ANNUAL REPORT 2012

NORTHLAND DISTRICT HEALTH BOARD

Te Poari Hauora Ā Rohe O Te Taitokerau

Reading our Annual Report

The annual report presents an account of Northland District Health Board's performance for the year from 1 July 2011 to 30 June 2012.

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

Key components of the report are outlined to the right.

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

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

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

Key Components

Board Chair and Chief Executive Report

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

Introduction

Northland District Health Board

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

2011/12: The Year in Review

Includes staff matters and 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 interests/shares in other organisations.

Statement of Service Performance

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

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

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Message from the
Board Chair and Chief Executive

On behalf of Northland District Health Board, we are pleased to present our Annual Report for the 2011/2012 financial year. It has been a privilege for us to lead our organisation through another year and to have the opportunity to describe the progress we have made towards improving the health and wellbeing of the people towards a Healthier Northland.

On the basis of strong financial management in challenging circumstances, we have reported a modest surplus for the financial year of $317,000. The Board and the executive leadership team have been meticulous in pursuing the often competing goals of increasing service and quality of care while living within our means.

We have had a pleasing performance across five of our health targets this year. Highlights were our outstanding performance in emergency department length of stay, elective surgery, cancer services and smoking cessation. Despite a concerted effort across the sector that did result in an improvement of our immunisation results, it was extremely disappointing not to achieve the immunisation target and this remains a considerable on-going focus of our work. In addition, as at 30 June 2012 Northland DHB achieved the target of not having any patients waiting on the surgical booking list for longer than six months. Our health targets performance is presented in detail later in this report.

There were a number of cases of meningococcal disease in Northland in the latter part of 2011. Tragically, the disease resulted in a number of deaths. Following the recommendation from the Ministry of Health's Immunisation Technical Forum Northland DHB undertook a targeted mass meningococcal C vaccination programme of our child and youth population aged 12 months up to 20 years. We aimed to immunise 85% of the target population (approximately 37,000 children and youth) by 16 December 2011.

Whilst we did not reach the 85% target we managed to vaccinate 32,270 children over about a 10-week period. This was an outstanding result and demonstrates how collectively the health sector in Northland can make a difference. Those involved in the planning and implementation of the programme are to be congratulated.

To ensure the continued smooth delivery of health services during the Rugby World Cup, Northland DHB engaged in planning and testing responses utilising the Rugby World Cup Health Emergency Framework. The event provided us with an opportunity to work closely with multiple agencies across the Northern region. Contingency and mass casualty planning was completed with a particular emphasis on the Bay of Islands. The increase of 16,000 visitors to Northland had minimal impact on our healthcare service, which demonstrates the value of being prepared, and working together.

The new $15.3 million Mental Health Unit 'Tumanako' was officially opened by the Minister of Health the Hon. Tony Ryall on 7 October 2011. Tumanako was the first stage of the Whangarei Hospital redevelopment. The unit is a state of the art facility for the delivery of mental health care, and demonstrates Northland DHB's commitment to providing well planned, long-term care.

In February 2012 the Board approved the Model of Care and Business Case for a new Maternity Services building at Whangarei Hospital. The new facility will be built on the site of the old mental health unit and will provide co-located services for antenatal, birth and postnatal care. It is anticipated that building will commence in March 2013 with a completion date estimated for April 2014.

After years of discussion, we now have a clinical training centre. The aim of the centre is to support staff in their professional development and ensure that they are able to continue to develop and improve their clinical skills locally.

The Executive Leadership Team restructure was completed to better support the concept of clinical integration and "One Health System", and to reduce the silos within our hospitals and between hospitals and primary care and our NGOs. We welcomed two new executive team members; Dr Mike Roberts our new Chief Medical Officer and Andrew Potts, previously General Manager of Surgical Services at Waitemata DHB, our new GM Clinical Services.

We continue to work with our Northern region colleagues on the Northern Region Health Plan. We are making steady progress with all three work streams; 'First do no harm' - improving patient safety with a number of key initiatives, 'Improving life and years' - focusing on our chronic disease burden, conditions such as diabetes, cardiovascular disease and cancer, and 'informed patient choices' - particularly regarding end of life decisions and advanced care planning.

The Board, in agreement with the eight Tai Tokerau Iwi collectives known as Te Waka A Taonui, has re-established a governance to governance level relationship with iwi. The "Māori Health Gains Council, He Mangai Hauora Mo Te Waka A Taonui", has been formed to provide governance over Māori health issues and the implementation of the Board's Māori Health Plan. This is a positive step forward for engagement with Iwi at a strategic level, and will provide a new mechanism for focusing on the Northland Health Services Plan and the Headline Target for reducing the life expectancy gap between Māori and non-Māori.

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

The next 20 years lay out a challenging future, one where the health needs of Northlanders are forecast to increase dramatically as a result of our growing population, people getting older, and escalating levels of diabetes, heart disease, cancer and the growing problem of obesity in our children and families.

These forecast increases in demand are expected to occur in an environment of significant ongoing fiscal constraints. It is clear that current growth in hospital services is unsustainable, that new models of care are needed and our populations' overall health status needs to improve, with a reduction in the gap between the health of Māori and non-Māori.

Under the stewardship of the Board and leadership from the CE, the Northland Health Services Plan 2012-2017 (NHSP) sets out the strategies and direction we need to take so that all Northlanders have the opportunity to access high quality, safe services in the community, and in our hospitals when needed.

Over the next five years we anticipate intensifying pressures with health targets, the need to improve patient access and better health outcomes, while at the same time improving quality and safety, and maintaining strong performance in productivity and cost containment. This Triple Aim of achieving improvements in population health, patient experience and value for money simultaneously is central to the NHSP and has been agreed to by key clinical and managerial health leaders across Northland.

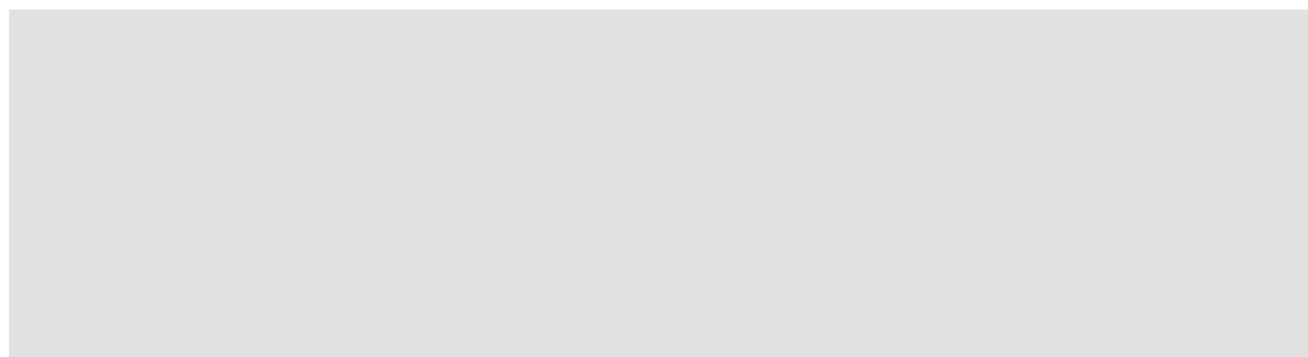
The Northland Health Services Plan provides us with our chance to leave a healthy legacy for future generations of Northlanders; our mokopuna – grandkids, our tamariki – children, our rangatahi – our youth, to enjoy better health and to be secure in the knowledge that the inequities between Māori and non-Māori which currently exist, will not persist.

In October 2011 we farewelled Karen Roach who returned to Australia after five years as Chief Executive. Karen added immense value to the organisation which included the completion of the additions and improvements, including a renal unit in Kaitaia Hospital, chairing the national employee relations' programme for several years and overseeing the construction of Tumanako, the first stage of the Whangarei Hospital redevelopment. Dr Nick Chamberlain commenced the position of Chief Executive in October 2011.

In closing we sincerely thank the members of the Board, our executive leadership team, all our staff, general practices, PHOs, Māori and community providers for their continued hard work, dedication and care. These efforts make a difference to the lives of Northlanders, and there have been numerous expressions of gratitude for the help and compassion that patients and their families/whānau have received.

Anthony Norman
Board Chair

Dr Nick Chamberlain
Chief Executive



Introduction:
Northland District Health Board

Our Role

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

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

It serves a projected population for 2012 of 160,100 and employs around 2,621 staff.

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

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

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

OUR COMMUNITIES

Population

Northland's projected population for 2012 was 160,100, 3.6% of New Zealand's population. Just over half live within the Whangarei District Council area, 37% live within the Far North District Council area and 12% live within the Kaipara District Council area.

Māori

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

Ageing population

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

Socio-economic status

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

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

Rurality

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

Our Health Profile

Māori

Māori experience low levels of health status across a whole range of health and socio economic statistics. They comprise 30% of Northland's population, but 52% of the child and youth population, a key group for achieving long-term gains. Māori experience early onset of long-term conditions like cardiovascular disease and diabetes, presenting to hospital services on average about 15 years younger than non-Māori.

Child and Youth

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

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

Older People

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

Long-Term Conditions

The 'big 3' are diabetes, cardiovascular disease and cancer.

36% of deaths of Northlanders are from cardiovascular disease (heart disease and stroke). 22% of adult Northlanders have been told they have high blood pressure and 14% told that they have high cholesterol, both known risk factors for cardiovascular disease.

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

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

Oral Health

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

Lifestyle Behaviours

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

Mental Health

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

Social Influences

Many of the causes of ill health rest with social and economic factors such as housing, education and economic prosperity. The health sector cannot affect these directly, but district health boards can work on them collaboratively with other government and local body organisations.

Our Vision, Mission & Values

Our Vision:

A Healthier Northland
He hauora Mo Te Tai Tokerau

Our Mission:

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

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

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

Our Values:

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

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

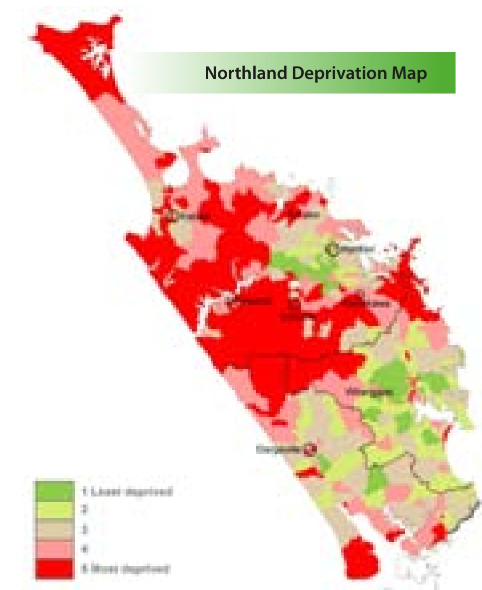
Caring - Manaaki
We nurture those around us, and treat all with dignity and compassion

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

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

New Zealand Deprivation Map

Northland Deprivation Map



Where the Money Goes

Whangarei, Dargaville, Bay of Islands and Kaitaia Hospitals (surgical and medical services, emergency departments, imaging, laboratories, maternity, public health, etc)	$244m
Primary Health (general practitioners, community dental services, radiology, etc)	$57m
Health of older people (including residential care, rehabilitation)	$46m
Mental health services	$42m
Māori health services	$6m
Community pharmacies	$41m
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)	$63m
TOTAL	**$507m**

Every Day in Northland

On average, every day in Northland:

116	Emergency department attendances
133	Inpatient discharges
1,730	Outpatient attendances
85	Outpatient missed appointments
12	Northland patients discharged by other DHBs
9	Chemotherapy attendances
40	Renal dialysis
42	Theatre events
208	Radiology exams
2,449	Lab tests, NDHB hospital
3,090	Lab tests, NDHB community
6	Babies born in hospital
4	Deaths in Northland
2	Mental health hospital admissions
453	Mental health community visits
1,468	General practice consultations
7,857	Prescriptions processed by pharmacies
110	Community visits by allied health services
202	District nursing visits
168	Oral health visits in primary schools
8	Immunisations for two year olds
7	Immunisations for eight month olds
40	Breast screens
839	Subsidised bed-days in aged residential care
1,780	Hours of home-based support services for older people
92	People assessed by hospice services nursing teams

And we do much more!

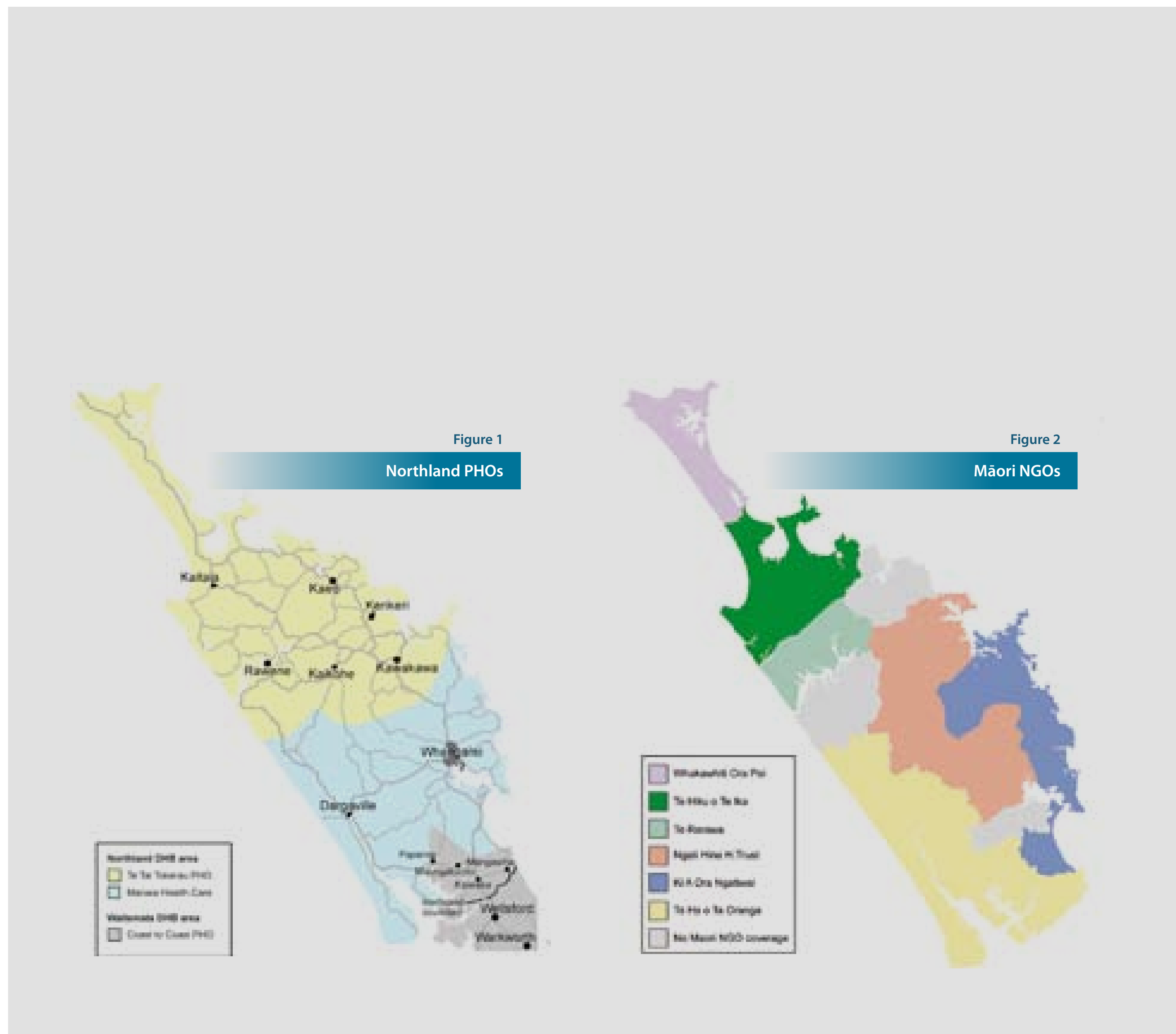


Figure 1
Northland PHOs

Figure 2
Māori NGOs

Our Services

There are currently 149 GPs and 154 practice nurses across 38 general practices providing primary health care to Northlanders enrolled with Northland PHOs (Figure 1), and non-enrolled and non-resident patients.

Northland DHB has 234 contracts with 178 non-Government Organisations (NGOs) including Māori health providers and Whānau Ora Collectives who provide a wide range of public health, primary health care and community services across Northland. (Figure 2 and 3).

Northland has one major secondary care hospital, Whangarei Hospital. A further four district hospitals provide urgent care and acute medical, primary maternity, intermediary, and rehabilitative care. (Figure 4).

Hospitals in Auckland, primarily Auckland City Hospital, provide more specialised (tertiary) services for Northlanders, mainly in cancer and cardiac care. Because of low patient volumes and the specialist skills and equipment required, these cannot be provided in Northland. It takes about two hours to reach Auckland by road from Whangarei. (Figure 5).

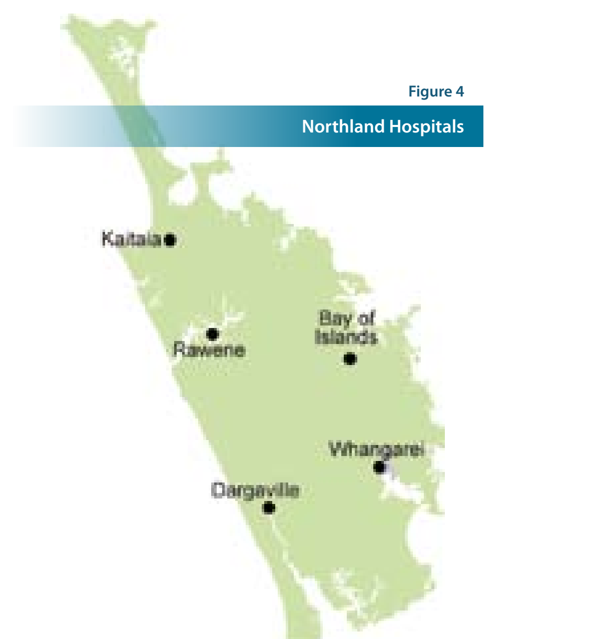
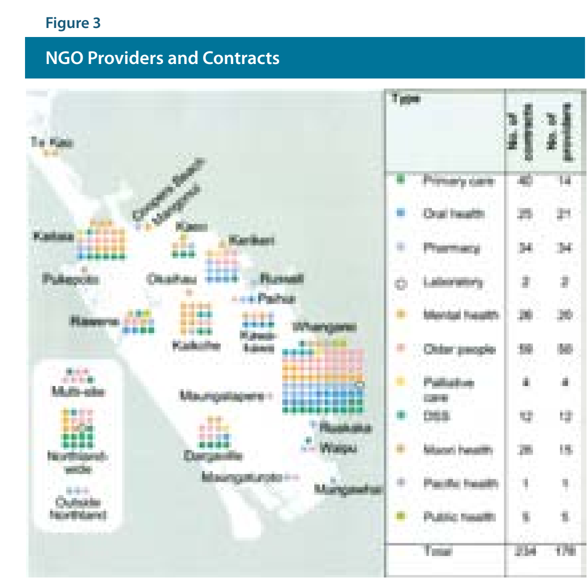


Figure 4
Northland Hospitals



Type	No. of contracts	No. of providers
Primary care	40	14
Oral health	25	21
Pharmacy	34	34
Laboratory	2	2
Mental health	26	20
Older people	59	58
Palliative care	4	4
DSS	12	12
Maori health	26	15
Pacific health	1	1
Public health	5	5
Total	234	178

Figure 3
NGO Providers and Contracts

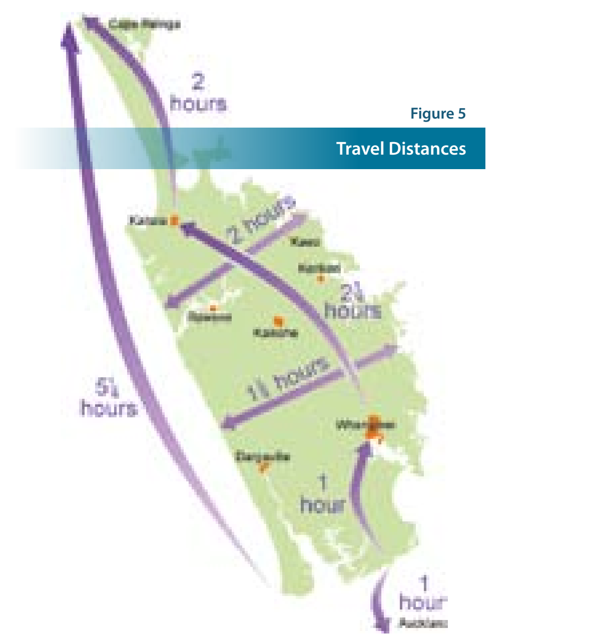


Figure 5
Travel Distances

Our People

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

Staff Engagement

A number of local engagement groups meet quarterly to encourage a cooperative working environment. Joint discussions are held to ensure that ongoing improvements and refinements to existing services together with the introduction of new services/technology are adopted as required. The groups that participated in this engagement include:

- Association of Salaried Medical Specialists (ASMS)
- Resident Doctors' Association (RDA)
- Bipartite Forum (all CTU affiliated unions are invited)
- Bipartite Action Group (strategic CTU affiliated union/ DHB forum)
- Local Engagement Groups (NDHB and APEX/MLWU)
- Safe Staff & Healthy Workplace.

