



Taranaki District Health Board

# Annual Report

2012-13



# 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

### Registered Office

Taranaki District Health Board  
27 David Street  
New Plymouth 4310  
Telephone: + 64 (6) 753 6139  
Facsimile + 64 (6) 753 7770  
Email: [corporate.contacts@tdhb.org.nz](mailto:corporate.contacts@tdhb.org.nz)  
Website: [www.tdhub.org.nz](http://www.tdhub.org.nz)

### Banker

TSB Bank  
120 Devon Street East  
New Plymouth 4310

ASB Bank  
PO Box 35  
Auckland 1140

### Advisors

Govett Quilliam  
Private Bag 2013  
New Plymouth 4342

### Auditors

Office of the Controller  
and Auditor General  
Agent - Ernst & Young  
PO Box 2146  
Auckland 1140



## 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, whānau, 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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Hawera Community Dental Clinic Opening, March 2013



Mary Bourke and Tony Foulkes signing the 'Open for Better Care' National Patient Safety Campaign

# INTRODUCTION BY CHAIR AND CHIEF EXECUTIVE

## Welcome to the Annual Report for the Taranaki District Health Board for 2012/2013.

Welcome to the Annual Report for the Taranaki District Health Board for 2012/2013. We would like to thank the Board and Committee members who have shared their skills and knowledge. 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 the development of an agreed outcomes based contracting framework with the National Hauora Coalition and Tui Ora Ltd, which marks a major milestone in enabling provider innovation to accelerate improvements in Māori health status. Overall health services to the value of \$326m continued to be funded and provided for the people of Taranaki in the year. As we continue to aim to balance high quality services with our reducing proportion of national population funding there continues to be real challenges. It is therefore

pleasing to note that the close to break-even consolidated financial result for the Board and associated companies.

We have taken measures and continue to look at how we organise services with a willingness to change to best suit our community. The hospital and specialist services like most have experienced growing demand and complexity of services. We are very proud of the work of all the teams involved in these services for taking an organisation wide look at improving processes and containing costs, whilst still delivering good quality care, and in many instances with shorter waits than before.

Our clinical and support teams have again exceeded many service level targets in both hospital and community based settings. With new models of care including improved Acute and Stroke patient pathways, Enhanced Recovery After Surgery, and Enhanced Intermediate Care and Treatment, helping older people return to independence in the community.

As the construction of Project Maunga (Taranaki Base Hospital redevelopment) reached a major milestone with the completion of clinical areas, staff have been able to proudly show off their new hospital. They are very excited about how much better it will be for them and most importantly for their patients. It has been fantastic to see the enthusiasm from the community, and we've had incredibly positive feedback. The Project continues within budget and on time to be completed in the first half of 2014.

With the support of local schools, businesses and individuals the community got behind the launch of Taranaki Health Foundation raising funds to provide some patient comfort extras in the wonderful Project Maunga. This was added to by the announcements of a grant of \$300,000 from the Taranaki Electricity Trust to provide a wireless environment to help clinicians share information; and \$4.5m from the TSB Community Trust towards the Children & Young People ward, which is an investment in the future of the whole community. All of this support is recognition of the





special place enhanced health services have in the minds of Taranaki people. We've continued to improve the planning and management of staffing costs whilst also increasing new graduate clinical staff. Other workforce development initiatives such as Whakatipuranga Rima Rau through partnerships with other agencies are investing in our workforce of the future with particular focus on Māori.

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 made significant contribution to meeting these health targets, and was notably the first DHB in the country to have no patients waiting over five months for either a first specialist assessment or treatment. General Practices have also made a major contribution towards the Targets, and together with Community Pharmacies have improved the support available to patients particularly those with chronic conditions.

We expect the greater integration of the hospital and community based services to continue, with important collaboration on the appropriate support and treatment of people with acute conditions being a particular

focus, together with the Midland Health Network – PHO.

Our partnerships with local councils and other agencies play an important role in the network of support, whether that be through the work such as the development of a shared Taranaki Disability Strategy, and Taranaki Palliative Care Plan; or the Public Health services collaborating to work with harder to reach parents, caregivers, young and older people to access support in their own community.

We'd like to congratulate South Taranaki District Council in responding to the advice from health professionals and local people in extending fluoridated water supplies to the Patea and Waverley community – an important contribution to their health and wellbeing.

Partnership with other DHBs is also 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 joint service planning, workforce and internal audit teams; 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. We expect our joint investment in technology and clinical support systems in the future to support clinicians and patients to have better and more timely access to information across services as we strive to enable greater shared care for patients.

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

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

A busy year of construction, preparation, orientation



PROJECT MAUNGA  
BASE HOSPITAL REDEVELOPMENT

*Over the 2012-13 year Project Maunga went from strength to strength. As the construction site grew, Taranaki DHB staff were also reaching new heights with the amount of preparation work they have been involved with for the redevelopment project. Project Maunga is more than a new building; it is a new way of doing things.*

## Construction



## Preparation

### CCDM working alongside Project Maunga

Care Capacity Demand Management (CCDM) was introduced to Taranaki DHB to support the work already undertaken with the planning and development of the new wards for Project Maunga. The co-location of wards in the new facility contributes to an organisational design where the workplace supports the work and the workers - a core principle of CCDM. The layout assists efficient work organisation and enhances teamwork across the hospital.

### TPOT initiatives increase productivity

The Productive Operating Theatre (TPOT) involves new initiatives that have assisted with the preparation for moving to the new building including the following:

- Use of an electronic whiteboard for management of acute surgical patients.
- Use of the 5S tool (sort, set, shine, structure, sustain) to present a well organised theatre.
- Use of a revised pre-operative checklist.
- Revised arrangements with suppliers and stores around the types and quantity of equipment and consumables provision.

### Releasing Time to Care prepares staff for move

There have been a number of quality improvements made this year within the Releasing Time to Care (RTC) Programme. Whilst this work is ongoing from a quality perspective, it is also delivering cost efficiency savings and has been valuable preparation in the lead up to the move to the new hospital building:

- Numbers of stock items reduced to reflect the daily supply from stores and changing needs of departments.
- Standardised bed making across all wards to reduce unnecessary linen usage.
- Introduction of a red tray system to more clearly identify patients who require assistance. This will be introduced across all acute wards.

- Meals module reduced the time for meal delivery by half and has reduced food wastage and incorrect orders significantly thereby achieving a cost reduction.
- Creating a consolidated area for all nursing documentation to be stored on the intranet. This will reduce the amount of hard copies being printed.
- Standardisation across all the acute areas for stores, equipment, multi-disciplinary-team requirements and clerical items. This will make it easier for staff to work across all areas.
- Rooms in the new hospital got the WOW treatment as part of Releasing Time to Care Well Organised Ward (WOW) module. The working group identified many quality improvements and have established a system that will be standardised across the hospital.



Electronic Whiteboard



Releasing Time to Care

## What did staff say?

***A lot of hard work has gone into Project Maunga and we are all very excited about it being completed. We know the patients and their families will enjoy the new ward environment and the lovely views!"***

Janet Gibson, Nurse Manager Medical Ward

***"It will be awesome, the child friendly ward is bright, vibrant and welcoming and bedrooms are a home away from home for our families"***

Meredith Garrick, Children & Young People Ward Nurse Manager

***"Our allied health staff are really looking forward to their facilities that have been specifically designed for patient rehabilitation. The physiotherapists are looking forward to having the new patient ceiling track hoist system in place which will be beneficial in preventing injuries in staff and patients"***

Jackie Sewell, Nurse Manager Older People's Health Ward

***"It's been great being able to see the progress out our windows and the kids have enjoyed the waves they get from the construction workers"***

Leonie Mercer, Children & Young People Ward Nurse Manager

***"I can't wait to move to our wonderful, spacious and modern Ward 3B. I am very excited to be part of 'history in the making'"***

Chris Clarry, Medical Ward Four Clerk

***"The relationship between theatre and SSD is a close one and being co-located is a huge advantage with regard to the reprocessing of instruments and interacting with staff"***

Judyth Marsh, Theatre Nurse Manager





Crowds wait for their tour at the Project Maunga Public Open Day



Grant Looker tests out one of the new hoists from a patient's perspective

## Orientation

### First step for staff in moving into redevelopment at Taranaki Base Hospital

At the end of May Taranaki DHB project manager Base Hospital redevelopment Steve Berendsen was delighted to be given the key to the doors of part of the new hospital by Fletcher Construction.

Handed the keys for level one which includes theatre, endoscopy, sterile services and day surgery, the children and young people ward, level two and the orthopaedic surgical ward on level three, Steve Berendsen said staff were eager to get in and have a look.

Orientation for staff was planned very carefully, with the first few weeks involving train the trainer sessions. Staff such as our nurse managers could then orientate other staff including:

- Support staff.
- Clinical staff working across departments.
- Ward based nurses and Health Care Assistants (HCAs).
- Level one staff including Sterile Services Department, Operating Theatre Suite, Endoscopy Suite, and Day Surgery.

### e-Whiteboard with touch screen first in New Zealand

From October 2012 Taranaki Base Hospital's Ward Five trialed the e-Whiteboard which became a first in New Zealand due to its easy to use touch screen. Replacing the manual whiteboard previously used, this technology savvy

patient status board will be rolled out to all inpatient wards moving to the new building.

Ward Five Nurse Manager Janet Gibson said, "The board is a great improvement for nurses. The future plan is to extend the use of this application to enhance the nurse handover process which will enable a more robust shift to shift transition".

Andrew Brown, HIQ Applications and Development Team Leader said, "This has been a fun and exciting application to develop and has been made successful by the close interaction we have had with clinical staff".

### Community flock to hospital for public open day

Hundreds of men, women and children lined up for a sneak preview of the new hospital during the Public Open Day on Saturday, 8 June. Staff from each ward and theatre were greeting the groups and giving them the grand tour of their area, and sharing the many improvements and new features it has.

Chief Executive Tony Foulkes said there was an overwhelming response. "It was fantastic to see the enthusiasm from the community. We have had incredibly positive feedback."

"It was wonderful for the staff who gave up their time to be able to proudly show off their new hospital. They are very excited about how much better it will be for them and most importantly for their patients."

"We are also very thankful to the Rotarians who gave up their day to support us and help make this such a successful open day," said Mr Foulkes.

### New building, new equipment, and new way of working

With a new environment for our staff and patients, much of the equipment is new to Taranaki DHB as well. During orientation staff have been learning the ropes in preparation for the move, including how to work the new ceiling track hoist system, the new nurse call system, the fire evacuation system and theatre lights and tables. "Staff are excited at the prospect of moving into the wonderful new facilities and keen to learn all about the various new equipment options," said Steve Berendsen.

Staff are very impressed with the technology of the ceiling hoists, noting that less staff would be required to move or turn bariatric patients and it would be much more comfortable for staff and for the patients.

In the new building there will be one hoist that holds up to 250kg per adult ward, a further portable 250kg hoist per floor and one hoist that lifts up to 500kg on each floor. In particular, one bariatric room is fitted with ceiling tracks that allow a patient to be hoisted and transported to the bathroom on the hoist.

"Having electronic ceiling hoists with this capability is fantastic," said Steve.

"Each hoist comes with different attachments for lifting. They can lift people lying flat, in a sitting position or even off the floor. They can also be used to turn a patient."



Taranaki Health Foundation launch



Taranaki Health Foundation receive a donation

# TARANAKI HEALTH FOUNDATION



On Thursday, 6 June, the Taranaki Health Foundation was born again. The Taranaki Health Foundation is a non-profit organisation which was first founded in 1998 to support the Taranaki District Health Board, so that they can better provide health and disability services, funding and planning for the entire Taranaki community.

Local businesses, contractors, and individual health champions who have donated to the foundation all came together to celebrate the relaunch and to get a sneak peak of the new hospital.

The Foundation's current fundraising efforts are focused around Project Maunga with the "Improve Your Stay" and "Connected Health" campaigns which will provide enhanced patient comforts and support Taranaki wide e-health services for the community.





Fitzroy School children donate over \$1400 to Taranaki Health Foundation



Tony Foulkes with Hayden Wano from TSB Community Trust

# TSB Community Trust



## Project Maunga receives TSB Community Trust's largest ever grant

TSB Community Trust has awarded its biggest grant ever to the Children and Young People Ward at Taranaki Base Hospital in the understanding that it will benefit our children and our future.

TSB Community Trust this year celebrates its 25th anniversary and wanted to give a gift to the whole community.

Trust Chair Hayden Wano said "It is fitting to make a gift of this magnitude to our community the year we celebrate our 25th anniversary."

"A hospital admission can be a traumatic experience for all involved and anything that will ease that

and make the experience more comfortable is invaluable. The new Children and Young People Ward will provide an environment that has aspects to make both the child's and the whānau's experience less stressful."

The Trust is also supporting an advanced nurse call system that will allow the patient to communicate directly with their nurse, this will aid in nurses ability to respond to the needs of the patient.

The advanced nurse call system means that nurses will carry a voice over internet phone (VOIP) with them when they are on duty so they can communicate with their patients wherever they are.

Head of Paediatrics Dr John Doran said this was a wonderful addition. "Children are often anxious when in hospital especially if they are left alone so this direct contact with their nurse will help them feel safe and mean they can get any help they need quickly."

TSB Community Trust has been involved with improving the health of the community for many years and this grant will benefit all.

"This grant is truly intergenerational; it will not only support the health of our children today but also for future generations to come," said Mr Wano.

**"This grant is truly intergenerational; it will not only support the health of our children today but also for future generations to come."**

HAYDEN WANO



# TET is wired for health for all

The TET invests in health and education, both of which are critical factors when it comes to a community's sense of well being.

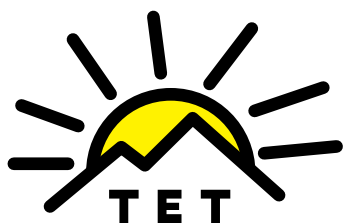
Taranaki Electricity Trust is supporting Project Maunga with a \$300,000 grant to enable wireless technology in the Taranaki Base Hospital redevelopment.

Wireless technology will have enormous improvements for patient care and safety and allow staff more flexibility.

Key health information will be available at the patient's bed on mobile devices. Information can be pushed to clinicians' smartphones and tablet devices such as iPads enabling more timely decisions regarding patient care. With information made securely available anywhere, anytime, patient care will be extended beyond hospital walls.

Wireless technology will improve patient safety in the hospital allowing clinical systems such as eMedications Management to grow into the future. It also has ability to monitor patients via wireless devices that alert clinical staff when a patient status changes and act quickly. This technology will also mean patients can utilise the nurse call system that will allow the capability to have two-way conversations with nursing staff.

Taranaki DHB Chief Executive Tony Foulkes said the grant was hugely significant and had been very forward thinking of the TET. "We are extremely grateful to the TET for this grant."



## Introducing Trustees

Bruce Moller



It is an honour to be a trustee of the Taranaki Health Foundation as it supports the Taranaki DHB in providing the best possible healthcare for the community.

Murali Bhaskar



As a practicing architect I work a lot with the local community. I have great regard for the wellbeing of this Taranaki community that I live in. I believe that the health and well being of our community is a shared responsibility.

Dr Greg Simmons



It is a privilege to be a trustee of the Taranaki Health Foundation and to put my best efforts into supporting not only the new development at Taranaki Base Hospital but for all services offered by the Taranaki DHB.

Dr John Doran



The Taranaki Health Foundation offers an opportunity for me to support a very important part of our community in a practical and meaningful way contributing to the well being of our family, friends and neighbours.

Tony Foulkes



I am proud to be associated with the great health services we have here in Taranaki. It is a real privilege to work with enthusiastic members of the community and the Health Foundation, to support making our hospital and broader community health services even better for our future.

Adrian Sole



I have a passion regarding Taranaki communities, and for local leadership and equality. I am looking forward to using my skills and energy to help achieve the goals the Taranaki Health Foundation is aspiring to.

\*Additional Trustees are in the process of being appointed.



# On Target



*Taranaki DHB continues to work hard towards the national health targets as set by the Ministry of Health. These targets are indicative of a wide range of services and efforts in priority areas.*



## SHORTER STAYS IN ED

Taranaki DHB continues to focus on improving the flow of patients in our acute pathway work. This has been an enormous effort by the Emergency Department and the whole hospital approach. We are very pleased to have improved through the past year to achieve the target of 95% of patients seen in ED admitted or transferred from the ED within six hours.

**Target 95%**  
**Achieved 96%**

### ED Clinical Nurse Specialists

A new initiative started in 2012 has seen the use of clinical nurse specialists in the Emergency Department. The new role provides huge benefit to both staff and patients, aiding the rapid assessment, treatment and discharge of the minor injury and minor illness patients' flows through the department. It also assists with the release of emergency medicine doctors to see higher complexity patients which have a longer length of stay.

Clinical Nurse Manager Cam Grant-Fargie said, "The clinical nurse specialist group have performed really well and quickly come to grips with the responsibility and knowledge required for the job.

"They are month on month seeing more patients per shift; the patient satisfaction is truly outstanding and full credit to them. They are actively contributing to the District Health Board's significant improvement in the 'Shorter Stays in ED' target."



## IMPROVED ACCESS TO ELECTIVE SURGERY

Taranaki DHB is pleased to see a continuous achievement in this target. Staff work hard to get good elective surgery results. We are also very pleased to have achieved our goal of zero patients waiting over five months for First Specialist Assessments (FSA).

**Target 100%**  
**Achieved 112%**

### Taranaki DHB first in country to reach five month target

Taranaki was the first DHB to reach the goal of no patients waiting over five months for either a First Specialist Assessment or treatment in June 2013.

The Ministry of Health congratulated Taranaki for being first in the country to meet the elective surgery health target of seeing patients within five months.

Taranaki DHB Chief Operating Officer Rosemary Clements said all DHBs are striving for the five month wait time and it is rewarding for Taranaki to be the first to achieve it.

"This means our patients who qualify to see a specialist will do so within five months, and if they require surgery that will be done within five months too. This is an excellent result and it's great for our community.

"A lot of staff worked very hard to ensure this target is met and to get there first in the country is a huge achievement."



Nicola Tanner (Clinical Nurse Manager, Hawera) and Cameron Grant-Fargie (Clinical Nurse Manager, Base Hospital ED)



Monique Bastin, Cancer Nurse Coordinator



## SHORTER WAITS FOR CANCER TREATMENT

Taranaki DHB will continue this strong performance and our collaborative relationship with MidCentral DHB to maintain the 100% cancer waiting time target.

Target 100%  
Achieved 100%

### Cancer nurse coordinator makes positive impact on cancer journey

In early 2013 Taranaki DHB was excited about the appointment of Monique Bastin into the position of a dedicated Cancer Nurse Coordinator.

This new role is responsible for the synchronisation of services which will result in timely and seamless patient centred care. The role acts as a single point of contact so patients and their families no longer have to deal with multiple people from different parts of the health service.

Monique said, "People are quite often given a diagnosis and it can be a few weeks before they're told the course of treatment, so quite often they don't know where to go from there.

"In the past there has been no-one there to support them. My role is to be there for question and answer time and support them through the experience I have in oncology."

Clinical Nurse Manager Lizzie Churches said it is an exciting new initiative for our services and tremendous to have Monique on board. "We're aware there has been a gap in the system from the time of diagnosis to treatment, so having someone there to support patients and be there as a point of contact will be invaluable."

Nursing has warmly welcomed this new role, which will vastly improve the treatment experience for patients by reducing delays, stress and duplication.



## BETTER HELP FOR SMOKERS TO QUIT

In February 2013 Taranaki DHB building and grounds became 100% Smokefree/Auahi Kore. Staff are proud of a workplace and environment that encourages smokefree lifestyles. We are working hard to ensure patients and visitors to our hospitals are given advice about quitting and we are pleased to have achieved the target for quarter three and four of this year.

**Hospital Target 95%**  
**Achieved 97%**

### Taranaki retail outlets tighten up on tobacco sales

A Controlled Purchase Operation (CPO) carried out by Taranaki DHB Public Health Unit had pleasing results regarding selling cigarettes to people under 18 years.

Taranaki DHB's Public Health staff visited 16 retail premises in Waitara and New Plymouth in a campaign to stop retailers selling tobacco to under age youths.

Health Promoter Carly Twaddle said staff at 15 of the 16 premises visited had followed correct procedure and refused to sell cigarettes to the 14 and 17 year-old volunteers who were briefed to give their correct age when asked.

"We need to work together to prevent young people from having access to cigarettes. We want retailers to help us work towards our vision of a smokefree Taranaki," said Miss Twaddle.

Medical Officer of Health Dr Jonathan Jarman said that smoking was a major health issue for the Taranaki District Health Board. "Half of all long-term smokers will die from a smoking-related disease. Around 5000 people die each year in New Zealand because of smoking or second-hand smoke exposure. That's 13 people a day."

**Primary Care Target 90%**  
**Achieved 65%**



## MORE HEART AND DIABETES CHECKS

Taranaki DHB will continue to work with the PHOs in developing their Diabetes Care Improvement Packages and Long Term Conditions programmes to meet this target. Diabetes and cardiovascular disease continue to be among the main causes of ill health in Taranaki.

**Target 75%**  
**Achieved 73%**

### Diabetes Education service deliver "Stay Well" advice to diabetics

The Taranaki DHB Diabetes Specialist Service run a successful group course that aims to give people with diabetes/pre-diabetes, more quality education time, the benefit of discussing information such as life experiences, hints and problems associated with diabetes, and to enable people to positively manage their diabetes.

The group courses are friendly and free of charge to all attendees. These courses are designed for people with newly diagnosed diabetes or pre-diabetes. They are also useful as a 'Refresher Course' for those people interested in an update/review of their diabetes.

On completing the course, all registrants receive an 'attainment certificate' and are referred back to their personal doctor or health provider for continuing care. The education sessions are presented by members of Taranaki DHB Diabetes Specialist Service including an endocrinologist, pharmacist, laboratory scientist, podiatrist, dietitian, nurse and diabetes educator.

The team operate from Taranaki Base Hospital, Hawera Hospital and Stratford Health Centre covering the New Plymouth, Mokau, Waitara, Stratford, Eltham, Opunake, Patea and Waverley districts.



Taranaki DHB Smokefree Coordinator  
Karmin Erueti-Thatcher

Aotea Māori Women Welfare League members with Immunisation Coordinator Mel Hurliman



## INCREASED IMMUNISATION

Increasing immunisation rates are a priority in order to reduce the incidence of preventable disease in our community. We are working closely with PHOs, hospital services, outreach immunisation services, National Immunisation Register and Well Child Providers on strategies to improve immunisation uptake, including early enrolment of newborns with a general practice. Taranaki DHB is pleased to have exceeded the target of 85% of all eight month olds immunised.



### Drop in clinic protects pregnant mums and their babies

A new drop-in clinic for pregnant mums to have free immunisation from debilitating diseases opened for the first time during Immunisation Week in 2013.

New Plymouth woman Dee Miller, who is 36 weeks pregnant, was one of the first to take advantage of the service, receiving her whooping cough vaccination.

Whooping cough, which can cause prolonged coughing affecting breathing, can be dangerous to young children.

Mrs Miller said she was very keen to have the shot after being made aware of the epidemic through the antenatal clinic and seeing distressing videos and television advertisements about the effects of whooping cough on small babies.

She said it was good to know that the effects of her immunisation would also benefit her baby. The baby would have immunity for the first six weeks before having his or her own vaccinations at six weeks of age.

Taranaki Medical Officer of Health Dr Jonathan Jarman said immunisation was one of the most successful and cost-effective health interventions to prevent serious disease and also one of the safest. Dr Jarman urges all parents to ensure their children are immunised on time for best protection.

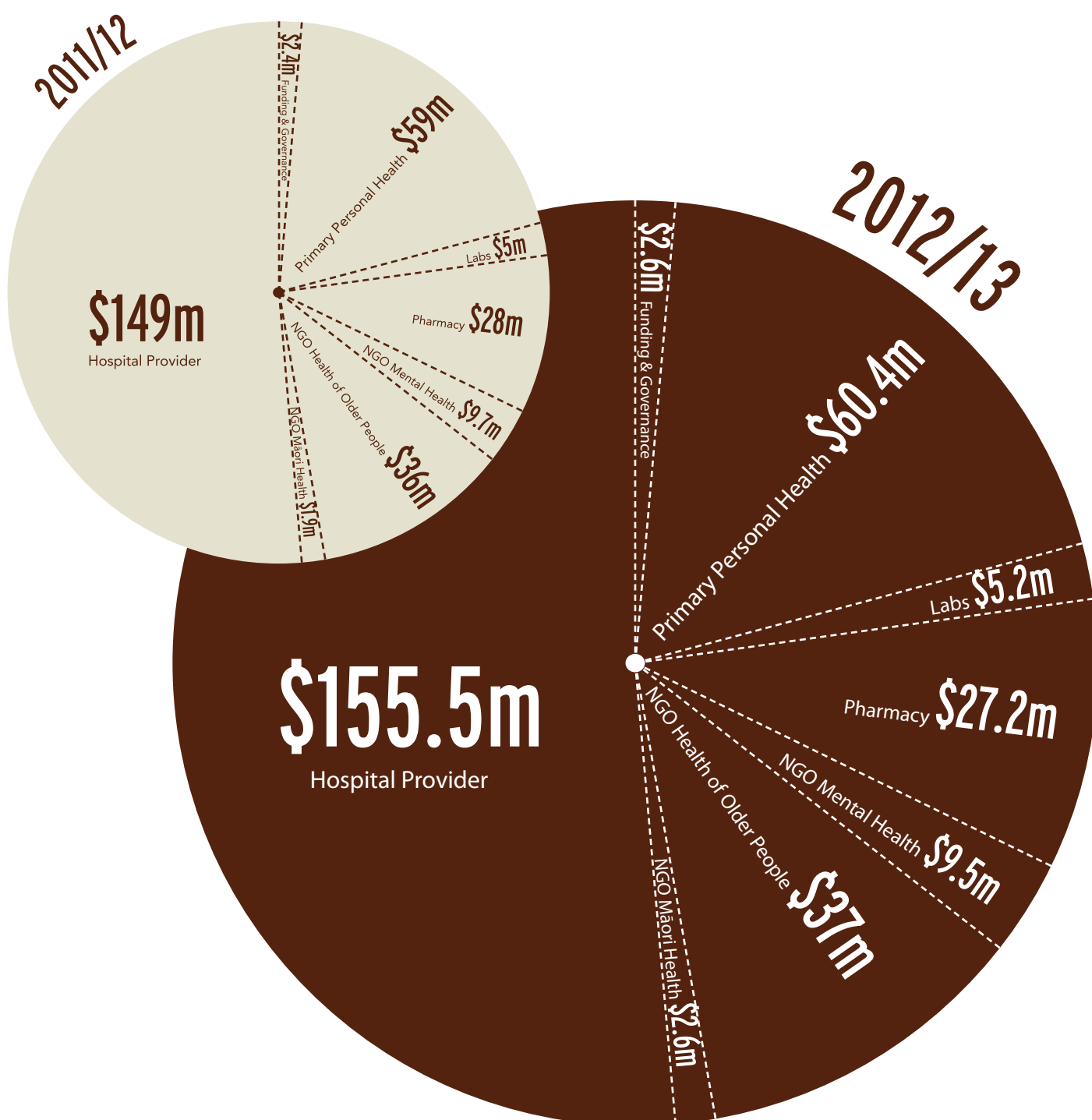
Both primary health organisations in Taranaki, Midlands Health Network and National Hauora Coalition, plus outreach services, and local Plunket branches are committed all year round to help keep our families healthy by encouraging immunisation.



# WHERE THE MONEY GOES

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

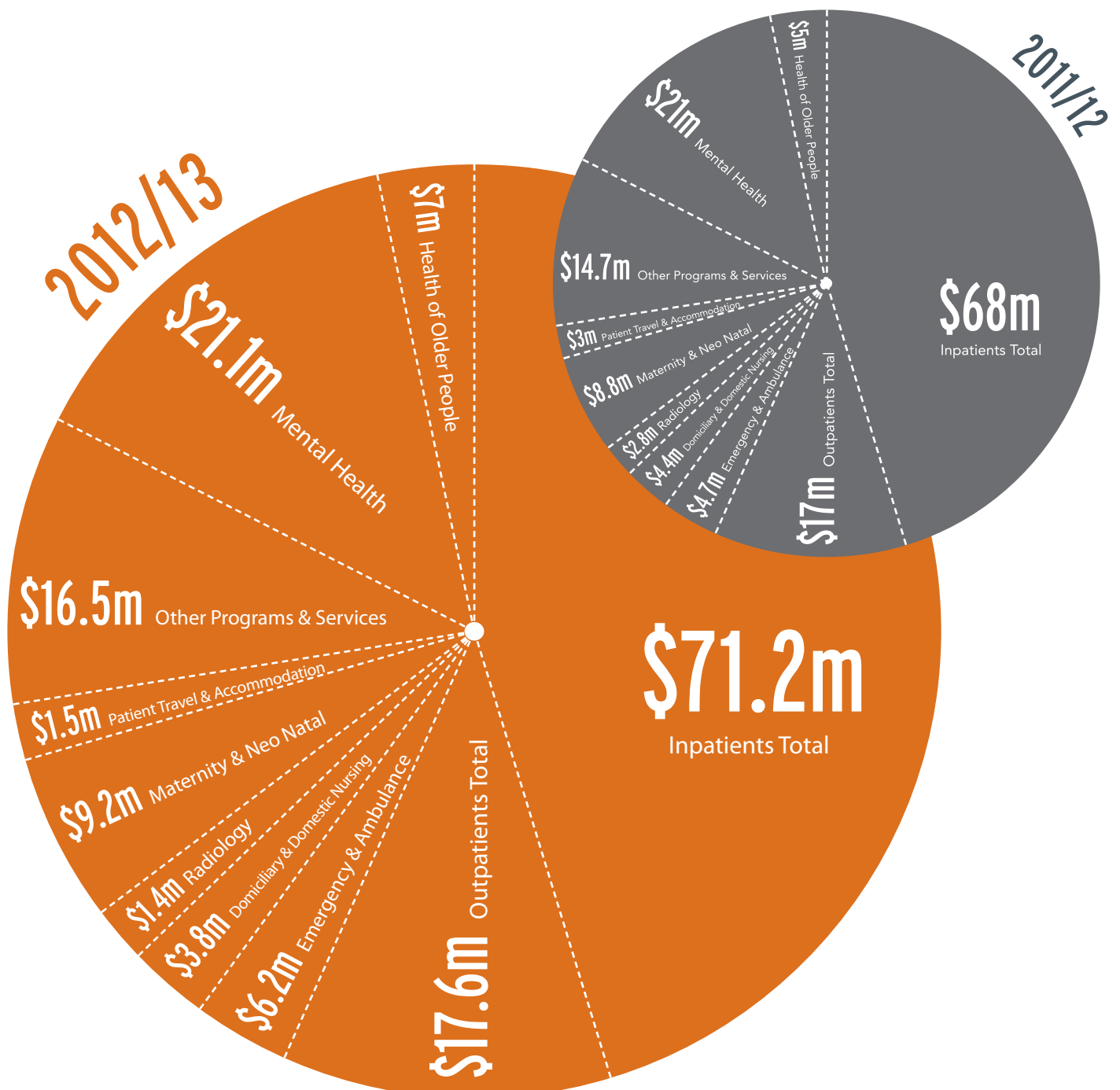
## >> 2012/13 Taranaki DHB Funding Allocation



We have **109,752** Taranaki residents.

