

A vertical decorative Maori pattern (hau) in a dark blue-grey color runs down the left side of the page.

Taranaki District Health Board

Annual Report

2011-12



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

Our Shared Vision / Te Matakite



OUR AIMS

A Matou Wawata

- 🐣 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

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How We Work Together and With Others (Nga Tikanga)

Me Pehea nga mahi ngatahi me etahi atu

The actions and behaviours described below are how we aim to contribute to all our relationships including those with our patients, clients, whanau, funded agencies, staff and members of the public.

We will work together by:

-  Treating people with trust, respect and compassion
-  Communicating openly, honestly and acting with integrity
-  Enabling professional and organisational standards to be met
-  Supporting achievement and acknowledging successes
-  Creating healthy and safe environments
-  Welcoming new ideas

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Mary Bourke and Tony Foulkes sign the Project Maunga Construction Contract

Ngamotu Beach

INTRODUCTION BY CHAIR AND CHIEF EXECUTIVE

Welcome to the Annual Report for the Taranaki District Health Board for 2011/2012.

We would like to thank the Board and Committee members, who have generously offered their knowledge and skills. Our Māori relationship partner, the Te Whare Punanga Korero Trust representing the eight iwi of Taranaki, have provided members of our Committees, in addition to contributing to various planning activities, as they support the governance of the DHB and our goals of improving Māori health and reducing health inequalities.

Our effort in this critical area has continued with an increase in funding Māori specific services as we support initiatives to build capacity in the Māori health sector. The formation of the Te Kawau Maro Alliance by Tui Ora Ltd and the National Hauora Coalition to be the DHB's preferred provider of Maori health services is hugely significant. We are confident that this will encourage further innovation and enable the blending of skills and resources, all focused on improving the health of Taranaki Māori.

Overall services to the value of just under \$320m continued to be funded and provided for the people of Taranaki in the year. As we aim to balance high quality health services with our reducing proportion of the national population funding there continues to be real challenges. It is therefore pleasing to note that the consolidated financial result for the Board and associated companies was close to break even. This was significantly aided by the result for our planning and funding responsibility.

Balancing future budgets will need everyone to look at how we organise services with a willingness to change, to best serve our community.

The hospital and specialist services have continued to experience cost growth as complexity and demand for services increase. Nevertheless, we're proud of the team involved in these services who have done a tremendous job in delivering good quality care and in many instances more services with shorter waits than before, whilst also balancing the resources available.

The clinical and support teams throughout Taranaki have again exceeded many service level targets in both hospital and community based settings. New service models have been introduced such as the significantly improved community oral health services seeing more pre-school children and adolescents.

The Midland Health Network, primary health organisation has commenced an exciting programme of Integrated Family Health Centre development. This has the potential to be of real benefit to general practices and patients alike, and we hope progress will accelerate in the year ahead.

We've continued to improve the planning and management of staffing costs whilst also increasing new graduate clinical staff. Other workforce development initiatives through partnerships with schools and other agencies are investing in our workforce of the future, with a special focus on Māori.



Ceremony to mark the beginning of construction for Project Maunga

'Project Maunga' - Base Hospital Redevelopment has had a busy year of construction and we expect Taranaki people to be benefiting from new operating theatres, day stay services, and inpatient wards in mid 2013. These exciting developments will provide a better quality environment for patients and staff, improved patient flows, more capacity and a facility fit for purpose with new models of care for the future.

The following pages provide a brief snapshot of some of the exciting changes already underway, and the busy life of our health sector from the past year.

Taranaki has always been innovative and is constantly seeking different ways of doing things. We can be proud of this characteristic, which will be called upon with continuous collaboration between hospital and community based services. In this vein we look forward to new 24/7 Primary Options for Acute Care being developed in the year ahead.

A new enhanced intermediate care service for older people will help those who would otherwise have an extended hospital stay or enter residential care. Projects releasing nursing time to care; the development of stroke, dementia, and pre-admission pathways; and improved discharge planning, along with improved

productivity in operating theatres and other initiatives; will all improve our quality services and need to help with our financial performance.

We also want to accelerate the benefits of the national health IT plan for Taranaki patients. A new hospital clinical portal is being implemented, consolidation of laboratory and radiology results underway, e-referrals for GPs, and being a national pilot site for hospital e-medications management has enabled exciting developments at the leading edge of health IT. We have further to go however, as we strive to enable greater shared care for patients across the community.

Whilst the national Health Targets capture perhaps only a small part of what is necessary and important to our community's health – they do provide a focus for action and improved performance in priority health and disability areas. Taranaki has contributed to the significant progress made in these areas, and other indicators as shown in the Statement of Service Performance section of this report.

Partnership with other DHBs is very important to ensure we can provide access to appropriate care and treatment for Taranaki people, as well as avoiding duplication wherever possible and getting the best value

for money. We have high expectations that our investment with other DHBs in Health Benefits Limited will bring significant savings to the sector in coming years.

Our strong collaborative approach with other DHBs has also continued through our joint venture companies, including; HealthShare with Tairāwhiti, Bay of Plenty, Lakes and Waikato DHBs which audits services in personal health, mental health and health of older people, as well as now providing a joint service planning team; Allied Laundry Services providing a shared laundry with Whanganui, MidCentral and Hawkes Bay DHBs.

We are implementing our Regional Services Plan with four other 'Midland' DHBs, which we expect will help maintain access to more vulnerable services across the region and support the development of others. Our joint commitment in the past year with the Midland Iwi Relationship Board to coordinate efforts and provide leadership towards a Smokefree region will continue.

In the meantime, we'd like to say a big thank you to everyone who plays a part in working tirelessly day and night for our patients and community. We look forward to working with and for the people of Taranaki in the year ahead.

Mary Bourke
BOARD CHAIR

Tony Foulkes
CHIEF EXECUTIVE



PROJECT MAUNGA

More than just a new building

There are several areas of work being carried out within the Taranaki DHB that link to Project Maunga. Taranaki DHB is adopting these projects now to ensure Project Maunga is not just about a new building but a new way of doing things. These include:

The Productive Operating Theatre (TPOT)

TPOT is a modular improvement programme developed by the UK National Health Service. It helps theatre teams work more effectively together to improve the quality of patient experience, the safety and outcomes of surgical services, the effective use of theatre time and staff experience. Project Maunga will see the theatre suite, day surgery unit, medical day intervention unit, endoscopy suite and a minor procedures room all located on the one floor.

Our theatre staff have been working together to identify the areas that need improvements and over the next year will ensure new processes are tested and in place before they move into the new facility.

Releasing Time to Care (RTC)

A programme also developed by the UK National Health Service, RTC focuses on improving ward processes and environments to help nursing staff spend more time on patient care and improve safety and efficiency.

Taranaki Base Hospital Wards Two, Three, Four and the Intensive Care Unit are currently involved in this programme. Ward Five will be joining the list by the end of 2012.

RTC allows our nurses to identify any areas for improvements and then work together as a team to find the right solution.

E-Medication Management

Taranaki DHB is one of three pilot sites for electronic medication management in New Zealand, targeting electronic medicines reconciliation, e-prescribing, administration and dispensing.

Electronic medication management aims to reduce adverse medication events, improve efficiencies and decrease waste, while improving value. The programme is jointly sponsored by the Health Quality & Safety Commission, and the National Health Board/National Health IT Board. Taranaki DHB's Ward Five and Ward One are currently involved in this project.

Project Maunga is progressing well with 1 July 2012 marking the first year of construction passed.

The redevelopment of Taranaki Base Hospital in New Plymouth will benefit all the people of Taranaki. The redevelopment will be a user friendly, modern and comfortable hospital with many new features.

What will we have? >>

New combined theatre suite including day surgery, endoscopy and day procedure services

Each of the 30 bed wards will have 14 single rooms & four 4-bed rooms all with ensuites

New 30 bed Older People's Health & Rehabilitation inpatient ward

6 new operating theatres

New Sterile Services department

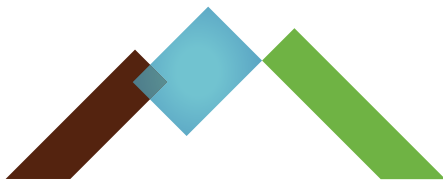
A new 22 bed children's ward consisting of:

- 2 x 4-bed rooms
- 2 acute assessment beds
- 2 short stay rooms
- 10 single rooms with ensuites

5 new 30 bed wards

An increase of 26 beds to a potential capacity of 172

(not all of these beds will be opened initially)



PROJECT MAUNGA

BASE HOSPITAL REDEVELOPMENT

Over the past year construction has moved fast and by mid year 2013 we will be ready to move into the new facility.



August 2011



August 2011

2011 - 2012

- Excavated **5,600 m³** – which is 600 trucks in and out of the site
- Poured **3,500 m³** of concrete – 750 concrete trucks (enough for 250 homes)
- Placed **900 tonne** of reinforcing steel
- Put up around **300 tonne** of structural steel
- More than **150** people working on site at any given time during June 2012
- At end June 2012, **460** people in total have worked on the site
- **162,000** hours worked



August 2011



October 2011



November 2011

2011

JULY
SITE
PREPARATION
COMMENCED

AUGUST
MAURI STONE
BURIAL

AUGUST
CONSTRUCTION
COMMENCED

NOVEMBER
VISIT FROM
PRIME
MINISTER
JOHN KEY

What we are looking forward to:

CONCRETE
STRUCTURE
COMPLETE
**AUGUST
2012**

BUILDING
TO BE
WEATHER
TIGHT
**SEPTEMBER
2012**

CONSTRUCTION
OF TEMPORARY
LINK TO REST
OF HOSPITAL
APRIL 2013

WARDS AND
THEATRES
MOVE IN TO
NEW FACILITY
AUGUST 2013

STANTON
BLOCK GETS
DEMOLISHED
**OCTOBER
2013**

NEW ENTRANCE
AND LINK
TO REST OF
HOSPITAL BUILT
**DECEMBER
2013**



January 2012



March 2012



March 2012



May 2012



June 2012



July 2012

2012

MARCH
INTERNAL WORK
INCLUDING
PARTITION
WALLS
COMMENCED IN
THE BASEMENT
AND LEVEL ONE

APRIL
FIT OUT WORK
COMMENCED

MAY
LEVEL ONE
ROOFING
COMPLETE

JUNE
ALL PRE-CAST
CONCRETE
FLOORS FOR
THE LEVELS
COMPLETE

JUNE
FAÇADE
INSTALLATION
COMMENCED

On Target



Taranaki DHB continues to work hard towards the national health targets, which are indicative of a wider range of services and efforts in priority areas.

Shorter
stays in



Emergency
Departments

SHORTER STAYS IN ED

Taranaki DHB has been working hard towards this target and acknowledges that it takes a whole hospital approach to be successful. Part of that approach has seen our Emergency Department and our Wards make changes to how they work.

Target 95%
Achieved 90%

Rapid Rounds

Having hospital beds readily available is one of the challenges when needing to move people on from the Emergency Department, and Taranaki DHB has tackled this problem with a multi pronged approach including the introduction of 'Rapid Rounds', estimated date of discharge and nurse facilitated discharges.

The medical ward has been trialling rapid rounds in 2012 and so far has seen great improvements with discharging patients earlier in the day so beds are available. Rapid Rounds work by bringing together the clinical staff on the ward for a short time each morning to talk briefly about each patient, their progress and their planned discharge date.

We are also introducing other initiatives, including increasing the amount of time our nurses spend with patients via the Releasing Time to Care programme, and introducing emergency observation and minor injuries units in the Emergency Department for cases that will not need to be admitted to a ward. These units improve the streaming of patients to enhance the quality and timeliness of their care

Improved
access to



Elective Surgery

IMPROVED ACCESS TO ELECTIVE SURGERY

Taranaki DHB has achieved elective services patient flow indicators compliance with no patients waiting over six months for either First Specialist Assessment (FSA) or surgery by year end. In order to achieve this staff worked hard to do additional surgery, mostly in ear and throat, general and orthopaedic surgery, which has reflected in our Improved Access to Elective Surgery target result. Our next goal is to achieve zero patients waiting over five months for FSA or surgery.

Target 100%
Achieved 120%

Cardiac Nurse Practitioner Intern

In February 2012, a Cardiac Nurse Practitioner intern role was created at the Taranaki DHB to help meet waiting times for the Cardiologist First Specialist Appointment (FSA) patients. In this exciting and innovative role, our Cardiac Nurse Practitioner intern, Jo-Ann Downie, provides expert clinical care and advice to those patients referred to cardiology services. Jo-Ann works across the community, primary and secondary interface in Taranaki. Working closely with the cardiologists, the role provides consultation, case management, and disease investigation. "With me seeing follow-up angiography patients, some of the long term follow-up patients, and post cardiac surgery patients, it has allowed the cardiologists to focus on seeing the FSA patients," said Jo-Ann.



Oncology patient Jean-Luc Danquigny with TDHB staff (left to right) Denise Green, Julie Elliott, Jenny Cleland, and Kirsty McIsaac



SHORTER WAITS FOR CANCER TREATMENT

Taranaki DHB will continue to maintain our collaborative relationship with MidCentral DHB to reach the 100% cancer waiting time target.

Target 100%
Achieved 100%

Cancer patient pleased with the service between Taranaki and MidCentral DHBs

Jean-Luc Danquigny was diagnosed with Lymphoma cancer in 2011 and finished his cancer treatment, shared between Taranaki DHB and MidCentral DHB, in May 2012.

In a letter to the Taranaki DHB Mr Danquigny thanks the oncology staff at New Plymouth for their outstanding abilities at making his treatment special. "I was never bored, I bought my book in to read but didn't have time to because I was entertained by staff all day," said Mr Danquigny.

"When I first started this journey it was bumpy and the uncertainty was scary," said Mr Danquigny.

His wife Sherry Danquigny was equally grateful. "He had a fear of the procedures to correctly diagnose the cancer but after consultation with Dr Kay Abraham, and being introduced to the oncology team, his fears went out the window. We cannot speak more highly of the staff, they were fantastic," said Mrs Danquigny.

Taranaki DHB Oncology Clinical Nurse Coordinator Denise Green said she was pleased at how happy Mr Danquigny was with his treatment. "It's a scary thing to go through and we only want to make it easy for our patients and see them get better".



Stefan Campbell getting a heart health check

Taranaki DHB Smoking Cessation Coordinator gives advice on quitting



BETTER HELP FOR SMOKERS TO QUIT

Taranaki DHB has dedicated smokefree liaison nurses who work hard at ensuring our staff give the appropriate advice to patients about quitting smoking. We continue to look at ways to keep smokefree assessment, education and awareness as a key area for all clinical staff. A comprehensive hospital action plan is in development to sustain and improve performance in the area.

Taranaki DHB is taking a lead role towards the goal of a smokefree Aotearoa 2025. In 2013 all Taranaki DHB sites will become smokefree.¹

Target 95%
Achieved 90%



MORE HEART AND DIABETES CHECKS

This target is new for 2012 and replaces the 'Better Diabetes and Cardiovascular Services' target. We continue to work with the PHOs in developing their diabetes care improvement packages and long term condition programmes to meet this target.

Target 60%
Achieved 54%

Healthy Hearts in Taranaki

Taranaki DHB Cardiac Clinical Nurse Specialists Maureen Spurway and Cathy Vickers organised heart health checks to be carried out on people in New Plymouth and Hawera during Heart Week 2012.

This was a joint venture between Taranaki DHB, The Heart Foundation, and Ngati Ruanui Tahua Trust.

"Some people were advised to see their GP for better blood pressure control but it was pleasing to see that many of the people approached already had regular blood pressure checks with their GP," said Maureen.



L to R: Stratford Mayor Neil Volzke, New Plymouth Deputy Mayor Alex Matheson and South Taranaki Mayor Ross Dunlop with Michael Ward



INCREASED IMMUNISATION

Increasing immunisation rates are a priority in order to reduce the incidence of preventable disease in our community. The DHB is working closely with the PHOs in Taranaki to educate and inform the community on the benefits and importance of immunisation. Taranaki DHB is also part of an Immunisation Strategy Group that meets quarterly to discuss immunisation in Taranaki.

Target 95%
Achieved 91%

Taranaki Mayors get behind Taranaki DHB for Immunisation Week

The Stratford Mayor, South Taranaki Mayor and New Plymouth Deputy Mayor were united in their drive to encourage their communities to get their flu vaccination early this year as part of Immunisation Week.

Medical Officer of Health, Dr Greg Simmons, was delighted to have the Mayors pushing the immunisation cause. "Immunisation not only protects the individual from preventable and sometimes severe illness, it also protects their whanau and friends," he said.

Neil Volzke, Ross Dunlop and Alex Matheson, have all had their vaccination early and they know the importance of receiving it no matter how fit and healthy you are.

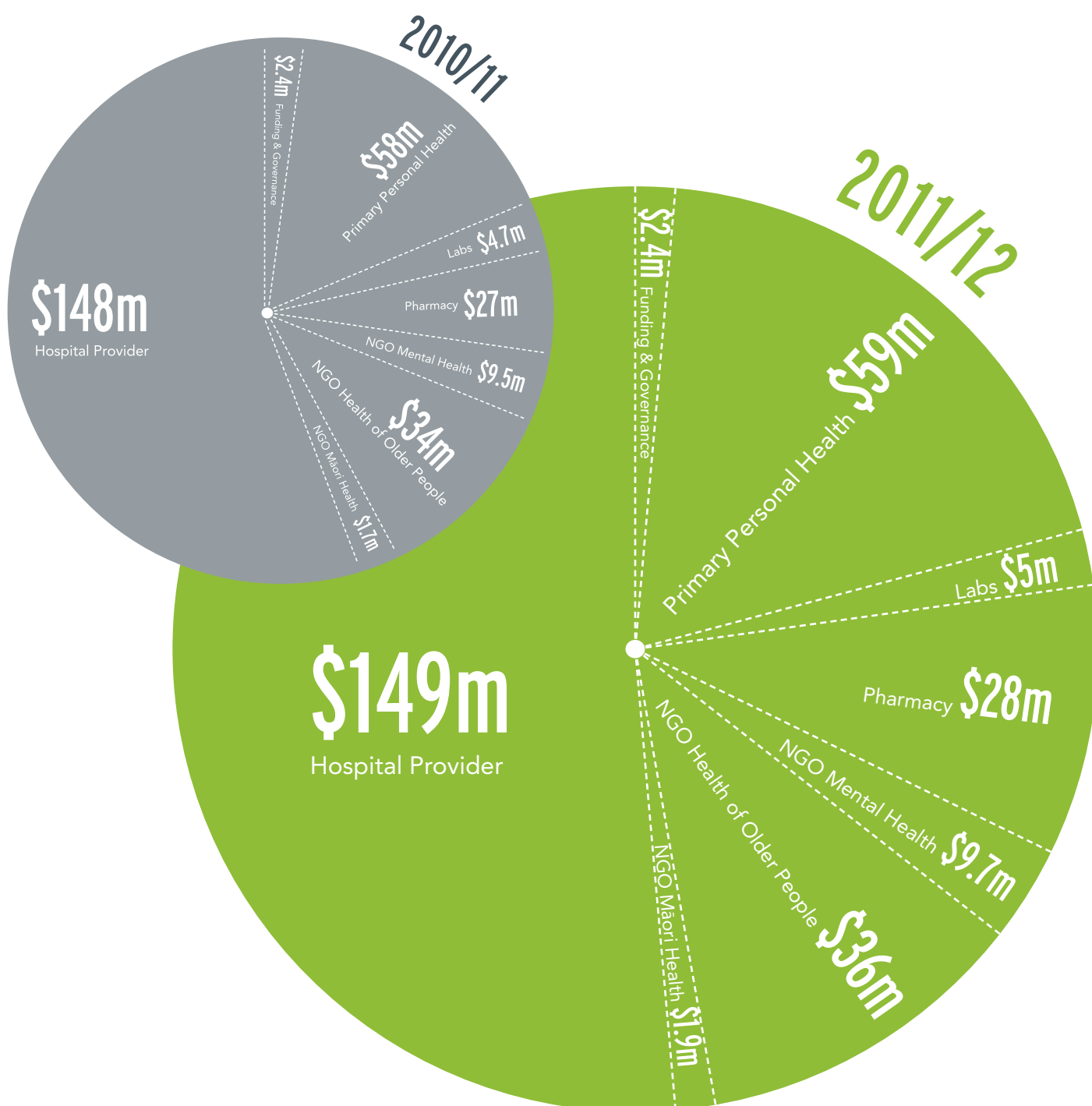
Stratford District Mayor Neil Volzke says, "It's not only about protecting yourself but also your friends and family around you. I need to make sure I can't spread the flu to those around me who are vulnerable and getting immunised every year does that."

National Immunisation Week ran from 23 to 29 April and was a perfect time to get on top of your family's immunisations. Immunisation Week provides an opportunity for people who have questions or concerns about immunisation to talk to their family doctor or health professional.

WHERE THE MONEY GOES

Taranaki DHB is the funder, planner and a key provider of health and disability services of the Taranaki region.

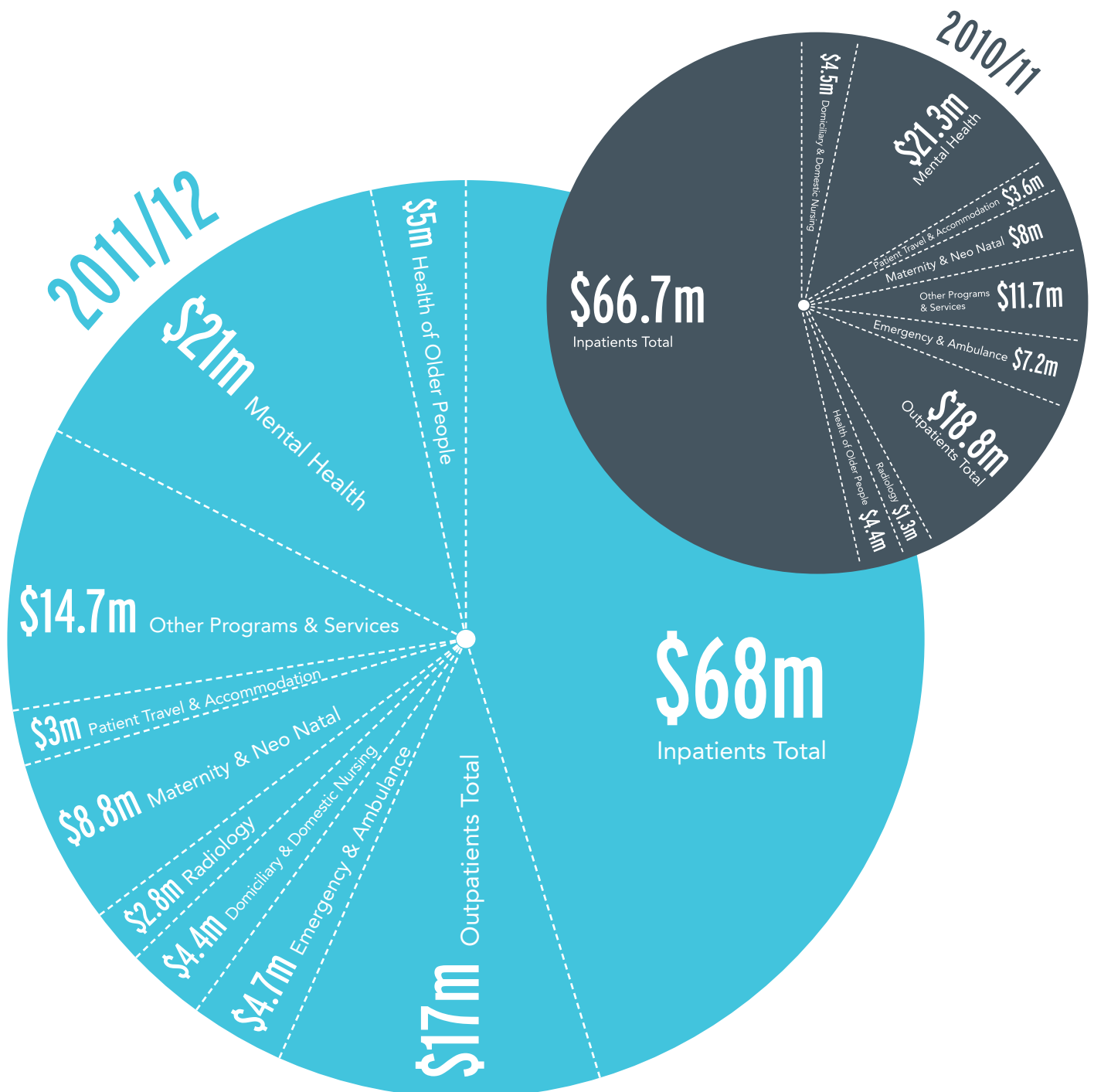
>> 2011/12 Taranaki DHB Funding Allocation



We have 104,280 Taranaki residents.

We planned, funded and provided nearly \$291 million of health and disability services. Of this, \$149.4 million was allocated to the Hospital Provider.

>> 2011/12 Hospital Provider Services Allocation





Mt Taranaki

PROFILING 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 Hawera. The rest of the population is scattered in and around small rural centres.

Population Profile

According to Statistics New Zealand, Taranaki DHB serves a population of 104,280 people, or 2.8% of New Zealand's population. Between the 2001 and 2006 Census, the population usually resident in the region increased by 1,266 or 1.2%.

The Māori population is projected to increase to 20.6% of the total population by 2026. The Māori, Pacific and Asian populations have grown slightly since 2001 and the population identified as European has declined, as at the 2006 Census. Taranaki has 8.1% identified as European and other, 15.2% as Māori, 1.3% as Pacific and 2.1% as Asian.

Age Structure

Our population is ageing. The proportion of people over the age of 64 is higher than the national average. The proportion of people aged between 15 and 39 is lower than the national average. A total of 21.8% are aged under 15 in Taranaki, while 47% of the Māori population is under 20.

Socio-Economic Indicators

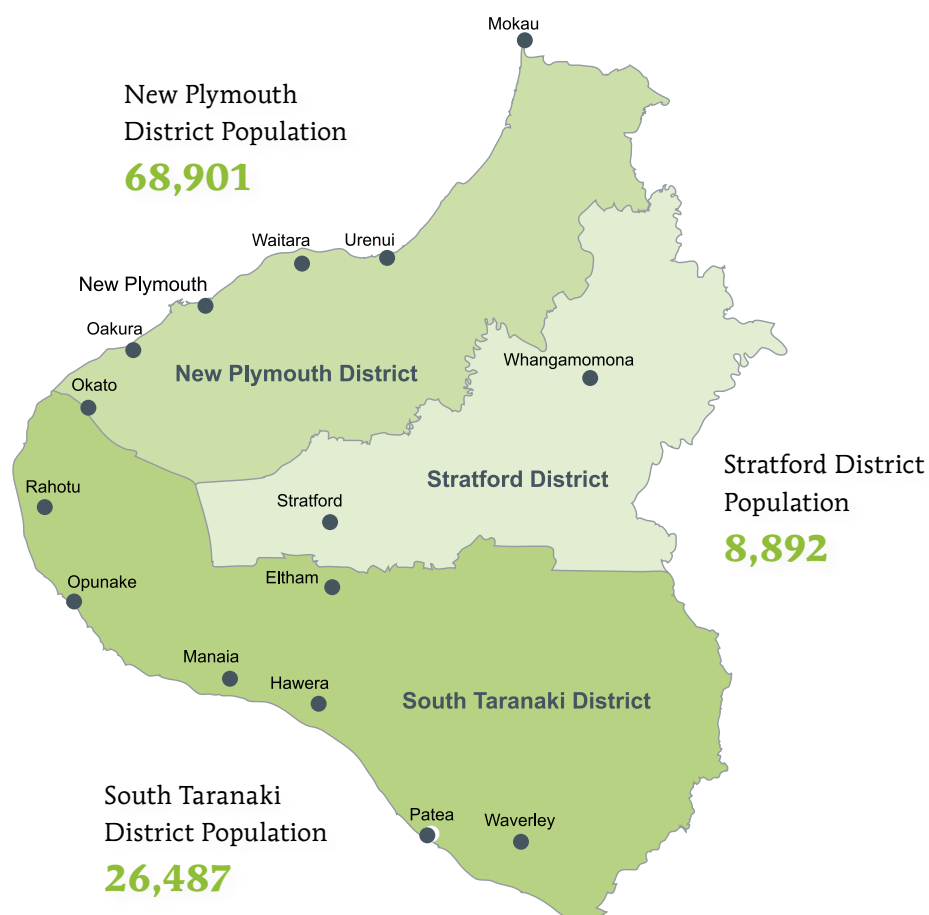
The Taranaki population sits towards the centre of the socio-economic range. There are higher percentages of people living in deciles 5-7 and lower in the decile four compared to the New Zealand average. Approximately 82% of the Māori population is resident in deciles 6-10 compared to 69% of non-Māori. Māori in decile four and five have a lower life expectancy than the most deprived non-Māori.



Patea



Manaia



We have...

- Relationships with two primary health organisations
- 85 general practitioners
- 18 dental practices
- 24 pharmacies
- 23 community personal health providers
- Providers of community laboratory services and radiology services
- 9 community based mental health, and alcohol & addictions service providers and 1 Māori mental health and alcohol & addictions service provider
- Support services for people with disability, including 29 residential facilities
- 16 providers of community health for older people services
- Hospital provider - facilities include Taranaki Base Hospital, Hawera Hospital and five community health centres in Waitara, Stratford, Opunake, Patea and Mokau



The Taranaki DHB worked to its first nationally standardised Māori Health Plan which focused on a total of 15 national, five regional and seven local Māori health priorities. The following table gives an overview of performance on national targets. The table summarises whether the targets have been achieved with non-Māori result included for inequalities context. Though few of the targets have been met, significant improvements were made over the year to achieve the results reported.

Taranaki 2011-12 Māori Health Plan Performance Summary

National Priorities and Indicators		Target	Māori	Non-Māori	Gap	Status
Data Quality	Ethnicity data accuracy in Taranaki DHB provider arm services	≤2%	1.23%			Achieved
Access to Care	Percentage of Māori enrolled in PHOs	95%	86%	96%	10%	Not Achieved
	Ambulatory sensitive hospitalisation (ASH) rate 0-4y, 45-64	<95%	83%	65%	18%	Achieved
	0-74y ASR per 100,000	<95%	86%	65%	21%	
Maternal Health	Percentage of infants exclusively breastfed at six weeks	<95%	81%	77%	4%	Not Achieved
	Three months	62%	58%	69%	11%	
	Six months	55%	43%	57%	14%	
Cardiovascular Disease	Number of tertiary cardiac interventions	18%	13%	22%	9%	TBA
	The proportion of the eligible population who have had the blood tests for CVD risk assessment in the last five years	TBA	TBA			Not Achieved
Diabetes	Percentage of diabetics who have attended a Diabetes Annual Review (DAR)	90%	54%			Not Achieved
	Percentage of diabetics who have completed DAR and are HbA1c <8%	95%	77%	70%	7%	Not Achieved
Cancer	Breast screening rate among the eligible population	80%	68%	80%	12%	Not Achieved
	Cervical screening rate among the eligible population	70%	End of Aug			
Smoking	Percentage of adults 15+ admitted to hospital either acutely or for elective procedures who are provided with advice and help to quit	69%	65%	87%	22%	Not Achieved
	Percentage of smokers in primary care who are provided with advice and help to quit	95%	91%	90%	1%	Not Achieved
Immunisation	Percentage of two year olds fully immunised	90%	20 Aug			
	Seasonal influenza immunisation rates for Māori aged 65 years and over	95%	91%	92%	1%	Not Achieved
Māori Health Workforce	Percentage of Māori staff in management, clinical, allied health, non-health support, administrative positions in Taranaki DHB	>68%	20-Aug			
		8%	6.70%	93.30%	86.60%	Not Achieved



Tamara Kahui-Tamau, WRR Oral Health Cadet



Dillon Manuirangi, WRR Medical Intern

HIGHLIGHTS FROM THE YEAR

In April 2012 a **Whānau Ora Health Needs Assessment** report was released. Co-authored by Dr Mihi Ratima and Taranaki DHB Service Manager - Population Health, Becky Jenkins, the assessment focuses on Taranaki Māori Health needs using a Whānau Ora framework. It is the first time Taranaki DHB has carried out a health needs assessment specific to Māori, and the first time any DHB has used a Whānau Ora framework in this way. The report is used by the DHB and NGO providers to guide planning decisions and service delivery.

Whakatipuranga Rima Rau (WRR) is a Māori health workforce development joint venture between Te Whare Punanga Korero, Taranaki DHB and MSD to get 500 Māori into the local health and disability workforce over 10 years. Incubator is a WRR project which showcases the different health career opportunities to year 12 and 13 High School students. More than 140 students took part in the

programme in 2011 with around 49 health professionals helping as mentors. Incubator aims to reach at least 160 students in the 2012 academic year, a target well in hand with 178 students registered as at 30 June.

A **cadetship and internship programme** has also been developed to give students workplace experience while studying health at a tertiary level. In 2011 there were six interns placed with Taranaki DHB and NGO providers to get first hand experience working in medical, physiotherapy, radiology, psychology, ambulance services and youth service areas. A dental cadetship achieved excellent results with the cadet progressing to undertake dental therapy studies at the Otago University. A new dental cadet is now in place with the Taranaki DHB Dental Unit, while a nursing cadet is soon to take up a permanent role with Tui Ora, and a youth health cadet with WAVES is studying for a social work degree at WITT.

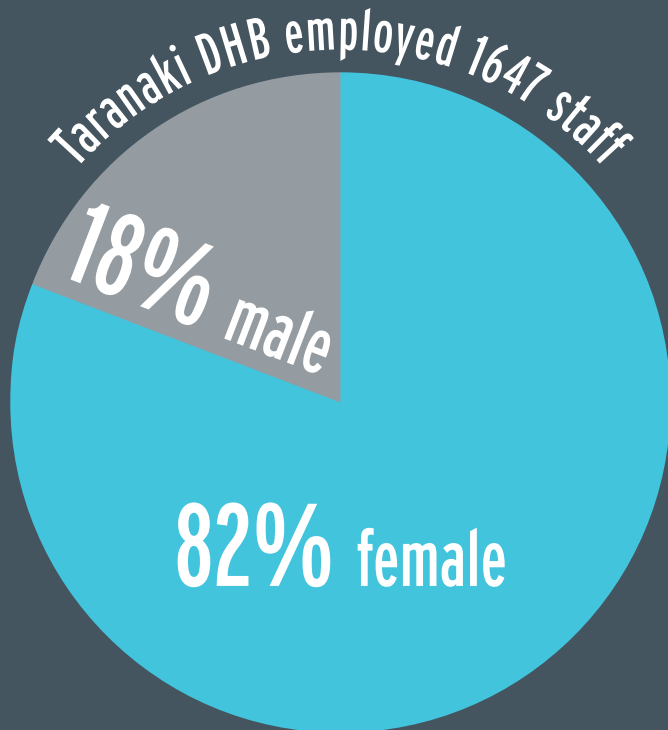
Tui Ora and the National Hauora Coalition have formed an alliance called '**Te Kawau Mārō**' to become the Taranaki DHBs preferred provider of health services for Māori in Taranaki. The alliance heralds a new energy

and commitment to harness the capacity and capabilities of the Māori health sector to deliver the best possible services with and for whānau and other high needs communities, under a common model of care throughout Taranaki. The alliance is significant in the implementation of Te Kawau Mārō, Taranaki Māori Health Strategy 2009 to 2029.

Despite a challenging fiscal year the Taranaki DHB increased its investment in **Māori-specific services** by 7% in 2011-12, over 2010-11. This includes funding to Māori providers, Māori services in the Taranaki DHB, Māori PHO services and Māori workforce development activity.

The paediatrics and dental units of the Taranaki DHB have had a cultural audit done using '**He Ritenga: Treaty of Waitangi Principles Health Audit Framework**'. The first cultural audit done by the DHB, an experienced team of Māori health auditors carried it out. The audit tool proved to be well worthwhile in guiding departments on appropriate responses to meeting Māori health needs, looking at governance, operational and clinical contexts. Taranaki DHB has committed all departments to undergoing 'He Ritenga' audits.