Talent Management

Services identify and support potential leaders in various occupational groups to develop both technical and managerial skills, ensuring succession planning is facilitated. An organisational development plan has been developed and will be implemented in 2012. Training and development initiatives provide the opportunity to participate in management, leadership and clinical programmes nationally and internationally including:

- Continuing Medical Education (CME) for medical staff
- Professional Development recognition programmes for nursing staff
- Specific training identified for Associate Clinical Nurse Managers
- Regular leadership workshops coordinated by the Learning and Development team
- "Grow our Own" staffing initiatives through additional Māori scholarships for staff and a Pirihau Hauroa Māori Scholarship for students who whakapapa to Te Tai Tokerau hapu and iwi
- Hosting advanced medical trainees under the Health Workforce New Zealand (HWNZ) Advanced Trainee Scheme (ATS)
- Participation in HWNZ Northern Regional Training Hub for the "Transitional Years" project for Post Graduate Year 1 and Post Graduate Year 2 medical graduates.

Management and leadership capability

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

- Clinical leadership operating at senior executive level
- Clinical governance mechanisms at various levels of the organisation to support better outcomes for patients.

Health and wellbeing

Northland DHB's Occupational Health and Safety team actively promotes a number of high profile programmes and initiatives including:

- Smokefree/auahi kore
- Employee Assistance Programme (EAP new provider effective 1 May 2012)
- Active management of ACC rehabilitation plans
- On site occupational health assessments
- Workstation assessment programme
- A range of specific policies and guidelines to protect and enhance employees' health, safety and wellbeing
- A collaborative approach to health and safety through a consultative agreement with unions on site.

Workforce profile and Equal Employment Opportunities

Northland DHB adheres to the good employer requirements in section 118 of the Crown Entities Act 2004 which cover:

- Good and safe working conditions
- An equal employment opportunities programme
- The impartial selection of suitably qualified persons for appointment
- Recognition within the workplace of the aspirations and needs of Māori, other ethnic or minority groups, women and people with disabilities
- Training and skill enhancement of employees.

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

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

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

Workforce Development

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

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

National:

Health Workforce New Zealand (HWNZ) identified aged care, mental health and rehabilitation as its key priority areas for 2011-12 with a focus on expanded roles and support for nursing; primary care and in particular general practice; the unregulated workforce; and the home support and self-care 'workforce'. This was seen as a commitment to increase the number of Māori and Pacific peoples entering and remaining in the health and disability workforce.

Regional:

During 2011-2012, Health Workforce New Zealand continued to work nationally to achieve a more strategic and integrated approach to career planning. A major focus of this work is the development of and support for regional postgraduate training hubs. Four regional training hubs - Northern, Midland, Central and South Island have been established.

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

Northland:

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

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

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

- Pihirau Hauora Māori Scholarship has supported and increased access to 107 Māori students studying at bachelor, masters and PhD degree level who whakapapa to Te Tai Tokerau hapu and iwi
- HWNZ and iwi non-regulated training fund has supported 56 Māori Kaimahi into building their capability and capacity to further their professional development in the health sector
- NDHB Te Poutokomanawa Māori Education Fund has supported 31 Māori employees of NDHB to enhance their professional development and build their capability and capacity in the health discipline they work in
- Oral health scholarships have been awarded to five successful candidates to complete their bachelor degree in Dentistry
- Kia Ora Hauora - Supporting Māori in Health Careers has seen a number of youth have workforce and workplace experience in the health sector. This was modelled on Programme Incubator (Hawkes Bay DHB) which has been successful in encouraging Year 12 and 13 students into the health study pathway.

CLINICAL LEADERSHIP

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

Regional:

Clinical leadership has been a strong feature of the development of the Northland Health Services Plan, which is based on the Triple Aim of population health, patient experience and cost/productivity. The plan states that achieving these aims implies:

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

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

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

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

Northland:

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

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

Medical Executive Leadership Team (MELT)

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

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

Nurse Executive Advancement Team (NEAT)

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

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

Allied Health Advisors (AHA)

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

The role of the group includes:

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

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

Te Tai Tokerau Alliance for Health Project

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

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

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

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

Some Highlights

National Health Targets

HT-01 Shorter Stays in Emergency Departments:

The target for shorter stays in emergency departments is 95% of patients admitted, discharged, or transferred from an emergency department within six hours.

Performance - Over the last year there was a steady improvement in performance. By June 2012 just under 95% of patients were admitted, discharged or transferred from the emergency department within six hours.

HT-02 improved access to elective surgery:

The target at a national level is that DHBs will deliver an average increase of 4,000 elective discharges each year in surgical specialties.

Performance - At the end of June 2012, Northland DHB had delivered 7,139 elective surgical discharges year-to-date compared with its target of 6,190 discharges. This represents a favourable variance of 15%.

HT-03 Shorter Waits for Cancer treatment (Radiotherapy):

Everyone needing radiation treatment (excluding those requiring combined chemotherapy and radiation therapy) will have this within six weeks by the end of July 2010 and within four weeks by December 2010.

Performance - The service achieved 100% delivery to the four week target for patients in priority categories A, B & C without a delay code. The service has been continuously target compliant for over two years.

HT-04 Increased Immunisation:

Immunisation coverage is measured using the National Immunisation Register (NIR). Immunisation targets for 2011/12 have been set nationally at 95% coverage i.e. 95% of children to be fully immunised at age two. Data is reported to the Ministry on a quarterly basis.

Performance - Northland DHB has faced challenges in meeting this target. We are working closely with our primary care colleagues to improve performance. By June 2012 performance stood at 84%, with coverage for Māori at 83%.

HT-05 Better help for smokers to quit:

90% of hospitalised smokers will be provided with advice and help to quit by July 2011; and 9% by July 2012.

Performance - Strong performance over the year. By June 2012, 95% of hospitalised smokers were provided with advice and help to quit, with 91% coded for the period. ABC implementation for Māori patients by June 2012 was at 95%.

HT-06 More Heart and Diabetes Checks - Completed Cardiovascular Risk Assessment and Diabetes Check:

The target is that an increased percentage of the eligible adult population will have had their CVD risk assessed in the last five years.

Performance - Current performance stands at 66%, a drop of 3% from the previous quarter. Achievement of the target has been a challenge and we are working closely with our primary care colleagues to improve performance.

Health Targets

As can be seen, there continues to be good improvement in our performance against the Health Targets. Of particular note is that we reached the ED Length of Stay target of 95% of patients waiting less than six hours. We have also seen a consistent improvement in our hospital better help for smokers to quit target performance.

The Immunisation target requires continual vigilance and multiple strategies are being employed across the sector to lift our performance to 95% of all 2 year olds have been immunised.

Associated Health Target Activities

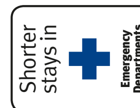
- ABC Cessation Target and presentation of certificate from Minister of Health
- Electives target recognition of consistently high results
- Target recognition of no patients waiting longer than six months for first specialist appointment or surgery at year end June 2012.

My District Health Board

2011/12 QUARTER FOUR (APRIL–JUNE) RESULTS

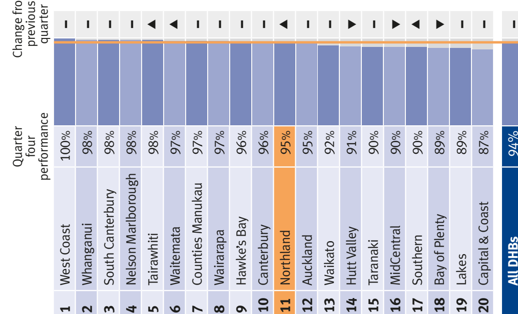
How to read the graphs

Ranking	District Health Board	Quarter four performance	DHB current performance / GOAL	Progress
00	District Health Board	00%		–



Shorter stays in Emergency Departments

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



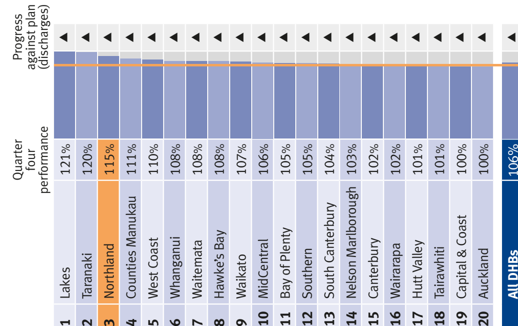
Rank	DHB	Quarter four performance	Change from previous quarter
1	West Coast	100%	–
2	Whanganui	98%	–
3	South Canterbury	98%	–
4	Nelson Marlborough	98%	–
5	Tairawhiti	98%	▲
6	Waitemata	97%	▲
7	Counties Manukau	97%	–
8	Wairarapa	97%	–
9	Hawke's Bay	96%	–
10	Canterbury	96%	–
11	Northland	95%	▲
12	Auckland	95%	–
13	Waikato	92%	–
14	Hutt Valley	91%	▼
15	Taranaki	90%	–
16	MidCentral	90%	▼
17	Southern	90%	▲
18	Bay of Plenty	89%	▼
19	Lakes	89%	–
20	Capital & Coast	87%	–
	All DHBs	94%	–

Goal: 95%

Improved access to elective surgery

The target is an increase in the volume of elective surgery by an average of 4000 discharges per year.

* *DHBs planned to deliver 144,000 discharges for the 2011/12 year, and have delivered 8991 more.*



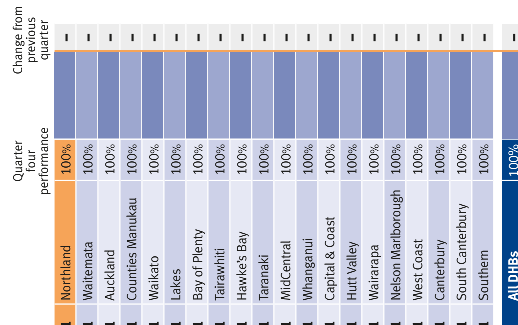
Rank	DHB	Quarter four performance	Progress against plan (discharges)
1	Lakes	121%	▲
2	Taranaki	120%	▲
3	Northland	115%	▲
4	Counties Manukau	111%	▲
5	West Coast	110%	▲
6	Whanganui	108%	▲
7	Waitemata	108%	▲
8	Hawke's Bay	108%	▲
9	Waikato	107%	▲
10	MidCentral	106%	▲
11	Bay of Plenty	105%	▲
12	Southern	105%	▲
13	South Canterbury	104%	▲
14	Nelson Marlborough	103%	▲
15	Canterbury	102%	▲
16	Wairarapa	102%	▲
17	Hutt Valley	101%	▲
18	Tairawhiti	101%	▲
19	Capital & Coast	100%	▲
20	Auckland	100%	▲
	All DHBs	106%	▲

Goal: 100%

Shorter waits for cancer treatment

The target is all patients, ready-for-treatment, wait less than four weeks for radiotherapy. Six regional cancer centres provide radiation oncology services. These centres are in Auckland, Hamilton, Palmerston North, Wellington, Christchurch and Dunedin.

From quarter one 2012/13, this target will be expanded to include patients needing chemotherapy for cancer, as well as radiotherapy.



Rank	DHB	Quarter four performance	Change from previous quarter
1	Northland	100%	–
1	Waitemata	100%	–
1	Auckland	100%	–
1	Counties Manukau	100%	–
1	Waikato	100%	–
1	Lakes	100%	–
1	Bay of Plenty	100%	–
1	Tairawhiti	100%	–
1	Hawke's Bay	100%	–
1	Taranaki	100%	–
1	MidCentral	100%	–
1	Whanganui	100%	–
1	Capital & Coast	100%	–
1	Hutt Valley	100%	–
1	Wairarapa	100%	–
1	Nelson Marlborough	100%	–
1	West Coast	100%	–
1	Canterbury	100%	–
1	South Canterbury	100%	–
1	Southern	100%	–
	All DHBs	100%	–

Goal: 100%

Increased Immunisation

The national immunisation target is 95 percent of two year olds will be fully immunised by July 2012. *This quarterly progress result includes children who turned two years between April and June 2012 and who were fully immunised at that stage.*

From quarter one 2012/13, the national immunisation target will change to 85 percent of eight month olds will have their primary course of immunisation at six weeks, three months and five months on time by July 2013.

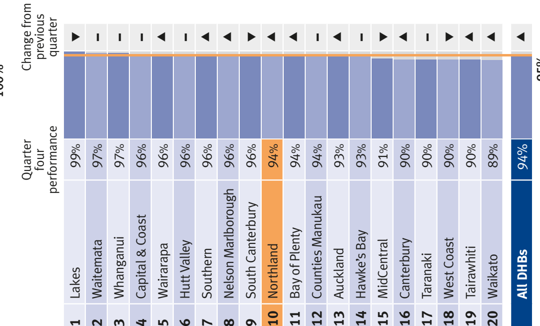
Rank	DHB	Quarter four performance	Change from previous quarter
1	South Canterbury	96%	▲
2	Hawke's Bay	96%	–
3	Auckland	95%	▲
4	MidCentral	95%	–
5	Southern	95%	–
6	Counties Manukau	95%	▲
7	Tairawhiti	95%	▲
8	Waitemata	95%	▲
9	Lakes	94%	–
10	Capital & Coast	94%	▲
11	Wairarapa	94%	▼
12	Hutt Valley	94%	▲
13	Waikato	92%	–
14	Taranaki	91%	▲
15	Canterbury	91%	▼
16	Whanganui	91%	▲
17	Bay of Plenty	91%	–
18	Nelson Marlborough	87%	▲
19	Northland	84%	▼
20	West Coast	78%	▼
	All DHBs	93%	–

Goal: 95%

Better help for smokers to quit

The target is that 95 percent of hospitalised smokers will be provided with advice and help to quit by July 2012. The data covers patients presenting to Emergency Departments, day stay and other hospital based interventions.

Results for the primary care 'Better help for smokers to quit' target can be found on www.health.govt.nz/healthtargets



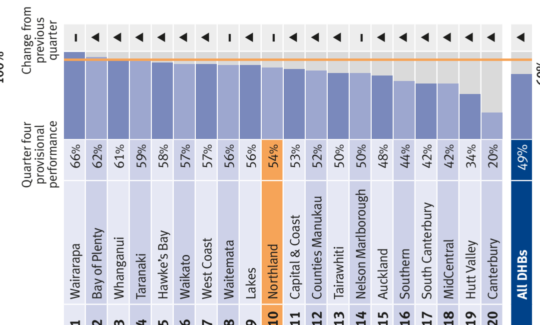
Rank	DHB	Quarter four performance	Change from previous quarter
1	Lakes	99%	▼
2	Waitemata	97%	–
3	Whanganui	97%	–
4	Capital & Coast	96%	–
5	Wairarapa	96%	▲
6	Hutt Valley	96%	–
7	Southern	96%	▲
8	Nelson Marlborough	96%	▲
9	South Canterbury	96%	▼
10	Northland	94%	▲
11	Bay of Plenty	94%	▲
12	Counties Manukau	94%	–
13	Auckland	93%	▲
14	Hawke's Bay	93%	–
15	MidCentral	91%	▼
16	Canterbury	90%	▲
17	Taranaki	90%	–
18	West Coast	90%	▼
19	Tairawhiti	90%	▲
20	Waikato	89%	▲
	All DHBs	94%	▲

Goal: 95%

More heart and diabetes checks

This target is 90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years to be achieved in stages by 1 July 2014. The first stage is to achieve 60 percent by July 2012, and 75 percent by July 2013.

Results for the diabetes indicators can be found on www.health.govt.nz/healthtargets.



Rank	DHB	Quarter four provisional performance	Change from previous quarter
1	Wairarapa	66%	–
2	Bay of Plenty	62%	▲
3	Whanganui	61%	▲
4	Taranaki	59%	▲
5	Hawke's Bay	58%	▲
6	Waikato	57%	▲
7	West Coast	57%	▲
8	Waitemata	56%	–
9	Lakes	56%	▲
10	Northland	54%	–
11	Capital & Coast	53%	▲
12	Counties Manukau	52%	▲
13	Tairawhiti	50%	▲
14	Nelson Marlborough	50%	–
15	Auckland	48%	▲
16	Southern	44%	▲
17	South Canterbury	42%	▲
18	MidCentral	42%	▲
19	Hutt Valley	34%	▲
20	Canterbury	20%	▲
	All DHBs	49%	▲

Goal: 60%

This information should be read in conjunction with the details on the website **www.health.govt.nz/healthtargets**

New Zealand Government

Northland Health Services Plan 2012 - 2017

Over the next 20 years, the health needs of the Northland population will increase as a result of population growth and ageing, and increasing prevalence of long-term conditions (LTCs).

Furthermore, health inequities between Māori and non-Māori may worsen, given the prevalence and impact of LTCs, associated risk factors such as obesity, relative differences in socioeconomic status, and the impact of poor local economy performance (Northland has the lowest GDP of any region in New Zealand).

Northland primary health, community and hospital services face increasing demand pressure. The forecast future escalation in demand will mean services will need considerably increased capacity, but this cannot simply be 'more of the same' if population outcomes are to improve, and inequities are to reduce. The need for change is compounded by medium to long-term forecasts of supply-side constraints in operational and capital funding, and availability of workforce. Some Northland facilities are already at or approaching, maximum capacity.

Together these factors point to the unsustainability of the Northland health system in its current form. Future-proofing requires different resource allocation patterns, and adoption of new ways of working that improves access, makes better use of the available workforce, and improves service performance. New and enhanced facilities and improved use of technologies are also required.

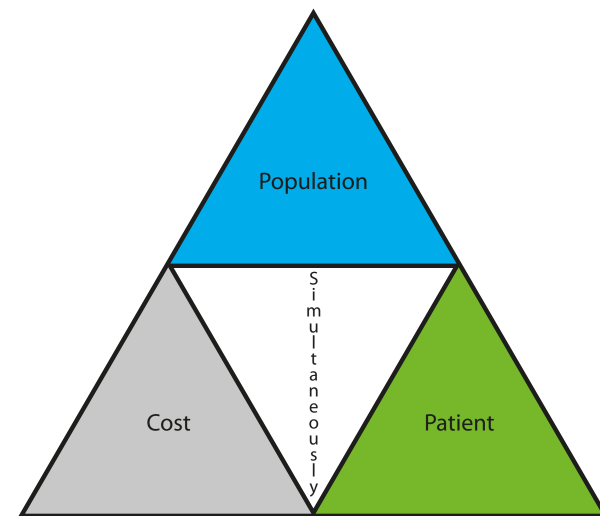
The Northland Health Services Plan (NHSP) describes these future challenges and the responses that will lay the foundation for long-term clinical and financial sustainability. The NHSP has been developed in conjunction with key clinical and managerial leaders from across Northland's health system, together with input from wider stakeholder groups. It builds on existing Northland DHB plans, and learnings from other systems, locally and regionally in New Zealand, and internationally.

The NHSP has a 20-year horizon, with a particular focus on the early actions that anticipate the intensifying pressures on Northland's health system, reducing the risk of crisis-driven, reactive responses.

An NHSP Outcomes Framework has been developed using the Triple Aim methodology: achieving improvements in population health, patient experience, and cost/productivity simultaneously. Six 2017 Headline Targets have been identified and a range of Headline Actions developed to contribute to achieving these targets. The targets are challenging but feasible. They demonstrate the commitment of Northland health sector leaders to making real improvements in the health and care experience of all Northlanders. Importantly they also demonstrate the strong commitment of these leaders to address longstanding health inequities between Northland Māori and non-Māori.

The targets are intended to focus efforts, rather than capture all achievements and associated activity undertaken in these areas. They have been set through extensive engagement with Northland sector leaders.

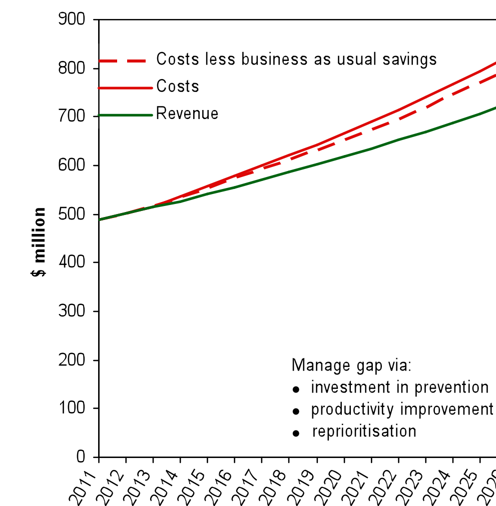
Triple Aim methodology



The actions in the first five years are intended to build momentum in Northland's health system towards addressing the intensifying challenges that it faces. They include a focus on assisting Northland's health sector to live within its available funding while improving population health and patient experience. The strategic direction is:

- Investment in 'upstream' prevention, early intervention and quality
- Productivity improvement and cost control
- Reprioritisation of lower value spending
- Shifting services to lower cost settings.

Strategy for living within available funding



Implementing the NHSP

It is critical that the initial momentum established by NHSP development is translated quickly into implementation planning and then action. Inertia is the greatest threat to the sustainability of Northland's health system. In order to translate the NHSP into action, the following elements will be critical:

Leadership

The Northland DHB Board has delegated implementation of the NHSP to its Chief Executive, who in turn will ensure accountability across the DHB's Executive Leadership Team (ELT). Members of ELT include DHB managerial and clinical leaders, and the chief executives of the PHOs. ELT will carry a collective accountability for NHSP delivery, and individual ELT members will be accountable for leading, planning and implementing each of the headline actions identified in the plan. A project coordinator has been appointed to coordinate and report on the action planning progress.

