ANNUAL REPORT 2016

A Healthier Northland
He Hauora Mo Te Tai Tokerau

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

Reading our Annual Report

The annual report presents an account of Northland DHB's performance for the year from July 1, 2015 to June 30, 2016.

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

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

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

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

Key Components

Chair and Chief Executive Report

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

Introduction

Northland District Health Board.

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

2015/16: The Year in Review

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

Governance and Partnerships

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

Financial and Audit Reports

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

Statement of Performance

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

Windows of Northland Mosaic Produced by: Pat and Steve George
Inside Front Cover Image: Emma Rogers

Contents

Paula Anderson

Message from the Chairman and Chief Executive

On behalf of Northland District Health Board, we are pleased to present our Annual Report for the year ending June 2016. It has, again, been a privilege for us to lead our organisation and to have the opportunity to describe the challenges we have faced and the progress we have made towards improving the health and wellbeing of our people and achieving a healthier Northland.

Northland DHB achieved a small surplus in 2015/16 in a challenging fiscal environment of ever-increasing acute demand across nearly all clinical specialities, as well as delivering towards national health targets. This was achieved by a continuous focus on improving productivity, reducing costs where possible and seeking value for money solutions and health outcomes without compromising clinical quality.

The Northland Health Services Plan (NHSP) 2012–2017 continues to be our guiding document towards implementing a collaborative, Northland-wide health sector response to the challenges of our ageing and high-need population. We have made good progress on the five strategic change projects

This year we commenced our Neighbourhood Healthcare Homes initiative, which is a major primary care collaboration between Te Tai Tokerau PHO, Manaia Health PHO and Northland DHB. It involves implementing a new model of primary healthcare in response to a number of challenges within the sector including health inequities, increasing numbers of people with long term conditions and an ageing workforce. To achieve these changes, the three boards of the PHOs and Northland DHB each supported business cases for new investment.

An expression of interest process called for applicants from all interested general practices in Northland. Fifteen practices applied and in the coming year six practices will be supported to go through the intensive change process to re-organise the way that they work and deliver services. Foundation work such as building a primary/secondary care shared data warehouse and researching access to general practice appointments has also underpinned the design of this new initiative. Locality networks of providers around Neighbourhood Healthcare Homes are also operating in two areas of Northland – Whangarei North and Kerikeri.

The Integrated Urgent Healthcare workstream has had two areas of focus – same-day access to primary care and the patient journey in acute general medicine. The research undertaken last year into general practice appointment availability across Northland produced valuable information that stimulated reflection and discussion about the existing appointment scheduling systems and different options for improvement. An individualised report was produced for each general practice, which outlined key information about each practice's appointment availability and their patient's use of White Cross and DHB hospital emergency department services. The information has also provided a baseline of appointment availability data which can be compared in future years when assessing general practice models of care.

Whangarei Hospital Urgent Care Clinical Governance Group has continued to lead a programme of work to improve the timelines of care of acutely ill patients at Whangarei Hospital. The exploratory phase of this work demonstrated that the size and location of an acute medical assessment unit were important factors for achieving the benefits of an assessment unit and improving patient flow. A substantive acute assessment unit is required and planning and development is being progressed as part of the site master plan developments for Whangarei Hospital. On the 23 December 2015, four additional triage bays were opened within the emergency department to support the ambulatory care stream for low acuity patients.

It is estimated that approximately 20 percent of infants in Northland are born to women who have health and social needs that require more than two additional services in addition to the usual primary care provision. Over the past three years, the First 2000 Days programme of work has focused on strengthening the delivery of maternity care in association with other health and social services delivery. One of the key areas has been to improve the coordination of care when a number of services need to be working together with a woman during her pregnancy and after her baby is born. The Maternal and Infant Care Coordination Forum has therefore been established which will enable services to work more transparently through collective planning and development of a single plan of care in partnership with pregnant women and their LMC.

Within the Patient and Whānau-centred Care project a new Partner in Care and Visitors Policy has been released, after extensive consultation with staff and consumers. The policy supports a more formal process for patients to nominate a partner in care who can be involved in planning and delivery of care at the level the patient chooses. For these people there are no restrictions on visiting hours. At an organisational level the Northland Health Consumer Council has been operating for 18 months and continues to participate in health service planning and delivery across a wide range of topics and areas throughout the organisation.

Te Roopu Kai Hapai Oranga, the Northland Alliance Leadership Team through the Fit for Life project action plan is realigning the Stop Smoking Services that will target Māori adults, youth, pregnant women and mental health services consumers and staff to make 1,000 Māori 'quits' a year a reality.

Te Roopu Kai Hapai Oranga also has obesity as a priority focus. An intersectoral working group held a number of workshops to collaboratively develop and inform the recommendations on what we can do in Northland to best tackle the obesity epidemic. The working group included wide representation from Primary and Secondary Care, Māori Providers, Sport Northland, Local Council, Cancer Society and the Heart Foundation. This course of action resulted in the development of the Tai Tokerau Childhood Obesity Prevention Framework.

The goal of the framework is 'To increase by five percent the number of Māori tamariki who are at a healthy weight through good kai within five years (2021)'. The priority groups that

all initiatives will target are mama and pepi and tamariki up to the age of 10 years, with a focus on Māori and the obesogenic environment.

The strategic objective of the framework is to 'Create environments that support healthy eating for all tamariki to: reduce consumption of energy-dense foods, increase consumption of fruits and vegetables, decrease consumption of sugary sweetened beverages, and raise awareness of good nutrition.' The four workstreams are: Food Security; Sugar Sweetened Beverages; Advocacy; and Policy and Health Literacy.

Our key population health goal of reducing the life expectancy gap between Māori and non-Māori has been progressed through the Alliance Leadership Team. There has been a significant increase in the proportion of Northland Māori aged 14 and 15 years who have never smoked, and a decrease in the proportion of Māori aged 15–24 years who smoke regularly and Northland's Sudden Unexpected Death in Infancy (SUDI) rate has improved from the previous Māori SUDI rate at 3.4 per 1,000 live births (aggregated 2007–2011) to 1.6 per 1,000 live births currently.

After many years in which 15-20 cases of acute rheumatic fever occurred per year in Northland, there has been a marked fall since early 2015. Admissions to Northland hospitals for first-time episodes of rheumatic fever dropped from 15 in 2014 to five cases in 2015 and in 2016 just one case was reported.

A new programme "Engaging Effectively with Māori" has been developed which promotes a relationship-centred care approach with Māori and their whānau. The programme is designed to challenge attitudes and behaviour, strengthen engagement and build relationships that result in equitable outcomes for everyone. Our staff are expected to attend this programme over the next 18 months.

The new maternity unit at Whangarei Hospital, Te Kotuku, was officially opened on 24 February 2016 by the Minister of Health Hon Jonathan Coleman. Te Kotuku replaces 40-year-old services with a modern, family-friendly facility and co-locates antenatal clinics, assessment rooms, birthing rooms and post-natal beds that were previously spread over two floors in Whangarei Hospital.

Breastfeeding is possibly the number one preventative intervention to improve infant health and reduce pediatric hospital admissions. Northland DHB is ranked first in the country with 96.4 percent of our women breastfeeding their baby on discharge from hospital, as reported in the New Zealand Baby Friendly Aotearoa 2015 data. As with the rest of New Zealand, the rates of exclusive breastfeeding after discharge from the hospital facility, show rapid decline. However at 77 percent, Northland DHB still leads New Zealand at the six-week mark.

In November 2015, the Jim Carney Cancer Treatment Centre celebrated one year since it opened its doors to patients. In the year since the centre opened, staff have seen 786 new cancer patients, offered 4,500 patient appointments and provided 3,358 treatments (up from 1,675 the previous year). Following a successful trial, a navigator role for Māori cancer patients was established – based in the Centre. The role has proven successful in assisting and advising Māori patients undergoing cancer treatment. The inception of the role has seen a significant reduction in the non-attendance rate for clinics and has been favourably received by patients.

This year, there has been a strengthening of clinical leadership with improved communication between hospital doctors in the three district hospitals enhancing safe, patient-centred healthcare with Rural Hospital Medicine Specialists. The establishment of a lead hospital doctor has facilitated an increase in patients transferred back to the local Dargaville hospital to be cared for locally and for patients to return to their local hospital sooner. Nursing staff have gained, and continue to gain, new skills to enable increasingly different types of patients (for example paediatric patients) to be cared for locally.

There continues to be a focus on enabling patient-centred, collaborative, interdisciplinary care within the information technology space. The general practice patient portal is now available in 25 Northland GP practices and is used by over 9,000 patients. The implementation has been financially supported by the DHB and PHOs for the first year. Northland has introduced access to Static Clinical Pathways by general practices and the pathways are being localised to align with Northland services. Further development of Dynamic Pathways which enable interdisciplinary clinical decision support has been slow due to contractual and implementation issues, but holds considerable promise.

This year the business case was developed and approved for the implementation of the Whānau e-Shared Care tool across Northland. This tool will allow primary, secondary and community providers to create patient-centred care plans that are accessible to patients via a portal. This has the potential to shift the paradigm of care for our patients with long-term conditions to a model that is interdisciplinary and collaborative. The tool also allows secure messaging among primary, secondary and community providers and with patients.

Patient safety and quality of care is a priority at all of our hospitals. The Copeland's Risk Adjusted Barometer (CRAB), an innovative system for assessing, monitoring and improving the quality of care in hospitals was introduced at Northland DHB in 2016. It uses our own data and compares us to a dataset of over 14 million patient records. CRAB will enable clinicians to understand morbidity and avoidable harm across the organisation.

At Bay of Islands Hospital compliance requirements, additional geotechnical testing of the proposal building platform and a change in the proposed methodology for the demolition of old buildings have delayed construction of the planned hospital upgrade and integrated family health centre. After an extensive review of the project, the preferred design has been identified, which has the Accident and Medical Centre on the ground floor that will provide the interface to Te Hauora o Pukepuke Rau with a single triage point to serve both the centre and hospital so that patients can access the most appropriate treatment quickly. Above the Accident and Medical Centre will be a new 19 bed ward.

Klein Architects were engaged in December 2015 to review the current Whangarei Hospital site master plan. The work to date has reconfirmed the top priorities for the site as a new Emergency Department collocated with an Acute Assessment Unit additional theatre capacity, expansion of outpatient areas and the replacement of ageing ward spaces and laboratory. Before building a clinical services block, some enabling work to relocate the kitchens will be required. We expect this review to be completed by early October 2016.

We initiated an external review in November 2015 of Mental Health and Addiction Services in response to rapidly growing demand that has caused service performance challenges, on-going concerns about the quality and safety of services and clinical risk. The access rates for people seeking mental health and addictions services are higher in Northland than in most other Districts. With significant poverty, isolation and poor employment opportunities in many areas this compounds the

pressure on mental health and addictions services. Volumes have grown at least five percent per annum over recent years.

The review prioritised eleven recommendations covering management, acute inpatient and community services. Several recommendations were implemented in 2015/ 2016, including the appointment of a general manager, zero based budgeting exercise, and placement of High and Complex Needs clients. Recommendations on appointment of a clinical director and a nursing director role are in process, as is work on the model of care.

One of our strengths is the partnership we have with our PHOs, Manaia Health and Te Tai Tokerau. There has been a strong focus within primary care during the last 12 months through engagement in the Neighbourhood Healthcare Homes programme to develop the new way of working in collaboration with other providers, and to place the consumer at the centre of both service planning and delivery. Over the last nine months the Board of Directors of Te Tai Tokerau and Manaia Health PHOs have embarked on a journey to explore a configuration that best meets the primary health needs of the Northland communities covered by the two PHOs. The strongly aligned mission and values of both organisations has reinforced the commitment to develop innovative strategies to reduce disparities between Māori and non-Māori.

The partnership this year between Northland DHB and the Northland Foundation has focused on encouraging community giving to benefit the health needs of all Northlanders, now and in the future. We work together, raising donations to provide extra equipment and to support innovation and new initiatives that give Northland DHB an extra edge in the delivery of healthcare to the Northland community. In this year the funds received and distributed have benefitted a wide range of services within the DHB including the Medical Outreach team, the Diabetes Fun Run/Walk, Osteoporosis Awareness Day, the Rural Service Level Alliance Team and the Emergency Department. Health Fund Plus+, a fundraising programme was developed in 2016 to encourage larger gifts, donations and endowments to Northland DHB.

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

Anthony Norman
Board Chairman

Dr Nick Chamberlain
Chief Executive

Introduction:
Northland District Health Board

Our Role

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

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

The DHB employs around 2,711 staff. Acute services are provided through the DHB's four hospitals, based at Whangarei, Dargaville, Kawakawa and Kaitaia, with elective surgery performed at Whangarei and Kaitaia. These services are supplemented by a network of community-based, outpatient and mental health services, a range of allied health services and a public and population health unit.

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

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

Our Communities

Population

Northland's population at the 2013 Census was 164,700, representing 3.6 percent of New Zealand's total population. About half live within the Whangarei District Council area, 37 percent within the Far North District Council area and 13 percent within the Kaipara District Council area.

Māori

Nga Iwi o Te Tai Tokerau comprises 32.4 percent of Northland's population. Out of the total Māori population, about half live in the Far North District, 40 percent in Whangarei, and 10 percent in Kaipara. Iwi in Northland include Ngati Kuri, Te Aupouri, Ngaitatoko, Te Rarawa, Ngati Kahu, Whaingaroa, Ngapuhi, Ngati Wai and Ngati Whatua.

Ageing population

Northland's population is 'ageing' because the number of children is decreasing while the older population is increasing significantly. The child population (0–14 years), is projected to drop from 21.6 percent in 2012 to 19.7 percent by 2026.

Northland's older population (65-plus years) is projected to grow from 16.9 percent to 24.5 percent over the same period.

Socio-economic status

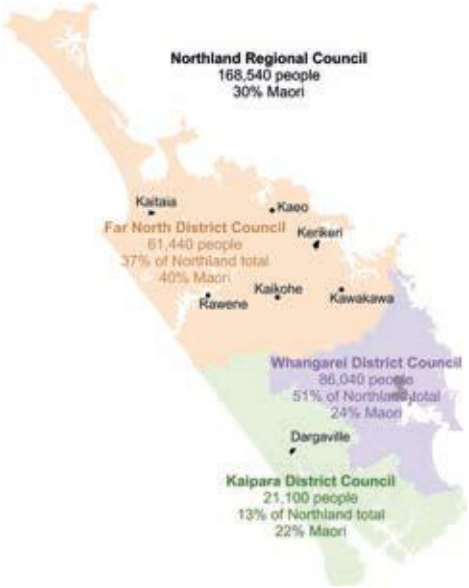
Northland has one of the most deprived populations in the country. While 20 percent of New Zealand's population is in the lowest quintile of the deprivation index, the equivalent measure for Northland is 35 percent.

The most deprived local authority area is the Far North District Council with 51 percent of the population in the lowest quintile; within this district the most deprived areas are Hokianga

(83 percent), Whangaroa (41 percent) and north of the Mangamukas (55 percent).

Rurality

The only true urban area in Northland is Whangarei, containing about one-third of the region's population. Kaitaia, Kerikeri, Kaikohe and Dargaville are rural centres with populations of about 5,000 each. Northland's population is distributed across a vast region. It 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 limited.



Our Health Profile

Māori

Māori experience low levels of health status across a range of health and socio-economic statistics. They comprise 32.4 percent of Northland's total population, but 52 percent of the child and youth population, a key group for achieving long-term gains. Māori experience early onset of long-term conditions like cardiovascular disease and diabetes, presenting to hospital services on average about 13 years younger than non-Māori.

Child and Youth

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

The deprivation index, which divides New Zealanders into ten groups according to their deprivation scores, placed 70 percent of Northland adults and 85 percent of Northland children on the most deprived half of the index.

Older People

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

Long-Term Conditions

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

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

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

Oral Health

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

Lifestyle Behaviours

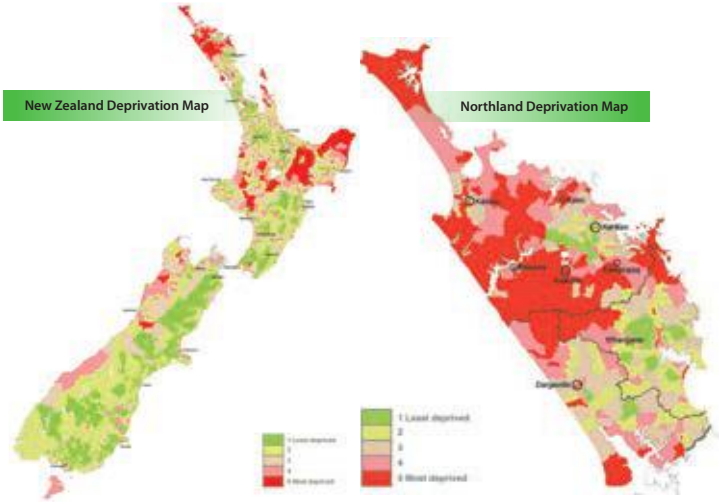
The way people live their lives and the behaviours they exhibit have an enormous effect on health status. There are a wide range of influences, but key ones are smoking, diet, alcohol and other drugs, and lack of physical activity.

Mental Health

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

Social Influences

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



Our Vision, Mission & Values

Our Vision:

A Healthier Northland
He Hauora Mo Te Tai Tokerau

Our Mission:

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 success, competence, confidence and innovation.

Where the Money Goes

Whangarei, Dargaville, Bay of Islands and Kaitaia Hospitals (surgical and medical services, emergency departments, imaging, laboratories, maternity), public health	$277m
Primary Health (general practitioners, community dental services, radiology)	$60m
Health of older people (including residential care, rehabilitation)	$59m
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)	$73m
TOTAL	$576m

EACH DAY IN NORTHLAND

On average, each day in Northland there are:

128	Emergency Department presentations
107	Inpatient discharges
2,133	Outpatient attendances
72	Outpatient missed appointments
14	Northland patients discharged by other DHBs
14	Chemotherapy attendances
52	Renal dialysis
46	Theatre events
256	Radiology exams
3,491	Lab test results – Hospital
3,690	Lab test results – Community
5	Babies born in hospital
5	Deaths in Northland
3	Mental health hospital admissions
506	Mental health community visits
1,891	General practice consultations
7,418	Prescription items processed by pharmacies
79	Community visits by allied health services
195	District nursing visits
192	Oral health visits in primary schools
8	Immunisations for 2-year-olds
8	Immunisations for 8-month-olds
40	Breast screens
927	Subsidised bed days in aged residential care
1,641	Hours of home-based support services for older people
17	People assessed by hospice services nursing teams

And we do much more!


Auckland
15

Our Services

There are currently 160 GPs and 163 practice nurses across 37 general practices providing primary healthcare to Northlanders enrolled with Northland PHOs, and non-enrolled and non-resident patients.

Northland DHB has 245 contracts with 127 non-government organisations (NGOs) including Māori health providers and Whānau Ora collectives that provide a range of public health, primary healthcare and community services across Northland.

Figure 1
Northland PHOs

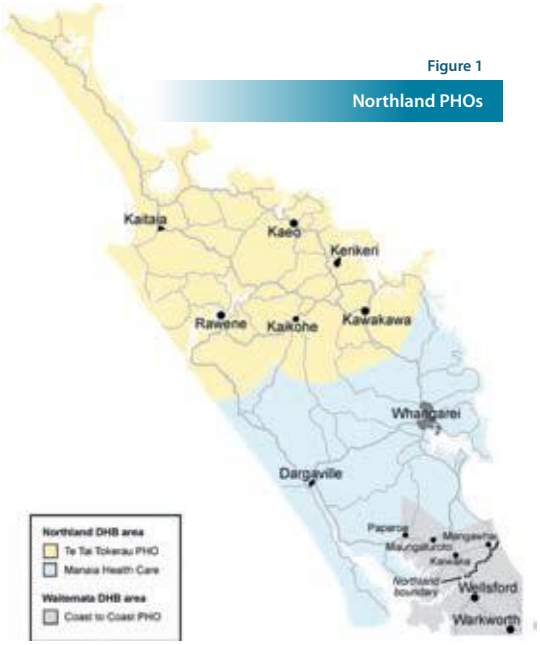


Figure 2
Māori NGOs

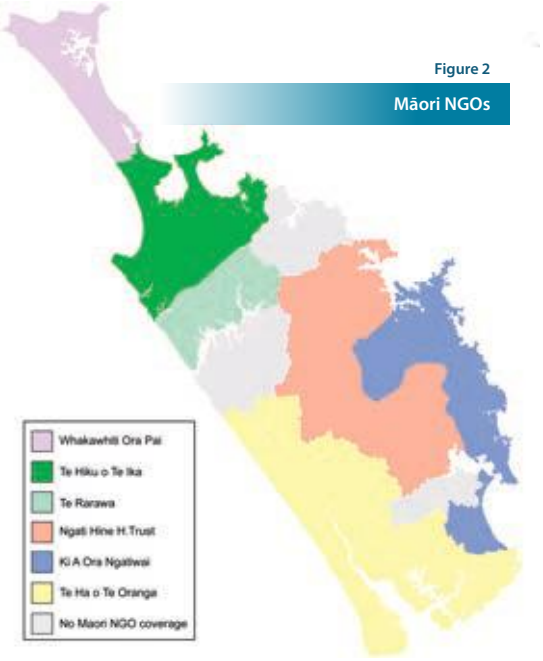


Figure 3
Northland Hospitals

Figure 4
Travel Distances

Our People

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

Demographics

Northland DHB workforce profile	Total workforce: 2,711 active employees
Age profile	Female average age: 47.4 years Male average age: 47.4 years
Ethnic profile	European:.....48.8 percent Māori: .....14.9 percent Asian:.....6.9 percent Pacific: .....0.7 percent Other:.....2.1 percent Not stated:.....26.6 percent
Disability profile	Specific data is not currently held for this category. Individuals with disabilities applying for vacancies are given full consideration based on the needs of the position
Gender profile	Female: 2,147 employees (79 percent) Male: 564 employees (21 percent)

Leadership, Accountability and Culture

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

Partnership models include:

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

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

Achievements in 2015/2016 include:

- Establishment of new senior leadership roles including Director Allied Health, Scientific and Technical and two Associate Chief Medical Officers
- The second annual Northland DHB Leadership Programme was successfully completed in March 2016. Now in its third year this is the DHB's flagship leadership programme and is delivered through 12 half-day modules. To date 56 staff have completed or are currently completing this programme
- Northland DHB is working with Northern Region partners to develop a regional approach to leadership and management

development training. In 2016 the Northern Region launched the Graduate Management Scheme that provides an entry-level opportunity into a health management career. A management development framework will be developed and additional regional courses deployed in 2017.

Recruitment, Selection and Induction

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

Māori are underrepresented in Northland DHB's workforce comprising just 14.9 percent (405) of the total staff. Northland DHB is committed to encouraging more Māori into health and disability fields. This applies particularly to areas where Māori are under-represented as health professionals and over-represented in their health needs. Our objective to 'grow our own' workforce has led to a number of development projects which have been implemented with much success. Northland DHB holds the regional hub contract for Kia Ora Hauora. This was established to increase the number of Māori entering first-year tertiary study, and to recruit and retain Māori in health-related career pathways and into the health sector workforce.

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

Achievements in 2015/2016 include:

- A total of 246 new students registered with Kia Ora Hauora across the Northern Region in 2015/2016. During the year students participated in site visits, Health Careers Exposure Days and the regional Kia Ora Hauora Rangatahi Health Symposium in Auckland. The Pukawakawa Cultural Programme continues to provide Kia Ora Hauora students with access to 5th and 6th year medical students to provide career guidance and support
- Welcomed 327 new employees through the Northland DHB Orientation Day
- New recruitment tools and manager training implemented on behavioral based interviewing
- New organisation wide employee orientation booklet 'Welcome' launched
- New careers website, online application process and branding updated.

Employee Development, Promotion and Exit

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

The Northland Workforce Roadmap was developed in 2015 to provide a long-term strategic view of Northland's workforce needs and objectives. The roadmap sets out four key objectives born from the Northland Health Services Plan whilst also reflecting evolving Health Workforce New Zealand and Northern Regional Alliance objectives. The Workforce roadmap provides guidance to services/departments in establishing service specific workforce development action plans.

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

Achievements in 2015/2016 include:

- Ngā Manukura o Āpōpō – the national Māori nursing and midwifery workforce programme is now into its 13th year. This programme is sponsored by the Director of Nursing and Midwifery of Northland DHB. Nearly 50 percent of the graduates from the Ngā Manukura o Āpōpō leadership programme have been from Northland
- Northland DHB's cultural quality programme was redesigned in 2016. A new training module titled "Engaging Effectively with Māori" has been developed which promotes a relationship centred care approach with Māori and their whānau. The programme will continue to be delivered through to 2018
- The Learning & Development Department provided over 140 internal course events in 2015/16, with over 2,000 attendances. Courses on offer include personal development, project management and leadership and communication skills. These courses are also open to Hospice and our PHO partners
- Further development and implementation of e-learning has enabled greater access to our primary healthcare and community partners to share learning, communication, knowledge transfer and skill development. This ensures best practice is implemented across Northland DHB and the wider health sector in Northland
- Cultural competency and Tikanga best practice workshops and online learning enable staff to increase their knowledge and understanding of Te Ao Māori (Māori world view)
- Continuing support for the non-regulated workforce in 2015/16 saw nine porters receive a Level 3 National Certificate in Health, Disability, and Aged Support (Orderlies), whilst ten laundry staff started study towards a Level 2 National Certificate in Laundry Processing. Dental assistants in the Oral Health service are also studying towards a new Level 3 National Certificate in Dental Assisting
- Employee voluntary turnover for 2015/16 was 9.1 percent, ahead of the average across all DHB's.

Flexibility and Work Design

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

Achievements in 2015/2016 include:

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

Our People *(continued)*

Remuneration, Recognition and Conditions

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

Achievements in 2015/2016 include

- Annual Nursing and Midwifery awards celebration held in May 2016. International Nurses Day and International Day of the Midwife was recognised and celebrated
- Development of the Northland Health and Social Sector Innovation Awards combining what used to be separate awards ceremonies for the health sector and social innovation. Organisers include Northland District Health Board, NorthAble Disability Services, Manaia Health and Te Tai Tokerau PHO. To be held on 26 November 2016, the awards will celebrate quality, innovation and integration across the Te Tai Tokerau health and social sectors.

Harassment and Bullying Prevention

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

Achievements in 2015/2016 include:

- With our union partners we have developed an electronic reporting tool for violence, bullying and harassment that will be launched in 2016. The tool provides an improved means to enable the reporting, escalation, investigation and resolution of bullying concerns raised by staff.

Safe and Health Environment

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

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

Employee wellness continues to be supported through employee assistance programmes, onsite gyms and swimming pools, healthy eating and smokefree support programmes, retirement planning, and training on resilience and dealing with stress.

Achievements in 2015/2016 include:

- Rollout of a new patient moving and handling training course across the DHB. Increased participation in De-escalation and Calming & Restraint training courses
- Implementation of Datix to centrally manage health and safety risks, incidents, and investigations
- Implementation of a range of system improvements to support the new Act
- New OHS performance indicators developed and reported quarterly
- The number of Lost Time Injuries (LTIs) increased in 2015/16. However the LTI Frequency Rate (number of LTIs per 1,000,000 employee hours) of 9.2 remains within the national average range for DHBs
- Successfully retained Tertiary (the highest) level accreditation in ACC's Partnership Programme audit.

Statement of Performance

What we are trying to achieve

How we go about it

Northland DHB provides a wide spectrum of health services that range from public health, through primary health to secondary (hospital) services.

Achieving Northland DHB's vision of a healthier Northland requires working with other organisations. No matter how well we organise ourselves, we can only achieve so much because people's health is affected by many factors outside our direct control.

We work in a collaborative way with other organisations in the health sector in Northland and in the Northern Region. Collectively we strive to coordinate and streamline services so they address health needs effectively, are easy for patients to access and follow, and are safe and of high quality – all while getting the best value out of our limited health dollar.

Achieving our vision also requires Northland DHB to work with organisations outside the health sector to address the factors in wider society that affect health. That means forming strategic partnerships with government bodies (especially major ones such as Ministry of Social Development and its agencies, Police, Ministry of Education) and Northland's local authorities. We also play our part in joint projects, such as the current placed-based one in Otangarei that is helping the community achieve transformational change, and the Northland Intersectoral Forum's social investment initiative focused on vulnerable children, young people and their families.

Real progress in Northland can only be achieved if we improve Māori health; improving equity is inherent in all the approaches described above. Northland's nine Māori health providers address needs according to Māori kaupapa, but most Māori contacts with the health system occur within mainstream services so improving their appropriateness and sensitivity is also vital. The knowledge that a significant contributor to health needs among Māori is deprivation reinforces the imperative for Northland DHB to adopt collaborative approaches outside the health sector.

How we plan

Northland DHB's strategic plan is our Northland Health Services Plan (NHSP). Published in 2012 it set a five-year timeframe to address the growth in demand posed by the two biggest challenges to the health sector – the increasing prevalence of long-term conditions and the ageing population.

The NHSP uses the 'Triple Aim' framework (as does the Northern Region Health Plan). This emphasises three interdependent and interlinked approaches: population health (improving health status overall and improving equity), patient experience (quality, safety and convenience of services), and value and sustainability (value for money, or how wisely we use our resources). The Triple Aim underpins the six Headline Targets (two for each aim) which have been driving the NHSP.

The Statement of Performance

The Statement of Performance's High-level Outcomes reflect the Triple Aim.

Of the High-level Measures, the first three are drawn from the NHSP. The fourth, concerning inequities, is a pervasive driver for Northland DHB in all contexts, while the other two (mortality overall and infant mortality) are internationally recognised indicators of whole-of-population wellbeing.

Improving value and sustainability is, in the context of the Statement of Performance, an enabler (also the reason for two of the NHSP's measures being excluded from the High-level Measures). Northland DHB's numerous initiatives are described in more detail in our Annual Plan.

The Impact Measures address *population health* needs across a spectrum. The most significant adverse lifestyle behaviour, smoking, is monitored, along with positive practices such as breastfeeding. Services designed to prevent illness (immunisation, blood sugar management among people with diabetes) and identify conditions as soon as possible (cancer screening, cardiovascular risk screening) are crucial to keeping people healthy and minimising demands on health services.

Performance of health services is also important. Low rates of ambulatory sensitive hospitalisations indicate primary and community services are performing well in keeping people out of hospital. In-hospital measures (ED waiting times, cancer treatment waiting times, acute admissions generally, readmission rates, mental health admission rates) help us keep an eye on how well we are dealing with major needs and causes of admission.

Patient experience is monitored through six quality measures, all of which prevent adverse outcomes that can be costly to both patients and DHB services. The six measures are falls, pressure injuries, surgical checklist (to make sure the right procedure will be carried out on the right patient, on the right site with the right preparation), hand hygiene, medicine reconciliation (reconciling GP-prescribed medications with those prescribed during a hospital stay), and central line infections (uncommon but costly).

Of the 25 impact measures, only 11 address services provided solely by Northland DHB (or in collaboration with our tertiary providers in Auckland). The other 14 either measure people's behaviour (smoking, breastfeeding) or activity provided by others in the Northland health sector (preventive services, screening services, primary care, services provided to older people).

