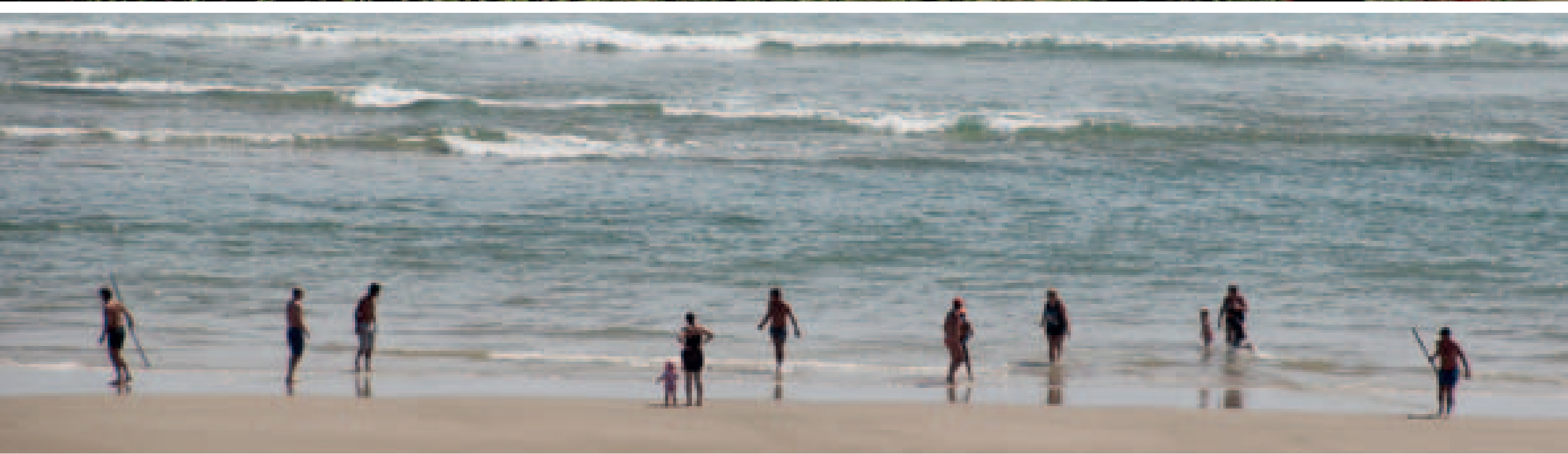
ANNUAL REPORT 2013



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 District Health Board's performance for the year from 1 July 2012 to 30 June 2013.

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

Key components of the report are outlined below.

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

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

Key Components

Board Chair and Chief Executive Report

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

Introduction

Northland District Health Board

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

2012/13: The Year in Review

Includes staff matters and the DHB's financial performance.

Governance and Partnerships

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

Financial and Audit Reports

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

Statement of Service Performance

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

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

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Message from the Board Chair and Chief Executive

On behalf of Northland District Health Board, we are pleased to present our Annual Report for the 2012/2013 financial year. It has been a privilege for us to lead our organisation through another year and to have the opportunity to describe the progress we have made towards improving the health and wellbeing of our people and achieving a healthier Northland.

We have placed significant focus during the year on ensuring we have continuous quality improvement throughout the organisation and within the services we deliver. Certification, our 'licence to operate', occurred which involved up to 20 auditors and Ministry of Health observers. Two years ago we had over 50 corrective actions, while this time we only had 17 and the auditors were extremely complimentary about our services. Credit must be given to our staff, who have worked hard to make the significant improvements that were necessary to achieve certification for the next three years.

Our patient safety and quality framework helps ensure that we continue to provide a high standard of patient care. The establishment of the Quality & Improvement Directorate, a Clinical Governance Board, development of our Quality Accounts and introduction of the Health Quality & Safety Commission New Zealand campaign '*Open for better care*' are all geared to put the patient first in everything that we do.

There has been significant work on our IT infrastructure with the upgrade to Windows 7 and Office 2010 in process. We are also installing a new patient administration system along with an upgrade of our laboratory and pharmacy systems. This means that, in time, all laboratory results and radiology reports from Northland DHB hospitals will be viewable by all DHB clinicians in the Northern region (Northland and all metro Auckland DHBs) as well as clinicians in the community. We now lead New Zealand in the use of our e-referral and specialist advice system, and all GP referrals are now electronic.

While we managed to break even as a DHB this year our financial result was in some ways disappointing. The extraordinary pressure on hospital services meant we could not invest as much as planned in the other side of our business, namely the primary and community services we contract and fund.

We were also unable to put in place as many of the Northland Health Services Plan (NHSP) initiatives that we planned and needed to start to reduce the growth in demand on our hospitals.

We have however made good progress in establishing the NHSP virtual portfolio office and the NHSP Oversight Group has been formed to provide governance for the implementation of the NHSP. Its membership is whole-of-health-sector, comprising representation from Māori Health Providers and the full Executive Leadership Team at Northland DHB which includes the two Primary Health Organisation Chief Executives. To ensure that we stay on track we have implemented dashboard reporting, results based accountability measures, and appointed a Programme Coordinator which are all key aspects of a successful implementation.

Detailed planning work has begun on developing two Integrated Family Health Centres (IFHCs) located at Bay of Islands Hospital and Dargaville Hospital. These new centres will support keeping people well in the community, and the delivery of a wider range of better coordinated services in community settings. This will require new models of care, and appropriate infrastructure. The business plans for these developments are due to be completed in March/April 2014. The planning of the IFHCs provides the opportunity to link primary care development with the Government's Whānau Ora policy. In this way, it will assist Northland DHB achieve its NHSP goals of improved Māori access, and reduced health inequalities for Māori.

Northland DHB entered into a consultation process on the 'Future PHO Configuration in Northland'. Wide consultation with the primary health sector and community was achieved including a number of locality meetings to enable face-to-face discussion. The majority of respondents wanted to maintain the current status quo of two PHOs. Certain minimum requirements are now being introduced to ensure that this configuration is robust and achieves performance targets and best serves the needs of the people they serve, especially Māori.

The very high number of suicides in Northland particularly with our youth resulted in an inter-sectoral governance response known as the Social Wellbeing Governance Group. This includes representatives from Iwi Chairs and all social sector leaders. Inter-agency collaboration and information sharing is vital and close linkages are being developed with community social agencies, iwi, hapu and whanau to ensure we have effective emergency, post-vention and longer-term resilience building strategies for our youth and their whanau.

Examples of these strategies are the work being done in our local response groups targeting high risk communities, the Matanui play delivered in many Northland schools and the training programmes we funded. Whangarei is one of two demonstration sites in New Zealand for the formation of a Vulnerable Children's Team that brings together frontline professionals working with children to better protect them. The new team is made up of local education, health, and social sector professionals to respond to the needs of vulnerable children. Our team will commence in October and start managing the care of up to 600 vulnerable children and families in Whangarei that do not qualify for Child Youth and Family care and protection. We hope that this will go a long way towards significantly reducing both the number of tragic cases presenting to our emergency department as well as dramatically reducing the harm that manifests in our alarming youth suicide statistics.

Not only are our children and youth vulnerable, poverty and household overcrowding are causing third world diseases in Northland. We are still seeing five or six sudden unexpected death in infant (SUDI) deaths a year in Northland, and we have also had 15-20 cases of Rheumatic Fever. Both are almost exclusively in our Māori population. Despite taking every opportunity to promote the benefits of immunisation the low uptake has resulted in a Pertussis (whooping cough) outbreak which was completely preventable.

Whilst it was extremely disappointing to not quite achieve the immunisation target, this remains a considerable ongoing focus of our work. However we have had a pleasing performance across the five other health targets this year. Highlights were our outstanding performance in emergency department waiting time, elective surgery, cancer services and smoking cessation.

We were disappointed to be informed by our auditor, Audit New Zealand, that they had decided to issue a qualified audit opinion in respect of Northland DHB's (and, we understand, all other DHBs) non-financial performance information. The qualification relates specifically to primary care target performance information, the data for which is kept by third parties, such as Primary Health Organisations, over whom the auditor considers Northland DHB has limited control. The auditor is of the view that there are no practical audit procedures available to check performance reports that would satisfy the evidential requirements of their audit standards. Northland DHB is satisfied that the Primary Health Organisations administered performance reporting is substantially accurate and complete. The auditor's decision to qualify our annual report in this respect was confirmed quite late in the audit process leaving us little time to adequately address the matter for the year ended 30 June 2013. However, we have agreed with the auditor to work together to resolve the matter going forward.

Northland DHB as part of BreastScreen Waitemata Northland met our national breast screen targets again. Over 20,000 women have been screened in the past two years and there is minimal inequity in the results between Māori and non-Māori. Overall coverage is 74% with Māori at 72.2% and non-Māori at 74.6%. Coverage has steadily improved and is a tribute to a large number of committed people within the community/primary care and BreastScreen Waitemata Northland.

The 2013 census provided us with an opportunity to make sure that everyone who should be counted was indeed counted. A comparison of Primary Health Organisation enrolment data and census projections indicated that there is a census shortfall of over 3,000 people in Northland. Under the population based funding formula, each person in Northland contributes health funding of around $3,000 per person, per year, so the under-count potentially equates to our funding being around $10 million dollars less than it should be. We ran a strong campaign to raise awareness of this problem and received a lot of support from local media and Northland intersectoral partners and are hopeful that this year's census results will be more accurate and be a true reflection of the number of people who live in Northland so that our share of funding increases.

The 100th year anniversary of the Bay of Islands Hospital in Kawakawa was marked in March this year. The hospital hosted a wonderful open day that was attended by people from far and wide who came together to celebrate and commemorate the provision of health services to the Mid North area for more than one hundred years.

The people of Northland have been hugely generous and embraced Project Promise – a project managed by the Northland Community Foundation on behalf of Northland DHB. At the end of June 2013, over $2 million dollars had been raised in donations towards the building of the cancer treatment centre.

Planning permission has been granted and tender documents for the Cancer Treatment Centre build and fit out are being prepared. The final cost of the cancer treatment centre is expected to be in the region of $5 million and if Project Promise can reach its original goal of $3 million, Northland DHB has agreed to contribute the balance. On behalf of the DHB we want to sincerely thank the Northland community for helping make this dream come true.

Design of the new maternity unit has been completed and by the end of the year demolition works will commence to be ready for construction in the New Year. The fit for purpose design complies with Australasian health facility guidelines and offers a whanau friendly environment. 'Mock up' rooms have allowed consumer and clinician representatives to develop a service delivery model that puts the mums and their families at the centre of the model of care.

Staff and Board members gathered in the Bay of Islands in June to farewell surgeon Mr Peter Milsom. Peter contributed more than 37 years service to the health of people in Tai Tokerau. Peter was presented with a unique, specially commissioned carving designed and made by Northland DHB Takawaenga Ned Peita. Peter also became the first recipient in Northland to be presented with a prestigious Royal Australasian College of Surgeons gown, which will be kept on his behalf within the department of surgery, in recognition of his significant contribution to surgical services in the region.

This year we farewelled Robert Paine GM Funding, Finance and Commercial Services. Robert had been a valued member of our executive team since 2007 and left to take up the role of Chief Financial Officer at Waitemata DHB. Meng Cheong has been appointed to this position and starts with Northland DHB in October 2013.

Finally we wish to acknowledge the contribution of Dr Jonathan Jarman, Medical Officer of Health who after 20 years in Northland moved to Taranaki. Passionate about public health Jonathon made a considerable contribution towards greatly reducing the levels of acute hepatitis A, hepatitis B, invasive haemophillus influenza B and meningococcal diseases and bringing down the incidence of tuberculosis to the lowest on record for Northland in 2012.

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

In closing we sincerely thank the members of the Board, our executive leadership team, all our staff, General Practices, Primary Health Organisations, Māori and other community providers throughout the health sector for their continued hard work, dedication and care. These efforts make a difference to the lives of Northlanders, and there have been numerous expressions of gratitude for the help and compassion that patients and their families/whanau have received.

Anthony Norman
Board Chair

Dr Nick Chamberlain
Chief Executive

Introduction:
Northland District Health Board

Our Role

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

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

It serves a projected population for 2013/14 of 159,795 and employs around 2,621 staff.

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

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

The district health board 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 non-government organisations (NGOs).

Our Communities

Population

Northland's projected population for 2013/14 is 159,795, 3.6% of New Zealand's population. Just over half live within the Whangarei District Council area, 37% live within the Far North District Council area and 12% live within the Kaipara District Council area.

Māori

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

Ageing population

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

Socio-economic status

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

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

Rurality

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

Our Health Profile

Māori

Māori experience low levels of health status across a whole range of health and socio-economic statistics. They comprise 30% of Northland's population, but 52% 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 15 years younger than non-Māori.

Child and Youth

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

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

Older People

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

Long Term Conditions

The 'big three' are diabetes, cardiovascular disease and cancer.

36% of deaths of Northlanders are from *cardiovascular disease* (heart disease and stroke). 22% of adult Northlanders have been told they have high blood pressure and fourteen percent told that they have high cholesterol, both known risk factors for cardiovascular disease.

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

39% of deaths of Northlanders are from *cancer*. The four most common sites are; trachea-bronchus-lung, colorectal, prostate and breast.

Oral Health

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

Lifestyle Behaviours

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

Mental Health

Mental health has been a priority since the publication of the Blueprint for Mental Health Services in NZ in 1998. Since then increasing amounts of resources have been progressively invested nationally to work towards a full range of mental health services.

Social Influences

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

Our Vision, Mission & Values

Our Vision:

A Healthier Northland
He hauora Mo Te Tai Tokerau

Our Mission:

Mission – Achieved by working together in partnership under the Treaty of Waitangi to:

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

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

Our Values:

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

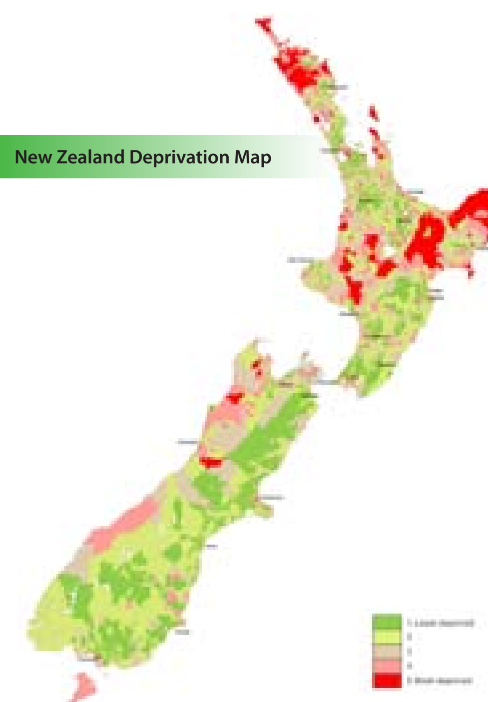
Respect - Whakaute (tuku mana) - We treat others as we would like to be treated

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

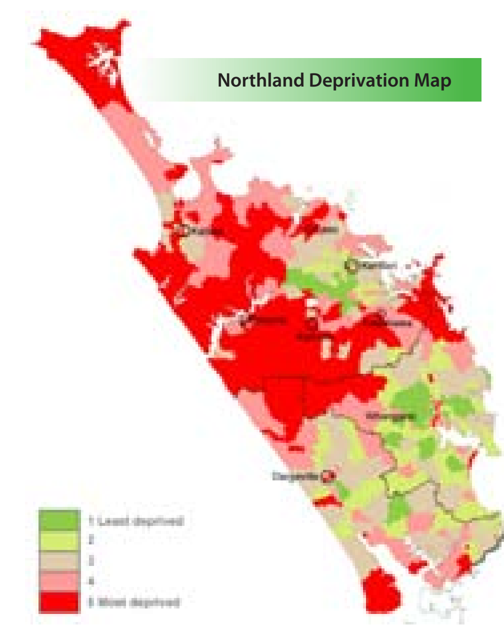
Communication - Whakawhitiwhiti korero -
We communicate openly, safely and with respect to promote clear understanding

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

New Zealand Deprivation Map



Northland Deprivation Map



Where the Money Goes

Whangarei, Dargaville, Bay of Islands and Kaitaia Hospitals (surgical and medical services, emergency departments, imaging, laboratories, maternity, public health, etc)	$248m
Primary Health (general practitioners, community dental services, radiology, etc)	$50m
Health of older people (including residential care, rehabilitation)	$51m
Mental health services	$53m
Māori health services	$7m
Community pharmacies	$39m
Community laboratory services	$8m
Inter-district flows (publicly funded health services paid to other district health boards and others for services provided to Northland patients)	$67m
TOTAL	$523m

EACH DAY IN NORTHLAND

On average, each day in Northland:

120	Emergency Department attendances
136	Inpatient discharges
1,902	Outpatient attendances
77	Outpatient missed appointments
12	Northland patients discharged by other DHBs
9	Chemotherapy attendances
40	Renal dialysis
42	Theatre events
208	Radiology exams
2,481	Lab tests, NDHB hospital
727	Lab tests, NDHB community
5	Babies born in hospital
4	Deaths in Northland
3	Mental health hospital admissions
501	Mental health community visits
1,468	General practice consultations
6,668	Prescriptions processed by pharmacies
109	Community visits by allied health services
195	District nursing visits
172	Oral health visits in primary schools
8	Immunisations for 2 year olds
7	Immunisations for 8 month olds
39	Breast screens
839	Subsidised bed days in aged residential care
1,780	Hours of home-based support services for older people
92	People assessed by hospice services' nursing teams

And we do much more!

Our Services

There are currently 148 GPs and 155 practice nurses across 38 general practices providing primary health care to Northlanders enrolled with Northland PHOs, and non-enrolled and non-resident patients.

Northland DHB has 228 contracts with 139 non-government organisations (NGOs) including Māori health providers and Whanau Ora collectives who provide a wide range of public health, primary health care and community services across Northland.

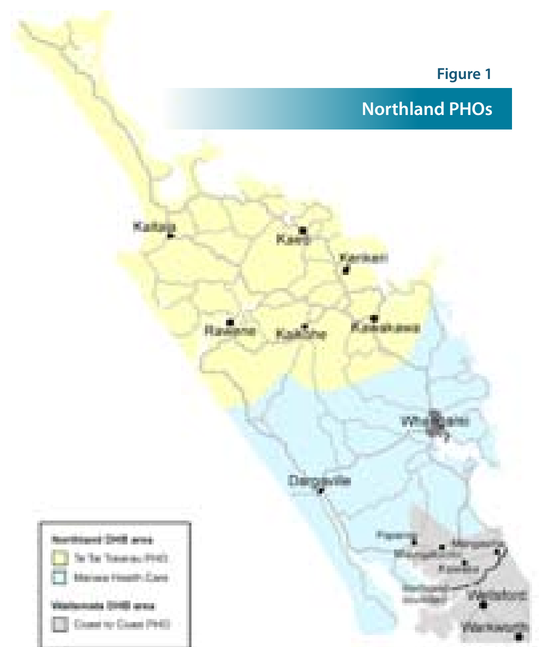


Figure 1
Northland PHOs

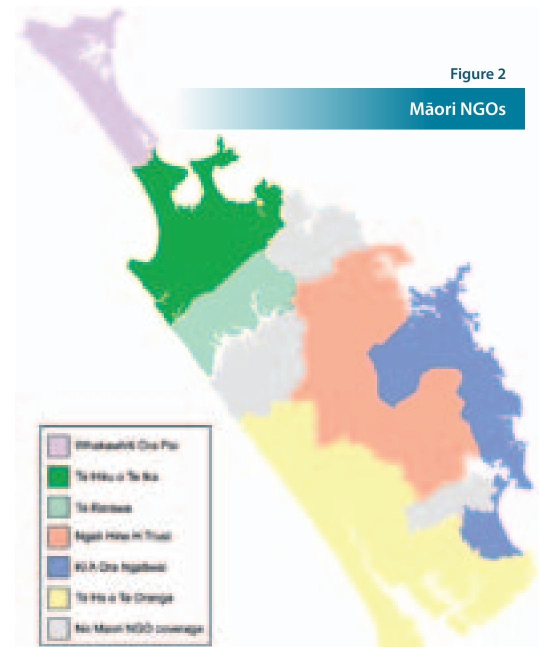


Figure 2
Māori NGOs

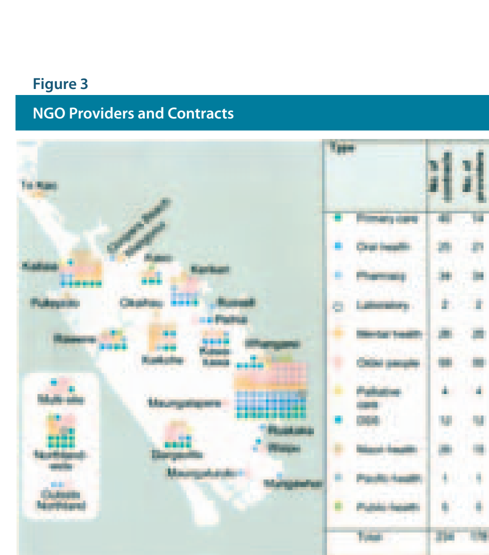


Figure 3
NGO Providers and Contracts

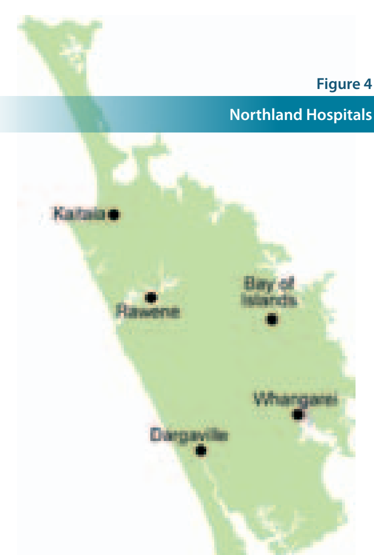


Figure 4
Northland Hospitals

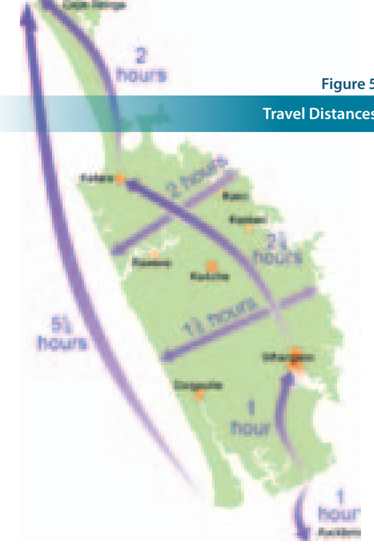


Figure 5
Travel Distances

Our People

One of the goals of the Northland District Health Board is to provide an environment that supports individual career development by engaging staff in their personal and professional growth, fostering key clinical and high performing staff, and providing managers with specific skills and expertise to ensure high quality services are achieved.

Staff Engagement

A number of local engagement groups meet regularly to encourage a cooperative working environment. The objective of these groups is to provide a mechanism and framework for implementation of constructive engagement between Northland DHB and the unions that represent its employees. They aim to:

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

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

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

Talent Management

- Services identify and support potential leaders in various occupational groups to develop both technical and managerial skills, ensuring succession planning is facilitated. An organisational development plan has been developed and will be implemented in 2013. Training and development initiatives provide the opportunity to participate in management, leadership and clinical programmes nationally and internationally including:
- Continuing Medical Education for medical staff
- Professional Development recognition programmes for nursing and midwifery staff
- Specific training identified for Associate Clinical Nurse Managers
- Regular leadership workshops coordinated by the Learning and Development team
- "Grow our Own" staffing initiatives through additional Māori scholarships for staff and a Pihirau Hauroa Māori Scholarship for students who whakapapa to Te Tai Tokerau hapu and iwi
- Ngā Manukura o Āpōpō – national Māori nursing and midwifery leadership training
- Hosting advanced medical trainees under the Health Workforce New Zealand (HWNZ) Advanced Trainee Scheme (ATS)
- Participation in HWNZ Northern Regional Training Hub for the 'Transitional Years' project for Post Graduate Year 1 and Post Graduate Year 2 medical graduates. Northland also supports the Pukawakawa programme in partnership with the University of Auckland.

Management and leadership capability

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

Partnership models include:

- Clinical leadership operating at senior executive level:
  - Medical Executive Leadership Team
  - Maternity Governance Group
  - Nursing Executive Advancement Team
  - Allied Health Advisory.
- Clinical governance mechanisms at various levels of the organisation to support better outcomes for patients. Clinical staff, including a representative from primary care, sits alongside managers on the Clinical Governance Board and work together to provide oversight of all DHB clinical activities.

Health and wellbeing

- Northland DHB's Occupational Health and Safety team actively promotes a number of high profile programmes and initiatives to help employees with their personal health choices and to advise management on risk management strategies:
  - Smokefree/auahi kore
  - Employee Assistance Programme (EAP new provider effective 1 May 2012)
  - Active management of ACC rehabilitation plans , both work and non-work towards a safe return to work
  - On-site occupational health assessments and physiotherapy treatment
  - Work place assessment programme
  - A range of specific policies and guidelines to protect and enhance employees' health, safety and wellbeing
  - A collaborative approach to health and safety through a consultative agreement with unions on site and scheduled health and safety forums
  - Incident reporting follow-up to ensure employee is supported and given best advice
  - Regular health and safety reporting to management and to the Ministry of Health.

Workforce profile and Equal Employment Opportunities

- Northland DHB adheres to the good employer requirements in section 118 of the Crown Entities Act 2004 which cover:
  - Good and safe working conditions
  - An equal employment opportunities programme
  - The impartial selection of suitably qualified persons for appointment
  - Recognition within the workplace of the aspirations and needs of Māori, other ethnic or minority groups, women and people with disabilities
  - Training and skill enhancement of employees.

Northland DHB workforce profile	Total workforce: 2,621 employees The workforce profile is similar to that of other DHBs although Māori representation is higher reflecting a greater percentage of Māori in our region as shown below
Age Profile	Female average age: 47.2 years Male average age: 47.3 years
Ethnic Profile	The introduction of a self help on-line staff kiosk in 2011 provides the following ethnicity data • European: 48.0% • Māori : 13.1% • Asian: 4.0% • Pacific: 0.8% • Other: 0.6% • Not stated 33.5%
Disability Profile	While specific data is not currently available for this category, individuals with disabilities applying for vacancies are given full consideration based on the needs of the position
Gender Profile	Female: 2,083 employees Male: 538 employees

Northland DHB's activities against the seven key elements of being a 'good employer' are summarised below:

Element	Activity
Leadership, accountability and culture	• Leadership encouraged and supported at all levels of the organisation • Involvement of Te Poutokomanawa/Māori Health Service Directorate operating at all levels of the organisation • Maintains and promotes organisational values at all levels of the organisation.
Recruitment, induction and selection	• Robust recruitment and selection processes • Clinical and managerial positions advertised in national recruitment portal • Regional and national collaboration for recruitment campaigns • Powhiri or Whakatau guidelines developed for visitors and new employees.
Employee development, promotion and exit	• Generic orientation day for all staff • Nursing and midwifery orientation days • Departmental orientation in place • Human Resources orientation for managers • Continuing medical education opportunities provided for senior medical staff • Nursing and midwifery staff encouraged and supported to participate in professional development programme • Development of e-learning packages on a range of clinical and non-clinical topics • Pihirau Hauroa Māori Scholarship for students who whakapapa to Te Tai Tokerau Hapu and Iwi.
Flexibility and work design	• Flexible work hours are available based on employee needs and the requirements of the position • Specific disabilities are recognised and provided for • Cultural competency and Tikanga best practice workshops and on-line learning enable staff to increase their knowledge and understanding of Te Ao Māori (Māori World view).
Remuneration, recognition and conditions	• Remuneration and conditions are in line with collective employment agreements • Transparent job evaluation criteria are in place for a range of employee groups developed in consultation with relevant unions • Specific merit progression criteria is available for most employee groups • Commitment and ongoing contributions of staff recognised through Long Service Award presentations • Development of an annual presentation/celebration for all Awards currently being recognised: ◦ Matariki Hauroa Māori Awards ◦ Northland DHB Quality Awards ◦ Nursing and Midwifery Awards ◦ Northland DHB published authors and presenters.
Harassment and bullying prevention	• Awareness and education strategy in support of the Unacceptable Behaviour in the Workplace policy continues to be implemented • Values Champions initiative has been developed and implemented in support of the above named policy • An "Acceptable Behaviour in the Workplace" poster has been developed (NDHB/union) and made available across the organisation • Managers trained in dealing and managing unacceptable behaviour in the workplace • Code of Conduct and related policies are available to all staff with a site on the staff intranet dedicated to 'Acceptable Behaviour in the Workplace' • The development of a 'staff code of rights' is in progress.
Safe and healthy environment	The DHB recognises its obligations to the safety and wellbeing of its staff. This is supported by the following programmes: • Employee assistance programme (EAP) • Health & Safety policy and training provided • Employee vaccination programme • ACC partnership programme • ACC annual partnership programme audit • Family violence resource available • Workstation assessment programme • Manual Handling programme • On-site occupational health clinicians • QUIT support including nicotine replacement patches • Provision of a gym and swimming pool • Care Capacity Demand Management programme.

