TARANAKI
District Health Board

E92

Taranaki District Health Board
Te Poari Hauora-ā-Rohe o Taranaki

ANNUAL REPORT

2020-2021






PRESENTED TO THE HOUSE OF REPRESENTATIVES PURSUANT TO SECTION 150 OF THE CROWN ENTITIES ACT 2004

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Haere Mai

WELCOME

E ngā mana, e ngā reo, e ngā karangatanga maha tēnā ra koutou katoa

E ngā mate huhua, kua riro atu ki te Pō
haere, haere, haere atu ra.
Oti atu koutou ki te Pō, nau mai Te Ao
Tihei mauri ora ki a tātou

On behalf of the Board, I am pleased to present the Taranaki District Health Board (Taranaki DHB) Annual Report for the year 1 July 2020 to 30 June 2021.

Another year has passed, and once again we pay tribute to the resilience of our community for living in the shadow of the COVID-19 pandemic. Along with the rest of New Zealand we have continued to adapt the way we live and work in order to be prepared for the impact of a resurgence of COVID-19. Hopes for a return to normal life have been made possible with the availability of a vaccination against the virus and, like other District Health Boards across the country, we have had to rapidly mobilise our health workforce to deliver the biggest vaccination roll out that our health service has ever experienced. As with the initial response to the pandemic, a wide range of iwi, primary care and other community organisations have extended their assistance with the vaccination programme to ensure that vaccine is accessible in an equitable way. Once again, I am humbled by the willingness of so many local health and community service providers to work in creative and flexible ways to meet the needs of our diverse community in the context of such uncertainty.

In the last year I have been privileged to serve as the Chair of Taranaki District Health Board alongside a committed team of elected and appointed board members. Our Board members bring diverse governance experience and skills and they are each personally committed to ensuring high quality and equitable care for the Taranaki community. Over this time, we have strengthened our relationship with

our Māori relationship partner, Te Whare Punanga Korero Trust. The Trust represents the eight iwi of Taranaki who contribute to strategic planning and the governance of the DHB through the Board and its respective committees as well as supporting our goals of achieving Māori health equity. With our continuing commitment to improve Māori health outcomes, the expertise and support that we received through our relationship with Te Whare Punanga Korero is essential.

Our commitment to Māori health improvement is encapsulated in the regional vision of Te Manawa Taki: *He kapa kī tahi - 'A Singular Pursuit of Māori Health Equity*'. This reflects the combined efforts across Taranaki, Lakes, Tairāwhiti, Bay of Plenty and Waikato DHBs to achieve equity in Māori health outcomes and wellbeing. Our Board have a strong commitment to realising this vision and recognise that at times this requires tough choices, adopting new ways of working to address long standing issues, and partnering across government and with other providers. We have collectively embraced this challenge and our commitment to this is outlined in the Te Manawa Taki Regional Equity Plan, which is a significant milestone. It epitomises the value of DHBs and Iwi engaging in respectful ways, not only to embed Te Tiriti in our health and disability system, but also to do what is tika/right with regard to tackling one of New Zealand's most persistent problems: Māori health inequity. The plan is a key enabler in driving our collective effort towards empowering people who need our support the most to flourish, to meet their self-determined aspirations and to achieve equitable health status.

The focus on *He kapa kī tahi* has required us to challenge the status quo and do things differently to ensure that those areas and populations groups that are most disadvantaged are prioritised. An example of this is the implementation of a new rural model of care in South Taranaki that has played a key role in increasing access to high quality primary and community services for the people in the South. Partnership with our primary care partners, Iwi health providers and the South Taranaki community remains critical to the success of this project and we would like to acknowledge and thank those who have supported us. The South Taranaki Rural Model of Care now offers a general practice service based at Hāwera Hospital which provides much needed additional primary capacity, particularly to those who have been unable to enrol with a local GP. The impact of the new model is evident with a significant reduction in the number of people attending the Hāwera Emergency Department with conditions that are more appropriately managed in primary care. Not only does this improve timely access to primary care for people living in South Taranaki but it also ensures our Emergency Department staff are available to treat those who most need urgent care.

Indeed the demand for health services continues to grow and, in line with the national trend, we have faced significant pressure on our acute hospital services and, in turn, community health services across our region. We are immensely proud of our hard-working health workforce who have shown resilience and dedication in providing quality patient care during some challenging times over the last year. These service demands have been intensified

as a result of the inevitable disruption caused by COVID-19 and the subsequent roll out of the COVID-19 vaccination programme. During periods of high acute demand we are aware that our staff step up and, where required, work long hours to ensure that patient care is not compromised. I would personally like to thank every one of our staff who goes the extra mile when the needs of our system are at their greatest.

The pressures on our health system in terms of increasing demand for health care and the inevitable demands that this places on our workforce are not new. Consequently, in April 2021, the Minister of Health announced a significant programme of Health Reforms across New Zealand that aim to future proof our health system. All DHBs will be replaced by one national organisation (Health New Zealand) which will be responsible for running hospitals and commissioning primary and community health services. A new Māori Health Authority will be appointed and will have the power to commission health services, monitor the state of Māori health and develop policy. In addition to this a new Public Health Agency will also be created, and the Ministry of Health's role will be strengthened to monitor performance and provide strategic advice on health matters to Government. The changes aim to put a greater emphasis on primary healthcare and ensuring fairer access for all New Zealanders. Our Board fully support the changes and are actively supporting the work of the Transition Unit leading the change process. We believe the changes will have a positive impact on the delivery of equitable healthcare in our region and we look forward to seeing the outcomes of the Reforms.

Investment in our services is inevitably challenging in the context of a fiscally constrained environment. As with previous years we would like to acknowledge the incredible work of the Taranaki Health Foundation (THF) and to highlight the difference the Trust makes to our healthcare system's resources. We also recognise the many community partners, businesses, donors and supporters who contribute to these campaigns and sincerely appreciate their support and generosity. THF plays a vital role in helping us to increase access to high quality services in our region as well as enabling us to purchase equipment that makes a real difference to the comfort and care of people who use our services. We also express gratitude to our community for continuing to contribute so generously to local THF campaigns that support our own local health services.

Finally, we extend our thanks to our staff for their high levels of performance, showing integrity and passion for their mahi throughout. We recognise how challenging this year has been in the context of relentless demand as a result of multiple pressures, not least of all COVID-19. We know that we could not have made it through this year without our staff working above and beyond to provide the care that patients need around the clock. We also pay tribute to the work of our community and primary care partners, volunteers and support groups who have worked tirelessly to improve the health services and outcomes for our community in such difficult circumstances. Our community and primary care partners play a critical role in promoting good health and well being and they are typically the first point of contact for whānau when they become unwell.

To our patients and service users, their families and whānau, we remain committed to bringing you high quality, accessible and equitable services that meet your needs within the resources available to us as we transition our services across to the new, reformed health system. We look forward to working with and for the people of Taranaki in the year ahead.

E te huinga, e te tuingā, tēnā ra koutou katoa

Cassandra Crowley
Chair

Rosemary Clements
Chief Executive

Te Pahunga (Marty) Davis
Chair, Te Whare Punanga Korero Trust

Our DHB

Our Vision, Aims & Values

TE MATAKITE, NGĀ WHAINGA & TE AHU

Our Shared Vision / Te Matakite

Taranaki Together, a Healthy Community
Taranaki Whānui, He Rohe Oranga

Our Aims / Ngā Whainga

- To promote healthy lifestyles and self responsibility
- To have the people and infrastructure to meet changing health needs
- To have people as healthy as they can be through promotion, prevention, early intervention and rehabilitation
- To have services that are people-centred and accessible, where the health sector works as one
- To have a multi-agency approach to health
- To improve the health of Māori and groups with poor health status
- To lead and support the health and disability sector and provide stability throughout change
- To make the best use of the resources available.

Our Values / Te Ahu

Partnership / Whanaungatanga
We work together to achieve our goals

Courage / Manawanui
We have the courage to do what is right

Empowerment / Mana motuhake
We support each other to make the best decisions

People matter / Mahakitanga
We value each other, our patients and whānau

Safety / Manaakitanga
We provide excellent service in a safe and trusted environment

TE AHU
TARANAKI DHB VALUES

Our People

TE HUNGA MAHI

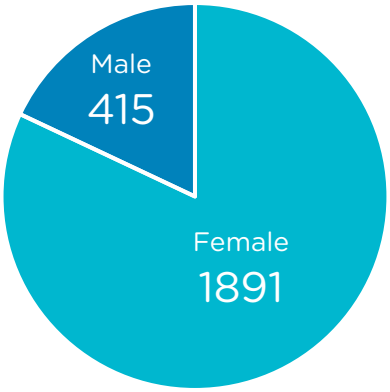
Healthcare is about people helping people.

In Taranaki we have a great team of health professionals and support staff all working together for our community. The make up of our team as at 30 June 2021 is as follows:

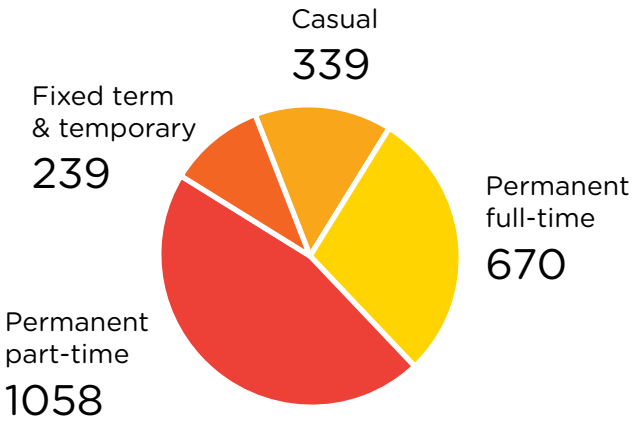
TOTAL STAFF

2306

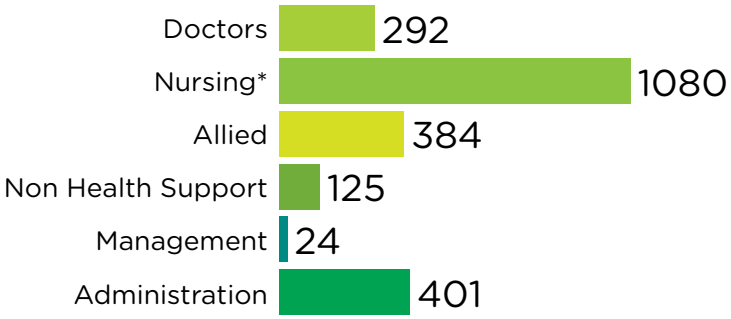
GENDER



TYPE OF EMPLOYMENT

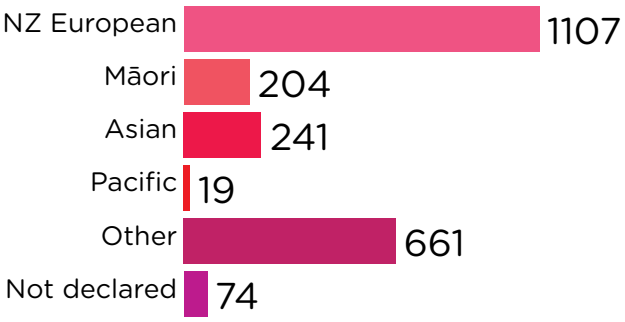


POSITION TYPE

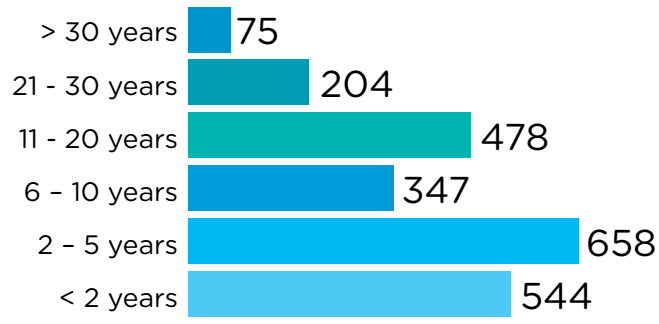


* (Includes midwives and health care assistants)

ETHNIC GROUP



LENGTH OF SERVICE



Reporting on 'Good Employer' Practices

PŪRONGO WHANONGA KAIMAHI PAI

Taranaki DHB's role in workforce planning and development is to identify strategic actions and mechanisms that when implemented will contribute to the organisation having health workers with appropriate clinical and 'soft' skills now and into the future. Actions identified are from a perspective of the DHB being a planner and a funder, a major employer, and a provider of health services in our district.

In addition to these sector wide responsibilities, Taranaki DHB is the largest single employer of health employees in Taranaki. The DHB ensures good employer practices are provided to staff, such as excellent leadership, people, culture, relationships and processes. The table below is a summary of those human resources practices that assist the organisation to be a good employer for its employees, with a patient-centric focus to its people management.

Element/ Measurement	Describe formal polices or procedures	Other Practices	Priority issues	Action taken

Leadership, Accountability and Culture	• Code of Conduct
	• Equal Employment Opportunities (EEO)
	• Taranaki DHB values documentation
	• Performance Review Policy
	• Unprofessional Behaviour Policy & Procedure
		• Employee engagement survey (July 2017, Dec 2018 and scheduled for Feb 2021)
		• 'Te Ahu Taranaki' Values (2018 launch)
		• Formal management and management/ union meetings
		• New managers' induction
		• Advanced Leadership (ALP) and Team Development & Collaboration programmes front-line leadership ('Leadership in Action'),
		• Change Management & Continuous Improvement programme
		• Team development workshops to support our 'Te Ahu Taranaki' Values and effective team functioning
			• Leadership and team development aligned with Taranaki DHB strategy
			• 'Te Ahu Taranaki' Values to support Taranaki DHB strategy
			• Unprofessional Behaviour Action Plan
			• COVID-19 leadership support
			• Leadership coaching opportunities
			• Culture survey
				• New suite of leadership & team development programmes for 2017/2018, continuing into 2019 & 2020. The following have been implemented:
				  • Advanced Leadership for Senior Leaders (three participants)
				  • 'Front-Line' Leadership (22 participants)
				  • NCEA level 3 & 4 Introduction to Management (40 participants)
				  • Team Development, Collaboration & External Partnering (27 participants)
				  • Change Management & Continuous Improvement (120 participants)
				  • Team building & development workshops (internally facilitated)
				• Unprofessional Behaviour Education Programme developed and launched (2020)
				• COVID-19 – Leadership support plan developed and launched
				• Coaching opportunity package developed and rolled out to 40 + managers (external provider)
				• Coaching for senior leaders – six + leaders receiving external coaching support
				• Culture survey will replace engagement survey using the same provider but different framework

Element/ Measurement	Describe formal polices or procedures	Other Practices	Priority issues	Action taken
Recruitment, Selection Induction	• Recruitment and Selection Policy • Recruitment Guideline Procedure • Induction and Orientation Policy • Worker Safety Check Policy and Procedures	• Comprehensive Induction Programme with elements online combining eLearning modules • Recruitment training for managers • Recruitment and Selection Toolkit • Scholarships across all disciplines • Schools Career Expo • Working with clinical schools to provide work experience placements • Police and Ministry of Justice criminal records checking • Behaviour-based recruitment	• Better management of the online talent pool to access suitable candidates • Use of social networking to target youth • Vulnerable Children's Act and the implementation of procedures relating to this legislation • Focus on hard to fill occupations to reduce re-advertising	• National Heath Careers website targeting students, return-to-work and international candidates • Continue to collaborate with the national Kiwi Health Jobs working group to promote the New Zealand health sector brand • Continue to collaborate with the Whakatipuranga Rima Rau project to place Māori into the health sector employment over 10 years • Implementation of Vulnerable Children's Act procedures • Electronic onboarding – to improve the new hire experience • Introduce values-based questions into patterned interview formats; use of personality profiles in recruitment • Full review of recruitment tools for managers • Participation in national and regional international recruitment campaigns
Employee Development, Performance, Promotion and Exit	• Study, conference and course leave • Termination of Employment Policy and Procedure • Medical Incapacity Policy • Professional Development Policy • Performance Review Policy • Performance and Disciplinary Policy • Employment Agreements • Continuing Medical Education (CME) policy	• Exit interview and survey • Coaching available to all staff • Clinical supervision • Employee Assistance Programme (EAP) • Non-clinical skills training for employee • Professional development funding • National qualifications for non regulated workforces (e.g. orderlies, cleaners and health care assistants) • Annual calendar of educational events • Performance appraisal	• Training needs analysis completed for 2019 & 2020 • Continuing development of e-learning resources • Enabling technology for accessing learning tools • Further rollout of non-regulated workforce training – NZQA • Review of performance review tools and processes to increase feedback • Rollout of the OMA process for nursing functions	• eLearning platform in operation, enabling greater access to eLearning resources. New clinical courses added. Aim to increase number of courses for non-clinical staff. Site also to be used for e-portfolios • Professional Development Policy finalised • Health care assistants, orderlies, cleaners, dental assistants, newborn hearing technicians enrolled in NZQA (Careerforce) training • New values-based performance appraisal & development framework (launched 2019) • Specific internal and external exit interview process implemented 2021
Employee Engagement	• Flexible Working • Request and Complaints Procedure • Collective employment agreements • Worker Engagement and Participation Agreement • Recognition framework – Values based (see below) • Wellbeing Framework Developed	• Work in conjunction with individuals and unions in consultative manner • Employee well-being initiatives • Stress & resilience resources for employees	• Employee engagement assessment • Employee wellbeing • Recognition framework – values-based (see next page)	• National (20 DHBs) Framework for Employee Wellbeing launched • Active Wellbeing programme in place • Values based peer-to-peer recognition scheme in operation (launched 2018) • On-going provision of stress & resilience seminars & workshops • Employee engagement – new format selected for 2021 culture survey

Element/ Measurement	Describe formal polices or procedures	Other Practices	Priority issues	Action taken
Remuneration, Recognition and Conditions	• Job evaluation procedure • Recognising long service procedure • Collective employment agreements • Recognition framework – values-based	• Comprehensive progression/merit criteria via collective agreements	• Recognition framework – values-based	• Promoting employee benefits for all staff • Values-based peer-to-peer recognition scheme in operation (see previous page)
Stress and Resilience Support; Harassment and Bullying Prevention	• Anti-Bullying/ Unprofessional Behaviour Policy and Procedure (incorporates Harassment) • Employee Assistance Programme (EAP) • Stress & resilience support initiatives • Wellbeing framework developed	• Interpersonal skills programmes • Coaching/training union reps • Conflict resolution • Stress & resilience training workshops provided for staff during restructures; 'lunch-n-learn' sessions for staff on stress, meditation, mindfulness etc. • Mental Health Awareness Week • EAP promoted regularly • After Critical Event Framework	• Launch new Anti-Bullying/ Unprofessional Behaviour programme (2020) • Change management training • COVID-19 – support plan for employees & leaders • Wellbeing	• New Anti-Bullying/Unprofessional Behaviour policy and procedure approved and implemented (2020) • Education & communication programme underway • Teams at high risk of bullying identified and change programmes with these teams implemented • COVID-19 supports plans instigated for leaders and employees • Wellbeing framework developed linking to national initiatives • After Critical Event Framework being trialled
Pay Gap – Pay Equity	• Recruitment and Selection Policy • Recruitment Guideline Procedure • Flexible Work Policy	• Participation in National 20-DHB initiatives, including pay equity claims being co-ordinated centrally by TAS	• Addressing gender pay gaps via National & Regional programmes.	• Active participation in National & Regional pay equity programmes
Equal Employment Opportunities	• Equal Employment Opportunities / Diversity Policy • Recruitment and Selection Policy • Recruitment Guideline Procedure • New flexible work guidelines	• Impartial selection of candidates in recruitment process • Recognition of employment requirements for Māori, ethnic or minority groups and persons with disabilities • WhyOra Māori recruitment programme • 'Subliminal Bias' training workshops • Engaging with Māori seminars to increase awareness of Māori culture, including recruitment, patient contact and working relationships • Complement of people permanently employed after participation in work skills development programme	• Increasing the number of Māori is a key strategic priority. 9% of employees are Māori vis-à-vis a Taranaki population of 19%. • Flexible work provides support for existing staff and assists with retention and assists with recruitment by widening options	• Through recruitment process, offering people the ability to have whānau present during an interview • Taranaki DHB, local iwi groups and community trusts fund the WhyOra Māori recruitment unit. This organisation provides programmes that support Māori to enter the health sector workforce in Taranaki. • Subliminal bias training in place and Midlands Region 'Institutional Racism and HR' training programme targeted for end of 2020 • New flexible work guidelines implemented 2020

Element/ Measurement	Describe formal polices or procedures	Other Practices	Priority issues	Action taken
Safe and Healthy Environment	• Health and safety specific policies and procedures • Risk management and compliance policies and procedures	• Health and Safety Programme • Pre-employment health declaration for all staff, contractors and students • Health and safety induction, orientation and compulsory refresher sessions • Health monitoring programme for applicable staff • Risk and hazard registers • Input into renovation/ construction and purchase of new equipment decisions • Member of ACC's Accredited Employer Programme • Accident/incident/near miss reporting system • Employee Assistance Programme • Free staff vaccination programme that includes the annual influenza vaccination • Health and safety representative and health and safety committee programmes • Bipartite Action Group • Quarterly reporting to the Taranaki DHB Board on health and safety matters • Wellness Committee • Security	• Accreditation maintained, and an active ACC partnership program is in place • Critical risks identified, and risk reviews underway to identify potential improvement areas. • Improving our health and safety reporting • Encouraging partnership by empowering the health and safety representative roles • Enhancing the worker rehabilitation program to promote early return to work practices • Strengthening our contractor management health and safety framework • Improving our hazardous substances framework	• Stage 1 rep training provided to all new health and safety representatives • Health and safety requirements in all job description templates and included in all staff performance reviews • Updating of existing health and safety procedures to ensure compliance with the Health and Safety at Work Act 2015 and associated regulations • Introduction of a pre-employment health declaration which includes improved health monitoring and vaccination processes. • Maintaining health monitoring and surveillance of staff exposed to workplace health risks • Joint venture with ACC and Safe 365 to develop contractor management and supply chain practices within the DHB • Hazardous substances project commenced • Development of fire and emergency training package security for safety project commenced • Recreation society available to all staff • Wellness Committee has run and number of wellness initiatives throughout the year

Māori Workforce

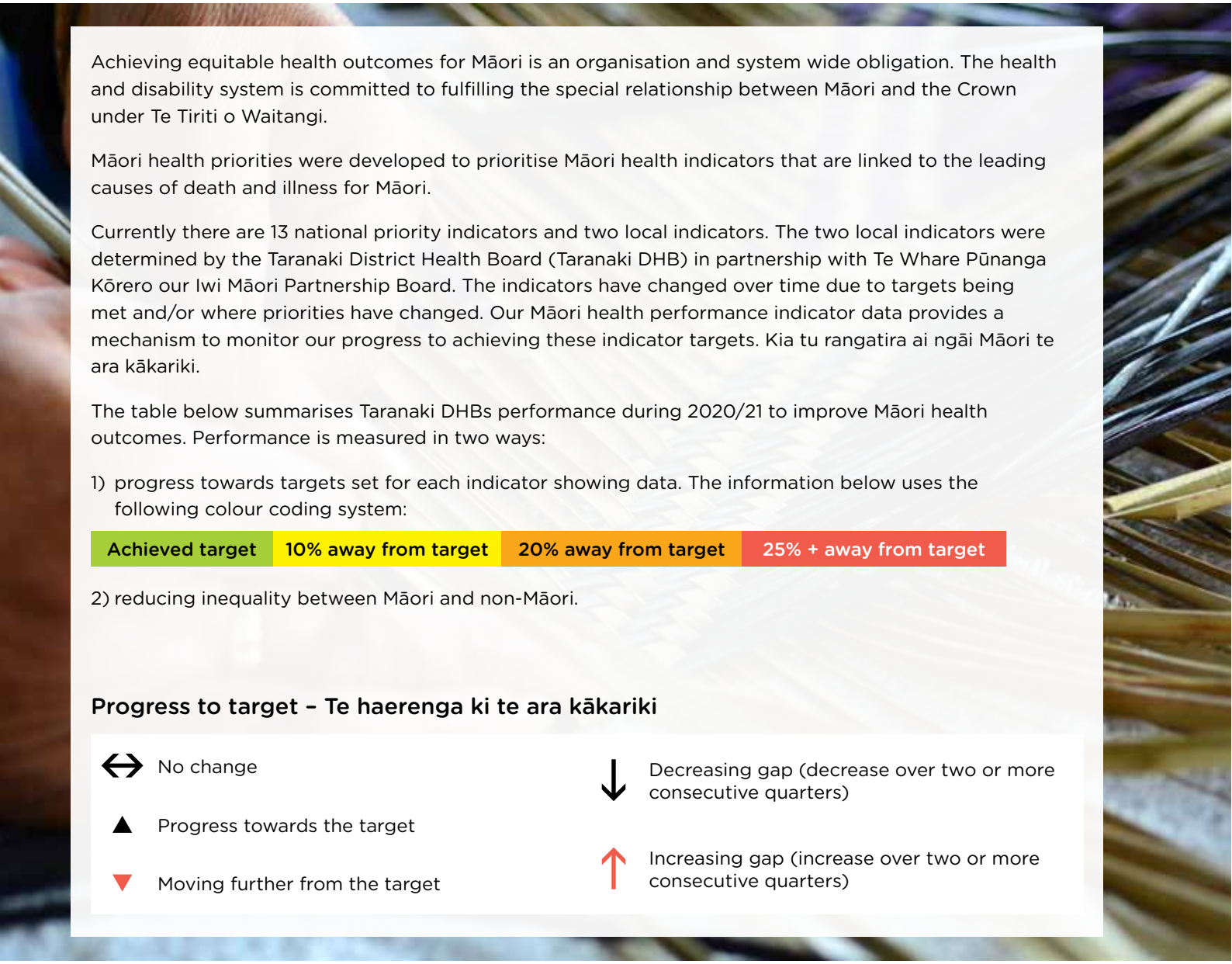
PAPA POUNAMU PRIORITY AREAS:

Cultural competence	Addressing bias
Te Kawau Mārō Strategy Refresh 2020 outlines the DHB's commitment to delivering on its obligations under te Tiriti o Waitangi, in particular the principle of 'Options' under which it is required to ensure that all health care services are provided in a culturally appropriate way.	Te Kawau Mārō Strategy Refresh commits the Taranaki DHB to addressing racism and discrimination in all its forms. The DHB aims to do this by: • building the knowledge of all Taranaki DHB staff in relation to Te Tiriti; • undertaking targeted training and increasing awareness of DHB staff of the impacts of historical trauma experienced by Māori communities as a result of colonisation of Aotearoa, New Zealand; • providing education for Taranaki DHB staff on the impacts of institutional racism on Māori health equity; • addressing bias in decision making; • enabling staff to participate in cultural safety training and development; • investment in a range of strategies from culture shift through to workforce, and • development and human resource processes
Plan – the DHB plans to deliver a comprehensive cultural competency training programme which all staff will be required to complete over time. With regard to te reo Māori revitalisation, Taranaki DHB's Te Reo Māori and Te Reo Māori Translation Policy commits the DHB to *"...using te reo Māori principally from a health literacy perspective of Māori, in ways that are appropriate to the intended audiences, and in ways that support tangata whenua to revitalise te reo o Taranaki."* The DHB is planning to incorporate a more comprehensive reo Māori curriculum within the cultural competency programme.	Delivery of Institutional racism training as part of the Tiriti, DHB and Me curriculum

Cultural competence	Addressing bias
Do – 'Tiriti, DHB and Me' is the cultural awareness programme initiated in 2019 that establishes the foundation for cultural competencies development in the DHB workforce. Delivered at Parihaka, the programme covers: • Taranaki history leading up to and following the signing of te Tiriti o Waitangi • historical trauma experienced by Taranaki Māori and the impacts of historical trauma on Māori communities and whānau • contemporary Treaty-based issues leading up to and including WAI 2575 Hauora Outcomes Claims • national, regional and local Māori health strategy • Institutional racism, white privilege - what is it and what do we do about it • Implementing te Tiriti o Waitangi principles – what success looks like • Basic te reo Māori pronunciation In anticipation of developing the comprehensive cultural competency programme in which revitalisation of te reo o Taranaki will be integral, the DHB initiated through Te Whare Wānanga o Awanuiārangi, Te Pokaitahi Reo, a level 3 certificated te reo Māori programme which is delivered to staff at Base and Hawera Hospitals, in New Plymouth. Under the guidance of outstanding te reo o Taranaki proponent Dr Ruakere Hond, this programme has been adapted to reflect the distinctively Taranaki reo Māori dialect.	A dedicated workshop on Institutional racism is delivered within the Tiriti, DHB and Me training programme delivered monthly at Parihaka. This is an interactive session during which teams are asked to identify and discuss issues of racism in the workplace. They are asked to record a commitment they are prepared to make to address racism in their respective workplaces / areas of influence.
Report – 358 DHB staff attended 11 Tiriti, DHB and Me workshops at Parihaka during 2020/21 including the DHB's Executive Leadership Team of 10. Currently three 18-month programmes are running, involving a total of 75 staff. The impacts of both programmes are noticeable across hospital services in particular where pronunciation of te reo Māori has improved significantly and there is a higher demand for Māori staff to be involved in co-design of services. The DHB has been unable to meet the demand for enrolments on both courses. Consideration is currently being given to how the throughput of staff can be increased with the aim of getting all staff through the programme in three-yearly cycles.	358 DHB staff attended 11 Tiriti, DHB and Me workshops at Parihaka during 2020/21 including the DHB's Executive Leadership Team of 10.

Te Hau Oranga Māori

MĀORI HEALTH PERFORMANCE



Achieving equitable health outcomes for Māori is an organisation and system wide obligation. The health and disability system is committed to fulfilling the special relationship between Māori and the Crown under Te Tiriti o Waitangi.

Māori health priorities were developed to prioritise Māori health indicators that are linked to the leading causes of death and illness for Māori.

Currently there are 13 national priority indicators and two local indicators. The two local indicators were determined by the Taranaki District Health Board (Taranaki DHB) in partnership with Te Whare Pūnanga Kōrero our Iwi Māori Partnership Board. The indicators have changed over time due to targets being met and/or where priorities have changed. Our Māori health performance indicator data provides a mechanism to monitor our progress to achieving these indicator targets. Kia tu rangatira ai ngāi Māori te ara kākariki.

The table below summarises Taranaki DHBs performance during 2020/21 to improve Māori health outcomes. Performance is measured in two ways:

1) progress towards targets set for each indicator showing data. The information below uses the following colour coding system:

Achieved target	10% away from target	20% away from target	25% + away from target

2) reducing inequality between Māori and non-Māori.

Progress to target – Te haerenga ki te ara kākariki

↔ No change

▲ Progress towards the target

▼ Moving further from the target

↓ Decreasing gap (decrease over two or more consecutive quarters)

↑ Increasing gap (increase over two or more consecutive quarters)

Priorities	Health Issue	Indicator(s) Target	Target	Māori June 2020	Māori June 2021	Non-Māori June 2021	Progress to target	Disparity Gap June 2021	Disparity Progress
NATIONAL PRIORITIES									
1	Data quality	Ethnicity data accuracy in PHO registers	Not available	Not available	Not available	Not available	Not available	Not available	Not available
Pinnacle Midlands Health Network has historically been using a PHO (Primary Health Organisation) enrollment audit data process, with voluntary quarterly randomly generated patient audits occurring. Results have not been collated. Pinnacle has been advised that they are now required to implement the EDAT tools, and to report on those quarterly.									
2	Access to care	Percentage of Māori enrolled in PHOs	95%	84.7%	78.8%	97.4%	▼	-18.5%	↔
The non-Māori population has met the target whilst the Māori population enrollment declined this year by 5.9%. There are a significant number of people in Waverley and surrounding southern districts who register with a Whanganui PHO based practice. Taranaki DHB launched a primary care practice in South Taranaki during the year, enrolment figures for this practice do not yet feature in these statistics systems for data capture and reporting are still being implemented. Taranaki DHB and Pinnacle are committed to developing an action plan to support increased Māori enrollments by 1 October 2021.									
3	Access to care	Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for the age group 0-4yrs	5,200	9,734	4,715	4,939	▲	4.6%	↓
As of 31 March 2021 the ASH rate had met target for both Māori and non -Māori populations. There was not an intervention that can be credited for this major drop in hospitalisations.									
4	Access to care	Ambulatory Sensitive Hospitalisation rates per 100,000 for the age group 45-64 yrs	4,990	9,057	8,266	4,588	▲	-57.2%	↔
The data shows a large decrease of admissions this year compared to last year. Māori continue to have almost 50% more admissions than that of the total non- Māori. The rates for Māori are still significantly higher than the target. GP visits may be a part of the issue with many having large wait times to get an appointment. There was not an intervention that can be credited for the drop in hospitalisations.									
5	Child Health	Exclusive breastfeeding at 3 months of age	70%	44.2%	41.7%	66.3%	▼	-24.6%	↔
Capacity of the lactation consultant workforce has increased this year and, through our scholarships have enabled a further two lactation consultants to qualify. We aim to continue to support further lactation consultancy training to ensure we have a sustainable workforce to support and improve this deliverable into the future. There is also significant work going into equity focused antenatal education through Hapū Wānanga and a new pilot programme, Āhuru Mōwai, which also links expectant mothers with lactation consultants before the birth of baby. We look forward to improving our results as an outcome of this work.									
6	Cancer	Cervical screening, among eligible population	80%	73.2%	67.7%	78.2%	▼	-10.5%	↔
Coverage rates for Māori women remained under target but are still above the national average. Post COVID -19 coverage decreased for all women screened, especially Māori women who already have lower rates of screening. The National Cervical Screening Programme is planning two initiatives to support an equitable recovery for Māori and Pacific women. The Regional Screening Unit continues to work with Māori health providers and Pinnacle PHO to promote and support community action and development for priority women in Taranaki.									
7	Cancer	Breast screening among eligible population	70%	62.7%	59.5%	73.4%	▼	-13.8%	↓
Breast screening rates are similar to previous years with a continuing disparity between Māori and non-Māori screening rates being evident. Data provided is only for the period to 31 December 2020. Our provider continues to actively promote breast screening and cervical screening awareness at all local Māori and iwi functions that they attend. They continue to use local knowledge and door knocking with Māori women who have not attended appointments or responded, and it is hoped this will drive a more equitable performance.									
8	Immunisation	Percentage of infants fully immunised by eight months of age	95%	77.6%	67%	87.6%	▼	-20.6%	↑
Taranaki DHB and our providers are experiencing significant vaccination workforce shortages which have contributed to the decreasing rates of childhood immunisation since the COVID-19 vaccine delivery programme has built momentum. We have now developed a comprehensive plan with both short- term and long- term objectives to work towards improved childhood immunisation rates while we navigate through the effects of the pandemic.									

