



STATEMENT OF INTENT 2010/11 – 2012/13

Vision

Creating a healthier Northland

Values

People first – Taangata i te tuatahi
Respect – Whakaute (tuku mana)
Caring – Manaaki
Communication – Whakawhitwhiti korero
Excellence – Taumata teitei (hiranga)

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1 Executive Summary

Northland District Health Board will continue to improve on the delivery of services during 2010/11 while maintaining a balanced budget. We will focus on key Ministerial priorities to achieve better, sooner, more convenient health services.

The Board has maintained a balanced financial position since 2003 and will continue to operate within a viable and financially sustainable cost structure. As well as sector-wide strategies such as procurement, workforce development and service improvement, we have developed specific Performance Improvement Actions aimed at achieving both cost savings and productivity gains.

Elective volumes will increase and we will continue to focus on reducing waiting times for emergency services and regional cancer care. Northland District Health Board will pursue the development of Integrated Family Health Centres which will see better access to a wider range of services closer to home. Several projects are working on ways to improve flows of patients and information between primary and secondary services.

Northland DHB will continue to strengthen relationships with our colleagues in the other three Northern Region DHBs. To build on the gains already made in various regional forums, the four DHBs are committed to progressively implementing the Northern Regional Network Strategy which will improve health gain through economies of scale, reducing transaction costs and improving equity of access across the region. Workstreams will focus on specific services areas, including regional clinical services, urgent and acute care, elective services, health of older people and radiology (which includes waiting times for cancer radiotherapy).

A clinician-led, management-supported model of clinical leadership will be further developed within Northland DHB. The District Health Board will continue to demonstrate our commitment to clinical leadership and will seek improvements to patient care through this model. The model will be extended to ensure that all clinical groups are represented.

The current financial constraints have inspired us to speed up the development of a tighter and more transparent prioritisation methodology. This methodology will be disseminated throughout the organisation to ensure a consistent approach is used. The Board can be confident that full engagement of all stakeholders occurs.

More details of initiatives described throughout the SOI are available in our District Annual Plan, available at <http://www.northlanddhb.org.nz/>.

Since the middle of 2009, Northland DHB has been working alongside Audit NZ in developing a more rigorous intervention logic to improve our SOI. This is encapsulated in our SOI Framework which neatly captures all the elements of the performance story in one diagram. Audit NZ have indicated they want to use the results of this joint work as a model for improving the SOIs of other DHBs.



Anthony Norman
Chair



Colin Kitchen
Board Member



Karen Roach
Chief Executive

2 Environmental scan

This section is a broad scan of the environment in which Northland DHB operates. It addresses the SOI's legislative context, the nature of the Northland environment and population, and key internal and external influences that affect how we work and what we achieve.

2.1 Strategic context for the SOI

This Statement of Intent (SOI) has been prepared by the Northland District Health Board to meet the requirements of section 139(1) of the Crown Entities Act 2004 and sections 42 and 39(8) of the Public Health and Disability Act 2000.

Northland DHB is one of 21 DHBs established in 2001 in accordance with section 19 of the Public Health and Disability Act 2000. Section 22 of the Act requires DHBs, among other things, to:

- improve, promote, and protect the health of people and communities
- promote the integration of health services, especially primary and secondary health services
- promote effective care or support for those in need of personal health services or disability support services
- promote the inclusion and participation in society and independence of people with disabilities
- reduce health disparities by improving health outcomes for Maori and other population groups
- uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations.

The DHB is categorised as a Crown Agent under section 7 of the Crown Entities Act 2004, section 49 of which states that boards of governance must ensure that DHBs act in a manner consistent with their legislative objectives and functions, and their SOI.

As well as performing according to the objectives in section 22 of the Public Health and Disability Act, DHBs must also adhere to the Minister of Health's priorities which he sets out in his annual Letter of Expectations (see [3.1 Health sector requirements](#)).

2.2 Population and health profile

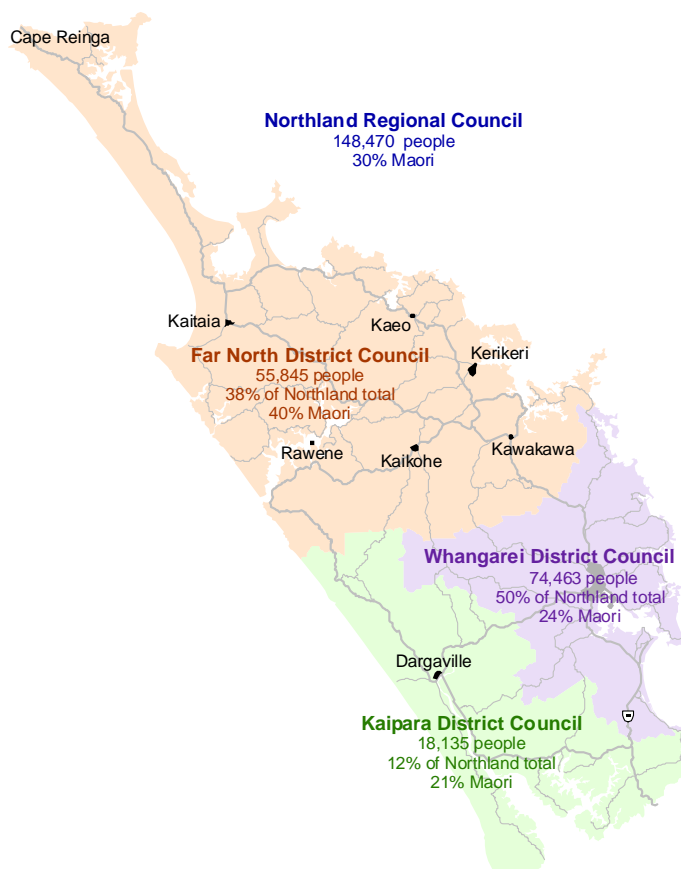
2.2.1 Northland and its population

Northland's projected population for 2010 is 157,420, 3.6% of New Zealand's population.

Just over half live in Whangarei District Council, 37% in the Far North District Council and 12% in Kaipara District Council.

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

Graphic 1 Northland and its population, 2006 Census



Ageing population

Northland's population is 'ageing' because the number of children is decreasing while the older population is increasing significantly. Children (0-14 years) are projected to drop from 23.1% of the population in 2006 to 21.1% by 2016, while older people (65+ years) are projected to grow from 14.5% to 18.9% over the same period. These percentages compare with 12.2% to 15.3% respectively for New Zealand, showing that Northland not only has a higher proportion of older people than the national average, but it is projected to grow at a faster rate.

Deprivation

Northland has one of the most deprived populations in the country. While 20% of NZ's population is in the lowest quintile of the deprivation index, the equivalent measure for Northland is 35%. The most deprived local authority area is the Far North District Council with 51% in the lowest quintile; within FNDC the most deprived areas are Hokianga 83%, Whangaroa 41% and north of the Mangamukas 55%.

Rurality

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

2.2.2 Health profile

Northland DHB compiles a health profile as part of our strategic planning process (→[3.3.1 NDHB Funder functions](#)). It was last formally published in 2005, though we continually scan for and update our health needs information.

Key priorities of Northland DHB

<i>Maori</i>	Maori experience low levels of health status across a whole range of health and socioeconomic statistics. They comprise 30% of Northland's population, but 52% of the child and youth population, a key group for achieving long-term gains. Maori experience early onset of long term conditions, presenting to hospital services on average about 15 years younger than non-Maori ¹ .
<i>Child and youth</i>	The child and youth population in Northland is projected to decline over the coming years, but it remains a priority because healthy children make for healthy adults. Children in Northland are also more needy than adults; areas whose deprivation rating is in the lower half of the scale contain 70% of Northland's adults but 85% of our children.
<i>Older people</i>	Our ageing population is placing significant demands on health services provided specifically for older people (residential care, home based support services, day care). It also affects the prevalence of long term conditions which become more common with age.
<i>Long term conditions</i>	<p>The 'big 3' are diabetes, cardiovascular and cancer.</p> <p>36% of Northlanders die from cardiovascular disease (heart disease and stroke). 22% of adult Northlanders have been told they have high blood pressure and 14% that they have high cholesterol, both known risk factors for cardiovascular disease.</p> <p>While diabetes is not a major killer in itself, it is a primary cause of heart disease and a great deal of unnecessary illness and hospitalisations are related to poor management of the condition.</p> <p>39% of Northlanders die from cancers. The four most common sites are, in order trachea-bronchus-lung, colorectal, prostate and breast.</p>
<i>Oral health</i>	Northland's 5-year olds have repeatedly had the country's highest average score of damaged (decayed, missing or filled) teeth and one of the lowest percentages of teeth without tooth decay (33% compared with the national 41%). Data for adolescent oral health is scanty, but it suggests a similar, if not worse, picture.
<i>Lifestyle behaviours</i>	The way people live their lives and the behaviours they exhibit have an enormous influence on health status. There are a wide range of influences, but key ones are smoking, diet and physical activity.
<i>Mental health</i>	A priority since the publication of the <i>Blueprint for Mental Health Services in NZ</i> ² in 1998. Since then increasing amounts of resources have been progressively invested nationally to work towards a full range of mental health services.
<i>Social influences</i>	Many of the causes of ill health rest with social and economic factors such as housing, education and economic prosperity. The health sector cannot affect these directly, but DHBs can work on them collaboratively with other government and local body organisations.

¹ Based on unpublished research commissioned by NDHB in 2006.

² <http://www.moh.govt.nz/moh.nsf/indexmh/mentalhealth-resources-publications>

2.3 Operating environment

Graphic 2 takes a broad scan of the environment within which Northland DHB operates and identifies factors which increase risks and provide opportunities for the organisation. How NDHB is addressing the opportunities is explained further throughout our District Annual Plan 2010/11³. Further details about our internal operating capability are in [5 Organisational capability](#).

Graphic 2 Risks and opportunities for Northland DHB

Factor	Risks	Opportunities
Demographics	Higher proportion of high-need groups (Maori and older people especially). Increased prevalence of health problems, especially long term conditions.	For high-need groups, continue to develop relationships with service providers, both Maori and mainstream, and negotiate requirements in their contracts. Analyses of funding patterns, productivity and cost-benefits. For long term conditions, ability to change models of care.
Social and economic factors	Northland has one of the most deprived populations of all DHBs.	Collaboration with govt and local body agencies to address the social and economic factors underlying deprivation. Target services to high-need populations.
Financial pressures	Tight financial environment for the foreseeable future; no real increases in NDHB funding for new services. Meet ever-increasing demands while managing expectations of both providers and the community.	Development of a rigorous, evidence-based prioritisation tool to reallocate resources within NDHB contracts.
Regionalisation	Difficulty in making the Northland case heard since we are one small, rural part of the Northern Region's largely urban population.	Relationships already developed with Northern Region DHBs are being strengthened. The three Auckland DHBs are increasingly willing to address better access, coverage and fairness across the whole Northland-Auckland population.
Workforce	The health sector has difficulties obtaining the right numbers and skill types in certain professional groups. Northland has additional problems in attracting and retaining staff, especially in rural areas.	Northland's climatic and environmental attractions are useful marketing tools. Continue to explore innovative "grow our own" solutions to workforce issues (such as Pukawakawa ⁴ , scholarships in oral health and Maori health).
New models of care	Introducing new ways of organising services could be interpreted as upheaval and a potential threat by some in the health sector. National structural barriers, such as employment law and agreements, that restrict flexibility of workforce practices.	Most Northland service providers have expressed a willingness to address new ways of working and to break down the "silos" in which health services tend to operate. Service structures, workforce practices, contracts, info flows and methods of practice can be changed to smooth patient flows, improve information flows, strengthen monitoring capabilities, enhance clinical leadership, use resources more productively and improve health outcomes. Consideration of new models of care should

³ Available on our website <http://www.northlanddhb.org.nz/>.

⁴ An arrangement under which a group of fifth year medical students from Auckland Medical School work in Northland as part of their training.

Factor	Risks	Opportunities
		<p>precede capacity planning, thus potentially reducing demand for capital funding.</p> <p>Continue involvement in and submissions to national processes that influence work practices.</p>
Information systems	<p>Inadequately developed and often incompatible systems that restrict the flow of quality and timely info across the health sector.</p> <p>Major investments are needed to remedy this. Local changes are difficult to pursue until national decisions are made on the structure and type of info systems.</p> <p>Even once decisions have been made, it will be several years before benefits are fully realised.</p>	<p>Longer term, a patient-centred system with data accessible from any point (service provider, geographical location).</p> <p>A major contributor to the benefits described under new models of care above.</p> <p>Limited gains are still possible with current systems.</p>
Inter-District Flows (IDFs)	<p>Over a quarter of the Funder's expenditure goes on IDFs, money we pay to other DHBs, mainly Auckland, for specialised (tertiary) services provided to Northlanders that are not available here. A major risk to the DHB, mainly because:</p> <ul style="list-style-type: none"> • referral is based on clinical need and therefore difficult to predict and control • for inpatient services (half of all IDFs), each patient treated is paid for at a nationally-agreed price, and demand for these services has been growing much faster than growth in NDHB's population and funding. 	<p>Maximising the number of patients treated in Northland by:</p> <ul style="list-style-type: none"> • maintaining and increasing the skill levels of NDHB's clinical staff • ensuring ready access to more specialised advice from tertiary providers • developing regional clinical protocols to specify when conditions should be referred. <p>Some thought has been given to increasing the range and complexity of services provided by NDHB, though setting up new services is expensive and complicated.</p>
Demand-driven contracts	<p>The majority of the Funder's expenditure is demand-based, paid for on a per-item basis (such as each drug prescribed on a pharmacy prescription, or each lab test undertaken). Volumes are driven by demand, so the Funder has limited control of them. We also have limited influence over the price per item because that is often determined nationally. There is no 'cap' on this spending.</p>	<p>Budgets for each new year are calculated based on historical expenditure and any known likely future impacts, though NDHB is still exposed to any unknown or unpredictable fluctuations.</p> <p>Continue to:</p> <ul style="list-style-type: none"> • monitor expenditure. • maintain effective working relationships with providers. • engage in regional and national activity on behalf of the NDHB.
Employment costs	<p>Workforce-related costs comprise at least three-quarters of NDHB's budgets. To a large extent we are at the mercy of nationally negotiated employment agreements. These are the single main driver of cost pressures for 2010/11 because several major employment contracts have been or are due to be renegotiated during 2010 and the first half of 2011 .</p>	<p>Continued and innovative attention to efficiencies, strict budget monitoring practices and close controls over workforce-related costs such as annual leave and use of locums.</p>

3 What we do and why we do it

This section describes the requirements put upon DHBs at national level by the Minister of Health and the Ministry of Health, and how Northland DHB is structured and functions.

