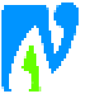
NORTHLAND DISTRICT HEALTH BOARD



STATEMENT OF INTENT

2009/10 – 2011/12

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1 Executive summary

For Northland District Health Board, the 2009/2010 financial year will see the consolidation of strategies many of which are in line with the Ministerial Letter of Expectation. The moving environment presents the District Health Board with challenges and opportunities to follow initiatives which reflect the evolution of the relationships within the district and across the Northern Region.

The development of stronger operational and strategic links with our providers as well as a growth in and strengthening of our relationship with the other District Health Boards in the Northern region signify a maturing of Northland District Health Board.

During this financial year we will consolidate the relationships with other providers and deliver on key ministerial initiatives engaging PHOs, Maori providers, aged care providers, maternity services and workforce and educational partners. We will further operationalise our relationship within the Northern Region and we will work to ensure that the Health Vote dollar allocated to future capital investment in the Northern Region is best allocated for the better health of our population, through regional cooperation and sound joint planning.

The staff serving the health sector in Northland is our most valuable resource and we will put our best endeavours forward to continue to demonstrate support and commitment to them in their efforts in their workplaces.

The Northland District Health Board looks forward to this year as one of positive change. We know that the challenges placed before us will be faced with courage, passion for the services we provide, based on the sound values of the Board.

He Tangata, He Tangata, He Tangata.

Lynette Stewart
Chairperson

Board member

Karen Roach
Chief Executive

2 Context

2.1 About the SOI

The SOI is for the period 2009/10 to 20011/12. It describes to Parliament and the Northland community what we intend to achieve over the next 3 years to promote, enhance and facilitate the health and wellbeing of our population. The SOI covers Northland DHB's activities at 3 levels:

- governance, the elected and appointed Board
- the Funder, that part of Northland DHB that allocates funding across the health sector in Northland according to the needs it has assessed and priorities it has set
- the Northland DHB Provider, our hospital and community health services.

It includes forecasts for 2009/10 and the subsequent 2 years of:

- performance measures for NDHB's output classes (sections 4.3 to 4.6)
- finance (section 4.7)

2.2 Legislation

This Statement of Intent (SOI) has been prepared by the Northland District Health Board to meet the requirements of section 42 and section 39(8) of the New Zealand Public Health and Disability Act 2000 and section 139(1) of the Crown Entities Act 2004. Once signed off, it will be available on our public website www.northlanddhb.org.nz/publications/.

Northland District Health Board is one of 21 DHBs established on 1 January 2001 in accordance with section 19 of the New Zealand Public Health and Disability Act 2000 (NZPHD Act 2000). Northland DHB is categorised as a Crown Agent under section 7 of the Crown Entities Act 2004, section 49 of which states that DHB Boards must ensure that DHBs act in a manner consistent with their objectives, functions, and this SOI.

The SOI is aligned to and consistent with:

- NZ Public Health and Disability Act 2000
- Crown Entities Act 2004
- Public Finance Act 1989 (and subsequent amendment acts)
- New Zealand Health Strategy 2000
- New Zealand Disability Strategy 2001
- He Korowai Oranga (Maori Health Strategy) 2002
- Te Tahuhu: Improving Mental Health 2005-2015 2005
- Health of Older People Strategy 2002
- Primary Health Care Strategy 2001
- Pacific Health and Disability Action Plan 2002
- Northland DHB's District Annual Plan 2007/08 (DAP)
- Northland DHB's District Strategic Plan 2005-2010 (DSP)
- Northland DHB's Crown Funding Agreements (CFA).

2.3 Population

Total population	Northland's projected population population for 2009 is 156,240, 3.6% of New Zealand's population.
Maori	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.

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% of the population in 2006 to 21% by 2016. Older people (65+ years) are projected to grow from 15% to 19% over the same period.

Deprivation Northland has one of the most deprived populations in the country. While 20% of NZ's population is in the lowest quintile of deprivation[1], the equivalent measure for Northland is 35%. The most deprived local authority area is the Far North DC with 51% in the lowest quintile; within FNDC the most deprived areas are Hokianga 83%, Whangaroa 41% and north of the Mangamukas 55%.

2.4 Health profile

What the HNA is Northland DHB's health profile is generated through a comprehensive Health Needs Assessment (HNA)[2] that describes our population and its health status and identifies key strategic priorities. It was prepared in consultation with stakeholders and published in 2005, and a partial update was prepared in 2008 through a unit of the Ministry of Health. We continue to expand the scope and improve the quality of information as a normal part of our work.

How we use the HNA The HNA's identification of health needs enabled us to develop a District Strategic Plan (DSP)[3] based on the key priorities and containing long-term strategic outcomes to meet our population's needs. This adds a local flavour to the nationally-driven requirements of the Public Health and Disability Act 2000, Ministry of Health priorities and Ministerial priorities that guide DHBs.

Key priorities of Northland DHB

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

Long term conditions The 'big 3' are diabetes, cardiovascular and cancer.

39% of Northlanders die from **cardiovascular diseases** (heart diseases 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.

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.

31% of Northlanders die from **cancers**. The four most common sites are (in order) trachea-bronchus-lung, colorectal, prostate and breast.

Oral health 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.

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[1] The Deprivation Index uses Census data to generate deprivation scores for the population, then divides it into 5 numerically equal groups, or quintiles.

[2] Available at http://www.northlanddhb.org.nz/publications/.

[3] Ibid.

Child and youth	The child and youth population in Northland is projected to decline over the coming years, but it remains a priority because healthy children make for healthy adults. Children in Northland are also more needy than adults; while 70% of Northland adults are categorised into the lowest half of the deprivation index, this applies to 85% of children.
Lifestyle behaviours	How people live their lives and the behaviours they exhibit have an enormous influence on health status. There are a vast range of influences, but key ones are smoking, diet and physical activity.
Mental health	A priority since the publication of the *Blueprint for Mental Health Services in NZ* in 1998. Since then increasing resources have been progressively invested nationally to work towards a full range of mental health services.
Older people	An increasing priority over recent years as our population ages. This has impacts on health services provided specifically for older people (age related residential care, home based support services, day care). It also affects the prevalence of long term conditions because these generally become more common as the population ages.

2.5 The role of Northland DHB

2.5.1 Legislative objectives and functions

The total Northland DHB budget is allocated about equally between our Provider and Funder roles, which have distinct functions. Before describing briefly what these entail, the rest of this section summarises the key objectives and functions of DHBs as listed in the legislation under which they come, the Public Health and Disability Act 2000.

Objectives of DHBs	**Functions of DHBs**
(a) improve, promote, and protect the health of people and communities (b) promote the integration of health services, especially primary and secondary health services (c) promote personal health services and disability support services (d) promote inclusion, participation and independence of people with disabilities (e) and (f) reduce health disparities (g) exhibit a sense of social responsibility (h) foster community participation (i) uphold ethical and quality standards (j) exhibit a sense of environmental responsibility (k) be a good employer.	(a) ensure the provision of services as specified in its Crown Funding Agreement (b) develop collaborative arrangements in the health and disability sector (c) issue information relevant to promoting paragraphs (a) and (b) (d) enable Maori to participate in and contribute to strategies for Maori health improvement (e) continue to foster the development of Maori capacity (f) provide information relevant promoting paragraphs (d) and (e) (g) regularly monitor the health status of the population (h) promote the reduction of adverse social and environmental effects (i) monitor the delivery and performance of services (j) participate in the training of health and disability workers (k) provide information to enable the performance of the DHB to be monitored

2.5.2 NDHB Funder functions

The Funder has two parts to its role: planning, and funding and contracting.

Planning pitches its focus at a strategic level to improve the health of the Northland population overall and reduce inequalities among population subgroups. The planning function does not allocate or control resources, but puts processes and systems in place that work towards improving the allocation of funding, the distribution of resources, and collaboration between organisations. The planning function includes assessing health needs, developing high-level plans to meet these, the use of prioritisation tools, monitoring the implementation of plans, and monitoring health status.

The funding and contracting role is focused on the contracts that NDHB has with a variety of providers in the wider health sector (often referred to as NGOs, or non-governmental organisations). Northland DHB holds 208 contracts with 145 health service providers. Over two-thirds of contracts are with primary health care providers (mostly GPs), pharmacists, mental health service providers and providers of residential care for older people. The remaining contracts cover Maori health providers, oral health, public health, palliative care, laboratory and Pacific people.