Priorities	Health Issue	Indicator(s) Target	Target	Māori June 2020	Māori June 2021	Non-Māori June 2021	Progress to target	Disparity Gap June 2021	Disparity Progress
9	Immunisation	Seasonal influenza immunisation rates 65+ year olds	75%	51%	51.8%	68.5%	▲	-16.7%	↓
Influenza rates increased by 12% for Māori in the 2020 season due to a huge team effort by all organisations, especially the Māori health providers who went over and above to immunise and protect the population during the COVID-19 level four protocols. Pop up clinics held in carparks around Taranaki were well utilised. Effort was made to recall patients and follow up calls for the over 65 year-old cohort by local GP clinics was also attributed to the success. Despite effort the disparity gap between Māori and non-Maori reduced only slightly.									
10	Rheumatic Fever	Number and rate of first episode rheumatic fever hospitalisations	0.3 / 100,000	0	0	0	↔	0	↔
There have been no first episode Rheumatic Fever hospitalisations in the past three years in Taranaki.									
11	Oral Health	Pre-school dental enrolments	95%	80.4%	87%	103%	▲	-16%	↔
Taranaki DHB achieved the target for the total population; however, we have not met the target for our Māori children. Despite this, the increase in enrolment for Māori children continues to increase which is encouraging. Taranaki DHB has very recently employed Kaiawhina to provide invaluable support to whānau and staff working in the service to facilitate positive and appropriate engagement, fostering relationships between frontline staff and whānau. We are acutely aware that pre- school dental enrollments do not convert to children receiving timely oral health assessment. Placing focus on measuring carries free at 5 years of age and reduction pre school enrollment arrears is beneficial.									
12	Mental Health	Mental Health Act Section 29 Community Treatment Orders (CTO)	115.2	281	288	85	▼	-108.8%	↔
There is a huge inequity for Māori regarding Section 29 CTOs. A lot of work needs to take place to find more culturally appropriate mental health care and treatment methods for Māori. Taranaki DHB is planning a transitional support service, exiting off the Section 29 CTOs orders, this approach aims to ensure access to the on-going support necessary to facilitate sustainable longer term outcomes (including funded medication and additional key worker support). This approach is awaiting budget prioritisation.									
13	SUDI	Five year average annualized SUDI infant deaths by DHB region	0	Not Available	Not Available	Not Available		Not Available	
Taranaki Tau te Moe, the Taranaki DHB safe sleep programme, continues to deliver safe sleep education and distribute safe sleep space to mothers and whānau who are most in need. More referrals are being received during the antenatal period rather than when the baby is born, which works well as it allows safe sleep messages and education to be shared earlier. The wahakura is now the preferred safe sleep space for Taranaki DHB; this reflects the need for culturally specific approaches to Sudden Unexpected Death in Infancy (SUDI) prevention. Numbers attending Hapū Wānanga continue to grow. The Taranaki DHB SUDI Prevention Coordinator presents the safe sleep session at Hapū Wānanga also with Taranaki DHB maternity and breastfeeding study days so safe sleep messaging across the region is consistent. An 11 week antenatal education and weaving wānanga called Āhuru Mōwai was piloted recently. Weaving was used as a mechanism to re-connect Māori mothers and their whānau with their ancestral heritage which aims to introduce and reinforce positive health and child development messages.									
LOCAL PRIORITIES									
14	Access to care	Did not attend (DNA) rate for outpatient appointments	5%	12.1%	12.4%	5.1%	▼	-7.4%	↔
Total DNA (Did Not Attend) rates continue to decrease in number for non- Māori; however they remain static for Māori. Patient centred booking, virtual consultations, telehealth and other patient centred initiatives are being considered to overcome some of the barriers to attendance. The Taranaki DHB will continue to monitor DNA rates and look for ways to improve engagement of patients in health services, especially for Māori.									
15	Workforce Development	Percentage of Māori employed by the DHB	18%	9.15%	9.16%		▲		↔
The Taranaki DHB has maintained Māori workforce levels at 9.16%, noting that the actual number of Māori employed has increased by 6% - from 197 to 208, keeping pace with the increase in FTE since last year. Taranaki DHB made the decision to establish a new Māori workforce leadership role. As well as reviewing and resetting Māori workforce planning, for 2021/22 the focus is on accelerating action on setting and addressing recruitment targets, establishing Māori staff well-being and retention activities and supporting the Why Ora programme with Māori coming through health workforce secondary and tertiary studies pipelines.									

PERFORMANCE SUMMARY

Performance to targets

- Performance improved on five indicators, significantly so for ASH rates for the 0-4 year's age group, ASH rates for the 45-64 year age group and the seasonal influenza target for 65 year olds and over which experienced a 12 percent increase. Preschool dental enrolments and percentage of Māori employed by the DHB also showed a small increase in performance.
- There were performance declines on six of the indicators. The targets that declined were ; percentage of Māori enrolled with PHOs, exclusive breastfeeding at 3 months, breast screening and cervical screening of eligible population, percentage of infants fully immunised at 8 months and Mental Health act Section 29 CTO.
- Data was absent for two of the targets; 5 year average annualised SUDI infant deaths by DHB region and ethnicity data accuracy in PHO registers.

Equity performance

- There was a reduced inequity gap on three indicators. ASH rates for the 0-4 year's age group significantly reduced from 26.7 percent in the second quarter to 4.6 percent in the fourth quarter. The inequity gap also reduced on the seasonal influenza target for 65 year and over and breast screening for the eligible population.
- Increases in disparity occurred for only one of the indicators – percentage of infants fully immunised by eight months of age.
- The disparity gap remained the same for nine of the targets.
- Data was absent for two of the targets; 5 year average annualised SUDI deaths by DHB region and ethnicity data accuracy in PHO registers.

Focussed action on the Māori health priorities from all parts of the health and disability system is urgently required if we are to make meaningful progress towards achievement of equitable and improved health outcomes for Māori.

The complex nature of inequity between Māori and non- Māori health outcomes means that success is reliant on the pursuit of a multi faceted approach that straddles out from the district health board, into the communities we serve, whilst working in a multi sectorial way.

The Māori sector and iwi have a critical role in co-designing, co-deciding and co-delivering health services in a way that responds appropriately to the total population. Taking a life course approach, and applying kaupapa Māori models and modes of care, that place whānau at the centre, where they are protected and have options for self determining what is an effective hauora plan for them and their community is critical.

The Taranaki DHB in partnership with Te Whare Punanga Kōrero are considering the priorities for 2021/22.

MĀORI LANGUAGE PLANNING

Taranaki DHB has not developed a Te Reo Māori Language Plan. However, the DHB has initiated some te reo Māori language revitalisation activities in 2020/2021.

Taranaki DHB's Te Reo Māori and Te Reo Māori Translation Policy commits the DHB to "using te reo Māori principally from a health literacy perspective of Māori, in ways that are appropriate to the intended audiences, and in ways that support tangata whenua to revitalise te reo o Taranaki".

The DHB is planning to incorporate a more comprehensive reo Māori curriculum within the cultural competency programme that is currently operating. In anticipation of this, the DHB has partnered with Te Whare Wānanga o Awanuiārangi to deliver Te Pokaitahi Reo, a level 3 certificated te reo Māori programme which is offered to staff at Base and Hāwera hospitals, in New Plymouth.

Under the guidance of outstanding te reo o Taranaki proponent Dr Ruakere Hond, this programme has been adapted to reflect the distinctively Taranaki reo Māori dialect.

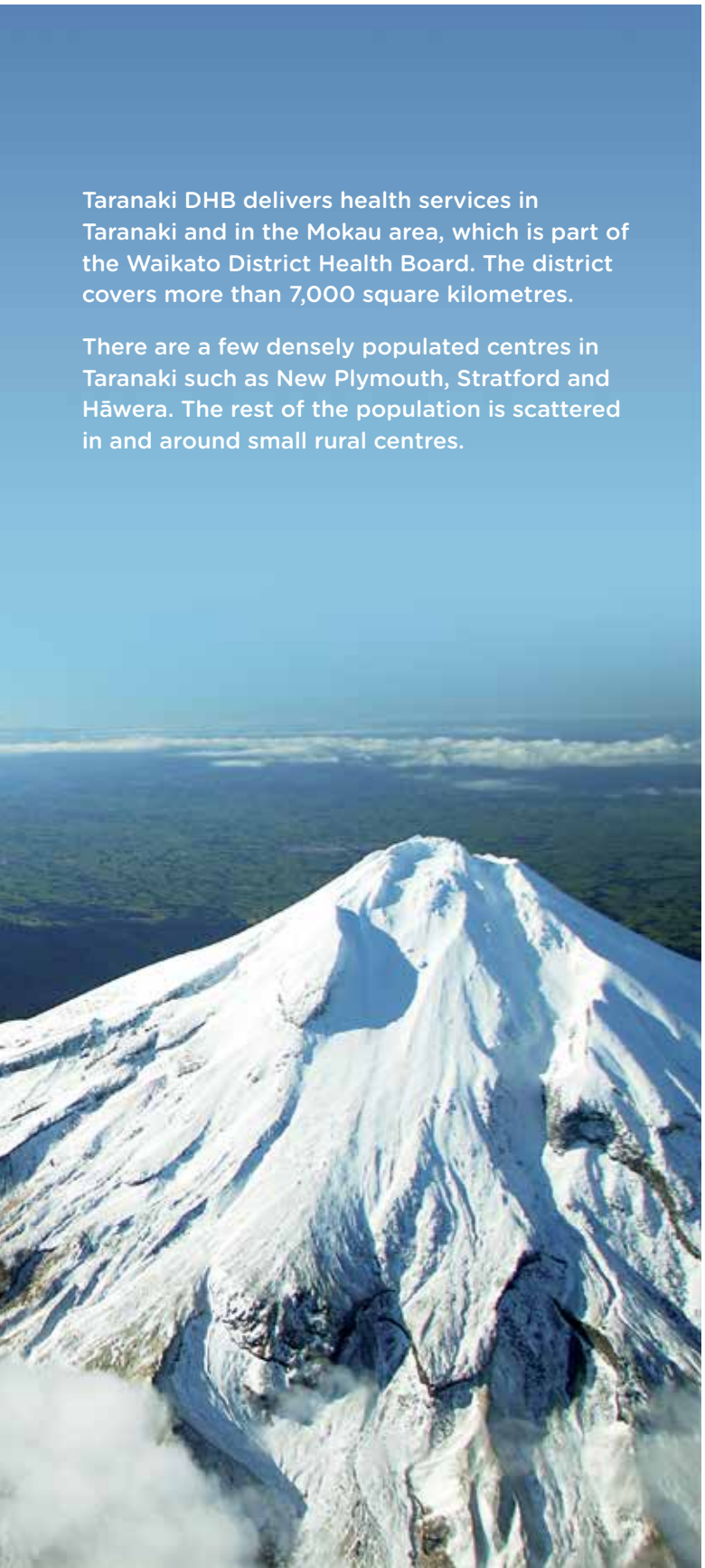
At the end of June 2021, there were three 18-month Pokaitahi Reo programmes running for which a total of 75 staff were enrolled.

Profiling Taranaki

TE AO HAUORA O TARANAKI

Taranaki DHB delivers health services in Taranaki and in the Mokau area, which is part of the Waikato District Health Board. The district covers more than 7,000 square kilometres.

There are a few densely populated centres in Taranaki such as New Plymouth, Stratford and Hāwera. The rest of the population is scattered in and around small rural centres.



We are responsible for the provision (or funding the provision) of the majority of health services in our district.

THESE SERVICES INCLUDE:

- **19** dental practices
- **30** pharmacies
- **1** specialist palliative care provider
- **10** community based mental health, and alcohol & addictions services
- **2** specialist mental health service providers (including 1 kaupapa Māori provider)
- **3** Māori health service providers
- relationship with one Primary Health Organisation (Pinnacle Midlands Health Network)
- **32** GP practices
- providers of community laboratory services and radiology services
- support services for people with disability, including 26 aged residential care facilities
- **2** hospitals - Taranaki Base Hospital and Hāwera Hospital. **5** community Health Centres in Waitara, Stratford, Opunake, Patea and Mokau
- access to tertiary and specialist hospital healthcare in other parts of New Zealand

POPULATION PROFILE

According to the 2018 Census, Taranaki DHB serves a population of 117,561 people[1]. This is approximately 2.5% of the New Zealand population.

Within Taranaki, the Māori population is projected to increase to 23.4% of the total population by 2033^. The European, Māori, Pacific and Asian populations have grown since 2006, as at the 2018 Census. Taranaki has 84.8% identified as European, 19.8% as Māori as compared to 15.7% nationally, 2.1% as Pacific and 4.5% as Asian[1].

Note: Where a person reported more than one ethnic group, they have been counted in each applicable group. As a result percentages do not add up to 100%.

AGE STRUCTURE

Our population is ageing and older than the national average, and is expected to age further in the future. Based on the latest forecast, the total number of people over the age of 65 is 23,330 (19.8% of the population)^.

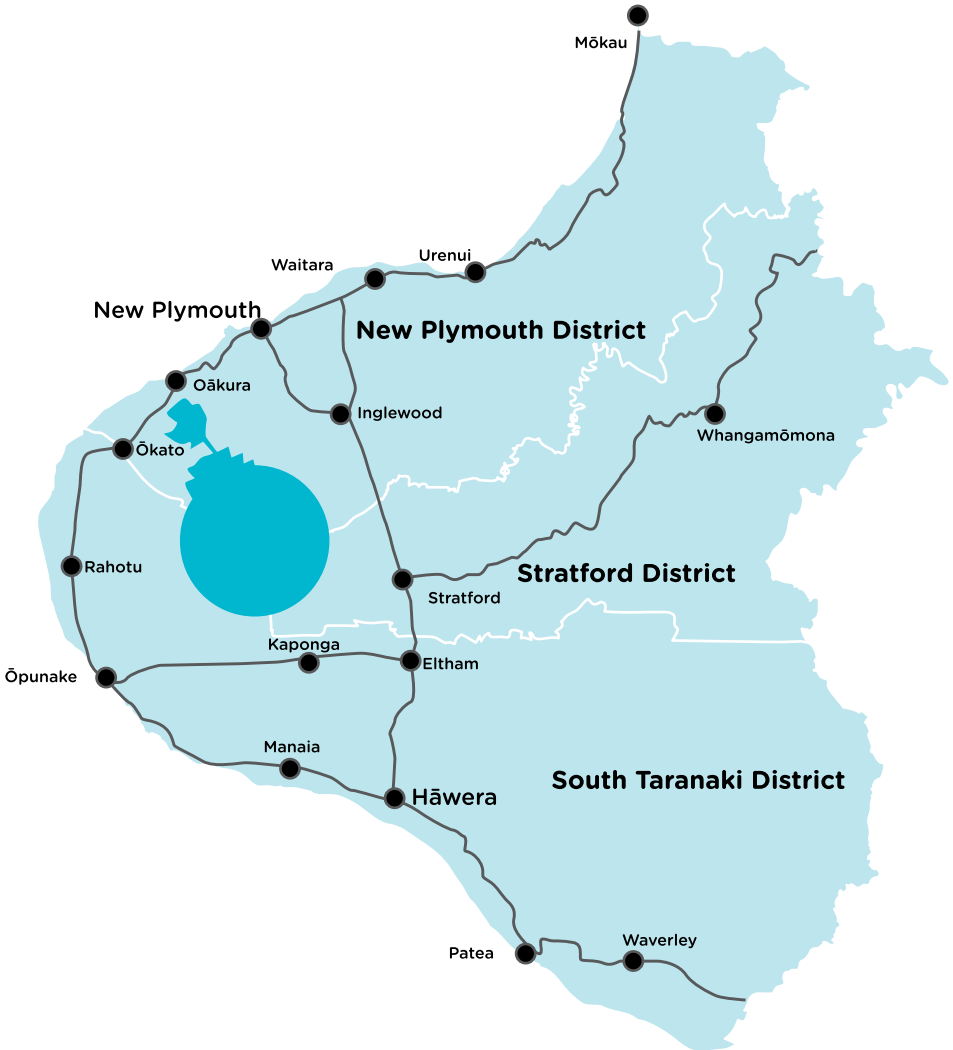
Latest forecasts also show the total number of people 24 years or younger are 39,235 (33.4%), the number of Māori in this age group is 13,100 which represent 49.2% of Māori in the region. 32.2% of Māori population is under 15 years as compared to 20.4% of the total population[1].

SOCIO-ECONOMIC INDICATORS

Around 37.3% of the Taranaki population lives in NZDEP2018 Decile 1 to 5 compared to 48.5% nationally and 62.7% in Decile 6 to 10 compared to 51.5%.

[1] *Based on usually resident population, 2018 Census*

^ *Based on updated information received from Statistics New Zealand Population Projection released December 2020*



New Plymouth District population
80,679 [1]

Stratford District population
9,474 [1]

South Taranaki District population
27,534 [1]

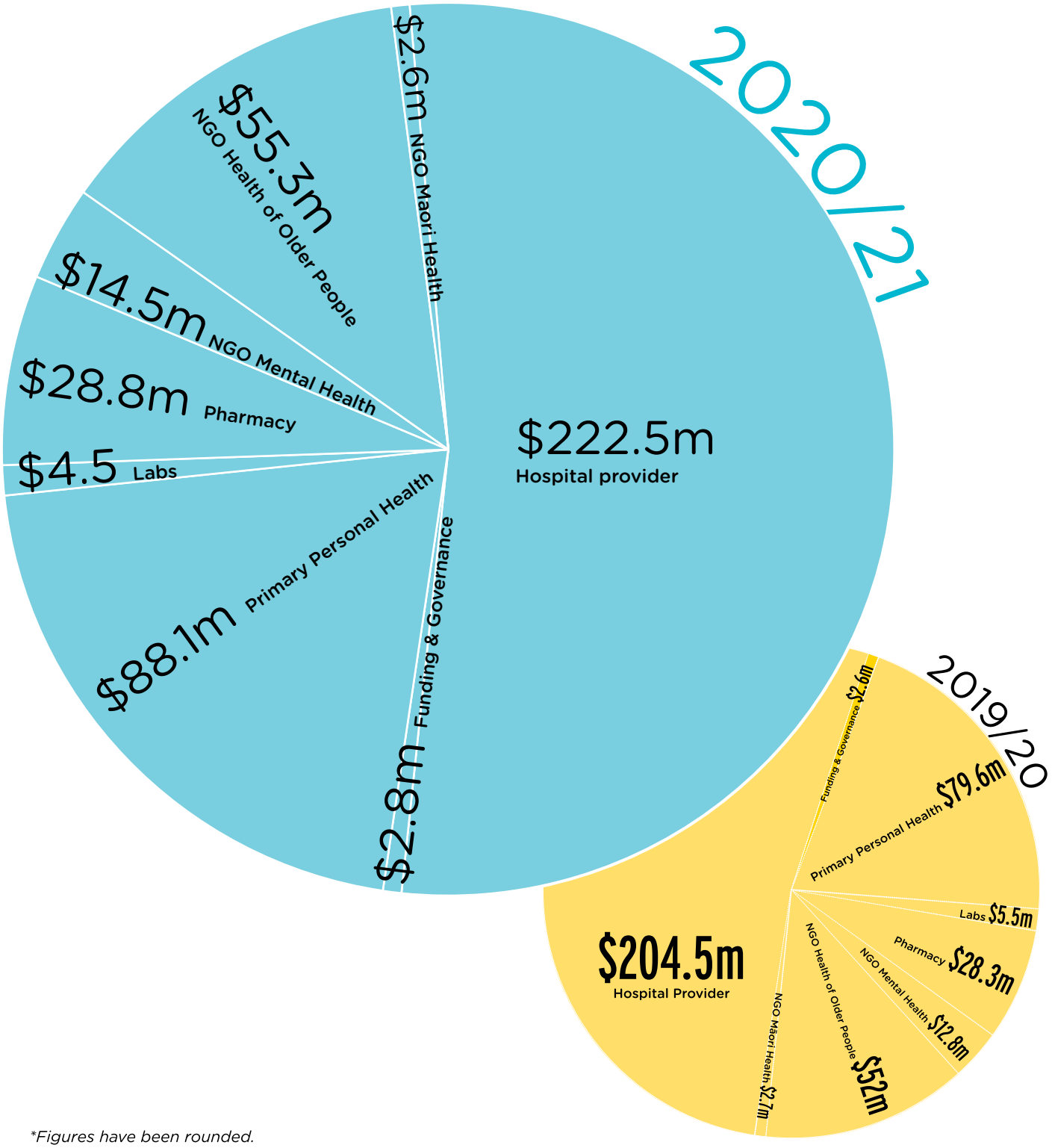
Where the Money Goes

TE TOHANGA PŪTEA

Taranaki DHB has two major divisions; the Planning and Funding division and Hospital and Specialist Services.

TARANAKI DHB PLANNING AND FUNDING ALLOCATION

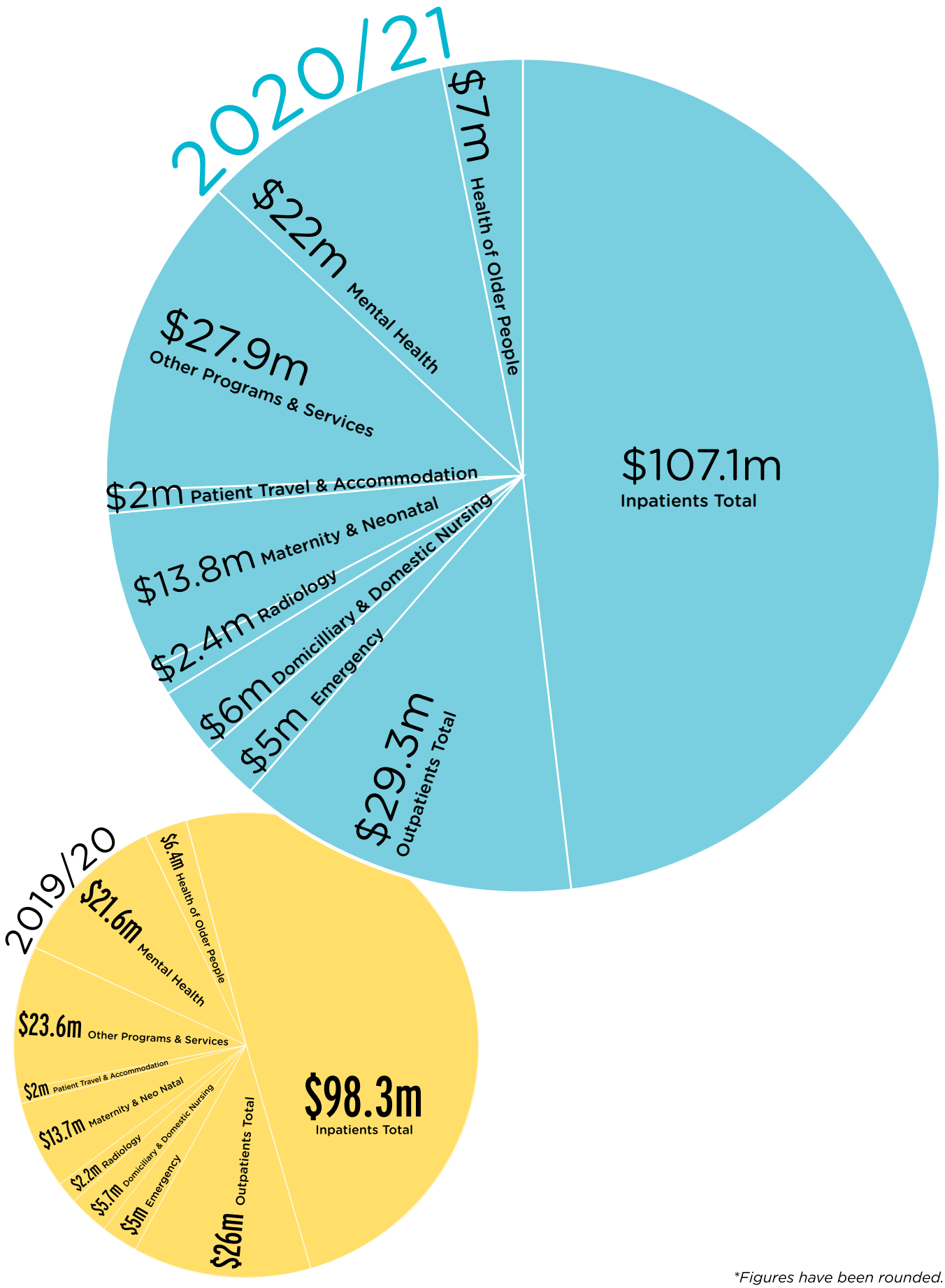
In 2020/21 the Planning and Funding division allocated its funding of $419 million as follows:



*Figures have been rounded.

HOSPITAL AND SPECIALIST SERVICES ALLOCATION

The $222.5 million allocated to the Hospital and Specialist Services during 2020/21 was further allocated as follows:



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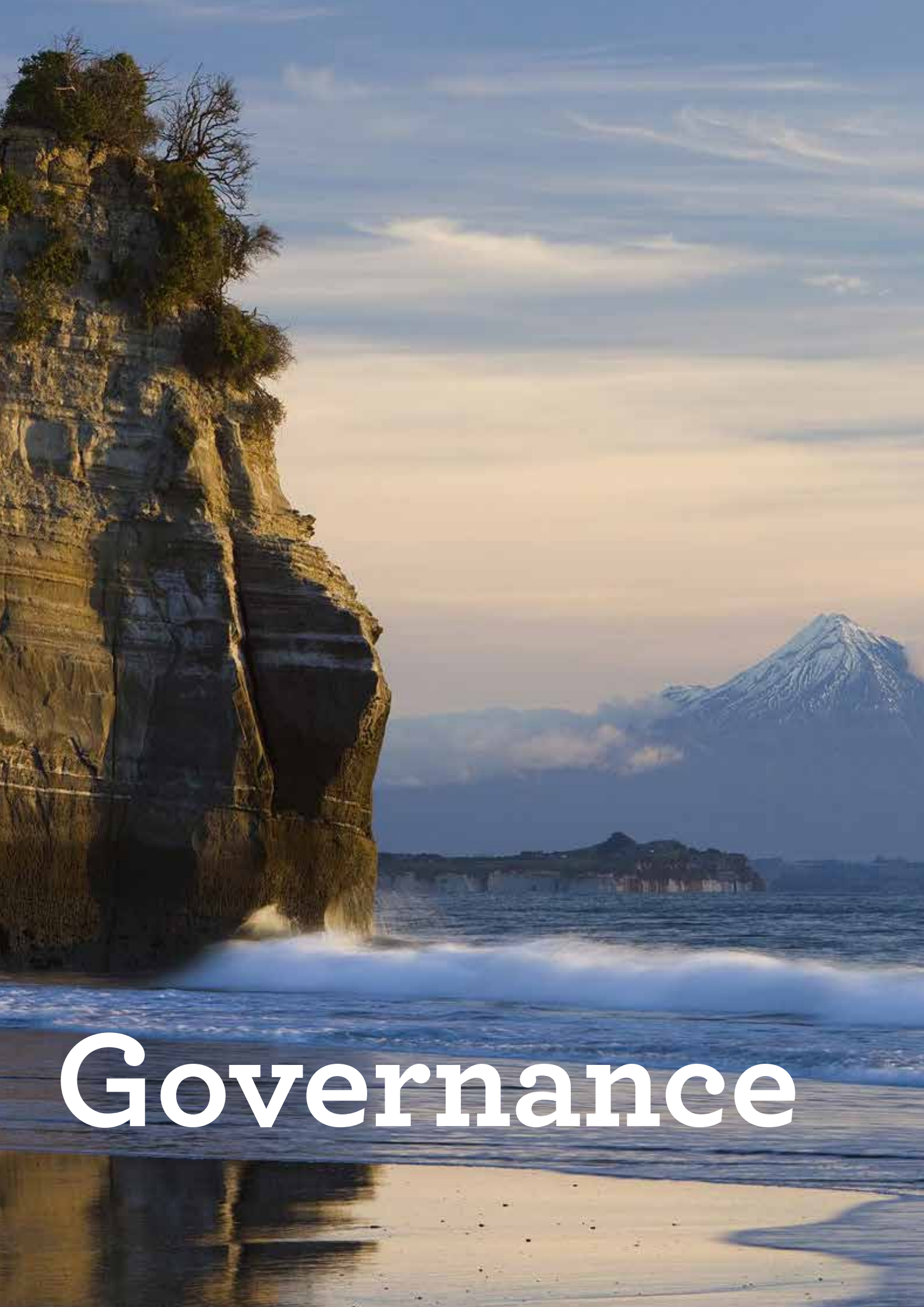


Governance

Governance Structure

TĀHUHU KĀWANATANGA

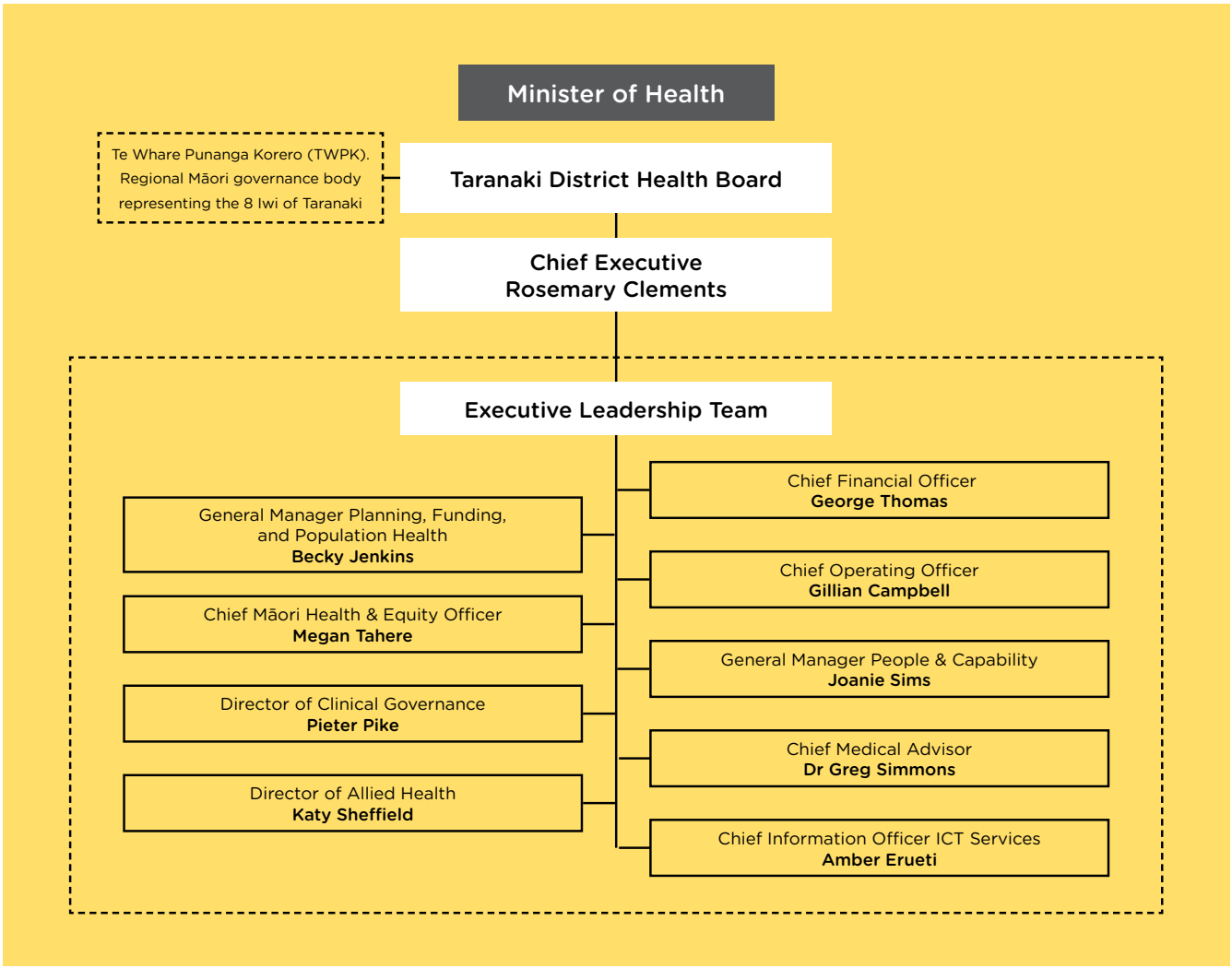
The governance structure for DHBs is set out in the NZ Public Health and Disability (NZPHD) Act 2000. The Board consists of up to 11 members and they have overall responsibility for the operation of Taranaki DHB. Seven of the members are elected as part of the three-yearly local body election process (last held in 2019) and up to four are appointed by the Minister of Health.

The Board is responsible for the overall governance of Taranaki DHB. Within this role the functions carried out directly by the Board include:

- Approving major strategic and policy documents including the District Strategic Plan, Annual Plan,
- Budget and considering recommendations on key issues.
- Monitoring the implementations of the Annual Plan and Budget.
- Monitoring the operating performance of the organisation.
- Maintaining and developing an effective working relationship with Te Whare Punanga Korero, its Iwi partner.
- Ensuring Taranaki DHB acts legally and responsibly.
- Appointing, evaluating and supporting the performance of the Chief Executive.

The governance of a District Health Board is a diverse and complex undertaking and the Board has established committees so that it can carry out its responsibilities effectively, recognising the requirements of the NZPHD Act 2000.

The balance of skills and experience of the Board is kept under regular review. Additional knowledge and expertise is recruited to assist where needed with the work of the advisory committees. The Board publishes when and where it or its advisory committees meet and members of the public are welcome to observe most of the meetings, other than items of a confidential or commercial nature.



Ministerial Directions

NGĀ TOHUTOHU A TE MINITA

Directions issued by a Minister during the 2016-17 financial year, or that remain current are as follows:

- The 2011 Eligibility Direction issued under s.32 of the NZ Public Health and Disability Act 2000.
- The requirement to implement the New Zealand Business Number (NZBN) in key systems by Dec 2018, issued in May 2016 under s.107 of the Crown Entities Act.
- The direction to support a whole of government approach issued in April 2014 under s.107 of the Crown Entities Act. The three directions cover Procurement , ICT and Property and the former two apply to DHBs.
- The direction on the use of authentication services issued in July 2008, which continues to apply to all Crown agencies apart from those with sizeable ICT business transactions and investment specifically listed within the 2014 direction.

Members of the Board

NGĀ KAINOHO POARI

Cassandra Crowley (Chair)

Cassandra originally hails from Kaponga, Taranaki. She is a fellow chartered accountant, barrister and solicitor of the High Court of New Zealand and a member of the Institute of Directors NZ.

In addition to her commercial advisory work, she holds a number of non-executive directorships across several sectors of the New Zealand economy. These roles include chairing several audit, finance, and risk committees as well as overseeing digital transformation. She is a past president of Chartered Accountants Australia and New Zealand and has been recognised for her leadership and governance contributions, with the supreme award for inspirational excellence in governance from Women on Boards New Zealand. In addition to being our Chair at Taranaki DHB, Cassandra also Chairs the DHB Chair group and participates in various working groups across the sector.

Interest Register (as at 30 June 2021):

Chair of:
- District Health Boards Chairs
- K.L.C Limited
- Nisa Clothing Limited (Advisory Board Chair)

Deputy Chair of:
- New Zealand Transport Agency

Trustee of:
- Ngāti Manawa Developments Incorporated
- Narsha Nayolet Foundation Trust
- The Skills Foundation

Director & shareholder of:
- Crescendi Group Limited
- Grand Debut Limited

Minority shareholder via nominee company of:
- Be Pure Health Limited
- Ossis Limited

Minority shareholder of:
- Zeffer Brewing Limited

Other:
- Board Member, Bledisloe Park Board
- Commercial Advisor, Te Arawa Management Limited
- Executive Member, Sacred Heart Girls' College New Plymouth Alumni Association
- Relatives employed by Taranaki DHB
  - Consultant Rural Health, Hāwera Hospital
  - Registered Medical Officer, Taranaki Base Hospital
  - Duty Nurse Manager, Taranaki Base Hospital
  - Public Health Nurse, Taranaki District Health Board
  - Booking & Outpatient Department Admin/Reception, Hāwera Hospital

Bridget Sullivan (Deputy Chair)

In addition to her role on the Taranaki DHB, Bridget works across the Taranaki region with a wide range of groups to develop projects that support regional economic development. She graduated from Otago University with a Bachelor of Arts and a Post Graduate Diploma (with Distinction) in Philosophy. Born and raised in Taranaki she has family spread around Taranaki Maunga. Bridget lives in New Plymouth with her partner Chris and two sons. She volunteers for a conservation trust and is a keen supporter of the arts.

Her previous roles include working as a manager at the New Zealand Treasury and as economic adviser to the Hon Annette King, the then Minister of Health. She has also worked at Te Puni Kōkiri and as a consultant where she managed projects such as service level reviews, cross-social sector funding allocation and budget processes.

Interest Register (as at 30 June 2021):

- Employee of Ministry of Business, Innovation and Employment
- Partner is a member of the Toi Foundation and a Partner in Young, Carrington, Ussher
- Family member employed by Taranaki DHB
- Trustee on Tiaki te Mauri o Parininihi

MEMBERS OF THE BOARD

Patsy Bodger (Pat)

Pat (Ngāti Mutunga, Te Atiawa, Taranaki, Ngāruahine, Ngāti Ruanui) was born in Opunake and lives in Waitara. She has four children and 16 grandchildren. Pat has 50 years' experience as a registered nurse and has worked in various nursing roles across the lifespan. Pat is the Te Atiawa representative on the Taranaki Iwi Relationship Board, Te Whare Pūnanga Kōrero. Pat is also on other Governance Boards including local marae and Boards that were established following the enacted Waitara Land Bill. Pat was an appointed member onto the Taranaki District Health Board and is very passionate about health equity and improved health outcomes for Māori.