3.1 Health sector requirements

While complying with the Public Health and Disability Act 2000, DHBs also have to meet requirements set by the Ministry of Health and the Minister of Health.

Graphic 3 Health sector requirements

Requirement	Explanation	Produced by	Frequency
Operational Policy Framework	"A set of business rules as well as policy and guideline principles that outline the operating functions of DHBs" – essentially how DHBs should carry out their functions.	Ministry of Health	Ongoing, updated annually during the early stages of each planning round.
Service Coverage Schedule	A policy document that describes what types of services that DHBs must ensure are provided.	Ministry of Health	Ongoing, updated annually during the early stages of each planning round.
National priorities and strategies	Strategic-level expressions of national health priorities and approaches for dealing with them (examples include the <i>Primary Health Care Strategy</i> and the Maori health strategy <i>He Korowai Oranga</i>).	Ministry of Health	Various dates, updated every few years.
Minister's Letter of Expectations	Describes the Minister's priorities for DHBs for the coming year.	Minister of Health	Annually, during the early stages of each planning round.

The priorities for DHBs that the Minister of Health has set out in his Letter of Expectations for 2010/11 are:

- remain within budget
- reprioritise capital spending to minimise external debt
- continuing to increase elective surgical volumes
- improve emergency department waiting times
- improve cancer treatment waiting times
- work with PHOs to advance primary care initiatives
- reduce the number of PHOs
- demonstrate clinical leadership
- demonstrate regional collaboration
- address new ways of procurement
- address quality and safety.

3.2 Monitoring by the Ministry of Health and Audit NZ

Northland DHB is required to report on non-financial performance in various ways, as described in the following table.

Type of report	Audience	Frequency	Explanation
Health Targets	Minister (via Ministry of Health)	Quarterly	Measures are set by Minister via MoH, and targets either set nationally or negotiated with DHBs. They cover six areas: diabetes and cardiovascular disease, cancer, immunisation, elective services, emergency department waiting times. Described in more detail in our District Annual Plan.
Other quarterly reporting measures	Ministry of Health	Quarterly	Measures are set by MoH and targets either set nationally or negotiated with DHBs. The second tier of measures below Health Targets that cover hospital performance, population health and funding allocation. Described in more detail in our District Annual Plan.
Additional reports	Ministry of Health	Quarterly	Reports 'additional' to the specific measures in the Health Targets and IDPs. They cover such things as new funding and contracts which arise during the year ("variations to the Crown Funding Agreement"), on which DHBs must report progress.
Statement of Service Performance (SSP)	Audit NZ, as an agent for the Office of the Auditor General	Annually	The measures and targets in sections 4.2 to 4.5 of the SOI. The SSP is also published in our Annual Report.

In addition to the regular reporting outlined below, we will consult with the Minister via the Ministry of Health on any significant developments or [service changes](#) not covered in this plan. Any proposed departures from the content of our 2010–11 District Annual Plan will undergo public consultation.

3.2 Northland DHB's outcomes

Section 141 of the Crown Entities Act requires that SOIs should contain information on "the specific impacts, outcomes, or objectives that the entity seeks to achieve or contribute to and, if the entity is directed to give effect to or have regard to government policy directions, how those objectives might relate to any outcomes or objectives referred to in the direction".

Northland DHB's response has been to develop a monitoring framework (explained in more detail at the start of section 4 and described in full in Appendix 5). Its highest-level ingredients – the vision, high-level outcomes and outcomes – are consistent with Ministerial and Ministry priorities, as described in Graphic 4.

Graphic 4 NDHB's outcomes and their relationship to health sector priorities

NDHB framework		Ministerial / govt reference ⁵	MoH reference
Vision	Whanau Ora – full participation in society	Part of the Government's current policy implementation schedule.	MoH SOI 2009-12 priority outcome: Achieving Whanau Ora.
High level outcomes	Improved health and disability status Improved equity	Govt goal: All NZers lead longer, healthier and more independent lives.	MoH SOI 2009-12 priority outcome: Every dollar is spent in the best way to improve health outcomes.

⁵ HT = Health Target; LoE = Letter of Expectations to DHBs 9 Feb 2010.

NDHB framework		Ministerial / govt reference ⁵	MoH reference
Outcomes	Improved wellness	Govt goal: All NZers lead longer, healthier and more independent lives.	MoH SOI 2009-12 priority outcome: Every dollar is spent in the best way to improve health outcomes. MoH SOI 2009-12 priority outcome: Whanau ora – Maori families are supported to achieve their maximum health and wellbeing.
	Independence for those with impairments	Govt goal: All NZers lead longer, healthier and more independent lives.	
	Prevention of illness and disease	HT: increased immunisation. LoE: work with PHOs to advance primary care initiatives.	MoH SOI 2009-12 priority outcome: Every dollar is spent in the best way to improve health outcomes. MoH SOI 2009-12 priority outcome: Whanau ora – Maori families are supported to achieve their maximum health and wellbeing.
	Cure of acute illness and disease	LoE: Better, sooner, more convenient services. Work with PHOs to advance primary care initiatives.	MoH SOI 2009-12 priority outcome: Faster access to high quality hospital services delivered locally in the community and in primary care.
	Minimal impacts for those with long term conditions	HT: better help for smokers to quit. HT: better diabetes and CVD services. LoE: work with PHOs to advance primary care initiatives.	National Health Committee report: <i>Meeting the needs of people with chronic conditions</i> and numerous MoH reports and strategies.

3.4 Structure and function of Northland DHB

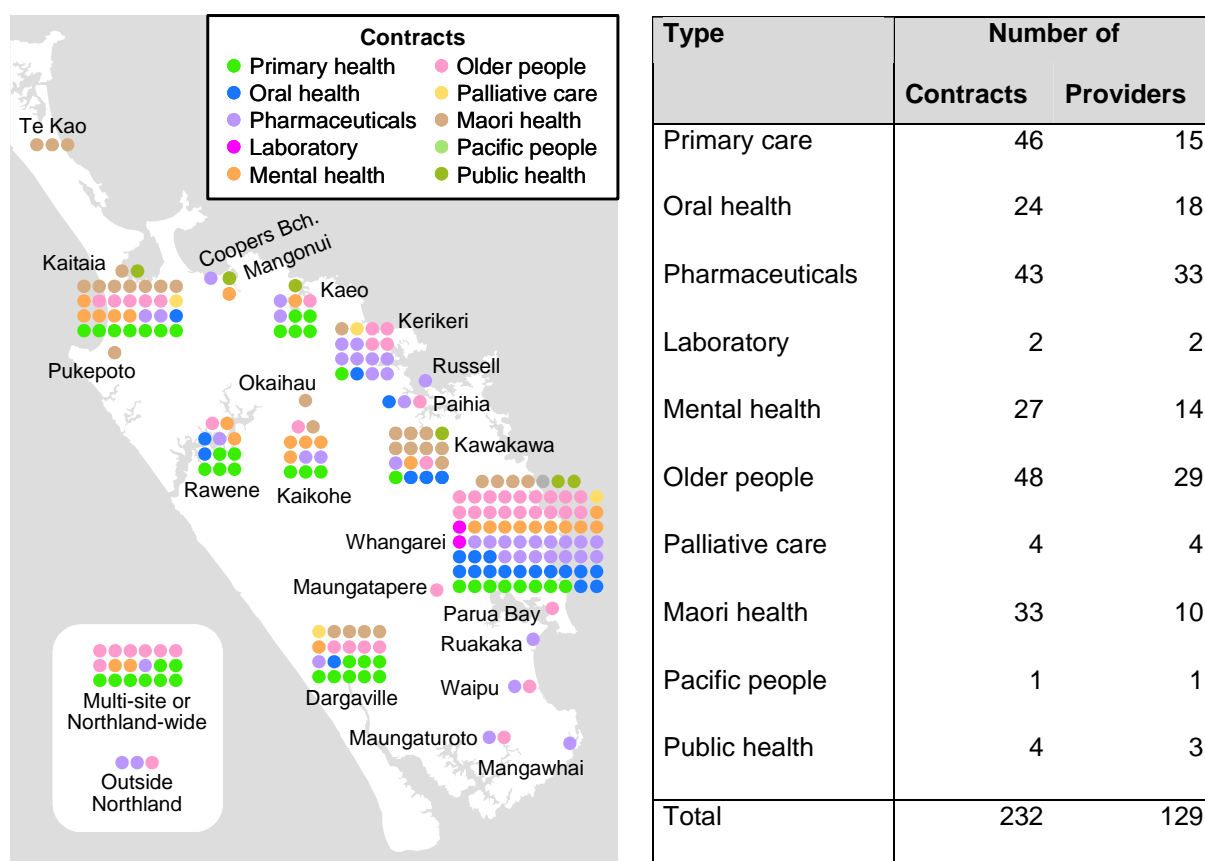
Northland DHB has two distinct parts, Funder and Provider. Provider staff comprise more than 99% of the organisation's total.

3.4.1 NDHB Funder functions

The DHB Funder has both funding and planning functions.

The **funding function** involves working with Northland's 129 NGOs, for whose performance Northland DHB is responsible. Funder staff build relationships with NGOs, negotiate 232 contracts with them, ensure they are paid, and monitor their progress. The NGOs provide many different types of services across the whole of Northland (Graphic 5).

Graphic 5 NGO providers and contracts, Feb 2010



The **planning function** tries to influence the way health services are organised and delivered to better meet the needs of the population. Needs are assessed at a population-wide level, and plans developed with involvement from across the health sector to explore how improvements can be made. An important part of the planning role is prioritisation: assessing how well the current distribution of resources meets needs, and whether this distribution needs to be changed.

The Funder fulfils both external and internal planning and monitoring requirements, as described in Graphic 6.

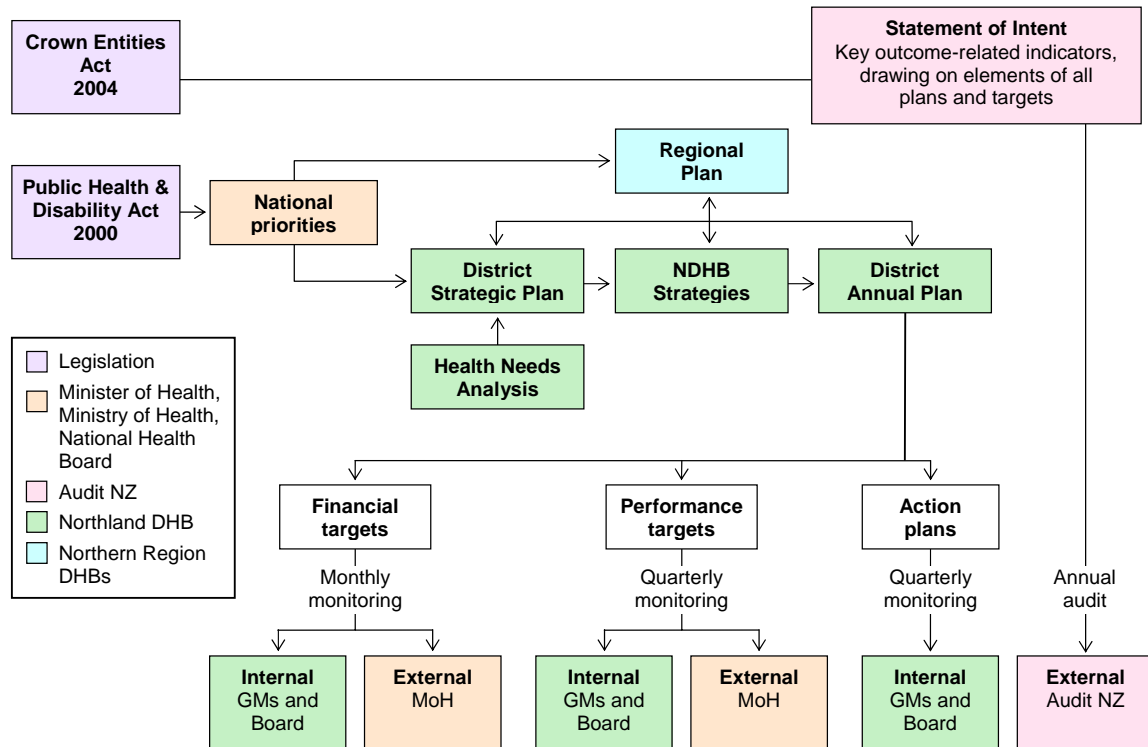
Externally, the Funder:

- produces the planning documents required by legislation (DSP, DAP and SOI)
- produces, in conjunction with the other three Northern Region DHBs, the Regional Plan

- supplies quarterly performance reports (Health Targets and other measures)
- contributes to monthly reporting requirements for financial performance
- produces the Statement of Intent on which we are audited by Audit NZ.

Internal monitoring to both the Board and senior management is also important. The Funder contributes to financial reports, and produces quarterly reports on indicators of performance and progress on the District Annual Plan's plans and actions. The Funder also coordinates the development of our strategies, internal NDHB planning documents of which there are ten so far for our various priorities (diabetes, child and youth health etc).

Graphic 6 DHB planning and monitoring framework, national and local



3.4.2 NDHB Provider functions

The DHB Provider comprises:

- hospital services
- population health, primary and community services provided by Child, Youth, Maternal, Public and Dental Services.

As described in the following table the Provider arm's services fall into four Output Classes (major groupings of services, further described in [4.1.3 Output Classes](#) and defined in [Appendix 4 Definitions of Output Classes](#)).