OUR PEOPLE



668 Nurses

34 Midwives

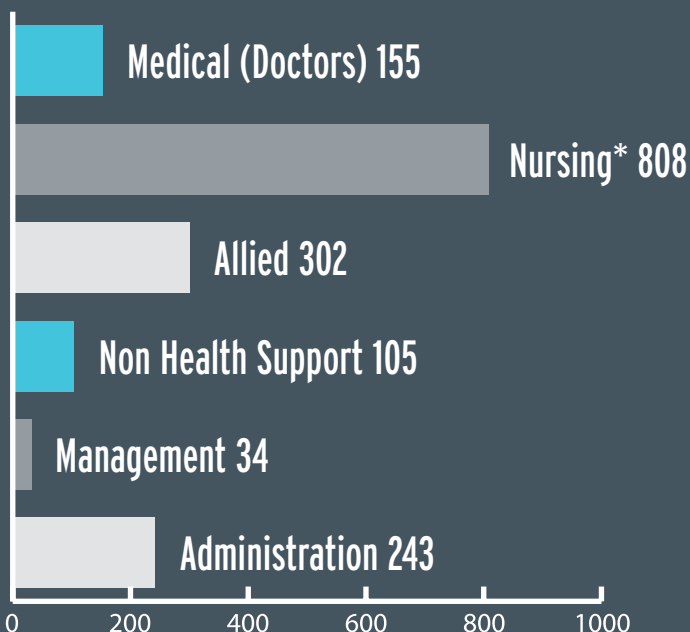
29 Orderlies

113 employees identify themselves as Māori, 1296 as New Zealanders, seven as Pacific Islanders, 67 Asian, 15 as other ethnic groups and the balance either as 'other' or 'not stated'

22 Pharmacy employees

19 Social Workers

27 Occupational Therapists



*This figure includes midwives and health care assistants

Healthcare is about people helping people. We have a great team of health professionals and support staff all working together for our community.

106 Health Care Assistants

48 HIQ (IT)

33 Cleaners

29 Physiotherapists

41 Laboratory
Employees

18 Dental Therapists

28 Scholarships
awarded

Taranaki DHB awarded 28 health scholarships to students in 2012 studying a range of areas including nursing, medicine, dental surgery, midwifery, social work, physiotherapy, medical laboratory science, dietetics, pharmacy, occupational therapy, and dental therapy. Of the recipients, 32% identified as Māori.

Senior Medical Officer RECRUITMENT

There continues to be success in recruiting senior medical officers into long term to permanent positions.

In the last 12 months this included:

- 1 consultant obstetrician and gynaecologist
- 3 consultant psychiatrists
- 2 consultant anaesthetists
- 1 internal medicine physician
- 1 consultant orthopaedic surgeon

Junior Doctors staying on

Of the 11 first year house surgeons employed in 2012, 10 will be back working with us in 2013.

Coming from throughout New Zealand they were keen to stay because of the familiarity of systems and staff members and getting to work in different areas, such as the Emergency Department and Paediatrics.



St John Friends of the Emergency Department

Campbell Hooker, WRR Physiotherapy Intern

WORKING TOGETHER

Locally

Taranaki DHB is part of a committed network of organisations who work closely with one another to make up the health system in Taranaki. These organisations include primary health organisations, NGO health providers, rest homes, other crown entities and individual health professionals.

HIGHLIGHTS FROM THE YEAR

Friends of the Emergency

Department (FEDs) was initiated with 19 St John volunteers recruited and trained to provide comfort, information and support of a non clinical nature to patients and their families while at the Emergency Department.

South Taranaki – Alive with opportunities for better health care.²

As part of **Kidsafe Taranaki Trust**, Taranaki DHB worked with ACC, Plunket and Tui Ora Limited to provide Taranaki communities with an interactive driveway safety kit to help prevent driveway run over injuries. The kit is held at Taranaki DHBs Public Health Unit and is available to the public to borrow.

In 2011 - 2012 Taranaki DHB and the wider **mental health and addictions** sector including Pathways, Tui Ora, Healthcare NZ, Ngati Ruanui, Linkage Trust, Progress to Health, Schizophrenia Fellowship, and Likeminds undertook a project on the Adult Continuum of Care.³


Taranaki DHB is a partner with the Te Whare Punanga Korero and Work and Income (MSD) in the **Whakatipuranga Rima Rau (WRR)** Trust.⁴


Youth Week – ‘Not Even’ was a collaborative project led by Taranaki DHB Public Health Unit and supported by Patea Youth Trust, Patea Pride Sports Club Inc, Te Runanga o Ngati Ruanui, Patea Area School, Te Korimako radio station and South Taranaki Youth. It was a fun, free evening for young people and their parents living in South Taranaki to look at ways of talking together about those hard conversations.

Taranaki DHB continues to be part of the Taranaki **Smokefree/ Auahi Kore** action group including New Plymouth District Council, The Cancer Society of NZ Taranaki Centre Inc., Taranaki National Heart Foundation, Ngati Ruanui Tahua Trust, Tui Ora Limited, Toi Ora Healthy Lifestyles Ltd, Midlands Health Network, and WITT Tertiary Education Provider.


Early 2012 has seen a lot of planning towards the **enhanced intermediate care for older people** component of the older people’s health intermediate care service.⁵


Uncomplicated dementia care pathway – Taranaki DHB Mental Health Service Older People (MHSOP) worked collaboratively with the primary and secondary sectors to establish a dementia care pathway consistent with the Ministry of Health Guidelines.⁶

 2 Visit our website and click on the South Taranaki button on the homepage for more information.

 3 See page 57 of this report for more information.

 4 For more information on WRR see page 19.

 5 See page 49 of this report for more information.

 6 See page 56 of this report for more information on this service.



Signing the Midland DHB Smokefree Vision



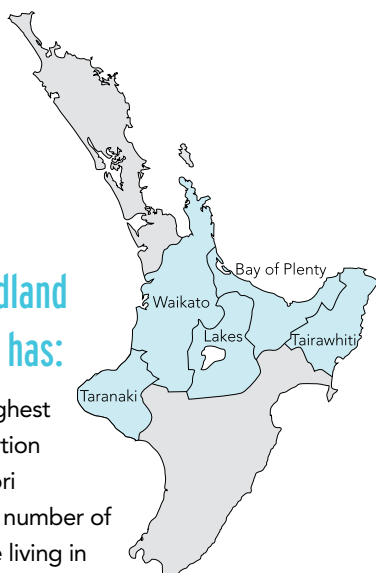
Midland DHB Midwifery Training

Regionally

Taranaki DHB has been part of significant regional collaboration for many years in the Midland region. The five Midland DHBs include Taranaki, Waikato, Bay of Plenty, Lakes and Tairāwhiti.

Our Midland Region has:

- The highest proportion of Māori
- A high number of people living in rural areas
- A relatively higher proportion of people living in areas identified as high deprivation
- Lower life expectancy than the New Zealand average
- Higher smoking rates than the New Zealand average



HIGHLIGHTS FROM THE YEAR

An inter-hospital transfer project was initiated between the five Midland DHBs to improve the way we transfer patients in and out of Waikato DHB, our tertiary centre. A dedicated position has been developed at Waikato DHB. This role liaises with the other Midland DHBs acting as a one-stop-shop for information on our patients that are in Waikato DHB or needing to be transferred to or from there. Daily communication with this new role has improved the flow of access to Waikato DHB services and information in a timely manner.

All five Midland DHBs have combined with the Midland Iwi Relationship Board (MIRB) to renew commitment to making their central North Island districts entirely Smokefree/Tobacco Free by 2025. The DHBs believe that tobacco and smoking are too visible in our communities. The group signed a refreshed smokefree Midland vision statement committing to continue to coordinate efforts and provide strong leadership to achieve the vision.

Taranaki DHB works with the Midland DHB emergency management teams on a regular basis. Some of the activities during the 2011-12 year have included: Participating in the Midland health emergency planners group; development of a Midland health emergency coordination plan and duty emergency coordinator roster; monthly communication testing between Midland DHB planners; sharing of health emergency plans and health incident learning's and assisting each other in emergency exercises.

A Regional Services Plan⁷ has been established describing a vision for the future of health services in the Midland Region and provides a framework for the five Midland DHBs to continue to plan and work cooperatively. The plan includes the following key areas:

- Renal services
- Maternity services
- Cardiac services
- Rural primary care services
- Midland Cancer Network
- Midland Mental Health and Addictions Network
- Trauma Network

Midland DHBs support each other to deliver these services across the region. For Taranaki it is about defining what services we can cater to and how we use the services of the other Midland DHBs. It also involves having peer support for our clinicians throughout the Midland Region.



⁷ The Midlands Regional Service Plan is available on our website.



Governance

2011/2012



GOVERNANCE STRUCTURE

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 2010) and up to four are appointed by the Minister of Health.

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

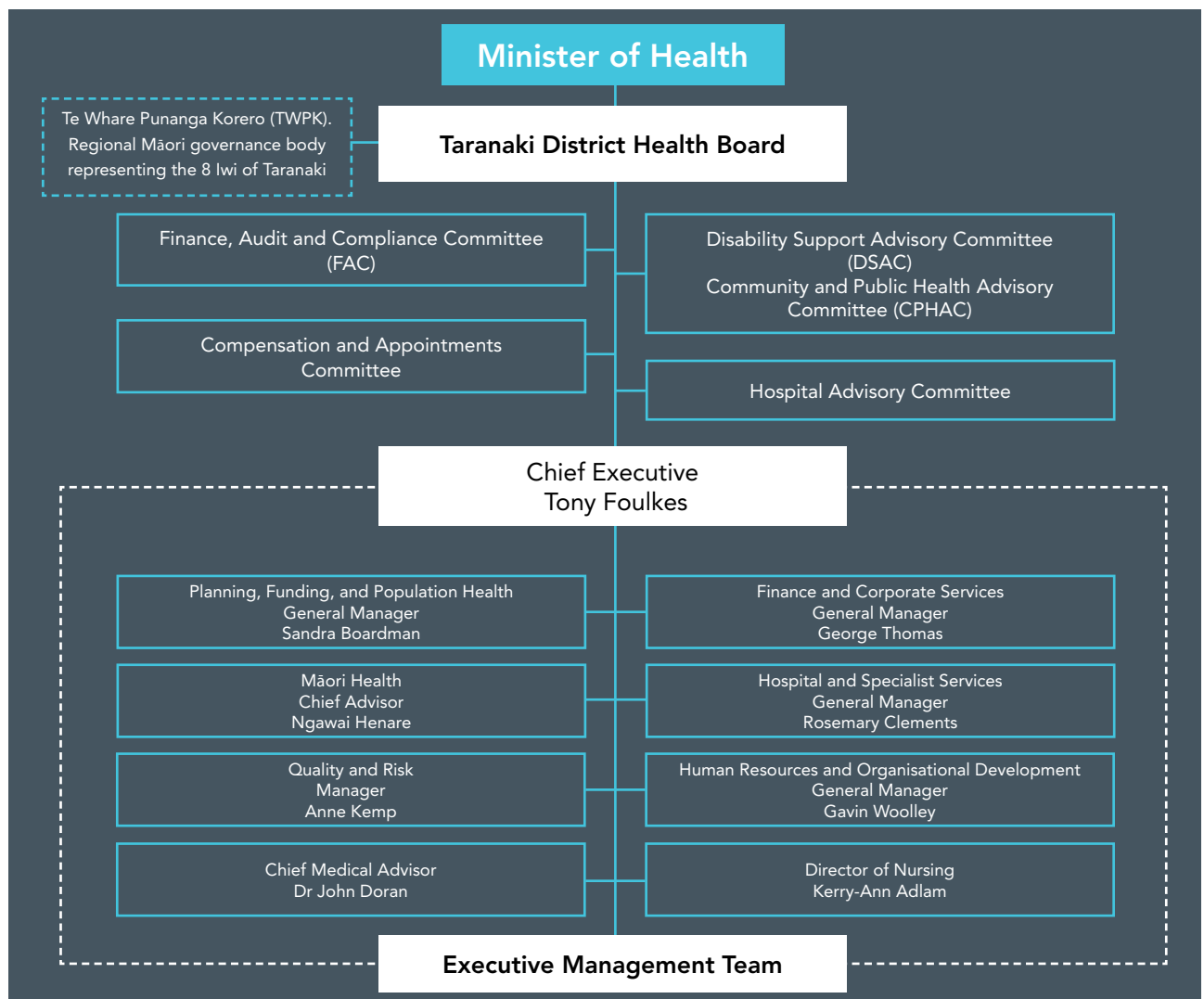
- Approving major strategic and policy documents including the District Strategic Plan, Annual Plan, Budget and considering recommendations on key issues.
- Monitoring the implementations of the Annual Plan and Budget.
- Monitoring the operating performance of the organisation.
- Maintaining and developing an effective

working relationship with Te Whare Punanga Korero, its Iwi partner.

- Ensuring the Taranaki DHB acts legally and responsibly.
- Appoints, evaluates and supports 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 has been 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.



BOARD MEMBER PROFILES



MARY BOURKE (CHAIR)

Mary is a former Mayor of the South Taranaki District and a long-term advocate for health services in the region. Her committee roles at the Health Board include the Hospital Advisory Committee and the Community Public Health and Disability Support Advisory Committee. Mary is a Trustee of the Bishop's Action Foundation in Taranaki and the TSB Community Trust. She chairs the WITT (Western Institute of

Technology in Taranaki) Council, and has recently accepted a role on the Interim Governance Board for a New Families Centre (locally). Mary is also the presiding member of the Lotteries Community Facilities Committee.

Interest Register: Member: Bishops Action Foundation, TSB Community Trust, and New Families Centre. Chair: Witt Council, Former Chair and founding member of Southcare, Presiding Member: Lotteries Community Facilities Committee.



PETER CATT (DEPUTY CHAIR)

Peter has been a GP with the Family Health Centre in New Plymouth for more than 27 years. He was elected to the Board and is Deputy Chairman. He is a member of all the statutory committees, the Finance and Audit Committee and the Performance and Compensation Committee.

Interest Register: General Practitioner in New Plymouth, Director and Shareholder of Family Health Centre, Secretary/Treasurer Taranaki Sub Faculty Royal New Zealand College GP, Chairman HIQ.



ALEX BALLANTYNE

Alex lives in Eltham in South Taranaki. He is married and has four children. His community involvement includes Deputy Mayor STDC, advocate Central and South Taranaki Advocacy Service and Parish Worker St Joseph's Eltham. He is also a member of the South Taranaki Community Advisory Partnership for the Midlands Health Network. Alex is a member of the

Finance Audit and Compliance Committee and Deputy Chairman of the Community and Public Health and Disability Support Advisory Committee.

Interest Register: Member South Taranaki Community Advisory Partnership for the Midlands Health Network. Councillor and Deputy Mayor South Taranaki District Council.



ELLA BORROWS

Ella has had wide involvement in education, social service and community law committees and boards since moving to South Taranaki in 1986. Currently she is Chair of the South Taranaki Medical Trust and until her election to the Board, was an Associate of the Health Consumer Service, a complaint resolution service for health consumers in the Taranaki region.

Ella is a member of the Community and Public Health and Disability Support Advisory Committee and is Chair of the Hospital Advisory Committee.

Interest Register: Chair South Taranaki Medical Trust (operational arm, SouthCare), Husband Chester Borrows, Member of Parliament Former Associate, Health Consumer Service, Waikato.



KURA DENNESS

Kura has a background in corporate finance. She is a director of the following organisations: Te Matai Whetu Limited, PHARMAC, TSB Community Trust, Te Rau Matatini, Te Atiawa (Taranaki) Holdings Limited and Te Atiawa (Taranaki) Settlements Trust, and is on the Council of Massey University. Kura is also Chairman of Tui Ora Limited and Hauora Taranaki PHO Ltd. Kura is Chairman of the Finance, Audit and Compliance

Committee and on the CEO Performance Review Committee. She is also Chair of the Allied Laundry Board. Kura is the mother of two wonderful sons and is of Te Atiawa descent.

Interest Register: Chair Taranaki Hauora PHO Ltd, Chair Tui Ora Ltd, Director PHARMAC, Director Te Matai Whetu Ltd, Chair Allied Laundry Services Limited, Member of Council – Massey University, Director Te Rau Matatini, Trustee TSB Community Trust.



KAREN EAGLES

Karen was elected for a second term as a member of the District Health Board. Prior to this she was a health and disability advocate for Taranaki, working under the Health & Disability Commissioner Act 1996. Her areas of concern for the people of Taranaki are rural people, women and children, and elderly, together with a special interest in those with disabilities who access

our services. Karen is a member of the Hospital Advisory Committee and the Community & Public Health and Disability Support Advisory Committee. In 2012 she was appointed to the WHO Panel on monitoring the International Code of Marketing Breast-milk Substitutes in NZ.

Interest Register: Husband John Eagles is a Senior Partner at Govett Quilliam providing legal services to Taranaki DHB.



FLORA GILKISON

Flora is an elected member of the District Health Board where she is the Chair of the Community and Public Health committee and the Disability Support Advisory Committee, a member of the Compensation and Appointments Committee, on the board of Fulford Radiology Services Ltd and currently Chairperson. She has a Doctorate in Management and a Master's in Education Administration with a background in senior management in tertiary education and health. Her current role is the

Chief Executive of the New Zealand Orthopaedic Association with previous roles as the Director of NZ Red Cross and the Principal of the Pacific International Hotel Management School. Her main focus as a board member is to ensure Taranaki people get a fair share of health funding for the DHB to continue to provide excellent health care for all who need it.

Interest Register: Husband employed as a General Surgeon at Taranaki Base Hospital and CEO of NZ Orthopaedic Association.



BRIAN JEFFARES

Brian is an elected member of the District Health Board and has previously been an appointed member of the Hospital Advisory Committee. He has an extensive background in community work having served nine years as the Mayor of Stratford District. Presently he chairs the Taranaki Electricity Trust and the Central

and South Youth Development Trust. He is also an elected member of the Taranaki Regional Council and chairs the Emergency Management Group.

Interest Register: Director – TET Holdings, Trustee – Taranaki Electricity Trust.

BOARD MEMBER PROFILES



PAULINE LOCKETT

Pauline has lived in New Plymouth since 1981 and is an appointed member of the District Health Board. Currently she is a Councillor with the New Plymouth District Council where she is also the Chairperson of the Investment Sub Committee and is a Councillor on the Monitoring Committee. Pauline is a member of the District Health Board's Hospital Advisory Committee

and the Finance, Audit and Compliance Committee.

Interest Register: Councillor on the New Plymouth District Council, Family Trust has shares in Fletcher Building Ltd. Pauline is a director of Landcorp Farming Ltd and is the Chairperson of Landcorp's Audit and Due Diligence Committee.



ALLISON RUMBALL

Alison has had a long and extensive involvement in educational, environmental and community affairs and was an elected New Plymouth District Councillor for nine years. Tertiary qualifications as a Hearing Commissioner have given her significant experience and an insight into Government legislation and the implications that has for Health Boards. Alison is a member of the Hospital Advisory Committee and the Community & Public Health and Disability

Support Advisory Committee. She is Vice President of the Taranaki Cancer Society of New Zealand, a member of the N.Z. Central Divisions Cancer Executive and Patron for the Community Service Centre Charitable Trust.

Interest Register: Daughter Paediatric Cardio-Thoracic Surgeon at Starship; Daughter and Son-in-law Anaesthetic Consultants at Waikato Hospital.



COLLEEN TUUTA

Colleen is affiliated to the following tribes: Taranaki Tūhura, Ngāti Mutunga, Te Ātiawa, and Ngāti Mahuta. Colleen is currently a Trustee on Mahia Mai a Whai-Tara Trust, Philanthropy NZ, Māori Advisory Committee member, a

Trustee of Te Runanga o Ngāti Mutunga, a Council member of Te Wananga o Aotearoa - Te Mana Whakahaere Council, Trustee Te Kahui Rongoa Trust.

Interest Register: Mahia Mai a Whai-Tara Trust, Waitara – Health Provider, Te Kete Centre Trust – Whanau Centre.

ADDITIONAL INTERESTS DECLARED



TONY FOULKES (CHIEF EXECUTIVE)

Interest Register: Director HIQ Ltd, Director HealthShare Ltd. Board member of National Health IT Board. Wife employed as General Practitioner by Te Aroha Medcare in New Plymouth,

Māori Health Governance Group for Taranaki

The members of this trust represent the eight iwi of Taranaki. There is a Memorandum of Understanding between Taranaki DHB and Te Whare Punanga Korero (TWPK). This is the vehicle through which the iwi of Taranaki influence the strategic agenda to improve Māori health and reduce Māori health inequalities.

Te Whare Punanga Korero interacts with Taranaki DHB and the wider sector through various Taranaki DHB, NGO and iwi Māori forums to advance its purposes. Some of those interactions include:

- Regular meetings with Taranaki DHB Board Chair, members and DHB officials to discuss, monitor and develop responses to Māori health needs
- Participation in the Taranaki DHB's strategic planning and governance training
- Participation in the development of, and joint approval with the Taranaki DHB of Māori Health strategies and plans
- Participation in a range of project-based steering group activities where projects impact significantly on Māori

An important role of Te Whare Punanga Korero is to work with Taranaki DHB in achieving the objectives of its annual Māori Health Plan and Māori health objectives of the Annual Plan, District Strategic Plan and in particular Te Kawau Mārō, Taranaki Māori Health Strategy 2009 – 2029.



Members of TWPK

Back Row: Pam Ritai (Te Atiawa), Peter Moeahu (Ngaruahine), Vicki Kershaw (Te Runanga O Ngati Mutunga)

Front Row: Hinemoerangi Ngatai Tangirua (Ngati Ruanui), Chairman Darryn Ratana (Te Kahui O Rauru), David Tamatea (Taranaki)

Inset top: Greg White (Ngati Tama)

Inset bottom: Chris Manukonga (Ngati Maru)



Board

2011/2012

Members' Responsibilities and Fees



BOARD MEMBERS, COMMITTEE MEMBERS AND DIRECTORS SCHEDULE

Name	Board Meetings	Hospital Advisory Committee	Community & Public Health & Disability Support Advisory Committee	Finance, Audit & Compliance Committee	Compensation & Appointments Committee	Allied Laundry Services Ltd	Fulford Radiology	HealthShare Ltd	HIQ	Fees Paid (\$)
Board Members										
Mary Bourke	*9 of 10	9 of 10	6 of 6		✓					\$40,749
Peter Catt	^8 of 10	^8 of 10	5 of 6	✓	✓				✓	\$26,375
Alex Ballantyne	7 of 10	4 of 10	4 of 6	✓						\$20,500
Ella Borrows	8 of 10	*8 of 10	3 of 6							\$21,750
Kura Denness	7 of 10	6 of 10+	2 of 6	✓	✓	✓				\$20,500
Karen Eagles	7 of 10	7 of 10	3 of 6							\$21,000
Flora Gilkison	8 of 10	8 of 10	*5 of 6		✓		✓			\$22,063
Brian Jeffares	9 of 10	8 of 10	0 of 6	✓						\$20,500
Pauline Lockett	6 of 10	7 of 10	3 of 6	✓						\$21,000
Alison Rumball	8 of 10	8 of 10	3 of 6							\$21,250
Colleen Tuuta	5 of 10	4 of 10	5 of 6							\$20,750
Co-Opted Committee Members										
Peter Moeahu		7 of 10								\$1,750
David Tamatea			5 of 6							\$1,250
Other Directors										
Tony Foulkes, Chief Executive								✓	✓	
George Thomas, GM Finance & Commercial Services									✓	
Simon Barrett, Group Financial Manager						✓	✓			

Key:

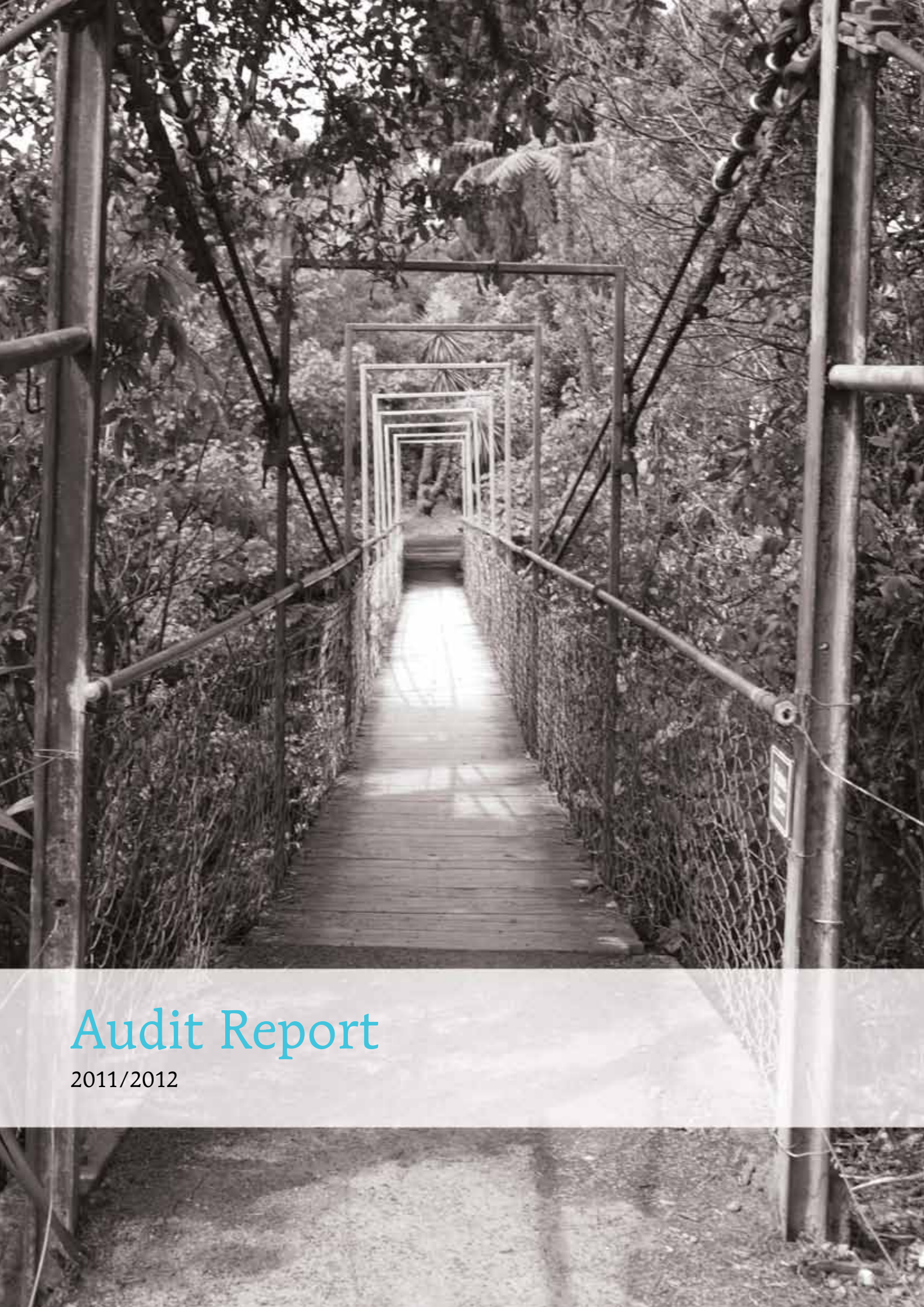
* = Chairman

^ = Deputy Chairman

+ = Absence from meetings due to attendance at Allied Laundry meetings

The Board resolved at its meeting held 10 March 2011 to have permanent Board members as Committee members effective from 1 July 2011.

NB - HAC and Board meetings not held in June 2012 due to lack of Quorum.



Audit Report

2011/2012

INDEPENDENT AUDITOR'S REPORT

TO THE READERS OF TARANAKI DISTRICT HEALTH BOARD AND GROUP'S FINANCIAL STATEMENTS AND STATEMENT OF SERVICE PERFORMANCE FOR THE YEAR ENDED 30 JUNE 2012

The Auditor-General is the auditor of Taranaki District Health Board (the Health Board) and group. The Auditor-General has appointed me, Lloyd Bunyan, using the staff and resources of Ernst & Young, to carry out the audit of the financial statements and statement of service performance of the Health Board and group on her behalf.

We have audited:

- the financial statements of the Health Board and group on pages 91 to 124, that comprise the Statement of Financial Position as at 30 June 2012, the Statement of Comprehensive Income, Statement of Changes in Equity and Statement of Cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the statement of service performance of the Health Board and group on pages 38 to 86.

Opinion

In our opinion:

- the financial statements of the Health Board and group on pages 91 to 124:
 - comply with generally accepted accounting practice in New Zealand; and
 - fairly reflect the Health Board and group's:
 - financial position as at 30 June 2012; and
 - financial performance and cash flows for the year ended on that date; and
- the statement of service performance of the Health Board and group on pages 38 to 86:
 - complies with generally accepted accounting practice in New Zealand; and
 - fairly reflects the Health Board and group's service performance for the year ended on 30 June 2012, including:
 - the performance achieved as compared with forecast targets specified in the statement of forecast service performance for the financial year; and
 - the revenue earned and output expenses incurred, as compared with the forecast revenues and output expenses specified in the statement of forecast service performance for the financial year.

Our audit was completed on 11 October 2012. This is the date at which our opinion is expressed.

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

Basis of opinion

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

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

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

An audit also involves evaluating:

- the appropriateness of accounting policies used and whether they have been consistently applied;
- the reasonableness of the significant accounting estimates and judgements made by the Board;
- the adequacy of all disclosures in the financial statements and statement of service performance; and
- the overall presentation of the financial statements and statement of service performance.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements and statement of service performance. We have obtained all the information and explanations we have required and we believe we have obtained sufficient and appropriate audit evidence to provide a basis for our audit opinion.

Responsibilities of the Board

The Board is responsible for preparing financial statements and a statement of service performance that:

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

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

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

Responsibilities of the Auditor

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

Independence

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

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



Lloyd Bunyan
Ernst and Young
On behalf of the Auditor-General
Auckland, New Zealand

Matters relating to the electronic presentation of the audited financial statements and statement of service performance

This audit report relates to the financial statements and statement of service performance of Taranaki District Health Board (the Health Board) for the year ended 30 June 2012 included on the Health Board's website. The Board is responsible for the maintenance and integrity of the Health Board's website. We have not been engaged to report on the integrity of the Health Board's website. We accept no responsibility for any changes that may have occurred to the financial statements and statement of service performance since they were initially presented on the website.

The audit report refers only to the financial statements and statement of service performance named above. It does not provide an opinion on any other information which may have been hyperlinked to or from these financial statements and statement of service performance. If readers of this report are concerned with the inherent risks arising from electronic data communication they should refer to the published hard copy of the audited financial statements and statement of service performance and related audit report dated 11 October 2012 to confirm the information included in the audited financial statements and statement of service performance presented on this website.

Legislation in New Zealand governing the preparation and dissemination of financial information may differ from legislation in other jurisdictions.



Statement of Service Performance

2011/2012



Statement of Service Performance



Taranaki Base Hospital

Overview

As an effective District Health Board we need to demonstrate accountability⁸ 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 on the following page. 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 detections and management
- Intensive assessment and treatment
- Rehabilitation and support

We have built our performance framework for 2011/12 using a mixture of lifespan, disease state and service settings in order to reflect our activity and goals. These are grouped as below;

- Child and youth health services
- Older people's health services
- Mental health and addiction services

- Hospital and specialist services
- Primary and community health services
- Health services for people with long term conditions

Some of the measures are a reflection of estimates of demand driven activity that we expected to be provided in 2011/12. Therefore they are a presentation of what activity we fund rather than a performance measure, for example the number of births.

Planned and Actual Revenue and Expenditure Allocated to Output Classes 2011-12

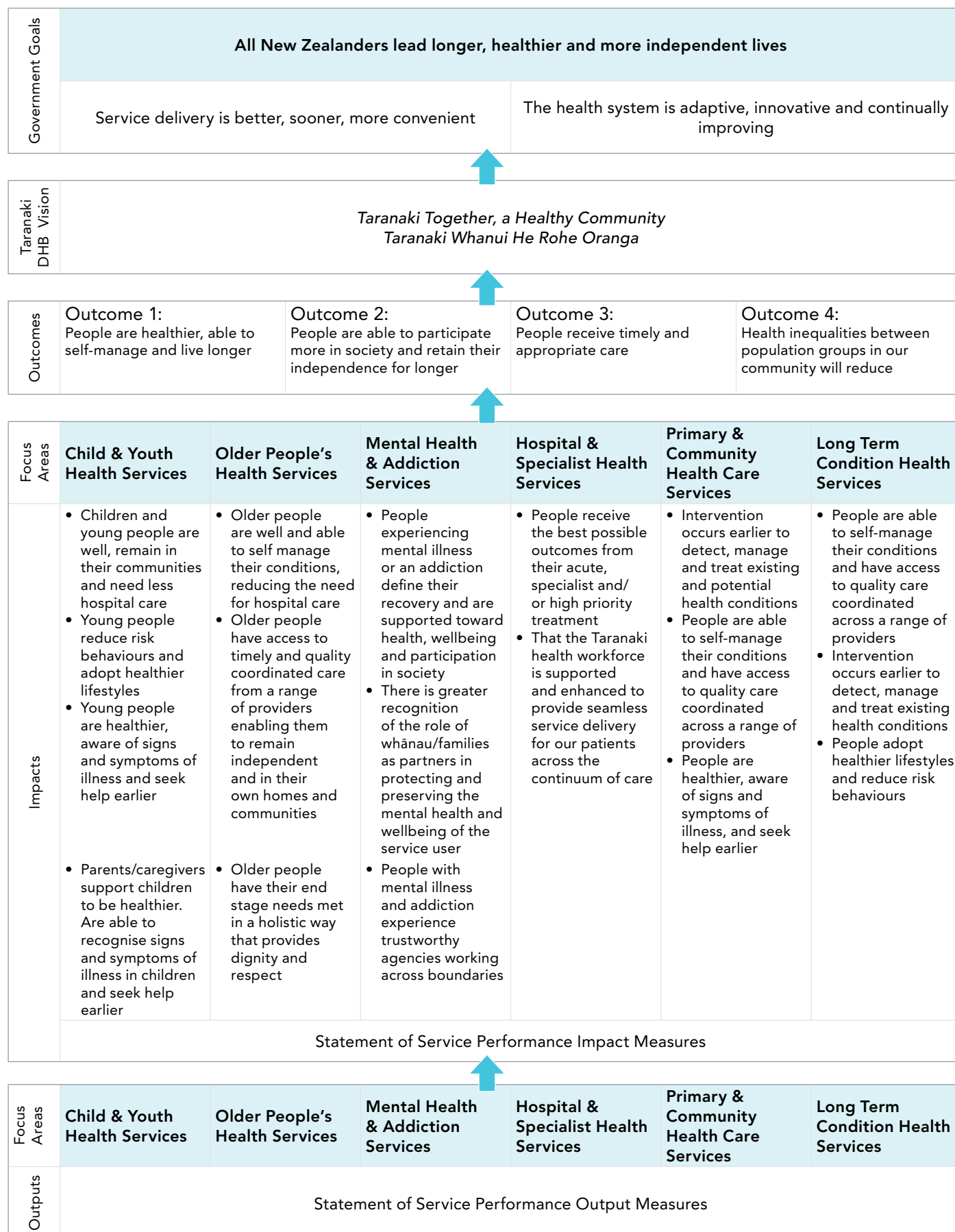
Output Class	Planned Revenue (\$000's)	Actual Revenue (\$000's)	Planned Expenditure (\$000's)	Actual Expenditure (\$000's)
Prevention	5,552	6,930	5,497	7,595
Early Detection and Management	94,332	94,615	93,390	86,777
Intensive Assessment and Treatment Services	163,701	163,820	162,066	181,513
Rehabilitation and Support	52,632	53,489	52,106	42,809
TOTAL	316,217	318,853	313,059	318,694

⁸ The 2004 Crown Entities Act requires under section 153 that a Statement of Service Performance be complete.
<http://www.legislation.govt.nz/act/public/2004/0115/latest/DLM330555.html>



Statement of Service Performance

Our Performance Story





Eltham Primary School celebrate toothbrushing

Kylie White (left) and Demelza Parlane breastfeeding at Espresso (BEWH)

CHILD & YOUTH HEALTH SERVICES

Children and young people are identified as a key population group which has the greatest opportunity to improve the health status in the short, medium and long term. The status of the health and wellbeing of our children is complex and is strongly influenced by socio-economic and other ecological factors in their environment. Good health and wellbeing of our children now and into the future will mean healthy, strong and successful communities and society as a whole.