Interest Register (as at 30 June 2021):

Member of:
- NPDC Accessibility, Aged and Issues & Working Party
- Taranaki Nurses Scholarship Grant Trust

Trustee of:
- Manukorihi Hapū Charitable Trust
- Manukorihi Paa Reserve Trust
- Te Kowhatu Tu Moana (NPDC Land Act 2018)
- Te Tai Pari Board – Waitara Perpetual Community Fund (NPDC Land Act 2018)
- Te Hanataua Family Trust

Other
- Chairperson of Manukorihi Hapū
- Te Atiawa representative of Te Whare Punanga Korero (TWPK)
- Board member of Hospice Taranaki Inc. Soc.
- Community Registered Nurse Mokau Health Centre
- Registered Nurse Tui Ora Ltd

Alison Brown

During Alison's 40 years of service with Taranaki DHB in various nursing roles she has had close association with management both nationally and locally as a lead advocate for nursing and a strong campaigner for patients and their rights. She has close ties to the rural sector and extensive knowledge and understanding of health services from both community/rural and hospital perspectives.

Alison was awarded honorary life membership to the New Zealand Nurses' Organisation for services to nursing and is also a board member of Age Concern Taranaki.

She believes a strong health board should be transparent and consult with and listen to the community it serves.

Interest Register (as at 30 June 2021):

- NZ Nurses' Organisation Honorary Life Membership
- Committee member of Grey Power
- Board member of Age Concern Taranaki
- Daughter is employed as a registered nurse by Capital & Coast, Wellington Hospital

Mike Davey

Mike is employed in the rural sector and is an elected member of the Taranaki Regional Council, deputy chair of Taranaki Electricity Trust (TET) and a member of the Taranaki Chamber of Commerce. He is also a board member of the Taranaki Health Foundation. Mike lives in Inglewood and is married with children and grandchildren. Mike is very active in the rural sector and is a member of Federated Farmers Taranaki.

As healthcare is important to us all, Mike intends to work diligently to ensure that we continue to offer a professional service in Taranaki.

Interest Register (as at 30 June 2021):

- Elected councillor at Taranaki Regional Council - sits on Consents & Regulatory and Policy & Planning committees, plus member of Ordinary meeting
- Deputy Chair at Taranaki Electricity Trust
- Taranaki Health Foundation board member
- Relative employed by Taranaki DHB as a pharmacy technician

MEMBERS OF THE BOARD

Te Pahunga (Marty) Davis (Chair for Te Whare Punanga Korero Trust (TWPK)

Born in Hāwera and schooled in Taranaki and Auckland, Marty has lived in Whanganui since 1976. He worked for 30 years in the agriculture and fisheries sectors, including 10 years in management, before returning to work for Ngā Rauru Kītahi iwi as its chief executive and chief negotiator. Before becoming the chief executive of Ngāti Ruanui iwi in Hāwera, Marty was elected to the pre-settlement board of Ngāruahine. In 2014 he returned to Whanganui and was elected Chair of Te Kāhui o Rauru Trust until retiring in October 2018.

Marty is currently the Chair of Taranaki Iwi Relationship Board, Te Whare Pūnanga Kōrero and Te Whakatipuranga Rima Rau Trust. He is a trustee of Tuituia Trust and the Taranaki Māori Trust Board, and a Taranaki Maunga negotiator. He is also a trustee at three marae in South Taranaki.

Health equity remains Marty's passion. He's also a musician and sometimes a golfer.

Interest Register (as at 30 June 2021):

Chair of:
- Te Whare Pūnanga Kōrero Trust

Co-Chair of:
- Taumaruroa

Trustee of:
- Tuituia Trust
- Taranaki Māori Trust Board
- Ngāti Ruaiti Nukumaru Marae Trust
- Wai-o-Turi Marae Trust
- Meremere Marae Trust

Director of:
- Tumararoa Properties Ltd

Other:
- Co-chair of Mental Health & Addictions Cross Sector Group
- Member of Taranaki DHB Infrastructure & Planning Working Group

David Lean

David has a proven record of community leadership and governance experience in Taranaki, having been New Plymouth mayor from 1980-92, serving as Civil Defence controller for more than three decades and leading Sport Taranaki as chair for 20 years.

David is keen to make a positive difference in the region's future healthcare and believes focus on health promotion and education is vital to community wellbeing. David is also deputy chair of the Taranaki Regional Council.

Interest Register (as at 30 June 2021):

Chair of:
- Rahotu Dairy Ltd
- David Lean & Associates Ltd

Other:
- Deputy Chair of Taranaki Regional Council
- Trustee of Cameron Clow Trust
- Surf Life Saving New Zealand Life Member
- Daughter employed by Taranaki DHB

Member and Advisor:
- Westland Industries for Sustainable Environment (WISE) – Charitable Trust

Shareholder and Advisor:
- Return 2 Earth Ltd

Shareholder, Company Director and Advisor:
- Bioplant Manawatu NZ Ltd
- Bioplant Tairawhiti NZ Ltd
- Bioplant Waikato NZ Ltd
- Bioplant Hokitika NZ Ltd
- Bioplant Canterbury NZ Ltd

Harry Duynhoven

Harry is New Plymouth-born and bred and has three adult children with his wife Margaret. He has serviced the community in many different roles, including as a Member of Parliament and New Plymouth Mayor, and he is currently a member of the New Plymouth District Council. Through these roles he has assisted many people to access the healthcare they need. Harry believes timely access to healthcare services is vital for Taranaki people, especially as the ageing population grows. Harry also does consultancy, charity and voluntary work, is an honorary member of two international advocacy organisations and is a board member of Habitat Taranaki.

Interest Register (as at 30 June 2021):

Patron of:
- Taranaki Disability Resource Centre
- Community Christmas Dinner Trust
- NP Model Aero Club

Other:
- Board Member, Habitat Taranaki
- Member, Automobile Association (Taranaki) Council
- Board Member, NZCAA (NZ Civil Aviation Authority)
- Elected Councillor, New Plymouth District Council
- Consultant – part-time
- President, NZ Federation of Motoring Clubs
- Board Secretary, Air Quality Asia (NGO based in USA)
- Member of several community charity organisations

MEMBERS OF THE BOARD

Carla White

Carla (Ngāti Tama, Ngāti Mutunga, Ngāti Toa Rangatira) lives in Pukearuhe and splits her time between home and work in Auckland. She is a director of Health Literacy New Zealand Limited which works with DHBs, PHOs and other health organisations to improve the design and delivery of their services from a health literacy perspective, to better meet the health needs of the public. Carla is also a consumer representative on the Pharmacy Expert Advisory Group.

Interest Register (as at 30 June 2021):

- Director of Health Literacy NZ Ltd working for health sector clients including:
- Ministry of Health
- Arthritis NZ
- Johnson&Johnson; Janssen-Cilag Ltd
- Waitemata DHB
- Te Pou Limited
- NZ Medical Journal, NZ Pharmacy and NZ Doctor (writing articles)
- ProCare (PHO Limited)
- National Hauora Coalition
- CARI (Caring for Australians with Renal Impairment)
- Auckland DHB
- University of Auckland
- Health Navigator NZ
- Health Quality & Safety Commission
- Mental Health Foundation

Member of:
- TAS Pharmacy Expert Advisory Group
- Ministry of Health project to improve gout management in primary care
- Prime Minister's Chief Science Advisor's Reference Group

Pauline Lockett

Pauline has lived in New Plymouth since 1981. She was a partner of PwC for 20 years until retiring in 2010. Appointed to the Taranaki District Health Board in 2010, she was appointed as the chair in 2013 and 2016. She is currently an advisory Trustee to the Ngāti Te Whiti Whenua Topu Trust and is the Chairperson of the Te Tai Pari Trust. Pauline is a fellow chartered accountant and is a chartered member of the Institute of Directors.

Interest Register (as at 30 June 2021):

Trustee of:
- P Lockett Family Trust
- Taranaki Work Trust (no transactions and interest noted only)

Other:
- Chairperson of Te Pai Pari Trust (Waitara Perpetual Fund currently known as 'The Board')
- Advisory Trust and Independent Contractor – Ngāti Te Whiti Whenua Topu Trust

Kevin Nielsen

Kevin spent 36 years working at Taranaki Newspapers, the last 16 as general manager, and then 15 years as chief executive of Hospice Taranaki until retirement in 2017. Kevin's top priority is to minimise the financial deficit of Taranaki hospitals whilst not compromising on primary healthcare. He wants all Taranaki people to benefit from quality health services. Kevin has a strong interest in the disability sector and is President of New Plymouth Riding for the Disabled and a Board member of the Conductive Education Taranaki Trust and the Flourish Charitable Trust.

Interest Register (as at 30 June 2021):

- Adviser of Conductive Education Taranaki Trust
- President of New Plymouth Riding for the Disabled
- Lifetime Member, Hospice Taranaki Inc
- Committee Member, Flourish Charitable Trust

Paul Verić

Paul is married to Angela (a local GP) and has two young boys. He was schooled in Taranaki and has lived here since returning in 2010. Paul has extensive management and governance experience including being chief executive in the not-for-profit sector and more recently, headmaster of New Plymouth Boys' High School. Paul has also worked for the very successful local medical manufacturer Howard Wright. Paul is community minded – demonstrable by being an elected member on the Kaitake Community Board and Oakura School Board of Trustees.

Paul considers himself privileged to serve Taranaki DHB and strives to improve the equity, quality and sustainability of healthcare for all.

Interest Register (as at 30 June 2021):

Director of:
- BTE Consulting Ltd
- PASS Ltd

Other:
- Board member of Kaitake Community Board
- Oakura School Board of Trustees
- Wife holds following positions which are connected to Taranaki DHB work:
  - GP at Vivian Medical Centre (partner)
  - On call doctor for Med SAC

Rosemary Clements - Chief Executive

Interest Register (as at 30 June 2021):

- Family trust affiliated to Carefirst Trust Ltd
- Trustee - pecuniary benefits

Board Members' Responsibilities & Fees

Board members, committee members and directors schedule

Name	Board Members to June 2021	Allied Laundry Services Ltd	HealthShare Ltd	Fees Paid ($)
Board Members – 2020/21				
Cassandra Crowley (Chair)	10 of 10			49,629.54
Bridget Sullivan (Deputy Chair)	8 of 10			32,962.96
Patsy Bodger	10 of 10			27,170.92
Alison Brown	10 of 10			27,170.92
Mike Davey	9 of 10			26,670.92
Te Pahunga (Marty) Davis **	7 of 10			6,000.00
Harry Duynhoven	10 of 10			27,170.92
David Lean	9 of 10			26,920.92
Pauline Lockett	9 of 10			26,920.92
Kevin Nielsen	10 of 10			27,170.92
Paul Verić	9 of 10			27,170.92
Carla White	10 of 10			27,170.92
Jane Parker-Bishop (from January 2021) ***	4 of 10			1,000.00
Other Directors				
Rosemary Clements, Chief Executive			✓	
Simon Barrett, Group Financial Manager		✓		

Key:

** Co-opted Board / Committee members

*** Board Observer

Te Kāhui o Te Whare Punanga Kōrero

TE WHARE PŪNANGA KŌRERO TRUST

Te Whare Pūnanga Kōrero Trust(TWPK) is the Iwi Māori Partnership Board which works strategically with the Taranaki District Health Board (DHB) to improve Māori health and reduce and eliminate Māori health inequalities. The members of the Trust represent the eight iwi of Taranaki – Ngā Rauru Kītahi, Ngāti Ruanui, Ngā Ruahinerangi, Taranaki, Te Atiawa, Ngāti Maru, Ngāti Mutunga and Ngāti Tama – and in terms of the Memorandum of Understanding it has with Taranaki DHB, exercises mana whenua status by providing kaitiakitanga or guardianship, for all Māori living in the region. Based on Statistics NZ population projections Māori made up 19.8% of the Taranaki population of 117,561.

TWPK participated in the DHBs strategic agenda through the following activities:

Strategic Planning

- With the support of Taranaki DHB, TWPK has led the Māori health sector in the review of Te Kawau Mārō, Taranaki Māori Health Strategy.
- The DHB has not undertaken any other strategic planning during the year.

Governance

a) The TWPK Chair participates on behalf of the Trust in all Taranaki DHB Board meetings, including confidential meetings. The Taranaki DHB Board acknowledges the value of having the specifically iwi/Māori lens contributing to its discussions at this strategic level;

b) TWPK Chair was appointed to and is a fully participating member of the Infrastructure and Planning Committee;

c) TWPK Chair participated as a member of Te Manawa Taki Region Governance Group alongside four other DHB Iwi Māori Relationship Board Chairs and the five Manawa Taki DHB Board Chairs;

d) TWPK Chair and one other TWPK member participated in Te Manawa Taki Region two-day governance training event;

e) TWPK was integral to the approval processes of the Taranaki DHB Annual Plans for 2019/2020 and 2020/2021;

f) The TWPK and Taranaki DHB Board Chairs have been in discussion regarding the governance relationship in the context of the review of the Memorandum of Understanding between the two Boards.

g) Two members of TWPK attended the Ministry of Health Hui Whakaoranga in June 2021

h) Six members of TWPK attended the Department of the Prime Minister and Cabinet Transition Unit meetings in June 2021.

Executive Management

a) The Chief Advisor, Māori Health and from May 2021 the Tumuaki Matua Hauora Māori - Chief Māori Health and Equity Officer, have provided monthly reports to TWPK on a range of Māori health-related matters, in particular progress towards eliminating Māori health inequalities;

b) The TWPK Chair and Taranaki DHB Chief Executive have had an open door policy to enable discussions as and when needed;

c) The General Manager Planning, Funding and Population Health and Chief Operating Officer attended TWPK meetings on request to provide briefings on planning and/or performance in addressing Māori health issues.

Te Whare Pūnanga Kōrero Trust representing the eight iwi of Taranaki:

Te Oti Katene
(Ngā Ruahine)

Rawinia Leatherby
(Taranaki iwi)

Eileen Hall
(Ngāti Maru)

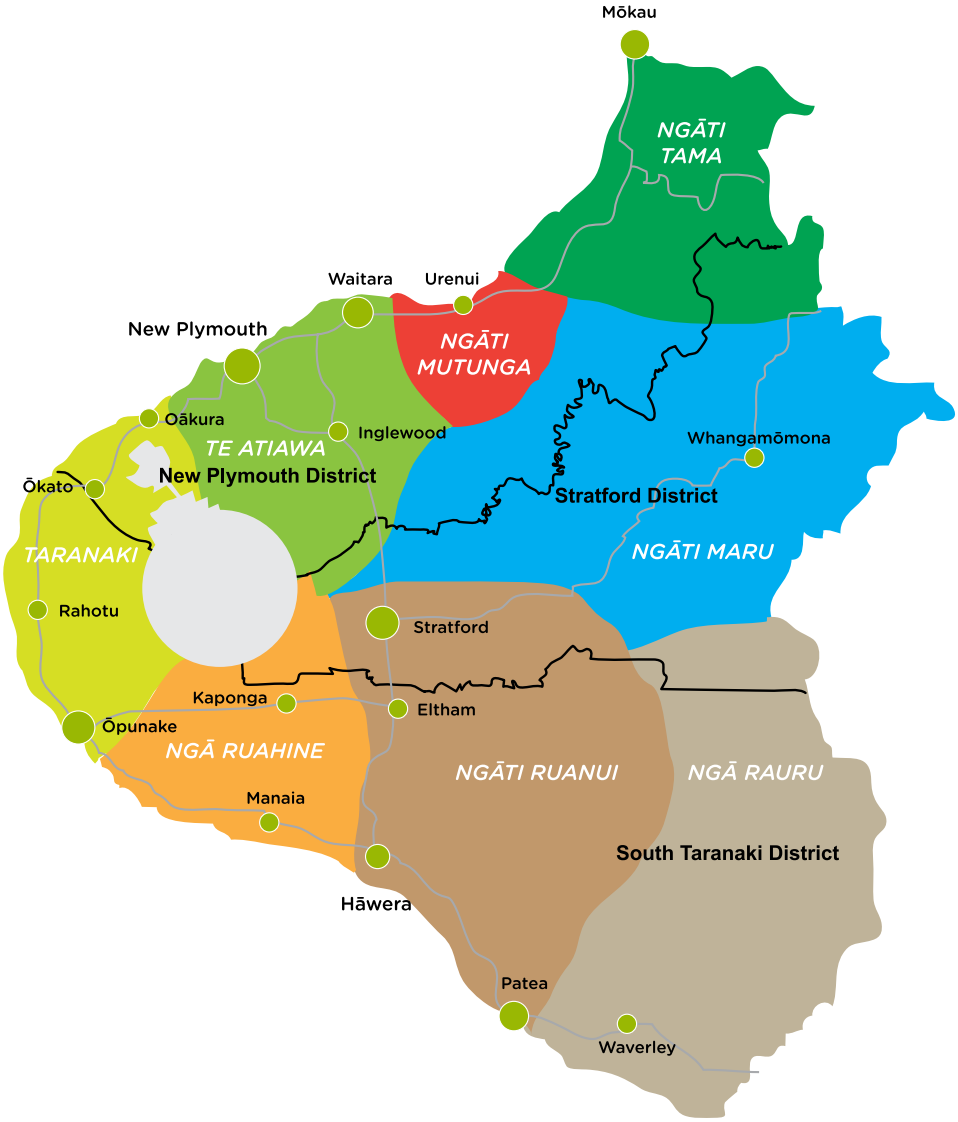
Ngapari Nui
(Ngāti Ruanui)

Greg White
(Ngāti Tama)

Te Pahunga (Marty) Davis (Ngā Rauru)

Patsy Bodger
(Te Atiawa)

Howie Tamati
(Ngāti Mutunga)



Looking back

Highlights

Taranaki Tau to moe

Taranaki DHB has renamed its Safe Sleep programme to Taranaki Tau te moe to promote a kaupapa Māori feel. The programme provides support and education for whānau of pēpi who are at risk of sudden unexpected death in infancy (SUDI) through factors such as pre-term birth or low birthweight, maternal smoking and other social circumstances.

A group of Taranaki weavers and their whānau who were affected by the death of a mokopuna (grandchild) to SUDI are lending their expertise and support to Taranaki Tau te moe by weaving wahakura (bassinets woven from harakeke/flax). The programme also provides opportunities for māmā/whānau to use the traditional Māori practice and weave their own wahakura to enhance Māori wellbeing.

A Seat at the Table

Jane Parker-Bishop was welcomed to the Taranaki District Health Board through a new governance initiative called 'A Seat at the Table' which mentors younger people interested in health board governance, in particular Māori, Pacific and disabled people.

The programme also aims to increase diversity on district health boards and is providing Jane the opportunity to develop governance skills by spending a year as part of the board and being mentored by board members.

Hāwera Hospital leads search for eMedicine system

Hāwera Hospital has been part of a ground-breaking project to trial an electronic medicines prescribing and administration system for Te Manawa Taki region district health boards.

Hāwera has piloted OPENeP, a secure eMedicine system which provides a clear overview of patients' medication records in a single, shared location. This technology reduces clinical risk, provides consistency in practice and a more collaborative and coordinated approach to patient care between healthcare providers throughout the health system.

OPENeP is the first regionally-led e-medicine trial in New Zealand, and in the Asia-Pacific region.

Measles pop-up clinics

Students at WITT (Western Institute of Technology at Taranaki) had the chance to be immunised for measles, mumps and rubella (MMR) at a pop-up clinic held on campus during O-Week. The initiative was led by Taranaki DHB as part of a nationwide immunization campaign which aimed to encourage 15-30 year olds to get vaccinated if they missed out when they were children.

Taranaki Health Excellence Awards

The inaugural Employee Health Excellence Awards were celebrated in February recognising outstanding initiatives which made a difference to the experience and health outcomes of patients, their whānau and the wider community in 2020.

Recognising the commitment of Taranaki DHB staff, nominations were based on the organisation's Te Ahu Taranaki DHB Values: whanaungatanga/partnership, manawanui/courage, mana motuhake/empowerment, mahakitanga/people matter, manaakitanga/safety. The award winners were announced at a gala event, hosted by the Taranaki Health Foundation, on the Bowl of Brooklands stage.

Taranaki patients help revolutionise understanding of breast cancer care

Taranaki DHB has joined the Breast Cancer Foundation National Register, a database that collects information about more than 38,000 past and present patients across the country. The register helps to ensure all breast cancer patients, regardless of ethnicity or geographical location, receive the same high standard of care and advances in treatment.

As well as providing a voice for Taranaki women in national research projects, it allows the DHB to conduct local research to compare how we're doing in Taranaki to other parts of New Zealand and make sure our patients are receiving the same high-quality care.

Taranaki DHB's Careers Expo

More than 100 Taranaki secondary school students visited a special Health Careers Expo to talk to healthcare staff and get a taste for what it's like working in the Medicine, Nursing and Allied Health professions.

There were some great activities on the day to get the students excited about pursuing a career in health – drilling 'decay' off plastic teeth, intubating a mannequin and taking blood pressure.

Citizens Award

Taranaki DHB's Alcohol and Drug Service family/whānau advisor, Sue Philipsom, was recognised for her family peer support community service at the 2020 New Plymouth District Council Citizens' Awards. Sue has been a driving force behind the Eating Disorder Support Group and is the facilitator for Families Overcoming Addiction.

Ministry of Health funding has enabled Sue to train more people to become family peer support workers and expand the addiction peer support service to meet growing need.

Working towards 'Go Zero Carbon' goals

Taranaki DHB is making positive steps towards achieving 'zero-carbon by 2050 and zero waste by 2040' through several sustainability projects which focus on waste, energy, transportation, green buildings, green spaces, food and water.

A major goal is to meet Green Star 5 certification for Project Maunga Stage Two, and to assist with this a building performance policy was developed. Waste has also been a focal point with a total of 29 waste streams being diverted from landfill and up to 44 tonnes of soft plastic being recycled.

Celebrating Go Zero Carbon week provided a good opportunity to promote sustainability to staff with fun events like the Smoothie Bike Challenge, e-bike and e-scooter open day, and the sale of discounted reusable cups and drinking bottles.

Taranaki DHB was also recognised as a Sustainable Business Champion by Sustainable Taranaki.

Building our health literacy

Taranaki DHB's journey to become a health literate organisation continues as we work to create a health system that provides services that are easy for people to understand and access.

Over the past year the Health Literacy Operational Oversight Group has worked hard to identify ways for our patients to obtain, process and understand basic health information and services in order to make informed and appropriate health decisions.

Staff have also been building their health literacy knowledge through online training and having access to new learning resources.

Oxfam trailblazers

Many brave Taranaki DHB staff trained for weeks to enter New Zealand's largest team endurance event, the Oxfam Trailwalker held in March. Teams of four entered to walk either 50km or 100km and raised money for the Oxfam charity towards combating worldwide poverty. Members of the executive leadership team took the opportunity to walk and promote different aspects of health by donning on different t-shirts for each leg of the walk; measles, sustainability and family violence intervention.

Twenty new defibrillators distributed around the region

Twenty Automated External Defibrillators (AEDs) were donated around the region throughout the year thanks to the 'AED into the Community' scheme funded by Taranaki's Department of Medicine Charitable Trust.

A total of 128 AEDs have been donated to community groups in the last 10 years, with New Plymouth police being one of the main users. The scheme has provided the police with 32 AEDs, which are kept in police stations and most police cars.

The scheme goes as far north as Uruti and as far south as Pātea and the Trust replaces any equipment, maintains the AEDs and provides training.

Quality Accounts

South Taranaki gets news GP service to meet community needs

A new general practice operating out of Hāwera Hospital is helping to meet the primary healthcare needs of the South Taranaki community.

The new South Taranaki Rural Health General Practice (the Practice) is one of many services being offered through a new model of care that has been developed specifically for the people of South Taranaki, with a focus on providing high quality, accessible, sustainable and culturally responsive community, primary and secondary healthcare services.

The Practice opened early 2021 and patients are seen by a team made up of senior nurses that are specialists in general practice care, and general practitioners with specialist training in rural hospital medicine.

New patient discharge lounge

Taranaki Base Hospital created a new patient discharge lounge, Te Pae Whakawhiti, to improve the flow of patients from Theatre and the Emergency Department into the inpatient units earlier in the day.

Nurses care for patients in Te Pae Whakawhiti as they wait for paper work, transport or simple education. A smooth process ensures patients are transferred from ward to lounge where they can wait comfortably for their time to go home.

The diabetes foot protection project

A Foot Protection Service has been commissioned by the Taranaki Diabetes Service Level Alliance Team to provide podiatry care to diabetes patients with foot risk.

Patients are triaged according to their needs and can access podiatry care across Taranaki, with three locations in north, central and south, and a fourth location being planned.

This big change in how the service works will help to reduce amputation rates and support patients and their whānau to make informed and supported decisions.

Hāwera Hospital patients benefit from new occupational therapy kitchen

A purpose-built rehabilitation kitchen at Hāwera Hospital is giving South Taranaki residents confidence to prepare their own meals again. The new mini-kitchen was a generous donation from the Isobel Bremer Medical Services Trust and aims to help patients recovering from conditions affecting their mobility prepare for returning home.

Occupational therapists are thrilled to have the new facility on the ward for carrying out functional assessments which help to speed up the process of assessing patients. The kitchen can also be used by families of palliative patients who stay over at the hospital.

In partnership with Tui Ora

Working together to deliver quality services to the people of Taranaki took an important step forward with the signing of a partnership agreement between Tui Ora and Taranaki District Health Board.

The first of its kind for Taranaki, the partnership supports the two organisations to collaborate while still retaining their independence. Both partners are working towards the preferred delivery model of Whānau Ora which puts families in control of the services they need to achieve their aspirations.

The partnership principles include building a strong mana-enhancing working relationship, transparent communication and making equity a central focus.

Improvements to surgical referrals and outpatient and theatre bookings

Taranaki DHB implemented new structures and processes to improve and optimise the booking and scheduling process for surgery. Following staff consultation and a trial of a different way of working, the new structure was embedded to ensure the management of referrals and booking end-to-end by specialty was a better model of care. A planned care clinical manager role was also appointed to provide clinical leadership across the Surgical Booking Office and preadmission service.

The service has significantly improved turnaround times for referrals received, and these now have one point of entry and are "handled" as little as possible to promote continuity. Staff turnover has been reduced and staff now have the expertise to manage referrals and bookings across services.

Real-time results at Taranaki's sexual health clinic

Treatment for Sexual Health Clinic patients is being fast-tracked thanks to a laboratory technician on the team with the ability to provide real-time information on the spot. With lab capabilities of this degree, conditions such as gonorrhea, trichomonas and other sexually transmitted infections (STIs) are being found much earlier.

Onsite testing also helps assess inflammatory conditions other than STIs that aren't easy to identify by standard community testing options. Treatment and management can be much more targeted to the actual issue causing the symptoms, giving patients and clinicians more confidence in positive health outcomes.

Health and wellness pathway shadowing programme

Year 12 and 13 students were fortunate to get some hands-on experience in our hospitals through a new shadowing programme which was developed through a partnership between Taranaki DHB, WhyOra and Career Force.

Students had the opportunity to shadow staff members for a day each week, working across all health-related jobs in the hospital. This partnership now means WhyOra students (Māori students on an employment pathway programme) will have access to gain qualifications, including unit standards in Treaty of Waitangi education, infection control and personal hygiene.

Dedicated pain relief pump for Maternity unit

Taranaki Base Hospital's Maternity unit has a new dedicated Patient Controlled Analgesia (PCA) Fentanyl pump to ensure patient safety during labour. The PCA pump is for specific use during birth and measures the appropriate pain relief medication in a well-controlled manner so the patient cannot overdose.

Collaboration between the Clinical Governance Support Unit, and the pain management and pharmacy teams resulted in this improvement for the maternity service, keeping mothers and their pepi as safe as possible.

Leading the way through COVID-19

First COVID-19 vaccination in Taranaki

MANAGING WITH COVID-19

Planning, preparing and managing the COVID-19 pandemic health response has been the focal point for Taranaki DHB throughout the period 1 July 2020 to 30 June 2021.

During this period Taranaki was mostly in Alert Level 1 with some periods in August 2020 and February 2021 in Alert Level 2. The last confirmed cases in Taranaki was prior to 30 June 2020.

There have been significant impacts for the health system and the Taranaki community in the COVID-19 context, including impact of:

- directly supporting the COVID-19 health response
- continuing to provide and fund health services

SUPPORTING THE COVID-19 RESPONSE

With incident control and coordination

The Taranaki COVID-19 Incident Management Team (IMT) is established to enable Taranaki Emergency Management and Taranaki DHB to provide a unified response. The IMT consisted of Taranaki DHB staff and a Taranaki Civil Defence liaison to ensure an all-of-government approach. This team is activated regularly when a COVID-19 response is required.

With a public health response

The Taranaki Public Health Unit (PHU) has a central role in the management of COVID-19 cases and their contacts. The team has worked in partnership with the National Contract Tracing Services to support a national approach to case management and contract tracing. This work is supported locally by the welfare team at the Taranaki Emergency Management Office ensuring that welfare needs of those impacts can be coordinated.

With action at the maritime border (Port Taranaki)

The PHU is also responsible for minimising risk of COVID-19 infection entering the country through the maritime port in New Plymouth. To best support public health measures, the team has worked closely with agencies such as the Port Authority, Customs and shipping agents when ships arrive from overseas destinations. In addition, the DHB has provided ongoing border facing COVID-19 surveillance testing and vaccination.

With a Māori health response

Collaboration has occurred amongst the multiple organisations involved in both COVID-19 testing and the vaccination programme. Māori providers, iwi, testing centre teams, Public Health Unit, Te Pa Harakeke Māori Health Unit, Pinnacle PHO and the communications teams working together to protect the community

With community COVID-19 testing

The more testing we do of people with symptoms, the more confidence we have there are no people with a COVID-19 infection in Taranaki. Throughout the year access to COVID-19 testing has been maintained with five designated testing clinics throughout the region to ensure good access to testing for our community seven days a week. This was further enhanced by local Māori Health providers providing several pop-up clinics around the region. Between 01 July 2020 -30 June 2021 over 19,000 swabs were taken in Taranaki.

Door control at Taranaki Base Hospital

COVID-19 testing at Taranaki Base Hospital

With vaccination

The COVID-19 Vaccination Programme was rolled out in 2020/21 starting with the Tier 1 vaccination of border workers and high-risk healthcare workers, then moving through the Government's sequencing framework for vaccination with an equitable focus.

Two main vaccination centres were established early in the roll-out, one in North and South Taranaki. The centres also served as a base for mobile units, which visited aged residential care facilities. Throughout the programme, collaboration has been pivotal to ensuring an equitable roll-out, so partnering with Māori health providers Ngati Ruanui in South Taranaki, and Tui Ora in New Plymouth, allowed for Māori communities to better access the vaccine.

Onboarding general practice and pharmacies to the programme to help vaccinate the community has also been an important focus, as well as mass vaccination events for the wider Taranaki population.

With planning for community isolation and quarantine

To support any specific cases or contacts locally with isolation and quarantine if required.

With planning and preparation

To support the safe delivery of hospital and community services during a COVID-19 response.

With communications

A public information management (PIM) role was part of the IMT team to ensure important key messages were provided in a timely, relevant and effective way to the following stakeholder work streams: hospital, community and primary care, public health, Māori and other ethnicities, and a wide variety of health sector stakeholders. Several internal and external communication channels were utilised during any COVID-19 response work including an IMT newsletter, website content, social media messaging and a range of collateral. Ensuring up-to-date and accurate information was shared broadly was critical to maintaining community confidence during the response.

IMPACT ON HEALTH SERVICES DELIVERY AND PERFORMANCE

The approach to service delivery changes at each Alert Level. Where possible and practical essential services continued to be provided. Some services needed to be reduced and others such as COVID-19 testing and vaccination are new responses needed to surge at different times. Model of service delivery also change in a COVID-19 response including a greater emphasis and access to virtual care, telephone and online support.

Demand for healthcare services has fluctuated during the COVID-19 response and as a result some services have required 'catch up' planning and additional services. Some examples of this include the extension of waiting times for planned surgery, increase in screening times, childhood immunisation, and the oral health service.

The DHB was still able to report largely against performance indicators but performance in some indicators will be impacted by the COVID-19 lock down and response.

Project Maunga Stage Two

Project Maunga Stage Two is progressing well at Taranaki Base Hospital. Despite a busy time during COVID-19, the project team have maintained planning and preparation work.

PROJECT MAUNGA
BASE HOSPITAL REDEVELOPMENT

- JULY 2020: **Geotech testing**
- AUGUST 2020: **Construction information session**
- OCTOBER 2020: **House demolition/ removal, David Street**
- OCTOBER 2020: **New chimneys going up**
- NOVEMBER 2020: **New oxygen tank being lifted into place**

Geotech testing

The geotech testing took place for the new East Wing building's structural design and Seismic Risk Management Plan.

Taranaki DHB appoints ECI contractor for Base Hospital redevelopment - July/August 2020

Taranaki DHB (TDHB) appointed Leighs Construction to provide Early Contractor Involvement services for Project Maunga Stage Two and the Seismic Risk Management Plan (SRMP) at Base Hospital.

A community informational session was held on 4 August

The Project Maunga team and Leighs Construction held an information session to update the community and construction market on the projects and highlighted opportunities to get involved.

Renal facility update: houses on the move

House removal and site clearance took place on David Street to make way for the new purpose-built, stand-alone 12-chair Renal Unit, which is the first clinical build off the rank for Project Maunga. Several houses were removed by truck, with some being reused in the region.

Old chimney now demolished

Demolition work on Taranaki Base Hospital's old concrete chimney was completed after weeks of careful removal work. The chimney has been part of the hospital skyline for more than 50 years but has been removed to enable the new Energy Centre to be built.

New oxygen tank

As part of the work required to address our earthquake prone buildings, tunnels and supply lines, we replaced our liquid oxygen tank (also known as the VIE tank) with a new and bigger tank.

Geotech testing

Construction information session

New chimneys going up

Changes to campus car parking

Around 180 car parks used by patients, visitors and staff were removed to make way for construction on the new East Wing Building. As part of our Transport Management Plan we had to explore off-site parking options, including remote and active transport. When considering parking at the hospital we needed to be mindful that patients and their whānau should always be a priority when it comes to ease and convenience of parking at the hospital.

Project Maunga Stage Two information evening

Local residents living in the neighbouring area of the hospital were invited to two special construction information sessions about the Taranaki Base Hospital redevelopment. The sessions aimed to give residents a better understanding of what the building impacts may be and gave them a chance to ask questions and get a response from the Project Maunga team.

Renal Unit

A key part of the Seismic Risk Management Plan (SRMP) is the demolition of the Block C building which currently houses the Renal department. To enable this, a new, purpose built Renal facility is being built on David Street. The new facility is a single storey, timber building of approximately 800m2 and will have a distinctly non-clinical feel in comparison to the existing department. The building will target Net Zero Energy Certification, meaning that the total energy use over a year will be neutral. This will be achieved by reducing the energy consumption and utilising roof mounted solar panels to generate energy. A pedestrian connection will link the Renal Unit to the main Base Hospital campus.

Working groups

Throughout the build we will be guided by Kahui Toi and Kahui Tikanga workgroups, led by Dr Ruakere Hond. These workgroups are designed to have input from the three waka of Taranaki, developing and guiding tikanga Māori throughout the build.

What's on offer with the new East Wing Building

The new East Wing Building will create new critical and acute care facilities, including:

- an Emergency Department, Acute Assessment Unit, Coronary Care Unit, High Dependency Unit and Intensive Care Unit
- a rooftop helipad which will mean faster, safer patient transfers
- purpose built maternity facilities including a Primary Birthing Unit, Delivery Suite, Postnatal Ward and Neonatal Unit
- Laboratory, Radiology Department and Biomedical facility
- Integrated Operations Centre
- a dedicated Tūpāpaku viewing room.

In addition, site-wide infrastructure upgrades will improve the resilience of the hospital campus with the addition of a second emergency power generator, increased water storage, replacement of the oxygen storage facility, provision of a new services routes for critical building services and the replacement of the secondary computer server room.