Workforce Development

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

To attract and grow our workforce to meet service needs, training and development initiatives include the opportunity to participate in management, leadership and clinical programmes nationally and internationally. Staff satisfaction and retention is enhanced as training and development aligns to organisational compliance requirements, service needs and staff's own professional development. Further development and implementation of e-learning is enabling greater access to learning, communication, knowledge transfer and skill development, ensuring best practice is implemented.

National:

Health Workforce New Zealand key priority areas for 2012-13 included:

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

Regional:

During 2012-2013, Health Workforce New Zealand (HWNZ) continued to work nationally to achieve a more strategic and integrated approach to career planning. A major focus of this work is the development of and support for regional postgraduate training hubs. Four regional training hubs – Northern, Midland, Central and South Island – have been established.

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

Northland:

Northland DHB continues to coordinate and allocate HWNZ funding for postgraduate study for nursing and midwifery and the non-regulated workforce. In addition Northland DHB pursues "Grow our Own" staffing initiatives by providing additional Māori Scholarships for staff and a Pihirau Hauora Māori Scholarship for students who whakapapa to Te Tai Tokerau hapu and iwi. There is also a training fund for non-regulated Māori health and disability workforce to build their capability and capacity.

Our relationships with Auckland University, Auckland University of Technology and North Tec (Northland's polytechnic) continue to provide future opportunities for doctors, nurses, midwives and allied health professionals to join the organisation.

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

- Pihirau Hauora Māori Scholarship has supported 45 Māori students studying at bachelor, masters and PhD degree level who whakapapa to Te Tai Tokerau hapu/iwi. (21 applications through NorthTec and 24 through other tertiary institutions)
- Health Workforce NZ Non-regulated training fund has supported 27 Māori Kaimahi into building their capability and capacity to further their professional development in the health sector
- Fields of study for the funds detailed above include Nursing, Physiotherapy, Medicine & Surgery, Psychology, Social Work, Pharmacy, Physical Education, Sport and Recreation, Practice Management, Aged Care, Health Promotion, Vision and Hearing Screening, Asthma and other Respiratory Conditions, Hauora Māori and Relaxation Massage
- The Northland DHB Te Poutokomanawa Māori Education Fund was discontinued in the last fiscal year
- Kia Ora Hauora (KOH) – Supporting Māori in Health Careers has seen a number of youth have workforce and workplace experience in the health sector. To June 2013, Northland has contributed to 234 of the 891 Māori that are registered on the KOH database with 46% currently on a health study pathway and 43% interested in health as a career.
- Of the five Oral Health Bachelor degree in Dentistry scholarships three of the recipients are employed in Northland and two are still on their study pathway.

CLINICAL LEADERSHIP

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

Regional:

Clinical leadership has been a strong feature of the development of the Northern Region Health Plan, which is based on the Triple Aim of population health, patient experience and cost/productivity.

The plan states that achieving these aims implies:

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

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

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

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

Northland:

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

To encourage and support clinical networks with clinicians, Northland DHB has refocused its clinical frameworks:

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

  As a senior medical leadership forum, the medical executive leadership team has oversight of medical workforce issues, quality and safety frameworks and ongoing review of medical leadership structures

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

- **Nurse Executive Advancement Team (NEAT)**

  The nurse executive advancement team provides strategic and operational nursing leadership across Te Tai Tokerau, Northland ensuring safe and competent nursing practice that contributes to effective health outcomes for the population we serve.

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

- **Allied Health Advisors (AHA)**

  This group comprises the professional advisors of all the allied health professions. The group reports directly to the chief executive. A chair and appropriate representatives for specific forums such as the regional clinical leadership meetings are elected each year by group members. Support is provided by Northland DHB's chronic and complex care service.

  The role of the group includes:

  - To effectively represent allied health within Northland DHB
  - A forum to discuss issues of common interest
  - Provide advice to senior management and others on allied health issues
  - Implement policies
  - Advocate on allied health issues.

These clinical networks provide clinical advice to Northland DHB's senior management group, made up of clinicians and management, Northland DHB's executive leadership team and chief executive. During the year, a review of clinical governance activities within the organisation and a quality workshop resulted in plans to significantly increase involvement of clinicians in quality improvement activities. Implementation of these plans will take place during the next year.

Te Tai Tokerau Alliance for Health Project:

Health care providers in Northland have risen to the challenge of providing better, sooner, more convenient health care through the establishment of an alliance partnership with Northland DHB, launching the Te Tai Tokerau Alliance for Health Project.

The partnership's principal objective is to reduce inequality and improve the health and wellbeing of all Northlanders. The project is seen as a new way of working to achieve real change in the delivery of health care in the region, enabling a move to closer integration of services across hospitals and the community.

For 2012/13 the Alliance Leadership Team (ALT) made up of senior representation from the DHB, PHOs and NGOs, including Whanau Ora Collectives has refocused its role to provide the overarching governance structure for sector integration, strategic direction and developing the broad vision of integrated health services. It has confirmed seven focus areas as its work plan for 2012/13 and these are:

- Information integration
- Long-term conditions
- Evidence-based clinical pathway development crossing organisational boundaries
- Development of youth health
- Integration between Māori health providers and Whanau Ora collectives and primary care
- Integration between hospital services and primary health care
- The Primary Options Programme Northland (POPN).

Overall Performance Progress

Northland DHB's overall progress is measured against both High Level Outcomes and Outcomes in the Statement of Service Performance. These are described in the summary diagram on p125 of our 2012/13 Annual Plan.

(Indicator descriptions throughout this section have been abbreviated for space reasons. Fuller descriptions are in the text of the Statement of Service Performance on page 87 and/or in the glossary).

High level outcomes

Improved health status

Results for 2012/13 are summarised in the table below.

Output Class	Indicators	Performance this year				Change since last year			
		Target met	Close to target	Target not met	No data	Better	Similar	Worse	No data
Prevention	Y10 never smoked								
	Breastfeeding 6 weeks								
	Imms 8 months								
	Breast cancer screening								
	Cervical cancer screening								
Early detection & management	% pop who smoke								
	Primary care smoking advice								
	Caries-free 5yo								
	DMFT Y8								
	% diabetics with DARs								
	% of above with good management								
	CVD risk assessments								
	Referrals to MHI Coordinators								
Intensive assessment & treatment	Hospital smoking advice								
	Referrals to CYFS								
	Cancer radiation treatment								
	Cancer chemo treatment								
	Mental health services coverage								
	Elective surgery ops								
	ED waiting times								
	Complaints per patient event								
	Complaints closed within 20 days								
	HDC complaints in breach								
	Surgical site infections								
	Hand hygiene compliance								
Rehab & support	% HBSS with interRAI assessment								
	% HBSS for higher needs clients								
	ARRC 3-year certification								
	Respite care beds utilised								
	29	11	8	9	1	11	14	3	1

This year, performance improved on 11 indicators and was poorer for only three compared to last year, demonstrating a steady underlying improvement across all levels of performance (target met, close to target, not met). Last year 15 targets were met, four were close to target and nine targets were not met.

Progress on inequities

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

Q1: For how many measures is Māori/ non-Māori data available so comparisons can be made?
- out of the 29 measures in the SSP, Māori data is readily available for only 13

Q2: Of the 13 measures for which data is available, has the 2012/13 target for Māori been met?
- target met: 5
- close to target: 3
- target not met: 5.

Q3: Where there was a variance in performance for Māori and non-Māori in 2011/12, and has the variance been reduced in 2012/13?
- in all eight measures that were either close to target or the target was not met, the gap is similar to last year.

Output Class	Indicators	Inequities						
		Performance for Maori (■ = Maori data not reported)			Over time the gap is...			
		Target met	Close to target	Target not met	Nil or minimal	Reducing	Similar	Widening
Prevention	Y10 never smoked							
	Breastfeeding 6 weeks							
	Imms 8 months							
	Breast cancer screening							
	Cervical cancer screening							
Early detection & management	% pop who smoke							
	Primary care smoking advice							
	Caries-free 5yo							
	DMFT Y8							
	% diabetics with DARs							
	% of above with good management							
	CVD risk assessments							
	Referrals to MHI Coordinators							
Intensive assessment & treatment	Hospital smoking advice							
	Referrals to CYFS							
	Cancer radiation treatment							
	Cancer chemo treatment							
	Mental health services coverage							
	Elective surgery ops							
	ED waiting times							
	Complaints per patient event							
	Complaints closed within 20 days							
	HDC complaints in breach							
	Surgical site infections							
	Hand hygiene compliance							
Rehab & support	% HBSS with interRAI assessment							
	% HBSS for higher needs clients							
	ARRC 3-year certification							
	Respite care beds utilised							
	29	5	3	5	5	1	7	0

Good progress towards eliminating the gap between Māori and non-Māori is evident with breast screening, hospital smoking advice, cancer treatments and mental health service coverage. The gap between Māori and non-Māori is similar to last year for breastfeeding at six weeks, cervical cancer screening, both oral health measures (caries-free five-year olds; decayed, missing and filled teeth in Year 8 pupils), percentage of diabetics with annual reviews, percentage of diabetics with good blood sugar management, and CVD risk assessment.

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

Ethnic data exists for the indicators marked with blue above, but it is not reported routinely; accessing it will require a variety of approaches. Three of the indicators (primary smoking, electives, Emergency Department waiting times) are Health Targets whose

reporting systems are designed nationally, but local solutions should be relatively simple because two of them are Northland DHB-sourced and the other comes through our PHOs. The five quality indicators (three x complaints, surgical site infections, hand hygiene compliance) will be dropped next year in favour of six new standard national quality measures which Northland DHB will work towards reporting by ethnicity. Two of the smoking indicators, Year 10 never-smoked and the percentage of the Northland population who smoke, are driven by national bodies (Action on Smoking and Health and Ministry of Health respectively), so requests will have to be made to them to obtain ethnic data. The four rehabilitation and support indicators are not generally reported by ethnicity because very few Māori use those services and any statistical analysis is therefore likely to be volatile.

Living within our means

During 2012/13 Northand DHB established the Financial Sustainability Programme, one of six under the Northland Health Services Plan. Initiatives put in place locally, regionally (working with Health Alliance) and nationally (working with Health Benefits Ltd) together contributed to our estimated savings during the year of $1.7M. In 2012/13 Northland DHB again broke even despite increasing demands on services and tight financial circumstances.

Outcomes

Northland DHB's performance against our six Outcomes is summarised below. Details about each indicator are in the Statement of Service Performance on page 87.

Outcomes	Indicators	Performance this year				Change since last year			
		Target met	Close to target	Target not met	No data	Better	Similar	Worse	No data
Healthy population	Y10 never smoked		■			■			
	Breastfeeding 6 weeks		■				■		
	Imms 8 months		■			■			
	Breast cancer screening	■					■		
	Cervical cancer screening			■		■			
	% pop who smoke				■				■
	Primary care smoking advice		■			■			
	Hospital smoking advice	■					■		
Prevention of illness and disease	% pop who smoke				■				■
	Primary care smoking advice		■			■			
	Caries-free 5yo			■		■			
	DMFT Y8			■		■			
	% diabetics with DARs			■		■			
	% of above with good management			■			■		
	CVD risk assessments		■				■		
Reversal of acute conditions	Caries-free 5yo			■		■			
	DMFT Y8			■		■			
	Referrals to CYFS	■				■			
	Referrals to MHI Coordinators	■				■			
Optimum quality of life for those with long term conditions	CVD risk assessments		■				■		
	% diabetics with DARs			■		■			
	% of above with good management			■			■		
	Cancer radiation treatment	■					■		
	Cancer chemo treatment	■					■		
	Mental health services coverage	■				■			
Independence for those with impairments or disability support needs	% HBSS with interRAI assessment			■		■			
	% HBSS for higher needs clients	■				■			
	ARRC 3-year certification			■				■	
	Respite care beds utilised			■			■		
Better, sooner, more convenient services	ED waiting times		■				■		
	Cancer radiation treatment	■					■		
	Cancer chemo treatment	■					■		
	Elective surgery ops	■					■		
	Complaints per patient event	■					■		
	Complaints closed within 20 days			■				■	
	HDC complaints in breach		■				■		
	Surgical site infections	■					■		
	Hand hygiene compliance	■					■		

Healthy population

Of the seven indicators with data available that fall under this Outcome, target was met for two (breast cancer screening, hospital smoking advice), we were close to target for four. We didn't meet target for cervical cancer screening, but the new raised target is proving a challenge for all DHBs, and Northland DHB has an improvement plan in place. Performance was maintained on three indicators and improved on four.

Prevention of illness and disease

For this Outcome, Northland did not achieve target peformance for any of the six indicators for which data is available, though we maintained performance on two and improved on four (primary care smoking advice, both oral health indicators, diabetes annual reviews).

Reversal of acute conditions

For all four indicators, performance has improved since last year and target was met for two (referrals to CYFS, referrals to mental health initiative coordinators). The two for which we did not meet target relate to oral health, which we know requires catch-up. The oral health service has undergone significant changes in the last four years which are now almost complete and performance improvements will soon follow.

Optimum quality of life for those with long term conditions

Performance against target was achieved for three of the indicators (both cancer waiting times, mental health services coverage), we were close to target for CVD risk assessments, but did not meet target for the two diabetes indicators. Performance has improved since last year on two indicators (diabetes annual reviews, mental health services coverage) and remained similar on the other four.

Independence for those with impairments or disability support needs

Target was met for only one of the four indicators (home based support services for higher needs clients), but performance improved on that indicator and interRAI assessments. Mitigating factors apply to performance on the other three indicators. The non-achievement of target for interRAI assessments is based on the original published target, but that was lowered during the year by MoH because it was deemed to be unrealistic to achieve in one year, and Northland DHB did achieve against the revised target. In response to a national audit report, MoH's requirements for three-year certification among aged residential care providers became more stringent to promote improved quality over time. This also meant however that 2012/13's performance, which in the past might have been acceptable, was being judged against a higher standard. Usage of respite care beds was not as high as expected because of factors outside Northland DHB's control (such as more residential beds becoming available unexpectedly and reducing demand for respite care).

Better, sooner, more convenient services

Target was met for six of the nine indicators. That high level of performance is why for most of the indicators it was unrealistic to expect an improvement from last year. For complaints closed within 20 days, target was not met and performance worsened compared with the year before, though remedial action has since been put in place to sharpen up the process.

National Health Targets

Health Targets 2012/2013 end of year results showed progress for Northland DHB, with an overall increase of performance in all areas except Immunisation.

Shorter stays in Emergency Departments

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

Improvements in ED length of stay performance has continued throughout the year with a higher annual average of 93% compared to 90% in the previous year; with a 3.3% increase in patient presentations since 2011/12.

However, the Quarter 4 (92%) result has decreased when compared to Quarter 4 (95%) in the previous year. Improvement activities continue within the ED to create sustainable improvements in ED Length of Stay performance, which include but not limited to:

- Reviewed medical staff rosters to match patient demand
- Appointment of two additional registered medical officers
- Overlapping of medical registrars in the early evening to enhance patient throughput
- Twice daily Senior Medical Officer rounds within ED
- The development of whole-of-system standard operating procedures which include the Care Capacity Demand Management process and Variance Response Management plans which have assisted with a formalised and standardised approach to the daily issues encountered throughout the hospital
- Some clinical pathways have also been redesigned to minimise the likelihood of an acute readmission new heart failure pathway, COPD.

A new ED and 30-bedded acute assessment unit is planned for Whangarei Hospital. However, it is recognised that this new facility will be dependent on capital resource and it is likely to be several years before this can be implemented. In the interim a six-bed admission area continues to be used with approximately 14% of ED patients utilising this facility.

Increased Immunisation

The national immunisation target is 85 percent of eight-month-olds have their primary course of immunisation at six weeks, three months and five months on time by July 2013, 90 percent by July 2014 and 95 percent by December 2014. This quarterly progress result includes children who turned eight-months between April and June 2013 and who were fully immunised at that stage.

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

Northland DHB reached 83% in June 2013 and has put extra emphasis into achieving the new targets set by the Ministry. Much collaborative work has been undertaken between Northland DHB and primary care to improve coverage rates for our children with key focuses on:

- All GP practices actively precall and recall, and since the introduction of the new eight-month-old health target more emphasis has been placed on the importance of pre-calling as well and better utilisation of TXT to remind
- Work is continuing on maximising opportunities through secondary care to refer to outreach or to immunise children whilst in child health clinics and ED prior to discharge. The rate of immunisations given in secondary care locations is improving
- Northland DHB community services is continuing to provide the services of a kaiawhina to help locate families for whom there is no current GP recorded on the NIR. The Māori Women's Welfare League are continuing with their support in tracking and tracing children
- Referral criteria to Outreach Immunisation Services (OIS) have been amended so that the services are focused on 0-2 year olds only. This is to maximise the positive effect of immunisations completed by OIS on the heath target
- It is positive to note that over the last quarter of the year there was a reduction in the number of referrals made to OIS providers in Northland, a reflection of both the reduced age criteria and the additional effort being made by primary care providers.

Our message is simple: please get your baby vaccinated ON TIME as soon as each immunisation milestone is reached – that's six weeks, three months and again at five months.

Improved access to elective surgery

The target is an increase in the volume of elective surgery by at least 4,000 discharges per year. DHBs planned to deliver 148,259 discharges for the 2012/13 year, and have delivered 10,223 more.

Northland DHB has achieved the Ministry targets in 2012/13 to have no patient waiting longer than five months for a first specialist appointment (FSA) and elective surgery.

To achieve this, an additional 269 patients had elective surgery and an additional 153 patients attended an FSA over the 12 month period. There were 6,778 elective surgeries performed this year which represents a 6.2% increase in elective surgeries performed from last year and performance of 106% of contracted delivery.

Additional resource was required to achieve this increase, while sustaining a reduction in waiting times and continuing to improve the service we provide to Northland patients. To achieve this Northland DHB has two major projects funded by the Ministry of Health; the Productive Operating Theatre (TPOT) and the Elective Orthopaedic Redesign project.

Both projects have a focus in developing systems, processes and ways of working that improve the patient's elective surgical journey. They both work towards reducing the wait time for elective surgery and specialist appointments.

Better help for smokers to quit

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

We achieved a result of 98% of our inpatient smokers being given advice and help to quit smoking from staff in our hospital services in Whangarei, Dargaville, Bay of Islands and Kaitaia. There are no disparities between Māori and non-Māori results for receiving brief advice and support to quit smoking. This has been possible through the ongoing commitment by our hospital leadership in our tobacco target steering group which comprises of both management and clinicians to promote and champion the Smokefree ABC (Ask, Brief, and Cessation) programme as a routine part of patient care.

A concerted effort has been made to ensure all charts are coded correctly. An e-learning module has been created to align with the new format which was available for the staff organisational orientation day from February 2013.

As the target is now being consistently met, planning has occurred to improve the quality of the brief advice given and to increase the number of referrals made. Other projects are being determined to extend the reach of ABC to support whanau who are not patients. Initiatives to support staff and their families/ whanau to stop smoking have begun.

Northland significantly improved our primary care results throughout the year from 38% of smokers assisted in quarter one to 72% in quarter four and we are now performing well above the national result. We are working hard to achieve the primary care target of 90% in 2013/14.

Shorter waits for cancer treatment

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

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

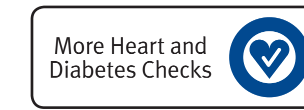
The introduction of videoconferencing for regional multi-disciplinary meetings (MDM) to discuss and confirm the plan of care for individual patients within the various tumour streams has been extremely useful. An upgrade of the videoconferencing equipment for these meetings across all Northern region DHBs is underway along with the electronic MDM forms for documenting each patient's diagnostic and treatment pathway. Faster cancer treatment indicators were introduced during the year.

Target times are:

- Indicator 1 from referral to commencement of first treatment within 62 days
- Indicator 2 from referral to first specialist appointment (FSA) within 14 days
- Indicator 3 from decision to treat to commencement of first treatment within 31 days.

In March 2013 a cancer tracker was appointed to report quarterly to the Ministry of Health on faster cancer treatment indicators. Ministry of Health funded cancer care coordinator positions also became available during the year enabling the appointment of three new clinical nurse specialists to coordinate care and improve patient outcomes.

More heart and diabetes checks



This target is 90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years, to be achieved in stages by July 2014. The current stage is to achieve 75 percent by July 2013.

The overall performance for Northland DHB for the last quarter was 74.1%, an increase of 5.5% on the previous quarter. The DHB exceeds the average national performance by 7.2% and is ranked fifth out of the 20 DHBs. Overall good progress towards the national target of 75% has been demonstrated.

This can in part be attributed to the use of IT tools to identify eligible populations. General practice continues to proactively contact and invite people due for CVD risk assessment to attend a clinic. Providers, primary and secondary (with the exception of one), utilise a common data source (Predict) to ensure a single source of data. Recall systems are in place to ensure that those people who are eligible are invited to attend.

Quality teams have been developed to ensure expertise, training and tools are available to enable providers to successfully complete the CVD risk assessment and meet clinical guidelines. There has also been an increase in nurse-led clinics.

PHOs are seeking to minimise financial barriers to access by providing free CVD screening to eligible high need populations.

Reducing Inequities

Northland's projected population for 2013/14 is 159,795, of whom 30% are Māori.

Out of the total Māori population, about half live in the Far North District, 40% in Whangarei, and 10% in Kaipara. 24% of Manaia Health PHO's registered population at June 2013 was Māori (23,672 out of 93,305). Te Tai Tokerau PHO had both a higher percentage of Māori (47%) as well as a higher number of Māori people (28,876).

The child and youth population (ages 0-24) comprised 52% of all Māori in 2006, compared with only 33% for the European population. People aged 65 or more comprise 17% of Northland's non-Māori population but only 6% of Māori. These features lend the Māori population pyramid a distinctive triangular shape that contrasts with the more rectangular profile of non-Māori.

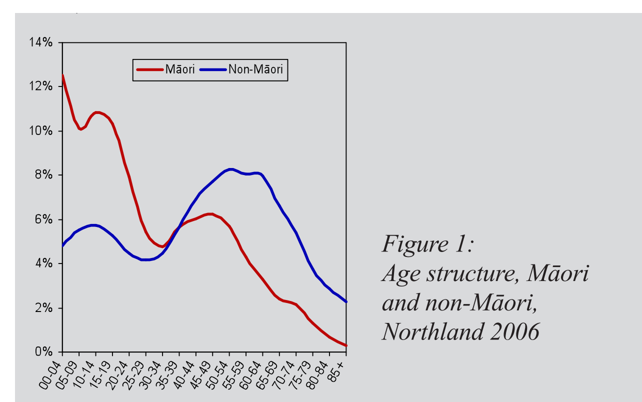


Figure 1: Age structure, Māori and non-Māori, Northland 2006

Over half (56%) of all Māori in Northland live in the most deprived quintile, as measured by the NZDep06 Index. Non-Māori in the region more closely matched the affluence of NZ as a whole, with just over one-fifth of their population (23.5%) in the most deprived one-fifth of NZ.

The high deprivation and large Māori population in Northland means that almost half (47%) the PHO enrolled clients were eligible for Services to Improve Access (SIA) funding.

The gap between Māori and non-Māori life expectancy improved from 13 years in 1996 to nine years in 2010 (recent evidence suggests that since then it may have widened again, but this cannot be verified until recalculations can be carried out using 2012 mortality data). Northland's nine year gap compares with the national figure of 7.6 years.

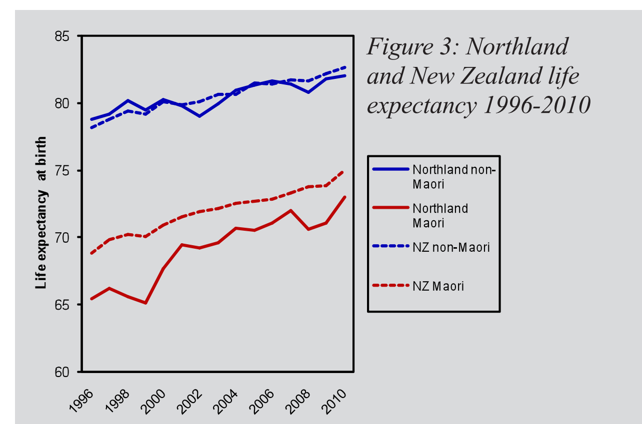


Figure 3: Northland and New Zealand life expectancy 1996-2010

Māori have about three times the avoidable mortality rate than non-Māori (308.3/100,000 compared with 106/100,000). Leading causes of death are ischaemic heart disease, lung cancer, diabetes, motor vehicle accidents, and suicide and self-inflicted injuries.

Far more Māori die in middle age, primarily from the effects of long-term conditions. Māori are admitted to hospital in Northland aged, on average, about 13 years younger than non-Māori.

Life expectancy for all Northlanders is lower than national averages, with life expectancy for Māori lower than that of the national Māori population and much lower than non-Māori Northlanders.

Northlanders have higher rates of health risk factors including:

- Tobacco use – 26% of Northland adults smoke compared with 19% for New Zealand. The smoking rate is extremely high for Māori (55%)
- Nutrition and physical activity – 30% of Northland adults are obese compared with 19% for NZ. The rate is higher for Māori (47%)
- Of Northland adults, 5.4% are estimated to have CVD – the highest in the Northern Region (Northland DHB together with Waitemata, Auckland and Counties Manukau DHBs).

Northland has significantly higher ambulatory sensitive hospitalisation (ASH) rates for Māori compared to all New Zealand Māori, while non-Māori rates are similar to the national average. Māori rates are twice that of non-Māori on an age-adjusted basis. Avoidable hospitalisations were also higher, with the Māori rate at 5,941/100,000 and non-Māori at 4,327/100,000. Leading causes of hospitalisation were respiratory infections, dental conditions, angina, asthma, ENT infections and gastroenteritis.

Northland has a relatively high neonatal and infant mortality rate compared with New Zealand, with Māori tamariki rates particularly high. It also has relatively high rates of hospital admissions for infections in children – skin, respiratory – and other conditions linked to socio-economic conditions, and particularly for Māori tamariki.

Northland's birth rate is higher than the national average, in particular for Māori. The teenage pregnancy rate is high.

Northland also has the third highest suicide rate (2004-2008), and third highest rate of female Māori intentional self-harm hospitalisations.

