NORTHLAND DISTRICT HEALTH BOARD
Te Poari Hauora A Rohe O Te Tai Tokerau

STATEMENT OF INTENT 2014/15

This document comprises the sections relevant to the Statement of Intent that have been copied from Northland DHB's Annual Plan 2014/15.

Contents

Signatories

7 JUL 2014
Agreement dated this ..... day of 2014

between

Her Majesty the Queen **In right of her Government of New Zealand** Acting by and through the Minister of Health	Minister of Health

Anthony Norman Chair, NDHB	Sally Macauley Deputy Chair	Dr Nick Chamberlain Chief Executive, NDHB

1 Introduction and strategic intentions

1.1 Executive summary

Northland District Health Board will continue to improve the delivery of services during 2014/15 while living within our means. Northland DHB has completed an extensive patient safety and quality improvement review and will commence the implementation of recommendations.

The Board has maintained a balanced financial position since 2003 and will continue to operate within a viable and financially sustainable cost structure. Northland DHB is committed to the Government's aim of delivering better public services within tight financial constraints, and to the four objectives of the Government's health plan: helping families stay healthy, better performance, best use of the health dollar, and a strong and trusted workforce.

We will maintain our performance improvement on the Health Targets. We now meet or exceed targets for elective services, cancer treatment, advice to smokers in hospital, ED waiting times and immunisation rates for non-Maori. We are close to target for immunisation rates for Maori, CVD screening rates for non-Maori, and advice to smokers in primary care continues to improve with each quarter. Northland DHB will contribute towards reducing the incidence of rheumatic fever and child violence, two of the ten whole-of-government key result areas, and remain a leader in developing and implementing Children's Action Plans.

This year's plan projects a break-even position. Northland DHB has a continuing commitment to improving efficiency. Significant savings are factored into our plan from the HBL finance, procurement and supply chain business case, and healthAlliance procurement savings.

This year's Annual Plan continues our emphasis on better integrating services across the health sector, and that means looking across both NDHB's own primary-community services and hospital services, and NDHB and community providers. We will explore a new model of care which involves multidisciplinary teams supporting networks of general practices. We will also continue to develop integrated IT solutions. These approaches are vital to meet the challenges posed by our ageing population, the rising tide of long term conditions, the relative poverty of our citizens (Northland has the lowest GDP in the country) and financial constraints. Integration is a key theme throughout module 2 of the plan and Northland has four Integrated Family Health Centres in development (two at the business case stage, two in early discussion).

Awareness of these challenges was the springboard for the development of the Northland Health Services Plan (NHSP), Northland DHB's foundation for future service improvement. The NHSP is the template for the future structure and provision of services across the whole health sector in Northland from 2012 to 2017. A Strategic Investment Fund of $1M has been established for projects that support the achievement of the Northland Health Services Plan's outcomes.

We will continue to develop the Alliance Leadership Team (ALT) and the underlying Service Level Alliance Teams for rural and youth health. The ALT will focus on reducing tobacco consumption and obesity, and review some of our Services to Improve Access programmes.

Northland DHB continues to work with primary and community services to deliver integrated services for older people to support them living independently in the community, manage long term conditions well and prevent admission to hospital. We are also continuing to improve the quality of residential care services (including dementia care), and stroke services.

The Annual Plan is closely aligned with the Northern Region Health Plan. Its Triple Aim of population health, patient experience and value/ sustainability formed the starting point for the NHSP. Relevant regional performance measures have been integrated into the Annual Plan. Regional planning processes, in which NDHB staff have been intimately and prominently involved, continue to develop models, pathways and protocols to guide future improvement across all four DHBs. Northland DHB monitors regional services' performance for Northland patients.

Improving Maori health and reducing inequities continue to be driving forces. The Maori Health Plan 2014/15, a companion document to the Annual Plan, sets out key performance measures for

health services. Maori health and reducing inequities are addressed throughout the Annual Plan and they form a headline target under the NHSP. NDHB continues to strengthen internal and external monitoring systems so that all indicators, including Health Targets, will be reported by ethnicity. Increasingly we are using a results based accountability framework for monitoring provider performance on population health measures.

The Annual Plan has been developed with the involvement of the Chief Executives of Northland's two PHOs, both of whom have written letters of support for the plan, and who are also members of NDHB's Executive Leadership Team.

1.2 Context

1.2.1 Background and operating environment

Legislation

Northland DHB is one of 20 District Health Boards established in 2001 in accordance with section 19 of the Public Health and Disability Act 2000. Section 22 of the Act requires Northland DHB to:

- improve, promote, and protect the health of people and communities
- promote the integration of health services, especially primary health and hospital services
- promote effective care or support for those in need of personal health services or disability support services
- promote the inclusion and participation in society and independence of people with disabilities
- reduce health disparities by improving health outcomes for Maori and other population groups
- uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations.

DHBs are categorised as Crown agents under section 7 of the Crown Entities Act 2004. As well as preparing an Annual Plan, Northland DHB must prepare a Statement of Intent according to section 139 of the Crown Entities Act.

DHBs have a statutory responsibility under the Treaty of Waitangi to put into practice its principles of partnership, protection and participation. NDHB is acutely conscious that Maori, who comprise about a third of our population, suffer most from health and other inequalities.

The health system

The Ministry of Health's Outcomes Framework provides the context for DHBs. The health system is driven by their two overarching outcomes of "New Zealanders living longer, healthier, more independent lives" and "the health system is cost effective and supports a productive economy". Contributing to these are their three high-level outcomes of "New Zealanders are healthier and more independent", "health services are delivered better, sooner and more conveniently" and "the future sustainability of the health system is assured".

In working towards these, the Ministry contributes to the Government's four overall national priorities, particularly "better public services", "a more competitive, productive economy" and "managing government finances".

Our population

Northland's population in 2013 was 151,692, 3.6% of New Zealand's population. About half live in the Whangarei District Council area, 37% in the Far North District Council and 13% in Kaipara District Council. Nga Iwi o Te Tai Tokerau comprise 30% of Northland's population.

Northland's population is 'ageing' because older age groups (age 65 or more) are forming an increasing proportion of the population. At the moment the older section of our population sits at 18%, but by 2026 this will rise to about a quarter.

The child and youth population declined by 5% between 2006 and 2013. However the Maori birth rate is about two-thirds higher than the non-Maori rate, and the numbers of Maori babies will not be declining for the foreseeable future.

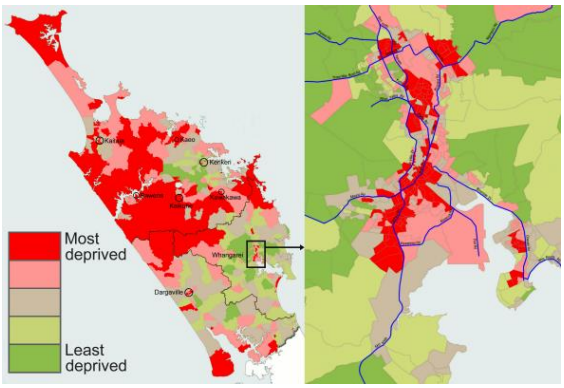
Our health

The health status of Northlanders is among the lowest in the country. Non-Maori Northlanders' health is generally comparable to that of national non-Maori, but Northland Maori uniformly fare worse. Maori life expectancy in Northland is 9 years less than non-Maori (whereas nationally the difference is 7.6 years), and the average age of Maori admitted to hospital is 13 years younger than that of non-Maori.

Poorer populations have lower health status, and Northlanders are among the most deprived in the country. In the 2013 national deprivation analysis, 20% of the nation's population was in the lowest band (quintile) of the index, but for Northland the figure was 43%. The most deprived local authority area is the Far North District Council.

Deprived populations tend to be less health literate (one of the main reasons Northland DHB is finding it hard to reach those last few percent of the immunisation Health Target, for example).

NZDep 2006 in Northland



The highest demands placed on health services, and the most common causes of death, come from long term conditions, which include cancers, heart disease, stroke, diabetes and respiratory disease. All these are strongly linked to unwise lifestyle choices, especially smoking, poor diet and lack of exercise.

These 'lifestyle conditions' occur more frequently with age, the main reason our ageing population is a major challenge. The older section of our population consumes several times more health resources than other sections of the population. Northland's proportion of the population over 65 (18.3% in 2013) is not only higher than the national average (14.3%), it is projected to grow at a faster rate (increasing by 6.4% to reach 24.7% in 2026, while NZ's will increase by 5.0% to reach 19.3%)

Two-thirds of Northland's population lives in rural towns and areas outside the Whangarei urban area, many in isolated areas accessible only by unsealed roads. It takes over five hours to travel from Northland's northern to southern extremities and up to two hours west to east. For many Northlanders, travelling to where health services are located poses a challenge, especially for people in the most isolated areas whose populations tend to have high needs.

1.2.2 Nature and scope of functions

Services provided

Northland DHB provides public health, primary and hospital (secondary) services to our population. These include medical, surgical, maternity, mental health and addictions, rehabilitation, child health, youth health, oral health, diagnostic services (imaging, laboratory) and clinical support services (pharmacy, physiotherapy, occupational therapy and so on).

Providing services to a moderate-scale population over an area the size of Northland is one of the biggest challenges for Northland DHB and other providers in the health sector – particularly so when we know that generally the more distant a population, the greater its health needs.

As a moderate-sized DHB, Northland is not large enough to be able to provide more specialised (tertiary) services; for these we rely on other DHBs, mainly Auckland.

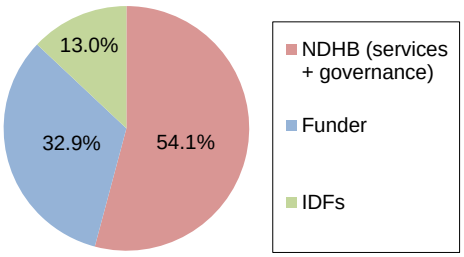
Northland DHB holds agreements with over a hundred primary and community organisations which provide a wide range of public health, primary and community services.

Northland DHB has responsibility under the Public Health and Disability Act for the overall planning of health services in Northland. This entails assessing health needs in the population and meeting these by achieving the best possible match of service provision and distribution. The Northland Health Services Plan (NHSP) is the Northland health sector's key strategic document. It looks forward twenty years to assess the nature and scale of the challenges ahead, then takes a five-year action focus over 2012-2017.

NDHB retains stewardship of crown assets valued at $164 million (2012/13 balance sheet). These consist of freehold land and buildings ($120 million), plant, equipment and vehicles ($12 million), work in progress ($11 million) and investments ($21 million).

Significant activity is underway to improve the capital infrastructure including the building of a new maternity unit, cancer centre, administration block and other site infrastructure improvements in Whangarei. Major IT developments include the rollout of Windows 7 and the implementation of a new patient administration system. Northland DHB is also involved in the development of Integrated Family Health Centres on hospital sites in Dargaville and Kawakawa, and improvements to Bay of Islands Hospital in Kawakawa.

Share of health funding in Northland



Out of Northland DHB's total 2014/15 budget of $547M, just over half is spent on NDHB-provided services, a third on community provider services, and the rest is paid to other DHBs for tertiary services through inter-district flows.

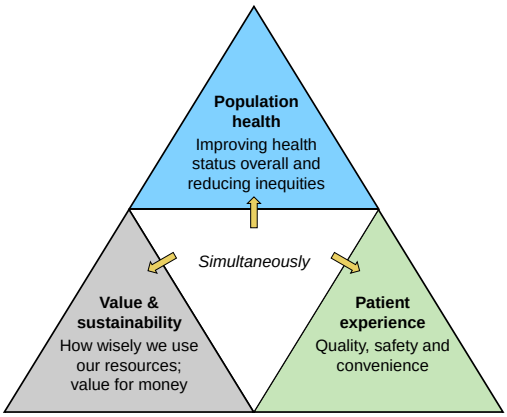
Governance

Governance of NDHB is provided by a Board of eleven, of whom seven are elected and four appointed by the Minister of Health.

The Chief Executive is responsible to the Board for the organisation's performance (organisational structure is detailed further in 5.1 Managing the organisation).

1.3 Strategic Intentions

The Northland Health Services Plan (NHSP) embodies Northland DHB's strategic intentions. The plan was developed around the Triple Aim framework, ensuring that all assessments and decisions are made by balancing the three factors simultaneously.



Each of the Triple Aims has two Headline Targets for 2017 which drive the NHSP:

Population health	The life expectancy gap between Maori and non-Maori is reduced by 2 years
	Unplanned hospital admissions for Northlanders are reduced by 2,000
Patient experience	Every Northlander with urgent health needs has same-day access to primary care
	More than 95% of patients report they would recommend the service provided
Value and sustainability	Value for money savings of $5M are achieved against projected cost increases each year
	Northland hospital labour productivity benchmarks in the top five DHBs

To deliver on the Headline Targets and objectives five new major projects are in development:

- Neighbourhood Healthcare Homes (better service integration)
- Right Care (right care in the right place at the right time)
- First 2,000 days (improving maternal, infant and child health)
- Patient and Family Centred Care (refocusing the delivery of healthcare around the needs of the patient and their whanau)
- Fit for Life (addressing smoking and obesity, the key priorities of the Alliance Leadership Team).

These major projects are in addition to existing project work focussed on the NHSP Headline Actions, including:

- enhancement of school based public health services
- establishment of new youth services
- piloting of secure messaging between primary and secondary providers
- diabetes health literacy development
- respiratory pathway projects.

Key national priorities and new ways of working are taken account of within the projects being developed within the NHSP, as well as through other mechanisms under Northland DHB. Better, sooner, more convenient services (BSMC) – one of the key priorities for the Minister and Ministry – is woven into the NHSP's planning and implementation. Essentially, the Triple Aim says the same thing as BSMC in different words.

One of the key projects for the NHSP is establishing Integrated Family Health Centres; so far planning is well advanced for IFHCs in Kawakawa (Bay of Islands) and Dargaville (Kaipara), and it is in the early stages in two other parts of Whangarei, Raumanga and Kensington.

The two major priorities of the Alliance Leadership Team (Te Roopu Kai Hapai Oranga), tobacco and healthy lifestyles (obesity-nutrition-exercise), are consistent with the Population Health Triple Aim.

Better access to primary and community services is being addressed in many contexts. It is a key plank of the NHSP, and numerous actions are contained throughout the Annual Plan, especially 2.2 Clinical integration. Primary care access is also a focus for the rural Service Level Alliance Teams (SLATs) set up in Northland.

Information services initiatives under the NHSP are aiming for a shared IS platform across the health sector with a single patient record. Shared IT and telephony systems are also integral to the establishment of IFHCs.

Clinical leadership is key to how NDHB works. Clinicians form an integral part of NDHB's management structures (described further in 5.1.3 Clinical leadership), and are active participants in Northern Region groups and processes. Northland's PHOs also have clinicians as prominent members of their organisations.

Northland DHB is involved in several social sector activities, including the Social Sector Trial in Kaikohe, Make it Happen Te Hiku and Youth Suicide Prevention. We are also running one of the two national Children's Team pilots in which our partners are MSD and Ministry of Education.

Northland DHB's priorities are consistent with those of the Northern Region Health Plan (NRHP). The overall strategic direction of the NRHP for 2014/15 will be substantially the same as last year and work will continue across prior NRHP areas of focus. In 2014/15 new regional emphasis will be placed on child health, health gain for Maori and health of older people, and a new workstream, focusing on major trauma, will be developed to reflect national developments and priorities.

Intervention logic

Northland DHB deals with several planning streams which are aligned as described in the diagram on the next page.*National priorities*

National priorities are determined by the Minister of Health and Ministry of Health.

A subset of the national priorities, those that focus mainly on secondary and primary clinical services, drive the Northern Region Health Plan (NRHP). The NRHP sets the strategic framework for Northland's clinical services, especially hospital services.

The Northern Region Health Plan

The Northern Region (the four DHBs in Northland, Auckland, Waitemata and Counties Manukau, plus the Northern Regional Alliance) are in year four of developing and implementing the Northern Region Health Plan. It has an emphasis on longer term planning, care closer to home and the better integration of health care for patients and communities within constrained funding increases. There is a focus on demonstrative collaboration and more detailed planning to deliver against priority regional goals and delivering on regional workforce, IT and capital objectives, and more detailed planning across regional priorities. This includes ongoing changes to our business support systems, in particular the regional focus around information systems, procurement and the supply chain.

Regional planning focuses on where regional health system collaboration will achieve tangible benefits in addressing important health issues for the population. Particular emphasis in 2014/15 will be placed upon accelerating gains in:

- child health
- inequalities amongst Maori, pacific, and other groups
- health of older people

The following priority goals have been agreed by the Northern Region:

- First, Do No Harm – reducing harm and improving patient safety
- Life and Years – reducing disparities and achieving longer, healthier and more productive lives
- The Informed Patient – ensuring patients and their whanau receive care, information and support appropriate to their context, including supporting the population to have greater involvement in their care.