The expected outcomes include:

- compliance with Earthquake Prone Building Amendment Act
- compliance with NZ Building Code
- reduced clinical risk
- improved resilience of Taranaki Base Hospital, including post-disaster provision of emergency medical and surgical response
- improved models of care that enable Taranaki DHB to manage acute demand by the improvement of patient pathways in ED
- the development of an Acute Assessment Unit to reduce hospital admissions
- improved equity of access for Māori via the inclusion of a Primary Birthing Unit adjacent to the Secondary Care Maternity Unit
- improved patient transfer times with the inclusion of a rooftop helipad with direct access to ED, ICU and theatres.

Taranaki Health Foundation

TE PUNA HAUORA O TARANAKI

Taranaki Health Foundation

Our vision

Dedicated to Taranaki. Committed to healthcare fundraising.

Our purpose

Supporting world-class healthcare for Taranaki whānau.

2020/21: A YEAR OF CHANGE AND GROWTH

A word from the general manager...

This last year has been filled with many challenges, the likes of which have never been seen. As I write this, we are facing the Delta variant of Covid-19 being on our shores. This is a timely reminder to us all why it is so important to protect healthcare, and why the work we do as a charitable foundation is vital to ensuring Taranaki's future healthcare is world-leading.

The 2020/21 year has seen many successful projects, as well as change. The success we have had would not have been possible without the amazing support we continuously receive from Taranaki businesses and public, from the TDHB and from the governance of our Taranaki Health Foundation (THF) trustees. So I would like to first acknowledge this and give a genuine thanks to everyone who has been involved with the foundation during the past year. Without this continued support, we really wouldn't be able to achieve anything.

The THF has had a few changes over the past year. Firstly, Bry Kopu-Scott who has been our General Manager since October 2014 left us in December 2020 to pursue other management roles that inspire and challenge her. Post Bry's departure, the board instigated a review on what resources we will need to achieve the $25 million fundraising target over the next four years and this included benchmarking other health charities nationwide and certain key metrics. This report identified that we would not achieve the target with our current resources, regardless of the passion and effort of the staff and trustees. So with the support of the TDHB we have 'right sized' the team for success and more on this follows.

This has meant that I have stepped down as Chair of the Board of Trustees and have taken a role as Interim General Manager to enable the transformational change required to achieve the target. I would like to thank Bry for all the hard work she has done over the years, achieving success across so many projects. On the board, Brain Ropitini stepped in as Chair, and in August 2020 we were joined by Ricky Malcolm. Ricky is a young local entrepreneur with a passion for people, community, business, music and events. Ricky brings a fresh perspective to the Board of Trustees as well as connections to the more youthful side of the region.

We have also expanded the foundation's skillset with three new employees - Grant Carter and Nikki Steadman are our Donor Relationship Managers for Taranaki North and Taranaki South. They bring years of sales and customer relationship experience as well as local knowledge. They will be tasked with nurturing our high value business partners and ensuring the foundation is well known among the business community. We have also employed Simon Velk as the foundation's Marketing Manager. Simon is a highly experienced marketer with experience both in strategy and creative. Simon comes from 14 years of working for advertising and marketing agencies and is excited to be back in Taranaki after two years in Auckland.

With this new team we are in an excellent position to move forward with our main focus for the next four years: Project Maunga Stage 2. While the groundwork for this project has started, we are focussing on our aim to raise $25 million for enhancements and to make sure the new facilities are world-class and future-proofed. This is a massive target - the biggest we have ever taken on. But we have a solid strategy developed to lock-in funding from key high value business partners and then approach smaller businesses and the community. We have agreement from several media partners to support us with advertising, as well as being given a grant from Google for up to $US10,000 of advertising in-kind each month.

Taranaki Health Foundation general manager Adrian Sole with Rob and Denise Dowman and their grandson Derek with the Babyleo incubator

BABYLEO INCUBATOR

At the end of 2020, we successfully raised $57,000 for a new Babyleo incubator for the Neo Natal Unit (NNU). This was to replace the existing unit that was nearing the end of its life. Without a unit like this, the babies born earlier than 32 weeks wouldn't be able to stay in Taranaki and instead would have to risk a long journey to Waikato to stand any chance of surviving, causing distress to the baby as well as the family. The Babyleo incubator has several features that support the child while still allowing for parent interaction.

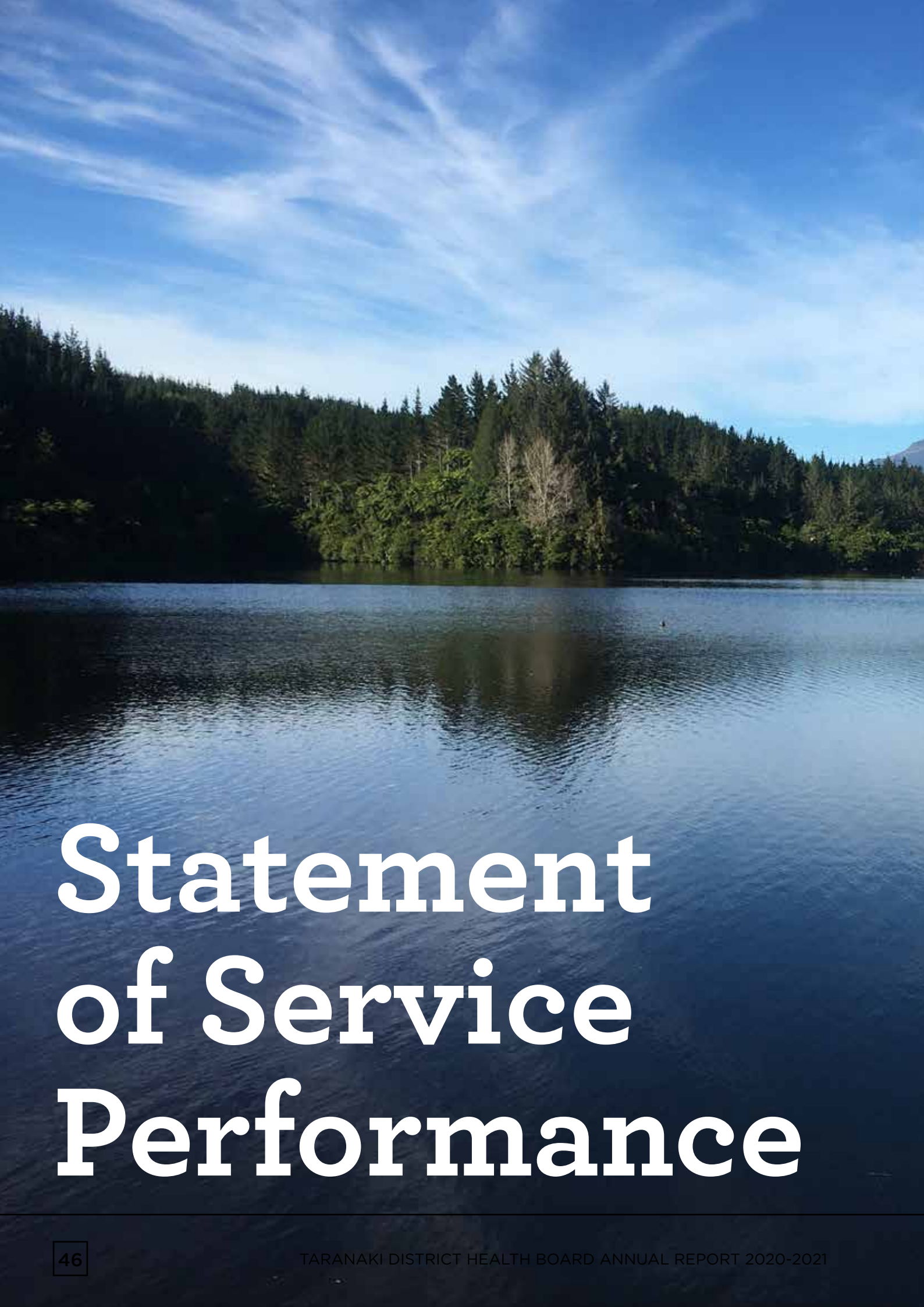
The really exciting news is that the Dowman family, who own New World New Plymouth, donated an additional $57,000 by themselves which allowed us to purchase two units. The Dowman's grandson, Derek, was born five years ago and required care in NNU himself. With this generous gift, NNU now has two units, meaning more premature babies can have the best possible start in life.

LOVE OUR KIDNEYS

As part of Project Maunga Stage Two, a new renal unit is being developed. We are currently raising $500,000 to provide enhancements to this new 12 bed unit to improve patient comfort as well as improving the green credentials of the building. We're expecting to have fantastic support for the renal unit campaign, including generous donations from the Lottery Grants Board and Taranaki Lions clubs. Currently we are working with Inglewood Lions Club, which is spearheading this fundraising. We have some exciting ideas in the pipeline for ways we can engage with the community and encourage fundraising initiatives.

Everything we do is only possible because of the never ending support from the businesses and the community across Taranaki. This, combined with our partnership with Taranaki DHB, will help us achieve our purpose of supporting world-class healthcare for Taranaki whānau. For that, I would like to say 'Thank You'.

Adrian Sole - Taranaki Health Foundation General Manager



Statement of Service Performance

Statement of Service Performance

NGĀ WHANAKETANGA RATONGA

Overview

As an effective District Health Board we need to demonstrate accountability[1] for the intended outcomes and impacts of our population by the services/outputs that we provide. During the annual planning phase, the Statement of Forecast Service Performance was developed which forms the performance framework for the impacts and services/outputs against which we report. Our performance story is detailed in the chart below. The performance and activity measures chosen are not an exhaustive list of all our activity but they do reflect a good representation of the full range of outputs that we fund and/or provide.

District Health Boards must report against groups of outputs known as output classes as listed below;

- Prevention
- Early Detection and Management
- Intensive Assessment and Treatment Services
- Rehabilitation and Support

We built our performance framework for 2020/21 by grouping our activities into the population long and medium term impacts we intended to influence.

Access to a significant proportion of public health services – such as laboratory tests and maternity services – is unrestricted or demand driven. For such areas we cannot set targets, however, volumes of actual usage can be estimated and are included to provide the reader with a more rounded view of utilisation trends across the health system. The measures which have been estimated have "est" next to the target.

Notes:

- The graphs contained within this Statement of Service Performance and associated achievement statements are reported by ethnicity (Māori) where the data is available at ethnicity level.
- Where we have stated 'Total' this represents all ethnicities which includes Māori.
- Where we have stated 'Other' then this would include all other combined ethnicities except Māori.
- Where graphs show a national result this is for the same period as the Taranaki DHB result (unless otherwise stated).

Taranaki DHB Planned and Actual Revenue and Expenditure Allocated to Output Classes 2020-21

Output Class	Planned Revenue ($000's)	Actual Revenue ($000's)	Planned Expenditure ($000's)	Actual Expenditure ($000's)
Prevention	9,425	9,781	9,679	10,303
Early Detection and Management	102,482	106,354	105,241	96,913
Intensive Assessment and Treatment Services	274,017	284,371	281,394	314,624
Rehabilitation and Support	59,984	62,251	61,600	63,794
TOTAL	**445,908**	**462,757**	**457,914**	**485,634**

[1] *The 2004 Crown Entities Act requires under section 153 that a Statement of Performance be complete.* http://www.legislation.govt.nz/act/public/2004/0115/latest/DLM330555.html

OUR PERFORMANCE STORY

Our Vision	Taranaki Together, a healthy Community – Taranaki Whānui He Rohe Oranga				
Our Outcomes	To improve the health of our population		To reduce or eliminate health inequalities		
Our Strategic Priorities	Meeting Health Targets	Addressing Māori health/ disparities	Supporting older people to live well within their community	Addressing a system wide approach to integrated services	Supporting wellness and managing chronic conditions

Long Term Outcome	**1. People are supported to take greater responsibility for their health**	**2. People stay well in their homes and communities**	**3. People receive timely and appropriate specialist care**
Intermediate Impacts	Fewer people smoke Reduction in vaccine preventable diseases Improving health behaviours	An improvement in childhood oral health Long-term conditions are detected early and managed well Fewer people are admitted to hospital for avoidable conditions More people maintain their functional independence	People receive prompt and appropriate acute and arranged care People have appropriate access to elective services Improved health status for people with a severe mental health illness and/or addiction More people with end-stage conditions are appropriately supported
Outputs[2]	Percentage of hospitalised patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking Percentage of eight months olds who will have their primary course of immunisation on time Number of people referred to the Green Prescription programmes	Percentage of children (0-4) enrolled in DHB funded dental services Percentage of population enrolled with a PHO Percentage of the eligible population will have had their cardiovascular risk assessed in the last five years Percentage of older people receiving long-term home support who have had a comprehensive clinical assessment and a completed care plan in the last 12 months	Percentage of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours Acute re-admission rate Elective and arranged day surgery rate Improving the percentage of long-term clients with up to date relapse prevention/ treatment plans

Output Classes	Prevention services	Early detection and management services	Intensive treatment and assessment	Rehabilitation and support services

Module 3

[2] *The outputs described are examples only.*

OUTCOME 1

People are supported to take greater responsibility for their health

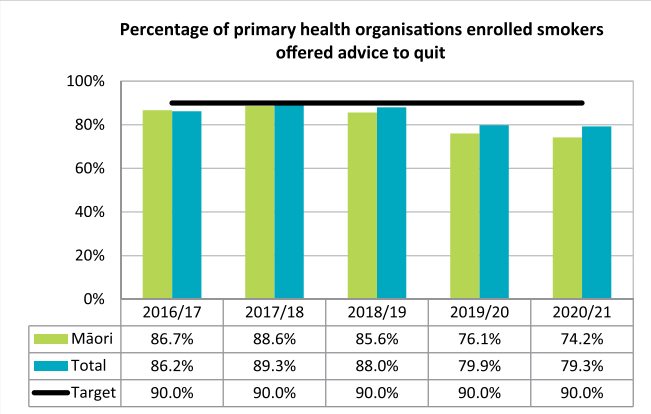
Expectation

Population health and prevention programmes ensure people are better protected from harm, more informed of the signs and symptoms of ill health and supported to reduce risk behaviours and modify lifestyles in order to maintain good health. These programmes create health-promoting physical and social environments which support people to take more responsibility for their own health and make healthier choices.

Fewer people smoke

Smoking and exposure to second-hand smoke causes 4,500 to 5,000 premature deaths annually and impacts directly on those who smoke and also through the effects of passive smoking on children and others who spend time with smokers. Tobacco smoking is a major contributor to preventable illness and long term conditions, such as cancer, respiratory disease, heart disease and strokes. Cancer is the leading cause of death in New Zealand (29.8%), and is a major cause of hospitalisation and driver of cost. Cancer also highlights continuing inequalities, with Māori experiencing a higher incidence (20% +), higher mortality and higher stage at presentation. In some communities, a sizeable portion of household income is spent on tobacco, resulting in less money being available for necessities such as nutrition, education and health. Supporting our population to say "no" to tobacco smoking is our foremost opportunity to target improvements in the health of our population and to reduce health inequalities for Māori.

OUTPUT MEASURES



	2016/17	2017/18	2018/19	2019/20	2020/21
Māori	86.7%	88.6%	85.6%	76.1%	74.2%
Total	86.2%	89.3%	88.0%	79.9%	79.3%
Target	90.0%	90.0%	90.0%	90.0%	90.0%

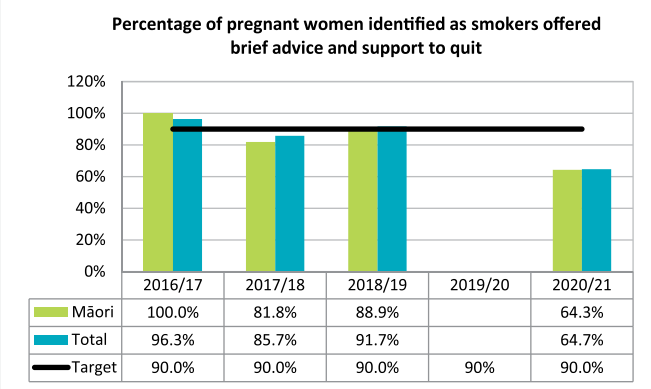
Data Source: Ministry of Health PHO enrollment Collection

Percentage of primary health organisations enrolled smokers offered advice to quit

Māori **Not Achieved**

Total **Not Achieved**

The addition of Kaitautoko and Health Improvement Practitioners (HIP) to priority primary care practices (practices in priority communities with high patient enrolments who identify as Māori or Pacifica) through the Te Manawanui programme has now been implemented and will support these providers with their ability to improve the amount of advice and support given for smokers to quit. Work will continue into the 21/22 financial year to work with the PHO, Māori Health and Te Kawau Mārō on supporting primary care providers with support for brief advice, this includes a reinvestment plan of Tobacco funds that reconfigures investment into a First 1,000 Days Model of Care that is Tiriti o Waitangi led, prioritises Whānau Ora, and is primary care integrated.



	2016/17	2017/18	2018/19	2019/20	2020/21
Māori	100.0%	81.8%	88.9%		64.3%
Total	96.3%	85.7%	91.7%		64.7%
Target	90.0%	90.0%	90.0%	90%	90.0%

Data Source: Midwifery and Maternity Provider Organisation (MMPO); LMC Services; Taranaki DHB

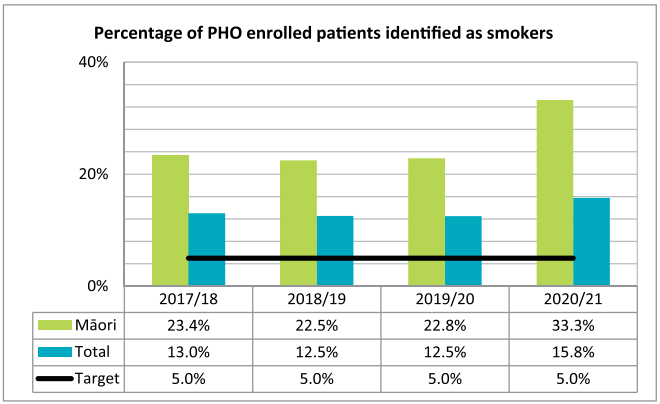
Percentage of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with lead maternity carer are offered brief advice with support to quit.

Māori **Not Achieved**

Total **Not Achieved**

Taranaki DHB looks forward to the implementation of the Best Start Kōwae throughout PHO practices in our region. This programme provides pregnancy assessment tools, including brief advice and support to stop smoking, to Primary Care and LMC's and provides for funded visits to engage hapū māmā at milestones including confirmation of pregnancy, 2nd Trimester, 6 week postpartum - mama and pēpi.

*** Data was not available for 2019/20***



	2017/18	2018/19	2019/20	2020/21
Māori	23.4%	22.5%	22.8%	33.3%
Total	13.0%	12.5%	12.5%	15.8%
Target	5.0%	5.0%	5.0%	5.0%

Data Source: Ministry of Health PHO enrollment Collection

Percentage of PHO enrolled patients identified as smokers

Māori **Not Achieved**

Total **Not Achieved**

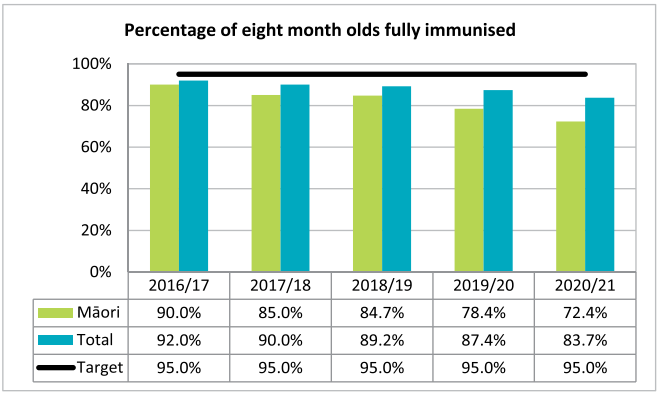
Work continues with the PHO and the Taranaki Stop Smoking Service to improve quit rates and thereby reduce the number of enrolled patients who identify as smokers. The Taranaki Stop Smoking Service continues to prioritise referrals for Māori, Pasifika, Hapū Māmā and people with mental health conditions but remains available to the general population also.

Reduction in vaccine preventable diseases

Immunisation can prevent a number of diseases and is a very cost-effective health intervention. Immunisation provides protection not only for individuals, but for the whole population by reducing the incidence of diseases and preventing them from spreading to vulnerable people or population groups.

Population benefits only arise with high immunisation rates, and New Zealand's current rates are low by international standards and insufficient to prevent or reduce the impact of preventable diseases such as measles or pertussis (whooping cough). These diseases are entirely preventable.

OUTPUT MEASURES



	2016/17	2017/18	2018/19	2019/20	2020/21
Māori	90.0%	85.0%	84.7%	78.4%	72.4%
Total	92.0%	90.0%	89.2%	87.4%	83.7%
Target	95.0%	95.0%	95.0%	95.0%	95.0%

Data Source: National Immunisation Register

Percentage of eight month olds fully immunised

Māori **Not Achieved**

Total **Not Achieved**

Taranaki DHB worked with our Māori Health Alliance partners to redesign Outreach Immunisation Services during the 2020-21 year. Outreach Immunisation Services was to become a component of their service called Whanau Hapai which is a comprehensive whanau ora based, life course driven, care programme starting with māmā and pēpi. Unfortunately our Provider has not been able to enable a way for us to enact this contracting so we have rolled over our existing contract with a mechanism to change or exit. Taranaki DHB and our providers are experiencing siginificant vaccinating workforce shortages which have contributed to the decreasing rates of childhood immunisation since the COVID-19 vaccine delivery programme has built momentum. We have now developed a comprehensive plan with both short term and long term objectives to work towards improved childhood immunisation rates while we navigate through the effects of the pandemic.

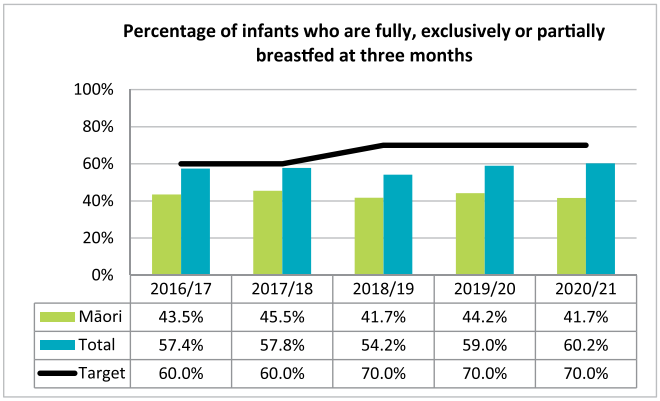
Improving health behaviours

In 2016 Body Mass Index (BMI) has overtaken tobacco as the leading preventable risk to New Zealanders' health. In October 2015 the Ministry of Health (MoH) released the Childhood Obesity Plan which aims to prevent and manage obesity in children and young people up to 18 years of age. The focus of the Plan is on food, the environment, and being active at each life stage starting during pregnancy and early childhood bringing together government agencies, the private sector, communities, schools, and whānau across 22 initiatives.

Development of the Plan drew on recent evidence including the World health Organisation's (WHO) Commission for Ending Childhood Obesity and Professor Peter Gluckman's, Chief Science Advisor to the Prime Minister and co-chair of the WHO Commission, research indicating that pre-conditions for obesity are set very early and the best intervention point is maternal and infant nutrition (including breastfeeding) and physical activity.

Increased physical activity and improved nutrition will impact rates of obesity and other conditions including high cholesterol, high blood pressure, heart disease, some cancers and mobility disorders however a multi-faceted approach is needed. Obesity disproportionately affects Māori, Pacific, and low socio-economic groups across New Zealand, thus Taranaki DHB interventions will be targeted to Māori to decrease this disparity.

OUTPUT MEASURES



	2016/17	2017/18	2018/19	2019/20	2020/21
Māori	43.5%	45.5%	41.7%	44.2%	41.7%
Total	57.4%	57.8%	54.2%	59.0%	60.2%
Target	60.0%	60.0%	70.0%	70.0%	70.0%

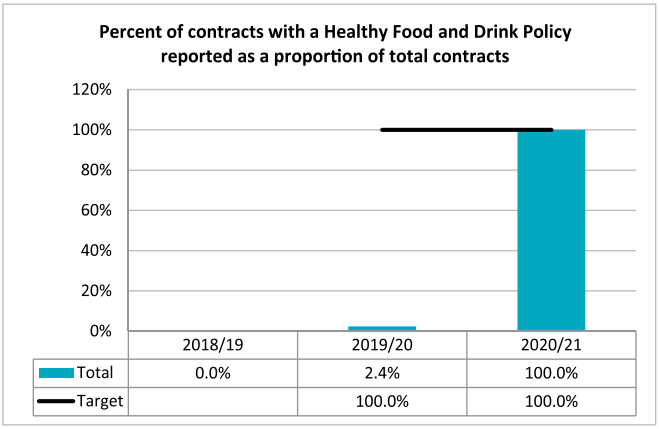
Well Child / Tamariki Ora Quality Improvemnet Framework Indicators data

Percentage of infants who are fully, exclusively or partially breastfed at three months

Māori **Not Achieved**

Total **Not Achieved**

Capacity of the lactation consultant workforce has increased this year and through our scholarships have enabled a further two consultants to qualify. This has allowed for restructuring of the regions service provision and means Te Kawau Mārō alliance has a service contract that now covers the region for breastfeeding services. This is in addition to contracting with 1 additional provider to ensure the region has adequate lactation consultancy coverage. We aim to continue to support further lactation consultancy training to ensure we have a sustainable workforce to support and improve this deliverable into the future. There is also significant work going into equity focussed antenatal education through Hapū Wananga and the Ahuru Mowai pilot - this work links expectant māmā with lactation consultants before the birth of pēpi to ensure māmā are aware of the supports available to enable successful breastfeeding outcomes. We look forward to improving our results as an outcome of the above work.



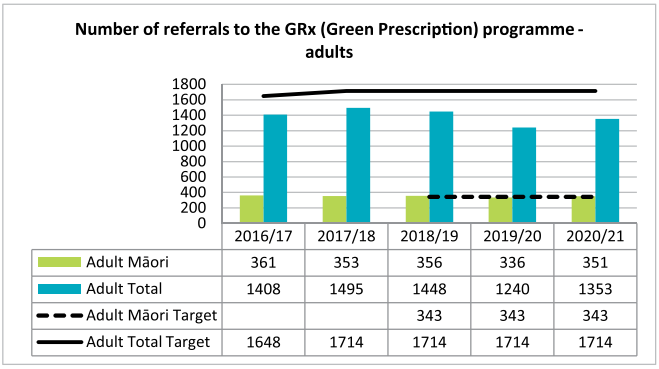
	2018/19	2019/20	2020/21
Total	0.0%	2.4%	100.0%
Target		100.0%	100.0%

Data Souce: Taranaki DHB Contracts Management System

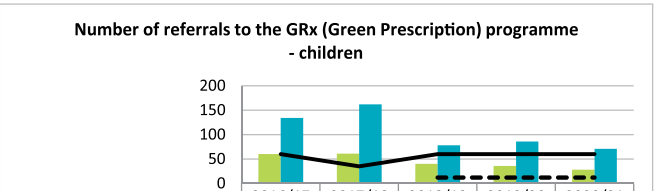
Percent of contracts with a Healthy Food and Drink Policy reported as a proportion of total contracts

Total **Achieved**

During 20/21 Taranaki DHB has been able to ensure all contracts (with the exception of nationally negotiated contracts) include a requirement for a Healthy Food and Drink policy. This will be a requirement in all non nationally negotatied contracts going forward.



	2016/17	2017/18	2018/19	2019/20	2020/21
Adult Māori	361	353	356	336	351
Adult Total	1408	1495	1448	1240	1353
Adult Māori Target			343	343	343
Adult Total Target	1648	1714	1714	1714	1714



	2016/17	2017/18	2018/19	2019/20	2020/21
Children Māori	60	61	40	36	28
Children Total	134	162	78	86	71
Children Māori Target			12	12*	12*
Children Target	60	35	60	60	60

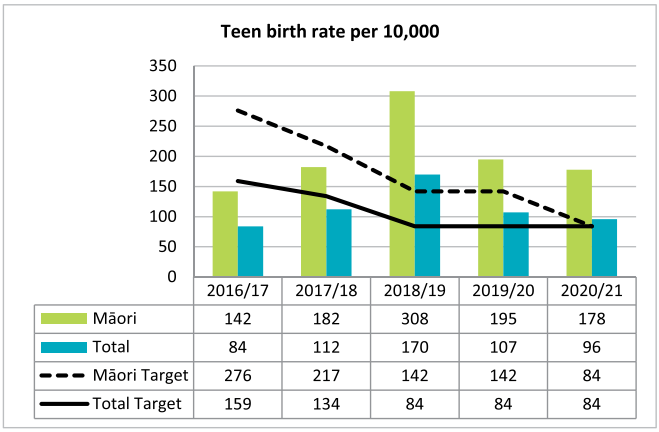
Data Source: Sports Taranaki Performance Monitoring Report 2020/21
Taranaki DHB Performance Monitoring Report 2020/21

The number of referrals to the GRx (Green Prescription) programme

Adult Māori **Achieved**
Adult Total **Not Achieved**
Children Māori **Achieved**
Children Total **Achieved**

Taranaki DHB worked with our contracted provider to redevelop the Green Prescription Service in readiness for the 2021/22 year. This work was undertaken during the 2020/21 year in recognition of the need for a more equity focussed service that was delivered in priority communities to our vulnerable population groups including Māori, Pacifica, diabetics and patients with co-morbidities. We anticipate these service changes will ensure that more of our priority groups will be engaged in the service and improve our results against the target. The children's service also had a change in contract, and saw the service provider change mid-year so that Active Families became a complete Taranaki DHB Whanau Pakari service, this has yielded positive change that we expect will continue to see us achieving the target.

*The 2019/20 Māori target for children has been altered from the number published in the previous annual report as an error was identified. Targets now correctly line up with the agreed annual plan figures.



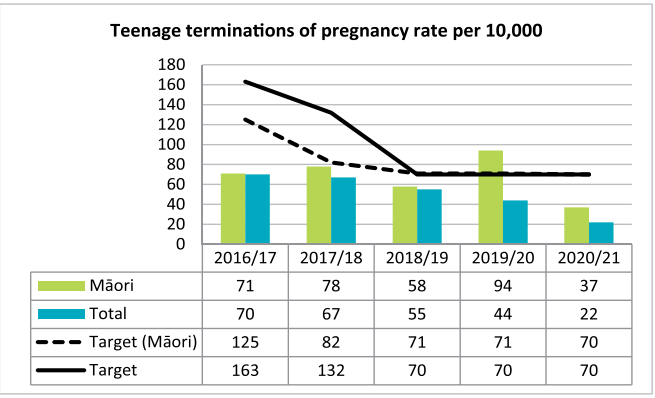
	2016/17	2017/18	2018/19	2019/20	2020/21
Māori	142	182	308	195	178
Total	84	112	170	107	96
Māori Target	276	217	142	142	84
Total Target	159	134	84	84	84

Data Source: Ministry of Health National Minimum Dataset

Reduce the teen birth rate per 10,000

Māori **Not Achieved**
Total **Not Achieved**

The teen birth rate has decreased in 2020/2021, as the overall trend continues to track downwards. Taranaki DHB continues to provide a range of services to the population, such as surgical and medical termination of pregnancy (TOP) and ongoing provision of Jadelle insertions. Public Health Nurses ensure that adolescents have self referral clinics for contraception and referral to TOP services. There is access to the free emergency contraceptive pill (ECP) via community pharmacies.



	2016/17	2017/18	2018/19	2019/20	2020/21
Māori	71	78	58	94	37
Total	70	67	55	44	22
Target (Māori)	125	82	71	71	70
Target	163	132	70	70	70

Data Source: Ministry of Health National Minimum Dataset

Reduce rate of teenage terminations of pregnancy rate - per 10,000

Māori **Achieved**
Total **Achieved**

Overall there has been a reduction in the rate of terminations of teenage pregnancy. Taranaki DHB continues to ensure contraception if free and readily available through self referral clinics to all adolescents in school and alternative education settings. With the extention of adolescents servcies via the Home, Education, Eating, Activities, Drugs and AlcohoL,Depression and Suicide, Sexuality and Safety (HEEADDSSS) contract, education and support is provided on an ongoing basis.

OUTCOME 2

People stay well in their homes and communities

Expectation

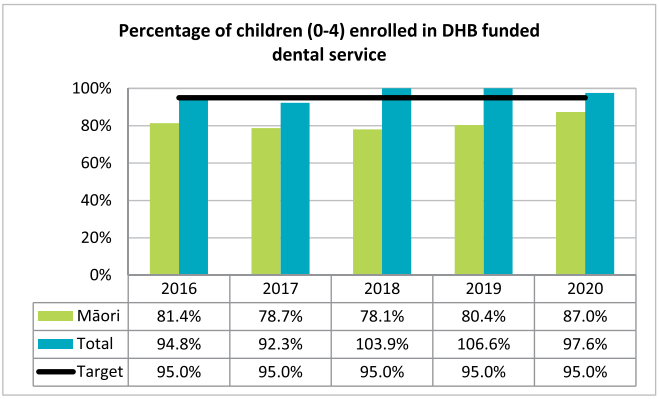
Primary and community services support people to stay well by providing earlier intervention, diagnostics and treatment and better managing their illness or long-term conditions. These services assist people to detect health conditions and risk factors earlier, making treatment and interventions easier and reducing the complications of injury and illness. They also support people to regain their functionality after illness and to remain healthy and independent.

An improvement in childhood oral health

Good oral health demonstrates early contact with health promotion and prevention services and reduced risk factors, such as poor diet, which has lasting benefits in terms of improved nutrition and healthier body weights. Oral health is also an integral component of lifelong health and impacts a person's comfort in eating (and ability to maintain good nutrition in old age), self-esteem and quality of life.

Māori children are three times more likely to have decayed, missing or filled teeth, and improved oral health is a proxy measure of equity of access and the effectiveness of mainstream services in targeting those most in need.

OUTPUT MEASURES



	2016	2017	2018	2019	2020
Māori	81.4%	78.7%	78.1%	80.4%	87.0%
Total	94.8%	92.3%	103.9%	106.6%	97.6%
Target	95.0%	95.0%	95.0%	95.0%	95.0%

Data Source: Taranaki DHB Dental Patient Management System - Titanium. Statistics New Zealand Population Projection 2018. Data is for the 2020 calendar year.

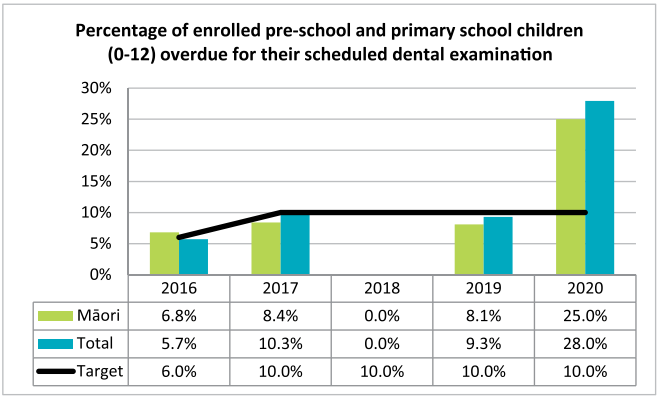
Percentage of children (0-4) enrolled in DHB funded dental service

Māori **Not Achieved**

Total **Achieved**

Once again Taranaki DHB achieved the target for the total population, however it has not met the target for our Māori tamariki. Despite this, the increase in enrolment for Māori tamariki continues to increase which is encouraging.

Taranaki DHB has very recently employed 0.7 FTE Kaiawhina South Taranaki and is recruiting for 0.5 FTE Kaiawhina for North Taranaki. The expectation is these Kaiawhina will provide invaluable support to whanau who may experience difficulty engaging with Community Oral Health Service. The Kaiawhina will also support those working in the service to ensure engagement is positive and appropriate, fostering relationships between frontline staff and whānau and cultivating health literacy.



