NORTHLAND DISTRICT HEALTH BOARD

ANNUAL REPORT 2017

A Healthier Northland
He Hauora Mo Te Tai Tokerau

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

Reading our Annual Report

The annual report presents an account of Northland DHB's performance for the year from 1 July 2016 to 30 June 2017.

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

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

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

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

Key Components

Chair and Chief Executive Report
A report from the chair and chief executive on the past year.

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

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

2016/17: The Year in Review
Includes staff and health sector activities and the DHB's financial performance.

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

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

Contents

MESSAGE FROM THE CHAIR & CHIEF EXECUTIVE

Although it's been an extremely challenging year, our staff, and indeed the whole health sector has responded magnificently to this challenge. We worry about the toll this has on everyone as all of our teams work to meet the insatiable demand for health services.

Sally Macauley
Board Chairman

Dr Nick Chamberlain
Chief Executive

For Northland DHB, the 2016/17 financial year has been one of our toughest. All of our services have been under extreme pressure with unprecedented growth (6-8 percent) and an inability to provide or fund everything Northlanders need and deserve. This is because we are not receiving all of the funding that should be allocated to our population. We have had our population based funding capped and are now the only DHB in New Zealand in this situation. Because of this cap, Northland DHB has had to forego $29.4 million of health funding.

The biggest driver of population based funding is the number of people in our catchment area and, and as we all know, our population is growing rapidly. In addition, because we are either first or second in New Zealand for rurality, percentage of aged over 65 years, percentage Māori, and level of poverty and unmet need, this drives significant health demand which our staff and services experience every day in their work.

One of the consequences of the cap is that most of our funding is consumed on providing universal services and not enough can be targeted to our highest need patients and communities. One thing we are all clear about is that we cannot deny Northlanders safe, high quality health services, and there are a number of initiatives that we simply cannot stop doing.

For the first time in our memory, Northland DHB posted a $2.5 million deficit for the year ended 30 June 2017. The Board and Executive Leadership team are absolutely committed to addressing the funding issue while ensuring that we continue to innovate and strive for excellence and improve the health of our population, reduce inequities, provide high quality patient care and protect and enhance the wellbeing of our staff.

There has been a disturbing increase in the number of motor vehicle crashes causing injury and incidents involving firearms. Many of our staff have known of or known one of the victims and because of the jobs we do, we are all caring people who can't help but reflect on how fragile life is. One particular incident was probably the biggest challenge to our emergency and surgical services in many years, and when presented with such extreme circumstances the entire hospital worked together, worked double shifts, teams were called in that weren't even on call. Many lives were saved, and the commitment and teamwork made us incredibly proud.

From a patient safety and quality point of view, Northland DHB is a very different organisation to a few years ago. Analysis of the data produced by our CRAB software is providing reassurance that our patient outcomes are significantly better than we might expect. Patient satisfaction has also increased over the last year.

Choosing Wisely is building momentum, particularly the projects involving the Department of Surgery working to reduce unnecessary blood tests, and the Renal Department who are working to ensure that potential dialysis patients have every opportunity possible to understand benefits and risks of this treatment so they can make an informed decision on what they want.

Work is also underway to improve the understanding of the Partners in Care programme and to ensure that all patients have the opportunity to be supported by those closest to them throughout their hospital stay.

This year our Health and Disability Commissioner (HDC) complaints and investigations dropped considerably. Northland DHB received 10 HDC complaints and averaged 27.6 complaints per 100,000 discharges (down from 55.82 per 100,000 discharges in 2015/16).

In the past twelve months there has been a strong emphasis towards collaborative arrangements to advance the Indigenous Health System and the review of the Treaty partnership between Te Kahu O Taonui (our iwi Chairs) and Northland DHB.

Sir Mason Durie led two workshops in 2016 with key stakeholders from Manaia Health and Te Tai Tokerau PHOs, Māori health providers, iwi representatives, the Board and management to explore how we could advance the health and wellbeing of Māori.

The broad consensus was to advance an Iwi/ Provider Alliance and explore commissioning for outcomes. The project has since merged with the primary healthcare collaboration project which seeks to align and integrate all primary health services and should provide the vehicle to pursue and achieve the goals and principles of the indigenous health system workstream. Both PHO Boards have signed off on the new enhanced model for primary healthcare with a single

Primary Care Intermediary and a number of localities supported by two PHO support centres.

We experienced significant national media interest about youth suicide. The innovation, information sharing, tasking, coordination, risk management and preventive work performed by our Mental Health and Addiction staff as well as Northland's other agencies and NGOs, and our local communities was not really acknowledged, but it did open up conversations about youth suicide and New Zealand's very high overall suicide rates. Youth suicide requires careful consideration, and it is important to do no further harm. In the 2016/17 financial year there were five suspected youth (under 24 years of age) suicides in Northland. While there has been a downward trend since 2012, we experienced a rise this year and remain committed to a zero youth suicide target in Northland.

We have had mixed results with the Health Targets this year. Northland DHB achieved 123 percent against the Improved Access to Elective Surgery Target (100 percent) which is well above the target and the national average. Northland DHB was well on track to meet the Healthy Kids Target of 95 percent by December 2017. And, despite the significant growth in acute demand we were close to achieving the Shorter Stays in EDs Target (95 percent), with 92.7 percent of patients admitted, discharged or transferred within six hours by year end.

Further work is needed however on Faster Cancer Treatment (81 percent averaged over the year), Better Help for Smokers to Quit (82 percent of the 90 percent target averaged over the year) and Increased Immunisation for eight-month olds (averaged 89 percent over the year).

Of considerable concern is the large number of families who are choosing not to immunise their children or delay immunisation - some even opting off the immunisation register. A more collaborative approach between the Northland DHB and PHOs/general practise has enabled system improvement to occur for tracking, tracing and immunising children via outreach services, and very few children are missed. Immunisation will continue to be a priority for the DHB.

With Northland's five-year-olds repeatedly having the country's highest average score of damaged (decayed, missing or filled) teeth we were extremely pleased to learn about the Health (Fluoridation of Drinking Water) Amendment Bill. This bill amends Part 2A of the Health Act 1956 by inserting a power for DHBs to make decisions and give directions about the fluoridation of local government drinking water supplies in their areas.

Our Neighbourhood Healthcare Homes programme has resulted in six general practices across eight sites delivering a new proactive model of care with improved patient access and satisfaction. There are also a number of innovations within the public health area including Project Energize which is now in 82 low decile schools and Under-5 Energize which was launched this year. With some seed funding, one of our NGOs has established a food rescue service. There is also innovation and collaboration occurring to support a further reduction in our smoking rates with a specific emphasis on Māori.

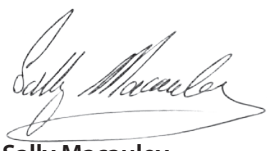
Our new pregnancy and parenting service He Tupua Wai-Ora was launched on 20 March 2017. The $1m per annum contract enables an assertive outreach addiction service to 100 pregnant women or young mums. The service is strongly aligned to Northland DHBs commitment to improve equity of access and to intervene (very) early to give our tamariki the opportunity to thrive.

Northland DHB and NZ Police have been funded $3m to deliver the Te Ara Oranga Methamphetamine Demand Reduction strategy pilot. The funding was made available under the Criminal Proceeds (Recovery) Act. Te Ara Oranga is an integrated model of police and health activity to reduce methamphetamine demand by enhancing treatment services and increasing our responsiveness.

In November 2016 Northland DHB, NorthAble Disability Services, Manaia Health and Te Tai Tokerau PHO came together to host the Northland Health & Social Innovation Awards celebrating quality, innovation and integration across the Te Tai Tokerau health and social sectors. The event showcased achievements from across the Northland health and social sectors over the last two years.

The partnership this year between Northland DHB and the Northland Foundation has focused on encouraging community giving to benefit the health needs of all Northlanders, now and in the future. We work together, raising donations to provide extra equipment and to support innovation and new initiatives that give Northland DHB an extra edge in the delivery of healthcare to the Northland community. This year grants that have been made include support for: the Jim Carney Cancer Centre (fish tank and new dishwasher), the Diabetes Fun Run/Walk, Osteoporosis Awareness Day, World Kidney Day Fun Run and Walk and improving patient experience through a sleep mask trial. This year the Foundation has received $147,362 on our behalf. We also want to thank Countdown and their staff, who yet again raised over $96,000 to purchase clinical equipment for our children.

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



Sally Macauley
Board Chairman

Dr Nick Chamberlain
Chief Executive

ABOUT NORTHLAND DHB

Who are we and what we do

Northland DHB is categorised as a Crown Agent under section 7 of the Crown Entities Act 2004.

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

The DHB employs 2,929 staff. Acute services are provided through the DHB's four hospitals, based at Whangarei, Dargaville, Kawakawa and Kaitaia, with elective surgery performed at Whangarei and Kaitaia. These services are supplemented by a network of community-based, outpatient and mental health services, a range of allied health services and a public and population health unit.

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

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

Our Health Profile

Māori

Māori experience low levels of health status across a range of health and socio-economic statistics. They comprise 34.9 percent of Northland's total population, but 54 percent of the child and youth population, a key group for achieving long-term gains. Māori experience early onset of long-term conditions like cardiovascular disease and diabetes, presenting to hospital services on average about 13 years younger than non-Māori.

Child and Youth

The child and youth proportion of Northland's population is projected to decline over the coming years from 32.5 percent in 2017 to 30.6 percent in 2027, but remains a priority because healthy children make for healthy adults and because children are more vulnerable than adults.

The deprivation index, which divides New Zealanders into ten groups according to their deprivation scores, placed 80 percent of the population on the most deprived half of the index.

Older People

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

Long-Term Conditions

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

Twenty percent of adult Northlanders have been told they have high blood pressure and 12 percent that they have high cholesterol, both known risk factors for cardiovascular disease.

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

Oral Health

Northland's five-year-olds have repeatedly had the country's highest average score of damaged (decayed, missing or filled) teeth and one of the lowest percentages of teeth without tooth decay (45 percent compared with the national 41 percent). Data for adolescent oral health is limited, but it suggests a similar, if not worse, picture.

Lifestyle Behaviours

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

Social Influences

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

ABOUT NORTHLAND DHB

$293m

Whangarei, Dargaville, Bay of Islands and Kaitaia Hospitals (surgical and medical services, emergency departments, imaging, laboratories, maternity), public health.

$64m

Primary Health (general practitioners, community dental services, radiology)

$65m

Health of older people (including residential care, rehabilitation)

$54m

Mental health services

$6m

Māori health services

$40m

Community pharmacies

$8m

Community laboratory services

$77m

Inter-district flows (publicly-funded health services paid to other district health boards and others for services provided to Northland patients)

Total $607m

EACH DAY IN NORTHLAND

On average, each day in Northland there are:

Emergency Department presentations

133

Theatre events

45

Mental health community visits

492

Immunisations for 8-month-olds

8

Inpatient discharges

108

Radiology exams

264

General practice consultations

1,924

Breast screens

40

Outpatient attendances

2,087

Lab test results – Hospital

3,566

Prescription items processed by pharmacies

7,701

Subsidised bed days in aged residential care

932

Outpatient missed appointments

72

Lab test results – Community

3,797

Community visits by allied health services

87

People assessed by hospice services nursing teams

17

Northland patients discharged by other DHBs

15

Babies born in hospital

5

District nursing visits

196

Hours of home-based support services for older people

1,697

Chemotherapy attendances

16

Deaths in Northland

5

Oral health visits in primary schools

163

Renal dialysis

54

Mental health hospital admissions

3

Immunisations for 2-year-olds

8

OUR SERVICES

There are currently 172 GPs and 175 practice nurses across 37 general practices providing primary healthcare to Northlanders enrolled with Northland PHOs, and non-enrolled and non-resident patients.

Northland DHB has 280 contracts with 126 non-government organisations (NGOs) including Māori health providers and Whānau Ora collectives that provide a range of public health, primary healthcare and community services across Northland.

Figure 1
Northland PHOs

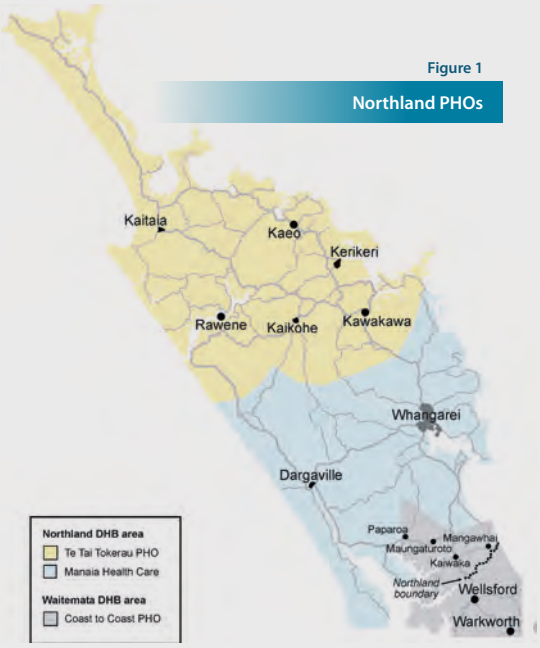


Figure 2
Māori NGOs

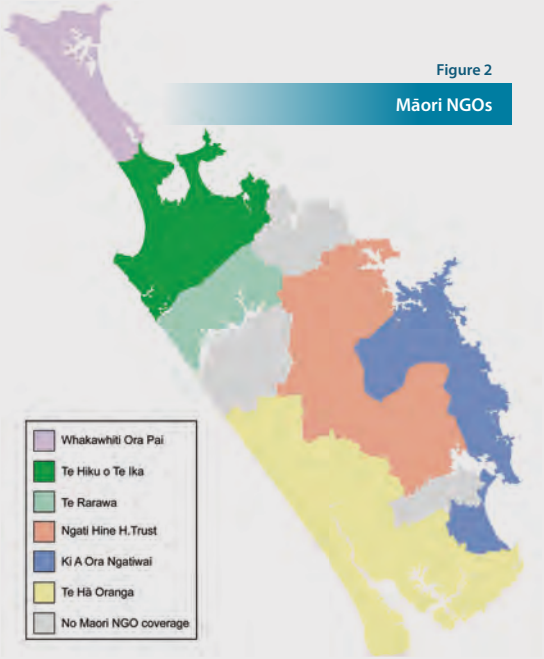


Figure 3
Northland Hospitals

Figure 4
Travel Distances

OUR PEOPLE

Northland DHB's people are its most valuable resource. They support our organisational culture. We engage our employees through positive relationships to foster leadership skills at all levels. Our aim is to recruit, develop and retain a workforce which continues to provide the highest professional levels of health services to the Northland population.

Demographics

Northland DHB workforce profile	Total workforce 2,929 active employees
Age profile	Female average age: 46.72 years Male average age: 46.38 years
Ethnic profile	Māori 16.15 percent Pacific 2.01 percent European 55.2 percent Asian 9.56 percent Other 3.86 percent Not stated 13.22 percent
Disability profile	Specific data is not currently held for this category. Individuals with disabilities applying for vacancies are given full considerations based on the needs of the position
Gender profile	Female: 2,325 employees (79.38 percent) Male: 604 employees (20.62 percent)

Leadership, Accountability and Culture

Leadership is encouraged and supported at all levels of the organisation. A key focus and priority for the DHB is the engagement between clinical networks, strengthening established partnerships between managers and clinicians at the clinical governance level. This has resulted in a greater number of senior clinical directors at the executive leadership table who together with our primary care leaders shape the strategic direction for the delivery of health care services in Te Tai Tokerau. Clinical leadership forums are established for medical, nursing, midwifery and allied health leaders to develop their roles and support professional development of leadership and management skills. Clinicians are an integral part of the decision-making process that drives key projects within the organisation.

Clinical partnership models include:

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

Collaboration across services and occupational groups contributes significantly to staff engagement and innovation as does the DHB's positive relationship with its union partners. Staff satisfaction and retention is enhanced as training and development aligns to the Northland DHB Values, organisational compliance requirements, service needs and staff's own professional development. Local engagement groups continue to meet regularly and remain integral to maintaining a cooperative working environment. The objective of the groups is to provide a forum for ongoing constructive engagement between Northland DHB and the unions that represent its employees.

Achievements in 2016/2017 include:

- Commitment to clinical leadership has been strengthened by the addition of three Clinical Directors of Innovation & Transformation and the Director of Health Intelligence & Translational Medicine to the Executive Leadership table. Northland DHB's executive team has more clinicians at the table than any other DHB, facilitating a genuine partnership between clinicians and managers
- The third annual Northland DHB Leadership Programme was successfully completed in March 2017. Now in its fourth year this is the DHB's flagship leadership programme and is delivered through 12 half-day modules. To date 77 staff have completed or are currently completing this programme
- Northland DHB continued its collaboration with its Northern Region partners to develop a regional approach to:
  - Strengthen clinical leadership and management capability throughout the workforce
  - Grow the capacity and capability of our Māori and Pacific workforce
  - Increase the flexibility of the workforce to manage rising demand
  - Build and align the capability of the workforce to deliver new models of care
  - Optimise the pipeline and improve the sustainability of priority workforces.

"More clinicians at the Executive Leadership table than any other DHB."

- The Health Round Table staff survey was undertaken in 2017. Survey results provided a guide for future focus to improve staff engagement in the areas of:
  - Safety and Wellbeing
  - Valued and Appreciated
  - Communication and Information Sharing
  - Career Development
  - Management & Leadership.

Recruitment, Selection and Induction

Our aim is to attract, recruit and develop high potential talent to future-proof our service delivery. Partnerships with education providers to promote health careers and strengthen student capability are key to nurturing a high quality entry pipeline. Our strong relationships with the University of Auckland, AUT University and NorthTec continue to provide future opportunities for doctors, nurses, midwives and allied health professionals to join the organisation.

Māori are underrepresented in Northland DHB's workforce comprising just 16.15 percent (473) of the total staff. Northland DHB is committed to encouraging more Māori into health and disability fields. This applies particularly to areas where Māori are under-represented as health professionals and over-represented in their health needs. Our objective to 'grow our own' workforce has led to a number of development projects which have been implemented with much success. Northland DHB holds the regional hub contract for Kia Ora Hauora. This was established to increase the number of Māori entering first-year tertiary study, and to recruit and retain Māori in health-related career pathways and into the health sector workforce.

We use robust safety screening processes and values based recruitment to select all staff. Staff are welcomed and inducted to Northland DHB through our 'Welcome' employee orientation booklet, Organisation Orientation, and department/team inductions. Pōwhiri or Whakatau guidelines are also available for visitors and new employees.

Achievements in 2016/2017 include:

- Kia Ora Hauora marketing and promotion of health careers to Māori students has had a significant impact on the number of registrations, up 50 percent (497) from 2015/2016
- Kia Ora Hauora supported 17 first year tertiary students with a scholarship towards their first year fees. Five Tertiary Student bodies were supported through the "Tertiary Support Grant" which allocates funds to support retention at tertiary level
- Welcomed 349 new employees through the Northland DHB Organisation Orientation.

Employee Development, Promotion and Exit

We support staff to participate in a variety of internal and external training courses, conferences, workshops and other developmental opportunities, to build capability and support career and personal development objectives. We provide medical staff with continuing medical education support and nursing and midwifery staff with professional development recognition programmes. Health Workforce NZ funding continues to be provided for postgraduate study for nursing and midwifery and the non-regulated workforce. The Learning and Development department continues to provide a range of professional and personal development training opportunities.

Northland has a history of low employee turnover. An online confidential Staff Exit Survey is offered to all departing staff, along with the opportunity for 'face to face' exit interviews.

Achievements in 2016/2017 include:

- Ngā Manukura o Āpōpō – the national Māori nursing and midwifery workforce programme is now in its 14th year. This programme is sponsored by the Director of Nursing and Midwifery of Northland DHB. Through the Nga Manukura o Āpōpō programme and in partnership with the National Māori Hauora Coalition, the 'Karangahia Te Ata' video has been developed that calls out for more Māori new graduate nurses to work in primary health care. The video is designed to promote career opportunities within primary health care for Māori nurses, and the importance of this workforce to improve health outcomes for Māori
- Northland DHB's cultural "Engaging Effectively with Māori" quality programme launched in 2016 has been attended by 63 percent of staff. The programme promotes a relationship centred care approach with Māori and their whānau
- The Learning & Development Department provided 204 internal course events in 2016/17, with almost 3,000 attendances. Courses included personal development, project management, leadership and communication skills. These courses are also open to Hospice and our PHO partners
- e-learning development and implementation continued to enable greater access to our primary healthcare and community partners to share learning, communication, knowledge transfer and skill development. This supports best practice across Northland DHB and the wider health sector
- 2016/17 saw ten laundry staff successfully complete and receive a Level 2 National Certificate in Laundry Processing, while two dental assistants in the Oral Health service successfully achieved the new Level 3 National Certificate in Dental Assisting. Enrolment from the dental service for this certificate continues
- Employee voluntary turnover for 2016/17 was 9.95 percent, lower than the average across all DHBs.

"Māori are underrepresented in Northland DHB workforce."

"Kia Ora Hauora registrations up 50 percent."

OUR PEOPLE

"63 percent of staff have attended Engaging effectively with Māori since it was launched in 2016."

Flexibility and Work Design

Northland DHB operates 24 hours a day, seven days a week, providing full-time and part-time opportunities. Flexible work hours based on employee needs and the requirements of the position are available. Specific disabilities are recognised and provided for.

Achievements in 2016/2017 include:

- Continuing to grow our video conferencing culture with easier and improved access to technology. Connecting teams and individuals (both clinical and administration) with the aim of reducing the need to travel for staff and patients and improving clinical support and education for remote teams in particular
- Enhanced remote access to online services to enable staff to connect from home.

"Employee voluntary turnover 9.95 percent lower than national DHB average."

Remuneration, Recognition and Conditions

Northland DHB's workforce is covered primarily by eighteen collective employment agreements. A smaller proportion of staff are on individual employment agreements. Transparent job evaluation criteria, developed in consultation with relevant unions, are in place for a range of employee groups. This includes specific merit programme criteria which is available for most employee groups.

Achievements in 2016/2017 include:

- International Nurses Day and International Day of the Midwife was recognised and celebrated with the annual nursing and midwifery awards held in May 2017
- On 26 November 2016, the Northland Health and Social Sector Innovation Awards celebrated quality, innovation and integration across the Te Tai Tokerau health and social sectors. Organisers included Northland District Health Board, NorthAble Disability Services, Manaia Health and Te Tai Tokerau PHO.

"80 Percent of staff vaccinated against the Flu."

Harassment and Bullying Prevention

Northland DHB has a zero tolerance to bullying and harassment. Policy, training and support are provided to all staff with clear guidelines outlined in the Managing Unacceptable Behaviour in the Workplace Policy. All current and new managers are required to attend training which supports their ability to recognise, investigate and ameliorate such concerns when they occur.

Achievements in 2016/2017 include:

- With our union partners we have developed an electronic reporting tool for violence, bullying and harassment to be launched in 2017. The tool provides an improved means to enable reporting, escalation, investigation and resolution of bullying concerns raised by staff.

"New electronic reporting tool for violence, bullying and harassment to be launched in 2017."

Safe and Healthy Environment

Northland DHB is committed to providing a safe and healthy workplace for all employees, patients, visitors and other workers.

The new Health & Safety at Work Act came into force in April 2016, requiring a number of changes within Northland DHB's Occupational Health & Safety (OHS) management system. This included the introduction of new risk management practices, an extension of our duty of care to other workers (non-Northland DHB employees), increased employee participation and consultation, and a new Board OHS governance programme and reporting.

Employee wellness continues to be supported through employee assistance programmes, onsite gyms and swimming pools, healthy eating and smokefree support programmes, retirement planning and mindfulness.

Achievements in 2016/2017 include:

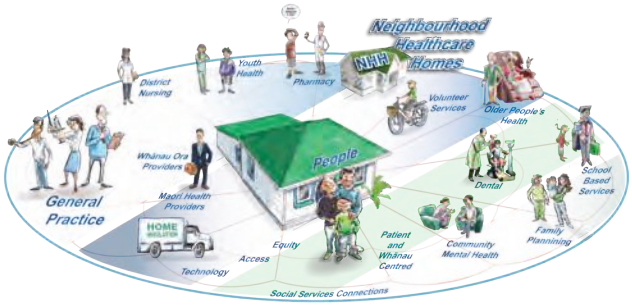
- Northland DHB is required by legislation and contractual obligations to have effective emergency and corporate risk management systems, and processes in place. Subsequently the role of Emergency and Corporate Risk Manager was established to provide oversight and accountability for emergency planning and corporate risk management across Northland
- 80 percent of staff across the four hospitals participated in the flu vaccination programme. This contributed to the health and safety of staff as well as that of our patients and communities
- The 2016/17 Health and Safety objectives for the Executive Leadership Team and Board have been achieved
- The number of lost time injuries were reduced by 30 percent over 2016/2017 which was partially due to a promotional campaign on moving and handling techniques
- Successfully retained Tertiary (the highest) level accreditation in ACC's Partnership Programme audit.

