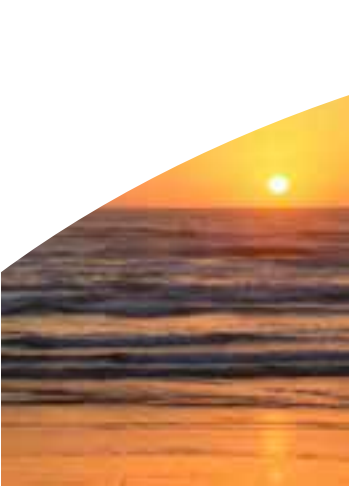
ANNUAL REPORT 2014



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 2013 to June 30 2014.

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

Key components of the report are outlined below.

Each year, the Board reviews progress on it's 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. It also covers the day-to-day operational performance of the Board.

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

Key Components

Board Chair and Chief Executive Report

A report from the Board Chair and Chief Executive on the year past.

Introduction

Northland District Health Board

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

2013/14: The Year in Review

Includes staff matters and the DHB's financial performance.

Governance and Partnerships

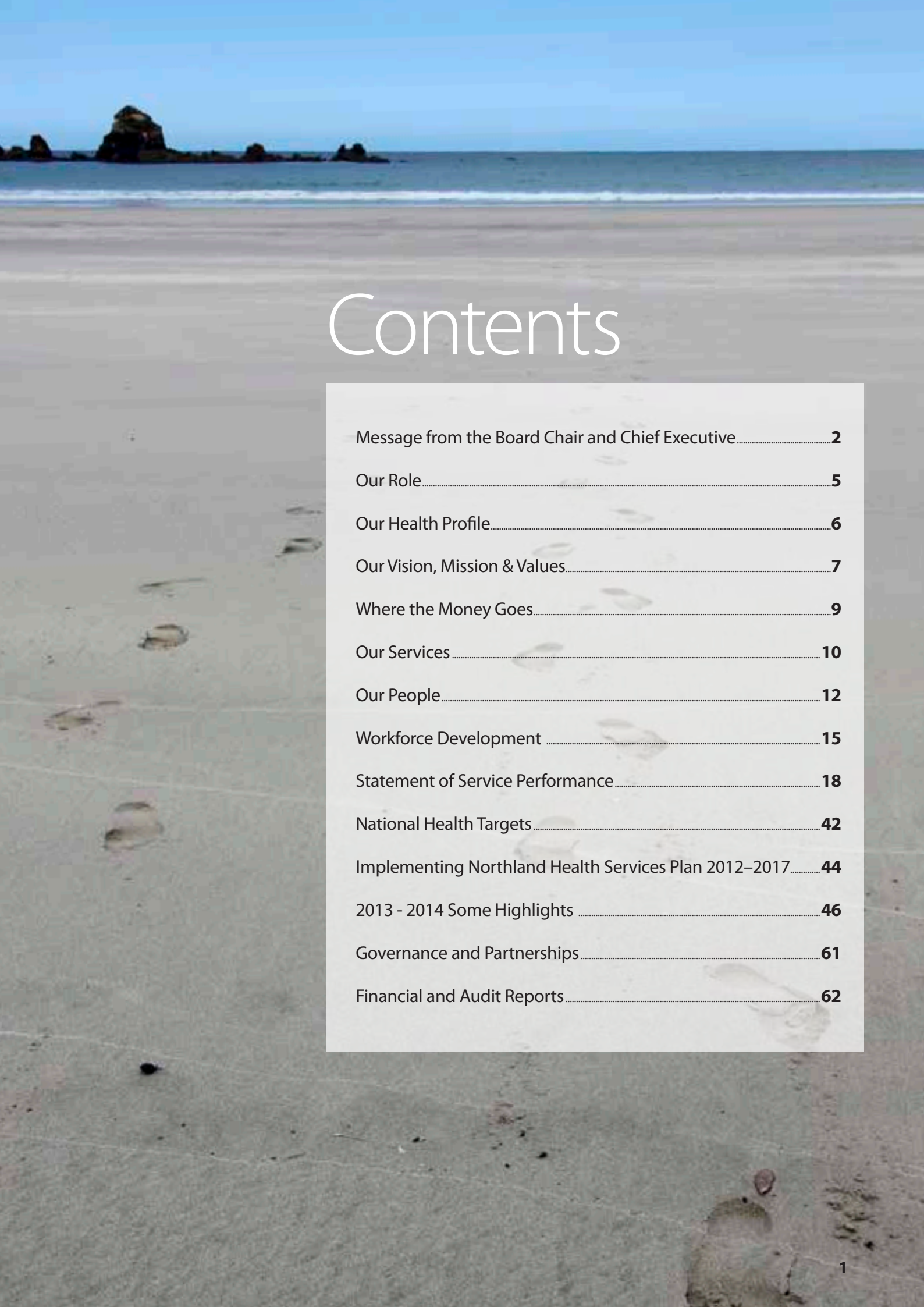
A report on how the Board of Northland DHB is structured and operates.

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 Service 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 Board Chair and Chief Executive

On behalf of Northland District Health Board, we are pleased to present our Annual Report for the 2013/2014 financial year. It has been a privilege for us to lead our organisation through another year 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.

Northland DHB is challenged by the practicalities of delivering health care to a largely rural, dispersed, economically-deprived population with significant health inequities between Māori and non-Māori. With over 30 percent of our population being Māori, significant poverty, and a very high percentage over 65 years, we are seeing unprecedented demand for our health services in Primary Care, our Hospitals, Mental Health and Aged Care.

Our strategic approach to addressing these challenges lies in the implementation of our Northland Health Services Plan. The Plan has provided the focus for a range of successful new initiatives over the last year.

We have seen the opening of Octane Youth health services in Whangarei, the Youth Space, and a number of successful child health initiatives, including the treatment of skin infections in schools and the Sudden Unexpected Death in Infancy (SUDI) prevention programme.

There have also been a number of successful IT integration programmes to improve communication and linkages between Primary Care and Hospital services. The “Shared Care Pilots” occurring in Northland are using two products, Manage my Health and a secure messaging system, Collaborative Care Management System (CCMS). A project to pilot CCMS between General Practices and Hospital specialists has commenced. Secure communication directly from the patient record the clinician is working in has been identified as a significant contributor to improving care in primary health and reducing attendances at hospitals. CCMS will also be used to share health information across three primary care providers; Te Whareora O Tikipunga, Paihia Medical Centre, and Ki A Ora Ngatiwai. Manage my Health has commenced in Dargaville, (between Dargaville Medical Centre, Te Ha Oranga o Ngati Whatua, and DHB district nursing services). There are also “patient portal pilots” underway at Bush Road, PrimeCare, and Kerikeri medical centres, and one of the GPs from Bush Rd has piloted "Open Notes" to any of his patients who want to have full access to their clinical record.

One of our biggest successes, which has taken a number of years to achieve, is that we now have 100 percent of our specialist referrals from GPs being transmitted electronically. However, in a number of other areas, progress has been slow, and over the next year we have decided to focus on five major projects, each headed by a project sponsor and clinical-lead supported by dedicated project management. The five projects are First 2000 Days, Urgent Healthcare, Patient & Family Centred Care, Neighbourhood Healthcare Homes and Fit for Life. The first three are self-explanatory, with a focus on our children, those who require urgent care, and what matters most to our patients. The Neighbourhood Healthcare Homes involves networks of General Practices supported by a virtual multidisciplinary team of Nurses and Allied Health Professionals from DHB staff and a number of other community providers coming together to care for the highest risk one - five percent of General Practice patients. This will require new ways of working across different organisations and appropriate, secure information sharing utilising new IT tools.

Fit for Life will be a major focus of Te Roopu Kai Hapai Oranga Alliance Leadership team and it has been agreed that our priority will be reducing smoking and obesity in Tai Tokerau. This team has been formed involving senior leadership from our nine Māori Health Providers, the two Northland PHOs and Northland DHB. Our purpose is to collectively seek improved outcomes for our communities. Progress is being made with the establishment of the Northland Rural Service Level Alliance Team (SLAT) which is the first of what will be several clinically-led SLATs in the future. These will all report to the Alliance Leadership Team.

To achieve "a healthier Northland", we need to provide safe, high-quality care to all our patients. Hence, we worked with our clinical leaders to agree the terms of reference for an in-depth external Patient Safety and Quality Improvement Review which we commissioned in October 2013. The review sits in a context of increasing expectations on healthcare providers to deliver high quality care and ensure patient safety. There is also an expectation of much greater patient and family involvement in care, and transparency if things go wrong.

From a national perspective, there is interest in the quality and safety of health care (with the establishment of the Health Quality and Safety Commission), external reporting (Quality and Safety markers), and recognition that measurement of DHB success involves more than meeting health targets or achieving financial performance. The review contained 75 recommendations which we have now prioritised and will be working through with our clinical teams. Some recommendations have already been addressed, and there have been over 1,000 downloads or views of the document by our staff which demonstrates the level of interest in improving the quality and safety of care for our patients.

We have maintained our excellent performance against the six National Health Targets. We now meet or exceed targets for elective services, cancer treatment, advice to smokers in hospital and ED waiting times, and immunisation rates are close to target after sustained improvement throughout the year. Our CVD screening rates continue to improve and are in the top quartile of DHBs. Both Te Tai Tokerau and Manaia Health PHO met the Increased Immunisation target with Manaia Health PHO also achieving the ‘better help for smokers to quit’ and ‘more heart and diabetes checks targets’.

Northland DHB has broken even financially this year, but it has been extremely challenging to achieve, and next year represents an even greater challenge while trying to deliver the various programmes within the Northland Health Services Plan. All services have a number of savings and value for money initiatives, there are tight financial and management controls in place, and the Health Benefits Ltd (HBL) initiatives and savings have been included within our budgets. To continue to achieve a stable financial position, it is critical that we control the growth in demand for our hospital services and many of our key initiatives are focused on achieving the Northland Health Services Plan headline target of reducing unplanned admissions by 2,000 per year by 2017.

The new Laboratory Information System (LIS) went live after two years of a highly-complex project that involved teams from Auckland (LabPlus) and Northern Region DHBs, and healthAlliance (our Northern Region Information System service

provider), along with the supplier. During the final stages, 44 project staff worked hard to ensure a smooth transition to the new system for the 70 Northland DHB lab staff across our four Northland hospitals. The new system, called Delphic, electronically manages requests for tests, the analysis of test information, and the transfer of results back to a new central repository called "TestSafe", other important, information such as discharge summaries including medication lists, are now available in TestSafe where a patient's GP or specialist can access them to improve and coordinate their care.

The graduation in May 2014 of the eighth cohort of Ngā Manukura o Āpōpō clinical leaders acknowledges a significant milestone. Over the last four years, 161 Māori nurses and midwives have graduated from the clinical leadership programme. Māori nurses and midwives from around Aotearoa have hugely benefited from this national programme and many have gone on and progressed their careers as health professionals into senior leadership roles. Northland DHB is the sponsor of this Ministry of Health workforce development programme.

The memorandum of understanding between Ngati Hine Health Trust and Northland DHB for the establishment of an Integrated Family Health Centre at Kawakawa – Bay of Islands Hospital was signed in December 2013. Northland DHB has agreed to lease part of its land at the Bay of Islands Hospital site to Ngati Hine Health Trust, who wish to build and operate an integrated family health centre on the site. Northland DHB will build and operate a new Accident & Medical facility and refurbish wards and other parts of the hospital. The proposed timeframe for completion is early 2016.

Co-location of different services is just one aspect of developing an Integrated Family Health Centre. The model of care development, which goes hand-in-hand with co-location of people, aims to bring about change, such as better coordination of care, multidisciplinary team work, shared health records and better access to a range of primary and secondary services. These changes are aimed at better care and outcomes for patients and a better working environment for health professionals, and must be agreed and completed before plans and designs are completed. This complex piece of work is well underway. Other Integrated Family Health Centre developments are progressing in Raumanga and Dargaville.

The Social Wellbeing Governance Group (a sub-group of the Northland Intersectoral Forum (NIF), which includes the leaders of all of our social sectors and Iwi Chair representation) continues to meet monthly and receives reports from the Fusion Group regarding Youth Suicide. The Northland DHB has been working with many partners to reduce youth suicide and build resilience with youth, whānau and community. We are continuing our youth suicide prevention multi-agency work in Northland and are constantly looking at other opportunities to strengthen these partnerships. Matanui's (a play about youth resilience funded by Northland DHB) second tour was presented free to Northland secondary schools during the second term, 19 May – 20 June 2014. The Matanui programme has now reached approximately 6,000 Northland high school students.

The Whangarei Vulnerable Children's team commenced in October 2013, one of two demonstration sites in New Zealand that brings together frontline professionals working with children and their families to better protect them. The Whangarei model involves a lead professional from non-government agencies (NGOs) and eight Northland NGOs have agreed to provide lead professionals. It also requires a health service broker, Paediatrician and Psychologists as part of the Children's team.

As at June 30 the team in Whangarei had received 52 referrals, of which 42 were accepted into the Children's Team; three were declined because they didn't meet the threshold and seven were escalated to Child Youth and Family.

Not only are our children and youth vulnerable, but poverty and household over-crowding are continuing to cause third world diseases in Northland. We have had 16 cases of Rheumatic Fever during the last year. Acute rheumatic fever rates in Northland Māori children aged 5-14 are similar to those seen in developing countries and nearly double the rates seen throughout New Zealand. The findings highlight the urgent need to address crowding, poverty and inequitable primary care access if rheumatic fever is to be eliminated. However, Northland DHB has extended and significantly broadened our school throat swabbing programme, redistributing some funding and also utilising our Public Health Nurses and Kaimahi funded through many of our Māori health and other community provider organisations. This is our starkest health inequity and, as well as continuing with the Healthy Housing Insulation programme, we also intend to work much more closely with Housing NZ on a programme to reduce over-crowding in high-risk families.

Earlier this year, we had high hopes that we might close the gap between Northland's population number based on the census and the number of people enrolled in primary care (a difference of 3,000 people). Despite health provider advocacy and a strong media campaign, including a national television story encouraging people to participate in the census; many did not complete the census, and this, along with an exodus of 5000 of our most productive age group, resulted in Northland DHB registering relatively low population growth which has reduced our annual funding increase from the Crown.

The culmination of over three years of fundraising activities occurred with a dawn blessing on 20 February 2014 and again later in the morning as the first sod was turned for the Jim Carney Cancer Treatment Centre. Around eighty people attended the sod-turning event, representing the businesses, community organisations, service groups, individuals and families who have supported Project Promise, which raised over $3million for the cancer centre in a little over three years. We are making good progress and expect the Jim Carney Cancer Treatment Centre to be opened in November 2014.

Our new Maternity Unit is also progressing well with an expected opening date in the first half of 2015. We expect to have completed the new office block before the end of 2014 with a future opportunity to sell the building and lease it back to preserve our capital for clinical buildings.

We acknowledge and record our appreciation to the Kaunihera Council of Elders (Kaumatua and Kuia) for their continuing advice and wisdom on matters of Tikanga Māori, and for the team working within our Māori Health Directorate, Te Poutokomanawa.

In closing, we sincerely thank the members of the Board, our executive leadership team, all our staff, General Practices, Primary Health Organisations, Māori and other community providers throughout the health sector for their continued hard work, dedication and care.

These efforts make a difference to the lives of Northlanders, and there have been numerous expressions of gratitude for the help and compassion that patients and their families/whānau have received.

Anthony Norman
Board Chair

Dr Nick Chamberlain
Chief Executive


TOLL


Emergency

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 2,637 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 (NGOs).

Our Communities

Population

Northland's population at the 2013 Census was 151,689, 3.6 percent of New Zealand's population. About half live within the Whangarei District Council area, 37 percent live within the Far North District Council area and 13 percent live 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. The Northland 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 whole range of health and socioeconomic 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 population in Northland is projected to decline over the coming years, but it 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 (21) percent of adult Northlanders have been told they have high blood pressure and 13 percent told 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 average of 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 influence 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 people who use both 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.

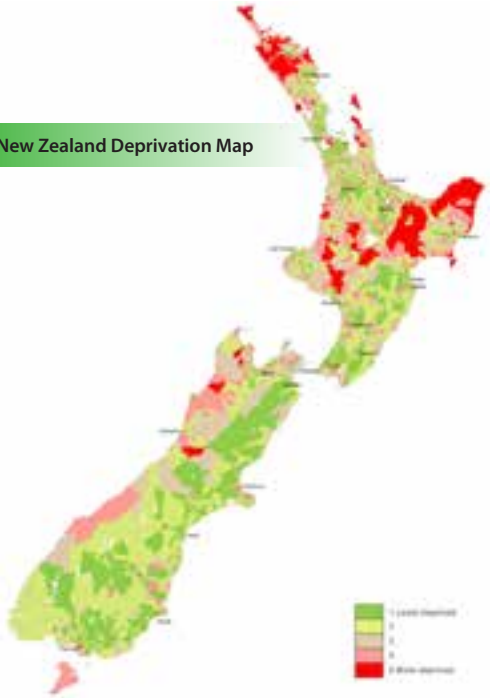
Respect - Whakaute (tuku mana) - We treat others as we would like to be treated.

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

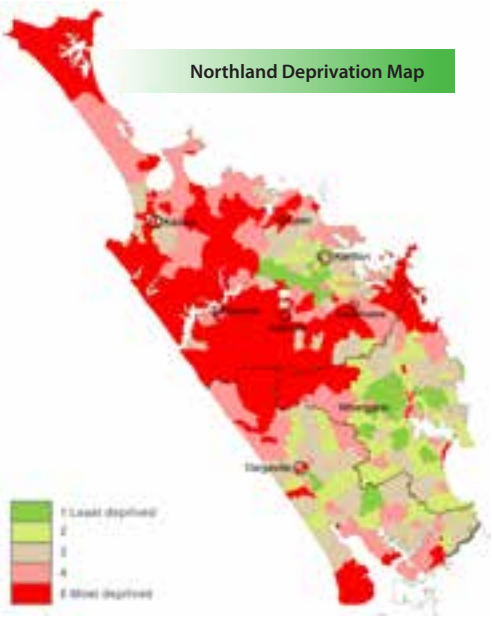
Communication - Whakawhitiwhiti korero - We communicate openly, safely and with respect to promote clear understanding.

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

New Zealand Deprivation Map



Northland Deprivation Map




RENAL

Where the Money Goes

Whangarei, Dargaville, Bay of Islands and Kaitaia Hospitals (surgical and medical services, emergency departments, imaging, laboratories, maternity, public health, etc.)	$251m
Primary Health (general practitioners, community dental services, radiology, etc.)	$57m
Health of older people (including residential care, rehabilitation)	$56m
Mental health services	$52m
Māori health services	$7m
Community pharmacies	$40m
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)	$65m
TOTAL	$535m

EACH DAY IN NORTHLAND

On average, each day in Northland:

121	Emergency Department attendances
100	Inpatient discharges
1,903	Outpatient attendances
73	Outpatient missed appointments
13	Northland patients discharged by other DHBs
9	Chemotherapy attendances
45	Renal dialysis
42	Theatre events
227	Radiology exams
2,169	Lab tests, NDHB hospital
717	Lab tests, NDHB community
5	Babies born in hospital
4	Deaths in Northland
3	Mental health hospital admissions
495	Mental health community visits
1,887	General practice consultations
6,556	Prescriptions processed by pharmacies
102	Community visits by allied health services
192	District nursing visits
179	Oral health visits in primary schools
8	Immunisations for 2 year olds
7	Immunisations for 8 month olds
39	Breast screens
839	Subsidised bed days in aged residential care
1,780	Hours of home-based support services for older people
92	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

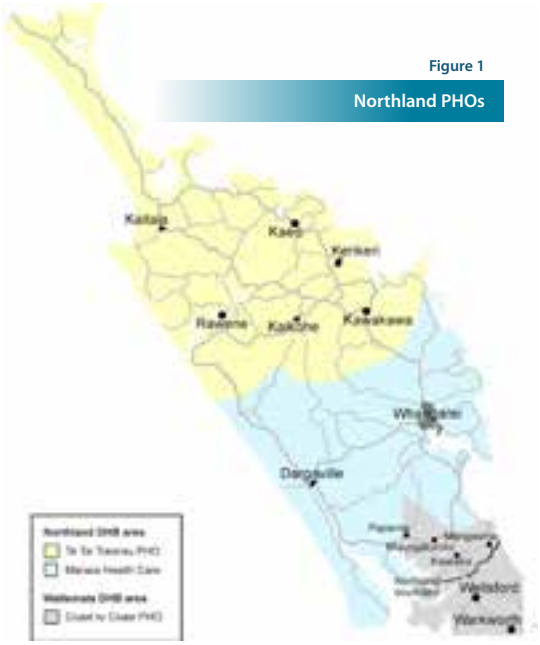


Figure 2
Māori NGOs

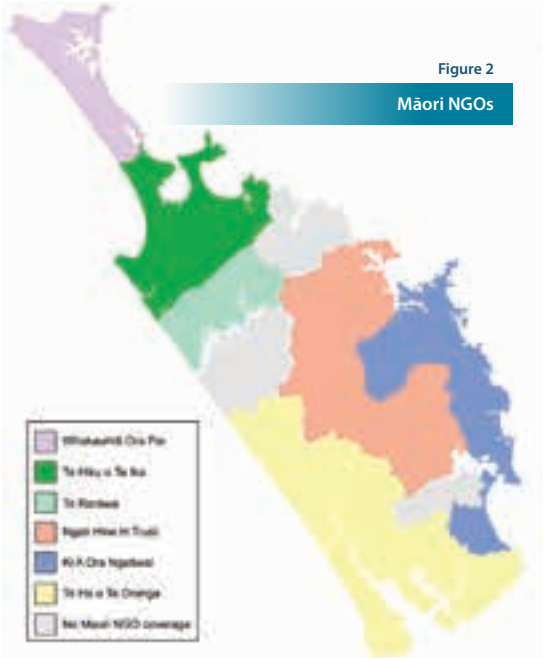
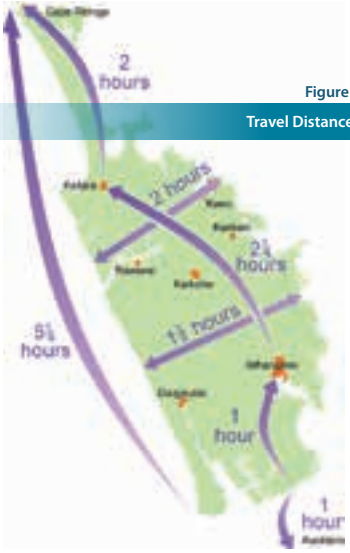


Figure 3
Northland Hospitals

Figure 4
Travel Distances



Our People

An important platform for ongoing growth and leadership in the organisation is the investment, and support of individual career and professional development plans for clinical and non-clinical staff. Enhanced knowledge and skills will enable the DHB to deliver on the aspirations of the Northland Health Services Plan 2012-2017.

Staff Engagement

A number of local engagement groups (noted below), established over the past few years, continue to meet regularly to maintain a cooperative 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 principle 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;
- There has been continued development of the partnership between clinical staff and management during the past year. Clinical staff have been engaged in the strategic decision-making relating to the site re-development master plan and were also closely engaged in the extensive Patient Quality & Safety Review which took place during the year;
- Senior clinicians have become involved in decision-making about capital expenditure for clinical equipment;
- Staff, both clinical and non-clinical, have been involved in the executive safety walk rounds which over the past year have covered most areas of the DHB hospital sites.
- 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 Groups (NZMLWU);
  - APEX/NZMLWU Forum (similar in format to the Bipartite Forum but involving unions not affiliated to the CTU);
  - Care Capacity Demand Management Council.

Talent Management

Services identify and support potential leaders in various occupational groups to develop both technical and managerial skills, ensuring 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;
- Annual leadership programme and other regular leadership workshops coordinated by the Learning and Development team;
- "Grow 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. However this scholarship was no longer available to students for the academic year in 2014. In 2013 there was an outstanding response to the scholarship. Sixty three (63) Māori students applied and had been endorsed to receive their disbursements for their health and disability related degree study. Some withdrawals from study programmes and non-acceptance (16) onto programme of study occurred. Consequently 47 Māori students received subsidised course fees in their course of study;
- Ngā Manukura o Āpōpō – the national Māori nursing and midwifery leadership training. This is sponsored by the Director of Nursing and Midwifery of Northland DHB. Nearly 50 percent of the graduates from the NMoA 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 Pukawakawa programme in partnership with the University of Auckland.

Management and leadership capability

- Clinical leadership forums have been established at Northland DHB for medical, nursing, and allied health leaders to develop their roles and support professional development of leadership and management skills. A key focus for the DHB is engaging in clinical networks and effective 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 Executive Advancement Team – the name of this group has since been revised and renamed as NMELT – the Nursing and Midwifery Executive Leadership Group to reflect our midwifery workforce;
- Allied Health Advisory;
- Clinical governance mechanisms at various levels of the organisation to support better 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. This year the terms of reference have been reviewed to provide a more balanced clinician/management input into the clinical governance board.

Health and Wellbeing

Northland DHB's Occupational Health and Safety team actively promotes a number of programmes and initiatives to help employees with their personal health choices and to advise management on risk management strategies:

- 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;
- Work place 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;
- Incident reporting follow-up to ensure employee is supported and given best advice;
- Regular health and safety reporting to management and to the 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.