Celebrating Oral Health with our Children

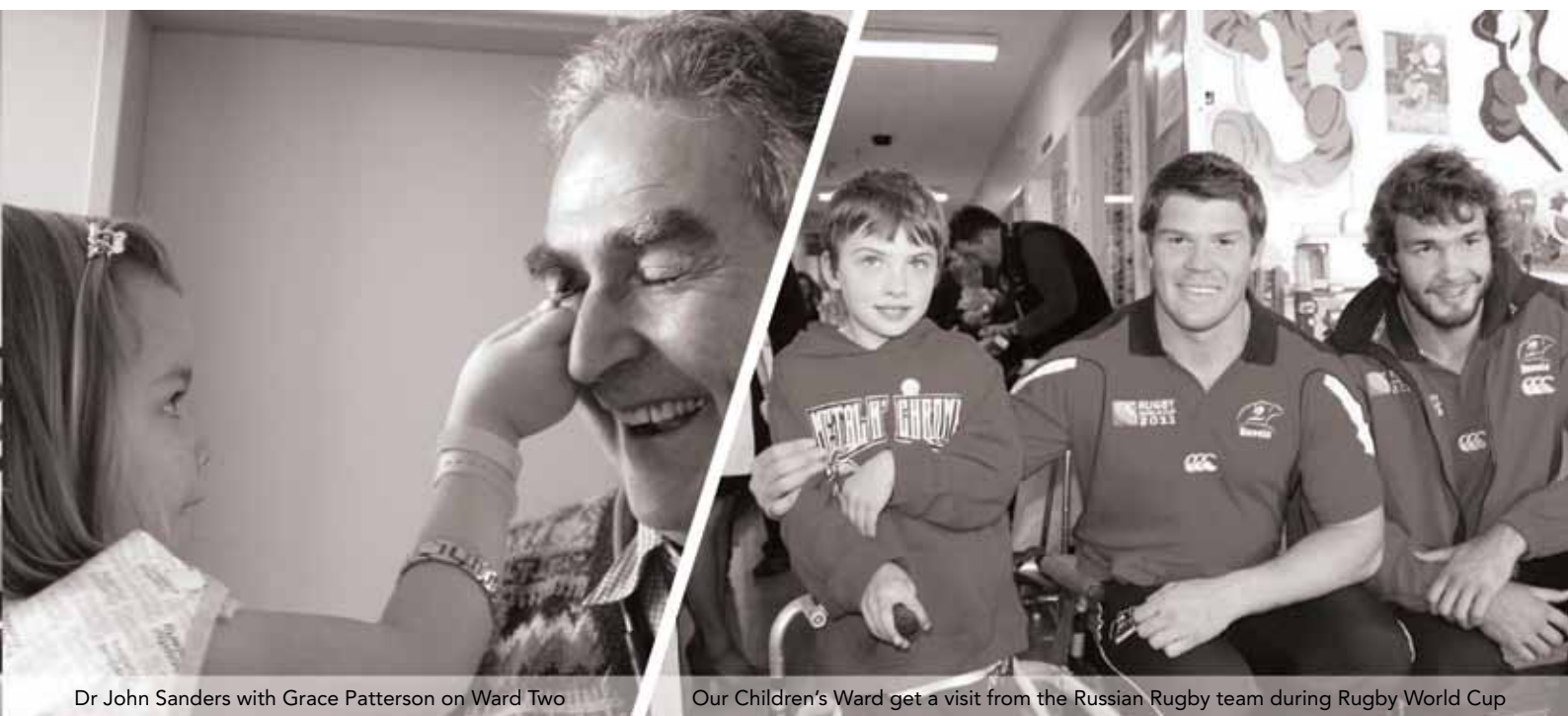
Eltham Primary School children were given a chance to brush up on their oral hygiene, thanks to a new school based tooth brushing programme launched as part of Oral Health Week in September 2011.

Eltham Primary School was chosen because children in the area have historically suffered high levels of dental decay and along with the school, Dental Therapist Lois Harrop was keen to support the new programme.

"Oral health is vital for children to be able to speak and eat properly, and is important for children's self esteem and quality of life," said Mrs Harrop. "Tooth brushing programmes are fantastic, because kids learn how to brush their teeth properly and most importantly learn that tooth brushing can be fun!"

The programme is a joint initiative between the Taranaki DHB's community oral health service, the New Zealand Dental Association and Colgate, who have supported the initiative by providing free toothbrushes and toothpaste.

Statement of Service Performance



Dr John Sanders with Grace Patterson on Ward Two

Our Children's Ward get a visit from the Russian Rugby team during Rugby World Cup

Baby Friendly Initiatives

On 13 October 2011, Hawera and Base Hospitals and Elizabeth R in Stratford were awarded with a certificate for being accredited as a Baby Friendly Hospital.

The Baby Friendly Hospital Initiative (BFHI) assists all maternity hospitals to become centres of breastfeeding support. A Baby Friendly Hospital adopts 10 steps to successful breastfeeding, and provides good care before, during and after birth.

Taranaki DHB also promotes breastfeeding through the Breastfeeding Welcome Here (BFWH) project which is a component of the Taranaki DHB Public Health Unit breastfeeding programme. Breastfeeding Welcome Here aims to increase support for breastfeeding in the community through highlighting breastfeeding friendly places. There are a variety of community settings in Taranaki including cafes, libraries, medical centres and other public places that are BFWH accredited.

HIGHLIGHTS FROM THE YEAR

Planning has been underway to implement a gateway co-ordinator in Taranaki in 2012. This role will see every child that is in Child Youth and Family (CYF) care receive a paediatrician assessment and referrals around immunisations, dental care, and vision and hearing testing. The initiative will reduce the risk of children not receiving the care they are entitled to as children and young people.

The Whānau Pakari project is well underway with a large number of children/young people and their families registered with the programme. The project is run in conjunction with Sport Taranaki. Children and their families' receive education and care around healthy eating choices, exercise, psychology and counselling support. The objective is to reduce unhealthy weight and reduce the risk of chronic illness later in life, for example diabetes and heart disease.

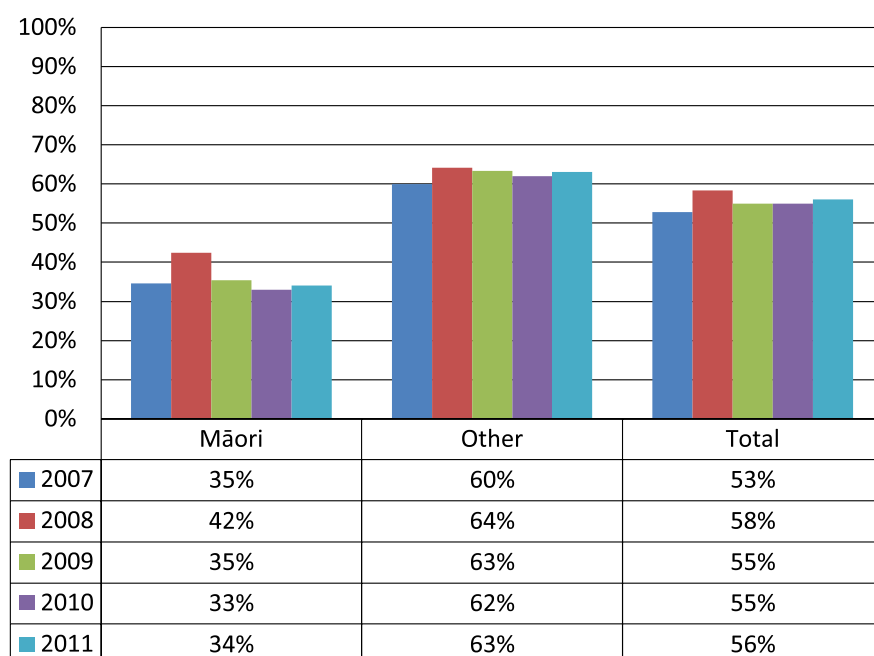
Work surrounding community oral health services for children and young people in South Taranaki was initiated in early 2012 with a decision to locate the South Taranaki Dental Clinic at Hawera Hospital. The state-of-the-art facility will enable improved access for dental care and oral health for children aged 0 – 18 and is due to open in late 2012.

Patients in Ward Two at Taranaki Base Hospital were delighted by members of the Russian and USA rugby teams coming to visit during the Rugby World Cup in 2011. Ward Two play therapist Sharon Luque had the children colouring and decorating the ward in their favourite rugby teams. The players played, chatted and laughed with the patients and their families and enjoyed the interactions. The Russian command of English was limited at times but the smiles on the faces of the children was enough to know they understood the significance of the visit and certainly enjoyed it.

Statement of Service Performance - Child & Youth Services

Impact Measures

The proportion of children caries-free at age 5



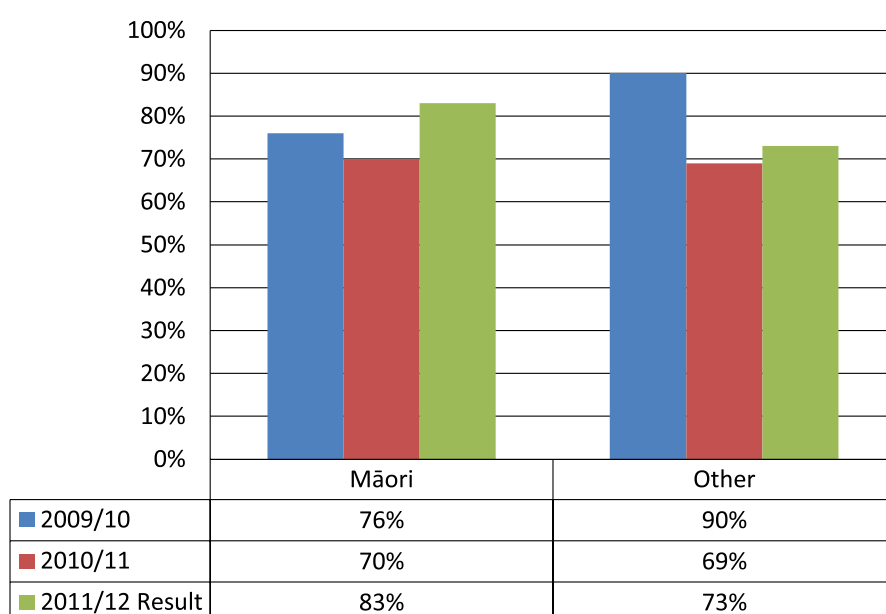
Target:

Māori	43%	Not Achieved
Other	66%	Not Achieved
Total	60%	Not Achieved

None of the targets were met for the proportion of five-year-olds with no holes or fillings. This is a medium term impact which is effected by many different factors.

New Plymouth, the largest urban area in Taranaki, has recently removed fluoride from the reticulated water supply. Although this will not have greatly impacted the status reported here it is likely to have an affect into the future. The dental team have been continuing activities which is hoped to mitigate the affect such as providing toothpaste and toothbrushes to all 'at risk' children, targeted tooth brushing programmes to low decile and topical fluoride applications to high risk patients as per MoH guidelines.

Ambulatory Sensitive Hospitalisations (ASH) rates for 0-4 year olds



Target:

Māori	<95%	Achieved
Other	<95%	Achieved

The expected Ambulatory Sensitive Hospitalisations (ASH) for the total population ages 0-4 years has been gradually improving over time. We have consistently achieved against the national target that we remain under 95% of the expected ASH.

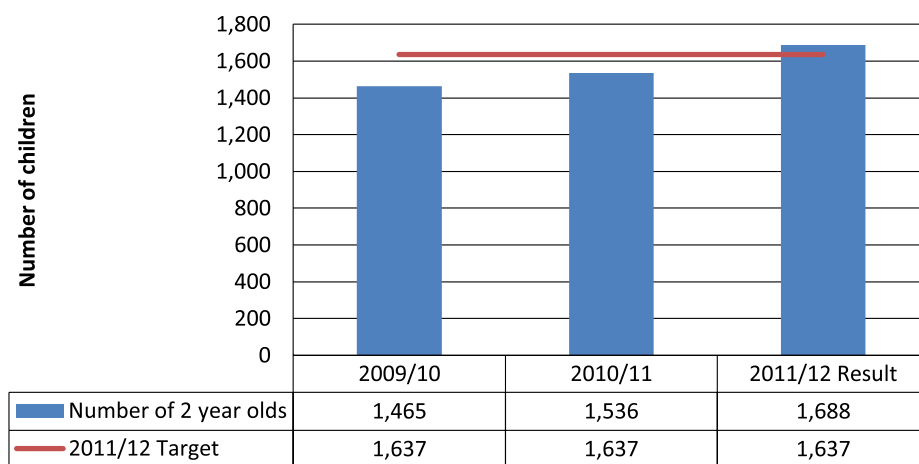
The result for Māori, although achieved, has increased slightly over time. We will continue to monitor to ensure both achievement of the target but also ensure that inequalities are reduced.

This is a medium-term impact affected by a variety of programmes and services. Reducing avoidable hospital admissions requires engagement across the whole of the health system and is therefore affected by many of the output measures reported.

Statement of Service Performance - Child & Youth Services

Output Measures: Prevention - More children and young people stay well

Number of children fully immunised at age 2

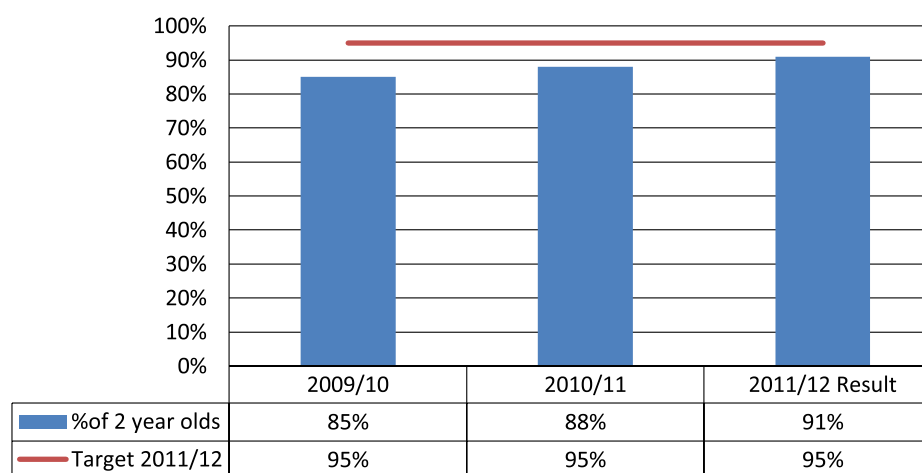


Target:

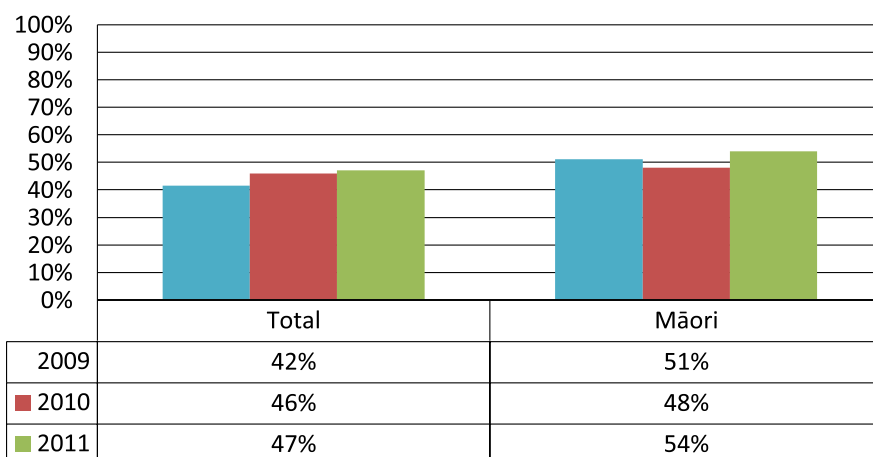
1,637 2yr old children	Achieved
95% of 2yr olds	Not Achieved

The number of two year olds who were fully immunised has increased substantially over the last three years to 1,688 in 2011-12. The target of 95% for total percentage of two year olds fully immunised was not achieved. However, there has been a general increasing trend over time from 85% in 2009/10 to 91% in 2011/12. The Taranaki Immunisation Steering Group has recently re-written the Taranaki Immunisation Strategy which is expected to achieve the desired outcome of continuing this trend.

Percentage of children fully immunised at age 2



Percentage of Year 8 girls fully vaccinated against HPV



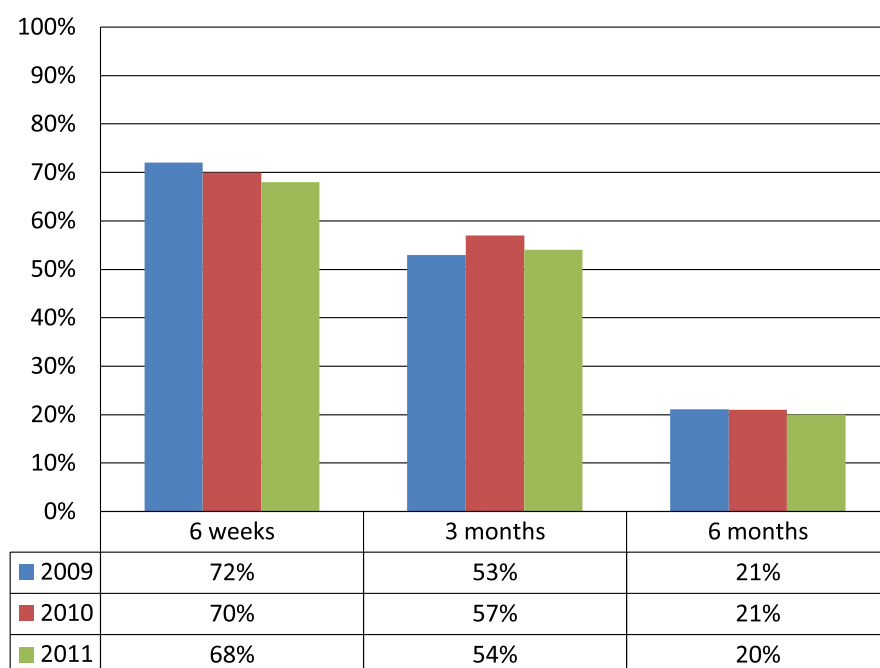
Target:

Total	50%	Not Achieved
Māori	55%	Not Achieved

Despite not achieving the targets, the rates for Māori have continued to track up this year, and the total vaccination has continue to increase. As the programme becomes further embedded as a core vaccination, we anticipate the uptake to steadily increase over time.

Statement of Service Performance - Child & Youth Services

Percentage of infants fully breastfed

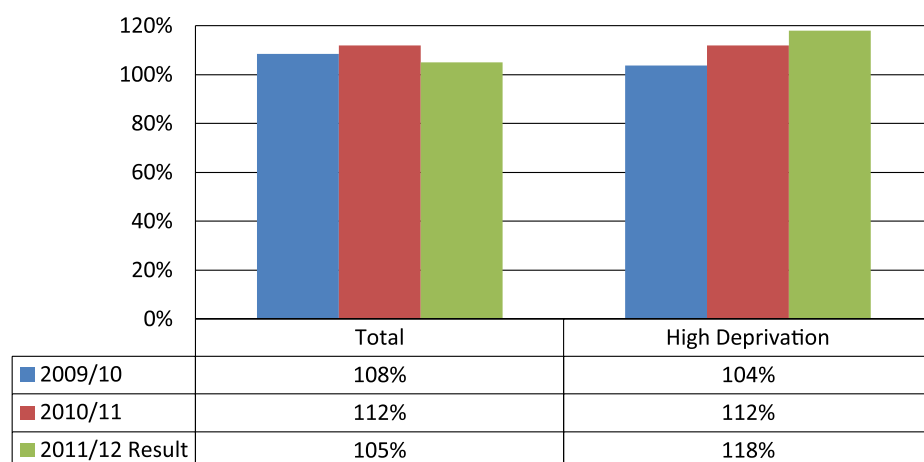


Target:		
6 weeks	74%	Not Achieved
3 months	55%	Not Achieved
6 months	26%	Not Achieved

Taranaki DHB acknowledges that the breastfeeding rates for the region need to improve. With the introduction and maintenance of the Baby Friendly Hospital accreditation the number of babies breastfeeding at discharge has steadily risen. Therefore, Taranaki DHB has recently channelled initiative funding through a Breastfeeding Community Support Service with the objective that the rates are maintained once the mothers and babies leave hospital. There are several streams to the initiative which include employing a Breastfeeding Coordinator, accrediting providers under the New Zealand Breastfeeding Authority Baby Friendly Community Initiative, and training Peer Support Counsellors in 'priority communities'.

Output Measures: Early Detection and Management - Children and young people are seen and treated early

Percentage of B4 School Checks target achieved

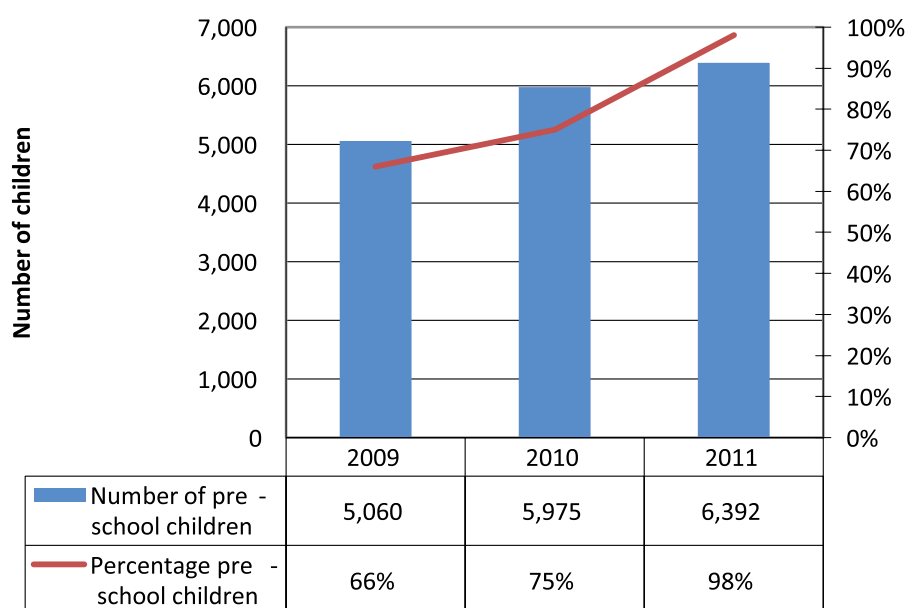


Target:		
Total	100%	Achieved
High deprivation	100%	Achieved

The hard work carried out by our B4 School Checks team has again ensured that children in Taranaki are receiving their B4 School Checks in a timely manner. It is very pleasing to see that the proportion of the high deprivation cohort receiving their checks has been increasing year on year.

Statement of Service Performance - Child & Youth Services

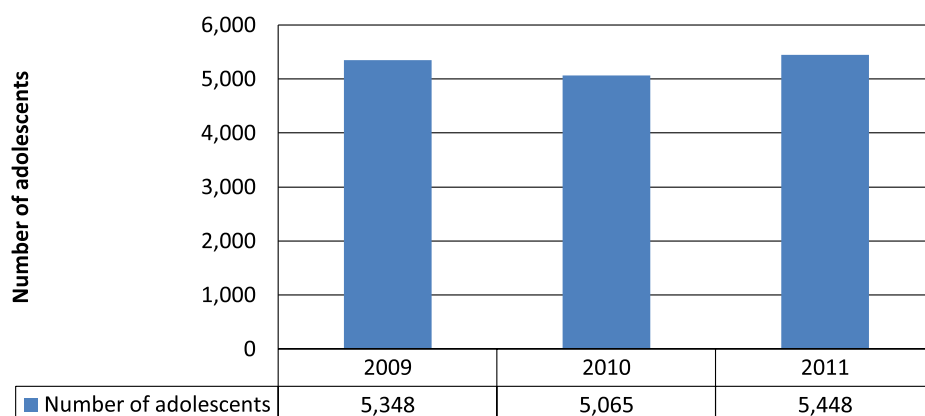
Pre-school children enrolled with DHB funded oral health services



Target:		
Number of pre-school children enrolled	6,500	Not Achieved
Percentage of pre-school children enrolled	80%	Achieved

The estimated number of pre-school children in Taranaki was 6,500 in 2011. Taranaki DHBs result of 98%, a 32% increase compared to 2010, reflects the considerable effort and work undertaken by the oral health team. The targeted number which was set at 6,500 was aspirational and against the 80% target should have been 5,200. Therefore we saw nearly 1,200 more children than was expected.

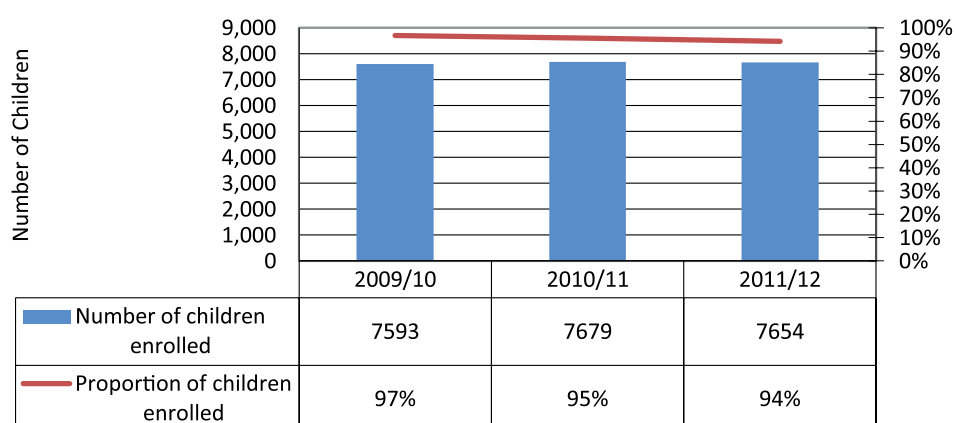
Number of adolescents provided with oral health services



Target:		
Number of adolescents provided with oral health services	5,912	Not Achieved

There was estimated to be 6,955 adolescents in Taranaki in 2011 and 78% were provided with Oral Health services funded by our DHB. This is a huge improvement compared with last year and Taranaki DHB are currently working with the Adolescent Oral Health Coordinator Services to review the current service delivery and to refocus efforts on areas likely to increase uptake in services.

Number and proportion of children 0-4 enrolled with a PHO



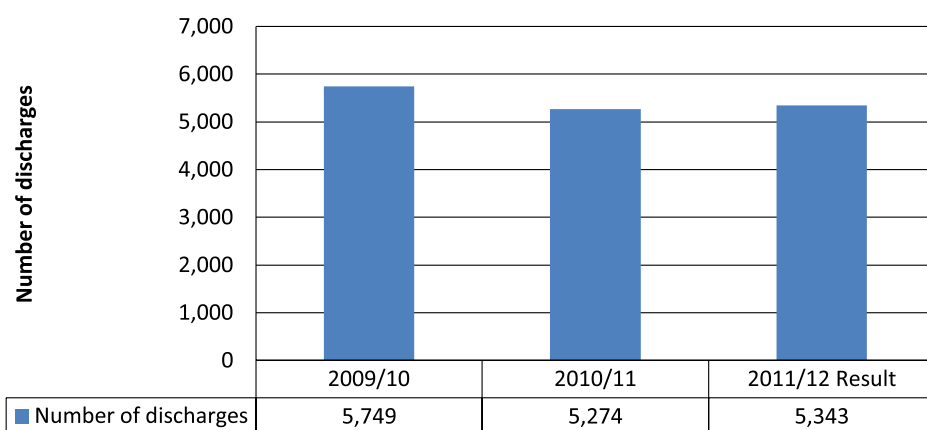
Target:		
Number of children 0-4 enrolled with a PHO	7,884	Not Achieved
Proportion of children enrolled with a PHO	98%	Not Achieved

Although the number of children between the ages of 0-4 enrolled with a PHO has not significantly changed over the last three years the projected population has increased by 3.5% over the same period. Work is underway through the Taranaki Immunisation Strategy Group to ensure more children are registered with a GP within two weeks of birth.

Statement of Service Performance - Child & Youth Services

Output Measures: Intensive Treatment and Assessment - Children and young people have timely access to appropriate specialist services

Number of Taranaki DHB domiciled discharges related to children and young people

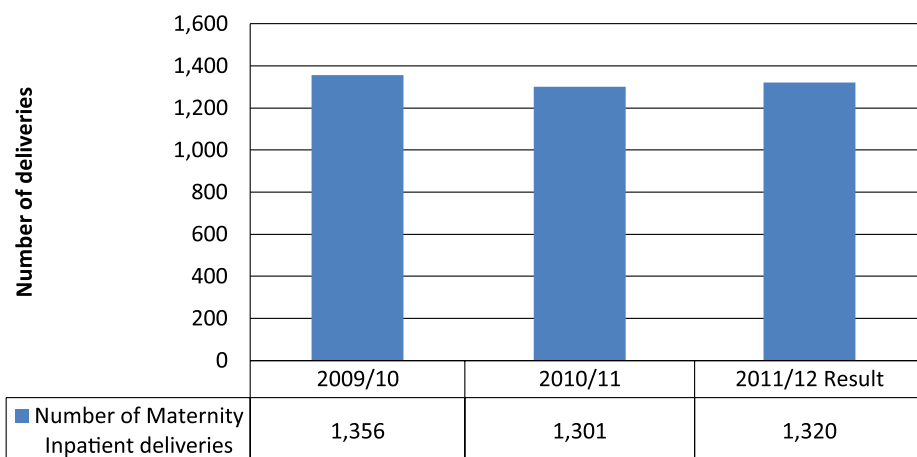


Target:

Number of Taranaki DHB domiciled discharges related to children and young people	<5,749	Achieved
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The target for a reduced number of discharges related to children and young people was met for 2011/12.

Number of maternity inpatient deliveries



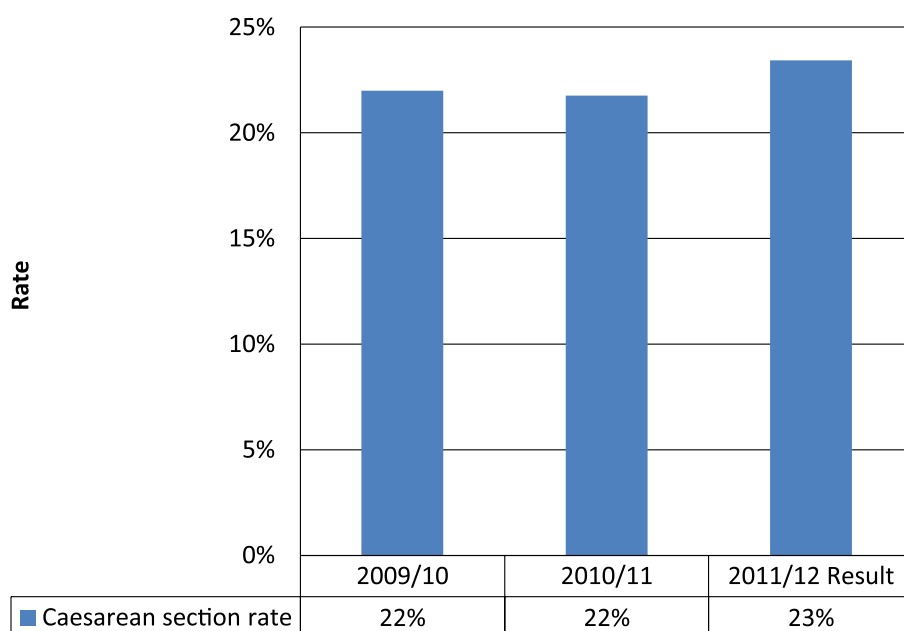
Target:

1,301	Achieved
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The target for the number of births in Taranaki was achieved. This is an output measure reflecting the services that we plan and fund and not a performance measure.

Statement of Service Performance - Child & Youth Services

Reduced caesarean section rate per birth of total NZStats recorded Taranaki births



Target:

<0.22

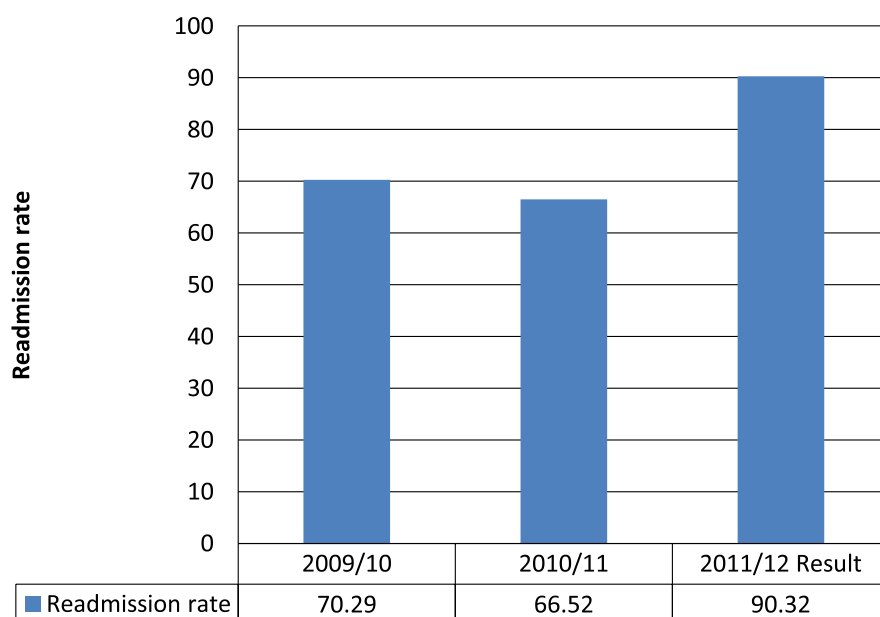
Not Achieved

There is no consensus of an optimal caesarean section rate for New Zealand. However, it is noted that Taranaki caesarean births have increased by 1% in this last year which may be due to an increase in more complex cases such as morbid obesity, gestational diabetes and older first time mothers.

In comparison to other NZ DHB's the Taranaki caesarean section rate is below the average rate, the highest being 35.2% and lowest being 18.8% in 2011 (Health Round Table Dec 2011).

The initiation of a local Maternity Quality Committee will implement a monitoring system for maternity outcomes, including caesarean section rates in Taranaki DHB to try and identify areas of clinical practice where improvements may be able to be made.

28 day acute readmission rate per 1,000 discharges for paediatric service



Target:

<70.29

Not Achieved

Taranaki DHB did not reach the targeted acute readmission rate for 2011-12. There are several re-admitting conditions which are consistent with the conditions contributing to the average length of stay target not being met. There is currently planning work both in the hospital and in primary settings which are being developed around some of these conditions which are likely to have an impact on the re-admission rates.



Ward Five share in the Ranfurly Shield celebrations

OLDER PEOPLE'S HEALTH SERVICES

Meeting the growth in demand for services associated with a growing older population and associated growth in the number of people with a long term condition is a national and international issue.

Dedicated Stroke Unit helps patient recovery

Taranaki DHB's dedicated Stroke Unit has been saving lives and aiding recovery to stroke victims across Taranaki. Ward One has a committed group of clinical staff working together to provide an improved stroke service, achieving timely diagnostics, appropriate assessments and treatment for stroke patients preventing complications and improving outcomes.

The stroke team consists of nurses, a physiotherapist, an occupational therapist, a social worker, a speech-language therapist, a dietician, and a geriatrician. This interdisciplinary approach utilises a range of health professions with expertise in stroke and rehabilitation. Taranaki DHB geriatrician Dr Bhavesh Lallu said that on average 180 Taranaki people suffer a stroke each year. Under the care of the multi-disciplinary team, nine patients will have a better outcome after their stroke. "And more patients will return home rather than go into full-time care," Dr Lallu said.

In the past, many of those patients were not being treated with urgency, did not get timely diagnostic scans, were cared for by a diverse number of clinicians and were spread throughout the hospital.

"Stroke Unit care is all about co-ordination and continuity of care, and being looked after by a team of professionals interested in stroke," Dr Lallu said.

Under the new stroke pathway, the aim is to have stroke patients transferred out of ED within six hours and into the hands of the team in either Intensive Care Unit or Ward One, depending on the severity of the stroke.

Statement of Service Performance



Claudi Hatcher checks in on patient Judith Johnston

Parkinsons Disease Team

Two dedicated Parkinsons Disease teams in Taranaki are improving services for those suffering from movement disorders. Geriatrician, Dr Dianne Stokes initiated the service, with community physiotherapist Carla Loevendie and Parkinson's Society Field Officer Sue Alleman, after seeing a growing number of older people suffering from the disease.

"Although Taranaki has very good visiting neurologists, patients are more comfortable contacting a local person with experience in dealing with Parkinson's and that is what the service offers" said Dianne.

The Parkinsons Disease teams in North and South Taranaki operate under the older peoples health community services, but can also manage younger people with Parkinsons or related movement disorders if needed. The two teams consist of a speech language therapist, physiotherapist, occupational therapist, Parkinsons Taranaki Field Officer and Kaimahi Hauora.

As of 30 June 2012 there were 126 patients on the database for the North Taranaki team and 53 for the South Taranaki team. Both teams meet once a month to discuss patients and plan interventions to ensure the best care is in place. The teams have been working really well, with patients valuing the local contact.

HIGHLIGHTS FROM THE YEAR

Early 2012 has seen a lot of planning towards the **enhanced intermediate care for older people** component of the older people's health intermediate care service. This service is targeted to older people who would otherwise face an extended length of stay in acute inpatient services or prematurely enter residential care. The service is normally delivered within a maximum of six weeks with some service users requiring as little as 1-2 weeks. Length of stay in the service will be under continual review by the Taranaki DHB ICATT (Intermediate Care Assessment & Treatment Team). The service is designed to facilitate the transition from hospital to home, and/or from medical dependence to optimal functional ability. Where the objectives of care are not primarily medical, the service user's discharge destination is anticipated and a clinical outcome of recovery (or restoration of health) is appropriate.