Annual Plan

The Annual Plan covers all the national priorities and is consistent with the NRHP.

Northland Health Services Plan

The Northland Health Services Plan incorporates all the above and more. Built upon a health needs assessment, it takes a global, system-wide view and considers any measures that will lift the health of the population and improve the way the health system works.

Statement of Performance Expectations

The Statement of Performance Expectations (SPE), a subset of the Annual Plan and the central component of the Statement of Intent, draws elements from all the other plans. The SPE is now consistent with the NHSP's outcomes and headline targets. It is substantively consistent with the direction being set by the NHSP's six Programmes, though they are still identifying their benefits and key measures; as these are firmed up they will be integrated fully with the SPE.

Vision and mission

Northland DHB's vision: "A Healthier Northland / *He Hauora Mo Te Tai Tokerau*"

Northland DHB's mission: Achieved by working together in partnership under the Treaty of Waitangi to:

- improve population health and reduce inequities
- improve the patient experience
- live within our means.

Mahi tahi te kaupapa o Te Tiriti o Waitangi he whakarapopoto nga whakaaro o te Whare Tapa Wha me te whakatuturutahi i te tino rangatiratanga te iwi whanui o Te Tai Tokerau.

Northland DHB will work towards the vision and mission through our Northland Health Services Plan, as outlined in the intervention logic above and in the introduction to 1.3.

Alignment of national, regional and local planning frameworks

National Outcome	All New Zealanders live longer, healthier, more independent lives
Regional Outcome	Improve health outcomes and reduce disparities by delivering high quality, high value, and better integrated services. We will do this in a way that meets future demand whilst living within our means.
NDHB Vision	A healthier Northland.
NDHB Mission	Working together in partnership under the Treaty of Waitangi to improve population health and reduce inequities, improve the patient experience, and live within our means.

Northland Health Services Plan Headline Targets

Population Health	*Patient Experience*	*Value and Sustainability*
Life expectancy gap between Maori and non-Maori is reduced by 2 years	Every Northlander with urgent health needs has same-day access to primary care	Value for money savings of $5M are achieved against projected cost increases each year
Unplanned hospital admissions for Northlanders are reduced by 2,000	More than 95% of patients report they would recommend the service provided	Northland hospital labour productivity benchmarks in the top five DHBs

Ministerial priorities

Health Targets	Child health: immunisations, rheumatic fever, reduce assaults	Integrated care: early intervention for long term conditions
Live within our means	Older people: continue living at home if possible; improved home care, stroke, dementia services	Regional, national collaboration

Plans and strategies[3]

National	*Regional*	*Local*
• NZ Health & Disability Strategy • He Korowai Oranga • Health Workforce NZ Strategic Plan • National Strategy for Quality Improvement • National Health IT Plan • Rising to the Challenge • Prime Minister's Youth Mental Health • Better Public Services • Better, Sooner, More Convenient services • Whanau Ora • National Entities (HBL etc)	• Northern Region Health Plan • Northern Region Workforce Plan • Northern Region Information Plan • First Do No Harm	• Northland Health Services Plan • Annual Plan • Maori Health Plan • Statement of Performance Expectations • HOP Model of Care • Oral Health Strategy • Rheumatic Fever Plan • Asset Management Plan

Statement of Performance Expectations

Outcomes				
Healthy population	Prevention of illness and disease	Reversal of acute conditions	Optimum quality of life for those with long term conditions	Independence for those with impairments, disabilities
Impacts				
Smoking cessation	Healthy children	People manage in the community through effective primary care	Symptoms of long term conditions, ameliorated or delayed	Increased likelihood of survival from cancer , reduced severity of symptoms
Mental disorders: impacts minimised for clients and whanau	Elective surgery: fewer debilitating conditions	More timely care in emergency departments	Higher quality and safer services	Older people receive services appropriate to their needs
Outputs (only those that contribute directly to the impacts above)				
Health promotion	Quit smoking support	Immunisation	Oral health services	Midwifery services
Primary care services	Screening services	Acute hospital services	Cancer treatment	Specialised mental health services
Elective surgical services	Emergency department services	Quality services and initiatives	Home based support services for older people	Residential care for older people

3 Statement of performance expectations

The section fulfils Northland DHB's obligation under the Crown Entities Act 2004 to supply measures by which our future performance can be measured by the Office of the Auditor General. Together with modules 1, 4 and 7, it comprises our Statement of Intent.

The Statement of Performance Expectations (SPE) tells our 'performance story' – what we are producing (outputs) and what this is trying to achieve (impacts and outcomes). The SPE highlights a few cornerstone measures that are representative of the wide range of services for which Northland DHB is responsible. There is considerable overlap between the SPE's outputs and measures and those in Annual Plan module 2; the latter is prepared in response to a specific list of national priorities, while the SPE takes a wider, more strategic view. The SPE is aligned with the Northland Health Services Plan (1.3 Strategic Intentions).

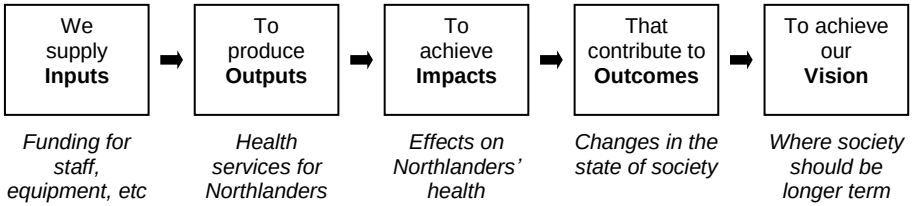
3.1 Output classes and intervention logic

Services are grouped into four output classes:

Prevention	Publicly funded services that protect and promote health across the whole population or particular sub-groups of the population. These services improve the health status of the population, as distinct from curative services (the other three output classes) which repair or support illness or injury.
Early detection and management	Commonly referred to as 'primary' or 'community' services, those that people can access directly in the community. They are delivered by a range of agencies including general practice, Maori health providers, pharmacies, and oral health services for children and adolescents. The services are generalist (non-specialist) in nature, and similar types of services are usually delivered in numerous locations across the community.
Intensive assessment and treatment	Complex, specialist services delivered by a range of health workers, commonly referred to as 'secondary' or 'hospital' services. They include emergency department, inpatient, outpatient, daypatient, and diagnostic services. They are accessible only by referral from a primary health practitioner and available in few locations.
Rehabilitation and support	Services for older people (home based support services, residential care and services for dementia) and palliative care services.

Sections 3.2 to 3.5 address each output class in turn. The key elements are summarised in the diagram on the next page.

The Statement of Service Performance is structured according to the following intervention logic.



The Impacts contribute to the High-level Measures. For example, higher rates of cessation among smokers and of immunisation among children help create a healthy population. Screening for cancers, cardiovascular disease and diabetes prevent illness and disease. Early identification and treatment of cancers, and effective mental health services create good quality of life for people with long term conditions. Home based support services help older people remain independent in the community, and residential care services offer the best quality of life for those no longer able to manage on their own.

Together the Impacts and Outcomes contribute to the High-level Outcomes, which are consistent with the Outcome Goals of the Northland Health Services Plan (NHSP). Wherever possible, Impacts are measured by Maori and non-Maori so that, as well as improving health overall, we can monitor

inequities and reduce these over time (the Population Health outcome). Quality services that are clinically and culturally safe, and provided in a timely manner encourage people to attend and be involved in their care, and that means better health status (the Patient Experience outcome). To cope with ever-rising demands on services and to free up resources for new models of care and other innovations, we must continue to improve productivity and prioritise resources to their most cost-effective uses (the Value and Sustainability outcome).

Summary of Northland DHB's Statement of Performance Expectations 2014/15

Vision	A healthier Northland									
High-level Outcomes	Population health: improved health of Northlanders and reduced health inequities		Patient experience: patients and whanau experience clinically and culturally safe, good quality, effective, efficient and timely care			Value and sustainability: the Northland health system lives within available funding by improving productivity and prioritising resources to their most cost-effective uses				
High-level Measures	Life expectancy gap between Maori and non-Maori ↓ by 2 years	↓ gaps between: (a) Maori and non-Maori (b) Northland and NZ	↓ mortality rate (age-standardised)	↓ infant mortality	Unplanned hospital admissions for Northlanders are reduced by 2,000 annually by 2017	>95% of patients report they would recommend the service provided				
Outcomes	Healthy population	Prevention of illness and disease	Reversal of acute conditions		Optimum quality of life for those with long term conditions				Independence for those with impairments or disability support needs	
Impacts	**Smoking cessation** Lower prevalence of smoking-related conditions	**Healthy children** Children are healthy from birth and have a healthy foundation for adulthood	**Effective primary care** People manage in the community through effective primary care services	**Long term conditions** Amelioration of disease symptoms and/or delay in their onset	**Cancer** If curable, increased likelihood of survival; if incurable, reduced severity of symptoms	**Mental disorders** Improved quality of life for both clients and their families Acute episodes are minimised, clients achieve greater stability in their condition	**Elective surgery** Fewer debilitating conditions and delayed onset of long term conditions	**ED waiting times** More timely assessment, referral and treatment	**Quality and safety** More satisfied patients Fewer adverse clinical events Lower rates of acute readmission to hospital	**Support for older people** Older people requiring support or care receive services appropriate to their needs.
Impact Measures	Year 10 students who have never smoked Adults who are current smokers	Full and exclusive breastfeeding at 3 months 8-month-olds who are fully immunised Average number of decayed, missing or filled teeth in Y8 students	Ambulatory sensitive hospitalisations ages 0-74	Good blood sugar management in diabetics People receiving CVD risk assessment in last 5 years Acute readmissions to hospital within 28 days	Breast cancer screening in eligible populations Cervical cancer screening in eligible populations Patients with a high suspicion of cancer who receive their first cancer treatment within 62 days	% of people with enduring mental illness aged 20-64 who are seen over a year	Increase in elective surgical discharges	ED patients with length of stay less than 6 hours	Falls causing harm in NDHB hospitals Pressure injuries in NDHB hospitals Surgical checklist compliance Hand hygiene compliance Central line infections in last 1000 bed days Medicines reconciled Acute readmissions to hospital	HBSS clients receiving interRai assessments HBSS providers certified ARRC providers with certification for at least 3 years
Output Classes	**Prevention**		**Early detection and management**			**Intensive assessment and treatment**			**Rehabilitation and support**	
Outputs	Health promotion programmes in schools through Smokefree/ Auahi Kore Advice and help offered to smokers in primary care Quit Card Providers Advice and help offered to smokers in hospital	Midwifery services Support by lactation consultants Oral health assessment and treatment Assessment, diagnosis, treatment and immunisations in primary care	Acute hospital services	Assessment, diagnosis and treatment in primary care Assessment, diagnosis and treatment in hospital	Screening for breast and cervical cancers Cancer risk assessments in primary care Provision of cancer therapies	Specialised clinical support by NDHB community mental health services Admission to hospital for those whose condition is unstable	Elective surgical procedures	Assessments, treatments and referrals performed in EDs	Leadership, advice and monitoring by the Chief Medical Advisor and Quality Resource Unit Effective clinical services, especially for long term conditions Patient pathways, hospital discharge processes Integration between secondary and primary services	Home based support services Residential care Work with providers on corrective action plans resulting from audit
Output Measures	Health promotion in schools Advice to students re stopping smoking % of smokers given advice and help to quit in primary care and in hospital	Support provided to mothers to breastfeed Lactation consultant contacts Immunisations by 8 months Oral health treatments for Y8 students Visits by children and youth to primary care	Acute hospital admissions	Risk assessments performed on people with diabetes and/or CVD Lab tests on people with diabetes Admissions and readmissions to hospital	Screening for breast and cervical cancer in eligible populations Radiation treatments Chemotherapy treatments	Contacts by community mental health workers with people who have enduring mental illness	Additional elective procedures	Emergency department attendances	Measures of the quality and safety of services	Assessments by NASC service Certification audits

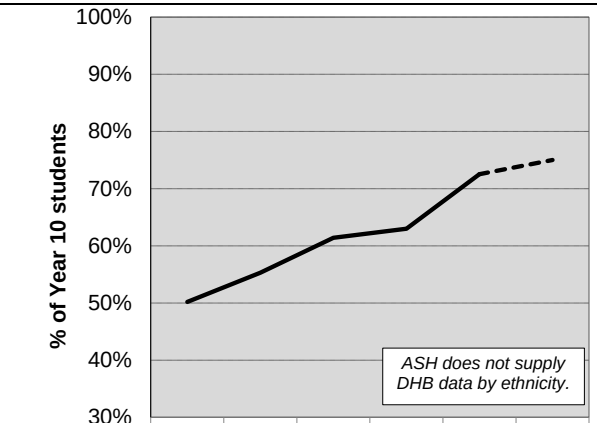
Key: Underlines = main measures. Yellow highlights = Health Targets. All measures to be by Maori and non-Maori where data is available.

3.2 Output class: Prevention

Outcome: Healthy population

Impact: Lower prevalence of smoking-related conditions.

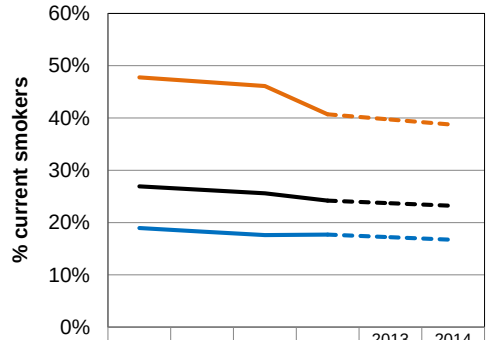
Measure: % of Year 10 students who have never smoked.



	2009	2010	2011	2012	2013	2014 target
Never smoked	50.2%	55.3%	61.4%	63.0%	72.5%	75.0%

Measure type: Coverage

Measure: % of Northland population who are current smokers



	2009	2010	2011	2012	2013 target	2014 target
Total	26.9%	26.3%	25.6%	24.2%	23.7%	23.2%
Maori	47.8%	46.9%	46.1%	40.7%	39.7%	38.7%
Non-Maori	19.0%	18.3%	17.6%	17.7%	17.2%	16.7%

Measure type: Coverage

Rationale

Smoking is one of the most significant lifestyle factors behind long term conditions.

It disproportionately affects Maori and other deprived populations (the 2011 NZ Health Survey showed 52% of Maori smoked and 21% of non-Maori).

Smoking during pregnancy accounts for an estimated 20% of all pre-term births and 35% of low birthweight babies.

Lower smoking rates at young ages should translate into lower smoking rates in the population in the future.

Smoking rates are the focus of one of the six national Health Targets.

New Zealand has committed to a goal of becoming totally smokefree by 2025.

Outputs

95,191 people who have ever smoked recorded in primary care, of whom 23,174 are current smokers, 17,895 were offered brief advice, and 3,576 were offered cessation support (as at 2013/14 Q3).

1,151 individual quit providers registered as at March 2014.

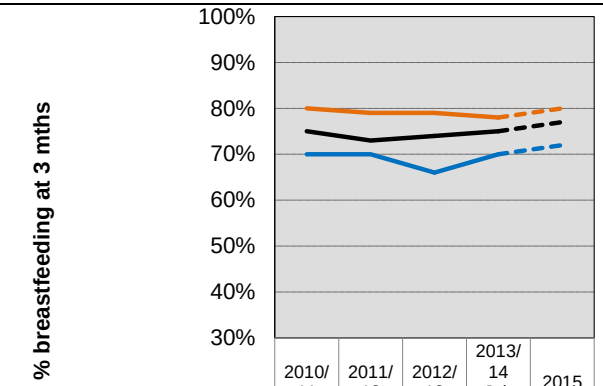
Number of schools health promotion programmes are offered to, 2013 CY: 146 (33 Far North, Mid North 32, Whangarei Area 56, Kaipara 25).

Total students advised about stopping smoking 2013 CY: 800.

Impact: Children are healthy from birth and have a healthy foundation for adulthood

Measure: Full and exclusive breastfeeding at 3 months

Measure type: Coverage



	2010/11	2011/12	2012/13	2013/14 Jul-Dec	2015
Total	75.0%	73.0%	74.0%	75.0%	77.0%
Maori	70.0%	70.0%	66.0%	70.0%	72.0%
Other (not incl. Pacfiic, Asian)	80.0%	79.0%	79.0%	78.0%	80.0%

Rationale

Higher rates of breastfeeding in infancy correlate with a lower chance later in life of developing health problems, including long term conditions.

Breastfeeding rates are lower among Maori.

A higher percentage of the child population is Maori, so improving child health will have a significant effect on improving the health of Maori.

