ANNUAL REPORT 2015

A Healthier Northland
He Hauora Mo Te Tai Tokerau

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

Reading our Annual Report

The annual report presents an account of Northland DHB's performance for the year from July 1, 2014 to June 30, 2015.

It sets out what Northland DHB committed to do in the year, and how we delivered on that commitment.

Each year, the board reviews progress on its vision and long-term strategy, and identifies what will be achieved over the next twelve months. This is documented in the Annual Plan.

A *Statement of Intent* is also prepared annually and is the formal accountability document between Northland DHB and the Government. It provides a concise summary of Northland's intentions for the year ahead, and covers both long-term and annual planning objectives.

This document, the Annual Report, tells you how Northland DHB performed against the **Statement of Intent and Annual Plan**. It provides a detailed account of how the health dollars allocated to this board were managed.

Key Components

Chair and Chief Executive Report

A report from the chair and chief executive on the past year.

Introduction

Northland District Health Board.

A brief overview of Northland DHB's role, the district it covers, and resources it manages.

2014/15: The Year in Review

Includes staff and health sector activities and the DHB's financial performance.

Governance and Partnerships

A report on how the board of Northland DHB is structured and operates.

Financial and Audit Reports

The annual financial accounts of the organisation. Includes notes and disclosures regarding remuneration, dividend payments, and interest/shares in other organisations.

Statement of Performance

A report on Northland DHB's performance against the targets set by the board, and agreed by the Minister of Health.

Contents

Message from the Chair and Chief Executive

On behalf of Northland District Health Board, we are pleased to present our Annual Report for the 2014/2015 financial year. It has, again, been a privilege for us to lead our organisation and to have the opportunity to describe the challenges we have faced and the progress we have made towards improving the health and wellbeing of our people and achieving a healthier Northland.

Our strategic approach to addressing health and wellbeing challenges lies in the implementation of our Northland Health Services Plan (NHSP). The Triple Aim of addressing Population Health, Improving our Patients' Experience, and ensuring Value and Sustainability has led to the establishment of the five NHSP projects. First 2000 Days, Urgent Healthcare, Patient and Whānau Centred Care, Neighbourhood Healthcare Homes and Fit for Life are giving us the traction we need to achieve the Triple Aim and NHSP's six headline targets.

The First 2000 Days programme aims to ensure 'No Child is Left Behind', and all Northland infants and children (from conception to age five) receive their entitlement of universal services and access to early intervention where need is identified. As there is an unacceptable inequity in health outcomes for Māori children in Northland, they are the central focus of all activity in this programme of work.

Within the Urgent Healthcare workstream, research is being undertaken to strengthen primary care understanding of same-day access by providing a baseline of the availability of same-day appointments in general practice in Northland. The findings will sit alongside analysis of ED and White Cross utilisation at general practice level and exploration of how various models of general practice appointment scheduling impact on these indicators.

Also in development is a new model of care for acute General Medicine. The aim is to more closely align capacity with workflow demand, improve the patient experience of timely care, and inform the development of the Acute Admissions Unit.

Patient and whānau centred care involves shared decision making with our patients and their families, and is quite different to the traditional way that healthcare is practised. Patients and families bring in fresh ideas, especially for chronic conditions where patients and families deliver the vast majority of their care themselves.

Central to the patient and whānau centred care work was the hosting of Values Week in April, which saw workshops for staff ('in our shoes') and patients ('in your shoes'). More than 750 staff and 139 patients attended 18 workshops throughout Northland. In addition, 429 staff and 349 patients responded to a Values survey. What we have learnt will continue to strengthen our organisation, our culture, and enrich and embed our values and behaviours. Our Values give us a platform to deliver great patient and staff experience.

The inaugural Consumer Council meeting was held in December. The Council had consumer input into the Values Week 'In Your Shoes' sessions, and is participating in the Maternity planning day, Advanced Care Planning, Partners in Care and Visitors Policy, Communication training and the Grand Round presentations. The Health Quality & Safety Commission showcased our process of establishing the Consumer Council.

The locality of Neighbourhood Healthcare Homes (NHH) will be centred on networks of general practices where the co-ordination work of a NHH will occur. Multi-disciplinary teams will provide care to the high risk population within these networks. A number of information system enablers are required to connect the various patient information systems and health providers. Care Select (an e-referral programme to enable general practice to refer patients to non-government organisations) was launched under the banner of NHH in Whangarei with 15 general practices taking up the opportunity to participate.

The Northland Alliance Leadership team through the Fit for Life project board hosted a Tobacco Control Consultation Hui at Manaia Health PHO. Using a Results Based Accountability workshop process, the hui aimed to develop an action plan to make 1,000 Māori 'quits' a year a reality. This is necessary to achieve our goal of being smokefree by 2025 and equity in quit rates, because current projections are that Māori will miss the goal by some 15 percent if we do not change our approach.

Our key population health goal of reducing the life expectancy gap between Māori and non-Māori has been progressed through the Alliance Leadership Team. The most recent analysis (2011, WDHB) now puts the life expectancy gap at about eight years, which is a small improvement. 'Life expectancy' is a key measure of inequity and the DHB works with other Government agencies and iwi Māori to help eliminate this difference.

The Patient Safety & Quality Improvement Review took a comprehensive look at our safety and quality systems with a key focus on improving patient experience. An electronic dashboard records the progress we are making on the review's 75 recommendations. It is pleasing to see that a large number of these actions have been completed. We are currently reviewing our visitors policy with the development of the principles that will underpin the new Partners in Care and Visitors Policy. The policy differentiates between partners in care (as identified by the patient and who are recognised as part of the care team) and visitors. The key principle of the policy is negotiation between our staff, the patient and whānau. The Consumer Council is providing valuable guidance in the development of this new policy.

Within a fast moving complex information technology (IT) environment, analysis to identify the best IT enablers to stratify enrolled populations against need, and provide a high quality shared care planning tool is being undertaken. Northland DHB is paving the way for future healthcare by trialing a high-tech, potentially life-saving telemedicine system using a video conferencing solution. Neonatal Examination and Management Online (NEMO) was developed in Australia to allow remote patient assessment and management.

In Northland, NEMO is primarily being used for acute care, particularly in the area of retrieval medicine for both adults and children. It aims to improve Whangarei Hospital ICU's remote acute assessment capabilities to the district hospital Emergency Departments (ED) and wards; patient safety through rapid patient assessment in ED and the ward, as well as advising on management of the critically unwell patient. This includes assisting with decision-making in determining the safest way to transport patients to Whangarei.

Integration and improved access to IT systems across the district have continued. The Nexxt dynamic clinical pathways tool has been installed as a pilot in eight Northland general practices. The Manage My Health patient portal has been installed in five practices.

This year our Health and Disability Commissioner complaints and investigations are the second lowest amongst the 20 DHBs in New Zealand. Northland DHB averaged 55.82 complaints per 100,000 discharges which is a relatively low level of complaints compared to the rest of the sector.

Datix, the new complaint and incident management software went live in December 2014 and is already being recognised as a superior system by staff who appreciate the ability to track responses to the incidents they report. It is also providing much closer oversight of the response to incidents and complaints.

We managed to report a small financial surplus despite the unfavourable variances in community pharmacy spend, 'winter-like' acute activity, mental health acute volumes and continued elective surgery activity. The extraordinary pressure on hospital services has been balanced against some additional income, significant work in procurement savings, as well as local cost savings initiatives. Health Benefits Limited was wound down and the assets and liabilities transferred to the new DHB-owned entity, NZ Health Partnerships Limited.

Construction of Te Kotuku, our new maternity facility, is nearing completion. The Board made the decision to construct a shell floor above the unit to avoid any disturbances to maternity services when the new hospital is gradually built. The necessary foundation and infrastructure work will have already been carried out in preparation for additional floors being added at a later stage.

Te Kotuku replaces the current 40-year-old maternity ward and delivery suite with a modern, family-friendly facility. The facility will co-locate antenatal clinics, assessment rooms, birthing rooms, pre and post-natal beds that are currently spread over two floors in the hospital. The new facility includes a high dependency unit and central staff base. Each birthing room and bedroom has full ensuite facilities. Completion and occupation of the unit will be in February 2016.

The office accommodation building was completed in April and named Tohorā House. The new facility allowed for the relocation and consolidation of a number of separate teams who were housed in different facilities throughout Whangarei. Clinical and non-clinical staff are now co-located, providing us with the opportunity to operate as a 'whole of system' organisation, and achieve operational savings on rent.

The need to redevelop Bay of Islands Hospital made way for an opportunity to partner with Ngāti Hine Health Trust to build an integrated family healthcare centre named Te Hauora o Pukepuke Rau ('a healthy chief sits on every hill'), adjacent to the hospital. The hospital refurbishment is underway and will see a new accident and medical department, which will also provide facilities for GPs to provide after-hours services. The accident and medical department will provide the interface to Te Hauora o Pukepuke Rau with a single triage point to serve both the centre and hospital. A new eight-bed renal unit is also being built in the courtyard between the maternity building and the existing general ward. The existing ward area will be refurbished to create a modernised 23-bed facility, nurses' station, staff offices and patient discharge lounge, including a chaplain's room.

In April 2015, we implemented paid car parking at the Whangarei Hospital campus. By charging for parking we are aiming to control demand, reduce congestion and increase the number of parks we have available. Paid car parking is never popular, but it has increased the availability of visitor parks and reduced the time visitors need to spend looking for a park.

Mental Health & Addiction Services continues to be pressured by rising demand throughout the system, including the Tumanako In patient Unit (IPU) and sub-acute units, along with the community-based services and the non-government organisations funded by the DHB. Management have supported clinical service teams with a number of initiatives including a system-wide review of the model of care and mapping demand, capacity and capability across Northland; a review of the Tumanako IPU, and structural issues to improve clinical governance, accountability and managerial partnership to ensure we deliver optimal patient/whānau centred care now and into the future.

In collaboration with Te Ao Maramatanga NZ College of Mental Health Nurses, Northland DHB, Manaia and Te Tai Tokerau Primary Health Organisations (PHOs) have supported 14 primary health nurses in gaining mental health and addiction credentialling in primary care. The effective working relationships between Northland DHB specialist mental health services and our PHOs have been credited with the success of the programme.

One of our strengths is the partnership we have with our PHOs, Manaia Health and Te Tai Tokerau. Knowing that cost is one of the significant barriers for families in accessing medical care, we rolled out early free GP access, including after-hours consultations, for children aged between six and 12 years (up to their 13th birthday) nine months earlier than the national programme. All of our 153 GPs from the 38 general practices across the PHOs signed up to this initiative. By Northland DHB and PHOs working together, the estimated 16,000 six to 12 year-olds enrolled with either PHO can now visit their GP for free and also pick up a prescription from their pharmacy without the burden of the $5 surcharge.

Two highly advanced CT scanners have been successfully installed at Whangarei Hospital to provide sufficient capacity to meet current and future demand. The new scanner enables us to develop new imaging services, including CT colonography and CT cardiac angiography. In addition, a new MRI scanner is being purchased and a second endoscopy room will enable the wait time for patients to be no more than one month by the end of October 2015.

Northland DHB has, once again, come out on top with the highest rates in the country for exclusive breastfeeding on discharge from maternity facilities. With an overall rating of 94.7 percent, the New Zealand Breastfeeding Authority commented that Northland DHB had the best rate of exclusive breastfeeding on discharge 'by far' compared to the rest of New Zealand.

The Jim Carney Cancer Treatment Centre was opened in November 2014 with a dawn blessing and an official opening attended by the Minister of Health, Hon Dr Jonathan Coleman. The new facility is proving popular with patients and staff, and there are projects to implement improved cancer treatment pathways to ensure an optimal experience for patients and the productive use of the new facilities.

The Governor General, Lieutenant General Sir Jerry Mateparae officially launched the Bronchiectasis Foundation as Patron in honour of Esther-Jordan Muriwai who passed away last year aged 24. The new foundation has been established to help families and their children who have bronchiectasis.

A highlight of our year was the extremely successful inaugural Northland Health Sector Awards. The Northland health sector came together to reward projects and behaviours in line with our values (Matariki awards) and Quality Improvement in August 2014. We were also privileged to celebrate with two of our surgeons, Jerry Gathercole and Peter Milsom, both of whom were the first New Zealand recipients of the Royal Australasian College of Surgeons Outstanding Service to Community Award.

It has been a pleasure this year to welcome new board members Debbie Evans and Dr Chris Reid. Each brings new skills and experiences to the board. We take this opportunity to acknowledge the re-appointment of board chair Anthony Norman and re-election of deputy chair Sally Macauley.

We would like to sincerely thank the members of our board, our executive team and all our wonderful staff for their continued strong commitment and passion in the execution of their roles during the year. Healthcare is always a challenge and we continue to pursue excellence in service provision while becoming a patient and whānau centred organisation. We would also like to record the appreciation of the board to the Kaunihera Council of Elders (Kaumātua and Kuia) for their continuing support, advice and wisdom on matters of tikanga Māori.

Anthony Norman
Board Chair

Dr Nick Chamberlain
Chief Executive

Introduction:
Northland District Health Board

Our Role

Northland DHB, established under the New Zealand Public Health and Disability Act (2000), is categorised as a Crown Agent under section 7 of the Crown Entities Act 2004.

Responsible for providing or funding the provision of health and disability services for the people of Northland, the DHB covers a large geographical area from Te Hana in the south to Cape Reinga in the north.

The DHB employs around 2,674 staff. Acute services are provided through the DHB's four hospitals, based at Whangarei, Dargaville, Kawakawa and Kaitaia, with elective surgery performed at Whangarei and Kaitaia. These services are supplemented by a network of community-based, outpatient and mental health services, a range of allied health services and a public and population health unit.

Some specialist services, like radiation treatment and rheumatology services, are provided from Auckland or through visiting specialists travelling to Northland.

The DHB allocates funding across the health sector in Northland, contracting with a range of community-based service providers such as primary health organisations (PHOs), dentists, pharmacies and other non-government organisations.

Our Communities

Population

Northland's population at the 2013 Census was 160,615, representing 3.6 percent of New Zealand's population. About half live within the Whangarei District Council area, 37 percent within the Far North District Council area and 13 percent within the Kaipara District Council area.

Māori

Nga Iwi o Te Tai Tokerau comprises 30 percent of Northland's population. Out of the total Māori population, about half live in the Far North District, 40 percent in Whangarei, and 10 percent in Kaipara. Iwi in Northland include Ngati Kuri, Te Aupouri, Ngaitatoko, Te Rarawa, Ngati Kahu, Whaingaroa, Ngapuhi, Ngati Wai and Ngati Whatua.

Ageing population

Northland's population is 'ageing' because the number of children is decreasing while the older population is increasing significantly. The child population (0-14 years), is projected to drop from 21.6 percent in 2012 to 19.7 percent by 2026. Northland's older population (65-plus years) is projected to grow from 16.9 percent to 24.5 percent over the same period.

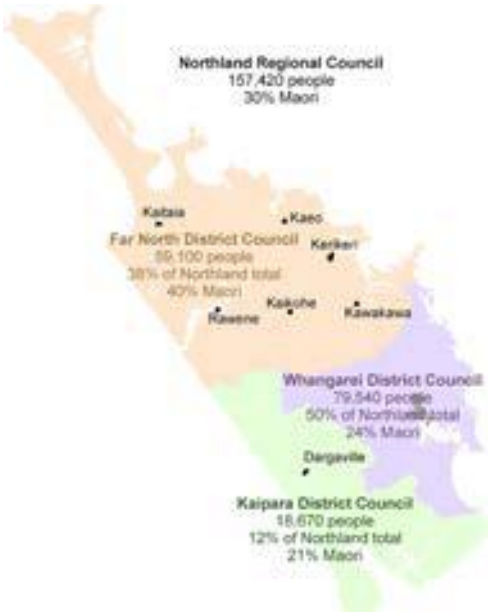
Socio-economic status

Northland has one of the most deprived populations in the country. While 20 percent of New Zealand's population is in the lowest quintile of the deprivation index, the equivalent measure for Northland is 35 percent.

The most deprived local authority area is the Far North District Council with 51 percent of the population in the lowest quintile; within this district the most deprived areas are Hokianga (83 percent), Whangaroa (41 percent) and north of the Mangamukas (55 percent).

Rurality

The only true urban area in Northland is Whangarei, which contains about one-third of the region's population. Kaitaia, Kerikeri, Kaikohe and Dargaville are rural centres with populations of about 5,000 each. Northland's population is distributed across a region which takes over five hours to travel from its northern to southern extremities and up to two hours west to east. Northland has the highest proportion of unsealed roads in New Zealand and public transport is very limited.



Our Health Profile

Māori

Māori experience low levels of health status across a range of health and socio-economic statistics. They comprise 30 percent of Northland's population, but 45 percent of the child and youth population, a key group for achieving long-term gains. Māori experience early onset of long-term conditions like cardiovascular disease and diabetes, presenting to hospital services on average about 13 years younger than non-Māori.

Child and Youth

The child and youth proportion of Northland's population is projected to decline over the coming years, but remains a priority because healthy children make for healthy adults and because children are more vulnerable than adults.

The deprivation index, which scores New Zealanders on a ten point deprivation scale, placed 70 percent of Northland adults and 85 percent of Northland children on the most deprived half of the index.

Older People

Our ageing population is placing significant demands on health services provided specifically for older people (residential care, home-based support services, day care). It also increases the prevalence of long-term conditions which become more common with age.

Long-Term Conditions

About three-quarters of deaths in Northland are from cardiovascular disease (heart disease and stroke) or cancer (the most common sites are trachea-bronchus-lung, colorectal, prostate and breast).

Twenty-one percent of adult Northlanders have been told they have high blood pressure and 13 percent that they have high cholesterol, both known risk factors for cardiovascular disease.

While diabetes is not a major killer in itself, it is a primary cause of heart disease and a great deal of unnecessary illness and hospitalisations are related to poor management of the condition.

Oral Health

Northland's five-year olds have repeatedly had the country's highest average score of damaged (decayed, missing or filled) teeth and one of the lowest percentages of teeth without tooth decay (33 percent compared with the national 41 percent). Data for adolescent oral health is scanty, but it suggests a similar, if not worse, picture.

Lifestyle Behaviours

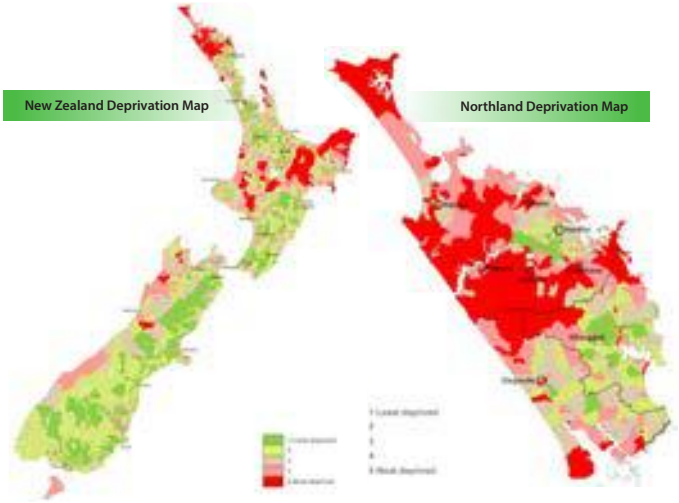
The way people live their lives and the behaviours they exhibit have an enormous effect on health status. There are a wide range of influences, but key ones are smoking, diet, alcohol and other drugs, and lack of physical activity.

Mental Health

'Rising to the Challenge', the latest national plan for mental health and addictions, outlines priorities for achieving further system-wide changes to improve service provision and outcomes. The plan covers both people who use primary and specialist mental health and addiction services, and their families and whānau.

Social Influences

Many of the causes of ill health rest with social and economic factors such as housing, education and economic prosperity. The health sector cannot affect these directly, but as a district health board we work collaboratively with other Government and local body organisations to achieve a healthier Northland.



Our Vision, Mission & Values

Our Vision:

A Healthier Northland
He Hauora Mo Te Tai Tokerau

Our Mission:

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.

Our Values:

People First - Taangata i te tuatahi - People are central to all that we do.

Respect - Whakaute (tuku mana) - We treat others as we would like to be treated.

Caring - Manaaki - We nurture those around us, and treat all with dignity and compassion.

Communication - Whakawhitiwhiti korero - We communicate openly, safely and with respect to promote clear understanding.

Excellence - Taumata teitei (hiranga) - Our attitude of excellence inspires confidence and innovation.

Values	Behaviours we want to see	Behaviours we don't want to see
People First Taangata i te tuatahi *People are central to all that we do*	• Makes people feel welcome, is polite, greets people and says 'hello', introduces themselves • Sees the person, takes time to make a connection • Smiles, warm, cheerful, friendly, polite	• Ignores people, unwelcoming • Dismissive, rude, puts their own needs first • Moody, grumpy, disinterested, unfriendly, moaning
Respect Whakaute (tuku mana) *We treat others as we would like to be treated*	• Clearly respects different cultures, backgrounds, views, ideas and roles. Takes my views seriously • Is supportive of people's dignity and privacy • Respects others' time. Is prompt, organised, prepared	• Makes people feel unimportant, judged, labelled, belittled, stigmatised or discriminated against • Rude or abrupt, gossips, makes people feel bullied • Reactive, late, rushing, keeps people waiting
Caring Manaaki *We nurture those around us, and treat all with dignity and compassion*	• Compassionate, gentle, considers people's feelings • Kind, attentive, helpful, checks if people need anything, takes time so people feel cared for • Acknowledges, appreciates and values people	• Ignores people's feelings, pain or discomfort • Puts own needs first, 'not my job', 'too busy', makes people feel like a nuisance, passes the buck • Doesn't thank people for their efforts, criticises
Communication Whakawhitiwhiti korero *We communicate openly, safely and with respect to promote clear understanding*	• Open, takes the time to listen and understand • Shares information, keeps people up to date, explains clearly, follows up. Honest • Works together and involves people, gives options	• Makes assumptions, doesn't really hear • Uses jargon, assumes people understand, keeps things to themselves, talks over or down to people • Dictates to / excludes family, whānau or colleagues
Excellence Taumata teitei (hiranga) *Our attitude of excellence inspires success, competence, confidence and innovation*	• Positive, aims high, keeps learning, shares knowledge • Is always self-aware, calm and professional • Safe, thorough, accurate, clean, hygienic • Speaks up, is accountable for their own actions	• Negative, 'it will do', stuck in old ways, closed mind • Unprofessional, overreacts, complaining, blame • Sloppy, untidy, dirty, cuts corners, inconsistency • Walks by poor care, is defensive when given feedback about behaviours or performance


KAI HANGAHIA HE HAUORA MO TE TAITOKERAU


Northland District Health Board
$129,054.00
countdown


A Healthier Northland
Population Health
Cost & Productivity
Patient Experience

Where the Money Goes

Whangarei, Dargaville, Bay of Islands and Kaitaia Hospitals (surgical and medical services, emergency departments, imaging, laboratories, maternity), public health	$265m
Primary Health (general practitioners, community dental services, radiology)	$58m
Health of older people (including residential care, rehabilitation)	$57m
Mental health services	$53m
Māori health services	$7m
Community pharmacies	$42m
Community laboratory services	$7m
Inter-district flows (publicly-funded health services paid to other district health boards and others for services provided to Northland patients)	$67m
TOTAL	$556m

EACH DAY IN NORTHLAND

On average, each day in Northland there are:

126	Emergency Department presentations
106	Inpatient discharges
2,113	Outpatient attendances
76	Outpatient missed appointments
14	Northland patients discharged by other DHBs
13	Chemotherapy attendances
46	Renal dialysis
45	Theatre events
251	Radiology exams
3,362	Lab Test Results - Hospital Laboratory Tests
3,570	Lab Test Results - Community Laboratory Tests
5	Babies born in hospital
5	Deaths in Northland
3	Mental health hospital admissions
500	Mental health community visits
1,887	General practice consultations
7,200	Prescriptions Items processed by Pharmacies
88	Community visits by allied health services
191	District nursing visits
133	Oral health visits in primary schools
8	Immunisations for 2 year olds
8	Immunisations for 8 month olds
40	Breast screens
880	Subsidised bed days in aged residential care
1,539	Hours of home-based support services for older people
28	People assessed by hospice services nursing teams

And we do much more!

Our Services

There are currently 153 GPs and 162 practice nurses across 38 general practices providing primary health care to Northlanders enrolled with Northland PHOs, and non-enrolled and non-resident patients.

Northland DHB has 220 contracts with 118 non-government organisations (NGOs) including Māori health providers and Whānau Ora collectives who provide a range of public health, primary health care and community services across Northland.

Figure 1
Northland PHOs

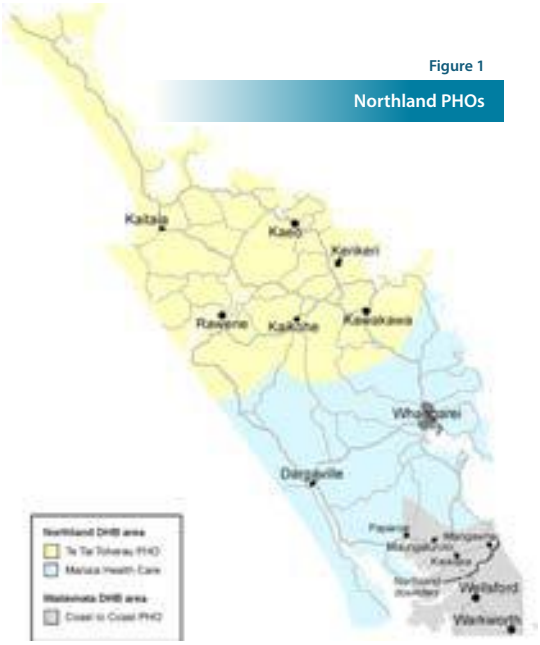


Figure 2
Māori NGOs

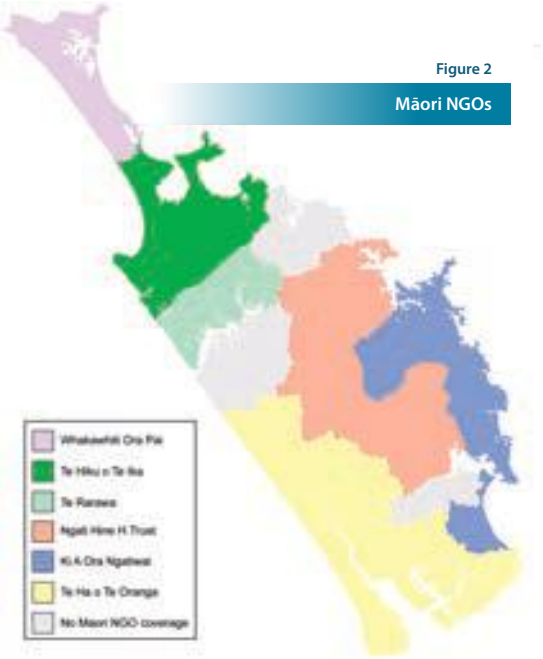


Figure 3
Northland Hospitals

Figure 4
Travel Distances


Every child has the right to...

Our People

The DHB's most valuable resource is its people. Engaging our employees through positive relationships fosters leadership at all levels and creates a dynamic and supportive organisational culture. This is integral to retaining and developing a workforce which contributes at the highest levels to providing the best health services to the Northland population.

Collaboration across services and occupational groups contributes significantly to staff engagement and innovation as does the DHB's positive relationship with its union partners.

Staff Engagement

Local engagement groups (noted below) continue to meet regularly and remain integral to maintaining a co-operative working environment. The objective of the groups is to provide a forum for ongoing constructive engagement between Northland DHB and the unions that represent its employees. They aim to:

- Ensure constructive and meaningful engagement between management and unions based on the principles of good faith;
- Ensure effective union participation and involvement through decision-making occurring as close as possible to the area of impact and involving input from unions throughout the process.

The partnership between clinical staff and management has continued to develop over the past year. Clinical staff have been engaged in strategic decision-making relating to the site re-development master plan and were also closely engaged in the extensive Patient Quality and Safety Review which took place in 2013/14.

The involvement of senior clinicians in decision-making about capital expenditure for clinical equipment has ensured greater robustness and enhanced engagement to ensure more effective procurement.

Executive safety walk-arounds covering most areas of the DHB hospital sites and involving both clinical and non-clinical staff were initiated in the previous 12 months. They have continued to provide staff with an opportunity to interact with management in a positive and constructive manner.

Union groups, made up of Northland DHB management representatives, union officials and delegates meet regularly, generally three or four times per annum. The groups include:

- Joint Consultative Committee – Association of Salaried Medical Specialists (ASMS);
- Local Engagement Group – Resident Doctors' Association (RDA);
- Bipartite Forum (all CTU affiliated unions are invited);
- Bipartite Action Group (strategic CTU affiliated union/DHB forum);
- Local Laboratory Engagement Group (NZMLWU);
- APEX/NZMLWU Forum (similar in format to the Bipartite Forum but involving unions not affiliated to the CTU);
- Care Capacity Demand Management Council (to become Care Capacity Operational Group).

Talent Management

Services identify and support potential leaders in various occupational groups to develop both technical and managerial skills, and ensure succession planning is facilitated. Training and development initiatives provide the opportunity to participate in management, leadership and clinical programmes locally, nationally and internationally including:

- Continuing medical education for medical staff;
- Professional development recognition programmes for nursing and midwifery staff;
- Conferences and courses for allied health and technical staff;
- Annual leadership programme and other regular leadership workshops co-ordinated by the Learning and Development team;
- 'Grown our Own' staffing initiatives through additional Māori scholarships for staff and a Pihirau Hauroa Māori Scholarship for students who whakapapa to Te Tai Tokerau hapu and iwi. (Note: This was the final year of the Pihirau Hauroa Māori Scholarship);
- Ngā Manukura o Āpōpō – the national Māori nursing and midwifery workforce programme. This programme is sponsored by the Director of Nursing and Midwifery of Northland DHB. Nearly 50 percent of the graduates from the Ngā Manukura o Āpōpō leadership programme have been from Northland;
- Hosting advanced medical trainees under the Health Workforce New Zealand (HWNZ) Advanced Trainee Scheme (ATS);
- Participation in HWNZ Northern Regional Training Hub for the 'Transitional Years' project for Post-Graduate Year 1 and Post Graduate Year 2 medical graduates. Northland also supports the Pūkawakawa programme in partnership with the University of Auckland.

Management and leadership capability

- Clinical leadership forums have been established for medical, nursing, midwifery and allied health leaders to develop their roles and support professional development of leadership and management skills. A key focus and priority for the DHB is the engagement between clinical networks and strengthening established partnerships between managers and clinicians at the clinical governance level. Clinicians are an integral part of the decision-making process that drives key projects within the organisation.

Partnership models include:

- Clinical leadership operating at senior executive level;
- Medical Executive Leadership Team;
- Maternity Governance Group;
- Nursing and Midwifery Executive Leadership Team;
- Allied Health Advisory.

Clinical governance mechanisms are established and operating at various levels of the organisation to support better decision-making and outcomes for patients. Clinical staff, including a representative from primary care, sits alongside managers on the Clinical Governance Board and work together to provide oversight of all DHB clinical activities.

The Northland Clinical Governance Forum was established this year to advise on and direct improvement in care and services across Northland with a particular focus on integration and clinical interface issues. The forum members are consumer representatives, clinical and management staff from Northland DHB and primary health care.

Health and Wellbeing

The Occupational Health and Safety team continues to promote a number of programmes and initiatives to assist employees with their personal health choices and to advise management on risk management strategies including:

- Pre-employment assessments and vaccinations;
- Influenza vaccinations for staff, students, contractors and volunteers;
- Smokefree/auahi kore support;
- Employee Assistance Programme;
- Active management of ACC rehabilitation plans, both work and non-work, towards a safe return to work;
- On-site occupational health assessments and physiotherapy treatment;
- Workplace assessment programme;
- Scheduled health surveillance programme;
- A range of specific policies and guidelines to protect and enhance employees' health, safety and wellbeing;
- Convenor of Health and Safety Review Committee to provide advice to senior managers on organisational risks and management of same;
- A collaborative approach to health and safety through a consultative agreement with unions on site and scheduled health and safety forums;
- Adverse event reporting follow-up to ensure employees are supported and given best advice;
- Regular health and safety reporting to management and to Ministry of Health;
- ACC Partnership Programme accreditation;
- Workplace hazard management advice;
- Deliver training programmes to managers, health and safety representatives and staff on patient moving and handling and health and safety;
- Managing staff ACC claims (rehabilitation);
- Retirement planning.

Northland DHB workforce profile	Total workforce: 2,674 active employees
Age Profile	Female average age: 47.5 years Male average age: 47.2 years
Ethnic Profile	European:.....44.4 percent Māori: .....14.1 percent Asian:.....5.9 percent Pacific: .....0.6 percent Other: .....3.1 percent Not stated:.....31.9 percent
Disability Profile	Specific data is not currently held for this category. Individuals with disabilities applying for vacancies are given full consideration based on the needs of the position
Gender Profile	Female: 2,117 employees Male: 557 employees

Element	Activity
Leadership, accountability and culture	• Leadership is encouraged and supported at all levels of the organisation; • Formal leadership groups exist across occupational groups; • The formal leadership programme implemented for senior clinicians in 2014 has been expanded to include non-clinical staff. The programme remains open to our Primary Health Organisation (PHO) partners; • A series, of in-house programmes is available to build leadership, accountability and is tied back to the values of the organisation; • 'In Your Shoes' and 'In Our Shoes' series of workshops was completed with patients and staff as part of the patient and whānau centered care programme which aims to build a positive organisational culture; • We re-launched our Values with Values-led behaviours focusing on positive behaviours that we expect to see from all staff; • Involvement of Te Poutokomanawa/Māori Health Service Directorate operating at all levels of the organisation.

Our People *(continued)*

Element	Activity
Recruitment, induction and selection	• Robust Northland DHB Values-based recruitment and selection processes; • Clinical and managerial positions are advertised via the national recruitment portal kiwihealthjobs; • Enhanced careers website and online recruitment process; • Improved pre-employment safety checks and compliance with the Vulnerable Children's Act; • Formalised Orientation Day for all new staff; • Pōwhiri or Whakatau guidelines developed for visitors and new employees; • Review of New Graduate Nursing Programme recruitment process; • Participation and support of the National Recruitment Process for Registered Medical Officers (RMOs).
Employee development, promotion and exit	• Local Workforce Enablement Group is developing a strong platform for growing capacity of clinical staff across the various occupational groups. This group includes our PHO and education partners; • Participation in the Regional Workforce Strategy Group; • Collegial relationships and a strong teaching programme help develop RMOs towards their career choices; • Learning and Development training programme continues to provide valuable programmes that meet the developmental needs of our workforce. These programmes are open to Hospice and our PHO partners; • e-learning programmes continue to be developed where appropriate to provide clinical and non-clinical education. These programmes are available to PHOs, NorthTec and some NGOs; • Nursing and Midwifery orientation days; • Departmental orientation in place; • Human Resource orientation for managers; • Continuing medical education opportunities provided for senior medical staff; • Nursing and Midwifery staff encouraged and actively supported to participate in professional development programmes; • On-line confidential Staff Exit Survey offered to all department staff, with the opportunity for 'face to face' exit interviews also offered.
Flexibility and work design	• Flexible work hours based on employee needs and the requirements of the position are available; • Specific disabilities are recognised and provided for; • Cultural competency and Tikanga best practice workshops and on-line learning enable staff to increase their knowledge and understanding of Te Ao Māori (Māori world view).
Remuneration, recognition and conditions	• Remuneration and conditions are in line with collective employment agreements; • Transparent job evaluation criteria, developed in consultation with relevant unions, are in place for a range of employee groups; • Specific merit programme criteria are available for most employee groups; • Annual Nursing and Midwifery awards celebration; • International Nurses Day and International Day of the Midwife are recognised and celebrated; • Development of the Northland Health Sector Awards, a 'whole of health sector' bi-annual award ceremony that includes Matariki Hauora Māori Awards, Northland DHB Quality Awards, Nursing and Midwifery Awards and recognitions of Northland DHB's published authors and presenters.
Harassment and bullying prevention	• Northland DHB has recently refreshed its corporate Values-led behaviours and the expectation of positive workplace relationships demonstrated by behaviours that do not support workplace harassment or bullying; • Values Champions are available to assist staff in addressing issues where requested; • The organisation continues to maintain an awareness of and intolerance for unacceptable behaviour in the workplace and to manage this in accordance with the revised Managing Unacceptable Behaviour in the Workplace policy; • Managers are required to attend training to assist and support their ability to manage unacceptable behaviour in the workplace; • The Managing Unacceptable Behaviour in the Workplace is referenced against the Code of Conduct and 'Northland DHB Values and Behaviours'. These policies are available to all staff via the 'Northland DHB intranet – Staff Central' which has a link dedicated to 'Acceptable Behaviour in the Workplace'.
Safe and healthy environment	Northland DHB recognises its obligations to the safety and wellbeing of its staff and continually reviews these obligations with a view to providing an environment and culture where safety and wellbeing are paramount. This is supported by the following programmes: • Employee Assistance programme; • Health and Safety Policy and training; • Employee vaccination programme; • ACC partnership programme; • ACC annual partnership audit programme; • Renewal of ACC Workplace Safety Management Practices; • Workstation assessment programme; • Moving and handling programme; • On-site Occupational Health Clinics; • Smokefree/auahi kore support; • Gym and swimming pool at Whangarei and a gym at Kaitaia Hospital; • Care Capacity Demand Management Programme; • Patient Safety and Quality Improvement Review; amendments to job descriptions to include Patient Safety and Whānau Centred Care plus Health and Safety key performance indicators.

Workforce Development

Our organisation continues to identify and support potential leaders in various occupational groups to develop both technical and managerial skills and ensure succession planning is facilitated. This is key to attracting and retaining skills for Northland DHB to provide high quality, fit-for-purpose care and services to meet both the current and future needs of the community in line with Government expectations.

To attract and grow our workforce to meet service needs, training and development initiatives are needed. These include opportunities to participate in management, leadership and clinical programmes locally, nationally and internationally. Staff satisfaction and retention is enhanced as training and development aligns to the Northland DHB Values, organisational compliance requirements, service needs and staff's own professional development. Further development and implementation of e-learning has enabled greater access to our primary health care and community partners to share learning, communication, knowledge transfer and skill development. This ensures best practice is implemented across Northland DHB and the wider health sector in Northland.

National:

Health Workforce New Zealand (HWNZ) priorities, aligned to the Statement of Intent 2014-2018 are to continue to strengthen the health and disability workforce by:

- Improving recruitment, retention and distribution of the health and disability workforce;
- Delivering on health and disability workforce priorities through increased collaboration, intersectoral partnerships and regional approaches to improve productivity and economies of scale;
- Aligning workforce development to meet service demand;
- Maximising workforce resources and reducing duplication;
- Strengthening health workforce intelligence to provide high quality support and advice;
- Developing the workforce.

Regional

During the 2014/15 financial year HWNZ continued to work nationally to achieve a more strategic and integrated approach to career planning. A major focus of this work is the development of and support for regional training hubs.

The Northern Regional Training Hub (NoRTH) continues to focus on integration and co-ordination of pre-vocational medical training as well as taking the opportunity to develop a multi-disciplinary approach to education and training, placements and HWNZ initiatives.

Northland DHB holds the regional hub contract for Kia Ora Hauora (KOH). This has been established to increase the number of Māori entering first-year tertiary study, and to recruit and retain Māori in health-related career pathways and into the health sector workforce. The National Co-ordination Centre co-ordinates all regional initiatives under one recognisable brand to best utilise promotion and communication tools.

The northern region achieved its annual goals by recruiting and supporting 220 Māori on to a health study pathway (target 125) with 1,243 Māori registered on the Kia Ora Hauora database. Of those registered, the northern region has supported:

- 717 Māori (total between 2010-2015) on a health study pathway;
- 132 Māori (April-June 2015) on a health study pathway;
- 164 Māori in 2015 who commenced their first year of tertiary study.

