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

ANNUAL PLAN 2013/14

incorporating

STATEMENT OF INTENT 2013/14 - 2015/16

About the Annual Plan

Structure

Northern Region Health Plan

Links to the NRHP are colour-coded as NRHP: [and a reference to the relevant content]

Statement of Intent as a subset of the Annual Plan

Northland DHB's Statement of Intent is a subset of the Annual Plan, and comprises sections 1, 2, 4, 5 and 7. The plan is also available as a separate document at http.northlanddhb.org.nz.

Contents

Minister's letter

Office of Hon Tony Ryall

Minister of Health

Minister for State Owned Enterprises

29 JUL 2013

Mr Tony Norman
Chair
Northland District Health Board
Private Bag 9742
WHANGAREI 0148

Dear Mr Norman

Northland District Health Board 2013/14 Annual Plan

This letter is to advise you I have approved and signed Northland District Health Board's (DHB) 2013/14 Annual Plan for three years.

I appreciate the significant work that goes into preparing such a thorough annual planning document and I thank you for your effort. I look forward to seeing your progress over the course of the year.

While recognising these are tight economic times, the Government is dedicated to improving the health of New Zealanders and continues to invest in key health services. In Budget 2013, Vote Health received the largest increase in government spending, demonstrating the Government's on-going commitment to protecting and growing our public health services.

Better Public Services (BPS): Results for New Zealanders

The Prime Minister has set ten whole-of-government key result areas. The health service is responsible for leading increased infant immunisation and reduced incidence of rheumatic fever. We are also involved in the key result areas of reducing the number of assaults on children, increasing participation in early childhood education and supporting the implementation of the white paper on vulnerable children.

DHBs are expected to actively engage and invest in these key result areas. Your DHB has included step targets in your Annual Plan to contribute to the Prime Ministerial challenges. Achieving these is not negotiable.

It is important that your board works closely with other social sector organisations and initiatives, including Whānau Ora.

National Health Targets

Your plan includes a good range of actions that will lead to improved or continued performance against the health targets. The target set has remained stable for 2013/14 allowing you to build on the results from the 2012/13 year.

Northland DHB is performing well in most health target areas. However, in the year ahead I expect Northland DHB to particularly focus attention on maintaining the recent pattern of improving performance for the primary care component of the Better help for smokers to quit target, and the More heart and diabetes checks target.

Quality Framework

I recently wrote to DHBs emphasising the need to maintain a focus on the quality and safety of services, both within hospitals and in wider services such as aged residential care and mental health. Ensuring quality will be an on-going focus for us all in the health sector. I expect that DHBs will use the framework that was provided to help shape DHB quality discussions. Also, that DHBs will produce a 'dashboard' of key quality and safety measures to regularly monitor performance and produce Quality Accounts in 2013.

Care Closer to Home

I expect DHBs to increase their focus on integration, particularly with respect to primary care, ensuring the scope of activity is broadened and rate of improvement is increased. I look forward to seeing an integrated approach driving service development, delivery and improved overall system performance; and in preparing to implement integration changes currently under development with the sector.

I am pleased to see an enhanced commitment to tangible actions in your Annual Plan to show how you will achieve real increases in access to diagnostic and treatment services for primary care and service shifts 'closer to home'. I expect DHBs to work in partnership with primary care, using their Alliances to drive service reconfiguration and improved system performance.

I am pleased to see your DHB has developed your Annual Plan jointly with your PHOs. It is an appropriate concern that primary care currently does not have the capacity and capability to take on your NIR services and I look forward to the development of increased breadth in primary care. I look forward to seeing the results of your work to improve the breadth of services with direct access from primary care. In particular, through the implementation of direct access to general surgery, orthopaedics and ENT surgical lists and improving direct access to specialist advice in respiratory, diabetes and cardiovascular services. It is positive that you intend to maintain the current primary care access to X-rays and ultrasounds while improving their access to your 'primary care options to acute care' programme.

Health of older people

The Government expects DHBs to continue to work with primary and community care to deliver integrated services and improve overall quality of care for older people. I am pleased to see that you have developed an Annual Plan which undertakes to meet the Government's expectations for the coming year. Notably, the implementation of a local dementia pathway that follows the national framework, the management of the risk of variable service quality of home and community support services, and proactive use of your HOP specialists to advise and train health professionals in primary and aged residential care. You have also committed to review your wraparound services, roll out the Comprehensive Clinical Assessments in aged residential care facilities, and to establish a fracture liaison service.

Regional and National Collaboration

Greater integration between regional DHBs supports more effective use of clinical and financial resources. I expect DHBs to make significant progress in implementing their Regional Service Plans, including actions for identified Government priorities and your agreed regional clinical priorities. It is evident from your Annual Plan that your DHB is working to realise the benefits of regional and sub-regional collaboration, and that this influences your local service planning. I look forward to seeing delivery on your agreed Regional Service Plan actions.

Guidance on national entity priorities was provided to all DHBs in April, for inclusion in final 2013/14 Annual Plans, following the successful completion of the Health Sector Forum lead work between the Ministry, national entities and DHBs. I expect that your DHB will deliver on these commitments, as included in your plan financials. Attached is a summary of National Entity Priority Initiatives that shows your DHB's commitments for 2013/14. I look forward to observing progress on the delivery of these priorities.

Living within our means
DHBs are required to budget and operate within allocated funding and to identify specific actions to improve year-on-year financial performance in order to live within their means. This includes seeking efficiency gains and improvements in purchasing, productivity and quality aspects of your DHB's operation and service delivery. Improvements through national, regional and sub-regional initiatives are expected to continue to be a key focus for all DHBs.

I am pleased to see that your DHB is planning to break even for the next three years.

Budget 2013
The expectation is that you will deliver on Budget 2013 initiatives. The Ministry of Health will discuss these more fully with you and develop monitoring arrangements during 2013/14.

Annual Plan Approval
My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the NHB. All service changes or service reconfigurations must comply with the requirements of the Operational Policy Framework and the NHB will be contacting you where change proposals need further engagement or are agreed subject to particular conditions. You will need to advise the NHB of any proposals that may require my approval as you review services during the year.

My acceptance of your Annual Plan does not mean approval for any capital projects requiring equity or new lending, or self-funded projects that require the support of the Capital Investment Committee. Approval of such projects is dependent on both completion of a sound business case, and evidence of good asset management and health service planning by your DHB. Approval for equity or new lending is also managed through the annual capital allocation round.

I would like to thank you, your Board and management for your valuable contribution and continued commitment to delivering quality health care to your population and wish you every success with the implementation of your 2013/14 Annual Plan. I will be monitoring your progress throughout the year and look forward to seeing your achievements.

Finally, please ensure that a copy of this letter is attached to the copy of your signed Annual Plan held by the Board and to all copies of the Annual Plan made available to the public.

Yours sincerely

Hon Tony Ryall
Minister of Health

Signatories

Agreement dated this ..... day of 2013

between

.....

[Minister]

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

and

.....

Anthony Norman
Chair, NDHB

.....

Dr Nick Chamberlain
Chief Executive, NDHB

Executive summary

Northland District Health Board will continue to improve the delivery of services during 2013/14 while living within our means. The Board has maintained a balanced financial position since 2003 and will continue to operate within a viable and financially sustainable cost structure. Northland DHB is committed to the Government's aim of delivering better public services within tight financial constraints.

We will maintain our performance improvement on the Health Targets. We now meet or exceed targets for elective services, cancer treatment, advice to smokers in hospital 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 PHOs. Northland DHB will also contribute towards reducing the incidence of rheumatic fever and child violence, two the ten whole-of-government key result areas.

This year's plan projects direct savings of $5M. Northland DHB has a continuing commitment to improving efficiency, reflected in the appointment this year of a position whose focus is on savings and productivity. Significant savings are factored into our plan from the HBL finance, procurement and supply chain business case, and healthAlliance procurement savings.

This year's Annual Plan continues our emphasis on better integrating services across the health sector – that means both primary-community services and hospital services, and NDHB and community providers. This is vital for meeting the challenges posed by our ageing population, the rising tide of long term conditions, the relative poverty of our citizens (Northland has the lowest GDP in the country) and financial constraints. Integration is a key theme in every section in module 3 of the plan.

Awareness of these challenges was the springboard for the development of the Northland Health Services Plan, Northland DHB's foundation for future service improvement. The NHSP is the template for the future structure and provision of services across the whole health sector in Northland from 2012 to 2017. NDHB has set up six programmes to provide focus and drive the changes required.

The Northern Region Health Plan continues to be the basis of our strategic planning. It's Triple Aim of population health, patient experience and cost/ productivity formed the starting point for the NHSP. Regional performance measures have been integrated into the Annual Plan. Regional planning processes, in which NDHB staff have been intimately and prominently involved, continue to develop models, pathways and protocols to guide future improvement across all four DHBs.

Improving Maori health and reducing inequities continue to be driving forces. The Maori Health Plan 2013/14, a companion document to the Annual Plan, sets out key performance measures for health services, Maori health and reducing inequities are addressed throughout the Annual Plan and they form a headline target under the NHSP. NDHB continues to strengthen internal and external monitoring systems so that all indicators, including Health Targets, can be reported by ethnicity. Increasingly we are using a results based accountability framework for monitoring provider performance on population health measures.

Northland DHB welcomes the new national PHO contract currently under negotiation. It will formalise the relationship between DHBs and PHOs, specifically by clarifying that PHOs are accountable to DHBs.

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

1 About Northland DHB

1.1 Legislation

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

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

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

1.2 Our population

Northland's projected population for 2013 is 159,795, 3.6% of New Zealand's population. Just over half live in the Whangarei District Council area, 37% in the Far North District Council and 12% in Kaipara District Council. Nga Iwi o Te Tai Tokerau comprise 30% of Northland's population.

Northland's population is 'ageing' because older age groups (age 65 or more) are increasing as a proportion of the population. At the moment the older section of our population sits at 17%, but by 2026 it will be about a quarter. Northland's older population is not only higher than the national average, it is also predicted to grow more quickly.

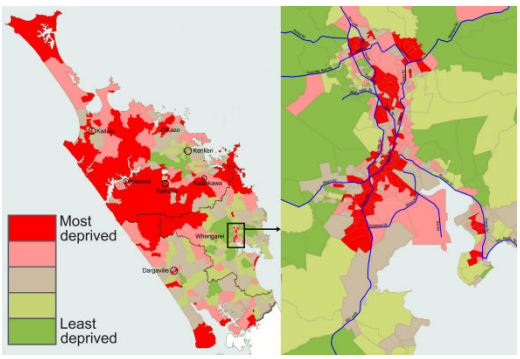
The child and youth population is declining. However the Maori birth rate is about two-thirds higher than the non-Maori rate, and the numbers of Maori babies will not be declining for the foreseeable future.

1.3 Our health

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

Poorer populations have lower health status, and Northlanders are among the most deprived in the country. In the 2006 national deprivation analysis, 20% of the nation's population was in the lowest band of the index, but for Northland the figure was 35%. The most deprived local authority area is the Far North District Council.

NZDep 2006 in Northland



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

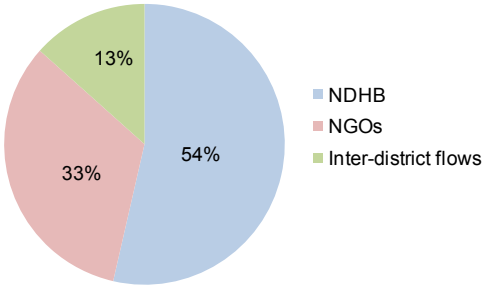
These ‘lifestyle diseases’ occur more frequently with age, the main reason our ageing population is a major challenge. Older people consume several times more health resources than other sections of the population. Northland’s proportion of the population over 65 (17.6% in 2013) is higher than the national average (14.2%), and it is projected to grow at a faster rate than the national average (increasing by 7.2% to reach 24.8% in 2026, while NZ’s will increase by 4.9% to reach 19.1%)

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

1.4 Services provided

Northland DHB provides public health, primary and hospital services to our population. We also hold 217 contracts with 138 community providers who provide a wide range of public, primary and community services. As a moderate-sized DHB, Northland is not large enough to be able to provide more specialised (tertiary) services; for these we rely on other DHBs, mainly Auckland.

Share of health funding in Northland



Out of Northland DHB’s total 2013/14 budget of $528M, just over half is spent on NDHB-provided services, a third on community provider services, and the rest is paid to other DHBs for tertiary services through inter-district flows.

1.5 Governance

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

The Chief Executive is responsible to the Board for the organisation’s performance (organisational structure is detailed further in 4.1 Managing the organisation).

2 Strategic direction

2.1 Priorities

National priorities

The Government's goals for the state sector are that New Zealanders have greater opportunities, enjoy greater security and experience greater prosperity. The NHSP contributes to these goals through a Northland population that is healthier and more productive.

The Minister of Health expresses his priorities in his annual Letter of Expectations. As well as continuing to stress the six national Health Targets (3.1 Health Targets), the key theme is improving clinical integration, which concerns shifting services into the community and away from hospitals. Clinical integration applies throughout the health system, including primary health and hospital services, child health, maternal health, health of older people, and services for long term conditions.

The Minister also asks DHBs to address other health needs: child health (especially abuse, rheumatic fever, cot death and immunisations), youth health (especially suicide), mental health, diagnostic services, whanau ora and DHBs living within their means.

Each year in the Budget the Minister announces new health funding which Northland DHB will apply in line with the Minister's requirements during 2013/14.

Regional priorities

The Northern Region Health Plan (NRHP) provides an overall framework for future planning, concentrating on clinical and financial sustainability to achieve more integrated services and improved health for the population. The NRHP contains regionally agreed actions which have been blended with the actions in the Annual Plan and/or referenced throughout. It is produced and coordinated by the Northern Regional Alliance (NRA).

The NRA is an amalgamation of two previous subsidiary companies, the Northern Region DHB Support Agency Limited and the Northern Regional Training Hub Limited. The NRA is owned in three equal shares by Waitemata, Auckland, and Counties Manukau District Health Boards.

NRA has applied for exemption from producing a Statement of Intent (SOI) for the 2013/14 year as a restructuring process is under way and key outputs and budgets are not able to be set until the new structure is in place. NRA will produce a Business Plan including budgets and key outputs for 2013/14 and will report internally and to shareholding DHBs against that business plan commencing with a report in October 2013 for the first quarter of 2013/14. The NRA Annual Report for 2013/14 will report actual results against the Business Plan in a similar manner to that which the two amalgamated companies reported against their annual Statements of Intent. The shareholding DHBs will monitor NRA performance against its Business Plan on a quarterly basis during 2013/14.

Local priorities

Northland DHB's vision is "A Healthier Northland" which we will achieve by implementing the Northland Health Services Plan[1]. The NHSP takes a sector-wide approach to tackling the challenges posed by the growth in the older population and in long term conditions. It addresses national and regional priorities while also addressing local health needs and Northland's particular geography and population characteristics. It contains a one-page Outcomes Framework (a high-level summary of which is in Appendix 1: NHSP) that encapsulates the future direction for the Northland health sector. The Outcomes Framework contains numerous Headline Targets and Headline Actions that provide a frame within which the Annual Plan's actions sit.

[1] Available at http://northlanddhb.org.nz/.

In line with our legislative obligations and the principles of the Treaty of Waitangi, Northland DHB remains committed to reducing inequalities and improving Maori health. The NHSP requires all measures to include Maori and non-Maori data. Our commitment to reducing inequalities is exemplified in our Maori Health Plan[2], which contains indicators of the state of Maori health at national, regional and local levels.

2.2 Key risks and mitigation

Factor	Risk	Mitigation
Increased demand for services	Demand for services is outstripping population growth, largely because of the ageing population, the increasing prevalence of long term conditions and the ever-increasing costs of health technologies.	Actions under the NHSP's triple aims address long term conditions by improving screening and management. Concentrate services' focus 'upstream' to prevent the development of ill health and enable earlier intervention when diseases do develop. Organise services in more effective, efficient and innovative ways ('new models of care'). Lessen demands from over 65s by maintaining their functionality and ability to manage in the community. Develop an outcome-focused contracting framework that uses results-based accountability (RBA). Work with other public sector organisations on intersectoral initiatives to improve the population's health and ability to cope with stressors.
High-need population	The deprived nature of the population is a major influence on demand for health services. Only 14% of Northlanders live a healthy lifestyle, if that is defined as avoiding the five major risk factors known to be linked with major diseases (smoking, excess alcohol use, inadequate exercise, inadequate diet, obesity).	
Demand-driven services	Most contracts with community providers are demand-driven (that is, the amount of service provided is driven by the needs patients present with, and budgets are not capped).	
Inter-district flows	NDHB pays for specialised (tertiary) services delivered in other DHBs. Costs are difficult to control because demand is based on clinical need, which has been increasing rapidly, and prices are set nationally and therefore beyond NDHB's control.	Increase the skill levels of NDHB's clinical staff. Ensure ready access by Northland staff to more specialised advice from tertiary providers. Participate in clinical networks. Apply regional clinical protocols that specify when conditions should be referred. Another option being tested is to increase the range and complexity of services provided by NDHB. A group is to be set up to investigate the potential for outsourced activity to be repatriated. Early examples of areas of interest include long term sleep apnea, ERCP, angiography, aspirin desensitization, non-schedule lab tests and some ENT services.
Staffing costs	Around 70% of NDHB's expenses are staff-related, so any changes to nationally or regionally negotiated employment contracts have significant impacts on our costs.	Continued and innovative attention to efficiencies, strict budget monitoring practices and close controls over workforce-related costs such as annual leave and use of locums.
Workforce factors	As a relatively small player in the national health sector, NDHB often struggles to attract and retain appropriate staff, especially in some clinical specialist roles. The average age of the workforce is increasing throughout the health sector in Northland. The ethnic composition of the workforce does not reflect the ethnic composition of the Northland population.	Continue to explore innovative "grow our own" solutions to workforce issues (such as Pukawakawa , scholarships in oral health and Maori health). Continue to develop a culture that attracts and retains key staff.
Innovation in primary care	Difficulty in achieving real change in primary care and other community services because they are independently managed.	Continue to involve non-NDHB organisations in planning and strategising to encourage innovative thinking, and a collective cross-sectoral sense of responsibility and response to the major challenges that lie ahead. Utilise our

[2] Also available at http://northlanddhb.org.nz/.

Factor	Risk	Mitigation
		new Alliancing agreement and Alliance Leadership Team.
Availability of technology	The Northland health sector's ability to introduce change is hampered because technology such as high-speed broadband is slow to be implemented and its geographic spread is limited. Generally, populations with higher needs have poorer access to new technologies.	Work closely with territorial local authorities and the Northland Intersectoral Forum to ensure we work with telco providers to help coordinate increased broadband coverage. Continue to expand use of telehealth and e-communication among clinicians. Pursue any opportunities to promote the benefits of new communications technology to appropriate decision makers.

3 Priorities and targets

3.1 Health Targets

NRHP top ten commitments: Achieve and maintain the Minister's health targets

3.1.1 Shorter stays in emergency departments

Objectives	Actions	Measures
More timely services in EDs to: • improve public confidence • speed up patient flows • make better use of available resources.	Implement the following actions with support from both clinical staff and management: Continue to develop patient care bundles to reduce the factors impacting on ED length of stay. Review roster patterns of clinical staff to ensure resources match service requirements. Engage with PHOs to identify opportunities to reduce ED attendances. Enhance existing opportunities within long term conditions project work. Integration of Hospital at a Glance, including ED, via the daily hospital coordination unit, patient flow meetings. Hold ongoing daily breach meetings, with weekly analysis and follow-up by General Manager and service managers. Evaluate the Hospital 2 Home pathway for cardiology and develop a COPD pathway to address their high readmission rates. Review and develop the inpatient specialty service levels agreements to improve ED attendance time.	95% of patients will be admitted, discharged, or transferred from Emergency Departments within six hours.

3.1.2 Improved access to elective surgery

Objectives	Actions	Measures
Improved and timelier access to elective services.	Northland DHB is committed to providing a further 130 elective surgery discharges in 2013/14 towards the Elective Health Target. Elective funding has been allocated to achieve this. A business case for an additional CT scanner is currently passing through the authorisation process. This will: • increase the level of diagnostic capacity • reduce waiting times • reduce one of the capacity constraints to achieving a four month maximum wait in 2014/15. The Productive Operating Theatre (TPOT) project will generate an increase in the number of patients having elective surgery through improvements in capacity planning, scheduling and patient processes. Specific changes being introduced are: • better theatre organisation to allow the introduction of four orthopaedic major joint surgeries per theatre session • highly effective orthopaedic surgery 'briefing' meetings will be rolled out to cover general surgery, thus covering 45% of all NDHB surgical discharges • the increased use of dedicated elective theatre lists. The management of interim alternative theatre capacity options will enable temporary increases in capacity in response to demand fluctuation. Two of these options	The [national] volume of elective surgery will be increased by at least 4,000 discharges per year. NDHB elective surgical discharge target: Base 4,896 Additional 1,668 Total 6,564

Objectives	Actions	Measures
	are: • flexible contracting with a private provider • increased utilisation of Kaitaia Hospital theatre capacity. The Acute Care Reform Programme, an NDHB-funded initiative that focuses on improvements to the acute pathway in NDHB, will develop better theatre, bed and SMO utilisation of acute care. These reforms will help NDHB expand elective capacity. The recruitment of an additional orthopaedic SMO and an ophthalmology registrar will increase the capacity of elective surgery. A business case is also being developed for an additional ophthalmology SMO. This range of measures will help ensure that no patient waits longer than five months for elective surgery during 2013/14. Changes made in structuring the process regarding the flow of patients from FSA to the Surgical Booking List in Orthopaedics particularly will see this specialty achieve 4 months by the end of Q3. NDHB will apply a similar approach in all other specialties, but challenges regarding the prioritisation of surgery and procedures have emerged and these will need to be worked through to achieve the 4 month target. (NDHB currently uses prioritisation tools introduced and mandated by the Ministry of Health to prioritise treatment. Where refinement of existing prioritisation tools is considered necessary to achieve better granularity in determining patient priority for treatment this will be done in conjunction with the Ministry. All patients are treated in accordance with assigned priority and wait times and exceptions to this occur only when clinical urgency/priority necessitates or there is a small window of clinical optimisation of the patient for surgery where it is preferable they have their surgery within this.)	