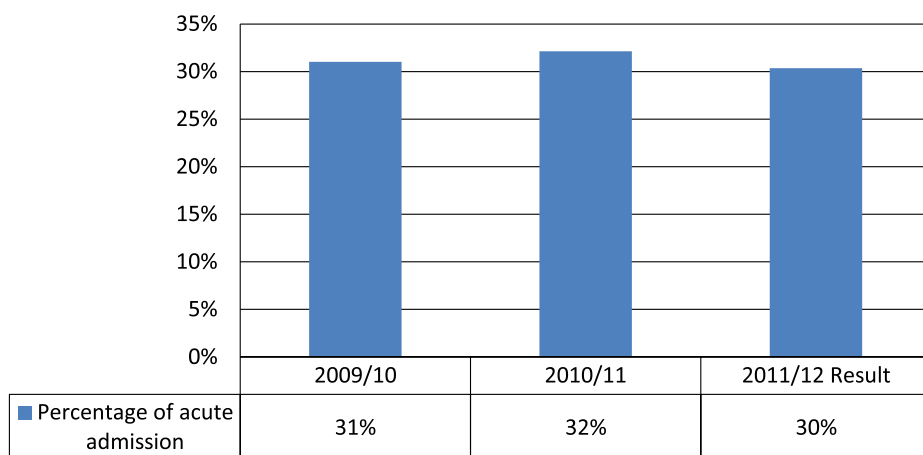
The **Older People's Health And Rehabilitation Service (OPHRS)** introduced two gerontology Clinical Nurse Specialist (CNS) roles within their service at the beginning of 2012. One for inpatients and the other for community. The inpatient CNS role has three main focus areas; stroke, orthogeriatrics, and delirium. The community CNS role focuses mostly on providing specialist nursing care for community patients in the OPHRS service. This includes the ICATT (Intermediate Care Assessment & Treatment Team) service and following up patients receiving complex care in the community.

The **older people's referral hub** became fully operational as of June 2012. This was a key initiative to fall out of Project Splice. All referrals for access to specialist services older people's health, i.e. community support services, community allied health, long and short term support services, are now managed within the referral hub.

Statement of Service Performance - Older People's Health Services

Impact Measures

Percentage of acute admissions



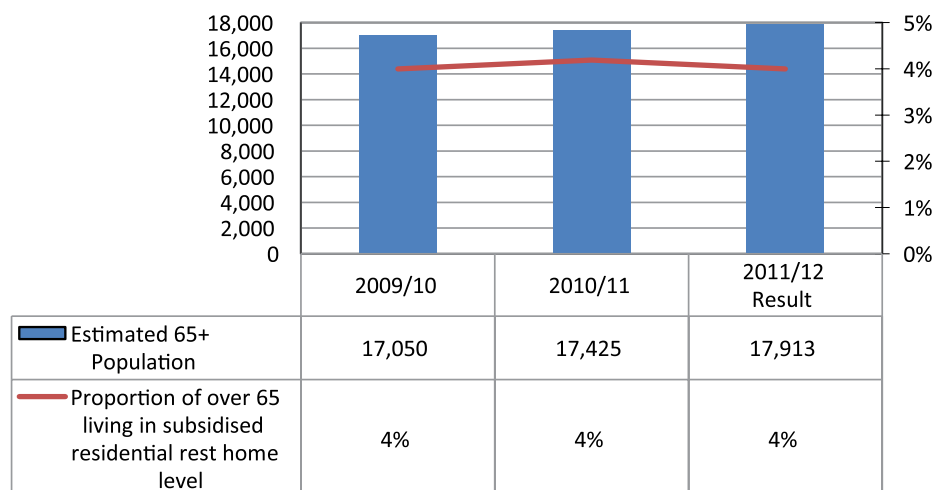
Target:

29%

Not Achieved

The target for the percentage of acute admissions for the 65+ age group was not met for 2011/12. A Primary Options for Acute Care (POAC) programme is being developed during 2012/13. POAC will be looking to provide a 24/7 response for older people allowing easy access to a number of short term package of care options aimed at reducing Emergency Department and hospital admission.

Proportion of over 65 yr population living in subsidised residential rest home level



Target:

4%

Achieved

Despite the estimated population projections for the over 65 age group increasing greater than expected, the proportion of this population group in subsidised Aged Residential Care has remained stable over the last three years. This is a medium term measure which is expected to be influenced by many factors, some of which are included in the output measures on the next page.

A reduction in the number of older people (75 years plus) admitted to hospital as a result of a fall

DATA UNAVAILABLE

Target:

4%

Data Unavailable

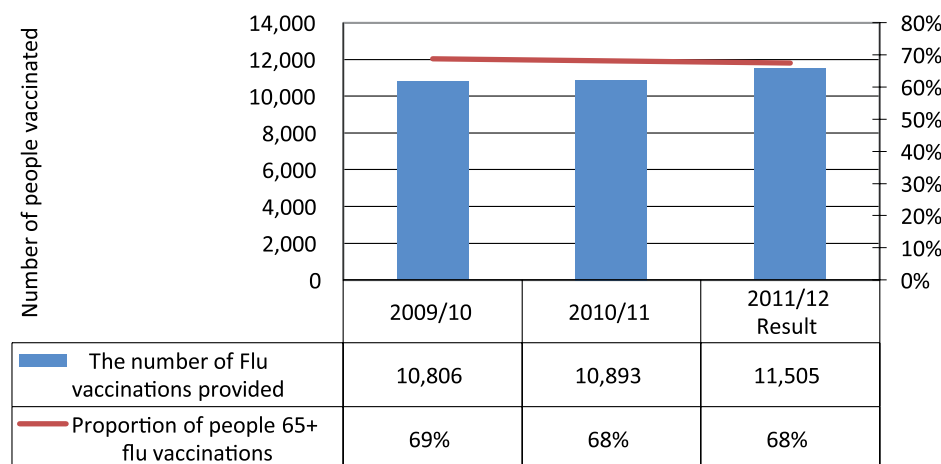
The Ministry of Health originally expected that during 2011-12 data would be collected against this measure with a view to informing a Health target in 2012-13. During the 2012-13 planning phase this measure was replaced and as such the data is unavailable.

However, there are various programmes and initiatives which are undertaken in Taranaki regarding falls prevention in the elderly.

Statement of Service Performance - Older People's Health Services

Output Measures: Prevention - Health and well-being of older people will be improved through population-based health initiatives and programmes

Flu vaccinations provided to people aged over 65



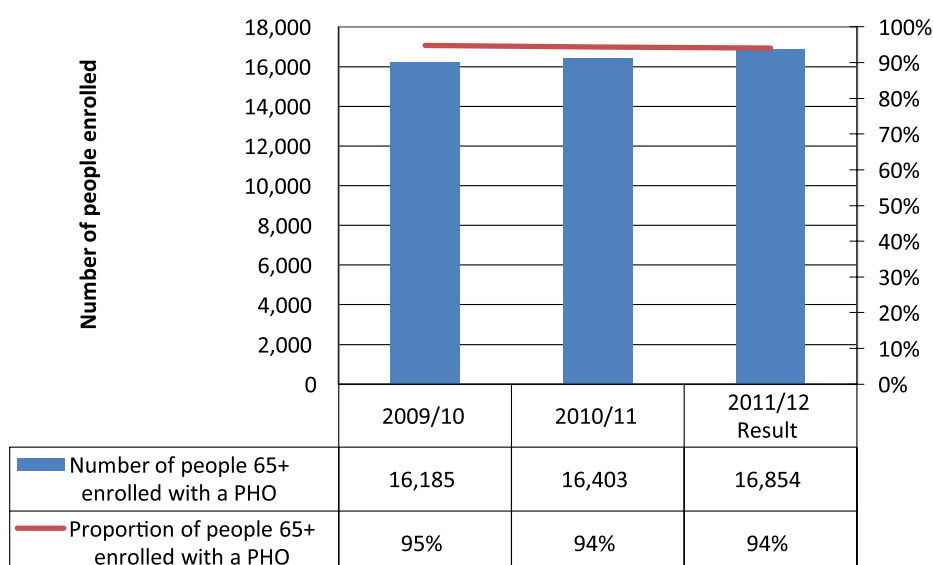
Target:

The number of Flu vaccinations provided to people aged over 65	11,300	Achieved
Proportion of people 65+ receiving seasonal influenza vaccinations	>70%	Not Achieved

Taranaki DHB achieved against the target of 11,300 people aged 65 or over receiving their influenza immunisation, however did not receive against the proportion of the 65+ population. Since 2009-10 the number of people enrolled with a PHO has increased by over 1,300 or 8%. The number of influenza immunisations has increased by 700 or 6.5%. We need to ensure that immunisations are increased in line with this growing vulnerable population.

Output Measures: Early Detection and Management - Older people are seen and treated early

Enrolment in Primary Health Organisations in the 65+ age group



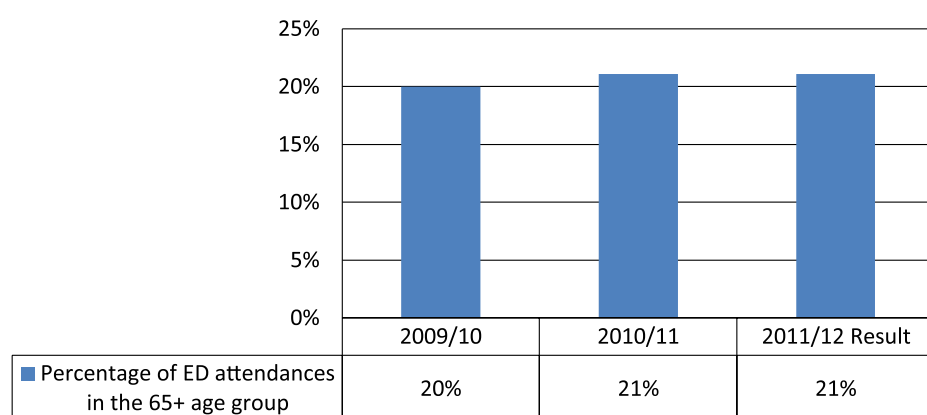
Target:

The number of people 65+ enrolled with a primary care provider	>16,185	Achieved
The proportion of people 65+ enrolled with a primary care provider	>95%	Not Achieved

During 2011/12 the estimated population projections for the over 65 age group were revised to a level higher than that previously predicted. As such, the target of people over 65 enrolled in a PHO was achieved but the proportion was not. There has been an increasing number of people in this age group enrolled every year and we need to ensure that enrolment is maintained in line with population growth.

Statement of Service Performance - Older People's Health Services

Percentage of Emergency Department attendances in the 65+ age group

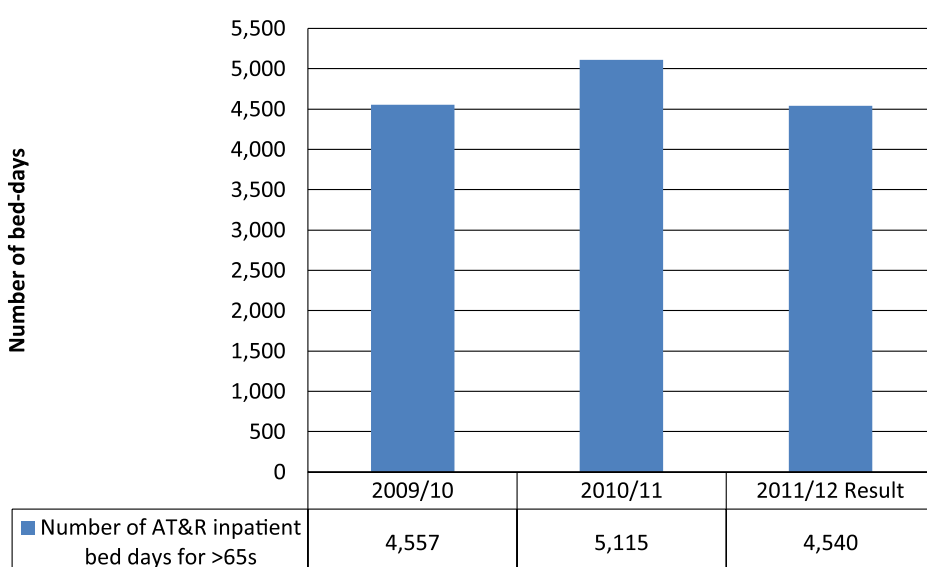


Target:		
Percentage of Emergency Department attendances in the 65+ age group	19%	Not Achieved

The target for the percentage of ED attendances in the 65+ age group was not met for 2011/12. The result has remained static over the last three years, which given the increase in this cohort is a positive result. However, there is work underway in both secondary and primary care looking at how some of the less urgent cases are managed into the future. We have also introduced sustainable after-hours GP services which are expected to reduce Emergency Department admissions.

Output Measures: Intensive Treatment and Assessment - those over 65 with acute, life-changing and life limiting conditions receive appropriate specialist treatment, care and support

Number of Assessment Treatment & Rehabilitation inpatient bed days for the 65+ age group

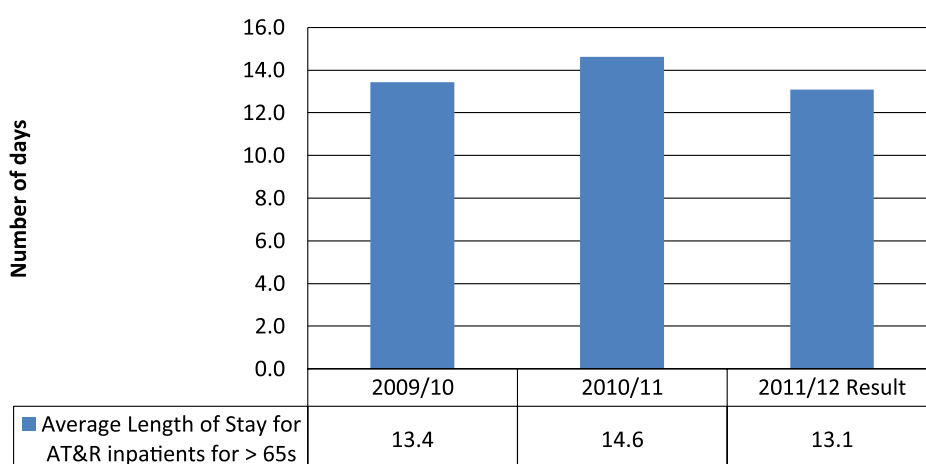


Target:	
≤4,824	Achieved

The target for the number of Assessment Treatment & Rehabilitation (AT&R) inpatient bed days for 2011-12 has been met. The management of the health of older people presentations to hospital is being supported through localised Care Pathways to cover assessment, diagnosis, treatment and referral management for commonly presenting issues.

Statement of Service Performance - Older People's Health Services

Average Length of Stay for Assessment Treatment & Rehabilitation inpatients for > 65s



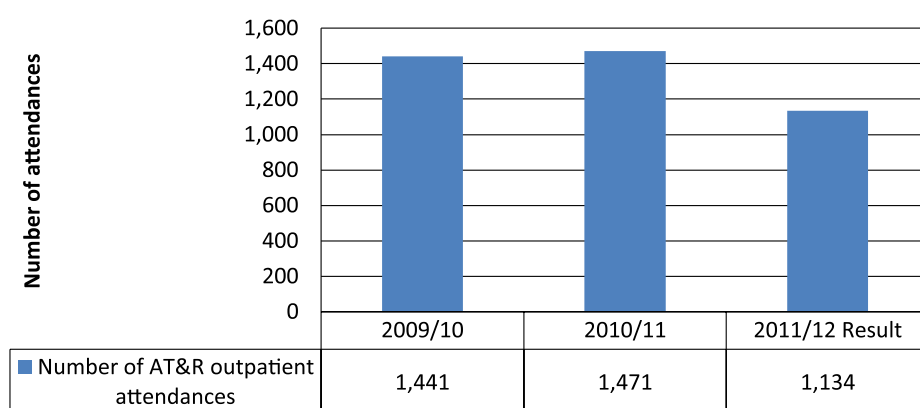
Target:

13 days

Not Achieved

Although the target was not met for 2011/12 by 0.1 day there has been a reduction in the Average Length of Stay for Assessment Treatment & Rehabilitation (AT&R) inpatients for 65+ age group compared to the 2009/10 year. There are several projects underway which will contribute toward achieving reduced length of stays. These include Releasing Time to Care, Stroke Pathways, The Productive Operating Theatre and Pre-Admission Pathways. In addition there is also work being undertaken to improve discharge planning from the time of admission. The introduction of an Intermediate care pathway will also contribute to a reduction in this indicator.

Number of Assessment Treatment & Rehabilitation outpatient attendances for the 65+ age group



Target:

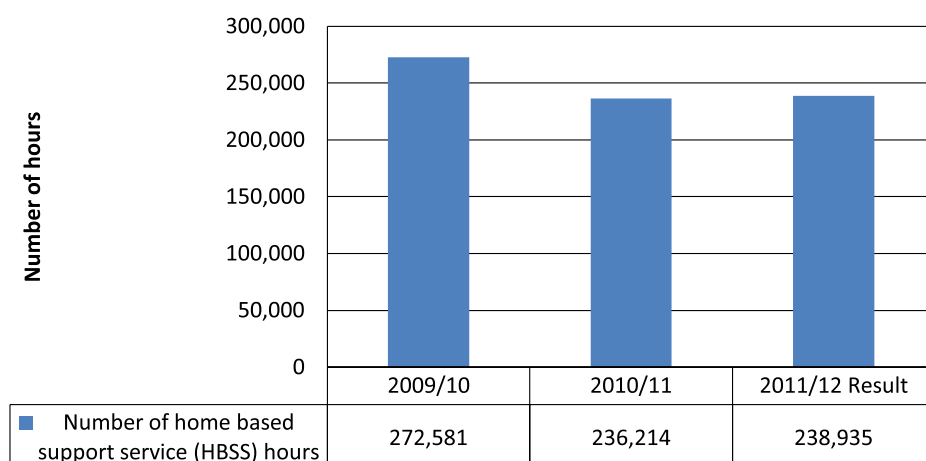
2,587

Not Achieved

The target for the number of assessment treatment and rehabilitation outpatient attendances for the 65+ age group has not been met. This measure is reflective of demand and the target was set too high. The management of the health of older people presentations to hospital is being supported through localised Care Pathways to cover assessment, diagnosis, treatment and referral management for commonly presenting issues.

Output Measures: Rehabilitation & Support - Older people's independence and quality of life will be improved

Number of home based support service (HBSS) hours



Target:

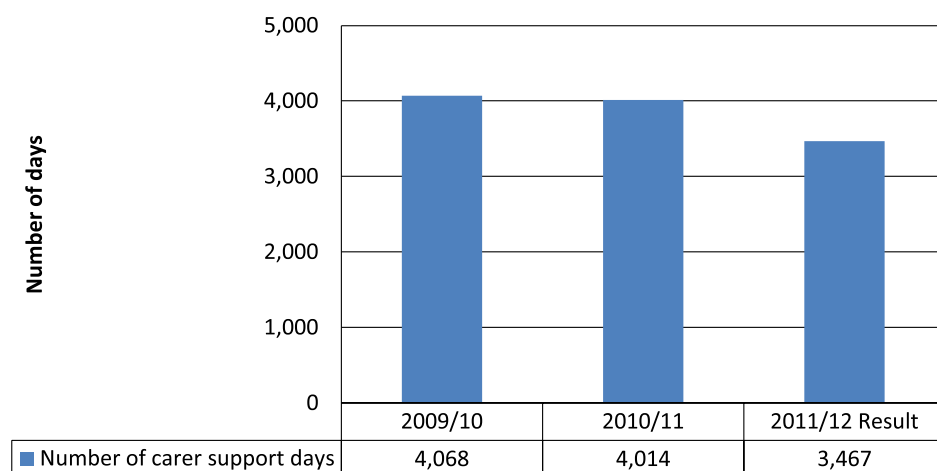
242,188

Not Achieved

Although the target of 242,188 home based support hours was not achieved for 2011/12 this was an estimation of the demand driven activity that we expected. The result of 238,935 represents 99% achievement against this estimation. The Needs Assessment and Coordination Service team, which controls the allocation for HBSS among others, was brought "in-house" during 2010/11. Since then we have implemented an increase in re-assessments under-taken to ensure that people are receiving the appropriate levels of care.

Statement of Service Performance - Older People's Health Services

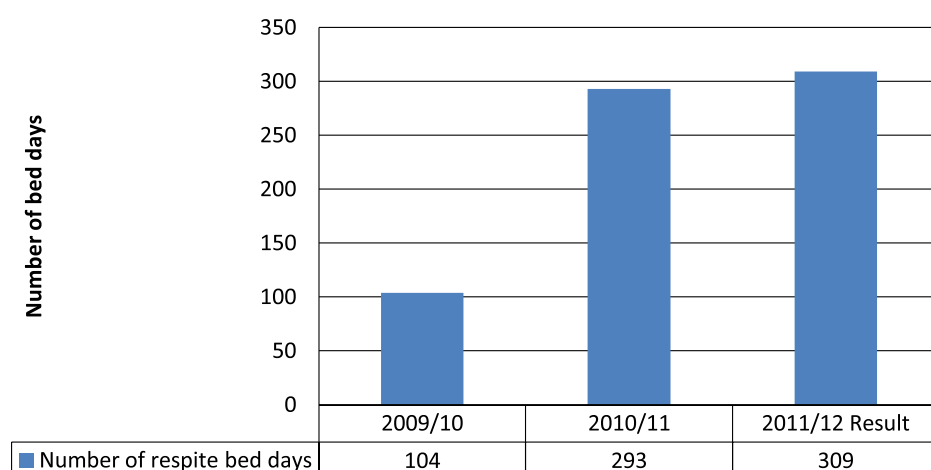
Number of carer support days



Target:		
Number of carer support days	4,271	Not Achieved
Number of respite care bed-days	505	Not Achieved
Number of specialist in-home dementia respite service	2524	Not Achieved
Number of specialist dementia day-care days	1557	Not Achieved
Number of day-care programme days	4,166	Achieved

Apart from the number of day-care programme days none of the targets in this section have been achieved.

Number of respite bed days



Following initial work on the development of a Specialist In-Home Dementia Respite Service, it became apparent that a more comprehensive review of carer support and respite services in Taranaki was required before establishing a new service. The targets for these services were not achieved in 2011/12 due to the extended timeframes required to review current service provision, to develop a suitable Service Specification and to undertake a Request for Proposals (RFP) process to identify a suitable provider.

This review identified a number of recommendations, including the following:

1. To lower the access threshold for Residential Respite.
2. Increase availability of Dementia Day Care Programmes in North and South Taranaki.
3. Development of an In-Home Respite Service aimed at clients with complex dementia.
4. Funding to support increase in hours of Alzheimer's Taranaki Field Officer in South Taranaki to encourage greater access to respite provision by carers of people with dementia.

(continued over...)

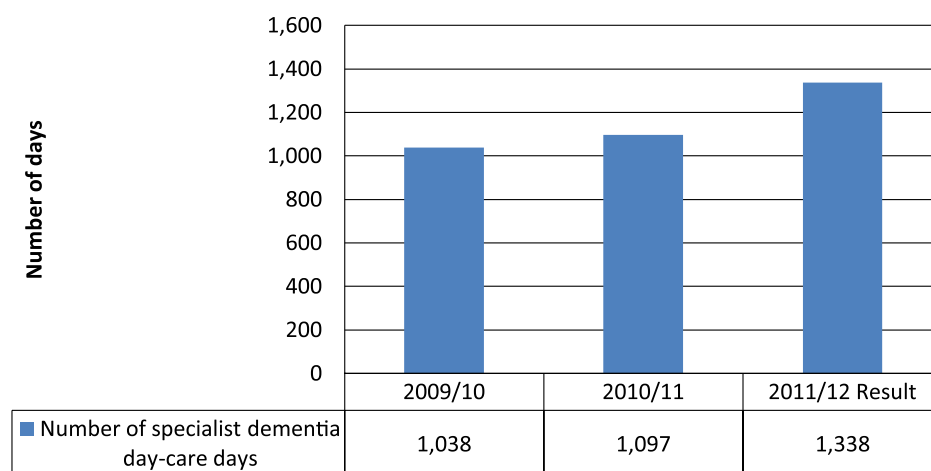
Number of specialist in-home dementia respite service

DATA UNAVAILABLE

Service not started in 2011-12

Statement of Service Performance - Older People's Health Services

Number of specialist dementia day-care days

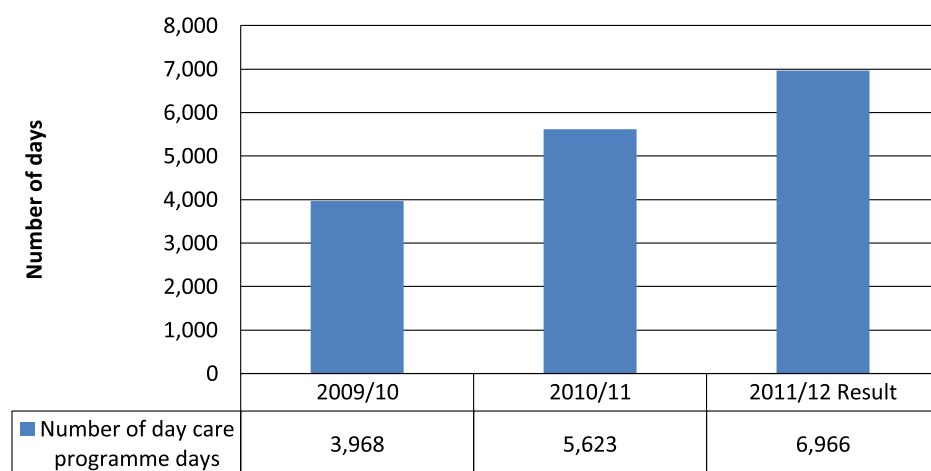


5. Carer Support to be used only for informal care arrangements with funded care packages allocated for all formal care services (e.g. Day Care, Residential Respite, In Home Respite).

The review found that while allocation of residential respite was high, actual utilisation of the service was low. Consultation undertaken as part of the review identified a number of reasons for this, including a reluctance amongst some carers (and clients) to use residential care and a preference for Day Care placements or informal care arrangements within the home. This is demonstrated by the significantly increased utilisation and expenditure on Day Care Services in 2011/12 as compared to other respite services.

All of our Aged Related Residential Care providers have been offered new Short Term Residential Care contracts from 1 July 2012 and these include day placements (6-8 hours per day) which will serve to increase availability and options for day care services even further in the future.

Number of day care programme days



The ratio of total dollars spent on Aged Residential Care (ARC) to Home Based Support Services (HBSS)

Target:

3.8:1

Not Achieved

There has been a gradual increase in the ratio of spending on Aged Residential Care services versus Home Based Support services over the last three years. The Residential Dementia Services received a greater price increase than the rest of the Older People's Health Services during 2011-12 which accounts for some of the difference. There has also been a reduction in the utilisation of the Household Management Services which has also contributed towards this change.

	2009/10	2010/11	2011/12 Result
Ratio	3.6:1	4.1:1	4.2:1



White Ribbon Day celebrations

MENTAL HEALTH AND ADDICTION SERVICES

Significant progress in improving the mental health and addiction services has been made over the past 15 years. However, mental health disorders and addictions continue to present major public health challenges equal to heart disease, diabetes and cancer. In meeting the obligations of Te Tahuhu and Te Kokiri, Taranaki DHB will continue to promote and support key sector initiatives and projects that will better identify, support and deliver seamless services to our most vulnerable service users, tangata whaiora and their families and whānau.

Living Well with Dementia

A seven session programme about living with the effects of dementia was first established in late 2011 and has since become a regular programme and well received by all attendants.

The programme was developed by Mental Health Services for Older People (MHSOP) team leader Marilla Tyler and occupational therapist Sonia Terry. "It is a further development on the memory clinics that used to run here and is in line with our dementia care pathway," said Marilla.

The programme helps both the person

diagnosed and their carer, be that wife, husband or other family member, deal with dementia in day-to-day life.

Over seven weeks sessions are held once a week and cover a variety of topics such as understanding dementia, looking after yourself, managing tasks and coping strategies, support networks, and finance and future planning.


Each session is organised informally and focused on reassurance. "It is easier to absorb information in an enjoyable way," said Marilla. The sessions

involve physical exercises, group work, and some role play with input from Alzheimers NZ, Sport Taranaki, social workers and occupational therapists.

"The group welcomes the opportunity for socialising, sharing and supporting each other," said Marilla.

The programme works well with GPs and allows them to have confidence in telling a patient where they can get help to cope with the diagnosis of dementia. The MSHOP team has also put together dementia packs for GPs to pass on to their patients.

Statement of Service Performance



Back Beach, New Plymouth

HIGHLIGHTS FROM THE YEAR

In 2011-2012 Taranaki DHB and the wider mental health and addictions sector including Pathways, Tui Ora, Healthcare NZ, Ngati Ruanui, Linkage Trust, Progress to Health, Schizophrenia Fellowship, and Likeminds undertook a project on the **adult continuum of care**. The project identifies 39 client pathways in and through adult mental health and addiction services and the approach is to ensure these services are streamlined and reduce complexity. A number of key areas were prioritised for development including:

- Crisis/planned respite
- Longer term ageing clients, like in age in interest, and severe and enduring with co-morbidities
- Alcohol and drug service
- South Taranaki - whole of system approach
- Adult rehabilitation and recovery beds

Each area has provided recommendations for the model of care configuration, which have been signed off and further work and implementation will be undertaken in 2012-2013. The next steps are to ensure the recommended models are affordable and prioritised.

New model of care in **Te Puna Waioira** - A new clinical lead (Consultant Psychiatrist) position has been established and dedicated to the Inpatient Unit. Along with the nursing leadership and allied health professionals, improvements to assessment/care planning and multi-disciplinary team processes have been made. This includes incorporating HoNOS (Health of the Nation Outcomes Scales). Te Puna Waioira remains within the top three Inpatient Units nationwide for compliance with HoNOS.

Intensive Psychiatric Care Unit redesign/refurbishment - In June 2012 a decision was made to upgrade the intensive Psychiatric Care Unit and a project team has been established. In conjunction with the redesign, models of care and alternate therapies, in particular sensory modulation, are being progressed as a range of strategies to minimise and reduce restraint and seclusion.

Acute intervention service - A new stand alone acute intervention service has been formed comprising of the crisis team, acute home based treatment team, a mental health consult liaison and mental health night triage nurse, with the appointment of a clinical nurse manager.

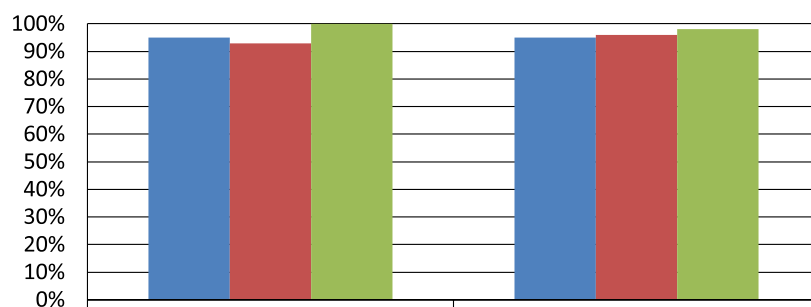
Clinical ethics advisory group - The clinical ethics advisory group is now a well established committee and is raising awareness of clinical ethics and offering support to clinicians in the DHB. It meets bi-monthly and is an open group which provides a forum for interesting topics for discussion and encourages lively debate.

Uncomplicated dementia care pathway - MHSOP worked collaboratively with the primary and secondary sectors to establish a dementia care pathway consistent with the Ministry of Health guidelines. An improved link with GPs offering them phone and email consultation with a specialist psycho-geriatrician, a tool kit of information to be given to an individual and their main caregiver at the point of diagnosis. The establishment of a regular "Living Well with Dementia" education group has been established. Supportive and educative sessions to GPs and practice nurses are ongoing. The MHSOP dementia care pathway has been provisionally adopted by the Midland DHBs and MHSOP is involved in the Ministry of Health dementia care pathway advisory group. The development of an in-home respite service for those experiencing dementia has been established along with an increase in the number of care facilities contracted to provide residential respite.

Statement of Service Performance - Mental Health and Addiction Services

Impact Measures

Percentage of adults (20+) long term clients with up-to-date relapse prevention/treatment plans

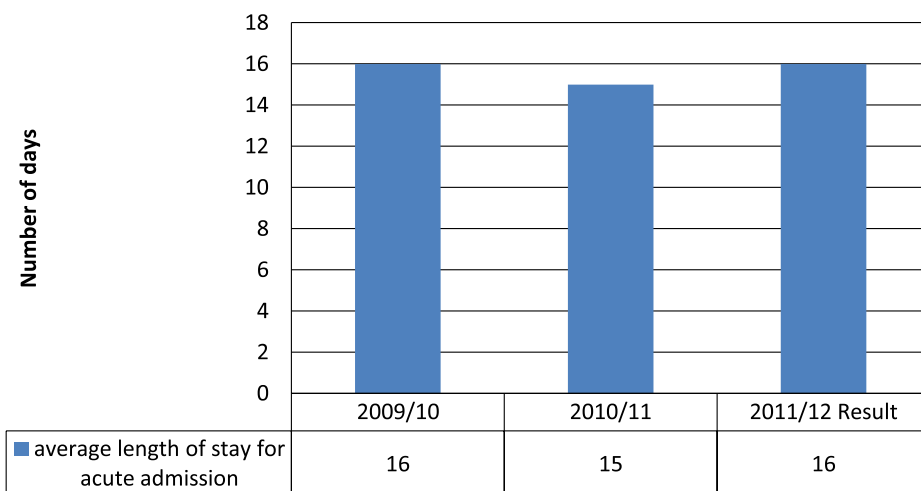


Target:

Māori	95%	Achieved
Non-Māori	95%	Achieved

Both targets have been achieved for the percentage of adult long term clients who have up-to-date relapse prevention/treatment plans. It is pleasing to note that all Māori have plans in place.

Average length of stay for acute admissions

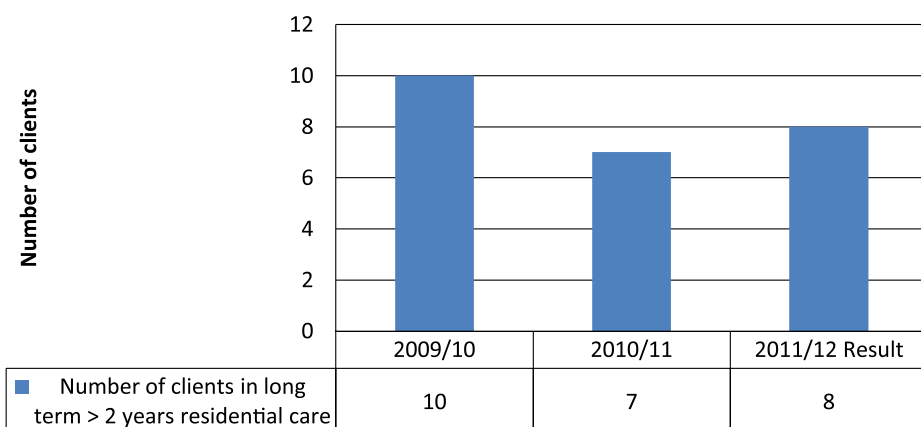


Target:

14-21 days	Achieved
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Although the average length of stay increased by one day in 2011/12 the figure is closer to the lower target days stay at 14.

Number of clients in long term > 2 years residential care



Target:

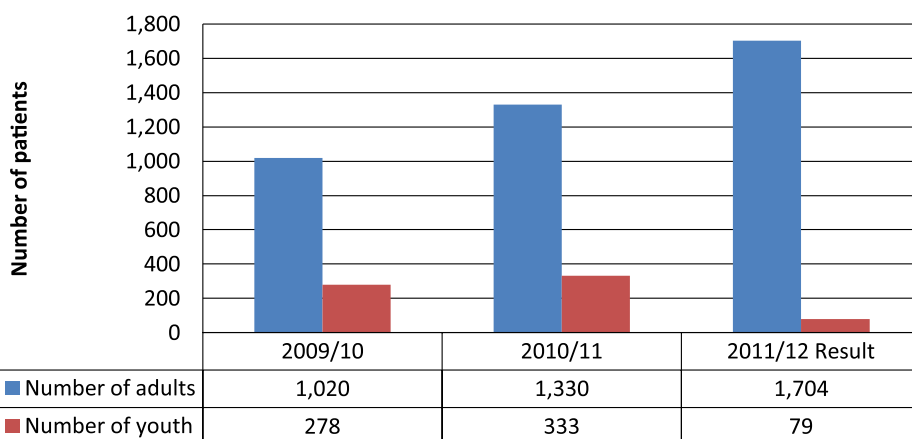
<10	Achieved
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The reduction in longer term clients would have been partially attributed to the closure of Mount View Trust who had four clients that had been in care for greater than two years. A number of clients are ageing and require permanent long term care. The Mental Health and Addictions Residential Review prioritised this cohort of clients to have a defined model of care - further service development to occur in 2012/13.