NDHB has a long history of effective partnering with Māori health and disability providers in designing, delivering, implementing and monitoring health services, and is cognisant of the imperative to ensure a whole-of-system response, of which Māori providers and Whānau Ora Collectives are a part, to achieve the outcome goals of the NHSP. There are a number of partnership relationships at Board, senior management and operational levels which enable engagement with Māori health leadership and will assist the successful implementation of the NHSP.

Action Planning

The NHSP Outcomes Framework established six Headline Targets and agreed Headline Actions using the Triple Aim methodology. Implementation plans will be developed for each of the headline actions over the next six months, and for the enablers that will support those actions. While the NHSP Implementation Roadmap gives a sense of the sequencing of the actions, it will not be until the individual action plans are developed and the linkages and dependencies between them are identified that specific milestones and resource requirements can be confirmed. It is at that stage, likely to be November 2012, that an overall implementation plan for the first five-years of the NHSP will be available for ELT and Board approval. Specific prioritised initiatives will have begun implementation by that time.

Managing Implementation/Monitoring

Following approval, the prioritised actions will be incorporated into the work programmes of the organisations concerned, and existing or new cross-organisational structures used where necessary to guide complex actions. Monitoring and reporting frameworks will be established, so that those accountable for delivery can track progress and input into reports for their own organisations and for the collective accountability of the DHB's ELT. A comprehensive Key Performance Indicator (KPI) framework will be developed to ensure trends can be tracked over time. Baseline measures will be established and targets set. A clear distinction will be made between population health accountabilities (held by relevant funder management/clinical leaders) and provider performance accountabilities. The latter will underpin contract performance arrangements and monitoring. Regular 'dashboard' reports will be generated for ELT and the boards of the DHB and Primary Health Organisations (PHO) and to inform communication to the wider Northland health sector.

Clinical/Stakeholder Engagement

An important platform for engagement was created by:

- Priority planning groups which included a wide range of stakeholders
- Three meetings with Northland general practitioners and pharmacists
- A district hospitals workshop with over 30 participants from all district hospitals and other stakeholders
- Workshop with five Northland Whānau Ora Collectives
- Four locality meetings with health and local government leaders
- 90 Northland health system leaders at the NHSP planning day
- Meetings of the Medical Executive Leadership Team (MELT)
- Meetings of the Service Management Group (SMG).

Two critical factors for the successful implementation of the NHSP is the ongoing active support and participation from clinical leaders, and motivation of the 'front-line' workforce. In addition to specific engagement initiatives by individual ELT members in their areas of responsibility, ELT and the clinical directors will be designing an engagement programme that will create opportunities for those working in hospital and community settings to have input into action planning and implementation and to be kept informed of overall progress.

REGIONAL ACTIVITIES AND ACTIONS

Under the Northern Region Health Plan there are ten patient-focused regional commitments

Three strategic priorities have been identified for regional actions as follows:

- First, Do No Harm
- Life and Years
- The Informed Patient.

Specific regional targets have been set.

All Interventions

1. Achieve and maintain the Minister's Health Targets

First, Do No Harm

2. Reduce the number of harmful falls in our hospitals by 20%
3. Reduce the number of patients who have pressure injuries in hospital or aged care by 20%

Life & Years

4. Ensure 50% of patients with lung cancer will have first surgical treatment within 14 days of multi-disciplinary meeting
5. 70% of patients admitted with acute coronary syndrome will go from 'door to catheter laboratory' within 72 hours
6. Increase to 80% the number of high needs diabetes patients with microalbuminuria/proteinuria who are taking ACE/ARB
7. Undertake retinal screening on 4,500 additional people in our region
8. For each DHB train two more specialist nurses and three diabetes nurse specialists as prescribers

The Informed Patient

9. Complete Whānau Ora Assessments for targeted population
10. 500 patients will have discussions regarding Advanced Care Plans.

Māori Health Gains Council, He Mangai Hauora Mo Te Waka A Taonui

The Board, in agreement with the eight Tai Tokerau Iwi collectives know as Te Waka A Taonui, has re-established a governance-to-governance level relationship with iwi. The "Māori Health Gains Council, He Mangai Hauora Mo Te Waka A Taonui", has been formed to provide governance over Māori health issues and the implementation of the Board's Māori Health Plan.

The council membership is made up of the Northland DHB board chair and Māori board members along with three Te Waka A Taonui nominees.

The Council is responsible for:

- Monitoring the health status and needs of the Northland/ Te Tai Tokerau Māori population
- Monitoring performance against the Māori Health Plan and all associated targets
- Advising the Board on the implications for planning and funding of nation-wide health strategies
- Advising the Board on strategies to reduce the disparities in health status between Māori and non-Māori in Northland/ Te Tai Tokerau
- Advising the Board on priorities for health improvement and independence as part of the strategic and annual planning process and monitoring progress on targets.

Tupeka Kore Smokefree Plan

The 2011-2013 Tupeka Kore Te Tai Tokerau Tobacco Free Northland Plan was approved by Northland District Health Board in March 2011.

The current plan adopts a wider population health approach to support the integration of Northland's tobacco control and smoking cessation programmes, district hospitals, community initiatives and funded provider services.

Northland DHB directly funds smoking cessation services which offer those who smoke, brief advice and support to quit smoking.

This includes general practices, Kaupapa Māori Services and vulnerable communities such as Hokianga and Whangaroa.

Whereas in absolute terms in Northland there are more non-Māori smokers than Māori smokers, in relative terms premature death and disease caused by tobacco are predominantly shouldered by Māori whānau.

Te Poutokomanawa received both mainstream and Kaupapa Māori education on the effects of smoking and smoking cessation interventions and the best way to engage with Māori on this subject in a manner which encourages whānau and individual engagement. All Takawaenga complete ABC for any Māori patients they are visiting that may not have been completed by clinical staff at time of visit. This focused activity has increased the proportion of Māori given ABC or receiving smoking cessation support and has lifted the Māori ABC rates.

MENTAL HEALTH, ADDICTION SERVICES AND DISTRICT HOSPITALS

7,310 people accessed mental health and addiction services over the last year. The most significant increases were in Psychiatric Services for Older People (9%), Child and Youth (7%) and Early Intervention (33%). These age groups were a priority for development in the previous year. 90,821 contacts were made which is a 13% increase in productivity within the sector.

October 2011 - New mental health unit officially opened at Whangarei Hospital

The new unit Tumanako, complete with state-of-the-art concepts and high levels of technology takes the unit to a new level of health care delivery, with an array of features being the first of their kind in New Zealand. The 25 single bed unit is divided into five separate wards, which include women's, men's, older person's, child and youth as well as intensive care facilities. Built to take advantage of up-to-the-minute technologies, the unit has a security system which enables clients to access their own private bedrooms and other authorised areas via their personally coded wristbands.

The unit is supported by three sub-acute units based in Kaitaia, Kaikohe and Whangarei, giving Northlanders more convenient access to mental health services across the district.

Sub-Acute Unit in Whangarei

A new sub-acute mental health unit adjacent to Whangarei Hospital was opened in October 2011 to coincide with the opening of the Tumanako unit. The close location of the unit to the Whangarei inpatient unit means staff and clients can easily move between both facilities as required. With six bedrooms, two bathrooms, kitchen, dining room, a lounge, and laundry; it is designed to function as a residence preparing its occupants for a return to their own home. The facility will support mental health clients who need help to transition from inpatient care to living independently in their community.

Other regional activity

The District Hospitals - Bay of Islands, Kaitaia and Dargaville - have continued to provide an important role in health service delivery in Northland.

Admissions increased in both Bay of Islands Hospital and Dargaville (2% in each) and 5% in Kaitaia.

Presentations to the accident and medical centres in Bay of Islands and Kaitaia also increased significantly - 9% in Kaitaia and 13% in Bay of Islands. Acute presentations in Dargaville are assessed and treated by GPs at the Dargaville Medical Centre.

Medical staffing at the Bay of Islands and Kaitaia has been challenging over the years, however the future is now much brighter with a full complement of staff in each area expected within the near future. It would appear that the development of Rural Hospital Specialists as a distinct and recognised speciality has increased the attractiveness of these roles.

A working group with representation from Bay of Islands Hospital and other DHB representatives, general practitioners, Te Tai Tokerau PHO and Ngati Hine Health Trust commenced planning the redevelopment of the Bay of Islands Hospital site, with the aim of integrating services on the hospital site.

Te Timatanga Hou - the Detoxification unit based at Dargaville Hospital extended to five beds from three in 2011/2012. There have been 82 admissions over the year. The service has been well received by people who needed the service, with outstanding feedback in relation to the facility and staff.

A joint project between a midwife from the maternity unit at Dargaville and the Early Years Hub (Ministry of Social Development) has seen the development of an educational package that is jointly delivered to teenage mothers through antenatal classes. It covers a broad range of subjects and is held over a six-week period. Attendance has been excellent.

The Joint Venture Board (comprising representation from Northland DHB and Kaipara Community Health Trust) invested in the development of an after-hours clinic for the general practitioners to enhance access for the public and co-locate all after-hours activity within close proximity.

Kaitaia has been working actively with different specialities to advance telemedicine, as it offers positive opportunities to increase access and reduce travel for people in the far north.

HOSPITAL AND SPECIALIST SERVICE ACTIVITIES

Telehealth

Renal services have extended the use of Telehealth to provide greater access to tertiary care. The renal team now attends regular vascular, transplant and pathology multi-disciplinary meetings facilitated by Auckland and Waitemata DHBs.

Using the high definition capability of the Telehealth units, the members of the Whangarei renal team are able to view clinical quality radiology and pathology images and discuss Northland patients in real time and in context with their colleagues in Auckland.

A project is underway to implement an acute care Telehealth system linking Whangarei Hospital ICU to Kaitaia Hospital ED. The key benefits are improving patient safety, reducing the number of flight transfers (and reducing costs), and introducing Rapid Response Nursing Team capability to Kaitaia Hospital's General Ward. If successful, the system could be extended to the other district hospitals

The past year has seen an increase in use of the Kaitaia Outpatient Telehealth Clinic room for paediatric and allied health clinics. Use of the facility has also been encouraged

in cases where flights are cancelled so that clinics suitable for Telehealth can still be held.

Engagement with orthopaedics is progressing and oncology Telehealth clinics will be trialled in late 2012. Managed by Auckland Regional Oncology Services, clinics in Whangarei and Kaitaia will be trialled as a priority with the aim of reducing the number of specialist clinic visits required from Auckland.

The recent appointment of a Telehealth Programme Manager at Auckland DHB to develop their strategy and launch initiatives has been very well received as it will speed up the establishment of Telehealth links to tertiary services for clinics and multi-disciplinary meetings.

An evaluation is currently underway which will report on the first three months of Telehealth services to mid and far north Community Mental Health and Addiction Services.

Retinal Screening

There is a fixed site in Whangarei and 21 mobile sites across Northland providing retinal screening. Northland DHB increased annual screening from 2,400 to 3,889 people over the 2011/12 year. This was achieved by offering more late afternoon and evening clinics. The team worked closely with Auckland and Waitemata DHBs using a regional software platform to record performance. They achieved the first year of a two year target to screen 80% of diabetics in Northland.

Breast Screening

Breast screened 74.8% of all women and 72.4% coverage for Māori women across a two year period. This result exceeds the national target of 70%. Northland women have been given increased access to breast screening with the mobile breast screening bus travelling to Russell and Pungaru for the first time.

Value for Money (VfM) and Productivity Increase

Northland DHB established a VfM steering group to oversee and support VfM projects, report benefits and ensure ongoing benefits are imbedded into the organisation. Launched in 2009, the aim of the group is to encourage staff to submit cost savings and efficient project and ideas.

Working through a number of great ideas in areas including electricity consumption, use of motor vehicles and procurement reviews, the district health board has saved over $1,200,000.

- New hospital shuttle between Auckland and Whangarei Hospitals
- New hospital shuttle for Kaikohe patients.

Northland DHB hospitals Baby Friendly

The Baby Friendly Hospital Initiative is a Ministry of Health requirement, with maternity services assessed every three years. Whangarei, Kaitaia, Dargaville and Bay of Islands hospitals were all recognised as baby friendly hospitals in March 2012. Whangarei Maternity has the highest exclusive breast feeding rate on discharge of all Secondary/Tertiary units in New Zealand.

Clinical Training Centre

A Clinical Training Centre (CTC) was opened at Whangarei Hospital. The CTC has been developed in a dedicated and appropriate resource and space, to support our staff in their personal development of clinical skills.

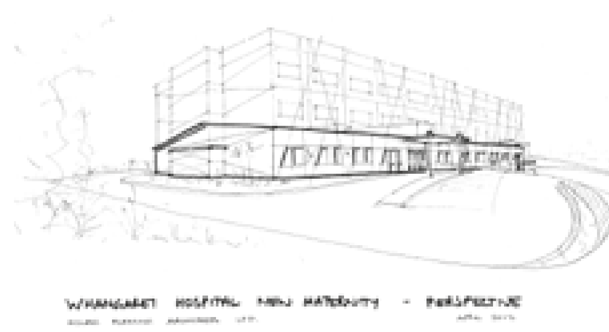
Poutama Programme Launched at NDHB

The Poutama programme is one of the key work streams of Nga Manukura o Apopo - a national Māori nursing and midwifery workforce development initiative. Northland DHB is one of two pilot sites that will implement Poutama in the region; the other site is Lakes DHB.

Poutama is a programme that supports Māori registered nurses, over a 12 month period, to become workplace assessors and mentors. The programme utilises existing courses such as excellence in preceptorship and workplace assessor (unit standard 4098) delivered in a specific order and situated in a Kaupapa Māori framework to achieve optimal learning.

Over the next two years 40 Māori nurses from various health care organisations in Te Tai Tokerau (Northland DHB, Māori Health Providers, Primary Health Care, Aged Care) will achieve the various components of the programme.

Whangarei Hospital Redevelopment



As part of the site redevelopment plan at Whangarei Hospital Northland DHB has signed off the building of a new maternity facility which is now in the design phase. Following consultation a floor plan has been developed which provides for contemporary maternity care.

An estimated investment of $9 million dollars will build a facility that allows for an integrated and collaborative multi-disciplinary team approach when caring for women and their babies. It also provides the Board the opportunity to align maternity services in Northland with the Australasian Health Facility Guidelines and Maternity Services Standards of Care.

The new facility will house all maternity services under one roof and includes eight birthing rooms with ensuite facilities, 22 inpatient beds consisting of mainly one and two bedroom units all with ensuite facilities and four antenatal clinic rooms. In addition an outside courtyard leading out from the maternity unit is being incorporated into the design for users of the service.

Also included in the new facility is a dedicated room for parents and families who lose their child from still birth or neonatal loss. Alongside this will be a new Maternity Assessment Unit with beds which will reduce the number of short stay patients.

The design phase involves a review of the floor plan by clinically-led workstreams to ensure that the rooms are fit for purpose and fully meet the needs of the patients, their families and the frontline workforce.

The maternity unit itself forms the footprint of a planned ward block on top for future development of the Whangarei Hospital site. The anticipated opening date for the new unit will be early 2014.

Emergency Department Assessment Unit

A new six bed assessment unit was established in the Whangarei Hospital Emergency Department in May 2012. The unit provides a ward-like environment with individual bed spaces for patients who are undergoing assessment and are expected to be admitted to a ward. On average, more than eight patients per day are cared for in the unit. The inception of the unit has helped to minimise instances of over-crowding in the Emergency Department and has made a major contribution to improved performance against the ED length of stay target.

Refurbished Cardiac Care Unit

The Cardiac Care Unit at Whangarei was comprehensively refurbished to provide a much improved environment for patients and staff. The refurbishment scheme, completed in April 2012, provided patient shower and lavatory facilities and a family room for the first time along with a dedicated medication area to enhance patient safety. All patients are now nursed in single rooms for privacy and comfort and the unit's design features provide a pleasant and healing environment for patients.

Installation of New Lift to Helipad

An upgrading programme for the lifts at Whangarei Hospital commenced with the installation of a new lift to the helipad. The new lift provides improved reliability and a more comfortable environment for critically ill patients being transferred into and out of the hospital. The lift upgrading programme will be completed in the 2012/13 financial year.

Fifth Intake of Pukawakawa Northland Regional-Rural Medical Programme

The Pukawakawa Northland Regional-Rural Medical Programme sees a select group of Year-5 medical students from Auckland University spend their 2012 study year in Northland. Based primarily at Whangarei Hospital and housed on-site, they also spend time in Kaitaia, Rawene, Bay of Islands and Dargaville Hospitals.

This highly successful programme, running with great success since 2008, has seen the number of students involved increased to twenty-four for 2012.

The 2012 student group consists of sixteen women and eight men.

MĀORI HEALTH

Increasing Access to Services

Though only a very small percentage of Northland's population live more than 60 or 90 minutes away from a hospital, access to services is difficult for many people.

Māori feature disproportionately in Outpatient Departments Do Not Attend (DNA) rates, particularly those who live in one of our poorest Whangarei suburbs, Otangarei.

Te Poutokomanawa are actively represented on an outpatients working group focussing on lifting the attendance rate of Māori to Outpatient Department (OPD) clinics. We have facilitated engagement between the OPD and Te Puawaitanga O Otangarei, a medical centre in Otangarei.

Initiatives being trialled have included reconciling demographic details between IT systems and informing the practice of patient appointments (and cancellations) ahead of time to reduce barriers to access such as appropriate times/dates and transport options. Northland DHB's OPD is exploring different options that include:

- Patient-focused booking system
- Better coordination of multiple appointment bookings
- Improved communication and information distribution
- Shuttle bus transport and partnership with other transport services
- Outreach clinics
- Supporting tobacco cessation programmes in hospitals.

Reducing health inequities through warmer housing

Northland DHB is a contributing funder to the Tai Tokerau Healthy Homes insulation effort within the Warm Up NZ strategy to provide fully subsidised assistance to high needs whānau who fit the criteria.

Over the last year, there has been a concerted effort to target children (0-15yrs) and elderly (65+) who are vulnerable and living in cold damp homes that are not conducive to their health.

The criteria for access to this programme has widened to include persons living in rental accommodation with added support financially from their landlord. In the last six months Northland DHB has 171 referrals with 151 whānau supported to have their houses insulated; 45% of referrals

lived in rental accommodation and 55% owned their own homes. This has had positive impacts on whānau; there are reduced electricity costs from not having to use heaters as much, health improvements, and homes are warmer and not so damp.

Te Poutokomanawa staff and social workers received an in-service presentation on the programme from Tai Tokerau Healthy Homes. The programme has been added to its service plan targets so that staff now screen all Māori hospital in-patients who present with specific health issues against the Tai Tokerau Healthy Homes eligibility criteria.

Te Poutokomanawa staff inform the patient and whānau about the programme and refer them directly to the Tai Tokerau Healthy Homes coordinator who conducts an assessment and reports back those who are successful or not successful for installation assistance.

Whānau Ora Collectives Progress:

Northland DHB supports the implementation of Whānau Ora and participates on the Regional Leadership Group coordinated by Te Puni Kokiri. We are actively supporting the four Whānau Ora Collectives within Te Tai Tokerau - Te Pu o Te Wheke, Te Hau Awhiowhio o Otangarei, Kaipara Whānau Ora Collective and Te Tai Tokerau Whānau Ora Collective, to support their growth and development as collectives.

Staff have contributed to the assessment process with the Ministry of Health regarding programmes of action, business cases, action research proposals and information systems strategic plans to provide analysis and understanding of the local area in which the collectives work in.

Programme Incubator

Programme Incubator ended its contract, with approximately 95 Year 12/13 High School students having participated throughout the year.

Northland schools who participated included Kamo High School, Whangarei Girls' High School, Tikipunga High School, Teen Parents Unit and Mangakahia Area School.

A wide range of health professionals visited the schools to advocate a career in health. This included 5th year medical students from Auckland University, Emergency Department manager and social worker, Podiatry, Theatre, Maternity, Medical Outreach, Pharmacy, Anatomical Pathologist, NorthTec students, Physiotherapy graduate, Psychiatric Nurse, Trendcare, Health promotions, Renal Nurse, Child health nurse, Dietitians, Associate Director of Nursing, Māori health service nurse and Māori health Liaisons.

PRIMARY HEALTH CARE ACTIONS

PUBLIC AND POPULATION HEALTH POINTS

Meningococcal C Immunisation Programme

During the winter of 2011, a community outbreak of meningococcal group C disease occurred in Northland, predominantly affecting children and young people. By the end of December 2011, nine cases of meningococcal C disease had been confirmed, with three deaths. Normally there is only an average of about one case of meningococcal C each year in Northland.

On 12 September 2011, the Ministry of Health recommended an emergency vaccination programme be implemented, offering free, single-dose meningococcal C conjugate vaccine (Meningitec®) to all children and young people in the NDHB area between the ages of 12 months and up to 20 years. The Northland emergency meningococcal C vaccination programme was planned and implemented in an extremely short timeframe.

Achieving overall vaccination coverage of 73% of the target population in a twelve-week programme, given historically low and inequitable immunisation coverage in Northland, was a significant achievement. The collaborative efforts of the Northland health sector enabled the timely delivery of a quality emergency vaccination programme to 32,270 children and young people.

Meningococcal disease is a seasonal disease and most cases occur in the colder months of the year.

The effectiveness of the vaccination campaign will not be obvious until the end of 2012 but there was only one case in Northland for the first half of 2012.

