E88

STATEMENT OF INTENT

Incorporating the 2017/18

STATEMENT OF PERFORMANCE EXPECTATIONS

and

STATEMENT OF FINANCIAL EXPECTATIONS

Presented to the House of Representatives pursuant to sections 149 and 149(L) of the Crown Entities Act 2004

Northland DHB's Statement of Intent is a subset of the Annual Plan 2017/18, comprising sections 1, 2.3, 4 and Appendix A. The Annual Plan is available as a separate document at http.northlanddhb.org.nz.

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1 Overview of strategic priorities

1.1 Strategic intentions and priorities

Vision and mission

Northland DHB's vision: "A Healthier Northland / *He Hauora Mo Te Tai Tokerau*"

Northland DHB's 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.

Strategic direction and Northland DHB's key priorities

Over recent years Northland DHB's main strategic document has been the **Northland Health Services Plan** (NHSP), whose five-year timeframe is due to end in June 2017. The NHSP will then undergo a formal review which will be completed by the end of 2017. Of the five original projects, four have become part of business as usual, while **Neighbourhood Healthcare Homes** (NHH) has developed into a strategic programme of its own that has now reached the implementation stage. The two PHOs, general practices and Northland DHB are together establishing a team based and locality networked healthcare delivery model, led by primary care clinicians, that aims to provide comprehensive and continuous health and social services. The overarching goal is to support individuals to achieve better outcomes. NHH aims to change the way patients and clinicians interact, and improve the journey through the health system.

Innovation, Improvement and Excellence. A plan to change the way Northland DHB operates by introducing new, contemporary models of care. Over the years numerous quality and 'lean' approaches have been tried, but financial sustainability has come under increasing pressure as acute demand continues to grow. A Director of Operational Excellence role is being established, along with a steering group comprising primary and secondary services, and five key workstreams:
- allocative efficiency (radiology exams, blood product utilisation, drugs prescribed)
- organisation sustainability (paper, waste, storage, power)
- productivity (theatre, endoscopy utilisation, outpatient clinics, district hospital utilisation)
- hospital services closer to home (cardiac catheterisation, IDF review)
- releasing time to care (an existing programme that draws on lean improvement techniques to improve patient safety and efficiency of care).

Health Intelligence. Northland DHB is establishing a new position of Director of Health Intelligence and Translational Medicine. The position will improve our understanding of health intelligence, develop new research projects and mentor existing ones, and enhance our ability to prioritise and plan. The role will translate health intelligence findings into action and improvements, and communicate the findings of research, analysis and interventions within Northland DHB, the health sector and the public.

Rapid Response and Stabilisation Service. A complete rethink of the resources currently devoted to Primary Options. An admission avoidance and supported discharge programme will be established in primary care, with scope and opportunity to be expanded as further opportunities to develop integrated care models. It is still in the early stages at the moment, but the intention is to cover a wide range of conditions, extend service hours, cut response time to four hours at the most, and develop a coordination point for multiple clinical and allied health services. It is driven by the need to reduce demand for hospital services, better meet patients' needs, and develop flexible packages of care.

Mobility. The Northern Region is currently reviewing our IS Strategic Plan (ISSP). This replan recognises the need to position ourselves for a digital transformation, and work is already underway to build some key foundations. However by definition this strategy will take some time to fully unfold, and

Northland meanwhile has an urgent need to get on with increasing the use of mobile technologies so staff can do more on the move.

Within the IS/IT portfolio, we have established the Telehealth & Mobility programme which promotes and manages the expansion of the clinical use of communications technology (telehealth) and its integration into clinical care. This includes the rapid expansion of the use of mobile applications for clinical and business use with key goals of improving productivity and patient care. The three workstreams of this programme are:

- Work with the regional Digital Foundations Programme to put in place the enterprise mobility management (EMM) platform and establish a foundation base of enrolled users
- Establish Northland DHB's Clinical mobile capability, including developing business cases for early opportunities and building Northland's application development framework and application platform. Key to speed will be leveraging what others in our region have done.
- Delivery of technology enablers. Current key priorities include Paging replacement, WIFI network, Regional VC

Indigenous Health System. In 2016, Northland DHB began working with its partners Te Kahu O Taonui/ Te Tai Tokerau Iwi Chairs Forum, Maori Health Providers and Manaia and Te Tai Tokerau Primary Health Organisations exploring the emergence of the Indigenous Health System and how services and performance could be improvement for Maori living in Northland. Two workshops with Sir Mason Durie came to an agreed preferred option of forming an Iwi/ Maori provider alliance and commissioning for outcomes.

Alongside this development both Manaia and Te Tai Tokerau PHO have been pursuing a collaborative process (kaupapa) facilitated by "Navigator Connect". Maori health providers sit on both PHOs. The project has been in the making for 18 months and is the vehicle to achieve a single primary care entity. The project has general support from the Boards of the PHOs and Northland DHB.

Given the synergies between the two projects, Maori health providers sitting on both PHO boards there was wide support to align and integrate both projects into the Primary Care Collaboration Project. This position was further supported by a letter received from Te Kahui O Taonui/ Te Taitokerau Iwi Chairs Forum on 22 June 2017. The work of the indigenous Health System will continue but as a project stream within the collaboration.

Maori Health Gains Council/ Hei Mangai Hauora Mo Te Waka A Taonui. Hei Mangai Hauora Mo Te Waka A Taonui (Council) is the governance relationship between Northland DHB Board (Board) and appointed representatives from Te Waka A Taonui (Iwi/ Hapu). The function of the Council is to provide advice on health and disability needs, any factors the Council believes may adversely affect the health status of Northland DHB's resident Maori population, and how the Board can effectively implement the Northland Maori Health Plan (and other plans) to improve the health status of Northland's resident Maori population. In a joint process agreed by Te Kahu O Taonui/ Te Taitokerau Iwi Chairs forum and the Board, the Council will be reviewed against the Crown Maori Instrument (2007) to revise the Terms of Reference covering the existing partnership and a structure considered that is supportive of meeting the aspirations of regional Iwi and the Board. This review will be completed by August 2017.

Northland DHB supports the proposed **Health (Fluoridation of Drinking Water) Amendment Bill** to transfer from local councils to DHBs the power to make decisions and give directions about the fluoridation of local government drinking water supplies in their areas. Northland has consistently had one of the country's highest tooth decay rates, especially among children and adolescents, with significant ethnic inequities – yet much of it is preventable. Community water fluoridation is considered worldwide as one of the cornerstones of prevention and one of the top ten greatest population-based public health measures in reducing the occurrence of tooth decay.

Kainga Ora. Social Investment is about the social sector applying rigorous, evidence-based investment practices to social services to achieve better outcomes for at-risk New Zealanders and their families. The Government's Social Investment Unit, launched in 2016, uses a Place Based Initiative (PBI) approach to address issues at the community or local level.

In 2017 Northland was one of the regions selected and three areas – Otangarei, Kaikohe and Kaitaia – were identified for PBI focus. Otangarei was chosen for initial focus under the Kainga Ora initiative. Northland DHB's CEO is a key player and he sits on Northland's Social Wellbeing Governance Group that oversees Northland's PBI initiatives.

The Social Investment Unit works in partnership with social agencies to support local communities in a collaborative process to address issues as they are experienced within each geographic area. Responses to those issues are then tailored to meet the local community's specific needs and address

underlying causes and influences. Decisions are made by those who best understand the individual, family and local circumstances.

Northland DHB is embarking on implementing **Results Based Accountability™**, an outcomes and management framework utilised by the Government (via the Ministry of Business, Innovation and Employment Streamlined Contracting process and as used by the Ministry of Health), and many NGOs. A project team has been set up to assist implementation. Our initial focus in 2017-2018 is on Mental Health and Addiction Services (NGOs only) and Oral Health Services (NDHB and NGOs).

In 2018 Northland DHB will begin the development of a new **strategic plan**.

Commitments

DHBs have a statutory responsibility under the **Treaty of Waitangi** to put into practice its principles of partnership, protection and participation. NDHB is acutely conscious that Maori, who comprise about a third of our population, suffer most from health and other inequities and we are committed to upholding the three Treaty principles.

Northland DHB is committed to the **New Zealand Health Strategy** and its five themes of people powered, closer to home, value and high performance, one team, and smart system.

Of all DHBs, Northland has one of the highest percentages of older people in its population (in 2017, 18.7% compared with 14.8% nationally) and it is also ageing faster that most other DHBs (by 2028, 26.6% compared with 20.2% nationally). Northland DHB is committed to the **Healthy Ageing Strategy** and its vision that older people live well, age well and have a respectful end of life in age-friendly communities.

Northland DHB is committed to the **UN Convention on the Rights of Persons with Disabilities**, whose purpose is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.

The **New Zealand Disability Strategy 2016-2026** (refer 2.1.19) also forms part of Northland DHB's disability strategic framework, with service improvements for 2017/18 focussing on:

- accessibility
- attitudes
- health and wellbeing
- leadership

Northland DHB is committed to the principles of Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014-2018, namely:

- respecting Pacific culture
- valuing family and communities
- quality health care
- working together – integration.

1.2 Message from Chair and Chief Executive

Northland District Health Board will continue to improve the delivery of services during 2017/18 while living within our means.

The Board has maintained a balanced financial position since 2003 and will continue to operate within a viable and financially sustainable cost structure. Northland DHB is committed to the Government's aim of delivering better public services within tight financial constraints, and to the goals of the Northland Health Services Plan and the NZ Health Strategy.

This year's Annual Plan projects a deficit budget. Northland DHB has a continuing commitment to improving efficiency and investing upstream to reduce demand for and the cost of expensive hospital care. Significant savings are factored into the plan from our own initiatives, procurement and supply chain savings. We are also committed to strengthening our organisation's 'Collective Leadership' and continuous improvement capability to assist in managing the significant and sustained demand growth, while improving employee wellbeing. Our Innovation, Improvement and Excellence programme will support this commitment.

We will continue to strive to improve performance on Health Targets. We meet or exceed targets for elective services, advice to smokers for maternity services and Raising Healthy Kids, and we aim to have our faster cancer treatment close to target by year end. ED waiting times remain slightly below target but ongoing service improvements have enabled performance to remain consistent in the face of significantly increasing demand. Advice to smokers in primary care is still below target and this is now receiving close attention from our PHOs. Immunisations remain stubbornly below target. This is as a result of the extraordinarily high decline rate in Northland rather than large numbers of missed children.

We continue to be challenged by health inequities for Maori, an ageing population, the rising tide of long term conditions, our rurality and the relative poverty of our citizens. We have also seen significant population growth and immigration from Auckland. This perfect storm of demographic change is driving unprecedented growth in demand (6% in 2016/17) across all services. Strategic guidance has been provided by the Northland Health Services Plan, whose five year span ended in June this year. Most of its original projects have been incorporated into business as usual. Our developmental focus remains on Neighbourhood Healthcare Homes, which is introducing new models of care that better integrate services across the health sector, and in which multidisciplinary teams support networks of general practices. We are currently supporting six practices to implement the new models, and another four will be supported in the second tranche of implementation during 2017/18.

The Annual Plan is closely aligned with the Northern Region Health Plan, whose Triple Aim of population health, patient experience and value/sustainability underpinned the Northland Health Services Plan. We are also aligning planning and projects with the NZ Health Strategy. Relevant regional performance measures have been integrated into the Annual Plan. Regional planning processes, in which Northland DHB staff have been intimately involved, continue to develop models, pathways and protocols to guide future improvement across all four northern DHBs.

Improving Maori health and reducing inequities continue to be driving forces. We are working with our Maori partner organisations to establish the principles of an Indigenous Health System that will work within a new Northland Primary Health Care collaboration. This has a greater emphasis on whanau, community and locality planning and services, and a single entity for commissioning, monitoring, reporting and accountability.

Northland DHB continues to work with primary and community services to deliver integrated services for older people to support them living independently in the community, manage long term conditions well and prevent admission to hospital. We are also continuing to improve the quality of residential care services (including dementia care), and stroke services.