Graphic 7 Services provided by the Northland DHB Provider

Output Class	Services provided by Northland DHB
Public and population health services	Health promotion and health protection services provided by the Child, Youth, Maternal, Public and Dental Services arm of the DHB.
Primary and community services	Dental services, home healthcare services and well child and youth services provided by the Child, Youth, Maternal, Public and Dental Services arm of the DHB.

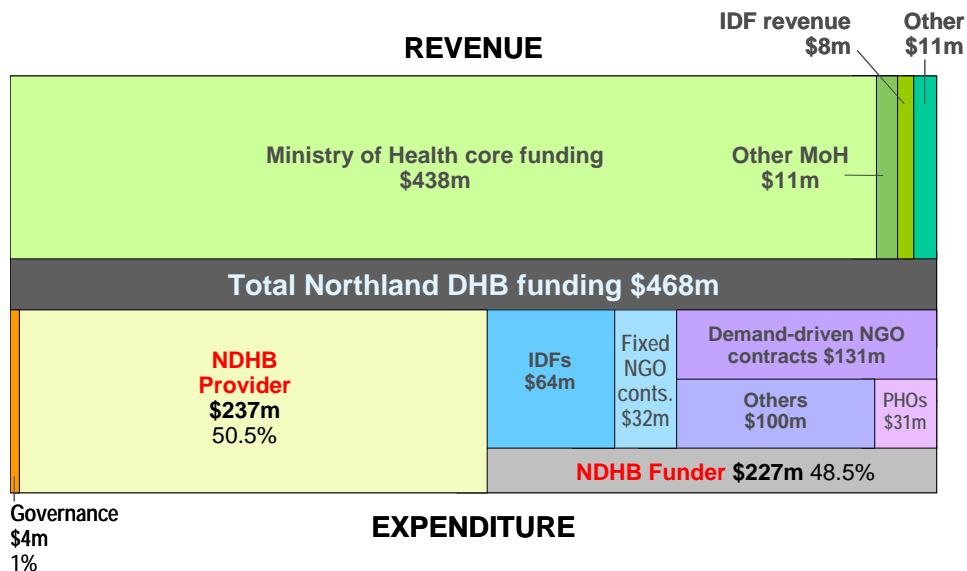
Output Class	Services provided by Northland DHB
Hospital services	<p>The main hospital at Whangarei, and smaller hospitals in Kaitaia, Kawakawa and Dargaville.</p> <p>Inpatient beds, outpatient clinics and day services across medical, surgical, child health and maternity services. Within these services there are a variety of specialties (medical specialties such as cardiac rehab, surgical specialities such as orthopaedics etc) and special units (Diabetes Service, the Special Care Baby Unit etc). Surgical services provide operations through theatre complexes in Whangarei and Kaitaia.</p> <p>Emergency departments exist at all hospital sites.</p> <p>Mental health, and alcohol and other drug services provide a full range of inpatient and community support services covering the needs of child and youth, adults, older people, and incorporating Maori mental health.</p>
Support Services	Needs Assessment and Service Coordination.

3.4.3 Funding allocation and controls

Northland DHB receives funding for all health service providers in Northland paid from the public purse (except for a few national contracts held by MoH with organisations such as Plunket and St John). Just over half of total funding goes to the NDHB Provider, and just under half to the Funder (Graphic 8).

Most of the Funder's allocation is spent on contracts with NGOs, but over a quarter goes to Inter-District Flows (IDFs), money we pay to other DHBs, mainly Auckland, for specialised (tertiary) services provided to Northlanders that are not available here. The level and type of these services, and therefore IDF expenditure, is a major risk for the DHB ([2.3 Operating environment](#)).

Graphic 8 Where funding comes from, where it goes, 2009/10



Of the non-IDF funding overseen by the Funder, over half (\$131m) is devoted to demand-driven contracts. These are typically paid on a fee-for-service basis for services such as GP visits, pharmaceuticals, lab tests and so on. Because the level of expenditure cannot be accurately predicted or controlled, these also represent a major risk for the Funder ([2.3 Operating environment](#)).

Information on how Northland DHB manages its finances is in [5.5 Management of finances and assets](#).

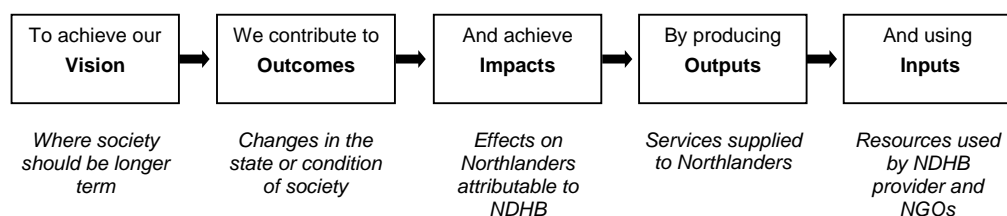
4 Statement of Service Performance (SSP)

4.1 Intervention logic framework

4.1.1 Intervention logic

Section 141 of the Crown Entities Act stipulates that an SOI must contain information on “the specific impacts, outcomes, or objectives that the entity seeks to achieve or contribute to”. Northland DHB has embodied these requirements in our Intervention Logic framework, summarised in Graphic 9. The full framework, the basis for the Statement of Service Performance, is in [Appendix 5](#).

Graphic 9 Northland DHB's Intervention Logic



4.1.2 The framework

The logic has been used to develop a framework that encapsulates the key things we should be “getting right” in making progress towards our Outcomes and Vision.

The framework’s Vision and Outcomes and their fit with Ministerial and Ministry priorities were described in [3.2 NDHB's outcomes](#).

How the Impacts relate to the Output Classes is described in Graphic 10 over the page.

Detail beyond the Impacts level – the Impact Measures, Outputs and Output Measures – is further developed in sections 4.2 to 4.5. Section 4.6 describes the reasoning behind NDHB’s choice of Impacts and how the Outputs contribute to them.

The role of NDHB’s organisational capability (workforce, information systems, quality processes, information services, management and leadership, collaboration) is described in [5 Organisational capability](#).

The framework is broadly consistent with Northland DHB’s District Strategic Plan in that it addresses big-picture priorities that are still current, such as long term conditions and Maori health. However the health environment has changed considerably since then (for example, there is a renewed focus on clinical priorities and new models of care), so the DSP, last published in 2005, is in need of revision. Northland DHB will produce a new DSP in 2011⁶.

⁶ Legislation requires the DSP to be redone every three years, but Northland was twice given licence, along with other DHBs, to delay its revision. Our previous DSP was signed off in May 2006, so May 2011 becomes the new target date.

Graphic 10 Intervention Logic Framework: how Impacts fit with Output Classes

Vision	Outcomes	Impacts	Output Class				
			Public & population services	Primary & cmtly. services	Hospital services	Support services	
Whanau Ora – full participation in society	Improved wellness Independence for those with impairments Prevention of illness and disease Cure of acute illness and disease Minimal impacts for those with long term conditions	<i>Tobacco</i> Healthier population with lower prevalence of smoking-related conditions.	✓	✓	✓		
		<i>Healthy children</i> Reduced likelihood of acquiring long term conditions later in life. Lower incidence of communicable disease. Healthier teeth and gums. Safer children.	✓ ✓	✓			
		<i>Diabetes and CVD</i> Amelioration of symptoms and/or delay in their onset.		✓			
		<i>Cancer</i> For curable cancers, increased likelihood of survival. For incurable cancers, reduced severity of disease symptoms.		✓ ✓	✓ ✓		
		<i>Mental disorders</i> Improved quality of life for both clients and their families. Acute episodes are minimised, clients achieve greater stability in their condition		✓ ✓	✓ ✓		
		<i>Elective surgery</i> Fewer debilitating conditions. Delayed onset of long term conditions.		✓ ✓	✓ ✓		
		<i>ED waiting times</i> More timely assessment, referral and treatment.				✓	
		<i>Quality</i> Patients who are more satisfied with their care. Fewer adverse clinical events resulting from patient care. People receive quality services from NGOs.				✓	
		<i>Support for older people</i> Older people requiring support or care receive services appropriate to their needs.					✓

4.1.3 Output Classes

Section 142 of the Crown Entities Act requires that the SSP “must describe the classes of outputs the Crown entity proposes to supply” as well as requiring measures of performance to be grouped in this way.

National agreement has been reached in the health sector on dividing all DHB services into four Output Classes:

- public and population health services
- primary and community services
- hospital services
- support services.

The Output Classes are defined in full in [Appendix 4 Definitions of Output Classes](#). Northland DHB's total inputs by Output Class are described in [6.1 Financial statements](#).

The Statement of Service Performance is structured by Output Class. Ideally each Output should be quantified as well, but information is not yet sufficiently developed for this to occur with rigour. Resource utilisation data relating to the Northland DHB Provider's activities is in reasonable shape, but is limited for NGOs because there is not enough detail available through the contracting mechanisms we have with them. Northland DHB will work on improving resource utilisation data for both our provider and NGOs, with a view to improving the picture of outputs in next year's SOI.

4.1.5 Main Measures

Northland DHB's Main Measures (of those in the Statement of Service Performance, the ones that are *most* important to us) are:

<i>Tobacco</i>	Proportion of young people who never start smoking.
<i>Healthy children</i>	Immunisation rates among two-year-olds.
<i>Diabetes and CVD</i>	Diabetics receiving annual free checks (AFCs) in primary care.
<i>Cancer</i>	For breast cancer, cervical cancer and major cancers, new cases, survival rates and deaths.

The Main Measures are highlighted in the full SSP framework in Appendix 4.

4.1.5 Time trends and benchmarking

Northland DHB is aware of the requirement for SOIs to describe the progress a Crown Entity is making on its performance measures. We can achieve this in two ways: analysing our own performance over time and benchmarking against other DHBs.

Time trends The tables in sections 4.2 to 4.5 contain time trend graphs for the measures for which data is readily available.

For the other measures, there were three main reasons why it is not yet possible to obtain data:

- some of those derived from the standard MoH quarterly indicators do not have comparable historical data, either because the measures are new and no baseline data exists yet, or the measurement criteria have been changed over time
- information is derived from the NGO sector (mainly primary care providers), where systems to collect performance data are still in the developmental stage
- data exists but there are no systems in place yet to collect it, or extraction would involve considerable work and could not be achieved within this SOI's

timeframe

Issues relating to time trend data are explained in the last column of the tables.

Benchmarking Most of the standard indicators on which DHBs report quarterly to the Ministry of Health are not routinely available for all DHBs.

Northland DHB is a member of the Health Roundtable in which member DHBs share information on performance and quality, but the tie-up between this data and the measures in the SOI is limited.

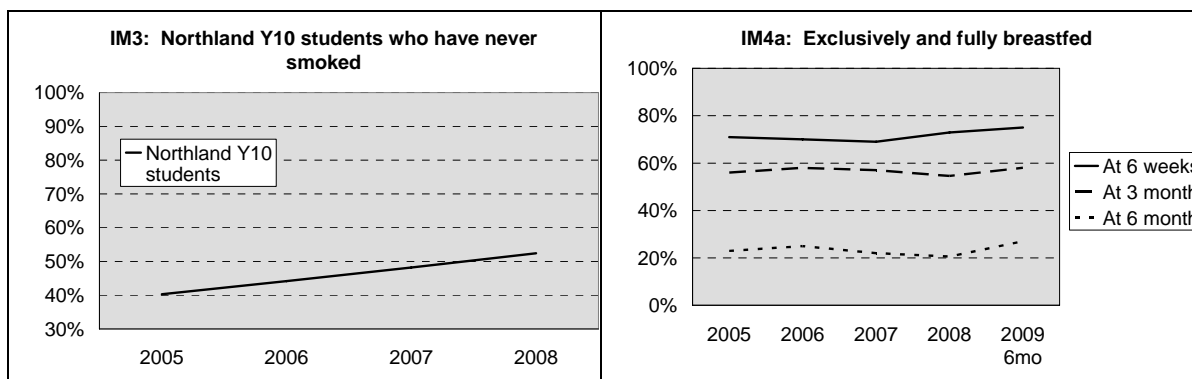
In future SOIs, Northland DHB will increase the number of measures on which time trends and benchmarking are possible.

4.2 Output Class 1: Public health services

Impacts	Impact Measures	Outputs	Output Measures	Baseline	Targets		
					2010/11	2011/12	2012/13
Tobacco: Healthier population with lower prevalence of smoking-related conditions.	1 Proportion of Year 10 students who have never smoked.	Health promotion programmes (Smokefree/ Auahi Kore).	1 Health promotion programmes in schools.	52.4% (2008 ASH Y10 survey)	53%	54%	55%
Healthy children: Reduced likelihood of acquiring long term conditions later in life. Lower incidence of communicable disease.	2a Infants exclusively and fully breastfed.	Midwifery services. Primary care services performing immunisations.	2a Support provided to mothers to breastfeed.	At 6 wks 75% At 3 mths 58% At 6 mths 27% (Jan-Jun 2009) ⁸	74%	75%	78%
	2b Two-year-olds who are fully immunised.		2b Immunisations performed on two-year-olds.	Total 74% Maori 70% Pacific 70% Euro 80% (2009/10 Q2)	87% ⁹	95%	¹⁰ 95%

Trends

Historical trend graphs have been provided where data makes this possible.

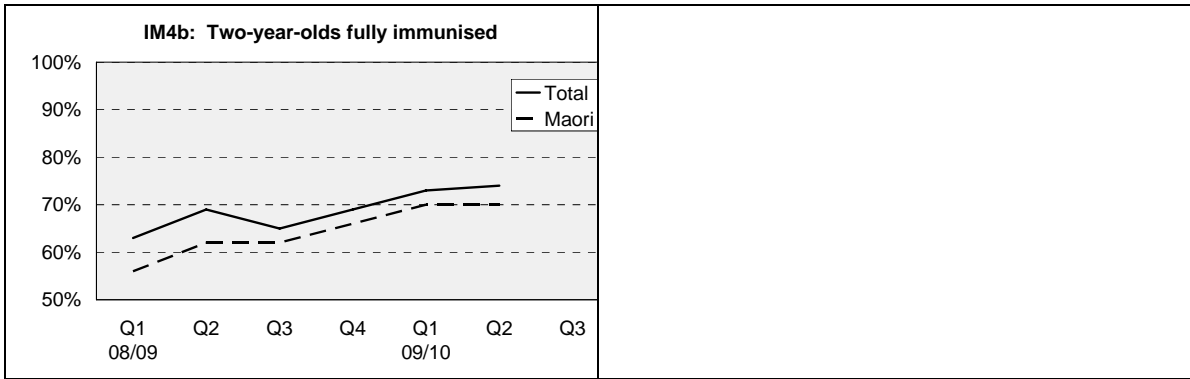


⁷ Youth smoking is addressed by other organisations (MoH media campaigns, Cancer Society etc) which NDHB supports through our work in schools.