Extent of Disparity-Rheumatic Fever

In terms of incidence rates (new cases), rheumatic fever (RF) shows the greatest health inequity of all in Te Tai Tokerau. More than 95% of those affected in our DHB are tamariki Māori. The rates of acute rheumatic fever (ARF) and rheumatic heart disease (RHD) can be considered as highly sensitive indicators of Māori: non-Māori child health inequities in Te Tai Tokerau.

Tamariki Māori in Northland have about a 1 in 200 chance of a damaged heart by the end of school - though this is preventable. The most recent data (2007-2011) estimates the annual incidence for Māori children aged 5-15years at 90/100,000, with a total population rate in Northland of 10-12/100,000 – nearly three times the national rate.

Efforts being made to reduce disparity

Key progress has been made in a variety of areas:

- Further implementation of RF prevention school projects (currently six school-based throat swabbing services which cover approximately 50% of Māori school children in Northland)
- Active community promotion in high-risk areas via the school projects (Kaikohe, Kaitaia, Whangarei, Whangaroa, Hokianga and Kawakawa/Moerewa)
- Development and implementation of a DHB-wide communications strategy led by the Public Health Unit in collaboration with Māori providers
- Development and implementation of the MedTech sore throat algorithm, standing orders and nurse-led management in primary care
- Ongoing regional coordination contract (Ngati Hine Health Trust)
- Audits of ARF notifications and the RF register, and of sore throat management in three general practices
- Re-orientation of the Healthy Homes Tai Tokerau programme widened the eligibility to prioritise child health issues including Group A Streptococci + and Acute Rheumatic Fever patients, and inclusion of tenanted properties. This has resulted in 700 referrals with 350 being approved for fully subsidised insulation over the last year
- Discussed and planned an intersectoral approach with key stakeholders in health, housing and social services and other community agencies to work towards the districts goal 10% lower than the average (17 per annum) over the last three years.

Extent of Cardio vascular disease disparity

The top cause of avoidable death for both Māori and non-Māori was ischaemic heart disease, accounting for 25% of all Northland avoidable deaths. For Māori, lung cancer, diabetes, motor vehicle crashes and chronic bronchitis/emphysema were the next most common causes of preventable death. Māori were over-represented in all of these causes but especially in diabetes. Rheumatic heart disease, widely considered a third world disease, was the tenth most common cause for Māori.

Efforts being made to reduce disparity

The two CVD/Diabetes pilot sites in Kaikohe (a disease management approach) and Kaitaia (an early intervention approach) have developed models of care that will improve responsiveness to Māori with diabetes and cardiovascular disease in primary care settings.

The Broadway Medical Centre programmes nurse-led initiative contributes to the health target of receiving a CVD/Diabetes risk assessment, improved patient HbA1c levels, prescribed medications, improved physical activity and the utilisation of green prescription, and patients being more health literate in managing their condition.

Te Hauora o Te Hiku o Te Ika's early intervention programme provided the opportunity to develop a model of care that was responsive to high-risk Māori pre-diabetic clients in an effort to delay the onset of diabetes. Whanau support was a key to supporting patients in this model of care with results reported as:

- Improved blood pressure readings
- Lowered cholesterol levels
- Lowered HbA1c levels
- Reduction in weight through adherence to exercise plans
- Improved health literacy and self management of their pre-diabetic condition.

Extent of Disparity - Lung Cancer

Northland has the highest regional rate of lung cancer in New Zealand, with the disease burden falling disproportionately upon Te Tai Tokerau Māori (Northland District Health Board, 2006). Reducing the incidence and impact of lung cancer is a priority area for Northland DHB.

Efforts being made to reduce disparity

- Ten year trend analysis (1997/98 – 2007/08) shows that there has been an improvement of 2.57 life in years for Northlanders living with cancer. However despite the changes to hospital systems and clinical pathway the gap between Māori and non-Māori in life in years and the gender gap continues to remain the same. More change is needed to continue to drive improvements in care and to close the gaps (Dr Mazin Ghafel, Auckland DHB Public Health Physician)
- Northland DHB now has five cancer care coordinators (clinical nurse specialists) who support cancer patient journeys across the nine cancer streams. The additional resources are part of the National Tumour Standards and Best Practice guidelines for Multidisciplinary Team Meeting and Cancer Care Coordination. The new staff members join a very successful team of clinical nurse specialists who support lung, bowel and breast cancer
- In June 2013, Healthy Homes Tai Tokerau celebrated the milestone of retrofitting insulation into 5,000 homes in Northland in the last five years. The aim was to make homes dryer, and warmer, preventing illness that would result in less GP visits, less hospital admissions and less days off work and school.
- Dampness is a key issue for Northland homes as is the poor quality of housing builds. The scheme provides free ceiling and under floor insulation to low income home owners with high health needs. For the last year this has also included high health needs whanau who reside in rental accommodation with the expectation that the landlord would contribute towards the insulation. Feedback from whanau/ families is positive where there is an immediate noticeable change in the warmth of their homes and has improved their respiratory health problems thereby reducing their need to be admitted to hospital for acute care.

Healthy Homes Tai Tokerau is a joint venture between the Community Business and Environment Centre (CBEC) in Kaitaia and He Iwi Kotahi Tatou Trust in Moerewa which services the whole of Northland.

Achievement of insulating 5,000 homes has come as a result of supportive third party funders such as the ASB Community Trust, Energy Efficiency Conservation Authority (EECA), Northland PHOs, Northland DHB, Top Energy and Northpower.

Northland Health Services Plan 2012 - 2017

In 2012 Northland District Health Board in conjunction with the wider Northland health sector developed the Northland Health Services Plan (NHSP) 2012-2017. The NHSP is a five-year plan with a 20-year horizon. It defines the challenges faced by Northland health services, and how the health system needs to respond. Specifically, it outlines the impending significant increase in demand for health services resulting from population ageing and increasing prevalence of long-term conditions within the context of constrained public funding increases. If Northland DHB continued to do what we've been doing in the way we've been doing it in fifteen years we will need 170 extra beds and be in debt by $70 million dollars annually.

The NHSP demonstrates the unsustainability of the Northland health system in its current form and makes the case for change. The actions in the plan are intended to build the momentum for doing things differently so that we can address the pressures of:

- An ageing population
- Continuing health inequities between Māori and non-Māori
- Increasing number of people suffering from long-term (chronic) conditions like diabetes, heart disease and cancer
- Capacity constraints in operational and capital funding and availability of workforce.

The NHSP takes into account our national priorities listed below. The six NHSP programmes described on the next page will strengthen and help us to better achieve these important areas of work:

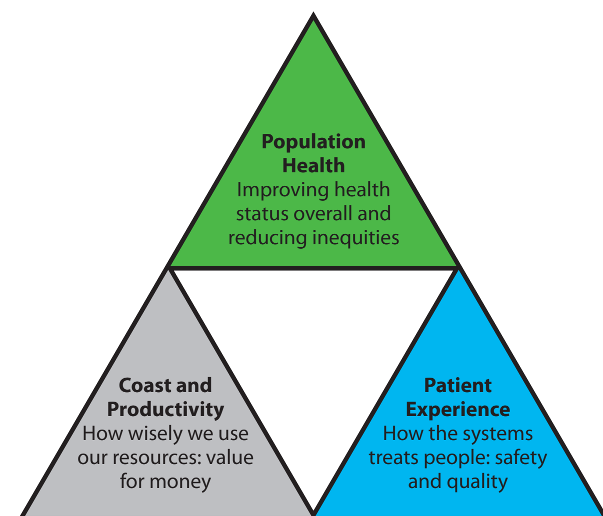
- Health Targets (shorter stays in emergency departments, better access to elective surgical services, shorter waits for cancer treatment, immunisation, better help for smokers to quit, cardiovascular risk assessments)
- Māori health
- Long-term conditions (cardiovascular disease, diabetes, cancer, respiratory diseases)
- Health of older people
- Acute and unplanned care
- Reducing growth in service demand
- Primary care
- Child and youth health
- Child and youth mental health
- Mental health
- Advance care planning
- Maternity services
- Whanau Ora
- Workforce Strategy.

The diagram below shows the balance that is going to be required to ensure clinical and financial sustainability going forward.

The NHSP takes a 'whole-of-health system' approach with a 'Triple Aim' focus of improving population health, delivering high quality patient experience whilst ensuring cost-effectiveness and productivity improvement. The aim is to take measures now that will reduce the need for crisis-driven, reactive responses in later years and that are in line with the changes being made throughout the New Zealand health sector. This requires action at a local and district level including:

- Consideration of different resource allocation patterns
- Making better use of technology
- Ensuring equity of access
- Making better use of the available workforce
- Improving service performance (cost, quality, outcomes).

The Triple Aim



Implementing the NHSP

The NHSP forms our Portfolio of development work for the next five or more years. In 2012/13 we have taken the following actions to help assist us in the implementation of the NHSP:

Appointed NHSP Coordinator

A NHSP coordinator has been appointed to oversee the implementation of the Plan.

The NHSP Oversight Group and its work

The NHSP Oversight Group has been formed and meets on a regular basis. The group acts as the governance group for the implementation of the NHSP. Its membership is whole-of-sector and comprises representation from the Māori Health Providers and the full Executive Leadership Team at Northland DHB which includes the two Primary Health organisation Chief Executives.

Early on this group identified the need for an implementation framework to assist in the successful delivery of such a large and complex change programme. Based on international best practice the decision has been made to use the Portfolio, Programme and Project (P30) methodology which is an internationally recognised best practice methodology.

As part of the implementation of the P30 approach we have formed six programmes of work. By the end of 2013 all of the programmes will have started work. The purpose of these programmes is to coordinate groups of projects which interlink and have synergy. The programmes will join together into a Portfolio which provides a cohesive approach and overarching blueprint of what we want to achieve.

The NHSP programmes are:

- Caring for our Future (children, youth, maternity)
- Reducing Inequities
- Integration
- Financial Sustainability
- Patient Safety and Quality
- Workforce Enablement.

This diagram illustrates the six programmes, how they interlink and the rationale behind each one.

To support the work of the programmes a 'virtual' NHSP support office has been established. This will operate as a matrix structure drawing on the skills and knowledge across Northland DHB and PHOs.

A prioritisation tool has also been developed to prioritise projects requiring Strategic Investment Funding. This tool is endorsed by the NHSP Oversight Group.

Finally, a standardised project management approach across the Northland health sector has been developed. This includes the development of consistent project management procedures, standardised project management documentation and the application of a consistent project management training methodology - PRINCE2.

In addition to this each NHSP Programme is in the process of identifying indicators to measure progress with implementing the various actions identified in the NHSP.

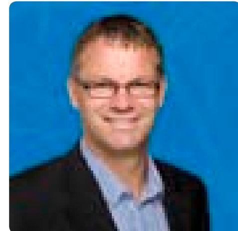
Workforce Enablement
Financial Sustainability
Patient Safety and Quality
Integration
Reducing Inequities
Child, Youth, Maternal

Prog.	Child, Youth, Maternal *Jeanette Wedding*	Reducing Inequities *Kim Tito*	Integration *Neil Beney* *Sue Wyeth*
Rationale	Healthy children make healthy adults. Whilst the number of our younger population is set to decline, child services remain one of our priorities. Children in Northland are needier than adults: areas in Northland whose deprivation rating is in the upper half of the scale contain 70% of Northland's adults but 85% of our children. The development of Child and Youth services are national priorities. A programme approach would provide the ability for us to develop a cohesive approach, particularly in youth services.	Whilst reducing inequities would remain an over-arching goal in all the programmes, a programme specifically around this subject makes it overt and explicit and provides a vehicle to raise the profile still further on this issue. It would give added life to our plans to improve Maori health outcomes. A programme approach develops an overview for a particular theme and will assist us in identifying other opportunities to help us achieve this headline target.	Integration, involving services provided closer to home, shifting services out of hospital and reducing unplanned hospital admissions, is a key national priority. Work has begun on providing a cohesive approach to our development of integrated services with the Alliance Leadership Team's priority integration areas but this does not cover all of the integration space. A programme approach would provide the ability for us to develop a cohesive approach and an over-arching blueprint of what we want to achieve. A broad interpretation of integration has been taken for this programme. It includes IT systems because any integration conversation frequently includes the necessity for integrated information systems.
Examples of Primary Drivers – Actions from NHSP	Priority actions for moderating expectant mother and young women's health risk factors identified. Expand and enhance youth friendly primary health and community services. Enhance and expand pre-school and school-based health services into institutions with high Maori rolls/ deprivation, with a particular emphasis on integrated models of care. Key priorities: skin infections, rheumatic fever, anxiety, depression, alcohol/drug addiction, STIs.	Increased emphasis on reducing tobacco uptake and improving cessation with particular focus on Maori and primary health care. Enhance screening for health condition risks particularly CVD and diabetes, with specific aim of 100% for Maori from age 35. All NDHB-funded provider organisations will have a policy on Maori cultural competence, and maintain plans to ensure their staff are culturally competent. Strengthen the health literacy of people with long term conditions through system improvements and programmes such as roll-out of Whakamana Hauora. Whanau Ora implementation and patient navigation through collectives. Increase collaboration and information sharing with Maori providers to decrease DNAs and to improve long term conditions compliance.	Strengthen discharge planning and develop hospital at home/ case management/ community specialist support MoCs. Implement same-day urgent access to primary health care. Design, implement and monitor clinical pathways for priority conditions. Strengthen the range of AOD interventions. Strengthen provision of home-based restorative services and their linkages with primary care. Develop coordinated multidisciplinary models of care across primary and community providers (inc. WOCs) and specialist services. Develop better support for lower dependency patients by increasing specialist support in community setting (eg through implementing 'hospital at home' and telehealth). Shared information environment across primary health, community, specialist and hospital services.

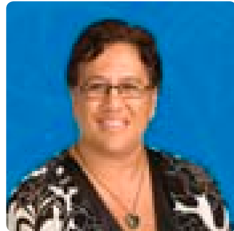
Prog.	Patient Safety & Quality *Mike Roberts*	Financial Sustainability *Meng Cheong*	Workforce Enablement *Margareth Broodkorn*
Rationale	The newly formed Quality and Improvement Directorate has been tasked with supporting the provision of high quality, person-centred, safe and evidence-based healthcare to our community. The Health Quality and Safety Commission (HQSC) is requiring DHBs to introduce 6 Quality Accounts and report on 16 Quality Markers. It is expected that this work will grow considerably in the near future and will become whole-of-sector rather than hospital focussed. We need to develop better formal integration for CQI with primary care and NGOs.	The NDHB is likely to face increasing financial constraints as described in the NHSP. Tackling these pressures and controlling costs requires a coherent set of actions implemented over time, actions which assist with moderating future demand for services, and controlling growth in service delivery costs. Careful planning of actions is required to ensure cost savings in one area do not detrimentally impact on another part of the system.	Our health care workforce is our most valuable asset. An ageing workforce and worldwide shortages of disciplines will impact on our ability to deliver services. We need to continually develop a workforce and culture that is flexible and will embrace change and new Models of Care. This will require supportive clinical leadership, a culture focussed on continuous improvements, and clinical networks to make best use of resources and ensure appropriate provision of services to all communities. We need to promote 'growing our own' and a workforce that reflects ethnically the population we serve.
Examples of Primary Drivers – Actions from NHSP	Strengthen patient quality and safety programme (prevention strategies and measurement), including medication review, infection control, fall reductions. Over first 2 years implement Global Trigger Tools across hospital and develop action plans and accountabilities for reducing rate of adverse events. Over next 2 years measure and improve cultural safety and responsiveness. Implement joint NDHB/ASMS Quality and Patient Safety Improvement Plan.	IDF analysis to identify service improvement and cost savings. NGO VfM review and action plan. Establish whole-of-system productivity and cost savings leadership group tasked with identifying and implementing ongoing actions. Hospital service VfM action plan developed. Assess/ benchmark hospital services against VfM measures, including cost effectiveness of clinical interventions, with a focus on high cost interventions. Establish Strategic Investment Fund.	Develop whole-of-system workforce strategy/ action plan. Identify options for better integration of NPs and Maori primary care nursing/ independent nurse practitioner in service delivery. Strengthen Maori health workforce. Establish affirmative action in recruitment and retention priorities. Establish Northland hospital network and clinical governance group. Work with sector to plan larger, more efficient ARC facilities.

Northland District Health Board Quality Accounts 2013

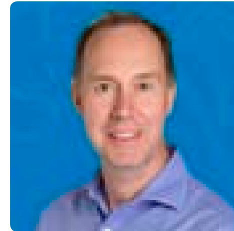
Quality is important to us all and we are making steady progress against each of our nominated priorities. We have a growing focus and commitment within the organisation for continuous improvement, striving to become a truly patient-centered organisation of excellence



Dr Nick Chamberlain
Chief Executive



Margareth Broodkoorn
Director of Nursing & Midwifery



Dr Mike Roberts
Chief Medical Officer

What are Quality Accounts?

Quality Accounts were introduced into the UK National Health Service (NHS) in 2009 and following testing in several NHS Trusts, became a reporting requirement for all trusts within the NHS during 2010. The aim was to demonstrate the importance of quality of care as being a core business for the NHS by placing the reporting of quality on an equal footing with financial reporting.

The Health Quality & Safety Commission New Zealand (HQSCNZ) identified in their Statement of Intent 2011-14 their priority to identify indicators of quality and safety in health, with the aim to standardise and streamline quality reporting across the New Zealand healthcare sector.

Purpose

The principal purpose of the Quality Accounts is to encourage Boards and leaders of healthcare organisations to assess quality across all of the healthcare services they offer and encourage them to engage in a wider process of continuous quality improvement.

Definition

Quality Accounts are annual reports from health and disability service providers about the quality of the services provided, and how each provider is progressing in terms of continuous quality improvement, the consumer experience and health outcomes.

Quality Accounts provide a mechanism through which health and disability service providers are able to transparently share their successes, learnings and future improvements with the public and the wider sector.

A broad range of clinicians (Medical, Nursing, Allied Health and Management) were engaged to scope and determine the initial six Northland DHB Quality Accounts. Priority has been given to areas that will help to improve the quality of care and the service provided to patients.

The six Northland DHB Quality Accounts are:

- Reducing harm from falls
- Improving the use of the surgical checklist
- Reducing central line infections
- Increasing medicine reconciliation
- Improving hand hygiene
- Preventing pressure areas.

QUALITY & IMPROVEMENT DIRECTORATE

ZERO HARM FROM FALLS

FALLS ARE COSTLY

A fall can be life changing for an older person, impacting on their independence and wellbeing, with implications for their family or whanau and significant others.

The cost of each patient fall that causes a minor injury is estimated at $600. A hip fracture causing a three week stay in hospital is estimated to cost $47,000 per patient and a hip fracture with complications and discharge to an aged residential care facility costs $135,000 per patient.

The direct cost of patient falls in hospital for 2010 - 2011 was between $3 million dollars and $5 million dollars in New Zealand. However, figures from international studies and analysis of New Zealand data suggest the total resources used by falls are 2 - 2.5 times higher than the direct costs, which could mean the true cost could have been around $6-12 million dollars per annum.

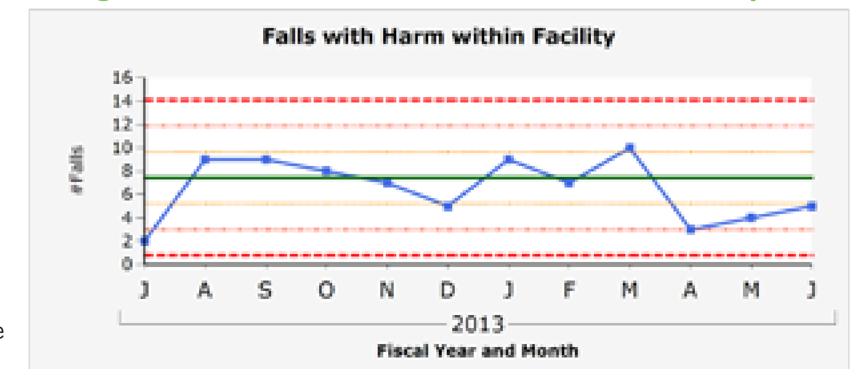
In 2011, 77 patients were harmed when they fell and Northland DHB was reporting approximately 12 falls each month. Whangarei Hospital's Ward 15 decided to do something about the falls and is making a positive difference.

"We are now working closely with the 'First Do No Harm', regional falls programme. All Northland DHB inpatient wards now have Falls Nurse Champions who lead the collection of data to analyse the number of falls per month. This data is then reviewed to understand better where in the ward the fall occurred, at what time of day and what activity the patient was involved in when they fell. Based on this data they are testing changes to their model of care or working environment to prevent further falls from occurring. Each patient that is assessed as a high risk for a fall has an individualised management plan to help prevent falls occurring", offered Associate Director of Nursing, Sheryll Beveridge.

"Nurses gave clear instructions when patients went to stand. The nurse took time with mum to help her stand, encouraging her to take her time and walking with her to the toilet", said a Patients daughter.

*LEFT: Trying on non-slip red socks, Mr Abbs a patient from Ward 15 and Student nurse Jason Wordsworth.
RIGHT: Falls Project Leaders Denise Watene Clinical Nurse Manager, Lisa Cutts Associate Clinical Nurse Manager, (Not in photo) Dr Christopher Hutchinson Consultant Geriatrician, Clinical Lead*

Target - no harm from falls whilst in an NDHB Hospital



Showhart Chart

System performance charts have a centre line as well as a upper and lower limit. These charts help us to learn about variation and to evaluate the impact of changes.

INCREASING THE USE OF THE SURGICAL CHECKLIST

Kia Tupato - Take Care! Taihoa - Take Time Out!

Gary Sakey Associate Clinical Nurse Manager - Perioperative Services

In June 2008 the Safe Surgery Saves Lives Initiative released the World Health Organisation Surgical Safety Checklist globally. Over the last two years more than 3,900 hospitals representing more than 122 countries have registered as Safe Surgery Saves Lives Participating Hospitals signifying their intent to introduce the World Health Organisation's Surgical Safety Checklist in their operating theatres.

"Northland DHB introduced the surgical checklist in 2010 with the key intent to improve patient safety in the operating theatre. The theatre team is currently revising the operative pathway that includes the Timeout Checklist. The aim is to have a more concise and user friendly checklist", said Marilyn Andela, Nurse Manager, Perioperative Services.

Target - 90% Compliance

Right Patient? Right Procedure? Right Site? Right Preparation? RIGHT RESULT!

CENTRAL-LINE ASSOCIATED BACTERAEMIA (CLAB)

PROBLEM ANALYSIS

Central venous lines are common in Intensive Care Units (ICU). Nationally there are approximately 19,000 ICU admissions each year. With these vulnerable patients, there is a serious risk of central line infection, and with it an associated mortality of 4 - 20%. Furthermore, the cost of each CLAB has been estimated to be between $NZ 20,000 and $54,000.

At Northland DHB we had:

- **Potential for ongoing morbidity and mortality from CLAB, even though we had one of the lowest CLAB rates in the country**
- **No standardised process for insertion and maintenance and surveillance of Central Venous Lines**
- **A good clinical teaching process in reducing CLAB, but there was ongoing potential for rates to increase - Dr Sven Karman, ICU Consultant and Clinical Leader for the CLAB Project.**

"We have been working with the national programme since July 2012 and to 30 June 2013 there have been NO central line infections. Insertion practice documentation and equipment has been standardised. The ICU team has used an improvement model working with PDSA Cycles (plan, do, study and act) to ensure our new processes are well embedded", said Sarah Pickery, Clinical Nurse Manager ICU.

"The CLAB project has raised awareness within the unit for strict hand hygiene when dealing with central lines, best practice is promoted and staff are now seeing the importance of the 'packages of care'. I am pleased with the change in culture and the hard work has paid off", explained Nina Gresswell, Associate Clinical Nurse Manager ICU.

"CLAB Prevention is well established in Whangarei ICU and is gradually being rolled out to other clinical areas to ensure we all actively reduce the risk of infection in all patients with a central line", said Sheryll Beveridge, Associate Director of Nursing.

Clinical Lead Dr Sven Karmen & Project Lead Nurse Manager Sarah Pickery

Target - No Infections

Days since Last Central Venous Line Infection

367

(As at July 2013)

MEDICINE RECONCILIATION

The latest Serious and Sentinel Events report showed that 18 serious medication errors were reported in New Zealand hospitals during the 2011/2012 period. This is just the tip of the iceberg - estimates vary, but somewhere between 2 and 13 % of patients admitted to hospital are estimated to have an adverse drug event of some description.

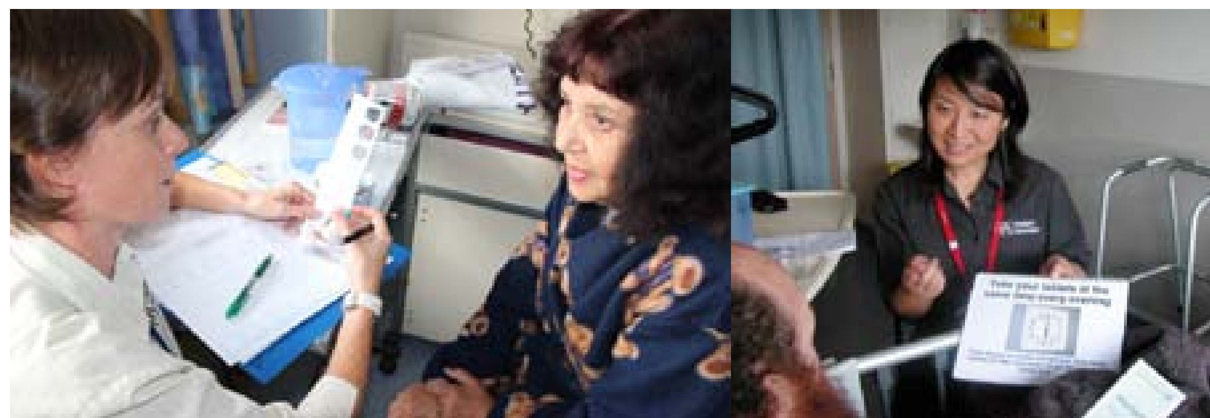
Some of these patients will be harmed as a result, or have to spend extra time in hospital. This is not only an unnecessary inconvenience to patients and their families, but it also increases costs to the health system (HQSCNZ 2013).

Medication errors and patient harm can result from inaccurate or incomplete medication histories that are subsequently used to generate medication regimens for hospitalised patients. Discrepancies may exist among what is documented in the patient's medical record, outpatient's clinic or office records, prescription bottles, outpatient pharmacy records and what medications the patient is actually taking.

Often patients are taking medications for which there is no documentation, some patients not taking their medications and there are differences in the dosage of medication being used. Without appropriate verification of the actual medication regimen (reconciliation) and failure to detect drug-related problems, missed diagnoses or errors in patient admission drug charts can occur.

"Medicine reconciliation is a routine service in some wards at Northland DHB. In these wards a pharmacist will collect medication-related information for newly admitted patients, and will compare the prescriptions on the inpatient medication chart to the medications the patient has been using before their hospital admission", said Helen Dunn, Pharmacy Manager.