"Lost time injuries were reduced by 30 percent."

NORTHLAND HEALTH SERVICES PLAN 2012 - 2017

Final reporting on the Northland Health Services Plan 2012 – 2017 is in development with the expectation that a final report will be completed and approved by the end of the 2017 calendar year.

Planning for the 2018-2023 new strategic plan is underway with a proposed plan and timeline being presented to the Board at the final 2017 meeting.



Neighbourhood Healthcare Homes

General Practice in Northland is undergoing great change thanks to Neighbourhood Healthcare Homes. The Neighbourhood Healthcare Homes (NHH) programme is a collaborative programme between Northland DHB and the Northland PHOs and holds promise as a way to transform how primary care is organised and delivered.

The pressure from an increasing and ageing population and an increase in people living with one or multiple long term conditions means that new options through technology for patient engagement was needed, and consumer expectations around quality of health services was growing.

A NHH is a team based healthcare delivery model led by primary care clinicians that provides comprehensive and continuous health and social care with the goal of supporting individuals to obtain maximised, equitable health outcomes.

GP phone triage is a core component of the NHH model and is implemented daily at the high traffic times identified through an analysis of calls into the Practice. GP phone triage enables each Practice to proactively manage acute demand and ensures appointment availability for those patients who do need to be seen on the same day. A patient who requests a same day appointment will receive a phone call in the morning from their GP. Many of these patients can have their needs met over the phone, others will be booked in for that day or later in the week depending on the need. This then creates capacity for those patients who require same day access or with complex needs and may require longer face-to-face appointments.

Call management is another core component of the NHH model. This component is focussed on having the right number of skilled people in place at the right times to handle an accurately forecasted workload of phone calls. This improves access to the practice helping patients receive the right services at the right time. Calls are moved away from reception so the reception area is mostly call free. This provides a quiet and calm environment for staff to focus on one patient at a time, improving the patient experience, reducing errors and improving privacy.

The use of patient portals is promoted to book appointments at a time that is convenient for patients, and provide the GP with information on what the consult is about, allowing pre-work to be done before the patient attends, reducing the need for multiple appointments.

Six Practices across Northland have recently completed the first phase of becoming a Neighbourhood Healthcare Home. They are Kerikeri Medical Centre, Te Hiku Hauora, Bush Road Medical Centre, West End Medical Centre, The Doctors Kamo and The Doctors Tikipunga. A further 4 Practices are beginning work with the NHH change facilitators. They are Dargaville Medical Centre, Te Whareora o Tikipunga, Broadway Medical Centre and Raumanga Medical Centre.

Practices in Northland implementing the NHH model of care have more than 50 percent of the total enrolled Northland population covered, and more than 54 percent of the total Māori population.

Whānau Tahi (Shared Care Electronic Tool) Implementation

Implementation of the Whānau Tahi Shared Care software platform is enabling the sharing of patient information in a number of ways. For all Northlanders registered with general practice a snapshot shared care record of key clinical data derived from the general practice PMS (Practice Management System) is able to be viewed by other healthcare teams with access to Whānau Tahi. For example, clinical staff at the DHB can access the shared care record directly from the patient front page in Concerto.

Community pharmacists are now able to access the shared care record via their PMS.

General practices are also in the process of identifying patients with long term conditions and complex needs (Kia Ora Vision) who would benefit from having a shared care plan. These plans are being created using the Whānau Tahi Personalised Care Plan template which is then able to be viewed and contributed to by other members of the patient's healthcare team as they engage with the patient about 'what matters to them' and their goals.

There are currently 1565 Personalised Care Plans that have been initiated across Northland.

Care Coordination

Governed by the NHH Steering Group a project is being scoped to provide better coordinated care for patients with long term, complex conditions. Informed by research and models used successfully elsewhere, the project will develop good practices to support effective working in a multidisciplinary manner. This will enable the teams to support patients (with chronic and complex needs) with the right range of care and support, closer to home as seamlessly and effectively as possible. The project team and working group have engaged with Auckland DHB to understand their move to a locality model (with nursing and allied health staff working in multidisciplinary teams) and the implementation of a central referral centre to allow better coordination of support and best use of resources closer to home.

"Six Practices across Northland have recently completed the first phase of becoming a Neighbourhood Healthcare Home."

Whānau Tahi (Shared Care Electronic Tool) Implementation

The implementation of the Whānau Tahi Connected Care software platform is enabling the sharing of patient information in a number of ways. For all Northlanders registered with general practice a snapshot shared care record of key clinical data derived from the general practice PMS (Practice Management System) is able to be viewed by other healthcare teams with access to Whānau Tahi. For example, clinical staff at the DHB accesses the shared care record directly from the patient front page in Concerto.

Community pharmacists are now able to access the shared care record via their PMS. Before this key functionality is more widely promoted, further work is underway to develop the Whānau Tahi product and embed the associated workflow actions required in general practice to ensure the information held in the shared care record is available and kept up-to-date when new patients enrol and when patients transfer between practices in Northland. The aim is to automate as much of this process as possible.

General practice are also in the process of identifying patients with long term conditions and complex needs (Kia Ora Vision) who would benefit from having a shared care plan. These plans are being created using the Whānau Tahi Personalised Care Plan template which is then able to be viewed and contributed to by other healthcare teams as they engage with the patient about 'what matters to them' and their goals.

We are undertaking a review of the status of completion of the 'Whānau Tahi initial implementation phase' ahead of scoping the next phase of the rollout in collaboration with key stakeholders.

Telehealth

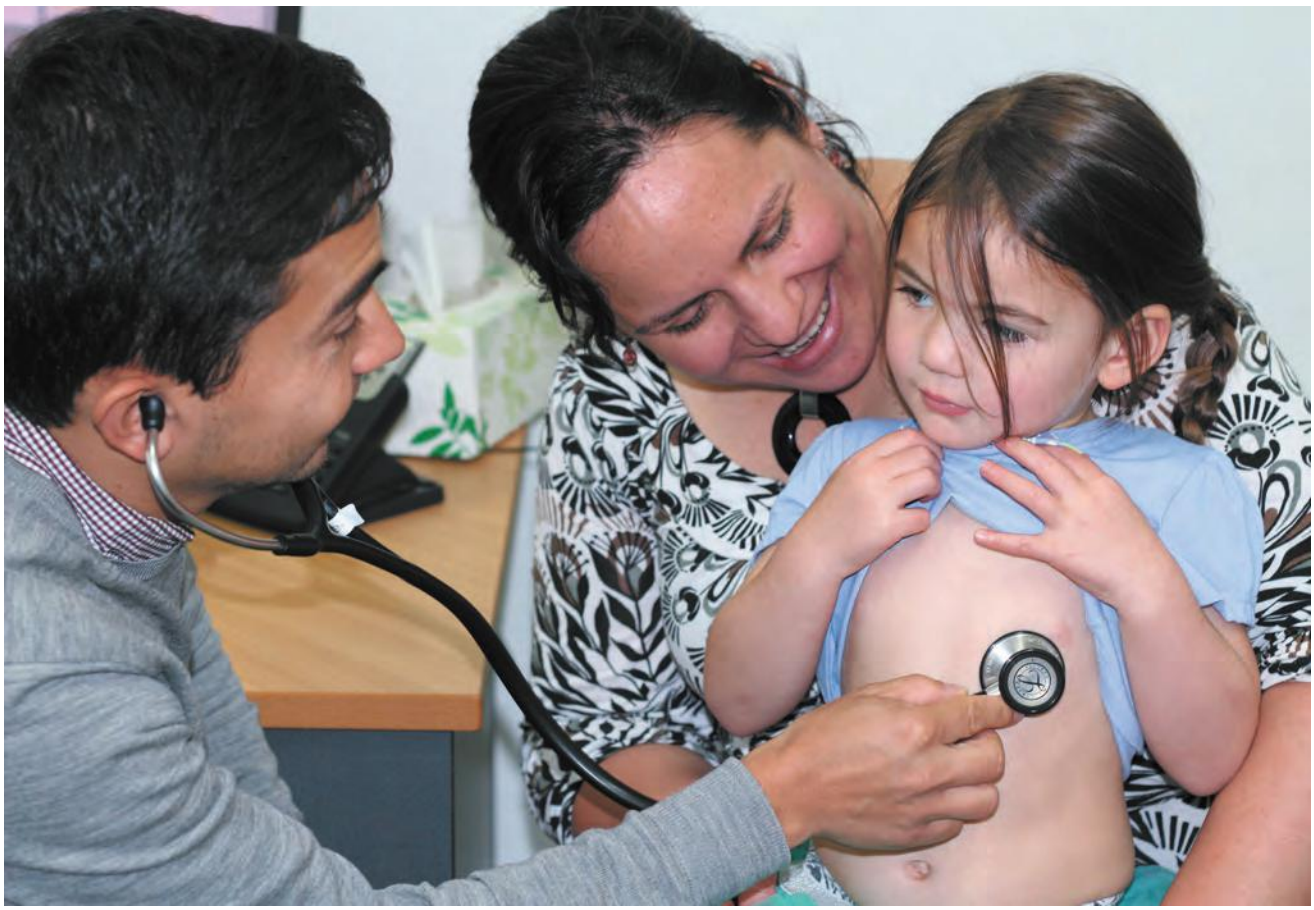
A selection of new technology for telehealth use is progressing in a Northern Region wide project in collaboration with healthAlliance. In its final stages of shortlisting for on-site trials before the end of the year, the opportunity this project provides is to provide a small panel of solutions that are easy to use, lower cost and suitable for clinical use in the Northland environment.

Access to the NZ Virtual Interpreter Service is being setup for across Northland DHB starting with Whangarei Hospital Outpatients. This service will enable deaf (and hearing impaired) interpreting to be delivered to our patient clinics via videoconferencing.

Mobility

New capability is being introduced to the regional mobility platform which includes access to the Datix Incident and Risk system, Éclair lab results and Auckland metro DHB Radiology imaging. Deployment is focused on small scale to start with and includes renal and community nursing teams as the targeted pilot areas. A process is being developed by the Northern region for introducing mobile apps and leveraging our commonalities in needs and approach for shared benefit.

A mobile clinical document strategy is also in development which aims to enable the use of forms which are linked to the patient record to be more easily used in our environment.



WHAT ARE WE TRYING TO ACHIEVE?

Our Vision is of "A Healthier Northland, He Hauora Mo Te Tai Tokerau".

We aim to achieve this by working together in partnership under the Treaty of Waitangi to:

- Improve population health and reduce inequities
- Improve the patient experience
- Live within our means.

We endeavour to work consistently according to our Values:

People First, Taangata i te tuatahi – People are central to all that we do.
Respect, Whakaute (tuku mana) – We treat others as we would like to be treated.
Caring, Manaaki – We nurture those around us, and treat all with dignity and compassion.
Communication, Whakawhitiwhiti korero – We communicate openly, safely and with respect to promote clear understanding.
Excellence, Taumata teitei (hiranga) – Our attitude of excellence inspires success, competence, confidence and innovation.

HAVE WE MADE A DIFFERENCE?

Our outcomes framework is an essential tool for holding us to account on whether we are making a difference to the health of our population.

The first section after the outcomes framework assesses our performance on our outcome measures. Outcomes have a long term focus. They are aimed at developing and maintaining positive trends over time rather than concentrating on specific annual targets. The nature of population health is such that it will take years, sometimes even decades, to see marked improvements in these outcomes.

The Statement of Performance, which follows the assessment of outcomes, is based on output measures which describe provision of services that contribute to the outcomes. Changes to output measures are viewed over a shorter time period of one to five years, so we monitor performance against them annually.

Outcomes Framework

National	MoH Purpose and Role	Improve and protect the health of New Zealanders				
	MoH High Level Outcomes	New Zealanders are healthier and more independent		High quality health and disability services are delivered in a timely and accessible manner	The future sustainability of the health and disability system is assured	
	NZ Health Strategy themes	People powered	Care closer to home	High value & performance	One team	Smart system
Northland	Vision	A Healthier Northland		He Hauora Mo Te Tai Tokerau		
	Mission	Achieved by working together in partnership under the Treaty of Waitangi to:				
	Outcome Measures	Improve population health and reduce inequities		Improve the patient experience	Live within our means	
		Life expectancy gap between Māori and non-Māori reduced by 2 years	Unplanned hospital admissions for Northlanders are reduced by 2,000 by 2017	>95% of patients report they would recommend the service provided	Gaps between: (a) Māori and non-Māori (b) Northland and NZ	Decrease in infant mortality	Mortality rate, age-standardised
	Output Measures	Year 10 students who have never smoked Adults who are current smokers Full and exclusive breastfeeding at 6 weeks 8-month-olds who are fully immunised Breast cancer screening in eligible populations Cervical cancer screening in eligible populations	Average number of decayed, missing or filled teeth in Y8 students Ambulatory sensitive hospitalisations, rate/1000 ages 0-4, 45-64 Good blood sugar management in diabetics Eligible people receiving CVD risk assessment in the last 5 years	Acute readmissions to hospital within 28 days Urgently referred patients with a high suspicion of cancer who receive their first cancer treatment within 62 days % of people with enduring mental illness aged 20-64 who are seen over a year Increase in elective surgical discharges ED patients with length of stay less than 6 hours % of acute patients readmitted to NDHB hospitals within 28 days Quality measures	HCSS clients assessed using interRai tool HCSS providers certified ARRC providers with at least 3 years certification	
	Output Classes	Prevention	Early detection and management	Intensive assessment and treatment	Rehabilitation and support	
	Enablers	Workforce	Information technology	Quality systems	Financial management	

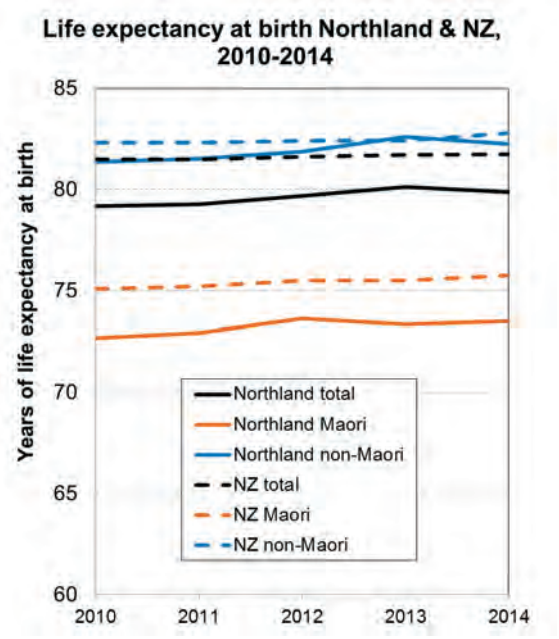
Outcomes

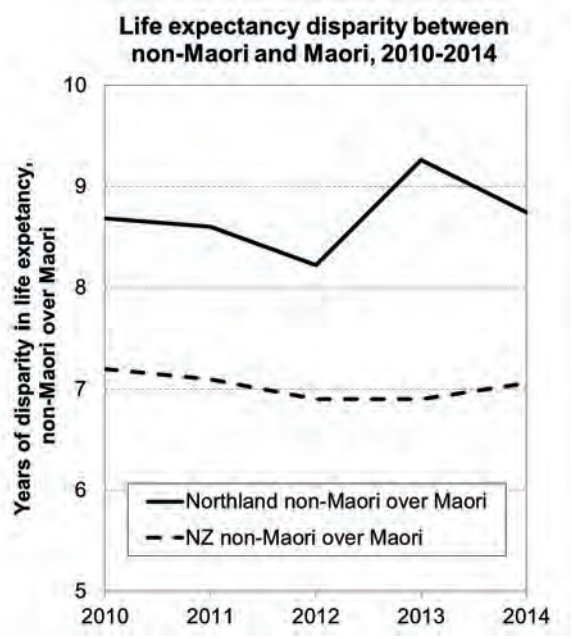
Overall we are making gains in most of our outcomes. Life expectancy continues to rise, age-standardised mortality continues to drop, and there have been minimal increases in acute admissions to hospital in the face of significant and growing pressures.

We still need to do more work to improve equity for Māori however. While the Māori share of acute admissions reduced in 2016/17, the life expectancy gap remains stubbornly at about nine years and infant mortality for Māori is higher than non-Māori.

Conclusions about patient satisfaction are difficult to draw because the way the NHSP target was worded is not comparable to the questions asked in the current patient survey. There was however a slight increase in average satisfaction between 2015/16 and 2016/17 across the detailed questions about patients' stay in hospital.

Life expectancy





Life expectancy at birth is an accepted high-level measure of the health of the population. Health services affect life expectancy only in small part; it is influenced by and associated with a number of other social and economic factors such as education, income, employment, housing and the environment.

In Northland life expectancy continues to rise, and is doing so for both Māori and non-Māori. That's good news, but what is not so good is that on average Māori live about nine years less than non-Māori. The gap in Northland has sat at about that level for the last few years, but it fluctuates year by year so it is difficult to draw out a clear trend. It remains to be seen if the Northland Health Services Plan (NHSP) goal of reducing the gap by two years between 2012 and 2017 will be achieved (we'll have to wait till 2020 until 2017 data emerges) but the indications so far are not encouraging; in the five years until the latest 2014 data, the gap reduced by only 0.8 percent.

A key influence on length of life is lifestyle, and two of the most harmful behaviours are smoking, and unhealthy diet which contributes to obesity. Northland's health service providers have numerous initiatives aimed at encouraging healthier behaviours that go some way towards reducing the problem. Advice is provided to smokers in the community and in hospital (especially pregnant women). Obesity is the target of the Under 5 Energize programme, Project Energize (aimed at school ages), advocacy on sugar sweetened beverages, and the Northland Food Rescue Service.

Other significant factors lie outside the influence of health services. The historical reduction in smoking rates has been influenced by the Government's policy of planned price rises, and high rates of excess weight are influenced by our society's obesogenic environment.

Life expectancy data is available only up to 2014. Its calculation involves mortality rates, and they always run about three years behind because it takes that long to finalise all causes of death.

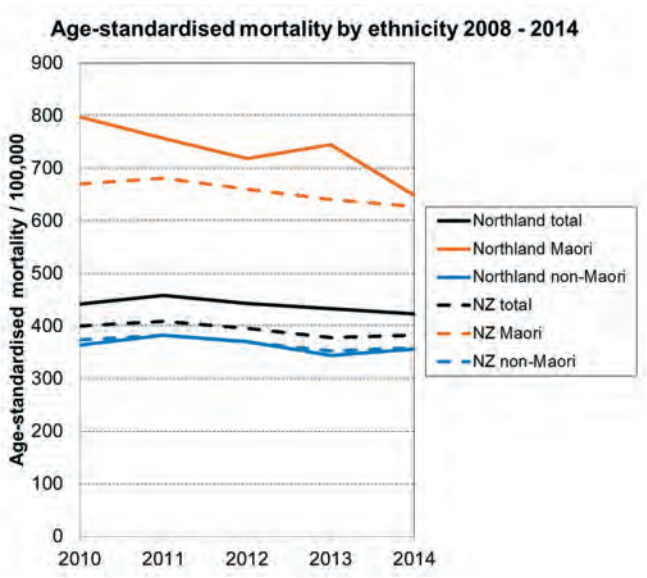
*"Life expectancy in Northland has risen by **2.0 years** in the last decade."*

*"For Māori it has improved by **3.4 years**, twice as much as non-Māori."*

*"The disparity however remains large at nearly **9 years**."*

HAVE WE MADE A DIFFERENCE?

Mortality overall[1]



*Between **2010 and 2014,** the Māori mortality rate has reduced much faster than non-Māori.*

Smoking rates are high among Māori at 35 percent.

50 percent of Māori are obese, compared with 28 percent of non-Māori.

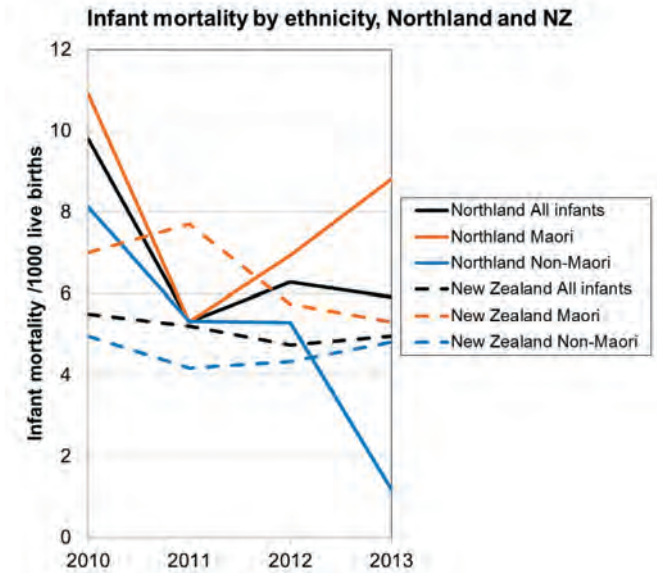
In the last two years, those needing urgent treatment for cancer and getting it within 62 days has risen from 66 percent to 80 percent.

Māori mortality rates are significantly higher than non-Māori, but they are reducing much faster. Since 2010 the Māori rate has dropped by about 150 per 100,000, while the non-Māori rate has dropped by only about 20 per 100,000. Also encouraging is that there has been a considerable narrowing of the gap between Northland Māori and all Māori in New Zealand.

The Māori rate has been higher mainly because of earlier onset of long term conditions such as heart disease and cancers. That is associated with the higher rates of smoking and obesity described under the life expectancy heading. What is harder to explain is why it has dropped so much in such a short time (short by mortality-rate standards). Smoking rates among Māori have continued to drop over the last few years, though not by as much as non-Māori. Any positive influence from that might well be countered by rates of obesity which for years had continued to rise among Māori, though we cannot see if this trend has continued because recent data by ethnicity in Northland is not available[2].

Recent years have seen an increased emphasis on services which intervene earlier in long term conditions so they can be better managed. Faster cancer treatment has become a Health Target, colonoscopy rates have risen, people have CT and MRI scans more quickly, access to services for stroke and acute heart conditions has improved, and primary care has continued to perform cardiovascular risk assessments. Not only has access improved generally, but equity for Māori has too, and it is logical to assume that this has been a factor in reducing the relative mortality rate for Māori. It is difficult to tell clearly though because formal performance monitoring for most of these services has a relatively recent history that doesn't reach back far enough in time to explain the improvement in mortality rates between 2010 and 2014.

Infant mortality



Overall infant mortality is similar to NZ's.

Māori rate is higher than non-Māori.

Hard to determine how much higher because the numbers are small and volatile.

[1] For this analysis actual rates per population cannot be used because the Māori population's much younger age structure would mask the real rate of earlier death in middle age. Māori and non-Māori mortality data has thus been adjusted as if both populations had the same age structure. The resulting mortality rates are not 'real', but they can be compared.

[2] The most reliable source is the Ministry of Health's NZ Health Survey whose latest data on obesity covers 2011-2014. Several years' data was amalgamated to create big enough numbers for analysis, but this also removed any prospect of working out a trend.

Infant mortality continued

It is difficult to gain a clear picture of infant mortality because data by DHB has been published by the Ministry of Health only for four years, and the low numbers in Northland make for a volatile trend.

Between 2010 and 2012 Māori infant mortality was higher than non-Māori in Northland, but the gap wasn't large, and Northland's rates for both ethnic groups were not much different than national rates.