⁸ This data is from Plunket services only. Others, such as Tamariki Ora (Maori well child) services, also collect breastfeeding data but it is not yet part of the national collection system.

⁹ 87% is the contribution NDHB will make towards the Northern Region (Auckland plus Northland) overall target of 90%, as agreed with MoH.

¹⁰ 95% is the long-term national target and the maximum realistically possible. At that rate of coverage populations achieve 'herd immunity', meaning that the likelihood of disease occurring is so minimal that the small group of unimmunised people are effectively protected as well.



4.3 Output Class 2: Primary and community services

Graphic 12 Primary and Community Services Output Class measures

Impacts	Impact Measures	Outputs	Output Measures	Baseline	Targets		
					2010/11	2011/12	2012/13
Tobacco: Healthier population with lower prevalence of smoking-related conditions.	3a Proportion of the population who smoke. 3b Proportion of smokers trying to quit.	Support provided to smokers in primary care to quit.	3 Percent of smokers in primary care provided with support to quit.	Due to be reported from July 2010, so baseline data will be collected during 2010/11.	80%	85%	90%
Healthy children: Healthier teeth and gums.	4a Five-year-olds who are caries-free.	Oral health assessment and treatment procedures.	4a Oral health assessment and treatment provided to five-year-olds.	Total 39.2% Maori 14.5% Other 56.7% (2008/09 Q3)	43% 20% 60%	43% 20% 60%	43% 20% 60%
	4b Average number of decayed, missing or filled teeth in Year 8s.		4b Oral health assessment and treatment provided to Year 8s.	Total 3.56 Maori 5.76 Other 1.91 (Q3 2008/09)	1.75 2.50 1.15	2.40 3.06 1.38	2.40 3.06 1.38
Diabetes and CVD: Amelioration of disease symptoms and/or delay in their onset.	5a Diabetics receiving annual free checks in primary care.	Risk assessments in primary care (annual free checks, blood tests, risk profiles).	5a Of those estimated to have diabetes, percent who have had annual free checks.	Total 60% Maori 60% Pacific 60% Other 60%	60% 60% 60% 60%	63% 63% 63% 63%	66% 66% 66% 66%
	5b Diabetics receiving annual free checks who have good blood sugar management.		Laboratory tests.	5b Laboratory tests for people with diabetes.	Total 76% Maori 70% Pacific 50% Other 80%	76% 70% 50% 80%	79% 73% 53% 83%
	5c Reduced incidence and prevalence of heart disease.		5c Of people in eligible populations ¹¹ , those who have had a CVD risk assessment in the last 5 years.	Total 76.3% Maori 69.3% Other 79.2% (2009/10 Q2)	¹² 77% 70% 80%	n/a	n/a
Cancer: For curable cancers, increased likelihood of survival.	6 For breast cancer, cervical cancer and major cancers: • new cases • survival rates	Cancer risk assessments in primary care. Screening for breast and	6a Targets for breast cancer screening in eligible populations.	Total 71.1% Maori 65.6% Other 67.5% For women aged 50-69, 2007/08 and 2008/09. ¹³	¹⁴ 70% 70% 70%	70% 70% 70%	70% 70% 70%

¹¹ Maori, Pacific, Indian subcontinent: men aged 35-79, women aged 45-79; European and other: men aged 45-79, women aged 55-79.

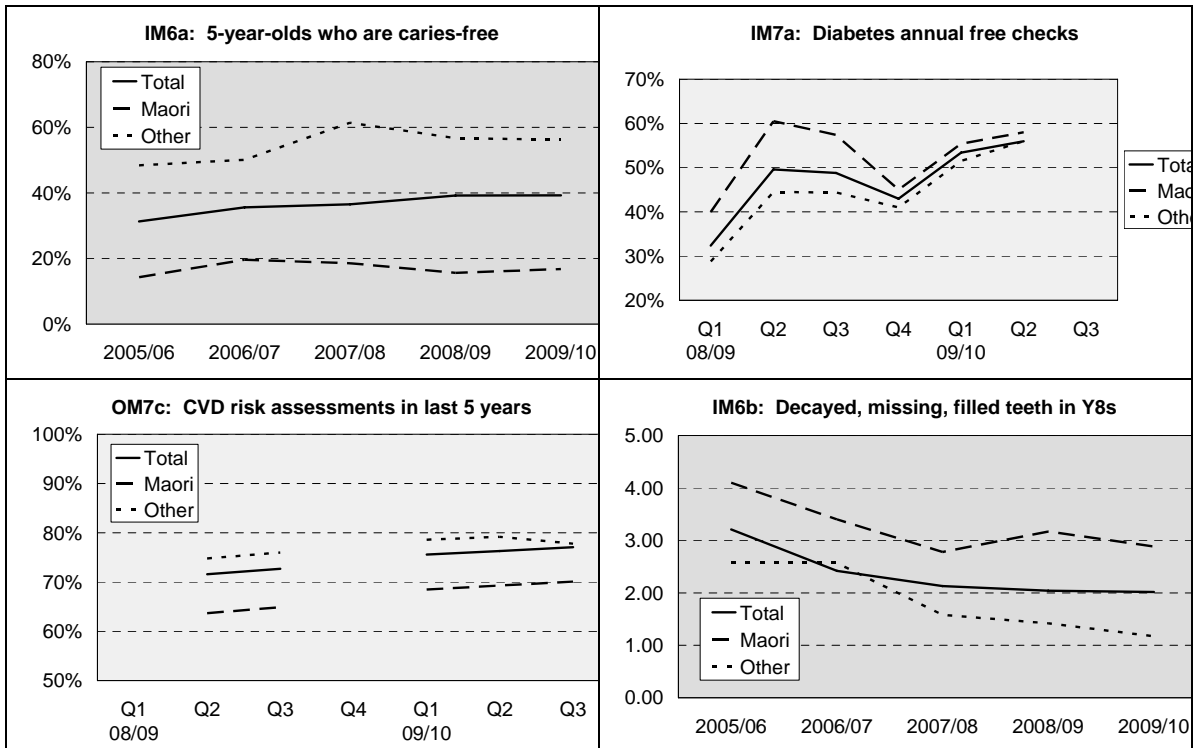
¹² The projected percentages are based on data held by MoH and are NDHB's best estimates of our projected performance. NDHB's projected performance shows only a slight increase because we have been consistently ahead of our targets up till now. The current measure (for tests on levels of lipids and glucose in the blood) is interim only and will be phased out after 2010/11, so projected targets are given only up till then. By 2011/12 systems will be set up nationally to record full CVD assessments; that year will be used to gather proper baseline data.

¹³ Targets do not include women aged 40-59 screened by NDHB, as there is insufficient international data from which to derive targets for this age group.

Impacts	Impact Measures	Outputs	Output Measures	Baseline	Targets		
					2010/11	2011/12	2012/13
For incurable cancers, reduced severity of symptoms.	• deaths.	cervical cancers.	6b Targets for cervical cancer screening in eligible populations.	289	295	301	307
Mental disorders: Improved quality of life for both clients and their families. Acute episodes are minimised, clients achieve greater stability in their condition.	9 The number of new active cases requiring intervention by specialist staff.	Care provided in a primary care setting for people with mild to moderate disorders whose condition is stable.	7 Number of referrals from GPs to Primary Mental Health Initiative Coordinators. ¹⁵	1,916	2,016	2,116	2,200

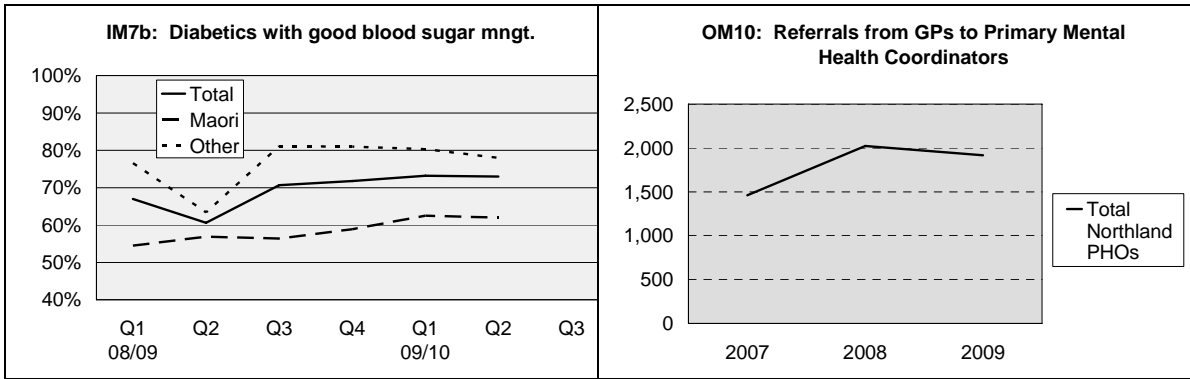
Trends

Historical trend graphs have been provided where data makes this possible.



¹⁴ 70% is the national target. There are no plans to increase it beyond this level.

¹⁵ Other useful measures exist, including the number of comprehensive assessments completed, and scores from GHQ12 (a primary care screening tool to detect the presence and severity of mild to moderate mental disorders). However this data is not reported consistently across providers, so NDHB will work on standardising this during 2010/11.



4.4 Output Class 3: Hospital services

Graphic 13 Hospital Services Output Class measures

Impacts	Impact Measures	Outputs	Output Measures	Baseline	Targets			
					2010/11	2011/12	2012/13	
Tobacco: Healthier population with lower prevalence of smoking-related conditions.	3a Proportion of the population who smoke.	Support for smokers in hospital to quit.	8a Percent of smokers admitted to hospital provided with support to quit.	Total (Q3 2009/10)	3	90%	95%	95% ¹⁶
	3b Proportion of smokers trying to quit. 7 Proportion of pregnant women who smoke.	Support for pregnant smokers to quit.	8b Percent of pregnant women provided with support to quit.	Total	¹⁷ 6	90%	95%	95%
Healthy children: Safer children	8 Referrals to CYFS of children suspected of being abused.	NDHB Child Protection services. Referrals to CYFS.	9a Referrals to CYFS of children suspected of being abused.	116 (Total 2009)	130	140	150	
			9b AUT Family Violence Audit score (out of 200). ¹⁸	1232 (2009 score)	140	150	160	
Cancer: For curable cancers, increased likelihood of survival. For incurable cancers, reduced severity of disease symptoms.	6 For breast cancer, cervical cancer and major cancers: • new cases • survival rates • deaths.	Provision of radiation therapy, chemotherapy.	10a People diagnosed with cancer who receive radiation treatment within 6 weeks (till Q1 2010/11) or 4 weeks (from Q2 2010/11).	6 weeks 10 4 weeks 10 (2009/10 Q2)	100%	100%	100%	
			10b People diagnosed with cancer who receive chemotherapy within 6 weeks.	6 weeks 9	100%	100%	100%	
Mental disorders: Improved quality of life for both clients and their families. Acute episodes are minimised, clients	9 The number of new active cases requiring intervention by specialist staff	Specialised clinical support by NDHB community mental health services. Admission to hospital for those whose condition is unstable.	11 Clients with severe mental illnesses who are seen over a year ¹⁷ (Baseline data is the average of 2009/10 Q1 & Q2.)	Ages 0-19:				
				Total	2.1	2.28%	2.15%	2.20%
				Maori	2.1	2.18%	2.15%	2.20%
				Ages 20-64:				
				Total	3.7	3.86%	3.80%	3.85%
				Maori	5.5	5.69%	5.55%	5.60%
				Other	3.0	3.14%	3.10%	3.15%
				Ages 65+:				
				Total	1.5	1.52%	1.55%	1.60%
				Maori	1.2	1.52%	1.53%	1.58%

¹⁶ Current national targets for provision of quit smoking advice only go as far as June 2012. This target assumes the June 2012 will be retained for the following year.

¹⁷ Baseline data is the May 2010 rate of provision of quit smoking advice in NDHB's maternity service.

¹⁸ An annual assessment of the state of NDHB's family violence services is performed through an audit by the Auckland University of Technology.

Impacts	Impact Measures	Outputs	Output Measures	Baseline	Targets		
					2010/11	2011/12	2012/13
achieve greater stability in their condition.				Other 1.5	1.52%	1.55%	1.60%
Elective surgery: Fewer debilitating conditions. Delayed onset of long term conditions.	10 Improvements in quality of life among patients receiving elective surgery.	Rate of provision of elective surgical procedures .	12 Rate of provision of elective procedures per 100,000 population, by selected specialties.	All 5,746 Hips 189 Knees 189 Cataracts 474 CABG ¹⁹ 42 Cardiac PR ²⁰ 74 (2009/10 forecast ²¹)	6,024 189 189 474 42 74	²² 6,224 190 190 477 57 99	6,424 191 191 480 57 99
Emergency Dept waiting times: More timely assessment, referral and treatment.	11 Waiting times in Emergency Departments.	Assessments, treatments and referrals performed in EDs.	13 Patients with an ED length of stay ²³ of less than 6 hours.	82% (2009/10 Q2)	95%	95%	95%
Quality: Patients who are more satisfied with their care. Fewer adverse clinical events resulting from patient care. People receive quality services from NGOs.	Measures of the quality and safety of services: 12a Satisfaction and complaints. 12b Readmissions to hospital. 12c Clinical measures of quality. 12d Compliance with contracts.	NDHB Provider services (described more fully in 5.2 Quality and safety).	14a Percent of patients surveyed who are 'satisfied' or 'very satisfied'. 14b Number of complaints to NDHB per patient contact 14c Complaints to NDHB closed within 20 working days 14d Health and Disability Commission complaints that result in a finding of breach of the Code.	88%	89%	90%	91%
				0.16%	0.15%	0.14%	0.13%
				70%	72%	74%	76%
				1	0	0	0

¹⁹ Coronary artery bypass graft. Arteries or veins from elsewhere in the patient's body are grafted to the heart's arteries to bypass narrowings and improve the blood supply to the heart muscle.