We planned, funded and provided over **\$300** million of health and disability services. Of this, **\$155.5** million was allocated to the Hospital Provider.

## » 2012/13 Hospital Provider Services Allocation





Lighthouse, Cape Egmont

# 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 109,752 people, or 2.6% of New Zealand's population. Between the 2006 and 2013 Census, the population usually resident in the region increased by 5,478 or 5.3%.

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.

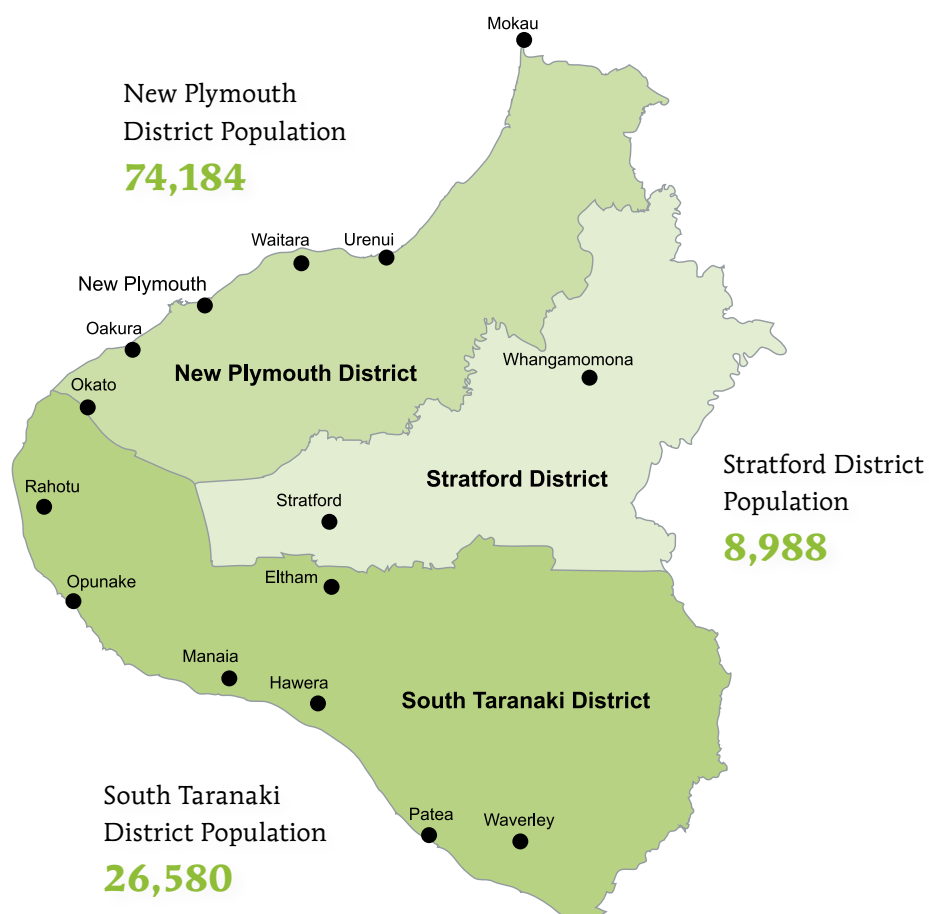
NOTE: At the time of publishing this report 2013 Census data on population ethnicity and age was not available.



King Edward Park, Stratford



Puke Ariki, New Plymouth



## We have...

- Relationships with two Primary Health Organisations.
- 72 General Practitioners.
- 20 dental practices.
- 25 pharmacies.
- 19 community personal health providers.
- Providers of community laboratory services and radiology services.
- Seven community based mental health and alcohol & addictions service providers.
- One Māori mental health and alcohol & addictions service provider.
- Support services for people with disability, including 28 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.





Marie Henry supports immunisation for her whānau



New Plymouth Girls' High School students attend the Incubator Programme

# MĀORI HEALTH



The DHB made important improvements during the year to be able to gauge how well we are doing to improve the health of whānau living in Taranaki. In particular reducing health inequalities between Māori and non-Māori is the primary focus and is based on addressing and monitoring key 'indicators' of health.

The tables on the following pages summarise the progress that's been made during the year to improve Māori health status in these key indicator areas.

## HIGHLIGHTS FROM THE YEAR

The Māori workforce development project ' ' achieved great results in 2012 and 2013 by:

- Running the '**Incubator**' programme in 13 Taranaki Secondary Schools (Patea, Hawera, Opunake, Coastal, Stratford, Inglewood, Spotswood, New Plymouth Boys' High, New Plymouth Girls' High, Frances Douglas, Waitara, Sacred Heart, St Mary's Diocesan) in 2012 and again in 2013. 'Incubator' is a programme that profiles the wide range of health career options, to secondary school students with a view to influencing their decisions to take up a health career pathway. In 2012, 178 year 12 and 13 Māori students took part in the programme while in 2013, 163 took part.
- More than 100 health professionals

from across Taranaki DHB and NGO health provider organisations contributed their time as mentors to the students involved in the Incubator programme.

- Piloting in conjunction with the Midland Region Kia Ora Hauora Māori workforce programme, a **science taster programme** involving 94 year 9 and 10 students from five Taranaki secondary schools (Hawera, Stratford, Frances Douglas, St Mary's Diocesan, Coastal). The aim of the programme is to encourage students to include science subjects as study options in subsequent years as a prerequisite to health career pathways.
- Three trainees completed their cadetships. Two were successful in securing permanent full time employment in the Taranaki health and disability sector and the third has enrolled in further study on a social work career pathway. One cadet is continuing a placement as a data analyst in the Taranaki DHB's Management Information Unit.
- Six students completed 10-week

work experience internships to support their tertiary training along health career pathways that include dental therapy, medicine, radiography, physiotherapy and nursing.

- The provision of **dedicated student support** is a key point of difference that WRR delivers in the health workforce development arena. Support provided to students during the year includes:
  - One-on-one support with applications for a wide range of scholarships.
  - Facilitating school release time to enable students to participate in the Incubator programme.
  - Contact with past Incubator students who are now undertaking tertiary studies to check on progress and provide support if needed.
  - Follow up on students who finished school during the year to support their transition to further study or work experience.

# TARANAKI DHB MAORI HEALTH PLAN

## PERFORMANCE DASHBOARD

Quarter 4 Update (to July 2013)

### National Priorities & Indicators

|   | Priority                      | Indicator                                                                                                                                                                  | Target                                      | Māori | Non-Māori or Total | Māori Health Plan Status | Māori Measure Status | Māori Target Progress | Disparity Gap |
|---|-------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|-------|--------------------|--------------------------|----------------------|-----------------------|---------------|
| 1 | <b>Data Quality</b>           | Ethnicity data accuracy in PHO registers                                                                                                                                   | Audit tool to be implemented during 2013-14 |       |                    |                          |                      |                       |               |
| 2 | <b>Access to Care</b>         | Percentage of Māori enrolled in PHOs                                                                                                                                       | 96%                                         | 88%   | 99%                | Behind Plan              | ☹                    | ▲                     | 11%           |
|   |                               | 0-4 yrs                                                                                                                                                                    | >95%                                        | 88%   | 85%                | On Track                 | ☺                    | ◀▶                    | 3%            |
|   |                               | 45-64 yrs                                                                                                                                                                  | >95%                                        | 84%   | 91%                | On Track                 | ☺                    | ◀▶                    |               |
|   |                               | 0-74 yrs                                                                                                                                                                   | >95%                                        | 90%   | 95%                | On Track                 | ☺                    | ◀▶                    |               |
| 3 | <b>Maternal Health</b>        | Percentage of infants exclusively breastfeeding at six months                                                                                                              | 26%                                         | 11%   | 20%                | On Track                 | ☹                    | ▼                     | 9%            |
| 4 | <b>Cardiovascular Disease</b> | Number of tertiary cardiac interventions                                                                                                                                   | Indicators yet to be determined by MOH      |       |                    |                          |                      |                       |               |
|   |                               | The proportion of the eligible population who have had the blood tests for CVD risk assessment in the last five years                                                      | 75%                                         | 63%   | 75%                | On Track                 | ☹                    | ▲                     | 12%           |
| 5 | <b>Cancer</b>                 | Breast screening rate among the eligible populations                                                                                                                       | >55%                                        | 63%   | 77%                | At Risk                  | ☺                    | ▲                     | 14%           |
|   |                               | Cervical screening rate among the eligible population                                                                                                                      | 80%                                         | 73%   | 88%                | On Track                 | ☺                    | ◀▶                    | 15%           |
| 6 | <b>Smoking</b>                | Percentage of adults 15+ admitted to hospital either acutely or for elective procedures who are provided with advice and help to quit                                      | 95%                                         | 97%   | 98%                | On Track                 | ☺                    | ▲                     | 1%            |
|   |                               | Percentage of smokers in primary care who are provided with advice and help to quit (high needs and total population result is shown – data is not provided by ethnicity). | 90%                                         | 58%   | 56%                | On Track                 | ☹                    | ▲                     |               |
| 7 | <b>Immunisation</b>           | Percentage of eight month olds fully immunised                                                                                                                             | 85%                                         | 81%   | 92%                | On Track                 | ☹                    | ▼                     | 11%           |
|   |                               | Seasonal influenza immunisation rates for Māori aged 65 years and over. (High needs and total population result is shown – data is not provided by ethnicity)              | 70%                                         | 67%   | 69%                | On Track                 | ☹                    | ◀▶                    | 2%            |

## Regional Priorities & Indicators

|    | Priority                                                                                                                                                                                                                                                                                   | Indicator                                                                                                                                                                                                                      | Target | Māori | Non-Māori or Total | Māori Health Plan Status | Māori Measure Status | Māori Target Progress | Disparity Gap |
|----|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|-------|--------------------|--------------------------|----------------------|-----------------------|---------------|
| 8  | <b>R1-Māori health Investment and Māori provider capacity development</b>                                                                                                                                                                                                                  | Investment in Māori-specific services including Māori provider service contracts, Māori-specific services in mainstream organisation, Māori PHOs (non-capitated funding) and Māori health and disability workforce development |        |       |                    | On Track                 | 😊                    | ▲                     | N/A           |
| 9  | <b>R2-Māori health workforce</b>                                                                                                                                                                                                                                                           | Increase the recruitment and retention of Māori into the Taranaki DHB workforce                                                                                                                                                | 8%     | 7%    |                    | Behind Plan              | 😞                    | ▲                     | N/A           |
| 10 | <b>R3-Action plans for the following regional priorities are provided in He Raranga-A-Tira Regional Services Plan, Midland Māori Health Accountability Framework, Section Two, Midland Regional Services Māori Health Action Plan. The priorities and indicators are summarised below:</b> |                                                                                                                                                                                                                                |        |       |                    |                          |                      |                       |               |
| 11 | <b>Active participation of Māori in decision-making/ promoting and monitoring Māori health gain</b>                                                                                                                                                                                        | Integrate a robust Māori Health component into the Midland Regional Services Plan (RSP)                                                                                                                                        |        |       |                    | Completed                | 😊                    | N/A                   |               |
|    |                                                                                                                                                                                                                                                                                            | Integrate Māori Health Plan priorities and monitoring framework into the Midland RSP                                                                                                                                           |        |       |                    | Completed                |                      | N/A                   |               |
| 12 | <b>Build Māori health workforce capacity within Midland region</b>                                                                                                                                                                                                                         | Kia Ora Hauora projects in secondary schools, tertiary institutes and Māori community completed                                                                                                                                |        |       |                    | Completed                | 😊                    | N/A                   |               |
|    |                                                                                                                                                                                                                                                                                            | Annual report on Midland DHBs’ Māori health workforce by professional group (R2)                                                                                                                                               |        |       |                    | On Track                 |                      | N/A                   |               |
|    |                                                                                                                                                                                                                                                                                            | Renal and cancer work-streams establish one day training for Midland Māori non-regulated workforce                                                                                                                             |        |       |                    | Completed                |                      | N/A                   |               |
|    |                                                                                                                                                                                                                                                                                            | Midland Tumu Whakarae represented on Midland Training Network Leadership Group                                                                                                                                                 |        |       |                    | Completed                |                      | N/A                   |               |
| 13 | <b>Mechanisms in place to audit and monitor cultural responsiveness of NGO and Midland DHBs</b>                                                                                                                                                                                            | He Ritenga cultural audit done in one regional service area in all Midland DHB's                                                                                                                                               |        |       |                    | On Track                 | 😊                    | N/A                   |               |
|    |                                                                                                                                                                                                                                                                                            | Midland staff have access to bicultural education                                                                                                                                                                              |        |       |                    |                          |                      |                       |               |

## HIGHLIGHTS FROM THE YEAR

An **outcomes based contracting framework** agreed between the Taranaki DHB and Te Kawau Maro alliance (Tui Ora and the National Hauora Coalition) preferred provider of health services for Māori, was finalised ready to begin on 1 July 2013. With the added advantage of a five-year term, the contract marked a major milestone in enabling provider innovation to accelerate improvements in Māori health status.

The year saw the conclusion of 71 projects that supported communities from through-out Taranaki implement a range of activities aimed at **improving nutrition and increasing participation in physical activity.**

- 69 of the 71 grants went to groups that had Māori as the majority of participants.
- Pacifica groups benefitted from the other two projects.
- 'Training the trainers' projects made up 70% of all the Community Action projects.
- Maraë, Iwi, Māori Health Providers,

Church and education groups were grant recipients.

- The majority of projects related to setting up gardens and orchards and involved workshops to pass resources and knowledge to participants.
- The projects were fairly evenly distributed throughout the Taranaki region with 20 projects implemented in South Taranaki, six in Central Taranaki and 32 in North Taranaki. 13 projects covered were implemented Taranaki-wide

## Local Priorities & Indicators

|    | Priority                                               | Indicator                                                                                                             | Target | Māori | Non-Māori or Total | Māori Health Plan Status | Māori Measure Status | Māori Target Progress | Disparity Gap |
|----|--------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|--------|-------|--------------------|--------------------------|----------------------|-----------------------|---------------|
| 14 | <b>L1-Access to services</b>                           | Did-Not-Attend (DNA) rate for outpatient appointments                                                                 | 11%    | 18%   | 8%                 | Behind Plan              | ☹️                   | ▲                     | 10%           |
| 15 | <b>L2-Oral Health</b>                                  | Percentage of five year olds in Taranaki caries-free                                                                  | 68%    | 34%   | 59%                | Behind Plan              | ☹️                   | ▼                     | 25%           |
|    |                                                        | Decayed, Missing and Filled Teeth (DMFT) scores at year 8 in Taranaki                                                 | 1.01   | 1.26  | 0.86               |                          | ☹️                   | ▲                     | 0.40          |
| 16 | <b>L3-Respiratory Health</b>                           | Asthma hospitalisation rate 0-14 years ASR per 100,000                                                                |        |       |                    | Behind Plan              | Not Available        | Not Available         |               |
| 17 | <b>L4-Sudden Unexplained Death of Infants Syndrome</b> | SUDI mortality rate per 1,000 live births of Māori infants                                                            |        |       |                    | Behind Plan              | Not Available        | Not Available         |               |
| 18 | <b>L5-Māori Health Workforce</b>                       | Report on the total number of Māori recruited to the Incubator programme                                              | 160    | 190   |                    | Complete                 | 😊                    | ▲                     |               |
| 19 | <b>L6-Whānau Ora</b>                                   | Te Kāwau Maro strategic alliance integrated outcomes-based contract                                                   |        |       |                    | On Track                 | 😊                    | N/A                   |               |
|    |                                                        | Support the implementation of Taranaki Ora provider collective business plan                                          |        |       |                    |                          | 😊                    | N/A                   |               |
|    |                                                        | An agreed framework for intersectoral planning to address the health and socio-economic needs of Taranaki communities |        |       |                    |                          | ☹️                   | N/A                   |               |
| 20 | <b>L7-Diabetes</b>                                     | Percentage of diabetics who have attended a Diabetes Management Programme;                                            | 95%    | 69%   | 65%                | On Track                 | ☹️                   | ▼                     |               |
|    |                                                        | Percentage of diabetics who have participated in a Diabetes Management Programme and are HbA1c<64 mmol/mol            | 83%    | 70%   | 82%                |                          | ☹️                   | ◀▶                    | 12%           |

Though in several areas we have failed to achieve the targets which were set, the column marked 'Māori Target Progress' indicates that in most areas the indicator has improved or remained static. Failure to meet the targets signals the need for the Taranaki DHB to work harder to accelerate the rate of improvement. The primary purpose of the relationship between the Taranaki DHB and Iwi Relationship board Te Whare Punanga Korero representing the eight iwi of Taranaki, is to monitor Māori health outcomes and work together strategically to bring about those improvements.

A new programme of **induction began for new Senior Medical Officers** to the Taranaki DHB. The programme includes powhiri, a brief introduction to the Treaty of Waitangi, local population profile, an insight into Māori health inequalities, a more detailed look at Tikanga Recommended Best Practice in the hospital setting, and a brief introduction to pronunciation of te reo Māori. The programme raises awareness of the DHB's medical team to cultural considerations relevant in the clinical decision-making processes they are involved in.

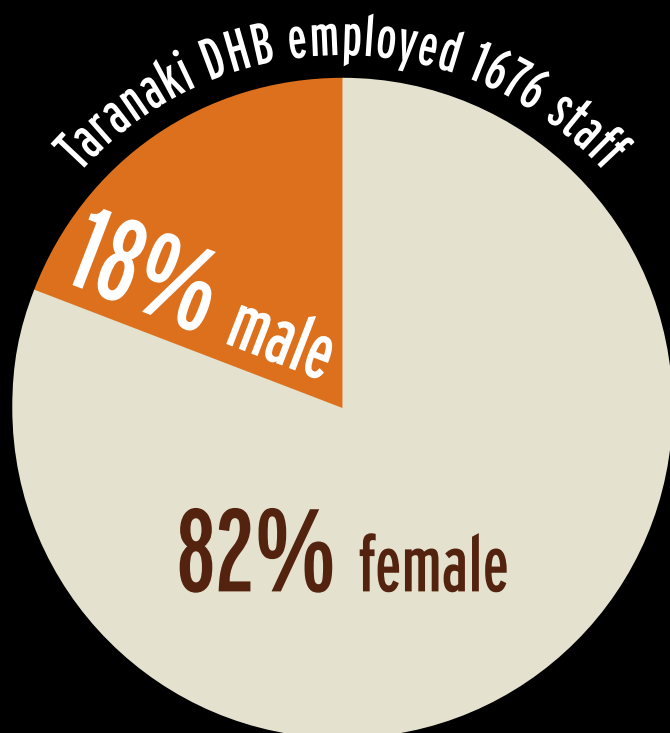
The intensive efforts of the DHB's Public Health, Dental, Planning and Funding and Māori Health units along with other committed community champions, contributed to the decision of the South Taranaki District Council to **fluoridate Patea and Waverley water supplies**. Being areas with high Māori and high-needs populations, the need for strong pro-fluoride advocacy was unquestionable. The exercise hopefully has led to greater Māori and public awareness of the necessity for and safety of fluoridating public water supplies.

A successful health promotion focus has been on accessing work places with high risk women to encourage more women, Māori in particular, to have regular cervical smears taken. This has been done in conjunction with occupational health nurses. The health promotion team also continues to work closely with PHOs and Māori providers to channel efforts into the high risk groups. Though still some way from achieving the target, the screening rate for Māori women has steadily increased from 67% at the start of the year to 73% by the end of the year.



# OUR PEOPLE

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



118 staff identified themselves as Māori, 8 Pacific Islanders, 18 Asian, and 1085 as New Zealanders.

## Scholarships Awarded

Taranaki DHB health scholarships were awarded to 26 students in 2013 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, 58% identified as Māori.

37 Midwives

30 Orderlies

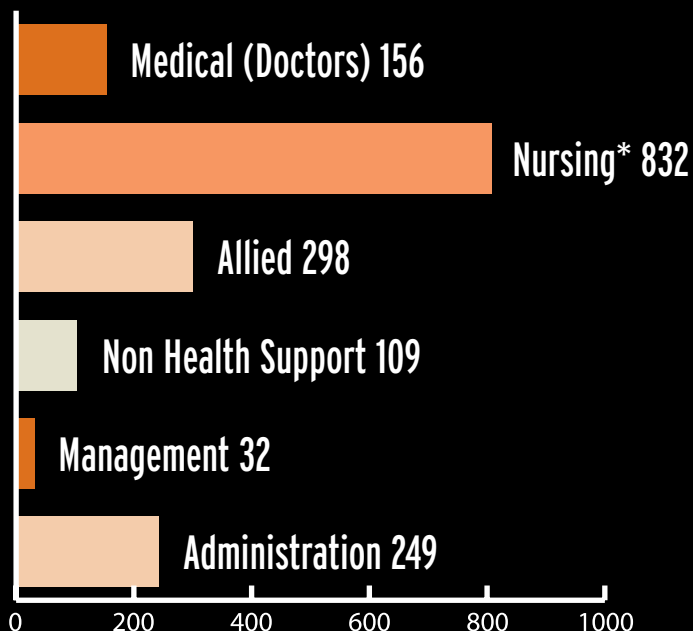
36 Cleaners

41

Laboratory Employees

22

Pharmacy employees



\*This figure includes midwives and health care assistants

694 Nurses

101 Health Care Assistants

26 Physiotherapists

27 Occupational Therapists

18 Dental Therapists

19

Social Workers

## 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 general surgeon
- 1 consultant paediatrician
- 1 consultant psychiatrist
- 2 consultants emergency medicine
- 1 medical officer obstetrics and gynaecology
- 1 medical officer Hawera Hospital

# A day in the life of...

At the end of 2012 Taranaki DHB staff were asked to showcase what their department does in a day through a camera lens.

Departments entered five photos capturing a "day in the life" of their work. Our winning departments were occupational therapy, chaplaincy services and Hawera Hospital. These are some of the photos...



Sterile Services Department



Hawera Hospital



Medical Records



Dietitians



Chaplaincy Services



Occupational Therapy



LabCare

## Over the 2012-13 year we carried out...

### 69,993 exams:

|              |       |
|--------------|-------|
| CT           | 10666 |
| General      | 45796 |
| Intervention | 994   |
| Mammogram    | 1090  |
| MRI          | 1866  |
| NM           | 804   |
| Screening    | 1147  |
| Ultrasound   | 7630  |

21,091 TREATMENTS FOR PEOPLE  
UNDER URGENT AND PLANNED SERVICES

391,392 LAB TESTS

33,309 DISTRICT NURSE VISITS

1387 BIRTHS 420 ANGIOGRAMS

18,871  
meals on wheels

TREATMENT OF 49,397  
PATIENTS IN OUR EMERGENCY DEPARTMENTS

8400 SURGICAL  
OUTPATIENT ATTENDANCES

27,591  
INPATIENT ADMISSIONS



Regional Releasing Time to Care Seminar

Child Cancer Foundation Family Support Coordinator (left) with Taranaki DHB staff

# WORKING TOGETHER

## Locally

Taranaki DHB is part of a committed network of organisations who work closely together to make up the health system in Taranaki. These organisations include primary health organisations, non-government organisation health providers, rest homes, other crown entities and individual health professionals.

## HIGHLIGHTS FROM THE YEAR

**Children living with cancer receive outstanding support in Taranaki** - Taranaki children with cancer, and their families, have benefitted from the support of a Child Cancer Foundation Family Support Coordinator during 2012-13. The Taranaki DHB multidisciplinary Paediatric Oncology team is appreciative of the relationship with the Taranaki Child Cancer Foundation.

**Taranaki DHB committed to reduce impact of disability in Taranaki** - Taranaki DHB has demonstrated its commitment to working collaboratively to reduce the impact of disability in our region by formally signing up as a partner to the Taranaki Disability Strategy.

**Preventing child driveway run over injuries in Taranaki** - Taranaki DHB Public Health Unit has teamed up with Kidsafe Taranaki Trust and now has a handy interactive kit that encourages parents and caregivers to think twice

about driveway safety. **Kidsafe Taranaki Trust** is a local child safety coalition group with membership including Taranaki DHB, ACC, Plunket and Tui Ora Limited.

**Severe Burns Course** - Taranaki DHB staff were fortunate to experience an Emergency Management of Severe Burns Course in 2013 for free with the help of local sponsors Methanex, ITL, TAG Oil, and Greymouth Petroleum. The course teaches emergency staff to recognise, assess, stabilise and transfer a severely burnt patient.

**A Maternity Quality Committee** was established in December 2012. It is a clinical governance group that has been set up to monitor and manage standards of clinical care. The group meets every month and brings together people who are involved with and committed to ensuring that a quality maternity service exists for the women and families of Taranaki.

**Whānau Pakari** is a collaboration between Sport Taranaki and the Taranaki DHB, and provides a multi-disciplinary support package for those referred with weight issues. Whānau Pakari focuses on the whole family, and since commencement

has received over 200 referrals. It especially aims to access Māori whānau, as Māori and Pacific Islanders are over-represented in national figures for those trying to manage weight issues. The services of a healthy lifestyles co-ordinator, dietitian, health development/physical activity advisor, psychologist, and paediatrician are provided for each individual in the programme.

**Community Coastal Transport initiative** - Taranaki DHB Public Health Unit has advocated to enhance transport services for the people of Coastal Taranaki to attend essential health appointments. Working with NZ Red Cross, Taranaki Regional Council, and the two organisations currently transporting people voluntarily, a Coastal Transport Trust was established.

**Nga Kete workshops** - A series of workshops for parents and caregivers on topics that contribute to Tamariki Ora were delivered in the communities of Patea, Opunake and Manaia. A total of 23 workshops or initiatives were held, with a total of 383 participants, 88% of which were Māori. All of the workshop topics were identified by members of each community.





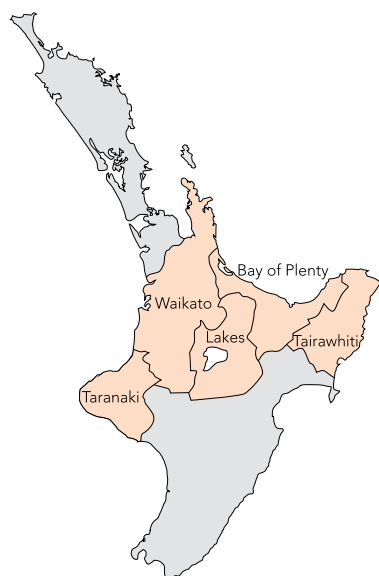
First 'homegrown' midwife Louise Hannah (2nd from left)



Taranaki DHB signs as partner to the Taranaki Disability Strategy

## Regionally

Taranaki DHB has been part of significant regional collaboration for many years in the Midland region. The Midland region comprises of five DHBs: 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

The current framework for the five Midland DHBs to plan and work cooperatively on include the following key areas:

- ERAS colorectal project
- Regional Trauma
- Midland Orthopaedics
- Midland Ophthalmology
- Midland Plastics
- Midland Vascular
- Midland Cardiac
- Midland Renal
- Midland Persistent Pain Management
- Health of Older People
- Midland Electives

**First 'homegrown' midwife** - An exciting milestone for Taranaki midwifery was accomplished in early 2013. Louise Hannah became Taranaki's first 'home grown' midwife after successfully completing her Bachelor of Health Sciences (Midwifery)

degree via the AUT Taranaki Satellite programme based in New Plymouth, and passing the Midwifery Council of New Zealand's National Midwifery Examination to become a registered midwife. Through the satellite programme and the use of modern technologies students can remain living with their families in Taranaki, and be a part of lectures coming out of AUT University's North Shore campus.

**Midland Midwifery Workshop** - In August 2012 Taranaki DHB was host to the first Technical Skills workshop to be presented as a shared Midland Regional Initiative. For this workshop a Bay of Plenty Educator visited Taranaki for two days, assisted by Taranaki DHB's Clinical Midwife Specialist, to present the compulsory programme to our local midwives.

**Releasing Time to Care** - On Friday, 23 November 2012 Taranaki DHB hosted the Releasing Time to Care (RTC) Regional Forum for the lower North Island. The forum was attended by 11 RTC staff from Waikato, Bay of Plenty, Whanganui and Wellington and 20 Taranaki DHB staff from the RTC wards.





# Governance

2012/2013



# GOVERNANCE STRUCTURE

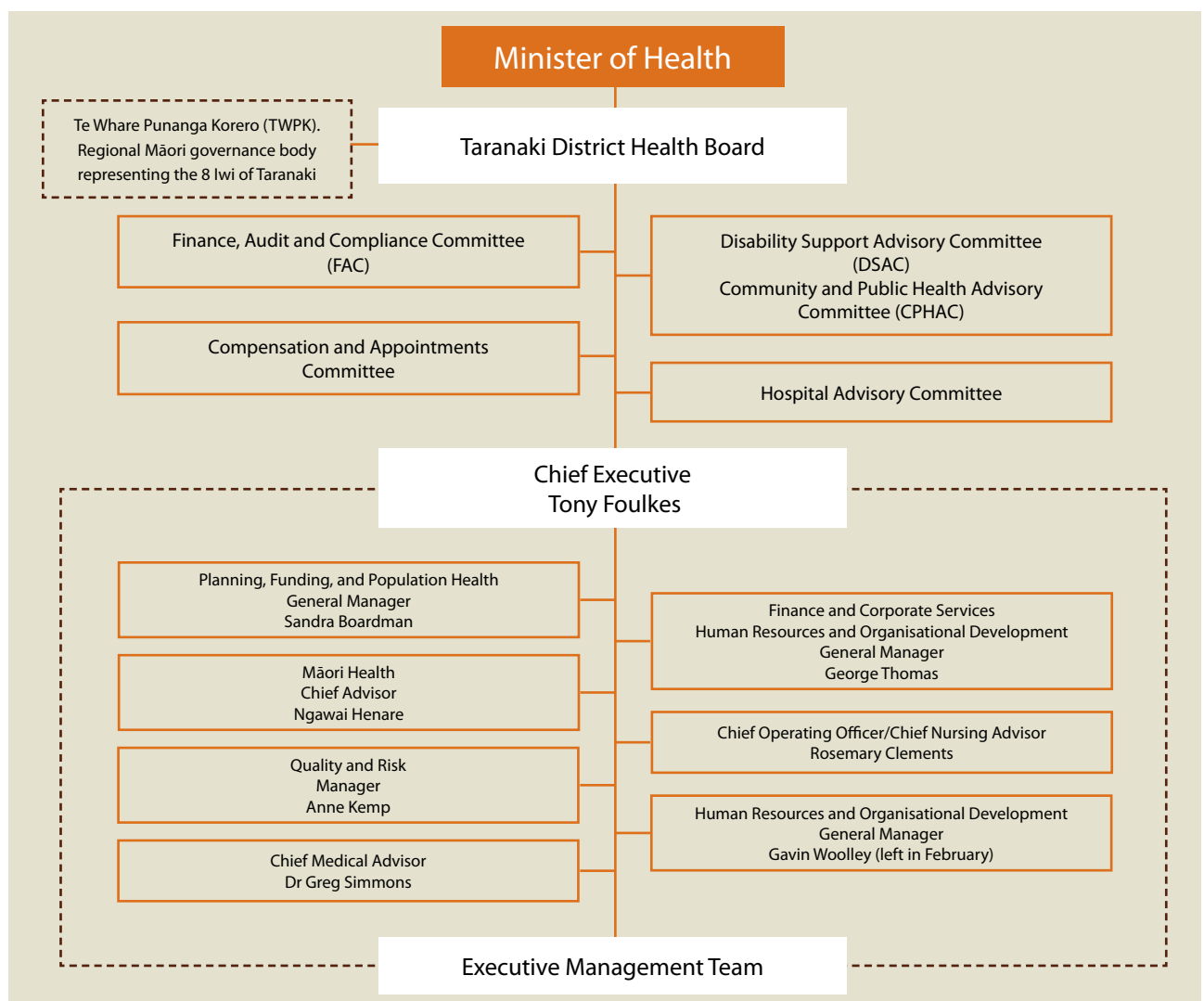
The governance structure for DHBs is set out in the NZ Public Health and Disability (NZPHD) Act 2000. The Board consists of up to 11 members and they have overall responsibility for the operation of Taranaki DHB. Seven of the members are elected as part of the three-yearly local body election process (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.
- Appointing, evaluating and supporting the performance of the Chief Executive.