Measles

Despite an ongoing outbreak of measles in Auckland and Northland having one of the lowest vaccination coverage rates in New Zealand, Northland was able to control the spread of this highly infectious disease during 2011 and 2012.

There were 11 probable and confirmed cases in Northland between July 2011 and June 2012. Each case and their contacts were carefully followed up by public health nurses. Non-immune contacts were offered MMR vaccination if appropriate and advice was given on the symptoms of measles and importance of isolation if likely to be infectious. Some cases had over 50 contacts.

Rheumatic fever

Rheumatic fever is a serious illness which follows an untreated streptococcal infection of the throat. Most cases need to spend several weeks in hospital and a proportion end up with permanent heart damage.

The number of rheumatic fever cases in Northland is increasing and has doubled since the early 1990s. There were 18 notifications of initial attacks and one notification of a recurrent attack of rheumatic fever in 2011 (January to December). This represents a rate of 11.7 per 100,000 for initial attack cases which are over three times higher than the national rate of 3.5 per 100,000. Virtually all cases in Northland occur in Māori school-aged children.

In 2002 the Northland District Health Board started a school-based rheumatic fever prevention programme in Whangaroa in partnership with Te Runanga o Whaingaroa and Whangaroa Health Services which has been very successful in reducing the level of disease. A health worker visits schools several times a week and identifies children with sore throats. Those with streptococcal infections are treated with ten days of antibiotics.

Similar projects have now started in Kaikohe, Kaitaia and in Otangarei and Raumanga schools. Other components of the programmes include home visits, healthy housing assessments, ongoing health promotion about "sore throats matter" and updating health professionals about the best forms of treatment. A key feature for these programmes is partnership between Māori and mainstream services. Further programmes will start shortly in the Hokianga and in Moerewa and Kawakawa.

Other quality improvement activities are also being undertaken including an audit of the quality of data stored on the Northland Rheumatic Fever register.

Child and Adolescent Oral Health

Northland DHB Oral Health Strategy (2007) objectives included:

- the development of a seamless dental service for Northlanders aged 0-17 years
- Development of facilities to enable a 'fixed and mobile' model
- Integrated, multi-provider dental service
- Equity of access and oral health outcomes for all Northlanders.

In order to achieve these outcomes capital funding from the Government was allocated to the building of fixed facilities at Kaitaia, Kerikeri and Whangarei and investment in mobile units for Rawene (to be utilised by Hokianga Health Trust), Kawakawa (to be utilised by Ngati Hine Health Trust) and two for Whangarei (NDHB Oral health service provider). Super fixed facilities were developed in Kaikohe, Whangarei and Dargaville.

Two fixed facilities in Whangarei are now operational.

Milk for Schools Programme Northland

Students in 117 schools throughout the Northland region are receiving daily milk from Fonterra - which equates to approximately 7,000 children daily.

Northland DHB's Health Promoting School's Advisor has maintained a link between Fonterra and the public health nurses (PHNs) to support them with product knowledge and information to assist schools with programme participation.

Public health nurses have encouraged and supported schools to enrol in the free programme.

Schools have reported benefits including; a difference in the performance of their children; better health, fewer days off sick, children have more energy, better participation and improved concentration.

Fonterra has started a clinical trial with Auckland University in three Northland Schools.

Alcohol Drug Helpline Referral

In August 2011 the Whangarei Hospital Emergency Department, supported by Northland District Health Board's Public Health and Mental Health and Addiction service entered into a collaborative partnership, referring clients to the Alcohol Drug Helpline.

Clients referred to the Helpline are offered information, insight and support about their drinking or drug taking. If they require further support they are referred through to local Mental Health and Addiction services for further assistance.

Public Health has also coordinated similar initiatives within Police and Work and Income.

By June 2012, over 500 Northlanders had been referred to the Alcohol Drug Helpline and a further 80 people called under their own volition after hearing about the service through the referral sites.

Between January and June 2012, Northland has seen a 92% increase in access to support from the Helpline, compared with 21% nationally.

In celebration of this partnership Northland has been designated as a 'demonstration site' for further Alcohol Drug Helpline Referral Projects in the areas of youth and isolated rural communities.

Recidivist Drunk Driver / Drive SOBA programme

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

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

144 people have completed the programme between June 2007 and December 2010. Data from the Police national Computer (PNC) at the end of August 2011 showed that only 12 people had re-offended (8%). A further 76 people have completed the programme between February 2011 and July 2011, and none show as re-offending at the end of August 2011.

This calendar year the following programmes have been funded:

- Whangarei - 10 Programmes (six funded by NDHB, four funded by RoadSafe Northland)
- Kaipara - two Programmes (funded by RoadSafe Northland)
- Kaikohe - three Programmes (funded by Road Safety Trust)
- Kerikeri - two Programmes (funded by Road Safety Trust)
- Kaitaia - three Programmes (funded by Road Safety Trust).

Acknowledgements

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

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

NORTHLAND COMMUNITY FOUNDATION AND NORTHLAND INTERSECTORAL FORUM

Project Promise

Project Promise, a joint initiative between Northland Community Foundation and Northland DHB to provide Northlanders' with their own patient-centric 'cancer centre'. A major project to raise $3 million for the centre, which will be a one-stop-shop that houses all cancer-related information and services, such as chemotherapy and multi-disciplinary outpatient consultations, providing a venue where education of patients, family/whānau, and health professionals can occur.

- As at 30 June 2012 $1.1M funds have been raised toward Project Promise
- Cancer survivor Api Theodore completed a fundraising run/walk throughout the Northland region called "Api's Magic Miles" raising funds toward Project Promise.

Countdown Kids Hospital Appeal

A fundraising campaign run by Countdown's parent company Progressive Enterprises, locally supported by Northland Community Foundation.

Each year, ten DHBs throughout New Zealand are the lucky recipients of funds raised via the Fresh Futures campaign, much of which is from donations by members of the community at their local Countdown supermarket. Funds raised are used in the purchase of much needed equipment for child health and special care baby units within local hospitals.

Northland District Health Board is using the funds donated this year toward a Giraffe Omnibed for Whangarei Hospital's Special Care Baby Unit.

The Giraffe Omnibed is a fully featured incubator and radiant warmer. With the touch of a button it can very quickly convert from one to the other. This means less stress for the baby and better access for the specialist staff.

The Giraffe Omnibed will enhance the quality of care provided to premature or sick newborns by eliminating the stress of bed-to-bed transfer for critically-ill infants. These babies are very fragile and minimal handling is essential to reduce trauma and stress. Other features include:

- inbuilt weight scales
- warmed pressure diffusion mattress
- rotating bedspace to assist positioning for procedures
- flexibility from closed incubator to radiant warming table. The Onmibed can receive the baby in delivery suite and transport it to SCBU for acute ongoing care without unnecessary handling
- reducing effects of cold-stress to those babies requiring emergency delivery by caesarean section in the cold environment of the operating theatre.

Northland Intersectoral Forum

Northland DHB is a member of the Northland Intersectoral Forum (NIF). NIF comprises of local and central government agencies working in a collaborative way to make a positive difference on the social, economic, environmental and culture well-beings of Northlanders.

The NIF mission is working together for the wellbeing of Northlanders.

The NIF purpose is to:

- build relationships, and share strategic information
- plan and make decisions on what to work on together and how
- identify areas for collective action that individual members commit funding, time, people and other resources to.

Sir Peter Blake Trust Leadership Week

The Sir Peter Blake Trust Leadership Week (22-29 June) is an annual event for all ages that highlights the value that great leadership provides for New Zealand. This year we celebrated young people in our community who demonstrate the attributes of Northland Community PRIDE and show leadership potential in Northland.

Nominations of all young dreamers and future leaders of Northland closed on 15th June 2012. 20 young Northlanders pursuing a dream for themselves or their community were selected from across Northland to take part in a calendar of events and workshops themed 'Dare to Dream".

Aged between 17-25 years old, these young Northlanders were selected based on their ability to demonstrate their potential as an emerging leader through the following characteristics:

Protect - has the initiative to pursue a dream or an idea

Respect - shows integrity

Involve - demonstrates a commitment to Northland

Develop - shows determination and a will to succeed

Educate - acts as a role model and an inspiration to others

Selected nominees who attended the workshops were Chris Wetere, Matangi Te Wake, Ashley Ball, Talbot Kupa, Sam Bridge, Renee Johnson, Cassandra Cocurullo-Whitford, Shaun Brown, Jasmine Sketchley, Ashleigh Whiu, Anna Jagger, Bradley Pitman, Jordan Poasa, Adam Janes.

BOARD & COMMITTEE MEMBERS ATTENDANCE 1 JULY 2011 - 30 JUNE 2012

	2011						2012						
BOARD	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**	**TOTAL**
Tony Norman	✓		✓	✓		✓	✓		✓	✓		✓	8
Sally Macauley	✓		✓	✓		✓	✓		✓	✓		✓	8
Pauline Allan-Downs	✓			✓		✓			✓	✓		✓	6
John Bain	✓		✓	✓		✓	✓			✓		✓	7
Craig Brown	✓		✓	✓		✓	✓		✓	✓			7
Bill Sanderson	✓		✓	✓		✓	✓		✓	✓		✓	8
Colin Kitchen	✓			✓			✓		✓	✓			5
Libby Jones	✓		✓	✓		✓	✓		✓	✓		✓	8
Greg Gent`	✓		✓	✓		✓	✓		✓	✓		✓	8
Sharon Shea	✓		✓	✓		✓	✓		✓	✓		✓	8
June McCabe	✓		✓			✓			✓	✓			5

HAC	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**	**TOTAL**
Bill Sanderson	✓	✓	✓	✓	✓	✓			✓	✓		✓	9
Pauline Allan-Downs	✓	✓	✓	✓		✓			✓	✓		✓	8
Tony Norman	✓	✓	✓	✓	✓		✓		✓	✓		✓	9
John Bain	✓		✓	✓	✓	✓	✓			✓		✓	8
Greg Gent	✓	✓	✓		✓	✓	✓		✓	✓		✓	9
Sally Macauley	✓	✓	✓	✓	✓	✓			✓	✓		✓	9
Maureen Allan	✓		✓	✓		✓	✓		✓	✓			7
Mike Roberts	✓	✓	✓	✓	✓	✓	✓		✓	✓		✓	10
Win Bennett	✓	✓	✓	✓	✓		✓		✓	✓			8

CPHAC/DiSAC	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**	**TOTAL**
Sally Macauley	✓	✓	✓	✓	✓	✓			✓	✓		✓	9
Tony Norman	✓	✓	✓	✓	✓		✓		✓	✓		✓	9
Libby Jones	✓	✓	✓	✓	✓	✓			✓	✓		✓	9
Craig Brown	✓	✓	✓		✓	✓	✓		✓	✓			8
Sharon Shea	✓	✓	✓	✓	✓	✓			✓	✓		✓	9
Colin Kitchen	✓		✓	✓	✓	✓	✓		✓	✓			8
Peter Jensen	✓	✓	✓	✓	✓	✓	✓					✓	8
Beryl Wilkinson	✓	✓	✓	✓	✓	✓	✓		✓			✓	9
John Wigglesworth	✓	✓	✓	✓	✓	✓				✓		✓	8
Mark Sears	✓		✓	✓	✓	✓	✓		✓	✓			8

(Shaded) No Meeting held

Governance and Partnerships

Board Members

Anthony Norman (Chair)
Sally Macauley (Deputy Chair)
Craig Brown
Colin Kitchen
Greg Gent
John Bain
June McCabe
Libby Jones
MC (Bill) Sanderson (Deputy Chair until 5 December 2010)
Pauline Allan-Downs
Sharon Shea

Community & Public Health and Disability Support Advisory Committee

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

Hospital Advisory Committee

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

Audit & Risk Management Committee

Greg Gent (Chair)
Anthony Norman
June McCabe
Sally Macauley

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

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

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

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

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

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

Our Health Priorities

Northland DHB's priorities for 2011/12 arose from a combination of national strategies, national health targets and priorities listed in the Minister of Health's annual Letter of Expectations.

Our priorities 2011/12

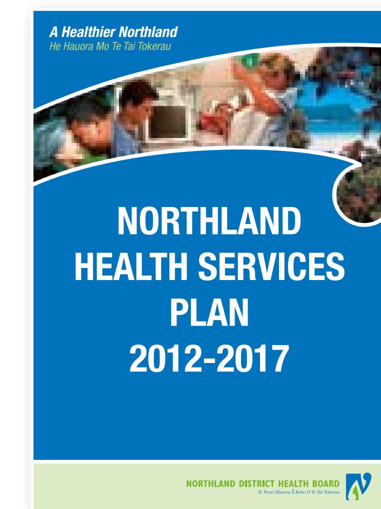
- Long-term conditions
- Cardiovascular disease
- Diabetes
- Cancer
- Respiratory diseases
- Health of older people
- Quality home and community support services for older people
- Comprehensive clinical assessment in residential care
- Dementia pathway
- Community specialist HOP teams
- Acute and unplanned care
- Shorter stays in emergency departments
- Reducing growth in service demand
- Primary care
- Immunisation
- Improved access to elective surgery
- Better help for smokers to quit
- Smokers in hospital
- Smokers in primary care
- Child and youth health
- Child and youth mental health
- Mental health
- Advance care planning
- Maternity services
- Māori health
- Whānau Ora
- Māori health and Northland DHB
- Telehealth
- Workforce Strategy.

Our Strategies

Northland DHB has progressively been developing strategies to deal with these priorities. Each strategy, which has had wide stakeholder involvement, is a vital driver of our planning activity and collectively they describe how the district health board intends to raise health status, improve equity and improve the way services work.

Our strategy adopted this year:

- Northland Health Services Plan.



Financial and Audit Reports

For the Year Ended 30 June 2012

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Statement of Responsibility

1. The Board and management of Northland District Health Board accepts responsibility for the preparation of the Annual Financial Statements and Statement of Service Performance and the judgements used in them.
2. The Board and management of Northland District Health Board accepts responsibility for establishing and maintaining a system of internal control, designed to provide reasonable assurance as to the integrity and reliability of financial and non-financial reporting.
3. In the opinion of the Board and management of Northland District Health Board, the Financial Statements and the Statement of Service Performance for the year ended 30 June 2012 fairly reflect the financial position and operations of Northland District Health Board.

Signed on behalf of the Board;

Anthony Norman
Chairperson

Date: 25 October 2012

Greg Gent
Board Member

Date: 25 October 2012

Dr Nick Chamberlain
Chief Executive

Date: 25 October 2012

Robert Paine
Chief Financial Officer

Date: 25 October 2012

Board Report

The Board have pleasure in submitting the Financial Statements and Statement of Service Performance for Northland District Health Board for the year to 30 June 2012.

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.

	2012	2011
Results and Distribution - Group	**$'000s**	**$'000s**
Surplus/(deficit) Before and After Tax	16	382
Financial Position		
Equity was represented by:		
Current Assets	58,183	52,679
Less Current Liabilities	(85,006)	(86,512)
Plus Non-Current Assets	175,450	134,620
Less Term Liabilities	(29,426)	(32,427)
Total Equity	119,201	68,360

Review of the Operations

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

Distributions to Owners

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

Board Member Fees

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

Staff Remuneration

The number of staff with total annualised cost to the entity for senior staff packages including salary and other benefits, such as superannuation, with totals in excess of $100,000 for the year to 30 June 2012 (in $10,000 bands):-

$100,001	-	$110,000	49	$110,001	-	$120,000	34
$120,001	-	$130,000	19	$130,001	-	$140,000	15
$140,001	-	$150,000	11	$150,001	-	$160,000	6
$160,001	-	$170,000	9	$170,001	-	$180,000	12
$180,001	-	$190,000	7	$190,001	-	$200,000	8
$200,001	-	$210,000	6	$210,001	-	$220,000	9
$220,001	-	$230,000	6	$230,001	-	$240,000	9
$240,001	-	$250,000	11	$250,001	-	$260,000	7
$260,001	-	$270,000	5	$270,001	-	$280,000	4
$280,001	-	$290,000	3	$290,001	-	$300,000	3
$300,001	-	$310,000	4	$310,001	-	$320,000	3
$320,001	-	$330,000	0	$330,001	-	$340,000	4
$340,001	-	$350,000	1	$350,001	-	$360,000	2
$360,001	-	$370,000	1	$370,001	-	$380,000	1
$380,001	-	$390,000	0	$390,001	-	$400,000	0
$400,001	-	$410,000	1				

Of the 250 staff shown above, 167 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 374, compared with the actual total number of staff of 250.

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 and none of the disclosed interests relate to transactions of the entity that any Board Member has or may have had an interest in.

Board Member's 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 2012.

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.

Board Report

Auditor's Remuneration

The Controller and Auditor-General is appointed under sections 150 and 156 of the Crown Entities Act 2004. Audit New Zealand is contracted to provide audit services on behalf of the Auditor-General. Audit New Zealand in their capacity as Auditors are due $157,545 for audit fees for the group.

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

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

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

Anthony Norman
CHAIRPERSON

Independent Auditor's Report

**To the readers of
Northland District Health Board and group's
financial statements and statement of service performance
for the year ended 30 June 2012**

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

We have audited:

- the financial statements of the Health Board and group on pages 42 to 74, that comprise the statement of financial position as at 30 June 2012, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the statement of service performance of the Health Board and group on pages 75 to 84.

Opinion

In our opinion:

- the financial statements of the Health Board and group on pages 42 to 74:
  - comply with generally accepted accounting practice in New Zealand; and
  - fairly reflect the Health Board and group's:
    - financial position as at 30 June 2012; and
    - financial performance and cash flows for the year ended on that date; and
- the statement of service performance of the Health Board and group on pages 75 to 84:
  - complies with generally accepted accounting practice in New Zealand; and
  - fairly reflects the Health Board and group's service performance for the year ended on 30 June 2012, including:
    - the performance achieved as compared with forecast targets specified in the statement of forecast service performance for the financial year; and
    - the revenue earned and output expenses incurred, as compared with the forecast revenues and output expenses specified in the statement of forecast service performance for the financial year.

Our audit was completed on 25 October 2012. This is the date at which our opinion is expressed.

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

Basis of opinion

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

Material misstatements are differences or omissions of amounts and disclosures that would affect a reader's overall understanding of the financial statements and statement of service performance. If we had found material misstatements that were not corrected, we would have referred to them in our opinion.

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

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

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 adequacy of all disclosures in the financial statements and statement of service performance; and
- the overall presentation of the financial statements and statement of service performance.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements and statement of service performance. We have obtained all the information and explanations we have required and 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 a statement of service performance that:

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

The Board is also responsible for such internal control as it determines is necessary to enable the preparation of financial statements and a statement of service performance that are free from material misstatement, whether due to fraud or error.

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

Responsibilities of the Auditor

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

Independence

When carrying out the audit, we followed the independence requirements of the Auditor General, which incorporate the independence requirements of the New Zealand Institute of Chartered Accountants.

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

John Scott
Audit New Zealand
On behalf of the Auditor-General
Auckland, New Zealand

Statement of Comprehensive Income

For the Year Ended 30 June 2012

	Notes	Parent Budget 2012 $000	Group 2012 $000	Group 2011 $000	Parent 2012 $000	Parent 2011 $000
Income						
Revenue	1	497,754	502,313	485,342	502,761	485,831
Finance Income	4a	2,750	3,562	4,331	3,547	4,315
Total Income		500,504	505,875	489,673	506,308	490,146
Expenditure						
Employee Benefit Costs	3	168,163	176,016	166,521	176,016	166,521
Depreciation, Amortisation and Impairment Expense	6,7	9,079	10,039	11,790	9,621	11,372
Outsourced Services		11,133	15,111	14,305	15,111	14,305
Clinical Supplies		40,133	39,314	36,666	39,314	36,666
Infrastructure and Non-Clinical Expenses	2	24,706	28,250	27,285	28,800	27,893
Payments to Non-Health Board Providers		240,230	230,096	224,419	230,096	224,419
Finance Costs	4b	1,670	1,389	3,095	1,389	3,095
Capital Charge	5	5,390	5,644	5,210	5,644	5,210
Total Expenses		500,504	505,859	489,291	505,991	489,481
Share of profit of equity accounted associates	8	0	0	0	0	0
Surplus/(deficit) Before and After Tax	12	0	16	382	317	665
Surplus attributable to:						
Northland District Health Board		0	76	427	317	665
Minority Interest		0	(60)	(45)	0	0
Other Comprehensive Income						
Movements on Property Revaluations		0	49,170	(717)	44,288	(680)
Financial Assets at fair value through other Comprehensive Income		0	(165)	499	(165)	499
Total other Comprehensive Income		0	49,005	(218)	44,123	(181)
Total Comprehensive Income		0	49,021	164	44,440	484
Total Comprehensive Income attributable to:						
Northland District Health Board		0	46,836	226	44,440	484
Minority Interest		0	2,185	(62)	0	0

At the end of the 2012 financial year, there was $0 Mental Health Ring Fence Funding unspent (2011: $0).
Explanations of major variances against budget are detailed in note 24.
The accompanying accounting policies and notes form part of these financial statements.