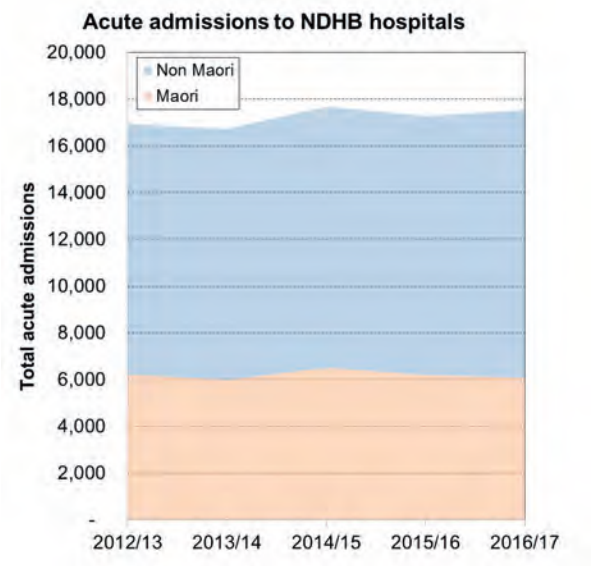
The large disparity between Māori and non-Māori in the most recent 2013 data is hard to assess. With only 10 to 20 infant deaths in Northland each year we can expect significant fluctuations over time, so while the 2013 disparity is concerning, it is not possible to know if it reflects a trend.

Northland health services have been making strenuous efforts in recent years to improve the health of infants, particularly Māori.

While we have not yet met the immunisation Health Target because of the high rate of parental declines (about 10 percent), the Māori rate among 8-month-olds has been about the same as non-Māori. Breastfeeding rates are contributing to creating healthier, more resilient babies. Rates of sudden unexpected death of an infant (SUDI) have decreased in the wake of risk factor assessments and the adoption of safer sleeping practices for babies. Northland also has the 'High Five' notification form that tells a mother post-birth about enrolment of their baby in the five key service providers.

We cannot be complacent because Māori infant mortality remains higher than non-Māori, but in the light of these and other initiatives and the volatility of the data, the 2013 data may prove to be an aberration.

Acute admissions to hospital



Acute admissions rose by only 600 between 2012 and 2017.

Percent Māori dropped by 2 percent.

Original goal underestimated how much need would increase.

Population has grown and aged more than projected.

The goal of reducing unplanned readmissions by 2,000 by 2017 was set in mid-2012 in the Northland Health Services Plan (NHSP). The idea behind it was to monitor how well conditions, especially long term conditions, were being managed by primary care services. There is no set definition of an unplanned readmission. As a proxy we have decided to measure acute admissions because they occur urgently, without forewarning (in contrast to elective admissions that can be planned ahead of time).

In 2012/13 there were 16,937 acute admissions which had risen by 600 to 17,537 in 2016/17. Although we didn't meet the deliberately ambitious target, the increase was kept to a mere 4 percent, and the percentage who were Māori actually dropped from 37 percent to 35 percent between the two years.

Those figures represent quite an achievement. That's because the population has grown faster over the years than was suggested by data at the time the NHSP was written[3]. It has also gained nearly 2,000 more over-65s than was predicted[4], and an older population creates higher health needs. The prevalence of long term conditions has increased too; the Ministry of Health estimate of people with diabetes, for example, was 7,831 in 2012 and 11,845 in 2017, an increase of more than half in five years.

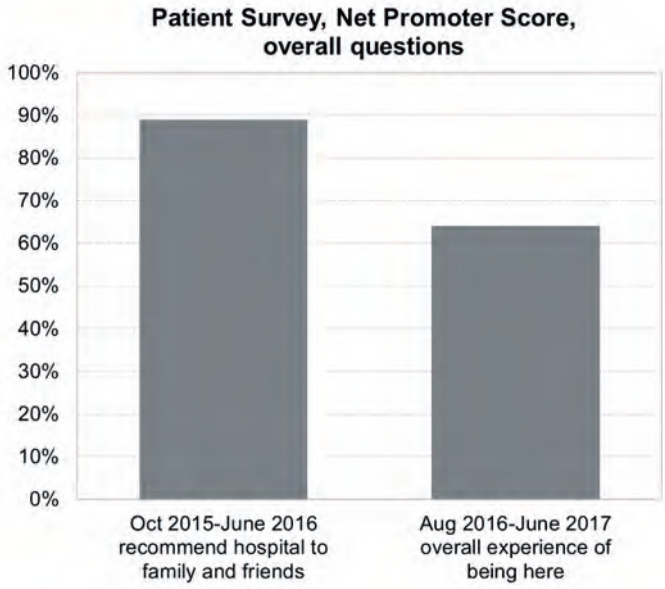
Maintaining control over acute admissions can be put down to a well-performing primary care sector. If long term conditions are monitored and managed well in the community, fewer complications will arise and there will be fewer acute admissions. To help the primary care sector manage increasing demands in the future from long term conditions and an ageing population, and in partnership with our PHO's, Northland DHB has been running the Neighbourhood Healthcare Homes programme (see Page 11). We are also planning to revamp and expand what was Primary Options, a programme that enabled GPs to treat specified conditions that would otherwise have resulted in a hospital admissions, into a more flexible service aimed at higher-need patients. Northland DHB's Mobility programme will also reduce demand on hospital services by increasing the use of mobile devices and easy-to-use apps so staff can do more 'on the move', increase their productivity in the community and achieve more and better ways of working remotely.

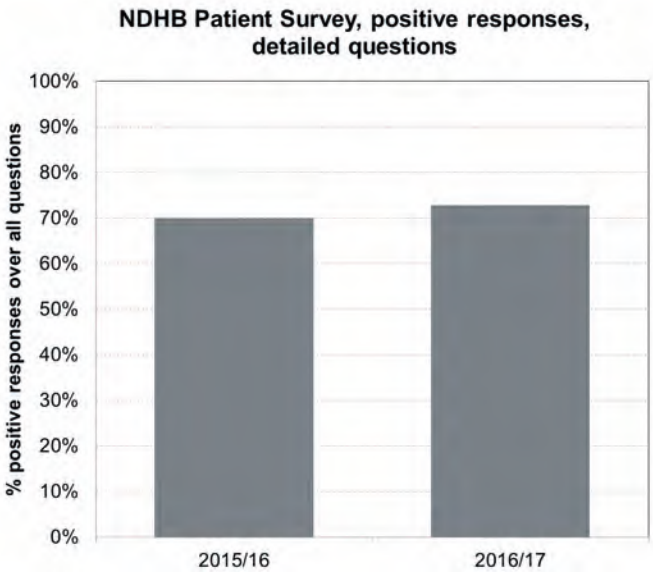
[3] 2006-base projections indicate Northland's population in 2017 would be 163,100, whereas latest 2013 projections put it at almost 170,000, a difference of nearly 7,000 people.

[4] 2006-base projections suggested that in 2017 Northland would have 31,890 people aged 65 or more, while 2013-base projections say 33,630.

HAVE WE MADE A DIFFERENCE?

Patient satisfaction





One of the six Headline Targets in the Northland Health Services Plan (NHSP) was "95 percent of patients report they would recommend the service provided". Performance on this can be addressed through the results of our internal patient survey[5] which contains an 'overall satisfaction' question as well as 15 or 16 questions[6] covering a range of details and issues about a stay in hospital.

The overall question has varied over the last two years from "If you had a choice would you recommend the hospital to family, friends, whānau?" between October 2015 and June 2016 to "How would you rate your overall experience of being here?" between August 2016 and June 2017. Although both attempt to address overall satisfaction, the different wordings generate different responses – 89 percent for the first and 64 percent for the second – so they are difficult to compare.

Comparison with the NHSP question is tricky too, for two reasons. First, while the first question is comparable to the NHSP target, the wording of the other is quite different. Second, the results are not comparable because of the method of analysis. The NHSP target focused on total positive responses, whereas the current patient survey subtracts less positive responses from the most positive to create a Net Promoter Score.[7]

Across all the detailed questions in the patient survey, the average positive response was 70 percent in 2015/16[8] and 73 percent in 2016/17, which shows an encouraging improvement. Again however it is not possible to compare these figures directly with the NHSP question. One issue is that the latter's overall focus is different from the detailed nature of the other questions. The other is the nature of the questions. It has also been noticeable from past experience that an overall question tends to generate a more positive response than a series of detailed ones; perhaps there is an important benefit from having an illness or injury treated in hospital that isn't captured in the individual questions, but respondents regard as being implicit in the overall question.

Patient satisfaction increased from 70 percent to 73 percent positive between 2015/16 and 2016/17.

Comparisons with the NHSP's patient satisfaction target are difficult to make.

[5] The Ministry of Health, through its Health Quality and Safety Commission, has a different patient survey which forms part of the System Level Measures. MoH prefer their survey because it is applied to all DHBs and provides a consistent basis for comparison. The low response rate (about 20%) does not inspire confidence however, so we prefer to use our own internal survey because the sample size is much larger.

[6] 15 questions from July to November 2015, 16 questions since.

[7] The overall question uses a ten-point scale. To create the Net Promoter Score, total 'detractor' responses (0-6) are subtracted from the total 'very satisfied' (9+10); 7 and 8 responses are left out of the equation.

[8] The result reported in the 2015/16 Statement of Performance was 59%

STATEMENT OF PERFORMANCE

The Statement of Performance is a selective snapshot of how the services provided for the Northland population are performing. The four output classes cover the spectrum of services from those promoting health in the population through to complex hospital services and later-in-life care.

The Statement of Performance assesses how well we are doing in 2016/17 compared with the targets set during the previous year's planning cycle. The measures selected are a combination of national priorities (including some of the Health Targets) and local priorities. Collectively they contribute to the high level outcomes described in the previous section. We have tried to keep the number of measures small by choosing a representative sample of key ones, while still covering the breadth of services.

The measures do not cover just Northland DHB's services. DHBs are legislatively responsible for the health of their populations, so as well as providing services ourselves we also contract with, monitor and evaluate other service providers in the health sector. Many of the measures, especially those in the first two output classes, describe performance in the wider health sector.

The Statement of Performance includes both impact measures (labelled **I**, that assess direct effects on people's health over a one to five year timeframe) and output measures (labelled **O**, that measure service activity and have a one-year timeframe). The longer-term focus of impact measures means they feature more prominently in the earlier output classes, while output measures appear more in the later classes.

Data from 2015/16 appears in two places in the tables. The 'baseline' columns are copied from the 2016/17 Statement of Performance Expectations, which had to be prepared before 2015/16 ended so the data does not cover the whole of the year. The "2015/16 result" column captures data for the whole year.

Achievement ratings

Achieved	Substantially achieved	Not achieved but progress made	Not achieved	No conclusion can be drawn
Target met or bettered	*Within 5%[9] of target*	*More than 5% from target, but progress made*	*Not achieved*	*Problems with data availability, changing definitions etc.*

Output Class 1: Prevention

This Output Class includes publicly funded services that protect and promote health across the whole population or particular subgroups of it.

These services improve the health status of population groups, as distinct from treatment services (the other three Output Classes) which deal with illnesses and injuries of individuals.

It includes:

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

[9] For most measures "within 5%" means within 5% absolute of the target. When targets are a small percentage (as in the mental health measure) or a small number (the oral health measure, some of the quality ones) a different sort of 'close to target' assessment is required. How that is addressed is described in footnotes.

Output Class 1: Prevention continued

Output measure	Ethnicity	2015/16 baseline from 2016/17 SPE		2015/16 result	2016/17 target	2016/17 result	Achievement
		Period	Data				
% of Year 10 students who have never smoked **I**	Total Māori Non-Māori	2015[10]	65.2% 58.8% 76.2%	65.2% 57.2% 76.2%	65.0%	67.5% 50.7% 85.2%	● ● ●
% of Northland adult population who are current smokers **I**	Total Māori Non-Māori	2011-14	25.0% 41.2% 18.4%	n/a[11]	21.4% 34.6% 16.0%	19.3% 34.7% 12.5%	●
Full and exclusive breastfeeding at 6 weeks **I**	Total Māori Non-Māori	Jul-Dec 2015[12]	76% 69% 82%	77% 69%	75%	79.3% 76.5% 83.7%	● ● ●
% of 8-month-olds who are fully immunised **I** National Health Target	Total Māori Non-Māori	2015/16 to Q3	89.4% 90.4% 88.1%	89% 90% 88%	95.0%	88.8% 89.9% 87.3%	● ● ●
Breast cancer screening in eligible populations **I**	Total Māori Non-Māori	2015	72.3% 68.5% 73.5%	71.0% 69.3% 71.5%[13]	70.0%	71.8% 70.5% 72.2%	● ● ●
Cervical cancer screening in eligible populations **I**	Total Māori Non-Māori	Apr 2014 - Mar 2017	74.1% 66.8% 77.3%	74.1% 64.8% 76.3%	75.0%	75.2% 68.3% 78.2%	● ● ●

Output Class 2: Early Detection and Management

Commonly referred to as 'primary' or 'community' services, these are accessible directly by individuals (as distinct from secondary services for which a referral is needed). They are delivered by a range of agencies and are typically generalist (non-specialist) in nature. Similar types of services are usually delivered in numerous locations across the community. It includes:

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

Output measure	Ethnicity	2015/16 baseline from 2016/17 SPE		2015/16 result	2016/17 target	2016/17 result	Achievement
		Period	Data				
Good blood sugar management in diabetics (equal to or less than 64 mmol/mol) **I**	Total Māori Non-Māori	2015/16	64.7% 55.5% 71.7%	61.5% 53.3% 67.7%	80.0%	39.5% 37.8% 40.8%[14]	● ● ●
Ambulatory sensitive hospitalisation rate, ages 0-4, 45-64 **I** [15]	Total Māori Non-Māori	n/a	n/a	0-4: Total 67.3 Māori 84.1 Non-M 46.0 45-64: Total 32.8 Māori 57.7 Non-M 24.2	No target set	65.2 76.6 50.5 36.4 63.1 27.1	● ● ● ● ● ●
Average number of decayed, missing or filled teeth in Y8 students **I**	Total Māori Non-Māori	2015	1.23 1.61 0.76	1.23 1.61 0.76	1.00	0.89 1.43 0.61	● ● ●
Eligible people receiving cardiovascular (CVD) risk assessment in the last 5 years **I**	Total Māori Non-Māori	2015/16 to Q3	91.4% 87.4% 93.1%	91.3% 87.4% 93.0%	90.0%	90.8% 87.1% 91.9%	● ● ●

[10] The data comes from an Action on Smoking and Health survey conducted annually in high schools throughout New Zealand, so the data covers the calendar year.

[11] Baseline data is drawn from the Ministry's NZ Health Survey. Its latest data covers only up to 2011 to 2014, so there is no result for 2015/16. Data was combined over 2011-2014 to increase the sample size and therefore validity, but it means it is not possible to monitor trends over that time. Updates of the NZHS are sporadic and the periods of time they cover are unpredictable, so the survey has proved of little use for monitoring. Up-to-date data is now being drawn from our PHOs, which shows a smoking rate for 2016/17 of 19.3% for the total population, 34.7% Māori and 12.5% non-Māori. This cannot be compared with NZHS data because the questions asked and the collection methods are different. The PHO data will be used in the 2017/18 SPE.

[12] The breastfeeding data is drawn from the Plunket database which, though old, is currently the most reliable source because it is comparable across DHBs and covers most women. It does not however include new mums supported by NGOs (which in Northland are Māori NGOs). New data due out later this year will cover all providers.

[13] Breast screening is recorded over a calendar year. These results are for 2016.

[14] The 2015/16 data reports those with good blood sugar control as a proportion of everyone on the general practice count of patients with diabetes. The 2016/17 figure is those with good blood sugar control who had a Diabetes Annual Review during the year as a proportion of all those on the Virtual Diabetes Register, MoH's estimate of the total number of people with diabetes in Northland. If we used the 2015/16 methodology this year the results would be Māori 47% non-Māori 61%, overall 55%, still under target but not by as much. The frequent changes MoH has made to the counting and analysis of this data and the inconsistent templates they have provided, have been detrimental to monitoring performance.

[15] In the SPE actuals data was mistakenly presented for 2014/15, not 2015/16. It was also by major condition groups (cardiovascular, dental, respiratory, gastrointestinal, diabetes), not as all conditions combined. No targets were set for 2015/16. For 2017/18 the ASH measure will change to the ages 0-4 one used in System Level Measure reporting and these issues will not arise again. For indicative purposes a retrospective analysis was performed on ASH data for the top four conditions combined for ages 45-64. This showed a rate per 100,000 of 33.1 in 2015/16 and 36.4 in 2016/17.

Output Class 3: Intensive Assessment and Treatment

These are specialist services that deal with complex or multiple problems, commonly referred to as 'secondary' or 'hospital' services. They are accessible only by referral from a primary practitioner. They are available in only a few locations, either on hospital sites or they use hospitals as the base from which to provide services in the community. The Output Class includes:

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

Output measure	Ethnicity	2015/16 baseline from 2016/17 SPE		2015/16 result	2016/17 target	2016/17 result	Achievement
		Period	Data				
% of patients who receive their first cancer treatment (or other management) within 62 days referred urgently with a high suspicion of cancer and a need to be seen within two weeks National Health Target **I**	Total Māori Non-Māori	2015/16	76.1%[16]	73.9% 65.4% 75.6%	85.0%	81.3% 75.0% 83.2%	● ● ●
% of people with enduring mental illness aged 20-64 who are seen over a year [17] **O**	Total Māori Non-Māori	2015/16	5.68% 8.96%	5.68% 8.98% 4.15%	5.70% 9.24%	5.76% 9.02%	● ●
Increase in elective service discharges **O** National Health Target	Total Māori Non-Māori	2015/16	10,123 3,462 6,661	10,123 3,462 6,661	8,575 [18] 2,924 5,626	10,570 2,341[19] 8,225	● ● ●
Patients with an emergency department length of stay of less than 6 hours **O** National Health Target	Total Māori Non-Māori	2015/16 to Q3	92.0% 93.0% 91.3%	92.0% 93.0% 91.3%	95.0%	92.7% 93.8% 92.1%	● ● ●
Number of falls causing harm in NDHB facilities **O**	Total	2015/16 to Q3	70	103	0	76	● [21]
Number of pressure injuries in Northland DHB facilities **O**	Total	2015/16 to Q3	52	64	0	56	●
% compliance with surgical checklist **O**	Total	2015/16 to Q3	94.6%	n/a	90.0%	n/a [22]	●
% hand hygiene compliance **O**	Total	2015/16 to Q3	83.0%	84%	90%	85%	●
% patients with medicines reconciled [23] **O**	Total	2015/16 to Q3	58.0%	60%	None set	67%	●

[16] The average of the four quarters in 2015/16. At the time the measure had existed for only two years, so data was provided by quarter.

[17] No data or target was included for non-Māori in the SPE because it is not part of MoH's reporting requirements.

[18] The correct total is 8,575, but the target in the SPE was incorrectly recorded as 8,550. The 2,924 and 5,626 for Māori and non-Māori respectively were based on the 8,550 total.

[19] The 2015/16 target figure for Māori was mistakenly set too high. Typically Māori have comprised 25% to 27% of all electives, whereas the 3,462 Māori in 2015/16 represents 34%.

[20] For the five quality measures (this one and the next four) there is no data by ethnicity, though there are plans to provide this in future.

[21] Although the result of 76 sounds a long way from the zero target, it forms a very small proportion (0.2%) of the combined 39,268 inpatients and day patients in Northland DHB's hospitals in 2016/17. Because the numbers are so small for both this and pressure injuries (where they are even lower), performance has been assessed as equivalent to being within 5% of target.

[22] From 2016/17 Q1 the Health Quality and Safety Commission changed the way this was reported by splitting it into three separate measures: sign in, time out and sign out. Not only does this make it difficult to compare with previous years, but the data is incomplete. HQSC does not accept data if it is drawn from fewer than 50 audits each quarter, which has been the case for six of the nine quarters to date in 2016/17 (Q4 data is not yet available).

[23] 'Reconciled' refers to monitoring consistency between medications prescribed by a patient's GP and those prescribed while they are in hospital.

STATEMENT OF PERFORMANCE

Output Class 4: Rehabilitation and Support Services

This Output Class covers services for older people and palliative care services:

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

Output measure	Ethnicity	2015/16 baseline from 2016/17 SPE		2015/16 result	2016/17 target	2016/17 result	Achieve-ment
		Period	Data				
% Home and Community Support Services (HCSS) clients assessed using interRai tool **I**	Total	2015/16	77%	81%	95%	89%	●
% of HCSS providers certified **O**	Total	2015/16	100%	100%	100%	100%	●
% of ARRC providers with at least 3-year certification **O**	Total	2015/16	83%	83%	87%	79% [24]	●

[24] The apparent lower performance is mainly an artefact of rules around change of ownership. Of our 24 facilities, four automatically received one-year certification during the year because they acquired new owners. Of the remaining 20, 3- or 4-year certification was received by 19, or 95%.

National Health Target results

Output measure	Ethnicity	2015/16 baseline from 2016/17 SPE		2015/16 result	2016/17 target	2016/17 result	Achieve-ment
		Period	Data				
Patients with an emergency department length of stay of less than 6 hours	Total Māori Non-Māori	2015/16 to Q3	92.0% 93.0% 91.3%	92.0% 93.0% 91.3%	95%	92.7% 93.8% 92.1%	 [25]
Increase in elective service discharges	Total Māori Non-Māori	2015/16	10,123 3,462 6,661	10,123 3,462 6,661	8,575 2,924 5,626	10,556 2,341 8,225	 [26]
% of patients who receive their first cancer treatment (or other management) within 62 days referred urgently with a high suspicion of cancer and a need to be seen within two weeks	Total Māori Non-Māori	2015/16	76.1% 70.3% 76.9%	73.9% 65.4% 75.6%	85.0%	81.3% 75.0% 83.2%	 [27]
% of 8-month-olds who are fully immunised	Total Māori Non-Māori	2015/16 to Q3	89.4% 90.4% 88.1%	89% 90% 88%	95%	88.8% 89.9% 87.3%	 [28]
% of PHO enrolled patients who smoke who have been offered help to quit by a health care practitioner in the last 15 months	Total [29]	2015/16	87.3%	[30]	90%	82.1%	[31]
% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking	Total Māori Non-Māori	2015/16	94.1% 94.9% 91.9%	[32]	90%	91.3% 94.4% 87.7%	
By Dec 2017, 95 percent of obese children identified in the Before School Check programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.	Total Māori Non-Māori	n/a [33]	n/a	[see footnote 33]	95%	78.4% 76.9% 81.5%	 [34]

[25] Performance constantly hovers two or three percent under target. Many initiatives (patient flow analysis, developing the medical workforce, nurse-led acute patient flow forum, among many others) have been implemented to streamline flows and reduce waiting times, but these enable us just to keep up with the ever-increasing demands on ED. Consistent achievement of target is likely only when the new ED and Medical Assessment Unit is established as part of the Whangarei Hospital site redevelopment, though this won't be for some years yet.

[26] MoH does not require electives to be reported by ethnicity so the ethnic split was determined from an internally generated data query. The total elective operations from the query didn't quite match the MoH data, so the Māori/ non-Māori split was determined from the query data and applied to the MoH number.

[27] Performance increased from Q1 to Q3 (75.8% to 82.7%) but fell back in Q4. The measure covers numerous types of cancer, and the treatment pathways of each need to be addressed individually. Most (head and neck, lung, skin, haematology [blood], upper GI and breast) are above target. Attention recently has shifted to gynaecological cancers, especially the diagnostic phase.

[28] Performance has constantly been four or five percent below target, largely because more than 10% of parents opt-off the immunisation register or decline immunisation for their children (the second highest of any DHB). NDHB continues to circulate positive messages about immunisation.

[29] Results on this Health Target are not made available publicly by ethnicity.

[30] Not reported in last year's Annual Report. Result was 87.3% (this Health Target is not reported by ethnicity).

[31] Since 2015/16 performance on this target has steadily declined. PHO performance is being addressed in the new 2017/18 tobacco control agreement and improvement is expected by 2017/18 Q2. Initiatives include 'league tables' so practices can compare performance, training in individual general practices (35 were covered during Q4), and increased contact between PHO-employed practice facilitators and practice staff.

[32] Not reported in last year's Annual Report. Results were: total 94.1%, Maori 94.9%, non-Maori 91.9%.

[33] Target was introduced in 2016/17.

[34] Although the annual average was more than 5% under target, this measure was newly introduced in 2016/17 and rapid progress was made through the year to achieve target in Q4: Q1 70.1%, Q2 72.7%, Q3 82.9%, Q4 94.7%.