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

The balance of skills and experience of the Board is kept under regular review. Additional knowledge and expertise 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

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### 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 of Bishop's Action Foundation, TSB Community Trust, and New Families Centre. Chair of WITT Council, Former Chair and founding member of Southcare, Presiding Member of 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 Chair. 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, Chair HIQ.



### ALEX BALLANTYNE

Alex lives in Eltham in South Taranaki. He is married and has four children. His community involvement includes Deputy Mayor South Taranaki District Council, advocate Central and South Taranaki Advocacy Service and Parish Worker St Joseph's Eltham. Alex is a member of the Finance Audit and Compliance Committee

and Deputy Chair of the Community and Public Health and Disability Support Advisory Committee.

**Interest Register:** 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. Former 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 Co-Chair of the Hospital Advisory Committee.

**Interest Register:** Former Associate, Health Consumer Service, Waikato; Former Chair, South Taranaki Medical Trust; Husband Chester Borrows, Member of Parliament.



#### 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 Chair of Tui Ora Limited. Kura is Chair 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 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 Chair. She has a Doctorate in Management and a Masters 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

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### 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. Pauline is a member of the District Health Board's Hospital Advisory Committee and the Finance, Audit and Compliance Committee. Pauline is also a

Director of Landcorp Farming Limited and is the Chair of the Audit and Due Diligence Committee.

**Interest Register:** Councillor on the New Plymouth District Council, Family Trust has shares in Fletcher Building Ltd, Director of Landcorp Farming Ltd.



### ALLISON RUMBALL

Allison 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 NZ 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 Tūturu, 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 ō 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 – Whānau Centre.

## ADDITIONAL INTERESTS DECLARED

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### TONY FOULKES (CHIEF EXECUTIVE)

**Interest Register:** Director HIQ Ltd (to June 2013), Director HealthShare Ltd. Board member of National Health IT Board (to January 2013). 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. The Memorandum of Understanding between Taranaki DHB and Te Whare Punanga Korero (TWPK) 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:

- Participation in the development of, and joint approval with the Taranaki DHB of Māori Health strategies and plans
- Regular meetings with the Taranaki DHB Board and management to monitor progress against the DHB's Māori Health Plan
- Participation in the Taranaki DHB's strategic planning and governance training
- Participation as trustees in the Tui Ora Trust which appoints the Directors of Tui Ora Ltd, the largest Māori health services provider in Taranaki

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



## Members of TWPK

**Left to right:** Chair Darryn Ratana (Ngaa Rauru Kaitahi), David Tamatea (Taranaki), Vicki Kershaw (Ngati Mutunga), Hinemoerangi Ngatai-Tangirua (Ngati Ruanui), Pam Ritai (Te Atiawa), Greg White (Ngati Tama), Tom Rangiaeaata (Ngati Maru).

**Absent:** Mere Brooks (Ngaruahine)



# Board

2012/2013

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 (\$) |
|-------------------------------------------------|----------------|-----------------------------|-------------------------------------------------------------------|---------------------------------------|---------------------------------------|-----------------------------|-------------------|-----------------|-----|----------------|
| <b>Board Members</b>                            |                |                             |                                                                   |                                       |                                       |                             |                   |                 |     |                |
| Mary Bourke (Chair)                             | *10 of 11      | 10 of 11                    | 6 of 6                                                            |                                       | ✓                                     |                             |                   |                 |     | \$41,000       |
| Peter Catt (Deputy Chair)                       | ^11 of 11      | 11 of 11                    | 5 of 6                                                            | ✓                                     | ✓                                     |                             |                   |                 | ✓   | \$27,375       |
| Alex Ballantyne                                 | 9 of 11        | 9 of 11                     | ^5 of 6                                                           | ✓                                     |                                       |                             |                   |                 |     | \$22,000       |
| Ella Borrows (Chair)                            | 9 of 11        | *9 of 11                    | 4 of 6                                                            |                                       |                                       |                             |                   |                 |     | \$22,123       |
| Kura Denness                                    | +8 of 11       | +8 of 11                    | +3 of 6                                                           | ✓                                     | ✓                                     | ✓                           |                   |                 |     | \$21,250       |
| Karen Eagles                                    | 11 of 11       | ^11 of 11                   | 6 of 6                                                            |                                       |                                       |                             |                   |                 |     | \$23,000       |
| Flora Gilkison (Chair)                          | 8 of 11        | 8 of 11                     | *5 of 6                                                           |                                       | ✓                                     |                             | ✓                 |                 |     | \$22,000       |
| Brian Jeffares                                  | 8 of 11        | 9 of 11                     | 6 of 6                                                            | ✓                                     |                                       |                             |                   |                 |     | \$21,000       |
| Pauline Lockett                                 | 10 of 11       | 10 of 11                    | 3 of 6                                                            | ✓                                     |                                       |                             |                   |                 |     | \$21,750       |
| Alison Rumball                                  | 8 of 11        | 8 of 11                     | 6 of 6                                                            |                                       |                                       |                             |                   |                 |     | \$22,000       |
| Colleen Tuuta                                   | 10 of 11       | 10 of 11                    | 3 of 6                                                            |                                       |                                       |                             |                   |                 |     | \$21,750       |
| <b>Co-Opted Committee Members</b>               |                |                             |                                                                   |                                       |                                       |                             |                   |                 |     |                |
| Peter Moeahu – member resigned January 2013     |                | 2 of 6                      |                                                                   |                                       |                                       |                             |                   |                 |     | \$ 500         |
| David Tamatea                                   |                |                             | 3 of 6                                                            |                                       |                                       |                             |                   |                 |     | \$ 750         |
| <b>Other Directors</b>                          |                |                             |                                                                   |                                       |                                       |                             |                   |                 |     |                |
| 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





# Audit Report

2012/2013

**INDEPENDENT AUDITOR'S REPORT**  
**TO THE READERS OF**  
**TARANAKI DISTRICT HEALTH BOARD AND GROUP'S**  
**FINANCIAL STATEMENTS AND PERFORMANCE INFORMATION**  
**FOR THE YEAR ENDED 30 JUNE 2013**

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 performance information of the Health Board and group on her behalf.

We have audited:

- the financial statements of the Health Board and group on pages 89 to 122, that comprise the statement of financial position as at 30 June 2013, 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 performance information of the Health Board that comprises the statement of service performance on pages 42 to 85.

**Unmodified opinion on the financial statements**

In our opinion the financial statements of the Health Board and group on pages 89 to 122:

- comply with generally accepted accounting practice in New Zealand; and
- fairly reflect the Health Board and group's:
  - financial position as at 30 June 2013; and
  - financial performance and cash flows for the year ended on that date.

**Qualified opinion on the performance information**

***Reason for our qualified opinion***

Some significant performance measures of the Health Board, (including some of the national health targets, and the corresponding district health board sector averages used as comparators), rely on information from third-party health providers, such as primary health organisations. The Health Board's control over much of this information is limited, and there are no practical audit procedures to determine the effect of this limited control. For example, the primary care measures that include advising smokers to quit and more heart and diabetes checks rely on information from general practitioners that we are unable to independently test.

***Qualified opinion***

In our opinion, except for the effect of the matters described in the "Reason for our qualified opinion" above, the performance information of the Health Board and group on pages 42 to 85:

- complies with generally accepted accounting practice in New Zealand; and
- fairly reflects the Health Board and group's service performance and outcomes for the year ended 30 June 2013, including for each class of outputs:
  - the service performance compared with forecasts in the statement of forecast service performance at the start of the financial year; and
  - the actual revenue and output expenses compared with the forecasts in the statement of forecast service performance at the start of the financial year.

Our audit was completed on 24 October 2013. 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 performance information are free from material misstatement.

Material misstatements are differences or omissions of amounts and disclosures that, in our judgement, are likely to influence readers' overall understanding of the financial statements and performance information. We were unable to determine whether there are material misstatements in the performance information because the scope of our work was limited, as we referred to in our opinion.

An audit involves carrying out procedures to obtain audit evidence about the amounts and disclosures in the financial statements and performance information. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and performance information, 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 performance information 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.

Our audit of the financial statements involved 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; and
- the adequacy of disclosures in, and overall presentation of, the financial statements.

Our audit of the performance information involved evaluating:

- the appropriateness of the reported service performance within the Health Board and group's framework for reporting performance;
- the material performance measures, including the national health targets; and
- the adequacy of disclosures in, and overall presentation of, the performance information.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements and performance information. Also we did not evaluate the security and controls over the electronic publication of the financial statements and performance information.

We obtained all the information and explanations we required about the financial statements. However, as referred in our opinion, we did not obtain all the information and explanations we required about the performance information. We believe we have obtained sufficient and appropriate audit evidence to provide a basis for our audit opinions.

## Responsibilities of the Board

The Board is responsible for preparing financial statements and performance information 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 and outcomes.

The Board is also responsible for such internal control as it determines is necessary to enable the preparation of financial statements and performance information that are free from material misstatement, whether due to fraud or error. The Board is also responsible for the publication of the financial statements and performance information, whether in printed or electronic form.

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

# Audit Report

## **Responsibilities of the Auditor**

We are responsible for expressing an independent opinion on the financial statements and performance information 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 External Reporting Board.

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

A handwritten signature in black ink, appearing to read 'Lloyd Bunyan', with a long horizontal flourish extending to the right.

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





# Statement of Service Performance

2012/2013





# Statement of Service Performance



## Overview

As an effective District Health Board we need to demonstrate accountability<sup>1</sup> for the intended outcomes and impacts of our population by the services/ outputs that we provide. During the annual planning phase, the Statement of Forecast Service Performance was developed which forms the performance framework for the impacts and services/ outputs against which we report. Our performance story is detailed in the chart overleaf. 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 2012/13 by grouping our activities into the population long and medium term impacts we intend to influence.

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

## Taranaki DHB Planned and Actual Revenue and Expenditure Allocated to Output Classes 2012-13

| Output Class                                | Planned Revenue (\$000's) | Actual Revenue (\$000's) | Planned Expenditure (\$000's) | Actual Expenditure (\$000's) |
|---------------------------------------------|---------------------------|--------------------------|-------------------------------|------------------------------|
| Prevention                                  | 9,336                     | 11,167                   | 9,257                         | 8,147                        |
| Early Detection and Management              | 79,279                    | 79,235                   | 78,614                        | 77,597                       |
| Intensive Assessment and Treatment Services | 185,369                   | 186,018                  | 183,813                       | 193,877                      |
| Rehabilitation and Support                  | 49,821                    | 50,542                   | 49,403                        | 47,262                       |
| TOTAL                                       | 323,805                   | 326,962                  | 321,087                       | 326,884                      |

<sup>1</sup> The 2004 Crown Entities Act requires under section 153 that a Statement of Service Performance be completed.  
See <http://www.legislation.govt.nz/act/public/2004/0115/latest/DLM330555.html>



# Statement of Service Performance

## Our Performance Story

### Our Vision and Mission

Vision: Taranaki Together, a Healthy Community – Taranaki Whanui He Rohe Oranga

Mission: Improving promoting, protecting and caring for the health and wellbeing of the people of Taranaki

### Our Outcomes

To improve the health of our population

To reduce or eliminate health inequalities

### Long Term Impacts

People are supported to take greater responsibility for their health

People stay well in their homes and communities

People receive timely and appropriate care

### Intermediate Impacts

- Fewer people smoke
- Reduction in vaccine preventable diseases
- Improving health behaviours
- Children and adolescents have better oral health
- Treatable conditions are detected early and people are better at managing their long term conditions
- Fewer people are admitted to hospital for avoidable conditions
- More people maintain their functional independence
- People receive prompt and appropriate acute and arranged care
- People have appropriate access to elective services
- Improved health status for people with a severe mental health illness and/or addiction
- More people with end-stage conditions are appropriately supported

### Outputs

Statement of Service Performance Measures





Debbie Shotter tears off a poster in the smokefree countdown      Opportunistic immunisation clinic is held in Waitara

Long Term Impact 1:

PEOPLE ARE SUPPORTED TO TAKE GREATER RESPONSIBILITY FOR THEIR HEALTH

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

|                      |                                                                      |                                           |                             |
|----------------------|----------------------------------------------------------------------|-------------------------------------------|-----------------------------|
| Long Term Impact     | People are supported to take greater responsibility for their health |                                           |                             |
| Intermediate Impacts | Fewer people smoke                                                   | Reduction in vaccine preventable diseases | Improving health behaviours |

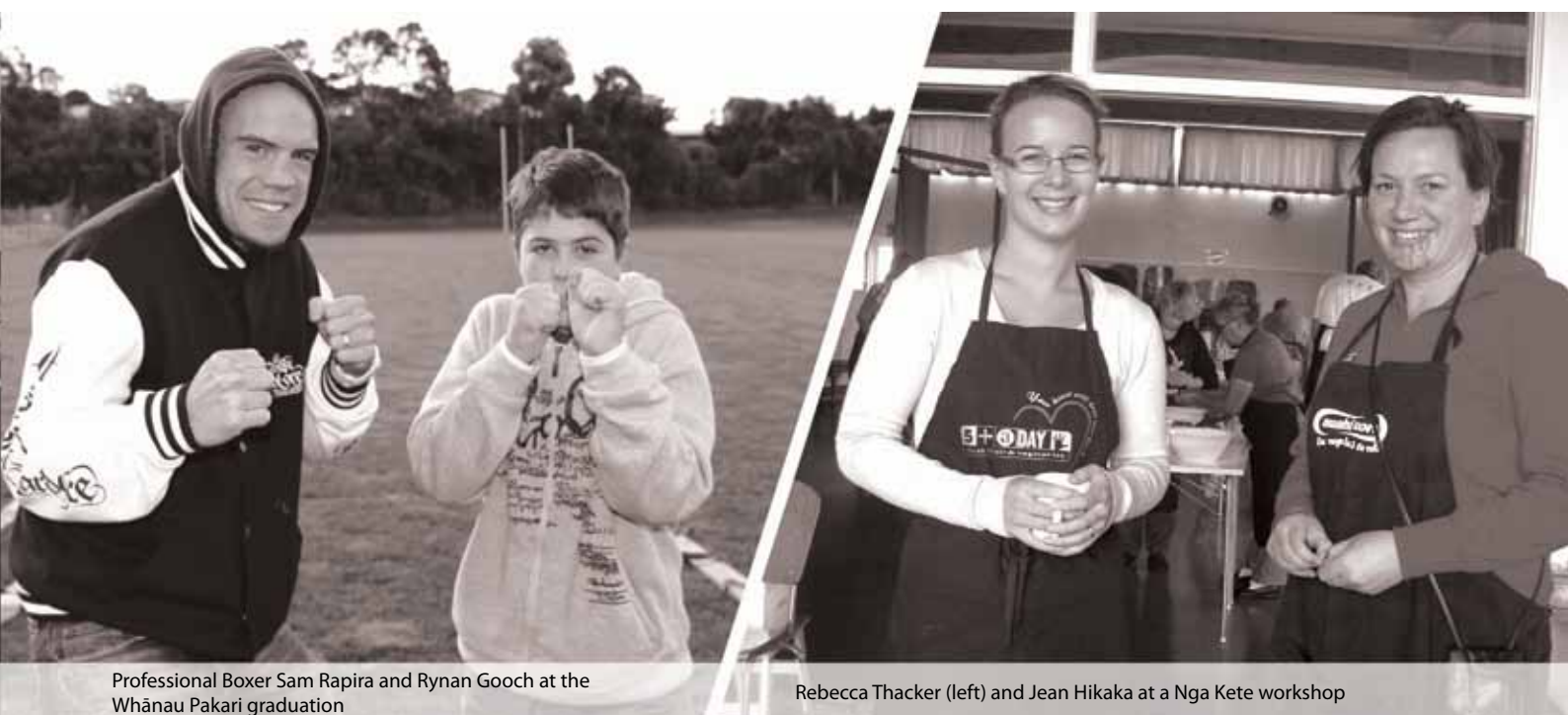
Fewer People Smoke

Smoking is a major contributor to preventable illness and long term conditions, such as cancer, respiratory disease, heart disease and strokes. Cancer is the leading cause of death in

New Zealand (29.8%), and is a major cause of hospitalisation and driver of cost. Cancer also highlights continuing inequalities, with Māori experiencing a higher incidence (20%+), higher mortality and higher stage at presentation. In some communities, a sizeable portion of household income is spent on

tobacco, resulting in less money being available for necessities such as nutrition, education and health. Supporting our population to say “no” to tobacco smoking is our foremost opportunity to target improvements in the health of our population and to reduce health inequalities for Māori.

# Statement of Service Performance



Professional Boxer Sam Rapira and Rynan Gooch at the Whānau Pakari graduation

Rebecca Thacker (left) and Jean Hikaka at a Nga Kete workshop

## Reduction in Vaccine Preventable Diseases

Immunisation can prevent a number of diseases and is a very cost-effective health intervention. Immunisation provides protection not only for individuals, but for the whole population by reducing the incidence of diseases and preventing them from spreading to vulnerable people or population groups. Population benefits only arise with high immunisation rates, and New Zealand's current rates are low by international standards and insufficient to prevent or reduce the impact of preventable diseases such as measles or pertussis (whooping cough). These diseases are entirely preventable.

## Improving Healthy Behaviours

Good nutrition is fundamental to health and to the prevention of disease and disability. Nutrition-related risk factors (such as high cholesterol, high blood pressure and obesity) jointly contribute to two out of every five deaths in New Zealand each year.

## HIGHLIGHTS FROM THE YEAR

**Whānau Pakari** - This is a project that has been running for over 12 months. Whānau Pakari is a community based programme that is aimed at reducing childhood obesity by supporting and educating families about healthy eating, the importance of exercise and healthy choices to support a healthy lifestyle.

**Taranaki retail outlets tighten up on tobacco sales** - A Controlled Purchase Operation (CPO) carried out by Taranaki DHB Public Health Unit had pleasing results regarding selling cigarettes to people under 18 years. "We need to work together to prevent young people from having access to cigarettes. We want retailers to help us work towards our vision of a smokefree Taranaki," said Health Promoter Carly Twaddle.

**Achieved the smokefree target** - Taranaki DHB achieved the Ministry of Health Smokefree target in quarters three and four.

**Taranaki Vaccinator Training** provides new vaccinators with the knowledge and skills needed to become authorised vaccinators.

**Taranaki DHB welcomes new immunisation position** - A Regional Immunisation Coordinator was appointed in the Taranaki DHB Regional Screening Unit. This is a new role for the DHB, one that was previously provided by the Immunisation Advisory Centre (IMAC). The role covers the Taranaki region and focuses on promotion of the National Immunisation Schedule and clinical assessment for vaccinators and Cold Chain assessment across both secondary and primary care. The role works closely with Taranaki DHB staff, Primary Health Organisations, GPs and other stakeholders such as Plunket, and Outreach Organisations, to ensure the Taranaki community is protected from vaccine preventable diseases.

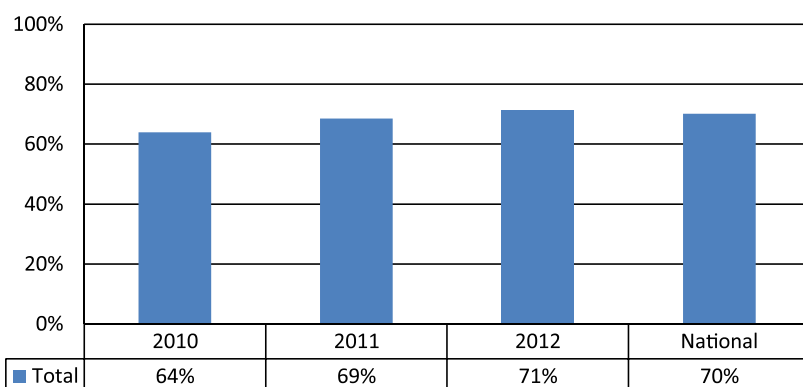
**Nga Kete workshops in the community** - See page 26 for more information.

**Green Feet programme** - Available at the 45Square45 in Opunake, Green Feet is about helping families choose budget friendly, healthy food choices. Green Feet recipes take into account nutrition, value for money, and are using food items that can be used on a day to day basis.

## FEWER PEOPLE SMOKE

### Impact Measures

**Percentage of year 10 students in Taranaki who have never smoked**

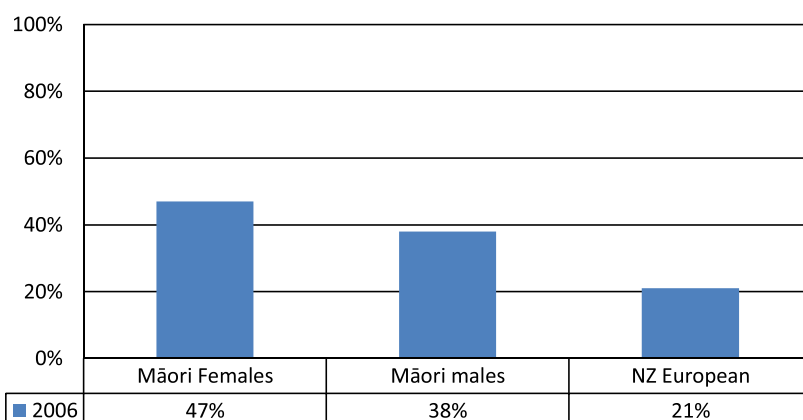


Data Source: Action on Smoking and Health (ASH) annual survey

### **An increase in the percentage of year 10 students who have never smoked**

The year 10 survey is an annual questionnaire of around 30,000 students in New Zealand of which 767 were surveyed in Taranaki in 2012. The survey is conducted each year in schools throughout the country for the last 10 years and is one of the biggest in its kind providing a valuable and robust insight into youth smoking. Each year Action on Smoking and Health (ASH) publishes a summary report showing youth smoking trends. Taranaki has seen a pleasing trend over the last three years in the increase of year 10 students who are recorded as never smoked.

**Percentage of population who are regular smokers - Census 2006**



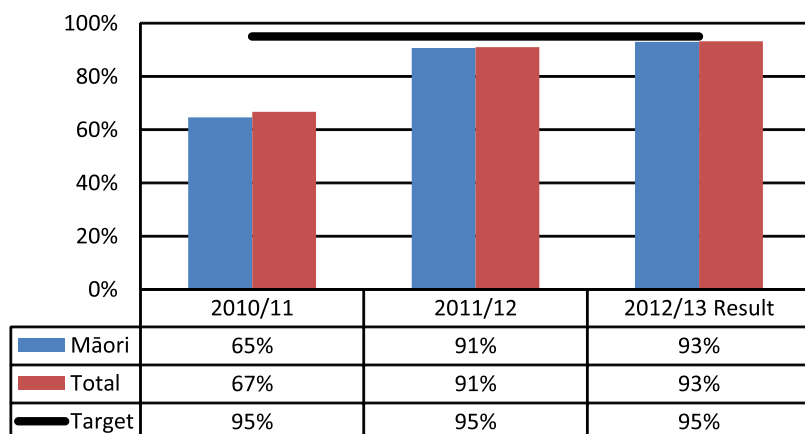
Data Source: New Zealand Statistics Census 2006

### **A decrease in the percentage of population who are regular smokers**

The census is ordinarily undertaken every five years but due to the earthquake in Christchurch in 2011 it was postponed until 2013. The results are not due until 2014. The census survey provides the most complete national and local picture of smoking rates. The Government made a commitment to New Zealand becoming smokefree by 2025 and the census should show us not only how we are trending but also the amount of work required to reduce smoking rates and inequalities over the next 12 years.

## Output Measures

**Percentage of hospitalised smokers provided with smoking cessation advice and support**



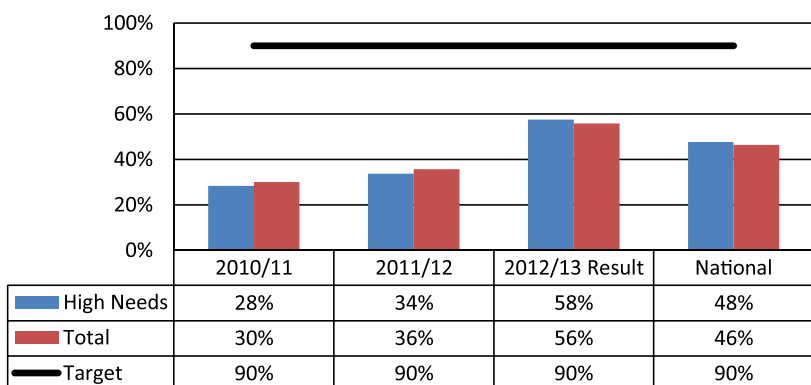
Data Source: Taranaki DHB Dental Patient Management System

**95% of hospitalised smokers are provided with cessation advice and support to quit**

|       |              |
|-------|--------------|
| Māori | Not Achieved |
| Total | Not Achieved |

Although the annual result for the 95% target has not been met Taranaki DHB has seen a significant improvement over the latter half of the year with quarter four result being 97% for total and 96% for Māori. Smokefree co-coordinators facilitate education and support across Taranaki DHB, ensuring patients are provided with advice/support to quit. This included individual education and support along with group in-service training. Regular monitoring and reporting to all levels help ensure the focus remains.

**Percentage of smokers provided with smoking cessation advice and support in Primary Care**



Data Source: Primary Health Organisation Performance Programme (PPP)

**90% of smokers in primary care are provided with cessation advice and support to quit**

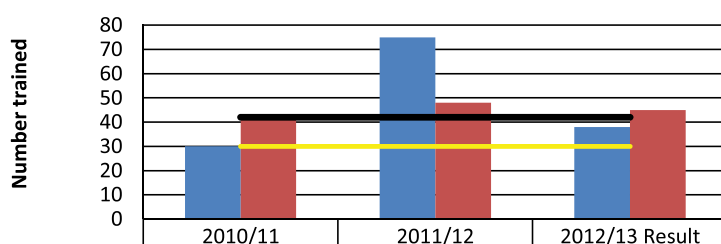
|            |              |
|------------|--------------|
| High Needs | Not Achieved |
| Total      | Not Achieved |

Taranaki DHB has not achieved the target for the percentage of primary care patients who are offered cessation advice and support to quit. However since the target was introduced in 2010/11 the result has steadily increased and Taranaki is 10% ahead of the National result for both the total and high needs population. The DHB continues to provide additional support to ensure the momentum continues.



# Statement of Service Performance

## Number of health professionals trained in smoking cessation support



|                  | 2010/11 | 2011/12 | 2012/13 Result |
|------------------|---------|---------|----------------|
| Secondary        | 30      | 75      | 38             |
| Primary          | 42      | 48      | 45             |
| Secondary Target | 30      | 30      | 30             |
| Primary Target   | 42      | 42      | 42             |

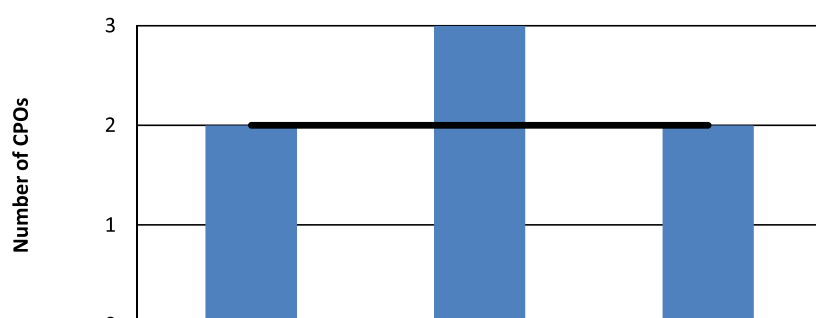
Data Source: Ministry of Health e-learning monthly report

## An increase in the number of health professionals trained in smoking cessation support

|           |          |
|-----------|----------|
| Secondary | Achieved |
| Primary   | Achieved |

Our largest Primary Health Organisation, Midland Health Network recently undertook a stock take of their workforce and more than 50% of their nurses are trained in cessation support and over 90% of General Practices have one or more people trained. The hospital services, through the smokefree coordinators, provide education and support for staff to become trained in cessation support.

## Number of tobacco Controlled Purchase Operations (CPOs)



|        | 2010/11 | 2011/12 | 2012/13 Result |
|--------|---------|---------|----------------|
| Total  | 2       | 3       | 2              |
| Target | 2       | 2       | 2              |

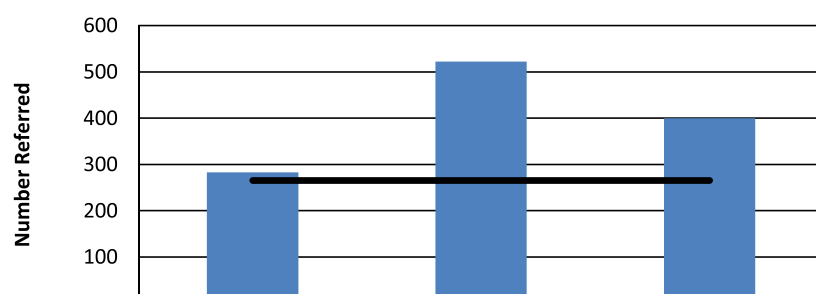
Data Source: Taranaki DHB Public Health Team

## Two tobacco controlled purchase operations

Achieved

Controlled Purchase Operations (CPOs) monitor and enforce retailer compliance with Section 30 (1) of the Smokefree Environments Act, 1990, which restricts youth access to tobacco and herbal smoking products. The Taranaki Public Health regulation officers undertook the planned two CPOs where 32 retailer premises were visited and there were five sales of products to underage volunteers.