3.1.3 Shorter waits for cancer treatment

NRHP Goal Two: Life and years, cancer priority

Objectives	Actions	Measures
Improve access to diagnostic and treatment services for people suspected of or diagnosed with cancer. All 9 cancer streams are well supported by Northern Cancer Network, NDHB and PHOs to meet Health Targets and faster cancer treatment (FCT) targets. Information sharing between secondary and tertiary care is supported with appropriate IT capacity.	*Information services initiatives* Fully operationalise the electronic MDM referral form for lung and bowel cancer: secure additional clinical functional support for Concerto ad hoc documents to be fully functional secure funding to upgrade VC equipment for MDM sustainability. Align Northland FCT reporting to the FCT timeframes for Lung and Bowel cancer targets • review feasibility of data collection and develop reporting protocols for the NDHB MDM measures for lung and bowel cancer • enable reporting of MDM measure across all tumour streams. *Quality initiatives* Implement the Lung Cancer Standards for Service Provision • conduct a review of the current clinical practices • develop action plan to align practice to standards.	HT: All patients, ready-for-treatment, wait less than four weeks from referral for radiotherapy and chemotherapy. DV1 faster cancer treatment measures: proportion of patients referred urgently with a high suspicion of cancer receive: • first specialist appointment (FSA) within 14 days • first treatment (or other management) within 31 days from when the decision to treat (DTT) is made • first treatment within 62 days from referral to first cancer treatment (or other management Improving wait times for colonoscopy: 50% of people receive colonoscopy within • 14 days for an urgent diagnostic colonoscopy • 42 days for a diagnostic colonoscopy

Objectives	Actions	Measures
	Establish NDHB Cancer Clinical Workstream Implement the Endoscopy Quality Improvement Programme • extend colonoscopy surveillance monitoring from 2 years to 5 years • reduce the priority settings to P1 & P2 and redistribute patient data in accordance with amended criteria. Appoint Cancer Care Coordinators (2 FTEs): • support them to attend national and regional training and mentoring forums • support 3 CNSs to achieve ACP L1 and L2 competency • support lung and bowel cancer tumour stream personnel to undertake ACP L1 competency online. Build awareness of the lung and bowel cancer patient pathways (lung): • across primary care (general practices including Maori health providers and whanau ora health providers) • across community cancer support groups for lung cancer. Conduct a survey of current cancer consumer support groups to establish a formal network and develop an action plan. NDHB to continue to participate in the development and implementation of the national standards and priorities for medical oncology and prostate cancer. Develop risk stratification criteria to identify cancer patients for the telehealth service.	• 84 days for a surveillance colonoscopy NDHB MDM measurements: number of lung and bowel cancer patients presented to MDM as % of total number of lung and bowel cancer patient referrals for high suspicion of lung and bowel cancer. Cancer Care Coordinators appointed. *(For ACP measures see ACP section in next row.)*
Implementation of Advance Care Planning.	By Q2 investigate IT mechanisms to increase reporting capability for monitoring ACP activities. Test IT mechanisms across the H2H heart failure and COPD streams, renal service and lung and bowel cancer streams. By Q1 develop the ACP agreement and coalition partners. By Q2 develop an action plan to support the ACP Alliance Agreement. By Q3 develop the business case for Alliance funding modelling. Support the regional programme of developing consumer resources and facilitation tools, and train-the-trainer community champion models.	IT mechanisms in place and available to ACP L2 practitioners Ad hoc documents functionality available. Concerto clinical support secured. IT platform developed and tested. By Q1 develop the ACP Alliance Agreement and coalition partners. By Q2 develop an action plan to support the ACP Alliance Agreement. ACP funding secured. Northland based training for L2 secured. Total number of planned ACP L2 trainees as a % of the total number of ACP L2 practitioners.
Clinically and culturally safe, good quality, effective, efficient and timely care.	Consumer awareness Build awareness of ACP with consumer groups ready for promotion. Conduct a survey to measure level of awareness of ACP across the community groups ready for ACP promotion.	Number of community support groups received awareness package as % of total number of support groups identified as ready for ACP promotion.

3.1.4 Increased immunisation

Objectives	Actions	Measures
Increase on-time immunisation for all	NDHB Immunisation Action Plan for 8-month and 24-month coverage adopted and implemented. This	90% of eight-month-olds will have their primary course of immunisation (six

Objectives	Actions	Measures
children to ensure coverage to meet or exceed the immunisation Health Target.	includes: • maintaining the Immunisation Steering Group that includes all the relevant stakeholders for the DHB's immunisation services with participation in regional and national forums • monitoring and evaluating immunisation coverage at DHB, PHO and practice level • managing identified service delivery gaps • triple enrolment (PHO, NIR, WCTO) on discharge from maternity services • working with primary care partners to implement the newborn enrolment policy and monitoring newborn enrolment rates • quality improvement programmes implemented within primary care for precall and recall systems • collaborative primary care and DHB operational team with focus on improved care coordination of unimmunised children across Northland, including ensuring appropriate providers are tracking/ tracing and immunising children • identifying immunisation status of children presenting at hospital and offering where appropriate opportunistic immunisation, either on-site or by referral to GP.	weeks, three months and five months immunisation events) on time by July 2014. (The actions will also contribute towards quarterly reporting measure PP21: 95% of two-year-olds are fully immunised and coverage is maintained, described in 8 Non-Health Target performance measures.)
	Once consultation and decisions on the reconfiguration of PHOs in Northland have been concluded, review possible options for reconfiguring the National Immunisation Register service in Northland (likely to occur in 2014/15).	
	Maintain quarterly meetings of the Immunisation Steering Group (that consists of NDHB CE, Manaia PHO CE, Te Tai Tokerau PHO CE, Primary Care Clinical Director, NDHB Clinical Lead for Immunisation, GM Child Youth Maternal Services); group to be chaired by NDHB's CE.	Evidence of minutes.
	Practice level data will be tabled at the ISG meeting and be analysed quarterly by the group, who will consider recommendations for improving and supporting the ten poorest performing general practices.	
	Maintain scheduled weekly meetings of the Te Tai Tokerau Immunisation Working Group (that includes NDHB NIR Coordinator, two Outreach Immunisation Coordinators, Primary Care Immunisation Coordinator and Secondary Care Immunisation Coordinator). Overdue children's reports will be analysed weekly by the Te Tai Tokerau Immunisation Working Group and plans formulated and actioned for tracking and tracing and vaccinating at home or in general practice.	
	Hold fortnightly teleconferences between GM Child Youth and Maternal Services and the CEOs of our PHOs to maintain oversight and troubleshoot any impediments to achieving the immunisation target.	
	Northland PHOs will implement a general practice self-audit tool to help improve immunisation activities which will be rolled out regionally. Northland PHOs will implement a Practice Coach to work intensively with underperforming practices as identified by the Primary Care Immunisation Coordinator.	Three-monthly monitoring of number of self audits completed
	GM Child Youth Maternal and Oral Health Services will write to other government agencies and key community provider stakeholders to reinforce the need for stronger	

Objectives	Actions	Measures
	collaboration and information sharing to ensure our infant population is vaccinated in a timely fashion.	
	NDHB will develop a pilot programme to implement a Well Child Clinic in at least one WINZ office in Whangarei by June 2014.	Well child clinic established

3.1.5 Better help for smokers to quit

Objectives	Actions	Measures
Encouraging and supporting smokers to make more quit attempts in order to increase the number of successful quit attempts.	**Hospital services** Strengthen smokefree systems that support ABC in hospital services to sustain maintenance of the health target by: • maintaining regular monitoring and audits and addressing issues with appropriate services	95% of hospitalised smokers will be provided with advice and help to quit by July 2014.
	• ensuring attendance of all new clinical staff on the bi-monthly courses on the ABC of smoking cessation, NRT and Standing Orders for NRT; provide additional refresher sessions for existing staff In consultation with the Aukati Kaipaipa providers increase referrals from DHB services. For whanau of Maori patients in NDHB hospital services with high smoking rates, provide smoking cessation advice and support by developing a pilot programme involving clinicians, nurses, allied health staff, Takawaenga, the Smokefree Service and referral to community support (initially in Whangarei Hospital, and planned for extension to other NDHB hospitals).	6 bi-monthly course held by Q4. A minimum of 20 ABC and NRT refresher education sessions completed by Q4. Pilot project plan developed by Q2. Implemented in Q3 and Q4.
	Improve support for pregnant women to stop smoking The Hapunga Auahi Kore Alliance and Charter signed off by LMCs, cessation providers and other key stakeholders to achieve a consistent and integrated approach to smoking cessation referral pathways and success quit attempts. Northland midwives trained in the ABC of smoking cessation, documentation and referral to culturally appropriate smoking cessation services by the end of Q1. Smokefree team to work with Maternity Services, NDHB Information Services and the Hapunga Auahi Kore o Te Tai Tokerau Alliance to improve data capture of smoking status and brief advice and support given to pregnant women by LMCs as recorded on the booking forms and entered into the DHB Solutions Plus database. Via the Hapunga Alliance and Midwife Education sessions, continue to strengthen links between LMCs, midwives and Aukati Kaipaipa services to increase referrals of pregnant women and their whanau. Monitor referrals from midwives to Aukati Kaipaipa services.	90% of Northland Midwives trained by Oct 2013. Baseline data to be captured Q1. Baseline data established for referrals by Midwives and NDHB Maternity services in Q1. Q2-Q4, report on numbers referred in relation to the baseline data.
	Primary services PHOs will provide active, dedicated management support to general practice by: • monthly health target meetings to coordinate actions • clinical and nursing leadership meetings have standardised agenda item for actioning Health Target improvements • monthly Dr Info audit checks implemented and	95% of smokers seen in general practice will be provided with advice and help to quit by July 2014. For this target, Northland's two PHOs will be in the top quartile of PHOs in the country. Increase in rates of Brief Advice and Cessation Support offered within

Objectives	Actions	Measures
	communicated to practice, 'delinquent' reports identify practices that require extra support • Smoking Cessation Coordinator provides support and advice to build achievement levels within practices • ensuring smoking status and ABC are coded correctly.	Primary health care
	Work collaboratively with runanga, marae, hapu, whanau ora collectives, kohanga reo, and whanau to achieve fifteen teams of ten on the Whanau End Smoking Regional Whanau Ora (WERO) Challenge programme.	50% of those participating in the 15 teams have a successful quit outcome for a period of 4 weeks/ 3 months post the end of the challenge (to be monitored quarterly).
	Establish and support the ongoing needs of the Hapunga Auahi Kore Alliance which includes LMCs, cessation providers and other key stakeholders, to achieve a consistent and integrated approach to smoking cessation referral pathways and successful quit attempts for pregnant smoking women.	Increase in the rate of pregnant women offered ABC.
	Provide training, support and IT solutions to enable GPs and practice nurses to consistently offer ABC to all patients who smoke.	Increase in the rate of ABC offered to patients who smoke and enrolled with a GP practice.
	Support the University of Auckland tobacco research initiatives to engage with whanau to increase successful quit attempts (Aunties Programme with Ringa Atawhai, Incentive Rewards programme).	Increase in the rate of pregnant women offered ABC.
	Provide funding from within current ABC resources to general practices with high-needs populations (Maori, high deprivation) to facilitate free smoking cessation services in general practice for high need smokers.	Resources are provided to General Practice to assist with following up patients who smoke.
	Complete a review of smoking cessation provision and produce recommendations for equitable coverage across Northland.	

3.1.6 More heart and diabetes checks

NRHP Goal Two: Life and years, cardiovascular disease priority, diabetes priority

Objectives	Actions	Measures
Long-term conditions are identified early and managed appropriately, thus aiding in the promotion and protection of good health and independence. Primary care services are better able to contribute to improved health.	Use IT tools to identify eligible populations: Proactively identify, contact and invite people due for CVD risk assessment. Practice specific plans to be developed. Ensure all providers (both primary health and hospital) utilise Predict as a common data source. Ensure through efficient invitation and recall systems that people attend CVD risk assessments. Monitor performance and agree action plans with general practices that are not achieving targets for their enrolled populations.	The following IT tools in place in all practices: Dr Info, Predict and Patient Dashboard Practice-specific plans in place by 31 December 2013. Standardised recall systems already in place in all practices. 90% of the eligible[3] adult population will have had their cardiovascular disease (CVD) risk assessed in the last five years: 69% currently (Q3) 75% by 1 July 2013 79% by 1 Aug 2013 83% by 1 Jan 2014 87% by 1 Apr 2014 90% by 30 June 2014 Performance will be measured quarterly and adjustments to the milestones will be made accordingly.
	Quality of service: Develop teams to ensure expertise, training and tools are available to enable providers to successfully complete the CVD risk assessment to meet clinical guidelines. Increase the use of nurse-led clinics. Develop a CVD assessment and management service in one large workplace in the Whangarei surrounds, to	

[3] Population eligible for CVDRA is: for Maori, Pacific, or Indian subcontinent ethnicity, males aged 35-74 and females aged 45-74; for other ethnicities, males aged 45-74 and females aged 55-74.

Objectives	Actions	Measures
	improve access to heart and diabetes checks for people in employment. *[Funded by Manaia PHO]* Expand the diabetes nurses' group, established in 2011/12. *[Funded by Manaia PHO]*	
	Minimise financial barriers to access by providing free CVD screening to eligible high need populations. *[Implemented and funded by PHOs]*	
	Continue to fund services and activities related to the achievement of the 90% target for More Heart and Diabetes Checks. These include: $56,000 for the Predict tool licence for all of Northland (from NDHB) Packages of care which include a CVD risk assessment component, including Manaaki Manawa (Kaupapa Maori cardiac rehab) from SIA funding ($192,000 from Manaia PHO, $278,980 from Te Tai Tokerau PHO) and Whakamana Hauora which uses the Stanford Model ($44,000 for from Manaia PHO, $38,000 from Te Tai Tokerau PHO	
	Improve consistency of access to services across NDHB's population through development of the Diabetes Care Improvement Package, which will continue to: Improve the skills and knowledge of the diabetes clinical workforce in primary care. At practice level, accurately identify all people with diabetes through risk stratification. Progress to include those with pre-diabetes. Capture patient-level clinical information and actively use audit tools to ensure the care provided to people with diabetes is consistent with the guidance in the New Zealand Primary Care Handbook. Continue to support patient self-management through use of Conversation Maps and Whakamana Hauora. Ensure effective clinical governance through appropriate structures and processes by linking clinical governance and reporting to the NDHB Long Term Conditions Framework and LTC Clinical Governance Group. In quarter one, develop a podiatry indicator to support a focus on primary detection and treatment of foot problems. Contribute to improved collaboration between hospital specialist nurses and primary care in supporting best practice in glycaemic control in primary care, including insulin. NDHB has allocated $370,554 to support the DCIP, of which some $320,662 (86.5%) is to be utilised for payments to general practice. The balance is to be used to develop IT support systems and quality improvement teams. No practice is to receive less than 90% of the level of funding they received under the prior annual free check programme, and in the majority of cases the payments made to general practices are expected to increase.	Ongoing high performance against agreed national indicators including: • all patients with diabetes have a cardiovascular risk assessment done • good diabetes control HbA1c <8% • monitoring of microalbuminuria • Each practice's progress towards targets, as detailed in individual practice plan: • to be reviewed quarterly • to be assessed for progress to date • practice level targets to be reviewed annually. Outcomes of quality improvement activities reviewed by 31 March 2014, prior to setting of goals for the next financial year. Skills and knowledge of diabetes clinical workforce to be measured by an annual knowledge survey of practice nurses to identify the number who have completed on-line education NZZSD or attended education days or achieved Level 2 Of Knowledge Skills Framework. Patients having Conversation Maps and Whakamana Hauora to increase by 10% each. Indicators are reported for both total and Maori populations *(in place).* Podiatry indicator developed (*by January 2014*).

3.2 Clinical integration

NRHP charter aim: Enable the component parts of the health and disability system to operate effectively together as a more unified system while recognising and leveraging the unique capabilities of the different providers

Objectives	Actions	Measures
Reduce pressures on acute hospital services resulting from the ageing population and increasing prevalence of long term conditions.	Reduce annual growth in bed days and reduce unplanned readmissions by: • redesigning and implementing pathways (current work includes orthopaedics, Maori, COPD, diabetes, heart failure, TIAs, suicide prevention, dementia) • following protocols for enhanced recovery after surgery • strengthening discharge planning and follow-up with an emphasis upon older people and Maori with long term conditions • reviewing ED frequent attenders and develop individual care plans • further developing Primary Options Programme Northland (POPN) to become a more comprehensive programme which provides innovative, cost-effective ways of reducing admissions to hospital and to provide alternative care in the community; quarterly requirement is 187 prevented admissions per quarter. • implementing strategies for over 75s (3.3 HOP, second row of actions) • refining the Global Trigger Tool methodology so it provides information that allows clearer identification of corrective actions to reduce risk of patient harm.	Bed day growth will change from an annual rate of 5.32% in 2013/14 to 2.82% in 2018/19. Unplanned admissions will reduce by 2,000 annually until 2017.
	Primary care access to NDHB plain xray and ultrasound services is already substantial. A second CT scanner should increase access by GPs to CT scanning; protocols and level of access will be explored further in discussions between PHOs' Primary Care Clinical Director and NDHB's Imaging Department head.	Access to diagnostics increased. Protocols on what to refer are developed. 85% of accepted referrals for CT scans and 75% of accepted referrals for MRI scans will receive their scans within 42 days.
	Achieve waiting times for diagnostic colonoscopy and surveillance colonoscopy.	50% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within 14 days, and 50% of people accepted for a diagnostic colonoscopy will receive their procedure within 42 days. 50% of people waiting for a surveillance or follow-up colonoscopy will wait no longer than 84 days beyond the planned date.
	Achieve waiting times for coronary angiography (provided by Auckland DHB).	85% of accepted referrals for elective coronary angiography will receive their procedure within 90 days.
	Northland clinicians will continue to ensure Northland patients have access to diagnostic services, including cardiology services provided by Auckland DHB, by prioritising and delivering services according to assigned priority.	Business as usual.
	PHOs' Primary Care Clinical Director to liaise with department heads to investigate the potential for direct referral by GPs to elective procedures in General Surgery, Orthopaedics and/or ENT. (Currently primary care has access to elective procedure lists without the need for patients to attend FSAs for endoscopy, ENT and skins (Lumps and Bumps Clinic). Discussions have commenced with the Orthopaedic department regarding GPs accessing elective procedure lists for	Referral process and protocol developed for each procedure.

Objectives	Actions	Measures
	some defined hand surgery.)	
	Continue to develop the e-referrals system whereby specialists triage referrals and either accept and prioritise them, or provide specialist advice and refer them back to GPs for management (this allows services to be provided closer to home, avoiding many first specialist appointments in outpatients). Develop protocols so the criteria on what is appropriate for referral are clear.	Protocols developed.
	Improve timely access to specialist nurse and/or medical advice in respiratory, diabetes and cardiovascular: • expanding and developing the electronic referral process to provide simple and comprehensive advice to referrers from primary care • trialling a nominated cardiologist of the week to facilitate improved access and advice for primary care.	Advice is made available to GPs. Use of specialist advice via e-referral system. Improved integrated COPD pathway.
	Develop business cases for Integrated Family Health Centres and Integrated Family Health Networks in Bay of Islands, Dargaville, Kaitaia, Whangarei (Otangarei, Raumanga, Tikipunga). Explore other sites for IFHCs and IFHNs.	Business cases developed.
	Implement same-day urgent access appointments across all general practices.	Appointments are made available in all general practices.
	Review opportunities for community nursing to become more integrated and responsive to primary care.	Review completed.
	Build on foundations established from Kaitaia telehealth outpatient clinics for oncology, orthopaedics, cardiology, renal, paediatric, allied health and extend to meet the needs of primary care providers; discussions are already underway with the PHOs.	Services designed and established that reflect the demonstrated needs of primary care.
	Minimise readmissions to hospital of people aged 75+.	9.7% of all age 75+ admissions (2% below the current national rate) (performance measure OS8).
	Continue NDHB's active participation in regional networks for cardiology, radiology and colonoscopy for the development and actioning regional plans and initiatives.	Continued NDHB involvement.

3.3 Health of older people

NRHP Goal Two: Life and years, health of older people priority

Objectives	Actions	Measures
Reduce the impact of stroke.	Continue development of dedicated services for people with stroke in line with NZ clinical guidelines and regional targets. Implement TIA pathway within the regional framework. Identify number of additional beds required to meet the stroke target by end of July 2013. Develop a business case with reinvestment options by end of October 2013. Implement to achieve target by June 2015. Complete current thrombolysis pathway development July 2013. Audit to identify process gaps Sep to Nov 2013. Implement any required change to meet target Dec 2013 to Feb 2014.	80% of acute stroke patients will be admitted to a stroke unit. 6% of acute stroke patients will receive thrombolysis. 5-year capacity identified.
Reduced readmissions and inappropriate admissions.	Strengthen discharge planning by: implementing the COPD pathway and clinics in primary health supporting the hospital to home clinic for heart failure completing the business case for reinvestment in supported discharge/ rehabilitation service (including rapid response, phase 2) by Oct 2013 secure investment for phase 1 actions and discharge service development Feb 2014.. Focus Gerontology Nurse Specialist activity on reducing readmission and inappropriate admissions for over 75s through transitional services and closer links with primary health.	Reduction in readmission rates and inappropriate admission rates for ages 75+ to 9.7% (2% below the current national rate) (performance measure OS8). Establish benchmark of NDHB's readmission rates with Northern Region and/or reducing inequalities DHBs.
Reduce the risk of variable service quality and failure of Home and Community Services in Northland.	All contracted home based support services will hold certification against the Home and Community Support Standards by 1 September 2013.	100% of providers to be certified by 1 September 2013.
	In partnership with HBSS providers review the cost implications for implementing the H&CSS. The review will focus on contracting and costing issues related to provision of services in rural areas.	Cost review completed by 31 October 2013.
	A HOP model of care will be developed to provide the framework for the review and development of Home and Community Support Services.	Model of care agreed by HOP Steering Group 30 September 2013.
	Home and Community Support Service Review and Development Plan.	31 October 2013
	Reinvestment Plan.	30 November 2013. Implementation subject to the acceptance of the reinvestment plan and business case.
	NDHB will utilise core quality measures at each level of management as identified by the DHB HOP Steering Group.	Timeframe: Once measures have been agreed by the DHB HOP Steering Group.
	In alignment with the MoH lead H&CSS complaints framework process, establish a baseline of complaints and incidents across home based support providers and use this as a basis for monitoring.	Home based support service contract providers' mechanisms for measuring client satisfaction in line with the national Home and Community Support Sector Standard will be evaluated (March 2013).
	Implement the Dementia Pathway so that people with	Reduce the annual rate of growth in

	dementia and their carers have access to best-practice dementia care.	dementia bed days from 7.1% (year ending Sep 2012) to 6.3% in 2013/14, thus reducing absolute growth from 615 bed days per year to 584.
	Complete the Dementia Pathway through the combined primary health and hospital working party. Complete Assessment and Diagnostic Pathway by 1 Aug 2013. Roll out to general practice by Dec 2013 and populate MedTech. Complete MoCA training in general practice and Alzheimers Society qualified workforce by Dec 2013. Review/ revise pathway following early implementation, Feb 2014. Actively participate in regional developments and agreed timelines for implementation.	Pathway implemented across all dementia-related services and aligned to regional dementia pathway development, thus avoiding duplication of effort such as referral systems and patient/ carer information resources.
	Identify one FTE within NDHB's specialist Health of Older People that is dedicated to supporting, advising and training professionals in primary care and aged residential care.	FTE identified and dedicated.
	Introduce new models of care by: • evaluating current resources for health of older people across the entire sector and identifying opportunities for their redistribution and reallocation • increasing availability of and access to services in primary and community settings, particularly restorative services.	Potential reallocation opportunities identified
Early identification of and intervention in abuse and neglect of older people.	NDHB and Age Concern Social Workers to develop local policy/ protocol and role clarification to achieve early identification and intervention in abuse and neglect of older people by 31 Sep 2013. NDHB and Age Concern Whangarei Elder Abuse Coordinator review the Elder Abuse Guidelines and carry out a gap assessment by Dec 2013. Workforce plan developed to enable NDHB's Family Violence Service to implement the national elder abuse guidelines. If necessary, business case developed for resources to address gaps, and develop workforce.	Protocol and role clarification developed by 31 Sep 2013. Gap assessment by Dec 2013. Workforce Plan by 31 Mar 2014. Business case by 30 June 2013.
Supporting older people in the community by linking them with existing primary and community services.	Realign SCOPE (Supporting Community wellness for Older PEople) contracts with NDHB's emergent HOP model of care, thus strengthening support for primary health care.	Devise indicators for measuring the impact of SCOPE on reducing hospital admissions and the need for both long term home support and age-related residential care.
Establish a Fracture Liaison Service.	Establish a multidisciplinary stakeholder group, with reference to regional modeling, by July. Identify requirements, by Sep. Complete business case with reinvestment options, by Nov. Identify funding pathway and complete implementation plan for July 2014 start (Jan 2014 to June 2014).	Fracture Liaison Service implantation plan in place
Support aged residential care facilities to implement Comprehensive Clinical Assessment	Support the InterRAI LTCF Training Programme within Northland, eg through liaising and recommending training venues to the Trainer Coordinator, and encouraging suitable people/facilities to attend the training sessions. Monitor the uptake of the training within Northland and raise any barriers or issues at the regional and national level.	Increase from 2 to 7 facilities that have completed training and using comprehensive clinical assessment (out of 23 ARRC providers within Northland).