Northland DHB works very closely with our intersectoral partners to help improve socioeconomic outcomes for Northlanders. We will continue our membership of the Northland Intersectoral Forum. Northland DHB is a key partner in Kainga Ora, Northland's Place Based Social Investment Programme which is working with children and youth in our most vulnerable "Kainga" (homes) in Kaitaia, Kaikohe and Otangarei. The aim is to achieve better social outcomes for children and youth and reduce their lifetime costs to society. The issues are proving to be complex, involving a range of networks (MSD / Oranga Tamariki, Police, NDHB, Corrections, housing, education among others) which necessitates a focus on kainga rather than individuals. The children and youth have to be triaged across multiple domains of risk and their families have often been subject to several generations of harm, so it is taking time to address needs. The original timeframe of achieving 570 children and youth identified, assessed and assigned integrated service plans has been revised from September 2017 to a more realistic June

2018. The early months have proven to be a valuable learning experience as they have prompted the establishment of a revised operating model that more effectively and thoroughly deals with the complexities.

We are actively participating in the Northern Region Long term Investment Plan and will also be completing a number of interim projects which include building two new Operating Theatres, an Endoscopy suite, a community Mental Health facility as well as the Bay of Islands Hospital redevelopment. We have an urgent need for a major redevelopment of Whangarei Hospital and will continue to progress our Programme Business Case through the Capital Investment Committee as rapidly as possible.

1.3 Signatories

Sally Macauley Chair, NDHB	Dr Nick Chamberlain Chief Executive, NDHB

2 Delivering on priorities

2.3 Financial performance summary

Statement of Comprehensive Income
$000s

	2015-16 Audited Actuals	2016-17 Forecast	2017-18 Budget	2018-19 Budget	2019-20 Budget	2020-21 Budget
DHB Provider Revenue	314,678	331,211	353,822	370,098	386,382	402,610
DHB Funder Revenue	248,713	259,143	260,409	272,387	284,372	296,316
DHB Governance & Administration	3,933	4,823	4,344	4,544	4,744	4,943
Inter District Flow Revenue	9,139	9,279	9,563	10,003	10,443	10,882
Total Revenue	576,462	604,455	628,138	657,032	685,942	714,751
DHB Provider Operating Expenditure	300,201	309,625	338,585	354,209	369,841	385,419
DHB Non Provider Funded Services	176,346	190,823	195,035	204,007	212,983	221,928
DHB Governance & Administration	3,242	4,899	4,344	4,544	4,744	4,943
Inter District Flow Expense	73,159	74,759	74,936	78,383	81,832	85,269
Total Operating Expenditure	552,947	580,105	612,900	641,143	669,400	697,560
Earnings before Interest, Depreciation, Abnormals & Capital Charge	23,514	24,350	15,238	15,889	16,541	17,191
Less						
Interest on Term Debt	963	910	80	83	87	91
Depreciation	12,199	12,739	14,088	14,736	15,385	16,031
Revaluation	-	-	-	-	-	-
Earnings before Abnormals & Capital Charge	10,353	10,700	1,070	1,070	1,070	1,070
Profit/(Loss) on Sale of Assets	-	-	-	-	-	-
Net Operating Surplus (Deficit)	10,353	10,700	1,070	1,070	1,070	1,070
Capital Charge	9,848	8,709	9,070	9,070	9,070	9,070
Surplus (Deficit)	**504**	**1,992**	**(8,000)**	**(8,000)**	(8,000)	(8,000)
Revaluation of Fixed Assets	-	-	-	-	-	-
(Gains)/Losses in Asset for Sale Financial Assets Reserve	83	-	-	-	-	-
Comprehensive Income	**421**	**1,992**	**(8,000)**	**(8,000)**	**(8,000)**	**(8,000)**

Statement of Movements in Equity
$000s

	2015-16 Audited Actuals	2016-17 Forecast	2017-18 Budget	2018-19 Budget	2019-20 Budget	2020-21 Budget
Equity at the beginning of the period	126,896	127,311	153,957	185,956	192,956	189,956
Surplus/Deficit for the period	504	1,992	(8,000)	(8,000)	(8,000)	(8,000)
Total Recognised Revenues and Expenses	127,401	129,303	145,956	177,956	184,956	181,955
Other Movements						
Revaluation of Fixed Assets	-	-	-	-	-	-
Other	(90)	3	-	-	-	-
Equity introduced (Repaid)	-	24,650	40,000	15,000	5,000	10,000
Equity at end of Period	**127,311**	**153,956**	**185,956**	**192,956**	**189,956**	**191,955**

Statement of Financial Position

$000s

	2015-16 Audited Actuals	2016-17 Forecast	2017-18 Budget	2018-19 Budget	2019-20 Budget	2020-21 Budget
Equity						
Crown Equity	40,355	40,355	65,005	105,005	120,005	125,005
Retained Earnings	4,615	6,608	(1,392)	(9,392)	(17,392)	(25,393)
Subsidiaries & unrestricted trusts	211	213	213	213	213	213
Revaluation Reserve	82,130	82,130	82,130	82,130	82,131	82,130
Capital Injections	-	24,650	40,000	15,000	5,000	10,000
Total Equity	127,311	153,956	185,956	192,956	189,956	191,955
Represented by:						
Assets						
Current Assets	37,748	27,222	25,589	24,789	24,355	24,665
Non-Current Assets	197,303	207,888	241,093	248,376	245,511	247,200
Total Assets	235,051	235,110	266,682	273,165	269,866	271,866
Liabilities						
Current Liabilities	66,367	64,629	64,629	64,725	64,426	64,426
Non-Current Liabilities	41,372	16,525	16,097	15,485	15,485	15,485
Total Liabilities	107,739	81,154	80,726	80,209	79,910	79,910
Net Assets	**127,312**	**153,957**	**185,956**	**192,956**	**189,956**	**191,955**

Statement of Cash Flows

$000s

	2015-16 Audited Actuals	2016-17 Forecast	2017-18 Budget	2018-19 Budget	2019-20 Budget	2020-21 Budget
Cash Flows from Operating Activities						
Operating Income	574,933	603,506	627,634	656,506	685,393	714,180
Operating Expenditure	567,871	591,532	621,970	650,213	678,470	706,633
Net Cash from Operating Activities	7,062	11,974	5,665	6,293	6,923	7,548
Cash Flows from Investing Activities						
Interest receipts 3rd Party	1,224	2,140	503	527	550	573
Sale of Fixed Assets	20	-	-	-	-	-
Purchase of Fixed Assets	(16,135)	(15,550)	(42,293)	(17,020)	(7,520)	(12,720)
Decrease in Investments and Restricted & Trust Funds Assets	2,214	7,226	(5,000)	(5,000)	(5,000)	(5,000)
Net Cash from Investing Activities	(12,677)	(6,185)	(46,790)	(21,493)	(11,970)	(17,147)
Cash Flows from Financing Activities						
Equity injections (repayments)	-	-	40,000	15,000	5,000	10,000
Borrowings	324	(394)	(428)	(517)	(299)	-
Interest Paid	(966)	(840)	(80)	(83)	(87)	(91)
Repaid debts	-	-	-	-	-	-
Other Non-Current Liability Movement	(6)	-	-	-	-	-
Net Cash from Financing Activities	(648)	(1,233)	39,493	14,400	4,614	9,909
Net Increase/(Decrease) in Cash held	(6,263)	4,556	(1,632)	(800)	(433)	310
Add opening cash balance	8,870	2,607	7,163	5,530	4,730	4,297
Closing Cash Balance	2,607	7,163	5,530	4,730	4,297	4,606

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

Key Financial Analysis and Banking Covenants

	2015-16 Audited Actuals	2016-17 Forecast	2017-18 Budget	2018-19 Budget	2019-20 Budget
Financial Analysis					
Term Liabilities and Current Liabilities	107,739	81,154	80,726	80,209	79,910
Debt	26,956	1,912	1,484	968	669
Owners Funds	127,312	153,957	185,956	192,956	189,956
Total Assets	235,051	235,110	266,682	273,165	269,866
Owners Funds to Total Assets	54.2%	65.5%	69.7%	70.6%	70.4%
Interest Expense	963	910	80	83	87
Depreciation Expense	12,199	12,739	14,088	14,736	15,385
Surplus/(Deficit)	395	1,992	- 8,000	- 8,000	- 8,000
Interest Cover	14.07	17.19	77.45	81.87	85.92
Debt/Debt + Equity Ratio	17%	1%	1%	0%	0%
Banking Covenants					
Debt/Debt + Equity Ratio	17.5%	1.2%	0.8%	0.5%	0.4%
Interest Cover	14.1	17.2	77.5	81.9	85.9
Interest Cover Minimum	3.0	3.0	3.0	3.0	3.0

Consolidated Statement of Financial Performance ($000s)

	2015-16 Audited Actuals	2016-17 Forecast	2017-18 Budget	2018-19 Budget	2019-20 Budget	2020-21 Budget
MOH Devolved Funding	538,996	567,832	590,826	618,004	645,196	672,294
MOH Non-Devolved Contracts (provider arm side contracts)	15,301	14,753	17,497	18,302	19,107	19,910
Other Government (not MoH or other DHBs)	5,242	5,918	4,877	5,101	5,325	5,549
Patient / Consumer sourced	636	444	282	295	308	321
Total Other Income	5,864	4,979	3,903	4,082	4,262	4,441
InterProvider Revenue (Other DHBs)	1,284	1,250	1,190	1,245	1,300	1,354
IDFs - All Other (excluding Mental Health)	9,139	9,279	9,563	10,003	10,443	10,882
Total Consolidated Revenue	576,462	604,455	628,138	657,032	685,942	714,751
Personnel Costs	208,184	214,145	231,004	241,263	251,526	261,754
Outsourced Services	25,082	27,008	30,305	31,699	33,093	34,483
Clinical Supplies	46,426	49,230	56,613	59,218	61,823	64,420
Infrastructure & Non-Clinical Supplies	23,751	24,140	25,006	26,574	28,142	29,705
Finance Costs	10,811	9,619	9,149	9,153	9,157	9,160
Depreciation	12,199	12,739	14,088	14,736	15,385	16,031
Personal Health	170,702	179,493	180,121	188,407	196,697	204,958
Mental Health	13,777	14,598	14,453	15,117	15,783	16,445
Disability Support Services	58,684	64,432	67,993	71,121	74,250	77,368
Public Health	697	1,330	1,701	1,780	1,858	1,936
Maori Health	5,645	5,729	5,704	5,966	6,228	6,490
Total Operating Expenditure	575,958	602,464	636,138	665,032	693,942	722,751
Surplus (Deficit)	**504**	**1,992**	**(8,000)**	**(8,000)**	**(8,000)**	**(8,000)**

Provider Statement of Financial Performance ($000s)	2015-16 Audited Actuals	2016-17 Forecast	2017-18 Budget	2018-19 Budget	2019-20 Budget	2020-21 Budget
MOH Non-Devolved Contracts (provider arm side contracts)	15,301	14,753	17,497	18,302	19,107	19,910
Other Government (not MoH or other DHBs)	5,242	5,918	4,877	5,101	5,325	5,549
Non-Government & Crown Agency Sourced	6,500	5,423	4,185	4,378	4,570	4,762
InterProvider Revenue (Other DHBs)	1,284	1,250	1,190	1,245	1,300	1,354
Internal Revenue (DHB Fund to DHB Provider)	286,351	303,867	326,073	341,073	356,080	371,035
Total Provider Revenue	314,678	331,211	353,822	370,098	386,382	402,610
Personnel Costs	206,789	212,544	230,013	240,226	250,444	260,626
Outsourced Services	24,331	26,211	29,107	30,446	31,785	33,120
Clinical Supplies	46,430	48,785	55,837	58,406	60,976	63,537
Infrastructure & Non-Clinical Supplies	22,651	22,085	23,628	25,132	26,636	28,136
Finance Costs	10,811	9,619	9,149	9,153	9,157	9,160
Depreciation	12,198	12,739	14,088	14,736	15,385	16,031
Total Operating Expenditure	323,211	331,983	361,822	378,098	394,383	410,611
Surplus (Deficit)	**(8,534)**	**(772)**	**(8,000)**	**(8,000)**	**(8,000)**	**(8,000)**