## Number of referrals our DHB has made to Quitline



|        | 2010/11 | 2011/12 | 2012/13 Result |
|--------|---------|---------|----------------|
| Total  | 283     | 522     | 400            |
| Target | 265     | 265     | 265            |

Data Source: Quit group monthly reports

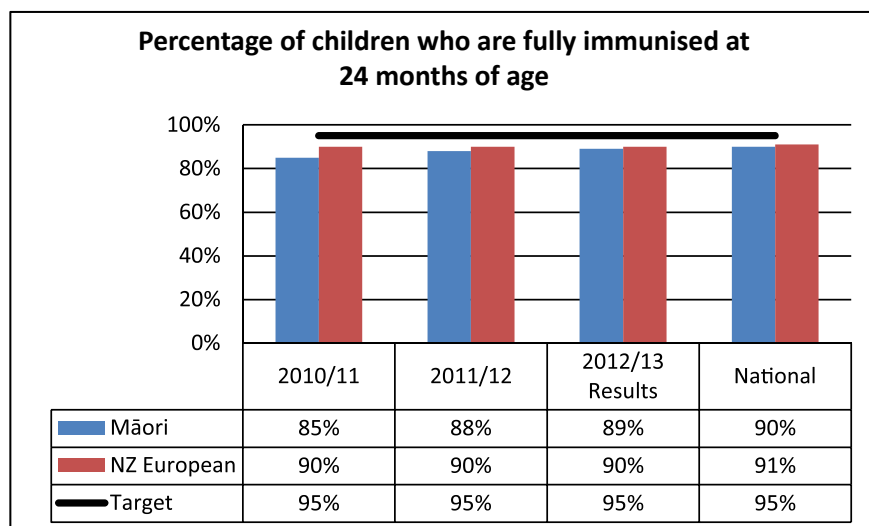
## More than 265 referrals our DHB has made to Quitline

Achieved

Quitline is operated by the Quit Group which provides smokers with support to quit via telephone, text or online and have a strong focus on Māori, Pacific peoples and pregnant woman. They also provide subsidised nicotine patches, gum and lozenges. We expect that the more people we are able to refer to Quitline the more quit attempts will be made.

## REDUCTION IN VACCINE PREVENTABLE DISEASES

### Impact Measures



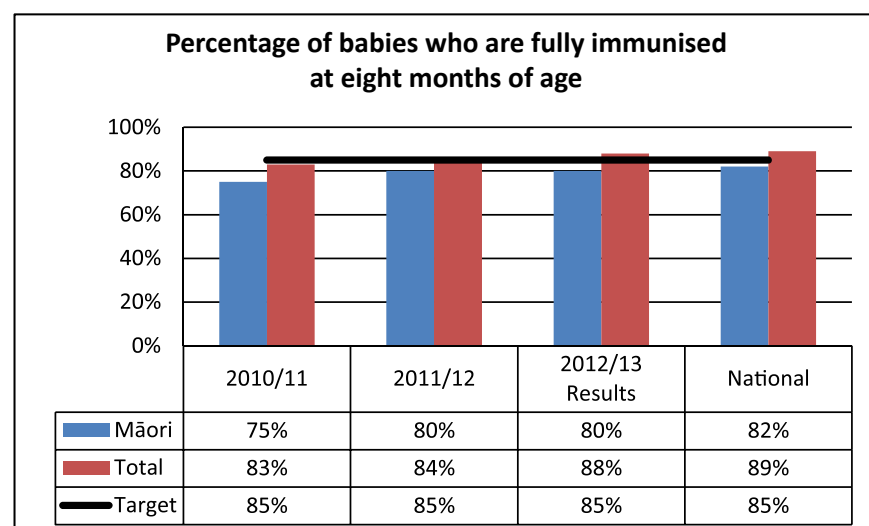
Data Source: National Immunisation Register

#### 95% of children are fully immunised at 24 months of age

|             |              |
|-------------|--------------|
| Māori       | Not Achieved |
| NZ European | Not Achieved |

Taranaki DHB has not achieved the target for children fully immunised at 24 months. However we have seen a slight increase in Māori being immunised. Significant work is continuing in community and hospital settings to ensure that immunisations are a focus. Education and advice sessions for midwives have been held in partnership with the Immunisation Advisory Centre (IMAC). Additional vaccinator training courses have also occurred increasing the number of vaccinators available for the Taranaki population.

### Output Measures



Data Source: National Immunisation Register

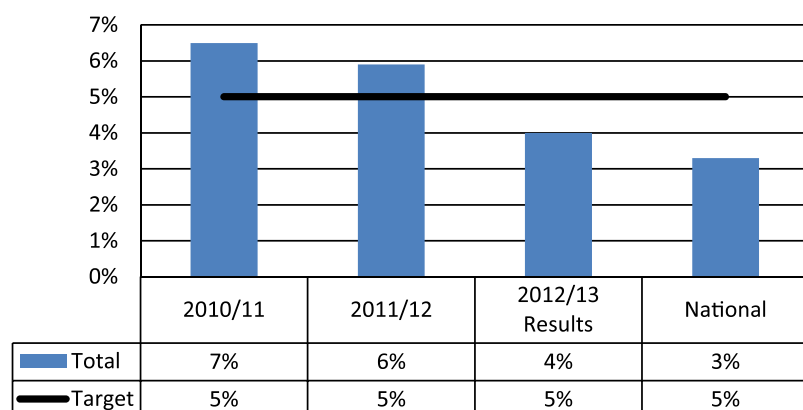
#### 85% of babies are fully immunised at eight months old

|       |              |
|-------|--------------|
| Māori | Not Achieved |
| Total | Achieved     |

The health target of 85% of babies fully immunised at eight months was achieved for the total population in Taranaki. The Māori population has yet to meet the target. The Taranaki immunisation administrator notifies all GP clinics of babies who are due to reach eight months within the next four weeks and have yet to be immunised. Those babies who do not have a clinic assigned are referred to outreach services.

# Statement of Service Performance

## Percentage of people who decline child immunisations at eight months



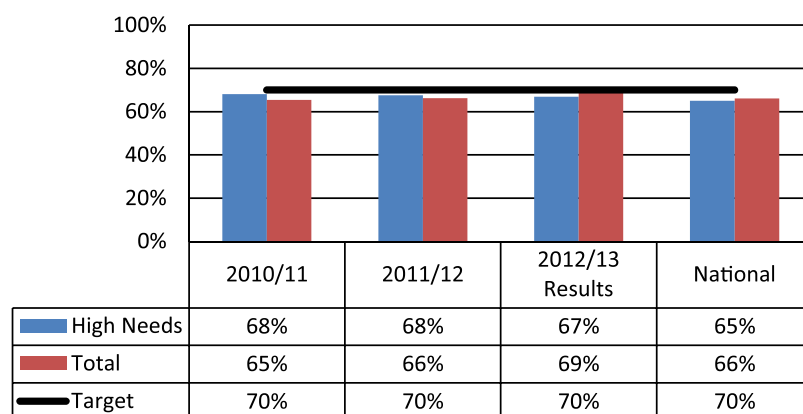
Data Source: National Immunisation Register

**≤5% of babies at eight months have had their age appropriate immunisations declined**

Achieved

Taranaki DHB has seen a pleasing downward trend in the percentage of eligible children being declined for immunisations. Immunisation is the most effective way to actively protect children from preventable diseases, ranging from whooping cough to meningitis and measles.

## Percentage of the population (>65 years) who have had the seasonal influenza immunisation



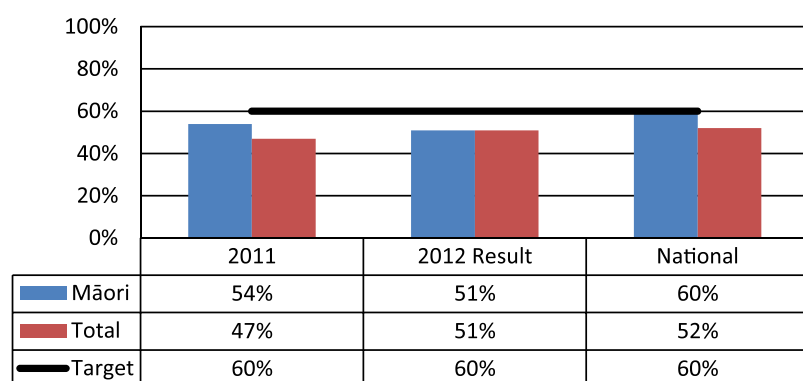
Data Source: Primary Health Organisation Performance Programme (PPP)

**70% of the population aged 65+ years have had their seasonal influenza immunisation**

|            |              |
|------------|--------------|
| High Needs | Not Achieved |
| Total      | Not Achieved |

During the immunisation awareness week Taranaki DHB, in partnership with the Māori Women's Welfare League, held an event in Waitara where the outreach immunisation teams had an opportunity to not only promote the benefits of immunisations but also to carry out a number of flu vaccinations. Taranaki DHB did not achieve against the targets set but achieved higher than the national average.

## Percentage of eligible young women (year 8) who have received dose three of the school based HPV vaccination in the academic year



Data Source: National Immunisation Register

**60% of eligible young women (year 8) receive dose three of the school based Human Papillomavirus (HPV) vaccination in the academic year**

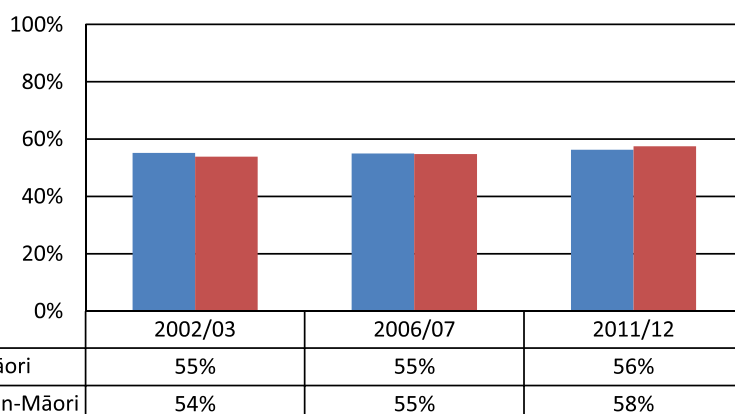
|       |              |
|-------|--------------|
| Māori | Not Achieved |
| Total | Not Achieved |

Taranaki DHB has yet to achieve the targets for the delivery of HPV vaccine. HPV can lead to genital warts and can progress in some cases to cervical cancer. We continue to provide education and advice to pupils and parents to encourage higher uptake. The HPV vaccinations are also undertaken through GPs which is not captured through the school based system.

## PEOPLE HAVE HEALTHIER DIETS

### Impact Measures

#### Prevalence of at least 30 minutes of moderate physical activity on at least five days of the week in adults 15+



Data Source: New Zealand Health Survey 2011/12

**Increase prevalence of at least 30 minutes of moderate physical activity on at least five days of the week in adults 15+**

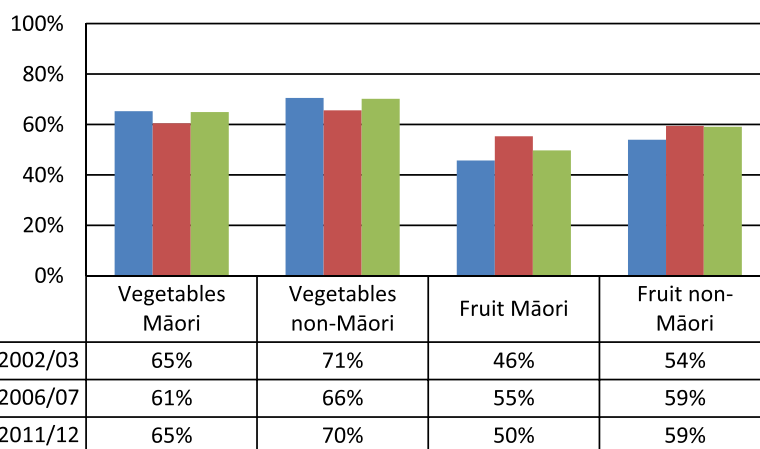
**Increase prevalence of fruit and vegetable consumption in adults 15+**

**Decrease prevalence of overweight and obesity in Taranaki in adults 15+**

The National Health Survey is suggesting that New Zealanders' physical activity and vegetable intake has not changed considerably over the last nine years. The percentage of people over the age of 15 years who are classed as overweight or obese has increased. Along with health promotion activities Taranaki DHB funds a Green Prescription programme which aim to increase physical activity and healthy eating for those people who are at risk. A Green Prescription (GRx) is a health professional's written advice to a patient to be physically active, as part of the patient's health management. Patients are provided with an advisor who will help set activity and nutritional goals. Research published in the New Zealand Medical Journal indicates that a Green Prescription is an inexpensive way of increasing activity.

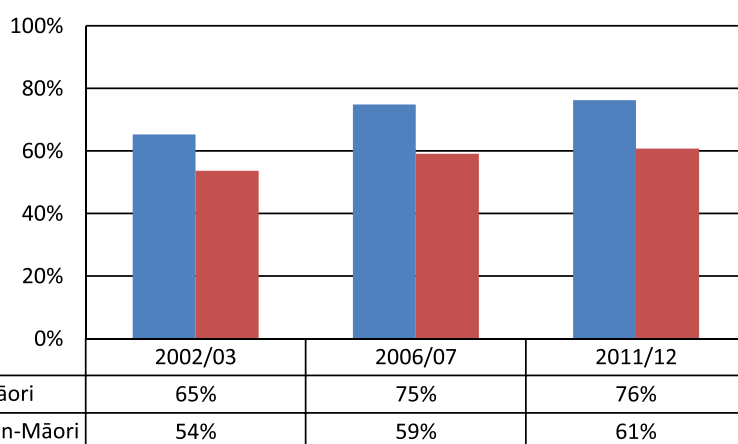
Taranaki DHB also funds the Whānau Pakari Programme supporting healthy lifestyle intervention to children and adolescents.

#### Prevalence of fruit and vegetable consumption in adults 15+



Data Source: New Zealand Health Survey 2011/12

#### Prevalence of overweight and obesity in adults 15+



Data Source: New Zealand Health Survey 2011/12



## Output Measures

**17 schools engaged in the Health Promoting Schools programme**

Achieved

**25% of schools in the district participate in the Health Promoting Schools programme**

Achieved

**91% of deciles one and two schools participating in the Health Promoting Schools programme**

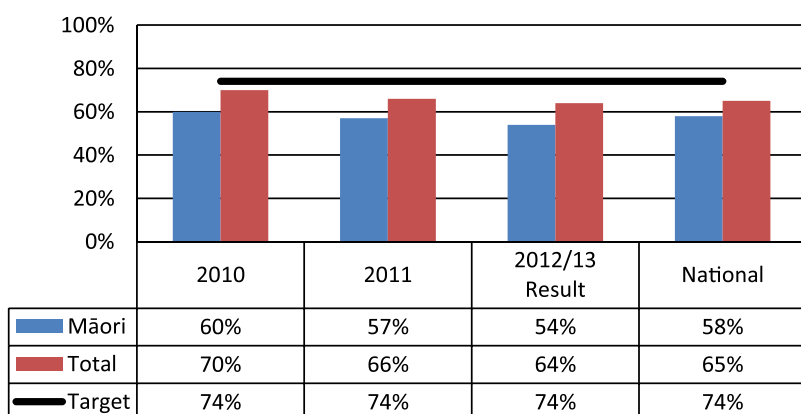
Achieved

Health Promoting Schools (HPS) is an approach where the whole school community works together to address the health and wellbeing of students, staff and their community. Schools include health and wellbeing in their planning and review processes, teaching strategies, curriculum and assessment activities. Taranaki DHB has maintained the number and percentage of schools who are engaged in the programme and during 2012/13 has responded to the implementation of a new health promoting schools framework.

Data Source: Taranaki DHB Public Health Team

# Statement of Service Performance

**Percentage of infants who are fully or exclusively breastfed at six weeks**



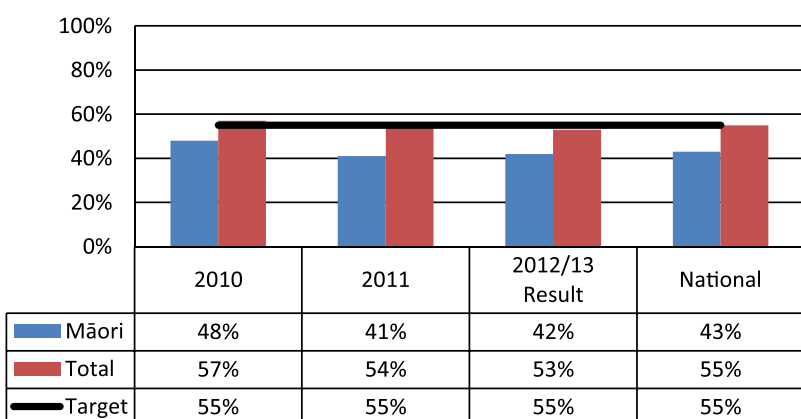
Data Source: National Plunket Data

**Increasing the number of infants who are exclusively breastfed at six weeks**

|       | 6 weeks      | 3 months     | 6 months     |
|-------|--------------|--------------|--------------|
| Māori | Not Achieved | Not Achieved | Not Achieved |
| Total | Not Achieved | Not Achieved | Not Achieved |

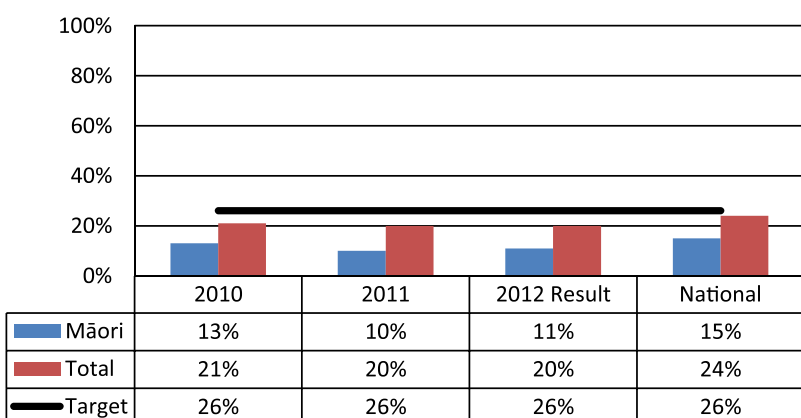
Taranaki DHB has yet to achieve against any of the nationally set breastfeeding targets. The Plunket results have been used as a proxy for the whole population as this data does not include our Tamariki Ora providers. During 2013/14 Ministry of Health aims to provide District Health Boards with a total population view. A new service was implemented in 2012/13 providing peer support to help encourage women to begin and maintain breastfeeding. Through this service we have worked with the Well Child/Tamariki Ora providers collectively to review breastfeeding rates on a quarterly basis. Looking to the future Taranaki DHB has gained additional funding for 2013/14 and 2014/15 for a Mama and Pepi Hauora programme which incorporates breastfeeding peer support into a wider service which includes healthy eating and activity during pregnancy and healthy first foods and physical activity for children at pre-school age. We aim to see an increase in the breastfeeding rates through these activities.

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



Data Source: National Plunket Data

**Percentage of infants who are fully or exclusively breastfed at six months**



Data Source: National Plunket Data



Hawera Oral Health Clinic Opening



Tainui Rest Home Senior Carer Pamela Hugill gives resident Elma Cochrane a spoon of sugar to help swallow the Vitamin D tablet.

Long Term Impact 2:

# PEOPLE STAY WELL IN THEIR HOMES AND COMMUNITIES

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

|                      |                                                    |                                                                                                      |                                                                |                                                    |
|----------------------|----------------------------------------------------|------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|----------------------------------------------------|
| Long Term Impact     | More people maintain their functional independence |                                                                                                      |                                                                |                                                    |
| Intermediate Impacts | Children and adolescents have better oral health   | Treatable conditions are detected early and people are better at managing their long term conditions | Fewer people are admitted to hospital for avoidable conditions | More people maintain their functional independence |

## Children and adolescents have better oral health

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

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

## Treatable conditions are detected early and people are better at managing their long term conditions

If we are to empower people to take greater responsibility for their health, to improve the health of our population and if we are to “contain costs” we have a significant opportunity by detecting conditions early. Early detection will lead to either successful treatment, or delaying or reducing the need for secondary and

# Statement of Service Performance

specialist care, enabling more people to stay well in their homes and communities for longer. Our greatest opportunity to do this is to manage Cardiovascular Disease (CVD or heart disease). It is one of the largest causes of death in New Zealand, and disproportionately higher for Māori. Often by the time heart problems are detected, the underlying cause of atherosclerosis (arterial disease) is usually well advanced. Our aim is to either prevent the disease by modifying risk factors such as healthy eating, exercise and avoiding smoking, or early detection and management.

## Fewer people are admitted to hospital for avoidable conditions

There are a number of admissions to hospital for conditions which are seen as avoidable through appropriate early intervention and a reduction in risk factors. As such, these admissions provide an indication of the effectiveness of screening, early intervention and community-based care. A reduction in these admissions will reflect better management and treatment of people across the whole system, will free up hospital resources for more complex and urgent cases and deliver on the Government's priority of "better, sooner, more convenient" healthcare. The key factor in reducing avoidable hospital admissions is an improved interface between primary and secondary services. Improving people's access to, and the effectiveness of, primary care will facilitate early interventions, particularly among Māori and Pacific people, which supports improving our population's health outcomes and reducing health inequalities for Māori.

## More people maintain their functional independence

If we are to deliver on our twin goals of improving health outcomes, and reducing or eliminating health inequalities, for our older population,

we aim to support people to maintain functional independence. With an increasing and ageing population, as this cohort increases, so does demand on our constrained funding. Aged Residential Care (ARC) is a specialist, high cost,

and scarce resource. We are looking to manage the expected growth in demand, through an ageing population, by improved models of care that support people to remain independent for as long as possible.

## HIGHLIGHTS FROM THE YEAR

### Community Oral Health Service

- The rollout of community hub facilities and mobile units is now complete with six fixed clinic sites and four mobile units travelling to high deprivation schools/areas to deliver care. The last mobile arrived and was operational by March 2013 and the final fixed clinic in Hawera was opened in March 2013.

**Gateway project** - A project that saw every child that was in, or came into, Child Youth and Family's (CYF) care assessed by a paediatrician. The children are also assessed to ensure they are up to date with immunisations. In addition they can then, if necessary, be referred onto specialist paediatrics, mental health, public health nurses and dental. In the first year of being underway with the Gateway project we have seen 100% of children who have come into CYF care and were in the first few hospitals in New Zealand to achieve this.

**B4 School Checks** - A programme run by the public health nurses, the objective is that every child has a full health check prior to starting school. Any gaps in their health care can then be managed with the objective that they are healthy and able to enter school ready to learn. Currently we have seen 80% of all eligible children. Of those seen 80% are high deprivation in terms of their wellbeing and health risks.

Molly Ryan, Maida Vale, Rhapsody and Tainui Rest homes have all **achieved a 100% prescribing rates for Vitamin D** supplementation, compared to a regional average of 70%.

Falls are a particular issue for older people living in aged residential care. A fall will often result in serious injury, reduced mobility and a loss of confidence and independence. ACC, DHBs and Primary Health Organisations are supporting a programme aimed at reducing falls in residential facilities by ensuring Vitamin D supplements are available to residents.

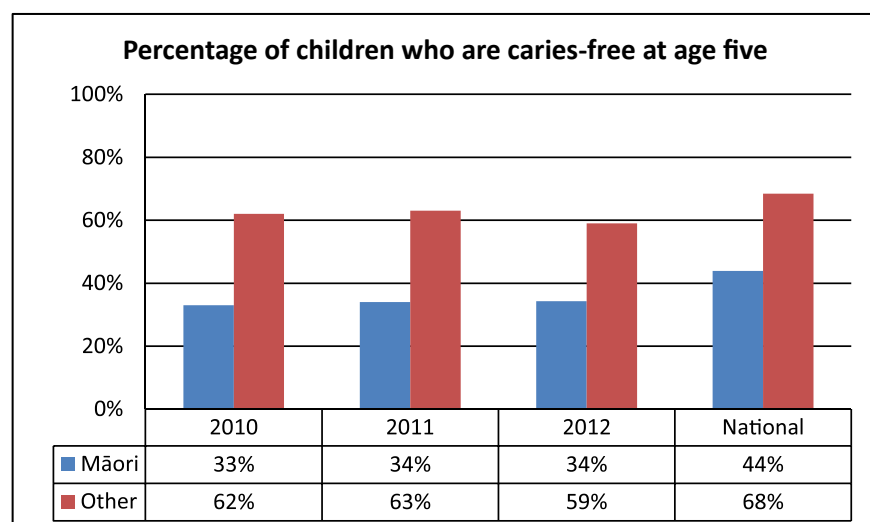
Taranaki continues to have the **highest uptake of cervical screening** in the country. Key activities that help to reach this goal include monthly meetings with practices with high needs patients, networking with practices with high Māori, Pacific and Asian enrolments, and Tui Ora Ltd Tamariki Ora registered nurses and Kaiawhina worked with occupational health nurses to assess workplaces and community based groups that have not been previously accessed.

July 2012 saw the implementation of the **Enhanced Intermediate Care for Older People** component of the Older Peoples Health Intermediate Care Service, which resulted in four contracted beds at Tainui Residential Care Facility. This service is targeted to those older people who would otherwise face an extended length of stay in acute inpatient services or prematurely enter residential care. Length of stay in the service is 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. To date 53 people have accessed the service that would otherwise have remained in a hospital bed.



## CHILDREN AND ADOLESCENTS HAVE BETTER ORAL HEALTH

### Impact Measures

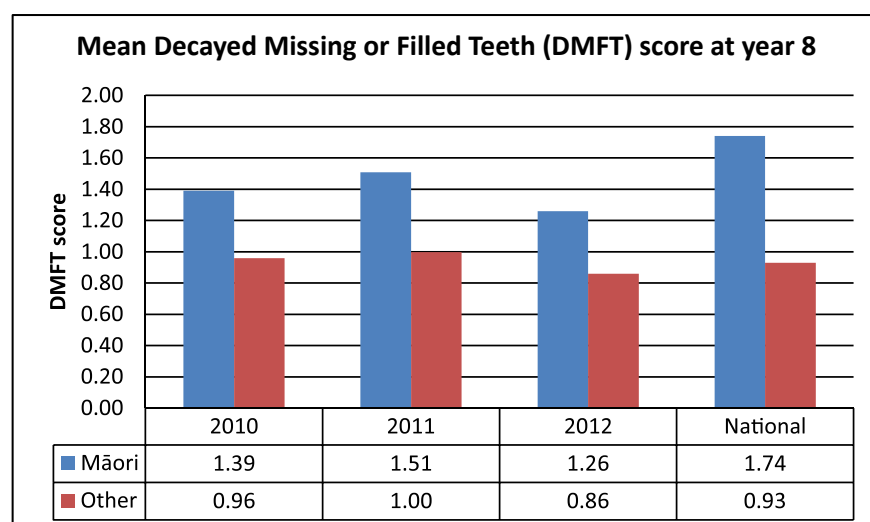


Data Source: Taranaki DHB Dental Patient Management System - Titanium. Statistics New Zealand Population Projection 2012

### Increase in percentage of children who are caries-free at age five

Caries is tooth decay mainly induced by diet. Children experiencing caries as infants or toddlers have a much greater probability of subsequent caries in primary and permanent teeth.

New Plymouth, the largest urban area in Taranaki removed fluoride from the reticulated water supply in December 2011. 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 effect such as providing toothpaste and toothbrushes to all 'at risk' children, targeted tooth brushing programme to low deciles and topical fluoride applications to high risk patients as per MoH guidelines.



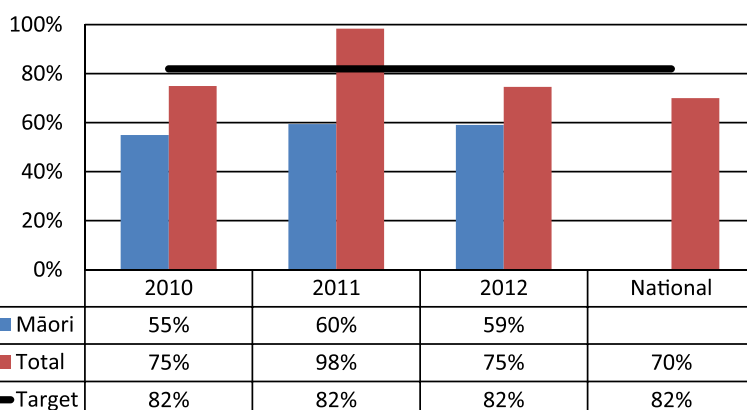
Data Source: Taranaki DHB Dental Patient Management System - Titanium. Statistics New Zealand Population Projection 2012

### Reduction in the mean DMFT score at year 8

DMFT is a count of Decayed, Missing or Filled Teeth in permanent dentition (permanent teeth) in a person's mouth. By year 8, children's teeth should be their permanent teeth and any damage at this stage is life long, so the lower a child's DMFT, the more likely that their teeth will last a life time. The rate of DMFT in Taranaki for Māori and total has gradually been decreasing over the last three years. Like the caries free at age 5 indicator DMFT in children at year 8 will be closely monitored in Taranaki over the next five years following the changes in community water fluoridation in New Plymouth (removal) and South Taranaki (extended to Patea and Waverley).

## Output Measures

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



Data Source: Taranaki DHB Dental Patient Management System - Titanium. Statistics New Zealand Population Projection 2012

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

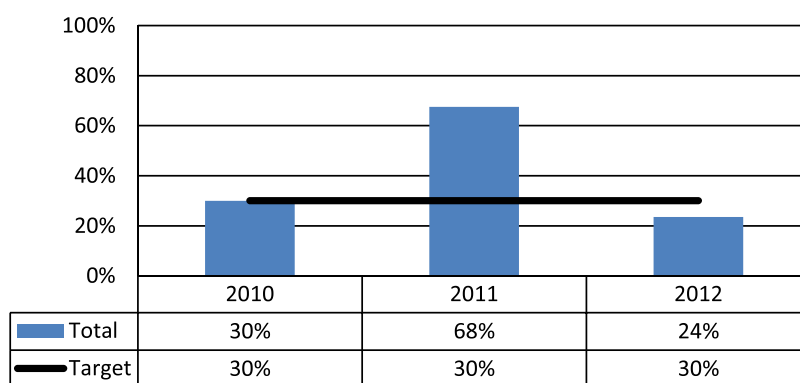
|       |              |
|-------|--------------|
| Māori | Not Achieved |
| Total | Not Achieved |

**A reduction in the inequalities gap between the percentage of Māori and other ethnicity 0-4 year olds enrolled with DHB funded dental service**

Achieved

Taranaki DHB has not enrolled the expected percentage of our children in the Community Dental service in 2012, but we have seen a reduction in the differential percentage of Māori and non-Māori children aged 0-4 who are enrolled. A project is underway to improve the enrolment rates across our region.