Northland DHB workforce profile	Total workforce: 2,637 active employees The workforce profile is similar to that of other DHBs although Māori representation is higher reflecting a greater percentage of Māori in our region as shown below
Age Profile	Female average age: 47.8 years Male average age: 47.6 years
Ethnic Profile	The introduction of a self-help on-line staff kiosk in 2011 provides the following ethnicity data • European: 46.5 percent • Māori: 13.3 percent • Asian: 4.8 percent • Pacific: 0.8 percent • Other: 0.6 percent • Not stated: 34.2 percent
Disability Profile	While specific data is not currently available for this category, individuals with disabilities applying for vacancies are given full consideration based on the needs of the position.
Gender Profile	Female: 2,062 employees Male: 575 employees

Element	Activity
Leadership, accountability and culture	• Leadership is encouraged and supported at all levels of the organisation. • A formal leadership programme implemented for senior clinicians which is open to our PHO partners. • A series of other in-house programmes are available to build leadership, accountability and are tied back to the values of the organisation. • Maintain, promotes and applies the organisational values at all levels of the organisation. • Involvement of Te Poutokomanawa/Māori Health Service Directorate operating at all levels of the organisation.
Recruitment, induction and selection	• Robust Northland DHB "Values-Based" recruitment and selection processes • Clinical and managerial positions advertised via the national recruitment portal kiwihealthjobs. • Powhiri or Whakatau guidelines developed for visitors and new employees • Northland DHB Organisational Orientation (OO) booklet providing values-based expectations and obligations required of all employees.
Employee development, promotion and exit	• Generic orientation day for all staff. • 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. • Development of e-learning packages on a range of clinical and non-clinical topics. • On-line confidential Staff Exit Survey offered to all departing staff. Staff are also offered the opportunity for a 'face-to-face' exit interview with a manager of their choice.
Flexibility and work design	• Flexible work hours are available based on employee needs and the requirements of the position. • 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 are in place for a range of employee groups developed in consultation with relevant unions. • Specific merit programme criteria is available for most employee groups. • Commitment and ongoing contributions of staff recognised through Long Service Award presentations. • Development of a 'whole of health sector' biannual award ceremony that includes Matariki Hauora Māori Awards, Northland DHB Quality Awards, Nursing and Midwifery Awards and the Northland DHB published authors and presenters.
Harassment and bullying prevention	• Awareness and education strategy in support of the Unacceptable Behaviour in the Workplace policy continues to be implemented at all levels in the organisation. • Values Champions initiative has been developed in support of the above-named policy. • An "Acceptable Behaviour in the Workplace" poster previously developed with unions is displayed widely across the organisation. • Managers have been required to attend training to assist and support their ability to manage unacceptable behaviour in the workplace. • The Managing Unacceptable Behaviour in the Workplace Policy is referenced against the Code of Conduct and 'Northland DHB Values & Behaviours' and these policies are available to all staff via the staff 'Northland DHB Intranet' with a site dedicated to 'Acceptable Behaviour in the Workplace'.
Safe and healthy environment	• The DHB recognises its obligations to the safety and wellbeing of its staff. This is supported by the following programmes: • Employee assistance programme (EAP); • Health & Safety policy and training provided; • Employee vaccination programme; • ACC partnership programme; • ACC annual partnership programme audit; • Workstation assessment programme; • Moving and Handling programme; • On-site occupational health clinicians; • Smokefree/auahi kore support; • Provision of a new gym and swimming pool (Whangarei site) and gym at Kaitaia • Care Capacity Demand Management programme; • Patient Safety and Family Centered Care Quality Review; • Amendments to Job Descriptions to include Patient Safety and Family Centered Care & Health & Safety key performance indicators.

Workforce Development

Our services continue to identify and support potential leaders in various occupational groups to develop both technical and managerial skills, ensuring 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 the Government's expectations.

To attract and grow our workforce to meet service needs, training and development initiatives include the opportunity 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 is enabling greater access to learning, communication, knowledge transfer and skill development, ensuring best practice is implemented across the wider health sector in Northland, such as the PHO's, NorthTec nursing students, North Haven Hospice and Kia Ora Ngati Wai.

National:

Health Workforce New Zealand key priority areas for 2013-14 included:

- Growing the capacity of the health workforce through strengthening recruitment, retention and repatriation;
- Building and expanding the capability of the health workforce;
- Delivering on health workforce priorities by working with others in the health system to increase system productivity;
- Shaping the future workforce through transformative change;
- Strengthening health workforce intelligence and providing high quality support and advice to support health sector outcomes.

Regional:

During 2013-2014, Health Workforce New Zealand (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. Four regional training hubs – Northern, Midland, Central and South Island – have been established.

The Northern Regional Training Hub (NoRTH) continue to focus their efforts on integration and coordination of pre-vocational medical training as well as taking the opportunity to develop a multidisciplinary approach to education and training, placements and HWNZ initiatives.

Northland DHB holds the regional hub contract for Kia Ora Hauora (KOH) - Māori Health as a Career Programme has been established as a whole-of-sector response aimed at increasing the recruitment and retention of Māori on to health-related career pathways and into the health sector workforce.

The aim of KOH is to increase the recruitment of Māori into a range of health careers. The programme coordinates existing recruitment and promotion initiatives and builds on those initiatives. The programme coordinates all national and regional initiatives under one recognisable brand to best utilise promotion and communication tools.

A KOH Regional Reference Group has been established to ensure collaboration between those local Northern region DHB initiatives and the Universities to support improved access for Māori into tertiary study in health programmes.

Over this last year, from July 1 2013 to June 30 2014, the Northern region achieved its annual goals by recruiting and supporting 191 new Māori on to a Health Study pathway (target: 125) and supported 52 Māori to enter into their first year health related tertiary study (target: 25)

Northland:

Northland DHB continues to coordinate and allocate HWNZ. 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 representation from primary, secondary health organisations and the local tertiary education provider. 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 coordinate and allocate HWNZ funding for postgraduate study for nursing and midwifery and the non-regulated workforce. In addition Northland DHB pursues "Grow our Own" staffing initiatives by providing additional Māori scholarships for staff and a Pihirau Hauora

Māori Scholarship for students who whakapapa to Te Tai Tokerau hapu and iwi, although this was discontinued at the end of December 2013. 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 North Tec (Northland's polytechnic) 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, in particular in 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:

- Pihirau Hauora Māori Scholarship has supported 47 Māori students studying at bachelor, masters and PhD degree level who whakapapa to Te Tai Tokerau hapu/iwi. (21 applications through NorthTec and 26 through other tertiary institutions);
- Health Workforce NZ non-regulated training fund has supported 39 Māori Kaimahi into building their capability and capacity to further their professional development in the health sector;
- Fields of study for the funds detailed above include nursing, physiotherapy, medicine, surgery, psychology, social work, pharmacy, physical education, sport and recreation, practice management, aged care, health promotion, vision and hearing screening, asthma and other respiratory conditions, Hauora Māori and relaxation massage;
- The Northland DHB Te Poutokomanawa Māori Education Fund was discontinued in the last fiscal year;
- Kia Ora Hauora (KOH) – Supporting Māori in Health Careers has seen a number of youth accessing workforce and workplace experience in the health sector. To June 2014, the Enhanced Kia Ora Hauora selection of Māori students is based on those interested in health as a profession in Years 9-13 and who are taking science subjects. Northland DHB work with a minimum of 20 students and a maximum of 35 students. Northland DHB has contributed to the success of more Māori registered on the KOH database and entering a health study pathway (as noted in the regional section).

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 involves clinicians from both Northland DHB and the community sector.

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 cost/productivity.

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 health care;
- 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 planning.

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

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 with clinicians, Northland DHB has refocused its clinical frameworks:

- **Medical Executive Leadership Team (MELT)**

  As a senior medical leadership forum, the medical executive leadership team 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 Health Roundtable. Chaired by Northland DHB's chief medical officer, membership includes clinical directors and clinical heads of department.

- **Alliance Leadership Team (Te Roopu Kai Hapai Oranga)**

  This team has been formed involving senior leadership from Māori Health Providers and Whānau Ora Collectives, the two Northland PHOs and Northland DHB. Our purpose is to collectively seek improved health and wellbeing outcomes for all Northlanders and reduce inequalities. Progress is being made with the establishment of the Northland Rural Service Level Alliance Team (SLAT) which is the first of what will be several clinically-led SLATs in the future. These will all report to the Alliance Leadership Team.

- **Nursing and Midwifery Executive Leadership Team (NMELT)**

  The Nursing and Midwifery Executive Leadership Team provides strategic and operational nursing and midwifery leadership across Te Tai Tokerau, Northland 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.

- **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 Northland 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 Service 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.

To give substance to our intentions, Northland DHB has produced 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 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 $70m annually.

The Northland Health Services Plan has six Headline Targets, two under each of the Triple Aims. Four of the Headline Targets have been incorporated into the Statement of Service Performance as High Level Measures (the two under the Value and Sustainabilty Triple Aim have been excluded because they don't fit into the SSP's intervention logic at this high level). In addition, the SSP 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. They are intentionally 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 SSP.

Life expectancy

Life expectancy has been rising steadily in Northland over the past decade and a half, the rate of increase roughly matching that of New Zealand overall.

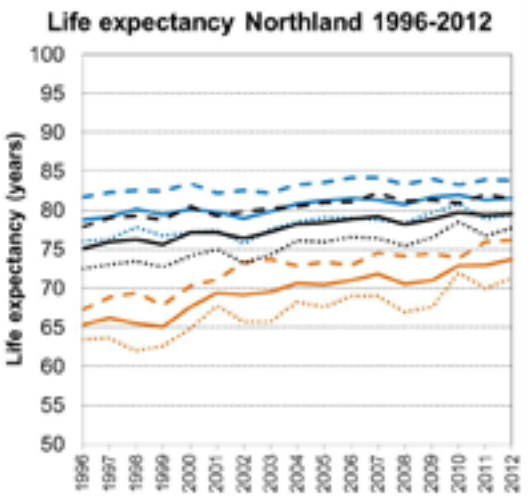
Māori life expectancy lags significantly behind non-Māori, though the gap has been closing slowly over time; in 1996 Māori in Northland lived on average 13.4 years less than non-Māori population, but by 2012 the difference was 7.8 years. While the trend is encouraging, the size of the gap remains a concern. (The Headline Target to reduce by two years the life expectancy gap between Māori and non-Māori cannot yet be assessed because the data only goes up to 2012, the year the Headline Target was set.)

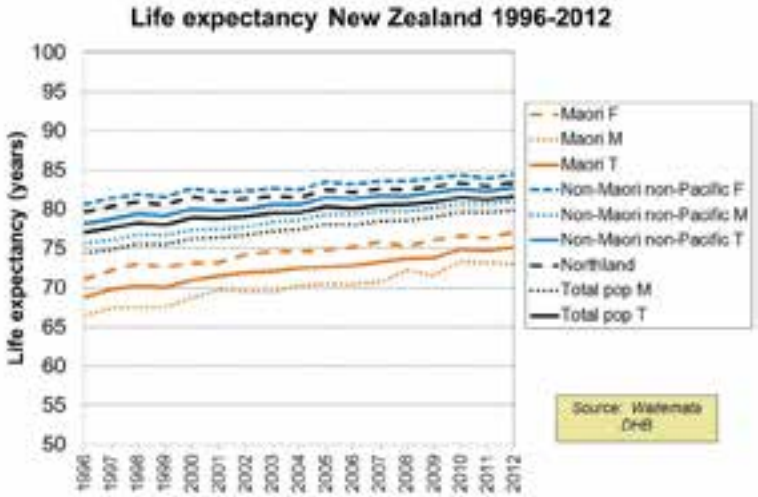
The gap between life expectancy for Māori in Northland and in New Zealand has also reduced over time. In 1996 Māori in Northland lived 3.4 years fewer than the national Māori population, but by 2012 the gap had reduced to 1.4 years.

While it is true to say that the state of health of Northlanders is comparatively poor, that statement obscures the size of need among Māori. In fact, as is evidenced by life expectancy data, Northland can be divided into two populations: non-Māori, who have about the same health status as New Zealanders as a whole, and Māori, whose health is poorer both in comparison with non-Māori in Northland and Māori in New Zealand.

Numerous activities are supporting increased life expectancy for Northlanders and a reduction in the ethnic 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 Family Centred Care, First 2000 Days) that should also have positive effects on life expectancy.

Life expectancy data is supplied through demographic analysis performed by Waitemata DHB , who update it annually.

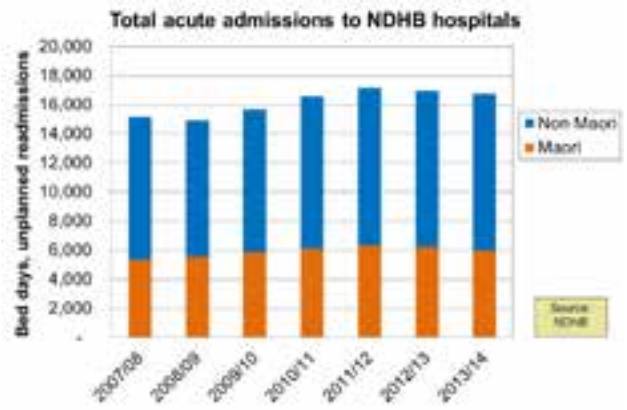




Total acute admissions to hospitals

The goal of reducing unplanned readmissions by 2,000 by 2017 was set in mid-2012. Between 2011/12 and 2013/14, acute admission bed day numbers have reduced from 17,148 to 16,729, a reduction of just over 400.

Māori comprised 36% of all total acute admission bed days in 2013/14, higher than the 30% of Māori in the Northland population, a reflection of higher need. Over the previous five years the figure sat consistently at 37%.



Numerous projects are in place that will contribute towards reducing acute admissions:

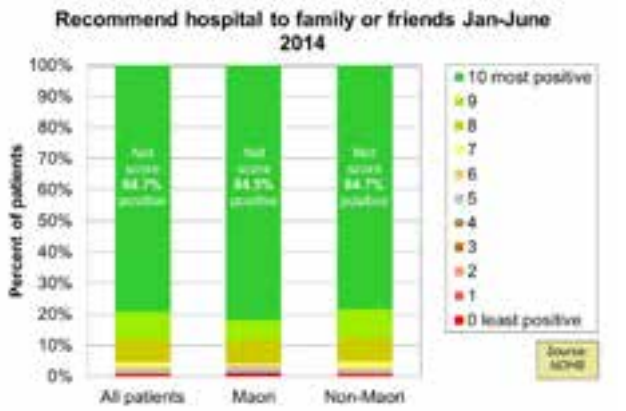
- a new pathway of care for chronic obstructive pulmonary disease
- eReferrals, which allows GPs timely access to advice from hospital specialists, thus enabling them to make more informed decisions about which patients it is appropriate to treat in the community and which are better referred to hospital services

The five major projects under the Northland Health Services Plan:

- Patient and Family Centred Care (improving quality, safety and the patient experience)
- Urgent Healthcare (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)
- Neighbourhood Healthcare Homes (integrated primary health care)
- Fit for Life (smoking and obesity).

Patient satisfaction

Since late 2013, Northland DHB has been trialling a new survey tool that surveys patients while they are still in hospital (it will replace the old post-discharge mailed-out survey which had a low-response rate, and used a different methodology so isn't comparable). It is currently used in most wards in Whangarei Hospital. There are plans to extend it to areas such as the childrens ward and maternity, but the tool will have to be adapted to suit their needs.



The "net score" referred to in the graph is the difference between the combined responses to the 9 and 10 ratings and to the 0 to 6 ratings (the 84.7% for all patients represents 87.8% for 9-10 minus 3.1% for 0-6). The ratings for both ethnic groups are high and there is no discernible difference between them.

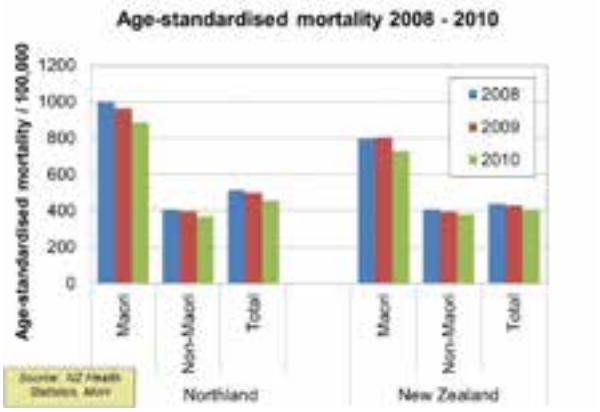
(Note that the 95% patient satisfaction Headline Target in the NHSP is not directly comparable with these figures because it effectively suggested that only the combined 9 & 10 scores – that is, 87.8% – be considered.)

Mortality overall

In this analysis, mortality rates for Māori and non-Māori have been age-standardised to remove the influence of the different age structures in their populations. The resulting mortality rates are not 'real', but they can be directly compared. (Data is published for each calendar year and 2010 is the latest.)

In Northland, the age-standardised mortality for Māori (884/100,000) is more than twice that of non-Māori (369/100,000). The Māori rate has dropped by 13% between 2008 and 2010, slightly faster than the non-Māori rate (11%).

Consistent with the discussion about life expectancy above, mortality among non-Māori in Northland is similar to that of non-Māori New Zealanders. Northland Māori are not only worse off in comparison with non-Māori, they also have a higher mortality rate than Māori New Zealanders as a whole.



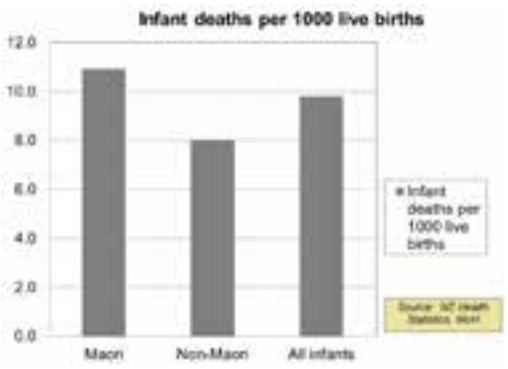
Overall mortality data is updated every year by the Ministry of Health through its Mortality and Demographic Data publications and associated data. It lags a few years (currently four) because of delays in determining causes of death for some people through coronial processes.

Infant mortality

Somewhat surprisingly, the difference in infant mortality rates between Māori and non-Māori is much smaller than it is in all-ages mortality for those population groups.

It is difficult at this point to know what to make of this. 2010 is the only year for which published data describes infant deaths at DHB level by ethnicity, so we don't know if the pattern shown in the 2010 data is a one-off or indicative of an encouraging trend. Northland DHB will work on acquiring more data to understand patterns and trends in infant mortality.

Northland DHB employs several initiatives which are working to reduce infant mortality, particularly among Māori. 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.

Infant mortality data is supplied by the Ministry of Health and updated annually. Like overall mortality data, it runs a few years behind because of delays in determining causes of death for some babies.

Reducing inequities

At the level of these global indicators, there remain substantial inequities between Māori and non-Māori, though there are signs of improvement. In Northland the life expectancy gap has been reducing over time, but it is still substantial at 7.8 years and Northland Māori live slightly shorter lives than Māori nationally (however that gap too has reduced). Māori patients in hospital are equally as satisfied as non-Māori. Māori are slightly disadvantaged in unplanned readmission bed days and the Māori share has remained stable. Discouragingly however, the age-standardised mortality rate for Māori is more than twice that of non-Māori, though the difference in infant mortality appears to be much smaller.

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 the primary care smoking cessation advice target has been achieved, the PHOs believe there should be more Māori patients receiving the primary care intervention based on the prevalence of Māori smoking rates. Hospital tobacco services are delivering well to Māori and show no inequity within service provision. Public health tobacco control has focused on youth and pregnant Māori women to provide more incentive to quit. 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 prediabetic 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 is coming to fruition. Breast cancer screening services have used a Māori health provider to assist Māori women in attending clinics and reduce 'did not attends'. Huge improvements have occurred in the last year for Māori receiving cardiovascular risk assessments in primary care. School Based Throat Swabbing services in Decile 1-3 schools have improved the rheumatic fever screening through detection of positive Group A Streptococci in Māori children aged 5 to 15. Immunisations for Māori children have improved markedly to be only marginally below target.

Living within our means

Northland DHB recorded a small surplus in 2013/14 despite a tight fiscal environment and ever-increasing acute demand, especially in clinical services and mental health. 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 to deliver a programme of regional procurement 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.

Quality initiatives, such as Blood as a Gift, laboratory demand management, utilisation of watches and specials, have also contributed to the 2013/14 balanced budget.

Overall summary

Overall the report card for Northland DHB is mixed, but there are encouraging signs. Life expectancy is improving, bed days for unplanned readmissions are reducing, and patients are generally very satisfied. Inequities are still significant, especially in mortality, but have not worsened in any of the High Level Measures, and there are signs of continuing improvement in life expectancy.

Outcomes

Northland DHB's performance against our six Outcomes is summarised below. Details about each indicator are in the Analysis of Impact Measures in the next section.

		Overall	
Outcome	**Indicator**	**Performance overall this year**	**Change since last year**
Healthy population	Y10 students never smoked	Target met	Better
	Breastfeeding 6 weeks	>5% from target	Similar
	Immunisations 8 months	Within 5% of target	Better
	Breast cancer screening	Target met	Similar
	Cervical cancer screening	Target met	Similar
	Primary care smoking advice	>5% from target	Better
	Hospital smoking advice	Target met	Similar
Prevention of illness and disease	Immunisations 8 months	Within 5% of target	Better
	Breast cancer screening	Target met	Similar
	Cervical cancer screening	Target met	Similar
	Primary care smoking advice	>5% from target	Better
	Decayed, missing, filled teeth (DMFT) Y8s	>5% from target	Similar
	Hospital smoking advice	Target met	Similar
Reversal of acute conditions	Referrals to Child, Youth and Family	Within 5% of target	Better
	Decayed, missing, filled teeth (DMFT) Y8s	>5% from target	Similar
Optimum quality of life for those with long term conditions	Diabetics with good management	>5% from target	Similar
	Cardiovascular risk assessments	>5% from target	Better
	Cancer radiation treatment	Target met	Similar
	Cancer chemotherapy treatment	Target met	Similar
	Mental health services coverage	Target met	Better
	HBSS clients receiving interRAI assess.	>5% from target	Worse
	ARRC providers 3-year certification	Target met	Better
	% HBSS for higher needs clients	Target met	Better
Independence for those with impairments or disability support needs	HBSS clients receiving interRAI assess.	>5% from target	Worse
	ARRC providers 3-year certification	Target met	Better
	% HBSS for higher needs clients	Target met	Better
Better, sooner, more convenient services	Cancer radiation treatment	Target met	Similar
	Cancer chemotherapy treatment	Target met	Similar
	Elective surgery operations	Target met	Better
	Emergency Dept waiting times	Within 5% of target	Similar
	Harm from falls	Within 5% of target	New measure
	Pressure injuries	Within 5% of target	New measure
	Compliance with surgical checklist	Target met	Better
	Hand hygiene compliance	>5% from target	Similar
	Central line infections	Target met	Better
	Medicine reconciliation	>5% from target	Better

Healthy population

Of the seven indicators that fall under this Outcome target four were met (never smoked among Year 10 students, breast cancer screening, cervical cancer screening, 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 CYFS of children suspected of 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 2013/14. Performance on the interRAI assessment indicator is mainly due to staffing shortages which have since been addressed, so 2014/15 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.

Analysis of Impact Measures

Northland DHB's performance against our six Outcomes is summarised below. Details about each indicator are in the Analysis of Impact Measures in the next section.

Peformance description	Colour used in summary table below	Code used in Impact Measures section
Target met	Target met	●
Within 5% of target	Within 5% absolute of target	●
More than 5% from target	> 5% absolute from target	●

Measures marked * identify 2012/13 data that was not included in the 2012/13 SSP, so this comparative information is therefore unaudited.

The introduction to the Statement of Service Performance describes how the Impact Measures relate to the High Level Measures, collectively forming a picture of the health of our population and how well services are performing.

The table below summarises results for 2013/14 overall and by equity.

		Overall		Equity	
Output Class	**Indicator**	**Performance overall this year**	**Change since last year**	**Performance for Maori**	**Change since last year**
Prevention	Y10 students never smoked	Target met	Better	>5% from target	Better
	Breastfeeding 6 weeks	>5% from target	Similar	>5% from target	Similar
	Immunisations 8 months	Within 5% of target	Better	Within 5% of target	Better
	Breast cancer screening	Target met	Similar	Target met	Similar
	Cervical cancer screening	Target met	Similar	>5% from target	Similar
Early detection and management	Primary care smoking advice	>5% from target	Better	No Maori data	No Maori data
	Decayed, missing, filled teeth (DMFT) Y8s	>5% from target	Similar	>5% from target	Similar
	Diabetics with good management	>5% from target	Similar	>5% from target	Similar
	Cardiovascular risk assessments	>5% from target	Better	>5% from target	Better
Intensive assessment and treatment	Hospital smoking advice	Target met	Similar	Target met	Similar
	Referrals to Child, Youth and Family	Within 5% of target	Better	No Maori data	No Maori data
	Cancer radiation treatment	Target met	Similar	Target met	Similar
	Cancer chemotherapy treatment	Target met	Similar	Target met	Similar
	Mental health services coverage	Target met	Better	Target met	Similar
	Elective surgery operations	Target met	Better	No Maori data	No Maori data
	Emergency Dept waiting times	Within 5% of target	Similar		
	Harm from falls	Within 5% of target	New measure		
	Pressure injuries	Within 5% of target	New measure		
	Compliance with surgical checklist	Target met	Better		
	Hand hygiene compliance	>5% from target	Similar		
	Central line infections	Target met	Better		
	Medicine reconciliation	>5% from target	Better		
Rehab and support	HBSS clients receiving interRAI assess.	>5% from target	Worse	No Maori data	No Maori data
	ARRC providers 3-year certification	Target met	Better		
	% HBSS for higher needs clients	Target met	Better		

Statement of Comprehensive Income by Output Class

For the year ended 30 June 2014

	Intensive Assessment & Treatment	Early Detection & Management	Prevention	Rehabilitation & Support Services	Total
	$000	$000	$000	$000	$000
Revenue	328,210	131,575	16,959	66,112	542,856
Offsets	(7,817)	-	-	-	-7,817
Total Revenue	320,393	131,575	16,959	66,112	535,039
Personnel Costs	131,335	18,485	4,851	6,185	160,856
Non Personnel Costs	110,371	10,608	2,602	5,677	129,258
Provider Payments	73,032	99,606	8,354	55,776	236,768
Offsets	7,817	-	-	-	7,817
Total Operating Expenditure	322,555	128,699	15,807	67,638	534,699
Surplus (Deficit)	(2,162)	2,876	1,152	(1,526)	340

Description of Output Classes

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

Prevention Output Class

Publicly-funded services that address health in the whole population or sub-population groups. They are distinct from treatment services (the other three Output Classes) which address individual health and disability needs. 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

Often referred to as 'primary and community' services. They are typically generalist, and similar services are usually available from a number of different providers and locations within a DHB's district. 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

These services use specialist clinical expertise and equipment. They are either located on hospital sites or 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

Rehabilitation and support services are delivered following a needs assessment process and subsequent coordination of services by Needs Assessment and Service Coordination services.

They include:

- needs assessment and service coordination;
- home based support;
- age related residential care beds ('rest homes' and 'long stay hospitals');
- respite care;
- day services;

- rehabilitation;
- palliative care;
- life-long disability services.

Overall performance

This year, 12 targets were met, five were within 5% of target and 8 eight targets were more than 5% from target. Performance improved on 13 indicators and was poorer for only one compared to last year, demonstrating a steady underlying improvement across all levels of performance.

All four indicators under early detection and management are red (more than 5% from target). For two of these, primary care smoking advice and cardiovascular disease assessments, the annual average performance obscures the fact that target was actually met during the fourth quarter, a level of performance that should continue into 2014/15. Good blood sugar management for people with diabetes is the subject of Diabetes Care Improvement Packages, while extensive use of new treatment techniques should see improvements in the oral health measure over the next few years.

Progress on equity

A key element of Northland DHB's performance measurement is the state of Māori health, particularly whether inequities have reduced. Three questions are relevant.

Q1: For how many measures is Māori/ non-Māori data available so comparisons be made?

- out of the 25 measures in the SSP, Māori data is readily available for only 12

Q2: Of the 12 measures for which data is available, has the 2013/14 target for Māori been met?