Northland DHB has been working with the Northern Regional Director of Training to develop a regional management training and development programme to support current staff in management roles, as well as succession planning.

Northland

A Workforce Enablement Steering Group has been established to ensure all workforce initiatives align to the Northland Health Services Plan and the national and regional workforce strategies. Membership of the Steering Group consists of representatives from primary and secondary health organisations and the local tertiary education provider NorthTec. The focus of the group includes:

- Gathering workforce data intelligence;
- Building a capability and capacity work plan;
- Culture and change leadership;
- Employment framework;
- Commitment to regional investment and collaboration;
- Reviewing and updating the Northland Workforce Plan.

Northland DHB continues to co-ordinate and allocate HWNZ funding for post-graduate study for nursing and midwifery and the non-regulated workforce. In addition, Northland DHB pursues 'Grown our Own' staffing initiatives by providing additional Māori scholarships for staff. There is also a training fund for non-regulated Māori health and disability workforce to build their capability and capacity.

Our relationships with the University of Auckland, Auckland University of Technology and NorthTec continue to provide

future opportunities for doctors, nurses, midwives and allied health professionals to join the organisation.

Over the last three years, a Northland DHB goal has been to encourage more Māori students and adults into health and disability fields. This applies particularly to areas where Māori are under-represented as health professionals and over-represented in terms of health needs. Our objective to 'grow our own' workforce has led to a number of development projects which have been implemented with much success:

- HWNZ non-regulated training fund has supported 20 Māori Kaimahi into building their capability and capacity to further their professional development in the health sector;
- The fields of study for the non-regulated training fund have predominantly covered training in the National Certificate L4 Hauora Māori;
- At a Northland level, there have been a number of youth accessing workforce and workplace experience in the health sector through the Kia Ora Hauora programme. Northland DHB provides access to the suite of tools and mechanisms to support students into a tertiary study career pathway in health.
- As at June 2015, 80 Year 9-13 Māori students from across the northern region, who are interested in health as a profession and who are taking science subjects, have participated in the inaugural Rangatahi Health Symposium at Ko Awatea in Counties Manukau DHB.

There, 20 Year 12-13 students accessed health professionals in nursing and midwifery, dietetics, medicine, physiotherapy, and Māori mental health to gain information about the various health disciplines.

Other non-regulated training has been undertaken by staff in hotel services with staff studying towards either a Level 3 Orderlies Qualification or a Level 2 in Laundry Processing.

Clinical Leadership

Involving clinicians in planning and management discussions and decisions is essential to improving services. Northland DHB's clinicians form an integral part of our management structure and processes and are closely involved in regional planning processes. A number of clinical governance groups have been established by Northland DHB to improve systems and quality of care, and involve clinicians from both Northland DHB and the community sector.

A Northland Clinical Governance Forum has been formed this year. The group focuses specifically on governance relating to interface issues between primary and secondary care and the integration work being done in this area. A number of senior GPs and other representatives from primary care join hospital clinicians and managers in this group.

Regional

Clinical leadership has been a strong feature of the development of the Northern Region Health Plan, which is based on the Triple Aim of population health, patient experience and value/sustainability. The plan states that achieving these aims implies:

- Health professionals leading the planning process;
- Trust and respect among health professionals supporting inter-disciplinary and inter-organisation collaboration;
- Multi-disciplinary patient-focused teams with alignment of expertise, capabilities, availability, desired outcomes;
- Strong clinical governance and clear accountability to deliver quality healthcare;
- Development of leadership capability to ensure effective utilisation of scarce resources.

The plan's three priority goals (First Do No Harm, Life and Years, and Informed Patients) have been informed by numerous work streams, all of which have strong clinical leadership and involvement. Clinicians design and lead the campaigns which form the focus of future activity for many of the work stream areas.

The plan promises that clinical leaders will be given stronger mandates to shape and deliver services in partnership with management. Accountability for delivering on the plan will naturally rest with chief executives and chief medical officers/advisors, but accountable to them is a regional clinical governance group which has oversight of the direction and implementation of the three strategic goals, service planning and relevant business partnering.

To support the ongoing development and implementation of the Northern Regional Health Plan, clinical leaders from Northland, including primary and secondary services, participate in regional clinical networks and regional working parties and committees.

Northland clinicians have taken lead roles in regional projects relating to colonoscopy services, major trauma, spinal impairment, care of the elderly and hyper-acute stroke.

Northland

The Government wants better, sooner, more convenient health care for all New Zealanders. This means strong priority is given to improving health care services within available resources.

To encourage and support clinical networks and clinicians, Northland DHB has re-focused its clinical frameworks.

Medical Executive Leadership Team

As a senior medical leadership forum, the Medical Executive Leadership Team (MELT) has oversight of medical workforce issues, quality and safety frameworks and ongoing review of medical leadership structures.

Key tasks include some inter-departmental case reviews, use of clinical indicators and audit and participation in benchmarking activities with the Health Roundtable. Chaired by Northland DHB's Chief Medical Officer, membership includes clinical directors and clinical heads of department.

Alliance Leadership Team

Northland DHB's Alliance Leadership Team - Te Roopu Kai Hapai Oranga - is made up of clinical leaders, key managers and other experts from across the Northland health sector. This consortium of organisations provides leadership and is responsible for strategic decisions to ensure the best use of health resources across the district.

Service Level Alliance Teams (SLATs) are established by the Alliance Leadership Team when required, to redesign or change the way specific services are implemented. The members of a SLAT bring specific experience or expertise relevant to the task of the group, and include both the health professionals and organisations directly impacted by the service.

A Rural SLAT was established in the 2014/15 year and has held eight meetings. The overall purpose of the Rural SLAT is to participate in assessing current rural health services and distribution of funding: planning for models of service delivery that best meet the needs of their rural communities and to ensure that there is equitable and effective access to rural primary healthcare services.

The Ministry of Health has devolved all rural after-hours funding to district health boards and this officially came under the oversight of the Rural SLAT from 1 July 2014.

Nursing and Midwifery Executive Leadership Team

The Nursing and Midwifery Executive Leadership Team (NMELT) provides strategic and operational nursing and midwifery leadership across Te Tai Tokerau ensuring safe and competent practice that contributes to effective health outcomes for the population we serve.

The aim of NMELT is to encourage promotion of evidence-based practice, quality improvement initiatives, workforce development and implementation of innovative models of service delivery across the continuum of care. Chaired by Northland DHB's director of nursing and midwifery, membership includes nursing and midwifery representatives from across Northland DHB and primary health care.

Northland's Taumata group is a senior nursing and midwifery leadership forum for the associate nursing and midwifery leaders across the district. Chaired by the director of nursing and midwifery, the membership of the group includes the associate director of nursing from Manaia and Te Tai Tokerau PHOs, the associate director of nursing and associate director of midwifery for Northland DHB, the professional nurse leaders for mental health and the nurse consultant/manager for health of older people.

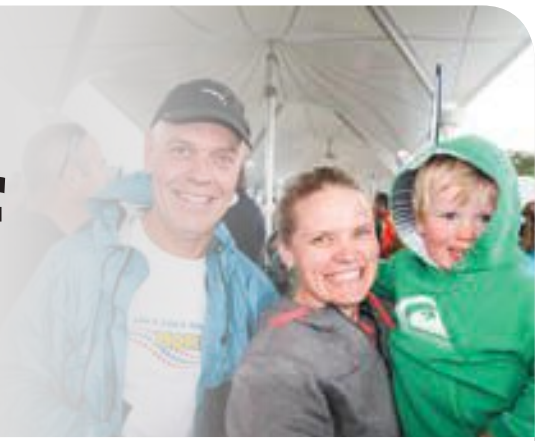
Allied Health Advisors (AHA)

This group comprises the professional advisors of all the allied health professions. The group reports directly to the chief executive and the clinical governance board. A chair and appropriate representatives for specific forums, such as the regional clinical leadership meetings, are elected each year by group members. Support is provided by Northlands DHB's Health of Older People and Clinical Support Service.

The professional advisors work through their own internal and external networks to provide advice to senior managers and to advocate on behalf of the patients that they care for. In addition, they advise on the various legislative and standards requirements of the individual professions.

Work is continuing to further develop this group to ensure that scientific and technical staff are represented in all the major decision-making forums within the organisation.

Statement of Performance



Overall progress – High Level Measures

Northland DHB's vision is for a healthier Northland. We aim to achieve this through implementing our Triple Aim objectives:

Population Health: improving health status overall and reducing inequities

Patient Experience: how the system deals with people; quality and safety

Value and Sustainability: how wisely we use our resources; value for money.

The Triple Aim forms the basis of the Northland Health Services Plan (NHSP). The plan was driven by the knowledge of an impending increase in demand from the ageing population and the continuing growth in numbers of people with long-term conditions (especially diabetes, heart disease, cancers and respiratory conditions). Predictions made in 2012 were that unless significant changes were made to services in Northland, by 2027 Northland DHB would need an extra 170 beds (almost as many as Whangarei Hospital presently has) and be in the red financially to the tune of $70 million annually.

The Northland Health Services Plan has six Headline Targets, two under each of the Triple Aims. Three of its Headline Targets (the first three below) have been incorporated into the Statement of Performance (SP) as High Level Measures. The other three – same day access to primary care; $5 million annual value-for-money savings; hospital labour productivity benchmarking in the top five DHBs – have been excluded because they are measures of outputs (provision of services) and not appropriate as High Level Measures (which should describe impacts on people's health). In addition the SP includes two other high level measures concerning overall mortality and infant mortality. The six High Level Measures are:

- Life expectancy gap between Māori and non-Māori to reduce by two years by 2017;
- Unplanned hospital admissions for Northlanders will reduce by 2,000 by 2017;
- >95% of patients report they would recommend the service provided;
- Mortality rate (age-standardised) for the total population;
- Infant mortality;
- Gaps between (a) Māori and non-Māori (b) Northland and NZ will reduce over time.

Collectively, these measures form a picture of how well Northland DHB is doing to improve health, which is why they are pitched at the whole-population level (apart from infant mortality which is recognised internationally as a sensitive indicator of the health of a society and the performance of its health services).

The rest of this section examines each of the High Level Measures in turn, ending with an overall summary of progress on inequities.

At the Impact Measure level, the next level down from High Level Measures, there are 25 further indicators that describe performance in relation to specific health services and population groups. These are examined in the second section of the SP.

Life expectancy

Between 2010 and 2014 Northland has seen increases in life expectancy (LE) for females of both Māori (73.9 to 75.9 years) and non-Māori (83.3 to 84.5 years) ethnicity. For males the picture is not so positive; Māori males were predicted to live slightly shorter lives (72.0 to 71.3 years) while non-Māori have shown no real change (both about 78.5 years).

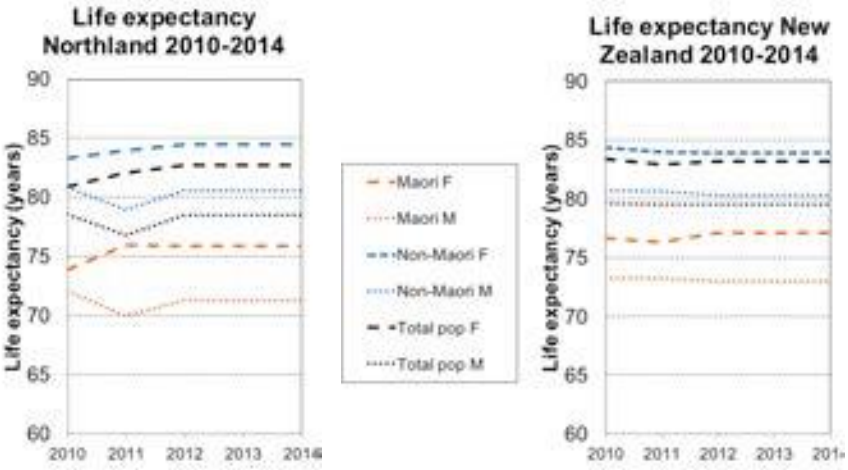
While Northland's LE lags slightly behind New Zealand's for all these population groups, the rate of improvement generally compares favourably with national trends. Across New Zealand, Māori females were predicted to live longer (76.6 to 77.1 years) but the opposite is true for non-Māori females (84.4 to 83.9 years). Males were predicted to live shorter lives whether they were Māori (73.3 to 73.0 years) or non-Māori (80.7 to 80.3 years).

In 2012 the Northland Health Services Plan set a Headline Target that over five years the life expectancy gap between Māori and non-Māori would reduce by two years. Between 2010 (the NHSP's baseline data year) and 2014 the LE gap for females reduced from 9.4 years to 8.6, suggesting that at the current rate of improvement we might get halfway towards target. For males however the trend is in the opposite direction, with the LE gap increasing from 8.8 to 9.3.

Numerous activities support an increase in life expectancy for Northlanders and a reduction in the ethnicity gap. A range of health promotion initiatives exist to encourage health behaviours. People in contact with primary and community services and hospital patients receive support and advice to stop smoking. Services such as immunisations, screening for cancer, monitoring of diabetes management and heart disease either prevent conditions developing, pick them up early so treatment can be most effective, or provide regular monitoring once they are established. Various initiatives to reduce suicide rates have been put in place across Northland in both the health and non-health sectors. The Northland Health Services Plan is establishing five major projects (Fit for Life, Urgent Healthcare, Neighbourhood Healthcare Homes, Patient and Whānau Centred Care, First 2000 Days) that should also have positive effects on life expectancy.

While life expectancy is affected by numerous economic, social and cultural factors outside a DHB's control, the above analysis suggests that Northland DHB is largely on the right track for women, but more thought needs to be given to strategies for males, especially Māori males.

Data availability and timing. Life expectancy data comes from Statistics New Zealand. Until 2011 it was produced for both sexes and total population, but since then it has been for males and females only. Representations are being made to Statistics NZ to remedy this.



Total acute admissions to hospitals

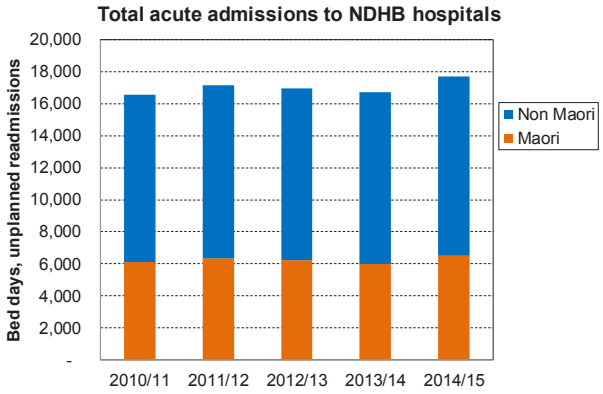
The goal of reducing unplanned readmissions by 2,000 by 2017 was set in mid-2012. The intention is that it will indicate how well conditions, especially long-term conditions, are being managed in the community and primary care settings.

There is no set definition of an unplanned readmission. As a proxy we have decided to measure acute admissions because they occur urgently, without forewarning (in contrast to elective admissions, which can be planned because the needs are less urgent).

Between 2011/12 and 2014/15, bed days for acute admissions increased by 538 from 17,148 to 17,686.

Over those years, Māori have comprised 36% or 37% of total acute admission bed days. This is higher than the 30% of Māori in the Northland population, a reflection of higher need.

The intention to reduce acute admissions by 2,000 over five years was a deliberately ambitious part of Northland DHB's strategy to shift the health system more "upstream". It represents a 12% decrease over the base year at a time



when health needs have been rising steadily. The Northland population has grown faster than suggested by the 2006 base projections which were current at the time the 2,000 bed days target was set (according to 2006-base projections Northland's population in 2015 would be 161,100, whereas latest estimates based on the 2013 Census put it at 168,200). The population is also ageing, and an older population creates higher needs.

It takes time to change health systems. Acute admissions cannot be seen in isolation but are a result of complex interactions between communities and providers (particularly primary and secondary services), so changes need to occur across the spectrum. Numerous projects are in place that will contribute towards reducing acute admissions in the medium term:

- Neighbourhood Healthcare Homes, one of the NHSP projects. It aims to free up capacity in primary care to meet the needs of an ageing population, ever more complex demands and improve Māori health. There are two key approaches. Firstly, though reorganising the way things are done in practices, such as using patient portals, increasing nurse clinics, stratifying the population to tailor care to need, changing booking systems, and standardising the workplace and processes. Secondly, through linking up general practice with other community-based services more effectively;
- a new pathway of care for chronic obstructive pulmonary disease;
- eReferrals, which allows GPs timely access to advice from hospital specialists, thus enabling them to make more informed decisions about which patients it is appropriate to treat in the community and which are better referred to hospital services
- the other projects under the Northland Health Services Plan:
    - Patient and Whānau Centred Care (improving quality, safety and the patient experience);
    - Integrated Urgent Health Care (ensuring access to the right care at the right time by the right people for acute need);
    - First 2000 Days (pre-conception to 5 years);
    - Fit for Life (smoking and obesity).

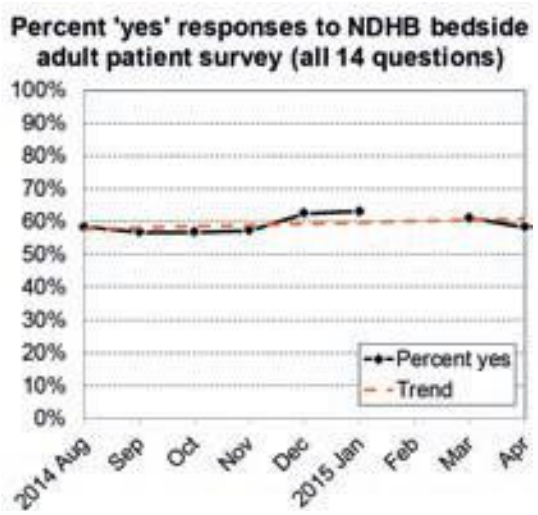
Patient satisfaction

One of the six Headline Targets in the Northland Health Services Plan was '95% of patient's report they would recommend the service provided'. Since then Northland DHB has introduced a new adult patient survey, but it no longer has a comparable question. Instead it asks fourteen questions about specific aspects of a hospital stay. This makes it difficult to compare the new survey's results with responses to the old 'overall satisfaction' question. An attempt was made by totalling the positive responses across all fourteen questions, which generated an overall result of 59%. This is far removed from the old survey's 'overall satisfaction' result of 88%.

Superficially this looks worrying, but service provision cannot have changed so radically in a year that inpatient satisfaction would drop by that much. More likely, there is a disconnect between the fourteen specific questions and the old question about the totality of the care provided. The fourteen questions ask about such things as knowing the role of each person involved in their care, being encouraged to ask questions, participation in discharge planning, access to patient records, signage around the hospital and navigation from carpark to hospital. All of these are important details, but it is possible that some of these might have been imperfect but a patient could still be satisfied overall. Patients have to be quite ill to be admitted to hospital, so their highest priority is to get as well as possible again; as long as that is achieved (and judging by surveys in past years it was for most patients most of the time) they are likely to be satisfied as a whole with their stay in a way that may not captured by the fourteen detailed questions.

The adult bedside survey uses iPads to survey ten patients per ward per week in Whangarei Hospital. Analysis so far has not been by ethnicity, but this will be carried out in future. The survey will be extended to district hospitals once access to WiFi is achieved.

The Health Quality and Safety Commission also has a survey of inpatient experience which asks twenty questions across five categories (communication, partnership, co-ordination, physical and emotional needs, other issues) but it too does not have an overall satisfaction question. It generates a 'weighted score' approach (which takes actual results and adjusts them to balance out differences in response rates between, say, females and males) to make across-DHB results comparable. On this basis Northland DHB at 84% compares well with the national average of 85% for May, the latest data available.



Dissemination and responses to the national survey are by text and email, a different delivery system from the previous paper-based postal survey. Response rates are low (Northland DHB's was 18% and nationally it was 24%). In Northland, Māori comprised 14% of discharged patients surveyed and only 8% of the total sample, so analysis by ethnicity is as yet not viable. Discussions aimed at improving the response rate are occurring across the country.

For children, in contrast to adults, the 2014/15 survey did contain a comparable 'overall satisfaction' question which asked about recommending the hospital to family and friends. The net positive response to this (9s plus 10s on a ten-point scale) was 93%, close to the 95% NHSP target.

It appears that for children we are more or less on track towards achieving the 95% Headline Target. For adults however it is difficult to assess performance because the information now being gathered doesn't relate directly to the target set three years ago. Since the new approach is being adopted nationally, it would make sense to set new targets based on the fourteen questions, and perhaps focus on a few that are of the highest priority.

Northland DHB's electronic bedside survey will be useful for implementing changes because it is more specific in identifying areas that need attention. Each month, individual wards will be given an A3-size poster displaying their results. This will

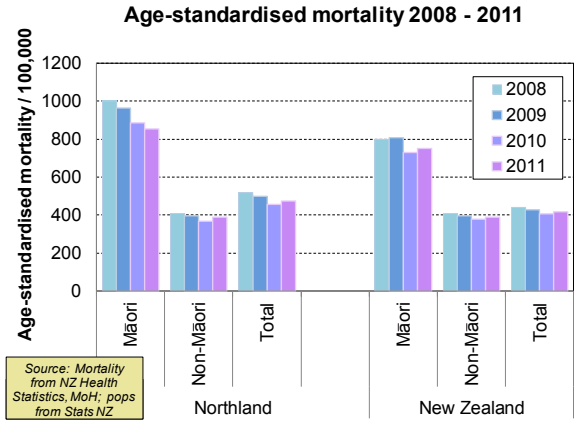
highlight areas of low ratings for improvement, and display the top three or four high ratings to celebrate what the wards have done well. The charts will also have an overall satisfaction score (the average of the 14 questions, as described above) which will incorporate trend information. Consideration will be given to add an 'overall satisfaction with current hospital stay' question which will give us an overall impression of inpatient satisfaction with the care and treatment provided that goes beyond a list of specifics.

Mortality overall

This analysis uses age-standardised mortality rates. If actual rates-per-population were used, the Māori population's much younger age structure would mask the real rate of death. Māori and non-Māori mortality data has thus been adjusted as if both populations had the same age structure. The resulting mortality rates are not 'real', but they can be compared.

In Northland, 2011 age-standardised mortality for Māori (854/100,000) is more than twice that of non-Māori (390/100,000). The Māori rate has dropped by 17% between 2008 and 2011, considerably faster than the non-Māori rate (5%).

Consistent with the discussion about life expectancy above,



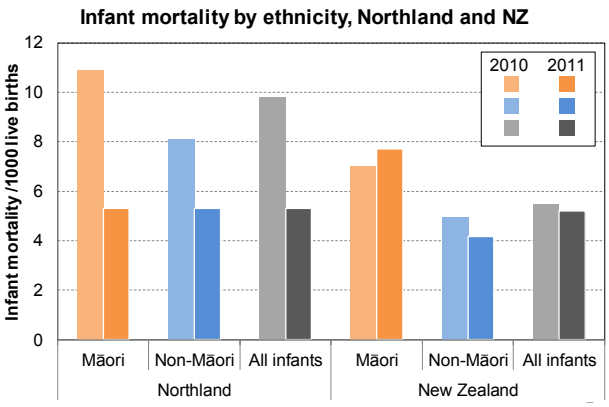
mortality among non-Māori in Northland (390/100,000) is almost identical to that of non-Māori New Zealanders (389/100,000). Northland Māori have a higher mortality rate than Māori New Zealanders as a whole (854/100,000 in Northland compared with 752/100,000 nationally) but the gap has been decreasing from 204/100,000 in 2008 to 103/100,000 in 2011.

The ethnic disparity is explainable largely through the early onset of long-term conditions among Māori. The Northland health sector has some influence on keeping people healthy and well. Studious and successful efforts have been made to reduce infant mortality (see under the next heading), there is an extensive range of preventive and health promotion measures, screening is undertaken for some cancers, and primary and community services emphasise early intervention and ongoing management of long term conditions (the impact measures section of the SP mentions breastfeeding rates, screening for breast and cervical cancer, immunisation, management of diabetes and monitoring of risk factors related to cardiovascular [circulatory] disease). Long-term conditions originate from a range of factors, on which the health sector can have at best partial influence. The two major factors are smoking and obesity, both of which have a strong relationship with deprivation.

Data availability and timing. 2011 is the latest mortality data that can be age-standardised (data on total deaths is available up till 2014, but it doesn't have ethnic or age breakdowns to allow age-standardising to be performed). It is updated annually by the Ministry of Health but lags a few years because of delays in determining causes of death for some people through coroners' processes.

Infant mortality

Unlike overall mortality, the signs in infant mortality are encouraging. Rates between 2010 and 2011 have been decreasing in both Māori (10.9 to 5.3/1,000 live births) and non-Māori (8.1 to 5.3). In 2010 the disparity between the two groups was much smaller than for all-ages mortality (10.9 Māori, 8.1 non-Māori) and in 2011 the rates were the same at 5.3/1,000 live births.



With limited years' data it is difficult to establish a clear picture, but Northland's infant mortality seems to be improving in relation to New Zealand's. For Māori in 2010, the Northland rate was higher than the New Zealand rate by 3.9/1,000 live births (10.9 compared with 7.0 respectively) but by 2011 the situation had reversed, and Northland's rate was lower than New Zealand's by 2.2/1000 live births (5.3/1000 live births compared with 7.7). While the non-Māori rate has shown an improvement between the two years (from 8.1 to 5.3) it remains higher than the national non-Māori rate of 4.2.

Northland's infant mortality in 2011 compares well with DHBs of similar population size and ethnic composition. For Māori our rate of 5.3/1000 live births is better than Taranaki and Tairawhiti (both 10.9), Hawkes Bay (9.7) and Lakes (7.6) DHBs. Our non-Māori rate, also 5.3/1000 live births, isn't as low as Taranaki's (3.0) but it is better than Tairawhiti (9.8), Hawkes Bay (8.2) and Lakes (6.3).

The improvements in infant mortality suggest that the initiatives put in place by Northland DHB, particularly among Māori, are working. Immunisations prevent communicable diseases from occurring. Initiatives to raise breastfeeding rates and reduce smoking rates among pregnant women will create healthier, more resilient babies. 'Pepi pods' and wahukura, specially made portable sleep spaces that ensure vulnerable babies can sleep safely, have been introduced to reduce risk factors for Sudden Unexplained Death of Infants. Also being

pursued is 'High Five' notification and enrolment of babies at five key service providers immediately after birth, so that the risk of infants falling through the gaps is minimised. A joint project between Manaia Health PHO and the Health Promotion Agency aims to reduce the impact of maternal/parental addiction to alcohol and other drugs (including tobacco), gambling and other significant issues such as domestic violence, depression and poor housing.

Data availability and timing. Data on infant mortality is sourced from the Ministry of Health, which has a rigorous process to ensure it is valid before releasing it. While data at DHB level stretches back many years, only the last two years of data have offered an analysis by ethnicity (it runs a few years behind for the same reasons as overall mortality data).

Reducing inequities

On these global indicators, there remain substantial inequities between Māori and non-Māori in Northland, though there are some signs of improvement. Between 2010 and 2014 the life expectancy gap between Māori and non-Māori females has reduced from 9.4 to 8.6 years. For Māori males the picture is worse however; over the same period the gap has increased from 8.8 to 9.3 years. Comparisons of life expectancy for Māori in Northland and New Zealand present a mixed picture too. While Māori females and Māori males in Northland both live shorter lives than Māori nationally, the gap is narrowing for females (from 2.7 to 1.2 years over the same period) but widening for Māori males (from 1.2 to 1.7 years).

Māori are disadvantaged in unplanned readmission bed days (comprising about 37% compared with their population share of 30%) though this share has remained stable for at least the last seven years.

Discouragingly, the age-standardised mortality rate for Māori is more than twice that of non-Māori (854/100,000 compared with 390/100,000). The Māori/non-Māori difference in infant mortality is much smaller and appears to be reducing, from 2.8/1000 live births in 2010 to zero in 2011.

The current patient survey does not analyse results by ethnicity, mainly because the sample size is too small to make the results valid. However analysis by ethnicity is planned for the future once sample sizes are increased.

A number of targeted approaches have been taken where there are greater inequities evident in health services, and these have produced some favourable results for this last year. While both tobacco targets (primary care and hospital) have been achieved, a more strategic approach to reducing smoking rates is being taken in Northland by going beyond the provision of advice and concentrating on cessation; the focus will be on priority groups, especially Māori, youth and pregnancy. Hospital tobacco services are delivering well to Māori and there is no disparity in service provision.

Public health tobacco control has focussed on youth and pregnant Māori women to provide more incentive to quit; reducing smoking among pregnant mums would have a marked effect on the health of babies, improving birthweight and overall health and reducing Sudden Unexplained Infant Deaths (SIDS). Lactation consultants have been predominantly supporting Māori women to continue breastfeeding and provide good education that meets their needs. An early intervention prevention pilot programme targeting Māori who are pre-diabetic focuses on health literacy, healthy activity and healthy eating. This has created good quality evidence on how to address the onslaught of diabetes in Māori, though more work is required regarding diabetes care and management. Planning and developing a role to support more Māori to access cancer treatment in a timely manner has come to fruition; other services also have the potential to be improved by such Māori-specific initiatives. Breast cancer screening services have used a Māori health provider to assist Māori women in attending clinics and reduce 'did not attends' (though, as described later on, coverage rates have effectively reduced as a result of changes in population data). Big improvements have occurred in the last couple of years for Māori receiving cardiovascular risk assessments in primary care (from 76.6% of the target population to 86.7%). School Based Throat Swabbing services in Decile 1-3 schools have improved rheumatic fever screening through detection of positive Group A Streptococci in Māori children aged 5 to 15 years. Immunisations for Māori children aged eight months have improved steadily (by 1% between 2013/14 and 2014/15) though they are still some way from target. Whānau Ora programmes such as One Heart Many Lives are established on a kaupapa Māori basis. Northland DHB has established an Equity Kaitiaki group to provide oversight and advice on a range of plans. Their task is to ensure that all of the Executive Leadership Team understands the importance of improving equity, how services may be improved and which interventions are effective.

Living within our means

Northland DHB recorded a small surplus in 2014/15 despite a tight fiscal environment of ever-increasing acute demand, especially in clinical services and mental health. There was also the requirement to move to a maximum four month wait for elective services. We achieved this by a continuous focus on improving productivity, reducing costs where possible and seeking value for money solutions and health outcomes.

At a national level, Northland DHB worked closely with Health Benefits Ltd to ensure that national initiatives such as Banking and Insurance, National Infrastructure Platform, Finance, Procurement and Supply Chain, etc. will deliver realisable and realised benefits to Northland DHB. At a regional level, Northland DHB also worked closely with healthAlliance and the Auckland DHBs to deliver a programme of regional procurement and capital planning that resulted in reduced operating costs and avoided capital costs.

At a local level, productivity and cost savings initiatives undertaken included an ACC revenue initiative, an inventory reduction programme, a vehicle fleet rationalisation exercise, and effective utilities management including installation of energy-efficient LED lighting.

Overall summary

High Level Measure	Target	Baseline	Result 2014/15	Performance	Comments	Data limitations
Life expectancy	Māori/non-Māori gap to reduce by 5 years 2012-2017	2010: 9.4 females 8.8 males	8.6 9.3	✓ ✖	For Northland Māori of both sexes LE is shorter than NZ's. Non-Māori of both sexes in Northland live longer.	Data not available by total population since 2012 (this gap is being addressed with Stats NZ).
Acute admissions to hospital	Reduce by 2,000 2012-2017	2012: 17,148	17,686	✖		
Patient satisfaction	95% of patients would recommend service provided	2014 88%	2015 59%	n/a	Results can't be compared with target because the questions asked are different. Limited national data, but so far NDHB is similar to the NZ average.	Current survey doesn't include: • an 'overall satisfaction' question to enable comparison with the target • data by ethnicity (though that will change).
Mortality overall (age-standardised)	No specific target, though both relate to the life expectancy target	2008: Total 516.6 Māori 1001.3 Non-M 409.4	2011: 439.5 797.3 408.8	✓ ✓ =	Māori/non-Māori disparity has been reducing for females but increasing for males. Māori rate in Northland still higher than NZ's, but gap is reducing. Non-Māori rates in Northland and NZ are essentially the same.	2011 data is the latest available for age-standardisation. Data exists for 2012-2014 but so far is for total Northland population only (i.e. it doesn't have the age and ethnic breakdowns to allow age-standardisation to be carried out).
Infant mortality		2010: Total 9.8 Māori 10.9 Non-Māori 5.3	5.3 5.3 5.3	✓ ✓ ✓	Māori rate in Northland now lower than NZ's. Non-Māori rate is still higher, but the gap has reduced.	Total Northland data for infant mortality stretches back some years, but data by ethnicity is available only for 2010 and 2011.

Overall the report card for Northland DHB is mixed, but there are encouraging signs:

- life expectancy is improving for females but not for males, and the Māori/non-Māori disparity in life expectancy has been reducing for females but increasing for males;
- age-standardised mortality rates are reducing over time, and while there is still a significant inequity it has reduced considerably;
- infant mortality has dropped considerably and there is now zero disparity between Māori and non-Māori;
- acute admissions have increased slightly, though the original target and its five-year timeframe now appear ambitious in the light of subsequent information about population growth;
- patient satisfaction is hard to assess because of changes to the way it is measured.

Analysis of Performance

Northland DHB's performance on our Impact Measures, grouped into the Output Classes, is summarised below. The table also summarises results by equity. This is followed by a section describing results by the six Outcomes, then the Impact Measures section analyses each indicator in detail.

Key to the ratings used:

Performance c/w target	Change since last year
Target met	Better or Target still met
Within 5% absolute of target	Siimilar
Beyond 5% absolute from target	Worse
	New measure since last year, so no rating is possible

Output class	Impact Measure	Overall		Equity	
		Performance c/w target	Change since last year	Performance for Māori	Change since last year
Prevention	Proportion of Year 10 students who have never smoked	Beyond 5%	Worse	Beyond 5%	Better
	% of Northland population who are current smokers	Within 5%	New measure	Within 5%	New measure
	Northland mothers who breastfeed fully and exclusively at 3 months	Beyond 5%	New measure	Beyond 5%	New measure
	% of eight-month-olds who are fully immunised	Beyond 5%	Similar	Beyond 5%	Similar
	Breast cancer screening in eligible populations	Target met	Similar	Within 5%	Worse
	Cervical cancer screening in eligible populations	Within 5%	Worse	Beyond 5%	Worse
Early detection and management	Ambulatory sensitive hospitalisation rate per 100,000, ages 0-74, age standardised	Target met	New measure	Target met	New measure
	Average number of decayed, missing or filled teeth (DMFT) among Year 8 students	Beyond 5%	Better	Beyond 5%	Similar
	Of people with diabetes receiving Diabetes Annual Reviews, % with good blood sugar management	Beyond 5%	Worse	Beyond 5%	Worse
	Of people in eligible populations, those who have had a CVD risk assessment in the last five years	Target met	Better	Within 5%	Better
Intensive assessment and treatment	Acute readmissions to hospital within 28 days	Within 5%	New measure	No Māori data	
	Increase in the number of elective services discharges	Target met	Better	No Māori data	
	Patients with an ED length of stay of less than six hours	Within 5%	Similar	Within 5%	Similar
	Harm from falls while in hospital	Within 5%	Similar	No Māori data	
	Pressure injuries while in hospital	Within 5%	Better	No Māori data	
	Compliance with surgical checklist	Target met	Similar	No Māori data	
	Compliance with hand hygiene practices	Target met	Better	No Māori data	
	Zero central line infections per 1000 bed days	Target met	Similar	No Māori data	
	Medicine reconciliation	Beyond 5%	Worse	No Māori data	
	% of patients referred urgently with high suspicion of cancer who receive their first cancer treatment within 62 days	Beyond 5%	New measure	Beyond 5%	New measure
	Proportion of people with enduring mental illness aged 20-64 who are seen over a year	Within 5%	Similar	Within 5%	Worse
Rehabilitation and support	% of long-term HBSS clients assessed using interRAI tool	Within 5%	Better	No Māori data	
	% of HBSS providers certified	Target met	New measure	No Māori data	
	% age related residential care facilities with at least 3 year certification	Target met	Better	No Māori data	

The Six Outcomes

Healthy population

Of the seven indicators that fall under this Outcome, target was met for four (never smokers among Year 10 students, breast cancer screening, cervical cancer screening and hospital smoking advice). We were within 5% for immunisations, though this represents a big improvement in one of our greatest performance challenges over recent years. We didn't meet target for primary care smoking advice, though each quarter saw improvements until the target was exceeded for the first time in the fourth quarter. Neither did we meet target for breastfeeding, for which it has been an ongoing challenge to improve rates; Northland DHB has implemented a plan which is discussed in more detail within the breastfeeding section.

Prevention of illness and disease

Last year Northland did not achieve target for any of the indicators under this heading. This year target was met for three (breast cancer screening, cervical cancer screening, hospital smoking advice) and we were within 5% for immunisations. We did not meet target for the primary care smoking advice indicator, which has been covered under the heading above. While the oral health DMFT measure remains an ongoing challenge, the numerous service improvements now being put in place should see significant future gains.

Reversal of acute conditions

Target was not met for either indicator. The oral health DMFT measure has been covered above. Referrals to Child, Youth and Family of children being abused were slightly less than expected and superficially this could be seen as a good thing, but the suspected high degree of under-reporting means it is unlikely to represent a real drop in need. The number could however be affected by some caregivers accessing preventive services earlier or because cases are being picked up by other services such as GPs.

Optimum quality of life for those with long-term conditions

Of the eight indicators, target was achieved for five while the other three (diabetes blood sugar management, cardiovascular risk assessments, interRAI assessments for home based support services clients) were more than 5% from target. The denominator for the diabetes indicator is an annual estimate provided by the Ministry of Health which increases each year, so even though the number of diabetics who are managing their blood sugar has continued to increase, the performance percentage has remained stable. Performance over the whole year on the cardiovascular disease indicator is still well below target, but it has kept improving and in fact rose over target for the first time in quarter four of 2014/15. Performance on the interRAI assessment indicator is mainly due to staffing shortages which have since been addressed, so 2015/16 should see improvements.

Independence for those with impairments or disability support needs

Target was met for two of the three indicators (providers of aged-related residential care with three-year certification, home based support services for higher needs clients). Performance on the interRAI indicator has been explained above.

Better, sooner, more convenient services

Target was met for five of the ten indicators. Three were within 5% of target: Emergency Department waiting times, harm from falls, and pressure injuries. For the ED indicator, performance hovers just below target and is affected by ever-increasing workloads and the department regularly working beyond capacity at peak times. The two quality indicators, falls and pressure injuries, both have challenging targets of zero, so even if performance improves greatly they will likely still be coded orange. The medicines reconciliation indicator is another for which average non-target performance over the year hides a steady and growing month-by-month improvement. Hand hygiene compliance has not met target either, though performance should be improved by the recent implementation of new system for monitoring and auditing that involves training of staff to work in their own service areas.

Comparison with last year

Across all 25 indicators, performance worsened for only one (interRAI assessments for home based support services clients) for which there are realistic expectations of improvement in 2014/15.

Impact Measures

Progress overall

Performance against target		
Assessment	**Overall**	**Equity**
Target met	9	1
Within 5%	8	5
Beyond 5%	7	7
No data	-	11

Change since last year		
Assessment	**Overall**	**Equity**
Better than last year	7	2
Similar to last year	7	3
Worse than last year	4	4
New measure/no data	6	15

This year, out of the 24 indicators, nine targets were met, eight were within 5% of target and seven indicators were more than 5% from target. This is a similar result to the previous year; fewer targets were met (last year it was 12), but more were within 5% of target (five last year).