Outputs

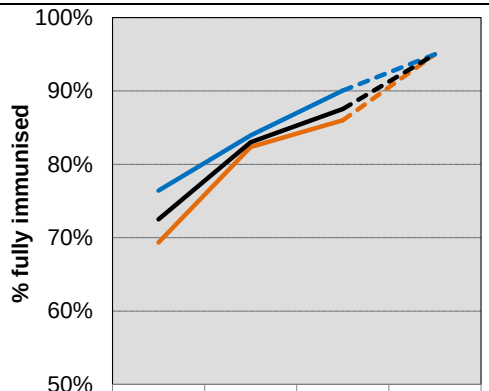
Mothers are provided with education and support to encourage them to breastfeed, whether they are supported by an NDHB midwife (hospital births) or an independent midwife (home and hospital births).

Hospital annual births 1,967 2012/13 CY.

3,638 lactation consultant patient contacts 2012/13.

Measure: % of 8-month-olds who are fully immunised

Measure type: Coverage



	2011/12	2012/13	2013/14	2014/15 target
Maori	69.3%	82.4%	86.0%	95.0%
Non-Maori	76.4%	83.9%	90.0%	95.0%
Total	72.5%	83.0%	87.5%	95.0%

Rationale

Improved immunisation coverage leads directly to reduced rates of vaccine-preventable (communicable) disease, and that means better health and independence for children and longer and healthier lives.

To reach the target immunisation coverage level, new systems need to be put in place to make sure all newborns are enrolled with their primary care provider soon after birth. Early enrolment of all children should encourage higher attendance rates at primary care in the future.

Immunisations (one of the six national Health Targets) are one of the most cost-effective ways of improving health.

Outputs

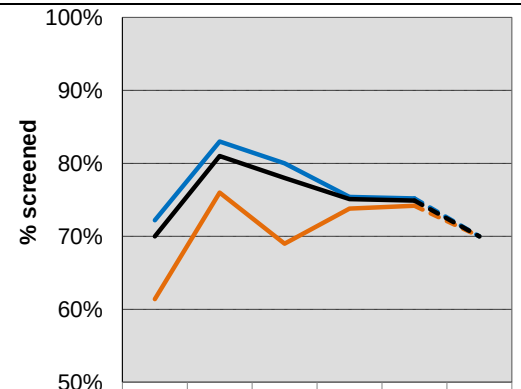
NDHB works with primary care providers to continue to improve the rate and timeliness of immunisation.

2,013 children immunised before 8 months, Apr 2013 - Mar 2014 CY.

Impact: If curable, increased likelihood of survival; if incurable, reduced severity of symptoms

Measure: Breast cancer screening in eligible populations

Measure type: Coverage



	2009	2010	2011	2012	2013	2014 target
Maori	61.4%	76.0%	69.0%	73.8%	74.2%	70.0%
Non-Maori	72.2%	83.0%	80.0%	75.4%	75.2%	70.0%
Total	70.0%	81.0%	78.0%	75.1%	74.9%	70.0%

Rationale

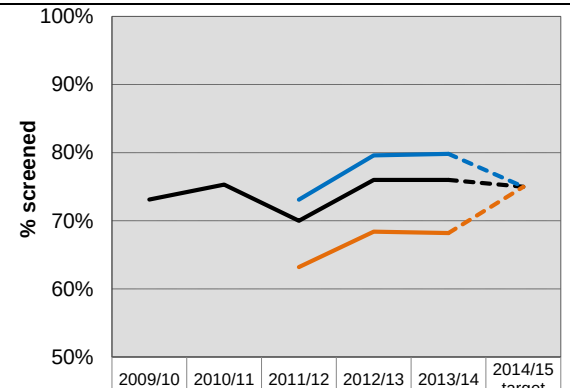
Screening in the community to identify cancers as early as possible improves the chances of prevention or, if the condition already exists, recovery. The only two formal screening programmes that exist in New Zealand are for breast and cervical cancer.

Outputs

10,654 Northland women were screened in CY 2013, including 2,302 Maori and 8,352 non-Maori.

Measure: Cervical cancer screening in eligible populations

Measure type: Coverage



	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15 target
Total 20-69y	73.1%	75.3%	70.0%	76.0%	76.0%	75%
Maori 20-69y			63.2%	68.4%	68.2%	75%
Non-Maori 20-69			73.1%	79.6%	79.8%	75%

Outputs

29,706 eligible women screened Jan 2011-Dec 2013.

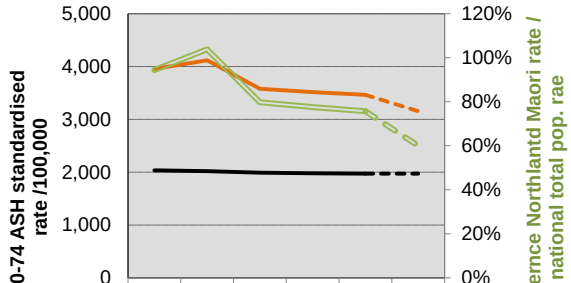
3.3 Output class: Early detection and management

Impact: People manage in the community through effective primary care services

Measure:

Ambulatory sensitive hospitalisation rate, ages 0-74, age standardised

Measure type:
Quality



	2009/10	2010/11	2011/12	2012/13	2013/14 to Dec	2014/15 target
Northland Maori rate /100,000	3,956	4,118	3,579	3,516	3,464	3,154
National total pop. rate /100,000	2,035	2,020	1,990	1,980	1,972	1,972
% difference Northland c/w national	94%	104%	80%	78%	76%	60%

Rationale

Ambulatory Sensitive Hospitalisations (ASH) are potentially avoidable through intervention in primary care (they are distinct from other hospitalisations that are avoidable through injury prevention or population-level strategies such as taxes on tobacco). They are therefore a useful measure of how well people are accessing primary care services and how effectively those services perform.

A substantial proportion of unplanned hospital admissions are ambulatory sensitive. Lower rates of ASH mean people are receiving services in the community and curing their conditions or keeping them under control without the need for a hospital admission. This frees up hospital resources for more acute and urgent cases, thus contributing to NDHB's value and sustainability High-level Outcome. ASH rates affect Maori inequitably, and reducing the disparity will support the population health High Level Outcome.

Managing the interface between primary and hospital services is key to reducing ASH rates. For example NDHB's e-referral initiative has created more prompt and effective communication between hospital specialists and GPs, enabling the latter to be better informed and manage more patients in the community rather than referring them to hospital outpatient services for assessment.

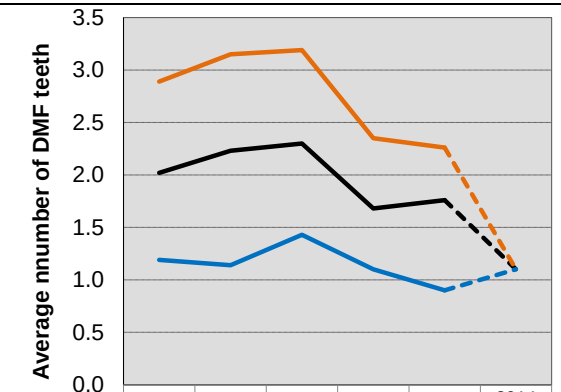
Outputs

Total acute discharges of Northland residents from any hospital (NDHB and other DHBs) 2012/13: Total 29,099, Maori 10,595, non-Maori 18,504.

Impact: Children are healthy from birth and have a healthy foundation for adulthood

Measure:
Average number of decayed, missing or filled teeth in Y8 students

Measure type:



	2009	2010	2011	2012	2013	2014 target
Total	2.02	2.23	2.30	1.68	1.76	1.10
Maori	2.89	3.15	3.19	2.35	2.26	1.10
Non-Maori	1.19	1.14	1.43	1.10	0.90	1.10

Rationale

Oral health directly affects the state of health of the mouth, and the effects of tooth and gum disease can be lifelong. Significant rates of disease can also limit what children can eat, affect self-image and confidence, and create pain and discomfort.

Northland has consistently had among the worst oral health statistics for children for many years.

Northland remains unfluoridated after a brief foray into reticulated fluoridation in two Far North communities was abandoned in 2009. Northland will always struggle to reach the oral health status of DHBs with fluoridated water supplies.

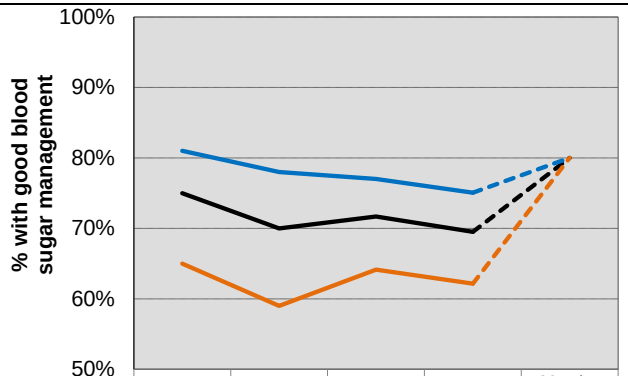
Outputs

Enrolments in NDHB-funded oral health services : 7,675 preschool, 21,389 primary school children (both 2013 CY), 6,790 (2012 CY) adolescents.

Impact: Amelioration of long term condition disease symptoms and/or delay in their onset

Measure: Good blood sugar management

Measure type: Coverage



	2010/11	2011/12	2012/13	2013/14	2014/15 target
Total	75.0%	70.0%	71.7%	69.5%	80.0%
Maori	65.0%	59.0%	64.1%	62.2%	80.0%
Non-Maori	81.0%	78.0%	77.0%	75.1%	80.0%

Rationale

Diabetes is an increasingly common long term condition.

Prevalence of LTCs increases with age, so action now is imperative in the face of the ageing population.

Diabetes is strongly associated with excess weight, which affects a disproportionate number of Northlanders.

It is a major cause of illness and a significant contributor to cardiovascular (heart and circulatory) disease. Screening for cardiovascular disease is one of the six national Health Targets.

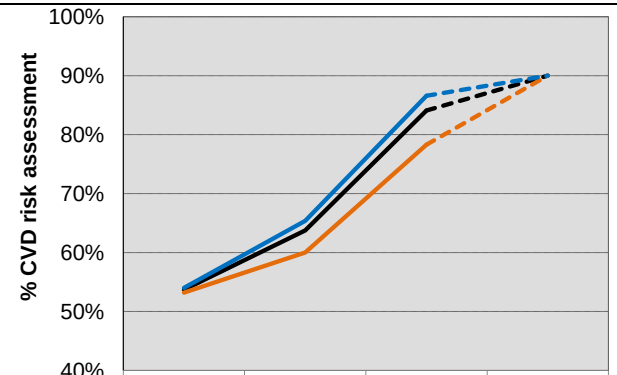
Although incurable, the effect of diabetes on daily life can be minimised through early detection, regular (annual) checks and good clinical management and a healthy lifestyle.

Outputs

5,965 diabetes annual reviews were performed in primary care in 2012/13 CY.

Measure: Eligible people receiving CVD risk assessment in the last 5 years

Measure type: Coverage



	2011/12	2012/13	2013/14	2014/15 target
Total	53.7%	63.7%	84.1%	90.0%
Maori	53.2%	60.0%	78.3%	90.0%
Non-Maori	54.0%	65.4%	86.6%	90.0%

Rationale

Along with cancer, cardiovascular disease is the most common long term condition.

Prevalence of long term conditions increases with age, so action now is imperative in the face of the ageing population.

Regular screening identifies those at risk of developing cardiovascular disease, for whom lifestyle and clinical interventions can prevent or delay its onset. Regular screening also helps earlier identification of those who already have the condition, and this promotes more healthy outcomes for them.

Screening for cardiovascular disease is one of the six national Health Targets.

Outputs

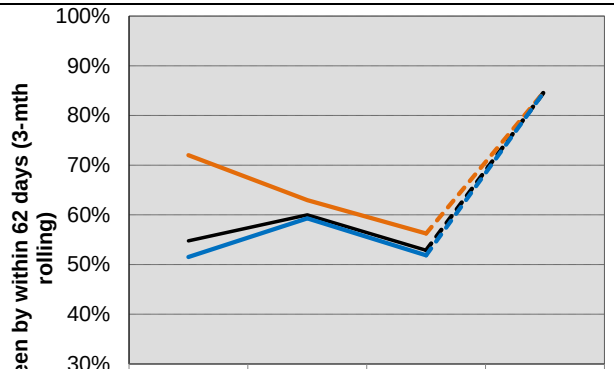
39,008 CVD risk assessments performed in primary care over the five years to June 2013. (The total number screened over five years is a more sensible indicator of coverage than the most recent annual figure, because different numbers of people have been screened during each of the five years.)

3.4 Output class: Intensive assessment and treatment

Impact: If curable, increased likelihood of survival; if incurable, reduced severity of symptoms

Measure: % of patients referred urgently with a high suspicion of cancer who receive their first cancer treatment (or other management) within 62 days

Measure type: Coverage



	2013/14 Q1	Q2	Q3	2014/15 target
Total	54.8%	60.0%	52.9%	85.0%
Maori	72.0%	63.0%	56.3%	85.0%
Other	51.5%	59.3%	51.9%	85.0%

Rationale

Along with cardiovascular disease, cancer is the most common long term condition.

For cancer, some of the biggest gains are to be made by ensuring early access to treatment to improve the chances of recovery or to alleviate symptoms.

Waiting times for both cancer radiation therapy and chemotherapy were until 2013/14 one of the six national Health Targets. In 2014/15 it will be replaced by this measure.

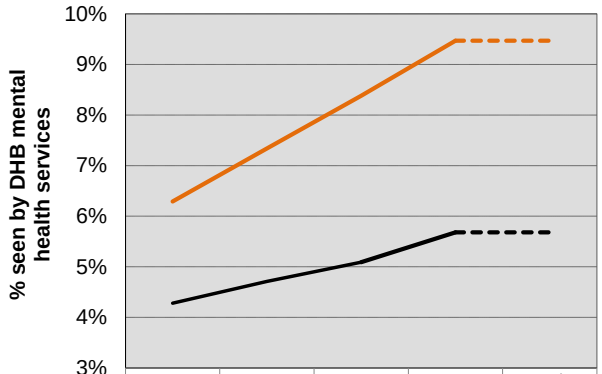
Outputs

199 patients referred urgently with high suspicion of cancer.

Impact: Improved quality of life for both clients and their families; acute episodes are minimised, clients achieve greater stability in their condition

Measure: % of people with enduring mental illness aged 20-64 who are seen over a year

Measure type: Coverage



	2010/11	2011/12	2012/13	2013/14	2014/15 target
Total	4.28%	4.71%	5.09%	5.68%	5.68%
Maori	6.29%	7.34%	8.38%	9.47%	9.47%

Rationale

Mental health has been a priority for the health sector since the Blueprint was published in 1998.

Severe disorders permanently affect 3% of the population.

Mild to moderate disorders affect 20% of the population at any one time and 90% over a lifetime.

Outputs

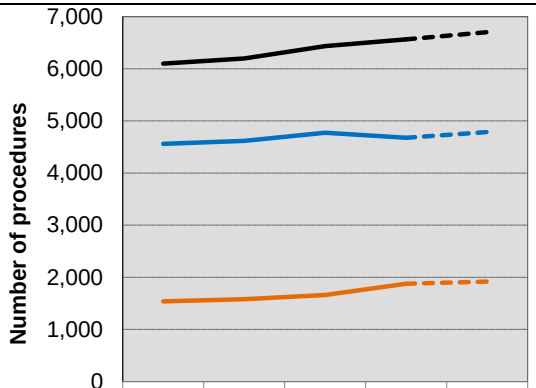
Number of contacts by community mental health services with people who have enduring mental illness (2013/14 extrapolated from 9 months data):

Direct (with client and/or whanau)	73,500
Care coordination (on behalf of client, with another agency)	23,700

Impact: Fewer debilitating conditions and delayed onset of long term conditions

Measure:
increase in elective service discharges

Measure type:
Coverage



	2010/11	2011/12	2012/13	2013/14	2014/15 target
Maori	1,537	1,580	1,660	1,877	1,917
Non-Maori	4,561	4,618	4,774	4,677	4,787
Total	6,098	6,198	6,434	6,564	6,703

Rationale

Elective surgery is an effective way of increasing people's functioning because it remedies or improves disabling conditions.

Increasing delivery will improve access and reducing waiting times and increase public confidence that the health system will meet their needs.

Timely access to elective services is considered by the Ministry of Health to be a measure of the effectiveness of the health system.

One of the six national Health Targets.

Outputs

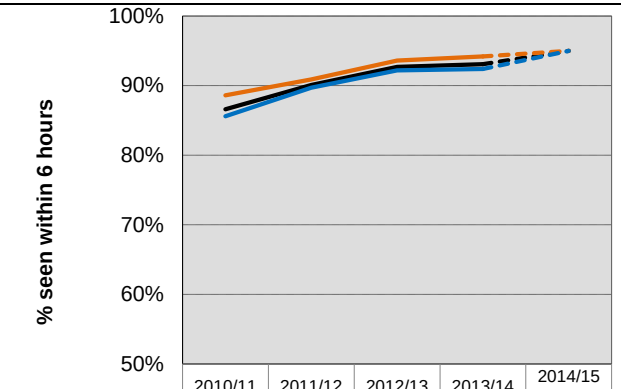
There were 7664 elective surgical discharges in the twelve months ended 31 Mar 2014.