Statement of Comprehensive Income *(Continued)*

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

2012 - Actual	Provider 2012 $000	Governance 2012 $000	Funder 2012 $000	Kaipara JV 2012 $000	Group 2012 $000
Revenue	269,091	3,597	233,768	(433)	506,023
Expenses	271,490	4,253	230,095	(132)	505,706
Surplus/(deficit) Before and After Tax	(2,399)	(656)	3,673	(301)	317

2012 - Budget	Provider 2012 $000	Governance 2012 $000	Funder 2012 $000	Kaipara JV 2012 $000	Group 2012 $000
Revenue	260,546	3,597	236,361	0	500,504
Expenses	260,546	3,597	236,361	0	500,504
Surplus/(deficit) Before and After Tax	0	0	0	0	0

Consolidated Statement of Changes in Equity

For the Year Ended 30 June 2012

	Notes	Parent Budget 2012 $000	Group 2012 $000	Group 2011 $000	Parent 2012 $000	Parent 2011 $000
Balance at 1 July		64,357	68,360	66,804	66,610	64,576
Total Comprehensive Income		0	49,021	164	44,440	484
Capital Contribution		1,530	1,964	1,550	1,964	1,550
Balance at 30 June	12	65,887	119,345	68,518	113,014	66,610
Distributions made to Minority interest		0	(143)	(158)	0	0
Balance at 30 June	12	65,887	119,201	68,360	113,014	66,610
Total comprehensive income attributable to:						
Northland District Health Board		65,887	115,420	66,621	113,014	66,610
Minority Interest		0	3,780	1,739	0	0
Balance at 30 June		65,887	119,201	68,360	113,014	66,610

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

Consolidated Statement of Financial Position

As at 30 June 2012

	Notes	Parent Budget 2012 $000	Group 2012 $000	Group 2011 $000	Parent 2012 $000	Parent 2011 $000
Assets						
Property, Plant and Equipment	6	109,334	151,022	97,678	143,376	94,496
Intangible Assets	7	1,052	45	83	45	83
Investments	8	39,288	24,382	36,859	26,144	38,621
Total Non-Current Assets		149,674	175,450	134,620	169,566	133,200
Inventories	9	4,419	4,104	4,015	4,104	4,015
Trade and Other Receivables	10	10,758	13,791	16,135	13,789	16,133
Prepayments		822	137	414	137	414
Cash and Cash Equivalents	11	2,228	24,217	24,450	24,160	24,090
Short Term Deposits	11	10,000	260	110	0	0
Short Term Investments	8	0	14,967	5,045	14,967	5,045
Property, Plant and Equipment held for sale	6	0	0	1,022	0	1,022
Intangible Assets held for sale	7	0	0	760	0	760
Trust/Special Fund Assets		736	707	728	707	728
Total Current Assets		28,963	58,183	52,679	57,864	52,207
Total Assets		178,637	233,633	187,299	227,430	185,407
Equity						
Crown Equity	12	38,419	41,649	41,870	44,557	42,593
Other Reserves	12	25,171	76,306	27,261	68,969	24,806
Retained Earnings/(Losses)	12	1,987	(3,241)	(3,238)	(1,219)	(1,517)
Trust/Special Fund Assets	12	310	707	728	707	728
Total Equity Attributable to Northland District Health Board		65,887	115,420	66,621	113,014	66,610
Minority Interest		0	3,780	1,739	0	0
Total Equity		65,887	119,201	68,360	113,014	66,610
Liabilities						
Interest-Bearing Loans and Borrowings	13	24,918	13,784	19,361	13,784	19,361
Employee Benefits	14	11,325	15,642	13,066	15,642	13,066
Total Non-Current Liabilities		36,243	29,426	32,427	29,426	32,427
Interest-Bearing Loans and Borrowings	13	38	11,076	5,576	11,076	5,576
Trade and Other Payables	16	47,240	43,391	51,542	43,375	51,400
Employee Benefits	14	29,229	28,691	28,443	28,691	28,443
Provisions	15	0	1,848	951	1,848	951
Total Current Liabilities		76,507	85,006	86,512	84,990	86,370
Total Liabilities		112,750	114,432	118,939	114,416	118,797
Total Equity and Liabilities		178,637	233,633	187,299	227,430	185,407

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

Anthony Norman
Chairperson

Date: 25 October 2012

Greg Gent
Board Member

Date: 25 October 2012

Consolidated Statement of Cash Flows

For the Year Ended 30 June 2012

	Notes	Parent Budget 2012 $000	Group 2012 $000	Group 2011 $000	Parent 2012 $000	Parent 2011 $000
Cash Flows from Operating Activities						
Cash Receipts from Ministry of Health and Patients		497,754	503,816	478,294	504,327	478,728
Cash Paid to Suppliers		(308,500)	(292,324)	(301,966)	(292,677)	(302,463)
Cash Paid to Employees		(172,033)	(173,161)	(163,993)	(173,161)	(163,993)
Cash Generated from Operations		17,221	38,331	12,335	38,489	12,272
Interest Received		2,750	3,632	4,186	3,617	4,169
Interest Paid		(1,670)	(1,397)	(1,544)	(1,397)	(1,544)
Net Taxes Refunded/(Paid) (Goods and Services Tax)		0	(25,578)	171	(25,570)	161
Capital Charge Paid		(5,390)	(6,528)	(5,159)	(6,528)	(5,159)
Net Cash Flows From Operating Activities	11	12,911	8,460	9,989	8,611	9,899
Cash Flows From Investing Activities						
Proceeds from Sale of Property, Plant and Equipment		0	172	51	172	51
Acquisition of Property, Plant and Equipment		(23,786)	(14,996)	(19,936)	(14,996)	(19,936)
Acquisition of Intangible Assets		(920)	(98)	(498)	(98)	(498)
Movement in Investments & Trust Fund Assets		0	4,341	4,045	4,493	3,960
Net Cash Flows From Investing Activities		(24,706)	(10,581)	(16,338)	(10,429)	(16,423)
Cash Flows from Financing Activities						
Proceeds from Equity Injection		1,530	1,964	1,550	1,964	1,550
Borrowings Raised (Repaid)		0	(76)	(76)	(76)	(76)
Net Cash Flows from Financing Activities		1,530	1,888	1,474	1,888	1,474
Net Increase/(Decrease) in Cash and Cash Equivalents		(10,265)	(233)	(4,875)	70	(5,050)
Cash and Cash Equivalents at Beginning of Year		12,493	24,450	29,325	24,090	29,140
Cash and Cash Equivalents at End of Year	11	2,228	24,217	24,450	24,160	24,090

The GST (net) component of operating activities reflects the net GST paid and received with the Inland Revenue Department. The GST (net) component has been presented on a net basis, as the gross amounts do not provide meaningful information for financial statement purposes.

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

Consolidated Statement of Contingent Liabilities and Assets

As at 30 June 2012
Contingent Liabilities and Assets:
NDHB and group have no contingent assets or liabilities (2011: nil)

Consolidated Statement of Commitments

As at 30 June 2012

	Group		Parent	
	2012	2011	2012	2011
	$000	$000	$000	$000
Capital Commitments	0	4,807	0	4,807
Operating Lease Commitments				
Not more than one year	2,870	2,779	2,720	2,779
One to two years	2,278	1,844	2,141	1,844
Two to five years	2,073	1,916	2,073	1,916
Over five years	118	230	118	230
	7,339	6,769	7,052	6,769
Total Commitments	7,339	11,576	7,052	11,576

Northland District Health Board leases a number of buildings, vehicles and office equipment (mainly photocopiers) under operating leases. The leases run for various lengths of time depending on requirements (for buildings) and typically 5 years (for vehicles and office equipment), with an option to renew the lease after that date. None of the leases include contingent rentals.
During the year ended 30 June 2012, $4,206,000 was recognised as an expense in the statement of financial performance in respect of operating leases (2011: $4,175,000).

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

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

Notes to Financial Statements

1 Revenue

	Notes	Group 2012 $000	Group 2011 $000	Parent 2012 $000	Parent 2011 $000
Health and Disability Services (MoH Contracted Revenue)		486,845	468,458	486,845	468,458
ACC Contract		2,677	3,211	2,677	3,211
Inter District Patient Inflows		7,242	8,139	7,242	8,139
Other Revenue		5,549	5,534	5,997	6,023
		502,313	485,342	502,761	485,831

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

2 Infrastructure and Non-Clinical Expenses

	Notes	Group 2012 $000	Group 2011 $000	Parent 2012 $000	Parent 2011 $000
Included in Infrastructure and Non-Clinical Expenses:					
Impairment of Trade Receivables (Bad and Doubtful Debts)	10	99	24	99	24
Loss/(Gain) on disposal of Property, Plant and Equipment		(1,048)	(37)	(1,048)	(14)
Audit Fees (Audit of Financial Statements)		157	144	157	152
Fees paid to Auditor for Other Services (Internal Audit)		105	80	105	111
Fees paid to Auditor for Other Services (Provider Audits)		33	63	33	75
Board and Committee Member Fees and Expenses		320	304	320	304

Northland District Health Board pays the audit fee of the Kaipara Total Health Care Joint Venture on the joint venture's behalf. The fee was $5,000 (2011: $4,000)

3 Employee Benefit Costs

	Group 2012 $000	Group 2011 $000	Parent 2012 $000	Parent 2011 $000
Wages and Salaries	173,192	164,493	173,192	164,493
Increase /Decrease in Employee Benefit Provisions	2,824	2,028	2,824	2,028
	176,016	166,521	176,016	166,521

4 Finance Income and Finance Costs
4a. Finance Income

	Group 2012 $000	Group 2011 $000	Parent 2012 $000	Parent 2011 $000
Interest Income	3,562	4,331	3,547	4,315

4b. Finance Costs

	Group 2012 $000	Group 2011 $000	Parent 2012 $000	Parent 2011 $000
Interest Expense	1,389	3,095	1,389	3,095

5 Capital Charge
Northland District Health Board pays a six monthly (2011: quarterly) capital charge to the Crown based on the greater of its actual or budgeted closing equity balance for the month. The capital charge rate for the period ended 30 June 2012 was 8% (2011: 8%).

6 Property, Plant and Equipment
(a) Group

	Freehold land (at valuation) $000	Freehold buildings (at valuation) $000	Plant, equipment and vehicles $000	Work in progress $000	Total $000
Cost					
Balance at 1 July 2010	8,349	72,227	57,316	3,859	141,751
Additions	141	4,384	7,371	0	11,896
Disposals	0	0	(10,781)	0	(10,781)
Movement due to Revaluation	(717)	0	0	0	(717)
Reclassification to Current PPE held for sale	0	0	(6,113)	0	(6,113)
Movement in Work in Progress	0	0	0	8,930	8,930
Balance at 30 June 2011	7,773	76,611	47,793	12,789	144,966
Balance at 1 July 2011	7,773	76,611	47,793	12,789	144,966
Additions	0	15,127	4,725	0	19,852
Disposals	0	(32)	(2,550)	0	(2,582)
Movement due to Revaluation	87	30,554	0	0	30,641
Reclassification of Land to Buildings	(275)	275	0	0	0
Movement in Work in Progress	0	0	0	(4,856)	(4,856)
Balance at 30 June 2012	7,585	122,535	49,968	7,933	188,021

	Freehold land (at valuation) $000	Freehold buildings (at valuation) $000	Plant, equipment and vehicles $000	Work in progress $000	Total $000
Depreciation and Impairment Losses					
Balance at 1 July 2010	0	6,600	45,535	0	52,135
Depreciation Charge for the year	0	5,985	5,179	0	11,164
Impairment Charge for the year	0	(193)	0	0	(193)
Reclassification to Current PPE held for sale	0	0	(5,091)	0	(5,091)
Disposals	0	0	(10,727)	0	(10,727)
Balance at 30 June 2011	0	12,392	34,896	0	47,288
Balance at 1 July 2011	0	12,392	34,896	0	47,288
Depreciation Charge for the year	0	6,191	3,651	0	9,842
Impairment Charge for the year	0	0	0	0	0
Accumulated Depreciation Reversal on Revaluation	0	(18,569)	0	0	(18,569)
Disposals	0	(15)	(1,548)	0	(1,562)
Balance at 30 June 2012	0	0	36,999	0	36,999

	Freehold land (at valuation) $000	Freehold buildings (at valuation) $000	Plant, equipment and vehicles $000	Work in progress $000	Total $000
Carrying amounts					
At 1 July 2010	8,349	65,627	11,781	3,859	89,616
At 30 June 2011	7,773	64,219	12,897	12,789	97,678
At 1 July 2011	7,773	64,219	12,897	12,789	97,678
At 30 June 2012	7,585	122,535	12,969	7,933	151,022

6 (b) Parent

	Freehold land (at valuation) $000	Freehold buildings (at valuation) $000	Plant, equipment and vehicles $000	Work in progress $000	Total $000
Cost					
Balance at 1 July 2010	7,875	68,646	57,316	3,859	137,696
Additions	141	4,384	7,371	0	11,896
Disposals	0	0	(10,781)	0	(10,781)
Movement due to Revaluation	(680)	0	0	0	(680)
Reclassification to Current PPE held for sale	0	0	(6,113)	0	(6,113)
Movement in Work in Progress	0	0	0	8,930	8,930
Balance at 30 June 2011	7,336	73,030	47,793	12,789	140,948
Balance at 1 July 2011	7,336	73,030	47,793	12,789	140,948
Additions	0	15,127	4,725	0	19,852
Disposals	0	(32)	(2,550)	0	(2,582)
Movement due to Revaluation	87	26,926	0	0	27,013
Reclassification to Current PPE held for sale	0	0	0	0	0
Movement in Work in Progress	0	0	0	(4,856)	(4,856)
Balance at 30 June 2012	7,423	115,051	49,968	7,933	180,375

	Freehold land (at valuation) $000	Freehold buildings (at valuation) $000	Plant, equipment and vehicles $000	Work in progress $000	Total $000
Depreciation and Impairment Losses					
Balance at 1 July 2010	0	6,182	45,535	0	51,717
Depreciation Charge for the year	0	5,567	5,179	0	10,746
Impairment charge/(reversal) for the year	0	(193)	0	0	(193)
Reclassification to Current PPE held for sale	0	0	(5,091)	0	(5,091)
Disposals	0	0	(10,727)	0	(10,727)
Balance at 30 June 2011	0	11,556	34,896	0	46,452
Depreciation and Impairment Losses					
Balance at 1 July 2011	0	11,556	34,896	0	46,452
Depreciation Charge for the year	0	5,773	3,651	0	9,424
Impairment charge/(reversal) for the year	0	0	0	0	0
Accumulated Depreciation Reversal on Revaluation	0	(17,315)	0	0	(17,315)
Disposals	0	(15)	(1,548)	0	(1,562)
Balance at 30 June 2012	0	0	36,999	0	36,999

	Freehold land (at valuation) $000	Freehold buildings (at valuation) $000	Plant, equipment and vehicles $000	Work in progress $000	Total $000
Carrying Amounts					
At 1 July 2010	7,875	62,464	11,781	3,859	85,979
At 30 June 2011	7,336	61,474	12,897	12,789	94,496
At 1 July 2011	7,336	61,474	12,897	12,789	94,496
At 30 June 2012	7,423	115,051	12,969	7,933	143,376

6 Property, Plant and Equipment *(Continued)*

Impairment
Impairment losses of $NIL (2011:$193,000 was expensed) have been reversed in the current year in respect of the Mental Health Inpatient Unit. The remaining impairment provision of $459,000 relates to other relocatable buildings used for delivering Mental Health services. The impairments are due to services having been moved off site and the need for these buildings to be physically relocated once alternative uses are identified. The impairment has been recognised in the Statement of Comprehensive Income in the line item "Depreciation, Amortisation and Impairment Expense".

Revaluation
Current Crown accounting policies require all crown entities to revalue land and buildings in accordance with NZIAS 16, Property, Plant and Equipment. Current valuation standards and guidance notes have been developed in association with the Treasury for the valuation of hospitals and tertiary institutions.
The revaluation of Land and Buildings was carried out as at 30 June 2012 by Peter Todd, an independent registered valuer of Darroch Limited and a member of the Property Institute of New Zealand. The valuations conform to International Valuation Standards and all land and buildings excluding work in progress have been valued at fair value. The valuer was contracted as an independent valuer. The next valuation will be completed by 30 June 2015.

Restrictions
Northland District Health Board does not have full title to crown land it occupies but transfer is arranged if and when land is sold. Some of the land is subject to Waitangi Tribunal claims. The disposal of certain properties may be subject to the provision of section 40 of the Public Works Act 1981.
Titles to land transferred from the Crown to Northland District Health Board are subject to a memorial in terms of the Treaty of Waitangi Act 1975 (as amended by the Treaty of Waitangi (State Enterprises) Act 1988). The effect on the value of assets resulting from potential claims under the Treaty of Waitangi Act 1975 cannot be quantified.

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

7 Intangible Assets
Parent and Group

Software	**2012**	**2011**
	$000	**$000**
Cost		
Balance at 1 July	712	5,108
Additions for the Year	104	502
Disposals	(6)	(315)
Reclassification to Current Intangible Assets held for sale	0	(4,583)
Balance at 30 June	810	712
Amortisation		
Balance at 1 July	629	3,945
Amortisation Charge for the Year	197	819
Disposals	(61)	(312)
Reclassification to Current Intangible Assets held for sale	0	(3,823)
Balance at 30 June	765	629
Carrying Amounts		
Balance at 1 July	83	1,163
Balance at 30 June	45	83

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

8 Investments	**Group**		**Parent**	
	2012	**2011**	**2012**	**2011**
	$000	**$000**	**$000**	**$000**
Investment in Subsidiary (at cost)	0	0	1,762	1,762
Investment in Associate (at cost)	2,610	0	2,610	0
Bonds with maturities > 12 months	21,772	36,859	21,772	36,859
Balance at 30 June	24,382	36,859	26,144	38,621
Short Term Investments				
Bonds with maturities 0 - 12 months	14,967	5,045	14,967	5,045
Balance at 30 June	14,967	5,045	14,967	5,045

Investment in Subsidiary
General Information

Name of Entity	**Principal Activity**	**Interest Held 2012**	**Interest Held 2011**	**Balance Date**
Kaipara Total Health Care Joint Venture	Medical Centre Delivering Health Services	54%	54%	30 June

Investment in Associate
General Information

Name of Entity	**Principal Activity**	**Interest Held 2012**	**Interest Held 2011**	**Balance Date**
healthAlliance N.Z. Limited	The Operation of shared services for Northland, Waitemata, Auckland and Counties Manukau District Health Boards	20%	0%	30 June

On 15 September 2011 Northland District Health Board acquired 20 Class A shares in healthAlliance for $200,000. On 29 June 2012 Northland District Health Board entered into a sale and purchase agreement to sell certain information technology and other related assets used by healthAlliance in the course of provision of services to Northland District Health Board. The $2,409,581 sale value of those assets was added to the carrying amount of the investment in healthAlliance.

The movement in the carrying value of equity accounted investees is:	**Group**	
	2012	**2011**
	$000	**$000**
Opening Balance	0	0
Investment in equity accounted investees	2,610	0
Share of profit after tax	0	0
Share of equity accounted investees' reserve movements	0	0
Closing Balance	2,610	0

The following amounts represent the aggregate assets,liabilities, revenue and profit of equity accounted investees:	As at and for the year ended 30 June 2012	As at and for the year ended 30 June 2011
	$000	**$000**
Assets:		
Non-current assets	42,553	0
Current assets	18,900	0
Total assets	61,453	0
Liabilities		
Non-current liabilities	2,962	0
Current liabilities	16,667	0
Total liabilities	19,629	0
Net assets	41,824	0
Revenue	90,485	0
Expenses (including interest and tax)	90,485	0
Profit after tax	0	0

8 Investments *(Continued)*

Bonds

Bonds are recognised at fair value. Fair value has been determined using quoted market prices in an active market.

Interest rates on the Bonds range from 4.775% to 7.5%

9 Inventories

	Group		Parent	
	2012	2011	2012	2011
	$000	$000	$000	$000
Pharmaceuticals	241	270	241	270
Surgical and Medical Supplies	3,863	3,745	3,863	3,745
Balance at 30 June	4,104	4,015	4,104	4,015

Write-down of Inventories to net realisable value amounted to $ NIL for 2012 (2011: $113,020).

No Inventories are pledged as security for liabilities.