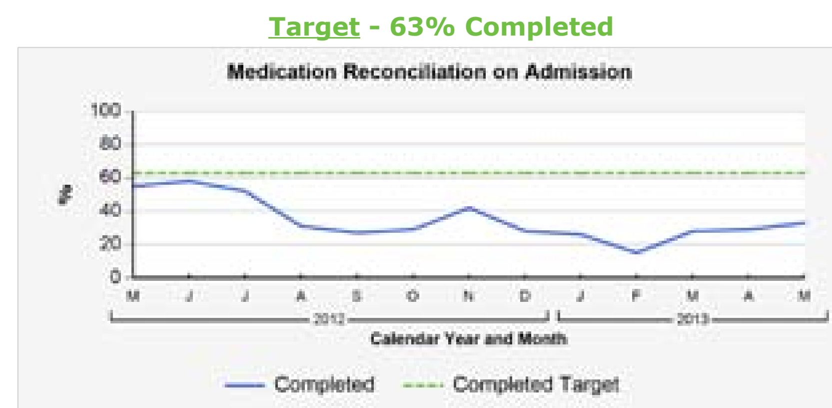
"Doctors will then look at the differences and decide what should continue to be prescribed. As the pharmacy team currently leads the initiation of the medicine reconciliation process, a reduction in pharmacy staffing levels can affect the number of medicine reconciliations Northland DHB can perform. Northland DHB is continuing to work on strategies to improve the delivery of the medicine reconciliation service."



Left: Pharmacist Kay Lengyel & Ward 14 patient Mrs Kirkham - RIGHT: Pharmacist Haruna Makita

"Its great that staff have time to talk to me about my medication. It makes all the difference", Mrs Kirkham said.

Target - 63% Completed



HAND HYGIENE

Patients health and welfare are put at "serious risk" as a result of poor hygiene practice, lets do it right!

The Hand Hygiene New Zealand project (HHNZ) was introduced at Northland DHB as part of the National Quality Improvement Programme in 2009. The Ministry of Health, in its 2006 publication 'Scoping Priorities for Quality Improvement in the Health and Disability sector' set out a national programme for Infection Prevention and Control (IPC). Included in this programme and 'first out of the blocks' was Hand Hygiene.

This was in response to the World Health Organisation (WHO) statement ***'the most simple and effective means of avoiding infections is good hand hygiene and failure to comply is the leading cause of healthcare associated infections. Poor hand hygiene contributes to the spread of multi-resistant organisms and is a significant contributor to infection outbreaks'.***

The IPC team rolled out this programme in 2009. Currently five areas are audited three times a year with 350 moments observed in each. These high risk area audit results are reported nationally with audit results available on the HQSCNZ website. In addition to the national audited areas, the IPC team audits all other areas in the hospitals and report these results locally. An organisational project, with a focus on further improving hand hygiene started at Northland DHB in August 2013.

Dr Usha Shan - General Surgeon & Midwife Shona Kaio

'The Simple habit of washing hands between every patient is not only good personal hygiene but it protects patients'. - Dr Usha Shan.

Target - 90%

Hand Hygiene Compliance

68.1%

As at Calendar Year 2013 Quarter 2

PREVENTING PRESSURE AREAS WHILST IN HOSPITAL

Thousands of New Zealanders have experienced a pressure injury of some degree in recent years on their hips, heels, backs, or elbows. At least eight patients have died as a result. Good nursing care is one key to preventing them. (Nursing Review 2013).

Pressure injuries are a major cause of preventable harm for healthcare services and develop most commonly over bony prominences as a result of sustained pressure or pressure in combination with shear. Injury sustained is classified into four stages, categories or grades whereby (1) is the least severe with a persistently reddened area of skin and (4) represents full thickness tissue destruction.

Patients can develop a pressure area for a number of reasons and include; age, lack of mobility, poor diet, moisture, friction and shearing, neurological and other physical problems, even from wrinkled bed sheets, sitting on hard chairs and also if they have had pressure ulcers in the past.

The ***First Do No Harm***, Pressure Injuries Collaborative has seen teams from across the northern region district health boards and residential aged care facilities engaged to raise the profile and change care practices to reduce the incidence of patients or residents developing pressure injuries.

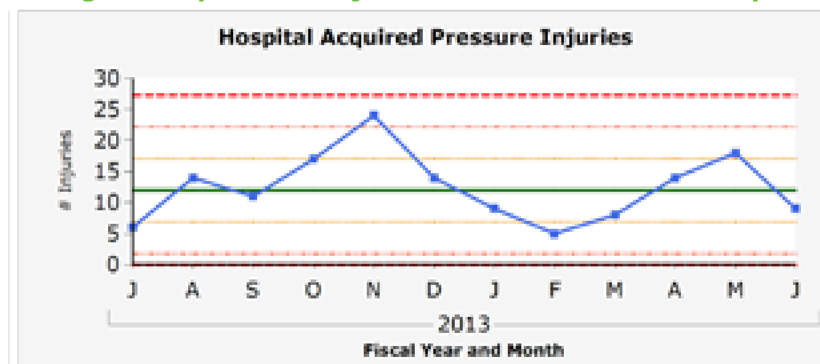
Ward 4 at Whangarei Hospital is leading the way in reducing pressure areas development whilst in hospital. Some of the things they have implemented are:

- ***Identifying patients who are at risk and using alerts so other staff are aware***
- ***Doing more in-depth risk assessment and implementing an individualised plan of care***
- ***Making sure all staff are educated, as well as the patient and their whanau/family.***

"The Pressure Injury Prevention interventions of care are now being implemented across all inpatient wards led by the areas delegated pressure injury prevention nurse champion. Staff have really engaged with this process", offered Associate Director of Nursing, Sheryll Beveridge.

Project lead for pressure area project, Associate Clinical Nurse Manager Sharon Kerwin and Clinical lead, Clinical Nurse Manager Phillipa Monteith with patients and staff in Ward 4.

Target - no pressure injuries whilst in an NDHB Hospital



2012 - 2013 Some Highlights

Chief Medical Officer

Northland DHB is proud to be a part of the Health Quality & Safety Commissions '*Open for better care*' national patient safety campaign. The campaign aligns and works with existing patient safety initiatives, such as the First, Do No Harm campaign in the Northern Region, and other local and national initiatives such as Hand Hygiene New Zealand and Target CLAB Zero. The campaign was launched on 17 May 2013 by the Associate Minister of Health, Hon Jo Goodhew.

While the Northland DHB was already focusing on similar key areas as that of the '*Open for better care*' national patient safety campaign, the formal partnership between First, Do No Harm and the Commission has strengthened our focus on preventing adverse events and reducing harm.

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

Child, Youth, Maternal and Oral Health

Breastfeeding

Breastfeeding is possibly the number one preventative intervention to reduce paediatric hospital admissions. Northland DHB is ranked second in the country with over 90% of our women breastfeeding on discharge from hospital.

Unfortunately like the rest of the country our stats decline rapidly after six weeks then again between 3-6 months with only 16% of women fully and exclusively breastfeeding at six months.

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

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

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

Oral health

Oral Health in Northland, within the public health system, is provided from seven fixed site facilities Dargaville, Onerahi, Kaitaia hospital, Kamo and Kerikeri (operated by Northland DHB), 100 mobile sites throughout Northland serviced by 12 mobiles operated by Northland DHB, three operated by Ngati Hine Health Trust and one operated by Hokianga Health Enterprise Trust.

NDHB has undertaken the implementation of a new mode of service delivery under a programme initiated via the Ministry of Health four years ago as part of its Oral Health Strategy. The DHB was provided with capital funding of $4.881 million dollars which has enabled the construction of fixed facilities known as community hubs along with new mobile facilities. The Northland DHB Board also received operational funding that enabled an increase in workforce amongst all providers.

Level of Enrolments

- 0 to 18 years of age enrolled (across all providers) 33,721
- Preschoolers enrolled (Māori 4,025, Other 3,354)
- School children enrolled 21,454
- Adolescents enrolled 4,888.

In 2012 there were 47,408 visits or appointments by children and adolescents in Northland.

There is a requirement by the Ministry of Health that these numbers increase by at least another 50%. Most providers are on track to achieve this by the end of 2013.

In 2012, 9.5% of children and adolescents Did Not Attend an appointment. We are on track to meet the target of 6.5% by end of 2013 calendar year. Almost all children enrolled with the public oral health providers in Northland are on an annual recall. As much as we would like to see this percentage decrease it is unlikely to improve greatly due to the transience of the population.

Northland DHB has established an oral health call centre. All patients, parents and caregivers can access the oral health service through phoning '0800 my teeth'. All calls are answered by a person, triaged and appointments are made at the time, as all call centre team members have access to every clinician's appointment book. The call centre has been well received by all oral health team members as it reduces their administration time which equates to more clinical time.

Whangarei Hospital Redevelopment

Design of the new maternity unit has been completed and by the end of the year demolition works will have started to be ready for construction in the New Year. The fit for purpose design complies with Australasian health facility guidelines and offers a whanau friendly environment. 'Mock up' rooms have allowed consumer and clinician representatives to develop a service delivery model that puts the mums and their families at the centre of the model of care.

A number of enabling projects have been undertaken or are in process to prepare the site for construction. These include:

- Relocation of the Clinical Training Centre
- Relocation of the Histology Store
- Relocation of Orthotics, Podiatry, Wheelchair Services and Equipment Services
- New staff/public access via Hospital Road
- Demolition of Wards 6, 7, 8 & 9.

Sudden Unexpected Death Infant (SUDI)

Northland has one of the highest rates for SUDI in New Zealand with 68.3% of the deaths occurring in infants aged between 28 days and one year being coded as SUDI during 2004–2009. There is a huge disparity between the numbers of Māori babies who have died compared with non-Māori. Seven Māori babies die before any non-Māori baby dies.

Northland DHB has taken a multi pronged approach by developing and implementing during 2012/13 the SUDI action plan known as Kohunga Aituaa Ohorere (sudden death of a baby).

The action plan is aligned with the northern regional SUDI strategy, including agreed principles and the development of a shared Safe Sleep Policy across the DHBs.

Key features include:

- Northland DHB programmes have jointly aligned and planned their services to address issues of infant vulnerability; smoking cessation, support for breastfeeding, maternal mental health, alcohol and drug issues and family violence
- A review of current screening tools and referral pathways with a stock-take of current referral levels. This includes identification of 'best' tools and pathways for referral and clear criteria to ensure each referral meets the threshold for service
- A six month pilot project between the Special Care Baby Unit and Whangarei Maternity Services started in April 2013. The pilot project aims to provide additional services to mothers whose babies are at greater risk of a SUDI. The pilot included the purchase of 50 Wahakura and 50 Pepe Pods (crib options) that were gifted to mums whose babies were at risk of SUDI. The pilot has been evaluated externally and the findings will be used to guide the development of educational resources especially for Māori 18-25 years of age.

Planning, Māori, Primary & Population Health

Smokefree Year 10

The ASH Year 10 Snapshot Survey is conducted in the second term of each year, with results generally released near the end of the calendar year. The 2011 survey showed significant gains in Northland with the daily smoking rate for year 10 students below the national rate for the first time since surveys started in 1999, and daily smoking rates for Māori 14-15 year olds also below the national rate.

For the 2012 survey 848 Northland students, from 14 schools, participated in the survey (not all schools took part), and the gains made during the previous year have continued with little if any changes:

- At 4.6% the 2012 daily smoking rate for Year 10 students in Northland had not changed significantly to 2011
- 3.8% of boys (3% in 2011) smoked daily and 5.3% of girls (4.8% in 2011)
- In Northland 63% of students have never smoked, a small but positive increase compared to 2011 (61.4%).

(Due to the small sample size ASH was unable to provide ethnicity and gender smoking data for Northland).

Smokefree Northland

Focused activity has seen success with the District Councils in Northland regarding the smokefree policy:

- Whangarei District Council (WDC) strengthened their Smoke Free (SF) policy implementation by adding 48 neighborhood parks as smokefree on 25 September 2011
- WDC agreed to extend SF Policy to cover six other Council-owned areas - Café in the Park at Tarewa Park, Central City Car Park, Clapham's Clocks, the Library Courtyard and the Canopy Bridge and Quarry Gardens. Smokefree signage was provided by the DHB
- Northland DHB was successful in their submissions to WDC re an Alfresco Dining policy. WDC promotes the identification of smoking and non-smoking areas with alfresco dining where practical
- Discussions were held with key WDC staff around the possibility of implementing a SF policy to cover Cameron Street Mall. Discussions were also held with Otago University School of Medicine regarding monitoring survey data collection for SF Cameron Street Mall
- Far North District Council 29 playgrounds, 64 sports grounds and reserves went Smokefree in late 2012.

Whanau Pack

The new Whanau Pack provides school counsellors and adolescent health service providers with a range of simple strategies to help parents and caregivers improve their communication and build stronger bonds with their teenagers.

The resource responds to several current issues confronting parents and those working with families. Firstly it supports parents who are now required by the new Sale and Supply of Alcohol Act 2012 to be responsible in providing boundaries around the provision of alcohol to teenagers in their care. It provides latest information on alcohol and teenagers and the reasons why it is important to delay the provision of alcohol to young people for as long as possible.

Secondly, it addresses the issue of youth suicide by providing core strategies that work to enhance the bonds and communication between parents/caregivers and their teenagers. Positive whanau and school environments are associated with lower rates of depression and other risk factors for suicide among young people.

Population and public health promotion

In partnership with the population and public health teams the communications team was instrumental in developing the Northland Health Services Plan marketing strategy which includes a mass market health promotion radio campaign, a health television channel in the Emergency Department, health messages on fleet car bumpers and a series of billboards in partnership with Whangarei District Council.

The overall aim was to build a positive profile of the Northland District Health Board to better position the organisation to effect change in the health status of the population and achieve a healthier Northland.

Key Objectives

- Raise community awareness of how easy it is to adopt a healthy lifestyle
- Encourage Northlanders to take care of their health and prevent long-term illness
- Improve the health literacy of all Northlanders
- Positively influence health choices individuals make daily.

Each Northland DHB fleet car travels on average 25,000 kms a year and the health message will remain on the vehicle for up to three years. Developed with the population and public health teams the messages have a strong focus on Ministry health targets such as increasing immunisation, quitting smoking and encouraging more people to have heart and diabetes checks.

In 2012 33,405 people visited Whangarei Hospital's Emergency Department. ED TV was produced with Channel North and features health related TV commercials every 15 minutes. The commercials use the same audio script as the radio campaign to reinforce the key health messages. We have produced nine hours of programming to date which is broadcast in the ED waiting room 24 hours a day. The goal is to deliver 12 hours of programming that loops twice a day.

In order for the billboards to have higher visibility Whangarei District Council's Field Officer agreed to work with Northland DHB and find sites that would give the billboards a higher profile in the community.

"Promoting a safe city includes supporting our network partners and this project meets one of the Whangarei Safer Communities criteria targeting high-risk and vulnerable groups", said Grant. "Placing billboards on buildings and land we manage gives the messages the prominence they deserve".

Guided by the Northland Health Services Plan the billboards feature key health promotion messages encouraging people to take good care of their health and the health of their children.

Te Poutokomanawa

Continuous quality improvement of service delivery and alignment with elements of the Northland Health Services Plan has been the primary focus for Te Poutokomanawa Māori Health Service throughout the year. The service model is a blend of cultural support and clinical outcomes focused on the provision of equitable treatment and care, a contribution to some health targets, and supports Māori patient discharge planning.

The Leadership Team together with the General Manager Planning, Māori, Primary & Population Health has focused on strengthening the clinical advocacy within the service with clinical leadership being provided by the Tapuhi Clinical Nurse Specialist. The role has worked with the Takawaenga to support their daily work plan and service plan key performance indicator expectations. Guidance has been provided in areas of health literacy, monitored data being captured against daily patient admissions, managed placements in the wards and prioritised Takawaenga patient engagement.

Takawaenga are required to contribute towards the following population health targets:

- **ED wait times** – Takawaenga support Māori patients in their knowledge awareness of the ED triage process and monitor wait times being mindful of patients whose condition may deteriorate and ensure they are being seen in a timely manner ensuring access is optimised. Takawaenga also ensure the environment is made safe for all visitors and staff to participate in.
- **Immunisation** - Takawaenga promote immunisation uptake on time for the protection of tamariki both in maternity and children's ward. They also check they are up to date with their vaccinations making any necessary referrals to the ward nurse educator.
- **Tobacco target** – Takawaenga complete ABC with Māori patients if not completed by clinic staff. Takawaenga also talk with Māori patients who identify as smokers, about a nicotine substitute while in hospital and about quitting.

Other indicators include:

- Takawaenga are required to identify vulnerable patients, children and elderly admitted into hospital and inform them about the healthy homes programme. Where patients meet the criteria or are unsure, Takawaenga make a referral to the Healthy Homes Coordinator to complete an assessment of eligibility to have their home insulated under the programme.

Patient experience

The Te Poutokomanawa Leadership Team has reviewed the Māori health service plan and staff key performance indicators. The plan encompasses both cultural and clinical service delivery supporting Māori patients admitted into hospital.

Goal 1: 80% of Māori patient discharges receive a ward visit from Takawaenga

- This takes into account Māori patient discharges admitted into hospital and still in hospital Monday to Friday between 8.00am and 5.00pm. Excluded are outpatients, renal, babies and mental health patients. Further improvement to reach 80% is required but is resource/capacity dependant.

Goal 2: Cultural Assessment completed for all Day 3 length of stay (LOS) patients

- This is a key MDT (Multi-disciplinary team) communication tool where Takawaenga document key information captured in the cultural assessment from Day 3 LOS patients, to inform clinical staff.

Goal 3: Referrals

- Takawaenga are required to respond to a MDT referral request within one hour of receiving the referral and prioritise when they will follow up the referral according to urgency of request
- Takawaenga identify patients with high health needs or health literacy requirements and refer to the Tapuhi Clinical Nurse Specialist in the team. This service focuses on patients in hospital for Day 5 LOS and cancer patients requiring support.

Cultural Safety

Cultural competency and a safe work place environment is an expectation of all staff. The Northland DHB cultural competency programme and policy was reviewed in 2012 with a pilot and implementation planned for 2013.

Workforce:

The national Māori workforce programme Kia Ora Hauora is supported by Te Poutokomanawa with a focus on Māori students and promotion of health career options.

- Te Poutokomanawa offer te reo me ona tikanga Māori programmes to encourage staff to engage safely and appropriately with patients who speak Māori, who have Māori world views and who live by traditional Māori practices.

Quality Improvement

The Te Poutokomanawa Leadership Team is committed to continuous quality improvement, invests in staff training and use of 'lean' tools and techniques to improve efficiency, effectiveness and quality service delivery.

Clinical Services

Telehealth

Funding has been approved for the Intensive Care Unit (ICU) District Hospital Emergency Department (ED) project with implementation planned for early November 2013. The project will provide an acute care telehealth system linking Kaitaia ED to Whangarei ICU. The key benefits are improving patient safety, reducing the number of flight transfers (and reducing costs), and introducing Rapid Response Nursing Team capability to the Kaitaia General Ward. As part of the project Northland DHB is entering into research collaboration with the University of Queensland Centre for Online Health which will assist in publishing the results of a proof of concept evaluation. If proven successful the system could be extended to the other District Hospital EDs and flight retrieval centres in Northland and also establish links to the Auckland tertiary ICUs.

This year has seen a significant increase in remote outpatient clinics with nearly 200 patient clinics in the 12 months to June 2013. Mostly these are to Kaitaia, with Dargaville and Bay of Islands District Hospitals also commencing clinics. Recently they have received donated telehealth equipment and are building the clinical teams needed to support remote clinics.

Specialties for outpatient clinics include oncology, orthopaedics, paediatrics, cardiology, renal, methadone, child and youth mental health. Allied health clinics such as child obesity, dietitian and talipes are also taking place.

In July 2013 regular tertiary oncology clinics will commence from Auckland City Hospital to Whangarei Hospital. The clinics will mean the Auckland specialist does not need to travel and more patients can be seen during what was previously travel time. It is anticipated that clinics to Kaitaia will be introduced later this year.

A process and technology review of Northern region cancer multi disciplinary meetings has been undertaken by the Regional Oncology Operating Group (ROOG) with the goal of meeting faster cancer treatment targets. Funding is currently being requested to upgrade the medical outpatients meeting room in Whangarei Hospital to the regional standard.

Renal services continue to utilise telehealth successfully and benefit greatly from being able to remotely attend the Auckland multi-disciplinary meetings, paper rounds (patient care plan reviews), staff support and education and acute assessment. Use remains steady and self managing within the department. Evaluation of usage data is in progress to ascertain cost and time benefit as well as sustainability.

Exposure to national level discussions and progress from other DHBs is primarily gained through attendance of the NZ Telehealth Forum Telehealth Leadership Group. Northland's initiatives along with those in Canterbury and West Coast, have been seen as leading the way in the establishment of telehealth in NZ over the past few years. Now there is significantly more activity beginning to happen in a number of other DHBs and the leadership group is well placed to provide support for these initiatives and foster regional and national alignment on strategies, technology and best practice.

Electronic Referrals

The scope of the electronic referrals system was expanded to include electronic triaging and the provision of advice to GPs by medical specialists regarding the care of patients. It has enabled many patients to be cared for by their GP without the need for a visit to a hospital clinic. This has also reduced pressure on hospital clinics, enabling reduced waiting times.

In September we processed our 100,000th electronic referral from general practice. There remains ongoing work to improve the system at both the sender and recipient ends. A recent advance is that the referral management system used to process the referrals and messages back to GPs has been opened up to visiting specialist services at Auckland District Health Board. This has the potential to deliver timelier triage and allow GPs to access advice from these sub-specialty clinicians.

We have also added the allied health staff for child health and mental health services to the electronic triage component of the system. The aim for the mental health service is to provide a more visible service to the GPs and develop non-contact support options for patients, enabling them to be managed well within the primary care setting.

Cancer Care Nurse Specialists

Nurse specialists in head, neck and skin cancer have been appointed to work alongside medical specialists as part of multi-disciplinary cancer care teams. The nurse specialists ensure that the care of patients is well coordinated as well as providing advice and support to patients. These posts were established as part of a national strategy to improve cancer care.

Productive Operating Theatre

The Productive Operating Theatre service improvement initiative has achieved some notable successes. These include dedicated full day joint replacement lists comprising four rather than three patients, the establishment of more consistent theatre teams including dedicated theatre nurses, improved communication within theatre teams following the introduction of briefings, and the development and implementation of a formal handover tool between the operating theatres, recovery, and the wards.

Chronic Obstructive Pulmonary Disease Pathway

The Whangarei Hospital Chronic Obstructive Pulmonary Disease (COPD) pathway was introduced in June 2013. COPD patients on the medical wards are being treated in accordance with standard protocols and the medical outreach team is providing valuable support immediately prior to and following discharge. This initiative has the potential to greatly improve care while preventing avoidable hospitalisation. Early indications are that the readmission rate has been reduced considerably and we are monitoring this progress with great interest.

Nursing & Midwifery

Care Capacity Demand Management

In 2010 Northland DHB introduced a system known as Care Capacity Demand Management (CCDM) in partnership with trades unions, notably the NZNO and the PSA. The objective is to achieve an optimal balance between workload and staffing. The programme includes an objective assessment of the typical workload in wards and departments to inform a review of the staffing plan for the ward or department concerned. This is called "Mix and Match". An FTE calculation process is also undertaken as a second step to this component. A further feature is the development of variance response plans to deal with any variance from the expected pattern. This may involve the movement of staff between departments. The recently installed Hospital At A Glance screens contribute to this by illustrating the workload/staffing situation and actual occupancy compared with physical bed capacity at any point in time across the various wards and departments. A CCDM Council has been established to oversee this programme with Local Data Councils governing ward/unit developments.

Ngā Manukura o Āpōpō

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

Ngā Manukura o Āpōpō aims to:

- increase access to leadership training to support emerging and current clinical leaders within nursing and midwifery
- increase the size and skill base of the Māori nursing and midwifery workforce, and

- expand our knowledge about the effectiveness of specific Māori health workforce development initiatives.

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

Clinical Leadership: Tomorrow's Clinical Leaders Programme provides registered nurses and midwives with practical tools, theoretical background and opportunities to gain leadership skills. These include strategic decision-making, organisational development and business management that is required for them to undertake clinical leadership roles within their own workplaces. Since its inception 115 Māori nursing and midwifery graduates have completed the clinical leadership training programme. Cohort 7 is currently in progress and being delivered at Ngāruawahia Marae. Cohort 8 will be the final programme and is planned for February 2014.

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

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

The tertiary scorecard was developed to assess the recruitment and retention of Māori students within New Zealand's national schools of nursing and midwifery. The Ngā Manukura o Āpōpō Steering group is working with the national Nurse Educators in the Tertiary Sector (NETS) group on the next iteration of the scorecard.

The HR toolkit that provides a guide on professional considerations and requirements of employing nurses, is currently being trialled to assess its utility for health providers.

The next phase of the ePortfolio project (Gold winner at the Learn X Asia Pacific awards) has commenced. This uses an open source e-portfolio system, enabling nurses to provide evidence of competence, no matter where they work or live. It is envisaged it will be accepted as a professionally robust tool, transportable and acceptable as a competent portfolio by any organisation. Interest in the ePortfolio has been significant with a large number of requests for inclusion in the next phase received.

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

Mental Health, Addiction & District Hospitals

The rise in youth suicide impacted greatly on demand within the mental health and addiction services. A total of 7,175 people were seen in the service over the year, a 4.5% increase from the previous year.

The majority of the increase was experienced in the child and adolescent service Kimiora, who saw a 17% increase in the number of youth seen by their clinicians.

Admissions to the child and youth unit more than doubled – 43 admissions compared with 20 in the previous year. The inpatient unit also faced considerable demand with a 23% increase in admissions, whereas in the previous year admissions had dropped by 10%.

Youth Resilience

Reflecting the complexity of issues and risk factors youth face today, Northland DHB commissioned three strands of activity to achieve the overall goal of increasing youth and communities resilience in Northland - the Matanui play stood alongside Skylight's Travellers Programme, QPR and Lifeline's ASIST training.

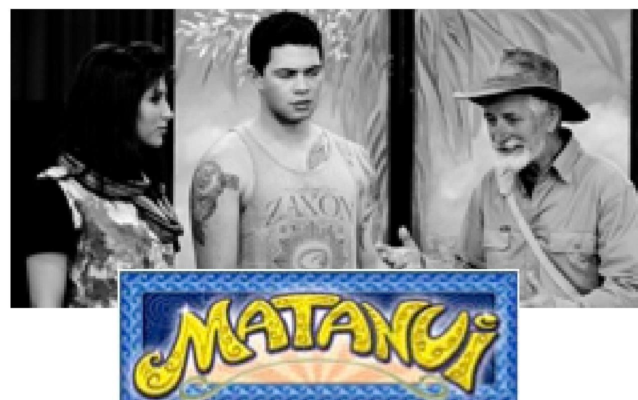


Photo by Sarah Marshall Photography

Broad content themes in the theatre included positive relationships, and some of the challenges young Northland people face including dealing with alcohol, teen pregnancy, sexual abuse and suicide.

"Matanui" aimed to empower youth and their communities, to build community resilience. The haka for "Matanui" was written by Tatai Henare and the waiata text by Sir James Henare, both of which were gifted to Matanui by the Henare whanau.

The maunga Matanui looks over a small Northland community where everything seems safe, ordinary, just the same as ever, where bad gets forgotten and good goes unnoticed. Relationships, dreams and dark histories collide as young Wiremu and friends try to make sense of it all. What's the secret ingredient a young person needs to thrive and how can they find it?

Following the play performance the students participated in a Drama in Education workshop that revisited the main events of the play. Using drama workshopping techniques the audience became participants and actors. Through discussion, role-play, improvisation and group process the participants investigated the characters' actions and the play's theme, drawing from and relating them to their own experiences.

The workshops also ensured the participants were introduced to local community support services, their networks and the pathways for accessing help.

Matanui was offered free to Northland High Schools and their communities and started at Tikipunga High School. TVNZ's Seven Sharp programme visited Tikipunga High School and produced a national primetime story on the positive work Northland DHB was doing.

Matanui visited 14 schools across Northland, performing 27 shows, including three community shows and facilitating 38 workshops over five weeks.

