHB) during the financial year. NMH's Board Chair, Jenny Black, was also the Board Chair of the WCDHB until December 2019. Board member Jacinta Newport is an employee of WCDHB. Revenue in the form of Inter District Flows (IDFs) from the WCDHB totalled $1.5 million during the financial year, while payments in the form of IDFs totalled $0.4 million. The services provided for and from the WCDHB were on normal commercial terms. There is no amount outstanding for outstanding receipts at year end.

There are close family members of key management personnel employed by NMH. 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.

22. Events after the balance date

The Health Sector Reforms are scheduled to come into effect on 1 July 2022, refer to the Statement of Accounting Policies for more detail.

In response to COVID-19, on 17 August 2021, the Nelson Marlborough region move to Alert Level 4 for two weeks, then to Alert Level 3 for one week and then down to Alert Level 2.

On 3 December 2021 the Alert Levels were replaced with the Covid Protection Framework (the "traffic light" system). Subsequently, New Zealand moved into the highest COVID-19 setting (red light) on 24 January 2022. At the time of publication there has been community transmission in the Nelson Marlborough district and some changes have occurred to the DHB's services and visitor policy. The impact of COVID-19 is considered a non-adjusting event for the purposes of these financial statements.

Other than as noted above, 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.

23. Financial instruments

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

NMH 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 NMH'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 2021 (2020: Nil).

Credit rate risk

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

Financial instruments which potentially subject NMH 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 95% of NMH'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.

NMH 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:

	2021 $000	2020 $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	(34)
Funds advanced to NZHP	19,409	9,168
Total counterparties without credit ratings	**19,415**	**9,134**
Receivables		
Existing counterparties with no defaults in the past	23,201	17,115
Existing counterparty with defaults in the past	47	9
Total receivables	**23,248**	**17,124**

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.

NMH had no foreign currency assets or liabilities as at 30 June 2021 (2020: 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 NMH's ability to meet its contractual obligations. NMH 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.

2021	Balance Sheet	Contractual Cash	6 mths or less	6-12 mths	1-2 years	2-5 years	More than 5 years
	$000	$000	$000	$000	$000	$000	$000
Finance lease liabilities	8,556	15,879	-	1,029	1,029	2,248	11,573
Creditors and other payables	59,553	59,553	59,553	-	-	-	-
Total current assets	68,109	75,432	59,553	1,029	1,029	2,248	11,573

2020	Balance Sheet	Contractual Cash	6 mths or less	6-12 mths	1-2 years	2-5 years	More than 5 years
	$000	$000	$000	$000	$000	$000	$000
Finance lease liabilities	9,106	16,938	-	1,029	1,029	2,456	12,425
Creditors and other payables	43,799	43,799	43,799	-	-	-	-
Total current assets	52,905	60,737	43,799	1,029	1,029	2,456	12,425

Sensitivity analysis

In managing interest rate risk, NMH 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 2021, it is estimated that a general increase of one percentage point in interest rates would decrease NMH's deficit by approximately $487,614 (2020: $402,752).

Market risk

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

Financial instrument categories

	Actual 2021 $000	Actual 2020 $000
Financial liabilities measured at amortised cost		
Payables (excluding deferred revenue, taxes payable and grants received subject to conditions)	52,878	38,470
Borrowings - Secured loans	-	-
Finance leases	8,556	9,105
Total financial liabilities measured at amortised cost	**61,434**	**47,575**
Financial assets measured at amortised cost (2018: Loans and receivables)		
Cash and cash equivalents	19,415	9,134
Receivables	23,248	17,124
Investments - term deposits	21,300	21,298
Total financial assets measured at amortised cost	**63,963**	**47,556**

24. Capital management

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

NMH 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.

NMH 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 NMH's management of capital during the year (2020: Nil).

25. Explanation of major variances against budget

Statement of comprehensive revenue and expense

The financial results for 20/21 have again been significantly influenced by the focu and costs associated with COVID-19 and Holidays Act remediation. Taking the COVID-19 net costs into account has resulted in a deficit of $6.0M compared to the planned deficit of $0.0M. However, the net costs associated with COVID-19 have contributed an estimated $0.7M to this deficit position.

Revenue

Revenue for the year was $13.8M greater than budget. Additional funding for Ministry of Health sub-contracts for a range of services received contributed $7.7 million to this variance. $4.1M of this Revenue variance related to Covid19. ACC contributed $1.2M due to an increase in volume in Elective and AT&R.

Expenditure

Additional costs from IDF cases, higher numbers in Residential care both hospital and rest homes and higher immunisation costs, have all contributed $8.7M to the adverse result. Volume driven clinical supplies especially in the areas of pharmaceuticals, blood products, treatment disposables and other associated expenses contributed $5.6M to variance.

A further $4.8M added to the provision for the Holidays Act compliance, bringing this to a total of $59M, this was also not known at the time the budgets were prepared.

Statement of financial position

The projections in the 2020/21 Annual Plan were based on forecasts prepared well before the end of the 2019/20 year. A comparison of the actual balances with the plan would include amounts reflecting differences between the forecast and reported 2019/20 balances. These amounts comprised increases of $42 million in assets, $72 million in liabilities and a decrease of $30 million in equity.

NMH has considered the impact of COVID-19 on the valuation of the assets and liabilities as at 30 June 2021. Based on the information available at the time of preparing these financial statements, COVID-19 has had no material impact on the statement of financial position.

Statement of cash flows

Net cash flows from Operating Activities was $8m higher than expected due to an increase in funding and a decrease in Capital charge, however this was offset by higher payments to suppliers.