	2016	2017	2018	2019	2020
Māori	6.8%	8.4%	0.0%	8.1%	25.0%
Total	5.7%	10.3%	0.0%	9.3%	28.0%
Target	6.0%	10.0%	10.0%	10.0%	10.0%

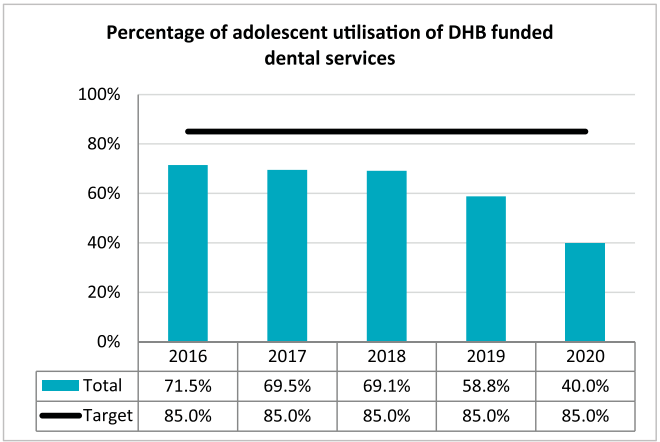
Data Source: Taranaki DHB Dental Patient Management System - Titanium. Statistics New Zealand Population Projection 2018. Data is for the 2019 calendar year.

Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination

Māori **Not Achieved**

Total **Not Achieved**

COVID-19 lockdown and the ongoing alert levels has had a catastrophic effect on the Community Oral Health Service. NZ Dental Council put restrictions in place to prevent the spread of COVID which meant only urgent and emergency care could be offered in lockdown. After lockdown schools did not want DHB staff on sites as they settled students back into learning and socialising safely, which meant disruption to our planned movements for the Mobile Dental Units. In alert levels 1 and 2 New Zealand Dental Council introduced new requirements which have affected the number of appointments we have been able to offer. In addition, Taranaki DHB continues to experience unrecruited vacancies in the Dental and Oral Health Therapy workforce. Also, therapists close to and beyond the age of retirement are reducing their FTE, which is also impacting the number of appointments which can be offered, and the number of clinics.



Data Source: Taranaki DHB Dental Patient Management System - Titanium. Statistics New Zealand Population Projection 2018. Data is for the 2020 calendar year.

Percentage of adolescent utilisation of DHB funded dental services

Total **Not Achieved**

Whilst Community Oral Health Service (COHS) has traditionally provided some dental care to adolescents, the effects of the national lockdown combined with unrecruited Dental and Oral Therapist FTE has required the service to concentrate resources in order to enable those aged from birth to 17 years of age will have access to quality care and preventive services.

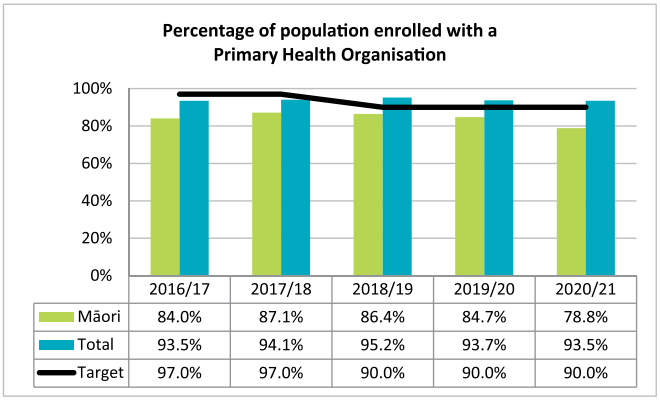
Community Oral Health service continues to facilitate the enrolment of Year 8 students from COHS to dentists in private practice who hold the Combined Dental Agreement (CDA) contract. This is done in conjunction with parents and whanau to ensure they are able to enrol with a dentist of their choice. The expectation is that enrolling with a dentist as a young adolescent will provide an opportunity to build a positive dentist-adolescent relationship which will continue through adolescence up to and beyond their 18th birthday.

*Data is currently not available for 2020/21

Long-term conditions are detected early and managed well

If we are to empower people to take greater responsibility for their health, to improve the health of our population and if we are to "contain costs" we have a significant opportunity by detecting conditions early. Early detection will lead to either successful treatment, or delaying or reducing the need for secondary and specialist care, enabling more people to stay well in their homes and communities for longer. Our greatest opportunity to do this is to manage Cardiovascular Disease (CVD or heart disease). It is one of the largest causes of death in New Zealand, and disproportionately higher for Māori. Often by the time heart problems are detected, the underlying cause of atherosclerosis (arterial disease) is usually well advanced. Our aim is to either prevent the disease by modifying risk factors such as healthy eating, exercise and avoiding smoking, or early detection and management.

OUTPUT MEASURES



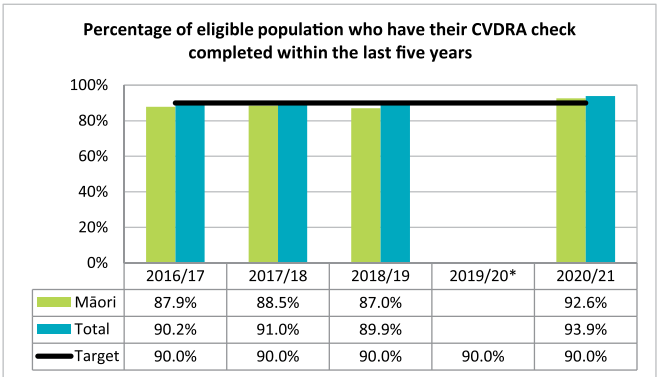
Data Source: Ministry of Health PHO enrollment Collection. Statistics New Zealand Population Projection 2018

Percentage of population enrolled with a Primary Health Organisation (PHO)

Māori **Not Achieved**

Total **Achieved**

PHO enrolment remains steady and has met the overall target. There are a significant number of people in Waverley and surrounding districts who register with a Whanganui PHO based practice. Additionally Taranaki DHB launched a primary care practice in South Taranaki during the year, enrolment figures for this practice do not yet feature in these statistics systems for data capture and reporting are still being implemented.



	2016/17	2017/18	2018/19	2019/20*	2020/21
Māori	87.9%	88.5%	87.0%		92.6%
Total	90.2%	91.0%	89.9%		93.9%
Target	90.0%	90.0%	90.0%	90.0%	90.0%

Data Source: Pinnacle (PHO) quarterly reporting until 2018/19. Pinnacle Diabetes Dashboard since 2020/21

Percentage of eligible population who have their Cardiovascular Disease Risk Assessment (CVDRA) assessed in the last five years

Māori **Achieved**

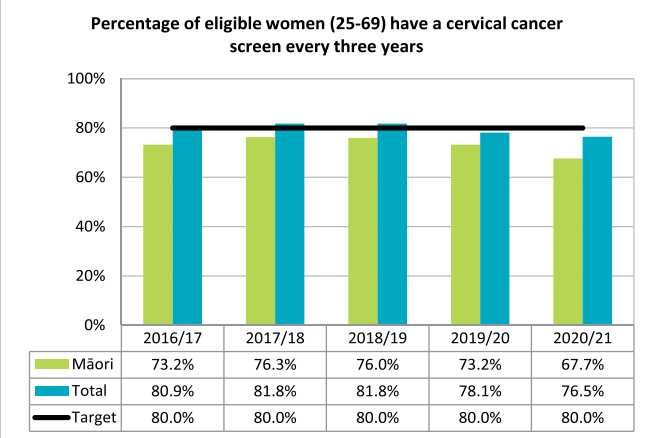
Total **Achieved**

While we have met the target, with only one data point under the new definition there is not sufficient information to confirm a sustained change. Quarterly reporting data for risk management shows that while performance was consistent across the first 3 quarters of the year, it has declined in the 4th quarter.

The quality plan for 2021/22 incentivizes practice activity on CVDRA and diabetes management for both total population and high needs populations.

Pinnacle continues to implement Health Care Homes (HCHs) as a model to improve performance at practice level around CVRA and diabetes management including equity for Māori.

2019/20 data was not available as MOH no longer provided the data. Data source changed for 2020/21



	2016/17	2017/18	2018/19	2019/20	2020/21
Māori	73.2%	76.3%	76.0%	73.2%	67.7%
Total	80.9%	81.8%	81.8%	78.1%	76.5%
Target	80.0%	80.0%	80.0%	80.0%	80.0%

Data Source: National Screening Unit

Percentage of eligible women (25-69) have a cervical cancer screen every three years

Māori **Not Achieved**

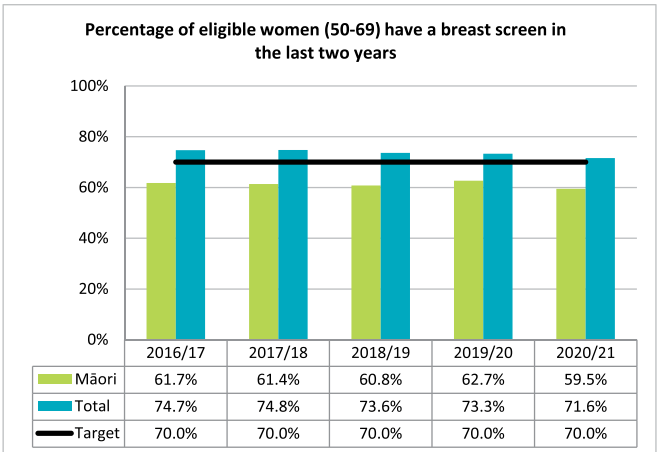
Total **Not Achieved**

2020/21 Coverage rates for Māori and Asian women remained under target but well above the national average. Post COVID coverage decreased for all women screened especially Māori and Asian who already have lower rates of screening. The National Cervical Screening Programme is planning two initiatives to support an equitable recovery for Māori and Pacific women.

DHBs having small prioritized ethnicity population numbers, especially Asian, see large differences in coverage percentages for the individual DHBs.

The national screening unit (NSU) produces population projections for the end of every month using a 'prospective smoothing' method. Annual population data is smoothed over a twelve month period starting in July for each year.

The regional screening unit continues to work with Māori health providers and PHO to promote and support community action, development to priority women in Taranaki.



	2016/17	2017/18	2018/19	2019/20	2020/21
Māori	61.7%	61.4%	60.8%	62.7%	59.5%
Total	74.7%	74.8%	73.6%	73.3%	71.6%
Target	70.0%	70.0%	70.0%	70.0%	70.0%

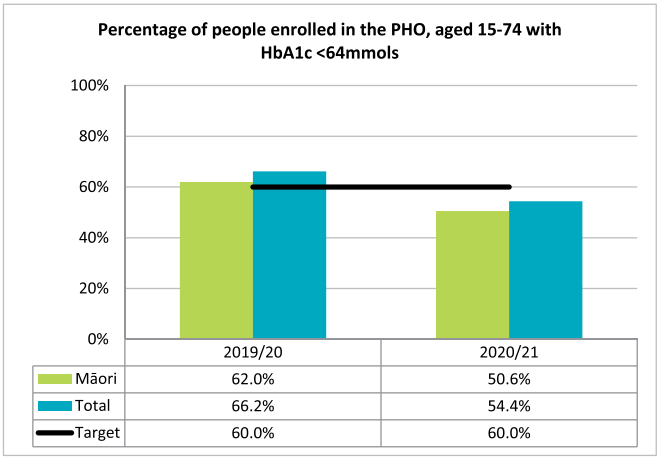
Data Source: Breast Screening Aotearoa

Percentage of eligible women (50-69) have a breast screen in the last two years

Māori **Not Achieved**

Total **Achieved**

Breast screening rates are similar to previous years with continuing disparity between Māori and non-Māori screening rates being evident. 2020/21 Data provided is only for the period to 31 December 2020. Our provider continues to actively promote breast screening and cervical screening awareness at all local Māori/Iwi functions that they attend. Local knowledge and door knocking with wāhine who have not attended appointments or responded and it is hoped this will drive more equitable performance.



Data Source: Pinnacle (PHO) Diabetes Dashboard
*Data refers to the diabetic population only

Percentage of people enrolled in the PHO, aged 15-74 with HbA1c <64mmols

Māori **Not Achieved**

Total **Not Achieved**

Overall the percentage of HbA1c in control has decreased in comparison to the previous year, however we have been monitoring this on a quarterly basis. Whilst the numbers are not at the target, we have had 3 consecutive quarters of improvement on diabetes annual review (DAR) rates. Note – An increase in DARs does not equate to HbA1c control. There was a significant impact on DAR rates from COVID-19 which may continue for some time.

Quarterly HbA1c recall is reliant on individual practices processes to recall those PWD and the uptake of those PWD to undertake this testing. Overall diabetes general practice management and oversight is part of our future changes of model of care which will be aided by the implementation of a diabetes integrated team.

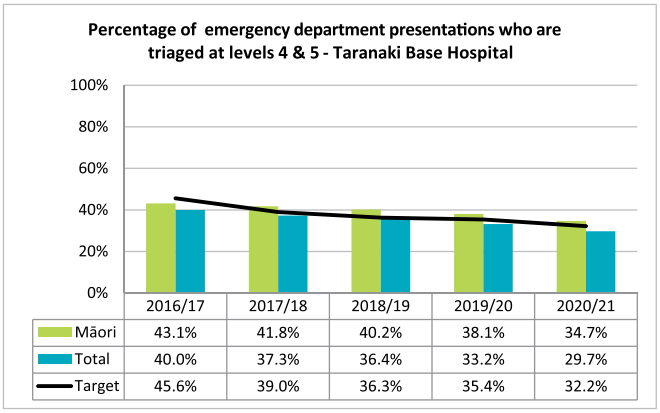
Fewer people are admitted to hospital for avoidable conditions

There are a number of admissions to hospital for conditions which are seen as avoidable through appropriate early intervention and a reduction in risk factors. As such, these admissions provide an indication of the effectiveness of screening, early intervention and community-based care.

A reduction in these admissions will reflect better management and treatment of people across the whole system, will free up hospital resources for more complex and urgent cases and deliver on the Government's priority of "better, sooner, more convenient" healthcare.

The key factor in reducing avoidable hospital admissions is an improved interface between primary and secondary services. Improving people's access to, and the effectiveness of, primary care will facilitate early interventions, particularly among Māori and Pacific people, which supports improving our population's health outcomes and reducing health inequalities for Māori.

OUTPUT MEASURES



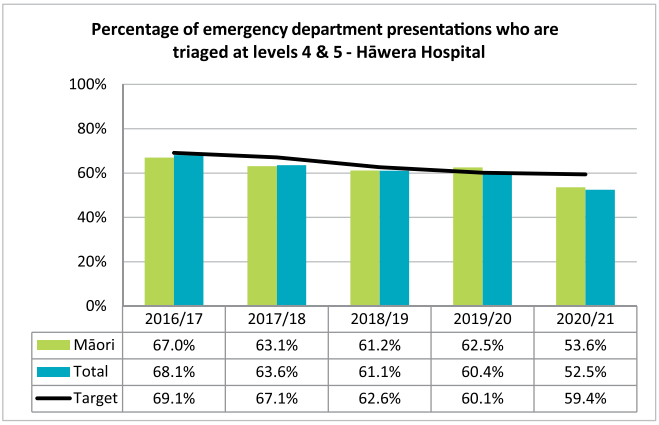
Data Source: DHB Patient Management System. Statistics New Zealand Population Projection 2018

Percentage of emergency department presentations who are triaged at levels 4 & 5 - Taranaki Base Hospital

Māori **Not Achieved**

Total **Achieved**

Taranaki DHB continues to see a reduction in triage 4 & 5 Emergency Department (ED) presentations at Taranaki Base Hospital for both Māori and total population. Initiatives that provide alternatives to ED admission for those with minor health issues such as public education campaigns, ED re-direction (re-directing patients to a booked GP visit where appropriate) and primary options for acute care in general practice continue to assist with this. Māori continue to present at slightly higher rates than non-Māori, the reasons for which is likely multifactorial, however the rate of presentations continues to reduce which is promising. Providing alternative pathways and new models of care continue to be a focus with the aim being to see a continued reduction in people presenting in these triage categories



	2016/17	2017/18	2018/19	2019/20	2020/21
Māori	67.0%	63.1%	61.2%	62.5%	53.6%
Total	68.1%	63.6%	61.1%	60.4%	52.5%
Target	69.1%	67.1%	62.6%	60.1%	59.4%

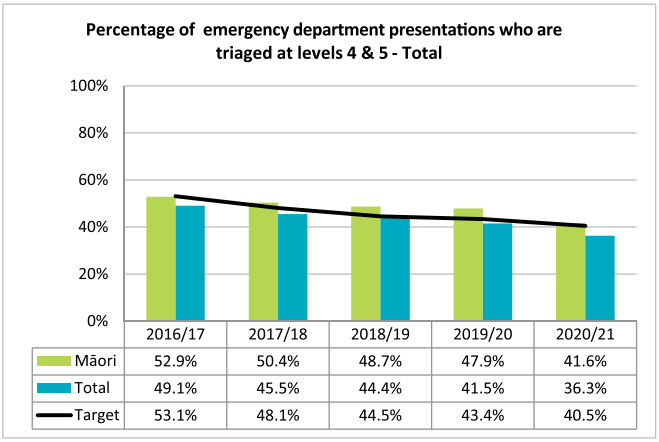
Data Source: DHB Patient Management System. Statistics New Zealand Population Projection 2018

Percentage of emergency department presentations who are triaged at levels 4 & 5 - Hāwera Hospital

Māori **Achieved**

Total **Achieved**

Taranaki DHB continues to see a reduction in triage 4 & 5 Emergency Department (ED) presentations at Hāwera Hospital for the total population and has met the 59.4% target. The presentation rate for Māori has also met target and has decreased from 62.5% last year to 53.6% this year. This reflects the success of initiatives that have been implemented in South Taranaki such as ongoing public education campaigns, ED-redirection and the introduction of the South Taranaki Rural Health (STRH) General Practice. The STRH officially launched February 2021 and already had a growing enrolled population of approximately 1200 STRH GP has provided the community in South Taranaki the much needed additional primary care access. Māori continue to present at slightly higher rates than non-Māori, the reasons for which is likely multifactorial (e.g. social determinants, affordability), however the rate of presentations continues to reduce.



	2016/17	2017/18	2018/19	2019/20	2020/21
Māori	52.9%	50.4%	48.7%	47.9%	41.6%
Total	49.1%	45.5%	44.4%	41.5%	36.3%
Target	53.1%	48.1%	44.5%	43.4%	40.5%

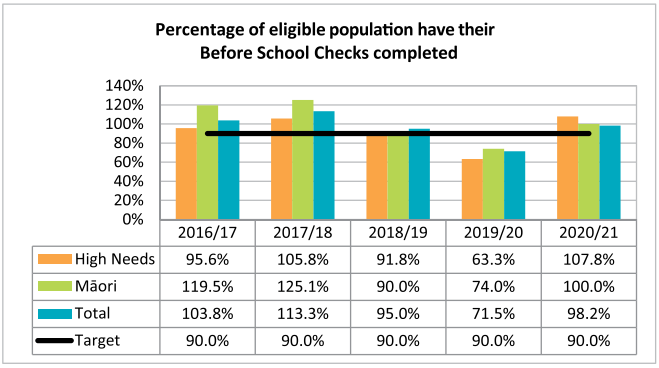
Data Source: DHB Patient Management System. Statistics New Zealand Population Projection 2018

Percentage of emergency department presentations who are triaged at levels 4 & 5 - Total

Māori **Not Achieved**

Total **Achieved**

Taranaki DHB continues to see an overall reduction in triage 4 & 5 Emergency Department (ED) presentations at Taranaki Base Hospital and Hāwera Hospital although Māori presentation rate targets have not been met. The reasons for this are complex and multifactorial. The DHB continues to implement a range of initiatives to provide alternatives to ED admission for those with minor health issues that can be managed in primary care including ongoing public education campaigns, ED re-direction (re-directing patients to a booked GP visit where appropriate) and implementation of primary options for acute care in general practice to provide alternative care pathways for patients that would otherwise present to ED. A range of initiatives including improving access to primary care services in South Taranaki, and alternative pathways and models of care across the DHB are in progress which we anticipate will have a positive impact on ED presentation rates in the future.



	2016/17	2017/18	2018/19	2019/20	2020/21
High Needs	95.6%	105.8%	91.8%	63.3%	107.8%
Māori	119.5%	125.1%	90.0%	74.0%	100.0%
Total	103.8%	113.3%	95.0%	71.5%	98.2%
Target	90.0%	90.0%	90.0%	90.0%	90.0%

Data Source: National Immunisation Register

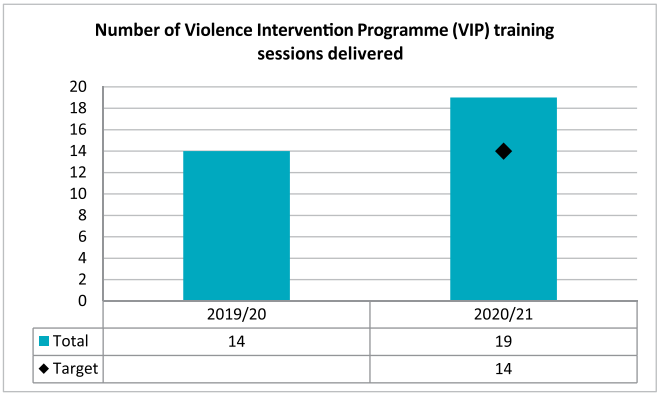
Percentage of eligible population have their Before School Checks completed

High Needs **Achieved**

Māori **Achieved**

Total **Achieved**

In Q1 there was a significant focus on catching up children who's checks were missed due to the lockdown, this was difficult as significant public health nursing resource within the DHB and with Providers was diverted during the pandemic. The services worked hard to provide additional clinics in school holidays and throughout the year to catch children up. Q3 posed further challenges as again the Public Health Nurses resources usually engaged to assist in B4SC's were being diverted to the COVID Vaccination campaign and catching up the School Based Programmes. By the end of the year our team had regained lost ground from the low Q1 completion rate of only 33% to recover delivery in Q4 to 98.2% of the total population and 107.8% of the High Needs population.

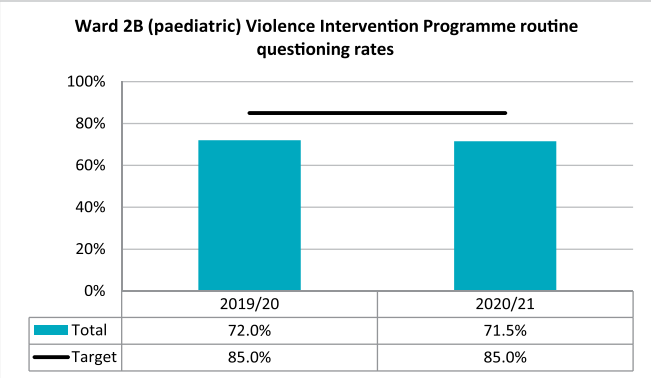


Data Source: Violence Intervention Programme Office records, Taranaki DHB

Number of Violence Intervention Programme (VIP) training sessions delivered

Total **Baseline being established**

During the 2020/21 year, Taranaki DHB Violence Intervention Programme (VIP) team have trained 202 health professionals in Core VIP Training. 46 health professionals received training in: "Safeguarding older adults and vulnerable adults, and 156 received advanced family violence assessment and intervention training. This was delivered in 19 training sessions which exceeded our planned target of 14.

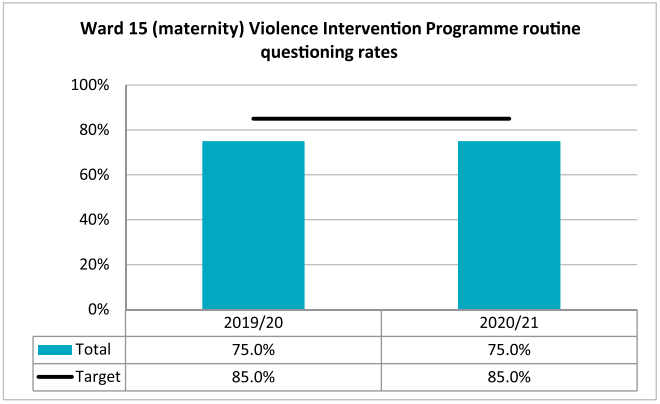


Data Source: Violence Intervention Programme Office records, Taranaki DHB

Ward 2B (paediatric) Violence Intervention Programme routine questioning rates

Total **Not Achieved**

During 2020/21 all Ward 2B staff have been attending core family violence training or refresher/advanced family violence training. Female boarder care givers are routinely asked about violence in the homes if they are on their own and private. During the pandemic the family violence questions were adapted to identify victims of violence during lockdown. Taranaki DHB family violence routine questioning rates in child health services are above the national average. During COVID-19 less children were admitted in the ward, and less boarder parents stayed on the ward.

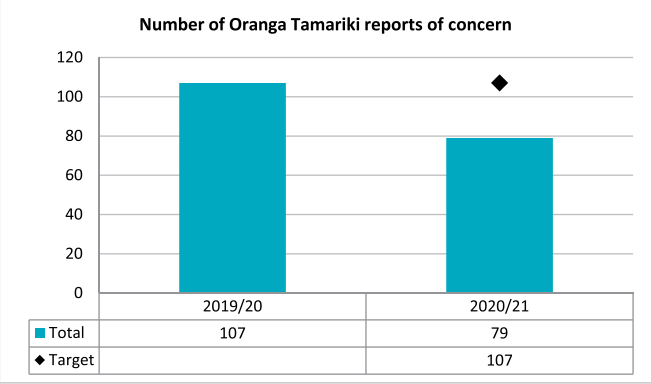


Data Source: Violence Intervention Programme Office records, Taranaki DHB

Ward 15 (maternity) Violence Intervention Programme routine questioning rates

Total **Not Achieved**

During pregnancy (ante and post natal care) a woman is asked about family violence (FV) three times. This happens before the birth by the midwife, after the birth in ward 15 and before being discharged by the midwife. Taranaki DHB FV routine questioning rates are above the national rates. Midwives are committed to talking about violence in the home as pregnancy is a risk factor for escalating FV.

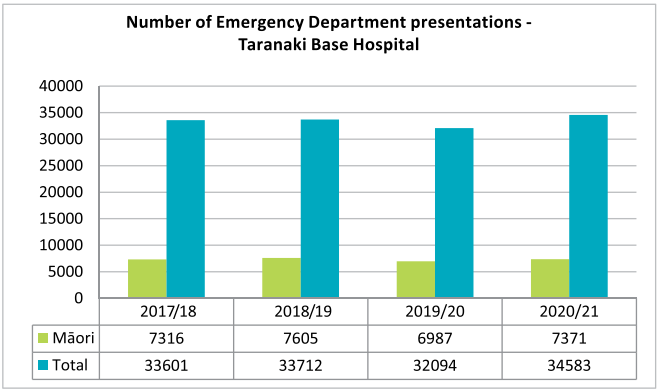


Data Source: Violence Intervention Programme Office records, Taranaki DHB

Number of Oranga Tamariki reports of concern

Total **Achieved**

Taranaki DHB health professionals maintain vigilance in identifying child protection concerns and reporting to Oranga Tamariki. Since the start of the pandemic lockdown the violence intervention coordinator worked with the child protection coordinator to maintain zoom daily meetings with the police and Oranga Tamariki to develop safety plans for at-risk families/whānau.

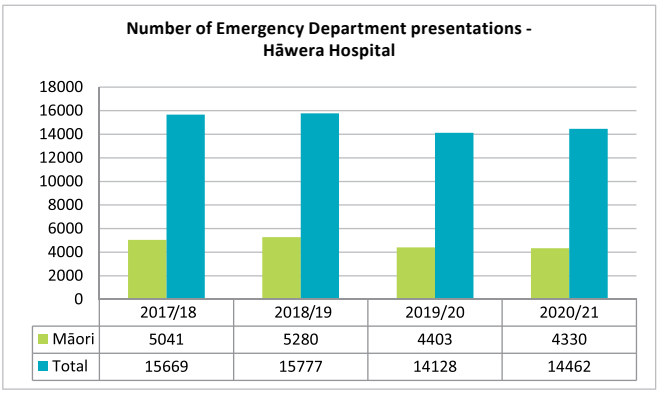


Data Source: Taranaki DHB Patient Management System

Number of Emergency Department presentations - Taranaki Base Hospital

Total **Baseline being established**

The number of ED presentations has increased slightly from 2019/20, however this may have been due to the impact of COVID. The overall trajectory has seen a slight reduction in Māori presentations and a slight increase overall. Taranaki DHB will continue to explore alternative models of care and care pathways that enable community based care where posible.

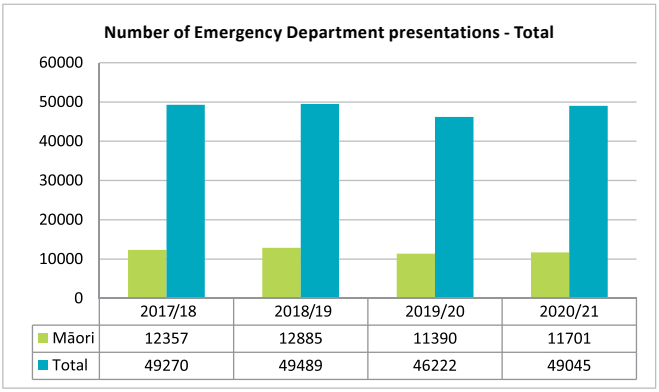


Data Source: Taranaki DHB Patient Management System

Number of Emergency Department presentations - Hāwera Hospital

Total **Baseline being established**

There has been a decrease in the number of ED presentations in Hāwera Hospital. The number of triage 2 patients seen in Hāwera ED has increased and is a reflection of the ageing population and more patients with long term conditions and complex care needs. However, the number of lower acuity patients (status 4 & 5) have decreased. This is a reflection of the success of initiatives that have been implemented in South Taranaki such as ongoing public education campaigns, ED-redirection and the introduction of the South Taranaki Rural Health GP practic (STRH). The STRH officially launched February 2021 and already has a growing enrolled population of 1200. This provides South Taranaki with much needed additional primary care access. The walk-in service is currently in its early stages of implementation and will further ease the burden in ED by providing an alternative service/access point for GP appropriate patients.



Data Source: Taranaki DHB Patient Management System

Number of Emergency Department presentations - Total

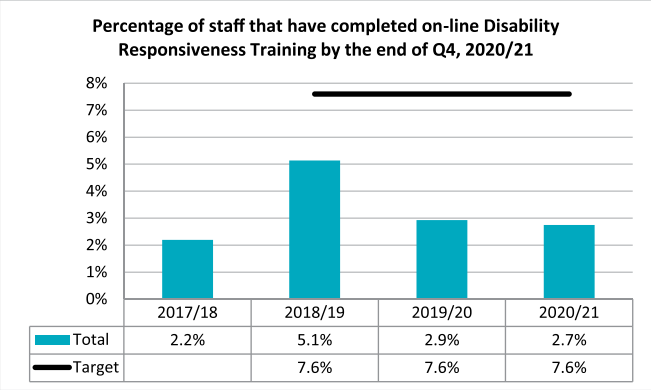
Total **Baseline being established**

The number of ED presentations has increased slightly from 2019/20, however this may have been due to the impact of COVID. The overall trajectory has seen a reduction in Māori presentations and a slight decrease in overall presentations, this may be as a result of improved access to primary care in South Taranaki. Taranaki DHB will continue to explore alternative models of care and care pathways that enable community based care where posible.

More people maintain their functional independence

If we are to deliver on our twin goals of improving health outcomes, and reducing or eliminating health inequalities, for our older population, we aim to support people to maintain functional independence. With an increasing and ageing population, as this cohort increases, so does demand on our constrained funding. Aged Residential Care (ARC) is a specialist, high cost, and scarce resource. We are looking to manage the expected growth in demand, through an ageing population, by improved models of care that support people to remain independent for as long as possible.

OUTPUT MEASURES



	2017/18	2018/19	2019/20	2020/21
Total	2.2%	5.1%	2.9%	2.7%
Target		7.6%	7.6%	7.6%

Data Source: Taranaki DHB

Percentage of staff that have completed on-line Disability Responsiveness Training by the end of Q4, 2020/21

Total **Not Achieved**

Taranaki DHB Disability Responsiveness e-learning plan and modules have increased numbers to 183 over the 2020/21 period. One face to face Disability Equity session saw 18 staff and three unconscious bias sessions were done with 63 in attendance throughout the year.

To aid uptake all new starters will now receive an automatic email to prompt them to do the online course at three months post-start (completion rates will be monitored by the Training & Ed dept & new starters who have not completed the training will be followed up).

OUTCOME 3

People receive timely and appropriate specialist care

Expectation

Secondary-level hospital and specialist services meet people's complex health needs, are responsive to episodic events and support community-based care providers. By providing appropriate and timely access to high quality complex services, people's health outcomes and quality of life can be improved.

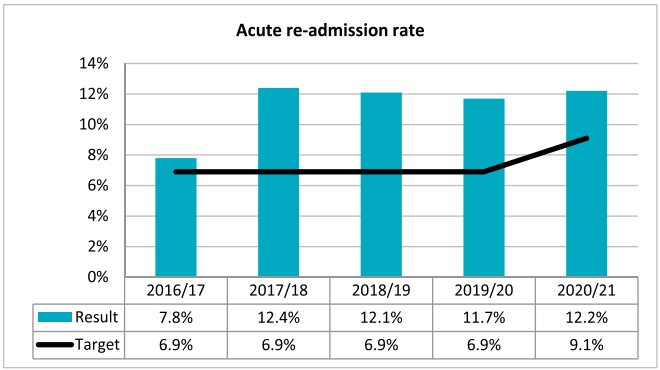
This goal reflects the importance of ensuring that hospital and specialist services are sustainable and that the Midland Region has the capacity to provide for the complex needs of its population now and into the future.

People receive prompt and appropriate acute and arranged care

Long stays in Emergency Departments (EDs) are linked to overcrowding of the ED, negative clinical outcomes and compromised standards of privacy and dignity for patients. Less time spent waiting and receiving treatment in an ED improves the health services DHBs are able to provide.

The duration of stay in ED is influenced by services provided in the community to reduce inappropriate ED presentations, the effectiveness of services provided in ED and the hospital and community services provided following exit from ED. Reduced waiting time in ED is indicative of a coordinated 'whole of system' response to the urgent needs of the population.

OUTPUT MEASURES



	2016/17	2017/18	2018/19	2019/20	2020/21
Result	7.8%	12.4%	12.1%	11.7%	12.2%
Target	6.9%	6.9%	6.9%	6.9%	9.1%

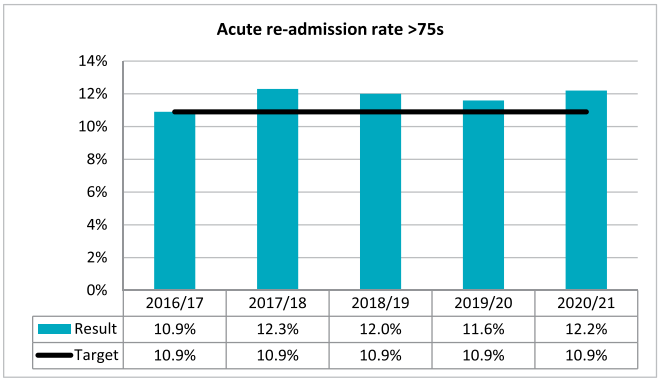
Data Source: National Minimum Dataset (NMDS)

Acute re-admission rates

Acute re-admission rate **Not Achieved**

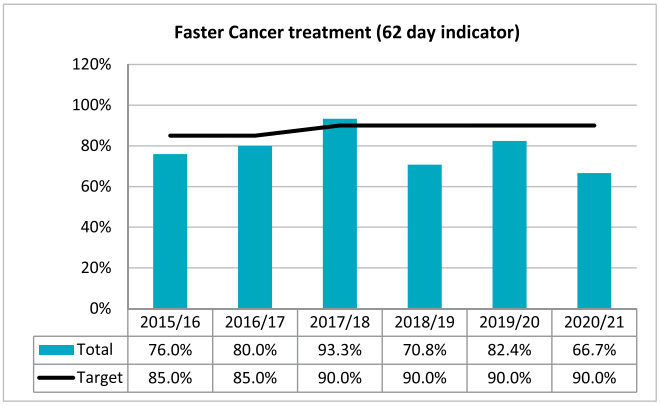
Acute re-admission rate >75s **Not Achieved**

Acute re-admission rates remain above target, largely as a result of increasing levels of acute demand and the complexity of patient conditions. An acute patient flow project is in progress that includes a range of elements focusing on early and comprehensive discharge planning which we hope will see a reduction in acute re-admission rates over time. The over 75 age group are more at risk of frailty, and also tend to have a higher risk of acute re-admission, a project aimed at implementing initiatives aimed at early identification and alternate pathways for those with frailty should support improved outcomes for this group.