- target met: 5
- within 5% of target: 1
- more than 5% from target: 6.

Q3: Where the target for Māori was not met, was the variance reduced in 2013/14?

- of the 7 indicators for which the target was not met, performance has improved for 3 and is similar to last year for the other 4.

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 and 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 Tumu Whakarae, the national Māori GMs group.

Three of the indicators (primary smoking, electives, Emergency Department waiting times) are Health Targets whose reporting systems are designed nationally and there is no requirement for data to be supplied publicly by ethnicity. Data for the primary smoking indicator is available by ethnicity through another reporting system, but it is often different to that reported for the Health Target and is thus unusable.

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.

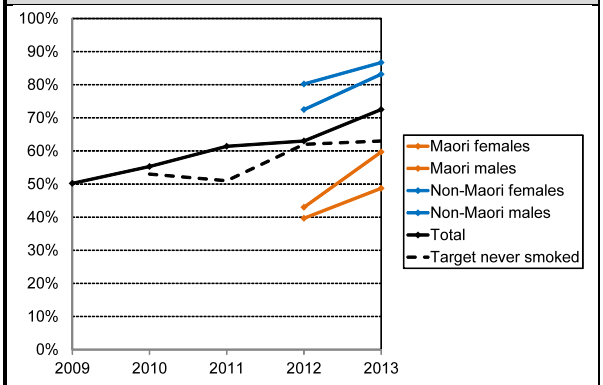
The focus with the development of the new Quality and Improvement Directorate has been in the first instance to establish a culture of quality improvement. Quality Accounts is a new programme of work for Northland DHB and because they have been developed in line with Health Quality and Safety Commission recommendations, they do not have a focus on equity measures. New projects being supported by the 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.

Analysis by indicator

Note that where performance is reported by quarter, the average of all four quarters is used in this analysis. This complies with the expectations of the Office of the Auditor-General. It contrasts with health sector reporting in which the end-of-year (that is, quarter four) result is typically taken as the key measure of annual performance.

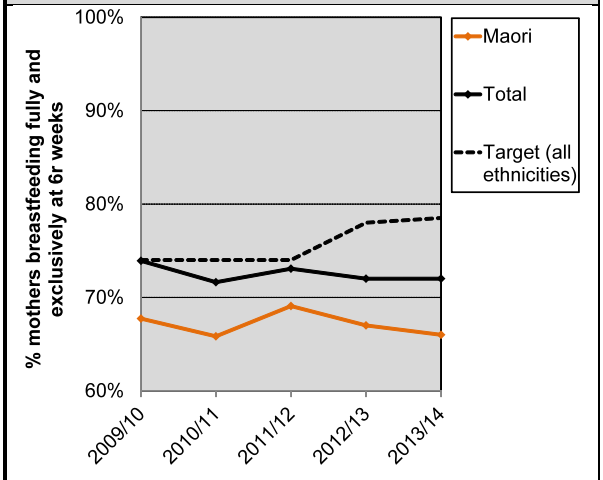
Output Class: Prevention

Impact	Tobacco: lower prevalence of smoking-related conditions		Notes
Impact measure *[& type]*	Proportion of Year 10 students who have never smoked *[coverage]*		Never-smoking rates among Year 10s continue to increase, from 63% in 2012 to 73% in 2013. For the first time, Year 10 data is available by ethnicity. All ethnic groups have shown marked increases in the percentage of never-smokers between 2012 and 2013. Especially pleasing are gains for Maori, with girls increasing from 40% to 49% and boys from 43% to 60%. In addition, the gap between Maori and non-Maori decreased between 2012 and 2013: among girls it dropped from 41% to 38%, and among boys from 30% to 24%. 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 2013 because Action on Smoking and Health conduct the Year 10 survey only once during each school year. The 2013 Year 10 ASH survey reported youth smoking at the lowest rate ever recorded for Northland.
Baseline 2012	**Target 2013**	**Result 2013**	
Total Y10 63%	63%	73% ●	
Trend			



Source: Year 10 Action on Smoking and Health (ASH) Survey Results 1999-2013: Trends in Tobacco Use by Students Aged 14-15 Years.

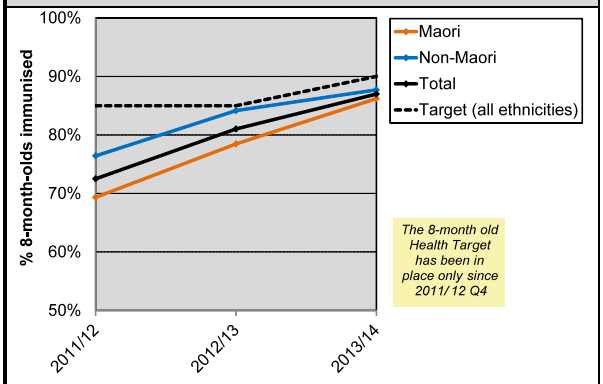
Impact	Healthy children: reduced likelihood of acquiring long term conditions later in life		Notes
Impact measure *[& type]*	Northland mothers who breastfeed fully and exclusively at six weeks *[coverage]*		Rates for both Maori and total population continue to be below target. They have fallen even further behind in 2013/14 because the target is slightly higher and performance has not improved. Data supplied is for Plunket only. While it covers the majority of the population, it does not include Tamariki Ora (Maori well child) providers. The two sets of data cannot be added together because Plunket supplies it as percentages, not numbers. Northland DHB will continue working to resolve this gap. We have formed a working group that includes the DHB, Plunket and all Maori NGO well child-tamariki ora providers. The group has identified breastfeeding rates as one of three indicators that will be focussed on in the coming year. They have committed to meeting every three months to identify trends, bottlenecks and opportunities; this will lead to improved processes across multiple providers which will in turn result in greater collaboration with other maternity providers in and out of the region. It is important that reporting captures the work undertaken by the Maori NGOs because it articulates the cohort of clients who are often difficult to provide care to due to access barriers.
Baseline 2012	**Target 2013/14**	**Result 2013/14**	
Maori 67% Total 72%	78.5% 78.5%	67% ● 72% ●	
Trend			



Impact	Healthy children: lower incidence of communicable disease	Notes
Impact measure *[& type]*	% of eight-month-olds who are fully immunised *[coverage] [Health Target]*	*Note that the published target of 85% was an error; it should have been 90%.* Northland DHB has made further progress in the last year, rising from 83% for all 8-month-olds in July 2013 to our current level of 87%. Rates for Maori continue to be on a par with non-Maori. The trend over the four quarters during 2013/14 has been gradually upward across all ethnic groups. Further improvement is anticipated as we work collectively with our partners in primary care. A Project Manager has been appointed to assist in implementation of all actions within the Immunisation Action Plan.

Baseline 2012/13		Target 2013/14		Result 2013/14
		Published	Actual	
Maori	81%	85%	90%	86% ●
Non-M	84.4%	85%	90%	88% ●
Total	83%	85%	90%	87% ●

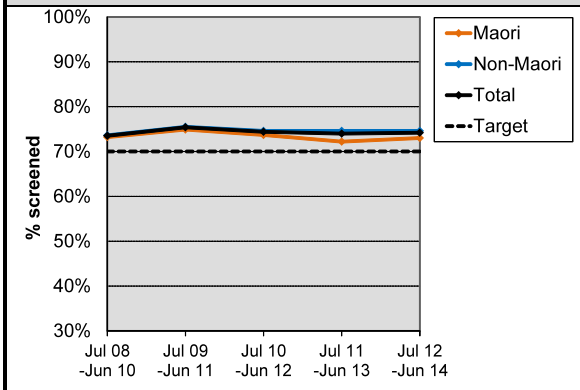
Trend



Impact	Cancer: if curable, increased likelihood of survival; if incurable, reduced severity of symptoms	Notes
Impact measure *[& type]*	Breast cancer screening in eligible populations *[coverage]*	Performance continues to be above target and is similar to last year. 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, and this is the way data is reported by the National Screening Unit. *Note that the published baseline figures covered only one year to June 2012 . Data has since been revised to cover the two years ending in June each year (to match the two-year recall period for breast screening). The published figures are only slightly different from the revised ones (Maori 72.2%, non-Maori 74.6%, total 74.0%) and both sets are well over target.*

Baseline June 2012		Target Jul 2012-Jun 2014	Result Jul 2012-Jun 2014
Maori	73.8%	70%	73.0% ●
Non-M	75.4%	70%	74.6% ●
Total	75.1%	70%	74.2% ●

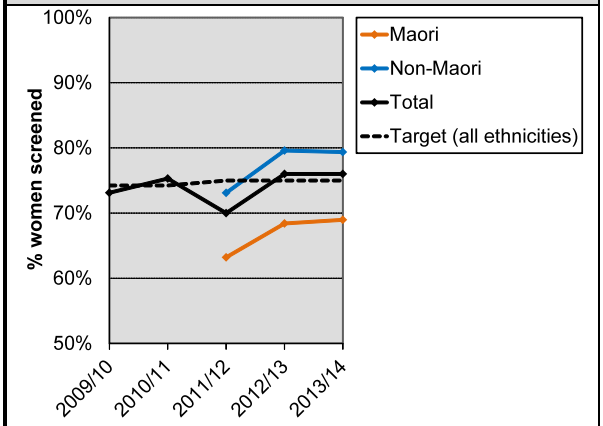
Trend



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

Baseline 2012/13		Target 2013/14		Result 2013/14
		Published	Actual	
Maori	68.4%	75%	80%	70.2%
Non-M	79.6%	75%	80%	78.3%
Total	76.0%	75%	80%	75.8%

Trend



Notes

Note that the 75% target in the published SSP 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%.

Performance for non-Maori is only just below target. For Maori it still lags behind, though there has been a gradual increase across the quarters during 2013/14 (68.5%, 68.2%, 71.3%).

During 2011/12 Northland DHB devolved responsibility for Cervical Screening Coordination, plus the associated funding, to primary care. Free smears were then introduced for priority group women in all general practices in Northland. Some improvement in performance has been seen, though not to the level anticipated. The 80% target is a challenge for all DHBs and the performance of Northland DHB is comparable with that of other DHBs.

Northland DHB, together with Northland PHOs, the Ministry and clinical advisors continues to review how cervical screening services can be optimised to maximise patient coverage. Following recommendation from an expert advisory group, a new service model is to be developed based upon the following principles:

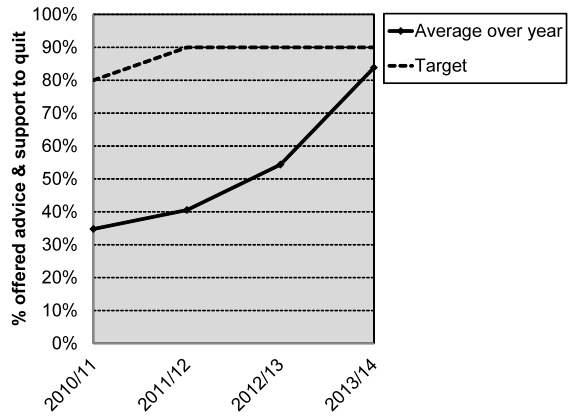
- access: consideration to be given to cost, opening hours, childcare, transport, environment;
- messaging and health literacy;
- cultural humility: use of appropriate language and cultural nuances;
- workforce development: ensure a culturally and clinically skilled workforce;
- practice plans: to enable general practices to understand their populations and to support engagement;
- education of local populations: to increase understanding of the reasons for the procedure.

Output Class: Early Detection and Management

Impact	Tobacco: lower prevalence of smoking-related conditions	Notes
Impact measure *[& type]*	Proportion of smokers in primary care provided with advice and help to quit *[coverage] [Health Target]*	The 83.8% annual average performance over 2013/14 hides a significant and consistent improvement over the four quarters from 76.9% to 96.6% (the first quarter the target has been achieved). This is a result of a concerted approach between the PHOs' Clinical Director and general practices to meet the Health Target. The data reported to PHOs by general practices is subject to a certain degree of checking by the PHOs, MoH and the Central Region [DHBs] Technical Advisory Services but it is not externally audited for validity and consistency

Baseline 2012/13	Target 2013/14	Result 2013/14
Total pop. 54.4%	90%	83.8% ●

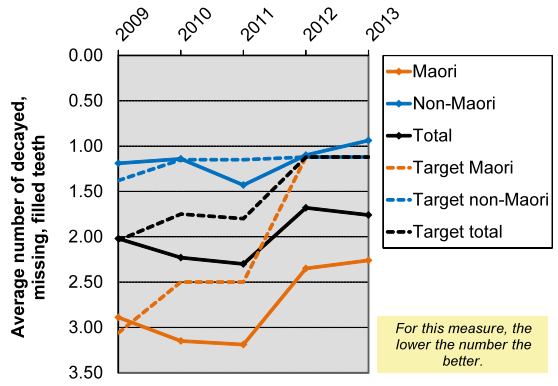
Trend



Impact	Healthy children: healthier teeth and gums	Notes
Impact measure *[& type]*	Average number of decayed, missing or filled teeth (DMFT) among Year 8 students *[quantity]*	Performance again meets target for non-Maori but Maori Year 8 students experience a significant inequity. Our DMFT figures have remained stable over recent years. We expect to see a more favourable trend over the next five years with the extensive use of fluoride varnish, fissure sealants and radiographs across the service, more engagement with parents and whanau at their children's appointments and the good coverage of oral health education and promotion being provided by many Maori providers in the community. Data is reported for each calendar year in line with the school year.

Baseline 2012		Target 2013	Result 2013
Maori	2.35	1.12	2.26 ●
Non-M	1.10	1.12	0.94 ●
Total	1.68	1.12	1.76 ●

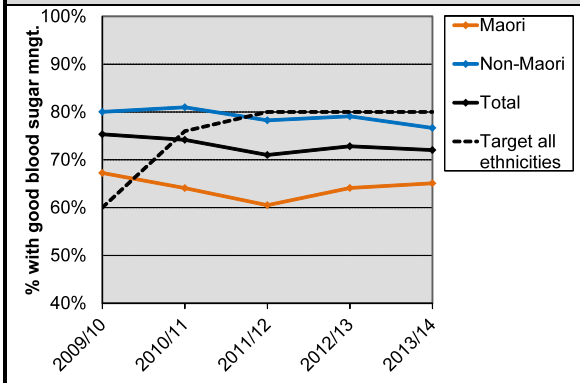
Trend



Impact	Long term conditions: Amelioration of disease symptoms and/or delay in their onset	Notes
Impact measure *[& type]*	Of people with diabetes receiving Diabetes Annual Reviews, % with good blood sugar management *[coverage]*	Performance remains stable, though below the national performance target. The numbers of people estimated by the Ministry of Health to have diabetes increases each year, 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 SSP) 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 2012/13		Target 2013/14	Result 2013/14
Maori	64.1%	80%	65.1% ●
Non-M	*77.0%	80%	76.7% ●
Total	72.8%	80%	72.0% ●

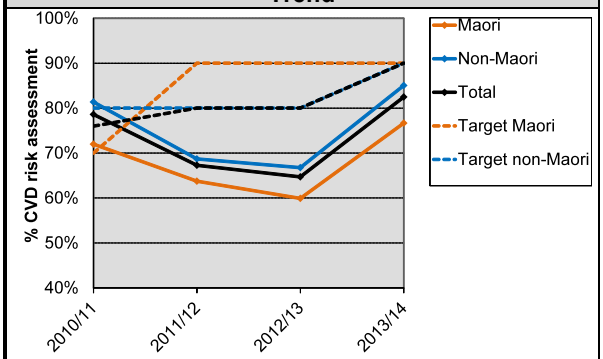
Trend



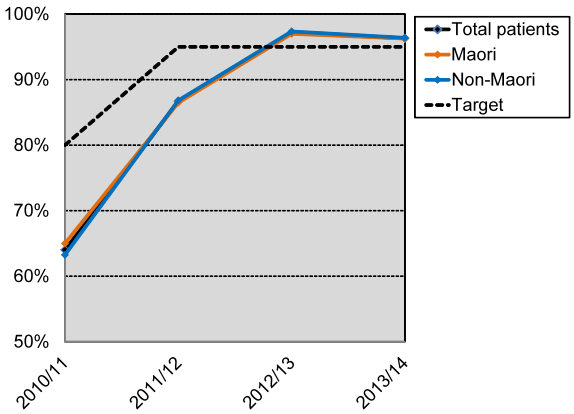
Impact	Long term conditions: Amelioration of disease symptoms and/or delay in their onset	Notes
Impact measure *[& type]*	Of people in eligible populations, those who have had a CVD risk assessment in the last five years *[coverage [Health Target]]*	Continued improvement has been evident in this indicator over the last couple of years, though at the same time the ever-rising target has left us behind. It is, however, encouraging to note that the Q4 result sits above target for both non-Maori (92.3%) and overall (90.1%). Performance for Maori is still behind at 85.0%, but it has been rising steadily since Q1's 69.8%. Northland is the fourth-best performer among all DHBs. Credit must go to Northland's PHOs and general practices who have improved their performance only 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.

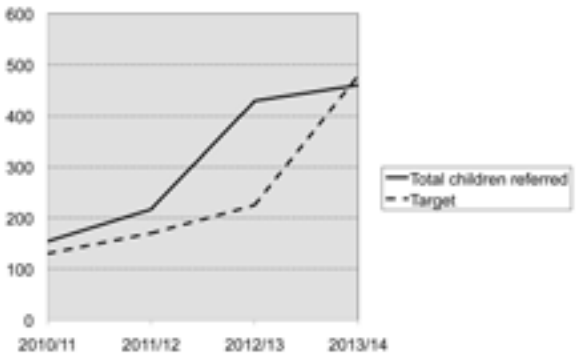
Baseline 2012/13		Target 2013/14	Result 2013/14
Maori	63.0%	90%	76.6% ●
Total	68.6%	90%	82.5% ●

Trend



Output Class: Intensive Assessment and Treatment

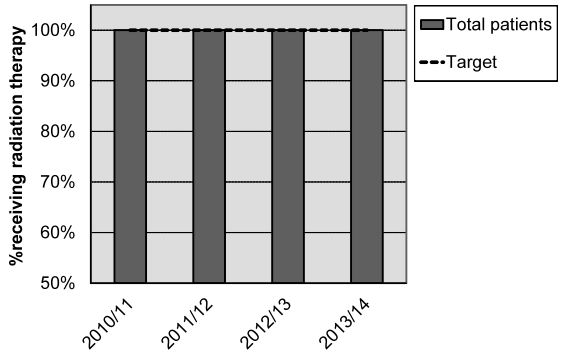
Impact	Tobacco: lower prevalence of smoking-related conditions		Notes
Impact measure *[& type]*	Percent of smokers admitted to hospital given advice and help to quit *[coverage]* *[Health Target]*		The target was exceeded for all ethnic groups during 2013/14. To ensure data quality regular audits on event coding are performed, though in 2013/14 they were not done as regularly as in previous years because the target was on track. To keep performance high, feedback on results is given monthly to services and managers. If necessary, discussions are held with wards on the need to improve results. All clinical staff who join Northland DHB receive education on how to go about the process of offering advice and help, and to explain Northland DHB policies on Smokefree and Nicotine Replacement Therapy.
Baseline 2012/13	**Target 2013/14**	**Result 2013/14**	
Maori 97.1% Total 97.3%	95% 95%	96.3% ● 96.3% ●	
Trend			
			

Impact	Healthy children: safer children		Notes
Impact measure *[& type]*	Referrals to CYFS of children suspected of being abused *[quantity]*		(In this case, more cases of abuse detected is regarded as a positive thing because it is accepted wisdom that child abuse is significantly under-reported.) For the first time for some years, performance has not exceeded target, though it is close. The long-term target is to reduce the rate of child abuse in Northland. It is unlikely that the slight drop-off in actual numbers compared to expectations is due to a lower level of need. It could be the result of caregivers accessing help earlier or visiting their GP rather than the Emergency Department. In the past two years there have been some high-profile child abuse cases in Northland involving multiple victims which have raised awareness and may have led to a slightly higher number of referrals in the last year. As per the Ministry of Health contract, training for family violence screening and the production of child protection reports of concern continues in targeted areas throughout the year at all district hospitals, Whangarei Hospital and for comunity services. Violence Intervention Programme (VIP) and Child Protection (CP) Coordinators together with paediatricians are available to provide 24/7 advice and support for staff to refer when concerns are noted. VIP and CP coordinators also audit patient notes and are able to target education into areas which show low notification rates or missed recognition of potential cases.
Baseline 2012	**Target 2013/14**	**Result 2013/14**	
Total 429	479	460 ●	
Trend			
			

Impact	Cancer: if curable, increased likelihood of survival; if incurable, reduced severity of symptoms	Notes
Impact measure *[& type]*	People diagnosed with cancer who receive radiation treatment within four weeks of the decision to treat *[timeliness] [Health Target]*	Target continues to be met. All radiotherapy treatment for Northlanders occurs in other DHBs, mainly Auckland. Patients are referred by their GPs and receive a First Specialist Assessment including investigations to aid diagnosis and treatment plans. Subsequently a Multi-Disciplinary Team meeting is held at which individual patients are discussed by a range of clinical specialists from Northland DHB and other DHBs and a plan of care is decided on. This is the "decision-to-treat" date. Data is extracted from electronic FCT forms that track steps in the process, and details are verified from electronic letters and other material available in Northland DHB's Concerto software.

Baseline 2012/13		Target 2013/14	Result 2013/14
Maori	100%	100%	100% ●
Total	100%	100%	100% ●

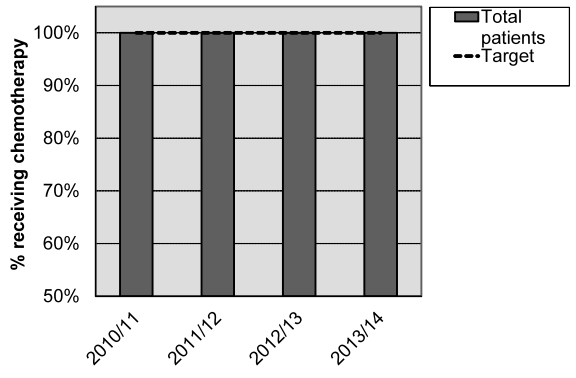
Trend



Impact	Cancer: if curable, increased likelihood of survival; if incurable, reduced severity of symptoms	Notes
Impact measure *[& type]*	People diagnosed with cancer who receive chemotherapy within four weeks of the decision to treat *[timeliness] [Health Target]*	Target continues to be met. Unlike radiotherapy, most chemotherapy treatment occurs in Whangarei (except where it is provided alongside radiotherapy in other DHBs). Patients are referred by their GPs and receive a First Specialist Assessment, often accompanied by investigations to aid diagnosis and treatment plans. Subsequently a Multi-Disciplinary Team meeting is held at which individual patients are discussed by a range of clinical specialists from Northland DHB and other DHBs and a plan of care is decided on. This is the "decision-to-treat" date. Patient data is extracted from Northland DHB's Alpha software. End-of-day reports provide data on all events associated with a patient's treatment, including decision to treat and waiting times.

Baseline 2012/13		Target 2013/14	Result 2013/14
Maori	100%	100%	100% ●
Total	100%	100%	100% ●

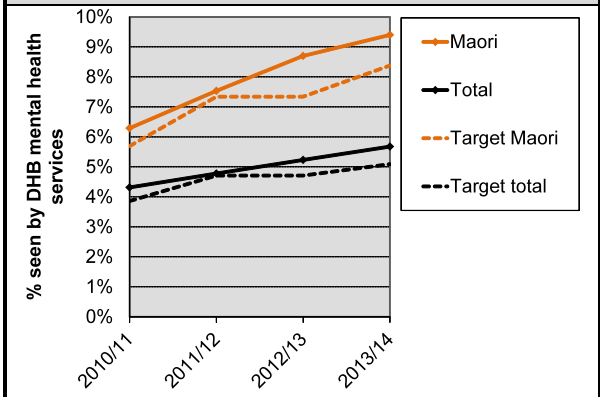
Trend



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]*	Proportion of people with enduring mental illness aged 20-64 who are seen over a year *[coverage]*	Performance continues to exceed target. There has been a 20% increase in access over the last five years The increase in access rates 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 2012/13		Target 2013/14	Result 2013/14
Maori	9.02%	5.09%	9.40% ●
Total	5.37%	5.09%	5.68% ●

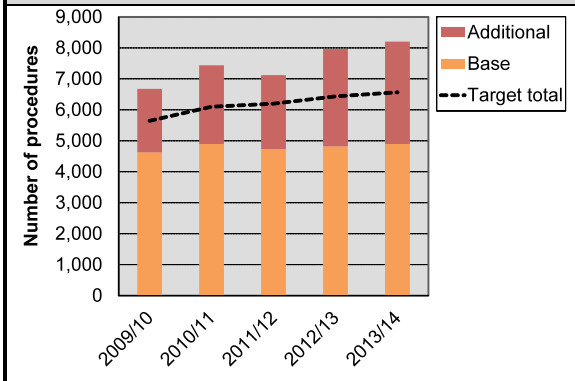
Trend



Impact	Elective surgery: fewer debilitating conditions; delayed onset of long term conditions	Notes
Impact measure *[& type]*	Increase in the number of elective services discharges *[quantity] [Health Target]*	Electives remain consistently above target, and Northland is one of the best performing DHBs. Northland DHB has provided 3% more elective surgery discharges than in 2012/13. There has been an accelerated level of performance towards the end of 2013/14 designed to reduce the scale of the surgical waiting list. This is part of preparation to ensure compliance with the surgical waiting time performance target that is set to reduce from the current maximum waiting time of five months to a maximum waiting time of four months effective from January 1 2015. *Note that the baseline and target data used 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. Actuals are presented using the traditional baseline/additional split for electives.*

Baseline 2012/13 forecast		Target 2013/14	Result 2013/14	
Maori	1,660	1,713	Baseline	4,896 ●
Non-M	4,774	4,851	Additional	3,306 ●
Total	6,434	6,564	Total	8,202 ●

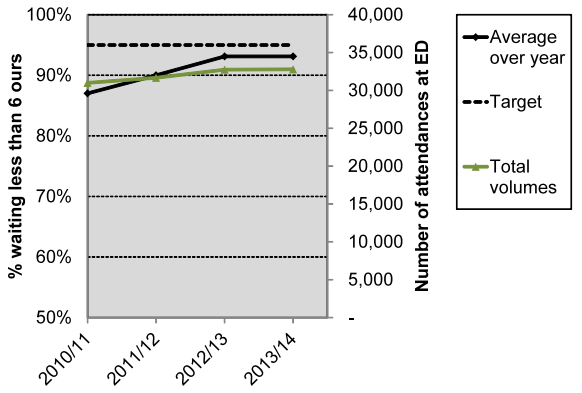
Trend



Impact	Emergency Department (ED) waiting times: more timely assessment, referral and treatment	Notes
Impact measure *[& type]*	Patients with an ED length of stay (time from presentation at ED to either admission to hospital, discharge home or transfer to another facility) of less than six hours *[quality] [Health Target]*	Northland DHB has remained slightly below target for this indicator over the past couple of years. 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 3.5% 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 2012/13	Target 2013/14	Result 2013/14
Total pts. 93.1%	95%	93.1% ●

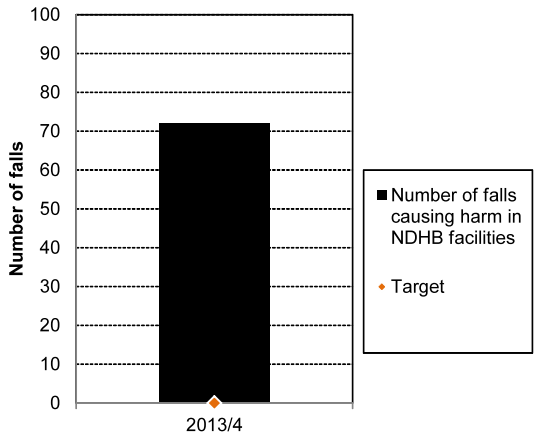
Trend



Improvements in ED include:

- the development of an urgent healthcare programme as part of the Northland Health Services Plan;
- redesigning the medical registrar workforce to match patient demand;
- appointment of an admitting medical House Officer;
- overlapping of medical registrars in the early evening to enhance patient throughput;
- redesign of a simplified whole-system standard operating procedure which is patient-centric, measurable and accountable for patient flow;
- a new ED and 30-bedded Acute Assessment Unit is planned for Whangarei Hospital; initial concept design work has commenced;
- in the interim a six-bed admission area continues in use with approximately 12% of ED patients utilising this facility.