3.4 Child health

NRHP Goal Two: Life and years, child and youth health priority

Objectives	Actions	Measures
More accessible and appropriate services for children through integrated models of care (medical, nursing, social).	As part of an April-Dec 2013 pilot in Decile 1 primary schools in Kaikohe, Otangarei and Manaia View, all PHNs will assess and treat skin infections, head lice/scabies, assessment and management of strep-A throat and carry out assessment and care coordination of chronic respiratory illness.	90% of students in decile 1-5 schools engaged in the pilot who are referred to the Public Health Nursing Service will receive HEADSSS/ SDQP assessment. 100% of all referred pupils will be assessed and treated as appropriate.
	Redesign and strengthen models of integrated health care for under-5-year-olds with WCTO providers and NDHB services. NDHB will ensure that any changes to the tier two national service specifications for WCTO regarding early childhood education will be promoted with WCTO providers. NDHB will implement the WCTO Quality Improvement Framework within six months of the national roll-out.	For Maori children aged 0-4 years, 10% reduction from 2010/11 rate in ASH, for cellulitis and post-strep GN. *Cellulitis annual admissions age 0-4:* Baseline (11 years data averaged) 61 Target 2013/14 55 *Post-strep GN Maori age 0-4 admissions:* Baseline 2011 34 Target 2013/14 <30
	Increased participation in early child hood education: • visit kindergartens, kohanga reo and play centres a minimum of 2 times per year • for other ECEs, visit as asked and required • develop a system for identifying whether children presenting to the Public Health Nursing service or the Child Health Service are engaged in early childhood education, and provide information to whanau on the benefits of early childhood education • use data from existing databases such as B4SC or MIS reporting systems as an aid to monitoring coverage of children in ECE.	Number of visits to ECEs. Report in Q2 and Q4 on progress to develop ECE.
	NDHB will participate and provide governance support through the NDHB Child and Youth Clinical Director to the B4SC Governance Group, and will ensure that the NDHB continues provision of the vision and hearing screening component of the B4SC.	Attendance at Governance Group meetings evidenced by minutes. By quarterly monitoring of hearing and vision screening, referral and outcome data to ensure compliance with target.
	Pilot telehealth models of service delivery for NDHB's paediatric services in 2013/14.	Number of successful consults completed during the pilot phase.
	Develop and implement a pilot project to trial a paediatric community based clinic within an Integrated Family Health Centre in order to move services closer to the community.	Pilot designed and implemented in 2013/14.
	NDHB has renewed the B4SC agreement with the current provider for 2013/14 which incorporates MoH target volumes for that period and provider has confirmed their ability to meet targets.	90% of children receive B4SC.
	Universal free after-hours services for under 6s is in place, with funding agreements with Northland PHOs to ensure ongoing provision.	100% free after-hours services for under 6s.
Reduced incidence of rheumatic fever in Northland.	Develop and implement a Rheumatic Fever Plan by Oct 2013. This will include: Implement a health promotion/ communications plan for rheumatic fever ("sore throats matter"). Define referral pathways to healthy homes in child and maternal health services. Identify ways of continuing some throat swabbing	Hospitalisation rate per 100,000 DHB total population for acute rheumatic fever is 10% lower than the average over the last 3 years (measured by National Minimum Data Set); for Northland this means the number of people diagnosed will reduce from a three-year average of 17 to 15 (9.5/100,000) in 2013/14.

Objectives	Actions	Measures
	services in schools through public health nurses. Increase primary care utilisation of the MedTech Sore Throat clinical guidelines, and audit compliance by end of 2013 with the National Heart Foundation 2008/ NZ Primary Care 2011 Sore Throat guidelines in primary care. NDHB is working with the MoH regarding future funding for throat swabbing services within Northland from July 2014.	
Improved response to housing-related communicable diseases.	Maximise referrals to Healthy Homes Te Tai Tokerau by improving the referral pathway. Increase awareness among whanau and health staff of housing conditions and their association with infectious diseases, particularly rheumatic fever. Participate in MoH's retrospective national survey of rheumatic fever clients and their housing. Investigate other approaches including: • supporting qualitative research by Te Kupenga Hauora Maori with whanau of rheumatic fever clients • advocacy to Housing NZ and Northland Housing Form, Iwi and Runanga to improve housing policy and practice.	As above for rheumatic fever. Reduced incidence of other communicable diseases related to housing.
Improved oral health in children and youth.	Develop an oral health promotion implementation plan for Northland by 2014, including: • promoting healthy diet and nutrition among all Northlanders, but particularly preschoolers, children and adolescents • promoting healthy diet and "Lift the Lip" among new mums • encourage and promote oral hygiene, particularly in early childhood centres, through programmes such as daily supervised tooth-brushing and oral health care with emphasis on the use of fluoride toothpaste.	2013/14 targets (8 Non-Health Target performance measures) for: • PP10 DMFT Y8 • PP11 caries-free age 5 • PP12 adolescent utilisation • PP13 child enrolments. Hospital admissions for ASH dental conditions for ages 2-6: Baseline 2011 238 Target 2018 190 Annual number of general anaesthesia dental procedures for ages 2-6: Baseline 2011 350 Target 2018 280
Safer, healthier children.	Participate in the implementation of the Vulnerable Children's Team as outlined in the 2012 white paper "Whangarei demonstration site" to: • help improve outcomes for vulnerable children • contribute to a reduction in the number of child assaults (which supports the Prime Minister's Better Public Services key result area for vulnerable children).	Establish baseline figures for child assaults and agree target reduction for 2013/14.
	Clear process and criteria for Reports of Concern have been established. VIP training will progress as per NDHB VIP Programme Plan. All referral pathways including timeframes reflect best practice and partnership with CYF. The National Child Protection Alert System Agreement will be signed off. Implementation plan will be completed as per agreement. Once all criteria have been met NDHB will commence the Alert System. MoU with CYF, NZ Police and NDHB signed. Reviewed as per agreed timeframe. We will meet with our partner agencies at a minimum of twice per year to discuss the programme and ensure compliance with the MoU. The Shaken Baby Prevention Programme will be implemented within NDHB. This will be incorporated	Quarterly audit of quality and timeliness of Reports of Concerns. Pre- and post-workshop evaluations with training. Quarterly monitoring of screening rates. National Child Protection Alert System is implemented as per MoH guidelines. The Shaken Baby Programme is implemented within the NDHB VIP Training Programme.

Objectives	Actions	Measures
	into the VIP Training Programme.	
	Ensure health governance arrangements are in place to support the successful implementation of Children's Teams.	Governance structure confirmed and in place and functioning effectively.
	Ensure appropriate and effective representation of NDHB health professionals on Children's Teams.	Health professionals identified and engaged in the Children's Teams.
	Agree with the Regional Children's Director, the health sector arrangements for the Children's Team and the associated service response.	Health sector arrangements and associated service response are agreed and documented.
	Contribute to the development, implementation and review of a common assessment framework, care planning tools and referral thresholds for Children's Teams.	Common assessment framework is developed and implemented. Care planning tools are agreed and utilised. Referral threshold is agreed.
	Support, or progress planning to support, all frontline staff and employees of all contracted services and providers who work with children, to undertake any necessary training to implement Children's Action Plan initiatives.	Plan developed and training implemented.
	Contribute to the evaluation of the Children's Team demonstration site initiative, including identifying areas for health service development, and share findings within NDHB's district, with other DHBs and with DHB regions.	Participate in any Children's Team evaluation and contribute to identifying areas for health service development and improvement.
Improved daily nutritional intake by primary school-aged children in Northland.	PHNs and Health Promoting Schools Advisors continue to support and encourage eligible primary schools to participate in the Fonterra Milk For Schools (MFS) and the Fruit in Schools (FIS) programmes.	All eligible primary schools in Northland will be supported and encouraged to participate in the MFS and FIS programmes.

3.5 Youth health

NRHP Goal Two: Life and years, child and youth health priority

Objectives	Actions	Measures
More responsive and appropriate services for youth.	To improve access for youth to primary care, further progress the development of new models of care within the community setting. Support more effective, youth-responsive services (sites include Te Aroha Noa Youth Clinic, Youth Space project, Youth Justice Pilot and Foyer Project, residential housing and support services for youth). Continue HEADSSS assessments to Yr 9 students in Decile 1 & 2 schools and include all Decile 3 schools as per MoH guidelines by December 2013. Commence roll-out to Kaipara and Whangarei Decile 3 schools by August 2013 and the rest of Northland by December 2013.	Increased numbers of youth attending primary care. Reduction of youth accessing ED as their primary care provider: *12-24 year olds with a ED triage level of 4 and 5* Baseline 2012 CY 3,805 Target Dec 2014 3,424
	Secondary schools: PHNs will carry out HEADSSS assessments, referring on when indicated and following up outcomes of referral, for all Year 9 students in decile 1-3 schools, and for students of concern in decile 4 -5 schools. Continue Public Health Nurse self-referral clinics in all high schools offering pregnancy tests, dhlamydia screening and treatment. Also picking up on youth at risk of bullying and violence and notifying the appropriate department heads in the school environment(s). PHN workforce will have access to ongoing professional development in HEADSSS assessment training and updates. Train PHNs in HEADSSS assessment.	90% of Year 9 students in decile 1-3 schools will receive HEADSSS assessments and appropriate follow up. 90% of students of concern in Decile 1-5 schools who are referred to the Public Health Nursing Service will receive HEADSSS/ SDQP assessment. 100% of all PHNs will be trained in delivering HEADSSS assessments.
	Northland PHOs and NDHB, working collaboratively with education services, to develop a new integrated model for school-based health services, focused on identified high need schools, teen parent and alternative education facilities that include physical and mental health, youth development and wellness checks, and health promotion.	New model of care developed.
	NPHOS to include HEEADSSS training in the primary care nursing credentialling project to increase the use of youth-appropriate wellness checks in primary care settings.	Audit use of HEADSSS.
	Deliver Gateway assessments to young people within CYF care.	100% of children seen within 6 weeks of all necessary documentation being received by the Gateway Coordinator, as per MoH guidelines.
	Be involved in the establishment of a Youth Space in Whangarei as a centre of excellence, innovation and leadership, that: • has shared governance and participation of young people in its operations • is based on a youth development framework • has a kaupapa of improving access to multi-sector services, 'youth' social enterprise and life skill development, community engagement and positive role-modelling • provides social and recreational activities • provides HEEADSSS wellness checks and primary care health services • provide leadership input and support for the intersectoral Social Wellbeing Governance Group	Establishment of the facility.

Objectives	Actions	Measures
	which has membership from leadership of iwi and all government agencies.	
Improved access for youth to mental health and addictions services. Services that are more youth-responsive. Respond to Government work programmes for: • youth mental health initiatives • drivers of crime • implementation of the Suicide Action Plan • welfare reforms.	As part of the Northland Suicide Action Plan (3.9 Mental health), establish a plan to deal with youth suicides, particularly for Maori youth.	Plan established.
	Expand primary mental health services to all youth aged 12-19 and their families: • joint decision making process and collaboration established with primary care partners and school-based health services (including alternative education students) to increase primary mental health interventions and responsiveness to youth, using resources reprioritised from Community Pharmacy funding • develop youth care pathways designed and supported by primary care partners, community and hospital services, including meeting Maori youth needs • support expansion of Youth AOD Helpline service by primary care providers across Northland as part of stepped-care AOD service provision. Work with primary care providers to implement internet-based e-therapy for youth that is being developed by MoH, if funding permits. In collaboration with local partners, undertake a stocktake of primary and community services for youth aged 12-19 by Dec 2013, and identify concrete and targeted actions during 2013/14.	Establish baseline data on the rates and types of referrals to primary mental health services (starting point is matching the age groups used in data by PHOs and Primary Mental Health Initiative providers). Set targets once baseline data is assembled.
	Increase access to the new Youth AOD Helpline services including primary care providers.	Establish baseline of number of calls to Youth AOD Helpline in Northland and distribution of calls throughout rohe.
	Collect data on youth referred between CAMHS / youth AOD services and primary care to enable the identification of ways to improve collaboration and information sharing, and to develop services most appropriate to the needs of youth.	Baseline data established.
	Enhance follow up of child and youth discharged from CAMHS/ AOD: • primary provider identified upon entry to service • implement 6 week post discharge follow up phone call by Dec 2013 • review template for discharge to include relapse prevention strategies by Sep 2013 • recovery plans sent to primary providers • work with PHOs to develop a system to monitor follow-up post discharge by Mar 2014.	95% contacted within 6 weeks 95% of recovery plans sent
	Implement phased waiting time targets for youth that by 2015 enable: • 80% to access services within 3 weeks of contact • 95% to access services within 8 weeks of contact.	In 2013/14: • 75% of youth access services within 3 weeks of contact • 90% of youth access services within 8 weeks of contact.
	Establish care pathways from specialist CAMHS to child and youth MHA support services.	Establish baseline of number of referrals to child and youth MHA support services in 2012/13.
	Collect data on the recently established child and youth specialist AOD services to determine the rates and types of referrals to it.	Meet the child- and youth-related targets (see 8 Non-Health Target performance measures) for: • PP6 improving the health status of people with severe mental illness through improved access • PP8 shorter waits for non-urgent mental health and addiction services.

Objectives	Actions	Measures
		Increase annual volumes by 5% in 2013/14.
Children of Parents with Mental Illness and Addictions (COPMIA)	Promote the wellbeing and reduce the risks associated with mental illness for infants, children, adolescents and their parents/ carers and families. Identify and provide responsive services for families where a parent has a mental illness. Strengthen the capacity of interagency partners to recognise and respond to the needs of children of parents with mental health problems. Support the workforce to provide appropriate family focused interventions and care to parents with a mental illness, their children and families. *[See also the first action under 3.9 Mental Health.]*	All Mental Health and Addiction Services staff to have undertaken training by end of 2013. Coordination and liaison between Mental Health Services, community providers and other agencies regarding activities, programmes and educational sessions for families. Development of educational/ training resources.

3.6 Maternal health

Objectives	Actions	Measures
Reduced health risks among expectant mothers.	Identify specific actions to embed the Maternity Quality and Safety programme as business as usual by June 2015.	95% of hospitalized women will be provided with advice and help to quit smoking.
	Maternity Services Governance Group will develop, approve, commission and distribute an information poster for display in areas where pregnant women visit that: • advertises how to access a midwife • encourages early engagement • includes contact numbers of maternity units including free phone numbers • includes directions to web pages through the NZ College of Midwives. The names and contact numbers of all LMCs will be available to all women through all NDHB antenatal services.	Three-monthly monitoring of the number of women enrolled by 12 weeks by PHO.
	All midwives will encourage any woman who has not seen their GP in the previous two years to contact the practice and ensure they are still enrolled or to re-enrol. NDHB Maternity Services will also provide a consent form to give to women without a GP that will allow maternity services to forward the woman's name to their local PHO who will then provide assistance to the woman to find a GP within her locality.	Three-monthly monitoring of the number of consent forms sent to the PHOs.
	Smoking screening to be completed by all Lead Maternity Carers at antenatal booking visit and to be documented in records.	90% compliance confirmed by audit.
	Smoking cessation screening will be completed on each hospital admission and brief intervention advice given.	90% compliance confirmed by audit.
	Hold a marae-based train-the-trainer breastfeeding programme. Commission new Maternity Unit in 2014, and introduce new models of care to improve care coordination from antenatal to postnatal. Introduce Baby Friendly Community Initiative.	Exclusive and full breastfeeding rates, for Maori and non-Maori: • at 6 weeks, at least 78% • at 3 months, at least 65% • at 6 months, at least 28%.
	Reduce sudden unexpected death in infancy (SUDI) by: • ensure the national SUDI toolkit is utilised by all health providers working with mums and babies, particularly with regard to consistent messages for bed sharing, breastfeeding and smoking • a safe sleep policy, aligned with regional policy, is developed, shared and agreed (led by Regional Child Health Group) • safe sleep practices are consistently modelled in by all health professionals.	Reduce 5-year rolling average of SUDI-related deaths for Northland Maori from 3.48 per 1000 live births to the non-Maori rate of <0.5. Assemble valid baseline data on the number of pregnant Maori women accessing smoking cessation programmes. Use this to set target figures to increase it.
	Review and strengthen systems and processes of health providers to ensure standardisation of the information related to SUDI risk communicated at patient care transition points: community to hospital, hospital to hospital, hospital to community. Increase the number of midwives who are quit card providers and increase referrals for follow-up in primary care as part of maternity discharges. All health professionals working with women and infants demonstrate attainment in agreed training modules that provide the necessary skills and resources required to deliver consistent verbal and written advice on SUDI Prevention. Training to be based on the MoH Toolkit	SUDI risk is communicated in all relevant patient documentation at transition of care points between NDHB service providers and from NDHB to others (verified by audit). Evidence of increase in the number of midwives who are quit card providers and increase in the number of referrals for follow-up in primary care as part of maternity discharges. E-learning/ workshop training modules uptake.

Objectives	Actions	Measures
	and delivered across the region. Support "train the trainers" approach. Day Care Centres and Te Kohanga Reo who have infants in their care under one year of age demonstrate awareness of safe sleep practices and are equipped with SUDI information. Work with LMCs and within maternity services to enable clinicians to support pregnant women who smoke to quit by increasing the number of women referred to smoking cessation services. Progress the provider alliance model of smoking cessation such as the Hapunga Auahi Kore. Consistent messages, regarding safe infant sleeping, increased breastfeeding and reduced smoke exposure in-utero and to infants, are delivered to mothers and whanau in all in maternal and infant health settings. This includes identification and SUDI risk factor training of champions. Families are provided with education and supports tailored to their level of need about safe sleeping and the hazards that arise in some sleeping situations. Support the identification, development and resource where needed, of additional models of care and support for vulnerable mothers and babies. Explore options and resources for models of kaupapa Maori antenatal courses for pregnant women and whanau. Safe sleeping arrangements are available for all infants after they are discharged home. Pilot a programme with SCBU and NDHB midwives of SUDI risk factor assessment, care coordination and wahakura provision. Support implementation of marae-based Wahakura model of antenatal preparation with Maori providers.	Audit of content of training to ensure consistency of the messages across the region within two years. Establish a system to collect valid and complete data on the percentage of pregnant women who smoke.
	The development of perinatal and infant mental health and alcohol and other drug services on ways to address mental health and AOD needs of Maori mothers and infants.	Following 3 training workshops for midwives in February, April and May 2013 will: Increase referrals from midwives to AOD Helpline by 25% between May 2013 and May 2014. Increase referrals for assessment to AOD by 50% between May 2013 and May 2014. Monitor the trend in referrals from midwives to Maori Mental Health between May 2013 and May 2014.
	Healthy beginnings Strengthen collaboration and coordination of services for maternal mental health. Workforce training for infant mental health. Develop referral pathway for infant mental health.	Pathway of care for infant mental health. Increase in the percentage of maternal and infant access to Mental Health Services.
	Provide training to Lead Maternity Carers on identification of depression and referral pathways to support services by specialist MHA clinicians.	50% of Lead Maternity Carers attend maternal depression training by December 2013.
	Implement, if funded, the programme for the provision of antenatal nutritional and physical activity promotion (based on the request for proposal submitted by NDHB, the PHOs and Northland Whanau Ora Collectives; lead provider would be Te Pu O Te Wheke).	Dependent on funding.

3.7 Long term conditions

NRHP Goal Two: Life and years, stroke priority, respiratory disease priority, cardiovascular disease priority, diabetes priority

Other sections deal with cancer (3.1.3 Short waits for cancer treatment), diabetes and cardiovascular disease (3.1.6 More heart and diabetes checks), and risk factors lying behind LTCs (3.1.5 Better help for smokers to quit). Measures relating to LTCs are contained within Module 8 (PP20, PP24, PP28). This section addresses overall LTC activity.