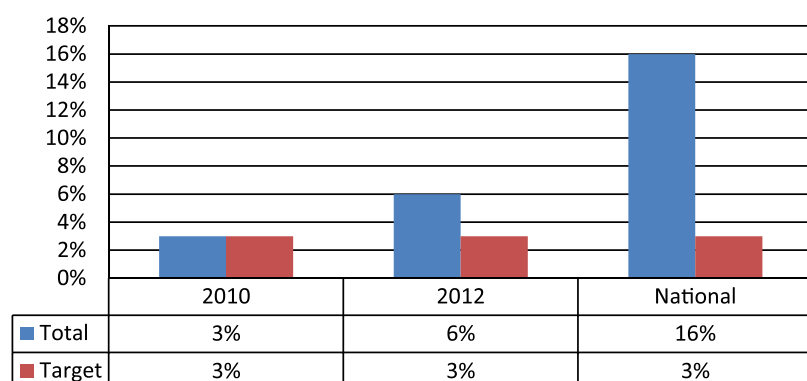
**Inequalities gap between the percentage of Māori and other ethnicity 0-4 year olds enrolled with DHB funded dental service**



Data Source: Taranaki DHB Dental Patient Management System - Titanium. Statistics New Zealand Population Projection 2012

# Statement of Service Performance

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



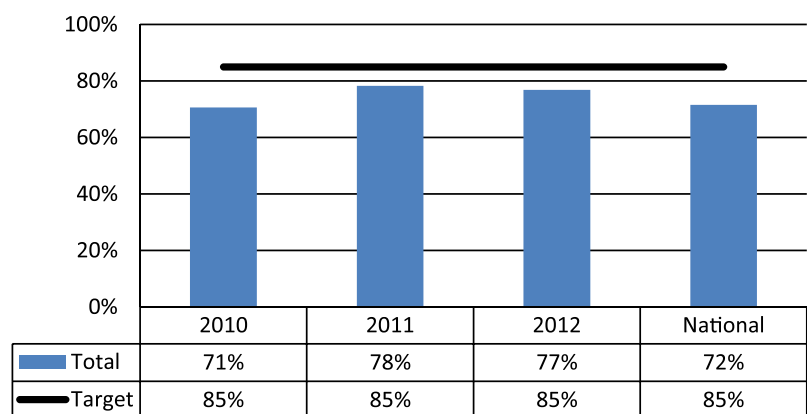
Data Source: Taranaki DHB Dental Patient Management System - Titanium. Statistics New Zealand Population Projection 2012

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

Total Not Achieved

Taranaki DHB has not met the target for 2012/13. The definitions for the measure have since been clarified by the Ministry of Health which resulted in a higher overdue percentage for Taranaki. We are unable to replicate historically. Even though our year end result is lower than the national result this is still an area of importance. Efforts have been focused on process enhancements to follow up on non-attendees.

## Percentage of adolescent utilisation of DHB funded dental services



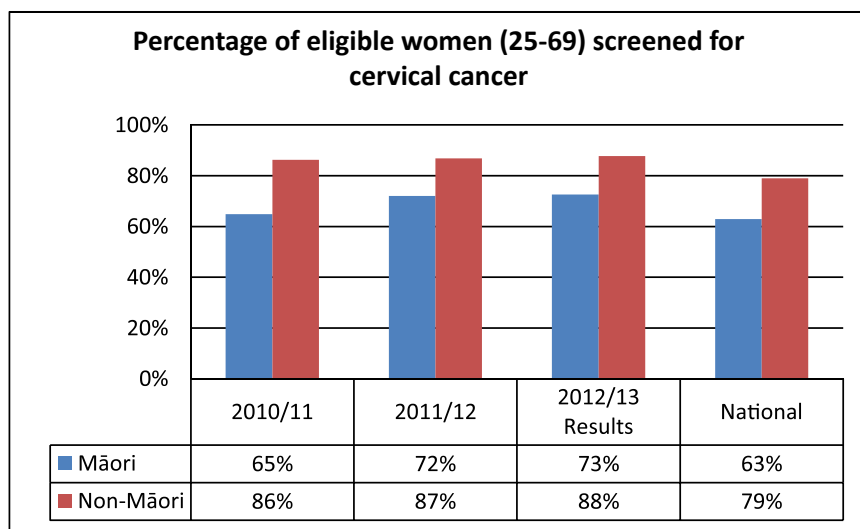
Data Source: DHB Provider Claims plus Taranaki DHB Dental Patient Management System - Titanium. Statistics New Zealand Population Projection 2012

## Percentage of adolescent utilisation of DHB funded dental services

Taranaki DHB funds dental services provided in the community for children in year 9 to youth aged 17 and under. The national target is for 85% of the adolescent population to access funded dental services. Although the target was not met for 2012, Taranaki DHB has consistently achieved better than the national average and will continue to monitor the activity in this area to ensure achievement in the future.

## TREATABLE CONDITIONS ARE DETECTED EARLY AND PEOPLE ARE BETTER AT MANAGING THEIR LONG TERM CONDITIONS

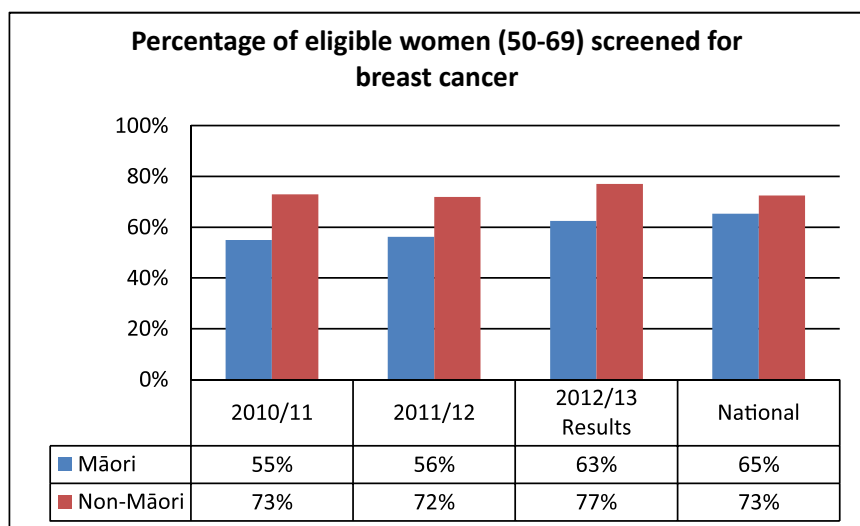
### Impact Measures



Data Source: National Screening Unit

#### Increased percentage of eligible women (25-69) screened for cervical cancer

Taranaki DHB's screening teams have been consistently achieving high coverage rates and for 2012/13 have the highest coverage rates in the country. We have also seen a decreasing gap in the rates between Māori and non-Māori.



Data Source: Breast Screening Aotearoa

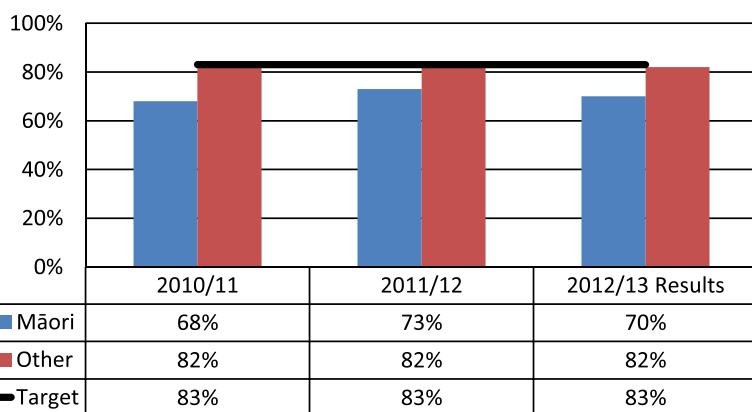
#### Increased percentage of eligible women (50-69) screened for breast cancer

Breast screening services in Taranaki are not provided by the District Health Board. We are, however, an active participant on the Central Cancer Network and also provide incentive payments to Primary Health Organisations to achieve higher rates of breast screening for their eligible patients. There has been a service delivery gap in north Taranaki which has been recently filled meaning easier access to more women to receive services.



# Statement of Service Performance

**Proportion of people with well managed diabetes  
(HbA1c ≤ 64mmols/mol)**



Data Source: Primary Health Organisation (PHO) reporting

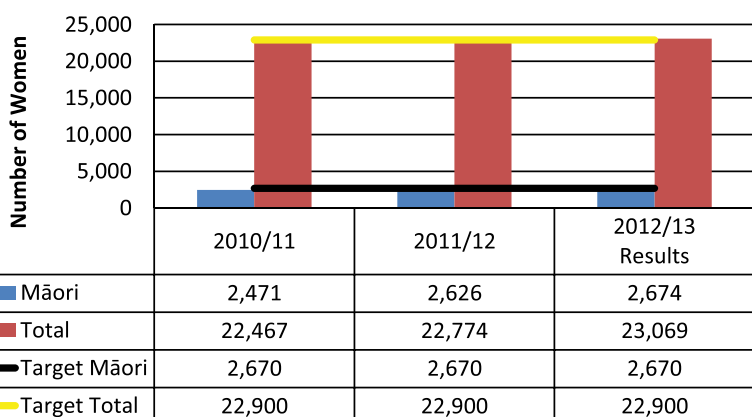
## Increase the proportion of people with well managed diabetes

|       |              |
|-------|--------------|
| Māori | Not Achieved |
| Other | Not Achieved |

Over time, diabetes can damage the heart, blood vessels, eyes, kidneys, and nervous system. Ensuring that our diabetic population manages their condition well has a huge impact on long term social and physical well-being. Good management also ensures that people are less likely to require early acute intervention. One way in which management can be measured is by recording the percentage of people with a blood glucose level of ≤ 64mmols/mol. Although Taranaki DHB has not achieved the desired result in 2012/13 there are plans being implemented in 2013/14 to change the model of care for those patients who are most at risk of various long-term conditions including diabetes and we expect improved patient outcomes to be demonstrated.

## Output Measures

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



Data Source: National Screening Unit

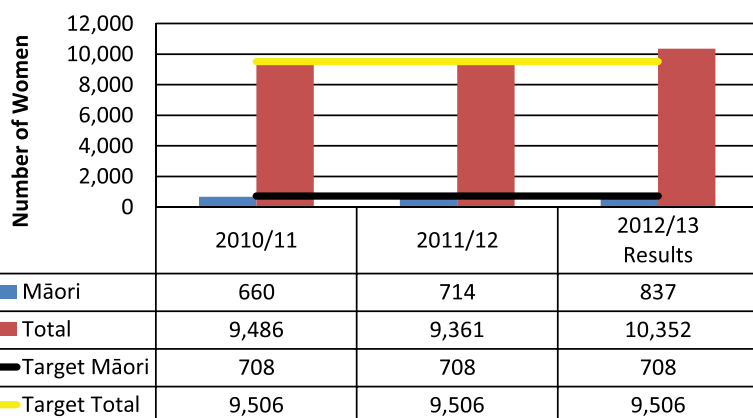
## Number of eligible women (25-69) who have a cervical cancer screen every three years

|       |          |
|-------|----------|
| Māori | Achieved |
| Total | Achieved |

As well as achieving higher cervical screening coverage rates Taranaki DHB has met the targets for the number of women we wanted to see screened for 2012/13. The increasing number of Māori is particularly pleasing reflecting the considerable efforts of our screening team.

# Statement of Service Performance

**Number eligible women (25-69) who have a breast screen every three years**



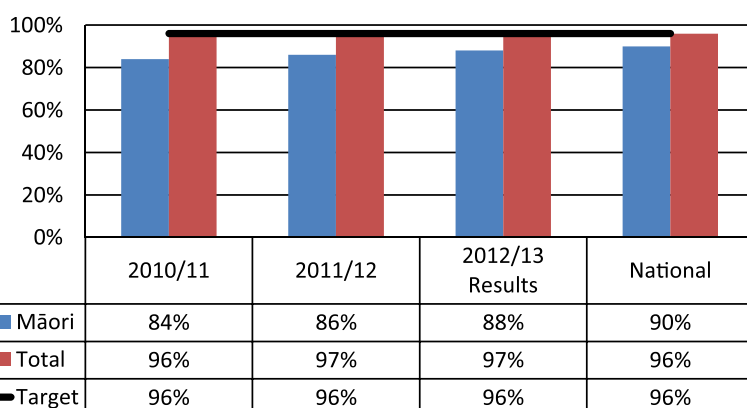
Data Source: Breast Screening Aotearoa

**Number of eligible women (50-69) who have had a breast screen**

|       |          |
|-------|----------|
| Māori | Achieved |
| Total | Achieved |

Taranaki DHB achieved against the expected number of eligible women who had a breast screen. 27% more Māori and 9% total population received a breast screen in 2012/13 than in 2010/11 which resulted in a closing of the inequality gap in terms of access.

**Percentage of population enrolled with a Primary Health Organisation**



Data Source: Ministry of Health PHO Enrolment Collection

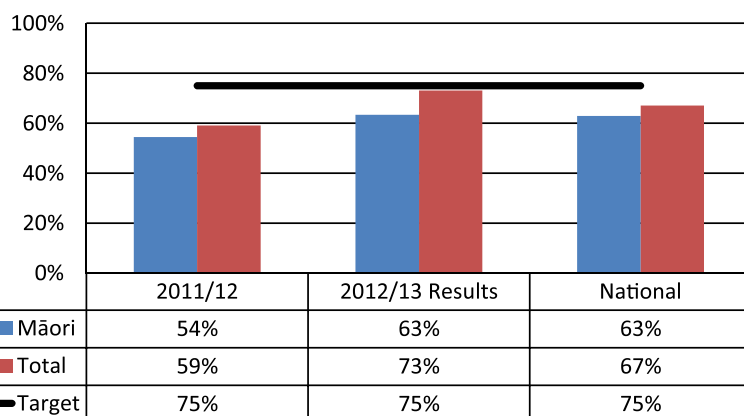
**Percentage of population enrolled with a Primary Health Organisation (PHO)**

|       |              |
|-------|--------------|
| Māori | Not Achieved |
| Total | Achieved     |

Access to primary care has been shown to have positive benefits in maintaining good health. It can reduce the economic cost of ill health by intervening early therefore we wish to see an increasing percentage of the population enrolled with a Primary Health Organisation. Taranaki DHB, in partnership with the Midland Health Network and National Hauora Coalition, has achieved the total target but not the Māori target. However we have seen a steady increase in the proportion of our Māori population being enrolled.

# Statement of Service Performance

**Percentage of eligible population who have their CVDRA check completed within the last five years**



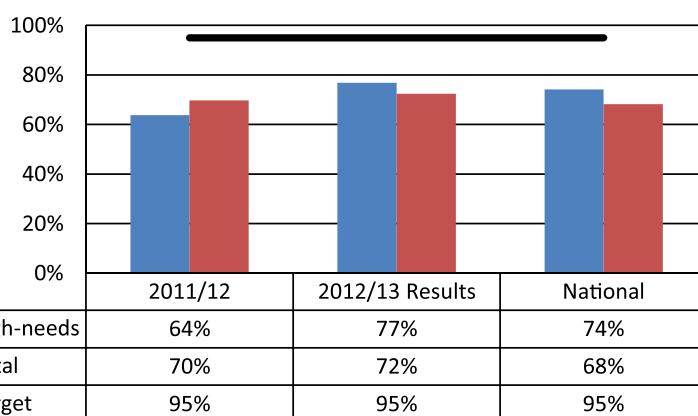
Data Source: Primary Health Organisation Performance Programme (PPP)

**Percentage of eligible population who have their Cardiovascular Disease Risk Assessment (CVDRA) check completed within the last five years**

|       |              |
|-------|--------------|
| Māori | Not Achieved |
| Total | Not Achieved |

Cardiovascular disease is one of the leading causes of mortality in New Zealand. Detecting and assessing risks early will enable individuals to receive support and advice in order that they can manage their health. Although Taranaki DHB did not achieve the national target of 75% we have seen a considerable improvement over the last 12 months. We are working with our primary partners to implement pathways to ensure that long term conditions are detected early and managed well, which will contribute towards the continuation of our performance.

**Percentage of diabetic reviews completed against the population expected to have been diagnosed with diabetes**



Data Source: Primary Health Organisation Performance Programme (PPP)

**Percentage of diabetic reviews completed against the population expected to have been diagnosed with diabetes**

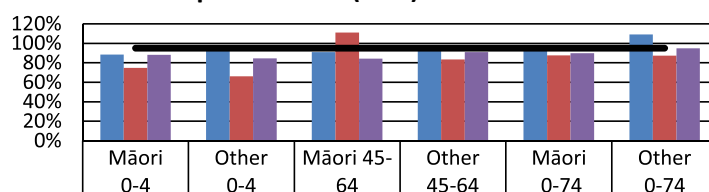
|            |              |
|------------|--------------|
| High-needs | Not Achieved |
| Total      | Not Achieved |

In New Zealand, it is estimated that the number of people diagnosed with diabetes exceeds 200,000 people (predominantly type 2 diabetes). There are also about 100,000 people who have diabetes but have not yet had it diagnosed. If we are to help to support people manage their conditions we must ensure that we have good detection systems in place. Although we have not reached our 2012/13 target there are plans in place for 2013/14 to implement a new clinical tool to aid GPs to detect and manage various long term conditions including diabetes.

## FEWER PEOPLE ARE ADMITTED TO HOSPITAL FOR AVOIDABLE CONDITIONS

### Impact Measures

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



|                | Māori 0-4 | Other 0-4 | Māori 45-64 | Other 45-64 | Māori 0-74 | Other 0-74 |
|----------------|-----------|-----------|-------------|-------------|------------|------------|
| 2010/11        | 89%       | 98%       | 91%         | 96%         | 93%        | 109%       |
| 2011/12        | 75%       | 66%       | 111%        | 84%         | 88%        | 87%        |
| 2012/13 Result | 88%       | 85%       | 84%         | 91%         | 90%        | 95%        |
| 2012/13 Target | 95%       | 95%       | 95%         | 95%         | 95%        | 95%        |

Data Source: Ministry of Health National Minimum Dataset

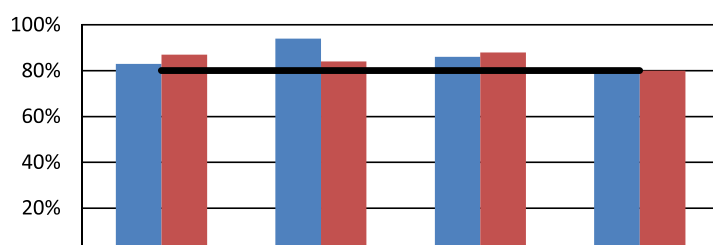
### Remain at or below 95% of the National Ambulatory Sensitive hospitalisation rate

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

Reducing Ambulatory Sensitive Hospital admissions (ASH) will help to demonstrate that patients who need services that can be provided in community settings receive them there rather than at hospitals. This will free up hospital staff and resources for more acute and urgent cases while also ensuring the services being funded in the community, including primary care, are easily accessed and are effective. During 2012-13 the DHB implemented free after hours access to primary care for the under sixes. All targets have been met for 2012/13.

### Output Measures

**Percentage of eligible population have their Before School Checks completed**



|            | 2010 | 2011 | 2012 Result | National |
|------------|------|------|-------------|----------|
| High Needs | 83%  | 94%  | 86%         | 80%      |
| Total      | 87%  | 84%  | 88%         | 80%      |
| Target     | 80%  | 80%  | 80%         | 80%      |

Data Source: National Immunisation Register

### 80% of eligible population have their Before School Checks completed

|            |          |
|------------|----------|
| High Needs | Achieved |
| Total      | Achieved |

The B4 School Check is a nationwide programme offering a free health and development check for four year olds. The programme aims to identify and address any health, behavioural, social, or developmental concerns which could affect a child's ability to get the most benefit from school, such as a hearing problem or communication difficulty. Taranaki DHB has achieved against both the high needs and total targets and is a high performing DHB in this area.

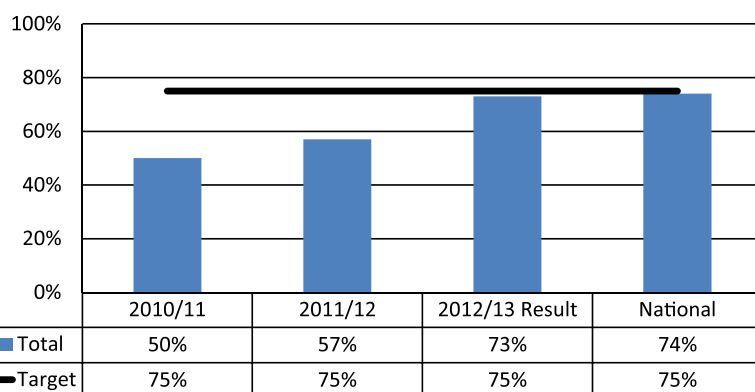
# Statement of Service Performance

## 80% of eligible population engaged in the DHB funded Well Child/Tamariki Ora Programme.

NOT AVAILABLE

The majority of Well Child services are held between the Ministry of Health and Plunket with Taranaki DHB holding a contract for a local Tamariki Ora provider. Data collection processes are underway at the Ministry of Health which will enable Well Child/Tamariki Ora reporting at a total population level. This will not be available until January 2014.

### Percentage of Rest Home residents receiving vitamin D supplement from their GP



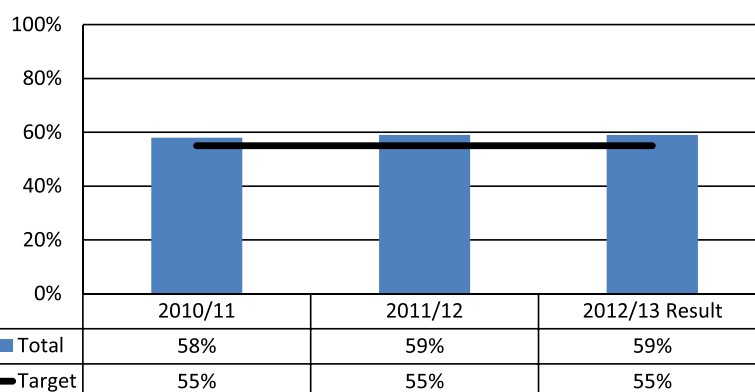
Data Source: Ministry of Health DHB claiming data

### 75% of rest home residents receive vitamin D supplement from their GP 75% of rest home residents receive vitamin D supplement from their GP

Not Achieved

Although Taranaki DHB has not achieved against the national target of 75% of rest home residents receiving vitamin D supplements from their GPs, we have seen a huge improvement over the last two years. This is reflective of the hard work that has locally gone into promoting the benefits of vitamin D which has been demonstrated to improve mineral bone density and reduce falls.

### Percentage of triage level 4 & 5s presenting to the Emergency Department



Data Source: National Non-admitted Patient Collections

### 55% of triage level 4 & 5s presenting to the Emergency Department

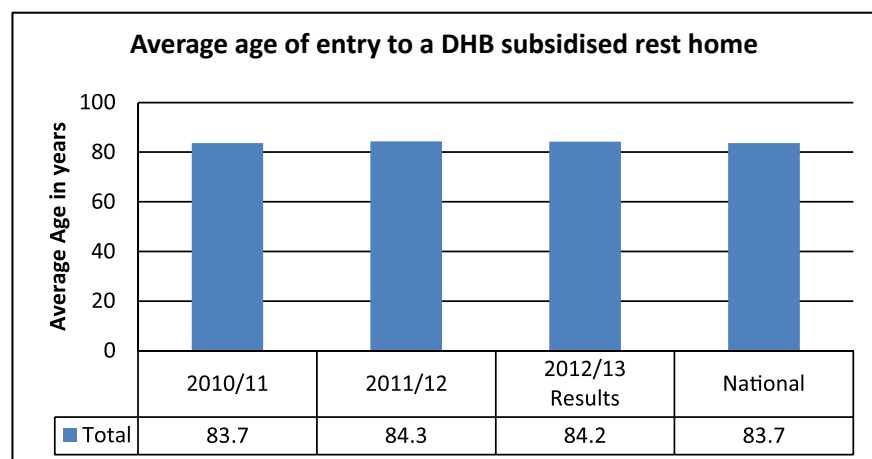
Not Achieved

Triaging is the assessment of patients on their arrival to decide on how urgent their injury or illness is and how soon treatment is required. Triage category 1 patients are very urgent, while triage category 5 patients are less urgent. We expect that enhancements in service models in primary care will result in a reducing proportion of people attending our emergency departments at levels 4 and 5. Although we have yet to see this eventuate for 2012/13 we are working with the Midland Health Network to address this.



## PEOPLE MAINTAIN THEIR FUNCTIONAL INDEPENDENCE

### Impact Measures



Data Source: Ministry of Health DHB Claiming data

#### **Increase the average age of entry to a DHB subsidised rest home**

We are looking to manage the expected growth in demand, through an ageing population, by improved models of care that support people to remain independent for as long as possible. Ideally, we would like to promote a model of care that reduces the proportional length of time an older person requires Aged Residential Care (ARC). As we do not currently capture this information, our best proxy indicator is to increase the average age at which an older person enters ARC. Taranaki's population on average enters a rest home at a slightly older age compared to the national average age.

### Output Measures

|        | 2010/11              | 2011/12             | 2012/13 Target       | 2012/13 Results     |
|--------|----------------------|---------------------|----------------------|---------------------|
| Result | \$1 HBSS = \$2.29 RC | \$1 HBSS = \$2.5 RC | \$1 HBSS = \$2.28 RC | \$1 HBSS = \$2.5 RC |

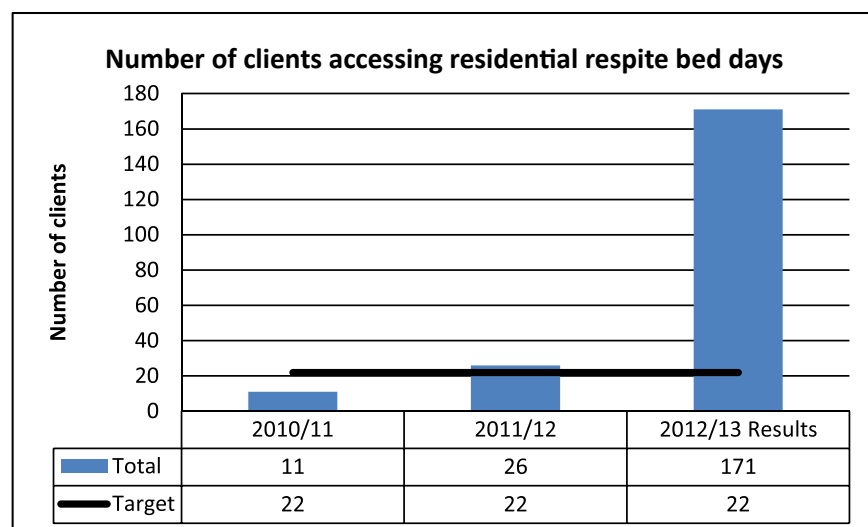
Data Source: Local Accounting System

#### **For those with aged related and chronic health conditions we will reduce the rate of Residential Care (RC) to Home Based Support Service (HBSS) funding**

Not Achieved

To reflect a desire to provide a model of aged care in the community which enables people to stay in their homes for longer we wanted to see a reduction of the Aged Residential Care (ARC) expenditure proportionally to the Home Based Support Services. We did not quite meet the budget expectation due mainly to the fact the implementation of the restorative model of care has been delayed to align with a Midland Regional approach. This is due to be rolled out during 2013/14.

# Statement of Service Performance

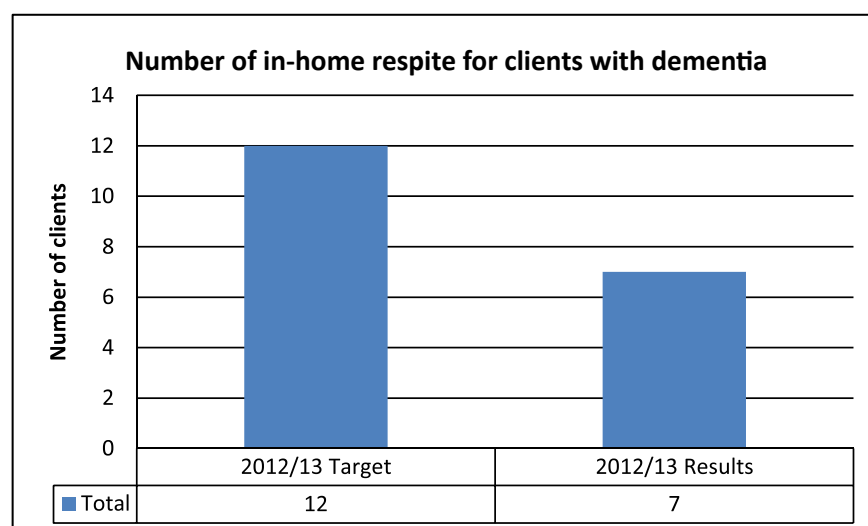


Data Source: Ministry of Health DHB Claiming data

## 22 clients accessing residential respite bed days

Achieved

Taranaki DHB achieved a significant increase in the number of clients accessing residential respite services during 2012/13. This is mainly due to the fact that our needs assessment and coordination team have been encouraging clients who are eligible for carer support to use the option of residential respite which reduces the need for clients to pay top up fees and therefore improves access to residential based respite. We have also invested in additional dementia field officer hours aimed at working with carers and promoting the use of residential respite services which has had a positive effect on uptake of all respite services.

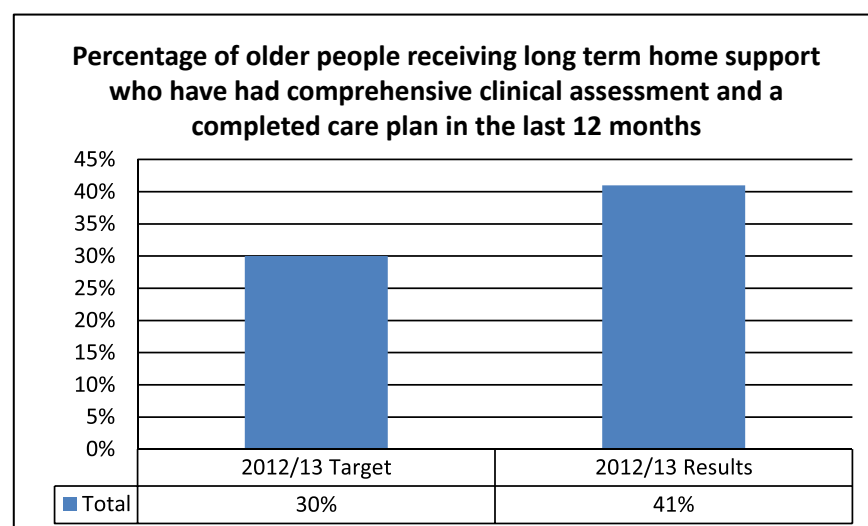


Data Source: Ministry of Health DHB Claiming data

## 12 dementia clients provided with in-home respite

Not Achieved

The in-home respite service for carers of people with dementia is new for 2012/13. Although the anticipated number of clients has yet to be achieved we expect that as the service becomes more established the number of clients will increase. This result has also been partially offset by the significant increase in residential respite services.