10 Trade and Other Receivables

	Group		Parent	
	2012	2011	2012	2011
	$000	$000	$000	$000
Trade Receivables from Non-related Parties	5,652	6,614	5,650	6,612
Ministry of Health Receivables	8,474	9,757	8,474	9,757
Less: Provision for Impairment	(335)	(236)	(335)	(236)
Balance at 30 June	13,791	16,135	13,789	16,133

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
	2012	2012	2011	2011
	$000	$000	$000	$000
Not past due	3,481	67	16,053	77
Past due 0-30 days	10,080	1	138	22
Past due 31-60 days	143	24	43	28
Past due 61-90 days	129	2	13	12
Past due >91 days	291	241	122	97
Total	14,124	335	16,369	236

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

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

	Group		Parent	
	2012	2011	2012	2011
	$000	$000	$000	$000
Balance 1 July	236	212	236	212
Additional/(reduced) Provision during the year	128	41	128	41
Receivables written off during the period	(29)	(17)	(29)	(17)
Balance at 30 June	335	236	335	236

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

	Group		Parent	
	2012	2011	2012	2011
	$000	$000	$000	$000
(a) Cash and Cash Equivalents				
Cash On Hand and at Bank	19,217	11,450	19,160	11,090
Short Term Deposits with maturities less than 3 months	5,000	13,000	5,000	13,000
Total Cash and Cash Equivalents in the Statement of Cash Flows	24,217	24,450	24,160	24,090
(b) Short Term Deposits with maturities 4-12 months				
Short Term Deposits with maturities 4-12 months	260	110	0	0
Total Cash and Cash Equivalents, Short Term Deposits and Short Term Investments	24,477	24,560	24,160	24,090

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

	2012		2011	
	Effective fixed interest rate	Actual	Effective fixed interest rate	Actual
	%	$000	%	$000
Short Term Deposits with maturities of 0-3 months:	3.74%	5,000	4.60%	9,000
		0	4.27%	4,000
Short Term Deposits with maturities of 4-12 months:		0	4.30%	110
Total Short Term Deposits		5,000		13,110

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:

		Group		Parent	
		2012	2011	2012	2011
	NOTES	$000	$000	$000	$000
Surplus for the Period	12	16	382	317	665
Add back Non-Cash Items:					
Depreciation And Assets Written Off		10,039	11,983	9,623	11,565
Add back items classified as Financing Activity:					
Movements in Working Capital:					
(Increase)/Decrease in Trade and Other Receivables		2,625	(6,749)	2,621	(6,750)
(Increase)/Decrease in Inventories		(89)	389	(89)	389
Increase/(Decrease) in Trade And Other Payables		(8,274)	1,005	(8,004)	1,051
Increase/(Decrease) In Employee Benefits		2,824	2,028	2,824	2,028
(Decrease)/Increase in Provisions		897	951	897	951
Net Movement in Working Capital		(2,017)	(2,376)	(1,751)	(2,331)
Items classified as investing and financing activities		422	0	422	0
Net Cash Inflow from Operating Activities		8,460	9,989	8,611	9,899

12 Equity

	Group		Parent	
	2012	2011	2012	2011
	$000	$000	$000	$000
General Funds				
Balance at 1 July	43,609	42,217	42,593	41,043
Distributions made	(144)	(158)		0
Capital Contribution	1,964	1,550	1,964	1,550
Balance at 30 June	45,429	43,609	44,557	42,593
Made up of:				
Parent	41,649	41,870	44,557	42,593
Minority Interest	3,780	1,739	0	0
Retained Earnings/(Losses)				
Balance at 1 July	(3,238)	(3,625)	(1,517)	(2,187)
Surplus	16	382	317	665
Transfer to Trust Funds	(72)	(83)	(72)	(83)
Transfer from Trust Funds	53	88	53	88
Balance at 30 June	(3,241)	(3,238)	(1,219)	(1,517)
Reserves				
Revaluation Reserve				
Balance at 1 July	26,329	27,046	23,874	24,554
Revaluations	49,210	(717)	44,328	(680)
Other Movements	0	0	0	0
Balance at 30 June	75,539	26,329	68,202	23,874
Revaluation Reserve consists of:				
Land	6,239	6,152	6,039	5,952
Buildings	69,300	20,177	62,163	17,922
Total Revaluation Reserve	75,539	26,329	68,202	23,874
Fair value through other Comprehensive Income Reserve				
Balance at 1 July	932	433	932	433
Net Revaluation gains(losses)	(165)	499	(165)	499
Balance at 30 June	767	932	767	932
Total Reserves	76,306	27,261	68,969	24,806
Trust/Special Funds				
Balance at 1 July	728	733	728	733
Revaluation of Land	(40)	0	(40)	0
Transfer from Retained Earnings in respect of:				
Funds received	61	72	61	72
Interest received	11	11	11	11
Transfer to Retained Earnings in respect of:				
Funds spent	(53)	(88)	(53)	(88)
Balance at 30 June	707	728	707	728
Total Equity at 30 June	119,201	68,360	113,014	66,610

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

Notes to Financial Statements

13 Interest-Bearing Loans and Borrowings

	Group		Parent	
	2012	2011	2012	2011
	$000	$000	$000	$000
Non-Current				
Secured Bank Loans	13,650	19,151	13,650	19,151
Crown Energy Efficiency Loan	134	210	134	210
	13,784	19,361	13,784	19,361
Current				
Secured Bank Loans	11,000	5,500	11,000	5,500
Crown Energy Efficiency Loan	76	76	76	76
	11,076	5,576	11,076	5,576
Total Interest-Bearing Loans and Borrowings	24,860	24,937	24,860	24,937

Secured Bank Loans

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

Interest Rate Summary	2012	2011
	Actual	Actual
New Zealand Debt Management Office (Formerly Crown Health Financing Agency) $1m facility	3.39%	3.92%
New Zealand Debt Management Office (Formerly Crown Health Financing Agency) $4m facility	3.91%	3.91%
New Zealand Debt Management Office (Formerly Crown Health Financing Agency) $4.5m facility	3.39%	7.47%
New Zealand Debt Management Office (Formerly Crown Health Financing Agency) $7m facility	7.26%	7.26%
New Zealand Debt Management Office (Formerly Crown Health Financing Agency) $8.15m facility	6.60%	6.60%
Energy Efficiency and Conservation Authority $0.210m (2011 $0.287m)	0.00%	0.00%

Repayable as follows:	Group		Parent	
	2012	2011	2012	2011
	$000	$000	$000	$000
Within two years	11,152	16,653	11,152	16,653
Two to five years	8,208	8,284	8,208	8,284
Six to nine years	5,500	0	5,500	0
Total	24,860	24,937	24,860	24,937

14 Employee Benefits

	Group		Parent	
	2012	2011	2012	2011
	$000	$000	$000	$000
Non-Current Liabilities				
Liability for Long-service Leave and Retirement Gratuities	13,665	11,195	13,665	11,195
Liability for Sabbatical Leave	1,232	868	1,232	868
Liability for Sick Leave	745	1,003	745	1,003
	15,642	13,066	15,642	13,066
Current Liabilities				
Liability for Long-Service Leave and Retirement Gratuities	1,997	1,387	1,997	1,387
Liability for Annual Leave	12,396	11,504	12,396	11,504
Liability for Sick Leave	511	224	511	224
Liability for Sabbatical Leave	52	19	52	19
Liability for Continuing Medical Education Leave	6,296	5,717	6,296	5,717
Salary and Wages Accrual	4,881	7,327	4,881	7,327
ACC Levy Payable	1,835	1,542	1,835	1,542
ACC Partnership Programme Liability	723	723	723	723
	28,691	28,443	28,691	28,443
Total Employee Benefits	44,333	41,509	44,333	41,509

The long service leave, retirement gratuities, sick and sabbatical leave were valued by an independent actuary.
The present value of the retirement and long service leave obligations depend on a number of factors that are determined on an actuarial basis using a number of assumptions. Two key assumptions used in calculating this liability include the discount rate and the salary inflation factor. Any changes in these assumptions will impact on the carrying amount of the liability.
The discount rates used were obtained by finding weighted averages of returns on government stock of different terms. The salary inflation factor has been determined after considering historical salary inflation patterns.

15 Provisions

	Group		Parent	
	2012	2011	2012	2011
	$000	$000	$000	$000
Balance at 1 July	951	0	951	0
Provision made during the year	983	951	983	951
Provision used during the year	(86)	0	(86)	0
Total Provisions	1,848	951	1,848	951

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

16 Trade and Other Payables

	Group		Parent	
	2012	2011	2012	2011
	$000	$000	$000	$000
Trade Payables to Non-Related Parties	4,108	4,449	4,108	4,449
Amounts Due to Related Parties	1,326	0	1,326	0
GST and PAYE Payable	3,876	4,656	3,860	4,514
Income in Advance relating to contracts with specific performance obligations	1,265	1,645	1,265	1,645
Capital Charge due to the Crown	442	1,326	442	1,326
Other Non-Trade Payables and Accrued Expenses	32,374	39,466	32,374	39,466
Total Trade and Other Payables	43,391	51,542	43,375	51,400

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

17 Financial Instruments

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

Credit Risk

Financial instruments, which potentially subject Northland District Health Board to concentrations of risk, consist principally of cash, short-term deposits, bonds and accounts receivable.

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

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

The status of trade receivables at the reporting date is shown in note 10.

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

		Group		Parent	
	Notes	2012	2011	2012	2011
		$000	$000	$000	$000
Cash on Hand and at Bank	11	19,217	11,450	19,160	11,090
Cash Equivalents - Short Term Deposits	11	5,260	13,110	5,000	13,000
Bonds	8	36,739	41,904	36,739	41,904
Trade and Other Receivables	10	13,791	16,135	13,789	16,133
Total		75,007	82,599	74,688	82,127

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

Liquidity Risk

Liquidity risk represents the Northland District Health Board's ability to meet its contractual obligations. The Northland District Health Board evaluates its liquidity requirements on an ongoing basis. In general, the Northland District Health Board generates sufficient cash flows from its operating activities to meet its obligations arising from its financial liabilities.
The table below analyses the Northland District Health Board's financial liabilities into relevant maturity groupings based on the remaining period at the balance sheet date to the contractual maturity date. The amounts disclosed are the contractual undiscounted cashflows.

	Notes	Carrying Amount	Contractual Cashflows	Less than 1 year	1-5 years	More than 5 years
		$000	$000	$000	$000	$000
Parent & Group 2012						
Secured Bank Loans	13	24,860	24,860	11,076	8,284	5,500
Provisions	15	1,848	1,848	1,848	0	0
Trade and Other Payables	16	43,391	43,391	43,391	0	0
Total		70,099	70,099	56,315	8,284	5,500
Parent & Group 2011						
Secured Bank Loans	13	24,937	28,194	5,642	22,552	0
Provisions	15	951	951	951	0	0
Trade and Other Payables	16	51,542	51,542	51,542	0	0
Total		77,430	80,687	58,135	22,552	0

17 Financial Instruments *(Continued)*

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

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

Foreign Currency Risk
Foreign exchange risk is the risk that the fair value of future cash flows of a financial instrument will fluctuate because of changes in foreign exchange rates.
Northland District Health Board does not consider there is any significant exposure to foreign currency risk. Only a small amount of purchases are denominated in a currency other than NZD, none of which were outstanding at 30 June.

Sensitivity Analysis
In managing interest rate and currency risks Northland District Health Board aims to reduce the impact of short-term fluctuations on its earnings. Over the long-term, permanent changes in foreign exchange and interest rates would have an impact on consolidated earnings.
At 30 June 2012, 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 $220,000 (2011: $120,000).

	2012		2011	
	$000		$000	
Interest Rate Risk	-100 bps	+100 bps	-100 bps	+100 bps
Financial Assets				
Cash, Cash Equivalents and Bonds (non-current)	(360)	360	(430)	430
Financial Liabilities				
Secured Bank Loans	140	(140)	310	(310)
Total	(220)	220	(120)	120

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	
	2012	2011	2012	2011
Loans and Receivables	$000	$000	$000	$000
Trade and Other Receivables	13,791	16,135	13,789	16,133
Trust/Special Fund Assets	707	728	707	728
Cash and Cash Equivalents	24,217	24,450	24,160	24,090
Short Term Deposits	260	110	0	0
Investment in Subsidiary	0	0	1,762	1,762
Investment in Associate	2,610	0	2,610	0
Fair Value through other Comprehensive Income				
Bonds	36,739	41,904	36,739	41,904
Financial Liabilities at Amortised Cost:				
Trade and Other Payables	43,391	51,542	43,375	51,400
Interest Bearing Loans and Borrowings	24,860	24,937	24,860	24,937

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

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

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

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

- Quoted market price (level 1) - Financial instruments with quoted prices for identical instruments in active markets.
- Valuation technique using observable inputs (level 2) - Financial instruments with quoted prices for similar instruments in active markets or quoted prices for identical or similar instruments in inactive markets and financial instruments valued using models where all significant inputs are observable
- Valuation techniques with significant non-observable inputs (level 3) - Financial instruments valued using models where one or more significant inputs are not observable.

Northland District Health Board holds Bonds measured at fair value in the statement of financial position, using quoted market prices (level 1). The fair value is $36,739k (2011: $41,904k).

18 Related Parties

Identity of Related Parties

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

Key Management Personnel Compensation

The key management personnel compensations are as follows:

	Group		Parent	
	2012	2011	2012	2011
	$000	$000	$000	$000
Salaries and Other Short Term Employee Benefits	2,323	2,028	2,323	2,028
Post-employment benefits	0	0	0	0
Other long-term benefits	49	48	49	48
Termination benefits	0	0	0	0
	2,372	2,076	2,372	2,076

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

During the 11/12 financial year there were personnel changes in the roles of Chief Executive, Chief Medical Officer and General Manager Clinical Services. The new Chief Medical Officer is paid for additional clinical duties performed after hours and at the weekend. During the year back pay was paid that related to prior financial periods. When these adjustments are taken into consideration, the underlying change in Key Management Remuneration showed a decrease of $54,711 from the prior year. This reduction was caused by vacancies as staff changes occurred, as well as a strong emphasis on living within our means. NDHB adheres to the Ministry of Health's guidelines on the remuneration of all staff, paying particular attention to Executive and managerial staff remuneration.

Board and Advisory Committee Member Fees

Current Board Members	2012	2011
Anthony Norman (Chairperson)	$50,636	$45,438
Colin Kitchen	$25,967	$22,250
Craig Brown	$23,000	$23,875
Elizabeth (Libby) Jones	$24,762	$13,250
Greg Gent	$27,242	$20,500
John Bain	$23,081	$13,000
June McCabe	$22,201	$12,250
MC (Bill) Sanderson	$24,670	$26,563
Pauline Allan-Downs	$23,286	$22,750
Sally Macauley (Deputy Chairperson)	$35,893	$28,563
Sharon Shea	$23,877	$13,063

Former Board Members		
Daniel Bolton	$0	$5,750
Debbie Evans	$0	$9,500
Erima Henare	$0	$9,750
Peter Jensen	$0	$8,750

Disclosure of Non Board Committee Members

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

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

	2012	2011
Mark Sears	$2,475	$750
Maureen Allan	$3,547	$1,000
Michael Roberts	$1,500	$500
Peter Jensen	$2,750	$2,000
Winfield Bennett	$1,978	$500
Beryl Wilkinson	$2,303	$2,000
John Wigglesworth	$428	$1,250

18 Related Parties *(Continued)*

Former Committee Members	2012	2011
Connie Hassan	$0	$1,250
Jonathan Wilkinson	$0	$1,000
Kevin Robinson	$0	$1,000
Noel Matthews	$0	$500
Scott Cameron	$0	$500

Board and Advisory Committee Members and Key Management Personnel

Services provided to Related Parties 2012

Board and Advisory Committee Member	Related Party	Relationship	Transaction by NDHB	Income $000's	Due From $000's
Beryl Wilkinson	• Accident Compensation Corporation	Consumer Advisory Group (General & HOP)	Various Health Services	2,481	197
Colin Kitchen	• Far North District Council	Council Member (Te Hiku Ward)	Health Inspection fees	295	-
	• Whakawhiti Ora Pai	Wife is an employee (Raina Kitchen)	Stores Purchases & Laundry	10	2
Sharon Shea	• Ministry of Health	Consultancy NHB Public Health Group & Contract for "Development of a Methodology to review the Value For Money of Māori Health Providers"	DHB Health Funding	486,259	1,245
John Bain	• The Order of St John	Chairman	Stores Purchases & Laundry	37	3
	• Sport Northland	Board Member	Room Rental	1	0.4
Mark Sears	• Whau Valley Whaiora Support Trust	Employee	Room Rental	15	-
John Wigglesworth	• Te Tai Tokerau PHO	Board Member	Rental of Premises	58	-
	• Hokianga Health Enterprise Trust	CEO	Stores purchases & Pharmacy Issues	454	12
Libby Jones	• NorthTec	Supervision (contractor)	Clinical Training,Stores purchases & Laundry	142	-
Maureen Allan	• Whakawhiti Ora Pai	Trustee	Stores Purchases & Laundry	10	2
	• Te Tai Tokerau PHO	Employee	Rental of Premises	58	-
MC (Bill) Sanderson	• Kensington Private Hospital	Shareholder	Stores Purchases & Laundry	62	8
Pauline Allan Downs	• Ngati Hine Health Trust	Clinical Supervision	Stores Purchases & Laundry	2	2
	• Ministry of Health	ABC - Smoking cessation advisory committee	DHB Health Funding	486,259	1,245
	• Asthma Society	Clinical Supervision	Room Rental & Photocopying	0.3	-
	• Sport Northland	Manaaki Manawa Māori Advisory	Room Rental	1	0.4
	• Te Hauora O Te Hiku O Te Ika Trust	Clinical Supervision	Stores Purchases	1	-
	• Manaia PHO	Clinical Supervision	Transport Costs	5	-
	• Whakawhiti Ora Pai	Clinical Supervision	Stores Purchases & Laundry	10	2
Peter Jensen	• Arataki Ministries Ltd	Director	Mental Health Services	3	0.2
Sally Macauley	• The Order of St John	Husband (Peter Macauley) Member, Kaikohe Area Chairman, Northern Region Trust Board	Stores Purchases & Laundry	37	3
	• Far North District Council	Councillor, Audit & Finance Committee, Economic Development Committee	Health Inspection fees	295	-
	• Northland Regional Corrections Facility	Visiting Justice	Counselling Programmes	0.1	4
Tony Norman	• healthAlliance	Board Member	Shared Health Services Costs	3,446	-
Win Bennett	• The University of Auckland	Employee	Student Teaching payments & Akld Students rental costs	351	34

18 Related Parties *(Continued)*

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

Services provided to Related Parties 2011

Board and Advisory Committee Member	Related Party	Relationship	Transaction by NDHB	Income $000's	Due From $000's
Colin Kitchen	• Far North District Council	Council Member (Northern Ward)	Health Inspection	289	-
Debbie Evans	• Kaipara Care PHO	Board Member	Room Rental, Photocopy Charges	7	-
	• The Kaipara Total Health Care Joint Venture	Committee Member	Maintenance and Management Contract, Distribution	304	-
Erima Henare	• NorthTec	Deputy Chairperson	Clinical Training, Laundry Services	114	-
John Bain	• Order of St John	Chairman	Pharmacy, Laundry and Consumable Supplies	36	3
	• Sport Northland	Board Member	Room Rentals	0.5	-
John Wigglesworth	• Hokianga Health Enterprise Trust	CEO	Pharmacy Supplies, Training Workshops, Consumable Supplies	154	14
Maureen Allan	• Whakawhiti Ora Pai	Board Director - Community Health Services	Laundry and Consumable Supplies	11	-
MC (Bill) Sanderson	• Kensington Hospital	Shareholder	Consumable Supplies	78	20
	• Northland Orthopaedics Ltd	Director & Shareholder	Consumable Supplies	0.1	-
	• M C Sanderson Ltd	Director & Shareholder	Consumable Supplies	0.2	-
Peter Jensen	• Arataki Ministries Ltd	Chairperson	Room Rentals	2	-
Sally Macauley	• Far North District Council	Deputy Mayor	Health Inspection	289	-

Executive Management Team	Related Party	Relationship	Transaction by NDHB	Income $000's	Due From $000's
Robert Paine	• The Kaipara Total Health Care Joint Venture	Board Member (Chair)	Maintenance and Management Contract, Distribution	348	-
Nick Chamberlain	• Sport Northland	Director	Room Rentals	0.5	-

Services provided from Related Parties 2012

Board and Advisory Committee Member	Related Party	Relationship	Transaction by NDHB	Expense $000's	Owed to $000's
Beryl Wilkinson	• Age Concern	President, Chair	Funding for Health of Older People Health Services Agreement	143	11
	• Accident Compensation Corporation	Consumer Advisory Group (General & HOP)	ACC Levies	765	-
Colin Kitchen	• Far North District Council	Council Member (Te Hiku Ward)	Water Rates, Land Rates	108	-
	• Age Concern	Chairman (Age Concern Far North)	Funding for Health of Older People Health Services Agreement	143	11
	• New Zealand Fire Service	Volunteer Support Officer	Fire call outs	15	-
	• Whakawhiti Ora Pai	Wife is an employee (Raina Kitchen)	Funding for Māori Health Services Agreement & Clinical Training Fees	582	52
	• Top Energy	Trustee	Power	1	-
Craig Brown	• Northland Regional Council	Chairman	Water rates, Training Courses and Inspection Fees	3	1