Outcome Framework

National	*MoH Purpose and Role*	Improve and protect the health of New Zealanders				
	MoH High Level Outcomes	New Zealanders are healthier and more independent		High quality health and disability services are delivered in a timely and accessible manner		The future sustainability of the health and disability system is assured
	NZ Health Strategy themes	People powered	Care closer to home	High value & performance	One team	Smart system
Regional	*Outcome*	Improve health outcomes and reduce disparities by delivering high quality, high value, and better integrated services. We will do this in a way that meets future demand while living within our means.				
	Triple Aim	Population Health		Patient Experience		Cost / Productivity
Northland	*Vision*	A Healthier Northland		*He Hauora Mo Te Tai Tokerau*		
	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
	NHSP Headline Targets	Population Health		Patient Experience		Value and Sustainability
		Life expectancy gap between Māori and non-Māori reduced by 2 years Unplanned hospital admissions for Northlanders are reduced by 2,000 annually by 2017		Everyone with urgent health needs has same-day access to primary care More than 95% of patients recommend service provided		Value for money savings of $5M against projected cost increases each year Northland hospital labour productivity benchmarks in the top five DHBs
	Statement of Performance Expectation High-level Measures	Life expect-ancy gap between Māori and non-Māori reduced by 2 years	Unplanned hospital admissions for Northlanders are reduced by 2,000 by 2017	>95% of patients report they would recommend the service provided	Gaps between: (a) Māori and non-Māori (b) Northland and NZ	Decrease in infant mortality	Mortality rate (age-standardised)
	Statement of Performance Impact Measures	Year 10 students who have never smoked Adults who are current smokers Full and exclusive breastfeeding at 6 weeks 8-month-olds who are fully immunised Breast cancer screening in eligible populations Cervical cancer screening in eligible populations	Average number of decayed, missing or filled teeth in Y8 students Ambulatory sensitive hospitalisations, rate/1000 ages 0-4, 45-64 Good blood sugar management in diabetics Eligible people receiving CVD risk assessment in the last 5 years	Acute readmissions to hospital within 28 days Urgently referred patients with a high suspicion of cancer who receive their first cancer treatment within 62 days % of people with enduring mental illness aged 20-64 who are seen over a year Increase in elective surgical discharges ED patients with length of stay less than 6 hours % of acute patients readmitted to NDHB hospitals within 28 days Quality measures x6		HCSS clients assessed using interRai tool HCSS providers certified ARRC providers with at least 3 years certification
	Output Classes	Prevention	Early detection and management	Intensive assessment and treatment		Rehabilitation and support
	Enablers	Workforce	Information technology	Quality systems		Financial management

So what have we achieved for our population?

The aim of our outcomes framework is to measure how healthy the Northland population is (High-level Measures), and how well its health services are performing (Impact Measures). Together they form a picture of how well we are doing in meeting our strategic goals and whether our population is living healthier and more independent lives.

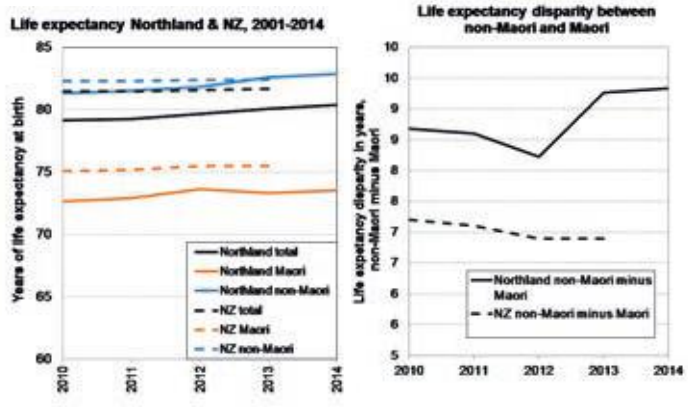
The High-level Measures take a small set of measures that collectively provide a picture of the overall wellbeing of the population. Typically, population-level outcomes take years to show improvement. They are affected by complex factors (some with positive effects, some with negative) that the health sector is unable to influence. Another characteristic of population health measures is that there is usually a time lag between people changing their behaviour (such as lower smoking rates) and when this shows up as an improvement in statistics. Our High-level Measures are a combination of population-wide (life expectancy, mortality) and lower-level proxy measures (unplanned admissions, patient satisfaction) that collectively provide a picture of progress.

Life expectancy

Numerous activities support an increase in life expectancy for Northlanders and a reduction in the ethnic disparity. A range of health promotion initiatives exist to encourage healthy behaviours. People in contact with primary and community services and hospital patients receive support and advice to stop smoking. Services such as immunisations, screening for cancer, monitoring of diabetes management and heart disease either prevent conditions developing, pick them up early so treatment can be most effective, or provide regular monitoring once they are established.

One of the major projects of the Northland Health Services Plan, Neighbourhood Healthcare Homes, is a key driver for change that, once it is fully implemented, will have positive effects on life expectancy. It is a team- and locality-based primary healthcare delivery model that provides comprehensive and continuous health and social care, with the goal of supporting individuals toward better health outcomes. A fully integrated, multidisciplinary team of providers is accountable for the health and wellness of its enrolled population and ensuring equitable access to its services for enrolled patients – especially those most in need.

Through Neighbourhood Healthcare Homes, general practice (and therefore the health system as a whole) will become more effective, sustainable and, ultimately, better for patients. The model will shift the health system's focus to a more patient-centric (rather than service-centric) approach. It will streamline operations, change the way patients and clinicians interact, and improve patient journeys through the health system by moving from reactive to proactive healthcare. Implementing the new model will involve the creation of greater capacity in primary care, and this will help deliver additional services to those most in need.



Establishing Neighbourhood Healthcare Homes is a complex process. So far six practices have been selected and they will begin the change management process in September 2016. Two further Expression of Interest processes will be conducted in the first halves of the 2017 and 2018 calendar years.

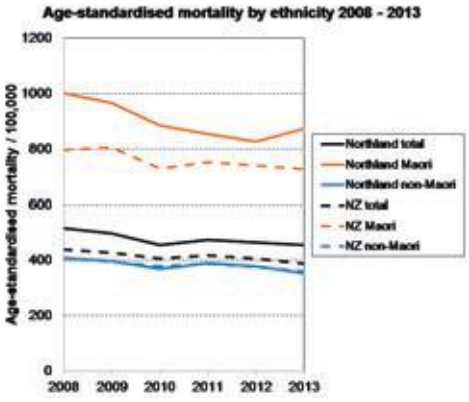
Mortality overall

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

In Northland, in 2013 age-standardised mortality for Māori (873/100,000) was two-and-a-half times that of non-Māori (354/100,000). The Māori rate dropped by 13% between 2008 and 2013, comparable to that experienced by non-Māori (14%).

Consistent with the discussion about life expectancy above, mortality among non-Māori in Northland (354/100,000) was similar to that of non-Māori New Zealanders (360/100,000). Northland Māori have a higher mortality rate than Māori New Zealanders as a whole (873/100,000 in Northland compared with 726/100,000 nationally) but the gap has been decreasing – from 204/100,000 in 2008 to 146/100,000 in 2013.

The ethnic disparity is explainable largely through the early onset of long-term conditions among Māori. The Northland health sector has some influence on keeping people healthy and well. Successful efforts have been made to reduce infant mortality (see below). There is an extensive range of preventive and health promotion measures. Screening is undertaken for some cancers, and primary and community services emphasise early intervention and ongoing management of long-term conditions (the impact measures section of the SP mentions



breastfeeding rates, screening for breast and cervical cancer, immunisation, management of diabetes and monitoring of risk factors related to cardiovascular [circulatory] disease). Long-term conditions originate from a range of factors, on which the health sector can only have partial influence. The two major factors are smoking and obesity, both of which have a strong relationship with deprivation.

Infant mortality

It is difficult to gain a clear picture of infant mortality because data by DHB has been published by the Ministry of Health only for three years. The Northland data also has to be treated with some caution because numbers are relatively small and therefore subject to significant variation year by year.

Nevertheless the signs are encouraging. Across all ethnic groups, Northland's infant mortality dropped relative to New Zealand's between 2010 and 2011, and showed only a small rise again in 2012.

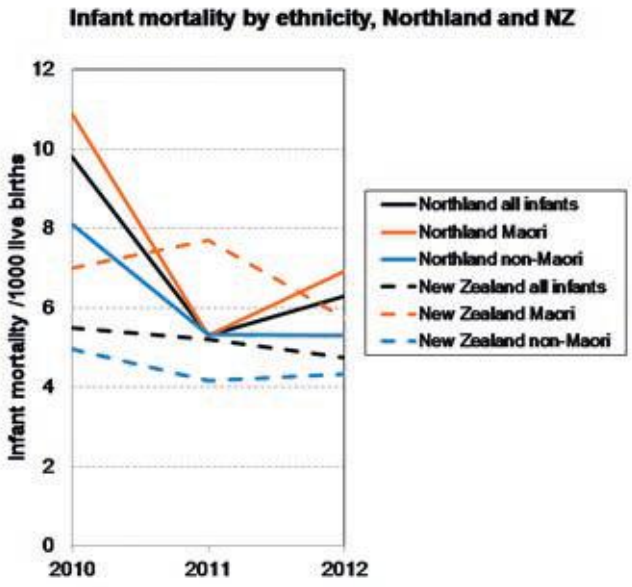
The improvements in infant mortality suggest that the initiatives put in place by Northland DHB, particularly among Māori, are working.

Immunisations prevent vaccine-preventable diseases from occurring, and the coverage rates are showing sustained improvement. Work continues toward understanding and addressing the decline rates for infant immunisation in Northland that are greater than most other regions.

Initiatives to raise breastfeeding rates are contributing to creating healthier, more resilient babies.

A comprehensive approach has been taken to reducing sudden unexpected death of an infant (SUDI) for Māori whānau. This includes risk factor assessments, education about safe sleep and the introduction of 'pepi pods' and wahakura (specially made portable sleep spaces that ensure vulnerable babies can sleep more safely).

Also introduced is the 'High Five' notification form that tells a mother post birth about enrolling their baby in the five key service providers. To facilitate timely enrolment and reduce numbers of babies who are not enrolled with a Well Child provider the High Five requests they identify their intended Well Child Tamariki Ora provider. Where none is identified, Plunket makes contact with the mother between four and six weeks post birth to enquire whether a choice has been made and facilitates the process of engagement with Well Child services.



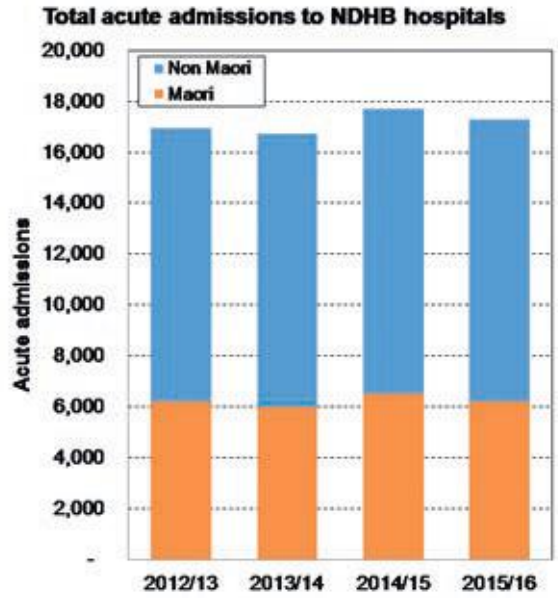
Progress toward establishment of the Maternal and Infant Care Coordination Forum is steady and it is planned to 'go live' in September. The current 'At Risk Register Forum' (a Child Youth & Family forum for management of pregnant women where there are significant care and protection concerns for both the woman and her unborn infant), will transition into the new model of care. The forum will be gifted a name and officially opened before 'going live'. The case management forum aims to reduce the impact of maternal/parental addiction to alcohol and other drugs (including tobacco), gambling and other significant issues such as domestic violence, depression and poor housing.

Total acute admissions to hospitals

The goal of reducing unplanned admissions by 2,000 by 2017 was set in mid-2012 in the Northland Health Services Plan. The intention was that it would indicate how well conditions, especially long-term conditions, are being managed in the community and primary care settings. There is no set definition of an unplanned readmission. As a proxy we have decided to measure acute admissions because they occur urgently, without forewarning (in contrast to elective admissions, which can be planned because the needs are less urgent).

Between 2012/13 (the NHSP's base year) and 2015/16, bed days for acute admissions increased by 342 from 16,937 to 17,279.

Since 2014/15 acute admissions have decreased by 407 (2%). That might not sound like much, but in the context of an ageing population and increasing prevalence of long-term conditions it represents quite an achievement. It also suggests that efforts in recent years in Northland to develop more integrated, streamlined and patient-centred services (also goals of Neighbourhood Healthcare Homes) are beginning to bear fruit.



The intention to reduce acute admissions by 2,000 over five years was a deliberately ambitious part of Northland DHB's strategy to shift the health system more 'upstream'. It represents a 12% decrease over the base year at a time when health needs have been rising steadily. The Northland population has grown faster than suggested by the 2006-base projections which were current at the time the 2,000 bed days target was set (according to 2006-base projections Northland's population in 2015 would be 161,100, whereas latest estimates based on the 2013 Census put it at 168,540). The population is also ageing, and an older population creates higher needs.

Acute admissions are significantly influenced by how well people's health conditions are managed in the community, particularly by primary care services. Neighbourhood Healthcare Homes will have an influence here, by improving the quality and consistency of care in the community, ensuring equitable access to services and actively managing people's health.

Numerous other projects being put in place will contribute towards reducing acute admissions in the medium term:

- eReferrals: allows GPs timely access to advice from hospital specialists, thus enabling them to make more informed decisions about which patients it is appropriate to treat in the community and which are better referred to hospital services
- Primary Options: reduce referrals and hospital admissions through providing an appropriate range of services in primary care. Primary Options is being reviewed to identify further opportunities to reduce burdens on hospital services.
- Telehealth: using communications technology to deliver health services closer to home for patients so they have to travel less, incur lower costs and require fewer hospital touch points such as outpatient clinic visits; for Northland DHB Telehealth reduces staffing needs, saves organisational time and reduces costs
- The Mental Health Stepped Care Model: improve responses to mental health and addiction needs by increasing timely access to the most appropriate services across primary and secondary care, and supporting primary and specialist services to work together to provide shared care arrangements
- Care Connect: a regional initiative to improve information sharing among community and hospital healthcare providers for the benefit of patients – in effect the beginning of an electronic health care record that will enable clinical partnerships spanning the health continuum and ensure the right information is available at the right time by the right provider
- Community pharmacy: pharmacists working to the top of their scope, offering additional services to patients that add value to health outcomes (consistent with the national Pharmacy Action Plan)
- Clinical Pharmacist Facilitator: a pilot project to reduce inappropriate polypharmacy, promote best practice prescribing behaviours, identify opportunities to reduce acute hospital admissions. Activities include medicines therapy assessments, medicines use reviews, patient referrals, opportunistic interventions, and desktop analytical approaches
- Whakamana Hauora (self-management programme for people with long-term conditions): a plan is being developed to strengthen this by introducing Northland-wide disease-specific models instead of the generic approach which has been used so far.

Patient satisfaction

One of the six Headline Targets in the Northland Health Services Plan was "95% of patient's report they would recommend the service provided". This can be addressed through the results of our patient surveys on adults and children. Patients were asked to score their response to an 'overall satisfaction' question on a zero-to-ten scale. The percentages below are the most positive responses, 9 plus 10, as a proportion of all responses.

For child patients the overall result this year was slightly down on last year, though both results are still below the 95% target. Non-Māori exceeded the target at 97%, but Māori felt less positive about their care (data by ethnicity was not collected in 2014/15).

These results amalgamate responses from child patients (older ones who can respond on their own) and adults (who respond on behalf of younger children). Results from the two groups were compared but have not been presented here because there was no clear pattern, possibly because of the relatively small sample size among the child respondents.

Last year our adult patient survey did not include a specific question along those lines. As a substitute, results from a range of questions about specific aspects of care were amalgamated. This year there was such a question, which means we can address the original 95% target (though we can't compare with last year). The result for non-Māori was close to target, but some distance away for Māori.

NDHB Child Patient Survey: "If you had a choice would you recommend this hospital to your family/friends/whānau?" – most positive responses (9+10 on a 10-point scale)

Year	All patients	Māori	Non-Māori
2014/15	93%		
2015/16	91%	86%	97%

NDHB Adult Patient Survey: "If you had a choice would you recommend this hospital to your family/ friends/ Whānau?" – most positive responses (9+10 on a 10-point scale)

Year	All patients	Māori	Non-Māori
2015/16	90%	81%	94%

Northland DHB has had a cultural competency programme in place for the last three or four years, but demonstrably it has not sufficiently improved Māori satisfaction with our services. To improve, we are embarking on an organisation-wide programme entitled 'Engaging Effectively with Māori'. The programme will aim to improve attitudes, behaviours and communication, and adopt a patient-centred rather than service-centred approach. The personnel who ran similar programmes in other DHBs have been engaged to help Northland DHB implement the programme. It begins in July 2016, will run for two years and be mandatory for all staff.

Restoration After Appendix Rupture

Sonny Christie would rather not have suffered a ruptured appendix, but now restored to health, he has nothing but praise for the care he received at Kaitaia Hospital. He was particularly grateful to enrolled nurse June Cherrington, and he returned to the hospital yesterday to thank her with flowers and morning tea to share with her team.

Ms Cherrington said she had just done her job, but the Pukemiro School teacher (who wasn't sure if his pupils were glad to see their 'grumpy' teacher back at work) was having none of that. She and her team were angels, he said, and his stay had been "absolutely fabulous". He now had a real appreciation of the pressure under which medical staff worked, and the English language did not have the words to express the positive impact these "true professionals who manifest care and a genuine interest in their patients' wellbeing" had had on him and his whānau.

The discharging of a fellow patient, whose home environment had not been conducive to healing, had been delayed for two weeks until medical staff were certain that he and his wife had decent accommodation to go to. "That made me cry. It wouldn't happen anywhere else," he said. "The support staff were just as amazing. It was great to have Raewyn Noa and Phoenix Pivac ensuring my needs were met. Hey, even the food was good," he added.

He had also seen how some people treated staff with rudeness, aggression, arrogance and ignorance. He described a young patient who displayed all those qualities as a "foul-mouthed piece of work. I just want the staff to know that they are appreciated, even if they are under-valued by some of the less favourable individuals in our community," he said.

Source – Northland Age

Improving Māori health, improving equity

Northland DHB is committed to achieving health outcomes for Māori that are as good as those for non-Māori. That is not an easy task because the gaps are often large, but we are committed to a health system that is responsive to the health needs of Māori. The health of Māori is influenced by many social and economic factors outside the health system's control, but we can influence these to some extent by working on joint projects with other agencies, as described earlier under 'what we are trying to achieve'.

For life expectancy, the disparity between Māori and non-Māori had been reducing until 2012, but it has widened since. The disparity between life expectancy of Māori in Northland and Māori in New Zealand is significant, whereas the gap for non-Māori is negligible.

Age-standardised mortality for Māori was two-and-a-half times that of non-Māori in the latest year of data available (2013), though it has dropped 13 percent since 2008.

With small numbers and only three years' data it is hard to get a clear picture on infant mortality, but over the last three years the difference between Māori and non-Māori in Northland has been either zero or small. Northland's rates have been comparable or slightly higher than New Zealand's for both Māori and non-Māori.

Over those years, Māori have consistently comprised 36 percent or 37 percent of acute admission bed days, higher than the 30 percent Māori in the Northland population and a reflection of higher need. The encouraging drop in the number of acute admissions between 2014/15 and 2015/16 has been evenly spread across Māori and non-Māori.

The patient satisfaction results for both Māori adults and Māori children are poorer than for non-Māori. The 'Engaging Effectively with Māori' programme described earlier will address this over the next two years.

What the achievement symbols mean:

Achieved	Substantially achieved	Not achieved but progress made	Not achieved	No conclusion can be drawn
✓	✓	↗	✘	●
Target met or bettered	Within 5%[1] of target	Not within 5% of target, but there has been movement towards it	Not within 5% of target, and performance has worsened or shown no improvement	Problems with data availability, changing definitions etc.

High Level Measure	Target	Baseline	Result	Performance	Comments	Data limitations
Life expectancy	Māori / non-Māori gap to reduce by 5 years 2012-2017	2010: 9.4 females 8.8 males	2014: 9.3 total	↗	Life expectancy of Northland Māori is shorter than for non-Māori, though the average for Māori has improved slightly.	Data not available by sex in 2014 data run.
Acute admissions to hospital	Reduce by 2,000 between 2012 and 2017	2011/12: 17,148	2015/16: 17,279	↗	Still a distance from target. Even so, about 400 admissions less than 2014/15 (17,686) is a significant achievement given the ageing population and increasing prevalence of long term conditions.	

[1] *If targets are a substantial proportion of 100%, ' within 5%' means within 5% absolute of the target. When targets are a small percentage (as in the mental health measure) or a number (some of the quality ones are zero) a different sort of 'close to target' assessment is required; how that is addressed is described in a footnote.*

High Level Measure	Target	Baseline	Result	Performance	Comments	Data limitations
Patient satisfaction	95% of patients would recommend service provided	2015 59%	2016: 90%	✓	Close to target for 2016, though 2015 survey result can't be compared (see next column).	2015 survey didn't have an 'overall satisfaction' question; the 59% was an average of the positive scores of all questions.
Mortality overall (age-standard-ised)	No specific target, though both relate to the life expectancy target	2011: Total 439.5 Māori 797.3 Non-M 408.8	2013: 456.3 872.7 353.6	✗	Total population rate has increased because the Māori rate has worsened more than the non-Māori has improved. Māori rate in Northland still higher than NZ Māori's (726.1). Non-Māori rate in Northland is slightly better than NZ's (360.1).	2013 data is the latest available.
Infant mortality		2011: Total 5.3 Māori 5.3 Non-Māori 5.3	2012: 6.3 6.9 5.3	•	Māori rate has increased since last year (but see next column).	Numbers are small so annual rates are subject to significant variation. Northland data for infant mortality by ethnicity is available only from 2010.

Overall the report card for Northland DHB is mixed:

- life expectancy for Māori overall has improved a little, though we can't see from the latest data how that is distributed across the sexes
- age-standardised mortality rates have worsened for Māori, and the Māori/non-Māori disparity has increased
- infant mortality appears to have worsened slightly, but the small numbers make firm conclusions difficult to draw
- acute admissions have decreased slightly since last year, a significant achievement given the ageing population and increasing prevalence of long term conditions (in the light of these, the target set in 2012 and its five-year timeframe now appear to have been ambitious)
- patient satisfaction is not far from target, though the changing nature of the questions asked mean it isn't possible to compare with last year's result.

Living within our means

Northland DHB achieved a small surplus in 2015/16 in a challenging fiscal environment of ever-increasing acute demand across nearly all clinical specialities, as well as delivering to national health targets. This was achieved by a continuous focus on improving productivity, reducing costs where possible and seeking value for money solutions and health outcomes without compromising clinical quality.

At a national level, Northland DHB continues to work closely with NZ Health Partnerships on national initiatives such as Banking and Insurance, National Infrastructure Platform, National Oracle Solution, National Procurement Programme to deliver benefits to Northland DHB. At a regional level, Northland DHB also continues to work closely with healthAlliance and the Auckland metropolitan DHBs to deliver a programme of regional procurement, capital planning, and shared information technology that results in reduced operating expenditure and avoided capital costs.

At a local level, productivity and cost savings initiatives undertaken included an ACC revenue initiative, improved supply chain management, a vehicle fleet rationalisation exercise, and effective utilities management including installation of energy-efficient heating solutions.

Statement of Performance

Introduction

Each year when we prepare the Annual Plan, we forecast in the Statement of Performance Expectations what we predict health services in Northland will achieve in the coming year. This document is our review of performance against expectations.

We deliberately do not try to measure the whole health system because it is too large and complex. The few measures selected are key indicators, either because they deal with services that have the greatest potential to contribute to health and wellbeing, or because they reflect critical parts of the health system that need to work effectively to manage current and future demand.

The review is not just about Northland DHB's performance; some of the measures describe services by other providers in Northland's health system, such as primary care.

The services provided are grouped into four 'Output Classes'. These reflect major groupings of health services and cover the spectrum from preventive activities through primary care services to hospital services and services for older people.

All data is for the 2015/16 financial year (1 July 2015 – 30 June 2016) unless otherwise stated.

Prevention Output Class

This Output Class includes publicly-funded services that protect and promote health across the whole population or particular subgroups of it. These services improve the health status of population groups, as distinct from treatment services (the other three Output Classes) which deal with illnesses and injuries of individuals. It includes:

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

Measure	Ethnic group	Result 2014/15 (baseline)	Target 2015/16	Result 2015/16	Achievement
Percentage of Year 10 students who have never smoked [2]	Total population	63.9%	65%	65.2%	✓
	Māori	M 52% F 44% T –	No target set	62.3% 52.2% 57.2%	↗
	Non-Māori	M 78% F 78% T –		76.1% 76.3% 76.2%	✗
Number of schools health promotion programmes offered		146 2014 CY [3]		146 2015 CY	
Number of students advised about stopping smoking		800 2014 CY		893 2015 CY	
Percentage of Northland adult population who are current smokers	Total population Māori Non-Māori	25.0% 41. 2% 18.4%	23.2% 37.9% 17.2%	No data[5]	• • •
People who have ever smoked recorded in primary care, of whom: current smokers offered brief advice offered cessation support		2014 CY	101,042 23,768 20,135 5,407 2014/15 Q3	106,402 24,167 23,041 7,916 2015/16	
Individual quit providers registered		1,177 Mar 2015		n/a [6] June 2016	

[2] *Data is for 2015 calendar year because Action on Smoking and Health collects it during the school (calendar) year.*

[3] *Incorrectly recorded in the 2015/16 SPE as 2015 CY.*

[4] *Data for this measure is drawn from the NZ Health Survey, but it is difficult to assess progress over recent years from this source because years are amalgamated to boost sample numbers, and the latest data only covers up to 2011-14. A good indication can however be obtained from PHO data on current smokers. Over the last four financial years (2012/13 to 2015/16) the smoking rate among non-Māori has declined from 16.0% to 13.8% and among Māori from 41.4% to 37.8%. The Government has set a national target of 5% smokers by 2025; in Northland, the decline among non-Māori is approximately on target to meet this, but the decline among Māori needs to accelerate.*

[5] *Data no longer available since the Quitline was taken over during 2015 by the national centralisation of phone help lines.*

Measure	Ethnic group	Result 2014/15 (baseline)	Target 2015/16	Result 2015/16	Achievement
Full and exclusive breastfeeding at 6 weeks [6]	Total population Māori [8] Non-Māori [9]	71% 60%	70%	77% [7] 69%	✓ ✓
Total NDHB hospital births for the twelve months		1,866 year ending Mar 2015		1,860 year ending Jun 2016	
Lactation consultant patient contacts		3,693 year ending Mar 2015		3,027 2015/16	
Percentage of eight-month-olds who are fully immunised	Total population Māori Non-Māori	87% 87% 87%	95%	89% 90% 88%	↗ ↗ ↗
Children immunised before 8 months of age		2,267 year ending Mar 2015		1,985 2015/16	
Breast cancer screening in eligible populations [10]	Total population Māori Non-Māori	71.9% 66.6% 73.6%	70%	71.0% 69.3% 71.5%	✓ ✓ ✓
Northland women screened: Total Māori Non-Māori		10,733 2,334 8,399 3 years to Dec 2014		11,445 2,901 8,544 3 years to June 2016	
Cervical cancer screening in eligible populations [11]	Total population Māori Non-Māori	72.4% 63.5% 73.6%	75%	74.1% 64.8% 76.3%	✓ ↗ ✓
Eligible women (aged 25-69) screened		41,179 [12] 3 years up to Dec 2014		29,948 3 years up to Dec 2015	

Early Detection and Management Output Class

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

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

6 *Data covers the two years to the end of June 2016.*

7 *Data is for Q1 and Q2 of 2015/16 only. Issues with Plunket's revised software have prevented the last two quarters' data being produced.*

8 *The 2014/15 SP measured breastfeeding at 3 months, but it was decided to change to 6 weeks in 2015/16. The 2014/15 data is unaudited.*

9 *Not supplied by Plunket.*

10 *Data is for July 2014 – June 2016 (breast screening works on a two-year cycle).*

11 *Between 2014/15 and 2015/16 MoH 'cleaned up' the data by improving how it was collected and analysed, so while the two years measure the same thing, their data doesn't compare exactly.*

12 *This figure incorrectly recorded the number of eligible women; the number screened was 30,864.*

13 *ASH hospitalisations are potentially avoidable through intervention in primary care. The data indicates how well people are accessing primary care services and how well those services meet their needs and manage the conditions effectively. Higher rates of ASH increase demand on scarce hospital resources, leading to increased costs and potentially negative impacts on patient care.*

Breast Screening Champions

A group of inspirational Northland women are no longer surprised when their whānau come running up to them excitedly shouting "Aunty, they're talking about you!" Northland's Breast Screening Champions gathered at the end of July to reflect on their contribution to the newly developed breast screening communications campaign.

Northland DHB has consistently achieved its breast screening target and, up until the new Census data was received, consistently exceeded the national target annually for Māori (73 percent) and non-Māori women (74.6 percent). The 2013 Census captured an additional 2,000 people (500 Māori) who had previously not been counted. Within that number are women we need to reach to offer the breast screening service. The communications strategy was developed as one initiative to achieve this goal.

The women celebrated the campaign by watching their video interviews on the big screen at Kerikeri's Cathay Cinemas. Their stories have helped raise awareness of Northland and Waitemata DHB's Mauri Ora Breast Clinic and mobile services, which contributed to an increased uptake of breast cancer screening services.

Breast screening service operations manager Barbara Miller thanked the women for their inspiring example. "Your stories are a gift and have helped us create awareness of breast screening, hope of survival and empowering us as women to take ownership of our health."

The communications strategy has included a number of elements including radio commercials voiced by the women, video clips and billboards.

Breast screening champion Raewyn Taaffe said seeing billboards around town have reminded her about her own breast screening appointments.

Breast screening champion Mahinaarangi Reihana said her bus driver tends to do a double-take when seeing her on a passing billboard. "It has been exciting and empowering," Mahinaarangi said. "I did a presentation [about breast cancer screening] at the marae with my sisters and brother and it was well received."

The video clips were also broadcast in the cinema before the showing of the kiwi film Mahana. "In The Warehouse one lady followed me around the shelves and then came up and said 'Have I seen you at the movies?' It gives me an opportunity to say to total strangers, go and get your breast screening," said Mahinaarangi. "The movies have been a great time to screen the interviews because so many mums and their kids go to the movies in the holidays."

The strategy focused on Māori and Pacific Island women, encouraging them to not put their screening off. May Seager, champion and manager of the Northland Pacific Islands Charitable Trust said the campaign has helped Pasifika women work through fear and anxiety around medical appointments. "For a lot of Pasifika women [breast screening] is something they are a little bit afraid of. But we can be proactive – don't be shy."

The breast screening mobile service visits 13 remote and rural towns across Northland. The Mauri Ora Breast Clinic service is based in Whangarei. A key aspect of the campaign has been to work with Breast Screen Champions from these local areas so that locals associate that the messages are important for them.