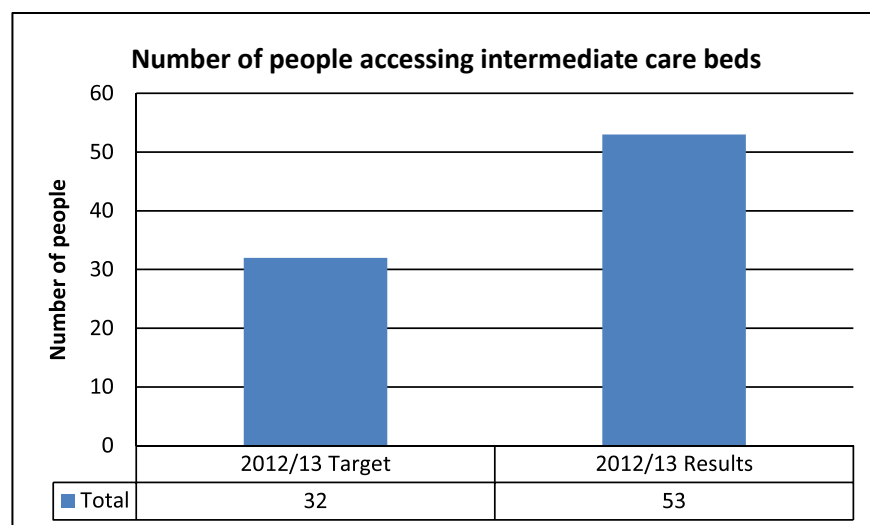
Data Source: InterRAI and Ministry of Health DHB Claiming data

## 30% of older people receiving long term home support who have had comprehensive clinical assessment and a completed care plan in the last 12 months

Achieved

The comprehensive clinical assessments are undertaken using an internationally accepted tool called InterRAI which uses a standard criteria. InterRAI was implemented in Taranaki DHB during the latter half of 2011/12. All new clients who are eligible for DHB funded Aged Related services are now required to receive an InterRAI assessment, also are clients who are re-assessed for their needs.

# Statement of Service Performance

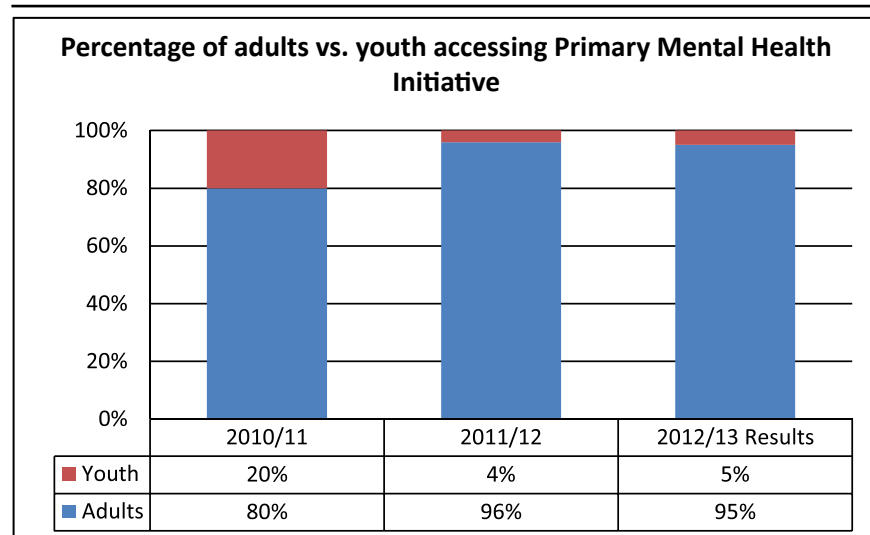


Data Source: Taranaki DHB Patient Management System

## 32 people accessing enhanced intermediate care beds

### Achieved

Intermediate care, implemented during 2012/13 is targeted to those older people who would otherwise face an extended length of stay in acute inpatient services. The service is designed to facilitate the transition from hospital to home. The estimated number of people who would access this service was exceeded meaning that more people avoided long stays in a hospital setting.

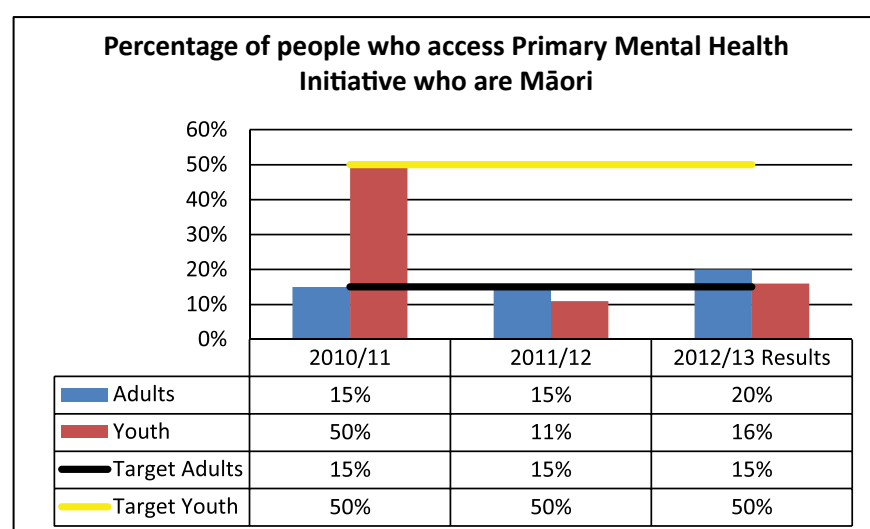


Data Source: Contract Reporting

## Percentage of people accessing Primary Mental Health Initiative

|        |     |              |
|--------|-----|--------------|
| Adults | 80% | Not Achieved |
| Youth  | 20% | Not Achieved |

The Primary Mental Health Initiative is funded to increase the availability of services in Primary Health Organisations for patients with mild to moderate mental health issues. We were expecting that the number of youth accessing the service would be maintained during 2012/13 however this was not achieved. The local youth specific provider of this service ceased providing health services during 2012/13 which accounted for the decrease. Taranaki developed a Taiohi Strategy during 2012/13 which included a review of options to increase youth engagement with primary care. We expect that future delivery models will achieve this.



Data Source: Contract Reporting

## Percentage of people who access Primary Mental Health Initiative who are Māori

|        |     |              |
|--------|-----|--------------|
| Adults | 20% | Achieved     |
| Youth  | 16% | Not Achieved |

The number of Māori adults who are accessing Primary Mental Health Initiatives (PMHI) has increased during 2012/13 and we have achieved expectations. As mentioned above the main provider of youth specific primary care services ceased. A high proportion of the clients who access these services were Māori accounting for the dramatic decline in the percentage of Māori who accessed PMHI in 2012/13.



Staff participate in The Productive Operating Theatre workshop

### Long Term Impact 3:

## PEOPLE RECEIVE TIMELY AND APPROPRIATE CARE

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

|                      |                                                               |                                                     |                                                                                        |                                                                   |
|----------------------|---------------------------------------------------------------|-----------------------------------------------------|----------------------------------------------------------------------------------------|-------------------------------------------------------------------|
| Long Term Impact     | People receive timely and appropriate care                    |                                                     |                                                                                        |                                                                   |
| Intermediate Impacts | People receive prompt and appropriate acute and arranged care | People have appropriate access to elective services | Improved health status for people with a severe mental health illness and/or addiction | More people with end-stage conditions are appropriately supported |

### People receive prompt and appropriate acute and arranged care

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

### People have appropriate access to elective services

Elective services are an important part of the health system, as they improve a patient’s quality of life by reducing pain or discomfort and improving independence and wellbeing. The Government wants more New Zealanders to have access to elective surgical services

(see Health Targets at [www.tdhub.org.nz](http://www.tdhub.org.nz)). Improved performance against this measure is also indicative of improved hospital productivity to ensure the most effective use of resources so that wait times can be minimised and year-on-year growth is achieved.

### Improved health status for people with a severe mental health illness and/or addiction

It is estimated that at any one time, 20% of the New Zealand population will have a mental illness or addiction, and 3% are severely affected by mental illness. The World Health Organisation (WHO) predicts that depression will be the second leading cause of disability by 2020. We have an ageing population, which places increased demand from people over 65 for mental health services appropriate to their life stage. The prevalence of mental illness in the

population increases with age, and older people have different patterns of mental illness, often accompanied by loneliness, frailty or physical illness.

### More people with end-stage conditions are appropriately supported

For people in our population who have end stage conditions, it is important that they, their family and whānau are supported to cope with the situation. Our focus is on ensuring that the patient is able to live comfortably, without undue pain or suffering. Early identification and recognition of end-of-life choices heavily influence the quality of life and individual experiences during the dying process. Rehabilitation and Support Services contribute to this impact. Programmes include palliative care, aged residential care, respite care and home based support services.

## HIGHLIGHTS FROM THE YEAR

**Taranaki Palliative Care Plan** - The vision for the Taranaki Palliative Care Plan is an integrated and co-ordinated palliative care service which provides all people with palliative care needs, their families and whānau, equitable access across Taranaki to an appropriate level and quality of palliative care services, provided in a culturally appropriate way. Palliative care is an approach which aims to optimise a person's quality of life until death by addressing the person's physical, psychosocial, spiritual and cultural needs; and supporting their family, whānau, and other caregivers where needed. This plan was developed using a consultation approach, which included both consumers and providers, to identify strengths and gaps in existing services. The plan seeks to build on existing services to meet future needs.

**The preadmission process** for ensuring patients are well informed and fit before surgery has been successfully redesigned. There are a broader range of options for preadmission assessment including telephone assessment, high risk clinics and on-the-day nurse assessment which has increased convenience for patients and better aligned clinical staff time to the patients who need it the most.

**Enhanced recovery pathways** bring together the best clinical evidence to optimise the patient outcome from pre-operative education right to theatre process, to inpatient stay, to recovery at home. Enhanced recovery pathways have been introduced for both colorectal and hip and knee joint replacement surgery. Early audit results show decreasing length of stay for these patients alongside decreased complications post-surgery and increased patient satisfaction and understanding of their surgery. The implementation of ERAS for colorectal

patients has also contributed to the DHB's success in reducing the number of patients admitted the day before surgery - over 90% of all surgical patients are now admitted on the same day they receive surgery.

**Patients get a heads up on their orthopaedic surgery** - Taranaki Base Hospital held its first pre-operative education class for patients in September 2012. The class was aimed at patients, and their carers and family, who are scheduled for total hip or knee replacements. Its purpose was to provide them with more detail on their surgery, what to expect and to answer any questions. The class was run by a team of health professionals and prepared patients for each step along the patient journey.

**The Productive Operating Theatre (TPOT)** continues to run with staff groups across the hospital. New initiatives started include - use of an electronic whiteboard for management of acute surgical patients, use of the 5S tool (sort, set, shine, structure, sustain) to present a well organised theatre, use of a revised pre-operative checklist, and revised arrangements with suppliers and stores around the types and quantity of equipment and consumables provision.

The above combination of improvement work through surgical projects and continued hard work of the DHB's administrative teams has led to the following performance improvements:

- Decreasing length of stay
- Increased Day Of Surgery Admission (DOSA) rate
- No patients waiting longer than five months for surgery (first DHB to achieve this in New Zealand)
- Improved patient satisfaction

**Intensive Psychiatric Care Unit Redesign/Refurbishment** - In 2012 the Taranaki DHB Facilities Committee gave the go ahead to upgrade this 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.

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 DHB Clinical Board** led by local clinicians has been operating since June 2009. Its role includes ensuring the DHB has appropriate systems in place for good quality clinical practice. It also aims to promote collaborative clinical projects between the primary and secondary sectors, and provides advice to the DHB on clinical governance issues. The Clinical Board is pleased to note several achievements during 2012-2013. These include:

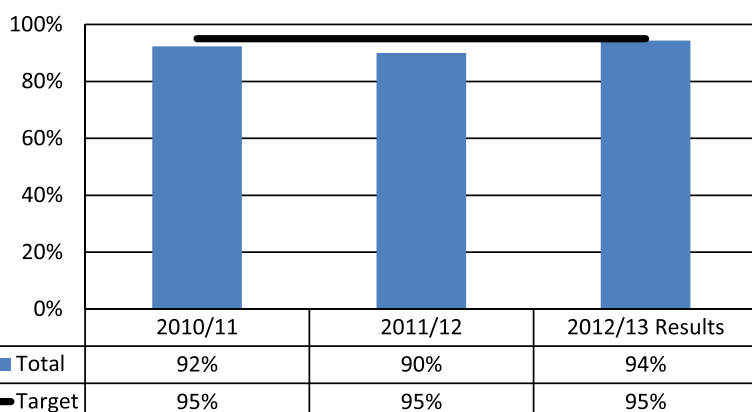
- The establishment of the Clinical Ethics Advisory Group under the Acting Chair, Dr Gail Riccitelli.
- A new policy on "Clinical Management of Tests and Investigation Results".
- An update of the "Not for CPR" policy.
- Annual Reports from Departments to the Clinical Board have been extended to include Nursing and Allied Health.
- All committees reporting to the Clinical Board now have medical staff representation.
- Increase in flu vaccination uptake from staff during the 2013 flu season.
- Clinical Board overseeing the production of the new "Quality Accounts" developed by the Health Quality & Safety Commission, to be published by all DHBs during 2013.
- Approved the Quality & Risk Strategic Plan 2012 – 2015 and performance against this will form the basis of the Quality Accounts.



## PEOPLE ARE SEEN PROMPTLY FOR ACUTE CARE

### Impact Measures

Percentage of patients will be admitted, discharged, or transferred from an emergency department within six hours



Data Source: Taranaki DHB Patient Management System

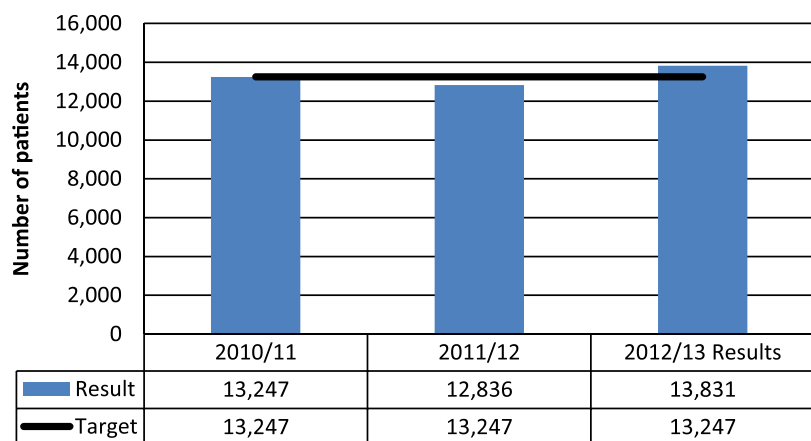
**95% of patients will be admitted, discharged, or transferred from an emergency department within six hours**

Not Achieved

The duration of stay in the Emergency Department (ED) is influenced by the number and severity of cases presenting to the service. The types of cases may also require a clinical treatment protocol to be followed which keeps the patient in ED. Reduced waiting times in ED is indicative of a co-ordinated 'whole of system' response to the urgent needs of the population. Therefore the number of inappropriate presentations from the community is significant. The ability of inpatient wards to receive patients also affects the length of time the patients spend waiting. While Taranaki DHB did not achieve the target for the full year we have shown improvement from the 2010/11 result and in fact achieved 96% in quarter four.

### Output Measures

Number of acute inpatient presentations



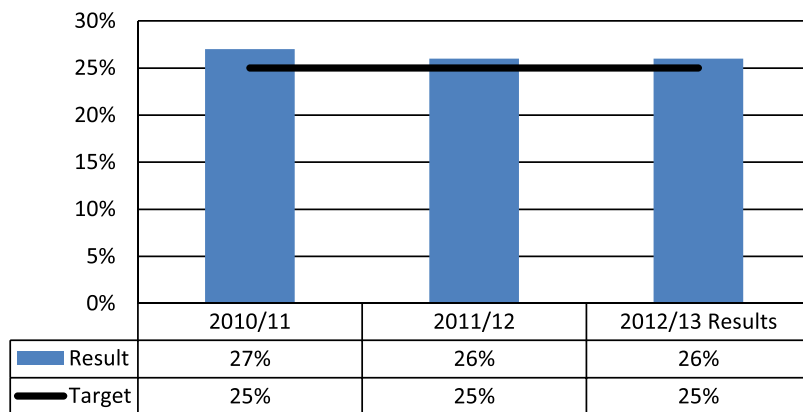
Data Source: National Minimum Dataset (NMDS)

**13,247 acute inpatient presentations**

Not Achieved

Taranaki DHB saw an increase in the number of acute inpatient presentations in 2012/13. We are working with our primary partners to review options on how acute care pathways can be managed in the future. We envisage that this will result in patients being treated closer to home as well as seeing a reduction in acute hospital demand.

## Percentage of Emergency Department presentations that are admitted



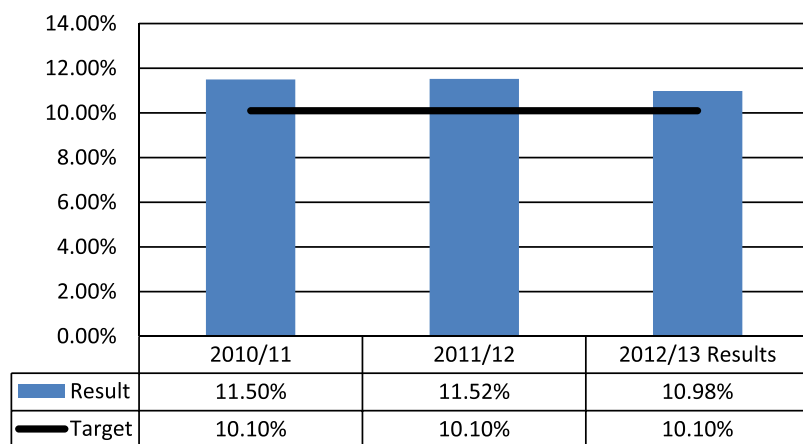
Data Source: National Non-Admitted Patient Collection (NNPAC)

## 25% of Emergency Department presentations that are admitted

### Achieved

Primary and secondary care are working together to explore and increase the options for acute care to be provided in the community. As these options are implemented we would expect that the proportion of cases presenting to our Emergency Department will require more complex care and therefore the need for admitting will increase.

## Acute readmission rate



Data Source: National Minimum Dataset (NMDs)

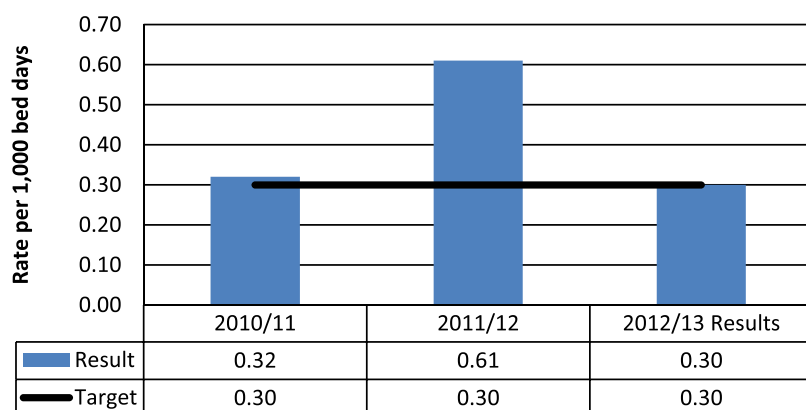
## Acute readmission rate 10.10%

### Not Achieved

An unplanned acute hospital readmission may often (though not always) occur as a result of the care provided to the patient by the health system. Reducing unplanned acute admissions can therefore be interpreted as an indication of improving quality of acute care, in the hospital and/or primary care, and ensuring that people receive timely and appropriate health and disability services. Although we have not achieved against the target we have seen a positive reduction in 2012/13.

# Statement of Service Performance

## The rate of hospital acquired bloodstream infections per 1,000 bed days



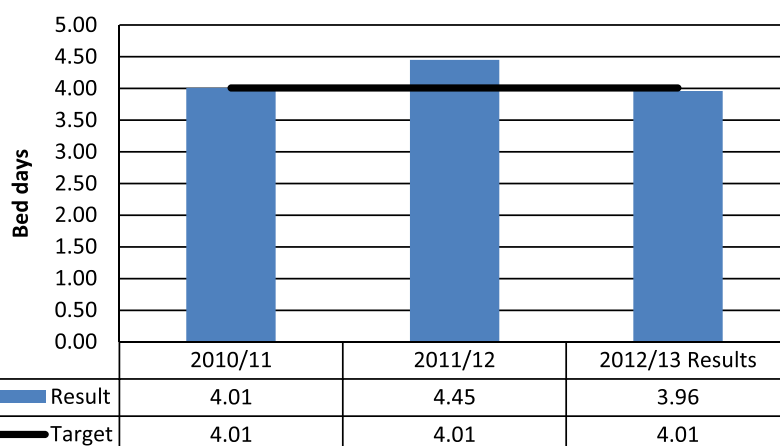
Data Source: Taranaki DHB Patient Management System

**The rate of hospital acquired bloodstream infections is less than 0.3 per 1,000 bed days**

Achieved

Hospital acquired infections are an important and often preventable cause of morbidity, mortality and cost. There were 19 blood stream infections recorded in 2012/13 compared to 21 in 2010/11.

## Inpatient average length of stay



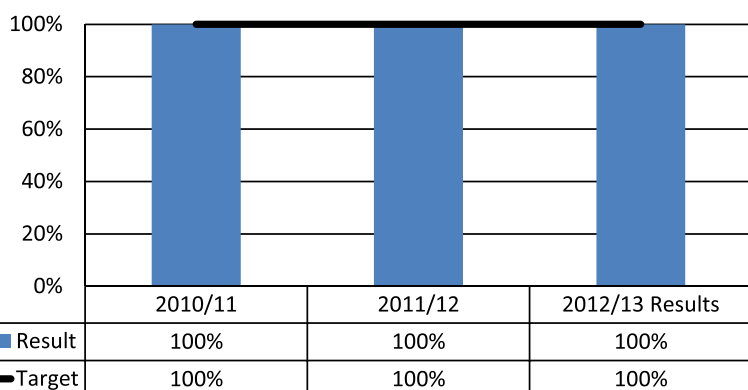
Data Source: National Minimum Dataset (NMDs)

**Inpatient average length of stay reduced**

Achieved

A patient's length of stay is impacted by numerous factors, such as reducing readmissions, and increasing integration activities that strengthen the ability of primary care to treat people more appropriately in the community. Supporting patients to return home sooner may, in part, be achieved by reducing the rate of patient complications and better use of the time clinical staff spend with patients. Patients will also be less at risk of contracting nosocomial (or hospital-acquired) infections. The enhanced intermediate care programme for older people is one example where we have introduced a community based service which has impacted on reducing average inpatient length of stay.

## Radiation oncology and chemotherapy wait times are within four weeks of being ready for treatment.



Data Source: Mid-Central DHB Patient Management System

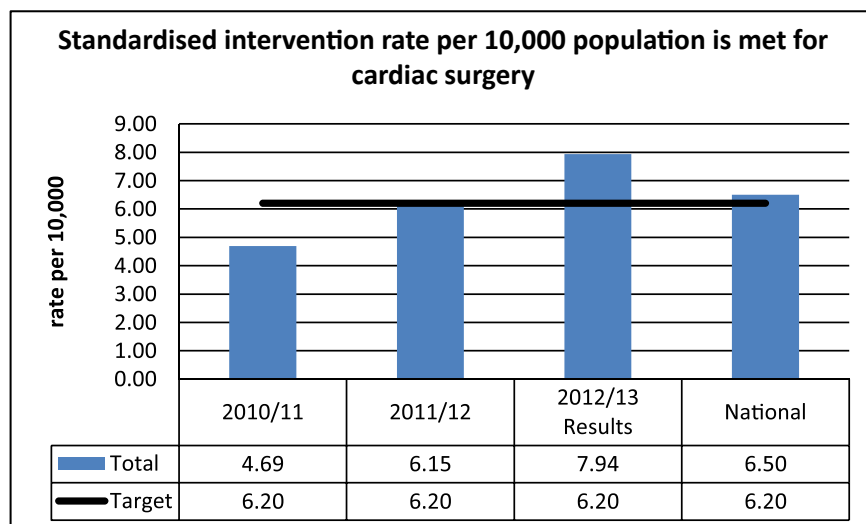
**100% radiation oncology and chemotherapy wait times are within four weeks of being ready for treatment**

Achieved

Radiotherapy and inpatient chemotherapy treatment is provided in Palmerston North by Mid-Central DHB for Taranaki patients and requires good collaboration between the two DHBs to continuously meet the target of ensuring all patients are seen within expected timeframes. Other chemotherapy is undertaken locally at Taranaki Base Hospital.

## PEOPLE HAVE APPROPRIATE ACCESS TO ELECTIVE SERVICES

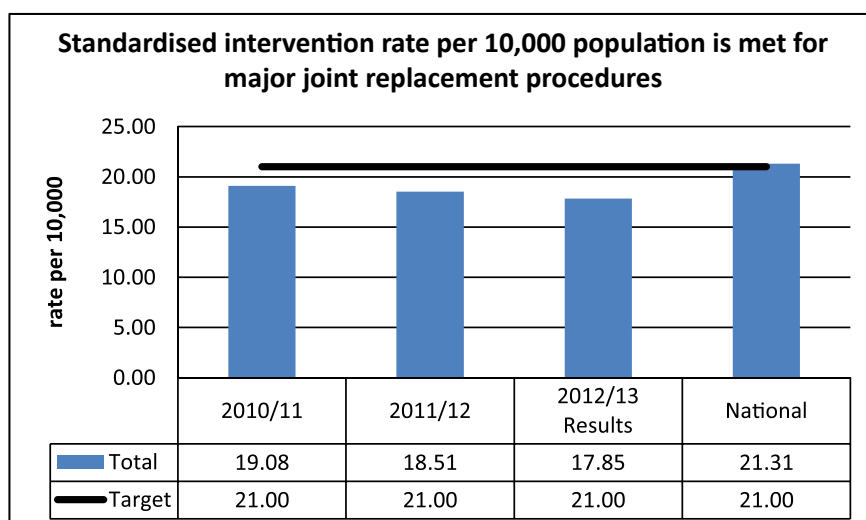
### Impact Measures



Data Source: National Minimum Dataset (NMDs)

#### Standardised intervention rate of 6.5 per 10,000 population is met for cardiac surgery

Meeting standard intervention rates for a variety of types of surgery means that access is fair, and not dependent upon where a person lives. Taranaki has a higher rate than nationally but is not significantly higher. The vast majority of cardiac surgery is performed in Waikato for the people of Taranaki. A Midland Cardiac group has been established to ensure quality care and equity of access across the region.



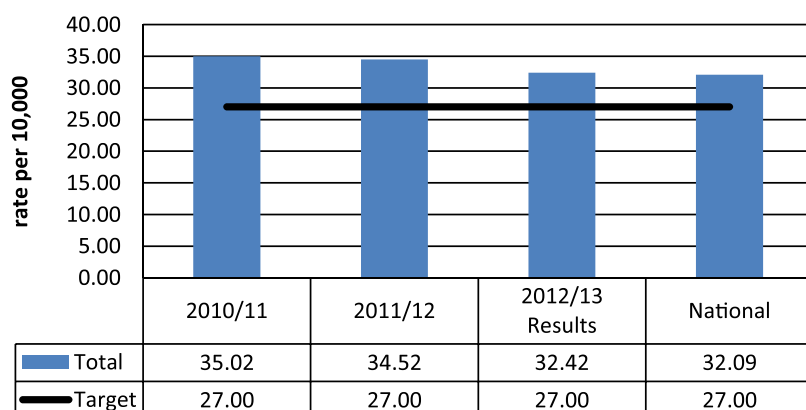
Data Source: National Minimum Dataset (NMDs)

#### Standardised intervention rate of 21 per 10,000 population is met for major joint replacement procedures

Taranaki has seen a decrease in the standardised rate of major joint surgery over the last three years, due mainly to a focus on delivering other types of orthopaedic procedures within the resources available. The DHB continues to monitor demand for major joint procedures along with others to ensure that those most in need receive their surgery.

# Statement of Service Performance

## Standardised intervention rate per 10,000 population is met for cataract procedures



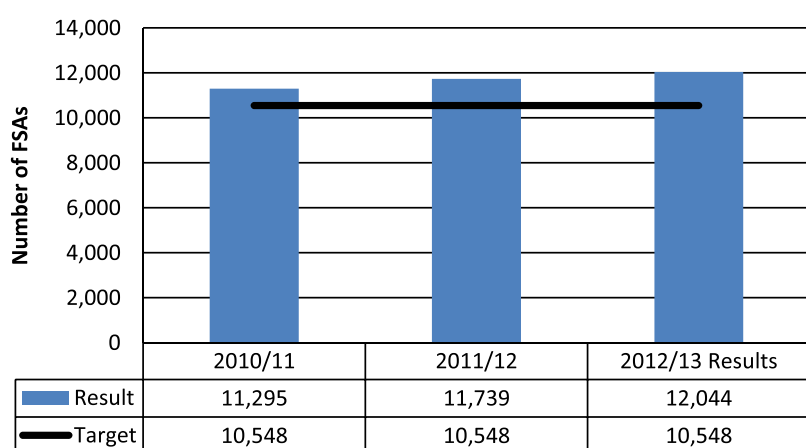
Data Source: National Minimum Dataset (NMDS)

## Standardised intervention rate 27 per 10,000 population is met for cataract procedures

The Taranaki population has consistently received greater than the national standard intervention rate for cataract surgery. The slightly reduced rate over the past three years brings the volumes closer to equity with other DHBs across the country.

## Output Measures

### Number of first specialist assessments



Data Source: National Minimum Dataset (NMDS)

## 10,548 First Specialist Assessments (FSAs)

### Achieved

Taranaki DHB over achieved against the target number of first special assessments in 2012/13. The increased volumes has allowed the DHB to reduce the time the patients are waiting to be seen at outpatients from six months to five months with the benefits of patients able to be seen and gain specialist advice and intervention earlier.

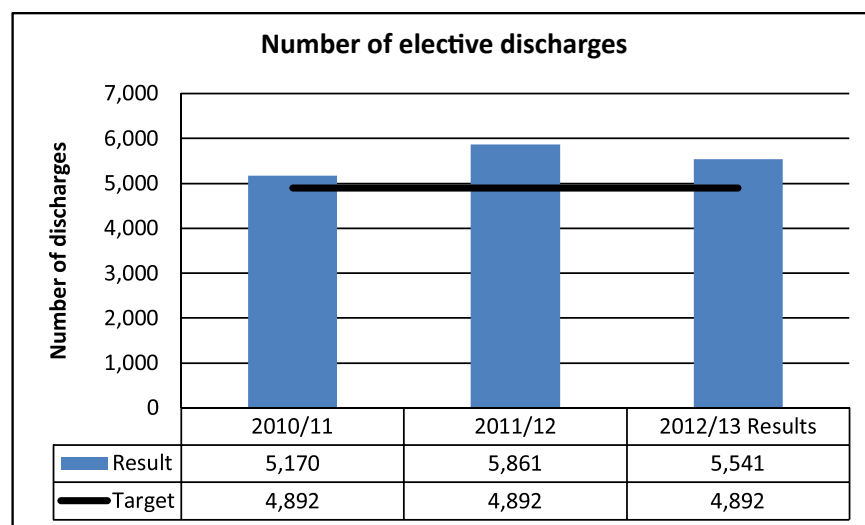
|        |                                                                                                                        |          |
|--------|------------------------------------------------------------------------------------------------------------------------|----------|
| ESPI 1 | All patient referrals are acknowledged and processed within 10 working days                                            |          |
|        | Result: 100%.                                                                                                          | Achieved |
| ESPI 2 | No patients wait longer than five months for their specialist assessment                                               |          |
|        | Result: 0%.                                                                                                            | Achieved |
| ESPI 3 | Less than 5% of patients are waiting without a commitment to treat                                                     |          |
|        | Result: 0%.                                                                                                            | Achieved |
| ESPI 6 | Less than 15% of patients who are in active review have not received a clinical assessments within the last six months |          |
|        | Result: 0%.                                                                                                            | Achieved |

Data Source: National Booking Reporting System (NBRS)

The Elective Services Patient Flow Indicators (ESPIs) are a measure of whether a DHB is meeting the patient requirements of some key decision points in a patient's journey through elective services. These include when the person is first referred for specialist assessment, through to final treatment and/or discharged back to a GP. Taranaki DHB has achieved against all these indicators for 2012/13.