Impact	Quality and safety: more satisfied patients	
Impact measure *[& type]*	Zero harm from falls *[quality]* *	
Baseline 2012/13	**Target 2013/14**	**Result 2013/14**
n/a	0	72 ●
Trend		



Notes

This is a new measure in 2013/14.

Although 72 falls might not look good in comparison with a target of zero, it is still only 0.2% of the combined total of 23,197 inpatients and 13,257 daypatients Northland DHB treated during 2013/14. That is still not acceptable however, and Northland DHB's aim is to reduce patient falls to zero.

The graph below shows the number of falls by month during 2013/14.

A significant amount of activities continue to support this project, for example a new falls video made in conjunction with our regional partners First Do No Harm (FDNH), regional collaborative workshops for staff, the HQSC patient safety campaign highlighted falls, and Northland DHB participated in National Falls Day activities.

The organisational admission to discharge planner has been revised to include a better focus on ethnicity and the need for better falls assessment and individualised patient falls plan. A stream of work has also begun at looking at the 'confused patient' and how we can prevent falls.

FDNH have been monitoring falls with harm in the region for 3 years, using a measure of rate of falls with harm/1000 bed days (which is not directly comparable with Northland DHB's absolute numbers approach). FDNH have demonstrated a 50% reduction in the rate of falls with harm.

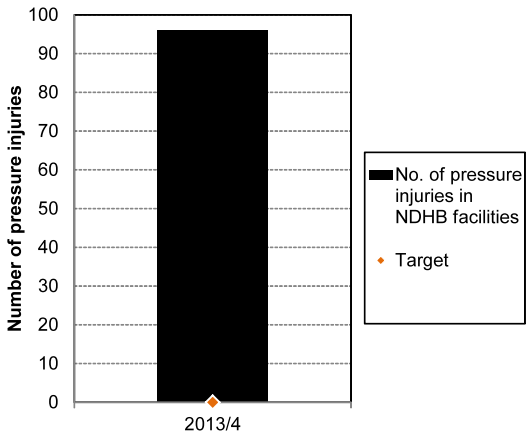
Impact	Quality and safety: more satisfied patients	
Impact measure *[& type]*	Zero pressure injuries *[quality]* *	
Baseline 2012/13	**Target 2013/14**	**Result 2013/14**
n/a	0	96 ●
Trend		

Notes

This is a new measure in 2013/14.

The comments made above about the number of falls in relation to total patient numbers apply here too.

The Quality Accounts dashboard measures pressure injuries using SPC. As demonstrated below we have 7 data points under the medium, close to the 8 points that identifies small

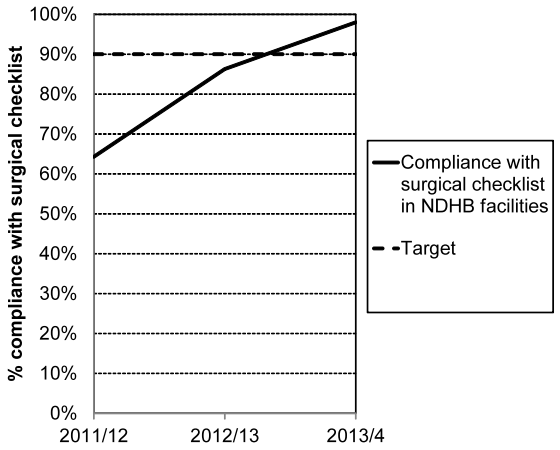


sustained changes.

The pressure injuries champions are currently implementing 'bundles of care' across inpatient areas, new patient stickers have been introduced which identify patients with pressure injuries to assist the clinical coders to code them correctly. There has been a noticeable improvement in nursing documentation. The pressure injuries group has finalised a policy and is reviewing their plan for the year.

The graph below shows the number of pressure injuries by month during 2013/14.

Impact	Quality and safety: more satisfied patients	
Impact measure *[& type]*	Compliance with surgical checklist *[quality]**	
Baseline 2012/13	**Target 2013/14**	**Result 2013/14**
86.3%	90.0%	98.0% ●
Trend		



Notes

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 considerably exceeded target and has shown rapid improvement over the past couple of years.

New work has commenced on briefing and debriefing in the operating theatre. This work supports the HQSC programme to reduce perioperative harm, and further augments a patient safety environment in the operating theatres.

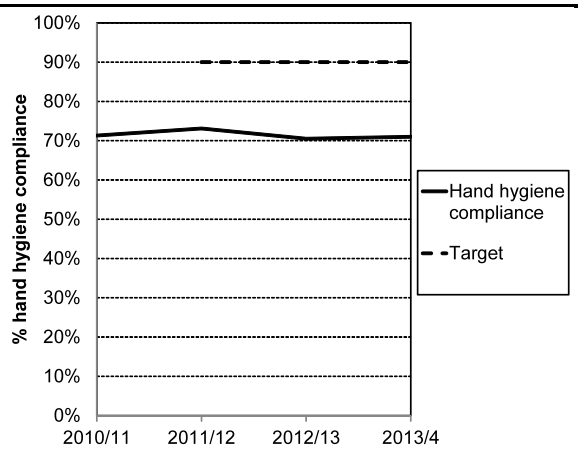
The graph below shows surgical checklist performance by month during 2013/14.

Impact	Fewer adverse clinical events	
Impact measure *[& type]*	Hand hygiene compliance *[quality]*	
Baseline 2012/13	**Target 2013/14**	**Result 2013/14**
Total pts. 70.5%	90.0%	71.0% ●
Trend		

Notes

Performance has not reached the target.

A training programme was recently held for Hand Hygiene Local Auditors, Northland DHB staff trained to Hand Hygiene NZ standards by accredited trainers. This has resulted in some frontline staff undertaking auditing in their own areas, and this practice will expand over time. This aligns well with the learning that five staff members (Quality Improvement



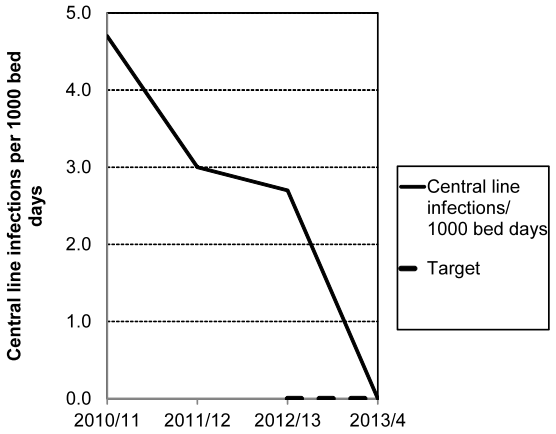
Facilitator, Infection Control Nurse and senior nursing staff from ED, Renal & Ward 15) took from the HHNZ Quality Improvement workshop in June 14. Focus for DHBs going forward is for clinical areas to take full ownership (FLO-front line ownership) of their Hand Hygiene audit and performance. This will be supported by new charts currently being developed to highlight performance and encourage healthy competition around compliance. With this in mind, the following promotions are underway or planned:

- a Grand Round led by the Clinical Microbiologist to enlist universal commitment to Hand Hygiene and leaders as role models;
- a call to action for all clinical nurse managers to support the work of Local Auditors in their areas and to be accountable for their team's performance;
- a new range of promotional polo shirts that will be showcased at the Grand Round and worn on a pre-arranged regular basis by 30 key staff;
- life-sized cardboard cutout figures of the Clinical Microbiologist are planned, to be positioned in varying areas of the hospital as a hand hygiene reminder.

Impact	Fewer adverse clinical events	Notes
Impact measure *[& type]*	Zero central line infections per 1000 bed days *[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. Northland DHB has traditionally had one of the lowest rates of central line infection in the country, but there was still potential for morbidity and mortality. Northland DHB now has a standard process for insertion, maintenance and surveillance of central lines.

Baseline 2012/13	Target 2013/14	Result 2013/14
2.7	0	0 ● (760 bed days so far)

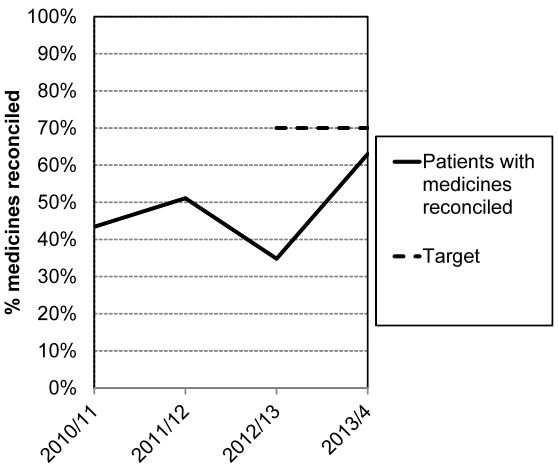
Trend

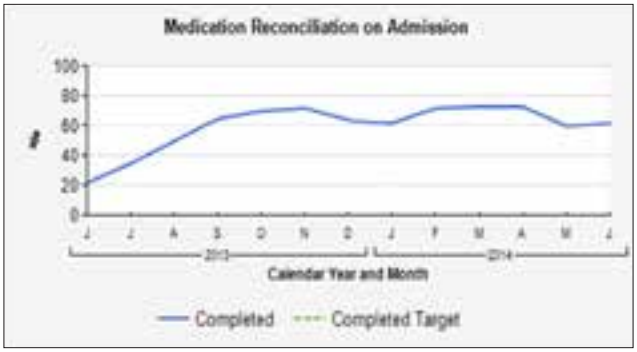


Impact	Fewer adverse clinical events	Notes
Impact measure *[& type]*	Medicine reconciliation *[quality]**	The medicine reconciliation on admission service continues to be delivered in a revised way, with good results. The target completion rate was achieved and the system was found to be sustainable. The new service delivery method will be continued as business as usual, and the medicine reconciliation leadership group will continue to meet to review and progress the broader medicine reconciliation strategy for Northland DHB. 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 are communicating with HQSC and are supportive of MR becoming a Quality and Safety Marker. The graph below shows medicine reconciliation performance by month during 2013/14.

Baseline 2012/13	Target 2013/14	Result 2013/14
34.8%	70.0%	63.0% ●

Trend



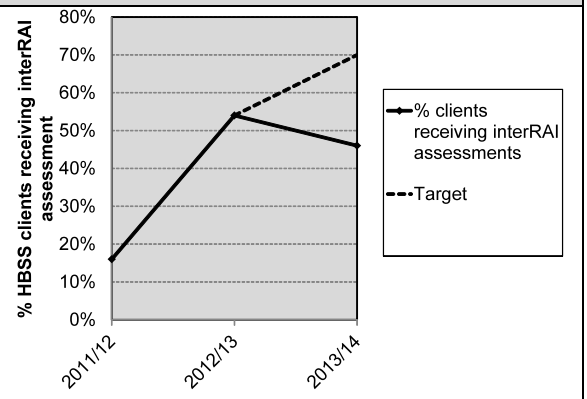


Output Class: Rehabilitation and Support

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]*	% of long-term HBSS clients assessed using interRAI tool *[coverage]*	In Quarter 1 2013/14 Northland DHB informed MoH of an issue with the data analysis carried out in 2012/13, which affected the accuracy of the results reported in 2012/13. In 2013/14 the Northern Region Alliance was appointed to carry out the data analysis for this measure on behalf of the four Northern Region DHBs. This provides quality data analysis for the Northern Region, and allows the performance of Northern Region DHBs to be monitored on a regional level. The lower performance reported in 2013/14 is the result of capacity issues within Northland DHB"s Needs Assessment and Service Coordination service. This has been partially addressed through the recruitment of three additional Need Assessor positions. In 2014/15 it is expected that there will be some increase in the number of home-based support service clients assessed using the InterRAI tool. However it is not anticipated that the 2013/14 target will be met until the additional staff have achieved InterRAI competency.

Baseline 2012/13	Target 2013/14	Result 2013/14
Clients assessed 60%	70%	46% ●

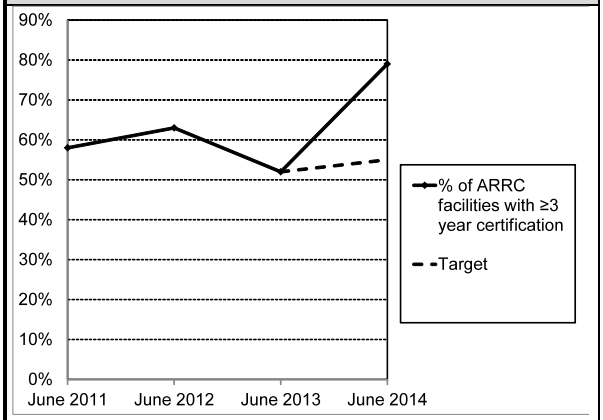
Trend



Impact	Support for older people: older people requiring support or care receive services appropriate to their needs	Notes
Impact measure *[& type]*	% Age Related Residential Care (ARRC) facilities with ≥3 year certification *[quality]*	Target has been achieved. 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 OAG report *Effectiveness of arrangements to check the standard of services provided by rest homes.* 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 2013/14 there are 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 June 2013	Target June 2014	Result June 2014
50%	55%	79% ●

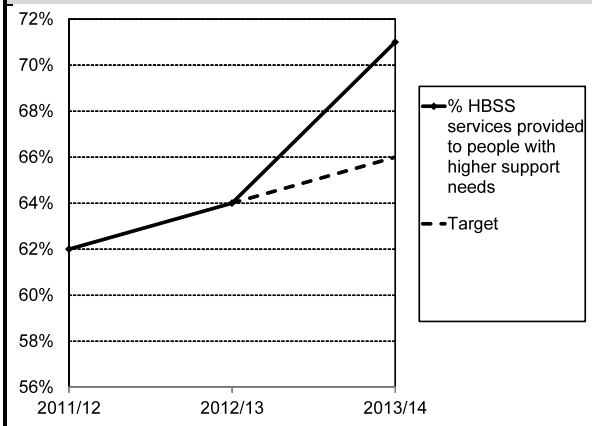
Trend



Impact	Support for older people: older people requiring support or care receive services appropriate to their needs	Notes
Impact measure *[& type]*	Rising % of Home Based Support Services (HBSS) provided to older people who have higher support needs *[coverage]*	Target continues to be achieved. HBSS resources are used more effectively if they are focused on those with higher needs, which in the case of HBSS means prioritising services for people who have personal care and supervision-related needs (rather than on people with low support needs who only want cleaning services). To ensure the highest need clients are supported, Northland DHB funds home-based support services to people who have an age-related disability which is likely to continue for a minimum of six months and result in a reduction of independent function to the extent that ongoing support is required and require help with showering, dressing or toileting or assistance or supervision with eating and drinking. Focusing on supporting people who have higher needs will enable more older people to remain in their own homes for longer ('age in place'), thus supporting the expressed desires of the majority, as well as aligning with national policy. This will reduce or delay demand for rest homes, which are more expensive than home-based support services.

Baseline 2012/13	Target 2013/14	Result 2013/14
Personal 66.6%	66%	71% ●

Trend



National Health Targets

The 2013/14 year saw three changes to the health targets. These included the introduction of agreed Level 2 hospital data in the shorter stays in emergency departments (ED), and a staged increase to 90 percent in the national goals for the increased immunisation and the more health and diabetes checks targets.

Northland health targets: quarter 4 (April–June) 2013/14 results							
	Shorter stays in emergency departments	Increased access to elective surgery	Shorter waits for cancer treatment (radiotherapy & chemotherapy)	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, 2013/14	15	1	1	18	16	6	4
Quarter 3, 2013/14	93.1%	111.6%	100.0%	87.5%	95.9%	84.6%	84.1%
Quarter 4, 2013/14	92.9%	125.0%	100.0%	88.0%	93.8%	96.6%	90.1%
National goal	95.0%	100.0%	100.0%	90.0%	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.

The DHB had a slight increase (92.9 percent 2013/14 Quarter 4) of performance when compared to Quarter 4 2012/13 (92 percent). We are working 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 'Urgent Healthcare'.

However, it has been acknowledged that, until we have a new ED and a co-located Acute Assessment Ward, we are unlikely to achieve a sustained >95 percent performance. The site master plan has some new innovations that should help us address these challenges in a shorter timeframe than was originally anticipated.

Improved access to elective surgery (DHB)

The target is an increase in the volume of elective surgery by at least 4,000 discharges per year. DHBs planned to deliver 152,287 discharges for the 2013/14 year, and have delivered 9,646 more.

Northland DHB has achieved its 2013/14 health target – Improved access to elective surgery reaching 125 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 seventh year in a row that Northland DHB have exceeded their full year health target. The Ministry of Health considers us an outstanding performer in elective services since 2007/2008.

Better help for smokers to quit (DHB)

The target is 95 percent of patients who smoke and are seen by a health practitioner in public hospitals.

Disappointingly our hospital target dropped in Quarter 4 to 93.8 percent from 95.9 percent in Quarter 3.

Shorter waits for cancer treatment (DHB)

The target is all patients, ready-for-treatment, wait less than four weeks for radiotherapy or chemotherapy. Six regional cancer centre DHBs provide radiation oncology services. These centres are in Auckland, Hamilton, Palmerston North, Wellington, Christchurch and Dunedin. Medical oncology services are provided by the majority of DHBs.

Northland DHB met the target of 100 percent of patients commencing treatment within four weeks of referral for radiation and chemotherapy treatment.

Primary Health Organisations (PHO) Health Target Performance

For 2013/14 there were three Primary Care Health Targets – More heart and diabetes checks, Better help for smokers to quit and increased immunisation rates.

Increased immunisation (PHO)

The national immunisation target is 90 percent of eight month-olds will 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 includes children who turned eight months between April and June 2014, are enrolled in a PHO 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.

Both PHOs met the increased immunisation target, a pleasing result from an increased effort in this area. Manaia Health PHO reached 92 percent, up four percent from 12/13 Quarter 4 (88 percent).

Te Tai Tokerau PHO reached 90 percent, up 11 percent from 12/13 Quarter 4 (79 percent).

The overall Northland result is 88 percent for the eight month milestone, up from 83 percent (2012/13). This is lower than the combined results of our two PHOs because the two PHOs do not cover the entire Northland population.

An immunisation communications strategy has been endorsed by the multi-agency (primary and secondary) steering committee focused on increasing timely immunisation rates in Northland.

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.

Manaia Health PHO result is up 30 percent from 12/13 Quarter 4 (79 percent) to 110 percent as, in addition to offering advice in primary care settings they contacted patients who had not recently attended their general practice to offer them brief advice and support to quit smoking.

Te Tai Tokerau PHO has made considerable improvement since last year, up 18 percent from 12/13 Quarter 4 (64 percent) to 82 percent 13/14 Quarter 4.

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 2014.

Manaia Health PHO has met this target reaching 92 percent, up 10 percent from 12/13 Quarter 4. Te Tai Tokerau PHO improved greatly, up 24 percent to 88 percent from 64 percent 12/13 Quarter 4.

What are the changes to the health targets in 2014/15?

Increased immunisation

From Quarter 1 2014/15 (July 2014 onwards), the Increased immunisation health target for children aged 8-months increases to 95 percent, to be achieved by December 2014.

Faster cancer treatment

From Quarter 2 2014/15 (October 2014 onwards), the 62 day faster cancer treatment indicator will become the cancer health target, and also from that date the current shorter waits for cancer treatment target will shift to be included in the DHB performance measures.

What is the Integrated Performance and Incentive Framework (IPIF)?

The IPIF is being developed with DHBs, PHOs, general practices and patients as a core mechanism to lift performance, improve clinical integration and improve quality in the primary health care sector over the next three - five years. The development and staged implementation of this improved performance programme is an important step to strengthen the wider health care system.

What is the relationship between health targets and the Integrated Performance and Incentive Framework?

Health targets will likely remain an important part of the IPIF. The first year of IPIF is a transitional year where the three primary care health targets form the majority of the IPIF measures. These are increased immunisation, better help for smokers to quit, and more heart and diabetes checks. Several DHBs and PHOs are already successfully meeting the health targets. In addition, IPIF will measure performance against cervical screening and two-year-old immunisation rates.

PHOs will receive incentive payments linked to how they perform against these targets. Individual PHO targets are phased in the transition year so that PHO cash flow is not significantly disrupted as the new system is put into practice. The sector is still expected to meet the primary care targets as soon as possible.

For 2015/16 and beyond it is likely that health targets will be incorporated into the IPIF, with the placement to be finalised. Work is underway to decide how financial incentives should best be applied.

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 and the governance and management structure to support the NHSP work. This year we report on progress with implementation.

Five major NHSP projects have been established to accelerate action towards achievement of our headline targets and the triple aim.

Each of the five projects: First 2000 Days, Urgent Healthcare, Patient & Family Centred Care, Neighbourhood Healthcare Homes and Fit for Life are sponsored by an Executive Leadership Team member and a senior medical professional provides clinical leadership. Dedicated project management resource has been provided to facilitate progress.

- First 2000 Days focuses on improving the health of our children by supporting young women pre-conception, through pregnancy and childbirth and then caring for children in their first five years.
- Urgent Healthcare is a project focused on ensuring people with acute need receive the right care at the right time in the right place.
- Patient and Family Centred Care will address a number of the recommendations of the Patient Safety and Quality Review. It is focused on changing the culture of health service delivery to engage with consumers at all levels of health service decision making, as partners in care.
- Neighborhood Healthcare Homes is a project involving the establishment of networks of general practices, primary and community health services working together in new ways to optimise the healthcare experience of families. These networks are also expected to strengthen the sustainability of general practice, primary and community health services through developments such as collaborative models of care and secure information sharing.
- Fit for Life provides a focus on healthy lifestyles towards achievement of our smokefree 2025 goal and the prevention and management of obesity. This project provides support to the work of Te Roopu Kai Hapai Oranga, Alliance Leadership team.

Alongside the five major NHSP projects, considerable effort is being applied to the NHSP headline actions through strategic innovation.

Information Technology Integration

A number of successful IT integration programmes are improving communication and linkages between Primary Care and Hospital services. Two Shared Care pilots are using two products, Manage my Health and Collaborative Care Management System (CCMS). A project to pilot the CCMS secure messaging system between general practices and hospital specialists has commenced. CCMS will also be used to share health information across three primary care providers; Te Whareora O Tikipunga, Paihia Medical Centre, and Ki A Ora Ngatiwai. An alternative information sharing application, Manage my Health, has commenced in Dargaville between the General Practice, Te Ha Oranga o Ngati Whatua, and the DHB District Nursing service. Piloting of portals to allow patient access to some clinical information and online communication with the general practice is underway at three general practices: Bush Road, PrimeCare and Kerikeri Medical Centre. One of these practices, Bush Rd, is undertaking a pilot to enable patients to have online access to their whole clinical record.

Health Literacy

The Diabetes Health Literacy Project is being undertaken by Workbase Education Trust, using rural primary care diabetes services in Northland as the pilot. Site reviews have been completed at Kerikeri Medical Centre, Te Hauora o te Hiku o te Ika and Hokianga Health. Action plans have been developed for each review site. A number of resources, including a Health Literacy poster and progression framework are being developed. These resources will be adaptable for other LTCs in the primary care environment.

Health literacy articles have been published in the Prescribe magazine and Northland DHB screensavers developed, promoting health literacy. A health literacy presence has also been established on the Northland DHB website.

High Five Enrolment

This project is aiming to implement systems that ensure all newborn babies are enrolled with:

1. A general practice;
2. The national immunisation register;
3. Newborn hearing screening;
4. A well child provider;
5. An oral health service.

Strengthening the Perinatal Journey for Women Experiencing Multiple Adversities in Pregnancy

This is a collaborative project between Northland DHB, Manaia PHO and the Health Promotion Agency. The primary objective is to improve outcomes for children by reducing the impact of maternal/parental adversity such as: addictions to alcohol and other drugs (including tobacco) gambling, domestic violence, depression; poor housing.

Workforce Enablement

A Whole of System Workforce Strategy and Action Plan is in development aligned with the workforce objectives of the NHSP.

Eliminating Inequities

An Equity Kaitiaki Group (EKG) has been established to ensure the NHSP projects are guided by an equity framework. The purpose of the EKG is to:

1. Provide advice and support relating to eliminating inequities to the NHSP Oversight Group as a Programme of work responsible for meeting the strategic goals of Northland DHB and the NHSP;
2. Provide advice and support to project managers on Māori health and issues of inequity in the development and implementation of the projects to ensure the projects do not increase inequities and contribute towards eliminating inequities;
3. Monitor progress on key initiatives/projects and recommend solutions to resolve issues with the implementation of the NHSP that may compromise the realisation of eliminating inequities.

The members of the Equity Kaitiaki Group are:

- Kim Tito (GM, Māori Health and Mental Health & Addictions);
- Lynette Stewart (CEO, Ki A Ora Ngatiwai);
- Ellie Berghan (Population Health Strategist Māori Health);
- Jensen Webber (Portfolio Manager, Māori and Pacific Health);
- Jim Palmer (Operations Manager, Te Poutokomanawa);
- Ngaire Rae (Health Promotion Manager, Northland PHOs);
- Liane Penney (NHSP Portfolio Manager);
- Lyn Rostern (Population Health Strategist, HOP, DSS & Palliative Care);
- Hemaima Reihana-Tait (Associate Director of Nursing, Primary Care);
- Win Bennett (GP Liaison Officer).