	2016/17	2017/18	2018/19	2019/20	2020/21
Result	10.9%	12.3%	12.0%	11.6%	12.2%
Target	10.9%	10.9%	10.9%	10.9%	10.9%

Data Source: National Minimum Dataset (NMDS)



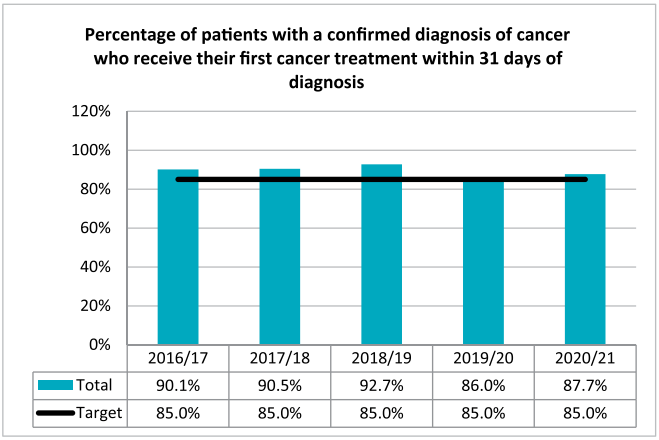
	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Total	76.0%	80.0%	93.3%	70.8%	82.4%	66.7%
Target	85.0%	85.0%	90.0%	90.0%	90.0%	90.0%

Data Source: National Cancer data set

Faster Cancer treatment (62 day indicator)

Total **Not Achieved**

Taranaki DHB has not met the target of 90% of all cancer patients receiving their first treatment within 62 days. Inability to reach the target is hindered by complex diagnostic procedures which require intervention outside of the region (CT guided lung biopsy). Availability of on site specialists and theatre space continues to prove challenging, especially for ENT and gynaecological services. Continued reliance on visiting specialties (lung) also prolongs appointment time frames. A breach analysis report is maintained to allow the Taranaki DHB to improve processes where able. Changes to the timing of preliminary data collected by the Cancer Control Agency (CCA) should result in increased accuracy in monthly reporting from Q1 2021/22. The Taranaki DHB Faster Cancer Treatment (FCT) governance group is well established and includes wide representation. Local successful Cancer Hui have paved way for planned approaches to Māori with cancer.

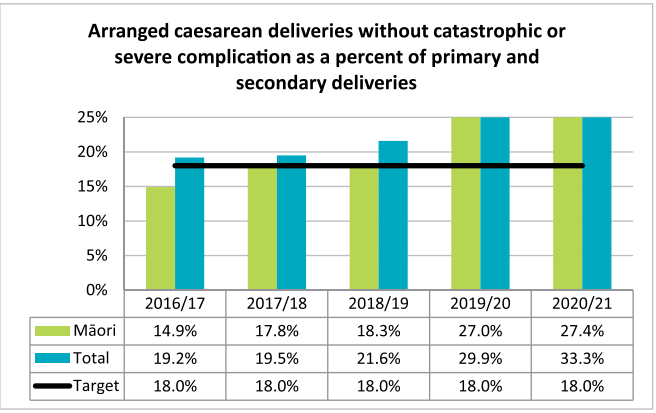


Data Source: National Cancer data set

Percentage of patients with a confirmed diagnosis of cancer who receive their first cancer treatment within 31 days of diagnosis

Total **Achieved**

The target of 85% of its patients receiving their treatment in 31 days has been achieved. Ongoing monitoring and promotion of staff awareness of this target will be undertaken to ensure this target continues to be met. A breach analysis report is maintained to allow the Taranaki DHB to improve processes where able. Changes to the timing of preliminary data collection by the Cancer Control Agency (CCA) should result in increased accuracy of monthly reporting from Q1 2021/2022.



Data Source: National Minimum Dataset (NMDS). Desired outcome is below the target rate

Arranged caesarean deliveries without catastrophic or severe complication as a percent of primary and secondary deliveries

Māori **Not Achieved**

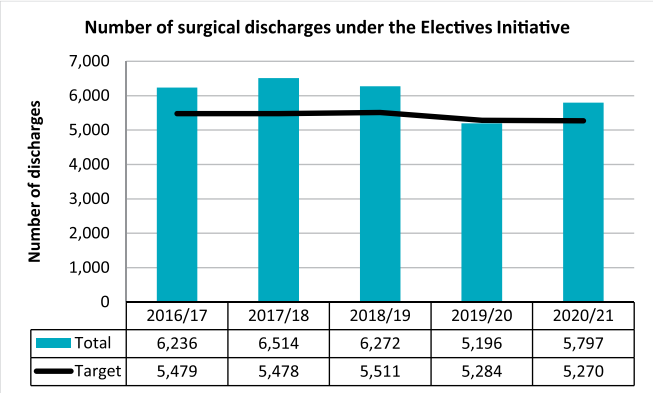
Total **Not Achieved**

Taranaki DHB remains committed to reducing the number of elective caesarean sections in our region. The indications for elective caesarean sections are multifactorial and includes factors such as higher risk women, co-morbidities in pregnant women, workforce issues and local availability of testing that continues to clinically drive these rates. Taranaki DHB plan to implement a new induction of labour (IOL) protocol using Misoprostal. Using Misoprostal other DHB have reported up to a 10% reduction in caesarean section rate.

People have appropriate access to elective services

Elective services are an important part of the health system, as they improve a patient's quality of life by reducing pain or discomfort and improving independence and wellbeing. The Government wants more New Zealanders to have access to elective surgical services. Improved performance on targets in this area are reflective of improved hospital productivity to ensure the most effective use of resources so that wait times can be minimised and year-on-year growth is achieved.

OUTPUT MEASURES



Data Source: National Minimum Dataset (NMDS)

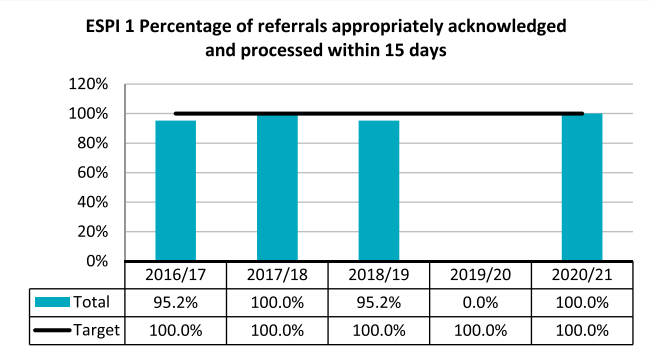
Number of surgical discharges under the Electives Initiative

Result **Achieved**

Taranaki DHB has achieved this initiative despite the challenges that have been faced over the year. Planning is ongoing to ensure continued delivery of surgical discharges alongside the increasing acute demand..

In 2019/20 the Electives Initiative was relaunched as the Planned Care Initiative. The surgical discharge component remains comparable to previous years

Due to cyber attack incident at Waikato DHB there may be delays to coding that impact discharge volumes. Waikato DHB is the regional tertiary hospital for Taranaki.

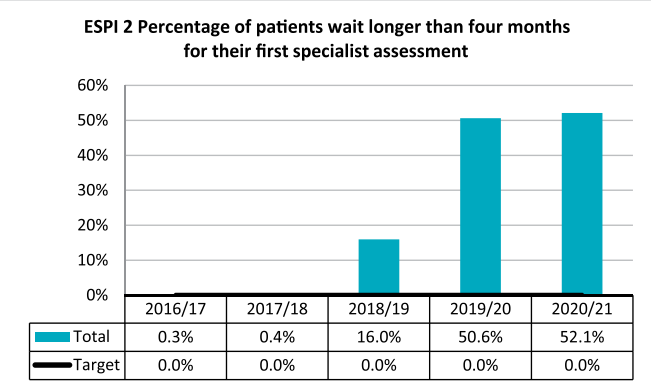


Data Source: National Booking Reporting System (NBRS)

ESPI 1 Percentage of referrals appropriately acknowledged and processed within 15 days

Result **Achieved**

The large majority of Taranaki DHB services acknowledge and process referrals within 15 days, unfortunately due to vacancies in a small number of services this has not been achieved for the DHB as a whole. Taranaki DHB continues to actively recruit into specialties where vacancies exist and to look to alternative ways to ensure timely delivery of services.

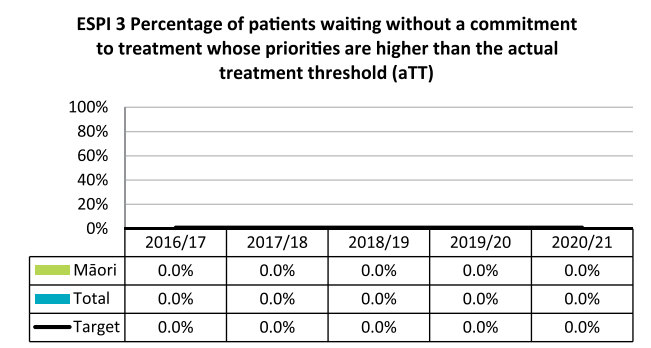


Data Source: National Booking Reporting System (NBRS)

ESPI 2 Percentage of patients wait longer than four months for their first specialist assessment

Result **Not Achieved**

Taranaki DHB continues to work towards meeting this target. COVID has had a significant impact on our ability to meet this target, DHB has been working to address the backlog of patients that were not able to be seen virtually during the periods of lockdown. In addition high acute demand and a low threshold for staff sickness has been challenging. Taranaki DHB is working on a range of initiatives including referral pathways, alternative models of care, and improved production planning in an effort to ensure resources are available to deliver services to patients in a timely manner.

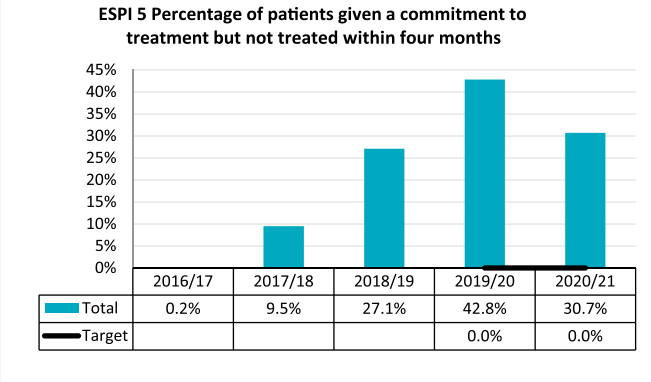


Data Source: National Booking Reporting System (NBRS)

ESPI 3 Percentage of patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold (aTT)

Result **Achieved**

Taranaki DHB continues to achieve this target.

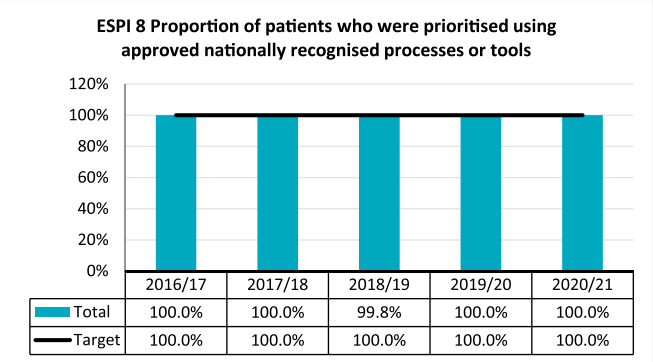


Data Source: National Booking Reporting System (NBRS)

ESPI 5 Percentage of patients given a commitment to treatment but not treated within four months

Result **Not Achieved**

Taranaki DHB continues to work towards meeting this target. COVID has had a significant impact on our ability to meet this target, we have been working to address the backlog of patients that were not able to be seen virtually during the periods of lockdown. In addition high acute demand and a low threshold for staff sickness has been challenging. We are working on a range of initiatives including referral pathways, alternative models of care, and improved production planning in an effort to ensure resources are available to deliver services to patients in a timely manner.



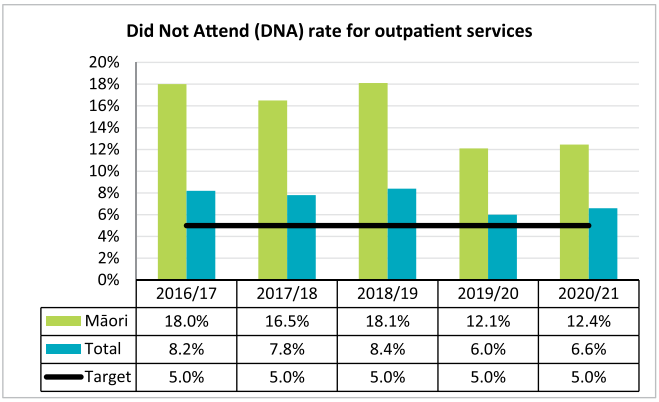
	2016/17	2017/18	2018/19	2019/20	2020/21
Total	100.0%	100.0%	99.8%	100.0%	100.0%
Target	100.0%	100.0%	100.0%	100.0%	100.0%

Data Source: National Booking Reporting System (NBRS)

ESPI 8 Proportion of patients who were prioritised using approved nationally recognised processes or tools

Result **Achieved**

Taranaki DHB uses all available nationally available processes or tools to facilitate prioritisation of patients requiring treatment.



	2016/17	2017/18	2018/19	2019/20	2020/21
Māori	18.0%	16.5%	18.1%	12.1%	12.4%
Total	8.2%	7.8%	8.4%	6.0%	6.6%
Target	5.0%	5.0%	5.0%	5.0%	5.0%

Data Source: National Non-admitted Patient dataset. Desired outcome is below the target rate

Did Not Attend (DNA) percentage for Outpatient services

Māori **Not Achieved**

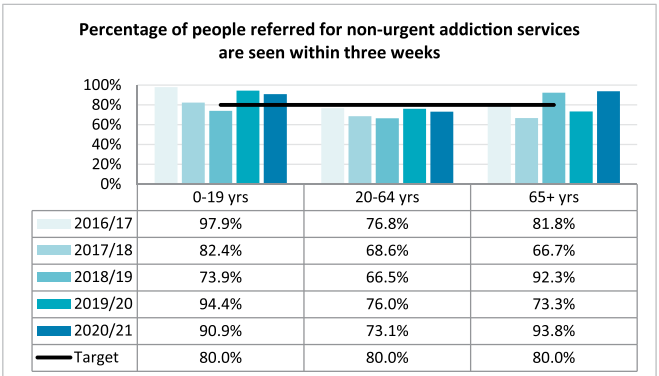
Total **Not Achieved**

Total DNA rates continue to decline, although remain static for Māori. The Māori health team continue to work with all specialties to assist patients to navigate through the health system. Patient centred booking, virtual consultations, telehealth and other patient centred initiatives are being considered to overcome some of the barriers to attendance. We will continue to monitor DNA rates and look for ways to improve engagement of patients in health services.

Improved health status for people with severe mental health illness

It is estimated that at any one time, 20% of the New Zealand population will have a mental illness or addiction, and 3% are severely affected by mental illness. With high suicide rates in some of our communities, we are working to reduce this rate and support our communities with Whānau Ora initiatives. There is also a high prevalence of depression with the economic downturn and other pressures. The World Health Organisation (WHO) predicts that depression will be the second leading cause of disability by 2020. We have an ageing population, which places increased demand from people over 65 for mental health services appropriate to their life stage. The prevalence of mental illness in the population increases with age, and older people have different patterns of mental illness, often accompanied by loneliness, frailty or physical illness.

OUTPUT MEASURES



	0-19 yrs	20-64 yrs	65+ yrs
2016/17	97.9%	76.8%	81.8%
2017/18	82.4%	68.6%	66.7%
2018/19	73.9%	66.5%	92.3%
2019/20	94.4%	76.0%	73.3%
2020/21	90.9%	73.1%	93.8%
Target	80.0%	80.0%	80.0%

Data Source: Programme for the Integration of Mental Health Data (PRIMHD)

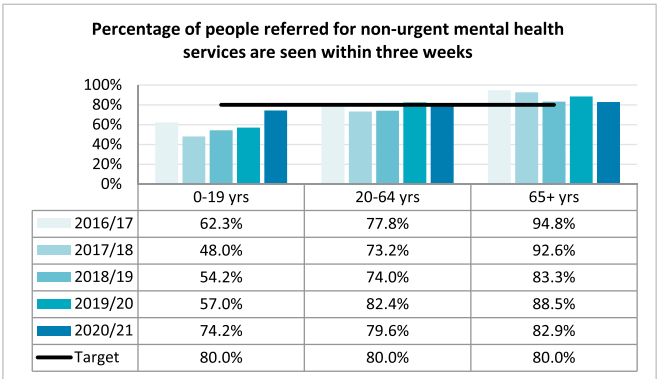
Percentage of people referred for non-urgent addiction services are seen within three weeks

0-19 yrs **Achieved**

20-64 yrs **Not Achieved**

65+ yrs **Achieved**

Alcohol and drug services have experienced staffing deficits over the last two quarters of 2020/21 which has impacted their ability to respond in a timely fashion. Additionally, there are data quality issues which will need to be further looked into as there has been face to face encounters within 3 weeks but this is not reflected in the data and reducing our percentage overall.



	0-19 yrs	20-64 yrs	65+ yrs
2016/17	62.3%	77.8%	94.8%
2017/18	48.0%	73.2%	92.6%
2018/19	54.2%	74.0%	83.3%
2019/20	57.0%	82.4%	88.5%
2020/21	74.2%	79.6%	82.9%
Target	80.0%	80.0%	80.0%

Data Source: Programme for the Integration of Mental Health Data (PRIMHD). Desired outcome is below the target rate

Percentage of people referred for non-urgent mental health services are seen within three weeks

0-19 yrs **Not Achieved**

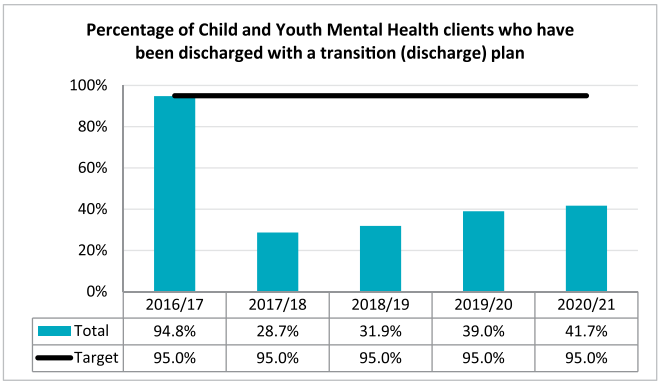
20-64 yrs **Not Achieved**

65+ yrs **Achieved**

0-19yrs: Child and Adolescent services continue to be overwhelmed with acute presentations which are prioritised. As a means to utilise resources more effectively and provide service to these whanau a new group programme has been implemented for 2021 to provide interventions for up to 10-12 rangatahi and their whanau for new referrals from primary services. The rangatahi work in a group and the whanau within a parallel group, initial reports are very promising . It is anticipated that many of these whai ora will be transitioned back to primary services as a result of the group intervention.

20-64: This age group was within 0.4% of achieving target.

65+: Demand continues to challenge resources/pathways for increasing access are regularly reviewed at both the business and clinical governance end to ensure these are aligned with people that present to this service.



	2016/17	2017/18	2018/19	2019/20	2020/21
Total	94.8%	28.7%	31.9%	39.0%	41.7%
Target	95.0%	95.0%	95.0%	95.0%	95.0%

Data Source: Taranaki DHB mental health department records

Percentage of Child and Youth Mental Health clients who have been discharged with a transition (discharge) plan

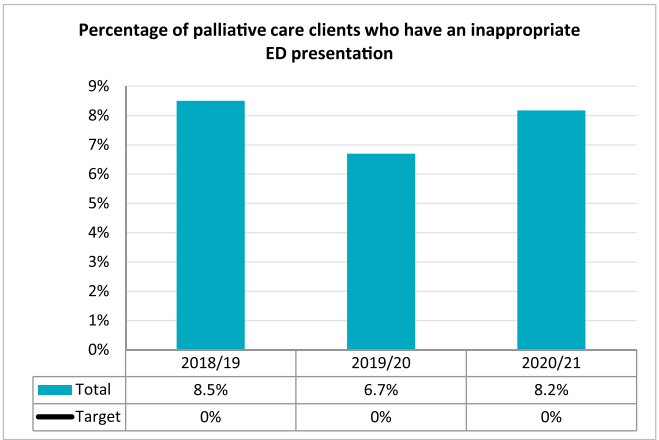
Total **Not Achieved**

Whilst quality processes are improving there remains inconsistency with audit approaches even with the standardised audit tools being used. An electronic collection mechanism has been requested of ICT services to embed collection alongside our Supplementary Consumer record and HoNOS systems to report Transition Plan completion in real time reducing resilience on labour intensive collection of audits.

People with end stage conditions are supported

Why is this important? It is important that people who have life threatening illness, along with their family and whānau, receive appropriate care and support to cope with their situation. Our focus is on ensuring that the patient is able to live comfortably, without undue pain or suffering. Early identification and recognition that end of life is imminent and commencement of a palliative approach to care and support will heavily influence the quality of life individuals and their family experience during the dying process. Support services during this time include palliative care, aged residential care, respite care and home based support services.

OUTPUT MEASURES



	2018/19	2019/20	2020/21
Total	8.5%	6.7%	8.2%
Target	0%	0%	0%

Data Source: Taranaki Hospice

A reduction in the percent of palliative care clients who have had an inappropriate Emergency Department (ED) presentation

Total **Not achieved**

A total of 189 patients registered with Hospice Taranaki Inc. (HTI) presented to ED in the 12 month period. This was less than the 195 who presented in the previous year.

There were 19 presentations which were considered as inappropriate. The previous year, there had been 13. All patients are advised to ring the hospice service for advice before presenting to ED. This does not always happen.

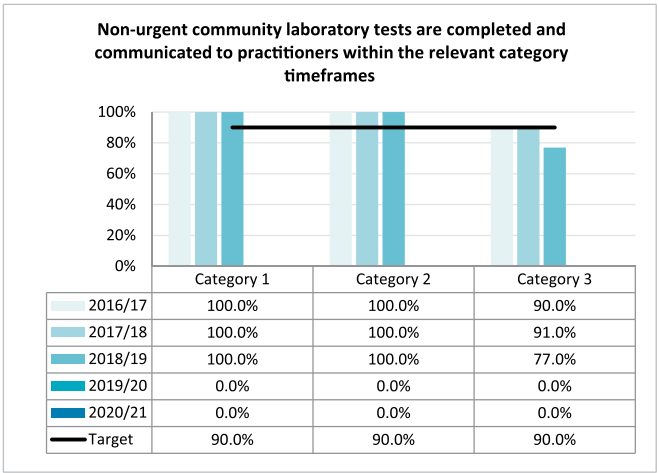
There were three admissions to hospital during the year where the hospice inpatient unit beds were full and the admission could not be managed.

There is a higher number of patients registered with HTI in some months of this past year.

The ED presentation schedule is reviewed by the clinical team each month and any trends are noted for discussion.

Support services

OUTPUT MEASURES



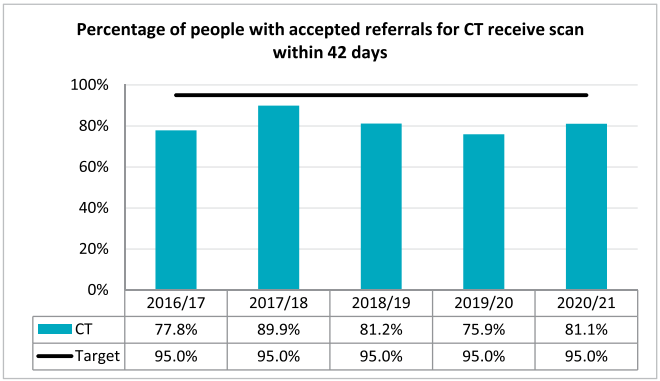
	Category 1	Category 2	Category 3
2016/17	100.0%	100.0%	90.0%
2017/18	100.0%	100.0%	91.0%
2018/19	100.0%	100.0%	77.0%
2019/20	0.0%	0.0%	0.0%
2020/21	0.0%	0.0%	0.0%
Target	90.0%	90.0%	90.0%

Data Source: Local contract Performance Monitoring

Non-urgent community laboratory tests are completed and communicated to practitioners within the relevant category timeframes

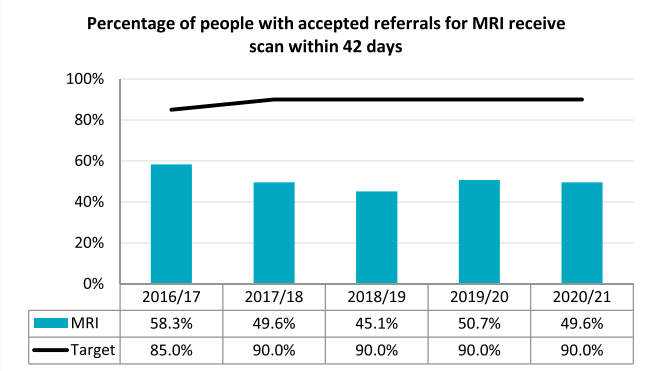
Category 1 **Not Available**
Category 2 **Not Available**
Category 3 **Not Available**

Taranaki had a change in lab providers which includes a different, more robust, set of performance measures. The above measure does not feature in the new contract, and this measure has been reworked for the 2021/22 year.



	2016/17	2017/18	2018/19	2019/20	2020/21
CT	77.8%	89.9%	81.2%	75.9%	81.1%
Target	95.0%	95.0%	95.0%	95.0%	95.0%

Data Source: Taranaki DHB



	2016/17	2017/18	2018/19	2019/20	2020/21
MRI	58.3%	49.6%	45.1%	50.7%	49.6%
Target	85.0%	90.0%	90.0%	90.0%	90.0%

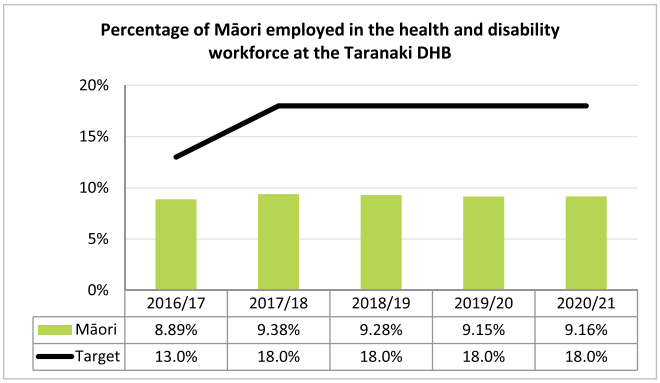
Data Source: Taranaki DHB

Improved wait times for diagnostic services - accepted referrals for Computed Tomography (CT) and Magnetic Resonance Imaging (MRI) within 42 days

CT **Not Achieved**

MRI **Not Achieved**

As with the previous year, we continue to experience rising referral rates for Computed Tomography (CT) and Magnetic Resonance Imaging (MRI). Additionally, our current radiologist vacancy rate accounts for approximately 1/3 of our budgeted FTE (we continue to actively recruit to these vacancies, exploring all options with our recruitment team). In order to respond to rising demands and provide timely services we have undertaken outsourcing to our local community providers as well as extending hours on a voluntary basis. We have one CT machine which is well utilised with minimal downtime over the past year. Our MRI machine is around 20 years old and image acquisition rate on this machine is much slower than on modern machines (e.g., 50 minutes/scan vs 30 minutes/scan). We are currently undergoing procurement for early replacement of our MRI and CT machines as part of our new hospital build process with tentative installation dates for new equipment set for December 2021/January 2022. These upgrades will improve our service capacity. In the meantime, we are undertaking a significant service review including detailed productivity planning which will provide clear guidance on improvement processes for improving demand management including reviewing protocols, booking practices, rostering, and scheduling in order to maximize our available capacity.



	2016/17	2017/18	2018/19	2019/20	2020/21
Māori	8.89%	9.38%	9.28%	9.15%	9.16%
Target	13.0%	18.0%	18.0%	18.0%	18.0%

Data Source: Taranaki DHB HR system

Percentage of Māori employed in the health and disability workforce at the Taranaki DHB

Māori **Not Achieved**

The DHB's Māori Health Unit experienced significant workforce issues of its own during 2020/21 and this has not had an insignificant impact on the programme of work that was planned for roll-out. Nevertheless we have maintained Māori workforce levels at 9.16%, noting that the actual number of Māori employed has increased by 6% - from 197 to 208, keeping pace with the increase in FTE since last year. On the positive side Taranaki DHB made the decision to establish a new Māori workforce leadership role which was to have started in January 2021 but in the event did not start till June 2021. As well as reviewing and resetting Māori workforce planning, for 2021/22 the focus is on accelerating action on setting and addressing recruitment targets, establishing Māori staff well-being and retention activities and supporting the WhyOra programme with young Māori coming through health workforce secondary and tertiary studies pipelines.

Implementing the COVID-19 vaccine strategy

The following tables set out the COVID-19 vaccine rollout as at 30 June 2021. Refer to page 40 and 41 for details on managing with COVID-19.

Vaccine doses administered by DHB			
DHB of service	**Dose 1**	**Dose 2**	**Total**
Taranaki	8,752	4,720	13,472

Vaccine doses administered by age group (note 4)			
Age range (years)	**Dose 1**	**Dose 2**	**Total**
12 to 15	0	0	0
16 to 19	79	57	136
20 to 24	276	213	489
25 to 29	420	338	758
30 to 34	476	350	826
35 to 39	483	380	863
40 to 44	478	374	852
45 to 49	551	408	959
50 to 54	655	497	1,152
55 to 59	725	510	1,235
60 to 64	777	538	1,315
65 to 69	930	348	1,278
70 to 74	1,003	271	1,274
75 to 79	749	145	894
80 to 84	558	117	675
85 to 89	321	86	407
90+	271	88	359
Total	8,752	4,720	13,472

Vaccine doses administered by ethnicity (note 4)			
Ethnicity	**Dose 1**	**Dose 2**	**Total**
Asian	539	390	929
European or other	7,014	3,628	10,642
Māori	970	562	1,532
Pacific peoples	152	91	243
Unknown	77	49	126
Total	**8,752**	**4,720**	**13,472**

Vaccine doses administered by sequencing group (note 4)			
Sequencing group (note 3)	**Dose 1**	**Dose 2**	**Total**
Group 1	466	445	911
Group 2	5,640	3,438	9,078
Group 3	2,145	691	2,836
Group 4	501	146	647
Total	**8,752**	**4,720**	**13,472**

By DHB: Eligible population fully vaccinated by DHB of residence (note 1) (note 5)	
DHB of residence	**Proportion fully vaccinated (note 1)**
Taranaki	5.35%

Eligible population fully vaccinated by age group (note 5)	
Age range (years)	**Proportion fully vaccinated (note 1)**
12 to 15	–
16 to 19	1.51%
20 to 24	4.47%
25 to 29	5.20%
30 to 34	4.84%
35 to 39	5.33%
40 to 44	5.28%
45 to 49	5.54%
50 to 54	6.55%
55 to 59	6.80%
60 to 64	7.05%
65 to 69	5.61%
70 to 74	4.96%
75 to 79	4.00%
80 to 84	4.80%
85 to 89	5.42%
90+	9.13%
Total	**5.35%**

Eligible population fully vaccinated by ethnicity (note 5)	
Ethnicity	**Proportion fully vaccinated (note 1)**
Asian	11.35%
European or other	5.16%
Māori	4.36%
Pacific peoples	8.36%
Unknown	9.79%
Total	**5.35%**

Note 1:

Fully vaccinated means two doses have been administered to an individual.

Note 2:

The health service user (HSU) population used for COVID-19 vaccine coverage reporting provides information about the number of people in New Zealand who used health services in 2020. People are included if they were alive as at 30 June 2020, were 12 years of age as of 30 June 2020, (note that this was initially 16 years but was reduced to 12 years when the eligibility criteria changed), and if they were enrolled with a primary health organisation or received health services in the 2020 calendar year. There are other data sets that estimate the total number of people in New Zealand.

These include three datasets produced by StatsNZ: Estimated Resident Population (produced every 5 years, following each Census), Subnational Population Estimates (produced every year), and non-official population projections produced by StatsNZ for the Ministry of Health (produced every year).

The Stats NZ population estimates are based on Census data adjusted for the number of people who are born, who have died, and who have migrated to or from New Zealand. The Stats NZ population estimates and projections are of people usually resident in New Zealand, including those usually resident who are temporarily overseas, while the HSU includes everyone in New Zealand who used health services in a given period.

The HSU was chosen by the Ministry of Health as the denominator for COVID-19 vaccine coverage reporting because it allows for the assignment of the same demographics (eg, location and ethnicity) to people in the numerator (the number of people vaccinated) as the denominator (reference population). The HSU is available for every demographic contained in health data including age, ethnicity, DHB, and gender, separately or in combination. Other information such as neighbourhood deprivation, Statistical Area 2, or territorial local authority can also be added. It is possible to generate flags for health-related information on the HSU, for example, those who are likely to have a long-term condition. Official Stats NZ estimates are not as flexible. For example, StatsNZ estimates by age, sex and Statistical Area 2/Territorial Authority/DHB are produced every year, but estimates that also include ethnicity are only produced every 5 years, the most recent being estimates for 2018. The projections StatsNZ produces for the Ministry every year do provide information by age, sex and broad ethnic group, but are only available at the DHB level.,.

The Total population estimate based on HSU as at 30 June 2020 is 123,082. This is 1,698 below the Stats NZ total projected population of 124,780 (from the non-official population projections StatsNZ produced in 2020). When classifying the population into ethnicity, age and DHB there are further differences. For example, a summary of the differences by ethnicity are summarised in the table below. These differences arise as the populations are derived from different sources. For example, an individual may identify as one ethnicity when registering with a health service and a different ethnicity when completing a census declaration.

By definition, the HSU is not a total population estimate and is likely to miss highly marginalised groups. For example, analysis suggests that groups underrepresented in the HSU include young people aged 15-45 years (men in particular), and people of Asian and Middle Eastern, Latin American and African ethnicity.

The HSU is considered by the Ministry of Health to be the best option for estimates of vaccine coverage, as it removes bias from calculated rates by ensuring demographic information in the numerator and denominator is consistent. For example, the ethnic group(s) with which someone identifies, and their location.

Total population	HSU	Stats NZ	Difference
Māori	22,303	25,700	(3,397)
Pacific	1,691	1,760	(69)
Asian	5,308	6,420	(1,112)
Other	93,780	90,900	2,880
Total	**123,082**	**124,780**	**(1,698)**

Note 3:

Group 1 includes border and managed isolation and quarantine employees and the people they live with. Group 2 includes high-risk frontline health care workforces; workers and residents in long-term residential environments; older Māori and Pacific peoples cared for by whānau, the people they live with, and their carers; people aged 65 years and older; people with relevant underlying health conditions. Group 3 includes people aged 65 years and older; people with relevant underlying health conditions; disabled people; and adults in custodial settings. Group 4 includes people aged 16 years and over. These definitions and population groups were occasionally updated based on operational and Cabinet decisions or updated estimates of the sizes of each group.

Note 4:

The data in this table is based on the DHB of service (where the vaccine dose was administered).

Note 5:

The data in this table is based on the DHB of residence of the individual receiving the vaccines. Ethnicity is based on the prioritised ethnicity classification system which allocates each person to a single ethnic group, based on the ethnic groups they identify with. Where people identify with more than one group, they are assigned in this order of priority: Māori, Pacific peoples, Asian, and European/Other. So, if a person identifies as being Māori and New Zealand European, the person is counted as Māori.

Financial Report

1 The Board and management of the Taranaki District Health Board accepts responsibility for the preparation of the Financial Statements and the judgements used in them.

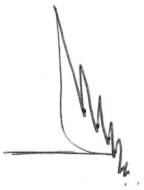
2 The Board and management of the Taranaki District Health Board accepts responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting.