Compared to the previous year, performance improved on seven indicators, was similar for seven and worse for four. On the face of it this looks worse, because the previous year 13 indicators had improved. However this analysis is affected by the six new indicators which have to be excluded because they have no baseline against which to measure progress.

Issues around the red indicators vary. Data from the Action on Smoking and Health survey of Year 10 students shows a decline in non-smoking from 75% to 64%, but a closer look at the trend over a number of years suggests that the 75% result in 2013/14 was inaccurately high, though the cause of this remains unknown. The number of Diabetes Annual Reviews continues to climb, but so too does the number of Northlanders whom the Ministry of Health estimates have diabetes (an evidence-based assessment whose size we can't predict), so we are always playing catch-up. Medicines reconciliation performance was heading in the right direction the previous year, but has shown a fall this time because demand (a rise in admissions) was not matched by resources (staff numbers didn't increase); this is being addressed for 2015/16. Northland DHB's performance on the relatively new 62-day cancer Health Target is improving gradually; we sit about midfield among all DHBs, and no DHB has yet met the target. The remaining red indicators describe issues that Northland DHB has grappled with for some years: breastfeeding, immunisations, oral health.

Progress on equity

Performance for Māori was met for only one indicator (ambulatory-sensitive hospitalisations), though it was within 5% of target for five others. This is a poorer result than last year (5 met target, 1 was within 5%), even allowing for the 11 indicators for which data for Māori was not available.

As well as these 11, there were four more indicators that are new this year, leaving only nine indicators on which to compare this year with the last. A similar picture emerges here, with performance being better for two, similar for three and worse for four.

Good progress towards eliminating the gap between Māori and non-Māori is evident with Year 10 never-smoking rates and cardiovascular risk assessments. The gap between Māori and non-Māori is similar to last year for immunisations, oral health and Emergency Department waiting times.

Good progress towards eliminating the gap between Māori and non-Māori is evident with Year 10 never-smoking rates, immunisations and management of blood sugar among people with diabetes. The gap between Māori and non-Māori is similar to last year for breastfeeding at six weeks, breastfeeding (over target for both ethnic groups), cervical cancer screening, the DMFT oral health measure, cardiovascular.

Northland DHB is currently trying to fill the gap in reporting on inequities by creating a Māori health dashboard for indicators across the sector (NDHB already has a dashboard for our own services). The dashboard will include the Māori health indicators being promoted nationally by Te Tumu Whakarae, the national Māori GMs group.

Gaps in ethnicity data

Because of an error in the way the breastfeeding indicator was compiled, there is no comparable ethnicity data for the previous year to compare with.

Reporting systems for two of the indicators (acute readmissions, electives) have been designed nationally and there is no requirement for data to be supplied publicly by ethnicity.

An ethnic comparison is not generally relevant to the three indicators relating to health of older people in the Rehabilitation and Support Output Class because the number and proportion of older people among Māori is comparatively small, and few of them use HOP services.

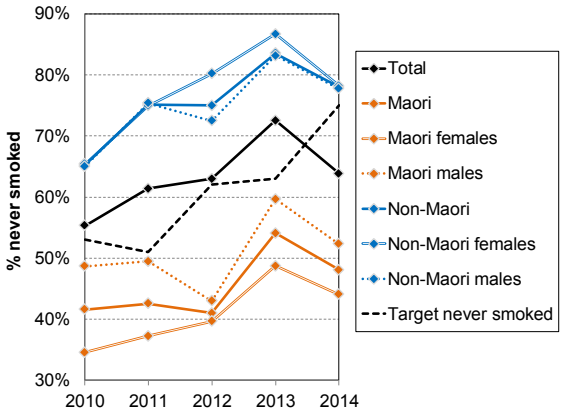
The focus with the development of the new Quality and Improvement Directorate has been in the first instance to establish a culture of quality improvement. Quality Accounts have been developed in line with Health Quality and Safety Commission recommendations which do not require a focus on equity. New projects being supported by Northland DHB's Quality and Improvement Directorate are now asked to complete a project charter, and within this charter is a section on measuring inequities that uses a simplified Health Equity Assessment Tool.

Output Class: Prevention

Impact	Tobacco: lower prevalence of smoking-related conditions
Impact measure *[& type]*	Percentage of Year 10 students who have never smoked *[coverage]*

Baseline 2013		Target 2014	Result 2014
Total Y10	73%	75.0%	64%
Māori M	60%	75.0%	52%
Māori F	49%	75.0%	44%
Non-M M	83%	75.0%	78%
Non-M F	87%	75.0%	78%

Trend



Source: Year 10 Action on Smoking and Health (ASH).

Notes

The never-smoking rate among all Year 10s has increased over the years, though the jump from 63% in 2012 to 73% in 2013 now appears to have been a 'blip' because the 2014 rate has settled at a historically more consistent 63.9%.

ASH has just made Year 10 data available by ethnicity from 2010 onwards. All ethnic groups have shown marked increases in the percentage of never-smokers between 2010 and 2014. Especially pleasing are gains for Māori, with girls increasing from 35% to 44% and boys from 49% to 52%.

The gap between Māori and non-Māori decreased between 2012 and 2014: among girls it dropped from 41% to 34%, and among boys from 30% to 26%.

Along with efforts to assist adult smokers to stop (as well as government policy decisions such as increasing the price of cigarettes), this data suggests good progress towards the national target of 95% smokefree by 2025.

There is however anecdotal evidence that though smoking rates are dropping in the mid-teens (as measured by the Year 10 survey), many youth start smoking after that age.

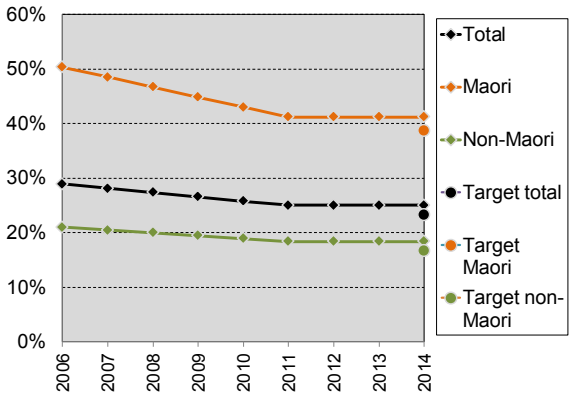
Data extends only to the end of 2014 because Action on Smoking and Health conduct the Year 10 survey only once during each school year.

Northland DHB will continue with health promotion programmes in schools and supporting students to stop smoking. These services are carried out jointly by Health Promotion staff and Public Health Nurses. Quit Cards (see description under next measure) are also available to youth.

Impact	Tobacco: lower prevalence of smoking-related conditions
Impact measure *[& type]*	Percentage of Northland population who are current smokers *[coverage] [new measure, comparative unaudited]*

Baseline 2012	Target 2014/15	Result 2014/15
Māori 40.7%	38.7%	41.2%
Non-Māori 17.7%	16.7%	18.4%
Total 24.2%	23.2%	25.0%

Trend



Source: NZ Health Survey 2011-14.

Notes

Smoking is one of the most significant lifestyle factors behind long-term conditions. It disproportionately affects Māori and other deprived populations and smoking during pregnancy accounts for an estimated 20% of all pre-term births and 35% of low birthweight babies.

Helping smokers to quit is one of the national Health Targets and New Zealand has a target of being 95% smokefree by 2025. Clinical staff employed by community and primary care providers and DHB hospitals provide advice to smokers and those who want to stop are referred to cessation services. Health and social service providers that come into contact with people who smoke hand out Quit Cards. Clients who wish to quit smoking redeem Quit Cards for government-subsidised nicotine gum or patches.

Up until 2011 progress was good, although we know that if we are to achieve the 2025 target, annual cessation rates among Māori have to increase from, on average, 250 (2013 Census data) to, as a minimum, 1,000-1,200. Since 2011 progress has been hard to gauge because of changes to NZ Health Survey methodology. Data from surveys done in different years was amalgamated for each DHB; while the purpose was to increase sample sizes and thus improve validity, it has also created average smoking rates across several years, producing a flat line that makes trends impossible to assess.

Within secondary care for 2014/15, Northland DHB either met or exceeded the 95% target for the Better Help for Smokers to Quit Health Target. The year ended well with a result of 97.3% for June. The overall figure for the year was 95.5%. Northland DHB will continue to maintain and improve the health target figure with more attention on increasing the rate of referrals for cessation support (the 'C' of the ABC of smoking cessation). The use of stop smoking medications and behavioral support increases the rate of successful quit attempts.

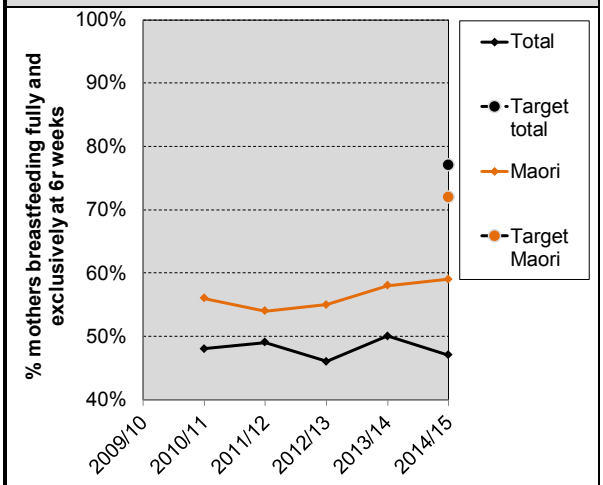
For the first three quarters of 2014/15 primary care has exceeded the 90% Better Help for Smokers to Quit Health Target, however due to staff leave and illnesses the result in quarter four was 84.8%. In future there will be more emphasis on embedding sustainable practice for ABC in general practice and increasing referrals to stop-smoking services.

The baseline data as published was taken from the MoH's 2012/13 NZ Health Survey. Since then that data has been combined with data from 2014 to create the 2011-14 NZ Health Survey (the intention being to increase the sample size to make the results more valid). The 2014/15 results are therefore not directly comparable with the 2012 baseline. The process of combining the data to create a four-year average will also obscure any trends over that time.

Impact	Healthy children: reduced likelihood of acquiring long-term conditions later in life
Impact measure *[& type]*	Full and exclusive breastfeeding at 3 months *[coverage] [new measure, comparative unaudited]*

Baseline 2013/14		Target 2014/15	Result 2014/15
Māori	67%	72.0%	47%
Total	72%	77.0%	59%

Trend



Notes

In 2014/15 it was decided to change the breastfeeding measure from 6 weeks to 3 months, but the published baseline and target figures unfortunately still referred to 6 weeks, when rates are typically much higher.

The 3 month targets for both total and Māori should have been 54%. On that basis the total population's breastfeeding rate is over target while Māori remain slightly under.

Data supplied is for Plunket only. While it covers the majority of the population, it does not include Tamariki Ora (Māori well child) providers. The two sets of data cannot be added together because Plunket supplies it as percentages, not numbers (without the raw numbers, non-Māori performance can't be calculated).

During the year, the Well Child-Tamariki Ora (WCTO) working group consisting of the DHB, Plunket and all Māori WCTO providers has completed an analysis specifically on timeliness of core contacts and barriers to access. It became evident that earlier engagement with WCTO providers would improve outcomes. The group, to this end, has identified several key actions:

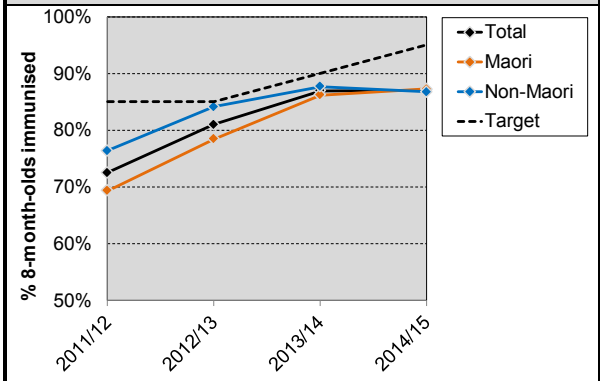
- engage with lead maternity carers (LMCs) on how to improve referral process to improve integration between LMCs and WCTO providers
- develop a pamphlet of WCTO providers in Northland to support discharge planning from maternity services and follow-up
- prioritise timeliness over other initiatives to ensure all assessments etc. have been delivered
- give families an opportunity to tell why they choose not to engage with WCTO providers so specific needs of hapu mama can be identified to increase service coverage.

It is envisaged that this will lead to improvements in systems, models of care, health literacy and quality.

Impact	Healthy children: lower incidence of communicable disease
Impact measure *[& type]*	Percentage of eight-month-olds who are fully immunised *[coverage] [Health Target]*

Baseline 2013/14		Target 2014/15	Result 2014/15
Māori	86%	95%	87%
Non-M	88%	95%	87%
Total	87%	95%	87%

Trend



Source: MoH data supplied across all DHBs.

Notes

Performance on immunisations has stabilised at around 87% for all ethnicities but Northland has fallen further behind because the target increased to 95% in 2014/15.

Further improvement is anticipated as we work collectively with our partners in primary care.

Multiple strategies have been implemented to improve our rates:

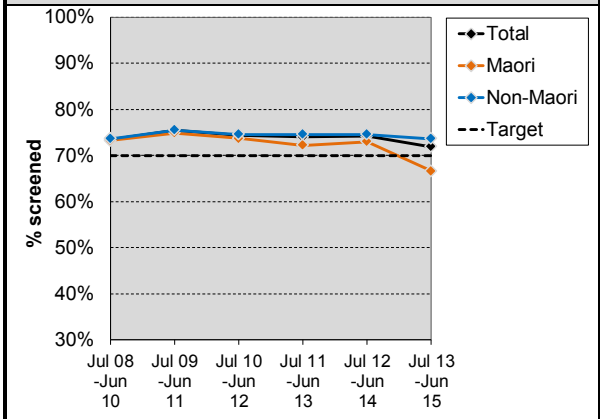
- extensive media coverage
- development of TV commercials with key respected individuals from Northland
- implementation of an 0800 number to link consumers with appropriate services and information
- input from the Medical Officer of Health into general practices with high decline rates
- extended outreach services have been implemented
- development of resources for health professionals to deliver confident conversations
- PHO chief executives have met with key practices and provider groups to mobilise them in supporting and promoting immunisation
- commencement of an Outreach Nurse to contact all those who decline in order to have a confident conversation and ensure the parent/caregiver is appropriately informed.

The Chief Executive has invited representatives from DHBs with high coverage to visit Northland to work with Northland DHB and primary care personnel on how to improve our coverage.

Impact	Cancer: if curable, increased likelihood of survival; if incurable, reduced severity of symptoms
Impact measure *[& type]*	Breast cancer screening in eligible populations *[coverage]*

Baseline July 2012-June 2014		Target Jul 2013-Jun 2015	Result Jul 2013-Jun 2015
Māori	73.0%	70%	66.6%
Non-M	74.6%	70%	73.6%
Total	74.2%	70%	71.9%

Trend



Notes

Performance continues to be above target for non-Māori and total population but has fallen below the line for Māori.

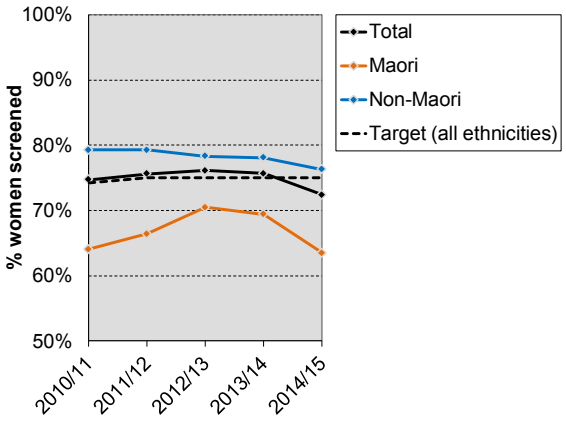
Though the number of screens of Māori has remained constant, the percentage coverage has dropped because of an unanticipated increase in the denominator. This occurred because the 2013 Census used by the National Screening Unit in 2015 revealed 500 more eligible Māori women than suggested by 2006-based projections (which had been used up till then as the basis). The breast screening service is now working to bridge the gap.

Each point on the graph covers the 24-months ending in June each year. Two years is prescribed by national policy as the screening period for the eligible population (ages 45-69), and this is the way data is reported by the National Screening Unit.

Impact	Cancer: if curable, increased likelihood of survival; if incurable, reduced severity of symptoms	Notes
Impact measure *[& type]*	Cervical cancer screening in eligible populations *[coverage]*	*Note that the 75% target in the published SP used to be the PHO Performance Programme target. That target has since been revised upwards to be consistent with the national screening target of 80%.*

Baseline 2013/14		Target 2014/15	Result 2014/15 (6mths only)
Māori	70.2%	75%	63.5%
Non-M	78.3%	75%	76.3%
Total	75.8%	75%	72.4%

Trend



Performance for non-Māori is just above target, but for Māori it still lags behind and seems to be dropping.

The target of 80% coverage for both the total population and the priority group remains challenging. Programme activities during 2014/15 have not manifested in a significant increase in coverage.

Some traction, however, has been obtained on the key areas of work identified by an expert advisory group. These include increasing access, messaging and health literacy, cultural humility, workforce development, general practice plans, and education of local populations.

Access to services continues to be addressed partially through the provision of free smears to priority group women in general practice. Services are also offered via iwi providers and through a new collaboration with Family Planning NZ.

General practices have developed and implemented plans to increase coverage for their eligible population. These address cultural needs, health literacy, workforce development, and invitation and recall processes.

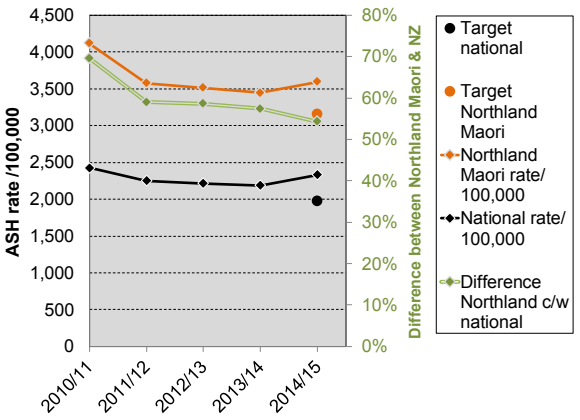
Workforce development was addressed through annual smear taker training coordinated and delivered with Family Planning NZ, and a smear taker update for practice nurses. A component of this training included education on cultural competency, the Northland Cervical Screening Programme and delivery of the yearly smear taker update. This event provided education to nurses, and was also an opportunity to discuss practice-level challenges around increasing screening coverage.

Output Class: Early Detection and Management

Impact	People manage in the community through effective primary care services
Impact measure *[& type]*	Ambulatory sensitive hospitalisation rate, ages 0-74, age standardised *[quality] [new measure, comparative unaudited]*

Baseline 2013/14		Target 2014/15	Result 2014/15
N'land Māori	3,464	3,154	3,597
NZ total	1,972	1,972	2,331

Trend



Notes

Ambulatory Sensitive Hospitalisations (ASH) are potentially avoidable through intervention in primary care (in contrast to hospitalisations that are avoidable through injury prevention or population-level strategies). They are a useful measure of how well people are accessing primary care services and how well those services perform. Lower rates of ASH free up hospital resources for more acute and urgent cases.

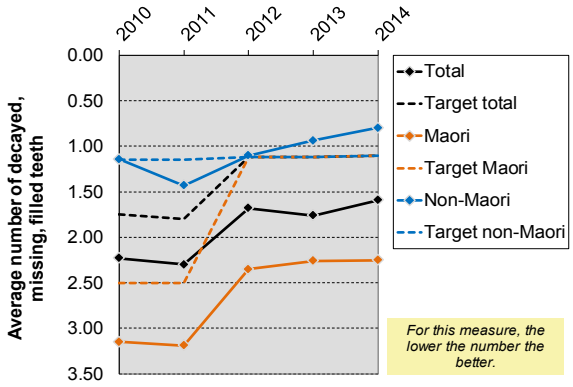
In this context the measure is the difference between the ASH rates for Northland Māori (who are substantially disadvantaged compared to non-Māori) and the total national population. The Northland Māori rate increased between 2013/14 and 2014/15, although because the national rate increased faster the difference between the two has decreased. Part of the reason for the increases is that the underlying population data is now being derived from the 2013 Census, though it is hard to assess how much influence this has had because MoH's methodology has not been made explicit.

Managing the interface between primary and hospital services is key to reducing ASH rates. For example Northland DHB's eReferral 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.

Impact	Healthy children: healthier teeth and gums
Impact measure *[& type]*	Average number of decayed, missing or filled teeth among Year 8 students *[quantity]*

Baseline 2013		Target 2014	Result 2014
Māori	2.26	1.10	2.25
Non-M	0.94	1.10	0.80
Total	1.76	1.10	1.59

Trend



Source: NDHB.

Notes

The Decayed, Missing and Filled teeth (DMFT) indicator reflects the amount of past and present dental decay in our child population. It measures the prevalence of a disease with many causes, with big contributors being:

- unhealthy lifestyle factors such as the frequent intake of sugary rich foods and beverages
- the lack of home-based tooth brushing with fluoride toothpaste
- the absence of water fluoridation in Northland.

Changing these is hard, and the oral health service unfortunately has limited influence. It is well documented that many families on lower incomes who live in higher deprivation areas find it harder to ensure healthy lifestyle habits can be implemented and sustained.

The oral health service provides accessible oral health care at or near where children go to school or live, with 100 fixed facilities and mobile dental units across Northland. Risk factors for dental decay are reduced by way of preventive interventions such as fluoride varnish and fissure sealants. Our model of care focuses on building good relationships with parents and lead caregivers, in a way that allows for the promotion of oral health messages. In doing so we are encouraging and helping families to put some of those positive healthy lifestyle changes in place within the home.

While the DMFT figures have shown improvement, outcome data confirms that the severity of dental decay within our child population is reducing, resulting in observable and positive 'quality of life' improvements such as functional, pain-free and infection-free mouths.

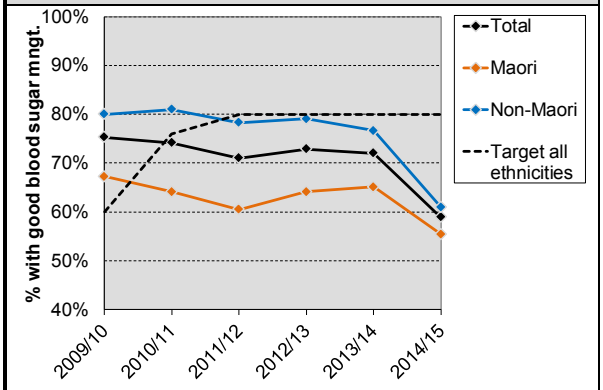
We predict that over the next four to five years these service interventions will result in a relatively slow but sustainable reduction in DMFT rates across all groups, including Māori.

Data is reported for each calendar year in line with the school year.

Impact	Long term conditions: Amelioration of disease symptoms and/or delay in their onset	Notes
Impact measure *[& type]*	Good blood sugar management *[coverage]*	Blood sugar is monitored and managed through blood tests being performed by a laboratory after referral by a GP, and the results reported back to GPs for discussion with patients as appropriate. Performance has dropped further below the national performance target. The numbers of people estimated by the Ministry of Health to have diabetes increases each year (in 2013/14 it was 7,736, but had increased to 8,256 by 2014/15), so although the performance appears not to have increased in percentage terms, in fact the number of people with good blood sugar management continues to increase. In line with the Triple Aim and the Northland Health Services Plan Headline Targets (described in the introduction to the SP) we will continue to focus efforts on high risk, high need populations. Diabetes Care Improvement Packages (DCIPs) are now in place within general practice. They include the development of an action plan for each practice to ensure progress is made in the delivery of care to all patients with diabetes. Other supports such as self-management programmes, support groups, supermarket tours, healthy kai and activities are also available on a location-by-location basis.

Baseline 2013/14		Target 2014/15	Result 2014/15
Māori	65.1%	80%	55.4%
Non-M	76.7%	80%	61.0%
Total	72.0%	80%	58.9%

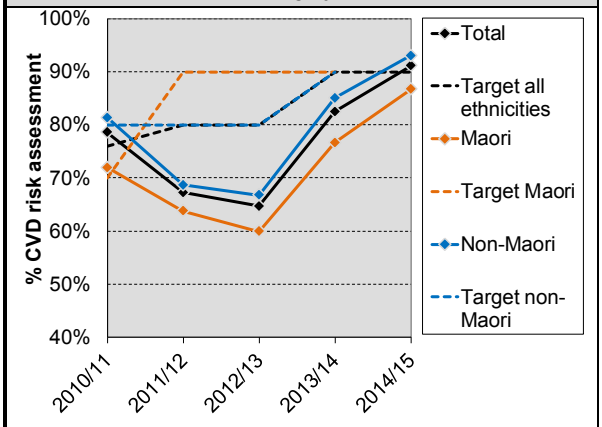
Trend



Impact	Long term conditions: Amelioration of disease symptoms and/or delay in their onset	Notes
Impact measure *[& type]*	Eligible people receiving CVD risk assessment in the last five years *[coverage] [Health Target]*	Continued improvement has been evident in this indicator over the last couple of years. In 2014/15 Northland reached target for non-Māori and total population, and though the Māori rate is just under target, it is rising steadily. Credit must go to Northland's PHOs and general practices who have improved their performance by making sterling efforts to reach some of the hardest-to-reach groups within the Northland population. They have been assisted by the availability of additional funding provided specifically for this purpose.

Baseline 2013/14		Target 2014/15	Result 2014/15
Māori	76.6%	90%	86.7%
Non-M	n/a	90%	93.0%
Total	82.5%	90%	91.1%

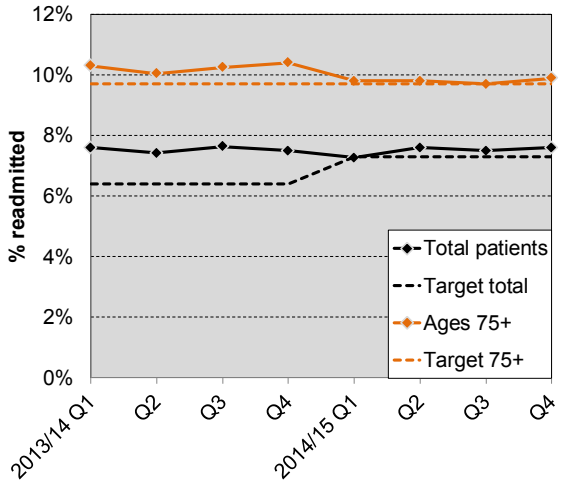
Trend



Output Class: Intensive Assessment and Treatment

Impact	Lower rates of acute admission to hospital		
Impact measure *[& type]*	Percentage of acute patients readmitted to NDHB hospitals within 28 days *[quality]* *[new measure, comparative unaudited]*		
Baseline 2013/14 Q3		**Target 2014/15**	**Result 2014/15**
All pts	7.64%	6.40%	7.49%
75+	10.25%	9.70%	9.80%

Trend



Notes

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 hospital and/or primary care settings, patient pathways, discharge planning and integration with outpatient and primary services.

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 (e.g. see eReferrals, described a few pages back under ambulatory sensitive hospitalisations)
- improving hospital discharge processes and coordinating support for targeted at-risk patient groups
- improving the interface between secondary and primary services to ensure continuity of care for patients.

During 2014/15 Northland DHB has been on or above target for all quarters for both the age 75+ and all-patient indicators.

Northland DHB originally included this measure because it is part of the suite of quarterly reports to Ministry of Health (MoH). However MoH has recently acknowledged that there are inadequacies with the method of analysis that make it difficult for DHBs to understand or replicate the results (it is based on MoH work carried out in 1991 and has not been revised since 1995/96 to allow for such things as changes in disease coding's). MoH is in the midst of revising the way the indicator is formulated, and until the new version emerges it is difficult to place faith in the reported data.

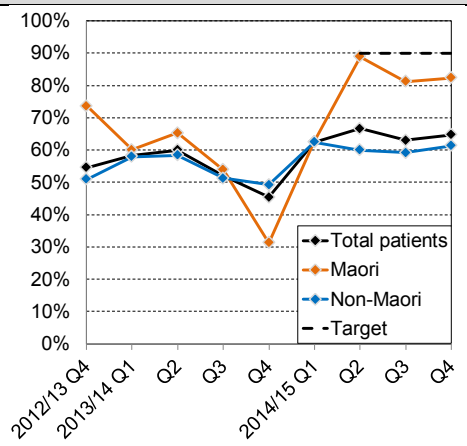
Northland DHB is transforming the acute medical inpatient journey and anticipates the development of an acute medical assessment unit by June 2016. Similar models at reference sites within New Zealand have demonstrated a significant reduction in length of stay for these patients. An ambulatory component within these sites has prevented a number of readmissions.

A transformed medical service, smoothing the current distribution of patient workload to teams, will enable a more manageable workload and greater focus on effective discharge.

Impact	If curable, increased likelihood of survival; if incurable, reduced severity of symptoms	Notes
Impact measure *[& type]*	Percentage of patients referred urgently with a high suspicion of cancer who receive their first cancer treatment (or other management) within 62 days *[timeliness] [Health Target] [new measure, comparative unaudited]*	People diagnosed with cancer may be treated with either or both of radiation therapy and chemotherapy. All radiation therapy for Northland DHB is performed at other DHBs (almost entirely at Auckland DHB). Chemotherapy alone is provided predominantly within Northland DHB, unless it is required simultaneously with radiation therapy, in which case it is provided by same provider as the radiotherapy. This Health Target has been monitored only since 2014/15 Q2, though older data has been included in the graph to provide historical context. The data here uses the latest six-month rolling analysis the Ministry now uses. Although performance is below target in 2014/15, it has increased significantly since 2013/14 (by 26% for Māori and 7% for non-Māori). Northland DHB is below target for both ethnic groups, though performance seems to be gradually improving. There has been improvement in rates especially for Māori over the last twelve months, which has coincided with the Māori and Pacific Navigator. Because this is a recently introduced target, no DHB has yet met it; 2014/15 Q3 results for DHBs ranged from 37% to 81%, with a national average of 67%, which is close to where we sit. Northland DHB is focusing on an improvement programme that is tumour-stream based and incorporates processes around the type of first treatment and diagnostic processes. We work closely with Auckland DHB and the Northern Region on improving performance. Data is presented by quarter because the measure has only been in place for a couple of years.

Baseline Q3 2013/14		Target 2014/15	Result 2014/15
Māori	56.3%	85.0%	78.8%
Total	52.9%	85.0%	64.2%

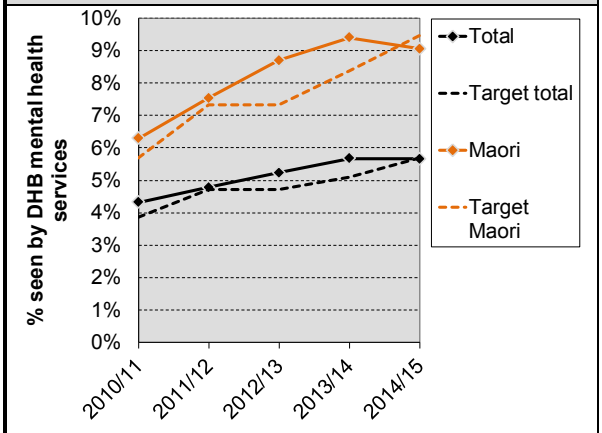
Trend



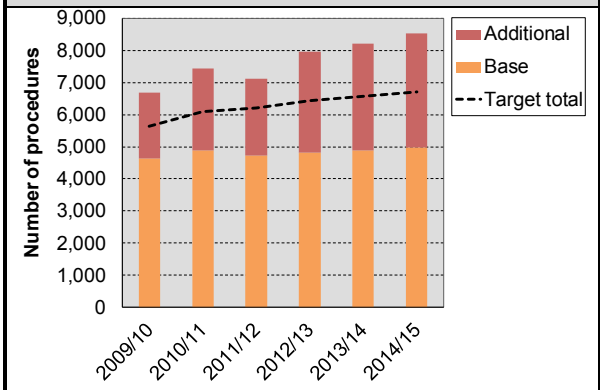
Impact	Mental disorders: improved quality of life for both clients and their families; acute episodes are minimised, clients achieve greater stability in their condition	Notes
Impact measure *[& type]*	Percentage of people with enduring mental illness aged 20-64 who are seen over a year *[coverage]*	Northland DHB has a range of community mental health services spread over four regions of the Far North, Mid North, Kaipara and Whangarei. Entry to the services is by referral, which can be from a GP, self/whānau or other community providers such as schools, Probation and Police. When a client is acutely unwell so that they can't be safely managed in the community, they will be admitted to an inpatient service. These inpatient services include the Tumanako Inpatient Unit in Whangarei, sub-acute units (Far North, Mid North, and Whangarei), NGO respite providers and NGO residential care providers. There has been a 20% increase in access over the last five years to 2013. This growth has now levelled out. The Northland access rate for Māori at 9.06% in 2014/2015 is still much higher than the New Zealand average of 7.3%. The New Zealand average has also plateaued over the last two years. There has been no change in the services offered or available to Māori. The high access rate is a reflection of the increased prevalence of mental illness in those under 25 years. Research suggests this may well be linked to economic and social pressures in the community. This, combined with the higher visibility of mental health services tailored to youth and young adults, has made services both more accessible and more accessed.

Baseline 2013/14		Target 2014/15	Result 2014/15
Māori	9.40%	9.47%	9.06%
Total	5.68%	5.68%	5.66%

Trend



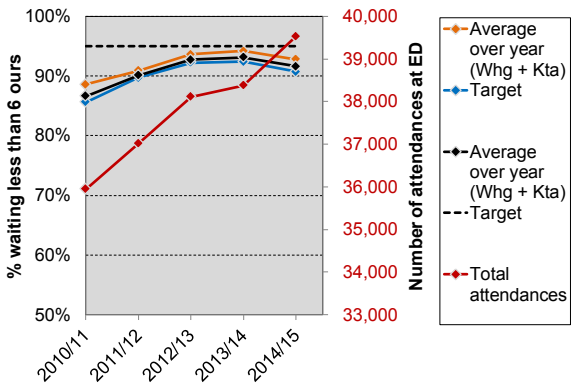
Impact	Elective surgery: fewer debilitating conditions; delayed onset of long term conditions		**Notes**
Impact measure *[& type]*	Increase in elective service discharges *[quantity] [Health Target]*		Electives remain consistently above target, and Northland DHB is one of the best performing DHBs. Northland DHB has provided 4% more elective surgery discharges than in 2013/14. There has been an accelerated level of performance in the middle of the year designed to reduce the maximum waiting time from 5 months to 4 months from 1 January 2015. *Note that the baseline and target data used to use an ethnicity split, but that has since been abandoned because the national system for determining elective operations numbers does not provide for ethnicity-based targets to compare performance with. To make comparisons between the old and the new clearer, Northland data has been analysed to create splits by both ethnicity and the traditional baseline/ additional approach.* Targets for each DHB are based on the previous year's target plus their fair share of an extra 4,000 discharges nationally. They are a minimum requirement.
Baseline 2013/14	**Target 2014/15**	**Result 2014/15**	
Māori 2,081 Non-Māori 6,121 Total 8,202	1,917 4,787 6,703	n/a n/a n/a	
Baseline 4,896 Additional 3,306 Total 8,202	4,979 1,725 6,704	4,979 3,550 8,529	
Trend			



Impact	Emergency Department (ED) waiting times: more timely assessment, referral and treatment	Notes
Impact measure *[& type]*	Patients with an ED length of stay of less than six hours *[quality] [Health Target] [data by ethnicity is comparative unaudited]*	Northland DHB has remained near target for this indicator over the past couple of years, and performance has fallen slightly since 2013/14. In part that has been the result of continuing increases in the volume of attendances at Emergency Departments in Whangarei and Kaitaia (there has been a 6.8% increase in patient volumes since 2011/12). The Whangarei Emergency Department regularly works beyond capacity during the peak demand period of 11am to 10pm.

Baseline 2013/14		Target 2014/15	Result 2014/15
Māori	94.2%	95%	92.8%
Non-Māori	92.4%	95%	90.7%
Total pts.	93.1%	95%	91.6%

Trend



Northland DHB has established the Whangarei Hospital Urgent Care Governance Group to improve the timeliness of care of acutely ill patients at Whangarei Hospital. The group will:

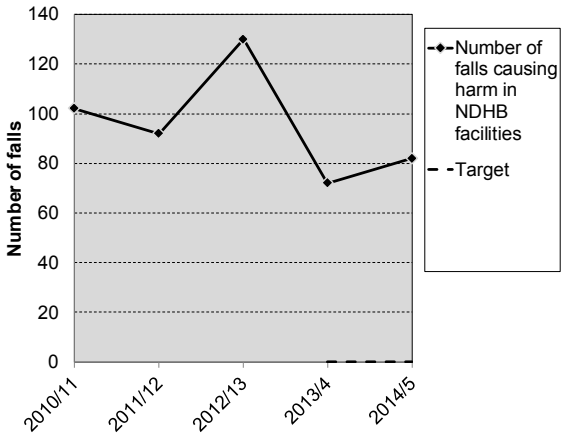
- Establish Acute Care Medicine specialty role(s) by September 2015.
- Explore and develop an interim Acute Medical Assessment Unit (AMAU) by June 2016.
- Establish a discharge planning role focusing on early discharge to District Hospitals and improving weekend discharge processes by the end of quarter one.
- Develop an ambulatory care facility by December 2015.
- Develop the indicative business case and model of care for the new ED/AMAU by May 2016.
- Create electronic document pathways to reduce duplication within the ED and speciality services by June 2016.
- Develop and agree specialty clinical pathways within each specialty by Sep 2015.
- Address the following mandatory quality measures, which have been identified by monitoring of ED quality framework patient journey indicators:
- delays in review by the Medical Service by September 2015
- timeliness of transfer to inpatient bed by September 2015
- requirement to create and enhance direct transfer to inpatient specialty service by Dece 2015.

A new ED and 30-bedded Acute Medical Assessment Unit is planned for Whangarei Hospital by 2019. Initial concept design work has commenced.

Impact	Quality and safety: more satisfied patients	Notes
Impact measure *[& type]*	Harm from falls while in hospital *[quality]*	Although 82 falls might not look good in comparison with a target of zero, it is still only 0.2% of the combined total of 24,582 inpatients and 13,828 day patients Northland DHB treated during 2014/15. That is still not acceptable however, and Northland DHB's aim is to reduce patient falls to zero. Falls with harm continue to be a challenge. A significant amount of activities continue to support this project. Northland DHB acute inpatient areas have promoted 'five steps of falls' prevention with banners in all areas. Wednesday has become "orange t-shirt" day; every Wednesday falls champions wear their orange t-shirt promoting the five steps of falls prevention. The Falls Prevention Group has reviewed the forum for falls with major harm root cause analysis form and been converting it to systems analysis with a more robust process led by the Assistant Director of Nursing. A campaign is planned to support the implementation of appropriate use of bedrails. The Falls Risk And Management Plan has been revised into one form and is being trialled in the orthopaedic ward. Implementation of this revised form will include ongoing monitoring of compliance. Work in aged care falls prevention has also commenced.