NHSP Office

The NHSP Office provides support to the NHSP governance, administers the Strategic Investment Fund Prioritisation Group and provides the centralised project management resource to the five major projects. An NHSP project management guide and templates have been developed and training provided to strengthen project management across NHSP projects. As the NHSP projects develop the NHSP Office will produce consolidated reporting on their outcomes and benefit.

2013 - 2014 Some Highlights

Manaia Health PHO

"Now that we are in the one Waka ……."

At the significant kohimarama conference of Northern Māori Chiefs, gathering after the signing of the Treaty of Waitangi, Whangarei Rangatira, Wiremu Pohe, made the following statement:

"Now that we have all embarked in one canoe, let us be careful that we do not pull backwards. Let us pull in the same direction, as those who sit in the bows; do not let the people in the stern, paddle in the opposite direction."

Over the past few years, little by little we have seen Northland health providers - including the DHB and PHOs, alongside community organisations, Māori health organisations, Government and non-Government organisations – gathering into the waka together.

We are slowly but surely becoming owner of the power of "collective impact", where we can achieve together what none of us can achieve alone.

As I look back over the past eleven years of Manaia Health PHO's life, I see our most significant achievement coming from being part of a wider group, working collectively for Northland's health.

For us, some significant areas of "collective impact" over the past year are:

- Collectively our General Practice teams having 362,248 patient consultations;
- The collective of funders and providers to insulate our 'high-need Northland homes' (6,200 insulated in the past five years);
- Along with Plunket, General Practices and Tamariki Ora providers, providing B4 School Checks to 96 percent of Northland four-year-olds;
- Being part of a programme that now sees 10,000 Northland children having free milk every day at school. Thank you, Fonterra;
- Collectively achieving the national health targets helping smokers to quit, and 90 percent of the eligible population having cardiovascular risk assessments in Quarter four and close to target for eight-month immunisation;
- Being part of the establishment of the Whangarei Youth Space;
- Primary health care nurses working together to lead healthcare improvement in our community.

When we work together, we can "grow the pie" and the whole becomes greater than the sum of its parts.

Chris Farrelly
Chief Executive
Manaia Health PHO

Te Tai Tokerau PHO

There has been significant and increased evidence of Northland Primary Health Organisations working closely in collaboration with Northland DHB during the 2013-2014 financial year.

The majority of the feedback following the Northland DHB's consultation process throughout the district in regard to the reconfiguration of two PHOs into one was to maintain the status quo of two PHOs, with Manaia PHO covering the more urban area of Whangarei and districts, and Te Tai Tokerau PHO covering the rural area from Kawakawa north.

This decision was accepted on the understanding there would be a commitment to further develop a strong shared-services approach, which is still in the planning stage.

Te Tai Tokerau PHO has 61,653 people enrolled through its 16 general practice providers, a population profile that includes 48 per cent Māori, less than three percent Pacifica, with 45 percent of the total population living in areas classified as Quintile 5. The PHO covers a wide geographical area with many remote communities, made vulnerable in regards to maintaining access to health care because of the impact of poverty, lack of employment opportunities and poor housing further compounded by distance from health services and poor infrastructure, such as roading and connectivity through telephone or broadband.

The attainment of Ministry of Health targets linked with the introduction of the integrated Performance and Incentive Framework (IPIF), a nationally-implemented measure of PHO performance, has become a priority focus for Te Tai Tokerau PHO. The targets include immunisation, more heart and diabetes checks, brief advice and referral to cessation support for those patients who are smokers, and cervical screening of high-risk women mindful of the significant effort required to engage with our high need, very mobile population, Te Tai Tokerau implemented an enhanced model using practice facilitators to provide support to our practices, helping with the systems processes and procedures necessary to achieve the targets in a "business as usual" way. This approach complements the regular feedback received through practice reports and run charts, enabling practices to compare progress and learn from strategies shared in collaborative workshops.

Although the PHO has not achieved 100 percent of targets, we are proud of the positive upward trends evident with all indicators.

Services for youth

Te Tai Tokerau PHO has always had a priority focus on the health and wellbeing of rangatahi, and one of the first Services to Improve Access programmes was the establishment in 2005 of three school-based health clinics adjacent to Bay of Islands College, Kaitaia College and Taipa Area School.

These clinics provide fully-subsidised access to health services provided by nurses specialised in working with young people and are supported with weekly GP clinics. Rangatahi present with a wide range of issues and health and wellbeing

concerns such as sexual health, mental health, pregnancy and contraception, and relationship difficulties.

The fact that young people take ownership of these services was demonstrated when students from Kaitaia College and Taipa Area School responded overwhelmingly to a request to rename their health clinics taking part of the "Be the Change" theme for Youth Week May 19-23, 2014.

A competition was held at both schools organised by the Senior Health Council of Kaitaia College and the Senior Student Representatives of Taipa Area School, supported by community businesses Mitre 10 Kaitaia, Pak-'n-Save, Shackleton's Amcal Pharmacy, Te Hauora o te Hiku o te Ika, Te Hiku Pharmacy, and Te Tai Tokerau Primary Health Organisation.

Recognising the value of its students, and to encourage ownership of their health and wellbeing, the competition was an opportunity for them to give the service a name that had meaning and relevance to them. The entries Te Rangatahi Ora meaning "Youth Health" and Herewaka meaning "Bridge Towards Health and Wellbeing" were chosen as the winning entries submitted by Ms Arlie Brydon Year 13 of Kaitaia College and Ms Kalanya Harrison Year 10 of Taipa Area School.

Meanwhile the utilisation of the services continues to grow due to the passion and resourcefulness of the staff involved.

Rose Lightfoot
Chief Executive
Te Tai Tokerau PHO

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.

Other Northland DHB projects include a drive to ensure patients are appropriately assessed to determine their need for venous thromboembolism prophylaxis, and the Quality Assurance division of the Quality & Improvement Directorate has developed a new and innovative patient experience survey which involves taking an iPad to both inpatients and outpatients, so that patients can complete the survey quickly and easily.

Child, Youth, Maternal and Oral Health

Breastfeeding

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

The New Zealand Breastfeeding Authority informed Northland DHB on Thursday July 31 that Northland is retaining the highest exclusive breastfeeding rate on discharge from our maternity facilities. We have increased our leading margin and this is something to celebrate and congratulate all staff.

Bay of Islands	Exclusive rate on discharge	93.1 percent
Kaitaia	Exclusive rate on discharge	100 percent
Dargaville	Exclusive rate on discharge	89.4 percent
Whangarei	Exclusive rate on discharge	95.1 percent

Northland DHB overall 94.7 percent

Unfortunately, like the rest of the country our stats decline rapidly after six weeks then again between three - six months. Between July – December 2013, Plunket report breastfeeding, full and exclusive at six months – Māori 21 percent, non-Māori 35 percent.

In an effort to improve these statistics Northland has introduced two new strategies - Baby Friendly Community Initiative (BFCI) and the HeHa Community Breast Feeding Support Programme.

Northland is the first DHB in the country to look at the BFCI programme. Our team works with community-based health workers and local businesses to promote breastfeeding as the norm e.g. "Breastfeeding is welcome here" stickers displayed in our local cafes. The HeHa programme works with women and their partners in the community recruiting breastfeeding champions.

The BFCI programme is currently in the Far North and Whangarei. The women and men who have come forward to be Champions are supported with education and resources by our coordinator and our lactation consultant team. The target group is young Māori and our team has been working with local marae and Kuia.

Oral health

Oral health in Northland, within the public health system, is provided from seven fixed site facilities Dargaville, Onerahi, Kaitaia Hospital, Kamo and Kerikeri (operated by Northland DHB), 93 mobile sites throughout Northland serviced by 12 mobiles operated by Northland DHB, three operated by Ngati 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 via the Ministry of Health four years ago as part of its Oral Health Strategy. The DHB was provided with capital funding of $4.881 million dollars which has enabled the construction of fixed facilities known as community hubs along with new mobile facilities. The Northland DHB Board 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) 34,571;
- Pre-schoolers enrolled (Māori 4,418, Other 3,418);
- School children enrolled 21,565;
- Adolescents enrolled 5,170.

In the 2013/14 financial year there were 55,905 dental visits or appointments by children and adolescents in Northland. This is up 20 percent on the 2012/13 figures. (12/13: 47,408).

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 2014.

In 2013, 9.8 percent of children and adolescents 'Did Not Attend' (DNA) an appointment. We did not meet the target of 6.5 percent set for 2013. This was due to increased DNAs over the Easter and Anzac weekend breaks. Currently 88 percent of the children and adolescents enrolled with Northland DHB, Ngati 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 has increased by 50 percent in 2013/14.

Public & Population Health

Northland DHB's Public and Population Health Service (PHU) delivers comprehensive public health services to the Northland population.

The service delivery includes working across several stakeholders, including Northland DHB (Planning, Māori Health and other relevant departments), Territorial Local Authorities (TLAs), New Zealand Police, Whānau Ora Collectives, Primary Health Organisations (PHOs), Māori Health providers, Non-Government Organisations (NGOs), to name a few. Cross-cutting areas of work included tobacco/alcohol, nutrition and physical activity, youth mental and sexual health, as well as relevant inter-sectoral work (e.g. housing).

Some of the key highlights of the Public Health services for the period covering July 2013–June 2014 are:

- Contribution to Northland DHB's Health Services Plan goals with focus on improving Māori health and reducing inequities in population health/preventable ill health and mortality;
- Key new approach (by Northland Public Health Unit) enhancing collaboration with Whānau Ora Collectives on areas of joint priority (rheumatic fever, oral health and immunisation) and involved in the social sector trials in Northland, and;
- Integrated planning with other services within Northland DHB (i.e., Planning, Māori Health, Child, Youth, Maternal, and Oral Health teams).

Northland Public and Population Health Services delivered its services through Medical Officers of Health, Public Health Strategists, Healthy Environments team (Health Protection Officers and Technical Officers), and the Healthy Lifestyles team (Health Promotion Advisors).

Service grouping	Highlights
Social Environments	• Strong representation by the Public Health Unit (PHU) at the Public Health Clinical Leadership group. • Several submissions in relation to Annual Plans made to Northland Regional Council, Whangarei District Council, Far North District Council and Kaipara District Council highlighting key public health issues. • Prepared the 'Position Statement on Alcohol Harm' and 'Community Water Fluoridation', this has been adopted by Northland DHB. Advocated "Fizzy-free" DHB policy which has now been adopted. • Involved in the Health Promoting Schools (HPS) National Advisory Group - implementation of Framework and rollout of workforce development plan.

Service grouping	Highlights
Medical Officer of Health	• Medical Officer of Health has been the chair of Grand Rounds at the hospital and has presented on reducing inequities, diabetes etc. • Northland Population Health Survey – PHU had sub-contracted National Research Bureau (NRB) to undertake a population health survey covering some of the key public health issues in Northland. The steering group comprises of representatives from Whānau Ora Collectives, Northland DHB Planning & Māori Health and PHOs. The survey will be completed by end of October 2014.
Communicable Diseases	• Five hundred and forty five communicable diseases notifications. • Ninety-five of these were for pertussis. • Majority were enteric diseases (371) as in previous years. • There were no cases of measles (18 suspected and not confirmed). • Three meningococcal cases (three confirmed cases in the period 2013/14 - two Group B, one not typable, 2<5 years, one aged six years). • Three confirmed cases each of legionella and leptospirosis. • Sixteen reported gastroenteritis outbreaks; all but two in residential aged care (one in Ward 14, Whangarei Hospital, one a family event). • Northland regional RF Plan signed off by Minister in November 2013. • All new ARF cases followed up - 16 new ARF and one recurrence in 2013/14 year (provisional data, not yet matched with NMDS hospital data for January-June2014). • Re-aligned pathway for Healthy Homes Tai Tokerau since July 2013 (all clients must meet health criteria).
Physical Environments	• Two Resource Management Act (RMA) applications were submitted. • All vessels (100 percent) arriving in Northland were granted free pratique (when requested) as per Health Act 1956 - 23 International Shipping Sanitation Inspection certificates were issued. • Routine inspections were undertaken against MoH criteria of relevant Northland ports (Refining NZ, Northport, Marsden Cove, Opua – Bay of Islands) and airports. • Three disinterment licenses were processed. • Five new Early Childhood Centers were inspected against regulatory standards and reported to the Ministry of Education. • Hazardous substances Issue - 17 complaints relating to non-compliance of Vertebrate Toxic Agents (VTAs) were investigated. Nine VTA permissions were issued. There has been an increasing interest in the use of 1080 on private land, which is likely to increase the workload in future. Misuse and illegal use of VTAs (especially cyanide) was found.
Health Protection	• One spray-drift complaint received and followed up with NRC. • One lead-based paint environmental contamination in Kaipara school - no outbreak but extensive work done with school to manage high lead potential exposure from re-painting of old school buildings. Public health advice was given to school, students and parents by the Medical Officer of Health. • Twenty asbestos samples tested. There has been an increase in demand for asbestos sampling. Five solaria premises were surveyed during this reporting period. • Northland DHB Civil Defense and Emergency Management (CDEM) planner has developed a Board-wide plan that we contributed to and includes the PHU plan. • Evaluated 100 percent of sewage spills and issued public health advisories as and when appropriate. • Three hundred and eighty four routine shellfish samples taken for biotoxin surveillance. • Waste management, including sewage treatment and disposal – database has been created including all refuse sites (from all TLAs) in Northland, 32 entered in the database, 12 were physically inspected during this reporting period. • Drinking water - some concerns relating to rural and semi-rural supplies have emerged over the last six months (Mangonui, Kaeo and Te Kao). These are being addressed, and progress made, with the relevant supply providers. Eighty-six water supplies at kohanga reos, play centres, schools, and marae were checked and advised of NZ Drinking Water Standards and Legislation. • An electronic data and application processing system is being adopted (Healthscape, CDHB) to reduce paperwork and speed up turn-around time.

Service grouping	Highlights
Social Environments	
Injury Prevention	• The review of Injury Prevention completed and, as a result, it has been re-oriented towards increasing the FTE in alcohol-related injury prevention. • Sport Northland is partly funded by the PHU for their water safety programme that aims to address the low level /lack of fundamental swimming skills, water safety awareness and associated survival skills of primary school-aged children, especially in Decile1 to4 schools in Northland.
Nutrition and Physical Activity	• Whānau Ora Collectives and Rununga were supported in their proposal to the Ministry for the Healthy Families NZ ROI and RFP. • Project Energize, Sport Northland-led 'Northland Swim for Life', promotion of 'Water is the Best Drink' and breastfeeding has taken place during this reporting period.
Alcohol and Other Drugs	• Position statement on Alcohol Harm adopted by Northland DHB. • Submitted submission to the Ministerial forum on Alcohol Advertising & Sponsorship to reduce alcohol-related harm. • Alcohol-related health data provided to Whangarei District Council and Far North District Council to inform their Local Alcohol Policy (LAP). FNDC have listed the Northland DHB documents on their website, along with their draft LAP seeking submissions - http://www.fndc.govt.nz/communication/consultation/reducing-community-harm. Advocating with Kaipara District Council on considering LAP. • Public health regulatory activity related to psychoactive substances in accordance with the Psychoactive Substances Act 2013 was carried out. Submissions were made to FNDC and KDC to support the development of LAPP - http://www.fndc.govt.nz/communication/consultation/reducing-community-harm. • Continued work with ED (Whangarei and Kaitaia hospitals) on the alcohol helpline project. There has been national interest in the Northland's Alcohol Drug Helpline interagency project. • The Kaikohe Social Sector Trial planning has begun – PHU is one of the stakeholders.
	• Northland DHB PHU funded a pilot recidivist drink driver programme Stop Alcohol Impaired Driving (SAID) in collaboration with Police, WDC, ACC, RoadSafe Northland, Safer Whangarei Network and Probation Services for Whangarei. • Third edition of the Whānau Pack resource was produced/printed (25,000 copies), e-copies, hard copies distributed locally and nationally. • Promoted FASD among pregnant women.
Sexual Health	• Sexual health needs assessment for Northland has been subcontracted to Innovate Change Ltd and is expected to be completed by October 2014.
Health Promoting Schools	• Supported the identification of student behavioural needs (with a particular focus on mental health – suicide prevention) and implemented "Matanui" programme in Far North, Whangarei and Kaipara (in collaboration with the Northland DHB suicide prevention coordinator and consultation with MoH). Has been a huge success.
Oral Health Promotion	• Position Statement on Community Water Fluoridation adopted by Northland DHB. • Increasing dental enrolments for zero-five-year-olds has been included as a performance indicator by Te Pu O te Wheke Whānau Ora Collective– a collaborative project • Submitted submission to FNDC to support installation of eight water fountains within the Te Pu O Te Wheke Whānau Ora Ngapuhi Collective (TPOTW) – partly funded by the Public Health Unit • Nearing completion of dental book resource for ECE's and Kohanga Reo.
Smokefree/ Tobacco Control	• Submission made to the Health Select Committee on tobacco plain packaging amendment bill. • Completion of Tai Tokerau Hapunga Auahi Kore Alliance Project - three locality Alliances established in Far North, Mid North, and Whangarei. Coordination now being managed through Tobacco Control Advisor - Pregnancy role. • WERO - Northland team won WERO North region of first national roll-out of the competition. • Successful submission for Smokefree Bus Stops in Whangarei city. • Twenty-one Far North and 18 Kaipara premises were visited in February/March to measure compliance under new Smokefree Environments (Controls and Enforcement) Amendment Bill (SFEA). • For the period July to December 2013, a total of 149 patients were referred for smoking cessation support by Northland DHB Hospital services. Of that 93 (62 percent) were Māori patients.

Clinical Services

Medical Oncology

The medical oncology service underwent considerable development in 2013/14 with the appointment of two New Zealand trained consultants, Dr Lisa Dawson and Dr Vince Newton, and the commencement of the Jim Carney Cancer Centre building, expected to be operational by November 2014.

Nurse specialist/cancer coordinator posts for urological and upper gastrointestinal cancer were also established. A bid to obtain funding from the Ministry of Health for a Māori patient navigator post was successful. The service continued to ensure all patients undergoing chemotherapy as their principal treatment commenced therapy within four weeks in accordance with the national health target.

Cardiology

A cardiologist of the week system was introduced to ensure that referrers are able to obtain a prompt specialist cardiologist opinion and any necessary investigations to inform the care of patients with heart conditions. The system proved successful and popular with referrers with reduced waiting times and more treatment able to be provided locally. Further development of the service is planned to ensure that patients with heart conditions can continue to access specialist cardiology care in Northland.

Orthopaedics

A successful programme of reform was completed in orthopaedics. This included the development of a specialist physiotherapist role to improve the assessment and pre-operative preparation of patients undergoing joint replacement surgery. Two New Zealand-trained consultants were appointed, Dr Jonathan Manson and Dr Lyndon Bradley, with respective specialist interests in spinal surgery and paediatric orthopaedics. The acute orthopaedic surgery service was also rationalised with increased consultant involvement and dedicated acute operating sessions. Enhanced services were provided at the regional hospitals, including the resumption of clinics at Dargaville Hospital and the commencement of orthopaedic operating sessions at Kaitaia Hospital. Telehealth clinics were also established to further improve local access to consultations for patients.

Elective Waiting Times

The achievement of a maximum five-month waiting time for first specialist assessments and elective surgery was a notable success. A number of specialties, including gynaecology, ENT, ophthalmology, and urology were able to make substantial progress toward a four-month maximum waiting time for elective surgery expected as of December 2014. Northland DHB exceeded the national target for elective surgery discharges by around 15 percent for the year and was the top performing DHB in the fourth quarter performing 25 percent more operations than the target level.

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 – both staff, expertise and facilities - is essential to ensure people have access to a comprehensive range of community and primary care services.

All of the sites – Dargaville, Bay of Islands and Kaitaia have infrastructure and services operating. Priorities in relation to work and project management input vary across the three sites.

Feedback from our Patients

All discharged patients are called by nurses from the three district hospitals. The purpose of these calls is to help make the transition from hospital to home a positive and safe experience, to check patients are receiving all the health services they need and to reduce avoidable acute readmissions within 28 days.

Preliminary results indicate advice is routinely given to patients in order for them to better manage their health needs at home. Although health needs on discharge are usually fully addressed by the ward, patients sometimes find the reality of coping at home quite different to what they expected and are thankful for the call offering advice and on what direction to take next. More work is being carried out on standardising processes across the three district hospitals in order to be better able to gather and evaluate data to determine quality improvement.

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. In order to make sure 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.

Known as the Shared Care Record, it is intended to safely share relevant health information from the patient's GP with other health professionals involved in their care.

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.

Lucky's Libraries

Dargaville's unwell children now have another option for keeping boredom at bay, thanks to the donation of 120 new books to Dargaville Hospital.

During March 2014 Scholastic delivered 10 new Lucky's Libraries to children's wards in hospitals throughout New Zealand - with five being in Northland.

Scholastic donated these libraries as part of their mission to encourage young New Zealanders to "Read every day, lead a better life" while spreading the joy of reading in New Zealand's hospitals.

Each custom-built library on wheels is packed with a selection of Scholastic's most popular titles suitable for all ages and interests. This includes classic New Zealand picture books such as Grandpa's Shed and Grandma McGarvey; beloved characters Clifford the Big Red Dog, Scooby Doo and Spiderman; as well as the most popular fiction series (Goosebumps and Babysitters Club) and non-fiction titles.

Kaitaia Hospital

Telehealth

In August the Northland DHB Executive and University of Queensland approved commencement of implementation and collaborative research evaluation for an acute care Telehealth system linking Kaitaia ED and General Ward with Whangarei ICU. Implementation is scheduled for late October with a two-year evaluation period starting once use and processes are bedded in six months later.

It is recognised that the research evaluation is a significant opportunity to better understand how effective Telehealth use is in acute care and will provide key direction in future product selection and the wider goals of the project. Participation in a formal, published evaluation is a key focus point for the clinical teams and engagement with the project.

Clinical terms of engagement are currently being identified by the Kaitaia and ICU clinical teams in preparation for use. The aim of this exercise is to achieve alignment and clarity in intent of use, when and in what situations it will be used as well as patient care and responsibility.

With a second GP practice located to the hospital in November 2012, the emphasis has been working with this practice to integrate services. The focus has been on better utilisation of the theatre facility. This has increased over the year with the introduction of orthopaedic surgery and the use of a local general surgeon.

Farewell

We farewelled Sue Wyeth (left) during the year after 14 years' service with Northland DHB. Sue began as Medical and Disability Support Services group manager, with her energy and experience soon seeing her appointed general manager of the Mental Health executive leadership team the following year. Sue's extensive experience and passion saw her play a leading role in the re-development of Kaitaia Hospital, and the new Mental Health Inpatient Unit. She also continued to develop and expand community mental health services throughout Northland. Sue has taken up a position in Tasmania.

Active workplace

Medical staff in the Far North have had an extra spring to their step since becoming the first within the Northland DHB to take part in Active Workplace.

Kaitaia Hospital and the Far North Mental Health and Addiction Services officially launched their Active Workplace in February 2014.

The programme is guided and supported by Sport Northland, with a mission and goal of "active workplace, healthy staff and healthy patients".

Active Workplace involves staff members undertaking on-site gym sessions, various aerobic, fitness and relaxation classes and team participation in local multi-sport events, to name a few.

The heads of departments plan a monthly calendar of events which is distributed to staff.

Events include on-site gym classes such as Zumba, boxing, circuit and step aerobics, as well as relaxation and stress-release classes. The calendar also includes team participation in half marathons and bike riding events.

In addition to exercise, healthy eating is promoted and a garden has been established to provide healthy produce for sub-acute mental health clients, their families and staff.

Success stories from those participating include a 25kg weight loss and a formerly overweight staff member becoming the programmes Zumba instructor.

Bay of Islands Hospital

Wednesday education sessions set up and run by individual hospital doctors for half an hour each week have been really successful.

Known as the 'soup sessions', doctors provide home-cooked soup to accompany education on a range of topics such as asthma, x-ray processes, bronchiolitis and ECGs. Their aim is to increase medical education to Bay of Islands staff and improve communication between services.

Staff who have attended, have included hospital nurses, district nurses, public health nurses and allied health staff. Aside from providing an opportunity to learn more on important health topics, the sessions are also improving communication between different hospital services.

Whangarei Hospital Redevelopment

Maternity

The construction is well underway and is scheduled for completion in March 2015. Earthworks and piling are completed and structural concrete nears completion.

Site Wide Infrastructure

The Site Wide Infrastructure Project is underway. Pipework has been installed in the service tunnel. Work has commenced in the energy centre. The project is scheduled for completion in April 2015.

Jim Carney Cancer Treatment Centre

The Jim Carney Cancer Treatment Centre project is progressing well and practical completion is scheduled for September 2014. This will be followed by operational commissioning, including installation of furniture, fittings and equipment. The official opening has been scheduled for November 7 2014.

Office Building

The project is well underway and is making significant progress. Early issues with ground conditions have been addressed by piling foundations and the installation of a retaining wall.

The fit-out design is complete. The base build construction is scheduled for completion in November 2014.

Other Projects completed in 2013/14 include:

- Service Tunnel Remediation;
- Fibre Optic Network Extension;
- Staff Gymnasium;
- Orthotics & Podiatry Fit-out (Wards 6 & 7);
- Wheelchairs & Equipment Services;
- 2nd Floor Access Ramp;
- Two Storey Link (Northlink).

Nursing and Midwifery Directorate

Care Capacity Demand Management

In 2010, Northland DHB introduced a system known as Care Capacity Demand Management (CCDM) in partnership with unions, notably the NZNO and the PSA. 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. A CCDM Council oversees this programme with Local Data Councils being developed to govern local ward/unit data.

Ngā Manukura o Āpōpō

Ngā Manukura o Āpōpō is a national Māori Nursing and Midwifery Workforce Development Programme. Established in 2008 and funded by the Ministry of Health, the programme recognises the urgent need to grow the number of Māori clinical leaders in the health and disability workforce. In October 2012, the programme moved from Auckland DHB to Northland DHB under the sponsorship of the Director of Nursing and Midwifery.

Ngā Manukura o Āpōpō aims to:

- increase access to leadership training to support emerging and current clinical leaders within nursing and midwifery;
- increase the size and skill base of the Māori nursing and midwifery workforce, and;
- expand our knowledge about the effectiveness of specific Māori health workforce development initiatives.

There are three key work streams of the Ngā Manukura o Āpōpō programme:

Clinical Leadership: Tomorrow's Clinical Leaders Programme provides registered nurses and midwives with practical tools, theoretical background and opportunities to gain leadership skills. These include strategic decision-making, organisational development and business management that is required for them to undertake clinical leadership roles within their own workplaces. 161 nurses and midwives have completed this programme, over half from the Te Tai Tokerau district.