Governance Statement of Financial Performance ($000s)	2015-16 Audited Actuals	2016-17 Forecast	2017-18 Budget	2018-19 Budget	2019-20 Budget	2020-21 Budget
Government & Crown Agency Sourced	3,933	4,823	4,344	4,544	4,744	4,943
Total Governance Revenue	3,933	4,823	4,344	4,544	4,744	4,943
Personnel Costs	1,395	1,601	991	1,037	1,083	1,128
Outsourced Services	751	796	1,198	1,253	1,308	1,363
Infrastructure & Non-Clinical Supplies	1,100	2,056	1,378	1,442	1,505	1,568
Depreciation	0	-	-	-	-	-
Total Operating Expenditure	3,242	4,899	4,344	4,543	4,743	4,943
Surplus (Deficit)	**691**	**(76)**	**0**	**0**	**0**	**0**

Funder Statement of Financial Performance ($000s)	2015-16 Audited Actuals	2016-17 Forecast	2017-18 Budget	2018-19 Budget	2019-20 Budget	2020-21 Budget
MOH Devolved Funding	538,996	567,832	590,826	618,004	645,196	672,294
Inter District Flows	9,139	9,279	9,563	10,003	10,443	10,882
Total Funder Arm Revenue	548,135	577,111	600,389	628,007	655,639	683,176
Personal Health	408,762	437,632	457,702	478,757	499,822	520,815
Mental Health	53,457	53,887	56,106	58,687	61,269	63,843
Disability Support Services	64,567	69,959	73,851	77,248	80,647	84,035
Public Health	2,372	2,103	2,519	2,635	2,750	2,866
Maori Health	6,696	5,868	5,866	6,136	6,406	6,675
Other	3,932	4,823	4,344	4,544	4,744	4,943
Total Operating Expenditure	539,787	574,271	600,389	628,007	655,639	683,176
Surplus (Deficit)	**8,347**	**2,840**	**0**	**0**	**0**	**0**

4 Stewardship

4.1 Managing our organisation

Reporting Entity:

The Northland District Health Board (Northland DHB) is a Crown entity as defined by the Crown Entities Act 2004 and is domiciled in New Zealand. The DHB's ultimate parent is the New Zealand Crown. Northland DHB has designated itself and the group as a public benefit entity (PBE) for financial reporting purposes. Northland DHB's activities range from delivering health and disability services through its public provider arm to shared services for both clinical and non-clinical functions such as laboratories and facilities management, as well as planning health service development, funding and purchasing both public and non-government health services for the district.

The forecast consolidated financial statements of Northland DHB comprise Northland DHB and its subsidiary (together referred to as 'Group') and Auckland DHB's interest in associates and jointly controlled entities. The Northland DHB group consists of the parent, Northland DHB and Kaipara Joint Venture Trust (51% ownership by Northland DHB). Northland DHB has a joint venture with the other Northern Region DHBs in healthAlliance NZ Limited (25%). The DHB's subsidiary, associates and joint venture are incorporated and domiciled in New Zealand.

Northland DHB's **finances** are thorougly monitored both internally and by external agencies.

Internally:
- our financial management systems enable us to set targets and monitor performance on finance, workforce and service delivery
- monthly Internal Planning, Performance Monitoring and Reporting meetings monitor finance and other performance based on the targets set above
- financial reports and reviews are also conducted at the Board's Audit and Risk Committee, and at Board meetings
- Delegated authorities are reviewed annually and approved by the Board.

Externally:
- the MoH monitors our financial performance through the reports we send them monthly
- once a year Audit NZ audits our financial statements and our Annual Report
- the regional internal audit service audits and monitors our financial systems and performance, as well as those of the Northern Region's shared service agency healthAlliance
- Northland DHB participates in regional and national processes aimed at achieving value-for-money; healthAlliance provides regional oversight of information systems and technology and NZ Health Partnerships was established nationally to save money by reducing administrative, support and procurement costs.

Our infrastructure, clinical equipment and information systems investment portfolios are each governed by a steering group comprising. clinical staff, consumer representatives and management. NDHB is currently in the process of imbedding the P3M3 framework to support our programme management.

NDHB's **clinicians** form an integral part of our management structures and processes and are intimately involved in regional and national planning processes and innovation, including:
- membership of the Clinical Governance Board which supports the development of strategy aimed to improve quality of care and patient safety
- the Capital Planning Committee which allows senior clinicians to prioritise bids for capital equipment
- a 12-month intensive leadership course to provide training for clinicians and managers aspiring to senior positions
- a clinical governance group spanning primary and secondary care which aims to improve systems and quality of care at the interface between hospital and community services
- the creation of an Associate CMO position during 2016 which has allowed an increased focus on management of Reportable Events, as well as strengthening the voice of clinicians within the Executive Leadership Team.

NDHB clinicians acknowledge as a priority their responsibility to provide excellent educational opportunities for trainees at all levels of their career. DHB management also recognises the importance of training and supports clinicians in their efforts to do this.

Our commitment to **quality and safety** aligns with the national vision and includes:

- the Quality and Safety Plan which explains the programme, principles, processes, structures, roles and relationships
- six-weekly quality reports produced for the Board's Hospital Advisory Committee, the Patient Safety Committee and the Clinical Governance Board
- monitoring clinical risk, adverse events and errors, complaints, benchmarking with other DHBs, improvements to clinical systems
- a dedicated clinical audit position that is supported by the Clinical Audit Committee
- an electronic risk register so all parts of the organisation can record and manage risk
- a Patient Safety and Quality Improvement framework, a commitment to our patients/ clients, staff and community to improve quality through focused targets and actions

Quality and safety includes monitoring clinical risk, adverse events and errors, complaints, benchmarking with other DHBs, improvements to clinical systems and undertaking clinical audit. Managing risk across the organisation is multifaceted and interconnected:

- the Datix software was introduced to Northland DHB to support the robust management of incidents and risks
- all incidents are recorded in this system with the most significant reviewed by a fortnightly Reportable Events Committee, whose membership is clinician-strong and led by the Associate CMO
- these incidents are investigated, lessons learned are disseminated and where appropriate transferred to the Risk Register for ongoing monitoring
- the electronic risk register allows all parts of the organisation to record and manage risk; the most serious risks are reviewed monthly with senior clinical staff to ensure they are mitigated to acceptable levels
- Northland DHB has recently appointed an Emergency and Corporate Risk Manager to review how risk is managed across the organisation with a view to make improvements where required.

Northland DHB has developed a ten-year Long Term Investment Plan (LTIP) setting out a proposed programme to develop our **fixed assets** and Integrated Family Health Centres across the district. Northland DHB is a Tier 2 Intensive Investment Agency under Treasury's Investment Management and Asset Performance (IMAP) and has a Cabinet-approved Investor Confidence Rating of "C". This reflects our ability to manage our asset portfolio and to successfully deliver promised benefits. Steps are underway to improve our portfolio management capability across a range of projects including assets. Northland DHB received approval on 30 May 2017 from the Capital Investment Committee to develop a programme business case for a major redevelopment ~~on the~~ of Whangarei Hospital. The aim of the redevelopment will be to transform health services in Northland with a focus on service and campus redesign. To enable ongoing safe clinical service delivery to be maintained during the planning and construction phases, a number of interim works will be necessary to create additional capacity in theatres, endoscopy, acute assessment unit and outpatient facilities as well as relocating community mental health services. The fit-out of the shell on the maternity building will be held over until there is more certainty on the overall direction of the long term redevelopment. The next steps are to identify a long list of options together with indicative costs and timeframes.

4.2 Building capability

Building capability within Northland DHB to enable us to run the organisation more effectively will be achieved through programmes, projects and actions throughout the Annual Plan.

1.1 Strategic intentions and priorities describes four key priorities:

Neighbourhood Healthcare Homes. Far-reaching changes to the way primary care is organised and run to improve patient outcomes, change the way patients and clinicians interact, and improve the journey through the health system. *[See also 2.1.7]*

Operational Excellence. Five workstreams that will change the way Northland DHB operates by introducing new, contemporary models of care.

Rapid Reponse and Stabilisation Service. A complete rethink of the resources currently devoted to Primary Options that will reduce demand for hospital services, better meet patients' needs, and develop flexible packages of care. *[See also 2.1.7]*

Mobility. The Telehealth & Mobility programme will promote and manage the expansion of clinical use of communications technology (telehealth) and its integration into clinical care. *[See also 2.2.1]*

2.1.1 HT Shorter Stays in Emergency Departments

Implementation of ED at a Glance IT system

Improved bed management system

Electronic admission and discharge planning

2.1.2 HT Improved Access to Elective Surgery

Improving theatre capacity

Additional operating hours

An improved preassessment system

2.1.5 HT Better Help for Smokers to Quit

Review Electronic Discharge Summary to improve information to GPs

2.1.6 HT Raising Healthy Kids

Review and improve B4school Check model of care to meet target

2.1.8 Living Well with Diabetes

Risk stratify patient registers to better support patients

Increase focus on Maori within Green Prescription

Screening of patients for low to moderate mental health needs

2.1.9 Pharmacy Action Plan

Implement the national pharmacy contract Integrated Pharmacist Services in the Community to better meet patient need and enhance services offered by pharmacists

2.1.12 Supporting Vulnerable Children

Extra staff (Health Broker, Psychologist, Paediatrician) to improve parenting, reach into schools, provide alcohol and drug programmes for caregivers

2.1.14 Reducing Unintended Teenage Pregnancy

Reorient youth health school based services to enable improved access to sexual health and contraception services

2.1.17 Healthy Ageing

Implement Northland Local Falls Pathway including single point of entry falls assessment and triage and in-home strength and balance programmes

Complete Dementia Model of Care; improving the indicator for informal carers expressing feelings of distress, anger and depression

2.1.19 Disability Support Services

Include consumer council engagement in site master planning.

Supported decision-making resources for those with intellectual and sensory impairment

2.1.20 Improving Quality and Safety for patients:

Incorporate patient experience component in House Officer training programme

Ongoing development and routine monitoring of in-house patient experience surveys and feedback mechanisms

Codesign project to develop a model for engaging for patients and whanau following a serious adverse event in hospital

Workforce Capability

- Implement the Northern Region Health Plan workforce development strategies.
- Development of a Northland DHB employee engagement strategy and leadership model.
- Development of a Northland region workforce development action plan focusing on Maori participation and succession planning.

Appendix A Statement of Performance Expectations

The section fulfils Northland DHB's obligation under the Crown Entities Act 2004 to supply measures by which our future performance can be measured by the Office of the Auditor General. Together with modules 1, 2.3 and 4, it comprises our Statement of Intent.

The Statement of Performance Expectations (SPE) tells our 'performance story' – what we are producing (outputs) and what this is trying to achieve (impacts and outcomes). The structure of the SPE is described in the diagram on the next page.

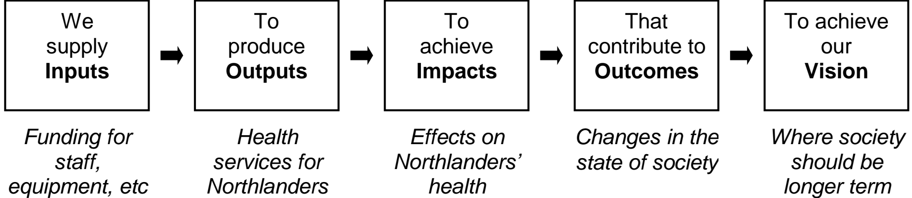
The SPE concentrates on cornerstone measures that represent the wide range of services for which Northland DHB is responsible. There is considerable overlap between the SPE's outputs and measures and those in section 2 of the Annual Plan; the latter is prepared in response to a specific list of national priorities, while the SPE takes a higher level, more strategic view.

Output classes and intervention logic

Services are grouped into four output classes:

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

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



Impacts contribute to the High-level Measures, and together Impacts and Outcomes contribute to the High-level Outcomes. For example, higher rates of cessation among smokers and immunisation among children create a healthier population. Screening for cancers, cardiovascular disease and diabetes prevent illness and disease or identify conditions at early stages so they can be monitored and treated more effectively. Ongoing monitoring and support of people with long term mental health condidtions help maintain their stability. Home and community support services help older people remain independent in the community, and residential care services offer the best quality of life for those no longer able to manage on their own. Quality services that are clinically and culturally safe, and provided in a timely manner encourage people to attend and be involved in their care, and that means better health status. To cope with ever-rising demands on services and to free up resources for new models of care and other innovations, we must continue to improve productivity and prioritise resources to their most cost-effective uses.