The data used here represents the targets set in each year's Annual Plan. These numbers do not represent total extra elective surgical discharges because every year MoH provides more funding for more procedures, and the amounts cannot be predicted. The most rational way of assessing NDHB's performance is against the targets agreed before the year starts.

Impact: More timely assessment, referral and treatment

Measure:
Patients with an emergency department length of stay of less than 6 hours

Measure type:
Timeliness



	2010/11	2011/12	2012/13	2013/14	2014/15 target
Total patients	86.6%	90.1%	92.7%	93.1%	95.0%
Maori patients	88.6%	90.9%	93.6%	94.2%	95.0%
Non-Maori patients	85.6%	89.7%	92.2%	92.4%	95.0%

Rationale

The purpose of emergency departments (EDs) is to provide urgent care, so by definition timeliness is important. Long times spent in waiting and receiving treatment in EDs are linked to overcrowding of the ED, compromised standards of privacy and dignity for patients, and poorer clinical outcomes (such as increased mortality and longer lengths of stay for people who are transferred into hospital as inpatients). Reducing ED length of stay will improve the public's confidence in being able to access services when they need to, increasing their level of trust in health services, as well as improving the outcomes from those services. It also addresses the Ministerial priority of living within our means by ensuring resources are used effectively and efficiently.

One of the six national Health Targets.

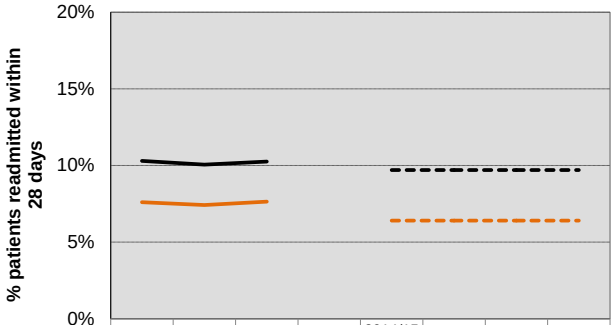
Outputs

Emergency services provided by EDs at Whangarei Hospital, NDHB's most specialised ED, as well as satellite services at the other three hospitals in Kaitaia, Kawakawa and Dargaville.

Emergency department attendances 2012/13 FY: 32,680.

Impact: Lower rates of acute readmission to hospital

Measure: % of acute patients readmitted to NDHB hospitals within 28 days



	2013/14 Q1	Q2	Q3	Q4	2014/15 target Q1	Target Q2	Target Q3	Target Q4
All patients	7.60%	7.42%	7.64%		6.40%	6.40%	6.40%	6.40%
75+	10.30%	10.05%	10.25%		9.70%	9.70%	9.70%	9.70%

Rationale

An unplanned acute hospital readmission often occurs as a result of the quality of care provided to the patient by health services. Reducing unplanned acute admissions therefore generally indicates improvements to the quality of acute care in both hospital and/or primary care settings.

Acute readmissions can be reduced by:

- more effective management of long term conditions
- redesigning patient pathways, particularly to improve primary care access to services to diagnose and treat people in the community (the eReferral system has been particularly effective in this regard in Northland)
- improving hospital discharge processes
- improving the interface between secondary and primary services to ensure continuity of care for patients.

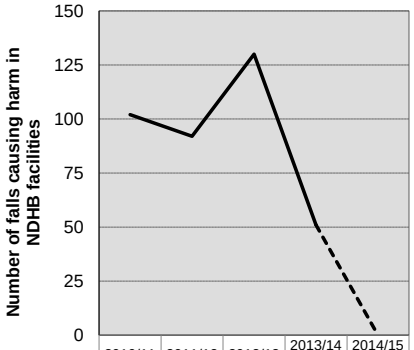
Outputs

Acute admissions CY 2013: 75+ 6,486, all patients 29,743.

Impact: Fewer adverse clinical events.

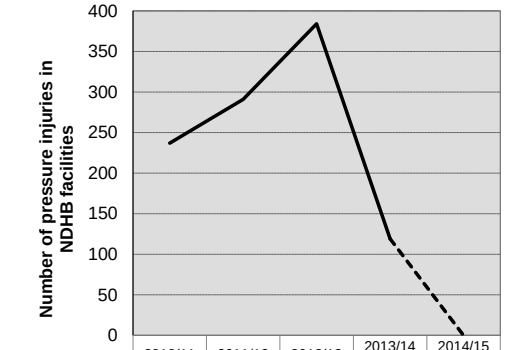
Measures type: Quality

Measure: Harm from falls while in hospital.



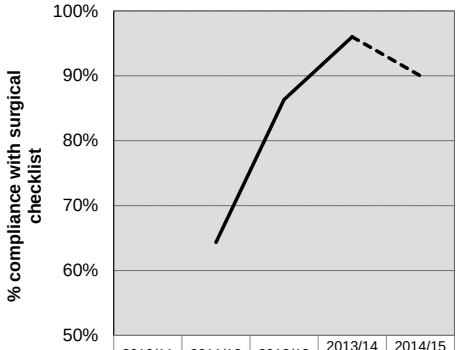
	2010/11	2011/12	2012/13	2013/14 est.	2014/15 target
Harm from falls in hospital	102	92	130	51	0

Measure: Pressure injuries while in hospital.



	2010/11	2011/12	2012/13	2013/14 est.	2014/15 target
Pressure injuries	237	291	384	119	0

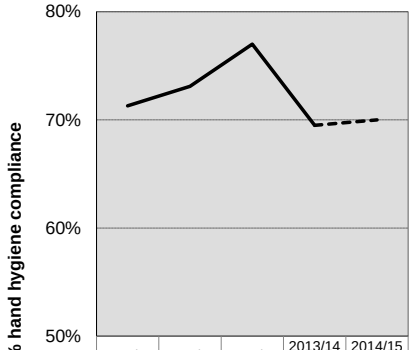
Measure: Compliance with surgical checklist



	2010/11	2011/12	2012/13	2013/14 (to Apr)	2014/15 target
Checklist compliance		64.3%	86.3%	96.0%	90.0%

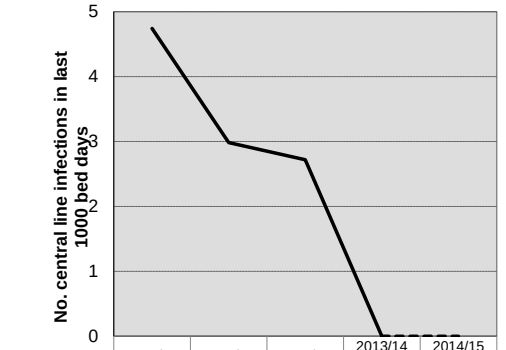
Actuals data for falls and pressure injuries is not presented because recent changes to improve the accuracy with which these are recorded make historical data incompatible with current and projected data.

Measure: Compliance with hand hygiene practices.



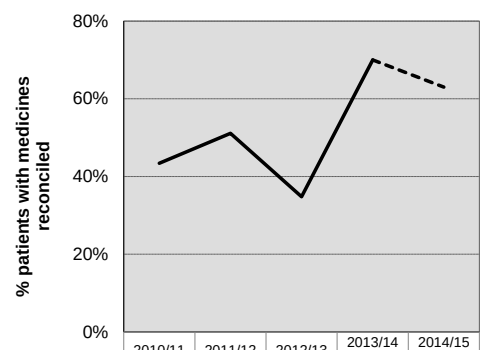
	2010/11	2011/12	2012/13	2013/14 (to Apr)	2014/15 target
Hand hygiene compliance	71.3%	73.1%	77.0%	69.5%	70.0%

Measure: Central line infections.



	2010/11	2011/12	2012/13	2013/14 (to Apr)	2014/15 target
CLI infections	4.7	3.0	2.7	0.0	0.0

Measure: Medicine reconciliation



	2010/11	2011/12	2012/13	2013/14 (to Apr)	2014/15 target
Reconciliations completed	43.4%	51.1%	34.8%	70.0%	63.0%

Rationale

A significant number of adverse and largely preventable events occur in health services. Quality in health care has become increasingly important over the past few years, and the health environment has demanded more from its quality information and reporting.

These measures comprise NDHB's Quality Accounts, a requirement from the national Health Quality and Safety Commission. Quality Accounts will require annual reports from health and disability service providers regarding the quality of service provided according to specific measures. The initial focus is on NDHB"s hospital services.

Outputs

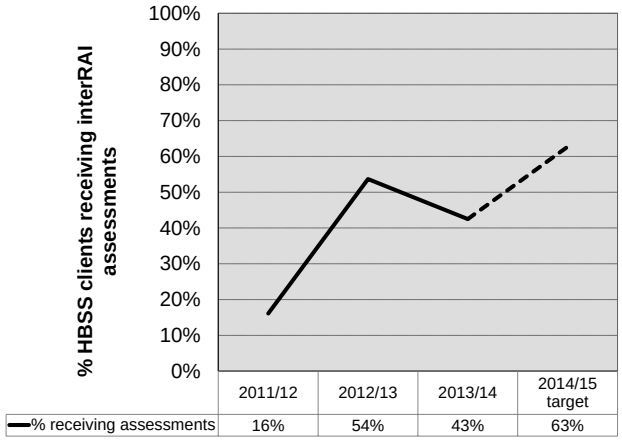
Advice and monitoring provided by the Quality and Improvement Directorate, which is overseen by the Chief Medical Advisor.

3.5 Output class: Rehabilitation and support

Impact: Older people requiring support or care receive services appropriate to their needs.

Measure: % HBSS clients assessed using interRai too**l**

Measure type: Coverage



Rationale

Older people who remain in the community with the assistance of home and community support services are more able to 'age in place' (that is, their lifestyle and supports are more appropriate to their needs). The more older people living safely and independently in the community, the less pressure there is on hospital and aged residential care resources. Good quality clinical assessment for older people who live at home contributes to achieving these aims.

interRAI is collaborative network of researchers in over 30 countries who promote evidence-based clinical practice and policy to improve health care for persons who are elderly, frail, or disabled.

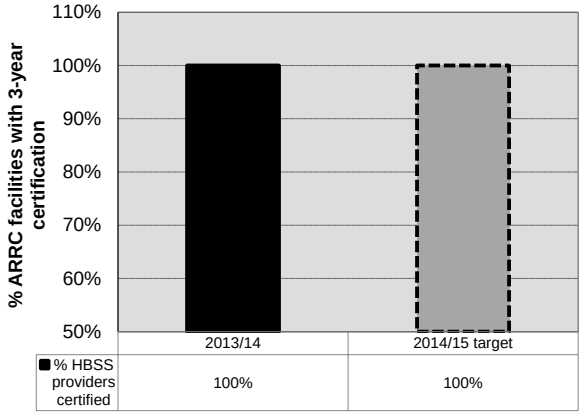
Outputs

1,007 clients who receive long term home based support services have ever been assessed using the interRAI assessment tool up to Dec 2013).

In 2013/14 NDHB informed MoH that we revised the methodology previously used to calculate the percentage of long-term HBSS clients receiving an interRAI assessment. This change has resulted in a decrease in performance. Since April 2014, NRA will be calculating these results for the four northern DHBs, so it can be expected that consistent and comparable calculations will occur. We will also be measuring the percentage of clients who have been assessed in the last twelve months.

Measure: % of HBSS providers certified

Measure type: Quality



Rationale

Certification against the Home and Community Support Sector Standard (NZS 8158:2012) is aimed at ensuring people receive good quality support in their homes. The standard sets out what people receiving home based support services can expect and the minimum requirements to be attained by organisations.

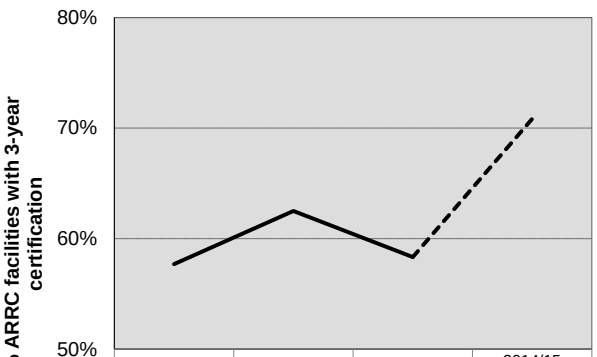
All NDHB home based support services are certified, and Northland DHB ensures providers maintain their certification status.

Outputs

9 providers of home based support services, providing support to 2,369 people in the community up to Dec 2013.

Measure: % of ARRC providers with at least 3-year certification

Measure type: Quality



Rationale

Certification reduces potential risks to residents by ensuring providers comply with the Health and Disability Services Standards.

The period of certification for aged residential care providers reflects their risk level – the fewer the number and the lower the level of risks identified during audits, the longer the period of certification.

Outputs

DHB aged care contract and MoH certification audit processes have been conducted through a single audit since August 2010. DHBs concentrate on working with providers on corrective action plans to address any matters identified though the audits, monitoring progress against the agreed corrective action plans, and managing risks that may arise. The measure does not include certification for any new providers because that automatically reverts to a single year and is therefore not necessarily related to quality of service.

The figure for 2013/14 comprises 13 facilities with 3-year certification and 1 with 4-year, out of a total of 24 facilities (14/24 = 58%). The 2014/15 target assumes 3 more facilities will achieve 3-year certification, resulting in a figure of 17 out of 24 (71%).

Statement of Financial Performance - By Output Class

	Intensive Assessment & Treatment	Early Detection & Management	Prevention	Rehabilitation & Support Services	
DHB Provider Revenue	225,728,412	23,813,563	7,909,897	8,771,403	266,223,276
Other Provider Revenue	19,283,678	2,545,064	4,533,444	408,399	26,770,585
Less Revenue Offsets - Note 1	-10,831,660				-10,831,660
DHB Funder Revenue	76,433,189	105,585,799	9,678,616	59,056,976	250,754,580
DHB Governance & Administration	1,904,638	867,236	104,509	469,176	3,345,559
Total SOI Revenue	312,518,257	132,811,662	22,226,467	68,705,955	536,262,340
Personnel Costs					
Medical Labour	49,503,910	2,314,069.87	701,186.73	279.24	52,519,446
Nursing Labour	59,662,340	6,595,108.32	487,063.49	3,987,476.96	70,731,989
Allied Health Labour	19,471,339	8,250,430.30	2,384,375.28	2,391,628.98	32,497,774
Non Clinical Support Labour	791,701	83,183.95	-	160,000.00	1,034,885
Management and Admin Labour	6,698,810	1,966,471.17	850,096.73	357,004.25	9,872,383
					0
Non-Personnel Operating Costs					0
Outsourced Clinical Services	4,681,427.62	598,750.15	119,250.00	136,823.27	5,536,251
Oth Clinical Supp	27,549,931.10	1,545,232.90	570,759.97	1,629,990.29	31,295,914
Implants	4,060,408.80	-	-	-	4,060,409
Pharmaceuticals	3,650,001.82	126,505.68	140.00	283,066.37	4,059,714
Infrastructure and Non Clinical	21,603,823.40	2,520,663.12	611,036.02	1,237,468.09	25,972,991
Allocated Pharmaceuticals	1,006,615.73	30,333.83	404.80	80,546.93	1,117,901
Corporate Departments	18,428,485.36	2,313,642.82	288,762.36	1,081,072.37	22,111,963
Cost of Capital	8,054,407.18	1,264,137.56	319,792.85	468,680.96	10,107,019
CTA Recoveries	- 3,009,329.16	- 112,508.02	- 91,060.71	- 49,332.57	-3,262,230
Patient Support	4,393,756.06	20,858.71	7,917.64	6,253.73	4,428,786
Service Based Departments	10,939,474.47	1,424,801.43	311,809.90	641,908.24	13,317,994
Sterile Supplies	228,875.52	1,121.17	501.04	30,753.43	261,251
					0
Provider Payments - to providers					0
Personal Health	58,050,060	103,871,255	3,757,068	8,584,463	174,262,846
Mental Health	12,660,454	1,293,383			13,953,837
Disability Support Services	106,145			56,238,961	56,345,106
Public Health			256,426		256,426
Maori Health		594,623	4,990,505	194,559	5,779,687
Total SOI Operating Expenditure	308,532,637	134,702,064	15,566,035	77,461,604	536,262,340
Surplus (Deficit)	3,985,620	-1,890,402	6,660,431	-8,755,649	0

Note One. Revenue Offsets for Costing Standards

4 Financial performance

4.1 Introduction

Northland DHB has consistently maintained a balanced budget. This has met the requirements of the Minister and has allowed the DHB some flexibility in allocating resources to new needs and services. In the climate of financial constraints and capped funding in real terms, maintaining a balanced budget remains an important goal of Northland DHB.