²⁰ Cardiac percutaneous revascularisation. A procedure used to improve blood flow by widening a narrowed coronary artery. A special balloon is passed along the artery to the narrowed part, then inflated. Also often inserted at the same time is a stent, a metal mesh or coiled tube that acts as a scaffold to keep the artery open.

²¹ Forecast performance levels in 2009/10, which in some cases are exceeding future targets.

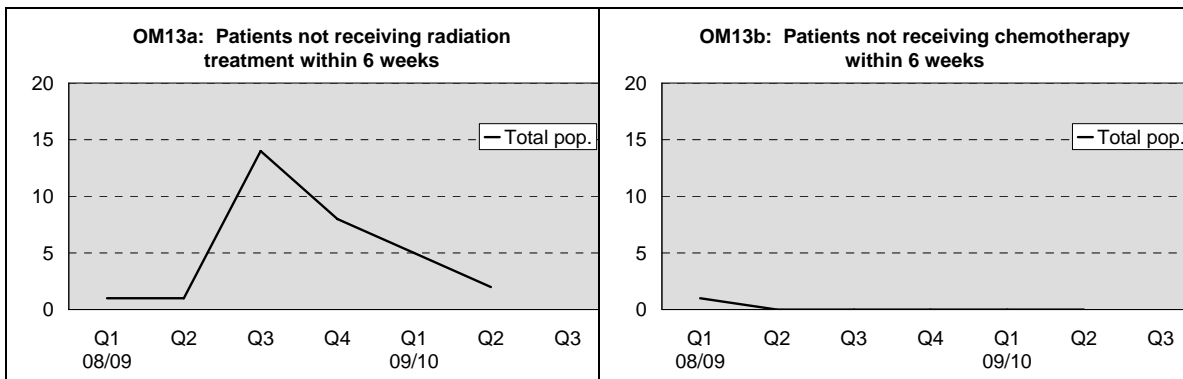
²² The targets in this table for 2011/12 and 2012/13 are based on a number of assumptions: (a) MoH will continue to want an annual national growth in elective surgery of 2,000 discharges; (b) in 2011/12 and 2012/13 MoH will continue to want NDHB to accelerate our rate of growth in electives to catch up with the ever-increasing national average rates for procedures in which we are behind; (c) MoH will want to see this growth include increases relating to population projections.

²³ ED length of stay is defined as the time from presentation to admission, discharge or transfer.

Impacts	Impact Measures	Outputs	Output Measures	Baseline	Targets		
					2010/11	2011/12	2012/13
			14e Readmission rates.	New measure being introduced in 2010/11. ²⁴	Achieve or remain lower than the national average rate. If higher than it, improve by 25% of the difference each quarter.		
			14f Surgical site infections.	<2%	²⁵ <2%	<2%	<2%
			14g Hand hygiene compliance.	60%	65%	70%	75%

Trends

Historical trend graphs have been provided where data makes this possible.



²⁴ Raw data on readmissions is available, but won't compare with the national measure being introduced in 2010/11. This compares each DHB's rate with the national rate, and there is no historical data on this.

²⁵ Less than 2% is recognised as the "gold standard" for this indicator. NDHB's rate has been consistently under this for some time.

4.5 Output Class 4: Support services

Graphic 14 Support Services Output Class measures

Impacts	Impact Measures	Outputs	Output Measures	Baseline	Targets		
					2010/11	2011/12	2012/13
Support for older people: Older people requiring support or care receive services appropriate to their needs.	13a Change in distribution of home based support services towards older people with higher support needs.	Home based support services provided by NGOs. Residential care provided by NGOs. Assessments by NDHB's NASC ²⁶ service.	15a Reduced proportion of people receiving low-level home based support services.	83.0 (Sep 2008-Aug 2009)	83.5	84	²⁷ 84

²⁶ Needs Assessment and Service Coordination. an organisation contracted by the Ministry of Health or a DHB to:
(a) determine a person's eligibility and need for publicly funded disability support services (needs assessment);
(b) allocate services which are then delivered by third party providers (service coordination).

²⁷ Target for this out-year has been set conservatively because it is difficult to predict the outcome of service trends, how soon they might have an impact, and what the ceiling age for entry might be.

4.6 Rationale behind Impacts and Outputs

Impact	Rationale	Contribution made by Outputs
<i>Tobacco</i>	<p>One of the most significant “lifestyle factors” behind long term conditions (see diabetes, CVD, cancer below).</p> <p>Tobacco smoking disproportionately affects Maori.</p> <p>Reducing the rate of smoking is one of the six national Health Targets.</p> <p>Smoking during pregnancy accounts for an estimated 20% of all pre-term births and 35% of low birthweight babies.</p>	<p>Reduction in tobacco smoking has a three-pronged approach:</p> <ul style="list-style-type: none"> • encouraging young people to never start (youth smoking rates continue to decline in Northland) • supporting adults who want to stop (research has shown persistence to be the key, because it takes an average of 14 attempts to give up before smokers are successful) • supporting pregnant women who smoke because of the harm smoking does to the fetus.
<i>Healthy children</i>	<p>Investment in the health of upcoming generations is an investment in the future health of Northlanders.</p> <p>A higher percentage of the child population is Maori, so improving child health will have a significant effect on improving the health of Maori.</p> <p>Higher rates of breastfeeding in infancy correlate with a lower chance later in life of developing ill health, including long term conditions.</p> <p>Breastfeeding rates are lower among Maori.</p> <p>Immunisations (one of the six national Health Targets) are one of the most cost-effective ways of improving health.</p> <p>Every child has the right to live in a safe, nurturing environment free from abuse and neglect.</p> <p>Northland has consistently had among the worst oral health statistics for children for many years.</p>	<p>NDHB has a Project Manager for child and youth health, who continues to support and develop responses to improve child health that are cross-sectoral (within health) and intersectoral (with agencies outside health).</p> <p>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).</p> <p>NDHB works with primary care providers (mostly GPs) to continue to improve the rate and timeliness of full immunisation for two-year-olds.</p> <p>The Family Violence service works to increase rates of identification and reporting throughout all NDHB’s services.</p> <p>A major restructure and expansion of NDHB’s oral health services is well on its way, accompanied by increased and improved treatment facilities and staffing numbers, and significant improvements in service performance (see 2.2.8 in Appendix 3).</p>
<i>Diabetes and CVD Cancer</i>	<p>Screening for diabetes and cardiovascular disease (CVD), and waiting times for cancer radiation therapy are two of the six national Health Targets.</p> <p>Together the three conditions account for about three-quarters of deaths and are major causes of illness and restricted functioning.</p> <p>They are “long term conditions” (LTCs), so called because once diagnosed, people usually have them for the rest of their lives.</p> <p>Prevalence of LTCs increases with age,</p>	<p>A three-pronged set of strategies is necessary:</p> <ul style="list-style-type: none"> • preventing LTCs (see above under obesity, tobacco, breastfeeding) • screening to pick up conditions as early as possible • effectively managing conditions once they have developed through an active partnership between clinicians and patients. <p>For cancer, some of the biggest gains are to be made in ensuring early access to treatment (both radiation therapy and chemotherapy) to improve the chances of recovery.</p> <p>NDHB has a Project Manager for LTCs, who is working with providers across the health sector to improve the detection and management of</p>

Impact	Rationale	Contribution made by Outputs
	so action now is imperative in the face of the ageing population.	conditions.
<i>Mental disorders</i>	<p>Mental health has been a priority for the health sector since the Blueprint²⁸ was published in 1998.</p> <p>Severe disorders permanently affect 3% of the population.</p> <p>Mild to moderate disorders affect 20% of the population at any one time and 90% over a lifetime.</p>	<p>Severe mental disorders and addictions require support and treatment by the specialised clinical workforce employed by NDHB.</p> <p>Mild to moderate disorders can be dealt with largely by primary care services, with support from specialised clinical services if conditions become unstable.</p> <p>NDHB has implemented the Primary Mental Health Initiative since 2005, and continues to enhance the roles of specialised staff and the primary care sector.</p>
<i>Elective surgery</i>	<p>One of the six national Health Targets.</p> <p>An important contributor to the Government's "better, sooner, more convenient" policy.</p> <p>Elective surgery is an effective way of increasing people's functioning because it remedies or improves disabling conditions.</p>	<p>Elective operations provided by NDHB's hospitals, the vast majority of which are provided at Whangarei Hospital. Between 2002/03 and 2010/11, when the Northland population increased by about 11%, the raw number of elective operations increased by 52% (89% when complexity of operations is allowed for).</p> <p>Hospital services traditionally give the greatest priority to those with the most acute and urgent needs, so NDHB has been making a concerted effort to consciously direct resources towards elective surgery.</p>
<i>ED waiting times</i>	<p>One of the six national Health Targets.</p> <p>The purpose of emergency departments (EDs) is to provide urgent care, so by definition timeliness is important.</p> <p>Medical and nursing literature has linked both long stays and overcrowding in EDs to poorer clinical outcomes, such as increased mortality and longer lengths of stay for people who are transferred into hospital as inpatients.</p>	<p>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.</p>
<i>Quality</i>	<p>Quality systems enhance the nature of care experienced by patients. They also reduce risks, cut down errors, smooth flows between services, improve staff morale and minimise resource wastage, so they are an important contributor to productivity and efficiency.</p>	<p>Space does not permit a full explanation here; Northland DHB's quality systems and the contribution they make are explained in more detail in 5.2 Quality and safety.</p>
<i>Services for older people</i>	<p>The increasing number of older people, along with their higher level of acuity, is placing increasing pressure on home based support and residential care budgets.</p> <p>Home based support services are coming under growing pressure</p>	<p>Northland DHB is piloting a service with PHOs which is aimed at early identification and intervention, including patient navigation, to support older people to maintain their independence and participation in their community.</p> <p>To improve the quality and consistency of</p>

²⁸ Mental Health Blueprint, the 1998 document that laid out proposed levels of services for the 3% of the population affected by severe mental disorders. Since then, funding and service provision have been gradually working towards achieving these levels.

Impact	Rationale	Contribution made by Outputs
	<p>because there is an increasing number of older people receiving them (currently approximately 12% of Northland's over 65 population). This growth will be sustainable only if we allocate resources to those most in need.</p> <p>When older people find they need to enter residential care, they have the right to receive services of an appropriate standard. Quality residential care providers receive at least three-year certification. Out of Northland's 25 aged residential care facilities, seven have certification that is for only one or two years, indicating risks from high volumes of non-conformities.</p>	<p>needs assessments Northland DHB's Needs Assessment and Service Coordination service will implement the InterRAI Minimum Data Set Home Care (MDS-HC) and Contact Assessment (CA).</p> <p>Northland DHB will increase the level of gerontology nurse specialist resource available to support the quality of clinical care provided within aged residential care. Priority projects are: transition of care arrangements between residential care and hospital services, advance health directives, and safety of care in residential care.</p> <p>NDHB will monitor the quality of residential care facilities through our regular contract monitoring process and through involvement in the new Integrated Audit process.</p>

5 Organisational capability

5.1 Human resources

Staffing numbers

In February 2010 Northland DHB employed 2,628 staff, representing 1,992 full-time equivalents (FTEs), as per the following table.

Category	No. of staff	FTEs	
		Number	% of total
Medical	235 (158 senior, 77 junior)	206 (130 senior, 76 junior)	10%
Nursing & midwifery	1,230 (1,152 nursing, 78 midwifery)	857 (813 nursing, 44 midwifery)	43%
Allied health	544	446	22%
Non-clinical support	90	72	4%
Management & admin	529	410	21%
Total	2,628	1,992	100%

Northland DHB does not hold staffing information on the NGO providers with whom we hold contracts. Analysis of the number and type of staff is an important ingredient in meeting health needs. It is an area in which Northland DHB will address in future.

Monitoring, planning and negotiation

Human resources reports are generated monthly for General Managers and discussed at the Senior Management Group. They include analyses of leave (annual, sick and other), attendance at conferences and courses, Continuing Medical Education days and expenditure, staff turnover by occupational group, and measures of productivity per FTE (hours worked compared with sick leave, annual leave etc).

Various forums exist for engagement of staff and unions. A Bipartite Forum meets quarterly for management and unions to discuss matters of common interest, and Joint Action Committees with ASMS (Association of Salaried Medical Specialists) and the NZ Nursing Organisation have been established. A joint committee with PSA has been established to ensure consistency of application of the process for career and salary progression as provided in the DHBs/PSA Allied, Public Health and Technical MECA. The Human Resources Department runs a series of training modules for managers to ensure their skills are updated on both practical and theoretical bases. Northland DHB has held staff satisfaction surveys in the past, but in 2007 we adopted the Health Roundtable template that is increasingly being used by other DHBs, so benchmarking will be possible in the future.

Matching staff numbers and skill mixes takes place at operational and strategic levels. In nursing, for example, TrendCare is used to compare service demands on wards with the staffing mix, so that the two can be matched as closely as possible. Northland DHB also contributes information to the Health Workforce Information Programme run by DHBNZ which seeks to analyse and project current and future workforce needs.

Good Employer requirements

Northland DHB adheres to the good employer requirements in S118 of the Crown Entities Act 2004, which cover:

- good and safe working conditions
- an equal employment opportunities programme
- the impartial selection of suitably qualified persons for appointment
- recognition within the workforce of the aspirations and needs of Maori, other ethnic or minority groups, women and people with disabilities
- training and skill enhancement of employees.