Through the measures described above and in the diagram on the next page, the SPE addresses the Triple Aims of population health, patient experience and value and sustainability.

Wherever possible, Impacts are measured by Maori and non-Maori so we can monitor inequities and reduce these over time (consistent with the Population Health aim).

Summary of Northland DHB's Statement of Performance Expectations 2017/18

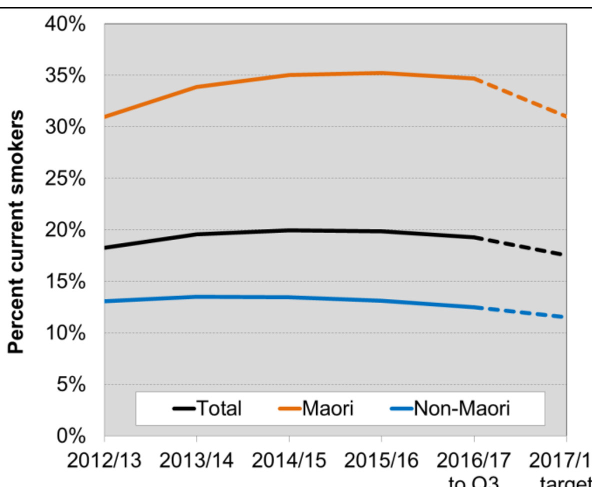
Vision	A healthier Northland									
High-level Outcomes	Population health: improved health of Northlanders and reduced health inequities		Patient experience: patients and whanau experience clinically and culturally safe, good quality, effective, efficient and timely care			Value and sustainability: the Northland health system lives within available funding by improving productivity and prioritising resources to their most cost-effective uses				
High-level Measures	Life expectancy gap between Maori and non-Maori ↓ by 2 years		↓ gaps between: (a) Maori and non-Maori (b) Northland and NZ		↓ mortality rate (age-standardised)	↓ infant mortality	Unplanned hospital admissions for Northlanders are reduced by 2,000 annually by 2017			>95% of patients report they would recommend the service provided
Outcomes	Healthy population	Prevention of illness and disease		Reversal of acute conditions		Optimum quality of life for those with long term conditions			Independence for those with impairments or disability support needs	
Impacts	**Smoking cessation** Lower prevalence of smoking-related conditions	**Healthy children** Children are healthy from birth and have a healthy foundation for adulthood	**Effective primary care** People manage in the community through effective primary care services	**Long term conditions** Amelioration of disease symptoms and/or delay in their onset	**Cancer** If curable, increased likelihood of survival; if incurable, reduced severity of symptoms	**Mental disorders** Improved quality of life for both clients and their families Acute episodes are minimised, clients achieve greater stability in their condition	**Elective surgery** Fewer debilitating conditions and delayed onset of long term conditions	**ED waiting times** More timely assessment, referral and treatment	**Quality and safety** More satisfied patients Fewer adverse clinical events Lower rates of acute readmission to hospital	**Support for older people** Older people requiring support or care receive services appropriate to their needs.
Impact Measures	Year 10 students who have never smoked Adults who are current smokers	Full and exclusive breastfeeding at 6 weeks 8-month-olds who are fully immunised Average number of decayed, missing or filled teeth in Y8 students	Ambulatory sensitive hospitalisations, rate/100,000 ages 0-4	Good blood sugar management in diabetics Eligible people receiving CVD risk assessment in the last 5 years	Breast cancer screening in eligible populations Cervical cancer screening in eligible populations Urgently referred patients with a high suspicion of cancer who receive their first cancer treatment within 62 days	% of people with enduring mental illness aged 20-64 who are seen over a year	Increase in elective surgical discharges	ED patients with length of stay less than 6 hours	Falls causing harm in NDHB facilities Pressure injuries in NDHB facilities Surgical checklist compliance Hand hygiene compliance Medicines reconciled % of acute patients readmitted to NDHB hospitals within 28 days	HCSS clients assessed using interRai tool HCSS providers certified ARRC providers with at least 3 years certification
Output Classes	**Prevention**		**Early detection and management**		**Intensive assessment and treatment**				**Rehabilitation and support**	
Outputs	Health promotion programmes in schools through Smokefree/ Auahi Kore Advice and help offered to smokers in primary care Quit Card Providers Advice and help offered to smokers in hospital	Midwifery services Support by lactation consultants Oral health assessment and treatment Assessment, diagnosis, treatment and immunisations in primary care	Acute hospital services	Assessment, diagnosis and treatment in primary care Assessment, diagnosis and treatment in hospital	Screening for breast and cervical cancers Cancer risk assessments in primary care Provision of cancer therapies	Specialised clinical support by NDHB community mental health services Admission to hospital for those whose condition is acutely unwell	Elective surgical procedures	Assessments, treatments and referrals performed in EDs	Leadership, advice and monitoring by the Chief Medical Advisor and Quality Resource Unit Effective clinical services, especially for long term conditions Patient pathways, hospital discharge processes Integration between secondary and primary services	Home based support services Residential care Work with providers on corrective action plans resulting from audit
Output Measures	Health promotion in schools Advice to students re stopping smoking % of smokers given advice and help to quit in primary care and in hospital	Support provided to mothers to breastfeed Lactation consultant contacts Immunisations by 8 months Oral health treatments for Y8 students Visits by children and youth to primary care	Acute hospital admissions	Risk assessments performed on people with diabetes and/or CVD Lab tests on people with diabetes Admissions and readmissions to hospital	Screening for breast and cervical cancer in eligible populations Radiation treatments Chemotherapy treatments	Contacts by community mental health workers with people who have enduring mental illness	Additional elective procedures	Emergency department attendances	Measures of the quality and safety of services	Assessments by NASC service Certification audits

Key: Underlines = main measures. Yellow highlights = Health Targets. All measures to be by Maori and non-Maori where data is available.

Output Class 1: Prevention

Impact: Lower prevalence of smoking-related conditions.

Measure: % of Northland adult population who are current smokers



Measure type: Coverage

Rationale

Smoking and obesity are the two most significant lifestyle factors behind long term conditions.

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

It disproportionately affects Maori and other deprived populations. The 2011-14 NZ Health Survey showed that in Northland 41% of Maori smoke and 18% of non-Maori.

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

Smoking rates are the focus of one of the six national Health Targets. New Zealand has committed to a goal of reducing smoking rates to 5% by 2025.

The adult data was formerly taken from the NZ Health Survey, but this is of minimal use for tracking progress towards the national target because it emerges only every few years and covers several years at once (the latest is 2011-2014). The data used now comes from PHO reports to MoH and is preferred because it is produced quarterly and it has excellent coverage (it includes all Northlanders enrolled with PHOs, which is always slightly more than the projected population at the same date). The two sets of data can't be compared directly because the measurement criteria are different.

Outputs

108,660 people who have ever smoked recorded in primary care, of whom 24,288 are current smokers (as at 2016/17 Q3).

Number of schools that health promotion programmes are offered to, 2016 CY: 146.

Total students advised about stopping smoking 2016 CY 820.

Notes about the data

Current adult smokers. NZ's target is to reduce smoking rates to 5% by 2025. Targets have been set on this basis, assuming straight-line progress until 2025.

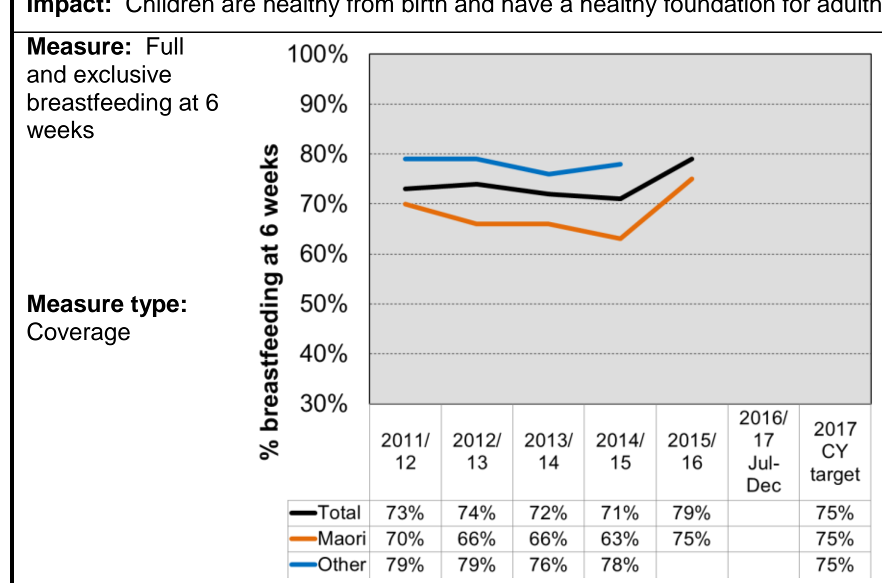
We can however gain an indication of progress from primary care Health Target data, which suggests that numbers are gradually dropping, from 24.5% in 2013/14 to 23.7% in 2014/15 and 23.0% 2015/16 to quarter three. No ethnic breakdown is available from this data.

This data is from MoH's NZ Health Survey, in which multiple years are amalgamated to boost sample sizes for mid-sized DHBs. Surveys were held in 2006 and 2011-2014, hence the flat line for the latter. It will not be possible to know for sure from this source what progress we are making until another national health survey is undertaken.

Impact: Children are healthy from birth and have a healthy foundation for adulthood

Measure: Full and exclusive breastfeeding at 6 weeks

Measure type: Coverage



	2011/ 12	2012/ 13	2013/ 14	2014/ 15	2015/ 16	2016/ 17 Jul-Dec	2017 CY target
Total	73%	74%	72%	71%	79%		75%
Maori	70%	66%	66%	63%	75%		75%
Other	79%	79%	76%	78%			75%

Rationale

Higher rates of breastfeeding in infancy correlate with a lower chance later in life of developing health problems, including long term conditions.

Breastfeeding rates are lower among Maori.

A higher percentage of the child population is Maori, so improving child health will have a significant effect on improving the health of Maori.

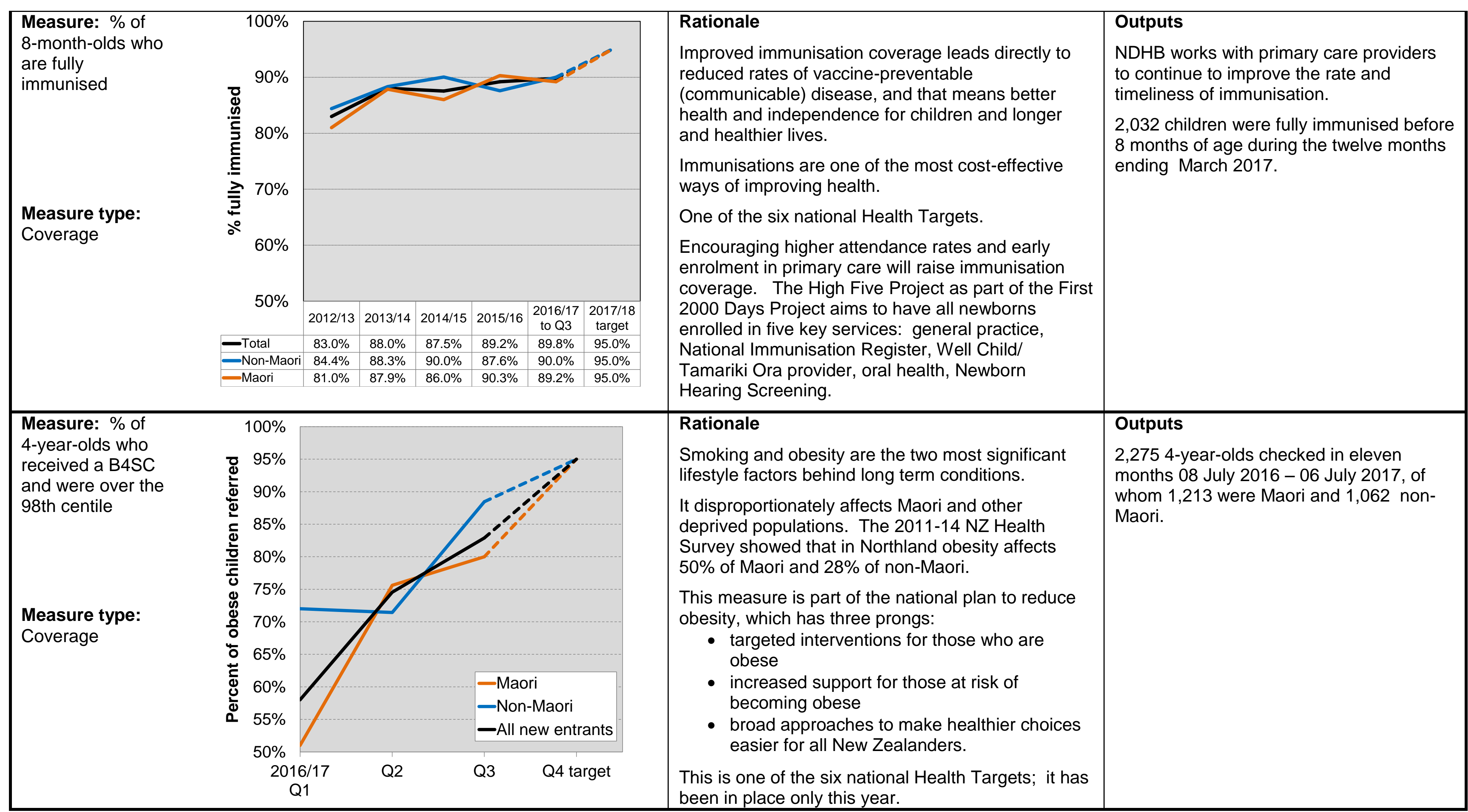
The target used is the national one, though Northland has been out-performing that for non-Maori and the total population.