Hokianga Breast screening champion Dawn Harris said hearing her voice in radio campaigns resulted in several women coming to see her, then booking their screenings.

Pane Matthews said her Hokianga billboards seemed very effective. "We were at the garage at Rawene filling up and my six-year-old mokopuna spotted my poster in the window and called out 'Nanny, there's you.' It was and I was wearing the same clothes."

Moana Poutai from Whakapara said her daughter Jeannie was thrilled to see her in a campaign on Facebook and 'raced off to find the billboard'. "I was encouraged by mum and it'll help my girls, too," Jeannie says in the campaign's YouTube interviews. Moana said women who don't know her have been approaching her outside coffee shops. "They say we know you, and there's been awesome feedback from our tribe, Ngāti Hau. "There's a lot of good feedback when you see yourself on a big screen."

"I have had lots of people approach me," said Melva Davis-Mahoney (breast cancer survivor from Kaitaia). "They have told me how they saw me at the movies and boom, you were there and your story was so realistic."

Measure	Ethnic group		Result 2014/15 (baseline)	Target 2015/16	Result 2015/16	Achievement
Ambulatory sensitive hospitalisation [13] (ASH) rate per 1,000	Total Māori	0-74 0-74[14]	36.0 23.3	None set[15]	n/a[15]	n/a
	Total pop.	0-4 45-64	69.4 [16] 34.9		67.3 32.8	↗
	Māori	0-4 45-64	85.2 57.6		84.1 57.7	✘ ↗
	Non-Māori	0-4 45-64	48.6 27.3		46.0 24.2	↗
Total acute discharges of Northlanders from any hospital (NDHB and other DHBs): Total Māori Non-Māori			27,900 10,322 17,579 2013/14		29,297 10,736 18,561 2015/16	
Average number of decayed, missing or filled teeth among Year 8 students [17]	Total population Māori Non-Māori		1.59 2.25 0.80	1	1.23 1.61 0.76	↗ ↗ ✓
Number of treatment visits completed: preschool primary school children adolescents			8,549 25,206 10,790 2014 CY		7,388 21,664 10,158 2015 CY	
Good blood sugar management in diabetics	Total population Māori Non-Māori		58.9% 55.4% 61.0%	80%	61.5% 53.3% [18] 67.7%	↗ ✘ ↗
Diabetes annual reviews performed in primary care			4,854 year ending Mar 2015		4,799 year ending Mar 2016	
Eligible people receiving cardiovascular (CVD) risk assessment in the last five years	Total population Māori Non-Māori		91.1% 86.7% 93.0%	90%	91.3% 87.4% 93.0%	✓ ↗ ✓
CVD risk assessments performed in primary care			49,659 5 years to June 2014		49,957 5 years to June 2015	

[14] *The analysis up till 2014/15 was on rates per 100,000 for ages 0-74. In 2015/16 this was changed to rate per 1,000 for ages 0-4 and 45-64. The numbers in this cell are the published 0-74 data converted to rates per 1000 so they are at least somewhat comparable with the new method.*

[15] *2014/15 actuals data in the SPE as was improperly labelled as a target, and no target for 2015/16 was actually set.*

[16] *Unpublished figures. The data was presented in the SPE by the most common causes (for ages 0-4: dental, respiratory, gastrointestinal, dermal; for 45-64: cardiovascular, respiratory, dermal, diabetes, gastrointestinal). The figures in this table combine the results for all causes to make for a more manageable analysis.*

[17] *Data is for the 2015 calendar year because the Oral Health Service organises itself around the school year.*

[18] *The Northland Diabetes Operational Workgroup is reviewing the strategic plans to focus work on improving primary care's focus on diabetes management. Activities include: developing pilot services to improve access to primary care support to people with poorly controlled diabetes and low to medium mental health needs, in which funding is prioritised to high needs patients; remodelling the Care Plus programme; focussing the work of Practice Facilitators to share best practice and support primary care to strengthen their diabetes care; developing a clear plan to target people with pre-diabetes, which includes prioritising funding to incentivise additional Māori referrals into the Green Prescription programme.*

Pilot project tackles dental health through GPs

A pilot project underway through a Raumanga medical centre has the potential to progress both the dental health and general health of Northland children.

Northland DHB general manager, Youth, Maternal, Oral & Public Health, Jeanette Wedding said she is delighted to form a partnership with the private GP practice to extend preventive dental health programmes.

Ministry of Health figures show that in 2013 more than three-quarters (77 percent) of Māori children in Northland have tooth decay by the age of five, compared with 68 percent of a similar population in the rest of New Zealand.

Raumanga Medical Centre GP Dr Conlin Locke said poor dental health leads to pain for children and is linked to other childhood illnesses. However, research shows that fluoride varnish can significantly decrease cavities. This free fluoride varnish – and accompanying dental education – is offered to children aged between one and seven when they visit their GP.

"Although Northland has particularly low numbers of children enrolled with dental services, they are being brought to doctors' clinics like ours for other reasons, so we have an opportunity at the same time to start getting them on the right track with their dental care."

After discussion and consent from parents/caregivers, the child's teeth are painted with a controlled concentrated, banana-flavoured fluoride varnish. The doctor or nurse then works through a book with the children, their siblings and parents, on increasing awareness of good dental hygiene, the availability and affordability of good food that has an impact on dental health, as well as the persuasive and pervasive marketing of sugar-laden products such as fizzy drinks.

"This is a simple project with some potentially big outcomes," says Dr Locke. "The positive effect is expected to be measurable in two to five years' time, in the form of a reduction in childhood pain and illnesses, and a decrease in hospital admissions and surgery carried out at hospital dental clinics."

Dr Lock says of the parents who have been spoken to about fluoride varnish, 99 percent have taken up the option, with 115 children having the varnish applied in the six months that the project has been running. "Twenty-five to 30 percent of those indicated that they hadn't been enrolled with any kind of dental service." The six-month mark also means it is now time for the first children to come back to have the varnish re-applied.

Dr Locke is hoping to present the project at a conference for GPs, and says it has the potential to be rolled out nationwide to improve child dental health.

Intensive Assessment and Treatment Output Class

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

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

Measure	Ethnic group		Result 2014/15 (baseline)	Target 2015/16	Result 2015/16	Achievement
Percentage of acute patients readmitted to NDHB hospitals within 28 days	All pts. Age 75+		7.44% [19] 9.80%	7.30% 9.70%	[20]	●
Inpatient discharges for acute and acute arranged patients: All patients Ages 75+			5,830 [21] 846 2014 CY		33,350 6,176 2015/16	
Increase in elective services discharges	Total pop.	Baseline Additional Total	4,979 3,550 8,529	8,275	10,123	✓
Elective surgical discharges			6,704 2014/15 target		10,123 2015/16	
Patients with an emergency department length of stay of less than six hours	Total population		91.6%		92.1%	✓
	Māori		92.8%	95%	93.1%	✓
	Non-Māori		90.7%		91.6%	✓
Emergency department attendances			39,367 year ending Mar 2015		42,190 2015/16	
% of patients who receive their first cancer treatment (or other management) within 62 days referred urgently with a high suspicion of cancer and a need to be seen within two weeks	Total population		64.2% [22]		73.9%	↗
	Māori		78.8% [23]	85%	65.4%	●
	Non-Māori		64.2% [24]		75.6%	↗

[19] *Because the measure was relatively new, data last year was presented by quarter; the figures in this cell are averages of the results from all four quarters.*

[20] *No result can be provided because from Q1 2015/16 MoH decided to revise how this measure would be collected, and during this time no data was provided. An alternative would have been for NDHB to reproduce it ourselves, but this was not possible because MoH adjusted data from DHBs in ways we have not been able to fully understand.*

[21] *This data is from the 2015/16SPE, but it was incorrect. It should have been 32,105 for all patients and 5,831 for 75+ (this data is for 2014/15 FY).*

[22] *Because the measure was relatively new last year, data for 2014/15 was at the time presented by quarter. This figure is the average of the four quarters' results published in the SPE for 2015/16 (57.6%, 56.9%, 63.9%, 74.45%) which used a 12-month rolling period. Since then the period has been changed to a rolling 6 months; the same data under the new system yields an annual average for 2014/15 of 64.2% (from quarterly figures of 62.5%, 66.6%, 63.0%, 64.7%).*

[23] *See note 24. The four quarters' data for Māori for 2014/15 (which used a 12-month rolling period) published in the 2015/16 SPE were 58.1%, 62.9%, 72.7% and 78.85%. The same period's data under the new rolling 6-months definition data is 62.5%,88.9%, 81.2%, 82.3%. The 78.8% average was artificially high because of the small numbers that it represents (over the four quarters it varied between about 60% and 90%).*

[24] *This target was not in the published SP for 2014/15, though it was recorded in the graph.*

Measure	Ethnic group	Result 2014/15 (baseline)	Target 2015/16	Result 2015/16	Achievement
Patients referred urgently with high suspicion of cancer		166 year ending Mar 2015		197 2015/16	
Percentage of people with enduring mental illness aged 20-64 who are seen over a year	Total population	5.66%	5.68%	5.68%	✓
	Māori	9.06%	9.47%	8.98% [25]	✗
	Non-Māori	–	–	4.15%	●
Contacts by community mental health services with people who have enduring mental illness: direct (with client and/or whanau) care coordination (on behalf of client, with another agency)		94,500 23,800 2014/15 extrapolated		109,940 24,799 2015/16 CY	
Harm from falls while in hospital [26]	Total population	82	0	103	✗
Number of falls with major harm		10 2014/15		5 2015/16	
Pressure injuries while in NDHB facilities	Total population	68	0	64	✗
Inpatients admitted to NDHB		44,164 2014/15		44,813 2015/16	
Compliance with surgical checklist [27]	Total population	92.5%	90%	n/a	●
Number of operations performed		12,803 2014/15		12,939 2015/16	
Hand hygiene compliance	Total population	78.2%	90%	84%	↗
Number of hand hygiene moments observed		23,199 2014/15		38,470 2015/16	
Number of central line infections in last 1,000 bed days	Total population	0	0	No data [28]	●
Number of ICU patients with central lines inserted		195 2014/15		213 2015/16	
Percentage of patients with medicines reconciled [29]	Total population	51%	n/a	60%	↗
No. patients with medicines reconciled		4,902 2014/15		4,463 2015/16	

[25] *Although the result is under target, Māori access in NDHB is 1.5% above the national average and has plateaued over the last 3 years. Non-Māori data has been included in the next row for comparison, though there is no baseline data and no target was set for this ethnic group.*

[26] *Although the total number of falls reported has risen, there has been a drop in the number with major harm (categories 1 and 2), and a higher proportion of falls with minor injuries such as skin tears (category 3). This has occurred in the context of increasing numbers of frail patients, and without the usual summer let-up in patient numbers and acuity. The increase in falls recorded is probably due to the increased emphasis on reporting during 2015/16; staff have been encouraged to carry out risk assessments on all patients and increase the rate of follow-up reporting.*

[27] *It is not possible to relate the target to performance in 2015/16. Firstly, because during the year HQSC implemented a national electronic data collection system which split the old single-figure measure into three parts: sign in (check have the right patient for the procedure), time out (check right patient, right procedure, identify side / site surgery, VTE prophylaxis, etc), and sign out (identifying any issues for follow-up). Secondly because full implementation was not required by HQSC until 1 July 2016, and NDHB spent Jan-June gradually introducing and refining the system. (As an indication however, data from May and June show NDHB's performance for all three measures to be consistently above 80% and sometimes above 90%.)*

[28] *The Central Line-Associated Bacteraemia (CLAB) project was conducted nationally for ICU patients only, until it came to its planned end in Northland DHB in May 2015. At its conclusion each DHB agreed to work on developing its own system for monitoring compliance with the checklists which are instrumental in preventing these infections. CLAB infections are still identified in the bloodstream infection reports presented every month to the Infection Control Committee; a recent review of 31 records showed 28 (90.3%) to be complying.*

[29] *When med rec first received attention in 2014, rapid and significant improvement was made from less than 40% to 60%. Though no target was set for 2015/16, to have maintained that level since then is considered an achievement in the light of an increased number of admissions, increased demand for other pharmacist services and no further FTE.*

ED Huddle – Emergency Department Length of Stay

The number of patients presenting to Whangarei Hospital ED continues to increase. The average number of people presenting per day in 2014/15 was 94, it rose to 97 per day in 2015/16, and was 100 per day for the first six months of 2016.

The first quarter of 2016 from 1 January to 31 March saw a busy acute workload at Whangarei Hospital with an average of 106 patients presenting to ED per day. The month of February was particularly busy with the highest ever average of 108 presentations per day (compared with 98 in February 2015) and included peak days of 130–134 presentations and 40–47 admissions.

"We're looking at every part of the patient journey and saying: 'Is there a way we could do this that would be better for the patient, in a shorter timeframe, without compromising the quality of care for the patient, and working within our resources?," says Northland DHB's clinical head of medicine Dr Lucille Wilkinson.

Some initiatives have already been put in place, such as an earlier Whangarei Hospital Emergency Department huddle at 7.45am each day to assist in the collective coordination of the acute patient flow for the day. This replaces the previous 8.30am ED breach meeting, which was a retrospective view of patient flow.

"The huddle looks forward rather than back – it brings people together earlier in the day to look at what's going to happen and how we're going to deal with it," says Dr Wilkinson. She adds that presentations to the Whangarei Hospital ED now average more than 100 a day and are increasing faster than population growth. "We will have some days when we are well above the 100 mark. The expectations of what care we can and do provide have risen substantially."

Rehabilitation and Support Output Class

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

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

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

Measure	Ethnic group	Result 2014/15 (baseline)	Target 2015/16	Result 2015/16	Achievement
% of long-term Home and Community Support Services (HCSS[30]) clients assessed using interRAI tool	Total population	58%	77%	81%	✓
Number of HCSS clients assessed		1,687 Dec 2015		1,781 March 2016	
% of HCSS providers certified	Total population	100%	100%	100%	✓
Number of HCSS providers in Northland		9 Dec 2015		9 June 2016	
% age-related residential care facilities with at least 3-year certification	Total population	83%	83%	83%	✓
Number of residential care facilities in Northland		23 Dec 2015		23 June 2016	

Progress on outcomes

This section assesses progress on the measures above against the five outcomes in the Statement of Performance Expectations for 2015/16.

Healthy population

Of the six measures that fall under this outcome, target was met for four (never smokers among Year 10 students, current smokers among the Northland population, breastfeeding, breast cancer screening) and we were within 5% of target for cervical cancer screening. Immunisations still did not meet target, but coverage has improved due to strenuous efforts among primary care and Northland DHB staff.

For Māori, target was achieved for the current smoker's measure and we were within 5% of target for breastfeeding and breast cancer screening. For the other three measures (Year 10 smoking, immunisations, cervical screening) we did not meet target but performance improved.

Prevention of illness and disease

Of the seven measures under this heading, we achieved only two (smoking rates among the Northland population, breast cancer screening) and we were within 5% of target for cervical screening. Immunisations and hand hygiene did not meet target but performance improved, while the target was not met for falls and pressure injuries.

For Māori, target was met for the population smoking rate and we were within 5% for immunisations and breast cancer screening. The cervical cancer screening target was not met but performance improved. There was no Māori data for the three quality measures (hand hygiene, falls, pressure injuries).

Reversal of acute conditions

Target was achieved for only one measure, elective surgical operations, and we were within 5% for emergency department length of stay. For three more, performance improved although target wasn't met (both ASH measures, the oral health DMFT measure, medicine reconciliations). It was not possible to make a comparison with the previous year for the others (acute readmissions within 28 days, compliance with surgical checklist, central line infections).

Issues with data and changing definitions mean comparisons with last year for Māori are possible for only four measures. Of these we were within 5% of target for one (emergency department length of stay), improved on two (ASH for 45-64 year olds, oral health DMFT) and did not meet target on the other (ASH for 0-4 year olds.

Optimum quality of life for those with long term conditions

Of the four measures, target was achieved for two (cardiovascular risk assessments, the proportion of those with enduring mental illness seen). Target was not achieved for blood sugar management among people with diabetes or for the 62-day cancer measure, although performance has improved for

[30] *This used to be HBSS (home based support services) but in 2015/16 the term was altered to HCSS; the services provided remain unchanged.*

both; we are making good progress towards the cancer target, given that it was introduced nationally only in 2014/15 Q2.

Performance for Māori was not encouraging. Performance for cardiovascular risk assessments has improved, but blood sugar management and the proportion of those with enduring mental illness seen both did not meet target. It is not possible to draw firm conclusions for the 62-day cancer measure for Māori patients because of small numbers.

Independence for those with impairments or disability support needs

Target was met for all three of the indicators (home and community support clients receiving interRAI assessments, home and community support providers certified, providers of aged-related residential care with three-year certification). Data for Māori is not reported for any of these measures.

Comparison with last year

Of the 24 measures, it is possible to compare 20 of them with the previous year. Of these, performance for the total population was better for 12, similar for seven and worse for only one (harm from falls while in hospital).

For Māori the comparison can be done for 11 measures. Of these, performance was better for 8, similar for 2 and worse for 1 (blood sugar management among those with diabetes).

Momentary Slip Impacts on Active Lifestyle

Gail Harbour is not your average 67-year-old. The active Tutukaka resident loves to play tennis and walk Earl the dog. That is until she fractured her ankle and was left bedridden in 2015.

It was just an average day when Gail arrived home and went to let her beloved Labradoodle through the ranch slider. However, she slid on a towel that had been left on a recently-polished patch of concrete floor to catch water from Earl's drinking bowl and fell backwards, hearing the break as her ankle jammed under the couch. Such a miniscule moment in time, but the impact was huge.

She spent the next six weeks bedridden in a cast while using a walking frame to hop on one leg to the shower and toilet, which she describes as "horrible and so inconvenient". In the early stages, her sister arrived from Australia to look after her as Gail's partner had to return to his overseas assignment. "I've been doing the same routine for seven years since we moved here from Australia. Why did this happen?" Gail asks.

Gail, who has never broken a bone in her life, had a routine check-up before her arrival in New Zealand seven years ago. A bone density scan revealed Osteopenia. This is when the bones begin to thin and will likely lead to Osteoporosis. However, her active lifestyle and healthy diet held her in good stead.

Although the accident could have happened to anybody, it has made her realise how fragile her bones are and how breaking them impacts on lifestyle. The active lifestyle has come to a standstill while Gail regains her strength. She watches her diet now more than ever and her daily routine includes gym workouts twice a week with a personal trainer to improve the muscle tone in the leg, as well as to strengthen the ankle.

"The ankle will never be the same again but I am a pretty strong person and persevere. I just live each day as it is, albeit a lot more slowly and carefully. I am more aware that, regardless of how fit anyone is, you can still break an ankle."

Gail's fall has also affected her protective Labradoodle Earl; he was so traumatised from what he saw through the ranch slider that he still avoids walking on the concrete floor. "He will always take the long way round on the carpet to get to where he wants to go. It must've been quite a scene."

Gail says the service after her accident has been "absolutely fabulous". "From the ambulance paramedics to the nurses and the surgeon who did a great repair, including the follow-up care and advice. It makes me emotional now because everybody was so wonderful." Gail is determined that her post-accident care, along with healthy lifestyle and attitude, will see her return to the tennis courts.

[25] *This used to be HBSS (home based support services) but in 2015/16 the term was altered to HCSS; the services provided remain unchanged.*

Actual Statement of Comprehensive Income by Output Class

For the year ended 30 June 2016	$000 Intensive Assessment & Treatment	$000 Early Detection & Management	$000 Prevention	$000 Rehabilitation & Support Services	$000 Total
DHB Provider Revenue	240,394	32,128	3,285	10,543	286,351
Other Provider Revenue	12,828	5,122	9,645	742	28,337
Less Revenue Offsets	(3,215)	(1,807)	(2,967)	(1,034)	(9,023)
DHB Funder Revenue	81,396	108,142	9,432	58,883	257,852
DHB Governance and Administration	3,933	0	0	0	3,933
Total Revenue	335,335	143,584	19,395	69,135	567,449
Personnel Costs					
Medical Labour	60,609	1,298	1,290	(16)	63,181
Nursing Labour	68,954	7,344	698	4,457	81,454
Allied Health Labour	22,792	8,101	2,732	2,680	36,305
Non Clinical Support Labour	4,430	226	71	93	4,820
Management and Admin Labour	23,036	3,084	1,359	1,137	28,616
Non-Personnel Operating Costs					
Outsourced Clinical Services	6,414	1,370	42	96	7,922
Other Clinical Support	29,210	1,990	528	1,955	33,684
Implants	5,207	0	0	0	5,207
Pharmaceuticals	6,846	91	5	245	7,187
Infrastructure and Non Clinical Supplies	30,830	3,681	1,007	1,740	37,257
Cost of Capital	9,094	1,015	306	436	10,852
CTA Recoveries	(3,691)	(170)	(52)	(67)	(3,980)
Patient Support	4,637	11	10	9	4,666
Sterile Supplies	264	4	1	3	272
Provider Payments - To Providers					
Personal Health	63,182	63,216	2,632	995	130,025
Mental Health	12,610	1,187	0	0	13,796
Disability Support Services	163	0	11	56,845	57,019
Public Health	0	41,456	1,642	0	43,098
Maori Health	0	513	4,990	64	5,567
Total Operating Expenditure	344,587	134,417	17,272	70,673	566,948
Surplus (Deficit)	(9,252)	9,168	2,123	(1,538)	500

Budget Statement of Comprehensive Income by Output Class

For the year ended 30 June 2016	$000 Intensive Assessment & Treatment	$000 Early Detection & Management	$000 Prevention	$000 Rehabilitation & Support Services	$000 Total
DHB Provider Revenue	238,622	32,128	3,285	10,543	284,579
Other Provider Revenue	9,165	5,122	9,645	742	24,674
Less Revenue Offsets	(3,545)	(1,856)	(3,495)	(269)	(9,166)
DHB Funder Revenue	77,761	108,142	9,432	58,883	254,217
DHB Governance and Administration	3,932	0	0	0	3,932
Total SOI Revenue	325,935	143,536	18,866	69,899	558,237
Personnel Costs					
Medical Labour	54,696	2,389	1,311	81	58,477
Nursing Labour	66,697	7,434	694	4,511	79,335
Allied Health Labour	22,567	7,307	2,540	2,863	35,277
Non Clinical Support Labour	4,396	218	55	107	4,777
Management and Admin Labour	22,484	3,468	1,423	1,378	28,753
Non-Personnel Operating Costs					
Outsourced Clinical Services	5,226	288	109	137	5,760
Other Clinical Support	28,874	2,326	785	1,922	33,906
Implants	4,408	0	0	0	4,408
Pharmaceuticals	5,824	68	4	259	6,155
Infrastructure and Non Clinical Supplies	28,853	4,277	1,027	1,995	36,152
Cost of Capital	8,193	867	269	475	9,803
CTA Recoveries	(3,468)	(174)	(43)	(49)	(3,735)
Patient Support	4,661	20	9	11	4,702
Sterile Supplies	237	7	1	4	249
Provider Payments - To Providers					
Personal Health	64,090	64,125	2,670	1,009	131,895
Mental Health	12,791	1,204	0	0	13,995
Disability Support Services	165	0	11	57,663	57,839
Public Health	0	42,052	1,666	0	43,718
Maori Health	0	520	5,062	65	5,647
Total SOI Operating Expenditure	330,695	136,395	17,592	72,431	557,113
Surplus (Deficit)	(4,760)	7,140	1,275	(2,531)	1,124

National Health Targets

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

Northland health targets results 2015/16 (average over four quarters)							
	Shorter stays in emergency departments	Increased access to elective surgery	Faster Cancer Treatment	Increased immunisation (8-month-olds)	Better help for smokers to quit – hospitals	Better help for smokers to quit – primary care	More heart & diabetes checks
Ranking quarter 4, 2015/16	15	1	10	18	11	13	10
Result	92.2%	122.3%	73.9%	89.2%	95.4%	87.3%	91.3%
National goal	95.0%	100.0%	90.0%	95.0%	95.0%	90.0%	90.0%

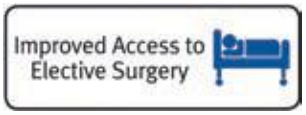
The DHB ranking shows the DHB's relative performance compared with that of other DHBs. In most cases a rank of one represents comparatively good performance, but when all DHB are close to target, a lower rank doesn't necessarily mean poorer performance.

Shorter stays in Emergency Departments (DHB)

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

We continue to work on measures to address acute patient flow and to work in a more integrated way across the health sector. We are particularly focusing on acute general medicine and reviewing the Site Master Plan for a revamped ED and a new Acute Assessment Unit.

Improved access to elective surgery (DHB)



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

Northland DHB has achieved its 2015/16 health target with improved access to elective surgery reaching 122.3 percent. For the full year, 10,123 people have been provided with elective surgery, which is 1,848 patients more than planned.

This is now the ninth year in a row that Northland DHB has exceeded our full year health target and we have consistently been the top-performing DHB.

Faster Cancer Treatment (DHB)

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

Northland's performance in starting treatment within 62 days for patients referred with a high suspicion of cancer continues to improve. This year's performance of 73.9 percent is about eight percent better than last year's.

A key focus is to improve the early stages of the lung cancer pathway so that there is no more than ten days from referral to tissue biopsy. This time incorporates the first specialist appointment, lung function tests, chest CT, and follow-up and bronchoscopy or CT guided biopsy in a single day. A Ministry-funded three-year Faster Cancer Treatment improvement project is in progress. Northland DHB is working with northern regional DHB colleagues on this.

Increased immunisation (DHB)

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

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

Our immunisation health target results have been improving, although they are still below target. Northland DHB achieved 89.2 percent to June 2016; below the target of 95 percent, but better than last year's 86.3 percent. There is an immense amount of work being done in this area with renewed initiatives and a steering group chaired by the chief executive. Northland has a challenging environment, particularly because of our rate of people declining immunisation (over eight percent, compared with the national average of about four percent).

Better help for smokers to quit (DHB and PHO)

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

Our performance on the hospital target is still over the 95 percent target at 95.4, similar to last year's 95.6 percent. Northland's PHOs had a mixed result on the primary care measure, with Manaia Health PHO exceeding the 90 percent target with a performance of 94.2 percent and Te Tai Tokerau below target at 78.9 percent. Increased immunisation.

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

Primary Health Organisations Health Targets (2015/16)

Increased immunisation

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

Manaia Health PHO reached 91 percent and Te Tai Tokerau PHO reached 90 percent, both below the target of 95 percent.

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

Better help for smokers to quit (PHO)

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

The Manaia Health PHO result was better than target at 94.2 percent.

Te Tai Tokerau PHO's result of 78.9 percent was below target by about 11 percent.

More heart and diabetes checks (PHO)

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

Manaia Health PHO has met this target reaching 92.3 percent, whereas Te Tai Tokerau PHO was close at 89.9 percent.

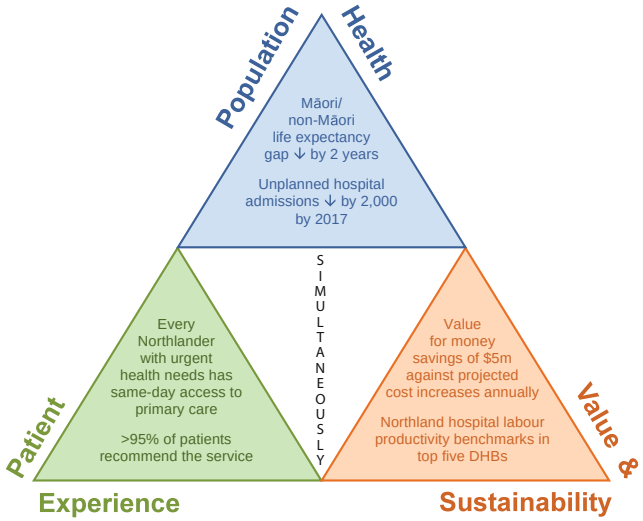
Primary Health Organisations health targets (2015/16)

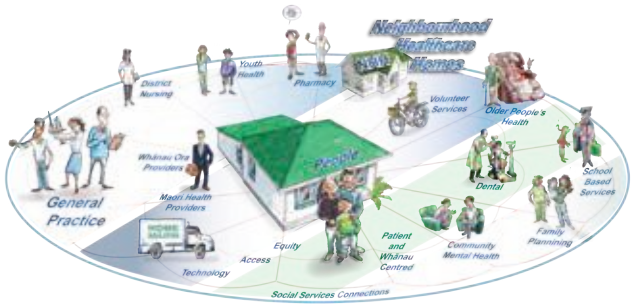
	Increased Immunisation	Better help for smokers to quit	More heart and diabetes checks
Manaia Health PHO Limited	91%	94.2%	92.3%
Te Tai Tokerau PHO Limited	90%	78.9%	89.9%
Northland	89% [26]	87.3%	91.3%
National goal	95%	90%	90%

[26] *The Northland figure includes some children in the Wellsford area who receive services from Northland.*

Implementing Northland Health Services Plan 2012–2017

The implementation of the Northland Health Services Plan (NHSP) 2012–2017 is a collaborative, Northland-wide health sector response to the challenges of our ageing and high-need population. We report below on progress with our major NHSP strategic change projects.





Neighbourhood Healthcare Homes

Neighbourhood Healthcare Homes (NHH) is a major primary care collaboration between Te Tai Tokerau PHO, Manaia Health PHO and Northland DHB. It is implementing a new model of primary healthcare, in response to the following challenges within the sector:

- an ageing population
- increasing numbers of people with long term conditions
- ageing workforce
- pressures on the hospital capacity
- health inequities
- increased consumer expectations.

These pressures, coupled with changing technology and an emphasis on the benefits of patient-centred care, have driven the development of this new model.

The aim of the project is:

"Northland primary healthcare becomes an exemplar of how a patient-centred, equity based model of care can improve health outcomes for the population, and attract a primary care workforce that feels passionate and excited about what they do."

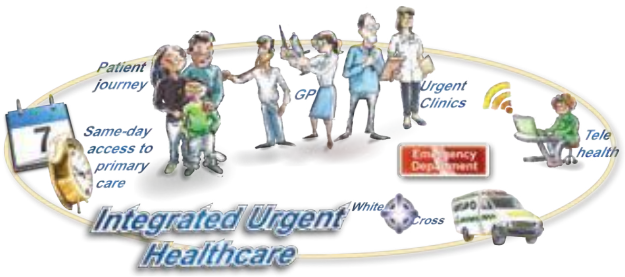
The model focuses on the following change areas:

- Equity initiatives to address inequities of access and services use
- Access initiatives to improve the way patients can engage with their practice team (for example patient portals, GP triage of urgent appointment requests, clinical and administrative pre work) to be fully prepared for patient visits, extended hours, flexible appointments related to need
- Releasing capacity within the practice system to enable change, especially to work more proactively with the high-need group of patients including those who are under served. Released capacity is also expected to enable more connection between general practice, hospital services, community and social services
- LEAN approaches to reducing waste (such as patient waiting) in the system and streamlining the patient journey
- Increased use of technology to enable connections and coordination between the health team and the service user
- Collaboration between the general practice and other health and social service teams
- Workforce initiatives that support the team to work at the top of their skill set and development of new roles to support the patient journey.