Workforce development

Services identify and support potential leaders in various occupational groups to develop both technical and managerial skills, ensuring succession planning is facilitated. This is key for NDHB to attract and retain skills to provide high quality, fit-for purpose care and services to meet both current and future health needs of the community.

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

Innovative models of care will be required to meet future needs and services are actively working with staff both locally, regionally and nationally to plan for future workforce requirements both in the provider arm and primary sector.

Northland DHB continues to provide a number of Clinical Training Agency scholarships for nursing and midwifery and the non-regulated workforce. In addition NDHB pursues "Grow our Own" staffing initiatives by providing additional Maori scholarships for staff and a Pihirau Hauora Maori Scholarship for secondary school students.

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

5.2 Quality and safety

Quality and safety are integral features of the way Northland DHB works. We have a Quality and Safety Framework to help staff understand the principles, processes, structures, roles and relationships that underpin quality and safety, as well as the workings of Northland DHB's quality systems and processes. We also produce quarterly quality reports for the Board's Hospital Advisory Committee and the Clinical Care Review Committee.

Northland DHB's quality activities are overseen by a Quality Improvement Committee whose four main goals at present focus on:

- Optimising the Patient Journey, now past its pilot phase and becoming integrated into 'business as usual'
- management of healthcare incidents, for which a new electronic reporting system was installed in 2009
- infection prevention and control, whose resources have been boosted, and which has a particular emphasis on hand hygiene
- safe medicines management, being addressed through numerous new systems and processes.

Specific quality initiatives in the Northland DHB Provider include:

- a Clinical Care Review Committee to oversee the quality framework and monitor activities
- monitoring and management of adverse events and errors
- monitoring of clinical indicators and management of detected problems
- clinical audit
- benchmarking
- research by clinicians
- projects dealing with Safe Use of Medicines, Physiologically Unstable Patients, hand hygiene.

The risk management framework, established in 2007/08, was enhanced in 2008/09 by the implementation of an electronic risk register system that 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.

Risks to the organisation exist in:

- managing acute demand
- after-hours services in rural communities
- recruitment and retention of skilled staff
- the quality of the physical facilities of NDHB
- the quality of information systems within NDHB.

Northland DHB's external quality and safety efforts are focussed on the primary health care sector. These include:

- GP liaison positions established by the DHB to provide links with the primary care sector and work on matters of mutual interest
- strong clinical governance within PHOs
- supporting accreditation in GP practices
- a governance group for the Primary Options initiative
- NGO membership of NDHB's proposed governance structures for long term conditions and child and youth health.

5.3 Information services

NDHB measures the capability of our Information Services by the extent to which:

- the expected services are known – both the "what", and the quality and standard of service
- performance against these service expectations can be measured, providing the platform for transparency, partnership, and continuous incremental improvement
- strategic direction is set, providing the framework upon which to make investment decisions regarding people, process, tools, technology, and information systems.

<i>Expected services are known</i>	There is strong engagement between the Information Service and its customers throughout NDHB, through a structured account management framework. There is good understanding of the services required, and there are agreed plans for 2010/11 which provide the basis on which to begin developing a Service Level Expectations framework.
<i>Performance</i>	The core infrastructure has been upgraded over the last few years, and the 2010/11 workplan will see monitoring and resilience developed to the next level. A sustainable platform of tools and processes is in place to support service delivery. The 2010/11 workplan includes further investment in tools and strengthening of the workflow processes to enable more effective, efficient service delivery and greater transparency of performance against Service Level Expectations.
<i>Strategic direction</i>	The development of the Information Services function at NDHB is guided by clear agreed vision statements and supported by a skilled management and leadership team. NDHB is a partner in the Northern Regional Information Strategy (RIS10-20), which has the endorsement of the region's four boards.

Over the past three years, substantial investment in people, process and technology, and the building of strategic relationships (with other DHBs, with national bodies, and with vendor partners) has provided a firm foundation. Service delivery could currently be described as "good", and we have a clear understanding of the path to follow to ensure the capabilities are in place to provide excellent, and sustainable, service delivery.

5.4 Clinical leadership

Clinical networks and effective partnerships between managers and clinicians at governance level will be a key focus.

Partnership models that include clinical leadership operate at senior executive level, and clinicians are an integral part of the decision-making process that drives key projects within the organisation. Clinical decisions at the closest point of contact are encouraged and clinical governance mechanisms are being developed and enhanced at various levels of the organisation. This will be an enabler for better outcomes for patients.

Leaders will be accountable and responsible for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which clinical leadership and excellence will flourish.

The organisation will work to develop and identify leaders. NDHB will foster opportunities for development through initiatives such as 360-degree coaching, personalised development pathways and leverage off existing international programmes, including national and international secondments.

In order to future-proof the concept of clinical leadership, a process of succession planning will be developed. This will focus at the Clinical Head of Department and Clinical Nurse Manager level.

5.5 Management of finances and assets

5.5.1 Management of finances

Northland DHB has consistently maintained a balanced budget. This has met the requirements of the Minister, avoided the risk of being put "on watch" by the Ministry and, most importantly, has allowed the DHB some flexibility in allocating resources to new needs and services. In the current climate of financial constraints and capped funding in real terms, keeping the books in the black is even more important.

Northland DHB's Financial Management Systems give us the ability to set targets and monitor performance against these. Target setting occurs with advice from the Ministry of Health and includes financial budgets, numbers of employees and service delivery targets.

Performance against these targets is monitored on a monthly basis. This starts with Internal Performance Management Reporting within each service which feeds into the Executive Leadership Team. The reports are consolidated each month for the board of governance and its associated subcommittees. We also meet MoH reporting requirements on a monthly basis. NDHB continues to seek efficiencies in the way we operate, including participating in regional and national processes (for procurement, for example). At least three-quarters of operating expenditure is on our workforce, and we continually reviewing patterns and levels of staffing to reduce costs.

5.5.2 Management of assets

To manage our assets, we use a product called SPM Property, a web-based asset planning system designed to assess the condition and performance of our assets and to efficiently formulate the priorities of physical works.

The product allows us to:

- assess the condition and performance of assets
- efficiently formulate the priorities of physical works
- choose the best position between resources and acceptable known risks
- prioritise projects using risk and criticality.

The product holds information on:

- key asset data – information at a component level, including condition grades, base lives, remaining lives, construction year, confidence grades, criticality criteria and replacement costs
- asset information – a wide range of fixed asset information is held including descriptions, addresses, valuations, photographs, geographic coordinates, user-definable fields, capital replacement values and immediate maintenance items
- component history – a full history of changes to components are recorded
- component workspace – comprehensive analysis of component data displayed in a grid or graphical display with options to select the basis for analysis
- property quality standards – analyses both condition status and various user-defined performance or quality standards associated with properties such as safety, health, sustainability and energy efficiency
- lifecycle analysis – a condition-based risk analysis to determine the likely timing of renewals and replacements, with an additional facility to define the threshold between operational and capital expenditure
- scenario modelling – allows 'what if' changes to the base data to determine effects on the lifecycle analysis
- cost analytics – enables asset managers to undertake targeted investigations on components either before they fail or before their maintenance costs become too significant
- project planning – enables asset managers to set up projects to address maintenance issues once scenarios have been finalised; users can match the timing of actual projects to suit available budgets and manage planning information from concept to implementation.

5.6 Collaboration

5.6.1 Collaboration at national level

Both the Funder and Provider arms of Northland DHB liaise closely with the Ministry of Health at strategic and operational levels. Senior managers take part in DHBNZ-sponsored forums for chief executives and GMs planning and funding. The Funder liaises closely with Shared Services, the Dunedin-based unit of the Ministry through which all contract payments for all DHBs are channelled.

5.6.2 Collaboration at regional level

The four Northern Region DHBs (Northland and the three Auckland DHBs) have for some time had:

- formally established forums with delegated decision-making authorities (Regional Governance Group, Regional CEO Forum, Regional Funding Forum, Regional Capital Group)
- a range of clinical networks and regional clinical services (including Network North for mental health and addiction services, the Northern Region Cancer Network, Auckland Regional Public Health Service, Auckland Region Dental Service)
- shared support agencies (NDHB is involved with the Northern DHB Support Agency which supports all four DHBs).

These collaborative approaches have aimed to maximise clinical and financial resources, but the four DHBs have agreed there is a need to step up the level of regional activity through a Northern Region Network strategy. The aims are to:

- achieve the greatest possible health gain for the population of the region

- provide equitable and appropriate access to DHB-provided and -funded health services
- reduce transactional costs and leverage scale where there is benefit from doing so
- maintain strong influence and control over crucial aspects of Northern Region DHBs' responsibilities
- be confident that we have a robust forum for long term planning of health services for our regionally unique demographics, both now and into the future.

The four Northern Region DHBs have been moving towards a Regional Clinical Service Plan. Phase one focused on establishing principles and agreeing on clinical resource requirements based on population growth. Phase two is concentrating on five key workstreams:

- clinical networks and regional services
- urgent and acute care
- planned and elective care
- health of older people
- radiology.

5.6.3 Collaboration at local level

The Funder has established close working relationships with the numerous providers in Northland's health sector with whom we hold contracts ([3.3.1 NDHB Funder functions](#)). We renegotiate contract terms, discuss funding and monitoring requirements, and build a supportive relationship to enhance providers' service delivery. The Funder involves health sector agencies in planning and clinical governance groups, including non-health sector agencies in areas such as Maori health and public health. We also work alongside non-health sector agencies in, for example, housing initiatives ([4.2 Output Class 1: Public health services](#)), and the Northland Intersectoral Forum (a body which includes government and territorial local authorities in planning on issues of joint interest).

The Provider works closely with other health sector agencies, the primary care sector in particular, on improving patient flows and the quality of service delivery. The Provider's Child, Youth, Maternal, Public Health and Dental Services arm works with territorial local authorities and a variety of government agencies on compliance with public health legislation, training of non-health sector staff in public health skills and knowledge, and control of communicable disease.

6 Financial performance

6.1 Financial statements

Statement of Comprehensive Income					
	2008-09				
	Audited	2009-10	2010-11	2011-12	2012-13
	Actuals	Forecast	Budget	Budget	Budget
DHB Provider Revenue	223,097	238,571	247,353	253,042	258,862
DHB Funder Revenue	210,928	220,063	223,381	229,262	234,818
DHB Governance & Administration	4,312	4,270	3,791	3,878	3,967
Inter District Flow Revenue	8,500	7,824	8,140	8,140	8,140
Total Revenue	446,837	470,729	482,666	494,323	505,788
DHB Provider Operating Expenditure	213,210	222,984	230,510	235,808	241,310
DHB Non Provider Funded Services	149,686	164,437	163,774	168,018	171,938
DHB Governance & Administration	4,077	4,157	3,770	3,857	3,946
Inter District Flow Expense	64,148	62,905	67,747	69,384	71,020
Total Operating Expenditure	431,120	454,482	465,802	477,066	488,214
Earnings before Interest, Depreciation, Abnormals & Capital Charge	15,717	16,247	16,864	17,256	17,574
<i>Less</i>					
Interest on Term Debt	1,697	1,712	1,670	1,708	1,748
Depreciation	9,266	10,114	10,140	10,374	10,612
Revaluation					
Earnings before Abnormals & Capital Charge	4,754	4,421	5,054	5,174	5,214
Profit/(Loss) on Sale of Assets	45	-	-	-	-
Net Operating Surplus (Deficit)	4,799	4,421	5,054	5,174	5,214
Capital Charge	4,265	4,420	5,054	5,174	5,214
Surplus (Deficit)	534	0	(1)	0	(0)
Revaluation of Fixed Assets	6,825	-	-	-	-
Comprehensive Income	7,359	0	(1)	0	(0)

Consolidated Statement of Financial Performance	2008-09				
	Audited Actuals	2009-10 Forecast	2010-11 Budget	2011-12 Budget	2012-13 Budget
Revenue	446,837	470,729	482,666	494,323	505,788
Personnel Costs	145,482	156,531	168,163	172,031	175,987
Outsourced Services	14,085	12,825	8,843	9,046	9,254
Clinical Supplies	35,622	36,504	36,506	37,345	38,204
Infrastructure & Non-Clinical Supplies	22,056	21,280	20,768	21,242	21,810
Finance Costs	5,962	6,132	6,724	6,883	6,962
Depreciation	9,266	10,114	10,140	10,374	10,612
Personal Health	154,374	160,183	159,246	163,335	167,122
Mental Health	14,778	15,975	15,903	16,323	16,727
Disability Support Services	38,111	44,181	48,869	50,056	51,241
Public Health	1,214	1,071	1,631	1,671	1,711
Maori Health	5,519	5,931	5,872	6,015	6,157
Total Operating Expenditure	446,469	470,728	482,666	494,323	505,788
Surplus (Deficit)	368	0	(1)	0	(0)

Provider Statement of Financial Performance	2008-09				
	Audited Actuals	2009-10 Forecast	2010-11 Budget	2011-12 Budget	2012-13 Budget
Revenue	223,097	238,571	247,353	253,042	258,862
Personnel Costs	143,921	154,754	166,224	170,047	173,958
Outsourced Services	12,933	12,335	8,402	8,595	8,793
Clinical Supplies	35,622	36,504	36,505	37,345	38,204
Infrastructure & Non-Clinical Supplies	20,689	19,391	19,379	19,821	20,356
Finance Costs	5,683	6,035	6,724	6,883	6,962
Depreciation	9,257	10,098	10,120	10,352	10,591
Total Operating Expenditure	228,104	239,117	247,353	253,042	258,862
Surplus (Deficit)	(5,007)	(546)	(0)	(0)	(0)

Governance Statement of Financial Performance	2008-09				
	Audited Actuals	2009-10 Forecast	2010-11 Budget	2011-12 Budget	2012-13 Budget
Revenue	4,312	4,270	3,791	3,878	3,967
Personnel Costs	1,561	1,777	1,939	1,984	2,029
Outsourced Services	1,152	491	441	451	462
Clinical Supplies	0	0	1	1	1
Infrastructure & Non-Clinical Supplies	1,364	1,888	1,390	1,422	1,454
Finance Costs	280	97	-	-	-
Depreciation	9	16	21	21	22
Total Operating Expenditure	4,365	4,269	3,791	3,878	3,967
Surplus (Deficit)	(54)	0	-	-	-