Statement of Service Performance - Mental Health and Addiction Services

Outcome Measure: Early Detection and Management - People with experience of mental illness and addiction are supported to remain in their homes and communities

Number of adults and youth accessing Primary Mental Health Initiative

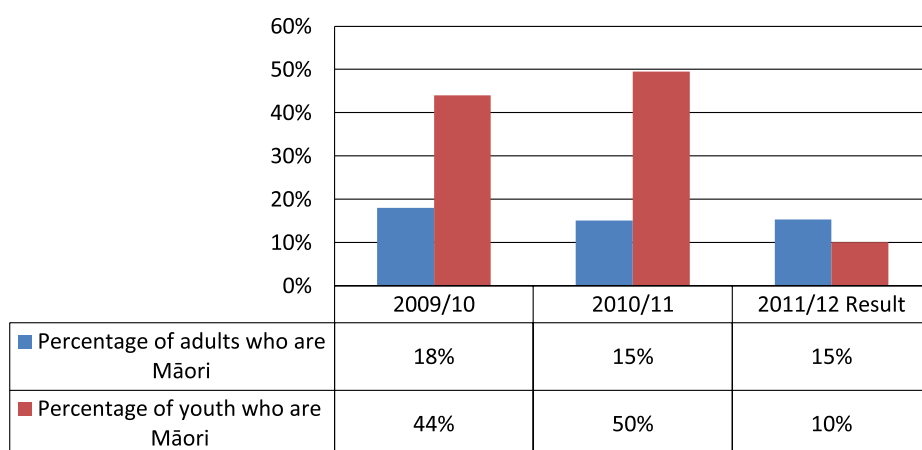


Target:

Number of adults accessing Primary Mental Health Initiative	>1,020	Achieved
Number of youth accessing Primary Mental Health Initiative	>278	Not Achieved

The way youth access the Primary Mental Health Initiative changed in 2011/12. The service was funding Psychologist time through WAVES. This ceased and youth accessed counselling via the vouchers allocated through General Practice (as does the Adult population). This was not running for the full 2011/12 year, hence the drop in access.

Percentage of adults and youth who are Māori accessing Primary Mental Health Initiative



Target:

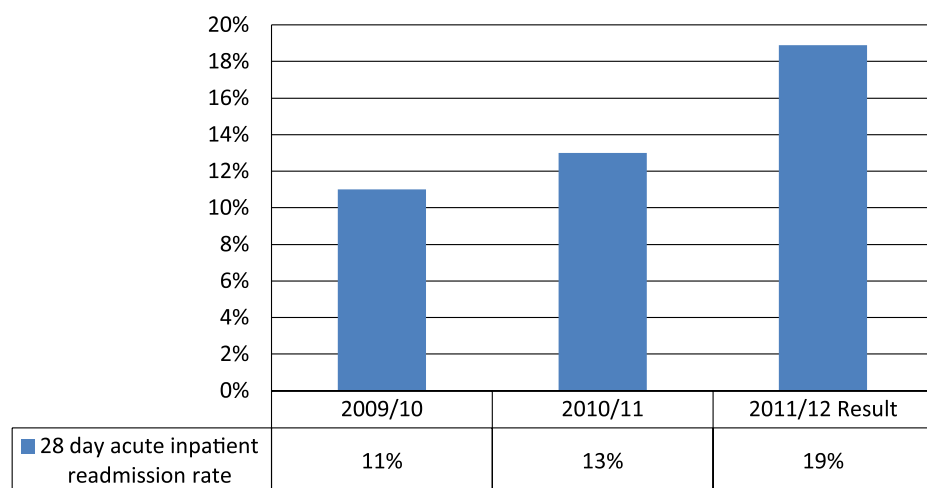
Percentage of adults who are Māori who are accessing PMHI	>20%	Not Achieved
Percentage of youth who are Māori who are accessing PMHI	44%	Not Achieved

As per above the change in the model of care has significantly impacted on the numbers of clients accessing the services. The low uptake for Māori youth may be consistent with rates of access for Māori youth at General Practice.

Statement of Service Performance - Mental Health and Addiction Services

Output Measures: Intensive Treatment and Assessment - People with acute and/or serious mental health and addiction issues will be treated and stabilised

28 day acute inpatient readmission rate

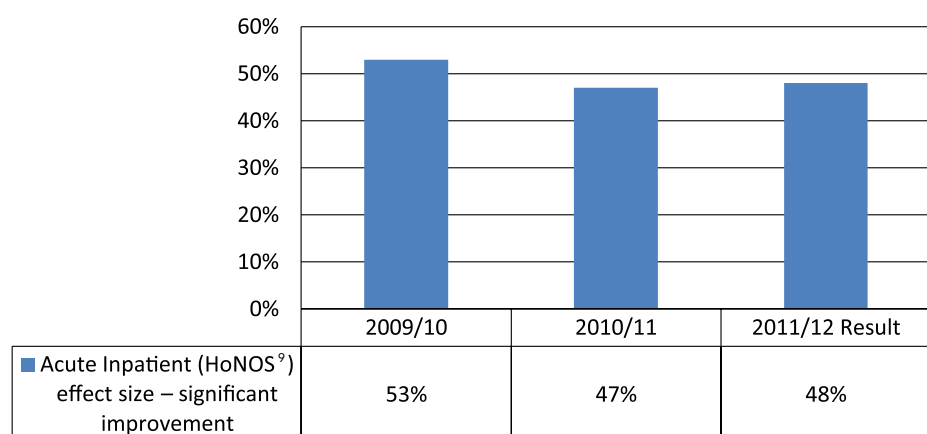


Target:

0-10% Not Achieved

Taranaki DHB did not achieve the 28 day acute inpatient admission rate for 2011-12. There has been a comprehensive questionnaire developed for patients being discharged which will help understand some of the issues surrounding readmission rates, also with the significant change management process occurring in the Kaupapa Māori sector, the provider has been carrying a significant number of vacancies which may also have an impact.

Acute Inpatient (HoNOS) effect size – significant improvement

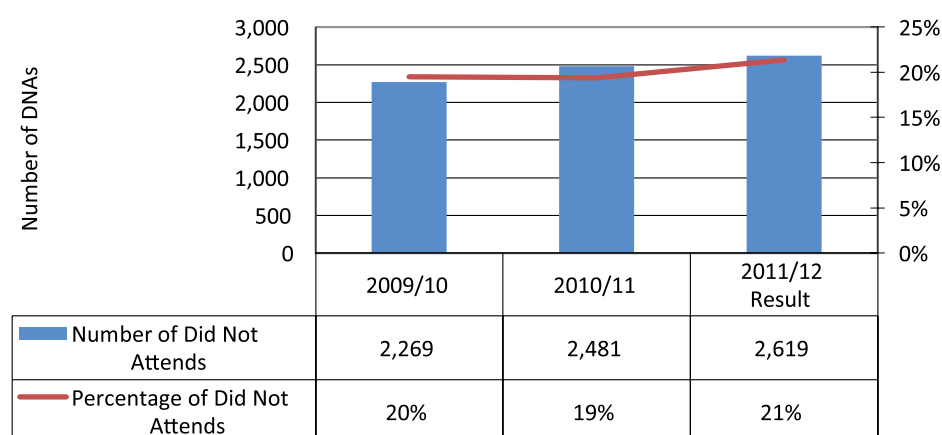


Target:

53% Not Achieved

Although the target was not achieved, the Provider Arm monitor the data quality closely. This is important for compliance. Significant improvement is determined by the scale being six or less.

Number and percentage of did-not-attends in addiction services



Target:

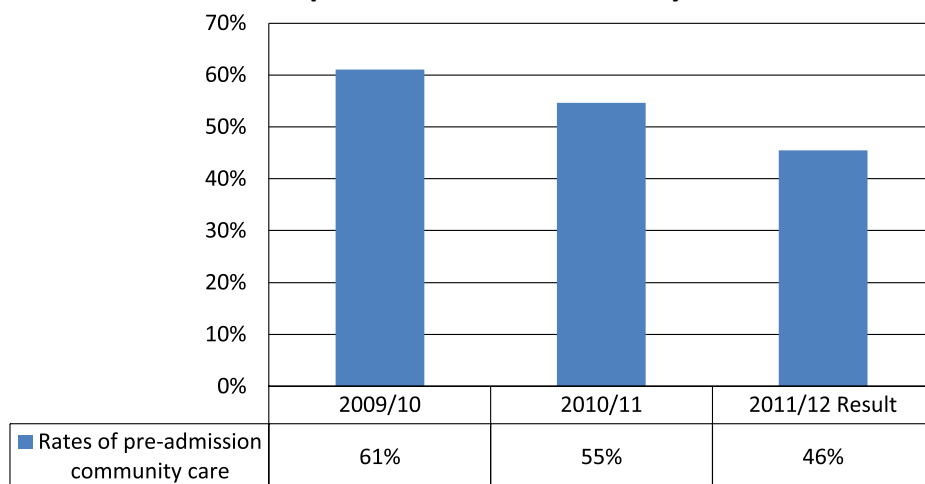
Number of did not attends for addiction services	<2,269	Not Achieved
Percentage of did not attends for addiction services	< 19%	Not Achieved

Provider Arm are reviewing the capture of data as the group sessions also include DNA's which is distorting the figures, therefore will look in more detail at the DNA rates for 1-1 counselling services.

Statement of Service Performance - Mental Health and Addiction Services

Output Measures: Rehabilitation & Support - People with acute and/or serious mental health and addiction issues will be supported through a recovery focused philosophy to care

Rates of pre-admission community care

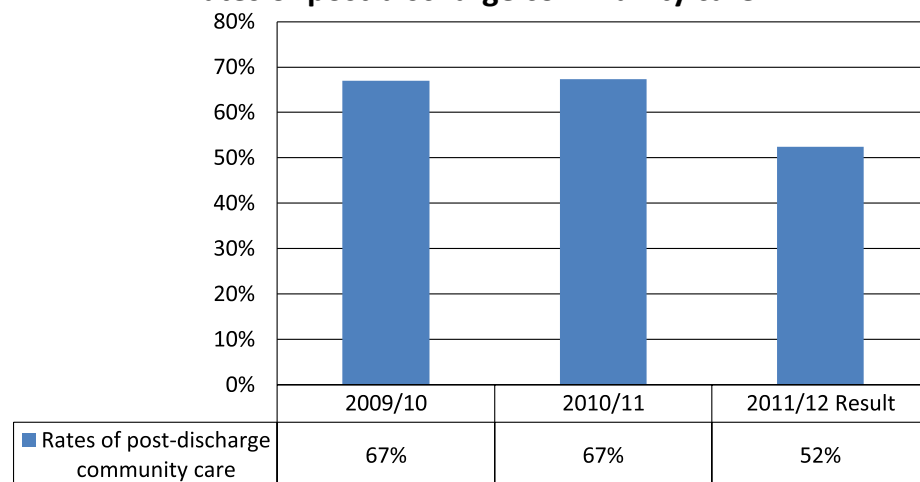


Target:

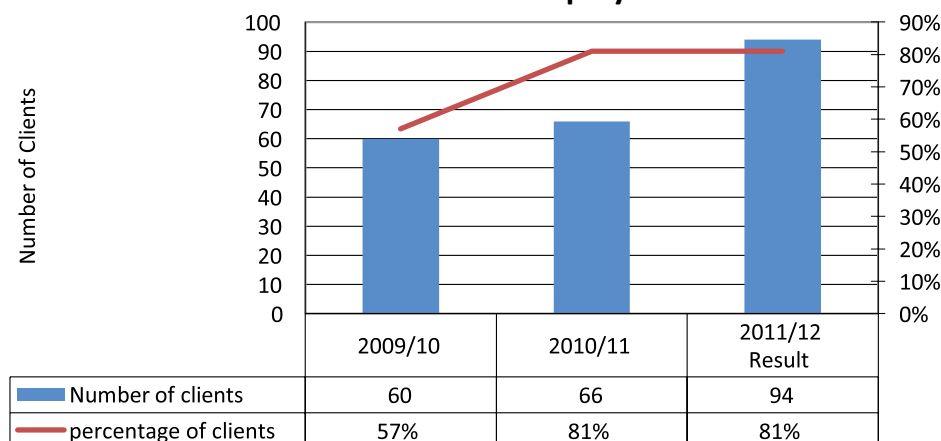
Rates of pre-admission community care	75%-100%	Not Achieved
Rates of post-discharge community care	90-100%	Not Achieved

Taranaki DHB has not achieved against the targets for rates of pre-admission and post-discharge community care. There has been significant change management and amalgamation of kaupapa Māori services which is likely to have impacted this result. There is also currently a large number of vacancies in the sector.

Rates of post-discharge community care



Number and percentage of clients in paid employment through Mental Health & Addiction employment service



Target:

Number of clients in paid employment through MH&A employment service	>60	Achieved
Percentage of clients on the MH&A employment services in paid employment	>32%	Achieved

There has been a significant increase in the results for those accessing employment services and being able to have some form of paid employment. Workwise is now working with Taranaki DHB provider arm as part of a team, which has created further integration across teams.



Theatre staff Kate Moffat and Mike Marchant

HOSPITAL AND SPECIALIST SERVICES

Hospital and specialist services provided from Taranaki Base Hospital, Hawera Hospital and associated health centres make up the single largest local health care provider funded by Taranaki DHB. These services facilitate acute, specialist and high priority treatments to the Taranaki population and are fundamental supports for a dynamic and integrated health service across primary care, community NGO services and the aged care sector.

Rural Hospital Accreditation for Hawera

Hawera Hospital achieved accreditation as a training site for rural hospital medicine and is hoping to have a registrar position filled in 2013.

The recognition comes from the NZ College of General Practitioners and means that doctors can be trained and work in both hospital medicine and emergency medicine.

This is a major achievement for doctors who are interested in working in rural communities. They will have the opportunity to work in the ward and in the Emergency Department.

Taranaki DHB House Surgeon, Hannah Crowley has jumped at the opportunity. "I want to stay in Taranaki and still fulfil my career opportunities," said Hannah.

"This accreditation means I can apply to stay in Taranaki where my family is and still receive training to enable me to work as a doctor in rural hospitals and general practice."

Doctors who complete the training would finish with a Fellowship in Rural Medicine and will be vocationally registered as a specialist in rural medicine.

Statement of Service Performance



Dental Unit staff and patient

HIGHLIGHTS FROM THE YEAR

We have achieved **elective services patient flow indicators** compliance with no patients waiting over six months for either First Specialist Assessment (FSA) or surgery by year end. The next goal is to achieve zero patients waiting over five months for FSA or surgery.

We successfully recruited two new **orthopaedic surgeons**, to achieve a full complement of consultant staff for this team. We are already seeing the benefits of this and we expect increased access into the service and to meet ongoing Ministry of Health requirements.

Taranaki DHB's **dental and oral maxillofacial department** was refurbished in January 2012. Comprehensive planning of the space has allowed for an additional consultation surgery and a large reprocessing area. Feedback from staff and patients has been excellent.

There has been a lot of work going into the **South Taranaki community oral health clinic** throughout 2012 and design planning is well underway with completion set for the end of 2012. Communication with the staff, community, key stakeholders and interested parties is well received.

A **Memorandum of Understanding (MOU)** has been agreed between Taranaki Medlab and LabCare Pathology (Taranaki DHB). The intention being that the pathology services in Taranaki work more closely together to ensure efficiencies regarding testing and equipment to best meet the needs of the province.

The creation of an **allied health service manager** has assisted with scientific and technical allied health professions working more closely with their colleagues to propose ways to support each other and assist the organisation in efficiency measures.

The Emergency Department (ED), Department of Medicine (DOM) and Hawera Hospital have all had significant improvement in recruitment of senior medical staff. The ED employed its third Fellow of Australasian College of Emergency Medicine (FACEM) in January and Hawera Hospital has recruited two permanent doctors.

Releasing Time to Care (RTC) is now live in Ward Two, Three, Four and ICU with Ward Five expected to join the programme in late 2012. Staff involved in the programme are motivated about the potential benefits Releasing Time to Care offers them and there has been outstanding feedback from the teams at their regular workshops.

Our theatre team have been busy with a number of projects. The projects include **Pre-Admission Pathway, The Productive Operating Theatre (TPOT) and Enhanced Recovery After Surgery (ERAS)**, and are focused on improving processes and pathways to support staff to provide a high quality service for patients. All three have a role in ensuring that the new theatre suite part of Project Maunga is supported by improved processes and approaches across the surgical pathway.

The draft **Midwifery Operational Annual Plan**, which was submitted to the Ministry of Health, has received excellent feedback. The plan is linked directly to national planning and initiatives and the quality and safety programme for maternity services.

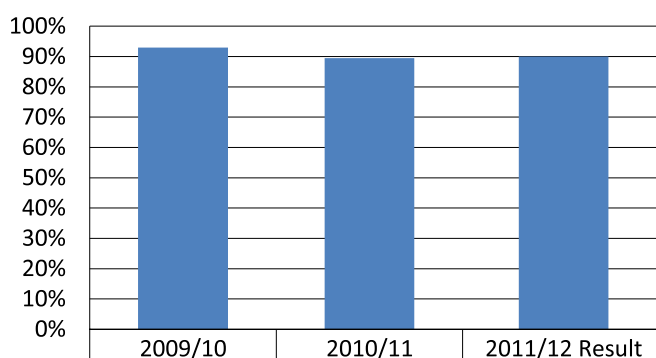
The portal **Concerto** has been implemented, firstly in ED and will be rolled out in other areas in 2012. As part of this roll-out a repository for laboratory and radiology results called Eclair has also been implemented across the hospital sites. Work is progressing on medications management with some components of this going live in Ward One in June 2012 with a roll out plan for the rest of the areas to follow at a later date.

Hawera Hospital achieved accreditation as a training site for rural hospital medicine and is hoping to have a registrar position filled in 2013.

Statement of Service Performance - Hospital and Specialist Services

Impact Measures

Percentage of people presenting to Emergency Department admitted, discharged or transferred within six hours



■ Percentage of people presenting to ED admitted, discharged or transferred within 6 hours

2009/10	2010/11	2011/12 Result
93%	89%	90%

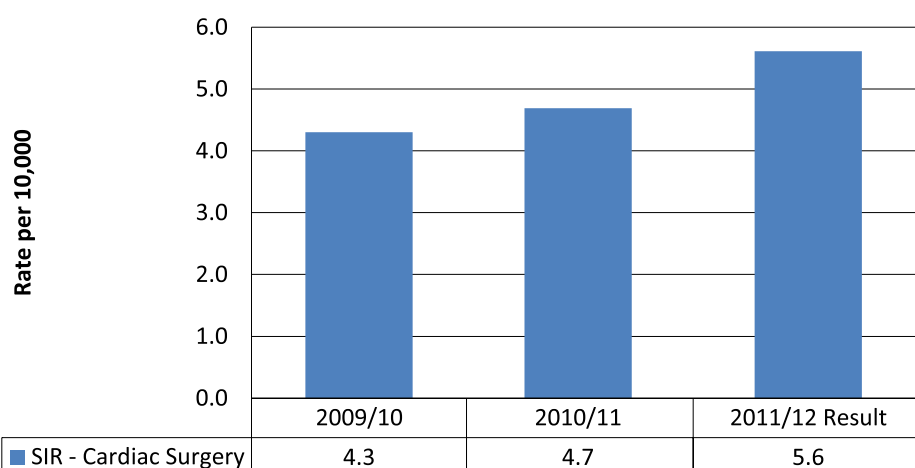
Target:

95%

Not Achieved

The target has not been met for 2011-12. Hawera Emergency Department achieved nearly 100% of patients being seen within six hours whereas Base Hospital in New Plymouth only achieved 85%. There is considerable work underway to address the shortfall including the introduction of an Emergency Department observation ward and an acute care pathway project both of which are expected to increase the patient management and flow through our Emergency Departments.

Standardised intervention rates per 10,000 of population are within national standards for cardiac surgery



■ SIR - Cardiac Surgery

Target:

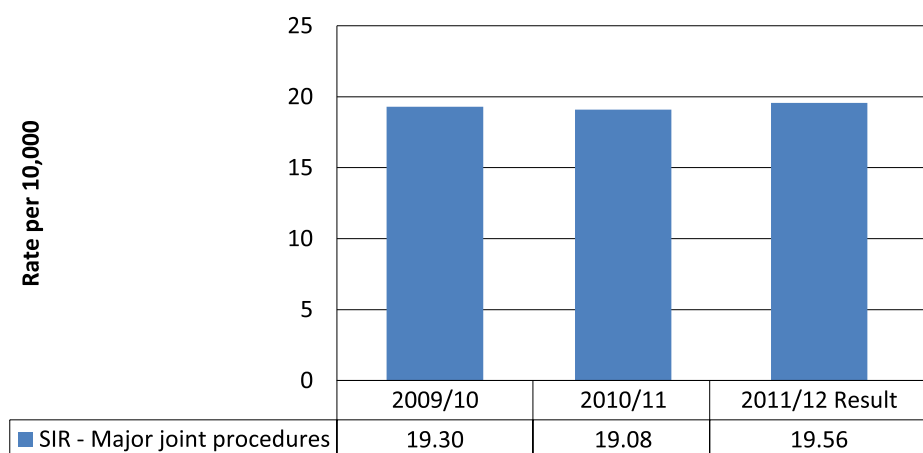
6.5 per 10,000

Not Achieved

Taranaki DHB did not achieve the target for the standardised intervention rates for cardiac surgery. However, there has been an increasing upward trend over the last three years and the result in 2011/12 is not significantly different to the National Rate of 6.37. The majority of the interventional surgery for cardiac conditions are performed by our regional tertiary provider, Waikato DHB. Taranaki has the lowest intervention rate in the region. Part of the Regional Services Plan¹⁰ includes a cardiac work stream which is addressing issues across the region to improve and manage patient flows and ensure equity of access. In line with this we are also reviewing the current service configuration and models of care to increase the access to diagnostics and interventions.

Statement of Service Performance - Hospital and Specialist Services

Standardised intervention rates per 10,000 of population are within national standards for major joint procedures



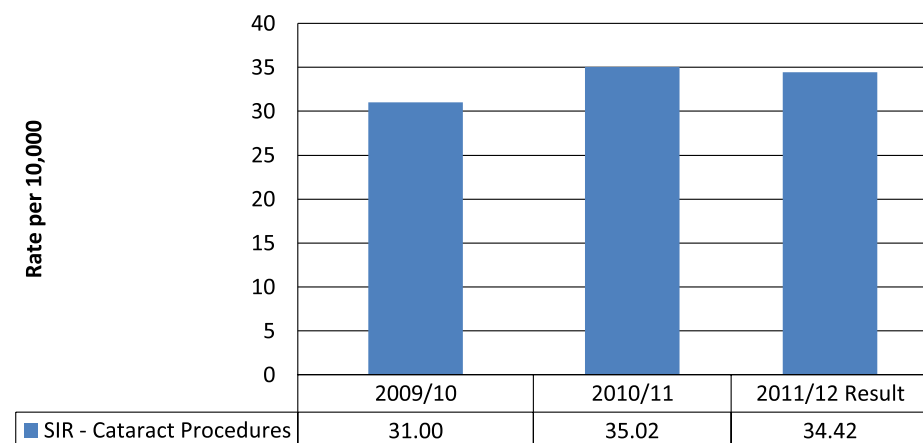
Target:

21 per 10,000

Not Achieved

Taranaki DHB did not achieve the target for the standardised intervention rates for major joint surgery. However, it is not significantly different to the national intervention rate of 20.35.

Standardised intervention rates per 10,000 of population are within national standards for cataract procedures



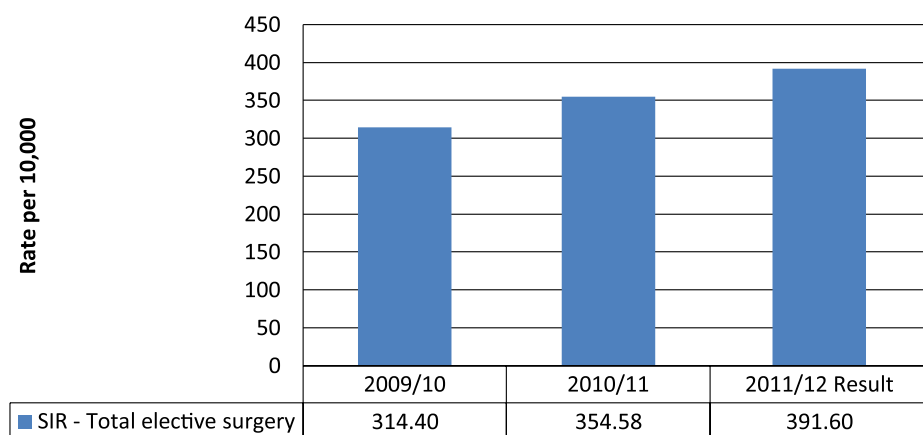
Target:

27 per 10,000

Achieved

Taranaki DHB achieved the target for the standardised intervention rates for cataract surgery and was significantly above the national rate of 31.67.

Standardised intervention rates per 10,000 of population are within national standards for total elective surgery



Target:

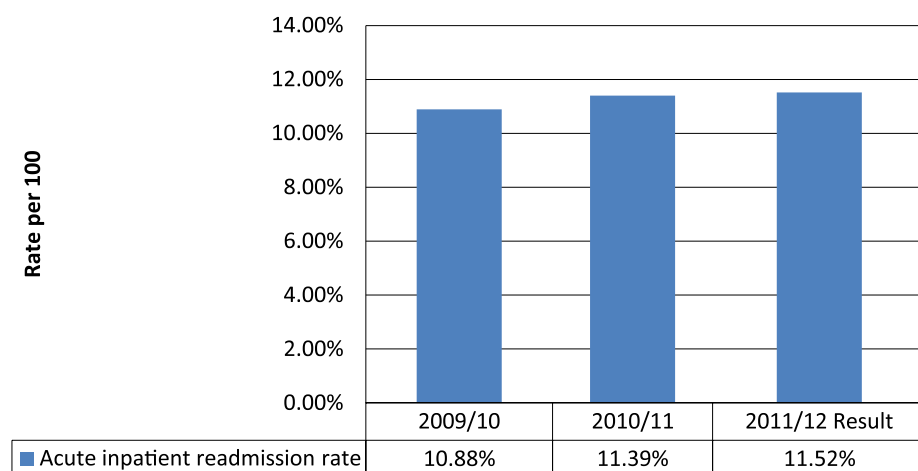
308 per 10,000

Achieved

Taranaki DHB achieved the target for the standardised intervention rates for all elective surgeries and was significantly above the national rate of 340.31.

Statement of Service Performance - Hospital and Specialist Services

Acute inpatient readmission rate



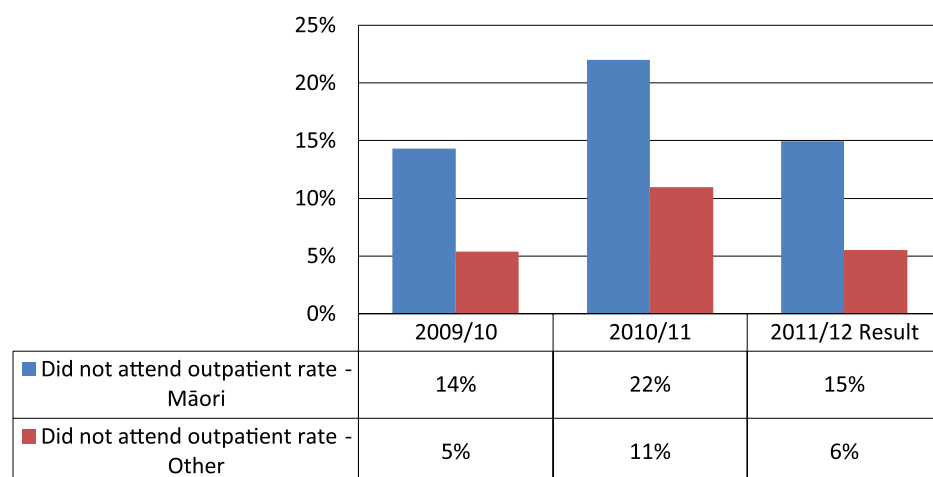
Target:

10.40%

Not Achieved

Taranaki DHB did not reach the acute readmission rate target for 2011-12. There are several readmitting conditions which are consistent with the conditions contributing to the average length of stay target not being met. There is currently planning work both in the hospital and in primary settings which are being developed around some of these conditions which are likely to have an impact on the readmission rates.

Did not attend outpatient rate



Target:

A reduction in the did not attend outpatient rate

Māori

13%

Not Achieved

Other

5%

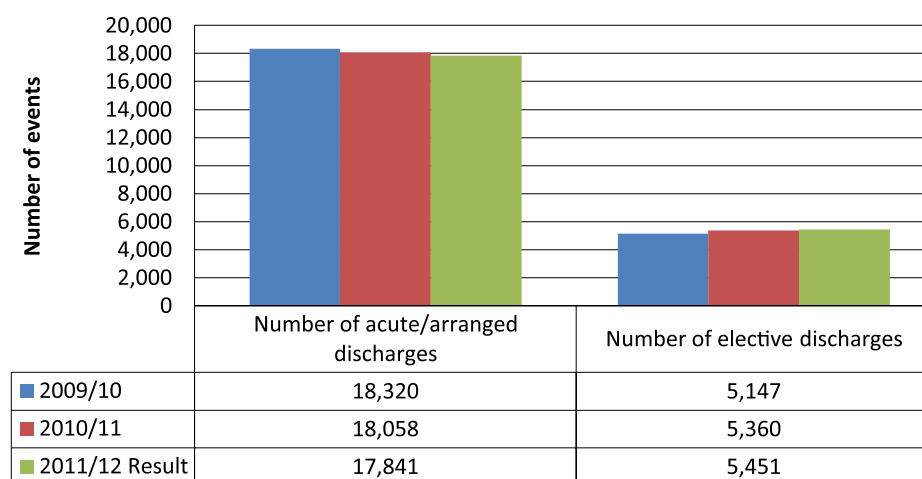
Not Achieved

Taranaki DHB did not meet the DNA target. The Hospital Outpatients Department has introduced a number of changes to the way outpatients appointments are booked. The decline in both Māori and Other DNA rates seen in the 2011/2012 year are largely the result of change to the booking policy and increased efforts to follow-up with patients for booked appointments. For the coming year additional systems tools such as a text reminder service and 0800 number coupled with a project focused on reducing DNA specifically for Māori patients will be in place - these efforts will see a continuation of the improvements seen in the last 12 months.

Statement of Service Performance - Hospital and Specialist Services

Output Measures: Intensive Treatment and Assessment - Timely and equitable access to high quality efficient services for our community

Number of acute/arranged and elective discharges

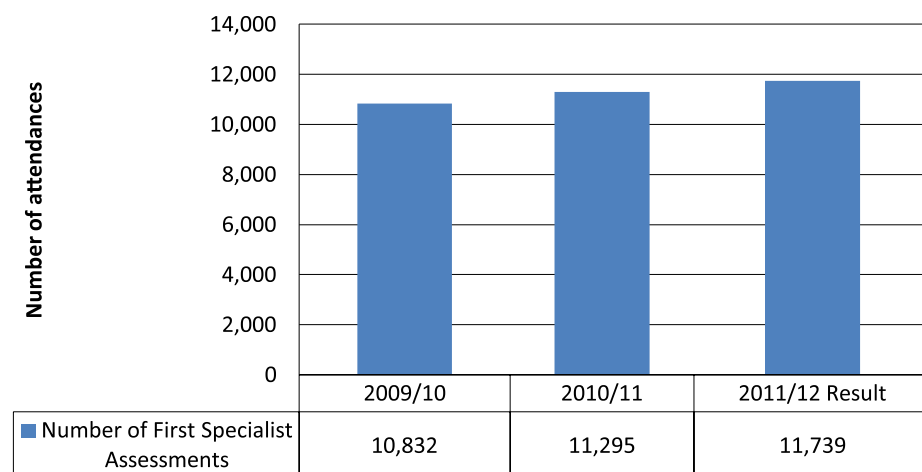


Target:

Number of acute/arranged discharges	≤ 15,901	Not Achieved
Number of elective discharges	5,276	Achieved

The target for the number of acute or arranged discharges was aspirational for where we would like to see the number against our population. There has been a consistent reduction over the last three years. We expect that the considerable work undertaken with the primary health sector managing the ambulatory sensitive hospitalisations along with projects in place managing acute readmissions will continue this trend into the future.

Number of First Specialist Assessments



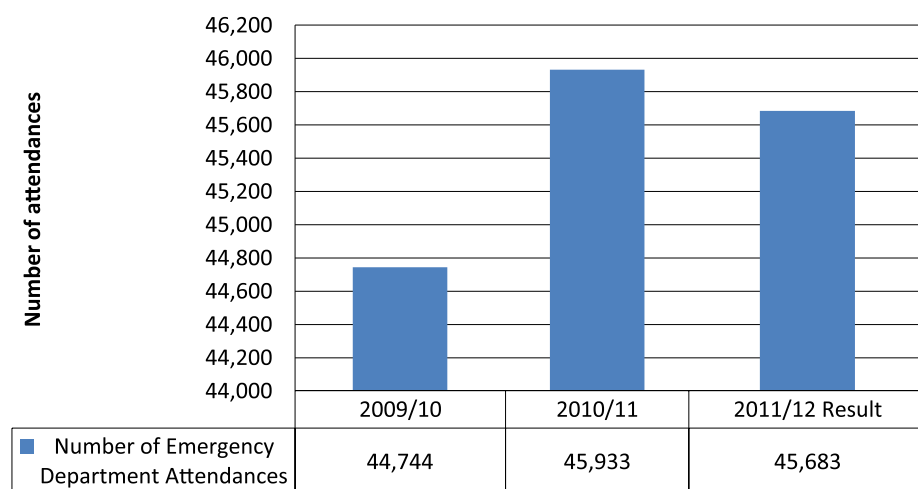
Target:

Number of First Specialist Assessments	10,458	Achieved
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The target for the number of First Specialist Assessments in 2011-12 has been met. The number of FSAs have increased over the last three years which is in line with an increase in the number of elective surgical discharges we undertake and fund. The main areas of increase are associated with the Ministry of Health standardised intervention rates for cardiac, cataract and major joint surgeries.

Statement of Service Performance - Hospital and Specialist Services

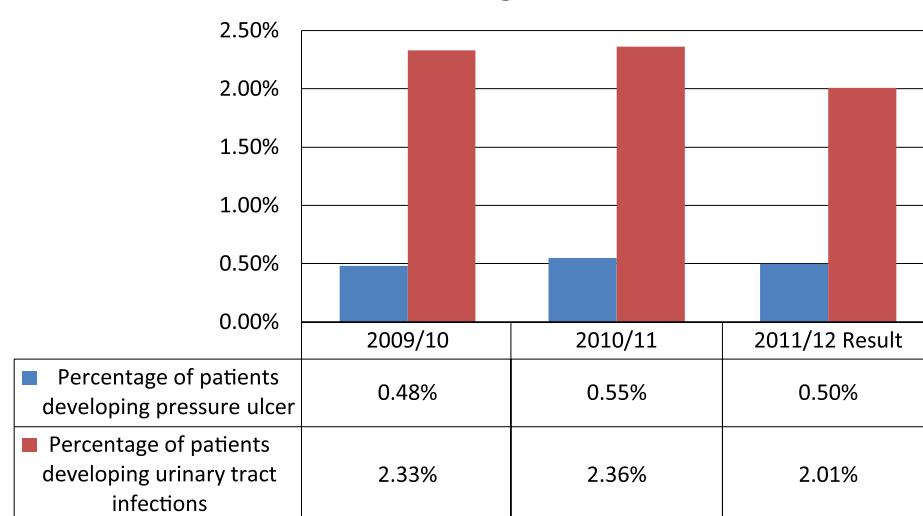
Number of Emergency Department Attendances



Target:		
Number of Emergency Department Attendances	36,183	Not Achieved

The target for the number of Emergency Department attendances has not been achieved for 2011/12. The target of 36,183 was aspirational and indicated that we wished to see more cases managed in a primary care setting. There is work underway in both secondary and primary care looking at how these primary type cases are managed into the future. We have also introduced a sustainable after-hours GP services which is expected to reduce Emergency Department admissions.