18 Related Parties *(Continued)*

Sharon Shea	• Ministry of Health	Consultancy NHB Public Health Group & Contract for "Development of a Methodology to review the Value For Money of Māori Health Providers"	Capital Charge	6,543	-
John Bain	• Northland Regional Council	Deputy Chairman	Water rates, Training Courses and Inspection Fees	3	1
	• Northland Emergency Services Trust	Chairman	Patient Transport by Helicopter	1,741	73
	• The Order of St John	Chairman	Air Services Paramedics, Venue Hire and Courses	877	16
	• Sport Northland	Board Member	Venue Hire and Healthy Action	112	1
Mark Sears	• Whau Valley Whaiora Support Trust	Employee	Funding for Health Services Agreement	33	-
Greg Gent	• Fonterra Co - Op Group	Director	Processed milk	177	14
John Wigglesworth	• Hokianga Health Enterprise Trust	CEO	Personal and Mental Health Services, Patient Care	5,663	663
	• Te Tai Tokerau PHO	Board Member	Funding for Health Services Agreement	15,136	240
Libby Jones	• NorthTec	Supervision (contractor)	Study Programme	83	2
	• Coast To Coast Hauora Trust	Trustee	Funding for Health Services Agreement	5	-
	• Coast To Coast Healthcare	Board Member	Respite Care Health Services Agreement	45	4
Maureen Allan	• Whakawhiti Ora Pai	Trustee	Funding for Māori Health Services Agreement & Clinical Training Fees	582	52
	• Te Tai Tokerau PHO	Employee	Funding for Health Services Agreement	15,136	240
MC (Bill) Sanderson	• Northland Orthopaedics Ltd	Director	Clinical services	493	8
	• NZ Orthopaedic Association Trust	Chairman	Orthopaedic Hospital Post Quinquennial Inspection	1	-
	• Kensington Private Hospital	Shareholder	Surgical Procedures and Supplies	164	5
	• Northland Medical Museum Trust	Trustee	Medical Museum	38	-
Pauline Allan Downs	• Ngati Hine Health Trust	Clinical Supervision	Outsourced Community Workers & Aides. Funding for Mental Health Services Agreement	5,428	625
	• Ministry of Health	ABC - Smoking cessation advisory committee	Capital Charge	6,543	-
	• Asthma Society	Clinical Supervision	Funding for Māori Health Services Agreement	158	14
	• Sport Northland	Manaaki Manawa Māori Advisory	Venue Hire and Healthy Action	112	1
	• Ki A Ora Ngati Wai	Clinical Supervision	Funding for Māori Health Services Agreement	826	73
	• Te Hauora O Te Hiku O Te Ika Trust	Clinical Supervision	Health Promotion & Funding for Health Services Agreement	2,223	152
	• Manaia PHO	Clinical Supervision	Healthy Homes funding	172	-
	• Whakawhiti Ora Pai	Clinical Supervision	Funding for Māori Health Services Agreement & Clinical Training Fees	582	52
Peter Jensen	• Arataki Ministries Ltd	Director	Mental Health Services	1,921	184
Sally Macauley	• The Order of St John	Husband (Peter Macauley) Member, Kaikohe Area Chairman, Northern Region Trust Board	Air Services Paramedics, Venue Hire and Courses	877	16
	• Far North District Council	Councillor, Audit & Finance Committee, Economic Development Committee	Water Rates, Land Rates	124	-
Tony Norman	• healthAlliance	Board Member	Delivery of Non-Frontline Transactional Support Services	7,717	1,824
Win Bennett	• The University of Auckland	Employee	Study Programmes	352	4

18 Related Parties *(Continued)*

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

Services provided from Related Parties 2011

Board and Advisory Committee Member	Related Party	Relationship	Transaction by NDHB	Expense $000's	Owed to $000's
Colin Kitchen	• Far North District Council	Council Member (Northern Ward)	Water Rates, Land Rates	149	-
Craig Brown	• Northland Regional Council	Councillor	Water rates, Training Courses and Inspection Fees	1	-
Debbie Evans	• The Kaipara Total Health Care Joint Venture	Committee Member	Lease of Building	610	-
John Bain	• Northland Regional Council	Councillor	Water rates, Training Courses and Inspection Fees	1	-
	• Northland Emergency Services Trust	Chairman	Patient Transport by Helicopter	1,616	-
	• The Order of St John	Chairman	Venue Hire and Courses	810	-
	• Sport Northland	Board Member	Venue Hire and Healthy Action	126	1
Erima Henare	• NorthTec	Deputy Chair	Study Programme	87	-
Gordon Hassett	• Klu'dup Ltd	A Principal of	Capital Project Consultant	28	-
Greg Gent	• Fonterra Co - Op Group	Director	Processed milk	136	3
John Wigglesworth	• Hokianga Health Enterprise Trust	CEO	Personal and Mental Health Services, Patient Care	6,533	508
June McCabe	• Te Wananga o Aotearoa	Councillor	Course, Certificate in Sports	1	-
	• Te Waka Pupuri Putea Ltd	Director	Venue Hire	0.2	-
Kevin Robinson	• Te Runanga O Te Rarawa	CEO	Māori, Personal and Mental Health Services	643	359
Libby Jones	• Coast To Coast Healthcare	Board Member	Respite Care	0.4	-
Maureen Allan	• Whakawhiti Ora Pai	Board Director - Community Health Services	Māori Health Services, Clinical Training Fees	575	49
MC (Bill) Sanderson	• Northland Orthopaedics Ltd	Director	Clinical services	558	-
	• Kensington Private Hospital	Shareholder	Surgical Procedures and Supplies	145	3
	• Northland Medical Museum Trust	Trustee	Medical Museum	31	-
Peter Jensen	• Arataki Ministries Ltd	Chairperson	Mental Health Services	1,968	175
	• Northland Regional Council	Councillor	Inspection fees and Training Courses	1	-
Sally Macauley	• Far North District Council	Councillor	Water Rates, Land Rates	149	-
Tony Norman	• healthAlliance	Board Member	Delivery of Non-Frontline Transactional Support Services	2,119	49
Win Bennett	• Non Stop Growth	Wife's Company	Oral Health Project Support	36	-

Executive Management Team	Related Party	Relationship	Transaction by NDHB	Expense $000's	Owed to $000's
Karen Roach	• Northern DHB Support Agency	Director	DHB Funder Support Agency	692	-
	• Auckland Regional RMO Services	Director	Regional Training, Recruitment	9	-
Margareth Broodkoorn	• College of Nurses Aotearoa	Board Member	Membership Fees	1	-
	• Northland Community Foundation	Board Member	Outsourced Salaries & Supplies	111	-
Nick Chamberlain	• Northland Rugby Union	Director	Sponsorship, Advertising	2	-
	• Sport Northland	Director	Venue Hire and Healthy Action	126	1
Robert Paine	• The Kaipara Total Health Care Joint Venture	Board Member (Chair)	Lease of Building	610	-

Notes to Financial Statements

18 Related Parties *(Continued)*

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

Northland DHB Received $3,446k from healthAlliance in this financial year ended 30 June 2012 and Northland DHB paid healthAlliance $7,717k for the financial year ended 30 June 2012. Northland DHB owed healthAlliance $1,824k as at 30 June 2012. The $1,824k is made up of $500k worth of invoices, and the remaining $1,326k owed to hA is detailed below;

	$000
Assets held for sale at 30 June 2011, transferred to healthAlliance during the year	(2,410)
Assets transferred to healthAlliance 30.06.12	(276)
Depreciation charged to NDHB for use of the transferred assets	1,242
Employee Entitlements transferred to hA	160
Owed for Class A Shares issued	200
Composition of remaining $1,326k owed by NDHB to hA	1,326

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

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

Lease
Northland District Health Board was granted a head lease of the Joint Venture property for a five year term with two rights of renewal of five years each. Annual rent is $550,000 plus GST, (2011: $500,000 plus GST), payable monthly in advance.

Maintenance, Administration and Management Contracts
Northland District Health Board is contracted to provide maintenance and administration for the Joint Venture.
Annual Maintenance Contract is $247,500 plus GST (2011: $247,500 plus GST), payable monthly in advance. Annual Administration and Management Contract is $30,000 plus GST (2011: $30,000 plus GST)
The Kaipara Total Health Care Joint Venture made a distribution to Northland District Health Board of $169,783 (2011: $185,225) . No related party debts have been written off or forgiven during the year. The amount outstanding at year end was $0 (2011:$nil)

Significant transactions with Government-related entities
Northland District Health Board received funding from the Crown and ACC of $489,372k (2011 $471,669k) to provide health services to the Northland area for the year ended 30 June 2012.

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

Northland District Health Board also purchases goods and services from entities controlled, significantly influenced, or jointly controlled by the Crown. Purchases from these government related entities for the year ended 30 June 2012 totalled $14,104k (2011 $8,021k). These purchases included the purchase of electricity from Meridian Energy, air travel from Air New Zealand, and postal services from New Zealand Post.

Other related parties
Health Benefits Limited is a related party as it has significant influence over the operating policies of the NDHB through an agreement. HBL was established as a Crown – owned Company in July 2010 with a mandate to help the health sector save money by leading initiatives which reduce administrative; support and procurement costs. Working with the DHB, it expects to deliver savings in these areas which will free up money to reinvest into clinical areas of DHBs. Northland DHB paid $380k to HBL and owes HBL $22k as at 30 June 2012. HBL paid NDHB $0 and owed NDHB $0 as at 30 June 2012. There were no provisions for doubtful debts between these two entities.

19 Termination Payments

For the year ended 30 June 2012 Northland District Health Board made no termination payments to employees. (2011: no payments)

20 Subsequent Events

Subsequent to balance date the Minister of Health approved the current A class shareholders of healthAlliance N.Z. Limited, of which the DHB is one, to acquire C class shares in healthAlliance. In the financial statements the DHB has recorded an investment in healthAlliance recognising the DHBs investment in healthAlliance for providing Information Systems services. This investment will now be converted to C class shares. There is no financial effect of this event.

21 Capital Management

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

22 Statement of Intent

Statement of Comprehensive Income by Output Class

For the year ended 30 June 2012	$000	$000	$000	$000	$000
	Intensive Assessment & Treatment	Early Detection & Management	Prevention	Rehabilitation & Support Services	Total
Revenue	262,217	158,636	19,059	66,396	506,308
Offsets	(6,164)				(6,164)
Total Revenue	256,053	158,636	19,059	66,396	500,144
Personnel Costs	125,881	16,561	6,160	7,364	155,966
Non Personnel Costs	100,610	9,760	3,956	5,755	120,082
Provider Payments	51,966	116,367	5,474	56,136	229,943
Offsets	(6,164)	-		-	(6,164)
Total Operating Expenditure	272,293	142,689	15,590	69,254	499,827
Surplus (Deficit)	(16,240)	15,947	3,469	(2,858)	317

23 Directions issued by Ministers

Northland District Health Board have not received any directions issued by Ministers during the year ended 30 June 2012.

24 Variance Analysis

Key Financial Information	Parent Actual 2012 $000s	Parent Budget 2012 $000s	Variance $000s
	506,308	500,504	5,804

Operational Revenue:

The increase in operational revenue against budget can be attributed to additional funding from the Ministry of Health. Of the additional funding $ 2.2 Million was a part refund of Meningococcal C costs, other additional funding included Electives, and sundry Ministry of Health Initiatives. Interest income was favourable $785k to budget.

The revenue budget is based on the funding envelope advised by the Ministry of Health in December 2010 for the current financial year. Subsequent to this advice further funding was made available for the above additional services.

Operational Cost (including Capital Charge)	505,991	500,504	5,487

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. The Meningococcal C campaign cost $3.2 Million.

Total Assets (excluding cash balances)	162,159	127,121	35,038

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

Total Liabilities (excluding loans)	89,556	87,794	1,762

Liabilities are not significantly different to budget.

Cash Resources (cash balances less loans)	40,411	26,560	13,851

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

Statement of Accounting Policies

For the year ended 30 June 2012

Reporting entity

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

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

The consolidated financial statements of NDHB and group for the year ended 30 June 2012 comprise NDHB, its joint venture subsidiary the Kaipara Total Health Care Joint Venture (54% owned) and its associate healthAlliance N.Z. Limited (20% owned).

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

The financial statements were authorised for issue by the Board on 25 October 2012.

Basis of preparation

Statement of compliance

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

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

Measurement Base

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

Functional and presentation currency

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

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

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

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

Land and buildings revaluations

Note 6 provides information about the estimates and assumptions applied in the measurement of revalued land and buildings.

Long service leave and retirement gratuities

Note 14 provides an analysis of the exposure in relation to estimates and uncertainties surrounding retirement and long service leave liabilities.

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

The useful lives and residual values of property, plant and equipment are reviewed at each balance date. Assessing the appropriateness of useful life and residual value estimates requires the 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 the DHB, and expected disposal proceeds (if any) from the future sale of the asset.

Changes in accounting policies

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

Early adopted amendments to standards

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

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

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

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

FRS-44 New Zealand Additional Disclosures and Amendments to NZ IFRS to harmonise with IFRS and Australian Accounting Standards (Harmonisation Amendments) – These were issued in May 2011 with the purpose of harmonising Australia and New Zealand's accounting standards with source IFRS and to eliminate many of the differences between the accounting standards in jurisdiction. The amendments must first be adopted for the year ended 30 June 2012. The DHB has not yet assessed the effects of FRS-44 and the Harmonisation Amendments.

Basis for consolidation

Subsidiaries

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

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

Transactions eliminated on consolidation

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

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

Equity accounted Investees: Associates

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

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

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

Budget Figures

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

Foreign currency transactions

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

Property, plant and equipment

Classes of property, plant and equipment

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

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

Owned assets

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

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

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

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

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

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

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

Disposal of property, plant and equipment

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

Additions to property, plant and equipment

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

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

Leased assets

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

Subsequent costs

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

Depreciation

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

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

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

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

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

Borrowing costs

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

Intangible assets

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

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

Subsequent expenditure

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

Amortisation

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

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

Impairment of property, plant and equipment and intangible assets

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

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

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

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

Financial Instruments

Non-derivative financial instruments

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

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

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

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

- Fair value through surplus or deficit; and
- Loans and receivables.

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

Financial assets at fair value through surplus or deficit

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

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

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

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

Loans and receivables

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

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

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

Cash and cash equivalents

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

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

Interest-bearing loans and borrowings

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

Trade and other receivables

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

Trade and other payables

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

Impairment

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

Loans and other receivables

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

Inventories

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

Cost is determined on a first in first out basis.

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

Interest bearing borrowings

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

Employee benefits

Defined contribution plan

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

Long service leave, sabbatical leave and retirement gratuities

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

Annual leave, conference leave and medical education leave

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

Sick leave

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

Provisions

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

Revenue relating to service contracts

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

Income tax

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

Goods and services tax

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

Revenue

Crown funding

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

Goods sold and services rendered

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

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

Rental income

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

Interest

Interest Income is recognised using the effective interest method.

Capital Charge

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

Expenses

Operating lease payments

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

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

Financing costs

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

Equity

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

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

Insurance Contracts

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

Contingent liabilities

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

Cost of Service (Statement of Service Performance)

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

Cost allocation

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

Cost allocation policy

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

Criteria for direct and indirect costs

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

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

Cost drivers for allocation of indirect costs

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

Statement of Service Performance

Description of Output Classes

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

Prevention Output Class

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

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

Early Detection and Management Output Class

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

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

Intensive Assessment and Treatment Output Class

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

- ambulatory services [for people not admitted to hospital] (including outpatient, district nursing and day services) across the range of secondary preventive, diagnostic, therapeutic, and rehabilitative services
- inpatient services (both acute and elective) including diagnostic, therapeutic and rehabilitative services
- emergency department services including triage, diagnostic and therapeutic services
- secondary mental health services
- secondary maternity services
- assessment treatment and rehabilitation.

Rehabilitation and Support Output Class

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

Includes:

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

Output Class: Prevention

OUTPUTS				IMPACTS						OUTCOMES	Notes
We will undertake these activities	And ensure these outputs are delivered	Belonging to Suboutput Class	Output measures	To lead to these impacts	Impact measures: Description	Categories	Baseline	Target 2011/12	Performance 2011/12	To achieve this outcome	
Increase number of schools participating in Action on Smoking and Health Year 10 survey Target schools with high Māori enrolments Implement smokefree school project plan and pilot smokefree schools toolkit Implement Brief Intervention (EBI) training and Quit support Regulatory enforcement on tobacco sales to minors	Health promotion programmes in schools through Smokefree/ Auahi Kore	Health promotion and education	Number of health promotion programmes in schools. Total students advised during school clinics, 2010 CY 754.	Tobacco: lower prevalence of smoking-related conditions.	Proportion of Year 10 students who have never smoked.	Total population	50.2% (2009 ASH Y10 survey)	51%	55.3% (2010 ASH Y10 survey, the latest data available) (green)	Healthy population	Smoking rates among Year 10s (about 16 years old) continue to show an encouraging decline. Alongside efforts to assist adult smokers to stop (as well as government policy decisions such as increasing the price of cigarettes), it augurs well for steady declines in smoking rates in the population. There is however anecdotal evidence that though smoking rates are dropping for those in their mid-teens, many youth are starting smoking after that age. Smoking data from the national survey (see Early Detection and Management output class) may complete the picture.
Identify populations with lower rates of breastfeeding Support midwives to encourage breastfeeding	Midwifery services by independent practitioners and hospital midwives Support by lactation consultants.	Health promotion and education	Support provided to mothers to breastfeed. Hospital annual births 2,151 2010 CY. Lactation Consultant patient contacts 1,467 Oct 2010-April 2011 (2,515 annual extrapolation).	Healthy children: reduced likelihood of acquiring long term conditions later in life.	Mothers who breastfeed fully and exclusively at 6 weeks.	Māori Non-Māori Total	67% 81% 73% (2009 CY)	68% 81% 74%	[1]69% 77% 73% (CY 2011) (orange)	Healthy population	The data reported currently does not reflect Northland's true performance because the national data system includes only mothers and babies under Plunket, not those under Tamariki Ora (Māori provider well child) services. From July 2012 DHBs will be required to include both sets of data.
Coordinate the activities of immunisation providers through the Immunisation Steering Group Actively support providers via the Regional NIR[2] Coordinator	Primary care services performing immunisations.	Immunis-ations	Number of completed series of immunisations by the second birthday. 5,840 children immunised before their 2nd birthday, 2010 CY	Healthy children: lower incidence of communicable disease.[3]	% of two-year-olds who are fully immunised.	Māori Non-Māori Total	77% 79% 78% (2010/11 Q2)	95% 95% 95%	83% 86% 84% (2011/12 Q4) (red)	Healthy population	Though many strategies have been put in place in the last year to improve immunisation performance and data capture and analysis, coverage rates are still similar to a year ago and still one of the poorest among DHBs. Northland will not be able to reach the 95% target while the opt-off rate (those who refuse to immunise their children) is nearly ten percent. Key efforts are now being directed at the process for precalls (recording of babies in the primary care data system promptly after birth, before immunisations are due) and recall (systems for prompt picking up of those who miss their due dates). Note that the Health Target measure for 2012/13 will be for eight-month-olds.
Cancer groups and pathways	Cancer risk assessments in primary care. Screening for breast and cervical cancers.	Community referred testing and diagnostics	Breast cancer screening in eligible populations. Northland women screened, average 2008/09 and 2009/10: ages 45-69 10,109, ages 50-69 7,766[4]	Cancer: if curable, increased likelihood of survival; if incurable, reduced severity of symptoms.	Breast cancer screening in eligible populations.[5]	Māori Non-Māori Total	67.5% 70.5% 70.4% (2008/09-2009/10)	70%	69% 80% 78% (CY 2011) (green)	Prevention of illness and disease Optimum quality of life for those with long term conditions	Performance continues to be above target.
			Cervical cancer screening in eligible populations (= IM).		Cervical cancer screening in eligible populations.	Total	74% (women smeared Oct 2007-Sep 2010)[6]	75%	Māori 66.4% Non-Māori 78.1% Total 74.4% (2011/12) (orange)		Rates for Māori lag behind non-Māori. During 2011/12 NDHB devolved responsibility for Cervical Screening Coordination, plus the associated funding, to primary care. Since then, free smears have been introduced for priority group women in all general practices in Northland. As a result of this, plus the increased direct involvement of primary care in coordinating the programme, increased utilisation is expected.

1 Data relates to Plunket mothers only because a national data system for non-Plunket (ie Well Child/ Tamariki Ora) providers will not be set up until 2012/13.
2 National Immunisation Register.
3 A better impact measure would be the incidence of communicable disease in the population, but this data is not readily available.
4 An unusually high number of screens was done in 2009/10, so two years have been averaged to provide a more representative number. Two age groups are reported because screens are performed on 45-69 year olds, but MoH requires reports only on 50-69 year olds.
5 The targets apply over two years, since that is the frequency with which women in the target age group should be screened. The achievement of targets may be variable yearly but meet the 2 year target of 70% set by the National Screening Unit.
6 Data covers three years because this is the recommended frequency for cervical cancer screening.