Baseline 2013/14	Target 2014/15	Result 2014/15
72	0	82

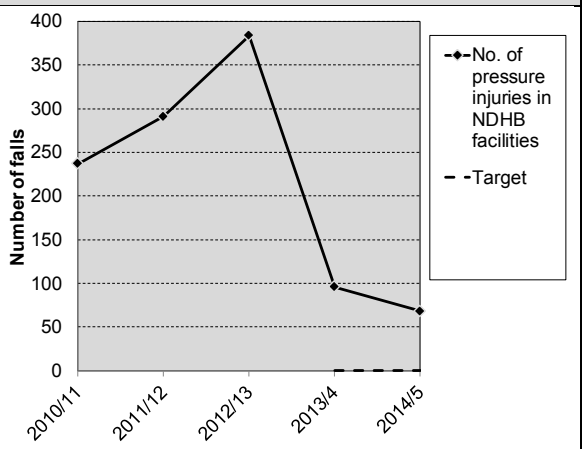
Trend



Impact	Quality and safety: more satisfied patients	Notes
Impact measure *[& type]*	Pressure injuries while in hospital *[quality]*	The comments made above about the number of falls in relation to total patient numbers apply here too. While the target was zero, 68 pressure injuries represent only 0.2% of the combined total of 24,582 inpatients and 13,828 day patients. The Pressure Injury Prevention Group is developing an education package in the form of a workbook, due for implementation in November 2015, as a mandatory competency for staff in acute inpatient areas. The Pressure Injury Prevention policy and bundles of care (care plans based on risk assessment) are due for updating and will be completed by November 2015. The risk assessment and bundles of care will be incorporated into Trendcare, Northland DHB's nursing acuity tool and workload management system, within six months.

Baseline 2013/14	Target 2014/15	Result 2014/15
96	0	68

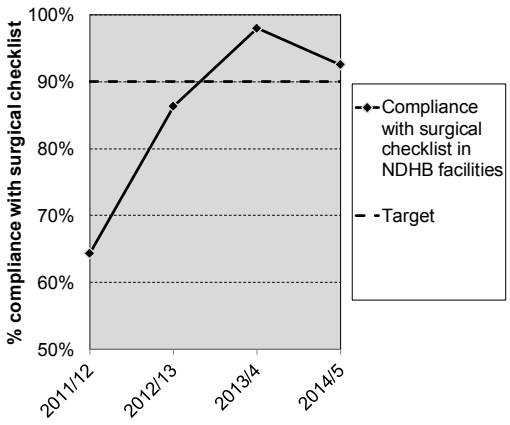
Trend



Impact	Quality and safety: more satisfied patients	Notes
Impact measure *[& type]*	Compliance with surgical checklist *[quality]*	Compliance with the surgical checklist involves a series of checks by theatre staff to ensure, for all operations, that the right procedure will be carried out on the right patient, on the right site with the right preparation. Northland DHB's performance has shown rapid improvement over the past couple of years. Again in 2014/15 it has exceeded target, though performance has dropped slightly from the previous year. New work on briefing and debriefing in the operating theatre is now established. This work supports the Health Quality & Safety Commission (HQSC) programme to reduce perioperative harm, and further augments a patient safety environment in the operating theatres. While Northland DHB has made comparative strides in implementing Briefing and Debriefing, the implementation of a paperless check list (the third component of HQSC Reducing Perioperative Harm initiative) will be the component Northland DHB has the farthest to go to develop prior to implementation.

Baseline 2013/14	Target 2014/15	Result 2014/15
98.0%	90.0%	92.5%

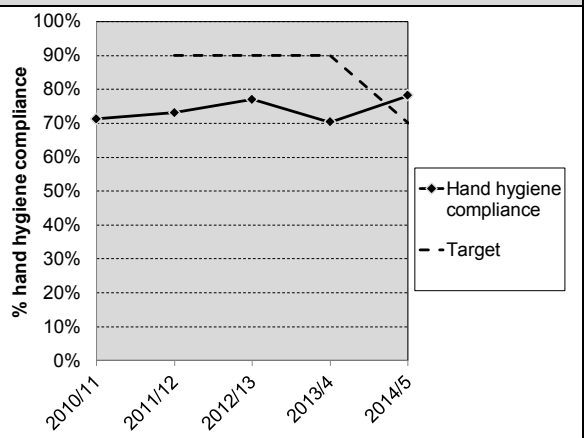
Trend



Impact	Fewer adverse clinical events	Notes
Impact measure *[& type]*	Compliance with hand hygiene practices *[quality]*	Performance has exceeded the national target of 70% in 2014/15. Northland DHB has set a more challenging internal target of 90% which will apply for the 2015/16 SP. The Responsibility to Remind campaign was rolled out in November 2014 and included: • Doctors • Ward round stickers • Cut-out models of the Northland DHB Microbiologist • Hand hygiene polo shirts worn by several staff on Fridays • Monthly hand hygiene report and feedback is given to all clinical areas who are encouraged to display them on their patient safety boards. Another training day was held in February 2015 and 11 Gold Auditors were successfully validated, including auditors in the regional Hospitals. Currently Northland DHB has 25 Gold Auditors, at least two in each area, and 17 areas currently audited. Some auditors are supported by their clinical nurse manager and allocated paid time for the auditing, while others audit in their own time. All auditors now have smart phones with hand hygiene apps, which saves time and enables more efficient ways of auditing.

Baseline 2013/14	Target 2014/15	Result 2014/15
71.0%	70.0%	78.2%

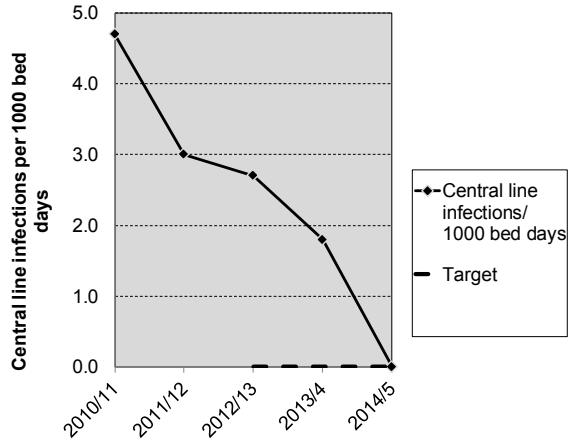
Trend



Impact	Fewer adverse clinical events	Notes
Impact measure *[& type]*	Central line infections *[quality]*	Central venous lines are commonly used in patients in intensive care. There is a serious risk of central line infection with associated mortality of between 4% and 20%. Each infection is also very costly to treat.

Baseline 2013/14	Target 2014/15	Result 2014/15
0	0	0

Trend



Traditionally Northland DHB had one of the lowest rates of central line infection in the country, but there was still potential for morbidity and mortality.

Northland DHB has met target for 2014/15.

In June 2015 the national surveillance programme ended, and each DHB is now responsible for monitoring and reporting of central line infections internally.

Northland DHB maintains a target of zero patients developing central line infections.

The infection control nurse specialists monitor all bloodstream infections and are cross-referencing patients who have had a central line inserted.

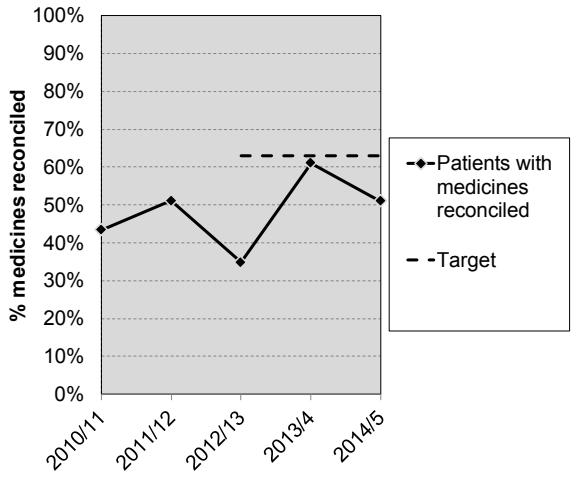
The monthly data is presented to the Infection Control Committee and documented in the minutes.

Due to this new process central line infections will no longer be displayed as a Quality Account.

Impact	Fewer adverse clinical events	Notes
Impact measure *[& type]*	Medicine reconciliation *[quality]*	Often patients admitted to hospital are taking medications for which there is no documentation, some are not taking what they have been prescribed by GPs or other doctors, or there are differences in medication dosages. Reconciliation aims to collect and document an accurate medication history, ensure any changes to medication at admission are recorded, detect and rectify any drug-related problems, missed diagnoses or errors in patient admission drug charts, and thus reduce patient harm. By ensuring that a correct list of medicines is obtained on admission to hospital and changes are well documented, medicine reconciliation improves information flow back to primary care once the patient is discharged. The electronic medicine reconciliation in admission service introduced on 2014 continues to be delivered as planned. However a drop in reconciliation has occurred this year, considered to be due to increased admissions (without increase in pharmacist FTE), reduced completion of electronic documentation by prescribers and a switch in focus of pharmacist led services to meet HQSC recommended priority patient criteria. The Medicine Reconciliation Leadership Group will continue to meet to review and progress the broader medicine reconciliation strategy for Northland DHB. Prescriber education to improve electronic reconciliation rates has since occurred. HQSC propose a new set of Quality and Safety Markers (QSMs) for medicine reconciliation. Unlike other QSMs, outcome measures will not be included at this stage. Using structure and process measures recognises that widespread medicines reconciliation will depend upon the successful implementation of Electronic Medicine Reconciliation (eMR) systems. This is currently a Medication Safety Programme and National Health IT Board priority; the first of the measures aligns with the 'Go for Gold' goal for eMR. The pharmacy team has already implemented eMR and has now aligned their prioritisation criteria to HQSC QSMs. Northland DHB is one of only two DHBs to roll out and report leading the country on this measure.

Baseline 2013/14	Target 2014/15	Result 2014/15
63%	63%	51%

Trend

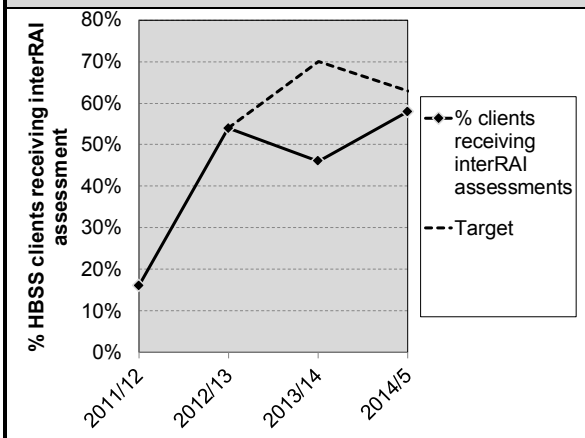


Output Class: Rehabilitation and Support

Impact	Quality assessment and Home Based Support Services (HBSS) lead to a reduction in the need for hospitalisation and residential care	Notes
Impact measure *[& type]*	Percentage of HBSS clients assessed using interRAI tool *[coverage]*	Performance has improved by 12% since 2013/14 now that Northland DHB's Needs Assessment and Service Coordination service has an appropriate level of staffing. The 2015/16 target of 77% will be a challenge, but Northland DHB has developed thorough internal monitoring systems that will assist us to reach it.

Baseline 2013/14	Target 2014/15	Result 2014/15
Clients assessed 46%	63%	58%

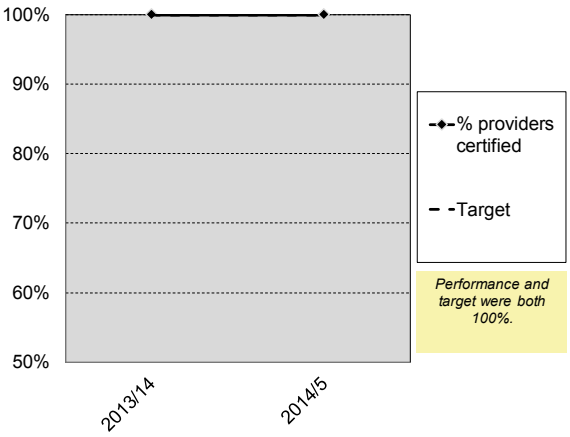
Trend



Impact	Support for older people: older people requiring support or care receive services appropriate to their needs	Notes
Impact measure *[& type]*	Percentage of HBSS providers certified *[quality] [new measure, comparative unaudited]*	All contracted HBSS providers are required to be certified under the Home and Community Support Sector Standards. All nine providers in Northland continue to hold certification. Holding certification is evidence that the provider has appropriate organisational systems in place and delivers services to the standard expected.

Baseline June 2014	Target June 2015	Result June 2015
100%	100%	100%

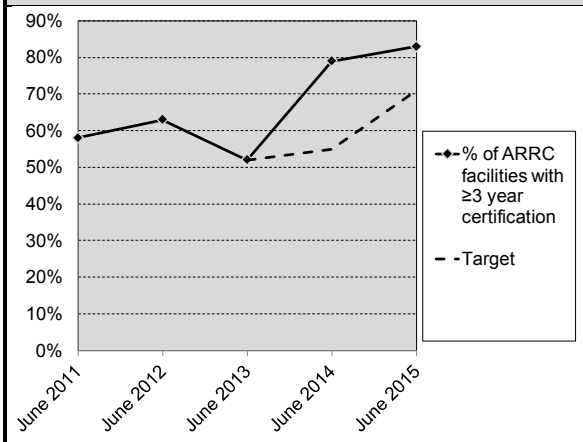
Trend



Impact	Support for older people: older people requiring support or care receive services appropriate to their needs	Notes
Impact measure *[& type]*	Percentage of Age Related Residential Care (ARRC) providers with at least three year certification *[quality]*	Target has again been exceeded. The results of integrated certification/ARRC contract audits are the best measurement we have for the quality of services delivered by ARRC providers. In the last couple of years MoH's requirements on auditing agencies and the audits they produce have become more rigorous as a result of the Office of Auditor General (OAG) report *Effectiveness of arrangements to check the standard of services provided by rest homes*[1]. The new certification environment has resulted in significant changes for some ARRC providers, improvements in the quality of auditing and in the long run will result in higher quality services. Northland DHB has a role in supporting and monitoring facilities to address any corrective actions arising from the audits. In recent years there has also been an emphasis on providing education and support to aged care services to improve quality. This is linked to the regional First Do No Harm project, and has a focus on reducing the rate of falls and pressure areas. In addition, Gerontology Nurse Specialists provide specialist nursing services and support for clients in aged care services.

Baseline 2013/14	Target 2014/15	Result 2014/15
79%	71%	83%

Trend



[1] Details can be found at http://www.oag.govt.nz/2012/rest-home-services-follow-up.

Statement of Comprehensive Income by Output Class

For the year ended 30 June 2015	$000 Intensive Assessment & Treatment	$000 Early Detection & Management	$000 Prevention	$000 Rehabilitation & Support Services	$000 Total
Revenue	332,992	135,890	26,119	69,409	564,411
Offsets	(3,210)	(1,680)	(3,164)	(244)	-8,298
Total Revenue	329,783	134,210	22,955	69,166	556,113
Personnel Costs	170,943	19,801	5,944	8,112	204,800
Non Personnel Costs	82,383	8,129	2,351	4,230	97,093
Provider Payments	74,842	103,388	9,477	57,828	245,534
Offsets	3,210	1,680	3,164	244	8,298
Total Operating Expenditure	331,378	132,998	20,937	70,413	555,725
Surplus (Deficit)	(1,595)	1,212	2,018	(1,247)	388

Annex: Description of Output Classes

Nationwide, DHBs structure all their services into four Output Classes, each of which has several Sub Output Classes.

Prevention Output Class

Publicly funded services that protect and promote health across the whole population or particular subgroups of it. These services improve the health status of the population, as distinct from treatment services (the other three Output Classes) which repair or support illness or injury. Includes:

- health promotion to prevent illness
- statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases
- population health protection services (immunisation, screening etc)
- well-child services.

Early Detection and Management Output Class

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 and are typically generalist (non-specialist) in nature. Similar types of services are usually delivered in numerous locations across the community. Includes:

- primary health care
- oral health
- primary community care programmes
- pharmacy services
- community referred testing and diagnostics (laboratory and imaging services)
- primary mental health services.

Intensive Assessment and Treatment Output Class

Complex, specialist services, commonly referred to as 'secondary' or 'hospital' services. They are accessible only by referral from a primary practitioner. They are available in only a few locations, either on hospital sites or they use hospitals as the base from which to provide services in the community. Includes:

- inpatient services, both acute (treatment is needed now) and elective (treatment can be scheduled at a later date), (includes diagnostic, therapeutic and rehabilitative services)
- ambulatory services for people treated by a hospital but not admitted as an inpatient (includes outpatient, district nursing and day services) across the range of secondary preventive, diagnostic, therapeutic, and rehabilitative services
- emergency department services including triage, diagnostic and therapeutic services
- secondary mental health services
- secondary maternity services
- assessment treatment and rehabilitation.

Rehabilitation and Support Output Class

Services for older people and palliative care services. They include:

- needs assessment and service coordination
- home-based support
- age related residential care beds
- respite care
- day services
- rehabilitation
- palliative care
- life-long disability services.

Reporting on Appropriations

The 2014/15 Vote Health Estimates of Appropriations noted that performance information for selected Non-departmental Appropriations (Health Workforce Training and Development, National Child Health Services, National Contracted Services, National Disability Support Services, National Elective Services, National Emergency Services, National Health Information Systems, National Maternity Services, National Mental Health Services, National Personal Health Services, and Primary Health Care Strategy) would be reported in part through DHBs 2014/15 Annual Reports. The Ministry of Health has advised DHBs that the Minister of Health will report this information instead of DHBs. Readers wishing to view the overall budget and performance information for these selected Non-departmental Appropriations will be able to refer to the Minister of Health's 2014/15 Vote Health Non-Departmental Expenditure report. This report will be made available on the Ministry of Health's website.

National Health Targets

These targets focus on improving the health sector's performance, and ensure our health and disability system is contributing to maintaining and improving health outcomes in these important areas.

Northland health targets: quarter 4 (April–June) 2014/15 results							
	Shorter stays in emergency departments	**Increased access to elective surgery**	**Faster Cancer Treatment**	**Increased immunisation (8-month-olds)**	**Better help for smokers to quit – hospitals**	**Better help for smokers to quit – primary care**	**More heart & diabetes checks**
Ranking quarter 4, 2014/15	18	1	11	19	8	18	4
Quarter 3, 2014/15	91.2%	133.0%	64.3%	86.7%	95.6%	91.7%	91.2%
Quarter 4, 2014/15	93.2%	127.2%	66.1%	86.3%	96.3%	84.8%	91.2%
National goal	95.0%	100.0%	85.0%	95.0%	95.0%	90.0%	90.0%

The DHB ranking shows the DHB's relative performance compared to other DHBs. In most cases a rank of one represents comparatively good performance, and a rank of 20 represents relatively poorer performance. However, where DHBs have achieved the national goal they are all considered to be good performers.

Shorter stays in Emergency Departments (DHB)

The target is 95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours. The target is a measure of the efficiency of flow of acute (urgent) patients through public hospitals, and home again.

We continue to work on measures to address acute patient flow and to work in a more integrated way across the health sector such as the Northland Health Services Plan project 'Whangarei Hospital Urgent Healthcare', with a particular focus on acute general medicine.

Improved access to elective surgery (DHB)

The target is an increase in the volume of elective surgery by at least 4,000 discharges nationally per year.

Northland DHB has achieved its 2014/15 health target with improved access to elective surgery reaching 127.2 percent. For the full year, 8,202 people have been provided with elective surgery, which is 1,638 patients (25 percent) more than planned.

This is now the eighth year in a row that Northland DHB has exceeded our full year health target. The Ministry of Health has considered us an outstanding performer in elective services since 2007/08.

Faster Cancer Treatment (DHB)

The target is 85 percent of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July 2016, increasing to 90 percent by June 2017. Results cover those patients who received their first cancer treatment between October 2014 and March 2015.

Northland's performance in commencing treatment within 62 days for patients referred with a high suspicion of cancer deteriorated slightly in the most recent quarter. Although there was substantial improvement for patients with breast cancer, this was offset by deterioration in respect of lung and colorectal cancer.

Current initiatives to reduce waiting times for cancer treatment have included the commissioning of a second CT scanner and a new MRI scanner, an upgrade to a new regional technical standard for cancer stream multi-disciplinary meetings, timelier medical oncology clinics, and much reduced waiting times for colonoscopy investigations. These and other initiatives will lead to improved services and reduced waiting times for patients in the future.

Increased immunisation (DHB)

The national immunisation target is 90 percent of eight-month-olds have their primary course of immunisation at six weeks, three months and five months on time by July 2014, and 95 percent by December 2014. This quarterly progress result includes children who turned eight-months between April and June 2014 and who were fully immunised at that stage.

Immunisation protects people against harmful infections which can cause serious complications, including death. It is one of the most effective and cost-effective medical interventions to prevent disease.

Our immunisation health target results have been disappointing. Northland DHB achieved 86.3 percent to June 2015, well below the target of 95 percent. There is an immense amount of work being done in this area with renewed initiatives and a steering group chaired by the chief executive. Northland has a challenging environment with high rates of people declining immunisation.

The immunisation communication strategy has been strengthened with the production of television commercials featuring local champions, including Dr Lance O'Sullivan, asking people to ensure they 'immunise on time'.

Better help for smokers to quit (DHB and PHO)

The target is 95 percent of patients who smoke and are seen by a health practitioner in public hospitals, and 90 percent of patients who smoke and are seen by a health practitioner in primary care, are offered brief advice and support to quit smoking.

Our hospital target reached 96.3 percent in quarter four 2014/15, up three percent on quarter four 2013/14. Northland DHB, alongside Northland PHOs, had a disappointing result in primary care, dropping to 84.8 percent from 96.6 percent quarter four 2013/14.

More heart and diabetes checks (PHO)

This target is 90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years.

Northland DHB achieved the target with a result of 91.2 percent, a one percent increase on the previous year.

Primary Health Organisations health targets (2014/15)

Increased immunisation

The national immunisation target is 95 percent of eight month-olds have their primary course of immunisation at six weeks, three months and five months on time.

Manaia Health PHO reached 92 percent and Te Tai Tokerau PHO reached 85 percent, both below the target of 95 percent.

(The PHO coverage for increased immunisation only includes those eight-month-olds that are enrolled in a PHO. Consequently the DHB coverage will be different to the combined PHO coverage.)

Better help for smokers to quit (PHO)

The national target is that 90 percent of patients who smoke and are seen by a health practitioner in primary care are offered brief advice and support to quit smoking.

The Manaia Health PHO result dropped 20 percent to 89 percent from 110 percent in the 2013/2014 year-end quarter.

Te Tai Tokerau PHO's result also dropped 3 percent to 79 percent from 82 percent in the 2013/2014 year-end quarter.

More heart and diabetes checks (PHO)

This target is 90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years by July 2015.

Manaia Health PHO has met this target reaching 92 percent, the same result as last year. Te Tai Tokerau PHO continued to improve, up two percent to 90 percent.

Primary Health Organisations health targets (2014/15)

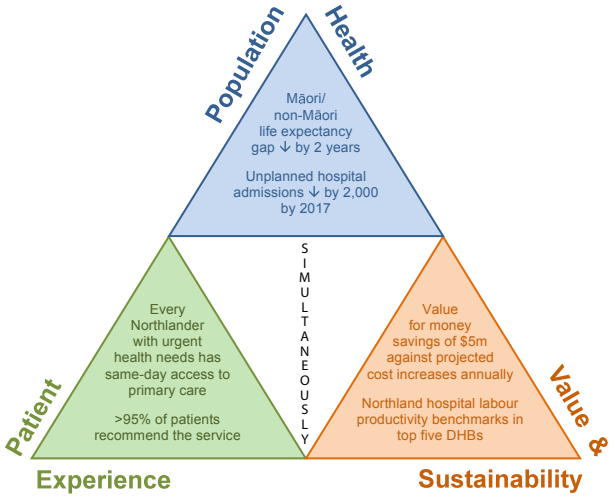
	Increased Immunisation	Better help for smokers to quit	More heart and diabetes checks
Manaia PHO Limited	92%	89%	92%
Te Tai Tokerau PHO Limited	85%	79%	90%
Northland DHB	86[(1)]%	85%	91%
National Goal	95%	90%	90%

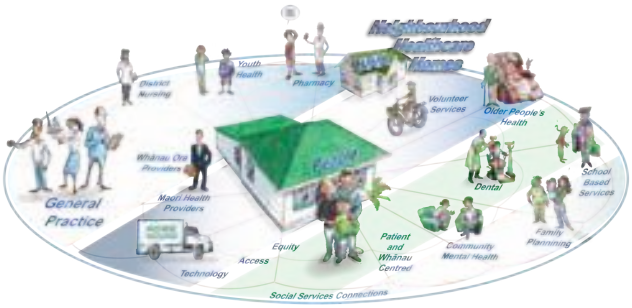
[1]The PHO coverage for increased immunisation only includes those eigth-month-olds that are enrolled in a PHO. Consequently the DHB coverage will be different to the combined PHO coverage.

Implementing Northland Health Services Plan 2012–2017

The implementation of the Northland Health Services Plan (NHSP) 2012-2017 is a collaborative, Northland-wide health sector response to the challenges of our ageing and high-need population. In previous years we have described the background rationale for the five-year strategic plan, the governance and management structure to support the NHSP work and the establishment of major projects to accelerate action towards achievement of our headline targets and the triple aim.

This year we report progress on the major projects.



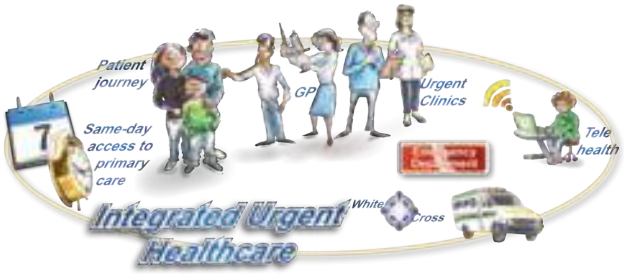


Neighbourhood Healthcare Homes

Neighbourhood Healthcare Homes is a change project aiming to lead the development of a new model of care in primary health, which is well connected, patient and whānau centred and will improve Māori health. To achieve this, in a context of an ageing population and workforce, as well as more complex demand, we need to free up capacity within general practice. There are two areas of focus to achieve this. Firstly, through reorganising the way services are delivered, such as using patient portals, using practice teams differently, changing booking systems, targeting intensive planned services to the highest need patients and streamlining the workplace and processes. Secondly, through linking up general practice with other community-based services more effectively to make the best use of the collective primary and community resources.

Progress to date

- Development of a new model of care for primary and community nurses in Whangarei is in progress so that they are better linked up and use the collective health resources more effectively;
- a volunteer network is being developed around a general practice to test the benefits of tapping into voluntary community resources;
- supporting E-Health initiatives such as Care Select, an e-referral platform between general practice and Non-Government Organisations and patient portals which will enable simple online communication with general practices;
- providing good healthcare utilisation information to general practices on their enrolled population across primary and secondary care;
- jointly planning a different way to proactively work with higher need patients, through grouping patients and tailoring services to their needs;
- working collaboratively in three localities.



The Integrated Urgent Health Care Project Board

This board was established in 2014 and comprises Northland DHB, St John Ambulance, White Cross, a Primary Health Organisation and a general practitioner. Managing acute demand requires taking a view across primary and secondary urgent care and the initial focus of the project has been on two priority areas:

- Same-day access to primary care;
- Patient journey – acute general medicine.

Same-day Access to Primary Care

Timely access to primary care is widely recognised as leading to improved health outcomes and a reduction in health inequities. Availability of GP appointments is not something that is routinely measured and there are varying perceptions regarding availability of same-day general practice appointments from the perspectives of patients, general practitioners, Northland DHB and White Cross. The aim of the project is to actively engage primary care in exploring and addressing the issue of same-day access for patients.

Metrics to measure routine and acute appointments have been identified and the methodology agreed to initiate a piece of research to audit GP appointment availability. The research findings will sit alongside descriptions of the current appointment booking systems and analysis of Accident and Medical and Emergency Department utilisation at general practice enrolled population level. The process for collation of these 'general practice information reports' is currently being finalised (refer also Neighbourhood Healthcare Homes).

A trial to enable patients seen by St John Ambulance to be taken to White Cross has also been initiated. This urgent care pathway, as an alternative to transfer to the Emergency

Department, where appropriate, is supported through Primary Options Northland funding.

Patient Journey – Acute General Medicine
The aim is to improve patients' experience of acute general medicine to ensure they receive the right care, in the right place, at the right time and for the DHB to achieve the Shorter Stays in ED Health Target which is an indicator of whole of system functioning.

The process to redesign the model of care and establish an acute medical assessment unit has been initiated. Significant effort has gone into understanding and building the case for change, agreeing the design principles to underpin the future patient pathway and staffing model, and learning from the experience of other hospitals.

The successful and timely implementation of a new model of care and acute medical admission unit and the achievement of Shorter Stays in ED is a priority for the organisation and a separate project steering group, the Whangarei Hospital Urgent Care Governance Group, chaired by the chief executive, has been established to drive this project.

First 2000 Days

First 2000 Days aims to ensure that 'No Child is Left Behind' – that all Northland infants and children (beginning from conception and to age five years) receive their entitlement of universal health services and the current inequities of health outcomes experienced for tamariki Māori are addressed.

There is widespread agreement on the role of universal child health services in identifying health needs within the family in order to provide families with support as early as possible. These services include well-child screening, assessment and parental education, information and support, access to free general practice medical care, oral health services and the immunisation schedule.

The focus of the work programme is currently on systems improvement and strengthening health literacy:

- Improvement of new born notification and enrolment to the five services delivering and or supporting well child health services; new-born hearing screening, general practice, National Immunisation Register (NIR), Well Child Tamariki Ora Services and oral health;
- Improvement of health literacy about key protective measures that improve infant wellbeing and reduce the risk of illness and Sudden Unexpected Death of an Infant (SUDI); maternal smoking cessation, infant safe sleep practices and breastfeeding. This project has also seen the provision of baby beds for at risk infants;
- Improving the health outcomes for Māori infants by working with pregnant women who are experiencing a complex range of issues, through better first point of contact assessment, case management and collaborative partnerships of Lead Maternity Carer with community Kaiāwhina;
- Improving access for Māori pregnant women to first trimester of pregnancy lead maternity care, antenatal education classes and pregnancy and parenting support networks.

At our best we are...

Patient and Whānau Centred Care

Enriching and Embedding Our Values

A key focus area for this project has been the Enriching and Embedding Our Values Campaign. Our expectation is that by consistently living up to our Values of caring, respect, people first, excellence and communication we will strengthen patient and whānau centred care, improve the staff and patient experience in our services and improve patient safety and quality.

As part of the campaign we held Values Week with 18 workshops throughout Northland involving 758 staff and 139 patients. 'In Your Shoes' patient listening sessions and 'In Our Shoes' staff listening sessions, as well as patient and staff values surveys, provided a wealth of material to inform an agreed set of values-led behaviours and priority actions.

We heard that when we listen, are kind and explain in ways that patients understand, and involve them and their whānau in their care the quality and safety of care improves.

'In Our Shoes' workshops for staff revealed the many good and not so good situations that contribute to our experiences at work. They also identified the types of behaviours staff want to see from the organisation's leadership. This has informed the development of an agreed set of leader specific behaviours.

Patient and Whānau Engagement

Establishment of the Northland Health Consumer Council has been an important foundation for enhancing patient and whānau engagement at Northland DHB, as partners in care and in service planning, development and evaluation. The Consumer Council was selected via a process of nomination by community organisations.

Ten volunteer members were selected:

- Kevin Salmon (Chairperson)
- Chelsea Edmonds (Deputy Chairperson)
- Hikurangi Cherrington
- Debbie Walker
- Kathryn Sadgrove
- Katherine Diamond
- Tania Moriarty
- Elizabeth Cassidy-Nelson
- Marilyn Edwards
- Brian Vickers.

Fit for Life Project

The Northland Health Services Plan project, Fit for Life, provides support to the tobacco control and obesity prevention focus of Te Roopu Kai Hapai Oranga.

Tobacco

The objective of the Fit for Life Tobacco Project was to undertake a review of the effectiveness of current tobacco control services, and provide recommendations to Northland's Alliance Leadership Team on the optimum investment in, and arrangement of, services across Northland for the attainment of the smokefree Northland 2025 goal.

In undertaking the information gathering phase of this project all cessation services and wider tobacco control services across Northland were assessed and summarised, providing an overview of what is being delivered across the district, describing each service and the outcomes being sought and achieved. To provide a consumer perspective on the effectiveness of existing tobacco services, and for the consumers to provide their input into what worked well and what hasn't worked so well, consumers were interviewed across the range of smoking cessation services that are being delivered in Northland.

Solutions were identified, and recommendations made on the future configuration of tobacco control services by working collaboratively with providers and consumers and using

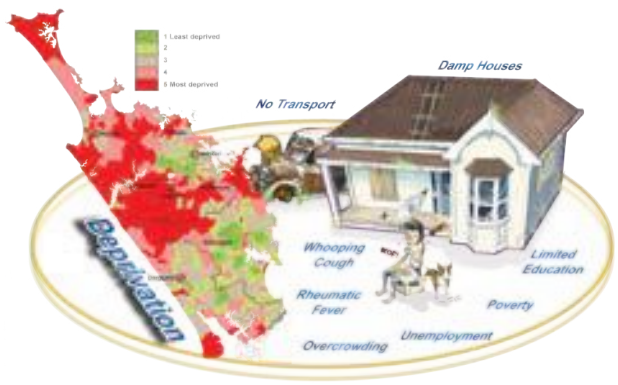
advice from experts on best practice. The recommendations were made in four sections, and are summarised below. All recommendations were endorsed by the Alliance Leadership Team.

- **Communication Plan** - The Northland DHB Public Health Unit develops a district-wide tobacco control communication strategy for 2015/16 in collaboration with all tobacco control providers to meet the needs of the priority groups, including a social marketing campaign and social media campaign.
- **Service Reconfiguration** - Reconfigure tobacco control services and resources to better meet the needs of our priority groups, being Māori Adult; Māori Youth; Hapu Mama and Mental Health. Service reconfiguration is to be based on population, geography and evidence.
- **Quality** - Develop a web based reporting and monitoring database within Northland DHB to capture all tobacco control reporting. Develop a district wide smoking register to target smokers and track quit attempts.
- **Mental Health** - Leadership within Mental Health to encourage and support mental health staff to become smokefree. Funders and providers of mental health services prioritise smoking cessation for clients of mental health services.

Obesity

The Fit for Life Obesity Project has a priority focus on obesity prevention in maternity and children up to the age of ten years, in particular Māori. There is also a focus on the obesogenic environment. The project will establish the current state for initiatives and work that is currently underway related to obesity prevention and intervention in Northland. A process will be undertaken to determine gaps in existing services. The view of experts, service providers and consumers will be considered, to provide recommendations to Northland's Alliance Health Leadership Team on the most effective projects that should be initiated to best tackle the obesity epidemic in Northland, and to deliver those endorsed projects.

Almost 90 active pieces of work have been identified across Northland to date. A process of consumer engagement is currently underway to capture the view of a wide range of consumers across Northland. An Obesity Working Group has been established consisting of a range of intersectoral stakeholders and experts. The Obesity Working Group will be involved throughout the project working collaboratively to inform the recommendations, which will be presented to the Alliance Leadership Team in December 2015.



Eliminating Inequities

Throughout the year Northland DHB has developed an Eliminating Inequities Steering Group programme of work to act as an enabler to the five projects arising out of the Northland Health Services Plan 2012-17.

The Equity Kaitiaki Group (EKG), are tasked with assisting and supporting the organisation to reduce those inequities by:

- developing policy;
- communicating and socialising the need to reduce inequities and;
- delivering training and development on how to change our approach by using an equity lens in decision-making to improve health outcomes for our Māori population.

Eliminating health inequities is the responsibility of all providers and all health professionals working in the health sector. It is noticeable that the key determinants of health are not equitably distributed in Te Tai Tokerau, and the poorer health outcomes for Māori that result can only partially be addressed by the health sector and health services.

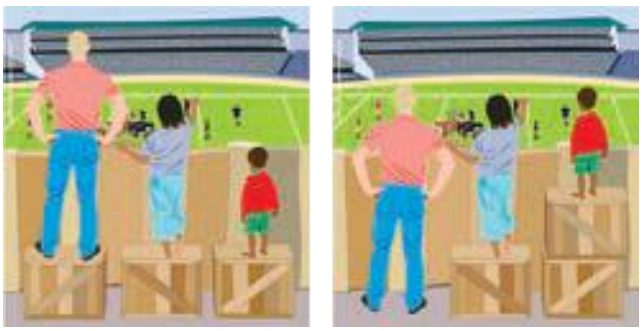
Therefore responsibility is extended out to the wider sector when we seek to accommodate whānau in their journey towards whānau ora. This can be seen through such services as the Social Sector Trials in Kaikohe, Children's Team in Whangarei, Make It Happen Te Hiku in the Far North, Child and Youth Friendly Cities in Whangarei and the Northland Intersectoral Forum where there are a number of community and Government agencies working alongside each other to achieve whānau ora.

Northland DHB is committed to eliminating inequities and improving Māori health gain because it is unacceptable that Māori whānau should die nine years earlier than non-Māori in Northland.

The graphic below depicts the difference and changes required to ensure equality by affecting an equitable response to systems, resources and quality of care in service delivery.

The image on the left gives a perspective on 'equality' where each component is given a perceived equal share of the resources and effort. However the starting point is never equal due to the impacts of socio-economic determinants on a particular portion of the population, in particular Māori. The image on the right shows that equity (extra resource, increase in access, reduction in differential treatment and care and focused effort to a targeted audience) is critical to ensuring equality is effective, particularly in health outcomes.

Equality **vs** **Equity**



Progress to Date

Te Tai Tokerau Whānau Ora Collective and Ki A Ora Ngātiwai receive 'Whānau Direct' funding to support whānau to build on their skills and ability, to grow resilience, and respond positively in situations, and enable access to resources especially at a time of great need:

- A new governance board for Māori Health Gains Council - He Mangai Hauora o Te Kahu A Taonui, re-formed with three iwi leaders from Ngati Whatua, Ngapuhi and Te Rarawa now partnering the Board;
- Results Based Accountability (RBA) training instituted to focus on outcomes rather than outputs to be achieved for Māori whānau, and communities;
- Instituted multi-year RBA contracts with high performing Māori health providers to improve accountability for population health outcomes and provider performance and to inform the question, "is anyone better off?";
- Two Whānau Ora Collectives (Te Tai Tokerau WOC and Te Pu O Te Wheke WOC) are represented on the Northland Health Services Plan Oversight Group where they monitor performance of the Plan and help the DHB better understand requirements for equity for Māori health access, service design, quality and outcomes;
- All four Whānau Ora Collectives are represented on the Te Roopu Kai Hapai Oranga (Alliance Leadership Team);
- Northland DHB and Te Tai Tokerau Whānau Ora chief executives meet quarterly to discuss strategic directions and policy change;
- Continued support and guidance to Māori youth to enter health careers through Kia Ora Hauora initiatives such as workforce exposure, science camps, study wananga, Māori workforce conference attendance;
- Collaborating with other Government agencies to improve whānau ora – Youth Sector Trials, Children's Teams, Make it Happen Te Hiku.

Trendly: Māori Health Performance Monitoring Tool

A new web-based monitoring tool, called Trendly, has been developed to help DHBs accelerate Māori health gains by increasing access to health performance information. This is an innovation of Dr George Gray (Bay of Plenty DHB) and the national Māori General Managers Group - Te Tumu Whakarae.

Each DHB Māori Health Plan identifies how they progress performance against a set of 16 health standardised indicators relating to Māori health which this tool will report on. Poorer outcomes and life expectancy are evident through multiple examples of Māori whānau experiencing poorer health system experiences which does require ongoing performance improvement. Trendly will give greater visibility, transparency and accountability of how each DHB is performing for both Māori and non-Māori.

The health priorities that Northland DHB has achieved targets for, where Māori/non-Māori data is recorded at Quarter 4 are:

- More support for smokers to quit, in secondary services;
- Breastfeeding at 6 months.

Access to the Māori Health Plan Monitoring Tool is available at www.trendly.co.nz

Policy

The Eliminating Inequities Policy is developed for Northland DHB to accelerate Māori health gain into the future and improve equity. Northland DHB health services will utilise the HEAT Tool and the MoH Equity Framework when making decisions regarding:

1. Processes and systems, resource allocation, and performance levels to enable system change;
2. Organisational structure, staffing levels, roles, skill requirements, culture;
3. Technology, IT systems, tools and equipment;
4. Information and data required for the future business operations and performance measures and monitoring of Māori health outcomes.