Alcohol Drug Helpline Referral

Since its inception the Alcohol and Drug Helpline has expanded and developed dedicated Māori and Pasifika lines as well as a Youth Line, including text and social media. Clients referred to the Helpline are offered information, phone, text and social media based counselling and support about their drinking or drug taking. If they require specialist treatment they are referred through to local Mental Health and Addiction services or to other providers as the Helpline hold the national directory of alcohol and drug service providers.

In August 2011 the Whangarei Hospital Emergency Department, supported by Northland District Health Board Public Health and Mental Health and Addiction service entered into a collaborative partnership, referring clients to the Alcohol Drug Helpline. Public Health also coordinated similar initiatives within Police and Work and Income.

By June 2012, over 500 Northlanders had been referred to the Alcohol Drug Helpline. In celebration of this partnership Northland was designated as a 'demonstration site' for further Alcohol Drug Helpline Referral Projects.

The Alcohol and Drug Helpline projects have extended to the emergency department in Kaitaia and to services and community groups working with youth. The Project was also adopted by the whole community of Whangaroa including the Runanga and the Whangaroa Health Trust.

In 2013 the Alcohol and Drug Helpline project was taken up by the Mental Health and Addiction Service at NDHB who utilise the Helpline to provide support and brief intervention especially when people live in remote locations. In addition it is used for post treatment programme relapse prevention support for people who have completed the recidivist drink drivers programme 'Drive Soba' and for offenders who have completed the intensive treatment programme at the Northern Region Correctional Facility 'Te Whare Tapa Wha'.

We are currently developing a project with Te Tai Tokerau and Manaia PHOs as part of a collaboration aimed at increasing alcohol screening and brief intervention in primary care by adding the Alcohol and Drug Helpline project to their alcohol screening and brief intervention dashboard. An e–referral platform between the Northland PHOs and the Alcohol and Drug Helpline is in the planning stages.

To date there have been 855 referrals to the Alcohol and Drug Helpline from Northland.

Northern region correctional facility Alcohol and Drug Intensive treatment programme

An intensive alcohol and drug treatment programme commenced at the Northern region correctional facility at Ngawha in October 2012. Based on Te Whare Tapa Wha, the spirit of motivational interviewing and cognitive behavioural therapy principles the eight week programme is delivered three days a week for two hours a day.

After an initial short term contract the current 16 month contract started in March 2013. 23 people have completed the programme and ten are currently enrolled.

The programme includes psycho education, motivational interviewing, Tikanga and Te Whare o Ngapuhi, problem solving and relapse prevention skills. Upon graduation all participants have an individual relapse prevention plan and are given the option of a referral to the Alcohol and Drug Helpline for support after release from prison.

The new contract includes the offer of a monthly follow up support group session for graduates who have not yet been released from prison.

Recidivist Drink Driver / Drive SOBA programme

Northland DHB's Alcohol and Drug Service have been offering a programme for Recidivist Drink Drivers since June 2007. The programme began as a pilot due to an increased number of referrals from the justice system via the courts for recidivist drink driving offenders to engage in treatment.

The aim of the 12 week programme is to reduce recidivist drink driving, address the level of binge drinking or dependence and provide strategies for reducing alcohol consumption levels. The programme is psycho-educational and includes elements of motivational interviewing, cognitive behavioural therapy, relapse prevention, problem solving theories and victim empathy.

Data from the Police National Computer indicated that only 6% of people that completed the programme between June 2007 and December 2012 had reoffended.

For the year ending 30 June 2013, 182 people completed the programme in the regions below:

- Whangarei – Nine Programmes
  (Three funded by NDHB, Four funded by RoadSafe Northland)
- Kaipara – Three Programmes
  (funded by RoadSafe Northland)
- Kaikohe – Three Programmes
  (funded by Road Safety Trust)

- Kerikeri – Two Programmes
  (funded by Road Safety Trust)
- Kaitaia – Four Programmes
  (One funded by MoH, three funded by Road Safety Trust)

Acknowledgements

Northland DHB acknowledges the support of the Road Safety Trust, through the provision of grants, which enabled eight Drive SOBA programmes to be provided in the Mid and Far North for the year ending 31 December 2011. The Road Safety Trust has also committed support for these programmes in the years ending 31 December 2012 and 2013.

Northland DHB acknowledges the support of RoadSafe Northland and the Whangarei and Kaipara District Councils through their Road User Safety Programme Funding, which has enabled six Drive SOBA programmes to be provided in Kaipara and Whangarei in the years ending 2011 and 2012. Funding is also expected for the next three years.

Health of Older People & Clinical Support

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

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

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

Support for Older People

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

Home-Based Support Services

At the start of the financial year, 17% of people receiving home-based support had been assessed using the InterRAI assessment tool.

Northland DHB set a target of 50% and by March 2013, 60% of these clients had received an InterRAI assessment, comfortably exceeding the target.

Proportion of Moderate and High Risk Corrective Actions Arising from Certification

Northland DHB holds age related residential care agreements with 23 providers. In 2012/13, 25 audits were carried out. The same number of audits (25) was carried out in 2011/12.

The total number of required corrective actions identified in the audits decreased from 220 in 2011/12 to 174 in 2012/13. The proportion of corrective actions assessed as moderate or high risk did not significantly change.

In 2011/12 61% of the required actions were identified as negligible or low risk (60% in 2012/13). In both years 37% were identified as moderate, and 3% identified as high. A small number of providers contribute to the majority of the moderate and high risks.

Proportion of Corrective actions assessed as moderate/high risk

	Negligible	Low	Mod	High	Total number of corrective actions
2011/12	2 (1%)	131 (60%)	81 (37%)	6 (3%)	220
2012/13	3 (2%)	101 (58%)	64 (37%)	6 (3%)	174

Northland DHB engages an Aged Residential Care Integrated Audit Monitor to support providers to take all corrective actions arising from a certification/contract audit, with immediate responses when areas of high risk are notified.

Northland DHB's Health of Older People Specialist Clinical Team is extending its relationship with all aged residential care facilities starting with an increase in the clinical support being provided by Gerontology Nurse Specialists.

Residential Respite Care Services

The estimated total funded bed days in 2012/13 were 4,362, of which 3,629 days (83%) were actually used by clients. The target was 4,200 utilised bed days.

The gap between funded and utilised bed days was due to a range of factors, such as unforeseen changes in clients' personal circumstances.

Up to 1 May 2013, Northland DHB purchased residential respite care via three funding streams:

- four dedicated residential respite care beds purchased to support access to respite care in the Mid and Far North and Whangarei
- managed respite bed days purchased on a fee-for-service basis to meet any additional demand
- where a waiting list occurred in an area closer to the client's home, clients were supported to organise their own respite through allocated carer support, and top-up funding from Northland DHB.

As from 1 May 2013, Northland DHB has increased the number of dedicated beds purchased from four to nine (3,285 bed days per annum) and will continue to apply flexible options on the occasions when additional demand occurs.

Breast cancer screening

Northland DHB was the first DHB across NZ to achieve a reduction in the gap between Māori and non-Māori eligible women against the National Breast Screening target of 70% of eligible women being screened for breast cancer.

For the 12 months ended 31 December 2012, 73.8% of eligible Māori women and 72.4% of non-Māori eligible women were screened. This is now the third year where Northland has successfully exceeded the national target. In the coming year work will begin with the staff at the Mauri Ora Breast Screening Unit to document their successful strategies so that learning can be transferred to other areas of disease and other DHBs.

Patient Administration System Upgrade

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

Northland DHB began the process of procuring a new PAS in August 2011, due to the age of the current system which is no longer being actively developed. The software supplier is withdrawing ongoing support but will continue until the new system is in place. The age and technology of the current system is also a barrier to upgrading other key clinical systems.

Northland DHB selected a product called webPAS as our solution. We embarked on an implementation planning study with the supplier CSC in February 2012 with workshops during February and March involving many of our staff. These were used to gather and define the strategy, requirements and specifications to complete a business case.

Laboratory Information System Upgrade

The laboratory information system, which links our clinical staff to our four Northland DHB laboratories and those under Auckland DHB, is also ageing and at the end of its useful life. Northland DHB has procured a new system that is linked to the Auckland laboratory service. This system allows Northland to share the underlying data storage and operating systems with Auckland thereby reducing some costs and providing some security in the event of a system failure.

It is expected that this new system will be fully operational in March 2014 after extensive alignment and testing.

Manaia Health PHO

Chris Farrelly

The action and outcomes witnessed in the America's Cup are underpinned by long unseen preparation, strong relationships within the team, and a commitment to a common goal. In Northland, the DHB and our PHOs are working more closely as one team, and identifying common goals which we can only achieve together. This 'not so visible' work is one highlight of the past year for me. Next year we hope to see more visible wins.

During the past year our 22 General Practices in Manaia provided 359,473 individual face to face consultations, some routine, and some very complex. Primary health care continues to be the backbone of our health system and it is under pressure. We have a very generous and highly capable workforce of primary health care professionals but their number is small. It was great therefore to see the opening of a new General Practice – Te Whareora O Tikipunga – during the year.

Another significant development has been the first steps towards a Whangarei Youth Space, which will provide a number of wrap-around health services for our young people, and be a hub to connect them with services that already exist. It is hoped that the Youth Space will open in December.

Manaia Health PHO has a particular focus on our children, and this is seen in our involvement in child poverty action, the Child Friendly Whangarei initiative, the B4 Schools Checks programme, good immunisation rates, "Healthy Homes", and the Whangarei Children's Team. In the words of Nelson Mandela –

"There can be no keener revelation of a society's soul than the way in which it treats its children".

For more information about Manaia Health PHO, please see our website – www.manaiapho.co.nz.

Te Tai Tokerau PHO

Rose Lightfoot

The last twelve months have seen the consolidation of the recent amalgamation of three PHOs into Te Tai Tokerau PHO with consequent changes to its governance and operational structure. Te Tai Tokerau PHO now covers the whole rural area north of Kawakawa in the southern Bay of Islands as outlined below:

Two PHOs were retained in Northland after Northland DHB's consultation process on the future of PHOs in the district. Te Tai Tokerau PHO has made significant progress over the last twelve months in embedding a collaborative way of working across the two PHOs. There has been an increase in the number of shared services delivered through combined contracts and combined roles which include the Register Management Services, Population Health Strategist, Primary Health Clinical Director, Health Promotion Advisory and Immunisation Coordination. Both PHO CEOs are members of the DHB Executive Leadership Team, and the new PHO agreement that was signed during June 2013 provides a direction for a strong Alliance leadership process in the future.

For the first time in its ten year history, in 2012 Te Tai Tokerau PHO invited representatives from both Northland DHB and Manaia Health PHO to participate in the annual strategic planning process. This has resulted in a strong alignment of the PHO Strategic Plan with the Northland Health Services Plan (NHSP), through specifying the PHO strategies that contribute to the Triple Aim Outcomes. Individual PHO team members are closely involved in the NHSP programmes.

Te Tai Tokerau PHO has a strong commitment to maintain an equal Māori voice in the governance of primary health in Northland and is guided by the principle of partnership, protection and participation as inherent in Te Tiriti o Waitangi.

An important achievement has been the development of Te Hononga Tikanga Guidelines by the Associate Director of Nursing, Hemaima Reihana-Tait, providing a model of cultural responsiveness to guide clinical practice.

Te Tai Tokerau PHO has achieved 88% of the PHO Performance Programme Targets at June 30th 2013 with performance for the high needs population exceeding that of the total population in smoking status, cardiovascular risk assessment and diabetes detection. With the implementation of continuous quality improvement processes at general practice level, pleasing progress is being seen in the Health Targets.

Over the last twelve months the implementation of the Diabetes Care Improvement Programme (DCIP) to replace the Diabetes Get Checked programme has provided a valuable model that has application for a range of other clinical programmes. The programme has introduced a different funding process away from a fee-for-service model, and shifted the responsibility for achieving outcomes by engaging the clinicians at the coal-face. Newly established Quality Improvement Team and Practice Facilitation roles along with regular comparative progress reports have stimulated best practice.

Examples of 'Services to Improve Access' provided over the year are school-based youth health services with fully subsidised nursing and medical services, Manaaki Manawa, a Kaupapa Māori cardiac rehabilitation service, primary podiatry services and outreach nursing in remote and high need areas.

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

Our Community

Northland Community Foundation

Northland Community Foundation (NCF) manages all donations and charitable accounts on behalf of Northland District Health Board. They raise funds to provide extra equipment and support over and above government funding to enhance the services delivered by the DHB to the communities of Northland.

The past 12 months have shown a strengthening of the partnership between Northland DHB and Northland Community Foundation. While finalising funding for Project Promise continued to be their main focus, work also occurred in other areas:

- The Countdown Kids Hospital Appeal 2012, which raises funds annually for Child Health, raised $83,300 for the purchase of child health equipment. This is the highest donation since they started supporting Northland Child Health services in 2008. Since then, Countdown Kids (formerly Fresh Futures) have donated over $282,000 towards helping keep Northland kids healthy.
- Managed sponsorship and funds for the inaugural Talipes (Club Foot) Awareness Day held in Whangarei in October 2012. Hosted by the Orthopaedics team, the event aims were to raise awareness and reduce stigma of Talipes in Northland. More than 400 families attended the free fun day also supported by the Northland Taniwhas, NZ Fire Service and Olympians Fiona Southorn and Alana Millington.
- The Northland DHB Sponsorship and Fundraising Policy is currently under review to streamline the process and to create a better understanding of NCF's role. The Charitable Account Committee has been reformed to better manage the Charitable Account and processes around allocation of funds. Financial reports of the fund status are now produced quarterly
- Project Promise is raising funds for a new stand-alone cancer treatment centre. While fundraising hasn't happened as quickly as hoped, the support from across Northland is outstanding and funds continue to flow in. The building site has been chosen on Hospital Road, resource and building consent are underway and the build is planned to start later in 2013. Funds are currently sitting at over $2 million, and a giving campaign to secure the remaining funds needed was to be launched in September.

Volunteers

He Tangata, He Tangata, He Tangata

It's People, It's People, It's People

Many people work together to make Northland District Health Board a special place, caring for the sick and the injured. Among these people are our Volunteers - a group of understanding people whose interest is in helping others.

We would like to acknowledge and praise our Volunteers for the countless hours and years they have dedicated to help and support staff at our hospitals.

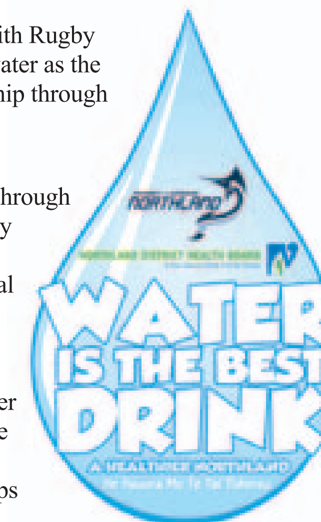
Volunteers add an extra dimension to the care and service provided to patients and visitors, by hospital staff. With the ongoing dedication and willingness that our volunteers have towards their designated duties they have become an integral part of the running of our hospitals - all happily contributing their energy and ideas and giving their "Gift of Time".

Daphne Griffin is Whangarei Hospital's longest serving volunteer – this year reaching a mighty 35 years. Daphne was recognised and presented with a certificate of appreciation from the Minister of Health, Tony Ryall during Volunteer Week in June 2013.

Daphne was judged as an Outstanding Achiever (runner up) in the Long Service Award category of the 2013 Minister of Health Volunteer Awards. Daphne began volunteering in 1978 as a meet and greet volunteer. This service provides welcome and support to patients and visitors as they arrive at the hospital and includes assisting people with wheelchairs and those with special needs and disabilities to find their way to appointments.

A wonderful role model, Daphne always welcomes new volunteers and is keen to share her experiences, guiding and mentoring them. We would like to acknowledge Daphne and her volunteer colleagues and give thanks and praise for the countless hours and years they have dedicated to help and support staff at all of our hospitals in Northland.

Water is the best drink – a partnership with Northland Rugby League



Northland DHB partnered up with Rugby League Northland to promote water as the best drink through the 'Leadership through League' programme.

NZ Warrior - Elijah Taylor - is ambassador of the 'Leadership through League' programme and strongly supported the key 'Water is the best drink' message. "The natural choice for hydration is water. It hydrates better than any other liquid, both before and during exercise", Elijah explains. "Water is much less expensive and more available than any other drink. Water is the best, but it only helps you if you drink it".

'Leadership through League' teaches college students coaching and leadership principles and has them interacting with primary school students to gain practical experience in what they have learnt.

The partnership between Rugby League Northland and Northland DHB utilises the Tuakana Teina relationship, an integral part of traditional Māori society that provides a model for buddy systems. Big brothers and sisters coaching and influencing little siblings provide role models to communicate key public health messages in schools.

Our aim is to create a lifelong habit of choosing water over fizzy or electrolyte drinks. Public health nurses trained rugby league development officers who in turn delivered this key health message through the young people into the community.

'Leadership through League' was hosted in 12 Colleges across Northland in 2013 and over 150 students received an NZ Rugby League Mini Mod Certificate. The students will go on to coach over 2,500 primary and intermediate students in 40 Northland Primary Schools.

BOARD & COMMITTEE MEMBERS ATTENDANCE 1 JULY 2012 - 30 JUNE 2013

	2012						2013						
BOARD	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**	**TOTAL**
Tony Norman	✓	✓		✓	✓		✓		✓	✓		✓	8
Sally Macauley	✓	✓		✓	✓		✓		✓	✓		✓	8
Pauline Allan-Downs	✓	✓		✓	✓		✓		✓	✓			7
John Bain		✓		✓	✓		✓		✓			✓	6
Craig Brown		✓		✓	✓		✓		✓	✓		✓	7
Bill Sanderson		✓		✓	✓		✓		✓			✓	6
Colin Kitchen	✓	✓		✓	✓		✓		✓	✓			7
Libby Jones	✓	✓		✓	✓		✓		✓	✓		✓	8
Greg Gent`	✓	✓		✓	✓		✓		✓	✓		✓	8
Sharon Shea	✓	✓		✓	✓		✓		✓	✓		✓	8
June McCabe	✓	✓					✓		✓	✓			5

HAC	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**	**TOTAL**
Bill Sanderson		✓		✓	✓		✓		✓			✓	6
Pauline Allan-Downs	✓	✓		✓	✓		✓		✓	✓			7
Tony Norman	✓	✓		✓	✓		✓		✓	✓		✓	8
John Bain		✓		✓	✓		✓		✓			✓	6
Greg Gent	✓	✓		✓	✓		✓		✓	✓		✓	8
Sally Macauley	✓	✓		✓	✓		✓		✓	✓		✓	8
Maureen Allan	✓	✓		✓	✓				✓	✓			6
Mike Roberts		✓		✓	✓		✓		✓	✓		✓	7
Win Bennett	✓	✓		✓			✓		✓	✓		✓	7

CPHAC/DiSAC	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**	**TOTAL**
Sally Macauley	✓	✓		✓	✓		✓		✓			✓	7
Tony Norman	✓	✓		✓	✓		✓		✓			✓	7
Libby Jones	✓	✓		✓	✓		✓		✓				6
Craig Brown		✓		✓	✓		✓		✓			✓	6
Sharon Shea	✓	✓		✓	✓		✓		✓				6
Colin Kitchen	✓	✓		✓	✓		✓		✓			✓	7
Peter Jensen		✓			✓		✓		✓			✓	5
Beryl Wilkinson	✓	✓		✓	✓		✓		✓			✓	7
John Wigglesworth	✓	✓										✓	3
Mark Sears	✓	✓		✓			✓		✓			✓	6

(Shaded) No Meeting held

Governance and Partnerships

In accordance with the New Zealand Public Health and Disability Act 2000, the Board has a membership of 11, seven of whom were elected in October 2010 and four of whom were appointed by the Minister of Health. The Board has three committees which provide a more detailed level of focus on particular issues:

Board Members:

Anthony Norman (Chair)
Sally Macauley (Deputy Chair)
Craig Brown
Colin Kitchen
Greg Gent
John Bain
June McCabe
Libby Jones
MC (Bill) Sanderson
Pauline Allan-Downs
Sharon Shea

Community & Public Health and Disability Support Advisory Committee:

Sally Macauley (Chair)
Anthony Norman
Beryl Wilkinson
Colin Kitchen
Craig Brown
John Wigglesworth
Libby Jones
Mark Sears
Peter Jensen
Sharon Shea

Hospital Advisory Committee:

MC (Bill) Sanderson (Chair)
Anthony Norman
Greg Gent
John Bain
Maureen Allan
Mike Roberts
Pauline Allan-Downs
Sally Macauley
Win Bennett

Audit, Finance & Risk Management Committee:

Greg Gent (Chair)
Anthony Norman
June McCabe
Sally Macauley

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

Anthony Norman
Ricky Houghton
Erena Kara
June McCabe
Katie Murray
Sharon Shea
Pauline Allan-Downs

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

Northland DHB understands the social and economic determinants which impact the health status of Northlanders, resulting in an unequal burden of early mortality, morbidity and poorer quality of health for Māori. The district health board is committed to reducing these inequalities and acknowledges its statutory responsibility and obligations to Māori established in the NZ Health and Disability Act 2000.

The Board has established a direct governance relationship with the eight Northland Iwi that they would be represented by three members from Te Waka a Taonui. The Māori Health Gains Coincil – Hei Mangai Hauora Mo Te Waka A Taonui – meets quarterly. The Council gives the Board advice on:

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

Financial and Audit Reports

For the Year Ended 30 June 2013

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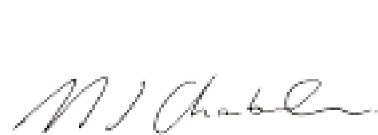
Statement of Responsibility

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

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

3 In the Board's opinion these Financial Statements and the Statement of Service Performance for the year ended 30 June 2013 fairly reflect the financial position and operations of Northland District Health Board.

Signed on behalf of the Board:



Anthony Norman
Chairperson
30 October 2013

Greg Gent
Board Member
30 October 2013

Dr Nick Chamberlain
Chief Executive
30 October 2013

Meng Cheong
Chief Financial Officer
30 October 2013

Board Report

The Board have pleasure in submitting the Financial Statements and Statement of Service Performance for Northland District Health Board for the year to 30 June 2013.

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.

	2013	2012
Results and Distribution - Group	$'000s	$'000s
Surplus/(deficit) Before and After Tax	73	16
Financial Position		
Equity was represented by:		
Current Assets	65,149	58,184
Less Current Liabilities	(71,752)	(85,006)
Plus Non-Current Assets	164,296	175,449
Less Term Liabilities	(39,465)	(29,426)
Total Equity	118,228	119,201

Review of the Operations

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

Distributions to Owners

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

Board Member Fees

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

Staff Remuneration

The number of staff with total annualised 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 2013 (in $10,000 bands):

$100,001	-	$110,000	49	$110,001	-	$120,000	37
$120,001	-	$130,000	17	$130,001	-	$140,000	17
$140,001	-	$150,000	9	$150,001	-	$160,000	5
$160,001	-	$170,000	10	$170,001	-	$180,000	7
$180,001	-	$190,000	10	$190,001	-	$200,000	7
$200,001	-	$210,000	6	$210,001	-	$220,000	5
$220,001	-	$230,000	9	$230,001	-	$240,000	8
$240,001	-	$250,000	7	$250,001	-	$260,000	5
$260,001	-	$270,000	8	$270,001	-	$280,000	9
$280,001	-	$290,000	5	$290,001	-	$300,000	5
$300,001	-	$310,000	6	$310,001	-	$320,000	3
$330,001	-	$340,000	4	$340,001	-	$350,000	5
$350,001	-	$360,000	2	$360,001	-	$370,000	1
$370,001	-	$380,000	1	$380,001	-	$390,000	1
$430,001	-	$440,000	1				

Of the 259 staff shown above, 174 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 366, compared with the actual total number of staff of 259.

Statement of Information

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

Interest Register

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

Board Member's Insurance

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

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

Events Subsequent to Balance Date

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

Donations

No donations were made for the year to 30 June 2013.

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 sections 150 and 156 of the Crown Entities Act 2004. 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 $166,200 for audit fees for the group.

Good Employer Obligations

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

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

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

Anthony Norman
CHAIRPERSON

Independent Auditor's Report

**To the readers of
Northland District Health Board and group's
financial statements and performance information
for the year ended 30 June 2013**

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

We have audited:

- the financial statements of the Health Board and group on pages 54 to 85, that comprise the statement of financial position as at 30 June 2013, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Health Board that comprises the statement of service performance on pages 87 to 102 and the report about outcomes on pages 18 to 21.

Unmodified opinion on the financial statements

In our opinion the financial statements of the Health Board and group on pages 54 to 85:
- comply with generally accepted accounting practice in New Zealand; and
- fairly reflect the Health Board and group's:
  - financial position as at 30 June 2013; and
  - financial performance and cash flows for the year ended on that date.

Qualified opinion on the performance information

Reason for our qualified opinion

Some significant performance measures of the Health Board, (including some of the national health targets, and the corresponding district health board sector averages used as comparators), rely on information from third party health providers, such as primary health organisations and general practices. The Health Board's control over much of this information is limited, and there are no practical audit procedures to determine the effect of this limited control.

Qualified opinion

In our opinion, except for the effect of the matters described in the "Reason for our qualified opinion" above, the performance information of the Health Board and group on pages 18 to 21and 87 to 102:
- complies with generally accepted accounting practice in New Zealand; and
- fairly reflects the Health Board and group's service performance and outcomes for the year ended 30 June 2013, including for each class of outputs:
  - the service performance compared with forecasts in the statement of forecast service performance at the start of the financial year; and
  - the actual revenue and output expenses compared with the forecasts in the statement of forecast service performance at the start of the financial year.

Our audit was completed on 30 October 2013. This is the date at which our opinion is expressed.
The basis of our opinion is explained below. In addition, we outline the responsibilities of the Board and our responsibilities, and we explain our independence.

Basis of opinion

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

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

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

Our audit of the financial statements involved evaluating:

- the appropriateness of accounting policies used and whether they have been consistently applied;
- the reasonableness of the significant accounting estimates and judgements made by the Board; and
- the adequacy of disclosures in, and overall presentation of, the financial statements.

Our audit of the performance information involved evaluating:

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

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

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

Responsibilities of the Board

The Board is responsible for preparing financial statements and performance information that:
- comply with generally accepted accounting practice in New Zealand;
- fairly reflect the Health Board and group's financial position, financial performance and cash flows; and
- fairly reflect the Health Board and group's service performance achievements and outcomes.

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

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

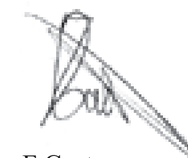
Responsibilities of the Auditor

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

Independence

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

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



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

Statement of Comprehensive Income

For the Year Ended 30 June 2013

	Notes	Parent Budget 2013 $000	Group 2013 $000	Group 2012 $000	Parent 2013 $000	Parent 2012 $000
Income						
Revenue	1	512,641	519,558	502,313	519,975	502,761
Finance Income	4a	2,750	3,660	3,562	3,648	3,547
Total Income		515,391	523,219	505,875	523,624	506,308
Expenditure						
Personnel Costs	3	180,811	178,762	176,016	178,762	176,016
Depreciation and Amortisation Expense	10, 11	12,141	11,518	10,039	11,111	9,621
Outsourced Services		15,489	24,087	15,111	24,087	15,111
Clinical Supplies		40,949	42,453	39,314	42,453	39,314
Infrastructure and Non-Clinical Expenses	2	19,431	19,706	28,250	20,266	28,800
Payments to Non-Health Board Providers		239,210	236,497	230,096	236,497	230,096
Finance Costs	4b	1,600	1,266	1,389	1,266	1,389
Capital Charge	5	5,760	8,855	5,644	8,855	5,644
Total Expenses		515,391	523,146	505,859	523,299	505,991
Share of profit of equity accounted associates	8	0	0	0	0	0
Surplus/(deficit) Before and After Tax	12	0	73	16	325	317
Surplus attributable to:						
Northland District Health Board		0	129	76	325	317
Non-controlling Interest		0	(57)	(60)	0	0
Other Comprehensive Income						
Movements on Property Revaluations		0	(533)	49,170	(533)	44,288
Financial Assets at fair value through other Comprehensive Income		0	(394)	(165)	(394)	(165)
Total other Comprehensive Income		0	(927)	49,005	(927)	44,123
Total Comprehensive Income		0	(854)	49,021	(602)	44,440
Total Comprehensive Income attributable to:						
Northland District Health Board		0	(798)	46,836	(602)	44,440
Non-controlling Interest		0	(57)	2,185	0	0

At the end of the 2013 financial year, there was $0 Mental Health Ring Fence Funding unspent (2012: $0).
Explanations of major variances against budget are detailed in note 24.
The accompanying accounting policies and notes form part of these financial statements.