Percentage of patients developing pressure ulcers or urinary tract infections during their admission



Target:		
Percentage of patients developing pressure ulcers during their admission	≤ 0.48%	Not Achieved
Percentage of patients developing urinary tract infections	≤ 2.33%	Achieved

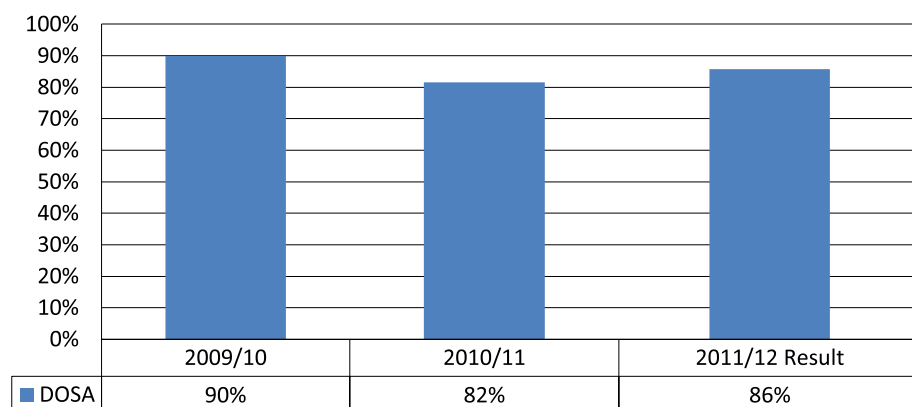
Taranaki DHB did not achieve the target for pressure ulcers - however the rate achieved is not significantly different to the target. Taranaki DHB is working to ensure that performance against this indicator improves and have introduced a number of initiatives.

Monthly reporting to capture whether hospital acquired, community acquired or preventative strategies have been put in place. Additionally, dedicated study days to educate staff regarding debilitation and cost associated with pressure injuries have been introduced along with dedicated protocols/ procedures and guidelines for staff to refer to as resources.

The DHB is also investing in more equipment (beds and mattresses) for patients who are identified as at risk of developing pressure ulcers.

Statement of Service Performance - Hospital and Specialist Services

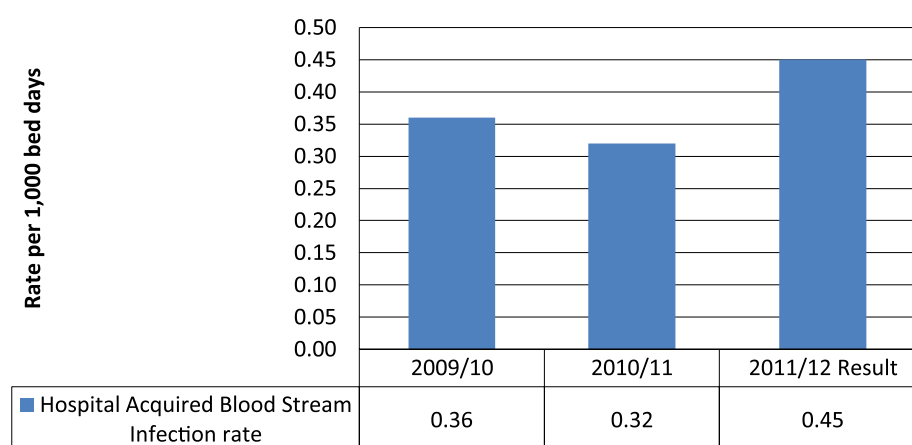
Elective and arranged services admission on day of surgery as a percentage of total elective and arranged admissions (DOSA)



Target:		
Elective and arranged services admission on day of surgery as a percentage of total elective and arranged admissions (DOSA)	90%	Not Achieved

Taranaki DHBs result of 86% against this measure is below expectation. There are projects currently underway which will contribute to improvements of Day of Surgery Admissions and Day Surgery cases. These include a Productive Operating Theatre initiative and a 'whole of system' review of the pre-assessment and scheduling process.

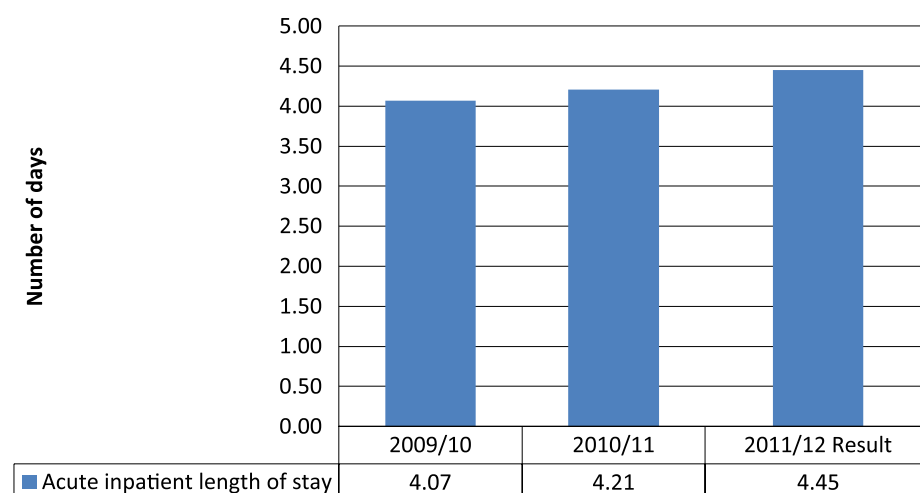
Hospital Acquired Blood Stream Infection rate per 1,000 bed days



Target:		
Hospital Acquired Blood Stream Infection rate per 1,000 bed days	0.25	Not Achieved

This year saw an increase in BSIs in the areas of surgery and intravenous device events. There was no single area affected or outbreak identified. Renal tunnel lines were not part of the increase. Taranaki DHB will continue to monitor this area closely and a number of interventions are in place to reduce the incidence of Hospital acquired BSI.

Acute inpatient length of stay



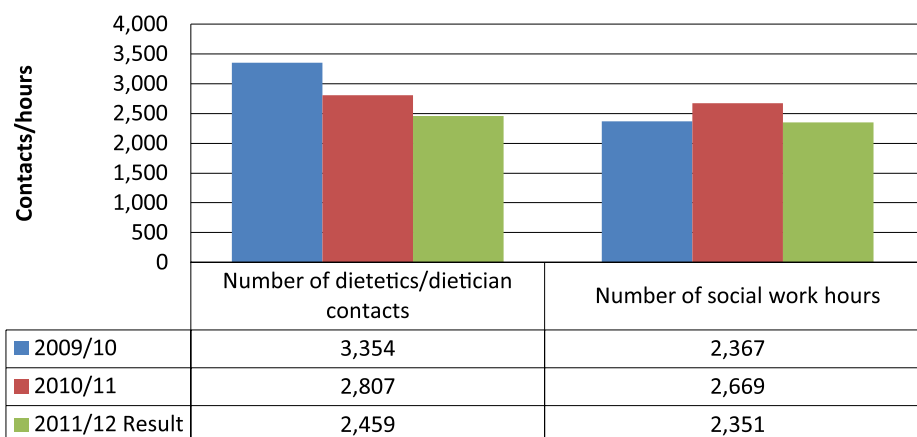
Target:		
Acute inpatient length of stay	3.9	Not Achieved

Taranaki DHB did not reach the expectations around the acute inpatient length of stay for 2011-12. There are several projects underway which will contribute toward achieving reduced length of stays. These include Releasing Time to Care, Stroke Pathways, The Productive Operating Theatre and Pre-Admission Pathways. In addition, there is also work being undertaken to improve discharge planning from the time of admission.

Statement of Service Performance - Hospital and Specialist Services

Output Measures: Rehabilitation & Support - Integrated and seamless access to appropriate rehabilitation services in a range of settings

Number of dietetic/dietitian contacts and social work hours

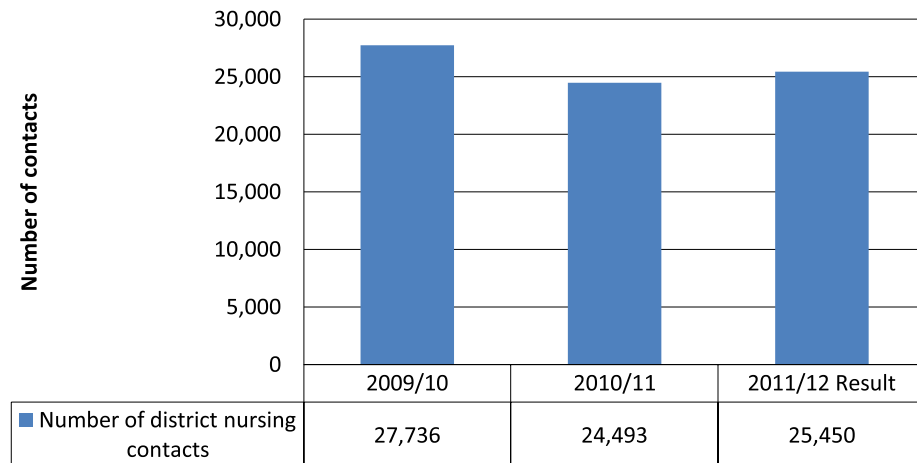


Target:

Number of dietetics/dietitian contacts	3,400	Not Achieved
Number of social work hours	2,400	Not Achieved
Number of district nursing contacts	28,000	Not Achieved

Although the targets for these measures were not met for the 2011-12 period these are more reflective of demand and can fluctuate year on year. During the planning process we undertake to estimate this demand based on past volumes. We have used these measures as a demonstration of the work undertaken by our dietitians, social workers and district nurses.

Number of district nursing contacts







Breastfeeding and wellbeing event at Parihaka Pa

PRIMARY AND COMMUNITY HEALTH SERVICES

Primary and community health services are a key area for delivery against better, sooner, more convenient health care. Good access to and delivery of primary health care services is key to reducing avoidable hospital admissions.

Inglewood community fights the flu early

A cup of tea and a get together in Inglewood was the key to keeping the flu bugs away this year.

The Inglewood Medical Centre ran a community flu clinic on Tuesday, 20 March and encouraged patients to take the opportunity to get immunised.

Practice Nurse, Rachael Thony said, "It's best to immunise early before people start getting sick and it's a great way to immunise a large number of people".

This was the sixth year that Dr Jones and Dr Finnigan from Inglewood Medical Centre had organised this combined one-day clinic for their patients as part of their influenza vaccination campaign.

The team at Inglewood Medical Centre say it is a very effective system that works well for their practice. "Inglewood is a very close knit community and people enjoy the social side of the day, often staying well beyond their 20 minute timeslot to chat to friends," said Practice Nurse Hayley Growcott.

HIGHLIGHTS FROM THE YEAR

The upgrade of the Parihaka water supply funded by the **drinking water assistance programme** took place from 2009 until early 2012. The training was coordinated by an experienced training provider from Parihaka. Taranaki District Health Board are also assisting with the development of a public health risk management plan for the water supply which will be the final step and when assessed by the drinking water assessor will mean that the water supply complies with the legislation. Parihaka Papakainga recently undertook their own training to upskill people on operating their water supply. Taranaki District Health Board have facilitated this development which has been a success.

Statement of Service Performance



World Smokefree Day, Huatoki Plaza

Stratford Health Centre Opening

Formation of the **Te Kāwau Māro strategic alliance** as the preferred provider of Māori health services in Taranaki; and DHB partner in planning and developing health and disability services.

Completion of a parent workshop series, '**Nga Kete Hauora**', was developed to deliver needs-based, useful, relevant and culturally appropriate workshops to increase the number of opportunities for parents and caregivers of children aged under 12. Topics included healthy kai, healthy eating behaviours, budgeting, cooking, first aid, being prepared for an emergency and flax weaving, and was delivered in Patea and Opunake.

Youth Week – 'Not Even' was a successful collaborative project led by Taranaki DHB Public Health Unit and supported by Patea Youth Trust, Patea Pride Sports Club Inc, Te Runanga o Ngati Ruanui, Patea Area School, Te Korimako radio station and South Taranaki Youth. An attendance of 180-200 local youth and their caregivers engaged in discussions around drugs and alcohol.

In 2011 Kidsafe Taranaki Trust launched the **new safety gate scheme** in Waitara, where 40 child safety gates are available to low income families with children aged under five years old. In 2012 this was rolled out in New Plymouth as well. The safety gates are available for free loan to eligible New Plymouth families. Kidsafe Taranaki Trust is a charitable trust formed in 1994 by a range of individuals and agencies with the common goal of reducing the incidence and severity of unintentional injuries to children/tamariki in Taranaki. Trust membership currently includes Taranaki District Health Board, ACC, Plunket, Tui Ora and community volunteers. Kidsafe is also a partner in the New Plymouth injury Safe (NPIS) Trust which is responsible for New Plymouth District's International Safe Community accreditation programme. By the end of 2012 it is anticipated that a total of 130 safety gates will be available throughout Taranaki. This project is a good example of collaborative Kidsafe activities. It has been achieved through a successful partnership between Kidsafe members, Taranaki Plunket and the Taranaki DHB Public Health Unit injury prevention health promotion programme, with funding from TSB Community Trust.

Taranaki DHB continues to be part of the **Taranaki Smokefree/ Auahi Kore** action group who meet face-to-face on a quarterly basis to provide a forum for local discussion and strategic thinking and actions on smokefree initiatives. A highlight from the 2011-12 year included the 'Workplace Quit Campaign' that was held during National Heart Week in February. The group provided six large local businesses occupational health nurses a resource information pack so they could develop and implement their own quit packs to support their staff to quit. The group were also involved in a number of other community initiatives to promote smokefree communities including WITT orientation day, Baldrics Day (Stratford), Pae Pae in the Park (Patea), Rugby League Carnival day and World Smokefree Day.

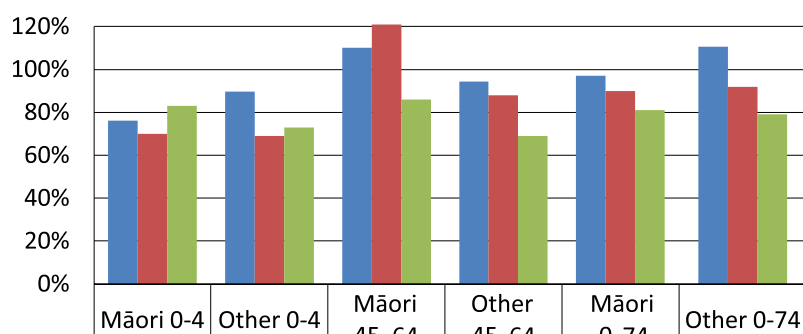
New model of care for **community pharmacy services** that focuses on assisting patients to manage complex medicines regimens.

In 2011 the **Stratford Health Centre** was officially opened by Hon. Tony Ryall, Minister of Health.

Statement of Service Performance - Primary and Community Health Services

Impact Measures

The percentage of actual to expected Ambulatory Sensitive Hospitalisations (ASH)



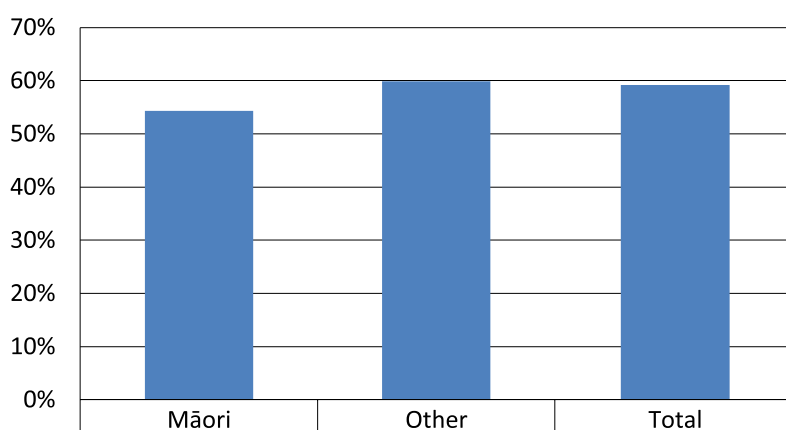
Target:

Remain at or below 95% of the expected Ambulatory Sensitive Hospitalisations

Māori 0-4	Achieved
Other 0-4	Achieved
Māori 45-64	Achieved
Other 45-64	Achieved
Māori 0-74	Achieved
Other 0-74	Achieved

Taranaki DHB has achieved all ASH targets for all population groups. Although the Māori 45-64 age group has the highest actual to expected hospitalisations there has been a significant change over the last year moving from being 21% in 2010/11 over the expected ambulatory sensitive hospitalisations to being 14% under in 2011/12.

Percentage of the eligible population with Cardio Vascular Disease (CVD) risk assessments completed



Target:

Percentage of the eligible population with CVD risk assessments completed: 90%

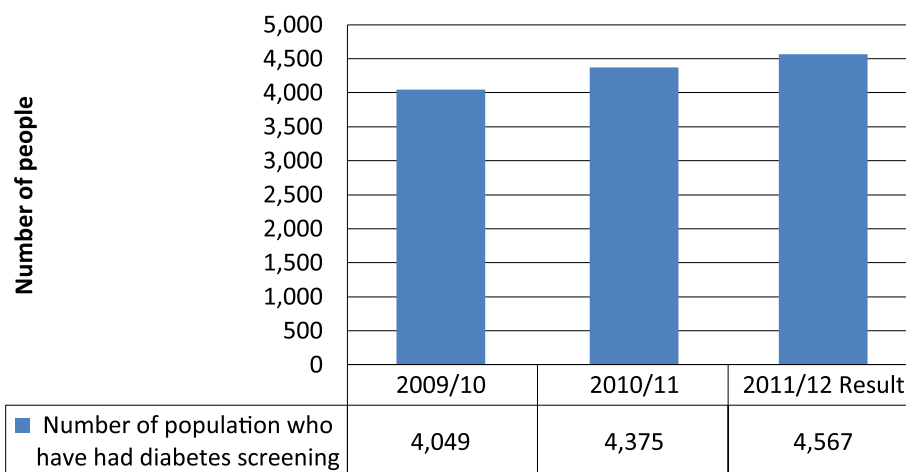
Māori	Not Achieved
Other	Not Achieved
Total	Not Achieved

The percentage of the eligible population with Cardio Vascular Disease (CVD) risk assessments completed was not achieved for 2011/12. The definition for this measure changed during 2011/12 which meant that there was a considerable drop in the percentage for all DHBs. The target has been amended to 75% for 2012/13 to reflect this. We have plans to introduce high performing multi-disciplinary primary health care teams during 2012/13 which will focus on patients with long-term conditions like diabetes and cardiovascular disease. We will also continue funding the Best Practice decision support software which assists GPs with recall of those who are due follow-up CVD risk-assessment appointments.

Statement of Service Performance - Primary and Community Health Services

Output Measures: Prevention - Prevention of onset of disease where possible

Number of the eligible population who have had diabetes screening



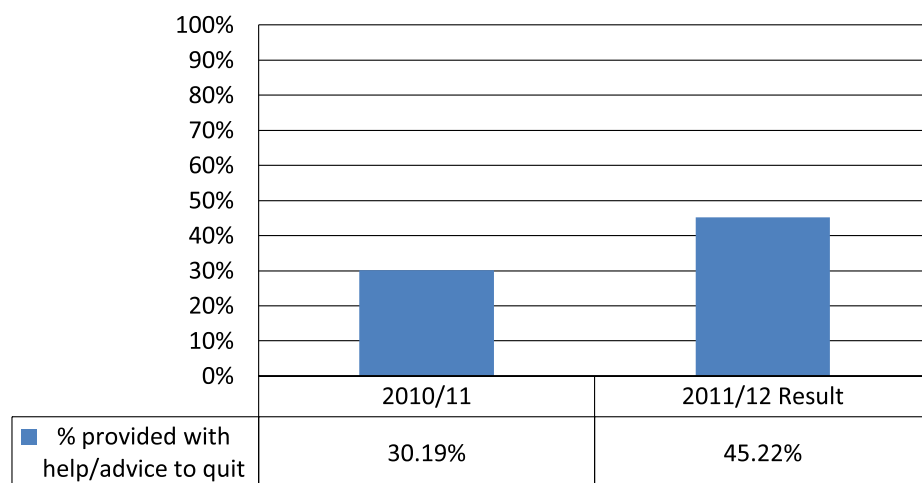
Target:

Number of eligible population who have had diabetes screening	5,000	Not Achieved
---	-------	--------------

Taranaki DHB did not achieve against the diabetes detection target.

During 2011-12 the MoH released a revised methodology for predicting diabetes prevalence across the country. Taranaki was found to have a greater prevalence than previously expected, increasing by 42% from 4,524 in 2010-11 to 6,419 in 2011-12. Therefore, even though the target was not achieved, a further 222 diabetics were detected in 2011-12 than in 2010-11.

The proportion of smokers identified in primary care and provided with help/advice to quit



Target:

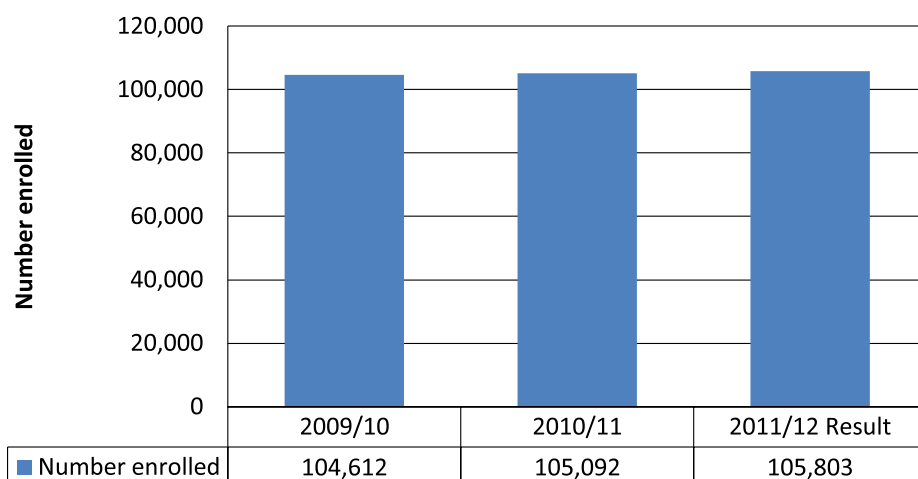
The proportion of smokers identified in primary care and provided with help/advice to quit	90%	Not Achieved
--	-----	--------------

The target for the proportion of smokers identified in primary care and provided with help/advice to quit was not met for the 2011/12 period. This target was introduced in 2010/11 and there has been gradual progress over the last two years. To accelerate this upward trend we are undertaking several programmes and initiatives with our primary care partners. These include the development of an action plan for specialist service to support quit attempts in a primary care setting, provide practices with support, coaching, education and training to deliver the ABC¹¹ approach to smoking cessation services in general practices and working collaboratively developing linkage and communications with smokefree services and stakeholders.

Statement of Service Performance - Primary and Community Health Services

Outcome Measure: Early Detection and Management - Access to primary care services to ameliorate the effects of disease

Number of people enrolled with a Primary Health Organisation (PHO)

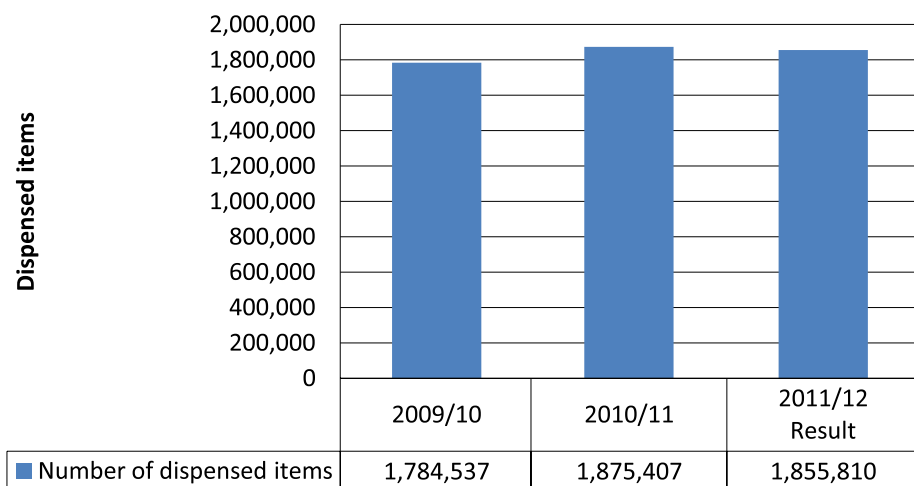


Target:

Number of people enrolled with a Primary Health Organisation (PHO)	105,000	Achieved
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Over the last 12 months there has been a further 711 people enrolled with a Primary Health Organisation despite there only being a population projected increase of just over 350.

Number of community pharmaceuticals dispensed items



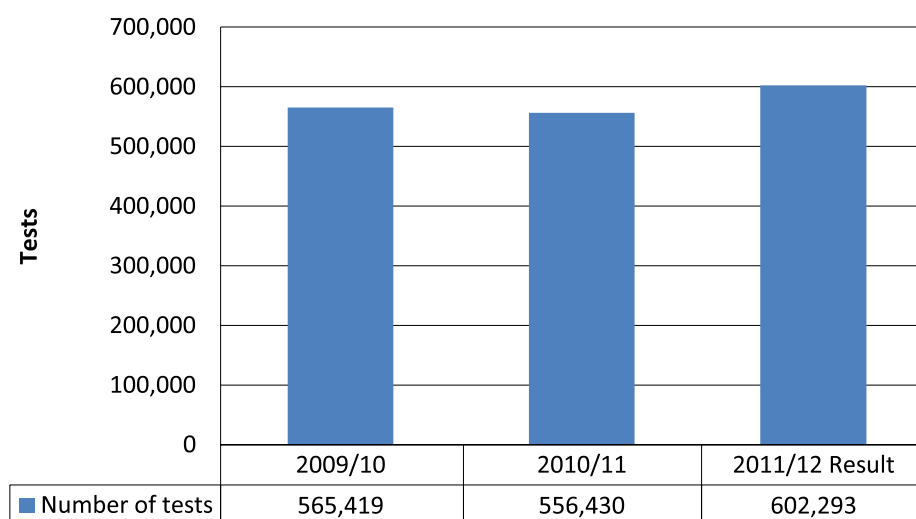
Target:

Number of community pharmaceuticals dispensed items	1,852,350	Achieved
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The target for the number of community pharmaceutical dispensed was met for 2011-12. This measure is used as a representation of the activity that we fund for community pharmacies rather than a performance target. However, our estimation for 2011-12 was within 0.18% of the result.

Statement of Service Performance - Primary and Community Health Services

Number of community laboratory tests

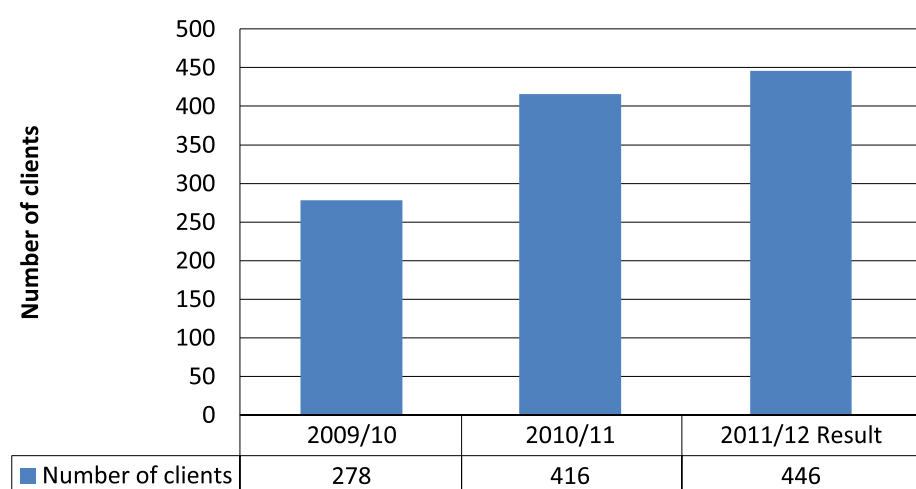


Target:

Number of community laboratory tests	580,911	Achieved
--------------------------------------	---------	----------

There has been a significant rise in the number of laboratory tests completed by our community laboratory. The majority of this increase was for HbA1c tests which is the main test undertaken to determine blood sugar levels for identifying and managing diabetes. The MoH released a Virtual Diabetes Register during 2011/12 which indicated that the prevalence of diabetes within Taranaki was much greater than previously thought. As such the services which support the identification and management of diabetes, like these laboratory tests, have inevitably increased.

Number of clients referred to the Primary Mental Health initiative



Target:

Number of clients referred to the Primary Mental Health initiative	>278	Achieved
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The average number of clients referred to the Primary Mental Health Initiative per quarter has increased considerably over the past three years from 278 in 2009/2010 to 446 in 2011/12.

Target: General Practices have a quality accreditation programme in place: 33 **Achieved**

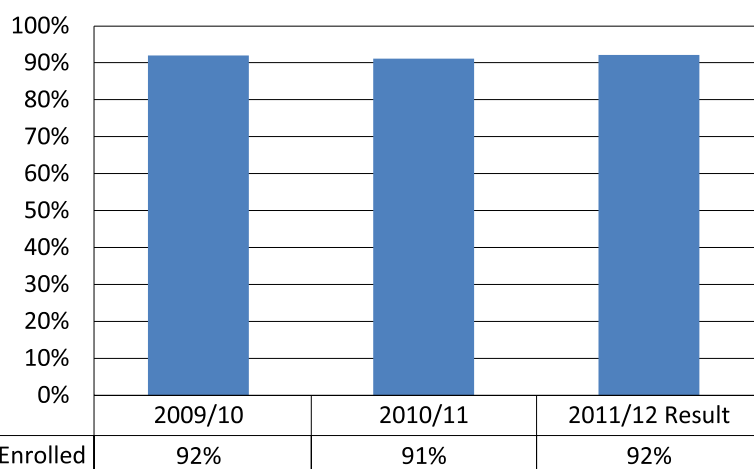
Midlands Health Network advise they currently use both Cornerstone Accreditation and Core Standards. Both processes are acceptable. Currently 32 of the 33 MHN GP Practices are accredited with the final practice undergoing the process at present. The National Hauora Coalition has three GP Practices in Taranaki. Two of the NHC GP Practices are Te Wana accredited.

Target: All PHOs have an up-to-date Māori Health Plan **Not achieved**

The Midlands Regional Health Network does not intend to develop a Māori Health Plan but is working on extrapolating Māori health priorities and indicators from the Midlands Health Network Māori Health Report 2012. This report includes a Māori Health profile for the enrolled service users of the Midlands Health Network. No agreed Māori Health Plan is in place. The National Hauora Coalition is a partner in Te Kawau Mārō with Tui Ora Ltd. Te Kawau Mārō is the Taranaki DHB provider of choice for Māori health services in Taranaki. It is the intention to leverage the development of Whānau Ora services in Taranaki through Te Kawau Mārō.

Statement of Service Performance - Primary and Community Health Services

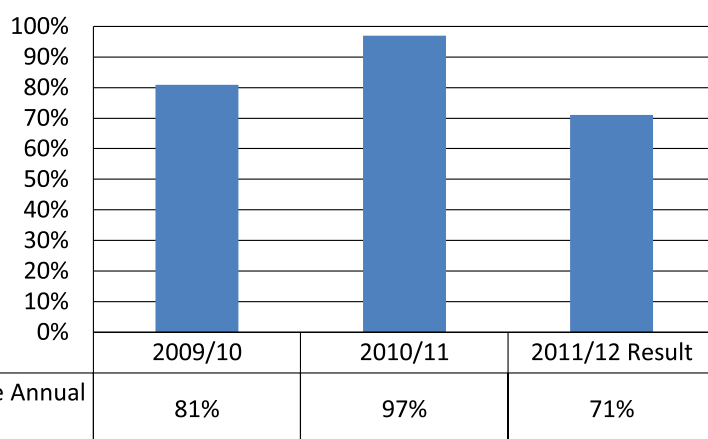
Proportion of the high needs population (NZDep 5) enrolled with a PHO



Target:		
Proportion of the high needs population (NZDep 5) enrolled with a PHO	95%	Not Achieved

The target for the number of the high needs population enrolled with a Primary Health Organisation was not met for 2011-12. Work is continuing with the PHOs through the 'Duty of Care Model' to ensure that the high needs population in Taranaki are engaged with primary care.

An increase in the percentage of people in all population groups estimated to have diabetes accessing free annual checks



Target:		
An increase in the percentage of people in all population groups estimated to have diabetes accessing free annual checks	95%	Not Achieved

Taranaki DHB did not achieve against the diabetes detection target.

During 2011-12 the MoH released a revised methodology for predicting diabetes prevalence across the country. Taranaki was found to have a greater prevalence than previously expected, increasing by 42% from 4,524 in 2010-11 to 6,419 in 2011-12. Therefore, even though the target was not achieved a further 222 diabetics were detected in 2011-12 than in 2010-11.





Pain Management session at Base Hospital

HEALTH SERVICES FOR PEOPLE WITH LONG TERM CONDITIONS

Long term conditions are a priority for the DHB due to the significant investment required in this area. Māori are over represented in all areas of chronic disease.

Friendly support encourages overdue woman to have smear

Sara Peacock, practice nurse at Regan Street Medical Centre in Stratford, this year convinced a patient 11 years overdue for a cervical smear to have a screening. "The patient had not had a chance to discuss her fears, and she did not realise the smear was required more than once in a lifetime," said Sara, who has been nursing for 26 years. During a visit to GP Dr Singh, Sara was able to discuss the procedure with her patient and convinced her to have the smear done. "I explained why it was important that she look after her own health and that this was a small way she could do this for herself, her family, and her community."

Sara was congratulated for her achievement by colleagues at the medical centre, and received recognition from Taranaki DHB's Cervical Screening Unit. "I love working with women and promoting women's health. There's a lot of misconceptions in the community and a large part of my job is allaying fears and educating. The patient has promised to encourage her family to be more proactive in caring for themselves," said Sara.

Statement of Service Performance



Huffy the Hearing Dog with a Renal patient using one of the hearing devices available at Base Hospital

Pain Management

Taranaki DHB offers two programmes to help patients manage long term persistent pain. These are PUEA which stands for Pain, Understanding, Exercise, and Adapt and the Pain Education Programme (PEP).

During 2011-12 Taranaki DHB had 42 patients involved in these pain management programmes which can take up to 10 people each programme.

PUEA, which means “to rise up” in Māori, aims to help people understand their pain and build on self management strategies so they can continue to function despite the pain.

The PUEA programme is 10 weeks long with participants attending sessions twice a week for the first six weeks and once a week for the last four weeks. PEP is a five week programme including two hour sessions once a week.

The group sessions include pain physiology and psychology. They use relaxation and exercise, and discuss topics such as goal setting, medication, changing habits, and communication skills.

The pain management team is multi-disciplinary and consists of pain specialists/anaesthetists, a persistent pain educator, a physiotherapist, and a psychologist.

Patients who attend usually have pain that would have persisted for more than three months, and may be the result of an injury or other condition. They may have had surgery and be taking medication for their pain.

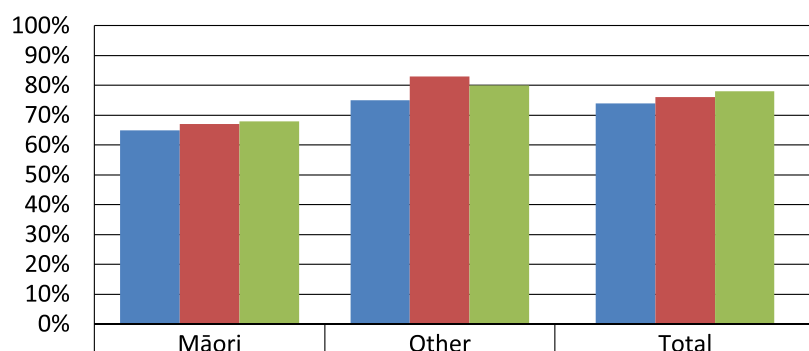
Kate Treves, Clinical Psychologist said that feedback from both programmes has been very positive. “When we look at the outcomes, the groups make improvements in all domains including pain experience, perceived disability, physical function, emotional wellbeing and sleep.” Patients also attend a six week and nine month follow-up.