To achieve these changes, the three boards of the PHOs and Northland DHB supported business cases for new investment. An expression of interest process called for applicants from all interested general practices in Northland. Fifteen practices applied and in the first year (2016/17) six practices will be supported to go through the intensive change process to re-organise the way that they work and deliver services. New change management and financial analyst roles have been established to support the change within practices. Over the following two years the expression of interest process will be run annually to select additional practices to adopt the Neighbourhood Healthcare Home model of care.

Foundation work such as building a primary/secondary care shared data warehouse and researching access to general practice appointments has also underpinned the design of this new initiative. Locality networks of providers around Neighbourhood Healthcare Homes are also operating in two areas of Northland – Whangarei North and Kerikeri.

Northland PHOs and Northland DHB have joined the NZ Healthcare Home Collaborative that includes organisations from other areas in New Zealand which are also building healthcare home models. There is considerable interest in and energy about this new model of care development. Although we are in the early implementation phase, support for the changes required is heartening and affirms the direction of travel.



Integrated Urgent Healthcare

The integrated urgent healthcare project has had two areas of focus:

- same-day access to primary care
- patient journey – acute general medicine.

The patient journey work has been integrated into a Whangarei Hospital Urgent Care Group and is reported elsewhere.

The 'Same-day access to primary care' project carried out research into general practice appointment availability across Northland. An individualised report was produced for each general practice, which outlined key information about each practice's appointment availability and their patient's use of White Cross and emergency department services. Reports were presented at continuing medical education sessions by GPs and included information and advice to support practices to review their appointment scheduling systems and consider ways to improve patient access to primary care.

The research included:

Identification of the time to 'Third Next Available Appointment' for each practice. This measures routine appointment availability and is an internationally validated metric. Of the 35 Northland general practices participating, 8 percent returned a result of one day until the third next available appointment, 29 percent between 1.1 and 1.9 days and 63 percent between 2 and 5.5 days.

Exploration of acute appointment availability. Research assistants called each practice in Northland and requested an urgent appointment. The time until the next available urgent appointment was recorded and the type of appointment – whether it was, for example, a double booking or blocked out urgent slot. With few exceptions a patient needing an urgent consultation was able to be seen on the same day. However, accessing urgent appointments relied on successfully negotiating a number of potential barriers.

White Cross patient attendance data was provided for Whangarei general practices and ED attendance data for all practices. During the same time period as the third next available appointment and urgent appointment research, the White Cross A&M service surveyed patients about reasons why they were attending White Cross. Results were provided to general practices. The survey found 76 percent of the 107 respondents had tried to get an appointment with their GP before coming to White Cross.

The intention of providing this information was to stimulate reflection and discussion about existing appointment scheduling systems and different options for improving access to general practice appointments. The information also provides a baseline of appointment availability information which can be compared in future years following general practice model of care changes as part of the Neighbourhood Healthcare Home developments.

Fit for Life Obesity Prevention

Obesity is predicted to become the leading preventable cause of health loss in New Zealand, overtaking the impact of tobacco in 2016. Obesity and being overweight increase the risk of chronic disease, including heart disease, stroke, type 2 diabetes and some forms of cancer. Pressure on the health system of our growing overweight and obese nation is unsustainable.

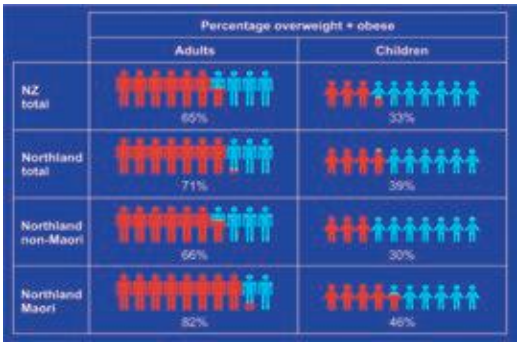
Obesity also has an impact on our economic, social, cultural and environmental wellbeing. At an individual and family level it can affect our income, educational achievement, self-esteem and social participation. The rates of obesity and overweight in Northland are significantly higher than they are nationally.

Te Roopu Kai Hapai Oranga (TRKHO), Northland's Health Alliance Leadership Team, have obesity as a priority focus. Last year an extensive and thorough process was undertaken to provide recommendations to TRKHO on what we can do in Northland to best tackle the obesity epidemic. The process included a stocktake of all existing projects and initiatives related to obesity and healthy lifestyles across Northland followed, by data analysis. National experts provided their knowledge and advice on what we can do at a local level. A consumer survey was carried out, resulting in close to 400 responses to what we can do to address obesity. An intersectoral working group held a number of workshops to collaboratively process and inform the recommendations. The working group included wide representation from Primary and Secondary Care, Māori Providers, Sport Northland, Local Council, Cancer Society and the Heart Foundation. This course of action resulted in the development of the Tai Tokerau Childhood Obesity Prevention Framework.

The goal of the framework is 'To increase the number of Māori tamariki who are at a healthy weight by 5 percent through good kai in five years (2021)'. The priority groups that all initiatives will target are mama and pepi and tamariki up to the age of 10 years, with a focus on Māori and the obesogenic environment.

Seven principles have been developed that all work undertaken will align with. These principles include:

Reduce inequalities for population groups most at need; Implementation through settings-based and systems approaches; Emphasise changing the food environment; and Enable community action.



Fit for Life: Tai Tokerau Childhood Obesity Prevention Framework

Goal	To increase the proportion of Maori tamariki who are at a healthy weight by 5% through good kai in five years (2021)						
Guiding Principles	Reduce inequities for population groups most at need	Work smarter not harder	Enable community action	Implementation through settings based and systems approaches	Emphasis on changing the food environment	Enable a co-ordinated and collaborative approach across sectors	Kaupapa Maori approach: Availability, Accessibility Affordability, Acceptability
Strategic Objective	Create environments that support healthy eating for all tamariki in order to:						
	Reduce consumption of energy dense foods	Increase consumption of fruits and vegetables	Decrease consumption of SSB's	Raise awareness of good nutrition			
Environments and Settings	ECE / Kohanga Reo	School / Kura Kaupapa	Workplaces (including all health organisations)	Social environments (homes, marae, community and recreational facilities, churches)			
Priority Groups	Mama and Pepi	Preschool Aged Tamariki	School Aged Tamariki up to the age of 10 years				
	Focus on Maori						
	Focus on Obesogenic Environment						
Workstreams	**Food Security** *Make access to healthy food more available and affordable* Informas / Foodback App Food Rescue Extension of Kai Ora Fund	**Sugar Sweetened Beverages (SSBs)** *Eliminate SSBs in all settings* SSB Advocacy Safe Drinking Water	**Advocacy and Policy** *Advocate via Leadership Groups / Intersectoral / Industry / Council* Sport Sponsorship Healthy Kai Food Policies Collaboration of School Services Food and Drink Industry	**Health Literacy** *Nutrition education to support informed choices* Under 5 Energize Extension of Oranga Kai Maternal and Infant Health			
Enablers	**Leadership, Partnerships, Advocacy** Northland Intersectoral Forum (NIF), Te Roopu Kai Hapai Oranga (TRKHO), NDHB Kaunihera, Iwi CEO Consortium, Iwi Chairs, Councils Regional Advocacy Programme, Inter-agency groups and coalitions, Child and Youth Friendly City, Te Kohanga Reo National Trust, Healthy Families NZ Governance Group, Healthy Eating Active Lifestyles (HEAL), Caring for our Futures Governance Group.						
	Workforce Development						
	Communications Plan						

First 2000 Days

Projects to Improve Health Outcomes for Tamariki Māori

On average 2,000 babies are born in Northland annually. For the majority of women, pregnancy is a normal and uncomplicated life event. Care in pregnancy is provided primarily by a Lead Maternity Carer (LMC) with general practice support for non-pregnancy related healthcare.

It is estimated that approximately 20 percent of infants in Northland are born to women who have health and social needs that require more than two additional services in addition to usual primary care provision. These services enable them to have a well-supported, healthy pregnancy and give birth to a healthy baby. Evidence shows that the social determinants of health (for example education, income, housing, social deprivation etc.) have a significant impact on outcomes for pregnant women and infants. Māori pregnant women and their babies experience poorer health outcomes than others living in Northland.

Over the past three years, a programme of work has been undertaken to strengthen the delivery of maternity in association with other health and social services delivery.

To understand the issues impacting on the health of pregnant women, a series of stakeholder hui, focus groups, and consultations with key providers were held around Northland. The objective was to gain feedback about the current provision of services to pregnant women and gather ideas for changes that could be made to improve their health and wellbeing. This feedback has informed a number of projects that aim to improve the consistency and effectiveness of services delivered to pregnant women.

Establishment of the Maternal and Infant Care Coordination Forum

One of the key areas of focus is to improve the coordination of care when a number of services need to be working together with a woman during her pregnancy and after her baby is born. The Maternal and Infant Care Coordination Forum has therefore been established. This interdisciplinary meeting will enable services to work more transparently through collective planning and development of a single plan of care in partnership with pregnant women and their LMC. Care planning will also ensure that after delivery, there is access to universal child health checks and services, such as newborn hearing screening, newborn enrolment with a general practice and a smooth transition of care between LMC and Well Child/Tamariki Ora provider.

Sudden Unexpected Death in Infancy (SUDI) Prevention Programme

Since 2013, Northland DHB has undertaken a multi-pronged approach to reduce SUDI deaths experienced for Māori whānau in the region.

A pilot project was completed during April and September of 2013 in both Whangarei and Kaitaia. Key components of the pilot included: implementation of a SUDI risk factor assessment tool; targeted additional safe sleep discussion (particularly the increased risk associated with smoking and bed sharing); and the offer of a wahakura waikawa or PepiPod to support a safer sleep option in bed sharing.

Marae-based wananga across Northland were held to facilitate community discussion about SUDI and the protective actions and promote the weaving of wahakura waikawa. The pilot was evaluated.

A business as usual model of assessment, education and safe sleep space distribution has been implemented, with babies in the Special Care Baby Unit a priority group for provision of a safe sleep space if needed. The programme focused on safe sleep for all infants but particularly for infants less than three months, where risk of SUDI is greatest.

A regional action plan and key performance measures have been developed in partnership with regional stakeholders.

SUDI prevention champions are in maternity and child health services across the region.

A regional Safe Infant Sleep Policy has been developed and implemented. Healthcare workforce education programmes are now mandatory, to enable delivery of consistent verbal and written advice on SUDI prevention to whānau.

Community awareness-raising of SUDI messages across the region has continued. Every opportunity has been taken to profile the safe sleep messages using a wide range of media. With the help of the regional Child Health Network, four safe sleep video commercials have been produced and these have been distributed widely.

Marae-based Wananga

Since the pilot programme began, the marae-based one-day wananga on SUDI prevention actions have continued across Northland focusing on reaching pregnant women and whānau with infants and young children. Over 40 marae have participated in this programme since we started in 2013. The wananga have been facilitated by Māori midwives working in partnership with a health promotor from Whakawhetu, local community providers of maternity, Well Child services and health promotion services. Key messages include: smoke and substance-free pregnancy and childhood, safe sleep for every sleep, breastfeeding and immunisation.

Feedback from participants reiterates the importance of kaupapa Māori to whānau who attend. Participants have consistently expressed their comfort in attending their own environment on the

marae for interactive learning. Whānau who have been attending wananga have been identified by service providers as whānau less likely to seek out healthcare and the wananga have provided an opportunity for service providers to make direct contact with whānau across a range of health and welfare topics. The weaving of wahakura continues to be an important component of the hui.

Kaupapa Māori Antenatal Education

Work continues toward improving access to antenatal education for Māori pregnant women and whānau who are not attending mainstream programmes.

Te Mata o Mua is a kaupapa Māori antenatal education programme delivered by Hauora Whanui in Kawakawa in partnership with local health promotion services. One-off funding through the Māori Health Plan for SUDI prevention has provided an opportunity to adapt and develop this hapu wananga model for delivery to urban communities in Whangarei on a monthly basis.

The programme is supported through the attendance of local service providers across the full range of health and social support services that are working with pregnant women and whānau with young children. The emphasis is on services that promote the key protective messages to prevent SUDI: smoking cessation, drug and alcohol free, nutrition and nutrition and exercise, breastfeeding and safe sleep. Immunisation and infant/preschool and maternal oral health are also promoted.

Pregnant women and their whānau are invited to attend. Transport support is provided. LMCs and other health and social services that are working with pregnant women and whānau are actively encouraged to identify pregnant women and support their participation.

The making of ipu whenua is an activity of the programme. The weaving of wahakura is an additional component of the programme with weaving demonstration taking place during the hui.

Discussions with key stakeholders about re-establishment of the group session antenatal programme in Kaitaia have occurred and agreement reached to develop and implement a hapu wananga programme out of Kaitaia Hospital. Every effort is being made to build the programme in Whangarei and Kaitaia utilising existing services and resources. It is acknowledged that some ongoing funding is required to sustain programme delivery and funding options are being explored.

An external evaluation of both the Marae/community based wananga and the hapu wananga Te mata o Mua has been undertaken and this will inform and support the DHB decision making about approaches in antenatal education and parenting preparation programmes for Māori whānau across Tai Tokerau.

Patient and Whānau-centred Care

The project has continued to build on the embedding and enriching our values campaign launched last year with the roll-out of our values-led behaviours. Resources to support staff in living up to our values have been developed and distributed, along with key learnings from values week to all staff. Across the multiple DHB sites, posters have been installed that promote our agreed behaviours to staff and public.

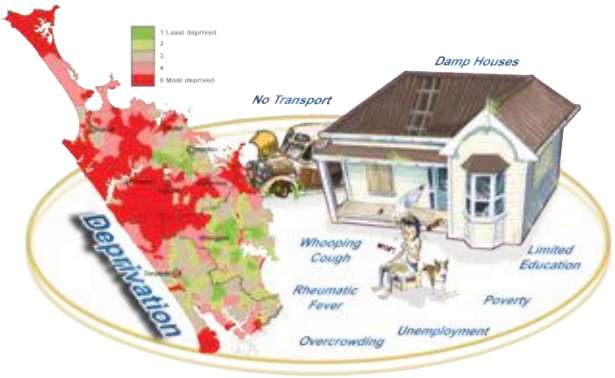
Engaging patients and whānau as partners is a key approach to establishing a patient and whānau-centred care philosophy and this has been another area of focus for the project. At an organisational level the Northland Health Consumer Council continues to participate in health service planning and delivery. At the individual experience level a new partner in care and visitors policy has been released, after extensive consultation with staff and consumers. The policy supports a more formal process for patients to nominate a partner in care who can be involved in planning and delivery of care at the level the patient chooses.

Patient and whānau-centred care (PWCC) is a widely recognised dimension of high quality care. Part-way through this year the project transitioned out of the NHSP project office to the Patient Safety and Quality Improvement Directorate (PSQID). Further information on PWCC can be found in the PSQID section of this document.

Northland Health Consumer Council

The Northland District Health Board Consumer Council has been operating for just over 18 months and, as Chair, I am proud of the engagement between the management, senior staff and those on the Council. Council members have openly shared their experiences, have offered their opinions on a wide range of topics and areas within the DHB, all helping to improve services and enhance the patient experience.

Currently we sit on 16 active project boards or steering groups that meet regularly. We have attended over 31 workshops and events, including a number of "In Your Shoes" sessions during Northland DHB Values week. We have developed a range of web-based forms to allow easy interaction with the Council, along with providing an intranet/internet presence. Meeting with other consumer council chairs nationally has given us the opportunity to share what we have developed to advance other DHB consumer councils



Eliminating Inequities

Throughout the year, Northland DHB has developed an Eliminating Inequities Steering Group programme of work to act as an enabler to the five projects arising out of the Northland Health Services Plan 2012–2017.

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

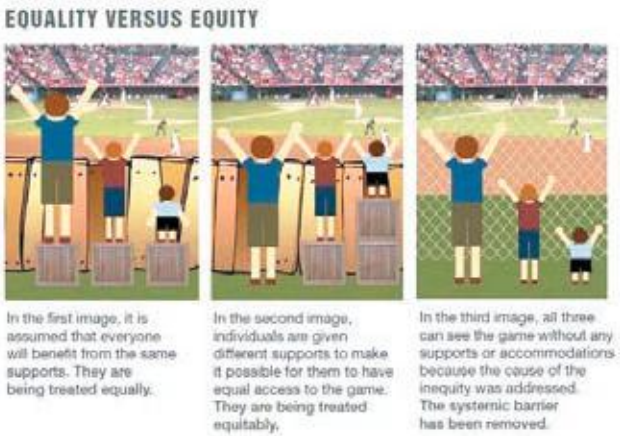
- reviewing policy
- communicating and socialising the need to reduce inequities through the Equity for Health Care for Māori framework
- delivering training and development on how to change our approach by using an equity lens in decision-making to improve health outcomes for our Māori population.

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

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

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

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



The image on the left gives a perspective on 'equality' where each component is given a perceived equal share of the resources and effort. However, the starting point is never equal due to the impacts of socio-economic determinants on a particular portion of the population, in particular Māori. The image in the middle shows that equity (extra resource, increase in access, reduction in differential treatment and care and focused effort to a targeted audience) is critical to ensuring equality is effective, particularly in health outcomes. The image on the right demonstrates that because the inequity is addressed and systemic barriers have been removed all three can see the game. One step further is to remove the 'fence'.

Progress to Date

There have been some health gains for Māori in the last 5–10 years:

- The life expectancy gap between Northland Māori and non-Māori at birth in 2001 was 10.27 years, improved in 2009 to 9.51 years and at 2013 is at 9.26 years. Nationally the life expectancy gap between Māori and non-Māori in 2013 was 6.9 years
- Our smoking prevalence has declined from 44 percent Māori in 2006 to 34 percent Māori in 2013. From the 2006 Census to 2013, there were approximately 1,700 more ex-smokers in Tai Tokerau
- There has been a significant increase in the proportion of Northland Māori aged 14 and 15 years who have never smoked, and a decrease in the proportion of Māori aged 15–24 years who smoke regularly
- Meeting the health target for more CVD and diabetes checks
- Consistently meeting our regional Kia Ora Hauora targets of 25 new Māori students per year into first-year tertiary study and recruiting 125 new Māori students per year onto a career in health study
- Māori enrolment in PHOs has been consistently high
- Māori breastfeeding rates in Northland have regularly been in the top five DHBs and improved significantly in all three milestones (6 weeks, 3 months and 6 months)
- Northland DHB's new Maternity Unit Te Kotuku was opened in February 2016 bringing all maternity services together. It is purpose-built to provide culturally and clinically safe maternity care
- Northlands rheumatic fever rates have reduced significantly from 9 per 100,000 in 2014 to 3 per 100,000 in 2015, with only one ARF notification since July 2015
- Childhood immunisation rates for Northland Māori and Non-Māori are equally served
- Māori Health non-government organisations are engaging in a new improved model of primary care (Neighbourhood Healthcare Homes) to improve efficiency and effectiveness of acute care in Northland
- Northland's Sudden Unexpected Death in Infancy (SUDI) rate has improved from the previous Māori SUDI rate at 3.4 per 1,000 live births (aggregated 2007–2011) to 1.6 per 1,000 live births currently
- Māori Mental Health Compulsory Treatment Orders have improved from Quarter 1 (2015) 518/100,00 to Quarter 1 (2016) 474/100,000 – approximately a 10 percent improvement

- In 2013, most Northland Māori adults (82 percent) reported that their whānau were doing well
- Two thirds of Māori infants were enrolled with a Primary Health Organisation by three months of age.

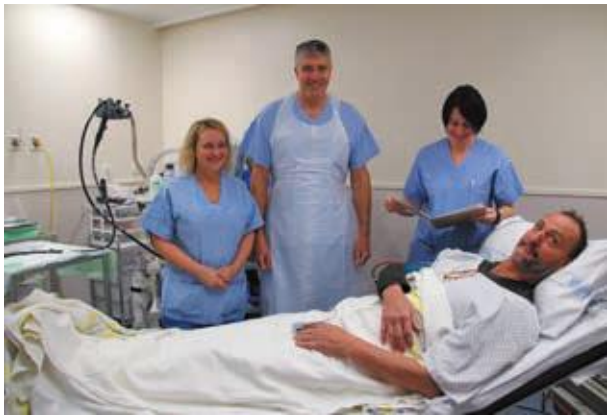
Trendly: Māori Health Performance Monitoring Tool

The web-based performance monitoring tool called Trendly has been helpful in assisting DHBs accelerate Māori health gains by increasing access to health performance information as it becomes available.

The main focus is towards new data notification with narratives provided to give guidance to DHBs on what it would take to reach the national indicator targets, both qualitatively and quantitatively. The data allows for real-time analysis and comparisons with benchmarking being offered on best performing DHBs and the home DHB.

New facilities are being developed which will:

- enable data to be viewed by PHO
- provide costs of disparities
- display mortality and morbidity costs
- provide for a mobile app to access Trendly data.



Manaia Health PHO

By Mary Carthew, Interim Chief Executive

Manaia Health PHO

Manaia Health was established on 1 July 2003 operating within the Whangarei and Kaipara district of Northland. With a current patient enrolment of approximately 96,000 the organisation has two equal shareholders: Terenga Paraoa Ltd, a grouping of Māori Health Providers and local Hapu, and Whangarei Healthcare Ltd which consists of GPs and practice nurses working in the Manaia coverage area.

Manaia Health works to provide services to improve the health of our entire enrolled population. Our work requires a patient-centred approach to healthcare, robust relationships with key stakeholders and an ability to work collaboratively across the health and social sector, and the wider Northland community. Key stakeholders include our General Practices, our Māori partners, the Northland District Health Board, key government agencies such as Housing, Social Development, Education, Police, District Councils and a large number of non-government organisations who work in our area.

Twenty-three general practices, 89 GPs and 100 practice nurses are a part of the wider team that services the people enrolled with the PHO. Members of this team have been actively engaged and working alongside the Northland DHB over the past year, to remodel primary care. The proposed Neighbourhood Healthcare Home model of care in Northland follows national and international evidence that patients want to be more involved with their care, and general practice staff desire change to ensure sustainability and greater work satisfaction. Four Manaia Health practices will join with two Tai Tokerau PHO practices in 2016/17 to lead the change process.

Implicit in the work we do, and within the changing model of primary care, is the recognition that Northland has significant health inequities which must define the way we do things. The Neighbourhood Healthcare Home model prioritises action to address these issues.

During 2015/16 a comprehensive consultation process took place with consumers, nurses, midwives and managers to examine the current model of primary and community nursing – a model that has been in place for several decades. The consumers were clear about their needs, and as a result a new model of care has been developed for the primary and community nursing teams of Northland. Implementation will begin in Whangarei during the 2016/17 year.

An excellent example of collaborative partnership this year is the opening of the child health hub – Te Aro o te Haa, bringing together the Northland DHB and PHO child health teams on one site at Manaia Health. The team of nurses, community health workers, and administration and National Immunisation Register personnel has resulted in a much improved 'joined up' child health service. Along with a lot of hard work by the whole primary health team, the immunisation rate of our Northland babies has risen steadily. Maintaining and improving the result will be possible with the whole team committed to this important goal.

The primary healthcare team continues to go from strength to strength. Our hard working nurses and doctors continue to embrace challenges – from the day-to-day intensity of meeting the high volume and demand of people seeking care and treatment, to the hours of professional development and training undertaken after busy work days.

This year in Northland we have more primary healthcare nurses completing their credential in mental health and addictions, training in the fundamentals of asthma and chronic obstructive pulmonary disease management, and extending their knowledge of diabetes management. Several GPs are taking strong clinical leadership roles on clinical governance groups and work streams, working collaboratively with our DHB and Te Tai Tokerau colleagues. We now have three experienced clinical directors covering the Northland district who provide valuable support and knowledge to our primary care teams.

Te Tai Tokerau PHO

By Rose Lightfoot Chief Executive

Te Tai Tokerau Primary Health Organisation has operated since April 2003 within the Mid and Far North of Northland from Kawakawa to the top of the Te Aupouri peninsula (see yellow portion of map). There are 62,760 people enrolled in Te Tai Tokerau PHO. The geographical area is serviced by 16 general practices with three additional satellite clinics that provide 24-hour, seven-day-a-week primary care services to address access in remote areas.

Te Tai Tokerau PHO works closely with the Northland DHB and Manaia Health PHO (covering Whangarei and Kaipara) to improve health status of population groups as well as individual patients and their whānau. Reducing health inequity across the whole Northland population is a key collective priority. Te Tai Tokerau PHO is committed to providing and facilitating high quality clinical services, working with other providers in programmes such as the housing initiative, to address key determinants of health, which include poverty and inequity of access to services, and to improve health status of Northlanders.

Over the last nine months the Board of Directors of Te Tai Tokerau and Manaia Health PHOs have embarked on a journey to explore a configuration that best meets the primary health needs of the Northland communities covered by the two PHOs. The strongly aligned mission and values of both organisations has reinforced the commitment to develop innovative strategies to reduce disparities between Māori and non-Māori. This will be an ongoing process in the coming year.

As at 30 June 2016, of the 62,760 enrolled patients in Te Tai Tokerau PHO 49 percent are Māori, 47 percent are Pakeha/European, two percent are Pacific People and two percent identify as Asian. Forty-five percent of those enrolled live in areas classified as Quintile 5, the highest level of deprivation. Consequently, the burden of disease is high, in particular from long-term conditions related to poverty such as respiratory conditions, diabetes and heart disease.

Te Tai Tokerau PHO GPs continue to maintain clinical partnerships between primary healthcare and secondary hospital services in the larger rural communities. There has been a strong focus within primary care during the last 12 months through engagement in the Neighbourhood Healthcare Homes programme to develop a new way of working in collaboration with other providers, and to place the consumer of services in the centre of both service planning and delivery. An exciting development has been the introduction of the patient portal, which gives direct access by the patient to their own health records held in general practice and opens the way to alternative means of consulting with their GP such as via email.

Te Tai Tokerau PHO strongly supports the contribution of nurses as active participants in the primary healthcare team. The Te Hononga model developed by Hemaima Reihana-Tait, Director of Nursing Primary Health Care, depicts the philosophy underpinning primary health nursing and along with tikanga guidelines provides a pathway for nurses striving to practice at the top of scope and with cultural responsiveness. What is exciting is the number of nurses growing in strength and competence. There are 20 rural primary health nurses engaged in postgraduate study, eight engaged in mental health credentialing training, two on the Nurse Practitioner pathway, two have graduated with Masters of Nursing and 14 are currently involved in PDRP. A further 40 will have completed PDRP requirements by the end of the year.

A continuing priority has been addressing the sustainability of the rural workforce. As in many areas of New Zealand the workforce is ageing and the demands of 24-hour care over seven days continue to escalate. The Rural Service Level Alliance team with representation from a range of primary care providers has focused on initiatives to relieve some of the demands of providing an after-hours service through additional financial investment, but innovative solutions are needed to reconfigure the current model. A roadmap identifying key strategies to support growing the capacity and competence of the current, future and locum rural workforce is under development.

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

We would like to acknowledge all our colleagues and the clients we work with for the successes of the past 12 months as we strive for the goal of equity for all and Northlanders living well and staying well.

Te Kotuku

The new maternity unit at Whangarei Hospital, Te Kotuku, was officially opened on 24 February 2016 by the Minister of Health Rt Hon Jonathan Coleman.

Te Kotuku replaces 40-year-old services with a modern, family-friendly facility and co-locates antenatal clinics, assessment rooms, birthing rooms and post-natal beds that were previously spread over two floors in Whangarei Hospital.

Te Kotuku has 18 inpatient beds in one- and two-bedroom units, four antenatal clinic rooms, two assessment rooms, a mothers' lounge and parents' lounge, two baby feeding rooms, two birthing pools, a room for antenatal classes and a visitors' waiting room. It also houses the butterfly room, a suite for families whose babies do not survive.

Te Kotuku maternity service is both a primary and secondary facility. Primary maternity services are provided to women and their babies for an uncomplicated pregnancy, labour and birth, and postnatal period. Secondary maternity services are provided where women or their babies experience complications that need additional maternity care involving obstetricians, paediatricians and other specialists.

Te kotuku (white heron) is a symbol of prestige, purity and uniqueness. Among Māori, one of the greatest compliments is to liken someone to kotuku, for it signifies everything rare and beautiful. Sometimes referred to as a darling or treasure, the Kotuku is one of New Zealand's rarest birds and is held in particularly high regard in Māori mythology. As with other birds, the kotuku stands for the connection between the afterlife – a messenger of the spirit world.

The logo was guided by the 'Windows of Northland' mosaic koru designed by Bill Tarver. The koru represents new life, with the mother, father and new-born baby within the drawing. The other koru represent other family members all coming together.

Carving

Northland DHB Kaumātua Te Ihi Tito commissioned Taane Matiu and Standford Wihongi to produce a carving for the lintel Te Pare (lifts tapu as you enter the building.)

Whakatauki o Rangi raua ko Papa. Proverb of Sky Father and Mother Earth.

Ko Rangi Ko Tama o te korekore atua o te wai tapu e, ka whakawehi a Rangi raua ko Papa ka whakapuke te tangi aue, kei a Rangi he tangi puunehunehu he tangi hotuhotu riporipo te moana roimata a Papatuanuku, He aroha koropupu Ka puta ki te whai ao ki te ao marama. Whano whano haere mai te toki haumi e! hui e! tae ki e.

The Pare Lintel depicts the creation of time from Te Kore (void of nothing) through to the world of enlightenment (the separation of Rangi and Papatuanuku by Taane Mahuta). This ethos is continually created when a women gives birth to her baby.

The middle figures are Rangi, the end figures are Papa and in between them is Taane. At night the centre glass piece of the foetus can be seen alight that represents all our special women te whare tangata the house man that give birth bringing forth our children from Te Kore and into the world of enlightenment. Kotuku that are known to be the carriers of the newborn are on the top of the foetus.

Mosaic

Pat George, a noted ceramic artist from Matakohe, with her husband Steve were commissioned to produce a mosaic artwork for the front entrance of Te Kotuku.

Entitled 'Windows of Northland', the mosaic features icons from across the region, with the east and west coasts presented at the front entrance and joined together by Bream Head, and the Te Kotuku logo placed along the top of the reception area.

Te Kotuku is for the whole of Northland so Northland DHB wants to ensure that everyone feels at home when they come here to have their babies or to visit.

This unique artwork for Te Kotuku features places we all know and captures our people, place and sense of identity. Two tiles were left off the mosaic and families of the first boy and girl born in Te Kotuku placed a tile with the child's name on it.

Butterfly Room

Our butterfly room is a suite for families whose babies do not survive. The suite is named the butterfly room in recognition that some people feel as though butterflies are messengers from loved ones.

The artwork in the butterfly room was designed by Whangarei artist Briar van Ameringen, who experienced loss of a baby. Briar and her family offered to produce the stunning artwork for Te Kotuku.

"I love the watercolour textures and I think water captures all aspects of emotion that you can go through; sometimes you are drowning in it, sometimes you float in it and just cry and sometimes you are overwhelmed by it. I've illustrated the creatures so that they arise from it and travel out far away into the distance as a representation of a beautiful afterlife."

Sands Northland kindly donated a sofa bed. Sands is a voluntary, parent-run, non-profit organisation set up to support parents and families who have experienced the death of a baby at any stage during pregnancy, as a baby or infant.