Outputs

Mothers are provided with education and support to encourage them to breastfeed, whether they are supported by an NDHB midwife (hospital births) or an independent midwife (home and hospital births).

Total NDHB hospital births 1,824 for the twelve months ending March 2016.

2,953 lactation consultant patient contacts for the twelve months ending March 2016.



Measure: % of 8-month-olds who are fully immunised

Measure type: Coverage

	2012/13	2013/14	2014/15	2015/16	2016/17 to Q3	2017/18 target
Total	83.0%	88.0%	87.5%	89.2%	89.8%	95.0%
Non-Maori	84.4%	88.3%	90.0%	87.6%	90.0%	95.0%
Maori	81.0%	87.9%	86.0%	90.3%	89.2%	95.0%

Rationale

Improved immunisation coverage leads directly to reduced rates of vaccine-preventable (communicable) disease, and that means better health and independence for children and longer and healthier lives.

Immunisations are one of the most cost-effective ways of improving health.

One of the six national Health Targets.

Encouraging higher attendance rates and early enrolment in primary care will raise immunisation coverage. The High Five Project as part of the First 2000 Days Project aims to have all newborns enrolled in five key services: general practice, National Immunisation Register, Well Child/ Tamariki Ora provider, oral health, Newborn Hearing Screening.

Outputs

NDHB works with primary care providers to continue to improve the rate and timeliness of immunisation.

2,032 children were fully immunised before 8 months of age during the twelve months ending March 2017.

Measure: % of 4-year-olds who received a B4SC and were over the 98th centile

Measure type: Coverage

Rationale

Smoking and obesity are the two most significant lifestyle factors behind long term conditions.

It disproportionately affects Maori and other deprived populations. The 2011-14 NZ Health Survey showed that in Northland obesity affects 50% of Maori and 28% of non-Maori.

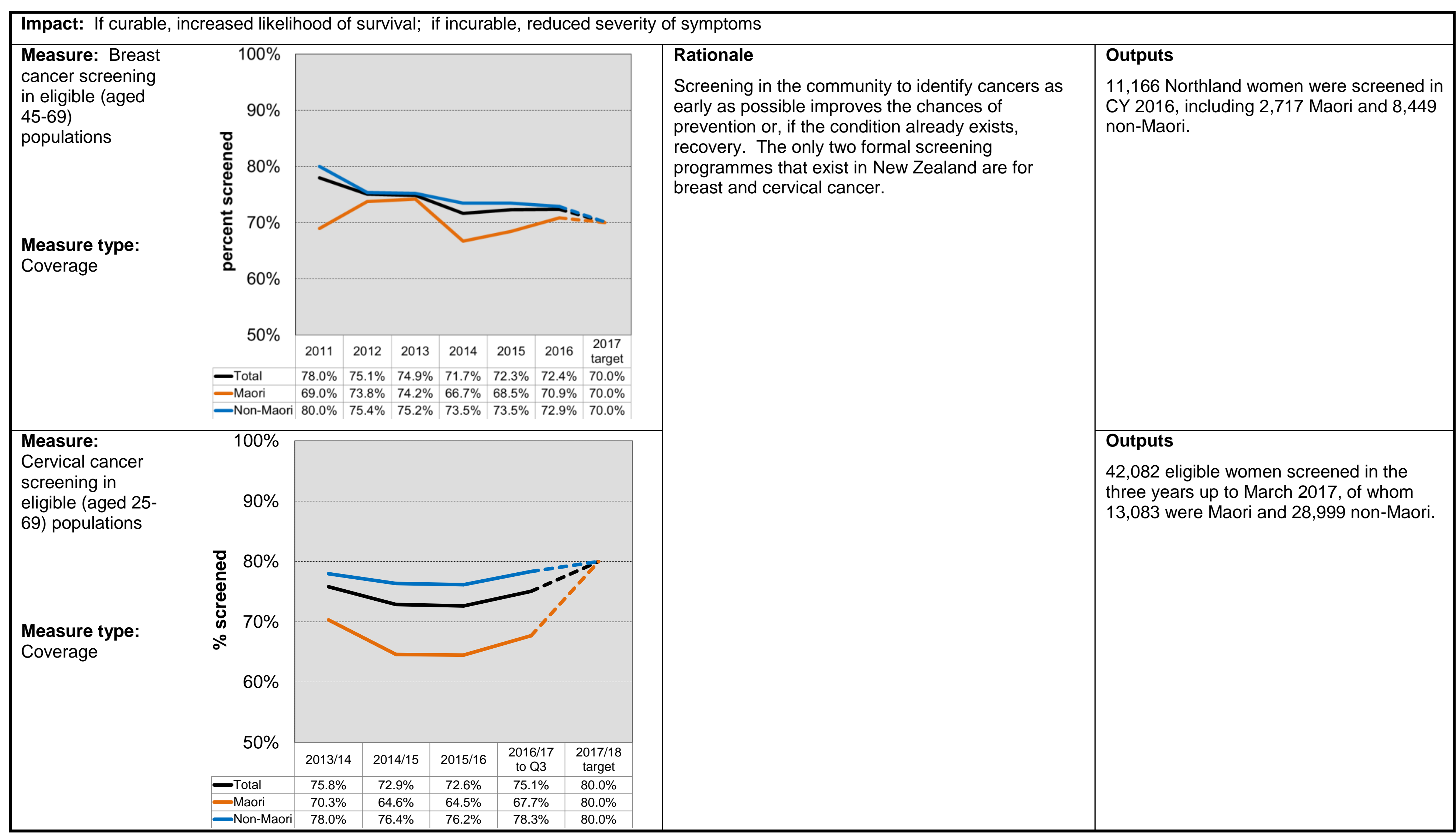
This measure is part of the national plan to reduce obesity, which has three prongs:

- targeted interventions for those who are obese
- increased support for those at risk of becoming obese
- broad approaches to make healthier choices easier for all New Zealanders.

This is one of the six national Health Targets; it has been in place only this year.

Outputs

2,275 4-year-olds checked in eleven months 08 July 2016 – 06 July 2017, of whom 1,213 were Maori and 1,062 non-Maori.



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

Measure: Breast cancer screening in eligible (aged 45-69) populations

Measure type: Coverage

	2011	2012	2013	2014	2015	2016	2017 target
Total	78.0%	75.1%	74.9%	71.7%	72.3%	72.4%	70.0%
Maori	69.0%	73.8%	74.2%	66.7%	68.5%	70.9%	70.0%
Non-Maori	80.0%	75.4%	75.2%	73.5%	73.5%	72.9%	70.0%

Rationale

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

Outputs

11,166 Northland women were screened in CY 2016, including 2,717 Maori and 8,449 non-Maori.

Measure: Cervical cancer screening in eligible (aged 25-69) populations

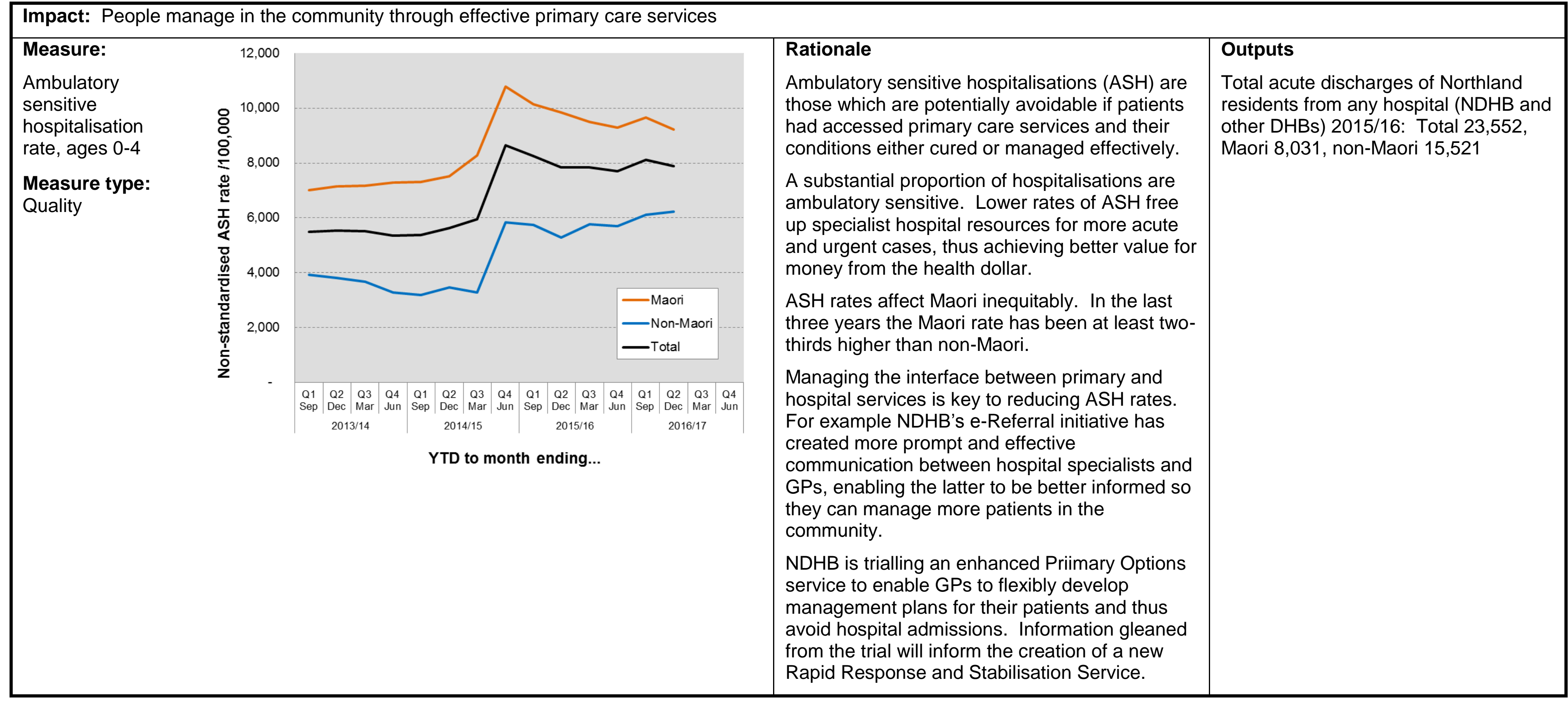
Measure type: Coverage

	2013/14	2014/15	2015/16	2016/17 to Q3	2017/18 target
Total	75.8%	72.9%	72.6%	75.1%	80.0%
Maori	70.3%	64.6%	64.5%	67.7%	80.0%
Non-Maori	78.0%	76.4%	76.2%	78.3%	80.0%

Outputs

42,082 eligible women screened in the three years up to March 2017, of whom 13,083 were Maori and 28,999 non-Maori.