Funder Statement of Financial Performance	2008-09				
	Audited Actuals	2009-10 Forecast	2010-11 Budget	2011-12 Budget	2012-13 Budget
Revenue	422,578	445,481	458,648	469,752	480,652
Personal Health	320,508	337,478	345,069	353,432	361,590
Mental Health	42,305	46,559	47,142	48,281	49,420
Disability Support Services	43,895	51,094	54,997	56,325	57,654
Public Health	1,702	1,143	2,300	2,356	2,411
Maori Health	6,537	6,198	6,813	6,977	7,142
Other	2,038	2,464	2,328	2,381	2,436
Total Operating Expenditure	416,985	444,936	458,648	469,752	480,653
Surplus (Deficit)	5,593	546	(0)	0	(0)

Statement of Movements in Equity

	2008-09 Audited Actuals	2009-10 Forecast	2010-11 Budget	2011-12 Budget	2012-13 Budget
Equity at the beginning of the period	53,870	55,053	55,053	56,353	57,853
Surplus/Deficit for the period	534	0	(1)	0	(0)
Total Recognised Revenues and Expenses	54,404	55,053	55,053	56,353	57,852
Other Movements					
Revaluation of Fixed Assets	6,825	-	-	-	-
Other	287	-	-	-	-
Equity introduced (Repaid)	362	-	1,300	1,500	500
Equity at end of Period	55,053	55,053	56,353	57,853	58,352

Statement of Financial Position

	2008-09 Audited Actuals	2009-10 Forecast	2010-11 Budget	2011-12 Budget	2012-13 Budget
Equity					
Crown Equity	35,341	35,341	35,341	35,341	35,341
Retained Earnings	1,140	1,140	1,140	1,140	1,140
Subsidiaries & unrestricted trusts	252	252	252	252	252
Revaluation Reserve	24,782	24,782	24,782	24,782	24,782
Capital Injections	362	362	1,662	3,162	3,662
Total Equity	61,877	61,877	63,177	64,677	65,177
Represented by:					
Assets					
Current Assets	92,254	93,494	76,420	69,024	69,136
Non-Current Assets	90,914	88,402	106,774	115,671	116,059
Total Assets	183,168	181,895	183,195	184,695	185,195
Liabilities					
Current Liabilities	86,654	85,381	85,381	85,381	85,381
Non-Current Liabilities	34,637	34,637	34,637	34,637	34,637
Total Liabilities	121,291	120,018	120,018	120,018	120,018
Net Assets	61,877	61,877	63,177	64,677	65,177

Statement of Cash Flows

	2008-09 Audited Actuals	2009-10 Forecast	2010-11 Budget	2011-12 Budget	2012-13 Budget
Cash Flows from Operating Activities					
Operating Income	441,339	467,668	478,152	489,705	501,064
Operating Expenditure	424,036	460,175	470,856	482,241	493,429
Net Cash from Operating Activities	17,303	7,493	7,296	7,464	7,635
Cash Flows from Investing Activities					
Interest receipts 3rd Party	6,929	3,061	4,514	4,618	4,724
Proceeds from sale of assets	206	-	-	-	-
Purchase of Fixed Assets	(11,688)	(7,602)	(28,513)	(19,270)	(11,000)
Increase in Investments and Restricted & Trust Funds Assets	(730)	(1)	-	-	0
Net Cash from Investing Activities	(5,283)	(4,541)	(23,999)	(14,652)	(6,276)
Cash Flows from Financing Activities					
Equity injections (repayments)	362	-	1,300	1,500	500
Borrowings	-	-	-	-	-
Interest Paid	(1,697)	(1,712)	(1,670)	(1,708)	(1,748)
Repaid debts	-	-	-	-	-
Other Non-Current Liability Movement	-	-	-	-	-
Net Cash from Financing Activities	(1,335)	(1,712)	(370)	(208)	(1,248)
Net Increase/(Decrease) in Cash held	10,684	1,240	(17,073)	(7,396)	112
Add opening cash balance	43,815	54,499	55,739	38,666	31,269
Closing Cash Balance	54,499	55,739	38,666	31,269	31,381

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

Statement of Financial Performance - By Output Class

	Hospital Services	Primary Services	Public Services	Support Services	2010-11 Budget Total
DHB Provider Revenue	206,306	19,909	11,405	9,733	247,353
Less Revenue Offsets	- 4,790	-	665	-	5,455
DHB Funder Revenue	57,229	107,090	2,231	64,973	231,522
DHB Governance & Administration	3,791				3,791
Total SOI Revenue	262,536	126,999	12,971	74,706	477,212
		4,269			
Personnel Costs					
Medical Labour	38,815	3,372	459	1	42,647
Nursing Labour	50,679	4,070	2,726	3,974	61,448
Allied Health Labour	15,298	10,680	3,387	1,863	31,227
Non Clinical Support Labour	110	0	144	3	257
Management and Admin Labour	7,628	1,610	1,128	371	10,737
	-	-	-	-	-
Non-Personnel Operating Costs					
Outsourced Clinical Services	3,939	344	129	366	4,778
Oth Clinical Supp	22,896	2,938	687	1,771	28,293
Implants	3,382	0	0	0	3,382
Pharmaceuticals	3,374	57	123	116	3,670
Infrastructure and Non Clinical	14,115	3,381	1,069	912	19,476
Allocated Pharmaceuticals	978	16	31	31	1,056
Corporate Departments	11,681	1,647	729	577	14,634
Cost of Capital	5,157	767	340	304	6,568
CSSD Overhead	607	31	0	91	730
CTA Recoveries	- 2,054	-93	-24	-0	2,170
Patient Support	3,890	147	8	70	4,115
Patient Support Overhead	- 555	-17	-0	-24	596
Service Based Departments	9,276	2,714	2,378	809	15,178
Sterile Supplies	215	11	3	31	259
Provider Payments					
Personal Health	54,450	99,538	1,540	4,614	160,142
Mental Health	2,645	1,720	-	11,539	15,903
Disability Support Services	134	-	10	47,830	47,974
Public Health	-	950	681	-	1,631
Maori Health	-	4,882	-	990	5,872
Total SOI Operating Expenditure	246,661	138,764	15,548	76,239	477,212
Surplus (Deficit)	15,875 -	11,766 -	2,576 -	1,533 -	0

6.2 Financial assumptions

Revenue is based on the PBF funding envelope announced December 2009.

NDHB Funder projections for 2010/11 are based on 2009/10 expenditure levels adjusted for expected volume and cost pressure. Inter District Flow revenue and costs have been budgeted in accordance with advice from the Ministry of Health.

Future devolution of services to primary health are not included in the projections.

No additional Mental Health Blueprint funding has been included.

NDHB Provider salary and salary-related costs are provided for at agreed settlement rates for 2010/11 and out-years.

NDHB Provider service supplies and expenses are based on current expenditure levels plus 2.4%, less procurement savings.

Cash from depreciation charges is applied to capital purchases.

Additional capital expenditure, all internally funded, relates to the replacement of the Mental Health Inpatient Unit, and enhances patient management information systems.

Interest costs for CHFA debt at 8.0%.

Capital charge is assessed at 8.0%.

NDHB has assumed we will be able to maintain the criteria for early payment of funding for DHBs categorised as good performers and the impact of this is reflected in the financial forecasts.

It is assumed that a balanced position will be maintained and the increased revenue will be matched by increased expense towards unmet health need.

6.3 Capital expenditure

Baseline capital expenditure relates to planned maintenance and replacement of current equipment and other plant and building infrastructure. It is planned to fund this from operating revenue and funding at the level of depreciation.

In addition, NDHB is building a replacement Mental Health Inpatient Unit that will open in late 2011, and we plan to enhance our patient management information systems.

6.4 Disposal of land

If Northland DHB decides to dispose of any land transferred to or vested in the DHB, we will do so under the Health Sector Transfers Act 1993. Northland DHB has no plans at present to dispose of any land.



Appendix 1: Glossary

Acute	Used to describe an illness or injury, either mild or severe, which lasts for a short time (contrasted with 'chronic' which describes disease or disability of long duration, which is usually incurable).
AFC	Annual Free Check, a service provided by GPs to people with diabetes.
AOD	Alcohol and other drugs.
ASH	Action on Smoking and Health, a national organisation committed to stopping tobacco smoking.
Benchmarking	The process of comparing the performance of different organisations .
Clinical Training Agency (CTA)	Established in late 2009 to provide advice on the rationalisation of workforce planning, training, education and purchasing within the health sector. It is an interim measure to drive immediate change while advice is developed on the longer-term placement of a health sector clinical training agency.
Continuing Medical Education	Provision for ongoing training and upskilling of medical staff.
CVD	Cardiovascular disease.
CYFS	Child, Youth and Family Services, part of the Ministry of Social Development.
DC	District Council.
Deprivation Index	Nine different types of Census data are analysed mathematically to produce deprivation scores for almost 24,000 small geographical areas across New Zealand. Once the scores are computed they are ranked and divided into five equally-sized population groups (quintiles).
DHB	District Health Board.
DHBNZ	A national organisation which acts in the interests of DHBs on agreed national issues.
District Annual Plan (DAP)	The annual business plan produced by each DHB.
District Strategic Plan (DSP)	The strategic plan produced by DHBs, based on a Health Needs Analysis. It forms the basis for the District Annual Plan.
ED	Emergency department.
FTE	Full time equivalent. A 40-hour week is represented by 1.0, and each half day by 0.1, so that someone working 3 days a week would be 0.6FTE.
Gerontology	The health specialty that deals with the consequences of ageing.
GP	General practitioner.
HDC	Health and Disability Commission (or Commissioner).
Health Roundtable	An organisation to which DHBs voluntarily belong to benchmark clinical and non-clinical services with each other. The process consists of data definitions, data analysis, comparisons, and then workshopping between districts and services to identify best-practice models that suit individual services.
Health Targets	The six measures of performance the Minister of Health considers the most important for DHBs to meet (level-one accountability measures, as distinct from the level-two IDPs).

IDFs (Inter-District Flows)	Money Northland DHB pays to other DHBs, mainly Auckland, for specialised (tertiary) services they provide to Northlanders that are not available here.
Long Term Conditions Framework	A tool that ensures that planning for long term conditions (diabetes, CVD, cancer, respiratory diseases) addresses all types of services and population groups.
Long term condition (LTC)	Formerly known as 'chronic diseases'. Conditions that, once acquired, cannot be cured, so the emphasis is on monitoring and management to maintain quality of life for as long as possible and reduce impacts on health services. Common examples are diabetes, cardiovascular disease (heart disease and strokes), cancer.
MECA	Multi-employer collective agreement, an employment agreement for a group of staff (such as nurses or doctors) that covers a number of employers.
MoH	Ministry of Health (see also <i>National Health Board</i>).
National Health Board (NHB)	A Crown Entity established in 2009 by the Minister of Health to oversee the implementation of changes to the health system. Its role differs from that of the Ministry of Health whose role is to be limited to policy and regulation.
NDHB	Northland District Health Board.
NGO	Non-government organisation. "NGOs" collectively means health service providers outside NDHB.
NZNO	New Zealand Nurses Organisation which represents over 44,000 nurses and other health workers in employment negotiations and promotes nursing and midwifery.
Optimising the Patient Journey	A national project involving step-by-step analyses from the perspectives of both the patient and the system as a whole. The aim is to streamline treatment processes by identifying and eliminating or reducing bottlenecks, while at the same time improving quality and safety.
PHO	Primary Health Organisation.
Primary Options	A scheme to enable primary care providers to provide treatment for people with selected acute conditions who would normally have been treated by secondary services.
PSA	Public Service Organisation.
Residential care	Rest home and hospital-level accommodation provided for older people who can no longer manage in the community.

Appendix 2: Statement of Accounting Policies

For the year ended 30 June 2010

Reporting entity

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

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

The consolidated financial statements of NDHB and group for the year ended 30 June 2010 comprise NDHB and its joint venture subsidiary the Kaipara Total Health Care Joint Venture (54% owned).

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

The financial statements were authorised for issue by the Board in October 2010.

Statement of compliance

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

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

Basis of preparation

The financial statements will be presented in New Zealand Dollars (NZD), rounded to the nearest thousand. The financial statements are prepared on historical cost basis except for land and buildings that are stated at their revalued amounts.

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

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

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

Basis for consolidation

Subsidiaries

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

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

Transactions eliminated on consolidation

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

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

Budget figures

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

Foreign currency transactions

Transactions in foreign currency are translated at the foreign exchange rate ruling at the date of the transaction. Monetary assets and liabilities denominated in foreign currencies at the balance sheet date are translated to NZD at the foreign exchange rate ruling at that date. Foreign exchange differences arising on translation are recognised in the statement of financial performance. 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. Non-monetary assets and liabilities denominated in foreign currencies that are at fair value are translated to NZD at foreign exchange rates ruling at the dates the fair value was determined.

Property, plant and equipment

Classes of property, plant and equipment

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

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

Owned assets

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

removing the items and restoring the site on which they are located, and an appropriate proportion of direct overheads.

Land and buildings are revalued to fair value as determined by an independent registered valuer every three years. Any increase in value of a class of land and buildings is recognised directly to equity unless it offsets a previous decrease in value recognised in the statement of financial performance. Any decreases in value relating to a class of land and buildings are debited directly to the revaluation reserve, to the extent that they reverse previous surpluses and are otherwise recognised as an expense in the statement of financial performance.

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

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

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

Property, plant and equipment vested from the hospital and health service

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

Disposal of property, plant and equipment

Where an item of plant and equipment is disposed of, the gain or loss recognised in the statement of financial performance 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 statement of financial performance in the period in which the transaction occurs. Any balance attributable to the disposed asset in the asset revaluation reserve is transferred to retained earnings.

Additions to property, plant and equipment

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

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

Leased assets

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

The property held under finance leases and leased out under operating lease is classified as investment property and stated at fair value. Property held under operating leases that would otherwise meet the definition of investment property may be classified as investment property on a property-by-property basis.