This goal is becoming increasingly challenging, especially with this year's funding envelope increase of 1.91%, the lowest growth in recent times, and MoH signals that this will continue into the out years. The year on year growth in demand – especially in acute clinical services, mental health and health of older people, means that we will need to focus on productivity improvements and cost efficiencies across all our services if we are to meet the goal of a balanced budget without service reductions.

Northland DHB continues to seek productivity improvements and cost efficiencies in the way we operate. At a local level, cost saving and productivity improvement targets are imbedded in each division. Regionally, we work with Waitemata DHB, Auckland DHB and Counties Manukau DHB through the Health Alliance (hA) and Northern Region Alliance (NRA) to maximise cost savings through regional shared services in finance, supply chain, procurement and information technology, while working to ensure regional consistency on funding decisions e.g. NGO, Community Laboratory, etc.

At an national level, Northland DHB has committed resources to the HBL shared services model. This includes Finance, Procurement and Supply Chain (FPSC), Food Services, Linen and Laundry, National Infrastructure Platform, Human Resources Management Information Systems and Banking and Insurance programmes. The hospital pharmaceuticals schedule is in place and operational.

Northland DHB will be working with PHARMAC to determine the impact this will have on budgets once PHARMAC has completed analysis on the data. This will involve the following activity:

Hospital medical devices interim procurement	Support PHARMAC in commencing this role. Any net budget-impact savings to DHBs from interim procurement activity not yet included.
Hospital medical devices category management establishment	Expected to have no impact on 2014/15 planning.
Hospital medical devices interim budget management	Expected to have no impact on 2014/15 planning, unless NHITB is able to increase its level of investment in hospital systems to meet PHARMAC's data requirements.
Hospital pharmaceuticals management	Support PHARMAC in progressing this role. Cost curve on hospital medicines costs should be starting to bend as new technologies are not able to be adopted without PHARMAC identified savings. Note: no data available on growth within existing medicines usage, so local cost forecasting will need to continue.
Hospital pharmaceuticals budget management	Expected to have no impact on 2014/15 planning.

The Northland Health Services Plan is currently being implemented, and $3.0 million has been set aside in the Strategic Investment Fund to fund initiatives to reduce acute demand on hospital services and deliver more care in the community setting.

4.2 The four year forecast

Northland DHB will achieve break even performance for each of the three years detailed in the financial template. Budgeting for revenue has been a “top down” approach and matches the 2014/15 funding envelope and other revenue estimates. Expenditure has been budgeted from the “bottom up” by each division as a business as usual approach. Known strategic initiatives, such as reducing elective wait times from 5 months to 4 months, have been budgeted as specific projects.

For the 2014/15 Financial Year, Health of Older People volume growth is projected at 6% ($2.8 million) and we have budgeted to recognise inflationary pressure with a price increase of 0.61% for all our community providers.

Within DHB-owned services, productivity improvement and / or cost savings targets of $4.0 million have been set to counter balance the increased depreciation, salary cost creep, reduced interest income due to our investment in strategic building development and information technology in recent years. Cost savings targets of $1.2 million have been set for the HBL-led National Procurement and Price Harmonisation programmes. Supply chain savings target of $0.5 million per annum have been set for the 2014/15 and 2015/16 financial years.

Northland DHB has committed resources to the National HBL work programmes and is awaiting the detailed business cases of the HBL programmes National Infrastructure Programme, Facilities Management and Support Services.

We also support the Pharmac initiative to progress national procurement of medical devices with the expected total sector cost savings of $4.33 million in 2014/15 and $14.76m in 2015/16.

4.3 Productivity initiatives

Our major productivity initiatives are detailed in 2.10 Living within our means.

Full time equivalent (FTE) staff management

Careful management on FTE numbers continues to be a focus. There have been increases in FTE as a result of in-sourcing renal patient transport services, and new funded services in Mental Health. Management and administrative FTEs have been held, despite increases in activity and new services. FTE levels remain under the FTE cap.

4.4 Capital plan

Strategic projects approved in the 13/14 financial year are scheduled for completion in 14/15 include site wide infrastructure and ancillary works at Whangarei Hospital to enable the building of the new maternity unit, the Jim Carney Cancer Treatment Centre, gymnasium, car parking. Implementation of our new patient management system is underway and is scheduled for completion in early 15/16. These strategic initiatives have been funded from existing cash resources and crown debt.

Baseline capital asset replacement for the 14/15 year has been budgeted at $4.5 million. A new MRI is currently budgeted for 15/16 but there is cash headroom to move this project forward to 14/15 if the business case demonstrates productivity improvements and / or cost reduction benefits.

Strategic projects currently under scope include Integrated Family Health Centres, Whangarei Kitchen relocation, refurbishing Whangarei Hospital wards. It is likely that these will require crown equity and crown debt financing.

4.5 Assets

Assets were re-valued on 30th June 2012 are due to be re-valued at 30th June 2015. No forecast of this revaluation has been made in these financial templates.

4.6 Disposal of land

If Northland DHB decides to dispose of any land transferred to or vested in the DHB, we will do so under the Health Sector Transfers Act 1993. Northland DHB has no plans at this time to dispose of any land.

4.7 Financial statements

Statement of Comprehensive Income

$000s

	2012-13 Audited Actuals	2013-14 Forecast	2014-15 Budget	2015-16 Budget	2016-17 Budget	2017-18 Budget
DHB Provider Revenue	282,957	285,942	293,150	295,955	301,252	306,645
DHB Funder Revenue	229,624	236,798	242,674	247,018	251,440	255,940
DHB Governance & Administration	3,469	3,454	3,346	3,405	3,466	3,528
Inter District Flow Revenue	7,534	7,366	7,924	8,066	8,210	8,357
Total Revenue	523,584	533,560	547,094	554,444	564,368	574,471
DHB Provider Operating Expenditure	261,736	266,400	271,710	274,484	279,585	284,746
DHB Non Provider Funded Services	169,424	172,865	176,497	179,656	182,872	186,145
DHB Governance & Administration	3,723	3,572	3,346	3,405	3,466	3,528
Inter District Flow Expense	67,074	69,307	74,101	75,428	76,778	78,152
Total Operating Expenditure	501,957	512,145	525,654	532,973	542,701	552,572
Earnings before Interest, Depreciation, Abnormals & Capital Charge	21,627	21,415	21,440	21,471	21,667	21,898
Less						
Interest on Term Debt	1,266	1,071	1,016	1,034	1,052	1,071
Depreciation	11,110	11,234	11,460	11,665	11,843	12,055
Revaluation						
Earnings before Abnormals & Capital Charge	9,250	9,110	8,964	8,772	8,772	8,772
Profit/(Loss) on Sale of Assets	-	-	-	-	-	-
Net Operating Surplus (Deficit)	9,250	9,110	8,964	8,772	8,772	8,772
Capital Charge	8,855	8,974	8,964	8,772	8,772	8,772
Surplus (Deficit)	**(395)**	**136**	**0**	**0**	0	0
Revaluation of Fixed Assets	394	-	-	-	-	-
(Gains)/Losses in Asset for Sale Financial Assets Reserve	394	-	-	-	-	-
Comprehensive Income	**393**	**136**	**0**	**0**	**0**	**0**

Statement of Movements in Equity

$000s

	2012-13 Audited Actuals	2013-14 Forecast	2014-15 Budget	2015-16 Budget	2016-17 Budget	2017-18 Budget
Equity at the beginning of the period	112,771	112,150	112,266	112,266	112,266	112,266
Surplus/Deficit for the period	395	(136)	(0)	(0)	(0)	(0)
Total Recognised Revenues and Expenses	113,166	112,013	112,266	112,266	112,266	112,266
Other Movements						
Revaluation of Fixed Assets	(394)	-	-	-	-	-
Other	(622)	(20)	-	-	-	1
Equity introduced (Repaid)	-	-	-	-	-	-
Equity at end of Period	**112,150**	**111,994**	**112,266**	**112,266**	**112,266**	**112,266**

Statement of Financial Position

$000s

	2012-13 Audited Actuals	2013-14 Forecast	2014-15 Budget	2015-16 Budget	2016-17 Budget	2017-18 Budget
Equity						
Crown Equity	40,364	40,335	40,335	40,335	40,335	40,335
Retained Earnings	3,346	3,491	3,492	3,491	3,491	3,491
Subsidiaries & unrestricted trusts	253	253	253	253	253	253
Revaluation Reserve	68,187	68,187	68,187	68,187	68,187	68,187
Capital Injections	-	-	-	-	-	1
Total Equity	112,150	112,266	112,267	112,266	112,266	112,267
Represented by:						
Assets						
Current Assets	64,603	69,954	50,005	41,454	46,297	36,352
Non-Current Assets	159,018	153,539	173,429	181,980	177,137	187,082
Total Assets	223,621	223,493	223,434	223,434	223,434	223,434
Liabilities						
Current Liabilities	71,753	71,567	71,508	71,508	71,508	71,507
Non-Current Liabilities	39,718	39,660	39,660	39,660	39,660	39,660
Total Liabilities	111,471	111,227	111,168	111,168	111,168	111,167
Net Assets	**112,150**	**112,266**	**112,267**	**112,266**	**112,266**	**112,267**

Statement of Cash Flows

$000s

	2012-13 Audited Actuals	2013-14 Forecast	2014-15 Budget	2015-16 Budget	2016-17 Budget	2017-18 Budget
Cash Flows from Operating Activities						
Operating Income	526,063	530,577	544,338	551,638	561,513	571,564
Operating Expenditure	519,695	521,318	534,115	541,742	551,470	561,341
Net Cash from Operating Activities	6,368	9,259	10,223	9,897	10,043	10,223
Cash Flows from Investing Activities						
Interest receipts 3rd Party	3,495	3,015	2,753	2,802	2,852	2,903
Sale of Fixed Assets	28	-	-	-	-	-
Purchase of Fixed Assets	(5,740)	(12,497)	(34,505)	(20,216)	(7,000)	(22,000)
Decrease in Investments and Restricted & Trust Funds Assets	11,194	8,368	8,395	-	-	-
Net Cash from Investing Activities	8,977	(1,114)	(23,357)	(17,414)	(4,148)	(19,097)
Cash Flows from Financing Activities						
Equity injections (repayments)	-	-	-	-	-	-
Borrowings	(76)	(18)	(58)	-	-	-
Interest Paid	(1,586)	(1,071)	(1,016)	(1,034)	(1,052)	(1,071)
Repaid debts	-	-	-	-	-	-
Other Non-Current Liability Movement	-	-	-	-	-	-
Net Cash from Financing Activities	(1,662)	(1,089)	(1,074)	(1,034)	(1,052)	(1,071)
Net Increase/(Decrease) in Cash held	13,683	7,055	(14,208)	(8,551)	4,843	(9,945)
Add opening cash balance	24,667	38,350	45,405	31,197	22,646	27,489
Closing Cash Balance	38,350	45,405	31,197	22,646	27,489	17,544

Note: *Cash balance includes short term investments which are considered cash or cash equivalents*

Key Financial Analysis and Banking Covenants

	2012-13 Audited Actuals	2013-14 Forecast	2014-15 Budget	2015-16 Budget	2016-17 Budget
Financial Analysis					
Term Liabilities and Current Liabilities	111,471	111,227	111,168	111,168	111,168
Debt	24,708	24,650	24,650	24,650	24,650
Owners Funds	112,150	112,266	112,267	112,266	112,266
Total Assets	223,621	223,493	223,434	223,434	223,434
Owners Funds to Total Assets	50.2%	50.2%	50.2%	50.2%	50.2%
Interest Expense	1,266	1,071	1,016	1,034	1,052
Depreciation Expense	11,110	11,234	11,460	11,665	11,843
Surplus/(Deficit)	395	136	0	0	0
Interest Cover	10.09	11.61	12.28	12.28	12.25
Debt/Debt + Equity Ratio	18%	18%	18%	18%	18%
Banking Covenants					
Debt/Debt + Equity Ratio	18.1%	18.0%	18.0%	18.0%	18.0%
Interest Cover	10.1	11.6	12.3	12.3	12.3
Interest Cover Minimum	3.0	4.0	3.0	3.0	3.0

Consolidated Statement of Financial Performance ($000s)	2012-13 Audited Actuals	2013-14 Forecast	2014-15 Budget	2015-16 Budget	2016-17 Budget	2017-18 Budget
MOH Devolved Funding	487,742	500,691	512,639	521,815	531,156	540,663
MOH Non-Devolved Contracts (provider arm side contracts)	15,255	12,466	11,337	11,540	11,746	11,957
Other Government (not MoH or other DHBs)	4,554	5,205	4,781	4,866	4,953	5,042
Patient / Consumer sourced	502	399	443	451	459	467
Total Other Income	6,842	6,292	8,881	6,597	6,715	6,835
InterProvider Revenue (Other DHBs)	1,156	1,141	1,090	1,110	1,129	1,150
IDFs - All Other (excluding Mental Health)	7,534	7,366	7,924	8,066	8,210	8,357
Total Consolidated Revenue	523,584	533,560	547,094	554,444	564,368	574,471
Personnel Costs	178,706	184,341	192,120	195,559	199,060	202,623
Outsourced Services	24,087	21,863	18,858	19,196	19,539	19,889
Clinical Supplies	42,453	40,758	40,224	40,944	41,677	42,423
Infrastructure & Non-Clinical Supplies	20,213	23,010	23,854	22,190	22,775	23,341
Finance Costs	10,122	10,045	9,980	9,806	9,824	9,843
Depreciation	11,110	11,234	11,460	11,665	11,843	12,055
Personal Health	162,654	168,271	172,486	175,573	178,716	181,915
Mental Health	14,461	13,445	13,954	14,204	14,458	14,717
Disability Support Services	53,232	54,238	57,644	58,676	59,726	60,795
Public Health	311	475	735	748	761	775
Maori Health	5,841	5,744	5,780	5,883	5,988	6,095
Total Operating Expenditure	523,189	533,424	547,094	554,444	564,368	574,470
Surplus (Deficit)	**395**	**136**	**(0)**	**0**	**0**	**0**

Provider Statement of Financial Performance ($000s)	2012-13 Audited Actuals	2013-14 Forecast	2014-15 Budget	2015-16 Budget	2016-17 Budget	2017-18 Budget
MOH Non-Devolved Contracts (provider arm side contracts)	15,255	12,466	11,337	11,540	11,746	11,957
Other Government (not MoH or other DHBs)	4,554	5,205	4,781	4,866	4,953	5,042
Non-Government & Crown Agency Sourced	7,344	6,691	9,323	7,047	7,173	7,302
InterProvider Revenue (Other DHBs)	1,156	1,141	1,090	1,110	1,129	1,150
Internal Revenue (DHB Fund to DHB Provider)	254,649	260,439	266,619	271,392	276,250	281,195
Total Provider Revenue	282,957	285,942	293,150	295,955	301,252	306,645
Personnel Costs	177,681	183,224	191,232	194,655	198,139	201,686
Outsourced Services	23,390	21,259	18,184	18,510	18,841	19,178
Clinical Supplies	42,453	40,758	40,224	40,944	41,677	42,423
Infrastructure & Non-Clinical Supplies	18,211	21,159	22,071	20,375	20,928	21,460
Finance Costs	10,122	10,045	9,980	9,806	9,824	9,843
Depreciation	11,104	11,234	11,460	11,665	11,843	12,055
Total Operating Expenditure	282,962	287,679	293,150	295,955	301,252	306,645
Surplus (Deficit)	**(5)**	**(1,737)**	**(0)**	**(0)**	**(0)**	**(0)**

Governance Statement of Financial Performance ($000s)	2012-13 Audited Actuals	2013-14 Forecast	2014-15 Budget	2015-16 Budget	2016-17 Budget	2017-18 Budget
Government & Crown Agency Sourced	3,469	3,454	3,346	3,405	3,466	3,528
Total Governance Revenue	3,469	3,454	3,346	3,405	3,466	3,528
Personnel Costs	1,024	1,117	888	904	921	937
Outsourced Services	697	604	674	686	699	711
Infrastructure & Non-Clinical Supplies	2,002	1,851	1,783	1,815	1,847	1,880
Depreciation	6	-	-	-	-	-
Total Operating Expenditure	3,729	3,572	3,346	3,405	3,466	3,528
Surplus (Deficit)	**(259)**	**(118)**	**0**	**0**	**0**	**0**

Funder Statement of Financial Performance ($000s)	2012-13 Audited Actuals	2013-14 Forecast	2014-15 Budget	2015-16 Budget	2016-17 Budget	2017-18 Budget
MOH Devolved Funding	487,742	500,691	512,639	521,815	531,156	540,663
Inter District Flows	7,534	7,366	7,924	8,066	8,210	8,357
Total Funder Arm Revenue	495,276	508,057	520,563	529,881	539,366	549,020
Personal Health	370,045	381,840	391,995	399,011	406,154	413,424
Mental Health	52,728	51,795	53,229	54,182	55,152	56,139
Disability Support Services	60,158	60,682	62,968	64,095	65,242	66,410
Public Health	1,380	1,569	2,243	2,283	2,324	2,365
Maori Health	6,837	6,726	6,783	6,905	7,028	7,153
Other	3,469	3,454	3,346	3,405	3,466	3,529
Total Operating Expenditure	494,616	506,066	520,563	529,881	539,366	549,020
Surplus (Deficit)	**660**	**1,991**	**0**	**0**	**0**	**0**

5 Stewardship

5.1 Managing the organisation

Six General Managers report to the Chief Executive. Four GMs oversee NDHB's service provision areas, as well as maintaining a strategic overview of the health sector:

- surgery and medicine
- mental health (who also covers Maori health)
- child health, youth health, maternity and oral health
- health of older people and clinical support services (labs, imaging, physiotherapy etc).