STATEMENT OF PERFORMANCE

Actual Cost of Service Statement

For the year ended 30 June 2017	$000 Intensive Assessment & Treatment	$000 Early Detection & Management	$000 Prevention	$000 Rehabilitation & Support Services	$000 Total
DHB Provider Revenue	262,456	27,799	1,978	12,004	304,238
Other Provider Revenue	9,791	5,525	8,941	2,977	27,234
Less Revenue Offsets	(2,693)	(2,400)	(3,694)	(1,130)	(9,916)
DHB Funder Revenue	84,393	109,685	9,592	64,957	268,627
DHB Governance & Administration	4,822	0	0	0	4,822
Total Revenue	358,768	140,610	16,818	78,809	595,005
Personnel Costs					
Medical Labour	63,603	2,320	1,306	(0)	67,229
Nursing Labour	70,746	7,573	745	4,444	83,508
Allied Health Labour	22,901	9,156	2,772	2,819	37,648
Non Clinical Support Labour	4,737	226	67	60	5,089
Management and Admin Labour	24,737	3,210	1,531	1,210	30,689
Non-Personnel Operating Costs					
Outsourced Clinical Services	7,224	1,667	11	117	9,019
Oth Clinical Supp	29,528	1,648	447	2,037	33,660
Implants	5,697	0	0	0	5,697
Pharmaceuticals	10,718	80	6	333	11,137
Infrastructure and Non Clinical	30,861	3,334	1,258	1,675	37,129
Cost of Capital	7,342	766	249	352	8,709
CTA Recoveries	(3,437)	(149)	(94)	(48)	(3,728)
Patient Support	4,698	10	9	7	4,725
Sterile Supplies	265	4	1	2	272
Provider Payments - To Providers					
Personal Health	68,782	107,114	4,551	1,908	182,356
Mental Health	13,415	2,770	0	0	16,185
Disability Support Services	112	0	0	62,107	62,219
Maori Health	0	522	5,075	65	5,662
Total Operating Expenditure	361,930	140,252	17,934	77,089	597,205
Surplus (Deficit)	(3,161)	357	(1,116)	1,719	(2,200)

Budget Cost of Service Statement

For the year ended 30 June 2017	$000 Intensive Assessment & Treatment	$000 Early Detection & Management	$000 Prevention	$000 Rehabilitation & Support Services	$000 Total
DHB Provider Revenue	263,267	27,799	1,978	12,004	305,049
Other Provider Revenue	8,533	5,525	8,941	2,977	25,977
Less Revenue Offsets	(3,059)	(1,720)	(2,823)	(983)	(8,584)
DHB Funder Revenue	81,712	109,685	9,592	64,957	265,947
DHB Governance & Administration	4,605	0	0	0	4,605
Total Revenue	355,059	141,290	17,689	78,955	592,994
Personnel Costs					
Medical Labour	56,742	2,996	1,420	43	61,201
Nursing Labour	71,493	7,581	612	4,652	84,339
Allied Health Labour	23,625	8,672	2,943	3,043	38,284
Non Clinical Support Labour	4,652	203	64	80	5,000
Management and Admin Labour	27,680	4,163	1,790	1,533	35,166
Non-Personnel Operating Costs					
Outsourced Clinical Services	5,559	1,202	31	137	6,929
Oth Clinical Supp	30,323	2,224	685	1,881	35,113
Implants	4,978	0	0	0	4,978
Pharmaceuticals	6,375	82	4	280	6,741
Infrastructure and Non Clinical	28,509	4,183	1,117	1,861	35,670
Cost of Capital	9,035	1,024	304	451	10,814
CTA Recoveries	(3,573)	(175)	(40)	(61)	(3,849)
Patient Support	4,585	10	10	13	4,618
Sterile Supplies	251	4	1	4	260
Provider Payments - To Providers					
Personal Health	68,604	106,837	4,539	1,903	181,883
Mental Health	13,380	2,763	0	0	16,143
Disability Support Services	112	0	0	61,945	62,057
Maori Health	0	520	5,062	65	5,647
Total Operating Expenditure	352,332	142,291	18,542	77,830	590,994
Surplus (Deficit)	2,727	(1,001)	(852)	1,126	2,000

HIGHLIGHTS

FIT for LIFE
Thriving Tamariki - Shaping our future together

At a social level obesity reduces life opportunities for individuals and whānau. It affects income levels, educational achievement, self-esteem and social participation.

Tamariki of obese parents are much more likely to be obese throughout their upbringing and later in life. Obesity affects educational attainment which reduces employment opportunities for whānau suffering from obesity. It also lowers productivity which means obese people earn less. They therefore have fewer opportunities to improve their income. It is a vicious cycle that we need to break.

Obesity also has serious health implications for individuals and whānau. It increases the risk of chronic heart disease, type 2 diabetes, stroke and some forms of cancer. It shortens life expectancy and the quality of a person's life.

Two of the main drivers of obesity relates to food manufacturers and the food environment. Food manufacturers pack hidden sugars into a majority of processed food and drink to make them taste appealing so we want and buy more.

The food manufacturers use aggressive marketing tactics to push cheap, processed and unhealthy foods onto our people. They don't just target adults with their marketing ploys they also target our easily influenced and vulnerable tamariki. Obesity is grabbing hold of our people, and playing havoc with their lives.

On average, New Zealanders consume 37 teaspoons of sugar per day. The World Health Organisation recommends that adults should consume less than about six teaspoons per day, and children less than about three teaspoons per day. We are consuming, on average more than 30 teaspoons of sugar per day than we should!

Health leaders in Tai Tokerau recognise that 'sorting out obesity' will require help from others and they have committed themselves to making that happen.

Using current literature, evidence and expert advice, these health leaders have developed a Tai Tokerau Childhood Obesity Prevention Framework. The Framework aims to create environments that support healthy eating for all our tamariki and whānau, raise the awareness of good nutrition, and put in place ways to reduce the consumption of sugary drinks and high fat convenience foods.

The goal of the Framework is to increase the number of tamariki Māori who are at a healthy weight by five percent through good kai in five years (2021).

To make a difference we will require cohesive action to influence change where we live, learn, work and play. This work will be calling upon local government, employers, retailers, education settings, health organisations, consumers, and others to do their bit. We are all responsible in making positive change for the future of our tamariki.

Fit for Life 2016/17 Highlights

In partnership with Waitangi National Trust, the Fit for Life working group supported Waitangi Day 2017 to be a fizz free event. The largest event nationally to be fizz free, received positive feedback from those attending and those holding a stall at the event. Waitangi National Trust is committed to seeing all future Waitangi Day fizz free.

A number of events across the region, and afar have adopted a fizz free approach as a result of the leadership from Waitangi National Trust.

Creating healthy environments starts with us. In November 2016, the Northland DHB Healthy Food and Drink Policy was recognised for its contribution to improving the health and wellbeing of Northland DHB staff and community at the Northland Health and Social Sector Innovation Awards. The implementation of a healthy food policy has been a catalyst for encouraging other organisations to adopt a healthy food policy, starting first with health organisations. Currently eight of 12 health organisations across the region have a healthy food policy, creating healthier environments for us all.

Research and innovation are part of the plan, keeping us informed with our current state and possible ways forward. Northland DHB has partnered with the University of Auckland on two occasions through the Fit for Life Project. In partnership with the INFORMAS research team, data about our current food environments has been collected and is being analysed. The data provides a benchmark of our food environments and where our work with the food and drink may have the biggest impact. Through the Information Technologies team at the university, research of an innovative way of engaging with young mums to improve health literacy is underway.

The Fit for Life project has created opportunity for further engagement with external stakeholders. A new relationship has been formed with the business sector in Northland, through Northland Inc, The HUB. Members of the Fit for Life working group have been involved in supporting small business ideas with a focus on health through the Northland Inc. The Pick 2017 competition.

The Health and Wellbeing and Food and Beverage categories provided engagement with community groups such as Local Food Northland and Northland Food Policy Network and have provided new ways of thinking about the approach to address childhood obesity in Northland.

HIGHLIGHTS

Project Energize

The initiative in Northland is based on Project Energize which was developed in the Waikato area, through Sport Waikato and the Waikato DHB, and has been running for over 10 years. The way in which schools use Energize looks completely different in each school.

The Northland DHB funded an initial pilot in 2013/14 and results illustrated improvements in the children's fitness, the reduction of sugary drinks and an increase in the consumption of water. Funding from Northland DHB and Sport New Zealand is allowing Sport Northland to expand Energize to 82 low decile primary schools across Northland during 2017.

Energizers support a cluster of schools and provide practical hands on support and assistance to schools and teachers with initiatives that we can add value to with increasing the quality and quantity of physical activity and or improve the uptake of healthy eating.

Energize kaimahi are available to assist schools with a whole range of initiatives and projects. For example:

- Assist teachers in providing varied and quality daily exercise activities
- Encourage children to choose more active play options at home
- Help promote healthy eating through information sessions with parents
- Provide useful resources for teachers.

Staff at Tangowāhine School have been proactive in making steps towards creating a healthier environment and have replaced their 'Sausage Sizzle Fridays' to 'Healthy Eating Fridays'.

Senior classroom teacher Huw Wanwright says "before we implemented healthy options, we sold sausages for $2.00 each and were selling our healthy eating options for $4.00. Despite the price of our healthy eating options, sales have increased!! We see more buy in from families at home which is great and we have senior students cooking the food in rotation. We also give them the choice to cook what they want. This week is homemade pizza and bolognaise."

Northland DHB signed a Memorandum of Understanding in October 2016 with the Under 5 Energize concept owner Sport Waikato.

Irrevocable evidence shows that eating and exercise patterns for life are determined in infancy and childhood. Early intervention is known to be both more effective and cost effective than late intervention. Early childhood centres offer a setting where healthy behaviours can be supported.

Early intervention not only improves health outcomes later in life therefore reducing long-term healthcare costs, it also reduces short-term healthcare costs. A recent study shows obese children aged two to five years old are two to three times more likely to be admitted to hospital and have 60 percent higher healthcare costs than healthy weight children.

The service is being delivered in the early childhood setting to both educators and parents. Te Hiku, based in Kaitaia, successfully secured the Under 5 Energize contract through a formal Request for Proposal process.

A 0.5 FTE manager was appointed in March 2017 along with 2 FTE Under 5 Energizers (Te Hiku and Ngāti Hine Health Trust). Professional development training delivered by Sport Waikato was completed in April, May and June 2017.

Five community Hui held with Early Years Forum, Kindergarten Association, Educare Facilities Coordination, Whare Takaporepore and Kuaka Wharau Purapura.

At 30 August 2017, 44 Early Childhood Education centres were in the establishment stage, with 15 centres having signed a Memorandum of Understanding. A total of 548 tamariki had engaged with the programme, 80.8 percent (443) of these were Māori.

Te Hiku has developed a web-based database to capture all data and information for reporting and evaluation processes. Professor Elaine Rush (AUT University) has been contracted to evaluate the U5E initiative for Northland DHB.

Matakohe School – Term Two 2017

Teacher (Sara McKinley) organised an afternoon tea for the last netball game after eight weeks of competition and all the food was healthy. This proved that the children did not need to have sweet things or unhealthy food as it all was eaten up!

Email from Sara McKinley to Sport Northland Energizer team: "I have a funny wee 'sugar free' story for you... I was speaking with a parent of a child in my class who recently had a birthday and invited most of his class mates to his birthday party. When it came to sitting down to eat some party yummies and the birthday cake - the children explained that they couldn't eat the party food because it had way too much sugar in it and that is what they have learnt from Clark! I thought this statement was absolutely fabulous as it really demonstrates that our students are beginning to think about their food choices as well as how to keep themselves healthy. Well done to you - keep up the great work!"

Northland Food Rescue Service

Northland's Health Alliance Leadership Team has collaboratively developed a Fit for Life: Tai Tokerau Childhood Obesity Prevention Framework. The overall goal is to increase the proportion of Māori tamariki who are at a healthy weight by five percent through good kai in five years. One of the four workstreams deals with food security with a focus on ensuring there is access to healthy food that it is affordable.

Food rescue is all about redistributing quality surplus food from food retailers to community groups who support people in need. It provides community groups with a wide range of healthy and nutritious food. The food is provided free of charge which allows community groups to focus their limited resources on providing valuable services. It also reduces food waste by stopping quality food from being thrown out.

Northland DHB carried out a feasibility study to assess the need for a food rescue service in Whangarei and the wider Northland region. There was overwhelming evidence that a food rescue service was necessary and it was also identified that there is a lack of perishable foods distributed by existing channels, such as fruit and vegetables, followed by diary and meat.

The project, in its formative stages at the beginning of 2017, is led by One Double Five in collaboration with Te Puawaitanga Marae Otangarei, Pehiaweri Marae, Northland DHB, Manaia Health PHO and Whangarei District Council.

In the first six months of operation, a chiller van was purchased, relationships developed with distributors, food safety procedures were set up and warehouse management system has been developed.

Negotiations are underway with Goodman Fielder and Countdown as suppliers. Food has also been dropped off by people with surplus at home or in their orchards. Community and Māori providers have entered into agreements to receive and distribute food. Agreements include guidelines on food safety, a commitment not to on-sell food and an indication as to who they intend the food for.

Food for Life: The lemons and mandarins donated from home trees will be made into juice to serve in the cafe, and some of the lemons will be made into lemon pickle. (This delivery fed 30)

Plunket: Mangawhai Playgroup appreciated their avocados very much with many going home with tamariki for their whānau to make some healthy kai. (Children fed 25)

HIGHLIGHTS

Healthy Families NZ is about encouraging people to live healthier lives by making good food choices, being physically active, moderating alcohol consumption and being smoke-free.

Healthy Families NZ is operating in ten locations and includes the Far North managed by Te Rarawa whose vision is Ka puta noa te mauri Te Taitokerau – a healthy, thriving Far North.

To mark Conservation Week 10–18 September 2016 the first Pipiwharauroa: Hikoi for Healthy Nature, Healthy People walk took place. A joint initiative between Ngai Takoto, the Department of Conservation and Healthy Families Far North, the inaugural event encouraged the community to take advantage of the district's bush walks, and improve their physical and mental health and wellbeing.

Morehu Marae has taken a stand to further ensure the survival of its descendants by becoming the first marae in Pawarenga to go auahi kore. The committee celebrated its adoption of its auahi kore marae policy in a bid to celebrate the health of its people and send a clear message to smokers to stop before they start. The policy comes on the back of the successful Wero stop smoking programme implemented by Te Hiku Hauora in the community last year. Of the ten smokers who took part, seven stopped for good.

After 40 years of business excellence in Northland, the annual Westpac Business Excellence Awards will this year see the Northland Chamber of Commerce incorporate Healthy Families New Zealand principles for the first time.

Northland Chambers of Commerce have been a key champion in supporting the Healthy Families NZ approach – to improve the health and lives of people where they live, learn, work and play.

Integrating the ethos of Healthy Families NZ within the existing awards framework, asked businesses to show that they are not only sustainable financially, but culturally, environmentally and socially as well. A big part of this is valuing their workforce wellbeing in ways that are broader than just workplace health and safety. It is about workplaces benefiting the communities in which they operate.

Healthy Families Far North is about enabling an approach to chronic disease prevention across the Far North District that embodies seven key principles, including Leadership. The Northland Chamber of Commerce has provided outstanding leadership for Northland businesses since the awards' inception 40 years ago and by supporting a holistic view of good business, will continue to champion good health in workplace settings across the region.

Photograph: Erena Hodgkinson

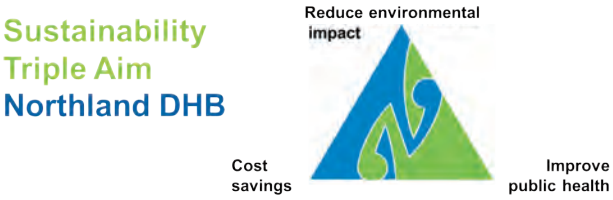
Organisational Sustainability

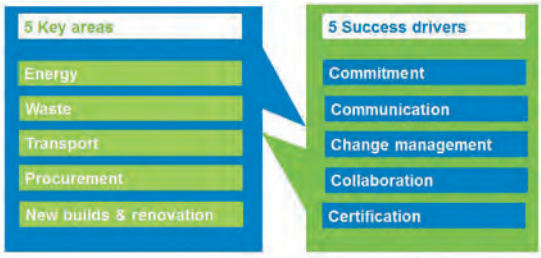
In June 2016 a proposal from Drs Roger Tuck, Mike Roberts and Clair Mills, with support from other colleagues, for the development of a Northland DHB sustainability policy and the appointment of a sustainability manager was approved.

Margriet Geesink was appointed in August as the Sustainability Development Manager. Her immediate priorities have been to review our energy and utility consumption, transport and travel and waste management and report on the opportunities we have to reduce consumption and waste.

The sustainability vision of the Northland DHB aligns with the overall DHB Vision and triple Aim and is defined:

"As professionals in healthcare we continuously care for healthy people living in a healthy climate where every one of us acts as Kaitiaki to take care of our resources and environment."





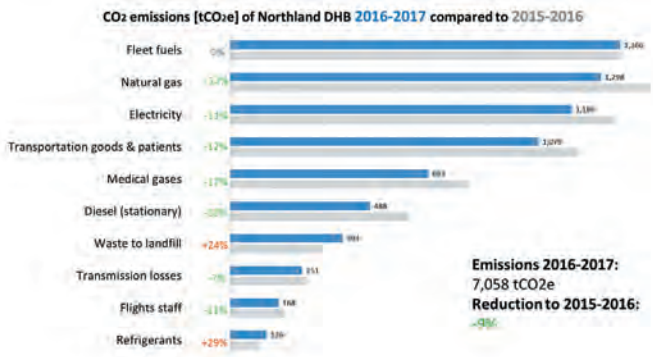
The sustainability triple aim strategy focuses on co-benefits between health, environment and costs.

Five key focus areas and success drivers were agreed as an outline for the sustainability strategy. The key focus areas were chosen for

their impact potential in greenhouse gas emission reduction, cost reduction, relation with health issues and possibility to influence.

They are also in line with key areas chosen by other DHBs and they are part of reporting and certification schemes. The key areas and success drivers as a strategy outline will be used to develop the action plan.

Northland DHB has made the commitment to reduce its carbon emissions by 15 percent in 2025 compared to 2016.



HIGHLIGHTS

I Am a Voice – Improving Access for Young People with Diabetes

Northland was one of two DHBs selected to implement a new innovative pilot programme aimed at helping patients with both diabetes and mental health issues. A partnership the Company of Giants was formed to deliver this programme of work.

Interventions for three key patient groups were identified;

1. Adults with low-medium mental health issues and poorly controlled diabetes
2. Young people aged 16-20 with poorly controlled type 1 diabetes, and
3. Children and whānau of newly diagnosed type 1 diabetes.

The programme of work has been collaborative and exciting with youth joined by representation from across diabetes and mental health services.

The nature of this project has been about integrating more pathways and connections within the specific context of the Whangarei community as well as address diabetes management through group work and conversation. Long term pathways of individuals have been affected by the amount of contact with different facilitators, artists, clinicians, leaders and other young people with type 1 diabetes.

The project focused on different platforms of self-expression as individuals and as a collective. Through photography, writing, performance poetry, song writing, screen printing, audio work, video making and storytelling the participants explored the experience of living with type 1 diabetes. This approach also served to help educate the whānau and Diabetes Centre staff around the physical and emotional experience of the participants and their journey with type 1 diabetes.

It has been acknowledged that to build strong communities and resilient young people we must provide them with opportunities to become aware of the people, resources and networks that are available to them and allow them to use the ones that become the most useful.

ONEONESIX, a community operated space in Whangarei open for original, innovative and unique forms of sharing, dialogue, performance, arts practice, citizen media, is a growing hub of community resource and activity and was an appropriate space to base the project because of this.

The final sharing of work was attended by around sixty people including whānau and friends and was a multimedia expression and celebration of the work carried out over the three cohorts. The evening centred around the idea of 'An expert's guide to T1 diabetes' - an opportunity for the group to share and express stories, ideas and journeys with T1 diabetes, educate their community and audience and also celebrate some of the things they had worked on together over the project.

Sudden Unexpected Death in Infancy Programme (SUDI)

Northland has been very proactive in this area with our approach since 2012 where our SUDI prevention plan aligned with the regional plan. We introduced a SUDI risk factor assessment, agreed key messages for whānau, hosted wananga and distributed safe sleep spaces – wahakura and PepiPod.

Northland's strategy has been a real success. Some highlight outcomes include:

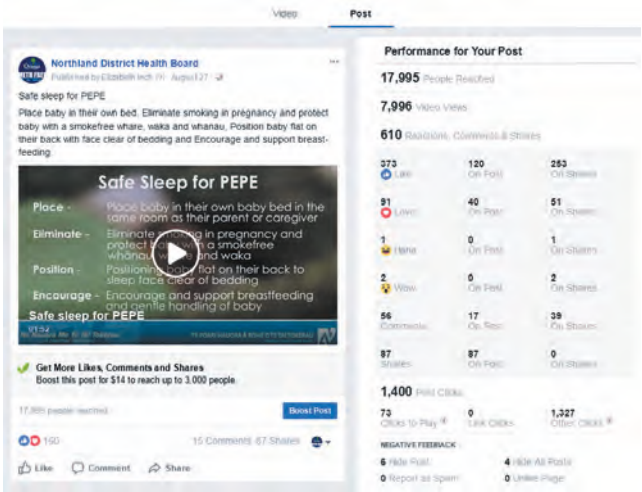
- 60 percent reduction in SUDI rates (over five year period) 2012 = 10 2017 = 2 (at 1 Sept 2017) All Māori infants
- Northland DHB has funded and distributed over 900 Safe Sleep Spaces (wahakura and PepiPod) to whānau with infants who have SUDI risk factors. (With a focus on Māori infants exposed to maternal smoking and alcohol and other drugs)
- 80 marae and community based wananga delivered.

A range of other evidence-based risk and protective factors will be incorporated in the 2017-18 year and include encouraging immunisation, breastfeeding, and sleeping baby on their back.

A further joint initiative between the general managers of Māori Health and Child Youth Maternal Oral and Public Health Services is being introduced called Hapu Wananga – a kaupapa Māori antenatal education programme which will support safe sleeping as part of its kaupapa.

In the 2016 calendar year 22 percent of women birthing Māori infants in Northland attended group session antenatal education and it is our aim to increase this to over 30 percent through this new programme.

In November 2016 we produced the Moe Haumaru video clip in Te Reo with English subtitles for distribution on social media. The video demonstrates how to safely place a baby in a wahakura. A most recent posting reached 17,995 people with 7,996 people viewing the video. The video was shared by 87 people demonstrating that Northland made video clips is a viable way to share important safe sleep information.



Cancer Therapy at Kaitaia Eases Travel Challenges

In June 2017 Kaitaia Hospital opened Tatau Ki Te Waka Oranga, a unit dedicated to treating non-complex oncology and haematology patients, meaning patients in the Far North have far shorter travel time to receive injections of lifesaving cancer medicines such as Bortezomib and Herceptin.

To set up the new Cancer Treatment Unit at Kaitaia, Jim Carney Cancer Treatment Centre staff visited Thames Hospital, where an oncology clinic operates as a satellite of Waikato Hospital. Setting up something similar at Kaitaia required dedicating a room, providing specialist refrigerators and infusion pumps and training nurses to know how to administer Bortezomib and Herceptin for patients experiencing myeloma, lymphoma and breast cancer.

"As cancer clinicians we are acutely aware about how our treatments impact on our patients' lives, not only in terms of side effects, but also taking away precious time that could be spent with family," said Dr Vince Newton, clinical director, Northland Cancer and Blood Service.

Two years ago the teams from Whangarei and Kaitaia started trialling video conference clinics with doctors in Kaitaia to see complex patients in clinic, and set out to explore how they could begin to deliver treatments as well.

"Within 12 months of mooting the establishment of a treatment unit in Kaitaia the nursing and medical staff have been enthusiastic and committed to making it happen," noted general manager Andrew Potts.

"I want to express my gratitude to all those involved and acknowledge that everyone has put our patients at the centre of everything they have done to make this unit a reality".

Irene Larsen is one of the patients who will be saved the burden of travel, receiving her Bortezomib treatment on the day the service was launched. Up until then, travelling to Whangarei for treatment for myeloma had a draining effect on Irene's family, as Irene's daughters needed to transport her, support her and liaise with clinicians.

The number of people who will utilise the Kaitaia service will be few initially, but it is known that over the last five years, 19 patients who lived closer to Kaitaia have had 302 visits to Whangarei for chemotherapy. Northland DHB expects patients who live in Kaitaia and surrounds will benefit from the service with new treatment drugs that are now becoming available.