26. Mental health ring-fenced accounts

NMH 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 2021 $000	Actual 2020 $000
Mental health funds		
Opening balance	(1,114)	995
Excess/(shortfall) of funding over payments	(324)	(2,109)
Adjustments to funds available		-
Total mental health funds	**(1,438)**	**(1,114)**

27. Summary of revenue and expenditure by output class

	Budget 2021 $000	Actual 2021 $000	Actual 2020 $000
Revenue			
Prevention services	8,993	14,583	9,018
Early detection and management services	135,070	150,652	150,989
Intensive assessment and treatment services	338,027	333,352	285,739
Support services	115,137	112,196	113,891
Total revenue	**597,227**	**610,782**	**559,638**
Expenditure			
Prevention services	8,898	13,974	9,075
Early detection and management services	133,090	147,120	151,482
Intensive assessment and treatment services	340,190	346,467	302,789
Support services	115,049	109,202	112,670
Total expenditure	**597,227**	**616,764**	**576,016**
Surplus/(deficit)			
Prevention services	95	608	(56)
Early detection and management services	1,980	3,531	(493)
Intensive assessment and treatment services	(2,163)	(13,115)	(17,050)
Support services	88	2,993	1,221
Total surplus/(deficit) attributable by output class	-	**(5,982)**	**(16,378)**
Holidays Act Remediation		(4,840)	(46,082)
Total surplus/(deficit)	-	**(10,822)**	**(62,460)**

The summary financial results by output class do not include any attribution of the Holidays Act remediation provision that has been made (refer to Note 16).

Audit report

To the readers of Nelson Marlborough District Health Board's financial statements and performance information for the year ended 30 June 2021

The Auditor-General is the auditor of Nelson Marlborough District Health Board (the District Health Board). The Auditor-General has appointed me, John Whittal, 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, on his behalf.

We have audited:

- the financial statements of the District Health Board on pages 14 and 37 to 74, that comprise the statement of financial position as at 30 June 2021, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information and
- the performance information of the District Health Board on pages 17 to 36.

Opinion

In our opinion, the financial statements of the District Health Board on pages 14 and 37 to 74:

- present fairly, in all material respects:
  - its financial position as at 30 June 2021; 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.
- the performance information of the District Health Board on pages 17 to 36:
  - presents fairly, in all material respects, the District Health Board's performance for the year ended 30 June 2021, 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; and
  - what has been achieved with the appropriations; and
  - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and
- complies with generally accepted accounting practice in New Zealand.

Our audit was completed late

Our audit was completed on 21 March 2022. This is the date at which our opinion is expressed. We acknowledge that our audit was completed later than required by the *Crown Entities Act 2004*, section 156(3)(a). This was due to an auditor shortage in New Zealand and the consequential effects of COVID-19, including lockdowns.

The basis for our opinion is explained below, and we draw attention to other matters. 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.

Emphasis of matters

Without modifying our opinion, we draw attention to the following matters.

The financial statements have been appropriately prepared on a disestablishment basis

The basis of preparation on page 41 outlines the health sector reforms announced by the Minister of Health on 21 April 2021. Legislation to disestablish all District Health Boards and establish a new Crown entity, is expected to come into effect on 1 July 2022. The District Health Board therefore prepared its financial statements on a disestablishment basis. The values of assets and liabilities have not changed because these will be transferred to the new Crown entity.

Uncertainties in estimating the holiday pay provision under the Holidays Act 2003

Note 16 on pages 60 and 61 outlines that the District Health Board has been investigating issues with the way it calculates holiday pay entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues. The District Health Board has estimated a provision of $59.4 million, as at 30 June 2021 to remediate these issues. However, until the process is completed, there are uncertainties surrounding the amount of this provision.

The District Health Board is reliant on financial support from the Crown

Note 16 on pages 60 and 61 outlines that Crown support would be required if the District Health Board was required to settle the estimated historical Holidays Act 2003 liability prior to its disestablishment. The District Health Board therefore obtained a letter of comfort from the Ministers of Health and Finance, which confirms that the Crown will provide the District Health Board with financial support, where necessary.

Impact of COVID-19

Note 25 to the financial statements and page 17 of the performance information outlines the impact of COVID-19 on the District Health Board.

HSU population information was used in reporting COVID-19 vaccine strategy performance results

Note 2 on page 35 outlines the information used by the District Health Board to report on its COVID-19 vaccine coverage. The District Health Board uses the Health Service User (HSU) population data rather than the population data provided by Statistics New Zealand (Stats NZ), for the reasons set out in note 2 on page 35. The note outlines that there would be differences in the reported results for the overall population if the Stats NZ population data was used. There would be further differences in the reported results of vaccination coverage if the Stats NZ population data is classified by ethnicity and age. The District Health Board has

provided a table that highlights the differences in the ethnicity groupings between the HSU population data and the Stats NZ population data.

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 opinion.

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

The Board is responsible on behalf of the District 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 District Health Board for assessing the District 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 the District 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 audit of 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.

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 District 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 District 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 District Health Board's framework for reporting its performance.
- We conclude on the appropriateness of the use of the disestablishment basis of accounting by the Board.
- 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 obtain sufficient appropriate audit evidence regarding the financial statements and the performance information of the entities or business activities within the District Health Board to express an opinion on the consolidated financial statements and the consolidated performance information. We are responsible for the direction, supervision and performance of the of the District Health Board audit. We remain solely responsible for our audit opinion.

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 are responsible for the other information. The other information comprises the information included on pages 1 to 74, 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 District 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: International 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.

John Whittal
Audit New Zealand

On behalf of the Auditor-General
Wellington, New Zealand

TE WAIORA Nelson Marlborough Health

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Nelson Marlborough Health