The Funder is also responsible for funding more specialised (tertiary) services not available in Northland, which mostly require people to travel to Auckland. Mostly these services comprise include heart and cancer treatments and highly specialised surgical operations.

2.5.3 NDHB Provider functions

NDHB Provider role

The DHB's own provider arm, which includes secondary services at our four hospital sites (in Whangarei, Kaitaia, Kawakawa and Dargaville) and the DHB's own community health services.

Clinical services	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.
Emergency	Emergency departments exist at all hospital sites.
Mental health, alcohol and other drugs	A full range of inpatient and community support services covering child and youth, adult, and older people, and incorporating Maori mental health.
Disability	Assessment and rehabilitation, wheelchairs and orthotics.
Community services	The Community, Dental and Public Health Services arm includes Public and Population Health Services (health promotion and health protection), dental services, home healthcare services and well child and youth services.

3 Outcomes framework

3.1 Government priorities

Our SOI aligns with Ministry and Government priorities and with Northland DHB's long term intention to improve the health and wellbeing of our community and reduce inequalities.

DHBs fund and plan for services in accordance with national health and disability strategies, with a local context added through our strategic planning process (referred to earlier in section 2.2). Each priority (diabetes, child and youth health etc) is developed into its own strategy to provide a thorough, but still fairly high level, analysis of how services should be changed to improve health status[4]. DHBs prepare a District Annual Plan[5] which is based on the plans relevant to each year from each of the strategies.

The Minister of Health writes a Letter of Expectations[6] in which he announces his specific expectations of DHBs for the coming year.

A set of national Health Targets has been identified to focus the efforts of DHBs and make more rapid progress on key national priorities. These Health Targets are included within the selection of performance measures in this SOI; they are also in section 5.1 of our DAP 2009/10.

3.2 Outcomes

Based on these national priorities and local health needs, Northland DHB has developed a vision of "Creating a healthier Northland". Underlying this are two key outcomes.

Improved health status	A population that looks after its own health by adopting healthier ways of living will have a greater sense of wellbeing. It is also crucial to "add life to years", supporting people to stay as healthy as possible for as long as possible. A healthier Northand population will be able to contribute more productively to society. It will also reduce demands on health services, especially the treatment of long term conditions (described in section 2.2).
Reduced inequalities	Reducing inequalities between population groups will not only improve the overall health status of Northlanders, but contribute to a stronger society and a more viable economy.

These outcomes are consistent with the purposes of the Crown Entities Act 2004 and the New Zealand Public Health and Disability Act 2000.

4 All strategies developed so far are on NDHB's website at http://www.northlanddhb.org.nz/publications/.
5 Ibid.
6 http://beehive.govt.nz/release/letter+expectations+dhbs+released

3.3 Key mechanisms for intervention

As described earlier in section 2.3, Northland DHB:

funds health and disability services through the contracts we have with NGOs

provides hospital and specialist services

promotes health and wellbeing among Northlanders through health promotion and public health programmes, both in our own provider arm and through contracts.

We want to ensure our interventions are relevant to our communities, coordinated and ensure best value for money. Before making decisions about funding, provision or promotion we:

plan in consultation with key stakeholders (Maori, Primary Health Organisations and NGOs) and our community

plan in collaboration with other DHBs (especially the three in Auckland), regional and national work[7]

prioritise how to spend Northland's health funds through a nationally agreed mechanism[8].

3.4 Intervention logic

The interventions we choose are consistent with achieving the outcomes described in section 3.2. We use the intervention logic model in Table 1.

Table 1 DHB intervention logic model

If we invest in ➡	And undertake ➡	Then we produce ➡	Which we group into ➡	That will achieve ➡	And contribute to
Inputs resources capability	**Activities** **Initiatives** **Projects**	**Outputs** services provided	**Output classes** public health services primary & community services hospital services support services	**Ministry of Health priorities** **MInister's expectations** **NDHB strategic goals**	**Improved health status** **Reduced inequalities**
		DHB enablers activities programmes projects	**DHB programmes** activities programmes projects		

Types of health need and interventions

How NDHB seeks to improve the health of the population depends on the type of health needs people have. To illustrate this, Table 2 describes the framework we have developed for dealing with long term conditions. It categorises the population into four subgroups according to their health status and ability to function in society, and describes the typical types of services applied to each of the groups.

Table 2 also suggests an inverse relationship between health status and the cost of providing services. Healthy people require very few, if any, resources from the health system. Once people

[7] Our District Annual Plan 2009/10 http://www.northlanddhb.org.nz/publications/ contains extensive descriptions of our collaborative relationships with others both inside and outside the health sector, especially in sections 3.3 to 3.5.
[8] http://www.moh.govt.nz/moh.nsf/pagesmh/4177?Open

develop a long term condition they require ongoing monitoring and management. If it reaches a severe stage, expensive treatments are usually necessary.

Table 2 NDHB Long Term Conditions Framework[9]

Four principles to guide the framework			
Equity in outcomes	Evidence-based practice	Quality systems	Efficiency

	Population subgroup			
	Healthy population and precursor risk	**At risk**	**Mild and advanced symptoms**	**End stage**
Definition of group	Healthy people and those with precursor risks[10].	Damage accumulates, risk factors combine, likelihood of disease increases.	Clinical indicators develop and begin to have an effect which increases with time. Long term condition is established and is usually progressive.	Severe debilitation, major loss of functioning and eventually death.
Types of services (outputs) provided	Supporting them to stay healthy or to reduce and eliminate risks to prevent disease developing.	Early detection and screening to enable early intervention. Assist people to eliminate or reduce risky behaviours and their effects.	Self-management and regular clinical checks to reduce harmful effects and maintain as high a level of wellness and functioning for as long as possible.	Hospitalisation and/or palliative care involving intensive, costly treatment.

Health status, ability to function

Level of disability, cost of services

Implications of Table 2

Maintaining health

Long term conditions cannot be eliminated and tend to become more common as we age. The challenge is to maintain a reasonable level of health and fitness for as long as possible and 'compress' the disease phase into a minimal period towards the end. For DHBs, Table 2 suggests that investing in services that keep people healthy and prevent or delay the onset of disease is the most cost-effective approach. It enables the population to function better in their daily lives, increasing their ability to contribute to their families and to society as a whole. It also enables health funders to restrain the ever-rising cost of health services.

Supporting people with long term conditions

Health services also have an obligation to provide treatment to people who develop diseases. Once a long term condition is acquired it can generally only be managed, not eliminated. The challenges are to persuade people to recognise when symptoms are significant, and to design services that detect conditions in their earliest stages while control is easiest. As conditions become more advanced, self management and regular visits to clinical services become increasingly important to maintain functionality for the individual and minimise impacts on health services.

[9] Abbreviated version; the full version which contains a number of rows describing various "Services, activities, programmes" is available in our District Annual Plan 2009/10 at http://www.northlanddhb.org.nz/publications/.
[10] Those who have no measurable symptoms of ill health, but have attributes that might lead to later problems, such as a smoking habit, inadequate exercise, increasing weight or an unbalanced diet.

3.4.1 Prioritisation of key interventions

Table 3 provides some examples to illustrate the intervention logic.

Table 3 Examples of intervention logic

Diabetes				
If we invest in ➡	**And undertake** ➡	**Then we produce (outputs, enablers)** ➡	**That will achieve (impacts)** ➡	**& contribute to (outcomes)**
Primary care services.	Annual free checks (AFCs) of diabetics. Improvements to info systems that support diabetes management, including linkages between primary and secondary services.	Info on diabetics who are managing their condition well (% with blood sugar under the recommended level). Info identifying individual diabetics who have not had their AFCs. Info by ethnicity, deprivation level, and geography to identify at-risk groups of diabetics not receiving AFCs.	More people who are better managing their diabetes and have fewer complications. Identification and follow-up of those who have not had their AFC, thus adding to the above group. Planning for improved services to capture the at-risk groups who are 'missing out'.	Improved health status. Reduced inequalities.

Oral health services for youth				
If we invest in ➡	**And undertake** ➡	**Then we produce (outputs, enablers)** ➡	**That will achieve (impacts)** ➡	**& contribute to (outcomes)**
Oral health services.	A reorganised, seamless, community-based oral health service. Increases in the oral health workforce.	Higher attendances at oral health services by youth. More equitable coverage (reduce gaps by ethnicity, deprivation level, geography).	Improved oral health status (fewer teeth that are decayed, missing, filled).	Improved health status. Reduced inequalities.
Rationale. While the oral health of children requires significant improvement, they are readily accessible to public oral health services through schools. Adolescents are harder to reach because traditionally once they reach secondary school they have come under private dentists, but it has been up to them to attend. There is scanty data on the oral health of adolescents, but we know intuitively it is poor. A single public oral health service covering ages 0-18 will help deal with many of these problems.				