“I have found PEP has given me a new set of tools that I can use to manage my pain. I know now that I am not alone and that there are other people out there whom are in the same boat.” - PEP participant October 2011

Statement of Service Performance - Health Services for People with Long Term Conditions

Impact Measures

The percentage of diabetics with well managed diabetes (HbA1c<=8%)



■ 2009/10	65%	75%	74%
■ 2010/11	67%	83%	76%
■ 2011/12 Result	68%	80%	78%

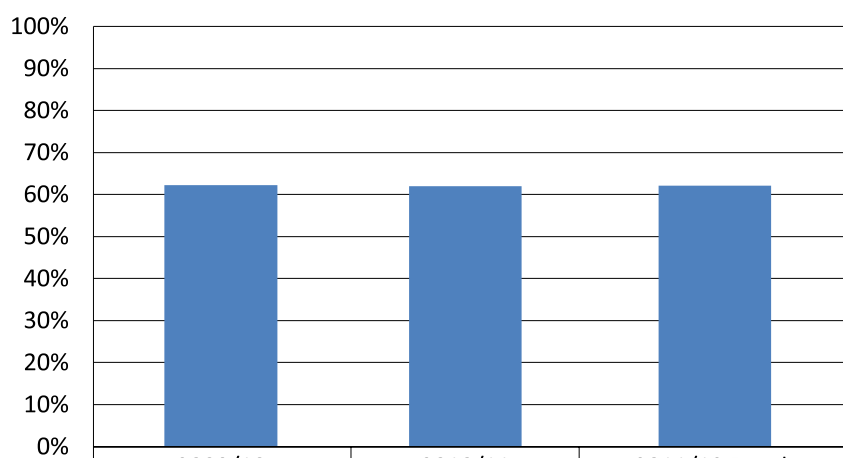
Target:

An increase in the percentage of people with diabetes have HbA1c<=8%¹²

Māori: 80%	Not Achieved
Other: 85%	Not Achieved
Total: 83%	Not Achieved

Taranaki DHB did not achieve against any of the diabetes management targets. However there has been a general increasing trend over time. There were 264 more people in Taranaki in 2011-12 who had their diabetes well-managed compared to 2010-11.

Breast screening rates - high needs



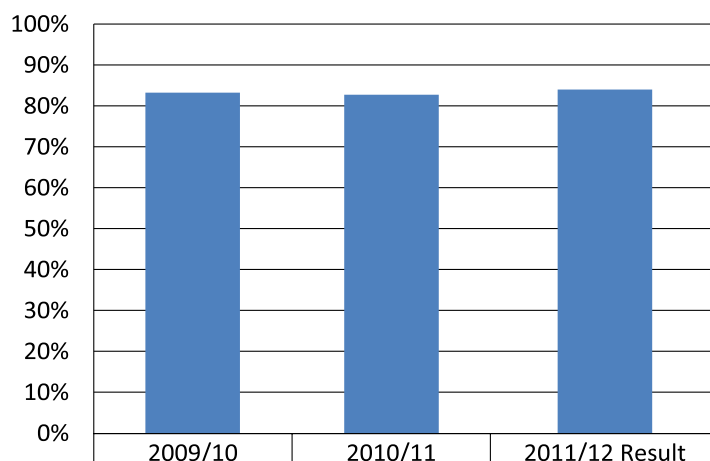
■ High Needs	62%	62%	62%
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Target:

Breast Screening Rates - High Needs	65%	Not Achieved
-------------------------------------	-----	--------------

Taranaki DHB did not achieve the breast screening rate for the high needs population for 2011-12. Although Taranaki DHB do not hold the contract or accountability for breast screening we are working with Primary Health Organisations in the monitoring of these rates through the PHO Performance Monitoring Programme.

Cervical screening rates



■ Cervical Screening rates	83%	83%	84%
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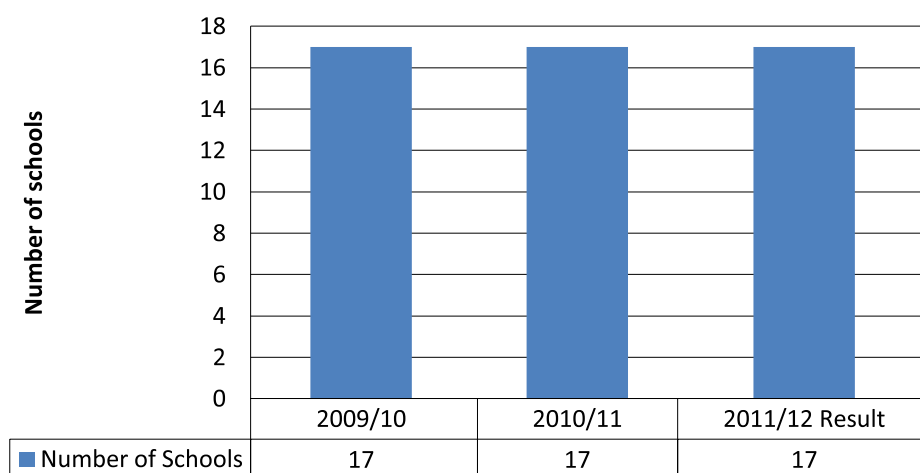
Target:

Cervical Screening rates	89%	Not Achieved
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Taranaki DHB did not achieve against the cervical screening rate target of 89%. However the National Screening Programme set a national target of 80% of which Taranaki DHB is only one of two DHB achieving this and is in fact the consistently highest performing DHB in the country. This is a reflection of the excellent work undertaken by the Taranaki District Health Board screening unit and primary care.

Output Measures: Prevention - Prevention of onset of disease where possible

Number of schools participating in the Health Promoting Schools programme

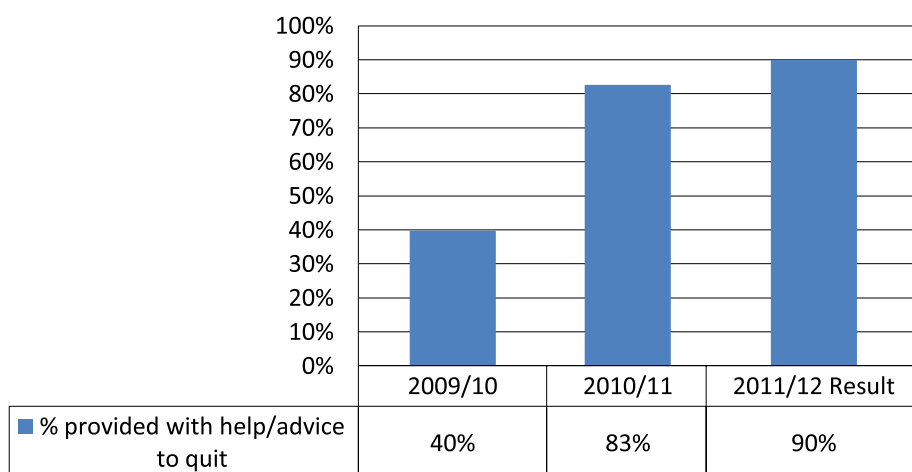


Target:

Number of schools participating in the Health Promoting Schools programme	17	Achieved
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During 2011/12 we continued to work with the schools that are participating in the Health Promoting Schools programme. Health Promoting Schools (HPS) is a World Health Organisation (WHO) programme which facilitates participation and action by the whole school community to "constantly strengthen schools' capacity as a healthy setting for living, learning and working".

Percentage of hospitalised smokers offered smoking cessation support

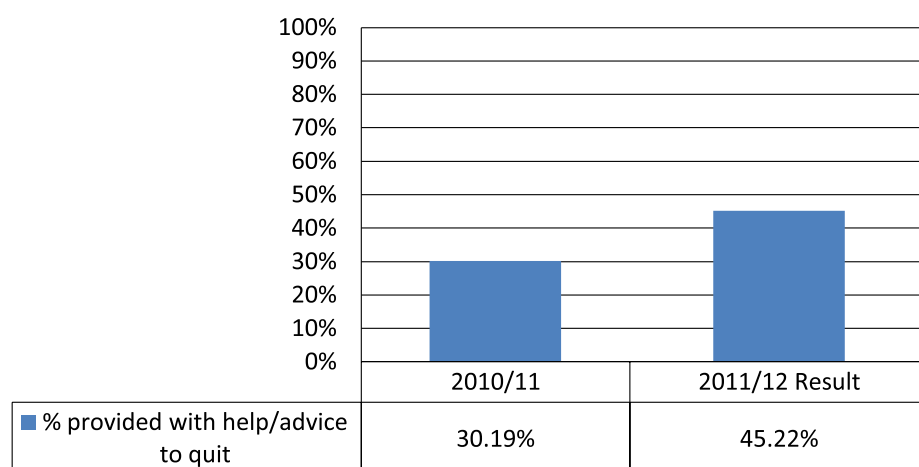


Target:

Percentage of hospitalised smokers offered smoking cessation support	95%	Not Achieved
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The target for the percentage of inpatients who are smokers and offered smoking cessation support was not achieved in 2011-12. The target was first introduced in 2009-10. Over the past three years the percentage has increased by 50% and although this is a great success we still need to improve. An organisation wide action plan has been finalised, the outcome of which we envisage contributing to an increasing proportion of smokers supported in Taranaki DHB's hospital facilities.

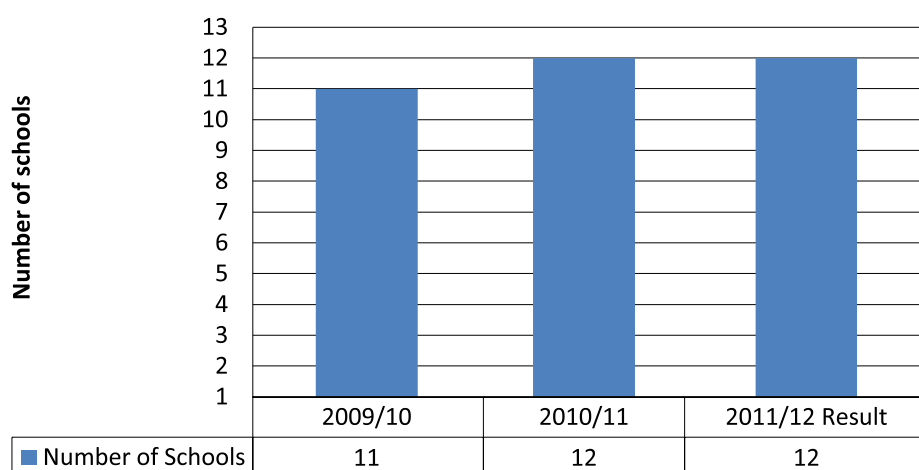
The proportion of smokers identified in primary care and provided with help/advice to quit



Target:		
The proportion of smokers identified in primary care and provided with help/advice to quit	90%	Not Achieved

The target for the proportion of smokers identified in primary care and provided with help/advice to quit was not met for the 2011/12 period. This target was introduced in 2010/11 and there has been gradual progress over the last two years. To accelerate this upward trend we are undertaking several programmes and initiatives with our primary care partners. These include the development of an action plan for specialist service to support quit attempts in a primary care setting, provide practices with support, coaching, education and training to deliver the ABC approach to smoking cessation services in general practices and working collaboratively developing linkages and communications with smokefree services and stakeholders.

Increasing the number of schools with a status of Active in the Health Promoting Schools programme

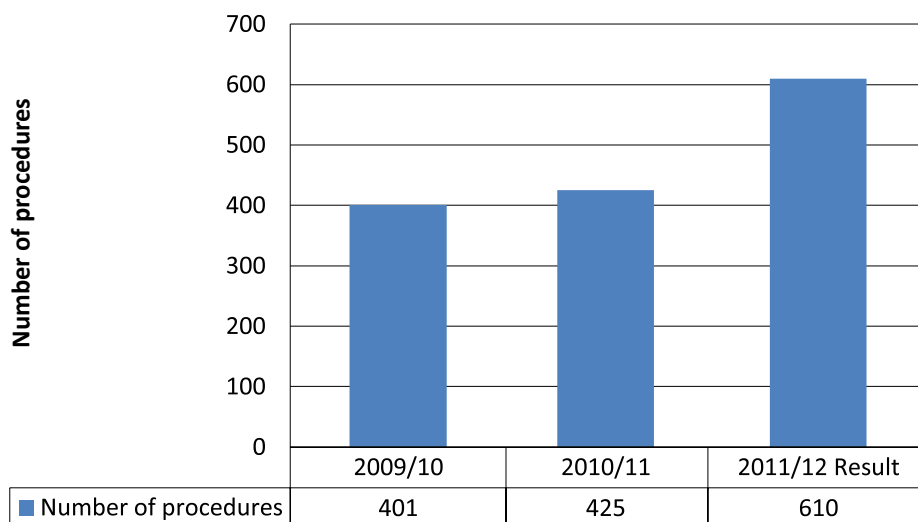


Target:		
Increasing the number schools with a status of Active in the Health Promoting Schools programme	12	Achieved

During 2011-12, the Public Health Unit continued to work with 17 schools. 12 schools remained "Active", meaning they had completed a community-wide consultation phase and commenced the implementation of health promotion plans. Five remained "Towards" schools, meaning they have engaged with or are considering the Health Promoting School process, as yet have not committed to being a Health Promoting School.

Output Measures: Early Detection and Management - Access to primary care services to ameliorate the effects of disease

Number of skin lesions removed

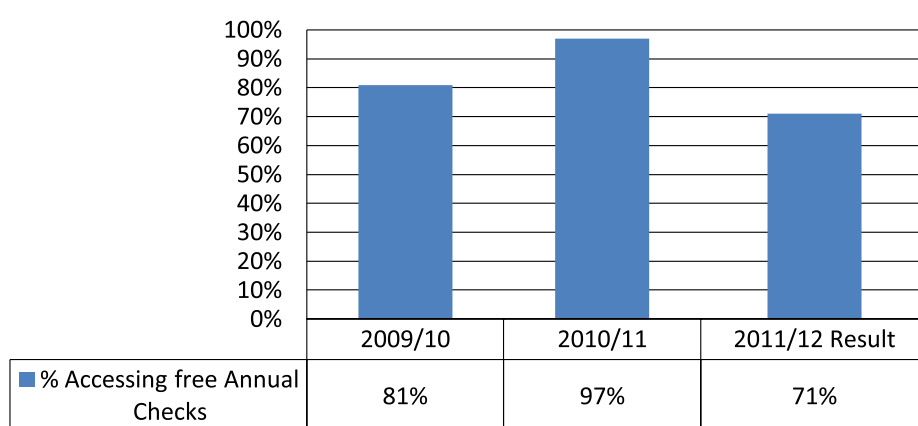


Target:

Number of skin lesions removed	441	Achieved
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Taranaki DHB provided considerably more Skin Lesions during 2011-12 than was targeted. Identification and removal of skin lesions are a major factor in reducing the rates of skin cancer in Taranaki, which has among the highest rates nationally.

An increase in the percentage of people in all population groups estimated to have diabetes accessing free annual checks



Target:

An increase in the percentage of people in all population groups estimated to have diabetes accessing free annual checks	95%	Not Achieved
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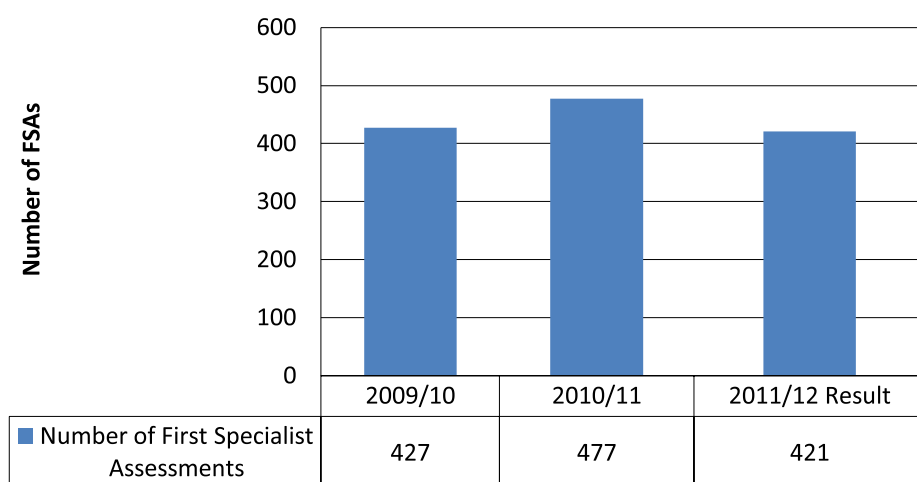
Taranaki DHB did not achieve against the diabetes detection target.

During 2011-12 the MoH released a revised methodology for predicting diabetes prevalence across the country. Taranaki was found to have a greater prevalence than previously expected, increasing by 42% from 4,524 in 2010-11 to 6,419 in 2011-12. Therefore, even though the target was not achieved a further 222 diabetics were detected in 2011-12 than in 2010-11.

Statement of Service Performance - Health Services for People with Long Term Conditions

Output Measures: Intensive Treatment and Assessment - Timely and equitable access to high quality efficient services for our community

Number of First Specialist Assessments in chemotherapy and radiotherapy specialties

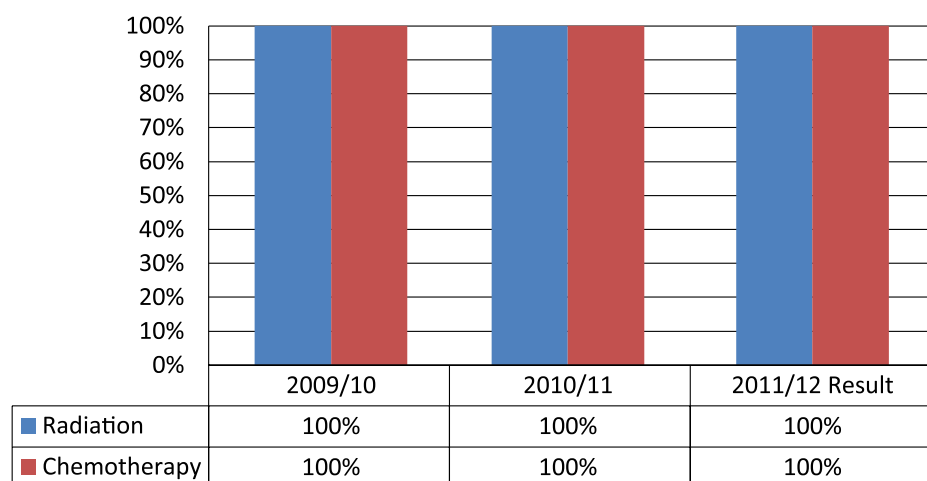


Target:

Number of First Specialist Assessments in chemotherapy and radiotherapy specialties	437	Not Achieved
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The target for the number of First Special Assessments in chemotherapy and radiotherapy was not met for 2011-12. This measure is used as a representation of the activity that we fund rather than a performance target. No patient waited longer than four weeks to access these services.

Radiation and chemotherapy waiting times within expected time frames



Target:

Radiation waiting times	100% within four weeks	Achieved
Chemotherapy waiting times	100% within four weeks	Achieved

Taranaki DHB has again worked hard with MidCentral DHB, our cancer tertiary provider, to ensure that our patients are seen within four weeks of commitment to treat.





Financial Report

2011/2012



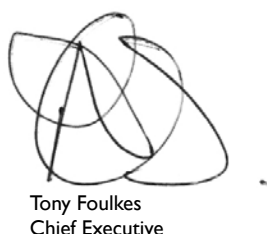
- 1 The Board and Management of the Taranaki District Health Board accepts responsibility for the preparation of the Financial Statements and the judgments used in them.
- 2 The Board and Management of the Taranaki District Health Board accepts responsibility for establishing and maintaining a system 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 2012, fairly reflect the financial position, operations, cash flows and service performance of the Taranaki District Health Board.



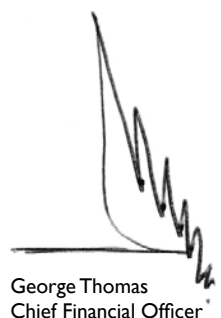
Mary Bourke
Chairman



Peter Catt
Deputy Chairman



Tony Foulkes
Chief Executive



George Thomas
Chief Financial Officer

Statement of Comprehensive Income

For the Year Ended 30 June 2012

	Notes	Group			Parent	
		Actual	Budget	Actual	Actual	Actual
		June 2012	June 2012	June 2011	June 2012	June 2011
			Unaudited			
		\$000	\$000	\$000	\$000	\$000
Revenue	1	317,485	314,107	311,719	316,634	311,256
Other income	2	1,376	2,110	61	1,376	61
Total income		318,861	316,217	311,780	318,010	311,317
Employee benefit costs	3	106,597	102,215	101,794	102,446	98,493
Depreciation expense		10,193	10,211	9,188	10,193	9,188
Outsourced services		22,203	21,351	24,258	22,203	24,257
Clinical supplies		23,141	21,366	20,626	23,142	20,626
Infrastructure and non-clinical expenses		8,089	8,107	10,907	12,966	14,300
Payments to non-health board providers		139,236	141,309	134,528	139,236	134,528
Other expenses	4	1,405	785	1,322	915	810
Capital charge	5	6,164	5,720	5,748	6,164	5,748
Financing costs	6	1,824	1,995	2,014	1,824	2,014
Total expenses		318,852	313,059	310,385	319,089	309,964
Surplus/(Loss) before share of associates attributable to the Parent		9	3,158	1,395	(1,079)	1,353
Share of surplus/(loss) of associates	13(c)	189	-	104	-	-
Surplus/(Loss) after surplus/(loss) of associates		198	3,158	1,499	(1,079)	1,353
Other comprehensive income		-	-	-	-	-
Total comprehensive surplus/(loss) for the period attributable to the Parent		198	3,158	1,499	(1,079)	1,353

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

Statement of Changes in Equity

For the Year Ended 30 June 2012

Consolidated					
Notes	Public Equity	Retained Earnings / (Losses)	Asset Revaluation Reserve	Trust Fund Reserve	Total
	\$000	\$000	\$000	\$000	\$000
At 30 June 2010	24,559	(5,185)	51,905	681	71,960
Total comprehensive surplus/(loss) for the period	-	1,499	-	-	1,499
Transfer from/(to) Trust Funds Reserves	-	(43)	-	43	-
	-	1,456	-	43	1,499
Transactions with the Crown					
Equity Injections	31	1,514	-	-	1,514
Equity repaid to the Crown	31	(959)	-	-	(959)
		555	-	-	555
At 30 June 2011	25,114	(3,729)	51,905	724	74,014
Total comprehensive surplus/(loss) for the period	-	198	-	-	198
Transfer from/(to) Trust Funds Reserves	-	(5)	-	5	-
	-	193	-	5	198
Transactions with the Crown					
Equity Injections	31	1,886	-	-	1,886
Equity repaid to the Crown	31	(959)	-	-	(959)
		927	-	-	927
At 30 June 2012	26,041	(3,536)	51,905	729	75,139

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

Statement of Changes in Equity

For the Year Ended 30 June 2012

Parent					
Notes	Public Equity	Retained Earnings / (Losses)	Asset Revaluation Reserve	Trust Fund Reserve	Total
	\$000	\$000	\$000	\$000	\$000
At 30 June 2010	24,559	(4,549)	51,905	-	71,915
Total comprehensive surplus/(loss) for the period	-	1,353	-	-	1,353
	-	1,353	-	-	1,353
Transactions with the Crown					
Equity Injections	31	1,514	-	-	1,514
Equity repaid to the Crown	31	(959)	-	-	(959)
		555	-	-	555
At 30 June 2011	25,114	(3,196)	51,905	-	73,823
Total comprehensive surplus/(loss) for the period	-	(1,079)	-	-	(1,079)
	-	(1,079)	-	-	(1,079)
Transactions with the Crown					
Equity Injections	31	1,886	-	-	1,886
Equity repaid to the Crown	31	(959)	-	-	(959)
		927	-	-	927
At 30 June 2012	26,041	(4,275)	51,905	-	73,671

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


Statement of Financial Position

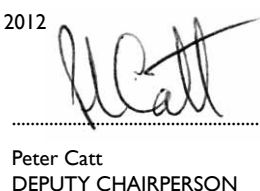
As at 30 June 2012

	Notes	Group			Parent	
		Actual	Budget	Actual	Actual	Actual
		June 2012	June 2012 Unaudited	June 2011	June 2012	June 2011
		\$000	\$000	\$000	\$000	\$000
ASSETS						
Current assets						
Cash and cash equivalents	7	3,433	2,054	3,069	3,407	2,849
Trade and other receivables	8	10,437	7,850	8,791	9,611	8,513
Inventories	9	2,654	2,625	2,628	2,654	2,628
Other financial assets	10	33,000	31,000	31,010	33,000	31,010
Assets classified as held for sale	11	-	-	-	-	-
Total current assets		49,524	43,529	45,498	48,672	45,000
Non-current assets						
Investments in subsidiaries	12	-	-	-	4,936	4,936
Investments in associates	13	1,107	879	918	1,451	1,451
Other financial assets	10	57	57	57	57	57
Property, plant and equipment	14	129,934	129,791	101,862	129,934	101,862
Restricted assets & trust funds	15	729	681	724	-	-
Total non-current assets		131,827	131,408	103,561	136,378	108,306
TOTAL ASSETS		181,351	174,937	149,059	185,050	153,306
LIABILITIES						
Current liabilities						
Trade and other payables	16	27,769	22,188	26,723	33,454	31,587
Interest bearing loans and borrowings	17	7,000	-	10,000	7,000	10,000
Employee benefits	18	20,142	18,355	18,509	19,624	18,083
Provisions	19	11	12	4	11	4
Total Current Liabilities		54,922	40,555	55,236	60,089	59,674
Non current liabilities						
Interest bearing loans and borrowings	17	49,800	61,500	19,000	49,800	19,000
Other Financial Liabilities		392	-	-	392	-
Employee benefits	18	1,098	837	809	1,098	809
Total non current liabilities		51,290	62,337	19,809	51,290	19,809
TOTAL LIABILITIES		106,212	102,892	75,045	111,379	79,483
NET ASSETS		75,139	72,045	74,014	73,671	73,823
EQUITY						
Public equity		26,041	23,784	25,114	26,041	25,114
Retained earnings/(losses)		(3,536)	(4,325)	(3,729)	(4,275)	(3,196)
Asset revaluation reserve		51,905	51,905	51,905	51,905	51,905
Trust fund reserve	15	729	681	724	-	-
TOTAL EQUITY		75,139	72,045	74,014	73,671	73,823

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 26th October 2012


 Mary Bourke
 CHAIRPERSON


 Peter Catt
 DEPUTY CHAIRPERSON

Statement of Cash Flows

For the Year Ended 30 June 2012

	Notes	Group			Parent	
		Actual	Budget	Actual	Actual	Actual
		June 2012	June 2012	June 2011	June 2012	June 2011
		Unaudited				
CASHFLOWS FROM OPERATING ACTIVITIES		\$000	\$000	\$000	\$000	\$000
Cash was provided from:						
Receipts from Government and Public		315,657	314,217	308,742	315,231	308,332
Interest Received		1,884	2,015	2,087	1,876	2,080
GST (Net)		-	-	462	-	485
		317,541	316,232	311,291	317,107	310,897
Cash was disbursed to:						
Payments to Suppliers		190,086	189,887	192,226	193,454	195,302
Payments to Employees		104,675	101,883	100,500	100,615	97,244
Capital Charge Paid		7,901	4,184	4,999	7,901	4,999
Interest Paid		2,218	1,995	2,018	2,218	2,018
GST (Net)		705	9,274	-	776	-
		305,585	307,223	299,743	304,964	299,563
Net Cash Inflow from Operating Activities	20	11,956	9,009	11,548	12,143	11,334
CASHFLOWS FROM INVESTING ACTIVITIES						
Cash was provided from:						
Dividends Received		2	-	2	2	2
Proceeds of loan repayments from associate company		10	-	55	10	55
Proceeds from Sale of Property, Plant & Equipment		14	-	157	14	157
		26	-	214	26	214
Cash was applied to:						
Purchase of Property, Plant & Equipment		38,339	40,199	11,906	38,339	11,906
Restricted Assets		6	-	43	-	-
Short Term Deposit		2,000	-	-	2,000	-
		40,345	40,199	11,949	40,339	11,906
Net Cash Outflow from Investing Activities		(40,319)	(40,199)	(11,735)	(40,313)	(11,692)
CASHFLOWS FROM FINANCING ACTIVITIES						
Cash was provided from:						
Equity vested by Crown		1,886	199	1,514	1,886	1,514
Proceeds from Debt Financing		27,800	32,500	-	27,800	-
		29,686	32,699	1,514	29,686	1,514
Cash was applied to:						
Repayment of Finance Leases		-	-	124	-	124
Repayment of Equity		959	959	959	959	959
		959	959	1,083	959	1,083
Net Cash Outflow from Financing Activities		28,727	31,740	431	28,727	431
Net Increase/(Decrease) in Cash Held		364	550	244	558	73
Cash and cash equivalents at beginning of year		3,069	1,504	2,825	2,849	2,776
Cash and cash equivalents at end of year		3,433	2,054	3,069	3,407	2,849

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

Significant accounting policies for the year ended 30 June 2012

(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 Finance Act 1989.

Taranaki District Health Board is a public benefit entity, as defined by NZIAS 1.

The Taranaki District Health Board consolidated financial statements comprise those of Taranaki District Health Board, a 100% investment in HIQ Limited, a 50% investment in Fulford Radiology Services Limited, a 25% investment in Allied Laundry Services Limited and a 20% investment in HealthShare Limited.

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 2012. The financial statements were authorised for issue by the Board on 11 October 2012.

(b) Statement of compliance and basis of preparation

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

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

(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:

Allowance for impairment loss on trade receivables (note 8)

A monthly assessment of non commercial debtors is made, with an impairment allowance 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 impairment allowance.

Fair value of buildings

Taranaki District Health Board revalues land and buildings on either a five year cycle or when there is a material (10% or over) 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.

An incorrect estimate of the useful life or residual value will impact on the depreciable amount of an asset, thereby impacting on the depreciation expense recognised in the statement of financial performance, and carrying amount of the asset in the statement of financial position.

The carrying amounts of land and buildings are disclosed in note 14.

(c) Basis of consolidation

Subsidiaries

Subsidiaries are all those entities over which Taranaki District Health Board has the power to govern the financial and operating policies so as to obtain benefits from their activities. In assessing control, potential voting rights that presently are exercisable or convertible are taken into account. The financial statements of subsidiaries are included in the consolidated financial statements from the date that control commences until the date that control ceases.

The financial statements of subsidiaries are prepared for the same reporting period as Taranaki District Health Board, using consistent accounting policies.

In preparing consolidated financial statements, all intercompany balances and transactions, income and expenses and profit and losses resulting from intra-group transactions are eliminated in full.

Taranaki District Health Board held a 100% shareholding in HIQ Limited as at 30 June 2012.

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:

- Fulford Radiology Services Limited 50% held
- Allied Laundry Services Limited 25% held
- HealthShare Limited 20% held

Taranaki District Health Board's investment in its associates is accounted for using the equity method of accounting in the consolidated financial statements and at cost in the parent. 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 if it has 20% or more of the voting rights.

Under the equity method, investments in associates are carried in the consolidated statement of financial position at cost plus post-acquisition changes in the Group's 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 profit or loss, 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 income 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 the 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 income.

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 Group 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 at Taranaki.

(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 balance sheet comprise cash in hand, 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 an allowance for impairment.

Collectability of trade receivables is reviewed on an ongoing basis at an operating unit level. Individual debts that are known to be uncollectible are written off when identified. An impairment provision is recognised when there is objective evidence that Taranaki District Health Board will not be able to collect the receivable.

At year end all debts that are over 365 days are written off against the provision for bad debts, the exception being where an invoice is currently being paid off by instalment.

(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.

(i) Non-current Assets held for sale

Non-current assets held for sale are classified as held for sale if their carrying amount will be recovered principally through a sale transaction, not through continuing use. Non-current assets held for sale are measured at the lower of their carrying amount and fair value less costs to sell. They are not depreciated or amortised. For an asset or disposal group to be classified as held for sale, it must be available for immediate sale in its present condition and its sale must be highly probable.

Any impairment losses for write-downs of non-current assets held for sale are recognised in the income statement.

Any increases in fair value (less costs to sell) are recognised up to the level of any impairment losses that have been previously recognised.

(j) 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 income statement.

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.

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

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. Such assets are carried at amortised cost using the effective interest method. Gains and losses are recognised in profit or loss when the loans and receivables are derecognised or impaired.

(k) 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 2008 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 income statement. 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 with the next revaluation due as at 30th June 2013, 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 income statement an expense 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 33 years	3-22.5%
Plant and equipment	2 to 18 years	5.5-48%
Motor vehicles	3 to 10 years	10-33.3%

Impairment

Non financial assets are tested for impairment whenever events of 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.

(l) 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.

(m) Operating Leases

Operating lease payments are recognised as an expense in the income statement on a straight-line basis over the lease term.

(n) 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.

(o) 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. Borrowing costs are recognised as an expense when incurred.

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.

(p) 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 is 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.

(q) 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.

(r) 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.

(s) 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 balance sheet.

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.

(t) New standards adopted and interpretations not yet adopted

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

NZ IFRS standards, amendments, and interpretations issued but not yet effective that have not been early adopted, and which are relevant to Taranaki District Health Board, are:

NZ IFRS 9 Financial Instruments

will eventually replace NZ IAS 39 Financial Instruments: Recognition and Measurement. NZ IAS 39 is being replaced through the following main phases: Phase 1 Classification and Measurement, Phase 2 Impairment Methodology, and Phase 3 Hedge Accounting. Phase 1 has been completed and has been published in the new financial instrument standard NZ IFRS 9. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39. The approach in NZ IFRS 9 is based on how an entity manages its financial assets and the contractual cash flow characteristics of the financial assets. The financial liability requirements are the same as those of NZ IAS 39, except for when an entity elects to designate a financial liability at fair value through the surplus or deficit. The new standard is required to be adopted for the year ended 30 June 2015. Taranaki District Health Board has not yet assessed the effect of the new standard and expects it will not be early adopted.

(u) Changes in accounting policy and disclosures

With the exception of capitalising borrowing costs where those borrowing costs are directly attributable to the acquisition or construction of a qualifying asset, there have been no changes to accounting policies during the year. The change did not have a material affect on the financial statements.

1 REVENUE

	Group		Parent	
	2012	2011	2012	2011
	\$000	\$000	\$000	\$000
Health and disability services (MoH contracted revenue)	302,488	295,015	302,357	294,954
ACC revenue	4,393	6,592	4,393	6,592
Inter District Patient Inflows	4,572	5,110	4,572	5,110
Interest received	1,884	2,087	1,876	2,080
Dividends received	2	2	2	2
Bad debts recovered	6	7	6	7
Other revenue	4,140	2,906	3,428	2,511
	317,485	311,719	316,634	311,256

2 OTHER INCOME

	Group		Parent	
	2012	2011	2012	2011
	\$000	\$000	\$000	\$000
Donations and bequests received	1,368	25	1,368	25
Gain on sale of property, plant and equipment	8	36	8	36
	1,376	61	1,376	61

3 EMPLOYEE BENEFIT COSTS

	Group		Parent	
	2012	2011	2012	2011
	\$000	\$000	\$000	\$000
Wages and salaries	105,058	100,788	100,995	97,512
Increase/(Decrease) in employee benefits provisions	1,539	1,006	1,451	981
	106,597	101,794	102,446	98,493

4 OTHER EXPENSES

	Group		Parent	
	2012	2011	2012	2011
	\$000	\$000	\$000	\$000
Impairment of trade receivables (bad and doubtful debts)	130	70	130	70
Loss on sale of property, plant and equipment	70	3	70	3
Audit fees - Ernst & Young (for the audit of the annual financial statements)	220	216	191	189
Audit fees - Verification New Zealand Limited (ACC partnership plan)	3	1	3	1
Audit fees - Healthshare Limited (Pharmacy Quality Audits)	-	30	-	30
Board members fees	244	236	237	221
Operating lease expenses	738	766	284	296
	1,405	1,322	915	810

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 2012 was 8% (2011: 8%).

6 FINANCING COSTS

	Group		Parent	
	2012	2011	2012	2011
	\$000	\$000	\$000	\$000
Interest on bank overdraft	5	11	5	11
Finance charges payable under finance leases	-	22	-	22
Interest on loans - Crown Health Financing Agency	1,819	1,981	1,819	1,981
	<u>1,824</u>	<u>2,014</u>	<u>1,824</u>	<u>2,014</u>

7 CASH AND CASH EQUIVALENTS

	Group		Parent	
	2012	2011	2012	2011
	\$000	\$000	\$000	\$000
Cash at bank and in hand	3,433	3,069	3,407	2,849
Short-term deposits maturing within 3 months of acquisition	-	-	-	-
Cash and cash equivalents	<u>3,433</u>	<u>3,069</u>	<u>3,407</u>	<u>2,849</u>

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.

8 TRADE AND OTHER RECEIVABLES

	Group		Parent	
	2012	2011	2012	2011
	\$000	\$000	\$000	\$000
Ministry of Health	4,539	4,871	4,514	4,871
Due from subsidiaries	-	1	1	1
Due from associates	95	100	95	100
Due from non-related parties	5,196	3,553	4,737	3,487
Prepayments	656	320	313	108
	<u>10,486</u>	<u>8,845</u>	<u>9,660</u>	<u>8,567</u>
Allowance for impairment loss (a)	(49)	(54)	(49)	(54)
Carrying amount of trade and other receivables	<u>10,437</u>	<u>8,791</u>	<u>9,611</u>	<u>8,513</u>

(a) Allowance for Impairment Loss

Trade receivables are non-interest bearing and are generally on terms of 20th of month following invoice. An allowance for impairment 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%).