Manaia Health PHO

By Chris Farrelly Chief Executive

Manaia Health PHO

The Road "Not Less Travelled"

The roadway between Manaia Health PHO and the Northland DHB is well worn. The two way traffic is increasing significantly. The relationship between the DHB and Northland PHOs is strong and perhaps the best of any district in the country. And shame on us if it wasn't! The degree of complexity of health need in Northland is such that we must work closely together at all levels. We not only work together, we share resources, positions, ideas and visions.

The past year has seen the formation of a Northland-wide Clinical Governance Forum which has some of the most experienced and wise clinicians from both secondary and primary care, and also two consumer representatives. Manaia Health has had a consumer council (also known as 'CoAG')

in place for over 10 years and it is a great joy to see the DHB Consumer Council inaugurated and the close links between these two groups. I have just counted over 50 steering oversight or governance groups that have joint PHO-DHB membership, which contributes to our shared care aspirations and goals. The next year will see the launch of a joint patient pathways project which will contribute significantly to joined-up shared care.

The PHO-DHB relationship is strong and healthy, contributing to a healthier Northland.

Chris Farrelly
Chief Executive
Manaia Health PHO

Te Tai Tokerau PHO

By Rose Lightfoot Chief Executive

Te Tai Tokerau PHO is a rural PHO which services the geographical area north of Kawakawa, which includes small remote communities located at some distance from both primary health and hospital services.

In June 2015 Te Tai Tokerau PHO had 61,897 enrolled patients, 48 percent of whom are Māori, 48 percent are of European descent, two percent are Pacific People and two percent identify as Asian with one percent classified as 'other'. Forty-five percent of those enrolled live in areas classified as Quintile 5, the highest level of deprivation, and a total of 68 percent of enrolled patients in Quintile 4 and 5. The geographical area is serviced by 16 general practices with three additional satellite clinics provided to address access in remote areas.

Despite a stretched workforce, and increased demand on primary care services from the influx of seasonal holiday makers during holiday periods, Te Tai Tokerau PHO GPs continue to maintain 24-hour services across the area through after-hours cooperatives and active partnerships between primary care and secondary hospital services in the larger rural communities. This is supported by Homecare Medical, a nursing phone triage service, which is the first point of call for patients after hours.

Te Tai Tokerau PHO's CEO and providers are actively involved in the Rural Service Level Alliance Team established in May 2014 and reporting to the Alliance Leadership Team. The team has wide representation from rural health providers and is comprised of six GPs, one primary health care nurse, two PHO representatives (one each from Te Tai Tokerau PHO and Manaia Health PHO), two Northland DHB representatives, two rural allied health providers and two Māori representatives.

The purpose of this group is to monitor and support the maintenance of a sustainable rural workforce by addressing challenges that impact on health providers in more remote areas, thereby ensuring people living in rural areas have equitable access to quality health care. In July 2014 Te Tai Tokerau PHO took over responsibility for the Rural Workforce Development contract which has provided additional resources to provide professional education across multidisciplinary groups and to coordinate locum relief to support the maintenance of a safe GP/patient ratio.

An exciting symposium was held in Waitangi at the end of June, led by Te Tai Tokerau PHO, entitled The First 2000 Days. The key focus of this work is the health and wellbeing of tamariki from conception to five years, offering strategies to ensure all children are fit and healthy when starting school. A line up of inspirational speakers, poster presentations, and related activities challenged an enthusiastic audience of predominantly nurses. What was evident from the engagement of those participating is that we have a truly committed and expert workforce that Northland can be proud of.

A high priority for Te Tai Tokerau PHO has been the reduction in disparity in the health status of Māori as compared with non-Māori. Building clinical and cultural competence continues to be a high priority within the PHO Annual Plan to achieve that goal. Te Tai Tokerau PHO has led the implementation of some innovative programmes over the last year to address the burden of disease related to diabetes:

- The embedding of the Diabetes Improvement Care Package and More Heart and Diabetes Checks into the routine care by general practices with the practice plans that have been developed resulting in a reduction in disparity of outcomes for Māori;
- A significant increase in access to a subsidised primary podiatry service for people with diabetes. This is facilitated through adherence to a clearly articulated risk stratification process, an electronic referral system and the engagement of a group of enthusiastic community podiatrists;
- The completion of a Health Literacy pilot funded by the Ministry of Health and led by Workbase with a focus on people with diabetes.

There are definite hubs of activity occurring throughout the PHO with several practices engaged in moves to reconfigure general practice to make the services more fit for purpose in meeting the needs of consumers.

There are examples of merging practices under one organisation such as Te Whare Ora o Te Hiku o Te Ika and Kaitaia Health Centre; the co-location of three general practices and the development of a new model of care as in the Integrated Family Health Care Centre led by Ngāti Hine Health Trust in the Bay of Islands; and Kerikeri Medical Centre and Broadway Health Centre extending the concept of a healthcare home to include the development of Neighbourhood Networks involving a range of providers. It is exciting to be part of this change which is also occurring in a wider national and international context.

The stakeholders and health providers are supported by a team of committed people who place a high value on relationships. The environment we work in provides many challenges: a high burden of disease, geographical distance, poverty, and deprivation. Despite this and constrained resources the team works hard to be inspirational and to be the best they can be.

We would like to acknowledge all our colleagues and the clients we work with for the successes of the past 12 months.

Rose Lightfoot
Chief Executive
Te Tai Tokerau PHO

2014 - 2015 Some Highlights

Chief Medical Officer

Northland DHB is proud to be a part of the Health Quality & Safety Commission's 'Open for Better Care' national patient safety campaign. The campaign aligns and works with existing patient safety initiatives, such as the First Do No Harm campaign in the Northern Region, and other local and national initiatives, such as Hand Hygiene New Zealand and Target CLAB Zero.

During the past year, work to reduce the risk of patients falling or developing pressure ulcers in hospital has significantly improved patient safety. Work has also been undertaken to reduce the risk of medication errors and, again, this has significantly improved patient safety.

Over the past year a 'Values' campaign has been introduced by Northland DHB. This promotes adoption of behaviours which strengthen the culture of the organisation. The Values are also aligned with the Patient and Whānau Centred Care work stream. Combined, these two very significant pieces of work will ensure that patients and their families receive the care they need and want in a respectful and supportive environment.

The Quality & Improvement Directorate aims to support the provision of high quality, person-centred, safe and evidence-based care to our community. The Directorate has a role that ensures that individual encounters are consistently person-centred, clinically effective and safe, by establishing a shared understanding of quality and a commitment to place it at the heart of everything we do. A substantive plan for the Directorate has been developed and will be implemented once the external review findings of the Directorate are implemented.

Highlights

Datix Development and Organisational Introduction

The new patient safety reporting system, Datix, was developed in late 2014 and introduced throughout the DHB in early 2015. The advantages are the degree of transparency for adverse events, complaints, and risk. Individual and service dashboards are now well utilised throughout the organisation. Other features of Datix are the ways it helps us understand issues better and assists with monitoring outcomes more closely. The use of open disclosure has now become a standard supported practice within Northland DHB; this process is monitored in Datix.

Clinical Audit Programme

The Clinical Audit Programme has evolved into a robust plan, particularly well supported by junior doctors. There were 19 active audits at June 30, 2015. Although clinical improvement has yet to occur as a result of the audit programme, we are confident that patient safety and outcomes will improve as a consequence. There has been significant interest in the programme from other DHBs in New Zealand.

Compliance Audit Programme

To support certification and to ensure we are doing the 'right thing', a group of interested staff met to develop and plan the implementation of an audit schedule. This is now in place and results available for staff to view.

In-house Improvement Science Staff Training

In conjunction with the Health Quality & Safety Commission, a full day workshop was held and 24 Northland DHB staff participated. Feedback was very positive, and as a result of demand, further workshops are to be scheduled.

In-house Development of Improvement Project Guide

To support staff to understand improvement, a guide has been developed by the Quality Directorate. This is available in hard copy and on the Quality Directorate Staff Central team site.

Reportable Events Committee Redesign

The reinvigoration of the Reportable Events Committee has resulted in agreements with services/committees to gain greater reporting accountability, and includes formal minutes to record actions.

Audit of Closed Complaints

Each month the Quality Improvement Directorate audits 10 closed complaints and five key questions are asked and a follow-up occurs if requested. The findings from the audits are shared through the Board report and via the Clinical Governance Board.

Regular promotional activity related to patient safety

This includes clinical audit promotion and grand rounds, supporting work from the Nursing Directorate and the use of Situation, Background, Assessment, and Recommendation (SBAR) as a communications tool, hand hygiene information, falls promotion and a two monthly Patient Safety newsletter.

Patient Experience Feedback

The feedback process has been in a development stage for quite some time. The information for feedback has now been determined and will be sent out to clinical areas on a regular basis for dissemination/display.

Tracer Audit Training

Tracer audits were introduced via the certification process to monitor the patient journey. Consequently the Quality Improvement Directorate has decided to establish tracer audit training for staff, as a way to help identify areas for improvement.

Introduction of Systems Analysis Investigations (London protocol) to Replace Root Cause Analysis

Eight staff attended Health Quality & Safety Commission training in August 2014 and an expert group has been formed to develop a standardised process for reviewing serious adverse events.

Quality Accounts

There has been an increase this year in the number of quality accounts we will be monitoring and reporting.

Keeping Patients Safe	Clinical audit programme High risk medication project Integrated patient safety system (Datix) Improving perioperative safety
Improving the Patient and Whānau experience	Patient and Whānau Centred Care Patient safety walkrounds Reducing waiting time for CT Transfer of Care (Electronic discharge summary)
Healthier Communities	Manage My Health Neighbourhood Healthcare Homes Integrated Urgent Healthcare
Our Future	First 2000 Days Fit for Life
Eliminating Inequities	Equity tool kit development

Quality Improvement Team

Child, Youth, Maternal, Oral and Public Health Services

Breastfeeding

Breastfeeding is possibly the number one preventative intervention to reduce paediatric hospital admissions. Northland DHB is ranked first in the country with 95 percent of our women breastfeeding their baby on discharge from hospital.

Unfortunately, like the rest of the country, our statistics decline rapidly in the first six weeks then again between three to six months after hospital discharge.

Bay of Islands	Exclusive rate on discharge	97 %
Kaitaia	Exclusive rate on discharge	79%
Dargaville	Exclusive rate on discharge	85%
Whangarei	Exclusive rate on discharge	90%

In an effort to improve these statistics Northland has introduced a teen breastfeeding and parenting support group known as 'yummy mummy'. This group is held every Tuesday at The Pulse in Whangarei and is aimed at young mums between the ages of 13 and 24. It is supported by the DHB, Plunket and Te Ora Hou Aotearoa.

The Lactation Consultant Team has the following initiatives in place:

- Drop-in clinics in Whangarei every Tuesday and Thursday, four hours duration, free to any breastfeeding mother;
- Community home visits to breastfeeding mothers by a lactation consultant – one day per week averaging four-six home visits per woman.

The Big Latch On was held at 'Te Puawai Ora' on 31 July 2014 and attracted over 70 mums and babies. This was a community initiative supported by the DHB, Childbirth Education Classes and the Lactation Team. This year the theme was 'returning to work and breastfeeding'.

The Baby Friendly Community Initiative programme is currently in the Far North and supported by a lactation consultant who is community based. This initiative is supported by the DHB with education and resources by our coordinator and our lactation consultant team. The target group is young Māori teenagers.

Oral Health

Oral health in Northland, within the public health system, is provided from eight fixed site facilities in Dargaville, Whangarei Hospital, Onerahi, Kaitaia Hospital, Kamo and Kerikeri (operated by Northland DHB), 93 mobile sites throughout Northland, 13 operated by Northland DHB, three operated by Ngāti Hine Health Trust and one operated by Hokianga Health Enterprise Trust.

Northland DHB has undertaken the implementation of a new model of service delivery under a programme initiated four years ago by the Ministry of Health as part of its Oral Health Strategy.

The DHB was provided capital funding of $4.881 million in 2008 which has enabled the construction of fixed facilities known as community hubs along with new mobile facilities. The DHB also received operational funding that enabled an increase in workforce amongst all providers.

Level of Enrolments

- 0 to 18 years of age enrolled (across all providers): 36,601;
- Pre-schoolers enrolled: Māori 4,522, Other 3,661;
- School children enrolled: 24,142;
- Adolescents enrolled: 5,180.

In the 2014/15 financial year there were 50,899 dental visits or appointments by children and adolescents in Northland. There is a requirement by the Ministry of Health that these numbers increase by at least another 30 percent. Most providers are on track to achieve this by the end of 2015.

In 2014, 5.7 percent of children and adolescents did not attend an appointment. This meets the target we set for 2014. Currently 90 percent of the children and adolescents enrolled with Northland DHB, Ngāti Hine Health Trust and Hokianga Health Enterprise Trust are being seen annually.

The Northland DHB oral health call centre implemented in 2012 has been a huge success. Every call is answered by a person who is able to triage patients, enrol patients and make appointments. The number of calls coming through the 0800 call centre continues to increase and we have added another person to the call centre phone tree based in Kaitaia.

Public & Population Health

Northland District Health Board's Public and Population Health Services (PHU) delivers comprehensive public health services to the Northland population. This report includes both strategic and operational activities delivered by Northland PHU during the 2014/2015 financial year.

The activities were aligned with Northland DHB's Health Services Plan 2012-2017, key Government priorities, health targets, policies and strategies, including the current Public Health Service Specifications in the Nationwide Service Framework Library, Northland DHB priorities, District Annual Plans, Māori Health Plan, Regional Service Plans and other relevant plans of the Northland DHB.

The service delivery included working across several stakeholders including Territorial Local Authorities, New Zealand Police, Primary Health Care Organisations, Māori Health providers and Non-Government Organisations. Cross cutting areas of work included tobacco/alcohol, nutrition and physical activity and potentially youth mental and sexual health, as well as relevant intersectoral work (e.g. housing).

Some of the key highlights of the Northland PHU for the period covering July 2014 – June 2015 were:

- Northland PHU contributed to NHSP goals with the focus on improving Māori health and reducing inequities in population health/preventable ill health and mortality;
- A key new approach was taken by Northland PHU with enhanced collaboration with Whānau Ora collectives on areas of joint priority (rheumatic fever, oral health and immunisation) and;
- Northland PHU was involved with the Kaikohe social sector trial in Northland.

Northland PHU delivered its services through medical officers of health (currently there is a shortage of medical officers of health[1]), public health strategists, healthy Environments team (health protection officers and technical officers), and the Healthy Lifestyles team (health promotion advisors). Key highlights of all service areas covering communicable diseases, physical environments, social environments, tobacco control, alcohol and other drugs, physical activity and nutrition, sexual health promotion and injury prevention, well child services (including health promotion in schools (delivered by public health nurses) and oral health promotion), health education/ health resource distribution and health promoting schools (HPS), are described on the following pages.

[1] While we were fortunate to have recruited two Medical Officers of Health during 2014, we have had a resignation from one Medical Officer of Health (since April/May 2015) and are currently recruiting for the position. Furthermore, one of our Medical Officers of Health, Dr Clair Mills, took up a 'tour of duty' in West Africa to help with the Ebola outbreak. Dr Mills offered her services in Freetown, Sierra Leone, for a three-month stint as medical coordinator for the Médecins Sans Frontières (MSF) programme.

Service grouping	Highlights
Social Environments	• Adequate Northland PHU representation (Service Manager and Clinical Lead) provided at the Public Health Clinical Leadership group. • Submission made on the proposed options for the sale of raw milk to consumers to the Ministry for Primary Industries (MPI) in July 2014. • Tai Tokerau Population Health Survey was completed and the initial data analysis is now complete. The final report should be complete and disseminated by December 2015. • Healthy Lifestyles team leader was involved in the Health Promoting Schools (HPS) National Advisory Group's implementation of the framework and rollout of the workforce development plan. • The project 'Building Whānau and Youth Resilience in Te Tai Tokerau' was judged the supreme winner of the Northland DHB's bi-annual Northland Health Sector Awards 2014. • Northland PHU coordinated the Northland Rheumatic Fever (RF) Prevention Plan 2013-17 and its implementation. • Northland PHU was represented (by Team Leader, Healthy Lifestyles) at the Northland Health Services Plan project stream – 'Fit for Life' steering group meetings. • Northland PHU was represented (by Service Manager and Medical Officer of Health) at the Healthy Homes Te Tai Tokerau governance group quarterly meetings. • Northland PHU represented (by Smokefree Co-ordinator) at the National SmokeFree Working Group (NSFWG). • Northland sexual health needs assessment completed (outsourced by Northland PHU to an independent contractor - Innovate Change). Northland PHU hosted a Hui for key stakeholders including representatives from the Ministry of Health, Northland DHB (planning, Māori health, sexual health clinical services), PHOs, Family Planning and Ngāti Hine Health Trust and shared the results from the sexual health needs assessment. The final report was disseminated to all key stakeholders. • Submissions made on: - Northland Regional Land Transport Plan; - Northland Regional Public Transport Plan; - Far North District Council's (FNDC) – Local Alcohol Policy (LAP), Local Approved Products Policy (LAPP), and Gambling Policy; - Proposed amendment to regulations under the Medicines Act 1981 – for fluoride containing substances. • Provided public health evidence to FNDC on LAP, LAPP and Gambling; • Provided public health evidence to Whangarei District Council's LAP; • Provided public health evidence to Kaipara District Council on alcohol and gambling policy. • Provided public health advice/input to other sectors by participating at: - Northland Intersectoral Forum[2] - Far North Alcohol Steering Group quarterly meeting; - Whangarei Alcohol management group; - Ongoing participation and collaboration with the TLAs (especially WDC) on maintaining the accreditation of WHO International Safer Communities and UNICEF's Child Friendly City initiative. • Northland PHU was part of the working group in the development of the ROI for the Healthy Families NZ initiative by Te Rarawa. • Evaluation of the Pharmacy pilot throat-swabbing services and treatment of GAS pharyngitis completed. • Clinical testing of a lab-validated point of care test for Group A Streptococcus is currently underway.

[2] The Northland Intersectoral Forum is comprised of local and central Government agencies working in a collaborative way to make a positive difference on the wellbeing of Northlanders. The member agencies include - Ministry of Social Development (Work and Income, Family and Community Services, Child Youth and Family, Ministry of Youth Development), New Zealand Police, Northland Regional Council, Far North, Whangarei and Kaipara District Councils, Te Puni Kokiri, Housing New Zealand, Northland Inc, Northland District Health Board, Ministry of Education, Department of Conservation, Sport Northland, Accident Compensation Corporation, Department of Internal Affairs, Northland PHOs, Department of Corrections, NorthTec, and Careers NZ.

Service grouping	Highlights
Communicable Diseases	• Ebola: substantial input was provided to the local and regional planning for potential Ebola virus disease cases in Northland. • Four cases of meningococcal disease reported in 2014/15; two were group B (P1.5, 10-7 epidemic strain), one group C in an unimmunised adult, and one untyped in bronchial washings of a patient with terminal lung malignancy. Thirty-four close contacts of these cases were followed up. • Nine outbreaks notified (two pertussis, one measles, one salmonella, two norovirus, the remainder gastroenteritis of unknown aetiology). • 16 notifications of acute Rheumatic Fever (six confirmed eight probable) to June 2015. No recurrences. (NB: acute Rheumatic Fever cases are yet to be matched versus hospitalisation data and checked with Child Health Services).
Physical Environments	• Thirty six vessels requesting and/or requiring shipping sanitation inspection inspected and an international Shipping Sanitation Inspection certificate issued where appropriate. • Regular fortnightly inspection against MoH criteria of relevant Northland ports (Refining NZ, Northport, Marsden Cove, Opua – Bay of Islands) and airports. • Two disinterments carried out. One complaint received alleging failure to consider tikanga Māori during a disinterment application which is currently under investigation by the PHU and the MoH. • Hazardous substances issue; Misuse and illegal use of vertebrate toxic agents (notably cyanide) found. One complaint received regarding dumping of asbestos and resolved by working closely with Northland Regional Council. • Sixty-four asbestos samples received in Northland and sent for analysis. • One school investigation resulted in 12 dust samples being taken to test for lead. • One complaint regarding sale of mothballs by retailer. • Six commercial solaria surveyed. • Seven new early childhood centres visited for compliance with Early Childhood Education Regulations. • A total of 444 seawater and shellfish samples were taken. Of those, 12 were reactive flesh samples. None of the 12 reactive tests exceeded the regulatory level of toxins that are safely allowable in recreational shellfish. • At least three Resource Management Act applications were received and commented on. Discharge of contaminants to air (including formaldehyde and isocyanates) was challenged by Northland PHU after reports of respiratory and skin problems. • Drinking water: Some ongoing concerns relating to rural and semi-rural supplies have continued over the last six months (notably Mangonui, Kaeo and Te Kao) and are being addressed with the relevant supply providers. • Recreational water issues: Several beaches in Northland had high levels of E coli (monitored and notified by Northland Regional Council). Northland PHU issued appropriate warning signs. • Algal bloom was identified in water used for recreational purposes and coastal and inland water with Cyanobacteria bloom in Lake Waiparera.

Service grouping	Highlights
Social Environments	
Nutrition and Physical Activity	• Northland DHB Sugar Sweetened Beverage policy restricting the sale of SSBs implemented across all facilities. • Collaboration with Whangarei District Council to install six drinking water fountains around Te Huarahi o Te Whai (Hatea Loop) walkway, Whangarei. • Review of Northland DHB Food policy including its vending machine clause which will see one vending machine supplier contracted and healthier options implemented. • Planning with Waitangi National Trust on Fizz-free policy for 2016 celebrations and with Te Runanga o Ngapuhi for 2016 Ngapuhi Festival. • Collaboration with Whangarei District Council to install exercise stations around Te Huarahi o Te Whai (Hatea Loop) walkway. • Initial discussions started with intersectoral group on cycle-ways initiative in Kaitaia. • Coordinated and facilitated Healthy Eating Active Living (HEAL) network meetings.
Alcohol and Other Drugs	• Much work is occurring around liquor outlet licensing. The Medical Officer of Health has been involved in many public meetings, hearings, and submissions to Whangarei District Council (WDC) and Far North District Council (FNDC). • Provided input into WDC and FNDC's Local Alcohol Plans (LAP). • Continued work with the Emergency Department (Whangarei and Kaitaia hospitals) on Alcohol Helpline project. • Alcohol and other drugs strategy completed for the Kaikohe Social Sector Trial. • 'Whānau Pack' won the 'Best Innovation - creating Social Wellbeing for Māori' award at the Northland social innovation awards. • 'Whānau Pack' also won the 'Taumata Teitei (Hiranga) – Excellence' 2014 Northland Health Sector's Matariki Hauora Māori Awards.
Sexual Health	• Sexual Health Needs Assessment for Northland completed. • Second year of the Kaikohe Emergency Contraceptive Pill Project completed. • A Facebook page 'Common Room' for sexual health issues has been launched. A communications plan was developed to increase youth engagement through page activity, promotion of the page through different avenues (sexual health clinics, public health nurses in schools, Whangarei Youth Space, youth workers, competitions). • Distributed 1,000 Plan Pack Protect (PPP) stickers to the 123 sexual health clinic to put in condom packs handed out to clients. • Distributed 1,000 PPP/Common Room Facebook page information cards to the 123 sexual health clinic to disseminate out to clients.
Well Child Services - Health Promotion in Schools (delivered by public health nurses (PHN)	• All schools in Northland that have Project Energize going into the school are supported by the public health nurses. The Project Energize team have met with the public health nurses and discussed working in collaboration and are supported in their mahi by the public health nurses. • As a part of routine work, public health nurses promote 'sore throats matter'. Public health nurses advocate to school staff and the community to get sore throats checked. Regular 'sore throat matters' messages are put into school newsletters. • An increase in opportunistic throat swabbing being completed. • The public health nurses opportunistically assess and treat under standing orders for skin infections and for the year to date they have assessed 233 students. Students and whānau also receiving education on skin infection treatment and prevention. During home visits, whānau participate in health promotion discussion. Siblings with sore throats or skin infection are identified, assessed, and treated as appropriate via standing orders. • The immunisation schedule is promoted with all parents the public health nurses come into contact with. Parents are referred to the GP for outstanding vaccinations.

Service grouping	Highlights
Oral Health Promotion	• Made submissions to Far North District Council, Whangarei District Council and Kaipara District Council's long-term plans advocating for introducing community water fluoridation to their reticulated water supplies. • Made a submission to the proposed amendment to regulations under the Medicines Act 1981 to exclude fluoride-containing substances. • Supported iwi providers to promote 'Water is the Best Drink' at Waitangi Day; promoted 'Water is the Best Drink' at Te Kura o Otangarei Kapa Haka festival and at Te Hiku Hauora Expo in Kaitaia, Rugby League Northland tournaments in Northland. • Supported the amendment of the 'Northland DHB Healthy Food Policy' that states that Northland DHB will not provide or offer for sale any beverages that are sugar-sweetened pre-point of sales. • Secured US$1,000 Wrigley/NZ Dental Association grant to promote adolescent enrolment and utilisation of public dental services in Northland. • Radio campaigns on promoting enrolment for adolescents broadcast on Flava, The Edge and Mai FM'. • One-off education sessions were delivered to 30 students of Mangakahia Area School and 75 students of Tikipunga Area School. The session looked at oral hygiene, sugar in diet and importance of fibre. • Supported Te Hiku Hauora and Northland DHB Far North dental team to hold coffee groups for young mothers and share oral health promotion messages. • Trained and supported kaimahi of Te Pu O Te Wheke (Whānau Ora Collective) to enrol preschool children into the Northland DHB School and Community Dental Services. • In collaboration with New Zealand Defence Force, Te Whakawhiti Ora Pai, Te Oranga, Te Hiku Hauora, Whangaroa Health Services, Ngati Hine Health Trust and Hokianga Health Enterprise Trust promoted oral hygiene, nutrition and physical activity for Te Kura Kaupapa O Pukemiro, Whangaroa College, Taipa Area School, Broadwood Area School, Abundant Life School, Te Rangi Aniwaniwa, Te Hapua School and Kaitaia College, Year 8-13 students. • Collaborated with health promotion coordinator for Heart Foundation to deliver a session on tooth decay and nutrition to Early Child Care Centre teachers, kaimahi from kōhanga reo and whānau. • Conducted 'Lift the Lip' training for kaimahi of Te Whakawhiti Ora Pai and kōhanga reo in Te Hapua. • Content of 'Te Pukapuka Oranga Niho' and 'The Happy Tooth Book' was finalised and the books were printed. This is the first Te Reo oral health book in Northland. • Under supervision of the Northland DHB clinical director Oral Health Services, conducted training for dental assistants and oral health promoters to apply fluoride varnish to five-year-olds in a school setting. • In collaboration with nutrition and physical activity advisor presented to 40 home-based caregivers of elderly at Hokianga Health Enterprise Trust and explained about the referral pathway for elderly into Northland DHB Public Dental Services. • Collaborated with Te Pu O Te Wheke Whānau Ora Collective, Far North District Council, Te Hauora O Kaikohe and Te Wahaora Roopu to install six water fountains in Mid and Far North townships. Promoted local ownership by doing art design competitions in each area with the theme 'Water is the best drink'.

Service grouping	Highlights
Smokefree/ Tobacco Control	• Nineteen Mid North and 21 Whangarei premises were visited to measure compliance under Smokefree Environments (Controls and Enforcement) Amendment Bill (SFEA). Electronic Cigarettes Compliance Checks undertaken on 10 of these premises. • Smokefree Retailers Toolkit was completed in collaboration with the Cancer Society. The resource is now available nationally. • Whangarei District Council Smokefree 2025 – Whangarei District Council meeting held in August 2014 unanimously passed resolutions: - to extend its smokefree policy into other outdoor areas; - to send a letter to all MPs requesting a ban on the commercial sale of tobacco by 1 January 2025. • Whangarei District Council Smokefree 2025 Logic Model Options Paper – A Smokefree 2025 Logic Model (5-year SF Plan) was submitted in collaboration with Cancer Society Northland for council consideration. • Local Government Remit - Working with the Cancer Society and Whangarei's Mayor regarding mayoral support for a remit that would prohibit smoking in all council-owned open green public spaces and all public transport facilities and hubs. • Submission to Kaipara District Council Long Term Plan 2015-2025. • Submission to Far North District Council Long Term Plan 2015-2025. • Worked with ASH to develop www.smokefreeshops.co.nz • Worked with the Cancer Society Northland, supported by Te Ara Ha Ora and National Smokefree Cars Working Group and developed a national 'Smokefree Cars Tool Kit' for health promoters and community workers. Worked with ASPIRE to host www.aspire2025.org.nz/smokefree-cars-tool-kit. • Kaikohe 'Smoking in Pregnancy Incentives' (Te Whare Oranga o Kaikohe) project started in collaboration with Te Tai Tokerau PHO. • Smokerlyser use trial by midwife service completed - submission completed for Northland-wide project. • Coordinated the WERO Challenge 'Quit to Win' competition (to generate mass quitting) in conjunction with the University of Auckland. • Meetings have been held with Ngātiwai Trust Board members and trustees and marae chairman. Support gained for a Smokefree Iwi initiative incorporating work within schools, Kohanga Reo, and sports clubs within the iwi region. Working committee established with input from Ngātiwai Trust Board members. • Provided face-to-face Cessation Service for 115 referrals (95% Māori) in the Mid north area, based in Kaikohe.

Service grouping	Highlights
Health Information/Education (PHU authorised provider role)	• Oranga Niho (Healthy Teeth) resource book for Early Childhood Centres and Kohanga Reo was completed after two years' work. • Tobacco Free Retailers Toolkit completed in collaboration with the Cancer Society – resource available nationally. • Smokefree Cars Toolkit completed in collaboration with the Cancer Society – resource available nationally. • Worked with MediaWorks Radio in Northland in liaison with health promoters to identify key messaging, creative briefs, script and audio approvals and aligned the campaign with key health issue dates/events and targeted groups. • Provided stickers to Whangarei District Council to be displayed in public toilets covering key messages on rheumatic fever, immunisation, hand hygiene and water is the best drink. • The Resource Unit has a new facility within the inward stores of the Whangarei Hospital campus. • Resources are also displayed in the administration building (Tohorā House) for interested organisations and individuals. • The Resource Unit Coordinator maintains an up-to-date contact list including with PHOs, GP practices, and NGOs including Hauora Māori. • Regular health information is circulated to regional organisations and individuals and regular communication is made with other authorised providers. • Northland PHU has a 0.5 FTE Resource Coordinator who is the 'authorised provider' point of contact for our Public and Population Health Services. • The catalogue was distributed in 2014 to all interested organisations and individuals and is also available on the HealthEd website.
Health Promoting Schools (HPS)	• HPS facilitators recruited for Far North, Mid North, and Whangarei/Kaipara areas and are completing initial contacts and assessments with schools. • Alignment with national training service was achieved.

Public & Population Health (continued).

Immunisation

In an effort to correct Northland's poor immunisation target result we have further developed the health promotion and communication partnership between Northland DHB, Well Child/Tamariki Ora providers and primary health care in reaching our communities. Working closely with our stakeholders in the production of the communication tools, the goal was to ensure the consistency of messages throughout the sector, improve access to information for both staff and whānau and encourage timely immunisation.

Early phases of the strategy focused on normalising immunisation, promoting the expectation of timely immunisation and ensuring people have access to services and information about immunisation. The methods we used included radio, social media, posters and video clips.

Immunisation and Pregnancy DVD

Northland DHB led a collaborative project with our Northern DHB partners and the Immunisation Advisory Centre.

A five-minute DVD was produced including Northland and Auckland whānau and clinicians. Consumer feedback guided the final product that is aimed at promoting immunisation 'on time' against preventable diseases.

I-Immunise Collateral

New collateral was developed with the kind permission of the ImmunisationAlliance Western Australia who agreed to us emulating their creative concept. Featuring local people, including statements about why they choose to immunise, posters and YouTube clips were developed and promoted via providers, Emergency Department TV (EDTV) and social media.

Project Objectives

1. Ensure all health professionals have key messages to engage in confident conversations about a child's immunisation status;
2. Build a health promotion and communication partnership between Northland DHB and Well Child/Tamariki Ora providers, and primary healthcare to ensure timely immunisation;
3. Develop a robust communications approach to support strategies focused on increasing timely immunisation rates in Northland;
4. Provide updated immunisation communication and marketing resources to delivery partners;

5. Increase the consistent awareness of key timely immunisation messages throughout Northland;
6. Immunisation is normalised and our community is informed.

Human Papillomavirus (HPV)

In 2014 a dedicated vaccination team was put in place to focus on delivering the HPV immunisation doses one, two and three and the Boostrix immunisation in schools. The aim of having a dedicated vaccination team was to increase coverage of these two immunisations.

The increased focus supported improvement with 95 percent of the consent forms returned (including both consents and declines). We just missed the 70 percent target for dose one, reaching 67 percent, and exceeded the dose two target (65 percent) with 66 percent and dose three with 63 percent (target 60 percent).

In the 2014 last school term, in recognition of the need for parents and caregivers to have clear information about HPV and the vaccine, public health nurses held information sessions in schools and informed parents that consent forms would be coming home with girls in Year 8.

Other strategies included a Northland produced information pamphlet aimed at parents and caregivers of Year 7 girls informing their parents and caregivers of the vaccination in Year 8. The pamphlet answered questions and provided accurate information so parents and caregivers could make an informed decision about HPV vaccination.

In February 2015 we undertook a promotional campaign on local radio. Vaccination team nurses were interviewed on the local iwi radio station Ngāti Hine FM, and a well-known member of a smaller Northland community championed the campaign, which informed the public of the vaccination programme.

Following the initial campaign, vaccination staff noticed an increase in public interest, including discussion and questions about the vaccine. The campaign was extended for a further three weeks.

The positive outcome of this work is reflected in the increased uptake of the vaccination. So far this year there has been a 96 percent return of consent forms and we have made the 70 percent target with dose one.

Sugar-sweetened beverages removed from DHB sites

In October 2014 Northland DHB removed sugar-sweetened beverages from onsite cafeterias and vending machines.

Sugary drinks removal is important in terms of Type 2 diabetes prevention, as well as obesity prevention, tooth decay and general health. There are more than 9,000 people with diabetes in Northland - that's six per cent of the total population and it's estimated to increase by 72 per cent between 2009 and 2026. Sugar-sweetened beverages can contain large amounts of sugar (and, therefore, energy) but few other nutrients. These generally include soft drinks, fruit drinks, iced tea, sports drinks, energy and vitamin water drinks. Low or no-sugar beverage options include water, unflavoured milk, non-sugar added fruit and vegetable juices, tea, coffee. The DHB is a role model for the community and this extends to healthy food and drink policies and practices. One way to achieve this is to provide an environment that makes the healthy choice the easy choice.

Clinical Services

Elective Waiting Times

Northland DHB succeeded in reducing the maximum waiting time for first specialist assessments and elective surgery from five months to four months during 2014/15. This was a huge achievement requiring many additional clinic consultations and operations, notably a large number of evening clinics and weekend operating sessions.

Achieving the waiting list reduction required a 10 percent increase in elective surgery compared to the previous year. This accomplishment was made even more challenging by the seven percent increase in acute surgery experienced during the year which displaced elective surgical capacity. The financial value of the additional elective surgery was around $3 million at national prices. Nearly 400 additional first specialist assessments were also provided, a two percent increase on the previous year.

Jim Carney Cancer Treatment Centre

Following a major public fundraising campaign, the Jim Carney Cancer Treatment Centre opened in November 2014. This new facility provides high-quality accommodation for patients undergoing assessment or treatment for cancer and the staff caring for them. It replaces a facility which was crowded and uncomfortable.

The new facility provides an excellent basis for Northland's developing local cancer services. New appointments were made to medical and nurse specialist posts. The role of Māori Cancer Care Navigator was established which proved highly successful in making cancer services more easily accessible for Māori patients.

Computerised Tomography (CT) Scanners

Northland DHB's 11-year-old eight slice CT scanner was decommissioned in June 2015 and replaced with two new scanners. One of the new scanners provides diagnostic imaging to the highest available specification. This will enable the DHB to provide new diagnostic services, including CT colonography for investigation of the bowel as an alternative to more invasive colonoscopy procedures. The development of CT coronary angiography will enable patients to undergo non-invasive heart investigations locally rather than having to travel to Auckland for invasive procedures.

The other scanner provides more basic functionality but the additional imaging capacity it provides will enable waiting times to be minimised. This will be particularly beneficial for patients undergoing acute investigation by enabling diagnoses to be made and treatment to be commenced with minimal delay.

Acute Hospital Admissions

Acute hospital admissions increased significantly in 2014/15 with 17,686 admissions compared to 16,729 the previous year. This 5.7 percent increase equated to an additional 845 acute case weights across Clinical Services with a financial value of around $4 million.

The growth in acute admissions resulted in high occupancy levels in the emergency department and on the medical and surgical wards. Medical ward occupancy increased by 4.5 percent resulting in regular outlying into non-medical wards with a peak of 22 outlying medical patients experienced in September 2014.

Acute surgical growth also resulted in major pressures in the operating theatres, including delays in acute surgery being performed and elective operations being cancelled. During 2014/15, there were 206 elective operation cancellations because of capacity and staffing constraints compared to 105 such cancellations the previous year.

Electronic Clinical Communication

Further development in Northland's electronic clinical communication systems was achieved. The electronic referral system was expanded to include the chronic pain service. Remote electronic triaging of referrals was introduced for visiting specialist services, including clinical immunology, dermatology, and vascular surgery which enabled more timely access to specialist advice.

Electronic referral for CT scans was also introduced, including expanded access by GPs based on clinical pathways. A system to automatically upload outpatient clinic letters to primary care information systems was introduced reducing delays in clinical information being conveyed and administrative costs in primary care.

Colonoscopy Waiting Times

The total waiting list for non-urgent colonoscopy procedures was reduced from around 1,100 patients in October 2014 to just over 400 patients by the end of June 2015. This substantial reduction in the waiting list will enable a maximum six-week waiting time for these investigations during 2015/16. The reduction was achieved by additional weekend colonoscopy sessions, use of locum colonoscopists, outsourcing to the private sector, and increased use of advanced CT scanning as an alternative to colonoscopy.

District Hospitals

Over the last year the district hospitals have been focusing on Integrated Family Health Centres. This is a priority of Northland DHB and the Ministry of Health. From a rural perspective, the co-location and effective utilisation of resources, including staff, expertise and facilities, is essential to ensure people have access to a comprehensive range of community and primary care services.

Feedback from our Patients

Both Dargaville and Bay of Islands Hospital continue to receive great feedback. We encourage patients who use the service to provide feedback and often receive some amazing gratitude for the care given. This information is recorded in the Datix system and then fed back to the appropriate departments. A lot of the feedback relates to having a local hospital that ensures they remain in their own community and have close whānau/family support. Below is part of a compliment that was received for a number of services, highlighting that shared care between services is much appreciated.

"Thank you to the hospital staff, doctors and nurses involved over the time my father was in your care and until he passed away. We were given excellent support. I valued the communication offered which was informative and caring. The Kowhai room was comforting for the family and I'm sure it was for dad too. What a great team of caring professionals you are!"

Staff Education

All three district hospitals and other primary nurses were invited to attend a five day training programme that was held

in Kawakawa in November and December of 2014. The course was run by Mobile Health and CPIT (a comprehensive training provider) and was a nursing assessment course. The course encourages nurses to practice at the top of their scope and was interactive. The nurses were taught a vast number of assessment skills that could easily be incorporated into their everyday practice. There was a rural focus and covered everything from the assessment of a child to adult. The feedback from the nursing staff who attended was very positive.