Objectives	Actions	Measures
Reduce readmissions.	Implement the COPD clinical pathway across the hospital setting and pilot across a small group of GP practices: By Q1 collect baseline data for COPD Maori and non-Maori patients. By Q1 develop feasible measures for reporting against baselines with equity measure. By Q2 develop the reporting format and mitigate IT barriers. By Q3 implement regular reporting of H2H COPD measures and readmissions data.	Reduce the readmission rate for COPD diagnosed patients (Maori and non-Maori) from 29% to 15% by June 2015. General practice pilot sites identified and engaged. Report format in place, measurements agreed. Report the readmissions rate of COPD diagnosed patients (ethnicity and age for Maori and non-Maori). All patients diagnosed with COPD are placed on the COPD Clinical Pathway, issued a blue card and offered an ACP conversation.
Self-management model in place.	Implementation of Stanford model for long term conditions: By Q1 develop baseline data for engagement levels for Maori and non-Maori patients enrolled on Care Plus programmes. By Q1 set the proportion of Maori and non-Maori patients enrolled on Care Plus who will be offered the Stanford tool. By Q2 develop the reporting for monitoring uptake of self management programmes. By Q3 develop online patient survey tool to assess patient efficacy regarding the tool.	Increase facilitators from existing baseline by 15%. Report the % of patients offered the Stanford tool by disease stream, by ethnicity and age. Survey tool developed and tested.
ACP work force development in hospital setting: Northland patients with advancing long term conditions who are admitted to hospital are offered ACP conversations, with the following areas targeted: lung and bowel cancer, H2H heart failure and H2H COPD, renal and medical outreach.	Baseline (June 2013) ACP L2 practitioners = 22: By Q4 increase the number of ACP L2 practitioners by 24% to baseline. By Q4 Increase the number of ACP L1 practitioners by 30% to baseline. By Q1 agree workforce development targets for staff in ACP L1 online training and ACP L2. Q3 develop reporting platforms for ACP workforce development (Trendcare).	All patients diagnosed with a high suspicion of lung and/or bowel cancer are offered ACP conversations; All H2H Heart failure patients are offered ACP conversations as part of the hospital bundle of care. All H2H COPD patients are offered ACP conversations as part of the hospital bundle of care.
ACP work force development community setting: work collaboratively with older peoples' community groups to promote and build awareness of ACP and identify community champions.	By Q1 identify the baseline number of consumer networks in Northland to build awareness. By Q2 identify the level of support for ACP by consumer networks. By Q3 identify ACP consumer representatives for ACP training.	Number of community group sessions undertaken. Number of consumer representatives identified for ACP training.
Develop a risk stratification tool for Care Plus to target interventions for people at high risk of readmission.	Investigate the use of the risk stratification tools identified at the LTC Workshop (implement the tool and allocate care bundles to high-risk patient bundles).	Report the number of Maori and non-Maori patients enrolled on the Care Plus programme who have been afforded a risk stratification category.

Objectives	Actions	Measures
	Information initiatives By Q1 develop baseline data for care plus programme enrollees (ethnicity, age, LTCs). By Q2 develop data matching between hospital admissions data and PHO Care Plus programme enrollees. By Q3 set the % measure for each stratification level for Maori and non-Maori. By Q1 develop the IT platform for monitoring ACP activity across the hospital settings. By Q2 trial the IT platform for monitoring ACP.	Report the % of Maori and non-Maori who are receiving the new care bundles in accordance to their risk stratification category.
Reduce the level of overweight and obesity.	Work with the early childhood sector to support healthy physical activity and nutrition policies consistent with MoH Food and Nutrition Guidelines.	Number of Early Childhood Centres, Kindergarten or Kohanga Reo completing continuing education and policy workshops.
	Implement Project Energise in primary level schools.	Number of participating schools.
	Promote the messages contained in the New Zealand Food and Nutrition Guidelines and the Physical Activity Guidelines to increase the level of community awareness about the benefits of healthy physical activity and nutrition.	Social marketing and media evaluations.
Achieve clinically appropriate, timely and equitable levels of access across the region, and optimally manage the patient journey from the community through primary, secondary and tertiary care settings. Information sharing between secondary and tertiary care is supported with appropriate IT capacity.	Manage CVD across the continuum of care Improve CVD assessment and management rates across the sector by continuing to support the implementation of key CVD risk recommendations. All patients on the H2H heart failure stream receive the blue card of their current health status. All patients on the H2H heart failure stream are offered Advance Care Planning (ACP) conversations as part of the hospital bundle of care. Widen the H2H heart failure bundles of care to include the primary care bundle for transition back to the general practice. Establish quality improvement groups in NDHB's cardiology department to support the regional initiatives and KPI targets. Investigate and develop a reporting mechanism to track the number of patients on the H2H heart failure stream and those in receipt of blue cards and ACP conversations. Maintain cardiac surgery to nationally agreed targets. Aim for 95% of outpatient echocardiograms to have been completed within 5 months of referral. Implement new models of care to better meet demand and improve quality of care across the continuum: • support Cardiac Nurse Specialists' attendance at the annual regional forum to share existing models of care across primary health and hospital levels. • support the development process to maintain acute coronary syndrome (ACS) guidelines as a living document to allow for continuous improvement. • NDHB will participate in the development of the regional primary PCI service developed in collaboration with St John Ambulance Services	90% of outpatient coronary angiograms to be seen within three months. 70% of patients referred for angiography presenting with ACS to be seen within three days of admission. 80% of patients presenting with STEMI referred for PCI] will be treated within 120 minutes. 80% of all outpatients triaged to chest pain clinics to be seen within six weeks for cardiology assessment and stress testing. By June 2014, 90% of eligible patients will have had a cardiovascular risk assessment in the last five years (Health Target). >95% of patients presenting with acute coronary syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection.

Objectives	Actions	Measures
	and Emergency Departments to improve transit times for selected patients • NDHB will support the development of a regional plan for electrophysiology services to better meet patient demand. NDHB will work collaboratively with the Northern Regional Cardiac Network to implement acute Predict within the hospital setting, improve access to echocardiogram for the heart failure stream and other conditions, including those requiring cardiac surgery.	

3.8 Whanau Ora

NRHP goal: Life and years (reducing disparities and achieving longer, healthier and more productive lives); Goal: The informed patient (ensuring patients and their whanau get care, information and support appropriate to their context)

Objectives	Actions	Measures
Increase the number of Northlanders who are health literate and living healthy lifestyles, with a particular focus on improving Maori health outcomes.	Support Whanau Ora Collectives through: • continued participation on the Whanau Ora Regional Leadership Group to maintain relationships with other agencies • continuing discussions on integrated contracting processes • NDHB continue to meet with Maori Health Gains Council (Hei Mangai Hauora Mo Te Waka A Taonui) at a governance level to discuss Maori health outcomes where Whanau Ora is a regular agenda item.	NDHB representation at meetings to ensure relationships are maintained and kept informed of health priorities. Ongoing discussions held with providers who have signalled a desire to enter into integrated contracts. Maori Health Gains Council issues identified and resolved.
Ensure patients and whanau are supported throughout their care pathways with early interventions to address health needs and risks, and linked with social services.	Support Whanau Ora Collectives to use a Results Based Accountability framework to report on whanau outcomes. Continue Whanau Ora Collective participation on the NHSP Oversight Group, where discussion occurs on key health issues and system changes to improve Maori health outcomes, to strengthen capability and capacity across WO management and service delivery.	RBA reporting templates adopted in service contracts after the value for money review. Whanau Ora Collective participation on NHSP Oversight Group.
Enhanced ability to measure progress on reducing inequalities.	Strengthen Maori health planning and intelligence by capturing, analysing and reporting on Maori and non-Maori data in all key areas of progress, including: • all national measures, including Health Targets and other quarterly performance measures • the Northland Health Services Plan's Headline Actions.	Maori and non-Maori data is captured, analysed and reported in all areas.
	Develop a Maori Health Dashboard that captures key measures concerning Maori health and reducing inequalities and report this to the Board, the Maori Health Gains Council and ELT.	Dashboard developed and circulated.
Strengthened Maori workforce capability and capacity.	Consolidate Kia Ora Hauora activity in supporting more Maori into health careers. Deliver health science camps to Year 9-10 Maori students. Nurture and support Maori Year 12-13 students to become rangatahi Kia Ora Hauora champions. Work with MoH and Maori providers to develop a Maori provider sustainability framework to inform future allocation and investment of Maori Provider Development Subsidy (MPDS) funding.	Increased number of Maori registered on the Kia Ora Haoura database that reside Northland. Health science camps delivered and attended by Northland college students. One student identified and supported to take up the role of Kia Ora Hauora champion. Effective use of MPDS to increase the capability and capacity of Maori providers

3.9 Mental health

NRHP Goal Two: Life and years, mental health and addictions priority

Note that mental health and addiction services for children and youth are addressed in 3.4 Child health and 3.5 Youth health, and for mothers-to-be in 3.6 Maternal health.

Objectives	Actions	Measures
Build the infrastructure for integration between primary and specialist services. Cement and build on gains in resilience and recovery for the most vulnerable.	Implement and evaluate the children of parents with mental illness and addictions (COPMIA) project, a joint project between community providers and CAMHS.	COPMIA Project evaluation report completed by 30 December 2014.
	Provide training for primary care providers on AOD identification and referral pathways involving AOD clinicians.	50% of primary care providers attend AOD training by December 2013.
	To enhance the confidence and capability of the primary care workforce: • introduce mental health credentialling for four primary care nurses through Manaia PHO as a pilot project • circulate the primary mental health toolkit through all Te Tai Tokerau PHO practices and provide support to practices.	Four nurses complete training under Manaia PHO. Toolkit circulated to all Te Tai Tokerau PHO practices.
	Complete the development of the new electronic primary mental health tool for referral, clinical feedback and reporting in primary care.	All primary mental health coordinators have access to a fully functioning tool.
	Clients of community support services are supported to attend GP/ primary care services every 12 months to address physical health needs.	Increase from current 80% to 85% by the end of 2014/15. 90% of JADE records identify GP details by Dec 2013.
	Increase the number of clients who have planned discharges from AOD Residential Treatment Programmes.	Increase planned discharges from AOD Residential Programmes from current 80% to 85% by 30 June 2013.
	Increase smoking cessation and support to clients of Community Mental Health and Addiction support services.	Increase smoking cessation and advice provided to clients from current 75% to 80% by the end of 2013/14.
	Increase social inclusion outcomes for clients of community specialist mental health services (community provider-provided).	Increase from current 30% to 35% by the end of 2014/15.
	Establish through community and intersectoral collaboration a Northland Suicide Action Plan by 30 June 2013.	Reduction in number of suicides in Northland during 2013/14.
	Increase the number of facilitators of Drive Soba Programmes (DSP) and increase access to DSP throughout Northland, if sufficient funding is received from MoH.	10 community provider staff complete DSP facilitator training by 30 December 2013.
	Review clinical processes to increase productivity.	35% of community service time will be spent in direct contact with service users by June 2014.
Value for money	NDHB is participating in the KPI Framework Project led by NRA and funded by MoH. This is a quality and performance improvement tool to improve outcomes for people accessing mental health and addictions services.	Measurement of milestones in the patient journey. Increase in staff productivity.
	Community providers have been trained in Results Based Accountability (RBA) reporting. There has been a voluntary agreement to report using RBA.	100% community providers consistently utilising RBA approach by Dec 2013.
Welfare reforms	Community providers to actively promote training, education and employment as part of clients' recovery plans, with referral systems and feedback from WINZ.	Increase in number of people with mental illness in employment, training and education (baseline to be established). Quarterly performance monitoring returns to show increase in number in

Objectives	Actions	Measures
		employment, training and education.
Regional activities	Work collaboratively with Auckland DHBs to reach regional targets.	NRHP quarterly reporting,.

3.10 Quality and safety

NRHP Goal one: First, do no harm (reducing harm and improving patient safety)

Objectives	Actions	Measures
Transparency and accountability for performance on quality and safety across the health sector in Northland	Work with HQSC, the National Patient Safety Committee and the regional First Do No Harm project to establish by June 2013 a system of Quality Accounts for NDHB that: • has meaningful and relevant measures • focuses on whole-of-system performance • focuses on continuous quality improvement. *(The intention is to expand the Quality Accounts to encompass primary care in future years.)*	Zero harm from falls while in hospital (plan available on Quality and Improvement Directorate [QID] section of NDHB's intranet webpage). Zero pressure areas while in a Northland DHB hospital (plan available on QID intranet webpage). 90% compliance with the use of the surgical checklist (plan available June 2013). 90% compliance with recommended hand hygiene practices (plan available June 2013). Zero central line infections (plan available on QID intranet webpage). Medicine reconciliation: complete 63% of those initiated (that is, 90% of the 70% initiated) (plan available on QID intranet webpage).
	Venous Thromboembolism (VTE) Project. Implement an evidenced-based VTE assessment tool that is used for all adult admissions in NDHB. (Plan available on QID intranet webpage).	By Dec 2013. Linked to HQSC campaigns on patient safety and reducing surgical harm.
	Surgical Site Infections (SSI) Project. Reduce SSIs. (Plan will be available on QID intranet webpage).	By 40% compared to the 2012 baseline by May 2013 (TBC). Linked to HQSC campaigns on patient safety, reducing HAI and reducing surgical harm.
	Patient experience surveys. Using Touching Base programme, iPads and intercept surveys, survey consumers/ patients/ whanau on their healthcare experiences and whether they would recommend our service/ hospital to their friends/ family/ whanau. (Plan will be available on QID intranet webpage).	70% net promoter score by May 2014. Linked with HQSC and KPMG improving the patient experience.
	Global Trigger Tools (GTTs). Collect and analyse GTT data and use this to further develop areas for improvement.	Stage one completed Dec 2013.
	Clinical audit tool. Redesign current process and tool, and implement a feedback loop to clinical staff and managers. (Plan not yet available).	By Dec 2013.
	Development of a Quality Improvement Guideline.	Available on QID intranet web site July 2013.
	SUDI Project: The pilot project aims to: • improve the consistency of safe sleep messages (particularly in regard to bed-sharing and maternal smoking) • offer a wahakura or pepipod. Key components are: • a SUDI risk assessment tool (sticker in the clinical record) • a referral form to the pilot project facilitators • contact made with mother and offer of either a pepipod or wahakura • notifying both LMCs/midwives and WCTO providers that the mother is in the project • approximately 2 months post-birth of the baby, complete a survey to obtain feedback from both LMCs/ midwives and WCTO providers.	In 2013/14, a significant reduction in the 5-year rolling average of SUDI-related deaths per 1,000 live births for Maori (3.48:1,000) towards that of non Maori (<0.5:1,000) by December 30 2017.

Objectives	Actions	Measures
	Develop a “do no harm” training package as part of the regional project that covers areas of risk in primary health care such as medication errors, transfer of care and errors of omission.	Package completed. 80% of GPs participate in training.
	Implement audit process for an agreed number of adverse events in primary care and review in peer groups.	80% of GPs attend training. 100% of known significant events are audited.

3.11 Living within our means

NRHP Triple Aim: Cost and productivity; Driver for change: financial sustainability

Objectives	Actions	Measures
Cost and productivity: the Northland health system will live within available funding by improving productivity and prioritising resources to their most cost-effective uses.	Establish whole-of-system productivity and cost savings governance and management framework.	Framework established and documented. 12 month rolling forward action plan, across various streams as outlined below, is widely communicated within NDHB.
	Undertake detailed analysis of inter-district flows to explore opportunities for service improvement and cost savings. Particular areas of focus for 2013-14 include: • oncology • labs • sleep apnoea • ear nose and throat • neonatal intensive care • gastroenterology.	$300k of IDF funds identified for redirection to Northland-based front-line services.
	Actively manage staff costs by reviewing vacancies, reducing use of locums, reviewing shift and on-call patterns, reviewing use of patient watch, and other non-planned activity.	Staff costs are held to 2012/13 levels.
	Back-office procurement: work with healthAlliance to agree and deliver a programme of NDHB procurement savings projects in line with Northern Region and HBL activity. Manage and deliver on the savings.	$3M savings reported through agreed monthly savings reports.
	Back-office supply chain: work with healthAlliance to deliver an agreed programme of Supply Chain savings (including reducing footprint and product lines of Central Stores and reducing imprest inventory levels).	Inventory levels reduced by 5%. Wastage and obsolete stock reduced by 20%. Product lines in stores reduced by 10%.
	Back-office other: continue systematically reducing other back-office costs, including: • continue review of telecommunications contracts and services • review size and use of cars fleet.	$200k savings recorded.
	Conduct a review of internal processes for managing ACC applications to reduce omissions and rejections.	Revenue increased by $300k over 2012/13 levels (adjusted for volumes).
	Introduce paid car parking for staff and public to provide more equitable access.	Net revenue of $200k, reinvested to improve facilities.
	Establish service development and strategic investment funds by each service running small, managed value for money programmes. Examples of planned initiatives include: • Blood is a gift • reduced biohazard waste • community provider contracts review • laboratory demand management.	$1.8M savings recorded (50% released to service development and strategic investment funds).

4 Stewardship

4.1 Managing the organisation

Six General Managers report to the Chief Executive. Four GMs oversee NDHB's clinical service areas (surgery, medicine, mental health, paediatrics, maternity, health of older people, and clinical support services such as labs and imaging) as well as maintaining a strategic overview of the health sector. The other two GMs are responsible for managing the business and finances of Northland DHB, and maintaining strategic and planning oversight of the health sector.

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

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

4.2 Monitoring finance and performance

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

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

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

4.3 Managing finances

NRHP Triple Aim: Cost and productivity; Driver for change: financial sustainability

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

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

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

4.4 Managing assets

NRHP enabler: Facilities and capital

We monitor the condition and performance of our assets and formulate priorities for physical works using project planning, life cycle analysis and asset management for prioritising asset maintenance. With shared services, greater emphasis will be placed on asset management planning from a regional perspective alongside the Auckland DHBs.

A number of new building projects are in the pipeline. Design of the new Maternity Unit nears completion, with construction scheduled to commence in September 2013. The design of the Cancer Centre will be

finished by the end of March 2013, and construction can then commence subject to funding. A concept design for a new-build laboratory has been completed, and options are also being developed for the laboratory to be retained within the hospital. The Kitchen project is on hold pending the outcome of the HBL national food services procurement process. Options for Whangarei office accommodation are being considered. A revision of the Whangarei Hospital Site Master Plan is underway which will reconsider future options. Redevelopment of BOI Hospital is being considered.

4.5 Community providers

Four Portfolio Managers negotiate with the 138 non-government organisations in Northland the 217 contracts NDHB holds with them. The Portfolio Managers monitor the contracts to analyse community provider performance in relation to service specifications, most of which are determined nationally, and to inform future planning.

4.6 Workforce

NRHP enabler: Workforce

4.6.1 NDHB

The Te Tai Tokerau / Northland Workforce Strategic Plan 2012-2016 is a companion document to the Northern Region Health Plan, the Northland DHB Annual Plan 2012-2013 and the Northland Health Service Plan 2012- 2017/26 which aligns with high level national, regional and district health priorities. The Plan strives to accommodate the whole of the health sector in Northland.

NDHB recognises that improvements to achieve both our district and regional goals must be delivered by the right number and type of staff. Numerous staff training programmes help to continually improve capability and practice, and we are working with the other DHBs within NoRTH (Northern Regional Training Hub) to share, develop and nurture career pathways for various occupational groups; the focus is currently on Registered Medical Officers. Improving the patient experience and streamlining patient flows require new ways of thinking and working. Initiatives to achieve better patient flows are being addressed by quality processes within NDHB and by the various clinical governance groups.

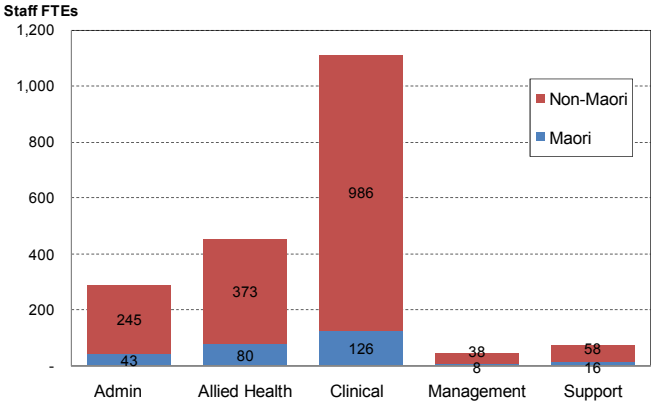
The Human Resources department produces monthly reports that help GMs manage their staff and provide updates on industrial wage negotiations. HR engages in numerous forums with unions across all occupational groups. Training modules ensure the skills of both clinical and non-clinical staff are kept up to date. HR also sponsors regular staff satisfaction surveys that assist with workforce planning and healthy workplace practices.

Northland DHB adheres to the good employer requirements in S118 of the Crown Entities Act. These cover safe working conditions, equal employment opportunities, impartial selection for employment, training of employees, and recognition of the needs and aspirations of Maori, other ethnic or minority groups, women and people with disabilities.

The Northern Region Training Hub (NoRTH), part of the Northern Regional Alliance, plays a key role in improving the support for postgraduate medical, nursing and allied health trainees. NoRTH works closely with Health Workforce NZ, the NoRTH Board, tertiary education providers and DHBs to decide on its workplan and align with wider workforce planning work being undertaken regionally and nationally. An initial priority group is Resident Medical Officers, and NoRTH is also assisting with delivering the Northern Region Health Plan by aligning recruitment, workforce planning and development to support delivery of new models of care.

The graph presents Northland DHB's workforce FTEs as at February 2013 in five categories[4]. Staff who identify as Maori make up 14% of the total.

Northland DHB staff Feb 2013, full time equivalents by type



4.6.2 The wider health sector

During the development of the *Northland Health Services Plan 2012-2017*, Northland DHB consulted with the health sector on priorities for services. Workforce development was seen as a key enabler for services to meet future demands and responsibilities. The *Northland Workforce Strategy 2012-2016* outlines our key priority focus areas for the next four years and should be read in conjunction with the Annual Plan. We utilise a six-monthly monitoring process to ensure that contents of the strategy are being delivered and are still relevant in the current environment. This is reported to the Executive Leadership Team.

Northland DHB's engagement follows the pipeline approach where there is local, regional and national engagement at all stages of the senior education system. This ranges from entry-level secondary schools (Year 9-13) through Kia Ora Hauora (Supporting Maori into Health Careers) to scholarship disbursements, through to students involved in health related degree level study at Universities and Polytechnics. NDHB also implements an Affirmative Action approach in recruitment and retention within the organisation.

The table below shows that there are 101 FTE general practitioners (GPs) and 111 FTE practice nurses (PNs) providing primary care in Northland[5]. Within the next six months the two PHOs will be completing a workforce census and profile of all general practices.

Primary health care staff type	FTEs
General practitioners, including locums	101
Practice nurses	111
Pharmacists	63
Physiotherapists	74
Midwives	62
Other	33
Total	**444**

As of June 2011 for Manaia PHO, there were:
- 81 general practitioners (56.8 FTE)
- 93 practice nurses (65.08 FTE)

Maori community providers

As of June 2011 nine Maori Providers[6] employed 665 staff of which 80% identify as Maori and 20% non-Maori. Te Runanga o Te Rarawa workforce has yet to be categorised, as does Te Runanga o Ngati Whatua.