# Statement of Service Performance

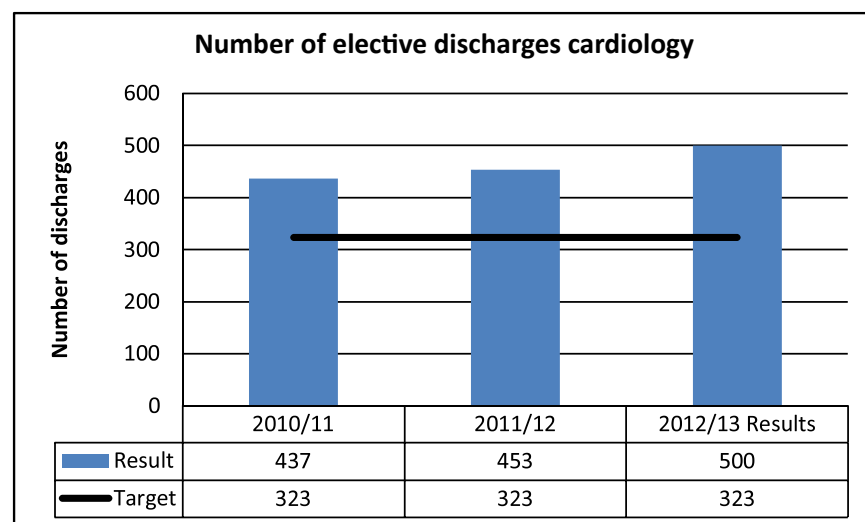


Data Source: National Minimum Dataset (NMDS)

## 4,892 elective discharges

### Achieved

Elective surgery and procedures are for patients who do not require an operation right away. Elective procedures can significantly improve a patient's quality of life including reinstating a person's independence. As the population increases the Ministry requires the District Health Board to increase the number of elective events that are performed to keep up with demand. Taranaki DHB yet again achieved the elective targets.

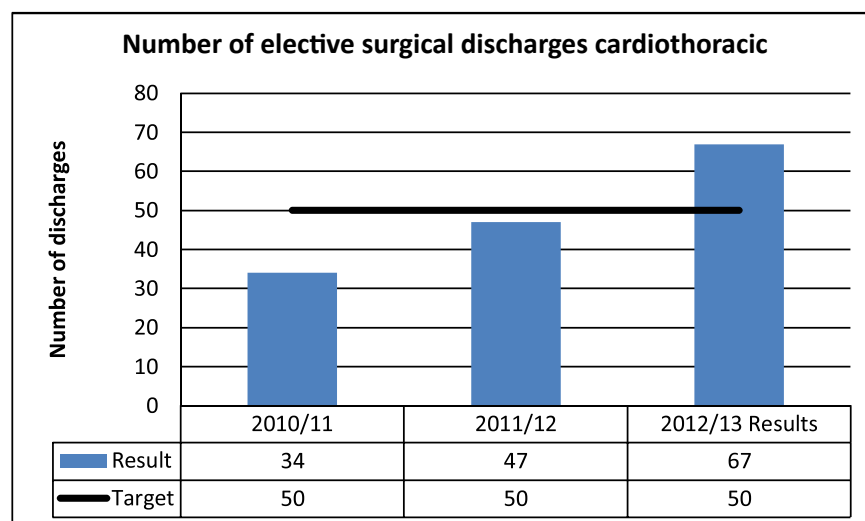


Data Source: National Minimum Dataset (NMDS)

## 323 elective discharges cardiology

### Achieved

Cardiology is a medical specialty which deals with the disorders of the heart. This includes medical diagnosis and treatment of congenital heart defects, coronary heart disease and heart failure. Taranaki DHB has over achieved against the cardiology target.



Data Source: National Minimum Dataset (NMDS)

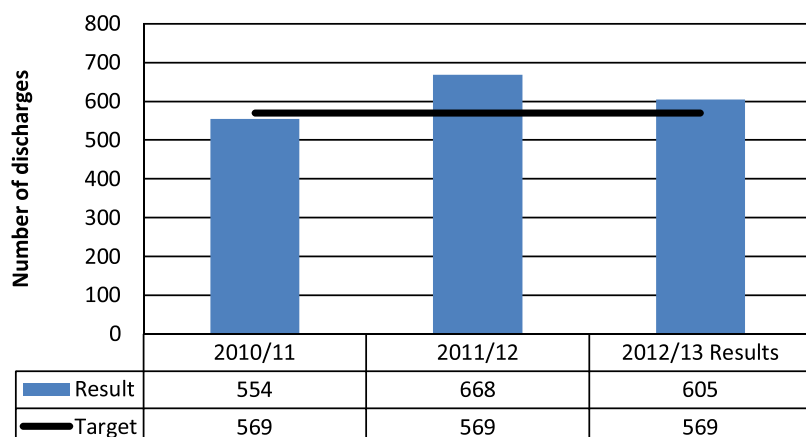
## 50 elective surgical discharges cardiothoracic

### Achieved

Cardiothoracic surgery is concerned with problems of the heart and chest. Taranaki DHB does not perform these surgeries on site but funds these to be provided by our tertiary hospitals. The majority of cases are sent to Waikato DHB with a smaller number sent to Auckland and Capital and Coast DHBs. The targeted number of surgeries was achieved for the Taranaki population in 2012/13.

# Statement of Service Performance

## Number of elective discharges orthopaedics



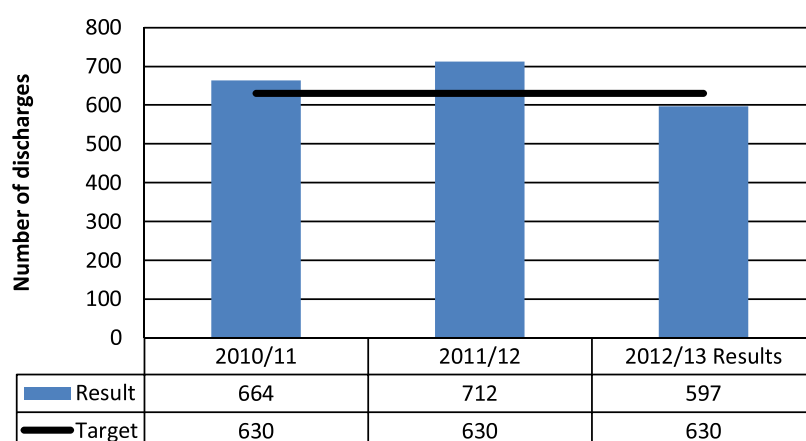
Data Source: National Minimum Dataset (NMDs)

## 569 elective discharges orthopaedics

Achieved

Orthopaedic surgery is concerned with conditions involving the musculoskeletal system. Orthopaedic surgeons use both surgical and nonsurgical means to treat musculoskeletal trauma, sports injuries, degenerative diseases, infections, tumours, and congenital disorders. Major joint surgery such as hip and knee is included. Taranaki DHB achieved the target number of orthopaedic surgeries set for 2012/13.

## Number of elective discharges ophthalmology



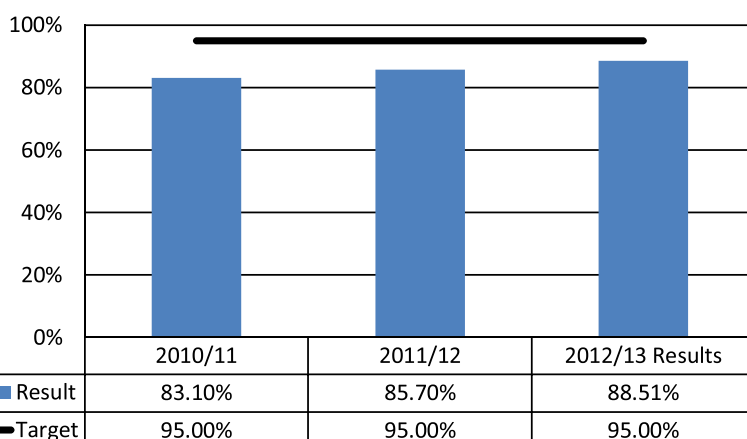
Data Source: National Minimum Dataset (NMDs)

## 630 elective discharges ophthalmology

Not Achieved

Ophthalmology is the branch of medicine that deals with the anatomy, physiology and diseases of the eye such as cataracts. Taranaki DHB missed the target set for 2012/13 by 5%.

## Elective and arranged day of surgery rate is achieved



Data Source: National Minimum Dataset (NMDs)

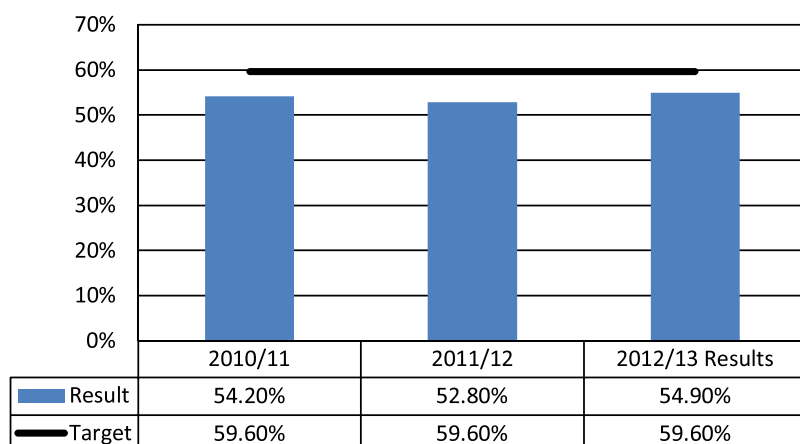
## Elective and arranged day of surgery rate 95% is achieved

Not Achieved

Timely access to elective services is considered a measure of the effectiveness of the health system. Admitting more patients on the day of surgery will reduce time spent in hospital, as well as reducing the disruption to patients' lives. By reducing the number of bed days used by surgical patients the hospital is better able to meet acute demand if required. Although the target was not reached for 2012/13 there has been a steady increase over the last three years and we expect this trend to continue.

# Statement of Service Performance

## Elective and arranged day surgery rate



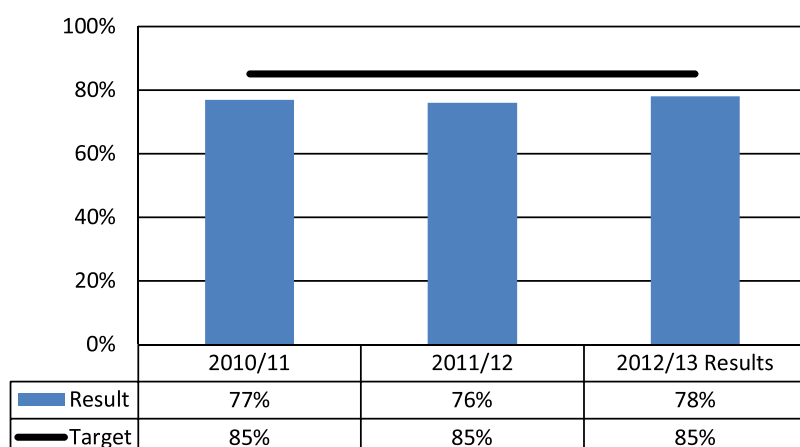
Data Source: National Minimum Dataset (NMDs)

## Elective and arranged day surgery 59.6% is achieved

Not Achieved

Increasing rates of day surgery will mean that resources are used in a more cost-effective manner, and that additional capacity is made available for achieving year on year growth in elective surgery. Taranaki DHB has not met the target for 2012/13 but with the opening of the new facility which has a dedicated day procedure suite we expect to see the number of day cases increase. Also ear, nose and throat surgeries have been undertaken offsite until recently due to lack of theatre capacity. These are being brought back on site with a view to seeing more day cases.

## Theatre utilisation percentage



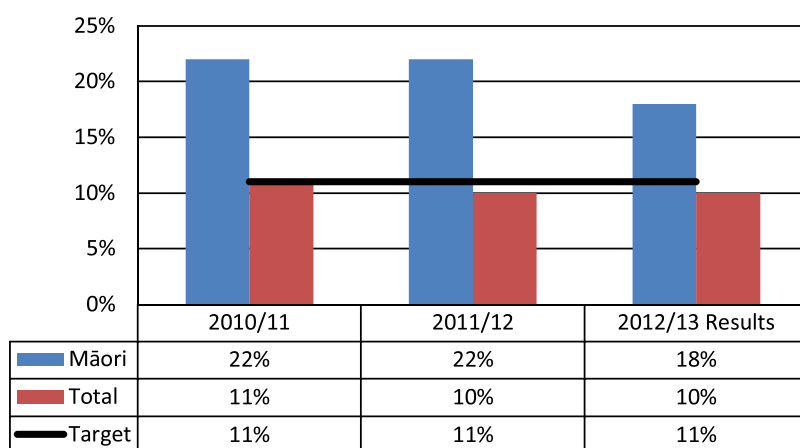
Data Source: Taranaki DHB

## Theatre utilisation of 85% is reached

Not Achieved

Theatre utilisation is a measure of theatre management in terms of operational processes for managing patients and their treatment. Although the national target of 85% has not been met for 2012/13 we have seen a slight increase over our 2010/11 baseline and continue to work on this measure through The Production Operating Theatre (TPOT) project.

## Did-not attend rate for outpatient services



Data Source: National Non-admitted Patient dataset

## Did-not attend <11% for outpatient services

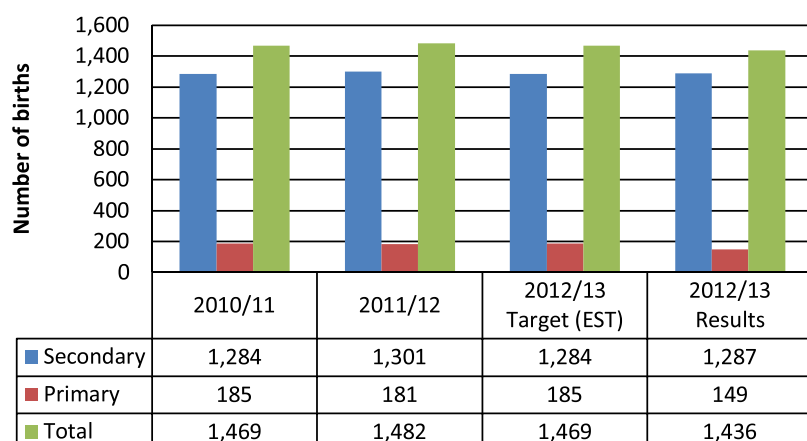
Māori Not Achieved

Total Achieved

The rates of patients who do not attend appointments represents a significant impact to the health system in terms of wasted resource and patient wait times. Taranaki DHB has achieved the target set for the total population for 2012/13. Although the Māori target was not achieved, we did see a 4% reduction over the previous two years. Several initiatives were implemented including a text reminder service which alerts patients to upcoming appointments.

# Statement of Service Performance

## Total number of funded maternity deliveries in the DHB region

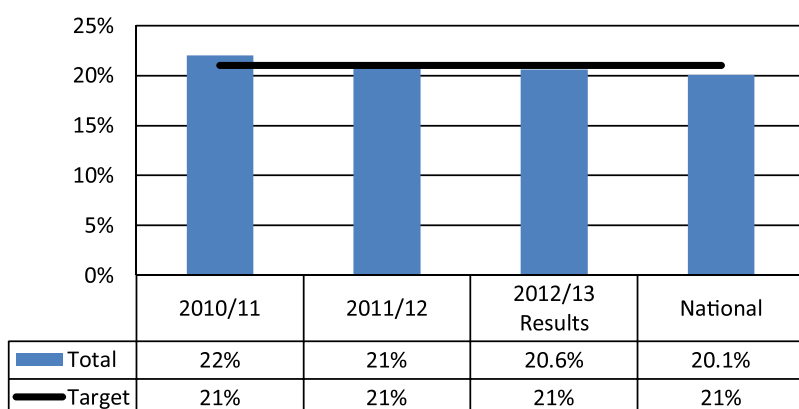


Data Source: National Minimum Dataset (NMDS)

## Total number of funded maternity deliveries in the DHB region

Taranaki DHB funds births at Base and Hawera hospitals as well as the birthing facility in Stratford. Tracking the number of births provides us with a good indication of future demands. As the measure is a reflection of demand we set an estimation of what we thought the demand would be rather than a target to be achieved or not.

## Arranged caesarean delivery complications as a % of total births



Data Source: National Minimum Dataset (NMDS)

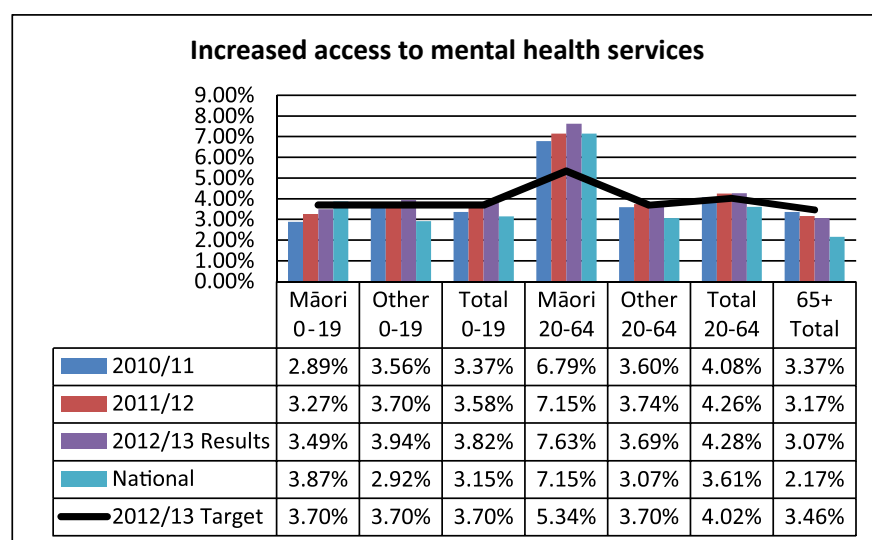
## <21% of total births require an arranged caesarean delivery without complications

Achieved

Caesarean sections can have some significant associated risks including infection, reduced fertility and psychological for mother, depressed immune function, respiratory complications, and slower neurological adaptation for the baby. Through education and advice we wish to see the percentage of caesarean sections decrease over time.

## IMPROVED HEALTH STATUS FOR PEOPLE WITH SEVERE MENTAL HEALTH AND ADDICTIONS

### Impact Measures



Data Source: Programme for the integration of Mental Health Data (PRMHD)

### Increased access to mental health services for our DHB domiciled population.

|                   |              |
|-------------------|--------------|
| Māori 0-19 years  | Not Achieved |
| Other 0-19 years  | Achieved     |
| Total 0-19 years  | Achieved     |
| Māori 20-64 years | Achieved     |
| Other 20-64 years | Not Achieved |
| Total 20-64 years | Achieved     |
| Total 65+ years   | Not Achieved |

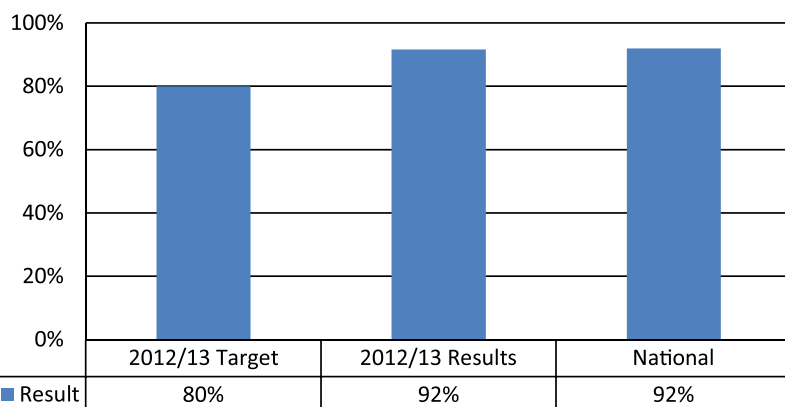
Better access to a broad range of services improves people's mental health and wellbeing, and contributes to recovery which impacts on the intermediate outcome to promote and protect good health and independence of New Zealanders who experience mental illness. The targets for three population groups were not met in 2012/13. The services needed to see 10 more Māori 0-19 year olds and five other 20-64 year old patients. By far the largest difference between target and result was for the 65+ year olds; the team would have had to see a further 300 patients to meet the target. The number of people seen in the service has remained static but the population in this age group is growing faster than any other. To cope with the increasing demand on the Mental Health Service for Older Patients (MHSOP), a dementia pathway has been developed that supports GPs and care facilities with care management, education sessions and advice. The number of people supported in this way is not captured here.



# Statement of Service Performance

## Output Measures

**Percentage of people referred for non-urgent mental health services seen within eight weeks**



Data Source: Programme for the integration of Mental Health Data (PRMHD)

**80% of people referred for non-urgent mental health services are seen within eight weeks**

Achieved

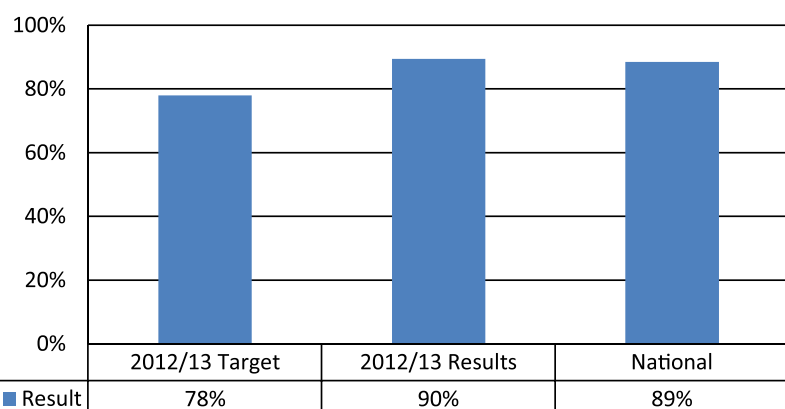
**78% of people referred for non-urgent addiction services are seen within eight weeks - Provider Arm and NGO**

Achieved

**55% of referrals for a young person (0-19 years) is seen by alcohol and other drug health professional within three weeks**

Achieved

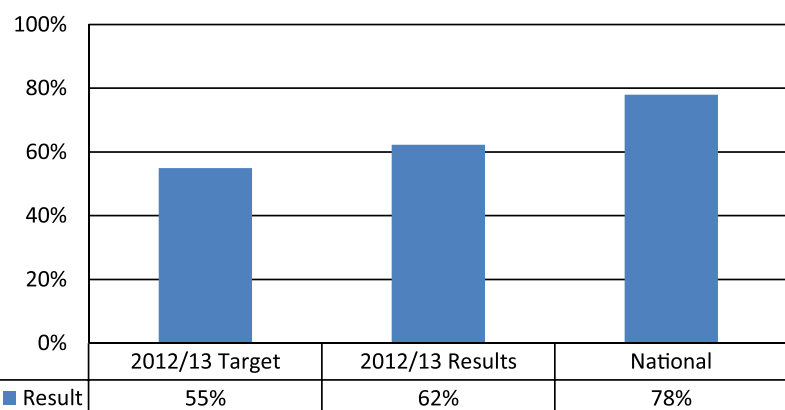
**Percentage of people referred for non-urgent addiction services seen within eight weeks**



Data Source: Programme for the integration of Mental Health Data (PRMHD)

Access and shorter waits are very important to patients regardless of the conditions. Earlier treatment in the progression of illness links to better outcomes as evidenced in international literature. Timeliness is also a key quality indicator in calls for improvement to the health care system. The shorter wait times target for non-urgent mental health and addictions services is new for 2012/13, and is also supported by Ministry of Justice and Department of Corrections particularly in relation to access to AOD services. The targets for all areas have been met in Taranaki DHB.

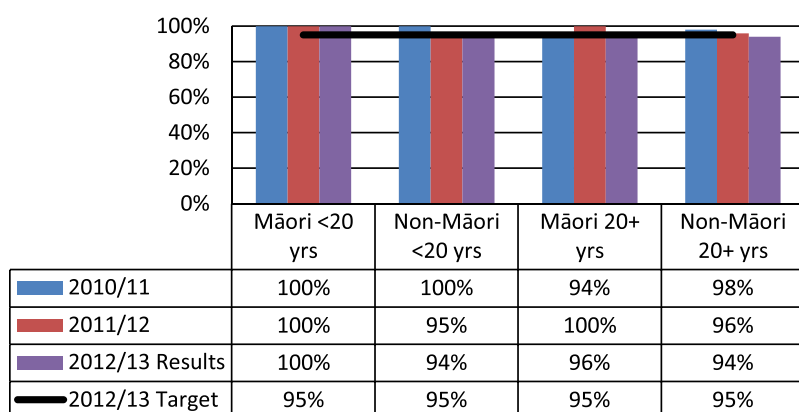
**Percentage of a young person (0-19 years) referred for non-urgent addiction services seen within three weeks**



Data Source: Programme for the integration of Mental Health Data (PRMHD)

# Statement of Service Performance

**Percentage of long-term clients with up to date relapse prevention/treatment plan**



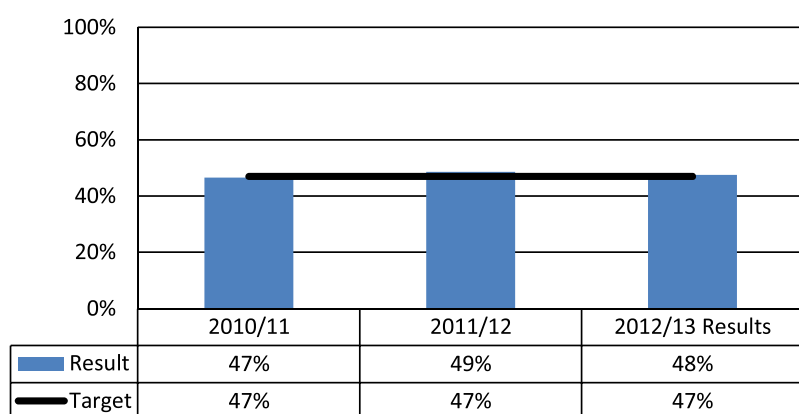
Data Source: Programme for the integration of Mental Health Data (PRMHD)

## Improving the percentage of long-term clients with up to date relapse prevention/treatment plans

|                     |              |
|---------------------|--------------|
| Māori <20 years     | Achieved     |
| Non-Māori <20 years | Not Achieved |
| Māori 20+ years     | Achieved     |
| Non-Māori 20+ years | Not Achieved |

People receive better health and disability services when long-term clients with serious mental illness have agreed relapse prevention plans that enable them to better co-produce their mental health and wellbeing outcomes. This in turn leads to longer healthier and more independent lives. Two targets were not reached for 2012/13 both for non-Māori. The Alcohol and Drugs team would have had to set relapse plans for an additional three clients over 20 years old and one patient under 20. A new role has been established to assist with clinical co-ordination of the Opiate Substitute Treatment (OST) team in conjunction with the specialty nurse to update the relapse prevention plans.

**Percentage of inpatients with a HoNOS score change of significant improvement**



Data Source: Programme for the integration of Mental Health Data (PRMHD)

## Acute inpatient (HoNOS) \* effect size – significant improvement

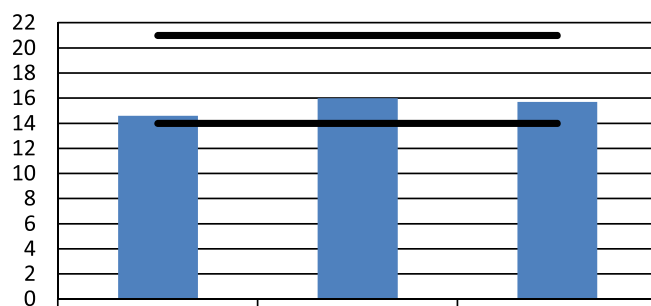
Achieved

HoNOS is a nationally collected clinical outcome measure. The 12 items that makes up the HoNOS includes problems that are commonly present with people that present with a severe mental illness. The measure is taken when a patient is admitted and again when a patient is discharged. Significant improvement represents an improvement in six or more points. Taranaki DHB achieved against the target set for 2012/13.

\*HoNOS: Health of the Nation Outcome Scale: Measures behaviour, impairment, symptoms and social functioning with the Mental Health Services. 'Significant improvement' is the count of compliant referral closures that have had a reduction in HoNOS score from admission to discharge of six points or more.

# Statement of Service Performance

**Average length of acute inpatient stays**



|              | 2010/11 | 2011/12 | 2012/13 Results |
|--------------|---------|---------|-----------------|
| Result       | 15      | 16      | 16              |
| Target Lower | 14      | 14      | 14              |
| Target Upper | 21      | 21      | 21              |

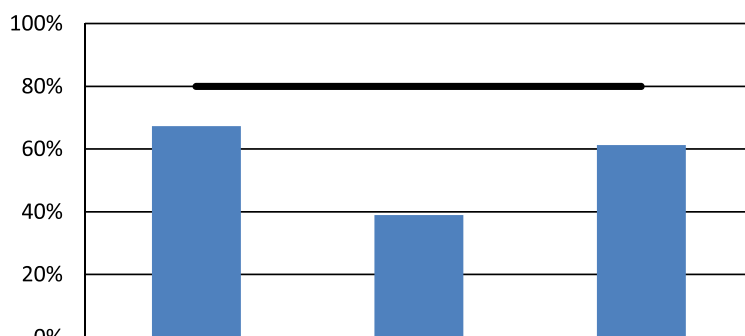
Data Source: Programme for the integration of Mental Health Data (PRMHD)

## Average length of acute inpatient stays between 14-21 days

Achieved

Mental health and addiction services seek to support service users in the least restrictive environment. The average length of acute inpatient stay is one indicator which can help inform how an inpatient unit is performing. Taranaki DHB achieved within the targeted range of days.

**Rates of post discharge community care**



|        | 2010/11 | 2011/12 | 2012/13 Results |
|--------|---------|---------|-----------------|
| Result | 67%     | 39%     | 61%             |
| Target | 80%     | 80%     | 80%             |

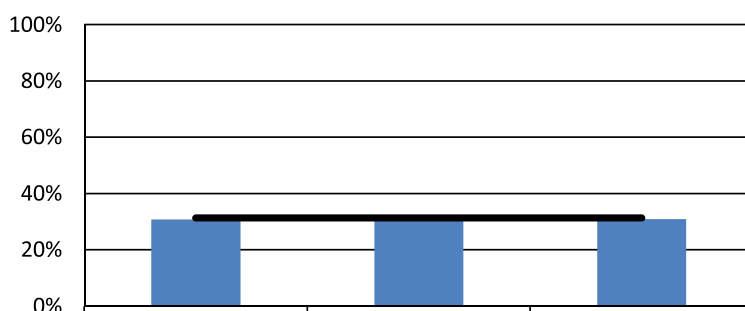
Data Source: Programme for the integration of Mental Health Data (PRMHD)

## 80% of post discharge patients are seen in the community within seven days

Not Achieved

A responsive community support system for people who have experienced an acute episode requiring hospitalisation is essential to maintain clinical and functional stability, and to minimise the need for hospital readmission. Taranaki DHB has not achieved against this target for 2012/13. There is a local KPI group that meets monthly and is closely monitoring this activity. As a result changes have been made to processes recently to more easily monitor discharges.