Mental health relapse plans				
If we invest in ➡	**And undertake** ➡	**Then we produce (outputs, enablers)** ➡	**That will achieve (impacts)** ➡	**& contribute to (outcomes)**
Mental health services.	Planning with clients, their families and significant others.	Relapse plans[11] for all clients with long term mental health conditions.	More stable lives for people with mental health conditions, their families and significant others. Fewer demands on mental health secondary services.	Improved health status. Reduced inequalities.

[11] A relapse plan is an individually tailored plan that identifies early warning signs of a recurring illness and describes for the client and their family what action to take, thus promoting prompt action and minimising the risk of deterioration.

3.4.2 Development of measures

For each intervention NDHB develops measures to describe the changes taking place in services and the impacts these have on patients and clients – in other words, whether we are 'making a difference'. For each of the examples above, Table 4 describes the measure, the baseline level of performance from current or most recently available data, and improvement targets for 2009/10 and the two following years.

Table 4 Examples of measures

Outputs	Measures	Baseline	Targets		
			2009/10	2010/11	20011/12
Diabetes Annual Free Checks (AFCs)	% of diabetics receiving an AFC: Maori Non-Maori Total population	 40% 29% 32%	 60% 60% 60%		
	% of diabetics receiving AFCs whose blood sugar is under 8%. Maori Non-Maori Total population	 54% 77% 67%	 70% 70% 70%		
A reorganised, seamless, community-based oral health service with an expanded workforce.	% of youth (Year 9 to ages 17) enrolled with oral health services: Maori Pacific Other	39.2%[12]	 44% 44% 52%		
Relapse plans for all clients with long term mental health conditions.	% of long-term mental health clients who have relapse plans. Maori, ≥ age 20 Maori, ≥ age 20 Maori, child & youth Maori, total	 95% 91% 92% 94%			
	Total ≥ age 20 Total, ≥ age 20, addictions only Total pop, child & youth Total pop	92% 93% 97% 93%			

[12] For total population only. Measure was introduced in 2007/08 and only for total population.

4 Statement of Forecast Service Performance (SFSP)

4.1 Introduction

Section 2 Section 2 of the SOI described the Northland population and its major health needs. It also explained that though the DHB is by far the largest health organisation in Northland, it is only one of many health service providers. Since the DHB does not directly control other providers, we must use other means to achieve progress such as negotiating and monitoring contracts, improving integration of services between the DHB and non-DHB providers, joint planning and collaborative ventures.

Section 3 Section 3 explained in a bigger-picture sense what Northland DHB is trying to achieve (priorities and outcomes), the thinking we use in designing services and programmes (our intervention logic) and gave some examples of how we measure progress.

Section 4: the SFSP Section 4 takes the process a step further. It develops a Statement of Forecast Service Performance (SFSP) by applying the intervention logic and measurement process to a range of key activities. It explains the impacts these have, the outcomes they support, the measures we apply, describes baseline levels of performance and sets future targets.

Key selected activities only The SFSP highlights a selection of activities that make key contributions to our outcomes and to national and local priorities. It does not attempt comprehensive coverage of Northland's health needs and health services (that is more the intent of our District Annual Plan mentioned in section 3.1).

Other accountability mechanisms Northland DHB is accountable through mechanisms other than the SFSP, as explained in section 5.1.

4.2 Output classes

Section 4 is organised around "output classes", broadly similar types of services grouped together for the purposes of the SOI to make it more understandable to audiences outside the health sector. Table 4 describes the four types of output classes.

Table 5 Output classes: description and who provides them

Output class	Description	Who provides	
		DHB	Non-DHB
Public health services	Services aimed at improving the health of the population as a whole (as distinct from personal health services delivered to individuals). They include health promotion, health protection, screening programmes (such as breast and cervical screening, B4 School Checks) and immunisation.	✓	✓
Primary and community services	Personal health services based in the community that people can access directly. They include general practitioners, Maori health providers, pharmacists, nurse practitioners, public health nurses, Plunket, midwives, health of older people services[13], and a host of others.	✓	✓
Hospital services	Services that are generally accessible only through referral by a health professional, commonly a GP. There are two levels of service: (a) secondary (general hospital services), as provided at Whangarei Hospital; (b) tertiary (super-specialty) mostly provided by Auckland DHB (for which NDHB pays). More details on secondary and tertiary services are included in section 2.3 and the flowchart in section 4.5.	✓ secondary services	✓ tertiary services
Support Services	Services which are not easily classifiable into one of the above three categories, usually because they cover more than one of them. Examples include palliative care services and Needs Assessment and Service Coordination[14].	✓	✓

4.3 SFSP for public health services

Table 6a Intervention logic for public health services

If we invest in ➡	And undertake ➡	Then we produce (outputs, enablers) ➡	That will achieve (impacts) ➡	& contribute to (outcomes)
Public health services	Health promotion	Smoking Cessation Programme referrals in primary health care.	Fewer people smoking (short term). Reduced incidence of smoking-related disease (longer term).	Improved health status. Reduced inequalities (through a focus on high-need groups with poorer health status indicators)
	Health protection	Investigations of communicable disease notifidcations.	Early identification of people who have contracted disease and early action to prevent its spread.	
		Monitoring of water supplies.	Higher standards of water available to the public, lower rates of gastrointestinal disease.	
	Population screening	Breast screens Cervical screens	Early detection of cancerous or pre-cancerous conditions.	

[13] These comprise age-related residential care, home-based support services and day services.
[14] NASC for short. An organisation contracted by the Ministry of Health or 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).

If we invest in ➡	And undertake ➡	Then we produce (outputs, enablers) ➡	That will achieve (impacts) ➡	& contribute to (outcomes)
		B4 School Checks	Early detection of health problems in school new entrants.	
	Well child services	2-year-olds fully immunised. Year 8 girls immunised against HPV[15].	Higher level of protection against communicable diseases in the population.	
	Healthy Eating, Healthy Action	% of mothers exclusively and fully breastfeeding at 6 weeks, 3 months and 6 months.	Adequately nourished babies. Higher levels of protection against disease.	

Table 6b SFSP for public health services

Services provided	Outputs, enablers	Baseline measure		Targets		
		Description	Data	2009/10	2010/11	2011/12
Health promotion	Smoking Cessation Programme referrals	No. of quit attempts supported by primary health care providers through ABC[16].	2,000	4,000	6,000	6,000
		Hospitalised smokers will be provided with advice and help to quit:	n/a[17]	80%	90%	95%
Population screening	Breast screens[18]	% of women aged 45-69 receiving breast screens:				
		Total population	33%	34%	35%	35%
		Maori	33%	34%	35%	35%
		Non-Maori	33%	34%	35%	35%
	Cervical screens	% of women aged 20-69 receiving cervical screens:				
		Total population	71%	75%	>75%	>75%
		Maori	71%	75%	>75%	>75%
		Non-Maori	71%	75%	>75%	>75%
	B4 School Checks	% of new entrants receiving B4SC:				
		Total population	n/a[19]	1,050	n/a	n/a
Well child services	2-year-old immunisations[20]	% of 2-year-olds fully immunised:				
		Total population	%	85%	90%	95%
		Maori	%			

[15] Human Papilloma Virus, two strains of which are known to cause most cervical cancer, and which the HPV immunisation guards against.

[16] A model of smoking cessation that comprises **A**ssessment, **B**rief intervention and referral to supported **C**essation services.

[17] Data systems to capture this reliably have not existed in the past.

[18] This is a 2 year programme. This needs to be taken into account for mobile areas in Northland as the number of weeks in each area can differ, that is 5 weeks in 2008 and 8 weeks in 2009. The coverage may meet the target for 2 years but be variable yearly. This programme is run in partnership with Waitemata DHB who are the lead providers and have set the targets. Variables affecting planning are the annual 3% increase in the target population and the requirement to screen additional numbers of women per annum to compensate for those who are screened twice within the 24 month period but only counted once. This is required to meet the BreastScreen Aoteatoa National Policy & Quality Standards and is predicted to affect 3,000-5,000 women across the BreastScreen Waitemata Northland programme.