Output Class 2: Early Detection and Management



Impact: People manage in the community through effective primary care services

Measure:

Ambulatory sensitive hospitalisation rate, ages 0-4

Measure type: Quality

Rationale

Ambulatory sensitive hospitalisations (ASH) are those which are potentially avoidable if patients had accessed primary care services and their conditions either cured or managed effectively.

A substantial proportion of hospitalisations are ambulatory sensitive. Lower rates of ASH free up specialist hospital resources for more acute and urgent cases, thus achieving better value for money from the health dollar.

ASH rates affect Maori inequitably. In the last three years the Maori rate has been at least two-thirds higher than non-Maori.

Managing the interface between primary and hospital services is key to reducing ASH rates. For example NDHB's e-Referral initiative has created more prompt and effective communication between hospital specialists and GPs, enabling the latter to be better informed so they can manage more patients in the community.

NDHB is trialling an enhanced Priimary Options service to enable GPs to flexibly develop management plans for their patients and thus avoid hospital admissions. Information gleaned from the trial will inform the creation of a new Rapid Response and Stabilisation Service.

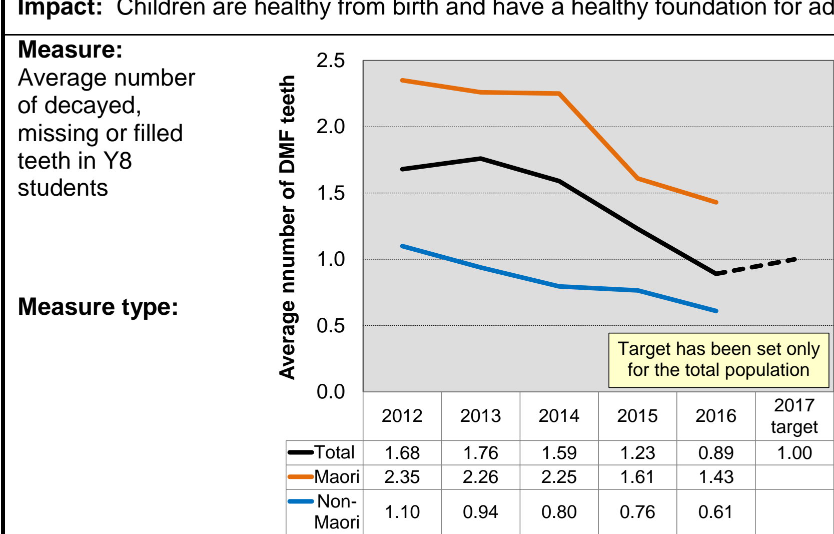
Outputs

Total acute discharges of Northland residents from any hospital (NDHB and other DHBs) 2015/16: Total 23,552, Maori 8,031, non-Maori 15,521

Impact: Children are healthy from birth and have a healthy foundation for adulthood

Measure:
Average number of decayed, missing or filled teeth in Y8 students

Measure type:



	2012	2013	2014	2015	2016	2017 target
Total	1.68	1.76	1.59	1.23	0.89	1.00
Maori	2.35	2.26	2.25	1.61	1.43	
Non-Maori	1.10	0.94	0.80	0.76	0.61	

Rationale

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

For many years Northland had among the worst oral health statistics for children, though significant improvements have been made in the last four years especially.

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

Outputs

Procedures in NDHB-funded oral health services :

- 10,605 preschool (2016 CY)
- 41,540 primary school children (2016 CY)
- 1,300 adolescents treated by NDHB's services in the 2016 CY.

Impact: Amelioration of long term condition disease symptoms and/or delay in their onset

Measure: Good blood sugar management in diabetics

Measure type:
Coverage

% with good blood sugar management

100%
90%
80%
70%
60%
50%
40%
30%
20%

	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18 target
Total	71.7%	69.5%	58.8%	61.5%	72.08%	80.0%
Maori	64.1%	62.2%	55.4%	53.3%	62.64%	80.0%
Non-Maori	77.0%	75.1%	61.1%	67.8%	78.72%	80.0%

Rationale

Diabetes is an increasingly common long term condition.

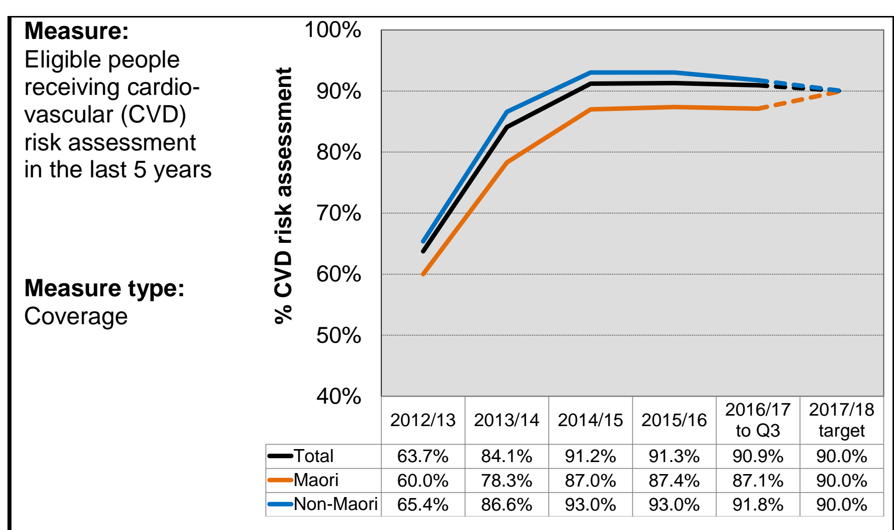
It is strongly associated with excess weight, which affects a disproportionate number of Northlanders. Prevalence also increases with age, so prompt action is imperative in the face of the ageing population.

It is a major cause of illness and a significant contributor to cardiovascular disease *(see below).*

Although incurable, the effect of diabetes on daily life can be minimised through early detection, regular (annual) checks, good clinical management and a healthy lifestyle.

Outputs

4,799 diabetes annual reviews were performed in primary care in the twelve months ending Mar 2016.



Measure:
Eligible people receiving cardio-vascular (CVD) risk assessment in the last 5 years

Measure type:
Coverage

	2012/13	2013/14	2014/15	2015/16	2016/17 to Q3	2017/18 target
Total	63.7%	84.1%	91.2%	91.3%	90.9%	90.0%
Maori	60.0%	78.3%	87.0%	87.4%	87.1%	90.0%
Non-Maori	65.4%	86.6%	93.0%	93.0%	91.8%	90.0%

Rationale

Along with cancer, cardiovascular (heart and circulatory) disease is the most common long term condition.

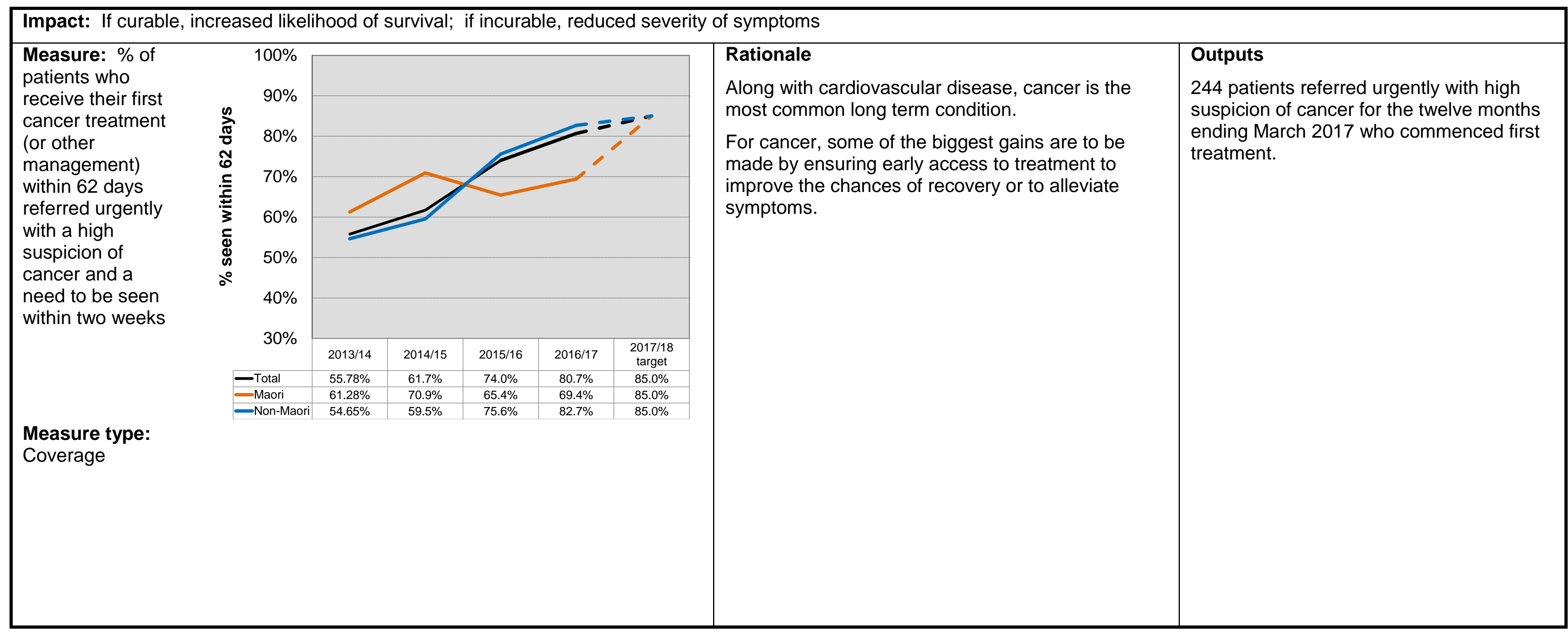
Prevalence of CVD increases with age, so in the face of the ageing population we need to carefully monitor and control the incidence and severity of these conditions.

Regular screening identifies those at risk of developing cardiovascular disease, for whom lifestyle and clinical interventions can prevent or delay its onset. Regular screening also helps earlier identification of those who already have the condition, and this promotes more healthy outcomes for them.

Outputs

52,312 CVD risk assessments performed in primary care over the five years to Mar 2017, of whom 15,636 were Maori and 36,676 non-Maori. The total number screened over five years is a more sensible indicator of coverage than the most recent annual figure, because different numbers of people have been screened during each of the five years.

Output Class 3: Intensive Assessment and Treatment



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

Measure: % of patients who receive their first cancer treatment (or other management) within 62 days referred urgently with a high suspicion of cancer and a need to be seen within two weeks

	2013/14	2014/15	2015/16	2016/17	2017/18 target
Total	55.78%	61.7%	74.0%	80.7%	85.0%
Maori	61.28%	70.9%	65.4%	69.4%	85.0%
Non-Maori	54.65%	59.5%	75.6%	82.7%	85.0%

Measure type: Coverage

Rationale

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

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

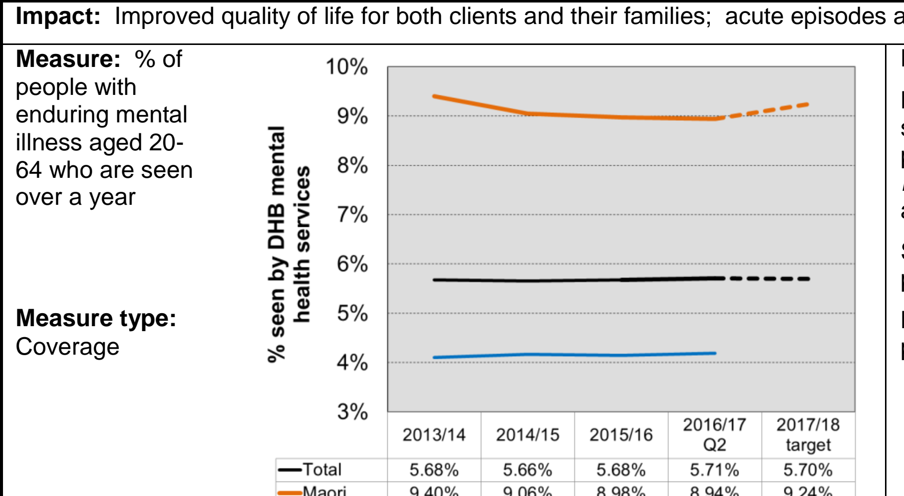
Outputs

244 patients referred urgently with high suspicion of cancer for the twelve months ending March 2017 who commenced first treatment.