Professional Development: Ngā Manukura o Āpōpō aims to enhance existing undergraduate and post-entry programmes to improve access to professional development opportunities. There are various projects within this work stream, including the ePortfolio project, tertiary scorecard and the Poutama programme.

The Poutama programme was developed from an identified need to increase access to workplace assessor training for Māori registered nurses with three years' experience and a current nursing portfolio at competent level or above. The Poutama Project is a 12-month workplace learning programme that covers excellence in preceptorship, workplace assessor training NZQA 4098, application to become a NCNZ competence assessor, career planning and an introduction to mentorship. The aim of the programme is to use existing and nationally recognised registered nursing programmes in a structured framework and deliver them in a specific order with facilitator support, to achieve optimal learning and workplace application. The two pilot sites, Lakes DHB (in collaboration with Waiariki Institute of Technology) and Northland DHB have graduated over 50 nurses from this programme.

The tertiary scorecard was developed to assess the recruitment and retention of Māori students within New Zealand's national schools of nursing and midwifery. The second scorecard is due for release shortly.

The ePortfolio project (Gold winner at the Learn X Asia Pacific awards) is progressing well, negotiations are underway to secure a platform to host the ePortfolio and roll-out across the sector. This uses an open source ePortfolio system, enabling nurses to provide evidence of competence, no matter where they work or live. It is being recognised as a professionally robust tool, transportable and acceptable as a competent portfolio by any organisation.

Recruitment and Profile Raising: this work stream is focused on developing strategies to support the marketing and promotion of nursing and midwifery professions as a career to Māori communities. This will raise the profile of nursing and midwifery careers for rangatahi and mature adults looking at health as a career. This work stream aligns itself with the Kia Ora Hauora programme to raise the profile of the nursing and midwifery professions to anyone considering a career in health.

The future of Nga Manukura o Apopo. a business case is currently with the Ministry of Health awaiting feedback to secure funding for a further three years of the programme. Building on these achievements, the business case details the plan for ongoing programme delivery between 2015-2017.

Within an overarching theme of leadership, the priorities that will guide the work programme include:

1. **Poutama programme:** To support preceptorship; mentorship and competence assessment in clinical practice.
2. **Clinical leadership:** To increase the critical mass of Māori nursing and midwifery clinical leaders prepared to make system change.
3. **Establishment of the Tuakana network:** to maximise the potential of past and present graduates and create opportunities for 'leadership in action.

Diabetes Nurse Prescribers

A joint Registration of Interest (ROI) was submitted to Health Workforce NZ by Northland DHB and Manaia PHO, supported within the Workforce development enabler of the Northland

Health Services Plan. The ROI was successful and the clinical nurse specialists undertook the "prescribing practicum and practicum for registered nurses practising in diabetes health". Each clinical nurse specialist attained registration through the Nursing Council.

We now have three clinical nurse specialists employed by Northland DHB with prescribing authority. Job descriptions have been re-written and their jobs have been re-scoped.

Nurse prescribing has been shown to:

- Improve patient care without compromising patient safety;
- Make it easier for patients to obtain the medicines they need;
- Increase patient choice in accessing medicines;
- Make better use of the skills of health professionals;
- Improve access for those groups who currently find it difficult to access services e.g. lower socioeconomic, children, youth, Māori and Pacific peoples.

MENTAL HEALTH AND ADDICTION SERVICES (MHAS)

Acute Inpatient Services (Tumanako)

The Tumanako acute psychiatric unit (IPU) provides a hospital inpatient service to people in Northland experiencing serious mental illness. The IPU occupancy was at 100 percent (and over) for most of 2013/14 year. This has increased the clinical risk to the service, although at this point no serious incidents have been a direct result of capacity constraints.

A growing challenge is a lack of appropriate services (including minimum secure residential services) for clients with high and complex needs to be discharged to in the community which contributes to the high IPU occupancy that is happening.

It is likely the prevalence of mental illness and addiction will continue to rise above national trends, due to the socio-economic deprivation in Northland and the higher percentage of Māori population. At the moment Māori males aged 20-29 years account for 10 percent of IPU utilisation but are only 1.56 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.

Various processes are used to manage the flow of clients between the IPU, sub-acute and NGO residential services. Clinical risk in the community services are effectively managed through a multipronged approach, including centralised management of "bed" services and creating extra respite services.

Service utilisation has significantly increased over the last five years, in both number of clients referred and number of service contacts, representing four percent year-on-year growth over the last three years. Mental Health and Addiction (DHB-provided services) saw 7,415 clients last year with a total of 79,175 client contacts events recorded. This clinical activity has increased 31 percent over the last three years. Despite the growth in caseloads, on average each client is being seen more frequently and as a result of increased staff productivity. Māori aged 0-10 years are under-represented in MHA services, while they are significantly over-represented by the age of 20 years. Across the service, an average of 42 percent of clients were Māori (compared with census 2013 approximately 32 percent). MHAS are exceeding national access targets for child and youth, and for adults.

New service developments, like enhanced perinatal infant mental health services and the exemplar co-existing problems Youth programme (partnership between Rubicon Charitable Trust (NGO) and Te Roopu Kimiora (DHB) in Whangarei – Kaipara and Far North areas) have expanded the range of specialist support available to Northland.

The sector-wide Align Model of Care Project involving primary care, community NGOs and specialist mental health and addiction services has been implemented with the aim of generating service system improvement ideas. The Te Tai Tokerau MHA Stakeholder Network Forum (DHB, NGO, PHO and consumer representatives) promoted collaborative work for the benefit of the people of Northland and leads the development of an integrated range of recovery-focused, community-based mental health and addiction services.

NGO and PHO Provided Services

NGOs provide a large range of services with support, packages of care, residential services, day programmes, peer support, family-whānau support, Kaupapa Māori services and Alcohol and Drug treatment programmes.

NGOs are providing increased help for smokers to quit by offering advice and help to quit smoking.

Every month in Northland NGOs and PHOs provide:

- Four hundred and ninety two adults (70 percent Māori) with support to live independently in the community;
- Fifty eight children and youth (77 percent Māori) with support to live safely and well within their whānau;
- Fifty nine adults (60 percent Māori) with housing and recovery services;
- Two hundred and fifty one adults (77 percent Māori) with AOD treatment services;
- Two hundred and sixty five children and youth receive AOD programmes in Whangarei-Kaipara;
- Three hundred and seventy five people (69 percent) with primary mental health and AOD services;
- Two hundred and ten people attend a package of counselling.

Alcohol Drug Helpline Referral

The Northland Alcohol Drug Helpline Project continues to support Northlanders. The Helpline service is especially conducive for Northland environments, providing free alcohol and drug counselling and support via landline, cell phone and social media platforms.

The Northland project has expanded into other areas of New Zealand, enabling over 1,300 referrals to the Alcohol Drug Helpline. Of those, over 1,100 have come from Northland.

Between July 2013 and June 14 2014, 58 percent of clients were able to be contacted. Of those:

- Thirty seven percent required no further action;
- Twenty nine percent received interventions;
- Twenty three percent received interventions, and registered for ongoing support with the Helpline;
- Five percent received resources, and;
- Five percent were referred for local Mental Health and Addiction support.

Examples of client feedback ranged from "Good to talk to someone", "Stopped drinking", "Doing well and I have changed a lot", - through to clients who reported having no issues with alcohol.

The Alcohol Drug Helpline referral project became a Health Services Plan project and was expanded into the Bay of Island and Dargaville Hospitals. The Whangarei Emergency Department is investigating an 'opt out' referral process to further support patients presenting with alcohol issues.

The Te Tai Tokerau MHA Stakeholder Network Forum (DHB, NGO, PHO and consumer representatives) promoted collaborative work for the benefit of the people of Northland and it leads the development of an integrated range of recovery-focused, community-based mental health and addiction services.

Programmes Addressing Drivers of Crime

Northland DHB has continued to offer the Drive SOBA Programme™ [1] for recidivist drink-drivers during 2013/14 with 187 people completing the programme in the region as follows:

(a)	Whangarei (6)	Four programmes funded by RoadSafe Northland Two programmes funded by Northland DHB
(b)	Kaipara	Three programmes funded by RoadSafe Northland
(c)	Kaikohe	Two programmes funded by MoH and Road Safety Trust
(d)	Kerikeri	One programme funded by Road Safety Trust
(e)	Kawakawa	One programme funded by MoH
(f)	Kaitaia	Six programmes funded by MoH and Road Safety Trust.

Acknowledgements

RoadSafe Northland
Safer people Safer roads Saving lives

Northland DHB acknowledges the support of RoadSafe Northland and the Whangarei and Kaipara District Councils through their Road User Safety Programme Funding, which has enabled seven Drive SOBA programmes to be provided in Kaipara and Whangarei in the year ending 2013. Funding is also available for the year ended 2015.

Evaluation of the programme from Police National Computer Data is not available until December 2014.

Whangarei Bridge AOD Day treatment programme outcome study reported five percent of participants who completed the programme (n= 240) were re-referred for AOD legal charges within 12 months (SANZT, 2014).

Resilience Project and Suicide Prevention

The Matanui programme was delivered in 17 Northland schools, four Tertiary Institutes, Ngawha Prison (Youth Unit) and six community venues with an estimated reach of 3,497 Northland Youth (16-24 years). Survey outcomes from programme report greater than 85 percent of participants recognising when to get help for self or others, how to do that and more confidence in identifying who to trust for support.

Over 100 Northlanders accessed the QPR (Gatekeeper and Advanced) Suicide Prevention training provided within key communities in the Rohe. Fourteen people were trained as trainers in the Skylight WAVES programme and can now provide the WAVES eight-week programme of Grief Education for Adults bereaved by suicide. Ngati Hine Health Trust have successfully gained funding for the "Kia Tupu Ake Ai Whānau" Programm. to work closely with Te Roopu Kimiora targeting the youth population with further building resilience-focused work (2014 to 2015).

FUSION (an interagency group with a current focus on prevention of youth suicide) have continued to meet monthly to share information, analyse data, develop actions and review responses. During 2013/14, 23 deaths were suspected to be self-inflicted in Northland, with five under 25 years (compared with 2012/13 year - 12 under 25 years). Staff won awards in recognition of excellence and quality achievement for the Suicide Prevention Plan and implementation. This award reflects the hard work and energy that has been applied to building resilience in Northland on multiple levels.

Māori Health

Te Poutokomanawa Māori Health Service

Patient and Whānau Centred Care is the primary focus for Te Poutokomanawa Māori Health Service ensuring that Māori patients and whānau are supported in their understanding of their diagnosis, the options for care and treatment and who will help them with their treatment plan decisions whilst in hospital and in preparation for discharge home.

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

Patient experience

Te Poutokomanawa service model is a blend of cultural and clinical support that focuses on equitable access, treatment and care and outcomes for Māori patients and whānau; the contribution to some health targets, and advocacy for Māori patient discharge planning in multidisciplinary team decisions.

A Leadership Team, together with the General Manager Māori Health and Mental Health & Addiction Services has focused on strengthening clinical advocacy within the service with clinical leadership being provided by the Tapuhi Clinical Nurse Specialist. This patient navigator role works alongside Takawaenga to support their daily work plan and service key performance indicator expectations. Guidance has been provided in areas of health literacy, accurate collection of data, monitoring daily patient admissions, managing staff placements in the wards and prioritising Takawaenga patient engagement.

Our key focus areas are:

Clinical Support

- ED wait times – Takawaenga support Māori with understanding 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 promote timely immunisation for the protection of tamariki, both in maternity and

[1] Drive SOBA programme is a 12 week programme to reduce recidivist drink driving and provide strategies for reducing alcohol consumption.

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 ABC with Māori patients if not completed by clinic staff. Takawaenga also talk with Māori patients who identify as smokers, about a nicotine substitute while in hospital and about quitting, making referrals if required;
- Sudden Unexpected Death of an Infant (SUDI) reduction – promoting safe sleep education and 'pepi pods' 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 patients meet the criteria or are unsure, Takawaenga make a referral to the Healthy Homes Coordinator to complete an assessment of eligibility;
- Body tissue return – support the process of identification, storage and return in a timely manner or appropriate disposal where necessary;
- Ensuring the concerns and feedback from Māori patients and whānau are heard and addressed in an appropriate, acceptable and timely response;
- Tangihanga/death process – ensuring the process is being conducted appropriately and in a timely manner in response to taha Māori culture and expectations. Supporting whānau on the 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.

Te Poutokomanawa provides tailored cultural education to departments across the organisation to raise their awareness and enhance their knowledge to support safe cultural practice. We work with departments to strengthen their models of care to ensure that services are meeting the need and expectations of Māori whānau in the appropriate way.

The Kaunihera Kaumātua representing the four Northland DHB hospital communities and Cultural Advisor are responsible for ensuring Northland DHB's workforce - the Board, Chief Executive, Executive Leadership, Managers and frontline staff are performing in a culturally safe manner.

Cultural Support

Provision of whanaungatanga (meeting/greeting and engaging) for new patient admissions into hospital followed up by manaakitanga (compassionate care and support) during the length of patient stay. Ensuring the principles of tikanga important to Māori patients and whānau are documented and communicated, recognised and acknowledged.

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.

Te Poutokomanawa offer te reo me ona tikanga Māori education programmes to support staff to engage safely and appropriately with patients 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.

Health of Older People & Clinical Support

Support for Older People

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

During 2013/14 the Health of Older People Model of Care was completed with input from sixty sector-wide representatives and seven consumers including Kaumātua and Kuia.

The Model of Care for Health of Older People Service Delivery proposes a stronger focus on rehabilitation with service initiatives that are consistent with addressing hospital admissions and re-admissions.

Home and community-based services will be locality-based, aligned with primary care but integrated with specialist service teams across Northland. Care will be flexible, to meet peoples' needs and focused on improving their ability to manage their own lives. Older people and their whānau will be partners in this process.

The ageing population continues to drive Northland DHB's emphasis on services for older people. Planning this year focused particularly on the provision of quality home and community support services, comprehensive clinical assessment in rest homes, hospitals and home-based support services, and improving access to respite care services.

The main aim is to support older people to maintain their functional independence and live safely in the community for as long as is clinically appropriate.

Planners, clinicians and older people have more confidence in services when consistent assessment and quality assurance tools and processes are used.

Home and Community Support Services

In the 2013/14 year Northland DHB funded 585,173 hours of home-based support services. This is an increase of 4.8 percent from the previous year.

In the 2013/14 year 46 percent of older people receiving long-term home-based support services had an InterRAI assessment. This was an increase of 17 percent from the previous year.

During 2013/14 there was further development of the SCOPE – Primary Health Programme for older people, implementing a revised service specification and strengthening the focus on primary health care. The service is delivered by a Primary Care Support Coordinator.

The service fits with the Northland Health Services Plan population health outcomes area – as it supports an increase of the number of older people who are health literate and live healthy lifestyles, and increases the availability of and

access to services in primary and community settings (as a restorative service).

Key result areas and monitoring requirements were set.

Dementia Pathway

Northland DHB adopted the northern regional dementia pathway decision support tool for primary care (dynamic pathway) with one urban and one rural general practice in Northland testing this electronic pathway.

The focus was on developing the assessment and diagnosis components and supporting GPs.

The development of a Northland-wide patient and whānau navigation and support pathway commenced, recognising the importance of early support and ongoing access to the services they need.

Quality Improvement in Age Related Residential Care

Northland DHB's Health of Older People Specialist Clinical Team and dedicated 1.7 FTE Gerontology Nurse Specialist hours have supported primary and community care and aged residential care quality improvement. across Northland's four sub-regions.

The total number of funded age-related residential care bed days was: 319,483 bed days, an increase of 1.7 percent from previous year.

All of Northland DHB's contracted Age Related Residential Care Services Registered Nurses are actively engaged in training or fully competent in the use of the InterRAI-long-term care facility (LTCF) resident assessment tool.

At the end of 2013/14 year, 79 percent of Northland DHB's Age Related Residential Care facilities achieved a three or maximum four-year certification period signalling an improvement in their quality systems and processes, up from 50 percent in the previous year.

Breast Cancer Screening

Northland DHB has consistently increased its breast screening rates and consistently exceeds the national target annually for Māori (73 percent) and non-Māori women (74.6 percent).

This is a notable achievement, considering 50 percent of Māori in Northland DHB are in the NZ Depravation categories of nine and ten.

A key to the success of the BreastScreen programme at Northland DHB has been a whole of community approach and a collaborative team effort, involving staff across the Northland and Waitemata region, PHOs, GPs and Māori health providers.

Patient Administration System Upgrade

Northland DHB is in the final stages of negotiating the replacement of the Patient Administration System (PAS). Northland DHB began the process of procuring a new PAS in August 2011, due to the age of the current system which is no longer being actively developed. The software supplier is withdrawing ongoing support but will continue until the new system is in place. The age and technology of the current system is also a barrier to upgrading other key clinical systems such as theatre management and flexible patient booking systems.

Some business changes will be required with the new system. Work has been undertaken with the business owners of the various processes to engage their teams in this important activity following an implementation planning study with the supplier involving many of our staff.

The Patient Administration System (PAS) is at the centre of hospital IT systems. Its uses can be many and include: registering and admitting patients, scheduling inpatient and outpatient events, managing theatre bookings and transferring and discharging patients. A constellation of other hospital applications connect to the PAS to exchange information about individual patients and their past, current and planned health care events.

Laboratory Information System Upgrade

The laboratory information system, which links our clinical staff to our four Northland DHB laboratories and those under Auckland DHB was also ageing and at the end of its useful life. Northland DHB procured a new system that is linked to the Auckland laboratory service. This system allows Northland to share the underlying data storage and operating systems with Auckland, thereby reducing some costs and providing some security in the event of a system failure. Results are placed in a central repository where they can be accessed by clinicians across the sector. This system was switched on in June 2014 and is now fully operational.

Our Community

Northland Community Foundation

During 2013/14 the Northland Community Foundation (NCF) focused on completing the huge task of working with the community to raise $3 million through the "Project Promise" appeal to build the Jim Carney Cancer Treatment Centre for Northland. This was the main health target of the Foundation for the year and the outcome of several years of effort.

The goal was achieved through the wonderful support of individuals, families, service groups, businesses and organisations. Construction of the cancer centre began in February 2014 with the official opening on November 7, 2014 and a public open day planned for Saturday November 8. Clinical services will commence in the new facility the following week.

One of the roles of the NCF is to work together with the Northland DHB, 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 NCF 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 2013, the "Dry July" programme benefited Northland DHB in support of the cancer centre through the provision of funds for a number of the specialised La-Z-Boy-type treatment chairs for the unit. Funds from Dry July passed through the NCF to the DHB for this purpose.

One of the special programmes that NCF coordinates annually is in association with Countdown Kids – a national appeal that has raised a huge amount of money for Child Health since 2008. In 2013/2014 the amount raised for Northland was $87,159 – well above the 2012/2013 total of $83,300. With the money raised, Child Health has bought all kinds of extra equipment especially designed to support healthcare for children.

The NCF helped Northland DHB welcome this year's intake of Pukawakawa students (5th year students from Auckland University Medical School), who arrived on clinical placement until October 2014. The annual welcome barbecue put on by the Foundation has become somewhat a tradition to finish off the first day of arrival for each year's student group.

Looking ahead, the NCF will be working closely with Northland DHB to find ways to raise funds through a variety of ways and for many different purposes – all of which will benefit Northlanders when they are involved in healthcare services.

Farewells

Doug Sands

We take this opportunity to acknowledge the passing of long-time Whangarei Hospital resident, Mr Doug Sands who died in July, aged 73

Doug's active life was destroyed in an instant in a car accident when he was 21, coupled with the loss of his younger brother Neale. At the time he was a Northland representative rugby player. He had taken a summer off to focus on improving his game. He loved the outdoors and he loved sport. When the accident happened he and his brother had been on their way to see Peter Snell and other greats of the New Zealand running scene compete in Auckland.

Doug is sadly missed by everyone, especially his sister Robyn, staff and friends from Ward 1. "We will miss your humour and you will be in our hearts forever," offered Ward 1 staff.

Esther–Jordan Muriwai

Tributes also flowed for a popular Whangarei Hospital resident: beauty queen, budding politician, campaigner, advocate and inspiration Esther-Jordan Muriwai.

Esther-Jordan died in June after spending 14 years, five months and five days of her 24 years at Whangarei Hospital battling the life-long ailment, bronchiectasis - a crippling respiratory condition that was the aftermath of a childhood bout of whooping cough.

During her 24 years Esther-Jordan achieved a lot and touched many lives along the way. She featured on Seven Sharp in March regarding her work towards establishing a Bronchiectasis Foundation and her goal of educating more people about this devastating condition. Earlier in the year she received a Bravery Award at the Asthma Foundation Achievers' Awards ceremony, hosted by the Governor General at Government House.

Born on April 7, 1990, Esther-Jordan spent more than half her life at Whangarei Hospital but her father noted she preferred to talk about the time she had spent out of hospital.

A family friend, Nina Williams, was one of those who encouraged Esther-Jordan to compete in the Miss Aotearoa 2012 pageant, in which she came second.

"No surprise really given her beauty inside and out," she said.

BOARD ATTENDANCE

Member Attendance 1 JULY 2013 - 30 JUNE 2014

	2013						2014					
BOARD	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**
Tony Norman *(Chair)*	✓	✓		✓	✓		✓		✓	✓		x
Pauline Allan-Downs	✓	✓		✓	✓							
John Bain	✓	✓		✓	✓		✓		✓	✓		✓
Craig Brown	✓	✓		✓	✓		✓		✓	✓		✓
Debbie Evans							✓		✓	✓		✓
Greg Gent	✓	✓		✓	✓		✓		✓	✓		✓
Libby Jones	✓	✓		✓	✓							
Colin Kitchen	✓	✓		x	x		✓		✓	✓		✓
Sally Macauley *(Deputy Chair)*	✓	x		✓	✓		✓		✓	x		✓
June McCabe	✓	✓		✓	✓		✓		✓	✓		x
Chris Reid							✓		✓	✓		✓
Bill Sanderson	✓	✓		x	✓		✓		✓	✓		✓
Sharon Shea	✓	✓		✓	✓		✓		x	✓		✓

	2013						2014					
CPHAC	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**
Tony Norman			✓						✓			✓
Sally Macauley *(Chair)*			✓						✓			✓
Craig Brown			✓						✓			
Libby Jones			✓									
Colin Kitchen			✓						x			✓
Sharon Shea			✓						✓			x
Debbie Evans												✓
Peter Jensen			✓						✓			✓
Beryl Wilkinson			✓						✓			✓
John Wigglesworth			✓									
Mark Sears			✓									✓

	2013						2014					
HAC	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**
Bill Sanderson *(Chair)*	✓	✓			✓				x	✓		✓
Pauline Allan-Downs	✓	✓			✓							
John Bain	✓	✓			✓				✓	✓		✓
Greg Gent	✓	✓			✓				✓	✓		✓
Sally Macauley	✓	x			✓				✓	x		✓
Tony Norman	✓	✓			✓				✓	✓		x
Chris Reid									✓	✓		✓
Win Bennett	✓	x			✓				✓	x		✓
Libby Jones									✓	✓		✓
Ariana Roberts												✓

No Meeting held
Not yet appointed
Membership ceased

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:

Current Board Members:

(Term commenced December 9 2013)
Anthony Norman (Chair)
Sally Macauley (Deputy Chair)
Dr Chris Reid
John Bain
Craig Brown
Greg Gent
Debbie Evans
Colin Kitchen
June McCabe
MC (Bill) Sanderson
Sharon Shea

Former Board Members:

(Term Ending December 8 2013)

Libby Jones
Pauline Allan-Downs

Current 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

Former Community & Public Health and Disability Advisory Committee Members

(Term Ending 30 November 2013)

John Wigglesworth
Libby Jones

Current Hospital Advisory Committee:

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

Former Hospital Advisory Committee Members
(Term Ending 30 November 2013)

Maureen Allan
Dr Mike Roberts
Pauline Allan-Downs

Audit, Finance & Risk Management Committee:

Greg Gent (Chair)
Anthony Norman
June McCabe
Sally Macauley

Current Māori Health Gains Council - Hei Mangai Hauora Mo Te Waka A Taonui

Anthony Norman
Erena Kara
June McCabe
Sharon Shea

Former Members Māori Health Gains Council – Hei Mangai Hauora Mo Te Waka A Taonui

Katie Murray
Pauline Allan-Downs
Ricky Houghton

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 Council 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 2014

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 Service 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 In the Board's opinion these Financial Statements and the Statement of Service Performance for the year ended 30 June 2014 fairly reflect the financial position and operations of Northland District Health Board.

Signed on behalf of the Board:

Anthony Norman
Chairperson
24th October 2014

Greg Gent
Board Member
24th October 2014

Dr Nick Chamberlain
Chief Executive
24th October 2014

Meng Cheong
Chief Financial Officer
24th October 2014

Board Report

The Board have pleasure in submitting the Financial Statements and Statement of Service Performance for Northland District Health Board for the year to 30 June 2014.

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.

	2014	2013
Results and Distribution - Group	$000s	$000s
Surplus/(Deficit) Before and After Tax	82	73
Financial Position		
Equity was represented by:		
Current Assets	72,054	65,150
Less Current Liabilities	(81,334)	(71,752)
Plus Non-Current Assets	159,719	164,295
Less Term Liabilities	(32,364)	(39,465)
Total Equity	118,075	118,228

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 2014 (in $10,000 bands):

$100,001	-	$110,000	66	$210,001	-	$220,000	10	$320,001	-	$330,000	5
$110,001	-	$120,000	33	$220,001	-	$230,000	5	$330,001	-	$340,000	2
$120,001	-	$130,000	20	$230,001	-	$240,000	4	$340,001	-	$350,000	6
$130,001	-	$140,000	13	$240,001	-	$250,000	9	$350,001	-	$360,000	2
$140,001	-	$150,000	14	$250,001	-	$260,000	4	$370,001	-	$380,000	1
$150,001	-	$160,000	10	$260,001	-	$270,000	9	$380,001	-	$390,000	2
$160,001	-	$170,000	7	$270,001	-	$280,000	5	$400,001	-	$410,000	1
$170,001	-	$180,000	9	$280,001	-	$290,000	7	$420,001	-	$430,000	1
$180,001	-	$190,000	8	$290,001	-	$300,000	4	$440,001	-	$450,000	1
$190,001	-	$200,000	7	$300,001	-	$310,000	9				
$200,001	-	$210,000	5	$310,001	-	$320,000	4				

Of the 283 staff shown above, 183 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 384, compared with the actual total number of staff of 283.

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 Member's 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 2014.

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 $171,555 (2013 $166,200) 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 2014

The Auditor-General is the auditor of Northland District Health Board (the Health Board) and group. The Auditor-General has appointed me, F Caetano, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and performance information of the Health Board and group on her behalf.

We have audited:

- the financial statements of the Health Board and group on pages 68 to 99, that comprise the statement of financial position as at 30 June 2014, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Health Board and group on pages 22 to 41 that comprises the statement of service performance, and which includes outcomes.