[19] No baseline data exists because the programme was only begun in Sep 2008. Targets don't exist for out-years because NDHB's contract with MoH is only up till June 2009, and with the provider until August 2010; if and when the contract is renewed, out-year targets will be established. The targets agreed with the provider don't include ethnicity.

[20] NDHB's ability to achieve these targets will be compromised by: (a) a substantial proportion (in excess of 5%) of parents who do not consent to having their child immunised; (b) the way data is reported to and from the NIR,resulting in an undercount of Northland immunisation rates estimated at between 7% and 9%.

Services provided	Outputs, enablers	Baseline measure		Targets		
		Description	**Data**	**2009/10**	**2010/11**	**2011/12**
		Non-Maori	%			
	Immunisations against HPV	% of Year 8 girls completing a course of immunisation against HPV:				
		Total population	n/a[21]n/an	80%	85%	90%
		Maori	/a	80%	85%	90%
		Non-Maori		80%	85%	90%
Healthy Eating, Healthy Action	Research into how to target non-breastfeeding Maori mothers more effectively. Increasing the coverage of breastfeeding data to include both Plunket and Tamariki Ora services.	% of mothers exclusively and fully breastfeeding:[22]				
		74% at 6 weeks	73%	73%	74%	75%
		57% at 3 months	55%	55%	57%	58%
		27% at 6 months	21%	24%	27%	28%

4.4 SFSP for Primary and community services

Table 7a Intervention logic for primary and community services

If we invest in ➡	And undertake ➡	Then we produce (outputs, enablers) ➡	That will achieve (impacts) ➡	& contribute to (outcomes)
GP services	Diabetes Annual Free Checks (AFCs)	Info on diabetics who are managing their condition well (% with blood sugar under the recommended level). Info identifying individual diabetics who have not had their AFCs. Info on AFC coverage of the diabetic population (by ethnicity, deprivation level, geography) to identify at-risk groups of diabetics not receiving AFCs	More people who are better managing their diabetes and have fewer complications. Identification of those who have not had their AFC, thus adding to the above group. Planning for improved services to capture those who are 'missing out'.	Improved health status. Reduced inequalities.
	Cardiac monitoring	CVD[23] risk assessments. Lipid and glucose tests performed on people who have had CVD risk assessments.	Knowledge of the level of risk of developing CVD.	
	Primary care assessment and treatment services	Conditions managed appropriately in a primary care setting. Protocols to assist GPs to refer appropriately.	Fewer admissions to hospital that are avoidable or preventable by appropriate treatment in primary care. Earlier resolution of	

[21] No baseline data exists because the programme was not begun until 2008/09.
[22] The data currently received by NDHB covers the clients of Plunket, but not Tamariki Ora (Maori provider) well-child services, so this year's targets have been set on a Plunket-only basis. NDHB is working on sourcing Tamariki Ora data to: (a) provide a more complete picture of breastfeeding in Northland and (b) enable meaningful Maori and non-Maori targets to be set.
[23] Cardiovascular disease, which comprises heart disease and strokes.

If we invest in ➡	And undertake ➡	Then we produce (outputs, enablers) ➡	That will achieve (impacts) ➡	& contribute to (outcomes)
			conditions for patients, less chance of complications, disease progression slowed.	
NDHB primary and community services	A reorganised, seamless, community-based oral health service. Increases in the oral health workforce.	Higher enrolments (and therefore attendances) at oral health services by youth. More equitable coverage (reduce gaps by ethnicity, deprivation level, geography).	Improved oral health status (teeth that are decayed, missing, filled). Reduced impact on overall personal health status.	
Health of older people services	SCOPE Community Wellness for Older Adults programme[24]	Assessment of need, innovative solutions customised to each individual.	Reduced GP visits Reduced hospital admissions	
	Restorative home based support.	Setting goals and establishing support packages with clients which enable them to regain independence in activities of daily living, or minimise their functional decline.	Increased mobility and functional ability. Delayed entry into aged residential services. Reduced demands on informal carers.	

Table 7b SFSP for primary and community services

Services provided	Outputs, enablers	Baseline measure		Targets		
		Description	Data	2009/10	2010/11	2011/12
GP services	Diabetes Annual Free Checks (AFCs)[25]	% of diabetics who are receiving AFCs:				
		Total	60%	60%	n/a	n/a
		Maori	60%	60%	n/a	n/a
		Pacific	60%	60%	n/a	n/a
		Other	60%	60%	n/a	n/a
		% of diabetics receiving AFCs whose blood sugar is under the recommended level.				
		Total	76%	76%	n/a	n/a
		Maori	70%	70%	n/a	n/a
		Pacific	50%	50%	n/a	n/a
		Other	80%	80%	n/a	n/a
	Cardiac monitoring	% of target groups who have had a CVD risk assessment in the last 5 years:				
		By sex and ethnicity	n/a[26]	n/a	n/a	n/a
NDHB primary and community services	A reorganised, a seamless, community-based oral health service.	% adolescents enrolled with oral health services.				
		Total	29%[27]	48%	60%	75%

[24] Workers contact older people in the community, assess their needs and negotiate innovative solutions to maintain independence, reduce functional and social decline and minimise health problems.

[25] Targets are set on the basis of MoH's estimates of a DHB's total number of diabetics. The Northland estimate jumped from 6,907 in 2008 to 8,191 in 2009, so though the percentage target has not increased for 2009/10, it represents 770 extra people checked.
Targets apply to CYs (eg 2008/09 is for 2008). Targets do not exist for out-years because, under the national service specification for Local Diabetes Teams, targets are set annually by the Local Diabetes Team.

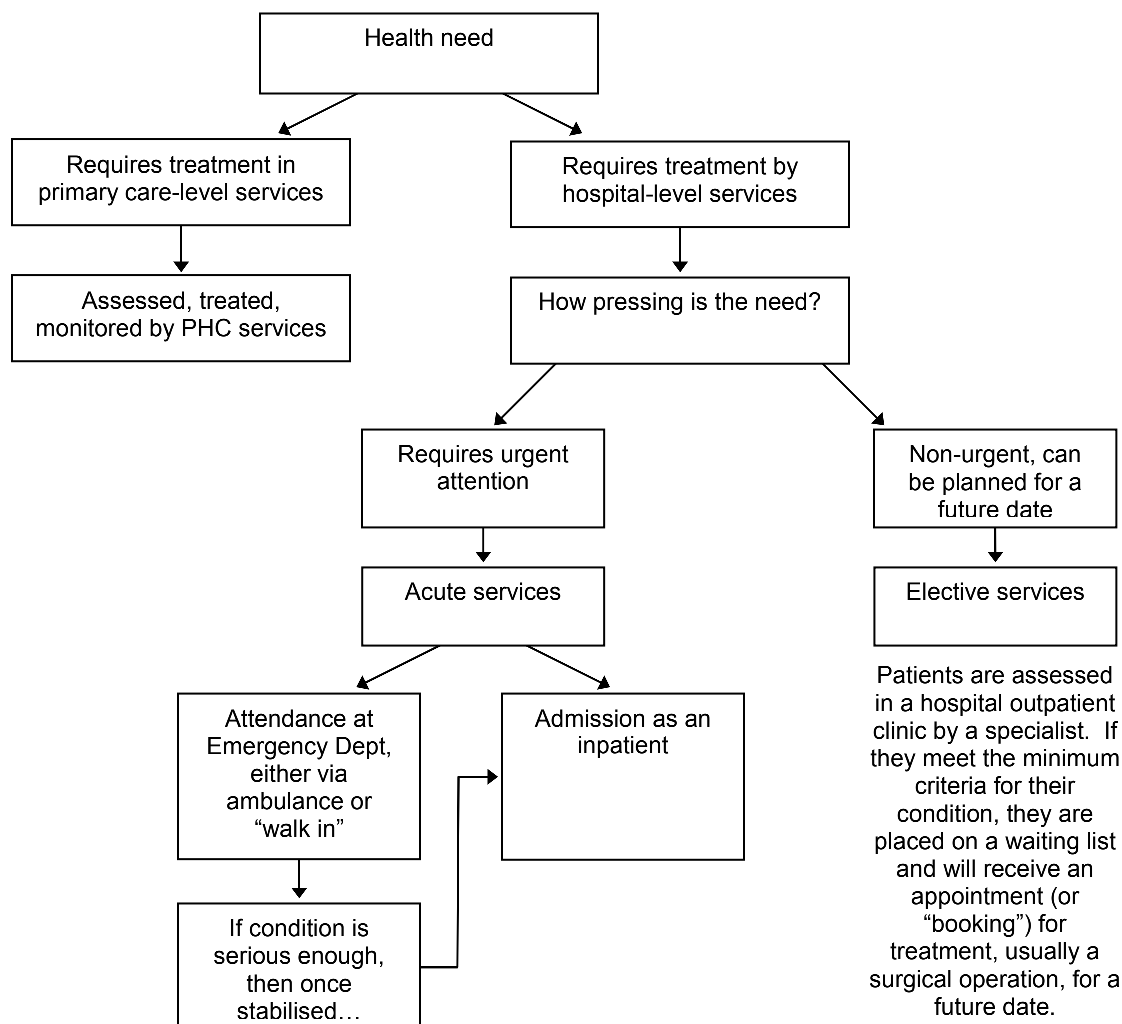
[26] Baseline data will become available during 2009/10 as the PHO performance programme becomes operational. This will enable targets to be set in next year's SOI. This measure is included this year to signal NDHB's intent to include it in future SOIs. Until the PHO reporting system begins, an interim measure, on lipid and glucose tests on people with CVD risk assessments, was captured until June 2009.