Both Dargaville and Bay of Islands Hospital were part of the fabulous Hand Hygiene campaign that was supported by the Northland Community Foundation. Each hospital has a large banner in prominent places, featuring local staff. The banners encourage patients to ask staff if their hands are clean.

Dargaville Hospital

Shared Care Record

Health information is routinely collected by GPs and other health care providers to give appropriate care and to plan health services. To ensure that those health professionals involved in a patient's care have all the information they need to make good decisions, a partnership between Dargaville Medical Centre, Te Hā Oranga o Ngāti Whātua, Orrs Pharmacy and Northland DHB district nursing services was formed in March 2014 and launched in September 2014.

The Shared Care Record is viewed using a secure electronic system called Manage My Health. The system is operated by Medtech Global and is securely hosted in New Zealand.

There has been very positive feedback over the past 12 months and the system works extremely well ensuring the relevant information is shared among healthcare providers. The governance group meets regularly to audit the notes and since implementation access has also been granted to Hospice Kaipara.

Provision of Medical Service

The DHB have been working closely with Dargaville Medical Centre to review the service delivery of medical care. From October 2015 Northland DHB will be providing the medical cover to the hospital to help ease the burden of after-hours on the GP service. Northland DHB will provide rural hospital medicine specialists to work full-time in Dargaville Hospital with clinical leadership supported by Kaitaia Hospital. Kaitaia Hospital is leading the Rural Hospital Medicine Specialist programme and can now look at how Dargaville Hospital can be incorporated into the programme.

Bay of Islands Hospital

Shared Medical Record

The Kerikeri Medical Centre and Northland DHB mid-north district nursing service, with Te Tai Tokerau PHO, have worked on a small project to encourage shared medical records. It has seen the district nurses given access to the Kerikeri Medical Centre Medtech system and participate in regular patient review meetings. This has encouraged more streamlined delivery of care for the patients in the practice. A small working party meets regularly to review the patient outcomes and discuss further improvements.

Redevelopment of Bay of Islands Hospital

Work continues on the redevelopment of the Bay of Islands Hospital site. Ngāti Hine Health Trust and Northland DHB are working closely on the integration of health services. The redevelopment, which will see a new renal service and an accident and medical service, will also house the after-hours GPs.

Ngāti Hine Health Trust are building a facility called Te Hauora o Pukepuke Rau ('A healthy chief on every hill') on the Bay of Island hospital site. Within the facility there will be a number of shared services including district nurses, physiotherapy, clinical nurse specialists, outpatient services, a GP practice and Ngāti Hine Health Trust's community nursing services.

Fundraising Activity

Most of the hospital participated in Junk Free June a fundraiser for the Cancer Society. Nearly $700 was raised through staff making healthy and delicious soup every Thursday and selling the soup to their colleagues. There was a ban on junk food in staff lunch rooms and lots of discussion on the benefits of healthy eating and exercise.

Kaitaia Hospital

The Hon Dr Jonathan Coleman visits Kaitaia Hospital

One of the highlights for the year was a visit from the Health Minister Dr Jonathan Coleman. Dr Coleman was very impressed with the facility and the work that was being done at Kaitaia Hospital.

Exercise Wisdom Tooth
Northland DHB Dental Service and NZ Defence Force

In partnership with the Northland DHB oral health service, a team of New Zealand Defence Force (NZDF) dental personnel and other associated health promotion personnel, provided a treatment and health promotion programme in October based at Kaitaia Hospital.

The free service, run as a NZDF training exercise, known as Exercise Wisdom Tooth, was aimed at those who hold a community service card. All community service card holders were referred by their GP, the Kaitaia Community Link and private dentists. Some of the patients came from as far away as Whangaroa, Pangaru, Okaihau, Te Kao and Te Hapua to take up the opportunity and during the two-week exercise, the team packed in 750 consultations and over 2,000 treatments (including a clean and scale, fillings, x-rays and extractions).

This exercise resulted in patients being free from pain, with corrective work and restored teeth that enabled some to no longer be ashamed of smiling or talking, and a commitment from them to look after their teeth and to ensure their children do as well.

An integral part of the exercise was a health promotion road show visiting eight schools in the Far North. Classroom learning about oral health and healthy lifestyles was combined with an army assault course team relay activity.

NZDF staff were treated to the renowned Far North hospitality with a hangi on the Saturday night and a seafood buffet on their last evening. A plaque was presented to Northland DHB from NZDF and has been placed in the front entrance of the hospital.

Rural Hospital Medical Training
Northland Leading the Way for Up-and-Coming Doctors

Medical graduates planning to specialise in Rural Hospital Medicine (RHM) no longer need to chase their dream around the country to obtain the required training, thanks to a New Zealand-first programme being rolled out by Northland DHB.

Northland DHB has collaborated to create a RHM training programme all under its collective roof. The sites for training are Whangarei, Kaitaia, Bay of Islands, Dargaville and Rawene.

Unlike other specialities, such as surgery, so far in New Zealand there has not been an all-inclusive programme for RHM trainees that guarantees training requirements within one region with one employer.

Northland DHB has developed a programme that guarantees all of the training requirements over a four-year period, all within Northland and all accredited by the division of rural hospital medicine, Royal NZ College of General Practitioners.

Generally in New Zealand, medical students graduate as house surgeons (surgical) or house officers (medical). After two years they usually apply to their specialist training programme, such as surgery, medicine, paediatrics, gynaecology, general practice and start training towards their vocational registration.

RHM is another type of specialty which began in New Zealand in 2008. It allows the specialist to work independently in rural hospitals, of which there are many in New Zealand, and cover a wide scope of practice, from emergency to inpatient work.

The four-year training programme is popular and includes time in general medicine, paediatrics, ICU/anaesthetics, emergency medicine, rural hospital (on two sites) and rural general practice, plus elective time for further training. Some course work is also involved.

The first four RHM registrars have been approved to train through this programme across Northland DHB and will begin in December 2015.

Kaitaia Hospital clinical leader and project driver Dr Sarah Clarke

Active Workplace

There was reason to celebrate this year as Kaitaia Hospital and Far North Mental Health and Addiction services acknowledged the first-year anniversary of their Active Workplace programme. Kaitaia Hospital staff have been actively participating in an Active Workplace Programme since November 2013. The aim is to improve staff health, coordinate activities and provide education to maintain health and wellbeing.

Every month, heads of department come together and form the steering group of the Active Workplace project. They jointly decide the calendar of events and consider groups or individuals that need support in their community.

Winners of the Northland Health Sector Awards Collaboration category and the Ministry of Social Development Leadership Award have been successes that the team has achieved. Fundraising over $5,000 to go towards a competition uniform was also achieved.

This year our Active Workplace programme focused on staff and families to align with the organisation's goal of being whānau centred.

The first project was to sponsor a young local up and coming athlete, 14 year old Kyla who has been doing cross-fit for the last two and a half years. Last year she competed in her first cross-fit competition and won the novice section representing Kaitaia College.

This year she competed in the New Zealand Junior Cross-Fit teen gauntlet at Hawkes Bay and came first in the Junior Varsity Division, ranking 8th in the world for her age group.

The second major project for the Active Workplace team was to help fundraise to support five local children (including Kyla) representing New Zealand to attend the Cross Fit Kids annual Gauntlet Gathering in California. The Kaitaia Hospital team fundraised over $10,000 to help the children achieve their goals.

A busy year culminated in a Bike/Run and Walk Challenge in September which saw 14 cyclists making their way from

Kaitaia Hospital north to Lake Ngatu, to the turn point and then racing back to Kaitaia Hospital where some cyclists had a relay runner.

There were several runners (without a cyclist team mate) who started their race soon after the first few cyclists returned. Of the 14 cyclists, 12 also completed the Okahu Road loop, either walking or running – a great achievement.

In addition, approximately 35 staff walked and talked their way around Okahu Road Loop.

Information Technology

Northland DHB with its partners in the Northern Region has been supporting an infrastructure upgrade, with detailed migration planning for the National Infrastructure Programme. The Lync telephony and unified communications system has been implemented in Tohorā House and the Jim Carney Cancer Treatment Centre, and significant upgrades on network, storage, and server infrastructure have been undertaken to provide network resilience.

A central component of the Neighbourhood Healthcare Home strategy is identifying the best IT enablers and brokering and providing opportunities for TeleHealth options to be discussed with primary care providers.

A collaborative process bringing together Primary Health Organisations, Public Health, planners and managers has produced a unique tool to support a population health approach in general practice. The tool enables the production of an in-depth report for each general practice on their enrolled population. The report shows health status information and primary and secondary care utilisation. The purpose of this information is to support engagement with general practice, encourage discussion about models of care and provide a baseline to measure impact of new models of care in the future.

The core hospital systems upgrade programme has seen planning studies completed and implementation has begun for both the central patient administration system, WebPAS and the hospital pharmacy system replacements. Medication reconciliation phase one was rolled out, and the Datix integrated incident and complaint management system was implemented. Use of this system has improved reporting of incidents and supported more robust investigations, and in doing so it has contributed to a significant improvement in patient safety.

Telehealth

As part of the Faster Cancer Treatment project, an upgrade to a new regional technical standard for cancer stream multi-disciplinary meetings has occurred for the Whangarei Medical Outpatients and Breast Screening meeting rooms. The improved capability enables sharing of clinical information in real time and high definition and improves access to specialist knowledge. It also improves the patient treatment pathway across the region for the approximately 20 weekly multi-disciplinary meetings. It is planned for the new maternity unit to also have an upgraded room in order to meet demand by early 2016.

Paediatrics, cardiology, renal, mental health and oncology specialist outpatient clinics have continued with expansion of the service into the number of clinics and locations. Consolidation of the northern region videoconferencing network is nearly complete and will mean cheaper and improved quality videoconferencing for the region. We have been gathering the clinical requirements for use of video-conferencing and mobile technology to meet our future needs and this work is being shared with healthAlliance to inform a unified communications strategy. The emphasis is on providing an accessible, secure, affordable technology solution to support the delivery of healthcare within the northern region DHBs and across the Northland health sector.

Whangarei Hospital Redevelopment

New Maternity Facility

The additional floor works have progressed well with a scheduled completion date of February 2016. Migration planning is underway with the intention of the unit being fully functional by early March 2016.

Site Wide Infrastructure

The site wide infrastructure works have been completed and practical completion has been issued.

Maunu House Refurbishment Project

Maunu House has been refurbished, and a review of the services to be located there has taken place to find the best combination of clinical and consumer services.

Paid Carparking Project

Paid car parking was implemented in April 2015. The NZ Transport Agency has agreed in principle with installation of traffic lights (by Northland DHB) to help control the Hospital Road intersection with SH14. Discussions regarding the final configuration and location of the lights are expected to be completed in September. In the interim, a live traffic camera was installed to allow staff to view congestion on Hospital Road so they can plan when to leave the campus.

Northland DHB continues to work with Whangarei District Council to address the issue of staff parking on residential streets around Whangarei Hospital campus.

Bay of Islands Hospital Redevelopment Project

Northland DHB and Ngāti Hine Health Trust are undertaking a joint project to upgrade, replace or build new buildings on the campus to create a Bay of Islands Integrated Family Health Centre, Te Hauora o Pukepuke Rau (‘A healthy chief on every hill’). Northland DHB intends to complete the redevelopment construction by June 2016.

A staff forum was held in Kawakawa to review the concept design and user groups have been initiated to progress the plan to developed design stage.

Discussions between Northland DHB, Ngāti Hine Health Trust and the Ministry of Health continue with regards to the proposed Integrated Family Health Centre ground lease.

Clinical Training Centre Project

Work on the scope and size of the facility was undertaken to be presented to the stakeholder teams. Subject to their agreement a business case will be developed for the governance teams and prospective financiers.

Whangarei Hospital Site Master Plan

A Request for Proposals from planning consultants was placed on the Government Electronic Tenders Service (GETS) website. A timeframe has been established for work to develop a strategic business case for the redevelopment of the Emergency Department, an Acute Admission Unit, the kitchens and Central Sterilisation Unit.

Tohorā House Project

This project was completed in March 2015 and staff from Maunu House, Dairy House and Kamo were successfully relocated to Tohorā House in April.

Whangarei Hospital Minor Works

A number of minor works are being developed or underway to mitigate current pressures in key areas. These works include:

- A procedure room for endoscopy to enable additional colonoscopies;
- Reconfiguring the entrance to the Emergency Department to improve departmental pressures and patient flows;
- Establishing eight additional beds in Wards 14 and 15 to meet the expected increase in winter demand;
- Identifying a possible location for a temporary Acute Medical Assessment Unit;
- The relocation of Paediatrics, Special Care Baby Unit and the Laboratory;
- The relocation of the laboratory in the Bay of Islands Hospital;
- Infrastructure works to the Dental Department.

Nursing and Midwifery Directorate

Care Capacity Demand Management

Northland DHB in partnership with the NZ Nurses Organisation and the Public Service Association are committed to the Care Capacity Demand Management (CCDM) programme. The objective is to achieve an optimal balance between workload and staffing.

The programme includes a variety of tools to assist with managing capacity and demand. The 'Mix and Match' process is an objective assessment of the typical workload in wards and departments to inform a review of the staffing plan for the ward or department concerned.

A Full Time Employee (FTE) calculation process is also undertaken as a second step to this component. A further feature is the development of variance response plans to deal with any variance from the expected pattern. This may involve the movement of staff between departments.

The Hospital At A Glance screens contribute to this by illustrating the workload/staffing situation and actual occupancy, compared with physical bed capacity at any point in time across the various wards and departments. The CCDM Council has handed over to the Care Capacity Operational Group to progress CCDM as business as usual across the organisation.

Ngā Manukura o Āpōpō

Ngā Manukura o Āpōpō – Tomorrow's Clinical Leaders (NMoA) is a national Māori nursing and midwifery clinical leaders network and workforce development programme that recognises the need to grow the number of Māori clinical leaders in the health and disability workforce. The Director of Nursing and Midwifery of Northland DHB is the sponsor of this Ministry of Health funded programme with the current contract effective from January 2015 to December 2016. Northland DHB has held the contract since 2012.

To date NMoA has had the following achievements:

- Fifty graduates from the Poutama programme, that was designed and implemented by Ngā Manukura o Āpōpō, aimed at preparing nurses to mentor and assess the practice of students and peers. The system has been accepted by the New Zealand Nursing Council for recertification audit;
- 161 graduates from Tomorrow's Clinical Leaders, Ngā Manukura o Āpōpō Clinical Leadership Programme;
- Effective national and regional strategic relationships to enable Ngā Manukura o Āpōpō to contribute to the health and disability and education sector;
- Using technology such as an award winning ePortfolio system for nurses to track and store relevant competency documents. Over 300 nurses are registered to date;
- Innovative solutions to track and monitor how Schools of Nursing are performing and supporting Māori students.

Building on the gains achieved from the previous work programme priorities, the next consolidation phase focuses on an overarching theme of leadership, reflected under five work streams:

- Tomorrow's Clinical leadership - Māori nursing and midwifery clinical leaders training;
- Establishment of the Tuakana network and work programme;
- Evaluation of the clinical leadership programme;
- Ngā Manukura o Āpōpō governance group and programme management;
- ePortfolio management.

Nurse Practitioners in Northland

Nurse practitioners are expert nurses who work within a specific area of practice incorporating advanced knowledge and skills. They practice both independently and in collaboration with other healthcare professionals to promote health, prevent disease and to diagnose, assess and manage people's health needs. Many are authorised prescribers under the Medicines Amendment Act 2013. Nurse practitioners demonstrate leadership as consultants, educators, managers and researchers.

In Northland we now have nine nurse practitioners practicing across the community and primary health care settings. Their respective areas of practice include primary health across the lifespan, Whānau Ora, adult and chronic disease management. The nurse practitioners have special interest in diabetes, high dependency nursing in primary healthcare and adult chronic disease management.

In order to maintain competency nurse practitioners are required to provide evidence that includes ongoing peer review of their prescribing practice, a minimum of 40 hours per year of professional development and a minimum of 40 days per year of ongoing nursing practice over a three-year period within their defined area.

Mental Health and Addiction Services (MHAS)

Acute Inpatient Services (Tumanako IPU)

The Tumanako acute psychiatric inpatient unit (IPU) provides a 25-bed hospital service to people in Northland experiencing serious mental illness at a level of acuity where they present a risk to themselves and/or others. The IPU occupancy continues at 100 percent this year. On discharge, patients may go to step-down subacute units (situated in Kaitaia, Kaikohe and Whangarei) which average 94 percent occupancy, to respite care or residential rehabilitation providers in the community, or home. Tumanako has a number of long stay patients with high and complex needs (HCN) and this effectively reduces the inpatient bed capacity and ability to admit patients from the community. There are limited services in Northland for these HCN patients, including minimum secure residential rehabilitation services.

It is likely the prevalence of mental illness and addiction will continue to rise above national trends, due to the socioeconomic deprivation in Northland and the higher percentage of Māori population. At the moment Māori account for 53 percent of IPU utilisation but are only 34 percent of the Northland population (Census 2013). Unmet mental health needs are the single greatest contributor to poor health and social outcomes at an individual, family and population level.

Community Services

Mental Health and Addiction (DHB-provided services) treated 7,483 clients in the year with a total of 107,194,000 client contact events recorded. A further 28,231 care coordination contacts with agencies on behalf of the client were recorded. Community services are located in Kaitaia, Kaikohe, Kerikeri, Dargaville, Kamo, Whangarei and Kaiwaka. Across the service, on average 48 percent of clients were Māori. Mental Health and Addiction Services are exceeding national access targets for child and youth, and for adults.

Additional funding this year was received from the Ministry of Health for Youth Forensic service positions in the Mid North and Whangarei.

Non-government Organisation and Primary Health Organisation Provided Services

Non-government organisations provide a range of services including community support, packages of care, residential services, day programmes, consumer/peer network support, family-whānau advisory, education and support, Kaupapa Māori services and alcohol and drug treatment programmes for all ages and across Northland. This year Northland has expanded the range of services to include medication oversight services in Kaikohe and Kaitaia.

The Taitokerau Kei Te Anga Whakamua: Forward Together - The Northland Way project commenced in September 2014. This project aims to align the model of care across all Northland DHB funded mental health services (including DHB, Non-Government Organisations (NGO), iwi/Māori and PHO providers) across the life cycle from primary to specialist services. The goal is to develop a sector-wide service approach to better meet the service needs of our Northland population for today and into the future.

The challenge is to align what we need to do for our people with Government policy direction and within an economically constrained environment where we have to 'do more and better with the same or less' to find new ways and solutions within existing funding and resources.

A dedicated Northland primary mental health programme leader position for primary mental health initiatives was appointed in March 2015, followed by the establishment of a Clinical Governance Committee for primary mental health initiatives in May 2015.

Every day in Northland, NGOs provide:

- 59 people with supported recovery focused accommodation;
- 22 people with residential alcohol and drug treatment;
- 8 people with acute respite care services;
- Experienced mental health nurses answer on average 15 calls overnight/after-hours from the Mental Health line.

Every month in Northland, NGOs provide:

- 420 adults with support to live independently in their community;
- 75 child and youth with support to live safely and well within their whānau;
- 240 adults with community-based alcohol and drug treatment services;
- 457 child and youth receive co-existing problems enhanced programmes in Whangarei, Kaipara and the Far North.

Last year in Northland Primary Health Organisations provided primary Mental Health and Alcohol and Other Drug services to:

- 330 youth aged 12 to 19 years with 36 percent identifying as Māori;
- 1,978 people aged 20 years +;
- 92 extended GP or practice nurse consultations;
- 951 brief intervention counselling sessions;
- 657 alcohol brief interventions;
- 1,121 packages of psychotherapeutic care with an average of four to five sessions per package;
- 73 percent reported being better off/improved mental health and alcohol status at discharge from services.

Alcohol Screening and Brief Intervention Project

This is a project which aims to screen all ACC patients over 10 years of age, seen in Northland Emergency Departments, for alcohol use in the last 12 hours. The intention is to provide free alcohol and drug counselling and support via landline, cell phone and social media platforms through the Alcohol Drug Helpline. Patients that have been seen three or more times in the past year are automatically referred to alcohol and drug services for follow up and addiction treatment.

The screening is well embedded in Kaitaia Hospital Accident and Medical department, with near 100 percent compliance, and is progressing in Whangarei Hospital Emergency Department with 60 percent compliance. Bay of Islands Hospital is in the initial stages, and Dargaville Hospital will begin once implementation issues are resolved.

Programmes Addressing Drivers of Crime

Northland DHB has continued to offer the Drive Soba Programme for recidivist drink-drivers during 2014/15 with 168 people completing the 18 programmes in the region.

Evaluation of the programme from Police National Computer Data indicates that from June 2007 to June 2014, 87 percent of those who completed the programme are not known to have re-offended.

This rate is well above international recommendations for programmes that are evidence-based on the principles of risk, need and responsiveness. A review conducted by Andrews and Dowden (2001) found on average a 50 percent reduction in recidivism for programmes that followed all the principles that are followed in the Drive Soba Programme.

Northland DHB Mental Health & Addiction Services are providing alcohol and drug programmes in the Northern Regional Corrections Facility, which range from a four hour brief intervention to an eight week intensive programme.

Resilience Project and Suicide Prevention

Northland DHB is committed to contributing to the goal of zero suicide in our region. Suicides are preventable and communities play a critical role in suicide prevention. They can provide social support to vulnerable individuals and engage in follow-up care, fight stigma and support those bereaved by suicide. A key role of providers is to support individuals, whānau and communities to develop their own solutions while providing knowledge, education and support to keep people safe.

Northland DHB's target group is youth (under 25 years) with a focus on Māori. The Northland region experienced a spike in deaths by suicide, serious suicide attempts and suicidal behaviour; particularly tamariki Māori during 2012. The following years have seen a reduction in deaths in those under the age of 25 years. There were seven deaths by suspected suicide during 2013, four in 2014 and from January to August 2015, there has been one death under the age of 25 years.

The Northland DHB chief executive co-chairs the Social Wellbeing Governance Group (SWGG) which provides leadership and executive oversight for Suicide Prevention, Family Violence and the Whangarei Children's Team. SWGG's collective strategic priorities are:

- Responding more effectively to youth wellbeing and family violence prevention;
- Improving outcomes for vulnerable children;
- Promoting healthy lifestyles.

Māori Health

Te Poutokomanawa Māori Health Service

Te Poutokomanawa Māori Health Service supports the concept that the patient as the rangatira/chief of the waka with their whānau directs the pathway of their health journey, ensuring that the paddlers (nga hoe) comprising medical and clinical staff, and key support workers, are all paddling in the same direction to achieve the desired outcomes for wellness and wellbeing of the patient and whānau.

Because clinical staff are the first point of contact with patients and whānau it is important that they are educated in their knowledge of Māori culture to enhance strong relationships with Māori whānau.

Patient and Whānau Centred Care is the primary focus for Te Poutokomanawa Māori Health Service ensuring that Māori patients and whānau are supported with their cultural beliefs and the expectation of those aspects that are important to them while they are in hospital. Takawaenga are cultural workers in the hospital who support Māori patients and whānau on how to navigate their way through the health system to achieve good outcomes.

Patients and whānau are informed of their rights as a consumer of health services and are encouraged to be involved in the discussions with doctors and clinical staff about what is happening for the patient. To clearly understand what is wrong, to be clear about the options for treatment and care, and who will help them with their treatment plan decisions whilst in hospital in preparation for a safe discharge home.

Patients and whānau are informed of the complaints process in the event of any issues that cannot be resolved in the ward.

Patient experience

Te Poutokomanawa's service model is a blend of strong cultural engagement in wairuatanga (spiritual wellness) and whānaungatanga (meeting/greeting and engaging) using te reo me ona tikanga to bond strong relationships and work with the ward multidisciplinary teams in a clinical environment.

This is followed up by manaakitanga (compassionate care and support) during the length of patient stay, while ensuring the principles of tikanga important to Māori patients and whānau are recognised, acknowledged, respected, documented and communicated.

The Tapuhi Clinical Nurse Specialist (CNS) guides the clinical focus for the service in equitable access, treatment and care and outcomes for Māori patients and whānau. Contribution is also given to some health targets, advocacy for Māori patient discharge planning in multidisciplinary team decisions, and addressing patient and whānau complaints.

The Tapuhi CNS has a support patient navigator role following up patient referrals from takawaenga and external clinicians. The quality function is to work alongside takawaenga to support their daily work plan and key service performance expectations, assist the team in their knowledge in areas of health literacy, monitor accurate collection of data, monitoring daily patient admissions, prioritising takawaenga patient engagement and guide staff placements in the hospital.

Our key health targets supported include:

- ED wait times – takawaenga support Māori with their understanding of the ED triage process; monitor wait times; being mindful of patients whose condition may deteriorate and ensure they are being seen in a timely manner; ensure the environment is safe for all visitors and staff to participate in;
- Immunisation – takawaenga play a support role to promote timely immunisation for the protection of tamariki, both in maternity and the children's ward and check they are up to date with their vaccinations, making any necessary referrals to the ward nurse educator;
- Tobacco target – takawaenga complete discussions on ABC (Ask, Brief Advice & Cessation support) with Māori patients if it has not been completed by clinic staff. Takawaenga are also encouraged to talk with Māori patients who identify as smokers, about a nicotine substitute that is available while in hospital and more importantly have the conversation about quitting, making referrals if required;

- Sudden Unexpected Death of an Infant (SUDI) reduction – promoting safe sleep education and option of 'pepi pods' available to mums in maternity services as a means of reducing Māori SUDI rates.

Other indicators include:

- Healthy Home referrals – Takawaenga identify vulnerable patients, children and elderly admitted into hospital and inform them about the Healthy Homes insulation programme. Where the homes of patients are not insulated, meet the criteria or they are unsure, takawaenga can make a referral to the Healthy Homes coordinator to complete an assessment of eligibility for support. This is generally done with the Tapuhi clinical nurse specialist.
- Body tissue return – support the process of identification, storage and return in a timely manner or appropriate disposal where necessary under the values of tikanga. The process of return and disposal of tissue and body parts in storage is monitored by the cultural advisor in conjunction with the mortuary where they are held separate from the deceased;
- Ensuring the concerns and feedback from Māori patients and whānau are heard and addressed in an appropriate, acceptable and timely manner to achieve a good outcome, bring about healing and reduce the risk of reoccurrence;
- Tangihanga/death process – ensuring the process is being conducted in a timely manner and appropriately in response to taha Māori culture and expectations by wairuatanga/prayer and manaakitanga/compassion. Supporting whānau on the coronial process in cases referred to the coroner.

Cultural Safety

Cultural competency and a safe work place environment is an expectation of all staff.

There are three training modules available to all staff to increase their awareness and knowledge on Māori culture: Module 1 Treaty of Waitangi (mandatory for all new staff); Module 2 Towards Cultural Competence; Module 3 Cultural Quality, the application of cultural safety best practice.

The cultural educator offers tailored cultural education to departments across the organisation to raise their awareness and enhance their knowledge to support safe cultural practice. Takawaenga and departments work together to strengthen their models of care to ensure; that services are meeting the cultural needs and expectations of Māori patients and whānau in the appropriate way; and assist patients to attend their hospital appointments.

The Kaunihera Kaumātua representing the four Northland DHB hospital communities and cultural advisor are responsible for ensuring all Northland DHB employees from the board, chief executive, executive leadership, managers and frontline staff are performing in a culturally safe manner. They support organisation events in their own community hospitals and key events at Whangarei Hospital. In addition they have a role of conduits within their own communities promoting key health messages with Māori whānau.

The cultural advisor oversees organisation cultural support, ensures tikanga is being implemented appropriately, and provides cultural advice by request to the organisation.

Cultural Support

Te Poutokomanawa coordinates requests for organisation cultural support with pōwhiri, whakatau, whakawatea and blessings. This is led by the cultural advisor with support of kaumātua and kuia takawaenga.

Workforce Enablement

The national Māori workforce programme Kia Ora Hauora is supported by Te Poutokomanawa by the promotion of health career options focusing on Māori student uptake in select Northland secondary schools. The focus is on raising awareness to students of career opportunities in health and to ensure the right support systems are in place for students who are accepted into University or Polytechnic institutions.

Te Poutokomanawa offer te reo me ona tikanga Māori education programmes to support staff to engage safely and appropriately with patients by enhancing their communication with patients and whānau who speak Māori, who have strong Māori world views, and who live by traditional Māori practices.

Quality Improvement

Te Poutokomanawa's Leadership Team is committed to continuous quality improvement across all facets of Māori health services, invests in staff training and development and the use of 'lean' tools and techniques to improve the provision of efficient, effective and quality service delivery. Current projects include; a review on effective after-hours cultural support, Advanced Care Planning for Māori, and reflections of the current Te Poutokomanawa Māori Health Service model.

Health of Older People & Clinical Support

Support for Older People

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

The Health of Older People model of care which was developed in the 2013/14 year has continued to be implemented. There has been an emphasis on supporting people to remain independent and living safely at home, supported by their neighbourhood primary care and community services. The aim is to provide timely access to specialist service teams across Northland with older people and their whānau participating in this process.

Home and Community Support Services

This year Northland DHB funded Home and Community Support Services for 2,326 Northlanders, compared to 2,420 people in the previous year. There was a 10 percent increase in those requiring personal care support to meet their needs.

There was a $1,068,000 increase in the allocated annual funding. With higher financial and service inputs, Northland is achieving good client outcomes such as lower use of aged residential care and lower than average acute admissions compared to other DHBs (MoH June 2015).

Fifty-eight percent of older people receiving long-term home-based support services have had an InterRAI assessment. This is an increase of 12 percent from the previous year.

Dementia Pathway

Northland DHB has been actively involved in the preparatory stages for implementing the Northern Region Interactive Clinical Pathway for the management of cognitive impairment. The pathway is designed to enable primary healthcare teams to make timely diagnoses of dementia and mild cognitive impairment. This will enable earlier provision of support and services for patients and families.

The focus has been on successively rolling out this electronic pathway in general practices across the northern region and developing the educational resources for GPs and practice nurses to enhance their confidence and utilisation of the pathway.

The coordination function is primarily about removing the obstacles patients face in accessing or receiving early treatment and support.

In 2015/16 both the interactive clinical and care coordination pathways will be implemented in the Mid North and evaluated.

Quality Improvement in Age Related Residential Care (ARRC)

All ARRC providers across Northland continue to be actively engaged in the quality improvement activity facilitated by a dedicated ARRC nurse coordinator, for practice development and a clinical nurse consultant. Our rate of engagement with ARRC providers is the highest in the northern region.

This year we were pleased to note an increase in the number of facilities which hold three or four year certification. At year end, 83 percent of facilities had achieved this level of certification.

The total number of funded age related residential care bed days this year was 321,137, an increase of 0.5 percent from the previous year. Demand for hospital level care continues to increase, with a decrease in demand for rest home care. This is consistent with our model of care which is supporting people to remain independently, and living safely, at home.

Over the year, Northland's ARRC Providers have continued to train their registered nurses to implement the Long Term Care Facility (LTCF) InterRAI clinical assessment tool, which will become mandatory from 2015/16. It aims to improve care quality and the adoption of this tool will ensure that every facility is using the same comprehensive clinical assessment tool to assess and develop care plans for residents. Over 2014/15, 88 percent of our contracted ARRC service providers had at least one nurse competent in InterRAI LTCF.

Fracture Liaison Service

The Fracture Liaison Service was initiated this year. The intention of the service is to follow up people at risk of fractures and to put in place strategies to prevent this occurring. This is part of a national initiative based on the knowledge that people who have had a fall or a fracture are at risk of subsequent fractures.

Breast Screening

Northland DHB has exceeded the national target for non-Māori and the total eligible population (71.9 percent).

Though the number of screens of Māori women remained constant, the percentage coverage has dropped in 2015 from 74.2 percent to 66.6 percent. This occurred because the 2013 Census (released by the NSU in 2015) revealed there were 500 more eligible Māori women than was suggested by the 2006-based projections. The Breast Screening service is now working to bridge the gap working in partnership with Primary Health Organisations, Māori Health Providers and GPs.

Retinal Screening

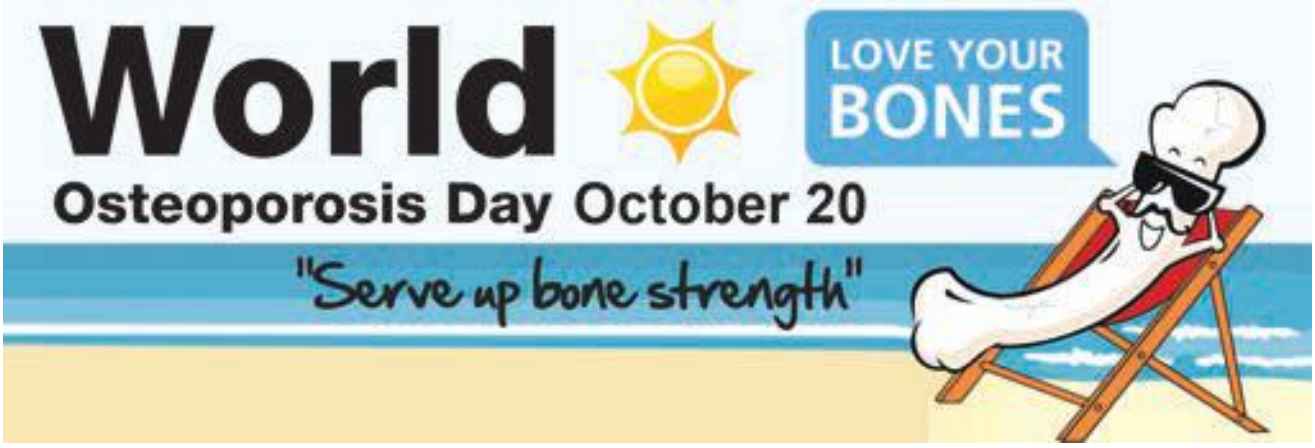
Northland DHB has exceeded the Ministry of Health target for eye screening of Northlanders with diabetes.

Patient-focused bookings are being trialed and during the initial phase the patient 'did not attend' rate has reduced by seven percent.

Patient Administration System Upgrade

Northland DHB has started the process of implementing the Patient Administration System, WebPAS, a new patient administration system.

WebPAS is at the centre of hospital IT systems. Its uses can be many and includes registering and admitting patients, scheduling inpatient and outpatient events, managing theatre bookings and transferring and discharging patients. A constellation of other hospital applications connects to WebPAS to exchange information about individual patients and their past, current and planned healthcare events.



Our Community

Northland Foundation

Health begins where we live and work, learn and play. Northland DHB's commitment to supporting people to stay well in the community means we partner with a range of other agencies to support healthy lifestyles.

The partnership between Northland DHB and Northland Foundation is focused on encouraging community giving to benefit the health needs of all Northlanders, now and in the future.

We work together, raising donations to provide extra equipment and to support innovation and new initiatives that give Northland DHB an extra edge in the delivery of healthcare to the Northland community.

The fundraising helps to get the 'optional extras' or top of the range equipment or services for the DHB that can make all the difference in providing the best quality healthcare possible. In this year the funds received and distributed have covered a wide range of services within the DHB.

Some of the combined activities of the Foundation and the DHB are outlined on this page.

Jim Carney Cancer Treatment Centre

In November 2014 after several years of enormous effort leading a fundraising campaign, the Northland Community Foundation was thrilled to participate in the opening of the Jim Carney Cancer Treatment Centre. Many representatives of the service clubs, businesses, families and individuals who contributed to the fundraising appeal were there to witness this very special occasion. Since the successful opening of the centre, further donations towards its ongoing operation have been received, including those from people who have purchased a 'brick' for the reception area, and also from money in lieu of flowers from patients' families or friends. We have also received donations from patients and their families who have organised special fundraising events to support the centre.

Once the cancer centre was fully operational, the Northland Community Foundation (now the Northland Foundation) was able to move back into its core role of supporting the Northland DHB through its Charitable Accounts Committee. This committee has representation from the Foundation and the DHB. Its job is to receive donations on behalf of the DHB and then to distribute the funds raised via a process under the fundraising, donations and sponsorship policy.

Countdown Kids Appeal

For a number of years, one of the biggest annual fundraising events for the DHB is the Countdown Kids Appeal, which raises funds for specialised equipment for our smallest patients. We work closely with the Countdown supermarkets in the region and last year this wonderful appeal raised $129,000 to support our children and babies through the provision of equipment and facilities which would otherwise not have been available. The support from Countdown Kids covers the whole of Northland, and the benefits are also spread around all the hospitals in the region.

Bronchiectasis Foundation

The Charitable Accounts committee approved a grant to the newly-established Bronchiectasis Foundation to develop their website. The Bronchiectasis Foundation was established by an inspirational young woman, Esther-Jordan Muriwai, and her whānau. Esther-Jordan spent a great deal of time in Whangarei Hospital with bronchiectasis before her death at 24 years of age in 2014. The development of the Foundation was a passion of hers and the launch of this extraordinary organisation was held on the anniversary of her birthday in April.

Hand Hygiene Banners

This year, a special campaign was launched throughout all Northland hospitals to increase the recognition of hand hygiene by health providers as a key way to manage infection control. The main message was spelled out in a unique and highly-visible way with life-size banners of staff members on the walls of the hospitals – encouraging patients and families to ask staff if their hands are clean. Thanks to a grant from the Charitable Accounts Committee, these banners were able to be presented in all Northland hospitals

First 2000 Days Conference

Another key use of donated funds, granted by the Charitable Accounts Committee was to the 'First 2000 Days' conference held in June 2015. The conference, aimed at primary health care nurses, focused on the key first 2000 days of life – as a major contributor to ongoing good health for individuals.

Bio-Impedance Machine

Apart from funds donated, the committee was also pleased this year to receive a donation of a bio-impedance unit for use in the Occupational Therapy service to support in the early detection of lymphodaema which is a common result of breast cancer. The device will add a valuable diagnostic tool to the service.

Endowment Fund – Renal Unit

Northland Foundation receives endowment funds and bequests when someone decides to leave money to the DHB, often in gratitude for wonderful services they have received. Northland Foundation has recently been advised that a person from the Bay of Islands has made provision in their will to leave a portion of their estate to the Renal Unit, with current indications that the likely amount is in the order of $100,000.

Inaugural Northland Health Sector Awards

Northland District Health Board hosted the successful inaugural Northland Health Sector awards in August 2014. With the theme of Working As One/Kotahitanga, the awards showcased innovation, quality and integration in healthcare across Te Tai Tokerau from the previous two years.

There were more than 20 awards in four categories: the Published Authors and Oral/Poster Presenters, the Matariki Hauora Māori Awards, the Quality Improvement Directorate Patient Quality & Safety Awards and the Royal Australasian College of Surgeons Awards. The keynote speaker was intensive care specialist Dr David Galler.

The Royal Australasian College of Surgeons Outstanding Service to the Community Award was presented for the first time in New Zealand to Northland surgeons Jerry Gathercole and Peter Milsom, both being recognised for outstanding service with their dedication and commitment to the Te Tai Tokerau community. The Outstanding Service to the Community Award has been designed to recognise Fellows who have given long and dedicated service to their local community.

The Northland Health Sector Awards will be a bi-annual event.

Guy Robinson - Photographer

Farewells

Retirement for Jerry and Sue Gathercole

The well-respected Northland ear, nose and throat surgeon Jeremy (Jerry) Gathercole and anaesthetist wife Sue were farewelled this year following their decision to retire to Wanaka.

Jerry, who pioneered ontological health and improving outcomes for indigenous people in Northland, had been the Otorhinolaryngology consultant/head and neck surgeon at Whangarei Hospital since 1980 after moving to New Zealand where he trained in otolaryngology.

In 1988, after taking time off to have two children, Sue joined the Anaesthetic Department as a specialist. For the last 27 years Sue has been a huge part of both the development of the hospital and the expansion and evolution of the anaesthetic department as it is today.