Unmodified opinion on the financial statements

In our opinion the financial statements of the Health Board and group on pages 68 to 99:

- comply with generally accepted accounting practice in New Zealand; and
- fairly reflect the Health Board and group's:
  - financial position as at 30 June 2014; and
  - financial performance and cash flows for the year ended on that date.

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

Reason for our qualified opinion

Some significant performance measures of the Health Board and 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 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 the performance information of the Health Board and group for the period ended 30 June 2013, which is reported as comparative information, was modified for the same reason.

Qualified opinion

In our opinion, except for the effect of the matters described in the "Reason for our qualified opinion" above, the performance information of the Health Board and group on pages 22 to 41:

- complies with generally accepted accounting practice in New Zealand; and
- fairly reflects the Health Board and group's service performance and outcomes for the year ended 30 June 2014, including for each class of outputs:
    - the service performance compared with forecasts in the statement of forecast service performance at the start of the financial year; and
    - the actual revenue and output expenses compared with the forecasts in the statement of forecast service performance at the start of the financial year.

Our audit was completed on 24 October 2014. This is the date at which our opinion is expressed.

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

Basis of opinion

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the International Standards on Auditing (New Zealand). Those standards require that we comply with ethical requirements and plan and carry out our audit to obtain reasonable assurance about whether the financial statements and 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 performance information. We were unable to determine whether there are material misstatements in the performance information 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 performance information. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and performance information, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the preparation of the Health Board and group's financial statements and performance information that fairly reflect the matters to which they relate. We consider internal control in order to design audit procedures that are appropriate in the circumstances but not for the purpose of expressing an opinion on the effectiveness of the Health Board and group's internal control.

Our audit of the financial statements involved 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; and
- the adequacy of disclosures in, and overall presentation of, the financial statements.

Our audit of the performance information involved evaluating:

- the appropriateness of the reported service performance within the Health Board and group's framework for reporting performance; and
- the adequacy of disclosures in, and overall presentation of, the performance information.

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

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

Responsibilities of the Board

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

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

The Board is also responsible for such internal control as it determines is necessary to enable the preparation of financial statements and 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 performance information, whether in printed or electronic form.

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

Responsibilities of the Auditor

We are responsible for expressing an independent opinion on the financial statements and performance information and reporting that opinion to you based on our audit. Our responsibility arises from section 15 of the Public Audit Act 2001 and the Crown Entities Act 2004.

Independence

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

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

F Caetano
Audit New Zealand
On behalf of the Auditor-General
Auckland, New Zealand

Statement of Comprehensive Income

For the Year Ended 30 June 2014

	Notes	Parent Budget 2014 $000	Group 2014 $000	Group 2013 $000	Parent 2014 $000	Parent 2013 $000
Income						
Revenue	1	526,463	531,098	519,559	531,512	519,976
Finance Income	4a	3,264	3,540	3,660	3,527	3,648
Total Income		529,727	534,638	523,219	535,039	523,624
Expenditure						
Personnel Costs	3	183,152	187,486	178,762	187,486	178,762
Depreciation and Amortisation Expense	10,11	10,977	11,563	11,518	11,156	11,111
Outsourced Services		17,671	24,120	24,087	24,120	24,087
Clinical Supplies		41,290	41,298	42,453	41,298	42,453
Infrastructure and Non-Clinical Expenses	2	23,676	23,299	19,706	23,849	20,266
Payments to Non-Health Board Providers		242,877	236,766	236,499	236,766	236,499
Finance Costs	4b	1,096	1,064	1,266	1,064	1,266
Capital Charge	5	8,988	8,960	8,855	8,960	8,855
Total Expenses		529,727	534,556	523,146	534,699	523,299
Share of Profit of Equity Accounted Associates	8	0	0	0	0	0
Surplus/(Deficit) Before and After Tax	12	0	82	73	340	325
Surplus attributable to:						
Northland District Health Board		0	139	130	340	325
Non-controlling Interest		0	(57)	(57)	0	0
Other Comprehensive Income						
Movements on Property Revaluations		0	0	(533)	0	(533)
Financial Assets at fair value through other Comprehensive Income		0	(120)	(394)	(120)	(394)
Total other Comprehensive Income		0	(120)	(927)	(120)	(927)
Total Comprehensive Income		0	(38)	(854)	220	(602)
Total Comprehensive Income attributable to:						
Northland District Health Board		0	19	(797)	220	(602)
Non-controlling Interest		0	(57)	(57)	0	0

At the end of the 2014 financial year, there was $0 Mental Health Ring Fence Funding unspent (2013: $0).

Explanations of major variances against budget are detailed in note 23.

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

Statement of Comprehensive Income *(Continued)*

Supplementary Information

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

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
Surplus/(Deficit) Before and After Tax	(575)	(7)	922	(258)	82

2014 - Budget	**Provider**	**Governance**	**Funder**	**Kaipara JV**	**Group**
	2014	**2014**	**2014**	**2014**	**2014**
	$000	**$000**	**$000**	**$000**	**$000**
Revenue	283,396	3,454	242,877	0	529,727
Expenses	283,396	3,454	242,877	0	529,727
Net Surplus/(Deficit)	0	0	0	0	0

2013 - Actual	**Provider**	**Governance**	**Funder**	**Kaipara JV**	**Group**
	2013	**2013**	**2013**	**2013**	**2013**
	$000	**$000**	**$000**	**$000**	**$000**
Revenue	282,997	3,469	237,158	(405)	523,219
Expenses	283,072	3,729	236,498	(153)	523,146
Net Surplus/(Deficit)	(75)	(260)	660	(252)	73

Statement of Changes in Equity

For the Year Ended 30 June 2014

		Parent Budget	**Group**		**Parent**	
	Notes	**2014**	**2014**	**2013**	**2014**	**2013**
		$000	**$000**	**$000**	**$000**	**$000**
Balance at 1 July		112,597	118,228	119,201	112,412	113,014
Total Comprehensive Income		0	(38)	(854)	220	(602)
Balance at 30 June	12	112,597	118,190	118,347	112,632	112,412
Distributions made to Non-controlling Interest		0	(115)	(119)	0	0
Balance at 30 June	12	112,597	118,075	118,228	112,632	112,412
Total Comprehensive Income attributable to:						
Northland District Health Board		112,597	114,641	114,623	112,632	112,412
Non-Controlling Interest		0	3,433	3,605	0	0
Balance at 30 June		112,597	118,075	118,228	112,632	112,412

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

Statement of Financial Position

As at 30 June 2014

	Notes	Parent Budget 2014 $000	Group 2014 $000	Group 2013 $000	Parent 2014 $000	Parent 2013 $000
Assets						
Cash and Cash Equivalents	6	24,140	50,539	37,977	50,474	37,893
Trade and Other Receivables	7	12,660	13,567	12,050	13,564	12,047
Short Term Deposits	6	0	260	260	0	0
Short Term Investments	8	8,395	3,095	10,021	3,095	10,021
Inventories	9	4,155	3,833	4,048	3,833	4,048
Prepayments		439	112	138	112	138
Trust/Special Fund Assets		479	648	656	648	656
Total Current Assets		50,268	72,054	65,150	71,726	64,803
Property, Plant and Equipment	10	154,676	144,753	143,618	137,920	136,379
Intangible Assets	11	1,260	2,355	1,802	2,355	1,802
Investments	8	12,948	12,611	18,875	14,373	20,637
Total Non-Current Assets		168,884	159,719	164,295	154,648	158,818
Total Assets		219,152	231,773	229,445	226,374	223,621
Equity						
Crown Equity	12	40,364	41,762	41,705	44,557	44,557
Other Reserves	12	68,485	75,259	75,379	67,922	68,042
Retained Earnings/(Losses)	12	3,071	(3,027)	(3,117)	(495)	(843)
Trust/Special Fund Assets	12	677	648	656	648	656
Total Equity Attributable to Northland District Health Board		112,597	114,642	114,623	112,632	112,412
Non-controlling Interest		0	3,433	3,605	0	0
Total Equity		112,597	118,075	118,228	112,632	112,412
Liabilities						
Trade and Other Payables	13	40,614	41,691	42,269	41,735	42,260
Interest-Bearing Loans and Borrowings	14	0	8,208	76	8,208	76
Employee Entitlements	15	25,590	30,695	29,207	30,695	29,208
Provisions	16	0	740	200	740	200
Total Current Liabilities		66,204	81,334	71,752	81,378	71,744
Interest-Bearing Loans and Borrowings	14	24,708	16,500	24,708	16,500	24,708
Employee Entitlements	15	15,642	15,864	14,757	15,864	14,757
Total Non-Current Liabilities		40,350	32,364	39,465	32,364	39,465
Total Liabilities		106,554	113,698	111,217	113,742	111,209
Total Equity and Liabilities		219,152	231,773	229,445	226,374	223,621

Explanations of major variances against budget are detailed in note 23.

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

Anthony Norman
Chairperson
24 October 2014

Greg Gent
Board Member
24 October 2014

Statement of Cash Flows

For the Year Ended 30 June 2014

	Notes	Parent Budget 2014 $000	Group 2014 $000	Group 2013 $000	Parent 2014 $000	Parent 2013 $000
Cash Flows from Operating Activities						
Cash Receipts from Ministry of Health and Patients		525,583	529,777	521,902	530,334	522,413
Cash Paid to Suppliers		(325,377)	(326,005)	(326,078)	(326,538)	(326,604)
Cash Paid to Employees		(183,152)	(185,773)	(179,382)	(185,773)	(179,382)
Cash Generated from Operations		17,054	17,999	16,442	18,023	16,427
Interest Received		3,264	3,480	3,507	3,468	3,495
Interest Paid		(1,096)	(1,063)	(1,443)	(1,063)	(1,443)
Net Taxes Refunded/(Paid) (Goods and Services Tax)		0	(1,256)	529	(1,249)	529
Capital Charge Paid		(8,992)	(8,960)	(8,855)	(8,960)	(8,855)
Net Cash Flows from Operating Activities	6	10,230	10,200	10,180	10,219	10,153
Cash Flows from Investing Activities						
Proceeds from Sale of Property, Plant and Equipment		0	431	28	431	28
Acquisition of Property, Plant and Equipment		(18,659)	(10,641)	(4,859)	(10,641)	(4,859)
Acquisition of Intangible Assets		0	(730)	(1,913)	(730)	(1,913)
Acquisition of Investments in Associates		0	(1,502)	0	(1,502)	0
Receipts from Maturity of Investments		9,205	14,880	10,400	14,880	10,400
Net Cash Flows from Investing Activities		(9,454)	2,438	3,656	2,438	3,656
Cash Flows from Financing Activities						
Borrowings Raised (Repaid)		(76)	(76)	(76)	(76)	(76)
Net Cash Flows from Financing Activities		(76)	(76)	(76)	(76)	(76)
Net Increase/(Decrease) in Cash and Cash Equivalents		700	12,562	13,760	12,581	13,733
Cash and Cash Equivalents at Beginning of Year		23,440	37,977	24,217	37,893	24,160
Cash and Cash Equivalents at End of Year	6	24,140	50,539	37,977	50,474	37,893

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

Statement of Contingent Liabilities and Assets

As at 30 June 2014
Contingent Liabilities and Assets:
Northland District Health Board and group have no contingent assets or liabilities (2013: nil)

Statement of Commitments

As at 30 June 2014

	Group		Parent	
	2014 $000	2013 $000	2014 $000	2013 $000
Capital Commitments	21,888	1,303	21,888	1,303
Intangible Commitments	104	779	104	779
Operating Lease Commitments				
Not more than one year	2,825	3,539	3,122	3,401
One to two years	1,854	2,297	2,151	2,296
Two to five years	1,927	1,981	2,818	1,981
Over five years	3,316	855	6,261	855
	9,922	8,672	14,352	8,533
Total Commitments	31,914	10,754	36,344	10,615

Capital commitments represent capital expenditure contracted for at balance date but not yet incurred. Current capital projects include the new Oncology Centre, Maternity Unit, Office Block and CT Scanner.

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

Operating Lease commitments as at 2013 have been updated to better reflect the commitment to the end of the lease period where Northland District Health Board intends to renew leases at renewal point.

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 2014, $4,182,000 was recognised as an expense in the statement of financial performance in respect of operating leases (2013: $3,985,000).

Notes to Financial Statements

1 Revenue

	Notes	Group 2014 $000	Group 2013 $000	Parent 2014 $000	Parent 2013 $000
Health and Disability Services (MoH Contracted Revenue)		515,030	502,997	515,030	502,997
ACC Contract		3,718	3,374	3,718	3,374
Inter District Patient Inflows from other District Health Boards		8,048	8,690	8,048	8,690
Other Revenue		4,302	4,498	4,716	4,915
		531,098	519,559	531,512	519,976

Revenue for Health Services includes all revenue received from the Crown (via the Ministry of Health), Accident Rehabilitation and Compensation Insurance Corporation (ACC) and other sources.

2 Infrastructure and Non-Clinical Expenses

Included in Infrastructure and Non-Clinical Expenses:		Group 2014 $000	Group 2013 $000	Parent 2014 $000	Parent 2013 $000
Impairment (reversal) of Trade Receivables (Bad and Doubtful Debts)	7	95	(150)	95	(150)
Loss/(Gain) on disposal of Property, Plant and Equipment		(1)	(11)	(1)	(11)
Audit Fees paid to Audit New Zealand for Audit of Financial Statements		172	166	166	161
Board and Committee Member Fees and Expenses		300	305	300	305

Northland District Health Board pays the audit fee of the Kaipara Total Health Care Joint Venture on the joint venture's behalf. The fee was $5,280 (2013: $5,000).

3 Personnel Costs

	Group 2014 $000	Group 2013 $000	Parent 2014 $000	Parent 2013 $000
Wages and Salaries	180,076	175,485	180,076	175,485
Contributions to Defined Contribution Schemes	4,816	3,646	4,816	3,646
Increase /(Decrease) in Employee Benefit Provisions	2,594	(369)	2,594	(369)
	187,486	178,762	187,486	178,762

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 2014 $000	Group 2013 $000	Parent 2014 $000	Parent 2013 $000
Interest Income	3,540	3,660	3,527	3,648

4b Finance Costs

	Group 2014 $000	Group 2013 $000	Parent 2014 $000	Parent 2013 $000
Interest Expense	1,064	1,266	1,064	1,266

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 2014 was 8% per annum (2013 8%pa).

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

	Group		Parent	
	2014	2013	2014	2013
	$000	$000	$000	$000
(a) Cash and Cash Equivalents				
Cash on Hand and at Bank	77	99	12	15
Cash on Deposit with Health Benefits Limited	45,331	37,878	45,331	37,878
Short Term Deposits with maturities less than 3 months	5,131	0	5,131	0
Total Cash and Cash Equivalents in the Statement of Cash Flows	50,539	37,977	50,474	37,893
(b) Short Term Deposits with maturities 4-12 months				
Short Term Deposits with maturities 4-12 months	260	260	0	0
Total Cash and Cash Equivalents, Short Term Deposits and Short Term Investments	50,799	38,237	50,474	37,893

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

	2014		2013	
	Effective fixed interest rate	Actual	Effective fixed interest rate	Actual
	%	$000	%	$000
Short Term Deposits with maturities of 0-3 months:	5.74%	5,131		0
Short Term Deposits with maturities of 4-12 months:	4.00%	260	4.00%	260
Total Short Term Deposits		5,391		260

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	
		2014	2013	2014	2013
		$000	$000	$000	$000
Surplus for the Period	12	82	73	340	325
Add back Non-Cash Items:					
Depreciation, Amortisation and Assets Written Off		11,563	11,518	11,156	11,111
Add back items classified as Financing Activity:					
Movements in Working Capital:					
(Increase)/Decrease in Trade and Other Receivables		(1,491)	1,740	(1,492)	1,741
(Increase)/Decrease in Inventories		215	56	215	56
Increase/(Decrease) in Trade and Other Payables		(3,301)	(1,190)	(3,134)	(1,063)
Increase/(Decrease) In Employee Benefits		2,594	(369)	2,594	(369)
Increase/(Decrease) in Provisions		540	(1,648)	540	(1,648)
Net Movement in Working Capital		(1,444)	(1,411)	(1,277)	(1,283)
Items classified as investing and financing activities		0	0	0	0
Net Cash Inflow from Operating Activities		10,201	10,180	10,219	10,153

7 Trade and Other Receivables

	Group		Parent	
	2014	2013	2014	2013
	$000	$000	$000	$000
Trade Receivables from Non-related Parties	6,292	3,738	6,289	3,735
Ministry of Health Receivables	7,555	8,497	7,555	8,497
Less: Provision for Impairment	(280)	(185)	(280)	(185)
Balance at 30 June	13,567	12,050	13,564	12,047

The carrying amount of receivables approximates their fair value.

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
	2014	2014	2013	2013
	$000	$000	$000	$000
Not past due	13,504	47	11,631	17
Past due 0-30 days	130	43	373	12
Past due 31-60 days	14	13	27	3
Past due 61-90 days	38	37	8	1
Past due >91 days	158	140	196	152
Total	13,844	280	12,235	185

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	
	2014	2013	2014	2013
	$000	$000	$000	$000
Balance 1 July	185	335	185	335
Additional/(reduced) Provision during the year	139	(29)	139	(29)
Receivables written off during the period	(44)	(121)	(44)	(121)
Balance at 30 June	280	185	280	185

8 Investments

	Group		Parent	
	2014	2013	2014	2013
	$000	$000	$000	$000
Investment in Subsidiary (at cost)	0	0	1,762	1,762
Investment in Associate (at cost)	9,457	7,478	9,457	7,478
Bonds with maturities > 12 months	3,154	11,397	3,154	11,397
Balance at 30 June	12,611	18,875	14,373	20,637
Short Term Investments				
Bonds with maturities 3 - 12 months	3,095	10,021	3,095	10,021
Balance at 30 June	3,095	10,021	3,095	10,021

Investment in Subsidiary
General Information

Name of Entity	Principal Activity	Interest Held 2014	Interest Held 2013	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 2014	Interest Held 2013	Balance Date
healthAlliance N.Z. Limited	The operation of shared services for Northland, Waitemata, Auckland and Counties Manukau 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 2014 $477,368 (2013 $3,277,476) sale value of those assets and $1,501,866 (2013 nil) 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	
	2014	2013
	$000	$000
Opening Balance	7,478	2610
Investment in equity accounted investees	1,979	4,868
Closing Balance	9,457	7,478

The following amounts represent the aggregate assets, liabilities, revenue and profit of equity accounted investees:	As at and for the year ended 30 June 2014	As at and for the year ended 30 June 2013
	$000	$000
Assets		
Current Assets	20,356	24,945
Non-current Assets	94,216	60,615
Total Assets	114,572	85,560
Liabilities		
Current Liabilities	15,016	16,168
Non-current Liabilities	4,142	3,038
Total Liabilities	19,158	19,206
Net Assets	95,414	66,354
Revenue	109,648	99,222
Expenses (including interest and tax)	109,648	99,222
Profit after tax	0	0

This financial information has been provided by healthAlliance and is subject to final audit clearance as at date of signing.

Bonds
Bonds are recognised at fair value. Fair value has been determined using quoted market prices in an active market.
Interest rates on the Bonds range from 5.735% to 6.315%.

9 Inventories

	Group		Parent	
	2014	2013	2014	2013
	$000	$000	$000	$000
Pharmaceuticals	228	180	228	180
Surgical and Medical Supplies	3,605	3,868	3,605	3,868
Balance at 30 June	3,833	4,048	3,833	4,048

Write-down of Inventories to net realisable value amounted to nil for 2014 (2013: nil).

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

The amount of inventories recognised as an expense during the year was $26,624m (2013: $26.731m), which is included in the clinical supplies line item in the statement of comprehensive income.

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 2012	7,585	122,535	49,968	7,933	188,021
Additions	0	0	0	7,761	7,761
Disposals	0	(6)	(312)	0	(318)
Movement due to Revaluation	0	(558)	0	0	(558)
Sale of Assets to healthAlliance ex Work in Progress	0	0	0	(3,277)	(3,277)
Transfer to Additions P,P&E	0	4,413	4,196	(8,609)	0
Balance at 30 June 2013	7,585	126,384	53,852	3,808	191,629
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)
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

	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 2012	0	0	36,999	0	36,999
Depreciation Charge for the year	0	6,661	4,701	0	11,362
Disposals	0	(1)	(349)	0	(350)
Balance at 30 June 2013	0	6,660	41,351	0	48,011
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

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 2012	7,585	122,535	12,969	7,933	151,022
At 30 June 2013	7,585	119,724	12,501	3,808	143,618
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

(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 2012	7,423	115,050	49,968	7,933	180,374
Additions	0	0	0	7,761	7,761
Disposals	0	(6)	(312)	0	(318)
Movement due to Revaluation	0	(558)	0	0	(558)
Sale of Assets to healthAlliance ex Work in Progress	0	0	0	(3,277)	(3,277)
Transfer to Additions P,P&E	0	4,413	4,196	(8,609)	0
Balance at 30 June 2013	7,423	118,899	53,852	3,808	183,982
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

	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 2012	0	0	36,999	0	36,999
Depreciation Charge for the year	0	6,254	4,701	0	10,955
Disposals	0	(1)	(349)	0	(350)
Balance at 30 June 2013	0	6,253	41,351	0	47,604
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

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 2012	7,423	115,050	12,969	7,933	143,375
At 30 June 2013	7,423	112,646	12,501	3,808	136,378
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

Impairment

No Impairments were recognised in the current year. (2013: nil was expensed)

Revaluation

Current Crown accounting policies require all Crown Entities to revalue land and buildings in accordance with NZIAS 16, 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 2012 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 2015.

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 Limited and Software

	HBL Shares 2014 $000	Software 2014 $000	Total 2014 $000	HBL Shares 2013 $000	Software 2013 $000	Total 2013 $000
Cost						
Balance at 1 July	1,469	1,254	2,723	0	810	810
Software Additions for the Year	0	81	81	0	444	444
Acquisition of B Class Shares in Health Benefits Limited	675	0	675	1,469	0	1,469
Disposals	0	(33)	(33)	0	0	0
Balance at 30 June	2,144	1,302	3,446	1,469	1,254	2,723
Amortisation						
Balance at 1 July	0	921	921	0	765	765
Amortisation Charge for the Year	0	177	177	0	156	156
Disposals	0	(7)	(7)	0	0	0
Balance at 30 June	0	1,091	1,091	0	921	921
Carrying Amounts						
Balance at 1 July	1,469	333	1,802	0	45	45
Balance at 30 June	2,144	211	2,355	1,469	333	1,802

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 2014, the Northland District Health Board had made payments totalling $675 (2013: $1,469) to Health Benefits Limited in relation to the Finance Procurement Supply Chain (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.

It is expected that the final costs of the FPSC Programme will exceed the original budget. Health Benefits Limited is undertaking an exercise to determine the revised costs of the programme and following this, formal approval to proceed will be required from the District Health Board's. The current expectation of the Board is that the FPSC Programme will proceed as originally planned. In this scenario, the DRC of the FPSC assets is considered to equate, in all material respects, to the costs capitalised to date such that the FPSC rights are not impaired. However, the future of the FPSC Programme is uncertain and any future decision to re-scope or discontinue the FPSC Programme will require a reassessment of the recoverable amount (i.e. DRC) of the FPSC rights.

12 Equity

	Group		Parent	
	2014 $000	2013 $000	2014 $000	2013 $000
General Funds				
Balance at 1 July	45,310	45,429	44,557	44,557
Distributions made	(115)	(119)	0	0
Capital Contribution	0	0	0	0
Balance at 30 June	45,195	45,310	44,557	44,557
Made up of:				
Parent	41,762	41,705	44,557	44,557
Non-controlling Interest	3,433	3,605	0	0
Retained Earnings/(Losses)				
Balance at 1 July	(3,117)	(3,241)	(843)	(1,219)
Surplus/(Deficit)	82	73	340	325
Transfer to Trust Funds	(40)	(40)	(40)	(40)
Transfer from Trust Funds	48	91	48	91
Balance at 30 June	(3,027)	(3,117)	(495)	(843)
Reserves				
Revaluation Reserve				
Balance at 1 July	75,006	75,539	67,669	68,202
Other Movements	0	(533)	0	(533)
Balance at 30 June	75,006	75,006	67,669	67,669
Revaluation Reserve consists of:				
Land	6,238	6,238	6,038	6,038
Buildings	68,768	68,768	61,631	61,631
Total Revaluation Reserve	75,006	75,006	67,669	67,669
Fair value through other Comprehensive Income Reserve				
Balance at 1 July	373	767	373	767
Net Revaluation gains(losses)	(120)	(394)	(120)	(394)
Balance at 30 June	253	373	253	373
Total Reserves	75,259	75,379	67,922	68,042
Trust/Special Funds				
Balance at 1 July	656	707	656	707
Transfer from Retained Earnings in respect of:				
Funds received	32	31	32	31
Interest received	8	9	8	9
Transfer to Retained Earnings in respect of:				
Funds spent	(48)	(91)	(48)	(91)
Balance at 30 June	648	656	648	656
Total Equity at 30 June	118,075	118,228	112,632	112,412

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	
	2014 $000	2013 $000	2014 $000	2013 $000
Trade Payables to Non-related Parties	3,648	3,085	3,701	3,085
Amounts due to Related Parties	1,326	1,326	1,326	1,326
GST and PAYE Payable	3,623	4,731	3,614	4,723
Income in Advance relating to contracts with specific performance obligations	2,092	1,772	2,092	1,772
Capital Charge due to the Crown	0	0	0	0
Other Non-trade Payables and Accrued Expenses	31,002	31,355	31,002	31,354
Total Trade and Other Payables	41,691	42,269	41,735	42,260

Trade and Other Payables are at fair value and payables within 12 months.