Services provided	Outputs, enablers	Baseline measure		Targets		
		Description	Data	2009/10	2010/11	2011/12
	Increases in the oral health workforce.					

4.5 SFSP for hospital services

To clarify the differences between patients who are treated by primary health care services and those treated by acute or elective hospital services, Figure 1 depicts typical patient-flow pathways.

Figure 1 Typical pathways for patients in primary health care services, elective and acute hospital services



4.5.1 Hospital services – acute

Table 8a Intervention logic for acute hospital services

[27] Baseline data is for 2007/08, the latest available because there is a long delay in the processing of claims by dentists.

If we invest in ➡	And undertake ➡	Then we produce (outputs, enablers) ➡	That will achieve (impacts) ➡	& contribute to (outcomes)
Primary care services	POPN[28]	More conditions treated appropriately in the primary care setting.	Illnesses detected and treated ASAP. Fewer admissions to hospital. Reduced costs to the health system. Higher patient satisfaction.	Improved health status. Reduced inequalities.
Quality systems	OPJ[29]	Clarity about how details of the treatment process work and how improvements can be made.	Shorter, safer, higher quality acute treatment processes. Fewer resources used. Less stressful experiences for patients.	
Mental health services.	Planning with clients, their families and significant others.	Relapse plans for all clients with long term mental health conditions.	More stable lives for people with mental health conditions, their families and significant others. Fewer demands on mental health secondary services.	

Table 8b SFSP for acute hospital services

Services provided	Outputs, enablers	Baseline measure		Targets		
		Description	Data	2009/10	2010/11	2011/12
Primary care services - POPN	Conditions treated appropriately in the primary health care setting.	Referrals into POPN for common potentially avoidable hospitalisations: cellulitis pneumonia and asthma dehydration (incl. gastroenteritis) deep vein thrombosis (DVT) Each of the above analysed by: age gender ethnicity patient satisfaction	2008/09 hospital admissions are being derived at the moment and will form baseline data. Referrals to POPN (= hospital admissions potentially avoided) will be monitored during 2009/10 to assess impacts. The overall objective is to manage 85% of referrals for the four named conditions at a maximum of $350 each, compared to an average inpatient day cost of $763.			
Cancer services	Radiation oncology treatments	% of patients waiting less than 6 weeks between first specialist assessment and the start of radiation oncology treatment[30].	100%	100%[31]	100%	100%
Mental health	Relapse plans for long-term	% of clients with long-term (known to services for ≥2 years) mental health conditions who have up-to-date relapse plans.				

[28] Primary Options Programme Northland, to be initiated in July 2009. A scheme to enable primary care providers to provide services for people with conditions that usually lead to admission to hospital. Other such projects in NZ suggest that substantial savings are possible in hospital service costs as well as higher patient satisfaction through being assessed and treated in the community.
[29] 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.
[30] Includes patients in category A (urgent, within 24 hours), B (curative, within 2 weeks) and C (palliative) but excluding D (combined radiotherapy and chemotherapy).
[31] The six-week target applies up to the end of July 2010, and will shorten to four weeks from December 2010.
[32] Baseline data is exceptionally high because of a one-off effort made to catch up on outstanding plans, but it will not be possible to apply this amount of resources routinely.

Services provided	Outputs, enablers	Baseline measure		Targets		
		Description	Data	2009/10	2010/11	2011/12
services	clients.[32]	Maori, ≥ age 20	95%	90%	92%	94%
		Maori, ≥ age 20, addictions only	91%	90%	92%	94%
		Maori, child & youth	92%	90%	92%	94%
		Maori, total	94%	90%	92%	94%
		Total ≥ age 20	92%	90%	92%	94%
		Total, ≥ age 20, addictions only	93%	90%	92%	94%
		Total pop, child & youth	97%	90%	92%	94%
		Total pop	93%	90%	92%	94%

4.5.2 Hospital services – elective

Table 9a Intervention logic for elective services

If we invest in ➡	And undertake ➡	Then we produce (outputs, enablers) ➡	That will achieve (impacts) ➡	& contribute to (outcomes)
Elective services	Improvements to processes and systems. Additional funding for additional procedures.	More elective procedures.	Lower level of illness and disability in the population. People whose ability to function is increased and who are more able to contribute to society.	Improved health status. Reduced inequalities.

Table 9b SFSP for elective services

Services provided	Outputs	Baseline measure		Targets		
		Description	Data	2009/10	2010/11	2011/12
Elective services	Improvements to processes and systems.	ESPIs[33]:				
		1 DHB services that appropriately acknowledge and process all patient referrals within ten working days.	>90%	>90%	>90%	>90%
		2 Patients waiting longer than six months for their first specialist assessment (FSA).	<2%	<2%	<2%	<2%
		3 Patients waiting without a commitment to treatment whose priorities are higher than actual treatment threshold (ATT).	<5%	<5%	<5%	<5%
		4 Patients without clarity of treatment status.	<5%	<5%	<5%	<5%
		5 Patients given a commitment to treatment but not treated within	<5%	<5%	<5%	<5%

[33] Elective Service Patient flow Indicators, measures of system performance at 8 critical points. A full explanation of the abbreviated wording in the table is available at http://www.electiveservices.govt.nz/indicators.html The existing targets are being exceeded. NDHB has set our own tougher targets which we work to, to create a buffer zone between them and the MoH targets. This is to both to ensure a high quality service and compliance with the MoH target. MoH has attached financial penalty clauses to its payment conditions for additional Electives Services funding. The NDHB 2009/10 DAP, on instruction from MoH, has included $8.6m of this Elective Services Funding. If NDHB agreed to tighter external (MoH) targets it would reduce the buffer zone between NDHB's internal targets and the MoH targets and therefore increase the risk of incurring financial penalties. NDHB does not propose to agree tougher ESPI targets than exist for 2008/09 as these financial penalties could result in MoH withdrawing some or all of the $8.6m.

Services provided	Outputs	Baseline measure		Targets		
		Description	Data	2009/10	2010/11	2011/12
		six months.				
		6 Patients in active review who have not received a clinical assessment within the last six months.	<15%	<15%	<15%	<15%
		7 Patients who have not been managed according to their assigned status and who should have received treatment.	<5%	<5%	<5%	<5%
		8 The proportion of patients treated who were prioritised using nationally recognised processes or tools.	>90%	>90%	>90%	>90%
	Additional funding for additional procedures.	Planned MoH Elective Initiative funded elective service discharges				
		Total	1,055	1,073	1,073	1,073

4.5.2 Hospital services – emergency

Table 10a Intervention logic for emergency services

If we invest in ➡	And undertake ➡	Then we produce (outputs, enablers) ➡	That will achieve (impacts) ➡	& contribute to (outcomes)
Emergency services	Redesigned data systems. Redesigned patient flow models[34].	Reduced length of stay in EDs. Reduced time from an ED request for an inpatient bed to admission onto a ward.	More efficient use of resources. Faster attention to needs for non-urgent patients. Less stressful experiences for patients.	Improved health status.