HIGHLIGHTS

Northland DHB and NZ Police have been funded $3m to deliver the Te Ara Oranga Methamphetamine Demand Reduction strategy pilot. The funding was made available under the Criminal Proceeds (Recovery) Act.

The joint venture is trialling an integrated model of Police and Health activity to reduce methamphetamine demand by enhancing treatment services and increasing responsiveness.

Police in Northland are dealing with methamphetamine related problems during most shifts. It is associated with crimes such as theft, fraud, poor driving, violence and episodes of family harm. Methamphetamine is impacting at all levels, and increasingly Police are seeing the impact it is having on our children and young people.

"What we are seeing is methamphetamine suppliers and high demand users are trapped by the addictive nature of the drug, pressured by the gangs and have poly substance abuse," notes Inspector Dean Robinson, NZ Police.

"They turn to illegitimate means to finance their addictions and its impacting their partners, children, and wider whānau. We will be working with these people and referring to treatment where at all possible."

Methamphetamine admissions to Timatanga Hou, Northland DHB's detox unit, are now second only to alcohol and methamphetamine has become the second or third most common reason for referral to DHB Drug and Alcohol services in Tai Tokerau.

"Those of us working in the Drug & Alcohol treatment sector have been experiencing the impact of methamphetamine increasingly over the past few years," said Jenny Freedman, Clinical Psychologist.

"We are very excited about the opportunity to provide a timelier and comprehensive range of evidence based treatments for people who use methamphetamine and also support their whānau who are affected by their drug use."

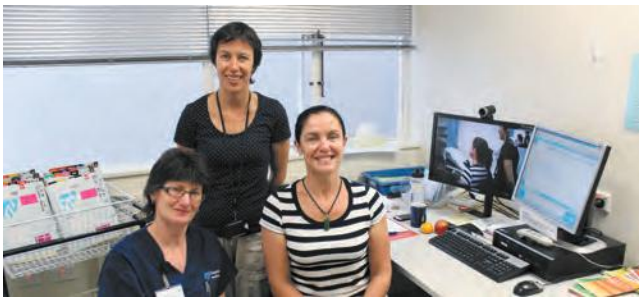
A range of new referral and treatment options for methamphetamine users and their whānau will be available across Northland and a team of seven police officers focused on reducing methamphetamine harm and supply will hit the beat.

Northland Patients Part of Worldwide Hep C Cure

Northland is among the locations worldwide where a drug to treat Hepatitis C is achieving a near-100 percent success rate. Curing the disease in individuals is hoped to contribute to the worldwide eradication of the debilitating liver disease as an epidemic. Viekira Pak is a combination of four antiviral medicines which PHARMAC began publicly funding from July 2016.

In Northland – where there are up to 500 people diagnosed with Hepatitis C, and many more undiagnosed – 73 patients had been successfully cured of Hep C as of the end February, with only one known unsuccessful treatment. As at the end of March, 108 patients had been initiated on Viekira Pak. Viekira and other antiviral drugs, combined with prevention programmes, are expected to eradicate the virus as a public health problem by the year 2030, the World Health Organization says. 50,000 New Zealanders are estimated to carry the blood-borne virus, although only half that number of people are currently diagnosed. Globally, WHO estimates up to 150 million people live with the disease.

Northland DHB physician Dr Kaye Logan and hepatitis clinical nurse specialist Sandra Meyst said the release of Viekira was "exciting" but also generated apprehension. For now, Kaye and Sandra can only use Viekira Pak with patients of Genotype 1, a genotype representing around 60 percent of patients. Because of the origins of Hep C infection, including blood exchange from intravenous drug needles or tattooing equipment, many patients have experienced guilt, shame or stigma around their condition, intensified by the low success rate of the Interferon and Ribavirin antiviral treatment options which were the norm until Viekira. These antivirals were expensive and many side effects would sicken those undergoing the treatment.



"For so many years it's been depressing to treat, very intensive, often disappointing, with patients unwell and miserable," Kaye said. The cure rate brings great news to the patients born between 1945 and 1965 most likely to suffer from Hepatitis C.

"In my job often you don't cure people," Kaye said. "It's nice to be able to cure something." Those who have successfully taken the course of Viekira "have had a big emotional burden lifted," Sandra added.

The next step in eliminating Hepatitis C as a public health problem will be ensuring Viekira is safely prescribed and dispensed and that GPs – who are able to treat patients without cirrhosis – understand safety around Viekira interacting with other drugs. Other factors in the patient's health will also affect the success of Viekira. For now, GPs are being educated about the funding available to get Hep C sufferers engaging with their clinic.

"When the dust settles we will go out and reach people who don't see their GP and aren't treating their disease," Kaye said. "We want to hunt them down and give them treatment – in future we want to eradicate the disease, like with smallpox."

UPSTANDER Programme Tours Northland Schools

Times are tough on Rocky Road. Everyone has their demons and the pressure to play along is way too strong. After all, who are we to think that we can change anything? The play UPSTANDER got Northland youth talking about the link between domestic violence, communication and bullying, and toured schools from May to June 2017.

UPSTANDER was written by Bryan Divers and supported by Northland DHB and Te Puni Kōkiri's Rangatahi Suicide Prevention Fund. Previously Northland DHB worked with Bryan to produce and tour Matanui, a play about youth suicide.

As with Matanui, UPSTANDER performances were followed by educational sessions in schools in which students and health and support agencies engage in korero and role-playing while revisiting parts of the play. This meant organisations including DHB nurses, Te Roopu Kimiora, Police, Oranga Tamariki and other agencies who work with the school could relate to students about what their work is all about and how they can be safely and confidentially be contacted. As Bryan put it, "The stage production is a conversation-starter to streamline support."

UPSTANDER followed characters along the aptly-named Rocky Road, starting with Jo (Tameka Sowman) who is friends with Lucy and Barry. Jo became an upstander against the bullying of Lucy (Johanna Cosgrove) by Barry (Mataara Stokes). Barry's character learned about his own motivations for bullying and violence after he was confronted in the play by Eric, Lucy's grandfather, played by director Bryan Divers. Tameka, who played Desiree in Matanui, said the underlying 'territory' of suicide awareness links Matanui with Bryan's new play. "It's not easy to talk about some of these topics – but conversations are a way forward," Tameka said. "[Theatre] is a platform for resilience."

Johanna added theatre is a great medium for that topic because theatre is a way to get open and honest dialogue happening. UPSTANDER toured 19 schools throughout Northland and also visited the Kea Unit, Northland Region Corrections Facility in total reaching an estimated audience of over 3000.

Photograph: Sarah Marshall

Parenting Service Launched for Mental Health and Addictions Clients

He Tupua Waiora
Pregnancy and Parental Service

A new service to help clients of Mental Health and Addictions Services (MHAS) was launched at Whangarei Hospital on March 20. Known as He Tupua Waiora Pregnancy and Parenting Service, the new approach is possible thanks to $1m in funding for each of the next four years and will reach 100 pregnant women and parents of young children every year.

He Tupua Waiora is aimed at preventing and reducing harm to children under three years old. It is based on a model of care developed by Waitemata DHB. DHBs in Tairawhiti and Hawkes Bay are providing a similar service to that launched in Northland. Its main work will be carried out in the Whangarei hub, with a 'spoke' of the hub located in Kaitaia.

He Tupua Waiora will provide its service in a flexible, non-judgemental, client-focused way, supporting whānau self- efficacy, empowerment and recovery, and will practice from a social justice perspective. It was brought about because Northland DHB could see more help was needed for mothers and mothers-to-be who have multiple complex and interacting issues including dependence disorders, cognitive impairment, histories involving neglect, abuse and domestic violence, multi-generational dysfunctional family patterns and involvement with child protection agencies and the justice system.

The service primarily aims for reduced substance abuse in mothers as well as safety and an enhanced psychosocial environment for infants, reduced family violence, improved housing and reduced offending. He Tupua Waiora was launched at Tohorā House, Whangarei Hospital, where He Roopu Kimiora Service Manager Agnes Daniels spoke about her years of experience working alongside at-risk mums. "Change has to come from within [clients]," Agnes said, adding that the new service aims "To touch people in their hearts."

Agnes said the service represents Northland DHB's official values. "Tumanako (hope) is the best value in this service. Because it's hard for children to act for themselves, it's our responsibility to work alongside the parents."

At the launch, Agnes emphasised to Richard Taylor of the Ministry of Health her gratitude for the funding for the service. Marijke Cederman and Robert Steenhuisen of Waitemata DHB were also thanked with a gift for their contribution to He Tupua Waiora. Stakeholders in the service will include PHOs, Salvation Army and Northland DHB's Child Protection Coordinator; and of course parents, whānau and caregivers.

HIGHLIGHTS

Sir Jerry Mateparae Agrees To Remain Bronchiectasis Foundation Patron

In July 2016, Camron Muriwai and his wife Ana Sadlier (representing the Bronchiectasis Foundation) attended the Vice-Regal Patronage reception at the invitation of former Governor-General Lt Gen The Rt Hon Sir Jerry Mateparae. The Bronchiectasis Foundation was one of many organisations selected to attend an evening of farewell speeches and acknowledgment of the contribution community groups make to New Zealand.

Sir Jerry Mateparae has been the patron of the Bronchiectasis Foundation since April 2015 after accepting a request from founder Esther-Jordan Muriwai, daughter of Camron and Ana. At the launch of the Foundation last year in Whangarei, Sir Jerry spoke about first meeting Esther-Jordan at the Asthma Achievers Awards at Government House in 2014.

"It was there that she asked me if I would become the Patron of her Foundation, and I am delighted I could eventually say yes to her request. 'Request' might not be the right word – I got the strong impression that saying 'no' to Esther wasn't an option. She may have been frail physically but her inner strength and determination were patently obvious," he said.

Guests at the Vice-Regal Reception on July 14 were given some private time with Sir Jerry, and Camron and Ana took the opportunity to provide him with an update on the Foundation's developments. "We shared the launch of the new website which is the platform we are using to support those that live with and care for people with bronchiectasis, along with raising awareness of and conducting research into the rare disease."

During the meeting Sir Jerry offered the couple the opportunity to apply to the incoming Governor-General for patronage of the Foundation. "We decided to ask Sir Jerry if he would consider continuing as Patron," Camron explains. "To our great surprise he said yes and has agreed to remain Patron of the Bronchiectasis Foundation for a further seven years."

The launch of the Bronchiectasis Foundation was on what would have been Esther-Jordan's birthday, and a poignant milestone in her remarkable legacy. The Foundation was so much her work that she even wrote its constitution deed, which she saw as a labour of love. It stands as an example of her courage and determination.

At the launch, Sir Jerry said, "Esther- Jordan's example reminded me of the words of author Leo Rosten who said: 'The purpose of life is not to be happy – but to matter, to be productive, to be useful, to have it make some difference that you have lived at all'. Esther mattered and her legacy, the Bronchiectasis Foundation, will continue to make a difference in the lives of others."

(The new Governor-General, Dame Patsy Reddy, was sworn it at Parliament on Wednesday 28 September.)

Understanding the links between poverty, health, housing, work and welfare, and the power of education to change outcomes is the foundation that underpins the relationship between I Have a Dream Charitable Trust and Northland DHB.

The I Have a Dream programme ran a pilot project with 53 children in the Wesley community of Mt Roskill from 2003 to now, with significant success. They have now expanded the programme to youth across four schools in the Tikipunga/Otangarei community known as the Ngātahi Education Initiative.

In the first 12 months of the programme the Ngātahi Education Initiative have engaged with 700 children across Tikipunga Primary School, Te Kura o Otangarei, Totara Grove Primary School and Tikipunga High School, hired six Navigators and began the roll-out of support activities.

Full-time Navigators follow each year-level of children from early primary, through secondary and into tertiary education to provide mentoring, academic oversight, advocacy and support. Having a Navigator that supports the child and whānau is essential in raising long-term student achievement and changing the lives of those students.

Northland DHB staff member, Dr Rachael Windsor, talked about her decision to support I Have a Dream:

"I often feel that working in the hospital is like being the ambulance at the bottom of the cliff , and I crave opportunities to make more of an upstream impact. There is no shortage of opportunities to donate to such causes.

But it's easy not to; you wonder where the money goes, the cause is so far removed from your own experience, or you wonder what your contribution will actually achieve."

"But giving to I Have a Dream was a no brainer for me – it supports the community in which I live and the young people that will be my favourite city's future. It's a privilege to be able to contribute what I can to make the kind of foundational changes needed to strengthen communities – good mentors for our young people. And even the smallest bits count if we can all give a little!

Scott Gilmour, chairperson of the I Have a Dream Board of Trustees notes that 2016 was a fantastic year, with the team building a solid foundation to be a long-term game changer in Whangarei.

"Major accomplishments in Whangarei include launching our daytime and after school programming across all four of our schools, our research project has been approved by the University of Auckland Ethics Committee and we have positive stories about our Navigator team coming back to us by principals, parents, teachers and the kids themselves."

There is also a change in awareness and attitude towards I Have a Dream in Whangarei by the business community. An example of this is feedback from Peter Ogle, a commercial real estate agent who signed up to sponsor a few kids and has significant connections in the business community.

"I think I Have a Dream is the most effective grass roots attempt at addressing the spiralling despair that many of our children face. We can raise happy healthy children who will in turn benefit the whole family and their community. By improving the hopes and dreams of our next generation 'our children' will thrive and reach their true potential."

Northland Health & Social Innovation Awards 2016

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

Hauora Māori AWARDS

Tangata I Te Tuatahi
PEOPLE FIRST
Drinking Fountain Project
Drinking Fountain Project
Te Roopu Wahaora, Te Hau Ora o Ngapuhi, Far North District Council, Kaipara District Council, Northland DHB, Northland Branch of NZ Dental Association, Kaipara Community Health Trust, Dargaville Gardens Trust.

Te Ara Whetu Award
BRIGHT STAR CHAMPION
Kaumātua Te Kopa Tipene

Manaaki
CARING
Cassandra Moar
Master Weaver

Whakaute (Tuku Mana)
RESPECT
Tukaha Milne
Ngāti Hine Health Trust
Atutangata Programme

Whakawhiwhiti Koero
COMMUNICATION
Sharon Henare
Māori Competency Framework

Whakawhiwhiti Koero
Taumata Teitei
SERVICE TO EXCELLENCE
SUPREME AWARD
Rhonda Zielinski-Toki
Te Ha Oranga Mobile Nursing Service

NorthAble
DISABILITY SERVICES

PATIENT SAFETY & QUALITY IMPROVEMENT DIRECTORATE
Quality & Improvement Awards

Te Tai Tokerau Primary Health Organisation
Hei Oranga Ra

Innovation Award
Cancer & Blood Services

Collaboration Award
Exercise Wisdom Tooth

Patient Safety Improvement Award
Kay Lengyel

Patient Whānau Centred Care Award
Far North Newborn Hearing Screening

Manaia Health PHO

Improvement Health & Safety Award
Northland DHB Healthy Food Policy Team

Scientific, Technical and Allied Health Award
Healthy Lifestyles Physiotherapy Outpatients

Supreme Nursing & Midwife Award
Sue Stebbeings
Emergency Department Whangarei Hospital

Cedric Kelly Supreme Award
Kay Lengyel

Senior Medical Officer of the Year
Dr David Hammer
Clinical Microbiologist Northland DHB

Social INNOVATION Awards
Celebrating Northland Entrepreneurship

Best Innovation for Social Outcomes
Far North Safer Community Council

Best Innovation creating Social Wellbeing for Māori
NorthTec & Pehiaweri Marae and Church

Best Contribution to Social Good by an Individual
Rowena Jones

Primary Care Awards

Manaia Health PHO

Auaha
Innovative Practice Award
Mental Health Credentialing For Nurses

Hautūtanga
Emerging Leadership Award
Rachael Hetaraka

Kotahitanga
Building collaborative relationships
Otuihau C 3

Matauranga
Implementing quality primary care research into practice Award
Access to Primary Healthcare Research Team

Primary Care Service Award
Rose Lightfoot

OUR COMMUNITY

Northland Foundation

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

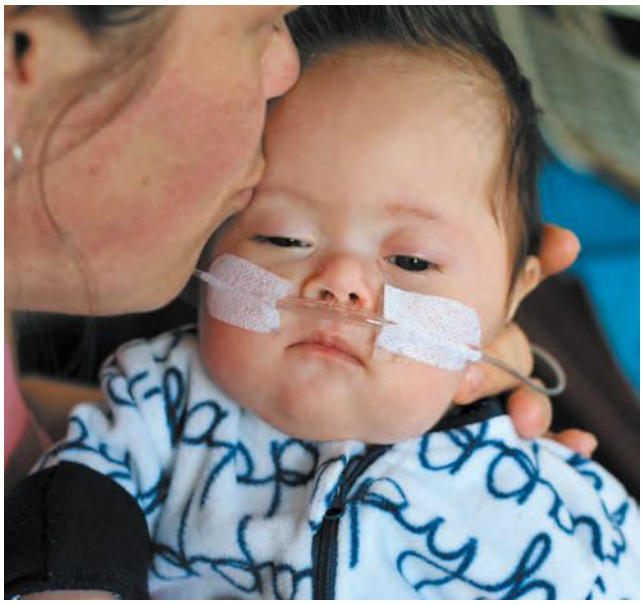
The partnership between Northland DHB and Northland Foundation is focused on encouraging community giving to benefit the health needs of all Northlanders, now and in the future.

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

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

Countdown Kids Hospital Appeal

For the last nine years, one of the biggest annual fundraising events for Northland DHB is the Countdown Kids Hospital Appeal, which raises funds for specialised equipment for our smallest patients. We work closely with the Countdown supermarkets in the region. Last year this wonderful appeal raised $96, 054 to support our children and babies through the provision of equipment and facilities, which would otherwise not have been available. The support from Countdown Kids Hospital Appeal covers the whole of Northland, and the benefits are spread around all of our hospitals in the region. Since it started, the Countdown Kids Appeal has raised $677,043 for the benefit of our children and babies.



Caring in Comfort

Fundraising from charity groups has provided enough money to purchase 21 Romeo Recliner chairs which will be used by whānau who are helping care for their loved one in hospital. The Whangarei Lions Club donated $17,765 being funds raised by the 2016 Fireworks night and proceeds from a fundraiser on the night of the Joseph Parker Fight night. Tutukaka and Onerahi Lions clubs and the Kamo Club have sponsored a chair each and Contractors for Charity and Gallagher's have sponsored two chairs each.

Northland DHB adopted the Partners in Care policy in 2015. Research shows that the presence of family members and close friends as partners in care can enhance the patient and family experience, improve the management of both acute and chronic medical problems and reduce the risk of medical error.

Contact Energy Fund

The Contact Energy Fund is managed by Northland Foundation on behalf of Northland DHB. It benefits renal patients and their families. This year 17 patients have received grants of up to $1000 each to support them with home dialysis.

The fund has also been used for a second highly successful seminar held in November 2016, giving dialysis patients an opportunity to share their experiences of living independently while being prepared for emergencies, especially the impact of power cuts on dialysis equipment.

At the seminar, patient Lois Samuels said her dialysis situation is particularly hard since her husband has passed away. Lois said she has anxiety about who she will call if something goes wrong. "I do worry. But I thoroughly enjoyed it today. You don't realise there are so many people that dialyse. I'm not alone, especially with social workers Nicolette [Crump] and Anna [Stewardson]. I look forward to people to talk to and I would certainly like to see today happen again."

The Charitable Accounts Committee

A committee of Northland DHB and Northland Foundation staff meets quarterly to receive and consider applications for funding from the many different services and departments of Northland DHB. Grants are made from funds held and administered by Northland Foundation that have been made over the years to support the work of Northland DHB. This year grants that have been made include support for: the Jim Carney Cancer Centre, the Diabetes Fun Run/Walk, Osteoporosis Awareness Day, World Kidney Day Fun Run and Walk and improving patient experience through a sleep mask trial.

Health Fund Plus

Health Fund Plus is the name given to the fundraising programme developed in 2016 to encourage larger gifts, donations and endowments to Northland DHB. These larger gifts and endowments can then be used for the optional extras that will support the Partners in Care programme and which enhance the patient or family/whānau experience of care. This year the Foundation has received gifts or notification of bequests amounting to $147,362.

This year the Foundation has received gifts or notification of bequests amounting to $147,362.

Photograph: Michael Cunningham

GOVERNANCE

Northland DHB Appropriation

	Parent	
	2017	2016
	$000	$000
Appropriation Revenue		
Original	539,583	509,308
Supplementary	(2,948)	2,478
Total Appropriation Revenue	536,635	511,786

The Appropriation Revenue received equals the Government's actual expenses incurred in relation to the appropriation which is a required disclosure from the Public Finance Act. It has been appropriated towards the provision of personal and mental health services including services for the health of older people, provision of hospital and related services and management outputs by Northland DHB. The Northland DHB has provided these services in alignment with Government priorities; the strategic direction set for the health sector by the Ministry of Health; the needs of the district population and regional considerations.

The performance measures are outlined in the DHB's Statement of Intent are used to assess our performance. For performance results, refer to the Statement of Performance.

Ministerial Direction

Directions issued by a Minister during the 2016/17 year, or that remain current are as follows:

- Direction to support a whole of government approach as to implementation of a New Zealand Business Number, issued in May 2016 under section 107 of the Crown Entities Act. http://www.mbie.govt.nz/info-services/business/better-for-business/nzbn.
- Health and Disability Services Eligibility Direction 2011, issued under section 32 of the New Zealand Public Health and Disability Act 2000. http://www.health.govt.nz/system/files/documents/pages/eligibility-direction-2011.pdf.
- Directions to support a whole of government approach, issued in April 2014 under section 107 of the Crown Entities Act. The three directions cover Procurement, ICT and Property. http://www.ssc.govt.nz/whole-of-govt-directions-dec2013
- The direction on the use of authentication services, issued in July 2008, continues to apply to all Crown agents apart from those with sizeable ICT business transactions and investment specifically listed within the 2014 direction. www.ssc.govt.nz/sites/all/files/AoG-direction-shared-authentication-services-july08.PDF

GOVERNANCE AND PARTNERSHIPS

In accordance with the New Zealand Public Health and Disability Act 2000, the Board has 11 members, seven of whom were elected in October 2016 and four of whom are appointed by the Minister of Health*. The Board also has three committees which provide a more detailed level of focus on particular issues. The Board has three committees that provide a more detailed level of focus on particular issues:

Board Members:

Term Commenced 5 December 2016

Sally Macauley (Chairman)
Sue Brown (Deputy Chair from 5 December 2016)*
Craig Brown
Colin Kitchen
Debbie Evans
Denise Jensen*
Dr Gary Payinda (5 December 2016)
John Bain
June McCabe*
Libby Jones (5 December 2016)
Sharon Shea*

Former Members - Term concluded 4 December 2016

Anthony Norman
Dr Chris Reid
MC (Bill) Sanderson

Community & Public Health and Disability Support Advisory Committee

This committee advises the Northland DHB Board on the health needs of Northlanders, including disability support needs, and any factors it believes may adversely affect the overall health status of the population. That advice must ensure that all service interventions funded and provided maximise the overall health gain such as the independence in society of people with disabilities.

Libby Jones (Chair)
Sally Macauley
Sue Brown
Craig Brown
Colin Kitchen
Sharon Shea
Beth Cooper (external member)
Beryl Wilkinson (external member)
Jonny Wilkinson (external member)

Former members - Term concluded 30 November 2016

Anthony Norman
Debbie Evans
Mark Sears
Peter Jensen

Hospital Advisory Committee:

This committee advises the Northland DHB Board on the financial and operational performance of Northland Health, the Board's provider of hospital and health related services. It is also required to assess strategic issues relating to the provision of these services.