The other two GMs are responsible for managing:

- the business and finances of Northland DHB
- planning, outcomes, integration and NDHB's district hospitals.

Two senior clinical advisory positions, the Chief Medical Officer and Director of Nursing and Midwifery, also report to the Chief Executive. They cover professional matters concerning nursing and medical staff, and oversee quality and safety matters.

Northland's two PHO Chief Executives are part of NDHB's Executive Leadership Team.

5.1.1 Financial management systems

The National Health Board monitors performance of DHBs. NDHB provides financial reports monthly and non-financial reports (Health Targets and other measures) every quarter.

Once a year, Audit NZ audits our financial statements and our Annual Report; the latter includes our Statement of Service Performance from the Statement of Intent.

Northland DHB monitors service-by-service progress on finance and performance at monthly Internal Planning, Performance Monitoring and Reporting (IPPMR) meetings, which are attended by senior managers and their business analysts.

Our financial management systems allow us to set targets and monitor performance on finance, workforce and service delivery through the monthly IPPMR meetings. The results are fed to the Executive Leadership Team and consolidated each month for the board of governance and its associated subcommittees.

NDHB participates in regional and national processes aimed at achieving value-for-money. Auckland-based healthAlliance provides regional oversight of information systems and technology, and has enabled NDHB to implement the Oracle financial system which offers a virtually paperless requisition-to-payment system. Health Benefits Ltd was established nationally to save money by reducing administrative, support and procurement costs.

At least two-thirds of NDHB's operating expenditure is on workforce, and we continually review staffing patterns and practices to reduce costs.

5.1.2 Information Services

Information systems are fundamental to the Northern Region's ability to deliver a whole of system approach to health service delivery. A key clinical driver is to improve the continuity of care for patients across primary, secondary and tertiary care. This relies on consistent and reliable access to core clinical information for all clinicians involved in patient care.

The Northern Regional Information Strategy (RIS 2010-20), and the Northern Region Information Systems Implementation Plan set the direction on information management, systems and services in the Northern Region. They align with national and regional information strategies and are a key enabler for us to achieve our clinical and business objectives.

Fundamental to the achievement of these objectives is the performance of our shared services support agency, healthAlliance NZ Ltd. The Northern Region CIO Group comprising representatives from each DHB and healthAlliance has been established to:

- define the business requirements of the Northern Region DHBs in IS shared services
- monitor the performance of IS shared services in line with regional priorities and requirements
- prioritise the regional ICT programme of work, ensuring that resilience and security risks are appropriately addressed
- provide strategic IS direction for the region
- prioritise national, regional and local capital IS projects
- monitor the performance of key projects
- reduce duplication through greater regional collaboration.

Historic underinvestment in IT infrastructure has resulted in an inherent service continuity risk for IS services and a bow wave of infrastructure upgrade and system resilience requirements in the Northern Region. The Northern Region DHBs began to address this in 2013/14 and this will continue in 2014/15, with investment in the following areas:

- upgrade of servers and Microsoft SQL Databases to latest Microsoft versions
- clinical and business systems upgrades to ensure systems remain on supportable versions and can realise the potential available with later versions
- clarification of DHB service requirements and realignment of IS services to better support the Northern Region within available funding
- improved resilience and security of IS systems to improve system availability, access and data integrity
- all DHBs will contribute to the development of a regional mobility strategy to guide our investment decisions, and we will install WiFi infrastructure to provide coverage across clinical and patient areas.

Prioritisation of the above areas is a fundamental prerequisite for maintenance of current IS services and investment in our future systems. The regional plan also supports a five-yearly computer replacement cycle to ensure these are regularly updated and fit for purpose.

In addition to the investment in core infrastructure and IS support processes, Northland DHB, as part of the Northern Region, will undertake the following activities with respect to key national and regional projects:

- NDHB is currently working with Auckland on a regional collaboration for ePharmacy, the software that is the foundation for eMR. ePharmacy is expected to go live after Auckland in Sep 2015. In the meantime NDHB has implemented a subset of electronic medicines reconciliation via Concerto.
- implementation of the CSC WebPAS solution to replace the legacy Patient Administration System, a tactical, medium-term investment to address the risk associated with an aged and unsupported system
- the new national standard for eDischarge will be implemented across DHB hospital services
- amalgamation with the Auckland metro eReferral system
- the Northland district will undertake a number of pilot and trial initiatives to continue developing their clinically-led integration strategy and capability; this includes shared care, dynamic clinical pathways, patient portal and clinician communication tools
- the PHOs have implemented Care Insight within general practice as an interim measure to provide after-hours access to key health information about patients; although this information is accessible for 95% of Northland's patients, it is largely used by primary care after-hours services and is not supported or accessed by ED
- Northland DHB has no plans to implement a self-care patient portal within primary care. The decision about whether to implement a self-care patient portal is with each individual general practice which will determine whether this is a priority for them and whether there is a business case that justifies the significant investment required. Accordingly, it is unlikely that the Ministry's KPIs in this area will be achieved.
- Northland DHB will commence implementation of eLab Orders following the completion of the move to the new Lab Information System
- implement the new National Patient Flow:
  - Phase 1, by July 2014, collection of FSA referral information including outcomes of referrals

- Phase 2, by July 2015, collection of other non-admitted and associated referral information, including diagnostic tests.

5.1.3 Clinical leadership

Involving clinicians in planning and management discussions and decisions is essential to improving services. NDHB's clinicians form an integral part of our management structures and processes and are intimately involved in regional and national planning processes and innovation. During 2014/15 the number of clinicians involved with the Clinical Governance Board will be increased significantly. A 12 month long intensive leadership course is being funded by NDHB to provide training for senior clinicians and managers aspiring to senior positions with the organisation. Clinical governance groups have been introduced by NDHB to improve systems and quality of care involving clinicians from both NDHB and the community provider sector. Senior clinicians within the organisation are offered regular training in leadership and management skills to ensure that their contribution to organisation is maximised (see 5.2 Building capability under the upskilling subheading).

5.1.4 Quality, safety and risk management

Northland DHB plays an active part in developing and implementing the region's 'First Do No Harm' quality improvement programme. This programme serves as a conduit for work coming through at national level from HQSC and also supports projects developed at regional level.

NDHB staff regularly attend quality and safety courses and seminars at Counties Manukau DHB's Ko Awatea facility. Quality and safety are integral to the way Northland DHB works. Our emphasis on quality and safety aligns with the aims of the Health Quality and Safety Commission and with the Regional Health Plan's First Do No Harm priority.

Quality and safety includes monitoring clinical risk, adverse events and errors, complaints, benchmarking with other DHBs, improvements to clinical systems and undertaking clinical audit. An electronic risk register allows all parts of the organisation to record and manage risk. The most serious risks are reviewed monthly with senior clinical staff to ensure they are mitigated to acceptable levels.

NDHB has an annually reviewed Quality and Safety Plan which lays out the programme, principles, processes, structures, roles and relationships that underpin quality and safety. Quarterly quality reports are produced for the Board's Hospital Advisory Committee, the Patient Safety Committee and the Clinical Governance Board

NDHB is increasing staffing levels in the Quality Improvement Directorate to provide greater support for development and implementation of quality improvement projects. During this financial year a qualified clinical auditor will be employed to promote and coordinate audit within the organisation.

5.1.5 Performance and management of assets

Northland DHB has redeployed staff to focus on fixed assets. This is a corporate role to effectively and efficiently manage and maintain NDHB's existing assets. It also ensures there is an effective capital planning and asset management function in place that ensures NDHB's ability to continue meeting health service provision requirements for the organisation well into the future. The role will assist by performing the following functions:

- actively supporting the NDHB capital expenditure function including capital planning and budgeting, approval, management, implementation, monitoring and reporting
- maintaining and updating NDHB's capital- and asset-related policies, procedures manuals and forms
- assisting services with the development and reviewing of capital proposals and business cases
- providing business analysis and financial management support to corporate and other services as required from time to time.

NDHB has a number of construction projects underway.

New Maternity Unit, Whangarei Hospital	This is being constructed on Hospital Road on the site of the former Wards 6-9. It comprises 5 birthing rooms, 2 assessment rooms, 4 clinic rooms and 18 antenatal beds.
Jim Carney Cancer Treatment Centre, Whangarei Hospital	Built with funds raised by Project Promise, the Jim Carney Cancer Treatment Centre comprises 9 general treatment spaces, 6 clinic rooms plus a separate child and youth clinic and treatment rooms.
Office Building, Whangarei Hospital	A new office building is being built on the Whangarei Hospital campus that will allow staff located in a number of leased properties to be colocated at the hospital and save $200k annually in building lease costs.
Integrated Family Healthcare Centre, BOI Hospital	NDHB, Ngati Hine Health Trust and local GPs are working together on the proposed development of an IFHC at BOI Hospital.
Integrated Family Healthcare Centre, Dargaville Hospital	NDHB and the Dargaville Medical Centre are working together on the proposed redevelopment of Dargaville Hospital.

5.1.6 Primary and community providers

All of NDHB's services link in some way to Northland's primary and community providers, including general practices and PHOs, pharmacies, the community lab, Maori health providers, mental health providers and aged-care providers. NDHB has agreements with over a hundred primary and community providers in Northland. These are negotiated through our Portfolio Managers who also monitor provider performance in relation to service specifications (most of which are determined nationally) and use this information to assist with planning.

Primary and community organisations are involved in various NDHB governance and planning groups. The two Northland PHOs' Chief Executives are members of NDHB's Executive Leadership Team (ELT). He Mangai Hauora mo te Waka a Taonui, which oversees Maori health at a governance level, has representation from three iwi. The Alliance Leadership Team (Te Roopu Kai Hapai Oranga) comprises ELT plus the four Northland Whanau Ora Collectives. The Northland Health Services Plan Oversight Group comprises ELT plus representatives from three Maori providers.

The Northland Community Pharmacy Service Development Group includes representation from the DHB, PHOs, community pharmacy and hospital pharmacy. This group supports and enables open communication between pharmacies and the DHB on issues relating to the delivery of community pharmacy services within Northland. The role of the group is to encourage the development and delivery of primary care services that can be delivered in a sustainable way by pharmacists and/or their teams to improve health outcomes of Northlanders. Funding has been allocated to this group to enable this.

In addition, a Northland representative attends the Metro Auckland Pharmacy Advisory Group, a similar joint DHB/ pharmacist advisory group, to ensure ideas, issues and solutions are shared across the Northern Region.

Northland pre-school and school based dental services are provided by a combination of both DHB and community dental providers. Representatives from all three providers, plus DHB funding and planning, meet regularly to ensure provider input into all strategic planning.

5.2 Building capability

Information and communications technology, clinical technology and communication

eReferrals	eReferrals involves specialists triaging referrals and either accepting and prioritising them, or providing specialist advice and referring them back to GPs for management. This allows services to be provided closer to home and avoiding many first specialist appointments in outpatients. *(Actions to extend eReferrals during 2014/15 are described under 2.2 Clinical integration.)*
Integration	Northland DHB recognises the fundamental importance of increasing the integration of our information systems across the district in order to support more patient-centric models of care.

Under the integration stream of the NHSP, a number of pilot and trial initiatives are planned to help us continue developing our integration and shared care capability. These include:

- a comparative evaluation of two products which will support secure two-way messaging between hospital and primary clinicians
- pilot implementation of an integrated electronic clinical pathway tool
- continued migration of clinical documents onto the regional clinical data repository
- investigation of options for more integrated access for primary clinicians to regional clinical data repository.

Telehealth

Steady growth occurred in the number of outpatient clinics held in 2013 with the following specialist areas regularly using the service: cardiology, oncology, orthopaedics, paediatrics, renal, methadone and allied health. Tertiary oncology, immunology and paediatrics are planned for 2014. Dargaville is the first district hospital to be linked by VC to the Intensive Care Unit for acute care use of Telehealth. Clinical engagement for this is currently in progress. Kaitaia and the Paediatric Intensive Care Unit are planned over the next quarter. A Dargaville after-hours on-call GP link to hospital emergency room pilot is currently in progress. Medical Outpatients meeting room will be upgraded to regional Cancer Multidisciplinary Meeting specifications in 2 months. This will enable greater interactive capability between teams and contribute to achieving the MoH's Faster Cancer Treatment targets.

Evaluation of two years of renal telehealth use was completed in January. Findings were that approximately $100K per annum would be needed to maintain the current level of service if Telehealth were not available.

eMedicines reconciliation

Fully electronic admission medicines reconciliation went live on the 15 June 2014. Our target is that 63% of all patients on higher risk wards (medical, surgical, orthopaedics, ICU, CCU, Stroke Unit) will have medicines reconciliation completed. This target is now being achieved routinely. eMR is also being rolled out to district hospitals. As well as the Concerto eMR programme, the process is also supported by the regional data repository (community dispensing component) and Care Insight (GP prescribing component).

By Dec 2014: 15 DHBs have implemented eMR; 12 DHBs are using the national clinical standard for eDischarges.

Regional clinical data repository

The process to migrate all NDHB laboratory and radiology and community laboratory results to the regional repository began in 2011. The project was completed on 22nd May 2014 with NDHB clinicians now able to view results only from the regional CDR. For the first time, laboratory results for a single patient can be viewed in cumulative format irrespective of where the test was processed in the Northern region. All GPs and other designated community providers have access to this repository via Testsafe. Access to NDHB electronic discharge summaries for community providers (including community pharmacists) is due to commence on a trial basis on 26th May 2014. If the two week trial is successful, this will become permanent. The single biggest obstacle to wider GP use of the CDR is lack of single logon (one click access from patient view in the PMS). This has a dramatic effect on GP access.

By Dec 2014: 75% of population have a CDR record available through a regional view.

Quality assurance and improvement

Incident reporting system

Northland DHB is working to implement an incident reporting system which will allow reporting from primary care as well as from hospital environments. This will allow for a much deeper understanding of patient harm (for example, post-operative complications developing after discharge and managed in primary care rarely come to the attention of hospital staff). Currently software is being used to allow GPs to report such incidents but the full solution should involve a product accessible to all clinical staff in the community.

Patient experience survey

The patient experience survey currently used within Northland DHB's hospitals has recently been developed to include surveys for patients on maternity and paediatric wards in addition to the existing general ward surveys. The surveys will continue to be modified in light of patient feedback.

Capital and infrastructure development

Building projects

Described in 5.1.5 Performance and management of assets.

Upskilling

First Do No Harm

Northland DHB continues to work with our First Do No Harm campaign to increase the capacity and capability of staff and their understanding and implementation of improvement science

principles. Over the next year we will be building on the successful workshops that have been run in partnership with the First Do No Harm team to upskill staff in health improvement methodology. Two of our staff are currently undertaking the Improvement Advisor training via Counties Manukau DHB's Ko Awatea unit.

Staff training

Northland DHB runs a wide range of training courses for staff. Courses that contribute to the organisation's capability and improved performance are (italics = new in 2013/14):

Human Resources modules: Performance Appraisal,; Managing Poor Performance; Performance and Development; Employee Agreements; Managing Leave; Misconduct and Investigation; Sick Leave Management; Unacceptable Behaviour; *Courageous Conversations*

Leadership: *Team Leadership in High Velocity Environments; Communication; Highly Effective Teams; Critical Thinking*

Recruit, Select, Retain

Service with Excellence

Writing for Success

Project Management – Prince 2 Lite (part of P3O)

All courses are aligned with Northland DHB's values. As training is delivered 'in-house', staff do not have to be sent to locations outside Northland, meaning more staff can receive training for equivalent amounts of funding.

P3O

Training for senior and middle managers on various aspects of the Portfolio, Programme and Project (P3O) model that is being used to implement the Northland Health Services Plan.