OUTPUTS				IMPACTS						OUTCOMES	Notes
We will undertake these activities	And ensure these outputs are delivered	Belonging to Suboutput Class	Output measures	To lead to these impacts	Impact measures					To achieve this outcome	
					Description	Categories	Baseline	Target 2011/12	Performance 2011/12		
Implement the Tupeka Kore (Smokefree) Plan ↑ funding for smoking cessation programmes, including Advice, Brief intervention, Cessation (ABC). Support Quit Card providers	Advice and help offered to smokers in primary care to quit.	Primary health care	Percentage of smokers in primary care offered advice and help to quit (= IM). Quit Card[7] providers: 466 registered as at March 2011.	Tobacco: lower prevalence of smoking-related conditions.	Proportion of the Northland population who smoke daily.	Māori Non-Māori Total	47.8 18.7 22.1 (2006/07 NZ Health Survey)	46.5% 18.5% 21.5%	n/a	Prevention of illness and disease	For population smoking rates, NDHB currently relies on the MoH's national Tobacco Use Survey. A new survey was done in 2009/10 but its small sample size prevented any DHB-level analysis. Another survey out with a larger sample size has been carried out, and MoH has promised DHB-level data early in 2013.
					Proportion of smokers in primary care provided with advice and help to quit.[8]	Total population	25% (PHO performance programme Sep 2010/)	90%	30.5% (2011/12 Q4)		Though Northland's performance is poor (unlike the hospital smoking target) we are in the mid range of DHBs, so this is a problem nationally. NDHB is part of national processes that share ideas and strategies among DHBs. NDHB's Tobacco Target Steering Group includes hospital and primary care staff and designated primary care Smokefree leaders who are engaged at every step of planning and implementation of prioritised projects to continue to progress our performance against the Health Target. Extra funding is being made available for vulnerable communities such as Hokianga and Whangaroa (and soon Kaipara). NDHB funds general practice for ABC completions.
Expand oral health services throughout Northland using the "hub and spoke" model of service delivery Target services to areas and populations with high needs Provide health promotion services to encourage good oral health	Oral health assessment and treatment.	Oral health	5,460 preschool and 17,903 primary school children enrolled in DHB-funded oral health services.	Healthy children: healthier teeth and gums.	Five-year-olds who are caries-free.	Māori Non-Māori Total	17% 56% 39%	21% 61% 44%	20% 51% 35% (CY 2011)	Prevention of illness and disease	Performance is similar to last year. Last year's SSP included a note which is still relevant this year: "NDHB has progressively been introducing a major overhaul of Northland's DHB-funded oral health services. This follows an expanded and improved model of care and requires the introduction of new facilities and equipment, and the hiring and training of extra staff. NDHB is trying to do all this at the same time as tackling the arrears in oral health statistics that we know exist. The services will first need to address the backlogged need, so it may not be until later in 2012 that significant improvements begin to show."
					Average number of decayed, missing or filled teeth among Year 8 students.	Māori Non-Māori Total	2.89 1.19 2.02 (2009 CY)	2.50 1.15 1.80	3.19 1.43 2.30 (CY 2011)		
Oversee the Local Diabetes Team contract to plan and coordinate services Establish a Northland-wide Clinical Governance framework	Risk assessments in primary care (annual free checks, blood tests, risk profiles). Laboratory tests.	Primary health care Community referred testing and diagnostics	Risk assessments performed (=IM).	Diabetes and CVD: amelioration of disease symptoms and/or delay in their onset.	Of those estimated to have diabetes, % who have had annual free checks.	Māori Non-Māori Total	71% 61% 64% (2010/11 Q2)	80% 80% 80%	69% 63% 65% (2011/12 Q4)	Optimum quality of life for those with long term conditions	Performance on both measures continues to lag behind target, though NDHB is in the mid range of DHBs so this is a national issue. It is believed that the removal of the subsidy for annual free checks may have had some impact on performance, and Northland's meningococcal C campaign during 2011 diverted attention in primary care.
					Of people with diabetes receiving annual free checks, % with good blood sugar management.	Māori Non-Māori Total	65% 80% 75% (2010/11 Q2)	80% 80% 80%	62% 78% 72% (2011/12 Q4)		NDHB has extensively consulted with primary care on the implementation of the Diabetes Care Improvement Package (DCIP). Its key aim is to reduce the disparity between Māori and non-Māori in the diabetes performance measures. To support this: • every general practices will develop a specific diabetes plan • clinical quality improvement teams will be established and visit identified general practices • positions of "champions" will be appointed in both PHOs • train-the-trainer conversation maps will be rolled out.
					Of people in eligible populations, those who have had a CVD risk assessment in the last 5 years.	M, P, I[9] E & other[10] Total	Old measure: 72% 81% 78% (2010/11 Q4) New measure: n/a n/a n/a	75% 80% 79% 60% 60% 60%	Māori 76% Other 83% Total 81% (2011/12 Q2) Māori 51.2% Other 55.3% Total 54.1% (2010/11 Q4)		Old measure: Up until Q2 2011/12, performance was calculated using a proxy measure (certain lab tests for heart conditions), and this became the basis for each DHB's locally-negotiated targets. On this basis, NDHB had achieved target. New measure: From Q3 2011/12, MoH changed the measure to record actual risk assessments completed, and a new nationally standardised target of 90% was set. On this basis NDHB failed to achieve target, though our overall performance was above the NZ average of 48.5%.
Fund PHOs to provide services for people with mild to moderate mental disorders	Care provided in a primary care setting for people with mild to moderate disorders whose condition is stable.	Primary health care	Number of referrals from GPs to Primary Mental Health Initiative Coordinators: 2007/08 1,933 2008/09 1,968 2009/10 1,852	Mental disorders: improved quality of life for both clients and their families; acute episodes are minimised, clients achieve greater stability in their condition.	Number of referrals from GPs to Primary Mental Health Initiative Coordinators.[11]	Total	1,852	[12]1,852	2,002 (2011/12)	Reversal of acute conditions	Performance exceeds target.

7 Quit Cards are exchange cards for subsidised nicotine patches, gum and lozenges for people wanting to quit smoking. They are made available through the Quit Group and distributed through trained Quit Card providers. This may be health professionals or other staff who have direct contact with people who smoke.
8 A better impact measure would be the proportion of smokers trying to quit, but this was not included when the Health Target was set up. The output measure is being used as a proxy in the interim.
9 Māori, Pacific, Indian: males aged 35-79, females aged 45-79.
10 European & other: males aged 45-79, females aged 55-79.
11 Used as a proxy impact measure in lieu of readily available data on the state of health of people with mild to moderate mental conditions who attend primary health care.
12 No increases are planned in the number of people treated because the funding has now been capped. Emphasis will shift to: (a) improving the quality of the service through new treatment tools, closer monitoring of outcomes etc; (b) targeting services to people with higher acuity

Output Class: Intensive Assessment and Treatment

OUTPUTS				IMPACTS						OUTCOMES	Notes
We will undertake these activities	And ensure these outputs are delivered	Belonging to Suboutput Class	Output measures	To lead to these impacts	Impact measures: Description	Categories	Baseline	Target 2011/12	Performance 2011/12	To achieve this outcome	
Services to support smokers in hospital Targeted smoking cessation services for pregnant women	Advice and help given to smokers in hospital to quit.	Acute services	Number of smokers in hospital who are offered advice and help to quit.	Tobacco: lower prevalence of smoking-related conditions.	Proportion of the population who smoke daily.	Māori Non-Māori Total	47.8 18.7 22.1 (2006/07 NZ Health Survey)	46.8 17.7 21.1	(See footnote 8 in the previous section)	Healthy population Prevention of illness and disease	See comments relating to this measure under the Prevention Output Class.
			5,466 smokers admitted to NDHB hospitals 2009/10.		Percent of smokers admitted to hospital given advice and help to quit.[13]	Māori Non-Māori Total	65% 78% 71% (2010/11 Q2)	95%	94.6% 94.1% 94.4% (2011/12 Q4)		NDHB's quarter-by-quarter results for total patients were 81%, 85%, 86% and 94%. Thus our annual average performance was 87%, though performance improved to be close to target by Q4. Ostensibly this looks like a drop in performance from the 2010/11 end-of-year result of 93%. However the latter was artificially high because, like most other DHBs, NDHB had been over counting the number of smokers helped (the denominator counted only smokers admitted during the last 28 days, but the numerator was counting all smokers who had asked for advice during that period, including those admitted before the last 28 days).
Provide a Child Protection Service Maintain close links with CYFS and Police	Identification of at-risk children through appropriate screening	Acute services	Referrals to CYFS of children suspected of being abused (=IM).	Healthy children: safer children	Referrals to CYFS of children suspected of being abused.[14]	Total population	154 (CY 2010)	170	316	Prevention of illness and disease	Performance exceeds target (MoH's rating was "outstanding").
Provide emergency department, inpatient and outpatient services for people with acute needs Fund Auckland DHB for those who need tertiary care Educate people with long term conditions about staying healthy	Specialist Diabetes Service	Acute services	(= IM)	Long term conditions: amelioration of disease symptoms and/or delay in their onset	2% increase in the number of referrals [15]	Māori Non-Māori Total	N/a[16]	n/a	n/a	Optimum quality of life for those with long term conditions	Regional priorities to focus on quality improvement programmes for diabetes in the 2010/11 year meant that the priorities set by the NDHB did not reflect the intention that evolved some time after February 2011. In May 2011, after the sign off of the priorities the Northland Diabetes Operations Workstream (NDOW) was formed and merged with the Local Diabetes Team. The group then forged its alliance with the Regional Diabetes Workstream to become heavily involved in the development of quality improvement programmes for diabetes management. This change diverted the planned focus on priorities for Northland DHB. Data collection capability and access to primary care data (to cross match against secondary care readmissions data) to establish baseline data and set a realistic platform for achievable KPIs was in conflict with the regional priorities. In addition, further distractions and delays resulted from restructuring of the DHB and the development of the Northland Health Service Plan. This gave rise to multiple projects involved in the same and similar pathway work and multiple stakeholders using different engagement processes with services and providers. These factors have led to delays and the diversion of resources and much needed energy away from the planned priorities of 2011/12.
Provide emergency department, inpatient and outpatient services for people with acute needs Fund Auckland DHB for those who need tertiary care Maintain and improve links with primary care and palliative care	Provision of cancer therapies	Acute services	Number of radiation therapy treatments (= IM).	Cancer: if curable, increased likelihood of survival; if incurable, reduced severity of symptoms.[17]	People diagnosed with cancer who receive radiation treatment within 4 weeks.	Māori Non-Māori Total	100% 100% 100% (2010/11 Q2)	100% 100% 100%	100% 100% 100%	Optimum quality of life for those with long term conditions	Target achieved. All radiation oncology treatment for Northlanders is provided in Auckland, so NDHB is dependent upon the three Auckland DHBs (mainly Auckland DHB itself) for our performance results.
			Number of chemotherapy treatments (= IM).		People diagnosed with cancer who receive chemotherapy within 4 weeks.	Māori Non-Māori Total	100% 100% 100% (2010/11 Q2)	100% 100% 100%	100% 100% 100%		Target achieved. Note that, unlike radiation therapy, about 90% of chemotherapy treatment is provided within NDHB, so performance is by and large our responsibility to manage.
Provide community mental health services Ensure people with enduring mental conditions have appropriate support in the community Provide inpatient care when people experience acute phases	Specialised clinical support by NDHB community mental health services. Admission to hospital for those whose condition is unstable.	Mental health	Number of contacts by community mental health services with people who have enduring mental illness[18]: Direct 76,646 Care coord'n 52,069 (2010/11 extrapolated from 10 months data)	Mental disorders: improved quality of life for both clients and their families; acute episodes are minimised, clients achieve greater stability in their condition.	Proportion of people with enduring mental illness aged 20-64 who are seen over a year.	Māori Non-Māori Total	5.69% 3.47% 4.28% (2010/11 Q2)	6.29% 3.47% 4.28%	7.73% 3.67% 4.85%	Independence for those with impairments or disability support needs Optimum quality of life for those with long term conditions	Target achieved.
Provide elective surgical services Fund Auckland DHB for those who need tertiary care	Elective surgical procedures.	Elective services	Number of additional elective procedures (no standard number because it is negotiated each year with MoH).	Elective surgery: fewer debilitating conditions; delayed onset of long term conditions.	Increase in the number of elective services discharges	Base Additional Total	6,098 (2010/11 forecast)	6,198	7,093	Reversal of acute conditions Better, sooner, more convenient services	Target achieved, and performance is regularly rated as 'outstanding' by MoH. Over the four quarters, NDHB has ranked an average of fourth among the 21 DHBs on this measure.

13 A better impact measure would be the proportion of smokers trying to quit, but this was not included when the Health Target was set up. The output measure is being used as a proxy in the interim.
14 This repeats the output measure because referral to CYFS is the extent of the impact health services can have on suspected victims of abuse.
15 The impact measure should really be the state of health of people with long term conditions who attend primary care, but this is not easily measurable. Reduced demand on hospital services, an output measure, is used as a proxy because it implies that primary care has been effective.
16 Baseline data will be developed as part of investigation and improving the identification of long term conditions.
17 A better impact measure would be: for breast cancer, cervical cancer and major cancers: new cases, survival rates and deaths. Data systems are not yet set up to generate this information promptly enough for timely monitoring, so the output measures are being used as proxies in the interim.
18 Direct = directly with client and/or whānau; care coordination = on behalf of client, with another agency.

Output Class: Intensive Assessment and Treatment *(Continued)*

OUTPUTS				IMPACTS						OUTCOMES	Notes
					Impact measures						
We will undertake these activities	And ensure these outputs are delivered	Belonging to Suboutput Class	Output measures	To lead to these impacts	Description	Categories	Baseline	Target 2011/12	Performance 2011/12	To achieve this outcome	
Provide emergency department services in all four NDHB hospitals	Assessments, treatments and referrals performed in EDs.	Acute services	Emergency department attendances: 2009/10 40072 2010/11 40956 (10 months extrapolated)	ED waiting times: more timely assessment, referral and treatment.	Patients with an ED length of stay (time from presentation to admission, discharge or transfer) of less than 6 hours.	Total	84%	95%	95% (2011/12 Q4)	Reversal of acute conditions Optimum quality of life for those with long term conditions Better, sooner, more convenient services	Performance over the four quarters was 86%, 87%, 92% and 95%, reflecting numerous initiatives progressively introduced during the year. Target was reached in the last quarter, though average performance over the quarter's was 90%.
Operate the Quality Resource Unit	Leadership advice and monitoring by the Chief Medical Advisor and Quality Resource Unit	Acute services Elective services	Measures of quality and safety of services.	Quality and safety: more satisfied patients.						Confidence and trust in the health system	(Note that a new suite of quality measures will be considered for next year's SSP.)
			Questionnaires distributed Jul-Dec 2010 3,592, returned 1,123.[19]		Percentage of inpatients and outpatients surveyed 'satisfied' or 'very satisfied' with their treatment.	Total	88.5% (average for 2010/11 Q1, Q2)	89%	90%	Better, sooner, more convenient services Living within our means	Target achieved.
			Total inputs + daypts + outputs: 2008/09 147,544 2009/10 172,421		Number of complaints to NDHB per patient contact	Total population	1.2%	1.2%	0.12%		Target achieved.
			As above		Complaints to NDHB closed within 20 working days	Total population	81%	82%	70%		Performance slightly below target, but the numbers are low, so small variations have a significant effect on the percentage.
			19 complaints to HDC 2011 CY.		HDC complaints that result in a finding of breach of the Code.	Total population	8% (CY 2009)	7%	0%		Target achieved.
			Total operations: 2008/09 9,887 2009/10 9,379 2010/11 4,925 (6 mth)	Fewer adverse clinical events	Surgical site infections.	Total	<2%	[20]<2%	1.7%		Target achieved.
			1,854 events observed 2010 CY.		Hand hygiene compliance.	Total	60%	70%	73%		Target achieved.

19 Measure was introduced to quarterly reporting in July 2010 and dropped after Dec 2010.
20 Less than 2% is recognised as the "gold standard" for this indicator. NDHB's rate has been consistently under this for some time.

Output Class: Rehabilitation and Support

OUTPUTS				IMPACTS						OUTCOMES	Notes
					Impact measures						
We will undertake these activities	And ensure these outputs are delivered	Belonging to Suboutput Class	Output measures	To lead to these impacts	Description	Categories	Baseline	Target 2011/12	Performance 2011/12	To achieve this outcome	
Fund providers of residential care and home based support services (HBSS) Reassess all recipients of HBSS over time	Home based support services provided by NGOs. Residential care provided by NGOs.	Needs assessment and service coordination	Hours funded for home based support services: 217,026 (41.0%) home maintenance, 312,862 (59.0%) personal cares (2010/11 forecast). 500 reassessments by NDHB's NASC service of people receiving household management only who have not been assessed since April 2009.	Support for older people: older people requiring support or care receive services appropriate to their needs.	Rising % of home based support services provided to older people who have higher support needs.[21]	Household mngt Personal care (hours paid)	42% 58% (CY 2009/10)	41% 59%	37% 63% (9 months data 1.07.2011-31.03.2012)[22]	Independence for those with impairments or disability support needs Optimum quality of life for those with long term conditions	Target achieved. Home based support services include personal care services and household management services; the aim is to raise the proportion of people receiving personal care services because this will reflect that people with higher levels of need are being prioritised, and higher needs met. Focusing on higher needs will enable more older people to remain in their own homes longer ('age in place'), thus supporting the expressed desires of the majority as well as aligning with national policy. This will reduce or delay demand for residential care services such as rest homes, which are more expensive than home-based support services.
Certification of age-related residential care (ARRC) facilities under Health and Disability Sector Standards.	Work with providers on corrective action plans resulting from audits.	Age related residential care beds.	26 ARRC facilities had certification audits conducted Oct 2010-May 2011.[23]		Decreasing percentage of high and medium risk corrective actions arising from certification.	Percentage of ARRC services with 3 year certification	58%	65%	57% (July 2012)		Target not achieved. Certification is the best measurement we have for the quality of services delivered by ARRC providers. The higher the number of years a facility is certified for, the more assurance the NDHB can have about quality and management of risk. 13/23 providers (57%) achieved 3 years certification, and 10/23 (43%) received 2 years. This year, no providers had 1 year certification due to significant quality issues (an improvement from last year, where we had two in that category). The numbers are small. If two further providers had achieved 3 year certification (15/23) we would have achieved the target.
Contracting of respite care beds.	Respite care services	Respite care.	3,600 respite care bed days occupied (extrapolated based on 6 months data 2010/11).		Number of respite care bed days utilised	Respite care bed days occupied	4,183	4,183	[24]4,050		Close to target.

21 IT systems at the moment cannot produce data on the number of HBSS hours provided according to different levels of need. In the absence of an IT system to correlate assessed level of need with number of hours of HBSS paid, we have used proxy measures of total number of hours paid for personal cares and the percentage share of total hours paid for personal cares.
22 The reassessment project was not carried out due to consideration of its projected cost ($200k). Changes have included: a change in eligibility criteria for household management, and the introduction of the InterRAI assessment tool. Older people who have personal care needs have been prioritised, and there has been a reduction in the number of household management hours funded (estimated to be 198,658 in 2012/13).
23 A database on this function was set up only in mid 2010, so only baseline data is available, not historical.
24 NDHB authorised 4,820 bed days but utilisation was affected by client factors such as death and entry to permanent care.

Overall progress

The 30 measures in the SSP can be broken down as follows:

Category	No.	Traffic light used in table
Target met	15	green
Close to target	4	orange
Target not met	9	red
Data not available	2	(none)
Total measures	30	

Overall this is slightly worse than the previous year's performance, in which 17 targets were met, nine were close to target and four targets were not met. The four targets not met in 2010/11 were again not met this year (these are: smokers in primary care provided with advice and support, the two oral health targets, and diabetes blood sugar management). Of the five extra unmet targets:

- *immunisations:* performance actually improved from last year (last year's rating was given as orange and should probably have been red)
- *diabetes annual free checks:* this also improved from last year, but performance against target this year looks worse because the target is so much higher (it is now standard nationally rather than negotiated with each DHB)
- *cardiovascular disease risk assessment in primary care:* this year the measure has a new definition that for the first time reflects actual assessments carried out, so it does not compare with previous years which used a proxy measure involving certain lab tests
- *home-based support:* last year there were numerous problems with the data and how the measure was defined (explained in a lengthy note in last year's SSP), so this year's more accurate data again can't be compared
- *complaints to NDHB closed within 20 working days:* this is the only measure in which performance can truly be said to have declined, but the numbers are very low (only 19 for the whole year) so slight variations can affect the percentage performance figure markedly
- *ARRC certifications:* because of the low number of providers (23), small numerical variations can affect percentage performance markedly; though performance is 8% lower than target, this represents only two providers.

Progress on Māori health

A key element of Northland DHB's performance measurement is the state of Māori health, particularly whether inequalities have reduced. Comparing performance data by ethnicity for 2011/12 and 2010/11, three questions can be addressed:

- for how many measures is there a gap in the data available that prevents any comparison being made?
- has the 2011/12 target for Māori been met?
- has the gap between Māori and non-Māori reduced between 2010/11 and 2011/12?

Out of the 30 measures in the SSP, Māori data is readily available for only 12 of them (of the other 18, data is generally recorded but not made available in reporting systems). Of these 12, performance was:

- at or above target for four
- close to target for two
- and the target was not met in the remaining six.

One of NDHB's high-level goals is to reduce inequalities between Māori and non-Māori. Between 2010/11 and 2011/12, of the 12 measures with Māori data:

- there was no gap to begin with in two
- the gap narrowed for three measures
- widened in three
- stayed about the same in two
- for two measures, no analysis could be performed because no comparative Māori data exists for 2010/11.

In some cases, Northland DHB is reliant on outside organisations for data, and they don't produce data on an ethnic basis. In other cases, ethnic data is now available but hasn't been in the past, so no historical comparison is possible. For most of the rest of the measures however, ethnic data is collected but not routinely reported. This is a gap that Northland DHB will try to fill through implementing the Northland Health Services Plan, which is taking a fresh look at what NDHB considers our key measures of performance. One of the practical outcomes of this is that ethnic reporting and monitoring will be built into everything done under the NHSP banner.

Acronyms

Acronym	Meaning
AAU	Acute Assessment Unit
AHA	Allied Health Advisors
ALOS	Average Length of Stay
ALT	Alliance Leadership Team
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)
CME	Continuing Medical Education
COPD	Chronic Obstructive Pulmonary Disease
CVD	Cardiovascular Disease
DHB	District Health Board
DNA	Did Not Attend
ECMS	Enterprise Content Management System, a large file-holding and file-sharing database
ED	Emergency Department
ELT	Executive Leadership Team (of Northland DHB)
FSA	First Specialist Appointment
FTE	Full Time Equivalent (= 40 hours a week of work time)
GDP	Gross Domestic Product
GP	General Practitioner
HOP	Health of Older People
HWNZ	Health Workforce New Zealand
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
NEAT	Nursing Executive Advancement team
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
SMG	Service 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

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