John Bain (Chair)
Sally Macauley
Sue Brown
Gary Payinda
Libby Jones
Denise Jensen
Debbie Evans

Former Members - Term concluded 30 November 2016

Anthony Norman
Dr Chris Reid
MC (Bill) Sanderson
Win Bennett (Term concluded 30 July 2016)

Audit, Finance & Risk Management Committee:

June McCabe (Chair)
Sally Macauley
Sue Brown
Craig Brown
Denise Jensen

Former Members - Term concluded 4 December 2016

Anthony Norman

Northland DHB Attendance at Board and Committee Meetings July 2016 – June 2017

Board Members	Board (8 meetings)	HAC (7 meetings)	Audit (4 meetings)	CPHAC/DiSAC (3 meetings)
 **Sally Macauley** (Deputy Board Chair) (Term as Deputy Board Chair Concluded 4 December 2016) (Term as Board Chair Commenced 5 December 2016)	8	7	4	3
 **John Bain**	8	7	x	x
 **Craig Brown**	7	x	1 (Appointed 31 January 2017)	1
 **Sue Brown** (Deputy Chair) (Term Commenced 5 December 2016)	4	3 (Appointed 31 January 2017)	2 (Appointed 31 January 2017)	2 (Appointed 31 January 2017)
 **Debbie Evans**	6	2 (Appointed 31 January 2017)	x	1 (Term Concluded 30 November 2016)
 **Denise Jensen**	7	6	4	x
 **Libby Jones** (Term Commenced 5 December 2016)	3	6	x	2 (Appointed 31 January 2017)
 **Colin Kitchen**	8	x	x	2
 **June McCabe**	8	x	4	x
 **Dr Gary Payinda** (Term Commenced 5 December 2016	4	3	x	x
 **Sharon Shea**	7	x	x	2
Beth Cooper (Term Commenced 1 March 2017)	x	x	x	2
Beryl Wilkinson (Reappointed - Term Commenced 1 March 2017)	x	x	x	3
Jonny Wilkinson (Term Commenced 1 March 2017)	x	x	x	2

x = not a member of the committee

Previous Board and Committee Members	Board (4 meetings)	HAC (4 meetings)	Audit (2 meetings)	CPHAC/DiSAC (1 meetings)
Anthony Norman (Board Chair) (Term Concluded 4 December 2016)	4	3	2	1
Winfield Bennett (Term Concluded 31 July 2016)	x	1	x	x
Dr Chris Reid (Term Concluded 4 December 2016)	4	4	x	x
Mark Sears (Term Concluded 30 November 2016)	x	x	x	0
Peter Jensen (Term Concluded 30 November 2016)	x	x	x	1
Dr Bill Sanderson (Term Concluded 30 November 2016)	3	3	x	x

x = not a member of the committee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FINANCIAL & AUDIT REPORTS

For the year ended 30 June 2017

Statement of Responsibility

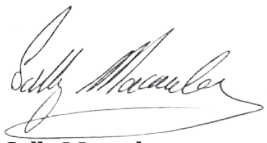
1 The Board is responsible for the preparation of the Northland District Health Board and group's Financial Statements and Statement of Performance and for the judgements made in them.

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

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

4 In the Board's opinion these Financial Statements and the Statement of Performance for the year ended 30 June 2017 fairly reflect the financial position and operations of Northland District Health Board.

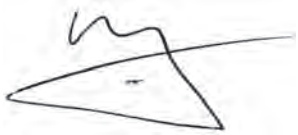
Signed on behalf of the Board:



Sally Macauley
Chairman
31 October 2017

June McCabe
Chairman - Audit Committee
31 October 2017

Dr Nick Chamberlain
Chief Executive
31 October 2017



Meng Cheong
Chief Financial Officer
31 October 2017

Board Report

The Board has pleasure in submitting the Financial Statements and Statement of Performance for Northland District Health Board for the year to 30 June 2017.

Principal Activities

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

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

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

	2017	2016
Results and Distribution - Group	**$000s**	**$000s**
Surplus/(deficit) Before and After Tax	(2,563)	138
Financial Position		
Equity was represented by:		
Current Assets	42,032	38,381
Less Current Liabilities	(74,766)	(66,368)
Plus Non-Current Assets	203,767	203,080
Less Non-Current Liabilities	(15,082)	(41,109)
Total Equity	155,951	133,984

Review of the Operations

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

Distributions to Owners

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

Board Member Fees

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

Staff Remuneration

The number of staff with total cost to the entity for senior staff packages including salary and other benefits, such as superannuation, with totals in excess of $100,000 for the year to 30 June 2017 (in $10,000 bands):

$100,001	- $110,000	73	$220,001	- $230,000	3	$340,001	- $350,000	3
$110,001	- $120,000	45	$230,001	- $240,000	6	$350,001	- $360,000	6
$120,001	- $130,000	33	$240,001	- $250,000	9	$360,001	- $370,000	3
$130,001	- $140,000	18	$250,001	- $260,000	15	$370,001	- $380,000	2
$140,001	- $150,000	18	$260,001	- $270,000	6	$380,001	- $390,000	2
$150,001	- $160,000	14	$270,001	- $280,000	6	$390,001	- $400,000	2
$160,001	- $170,000	17	$280,001	- $290,000	11	$400,001	- $410,000	1
$170,001	- $180,000	11	$290,001	- $300,000	7	$430,001	- $440,000	1
$180,001	- $190,000	5	$300,001	- $310,000	10	$440,001	- $450,000	1
$190,001	- $200,000	8	$310,001	- $320,000	6	$490,001	- $500,000	1
$200,001	- $210,000	4	$320,001	- $330,000	7			
$210,001	- $220,000	4	$330,001	- $340,000	7			

Of the 365 staff shown above, 221 are or were medical or dental staff.

If the remuneration of part-time staff were grossed-up to an FTE basis, the total number of staff with FTE salaries of $100,000 or more would be 490, compared with the actual total number of staff of 365.

Board Report

During the year ended 30 June 2017, 67 (2016: 51) employees received compensation and other benefits in relation to cessation totalling $1,283,977 (2016: $869,020).

Statement of Information

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

Interest Register

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

Board Members' Insurance

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

Events Subsequent to Balance Date

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

Donations

No donations were made for the year to 30 June 2017, (2016: $0).

Changes in Accounting Policies

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

Auditor's Remuneration

The Controller and Auditor-General is appointed under section 15 of the Public Audit Act 2001. Audit New Zealand is contracted to provide audit services on behalf of the Auditor-General. Audit New Zealand in their capacity as Auditors are due $184,252 (2016: $179,938) for audit fees for the group.

Good Employer Obligations

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

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

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

Sally Macauley
Chairman

Independent Auditor's Report

To the readers of Northland District Health Board and group's financial statements and performance information for the year ended 30 June 2017

The Auditor-General is the auditor of Northland District Health Board (the District Health Board) and group. The Auditor-General has appointed me, Karen MacKenzie, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and the performance information, including the performance information for an appropriation, of the District Health Board and group on his behalf.

We have audited:

- the financial statements of the District Health Board and group on pages 50 to 77, that comprise the statement of financial position and statement of contingent liabilities and assets as at 30 June 2017, the statement of comprehensive revenue and expenditure, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and

- the performance information of the District Health Board and group on pages 14 to 24 and on page 39.

Opinion

Unmodified opinion on the financial statements

In our opinion, the financial statements of the District Health Board and group on pages 50 to 77:

- present fairly, in all material respects:
    - the financial position as at 30 June 2017; and
    - the financial performance and cash flows for the year then ended; and
- comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards.

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

In respect of the 30 June 2016 comparative information only, some significant performance measures of the District Health Board and group (including some of the national health targets, and the corresponding district health board sector averages used as comparators), relied on information from third-party health providers, such as primary health organisations. The District Health Board and group's control over much of this information was limited, and there were no practical audit procedures to determine the effect of this limited control. For example, the primary care measure that included advising smokers to quit relied on information from general practitioners that we were unable to independently test.

The limited control over information from third-party health providers meant that our work on the affected performance information contained in the statement of performance for the comparative year was limited, and our audit opinion on the statement of performance for the year ended 30 June 2016 was modified accordingly.

The limited control over information from third parties has been resolved for the 30 June 2017 year, however, the limitation cannot be resolved for the 30 June 2016 year, which means that the District Health

Board and group's performance information reported in the statement of performance for the 30 June 2017 year, may not be directly comparable to the 30 June 2016 performance information.

In our opinion, except for the matters described above, the performance information of the District Health Board and group on pages 14 to 24 and page 39:

- presents fairly, in all material respects, the District Health Board and group's performance for the year ended 30 June 2017, including:
    - for each class of reportable outputs:
        - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
        - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year;
    - what has been achieved with the appropriation; and
    - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and
- complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 31 October 2017. This is the date at which our opinion is expressed.

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

Basis for our opinion

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the Professional and Ethical Standards and the International Standards on Auditing (New Zealand) issued by the New Zealand Auditing and Assurance Standards Board. Our responsibilities under those standards are further described in the Responsibilities of the auditor section of our report.

We have fulfilled our responsibilities in accordance with the Auditor-General's Auditing Standards.

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

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

The Board is responsible on behalf of the District Health Board and group for preparing financial statements and performance information that are fairly presented and comply with generally accepted accounting practice in New Zealand.

The Board is responsible for such internal control as it determines is necessary to enable it to prepare financial statements and performance information that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements and the performance information, the Board is responsible on behalf of the District Health Board and group for assessing the District Health Board and group's ability to continue as a going concern. The Board is also responsible for disclosing, as applicable, matters related to going concern and using the going concern basis of accounting, unless there is an intention to liquidate the District Health Board and group or there is no realistic alternative but to do so.

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

Responsibilities of the auditor for the audit of the financial statements and the performance information

Our objectives are to obtain reasonable assurance about whether the financial statements and the performance information, as a whole, are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit carried out in accordance with the Auditor-General's Auditing Standards will always detect a material misstatement when it exists. Misstatements are differences or omissions of amounts or disclosures, and can arise from fraud or error. Misstatements are considered material if, individually or in the aggregate, they could reasonably be expected to influence the decisions of readers, taken on the basis of these financial statements and the performance information. We were unable to determine whether there are material misstatements in the statement of performance because the scope of our work was limited, as we referred to in our opinion.

For the budget information reported in the financial statements and the performance information, our procedures were limited to checking that the information agreed to the District Health Board and group's statement of performance expectations.

We did not evaluate the security and controls over the electronic publication of the financial statements and the performance information.

As part of an audit in accordance with the Auditor-General's Auditing Standards, we exercise professional judgement and maintain professional scepticism throughout the audit. Also:

- We identify and assess the risks of material misstatement of the financial statements and the performance information, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- We obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the District Health Board and group's internal control.

- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board.

- We evaluate the appropriateness of the reported performance information within the District Health Board and group's framework for reporting its performance.

- We conclude on the appropriateness of the use of the going concern basis of accounting by the Board and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast a significant doubt on the District Health Board and group's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements and the performance information or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the District Health Board and group to cease to continue as a going concern.

- We evaluate the overall presentation, structure and content of the financial statements and the performance information, including the disclosures, and whether the financial statements and the

performance information represent the underlying transactions and events in a manner that achieved fair presentation.

- We obtain sufficient appropriate evidence regarding the financial statements and the performance information of the entities or business activities within the group to express an opinion on the consolidated financial statements and the consolidated performance information. We are responsible for the direction, supervision and performance of the group audit. We remain solely responsible for our audit opinion.

We communicate with the Board regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Our responsibilities arise from the Public Audit Act 2001.

Other information

The Board is responsible for the other information. The other information comprises the information included on pages 2 to 13, 25 to 45, 77 and 78 but does not include the financial statements and the performance information, and our auditor's report thereon.

Our opinion on the financial statements and the performance information does not cover the other information and we do not express any form of audit opinion or assurance conclusion thereon.

In connection with our audit of the financial statements and the performance information, our responsibility is to read the other information. In doing so, we consider whether the other information is materially inconsistent with the financial statements and the performance information or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on our work, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Independence

We are independent of the Group in accordance with the independence requirements of the Auditor-General's Auditing Standards, which incorporate the independence requirements of Professional and Ethical Standard 1(Revised): Code of Ethics for Assurance Practitioners issued by the New Zealand Auditing and Assurance Standards Board.

Other than the audit, we have no relationship with, or interests in, the group.

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

Statement of Comprehensive Revenue and Expenditure

For the Year Ended 30 June 2017

	Notes	Parent Budget 2017 $000	Group 2017 $000	Group 2016 $000	Parent 2017 $000	Parent 2016 $000
Revenue						
Patient Care Revenue	1	595,737	598,898	569,738	598,898	569,738
Finance Revenue	4a	1,293	1,191	1,751	1,179	1,736
Other Revenue	1	4,549	4,415	4,569	4,844	4,998
Total Revenue		601,579	604,504	576,058	604,921	576,472
Expenditure						
Personnel Costs	3	216,470	216,990	208,196	216,990	208,196
Depreciation and Amortisation Expense	10,11	13,143	13,264	12,696	12,768	12,198
Outsourced Services		21,805	27,857	25,082	27,857	25,082
Clinical Supplies		43,838	47,054	43,210	47,054	43,210
Infrastructure and Non-Clinical Expenses	2	27,779	26,771	26,420	27,321	26,970
Payments to other District Health Boards		76,857	79,269	75,466	79,269	75,466
Payments to Non-Health Board Providers		188,873	187,152	174,039	187,152	174,039
Finance Costs	4b	889	643	963	643	963
Capital Charge	5	9,925	8,067	9,848	8,067	9,848
Total Expenses		599,579	607,067	575,920	607,121	575,972
Surplus/(deficit) Before and After Tax		2,000	(2,563)	138	(2,200)	500
Surplus attributable to:						
Northland District Health Board		2,000	(2,460)	240	(2,200)	500
Minority Interest		0	(103)	(102)	0	0
Other Comprehensive Revenue and Expenditure						
Financial Assets (bonds) at fair value through other Comprehensive Revenue	12	0	0	(83)	0	(83)
Total other Comprehensive Revenue and Expenditure		0	0	(83)	0	(83)
Total Comprehensive Revenue and Expenditure		2,000	(2,563)	55	(2,200)	417
Total Comprehensive Revenue and Expenditure attributable to:						
Northland District Health Board		2,000	(2,460)	157	(2,200)	417
Minority Interest		0	(103)	(102)	0	0

Explanations of major variances against budget are detailed in note 21.

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

Statement of Comprehensive Revenue and Expenditure *(Continued)*

Supplementary Information

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

2017 - Actual	**Provider**	**Governance**	**Funder**	**Kaipara JV**	**Group**
	2017	**2017**	**2017**	**2017**	**2017**
	$000	**$000**	**$000**	**$000**	**$000**
Revenue	331,470	4,822	268,627	(415)	604,504
Expenses	336,824	3,873	266,422	(52)	607,067
Surplus/(Deficit) Before and After Tax	(5,354)	949	2,205	(363)	(2,563)

2017 - Budget	**Provider**	**Governance**	**Funder**	**Kaipara JV**	**Group**
	2017	**2017**	**2017**	**2017**	**2017**
	$000	**$000**	**$000**	**$000**	**$000**
Revenue	331,027	4,822	265,730	0	601,579
Expenses	329,027	4,822	265,730	0	599,579
Net Surplus/(Deficit)	2,000	0	0	0	2,000

2016 - Actual	**Provider**	**Governance**	**Funder**	**Kaipara JV**	**Group**
	2016	**2016**	**2016**	**2016**	**2016**
	$000	**$000**	**$000**	**$000**	**$000**
Revenue	314,687	3,933	257,852	(414)	576,058
Expenses	323,225	3,242	249,505	(52)	575,920
Net Surplus/(Deficit)	(8,538)	691	8,347	(362)	138

Kaipara JV represents Kaipara Total Joint Venture unaudited results net of consolidation eliminations.

Statement of Changes in Equity

For the Year Ended 30 June 2017

		Parent Budget	**Group**		**Parent**	
	Notes	**2017**	**2017**	**2016**	**2017**	**2016**
		$000	**$000**	**$000**	**$000**	**$000**
Balance at 1 July		127,005	133,984	134,050	127,585	127,168
Total Comprehensive Revenue and Expenditure		2,000	(2,563)	55	(2,200)	417
Capital Contribution (Owner Transaction)	12	0	24,650	0	24,650	0
Balance at 30 June	12	129,005	156,071	134,105	150,035	127,585
Distributions made to Minority Interest		0	(120)	(121)	0	0
Balance at 30 June	12	129,005	155,951	133,984	150,035	127,585
Total Equity attributable to:						
Northland District Health Board		129,005	152,300	130,110	150,035	127,585
Minority Interest		0	3,651	3,874	0	0
Balance at 30 June		129,005	155,951	133,984	150,035	127,585

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

Statement of Financial Position

As at 30 June 2017

	Notes	Parent Budget 2017 $000	Group 2017 $000	Group 2016 $000	Parent 2017 $000	Parent 2016 $000
Assets						
Cash and Cash Equivalents	6	9,094	12,274	2,252	12,262	2,187
Trade and Other Receivables	7	12,360	22,665	16,449	22,662	16,446
Short Term Deposits	6	0	409	15,343	0	15,000
Inventories	9	3,843	3,644	3,395	3,644	3,395
Prepayments		1,478	2,374	302	2,374	302
Trust/Special Fund Assets		638	666	640	666	640
Total Current Assets		27,413	42,032	38,381	41,608	37,970
Property, Plant and Equipment	10	195,693	187,835	189,905	180,572	182,146
Intangible Assets	11	2,246	2,254	2,271	2,254	2,271
Investments in controlled entities	8	1,762	0	0	1,762	1,762
Investment in equity accounted investees	8	10,823	13,678	10,904	13,678	10,904
Total Non-Current Assets		210,524	203,767	203,080	198,266	197,083
Total Assets		237,937	245,799	241,461	239,874	235,053
Equity						
Crown Equity	12	40,355	69,207	44,557	69,207	44,557
Other Reserves	12	81,965	86,916	86,916	81,966	81,966
Accumulated Surplus/(Deficit)	12	6,048	(4,489)	(2,003)	(1,804)	421
Trust/Special Fund Assets	12	637	666	640	666	640
Total Equity Attributable to Northland District Health Board		129,005	152,300	130,110	150,035	127,584
Minority Interest	12	0	3,651	3,874	0	0
Total Equity		129,005	155,951	133,984	150,035	127,584
Liabilities						
Trade and Other Payables	13	39,628	40,338	34,352	40,329	34,344
Interest Bearing Loans and Borrowings	14	372	712	505	712	505
Employee Entitlements	15	27,561	33,566	30,967	33,566	30,967
Provisions	16	0	150	544	150	544
Total Current Liabilities		67,561	74,766	66,368	74,757	66,360
Interest Bearing Loans and Borrowings	14	25,463	1,775	26,451	1,775	26,451
Employee Entitlements	15	15,908	13,307	14,658	13,307	14,658
Total Non-Current Liabilities		41,371	15,082	41,109	15,082	41,109
Total Liabilities		108,932	89,848	107,477	89,839	107,469
Total Equity and Liabilities		237,937	245,799	241,461	239,874	235,053

Explanations of major variances against budget are detailed in note 21.

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

Sally Macauley
Chairman
31 October 2017

June McCabe
Chairman - Audit, Finance & Risk Management Committee
31 October 2017

Statement of Cash Flows

For the Year Ended 30 June 2017

	Notes	Parent Budget 2017 $000	Group 2017 $000	Group 2016 $000	Parent 2017 $000	Parent 2016 $000
Cash Flows from Operating Activities						
Cash Receipts from Ministry of Health and Patients		600,285	599,826	574,504	600,255	574,933
Cash Paid to Suppliers		(359,152)	(367,443)	(348,802)	(367,993)	(349,232)
Cash Paid to Employees		(216,470)	(217,098)	(207,994)	(217,098)	(207,994)
Cash Generated from Operations		24,663	15,285	17,708	15,164	17,707
Interest Received		2,171	2,138	1,240	2,126	1,224
Interest Paid		(889)	(734)	(966)	(734)	(966)
Net Taxes Refunded/(Paid) (Goods and Services Tax)		0	349	448	349	448
Capital Charge Paid		(9,924)	(8,067)	(9,848)	(8,067)	(9,848)
Net Cash Flows from Operating Activities	6	16,021	8,971	8,582	8,838	8,565
Cash Flows From Investing Activities						
Proceeds from Sale of Property, Plant and Equipment		0	3	20	3	20
Acquisition of Property, Plant and Equipment		(24,740)	(11,173)	(17,381)	(11,173)	(17,381)
Acquisition of Investments in Associates	8	0	(2,774)	0	(2,774)	0
Acquisition of Investments		0	(66)	(8)	0	0
Receipts from Maturity of Investments		15,000	15,000	2,214	15,000	2,214
Net Cash Flows from Investing Activities		(9,740)	990	(15,155)	1,056	(15,147)
Cash Flows from Financing Activities						
Borrowings Raised		0	721	324	721	324
Borrowings (Repaid)		(399)	(540)	0	(540)	0
Distributions (Paid)	12	0	(120)	0	0	0
Net Cash Flows from Financing Activities		(399)	61	324	181	324
Net Increase/(Decrease) in Cash and Cash Equivalents		5,882	10,022	(6,249)	10,075	(6,258)
Cash and Cash Equivalents at Beginning of Year		3,212	2,252	8,501	2,187	8,445
Cash and Cash Equivalents at End of Year	6	9,094	12,274	2,252	12,262	2,187

The accompanying accounting policies and notes form part of these financial statements.
The conversion of Crown Loans into Equity (refer to note 14) was completed by a non-cash transaction.

Statement of Contingent Liabilities and Assets

As at 30 June 2017
Contingent Liabilities and Assets:

Northland DHB and group have no contingent assets or liabilities (2016: $0).

Statement of Commitments

As at 30 June 2017

	Group		Parent	
	2017	2016	2017	2016
	$000	$000	$000	$000
Capital Commitments				
Buildings	1,431	625	1,431	625
Plant, equipment and vehicles	0	2	0	2
	1,431	627	1,431	627
Operating Lease Commitments				
Not more than one year	2,806	2,213	3,103	2,510
One to two years	2,285	1,975	2,582	2,272
Two to five years	3,299	3,226	4,190	4,117
Over five years	3,308	2,977	5,362	5,328
	11,698	10,391	15,237	14,227
Total Commitments	13,129	11,018	16,668	14,854

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

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

During the year ended 30 June 2017, $3,784,000 was recognised as an expense in the statement of comprehensive revenue and expenditure in respect of operating leases (2016: $3,644,000).

Notes to Financial Statements

1 Revenue

	Notes	Group 2017 $000	Group 2016 $000	Parent 2017 $000	Parent 2016 $000
Patient Care Revenue					
Ministry of Health population-based funding		568,257	538,996	568,257	538,996
Ministry of Health other contracts		14,716	15,301	14,716	15,301
Inter-district flows		10,681	10,423	10,681	10,423
ACC contract revenue		4,791	4,382	4,791	4,382
Other patient care related revenue		453	636	453	636
Total Patient Care Revenue		598,898	569,738	598,898	569,738
Other Revenue					
Cash Donation Revenue		0	109	0	109
Other Revenue		4,415	4,460	4,844	4,889
Total Other Revenue		4,415	4,569	4,844	4,998

2 Infrastructure and Non-Clinical Expenses

Included in Infrastructure and Non-Clinical Expenses:		Group 2017 $000	Group 2016 $000	Parent 2017 $000	Parent 2016 $000
Impairment (reversal) of Trade Receivables (Bad and Doubtful Debts)	7	(58)	(27)	(58)	(27)
Loss/(Gain) on disposal of Property, Plant and Equipment		3	(13)	3	(13)
Audit Fees paid to Audit New Zealand for Audit of Financial Statements		185	180	179	174
Board and Committee Member Fees and Expenses		296	274	296	274

Northland DHB pays the audit fee of the Kaipara Total Health Care Joint Venture on the controlled entity's behalf. The fee was $5,706 (2016: $5,580).

3 Personnel Costs

	Group 2017 $000	Group 2016 $000	Parent 2017 $000	Parent 2016 $000
Wages and Salaries	209,575	204,191	209,575	204,191
Contributions to Defined Contribution Schemes	6,167	5,650	6,167	5,650
Increase /(Decrease) in Employee Benefit Provisions	1,248	(1,645)	1,248	(1,645)
	216,990	208,196	216,990	208,196

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

4 Finance Income and Finance Costs

4a Finance Income

	Group 2017 $000	Group 2016 $000	Parent 2017 $000	Parent 2016 $000
Interest Income	1,191	1,751	1,179	1,736

4b Finance Costs

	Group 2017 $000	Group 2016 $000	Parent 2017 $000	Parent 2016 $000
Interest Expense	643	963	643	963

5 Capital Charge

The Northland DHB pays a capital charge every six months to the Crown. The charge is based on actual closing equity as at 30 June and 31 December each year. The capital charge for the year ended 30 June 2017 was 7% for the 6 months to 31 December and 6% for the 6 months to June. (2016: 8% p.a.).