Impact: Improved quality of life for both clients and their families; acute episodes are minimised, clients achieve greater stability in their condition

Measure: % of people with enduring mental illness aged 20-64 who are seen over a year

Measure type: Coverage



	2013/14	2014/15	2015/16	2016/17 Q2	2017/18 target
Total	5.68%	5.66%	5.68%	5.71%	5.70%
Maori	9.40%	9.06%	8.98%	8.94%	9.24%
Non-Maori	4.11%	4.17%	4.15%	4.19%	

Rationale

Mental health has been a priority for the health sector since the Mental Health Blueprint was published in 1998; it has since been overtaken by *Rising to the Challenge*, the national mental health and addictions strategy 2012-2017.

Severe disorders permanently affect 3% of the population.

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

Outputs

Number of contacts by community mental health services with people who have enduring mental illness (2014/15 extrapolated from 9 months data):

Direct (with client and/or whanau)	95,000
Care coordination (on behalf of client, with another agency)	18,000

Impact: Fewer debilitating conditions and delayed onset of long term conditions

Measure: Increase in elective service discharges

Measure type: Coverage

Number of procedures

10,000
9,000
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17 to Q3	2017/18 target
Total	6,098	6,198	6,434	6,564	6,704	8,275	8,550	8,845
Maori	1,537	1,580	1,660	1,877	1,702	2,110	2,188	2,264
Non-Maori	4,561	4,618	4,774	4,677	5,002	6,165	6,362	6,581

Rationale

Elective surgery is an effective way of increasing people's functioning because it remedies or improves disabling conditions.

Increasing delivery will improve access and reducing waiting times as well as increase public confidence that the health system will meet their needs.

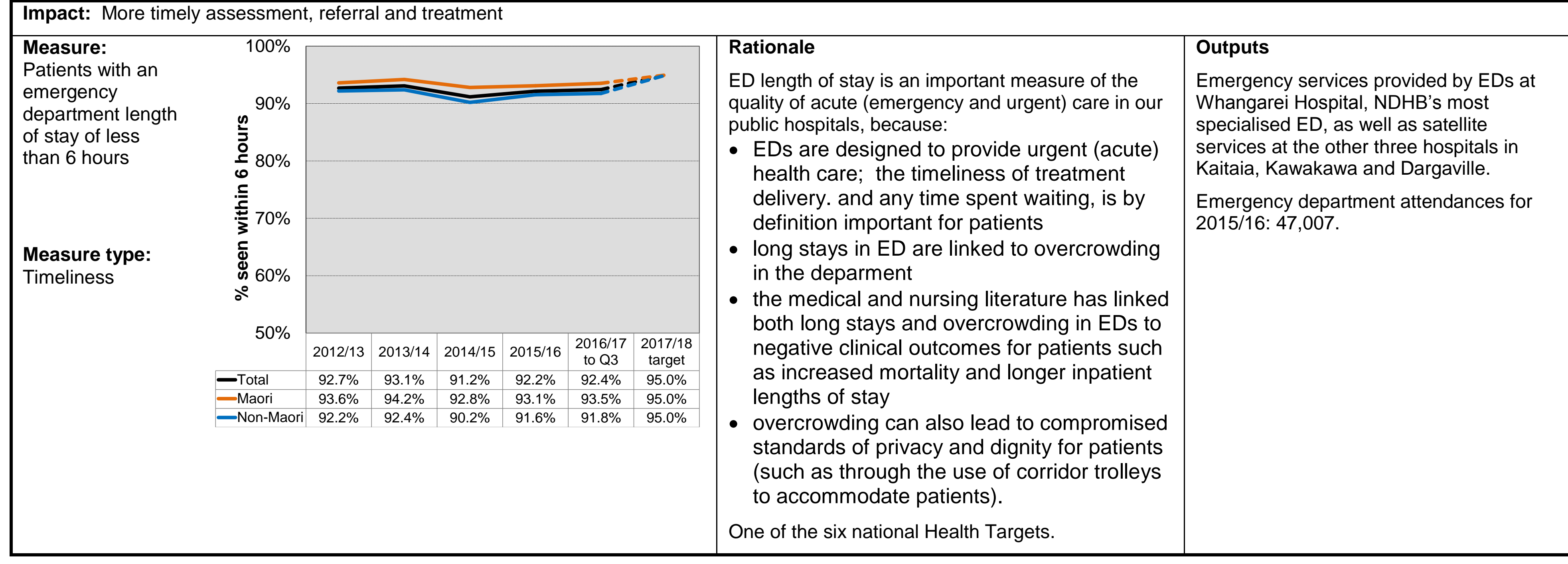
Timely access to elective services is considered by the Ministry of Health to be a measure of the effectiveness of the health system.

One of the six national Health Targets.

Outputs

8,845 elective surgical discharges target for 2017~~6~~/18~~7~~.

The data used here represents the targets set in each year's Annual Plan. These numbers do not represent total extra elective surgical discharges because every year MoH provides more funding for more procedures, and the amounts cannot be predicted. The most rational way of assessing NDHB's performance is against the targets agreed before the year starts.



Impact: More timely assessment, referral and treatment

Measure:
Patients with an emergency department length of stay of less than 6 hours

Measure type:
Timeliness

	2012/13	2013/14	2014/15	2015/16	2016/17 to Q3	2017/18 target
Total	92.7%	93.1%	91.2%	92.2%	92.4%	95.0%
Maori	93.6%	94.2%	92.8%	93.1%	93.5%	95.0%
Non-Maori	92.2%	92.4%	90.2%	91.6%	91.8%	95.0%

Rationale

ED length of stay is an important measure of the quality of acute (emergency and urgent) care in our public hospitals, because:

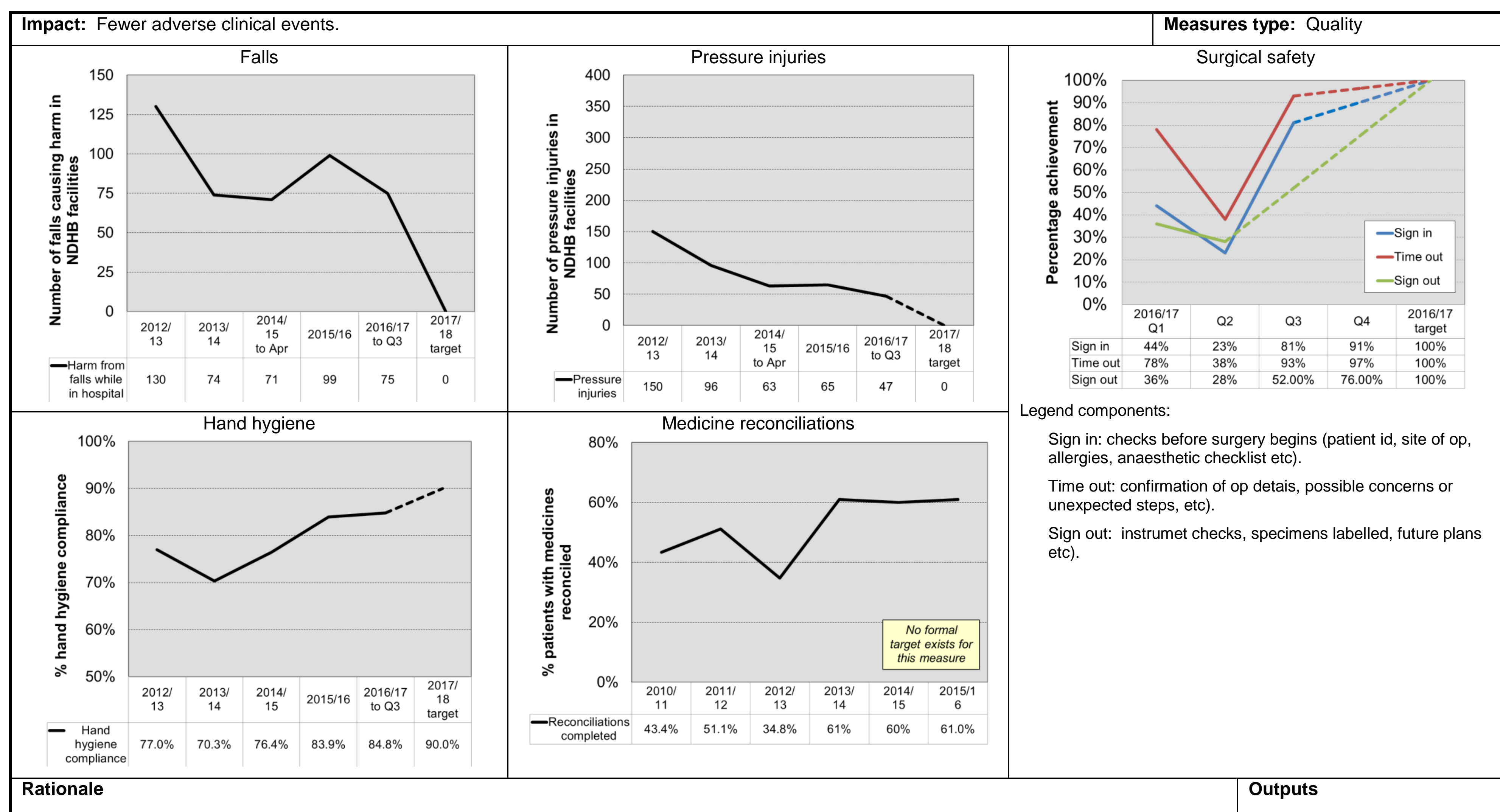
- EDs are designed to provide urgent (acute) health care; the timeliness of treatment delivery. and any time spent waiting, is by definition important for patients
- long stays in ED are linked to overcrowding in the deparment
- the medical and nursing literature has linked both long stays and overcrowding in EDs to negative clinical outcomes for patients such as increased mortality and longer inpatient lengths of stay
- overcrowding can also lead to compromised standards of privacy and dignity for patients (such as through the use of corridor trolleys to accommodate patients).

One of the six national Health Targets.

Outputs

Emergency services provided by EDs at Whangarei Hospital, NDHB's most specialised ED, as well as satellite services at the other three hospitals in Kaitaia, Kawakawa and Dargaville.

Emergency department attendances for 2015/16: 47,007.