Table 10b SFSP for emergency services

Services provided	Outputs, enablers	Baseline measure		Targets		
		Description	Data	2009/10	2010/11	2011/12
Emergency services	Reduced length of stay in EDs.[35]	Percentage of ED patients who were admitted, transferred or discharged from ED within 6 hours.	n/a	n/a	n/a	n/a

4.6 SFSP for support services

Table 11a Intervention logic for support services

If we invest in ➡	And undertake ➡	Then we produce (outputs, enablers) ➡	That will achieve (impacts) ➡	& contribute to (outcomes)

[34] Such as MoH's Model of Care Project which requires a maximum stay of 6 hours for 95% of ED attendances.
[35] Work on reducing ED waiting times has been occurring in NDHB for some months, but a system to collect reliable data awaits the imminent purchase of a new ED Information System. Data on this measure is a new requirement under the latest Ministerial Health Target measures announced in May 2009, and 2009/10 will be used to collect baseline information. This measure is included this year to signal NDHB's intent to include it in future SOIs.

If we invest in ➡	And undertake ➡	Then we produce (outputs, enablers) ➡	That will achieve (impacts) ➡	& contribute to (outcomes)
NASC (Needs Assessment and Service Coordin-ation)	Needs assessment: determining eligibility and need for publicly-funded disability support services. Service coordination: allocating services to third party providers.	Packages of care aligned to clients' disability support needs. More regular client reviews. Informal carer impact assessment.	Timely access to appropriate services. Reduction in ED presentations and avoidable hospital admissions (falls especially). People living in their own homes longer. Less impact on informal carers.	Improved health status. Reduced inequalities.
Palliative care	Palliative Care Liaison Team for Secondary Services[36]	Earlier referrals to palliative care services in the curative stage of cancers.	Reduced impacts of conditions on patients and their families.	

Table 11b SFSP for support services

Services provided	Outputs, enablers	Baseline measure		Targets		
		Description	**Data**	**2009/10**	**2010/11**	**2011/12**
Health of older people services	Community Wellness for Older Adults programme.	Average self-defined perception of health status using EuroQol.[37]	63%	80%	83%	86%
	Restorative home based support.	Average scores on the EADL scale.[38]				
		Clients with complex needs	48.7	50.0	52.0	54.0
		Clients with non-complex needs	50.6	53.0	60.0	66.0
		Self-defined perception of health status using EuroQol	70%	80%	83%	86%
Palliative care	Palliative Care Liaison Team for Secondary Services.	No. of patient referrals to the new service.	0	520	572	629

[36] A new service for both Northland and NZ, provided in hospital by by an NGO palliative care provider, to provide support to people with cancer in the earlier curative stages to improve quality of life for patients.

[37] EuroQol is a tool for measuring self defined health status, and measures mobility, self care, daily activiteis, pain & discomfort, and anxiety or depression. These scores use EuroQol's Visual Analogue Scale (VAS) in which a higher score indicates a perceived higher health related quality of life and a low score indicates that a client perceives their health related qualtiy of life as poor.

[38] The EADL is an assessment of functional ability. It is scored out of 66, with a hgiher score equating to a greater level of independence. Therefore it is expected that complex clients would have lower scores than non-complex clients. The tools are used as a measure of the effectiveness of the Restorative Home Support PIlot project, and will be evaluated by Auckland Uniservices during 2009/2010.

4.7 Financial performance

4.7.1 Financial statements

Statement of Financial Performance

	2007-08 Audited Actuals	2008-09 Forecast	2009-10 Budget	20010-11 Budget	20011-12 Budget
DHB Provider Revenue	205,556	222,275	237,063	246,308	254,683
DHB Funder Revenue	188,785	204,195	219,624	228,190	235,948
DHB Governance & Administration	7,156	3,733	3,960	4,115	4,255
Inter District Flow Revenue	8,088	8,328	7,824	8,129	8,406
Total Revenue	409,585	438,530	468,472	486,742	503,291
DHB Provider Operating Expenditure	191,129	207,832	222,163	231,068	239,316
DHB Non Provider Funded Services	141,195	154,378	163,745	170,131	175,916
DHB Governance & Administration	6,935	3,444	3,855	4,013	4,150
Inter District Flow Expense	54,851	58,145	63,704	66,188	68,438
Total Operating Expenditure	394,109	423,799	453,467	471,400	487,820
Earnings before Interest, Depreciation, Abnormals & Capital Charge	15,476	14,732	15,004	15,342	15,472
Less					
Interest on Term Debt	1,478	1,732	1,753	1,822	1,884
Depreciation	8,828	8,847	8,962	9,064	8,980
Revaluation					
Earnings before Abnormals & Capital Charge	5,169	4,153	4,290	4,456	4,608
Profit/(Loss) on Sale of Assets	(38)	89	-	-	-
Net Operating Surplus (Deficit)	5,131	4,242	4,290	4,456	4,608
Capital Charge	4,208	4,242	4,291	4,458	4,610
Surplus (Deficit)	**923**	**0**	**(1)**	**(2)**	**(2)**

Consolidated Statement of Performance

2009-10 Financial Year

	Funder Gross $000s	Eliminations $000	Funder Net $000s	Governance & Funding Admin $000s	DHB Hospital Provider (includes Joint Ventures) $000s	2009/10 DAP $000s
Revenue						
Government & Crown Agency Sourced	445,516	218,068	227,448	2,321	217,176	446,946
Crown				100	14,479	14,579
Other				1,539	5,408	6,947
Total Revenue	445,516	218,068	227,448	3,960	237,063	468,472
Expenses						
Personnel Costs				2,095	159,523	161,618
Non Personnel Operating Costs						-
Outsourced Services				546	10,191	10,737
Clinical Supplies				1	34,338	34,339
Infrastructure & Non Clinical Supplies				863	18,462	19,325
Internal Allocation				351	(351)	-
Payment to Providers						-
Personnal Health	341,418	178,480	162,938			162,938
Mental Health	45,863	30,015	15,849			15,849
Disability Support Services	48,208	6,913	41,295			41,295
Public Health	1,563	72	1,492			1,492
Maori Health	6,143	267	5,876			5,876
Governance & Administration	2,321	2,321	-			-
Depreciation				9	8,953	8,962
Interest Costs				-	1,753	1,753
Capital Charge				97	4,194	4,291
Expenses Total	445,516	218,067	227,449	3,960	237,063	468,473
Net Surplus/(Deficit)	(0)	0	(1)	(0)	(0)	(1)
This includes movements in Trust Funds						
Reconciliation to Accumulated Funds						
Total equity at beginning of the period						53,853
Equity Introduced						
Revaluation Reserve						
Movement in Trust and Special Funds						
Net Results					-	1
Total Equity at End of Period	-	-	-	-		**53,852**

Statement of Movements in Equity

	2007-08 Audited Actuals	2008-09 Forecast	2009-10 Budget	20010-11 Budget	20011-12 Budget
Equity at the beginning of the period	52,936	53,870	53,853	58,853	58,851
Surplus/Deficit for the period	923	0	(1)	(1)	(1)
Total Recognised Revenues and Expenses	53,859	53,870	53,853	58,851	58,850
Other Movements					
Revaluation of Fixed Assets	-	-	-	-	-
Other	11	(17)	-	-	-
Equity introduced (Repaid)	-	-	5,000	-	-
Equity at end of Period	**53,870**	**53,853**	**58,853**	**58,851**	**58,850**

Statement of Financial Position

	2007-08 Audited Actuals	2008-09 Forecast	2009-10 Budget	20010-11 Budget	20011-12 Budget
Equity					
Crown Equity	35,341	35,341	40,341	40,341	40,341
Retained Earnings	469	469	468	467	466
Subsidiaries & unrestricted trusts	288	271	271	271	271
Revaluation Reserve	17,772	17,772	17,772	17,772	17,772
Total Equity	53,870	53,853	58,852	58,851	58,850
Represented by:					
Assets					
Current Assets	81,752	80,434	76,168	55,062	54,379
Non-Current Assets	81,598	82,163	91,428	112,533	113,214
Total Assets	163,350	162,597	167,596	167,595	167,593
Liabilities					
Current Liabilities	77,903	77,162	77,162	77,162	77,162
Non-Current Liabilities	31,577	31,582	31,582	31,582	31,582
Total Liabilities	109,480	108,744	108,744	108,744	108,744
Net Assets	**53,870**	**53,853**	**58,852**	**58,851**	**58,849**

Statement of Cash Flows

	2007-08 Audited Actuals	2008-09 Forecast	2009-10 Budget	20010-11 Budget	20011-12 Budget
Cash Flows from Operating Activities					
Operating Income	396,600	441,112	464,456	482,570	498,977
Operating Expenditure	388,892	435,799	459,511	477,680	494,313
Net Cash from Operating Activities	7,708	5,314	4,945	4,890	4,664
Cash Flows from Investing Activities					
Interest receipts 3rd Party	6,281	5,106	4,016	4,172	4,314
Proceeds from sale of assets	38	(89)	-	-	-
Purchase of Fixed Assets	(13,763)	(9,424)	(18,227)	(30,168)	(9,661)
Increase in Investments and Restricted & Trust Funds Assets	(19,300)	4,300	-	-	-
Net Cash from Investing Activities	(26,743)	(107)	(14,211)	(25,996)	(5,347)
Cash Flows from Financing Activities					
Equity injections (repayments)	-	-	5,000	-	-
Borrowings	8,150	-	-	-	-
Repaid debts	-	1	2	3	4
Other Non-Current Liability Movement	-	-	-	-	-
Net Cash from Financing Activities	8,150	1	5,002	3	4
Net Increase/(Decrease) in Cash held	(10,885)	5,208	(4,265)	(21,104)	(679)
Add opening cash balance	54,699	43,813	49,021	44,757	23,653
Closing Cash Balance	43,813	49,021	44,757	23,653	22,974

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

4.7.2 Financial assumptions

Revenue is based on the PBF funding envelope announced December 2008.