Wall Art

A collection of black and white photographs is displayed throughout the unit. Donated by Northland families, the photos depict newborn babies, siblings, parents and scenic images. Northland DHB is honoured to have been given the photographs, which complete a truly unique and purpose built facility.

Mosaic Koru - Designed by Bill Tarver

2015 - 2016 Some Highlights

PATIENT SAFETY & QUALITY IMPROVEMENT DIRECTORATE

The Patient Safety and Quality Improvement Directorate aims to support the provision of high-quality, person-centered, safe and evidence-based care to our community. The Directorate has a role that ensures that individual encounters are consistently person centered, clinically effective and safe, by establishing a shared understanding of quality and a commitment to place it at the heart of everything we do.

What matters to our patients is what matters to us.

Our organisation strives to provide high-quality care with compassion and respect.

Our success is measured by the experiences of our patients and reflects the passion and performance of our people.

Copeland's Risk Adjusted Barometer (CRAB)

CRAB was introduced to the organisation by the Chief Medical Officer. CRAB is an innovative system for assessing, monitoring and improving the quality of care in hospitals. It uses our own data and compares us to a dataset of over 14 million patient records. It enables clinicians to understand morbidity and avoidable harm across the organisation. Progress to date at Northland DHB includes: patient data for the period July 2010–November 2015 has been uploaded to a development server and is available for analysis and checking. We are working on automating data extracts for CRAB and a benchmarking group led by the Chief Medical Officer has been set up to oversee the interrogation and analysis of data. The first meeting was held in January 2016. Terms of Reference for the group have been completed.

Quality Systems and Performance Analyst

The introduction of this new role into the Patient Safety and Quality Directorate has supported one of our five key objectives – Our practices are evidence based and supported by data. To date, several reports have been developed (including CRAB and HRT data) for individual departments to assist with the 'problem definition' and ongoing measurements for improvement.

Patient and Whānau-centered Care

Development of a framework and three-year plan is now in place. This framework provides direction for Northland DHB in relation to patient and whānau-centered practices. It recognises that there are many good examples of effective patient and whānau participation and collaboration already occurring within the organisation at individual clinical, service and governance levels. However, we are still a long way from reliably providing an excellent patient experience. We believe the plan will help us on this journey.

Clinical Audit Programme

There were 38 new audits at 30 June 2016. A process to ensure completion and any subsequent need for a clinical improvement plan is now in place.

In-house Improvement – Science Staff Training

In conjunction with the Health Quality & Safety Commission, a full-day workshop was held again and 26 Northland DHB staff participated. Feedback was positive and, as a result of demand, further workshops have been planned.

Development of Directorate Intranet Site

The Patient Safety and Quality Improvement Directorate intranet page is in development and it is anticipated that this will go live by December 2016.

Patient First Newsletter

A two-monthly newsletter dedicated to organisational activity which focuses on the patient experience, safety and quality is now a regular occurrence at the DHB.

Tracer Audit

Tracer audits were introduced via the certification process to monitor the patient journey. Twelve staff are now trained. Monthly tracer audits have been carried out over the past five months. PDSA methodology was used and we are now confident that we have a robust process which is inclusive of patients post discharge evaluation. This robust process was endorsed during Northland DHB Certification in June 2016 and direct credit was attributed to the tracer team for a job well done.

Safety Thermometer

Working with the Patient Safety and Quality Improvement Directorate the Whangarei District Nursing Service agreed to participate in a national project to test the British National Health Sector (NHS) classic safety thermometer that had been led by the Health Quality and Safety Commission and The Halo Institute from the NHS.

The classic safety thermometer is used for measuring 'harm free care' and can be used in many settings across healthcare. Four District Health Boards across New Zealand were accepted to participate. Initially Northland was the only DHB to have a community focus rather than a hospital focus.

The District Nurse team has seen positive outcomes for their patients and their staff and have decided to continue using the safety thermometer.

Serious Event Analysis

The reportable events team now consists of six senior doctors including one from primary care, the Director of Nursing, Associate Directors of Nursing, Nurse Manager and Quality Directorate staff. The chair is now the Associate Chief Medical Officer.

A workshop was held late last year to develop a robust process for serious events analysis, which focuses on system failures. This process is used for confirmed Severity Assessment Codes 1&2 events.

A combination of London Protocol and RCA 2 was adapted and tested. This process has now been successfully implemented. A key function of the process includes: a team approach to the investigation, senior management sign off on recommendations, only up to five recommendations are acceptable and four must be Strong (Action Hierarchy, VA National Centre for patient safety).

A follow-up process is now also in place after three months with a one-year sustainability check also part of the quality loop. The standards archived by this new programme have been recognised and acknowledged by the Health Quality and Safety Committee.

Serious Event Analysis-Standard Operating Procedures and Tool

This has been developed by the Directorate to support the reportable events committee and the wider organisation to better understand the requirements of reporting, investigation analysis recommendations and follow up.

Reportable Events and Mortality and Morbidity

A memorandum of understanding is now in place with most of the medical teams for the purpose of sharing adverse events. To date this has proved advantageous. Escalation of issues has been sent to reportable events for further analysis. This has become another avenue for the organisation on its journey toward a 'just culture' of openness, transparency, support and patient-centered care.

National and Regional Quality Directorate Staff Representation

Staff from the Directorate was asked to join the Health Quality & Safety Commission national adverse events learning programme and also to be the Northland DHB lead at the northern regional patient safety programme (replacing First Do No Harm).

Patient Safety & Quality Directorate Plan 2016–2018

The plan uses a measurement and monitoring framework (Vincent et al) [27] and five key organisational quality objectives.

1. Patients and whānau are at the centre of what we do (PWCC Framework and Plan 2016).

Keeping Patients Safe	CRAB; Copland Risk Adjusted Barometer Safe Surgery Programme Reportable Events Committee Re-design Tracer Audit Programme Clinical Audit-Results
Improving the Patient and Whānau experience	Patient and Whānau-centered Care Oncology and Respiratory Fast Track Reducing Paediatric Readmissions from Respiratory –ASH
Healthier Communities	NHS Safety Thermometer Reducing Falls in Aged Residential Care Family Violence Screening Primary Care – Same-day Access, third next available appointment, Health Neighbourhood HealthCare Homes and Integrated Urgent Health Care
Our Future	Rheumatic Fever Project Paediatric Assessment Tool Fluoride Varnish Project

2. We have an organisational culture of safety and quality.
3. We learn from experience and become a 'learning' organisation.
4. Our practices are evidence-based and supported by data.
5. We strive to meet all Health and Disability Standards.

Certification 2016

- There were eight (8) Corrective Actions in 2016
- There were twenty-two (22) Corrective Actions in 2012
- There were sixty-six (66)Corrective Actions in 2008

The 2016 excellent results are a reflection of the work of staff with a primary focus of patient safety, quality and improving the patient experience.

Patient Safety and Quality and Improvement Inpatient Boards

Twenty services now publically display their own patient safety and quality improvement work and activities for staff and patients to see.

Quality Accounts

There has been an increase in the number of Quality Accounts that we will be monitoring and reporting this year.

[27] *Vincent C, Burnett S, Carthey J (2013) The Measurement and Monitoring of Safety. Health Foundation. UK: London.*

Child, Youth, Maternal, Oral and Public Health Services

Child and Youth

Immunisation

Northland DHB has seen a marked improvement in consistency with immunisation coverage and timeliness over the past year. The achievements made are due to a collaboration of improvement strategies outlined below.

Q1 2015 – 88 percent

Q2 2015 – 90 percent

Q3 2016 – 90 percent

Q4 2016 – 89 percent

With robust systems now in place, Northland DHB rate third highest in the country for the fewest children missed.

New Zealand average – 2.5 percent

Northland DHB – 1.1 percent

Co-location (Te Aro o te Ha)

The National Immunisation Register (NIR) team from Northland DHB were moved to Manaia PHO to share a purpose-built space with the Manaia outreach team, B4SC (before school) team and Immunisation Coordinator. Virtual communication via teleconference and email with Te Tai Tokerau PHO and Te Ha Oranga is also coordinated from this space. This has strengthened communication, information sharing and relationships with key stakeholders and delivery services.

Monitoring Tool

vWaitemata DHB developed a spreadsheet/monitoring tool and shared this with our DHB. All cohort data is entered into this and filtered. From this the Immunisation Coordinator is able to track and monitor all overdue children and facilitate them into their General Practitioner or one of the three outreach teams in a timely manner.

Delay and Decline Work

Declines averaging from 7 to 10 percent still remain an issue for Northland, affecting the overall coverage rate for children aged eight months.

For every child that has had immunisations delayed or declined by their parents contact is made by the Immunisation Coordinator with their nominated health provider. It is an expectation that each of those parents have had a discussion with their chosen health professional around their decision. If this has not happened, a referral is made to the outreach team and the nurse from that team will make contact with that parent to offer education or answer any uncertainties that the family may have.

A letter from the Immunisation Coordinator is also sent out to families inviting them to make contact if they have any unanswered questions or uncertainties.

Changes to Precall/Recall System

It was identified that Tamariki Māori referred to outreach services were being protected through immunisation by the eight month milestone.

This shows that there was some potential to have them vaccinated and protected sooner. Change in the Precall/Recall system was implemented. Māori children are now being referred to outreach at 24 weeks old. This has resulted in a steady increase in coverage of Māori children by six months of age.

- June 2014/15 – six month coverage rate for Māori 60 percent.
- June 2015/16 – six month coverage rate for Māori 66 percent.

Education Forums

Over the past year the Immunisation Coordinator has developed educational workshops for the Allied Health Workforce. The aim of these workshops is to give those working alongside health professionals an opportunity to have a more in-depth understanding of the immunisation programme, vaccine components, immunology and its relationship with timeliness and to build confidence in their daily conversations with whānau.

Immunisation workshops for health professionals were also held. Guest speakers discussed vaccine science, how to speak to parents and offered ideas on how to make general practice more user friendly.

Media & Health Promotion

Dr Juliet Rumball-Smith came up with a concept of sound bites and worked with the communications team to develop the "Did you know" media campaign outlining brief messages about childhood diseases and the possible outcomes.

"I Immunise" posters were re-run. These feature local people and statements about why they choose to immunise. The posters have been distributed to all child health providers across Northland. Short video clips containing local people and their immunisation messages are also available on You Tube.

A 5.7 metre billboard promoting Immunisation on time has been erected at Manaia PHO just outside the entrance to the purpose-built immunisation hub Te Aro o te Ha.

Immunisation Week

This year Immunisation week promoted protection through Boostrix and Influenza vaccine for pregnant woman. With support from the immunisation coordinator and communicable disease team local midwife Sam Harris promoted, offered and delivered Boostrix and Flu vaccine at the Northland Baby Expo. With midwives engaging in the promotion of vaccination, expectant parents feel re-assured that immunisation is safe and effective.

In general practice all women who received either of the vaccines during immunisation week went into the draw to win a safe-to-sleep basket filled with baby products and health promotion information for their newborns.

Human Papilloma virus (HPV)

A dedicated vaccination team continues to deliver the HPV vaccine Gardasil in schools. The team continues to show consistency in following up each consenting girl, with most of them completing all three doses.

The consent rate for 2016 decreased, possibly due to a large anti-vaccine campaign that was sent via a letter to all schools nationally.

Dose one 2015 – 69 percent

Dose one 2016 – 59 percent

Project Objectives

- Continue focus on vaccine hesitant families/whānau. Use Kaiāwhina for hesitant Māori families. Offer support to these families in a way that is suited and individual to them
- Specific focus on vaccine hesitant group that have received one or two vaccines and then refuse to complete programme
- A change in the Newborn Enrolment process to be implemented. NIR will have contact with expecting mothers and gather enrolment data rather than at post-delivery of baby. This information will be reconciled with data collected by Northland PHOs
- A four-year target is now in place. Accumulated reports are currently available and will be used to follow up general practice for children in this age group. Options are being explored around the integration of immunisation catch up, before school programme and the outreach delivery service
- As from 2017 the Gardasil vaccine will be offered and funded for boys and girls and will be a two-dose regimen. Plans are being put in place for consistent safety communication around this vaccine that will be extended out to the wider community.

Rheumatic Fever Prevention

Northland DHB is seeing positive results from a campaign to get children treated for Strep Throat A.

After many years in which 15-20 cases of acute rheumatic fever occurred per year in Northland, there has been a marked fall since early 2015. It is likely that the focus on early identification and management of strep throat, much greater access for children at risk to free treatment via schools and pharmacies, and an extensive national and regional communications strategy have contributed to the recent decline.

The school-based throat swabbing programme in all schools decile 1-4 in Northland is delivered by non-government organisation providers along with Public Health nurses providing opportunistic throat swabbing in schools, rapid response clinics in three pharmacies, free GP services for under 13 year olds, and the Sore Throats Matter publicity campaign.

The School Based throat swabbing programme is delivered by Māori Health Providers Hokianga Health, iMoko, Te Hau Ora O Ngāpuhi, Te Rūnanga O Whaingaroa, Ki A Ora Ngātiwai and Ngāti Hine Health Trust. Admissions to Northland hospitals for first-time episodes of rheumatic fever dropped from 15 in 2014 to five cases in 2015 and in 2016 just one case was reported.

Abe Botur, 5, benefited when Northland DHB public health nurses picked up his Strep Throat infection in early September. Abe had had a sore throat for two weeks before nurses swabbed his throat at Whangarei Primary School. His parents were then informed and Amoxicillin was given to him at school, along with a sticker chart so Abe could keep track of his ten doses of antibiotic. These sticker charts have been particularly effective in increasing rates of adherence, meaning family members ensure the entire course of antibiotics is taken over the prescribed number of days.

Maternal

Breastfeeding

Breastfeeding is possibly the number one preventative intervention to improve infant health and reduce pediatric hospital admissions. Northland DHB is ranked first in the country with 96.4 percent of our women breastfeeding their baby on discharge from hospital, as reported in the New Zealand Baby Friendly Aotearoa 2015 data.

As with the rest of New Zealand the rates of exclusive breastfeeding, after discharge from the hospital facility, show rapid decline. However at 77 percent, Northland DHB still leads New Zealand at the six-week mark; but at three and six months we fall behind.

Evidence shows that DHBs undertaking the Baby Friendly Community Initiative (BFCI) programme have improved data at three and six months. This programme runs along similar lines to the Baby Friendly Hospital Initiative with steps, for example, to ensure consistent education is offered to all health and other professionals who come into contact with infants in the first year.

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

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

In 2016, Northland DHB also started supporting a new initiative Te Mata O Mua. This is a two-day free antenatal class run in conjunction with Māori health providers. Several weekend classes have been held already and interest is growing in the Māori community for culturally-based education.

Popular drop-in clinics in Whangarei continue every Tuesday and Thursday, free to any breastfeeding mother. The four-hour clinics are held at our community facility Te Pura Wai Ora, Commerce Street, Whangarei.

The Big Latch On was held at Toll Stadium on 5 August 2016 and attracted over 79 mums and babies, including three sets of twins. This was a community initiative supported by the DHB, childbirth education classes and the lactation team.

Three new trainee lactation consultants have been appointed in the Whangarei inpatient and outpatient setting, to grow the service. We are also hoping to grow the lactation consultant service in the regional hospitals, so each unit has a consultant with dedicated clinical time to undertake assessment and education.

Oral Health

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

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

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

Level of Enrolments

- 0 to 18 years of age enrolled (across all public oral health providers): 39,145
- Pre-schoolers enrolled: Māori 4,535; Other 3,729
- School children enrolled: 25,249
- Adolescents enrolled: 5,633.

Currently 90 percent of the children and adolescents enrolled with Northland DHB and Ngāti Hine Health Trust are being seen for their annual examination and any treatment if required.

The Northland DHB oral health call centre implemented in 2012 has been a huge success. Every call is answered by a person who can triage and enroll patients, and make appointments. The number of calls coming through the 0800 call centre continues to increase and another part-time employee has joined the team.

Public & Population Health

Northland District Health Board's Public and Population Health Services (PHU) deliver comprehensive public health services to the Northland population. The service delivery includes working across several stakeholders including Territorial Local Authorities, New Zealand Police, Primary Health Care Organisations, Māori health providers and Non-Government Organisations. Cross-cutting areas of work included tobacco/alcohol, nutrition and physical activity and sexual health, as well as relevant intersectoral work (for example, housing).

Key highlights of all service areas covering communicable diseases, physical environments, social environments, tobacco control, alcohol and other drugs, physical activity and nutrition, sexual health promotion and injury prevention, Well Child services (including health promotion in schools (delivered by public health nurses) and oral health promotion), health education/health resource distribution and health promoting schools (HPS[28]), are described below.

Influenza

The Ministry of Health promotes national influenza vaccination via television advertisements and flu packs are sent out to each general practice.

General practices across Northland follow up with all of their eligible population through a letter and phone call inviting patients to come in for their flu vaccine. The Northland DHB communication team supply local radio stations and newspapers with an influenza immunisation message throughout the flu season.

This year Northland DHB, Manaia Health and Te Tai Tokerau PHOs funded a brochure called "Winter Wellness" offering guidance on how to keep warm, dry and free from flu by way

[28] *Health Promoting Schools (HPS) is an approach where the whole school community works together to address the health and wellbeing of students, staff and their community. Schools include health and wellbeing in their planning and review processes, teaching strategies, curriculum and assessment activities.*

[29] *Exercise Tangaroa is a national (Tier 4) exercise under the National CDEM Exercise Programme and the first full exercise held under the Interagency National Exercise Programme. The Exercise takes place over three days – on 31 August, 14 September, and 28 September 2016 – and will be based on a regional source tsunami scenario. This will test New Zealand's preparations for, response to, and recovery from, a national tsunami impact.*

[30] *Controlled purchase operations (CPOs) are planned operations designed to monitor and enforce the provisions relating to the sale of tobacco or liquor to minors in compliance to the Smoke-free Environments Act 1990 or the Sale and Supply of Alcohol Act 2012 (SSAA). They involve supervised volunteers aged under 18 years attempting to buy tobacco or alcohol from licensed premises. If a volunteer's purchase proves successful, the premise's operator, manager or licensee is liable to prosecution or other sanction via the Alcohol Regulatory and Licensing Authority (ARLA) or the District Court.*

[31] *The project in Northland is based on Project Energize which was developed in the Waikato area. Essentially Energize is more of a change agent and aims to meet the school needs to help them to improve their children's physical activity and nutrition, and ultimately to improve overall health. Energizers support a cluster of schools and provide practical hands-on support and assistance to schools and teachers with any initiatives that will increase the quality and quantity of physical activity and or improve the uptake of healthy eating. The Northland DHB funded a pilot of Project Energize in 2013 and initial results have shown improvements in the children's fitness, the reduction of sugary drinks and an increase in water consumption. Funding from Northland DHB and Sport New Zealand is allowing Sport Northland to expand Energize to a further 62 primary schools across Northland.*

[32] *The smokerlyzers range of carbon monoxide (CO) monitors and testers is used during smoking cessation programmes to give the smoker visible proof of damaging CO levels and to help motivate by charting their progress during the programme. All the instruments are surgically non-invasive, lightweight, battery powered, simple to operate and use hygienic inexpensive disposable mouthpieces. A simple breath test with a smokerlyzers CO monitor will measure the levels of toxic CO inhaled from tobacco smoke. CO in itself is harmful, as it reduces the amount of oxygen taken up by the body, but it can also act as an indicator as to the possible level of some 4,000 toxic substances in cigarette smoke, 60 of which cause cancer.*

of vaccination. At the end of June 2016, flu vaccine coverage for Northland showed an increase of 4,020 vaccines delivered which is an improvement of 11.5 percent compared with 2015 rates.

Communicable Diseases

The measles outbreak in Waikato and the following occurrence of measles in Northland was one of the key highlights. There were six cases of measles, four confirmed and one probable case of meningococcal disease, three cases of mumps, 15 cases of pertussis, four cases of hepatitis A, one case of hepatitis B, four cases of hepatitis C, two cases of tuberculosis, 32 cases of invasive pneumococcal disease, and one recurrent case of rheumatic fever in Northland.

Health Protection

Routine regulatory work in the areas of border protection, air quality, drinking water, recreational water, burial and cremation, ionising and non-ionising radiation, contaminated land, environmental noise, hazardous substances sewage treatment and disposal and waste management was undertaken to protect the health of Northland communities. Two events of shellfish poisoning were managed with appropriate and timely public health alerts issued, preventing the occurrence of any serious cases. The Whangarei harbour oil spill was investigated and precautionary public health advice was provided on the collection of shellfish from the area. Northland PHU provided input in the planning of the National Civil Defence Exercise 'Exercise Tangaroa'[29].

Submissions were made on the Territorial Local Authorities annual plans and district plans where appropriate, emphasising the public health concerns. Submissions were made on Resource Management Act applications for consent where public health risks for communities were highlighted. A number of controlled purchase operations (CPOs[30]) were conducted in collaboration with Police to monitor the sale of liquor and cigarettes to minors in compliance with the respective alcohol and SmokeFree Acts.

Northland PHU's Medical Officer of Health in collaboration with other Northland DHB's clinicians presented a paper on 'sustainability, climate change and cost savings for Northland DHB' with key recommendations advocating for the adoption of a Northland DHB sustainability policy.

Health Promotion

Obesity prevention was one of the major areas for health promotion. Northland PHU advocated and supported the development and implementation of the Northland DHB's 'Healthy Food and Beverage' policy that includes the complete removal of all carbonated drinks in Northland DHB's premises, taking effect from 1 January 2016. Joint advocacy with Te Hauora o Ngāpuhi resulted in a 'fizzy-free' policy from the organisers of the 'Ngāpuhi Festival', Northland's largest iwi event. The Hatea-loop walkway equipment and exercise stations were installed in collaboration with Whangarei District Council. Northland PHU are working in collaboration with Whangarei District Council to develop a 'sugar-free beverages' policy to be implemented across Whangarei District Council's premises.

Northland PHU continues to support the implementation of Project Energize[31], with the emphasis of rolling out the programme to all low decile schools (decile 1 to 3) with a high Māori enrolment. There was an increase in the number of schools participating in Project Energize. Northland PHU in collaboration with University of Auckland are undertaking a food environment mapping project looking at the food security environment in Northland.

Northland Health Promoting School's facilitators achieved a 70 percent engagement with their schools – one of the highest in the country. Following the Ministry of Education's encouragement for schools to adopt 'water only' policies, Northland PHU's Health Promoting School staff supported schools to develop and implement such policies. Northland PHU staff also met with Te Hauora O Ngāpuhi Chief Executive to develop a plan to support schools in 'water only' policies.

Whangarei District Council have voted for a district-wide smokefree policy which will see further measures put in place restricting smoking in public places. The 'smokerlyzers[32] for midwives' project was implemented and all midwives across the region were provided with smokerlyzers. The midwives refer the pregnant women who smoke to cessation support services.

Northland PHU continued to raise awareness of the harm caused by alcohol consumption on the wellbeing of the foetus during pregnancy. Northland PHU supported the second northland Regional Foetal Alcohol Spectrum Disorder (FASD) network hui and provided input in the drafting of strategies and activities with timeframes, including the development of an FASD toolkit. Northland PHU is also currently leading the development of a 'Northland Alcohol Harm Reduction' plan that will include strategies and activities to reduce alcohol-related harm in Northland.

Besides the promotion of healthy diet, increased physical activity, smokefree environments and interventions to reduce alcohol-related harm in the communities, Northland PHU actively participates in the Whangarei District Council's 'Safe City' and the UNICEF's child-friendly city initiatives. Northland PHU also supported the implementation of 'Water Safety' programme by Sport Northland in lower decile schools in Northland.

Surgical, Pathology and Ambulatory Services

Clinical Haematology Service

A locally based clinical haematology service was established in October 2015 with the appointment of Dr Sarah Poplar to the newly created specialist position. This has improved the access of Northland patients to specialist haematology services. Previously, weekly outpatient clinics and a limited range of chemotherapy treatments were provided in Whangarei by visiting specialists. The newly expanded service has enabled reduced waiting times, a greater range of locally available treatment, and readier access by staff to specialist opinion.

Lung Pathway

A streamlined process for the investigation of suspected lung cancer was introduced following a patient pathway review project. Patients now have rapid access to different appointments on a single day including assessment by a respiratory physician, a computerised tomography scan, lung function tests, a bronchoscopy procedure and biopsy and discussion of test results. The new process has shortened the patient journey by two to three weeks and has been favourably received by patients who greatly appreciate early confirmation of their diagnosis.

Māori Cancer Patient Navigator

Following a successful trial, a navigator role for Māori cancer patients was established – based in the Jim Carney Cancer Treatment Centre. The role has proven successful in assisting and advising Māori patients undergoing cancer treatment. The inception of the role has seen a significant reduction in the non-attendance rate for clinics and has been favourably received by patients.

MRI Scanner

A new magnetic resonance imaging scanner was commissioned in February 2016 at Whangarei Hospital to replace the previous scanner which had reached the end of its useful life. The new scanner is able to provide a comprehensive range of scans and with much improved image quality. It is also considerably quicker, enabling more scans to be performed.

Peri-operative Safety

Northland DHB was one of the first DHBs to implement a national suite of initiatives to enhance peri-operative safety. The initiatives included operating team briefing and debriefing processes and the introduction of a paperless patient safety checklist.

Jim Carney Cancer Treatment Centre 1st Birthday

The Jim Carney Cancer Treatment Centre celebrated one year since it opened its doors to patients in November 2015. Based at Whangarei Hospital, the centre was purpose-built, with more than twice the space of the previous cancer treatment facilities. Other benefits of the new facility included more privacy, multi-disciplinary meeting areas, designated areas for children's treatment and space for future expansion if required.

The centre provides day-stay treatment for cancer patients, including initial consultations, chemotherapy treatments and follow-up from a team of medical experts, including other related nursing and support services.

Named after a prominent Whangarei businessman and philanthropist who died in November 2000, the centre came about as the result of collaboration between Northland DHB and the community, led by The Northland Foundation/Through Project Promise. Hundreds of Northlanders were involved in a huge variety of fundraising events and activities and raised more than $3 million towards the $5 million project (Northland DHB funded the other $2 million) to make the cancer centre 'promise' come true.

In the year since the centre opened, staff have seen 786 new cancer patients, offered 4,500 patient appointments and provided 3,358 treatments (up from 1,675 the previous year).

District Hospitals

The District Hospitals are working more closely together to enhance safe, patient-centred healthcare. While operations managers have a history of working together, as do allied health, there are now several other examples of services working together.

There has been a strengthening of clinical leadership with improved communication between hospital doctors in the three hospitals.

Dargaville Hospital is extremely grateful to Kaitaia medical staff for covering the Dargaville roster over the last year. From November 2016, Dargaville Hospital aims to take on its own roster. This shared doctor resource has led to combined Mortality and Morbidity meetings between the two hospitals.

From the nursing perspective the formation of the district hospitals clinical nurse managers meeting, membership of which includes Hokianga Health and Northland DHB's Director or Associate Director of Nursing & Midwifery, has greatly assisted communication between general ward nursing staff.

The employment of a district hospitals quality manager has led to monitoring of trends across the three hospitals, particularly through patient feedback, audits and adverse events and subsequent identification of common issues where quality improvement work is best directed.

The District Hospitals Quality Plan 2016–2017 was developed in consultation with all staff and provides shared goals and objectives for improving patient care.

The recent formation of the district hospitals quality meeting, membership of which includes lead doctors, clinical nurse managers, and general manager will help give further direction to quality work.

Patient feedback, through the online Patient Experience Survey, is compared across the three hospitals. Feedback indicates that most patients are happy with the way staff deal with them and their families with around 90 percent of patients responding that they are always treated with respect and dignity, staff always introduce themselves and their role, and the hospitals always allow visiting by families when they like.

The same survey results indicate the need for improvement in advising patients who are in multi-bedded rooms that there is space available for them to have a private conversation and advising patients that they can access their medical notes while they are being treated. Also, less than 60 percent of patients responded that they get a good night's sleep which has led to quality improvement work to identify what the interruptions are and what we can do to ensure our patients sleep as well as possible.

Dargaville Hospital

Dargaville Hospital has flourished under the direction of Northland DHB-employed hospital doctors. The establishment of a lead hospital doctor has facilitated an increase in patients transferred back to the local hospital. Nursing staff have gained, and continue to gain, new skills to enable increasingly different types of patients (for example paediatric patients) to be cared for locally and for patients to return to their local hospital sooner. Low acuity mental health patients are also now able to be cared for locally.

The Ab Fab awards were introduced earlier in 2016 as a way to acknowledge staff who demonstrate the Northland DHB values in their day-to-day work. There has been a good uptake from staff that recognise the importance of acknowledging the staff member for a job well done.

Dargaville Hospital, Dargaville Medical Centre, Te Ha Oranga and Dargaville Orrs Unichem pharmacy continue working together to become more integrated. Work is underway to have Dargaville Orrs Unichem pharmacy operate a small pharmacy out of the Dargaville Health Centre campus. Work to improve the clinical space for the Dargaville Medical Centre and an increase in space for Te Ha Oranga is also underway.

Earlier this year Dargaville Hospital celebrated its 60th birthday. There was a shared lunch with current staff and fellow health colleagues. Everyone enjoyed the day.

Mobile Surgical Services has been coming to Dargaville since 2003 and in March this year performed its 20,000th procedure in Dargaville. The procedure was child dental, and every child who came on the bus during the day was given a small gift from Mobile Health to acknowledge this achievement.

Bay of Islands Hospital

Redevelopment plans continue for the Bay of Islands site. Work on this project had been delayed while unidentified contamination of the site was addressed and the planning refined. Things are back on track with renewed enthusiasm for the project.

The Bay of Islands Hospital general ward remained busy throughout the year. Patient numbers increased through the accident and medical department and increased acuity within the general ward. Staff continued to work hard to maintain a professional and caring service to the community.

A number of staff who worked at Bay of Islands Hospital retired from their positions after many years of loyalty to their local hospital. We acknowledge each and every one of them and wish them well for a happy retirement.

The Mid North Kerikeri district nurses were nominated for and won an award for their innovative project around integration with the local GP service – Kerikeri Medical Centre. They were acknowledged at the annual nursing and midwifery service awards held in Kaikohe in May 2016. They have worked closely with the GPs and practice nurses to enhance the shared care between the two services. They have now taken the concept to another GP practice.

Kaitaia Hospital

There have been many highs and lows over the last year with the loss of a couple on long-term staff members and the withdrawal of Air New Zealand flights to Kaitaia, but in typical Far North style we continue to keep positive and forge ahead. The Rural Hospital Medicine (RHM) training programme has been a great success with our first Registrar completing her six-month rotation.

Northland DHB has collaborated to create a RHM training programme all under its collective roof. RHM is another type of specialty which began in New Zealand in 2008. It allows the specialist to work independently in rural hospitals, of which there are many in New Zealand, and cover a wide scope of practice, from emergency to inpatient work.

The sites for training are Whangarei, Kaitaia, Bay of Islands, Dargaville and Rawene. The first four RHM registrars have been approved to train through this programme across Northland DHB and begin in December 2016.

The training programme has provided one of our local doctors the opportunity of a placement in Rarotonga. Dr Joel Pirini and his family are in the Cook Islands for six months during 2016 as part of completing his RHM training.