Movements in the allowance for impairment loss were as follows:

	Group		Parent	
	2012	2011	2012	2011
	\$000	\$000	\$000	\$000
At 1 July	54	38	54	38
Charge for the year	130	70	130	70
Amounts written off	(135)	(54)	(135)	(54)
At 30 June	49	54	49	54

	Group		Parent	
	2012	2011	2012	2011
	\$000	\$000	\$000	\$000
Total non commercial debt	111	191	111	191
Non commercial debt with no impairment allowance	62	137	62	137

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.

As at 30 June 2012 and 2011, all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below:

	Actual		Actual	
	2012	2012	2011	2011
	Gross	Impairment	Gross	Impairment
	\$000	\$000	\$000	\$000
Taranaki District Health Board Parent				
Not past due	8,719	-	8,037	-
Past due 1 - 60 days	768	-	368	(5)
Past due 61 - 90 days	27	(1)	50	(13)
Past due > 90 days	146	(48)	112	(36)
	9,660	(49)	8,567	(54)

Taranaki District Health Board Group

Not past due	9,333	-	8,281	-
Past due 1 - 60 days	980	-	378	(5)
Past due 61 - 90 days	27	(1)	42	(13)
Past due > 90 days	146	(48)	144	(36)
	10,486	(49)	8,845	(54)

(b) Related Party Receivables

For specific amounts owing from related parties, including associate companies refer to note 21.

(c) Credit Risk and Effective Interest Rate Risk

Details regarding the credit risk and effective interest rate of current receivables is disclosed in note 24.

9 INVENTORIES

	Group		Parent	
	2012	2011	2012	2011
	\$000	\$000	\$000	\$000
Pharmaceuticals	547	556	547	556
Surgical and Medical Supplies	1,532	1,550	1,532	1,550
Other Supplies	575	522	575	522
	<u>2,654</u>	<u>2,628</u>	<u>2,654</u>	<u>2,628</u>

Write-down of inventories amounted to \$64k for 2012 (2011 \$35k).

No inventories are pledged as security for liabilities.

10 OTHER FINANCIAL ASSETS

	Group		Parent	
	2012	2011	2012	2011
	\$000	\$000	\$000	\$000
Current portion				
Loan - Allied Laundry Services Limited	-	10	-	10
Short-term deposits with maturities of 3-12 months	33,000	31,000	33,000	31,000
	<u>33,000</u>	<u>31,010</u>	<u>33,000</u>	<u>31,010</u>
Non-current portion				
Loan - Allied Laundry Services Limited	-	-	-	-
Shares in King Country Energy Limited	1	1	1	1
Shares in Pharmacy Wholesalers Limited	56	56	56	56
	<u>57</u>	<u>57</u>	<u>57</u>	<u>57</u>

11 ASSETS CLASSIFIED AS HELD FOR SALE

	Group		Parent	
	2012	2011	2012	2011
	\$000	\$000	\$000	\$000
Surplus Investment Property held for Sale	-	-	-	-

12 INVESTMENT IN SUBSIDIARY COMPANY

	Group		Parent	
	2012	2011	2012	2011
	\$000	\$000	\$000	\$000
Investment details				
HIQ Limited unlisted ordinary shares	-	-	4,936	4,936
	<u>-</u>	<u>-</u>	<u>4,936</u>	<u>4,936</u>

The principal activity of the subsidiary is the provision of IT services.

13 INVESTMENT IN ASSOCIATE COMPANIES

	Group		Parent	
	2012	2011	2012	2011
(a) Investment details	\$000	\$000	\$000	\$000
HealthShare Limited unlisted ordinary shares	-	-	-	-
HealthShare Limited Share of Retained Earnings	38	-	-	-
Allied Laundry Services Limited unlisted ordinary shares	750	750	750	750
Allied Laundry Services Limited Share of Retained Earnings	90	51	-	-
Fulford Radiology Services Limited unlisted ordinary shares	401	401	401	401
Fulford Radiology Services Limited Share of Accumulated Deficit	(472)	(584)	-	-
Fulford Radiology Services Limited loan to purchase assets	300	300	300	300
	1,107	918	1,451	1,451

There is no intention to seek repayment of the Fulford Radiology Services Limited loan of \$300k (2011: \$300k).

Details of each Associate Company are as follows:

	Balance date	Interest held at 30 June 2012	Interest held at 30 June 2011
HealthShare Limited	30 June	20%	20%

The principal activity of the associate is the provision of contract processing, auditing services and regional initiatives for the 5 Midland Region District Health Board's.

Fulford Radiology Services Limited	30 June	50%	50%
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The principal activity of the associate is the provision of radiology services.

Allied Laundry Services Limited	30 June	25%	25%
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The principal activity of the associate is the provision of laundry services

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

Summarised unaudited financial information - 2012:	Assets	Liabilities	Equity	Revenues	Profit/(loss)
	\$000	\$000	\$000	\$000	\$000
Healthshare Limited	-	-	-		
Fulford Radiology Services Limited	3,415	2,959	456	11,106	599
Allied Laundry Services Limited	4,852	1,374	3,478	6,622	359
	8,267	4,333	3,934	17,728	958

Summarised audited financial information - 2011:

	Assets	Liabilities	Equity	Revenues	Profit/(loss)
	\$000	\$000	\$000	\$000	\$000
Healthshare Limited	453	262	191	1,395	(62)
Fulford Radiology Services Limited	2,562	2,705	(143)	10,729	224
Allied Laundry Services Limited	4,982	1,624	3,358	6,261	
	7,997	4,591	3,406	18,385	316

The above information has been extracted from the associate companies unaudited management accounts (2012) and audited financial statements (2011).

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

	Group	
	2012	2011
	\$000	\$000
Balance at 1 July	918	814
New investments during the year	-	-
Share of total recognised revenues and expenses	189	104
Balance at 30 June	1,107	918

14 PROPERTY, PLANT AND EQUIPMENT

Group and Parent	Freehold Land	Freehold Buildings	Plant and Equipment	Motor Vehicles	Leased Motor Vehicles	Work in Progress	Total
Year ended 30 June 2012							
Cost/revaluation 30-Jun-11	7,890	79,040	40,886	2,362	-	19,917	150,095
Accumulated depreciation and impairment charges 30-Jun-11	-	(17,077)	(28,992)	(2,164)	-	-	(48,233)
Carrying amount 30-Jun-11	7,890	61,963	11,894	198	-	19,917	101,862
Current year additions	-	2,107	11,746	500	-	23,987	38,340
Current year disposals	-	(72)	(2)	(1)	-	-	(75)
Current year depreciation	-	(6,334)	(3,679)	(180)	-	-	(10,193)
At 30 June 2012 net of accumulated depreciation and impairment	7,890	57,664	19,959	517	-	43,904	129,934
At 30 June 2012							
Cost or fair value	7,890	81,034	52,518	2,840	-	43,904	188,186
Accumulated depreciation and impairment	-	(23,370)	(32,559)	(2,323)	-	-	(58,252)
	7,890	57,664	19,959	517	-	43,904	129,934

Group and Parent	Freehold Land	Freehold Buildings	Plant and Equipment	Motor Vehicles	Leased Motor Vehicles	Work in Progress	Total
Year ended 30 June 2011							
Cost/revaluation 30-Jun-10	7,890	77,388	37,113	2,531	1,124	14,109	140,155
Accumulated depreciation and impairment charges 30-Jun-10	-	(11,369)	(26,524)	(1,957)	(638)	-	(40,488)
Carrying amount 30-Jun-10	7,890	66,019	10,589	574	486	14,109	99,667
Current year additions	-	1,651	4,447	-	-	5,808	11,906
Current year disposals	-	-	(109)	(21)	(393)	-	(523)
Current year depreciation	-	(5,707)	(3,033)	(355)	(93)	-	(9,188)
At 30 June 2011 net of accumulated depreciation and impairment	7,890	61,963	11,894	198	-	19,917	101,862
At 30 June 2011							
Cost or fair value	7,890	79,040	40,886	2,362	-	19,917	150,095
Accumulated depreciation and impairment	-	(17,077)	(28,992)	(2,164)	-	-	(48,233)
	7,890	61,963	11,894	198	-	19,917	101,862

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 2008 by Ian D. Baker ANZIV, SNZPI, 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 NZ IAS 16 as issued by The Institute of Chartered Accountants of New Zealand (ICANZ), 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 30th June 2012 (2011: Nil).

15 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.

	Group		Parent	
	2012	2011	2012	2011
	\$000	\$000	\$000	\$000
Opening Balance	724	681	-	-
Funds Received	98	89	-	-
Interest Received	21	36	-	-
Funds Spent	(114)	(82)	-	-
Closing Balance Restricted Assets	729	724	-	-

Represented By:

Cash at Bank	4	25	-	-
Short Term Deposits	719	699	-	-
Shares & Other	6	-	-	-
Total Restricted Assets	729	724	-	-

16 TRADE AND OTHER PAYABLES

	Group		Parent	
	2012	2011	2012	2011
	\$000	\$000	\$000	\$000
Trade Payables	21,800	20,205	21,467	18,486
Capital Charge Payable	1,584	3,322	1,584	3,322
Income received in advance	1,339	1,329	1,329	1,329
Interest Payable	470	395	470	395
Current Account with Subsidiary Company	-	-	6,028	6,583
Owing to Associates	767	742	767	742
Other Related Parties	1,809	730	1,809	730
	27,769	26,723	33,454	31,587

Most trade and other payables are non-interest bearing and normally settled by the 20th of the month following service or delivery of goods. The exception is capital charge paid to the Ministry of Health, and interest paid to the Crown Health Financing Agency. Capital charges are paid quarterly in arrears, on a July, October, January and April cycle. Interest paid to the Crown Health Financing Agency on term loans is paid either on a three or six monthly cycle.

The current account balance is related to HIQ Limited. This is partially offset by the investment of Taranaki District Health Board in HIQ Limited. HIQ Limited will not be seeking repayment from Taranaki District Health Board.

17 INTEREST-BEARING LOANS AND BORROWINGS

	Group		Parent	
	2012	2011	2012	2011
	\$000	\$000	\$000	\$000
Finance Lease Liability	-	-	-	-
Government Sector Borrowing	56,800	29,000	56,800	29,000
Total Loans	56,800	29,000	56,800	29,000
Less Current Portion	7,000	10,000	7,000	10,000
Term Portion	49,800	19,000	49,800	19,000
INTEREST RATES:	2012		2011	
Government Sector Borrowing	3.67% - 7.32%		6.30% - 7.32%	

	Group		Parent	
	2012	2011	2012	2011
	\$000	\$000	\$000	\$000
GOVERNMENT SECTOR BORROWING				
Due for repayment:				
within one year	7,000	10,000	7,000	10,000
within two years	-	7,000	-	7,000
within three years	12,000	-	12,000	-
within four years	19,200	12,000	19,200	12,000
within five years	-	-	-	-
after five years	18,600	-	18,600	-
	56,800	29,000	56,800	29,000

The term loans denoted are financed by the Crown Health Financing Agency (acting as an agent of the Crown) and the interest is based on two components - a fixed rate and a margin. The margin may decrease on account of efficiencies derived by the Crown Health Financing Agency and passed onto the Taranaki District Health Board, whilst any increase in the margin will be capped and cannot exceed the original margin agreed at the time of the loan drawdown.

Government sector borrowings are unsecured and repayment is classified in line with the terms of borrowing with the Crown Health Financing Agency.

FAIR VALUE OF GOVERNMENT BORROWING

The fair value of the \$56,800k (2011: \$29,000K) of Government Borrowing at 30th June 2012 was calculated at \$60,643k (2011: \$31,118k). This calculation is done by discounting the expected future cash flows at prevailing interest rates. Crown Health Financing Agency has used the Government Bond Rate plus 15 basis points based on mid market pricing, this being the same basis on which District Health Board debt is funded, to establish the fair value.

18 EMPLOYEE BENEFITS

	Group		Parent	
	2012	2011	2012	2011
	\$000	\$000	\$000	\$000
Salary & wages accrual	3,968	3,583	3,851	3,472
Annual Leave	12,844	11,741	12,442	11,426
Sick Leave	305	322	305	322
Long Service Leave	1,244	1,044	1,244	1,044
Retirement gratuities	1,090	1,026	1,090	1,026
Continuing Medical Education	1,557	1,388	1,557	1,388
Sabbatical Leave	233	214	233	214
	21,241	19,318	20,722	18,892

Made up of:

Current	20,142	18,509	19,624	18,083
Non-current	1,098	809	1,098	809
	21,240	19,318	20,722	18,892

19 PROVISIONS

	Group		Parent	
	2012	2011	2012	2011
	\$000	\$000	\$000	\$000
Current provisions				
ACC Partnership Programme	11	4	11	4
	11	4	11	4

The liability valuation on the ACC Partnership Program has been calculated by Aon New Zealand Limited as at the 30th June 2012. All outstanding claims by Taranaki District Health Board's employees are estimated by claim managers as at this point.

20 RECONCILIATION OF NET SURPLUS/(DEFICIT) AFTER TAXATION WITH CASH OUTFLOW FROM OPERATING ACTIVITIES

	Group		Parent	
	2012	2011	2012	2011
	\$000	\$000	\$000	\$000
Net Surplus/(Loss)	198	1,499	(1,079)	1,353
Add/(Less) Non-Cash Items:				
Depreciation	10,193	9,188	10,193	9,188
(Decrease)/Increase in Provision for Doubtful Debts	(5)	16	(5)	16
(Decrease)/Increase in Employee Entitlements	1,923	1,294	1,831	1,249
	12,111	10,498	12,019	10,453
Add back items classified as investment/financing activities:				
Decrease/(Increase) in Investments Held	(189)	(103)	-	-
Net Loss/(Gain) of Disposal of Assets	61	(34)	61	(34)
	(128)	(137)	61	(34)
Add/(Less) Movements in Working Capital:				
(Increase)/Decrease in Receivables & Prepayments	(1,641)	(886)	(1,093)	(921)
(Increase)/Decrease in Inventories	(25)	(55)	(25)	(55)
(Decrease)/Increase in Payables & Accruals	1,441	629	2,260	538
	(225)	(312)	1,142	(438)
Net Cash Inflow/(Outflow) from Operating Activities	11,956	11,548	12,143	11,334

21 RELATED PARTY TRANSACTIONS

Taranaki District Health Board is a wholly owned entity of the Crown. The Government significantly influences the role of the Board as well as being its major source of revenue.

Taranaki District Health Board enters into numerous transactions with government departments and other Crown agencies outside of the funding relationship. Where these parties are acting in the course of their normal dealings with Taranaki District Health Board, related party disclosures have not been made for transactions of this nature.

Related Party Transactions and Balances

(a) Funding

Taranaki District Health Board received \$302m from the Ministry of Health to provide health services to the Taranaki area (2011: \$295m). The amount outstanding at year end was \$4.35m (2011: \$4.87m).

(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:

	Parent Owed to TDHB		Parent Income to TDHB	
	2012	2011	2012	2011
	\$000	\$000	\$000	\$000
Allied Laundry Services Limited	62	2	21	21
Fulford Radiology Services Limited	33	39	315	314
Healthshare Limited	-	-	-	-
HIQ Limited	1	1	94	506
	96	42	430	841

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

	Parent Owed by TDHB		Parent Expense to TDHB	
	2012	2011	2012	2011
	\$000	\$000	\$000	\$000
Allied Laundry Services Limited	106	118	1,008	996
Fulford Radiology Services Limited	619	624	7,235	7,441
Healthshare Limited	25	-	-	110
HIQ Limited	-	-	3,549	3,736
	750	742	11,792	12,283

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

Board Members and Key Management - 2012

TDHB Board Member	Related Party	Relationship	TDHB Transaction	Expense for Year 30 June 2012 \$000	Owed by TDHB at 30 June 2012 \$000
Alex Ballantyne	Peak Health	Local Management Group Member	GP and Health Services		
	TSB Community Trust	Member	Community Funding		
	STDC	Councillor	Local Authority	17	3
Ella Borrows	South Taranaki Medical Trust	Member	GP and Health Services	87	2
Mary Bourke	TSB Community Trust	Member	Community Funding		
	Bishops Action Foundation	Member	Community and Health Projects		
	WITT Polytechnic	Chairperson	Training organisation	3	-
	Lotteries Community Grant Committee	Member	Community Funding		
	New Families Interim Trust	Member	Community and Health Projects		
	South Taranaki Medical Trust	Former Chair	GP and Health Services	87	2
Peter Catt	Family Health Care Centre	GP and Shareholder	GP and Health Services		
	Taranaki Sub Faculty RNZCGP	Secretary Treasurer			
	Workforce Development Group	Member			
	HIQ Ltd	Director	Information Technology Provider	3,549	
Kura Denness	Hauora Taranaki PHO (Taranaki PHO Ltd)	Chairperson	GP and Health Services	15	-
	Midland Regional Health Network		GP and Health Services	19,727	406
	Tui Ora Ltd	Chairperson	Health Services	7,462	1,204
	Massey University	Council Member	Education Provider	12	-
	Te Aroha MedCare	Chairperson	GP and Health Services	17	-
	Pharmac	Director	DHB Funding	457	164
	Te Matai Whetu Ltd	Personal			
	MidCentral Zone Rugby League	Chairperson	TDHB Funding of Smokefree Programme for League Club		
	Allied Laundry Services	Director	Supplier of Laundry Services	1,008	106
	Bayley Road Trust	Trustee			
Karen Eagles	Govett Quilliam	Husband Senior Partner	Legal rep of TDHB	25	-
	Plunket NZ	National Councillor			
Flora Gilkison	Taranaki DHB	Husband employed as surgeon			
	Fulford Radiology Services	Director	Supplier of Radiology Services	7,235	619
Brian Jeffares	Stratford Health Trust	Member	GP and Health Services	39	-
	Taranaki Electricity Trust	Member	Community Funding		
Pauline Lockett	New Plymouth District Council	Member	Local Authority	204	30
	Tui Ora	Contractor to (formerly)	Health Services	7,462	1,204
Alison Rumball	Taranaki Cancer Society	Member	Health Services	2	-
Colleen Tuuta	TSB Community Trust		Community Funding		
	Tui Ora Ltd		Health Services	7,462	1,204

Board Members and Key Management - 2011

TDHB Board Member	Related Party	Relationship	TDHB Transaction	Expense for Year 30 June 2011	Owed by TDHB at 30 June 2011
				\$000	\$000
Alex Ballantyne	Peak Health	Local Management Group Member	GP and Health Services	3,114	
	TSB Community Trust	Member	Community Funding		
	STDC	Councillor	Local Authority	12	
Ella Borrowes	South Taranaki Medical Trust	Member	GP and Health Services		
Mary Bourke	TSB Community Trust	Member	Community Funding		
	Bishops Action Foundation	Member	Community and Health Projects		
	WITT Polytechnic	Chairperson	Training organisation	4	
	Lotteries Community Grant Committee	Member	Community Funding		
	New Families Interim Trust	Member	Community and Health Projects		
	South Taranaki Medical Trust	Former Chair	GP and Health Services		
Peter Catt	Family Health Care Centre	GP and Shareholder	GP and Health Services	8	
	Taranaki Sub Faculty RNZCGP	Secretary Treasurer			
	Workforce Development Group	Member			
	HIQ Ltd	Director	Information Technology Provider	3,736	
Kura Denness	Hauora Taranaki PHO (Taranaki PHO Ltd)	Chairperson	GP and Health Services	2,509	
	Midland Regional Health Network		GP and Health Services	13,993	218
	Tui Ora Ltd	Chairperson	Health Services	5,444	457
	Massey University	Council Member	Education Provider		
	Te Aroha MedCare	Chairperson	GP and Health Services	17	
	Pharmac	Director	DHB Funding	79	
	Te Matai Whetu Ltd	Personal			
	MidCentral Zone Rugby League	Chairperson	TDHB Funding of Smokefree Programme for League Club	30	18
	Allied Laundry Services	Director	Supplier of Laundry Services	996	118
	Bayley Road Trust	Trustee			
Karen Eagles	Govett Quilliam	Husband Senior Partner	Legal rep of TDHB	50	
	Plunket NZ	National Councillor			
Flora Gilkison	Taranaki DHB	Husband employed as surgeon			
	Fulford Radiology Services	Director	Supplier of Radiology Services	7,441	624
Brian Jeffares	Stratford Health Trust	Member	GP and Health Services		
	Taranaki Electricity Trust	Member	Community Funding		
Pauline Lockett	New Plymouth District Council	Member	Local Authority	471	
	Tui Ora	Contractor to	Health Services	5,444	457

TDHB Board Member	Related Party	Relationship	TDHB Transaction	Expense for Year 30 June 2011	Owed by TDHB at 30 June 2011
				\$000	\$000
Alison Rumball	Taranaki Cancer Society	Member	Health Services	70	6
Colleen Tuuta	TSB Community Trust		Community Funding		
	Tui Ora Ltd		Health Services	5,444	457
Dan Devadhar (former member)	Independent Health Advocate				
	ACC Advocate				
Grant Knuckey (former member)	Te Atiawa Medical Trust	CEO	GP and Health Services	207	17
	Te Tihi Hauora o Taranaki	Chairman	GP and Health Services	1,326	14
	Health Aotearoa	Executive Member			
	Bayley Road Trust	Trustee			
Jenny Nager (former member)	Mary Ann Rest Home Stratford	Daughter in Law is an employee	TDHB Funds services		
	Grey Power South Taranaki	Secretary			
Tony Ruakere (former member)	Te Atiawa Medical Centre	Employee/General Practitioner	GP and Health Services	207	17
	Te Pou Heretaunga Disability Committee of Tui Ora	Member	Health and Disability Services	5,444	457

22 RELATED PARTIES - KEY MANAGEMENT PERSONNEL

	Group		Parent	
	2012	2011	2012	2011
	\$000	\$000	\$000	\$000
Compensation of key management personnel				
Short-term employee benefits	1,745	1,977	1,745	1,977
Post-employment benefits	-	-	-	-
Other long-term benefits	-	-	-	-
Termination benefits	-	-	-	-
	<u>1,745</u>	<u>1,977</u>	<u>1,745</u>	<u>1,977</u>

Key management personnel include all board members and members of the executive management team.

23 FINANCIAL INSTRUMENT CATEGORIES

The carrying amounts of financial instruments in each of the NZ IAS 39 categories are as follows:

	Note	Group		Parent	
		2012	2011	2012	2011
		\$000	\$000	\$000	\$000
FINANCIAL ASSETS					
Loans and receivables					
Cash and cash equivalents	7	3,433	3,069	3,407	2,849
Debtors and other receivables	8	10,437	8,791	9,611	8,513
Loans to associates	10	-	10	-	10
Other investments	10	57	57	57	57
Term deposits	10	33,000	31,000	33,000	31,000
Restricted Assets and Trust Funds	15	729	724	-	-
Total loans and receivables		<u>47,656</u>	<u>43,651</u>	<u>46,075</u>	<u>42,429</u>

FINANCIAL LIABILITIES

Financial liabilities at amortised costs

	Note	2012	2011	2012	2011
Trade and other payables	16	26,430	25,394	32,125	30,258
Finance lease liabilities	17	-	-	-	-
Loans from Crown Health Financing Agency	17	56,800	29,000	56,800	29,000
Total financial liabilities		<u>83,230</u>	<u>54,394</u>	<u>88,925</u>	<u>59,258</u>

The fair value of all of the above financial instruments approximately equal their carrying value with the exception of loans from Crown Health Financing Agency.

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

The fair value of the \$56,800k of loans from the Crown Health Financing Agency at 30th June 2011 was calculated at \$60,643k (2011: \$31,118k).

24 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 debtors (note 8) and other financial assets (note 10).

Taranaki District Health Board has no significant concentrations of credit risk as government sourced revenue for Taranaki District Health Board was 96% (2011: 97%) whilst it accounted for 81% (2011: 96%) 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

Group - 2012

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

	Carrying value \$000	Contractual Cash Flows \$000	0-3 month \$000	3-12 months \$000	1-3 years \$000	3-7 years \$000
Non-derivative financial liabilities						
Trade and other payables	26,430	26,430	26,430	-	-	-
Loans and borrowings	56,800	66,524	111	9,651	16,537	40,225
	83,230	92,954	26,541	9,651	16,537	40,225

Group - 2011

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

	Carrying value \$000	Contractual Cash Flows \$000	0-3 month \$000	3-12 months \$000	1-3 years \$000	3-7 years \$000
Non-derivative financial liabilities						
Trade and other payables	25,394	25,394	25,394	-	-	-
Loans and borrowings	29,000	33,551	10,158	1,354	9,197	12,842
	54,394	58,945	35,552	1,354	9,197	12,842

Parent - 2012

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

	Carrying value \$000	Contractual Cash Flows \$000	0-3 month \$000	3-12 months \$000	1-3 years \$000	3-7 years \$000
Non-derivative financial liabilities						
Trade and other payables	26,097	26,097	26,097	-	-	-
Loans and borrowings	56,800	66,524	111	9,651	16,537	40,225
	82,897	92,621	26,208	9,651	16,537	40,225

The current account balance to HIQ Limited is excluded from Trade and other payables. This is due to HIQ Limited not requiring repayment from Taranaki District Health Board.

Parent - 2011

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

	Carrying value \$000	Contractual Cash Flows \$000	0-3 month \$000	3-12 months \$000	1-3 years \$000	3-7 years \$000
Non-derivative financial liabilities						
Trade and other payables	23,675	23,675	23,675	-	-	-
Loans and borrowings	29,000	33,551	10,158	1,354	9,197	12,842
	52,675	57,226	33,833	1,354	9,197	12,842

The current account balance to HIQ Limited is excluded from Trade and other payables. This is due to HIQ Limited not requiring repayment from Taranaki District Health Board.

The current account balance to HIQ Limited is excluded from Trade and other payables. This is due to HIQ Limited not requiring repayment from Taranaki District Health Board.

(e) Sensitivity Analysis

In managing interest rate risk Taranaki District Health Board has adopted two strategies, (i) having term borrowings with the Crown Health Financing Agency on fixed rates, and (ii) having the maturity dates of the five individual loans to the Crown Health Financing Agency at different dates. Any increase in interest rates on a specific term loan when it matures and is rolled is therefore reduced, as only that specific loan is impacted.

As at 30 June 2012, if floating interest rates had been 100 basis points higher/lower, with all other variables held constant, the surplus for the year would have been \$330k higher/lower.

The following sensitivity analysis is based on the interest rate risk exposures in existence at the reporting date.

Judgements of reasonably possible movements

Consolidated and Parent	Surplus for the period	
	Higher/(lower)	
	2012	2011
	\$000	\$000
+1% (100 basis points)	330	310
-1% (100 basis points)	(330)	(310)

25 CONTINGENT LIABILITIES

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 do not consider the outcome of these claims will have a material adverse affect on the financial position of Taranaki District Health Board.

26 CAPITAL COMMITMENTS AND OPERATING LEASES

	Group		Parent	
	2012	2011	2012	2011
	\$000	\$000	\$000	\$000
Capital Commitments				
Property, plant and equipment	32,077	52,051	32,077	52,051
	32,077	52,051	32,077	52,051

Operating leases as lessee

Taranaki District Health Board leases buildings, vehicles and equipment. These non-cancellable leases typically range from 3 to 5 years (vehicles and equipment).

Not later than one year	563	204	563	204
Later than one and not later than two years	525	142	525	142
Later than two and not later than five years	950	109	950	109
Later than five years	118	127	118	127
	2,156	582	2,156	582

27 MAJOR VARIATIONS FROM BUDGET (unaudited)

Income Statement Variances - Revenue

Taranaki District Health Board recorded a surplus of \$0.199 million compared with a budgeted surplus of \$3.158 million.

A total of \$2.6 million additional revenue over budget was received as follows (2011: \$3.8m):

	Variance unaudited 2012 \$000	Variance unaudited 2011 \$000
Ministry of Health Funding	3,815	4,223
Accident Compensation Revenue (ACC)	(1,237)	(417)
Inter District Flows	4	396
Inter Provider Revenue	9	(170)
Interest Received	(141)	12
Donations Received	(742)	7
Other	936	(260)
	<u>2,644</u>	<u>3,791</u>

Income Statement Revenue Explanations

Ministry of Health Funding

Additional funding devolved from Ministry in excess of funding envelope advised.

Accident Compensation Revenue (ACC)

(i) No price increases from ACC, (ii) reduced referrals from ACC.

Inter District Flows

Inflow of other DHB population greater than expected.

Other

National and Regional IT initiatives

Income Statement Variances - Expenditure

A total of \$5.8m additional expenditure over budget were incurred as follows (2011: \$0.1m):

	Variance Unaudited 2012 \$000	Variance Unaudited 2011 \$000
Employee Benefit costs	3,890	(1,746)
Outsourced services	806	3,023
Clinical supplies	1,644	(247)
Payments to non-health board providers	(1,776)	785
Other	1,229	(1,718)
	<u>5,793</u>	<u>97</u>

Income Statement Expenditure Explanations

Employee Benefit costs

Increased staffing hours

Outsourced services

Locum costs and work outsourced.

Clinical supplies

Increased production

Payments to non-health board providers

Reduced costs for demand driven care

Other

Increased facility and interest costs related to Hospital Redevelopment Project

	Variance Unaudited 2012 \$000	Variance Unaudited 2011 \$000
Balance Sheet Variances		
Cash & S/T Deposits	1,379	519
Other Financial Assets	2,000	10
Property, plant and equipment	143	4,067
Receivables & Prepayments	2,587	509
Employee Entitlements	2,048	(574)
Payables	5,581	1,625

Balance Sheet Explanations

Cash & S/T Deposits	Timing of payments to suppliers.
Other Financial Assets	Increase in term investments
Property, Plant and Equipment	Preliminary Project Maunga expenditure in work in progress.
Employee Entitlements	Timing of Payroll payments.
Payables	Timing of payments to suppliers

28 AUDITORS' REMUNERATION

Fees to principal auditor (Ernst & Young)

Audit of annual financial statements

Other assurance-related services

Tax compliance

Due diligence services

Group		Parent	
2012	2011	2012	2011
\$000	\$000	\$000	\$000
220	216	191	189
-	-	-	-
-	-	-	-
-	-	-	-
220	216	191	189

Other Audit Fees paid (non Ernst & Young)

ACC Partnership Program - Verification New Zealand Limited

HealthShare Ltd Pharmacy Quality Audits

Group		Parent	
2012	2011	2012	2011
\$000	\$000	\$000	\$000
3	1	3	1
-	30	-	30

29 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 2012	Actual 2011
100,000 - 110,000	14	14
110,001 - 120,000	16	14
120,001 - 130,000	6	8
130,001 - 140,000	1	10
140,001 - 150,000	6	11
150,001 - 160,000	5	2
160,001 - 170,000	3	5
170,001 - 180,000	5	6
180,001 - 190,000	9	4
190,001 - 200,000	6	3
200,001 - 210,000	6	4
210,001 - 220,000	4	1
220,001 - 230,000	3	2
230,001 - 240,000	3	3
240,001 - 250,000	2	2
250,001 - 260,000	3	4
260,001 - 270,000	6	3
270,001 - 280,000	4	1
280,001 - 290,000	1	2
290,001 - 300,000	1	3
300,001 - 310,000	2	1
310,001 - 320,000	1	-
370,001 - 380,000	1	1
450,001 - 460,000	1	1
	109	105
Clinicians	90	86
Management	19	19
Total	109	105

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 132 (2011: 134)

30 TERMINATION PAYMENTS

For the period to 30 June 2011, 8 employees or former employees of Taranaki District Health Board received payment in respect of termination of employment totalling \$57,189 (2011: 5 payments totalling \$51,949).

31 CAPITAL MANAGEMENT

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.

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 injected \$1,886k (2011: \$1,514k) for (i) Community Oral Health Service of \$190k (2011: \$786k), (ii) for the interRAI National DHB Implementation Project of \$1696k (2011: \$166k), and (iii) Medicines Reconciliation \$0k (2011: \$561k). Public equity of \$959k (2011: \$959k) was repaid to the Crown during the year. The repayments in both 2012 & 2011 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.

Taranaki District Health Board is not subject to external banking covenants.

32 EVENTS SUBSEQUENT TO BALANCE DATE

There were no material movements or events subsequent to the balance date

Reporting on 'good employer' practices

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

In addition to these sector wide responsibilities, Taranaki DHB is the largest single employer of health employees in Taranaki. Taranaki District Health Board ensures good employer practices are provided to staff, such as excellent leadership, people, culture, relationships and processes. The table below is a quick summary of those human resource practices that assist the DHB as a good employer.

Element/Measurement	Describe Formal Policies or Procedures	Other Practices	Priority Issues	Action Taken
Leadership, Accountability and Culture	Code of Conduct Policy. Equal Employment Opportunities (EEO). Professional Development Policy. Values Statements embedded through all documentation.	Comprehensive leadership programme developed for new and existing managers. Development and Career planning Formal management and management/union meetings. Wellness Programmes. Employee Benefits Programme. Staff Engagement and Participation. Clinical Board.	Foundation and advanced management training.	Policies and Procedures continuously being reviewed. TDHB specific "How to" training. Peer mentoring.
Recruitment, Selection and Induction	Recruitment and Selection Policy. Recruitment Guideline Procedure. Induction and Orientation Policy. HR Toolkit – Recruitment modules.	Regional recruitment and talent management platform (national job portal, Midlands Workforce Development), Voluntary Bonding Scheme. Responding to audit and accreditation requirements to provide statistical data on employees successfully completing induction and orientation processes. Strategy targeting new entrants to the workforce supported by Careers Expo, Scholarship, clinical placements. Focus on ensuring vulnerable services have a plan to develop capability and capacity for those services.	Managing the process to achieve regionalisation in specific areas of recruitment; E-recruitment system, Policies and Procedures, Recruitment Centre.	Establishment of the National KiwiHealthJobs website as a "One Stop Shop" job-board for all DHBs. Recruitment Centre Implementation of regional recruitment candidate selection workflow. Implementation of a system to measure induction and orientation success. Implementation of the Whakatipuranga Rima Rau project to place 500 Maori into the health sector employment over 10 years. This includes the Incubator Programme supported by clinical placements for secondary school students. Develop Action Plan to ensure the activity stated in the TDHB Workforce Plan 2012-2013 are delivered on.
Employee Development, Promotion and Exit	Performance Appraisal Policy and Procedure. Study, Conference and Course Leave. Termination of Employment Policy and Procedure. Medical Incapacity Policy. Workforce Development Strategy. Learning and Development. Talent Management Framework.	Exit interview and survey. Coaching available to all staff. Clinical Supervision. Employee Assistance Programme (EAP). Interpersonal skills training. Secondments. Professional Development Appraisal Committee. Organisational Learning Reference Group.	Reviewing reasons why staff are leaving the DHB. Performance Management Training programme.	Process established to record / monitor reasons for exiting. Preceptorship training. Mentoring training.
Flexibility and Work Redesign	Flexible Working - Request and Complaints Procedure. Collective Employment Agreements. Employee Participation Agreement.	Care Capacity Demand. Project Whakapai. Releasing Time to Care.	Future lifestyle planning. Retirement courses.	
Remuneration, Recognition and Conditions	Job Evaluation Procedure. Recognising Long Service Procedure. Superannuation contributions. Collective Employment Agreements. Performance Appraisal Policy. Professional Development Policy.	Job Evaluation Committee. Comprehensive Progression/Merit criteria via collective agreements; including PSA Career and Salary Progression. Employee Benefits and Staff Discounts. Project Maunga.		Promoting employee benefits for all staff.
Harassment and Bullying Prevention	Harassment Policy and Procedure. Employee Assistance Programme.	Interpersonal skills programmes. Coaching / training Union Reps. Conflict Resolution.	Resolve issues as soon as possible at first level if appropriate	HR to monitor and report to Service Managers any harassment / bullying cases. Working with key unions around establishing an awareness around all behaviours in the workplace. Quality and Risk Department responsible for majority of these procedures. Recreation Society available to all staff.
Safe and Healthy Environment	Health and Safety Policy. Staff Health and Monitoring. Significant Hazard Control Plan. Material Safety Data Sheets. Infection Control. Educational Information. Nursing Core Procedures. Pharmacy Procedures. Clinical Practices. Critical Incident Debriefing. Occupational Health.	Pre-employment Health Questionnaire for all staff. Employee Assistance Programme. Workplace health assessments. Annual flu jabs. Indoor sports and exercise programmes. Health and Safety Reps in each work area. Health and Safety orientation. Police Vetting.		





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

TARANAKI
like no other