[4] Northland DHB workforce within Aged Care and Rehabilitation services has not been included.

[5] The FTE estimates for occupational groups other than GPs, PNs, and Community Pharmacists are estimates using high level national assumptions.

Staff type	FTEs		
	Maori	Non-Maori	All staff
Admin	63.5	9.9	73.4
Allied health	21.0	9.0	30.0
Clinical	29.8	26.6	56.4
Management	26.0	4.0	30.0
Support	397.9	78.0	475.9
Total	**538**	**128**	**665.6**

4.6.3 Workforce strategies

NDHB will utilise the following strategies as enablers to address specific workforce issues. These strategies will contribute to the wider regional capacity and capability requirements in the Northern Region Health Plan and Northland Health Services Plan.

While Northland DHB has developed a workforce plan pertinent to Northland's requirements, NDHB will also contribute to a regional workforce planning in partnership with the Northern Regional Director of Training. Aligning the workforce components of the Northern Region Health Plan, Northland Health Services Plan and NDHB's Annual Plan will be a priority.

For the 2013/2014 year the activities and governance of the training hub will be more closely aligned with the Regional Health Plan, as the former NoRTH and NDSA organisations have been amalgamated into the Northern Regional Alliance (NRA). NRA and in particular the training hub will work closely with Northern Region DHBs, HWNZ, tertiary education providers and the Northern Region Clinical Leaders Forum to implement its work plan. NRA is aware of the 70/20/10 model for the allocation of postgraduate medical education funds, and the regional service plan takes account of this. Some of the metrics still need to be defined, and as such Northland DHB endeavours to work collaboratively with the training hubs and HWNZ to achieve these targets.

Objective	Actions	Measure
Identify best practice models to improve integrated care pathways.	Care pathways developed. Identify workforce requirements in new models of care and practice.	Care pathways are inclusive of all providers across the continuum of care. Workforce requirements identified and incorporated into model of care plans.
Learning and development activity to maximise training and development effort.	Enhance Moodle options for staff within and external to NDHB.	Moodle training programmes are accessible to the primary and community sector.
Continued development with Pukawakawa students through joint venture with University of Auckland.	University of Auckland relationship maintained.	25 new fifth year medical students enter into NDHB annually.
Increase the capability and capacity of Maori and Pacific nurses.	Affirmative action to increase the number of Maori health clinicians into positions.	Increase in Maori staff into clinical positions and positions of influence. Scholarships available to Maori.
Promote and support staff to enter into leadership programmes.	Maori nurses participate in Nga Manukura o Apopo.	25 Maori nurses across the district participate in the programme.

6 The Maori community providers contributing to the information were Whakawhiti Ora Pai, Te Hauora o Te Hiku o Te Ika, Te Hauora o Kaikohe, Ngati Hine Health Trust, Ki A Ora Ngatiwai, He Korowai Trust, Nga Morehu Trust, Ngati Kahu Iwi Social Services, Te Runanga o Whaingaroa

Objective	Actions	Measure
Nurse-led clinics developed within practices to accommodate the management of LTCs.	Monitor CVD/ diabetes demonstration sites for models of practice.	Nurse practitioners utilised to support the models of practice developed.
Practice Care Assistant training.	Recruit five of the non-regulated workforce into training for the Primary Care Assistant role within 3 general practices. Manaia PHO to support the in-training PCAs on the 18 month training programme.	New trainees on programme. Trainee supported in the training to complete studies.
Nurse practitioners in ED.	Scope out the role, function, benefits and viability of a NP to address level 4-5 triaging within ED. NP engaged into scope of role and function.	Scoping document completed and presented to Executive Leadership Team and NoRTH. Trialing of NP role and function in ED. Monitoring and evaluation of level of achievement in meeting objectives.
Pharmacy Technician in medication reconciliation.	Role and function of Pharmacy Technician implemented across hospital services and community pharmacy.	Accurate lists of patient medicines, allergies and adverse drug reactions collected. Discrepancies documented and reconciled. NDHB medicine reconciliation targets met. Pharmacist is able to work at top of scope. Model of care shared with other DHBs.
Programme Incubator to work with Year 12 and 13 students in high schools.	Utilise Maori health professionals in the coaching and mentoring role with students.	The number of Maori students participating in Programme Incubator.
Increase Maori nurses and midwives in hospital services.	Support affirmative action in recruitment and selection processes.	Increase of Maori staff by 1% per annum.
Implement Kia Ora Hauora at a local and regional level to increase students' career choices into health study.	Health science camps for year 9 to 13 high school students.	30% of students enter into tertiary study in a health-related career.
Scholarships provided to support access into tertiary study.	Pihirau Hauora Maori scholarships disbursed for the next two years.	Minimum of 45 students receive scholarship per annum.
Recruitment and retention of staff.	NDHB will continue to be a good employer and implement best practice.	Departments with high staff turnover will be reviewed.
Grow Our Own workforce.	Monitor the number of immigrants offered positions within the organisation, compared to NZ residents.	Number of filled positions offered to NZ personnel is higher than immigrant personnel in a financial year.
Strengthen governance of workforce development of the PG medical, nursing, allied health professions.	NoRTH forum utilised to oversee the development of the professions.	Strong clinical oversight of medical, nursing and allied health professions.
Introduce and implement innovative new clinical	Nursing placements are negotiated and	Nursing Entry to Practice placements

Objective	Actions	Measure
placements across settings.	agreed to between PHOs and NDHB. Paediatric posts to support SMO in child health.	into primary care. Paediatric post in place.
Support vocational training in general practice.	Pukawakawa fifth year medical students are organised and supported to participate in vocational training in general practices. Ensure collegial support by GPs for supervision in placements.	CMO responsible for verifying the medical council that continuing professional development is met.

4.7 Clinical leadership

NRHP: Strengthening clinical leadership is a priority under workforce

Involving clinicians in planning and management discussions and decisions is essential to improving services. NDHB's clinicians form an integral part of our management structures and processes and are intimately involved in regional planning processes. Clinical governance groups have been introduced by NDHB to improve systems and quality of care involving clinicians from both NDHB and the community provider sector. Senior clinicians within the organisation are offered regular training in leadership and management skills to ensure that their contribution to organisation is maximised.

4.8 Quality and safety

NRHP Goal one: First, do no harm (reducing harm and improving patient safety)

Quality and safety are integral to the way Northland DHB works. Our emphasis on quality and safety aligns with the aims of the Health Quality and Safety Commission and with the Regional Health Plan's First Do No Harm priority.

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

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

4.9 Information services

NRHP enabler: Workforce

[This is a summarised version of the Information services section of the Northern Region Health Plan for 2013/14.]

To address service continuity risks for IS services, healthAlliance and DHB executive teams have agreed to reprioritise IS investment to address these underlying risks:

- Microsoft software upgrades in workspace and infrastructure to keep licensing at formally supported levels
- clinical and business systems upgrades to ensure systems can operate in these upgraded workspace and infrastructure environments
- ongoing improvement of IS process, capability and capacity to cope with the levels of complexity and volume of IS service requirements
- improve resilience of (existing) IS systems to improve system availability, access, data integrity and security.

The Northern Region will continue to implement the National and Regional Information Strategy through nine workstream:

- quality information for primary healthcare (clinical pathways stage 1)
- continuum of care (e-referrals, electronic discharge summaries)
- safe medication management (e-prescribing, medicines reconciliation, regional e-medicines investment plan)
- clinical support (ten projects, including pharmacy, labs, maternity, preoperative, cardiovascular risk assessment, oncology)
- patient administration systems (implement Northland Patient Administration System)
- population health (establish capability, develop outcome measures, confirm regional dataset)
- business support (support national shared procurement, Regional Enterprise Content Management System platform)
- safe sharing foundations (regional and national system upgrades)
- shared care (operationalise Regional Shared Care platform, agree regional Patient Portal Strategy).

4.10 Working with others

Northland DHB must work with other agencies. Our principal relationships are described in the following table.

Level	Nature of relationship
National	Ministry of Health provides advice about policy and related matters, and NDHB responds when consulted while policy is being considered. National Health Board funds and monitors DHBs, manages the annual funding and planning round, and oversees regional planning and national services.
Regional	NDHB provider clinicians refer patients to tertiary (more specialised) services in Auckland. NDHB engages with the three Auckland DHBs to develop and implement the Northern Region Health Plan, which includes numerous workstreams on clinical services, information services etc. NDHB has a firm relationship with the Northern Regional Alliance, jointly funded by the four Northern Region DHBs to provide some shared services, including mental health planning for the region. Back-office' functions such as payroll, procurement and information services are provided by healthAlliance, the shared services organisation for the Northern Region.
Local	All of NDHB's services link in some way to Northland's community providers, including general practices and PHOs, the community lab, Maori health providers, mental health providers and aged-care providers. NDHB holds 217 contracts with 138 non-government organisation providers of health services, and employs portfolio managers to negotiate and monitor them. The two Northland PHOs' Chief Executives are members of NDHB's Executive Leadership Team. NDHB involves health sector agencies in various planning and clinical governance groups.
Intersectoral	Northland DHB is a member of the Northland Intersectoral Forum, a collaboration of public sector and territorial local authority agencies from throughout Northland. NDHB is an active participant in the Social Wellbeing Governance Group which oversees major social issues such as youth suicide, family violence and vulnerable children. NDHB's population health services team works with territorial local authorities and a variety of government agencies on compliance with public health legislation, training of non-health sector staff in public health skills and knowledge, and control of communicable disease.

5 Statement of Service Performance

The section fulfils Northland DHB's obligation under the Crown Entity Act 2004 to supply measures by which our future performance can be measured by the Office of the Auditor General. Together with modules 1, 2, 4 and 7, it comprises our Statement of Intent.

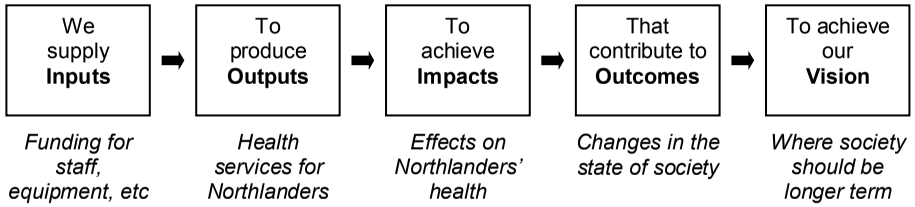
5.1 Output classes and intervention logic

The Statement of Service Performance groups services into four output classes:

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

Sections 5.2 to 5.5 address each output class in turn. The key elements are summarised in the diagram on the next page.

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



Summary of Northland DHB's Statement of Service Performance

Vision	A healthier Northland								
High Level Outcomes	Improved health status		Improved equity		Living within our means		Confidence and trust in the health system		
High Level Measures	Life expectancy gap between Maori and non-Maori ↓ by 2 years		↓ gaps between: (a) Maori and non-Maori (b) Northland and NZ		↓ mortality rate (age-standardised)	↓ infant mortality	Unplanned hospital admissions for Northlanders are reduced by 2,000 annually by 2017	>95% of patients report they would recommend the service provided	
Outcomes	Healthy population		Prevention of illness and disease		Reversal of acute conditions		Optimum quality of life for those with long term conditions	Independence for those with impairments or disability support needs	
Impacts	**Tobacco** Lower prevalence of smoking-related conditions	**Healthy children** Reduced likelihood of acquiring long term conditions later in life Lower incidence of communicable disease Healthier teeth and gums Safer children	**Long term conditions** Amelioration of disease symptoms and/or delay in their onset	**Cancer** If curable, increased likelihood of survival If incurable, reduced severity of symptoms	**Mental disorders** Improved quality of life for both clients and their families Acute episodes are minimised, clients achieve greater stability in their condition	**Elective surgery** Fewer debilitating conditions Delayed onset of long term conditions	**ED waiting times** More timely assessment, referral and treatment	**Quality and safety** More satisfied patients Fewer adverse clinical events	**Support for older people** Older people requiring support or care receive services appropriate to their needs.
Impact Measures	% of Year 10 students who have never smoked % of smokers in primary care given advice and help to quit % of smokers admitted to hospital given advice and help to quit	Full and exclusive breastfeeding at 6 weeks % of 8-month-olds who are fully immunised Average number of decayed, missing or filled teeth in Y8 students Referrals to CYFS of children suspected of being abused	of people with diabetes with annual reviews, % with good blood sugar management Eligible people receiving CVD risk assessment in the last 5 years	Breast cancer, cervical cancer screening in eligible populations People diagnosed with cancer who receive radiation treatment and chemotherapy within 4 weeks	% of people with enduring mental illness aged 20-64 who are seen over a year	↑ in elective service discharges	Patients with ED length of stay of less than 6 hours	Zero harm from falls. Zero pressure areas. 90% compliance with surgical checklist. 90% hand hygiene compliance. Zero central line infections. Medicine reconciliation	% HBSS clients assessed using interRai tool % of high and medium risk corrective actions arising from certification Respite care bed days utilised
Output Classes	**Prevention**		**Early detection and management**		**Intensive assessment and treatment**			**Rehabilitation and support**	
Outputs	Health promotion programmes in schools through Smokefree/ Auahi Kore Advice and help for smokers in primary care to quit Advice and help for smokers in hospital to quit	Midwifery services Support by lactation consultants Primary care services performing immunisations Oral health assessment and treatment Identifying at-risk children through screening	Risk assessments in primary care (diabetes annual reviews, blood tests, risk profiles) Laboratory tests	Cancer risk assessments in primary care Screening for breast and cervical cancers Provision of cancer therapies	Specialised clinical support by NDHB community mental health services Admission to hospital for those whose condition is unstable	Elective surgical procedures	Assessments, treatments and referrals performed in EDs	Leadership, advice and monitoring by the Chief Medical Advisor and Quality Resource Unit	Home based support services Residential care Work with providers on corrective action plans resulting from audit Respite care services
Output Measures	Health promotion programmes in schools Students advised about stopping smoking Advice and help offered to smokers in primary care Quit Card Providers. Advice and help offered to smokers in hospital	Support provided to mothers to breastfeed Lactation consultant contacts Immunisations completed by eight months Oral health treatments for Y8 students Referrals to CYFS of children suspected of being abused	Risk assessments performed on people with diabetes and/or CVD Lab tests on people with diabetes	Breast cancer screening in eligible populations Cervical cancer screening in eligible populations Radiation treatments Chemotherapy treatments	Contacts by community mental health workers with people who have enduring mental illness	Additional elective procedures	Emergency department attendances	Measures of the quality and safety of services	Assessments by NASC service Certification audits Respite care bed days utilised

Key: Underlines = main measures. Yellow highlights = Health Targets.

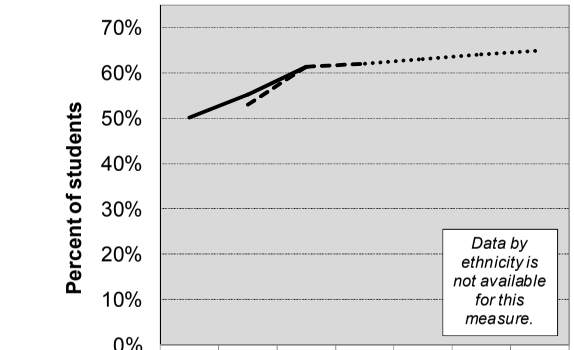
5.2 Output class: Prevention

Outcome: Healthy population

Impact: Lower prevalence of smoking-related conditions.

Type of measure: Coverage

Measure: % of Year 10 students who have never smoked[7].



	2009	2010	2011	2012	2013	2014	2015
Never smoked	50.2%	55.3%	61.4%				
Target historical		53.0%	61.4%	62.0%			
Target projected				62.0%	63.0%	64.0%	65.0%

2011 is the latest data available.

Rationale

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

It disproportionately affects Maori and other deprived populations.

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

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

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

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

Outputs

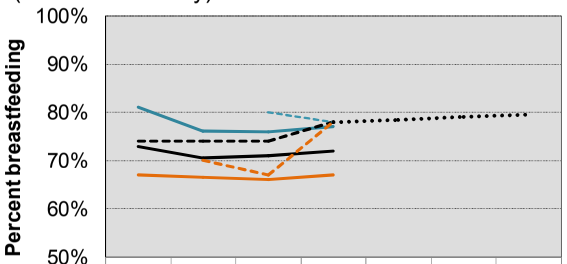
84,334 smokers recorded in primary care. 20,751 current smoker recorded, 10,905 offered brief advice. 4,691 offered cessation support (CY 2012).

1,044 individual quit providers registered as at March 2013.

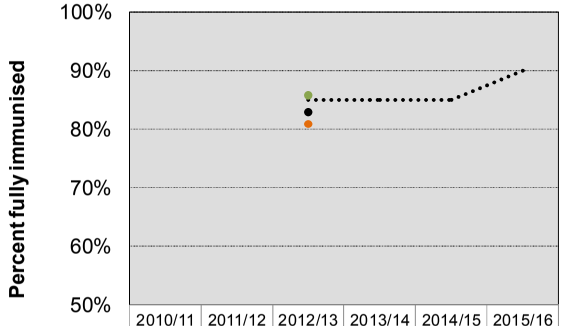
Number of schools health promotion programmes are offered to, 2011 CY: 28 (18 Far North, 10 Northern Wairoa).

Total students advised about stopping smoking 2012 CY: 800.

[7] Last year's SSP had a measure on the percentage of the Northland population who smoke. Changes to the way this data is collected by MoH under the NZ Health Survey mean that Northland data, last available in 2006, now won't be available until 2014 at the earliest.

Impact: Reduced likelihood of acquiring long term conditions later in life.		**Type of measure:** Coverage
Measure: Northland mothers who breastfeed fully and exclusively at 6 weeks (Plunket data only).  	**Rationale** Higher rates of breastfeeding in infancy correlate with a lower chance later in life of developing health problems, including long term conditions. Breastfeeding rates are lower among Maori. A higher percentage of the child population is Maori, so improving child health will have a significant effect on improving the health of Maori.	**Outputs** Mothers are provided with education and support to encourage them to breastfeed, whether they are supported by an NDHB midwife (hospital births) or an independent midwife (home and hospital births). Hospital annual births 2,015 2012 CY. 4,365 lactation consultant patient contacts (annual extrapolation from Jul-Feb 2012/13 data).

	2009	2010	2011	2012	2013	2014	2015
Total	73.0%	70.6%	71.0%	72.0%			
Maori	67.0%	66.6%	66.0%	67.0%			
Non-Maori	81.0%	76.1%	76.0%	77.0%			
Target historical	74.0%	74.0%	74.0%	78.0%			
Target Maori		70.0%	67.0%	78.0%			
Target non-Maori			80.0%	78.0%			
Target all projected				78.0%	78.5%	79.0%	79.5%

Impact: Lower incidence of communicable disease		**Type of measure:** Coverage
Measure: % of eight-month-olds who are fully immunised (HT).  	**Rationale** Improved immunisation coverage leads directly to reduced rates of vaccine-preventable (communicable) disease, and that means better health and independence for children and longer and healthier lives. To reach the target immunisation coverage level, new systems need to be put in place to make sure all newborns are enrolled with their primary care provider soon after birth. Early enrolment of all children should encourage higher attendance rates at primary care in the future. Immunisations (one of the six national Health Targets) are one of the most cost-effective ways of improving health.	**Outputs** NDHB works with primary care providers to continue to improve the rate and timeliness of immunisation. 2,051 children immunised before 8 months, 2099 CY.

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Maori			80.9%			
Non-Maori			85.8%			
Total			82.9%			
Target all historical			85.0%			
Target all projected			85.0%	85.0%	85.0%	90.0%

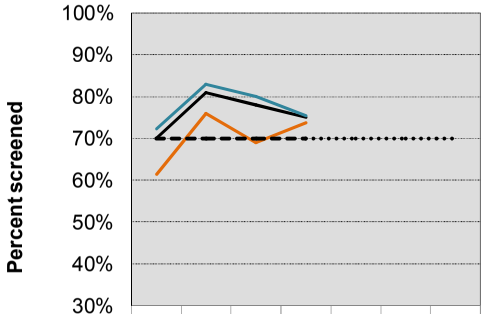
The Datamart, which holds immunisation data, is not able to generate data for years earlier than 2012/13.

Outcome: prevention of illness and disease

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

Type of measure: Coverage

Measure: Breast cancer screening in eligible populations.



	2009	2010	2011	2012	2013	2014	2015
Total	70.0%	81.0%	78.0%	75.1%			
Maori	61.4%	76.0%	69.0%	73.8%			
Non-Maori	72.2%	83.0%	80.0%	75.4%			
Target all historical	70.0%	70.0%	70.0%	70.0%			
Target all projected				70.0%	70.0%	70.0%	70.0%

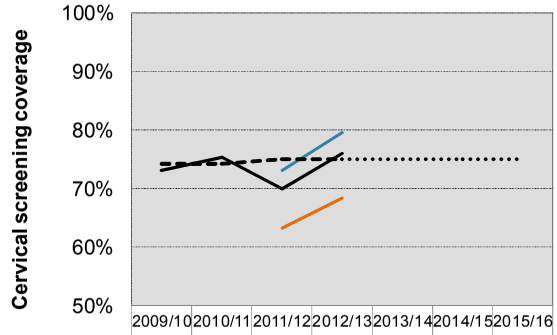
Rationale

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

Outputs

10,227 Northland women screened CY 2012, including 2,340 Maori, 7,887 non-Maori.

Measure: Cervical cancer screening in eligible populations.



	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Total 20-69y	73.1%	75.3%	70.0%	76.0%			
Maori 20-69y			63.2%	68.4%			
Non-Maori 20-69			73.1%	79.6%			
Target all historical	74.2%	74.2%	75%	75%			
Target all projected				75%	75%	75%	75%

Outputs

31,742 eligible women screened June 2009-June 2012.

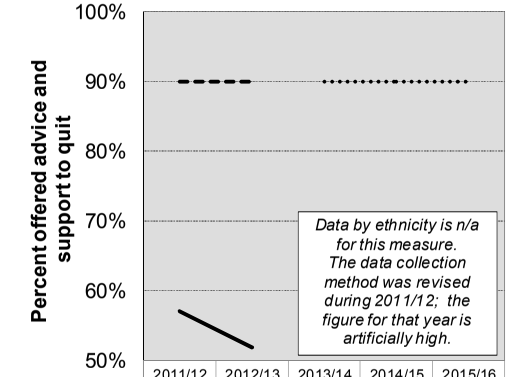
5.3 Output class: Early detection and management

Outcome: Prevention of illness and disease

Impact: Lower prevalence of smoking-related conditions.

Type of measure: Coverage

Measure: % of smokers in primary care given advice and help to quit (HT).