From the Cook Islands side, their Medical Officers now have the opportunity to further their postgraduate careers by completing the Cook Islands Fellowship in General Practice. This involves a one-year attachment in two General Practice sites in New Zealand, participating in the GP year 1 training programme and completing postgrad papers through the University of Otago. Dr Mareta Jacob is the first Cook Island doctor to come to New Zealand. She has already spent six months at Rawene Hospital and is currently in Wellsford completing her second six-month attachment.

Kaitaia Hospital staff active at work

Kaitaia Hospital has been involved with Sport Northland's Active Workplace programme for two years now. The initial idea came from chief executive Dr Nick Chamberlain. Since then the programme has been led by the heads of department.

A wellness-check day had around 130 staff out of 200 take part. It inspired some to look at their health habits and make some changes. The programmes initiatives include all forms of wellness from physical activity, nutrition, general health, mental wellbeing, and being smoke and alcohol free.

Over the two years Kaitaia Hospital has been involved, the amount of wellness activities has increased by 25 percent. Sport Northland had 46 teams entered into the 10,000-step challenge. Kaitaia came 1st, 2nd and 3rd. Sharon Adams from Sport Northland made a presentation to the teams. It was a fantastic effort from staff.

New Zealand Baby Friendly Association – reaccreditation

This year we received notification that Kaitaia Hospital's maternity facility has once again been accredited as a Baby Friendly Hospital Initiative (BFHI), once again meeting the standard criteria and passing all of the Ten Steps.

Capital investment

Ongoing capital investment at Kaitaia Hospital has included $40,000 on operating theatre lights, $20,000 on security cameras and $20,000 on a portable ultrasound machine.

Farewell Mr Peter Dryburgh

A celebration dinner was held on Saturday 21 May at the fire station in Kaitaia for Mr Peter Dryburgh who retired after 36 years of service. The evening celebrated his medical career and the contribution that he and his family have made to the community since first arriving in 1980.

Peter's presence influenced many experiences and learnings and his passion and skills lay in the work he performed in the operating theatre. The range of surgery that Peter preformed was outstanding, and included general surgery, gynae, caesarean sections, and orthopedic surgery. Today there are different specialists for each of these specialties. Peter has performed thousands and thousands of procedures. The community thanked Peter's wife Dinny and their children for allowing Peter to serve this community and do what he did for so many years. Sadly, Dinny passed away on 16 July 2016 following a battle with cancer

Nursing and Midwifery Directorate

NETP Programme – new entry to practice

The new entry to practice programme provides a structured and supportive framework for the first year of practice for new graduate nurses. As a vacancy-based programme, new graduate nurses are employed into the DHB, Māori providers, non-government organisations, primary healthcare and aged care facilities.

A review of the programme was undertaken in 2016 to reflect the national strategic direction of employing 100 percent new graduates and developing a workforce that reflects the population. Over the past five years Northland has on average supported 20 new graduates every intake (two per year) with an average of 28 percent of these cohort being Māori.

Professional Development Recognition Programme (PDRP)

Northlands PDRP programme is a New Zealand Nurses Council endorsed programme that aims to promote and reward nursing expertise and recognise the contribution of nurses to deliver quality patient health outcomes.

Northland DHB has a voluntary programme with the current uptake at 39 percent. Every three years the nurse is required to submit a portfolio for assessment against the nursing council competencies.

Nursing Council audited the programme in May 2016 and, apart from a few recommendations for improvement, was impressed with the programme overall.

Nurse Practitioners in Northland

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

We have nine nurse practitioners in Northland practicing in primary healthcare settings, including our first nurse practitioner in secondary services in the Whangarei Hospital emergency department. Their respective areas of practice include primary health across the lifespan, whānau ora, adult and chronic disease management, and emergency medicine. The nurse practitioners have special interest in diabetes, high dependency nursing in primary healthcare and adult chronic disease management.

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

Care Capacity Demand Management

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

The programme includes a variety of tools to assist with managing capacity and demand. Over the past four years Northland has implemented most of the CCDM tools, many of which are described below.

The 'Mix and Match' process is an objective assessment of the typical workload in wards and departments to inform a review of the staffing plan for the ward or department concerned.

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

The Hospital at a Glance (HaaG) screen contributes to this by illustrating the workload/staffing situation and actual occupancy, compared with physical bed capacity at any point in time across the various wards and departments.

The Care Capacity Operational Group continues to monitor the progress of the CCDM programme at Northland DHB and has renewed the letter of agreement with the Safe Staffing Workplace Unit.

Ngā Manukura o Āpōpō

Ngā Manukura o Āpōpō – Tomorrow's Clinical Leaders (NMoA) is the national Māori nursing and midwifery workforce development programme that recognises the need to grow the number of Māori clinical leaders in the health and disability workforce. The Director of Nursing and Midwifery of Northland DHB is the sponsor of this Ministry of Health-funded programme with the current contract ending in December 2016. A business case is planned for submission in September 2016 to secure future funding.

Northland DHB has held the contract since 2012. To date, NMoA has had the following achievements:

- Fifty graduates from the Poutama programme, that was designed and implemented by Ngā Manukura o Āpōpō, aimed at preparing nurses to mentor and assess the practice of students and peers
- The thirteenth cohort is in progress. Once completed, 260 Māori nurses and midwives will have graduated from Tomorrow's Clinical Leaders, NMoA's Clinical Leadership Programme
- An employer toolkit which assist management teams in the employment of nurses
- A Māori midwifery mapping project identifying where Māori midwives are located around New Zealand
- Effective national and regional strategic relationships to enable NMoA to contribute to the health and disability and education sector
- Using technology such as an award-winning ePortfolio system for nurses to track and store relevant competency documents
- Innovative solutions to track and monitor how Schools of Nursing and Midwifery Schools are performing and supporting Māori students
- Establishment of the Tuakana network and work programme
- Governance and Preceptorship training
- Evaluation of the clinical leadership programme
- NMoA governance group and programme management.

Hospital Smokefree Target

The smokefree hospital facilitator is located within the Nursing and Midwifery Directorate and supports the organisation to achieve the 'better help for smokers to quit' for hospital and maternity.

To June 2016, there has been a sustained achievement of the hospital target that has been in excess of the 95 percent target. The maternity target remains a work in progress to reach the 90 percent target (quarter four was 87.5 percent).

Options for nicotine withdrawal management were the focus of the 31 May World Smokefree Day 2016 in the Tumanako Mental Health Inpatient Unit when it went smokefree.

Mental Health and Addiction Services

External Review

An external review of adult Mental Health and Addiction Services (MHAS) was carried out in November 2015. The review prioritised eleven recommendations covering management, acute inpatient and community services. Several recommendations were implemented in 2015–2016 including the appointment of a general manager, a zero-based budgeting exercise and placement of high and complex needs clients. Recommendations on appointment of a clinical director and a nursing director role are in process, as is work on the model of care.

Funding for the other recommendations was approved in the budget for 2016–2017, with start dates in the first two quarters of this financial year. Included are an additional four beds for Tumanako IPU and additional clinical community staff for crisis teams, kaupapa Māori team, intensive community team and consult liaison and alcohol and drug team

Acute Psychiatric Inpatient Unit (Tumanako IPU)

The Tumanako IPU provides a 25-bed hospital service to adults and older adults in Northland experiencing serious mental illness at a level of acuity where they present a risk to themselves and/or others. The Tumanako IPU occupancy averaged 98 percent this year. On discharge patients may go to step-down subacute units (situated in Kaitaia, Kaikohe and Whangarei), which average 93 percent occupancy, to respite care or residential rehabilitation providers in the community or go home. Tumanako IPU has successfully transitioned five long-stay patients with high and complex needs (HCN) into appropriate community settings. This transition has effectively increased the inpatient bed capacity and ability to admit patients from the community. There are limited services in Northland for these HCN patients, including minimum secure residential rehabilitation services.

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

Service Development Unit

In February 2016, the Service Development Unit was set up in Mental Health and Addiction Services to enhance the efficiency and effectiveness of mental health service delivery. Various frameworks of service enhancement including continuous quality improvement, patient-centred design and project methodology were combined. The roles of quality manager, consumer advisors and project lead make up this business unit.

Service development aims to enhance Mental Health and Addiction Services by focusing on key areas of core work. This includes workforce development, quality plan, integrated models of care using co design principles and sustainable ongoing learning through the implementation of a service development hub within Mental Health and Addiction Services.

[33] *Andrews, D .A., & Dowden, C. (2005). Managing correctional treatment for reduced recidivism: A meta- analytic review of program integrity. Legal and Criminological Psychology, 19, 173-187.*

Non-government Organisation and Primary Health Organisation Provided Services

Non-government organisations (NGOs) continue to provide a broad range of services across Northland including community support, packages of care, residential services, day programmes, consumer/peer network support, medication oversight, family-whānau advisory, education and support, kaupapa Māori services and alcohol and drug treatment programmes for all ages.

The Taitokerau Kei Te Anga Whakamua: Forward Together – The Northland Way steering committee is currently in recess. However there are plans to reinstate a renewed forum now that the Northland DHB external review process has been completed. The overarching vision for the sector continues to be to align the model of care across all Northland DHB-funded mental health services (including DHB, NGO, iwi/Māori and PHO providers) across the life cycle from primary to specialist services to better meet the service needs of our Northland population.

Part of the re-alignment project involved the introduction of a new system of reporting – NHI based Results Based Accountability/Outcome (RBA) measures. From 1 July 2015 Northland DHB NGOs began reporting NHI based data on identified RBA matters.

NGOs had expressed a desire to develop some simple social outcome indicators for inclusion in the RBA framework that better reflected service user recovery and which acknowledged the significant impact that community engagement has on people's health and wellbeing. On the basis of these recommendations the new RBA reporting process proposes a simple indicator schedule for the following four social outcome areas:

- employment
- housing
- equally well (physical health and wellbeing)
- social connectedness.

Each NGO will report how service provision impacts on the quality of life of service users. With the introduction of RBA reporting, it is anticipated that Northland DHB will be in a better position to demonstrate how the services being provided assist Northlanders to live longer, healthier and more independent lives through an integrated health and social service system.

In June 2016 NGOs in Northland provided:

- 59 people with supported recovery-focused accommodation
- 22 people with residential alcohol and drug treatment
- Eight people with acute respite care services.
- 420 adults with support to live independently in their community [bullet points?]
- 75 child and youth with support to live safely and well within their whānau
- 240 adults with community-based alcohol and drug treatment services
- 293 child and youth with co-existing problems-enhanced programmes in Whangarei, Kaipara and the Far North.

Alcohol Screening and Brief Intervention Project

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

The screening is well embedded in Kaitaia Hospital Accident and Medical department with near 100 percent compliance, and is progressing in Whangarei Hospital Emergency Department with 51 percent compliance. Results show that Māori women are most likely to present with alcohol-related harm, followed by Māori men, other men then other women

Programmes Addressing Drivers of Crime

Northland DHB has continued to offer the Drive Soba Programme for recidivist drink-drivers during 2015/16, with 15 programmes in the region. Evaluation of the programme from Police National Computer Data indicates that from June 2007 to June 2014, 87 percent of those who completed the programme are not known to have reoffended.

This rate is well above international recommendations for programmes that are evidence-based on the principles of risk, need and responsiveness. A review conducted by Andrews and Dowden (2005[33]) found on average a 50 percent reduction in recidivism for programmes that followed all the principles that are followed in the Drive Soba Programme.

Northland DHB Mental Health & Addiction Services are providing alcohol and drug programmes in the Northern Regional Corrections Facility, which range from a four-hour brief intervention to an eight-week intensive programme. Brief Impaired Driving courses funded by the Department of Corrections are also being provided to Probation clients.

Kaiwhakamanawaroa – Programme Lead, Resilience

Northland DHB is committed to contributing to the goal of zero suicide in our region. Suicides are preventable and communities play a critical role in suicide prevention. They can provide social support to vulnerable individuals and engage in follow-up care, fight stigma and support those bereaved by suicide.

Northland DHB's target group is youth (under 25 years) with a focus on Māori. The Northland region experienced a spike in deaths by suicide, serious suicide attempts and suicidal behavior; particularly tamariki Māori during 2012. The following years have seen a year on year reduction in deaths in those under the age of 25 years. There was one death under the age of 25 years in 2015.

Sadly, 2016 has seen an increase in suspected youth suicide, which highlights the need for ongoing preventative and supportive programmes/interventions. UPSTANDER, a programme that builds on the success of Matanui will be toured throughout Northland in term 2, 2017 to help rangatahi be more resourceful in recognising strategies to reduce/eliminate bullying and/or family harm.

The Northland DHB chief executive co-chairs the Social Wellbeing Governance Group, which provides leadership and executive oversight for suicide prevention, family violence and the Whangarei Children's Team. This includes daily oversight of suicide and family harm to provide a coordinated intervention.

Māori Health

Te Poutokomanawa Māori Health Service

Te Poutokomanawa Māori Health Service is a provider of services by Māori for Māori within our Northland DHB hospitals. Our services are underpinned by te reo me ona tikanga in response to our Māori population representing 32.4 percent of Northlands total population.

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

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

Equitable outcomes are the responsibility of all people; health providers and whānau. Equity starts when contact is made the first time with your patients and their whānau. When the patient fully understands their health issues and the options available for treatment and care, trust is then built between people and the healing can begin.

Patient safety and whānau-centred care is the primary focus for Te Poutokomanawa Māori Health Service. This ensures that Māori patients and whānau are supported with their cultural beliefs and the expectation of those aspects that are important to them while they are in hospital.

Takawaenga are cultural workers in the hospital who support Māori patients and whānau on how to navigate their way through the health system, and walk alongside them to achieve good outcomes.

Takawaenga apply a strengths-based approach to their work with patients and their whānau to understand what they can do differently and to better manage their quality of health and reduce the need for hospital care.

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

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

Patient experience

The service model delivered by Te Poutokomanawa is a blend of strong cultural engagement in wairuatanga (spiritual wellness) and whānaungatanga (meeting/greeting and engaging) using te reo me ona tikanga to bond strong relationships.

Ensuring the concerns and feedback from Māori patients and whānau are heard and addressed in an appropriate, acceptable and timely manner to achieve a good outcome, bring about healing and reduce the risk of reoccurrence

This is followed up by manaakitanga (compassionate care and support) during the length of patient stay, while ensuring the principles of tikanga important to Māori patients and whānau are recognised, acknowledged, respected, documented and communicated. Takawaenga Māori cultural support staff work with the ward multidisciplinary teams in a clinical environment in support of a strong discharge plan for Māori patients.

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

The Tapuhi CNS has a support patient navigator role following up patient referrals from Takawaenga and external clinicians.

The quality function is to work alongside Takawaenga to support their daily work plan and key service performance expectations, assist the team in their knowledge in areas of health literacy, monitor accurate collection of data, monitoring daily patient admissions, prioritise Takawaenga/patient engagement and guide staff placements in the hospital.

Our key health targets supported include:

ED wait times – Takawaenga support Māori with their understanding of the ED triage process; monitor wait times; are mindful of patients whose condition may deteriorate and ensure they are being seen in a timely manner; ensure the environment is safe for all visitors and staff to participate in

Immunisation – Takawaenga play a support role to promote timely immunisation for the protection of tamariki, both in maternity and the children's ward and check they are up to date with their vaccinations, making any necessary referrals to the ward nurse educator

Tobacco target – Takawaenga complete discussions on Ask, Brief Advice & Cessation support (ABC) with Māori patients if they have not been completed by clinic staff. Takawaenga are also encouraged to talk with Māori patients who identify as smokers, about a nicotine substitute that is available to them while in hospital. From 2017 Takawaenga will have conversations about quitting, making appropriate referrals as the contribution to the stop smoking target in Te Taitokerau

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

Other indicators include:

Healthy Home referrals – Takawaenga identify vulnerable patients, children and elderly admitted into hospital and inform them about the Healthy Homes insulation programme. Where the homes of patients are not insulated, meet the criteria or they are unsure, Takawaenga can make a referral to the Healthy Homes coordinator to complete an assessment of eligibility for support. This is generally done with the Tapuhi clinical nurse specialist

Body tissue return – support the process of identification, storage and return in a timely manner or appropriate disposal where necessary under the values of tikanga. The process of return and disposal of tissue and body parts in storage is monitored by the cultural advisor in conjunction with the mortuary where they are held separate from the deceased

Tangihanga/death process – ensuring the process is being conducted in a timely manner and appropriately in response to taha Māori culture and expectations by wairuatanga/prayer and manaakitanga/compassion. Supporting whānau on and during the coronial process in cases referred to the coroner for post-mortems.

Cultural Safety

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

With the appointment of Harold Wereta, the new general manager Māori health, all training modules are in process of review. A new programme "Engaging Effectively with Māori" has been developed which promotes a relationship-centred care approach with Māori and their whānau. The programme is designed to challenge attitudes and behaviour, strengthen engagement and build relationships that result in equitable outcomes for everyone.

The cultural educator offers tailored cultural education to departments across the organisation to raise their awareness and enhance their knowledge to support safe cultural practice.

Takawaenga and departments work together to strengthen their models of care to ensure that services are meeting the cultural needs and expectations of Māori patients and whānau in the appropriate way and assist patients to attend their hospital appointments.

Examples include patient/whānau-centred care and partners in care programmes.

The Kaunihera Kaumātua representing the four Northland DHB hospital communities and cultural advisor are responsible for ensuring all Northland DHB employees from the board, chief executive, executive leadership, managers and frontline staffs are performing in a culturally safe manner.

They support organisation events in their own community hospitals and key events at Whangarei Hospital. They also have a role of conduits within their own communities promoting key health messages with Māori whānau.

The cultural advisor oversees organisation cultural support, ensures tikanga is being implemented appropriately, advises on requests for translations in te reo Māori and provides cultural advice by request to the organisation.

Cultural Support

Te Poutokomanawa coordinates requests for organisation cultural support with pōwhiri, whakatau, whakawatea and blessings. This is led by the Cultural Advisor, with support of Kaumātua and Kuia Takawaenga.

Workforce Enablement

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

In 2017 the focus includes employment opportunities and recruitment of graduates.

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

Quality Improvement

Te Poutokomanawa's Leadership Team is committed to continuous quality improvement in the systems across all facets of health services to Māori, invests in staff training and development and the use of key tools and techniques to improve the provision of efficient, effective and quality service delivery.

Te Poutokomanawa supports general manager Harold Wereta's vision of the transformational change improvements that are being introduced across Northland DHB and the health sector during 2017.

Medicine, Health of Older People, Emergency Department and Clinical Support Services

Support for Older People

Older People continue to be a growing proportion of Northland's population with currently one in five people being over the age of sixty-five years of age.

The ageing population continues to drive Northland DHBs emphasis on services for older people with older people receiving care and services based on their assessed needs.

As well as supporting older people to age well at home, planning this year has also focused on providing Health of Older People Specialist Nursing support and education to Aged Residential Care, Primary and Community and Hospice Services.

An integrated approach across a range of health and community based services was adopted to improve the health, independence and wellbeing of our older people particularly those living with long term conditions or those with high and complex needs, ensuring older people have a respectful end of life.

During 2015/16 there has been significant engagement with patients, family carers and whānau to capture their experiences of using Northland's health and community services. Service quality improvements have been based on patients and whānau taking an active role in the review and development of dementia care, palliative care, cardiac rehabilitation and stroke services.

Our services have been redesigned around patient experience and recognises the vital role carers and whānau play in the care of family members.

Home and Community Support Services

In the 2015/16 year Northland DHB funded 598,876 hours of home based support services for a total 2,723 older Northlanders, compared to a total of 561,850 hours delivered to 2,764 people in the previous year.

There was a $956,494 increase in annual expenditure. With higher financial and service inputs Northland is continuing to achieve good client outcomes such as a lower use of aged residential care and lower than average acute admissions compared to other DHBs (MoH, 2016).

Eighty one percent of older people receiving long-term home-based support services have had an InterRAI assessment. This is an increase of twenty percent from the previous year. The

interRAI Home Care Assessment System (HC) is a reliable, person-centered assessment system that focuses on the person's functioning and quality of life by assessing needs, strengths and preferences, and facilitates referrals to other services when appropriate.

Dementia Pathway

During 2015/16 Northland DHB continued to implement the Northern Region Interactive Clinical Pathway for the management of dementia, within twelve general practices in Northland. The static dementia pathway is also accessible for practices and health professionals, through their computers on their desks.

Northland's primary healthcare teams have also been supported through dementia education and training opportunities and the development of northern regional DHB education resources.

The aim of the clinical pathways is to support earlier diagnosis and support for those experiencing dementia. Following implementation, there has been an incremental increase in referrals to the Northland Alzheimer's Society with fifty new referrals in the last twelve months.

The Dementia Care Coordination Pathway was completed in October 2015 and two pilot programmes are being delivered in two Mid North general practices. A Dementia Care Coordinator role is engaged within the primary healthcare team to coordinate the non-clinical aspects of patient care in conjunction with carers, family and whānau and general practice. Through this process patients and carers gain prompt access to health, community and social services. In the first six months of the two-care coordination services the participating GPs referred seventeen newly diagnosed patients and eight previously diagnosed patients for dementia care coordination support.

Community Specialist HOP Teams

Over the 2015/2016 period, a dedicated team of community gerontology specialist nurses have supported Northland DHB's geriatricians to pre-screen all older people referred for their first specialist geriatrician assessment. The team has focused on improving access to specialist assessments with doctors and specialist nurses assessing patients at home and introducing telehealth long-distance communication technology in elder clinics.

The Health of Older People Gerontology team has also increased the number of general practices they are engaged with, providing GPs with clinical nursing and post hospital discharge assessments for their patients returning to the community.

Quality Improvement in Aged Residential Care

In the 2015/16 year the Gerontology Nurse Specialists have maintained collaborative working relationships with Northland's twenty-four aged residential care facilities with the aim to improve the safety and quality of care for all residents. The focus has been on developing a culture that firmly values older people and places the safety of residents and the quality of care at the centre of all practice. Clinical quality improvement included medication safety, challenging behaviours, admissions to the emergency department and a range of injury prevention and harm reduction initiatives.

This quality innovation activity was presented at the 2015 International Quality Forum through a poster presentation and was highly commended.

Northland has demonstrated a committed approach to improving safe care and is leading the way in reporting their data in the region.

Fracture Liaison Service

Northland DHB has continued to develop the Fracture Liaison Service, employing a 0.5 FTE fracture liaison nurse. During 2015/16, 349 fragility fractures were captured by the service. Twenty percent of clients captured by the service and referred for a bone scan had an abnormal result, which may have otherwise been missed. Streamlining clinical processes has resulted in most of the initial screening of patients occurring within eight weeks of injury. This has met the International Osteoporosis Foundation best practice gold standard timeframe.

Screening

Breast Screening

Northland DHB has exceeded the national target for non-Māori and the total eligible population (71 percent).

Although the number of screens of Māori women remained constant, the percentage coverage dropped in 2015 from 74.2 percent to 66.6 percent. This occurred because the 2013 Census (released by the NSU in 2015) revealed there were 500 more eligible Māori women than was suggested by the 2006-based projections. The breast screening service is now working to bridge the gap working in partnership with primary health organisations, Māori health providers and GPs. The initiatives implemented have resulted in coverage for Māori improving to 70 percent in the second year of the two-year screening period, and a 69.3 percent result over the whole two years.

Retinal Screening

Northland DHB achieved the northern regional 80 percent target of retinal screening for eligible patients with diabetes in Northland.

Health Target – Shorter Stays in Emergency Departments

During 2015/16 the Whangarei Hospital Urgent Care Clinical Governance Group (WHUCGG) has continued to lead a programme of work to improve the timelines of care of acutely ill patients at Whangarei Hospital.

The initial focus of the WHUCGG was on the establishment of an interim acute medical assessment unit (AMAU) and associated model of care. The exploratory phase of this work demonstrated that the size and location of an AMAU were important factors for realising the benefits of an assessment unit and improving patient flow. A substantive acute assessment unit is required and planning and development is being progressed as part of the site master plan developments for Whangarei Hospital.

In the intervening period there has been an organisational realignment of management service portfolios and recruitment to a number of lead clinical roles within general medicine and the emergency department. This has enabled a renewed focus on measures to address acute patient flow, including working with the ward teams to improve the patient's journey.

On the 23 December 2015, four additional triage bays were opened within the emergency department to support the ambulatory care stream for low acuity patients.

[34] *Under the Better Business Case model adopted for major investments requiring Crown funding*

Information Technology

There continues to be a focus on enabling patient-centred, collaborative, interdisciplinary care. The general practice patient portal is now available in 25 Northland GP practices and is used by over 9,000 patients. The implementation has been financially supported by the DHB and PHOs for the first year. Northland has introduced access to Static Clinical Pathways by general practices and the pathways are being localised to align with Northland services. Further development of Dynamic Pathways which enable interdisciplinary clinical decision support has been slow due to contractual and implementation issues, but holds considerable promise.

The business case was developed and approved for the implementation of the Whānau e-Shared Care tool across Northland. This tool will allow primary, secondary and community providers to create patient-centred care plans that are accessible to patients via a portal. This has the potential to shift the paradigm of care for our patients with long-term conditions to a model that is interdisciplinary and collaborative. The tool also allows secure messaging between primary, secondary and community providers and with patients. We are in early discussions about the introduction of e-Lab ordering and e-Prescribing.

The ongoing programme to maintain the Northern region's ICT infrastructure saw the implementation of a WIFI service for staff and patients as well as upgrading the network infrastructure across the Whangarei campus to accommodate projected growth in demand. The Lync telephony system was deployed successfully in Te Kotuku (new maternity unit), and the internet circuit was upgraded to provide greater capacity and improved security and management.

In partnership with the office of the Government Chief Information Officer and our shared service partner

healthAlliance, we have developed more robust ICT assurance, security and risk management frameworks. These will support us in a more preventative approach to the security and reliability of the IT systems that support our clinical and business services.

Northland DHB's pharmacy dispensing and stock management system was replaced with a regionally shared system, currently in use by Northland DHB and Auckland DHB. This investment has enabled the implementation of a modern, resilient and comprehensive system that improves efficiency and data collection. It will further enable future technologies such as electronic prescribing and administration to be integrated, producing significant improvements in patient safety.

Progress has been made this year on the replacement of the aged patient management system. The upgrade will provide a responsive and supported platform to enable ongoing improvements in patient administration functionality. There are two key streams of work: the actual implementation, and the design of processes and standardisation to support the new functionality. The scale of change for Northland DHB is significant and there is a team dedicated to ensuring the changes are well planned and supported for staff and patients.

Telehealth

Telehealth Enabled Health Outcomes Northland (Te Hono) is a monthly one-hour case review discussion with specialists and primary care clinical teams via video conferencing. It is being trialed in collaboration with Northland's two most northern health providers, Whakawhiti Ora Pai and Te Hiku Hauora.

Based on case-based concept learning, the principle is that knowledge is spread as widely as possible through both secondary and primary care clinical teams, especially for teams in remote locations. This enables improved case management, particularly for more complex cases where there is an increased chance for earlier detection. Renal, respiratory, rheumatology and oncology have participated to date, with the model being highly scalable. Additional primary care clinics will be invited to join before the end of 2016.

Northland is the first to use NEMO (Neonatal Examination and Management Online) for both adults and children. This tool is enhancing assistance and decision-making for acute care clinical teams by linking Kaitaia Hospital with Whangarei Hospital Intensive Care Unit via real-time video. NEMO is proving beneficial for assisting in patient transfer decision-making. This model is being replicated around the other district hospitals.

Last year's Telehealth future vision work captured clinical scenarios and requirements for remote consultations and other clinical uses of technology, undertaken in collaboration with the northern region health sector. mHealth (mobile) and other innovation components have been added, with consumer input currently in progress.

This work feeds into the transition to a more digital and mobile delivery of health services. The first stage is currently underway with the roll-out of a secure mobile platform in collaboration with our regional IT provider healthAlliance.

A separate work stream is looking at unified communications with the aim of providing accessible, secure, and affordable communications technology solutions, including video conferencing, messaging and a file-sharing platform suitable for clinical use.

Hospital Redevelopment

Review of Whangarei Hospital Site Master Plan

Klein Architects were engaged in December 2015 to review the current Whangarei Hospital site master plan as a precursor to the preparation of a five-stage business case[34] for a redevelopment programme. A series of workshops with the executive team and senior clinical staff will examine short and long-term options for how the site might evolve over the next 10 years.

The work to date has reconfirmed the priorities for the site as ED/AAU plus additional theatre capacity, expansion of outpatient areas and the replacement of ageing ward spaces and laboratory. Before building a clinical services block can start, some enabling work to relocate the kitchens will be required. We expect this review to be completed by early October 2016.

New Maternity Facility Whangarei

This facility was opened in February 2016 and fully operational by mid-March. The unit brings together the delivery suite, antenatal outpatients and ward spaces previously located in three separate areas.

Maunu House Refurbishment Project

Following the review of Mental Health Services planning is underway to find alternative accommodation for the community Mental Health team. Maunu House will be used as a decant space for non-essential functions to address pressures for additional clinical spaces in Whangarei Hospital.

Improved Vehicle Access

Discussions have continued with the NZ Transport Agency on the installation of traffic lights to help control the Hospital Road intersection with SH14. Latest indications are that work is expected to begin in the last quarter of 2016.

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

Bay of Islands Hospital Redevelopment Project

Northland DHB and Ngāti Hine Health Trust are undertaking a joint project to upgrade, replace or build new buildings on the campus to create a Bay of Islands Integrated Family Health Centre, Te Hauora o Pukepuke Rau ('A healthy chief on every hill'). Work on this project has been delayed while unidentified contamination of the site was addressed and the planning refined. The next step in this project is to seek user and consumer feedback on the revised concept plan.

Ministerial approval of the ground lease between Northland DHB and Ngāti Hine Health Trust is awaited.

Clinical Training Centre Project

Work on this project has been parked while a review of the Site Master Plan for Whangarei Hospital Campus is undertaken.

Dargaville Hospital

Planning is underway for the integration of the community pharmacy into this complex. A review of the future opportunities for this site will be undertaken in 2017 in conjunction with the Kaipara Community Health Trust.

Whangarei Hospital Minor Works

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

- An increase in theatre capacity by using the former delivery suite
- A storage area to manage biohazard waste
- A temporary reorganisation of the laboratory areas to address compliance requirements
- Reconfiguration of the renal department
- Refurbishment of Ward 15
- Progressively refurbish the bathrooms in the surgical block.

Photo: Northern Advocate

Our Community

Northland Foundation

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

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

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

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

Countdown Kids Appeal

For the last seven years, one of the biggest annual fundraising events for Northland DHB is the Countdown Kids Appeal, which raises funds for specialised equipment for our smallest patients. We work closely with the Countdown supermarkets in the region. Last year this wonderful appeal raised $83,000 to support our children and babies through the provision of equipment and facilities, which would otherwise not have been available. The support from Countdown Kids covers the whole of Northland, and the benefits are spread around all of our hospitals in the region. Since it started, the Countdown Kids Appeal has raised $580,000 for the benefit of our children and babies.

Health Fund PLUS

Contact Energy Fund

The Contact Energy Fund is managed by Northland Foundation on behalf of Northland DHB. It benefits renal patients and their families. This year several patients have received grants amounting to $1000 each to support them with home dialysis. The fund has also been used for a highly successful seminar held in March, bringing patients and their caregivers together to share information as well as networking and support. Participants at the seminar said, "It has meant that we could get out of our homes and connect with like-minded people, make new friends, today has been great."