Rationale

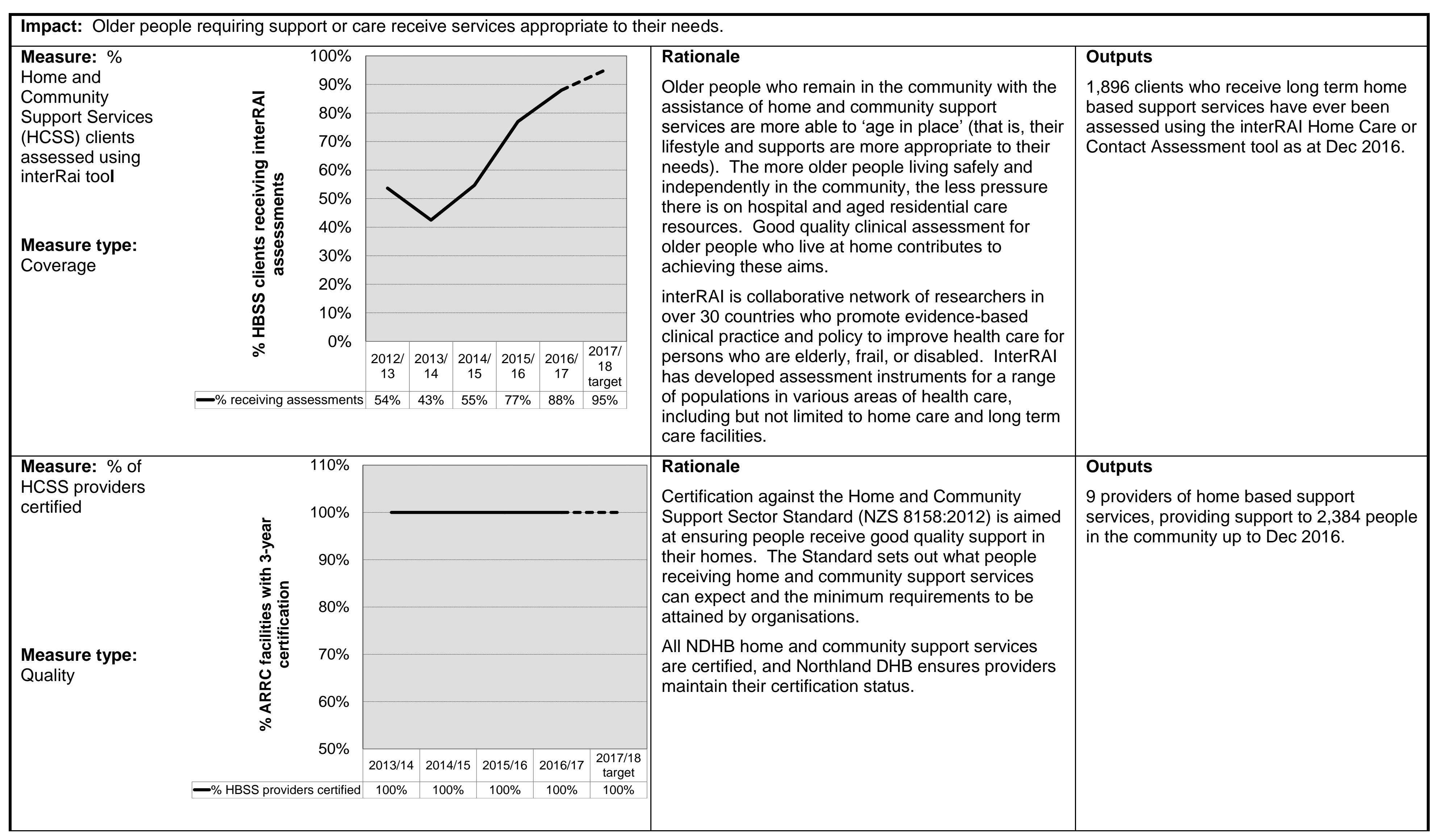
In the last decade considerable efforts have been made to improve the safety of healthcare. We know that if we cannot measure safety outcomes we cannot manage them, hence NDHB is actively working toward measuring outcomes as indicators of success.

These measures comprise key areas of known patient harm. Along with many more measures they are reported to the Board and Clinical Goverance on a monthly basis.

Outputs

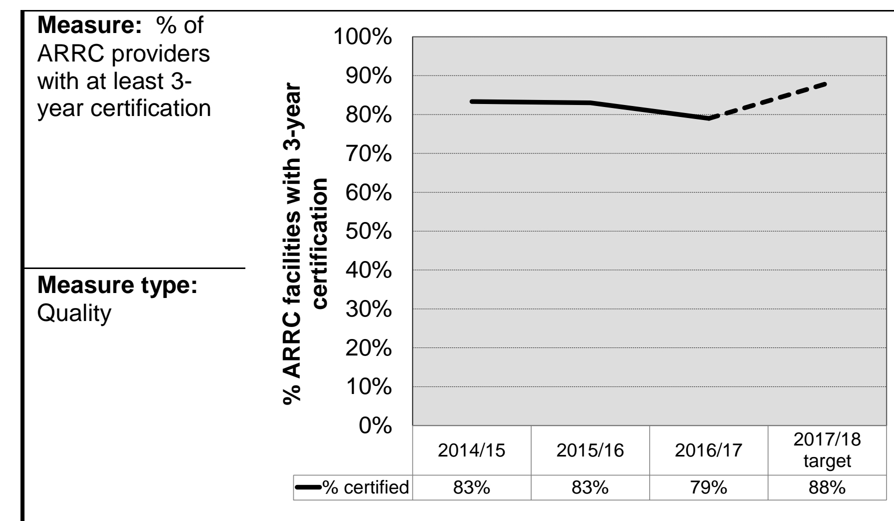
Advice and monitoring provided by the Quality and Improvement Directorate, which is overseen by the Chief Medical Advisor.

Output Class 4: Rehabilitation and Support



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

Measure	Rationale	Outputs
Measure: % Home and Community Support Services (HCSS) clients assessed using interRai tool **Measure type:** Coverage	**Rationale** Older people who remain in the community with the assistance of home and community support services are more able to 'age in place' (that is, their lifestyle and supports are more appropriate to their needs). The more older people living safely and independently in the community, the less pressure there is on hospital and aged residential care resources. Good quality clinical assessment for older people who live at home contributes to achieving these aims. interRAI is collaborative network of researchers in over 30 countries who promote evidence-based clinical practice and policy to improve health care for persons who are elderly, frail, or disabled. InterRAI has developed assessment instruments for a range of populations in various areas of health care, including but not limited to home care and long term care facilities.	**Outputs** 1,896 clients who receive long term home based support services have ever been assessed using the interRAI Home Care or Contact Assessment tool as at Dec 2016.
Measure: % of HCSS providers certified **Measure type:** Quality	**Rationale** Certification against the Home and Community Support Sector Standard (NZS 8158:2012) is aimed at ensuring people receive good quality support in their homes. The Standard sets out what people receiving home and community support services can expect and the minimum requirements to be attained by organisations. All NDHB home and community support services are certified, and Northland DHB ensures providers maintain their certification status.	**Outputs** 9 providers of home based support services, providing support to 2,384 people in the community up to Dec 2016.

Measure: % of ARRC providers with at least 3-year certification **Measure type:** Quality		**Rationale** Certification reduces potential risks to residents by ensuring providers comply with the Health and Disability Services Standards. The period of certification for aged residential care providers reflects their risk level – the fewer the number and the lower the level of risks identified during audits, the longer the period of certification.	**Outputs** DHB aged care contract and MoH certification audit processes have been conducted through a single audit since August 2010. DHBs concentrate on working with providers on corrective action plans to address any matters identified though the audits, monitoring progress against the agreed corrective action plans, and managing risks that may arise. The measure does not include certification for any new providers because that automatically reverts to a single year and is therefore not necessarily related to quality of service. In 2016/17 there are 24 facilities, of which four have new owners and automatically receive a one-year certification but aren't yet counted in the performance data. Of the remaining 20, 17 have 3-year certification and 2 have 4-year; 19/20 = 95%.

Statement of Financial Performance - By Output Class

$000s

	Intensive Assessment & Treatment	Early Detection & Management	Prevention	Rehabilitation & Support Services	
DHB Provider Revenue	280,618	32,202	1,764	11,490	326,073
Other Provider Revenue	7,535	6,716	10,336	3,162	27,749
Less Revenue Offsets - Note 1	(2,289)	(2,040)	(3,140)	(961)	(8,429)
DHB Funder Revenue	80,390	114,017	9,971	65,593	269,972
DHB Governance & Administration	4,344	-	-	-	4,344
Total SOI Revenue	370,598	150,895	18,932	79,285	619,710
Personnel Costs					
Medical Labour	64,339	3,000	1,472	107	68,918
Nursing Labour	75,967	8,002	601	4,648	89,219
Allied Health Labour	24,102	9,458	2,735	2,959	39,254
Non Clinical Support Labour	4,702	195	62	74	5,033
Management and Admin Labour	26,973	3,473	1,828	1,641	33,915
Non-Personnel Operating Costs					
Outsourced Clinical Services	6,393	2,661	30	137	9,221
Oth Clinical Supp	36,303	2,363	756	2,220	41,642
Implants	5,146	-	-	-	5,146
Pharmaceuticals	9,046	68	5	313	9,433
Infrastructure and Non Clinical	38,003	3,960	1,677	1,865	45,505
Allocated Pharmaceuticals					-
Cost of Capital	7,715	792	266	376	9,149
CTA Recoveries	(3,484)	(153)	(104)	(60)	(3,801)
Patient Support	4,801	12	10	9	4,831
Sterile Supplies	268	4	1	2	276
Provider Payments - to providers					
Personal Health	65,200	108,216	4,621	1,021	179,059
Mental Health	12,365	2,554	-	-	14,918
Disability Support Services	124	-	-	68,482	68,606
Public Health	-	1,353	395	-	1,748
Maori Health	-	520	5,056	65	5,641
Total SOI Operating Expenditure	377,962	146,478	19,411	83,859	627,710
Surplus (Deficit)	(7,364)	4,417	(478)	(4,574)	(8,000)

Note One. Revenue Offsets for Costing Standards

Appendix Statement of Accounting Policy

For the year ended 30 June 2017

Reporting entity

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

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

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

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

Basis of preparation

Statement of compliance

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

Presentation currency

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

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

Critical accounting estimates and assumptions

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

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

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

Land and buildings revaluations

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

Long service leave and retirement gratuities

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

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

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

Critical judgments in applying accounting policies

Leases classification

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

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

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

Changes in accounting policies

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

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

PBE IPSAS 3.33

Impairment of Revalued Assets

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

PBE IPSAS 21.83.5

From the 30 June 2017 year onwards, the DHB is required to assess at each reporting date whether there is any indication that an asset may be impaired. If any indication exists, the DHB is required to assess the recoverable amount of that asset and recognise an impairment loss if the recoverable amount is less than the carrying amount. The DHB can therefore impair a revalued asset without having to revalue the entire class of assets to which the asset belongs.

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

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

PBE IPSAS 34 - 38

Interests in other entities

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

The new standards:

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

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

PBE IFRS 9

Financial instruments

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

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

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

Basis for consolidation

Subsidiaries

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

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

Transactions eliminated on consolidation

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

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

Equity accounted Investees: Associates

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

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

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

Budget figures

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

Foreign currency transactions

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

Cash and cash equivalents

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

Trade and other receivables

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

Trade and other payables

Trade and other payables are recorded at their face value.

Investments

Bank term deposits

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

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

Inventories

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

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

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

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

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

Interest bearing borrowings

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

of the borrowings on an effective interest basis. Borrowings are classified as current liabilities unless Northland DHB has an unconditional right to defer settlement of the liability for at least 12 months after balance date.

Property, plant and equipment

Classes of property, plant and equipment

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

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

Owned assets

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

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

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

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

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

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

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

Disposal of property, plant and equipment

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

Additions to property, plant and equipment

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

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

Subsequent costs

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

Depreciation

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

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

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

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

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

Borrowing costs

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

Intangible Assets

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

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

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

Finance Procurement Supply Chain, including National Oracle Solution

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

Subsequent expenditure

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

Amortisation

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

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

Impairment of property, plant and equipment and intangible assets

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

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

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

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

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

Employee benefits

Defined contribution schemes

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

Defined benefit schemes

Northland DHB makes employer contributions to the Defined Benefits Plan Contributors Scheme (the scheme), which is managed by the Board of Trustees of the National Provident Fund. The scheme is a multi-employer defined benefit scheme.

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

Long service leave, sabbatical leave and retirement gratuities

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

Annual leave, conference leave and medical education leave and expenses

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

Sick leave

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

Bonuses

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

Provisions

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

Restructuring

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

ACC Accredited Employers Programme

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

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

Equity

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

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

Property revaluation reserve

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

Fair value through other comprehensive revenue and expense reserves

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

Revenue

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

Ministry of Health population-based revenue

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

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

Ministry of Health Contract Revenue

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

Goods sold and services rendered

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

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

Revenue from other DHBs

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

Donated services

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

ACC contract revenue

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

Rental revenue

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

Interest

Interest revenue is recognised using the effective interest method.

Expenses

Operating leases

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

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

Finance leases

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

Financing costs

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

Capital charge

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

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

Contingent liabilities

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

Cost of service (Statement of Performance)

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

Cost allocation

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

Cost allocation policy

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

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

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

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

Income tax

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

Goods and services tax

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

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

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

Commitments and contingencies are disclosed exclusive of GST.