14 Interest Bearing Loans and Borrowings

	Group		Parent	
	2014 $000	2013 $000	2014 $000	2013 $000
Non-Current				
Crown Loans	16,500	24,650	16,500	24,650
Crown Energy Efficiency Loan	0	58	0	58
	16,500	24,708	16,500	24,708
Current				
Crown Loans	8,150	0	8,150	0
Crown Energy Efficiency Loan	58	76	58	76
	8,208	76	8,208	76
Total Interest Bearing Loans and Borrowings	24,708	24,784	24,708	24,784

Crown Loans

Northland District Health Board has 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	2014 Actual	2013 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	6.60%	6.60%
Energy Efficiency and Conservation Authority $0.576m (2013 $0.134m)	0.00%	0.00%

14 Interest Bearing Loans and Borrowings *(Continued)*

Repayable as follows:	Group		Parent	
	2014	2013	2014	2013
	$000	$000	$000	$000
Within two years	8,208	8,284	8,208	8,284
Two to five years	7,000	7,000	7,000	7,000
Six to nine years	9,500	9,500	9,500	9,500
Total	24,708	24,784	24,708	24,784

15 Employee Entitlements

	Group		Parent	
	2014	2013	2014	2013
	$000	$000	$000	$000
Current Liabilities				
Liability for Long Service Leave and Retirement Gratuities	3,112	3,063	3,112	3,063
Liability for Annual Leave	14,164	13,698	14,164	13,698
Liability for Sick Leave	274	312	274	312
Liability for Sabbatical Leave	79	33	79	33
Liability for Continuing Medical Education Leave	6,306	6,466	6,306	6,466
Salary and Wages Accrual	5,329	4,034	5,329	4,034
ACC Levy Payable	714	834	714	834
ACC Partnership Programme Liability	717	768	717	768
	30,695	29,208	30,695	29,208
Non-Current Liabilities				
Liability for Long Service Leave and Retirement Gratuities	13,741	12,996	13,741	12,996
Liability for Sabbatical Leave	1,235	1,034	1,235	1,034
Liability for Sick Leave	888	727	888	727
	15,864	14,757	15,864	14,757
Total Employee Entitlements	46,559	43,965	46,559	43,965

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 3.7% (2013 2.71%) and the salary inflation factor 4% (2013 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	
	2014	2013	2014	2013
	$000	$000	$000	$000
Balance at 1 July	200	1,848	200	1,848
Provision made during the year	545	0	545	0
Provision used during the year	(5)	(1,648)	(5)	(1,648)
Total Provisions	740	200	740	200

Provisions have been made for legal actions against Northland District Health Board, vehicle return costs and property lease agreements' make good clauses.

17 Financial Instruments

Northland District Health Board is party to financial instruments as part of its everyday operations. These include instruments such as bank balances, investments, accounts receivable, 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 income 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	2014	2013	2014	2013
		$000	$000	$000	$000
Cash on Hand and at Bank	6	77	99	12	15
Cash on Deposit with Health Benefits Limited	6	45,331	37,878	45,331	37,878
Cash Equivalents - Short Term Deposits	6	5,391	260	5,131	0
Bonds	8	6,249	21,418	6,249	21,418
Trade and Other Receivables	7	13,567	12,050	13,564	12,047
Total		70,615	71,705	70,287	71,358

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 below 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.

	Notes	Carrying Amount	Contractual Cashflows	Less than 1 year	1-5 years	More than 5 years
		$000	$000	$000	$000	$000
Parent & Group 2014						
Crown Loans	14	24,708	24,708	58	15,150	9,500
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
Parent & Group 2013						
Crown Loans	14	24,784	24,784	76	15,208	9,500
Provisions	16	200	200	200	0	0
Trade and Other Payables	13	42,269	42,269	42,269	0	0
Total		67,253	67,253	42,545	15,208	9,500

17 Financial Instruments *(Continued)*

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 2014, 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 $240,000 (2013: $240,000).

	2014 $000		2013 $000	
Interest Rate Risk	-100 bps	+100 bps	-100 bps	+100 bps
Financial Assets				
Cash, Cash Equivalents and Bonds (non-current)	(350)	350	(370)	370
Financial Liabilities				
Crown Loans	110	(110)	130	(130)
Total	(240)	240	(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	
	2014	2013	2014	2013
Loans and Receivables	$000	$000	$000	$000
Trade and Other Receivables	13,567	12,050	13,564	12,047
Trust/Special Fund Assets	648	656	648	656
Cash and Cash Equivalents	50,539	37,977	50,474	37,893
Short Term Deposits	260	260	0	0
Investment in Subsidiary	0	0	1,762	1,762
Investment in Associate	9,457	7,478	9,457	7,478
Fair Value through other Comprehensive Income				
Bonds	6,249	21,418	6,249	21,418
Financial Liabilities at Amortised Cost:				
Trade and Other Payables	41,179	41,866	41,223	41,859
Interest Bearing Loans and Borrowings	24,708	24,784	24,708	24,784

Credit Quality of Financial Assets	Group		Parent	
	2014	2013	2014	2013
Counterparties with credit ratings	$000	$000	$000	$000
Cash and cash equivalents and Investments				
AA-	8,611	18,661	8,285	18,317
Counterparties without credit ratings				
Cash and cash equivalents and Investments	43,046	40,734	43,307	40,994
Debtors and other receivables with no default in the past	13,567	12,050	13,564	12,047
Total Counterparties without credit ratings	56,613	52,784	56,871	53,041

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 $11,380k (2013: $21,418k).

18 Related Parties

Identity of Related Parties
Northland District Health Board has a related party relationship with its subsidiary, associate and with its board members and key management personnel.

Key Management Personnel Compensation
The key management personnel compensations are as follows:

	Group		Parent	
	2014	2013	2014	2013
	$000	$000	$000	$000
Salaries and Other Short Term Employee Benefits	2,262	2,423	2,262	2,423
Post-employment benefits	47	44	47	44
Other long-term benefits	0	0	0	0
Termination benefits	0	0	0	0
	2,309	2,467	2,309	2,467

Key management personnel costs include any compensation or other benefits paid or payable. Key management personnel consist of the CEO, 6 General Manager roles, Chief Medical Advisor, Director of Nursing and Midwifery.

Board and Advisory Committee Member Fees

Current Board Members	2014	2013
Anthony Norman (Chairperson)	$47,600	$46,625
Christopher Reid	$13,245	$0
Colin Kitchen	$21,920	$22,500
Craig Brown	$22,170	$22,250
Debbie Evans	$12,745	$0
Greg Gent	$23,858	$24,250
John Bain	$22,920	$22,500
June McCabe	$22,420	$21,500
MC (Bill) Sanderson	$22,983	$22,563
Sally Macauley (Deputy Chairperson)	$29,838	$30,813
Sharon Shea	$21,920	$22,500
Former Board Members		
Pauline Allan-Downs	$9,925	$22,750
Elizabeth (Libby) Jones	$9,925	$22,500

Disclosure of Non-Board Committee Members
In accordance with section 152(b) of the Crown Entities Act, the following people are Non Board Committee members.

Current Committee Members (Board Committee Members are classed under Board Members)

	2014	2013
Mark Sears	$500	$1,250
Peter Jensen	$750	$1,000
Beryl Wilkinson	$750	$1,500
Erena Kara	$1,000	$1,250
Winfield Bennett	$500	$1,000
Former Committee Members		
Maureen Allan	$750	$1,500

18 Related Parties *(Continued)*

Board and Advisory Committee Members and Key Management Personnel

The table below sets out details of transactions with related parties entities, which are related entities by consequence of the positions in those entities of Board and Committee Members and Management team members of Northland District Health Board. We have included information on the types of transactions which occur between Northland District Health Board and the related entities. We have disclosed the total amounts transacted between Northland District Health Board and the balances outstanding at 30 June 2014.

Services provided to Related Parties 2014					
Board and Advisory Committee Member	**Related Party**	**Relationship**	**Transaction by NDHB**	**Income $000's**	**Due From $000's**
Colin Kitchen	• Far North District Council	Council Member (Te Hiku Ward)	Health Inspection fees	295	-
Debbie Evans	• Northland Community Foundation	Member	Fundraising	35	12
John Bain	• The Order of St John	Chairman	ID Cards and Laundry services	39	5
John Wigglesworth	• Te Tai Tokerau PHO	Deputy Chairman	Rental of facilities at Kaitaia	162	15
Libby Jones	• Northland Orthopaedic Centre	Director	Laundry Services	11	1
MC (Bill) Sanderson	• Kensington Private Hospital	Shareholder	Stores Purchases, Laundry Services and Theatre Loan Items	66	9
Peter Jensen	• Arataki Ministries Ltd	Director	Room Rental and Meals on Wheels	3	-
Sally Macauley	• The Order of St John	Husband (Peter Macauley) Member, Kaikohe Area Chairman, Northern Region Trust Board	Stores Purchases and Laundry Services	39	5
	• Far North District Council	Councillor, Audit and Finance Committee, Economic Development Committee	Health Inspection fees	295	-
Sharon Shea	• Ministry of Social Development	Contractor	Gateway Assessment contract claims, Mainstream Employment Programme	186	-
Tony Norman	• Waitemata DHB	Deputy Chairman	Ambulance, patient clinics and procedures and IDF and Māori Workforce Contract	1,322	25
	• healthAlliance	Board Member	Shared Health Services Costs	1,110	201

Executive Management Team	**Related Party**	**Relationship**	**Transaction by NDHB**	**Income $000's**	**Due From $000's**
Margareth Broodkoorn	• Northland Community Foundation	Trustee / Board Member	Equipment Purchases	35	12
Meng Cheong	• The Kaipara Total Health Care Joint Venture	Board Member (Chair)	Maintenance and Management Contract, Distribution	278	-
Sam Bartrum	• The Kaipara Total Health Care Joint Venture	Board Member	Maintenance and Management Contract, Distribution	278	-

Services provided to Related Parties 2013					
Board and Advisory Committee Member	**Related Party**	**Relationship**	**Transaction by NDHB**	**Income $000's**	**Due From $000's**
Colin Kitchen	• Far North District Council	Council Member (Te Hiku Ward)	Health Inspection fees	44	-
John Bain	• The Order of St John	Chairman	ID Cards and Laundry services	34	3
	• Sport Northland	Board Member	Room Rental	1	-
John Wigglesworth	• Te Tai Tokerau PHO	Deputy Chairman	Rental of Premises	69	7
	• Hokianga Health Enterprise Trust	CEO	Stores purchases, Pharmacy and Ostomy	346	16
Libby Jones	• Kaipara Community Health Trust	Trustee (Removed 11/03/13)	Telehealth Equipment	2	-
	• Northland Orthopaedic Centre	Director	Laundry Services	2	1
MC (Bill) Sanderson	• Kensington Private Hospital	Shareholder	Stores Purchases, Laundry Services and Theatre Loan Items	59	4

18 Related Parties *(Continued)*

Peter Jensen	• Arataki Ministries Ltd	Director	Room Rental and Meals on Wheels	3	-
Sally Macauley	• The Order of St John	Husband (Peter Macauley) Member, Kaikohe Area Chairman, Northern Region Trust Board	Stores Purchases and Laundry Services	34	3
	• Far North District Council	Councillor, Audit and Finance Committee, Economic Development Committee	Health Inspection fees	44	-
Tony Norman	• healthAlliance	Board Member	Shared Health Services Costs	2,120	282

Executive Management Team	Related Party	Relationship	Transaction by NDHB	Income $000's	Due From $000's
Margareth Broodkoorn	• Northland Community Foundation	Trustee / Board Member	Equipment Purchases	52	8
Nicholas Chamberlain	• Sport Northland	Director	Room Rentals	1	-
Robert Paine	• The Kaipara Total Health Care Joint Venture	Board Member (Chair)	Maintenance and Management Contract, Distribution	278	-

Services provided from Related Parties 2014

Board and Advisory Committee Member	Related Party	Relationship	Transaction by NDHB	Expense $000's	Owed to $000's
Beryl Wilkinson	• Age Concern	President, Chair	Funding for Respite Care, Advocacy and Carer Support	33	1
Colin Kitchen	• Far North District Council	Council Member (Te Hiku Ward)	Water Rates, Land Rates	132	-
	• Top Energy	Trustee Top Energy Consumer (removed 15/7/13)	Car parking fees Kerikeri	4	-
Chris Reid	• Kerikeri Medical Centre	Trustee	Rental and Clean Offices	16	-
Debbie Evans	• Access Home Health Ltd	Owner	Respite Care and Home Support	3,066	151
	• Northland Community Foundation	Member	Donated funds for purchasing equipment	117	23
Craig Brown	• Northland Regional Council	Chairman	Water rates, Training Courses and Inspection Fees	5	-
John Bain	• Northland Regional Council	Deputy Chairman	Water rates and CIMS Training courses	5	-
	• Northland Emergency Services Trust	Chairman	Patient Transport by Helicopter	2,116	114
	• The Order of St John	Chairman	Air Services Paramedics, Venue Hire and Courses	818	195
	• Sport Northland	Board Member	Venue Hire, Green Prescription and Project Energise Agreements	358	36
John Wigglesworth	• Hokianga Health Enterprise Trust	CEO	Contract Services, Diabetes Nurse and Mental Health Practitioner	20	-
	• Te Tai Tokerau PHO	Deputy Chairman	Funding for Health Services Agreement	17,123	253
MC (Bill) Sanderson	• Northland Orthopaedics Ltd	Director	Orthopaedic Clinics	7	-
	• Kensington Private Hospital	Shareholder	Surgical Procedures and supplies. Funder Primary Care services via PHO agreement	781	165
	• Northland Medical Museum Trust	Trustee	Medical Museum	10	-
Peter Jensen	• Arataki Ministries Ltd	Director	Mental Health Services	2,158	216
Sally Macauley	• The Order of St John	Husband (Peter Macauley) Member, Kaikohe Area Chairman, Northern Region Trust Board	Air Services Paramedics, Venue Hire and Courses	818	195
	• Far North District Council	Councillor, Audit and Finance Committee, Economic Development Committee	Water Rates, Land Rates	132	-
Tony Norman	• healthAlliance	Board Member	Delivery of Non-Frontline Transactional Support Services	11,214	1,329
	• Waitemata DHB	Deputy Chairman	Patient transfers, Breast Screening, staff leave transfers	6,381	20

18 Related Parties *(Continued)*

Executive Management Team	Related Party	Relationship	Transaction by NDHB	Expense $000's	Owed to $000's
Margareth Broodkoorn	• College of Nurses Aotearoa	Board Member	Membership Fees	1	-
	• Northland Community Foundation	Trustee / Board Member	Outsourced Salaries and Supplies	117	23
	• National Council of Māori Nurses	Board Member	Sponsorship and Hui Attendence	5	-
Meng Cheong	• The Kaipara Total Health Care Joint Venture	Board Member (Chair)	Lease of Building	550	53
Nick Chamberlain	• Northland Rugby Union	Director	Health Promotion Campaign	20	-
	• Sport Northland	Director	Venue Hire, Green Prescription and Project Energise Agreements	358	41
Sam Bartrum	• The Kaipara Total Health Care Joint Venture	Board Member	Lease of Building	550	53

Services provided from Related Parties 2013

Board and Advisory Committee Member	Related Party	Relationship	Transaction by NDHB	Expense $000's	Owed to $000's
Beryl Wilkinson	• Age Concern	President, Chair	Funding for Respite Care, Advocacy and Carer Support	129	9
Colin Kitchen	• Far North District Council	Council Member (Te Hiku Ward)	Water Rates, Land Rates	86	-
	• Age Concern	Chairman (Age Concern Far North removed 08/10/12)	Funding for Health of Older People Health Services Agreement	129	9
	• Top Energy	Trustee Top Energy Consumer	Car parking fees Kerikeri	5	-
Craig Brown	• Northland Regional Council	Chairman	Water rates, Training Courses and Inspection Fees	6	-
John Bain	• Northland Regional Council	Deputy Chairman	Water rates and CIMS Training courses	6	-
	• Northland Emergency Services Trust	Chairman	Patient Transport by Helicopter	1,771	149
	• The Order of St John	Chairman	Air Services Paramedics, Venue Hire and Courses	942	77
	• Sport Northland	Board Member	Venue Hire, Green Prescription and Project Energise Agreements	260	23
John Wigglesworth	• Hokianga Health Enterprise Trust	CEO	Contract Services, Diabetes Nurse and Mental Health Practitioner	5,674	487
	• Te Tai Tokerau PHO	Deputy Chairman	Funding for Health Services Agreement	15,864	138
Libby Jones	• Kaipara Community Health Trust	Trustee (Removed 11/03/13)	Volunteer Surveys	1	-
MC (Bill) Sanderson	• Northland Orthopaedics Ltd	Director	Orthopaedic Clinics	106	-
	• Kensington Private Hospital	Shareholder	Surgical Procedures and supplies. Funder Primary Care services via PHO agreement	467	229
	• Northland Medical Museum Trust	Trustee	Medical Museum	38	-
Peter Jensen	• Arataki Ministries Ltd	Director	Mental Health Services	2,143	186
Sally Macauley	• The Order of St John	Husband (Peter Macauley) Member, Kaikohe Area Chairman, Northern Region Trust Board	Air Services Paramedics, Venue Hire and Courses	942	77
	• Far North District Council	Councillor, Audit and Finance Committee, Economic Development Committee	Water Rates, Land Rates	86	-
Tony Norman	• healthAlliance	Board Member	Delivery of Non-Frontline Transactional Support Services	10,196	1,571

Executive Management Team	Related Party	Relationship	Transaction by NDHB	Expense $000's	Owed to $000's
Margareth Broodkoorn	• College of Nurses Aotearoa	Board Member	Membership Fees	1	-
	• Northland Community Foundation	Trustee / Board Member	Outsourced Salaries and Supplies	101	-
Nick Chamberlain	• Northland Rugby Union	Director	Health Promotion Campaign	20	-
	• Sport Northland	Director	Venue Hire, Green Prescription and Project Energise Agreements	260	23
Robert Paine	• The Kaipara Total Health Care Joint Venture	Board Member (Chair)	Lease of Building	550	-

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 DHB's and Health Benefits Limited. healthAlliance provides Northland District Health Board with delivery of non-frontline transactional support services.

Northland District Health Board received $1,110k from healthAlliance in this financial year ended 30 June 2014 and Northland District Health Board paid healthAlliance $11,214k for the financial year ended 30 June 2014. Northland District Health Board owed healthAlliance $1,329k as at 30 June 2014. The $1,329k is made up of $3k worth of invoices, and the remaining $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 remaining $1,326k 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 24th May 2014. Annual rent is $550,000 plus GST, (2013: $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 GSTcommencing 24th May 2014 (2013: $247,500 plus GST), payable monthly in advance. Annual Administration and Management Contract is $30,000 plus GST (2013: $30,000 plus GST).

The Kaipara Total Health Care Joint Venture made a distribution to Northland District Health Board of $135,489 (2013: $139,050). No related party debts have been written off or forgiven during the year. The amount outstanding at year end was nil (2013: nil).

Significant transactions with Government-related entities

Northland District Health Board received funding from the Crown and ACC of $518,749k (2013 $506,371k) to provide health services to the Northland area for the year ended 30 June 2014. The Crown owes Northland District Health Board $7,555k as at the end of June 2014 (2013 $8,497k).

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.

18 Related Parties *(Continued)*

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 2014 totalled $13,120k (2013 $19,126k). These purchases included the purchase of electricity from Meridian Energy, air travel from Air New Zealand, blood products and tests from NZ Blood Services and postal services from New Zealand Post.

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 $758k to HBL (2013: $478k) and owes HBL $76k as at 30 June 2014. HBL paid Northland District Health Board $2,571k in Interest on deposit account (2013: $1,381k) and owed Northland District Health Board $528.3k interest as at 30 June 2014. 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 $24,904k. In the terms the NZIFRS 7 disclosure requires for the credit quality of the financial assets.

19 Termination Payments

For the year ended 30 June 2014 Northland District Health Board made a $2,000 termination payment to 1 employee. (2013: $10,000 to one employee)

20 Subsequent Events

There are no significant events subsequent to balance date.

21 Capital Management

Northland District Health Board's capital is its equity, which comprises crown equity, reserves, trust/special funds and retained earnings. 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.

22 Directions issued by Ministers

Northland District Health Board has 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, ICT and property functional leadership. The procurement and ICT directions apply to Northland 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.

23 Variance Analysis

Key Financial Information	Parent Actual 2014 $000	Parent Budget 2014 $000	Variance $000
Operational Revenue:	**535,039**	**529,727**	**5,312**

The increase in operational revenue against budget can be attributed to additional ACC revenue earned during the year $705,000, Clinical Training Agency revenue $560,000, additional interest income $255,000 and increased MoH revenue for various programmes including the Exemplar Co-exisitng problems programme $712,000, additional heart and diabetes checks $270,000 and smokefree funding $250,000.

The revenue budget is based on the funding envelope advised by the Ministry of Health in December 2012 for the current financial year. Subsequent to this advice further funding was made available for the above additional services.

Operational Cost (including Capital Charge)	**534,699**	**529,727**	**4,972**

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)	**158,432**	**173,669**	**(15,237)**

Total Assets (excluding cash, deposits and investment balances) are less than budget, this is due to lower than expected expenditure on Property Plant and Equipment.

Total Liabilities (excluding loans)	**89,034**	**81,846**	**7,188**

Liabilities are higher than budget due to employee provisions and payables being higher than budget.

Cash Resources (cash, deposit and investment balances less loans)	**43,234**	**20,774**	**22,460**

Cash Resources (cash, deposits and investment balances less loans) are higher than budget due to less expenditure on Property Plant and Equipment than budgeted.

Statement of Accounting Policies

For the year ended 30 June 2014

Reporting entity

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

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

The consolidated financial statements of NDHB and group for the year ended 30 June 2014 comprise NDHB, its joint venture subsidiary the Kaipara Total Health Care Joint Venture (54% owned) and its associate healthAlliance N.Z. Limited (20% owned).

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

The financial statements were authorised for issue by the Board on 30th October 2014.

Basis of preparation

Statement of compliance

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

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

Measurement Base

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

Functional and presentation currency

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

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

Critical accounting estimates and assumptions

The preparation of financial statements in conformity with NZIFRS requires management to make judgments, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, income and expenses. The estimates and associated assumptions 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 the NDHB to consider a number of factors such as the physical condition of the asset, advances in medical technology, expected period of use of the asset by the NDHB, and expected disposal proceeds (if any) from the future sale of the asset.

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 the NDHB.

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

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

Changes in accounting policies

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

Early adopted amendments to standards

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

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

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

The Minister of Commerce has approved a new Accounting Standards Framework (incorporating a Tier Strategy) developed by the External Reporting Board (XRB). Under this Accounting Standards Framework, the NDHB is classified as a Tier 1 reporting entity and it will be required to apply full public sector Public Benefit Entity Accounting Standards (PAS). These standards have been developed by the XRB and are mainly based on current International Public Sector Accounting Standards. The effective date for the new standards for public sector entities is expected to be for reporting periods beginning on or after 1 July 2014. This means the NDHB expects to transition to the new standards in preparing its 30 June 2015 financial statements. The NDHB have not assessed the implications of the new Accounting Standards Framework at this time.

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

Basis for consolidation

Subsidiaries

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

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

Transactions eliminated on consolidation

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

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

Equity accounted Investees: Associates

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

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

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

Budget Figures

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

Foreign currency transactions

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

Property, plant and equipment

Classes of property, plant and equipment

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

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

Owned assets

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

Land and buildings are revalued to fair value as determined by an independent registered valuer every three years or where there is evidence of a significant change in fair value. The net revaluation results are credited or debited to other comprehensive income and is accumulated to an asset revaluation reserve in equity for that class of asset. Where this would result in a debit balance in the asset revaluation reserve, this balance is not recognised in other comprehensive income but is recognised in the surplus or deficit. Any subsequent increase on revaluation that off-sets a previous decrease in value recognised in the surplus or deficit will be recognised first in the surplus or deficit up to the amount previously expensed, and then recognised in other comprehensive income.

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

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

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

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

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

Disposal of property, plant and equipment

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

Additions to property, plant and equipment

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

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

Leased assets

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

Subsequent costs

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

Depreciation

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

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

Class of asset	Estimated life	Depreciation rate
Buildings		
- Structure	1 - 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

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

Intangible assets

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

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

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

Subsequent expenditure

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

Amortisation

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

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

Impairment of property, plant and equipment and intangible assets

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

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

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

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

Financial instruments

Non-derivative financial instruments

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

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

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

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

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

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

Financial assets at fair value through surplus or deficit

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

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

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

Fair value through other comprehensive income

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

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

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

Loans and receivables

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

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

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

Cash and cash equivalents

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

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

Interest-bearing loans and borrowings

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

Trade and other receivables

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

Trade and other payables

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

Impairment

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

Loans and other receivables

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

Inventories

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

Cost is determined on an average weighted cost basis.

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

Interest bearing borrowings

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

Employee benefits

Defined contribution plan

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

Long service leave, sabbatical leave and retirement gratuities

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

Annual leave, conference leave and medical education leave

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

Sick leave

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

Provisions

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

Revenue relating to service contracts

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

Income tax

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

Goods and services tax

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

Revenue

Crown funding

The majority of revenue is provided through an appropriation in association with a Crown Funding Agreement. Revenue is recognised monthly in accordance with the Crown Funding

Agreement payment schedule, which allocates the appropriation equally throughout the year. It is measured at fair value of consideration received or receivable.

Goods sold and services rendered

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

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

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 MoH 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.

ACC contract revenue

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

Rental income

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

Interest

Interest income is recognised using the effective interest method.

Expenses

Operating lease payments

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

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

Financing costs

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

Capital Charge

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

Equity

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

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

Insurance Contracts

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

Contingent liabilities

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

Cost of Service (Statement of Service Performance)

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

Cost allocation

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

Cost allocation policy

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

Criteria for direct and indirect costs

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

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

Cost drivers for allocation of indirect costs

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

Comparative information

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

- Operating lease commitments reflect NDHB intention to remain until the end of the lease rather than renewal point.
- Board members fees adjusted to exclude travel and reimbursements

SSP 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
SSP	Statement of Service 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)
Dr 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, Health of Older People & Clinical Support
Margareth Broodkoorn, Director of Nursing and Midwifery
Andrew Potts, General Manager, Clinical Services
Dr Mike Roberts, Chief Medical Officer
Meng Cheong, General Manager, Finance, Funding & Commercial Services
Kim Tito, General Manager, Māori Health, 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

REGISTERED OFFICE

Northland DHB Office, Maunu Road, Whangarei

POSTAL ADDRESS

Northland DHB Office, Private Bag 9742, Whangarei 0148

TELEPHONE

(09) 470 0000

FACSIMILE

(09) 470 0001

WEBSITE

www.northlanddhb.org.nz

AUDITOR

Audit New Zealand on behalf of the Office of the Controller & Auditor General

BANKERS

Westpac New Zealand Limited
Bank of New Zealand

SOLICITORS

Webb Ross Lawyers, Whangarei

Northland District Health Board
Maunu Road
Private Bag 9742
Whangarei 0148
Phone: (09) 470 0000
Fax: (09) 470 0001

Bay of Islands Hospital
Hospital Road
PO Box 290
Kawakawa 0243
Phone: (09) 404 0280
Fax: (09) 404 2850

Dargaville Hospital
Awakino Road
PO Box 112
Dargaville 0340
Phone: (09) 439 3330
Fax: (09) 439 3531

Kaitaia Hospital
29 Redan Road
PO Box 256
Kaitaia 0441
Phone: (09) 408 9180
Fax: (09) 408 9251

Whangarei Hospital
Maunu Road
Private Bag 9742
Whangarei 0148
Phone: (09) 430 4100
Fax: (09) 430 4115 *during working hours*
Fax: (09) 430 4132 *after hours*

www.northlanddhb.org.nz

NORTHLAND DISTRICT HEALTH BOARD
Te Poari Hauora Ā Rohe O Te Taitokerau