3 In the opinion of the Board and management of the Taranaki District Health Board, the Financial Statements for the twelve months ended 30 June 2021, fairly reflect the financial position, operations, cash flows and service performance of the Taranaki District Health Board.

Cassandra Crowley
Chairperson
22 December 2021

Bridget Sullivan
Deputy Chairperson
22 December 2021

Rosemary Clements
Chief Executive Officer
22 December 2021



George Thomas
Chief Financial Officer
22 December 2021

	Notes	Actual June 2021 $000	Budget June 2021 Unaudited $000	Actual June 2020 $000
Revenue	1	460,411	444,505	419,676
Other income	2	2,346	1,403	248
Total revenue		462,757	445,908	419,924
Employee benefit costs	3	194,623	175,882	170,050
Depreciation expense	12	15,561	17,966	16,799
Outsourced services		16,082	9,392	14,095
Clinical supplies		38,847	38,665	34,624
Infrastructure and non-clinical expenses		17,618	14,015	21,358
Payments to non-health board providers		194,105	191,861	181,039
Other expenses	4	1,231	1,058	950
Capital charge	5	7,535	9,075	9,605
Financing costs	6	32	-	43
Total expenses		485,634	457,914	448,563
(Loss) before share of associates		(22,877)	(12,006)	(28,639)
Share of surplus/(loss) of associates	11(c)	115	-	11
(Loss) after surplus of associates		(22,762)	(12,006)	(28,628)
Other comprehensive revenue and expense				
Revaluation of land and buildings		15,561	-	-
Total other comprehensive revenue and expense		15,561	-	-
Total comprehensive revenue and expense		(7,201)	(12,006)	(28,628)

This statement should be read in conjunction with the accompanying notes.

	Note	Public Equity	Accumulated Revenue and Expense	Asset Revaluation Reserve	Trust Fund Reserve	Total
		$000	$000	$000	$000	$000
At 30 June 2019		106,930	(47,451)	116,541	719	176,739
Comprehensive revenue and expense						
Deficit support from Crown	27	18,000	-	-	-	18,000
(Loss) for the year		-	(28,628)	-	-	(28,628)
Transfer from/(to) Trust Funds Reserve		-	(78)	-	78	-
		18,000	(28,706)	-	78	(10,628)
Transactions with the Crown						
Equity repaid to the Crown	27	(958)	-	-	-	(958)
		(958)	-	-	-	(958)
At 30 June 2020		123,972	(76,157)	116,541	797	165,153
Comprehensive revenue and expense						
Equity injections for Capital	27	32,968	-	-	-	32,968
Deficit support from Crown	27	-	-	-	-	-
(Loss) for the year		-	(22,762)	-	-	(22,762)
Change in asset revaluation reserve		-	-	15,561	-	15,561
Transfer from/(to) Trust Funds Reserve		-	85	-	(85)	-
		32,968	(22,677)	15,561	(85)	25,767
Transactions with the Crown						
Equity repaid to the Crown	27	(959)	-	-	-	(959)
		(959)	-	-	-	(959)
At 30 June 2021		155,981	(98,834)	132,102	712	189,961

This statement should be read in conjunction with the accompanying notes.

	Notes	Actual June 2021	Budget June 2021 Unaudited	Actual June 2020
		$000	$000	$000
ASSETS				
Current assets				
Cash and cash equivalents	7	401	390	390
Trade and other receivables	8	19,595	16,247	15,427
Inventories	9	4,132	4,006	3,990
Total current assets		24,128	20,643	19,807
Non-current assets				
Investments in associates	11	1,884	1,643	1,643
Other financial assets	10	192	56	56
Property, plant and equipment	12	253,930	223,966	219,895
Intangible assets	13	1,289	1,600	1,426
Restricted assets & trust funds	14	712	797	797
Total non-current assets		258,007	228,062	223,817
TOTAL ASSETS		282,135	248,705	243,624
LIABILITIES				
Current liabilities				
Cash and cash equivalents	7	5,764	7,502	12,670
Trade and other payables	15	29,982	26,289	21,095
Employee benefits	16	55,020	43,768	42,292
Provisions	17	33	61	1,139
Total Current Liabilities		90,799	77,620	77,196
Non current liability				
Employee benefits	16	1,375	1,305	1,275
Total non current liability		1,375	1,305	1,275
TOTAL LIABILITIES		92,174	78,925	78,471
NET ASSETS		189,961	169,780	165,153
EQUITY				
Public equity		155,981	141,013	123,972
Retained (losses)		(98,834)	(88,570)	(76,157)
Asset revaluation reserve		132,102	116,540	116,541
Trust fund reserve	14	712	797	797
TOTAL EQUITY		189,961	169,780	165,153

This statement should be read in conjunction with the accompanying notes.

For and on behalf of the Board, who authorised the issue of these financial statements on the 22 December 2021

Cassandra Crowley
CHAIRPERSON

Bridget Sullivan
DEPUTY CHAIRPERSON

	Note	Actual June 2021 $000	Budget June 2021 Unaudited $000	Actual June 2020 $000
CASHFLOWS FROM OPERATING ACTIVITIES				
Cash was provided from:				
Receipts from Government and Public		461,049	448,168	420,410
Interest Received		35	10	45
		461,084	448,178	420,455
Cash was disbursed to:				
Payments to Suppliers		260,261	252,703	254,360
Payments to Employees		182,906	174,377	161,915
Capital Charge Paid		7,535	9,075	9,605
Interest Paid		32	72	43
GST (Net)		1,239	-	1,688
		451,973	436,227	427,611
Net Cash Inflow/(Outflow) from Operating Activities	18	9,111	11,951	(7,156)
CASHFLOWS FROM INVESTING ACTIVITIES				
Cash was provided from:				
Dividends Received		2	-	140
Proceeds from Restricted Assets		84	-	-
Proceeds from Sale of Property, Plant & Equipment		348	-	30
		434	-	170
Cash was applied to:				
Purchase of Property, Plant & Equipment		34,349	23,650	20,194
Investments		134	174	-
Purchase of Intangible Assets		154	-	418
Restricted Assets		-	-	78
		34,637	23,824	20,690
Net Cash Outflow from Investing Activities		(34,203)	(23,824)	(20,520)
CASHFLOWS FROM FINANCING ACTIVITIES				
Cash was provided from:				
Capital equity injections from Crown		32,968	8,000	-
Deficit support received from Crown		-	10,000	18,000
		32,968	18,000	18,000
Cash was applied to:				
Repayment of Equity		959	959	959
		959	959	959
Net Cash Inflow from Financing Activities		32,009	17,041	17,041
Net (Decrease)/Increase in Cash Held		6,917	5,168	(10,635)
Cash and cash equivalents at beginning of year		(12,280)	(12,280)	(1,645)
Cash and cash equivalents at end of year		(5,363)	(7,112)	(12,280)

This statement should be read in conjunction with the accompanying notes.

Significant accounting policies for the year ended 30 June 2021

(a) Reporting entity

Taranaki District Health Board is a Health Board established by the New Zealand Public Health and Disability Act 2000. Taranaki District Health Board is a crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand.

The financial statements of Taranaki District Health Board have been prepared in accordance with the requirements of the New Zealand Public Health and Disability Act 2000 and Public Finance Act 1989.

Taranaki District Health Board is a public sector, public benefit entity (PS PBE), as defined under External Reporting Board (XRB) Standard A1. PS PBE's are reporting entities whose primary objective is to provide goods or services for community or social benefit and where any equity has been provided with a view to supporting that primary objective rather than for a financial return to equity holders.

The Taranaki District Health Board financial statements comprise those of Taranaki District Health Board, a 16.67% shareholding in Allied Laundry Services Limited and a 20% shareholding in HealthShare Limited. These associated entities are included as an activity as Taranaki District Health Board has significant influence in those entities.

Taranaki District Health Board operates in Taranaki. It has three key roles, namely (i) Planning to determine the health needs of Taranaki and how these can be met, (ii) Funding organisations and individuals to provide specific health services and (iii) Providing specific health services to the Taranaki community.

The financial statements of Taranaki District Health Board are for the year ended 30 June 2021. The financial statements were authorised for issue by the Board on 22 December 2021.

(b) Statement of compliance and basis of preparation

The financial statements have been prepared on a disestablishment basis, and the accounting policies have been applied consistently throughout the period.

The financial statements have been prepared in accordance with and comply with the Public Benefit Entity International Public sector Accounting Standards (PBE IPSAS) (Tier 1).

Health Sector Reforms

On 21 April 2021 the Minister of Health announced the health sector reforms in response to the Health and Disability System review.

The reforms will replace all 20 District Health Boards (DHBs) with a new Crown entity, Health New Zealand, that will be responsible for running hospitals and commissioning primary and community health services. It will have four regional divisions.

As a result of the reforms, responsibility for public health issues will rest with a new Public Health Authority. A new maori Health Authority will monitor the state of Maori health and commission services directly.

Legislation to establish the new entities and disestablish DHBs is scheduled to come into effect on 1 July 2022.

Because of the expected date of these reforms the financial statements of the DHB have been prepared on a disestablishment basis. No changes have been made to the recognition and measurement, or presentation in these financial statements, because all assets, liabilities, functions and staff of the DHBs and shared service agencies will transfer to Health New Zealand.

(i) Operating and Cash flow forecast

Operating and cash flow forecasts indicate that the DHB will have sufficient funds (including equity funding from the Crown for approved capital projects) to meet the forecast operating and investing cash flow requirements of the DHB for the 2021/22 financial year. However, if the DHB was required to settle the holiday pay liability disclosed in note 23 prior to 1 July 2022, additional financial support would be needed from the Crown.

(ii) Borrowing covenants and forecast borrowing requirements

The District Health Board is subject to borrowing restrictions in the Ministry of Health Operations Policy Framework. The cash flow forecast for the next year prepared by the District Health Board reflects the equity funding or lease funding, together with the working capital facilities will be required to meet cash requirements. Whilst there is uncertainty regarding the mechanism that will be used to meet such cash requirements, the Board is confident that this can be achieved without breaching covenants or other borrowing restrictions.

(iii) Letter of comfort

Taranaki District Health Board is faced with increasing cashflow pressures which include amongst others a number of active capital building projects, increased demands on its services and the impacts of COVID-19 on its operations. There is therefore the question whether Taranaki District Health Board will be able to settle its liabilities, including the estimated historical Holidays Act 2003 liability should they precipitate in the short term. Taranaki District Health Board therefore obtained a letter of comfort dated 13 October 2021 from the Ministers of Health and Finance, which confirms that the Crown will provide Taranaki District Health Board with financial support where necessary, and due to the scheduled health sector reforms all assets, liabilities, functions and staff of the District Health Boards and shared service functions will transfer to Health New Zealand on 01 July 2022 post legislative change to give effect to the reforms.

(iv) COVID-19

Taranaki District Health Board has considered the impact of COVID-19 as part of its impairment testing of assets on its Statement of Financial Position and going concern assumption. The provision of personal health services, public health services and disability support services is considered an essential service, consequently, Taranaki District Health Board continued operating throughout all alert levels (one to four), including the full lockdown period. This limited the impact of COVID-19 on Taranaki District Health Board's assets and forecasts and as a result the impact of COVID-19 is unlikely to have a significant sustained financial effect. This assessment is effective as at 30 September 2021 and has made use of all available information at that time.

Taranaki District Health Board have assessed the impact of the novel coronavirus as part of its impairment testing of assets on the Statement of Financial Position at 30 June 2021. Whilst the impact of COVID-19 has not had a significant financial effect on asset values it has had an impact to the services the District Health Board has been able to provide the local community. COVID-19 has caused inevitable disruption and delays in services which will have longer term consequences. For further information on managing COVID-19, refer to page 40-41 for detail.

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

The financial statements have been prepared on a historical cost basis, modified by the revaluation of land and buildings and certain investments.

(i) Functional and presentation currency
The financial statements are presented in New Zealand dollars which is the functional currency of Taranaki District Health Board. All financial information presented in New Zealand dollars has been rounded to the nearest thousand ($'000) unless stated otherwise.

(ii) Use of estimates and judgements
In preparing these financial statements Taranaki District Health Board has made estimates and assumptions concerning the future. These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed below:

Expected credit losses (note 8)
A monthly assessment of non commercial debtors is made, with expected credit losses being provided for based on the age of these debts. In June of each year all non commercial debts that are aged over 12 months that are not being paid off by the debtor is written off. Refer to note 8 for the amount per year of non commercial debt after the expected credit losses.

Estimation of employee entitlement accruals
The liability relating to back pay and long term employee benefits (long service leave, gratuities and sabbatical leave) is based on a number of assumptions in relation to the estimated length of service, the timing of release of the obligation and the rate at which the obligation will be paid to be applied in determining the present value. If any of these factors changed significantly, the actual outcome could be materially different to the estimate provided in the financial statements. The carrying value of the accruals has been disclosed in note 16.

Fair value of buildings
Taranaki District Health Board revalues land and buildings on either a five year cycle or when there is a material change between the independent valuation and the carrying value of the land and buildings. The independent valuation also determines the remaining life of buildings, and therefore the annual depreciation cost in future years. A fair value assessment was performed to ensure there is no material movement in the current year.

Useful lives of property, plant and equipment
Taranaki District Health Board reviews the estimated useful lives of property, plant and equipment at the end of each annual reporting period. In addition to this, at least every five years the land and buildings are revalued by an independent valuer, estimating the remaining life of these assets thus setting the annual depreciation to reflect this.

(c) Basis of consolidation

Subsidiaries
Taranaki District Health Board did not have any subsidiaries included in their financial statements for the year ended 30 June 2021.

Associates
An associate is an entity over which Taranaki District Health Board has significant influence, but not control. Taranaki District Health Board has shareholdings in the following associates:

Allied Laundry Services Limited 16.67% held
HealthShare Limited 20% held

Taranaki District Health Board's investment in its associates is accounted for using the equity method of accounting. The associates are entities over which Taranaki District Health Board has significant influences and that are neither subsidiaries nor joint ventures.

Taranaki District Health Board generally deems it has significant influence due to participation in commercial and financial policy decisions of the entities.

Under the equity method, investments in associates are carried in the statement of financial position at cost plus post-acquisition changes in the share of net assets of the associates. Goodwill relating to an associate is included in the carrying amount of the investment and is not amortised. After application of the equity method, Taranaki District Health Board determines whether it is necessary to recognise any impairment loss with respect to Taranaki District Health Board's net investment in associates. Goodwill included in the carrying amount of the investment in associate is not tested separately; rather the entire carrying amount of the investment is tested for impairment as a single asset. If an impairment is recognised, the amount is not allocated to the goodwill of the associate.

Taranaki District Health Board's share of associate's profits or losses is recognised in comprehensive revenue and expense, and its share of movements in other comprehensive income is recognised in other comprehensive income. The cumulative movements are adjusted against the carrying amount of the investment. Dividends receivable from associates are recognised in the parent entity's statement of comprehensive revenue and expense as a component of other income.

After applications of the equity method, Taranaki District Health Board determines whether it is necessary to recognise an additional impairment loss on Taranaki District Health Board's investment in its associate. Taranaki District Health Board determines at each reporting date whether there is any objective evidence that the investment in the associate is impaired. If this is the case Taranaki District Health Board calculates the amount of impairment

as the difference between the recoverable amount of the associate and its carrying value and recognises the amount in the "share of profit of an associate" in the statement of comprehensive revenue and expense.

When Taranaki District Health Board's share of losses in an associate equals or exceeds its interest in the associate, including any unsecured long-term receivables and loans, Taranaki District Health Board does not recognise further losses, unless it has incurred obligations or made payments on behalf of the associate.

The reporting dates of the associates and Taranaki District Health Board are identical and the associates' accounting policies conform to those used by Taranaki District Health Board for like transactions and events in similar circumstances.

(d) Budget figures

The budget figures are those approved by Taranaki District Health Board in its Annual Plan and included in the Statement of Intent tabled in Parliament. The budget figures have been prepared using accounting policies that are consistent with those adopted by Taranaki District Health Board for the preparation of the financial statements.

Budget figures have not been audited.

(e) Revenue

Revenue is recognised and measured at the fair value of consideration received or receivable to the extent it is probable that the economic benefits will flow to the Entity and the revenue can be reliably measured. The following specific recognition criteria must also be met before the revenue is recognised:

(i) Health and disability services (MoH contracted revenue)

The majority of revenue earned is related to the provision of services associated with planning, funding and the provision of health services and disability services. This 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.

(ii) ACC revenue

Taranaki District Health Board has a number of contracts with the Accident Compensation Corporation. Revenue on these contracts is recognised when it is probable that the economic benefits will flow to Taranaki District Health Board, and this revenue can be reliably measured.

(iii) Inter district patient inflows

Inter district patient inflow revenue occurs when a patient treated within the Taranaki District Health Board region is domiciled outside of Taranaki. The Ministry of Health credits Taranaki District Health Board with a budgeted monthly amount based on expected patient treatment for non Taranaki residents within Taranaki. An annual wash up occurs to reflect the actual non Taranaki patients treated within the Taranaki region.

(iv) Interest received

Revenue is recognised using the effective interest method.

(v) Dividends received

Revenue is recognised when the right to receive payment has been established.

(vi) Sale of goods

Revenue from goods sold is recognised when the significant risks and rewards of ownership of the goods have passed to the buyer and the costs incurred or to be incurred in respect of the transaction can be measured reliably. Risks and rewards of ownership are considered passed to the buyer at the time of delivery of the goods to the customer.

(vii) Rental revenue

Revenue is recognised in the income statement on a straight-line basis over the term of the lease.

(viii) Donation revenue

Donations and bequests to Taranaki District Health Board are recognised as revenue when control over assets is obtained. Donations and bequests received are treated as revenue on receipt in the statement of comprehensive income. Those with restrictive conditions are subsequently appropriated to trust funds forming part of equity.

(f) Cash and cash equivalents

Cash and cash equivalents in the statement of financial position comprise cash in hand, a demand fund held with NZ Health Partnerships Limited (NZHPL), cash at bank, deposits held with an original maturity of three months or less.

Any bank overdrafts that are repayable on demand and form an integral part of Taranaki District Health Board's cash management are included as a component of cash and cash equivalents for the purpose of the statement of cash flows.

(g) Trade and other receivables

Trade and other receivables are stated at amortised cost.

Trade receivables, which generally have 30 day terms, are recognised initially at fair value and subsequently measured at amortised cost less expected credit losses.

Short term receivables are recorded at the amount due, less an allowance for credit losses. Taranaki District Health Board applies the simplified expected credit loss model of recognising lifetime expected credit losses for receivables.

In measuring expected credit losses, short-term receivables have been assessed on a collective basis as they possess shared credit risk characteristics. They have been grouped together based on the days past due.

Short-term receivables are written off when there is no reasonable expectation of recovery. Indicators that there is no reasonable expectation of recovery include the debtor being in liquidation.

(h) Inventories

Inventories are valued at the lower of cost, determined at weighted average value, 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.

All inventory purchased was acquired through exchange contracts.

(i) Investments and Other Financial Assets

Financial assets are initially measured at fair value plus transaction costs unless they are carried at fair value through profit or loss in which case the transaction costs are recognised in the statement of comprehensive revenue and expense.

Purchases and sales of investments are recognised on trade-date, the date on which Taranaki District Health Board commits to purchase or sell the asset. Financial assets are derecognised when the rights to receive cash flows from the financial assets have expired, or have been transferred and Taranaki District Health Board has transferred substantially all the risks and rewards of ownership.

The fair value of financial instruments traded in active markets is based on quoted market prices at balance date. The fair value of financial instruments that are not traded in an active market is determined using valuation techniques. Such techniques include: using arm's length market transactions; reference to the current market value of another instrument that is substantially the same; discounted cash flow analysis and option pricing models.

For those instruments recognised at fair value in the statement of financial position, fair values are determined according to the following hierarchy (i) quoted market price (level 1), valuation technique using observable inputs (level 2), or (iii) valuation technique with significant non-observable inputs (level 3). Taranaki District Health Board does not have any financial instruments that are recognised at fair value in the statement of financial position.

Taranaki District Health Board classifies its financial assets at amortised cost. Management determines the classification of its investments at initial recognition and re-evaluates this designation at every reporting date.

(j) Property, Plant and Equipment

Owned assets

Except for land and buildings, items of property, plant and equipment is stated at historical cost less any accumulated depreciation and any 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.

Leased assets

Leases where Taranaki District Health Board assumes substantially all of the risks and benefits incident to ownership of the leased item, are capitalised at the lower of the fair value of the leased asset at the inception of the lease, or the present value of the minimum lease payments.

Land and buildings revalued

Land and buildings were revalued as at 30 June 2021 by an independent valuer on the basis of fair value. Changes in valuations are transferred to an asset revaluation reserve for that class of asset. Where such transfer results in a debit balance in the revaluation reserve the deficit is transferred to the statement of comprehensive revenue and expense. Any subsequent revaluation gains are written back through the income statement only to the extent of past deficits written off. Land and buildings are revalued every five years, unless the value of land and buildings materially alter prior to that date.

Additions

The cost of an item of property, plant and equipment is recognised as an asset if, and only if, it is probable the future economic benefits or service potential associated with the item will flow to Taranaki District Health Board 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.

Subsequent costs

Subsequent costs are added to the carrying value of an item of property, plant and equipment when that cost is incurred if it is probable that the future economic benefits embodied with the item will flow to Taranaki District Health Board and the cost of the item can be measured reliably. All other costs are recognised in the statement of comprehensive revenue and expense, and expensed as incurred.

Disposals

An item of property, plant and equipment is derecognised upon disposal or when no further future economic benefits are expected from its use or disposal. Any gain or loss arising on derecognition of the asset (calculated as the difference between the net disposal proceeds and the carrying amount of the asset) is included in profit or loss in the year the asset is derecognised.

Depreciation

Depreciation is calculated on a straight line basis on all tangible property, plant and equipment other than freehold land, at rates which will write off the cost or valuation of the assets, less estimated residual values, over their estimated useful lives as follows:

Capitalised leases are depreciated over the shorter of the estimated life of the asset and the lease term if there is no reasonable certainty that Taranaki District Health Board will obtain ownership by the end of the lease term.

Class of Asset	Estimated life	Depreciation rate
Land	not depreciated	n/a
Buildings	4 to 100 years	1-25%
Plant and equipment	2 to 18 years	2-50%
Motor vehicles	3 to 10 years	10-33.3%

Impairment
Non financial assets are tested for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable.

Taranaki District Health Board conducts an annual internal review of asset values, which is used as a source of information to assess for any indicators of impairment. External factors, such as changes in expected future processes, technology and economic conditions, are also monitored to assess for indicators of impairment. If any indication of impairment exists, an estimate of the assets recoverable amount is calculated.

An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount. Recoverable amount is the higher of an asset's fair value less costs to sell and value in use. Non-financial assets other than goodwill that suffer an impairment are tested for possible reversal of the impairment whenever events or changes in circumstances indicate that the impairment may have reversed.

(k) Intangible Assets

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

Information technology shared services rights
Taranaki District Health Board has provided funding for the development of information technology (IT) shared services across the DHB sector and the rights to the shared services is recognised as an intangible asset at the cost of Taranaki District Health Boards share of investment.

Amortisation
The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life. Amortisation begins when the asset is available for use and ceases at the date that the asset is derecognised. The amortisation charge for each financial year is recognised in the statement of comprehensive revenue and expense.

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

(m) Finance Leases
The determination of whether an arrangement is or contains a lease is based on the substance of the arrangement and requires an assessment of whether the fulfilment of the arrangement is dependent on the use of a specific asset or assets and the arrangement conveys a right to use the asset.

Finance leases, which transfer to Taranaki District Health Board substantially all the risks and benefits incidental to ownership of the leased item, are capitalised at the inception of the lease at the fair value of the leased asset or, if lower, at the present value of the minimum lease payments. Lease payments are apportioned between the finance charges and reduction of the lease liability so as to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised as an expense in profit or loss.

(n) Operating Leases
Operating lease payments are recognised as an expense in the statement of comprehensive revenue and expense on a straight-line basis over the lease term.

(o) Trade and Other Payables
Trade payables and other payables are carried at amortised cost. They represent liabilities for goods and services provided to Taranaki District Health Board prior to the end of the financial year that are unpaid and arise when Taranaki District Health Board becomes obliged to make future payments in respect of these goods and services. The amounts are unsecured and generally paid within 30 days of recognition.

All trade and other payables are exchange transactions.

(p) Interest-bearing Loans and Borrowings
All loans and borrowings are initially recognised at fair value less transaction costs. After initial recognition, all borrowings are measured at amortised cost using the effective interest method.

Borrowings are classified as current liabilities unless Taranaki District Health Board has an unconditional right to defer settlement of the liability for at least 12 months after balance date.

Borrowing costs directly attributable to the acquisition, construction or production of a qualifying asset (i.e. an asset that necessarily takes a substantial time to get ready for its intended use) are capitalised as part of the that asset. All other borrowing costs are expensed in the period they occur. Borrowing costs consist of interest and other costs that an entity incurs in connection with the borrowing of funds.

All loans and borrowings were converted to equity in 2017. Refer to note 27 for further detail.

(q) Employee Leave Benefits

Short-term benefits
Employee benefits that Taranaki District Health Board expects to be settled within 12 months of the reporting date are measured at nominal values based on accrued entitlements at current rates of pay.

These include (i) salaries and wages accrued up to balance date, (ii) annual leave earned to, but not yet taken at balance date, (iii) continuing medical education, (iv) retiring and long-service leave entitlements (v) sabbatical leave expecting to be settled within 12 months, and (vi) sick leave. Taranaki District Health Board recognises a liability for sick leave. The amount is calculated based on the unused sick leave entitlement that can be carried forward at balance date, to the extent that Taranaki District Health Board anticipates it will be used by staff to cover those future absences.

Long-term benefits
Entitlements that are payable beyond 12 months are calculated and included here.

Long service leave and retirement gratuities are calculated based on the probability of long service leave being liable after employees achieve certain service periods.

Sabbatical leave is calculated based on employee entitlements to this leave against what has been used historically.

(r) Provisions
Taranaki District Health Board recognises a provision for future expenditure of uncertain amount or timing when there is a present obligation (either legal or constructive) as a result of a past event, it is probable that expenditures will be required to settle the obligation and a reliable estimate can be made of the amount of the obligation.

ACC Partnership Program
Taranaki District Health Board belongs to the ACC Partnership Program whereby Taranaki District Health Board accepts the management and financial responsibility of work related illnesses and accidents of employees. Under the ACC Partnership Program Taranaki District Health Board is effectively providing accident insurance to employees and this is accounted for as an insurance contract. The value of this liability represents the expected future payments in relation to accidents and illnesses occurring up to balance date for which Taranaki District Health Board has responsibility under the terms of the Partnership Program. The liability for claims reported prior to balance date has been determined by an assessment from Taranaki District Health Board's workplace claims provider.

(s) Income Tax
Taranaki District Health Board is a public authority 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.

(t) Goods and Services Tax (GST)
The Financial Statements have been prepared exclusive of goods and services tax (GST) apart from receivables and payables which are stated inclusive of GST. Where GST is irrecoverable as an input tax then it is recognised as part of the related asset or expense.

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

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

Commitments and contingencies are disclosed exclusive of GST.

(u) Standards, amendments and interpretations effective in the current period
PBE IPSAS 1
Going Concern Disclosures (Amendments to PBE IPSAS 1) [effective for reporting periods ending on or after 30 September 2020]. The standard required further disclosure where there are material uncertainties around the DHB's ability to continue as a going concern. Disclosure around the sector reform and the financial statements being prepared on a disestablishment basis has been reflected in these financial statements.

PBE IAS 12
Uncertainty over Income Tax Treatments Amendments to PBE IAS 12 [1 January 2020]. This standard has had no impact on the DHB in the current year.

PBE IPSAS 30
PBE Interest Rate Benchmark Reform (Amendments to PBE IPSAS 30) [1 January 2020]. This standard has had no impact on the DHB in the current year.

(v) Standards issued, not yet effective and not early adopted
PBE IPSAS 2
An amendment to PBE IPSAS 2 requires entities to provide disclosures that enable users of financial statements to evaluate changes in liabilities arising from financing activities, including both changes arising from cash flows and non-cash changes. This amendment is effective for reporting periods beginning on or after 1 January 2021, with early application permitted. This amendment will result in additional disclosures. Taranaki District Health Board has not early adopt the amendment.

PBE FRS 48
PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 Presentation of Financial Statements and is effective for reporting periods beginning on or after 1 January 2022, with earlier adoption permitted. The timing of TDHB adopting this standard will be guided by the Treasury's decision on when the Financial Statements of the Government will adopt this standard. TDHB has not yet assessed the effect of this new standard.

PBE IPSAS 41
PBE IPSAS 41 replaces PBE IFRS 9 Financial Instruments and is effective for reporting periods beginning on or after 1 January 2022, with earlier adoption permitted. TDHB has assessed that there will be little change as a result of adopting the new standard as the requirements are similar to those contained in PBE IFRS 9. The timing of TDHB adopting this standard will be guided by the Treasury's decision on when the Financial Statements of the Government will adopt this standard.

1 REVENUE

	2021 $000	2020 $000
Health and disability services (Crown appropriation revenue)*	441,191	403,805
ACC revenue	8,170	6,484
Inter District Patient Inflows	6,148	5,125
Interest received	35	45
Dividends received	59	71
Bad debts recovered	6	5
Other revenue	4,802	4,141
	460,411	419,676

*Performance against this appropriation is reported in the Statement of Performance on pages 46-73. The appropriation revenue received by Taranaki District Health Board equals the Government's actual expenses incurred in relation to the appropriation, which is a required disclosure from the Public Finance Act.

(a) Revenue from Exchange Transactions and non-exchange transactions

	2021 $000	2020 $000
Non-exchange transactions	444,333	406,481
Exchange transactions	16,078	13,195
	460,411	419,676

2 OTHER INCOME

	2021 $000	2020 $000
Donations and bequests received	2,314	218
Gain on sale of property, plant and equipment	32	30
	2,346	248

(a) Other income from Exchange Transactions and non-exchange transactions

	2021 $000	2020 $000
Non-exchange transactions	2,314	218
Exchange transactions	32	30
	2,346	248

3 EMPLOYEE BENEFIT COSTS

	2021 $000	2020 $000
Wages and salaries	179,497	160,650
Contributions to defined contribution schemes	2,300	2,228
Increase in employee benefits provisions	12,826	7,172
	194,623	170,050

4 OTHER EXPENSES

	2021 $000	2020 $000
Impairment for credit losses on receivables	121	5
Loss on sale of property, plant and equipment	-	20
Audit fees - Deloitte Limited (for the audit of the annual financial statements)	199	193
Audit fees - ACC Accreditation Audit	6	6
Board and Advisory members fees	332	302
Operating lease expenses	573	424
	1,231	950

5 CAPITAL CHARGE

District Health Boards are required to pay a capital charge to the Crown based on the greater of its actual or budgeted closing equity at year end, less adjustments for donated assets. The capital charge rate for the period ended 30 June 2021 was 5% (2020: 6%).

6 FINANCING COSTS

	2021 $000	2020 $000
Interest - NZ Health Partnerships Limited	32	43
	32	43

7 CASH AND CASH EQUIVALENTS

	2021 $000	2020 $000
Cash at bank and in hand	401	390
Demand funds with NZ Health Partnerships Limited	(5,764)	(12,670)
Cash and cash equivalents	(5,363)	(12,280)
Made up of:		
Asset	401	390
Liability	(5,764)	(12,670)
	(5,363)	(12,280)

Cash at bank earns interest at floating rates based on daily bank deposit rates. The carrying amounts of cash and cash equivalents represent fair value.

Working Capital Facility

Taranaki District Health Board is party to the "DHB Treasury Services Agreement" between New Zealand Health Partnerships Limited (NZHP) and the participating DHB's. The agreement enables NZHP to sweep DHB bank accounts and invest surplus funds on their behalf. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with NZHPL, which will incur interest at the on-call interest rate received by NZHPL plus an administrative margin. The maximum working capital facility limit for Taranaki District Health Board at 30 June 2021 is $ 20.9m (2020: $ 19.0m).

8 TRADE AND OTHER RECEIVABLES

	2021	2020
	$000	$000
Ministry of Health	9,943	6,132
GST Refund Due	987	-
Due from associates	195	329
Due from non-related parties	7,161	7,517
Prepayments	1,485	1,528
	19,771	15,506
Allowance for credit loss (a)	(176)	(79)
Carrying amount of trade and other receivables	19,595	15,427

(a) Allowance for Credit Loss

Trade receivables are non-interest bearing and are generally on terms of 20th of month following invoice. An allowance for credit loss is calculated on non commercial debt based on the balance in age bands of the debts as follows: over 30 days (10%), over 60 days (50%), over 90 days (50%).

30 June 2021

	Receivable days past due				
	Current	More than 30 days	More than 60 days	More than 90 days	Total
Expected credit loss rate	0.0%	0.0%	0.2%	61.4%	
Gross carrying amount ($000)	18,771	64	651	285	19,771
Lifetime expected credit loss ($000)	-	-	1	175	176

30 June 2020

	Receivable days past due				
	Current	More than 30 days	More than 60 days	More than 90 days	Total
Expected credit loss rate	0.0%	0.0%	2.8%	34.8%	
Gross carrying amount ($000)	15,211	35	36	224	15,506
Lifetime expected credit loss ($000)	-	-	1	78	79

	2021	2020
	$000	$000
Allowance for credit losses as at 1 July	79	103
Increase in loss allowance made during the year	121	5
Receivables written off during the year	(24)	(29)
	176	79

	2021	2020
	$000	$000
Total non commercial debt	318	210
Non commercial debt with no expected credit loss	142	131

Non-commercial debt relates to amounts owing from individuals, rather than commercial entities.

Other balances within trade and other receivables do not contain impaired assets and are not past due. It is expected that these other balances will be received when due.

(b) Receivables from exchange and non-exchange transactions

	2021	2020
	$000	$000
Non-exchange transactions	9,943	6,132
Exchange transactions	9,652	9,295
	19,595	15,427

Bulk funding received from the Ministry of Health is received in the month it relates to.

(c) Related Party Receivables

For specific amounts owing from related parties, including associate companies refer to note 20.

(d) Credit Risk and Effective Interest Rate Risk

Details regarding the credit risk and effective interest rate of current receivables is disclosed in note 22.

9 INVENTORIES

	2021	2020
	$000	$000
Pharmaceuticals	683	567
Surgical and Medical Supplies	2,355	2,499
Other Supplies	1,094	924
	4,132	3,990

Inventory recognised as an expense for the year ended 30 June 2021 totalled $ 33.716m (2020: $29.638m)

The write-down of inventories held for distribution amounted to $0.164m (2020 $0.083m). There have been no reversals of write-downs.

No inventories are pledged as security for liabilities.

10 OTHER FINANCIAL ASSETS

	2021	2020
	$000	$000
Non-current portion		
Shares in CDC Pharmaceuticals Limited	56	56
Retentions held	136	-
	192	56

The retentions deducted from progress claims on Project Maunga stage 2 are held in Govett Quilliam, Taranaki District Health Board's solicitors trust account

11 INVESTMENT IN ASSOCIATE COMPANIES

	2021	2020
(a) Investment details	$000	$000
Allied Laundry Services Limited unlisted ordinary shares	1,150	1,150
Allied Laundry Services Limited Share of Retained Earnings	199	64
HealthShare Limited unlisted ordinary shares	-	-
HealthShare Limited Share of Retained Earnings	535	429
	1,884	1,643

Taranaki District Health Board's share of retained earnings in 2021 relates to the year ended June 2020, plus $107k (2020: $14k deficit) for 20% share of HealthShare Limited's unaudited 2021 surplus, plus $ 127k (2020: $ Nil) for Dividends accrued for Allied Laundry Services Limited not declared or paid.

Details of each Associate Company are as follows:	**Balance date**	**Interest held at 30 June 2021**	**Interest held at 30 June 2020**
HealthShare Limited	30 June	20%	20%

HealthShare Limited is a limited liability company registered in New Zealand. It is an unlisted company, and therefore there are no published market prices for this investment.

HealthShare Limited provides contract processing, auditing services and regional initiatives for the 5 Midland Region District Health Boards.

Allied Laundry Services Limited	30 June	16.67%	16.67%

Allied Laundry Services Limited is a limited liability company registered in New Zealand. It is an unlisted company, therefore there are no published market prices for this investment.