During her time in Whangarei Sue has been involved with many projects, especially the development of both the Surgical Admissions Unit and Anaesthetic Pre-assessment Team.

In her last few years at Northland DHB Sue took on the most important role of Supervisor of Training for our college registrars. During her time as supervisor Whangarei Hospital became a sought after place to train, much of it due to her hard work, common sense and mentoring skills.

After being appointed as consultant at Whangarei Hospital, Jerry soon earned a reputation as a knowledgeable and caring doctor. Jerry was involved in establishing the middle ear caravan service in Northland and he pioneered the programme of Grommet Blitz to accelerate the process of identifying the children with glue ear and providing an early surgical intervention service throughout Northland. He always took an active interest in indigenous ENT health and ran fortnightly clinics in the Far North where accessing healthcare can be a challenge.

Other accolades include pioneering tympanic reconstruction techniques, as well as university teaching. He also co-authored a popular glue ear book for general practitioners which is used throughout the country as reference work.

When asked what he will miss the most Jerry said the patients - 'the grateful, grateful patients; and the team, staff and colleagues.'

As well as his passion for the job, Jerry fell in love with the outdoors in New Zealand and has spent many hours fishing and hunting and the couple plan a lifestyle switch to Wanaka. 'I've really enjoyed the lifestyle of Northland but we've decided to retire to Wanaka for a change.'

We Remember

Peter Britton Milsom passed away peacefully at his home in Pakaraka on February 25 surrounded by family and friends. Colleagues paid tribute to a hugely respected, but humble, surgeon whose dedication to his patients went well beyond the call of duty.

Throughout his time as a surgeon Mr Milsom displayed a deep sense of dedication to the public, especially Northland's many poor and Māori residents.

Peter was a hugely respected and humble man with a passion for family, medicine, music and his incredible garden. He remembered his patients' names, their families and whānau and was accepted as a valued member of their community.

Mr Milsom gained his medical degree at Otago University and trained in general surgery in Auckland. He was awarded his FRACS (Fellowship of the Royal Australasian College of Surgeons) in 1972. In 1973-74 he joined the New Zealand surgical team based at Qui Nhon during the Vietnam War.

His commitment to the health of Northlanders began in the 1970s, initially as a GP in Moerewa.

He is survived by his wife Gerry, children and grandchildren.

BOARD ATTENDANCE

Member Attendance 1 JULY 2014 - 30 JUNE 2015

	2014						2015					
BOARD	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**
Tony Norman (Chair)	✓	✓		✓	✓		✓		✓	✓		✓
Sally Macauley (Deputy Chair)	✓	x		✓	✓		✓		✓	✓		✓
John Bain	✓	✓		✓	✓		✓		✓	x		✓
Craig Brown	x	✓		✓	✓		✓		✓	✓		✓
Debbie Evans	✓	✓		✓	✓		✓		✓	✓		✓
Greg Gent	✓	✓		✓	✓		✓		✓	x		✓
Colin Kitchen	✓	✓		✓	✓		✓		✓	✓		✓
June McCabe	✓	✓		✓	✓		✓		✓	✓		x
Chris Reid	✓	x		✓	✓		✓		✓	✓		✓
Bill Sanderson	✓	✓		✓	✓		x		✓	✓		✓
Sharon Shea	✓	✓		x	✓		✓		✓	x		✓

	2014						2015					
CPHAC	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**
Sally Macauley (Chair)			✓			✓	✓		✓			✓
Craig Brown			✓			x	✓		x			x
Debbie Evans			✓			✓	✓		✓			✓
Peter Jensen			✓			✓	✓		✓			✓
Colin Kitchen			✓			x	✓		x			✓
Tony Norman			✓			✓	✓		✓			✓
Mark Sears			✓			✓	x		✓			✓
Sharon Shea			✓			✓	✓		✓			✓
Beryl Wilkinson			✓			✓	✓		✓			✓

	2014						2015					
HAC	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**
Bill Sanderson (Chair)	✓	✓		✓	✓		x		✓	✓		✓
John Bain	✓	✓		✓	✓		✓		✓	x		✓
Win Bennett	✓	✓		✓	✓		✓		✓	✓		x
Greg Gent	✓	✓		✓	✓		✓		✓	x		✓
Libby Jones	✓	✓		✓	✓		✓		✓	x		✓
Sally Macauley	✓	x		✓	✓		✓		✓	✓		✓
Tony Norman	✓	✓		✓	✓		✓		✓	✓		✓
Chris Reid	✓	x		✓	✓		✓		✓	✓		✓
Ariana Roberts	✓	✓		✓	✓		x		✓	✓		✓

No Meeting held

Governance and Partnerships

In accordance with the New Zealand Public Health and Disability Act 2000, the Board has a membership of 11, seven of whom were elected in October 2013 and four of whom were appointed by the Minister of Health. The Board has three committees which provide a more detailed level of focus on particular issues:

Board Members:

Anthony Norman (Chair)
Sally Macauley (Deputy Chair)
Chris Reid
John Bain
Craig Brown
Greg Gent
Debbie Evans
Colin Kitchen
June McCabe
MC (Bill) Sanderson
Sharon Shea

Community & Public Health and Disability Support Advisory Committee

Sally Macauley (CPHAC/DiSAC Chair)
Craig Brown
Debbie Evans
Peter Jensen
Colin Kitchen
Anthony Norman
Mark Sears
Sharon Shea
Beryl Wilkinson

Hospital Advisory Committee:

MC (Bill) Sanderson (HAC Chair)
John Bain
Win Bennett
Greg Gent
Libby Jones
Sally Macauley
Anthony Norman
Chris Reid
Ariana Roberts

Audit, Finance & Risk Management Committee:

Greg Gent (Chair)
Anthony Norman
June McCabe
Sally Macauley

Māori Health Gains Council - Hei Mangai Hauora o Te Kura o Taonui

Anthony Norman
Naida Glavish
Erena Kara
June McCabe
Haami Piripi
Sharon Shea
Sonny Tau

The chief executive is the Board's sole employee and is responsible for implementing the strategic direction of the Board. The chief executive is supported by a strong executive leadership team which oversees clinical, support and advisor services.

Northland DHB understands the social and economic determinants which impact the health status of Northlanders, resulting in an unequal burden of early mortality, morbidity and poorer quality of health for Māori.

The DHB is committed to reducing these inequalities and acknowledges its statutory responsibility and obligations to Māori established in the NZ Health and Disability Act 2000.

The Maori Health Gains Council - **Hei Mangai Hauora o Te Kura o Taonui** gives the Board advice on:

- The health and disability needs, and any factors the Council believes may adversely affect the health status of Northland DHB's resident Māori population;
- How the Board can effectively implement the Northland Māori Health Plan (and other plans) to improve the health status of Northland's resident Māori population.

Financial and Audit Reports

For the year ended 30 June 2015

Statement of Responsibility

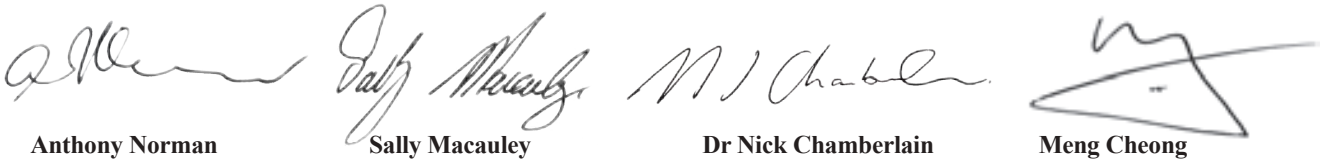
1 The Board are responsible for the preparation of the Northland District Health Board and group's Financial Statements and Statement of Performance and for the judgements made in them.

2 The Board of Northland District Health Board have the responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial and non-financial reporting.

3 The Board is responsible for any end-of-year performance information provided by Northland District Health Board under section 19A of the Public Finance Act 1989.

4 In the Board's opinion these Financial Statements and the Statement of Service Performance for the year ended 30 June 2015 fairly reflect the financial position and operations of Northland District Health Board.

Signed on behalf of the Board:



Anthony Norman
Chairperson
29 October 2015

Sally Macauley
Deputy Chair
29 October 2015

Dr Nick Chamberlain
Chief Executive
29 October 2015

Meng Cheong
Chief Financial Officer
29 October 2015

Board Report

The Board have pleasure in submitting the Financial Statements and Statement of Performance for Northland District Health Board for the year to 30 June 2015.

Principal Activities

The entity's principal activities during the period were funding and the provision of health and disability services for the people of Northland with specialist treatment, community nursing, health promotion and health protection services, most of which were based on contractual arrangements with the Ministry of Health.

Northland District Health Board operates the following hospitals and related services:

- Whangarei Hospital
- Kaitaia Hospital
- Bay of Islands Hospital (Kawakawa)
- Dargaville Hospital
- Primary and community health services providing community, district and public health nursing, public health services, health promotion and health protection services.

	2015	2014
Results and Distribution - Group	$000s	$000s
Surplus/(deficit) Before and After Tax	116	82
Financial Position		
Equity was represented by:		
Current Assets	33,087	72,054
Less Current Liabilities	(71,130)	(81,334)
Plus Non-Current Assets	213,860	159,719
Less Term Liabilities	(41,767)	(32,364)
Total Equity	134,050	118,075

Review of the Operations

A review of the entity's operations accompanies this report under the headings of Chairperson's Report and Chief Executive Officer's Report.

Distributions to Owners

The Board have made payments by way of a specified health payment (capital charge) based on net equity which is treated as an expense not a distribution.

Board Member Fees

No board member of the entity has, since the establishment of the Board, received or become entitled to receive a benefit, except for board and committee member fees and travel allowance, as set by the Ministry of Health. Fees paid to Board and Committee members are detailed in Note 18 of the Financial Statements.

Staff Remuneration

The number of staff with total cost to the entity for senior staff packages including salary and other benefits, such as superannuation, with totals in excess of $100,000 for the year to 30 June 2015 (in $10,000 bands):

$100,001	- $110,000	62	$210,001	- $220,000	7	$320,001	- $330,000	6
$110,001	- $120,000	44	$220,001	- $230,000	8	$330,001	- $340,000	4
$120,001	- $130,000	22	$230,001	- $240,000	7	$340,001	- $350,000	6
$130,001	- $140,000	18	$240,001	- $250,000	7	$350,001	- $360,000	3
$140,001	- $150,000	15	$250,001	- $260,000	6	$360,001	- $370,000	2
$150,001	- $160,000	8	$260,001	- $270,000	7	$370,001	- $380,000	3
$160,001	- $170,000	8	$270,001	- $280,000	10	$380,001	- $390,000	2
$170,001	- $180,000	7	$280,001	- $290,000	9	$420,001	- $430,000	1
$180,001	- $190,000	11	$290,001	- $300,000	6	$440,001	- $450,000	1
$190,001	- $200,000	4	$300,001	- $310,000	7			
$200,001	- $210,000	5	$310,001	- $320,000	2			

Of the 308 staff shown above, 196 are or were medical or dental staff.

If the remuneration of part-time staff were grossed-up to an FTE basis, the total number of staff with FTE salaries of $100,000 or more would be 412, compared with the actual total number of staff of 308.

During the year ended 30 June 2015, 49 (2014: 26) employees received compensation and other benefits in relation to cessation totalling $1,073,394 (2014: $364,947).

Statement of Information

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

Interest Register

All relevant and required disclosures relating to Board members' interests have been effected during the year.

Board Members' Insurance

Northland District Health Board and its Board members have taken out liability insurance providing cover against particular liabilities.

Northland District Health Board have provided a deed of indemnity to Board members for certain activities undertaken in the performance of the Northland District Health Board's functions.

Events Subsequent to Balance Date

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

Donations

No donations were made for the year to 30 June 2015.

Changes in Accounting Policies

There have been no changes in accounting policies from those adopted in the Northland District Health Board's last audited financial statements, other than those required by new standards or amendments adopted as detailed in the accounting policies.

Auditor's Remuneration

The Controller and Auditor-General is appointed under section 15 of the Public Audit Act 2001. Audit New Zealand is contracted to provide audit services on behalf of the Auditor-General. Audit New Zealand in their capacity as Auditors are due $175,479 (2014: $171,555) for audit fees for the group.

Good Employer Obligations

In accordance with section 151(1)(g) of the Crown Entities Act 2004 Northland District Health Board is compliant with its obligation to be a good employer (including its equal employment opportunities programme).

Northland District Health Board has a comprehensive range of human resource management policies and procedures in place in order that it can uphold its good employer status. These include but are not restricted to appointment, orientation, recruitment, leave, continuing education, credentialing, performance management, disciplinary procedures, harassment protection, impaired staff, work and family, workplace rehabilitation and equal employment opportunities.

For and on behalf of the Board of Northland District Health Board.

Anthony Norman
CHAIRPERSON

Independent Auditor's Report

To the readers of
Northland District Health Board and group's financial statements and performance information for the year ended 30 June 2015

The Auditor-General is the auditor of Northland District Health Board and its subsidiaries and other controlled entities. The Auditor-General has appointed me, Karen MacKenzie, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and the performance information, including the performance information for an appropriation, of the group consisting of Northland District Health Board and its subsidiaries and other controlled entities (collectively referred to as 'the Group'), on her behalf.

We have audited:

- the financial statements of Northland District Health Board and the Group on pages 84 to 112, that comprise the statement of financial position, statement of contingent liabilities and assets, and statement of commitments as at 30 June 2015, the statement of comprehensive revenue and expenditure, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of Northland District Health Board and the Group on pages 18 to 45.

Unmodified opinion on the financial statements

In our opinion:

- the financial statements of Northland District Health Board and the Group:
  - present fairly, in all material respects:
    - the financial position as at 30 June 2015; and
    - the financial performance and cash flows for the year then ended; and
  - comply with generally accepted accounting practice in New Zealand and have been prepared in accordance with Public Benefit Entity Reporting Standards.

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

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

Our audit opinion on performance information of Northland District Health Board and the Group for the period ended 30 June 2014, which is reported as comparative information, was modified for the same reason.

In our opinion, except for the effect of the matters described above, the performance information of Northland District Health Board and the Group on pages 18 to 45:

- presents fairly, in all material respects, the Northland District Health Board and Group's performance for the year ended 30 June 2015, including:
  - for each class of reportable outputs:
    - its standards of performance achieved as compared with forecasts included in the statement of performance expectations for the financial year;
    - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year;
  - what has been achieved with the appropriation; and
  - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure.
- complies with generally accepted accounting practice in New Zealand.

Our audit was completed on 29 October 2015. This is the date at which our opinion is expressed.

The basis of our opinion is explained below. In addition, we outline the responsibilities of the Board and our responsibilities, and explain our independence.

Basis of opinion

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

Material misstatements are differences or omissions of amounts and disclosures that, in our judgement, are likely to influence readers' overall understanding of the financial statements and the performance information. We were unable to determine whether there are material misstatements in the statement of performance because the scope of our work was limited, as we referred to in our opinion.

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

An audit also involves evaluating:

- the appropriateness of accounting policies used and whether they have been consistently applied;
- the reasonableness of the significant accounting estimates and judgements made by the Board;
- the appropriateness of the reported performance information within the Northland District Health Board and Group's framework for reporting performance;

- the adequacy of the disclosures in the financial statements and the performance information; and
- the overall presentation of the financial statements and the performance information.

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

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

Responsibilities of the Board

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

- comply with generally accepted accounting practice in New Zealand and Public Benefit Entity Reporting Standards;
- present fairly the Northland District Health Board and Group's financial position, financial performance and cash flows; and
- present fairly the Northland District Health Board and Group's performance.

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

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

Responsibilities of the Auditor

We are responsible for expressing an independent opinion on the financial statements and the performance information and reporting that opinion to you based on our audit. Our responsibility arises from the Public Audit Act 2001.

Independence

When carrying out the audit, we followed the independence requirements of the Auditor-General, which incorporate the independence requirements of the External Reporting Board.

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

Karen MacKenzie
Audit New Zealand
On behalf of the Auditor-General
Auckland, New Zealand

Statement of Comprehensive Revenue and Expenditure

For the Year Ended 30 June 2015

	Notes	Parent Budget 2015 $000	Group 2015 $000	Group 2014 $000	Parent 2015 $000	Parent 2014 $000
Revenue						
Patient Care Revenue	1	536,865	545,780	527,273	545,780	527,273
Finance Revenue	4a	2,753	3,084	3,540	3,069	3,527
Other Revenue	1	7,476	6,834	3,825	7,264	4,239
Total Revenue		547,094	555,698	534,638	556,113	535,039
Expenditure						
Personnel Costs	3	192,120	197,927	187,486	197,927	187,486
Depreciation and Amortisation Expense	10,11	11,461	11,595	11,563	11,188	11,156
Outsourced Services		18,857	23,956	24,120	23,956	24,120
Clinical Supplies		40,224	40,217	37,933	40,217	37,933
Infrastructure and Non-Clinical Expenses	2	23,854	26,384	26,664	26,934	27,214
Payments to other District Health Boards		76,237	69,649	67,875	69,649	67,875
Payments to Non-Health Board Providers		174,361	175,885	168,891	175,885	168,891
Finance Costs	4b	1,016	1,070	1,064	1,070	1,064
Capital Charge	5	8,964	8,899	8,960	8,899	8,960
Total Expenses		547,094	555,582	534,556	555,725	534,699
Share of surplus of equity accounted associates	8	0	0	0	0	0
Surplus/(deficit) Before and After Tax	12	0	116	82	388	340
Surplus attributable to:						
Northland District Health Board		0	176	139	388	340
Minority Interest		0	(60)	(57)	0	0
Other Comprehensive Revenue and Expenditure						
Movements on Property Revaluations		0	16,148	0	14,316	0
Financial Assets at fair value through other Comprehensive Revenue		0	(169)	(120)	(169)	(120)
Total other Comprehensive Revenue and Expenditure		0	15,979	(120)	14,147	(120)
Total Comprehensive Revenue and Expenditure		0	16,095	(38)	14,535	220
Total Comprehensive Revenue and Expenditure attributable to:						
Northland District Health Board		0	15,312	19	14,535	220
Minority Interest		0	783	(57)	0	0

At the end of the 2015 financial year, there was $0 Mental Health Ring Fence Funding unspent (2014: $0).

Explanations of major variances against budget are detailed in note 22.

The accompanying accounting policies and notes form part of these financial statements.

Statement of Comprehensive Revenue and Expenditure *(Continued)*

Supplementary Information

The following table shows the cost of service statements for each operating division:

2015 - Actual	**Provider**	**Governance**	**Funder**	**Kaipara JV**	**Group**
	2015	**2015**	**2015**	**2015**	**2015**
	$000	**$000**	**$000**	**$000**	**$000**
Revenue	305,933	3,346	246,834	(414)	555,699
Expenses	306,328	3,864	245,534	(143)	555,583
Surplus/(Deficit) Before and After Tax	(395)	(518)	1,300	(271)	116

2015 - Budget	**Provider**	**Governance**	**Funder**	**Kaipara JV**	**Group**
	2015	**2015**	**2015**	**2015**	**2015**
	$000	**$000**	**$000**	**$000**	**$000**
Revenue	293,150	3,345	250,598	0	547,093
Expenses	293,150	3,345	250,598	0	547,093
Net Surplus/(Deficit)	0	0	0	0	0

2014 - Actual	**Provider**	**Governance**	**Funder**	**Kaipara JV**	**Group**
	2014	**2014**	**2014**	**2014**	**2014**
	$000	**$000**	**$000**	**$000**	**$000**
Revenue	293,867	3,483	237,690	(401)	534,639
Expenses	294,442	3,490	236,768	(143)	534,557
Net Surplus/(Deficit)	(575)	(7)	922	(258)	82

Statement of Changes in Equity

For the Year Ended 30 June 2015

		Parent Budget	**Group**		**Parent**	
	Notes	**2015**	**2015**	**2015**	**2015**	**2015**
		$000	**$000**	**$000**	**$000**	**$000**
Balance at 1 July		112,519	118,075	118,228	112,632	112,412
Total Comprehensive Revenue and Expenditure		0	16,095	(38)	14,535	220
Balance at 30 June	12	112,519	134,170	118,190	127,167	112,632
Distributions made to Minority Interest		0	(121)	(115)	0	0
Balance at 30 June	12	112,519	134,049	118,075	127,167	112,632
Total Equity attributable to:						
Northland District Health Board		112,519	129,953	114,642	127,167	112,632
Minority Interest		0	4,096	3,433	0	0
Balance at 30 June		112,519	134,049	118,075	127,167	112,632

The accompanying accounting policies and notes form part of these financial statements.

Statement of Financial Position

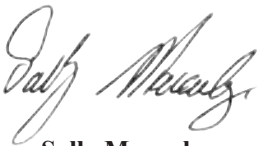
As at 30 June 2015

	Notes	Parent Budget 2015 $000	Group 2015 $000	Group 2014 $000	Parent 2015 $000	Parent 2014 $000
Assets						
Cash and Cash Equivalents	6	30,741	8,501	50,539	8,445	50,474
Trade and Other Receivables	7	12,015	16,402	13,567	16,399	13,564
Short Term Deposits	6	0	335	260	0	0
Short Term Investments	8	3,155	3,124	3,095	3,124	3,095
Inventories	9	3,500	3,818	3,833	3,818	3,833
Prepayments		138	263	112	263	112
Trust/Special Fund Assets		456	644	648	644	648
Total Current Assets		50,005	33,087	72,054	32,693	71,726
Property, Plant and Equipment	10	160,429	186,429	144,753	178,172	137,920
Intangible Assets	11	2,260	2,314	2,355	2,314	2,355
Investments	8	10,740	15,000	3,154	16,762	4,916
Investment in equity accounted investees	8		10,117	9,457	10,117	9,457
Total Non-Current Assets		173,429	213,860	159,719	207,365	154,648
Total Assets		223,434	246,947	231,773	240,058	226,374
Equity						
Crown Equity	12	40,335	44,557	44,557	44,557	44,557
Other Reserves	12	68,042	87,000	71,884	82,050	67,922
Accumulated Surplus/(Deficit)	12	3,486	(2,247)	(2,447)	(83)	(495)
Trust/Special Fund Assets	12	656	644	648	644	648
Total Equity Attributable to Northland District Health Board		112,519	129,954	114,642	127,168	112,632
Minority Interest		0	4,096	3,433	0	0
Total Equity		112,519	134,050	118,075	127,168	112,632
Liabilities						
Trade and Other Payables	13	43,909	38,326	42,405	38,319	42,449
Interest-Bearing Loans and Borrowings	14	0	372	8,208	372	8,208
Employee Entitlements	15	27,599	31,762	29,981	31,762	29,981
Provisions	16	0	670	740	670	740
Total Current Liabilities		71,508	71,130	81,334	71,123	81,378
Interest-Bearing Loans and Borrowings	14	24,650	26,259	16,500	26,259	16,500
Employee Entitlements	15	14,757	15,508	15,864	15,508	15,864
Total Non-Current Liabilities		39,407	41,767	32,364	41,767	32,364
Total Liabilities		110,915	112,897	113,698	112,890	113,742
Total Equity and Liabilities		223,434	246,947	231,773	240,058	226,374

Explanations of major variances against budget are detailed in note 22.

The accompanying accounting policies and notes form part of these financial statements.

Anthony Norman
Chairperson
29 October 2015



Sally Macauley
Deputy Chair
29 October 2015

Statement of Cash Flows

For the Year Ended 30 June 2015

	Notes	Parent Budget 2015 $000	Group 2015 $000	Group 2014 $000	Parent 2015 $000	Parent 2014 $000
Cash Flows from Operating Activities						
Cash Receipts from Ministry of Health and Patients		544,341	548,764	529,777	549,193	530,334
Cash Paid to Suppliers		(333,035)	(339,494)	(326,005)	(339,968)	(326,538)
Cash Paid to Employees		(192,119)	(197,109)	(185,773)	(197,109)	(185,773)
Cash Generated from Operations		19,187	12,161	17,999	12,116	18,023
Interest Received		2,753	3,265	3,480	3,251	3,468
Interest Paid		(1,016)	(1,063)	(1,063)	(1,063)	(1,063)
Net Taxes Refunded/(Paid) (Goods and Services Tax)		0	444	(1,256)	437	(1,249)
Capital Charge Paid		(8,964)	(8,899)	(8,960)	(8,899)	(8,960)
Net Cash Flows from Operating Activities	6	11,960	5,908	10,200	5,842	10,219
Cash Flows From Investing Activities						
Proceeds from Sale of Property, Plant and Equipment		0	12	431	12	431
Acquisition of Property, Plant and Equipment		(34,505)	(36,968)	(10,641)	(36,968)	(10,641)
Acquisition of Intangible Assets		0	(29)	(730)	(29)	(730)
Acquisition of Investments in Associates		0	(765)	(1,502)	(765)	(1,502)
Acquisition of Investments		0	(15,075)	0	(15,000)	0
Receipts from Maturity of Investments		8,395	2,955	14,880	2,955	14,880
Net Cash Flows from Investing Activities		(26,110)	(49,870)	2,438	(49,795)	2,438
Cash Flows from Financing Activities						
Proceeds from Equity Injection		0	0	0	0	0
Borrowings Raised (Repaid)		(58)	1,924	(76)	1,924	(76)
Net Cash Flows from Financing Activities		(58)	1,924	(76)	1,924	(76)
Net Increase/(Decrease) in Cash and Cash Equivalents		(14,208)	(42,038)	12,562	(42,029)	12,581
Cash and Cash Equivalents at Beginning of Year		44,949	50,539	37,977	50,474	37,893
Cash and Cash Equivalents at End of Year	6	30,741	8,501	50,539	8,445	50,474

The accompanying accounting policies and notes form part of these financial statements.

Statement of Contingent Liabilities and Assets

As at 30 June 2015
Contingent Liabilities and Assets:
Northern District Health Board and group have no contingent assets or liabilities (2014: nil)

Statement of Commitments

As at 30 June 2015

	Group		Parent	
	2015	2014	2015	2014
	$000	$000	$000	$000
Capital Commitments				
Buildings	3,894	19,245	3,894	19,245
Plant, equipment and vehicles	704	2,643	704	2,643
	4,598	21,888	4,598	21,888
Intangible Commitments	0	104	0	104
Operating Lease Commitments				
Not more than one year	2,406	2,825	2,703	3,122
One to two years	1,276	1,854	1,573	2,151
Two to five years	2,093	1,927	2,984	2,818
Over five years	3,005	3,316	5,653	6,261
	8,780	9,922	12,913	14,352
Total Commitments	13,378	31,914	17,511	36,344

Capital commitments represent capital expenditure contracted for at balance date but not yet incurred. Current capital projects include the Maternity Unit.

Intangible commitments relate to the issued but uncalled class B shares for Health Benefits Limited.

Northland District Health Board leases a number of buildings, vehicles and office equipment (mainly photocopiers) under operating leases. The leases run for various lengths of time depending on requirements (for buildings) and typically 5 years (for vehicles and office equipment), with an option to renew the lease after that date. None of the leases include contingent rentals.

During the year ended 30 June 2015, $4,249,000 was recognised as an expense in the statement of comprehensive revenue and expenditure in respect of operating leases (2014: $4,180,000).

Notes to Financial Statements

1 Revenue

	Notes	Group 2015 $000	Group 2014 $000	Parent 2015 $000	Parent 2014 $000
Patient Care Revenue					
Ministry of Health population-based funding		516,264	502,180	516,264	502,180
Ministry of Health other contracts		14,586	12,850	14,586	12,850
Inter-district flows		10,101	8,048	10,101	8,048
ACC contract revenue		4,221	3,718	4,221	3,718
Other patient care related revenue		608	477	608	477
Total Patient Care Revenue		545,780	527,273	545,780	527,273
Other Revenue					
Cash Donation Revenue		2,773	0	2,773	0
Other Revenue		4,061	3,825	4,491	4,239
Total Other Revenue		6,834	3,825	7,264	4,239

2 Infrastructure and Non-Clinical Expenses

Included in Infrastructure and Non-Clinical Expenses:		Group 2015 $000	Group 2014 $000	Parent 2015 $000	Parent 2014 $000
Impairment (reversal) of Trade Receivables (Bad and Doubtful Debts)	7	(69)	95	(69)	95
Loss/(Gain) on disposal of Property, Plant and Equipment		(12)	(1)	(12)	(1)
Audit Fees paid to Audit New Zealand for Audit of Financial Statements		175	172	170	166
Board and Committee Member Fees and Expenses		282	300	282	300

Northland District Health Board pays the audit fee of the Kaipara Total Health Care Joint Venture on the controlled entity's behalf. The fee was $5,430 (2014: $5,280).

3 Personnel Costs

	Group 2015 $000	Group 2014 $000	Parent 2015 $000	Parent 2014 $000
Wages and Salaries	191,361	180,076	191,361	180,076
Contributions to Defined Contribution Schemes	5,141	4,816	5,141	4,816
Increase /(Decrease) in Employee Benefit Provisions	1,425	2,594	1,425	2,594
	197,927	187,486	197,927	187,486

Employer contributions to defined contribution schemes include contributions to Kiwisaver, National Provident Scheme and the Government Superannuation Fund.

4 Finance Income and Finance Costs

4a Finance Income

	Group 2015 $000	Group 2014 $000	Parent 2015 $000	Parent 2014 $000
Interest Income	3,084	3,540	3,069	3,527

4b Finance Costs

	Group 2015 $000	Group 2014 $000	Parent 2015 $000	Parent 2014 $000
Interest Expense	1,070	1,064	1,070	1,064

5 Capital Charge

The Northland District Health Board pays a capital charge every six months to the Crown. The charge is based on actual closing equity as at 30 June and 31 December each year. The capital charge for the year ended 30 June 2015 was 8% per annum (2014: 8%p.a.)

6 Cash and Cash Equivalents, Short Term Deposits and Short Term Investments

	Group		Parent	
	2015	2014	2015	2014
	$000	$000	$000	$000
(a) Cash and Cash Equivalents				
Cash On Hand and at Bank	65	77	9	12
Cash on Deposit with Health Benefits Limited	8,436	45,331	8,436	45,331
Short Term Deposits with maturities less than 3 months	0	5,131	0	5,131
Total Cash and Cash Equivalents in the Statement of Cash Flows	8,501	50,539	8,445	50,474
(b) Short Term Deposits with maturities 4-12 months				
Short Term Deposits with maturities 4-12 months	335	260	0	0
Total Cash and Cash Equivalents, Short Term Deposits and Short Term Investments	8,836	50,799	8,445	50,474

The maturity dates and effective interest rates of short term deposits and investments are as follows:

	2015		2014	
	Effective fixed interest rate	Actual	Effective fixed interest rate	Actual
	%	$000	%	$000
Short Term Deposits with maturities of 0-3 months:	0.00%	0	5.74%	5,131
Short Term Deposits with maturities of 4-12 months:	4.04%	335	4.00%	260
Total Short Term Deposits		335		5,391

There were no impairment provisions for cash and cash equivalents.

The carrying amounts of short term deposits approximate their fair value.

(c) Reconciliation of Surplus for the period with Net Cash Flows from Operating Activities:

	Notes	Group		Parent	
		2015	2014	2015	2014
		$000	$000	$000	$000
Surplus for the Period	12	116	82	388	340
Add back Non-Cash Items:					
Depreciation, Amortisation and Assets Written Off		11,595	11,563	11,188	11,156
Add back items classified as Financing Activity:					
Movements in Working Capital:					
(Increase)/Decrease in Trade and Other Receivables		(2,986)	(1,491)	(2,986)	(1,492)
(Increase)/Decrease in Inventories		15	215	15	215
Increase/(Decrease) in Trade and Other Payables		(4,187)	(3,303)	(4,118)	(3,134)
Increase/(Decrease) In Employee Benefits		1,425	2,594	1,425	2,594
Increase/(Decrease) in Provisions		(70)	540	(70)	540
Net Movement in Working Capital		(5,803)	(1,445)	(5,734)	(1,277)
Items classified as investing and financing activities		0	0	0	0
Net Cash Inflow from Operating Activities		5,908	10,200	5,842	10,219

7 Trade and Other Receivables

	Group		Parent	
	2015	2014	2015	2014
	$000	$000	$000	$000
Trade Receivables from Non-related Parties	8,623	6,292	8,620	6,289
Ministry of Health Receivables	7,990	7,555	7,990	7,555
Less: Provision for Impairment	(211)	(280)	(211)	(280)
Balance at 30 June	16,402	13,567	16,399	13,564

The carrying amount of receivables approximates their fair value.

Total receivables comprise:				
Receivables from exchange transactions	10,060	7,340	10,057	7,337
Receivables from non exchange transactions	6,342	6,227	6,342	6,227
	16,402	13,567	16,399	13,564

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

	Parent		Parent	
	Gross Receivable	Impairment	Gross Receivable	Impairment
	2015	2015	2014	2014
	$000	$000	$000	$000
Not past due	16,285	84	13,504	47
Past due 0-30 days	27	12	130	43
Past due 31-60 days	153	22	14	13
Past due 61-90 days	24	23	38	37
Past due >91 days	121	70	158	140
Total	16,610	211	13,844	280

The provision for impairment has been calculated based on expected losses for the Northland District Health Board's pool of debtors. Expected losses have been determined based on an analysis of the Northland District Health Board's losses in previous periods and review of specific debtors.

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

	Group		Parent	
	2015	2014	2015	2014
	$000	$000	$000	$000
Balance 1 July	280	185	280	185
Additional/(Reduced) Provision during the year	(2)	139	(2)	139
Receivables written off during the period	(67)	(44)	(67)	(44)
Balance at 30 June	211	280	211	280

8 Investments

	Group		Parent	
	2015	2014	2015	2014
	$000	$000	$000	$000
Investment in Controlled Entity (at cost)	0	0	1,762	1,762
Investment in Associate (at cost)	10,117	9,457	10,117	9,457
Bonds with maturities > 12 months	0	3,154	0	3,154
Fixed term Deposits > 12 months	15,000	0	15,000	0
Balance at 30 June	25,117	12,611	26,879	14,373
Short Term Investments				
Bonds with maturities 3 - 12 months	3,124	3,095	3,124	3,095
Balance at 30 June	3,124	3,095	3,124	3,095

Investment in Controlled Entity
General Information

Name of Entity	Principal Activity	Interest Held 2015	Interest Held 2014	Balance Date
Kaipara Total Health Care Joint Venture	Medical Centre delivering Health Services	54%	54%	30 June

Investment in Associate
General Information

Name of Entity	Principal Activity	Interest Held 2015	Interest Held 2014	Balance Date
healthAlliance N.Z. Limited	The Operation of shared services for Northland, Waitemata, Auckland, Counties Manukau and Hutt Valley District Health Boards	20%	20%	30 June

On 29 June 2012 Northland District Health Board entered into a sale and purchase agreement to sell certain information technology and other related assets used by healthAlliance in the course of provision of services to Northland District Health Board. On 28 June 2013 Northland District Health Board acquired 1,590,665 Class C shares in healthAlliance for $1,590,665. During 2015 nil (2014: $477,368) sale value of those assets and $660,134 (2014: $1,501,866) for Windows 7 migration was added to the carrying amount of the investment in healthAlliance.

The movement in the carrying value of equity accounted investees is:	Group	
	2015	2014
	$000	$000
Opening Balance	9,457	7,478
Investment in equity accounted investees	660	1,979
Closing Balance	10,117	9,457

The following amounts represent the aggregate assets, liabilities, revenue and profit of equity accounted investees:	As at and for the year ended 30 June 2015	As at and for the year ended 30 June 2014
	$000	$000
Assets:		
Current assets	19,057	20,356
Non-current assets	106,332	94,216
Total assets	125,389	114,572
Liabilities		
Current liabilities	19,466	15,016
Non-current liabilities	4,026	4,142
Total liabilities	23,492	19,158
Net assets	101,897	95,414
Revenue	123,276	109,648
Expenses (including interest and tax)	123,276	109,648
Profit after tax	0	0

Bonds
Bond is recognised at fair value. Fair value has been determined using quoted market price in an active market. Interest rate on the Bond is 6.315% p.a.

9 Inventories

	Group		Parent	
	2015	2014	2015	2014
	$000	$000	$000	$000
Pharmaceuticals	246	228	246	228
Surgical and Medical Supplies	3,572	3,605	3,572	3,605
Balance at 30 June	3,818	3,833	3,818	3,833

No inventories are pledged as security for liabilities. However some inventories are subject to retention of title clauses.

Write-down of Inventories to net realisable value amounted to nil for 2015 (2014: nil).

The amount of inventories recognised as an expense during the year was $27.890m (2014: $26.624m), which is included in the clinical supplies line item in the Statement of Comprehensive Revenue and Expenditure.

10 Property, Plant and Equipment

(a) Group

	Freehold land (at valuation)	Freehold buildings (at valuation)	Plant, equipment and vehicles	Work in progress	Total
	$000	$000	$000	$000	$000
Cost					
Balance at 1 July 2013	7,585	126,384	53,852	3,808	191,629
Additions	0	0	0	13,404	13,404
Disposals	0	(434)	(929)	0	(1,363)
Movement due to Revaluation	0	0	0	0	0
Sale of Assets to healthAlliance ex Work in Progress	0	0	0	(477)	(477)
Transfer to Additions P,P&E	0	4,103	2,035	(6,138)	0
Balance at 30 June 2014	7,585	130,053	54,958	10,597	203,193
Balance at 1 July 2014	7,585	130,053	54,958	10,597	203,193
Additions	0	0	0	36,973	36,973
Disposals	0	0	(631)	0	(631)
Movement due to Revaluation	585	(5,268)	0	0	(4,683)
Sale of Assets to healthAlliance ex Work in Progress	0	0	0	0	0
Transfer to Additions P,P&E	0	19,123	5,547	(24,670)	0
Balance at 30 June 2015	8,170	143,908	59,874	22,900	234,852

	Freehold land (at valuation)	Freehold buildings (at valuation)	Plant, equipment and vehicles	Work in progress	Total
	$000	$000	$000	$000	$000
Depreciation and Impairment Losses					
Balance at 1 July 2013	0	6,660	41,351	0	48,011
Depreciation Charge for the year	0	6,934	4,452	0	11,386
Disposals	0	(50)	(907)	0	(957)
Balance at 30 June 2014	0	13,544	44,896	0	58,440
Balance at 1 July 2014	0	13,544	44,896	0	58,440
Depreciation Charge for the year	0	7,374	4,046	0	11,420
Movement due to Revaluation		(20,810)			(20,810)
Disposals	0	0	(627)	0	(627)
Balance at 30 June 2015	0	108	48,315	0	48,423

10 Property, Plant and Equipment *(Continued)*

	Freehold land (at valuation)	Freehold buildings (at valuation)	Plant, equipment and vehicles	Work in progress	Total
	$000	$000	$000	$000	$000
Carrying amounts					
At 1 July 2013	7,585	119,724	12,501	3,808	143,618
At 30 June 2014	7,585	116,509	10,062	10,597	144,753
At 1 July 2014	7,585	116,509	10,062	10,597	144,753
At 30 June 2015	8,170	143,800	11,559	22,900	186,429

(b) Parent

	Freehold land (at valuation)	Freehold buildings (at valuation)	Plant, equipment and vehicles	Work in progress	Total
	$000	$000	$000	$000	$000
Cost					
Balance at 1 July 2013	7,423	118,899	53,852	3,808	183,982
Additions	0	0	0	13,404	13,404
Disposals	0	(434)	(929)	0	(1,363)
Sale of Assets to healthAlliance ex Work in Progress	0	0	0	(477)	(477)
Transfer to Additions P,P&E	0	4,103	2,035	(6,138)	0
Balance at 30 June 2014	7,423	122,568	54,958	10,597	195,546
Balance at 1 July 2014	7,423	122,568	54,958	10,597	195,546
Additions	0	0	0	36,973	36,973
Disposals	0	0	(631)	0	(631)
Movement due to Revaluation	571	(5,864)	0	0	(5,293)
Sale of Assets to healthAlliance ex Work in Progress	0	0	0	0	0
Transfer to Additions P,P&E	0	19,123	5,547	(24,670)	0
Balance at 30 June 2015	7,994	135,827	59,874	22,900	226,595

	Freehold land (at valuation)	Freehold buildings (at valuation)	Plant, equipment and vehicles	Work in progress	Total
	$000	$000	$000	$000	$000
Depreciation and Impairment Losses					
Balance at 1 July 2013	0	6,253	41,351	0	47,604
Depreciation Charge for the year	0	6,527	4,452	0	10,979
Disposals	0	(50)	(907)	0	(957)
Balance at 30 June 2014	0	12,730	44,896	0	57,626
Depreciation and Impairment Losses					
Balance at 1 July 2014	0	12,730	44,896	0	57,626
Depreciation Charge for the year	0	6,967	4,046	0	11,013
Movement due to Revaluation		(19,589)			(19,589)
Disposals	0	0	(627)	0	(627)
Balance at 30 June 2015	0	108	48,315	0	48,423

10 Property, Plant and Equipment *(Continued)*

	Freehold land (at valuation)	Freehold buildings (at valuation)	Plant, equipment and vehicles	Work in progress	Total
	$000	$000	$000	$000	$000
Carrying Amounts					
At 1 July 2013	7,423	112,646	12,501	3,808	136,378
At 30 June 2014	7,423	109,838	10,062	10,597	137,920
At 1 July 2014	7,423	109,838	10,062	10,597	137,920
At 30 June 2015	7,994	135,719	11,559	22,900	178,172

Work in progress

Property, plant and equipment in the course of construction by class of asset is detailed below

Group & Parent	**2014**	**2015**
	$000	$000
Buildings	10,133	22,198
Plant, equipment and vehicles	464	702
Total work in progress	10,597	22,900

Impairment

No Impairments were recognised in the current year. (2014: $nil was expensed)

Equipment Held under Finance Lease

The net carrying amount of equipment held under finance leases is $2m (2014: $nil).