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

	Group		Parent	
	2017	2016	2017	2016
	$000	$000	$000	$000
(a) Cash and Cash Equivalents				
Cash On Hand and at Bank	22	75	10	10
Cash on Deposit with NZ Health Partnerships Limited	12,252	2,177	12,252	2,177
Total Cash and Cash Equivalents in the Statement of Cash Flows	12,274	2,252	12,262	2,187
(b) Short Term Deposits with maturities 4-12 months				
Short Term Deposits with maturities 4-12 months	409	15,343	0	15,000
Total Cash and Cash Equivalents, Short Term Deposits and Short Term Investments	12,683	17,595	12,262	17,187

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

	2017		2016	
	Effective fixed interest rate	Actual	Effective fixed interest rate	Actual
	%	$000	%	$000
Short Term Deposits with maturities of 4-12 months:	3.50%	409	4.72%	15,343

There were no impairment provisions for cash and cash equivalents.

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

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

	Notes	Group		Parent	
		2017	2016	2017	2016
		$000	$000	$000	$000
Surplus/(deficit) for the Period		(2,563)	240	(2,200)	500
Add back Non-Cash Items:					
Depreciation, Amortisation and Assets Written Off		13,267	12,696	12,771	12,198
Movements in Working Capital:					
(Increase)/Decrease in Trade and Other Receivables		(8,288)	(86)	(8,288)	(86)
(Increase)/Decrease in Inventories		(249)	423	(249)	423
Increase/(Decrease) in Trade and Other Payables		5,950	(2,920)	5,950	(2,699)
Increase/(Decrease) In Employee Benefits		1,248	(1,645)	1,248	(1,645)
Increase/(Decrease) in Provisions		(394)	(126)	(394)	(126)
Net Movement in Working Capital		(1,733)	(4,354)	(1,733)	(4,133)
Net Cash Inflow from Operating Activities		8,971	8,582	8,838	8,565

7 Trade and Other Receivables

	Group		Parent	
	2017	2016	2017	2016
	$000	$000	$000	$000
Trade Receivables from Non-related Parties	7,586	9,390	7,583	9,387
Ministry of Health Receivables	15,205	7,243	15,205	7,243
Less: Provision for Impairment	(126)	(184)	(126)	(184)
Balance at 30 June	22,665	16,449	22,662	16,446

The carrying amount of receivables approximates their fair value.

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

	Parent		Parent	
	Gross Receivable	Impairment	Gross Receivable	Impairment
	2017	2017	2016	2016
	$000	$000	$000	$000
Not past due	22,320	30	16,107	13
Past due 0-30 days	303	2	67	15
Past due 31-60 days	30	15	259	10
Past due 61-90 days	2	3	10	1
Past due >91 days	133	77	187	145
Total	22,788	126	16,630	184

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

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

	Group		Parent	
	2017	2016	2017	2016
	$000	$000	$000	$000
Balance 1 July	184	211	184	211
Additional/(Reduced) Provision during the year	12	8	12	8
Receivables written off during the period	(70)	(35)	(70)	(35)
Balance at 30 June	126	184	126	184

The carrying amount of receivables that would otherwise be past due or impaired and whose terms have been renegotiated is $66,059 (2016: $34,983).

The Northland DHB and group holds no collateral as security or other credit enhancements over receivables that are either past due or impaired.

8 Investments

	Group		Parent	
	2017	2016	2017	2016
	$000	$000	$000	$000
Investment in Controlled Entity (at cost)	0	0	1,762	1,762
Investment in Associate	13,678	10,904	13,678	10,904
Balance at 30 June	13,678	10,904	15,440	12,666

Investment in Controlled Entity
General Information

Name of Entity	Principal Activity	Interest Held 2017	Interest Held 2016	Balance Date
Kaipara Total Health Care Joint Venture	Landlord of Dargaville Hospital	54%	54%	30 June

Investment in Associate (equity accounted investee)
General Information

Name of Entity	Principal Activity	Interest Held 2017	Interest Held 2016	Balance Date
healthAlliance N.Z. Limited	The operation of shared services for Northland, Waitemata, Auckland and Counties Manukau District Health Boards	25%	25%	30 June

During 2017 $349,836 of information technology and related assets (2016: $80,662) and $2,423,954 information technology capital expenditure (2016: $706,000) was added to the carrying amount of the investment in healthAlliance. As at June 2017 Northland DHB held 9.48% of allocated C class shares (2016: 9.81%).

The following amounts represent the aggregate assets, liabilities, revenue and profit of equity accounted investees:	As at and for the year ended 30 June 2017	As at and for the year ended 30 June 2016
	$000	$000
Assets		
Current assets	15,861	18,118
Non-current assets	156,777	136,084
Total assets	172,638	154,202
Liabilities		
Current liabilities	20,694	22,360
Non-current liabilities	6,350	3,440
Total liabilities	27,044	25,800
Net assets	145,594	128,402
Revenue	135,152	125,840
Expenses (including interest and tax)	133,808	126,740
Profit after tax	1,344	(900)

The 2017 financial information for healthAlliance is provided as a draft and is subject to final audit clearance as at date of signing. The 2016 numbers have been restated to reflect the final result.

9 Inventories

	Group		Parent	
	2017	2016	2017	2016
	$000	$000	$000	$000
Pharmaceuticals	293	283	293	283
Surgical and Medical Supplies	3,351	3,112	3,351	3,112
Balance at 30 June	3,644	3,395	3,644	3,395

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

Write-down of Inventories to net realisable value amounted to $240,000 for 2017 (2016: $0).

The amount of inventories recognised as an expense during the year was $36.265m (2016: $31.537m), which is included in the clinical supplies line item in the Statement of Comprehensive Revenue and Expenditure.

10 Property, Plant and Equipment

(a) Group

	Freehold land	Freehold buildings	Plant, equipment and vehicles	Work in progress	Total
	$000	$000	$000	$000	$000
Cost					
Balance at 1 July 2015	8,170	143,908	59,874	22,900	234,852
Additions	0	0	0	16,135	16,135
Disposals	0	0	(1,137)	0	(1,137)
Transfers	0	28,252	7,205	(35,457)	0
Balance at 30 June 2016	8,170	172,160	65,942	3,578	249,850
Balance at 1 July 2016	8,170	172,160	65,942	3,578	249,850
Additions	0	0	0	11,183	11,183
Disposals	0	0	(843)	0	(843)
Transfers	0	2,427	3,405	(5,832)	0
Balance at 30 June 2017	8,170	174,587	68,504	8,929	260,190

	Freehold land	Freehold buildings	Plant, equipment and vehicles	Work in progress	Total
	$000	$000	$000	$000	$000
Depreciation and Impairment Losses					
Balance at 1 July 2015	0	108	48,315	0	48,423
Depreciation Charge for the year	0	8,389	4,264	0	12,653
Disposals	0	0	(1,131)	0	(1,131)
Balance at 30 June 2016	0	8,497	51,448	0	59,945
Balance at 1 July 2016	0	8,497	51,448	0	59,945
Depreciation Charge for the year	0	9,126	4,121	0	13,247
Disposals	0	0	(837)	0	(837)
Balance at 30 June 2017	0	17,623	54,732	0	72,355

10 Property, Plant and Equipment *(Continued)*

	Freehold land	Freehold buildings	Plant, equipment and vehicles	Work in progress	Total
	$000	$000	$000	$000	$000
Carrying amounts					
At 1 July 2015	8,170	143,800	11,559	22,900	186,429
At 30 June 2016	8,170	163,663	14,494	3,578	189,905
At 1 July 2016	8,170	163,663	14,494	3,578	189,905
At 30 June 2017	8,170	156,964	13,772	8,929	187,835

(b) Parent

	Freehold land	Freehold buildings	Plant, equipment and vehicles	Work in progress	Total
	$000	$000	$000	$000	$000
Cost					
Balance at 1 July 2015	7,994	135,827	59,874	22,900	226,595
Additions	0	0	0	16,135	16,135
Disposals	0	0	(1,137)	0	(1,137)
Transfers	0	28,252	7,205	(35,457)	0
Balance at 30 June 2016	7,994	164,079	65,942	3,578	241,593
Balance at 1 July 2016	7,994	164,079	65,942	3,578	241,593
Additions	0	0	0	11,183	11,183
Disposals	0	0	(843)	0	(843)
Transfers	0	2,427	3,405	(5,832)	0
Balance at 30 June 2017	7,994	166,506	68,504	8,929	251,933

	Freehold land	Freehold buildings	Plant, equipment and vehicles	Work in progress	Total
	$000	$000	$000	$000	$000
Depreciation and Impairment Losses					
Balance at 1 July 2015	0	108	48,315	0	48,423
Depreciation Charge for the year	0	7,891	4,264	0	12,155
Disposals	0	0	(1,131)	0	(1,131)
Balance at 30 June 2016	0	7,999	51,448	0	59,447
Depreciation and Impairment Losses					
Balance at 1 July 2016	0	7,999	51,448	0	59,447
Depreciation Charge for the year	0	8,630	4,121	0	12,751
Disposals	0	0	(837)	0	(837)
Balance at 30 June 2017	0	16,629	54,732	0	71,361

10 Property, Plant and Equipment *(Continued)*

	Freehold land	Freehold buildings	Plant, equipment and vehicles	Work in progress	Total
	$000	$000	$000	$000	$000
Carrying Amounts					
At 1 July 2015	7,994	135,719	11,559	22,900	178,172
At 30 June 2016	7,994	156,080	14,494	3,578	182,146
At 1 July 2016	7,994	156,080	14,494	3,578	182,146
At 30 June 2017	7,994	149,877	13,772	8,929	180,572

Work in progress

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

Group & Parent	**2017**	**2016**
	$000	$000
Buildings	7,187	2,520
Plant, equipment and vehicles	1,742	1,058
Total work in progress	8,929	3,578

Impairment

No Impairments were recognised in the current year (2016: $0 was expensed).

Equipment Held under Finance Lease

The net carrying amount of equipment held under finance leases is $1.6m (2016: $1.8m).

Revaluation

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

The revaluation of land and buildings was carried out as at 30 June 2015 by Peter Todd, an independent registered valuer of Darroch Limited and a member of the Property Institute of New Zealand. The valuations conform to International Valuation Standards. Land has been valued on a market basis and buildings excluding work in progress have been valued on a depreciated replacement cost basis because no reliable market data is available for such buildings. The valuer was contracted as an independent valuer. The next valuation is due to be completed by 30 June 2018.

Depreciated replacement cost is determined using a number of significant assumptions. Significant assumptions include:

- The replacement asset is based on the replacement with modern equivalent assets, with adjustments where appropriate for optimisation due to over-design or surplus capacity.
- The replacement cost is derived from recent construction contracts of similar assets and Property Institute of New Zealand cost information.
- For earthquake-prone buildings that are expected to be strengthened, the estimated earthquake strengthening costs have been deducted off the depreciated replacement cost in estimating fair value.
- The remaining useful life of assets is estimated using recent asset management information.
- Straight-line depreciation has been applied in determining the depreciated replacement cost value of the asset.

Restrictions

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

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

Two fixed assets (CT scanners) of Northland DHB are pledged as security for liabilities due to being financed by a finance lease with GE Finance.

11 Intangible Assets

Parent and Group

B Class Shares in NZ Health Partnerships Limited and Software

	NZHP Shares 2017 $000	Software 2017 $000	Total 2017 $000	NZHP Shares 2016 $000	HBL Shares 2016 $000	Software 2016 $000	Total 2016 $000
Cost							
Balance at 1 July	2,249	1,331	3,580	0	2,249	1,331	3,580
Contribution to NOS assets being developed by NZ Health Partnerships Limited	0	0	0	2,249	0	0	2,249
Transfer of FPSC rights in Health Benefits Limited	0	0	0	0	(2,249)	0	(2,249)
Balance at 30 June	2,249	1,331	3,580	2,249	-	1,331	3,580
Amortisation							
Balance at 1 July	0	1,309	1,309	0	0	1,266	1,266
Amortisation Charge for the Year	0	17	17	0	0	43	43
Balance at 30 June	0	1,326	1,326	0	0	1,309	1,309
Carrying Amounts							
Balance at 1 July	2,249	22	2,271	0	2,249	65	2,314
Balance at 30 June	2,249	5	2,254	2,249	0	22	2,271

There are no development costs accounted for as intangible assets.

There are no restrictions over the title of Northland DHB's intangible assets, nor are any intangible assets pledged as security for liabilities.

New Zealand Health Partnerships Limited has issued B class shares to DHB's to fund the development of the Finance, Procurement and Supply Chain (FPSC) Programme. In return for these shares, Northland DHB gained rights to access the FPSC asset, which includes the National Oracle Solution (NOS) programme. In the event of liquidation or dissolution of NZHPL, Northland DHB shall be entitled to be paid from the surplus assets, an amount equal to their proportionate share of the liquidation value based on its proportional share of the total FPSC/NOS rights that have been issued. The FPSC/NOS rights have been tested for impairment by comparing the carrying amount of the intangible asset to its depreciated replacement cost (DRC), which is considered to equate to Northland DHB's share of the DRC of the underlying FPSC/NOS assets. The current expectation of the Board is that the FPSC/NOS programme will proceed as planned. In this scenario, the DRC of the FPSC/NOS rights is consider to equate to, in all material respects, to the costs capitalised to date such that the FPSC/NOS rights are not impaired.

12 Equity

		Group		Parent	
		2017 $000	2016 $000	2017 $000	2016 $000
General Funds					
Balance at 1 July		44,557	44,557	44,557	44,557
Capital Contribution (Crown Debt to Equity)	14	24,650	0	24,650	0
Balance at 30 June		69,207	44,557	69,207	44,557
Accumulated Surplus/(Deficit)					
Balance at 1 July		(2,003)	(2,247)	421	(83)
Surplus/(Deficit)		(2,460)	240	(2,200)	500
Transfer to Trust Funds		(30)	(10)	(30)	(10)
Transfer from Trust Funds		4	14	4	14
Balance at 30 June		(4,489)	(2,003)	(1,804)	421
Reserves					
Revaluation Reserve					
Balance at 1 July		86,916	86,916	81,966	81,966
Balance at 30 June		86,916	86,916	81,966	81,966
Revaluation Reserve consists of:					
Land		6,726	6,726	6,610	6,610
Buildings		80,190	80,190	75,356	75,356
Total Revaluation Reserve		86,916	86,916	81,966	81,966
Fair value through other Comprehensive Revenue Reserve					
Balance at 1 July		0	84	0	84
Net Revaluation gains/(losses) on bonds		0	(84)	0	(84)
Balance at 30 June		0	0	0	0
Total Reserves		86,916	86,916	81,966	81,966
Trust/Special Funds					
Balance at 1 July		640	644	640	644
Funds received		24	2	24	2
Interest received		6	8	6	8
Funds spent		(4)	(14)	(4)	(14)
Balance at 30 June		666	640	666	640
Minority Interest					
Balance at 1 July		3,874	4096	0	0
Surplus/Deficit for period		(103)	(102)	0	0
Distributions made		(120)	(120)	0	0
Total Minority Interest		3,651	3,874	0	0
Total Equity at 30 June		**155,951**	**133,984**	**150,035**	**127,584**

All trust funds are held in bank accounts that are separate from Northland DHB's normal banking facilities.
Fair value through other comprehensive revenue reserve represents net revaluations on investments in bonds.

13 Trade and Other Payables

	Group		Parent	
	2017 $000	2016 $000	2017 $000	2016 $000
Payables under exchange transactions				
Trade Payables to Non-related Parties	5,792	4,780	5,792	4,780
Amounts due to Related Parties	1,326	1,326	1,326	1,326
Revenue in Advance	4,730	1,018	4,730	1,018
Other Non-trade Payables and Accrued Expenses	21,656	20,720	21,656	20,720
Total payables under exchange transactions	33,504	27,844	33,504	27,844
Payables under non-exchange transactions				
Taxes and ACC Levy payable (GST, PAYE, FBT, Withholding tax and rates)	6,834	6,508	6,825	6,500
Total payables under non-exchange transactions	6,834	6,508	6,825	6,500
Total Trade and Other Payables	40,338	34,352	40,329	34,344

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

14 Interest Bearing Loans and Borrowings

	Group		Parent	
	2017 $000	2016 $000	2017 $000	2016 $000
Current				
Crown Energy Efficiency Loan	284	106	284	106
Term loans - Finance Leases	428	399	428	399
	712	505	712	505
Non-Current				
Crown Loans	0	24,650	0	24,650
Crown Energy Efficiency Loan	993	591	993	591
Term loans - Finance Leases	782	1,210	782	1,210
	1,775	26,451	1,775	26,451
Total Interest Bearing Loans and Borrowings	2,487	26,956	2,487	26,956

The Energy Efficiency and Conservation Authority $1,277k (2016: $697k) loan is interest free (2016 0%)

Crown Loan

The Crown Loan of $24.65m previously provided by the Ministry of Health was converted into Crown equity effective from 15 February 2017. This is in accordance with the Government's change in policy on the capital financing of District Health Boards whereby, all DHB sector Crown debt was converted to Crown equity and, DHBs no longer have access to Crown debt financing for funding capital investment. Instead, the Crown's contribution to DHB capital investment will now be solely funded via Crown equity injections.

14 Interest Bearing Loans and Borrowings *(Continued)*

Repayable as follows:	Group		Parent	
	2017	2016	2017	2016
	$000	$000	$000	$000
Within two years	567	7,240	567	7,240
Two to five years	710	18,072	710	18,072
Six to nine years	0	35	0	35
Total	1,277	25,347	1,277	25,347

Finance lease liabilities are effectively secured, as the rights to the leased asset revert to the lessor in the event of default. The net carrying amount of assets held under finance leases is disclosed in note 10.

Analysis of Financial Leases	Group		Parent	
	2017	2016	2017	2016
	$000	$000	$000	$000
Minimum Lease payments payable				
Within one year	428	399	428	399
Two to five years	782	1,210	782	1,210
Total	1,210	1,609	1,210	1,609

15 Employee Entitlements

	Group		Parent	
	2017	2016	2017	2016
	$000	$000	$000	$000
Current Liabilities				
Liability for Long Service Leave and Retirement Gratuities	4,365	3,214	4,365	3,214
Liability for Annual Leave	17,160	16,573	17,160	16,573
Liability for Sick Leave	232	230	232	230
Liability for Sabbatical Leave	33	33	33	33
Liability for Continuing Medical Education Leave	6,179	6,239	6,179	6,239
Salary and Wages Accrual	4,805	3,951	4,805	3,951
ACC Partnership Programme Liability	792	727	792	727
	33,566	30,967	33,566	30,967
Non-Current Liabilities				
Liability for Long Service Leave and Retirement Gratuities	11,743	12,842	11,743	12,842
Liability for Sabbatical Leave	711	702	711	702
Liability for Sick Leave	853	1,114	853	1,114
	13,307	14,658	13,307	14,658
Total Employee Entitlements	46,873	45,625	46,873	45,625

The long service leave, retirement gratuities, sick and sabbatical leave were valued by an independent actuary.

The present value of the retirement, sabbatical and long service leave obligations depend on a number of factors that are determined on an actuarial basis using a number of assumptions. Two key assumptions used in calculating this liability include the discount rate 1.97% (2016: 1.95%) and the salary inflation factor 1.7% (2016: 1.7%). Any changes in these assumptions will impact on the carrying amount of the liability.

The discount rates used were obtained by finding weighted averages of returns on Government stock of different terms. The salary inflation factor has been determined after considering historical salary inflation patterns.

The valuation result is most sensitive to the assumed rates of salary growth and resignation rates. Resignation rates vary with age and length of service and reflect the experience of company superannuation schemes in New Zealand.

Based on all other assumptions being unaltered, an increase in the salary inflation factor of 1% would increase the employee entitlements by $997k. A 1% decrease would reduce the employee entitlements by $884k. A resignation rate 50% of the assumed rate would increase the value of entitlements by $374k, a resigntion rate 150% of the assumed rate would decrease the valuation by $311k.

16 Provisions

	Group		Parent	
	2017	2016	2017	2016
	$000	$000	$000	$000
Balance at 1 July	544	670	544	670
Provision made during the year	150	300	150	300
Provision used during the year	(544)	(426)	(544)	(426)
Total Provisions	150	544	150	544

Provisions have been made for legal actions against Northland DHB and employee cessation costs.

17 Financial Instruments

Northland DHB is party to financial instruments as part of its everyday operations. These include instruments such as bank balances, investments, accounts receivable, accounts payable and loans.

Credit Risk
Financial instruments, which potentially subject Northland DHB to concentrations of risk, consist principally of cash, counterparties without credit risk, short-term deposits, bonds and accounts receivable.

Northland DHB places its cash and short-term deposits with high quality financial institutions and the Northland DHB has a policy that limits the amount of credit exposure to any one financial institution.

Concentrations of credit risk from accounts receivable are limited due to the large number and variety of customers. Northland DHB receives 95% of its revenue from the Ministry of Health, who is also the largest single debtor. It is assessed to be a low risk and high quality entity due to its nature as the Government funded purchaser of health and disability support services.

The status of trade receivables at the reporting date is shown in note 7.

The table below analyses the Northland DHB's Financial Instruments maximum credit exposure. The amounts disclosed are the contractual undiscounted cashflows.

		Group		Parent	
	Notes	2017	2016	2017	2016
		$000	$000	$000	$000
Cash on Hand and at Bank	6	22	75	10	10
Cash on Deposit with NZ Health Partnership Limited	6	12,252	2,177	12,252	2,177
Cash Equivalents - Short Term Deposits	6	409	15,343	0	15,000
Trade and Other Receivables	7	22,665	16,449	22,662	16,446
Total		35,348	34,044	34,924	33,633

At balance date there were no significant other concentrations of credit risk. The maximum exposure to credit risk is represented by the carrying amount of each financial asset in the statement of financial position.

Liquidity Risk
Liquidity risk represents the Northland DHB's ability to meet its contractual obligations. The Northland DHB is reliant on Crown funding and evaluates its liquidity requirements on an ongoing basis. In general, the Northland DHB generates sufficient cash flows from its operating activities to meet its obligations arising from its financial liabilities.

The table on the following page analyses the Northland DHB's financial liabilities into relevant maturity groupings based on the remaining period at the balance sheet date to the contractual maturity date. The amounts disclosed are the contractual undiscounted cashflows.

17 Financial Instruments *(Continued)*

	Notes	Carrying Amount $000	Contractual Cashflows $000	Less than 1 year $000	1-5 years $000	More than 5 years $000
Parent & Group 2017						
Crown Energy Efficiency Loan	14	1,277	1,277	284	993	0
Finance Leases	14	1,210	1,328	498	830	0
Trade and Other Payables	13	28,774	28,774	28,774	0	0
Total		31,261	31,379	29,556	1,823	0
Parent & Group 2016						
Crown Loans	14	25,347	28,091	889	27,167	35
Finance Leases	14	1,609	1,827	498	1,329	0
Trade and Other Payables	13	26,826	26,826	26,826	0	0
Total		53,782	56,744	28,213	28,496	35

Market Risk
The interest rates on Northland DHB's cash and cash equivalents are disclosed in note 6.

The Board has a series of policies providing risk management for interest rates and the concentration of credit. The Board is risk averse and seeks to minimise exposure from its treasury activities.

Interest Rate Risk
Interest rate risk is the risk that the fair value of a financial instrument will fluctuate, or the cash flows from a financial instrument will fluctuate, due to changes in market interest rates.

Northland DHB does not consider there is any significant exposure to the interest rate risk on its investments. They are limited to bank deposits and bonds, which are held over various terms. All borrowings are at fixed interest rates for the term of the loan.

Foreign Currency Risk
Foreign exchange risk is the risk that the fair value of future cash flows of a financial instrument will fluctuate because of changes in foreign exchange rates.

Northland DHB does not consider there to be any significant exposure to foreign currency risk. Only a small amount of purchases are denominated in a currency other than NZD, none of which were outstanding at 30 June.

Sensitivity Analysis
In managing interest rate and currency risks, Northland DHB aims to reduce the impact of short-term fluctuations on its earnings. Over the long-term, permanent changes in foreign exchange and interest rates would have an impact on consolidated earnings.

At 30 June 2017, it is estimated that a general increase of one percentage point in interest rates would decrease Northland DHB's surplus before tax by approximately $60,000 (2016: $80,000).