NDHB Funder projections for 2009/10 are based on 2008/09 expenditure levels adjusted for expected volume and cost growth. Inter-District Revenue and Cost has been budgeted in accordance with advice from the Ministry of Health.

Future devolution of services and public health are not included in the projections.

No additional Mental Health Blueprint funding has been included.

NDHB Provider Service salary and salary-related costs are provided for at agreed settlement rates for 2008/09 and out-years.

NDHB Provider Service supplies and expenses are based on current expenditure levels plus 3.1%, less procurement savings.

Cash from depreciation charges is applied to capital purchases.

Additional capital expenditure, all internally funded, relates to the replacement of the 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.

A revaluation of assets will occur as at 30 June 2009. The results of this revaluation are not forecast in the DAP financials.

4.7.3 Capital expenditure

Capital expenditure relates to replacement of current equipment and other plant and building infrastructure as well as provision of assets for service justification requirements. It is planned to replace existing equipment from depreciation provisions and additional assets for service justification from baseline and strategic capital.

4.7.4 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.

4.7.5 Subsidiaries

The only part ownership venture Northland DHB is involved in is Kaipara Health Centre (Dargaville Hospital) in which we hold a 54% share. The balance is held by the Kaipara Community Health Trust which is community owned.

5 Organisational capability

Most of the information in this section is explained in more detail in Northland DHB's District Annual Plan 2009/10[39]

5.1 Accountability

To the public Seven of the eleven members of the Northland DHB are elected at the three-yearly local body elections and the remaining four appointed by the Minister of Health. The public are welcome to observe the meetings of the board and its statutory committees. Details of forthcoming monthly meetings are notified publicly in the local newspaper and available on our website[40]. The website also contains agendas and minutes of past meetings. Occasionally the Board or its committees have discussions from which they may decide to exclude the public; this is allowed for under the Public Health and Disability Act 200 under which DHBs operate.

To the Minister and Minstry Northland DHB is accountable to the Minister of Health and/or Ministry of Health for our financial performance. We also report on non-financial measures as described in Table 12.

Table 12 Measures for which Northland DHB is accountable to the Minister of Health and/or Minsitry of Health (MoH)

Type of report	Audience	Frequency	Explanation
Health Targets	Minister (via Ministry of Health)	Quarterly	Cover the major national health priorities and are signed off by the Minister of Health. Targets are agreed either nationally or in negotiation with DHBs.
Indicators of DHB performance (IDPs)	Ministry of Health	Quarterly	Cover major national health priorities in more detail, as well as other health priorities. Most targets are agreed in negotiation with DHBs.
Additional reports	Ministry of Health	Quarterly	Reports 'additional' to Health Targets and IDPs. They largely cover new funding and contracts which arise during the year ("variations to the Crown Funding Agreement"), on which DHBs must report progress.
Hospital Benchmark Indicators	Ministry of Health, DHBs	Quarterly	DHB-derived data analysed by MoH to produce a nationally consistent set of measures for comparing the performance of hospital services on three sets of data: quality and patient outcome, process and efficiency, organisational health (workforce-related).

As well as health sector accountabilities, Northland DHB is also accountable to the Government through this Statement of Intent, whose monitoring is overseen by the Office of the Auditor General. DHBs reproduce the Statement of Forecast Service Performance section of the SOI in their Annual Reports.

[39] http://www.northlanddhb.org.nz/publications/
[40] http://www.northlanddhb.org.nz/the-board/

5.2 Collaborative activity[41]

5.2.1 Collaboration within Northland

Northland DHB works with other organisations both in and outside the health sector in order to achieve our goals.

Within the health sector

The Funder arm of the DHB has strong relationships with the many health providers with whom we contract (as described in section 2.3). We also work closely with others such as voluntary organisations and those whose contracts are held nationally (Plunket, St John).

Outside the health sector

Working intersectorally is the only way the health sector can hope to influence many of the cultural, social and economic factors which underlie poor health in our society. There is a growing consensus in Northland about the need for a concerted approach. It is the driving force behind the Northland Intersectoral Forum[42], and the reason the DHB works in partnership with Housing NZ to improve housing quality and with Sport Northland and others on the Northland Sport and Physical Activity Strategy. The plans for Maori health and public health43 both take as their starting point the need to address the socioeconomic fundamentals which are strongly linked with poor health.

5.2.2 Collaboration regionally

Why this is an important priority for NDHB

Northland DHB participates in collaborative activities within the Northern Region in order to:

- address the challenges the region is facing around high population growth, ageing and disease trends, as well as workforce shortages and ensuring the sustainability of the region's services
- provide services for a population which is mobile and accesses services across DHB boundaries
- utilise the region's scarce human and financial resources effectively and efficiently, including reducing transactional costs and using economies of scale where appropriate
- recognise shared interests in many national projects.

The planning context for 2009/10

Northern Regional Network Strategy. Detailed implementation planning, recognising that this will need to be aligned with the Minister's and MoH's directions regarding national, regional and local service planning as it emerges, and implementation of agreed initial recommendations.

Phase 2 of the Regional Plan. This focuses on secondary and tertiary services which have significant regional impact (and acknowledges primary care interlinkages). Key workstreams are around clinical networks, regional services and clinical leadership, elective surgery and planned care, and urgent and emergency care. The Phase 2 report is due July/ August 2009 to coincide with National Capital Committee timeframes.

[41] See also District Annual Plan 2009/10 sections 3.3 and 3.4.
[42] NIF has membership from government organisations and local government bodies and provides a whole-of-government collaborative approach to Northland's social and economic growth[42].
[43] *Te Tai Tokerau Maori Health Plan 2007-2013,* and *Te Tai Tokerau Strategic Public Health Plan 2007-2010*, both available at http://www.northlanddhb.org.nz/publications/.

Regional Service Planning

NDHB will continue to work with the three Auckland DHBs on Regional Service Planning. This close working relationship will include the development of operational protocols for the optimal management of the patient journey. It will manage both planned and unplanned service changes as well as longer term strategic service developments that are closely linked to long term capital expenditure planning.

Services that will receive attention regarding regional service development and the strengthening of clinical networks include urology, cancer, plastic surgery, radiology, major head and neck surgery, eating disorders. Specific focuses for 2009/10 that may have an affect on Northland-based health service delivery are:

Cancer services including both radiotherapy and chemotherapy. NDHB will be working on a project to understand the reasons for the relatively low take-up rate of radiotherapy by Northlanders and to improve access to this service. Options will also be explored for extending the volume and range of oncology services that could be provided from Whangarei which may remove the need for some patients to travel to Auckland. NDHB will work with ADHB to review the existing contractual arrangements that support the cancer service provided to Northland residents and agree on any changes that will improve the management of the service.

Cardiothoracic surgery, cardiology and vascular surgery are all being investigated for their potential contribution to the service profile housed within the planned rebuilding and expansion of Whangarei Hospital. The Regional Service Planning process will ensure that any changes are coordinated between DHBs.

Distribution of services between Northland and Auckland. Northlanders travel to Auckland for other services that are not regional but that have historically been treated by Auckland DHB. The rationale for continuing with these referral paths is being questioned. For 2009/10 the potential for sleep apnoea, respiratory lung function testing and cardiac holter analysis are being considered. Agreement has already been made with ADHB to manage Northland's Pain Service from Whangarei Hospital which will affect all referrals to this service in 2009/10. These developments have the potential to improve access, reduce DNAs, reduce associated administration costs, reduce travel time and reduce cost to patients and the health system.