Revaluation

Current Crown accounting policies require all Crown Entities to revalue land and buildings in accordance with PBE IPSAS 17, Property, Plant and Equipment. Current valuation standards and guidance notes have been developed in association with the Treasury for the valuation of hospitals and tertiary institutions.

The revaluation of land and buildings was carried out as at 30 June 2015 by Peter Todd, an independent registered valuer of Darroch Limited and a member of the Property Institute of New Zealand. The valuations conform to International Valuation Standards. Land has been valued on a market basis and buildings excluding work in progress have been valued on a depreciated replacement cost basis. The valuer was contracted as an independent valuer. The next valuation is due to be completed by 30 June 2018.

Restrictions

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

Titles to land transferred from the Crown to Northland District Health Board are subject to a memorial in terms of the Treaty of Waitangi Act 1975 (as amended by the Treaty of Waitangi (State Enterprises) Act 1988). The effect on the value of assets resulting from potential claims under the Treaty of Waitangi Act 1975 cannot be quantified.

No fixed assets of Northland District Health Board are pledged as security for liabilities.

11 Intangible Assets

Parent and Group

B Class Shares in Health Benefits Ltd and Software

	FPSC Rights 2015 $000	Software 2015 $000	Total 2015 $000	FPSC Rights 2014 $000	Software 2014 $000	Total 2014 $000
Cost						
Balance at 1 July	2,144	1,302	3,446	1,469	1,254	2,723
Software Additions for the Year	0	29	29	0	81	81
Acquisition of FPSC rights in Health Benefits Limited	105	0	105	675	0	675
Disposals	0	0	0	0	(33)	(33)
Balance at 30 June	2,249	1,331	3,580	2,144	1,302	3,446
Amortisation						
Balance at 1 July	0	1,091	1,091	0	921	921
Amortisation Charge for the Year	0	175	175	0	177	177
Disposals	0	0	0	0	(7)	(7)
Balance at 30 June	0	1,266	1,266	0	1,091	1,091
Carrying Amounts						
Balance at 1 July	2,144	211	2,355	1,469	333	1,802
Balance at 30 June	2,249	65	2,314	2,144	211	2,355

There are no development costs accounted for as intangible assets.

There are no restrictions over the title of Northland District Health Board's intangible assets, nor are any intangible assets pledged as security for liabilities.

At 30 June 2015, the Northland District Health Board had made payments totalling $780k (2014: $675k) to Health Benefits Limited in relation to the FPSC Programme, which was in progress at year end. The FPSC rights have been tested for impairment by comparing the carrying amount of the intangible asset to its depreciated replacement cost (DRC), which is considered to equate to the Northland District Health Board's share of the DRC of the underlying FPSC assets.

12 Equity

	Group		Parent	
	2015 $000	2014 $000	2015 $000	2014 $000
General Funds				
Balance at 1 July	44,557	44,557	44,557	44,557
Distributions made	0	0	0	0
Capital Contribution	0	0	0	0
Balance at 30 June	44,557	44,557	44,557	44,557
Accumulated Comprehensive Revenue and Expense				
Balance at 1 July	(2,447)	(2,594)	(495)	(843)
Surplus/(Deficit)	176	139	388	340
Transfer to Trust Funds	(19)	(40)	(19)	(40)
Transfer from Trust Funds	43	48	43	48
Balance at 30 June	(2,247)	(2,447)	(83)	(495)
Reserves				
Revaluation Reserve				
Balance at 1 July	71,631	71,631	67,669	67,669
Revaluations	15,285	0	14,297	0
Other Movements	0	0	0	0
Balance at 30 June	86,916	71,631	81,966	67,669
Revaluation Reserve consists of:				
Land	6,726	6,146	6,610	6,038
Buildings	80,190	65,485	75,356	61,631
Total Revaluation Reserve	86,916	71,631	81,966	67,669
Fair value through other Comprehensive Revenue Reserve				
Balance at 1 July	253	373	253	373
Net Revaluation gains/(losses)	(169)	(120)	(169)	(120)
Balance at 30 June	84	253	84	253
Total Reserves	87,000	71,884	82,050	67,922
Trust/Special Funds				
Balance at 1 July	648	656	648	656
Revaluation of Land	20	0	20	0
Transfer from Accumulated Comprehensive Revenue and Expense in respect of:				
Funds received	7	32	7	32
Interest received	12	8	12	8
Transfer to Accumulated Comprehensive Revenue and Expense in respect of:				
Funds spent	(43)	(48)	(43)	(48)
Balance at 30 June	644	648	644	648
Minority Interest				
Balance at 1 July	3433	3605	0	0
Surplus/Deficit for period	783	(57)	0	0
Distributions made	(120)	(115)	0	0
Total Minority Interest	4096	3433	0	0
Total Equity at 30 June	**134,050**	**118,075**	**127,168**	**112,632**

All trust funds are held in bank accounts that are separate from Northland District Health Board's normal banking facilities.

13 Trade and Other Payables

	Group		Parent	
	2015 $000	2014 $000	2015 $000	2014 $000
Payables under exchange transactions				
Trade Payables to Non-related Parties	4,678	3,648	4,678	3,701
Amounts due to Related Parties	1,326	1,326	1,326	1,326
Revenue in Advance relating to contracts with specific performance obligations	1,277	2,092	1,277	2,092
Other Non-trade Payables and Accrued Expenses	26,025	31,002	26,025	30,999
Total payables under exchange transactions	33,306	38,068	33,306	38,118
Payables under non-exchange transactions				
Taxes payable (GST, PAYE, FBT, withholding tax and rates)	4,217	3,623	4,210	3,617
ACC Levy Payable	803	714	803	714
Total payables under non-exchange transactions	5,020	4,337	5,013	4,331
Total Trade and Other Payables	38,326	42,405	38,319	42,449

Trade and Other Payables are at fair value and payable within 12 months.

14 Interest Bearing Loans and Borrowings

	Group		Parent	
	2015 $000	2014 $000	2015 $000	2014 $000
Non-current				
Crown Loans	24,650	16,500	24,650	16,500
Term loans - Finance Leases	1,609	0	1,609	0
	26,259	16,500	26,259	16,500
Current				
Crown Loans	0	8,150	0	8,150
Crown Energy Efficiency Loan	0	58	0	58
Term loans - Finance Leases	372	0	372	0
	372	8,208	372	8,208
Total Interest Bearing Loans and Borrowings	26,631	24,708	26,631	24,708

Security

Northland District Health Board has secured crown loans with the New Zealand Debt Management Office (Formerly Crown Health Financing Agency). The details of terms and conditions are as follows:

Interest Rate Summary	2015 Actual	2014 Actual
New Zealand Debt Management Office (Formerly Crown Health Financing Agency) $1m facility	3.39%	3.39%
New Zealand Debt Management Office (Formerly Crown Health Financing Agency) $4m facility	3.35%	3.35%
New Zealand Debt Management Office (Formerly Crown Health Financing Agency) $4.5m facility	3.39%	3.39%
New Zealand Debt Management Office (Formerly Crown Health Financing Agency) $7m facility	2.94%	2.94%
New Zealand Debt Management Office (Formerly Crown Health Financing Agency) $8.15m facility	3.25%	6.60%
Energy Efficiency and Conservation Authority $0 (2014 $0.576m)	0.00%	0.00%

14 Interest Bearing Loans and Borrowings *(Continued)*

Repayable as follows:	Group		Parent	
	2015	2014	2015	2014
	$000	$000	$000	$000
Within two years	0	8,208	0	8,208
Two to five years	19,150	7,000	19,150	7,000
Six to nine years	5,500	9,500	5,500	9,500
Total	24,650	24,708	24,650	24,708

Finance lease liabilities are effectively secured, as the rights to the leased asset revert to the lessor in the event of default. The net carrying amount of assets held under finance leases is disclosed in note 10.

Analysis of Financial Leases	Group		Parent	
	2015	2014	2015	2014
	$000	$000	$000	$000
Minimum Lease payments payable				
Within one year	372	0	372	0
Two to five years	1,609	0	1,609	0
Total	1,981	0	1,981	0

15 Employee Entitlements

	Group		Parent	
	2015	2014	2015	2014
	$000	$000	$000	$000
Current Liabilities				
Liability for Long Service Leave and Retirement Gratuities	3,181	3,112	3,181	3,112
Liability for Annual Leave	15,282	14,164	15,282	14,164
Liability for Sick Leave	179	274	179	274
Liability for Sabbatical Leave	64	79	64	79
Liability for Continuing Medical Education Leave	6,330	6,306	6,330	6,306
Salary and Wages Accrual	6,029	5,329	6,029	5,329
ACC Partnership Programme Liability	697	717	697	717
	31,762	29,981	31,762	29,981
Non-Current Liabilities				
Liability for Long Service Leave and Retirement Gratuities	13,365	13,741	13,365	13,741
Liability for Sabbatical Leave	1,231	1,235	1,231	1,235
Liability for Sick Leave	912	888	912	888
	15,508	15,864	15,508	15,864
Total Employee Entitlements	47,270	45,845	47,270	45,845

The long service leave, retirement gratuities, sick and sabbatical leave were valued by an independent actuary.

The present value of the retirement and long service leave obligations depend on a number of factors that are determined on an actuarial basis using a number of assumptions. Two key assumptions used in calculating this liability include the discount rate 3.6% (2014: 3.7%) and the salary inflation factor 2% (2014: 4%). Any changes in these assumptions will impact on the carrying amount of the liability.

The discount rates used were obtained by finding weighted averages of returns on Government stock of different terms. The salary inflation factor has been determined after considering historical salary inflation patterns.

16 Provisions

	Group		Parent	
	2015	2014	2015	2014
	$000	$000	$000	$000
Balance at 1 July	740	200	740	200
Provision made during the year	360	545	360	545
Provision used during the year	(430)	(5)	(430)	(5)
Total Provisions	670	740	670	740

Provisions have been made for legal actions against Northland District Health Board, vehicle return costs, and employee cessation costs.

17 Financial Instruments

Northland District Health Board is party to financial instruments as part of it's everyday operations. These include instruments such as bank balances, investments, accounts receiveable, accounts payable and loans.

Credit Risk
Financial instruments, which potentially subject Northland District Health Board to concentrations of risk, consist principally of cash, counterparties without credit risk, short-term deposits, bonds and accounts receivable.

Northland District Health Board places its cash and short-term deposits with high-quality financial institutions and the Health Board has a policy that limits the amount of credit exposure to any one financial institution.

Concentrations of credit risk from accounts receivable are limited due to the large number and variety of customers. Northland District Health Board receives 95% of its revenue from the Ministry of Health, who is also the largest single debtor. It is assessed to be a low risk and high-quality entity due to its nature as the Government funded purchaser of health and disability support services.

The status of trade receivables at the reporting date is shown in note 7.

The table below analyses the Northland District Health Board's Financial Instruments maximum credit exposure. The amounts disclosed are the contractual undiscounted cashflows.

		Group		Parent	
	Notes	2015	2014	2015	2014
		$000	$000	$000	$000
Cash on Hand and at Bank	6	65	77	9	12
Cash on Deposit with Health Benefits Limited	6	8,436	45,331	8,436	45,331
Cash Equivalents - Short Term Deposits	6	335	5,391	0	5,131
Bonds	8	3,124	6,249	3,124	6,249
Trade and Other Receivables	7	16,402	13,567	16,399	13,564
Total		28,362	70,615	27,968	70,287

At balance date there were no significant other concentrations of credit risk. The maximum exposure to credit risk is represented by the carrying amount of each financial asset in the statement of financial position.

Liquidity Risk
Liquidity risk represents the Northland District Health Board's ability to meet its contractual obligations. The Northland District Health Board evaluates its liquidity requirements on an ongoing basis. In general, the Northland District Health Board generates sufficient cash flows from its operating activities to meet its obligations arising from its financial liabilities.

The table on the following page analyses the Northland District Health Board's financial liabilities into relevant maturity groupings based on the remaining period at the balance sheet date to the contractual maturity date. The amounts disclosed are the contractual undiscounted cashflows.

17 Financial Instruments *(Continued)*

	Notes	Carrying Amount $000	Contractual Cashflows $000	Less than 1 year $000	1-5 years $000	More than 5 years $000
Parent & Group 2015						
Crown Loans	14	24,650	24,650	0	19,150	5,500
Finance Leases	14	1,981	1,981	372	1,609	
Provisions	16	670	670	670	0	0
Trade and Other Payables	13	38,326	38,326	38,326	0	0
Total		65,627	65,627	39,368	20,759	5,500
Parent & Group 2014						
Crown Loans	14	24,708	24,708	58	15,150	9,500
Finance Leases	14	0	0	0	0	0
Provisions	16	740	740	740	0	0
Trade and Other Payables	13	41,691	41,691	41,691	0	0
Total		67,139	67,139	42,489	15,150	9,500

Market Risk
The interest rates on Northland District Health Board's cash and cash equivalents are disclosed in note 6 and 8.

The Board has a series of policies providing risk management for interest rates and the concentration of credit. The Board is risk averse and seeks to minimise exposure from its treasury activities.

Its policies do not allow any transactions which are speculative in nature to be entered into.

Interest Rate Risk
Interest rate risk is the risk that the fair value of a financial instrument will fluctuate or the cash flows from a financial instrument will fluctuate, due to changes in market interest rates.

Northland District Health Board does not consider there is any significant exposure to the interest rate risk on its investments. They are limited to bank deposits and bonds, which are held over various terms. All borrowings are at fixed interest rates for the term of the loan.

Foreign Currency Risk
Foreign exchange risk is the risk that the fair value of future cash flows of a financial instrument will fluctuate because of changes in foreign exchange rates.

Northland District Health Board does not consider there is any significant exposure to foreign currency risk. Only a small amount of purchases are denominated in a currency other than NZD, none of which were outstanding at 30 June.

Sensitivity Analysis
In managing interest rate and currency risks Northland District Health Board aims to reduce the impact of short-term fluctuations on its earnings. Over the long-term, permanent changes in foreign exchange and interest rates would have an impact on consolidated earnings.

At 30 June 2015, it is estimated that a general increase of one percentage point in interest rates would decrease Northland District Health Board's surplus before tax by approximately $200,000 (2014: $240,000).

	2015 $000		2014 $000	
Interest Rate Risk	-100 bps	+100 bps	-100 bps	+100 bps
Financial Assets				
Cash, Cash Equivalents and Bonds (non-current)	(310)	310	(350)	350
Financial Liabilities				
Crown Loans	110	(110)	110	(110)
Total	(200)	200	(240)	240

17 Financial Instruments *(Continued)*

Categories of Financial Assets and Liabilities

The classification and fair values together with the carrying amounts in the statement of financial position are as follows:

	Group		Parent	
	2015	2014	2015	2014
Loans and Receivables	$000	$000	$000	$000
Trade and Other Receivables	16,402	13,567	16,399	13,564
Trust/Special Fund Assets	644	648	644	648
Cash and Cash Equivalents	8,501	50,539	8,445	50,474
Short Term Deposits	335	260	0	0
Investment in Subsidiary	0	0	1,762	1,762
Investment in Associate	10,117	9,457	10,117	9,457
Fair Value through other Comprehensive Revenue				
Bonds	3,124	6,249	3,124	6,249
Financial Liabilities at Amortised Cost:				
Trade and Other Payables	37,814	41,179	37,807	41,223
Interest Bearing Loans and Borrowings	26,631	24,708	26,631	24,708

Credit Quality of Financial Assets	Group		Parent	
	2015	2014	2015	2014
Counterparties with credit ratings	$000	$000	$000	$000
Cash and cash equivalents and Investments				
AA-	3,450	8,611	3,124	8,285
Counterparties without credit ratings				
Cash and cash equivalents and Investments	8,175	43,046	8,445	43,307
Debtors and other receivables with no default in the past	16,402	13,567	16,399	13,564
Total Counterparties without credit ratings	24,577	56,613	24,844	56,871

The following summarises the major methods and assumptions used in estimating the fair values of financial instruments reflected in the above table.

Interest-Bearing Loans and Borrowings
Fair value is calculated based on discounted expected future principal and interest cash flows.

Trade and Other Receivables/Payables
For receivables/payables with a remaining life of less than one year, the notional amount is deemed to reflect the fair value. All other receivables/payables are discounted to determine their fair value.

Fair Value Hierarchy Disclosures
For those instruments recognised at fair value in the statement of financial position, fair values are determined according to the following hierarchy:

- Quoted market price (level 1) - Financial instruments with quoted prices for identical instruments in active markets.
- Valuation technique using observable inputs (level 2) - Financial instruments with quoted prices for similar instruments in active markets or quoted prices for identical or similar instruments in inactive markets and financial instruments valued using models where all significant inputs are observable
- Valuation techniques with significant non-observable inputs (level 3) - Financial instruments valued using models where one or more significant inputs are not observable.

Northland District Health Board holds Bonds measured at fair value in the statement of financial position, using quoted market prices (level 1). The fair value is $3,124k (2014: $11,380k).

18 Related Parties

Related party disclosures have not been made for transactions with related parties that are within a normal supplier or client/recipient relationship on terms and condition no more or less favourable than those that it is reasonable to expect Northland District Health Board would have adopted in dealing with the party at arms length in the same circumstances. Further, transactions with other Government agencies (for example Government Departments and Crown Entities) are not disclosed as related party transactions when they are consistent with the normal operating arrangements between Government agencies and undertaken on the normal terms and conditions for such transactions.

Related Party transactions to be disclosed
Northland District Health Board has a related party relationship with its controlled entity, associate and with its Board members and key management personnel.

Key Management Personnel Compensation
The key management personnel compensations are as follows:

	Group		Parent	
	2015	2014	2015	2014
	$000	$000	$000	$000
Board Members				
Remuneration	263	281	263	281
Full time equivalent members	11	11	11	11
Executive Team				
Remuneration	2,552	2,309	2,552	2,309
Full time equivalent members	9	8	9	8
Total key management personnel remuneration	2,815	2,590	2,815	2,590
Total full time equivalent personnel	20	19	20	19

The full-time equivalent for Board members has been determined based on one full time equivalent (fte) per board member as it is difficult to quantify the estimated time for Board members.

Key management personnel costs include any compensation or other benefits paid or payable. Key management personnel consist of the CEO, six General Manager roles, Chief Medical Advisor, Director of Nursing and Midwifery. 2014 is one less fte due to two General Manager roles having a period of vacancy during the replacement recruitment process.

Board Member Fees

Current Board Members	**2015**	**2014**
Anthony Norman (Chairperson)	$44,175	$47,600
Christopher Reid	$21,385	$13,245
Colin Kitchen	$20,635	$21,920
Craig Brown	$20,135	$22,170
Debbie Evans	$20,885	$12,745
Greg Gent	$22,635	$23,858
John Bain	$21,385	$22,920
June McCabe	$20,385	$22,420
MC (Bill) Sanderson	$21,823	$22,983
Sally Macauley (Deputy Chairperson)	$28,544	$29,838
Sharon Shea	$20,635	$21,920
Former Board Members		
Pauline Allan-Downs	$0	$9,925
Elizabeth (Libby) Jones	$0	$9,925

18 Related Parties *(Continued)*

Associates
Northland District Health Board has a 20% shareholding in healthAlliance, a shared services organisation for Northland, Waitemata, Auckland and Counties Manukau District Health Boards. healthAlliance is owned jointly by these four DHBs and Health Benefits Limited. healthAlliance provides Northland DHB with delivery of non-frontline transactional support services.

Northland District Health Board Received $1,019k from healthAlliance in this financial year ended 30 June 2015 and Northland District Health Board paid healthAlliance $10,437k for the financial year ended 30 June 2015. Northland District Health Board owed healthAlliance $1,326k as at 30 June 2015. The $1,326k owed to healthAlliance is detailed below;

	$000
Assets transferred to healthAlliance 30.06.12	(276)
Depreciation charged to NDHB for use of the transferred assets	1,242
Employee Entitlements transferred to hA	160
Owed for Class A Shares issued	200
Composition of balance owed by NDHB to hA	1,326

There were no provisions for doubtful debts between these two entities.

Subsidiaries
Northland District Health Board has a 54% shareholding in The Kaipara Total Health Care Joint Venture, a medical centre delivering health services to the people of Kaipara district, Northland, New Zealand. The Kaipara Total Health Care Joint Venture has a balance sheet date of 30 June.

The Kaipara Total Health Care Joint Venture has entered into the following lease and other contracts with Northland District Health Board:

Lease:
Northland District Health Board was granted a head lease of the Joint Venture property for a five year term with two rights of renewal of five years each. This agreement was renewed for a further period of 15 years from 24 May 2014. Annual rent is $550,000 plus GST, (2014: $550,000 plus GST), payable monthly in advance.

Maintenance, Administration and Management Contracts:

Northland District Health Board is contracted to provide maintenance and administration for the Joint Venture. Annual Maintenance Contract is $257,500 plus GST commencing 24 May 2014 (2014: $257,500 plus GST), payable monthly in advance. Annual Administration and Management Contract is $30,000 plus GST (2014: $30,000 plus GST)

The Kaipara Total Health Care Joint Venture made a distribution to Northland District Health Board of $141,358 (2014: $135,489). No related party debts have been written off or forgiven during the year. The amount outstanding at year end was nil (2014:nil)

Significant transactions with government-related entities

Northland District Health Board received funding from the Crown and ACC of $536,320k (2014: $519,546k) to provide health services to the Northland area for the year ended 30 June 2015. The Crown owes Northland District Health Board $12,378k as at the end of June 2015.

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

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

Northland District Health Board also purchases goods and services from entities controlled, significantly influenced, or jointly controlled by the Crown. Purchases from these Government related entities for the year ended 30 June 2015 totalled $14,760k (2014: $13,120k). These purchases included the purchase of electricity from Genesis Power Ltd, air travel from Air New Zealand, blood products and tests from NZ Blood Services and postal services from New Zealand Post.

18 Related Parties *(Continued)*

Other related parties

Health Benefits Limited (HBL) is a related party as it has significant influence over the operating policies of the Northland District Health Board through an agreement. HBL was established as a Crown owned company in July 2010 with a mandate to help the health sector save money by leading initiatives which reduce administrative support and procurement costs. Working with the Northland District Health Board, it expects to deliver savings in these areas which will free up money to reinvest into clinical areas of District Health Boards. Northland District Health Board paid $1,115k to HBL (2014: $1,246k) and owes HBL $0 as at 30 June 2015. HBL paid Northland District Health Board $3,131k in interest on deposit account (2014: $2,751k) and owed Northland District Health Board $361.9k interest as at 30 June 2015. There were no provisions for doubtful debts between these two entities.

Northland District Health Board is a party to the DHB Treasury Services Agreement between Health Benefits Limited (HBL) and the participating DHBs. This Agreement enables HBL to "sweep" DHB bank accounts and invest surplus funds. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with HBL, which will incur interest at the credit interest rate received by HBL plus an administrative margin. The maximum debit balance that is available to any DHB is the value of provider arm's planned monthly Crown revenue, used in determining working capital limits, is defined as 1/12th of the annual planned revenue paid by the funder arm to the provider arm as denoted in the most recently agreed Annual Plan inclusive of GST. For Northland District Health Board that equates to $27,272k. In the terms the PBE IPSAS 30 disclosure requires for the credit quality of the financial assets.

A revised Finance, Procurement and Supply Chain (FPSC) programme business case was approved by all DHBs by 30 June 2015 and all DHBs have committed to providing funding required to complete the FPSC programme. The programme will be implemented by a DHB owned vehicle (NZ Health Partnerships Limited), in which all DHBs own equal "A" class voting shareholding of 5%. The investment in the FPSC asset transferred into the new company on 1 July 2015 with no change to the "B" class shareholding as there was no economic event giving rise to a change in the asset. The revised business case demonstrates that the investment generates a positive Net Present Value for Northland District Health Board. On this basis, the Depreciated Replacement Cost of the FPSC rights is considered to equate, in all material respects, to the costs capitalised to date such that the FPSC rights are not impaired.

19 Subsequent Events

There are no significant events subsequent to balance date.
On 1 July 2015, Health Benefits Limited's business and operations were transferred over to a newly formed entity, NZ Health Partnerships Limited. All the assets and liabilities, including Northland District Health Board's interest in the FPSC rights transfer over to the new entity with no adjustment.

20 Capital Management

Northland District Health Board's capital is its equity, which comprises crown equity, reserves, trust/special funds and Accumulated Comprehensive Revenue and Expense. Equity is represented by net assets. The Northland District Health Board manages its revenues, expenses, assets, liabilities and general financial dealings prudently in compliance with the budgetary processes. The Northland District Health Board's policy and objectives of managing the equity is to ensure the Northland District Health Board effectively achieves its goals and objectives, whilst maintaining a strong capital base. The Northland District Health Board policies in respect of capital management are reviewed regularly by the governing Board. There have been no material changes in the Northland District Health Board's management of capital during the period.

21 Directions issued by Ministers

Northland District Health Board received a direction from the Minister of State Services and the Minister of Finance pursuant to section 107 and subject to the provisions of section 113 of the Crown Entities Act 2004 to apply to a whole of Government approach to procurement, Information, Communication and Technology (ICT) and property functional leadership. The procurement and ICT directions apply to Northern District Health Board. The dates when the directions apply are 1 February 2015 for procurement and 1 July 2015 for ICT. Implementation will be managed by healthAlliance.

22 Variance Analysis

Key Financial Information	Parent Actual 2015 $000	Parent Budget 2015 $000	Variance $000
Operational Revenue	**556,113**	**547,094**	**9,019**

The increase in operational revenue against budget can be attributed to additional electives revenue $2.1M, ACC revenue earned during the year $790,000, Clinical Training Agency revenue $370,000, additional interest revenue $304,000 and increased Ministry of Health revenue for various programmes.

The revenue budget is based on the funding envelope advised by the Ministry of Health in December 2013 for the current financial year. Subsequent to this advice further funding was made available for the above additional services.

Operational Cost (including capital charge)	**555,725**	**547,094**	**8,631**

The major factor contributing to the increase in operational expenditure is the provision of additional services, as detailed in the above revenue comment. Such costs are incurred as employee costs, the costs of clinical supplies and the payment to third party provider organisations.

Total Assets (excluding cash, deposits and investment balances**)**	**211,727**	**178,798**	**32,929**

Total Assets (excluding cash, deposits and investment balances) are greater than budget, this is largely due to Revaluation of Land and Buildings, additional expenditure on Property Plant and Equipment and increased Debtors at year end due to Pharmac Rebate.

Total Liabilities (excluding loans)	**86,259**	**86,265**	**(6)**

Liabilities close to budget, higher employee benefits are offset by lower trade payables.

Cash Resources (cash, deposit and investment balances less loans)	**1,700**	**19,986**	**(18,286)**

Cash Resources (cash, deposits and investment balances less loans) are less than budget due to higher expenditure on Property Plant and Equipment and operational expenditure than budgeted.

23 Adjustments arising on transition to the new PBE accounting standards

Reclassification adjustments

There have been no reclassifications to the face of the financial statements in adopting the new PBE accounting standards.

Statement of Accounting Policies

For the year ended 30 June 2015

Reporting entity

Northland District Health Board (Northland DHB) is a Health Board established by the New Zealand Public Health and Disability Act 2000. Northland DHB has designated itself as a Public Benefit Entity (PBE) for financial reporting purposes, it is owned by the Crown and domiciled in New Zealand. Northland DHB is a public benefit entity for the purposes of the NZ Public Health and Disability Act 2000, the Crown Entities Act 2004 and the Public Finance Act 1989.

The consolidated financial statements of Northland DHB and group for the year ended 30 June 2015 comprise Northland DHB, its controlled entity the Kaipara Total Health Care Joint Venture (54% owned) and its associate healthAlliance N.Z. Limited (20% owned).

Northland DHB'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 29 October 2015.

Basis of preparation

Statement of compliance

The financial statements have been prepared in accordance with generally accepted accounting practice in New Zealand (NZGAAP). They have been prepared in accordance with Tier 1 PBE Accounting Standards. These financial statements comply with PBE accounting standards.

These financial statements are the first financial statements presented in accordance with the new PBE accounting standards. The material adjustments arising on transition to the new PBE accounting standards are explained in note 23.

Measurement base

The financial statements have been prepared on a historical cost basis, except where modified by the revaluation of land and buildings to 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 ($000). The functional currency of the Northland DHB and its subsidiary is New Zealand dollars (NZ$).

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 PBE accounting standards requires management to make judgments, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, revenue and expenses. The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances, the results of which form the basis of making 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 Northland DHB 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 Northland DHB, and expected disposal proceeds (if any) from the future sale of the asset.

Critical judgements in applying accounting policies

Leases classification

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

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.

Northland DHB has exercised its judgement on the appropriate classification of leases, and has determined one lease arrangement is a finance lease.

Changes in accounting policies

The accounting policies have been updated to reflect the changes to PBE accounting standards. These updates have not resulted in any 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 earlier adopted

In May 2013, the External Reporting Board issued a new suite of PBE accounting standards for application by public sector entities for reporting periods beginning on or after 1 July 2014. Northland DHB has applied these standards in preparing the 30 June 2015 financial statements.

In October 2014, the PBE suite of accounting standards was updated to incorporate requirements and guidance for the not-for-profit sector. These updated standards apply to PBEs with reporting periods beginning on or after 1 April 2015. Northland DHB will apply these updated standards in preparing its 30 June 2016 financial statements. Northland DHB expects there will be minimal or no change in applying these updated accounting standards.

Basis for consolidation

Subsidiaries

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

Transactions eliminated on consolidation

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

Investments in subsidiaries are carried at cost in Northland DHB's own parent entity financials statements.

Equity accounted Investees: Associates

Associates are entities over which Northland DHB 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 Northland DHB'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 Northland DHB's own parent entity financial statements.

Budget figures

The budget figures are those approved by the Northland DHB 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 PBE accounting standards and other applicable Financial Reporting Standards as appropriate for public benefit entities. Those standards are consistent with the accounting policies adopted by Northland DHB 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.

Cash and cash equivalents

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

Trade and other receivables

Short-term receivables are recorded at their face value, less any provision for impairment. A receivable is considered impaired when there is evidence that Northland DHB will not be able to collect the amount due. The amount of the impairment is the difference between the carrying amount of the receivable and the present value of the amounts expected to be collected.

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.

Investments

Bank term deposits

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

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

Equity investments

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

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

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

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

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

Inventories

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

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

Inventories held for use in the provision of goods and services on a commercial basis are valued at the lower of cost (using the average weighted cost method) and net realisable value.

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.

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

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 revenue 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 revenue but is recognised in the surplus or deficit. Any subsequent increase on revaluation that offsets a previous decrease in value recognised in the surplus or deficit will be recognised first in the surplus or deficit up to the amount previously expensed, and then recognised in other comprehensive revenue.

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) were vested in Northland District Health Board on 1 January 2001. Accordingly, assets were transferred to Northland DHB 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 Northland DHB 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 through a non-exchange transaction, it is recognised at its fair value as at the date of acquisition.

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 Northland DHB. All other costs are recognised in the statement of comprehensive revenue as an expense as incurred. The costs of day-to-day servicing of property, plant and equipment are recognised in the surplus or deficit as they are incurred.

Depreciation

Depreciation is provided 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 - 65 years	(1.5% - 100%)
- Services	1 - 25 years	(4% - 100%)
- Fit out	1 - 10 years	(10% - 100%)
Plant and Equipment	1 - 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

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

Intangible assets

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

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

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 is 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 - 3 years	(33% - 50%)

Impairment of property, plant and equipment and intangible assets

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

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 revenue 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.

Employee benefits

Defined contribution schemes

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

Defined benefit schemes

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

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

Long service leave, sabbatical leave and retirement gratuities

Northland DHB's 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 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. All other employee entitlements are classified as current liabilities.

Annual leave, conference leave, medical education leave and expenses

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

Sick leave

Northland DHB 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 Northland DHB anticipates it will be used by staff to cover those future absences.

Bonuses

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

Provisions

A provision is recognised at fair value when Northland DHB 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.

Restructuring

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

ACC Accredited Employers Programme

Northland DHB belongs to the ACC Accredited Employers Programme (the "Full Self Cover Plan") whereby Northland DHB accepts the management and financial responsibility for employee work-related illnesses and accidents. Under the programme, Northland DHB is liable for all claims costs for a period of two years after the end of the cover period in which the injury occurred. At the end of the two-year period, Northland DHB pays a premium to ACC for the value of residual claims, and from that point the liability for ongoing claims passes to ACC.

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

Equity

Equity is 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 minority interest in the group is represented by the other partner in the controlled entity. 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.

Property revaluation reserve

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

Fair value through other comprehensive revenue and expense reserves

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

Revenue

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

Ministry of Health population-based revenue

Northland DHB receives annual funding from the Ministry of Health, which is based on population levels within the Northland DHB region.

Ministry of Health population-based revenue for the financial year is recognised based on the funding entitlement for that year.

Ministry of Health Contract Revenue

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

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

Goods sold and services rendered

Revenue from goods sold is recognised when Northland DHB has transferred to the buyer the significant risks and rewards

of ownership of the goods and Northland DHB 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 Northland DHB and that payment can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied by Northland DHB.

Revenue from other DHBs

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

Donated services

Certain operations of the Northland DHB are reliant on services provided by volunteers. Volunteers services received are not recognised as revenue or expenditure by Northland DHB.

ACC contract revenue

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

Rental revenue

Rental revenue 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 revenue over the lease term.

Interest

Interest revenue is recognised using the effective interest method.

Expenses

Operating leases

An operating lease is a lease whose term is short compared to the useful life of the asset or piece of equipment and does not transfer substantially all the risks and rewards incidental to ownership of the asset to the lessee.

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.

Finance leases

A finance lease is a lease that transfers to the lessee substantially all the risks and rewards incidental to ownership of an asset, whether or not title is eventually transferred. At the commencement of the lease term, finance leases where Northland DHB is the lessee are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased item or the present value of the minimum lease payments. The finance charge is charged to the surplus or deficit over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability.

Financing costs

Net financing costs comprise interest paid and payable on borrowings calculated using the effective interest rate method and are recognised as an expense in the financial year in which they are incurred.

Capital charge

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

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 Performance)

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

Cost allocation

Northland DHB 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.

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.

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.

Income tax

Northland DHB 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 cash flows.

Commitments and contingencies are disclosed exclusive of GST.

SP Glossary

Term	Definition or explanation
AFC	Annual Free Check (for diabetes).
CVD	Cardiovascular disease
CYFS	Child Youth and Family Service; part of the Ministry of Social Development
DCIP	Diabetes Care Improvement Package
DHB	District Health Board
DMFT	Decayed, missing, filled teeth; a measure of total damaged teeth in the mouth
ED	Emergency Department
GP	General Practitioner
HBSS	Home-based support services (for older people)
HDC	Health and Disability Commission(er)
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
MDT	Multi-Disciplinary Team (meeting) of health professional workers of various types and specialties to discuss patients
PHO	Primary Health Organisation
Q	Quarter (of the year); either Jul-Sep, Oct-Dec, Jan-Mar or Apr-Jun
SP	Statement of Performance, the core performance section of the Statement of Intent
Statement of Intent (SOI)	A plan required of all 70 or so Crown Entities in New Zealand that anticipates their performance for the coming year. For DHBs, it is incorporated into their Annual Plans

Acronyms

Acronym	Meaning
AAU	Acute Assessment Unit
ALOS	Average length of stay
ARC	Aged residential care
ASH	Ambulatory sensitive hospitalisation, a subset of avoidable hospitalisations (sometimes also Action on Smoking and Health)
ASMS	Association of Salaried Medical Specialists
BAU	Business as usual
BMI	Body Mass Index (a measure of healthy weight)
COPD	Chronic obstructive pulmonary disease
CVD	Cardiovascular disease
DNA	Did not attend
ECMS	Enterprise Content Management System, a large file-holding and file-sharing database
ED	Emergency Department
ELT	Executive Leadership Team (of Northland DHB)
FSA	First specialist appointment
FTE	Full time equivalent (= 40 hours a week of work time)
GDP	Gross Domestic Product
HOP	Health of older people
IFHC	Integrated family health centre
IT	Information technology
KPI	Key performance indicator
KRONOS	A business support financial system
LTC(s)	Long-term condition(s)
MELT	Medical Executive Leadership Team
NDHB	Northland District Health Board
NGO	Non-government organisation
NHSP	Northland Health Services Plan
PBF(F)	Population Based Funding (Formula)
PHO	Primary Health Organisation
POPN	Primary Options Programme Northland
ROERS	Radiology orders and eResults sign-off
OMG	Operational Management Group
SMO	Senior Medical Officer
STI	Sexually transmitted infection
SUDI	Sudden unexpected death in infancy (also sometimes sudden unexplained death in infancy)
SWOT	Strengths, weaknesses, opportunities, threats
TLA	Territorial Local Authority
VfM	Value for money

Directory

BOARD MEMBERS

Anthony Norman (Chair)
Sally Macauley (Deputy Chair)
Chris Reid
John Bain
Craig Brown
Greg Gent
Debbie Evans
Colin Kitchen
June McCabe
MC (Bill) Sanderson
Sharon Shea

EXECUTIVE OFFICERS

Dr Nick Chamberlain, Chief Executive
Neil Beney, General Manager, Medicine, Health of Older People, Emergency Department & Clinical Support
Margareth Broodkoorn, Director of Nursing and Midwifery
Andrew Potts, General Manager, Surgical, Intensive Care, Ambulatory & Diagnostic Services
Dr Mike Roberts, Chief Medical Officer
Meng Cheong, General Manager, Finance, Funding & Commercial Services
Kim Tito, General Manager, Māori Health and Mental Health & Addiction Services
Jeanette Wedding, General Manager, Child, Youth, Maternal & Oral Health (Lead General Manager)
Sam Bartrum, General Manager, Planning, Outcomes, Integrated Care and District Hospitals

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NORTHLAND DISTRICT HEALTH BOARD
Te Poari Hauora Ā Rohe O Te Taitokerau