	2011/12	2012/13	2013/14	2014/15	2015/16
Total	57.0%	51.8%			
Target historical	90.0%	90.0%			
Target projected			90.0%	90.0%	90.0%

Rationale

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

It disproportionately affects Maori and other deprived populations.

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

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

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

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

Outputs

Services to reduce tobacco smoking focus on three key areas to reduce harm:

encouraging young people to never start (youth smoking rates continue to decline in Northland)

supporting adults who want to stop

supporting pregnant women who smoke because of the harm smoking does to the fetus.

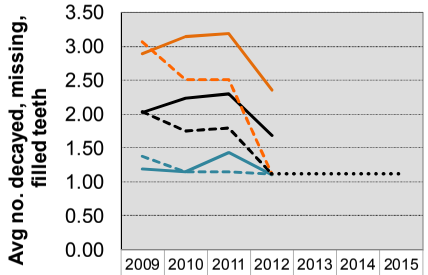
84,334 smokers recorded in primary care. 20,751 current smokers recorded, 10,905 offered brief advice. 4,691 offered cessation support (CY 2012).

1,044 quit providers (individuals) registered as at March 2013.

Impact: Healthier teeth and gums

Type of measure: Quantity

Measure: Average no. decayed, missing, filled teeth in Y8 students (PP10).



	2009	2010	2011	2012	2013	2014	2015
Total	2.02	2.23	2.30	1.68			
Maori	2.89	3.15	3.19	2.35			
Non-Maori	1.19	1.14	1.43	1.10			
Target all historical	2.04	1.75	1.80	1.12			
Target Maori hist.	3.06	2.50	2.50	1.12			
Target non-Maori hist.	1.38	1.15	1.15	1.12			
Target all projected				1.12	1.12	1.12	1.12

Rationale

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

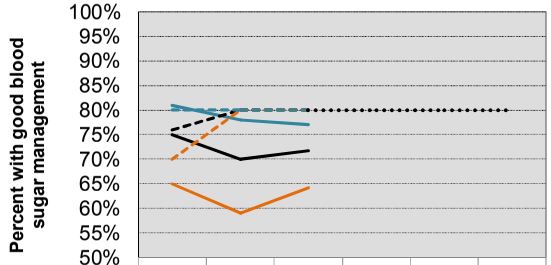
Northland has consistently had among the worst oral health statistics for children for many years.

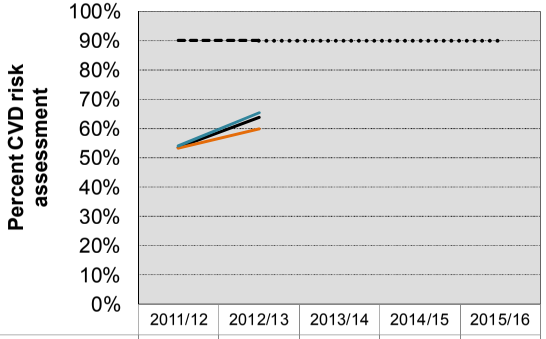
Northland remains unfluoridated after a brief foray into reticulated fluoridation in two Far North communities was abandoned in 2009. Northland will always struggle to reach the oral health status of DHBs with fluoridated water supplies.

Outputs

Enrolments in NDHB-funded oral health services 2011 CY: 7,251 preschool, 20,715 primary school children, 6,370 adolescents.

Outcome: Optimum quality of life for those with long term conditions

<table>
<tr><td colspan="2">Impact: Amelioration of disease symptoms and/or delay in their onset</td><td>Type of measure: Coverage</td></tr>
<tr><td>Measure: Of people with diabetes receiving annual free checks, % with good blood sugar management. (PP20)
 

<table>
<tr><th></th><th>2010/11</th><th>2011/12</th><th>2012/13</th><th>2013/14</th><th>2014/15</th><th>2015/16</th></tr>
<tr><td>Total</td><td>75.0%</td><td>70.0%</td><td>71.7%</td><td></td><td></td><td></td></tr>
<tr><td>Maori</td><td>65.0%</td><td>59.0%</td><td>64.1%</td><td></td><td></td><td></td></tr>
<tr><td>Non-Maori</td><td>81.0%</td><td>78.0%</td><td>77.0%</td><td></td><td></td><td></td></tr>
<tr><td>Target historical</td><td>76.0%</td><td>80.0%</td><td>80.0%</td><td></td><td></td><td></td></tr>
<tr><td>Target Maori</td><td>70.0%</td><td>80.0%</td><td>80.0%</td><td></td><td></td><td></td></tr>
<tr><td>Target non-Maori</td><td>80.0%</td><td>80.0%</td><td>80.0%</td><td></td><td></td><td></td></tr>
<tr><td>Target all projected</td><td></td><td></td><td>80.0%</td><td>80.0%</td><td>80.0%</td><td>80.0%</td></tr>
</table></td><td>Rationale
Diabetes is an increasingly common long term condition.
Prevalence of LTCs increases with age, so action now is imperative in the face of the ageing population.
Diabetes is strongly associated with excess weight, which affects a disproportionate number of Northlanders.
It is a major cause of illness and a significant contributor to cardiovascular (heart and circulatory) disease. Screening for cardiovascular disease is one of the six national Health Targets.
Although incurable, the effect of diabetes on daily life can be minimised through early detection, regular (annual) checks and good clinical management and a healthy lifestyle.</td><td>Outputs
5,081 diabetes annual reviews were performed in primary care in 2012 CY.
Of that number, 3,637 diabetics (72%) had good blood sugar management.</td></tr>
<tr><td>Measure: Of people in eligible populations, those who have had a CVD risk assessment in the last 5 years. (HT)
 

<table>
<tr><th></th><th>2011/12</th><th>2012/13</th><th>2013/14</th><th>2014/15</th><th>2015/16</th></tr>
<tr><td>Total</td><td>53.7%</td><td>63.7%</td><td></td><td></td><td></td></tr>
<tr><td>Maori</td><td>53.2%</td><td>60.0%</td><td></td><td></td><td></td></tr>
<tr><td>Non-Maori</td><td>54.0%</td><td>65.4%</td><td></td><td></td><td></td></tr>
<tr><td>Target all historical</td><td>90.0%</td><td>90.0%</td><td></td><td></td><td></td></tr>
<tr><td>Target all projected</td><td></td><td>90.0%</td><td>90.0%</td><td>90.0%</td><td>90.0%</td></tr>
</table></td><td>Rationale
Along with cancer, cardiovascular disease is the most common long term condition.
Prevalence of long term conditions increases with age, so action now is imperative in the face of the ageing population.
Regular screening identifies those at risk of developing cardiovascular disease, for whom lifestyle and clinical interventions can prevent or delay its onset. Regular screening also helps earlier identification of those who already have the condition, and this promotes more healthy outcomes for them.
Screening for cardiovascular disease is one of the six national Health Targets.</td><td>Outputs
7,899 CVD risk assessments performed in primary care 2011/12.</td></tr>
</table>

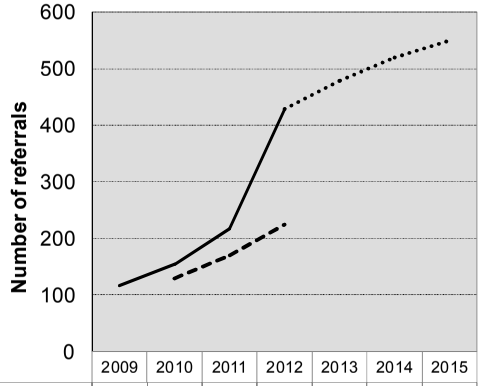
5.4 Output class: Intensive assessment and treatment

Outcome: Prevention of illness and disease

Impact: Safer children

Type of measure: Quantity

Measure: Referrals to CYFS of children suspected of being abused.



	2009	2010	2011	2012	2013	2014	2015
Total	117	154	217	429			
Target historical		130	170	225			
Target projected				429	479	519	549

Rationale

Every child has the right to live in a safe, nurturing environment free from abuse and neglect.

Outputs

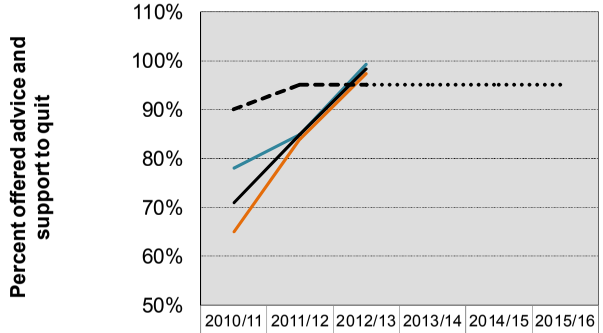
The Family Violence Service works to increase rates of identification and reporting throughout all NDHB's services but especially the Emergency Department, paediatric ward, the Special Care Baby Unit, the Child Health Centre and Maternity Services.

429 referrals to CYFS of children suspected of being abused in 2012 CY.

Impact: Lower prevalence of smoking-related conditions

Type of measure: Coverage

Measure: % of smokers in hospital given advice and help to quit. (HT)



	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Maori	65.0%	84.0%	97.3%			
Non-Maori	78.0%	85.0%	99.2%			
Total	71.0%	85.0%	98.2%			
Target all historical	90.0%	95.0%	95.0%			
Target all projected			95.0%	95.0%	95.0%	95.0%

Rationale

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

It disproportionately affects Maori and other deprived populations.

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

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

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

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

Outputs

Services to reduce tobacco smoking focus on three key areas to reduce harm:

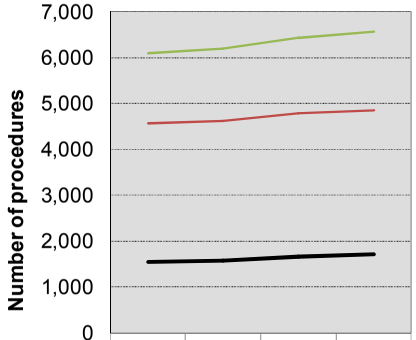
encouraging young people to never start (youth smoking rates continue to decline in Northland)

supporting adults who want to stop

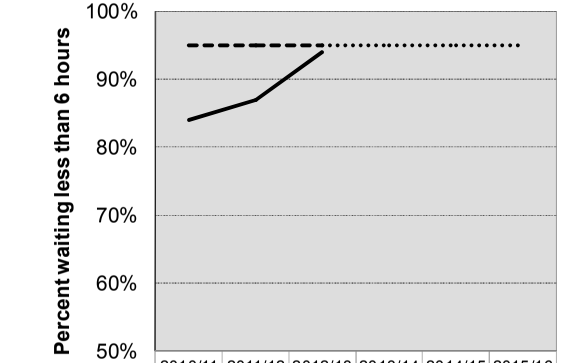
supporting pregnant women who smoke because of the harm smoking does to the fetus.

6,833 smokers admitted to NDHB hospitals 2011/12, of whom 6,400 (94%) were offered advice and help to quit.

Outcome: Reversal of acute conditions

Impact: Fewer debilitating conditions and delayed onset of long term conditions.		**Type of measure:** Quantity
Measure: Increase in the number of elective services discharges. (HT)  	**Rationale** Elective surgery is an effective way of increasing people's functioning because it remedies or improves disabling conditions. Increasing delivery will improve access and reducing waiting times and increase public confidence that the health system will meet their needs. Timely access to elective services is considered by the Ministry of Health to be a measure of the effectiveness of the health system. One of the six national Health Targets.	**Outputs** 3,759 elective procedures Jul-Dec 2012 (though there is no standard number or pattern because the number of procedures is negotiated each year with MoH).

	2010/11	2011/12	2012/13	Target 2013/14
Maori	1,537	1,580	1,660	1,713
Non-Maori	4,561	4,618	4,774	4,851
Total	6,098	6,198	6,434	6,564

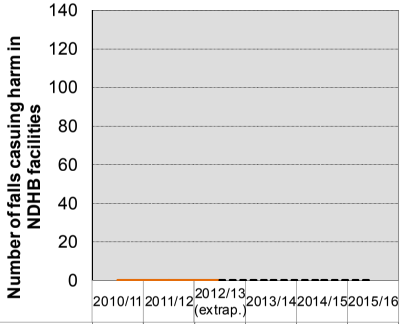
Impact: More timely assessment, referral and treatment.		**Type of measure:** Quantity
Measure: Patients with an emergency department length of stay (time from presentation to admission, discharge or transfer) of less than 6 hours. (HT)  	**Rationale** The purpose of emergency departments (EDs) is to provide urgent care, so by definition timeliness is important. Long times spent in waiting and receiving treatment in EDs are linked to overcrowding of the ED, compromised standards of privacy and dignity for patients, and poorer clinical outcomes (such as increased mortality and longer lengths of stay for people who are transferred into hospital as inpatients). Reducing ED length of stay will improve the public's confidence in being able to access services when they need to, increasing their level of trust in health services, as well as improving the outcomes from those services. It also addresses the Ministerial priority of living within our means by ensuring resources are used effectively and efficiently. One of the six national Health Targets.	**Outputs** Emergency services provided by EDs at Whangarei Hospital, NDHB's most specialised ED, as well as satellite services at the other three hospitals in Kaitaia, Kawakawa and Dargaville. Emergency department attendances 2011/12 FY: 42,590

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Total	84.0%	87.0%	94.0%			
Target historical	95.0%	95.0%	95.0%			
Target projected			95.0%	95.0%	95.0%	95.0%

Impact: Fewer adverse clinical events.

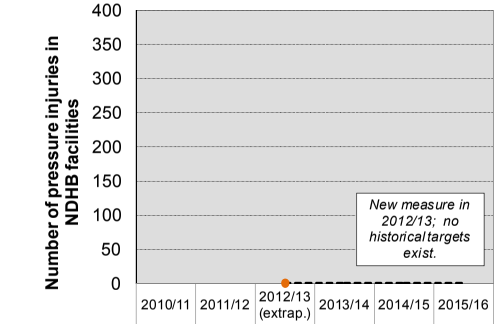
Type of measure: Quality

Measure: Harm from falls while in hospital.



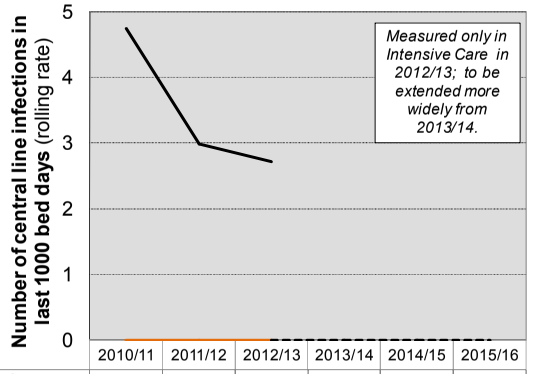
	2010/11	2011/12	2012/13 (extrap.)	2013/14	2014/15	2015/16
Harm from falls in hospital						
Target historical	0	0	0			
Target projected			0	0	0	0

Measure: Pressure injuries while in hospital.



	2010/11	2011/12	2012/13 (extrap.)	2013/14	2014/15	2015/16
Pressure injuries						
Target historical			0			
Target projected			0	0	0	0

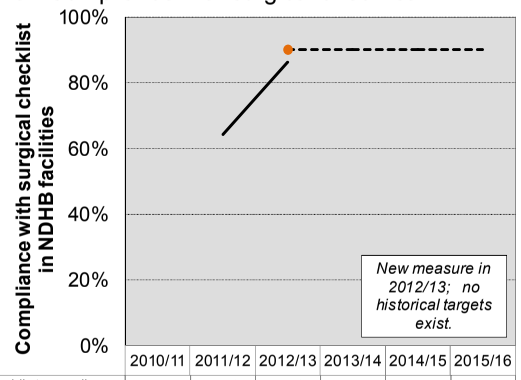
Measure: Central line infections.



	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
CL infections	4.7	3.0	2.7			
Target historical	0.0	0.0	0.0			
Target projected			0.0	0.0	0.00	0.00

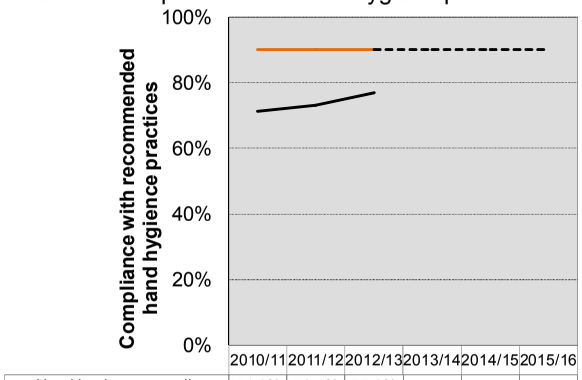
Actuals data for falls and pressure injuries is not presented because recent changes to improve the accuracy with which these are recorded make historical data incompatible with current and projected data.

Measure: Compliance with surgical checklist.



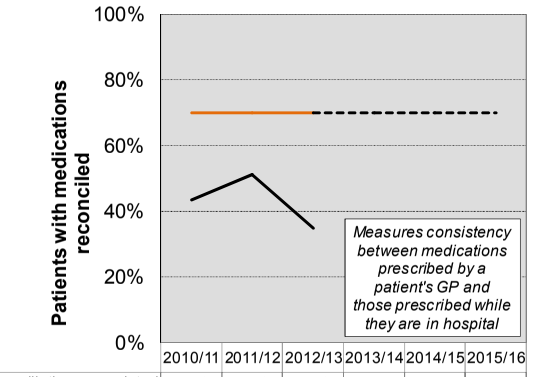
	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Checklist compliance		64.3%	86.3%			
Target historical			90.0%			
Target projected			90.0%	90.0%	90.0%	90.0%

Measure: Compliance with hand hygiene practices.



	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Hand hygience compliance	71.3%	73.1%	77.0%			
Target historical	90.0%	90.0%	90.0%			
Target projected			90.0%	90.0%	90.0%	90.0%

Measure: Medicine reconciliation



	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Reconciliations completed	43.4%	51.1%	34.8%			
Target historical	70.0%	70.0%	70.0%			
Target projected			70.0%	70.0%	70.0%	70.0%

Rationale

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

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

Outputs

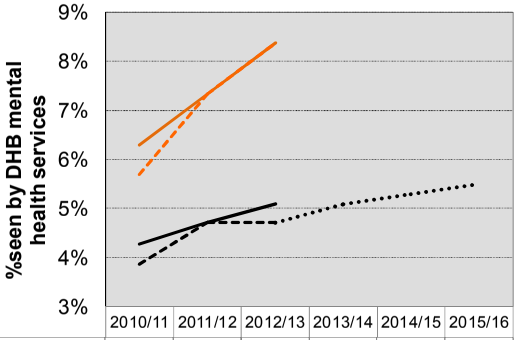
Advice and monitoring provided by the Quality and Improvement Directorate, which is overseen by the Chief Medical Advisor.

Outcome: Independence for those with impairments of disability support needs

Impact: Acute episodes are minimised, clients achieve greater stability in their condition, and they and their families have improved quality of life

Type of measure: Coverage

Measure: Proportion of people with enduring mental illness aged 20-64 who are seen over a year. (PP6)



	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Total	4.28%	4.71%	5.09%			
Maori	6.29%	7.34%	8.38%			
Target all historical	3.86%	4.71%	4.71%			
Target Maori	5.69%	7.34%	8.38%			
Target all projected			4.71%	5.09%	5.30%	5.50%

Rationale

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

Severe disorders permanently affect 3% of the population.

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

Outputs

Number of contacts by community mental health services with people who have enduring mental illness (2011/12 extrapolated from 9 months data):

Direct 96,000
(with client and/or whanau)

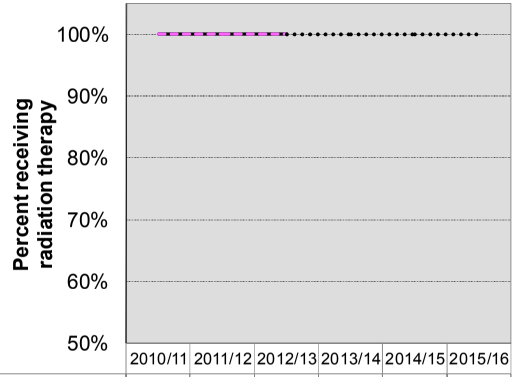
Care coordination 41,000
(on behalf of client, with another agency)

Outcome: Optimum quality of life for those with long term conditions

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

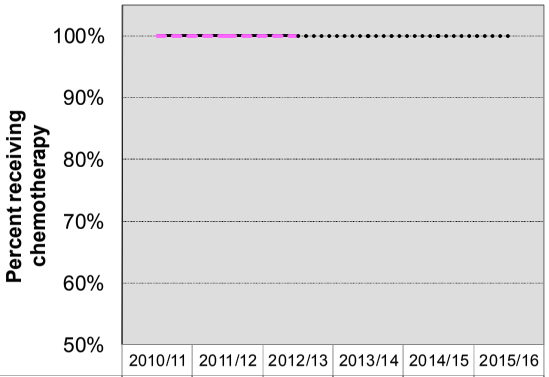
Type of measure: Timeliness

Measure: People diagnosed with cancer who receive radiation treatment within 4 weeks. (HT)



	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Total	100%	100%	100%			
Target historical	100%	100%	100%			
Target projected			100%	100%	100%	100%

Measure: People diagnosed with cancer who receive chemotherapy within 4 weeks. (HT)



	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Total	100%	100%	100%			
Target historical	100%	100%	100%			
Target projected			100%	100%	100%	100%

Rationale

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

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

Waiting times for both cancer radiation therapy and chemotherapy are one of the six national Health Targets.

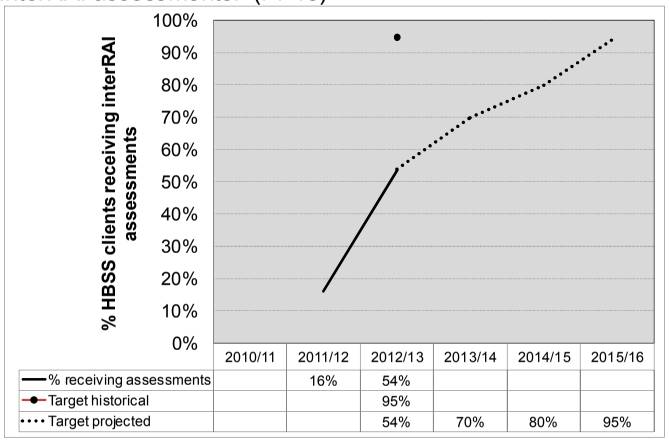
Outputs

296 radiation therapy treatments for new Northland patients in Auckland Hospital 2011/12.