Regional Funding Forum

Northland DHB attends the monthly meetings of the Regional Funding Forum which brings together funding and planning GMs from the four Northern Region (Northland and Auckland) DHBs to discuss matters of mutual interest.

5.2.3 Collaboration nationally

Northland DHB works at a national level with numerous organisations and groups to ensure efforts are coordinated, information shared and matters of joint interest are addressed. Some of the key links include DHBNZ's forum for CEOs, its groups for workforce and service improvement and its committees on national projects it coordinates. Northland DHB senior managers also attend the Resident Medical Officer executive, forums for chief financial officers, chief information officers and chief operating officers, and meetings for GMs funding and planning and GMs Maori.

5.3 Workforce development and organisational health[44]

Good Employer requirements

Northland DHB adheres to the Good Employer requirements of the Crown Entities Act 2004[45], 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 strategies

Workforce development and strong organisational health are central to Northland DHB ensuring that we provide high quality effective services and meet the continued challenges of the health needs of our community. We have a range of strategies for expanding and improving the workforce across our services, including innovative recruitment approaches, training for staff, supporting Maori workers and applying a Maori cultural quality programme Te Kaupapa Whakaruruhau I te Oranga mo te Iwi Maori to Northland DHB Provider services.

Clinical leadership

We recognise the importance of clinical leadership within the DHB and have strong relationships with clinicians. They are at the heart of the decision-making processes within NDHB, including developing new models of care that support workforce development both within the provider arm and primary care sector. Clinical leader positions have been created in all specialties, and clinicians are involved in quality and risk committees and processes. They are involved in planning within both the NDHB Funder and NDHB Provider; they will be consulted extensively during the Mid North Review (see section 5.5), for example. Clinicians are also involved in discussions over regional planning initiatives.

5.4 Quality and safety[46]

Quality and safety generally

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 a *Quality Action Plan* that is based on the MoH's *Improving Quality* report.

Quality Improvement 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[47]
- management of healthcare incidents
- infection prevention and control
- safe medicines management.

Specific intiatives in the NDHB

Specific quality initiatives in the Northland DHB Provider include:

- a Clinical Care Improvement Committee to oversee the quality framework and monitor activities

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[44] See also District Annual Plan 2009/10 section 3.6.
[45] Section 118 in http://www.legislation.govt.nz/act/results.aspx?search=ts_act_crown+entities+act_resel.
[46] See also District Annual Plan 2009/10 section 3.2.
[47] Described earlier in section 4.5.1, as well as District Annual Plan 2009/10 section 3.2.3.

Provider

- monitoring and management of adverse events and errors
- monitoring of clinical indicators and management of detected problems
- clinical audit
- benchmarking
- maintaining accreditation under EQuiP4
- research by clincians
- projects dealing with Safe Use of Medicines, Physiologically Unstable Patients, Hospital at Night/ Handover.

Risk management

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 the senior clinical staff to ensure that appropriate mitigation reduces them to acceptable levels.

Major risks to the organisation exist in the following areas:

- 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.

Primary health care sector

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 governance within PHOs
- supporting accreditation in GP practices
- a governance group for the primary mental health initiative
- PHO membership of the DHB's Long Term Conditions Framework Group[48]

5.5 Distribution of buildings and services

Site Master Plan

Northland DHB has adopted a Site Master Plan for Whangarei Hospital. A Business Case for Stage 1 of this proposed redevelopment has been submitted to the Minister of Health for approval. The Site Master Plan is the culmination of a lot of work and has tied together a number of different plans and projects. It has included the following work streams:

- Clinical Services Plan Review
- Health Needs Analysis
- Models of Care
- Volume Modelling and Demand Projection
- Building Condition Survey
- Asset Management Plan

NDHB is confident that the Site Master Plan will, when implemented, allow us to fully implement our service delivery plans and assist us to meet the health needs of Northlanders.

[48] The framework was described earlier in section 3.4.

Mid North Review

Northland DHB is reviewing the type and distribution of services in Northland' s Mid North area (Bay of Islands, Kaikohe area, Hokianga and Whangaroa) to determine the most appropriate mix and location of services for the future.

5.6 Information services[49]

Northland DHB Provider

During 2008/09, the remaining significant legacy IS organisational, infrastructure and operational challenges have been addressed, and considerable foundation work has been completed to strengthen the Information Service.

2009/10 will see us building on these foundations to begin developing a more proactive and strategic service provider which works in partnership with our customers. In particular, significant progress will be made on the long-awaited replacement/ upgrade of the DHB's core patient management and clinical systems.

Links with other providers in Northland

Northland PHOs recognise the importance of quality information systems in providing a collaborative and functional primary health care service within the district. In the past year, good progress has been made on information services planning and delivery. The information governance groups of NDHB and the PHOs have common members, and our close working relationship is illustrated by our joint view of information priorities, and our shared vision for Northland's patient management and clinical systems.

Our aim for the next year is to build on these strong foundations to further converge the planning and delivery of our information services, within the district and across the region.

We are beginning to deepen our information management relationship with other health providers within the district. Plans for this year include delivery of an inpatient palliative care service in partnership with North Haven Hospice, and deployment of the DHB-based mental health patient management system to a mental health NGO.

Regional links

In the past year, Northland has joined the Northern Region Information Governance Group (NRIGG), an initial view of fully regional projects has been developed, and good progress has been made on the Regional Information Strategic Plan 2009 (RISP 09). Northland DHB has entered the Health Management System Collaborative (HMSC) on behalf of the Northern Region.

[49] Fuller details of IS plans and issues are available in the District Annual Plan 2009/10 section 3.5.

Appendix: Statement of Accounting Policy

For the year ended 30 June 2009

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 2009 comprise NDHB and its joint venture partner 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 will be authorised for issue by the Board in October 2009.

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.

The financial statements for the year ended 30 June 2008 will be NDHB's first NZ IFRS financial statements and NZ IFRS 1 will be applied

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 fair value.

The accounting policies as set out below have been applied consistently to all periods presented in these consolidated financial statements and in preparing an opening NZFRS Statement of Financial Position as at 1 July 2006 for the purposes of the transition to NZIFRS.

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

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

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.

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 NZGAAP. They comply with NZIFRS and other applicable Financial Reporting Standards as appropriate for public benefit entities. Those standards are consistent with the accounting policies adopted by NDHB for the preparation of these financial statements.

Foreign currency transactions

Transactions in foreign currency are translated at the foreign exchange rate ruling at the date of the transaction. Monetary assets and liabilities denominated in foreign currencies at the balance sheet date are translated to NZD at the foreign exchange rate ruling at that date. Foreign exchange differences arising on translation are recognised in the 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.

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.

Impairment gains and losses, for items of property, plant and equipment that are revalued on a class of assets basis, are also recognised on a class basis.

Reversals of impairment

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

An impairment loss on items of property, plant and equipment carried at fair value is reversed through the relevant reserve. All other impairment losses are reversed through the statement of financial performance.

An impairment loss is reversed only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised.

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.

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.

Subsequent to initial recognition, other non-derivative financial instruments 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.

Interest-bearing loans and borrowings

Interest-bearing loans and borrowings are classified as other non-derivative financial instruments.

Trade and other payables

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

Impairment of financial assets

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

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).

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 using the projected unit credit method and is discounted to its present value. The discount rate is the market yield on relevant New Zealand government bonds at the balance sheet date.

Annual leave, conference leave, sick leave and medical education leave

Annual leave, conference leave, sick 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.

Provisions

A provision is recognised at fair value when NDHB has a present legal or constructive obligation as a result of a past event, and it is probable that an outflow of economic benefits will be required to settle the obligation. 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.

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 amounts are shown exclusive of Goods and Services Tax (GST), except for receivables and payables that are stated inclusive of GST. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

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

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.

Net financing costs

Net financing costs comprise interest paid and payable on borrowings calculated using the effective interest rate method, interest received and receivable on funds invested calculated using the effective interest rate method, dividend income and gains and losses on hedging instruments that are recognised in the statement of financial performance.

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.

New standards adopted and interpretations not yet adopted

Certain new standards, amendments and interpretations to existing standards have been published that are not yet effective for the year ended 30 June 2009, and have not been applied in preparing these consolidated financial statements. The adoption of the following standards is not expected to have a material impact on the NDHB's consolidated financial statements.

Details of these standards will be advised after 30 June 2009.

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.