Statement of Comprehensive Income *(Continued)*

Supplementary Information
The following table shows the consolidation of the cost of service statements for each output class:

2013 - Actual	Provider 2013 $000	Governance 2013 $000	Funder 2013 $000	Kaipara JV 2013 $000	Group 2013 $000
Revenue	282,998	3,469	237,158	(405)	523,219
Expenses	283,072	3,729	236,498	(153)	523,146
Surplus/(deficit) Before and After Tax	(74)	(260)	660	(252)	73

2013 - Budget	Provider 2013 $000	Governance 2013 $000	Funder 2013 $000	Kaipara JV 2013 $000	Group 2013 $000
Revenue	272,585	3,597	239,210	0	515,391
Expenses	272,585	3,597	239,210	0	515,391
Net Surplus/(Deficit)	0	0	0	0	0

Statement of Changes in Equity

For the Year Ended 30 June 2013

	Notes	Parent Budget 2013 $000	Group 2013 $000	Group 2012 $000	Parent 2013 $000	Parent 2012 $000
Balance at 1 July		67,898	119,201	68,360	113,014	66,610
Total Comprehensive Income		0	(854)	49,021	(602)	44,440
Capital Contribution		0	0	1,964	0	1,964
Balance at 30 June	12	67,898	118,347	119,345	112,412	113,014
Distributions made to Non-controlling Interest		0	(119)	(144)	0	0
Balance at 30 June	12	67,898	118,228	119,201	112,412	113,014
Total comprehensive income attributable to:						
Northland District Health Board		67,898	114,622	115,421	112,412	113,014
Non-controlling Interest		0	3,605	3,780	0	0
Balance at 30 June		67,898	118,228	119,201	112,412	113,014

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

Statement of Financial Position

As at 30 June 2013

	Notes	Parent Budget 2013 $000	Group 2013 $000	Group 2012 $000	Parent 2013 $000	Parent 2012 $000
Assets						
Cash and Cash Equivalents	6	2,515	37,977	24,217	37,893	24,160
Trade and Other Receivables	7	14,732	12,050	13,791	12,047	13,789
Short Term Deposits	6	0	260	260	0	0
Short Term Investments	8	4,924	10,021	14,968	10,021	14,967
Inventories	9	4,229	4,048	4,104	4,048	4,104
Prepayments		771	138	137	138	137
Trust/Special Fund Assets		240	656	707	656	707
Total Current Assets		27,411	65,149	58,184	64,802	57,864
Property, Plant and Equipment	10	109,895	143,618	151,022	136,379	143,376
Intangible Assets	11	847	1,802	45	1,802	45
Investments	8	33,464	18,876	24,382	20,638	26,144
Total Non-Current Assets		144,206	164,296	175,449	158,819	169,566
Total Assets		171,617	229,445	233,633	223,621	227,430
Equity						
Crown Equity	12	38,450	41,705	41,649	44,557	44,557
Other Reserves	12	24,972	75,379	76,306	68,042	68,969
Retained Earnings/(Losses)	12	4,161	(3,117)	(3,241)	(843)	(1,219)
Trust/Special Fund Assets	12	315	656	707	656	707
Total Equity Attributable to Northland District Health Board		67,898	114,623	115,421	112,412	113,014
Non-controlling Interest		0	3,605	3,780	0	0
Total Equity		67,898	118,228	119,201	112,412	113,014
Liabilities						
Trade and Other Payables	13	46,728	42,269	43,391	42,261	43,375
Interest-Bearing Loans and Borrowings	14	0	76	11,076	76	11,076
Employee Entitlements	15	24,282	29,207	28,691	29,207	28,691
Provisions	16	0	200	1,848	200	1,848
Total Current Liabilities		71,010	71,752	85,006	71,744	84,990
Interest-Bearing Loans and Borrowings	14	19,398	24,708	13,784	24,708	13,784
Employee Entitlements	15	13,311	14,757	15,642	14,757	15,642
Total Non-Current Liabilities		32,709	39,465	29,426	39,465	29,426
Total Liabilities		103,719	111,217	114,432	111,209	114,416
Total Equity and Liabilities		171,617	229,445	233,633	223,621	227,430

Explanations of major variances against budget are detailed in note 24.
The accompanying accounting policies and notes form part of these financial statements.

Anthony Norman
Chairperson
30 October 2013

Greg Gent
Board Member
30 October 2013

Statement of Cash Flows

For the Year Ended 30 June 2013

	Notes	Parent Budget 2013 $000	Group 2013 $000	Group 2012 $000	Parent 2013 $000	Parent 2012 $000
Cash Flows from Operating Activities						
Cash Receipts from Ministry of Health and Patients		511,512	521,902	503,816	522,413	504,327
Cash Paid to Suppliers		(313,154)	(326,078)	(317,557)	(326,604)	(317,910)
Cash Paid to Employees		(180,811)	(179,382)	(173,161)	(179,382)	(173,161)
Cash Generated from Operations		17,547	16,442	13,098	16,427	13,256
Interest Received		3,000	3,507	3,632	3,495	3,617
Interest Paid		(1,600)	(1,443)	(1,397)	(1,443)	(1,397)
Net Taxes Refunded/(Paid) (Goods and Services Tax)		0	529	(767)	529	(759)
Capital Charge Paid		(5,760)	(8,855)	(6,528)	(8,855)	(6,528)
Net Cash Flows From Operating Activities	6	13,187	10,180	8,038	10,153	8,189
Cash Flows From Investing Activities						
Proceeds from Sale of Property, Plant and Equipment		0	28	172	28	172
Acquisition of Property, Plant and Equipment		(23,453)	(4,859)	(14,574)	(4,859)	(14,574)
Acquisition of Intangible Assets		0	(1,913)	(98)	(1,913)	(98)
Movement in Investments & Trust Fund Assets		0	10,400	4,341	10,400	4,493
Net Cash Flows From Investing Activities		(23,453)	3,656	(10,159)	3,656	(10,007)
Cash Flows from Financing Activities						
Proceeds from Equity Injection		0	0	1,964	0	1,964
Borrowings Raised (Repaid)		0	(76)	(76)	(76)	(76)
Net Cash Flows from Financing Activities		0	(76)	1,888	(76)	1,888
Net Increase/(Decrease) in Cash and Cash Equivalents		(10,266)	13,760	(233)	13,733	70
Cash and Cash Equivalents at Beginning of Year		12,781	24,217	24,450	24,160	24,090
Cash and Cash Equivalents at End of Year	6	2,515	37,977	24,217	37,893	24,160

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

Statement of Contingent Liabilities and Assets

As at 30 June 201
Contingent Liabilities and Assets:
NDHB and group have no contingent assets or liabilities (2012: nil)

Statement of Commitments

As at 30 June 2013

	Group		Parent	
	2013	2012	2013	2012
	$000	$000	$000	$000
Capital Commitments	1,303	0	1,303	0
Intangible Commitments	779	0	779	0
Operating Lease Commitments				
Not more than one year	3,398	2,870	3,261	2,720
One to two years	1,925	2,278	1,925	2,141
Two to five years	1,056	2,073	1,056	2,073
Over five years	155	118	155	118
	6,534	7,339	6,397	7,052
Total Commitments	8,616	7,339	8,479	7,052

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

Northland District Health Board leases a number of buildings, vehicles and office equipment (mainly photocopiers) under operating leases. The leases run for various lengths of time depending on requirements (for buildings) and typically five 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 2013, $3,985,000 was recognised as an expense in the statement of financial performance in respect of operating leases (2012: $4,206,000).

Fixed Contracts
Northland District Health Board contracts with a wide variety of service providers with whom there are differing contractual terms. These are renegotiated periodically, reflecting the general principle that an ongoing business relationship exists with these providers. Included in the commitments total is only the actual contracted amount.

Demand-driven Contracts
Total commitments does not include demand-driven contracts as this expenditure is ultimately paid to individual consumers on a population or needs basis.

Notes to Financial Statements

1 Revenue

	Notes	Group		Parent	
		2013	2012	2013	2012
		$000	$000	$000	$000
Health and Disability Services (MoH Contracted Revenue)		502,997	486,845	502,997	486,845
ACC Contract		3,374	2,677	3,374	2,677
Inter District Patient Inflows		8,690	7,242	8,690	7,242
Other Revenue		4,498	5,549	4,915	5,997
		519,558	502,313	519,975	502,761

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

2 Infrastructure and Non-Clinical Expenses

	Notes	Group		Parent	
		2013	2012	2013	2012
Included in Infrastructure and Non-Clinical Expenses:		$000	$000	$000	$000
Impairment of Trade Receivables (Bad and Doubtful Debts)	7	(150)	99	(150)	99
Loss/(Gain) on disposal of Property, Plant and Equipment		(11)	(1,048)	(11)	(1,048)
Audit Fees paid to Audit New Zealand for Audit of Financial Statements		166	157	161	157
Board and Committee Member Fees and Expenses		305	320	305	320

Northland District Health Board pays the audit fee of the Kaipara Total Health Care Joint Venture on the joint venture's behalf. The fee was $5,000 (2012: $5,000)

3 Personnel Costs

	Group		Parent	
	2013	2012	2013	2012
	$000	$000	$000	$000
Wages and Salaries	179,131	173,192	179,131	173,192
Increase /(Decrease) in Employee Benefit Provisions	(369)	2,824	(369)	2,824
	178,762	176,016	178,762	176,016

4 Finance Income and Finance Costs
4a. Finance Income

	Group		Parent	
	2013	2012	2013	2012
	$000	$000	$000	$000
Interest Income	3,660	3,562	3,648	3,547

4b. Finance Costs

	Group		Parent	
	2013	2012	2013	2012
	$000	$000	$000	$000
Interest Expense	1,266	1,389	1,266	1,389

5 Capital Charge

The Northland District Health Board pays a capital charge every six months to the Crown. The charge is based on actual closing equity as at 30 June and 31 December each year. The capital charge for the year ended 30 June 2013 was 8% per annum (2012 8%).

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

	Group 2013 $000	Group 2012 $000	Parent 2013 $000	Parent 2012 $000
(a) Cash and Cash Equivalents				
Cash On Hand and at Bank	99	19,217	15	19,160
Cash on Deposit with Health Benefits Limited	37,878	0	37,878	0
Short Term Deposits with maturities less than 3 months	0	5,000	0	5,000
Total Cash and Cash Equivalents in the Statement of Cash Flows	37,977	24,217	37,893	24,160
(b) Short Term Deposits with maturities 4-12 months				
Short Term Deposits with maturities 4-12 months	260	260	0	0
Total Cash and Cash Equivalents, Short Term Deposits and Short Term Investments	38,237	24,477	37,893	24,160

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

	2013 Effective fixed interest rate %	2013 Actual $000	2012 Effective fixed interest rate %	2012 Actual $000
Short Term Deposits with maturities of 0-3 months:		0	3.74%	5,000
Short Term Deposits with maturities of 4-12 months:	4.00%	260	4.30%	260
Total Short Term Deposits		260		5,260

There were no impairment provisions for cash and cash equivalents

The carrying amounts of short term deposits approximate their fair value

(c) Reconciliation of surplus for the period with net cash flows from operating activities:

	Notes	Group 2013 $000	Group 2012 $000	Parent 2013 $000	Parent 2012 $000
Surplus for the Period	12	73	16	325	317
Add back Non-Cash Items:					
Depreciation And Assets Written Off		11,518	10,039	11,111	9,623
Add back items classified as Financing Activity:					
Movements in Working Capital:					
(Increase)/Decrease in Trade and Other Receivables		1,740	2,625	1,741	2,621
(Increase)/Decrease in Inventories		56	(89)	56	(89)
Increase/(Decrease) in Trade and Other Payables		(1,190)	(8,274)	(1,063)	(8,004)
Increase/(Decrease) In Employee Benefits		(369)	2,824	(369)	2,824
Increase/(Decrease) in Provisions		(1,648)	897	(1,648)	897
Net Movement in Working Capital		(1,411)	(2,017)	(1,283)	(1,751)
Items classified as investing and financing activities		0	0	0	0
Net Cash Inflow from Operating Activities		10,180	8,038	10,153	8,189

7 Trade and Other Receivables

	Group 2013 $000	Group 2012 $000	Parent 2013 $000	Parent 2012 $000
Trade Receivables from Non-related Parties	3,738	5,652	3,735	5,650
Ministry of Health Receivables	8,497	8,474	8,497	8,474
Less: Provision for Impairment	(185)	(335)	(185)	(335)
Balance at 30 June	12,050	13,791	12,047	13,789

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 Gross Receivable 2013 $000	Parent Impairment 2013 $000	Parent Gross Receivable 2012 $000	Parent Impairment 2012 $000
Not past due	11,631	61	3,481	67
Past due 0-30 days	373	41	10,080	1
Past due 31-60 days	27	3	143	24
Past due 61-90 days	8	1	129	2
Past due >91 days	196	152	291	241
Total	12,235	258	14,124	335

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

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

	Group 2013 $000	Group 2012 $000	Parent 2013 $000	Parent 2012 $000
Balance 1 July	335	236	335	236
Additional/(reduced) Provision during the year	(29)	128	(29)	128
Receivables written off during the period	(121)	(29)	(121)	(29)
Balance at 30 June	185	335	185	335

8 Investments

	Group 2013 $000	Group 2012 $000	Parent 2013 $000	Parent 2012 $000
Investment in Subsidiary (at cost)	0	0	1,762	1,762
Investment in Associate (at cost)	7,478	2,610	7,478	2,610
Bonds with maturities > 12 months	11,397	21,772	11,397	21,772
Balance at 30 June	18,875	24,382	20,638	26,144
Short Term Investments				
Bonds with maturities 0 - 12 months	10,021	14,967	10,021	14,967
Balance at 30 June	10,021	14,967	10,021	14,967

Investment in Subsidiary
General Information

Name of Entity	Principal Activity	Interest Held 2013	Interest Held 2012	Balance Date
Kaipara Total Health Care Joint Venture	Medical Centre Delivering Health Services	54%	54%	30 June

Investment in Associate
General Information

Name of Entity	Principal Activity	Interest Held 2013	Interest Held 2012	Balance Date
healthAlliance N.Z. Limited	The Operation of shared services for Northland, Waitemata, Auckland and Counties Manukau District Health Boards	20%	20%	30 June

On 29 June 2012 Northland District Health Board entered into a sale and purchase agreement to sell certain information technology and other related assets used by healthAlliance in the course of provision of services to Northland District Health Board. On 31 May 2013 $3,277,476 sale value of those assets was added to the carrying amount of the investment in healthAlliance. On 28 June 2013 Northland District Health Board acquired 1,590,665 Class C shares in healthAlliance for $1,590,665.

The movement in the carrying value of equity accounted investees is:

	Group 2013 $000	Group 2012 $000
Opening Balance	2,610	0
Investment in equity accounted investees	4,868	2,610
Share of profit after tax	0	0
Share of equity accounted investees' reserve movements	0	0
Closing Balance	7,478	2,610

The following amounts represent the aggregate assets, liabilities, revenue and profit of equity accounted investees:	As at and for the year ended 30 June 2013 $000	As at and for the year ended 30 June 2012 $000
Assets:		
Current assets	24,945	18,900
Non-current assets	60,615	42,553
Total assets	85,560	61,453
Liabilities		
Current liabilities	16,168	16,667
Non-current liabilities	3,038	2,962
Total liabilities	19,206	19,629
Net assets	66,354	41,824
Revenue	99,222	90,485
Expenses (including interest and tax)	99,222	90,485
Profit after tax	0	0

Bonds
Bonds are recognised at fair value. Fair value has been determined using quoted market prices in an active market.
Interest rates on the Bonds range from 4.775% to 7.5%

9 Inventories

	Group 2013 $000	Group 2012 $000	Parent 2013 $000	Parent 2012 $000
Pharmaceuticals	180	241	180	241
Surgical and Medical Supplies	3,868	3,863	3,868	3,863
Balance at 30 June	4,048	4,104	4,048	4,104

Write-down of Inventories to net realisable value amounted to $ NIL for 2013 (2012: $ NIL).

No Inventories are pledged as security for liabilities.

10 Property, Plant and Equipment

(a) Group

	Freehold land (at valuation) $000	Freehold buildings (at valuation) $000	Plant, equipment and vehicles $000	Work in progress $000	Total $000
Cost					
Balance at 1 July 2011	7,773	76,611	47,793	12,789	144,966
Additions	0	0	0	14,996	14,996
Disposals	0	(32)	(2,550)	0	(2,582)
Movement due to Revaluation	87	30,554	0	0	30,641
Reclassification of Land to Buildings	(275)	275	0	0	0
Transfer to Additions P,P&E	0	15,127	4,725	(19,852)	0
Balance at 30 June 2012	7,585	122,535	49,968	7,933	188,021
Balance at 1 July 2012	7,585	122,535	49,968	7,933	188,021
Additions	0	0	0	7,761	7,761
Disposals	0	(6)	(312)	0	(318)
Movement due to Revaluation	0	(558)	0	0	(558)
Sale of Assets to healthAlliance ex Work in Progress	0	0	0	(3,277)	(3,277)
Transfer to Additions P,P&E	0	4,413	4,196	(8,609)	0
Balance at 30 June 2013	7,585	126,384	53,852	3,808	191,629

	Freehold land (at valuation) $000	Freehold buildings (at valuation) $000	Plant, equipment and vehicles $000	Work in progress $000	Total $000
Depreciation and Impairment Losses					
Balance at 1 July 2011	0	12,392	34,896	0	47,288
Depreciation Charge for the year	0	6,191	3,651	0	9,842
Accumulated Depreciation Reversal on Revaluation	0	(18,569)	0	0	(18,569)
Disposals	0	(15)	(1,548)	0	(1,562)
Balance at 30 June 2012	0	0	36,999	0	36,999
Balance at 1 July 2012	0	0	36,999	0	36,999
Depreciation Charge for the year	0	6,661	4,701	0	11,362
Disposals	0	(1)	(349)	0	(350)
Balance at 30 June 2013	0	6,660	41,351	0	48,011

10 Property, Plant and Equipment *(Continued)*

	Freehold land (at valuation)	Freehold buildings (at valuation)	Plant, equipment and vehicles	Work in progress	Total
	$000	$000	$000	$000	$000
Carrying amounts					
At 1 July 2011	7,773	64,219	12,897	12,789	97,678
At 30 June 2012	7,585	122,535	12,969	7,933	151,022
At 1 July 2012	7,585	122,535	12,969	7,933	151,022
At 30 June 2013	7,585	119,724	12,501	3,808	143,618

10 (b) Parent

	Freehold land (at valuation)	Freehold buildings (at valuation)	Plant, equipment and vehicles	Work in progress	Total
	$000	$000	$000	$000	$000
Cost					
Balance at 1 July 2011	7,336	73,030	47,793	12,789	140,948
Additions	0	0	0	14,996	14,996
Disposals	0	(32)	(2,550)	0	(2,582)
Movement due to Revaluation	87	26,926	0	0	27,013
Transfer to Additions P,P&E	0	15,127	4,725	(19,852)	0
Balance at 30 June 2012	7,423	115,051	49,968	7,933	180,375
Balance at 1 July 2012	7,423	115,051	49,968	7,933	180,375
Additions	0	0	0	7,761	7,761
Disposals	0	(6)	(312)	0	(318)
Movement due to Revaluation	0	(558)	0	0	(558)
Sale of Assets to healthAlliance ex Work in Progress	0	0	0	(3,277)	(3,277)
Transfer to Additions P,P&E	0	4,413	4,196	(8,609)	0
Balance at 30 June 2013	7,423	118,900	53,852	3,808	183,983

	Freehold land (at valuation)	Freehold buildings (at valuation)	Plant, equipment and vehicles	Work in progress	Total
	$000	$000	$000	$000	$000
Depreciation and Impairment Losses					
Balance at 1 July 2011	0	11,556	34,896	0	46,452
Depreciation Charge for the year	0	5,773	3,651	0	9,424
Accumulated Depreciation Reversal on Revaluation	0	(17,315)	0	0	(17,315)
Disposals	0	(15)	(1,548)	0	(1,562)
Balance at 30 June 2012	0	0	36,999	0	36,999
Depreciation and Impairment Losses					
Balance at 1 July 2012	0	0	36,999	0	36,999
Depreciation Charge for the year	0	6,254	4,701	0	10,955
Disposals	0	(1)	(349)	0	(350)
Balance at 30 June 2013	0	6,253	41,351	0	47,604

	Freehold land (at valuation)	Freehold buildings (at valuation)	Plant, equipment and vehicles	Work in progress	Total
	$000	$000	$000	$000	$000
Carrying Amounts					
At 1 July 2011	7,336	61,474	12,897	12,789	94,496
At 30 June 2012	7,423	115,051	12,969	7,933	143,376
At 1 July 2012	7,423	115,051	12,969	7,933	143,376
At 30 June 2013	7,423	112,647	12,501	3,808	136,379

Impairment

No Impairments were recognised in the current year. (2012:$NIL was expensed)

Revaluation

Current Crown accounting policies require all crown entities to revalue land and buildings in accordance with NZIAS 16, Property, Plant and Equipment. Current valuation standards and guidance notes have been developed in association with the Treasury for the valuation of hospitals and tertiary institutions.

The revaluation of land and buildings was carried out as at 30 June 2012 by Peter Todd, an independent registered valuer of Darroch Limited and a member of the Property Institute of New Zealand. The valuations conform to International Valuation Standards and all land and buildings excluding work in progress have been valued at fair value. The valuer was contracted as an independent valuer. The next valuation is due to be completed by 30 June 2015.

Restrictions

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

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

No fixed assets of Northland District Health Board are pledged as security for liabilities.

11 Intangible Assets

Parent and Group

B Class Share in Health Benefits Ltd and Software

	HBL Shares 2013 $000	Software 2013 $000	Total 2013 $000	Software 2012 $000	Total 2012 $000
Cost					
Balance at 1 July	0	810	810	712	712
Software Additions for the Year	0	444	444	104	104
Acquisition of B Class Shares in Health Benefits Limited	1469	0	1,469	0	0
Disposals	0	0	0	(6)	(6)
Balance at 30 June	1,469	1,254	2,723	810	810
Amortisation					
Balance at 1 July	0	765	765	629	629
Amortisation Charge for the Year	0	156	156	197	197
Disposals	0	0	0	(61)	(61)
Balance at 30 June	0	921	921	765	765
Carrying Amounts					
Balance at 1 July	0	45	45	83	83
Balance at 30 June	1,469	333	1,802	45	45

There are no development costs accounted for as intangible assets.

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

12 Equity

	Group		Parent	
	2013 $000	2012 $000	2013 $000	2012 $000
General Funds				
Balance at 1 July	45,429	43,609	44,557	42,593
Distributions made	(119)	(144)	0	0
Capital Contribution	0	1,964	0	1,964
Balance at 30 June	45,310	45,429	44,557	44,557
Made up of:				
Parent	41,705	41,649	44,557	44,557
Non-controlling Interest	3,605	3,780	0	0
Retained Earnings/(Losses)				
Balance at 1 July	(3,241)	(3,238)	(1,219)	(1,517)
Surplus (Deficit)	73	16	325	317
Transfer to Trust Funds	(40)	(72)	(40)	(72)
Transfer from Trust Funds	91	53	91	53
Balance at 30 June	(3,117)	(3,241)	(843)	(1,219)
Reserves				
Revaluation Reserve				
Balance at 1 July	75,539	26,329	68,202	23,874
Revaluations	0	49,210	0	44,328
Other Movements	(533)	0	(533)	0
Balance at 30 June	75,006	75,539	67,669	68,202
Revaluation Reserve consists of:				
Land	6,238	6,239	6,038	6,039
Buildings	68,768	69,300	61,631	62,163
Total Revaluation Reserve	75,006	75,539	67,669	68,202
Fair value through other Comprehensive Income Reserve				
Balance at 1 July	767	932	767	932
Net Revaluation gains(losses)	(394)	(165)	(394)	(165)
Balance at 30 June	373	767	373	767
Total Reserves	75,379	76,306	68,042	68,969
Trust/Special Funds				
Balance at 1 July	707	728	707	728
Revaluation of Land	0	(40)	0	(40)
Transfer from Retained Earnings in respect of:				
Funds received	31	61	31	61
Interest received	9	11	9	11
Transfer to Retained Earnings in respect of:				
Funds spent	(91)	(53)	(91)	(53)
Balance at 30 June	656	707	656	707
Total Equity at 30 June	118,228	119,201	112,412	113,014

All trust funds are held in bank accounts that are separate from Northland District Health Board's normal banking facilities.

13 Trade and Other Payables

	Group 2013 $000	Group 2012 $000	Parent 2013 $000	Parent 2012 $000
Trade Payables to Non-Related Parties	3,085	4,108	3,085	4,108
Amounts Due to Related Parties	1,326	1,326	1,326	1,326
GST and PAYE Payable	4,731	3,876	4,723	3,860
Income in Advance relating to contracts with specific performance obligations	1,772	1,265	1,772	1,265
Capital Charge due to the Crown	0	442	0	442
Other Non-Trade Payables and Accrued Expenses	31,355	32,374	31,355	32,374
Total Trade and Other Payables	42,269	43,391	42,261	43,375

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

14 Interest-Bearing Loans and Borrowings

	Group 2013 $000	Group 2012 $000	Parent 2013 $000	Parent 2012 $000
Non-Current				
Secured Bank Loans	24,650	13,650	24,650	13,650
Crown Energy Efficiency Loan	58	134	58	134
	24,708	13,784	24,708	13,784
Current				
Secured Bank Loans	0	11,000	0	11,000
Crown Energy Efficiency Loan	76	76	76	76
	76	11,076	76	11,076
Total Interest-Bearing Loans and Borrowings	24,784	24,860	24,784	24,860

Secured Bank Loans

Northland District Health Board has secured bank loans with the New Zealand Debt Management Office (Formerly Crown Health Financing Agency). The details of terms and conditions are as follows:

Interest Rate Summary	2013 Actual	2012 Actual
New Zealand Debt Management Office (Formerly Crown Health Financing Agency) $1m facility	3.39%	3.39%
New Zealand Debt Management Office (Formerly Crown Health Financing Agency) $4m facility	3.35%	3.91%
New Zealand Debt Management Office (Formerly Crown Health Financing Agency) $4.5m facility	3.39%	3.39%
New Zealand Debt Management Office (Formerly Crown Health Financing Agency) $7m facility	2.94%	7.26%
New Zealand Debt Management Office (Formerly Crown Health Financing Agency) $8.15m facility	6.60%	6.60%
Energy Efficiency and Conservation Authority $0.134m (2012 $0.210m)	0.00%	0.00%

14 Interest-Bearing Loans and Borrowings *(Continued)*

Repayable as follows:	Group 2013 $000	Group 2012 $000	Parent 2013 $000	Parent 2012 $000
Within two years	8,284	11,152	8,284	11,152
Two to five years	7,000	8,208	7,000	8,208
Six to nine years	9,500	5,500	9,500	5,500
Total	24,784	24,860	24,784	24,860

15 Employee Entitlements

	Group 2013 $000	Group 2012 $000	Parent 2013 $000	Parent 2012 $000
Current Liabilities				
Liability for Long-Service Leave and Retirement Gratuities	3,063	1,997	3,063	1,997
Liability for Annual Leave	13,698	12,396	13,698	12,396
Liability for Sick Leave	312	511	312	511
Liability for Sabbatical Leave	33	52	33	52
Liability for Continuing Medical Education Leave	6,466	6,296	6,466	6,296
Salary and Wages Accrual	4,034	4,881	4,034	4,881
ACC Levy Payable	834	1,835	834	1,835
ACC Partnership Programme Liability	768	723	768	723
	29,207	28,691	29,207	28,691
Non-Current Liabilities				
Liability for Long-service Leave and Retirement Gratuities	12,996	13,665	12,996	13,665
Liability for Sabbatical Leave	1,034	1,232	1,034	1,232
Liability for Sick Leave	727	745	727	745
	14,757	15,642	14,757	15,642
Total Employee Entitlements	43,964	44,333	43,964	44,333

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

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

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

16 Provisions

	Group 2013 $000	Group 2012 $000	Parent 2013 $000	Parent 2012 $000
Balance at 1 July	1,848	951	1,848	951
Provision made during the year	0	983	0	983
Provision used during the year	(1,648)	(86)	(1,648)	(86)
Total Provisions	200	1,848	200	1,848

Provisions have been made for legal actions against Northland District Health Board.