The Charitable Accounts Committee

A committee of Northland DHB and Northland Foundation staff meets quarterly to receive and consider applications for funding from the many different services and departments of Northland DHB. Grants are made from funds held and administered by Northland Foundation that have been made over the years to support the work of Northland DHB. This year grants that have been made include support for: the Jim Carney Cancer Centre, the Medical Outreach team, the Diabetes Fun Run/Walk, Osteoporosis Awareness Day, the Rural Service Level Alliance Team and the Emergency Department.

Health Fund Plus+

Health Fund Plus+ is the name given to the fundraising programme developed in 2016 to encourage larger gifts, donations and endowments to Northland DHB. These larger gifts and endowments can then be used for the optional extras that will support the Partners in Care programme and which enhance the patient or family/whānau experience of care. This year the Foundation has received gifts or notification of bequests amounting to $1.6m.

Bay of Islands Hospital Redevelopment (Wishing Tree)

Engaging with the local community, Northland Foundation is supporting Northland DHB to identify the things that would enhance the new ward at Bay of Islands Hospital and make it a special and vibrant place. Patients, staff, families and whānau are being asked to contribute their ideas through a "Wishing Tree". Northland Foundation will then match ideas with donors, community organisations, service clubs and others to deliver as many of the wishing tree ideas as possible.

Farewells

Kim Tito

Kim Tito, a long-serving health sector executive and champion for Māori health, ended his time with Northland DHB 44 years after he originally joined the organisation. Kim was the first man to gain his registered nursing qualification in Whangarei in 1976. Kim's last role was the latest in a series of executive management appointments he held from 1988. He finished with Northland DHB in mid-February, 2016.

However, Kim says he expects to maintain some involvement with the health sector – returning to auditing is one option, and governance is another. "NGOs, and in particular Māori NGOs, face a paucity of governance. My experience as an executive working with boards since 1988 has given me a reasonable understanding of what makes a good director. I'm interested in supporting building capacity in governance in NGOs and working backwards from the outside with my colleagues in DHBs and PHOs."

Kim is preparing for kaumātuaship of his hapu, Te Parawhau – "I'm in the next line up" – and Northland DHB Kaumātua Te Ihi Tito is an uncle. "He is the head of our clan and has taught me a lot over the past five years. I'm looking forward to spending more time with him and embedding more of his knowledge so that I can pass it on to my children and grandchildren and support our hapu."

Chris Farrelly

Chief executive of Mania Health PHO and DHB executive leadership team member Chris Farrelly resigned in March 2016 to become CEO/City Missioner of Auckland City Mission.

Chris was Manaia Health's foundation chief executive and had been in the role since 2003, contributing significantly to the development of integrated primary healthcare in Northland and health improvement for some of the region's most vulnerable.

Building and fostering strong relationships with member general practices, Māori organisations, community groups, DHB, non-government agencies, government organisations and other PHOs throughout New Zealand has been a hallmark of Chris's vision and focus. Championing a collaborative spirit, Chris led work that made significant inroads into addressing some of the key determinants of poor health such as poverty, particularly child poverty and food poverty, and sub-standard housing in Northland.

Chris worked in Northland's health system for 25 years, after he joined the then area health board in 1991 and worked in the area of HIV/Aids care, support, education and advocacy. For three years he managed Dargaville Hospital and worked to bring the Dargaville Medical Centre on to the hospital site.

Mr David Lyon

Orthopaedic surgeon Mr David Lyon was farewelled in December 2015, having spent the majority of his career to date working with Northland DHB. After completing his training, Mr Lyon spent a year each in Scotland and England before coming to Northland, beginning work here in September 1990.

He is continuing with his private practice and says his decision to step away from Northland DHB work is to free up more time. "Everybody tells me we all retire too late, so I thought I would do that now while I'm hopefully still young enough to do stuff I want to do." More squash and golf are high on the list.

Mr Lyon says highlights have included the development of the Orthopaedics Department "from three surgeons when I arrived to nine now, and from one registrar to five or six. "It has developed into a very good training and teaching facility, to the extent that we are one of the 'choice' places for registrars to come to, rather than bottom of the list as we used to be. This is due to colleagues of mine and the efforts that they put into teaching."

His career has also spanned the evolution of orthopaedic treatment: "When I arrived, the ward would be half full of patients in traction lying around for weeks and weeks. "Now many of them are operated on and out of hospital. There's a lot more surgery and a lot of advances in surgery. Orthopaedics is an interesting and exciting specialty to be involved in – to see the rapid evolution and change has been great. There's also been a lot of improvement across the hospital as a whole."

Governance and Partnerships

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

Board Members:

Anthony Norman (Chairman)
Sally Macauley (Deputy Chair)
Chris Reid
Craig Brown
Colin Kitchen
Debbie Evans
Denise Jensen (from 3 March 2016)
Greg Gent (to 31August 2015)
John Bain
June McCabe
MC (Bill) Sanderson
Sharon Shea

Community & Public Health and Disability Support Advisory Committee

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

Hospital Advisory Committee:

MC (Bill) Sanderson (HAC Chair)
Anthony Norman
Ariana Roberts (to 18 December 2015)
Chris Reid
Denise Jensen (from 3 March 2016)
John Bain Greg Gent (to 31 August 2015)
Libby Jones
Sally Macauley
Win Bennett

Audit, Finance & Risk Management Committee:

Greg Gent (Chair to 31 August 2015)
Anthony Norman
Denise Jensen (from 3 March 2016
June McCabe (Chairman from 1 Sept 2015)
Sally Macauley

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

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

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

Governance – The Board

Back row: Craig Brown, Dr Nick Chamberlain (CE), Sharon Shea, Colin Kitchen, John Bain.
Front row: June McCabe, Anthony Norman (Chairman), Sally Macauley (Deputy Chair), Dr Chris Reid, Denise Jensen.

BOARD ATTENDANCE
Member Attendance 1 JULY 2015 - 30 JUNE 2016

	2015						2016					
BOARD	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**
Tony Norman (Chair)	✓	✓		✓	✓		✓		✓	x	✓	
Sally Macauley (Deputy Chair)	x	✓		✓	✓		✓		✓	✓	✓	
John Bain	✓	x		✓	✓		✓		✓	✓	✓	
Craig Brown	x	✓		✓	✓		✓		✓	✓	✓	
Debbie Evans	✓	✓		✓	✓		✓		✓	x	✓	
Greg Gent	✓	✓										
Denise Jensen									✓	✓	✓	
Colin Kitchen	✓	✓		✓	x		✓		✓	✓	✓	
June McCabe	✓	✓		x	✓		✓		✓	x	✓	
Chris Reid	✓	✓		✓	✓		✓		✓	✓	✓	
Bill Sanderson	✓	✓		✓	✓		✓		✓	x	✓	
Sharon Shea	✓	✓		✓	✓		✓		✓	x	✓	

MC (Bill) Sanderson

Debbie Evans

No Meeting held
Appointed 4.3.16
Member Resigned

	2015						2016					
CPHAC	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**
Sally Macauley (Chair)			✓			✓	✓		✓			✓
Craig Brown			✓			x	✓		✓			x
Debbie Evans			✓			✓	✓		✓			✓
Peter Jensen			✓			✓	✓		✓			✓
Colin Kitchen			✓			✓	✓		✓			✓
Tony Norman			✓			✓	✓		✓			✓
Mark Sears			✓			✓	✓		x			x
Sharon Shea			✓			✓	✓		✓			✓
Beryl Wilkinson			✓			✓	✓		✓			✓

No Meeting held

	2015						2016					
HAC	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**
Bill Sanderson (Chair)	✓	✓		✓	✓		✓		✓	x	✓	
John Bain	✓	x		✓	✓		✓		✓	✓	✓	
Win Bennett	✓	✓		✓	✓		✓		✓	✓	x	
Greg Gent	✓	✓										
Denise Jensen									✓	✓	✓	
Libby Jones	✓	✓		✓	✓		x		✓	✓	✓	
Sally Macauley	x	✓		✓	✓		✓		✓	✓	✓	
Tony Norman	✓	✓		✓	x		✓		✓	x	✓	
Chris Reid	✓	✓		✓	✓		✓		✓	✓	✓	
Ariana Roberts	✓	✓		✓	x							

No Meeting held
Appointed 4.3.16
Member Resigned

Paula Anderson

Financial and Audit Reports

For the year ended 30 June 2016

Statement of Responsibility

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

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

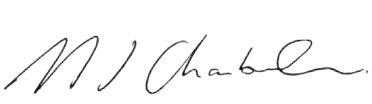
3 The Board are responsible for any end-of-year performance information provided by Northland District Health Board under section 19A of the Public Finance Act 1989.

4 In the Board's opinion these Financial Statements and the Statement of Performance for the year ended 30 June 2016 fairly reflect the financial position and operations of Northland District Health Board.

Signed on behalf of the Board:

Anthony Norman
Chairman
18 October 2016

June McCabe
Chairman - Audit Committee
18 October 2016



Dr Nick Chamberlain
Chief Executive
18 October 2016

Meng Cheong
Chief Financial Officer
18 October 2016

Board Report

The Board have pleasure in submitting the Financial Statements and Statement of Performance for Northland District Health Board for the year to 30 June 2016.

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.

	2016	2015
Results and Distribution - Group	$000s	$000s
Surplus/(deficit) Before and After Tax	138	116
Financial Position		
Equity was represented by:		
Current Assets	38,381	33,087
Less Current Liabilities	(66,368)	(71,130)
Plus Non-Current Assets	203,080	213,860
Less Term Liabilities	(41,109)	(41,767)
Total Equity	133,984	134,050

Review of the Operations

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

Distributions to Owners

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

Board Member Fees

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

Staff Remuneration

The number of staff with total cost to the entity for senior staff packages including salary and other benefits, such as superannuation, with totals in excess of $100,000 for the year to 30 June 2016 (in $10,000 bands):

$100,001	-	$110,000	76	$200,001	-	$210,000	6	$300,001	-	$310,000	5
$110,001	-	$120,000	35	$210,001	-	$220,000	5	$310,001	-	$320,000	7
$120,001	-	$130,000	28	$220,001	-	$230,000	8	$320,001	-	$330,000	9
$130,001	-	$140,000	12	$230,001	-	$240,000	5	$330,001	-	$340,000	5
$140,001	-	$150,000	16	$240,001	-	$250,000	13	$340,001	-	$350,000	3
$150,001	-	$160,000	14	$250,001	-	$260,000	7	$350,001	-	$360,000	4
$160,001	-	$170,000	13	$260,001	-	$270,000	10	$360,001	-	$370,000	2
$170,001	-	$180,000	5	$270,001	-	$280,000	11	$370,001	-	$380,000	3
$180,001	-	$190,000	6	$280,001	-	$290,000	9	$380,001	-	$390,000	1
$190,001	-	$200,000	7	$290,001	-	$300,000	3	$450,001	-	$460,000	2

Of the 330 staff shown above, 202 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 464, compared with the actual total number of staff of 330.

Board Report

During the year ended 30 June 2016, 51 (2015: 49) employees received compensation and other benefits in relation to cessation totalling $869,020 (2015: $1,073,394).

Statement of Information

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

Interest Register

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

Board Members' Insurance

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

Events Subsequent to Balance Date

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

Donations

No donations were made for the year to 30 June 2016, (2015: $0).

Changes in Accounting Policies

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

Auditor's Remuneration

The Controller and Auditor-General is appointed under section 15 of the Public Audit Act 2001. Audit New Zealand is contracted to provide audit services on behalf of the Auditor-General. Audit New Zealand in their capacity as Auditors are due $179,938 (2015: $175,479) for audit fees for the group.

Good Employer Obligations

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

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

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

Anthony Norman
Chairman

Independent Auditor's Report

To the readers of Northland District Health Board and Group's financial statements and performance information for the year ended 30 June 2016

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

We have audited:

- the financial statements of Northland District Health Board and the Group on pages 74 to 102, that comprise the statement of financial position, statement of contingent liabilities and assets and statement of commitments as at 30 June 2016, the statement of comprehensive revenue and expenditure, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of Northland District Health Board and the Group on pages 15 to 34 and in note 23 on page 96.

Unmodified opinion on the financial statements

In our opinion:

- the financial statements of Northland District Health Board and the Group on pages 74 to 102:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2016; and
        - its financial performance and cash flows for the year then ended; and
    - comply with generally accepted accounting practice in New Zealand and have been prepared in accordance with Public Benefit Entity Reporting Standards.

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

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

Our audit opinion on the performance information of Northland District Health Board and the Group for the period ended 30 June 2015, which is reported as comparative information, was modified for the same reason.

In our opinion, except for the effect of the matters described above, the performance information of the Group on pages 15 to 34 and in note 23 on page 96:

- presents fairly, in all material respects, Northland District Health Board and the Group's performance for the year ended 30 June 2016, including:
    - for each class of reportable outputs:
        - its standards of performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
        - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year;
    - what has been achieved with the appropriation; and
    - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure.
- complies with generally accepted accounting practice in New Zealand.

Our audit was completed on 27 October 2016. This is the date at which our opinion is expressed.

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

Basis of opinion

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

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

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

An audit also involves evaluating:

- the appropriateness of accounting policies used and whether they have been consistently applied;
- the reasonableness of the significant accounting estimates and judgements made by the Board;

- the appropriateness of the reported performance information within Northland District Health Board and the Group's framework for reporting performance;
- the adequacy of the disclosures in the financial statements and the performance information; and
- the overall presentation of the financial statements and the performance information.

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

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

Responsibilities of the Board

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

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

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

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

Responsibilities of the Auditor

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

Independence

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

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

KS Mackenzie

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

Statement of Comprehensive Revenue and Expenditure

For the Year Ended 30 June 2016

	Notes	Parent Budget 2016 $000	Group 2016 $000	Group 2015 $000	Parent 2016 $000	Parent 2015 $000
Revenue						
Patient Care Revenue	1	561,545	569,738	545,780	569,738	545,780
Finance Revenue	4a	2,143	1,751	3,084	1,736	3,069
Other Revenue	1	3,714	4,569	6,834	4,998	7,264
Total Revenue		567,402	576,058	555,698	576,472	556,113
Expenditure						
Personnel Costs	3	202,423	208,196	197,927	208,196	197,927
Depreciation and Amortisation Expense	10,11	12,243	12,696	11,595	12,198	11,188
Outsourced Services		22,940	25,082	23,956	25,082	23,956
Clinical Supplies		39,307	43,210	40,217	43,210	40,217
Infrastructure and Non-Clinical Expenses	2	26,508	26,420	26,384	26,970	26,934
Payments to other District Health Boards		76,521	75,466	69,649	75,466	69,649
Payments to Non-Health Board Providers		176,573	174,039	175,885	174,039	175,885
Finance Costs	4b	991	963	1,070	963	1,070
Capital Charge	5	8,772	9,848	8,899	9,848	8,899
Total Expenses		566,278	575,920	555,582	575,972	555,725
Share of surplus of equity accounted associates	8	0	0	0	0	0
Surplus/(deficit) Before and After Tax	12	1,124	138	116	500	388
Surplus attributable to:						
Northland District Health Board		1,124	240	176	500	388
Minority Interest		0	(102)	(60)	0	0
Other Comprehensive Revenue and Expenditure						
Movements on Property Revaluations		0	0	16,148	0	14,316
Financial Assets (bonds) at fair value through other Comprehensive Revenue	12	(114)	(83)	(169)	(83)	(169)
Total other Comprehensive Revenue and Expenditure		(114)	(83)	15,979	(83)	14,147
Total Comprehensive Revenue and Expenditure		1,010	55	16,095	417	14,535
Total Comprehensive Revenue and Expenditure attributable to:						
Northland District Health Board		1,010	157	15,312	417	14,535
Minority Interest		0	(102)	783	0	0

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

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

Statement of Comprehensive Revenue and Expenditure *(Continued)*

Supplementary Information

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

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

2016 - Budget	**Provider**	**Governance**	**Funder**	**Kaipara JV**	**Group**
	2016	**2016**	**2016**	**2016**	**2016**
	$000	**$000**	**$000**	**$000**	**$000**
Revenue	309,253	3,932	254,217	0	567,402
Expenses	309,253	3,932	253,093	0	566,278
Net Surplus/(Deficit)	0	0	1,124	0	1,124

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

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

Statement of Changes in Equity

For the Year Ended 30 June 2016

		Parent Budget	**Group**		**Parent**	
	Notes	**2016**	**2016**	**2015**	**2016**	**2015**
		$000	**$000**	**$000**	**$000**	**$000**
Balance at 1 July		112,607	134,050	118,076	127,168	112,633
Total Comprehensive Revenue and Expenditure		1,010	55	16,095	417	14,535
Balance at 30 June	12	113,617	134,105	134,171	127,585	127,168
Distributions made to Minority Interest		0	(121)	(121)	0	0
Balance at 30 June	12	113,617	133,984	134,050	127,585	127,168
Total Equity attributable to:						
Northland District Health Board		113,617	130,110	129,954	127,585	127,168
Minority Interest		0	3,874	4,096	0	0
Balance at 30 June		113,617	133,984	134,050	127,585	127,168

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

Statement of Financial Position

As at 30 June 2016

	Notes	Parent Budget 2016 $000	Group 2016 $000	Group 2015 $000	Parent 2016 $000	Parent 2015 $000
Assets						
Cash and Cash Equivalents	6	3,884	2,252	8,501	2,187	8,445
Trade and Other Receivables	7	11,454	16,449	16,402	16,446	16,399
Short Term Deposits	6	9,000	15,343	335	15,000	0
Short Term Investments	8	0	0	3,124	0	3,124
Inventories	9	3,884	3,395	3,818	3,395	3,818
Prepayments		138	302	263	302	263
Trust/Special Fund Assets		656	640	644	640	644
Total Current Assets		29,016	38,381	33,087	37,970	32,693
Property, Plant and Equipment	10	194,063	189,905	186,429	182,146	178,172
Intangible Assets	11	2,278	2,271	2,314	2,271	2,314
Investments	8	1,762	0	15,000	1,762	16,762
Investment in equity accounted investees	8	10,117	10,904	10,117	10,904	10,117
Total Non-Current Assets		208,220	203,080	213,860	197,083	207,365
Total Assets		237,236	241,461	246,947	235,053	240,058
Equity						
Crown Equity	12	40,355	44,557	44,557	44,557	44,557
Other Reserves	12	67,783	86,916	87,000	81,966	82,050
Accumulated Surplus/(Deficit)	12	4,823	(2,003)	(2,247)	421	(83)
Trust/Special Fund Assets	12	656	640	644	640	644
Total Equity Attributable to Northland District Health Board		113,617	130,110	129,954	127,584	127,168
Minority Interest		0	3,874	4,096	0	0
Total Equity		113,617	133,984	134,050	127,584	127,168
Liabilities						
Trade and Other Payables	13	41,383	34,352	38,326	34,344	38,319
Interest Bearing Loans and Borrowings	14	473	505	372	505	372
Employee Entitlements	15	29,365	30,967	31,762	30,967	31,762
Provisions	16	0	544	670	544	670
Total Current Liabilities		71,221	66,368	71,130	66,360	71,123
Interest Bearing Loans and Borrowings	14	37,641	26,451	26,259	26,451	26,259
Employee Entitlements	15	14,757	14,658	15,508	14,658	15,508
Total Non-Current Liabilities		52,398	41,109	41,767	41,109	41,767
Total Liabilities		123,619	107,477	112,897	107,469	112,890
Total Equity and Liabilities		237,236	241,461	246,947	235,053	240,058

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

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

Anthony Norman
Chairman
18 October 2016

June McCabe
Chairman - Audit, Finance & Risk Management Committee
18 October 2016

Statement of Cash Flows

For the Year Ended 30 June 2016

	Notes	Parent Budget 2016 $000	Group 2016 $000	Group 2015 $000	Parent 2016 $000	Parent 2015 $000
Cash Flows from Operating Activities						
Cash Receipts from Ministry of Health and Patients		565,259	574,504	548,764	574,933	549,193
Cash Paid to Suppliers		(341,850)	(348,802)	(339,494)	(349,232)	(339,968)
Cash Paid to Employees		(202,422)	(207,994)	(197,109)	(207,994)	(197,109)
Cash Generated from Operations		20,987	17,708	12,161	17,707	12,116
Interest Received		2,143	1,240	3,265	1,224	3,251
Interest Paid		(991)	(966)	(1,063)	(966)	(1,063)
Net Taxes Refunded/(Paid) (Goods and Services Tax)		0	448	444	448	437
Capital Charge Paid		(8,772)	(9,848)	(8,899)	(9,848)	(8,899)
Net Cash Flows from Operating Activities	6	13,367	8,582	5,908	8,565	5,842
Cash Flows From Investing Activities						
Proceeds from Sale of Property, Plant and Equipment		0	20	12	20	12
Acquisition of Property, Plant and Equipment		(44,695)	(17,381)	(36,968)	(17,381)	(36,968)
Acquisition of Intangible Assets		0	0	(29)	0	(29)
Acquisition of Investments in Associates		0	0	0	0	(765)
Acquisition of Investments		0	(8)	(75)	0	(15,000)
Receipts from Maturity of Investments		9,155	2,214	(12,810)	2,214	2,955
Net Cash Flows from Investing Activities		(35,540)	(15,155)	(49,870)	(15,147)	(49,795)
Cash Flows from Financing Activities						
Borrowings Raised (Repaid)		11,563	324	1,924	324	1,924
Net Cash Flows from Financing Activities		11,563	324	1,924	324	1,924
Net Increase/(Decrease) in Cash and Cash Equivalents		(10,609)	(6,249)	(42,038)	(6,258)	(42,029)
Cash and Cash Equivalents at Beginning of Year		14,493	8,501	50,539	8,445	50,474
Cash and Cash Equivalents at End of Year	6	3,884	2,252	8,501	2,187	8,445

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

Statement of Contingent Liabilities and Assets

As at 30 June 2016
Contingent Liabilities and Assets:
Northland DHB and group have no contingent assets or liabilities (2015: $0)

Statement of Commitments

As at 30 June 2016

	Group		Parent	
	2016	2015	2016	2015
	$000	$000	$000	$000
Capital Commitments				
Buildings	625	3,894	625	3,894
Plant, equipment and vehicles	2	704	2	704
	627	4,598	627	4,598
Operating Lease Commitments				
Not more than one year	2,213	2,406	2,510	2,703
One to two years	1,975	1,276	2,272	1,573
Two to five years	3,226	2,093	4,117	2,984
Over five years	2,977	3,005	5,328	5,653
	10,391	8,780	14,227	12,913
Total Commitments	11,018	13,378	14,854	17,511

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

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

During the year ended 30 June 2016, $3,644,000 was recognised as an expense in the statement of comprehensive revenue and expenditure in respect of operating leases (2015: $4,249,000).

Notes to Financial Statements

1 Revenue

	Notes	Group 2016 $000	Group 2015 $000	Parent 2016 $000	Parent 2015 $000
Patient Care Revenue					
Ministry of Health population-based funding		538,996	516,264	538,996	516,264
Ministry of Health other contracts		15,301	14,586	15,301	14,586
Inter-district flows		10,423	10,101	10,423	10,101
ACC contract revenue		4,382	4,221	4,382	4,221
Other patient care related revenue		636	608	636	608
Total Patient Care Revenue		569,738	545,780	569,738	545,780
Other Revenue					
Cash Donation Revenue		109	2,773	109	2,773
Other Revenue		4,460	4,061	4,889	4,491
Total Other Revenue		4,569	6,834	4,998	7,264

2 Infrastructure and Non-Clinical Expenses

Included in Infrastructure and Non-Clinical Expenses:		Group 2016 $000	Group 2015 $000	Parent 2016 $000	Parent 2015 $000
Impairment (reversal) of Trade Receivables (Bad and Doubtful Debts)	7	(27)	(69)	(27)	(69)
Loss/(Gain) on disposal of Property, Plant and Equipment		(13)	(12)	(13)	(12)
Audit Fees paid to Audit New Zealand for Audit of Financial Statements		180	175	174	170
Board and Committee Member Fees and Expenses		274	282	274	282

Northland DHB pays the audit fee of the Kaipara Total Health Care Joint Venture on the controlled entity's behalf. The fee was $5,580 (2015: $5,430).

3 Personnel Costs

	Group 2016 $000	Group 2015 $000	Parent 2016 $000	Parent 2015 $000
Wages and Salaries	204,191	191,361	204,191	191,361
Contributions to Defined Contribution Schemes	5,650	5,141	5,650	5,141
Increase /(Decrease) in Employee Benefit Provisions	(1,645)	1,425	(1,645)	1,425
	208,196	197,927	208,196	197,927

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

4 Finance Income and Finance Costs

4a Finance Income

	Group 2016 $000	Group 2015 $000	Parent 2016 $000	Parent 2015 $000
Interest Income	1,751	3,084	1,736	3,069

4b Finance Costs

	Group 2016 $000	Group 2015 $000	Parent 2016 $000	Parent 2015 $000
Interest Expense	963	1,070	963	1,070

5 Capital Charge

The Northland DHB pays a capital charge every six months to the Crown. The charge is based on actual closing equity as at 30 June and 31 December each year. The capital charge for the year ended 30 June 2016 was 8% per annum (2015: 8% p.a.).

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

	Group		Parent	
	2016	2015	2016	2015
	$000	$000	$000	$000
(a) Cash and Cash Equivalents				
Cash On Hand and at Bank	75	65	10	9
Cash on Deposit with NZ Health Partnerships Limited (2015: Health Benefits Limited)	2,177	8,436	2,177	8,436
Total Cash and Cash Equivalents in the Statement of Cash Flows	2,252	8,501	2,187	8,445
(b) Short Term Deposits with maturities 4-12 months				
Short Term Deposits with maturities 4-12 months	15,343	335	15,000	0
Total Cash and Cash Equivalents, Short Term Deposits and Short Term Investments	17,595	8,836	17,187	8,445

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

	2016		2015	
	Effective fixed interest rate	Actual	Effective fixed interest rate	Actual
	%	$000	%	$000
Short Term Deposits with maturities of 0-3 months:	0.00%	0	0.00%	0
Short Term Deposits with maturities of 4-12 months:	4.72%	15,343	4.04%	335
Total Short Term Deposits		15,343		335

There were no impairment provisions for cash and cash equivalents.

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

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

	Notes	Group		Parent	
		2016	2015	2016	2015
		$000	$000	$000	$000
Surplus for the Period	12	240	176	500	388
Add back Non-Cash Items:					
Depreciation, Amortisation and Assets Written Off		12,696	11,595	12,198	11,188
Add back items classified as Financing Activity:					
Movements in Working Capital:					
(Increase)/Decrease in Trade and Other Receivables		(86)	(2,986)	(86)	(2,986)
(Increase)/Decrease in Inventories		423	15	423	15
Increase/(Decrease) in Trade and Other Payables		(2,920)	(4,247)	(2,699)	(4,118)
Increase/(Decrease) In Employee Benefits		(1,645)	1,425	(1,645)	1,425
Increase/(Decrease) in Provisions		(126)	(70)	(126)	(70)
Net Movement in Working Capital		(4,354)	(5,863)	(4,133)	(5,734)
Items classified as investing and financing activities		0	0	0	0
Net Cash Inflow from Operating Activities		8,582	5,908	8,565	5,842

7 Trade and Other Receivables

	Group		Parent	
	2016	2015	2016	2015
	$000	$000	$000	$000
Trade Receivables from Non-related Parties	9,390	8,623	9,387	8,620
Ministry of Health Receivables	7,243	7,990	7,243	7,990
Less: Provision for Impairment	(184)	(211)	(184)	(211)
Balance at 30 June	16,449	16,402	16,446	16,399

The carrying amount of receivables approximates their fair value.

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

	Parent		Parent	
	Gross Receivable	Impairment	Gross Receivable	Impairment
	2016	2016	2015	2015
	$000	$000	$000	$000
Not past due	16,107	13	16,285	84
Past due 0-30 days	67	15	27	12
Past due 31-60 days	259	10	153	22
Past due 61-90 days	10	1	24	23
Past due >91 days	187	145	121	70
Total	16,630	184	16,610	211

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

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

	Group		Parent	
	2016	2015	2016	2015
	$000	$000	$000	$000
Balance 1 July	211	280	211	280
Additional/(Reduced) Provision during the year	8	(2)	8	(2)
Receivables written off during the period	(35)	(67)	(35)	(67)
Balance at 30 June	184	211	184	211

The carrying amount of receivables that would otherwise be past due or impaired and whose terms have been renegotiated is $34,983 (2015: $53,486).

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

8 Investments

	Group		Parent	
	2016	2015	2016	2015
	$000	$000	$000	$000
Investment in Controlled Entity (at cost)	0	0	1,762	1,762
Investment in Associate (at cost)	10,904	10,117	10,904	10,117
Fixed term Deposits > 12 months	0	15,000	0	15,000
Balance at 30 June	10,904	25,117	12,666	26,879
Short Term Investments				
Bonds with maturities 3 - 12 months	0	3,124	0	3,124
Balance at 30 June	0	3,124	0	3,124

Investment in Controlled Entity
General Information

Name of Entity	Principal Activity	Interest Held 2016	Interest Held 2015	Balance Date
Kaipara Total Health Care Joint Venture	Landlord of Dargaville Hospital	54%	54%	30 June

Investment in Associate
General Information

Name of Entity	Principal Activity	Interest Held 2016	Interest Held 2015	Balance Date
healthAlliance N.Z. Limited	The operation of shared services for Northland, Waitemata, Auckland, Counties Manukau and Hutt Valley District Health Boards	25%	20%	30 June

On 1st July 2015 the 20% shareholding of class A shares held by Health Benefits Ltd were removed from the shareholding. This resulted in a percentage increase in shareholding for Northland DHB from 20% to 25%. During 2016 $80,662 of information technology and related assets (2015: $0) and $706,000 information technology capital expenditure (2015: $660,134 for Windows 7 migration) were added to the carrying amount of the investment in healthAlliance. As at June 2016 Northland DHB held 9.81% of allocated C class shares (2015: 9.81%).

The movement in the carrying value of equity accounted investees is:	Group	
	2016	2015
	$000	$000
Opening Balance	10,117	9,457
Investment in equity accounted investees	787	660
Closing Balance	10,904	10,117

The following amounts represent the aggregate assets, liabilities, revenue and profit of equity accounted investees:	As at and for the year ended 30 June 2016	As at and for the year ended 30 June 2015
	$000	$000
Assets		
Current assets	18,649	19,057
Non-current assets	136,302	106,332
Total assets	154,951	125,389
Liabilities		
Current liabilities	23,109	19,466
Non-current liabilities	3,440	4,026
Total liabilities	26,549	23,492
Net assets	128,402	101,897
Revenue	125,839	123,276
Expenses (including interest and tax)	125,839	123,276
Profit after tax	0	0

The above financial information for healthAlliance is provided as a draft and is subject to final audit clearance as at date of signing.

Bonds
Bonds are recognised at fair value. Fair value has been determined using quoted market price in an active market. There were no Bonds as at 30th June 2016. Interest rate on the Bond that matured is 6.315% p.a.

9 Inventories

	Group		Parent	
	2016	2015	2016	2015
	$000	$000	$000	$000
Pharmaceuticals	283	246	283	246
Surgical and Medical Supplies	3,112	3,572	3,112	3,572
Balance at 30 June	3,395	3,818	3,395	3,818

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

Write-down of Inventories to net realisable value amounted to nil for 2016 (2015: $0).