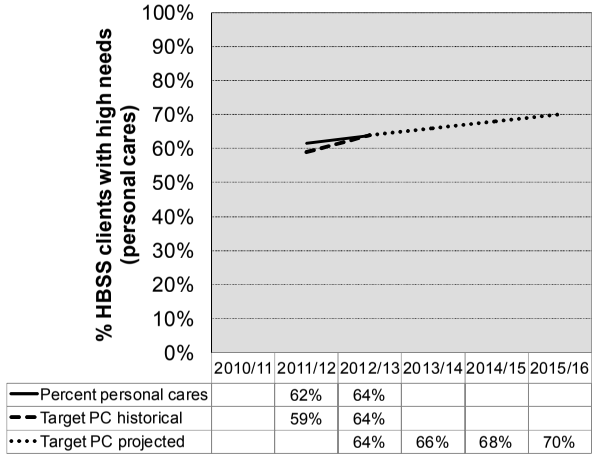
Chemotherapy treatments for Northland patients in 2011/12: 368 Auckland Hospital, 1,584 Whangarei Hospital.

5.5 Output class: Rehabilitation and support

Outcome: Independence for those with impairments of disability support needs

<table>
<tr><td colspan="2">Impact: Older people requiring support or care receive services appropriate to their needs.</td><td>Type of measure: Coverage</td></tr>
<tr><td>Measure: Home based support services (HBSS) clients receiving interRAI assessments. (PP18)
 
</td><td>Rationale

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

1,420 interRAI assessments completed for a total of 2,646 HBSS clients (extrapolated from first quarter of 2012/13).</td></tr>
<tr><td>Measure: Rising % of home based support services provided to older people who have higher support needs.
 
</td><td>Rationale

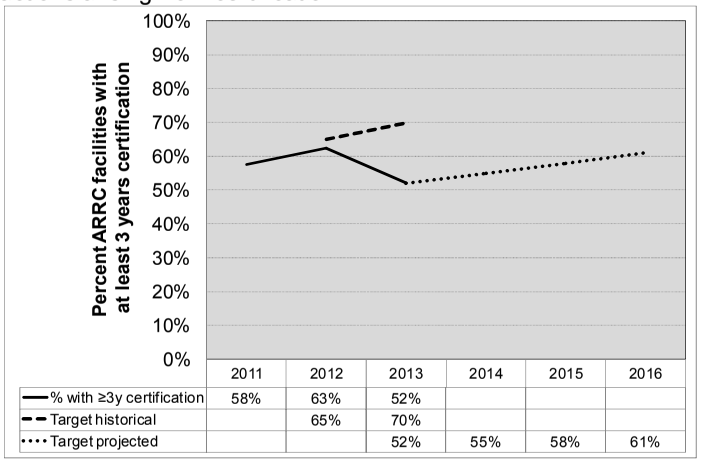
The increasing number of older people, along with their higher level of acuity, is placing increasing pressure on budgets for residential care and home based support services.

In recent years the number of people receiving home based support services has been contained at approximately 2,700 people. However total hours funded have risen, reflecting a shift towards clients with higher needs. There has been a swing from household management to personal care.

While the ageing in place policy has contributed to a decline in rest home admissions, demand for higher level care (dementia and hospital level care) will continue to grow.

In order for HOP support services to be sustainable, we need to allocate resources to home and community support services based on a restorative approach and to target those people who really need them, as determined by appropriate assessment tools.</td><td>Outputs

544,413 hours of HBSS services, of which 347,603 were for personal cares and 196,810 were for home maintenance (2012 calendar year).</td></tr>
</table>

Measure: Decreasing percentage of high and medium risk corrective actions arising from certification.  2011 2012 2013 2014 2015 2016 % with ≥3y certification 58% 63% 52% Target historical 65% 70% Target projected 52% 55% 58% 61%	Certification reduces potential risks to residents by ensuring providers comply with the Health and Disability Services Standards. The period of certification for aged residential care providers reflects their risk level – the fewer the number and the lower the level of risks identified during audits, the longer the period of certification.	**Type of measure:** Quality **Outputs** DHB aged care contract and MoH certification audit processes have been conducted through a single audit since August 2010. DHBs concentrate on working with providers on corrective action plans to address any matters identified though the audits, monitoring progress against the agreed corrective action plans, and managing risks that may arise. (The measure does not include certification for any new providers because that automatically reverts to a single year and is therefore not necessarily related to quality of service.)

Statement of Financial Performance - By Output Class

	Intensive Assessment & Treatment	Early Detection & Management	Prevention	Rehabilitation & Support Services	
DHB Provider Revenue	215,205,276	24,553,645	7,466,930	8,940,947	256,166,797
Other Provider Revenue	18,706,402	2,490,330	5,545,208	486,965	27,228,905
Less Revenue Offsets - Note 1	-9,441,657				-9,441,657
DHB Funder Revenue	74,735,703	104,162,471	9,330,746	54,648,455	242,877,377
DHB Governance & Administration	3,454,128				3,454,128
					0
Total SOI Revenue	302,659,852	131,206,447	22,342,884	64,076,367	520,285,550
Personnel Costs					
Medical Labour	48,336,637	1,834,683.28	1,079,464.69	60,284.29	51,311,069
Nursing Labour	57,049,001	4,773,126.12	995,711.89	4,075,374.47	66,893,213
Allied Health Labour	17,333,917	8,483,137.35	3,063,459.01	2,778,474.91	31,658,988
Non Clinical Support Labour	182,662	77,459.58	4,058.30	-	264,180
Management and Admin Labour	6,739,220	1,340,542.10	977,782.92	346,468.40	9,404,013
Non-Personnel Operating Costs					
Outsourced Clinical Services	3,973,247	455,234	61,238	385,895	4,875,613
Oth Clinical Supp	30,779,265	1,341,572	628,640	1,523,826	34,273,303
Implants	4,186,296	-	-	-	4,186,296
Pharmaceuticals	3,759,147	141,864	4,433	328,321	4,233,765
Infrastructure and Non Clinical	23,242,650	2,109,741	447,089	1,209,171	27,008,651
Allocated Pharmaceuticals	1,008,166	27,431	1,299	80,808	1,117,703
Corporate Departments	13,433,527	1,306,554	548,209	1,570,529	16,858,819
Cost of Capital	8,738,401	763,530	274,819	539,896	10,316,647
CTA Recoveries	- 1,896,649	- 17,991	- 4,557	- 2,601	-1,921,796
Patient Support	4,647,806	12,314	8,253	124,363	4,792,736
Service Based Departments	9,830,722	1,390,797	473,845	368,531	12,063,896
Sterile Supplies	281,631	739	500	31,929	314,800
Provider Payments - to providers					
Personal Health	62,071,743	100,806,299	3,331,487	744,507	166,954,037
Mental Health	12,301,073	2,511,511			14,812,584
Disability Support Services	58,767	50,000	9,004	53,730,523	53,848,295
Public Health	60,396		1,186,134		1,246,530
Maori Health		794,661	4,804,121	173,425	5,772,207
Total SOI Operating Expenditure	306,117,625	128,203,204	17,894,992	68,069,726	520,285,550
Surplus (Deficit)	-3,457,773	3,003,242	4,447,892	-3,993,359	0

6 Service configuration

6.1 Service coverage

The Ministry of Health's Service Coverage Schedule specifies the services a DHB must ensure are provided. This section deals with any significant exceptions that might be sought. Northland DHB seeks no such exceptions.

6.2 Service issues

Northland DHB has no emerging service issues other than what is already covered under 6.3 or described within the context of the Northern Region Health Plan.

6.3 Service change

This is a list of "significant" service changes possible in the next year. It does not include possible changes emerging from the Northland Health Services Plan because the plan is still under development and specific proposals and changes are yet to emerge and be agreed upon.

Northland DHB will follow the Service Change Protocols in the Operational Policy Framework. We will notify the National Health Board of any service changes resulting from planned service reviews or that may arise during 2013/14.

Title	Description	Rationale	Timing	Risk	
				Description	L/M/H
Whangaroa review	Concerns expressed by Whangaroa Health Services Trust to NDHB about their future sustainability led to NDHB conducting a comprehensive value for money review including current service configuration and model of care delivery system.	Equity and access: Whangaroa population receives a significantly higher level of resourcing (funding, clinical FTEs etc) than other comparable populations in Northland, yet no population health or quality benefits are discernible from data.	Options developed for April NDHB Board meeting. Consultation on the "preferred Model of Care" consulted on during May-June, with final Model of Care options paper by July 2013. Detailed implementation planning will commence pending Board decision in July 2013.	Reaction from the Whangaroa public to the changes proposed. These will likely include enhanced primary health service delivery closer to coastal communities, but with some services such as aged care being redistributed geographically.	H

7 Financial performance

7.1 Managing the funding

Northland DHB has consistently maintained a balanced budget. This has met the requirements of the Minister and has allowed the DHB some flexibility in allocating resources to new needs and services. In the current climate of financial constraints and capped funding in real terms, keeping the books in the black is even more important.

Northland DHB's Financial Management Systems give us the ability to set targets and monitor performance against these. Target setting occurs with advice from the Ministry of Health and includes financial budgets, numbers of employees and service delivery targets.

Performance against these targets is monitored on a monthly basis. This starts with Internal Performance Management Reporting within each service which feeds into the Executive Leadership Team. The reports are consolidated each month for the board of governance and its associated subcommittees. We also meet MoH reporting requirements on a monthly basis.

NDHB continues to seek efficiencies in the way we operate, including participating in regional and national processes. At least three-quarters of operating expenditure is on our workforce, and we are continually reviewing patterns and levels of staffing to reduce costs.

Our savings plan includes significant assumptions from the HBL finance, procurement and supply chain business case, and healthAlliance procurement savings.

Northland DHB is setting up a Steering Group for Financial Sustainability, one of the six programmes established under the Northland Health Services Plan. One of its major tasks is to identify $3M from productivity and savings initiatives so the Strategic Investment Fund for new projects can be set up, and for this the group will cast its net across the entire the health sector in Northland.

Northland DHB received a total increase of $10.3m in the December 2012 Funding Envelope. This population based funding increase is a contribution to both our cost and population growth pressures. The 2013/14 contribution to cost pressure is $4.1M (0.89%) and the contribution to demographic growth is $6.2M (1.34%).

7.2 The three-year forecasts

NDHB will achieve a break-even performance for each of the three years detailed in the financial template.

The 2013/14 result has been arrived at after taking into account all the currently known cost increases we forecast to occur. Included are the increased operational costs of new information systems (including additional depreciation and the loss of interest income as cash resources diminish) and support for shared services. Wage increases after the expiry of current employment agreements have been budgeted at 2%. Total new operational savings are expected to be approximately $5M in 2013/14.

The outer years have been reported as break-even. Savings assumptions have needed to be included in those results because of the increased depreciation, operating costs (including automatic step increases included in wage agreements) and loss of interest income resulting from continuing investment in building development and information technology, coupled with advice from the Ministry of Health that future funding increases will be no more in actual terms than that received this year.

The level of savings assumed for these out-years is approximately $5M in 2014/15 and a further $5M in 2015/16. It will be achieved from savings of the regional shared service organisation (healthAlliance) as well as savings realised from the investments themselves.

The 2013/14 and 2014/15 projections have been based on the following assumptions:

- core revenue increases will continue at their current dollar value, approximately $13.8m per annum; any reduction in this increase will increase the savings targets

- other revenue will increase at 1.49% (the current Contribution to Cost Pressures funding level) with the exception of interest income which will decline as capital expenditure increases
- staff costs will rise by 4% per annum
- outsourced services will rise by 4% per annum
- clinical supplies will rise by 4% per annum
- infrastructure and non-clinical supplies will rise by 4% per annum
- payments to community providers will rise by 2% per annum.

7.3 Productivity initiatives

Our major productivity initiatives are described in 3.11 Living within our means.

7.4 Full time equivalent (FTE) staff management

Emphasis has been placed on controlling FTE numbers. Increases arise from the substitution of locum costs with employed FTE positions, specifically-funded new positions (oral health for example) and clinical positions driven by increased patient demand.

Management and administrative FTEs have been held, despite increases in activity and new services. FTE level remains well below the FTE cap.

7.5 Capital plan

The financial templates include the capital plan for Northland DHB. Baseline capital, funded via depreciation, is the common description of the plan which funds the replacement of existing assets.

Strategic capital is funded from the DHB's cash resources, Crown equity and Crown debt. Northland DHB's strategic capital intentions signalled in the Annual Plan represent ambitions to renew our building stock on the Whangarei and Kawakawa campuses, and to upgrade our essential clinical information systems.

7.6 Assets

Assets were last valued on 30 June 2012 and will be revalued as at 30 June 2015. No forecast of this revaluation has been made in the financial templates.

7.7 Disposal of land

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

7.8 Financial statements

Statement of Comprehensive Income

$000s

	2011-12 Audited Actuals	2012-13 Forecast	2013-14 Budget	2014-15 Budget	2015-16 Budget
DHB Provider Revenue	268,869	279,898	283,396	289,064	294,845
DHB Funder Revenue	226,423	229,749	235,511	240,222	245,026
DHB Governance & Administration	3,597	3,453	3,454	3,523	3,594
Inter District Flow Revenue	7,242	7,854	7,366	7,513	7,664
Total Revenue	506,131	520,953	529,727	540,322	551,128
DHB Provider Operating Expenditure	253,906	256,508	262,356	267,605	272,956
DHB Non Provider Funded Services	167,109	167,159	172,207	175,651	179,164
DHB Governance & Administration	4,239	3,432	3,433	3,502	3,572
Inter District Flow Expense	62,883	70,444	70,670	72,084	73,525
Total Operating Expenditure	488,138	497,544	508,667	518,842	529,218
Earnings before Interest, Depreciation, Abnormals & Capital Charge	17,994	23,410	21,060	21,480	21,910
Less					
Interest on Term Debt	1,389	1,900	1,096	1,118	1,140
Depreciation	10,662	12,316	10,977	11,196	11,420
Revaluation					
Earnings before Abnormals & Capital Charge	5,943	9,193	8,988	9,166	9,350
Profit/(Loss) on Sale of Assets	-	-	-	-	-
Net Operating Surplus (Deficit)	5,943	9,193	8,988	9,166	9,350
Capital Charge	5,644	9,022	8,988	9,168	9,351
Surplus (Deficit)	**299**	**172**	**0**	**(1)**	**(0)**
(Gains)/Losses on Property Revaluations	(44,189)	-	-	-	-
(Gains)/Losses in Asset for Sale Financial Assets Reserve	-	172	267	221	74
Comprehensive Income	**44,488**	**0**	**(267)**	**(222)**	**(75)**

Statement of Movements in Equity

$000s

	2011-12 Audited Actuals	2012-13 Forecast	2013-14 Budget	2014-15 Budget	2015-16 Budget
Equity at the beginning of the period	66,371	112,771	112,689	112,346	111,951
Surplus/Deficit for the period	299	173	(0)	0	(0)
Total Recognised Revenues and Expenses	66,670	112,944	112,689	112,347	111,951
Other Movements					
Revaluation of Fixed Assets	44,188	(253)	-	-	-
Other	(51)		(343)	(395)	(155)
Equity introduced (Repaid)	1,964	-	-	-	-
Equity at end of Period	**112,771**	**112,689**	**112,346**	**111,951**	**111,796**

Statement of Financial Position

$000s

	2011-12 Audited Actuals	2012-13 Forecast	2013-14 Budget	2014-15 Budget	2015-16 Budget
Equity					
Crown Equity	38,490	40,394	40,394	40,394	40,394
Retained Earnings	2,956	3,109	3,071	2,984	2,944
Subsidiaries & unrestricted trusts	247	251	251	251	251
Revaluation Reserve	69,140	68,935	68,630	68,322	68,207
Capital Injections	1,939	-	-	-	-
Total Equity	112,771	112,689	112,346	111,951	111,796
Represented by:					
Assets					
Current Assets	47,466	51,053	50,267	54,103	58,368
Non-Current Assets	179,964	169,264	168,884	164,654	160,234
Total Assets	227,430	220,317	219,152	218,757	218,602
Liabilities					
Current Liabilities	73,910	66,950	66,204	66,204	66,204
Non-Current Liabilities	40,749	40,677	40,601	40,601	40,601
Total Liabilities	114,659	107,628	106,805	106,805	106,805
Net Assets	**112,771**	**112,689**	**112,346**	**111,952**	**111,797**

Statement of Cash Flows

$000s

	2011-12 Audited Actuals	2012-13 Forecast	2013-14 Budget	2014-15 Budget	2015-16 Budget
Cash Flows from Operating Activities					
Operating Income	504,327	521,527	525,583	536,992	547,732
Operating Expenditure	497,996	523,364	517,521	528,108	538,568
Net Cash from Operating Activities	6,331	(1,837)	8,061	8,884	9,163
Cash Flows from Investing Activities					
Interest receipts 3rd Party	3,617	3,400	3,264	3,330	3,396
Sale of Fixed Assets	172	-	-	-	-
Purchase of Fixed Assets	(14,996)	(10,328)	(18,659)	(10,017)	(7,000)
Decrease in Investments and Restricted & Trust Funds Assets	5,000	9,994	9,205	7,896	3,000
Net Cash from Investing Activities	(6,207)	3,065	(6,190)	1,209	(604)
Cash Flows from Financing Activities					
Equity injections (repayments)	1,964	-	-	-	-
Borrowings	(114)	(76)	(76)	-	-
Interest Paid	(1,397)	(1,900)	(1,096)	(1,118)	(1,140)
Repaid debts	-	-	-	-	-
Other Non-Current Liability Movement	-	-	-	-	-
Net Cash from Financing Activities	453	(1,976)	(1,172)	(1,118)	(1,140)
Net Increase/(Decrease) in Cash held	577	(748)	700	8,976	7,420
Add opening cash balance	24,090	24,667	23,919	24,619	33,594
Closing Cash Balance	24,667	23,919	24,619	33,594	41,014

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

Consolidated Statement of Financial Performance ($000s)	2011-12 Audited Actuals	2012-13 Forecast	2013-14 Budget	2014-15 Budget	2015-16 Budget
MOH Devolved Funding	475,130	486,745	495,132	505,035	515,136
MOH Non-Devolved Contracts (provider arm side contracts)	11,565	11,217	11,481	11,711	11,945
Other Government (not MoH or other DHBs)	3,397	3,730	4,205	4,289	4,375
Patient / Consumer sourced	530	461	404	412	420
Total Other Income	6,899	9,776	10,074	10,275	10,480
InterProvider Revenue (Other DHBs)	1,368	1,170	1,065	1,086	1,108
IDFs - All Other (excluding Mental Health)	7,242	7,854	7,366	7,513	7,664
Total Consolidated Revenue	506,131	520,953	529,727	540,322	551,128
Personnel Costs	175,962	177,871	183,152	186,815	190,552
Outsourced Services	15,111	17,773	17,671	18,019	18,374
Clinical Supplies	42,840	42,668	41,290	42,121	42,968
Infrastructure & Non-Clinical Supplies	24,232	21,629	23,676	24,150	24,633
Finance Costs	7,033	10,922	10,083	10,285	10,491
Depreciation	10,662	12,316	10,977	11,196	11,420
Personal Health	161,882	165,162	168,959	172,338	175,785
Mental Health	13,395	14,489	13,443	13,712	13,986
Disability Support Services	48,346	51,762	54,272	55,358	56,465
Public Health	832	590	459	469	478
Maori Health	5,539	5,745	5,745	5,860	5,977
Total Operating Expenditure	505,834	520,926	529,727	540,322	551,128
Surplus (Deficit)	**297**	**27**	**(0)**	**(0)**	**0**

Key Financial Analysis and Banking Covenants

	2011-12 Audited Actuals	2012-13 Forecast	2013-14 Budget	2014-15 Budget	2015-16 Budget
Financial Analysis					
Term Liabilities and Current Liabilities	114,659	107,628	106,805	106,805	106,805
Debt	24,650	24,650	23,650	23,650	23,650
Owners Funds	112,771	112,689	112,346	111,952	111,797
Total Assets	227,430	220,317	219,152	218,757	218,602
Owners Funds to Total Assets	49.6%	51.1%	51.3%	51.2%	51.1%
Interest Expense	1,389	4,269	1,096	1,118	1,140
Depreciation Expense	10,662	12,316	10,977	11,196	11,420
Surplus/(Deficit)	299	173	- 0	0	- 0
Interest Cover	8.89	3.93	11.02	11.02	11.02
Debt/Debt + Equity Ratio	18%	18%	17%	17%	17%
Banking Covenants					
Debt/Debt + Equity Ratio	17.9%	17.9%	17.4%	17.4%	17.5%
Interest Cover	8.9	3.9	11.0	11.0	11.0
Interest Cover Minimum	3.0	3.0	3.0	3.0	3.0

8 Non-Health Target performance measures

The Ministry of Health has created the DHB monitoring framework to provide the Minister and stakeholders with a rounded view of performance. It uses a range of performance markers so it is possible to 'see at a glance' how well DHBs are performing across the breadth of their activity, with measures focused on both government priorities and legislative requirements.

MoH uses four dimensions, each with their own code, to reflect DHBs' functions as owners, funders and providers of health and disability services.

Code	Dimension	Definition
PP	Policy Priorities	Achieving Government's priority goals, objectives and targets
SI	System Integration	Meeting service coverage requirements and supporting sector inter-connectedness
OP	Outputs	Providing quality services efficiently
OS	Ownership	Purchasing the right mix and level of services within acceptable financial performance

There is also a developmental (DV) dimension for new measures for which baseline data is being sought to enable targets to be set in future.

Many of these measures and targets are also used in 5 Statement of Forecast Service Performance.