17 Financial Instruments

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

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

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

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

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

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

		Group		Parent	
	Notes	2013	2012	2013	2012
		$000	$000	$000	$000
Cash on Hand and at Bank	6	99	19,217	15	19,160
Cash on Deposit with Health Benefits Limited	6	37,878	0	37,878	0
Cash Equivalents - Short Term Deposits	6	260	5,260	0	5,000
Bonds	8	21,418	36,739	21,418	36,739
Trade and Other Receivables	7	12,050	13,791	12,047	13,789
Total		71,705	75,007	71,358	74,688

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

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

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

	Notes	Carrying Amount	Contractual Cashflows	Less than 1 year	1-5 years	More than 5 years
		$000	$000	$000	$000	$000
Parent & Group 2013						
Secured Bank Loans	14	24,784	24,784	76	15,208	9,500
Provisions	16	200	200	200	0	0
Trade and Other Payables	13	42,269	42,269	42,269	0	0
Total		67,253	67,253	42,545	15,208	9,500
Parent & Group 2012						
Secured Bank Loans	14	24,860	24,860	11,076	8,284	5,500
Provisions	16	1,848	1,848	1,848	0	0
Trade and Other Payables	13	43,391	43,391	43,391	0	0
Total		70,099	70,099	56,315	8,284	5,500

17 Financial Instruments *(Continued)*

Market Risk
The interest rates on Northland District Health Board's Cash and Cash equivalents are disclosed in note 8 and 11
The Board has a series of policies providing risk management for interest rates and the concentration of credit. The Board is risk averse and seeks to minimise exposure from its treasury activities.
Its policies do not allow any transactions which are speculative in nature to be entered into.

Interest Rate Risk
Interest rate risk is the risk that the fair value of a financial instrument will fluctuate or the cash flows from a financial instrument will fluctuate, due to changes in market interest rates.
Northland District Health Board does not consider there is any significant exposure to the interest rate risk on its investments. They are limited to bank deposits and bonds, which are held over various terms. All borrowings are at fixed interest rates for the term of the loan.

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

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

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

At 30 June 2013, it is estimated that a general increase of one percentage point in interest rates would decrease Northland District Health Board's surplus before tax by approximately $240,000 (2012: $220,000).

	2013		2012	
	$000		$000	
Interest Rate Risk	-100 bps	+100 bps	-100 bps	+100 bps
Financial Assets				
Cash, Cash Equivalents and Bonds (non-current)	(370)	370	(360)	360
Financial Liabilities				
Secured Bank Loans	130	(130)	140	(140)
Total	(240)	240	(220)	220

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	
	2013	2012	2013	2012
Loans and Receivables	$000	$000	$000	$000
Trade and Other Receivables	12,050	13,791	12,047	13,789
Trust/Special Fund Assets	656	707	656	707
Cash and Cash Equivalents	37,977	24,217	37,893	24,160
Short-Term Deposits	260	260	0	0
Investment in Subsidiary	0	0	1,762	1,762
Investment in Associate	7,478	2,610	7,478	2,610
Fair Value through other Comprehensive Income				
Bonds	21,418	36,739	21,418	36,739
Financial Liabilities at Amortised Cost:				
Trade and Other Payables	42,269	43,391	42,261	43,375
Interest Bearing Loans and Borrowings	24,784	24,860	24,784	24,860

The following summarises the major methods and assumptions used in estimating the fair values of financial instruments reflected in the above table.

Interest-Bearing Loans and Borrowings
Fair value is calculated based on discounted expected future principal and interest cash flows.

Trade and Other Receivables / Payables
For receivables / payables with a remaining life of less than one year, the notional amount is deemed to reflect the fair value. All other receivables / payables are discounted to determine their fair value.

Fair Value Hierarchy Disclosures
For those instruments recognised at fair value in the statement of financial position, fair values are determined according to the following hierarchy:

- Quoted market price (level 1) - Financial instruments with quoted prices for identical instruments in active markets.

- Valuation technique using observable inputs (level 2) - Financial instruments with quoted prices for similar instruments in active markets or quoted prices for identical or similar instruments in inactive markets and financial instruments valued using models where all significant inputs are observable.

- Valuation techniques with significant non-observable inputs (level 3) - Financial instruments valued using models where one or more significant inputs are not observable.

Northland District Health Board holds Bonds measured at fair value in the statement of financial position, using quoted market prices (level 1). The fair value is $21,418k (2012: $36,739k).

18 Related Parties

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

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

	Group		Parent	
	2013	2012	2013	2012
	$000	$000	$000	$000
Salaries and Other Short Term Employee Benefits	2,467	2,323	2,467	2,323
Post-employment benefits	0	0	0	0
Other long-term benefits	0	49	0	49
Termination benefits	0	0	0	0
	2,467	2,372	2,467	2,372

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

Board and Advisory Committee Member Fees

Current Board Members	**2013**	**2012**
Anthony Norman (Chairperson)	$50,531	$50,636
Colin Kitchen	$24,478	$25,967
Craig Brown	$22,500	$23,000
Elizabeth (Libby) Jones	$23,103	$24,762
Greg Gent	$26,751	$27,242
John Bain	$22,693	$23,081
June McCabe	$21,950	$22,201
MC (Bill) Sanderson	$22,563	$24,670
Pauline Allan-Downs	$23,178	$23,286
Sally Macauley (Deputy Chairperson)	$32,970	$35,893
Sharon Shea	$22,990	$23,877

Former Board Members
-

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

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

	2013	2012
Mark Sears	$1,562	$2,475
Maureen Allan	$2,972	$3,547
Michael Roberts	$99	$1,500
Peter Jensen	$1,250	$2,750
Winfield Bennett	$1,525	$1,978
Beryl Wilkinson	$1,791	$2,303
John Wigglesworth	$0	$428
Erena Kara	$1,917	$0

Former Committee Members
-

18 Related Parties *(Continued)*

Board and Advisory Committee Members and Key Management Personnel

The table below sets out details of transactions with related parties entities, which are related entities by consequence of the positions in those entities of Board and Committee Members and Management team members of Northland District Health Board. We have included information on the types of transactions which occur between Northland District Health Board and the related entities. We have disclosed the total amounts transacted between Northland District Health Board and the balances outstanding at 30 June 2013.

Board and Advisory Committee Members and Key Management Personnel

Services provided to Related Parties 2013

Board and Advisory Committee Member	Related Party	Relationship	Transaction by NDHB	Expense $000's	Owed to $000's
Colin Kitchen	• Far North District Council	Council Member (Te Hiku Ward)	Health Inspection fees	44	-
John Bain	• The Order of St John	Chairman	ID Cards and Laundry services	34	3
	• Sport Northland	Board Member	Room Rental	1	-
John Wigglesworth	• Te Tai Tokerau PHO	Deputy Chairman	Rental of Premises	69	7
	• Hokianga Health Enterprise Trust	CEO	Stores purchases, Pharmacy and Ostomy	346	16
Libby Jones	• Kaipara Community Health Trust	Trustee (Removed 11/03/13)	Telehealth Equipment	2	-
	• Northland Orthopaedic Centre	Director	Laundry Services	2	1
MC (Bill) Sanderson	• Kensington Private Hospital	Shareholder	Stores Purchases, Laundry Services and Theatre Loan Items	59	4
Peter Jensen	• Arataki Ministries Ltd	Director	Room Rental and Meals on Wheels	3	-
Sally Macauley	• The Order of St John	Husband (Peter Macauley) Member, Kaikohe Area Chairman, Northern Region Trust Board	Stores Purchases and Laundry Services	34	3
	• Far North District Council	Councillor, Audit and Finance Committee, Economic Development Committee	Health Inspection fees	44	-
Tony Norman	• healthAlliance	Board Member	Shared Health Services Costs	2,120	282

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

Services provided to Related Parties 2012

The 2012 related parties disclosure have been restated to more accurately reflect the definition of related parties for disclosures. As such, certain Board and Committees members and Management Team member relationships with entities which do not reflect controlling interests in or significant influence over these entities have been removed to provide comparability with the current year disclosures.

Board and Advisory Committee Member	Related Party	Relationship	Transaction by NDHB	Expense $000's	Owed to $000's
Colin Kitchen	• Far North District Council	Council Member (Te Hiku Ward)	Health Inspection fees	295	-
John Bain	• The Order of St John	Chairman	Stores Purchases and Laundry	37	3
	• Sport Northland	Board Member	Room Rental	1	0.4
John Wigglesworth	• Te Tai Tokerau PHO	Board Member	Rental of Premises	58	-
	• Hokianga Health Enterprise Trust	CEO	Stores purchases and Pharmacy Issues	454	12
Maureen Allan	• Whakawhiti Ora Pai	Trustee	Stores Purchases and Laundry	10	2
MC (Bill) Sanderson	• Kensington Private Hospital	Shareholder	Stores Purchases and Laundry	62	8
Peter Jensen	• Arataki Ministries Ltd	Director	Mental Health Services	3	0.2
Sally Macauley	• The Order of St John	Husband (Peter Macauley) Member, Kaikohe Area Chairman, Northern Region Trust Board	Stores Purchases and Laundry	37	3
	• Far North District Council	Councillor, Audit and Finance Committee, Economic Development Committee	Health Inspection fees	295	-
Tony Norman	• healthAlliance	Board Member	Shared Health Services Costs	3,446	-

Executive Management Team	Related Party	Relationship	Transaction by NDHB	Expense $000's	Owed to $000's
Robert Paine	• The Kaipara Total Health Care Joint Venture	Board Member (Chair)	Maintenance and Management Contract, Distribution	371	-
Nicholas Chamberlain	• Sport Northland	Director	Room Rentals	1	0.4

Services provided from Related Parties 2013

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

Executive Management Team	Related Party	Relationship	Transaction by NDHB	Expense $000's	Owed to $000's
Margareth Broodkoorn	• College of Nurses Aotearoa	Board Member	Membership Fees	1	-
	• Northland Community Foundation	Trustee / Board Member	Outsourced Salaries and Supplies	101	-

18 Related Parties *(Continued)*

Nick Chamberlain	• Northland Rugby Union	Director	Health Promotion Campaign	20	-
	• Sport Northland	Director	Venue Hire, Green Prescription and Project Energise Agreements	260	23
Robert Paine	• The Kaipara Total Health Care Joint Venture	Board Member (Chair)	Lease of Building	550	-

Services provided from Related Parties 2012

Board and Advisory Committee Member	Related Party	Relationship	Transaction by NDHB	Expense $000's	Owed to $000's
Beryl Wilkinson	• Age Concern	President, Chair	Funding for Health of Older People Health Services Agreement	143	11
Colin Kitchen	• Far North District Council	Council Member (Te Hiku Ward)	Water Rates, Land Rates	108	-
	• Age Concern	Chairman (Age Concern Far North)	Funding for Health of Older People Health Services Agreement	143	11
	• Top Energy	Trustee	Power	1	-
Craig Brown	• Northland Regional Council	Chairman	Water rates, Training Courses and Inspection Fees	3	1
John Bain	• Northland Regional Council	Deputy Chairman	Water rates, Training Courses and Inspection Fees	3	1
	• Northland Emergency Services Trust	Chairman	Patient Transport by Helicopter	1,741	73
	• The Order of St John	Chairman	Air Services Paramedics, Venue Hire and Courses	877	16
	• Sport Northland	Board Member	Venue Hire and Healthy Action	112	1
Greg Gent	• Fonterra Co - Op Group	Director	Processed milk	177	14
John Wigglesworth	• Hokianga Health Enterprise Trust	CEO	Personal and Mental Health Services, Patient Care	5,663	663
	• Te Tai Tokerau PHO	Board Member	Funding for Health Services Agreement	15,136	240
Libby Jones	• Coast To Coast Hauora Trust	Trustee	Funding for Health Services Agreement	5	-
	• Coast To Coast Healthcare	Board Member	Respite Care Health Services Agreement	45	4
Maureen Allan	• Whakawhiti Ora Pai	Trustee	Funding for Maori Health Services Agreement and Clinical Training Fees	582	52
MC (Bill) Sanderson	• Northland Orthopaedics Ltd	Director	Clinical services	493	8
	• NZ Orthopaedic Association Trust	Chairman	Orthopaedic Hospital Post Quinquennial Inspection	1	-
	• Kensington Private Hospital	Shareholder	Surgical Procedures and Supplies	164	5
	• Northland Medical Museum Trust	Trustee	Medical Museum	38	-
Peter Jensen	• Arataki Ministries Ltd	Director	Mental Health Services	1,921	184
Sally Macauley	• The Order of St John	Husband (Peter Macauley) Member, Kaikohe Area Chairman, Northern Region Trust Board	Air Services Paramedics, Venue Hire and Courses	877	16
	• Far North District Council	Councillor, Audit and Finance Committee, Economic Development Committee	Water Rates, Land Rates	124	-
Tony Norman	• healthAlliance	Board Member	Delivery of Non-Frontline Transactional Support Services	7,717	1,824

Executive Management Team	Related Party	Relationship	Transaction by NDHB	Expense $000's	Owed to $000's
Margareth Broodkoorn	• College of Nurses Aotearoa	Board Member	Membership Fees	1	-
	• Northland Community Foundation	Board Member	Outsourced Salaries and Supplies	90	-
Nick Chamberlain	• Sport Northland	Director	Venue Hire and Healthy Action	112	1
Robert Paine	• The Kaipara Total Health Care Joint Venture	Board Member (Chair)	Lease of Building	550	-

18 Related Parties *(Continued)*

Associates
Northland District Health Board has a 20% shareholding in healthAlliance, a shared services organisation for Northland, Waitemata, Auckland and Counties Manukau District Health Boards. healthAlliance is owned jointly by these four DHBs and Health Benefits Limited. healthAlliance provides Northland DHB with delivery of non-frontline transactional support services.

Northland DHB Received $2,120k from healthAlliance in the financial year ended 30 June 2013 and Northland DHB paid healthAlliance $10,196k for the financial year ended 30 June 2013. Northland DHB owed healthAlliance $1,406k as at 30 June 2013. The $1,571k is made up of $245k worth of invoices, and the remaining $1,326k owed to hA is detailed below:

	$000
Assets transferred to healthAlliance 30.06.12	(276)
Depreciation charged to NDHB for use of the transferred assets	1,242
Employee Entitlements transferred to hA	160
Owed for Class A Shares issued	200
Composition of remaining $1,326k owed by NDHB to hA	1,326

There were no provisions for doubtful debts between these two entities.

Subsidiaries
Northland District Health Board has a 54% shareholding in The Kaipara Total Health Care Joint Venture, a medical centre delivering health services to the people of the Kaipara district, Northland, New Zealand. The Kaipara Total Health Care Joint Venture has a balance sheet date of 30 June.

The Kaipara Total Health Care Joint Venture has entered into the following lease and other contracts with Northland District Health Board:

Lease:
Northland District Health Board was granted a head lease of the Joint Venture property for a five year term with two rights of renewal of five years each. Annual rent is $550,000 plus GST, (2012: $550,000 plus GST), payable monthly in advance.

Maintenance, Administration and Management Contracts
Northland District Health Board is contracted to provide maintenance and administration for the Joint Venture. Annual Maintenance Contract is $247,500 plus GST (2012: $247,500 plus GST), payable monthly in advance. Annual Administration and Management Contract is $30,000 plus GST (2012: $30,000 plus GST).

The Kaipara Total Health Care Joint Venture made a distribution to Northland District Health Board of $139,050 (2012: $169,783) . No related party debts have been written off or forgiven during the year. The amount outstanding at year end was $nil (2012:$nil)

Significant transactions with Government-related entities
Northland District Health Board received funding from the Crown and ACC of $504,177k (2012 $489,372k) to provide health services to the Northland area for the year ended 30 June 2013.

Collectively, but not individually, significant, transactions with government-related entities
In conducting its activities, Northland District Health Board is required to pay various taxes and levies (such as GST, FBT, PAYE and ACC levies) to the Crown and entities related to the Crown. The payment of these taxes and levies other than income tax, is based on the standard terms and conditions that apply to all tax and levy payers. Northland District Health Board is exempt from paying income tax.

Northland District Health Board also purchases goods and services from entities controlled, significantly influenced, or jointly controlled by the Crown. Purchases from these government related entities for the year ended 30 June 2013 totalled $19,126k (2012 $14,104k). These purchases included the purchase of electricity from Meridian Energy, air travel from Air New Zealand, and postal services from New Zealand Post.

Other related parties
Health Benefits Limited is a related party as it has significant influence over the operating policies of the NDHB through an agreement. HBL was established as a Crown-owned Company in July 2010 with a mandate to help the health sector save money by leading initiatives which reduce administrative; support and procurement costs. Working with the DHB, it expects to deliver savings in these areas which will free up money to reinvest into clinical areas of DHBs. Northland DHB paid $478k to HBL (2012: $380k) and owes HBL $76k as at 30 June 2013. HBL paid NDHB $1,381k in Interest on deposit account (2012: NIL) and owed NDHB $362.5k interest as at 30 June 2013. There were no provisions for doubtful debts between these two entities.

Northland District Health Board is a party to the "DHB Treasury Services Agreement" between Health Benefits Limited (HBL) and the participating DHBs. This Agreement enables HBL to "sweep" DHB bank accounts and invest surplus funds. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with HBL, which will incur interest at the credit interest rate received by HBL plus an administrative margin. The maximum debit balance that is available to any DHB is the value of provider arm's planned monthly Crown revenue, used in determining working capital limits, is defined as one-12th of the annual planned revenue paid by the funder arm to the provider arm as denoted in the most recently agreed Annual Plan inclusive of GST. For Northland District Health Board that equates to $24,880k. In the terms the NZIFRS 7 disclosure requirements for the credit quality of the financial assets.

19 Termination Payments

For the year ended 30 June 2013 Northland District Health Board made a $10,000 termination payment to one employee. (2012: no payment)

20 Subsequent Events

There are no significant events subsequent to balance date.

21 Capital Management

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

22 Statement of Intent

Statement of Comprehensive Income by Output Class

For the year ended 30 June 2013	$000	$000	$000	$000	$000
	Intensive Assessment & Treatment	Early Detection & Management	Prevention	Rehabilitation & Support Services	Total
Revenue	296,630	130,909	20,630	64,294	512,463
Offsets	11,162	-	-	-	11,162
Total Revenue	307,792	130,909	20,630	64,294	523,625
Personnel Costs	130,742	17,311	5,372	6,704	160,129
Non Personnel Costs	98,620	9,336	1,719	5,836	115,511
Provider Payments	69,098	104,165	9,112	54,123	236,498
Offsets	11,162	-	-	-	11,162
Total Operating Expenditure	309,622	130,812	16,203	66,663	523,300
Surplus (Deficit)	(1,830)	97	4,427	(2,369)	325

23 Directions issued by Ministers

Northland District Health Board have not received any directions issued by Ministers during the year ended 30 June 2013.

24 Variance Analysis

Key Financial Information	Parent Actual 2013 $000	Parent Budget 2013 $000	Variance $000
	523,624	**515,391**	**8,233**

Operational Revenue

The increase in operational revenue against budget can be attributed to additional demographic funding from the Ministry of Health $7m, additional funding also included Electives, contribution to cost pressures and sundry Ministry of Health Initiatives. Interest income was favourable $902k to budget.

The revenue budget is based on the funding envelope advised by the Ministry of Health in December 2011 for the current financial year. Subsequent to this advice further funding was made available for the above additional services.

Operational Cost (including Capital Charge)	**523,299**	**515,391**	**7,908**

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

Total Assets (excluding cash, deposits and investment balances)	**155,070**	**135,638**	**19,432**

Total Assets (excluding cash, deposits and investment balances) are greater than budget, this is principally driven by the increased replacement cost of buildings in the revaluation as at 30 June 2012.

Total Liabilities (excluding loans)	**86,425**	**84,321**	**2,104**

Liabilities are not significantly different to budget.

Cash Resources (cash, deposits and investment balances)	**43,768**	**21,505**	**22,263**

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

Statement of Accounting Policies

For the year ended 30 June 2013

Reporting entity

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

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

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

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

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

Basis of preparation

Statement of compliance

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

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

Measurement Base

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

Functional and presentation currency

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

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

Critical accounting estimates and assumptions

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

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

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

Land and buildings revaluations

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

Long service leave and retirement gratuities

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

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

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

Leases classification

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

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

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

Changes in accounting policies

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

Early adopted amendments to standards

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

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

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

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

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

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

Basis for consolidation

Subsidiaries

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

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

Transactions eliminated on consolidation

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

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

Equity accounted Investees: Associates

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

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

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

Budget Figures

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

Foreign currency transactions

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

Property, plant and equipment

Classes of property, plant and equipment

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

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

Owned assets

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

Land and buildings are revalued to fair value as determined by an independent registered valuer every three years or where there is evidence of a significant change in fair value. The net

revaluation results are credited or debited to other comprehensive income and is accumulated to an asset revaluation reserve in equity for that class of asset. Where this would result in a debit balance in the asset revaluation reserve, this balance is not recognised in other comprehensive income but is recognised in the surplus or deficit. Any subsequent increase on revaluation that off-sets a previous decrease in value recognised in the surplus or deficit will be recognised first in the surplus or deficit up to the amount previously expensed, and then recognised in other comprehensive income.

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

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

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

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

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

Disposal of property, plant and equipment

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

Additions to property, plant and equipment

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

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

Leased assets

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

Subsequent costs

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

Depreciation

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

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

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

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

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

Borrowing costs

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

Intangible Assets

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

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

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

Subsequent expenditure

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

Amortisation

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

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

Impairment of property, plant and equipment and intangible assets

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

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

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

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

Financial Instruments

Non-derivative financial instruments

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

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

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

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

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

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

Financial assets at fair value through surplus or deficit

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

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

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

Fair value through other comprehensive income

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

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

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

Loans and receivables

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

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

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

Cash and cash equivalents

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

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

Interest-bearing loans and borrowings

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

Trade and other receivables

Trade and other receivables are initially recognised at fair value and subsequently stated at their amortised cost less impairment

losses. Bad debts are written off during the period in which they are identified.

Trade and other payables

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

Impairment

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

Loans and other receivables

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

Inventories

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

Cost is determined on an average weighted cost basis.

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

Interest bearing borrowings

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

Employee benefits

Defined contribution plan

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

Long service leave, sabbatical leave and retirement gratuities

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

Annual leave, conference leave and medical education leave

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

Sick leave

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

Provisions

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

Revenue relating to service contracts

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

Income tax

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

Goods and services tax

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

Revenue

Crown funding

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

Goods sold and services rendered

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

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

Rental income

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

Interest

Interest Income is recognised using the effective interest method.

Capital Charge

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

Expenses

Operating lease payments

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

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

Financing costs

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

Equity

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

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

Insurance Contracts

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

Contingent liabilities

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

Cost of Service (Statement of Service Performance)

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

Cost allocation

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

Cost allocation policy

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

Criteria for direct and indirect costs

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

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

Cost drivers for allocation of indirect costs

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

Comparative Information

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

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

Statement of Service Performance

Description of Output Classes

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

Prevention Output Class

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

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

Early Detection and Management Output Class

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

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

Key to the dots used in the SSP:

- Achieved
- Close to achievement
- Not achieved

Intensive Assessment and Treatment Output Class

These services use *specialist* clinical expertise and equipment. They are either located on hospital sites or use hospitals as the base from which to provide services in the community. Includes:

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

Rehabilitation and Support Output Class

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

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

Output Class: Prevention

Impact	Tobacco: lower prevalence of smoking-related conditions	
Impact measure ***[& type]***	Proportion of Year 10 students who have never smoked *[coverage]*	
Baseline 2011	**Target 2012/13**	**Result 2012/13**
Total Y10 61.4%	65.0%	63.0% ●
Trend		

Notes

Never-smoking rates among Year 10s continue to increase. Along with efforts to assist adult smokers to stop (as well as government policy decisions such as increasing the price of cigarettes), it augurs well for steady declines in smoking rates in the population.

There is however anecdotal evidence that though smoking rates are dropping for those in their mid-teens, many youth are starting smoking after that age.

Data only extends to the end of the 2012 calendar year because Action on Smoking and Health conduct the Year 10 survey only once during each school year, and the results are not available until the middle of the following year.

Impact	*Healthy children:* reduced likelihood of acquiring long term conditions later in life	
Impact measure ***[& type]***	Northland mothers who breastfeed fully and exclusively at 6 weeks *[coverage]*	
Baseline 2010/11	**Target 2012/13**	**Result 2012/13**
Māori 68% Total 72%	78% 78%	67% ● 72% ●
Trend		

Notes

Rates for both Māori and total population continue to be below target. They have fallen even further behind in 2012 through a combination of a higher target and slight drop-off in performance.

Data is for Plunket only; it does not include Tamariki Ora (well child) providers. The nature of the data from Plunket and Tamariki Ora providers means it can't be added together, and one of the latter four providers is yet to supply data.

Breastfeeding data has in the past been required by MoH only once a year, but the data is no longer part of the national quarterly reporting requirements. The once-a-year requirement means that 2013 data is not due to be produced until 2014.

Breastfeeding is a key measure of infant health so Northland DHB will attempt to establish a reliable and comprehensive data system during 2013/14. We will be working with all the Māori providers throughout the year to require them to supply their denominator populations. Ideally we would add their numbers to Plunket's to generate an overall breastfeeding figure for Northland, but we have been unable to obtain numerical data from Plunket. We will continue to work on obtaining the latter, but until then the above approach will cover the whole population, albeit with two separate percentages.

Impact	Healthy children: lower incidence of communicable disease	
Impact measure ***[& type]***	% of eight-month-olds who are fully immunised *[coverage] [Health Target]*	
Baseline 2011	**Target 2012/13**	**Result 2012/13**
Māori n/a Total n/a[1]	85% 85%	81% ● 83% ●
Trend		

Notes

Northland DHB has made considerable progress in the last year, rising from 71% in July 2012 to our current level of 83%.

This is directly attributable to achieving 39/50 actions in our Immunisation Action Plan during this time. Further improvement is anticipated as we complete the remaining actions and strengthen our collaboration with our partners in primary care.