	2017 $000		2016 $000	
Interest Rate Risk	-100 bps	+100 bps		+100 bps
Financial Assets				
Cash, Cash Equivalents and Bonds (non-current)	(120)	120	(180)	180
Financial Liabilities				
Crown Loans	60	(60)	100	(100)
Total	(60)	60	(80)	80

17 Financial Instruments *(Continued)*

Categories of Financial Assets and Liabilities

The classification and fair values together with the carrying amounts in the statement of financial position are as follows:

	Group		Parent	
	2017	2016	2017	2016
Loans and Receivables	$000	$000	$000	$000
Trade and Other Receivables	22,665	16,449	22,662	16,446
Trust/Special Fund Assets	666	640	666	640
Cash and Cash Equivalents	12,274	2,252	12,262	2,187
Short Term Deposits	409	15,343	0	15,000
Financial Liabilities at Amortised Cost				
Trade and Other Payables	28,774	26,826	28,774	26,826
Interest Bearing Loans and Borrowings	2,487	26,956	2,487	26,956

Credit Quality of Financial Assets	Group		Parent	
	2017	2016	2017	2016
Counterparties with credit ratings	$000	$000	$000	$000
Cash and cash equivalents and Investments AA-	421	15,408	0	15,000
Counterparties without credit ratings				
Cash and cash equivalents and Investments	12,262	2,187	12,262	2,187
Debtors and other receivables with no default in the past	22,665	16,449	22,662	16,446
Total Counterparties without credit ratings	34,927	18,636	34,924	18,633

Treasury Services Agreement
Northland DHB is a party to the "DHB Treasury Services Agreement" between NZHP and the participating DHBs. This Agreement enables NZHP to "sweep" DHB bank accounts and invest surplus funds. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with NZHP, which will incur interest at the credit interest rate received by NZHP plus an administrative margin. The maximum debit balance that is available to any DHB is the value of provider arm's planned monthly Crown revenue, used in determining working capital limits, is defined as 1/12th of the annual planned revenue paid by the funder arm to the provider arm as denoted in the most recently agreed Annual Plan inclusive of GST. For Northland DHB that equates to $29,695k. Due to the PBE IPSAS 30 disclosure requirements for the credit quality of the financial assets, the money with NZHP is classified under "counterparties with no credit rating".

Fair Value of Financial Instruments
There are no financial instruments measured at fair value. The fair value is approximated by the carrying value in the statement of financial position.

18 Related Parties

Related party disclosures have not been made for transactions with related parties that are within a normal supplier or client/recipient relationship on terms and condition no more or less favourable than those that it is reasonable to expect Northland DHB would have adopted in dealing with the party at arms length in the same circumstances. Further, transactions with other government agencies (for example Government Departments and Crown Entities) are not disclosed as related party transactions when they are consistent with the normal operating arrangements between government agencies and undertaken on the normal terms and conditions for such transactions.

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

	Group		Parent	
	2017	2016	2017	2016
	$000	$000	$000	$000
Board members				
Remuneration	285	274	285	274
Full time equivalent members	11	11	11	11
Executive team				
Remuneration	2,891	2,587	2,891	2,587
Full time equivalent members	11	10	11	10
Total key management personnel remuneration	3,176	2,861	3,176	2,861
Total full time equivalent personnel	22	21	22	21

The full time equivalent for Board members has been determined based on 1 full time equivalent (FTE) per board member as it is difficult to quantify the estimated time for Board members.

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

Board Member Fees

Current Board Members	**2017**	**2016**
Sally Macauley (Chairperson)	$40,506	$31,150
Sue Brown (Deputy Chairperson)	$16,869	-
Craig Brown	$21,420	$22,170
Colin Kitchen	$21,920	$22,670
Debbie Evans	$22,170	$22,670
Denise Jensen	$23,920	$8,140
Gary Payinda	$15,030	-
John Bain	$23,357	$23,170
June McCabe	$22,670	$22,608
Libby Jones	$14,307	-
Sharon Shea	$22,170	$22,670
Former Board Members		
Anthony Norman (Chairperson)	$20,687	$47,600
Greg Gent	-	$4,383
MC (Bill) Sanderson	$9,862	$23,295
Christopher Reid	$9,925	$23,170

19 Subsequent Events

There are no significant events subsequent to balance date.

20 Capital Management

Northland DHB's capital is its equity, which comprises of crown equity, reserves, trust/special funds and accumulated comprehensive revenue and expenditure. Equity is represented by net assets. The Northland DHB manages its revenues, expenses, assets, liabilities and general financial dealings prudently in compliance with the budgetary processes. The Northland DHB's policy and objectives of managing the equity is to ensure the Northland DHB effectively achieves its goals and objectives, whilst maintaining a strong capital base. The Northland DHB policies in respect of capital management are reviewed regularly by the governing Board. There have been no material changes in the Northland DHB's management of capital during the period.

21 Variance Analysis

Key Financial Information	Parent Actual 2017 $000	Parent Budget 2017 $000	Variance $000
Operational Revenue	604,921	601,579	3,342

The increase in operational revenue against budget can be attributed to ACC revenue earned during the year and increased MoH revenue for various programmes.

The revenue budget is based on the funding envelope advised by the Ministry of Health in December 2015 for the current financial year. Subsequent to this advice, further funding was made available for additional services.

Operational Cost (including Capital Charge)	607,121	599,579	7,542

The major factor contributing to the increase in operational expenditure is the provision of additional services, as detailed in the above revenue comment. Such costs are incurred as employee costs, the costs of clinical supplies and outsourced services.

Total Assets (excluding cash, deposits and investment balances)	227,612	228,843	(1,231)

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

Total Liabilities (excluding loans)	87,352	83,097	4,255

Liabilities are higher than budget due to larger employee entitlement accruals.

Cash Resources (cash, deposit and investment balances less loans)	9,775	(16,741)	26,516

Cash Resources (cash, deposits and investment balances less loans) are higher than budget due to the Crown Loan of $24.65m previously provided by the Ministry of Health being converted into Crown equity effective from 15 February 2017. See Note 14 for further details.

The budget figures included in the financial statements are the budget figures for the DHB parent, which were included in the Statement of Intent. Group budget figures have not been included in the financial statements as required by the Crown Entities Act 2004 on the basis that the group budget figures would not be materially different to the parent budget figures presented.

Statement of Accounting Policies

For the year ended 30 June 2017

Reporting entity

Northland District Health Board (Northland DHB) is a Health Board established by the New Zealand Public Health and Disability Act 2000. Northland DHB has designated itself as a Public Benefit Entity (PBE) for financial reporting purposes. It is domiciled and operates in New Zealand. Northland DHB is a Crown Entity as defined by the Crown Entities Act 2004. Northland DHB's ultimate parent is the Crown.

The consolidated financial statements of Northland DHB and group for the year ended 30 June 2017 comprise Northland DHB, its controlled entity the Kaipara Total Health Care Joint Venture (54% owned) and its associate healthAlliance N.Z. Limited (25% owned).

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

The financial statements were authorised for issue by the Board on 31 October 2017.

Basis of preparation

Statement of compliance

The financial statements have been prepared in accordance with generally accepted accounting practice in New Zealand (NZGAAP). They have been prepared in accordance with Tier 1 PBE Accounting Standards. These financial statements comply with PBE accounting standards.

Presentation currency

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

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

Critical accounting estimates and assumptions

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

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

The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed below:

Land and buildings revaluations

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

Long service leave and retirement gratuities

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

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

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

Critical judgements in applying accounting policies

Leases classification

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

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

Northland DHB has exercised its judgment on the appropriate classification of leases, and has classified finance lease appropriately.

Changes in accounting policies

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

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

PBE IPSAS 3.33

Impairment of Revalued Assets

In April 2017, the XRB issued Impairment of Revalued Assets, which now scopes in revalued property, plant, and equipment into the impairment accounting standards. Previously, only property, plant, and equipment assets measured at cost were scoped into the impairment accounting standards.

PBE IPSAS 21.83.5

From the 30 June 2018 year onwards, the DHB is required to assess at each reporting date whether there is any indication that an asset may be impaired. If any indication exists, the DHB is required to assess the recoverable amount of that asset and recognise an impairment loss if the recoverable amount is less than the carrying amount. The DHB can therefore impair a revalued asset without having to revalue the entire class of assets to which the asset belongs.

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

PBE IPSAS 34 - 38

Interests in other entities

In January 2017, the XRB issued new standards for interests in other entities. These new standards replace the existing standards for interests in other entities (PBE IPSAS 6 - 8). The new standards are effective for annual periods beginning on or after 1 January 2019, with early application permitted.

The new standards:

- introduce an amended definition of control and extensive guidance on control (and continues to require all controlled entities to be consolidated in the controlling entity's financial statements, except as noted below)
- Introduce the concept of "investment entity", exempts investment entities from consolidating controlled entities, and requires investment entities to recognise controlled entities at fair value through surplus or deficit instead;
- introduce a new classification of joint arrangements, set out the accounting requirements for each type of arrangement (joint operations and joint ventures), and remove the option of using the proportionate consolidation method
- require PBEs to disclose information on their interests in other entities, including some additional disclosures that are not currently required under PBE IPSAS 6, 7 and 8.

The DHB plans to apply the new standards in preparing the 30 June 2020 financial statements. The DHB and group has not yet assessed the effects of these new standards.

PBE IFRS 9

Financial instruments

In January 2017, the XRB issued PBE IFRS 9 Financial Instruments. This standard replaces PBE IPSAS 29 Financial Instruments: Recognition and Measurement. PBE IFRS 9 is effective for annual periods beginning on or after 1 January 2021, with early application permitted. The main changes under PBE IFRS 9 are:

- New financial asset classification requirements for determining whether an asset is measured at fair value or amortised cost.
- A new impairment model for financial assets based on expected losses, which may result in the earlier recognition of impairment losses.

The DHB plans to apply this standard in preparing its 30 June 2022 financial statements. The DHB and Group has not yet assessed the effects of the new standard.

Basis for consolidation

Subsidiaries

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

The consolidated financial statements include the parent (Northland DHB) and its subsidiary. The subsidiary is accounted for using the acquisition method, which involves adding together corresponding assets, liabilities, revenues and expenses on a line by line basis.

Transactions eliminated on consolidation

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

Investments in subsidiaries are carried at cost in Northland DHB's own "parent entity" financial statements.

Equity accounted Investees: Associates

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

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

Investments in associates are carried at cost in Northland DHB's own parent entity financial statements.

Budget figures

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

Foreign currency transactions

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

Statement of Accounting Policies

Cash and cash equivalents

Cash and cash equivalents include cash on hand, cash on deposit with NZ Health Partnerships Limited, deposits held on call with banks and other short-term highly liquid investments with original maturities of three months or less.

Trade and other receivables

Short-term receivables are recorded at their face value, less any provision for impairment. A receivable is considered impaired when there is evidence that Northland DHB will not be able to collect the amount due. The amount of the impairment is the difference between the carrying amount of the receivable and the present value of the amounts expected to be collected.

Trade and other payables

Trade and other payables are recorded at their face value.

Investments

Bank term deposits

Investments in bank term deposits are initially measured at the amount invested.

After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest method, less any provision for impairment

Inventories

Inventories held for distribution in the provision of services that are not supplied on a commercial basis are measured at cost (using the average weighted cost method) and adjusted when applicable, for any loss of service potential.

Inventories acquired through non-exchange transactions are measured at fair value at the date of acquisition.

Inventories held for use in the provision of goods and services on a commercial basis are valued at the lower of cost (using the average weighted cost method) and net realisable value.

Net realisable value is the estimated selling price in the ordinary course of business, less the estimated costs of completion and selling expenses.

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

Interest bearing borrowings

Interest bearing borrowings are recognised initially at fair value less attributable transaction costs. Subsequent to initial recognition, interest bearing borrowings are stated at amortised cost with any difference between cost and redemption value being recognised in the surplus or deficit over the period of the borrowings on an effective interest basis. Borrowings are classified as current liabilities unless Northland DHB has an unconditional right to defer settlement of the liability for at least 12 months after balance date.

Property, plant and equipment

Classes of property, plant and equipment

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

- freehold land
- freehold buildings
- plant, equipment and vehicles

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 at least every three years or, where there is evidence of a significant change in fair value. The net revaluation results are credited or debited to other comprehensive revenue and is accumulated to an asset revaluation reserve in equity for that class of asset. Where this would result in a debit balance in the asset revaluation reserve, this balance is not recognised in other comprehensive revenue but is recognised in the surplus or deficit.

Any subsequent increase on revaluation that offsets a previous decrease in value recognised in the surplus or deficit will be recognised first in the surplus or deficit up to the amount previously expensed, and then recognised in other comprehensive revenue.

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

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

Property, plant and equipment vested from the Hospital and Health Service

Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets of Northland Health Limited (a hospital and health service company) were vested in Northland DHB on 1 January 2001. Accordingly, assets were transferred to Northland DHB at their net book values as recorded in the books of the hospital and health service. In effecting this transfer, the Northland DHB 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 or 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 it is probable that future economic benefits or service potential associated with the item will flow to Northland DHB and the cost of the item can be measured reliably.

In most instances, an item of property, plant and equipment is recognised at its cost. Where an asset is acquired through a non-exchange transaction, it is recognised at its fair value as at the date of acquisition.

Subsequent costs

Subsequent costs are added to the carrying amount of an item of property, plant and equipment when that cost is incurred, if it is probable that the service potential or future economic benefits embodied within the new item will flow to Northland DHB. All other costs are recognised in the statement of comprehensive revenue as an expense as incurred. The costs of day-to-day servicing of property, plant and equipment are recognised in the surplus or deficit as they are incurred.

Depreciation

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

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

Class of asset	Estimated life	Depreciation rate
Buildings		
- Structure	1 - 65 years	(1.5% - 100%)
- Services	1 - 25 years	(4% - 100%)
- Fit out	1 - 10 years	(10% - 100%)
Plant and Equipment	1 - 25 years	(4% - 100%)
Motor Vehicles	5 - 15 years	(6.6% - 20%)

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

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

Borrowing costs

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

Intangible assets

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

Acquired computer software licences are capitalised on the basis of the costs incurred to acquire and bring to use the specific asset.

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

Finance Procurement Supply Chain, including National Oracle Solution

The Finance Procurement Supply Chain (FPSC), which includes the National Oracle Solution (NOS), is a national initiative funded by DHBs and facilitated by NZ Health Partnerships Limited (NZHPL) to deliver sector wide benefits. NZHPL holds an intangible asset recognised at the capital cost of development relating to this programme. Northland DHB holds an asset at cost of capital invested by Northland DHB in the FPSC programme. This investment represents the right to access the FPSC assets and are considered to have an indefinite life. DHBs have the ability and intention to review the service level agreement indefinitely and the fund established by NZHPL through the on-charging of depreciation and amortisation on the assets to the DHBs will be used to, and is sufficient to, maintain the assets standard of performance or service potential indefinitely. As the rights are considered to have an indefinite life, the intangible asset is not amortised and will be tested for impairment annually.

Subsequent expenditure

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

Amortisation

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

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

Impairment of property, plant and equipment and intangible assets

Northland DHB does not hold any cash-generating assets. Assets are considered cash-generating where their primary objective is to generate a cash return.

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

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

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

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

Employee benefits

Defined contribution schemes

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

Defined benefit schemes

Northland DHB makes employer contributions to the Defined Benefits Plan Contributors Scheme (the scheme), which is

managed by the Board of Trustees of the National Provident Fund. The scheme is a multi-employer defined benefit scheme.

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

Long service leave, sabbatical leave and retirement gratuities

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

Annual leave, conference leave, medical education leave and expenses

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

Sick leave

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

Bonuses

A liability and an expense are recognised for bonuses where there is a contractual obligation or where there is a past practice that has created a constructive obligation and a reliable estimate of the obligation can be made.

Provisions

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

Restructuring

A provision for restructuring is recognised when an approved detailed formal plan for the restructuring has either been announced publicly to those affected, or for which implementation has already commenced.

ACC Accredited Employers Programme

Northland DHB belongs to the ACC Accredited Employers Programme (the "Full Self Cover Plan") whereby Northland DHB accepts the management and financial responsibility for employee work-related illnesses and accidents. Under the programme, Northland DHB is liable for all claims costs for a period of two years after the end of the cover period in which the injury occurred. At the end of the two-year period, Northland DHB pays a premium to ACC for the value of residual claims, and from that point the liability for ongoing claims passes to ACC.

The liability for the ACC Accredited Employers Programme is measured using actuarial techniques at the present value of expected future payments to be made in respect of the employee injuries and claims up to balance date. Consideration is given to anticipated future wage and salary levels and experience of employee claims and injuries. Expected future payments are discounted using market yields on government bonds at balance date with terms to maturity that match, as closely to possible, the estimated future cash outflows.

Equity

Equity is the community's interest in Northland DHB 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), Fair value through other Comprehensive Revenue Reserve (Bond Investments), non-controlling interest in the group and Trust/Special Funds. The minority interest in the group is represented by the joint venture partner in the controlled entity. Trust/Special funds are funds donated or bequeathed for a specific purpose. The use of these assets must comply with the specific terms of the sources from which the funds were derived. The revenue and expenditure in respect of these funds is included in the surplus or deficit. An amount equal to the expenditure is transferred from the trust fund component of equity to retained earnings. An amount equal to the revenue is transferred from revenue earnings to trust funds.

Property revaluation reserve

This reserve relates to the revaluation of property, plant, and equipment to fair value.

Fair value through other comprehensive revenue and expense reserves

This reserve comprises the cumulative net change of financial assets (Bond Investments) classified as fair value through other comprehensive revenue and expense.

Revenue

The specific accounting policies for significant revenue items are explained below.

Ministry of Health population-based revenue

Northland DHB receives annual funding from the Ministry of Health, which is based on population levels within the Northland DHB region.

Ministry of Health population-based revenue for the financial year is recognised based on the funding entitlement for that year

Statement of Accounting Policies

Ministry of Health Contract Revenue

The revenue recognition approach for Ministry of Health contract revenue depends on the contract terms. Those contracts where the amount of revenue is substantively linked to the provision of quantifiable units of service are treated as exchange contracts and revenue is recognised as Northland DHB provides the services. For example, where funding varies based on the quantity of services delivered, such as number of screening tests or heart checks. Other contracts are treated as non-exchange and the total funding receivable under the contract is recognised as revenue immediately, unless there are substantive conditions in the contract. If there are substantive conditions, revenue is recognised when the conditions are satisfied. A condition could include the requirement to provide services to the satisfaction of the funder to receive or retain funding. Revenue for future periods is not recognised where the contract contains substantive termination provisions for failure to comply with the service requirements of the contract. Conditions and termination provisions need to be substantive, which is assessed by considering factors such as the past practice of the funder. Judgement is often required in determining the timing of revenue recognition for contracts that span a balance date and multi-year funding arrangements.

Goods sold and services rendered

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

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

Revenue from other DHBs

Inter-district patient inflow revenue occurs when a patient treated within the Northland DHB region is domiciled outside of Northland. The Ministry of Health credits Northland DHB with a monthly amount based on an estimated patient treatment for non-Northland residents within Northland. An annual wash-up occurs at year end to reflect the number of non-Northland patients treated at Northland DHB.

Donated services

Certain operations of the Northland DHB are reliant on services provided by volunteers. Volunteer services received are not recognised as revenue or expenditure by Northland DHB.

ACC contract revenue

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

Rental revenue

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

Interest

Interest revenue is recognised using the effective interest method.

Expenses

Operating leases

An operating lease is a lease whose term is short compared to the useful life of the asset or piece of equipment and does not transfer substantially all the risks and rewards incidental to ownership of the asset to the lessee.

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

Finance leases

A finance lease is a lease that transfers to the lessee substantially all the risks and rewards incidental to ownership of an asset, whether or not title is eventually transferred. At the commencement of the lease term, finance leases where Northland DHB is the lessee are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased item or the present value of the minimum lease payments. The finance charge is charged to the surplus or deficit over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability.

Financing costs

Net financing costs comprise interest paid and payable on borrowings, calculated using the effective interest rate method and are recognised as an expense in the financial year in which they are incurred.

Capital charge

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

The intention of the capital charge is to make explicit the true costs of the taxpayers' investment by requiring recognition of those costs.

Contingent liabilities

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

Cost of service (Statement of Performance)

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

Cost allocation

Northland DHB has arrived at the net cost of service for each significant activity using the cost allocation system outlined below:

Cost allocation policy

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

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

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

Statement of Accounting Policies

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

Income tax

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

Goods and services tax

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

SP Glossary

Term	Definition or explanation
AFC	Annual Free Check (for diabetes).
CVD	Cardiovascular disease
CYFS	Child Youth and Family Service; part of the Ministry of Social Development
DCIP	Diabetes Care Improvement Package
DHB	District Health Board
DMFT	Decayed, missing, filled teeth; a measure of total damaged teeth in the mouth
ED	Emergency Department
GP	General Practitioner
HBSS	Home-based support services (for older people)
HDC	Health and Disability Commission(er)
interRAI	A collaborative network of researchers in over 30 countries who promote evidence-based clinical practice and policy to improve health care for persons who are elderly, frail, or disabled
MDT	Multi-Disciplinary Team (meeting) of health professional workers of various types and specialties to discuss patients
PHO	Primary Health Organisation
Q	Quarter (of the year); either Jul-Sep, Oct-Dec, Jan-Mar or Apr-Jun
SP	Statement of Performance, the core performance section of the Statement of Intent
Statement of Intent (SOI)	A plan required of all 70 or so Crown Entities in New Zealand that anticipates their performance for the coming year. For DHBs, it is incorporated into their Annual Plans

Acronyms

Acronym	Meaning
AAU	Acute Assessment Unit
ALOS	Average length of stay
ARC	Aged residential care
ASH	Ambulatory sensitive hospitalisation, a subset of avoidable hospitalisations (sometimes also Action on Smoking and Health)
ASMS	Association of Salaried Medical Specialists
BAU	Business as usual
BMI	Body Mass Index (a measure of healthy weight)
COPD	Chronic obstructive pulmonary disease
CVD	Cardiovascular disease
DNA	Did not attend
ECMS	Enterprise Content Management System, a large file-holding and file-sharing database
ED	Emergency Department
ELT	Executive Leadership Team (of Northland DHB)
FSA	First specialist appointment
FTE	Full time equivalent (= 40 hours a week of work time)
GDP	Gross Domestic Product
HOP	Health of older people
IFHC	Integrated family health centre
IT	Information technology
KPI	Key performance indicator
KRONOS	A business support financial system
LTC(s)	Long-term condition(s)
MELT	Medical Executive Leadership Team
NDHB	Northland District Health Board
NGO	Non-government organisation
NHSP	Northland Health Services Plan
PBF(F)	Population Based Funding (Formula)
PHO	Primary Health Organisation
POPN	Primary Options Programme Northland
ROERS	Radiology orders and eResults sign-off
OMG	Operational Management Group
SMO	Senior Medical Officer
STI	Sexually transmitted infection
SUDI	Sudden unexpected death in infancy (also sometimes sudden unexplained death in infancy)
SWOT	Strengths, weaknesses, opportunities, threats
TLA	Territorial Local Authority
VfM	Value for money

Directory

CURRENT BOARD MEMBERS AS AT 30 JUNE 2017

Sally Macauley (Chair)
Sue Brown (Deputy Chair)
Craig Brown
Colin Kitchen
Debbie Evans
Denise Jensen
Gary Payinda
John Bain
June McCabe
Libby Jones
Sharon Shea

EXECUTIVE OFFICERS AS AT 30 JUNE 2017

Dr Nick Chamberlain, Chief Executive
Andrew Potts, General Manager, Surgical, Pathology and Ambulatory Services
Harold Wereta, General Manager, Māori Health
Ian McKenzie. General Manager, Mental Health & Addiction Services
Jeanette Wedding, General Manager, Child, Youth, Maternal & Oral Health and District Hospitals (Lead General Manager)
John Wansbone, General Manager, Planning, Integration, People & Performance
Margareth Broodkoorn, Director of Nursing and Midwifery
Mike Roberts, Chief Medical Officer
Meng Cheong, General Manager, Finance, Funding & Commercial Services
Neil Beney, General Manager, Medicine, Health of Older People, Emergency & Clinical Support
Pip Zammit, Director of Scientific, Technical, Allied Health

REGISTERED OFFICE

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AUDITOR

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

BANKERS

Westpac New Zealand Limited
ASB Bank Limited

SOLICITORS

Webb Ross Lawyers, Whangarei


Te Mātauranga

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www.northlanddhb.org.nz

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