The amount of inventories recognised as an expense during the year was $31.537m (2015: $27.890m), which is included in the clinical supplies line item in the statement of Comprehensive Revenue and Expenditure.

10 Property, Plant and Equipment

(a) Group

	Freehold land (at valuation)	Freehold buildings (at valuation)	Plant, equipment and vehicles	Work in progress	Total
	$000	$000	$000	$000	$000
Cost					
Balance at 1 July 2014	7,585	130,053	54,958	10,597	203,193
Additions	0	0	0	36,973	36,973
Disposals	0	0	(631)	0	(631)
Movement due to Revaluation	585	(5,268)	0	0	(4,683)
Transfer to Additions P,P&E	0	19,123	5,547	(24,670)	0
Balance at 30 June 2015	8,170	143,908	59,874	22,900	234,852
Balance at 1 July 2015	8,170	143,908	59,874	22,900	234,852
Additions	0	0	0	16,135	16,135
Disposals	0	0	(1,137)	0	(1,137)
Transfer to Additions P,P&E	0	28,252	7,205	(35,457)	0
Balance at 30 June 2016	8,170	172,160	65,942	3,578	249,850

	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 2014	0	13,544	44,896	0	58,440
Depreciation Charge for the year	0	7,374	4,046	0	11,420
Movement due to Revaluation	0	(20,810)	0	0	(20,810)
Disposals	0	0	(627)	0	(627)
Balance at 30 June 2015	0	108	48,315	0	48,423
Balance at 1 July 2015	0	108	48,315	0	48,423
Depreciation Charge for the year	0	8,389	4,264	0	12,653
Disposals	0	0	(1,131)	0	(1,131)
Balance at 30 June 2016	0	8,497	51,448	0	59,945

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 2014	7,585	116,509	10,062	10,597	144,753
At 30 June 2015	8,170	143,800	11,559	22,900	186,429
At 1 July 2015	8,170	143,800	11,559	22,900	186,429
At 30 June 2016	8,170	163,663	14,494	3,578	189,905

(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 2014	7,423	122,568	54,958	10,597	195,546
Additions	0	0	0	36,973	36,973
Disposals	0	0	(631)	0	(631)
Movement due to Revaluation	571	(5,864)	0	0	(5,293)
Transfer to Additions P,P&E	0	19,123	5,547	(24,670)	0
Balance at 30 June 2015	7,994	135,827	59,874	22,900	226,595
Balance at 1 July 2015	7,994	135,827	59,874	22,900	226,595
Additions	0	0	0	16,135	16,135
Disposals	0	0	(1,137)	0	(1,137)
Transfer to Additions P,P&E	0	28,252	7,205	(35,457)	0
Balance at 30 June 2016	7,994	164,079	65,942	3,578	241,593

	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 2014	0	12,730	44,896	0	57,626
Depreciation Charge for the year	0	6,967	4,046	0	11,013
Movement due to Revaluation	0	(19,589)	0	0	(19,589)
Disposals	0	0	(627)	0	(627)
Balance at 30 June 2015	0	108	48,315	0	48,423
Depreciation and Impairment Losses					
Balance at 1 July 2015	0	108	48,315	0	48,423
Depreciation Charge for the year	0	7,891	4,264	0	12,155
Disposals	0	0	(1,131)	0	(1,131)
Balance at 30 June 2016	0	7,999	51,448	0	59,447

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 2014	7,423	109,838	10,062	10,597	137,920
At 30 June 2015	7,994	135,719	11,559	22,900	178,172
At 1 July 2015	7,994	135,719	11,559	22,900	178,172
At 30 June 2016	7,994	156,080	14,494	3,578	182,146

Work in progress

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

Group & Parent	**2016**	**2015**
	$000	$000
Buildings	2,520	22,198
Plant, equipment and vehicles	1,058	702
Total work in progress	3,578	22,900

Impairment

No Impairments were recognised in the current year (2015: $0 was expensed).

Equipment Held under Finance Lease

The net carrying amount of equipment held under finance leases is $1.8m (2015: $2m).

Revaluation

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

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

Restrictions

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

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

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

11 Intangible Assets

Parent and Group

B Class Shares in NZ Health Partnerships Limited and Software

	NZHP Shares 2016 $000	HBL Shares 2016 $000	Software 2016 $000	Total 2016 $000	HBL Shares 2015 $000	Software 2015 $000	Total 2015 $000
Cost							
Balance at 1 July	0	2,249	1,331	3,580	2,144	1,302	3,446
Software Additions for the Year	0	0	0	0	0	29	29
Contribution towards FPSC assets being developed by Health Benefits Limited	0	0	0	0	105	0	105
Contribution to NOS assets being developed by NZ Health Partnerships Limited	2,249	0	0	2,249	0	0	0
Transfer of FPSC rights in Health Benefits Limited	0	(2,249)	0	(2,249)	0	0	0
Balance at 30 June	2,249	0	1,331	3,580	2,249	1,331	3,580
Amortisation							
Balance at 1 July	0	0	1,266	1,266	0	1,091	1,091
Amortisation Charge for the Year	0	0	43	43	0	175	175
Disposals	0	0	0	0	0	0	0
Balance at 30 June	0	0	1,309	1,309	0	1,266	1,266
Carrying Amounts							
Balance at 1 July	0	2,249	65	2,314	2,144	211	2,355
Balance at 30 June	2,249	0	22	2,271	2,249	65	2,314

There are no development costs accounted for as intangible assets.

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

The contribution provides (through class B shares issued) a contractual right to access shared services that will be provided using the assets funded.

On the 1st July 2015, by order in council dated 22nd of June 2015, and pursuant to the section 5 of the Health Sector (Transfers) Act 1993, all assets and liabilities of Health Benefits Ltd ("HBL") were transferred to a new entity, NZ Health Partnerships Ltd ("NZHP").

During the year ended 30 June 2016, the Northland DHB had made payments totalling $0 to NZ Health Partnerships Ltd (2015: $780k to Health Benefits Limited) in relation to the National Oracle Solution (NOS) (2015: FPSC) asset, which was in progress at year end. The NOS rights have been tested for impairment by comparing the carrying amount of the intangible asset to its depreciated replacement cost (DRC), which is considered to equate to the Northland DHB's share of the DRC of the underlying NOS assets. Northland DHB holds 3.29% at the share capital of NZHP.

Notes to Financial Statements

12 Equity

	Group		Parent	
	2016 $000	2015 $000	2016 $000	2015 $000
General Funds				
Balance at 1 July	44,557	44,557	44,557	44,557
Distributions made	0	0	0	0
Capital Contribution	0	0	0	0
Balance at 30 June	44,557	44,557	44,557	44,557
Accumulated Surplus/(Deficit)				
Balance at 1 July	(2,247)	(2,447)	(83)	(495)
Surplus/(Deficit)	240	176	500	388
Transfer to Trust Funds	(10)	(19)	(10)	(19)
Transfer from Trust Funds	14	43	14	43
Balance at 30 June	(2,003)	(2,247)	421	(83)
Reserves				
Revaluation Reserve				
Balance at 1 July	86,916	71,631	81,966	67,669
Revaluations	0	15,285	0	14,297
Balance at 30 June	86,916	86,916	81,966	81,966
Revaluation Reserve consists of:				
Land	6,726	6,726	6,610	6,610
Buildings	80,190	80,190	75,356	75,356
Total Revaluation Reserve	86,916	86,916	81,966	81,966
Fair value through other Comprehensive Revenue Reserve				
Balance at 1 July	84	253	84	253
Net Revaluation gains/(losses) on bonds	(84)	(169)	(84)	(169)
Balance at 30 June	0	84	0	84
Total Reserves	86,916	87,000	81,966	82,050
Trust/Special Funds				
Balance at 1 July	644	648	644	648
Revaluation of Land respect of:	0	20	0	20
Funds received	2	7	2	7
Interest received respect of:	8	12	8	12
Funds spent	(14)	(43)	(14)	(43)
Balance at 30 June	640	644	640	644
Minority Interest				
Balance at 1 July	4096	3433	0	0
Surplus/Deficit for period	(102)	783	0	0
Distributions made	(120)	(120)	0	0
Total Minority Interest	3,874	4,096	0	0
Total Equity at 30 June	**133,984**	**134,050**	**127,584**	**127,168**

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

13 Trade and Other Payables

	Group		Parent	
	2016 $000	2015 $000	2016 $000	2015 $000
Payables under exchange transactions				
Trade Payables to Non-related Parties	4,780	4,678	4,780	4,678
Amounts due to Related Parties	1,326	1,326	1,326	1,326
Revenue in Advance	1,018	1,277	1,018	1,277
Other Non-trade Payables and Accrued Expenses	20,720	26,025	20,720	26,025
Total payables under exchange transactions	27,844	33,306	27,844	33,306
Payables under non-exchange transactions				
Taxes payable (GST, PAYE, FBT, withholding tax and rates)	5,765	4,217	5,757	4,210
ACC Levy Payable	743	803	743	803
Total payables under non-exchange transactions	6,508	5,020	6,500	5,013
Total Trade and Other Payables	34,352	38,326	34,344	38,319

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

14 Interest Bearing Loans and Borrowings

	Group		Parent	
	2016 $000	2015 $000	2016 $000	2015 $000
Current				
Crown Energy Efficiency Loan	106	0	106	0
Term Loans - Finance Leases	399	372	399	372
	505	372	505	372
Non-Current				
Crown Loans	24,650	24,650	24,650	24,650
Crown Energy Efficiency Loan	591	0	591	0
Term loans - Finance Leases	1,210	1,609	1,210	1,609
	26,451	26,259	26,451	26,259
Total Interest Bearing Loans and Borrowings	26,956	26,631	26,956	26,631

Security

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

Interest Rate Summary	2016 Actual	2015 Actual
New Zealand Debt Management Office (formerly Crown Health Financing Agency) $1m facility	3.39%	3.39%
New Zealand Debt Management Office (formerly Crown Health Financing Agency) $4m facility	3.35%	3.35%
New Zealand Debt Management Office (formerly Crown Health Financing Agency) $4.5m facility	3.39%	3.39%
New Zealand Debt Management Office (formerly Crown Health Financing Agency) $7m facility	2.94%	2.94%
New Zealand Debt Management Office (formerly Crown Health Financing Agency) $8.15m facility	3.25%	3.25%
Energy Efficiency and Conservation Authority $697k (2015: $0)	0.00%	0.00%

14 Interest Bearing Loans and Borrowings *(Continued)*

Repayable as follows:	Group		Parent	
	2016	2015	2016	2015
	$000	$000	$000	$000
Within two years	7,240	0	7,240	0
Two to five years	18,072	19,150	18,072	19,150
Six to nine years	35	5,500	35	5,500
Total	25,347	24,650	25,347	24,650

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

Analysis of Financial Leases	Group		Parent	
	2016	2015	2016	2015
	$000	$000	$000	$000
Minimum Lease payments payable				
Within one year	399	372	399	372
Two to five years	1,210	1,609	1,210	1,609
Total	1,609	1,981	1,609	1,981

15 Employee Entitlements

	Group		Parent	
	2016	2015	2016	2015
	$000	$000	$000	$000
Current Liabilities				
Liability for Long Service Leave and Retirement Gratuities	3,214	3,181	3,214	3,181
Liability for Annual Leave	16,573	15,282	16,573	15,282
Liability for Sick Leave	230	179	230	179
Liability for Sabbatical Leave	33	64	33	64
Liability for Continuing Medical Education Leave	6,239	6,330	6,239	6,330
Salary and Wages Accrual	3,951	6,029	3,951	6,029
ACC Partnership Programme Liability	727	697	727	697
	30,967	31,762	30,967	31,762
Non-Current Liabilities				
Liability for Long Service Leave and Retirement Gratuities	12,842	13,365	12,842	13,365
Liability for Sabbatical Leave	702	1,231	702	1,231
Liability for Sick Leave	1,114	912	1,114	912
	14,658	15,508	14,658	15,508
Total Employee Entitlements	45,625	47,270	45,625	47,270

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

The present value of the retirement, sabbatical and long service leave obligations depend on a number of factors that are determined on an actuarial basis using a number of assumptions. Two key assumptions used in calculating this liability include the discount rate 1.95% (2015: 3.6%) and the salary inflation factor 1.7% (2015: 2%). 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.

Credit Risk

The valuation result is most sensitive to the assumed rates of salary growth and resignation rates.

Based on all other assumptions being unaltered, an increase in the salary inflation factor of 1% would increase the employee entitlements by $1.05m. A 1% decrease would reduce the employee entitlements by $927k. A resignation rate 50% of the assumed rate would increase the value of entitlements by $401k, a resignation rate 150% of the assumed rate would decrease the valuation by $337k.

16 Provisions

	Group		Parent	
	2016	2015	2016	2015
	$000	$000	$000	$000
Balance at 1 July	670	740	670	740
Provision made during the year	300	360	300	360
Provision used during the year	(426)	(430)	(426)	(430)
Total Provisions	544	670	544	670

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

17 Financial Instruments

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

Credit Risk

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

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

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

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

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

		Group		Parent	
	Notes	2016	2015	2016	2015
		$000	$000	$000	$000
Cash on Hand and at Bank	6	75	65	10	9
Cash on Deposit with Health Benefits Limited	6	0	8,436	0	8,436
Cash on Deposit with NZ Health Partnership Limited	6	2,177	0	2,177	0
Cash Equivalents - Short Term Deposits	6	15,343	335	15,000	0
Bonds	8	0	3,124	0	3,124
Trade and Other Receivables	7	16,449	16,402	16,446	16,399
Total		34,044	28,362	33,633	27,968

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

Liquidity Risk

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

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

17 Financial Instruments *(Continued)*

	Notes	Carrying Amount $000	Contractual Cashflows $000	Less than 1 year $000	1-5 years $000	More than 5 years $000
Parent & Group 2016						
Crown Loans	14	25,347	28,091	889	27,167	35
Finance Leases	14	1,609	1,827	498	1,329	0
Provisions	16	544	544	544	0	0
Trade and Other Payables	13	28,587	28,587	28,587	0	0
Total		56,087	59,049	30,518	28,496	35
Parent & Group 2015						
Crown Loans	14	24,650	28,184	791	21,730	5,663
Finance Leases	14	1,981	2,325	498	1,827	0
Provisions	16	670	670	670	0	0
Trade and Other Payables	13	34,109	34,109	34,109	0	0
Total		61,410	65,288	36,068	23,557	5,663

Contractual cashflows for 2015 have been restated to include future interest payments for Crown loans and Finance Leases.

Market Risk
The interest rates on Northland DHB's cash and cash equivalents are disclosed in note 6 and 8.

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

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

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

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

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

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

At 30 June 2016, 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 $80,000 (2015: $200,000).

	2016 $000		2015 $000	
Interest Rate Risk	-100 bps	+100 bps	-100 bps	+100 bps
Financial Assets				
Cash, Cash Equivalents and Bonds (non-current)	(180)	180	(310)	310
Financial Liabilities				
Crown Loans	100	(100)	110	(110)
Total	(80)	80	(200)	200

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	
	2016	2015	2016	2015
Loans and Receivables	$000	$000	$000	$000
Trade and Other Receivables	16,449	16,402	16,446	16,399
Trust/Special Fund Assets	640	644	640	644
Cash and Cash Equivalents	2,252	8,501	2,187	8,445
Short Term Deposits	15,343	335	15,000	0
Fair Value through other Comprehensive Revenue				
Bonds	0	3,124	0	3,124
Financial Liabilities at Amortised Cost				
Trade and Other Payables	28,587	34,109	28,587	34,109
Interest Bearing Loans and Borrowings	26,956	26,631	26,956	26,631

Credit Quality of Financial Assets	Group		Parent	
	2016	2015	2016	2015
Counterparties with credit ratings	$000	$000	$000	$000
Cash and cash equivalents and Investments AA-	15,408	3,515	15,000	3,124
Counterparties without credit ratings				
Cash and cash equivalents and Investments	2,187	8,445	2,187	8,445
Debtors and other receivables with no default in the past	16,449	16,402	16,446	16,399
Total Counterparties without credit ratings	18,636	24,847	18,633	24,844

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

Northland DHB held Bonds measured at fair value in the statement of financial position, using quoted market prices (level 1). The fair value is $0 (2015: $3,124k).

18 Related Parties

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

Related Party transactions to be disclosed
Northland DHB has a related party relationship with its controlled entity, associate and with its Board members and key management personnel.

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

	Group		Parent	
	2016	2015	2016	2015
	$000	$000	$000	$000
Board members				
Remuneration	274	263	274	263
Full time equivalent members	11	11	11	11
Executive team				
Remuneration	2,587	2,552	2,587	2,552
Full time equivalent members	11	9	11	9
Total key management personnel remuneration	2,861	2,815	2,861	2,815
Total full time equivalent personnel	22	20	22	20

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

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

Board Member Fees

Current Board Members	**2016**	**2015**
Anthony Norman (Chairman)	$47,600	$44,175
Christopher Reid	$23,170	$21,385
Colin Kitchen	$22,670	$20,635
Craig Brown	$22,170	$20,135
Debbie Evans	$22,670	$20,885
Denise Jensen	$8,140	$0
John Bain	$23,170	$21,385
June McCabe	$22,608	$20,385
MC (Bill) Sanderson	$23,295	$21,823
Sally Macauley (Deputy Chairperson)	$31,150	$28,544
Sharon Shea	$22,670	$20,635
Former Board Members		
Greg Gent	$4,383	$22,635

18 Related Parties *(Continued)*

Associates
Northland DHB has a 25% (2015: 20%) shareholding in healthAlliance, a shared services organisation for Northland, Waitemata, Auckland and Counties Manukau District Health Boards. healthAlliance is owned jointly by these four DHB's. healthAlliance provides Northland DHB with delivery of non-frontline transactional support services.

Northland DHB received $1,251k from healthAlliance in the financial year ended 30 June 2016 and Northland DHB paid healthAlliance $10,915k for the financial year ended 30 June 2016. Northland DHB owed healthAlliance $1,326k as at 30 June 2016. The $1,326k owed to healthAlliance is detailed below:

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

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

Subsidiaries
Northland DHB has a 54% share in The Kaipara Total Health Care Joint Venture.

The Joint Venture's sole business is landlord of Dargaville Hospital, leased for the purpose of delivering health services to the people of Kaipara district, Northland, New Zealand. The Kaipara Total Health Care Joint Venture has a balance sheet date of 30 June.

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

Lease
Northland DHB was granted a head lease of the Joint Venture property for a five year term with two rights of renewal of five years each. This agreement was renewed for a further period of 15 years from 24th May 2014. Annual rent is $550,000 plus GST (2015: $550,000 plus GST), payable monthly in advance.

Maintenance, Administration and Management Contracts

Northland DHB is contracted to provide maintenance and administration for the Joint Venture. Annual Maintenance Contract is $257,500 plus GST (2015: $257,500 plus GST), payable monthly in advance. Annual Administration and Management Contract is $30,000 plus GST (2015: $30,000 plus GST).

The Kaipara Total Health Care Joint Venture made a distribution to Northland DHB of $140,869 (2015: $141,358) . No related party debts have been written off or forgiven during the year. The amount outstanding at year end was nil (2015: $0).

Significant transactions with government-related entities

Northland DHB received funding from the Crown and ACC of $559,539k (2015: $536,320k) to provide health services to the Northland area for the year ended 30 June 2016. The Crown owes Northland DHB $12,312k as at the end of June 2016.

Collectively, but not individually, significant, transactions with government-related entities

In conducting its activities, Northland DHB 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 DHB is exempt from paying income tax.

Northland DHB 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 2016 totalled $14,415k (2015: $14,760k). These purchases included the purchase of electricity from Genesis Power Ltd, air travel from Air New Zealand, blood products and tests from NZ Blood Services and postal services from New Zealand Post.

18 Related Parties *(Continued)*

Other related parties

NZ Health Partnerships Limited (NZHP) (2015: Health Benefits Limited) is a related party as it has significant influence over the operating policies of the Northland DHB through an agreement. NZHP was established as a multi-parent crown subsidary in July 2015 with a mandate to help the health sector save money by leading initiatives which reduce administrative support and procurement costs. Working with the Northland DHB, it expects to deliver savings in these areas which will free up money to reinvest into clinical areas of District Health Boards. Northland DHB paid $748k to NZHP (2015: $1,115k HBL) and owes NZHP $0 as at 30 June 2016. NZHP paid Northland DHB $853k in interest on deposit account (2015: $2,576k HBL) and owed Northland DHB $223k interest as at 30 June 2016. There were no provisions for doubtful debts between these two entities.

Northland DHB is a party to the "DHB Treasury Services Agreement" between NZHP and the participating DHBs. This Agreement enables NZHP to "sweep" DHB bank accounts and invest surplus funds. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with NZHP, which will incur interest at the credit interest rate received by NZHP plus an administrative margin. The maximum debit balance that is available to any DHB is the value of provider arm's planned monthly Crown revenue, used in determining working capital limits, is defined as 1/12th of the annual planned revenue paid by the funder arm to the provider arm as denoted in the most recently agreed Annual Plan inclusive of GST. For Northland DHB that equates to $27,649k. Due to PBE IPSAS 30 disclosure requirements for the credit quality of the financial assets, the money with NZHP is classified under "counterparties with no credit rating".

A DHB Procurement Strategy was unanimously endorsed by all DHBs on 14 April 2016 and all DHBs have committed to providing funding required to complete the National Oracle Solution (NOS) programme. The programme will be implemented by a DHB owned vehicle (NZ Health Partnerships Limited), in which all DHBs own equal "A" class voting shareholding of 5%. The investment in the NOS (2015: FPSC) asset transferred into the new company on 1 July 2015 with no change to the "B" class shareholding as there was no economic event giving rise to a change in the asset. The revised business case demonstrates that the investment generates a positive Net Present Value for Northland DHB. On this basis, the Depreciated Replacement Cost of the NOS rights is considered to equate, in all material respects, to the costs capitalised to date such that the NOS rights are not impaired.

19 Subsequent Events

There are no significant events subsequent to balance date.

20 Capital Management

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

21 Directions issued by Ministers

Northland DHB received a direction from the Minister of State Services and the Minister of Finance pursuant to section 107 and subject to the provisions of section 113 of the Crown Entities Act 2004 to apply to a whole of Government approach to procurement, ICT and property functional leadership. The procurement and ICT directions apply to Northland DHB. The dates when the directions applied are 1 February 2015 for procurement and 1 July 2015 for ICT. Implementation will be managed by healthAlliance.

22 Variance Analysis

Key Financial Information	Parent Actual 2016 $000	Parent Budget 2016 $000	Variance $000
Operational Revenue	576,472	567,402	9,070

The increase in operational revenue against budget can be attributed to ACC revenue earned during the year $815,000, Clinical Training Agency revenue $245,000 and increased MoH revenue for various programmes.

The revenue budget is based on the funding envelope advised by the Ministry of Health in December 2014 for the current financial year. Subsequent to this advice, further funding was made available for additional services.

Operational Cost (including capital charge)	575,972	566,278	9,694

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)	216,104	222,590	(6,486)

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

Total Liabilities (excluding loans)	80,513	85,505	(4,992)

Liabilities are less than budget due to lower trade payables and accruals.

Cash Resources (cash, deposit and investment balances less loans)	(23,007)	(23,468)	461

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

23 Statement of Appropriations

	Parent Budget 2016 $000	Parent 2016 $000	2015 $000
Appropriation Revenue			
Original	509,308	509,308	485,966
Supplementary	2,478	2,466	1,903
Total Appropriation Revenue	511,786	511,774	487,869
Other Revenue	55,616	64,698	68,244
Total Revenue	567,402	576,472	556,113
Expenditure	566,278	575,972	555,725
Surplus/(Deficit)	1,124	500	388

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

The performance measures of these services and outputs are outlined in the Statement of Intent reported in the Statement of Performance.

Statement of Accounting Policies

For the year ended 30 June 2016

Reporting entity

Northland District Health Board (Northland DHB) is a Health Board established by the New Zealand Public Health and Disability Act 2000. Northland DHB has designated itself as a Public Benefit Entity (PBE) for financial reporting purposes, it is owned by the Crown and domiciled and operates in New Zealand. Northland DHB is a reporting entity for the purposes of the NZ Public Health and Disability Act 2000, the Crown Entities Act 2004 and the Public Finance Act 1989. Northland DHB's ultimate parent is the Crown.

The consolidated financial statements of Northland DHB and group for the year ended 30 June 2016 comprise Northland DHB, its controlled entity the Kaipara Total Health Care Joint Venture (54% owned) and its associate healthAlliance N.Z. Limited (25% owned).

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

The financial statements were authorised for issue by the Board on 18 October 2016.

Basis of preparation

Statement of compliance

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

Measurement base

The financial statements have been prepared on a historical cost basis, except where modified by the revaluation of land and buildings and bonds to fair value through other comprehensive revenue and expenditure.

Functional and presentation currency

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

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

Critical accounting estimates and assumptions

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

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

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

Land and buildings revaluations

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

Long service leave and retirement gratuities

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

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

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

Critical judgements in applying accounting policies

Leases classification

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

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

Northland DHB has exercised its judgement on the appropriate classification of leases, and has determined one lease arrangement is a finance lease.

Changes in accounting policies

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.

Statement of Accounting Policies

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

In 2015, the External Reporting Board issued the Disclosure Initiative (Amendments to PBE IPSAS 1), 2015 Omnibus Amendments to PBE Standards, and Amendments to PBE Standards and Authoritative Notice as a Consequence of XRB A1 and Other Amendments. These amendments apply to PBEs with reporting periods beginning on or after 1 January 2016. Northland DHB will apply these amendments in preparing its 30 June 2017 financial statements. Northland DHB expects there will be no effect in applying these amendments.

Basis for consolidation

Subsidiaries

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

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

Transactions eliminated on consolidation

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

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

Equity accounted Investees: Associates

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

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

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

Budget figures

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

Foreign currency transactions

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

Cash and cash equivalents

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

Trade and other receivables

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

Trade and other payables

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

Investments

Bank term deposits

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

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

Equity investments

Northland DHB designates equity investments at fair value through other comprehensive revenue and expense, which are initially measured at fair value plus transaction costs.

After initial recognition, these investments are measured at their fair value with gains and losses, due to immateriality not being recognised in other comprehensive revenue and expense, except for impairment losses that are recognised in the surplus or deficit.

On derecognition, the cumulative gain or loss previously recognised in other comprehensive revenue and expense is reclassified to the surplus or deficit.

A significant or prolonged decline in the fair value of the investment below its cost is considered objective evidence of impairment. If impairment evidence exists, the cumulative loss recognised in other comprehensive revenue and expense is reclassified from equity to the surplus or deficit.

Impairment losses recognised in the surplus or deficit are not reversed through the surplus or deficit.

Inventories

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

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

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

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

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

Interest bearing borrowings

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

Property, plant and equipment

Classes of property, plant and equipment

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

- freehold land
- freehold buildings
- plant 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, the costs of dismantling and removing the items and restoring the site on which they are located, and an appropriate proportion of direct overheads.

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

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

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

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

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

Disposal of property, plant and equipment

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

Additions to property, plant and equipment

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

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

Subsequent costs

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

Depreciation

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

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

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

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

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

Borrowing costs

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

Intangible assets

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

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

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

The investment in the Finance and Procurement Supply Chain changed on the 1st July 2015, by order in council dated 22nd of June 2015, and pursuant to the section 5 of the Health Sector (Transfers) Act 1993, all assets and liabilities of Health Benefits Ltd ("HBL") were transferred to a new entity, NZ Health Partnerships Ltd ("NZHP") and was renamed to National Oracle Solution ("NOS"). It is recognised at the cost of capital invested. This is an indefinite life asset which is tested for impairment annually.

Subsequent expenditure

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

Amortisation

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

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

Impairment of property, plant and equipment and intangible assets

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

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

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

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

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

Employee benefits

Defined contribution schemes

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

Defined benefit schemes

Northland DHB makes employer contributions to the Defined Benefits Plan Contributors Scheme (the scheme), which is managed by the Board of Trustees of the National Provident Fund. The scheme is a multi-employer defined benefit scheme.

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

Long service leave, sabbatical leave and retirement gratuities

Northland DHB's obligation in respect of long service leave, sabbatical leave and retirement gratuities is the amount of future benefit that employees have earned in return for their service in the current and prior periods. The obligation is calculated on an actuarial basis and involves the projection, on a year by year basis, of the entitlements, based on accrued service. These benefits are estimated in respect of their incidence according to assumed rates of death, disablement, resignation and retirement and in respect of those events according to assumed rates of

salary progression. A value is placed on the resulting liabilities by discounting the projected entitlements back to the valuation date using a suitable discount rate. All other employee entitlements are classified as current liabilities.

Annual leave, conference leave, medical education leave and expenses

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

Sick leave

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

Bonuses

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

Provisions

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

Restructuring

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

ACC Accredited Employers Programme

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

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

Equity

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

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

Property revaluation reserve

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

Fair value through other comprehensive revenue and expense reserves

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

Revenue

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

Ministry of Health population-based revenue

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

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

Ministry of Health Contract Revenue

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

Statement of Accounting Policies

Goods sold and services rendered

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

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

Revenue from other DHBs

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

Donated services

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

ACC contract revenue

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

Rental revenue

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

Interest

Interest revenue is recognised using the effective interest method.

Expenses

Operating leases

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

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

Finance leases

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

Financing costs

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

Capital charge

The capital charge is recognised as an expense in the financial year to which the charge relates. From 1 July 1998, Capital charge is required to be paid to the Crown, based on a rate of 8% of Northland DHB's equity. The intention of the capital charge is to make explicit the true costs of the taxpayers' investment by requiring recognition of those costs.

Contingent liabilities

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

Cost of service (Statement of Performance)

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

Cost allocation

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

Cost allocation policy

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

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

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

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

Income tax

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

Goods and services tax

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

SP Glossary

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

Acronyms

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

Directory

BOARD MEMBERS

Anthony Norman (Chairman)
Sally Macauley (Deputy Chair)
Chris Reid
Craig Brown
Colin Kitchen
Debbie Evans
Denise Jensen (from 3 March 2016)
Greg Gent (to 31 August 2015)
John Bain
June McCabe
MC (Bill) Sanderson
Sharon Shea

EXECUTIVE OFFICERS

Dr Nick Chamberlain, Chief Executive
Andrew Potts, General Manager, Surgical, Intensive Care, Ambulatory & Diagnostic Services
Harold Wereta, General Manager, Māori Health
Ian McKenzie. General Manager, Mental Health & Addiction Services
Jeanette Wedding, General Manager, Child, Youth, Maternal & Oral Health (Lead General Manager)
Kim Tito, General Manager, Māori Health and Mental Health & Addiction Services(up until February 2016)
Margareth Broodkoorn, Director of Nursing and Midwifery
Mike Roberts, Chief Medical Officer
Meng Cheong, General Manager, Finance, Funding & Commercial Services
Neil Beney, General Manager, Medicine, Health of Older People, Emergency Department & Clinical Support
Pip Zammit, Director, Allied Health, Scientific and Technical
Sam Bartrum, General Manager, Planning, Outcomes, Integrated Care and District Hospitals

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ASB Bank Limited

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www.northlanddhb.org.nz

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