Impact	Cancer: if curable, increased likelihood of survival; if incurable, reduced severity of symptoms	
Impact measure ***[& type]***	Breast cancer screening in eligible populations *[coverage]*	
Baseline Jul 2011-Jun 2012	**Target Jul 2012-Jun 2013**	**Result 2012**
Māori 73.7% Non-M 74.6% Total 74.4%	70% 70% 70%	72.2% ● 74.6% ● 74.0% ●
Trend		

Notes

Performance continues to be above target. The slight drop-off in performance is due to problems in staffing the mobile service which is run by Waitemata DHB.

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

The targets and data in past years' published SSPs were artificially generated to fit with the SSP's normal one-year reporting period. However they did not reflect the real world of breastscreening practice and were difficult to understand and interpret. This year's SSP revises the original targets – Māori 73.6%, total 75.4% (there was no non- Māori target) – as a basis for more rational comparison now and in the future.

[1] No baseline data was available at the time of writing because the 8-month target applied only from July 2012 (previously it related to two-year-olds). It has proved impossible to extract old 8-month data from the National Immunisation Register software.

Impact	Cancer: if curable, increased likelihood of survival; if incurable, reduced severity of symptoms		Notes
Impact measure *[& type]*	Cervical cancer screening in eligible populations *[coverage]*		During 2011/12 N Northland DHB devolved responsibility for Cervical Screening Coordination, plus the associated funding, to primary care. Free smears were then introduced for priority group women in all general practices in Northland. Some improvement in performance has been seen, though not to the level anticipated. The 80% target is a challenge for all DHBs and the performance of Northland DHB is comparable with that of other DHBs.
Baseline 2008 – 2011	**Target 2012/13**	**Result 2012/13**	
Total pop. 75.3%	80%	Māori 68.4% ● Total 76.0% ●	
Trend			Northland DHB, together with Northland PHOs, the Ministry and clinical advisors continues to review how cervical screening services can be optimised to maximise patient coverage. Following recommendation from an expert advisory group, a new service model is to be developed based upon the following principles: • access: consideration to be given to cost, opening hours, childcare, transport, environment • messaging and health literacy • cultural humility: use of appropriate language and cultural nuances • workforce development: ensure a culturally and clinically skilled workforce • practice plans: to enable general practices to understand their populations and to support engagement • education of local populations: to increase understanding of the reasons for the procedure.

Output Class: Early Detection and Management

Impact	Tobacco: lower prevalence of smoking-related conditions		Notes
Impact measure *[& type]*	Proportion of the Northland population who smoke daily *[coverage]*		For population smoking rates, Northland DHB currently relies on the MoH's NZ Health Survey but the latest Northland data applies to 2006/07. 2011/12 data has just been released, but has been made available at the DHB level only for the seven largest DHBs.
Baseline 2006/07	**Target 2012/13**	**Result 2012/13**	
Māori 47.8 Total pop. 22.1	46.8% 21.1%	n/a *(see text below)*	Though there have been delays in obtaining current data for Northland for this measure, it is being retained because that problem will soon be remedied and it is one of the fundamental indicators of the health of our population.
Trend			

Impact	Tobacco: lower prevalence of smoking-related conditions		Notes
Impact measure *[& type]*	Proportion of smokers in primary care provided with advice and help to quit *[coverage] [Health Target]*		The 54.4% annual average performance for 2012/13 hides a significant and consistent improvement over the four quarters of 38.4%, 51.8%, 55.6% and 71.6%. This is a result of a concerted approach between the PHOs' Clinical Director and general practices to meet the Health Target.
Baseline 2011/12 Q2	**Target 2012/13**	**Result 2012/13**	
Total pop. 40.5%	95%	54.4% ●	The data reported by general practices is subject to rigorous checks to ensure its accuracy. PHOs submit the data to MoH which performs its own quality controls, then returns the data to the PHOs for verification.
Trend			(Note: the 57.0% baseline in the published SSP was the Q4 end-of-year figure, now no longer used for reporting. It has been revised to the annual average of 40.5%.)

Impact	Healthy children: healthier teeth and gums	
Impact measure *[& type]*	Five-year-olds who are caries-free *[quantity]*	
Baseline 2011	Target 2012/13	Result 2012/13
Māori 20%	55%	23.9% ●
Total 35%	55%	38.8% ●

Trend

Notes

As noted last year, the oral health service has undergone significant changes in the last four years which are now almost complete. Community oral health facilities have been reconfigured to a 'hub and spoke' model (major clinic hubs supported by smaller satellite clinics and mobile services). Services for 0-17 year olds have been redesigned according to a community-based whanau ora approach, which has included changes to the existing School Dental Service and transfer of some services to other providers. The adolescent service has been rebuilt and is expanding.

The focus of the service now is on preventive approaches to help improve the number of decay-free five year olds, particularly in Māori . The service has begun working closely with Māori health providers and their kaimahi to encourage parents and caregivers to enrol their babies and preschoolers as early as possible with oral health services in Northland DHB.

Data is normally reported for each calendar year because that matches school years, so 2013 data will not be available until 2014.

Impact	Healthy children: healthier teeth and gums	
Impact measure *[& type]*	Average number of decayed, missing or filled teeth (DMFT) among Year 8 students *[quantity]*	
Baseline 2011	Target 2012/13	Result 2012/13
Māori 3.19%	1.12	2.35 ●
Total 2.30%	1.12	1.68 ●

Trend

Notes

The oral health service has undergone significant changes in the last four years, as described under the above indicator.

The focus of the service now is on preventive approaches to help decrease DMFT numbers, particulary in Māori . The service has begun working closely with Māori health providers and their kaimahi to encourage parents and caregivers to enrol their babies and preschoolers as early as possible with oral health services in Northland DHB.

Data is normally reported for each calendar year because that matches school years, so 2013 data will not be available until 2014.

Impact	Long term conditions: Amelioration of disease symptoms and/or delay in their onset	
Impact measure *[& type]*	Of those estimated to have diabetes, % who have had a Diabetes Annual Review *[coverage]*	
Baseline 2011/12 Q2	Target 2012/13	Result 2012/13 (annual avg.)
Māori 73%	80%	70.9% ●
Total 69%	80%	63.8% ●

Trend

Notes

Last year's commentary noted that the previous free diabetes annual review programme was to cease and be replaced by the Diabetes Care Improvement Package (DCIP) and it was predicted that this change may affect annual checks. Nationally it would appear that the change has negatively impacted on the number of reviews done, but overall performance in Northland has remained reasonably high. The actual number of reviews has increased from 5,081 during 2011/12 to 5,965 during 2012/13. However during the same timeframe there has also been an increase in the estimated population of those with diabetes, from 7,831 to 8,901. Thus although an additional 884 reviews were done during 2012/13, proportionally performance has not significantly increased.

Impact	Long term conditions: Amelioration of disease symptoms and/or delay in their onset	
Impact measure *[& type]*	Of people with diabetes receiving Diabetes Annual Reviews, % with good blood sugar management *[coverage]*	
Baseline 2011/12 Q2	Target 2012/13	Result 2012/13 (annual avg.)
Māori 59%	80%	64.1% ●
Total 70%	80%	72.8% ●

Trend

Notes

Performance remains stable, though below the national performance target. However, given that primary care diabetes services are in transition to the new Diabetes Care Improvement Package (DCIP), it is pleasing to see that this transition has not had any associated reduction in coverage, which may have been anticipated.

DCIPs are now in place within general practice and include the development of a practice action plan to ensure progress is made in the delivery of care to all patients with diabetes.

Other supports such as self-management programmes, support groups, supermarket tours, healthy kai and activities are also available on a location-by-location basis.

Impact	Long term conditions: Amelioration of disease symptoms and/or delay in their onset	
Impact measure *[& type]*	Of people in eligible populations, those who have had a CVD risk assessment in the last five years *[coverage [Health Target]]*	
Baseline 2011/12 Q3	**Target 2012/13**	**Result 2012/13**
Māori 53%	75%	63.0% ●
Total 54%	75%	68.6% ●

Trend

Notes

Very good progress demonstrated against this indicator with an overall performance of 68.6% (national average was 58.9%). Although the target for Māori has not been met, it is noted that no other DHBs have achieved this either. The average national performance for Māori was 63.0%, compared to Northland's 57.5%.

The target for 2013/14 is 90%. As the PHOs work towards this they will need to reach those members of the eligible population who do not regularly have contact with primary care. This will be a hard group to reach. PHOs will be assisted in reaching the CVD risk assessment target for this population, utilising additional funding that has been provided specifically for this purpose.

This year data is presented quarterly because the current indicator definition (actual assessments peformed) has been in place only since 2011/12 Q3, so whole-year results would not be appropriate. Prior to that a proxy measure involving particular laboratory tests was used, so its data is not comparable.

- *(Note that the published 2012/13 SSP incorrectly recorded the target as 70%.)*

Impact	Mental disorders: improved quality of life for both clients and their families; acute episodes are minimised, clients achieve greater stability in their condition	
Impact measure *[& type]*	Number of referrals from GPs to Primary Mental Health Initiative Coordinators *[quantity]*	
Baseline 2010/11	**Target 2012/13**	**Result 2012/13**
All clients 1,838	1,838	2,470 ●

Trend

Notes

As a result of a number of suicides in Northland in recent times, there has been heightened awareness in the population about seeking assistance early, and this has resulted in growth in demand for primary care services. These deal with mild to moderate mental health disorders and are provided by counsellors and psychologists in the community. The primary care growth parallels the increase in demand for specialist (hospital-level) mental health services described under the next Output Class.

GPs comprise the majority of referrers to primary mental health services. Reporting systems at present do not permit separate counting of GP referrals. The 2,470 clients reported above counts all referrals to primary mental health services, the large majority of which are from GPs. Accuracy will improve in the future because the PHOs are now fully utilising their e-referral system.

Output Class: Intensive Assessment and Treatment

Impact	Tobacco: lower prevalence of smoking-related conditions	
Impact measure *[& type]*	Percent of smokers admitted to hospital given advice and help to quit *[coverage] [Health Target]*	
Baseline 2011/12 Q2	**Target 2012/13**	**Result 2012/13 (annual avg.)**
Māori 84%	95%	97.1% ●
Total 84%	95%	97.3% ●

Trend

Notes

Target has been exceeded in all four quarters for all ethnic groups (except for 94.8% for non- Māori in Q1).

A steady increase in the number of smokers given advice and support to stop smoking during 2012/13 was due to a concerted effort with staff training, the implementation of systems to support staff in addressing and recording smoking, and a commitment from senior management. Improvements in processes in the Emergency Department and Surgical Admission Unit, two high volume short-stay areas, have seen Northland DHB reach and continue to exceed the 95% target since Q2 2012/13.

To ensure data quality, monthly audits on event coding are performed and there are spot audits on wards. To keep performance high, feedback on results is given monthly to services and managers. If necessary, discussions are held with wards on the need to improve results. All clinical staff who join Northland DHB receive education on how to go about the process of offering advice and help, and to explain Northland DHB policies on Smokefree and Nicotine Replacement Therapy.

Impact	Healthy children: safer children	
Impact measure *[& type]*	Referrals to CYFS of children suspected of being abused *[quantity]*	
Baseline 2011	**Target 2012/13**	**Result 2012/13**
Total 217	225	429 ●

Trend

Notes

Performance continues to exceed target.

The large jump in numbers is due to good consistent reporting by staff as a result of continued awareness-raising among staff by the Child Protection Service. It has also been influenced in recent months by the large sexual abuse case in Kaitaia with disclosures from children and youth following the arrest of the Deputy Principal at Pamapuria Primary School.

Impact	Cancer: if curable, increased likelihood of survival; if incurable, reduced severity of symptoms			Notes
Impact measure ***[& type]***	People diagnosed with cancer who receive radiation treatment within four weeks of the decision to treat *[timeliness] [Health Target]*			Target continues to be met. All radiotherapy treatment for Northlanders occurs in other DHBs, mainly Auckland. Patients are referred by their GPs and receive a First Specialist Assessment including investigations to aid diagnosis and treatment plans. Subsequently a Multi-Disciplinary Team (MDT) meeting is held at which individual patients are discussed by a range of clinical specialists from Northland DHB and other DHBs and a plan of care is decided on. This is the "decision-to-treat" date. Data is extracted from electronic FCT forms that track steps in the process, and details are verified from electronic letters and other material available in Northland DHB's Concerto software.
	Baseline 2011/12 Q2	**Target 2012/13**	**Result 2012/13**	
Māori	100%	100%	100% ●	
Total	100%	100%	100% ●	
Trend				

%receiving radiation therapy (chart; legend: Total patients, Target; y-axis 50%–100%; x-axis 2009/10, 2010/11, 2011/12, 2012/13)

Impact	Cancer: if curable, increased likelihood of survival; if incurable, reduced severity of symptoms			Notes
Impact measure ***[& type]***	People diagnosed with cancer who receive chemotherapy within four weeks of the decision to treat *[timeliness] [Health Target]*			Target continues to be met. Unlike radiotherapy, most chemotherapy treatment occurs in Whangarei (except where it is provided alongside radiotherapy in other DHBs). Patients are referred by their GPs and receive a First Specialist Assessment, often accompanied by investigations to aid diagnosis and treatment plans. Subsequently a Multi-Disciplinary Team (MDT) meeting is held at which individual patients are discussed by a range of clinical specialists from Northland DHB and other DHBs and a plan of care is decided on. This is the "decision-to-treat" date. Patient data is extracted from Northland DHB's Alpha software. End-of-day reports provide data on all events associated with a patient's treatment, including decision to treat and waiting times.
	Baseline 2011/12 Q2	**Target 2012/13**	**Result 2012/13**	
Māori	100%	100%	100% ●	
Total	100%	100%	100% ●	
Trend				

% receiving chemotherapy (chart; legend: Total patients, Target; y-axis 50%–100%; x-axis 2009/10, 2010/11, 2011/12, 2012/13)

Impact	Mental disorders: improved quality of life for both clients and their families; acute episodes are minimised, clients achieve greater stability in their condition			Notes
Impact measure ***[& type]***	Proportion of people with enduring mental illness aged 20-64 who are seen over a year *[coverage]*			Performance continues to exceed target. The increase in access rates is a reflection of the increased prevalence of mental illness in those under 25 years. Research suggests this may well be linked to economic and social pressures in the community. This, combined with the higher visibility of mental health services tailored to youth and young adults, has made services both more accessible and more accessed.
	Baseline 2011/12 Q2	**Target 2012/13**	**Result 2012/13**	
Māori	7.34%	7.34%	9.02% ●	
Total	4.71%	4.71%	5.37% ●	
Trend				

% seen by DHB mental health services (chart; legend: Maori, Non-Maori, Total, Target Maori, Target non-Maori, Target total; y-axis 0%–10%; x-axis 2010/11 Q2, Q4, 2011/12 Q2, Q4, 2012/13 Q2, Q4)

This indicator is reported only every 6 months. Data for non-Maori is collected by NDHB but has not been required by MoH for reporting since 2011/12 Q2.

Impact	Elective surgery: fewer debilitating conditions; delayed onset of long term conditions				Notes
Impact measure ***[& type]***	Increase in the number of elective services discharges *[quantity] [Health Target]*				Consistently above target. In electives, Northland DHB is one of the best performing DHBs. Our rankings in 2012/13 are: Q1 fifth, Q2 first, Q3 first, Q4 first. *Note: the 2,264 additional elective surgery discharges for 2011/12 was a misprint; it should have read 1,464 and the target total should have been 7,120.*
	Baseline 2011/12 forecast		**Target 2012/13**	**Result 2012/13**	
Base	4,734		4,821	4,821	
Additional	2,386		1,613	3,142	
Total	7,120		6,434	7,963 ●	
Trend					

Number of procedures (chart; legend: Additional, Base, Target total; y-axis 0–9,000; x-axis 2008/09, 2009/10, 2010/11, 2011/12, 2012/13)

Impact	Emergency Department (ED) waiting times: more timely assessment, referral and treatment		Notes
Impact measure *[& type]*	Patients with an ED length of stay (time from presentation at ED to either admission to hospital, discharge home or transfer to another facility) of less than six hours *[quality] [Health Target]*		Despite a 5.7% increase in patient volumes since 2010/11 (compared to projected population growth over the same period of 0.9%), performance in 2012/13 has improved from 2011/12's annual average of 90%. However it has not quite reached target in any quarter. High volumes during the peak period 11am-10pm are resulting in the Emergency Department working beyond capacity. Improvements in ED have included changes in staffing rosters, overlapping of medical handover, extra staff appointed, redesign of clinical pathways for some conditions, and standardising procedures within ED. Further work is being done on the after-hours medical roster to manage the high volume of medical patients. Planning for a new ED is still underway. Appointment of a new Clinical Head of Department is imminent.
Baseline 2011/12 Q2	Target 2012/13	Result 2012/13 (annual avg.)	
Total pts. 87%	95%	93.1% ●	
Trend			

Impact	Quality and safety: more satisfied patients		Notes
Impact measure *[& type]*	Number of complaints to Northland DHB per patient event *[quality]*		Target continues to be achieved. The Complaints Policy guides staff in responding to complaints. Complainants are acknowledged within five working days of receipt and all attempts are made to have a final response to them within 20 working days according to the Health and Disability Commissioner's Code of Rights. If there is a delay in getting a final response, a progress letter is sent advising of the delay. Reports are run monthly to show any trends. If a complaint follows an adverse event, the results of the Root Cause Analysis process will indicate any recommendations to be followed up.
Baseline 2011/12	Target 2012/13	Result 2012/13	
Total pts. 0.12%	0.2%	0.1% ●	
Trend			

Impact	Quality and safety: more satisfied patients		Notes
Impact measure *[& type]*	Complaints to Northland DHB closed within 20 working days *[quality]*		A longer process in achieving final resolution of complaints in Clinical Services, one of the larger services, is behind the downturn on the graph. That was partly because of the complexity of Clinical Service's complaints, but also because they had added another layer of staff for complaints to go through. The process has now been revised with the General Manager having more input to ensure responses to complaints are made in a timely manner.
Baseline 2011/12	Target 2012/13	Result 2012/13	
Total pts. 75%	80%	58.9% ●	
Trend			

Impact	Quality and safety: more satisfied patients		Notes
Impact measure *[& type]*	Health and Disability Commission (HDC) complaints that result in a finding of breach of the Code *[quality]*		The result presented for 2012/13 actually applies to 2010 because the outcomes of those cases were not announced by HDC until this year. Potential breaches that occureed in 2012/13 are still being considered by the Commission. Complainants may take one of several paths. They often copy their complaint to the Health and Disability Commissioner (HDC) at the same time it comes to Northland DHB, or because they feel they have had an unsatisfactory response to their complaint from Northland DHB. They may also resolve the matter through direct contact with the DHB without making a formal complaint, or Northland DHB may advise them to go to HDC if we feel we have made a good attempt at resolving their issues.
Baseline 2011	Target 2012/13	Result 2012/13	
Total pts. 8%	8%	5% ●	
Trend			

Impact	Fewer adverse clinical events	
Impact measure ***[& type]***	Surgical site infections (SSIs) *[quality]*	
Baseline 2011	**Target 2012/13**	**Result 2012/13**
Total pts. <2%	<2%	Cat. 1 0.8% ● Cat. 2 0.5% ●

Trend

Target has been set at 2.0% for both categories.

Notes

Target continues to be achieved.

Northland DHB reports on two categories that are clearly defined internationally: Category 1, clean surgery (most orthopaedic and limited general surgery) and Category 2, clean-contaminated (surgery where controlled conditions are required for surgery because of the inherently higher risk of infection).

The Infection Prevention and Control (IPC) team review on a daily basis all patients who have had surgery, specifically looking for any clinical signs of infection.

Suspected SSIs will be reviewed again in relation to the definition and criteria to be applied before they are confirmed. In cases where there maybe some doubt, consultation with the Northland DHB Clinical Microbiologist is sought for confirmation. Once confirmed all SSIs are entered into a spreadsheet by the IPC Clinical Nurse Specialist. From this data control charts are produced and presented to the Infection Control Committee every two months. Any trends beyond acceptable limits are investigated by IPC and Clinical Microbiologist.

Impact	Fewer adverse clinical events	
Impact measure ***[& type]***	Hand hygiene compliance *[quality]*	
Baseline 2011	**Target 2012/13**	**Result 2012/13**
Total pts. 60%	70%	70.5% ●

Trend

Target has existed only since 2011; earlier data is provided for comparison.

Notes

Target continues to be achieved.

The National hand hygiene project is based on the World Health Organisation guidelines on Hand Hygiene in Health Care (2006) which currently falls under the Health Quality and Safety Commission.

At the introduction of the Hand Hygiene New Zealand (HHNZ) campaign in 2009, the national baseline for hand hygiene compliance was below 70%. Targets were therefore set for 70% initially and incrementally raised annually as the culture of hand hygiene was embedded and compliance increased. The new health quality marker is 90% which is also what Northland DHB has set for the future.

Northland DHB has three Gold Auditors who are required to confirm their auditor status annually and are independently assessed to ensure consistency.

Based on Northland DHB's total bed numbers, we are required to audit five areas, three times a year, observing 350 hand hygiene "moments" in each area for the national project. Other high risk areas within Northland DHB, including district hospitals, are audited as time permits. Data isentered onto either an iPhone or a manual data collection sheet and then onto the webpage and sent to HH Australia where all the data is collated. Reports can be generated for each area audited confirming compliance rates which can be accessed immediately. These reports are given to the wards so their compliance rates and progress are monitored. Northland DHB's compliance rate is benchmarked against all other DHBs within New Zealand. The compliance rates have been anonymised until the most recent audit period, the first time DHBs were named (previous to that data was anonymised).

Output Class: Rehabilitation and Support

Impact	Quality assessment and Home Based Support Services (HBSS) lead to a reduction in the need for hospitalisation and residential care	
Impact measure ***[& type]***	95% of long-term HBSS clients entitled to an interRAI assessment will receive one *[coverage]*	
Baseline Jun 2012	**Target 2012/13**	**Result 2012/13**
HBSS clients 17%	50%	60% ● (●)

Trend

Notes

At the time this target was set, 95% was the national expectation. In Northland 2,500 people receive HBSS services, and Northland DHB advised MoH that it did not have sufficient assessment capacity to meet the 95% target within one year (Northland DHB's baseline as at June 2012 was 17%). The MoH requested each DHB to set a realistic target so that we are transparent about the target from the start, rather than have to explain why we failed to reach the target, which it negotiated with each DHB individually. The target agreed on between Northland DHB and MoH changed to 50%, on the understanding that all *new* long term clients will receive an interRAI assessment during the year.

This measure is calculated based on data that is one quarter in arrears, in accordance with MoH reporting guidelines. It is pleasing to note Northland DHB achieved 60% coverage as at 31 March 2013, and has therefore exceeded the 50% target. In future years the target will rise: 70% in 2013/14, 80% in 2014/15 and 95% in 2015/16.

We are currently working with Northern Region DHBs to develop a system for northern region shared reporting, which will help us to benchmark our performance in the northern region.

Impact	Support for older people: older people requiring support or care receive services appropriate to their needs	
Impact measure ***[& type]***	Rising % of Home Based Support Services (HBSS) provided to older people who have higher support needs *[coverage]*	
Baseline 2011	**Target 2012/13**	**Result 2012/13**
Household 38% Personal 62%	36% 64%	33.4% 66.6% ●

Trend

Notes

Target continues to be achieved.

HBSS resources are used more effectively if they are focused on those with higher needs, which in the case of HBSS means prioritising services for people who have personal care and supervision related needs (rather than on people with low support needs who only want cleaning services). This is a proxy measure of support services increasingly meeting the needs of clients with complex needs who live in the community.

Northland DHB has changed its eligibility criteria for a needs assessment. People now need to have an age-related disability which is likely to continue for a minimum of six months and result in a reduction of independent function to the extent that ongoing support is required and require help with showering, dressing or toileting or assistance or supervision with eating and drinking.

Focusing on supporting people who have higher needs will enable more older people to remain in their own homes for longer ('age in place'), thus supporting the expressed desires of the majority as well as aligning with national policy. This will reduce or delay demand for rest homes, which are more expensive than home-based support services.

Output Class: Rehabilitation and Support

Impact	Support for older people: older people requiring support or care receive services appropriate to their needs			Notes
Impact measure *[& type]*	Increasing percentage of Age-Related Residential Care (ARRC) providers achieving certification for three or more years *[quality]*			The results of integrated certification/ ARRC contract audits are the best measurement we have for the quality of services delivered by ARRC providers. In the last couple of years MoH's requirements on auditing agencies and the audits they produce have become more rigorous as a result of the OAG report *Effectiveness of arrangements to check the standard of services provided by rest homes*[2]. The new certification environment has resulted in significant changes for some ARRC providers, and improvements in the quality of auditing. As a result several providers in Northland in the past year have had their certification period reduced. However in the long run this will result in higher quality services. Northland DHB has a role in supporting and monitoring facilities to address any corrective actions arising from the audits.
Baseline Dec 2011		**Target 2012/13**	**Result 2012/13**	
ARRC providers	63%	70%	50% ●	
Trend				
Chart: % ARRC providers with 3 or 4 year certification (0%–100%); May 2011, Mar 2012, Jun-13; legend: % providers with 3 or 4 year certification; Target				

Impact	Support for older people: older people requiring support or care receive services appropriate to their needs			Notes
Impact measure *[& type]*	Number of respite care bed days utilised *[coverage]*			Total funded bed days in 2012/13 were 4,362 which exceeds target, but only 3,629 were actually utilised by clients and their families. This was because demand for respite care beds decreased due to factors beyond Northland DHB's control. One factor was the establishment of new long term hospital and dementia beds, mainly in Whangarei, while in other cases there were unforeseen changes in clients' personal circumstances. In 2012/13 Northland DHB underwent an RFP process which resulted in the purchase of nine dedicated beds, and other beds on a demand basis. The programme will continue to be managed by a Gerontology Nurse Specialist. The number, location and level of care of beds purchased is based on analysis of trends, which is monitored on an ongoing basis. However, actual utilisation of the respite beds is sometimes affected by factors outside Northland DHB control, such as client admission to hospital or death.
Baseline 2011		**Target 2012/13**	**Result 2012/13**	
Days utilised	4,183	4,200	3,629 ●	
Days funded	4,820		4,362	
Trend				
Chart: Number of days of respite care (0–5,000); 2010/11, 2011/12, 2012/13; legend: Number of days utilised; Target; Number of days funded				

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

SSP Glossary

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

Acronyms

Acronym	Meaning
AAU	Acute Assessment Unit
ALOS	Average length of stay
ARC	Aged residential care
ASH	Ambulatory sensitive hospitalisation, a subset of avoidable hospitalisations (sometimes also Action on Smoking and Health)
ASMS	Association of Salaried Medical Specialists
BAU	Business as usual
BMI	Body Mass Index (a measure of healthy weight)
COPD	Chronic obstructive pulmonary disease
CVD	Cardiovascular disease
DHB	District Health Board
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
GP	General Practitioner
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

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Sally Macauley (Deputy Chair)
Pauline Allan-Downs
John Bain
Craig Brown
Greg Gent
Libby Jones
Colin Kitchen
June McCabe
MC (Bill) Sanderson
Sharon Shea

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Neil Beney, General Manager, Health of Older People & Clinical Support
Margareth Broodkoorn, Director of Nursing and Midwifery
Andrew Potts, General Manager, Clinical Services
Dr Mike Roberts, Chief Medical Officer
Robert Paine, General Manager, Finance, Funding & Commercial Services
Kim Tito, General Manager, Planning, Māori, Primary & Population Health
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Te Poari Hauora Ā Rohe O Te Taitokerau