IHI improvement science training

Currently HQSC have funded about 20 people from around NZ to do the IHI model for improvement course. Northland DHB is linked into the FDNH workshops . To date about 20 staff have participated and in the forthcoming programme we have also included service managers. In this way we will increase our capacity and capability using standardise process for improvement.

Quality and Safety Review

Northland DHB has commissioned a comprehensive external review of quality and safety within the organisation. When the report from the review body is available, it will provide guidance to ensure appropriate staff gain the necessary skills to deliver a high quality patient experience.

Cooperative developments

Pukawakawa

The Pukawakawa initiative allows the University of Auckland's Medical School to send its fifth-year medical students to Northland to continue their training. It was made possible by additional MBChB funding received in 2006 and close collaboration with Northland DHB. It is anticipated that the programme will assist with long-term medical staffing in Northland.

Childrens Action Plans

The pilot development of a Children's Action Plan in Whangarei will address the fundamental question of how Te Tai Tokerau can achieve better lives and better outcomes for our children.

Northland Intersectoral Forum (NIF)

NIF comprises local and central government agencies working in a collaborative way to make a positive difference on the wellbeing of Northlanders. The forum involves:

- building relationships, sharing strategic information
- planning and making decisions on what to work on together and how
- identifying areas for collective action to which individual members commit funding, time, people and other resources.

Clinical training

Northland DHB currently has a modest clinical training centre catering to mainly in-house resuscitation training across the organisation. To better meet the needs of the wider community and ensuring linkages with our education providers, over the 2014/15 period we will be embarking on the development of a larger purpose-built education facility supporting clinical education.

5.3 Workforce

See also Upskilling under 5.2 Building capability.

Objectives	Actions	Measures	Links
A strengthened workforce	Support the training and development of diabetes nurse prescribers during 2013/14 and 2014/15.	At least 2 diabetes nurse prescribers trained.	

Objectives	Actions	Measures	Links
	Implement and evaluate the General Practice Education Programme, involving 2 registrars being trained alongside doctors registered in another vocational scope during 2014/15.	2 registrars trained.	
	Maintain the number of trainee sonographers to meet current and expected future demands.	2 trainee sonographers complete their training.	
	Provide robust career advice, guidance and support to all HWNZ funded trainees to advance their career development.	All trainees receiving HWNZ-funded training will provide their career plans to support their career development.	

NDHB is supportive of the regional programme to address key workforce requirements for diabetes nurse prescribers, the General Practice Education Programme and sonographers.

Child Protection Policies

Section 17 of the Vulnerable Children's Bill requires DHB boards to adopt and report on a child protection policy. Northland DHB confirms that our board has adopted a Child Protection Policy that meets all of the criteria below:

- adopt, as soon as is practicable, a child protection policy
- report in our annual report (under the New Crown Entities Act 2004, s150) on whether, or on the extent to which, our operations have implemented the policy
- ensure that a copy of the policy is made available on an Internet site maintained by or on behalf of the board
- ensure that every contract or funding arrangement, that after commencement the board enters into with an independent person requires the person as soon as practicable to adopt a child protection policy
- review the policy within 3 years.

Children's worker safety checks

The Vulnerable Children Bill is expected to receive royal assent in June 2014 which will see a further strengthening of Northland DHB's recruitment process. Since May 2012 all doctors, registered nurses, registered midwives, health care assistants and allied health staff acting in a role predominantly involving the care and protection of a child, young person or more vulnerable member of society have as a condition of their employment been required to undergo a comprehensive police check.

After the introduction of the legislation, Northland DHB will engage with employees and their representative unions to implement a process to retrospectively undertake comprehensive police checks for all staff working with a child or young person. The Human Resources Information System will be the vehicle which identifies staff required to undertake further three-yearly police checks.

Northland DHB's recruitment process currently requires all new staff to produce appropriate identification (including identification and police checks for overseas-sourced employees to maintain our accredited employer status with New Zealand Immigration). Reference checks are comprehensive in nature and will be further revised to include specific questions on working with children and young people where appropriate.

Northland DHB will take appropriate action to build on existing recruitment processes to ensure the organisation meets our obligations under the Vulnerable Children Act. This includes:

- making safety-check information available to the Director General of Health, as required under S38
- allowing for the future introduction of safety checks and three-yearly reassessments for existing employees within the two years prescribed in regulations.

Organisation health

Northland DHB's Equal Opportunities Policy commits to having a workplace where everyone is able to participate and compete equitably, develop their full potential and be rewarded fairly for their contribution regardless of gender, ethnicity, disability, sexual orientation, age or family circumstances. Management and staff have responsibility to behave according to the organisation's Values and Codes of Conduct, particularly those related to fairness and non-discriminatory behaviour.

Northland DHB monitors organisation health via a staff satisfaction survey every two years.

In addition Northland DHB promotes a culture of leadership and accountability. Health and safety, recruitment, selection and induction processes, flexible hours and work design are core to organisational health goals and in line with its Equal Opportunities Policy.

General practice training

Northland DHB has recognised the need to offer General Practice Employment Programme registrars the opportunity to train with doctors of other professional scopes. We have identified all GPEP registrars and contacted them to ask if they would like to include such placement in their training programme. Northland DHB will ensure registrars have the opportunity to take up such positions if they are requested.

National processes

Northland DHB will work with and support the National Health Committee (NHC) in its work programme which consists of:

- investigating large and growing health service spends, including those that are driven by new technologies and that can be managed by improving pathways of care (the Burden of Disease Review)
- investigating new and significantly expanding technology cost drivers in the health sector that are not captured by the Burden of Disease Review
- work with and through the Northern Region Clinical Prioritisation Committee to provide expert clinical and business opinion to working and advisory groups for up to 15 health technology assessments to assist development of recommendations the sector will be able to consistently implement
- identifying technologies which are driving fast growing spend which have not been prioritised for assessment at a national level, and refer them to the Regional Prioritisation Network for assessment where appropriate
- designing and running field evaluations to support the development of NHC recommendations.

Health Benefits Ltd is developing a national Indicative Case for Change to seek improvements to human resources management information systems in DHBs. When the Indicative Case for Change is announced, Northland DHB will consider its implications in relation to our own Human Resources Information System.

Appendix A: Glossary

Term	Definition or explanation
#NOF	fractured neck of femur, or "broken hip"
ABC	a service for helping smokers to quit which consists of Ask, Brief intervention and Cessation
ACP	Advance Care Planning; forward planning for end-of-life care for people with terminal conditions
ACS	acute coronary syndrome
ADHB	Auckland District Health Board
ALT	Alliance Leadership Team
ANZACS-QI	All New Zealand Acute Coronary Syndrome Quality Improvement
AOD	alcohol and other drugs
ARRC	age-related residential care
ASH	ambulatory sensitive hospitalisations; a subset of avoidable hospitalisations
B4SC	Before School Checks, performed on all children as part of the Well Child Tamariki Ora schedule
BMI	body mass index, a measure of how healthy a person's weight is
BSMC	better, sooner, more convenient
CAMHS	Child and Adolescent Mental Health Service
CE	Chief Executive
CEP	co-existing problems (in mental health and addictions)
CIO	Chief Information Officer
CMO	Chief Medical Officer
Community provider	Also known as a non-governmental organisation or NGO (in health, usually used to refer to all organisations in the health sector outside a DHB)
COPMIA	children of parents with mental illness and/or addiction
COPD	chronic obstructive pulmonary (lung) disease
CQI	continuous quality improvement
CT	computerised tomography, a type of body imager/ scanner
CVD	cardiovascular disease
CY	calendar year (compare with FY)
DCIP	Diabetes Care Improvement Package
DHB	District Health Board
DON	Director of Nursing / Director of Nursing and Midwifery
DTT	decision to treat, the point at which a consultant decides to go ahead with treatment after appropriate investigations have been made and a diagnosis reached
ED	Emergency Department
ELT	Executive Leadership Team
ERAS	enhanced recovery after surgery
ESPWP	Elective Services Productivity and Workforce Programme
FCT	faster cancer treatment
FDNH	First Do No Harm, a Northern Region harm reduction programme
FSA	first specialist appointment; a patient's first appointment with a specialist after referral by their GP
FTE	full time equivalent; 40 hours per week of work time
FY	financial year; for DHBs, 1 July to 30 June (compare with CY)
GP	General Practitioner

Term	Definition or explanation
GPEP	general practice education programme
GTT	global trigger tool; analysis of random samples of hospital patient records to find 'triggers' that indicate errors, then use of that information to improve the quality and safety of services
HbA1C	a measurement of the amount of sugar in the blood
HBL	Health Benefits Limited; a national organisation established in 2010 to reduce costs and deliver savings in administrative, support and procurement services for the health sector
HBSS	home based support services (for older people)
HDC	Health and Disability Commission (or Commissioner)
HOP	health of older people
HQSC	Health Quality and Safety Commission; a national organisation established under amendments to the Public Health and Disability Act in 2010
HWNZ	Health Workforce New Zealand
IFHC	Integrated Family Health Centre (for urban areas), Integrated Family Health Network (for rural areas)
ICT	information and communications technology
interRAI	a collaborative network of researchers in over 30 countries who promote evidence-based clinical practice and policy to improve health care for persons who are elderly, frail, or disabled
IPPMR	Internal Planning, Performance Monitoring and Reporting (meeting)
IS	information systems
IT	information technology
JADE	A computer software product (and the company that makes it)
Kimiora	Northland DHB's Child and Youth Mental Health Service
KPI	key performance indicator
LMC	Lead Maternity Carer; the midwife who oversees a pregnant woman's care
LOS	length of stay
LTC	long term condition; includes CVD, diabetes, cancer and respiratory diseases
LTCF	long term care facility
MDM	multidisciplinary meeting; health workers of various types and specialties meet to discuss patients
MMR	measles, mumps and rubella
MHA	mental health and addictions
MoH	Ministry of Health
MPDS	Maori Provider Development Subsidy
MRI	magnetic resonance imaging, a type of body imaging used especially for looking at body structures that do not show up well on xray
NASC	Needs Assessment and Service Coordination
NCPAS	National Child Protection Alert System
NDHB	Northland District Health Board
NHC	National Health Committee
NHSP	Northland Health Services Plan (explained in 1.3 Strategic Intentions)
NIF	Northland Intersectoral Forum
NIR	National Immunisation Register
NMDS	National Minimum Data Set, a national collection of public and private hospital discharge information
NNPAC	National Non-admitted Patients Collection
NBRS	National Booking Reporting System
NGO	non-government organisation
NPHOS	Northland Primary Health Organisations; an analytical function shared between Manaia PHO and Te Tai Tokerau PHO that deals with enrolments, performance data and so on

Term	Definition or explanation
NRA	Northern Regional Alliance (a merger of the old Northern DHB Support Agency and the Northern Region Training Hub)
NRHP	Northern Region Health Plan
NRT	nicotine replacement therapy
PBFF	Population Based Funding Formula, the method used by MoH to allocate Vote:Health to DHBs
PCI	percutaneous revascularisation, a technique for managing heart vessel blockages with catheters
PCRMS	Primary Care Referral Management System
PHARMAC	Pharmaceutical Management Agency, the Crown agency that decides, on behalf of DHBs, which medicines and related products are subsidised for use in the community and public hospitals
PHO	Primary Health Organisation
POPN	Primary Options Programme Northland, which enables GPs to carry out minor procedures that would otherwise be done in hospital
RBA	Results-Based Accountability, a framework for monitoring performance
RTC	Rising To the Challenge, a Dec 2012 national plan for mental health and addiction services
SLAT	Service Level Alliance Team
SPE	Statement of Performance Expectations, required of all Crown Entities under the Crown Entities Act
SSI	surgical site infections
SUDI	sudden unexpected death in infancy (sometimes also used to mean sudden unexplained death in infancy)
TPK	Te Puni Kokiri, the Ministry of Maori Development
TPOT	The Productive Operating Theatre
Triple Aim	the highest level of purpose in the NHSP (see Appendix 1) and NRHP
VC	video conference
VIP	Violence Intervention Programme
VTE	venous thromboembolism (blood clot)
WCTO	well child, tamariki ora; mainstream and Maori providers of well-child services
WERO	whanau end-smoking regional whanau ora challenge
WINZ	Work and Income NZ, part of the Ministry of Social Development
WO	Whanau Ora
WOC	Whanau Ora Collective, or Whanau Ora Provider Collective

Appendix B: Statement of Accounting Policies

For the year ended 30 June 2013

The Financial Statements included in this plan have been prepared using the following Accounting Policies. These policies are also used by the Northland District Health Board to prepare its Annual Report which is audited by Audit New Zealand. There have been no changes to the Accounting policies during the periods reported upon.

Statement of accounting policies

Reporting entity

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

NDHB is a public benefit entity (PBE), as defined under NZIAS 1.

The consolidated financial statements of NDHB and group for the year ended 30 June 2013 comprise NDHB, its joint venture subsidiary the Kaipara Total Health Care Joint Venture (54% owned) and its associate healthAlliance N.Z. Limited (20% owned).

NDHB's activities involve funding and delivering health and disability services in a variety of ways to the community.

The financial statements were authorised for issue by the Board on 30th October 2013.

Basis of preparation

Statement of compliance

The financial statements have been prepared in accordance with generally accepted accounting practice in New Zealand (NZGAAP). They comply with New Zealand equivalents to International Financial Reporting Standards (NZIFRS) as appropriate for public benefit entities, and other applicable Financial Reporting Standards as appropriate for public benefit entities.

In addition, funds administered on behalf of patients have been reported as a note to the financial statements.

Measurement Base

The financial statements have been prepared on a historical cost basis, except where modified by the revaluation of land and buildings at fair value.

Functional and presentation currency

The financial statements are presented in New Zealand Dollars and all values are rounded to the nearest thousand dollars ($000). The functional currency of the NDHB and its subsidiary is New Zealand dollars (NZ$).

The accounting policies as set out below have been applied consistently to all periods presented in these consolidated financial statements.

Critical accounting estimates and assumptions

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

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

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:

Land and buildings revaluations

Note 10 provides information about the estimates and assumptions applied in the measurement of revalued land and buildings.

Long service leave and retirement gratuities

Note 15 provides an analysis of the exposure in relation to estimates and uncertainties surrounding retirement and long service leave liabilities.

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

The useful lives and residual values of property, plant and equipment are reviewed at each balance date. Assessing the appropriateness of useful life and residual value estimates requires the NDHB to consider a number of factors such as the physical condition of the asset, advances in medical technology, expected period of use of the asset by the NDHB, and expected disposal proceeds (if any) from the future sale of the asset.

Leases classification

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

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.

The NDHB has exercised its judgement on the appropriate classification of leases, and has determined no lease arrangements are finance leases.

Changes in accounting policies

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

Early adopted amendments to standards

There have been no early adopted amendments to standards in the current year.

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

Standards, amendments, and interpretations issued that are not yet effective and have not been early adopted, and are relevant to NDHB include:

NZ IFRS 9 Financial Instruments will eventually replace NZ IAS 39 Financial Instruments: Recognition and Measurement. NZ IAS 39 is being replaced through the following 3 main phases: Phase 1 Classification and Measurement, Phase 2 Impairment Methodology, and Phase 3 Hedge Accounting. Phase 1 on the classification and measurement of financial assets has been completed and has been published in the new financial instrument standard NA IFRS 9. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39. The approach in NZ IFRS 9 is based on how an entity manages its financial instruments (its business model) and the contractual cash flow characteristics of the financial assets. The new standard also requires a single impairment method to be used, replacing the many different impairment methods in NZ IAS 39. The new standard is required to be adopted for the year ended 30 June 2016. NDHB has not yet assessed the effect of the new standard and expects it will not be early adopted.

The Minister of Commerce has approved a new Accounting Standards Framework (incorporating a Tier Strategy) developed by the External Reporting Board (XRB). Under this Accounting Standards Framework, the NDHB is classified as a Tier 1 reporting entity and it will be required to apply full public sector Public Benefit Entity Accounting Standards (PAS). These standards are being developed by the XRB and are mainly based on current International Public Sector Accounting Standards. The effective date for the new standards for public sector entities is expected to be for reporting periods beginning on or after 1 July 2014. This means the NDHB expects to transition to the new standards in preparing its 30 June 2015 financial statements. As the PAS are still under development, the NDHB is unable to assess the implications of the new Accounting Standards Framework at this time.

Due to the change in the Accounting Standards Framework for public benefit entities, it is expected that all new NZ IFRS and amendments to existing NZ IFRS will not be applicable to public benefit entities. Therefore, the XRB has effectively frozen the financial reporting requirements for public benefit entities up until the new Accounting Standards Framework is effective. Accordingly, no disclosure has been made about new or amended NZ IFRS that exclude public benefit entities from their scope.