Subsequent costs

Subsequent costs are added to the carrying amount of an item of property, plant and equipment when that cost is incurred if it is probable that the service potential or future economic benefits

embodied within the new item will flow to NDHB. All other costs are recognised in the statement of financial performance as an expense as incurred.

Depreciation

Depreciation is charged to the statement of financial performance using the straight line method. Land is not depreciated.

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

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

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

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

Borrowing costs

For each property, plant and equipment asset project, borrowing costs incurred during the period required to complete and prepare the asset for its intended use are expensed.

Intangible assets

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

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 charged to the statement of financial performance 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% - 55%)

Impairment of property, plant and equipment and intangible assets

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

Value in use is depreciated replacement cost for an asset where the future economic benefits or service potential of the asset are not primarily dependent on the asset's ability to generate net cash inflows and where the entity would, if deprived of the asset, replace its remaining future economic benefits or service potential. The value in use for cash-generating assets and cash generating units is the present value of expected future cash flows.

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 against the revaluation reserve for that class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised in the statement of financial performance.

For assets not carried at a revalued amount, the total impairment loss is recognised in the statement of financial performance. The reversal of an impairment loss on a revalued asset is credited to the revaluation reserve. However, to the extent that an impairment loss for that class of asset was previously recognised in statement of financial performance, a reversal of the impairment loss is also recognised in the statement of financial performance. For assets not carried at a revalued amount (other than goodwill) the reversal of an impairment loss is recognised in the statement of financial performance.

Financial instruments

Non-derivative financial instruments

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

Non-derivative financial instruments are recognised initially at fair value plus, for instruments not at fair value through profit or loss, any directly attributable transaction costs. Subsequent to initial recognition non-derivative financial instruments are measured as described below.

A financial instrument is recognised if the NDHB becomes a party to the contractual provisions of the instrument. Financial assets are derecognised if the NDHB's contractual rights to the cash flows from the financial assets expire or if the NDHB transfers the financial asset to another party without retaining control or substantially all risks and rewards of the asset. Regular way purchases and sales of financial assets are accounted for at trade date, i.e., the date that the NDHB commits itself to purchase or sell the asset. Financial liabilities are derecognised if the NDHB's obligations specified in the contract expire or are discharged or cancelled.

NDHB classifies its financial assets into the following categories: fair value through profit or loss, held-to-maturity investments, loans and receivables and fair value through equity. The classification depends on the purpose for which the investments were acquired. Management determines the classification of its investments at initial recognition.

Loans and receivables

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

After initial recognition they are measured at amortised cost using the effective interest method less impairment. Gains and losses when the asset is impaired or derecognised are recognised in the statement of financial performance.

Fair value

The fair value of financial instruments traded in active markets is based on quoted market prices at the balance sheet date. The quoted market price used is the current bid price.

The fair value of financial instruments that are not traded in an active market is determined using valuation techniques. NDHB uses a variety of methods and makes assumptions that are based on

market conditions existing at each balance date. Other techniques, such as discounted expected cash flows, are used to determine fair value for the remaining financial instruments.

Cash and cash equivalents

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

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

Interest-bearing loans and borrowings

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

Trade and other receivables

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

Trade and other payables

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

Effective interest rate method

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

Impairment

At each balance sheet date NDHB assesses whether there is any objective evidence that a financial asset or group of financial assets is impaired.

Loans and other receivables

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

Quoted and unquoted equity investments

For equity investments classified as fair value through equity, a significant or prolonged decline in the fair value of the investment below its cost is considered an indicator of impairment. If such evidence exists for investments at fair value through equity, the cumulative loss (measured as the difference between the acquisition cost and the current fair value, less any impairment loss on that financial asset previously recognised in the statement of financial performance on equity investments are not reversed through the statement of financial performance) is removed from equity and recognised in the statement of financial performance.

Impairment losses recognised in the statement of financial performance on equity investments are not reversed through the statement of financial performance.

Calculation of recoverable amount

The recoverable amount of receivables carried at amortised cost is calculated as the present value of estimated future cash flows, discounted at their original effective interest rate (i.e. the effective interest rate computed at initial recognition of these financial assets). Receivables with a short duration are not discounted.

Estimated recoverable amount of other assets is the greater of their fair value less costs to sell and value in use. Value in use is calculated differently depending on whether an asset generates cash or not. For an asset that does not generate largely independent cash inflows, the recoverable amount is determined for the cash-generating unit to which the asset belongs.

For non-cash generating assets that are not part of a cash generating unit value in use is based on depreciated replacement cost (DRC). For cash generating assets value in use is determined by estimating future cash flows from the use and ultimate disposal of the asset and discounting these to their present value using a pre-tax discount rate that reflects current market rates and the risks specific to the asset.

Reversals of impairment

Impairment losses are reversed when there is a change in the estimates used to determine the recoverable amount.

Impairment losses, other than items of property, plant and equipment, are recognised in the statement of financial performance.

Inventories

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

Cost is determined on a first in first out basis.

The amount of any write-down for the loss of service potential or from cost to net realisable value is recognised in the Statement of Financial Performance 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 Statement of Financial Performance over the period of the borrowings on an effective interest basis.

Employee benefits

Defined contribution plan

Obligations for contributions to defined contribution plans are recognised as an expense in the statement of financial performance as incurred.

Long service leave, sabbatical leave and retirement gratuities

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

value is placed on the resulting liabilities by discounting the projected entitlements back to the valuation date using a suitable discount rate.

Annual leave, conference leave and medical education leave

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

Sick leave

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

Provisions

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

Revenue relating to service contracts

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

Income tax

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

Goods and services tax

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

Revenue

Crown funding

The majority of revenue is provided through an appropriation in association with a Crown Funding Agreement. Revenue is recognised monthly in accordance with the Crown Funding Agreement payment schedule, which allocates the appropriation equally throughout the year.

Goods sold and services rendered

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

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

Rental income

Rental income from investment property is recognised in the statement of financial performance on a straight-line basis over the term of the lease. Lease incentives granted are recognised as an integral part of the total rental income over the lease term.

Interest

Interest Income is recognised using the effective interest method.

Expenses

Operating lease payments

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

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

Financing costs

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

Equity

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

The components of equity are Retained Earnings, Revaluation Reserve (consisting of Land and Buildings) and Trust/Special Funds.

Special funds are funds donated or bequeathed for a specific purpose. The use of these assets must comply with the specific terms of the sources from which the funds were derived. The revenue and expenditure in respect of these funds is included in the statement of financial performance. An amount equal to the expenditure is transferred from the Trust fund component of equity to retained earnings. An amount equal to the revenue is transferred from revenue earnings to trust funds.

Insurance contracts

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

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.

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

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

Cost of service (Statement of Service Performance)

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

Cost allocation

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

Cost allocation policy

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

Criteria for direct and indirect costs

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

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

Cost drivers for allocation of indirect costs

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

Appendix 3 Performance Improvement Actions

2.2 Productivity Improvement Actions

DHBs are required to respond to the Government's request to all Crown Entities to develop performance improvement actions (PIAs) as part of "Improving the Business of Government: Delivering Better, Smarter Public Services for Less". In May 2009, Cabinet agreed that Crown Entities are to identify key actions to improve efficiency, effectiveness and alignment of the spending they administer with Government priorities.

In summary, Northland DHB aims to achieve the following:

Expectation	Planned achievement
Achieving financial security through efficiencies	\$1.2M
Improving productivity and quality	No currently identified direct savings, but increases in throughputs for services and gains in quality.
Enhancing regional cooperation	Most improvements will be in increases in throughputs and gains in quality. Some cost savings will arise through back-office functions such as procurement, but these cannot be quantified yet.

Northland DHB's total savings from PIAs in 2010/11 will be \$1.2M.

Appendix 4 Definitions of Output Classes

Public health services

Publicly funded services that protect and promote health in the whole population or identifiable sub-populations. They comprise services designed to enhance the health status of the population as distinct from curative services which repair and/or support health and disability dysfunction.

Public health services address individual behaviours by targeting population-wide physical and social environments to influence health and wellbeing. Public health services include:

- health promotion to ensure that illness is prevented and unequal outcomes are reduced
- statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases
- individual health protection services such as immunisation and screening services.

Primary and community health care services

Services that are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. They include general practice, community and Maori health services, pharmacist services, community pharmaceuticals (the Schedule) and child and adolescent oral health and dental services. These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB.

Hospital (secondary) services

Services that are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are usually integrated with 'facilities' classified as hospitals to enable co-location of clinical expertise and specialised equipment. They are generally complex and provided by health care professionals who work closely together. They include:

- Ambulatory services (including outpatient, district nursing and day services), across the range of secondary preventive, diagnostic, therapeutic, and rehabilitative services
- Inpatient services (both acute and elective streams), including diagnostic, therapeutic and rehabilitative services
- Emergency Department services, including triage, diagnostic, therapeutic and disposition services

Support Services

Services delivered following a 'needs assessment' process and coordination input by NASC (Needs Assessment and Service Coordination) services for a range of services including palliative care services, home-based support services and residential care services

Appendix 5 Full Intervention Logic Framework

Vision	Whanau Ora – full participation in society								
High Level Outcomes	Improved health and disability status				Improved equity				
High Level Measures	↑ life expectancy for the Northland population		↓ mortality rate (age-standardised)		↓ infant mortality		↓ gaps between: (a) Maori and non-Maori (b) Northland and NZ		
Outcomes	Improved wellness		Independence for those with impairments		Prevention of illness and disease		Cure of acute illness and disease		Minimal impacts for those with long term conditions
Impacts	Tobacco Healthier population with lower prevalence of smoking-related conditions.	Healthy children Reduced likelihood of acquiring long term conditions later in life. Lower incidence of communicable disease. Healthier teeth and gums. Safer children.	Diabetes and CVD Amelioration of disease symptoms and/or delay in their onset.	Cancer For curable cancers, increased likelihood of survival. For incurable cancers, reduced severity of disease 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. Delayed onset of long term conditions.	ED waiting times More timely assessment, referral and treatment.	Quality Patients who are more satisfied with their care. Fewer adverse clinical events resulting from patient care. People receive quality services from NGOs.	Support for older people Older people requiring support or care receive services appropriate to their needs.
Impact Measures Main Measures	1 Proportion of Year 10 students who have never smoked. 3a Proportion of the population who smoke. 3b Proportion of smokers trying to quit. 7 Proportion of pregnant women who smoke.	2a Infants exclusively and fully breastfed. 2b Two-year-olds who are fully immunised. 4a Five-year-olds who are caries-free. 4b Average number of decayed, missing or filled teeth in Year 8s. 8 Referrals to CYFS of children suspected of being abused.	5a Diabetics receiving annual free checks in primary care. 5b Diabetics receiving annual free checks who have good blood sugar management. 5c Reduced incidence and prevalence of heart disease.	6 For breast cancer, cervical cancer and major cancers: • new cases • survival rates • deaths.	9 The number of new active cases requiring intervention by specialist staff.	10 Improvements in quality of life among patients receiving elective surgery.	11 Waiting times in Emergency Departments.	Measures of the quality and safety of services: 12a satisfaction and complaints 12b readmissions to hospital 12c clinical measures of quality 12d compliance with contracts.	13a Change in distribution of home based support services towards older people with higher support needs. 13b Avoidable admissions from residential care to emergency departments.
Output Classes	Public and population health		Primary and community services		Secondary services		Support Services		
Outputs	Health promotion programmes (Smokefree/Auahi Kore). Support provided to smokers in primary care to quit. Support for smokers in hospital to quit. Support for pregnant smokers to quit.	Midwifery services Primary care services performing immunisations. Oral health assessment and treatment procedures. NDHB Child Protection services. Referrals to CYFS.	Risk assessments in primary care (annual free checks, blood tests, risk profiles). Laboratory tests.	Screening for breast and cervical cancers. Provision of radiation therapy, chemotherapy.	Care provided in a primary care setting for people with mild to moderate disorders whose condition is stable. Specialised clinical support by NDHB community mental health services. Admission to hospital for those whose condition is unstable.	Rate of provision of elective surgical procedures by hospitals.	Assessments, treatments and referrals performed in EDs.	NDHB Provider services (described more fully in SOI section 5.2 Quality and safety).	Home based support services provided by NGOs. Residential care provided by NGOs. Assessments by NDHB's NASC service. End-of-life programmes delivered to providers of aged residential care.
Output Measures Health Targets	1 Health promotion programmes in schools. 3 Percent of smokers in primary care provided with support to quit. 8a Percent of smokers admitted to hospital provided with support to quit. 8b Percent of pregnant women provided with support to quit.	2a Support provided to mothers to breastfeed. 2b Immunisations performed on two-year-olds. 4a Oral health assessment and treatment provided to five-year-olds. 4b Oral health assessment and treatment provided to Year 8s. 9a Referrals to CYFS of children suspected of being abused. 9b AUT Family Violence Audit score.	5a Of those estimated to have diabetes, percent who have had annual free checks. 5b Laboratory tests on people with diabetes. 5c Of people in eligible populations, those who have had a CVD risk assessment in the last 5 years.	6a Targets for breast cancer screening in eligible populations. 6b Targets for cervical cancer screening in eligible populations. 10a People diagnosed with cancer who receive radiation treatment within 6 weeks (till Q1 2010/11) or 4 weeks (from Q2 2010/11). 10b People diagnosed with cancer who receive chemotherapy within 6 weeks.	7 Number of referrals from GPs to Primary Mental Health Initiative Coordinators. 11 Clients with severe mental illnesses who are seen over a year.	12 Rate of provision of elective procedures per 100,000 population, by selected specialties.	13 Patients with an ED length of stay (time from presentation to admission, discharge or transfer) of less than 6 hours.	14a Percent of patients surveyed who are 'satisfied' or 'very satisfied'. 14b Number of complaints to NDHB per patient contact 14c Complaints to NDHB closed within 20 working days 14d HDC complaints that result in a finding of breach of the Code. 14e Readmission rates. 14f Surgical site infections. 14g Hand hygiene compliance.	15a Reduced proportion of people receiving low-level home based support services. 15b Admissions from residential care to emergency departments.