Allied Laundry Services Limited principal activity is the provision of laundry services.

(b) Summary of financial information of associate companies (100%)

Summarised financial information - for the year ended 30 June 2021:	**Assets**	**Liabilities**	**Equity**	**Revenues**	**Profit**
	$000	$000	$000	$000	$000
Allied Laundry Services Limited	13,026	4,651	8,375	13,031	626
HealthShare Limited	37,274	33,909	3,365	21,352	1,205

Summarised financial information - for the year ended 30 June 2020:	**Assets**	**Liabilities**	**Equity**	**Revenues**	**Profit**
	$000	$000	$000	$000	$000
Allied Laundry Services Limited	9,786	2,150	7,636	11,761	765
HealthShare Limited	37,604	35,460	2,144	18,630	(72)

(c) Movements in the carrying value of investments in associates:

This is based on an investment in HealthShare Limited of 20% (2020: 20%) and Allied Laundry Services Limited of 16.67% (2020: 16.67%)

	2021 $000	2020 $000
Balance at 1 July	1,643	1,632
Share of total recognised revenues and expenses	115	11
Dividends accrued per shareholders agreement not declared or paid	126	-
Balance at 30 June	1,884	1,643

*the share of total recognised revenue and expenses has been based on preliminary results and will differ slightly to actual results above

12 PROPERTY, PLANT AND EQUIPMENT

	Freehold Land $000	Freehold Buildings $000	Plant and Equipment $000	Motor Vehicles $000	Work in Progress $000	Total $000
Year ended 30 June 2020						
Cost/revaluation 30 June 2020	13,809	169,743	115,025	3,330	29,634	331,541
Accumulated depreciation 30 June 2020	-	(15,911)	(93,825)	(1,910)	-	(111,646)
Carrying amount 30 June 2020	13,809	153,832	21,200	1,420	29,634	219,895
Current year additions	-	-	-	-	34,349	34,349
Current year work in progress capitalised	-	3,329	3,604	75	(7,008)	-
Current year revaluations	3,526	12,035	-	-	-	15,561
Current year disposals		(313)	(1)	-	-	(314)
Current year depreciation		(8,084)	(7,248)	(229)	-	(15,561)
At 30 June 2021 net of accumulated depreciation	17,335	160,799	17,555	1,266	56,975	253,930
At 30 June 2021						
Cost or fair value	17,335	160,799	117,781	3,235	56,975	356,125
Accumulated depreciation		-	(100,226)	(1,969)	-	(102,195)
	17,335	160,799	17,555	1,266	56,975	253,930

	Freehold Land $000	Freehold Buildings $000	Plant and Equipment $000	Motor Vehicles $000	Work in Progress $000	Total $000
Year ended 30 June 2020						
Cost/revaluation 30 June 2019	12,555	168,162	111,549	3,283	18,691	314,240
Accumulated depreciation 30 June 2019	-	(7,913)	(88,078)	(1,724)	-	(97,715)
Carrying amount 30 June 2019	12,555	160,249	23,471	1,559	18,691	216,525
Current year additions	-	-	-	-	20,189	20,189
Current year work in progress capitalised	1,254	1,581	6,282	129	(9,246)	-
Current year disposals	-	-	(20)	-	-	(20)
Current year depreciation	-	(7,998)	(8,533)	(268)	-	(16,799)
At 30 June 2020 net of accumulated depreciation	13,809	153,832	21,200	1,420	29,634	219,895
At 30 June 2020						
Cost or fair value	13,809	169,743	115,025	3,330	29,634	331,541
Accumulated depreciation	-	(15,911)	(93,825)	(1,910)	-	(111,646)
	13,809	153,832	21,200	1,420	29,634	219,895

In the year end 30 June 2021, there are no claims (2020: $Nil) outstanding which relates to completed remedial work.

Restrictions

Taranaki District Health Board does not have full title to Crown land it occupies but transfer is arranged if and when land is sold. Some of the land may be subject to Waitangi Tribunal claims. The disposal of certain properties may be subject to the provision of section 40 of the Public Works Act 1981.

Titles to land transferred from the Crown to Taranaki District Health Board may be subject to claims under the terms of the Treaty of Waitangi Act 1975 (as amended by the Treaty of Waitangi (State Enterprises) Act 1988). The Board is of the view that the effect on the value of assets resulting from potential claims under the Treaty of Waitangi Act 1975 is not significant.

Valuation

Land and buildings were independently valued as at 30th June 2021 by Mike Drew BBS (VPM) ANZIV, MPINZ, registered valuer Telfer Young (Taranaki) Limited.

The valuation process was undertaken in accordance with guidelines and recommendations contained within the New Zealand Property Institute (NZPI) Valuation Standard VS-3, the Accounting Standard PBE IPSAS 17 as issued by External Reporting Board (XRB), and valuation guidelines for specialised items in the Health sector issued by Treasury.

Land has been valued at fair value on the basis of highest and best use. Consideration has been given to the open market value of the land, but acknowledging any steps that would be required to prepare it for sale.

Buildings have been valued on an Optimised Depreciated Replacement Cost (ODRC) basis as they are specialised in nature. Optimisation has been applied for obsolescence and relevant surplus capacity, and has been considered as part of the valuation process for buildings.

ODRC is a method to arrive at an alternative where there is no market value for specialised properties. It is commonly applied to the valuation of property where there is no active market.

The ODRC approach has included assessment of recent contracts carried out in the market, reference materials supplied by Rawlinsons (quantity surveying business), referral to the building, as well as knowledge of the construction market and the type and nature of the buildings.

Impairment

The assessment of assets indicated no impairment for the year ended 30 June 2021 (2020: Nil).

13 INTANGIBLE ASSETS

	ePharmacy Licence	Shares in NZ HPL	Total
	$000	$000	$000
Year ended 30 June 2021			
Carrying amount 30 June 2020	196	1,230	1,426
Additions for year	-	154	154
Amortisation charge for year	(107)	(184)	(291)
At 30 June 2021 net of accumulated amortisation	89	1,200	1,289
At 30 June 2021			
Cost or fair value	747	2,230	2,977
Accumulated amortisation and impairment	(658)	(1,030)	(1,688)
	89	1,200	1,289

	ePharmacy Licence	Shares in NZ HPL	Total
	$000	$000	$000
Year ended 30 June 2020			
Carrying amount 30 June 2019	303	812	1,115
Additions for year	-	418	418
Impairment for year	-	-	-
Amortisation charge for year	(107)	-	(107)
At 30 June 2020 net of accumulated amortisation	196	1,230	1,426
At 30 June 2020			
Cost or fair value	747	2,076	2,823
Accumulated amortisation and impairment	(551)	(846)	(1,397)
	196	1,230	1,426

Finance Procurement Supply Chain, including Finance Procurement and Information Management System

At 30 June 2021 Taranaki District Health Board had made payments totalling $2,230k (2020: $2,076k) in relation to the Finance, Procurement and Supply Chain (FPSC) programme. This is a national initiative and is managed on behalf of DHBs by NZ Health Partnerships Limited (NZHP).

In return for these payments, Taranaki District Health Board gained rights to access the FPSC asset, which includes the Finance Procurement and Information Management System (FPIM) programme. In the event of the liquidation or dissolution of NZHP, Taranaki District Health Board shall be entitled to be paid from the surplus assets, an amount equal to their proportionate share of the liquidation value based on its proportional share of the total FPSC/FPIM rights that have been issued.

The FPSC/NOS rights have been tested independently for impairment by comparing the carrying value of the intangible asset to its depreciated replacement cost (DRC). As at 30th June 2021 there is considered to be an accumulated impairment and amortisation of $846k (2020: $846k) to Taranaki District Health Board's share of the DRC of the underlying FPSC/FPIM assets.

14 RESTRICTED ASSETS AND TRUST FUNDS

Restricted assets are funds donated and bequeathed for specific purposes. The use of these assets must comply with the specific terms of the sources from which the funds were derived.

	2021	2020
	$000	$000
Opening Balance	797	719
Funds Received	61	113
Interest Received	4	22
Funds Spent	(150)	(57)
Closing Balance Restricted Assets	712	797

	2021	2020
	$000	$000
Represented By:		
Cash at Bank	107	793
Short Term Deposits	600	-
Shares & Other	5	4
Total Restricted Assets	712	797

Restricted Assets and Trust Funds are shown as non current assets in the statement of financial position. This is because it is the intention of the Taranaki District Health Board Trust to not dispose of its investments, with revenue earnt on those investments dispersed against funding requests.

15 TRADE AND OTHER PAYABLES

	2021 $000	2020 $000
Trade Payables	24,712	18,072
Income received in advance	3,864	2,254
Owing to Associates	1,406	517
GST Payable	-	252
	29,982	21,095

Most trade and other payables are non-interest bearing. The exception is capital charge paid to the Ministry of Health. Capital charges are paid six monthly in arrears against invoices raised by the Ministry of Health at the end of December and June.

16 EMPLOYEE BENEFITS

	2021 $000	2020 $000
Salary & wages accrual	11,728	9,698
Annual Leave	36,786	27,169
Sick Leave	552	516
Long Service Leave	2,501	2,326
Retirement gratuities	550	571
Continuing Medical Education	3,935	2,965
Sabbatical Leave	343	322
	56,395	43,567
Made up of:		
Current	55,020	42,292
Non-current	1,375	1,275
	56,395	43,567

Compliance with Holidays Act 2003

Details regarding the provision for underpayments relating to this Act are disclosed in note 23.

The private and public sector have experienced widespread payroll issues relating top the Holiday's Act and employment agreements. This is particularly for a workforce with rostered employees working on varying work patterns. A proactive approach to finding a long term pay process solution is currently being undertaken by management to identify risk areas focusing on systems, reporting & analytics, people and processes.

Since the issues are currently being reviewed the holiday pay provision recognised is estimated based on the best information available at the date of the annual report. Once the issues have been resolved the actual liability may be different. Taranaki District Health Board estimates the impact over the last nine years to be $10.0m (2020: $3.10m). The provision has increased by $ 6.9m from the previous year. As outlined in note 23, the remediation project has advanced, the increase in the provision is attributed to more information being made available to Taranaki District Health Board to enable a refinement to the prior year liability.

17 PROVISIONS

	2021 $000	2020 $000
Current provisions		
ACC Partnership Programme	33	61
Other Provisions	-	1,078
	33	1,139

The liability valuation on the ACC Partnership Program has been calculated by Aon New Zealand Limited as at 30 June 2021. All outstanding claims by Taranaki District Health Board's employees are estimated by claim managers as at this point.

18 RECONCILIATION OF NET LOSS WITH CASH OUTFLOW FROM OPERATING ACTIVITIES

	2021 $000	2020 $000
Net Loss	(22,762)	(28,628)
Add Non-Cash Items:		
Depreciation	15,561	16,799
Amortisation and impairment of Intangible assets	291	107
Increase/(Decrease) in Provision for Doubtful Debts	97	(24)
Increase in Employee Entitlements and Employee provisions	11,718	8,135
	27,667	25,017
Add back items classified as investment/financing activities:		
Decrease/(Increase) in Investments Held	(185)	(79)
Net (Gain) / Loss on Disposal of property, plant and equipment	(32)	(10)
	(217)	(89)
Movements in Working Capital:		
(Increase) in Receivables & Prepayments	(3,277)	(776)
(Increase) in Inventories	(142)	(513)
Increase in Income in Advance	1,610	1,715
Increase in Payables & Accruals	6,232	(3,882)
	4,423	(3,456)
Net Cash Inflow from Operating Activities	9,111	(7,156)

19 RELATED PARTIES - KEY MANAGEMENT PERSONNEL

	2021 $000	2020 $000
Board Members		
Remuneration	332	302
Full-time equivalent members	1.4	1.5
Executive management		
Remuneration	2,182	2,238
Full-time equivalent employees	8.4	9.0
Total key management personnel remuneration	2,514	2,540
Total full-time equivalent personnel	9.8	10.5

20 RELATED PARTY TRANSACTIONS

Taranaki District Health Board is a wholly owned entity of the Crown. All related party transactions have been entered into on an arm's length basis.

Transactions with other government agencies are not disclosed as related party transactions when they are consistent with the normal operating arrangements between government agencies and undertaken on the normal terms and conditions for such transactions.

Related Party Transactions and Balances

(a) Funding

Taranaki District Health Board received $441.941m from the Ministry of Health to provide health services to the Taranaki area (2020: $403.805m). The amount outstanding at year end was $9.943m (2020: $6.132m).

(b) Inter-Group Transactions and balances:

Taranaki District Health Board charged the following expenses during the year for services performed, administration, rental, general facility services, and interest received and had the following balances at year end:

		Owed to TDHB		Income to TDHB	
		2021	2020	2021	2020
		$000	$000	$000	$000
	TDHB Transactions				
Allied Laundry Services Limited	Dividend and board fees	1	70	15	84
NZ Health Partnerships Limited	DHB national collective service agreements	-	-	-	-
Healthshare Limited	IT consultancy	193	259	889	582
		194	329	904	666

Taranaki District Health Board incurred the following expenses during the year for services performed and had the following outstanding balances at year end:

	Owed by TDHB		Payments by TDHB	
	2021	2020	2021	2020
	$000	$000	$000	$000
Allied Laundry Services Limited	133	119	1,321	1,194
NZ Health Partnerships Limited	77	170	1,041	1,296
Healthshare Limited	1,273	398	4,051	3,246
	1,483	687	6,413	5,736

Board Member Fees paid to Board Members of the above Associates are included in the Annual Report under Board Fees.

21 FINANCIAL INSTRUMENT CATEGORIES

The carrying amounts of financial instruments categorised are as follows, together with fair values:

		Carrying amount	Fair value	Carrying amount	Fair value
		2021	2021	2020	2020
FINANCIAL ASSETS	**Notes**	$000	$000	$000	$000
Amortised cost					
Cash and cash equivalents	7	401	401	390	390
Trade and other receivables	8	17,123	17,123	13,899	13,899
Other financial assets - non current	10	192	192	56	56
Restricted Assets and Trust Funds	14	712	712	797	797
Total amortised cost		18,428	18,428	15,142	15,142

Trade and other receivables does not include GST refunds due from the IRD

		Carrying amount 2021	Fair value 2021	Carrying amount 2020	Fair value 2020
FINANCIAL LIABILITIES	**Notes**	$000	$000	$000	$000
Financial liabilities at amortised costs					
Cash and cash equivalents	7	5,764	5,764	12,670	12,670
Trade and other payables	15	26,118	26,118	18,589	18,589
Total financial liabilities		31,882	31,882	31,259	31,259

The fair value of all of the above financial instruments approximately equal their carrying value.

The value of Trade and other payables excludes income received in advance and GST payable.

22 FINANCIAL INSTRUMENT RISKS

Taranaki District Health Board's activities expose it to a variety of financial instrument risks, including market risk, credit risk and liquidity risk.

(a) Market Risk

Fair value interest rate risk

Fair value interest rate risk is the risk that the value of a financial instrument will fluctuate due to changes in market interest rates. Taranaki District Health Board's exposure to fair value interest rate risk is limited to its fixed interest borrowings and bank deposits. However, because these borrowings and bank deposits are not accounted for at fair value, fluctuations in interest rates do not have an impact on the surplus / deficit of Taranaki District Health Board or the carrying amount of the financial instruments recognised in the statement of financial position.

Cash flow interest rate risk

Cash flow interest rate risk is the risk that the cash flows from a financial instrument will fluctuate because of changes in market interest rates. Borrowings and investments issued at variable interest rates expose Taranaki District Health Board to cash flow interest rate risk.

Taranaki District Health Board deposits surplus funds with a spread of maturity dates to limit exposure to short term interest rate movements.

Taranaki District Health Board spreads the maturity of term borrowings to limit the exposure to short term interest rate movements.

Currency risk

Currency risk is the risk that the value of a financial instrument will fluctuate due to changes in foreign exchange rates. Taranaki District Health Board is exposed to foreign currency risk on minor purchases for goods and services which require it to enter into transactions in foreign currencies. Transactions in foreign currencies are translated at the foreign exchange rate at the date of the transaction. As a result of this Taranaki District Health Board has limited exposure to currency risk.

(b) Credit Risk

Credit risk is the risk that a 3rd party will default on its obligations to Taranaki District Health Board, causing a loss to be incurred.

Due to the timing of its cash inflows and outflows, Taranaki District Health Board invests surplus cash into term deposits with registered banks.

Taranaki District Health Board maximum credit exposure for each class of financial instrument is represented by the total carrying amount of cash equivalents (note 7), net trade receivables (note 8) and other financial assets (note 10).

Taranaki District Health Board has no significant concentration of credit risk as government sourced revenue for Taranaki District Health Board was 97% (2020: 98%) whilst it accounted for 97% (2020: 97%) of receivables.

(c) Liquidity Risk

Liquidity risk is the risk that Taranaki District Health Board will encounter difficulty raising liquid funds to meet commitments as they fall due. Prudent liquidity risk management implies maintaining sufficient cash, the availability of funding through an adequate amount of committed credit facilities and the ability to close out market positions.

In general, Taranaki District Health Board generates sufficient cash flows from its operating activities to meet its obligations arising from its financial liabilities and can break term deposits with financial institutions if required.

(d) Contractual Liquidity Table

2021

The following table sets out the contractual cash flows for all financial liabilities:

	Carrying value	Contractual Cash Flows	0-3 months	3-12 months	1-3 years	3-8 years
	$000	$000	$000	$000	$000	$000
Non-derivative financial liabilities						
Trade and other payables	26,118	26,118	26,118	-	-	-
	26,118	26,118	26,118	-	-	-

2020

The following table sets out the contractual cash flows for all financial liabilities:

	Carrying value	Contractual Cash Flows	0-3 months	3-12 months	1-3 years	3-8 years
	$000	$000	$000	$000	$000	$000
Non-derivative financial liabilities						
Trade and other payables	18,589	18,589	18,589	-	-	-
	18,589	18,589	18,589	-	-	-

(e) Sensitivity Analysis

The following sensitivity analysis is based on the interest rate risk exposures in existence on term deposits at the reporting date. Sensitivity on term debt has been excluded as they are at fixed rates.

Judgements of reasonably possible movements

	Surplus for the period	
	Higher/(lower)	
	2021	2020
	$000	$000
+1% (100 basis points)	-	-
-1% (100 basis points)	-	-

23 CONTINGENT LIABILITIES AND COMPLIANCE WITH HOLIDAY PAY ACT 2003

Taranaki District Health Board sometimes has claims that have been made by or against Taranaki District Health Board in the ordinary course of business. The Board Members consider the outcome of these claims will not have a material adverse affect on the financial position of Taranaki District Health Board.

A number of New Zealand's public and private organisations have identified issues with the calculation of leave entitlements under the Holidays Act 2003 ("the Act").

Work has been ongoing since 2016 on behalf of 20 DHB's and the New Zealand Blood Service (NZBS), with the Council of Trade Unions (CTU), health sector unions and Ministry of Business Innovation and Employment (MBIE) Labour Inspectorate, for an agreed and national approach to identify, rectify and remediate any Holidays Act non-compliance by DHB's. DHB's have agreed to a Memorandum of Understanding (MOU), which contains a method for determination of individual employee earnings, for calculation of liability for any historical non-compliance.

For employers such as the DHBs that have workforces that include differential occupational groups with complex entitlements, non-standard hours, allowances and/or overtime, the process of assessing non-compliance with the Act and determining any additional payment is time consuming and complicated.

The remediation project associated with the MOU is a significant undertaking and work to assess all non-compliance will continue through the 2020/21 financial year. The review process agreed as part of the MOU will roll-out in tranches to the DHBs and NZBS, expected to be over 2 years although DHB readiness and availability of resources (internal and external to the DHB) may determine when a DHB can commence the process. The final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed.

Notwithstanding, as at 30 June 2021, in preparing these financial statements, Taranaki District Health Board recognises it has an obligation to address any historical non-compliance under the MOU and has made estimates and assumptions to determine a potential liability based on its own review of payroll processes which identified instances of non-compliance with the Act and the requirements of the MOU. This was based on selecting a sample of current and former employees; making a number of early assumptions; calculating an indicative liability for those curent and former employees; and extrapolating the result.

This indicative liability amount is the DHBs best estimate at this stage of the outcome from this project. However, until the project has progressed further, there remains substantial uncertainties. To arrive at this estimate Taranaki District Health Board has used information collated by the Ministry of Health where the provision should be in the range of 0.3% to 0.8% of annual gross payroll over the nine year period

The estimates and assumptions may differ to the subsequent actual results as further work is completed and result in further adjustment to the carrying amount of the provision liabilities within the next financial year.

Taranaki District Health Board has applied the intent of the Memorandum of Understanding in determining the provisioning of $10.0 million of Holidays Act costs as at 30 June 2021 (2020: $3.1m). The $ 10m Holiday Act Provision is included as an Employee Benefits per Note 16. There is still work to be completed to finalise the value of the full cost.

24 CAPITAL COMMITMENTS AND OPERATING LEASES

	2021	2020
	$000	$000
Capital Commitments		
Property, plant and equipment	64,654	1,271
	64,654	1,271

Project Maunga Stage 2 accounts for $ 63.70m (2020: $ Nil) of the capital commitments as at 30 June 2021, with this projected to be all spent within the 2021-22 financial year.

Operating leases as lessee

Taranaki District Health Board leases buildings and equipment. The equipment non-cancellable leases typically range from 3 to 5 years.

	2021	2020
	$000	$000
Not later than one year	570	323
Later than one and not later than two years	321	138
Later than two and not later than five years	763	116
Later than five years	66	80
	1,720	657

25 MAJOR VARIATIONS FROM BUDGET (unaudited)

Income Statement Variances - Revenue

Taranaki District Health Board recorded a deficit of $22.76 million compared to a budgeted deficit of $12.01 million.

Revenue received during the year was $16.85 million over budget as follows (2020 $6.45m increased):

	Variance 2021	Variance 2020
	$000	$000
Health and disability services (Crown appropriation revenue)	12,635	6,415
Accident Compensation Revenue (ACC)	1,533	290
Inter District Flows	477	68
Inter Provider Revenue	27	(48)
Interest Received	25	45
Donations Received	911	(288)
Other	1,241	(37)
	16,849	6,445

Income Statement Revenue Explanations

Health and disability services (Crown appropriation revenue)	Funding for the impact of COVID-19, plus other additional funding programmes that were not budgeted
Accident Compensation Revenue (ACC)	Increased activity, offset by associated increased expenditure
Donations Received	Donation related to Project Maunga received all in the one year
Other	Haemophilia Pool revenue and additional contracts with third parties

Income Statement Variances - Expenditure

Expenditure was $27.720m in excess of budget as follows (2020: $17.061m):

	Variance 2021 $000	Variance 2020 $000
Income Statement Expenditure Explanations		
Employee Benefit costs	18,741	11,325
Depreciation expense	(2,405)	(1,804)
Outsourced services	6,690	2,736
Clinical supplies	182	(375)
Infrastructure and non-clinical expenses	3,603	5,825
Payments to non-health board providers	2,244	90
Other	(1,335)	(736)
	27,720	17,061

Income Statement Expenditure Explanations

Employee Benefit costs	Additional staffing to meet increased acute demand, one on one patient care, compliance with MECA provisions, and increased wage settlements over budget assumptions
Depreciation expense	Due to timing of capital investment
Outsourced services	Increased activity especially delayed surgery due to Covid and vacancies
Infrastructure and non-clinical expenses	Lower realisation of gains against the savings plan
Payments to non-health board providers	Costs incurred related to the impact of COVID-19

	Variance 2021 $000	Variance 2020 $000
Balance Sheet Variances		
Cash and cash equivalents	1,749	(12,045)
Trade and other receivables	3,348	1,717
Property, plant and equipment	29,964	6,325
Intangible assets	(311)	(1,396)
Trade and other payables	3,693	(3,961)
Employee benefits	11,322	5,795

Balance Sheet Explanations

Trade and other receivables	Additional invoicing for Covid related revenue
Property, plant and equipment	Hospital redevelopment and the impact of land and building revaluation
Trade and other payables	Project Maunga expenditure and timing of NGO payments
Employee benefits	Additional employees, and increased provision for the Holidays Pay Act 2003 liability

26 AUDITORS' REMUNERATION

		2021	2020
		$000	$000
Fees to principal auditor (Deloitte Limited)	**Note**		
Audit of annual financial statements	4	199	193

		2021	2020
		$000	$000
Other Audit Fees paid (non Deloitte Limited)	**Note**		
ACC Accreditation Audit	4	6	6

27 CAPITAL MANAGEMENT

Taranaki District Health Board's capital is its equity, which comprises public equity, accumulated revenue and expense and asset revaluation reserve.

Taranaki District Health Board's policy and objectives of managing the equity is to ensure Taranaki District Health Board effectively achieves its goals and objectives, whilst maintaining a strong capital base. Taranaki District Health Board policies in respect of capital management are reviewed regularly by the governing Board.

From 15 February 2017, DHB's no longer have access to Crown debt financing and funding of capital investment. Instead, the Crown contributions to DHB capital will now be solely funded via Crown equity injections. In addition the existing Crown debt held by DHB's have also been converted to Equity.

Changes in public equity are as a result of the Crown either (i) injecting equity for specific funding, or (ii) requiring Taranaki District Health Board to repay equity as specified by the Crown.

During the year the Crown increased Equity by paying for Capital funding of $33.0m (2020 $ Nil) and Deficit Support Funding of $ Nil (2020: $18.0m). Public equity of $0.959m (2020: $0.958m) was repaid to the Crown during the year. The repayments in both 2021 & 2020 were to repay the Ministry of Health funding of additional depreciation expense on buildings revalued at 30 June 2006.

There have been no changes in Taranaki District Health Board's management of capital during the year.

28 EMPLOYEE REMUNERATION

Employees (excluding board members), including management and medical staff, receiving remuneration in excess of $100,000 per annum are as follows:

Remuneration Range	Actual 2021	Actual 2020
100,000 - 110,000	111	84
110,001 - 120,000	52	35
120,001 - 130,000	37	41
130,001 - 140,000	22	22
140,001 - 150,000	14	9
150,001 - 160,000	10	10
160,001 - 170,000	10	8
170,001 - 180,000	10	5
180,001 - 190,000	9	8
190,001 - 200,000	8	6
200,001 - 210,000	8	7
210,001 - 220,000	6	10
220,001 - 230,000	10	1
230,001 - 240,000	5	7
240,001 - 250,000	2	4
250,001 - 260,000	8	9
260,001 - 270,000	7	6
270,001 - 280,000	4	5
280,001 - 290,000	4	6
290,001 - 300,000	5	3
300,001 - 310,000	8	8
310,001 - 320,000	2	3
320,001 - 330,000	4	3
330,001 - 340,000	3	5
340,001 - 350,000	5	3
350,001 - 360,000	4	7
360,001 - 370,000	3	4
370,001 - 380,000	-	3
380,001 - 390,000	2	-
390,001 - 400,000	2	-
400,001 - 410,000	3	-
410,001 - 420,000	3	-
420,001 - 430,000	1	3
430,001 - 440,000	1	-
440,001 - 450,000	1	-
490,001 - 500,000	1	-
	385	325
Clinicians	328	282
Non Clinical	57	43
Total	385	325

If the remuneration of part time clinical staff was grossed up to a full time equivalent (FTE) basis, the total of employees with salaries of $100,000 or more would be 637 (2020: 486).

29 TERMINATION PAYMENTS

For the period to 30 June 2021, 6 employees or former employees of Taranaki District Health Board received payment in respect of termination of employment for $115,000 (2020: 11 payments totalling $268,700).

30 EVENTS SUBSEQUENT TO BALANCE DATE

(i) COVID-19

On 17 August 2021, a community case of COVID-19 was discovered in Auckland. The New Zealand Government implemented a nationwide full-lockdown of non-essential services on 18 August 2021, with Taranaki moving into level 2 on the 8 September 2021.

Taranaki District Health Board have assessed the impact of the novel coronavirus as part of its impairment testing of assets on the Statement of Financial Position at 30 June 2021. Whilst the impact of COVID-19 has not had a significant financial effect on asset values it has had an impact to the services the District Health Board has been able to provide the local community. COVID-19 has caused inevitable disruption and delays in services which will have longer term consequences. For further information on managing COVID-19, refer to page 40-41 for detail.

(ii) Health Sector Reform

Legislation will be enacted to disestablish Taranaki District Health Board on the 1 July 2022, following an announcement from the Minister of Health. Because of this the financials of Taranaki District Health Board have been prepared on a disestablishment basis, with more detail on the impact of this outlined in the above Accounting Policies.

Deloitte.

INDEPENDENT AUDITOR'S REPORT

TO THE READERS OF TARANAKI DISTRICT BOARD'S FINANCIAL STATEMENTS AND PERFORMANCE INFORMATION FOR THE YEAR ENDED 30 JUNE 2021

The Auditor-General is the auditor of Taranaki District Health Board (the Health Board). The Auditor-General has appointed me, Matt Laing, using the staff and resources of Deloitte Limited, to carry out the audit of the financial statements and the performance information, including the performance information for appropriations, of the Health Board on his behalf.

We have audited:

- the financial statements of the Health Board on pages 77 to 105, that comprise the statement of financial position as at 30 June 2021, the statement of comprehensive revenue and expense, statement of changes in net assets/equity and statement of cash flows for the year ended on that date, and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Health Board on pages 48 to 73.

Opinion

Qualified opinion on the financial statements

In our opinion, except for the possible effects of the matter described in the Basis for our qualified opinion section of our report, the financial statements of the Health Board on pages 77 to 105:

- present fairly, in all material respects:
    - its financial position as at 30 June 2021; and
    - its financial performance and cash flows for the year then ended; and
- comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards.

Unmodified opinion on the performance information

In our opinion, the performance information of the Health Board on pages 48 to 73:

- presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2021, including:
    - for each class of reportable outputs:
        - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
        - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
    - what has been achieved with the appropriation; and
    - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and
- complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 22 December 2021. This is the date at which our opinion is expressed.

The basis for our opinion is explained below, and we draw attention to other matters. In addition, we outline the responsibilities of the Board and our responsibilities relating to the financial statements and the performance information, we comment on other information, and we explain our independence.

Deloitte.

Basis for our opinion

The financial statements are qualified due to uncertainties over the provision for holiday pay entitlements under the Holidays Act 2003

As outlined in note 23 on page 100, the Health Board has been investigating issues with the way it calculates holiday pay entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues.

The provision for employee entitlements includes a provision of $10 million for the estimated amounts owed to current and past employees. Due to the complex nature of health sector employment arrangements, the Health Board's process is ongoing, and there is a high level of uncertainty over the amount of the provision. Because of the work that is yet to be completed, we have been unable to obtain sufficient appropriate audit evidence to determine if the amount of the provision is reasonable.

We were also unable to obtain sufficient appropriate audit evidence of the $3.1 million provision as at 30 June 2020. We accordingly expressed a qualified opinion on the financial statements for the year ended 30 June 2020.

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the Professional and Ethical Standards and the International Standards on Auditing (New Zealand) issued by the New Zealand Auditing and Assurance Standards Board. Our responsibilities under those standards are further described in the Responsibilities of the auditor section of our report.

We have fulfilled our responsibilities in accordance with the Auditor-General's Auditing Standards.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide the basis for our qualified opinion on the financial statements and the basis for our opinion on the performance information.

Emphasis of matters

Without further modifying our opinion, we draw attention to the following disclosures.

The financial statements have been appropriately prepared on a disestablishment basis

Note b on page 81, which outlines the health sector reforms announced by the Minister of Health on 21 April 2021. Legislation to disestablish all District Health Boards and establish a new Crown entity, is expected to come into effect on 1 July 2022. The Health Board therefore prepared its financial statements on a disestablishment basis. The values of assets and liabilities have not changed because these will be transferred to the new Crown entity.

The Health Board is reliant on financial support from the Crown

Note b(iii) on page 81, which outlines the Health Board's financial performance difficulties. There is uncertainty whether the Health Board will be able to settle its liabilities, including the estimated historical Holidays Act 2003 liability, if they were to become due within one year of approving the financial statements. The Health Board therefore obtained a letter of comfort from the Ministers of Health and Finance, which confirms that the Crown will provide the Health Board with financial support, where necessary.

HSU population information was used in reporting Covid-19 vaccine strategy performance results

Page 72 to 73 outlines the information used by the DHB to report on its Covid-19 vaccine coverage. The DHB uses the Health Service User (HSU) population data rather than the population data provided by Statistics New Zealand (Stats NZ), for the reasons set out on page 73. The notes on page 73 outlines that there would be differences in the reported results for the overall population if the Stats NZ population data was used. There would be further differences in the reported results of vaccination coverage if the Stats NZ population data is classified by ethnicity and age. The DHB has provided a table that highlights the differences in the ethnicity groupings between the HSU population data and the Stats NZ population data.

Impact of Covid-19

Note b(iv) on page 81-82 to the financial statements and page 72 and 73 of the performance information, which outline(s) the ongoing impact of Covid-19 on the Health Board.

Deloitte.

Responsibilities of the Board for the financial statements and the performance information

The Board is responsible on behalf of the Health Board for preparing financial statements and performance information that are fairly presented and comply with generally accepted accounting practice in New Zealand.

The Board is responsible for such internal control as it determines is necessary to enable it to prepare financial statements and performance information that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements and the performance information, the Board is responsible on behalf of the Health Board for assessing the Health Board's ability to continue as a going concern. The Board is also responsible for disclosing, as applicable, matters related to going concern and using the going concern basis of accounting, unless there is an intention to liquidate the Health Board or there is no realistic alternative but to do so.

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

Responsibilities of the auditor for the audit of the financial statements and the performance information

Our objectives are to obtain reasonable assurance about whether the financial statements and the performance information, as a whole, are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit carried out in accordance with the Auditor General's Auditing Standards will always detect a material misstatement when it exists. Misstatements are differences or omissions of amounts or disclosures, and can arise from fraud or error. Misstatements are considered material if, individually or in the aggregate, they could reasonably be expected to influence the decisions of readers taken on the basis of these financial statements and the performance information.

For the budget information reported in the financial statements and the performance information, our procedures were limited to checking that the information agreed to the Health Board's statement of performance expectations.

We did not evaluate the security and controls over the electronic publication of the financial statements and the performance information.

As part of an audit in accordance with the Auditor-General's Auditing Standards, we exercise professional judgement and maintain professional scepticism throughout the audit. Also:

- We identify and assess the risks of material misstatement of the financial statements and the performance information, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- We obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Health Board's internal control.

- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board.

- We evaluate the appropriateness of the reported performance information within the Health Board's framework for reporting its performance.

- We conclude on the appropriateness of the use of the going concern basis of accounting by the Board and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast a significant doubt on the Health Board's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements and the performance information or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Health Board to cease to continue as a going concern.

- We evaluate the overall presentation, structure and content of the financial statements and the performance information, including the disclosures, and whether the financial statements and the performance information represent the underlying transactions and events in a manner that achieves fair presentation.

- We obtain sufficient appropriate audit evidence regarding the financial statements and the performance information of the entities or business activities within the Health Board to express an opinion on the consolidated financial statements and the consolidated performance information. We are responsible for the direction, supervision and performance of the of the Health Board audit. We remain solely responsible for our audit opinion.

We communicate with the Board regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Our responsibilities arise from the Public Audit Act 2001.

Other Information

The Board is responsible for the other information. The other information comprises the information included on pages 4 to 45 and page 76, but does not include the financial statements and the performance information, and our auditor's report thereon.

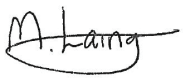
Our opinion on the financial statements and the performance information does not cover the other information and we do not express any form of audit opinion or assurance conclusion thereon.

In connection with our audit of the financial statements and the performance information, our responsibility is to read the other information. In doing so, we consider whether the other information is materially inconsistent with the financial statements and the performance information or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on our work, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Independence

We are independent of the Health Board in accordance with the independence requirements of the Auditor-General's Auditing Standards, which incorporate the independence requirements of Professional and Ethical Standard 1: *International Code of Ethics for Assurance Practitioners* issued by the New Zealand Auditing and Assurance Standards Board.

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



Matt Laing
Partner
for Deloitte Limited on behalf of the Auditor-General
Hamilton, New Zealand