Basis for consolidation

Subsidiaries

Subsidiaries are entities controlled by NDHB. Control exists when NDHB has the power, directly or indirectly, to govern the financial and operating policies of an entity so as to obtain benefits from its activities. In assessing control, potential voting rights that presently are exercisable or convertible are taken into account. The financial statements of subsidiaries are included in the consolidated financial statements from the date that control commences until the date that control ceases.

The consolidated financial statements include the parent (Northland District Health Board) and its subsidiary. The subsidiary is accounted for using the acquisition method, which involves adding together corresponding assets, liabilities, revenues and expenses on a line by line basis. All inter-entity transactions are eliminated on consolidation.

Transactions eliminated on consolidation

Intragroup balances and any unrealised gains and losses or income and expenses arising from intragroup transactions, are eliminated in preparing the consolidated financial statements.

Investments in subsidiaries are carried at cost in NDHB's own "parent entity" financials statements.

Equity accounted Investees: Associates

Associates are entities over which NDHB has significant influence, but not control, over the financial and operating policies. Equity accounted investees are initially recognised at cost. Subsequent to initial recognition they are accounted for using the equity method in the consolidated financial statements.

The consolidated financial statements include NDHB's share of the profit or loss after tax of equity accounted investees from the date that significant influence commenced. Distributions received from an associate reduce the carrying amount of the investment. Where the group transacts with an associate, surpluses or deficits are eliminated to the extent of the group's interest in the associate.

Investments in associates are carried at cost in NDHB's own "parent entity" financial statements.

Budget Figures

The budget figures are those approved by the health board in its Statement of Intent and included in the Statement of Intent tabled in parliament. The budget figures have been prepared in accordance with NZGAAP. They comply with NZIFRS and other applicable Financial Reporting Standards as appropriate for public benefit entities. Those standards are consistent with the accounting policies adopted by NDHB for the preparation of these financial statements.

Foreign currency transactions

Transactions in foreign currency are translated at the foreign exchange rate ruling at the date of the transaction. Monetary assets and liabilities denominated in foreign currencies at the balance sheet date are translated to NZD at the foreign exchange rate ruling at that date. Foreign exchange differences arising on translation are recognised in the surplus or deficit. Non-monetary assets and liabilities that are measured in terms of historical cost in a foreign currency are translated using the exchange rate at the date of the transaction.

Property, plant and equipment

Classes of property, plant and equipment

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

- freehold land
- freehold buildings
- plant and equipment
- vehicles
- work in progress.

Owned assets

Except for land and buildings and the assets vested from the hospital and health service (see below), items of property, plant and equipment are stated at cost, less accumulated depreciation and accumulated impairment losses. The cost of self-constructed assets includes the cost of materials, direct labour, the initial estimate, where relevant, of the costs of dismantling and removing the items and restoring the site on which they are located, and an appropriate proportion of direct overheads.

Land and buildings are revalued to fair value as determined by an independent registered valuer every three years or where there is evidence of a significant change in fair value. The net revaluation results are credited or debited to other comprehensive income and is 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 income but is recognised in the surplus or deficit. Any subsequent increase on revaluation that off-sets 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 income.

Accumulated depreciation at revaluation date is eliminated against the gross carrying amount so that the carrying amount after revaluation equals the revalued amount.

Property that is being constructed or developed for future use as investment property is classified as property, plant and equipment and stated at cost until construction or development is complete, at which time it is reclassified as investment property.

Where material parts of an item of property, plant and equipment have different useful lives, they are accounted for as separate components of property, plant and equipment.

Property, Plant and Equipment Vested from the Hospital and Health Service

Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets of Northland Health Limited (a hospital and health service company) vested in Northland District Health Board on 1 January 2001. Accordingly, assets were transferred to NDHB at their net book values as recorded in the books of the hospital and health service. In effecting this transfer, the health board has recognised the cost and accumulated depreciation amounts from the records of the hospital and health service. The vested assets will continue to be depreciated over their remaining useful lives.

Disposal of property, plant and equipment

Where an item of plant and equipment is disposed of, the gain or loss recognised in the surplus or deficit is calculated as the difference between the net sales price and the carrying amount of the asset. The gain or loss is recognised in the reported net surplus of deficit in the period in which the transaction occurs. Any balance attributable to the disposed asset in the asset revaluation reserve is transferred to retained earnings.

Additions to property, plant and equipment

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

In most instances, an item of property, plant and equipment is recognised at its cost. Where an asset is acquired at no cost, or for a nominal cost, it is recognised at fair value as at the date of acquisition.

Leased assets

Leases where NDHB assumes substantially all the risks and rewards of ownership are classified as finance leases. The assets acquired by way of finance lease are stated at an amount equal to the lower of their fair value and the present value of the minimum lease payments at inception of the lease, less accumulated depreciation and impairment losses.

Subsequent costs

Subsequent costs are added to the carrying amount of an item of property, plant and equipment when that cost is incurred if it is probable that the service potential or future economic benefits embodied within the new item will flow to NDHB. All other costs are recognised in the statement of comprehensive income as an expense as incurred.

Depreciation

Depreciation is provided using the straight line method on all property plant and equipment other than land, and recognised in the surplus or deficit.

Depreciation is set at rates that will write off the cost or fair value of the assets, less their estimated residual values, over their useful lives. The estimated useful lives of major classes of assets and resulting rates are as follows:

Class of asset	Estimated life	Depreciation rate
• Buildings		
- Structure	1 to 65 years	(1.5% - 100%)
- Services	1 to 25 years	(4% to 100%)
- Fit out	1 to 10 years	(10% - 100%)
• Plant and Equipment	1 to 10 years	(10% - 100%)
• Motor Vehicles	5 years	(20%)

The residual value of assets is reassessed annually to determine if there is any indication of impairment.

Work in progress is recognised at cost less impairment and is not depreciated. The total cost of a project is transferred to the appropriate class of asset on its completion and then depreciated.

Borrowing costs

For each property, plant and equipment asset project, borrowing costs are recognised as an expense in the period which they are incurred.

Intangible Assets

Intangible assets that are acquired by NDHB are stated at cost less accumulated amortisation and impairment losses.

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

The investment in the Finance and Procurement Supply Chain with Health Benefits Limited is recognised at the cost of capital invested. This is an indefinite life asset which will be tested for impairment annually.

Subsequent expenditure

Subsequent expenditure on intangible assets is capitalised only when it increases the service potential or future economic benefits embodied in the specific asset to which it relates. All other expenditure is expensed as incurred.

Amortisation

Amortisation is provided in the surplus or deficit on a straight-line basis over the estimated useful lives of intangible assets unless such lives are indefinite. Intangible assets with an indefinite useful life are tested for impairment at each balance sheet date. Other intangible assets are amortised from the date they are available for use.

Class of asset	Estimated life	Amortisation rate
Software	2 to 3 years	(33% - 50%)

Impairment of property, plant and equipment and intangible assets

Intangible assets that have an indefinite useful life, or not yet available for use, are not subject to amortisation and are tested annually for impairment. Assets that have a finite useful life are reviewed for indicators of impairment at each balance date. When there is an indicator of impairment the asset's recoverable amount is estimated. An impairment loss is recognised for the amount by which the asset's

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

Value in use is depreciated replacement cost for an asset where the fair value of an asset cannot be reliably determined by reference to market based evidence.

If an asset's carrying amount exceeds its recoverable amount, the asset is impaired and the carrying amount is written down to the recoverable amount. For revalued assets the impairment loss is recognised in other comprehensive income to the extent the impairment loss does not exceed the amount in the revaluation reserve in equity for that same class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised in the surplus or deficit.

For assets not carried at a revalued amount, the reversal of an impairment loss is recognised in the surplus or deficit.

Financial Instruments

Non-derivative financial instruments

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

Financial instruments are initially recognised at fair value plus transaction costs unless they are carried at fair value through surplus or deficit in which case the transaction costs are recognised in the surplus or deficit.

Financial instruments are derecognised when the rights to received cash flows have expired or have been transferred and NDHB have transferred substantially all the risks and rewards of ownership.

Financial assets are classified into the following categories for the purposes of measurement:

- Fair value through surplus or deficit;
- Fair Value through other comprehensive income;
- Loans and receivables.

Classification of the financial asset depends on the purpose for which the instruments were acquired.

Financial assets at fair value through surplus or deficit

Financial assets at fair value through surplus or deficit include financial assets held for trading. A financial asset is classified in this category if acquired principally for the purpose of selling in the short-term or is part of a portfolio that are managed together and for which there is evidence of short-term profit-taking.

Financial assets acquired principally for the purpose of selling in the short-term or part of a portfolio classified as held for trading are classified as a current asset.

After initial recognition financial assets in this category are measured at their fair values with gains or losses on re-measurement recognised in the surplus or deficit.

Fair value through other comprehensive income

Financial assets at fair value through other comprehensive income are those that are designated into the category at initial recognition or are not classified in any of the other categories above. They are included in non-current assets unless management intends to dispose of, or realise, the investment within 12 months of balance date. The NDHB and group includes in this category, bond investments that it intends to hold long-term but which may be realised before maturity.

These investments are measured at their fair value, with gains and losses recognised in other comprehensive income, except for impairment losses, which are recognised in the surplus or deficit.

On de-recognition, the cumulative gain or loss previously recognised in other comprehensive income is reclassified from equity to the surplus or deficit.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. They are included in current assets, except for maturities greater than 12 months after the balance date, which are included in non-current assets. NDHB's loans and receivables comprise cash and cash equivalents, trade and other receivables, term deposits, Trust / Special Fund assets and related party loans.

After initial recognition they are measured at amortised cost using the effective interest method less any provision for impairment. Gains and losses when the asset is impaired or derecognised are recognised in the surplus or deficit.

The effective interest rate method is a method of calculating the amortised cost of a financial instrument and of allocating interest over the relevant period. The effective interest rate is the rate that exactly discounts future cash receipts or payments through the expected life of the financial instrument, or where appropriate, a shorter period to the net carrying amount of the financial instrument.

Cash and cash equivalents

Cash and cash equivalents comprise cash balances and call deposits with maturity of no more than three months from the date of acquisition.

Accounting for finance income and expense is explained in a separate note.

Interest-bearing loans and borrowings

Subsequent to initial recognition, other non-derivative financial instruments such as Interest bearing loans and borrowings, are measured at amortised cost using the effective interest method, less any impairment losses.

Trade and other receivables

Trade and other receivables are initially recognised at fair value and subsequently stated at their amortised cost less impairment losses. Bad debts are written off during the period in which they are identified.

Trade and other payables

Trade and other payables are initially measured at fair value and subsequently stated at amortised cost using the effective interest rate method.

Impairment

At each balance sheet date NDHB assesses whether there is any objective evidence that a financial asset or group of financial assets is impaired. Any impairment losses are recognised in the surplus or deficit.

Loans and other receivables

Impairment of a loan or a receivable is established when there is objective evidence that NDHB will not be able to collect amounts due according to the original terms. Significant financial difficulties of the debtor/issuer, probability that the debtor/issuer will enter into bankruptcy, and default in payments are considered indicators that the asset is impaired. The amount of the impairment is the difference between the asset's carrying amount and the present value of estimated future cash flows, discounted using the original effective interest rate. For debtors and other receivables, the carrying amount of the asset is reduced through the use of an allowance account, and the amount of the loss is recognised in the surplus or deficit. When the receivable is uncollectible, it is written off against the allowance account. Overdue receivables that have been renegotiated are reclassified as current (i.e. not past due). For other financial assets, impairment losses are recognised directly against the instruments carrying amount.

Inventories

Inventories are stated at the lower of cost and net realisable value. Net realisable value is the estimated selling price in the ordinary course of business, less the estimated costs of completion and selling expenses.

Cost is determined on an average weighted cost basis.

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

Interest bearing borrowings

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

Employee benefits

Defined contribution plan

Obligations for contributions to defined contribution plans are recognised as an expense in the surplus or deficit as incurred.

Long service leave, sabbatical leave and retirement gratuities

NDHB's net obligation in respect of long service leave, sabbatical leave and retirement gratuities is the amount of future benefit that employees have earned in return for their service in the current and prior periods. The obligation is calculated on an actuarial basis and involves the projection, on a year by year basis, of the entitlements, based on accrued service. These benefits are estimated in respect of their incidence according to assumed rates of death, disablement, resignation and retirement and the in respect of those events according to assumed rates of salary progression. A value is placed on the resulting liabilities by discounting the projected entitlements back to the valuation date using a suitable discount rate.

Annual leave, conference leave and medical education leave

Annual leave, conference leave and medical education leave are short-term obligations and are calculated on an actual basis at the amount NDHB expects to pay. These are recognised in the surplus or deficit when they accrue to employees. NDHB accrues the obligation for paid absences when the obligation both relates to employees' past services and it accumulates.

Sick leave

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

Provisions

A provision is recognised at fair value when NDHB has a present legal or constructive obligation as a result of a past event, it is probable that an outflow of economic benefits will be required to settle the obligation and that a reliable estimate can be made. If the effect is material, provisions are determined by discounting the expected future cash flows at a pre-tax rate that reflects current market rates and, where appropriate, the risks specific to the liability. The movement in provisions are recognised in the surplus or deficit.

Revenue relating to service contracts

NDHB is required to expend all monies appropriated within certain contracts during the year in which it is appropriated. Should this not be done, the contract may require repayment of the money or NDHB, with the agreement of the Ministry of Health, may be required to expend it on specific services in subsequent years. The amount unexpended is recognised as a liability.

Income tax

NDHB is a crown entity under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under section CB3 of the Income Tax Act 1994.

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 then it is recognised as part of the related asset or expense.

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

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

Commitments and contingencies are disclosed exclusive of GST.

Revenue

Crown funding

The majority of revenue is provided through an appropriation in association with a Crown Funding Agreement. Revenue is recognised monthly in accordance with the Crown Funding Agreement payment schedule, which allocates the appropriation equally throughout the year. It is measured at fair value of consideration received or receivable.

Goods sold and services rendered

Revenue from goods sold is recognised when NDHB has transferred to the buyer the significant risks and rewards of ownership of the goods and NDHB does not retain either continuing managerial involvement to the degree usually associated with ownership nor effective control over the goods sold.

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

Rental income

Rental income is recognised in the surplus or deficit on a straight-line basis over the term of the lease. Lease incentives granted are recognised as an integral part of the total rental income over the lease term.

Interest

Interest Income is recognised using the effective interest method.

Capital Charge

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

Expenses

Operating lease payments

An operating lease is a lease whose term is short compared to the useful life of the asset or piece of equipment.

Payments made under operating leases are recognised in the surplus or deficit on a straight-line basis over the term of the lease. Lease incentives received are recognised in the surplus or deficit over the lease term as an integral part of the total lease expense.

Financing costs

Net financing costs comprise interest paid and payable on borrowings calculated using the effective interest rate method.

Equity

Equity is the community's interest in Northland District Health Board and is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified into a number of components.

The components of equity are Retained Earnings, Revaluation Reserve (consisting of Land and Buildings), non-controlling interest in the group and Trust/Special Funds. The non- controlling interest in the group is represented by the joint venture partner in the subsidiary. Special funds are funds donated or bequeathed for a specific purpose. The use of these assets must comply with the specific terms of the sources from which the funds were derived. The revenue and expenditure in respect of these funds is included in the surplus or deficit. An amount equal to the expenditure is transferred from the trust fund component of equity to retained earnings. An amount equal to the revenue is transferred from revenue earnings to trust funds.

Insurance Contracts

The future cost of ACC claims liabilities is revalued annually based on the latest actuarial information. Movements of the liability are reflected in the surplus or deficit. Financial assets backing the liability are designated at fair value through surplus and deficit.

Contingent liabilities

Contingent liabilities are recorded in the Statement of Contingent Liabilities at the point at which the contingency is evident. Contingent liabilities are disclosed if the possibility that they will crystallise is not remote.

Cost of Service (Statement of Service Performance)

The cost of service statements, as reported in the statement of service performance, report the net cost of services for the outputs of NDHB and are represented by the cost of providing the output less all the revenue that can be allocated to these activities.

Cost allocation

NDHB has arrived at the net cost of service for each significant activity using the cost allocation system outlined below.

Cost allocation policy

Direct costs are charged directly to output classes. Indirect costs are charged to output classes based on cost drivers and related activity and usage information.

Criteria for direct and indirect costs

Direct costs are those costs directly attributable to an output class.

Indirect costs are those costs that cannot be identified in an economically feasible manner with a specific output class.

Cost drivers for allocation of indirect costs

The cost of internal services not directly charged to outputs is allocated as overheads using appropriate cost drivers such as actual usage, staff numbers and floor area.

Comparative Information

Comparative information has been reclassified to achieve consistency with current year disclosures.

- Net taxes refunded (paid) (Goods and Services Tax) in the consolidated statement of cash flow shows the amounts as net rather than gross.
- Transfers between work in progress and asset classes are now disclosed in note 10 property, plant and equipment.