Performance measure	2013/14 performances expectation or targets		
PP1: Workforce, improving clinical leadership	Report progress of DHB work to improve clinical leadership and engagement across all levels of the DHB and the Regional Training Hubs.		
PP6: Improving the health status of people with severe mental illness through improved access	Age 0-19	Maori	4.30
		Total	4.18
	Age 20-64	Maori	8.38
		Total	5.09
	Age 65+	Maori	1.85
		Total	1.87
PP7: Improving mental health services using relapse prevention planning	Age 20+		97%
	Children and youth		95%
PP8: Shorter waits for non-urgent mental health and addiction services	*Mental health (NDHB)*		
	Age	≤ 3 weeks	≤ 8 weeks
	0-19	70%	95%
	20-64	80%	95%
	65+	80%	95%
	Total	80%	95%
	Addictions (NDHB and community providers)		
	Age	≤ 3 weeks	≤ 8 weeks
	0-19	70%	85%
	20-64	70%	95%
	65+	80%	95%

Performance measure	2013/14 performances expectation or targets		
	Total	70%	95%
PP10: Oral Health- Mean DMFT score at Year 8	Ratio year 1 (2013)		1.12
	Ratio year 1 (2014)		1.12
PP11: Children caries-free at five years of age	Ratio year 1 (2013)		55%
	Ratio year 1 (2014)		58%
PP12: Utilisation of DHB-funded dental services by adolescents (school Year 9 up to and including age 17 years)	% year 1 (2013)		75%
	% year 1 (2014)		80%
PP13: Improving the number of children enrolled in DHB-funded dental services	Ages 0-4	Year 1 (2013)	70%
		Year 2 (2014	75%
	Children not examined age 0-12	Year 1 (2013)	15%
		Year 2 (2014)	15%
PP18: Improving community support to maintain the independence of older people	The percentage of older people receiving long-term home support who have a comprehensive clinical assessment and an individual care plan		70%
PP20: improved management for long term conditions (CVD, diabetes, stroke)			
Focus area 1: cardiovascular disease	70% of high-risk patients will receive an angiogram within 3 days of admission. ('day of admission' being 'day 0')		70%
	>95% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PC registry data collection		>85%
Focus area 2: stroke services	6% of potentially eligible stroke patients thrombolysed		6%
	80% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway		80%
Focus area 3: diabetes – management (microalbuminuria and on an ACEI or ARB)	Percentage of of enrolled people aged 45-74 in the PHO with diabetes and microalbuminuria, who are prescribed an ACEI or ARB		Maintain or improve
Focus area 3: diabetes management (HbA1c)	Percentage of enrolled people aged 15-74 with diabetes in the PHO and the most recent HbA1c during the past 12 months of equal to or less than 64 mmol/mol		75%
PP21: Immunisation coverage (previous Health Target)	Two-year-olds fully immunised.		95%
PP22: Improving system integration	Report on delivery of the actions and milestones identified in the Annual Plan.		
PP23: Improving wrap-around services, health of older people	Report on delivery of the actions and milestones identified in the Annual Plan.		
PP24: Improving waiting times, cancer multidisciplinary meetings	Report on delivery of the actions and milestones identified in the Annual Plan.		
PP25: Prime Minister's youth mental health project	Provide a written stocktake, gaps analysis and actions being considered.		
PP26: Mental Health and Addiction Service Development Plan	Provide gaps analysis and report against SDP milestones.		
PP27: Delivery of the Children's Action Plan	Definitions to be confirmed.		

PP28: Reducing rheumatic fever	Provide a progress report against DHBs' rheumatic fever prevention plan	
	Hospitalisation rates (per 100,000 DHB total population) for acute rheumatic fever are 10% lower than the average over the last 3 years	9.5/ 100,000 (15 cases)
SI1: Ambulatory sensitive (avoidable) hospital admissions	Age 0-4	108%
	Age 45-64	96%
	Age 0-74	104%
SI2: Delivery of Regional Service Plans	A single progress report on behalf of the region agreed by all DHBs within that region	
SI3: Ensuring delivery of service coverage	Report progress achieved during the quarter towards resolution of: exceptions to service coverage identified in the Annual Plan and not approved as long term exceptions any other gaps in service coverage	
SI4: Standardised intervention rates (SIRs)	Major joint replacement	21.0 per 10,000 population
	Cataract procedures	27.0 per 10,000 population
	Cardiac surgery	Target of 6.5 per 10,000 population (or if previous rate is 6.5 per 10,000 or above, maintain this rate)
	Percutaneous revascularisation	Target of at least 11.9 per 10,000 population
	Coronary angiography services	Target of at least 33.9 per 10,000 population
SI5: Delivery of Whanau Ora	Report progress on planned activities with providers to improve service delivery and develop mature providers	
OS3: Inpatient length of stay	Elective LOS	3.50
	Acute LOS	4.15
OS8: Reducing acute readmissions to hospital	% total population	6.40%
	% age 75+	9.70%
OS10: Improving the quality of data submitted to National Collections	National Health Index duplications	Greater than 3.00% and less than or equal to 6.00%
	Ethnicity set to 'not stated' or 'response unidentifiable' in the National Health Index	Greater than 0.50% and less than or equal to 2%
	Standard versus edited descriptors	Greater than or equal to 75.00% and less than 90.00%
	Timeliness of NMDS data	Greater than 2.00% and less than or equal to 5.00% late
	NNPAC emergency department-admitted events have a matched NMDS event	Greater than or equal to 97.00% and less than 99.50%
	PRIMHD file success rate	Greater than or equal to 98.0% and less than 99.5%

DV2: Improving waiting times for diagnostic services	Indicator 1	>70% of high risk Acute Coronary Syndrome patients accepted for coronary angiography having it within 3 days of admission (Day of admission=Day 0)
	Indicator 2	>95% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection
Output 1: Mental health output delivery against plan	Volume delivery for specialist mental health and addiction services is within: a) 5% of planned volumes for services measured by FTE b) 5% variance of a clinically safe occupancy rate of 85% for inpatient services, measured by available bed days c) actual expenditure on the delivery of programmes or places is within 5% of the year-to-date plan	

Appendix 1: Northland Health Services Plan

The problem

Over the next 20 years, the health needs of the Northland population will increase as a result of population growth and ageing, and increasing prevalence of long term conditions (LTCs). Health inequities between Maori and non-Maori may worsen, given the prevalence and impact of LTCs, associated risk factors such as obesity, relative differences in socioeconomic status, and the impact of Northland's poor local economy performance.

Today, all services in Northland – primary care, community and hospital – are under demand pressures, and some facilities are at or approaching capacity. 'More of the same' though will not cut it in the future. The need for change is compounded by medium- to long-term forecasts of constraints in operational and capital funding, and availability of workforce.

'Future-proofing' requires different resource allocation patterns and adoption of new ways of working that improve access, make better use of the available workforce, and improve service performance ('new models of care'). New and enhanced facilities and improved use of technologies are also required.

The plan

To respond to these challenges, the Northland Health Services Plan (NHSP) was developed with wide involvement from across the health sector and stakeholder groups. It is a 5-year action plan with a 20-year horizon, with a particular focus on early actions to reduce the risk of crisis-driven, reactive responses. It builds on existing NDHB plans and learnings from local, regional and international settings.

The next two pages describe the highest levels of the NHSP's Outcomes Framework and present the Roadmap that was drawn from it. The NHSP uses the Triple Aim methodology that also formed the basis of the Northern Region Health Plan: achieving improvements in population health, patient experience, and cost / productivity simultaneously.

NHSP Outcomes Framework (highest levels only)

Outcome Areas	Population health		Patient experience		Cost and productivity	
Outcome Goals	Improve the health of Northlanders and reducing health inequities		Patients and whanau experience clinically and culturally safe, good quality, effective, efficient and timely care		The Northland health system lives within available funding by improving productivity and prioritising resources to their most cost effective uses	
2017 Headline Targets	Life expectancy gap between Maori and non-Maori is reduced by 2 years	Unplanned hospital admissions for Northlanders are reduced by 2,000 annually by 2017	Every Northlander with urgent health needs has same day access to primary care	>95% of patients report they would recommend the service provided	Value for money savings of $5m achieved against projected cost increases every year	Northland hospital labour productivity benchmarks in top 5 of DHBs

Objectives	Increasing the number of Northlanders who are health literate and living healthy lifestyles, with a particular focus on improving Maori health outcomes. Increasing the availability of and access to services in primary and community settings, particularly urgent, intermediary ('step down') and restorative services. Improving primary care access to specialist advice to support community-based care.	Ensuring patients and their whanau are supported throughout their care pathways with early interventions to address health needs and risks, and links with social services. Providing patients and whanau with access to more personalised health services, including active involvement in their own care planning. Ensuring Northland health organisations operate with cultural competence.	Working smarter to reduce duplication and waste. Ensuring service investment and provider performance demonstrates value for money. Strategic investment in new models of care, service innovations and capacity development.

The full plan is available at http://northlanddhb.org.nz/.

Appendix 2: Commitments

Community Pharmacy Service Agreement

Northland DHB is fully committed to the roll-out and implementation of the Community Pharmacy Service Agreement (CPSA). NDHB has maintained ongoing, open discussion with pharmacy service providers throughout the change process and achieved 100% signatories to the initial roll-out of the agreement at 1 July 2012, and again for the first variation at 1 March 2013. Communication processes have included mail-outs, emails, workshops, group meetings, individual meetings, and one-to-one phone conversations. Northland's PHOs have similarly been kept informed of all service changes, and they have indicated their commitment and support for the CPSA. NDHB will continue to work closely with our PHOs, PHO pharmacy facilitator and clinical director to ensure ongoing support from primary care.

Northern Region DHBs' programme managers meet frequently to ensure consistency of approach across the region, and the four regional DHBs have jointly employed a Pharmacy Project Manager, located at the Northern DHB Support Agency, to facilitate communications pertaining to the CPSA across the Northern Region.

Northland DHB recognises community pharmacy as a key provider of health services within Northland and maintains a close relationship with providers to ensure the provision of quality, sustainable, accessible community pharmacy services. Community pharmacy, hospital pharmacy and DHB funding and planning are jointly represented at the Northland Community Pharmacy Service Improvement Group. This group was developed to:

- provide two-way communication between community pharmacy representatives and Northland DHB on issues relating to the delivery of community pharmacy services within Northland
- encourage the development and implementation of primary health care services that can be delivered in a sustainable way by pharmacists and/or their teams to improve health outcomes of Northlanders.

Northland DHB has allocated funding specifically to this group to be utilised in developing robust, sustainable community pharmacy services within Northland. Programmes introduced to date have included Warfarin counselling, pharmacy waste management, motivational interviewing and SSRI counselling programmes.

Pharmac

Northland DHB recognises the key role that Pharmac plays in managing and promoting the optimal use of medicines and medical devices within New Zealand. NDHB is committed to supporting Pharmac in this role. Our financial planning for pharmacy is based on the annual budget recommendations as provided by Pharmac. Northland DHB will continue to work in partnership with Pharmac in planning the delivery of further improvements in quality, efficiency and cost control as necessary.

Appendix 3: Statement of Accounting Policies

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

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 NZ IAS 1.

The consolidated financial statements of NDHB and group for the year ended 30 June 2010 comprise NDHB and its joint venture subsidiary the Kaipara Total Health Care Joint Venture (54% owned).

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

Statement of compliance

The consolidated financial statements have been prepared in accordance with generally accepted accounting practice in New Zealand (NZ GAAP). They comply with New Zealand equivalents to International Financial Reporting Standards (NZ IFRS) 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.

Basis of preparation

The financial statements will be presented in New Zealand Dollars (NZD), rounded to the nearest thousand. The financial statements are prepared on historical cost basis except for land and buildings that are stated at their revalued amounts.

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

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

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

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

The Board and group have adopted the following revisions to accounting standards during the financial year, which have only had a presentational or disclosure effect:

NZ IAS 1 Presentation of Financial Statements (Revised 2007) replaces NZ IAS 1 Presentation of Financial Statements (Issued 2004). The revised standard requires information in financial statements to be aggregated on the basis of shared characteristics and introduces a statement of comprehensive income. The statement of comprehensive income will enable readers to analyse changes in equity resulting from non-owner changes separately from transactions with owners. The Board and group have decided to prepare a single statement of comprehensive income for the year ended 30 June 2010

under the revised standard. Financial statement information for the year ended 30 June 2009 has been restated accordingly. Those items of other comprehensive income presented in the statement of comprehensive income were previously recognised directly in the statement of changes in equity.

Amendments to NZ IFRS 7 Financial Instruments: Disclosures. The amendments introduce a three-level fair value disclosure hierarchy that distinguishes fair value measurements by the significance of valuation inputs used. A maturity analysis of financial assets is also required to be prepared if this information is necessary to enable users of the financial statements to evaluate the nature and extent of liquidity risk. The transitional provisions of the amendment do not require disclosure of comparative information in the first year of application.

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

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

NZ IFRS 9 Financial Instruments will eventually replace NZ IAS 39 Financial Instruments: Recognition and Measurement. NZ IAS 39 is being replaced through the following 3 main phases: Phase 1 Classification and Measurement, Phase 2 Impairment Methodology, and Phase 3 Hedge Accounting. Phase 1 on the classification and measurement of financial assets has been completed and has been published in the new financial instrument standard NZ IFRS 9. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39. The approach in NZ IFRS 9 is based on how an entity manages its financial instruments (its business model) and the contractual cash flow characteristics of the financial assets. The new standard also requires a single impairment method to be used, replacing the many different impairment methods in NZ IAS 39. The new standard is required to be adopted for the year ended 30 June 2014. NDHB has not yet assessed the effect of the new standard and expects it will not be early adopted.

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 purchase method, which involves adding together corresponding assets, liabilities, revenues and expenses on a line by line basis. All significant 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" financial statements.

Budget Figures

The budget figures are those approved by the health board in its District Annual Plan and included in the Statement of Intent tabled in parliament. The budget figures have been prepared in accordance with NZ GAAP. They comply with NZ IFRS 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. Non-monetary assets and liabilities denominated in foreign currencies that are at fair value are translated to NZD at foreign exchange rates ruling at the dates the fair value was determined.

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. 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 offsets a previous decrease in value recognised in the surplus or deficit will be recognised first in the surplus or deficit up to the amount previously expensed, and then recognised in other comprehensive 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.

The property held under finance leases and leased out under operating lease is classified as investment property and stated at fair value. Property held under operating leases that would otherwise meet the definition of investment property may be classified as investment property on a property-by-property basis.

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:

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

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

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

Borrowing costs

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

Intangible assets

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

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

Subsequent expenditure

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

Amortisation

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

Class of asset	Estimated life	Amortisation rate
Software	2 to 3 years	33% - 55%

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 future economic benefits or service potential of the asset are not primarily dependent on the asset's ability to generate net cash inflows and where the entity would, if deprived of the asset, replace its remaining future economic benefits or service potential.

The value in use for cash-generating assets and cash generating units is the present value of expected future cash flows.

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 of 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 of 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
- loans and receivables
- fair value through other comprehensive income.

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 remeasurement recognised in 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.

Financial assets at fair value through other comprehensive income

Financial assets at fair value through other comprehensive income are those that are designated as fair value through other comprehensive income or are not classified in any of the other categories above. They are included in non-current assets unless management intends to dispose of the investment within 12 months of the balance date.

NDHB's Bond investments that it intends to hold long-term but which may be realised before maturity are held in this category.

After initial recognition 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 derecognition the cumulative gain or loss previously recognised in other comprehensive income is re classified from equity to the surplus or deficit.

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.

Financial assets at fair value through other comprehensive income

For equity investments, a significant or prolonged decline in the fair value of the investment below its cost is considered objective evidence of impairment.

For debt investments, significant financial difficulties of the debtor, probability that the debtor will enter into bankruptcy, and default in payments are considered objective indicators that the asset is impaired.

If impairment evidence exists for investments at fair value through other comprehensive income, the cumulative loss (measured as the difference between the acquisition cost and the current fair value, less

any impairment loss on that financial asset previously recognised in the surplus or deficit) recognised in other comprehensive income is reclassified from equity to the surplus or deficit.

Equity instrument impairment losses recognised in the surplus or deficit are not reversed through the surplus or deficit.

If in a subsequent period the fair value of a debt instrument increases and the increase can be objectively related to an event occurring after the impairment loss was recognised, the impairment loss is reversed in the surplus or deficit.

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 a first in first out basis.

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

Interest bearing borrowings

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

Employee benefits

Defined contribution plan

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

Long service leave, sabbatical leave and retirement gratuities

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

Annual leave, conference leave and medical education leave

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

Sick leave

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

Provisions

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

Revenue relating to service contracts

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

Income tax

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

Goods and services tax

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

Revenue

Crown funding

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

Goods sold and services rendered

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

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

Rental income

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

Interest

Interest Income is recognised using the effective interest method.

Expenses

Operating lease payments

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

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

Financing costs

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

Equity

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

The components of equity are Retained Earnings, Revaluation Reserve (consisting of Land and Buildings), Trust/Special Funds and fair value through other comprehensive income reserves. Special funds are funds donated or bequeathed for a specific purpose. The use of these assets must comply with the specific terms of the sources from which the funds were derived. The revenue and expenditure in respect of these funds is included in the surplus or deficit. An amount equal to the expenditure is transferred from the Trust fund component of equity to retained earnings. An amount equal to the revenue is transferred from revenue earnings to trust funds.

Insurance Contracts

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

Contingent liabilities

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

Cost of Service (Statement of Service Performance)

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

Cost allocation

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

Cost allocation policy

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

Criteria for direct and indirect costs

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

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

Cost drivers for allocation of indirect costs

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

Appendix 4: Glossary

Term	Definition or explanation
ABC	a service for helping smokers to quit which consists of Ask, Brief intervention and Cessation
ACE, ARB	angiotensin-converting enzyme, angiotensin receptor blocker; drugs to control high blood pressure
ACP	Advance Care Planning; forward planning for end-of-life care for people with terminal conditions
ACS	acute coronary syndrome
ADHB	Auckland District Health Board
ANZACS	Australia and New Zealand Acute Coronary Syndrome (registry)
AOD	alcohol and other drugs
ARRC	age-related residential care
ASH	ambulatory sensitive hospitalisations; a subset of avoidable hospitalisations
B4SC	Before School Checks, performed on all children as part of the Well Child Tamariki Ora schedule
CAMHS	Child and Adolescent Mental Health Service
CNS	clinical nurse specialist
Community provider	Also known as a non-governmental organisation or NGO (in health, usually used to refer to all organisations in the health sector outside a DHB)
COPD	chronic obstructive pulmonary (lung) disease
CPSA	Community Pharmacy Service Agreement
CT	computerised tomography, a type of body imaging
CVD	cardiovascular disease
CY	calendar year (compare with FY)
CYFS	Child Youth and Family Service; part of the Ministry of Social Development
CYMOS	Child, Youth, Maternal and Oral Services (of NDHB)
DCIP	Diabetes Care Improvement Package
DHB	District Health Board
DMFT	decayed, missing, filled teeth; a measure of total damaged teeth in the mouth
DSP	Drive Soba (sober) Programmes
DTT	decision to treat, the point at which a consultant decides to go ahead with treatment after appropriate investigations have been made and a diagnosis reached
ECRP	Endoscopic retrograde cholangiopancreatography, a gastrointestinal diagnostic procedure to examine the bile and pancreatic ducts
ED	Emergency Department
ENT	ear, nose and throat
FCT	faster cancer treatment
FIS	Fruit in Schools
FSA	first specialist appointment; a patient's first appointment with a specialist after referral by their GP
FTE	full time equivalent; 40 hours per week of work time
FY	financial year; for DHBs, 1 July to 30 June (compare with CY)

Term	Definition or explanation
GDP	Gross Domestic Product, a measure of the total value of goods and services produced by workers and capital in a country
GM	General Manager
GP	General Practitioner
H2H	Hospital to Home, a service that provides certain clinical services in the community rather than requiring people to go to hospital for treatment
HbA1C	a measurement of the amount of sugar in the blood
HBL	Health Benefits Limited; a national organisation established in 2010 to reduce costs and deliver savings in administrative, support and procurement services for the health sector
HBSS	home based support services (for older people)
HEADSSS	an international screening tool for adolescents, comprising Home, Education, Activities, Drugs, Sex, Suicidality and Safety
HOP	health of older people
HQSC	Health Quality and Safety Commission; a national organisation established under amendments to the Public Health and Disability Act in 2010
HR	Human Resources (department)
IFHC, IFHN	Integrated Family Health Centre (for urban areas), Integrated Family Health Network (for rural areas)
interRAI	a collaborative network of researchers in over 30 countries who promote evidence-based clinical practice and policy to improve health care for persons who are elderly, frail, or disabled
IPPMR	Internal Planning, Performance Monitoring and Reporting (meeting)
IDF	Inter District Flows; services provided by DHBs for people outside their areas, for which funds are exchanged between DHBs in an attempt to 'balance the books'.
IS	information systems
IT	information technology
JADE	A computer software product (and the company that makes it)
KPI	key performance indicator
KPMG	a private company that provides audit, tax and advisory services
LMC	Lead Maternity Carer; the midwife who oversees a pregnant woman's care
LOS	length of stay
LTC	long term condition; includes CVD, diabetes, cancer and respiratory diseases
LTCF	long term care facility (for older people)
MDM	multidisciplinary meeting; health workers of various types and specialties meet to discuss patients
MIS	Milk in Schools
MoCA	Montreal Cognitive Assessment, a screening test designed to assist health workers to detect mild cognitive impairment
MoH	Ministry of Health
MoU	memorandum of understanding
MPDS	Maori Provider Development Subsidy
MRI	magnetic resonance imaging, a type of body imaging used especially for looking at body structures that do not show up well on xray
NASC	Needs Assessment and Service Coordination
NDHB	Northland District Health Board
Community	non-governmental organisation (in health, usually used to refer to all organisations in the

Term	Definition or explanation
provider	health sector outside a DHB)
NHSP	Northland Health Services Plan (explained in Appendix 1)
NIR	National Immunisation Register
NMDS	National Minimum Data Set, a national collection of public and private hospital discharge information
NNPAC	National Non-Admitted Patient Collection, data on outpatient and ED patients
NoRTH	Northern Region Training Hub
NPHOS	Northland Primary Health Organisations; an analytical function shared between Manaia PHO and Te Tai Tokerau PHO that deals with enrolments, performance data and so on
NRA	Northern Regional Alliance (a merger of the old Northern DHB Support Agency and the Northern Region Training Hub)
NRHP	Northern Region Health Plan
NZD	New Zealand dollars
NZ IAS	New Zealand International Accounting Standards
NZ IFRS	New Zealand International Financial Reporting Standards
NZ GAAP	New Zealand generally accepted accounting practice
PCI	percutaneous coronary intervention, a technique for managing heart vessel blockages with catheters
PHN	public health nurse
PHO	Primary Health Organisation
post-strep GN	poststreptococcal glomerulonephritis, an autoimmune kidney inflammation causing temporary renal impairment associated with Group A streptococcal infection, usually of the skin
PRIMHD	Programme for the Integration of Mental Health Data (MoH's single national mental health and addiction information database)
QID	the Quality and Improvement Directorate of Northland DHB
RBA	results-based accountability
SBL	Surgical Booking List
SCBU	Special Care Baby Unit (= neonatal intensive care)
SDQP	a screening tool for families of adolescents
SIR	standardised intervention rate; crude rates are statistically adjusted so that datasets relating to different populations with different age structures are made comparable
SSRI	selective serotonin re-uptake inhibitors; a type of antidepressant medication
STEMI	ST-segment elevation myocardial infarction, a type of heart attack
SUDI	sudden unexpected death in infancy (sometimes also used to mean sudden unexplained death in infancy)
TIA	trans ischaemic attack; a warning sign of a potential stroke
Triple Aim	the highest level of purpose in the NHSP (see Appendix 1) and NRHP
WCTO	well child, tamariki ora; mainstream and Maori providers of well-child services
WINZ	Work and Income NZ, part of the Ministry of Social Development