**Percentage of mental health and addiction funding allocated to Primary versus Secondary providers**



|        | 2010/11 | 2011/12 | 2012/13 Results |
|--------|---------|---------|-----------------|
| Result | 31%     | 32%     | 31%             |
| Target | 31%     | 31%     | 31%             |

Data Source: Programme for the integration of Mental Health Data (PRMHD)

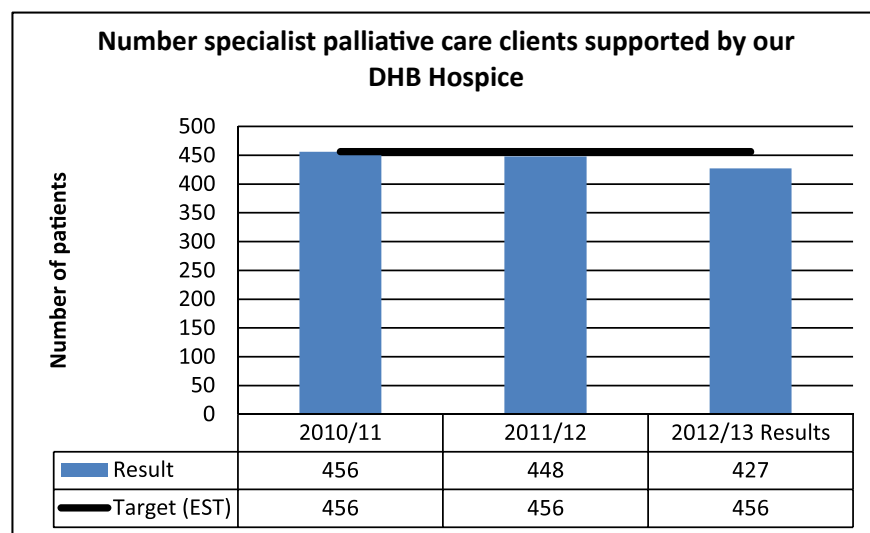
## Percentage of mental health and addiction funding allocated to primary versus secondary providers

Achieved

The level of investment within the NGO sector provides information about the development of a broad range of specialist mental health services, choices for service users and the opportunities to support people in the least restrictive environment. We achieved our targeted budget expectation for 2012/13.

## PEOPLE WITH END STAGE CONDITIONS ARE SUPPORTED

### Output Measures

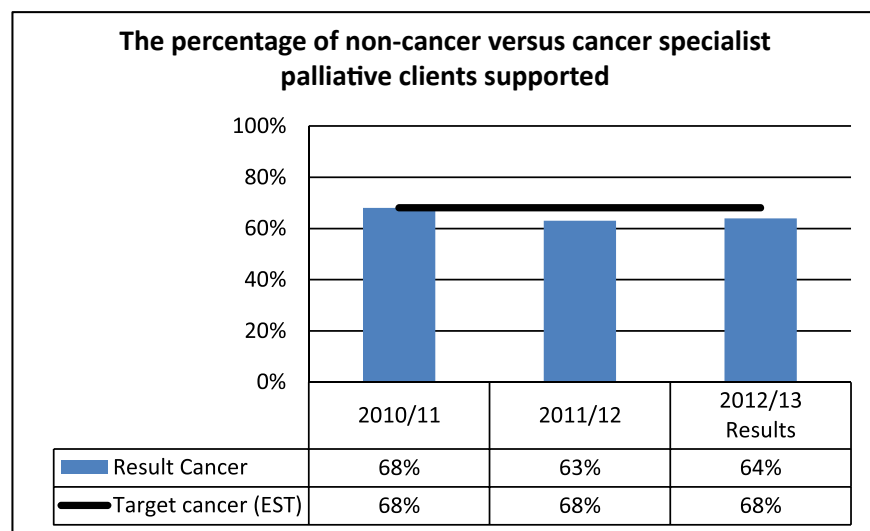


Data Source: Local Hospice Contract Reporting

### Number of specialist palliative care clients supported by the Hospice in Taranaki

### The percentage of non-cancer versus cancer specialist palliative clients supported

Hospice Taranaki provide a wide range of services including an inpatient unit, community palliative nursing, Aged Care facilities support, Respite Care, as well as support services for patients and whānau. The number of people supported and the number referred for cancer and non-cancer diagnosis is reflective of the current need and as such is not a target but an indication of the activity that the DHB funds.



Data Source: Local Hospice Contract Reporting

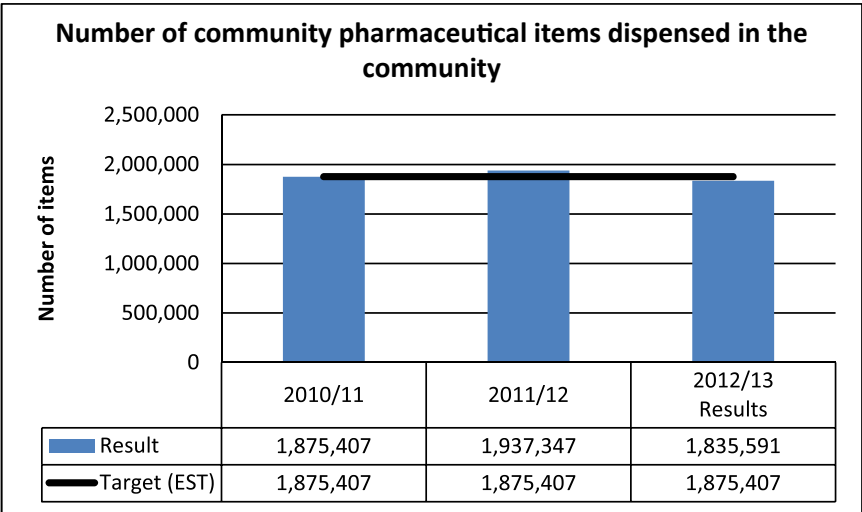


## Long Term Impact 4

# SUPPORT SERVICES

We also fund and deliver services through community pharmacies, community laboratories and community radiology which contribute towards the achievement of a range of long and medium term impacts. For example certain drugs will be required for long-term conditions to be managed well and with more personal control in the community. We fund the community pharmacies for the cost of the drugs. We also fund Nicotine Replacement Therapy through community pharmacies which will contribute towards reducing our smoking rates.

## Output Measures



Data Source: Pharmacy National Dataset

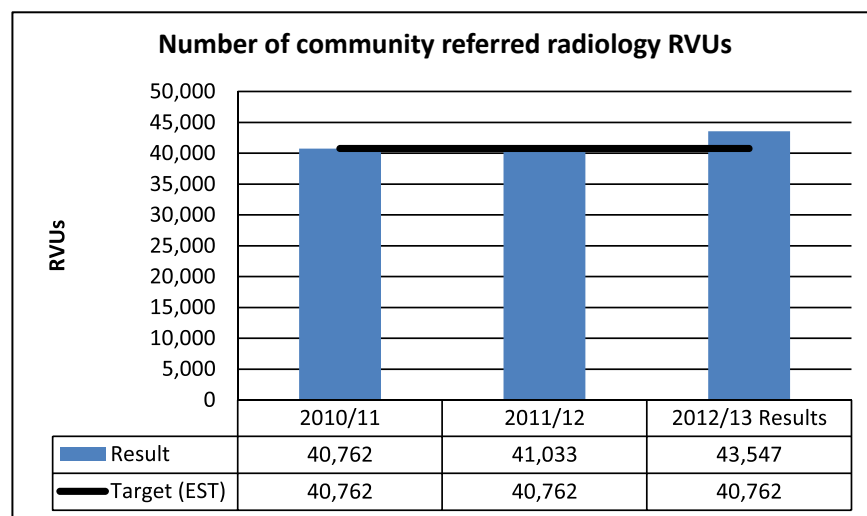
### 1,875,407 pharmaceutical items dispensed in the community

#### Achieved

District Health Boards fund the drug costs and subsidise the dispensing fee associated with community dispensed pharmaceuticals. The new National Pharmacy contract is part way through implementation out of which we expect to see a more patient centred model of care. Taranaki DHB expected that no further growth in the number of items dispensed for 2012/13 and in fact we saw a reduction.



# Statement of Service Performance



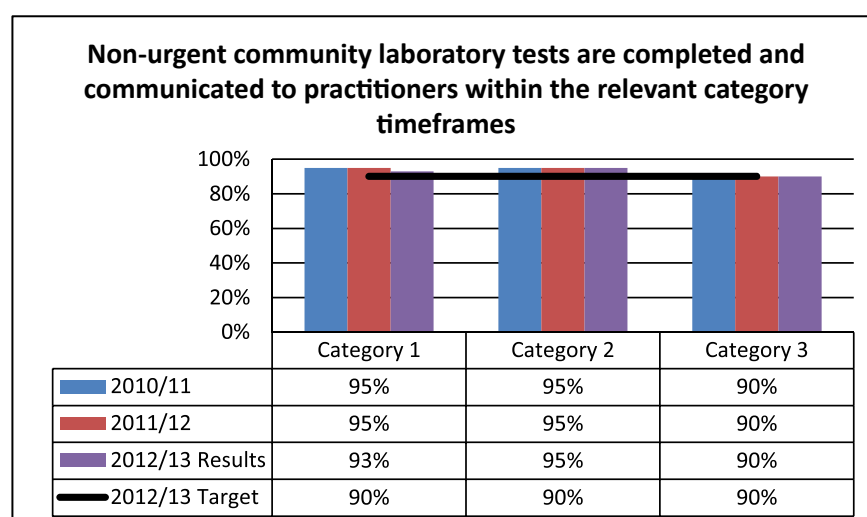
Data Source: National Non-Admitted Patient dataset

## 40,762 community referred radiology Relative Value Units (RVUs)\*

### Achieved

The purpose of community referred radiology is to provide access to GPs, medical specialists or other approved practitioners to refer their patients to radiology services. These include Computerised Tomography (CT) scans, Ultrasounds and X-rays. Taranaki DHB has seen an increase in activity and has achieved the target for 2012/13.

\*Relative Value Unit: An RVU is a calculation to show the relative cost associated with an event. So for example if 1 RVU equates to \$45 and an average CT scan costs \$675 then CT scan on average equates to 15 RVUs.



Data Source: Local contract Performance Monitoring

## 90% of non-urgent community laboratory tests are completed and communicated to practitioners within the relevant category timeframes

|            |          |
|------------|----------|
| Category 1 | Achieved |
| Category 2 | Achieved |
| Category 3 | Achieved |

Diagnostics are a vital step in the pathway to access appropriate treatment. Improving waiting times for diagnostics can reduce delays to a patient's episode of care and improve DHB demand and capacity management. Our community laboratory services have consistently achieved against the timeliness standards.



# Financial Report

2012/2013

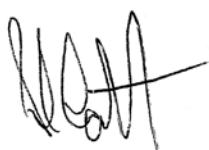




- 1 The Board and management of the Taranaki District Health Board accepts responsibility for the preparation of the Financial Statements and the judgments used in them.
- 2 The Board and management of the Taranaki District Health Board accepts responsibility for establishing and maintaining a system 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 2013, fairly reflect the financial position, operations, cash flows and service performance of the Taranaki District Health Board.



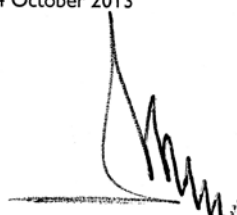
Mary Bourke  
Chairperson  
24 October 2013



Peter Catt  
Deputy Chairperson  
24 October 2013



Tony Foulkes  
Chief Executive  
24 October 2013



George Thomas  
Chief Financial Officer  
24 October 2013

# Statement of Comprehensive Income

For the Year Ended 30 June 2013

|                                                                                     | Notes | Group          |                        |                | Parent         |                |
|-------------------------------------------------------------------------------------|-------|----------------|------------------------|----------------|----------------|----------------|
|                                                                                     |       | Actual         | Budget                 | Actual         | Actual         | Actual         |
|                                                                                     |       | June 2013      | June 2013<br>Unaudited | June 2012      | June 2013      | June 2012      |
|                                                                                     |       | \$000          | \$000                  | \$000          | \$000          | \$000          |
| Revenue                                                                             | 1     | 324,637        | 321,805                | 317,485        | 323,873        | 316,634        |
| Other income                                                                        | 2     | 2,109          | 2,000                  | 1,376          | 2,109          | 1,376          |
| <b>Total income</b>                                                                 |       | <b>326,746</b> | <b>323,805</b>         | <b>318,861</b> | <b>325,982</b> | <b>318,010</b> |
| Employee benefit costs                                                              | 3     | 111,099        | 106,587                | 106,597        | 106,252        | 102,446        |
| Depreciation expense                                                                | 13    | 11,663         | 12,068                 | 10,193         | 11,663         | 10,193         |
| Outsourced services                                                                 |       | 21,721         | 19,751                 | 22,203         | 21,711         | 22,203         |
| Clinical supplies                                                                   |       | 21,790         | 22,023                 | 23,141         | 21,790         | 23,142         |
| Infrastructure and non-clinical expenses                                            |       | 9,819          | 9,461                  | 8,089          | 14,382         | 12,966         |
| Payments to non-health board providers                                              |       | 141,938        | 141,998                | 139,236        | 141,938        | 139,236        |
| Other expenses                                                                      | 4     | 1,233          | 1,299                  | 1,405          | 734            | 915            |
| Capital charge                                                                      | 5     | 5,778          | 6,100                  | 6,164          | 5,778          | 6,164          |
| Financing costs                                                                     | 6     | 1,832          | 1,800                  | 1,824          | 1,832          | 1,824          |
| <b>Total expenses</b>                                                               |       | <b>326,873</b> | <b>321,087</b>         | <b>318,852</b> | <b>326,080</b> | <b>319,089</b> |
| <b>Surplus/(Loss) before share of associates attributable to the Parent</b>         |       | <b>(127)</b>   | <b>2,718</b>           | <b>9</b>       | <b>(98)</b>    | <b>(1,079)</b> |
| Share of surplus/(loss) of associates                                               | 12(c) | 134            | -                      | 189            | -              | -              |
| <b>Surplus/(Loss) after surplus/(loss) of associates</b>                            |       | <b>7</b>       | <b>2,718</b>           | <b>198</b>     | <b>(98)</b>    | <b>(1,079)</b> |
| <b>Other comprehensive income</b>                                                   |       | <b>-</b>       | <b>-</b>               | <b>-</b>       |                |                |
| Revaluation of land and buildings                                                   |       | 15,545         | -                      | -              | 15,545         | -              |
| Total other comprehensive income/(expense)                                          |       | 15,545         | -                      | -              | 15,545         | -              |
| <b>Total comprehensive surplus/(loss) for the period attributable to the Parent</b> |       | <b>15,552</b>  | <b>2,718</b>           | <b>198</b>     | <b>15,447</b>  | <b>(1,079)</b> |

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



# Statement of Changes in Equity

For the Year Ended 30 June 2013

|                                         |       | Group         |                              |                           |                    |        |
|-----------------------------------------|-------|---------------|------------------------------|---------------------------|--------------------|--------|
|                                         | Notes | Public Equity | Retained Earnings / (Losses) | Asset Revaluation Reserve | Trust Fund Reserve | Total  |
|                                         |       | \$000         | \$000                        | \$000                     | \$000              | \$000  |
| <b>At 30 June 2011</b>                  |       | 25,114        | (3,729)                      | 51,905                    | 724                | 74,014 |
| <b>Comprehensive income / (expense)</b> |       |               |                              |                           |                    |        |
| Surplus / (deficit) for the year        |       | -             | 198                          | -                         | -                  | 198    |
| Transfer from/(to) Trust Funds Reserve  |       | -             | (5)                          | -                         | 5                  | -      |
|                                         |       | -             | 193                          | -                         | 5                  | 198    |
| <b>Transactions with the Crown</b>      |       |               |                              |                           |                    |        |
| Equity Injections                       | 31    | 1,886         | -                            | -                         | -                  | 1,886  |
| Equity repaid to the Crown              | 31    | (959)         | -                            | -                         | -                  | (959)  |
|                                         |       | 927           | -                            | -                         | -                  | 927    |
| <b>At 30 June 2012</b>                  |       | 26,041        | (3,536)                      | 51,905                    | 729                | 75,139 |
| <b>Comprehensive income / (expense)</b> |       |               |                              |                           |                    |        |
| Surplus / (deficit) for the year        |       | -             | 7                            | -                         | -                  | 7      |
| Other comprehensive income              |       | -             | -                            | 15,545                    | -                  | 15,545 |
| Transfer from/(to) Trust Funds Reserve  |       | -             | 28                           | -                         | (28)               | -      |
|                                         |       | -             | 35                           | 15,545                    | (28)               | 15,552 |
| <b>Transactions with the Crown</b>      |       |               |                              |                           |                    |        |
| Equity repaid to the Crown              | 31    | (959)         | -                            | -                         | -                  | (959)  |
|                                         |       | (959)         | -                            | -                         | -                  | (959)  |
| <b>At 30 June 2013</b>                  |       | 25,082        | (3,501)                      | 67,450                    | 701                | 89,732 |

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

# Statement of Changes in Equity

For the Year Ended 30 June 2013

## Parent

|                                         | Notes | Public Equity<br>\$000 | Retained<br>Earnings /<br>(Losses)<br>\$000 | Asset<br>Revaluation<br>Reserve<br>\$000 | Trust Fund<br>Reserve<br>\$000 | Total<br>\$000 |
|-----------------------------------------|-------|------------------------|---------------------------------------------|------------------------------------------|--------------------------------|----------------|
| <b>At 30 June 2011</b>                  |       | 25,114                 | (3,196)                                     | 51,905                                   | -                              | 73,823         |
| <b>Comprehensive income / (expense)</b> |       |                        |                                             |                                          |                                |                |
| Surplus / (deficit) for the year        |       | -                      | (1,079)                                     | -                                        | -                              | (1,079)        |
| Other comprehensive income              |       | -                      | -                                           | -                                        | -                              | -              |
|                                         |       | -                      | (1,079)                                     | -                                        | -                              | (1,079)        |
| <b>Transactions with the Crown</b>      |       |                        |                                             |                                          |                                |                |
| Equity Injections                       | 31    | 1,886                  | -                                           | -                                        | -                              | 1,886          |
| Equity repaid to the Crown              | 31    | (959)                  | -                                           | -                                        | -                              | (959)          |
|                                         |       | 927                    | -                                           | -                                        | -                              | 927            |
| <b>At 30 June 2012</b>                  |       | 26,041                 | (4,275)                                     | 51,905                                   | -                              | 73,671         |
| <b>Comprehensive income / (expense)</b> |       |                        |                                             |                                          |                                |                |
| Surplus / (deficit) for the year        |       | -                      | (98)                                        | 15,545                                   | -                              | 15,447         |
| Other comprehensive income              |       | -                      | -                                           | -                                        | -                              | -              |
|                                         |       | -                      | (98)                                        | 15,545                                   | -                              | 15,447         |
| <b>Transactions with the Crown</b>      |       |                        |                                             |                                          |                                |                |
| Equity repaid to the Crown              | 31    | (959)                  | -                                           | -                                        | -                              | (959)          |
|                                         |       | (959)                  | -                                           | -                                        | -                              | (959)          |
| <b>At 30 June 2013</b>                  |       | 25,082                 | (4,373)                                     | 67,450                                   | -                              | 88,159         |

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

# Statement of Financial Position

As at 30 June 2013

|                                       | Notes | Group          |                        |                | Parent         |                |
|---------------------------------------|-------|----------------|------------------------|----------------|----------------|----------------|
|                                       |       | Actual         | Budget                 | Actual         | Actual         | Actual         |
|                                       |       | June 2013      | June 2013<br>Unaudited | June 2012      | June 2013      | June 2012      |
|                                       |       | \$000          | \$000                  | \$000          | \$000          | \$000          |
| <b>ASSETS</b>                         |       |                |                        |                |                |                |
| <b>Current assets</b>                 |       |                |                        |                |                |                |
| Cash and cash equivalents             | 7     | 4,751          | 1,504                  | 3,433          | 4,747          | 3,407          |
| Trade and other receivables           | 8     | 7,092          | 9,590                  | 10,437         | 6,730          | 9,611          |
| Inventories                           | 9     | 2,514          | 2,695                  | 2,654          | 2,513          | 2,654          |
| Other financial assets                | 10    | 11,000         | 8,000                  | 33,000         | 11,000         | 33,000         |
| <b>Total current assets</b>           |       | <b>25,357</b>  | <b>21,789</b>          | <b>49,524</b>  | <b>24,990</b>  | <b>48,672</b>  |
| <b>Non-current assets</b>             |       |                |                        |                |                |                |
| Investments in subsidiaries           | 11    | -              | -                      | -              | 4,936          | 4,936          |
| Investments in associates             | 12    | 1,241          | 927                    | 1,107          | 1,451          | 1,451          |
| Other financial assets                | 10    | 57             | 57                     | 57             | 57             | 57             |
| Property, plant and equipment         | 13    | 186,604        | 170,657                | 129,934        | 186,604        | 129,934        |
| Intangible assets                     | 14    | 729            | -                      | -              | 729            | -              |
| Restricted assets & trust funds       | 15    | 701            | 724                    | 729            | -              | -              |
| <b>Total non-current assets</b>       |       | <b>189,332</b> | <b>172,365</b>         | <b>131,827</b> | <b>193,777</b> | <b>136,378</b> |
| <b>TOTAL ASSETS</b>                   |       | <b>214,689</b> | <b>194,154</b>         | <b>181,351</b> | <b>218,767</b> | <b>185,050</b> |
| <b>LIABILITIES</b>                    |       |                |                        |                |                |                |
| <b>Current liabilities</b>            |       |                |                        |                |                |                |
| Trade and other payables              | 16    | 30,167         | 21,645                 | 27,769         | 36,363         | 33,454         |
| Interest bearing loans and borrowings | 17    | -              | -                      | 7,000          | -              | 7,000          |
| Employee benefits                     | 18    | 21,075         | 20,130                 | 20,142         | 20,530         | 19,624         |
| Provisions                            | 19    | 15             | 5                      | 11             | 15             | 11             |
| <b>Total Current Liabilities</b>      |       | <b>51,257</b>  | <b>41,780</b>          | <b>54,922</b>  | <b>56,908</b>  | <b>60,089</b>  |
| <b>Non current liabilities</b>        |       |                |                        |                |                |                |
| Interest bearing loans and borrowings | 17    | 72,000         | 74,000                 | 49,800         | 72,000         | 49,800         |
| Other Financial Liabilities           |       | 980            | 905                    | 392            | 980            | 392            |
| Employee benefits                     | 18    | 720            | 825                    | 1,098          | 720            | 1,098          |
| <b>Total non current liabilities</b>  |       | <b>73,700</b>  | <b>75,730</b>          | <b>51,290</b>  | <b>73,700</b>  | <b>51,290</b>  |
| <b>TOTAL LIABILITIES</b>              |       | <b>124,957</b> | <b>117,510</b>         | <b>106,212</b> | <b>130,608</b> | <b>111,379</b> |
| <b>NET ASSETS</b>                     |       | <b>89,732</b>  | <b>76,644</b>          | <b>75,139</b>  | <b>88,159</b>  | <b>73,671</b>  |
| <b>EQUITY</b>                         |       |                |                        |                |                |                |
| Public equity                         |       | 25,082         | 24,925                 | 26,041         | 25,082         | 26,041         |
| Retained earnings/(losses)            |       | (3,501)        | (910)                  | (3,536)        | (4,373)        | (4,275)        |
| Asset revaluation reserve             |       | 67,450         | 51,905                 | 51,905         | 67,450         | 51,905         |
| Trust fund reserve                    | 15    | 701            | 724                    | 729            | -              | -              |
| <b>TOTAL EQUITY</b>                   |       | <b>89,732</b>  | <b>76,644</b>          | <b>75,139</b>  | <b>88,159</b>  | <b>73,671</b>  |

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 24th October 2013

  
Mary Bourke  
CHAIRPERSON

  
Peter Catt  
DEPUTY CHAIRPERSON

# Statement of Cash Flows

For the Year Ended 30 June 2013

|                                                       | Notes | Group     |                        |           | Parent    |           |
|-------------------------------------------------------|-------|-----------|------------------------|-----------|-----------|-----------|
|                                                       |       | Actual    | Budget                 | Actual    | Actual    | Actual    |
|                                                       |       | June 2013 | June 2013<br>Unaudited | June 2012 | June 2013 | June 2012 |
| <b>CASHFLOWS FROM OPERATING ACTIVITIES</b>            |       | \$000     | \$000                  | \$000     | \$000     | \$000     |
| <b>Cash was provided from:</b>                        |       |           |                        |           |           |           |
| Receipts from Government and Public                   |       | 328,594   | 322,100                | 315,657   | 327,445   | 315,231   |
| Interest Received                                     |       | 1,308     | 960                    | 1,884     | 1,304     | 1,876     |
| GST (Net)                                             |       | 303       | -                      | -         | 296       | -         |
|                                                       |       | 330,205   | 323,060                | 317,541   | 329,045   | 317,107   |
| <b>Cash was disbursed to:</b>                         |       |           |                        |           |           |           |
| Payments to Suppliers                                 |       | 192,776   | 195,936                | 190,086   | 196,387   | 193,454   |
| Payments to Employees                                 |       | 110,546   | 105,512                | 104,675   | 105,725   | 100,615   |
| Capital Charge Paid                                   |       | 6,581     | 6,820                  | 7,901     | 6,581     | 7,901     |
| Interest Paid                                         |       | 1,798     | 1,800                  | 2,218     | 1,798     | 2,218     |
| GST (Net)                                             |       | -         | 2,733                  | 705       | -         | 776       |
|                                                       |       | 311,701   | 312,801                | 305,585   | 310,491   | 304,964   |
| <b>Net Cash Inflow from Operating Activities</b>      | 20    | 18,504    | 10,259                 | 11,956    | 18,554    | 12,143    |
| <b>CASHFLOWS FROM INVESTING ACTIVITIES</b>            |       |           |                        |           |           |           |
| <b>Cash was provided from:</b>                        |       |           |                        |           |           |           |
| Dividends Received                                    |       | 62        | -                      | 2         | 62        | 2         |
| Proceeds from Short Term Deposit                      |       | 22,000    | 24,000                 | -         | 22,000    | -         |
| Proceeds from Restricted Assets                       |       | 28        | -                      | -         | -         | -         |
| Proceeds of loan repayments from associate company    |       | -         | -                      | 10        | -         | 10        |
| Proceeds from Sale of Property, Plant & Equipment     |       | 7         | -                      | 14        | 7         | 14        |
|                                                       |       | 22,097    | 24,000                 | 26        | 22,069    | 26        |
| <b>Cash was applied to:</b>                           |       |           |                        |           |           |           |
| Purchase of Property, Plant & Equipment               |       | 52,795    | 52,000                 | 38,339    | 52,795    | 38,339    |
| Purchase of Intangible Assets                         |       | 729       | -                      | -         | 729       | -         |
| Restricted Assets                                     |       | -         | -                      | 6         | -         | -         |
| Short Term Deposit                                    |       | -         | -                      | 2,000     | -         | 2,000     |
|                                                       |       | 53,524    | 52,000                 | 40,345    | 53,524    | 40,339    |
| <b>Net Cash Outflow from Investing Activities</b>     |       | (31,427)  | (28,000)               | (40,319)  | (31,455)  | (40,313)  |
| <b>CASHFLOWS FROM FINANCING ACTIVITIES</b>            |       |           |                        |           |           |           |
| <b>Cash was provided from:</b>                        |       |           |                        |           |           |           |
| Equity vested by Crown                                |       | -         | -                      | 1,886     | -         | 1,886     |
| Proceeds from Debt Financing                          |       | 15,200    | 17,200                 | 27,800    | 15,200    | 27,800    |
|                                                       |       | 15,200    | 17,200                 | 29,686    | 15,200    | 29,686    |
| <b>Cash was applied to:</b>                           |       |           |                        |           |           |           |
| Repayment of Equity                                   |       | 959       | 959                    | 959       | 959       | 959       |
|                                                       |       | 959       | 959                    | 959       | 959       | 959       |
| <b>Net Cash Outflow from Financing Activities</b>     |       | 14,241    | 16,241                 | 28,727    | 14,241    | 28,727    |
| <b>Net Increase/(Decrease) in Cash Held</b>           |       | 1,318     | (1,500)                | 364       | 1,340     | 558       |
| <b>Cash and cash equivalents at beginning of year</b> |       | 3,433     | 3,004                  | 3,069     | 3,407     | 2,849     |
| <b>Cash and cash equivalents at end of year</b>       |       | 4,751     | 1,504                  | 3,433     | 4,747     | 3,407     |

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

## Significant accounting policies for the year ended 30 June 2013

### (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 NZ IAS 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 2013. The financial statements were authorised for issue by the Board on 24 October 2013.

### (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.

#### (iii) Changes in accounting policies

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

Where applicable, certain comparatives have been restated to comply with the accounting presentation adopted for the current year.

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 13.



### (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 2013.

#### 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 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, loans and receivables. 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 2013 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 2018, 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 as expenses 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   | 3-25%             |
| Plant and equipment | 2 to 18 years   | 2-50%             |
| Motor vehicles      | 3 to 10 years   | 10-33.3%          |

## Impairment

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

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

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

## (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.

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

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

**(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.



## **PBE Standards for Tier 1 and Tier 2 Public Sector Entities**

The package of PBE standards issued, applicable for Tier 1 and Tier 2 public sector PBE consist of the following standards:

- (i) Standard XRB A1 *Accounting Standards Framework*, which is the overarching standard that sets out the accounting standards framework;
- (ii) A suite of 39 PBE standards; and
- (iii) The Public Benefit Entities (conceptual) framework.

The new PBE Standards are based on International Public Sector Accounting Standards, which are themselves based on IFRS. Therefore major changes to accounting policies are not expected. Nevertheless, there are some potentially significant differences and also a range of smaller differences between the PBE Standards and IFRS.

Examples of potential significant differences could include:

- (i) PBE Standards with no equivalent NZ IFRS
  - PBE IPSAS 23 *Revenue from Non-Exchange Transactions*, which prescribes requirements for accounting for revenue from non-exchange transactions;
  - PBE IPSAS 32 *Service Concession Arrangements: Grantor*, which prescribes the accounting for service concession arrangements by the grantor.
- (ii) Differences between equivalent standards
  - PBE IPSAS 20 *Related Party Disclosures*, exempts all transactions between related parties (except key management personnel remuneration) that occur on arm's length terms and conditions from disclosure, and provides a potentially wider definition of key management personnel compared to NZ IFRS 24. *Related Party Disclosures*

The application date for the standard and the group will be 1 July 2014. These standards will impact the disclosures in the financial statements.

Please note this is not a complete list of differences between PBE standards and NZ IFRS.

Early adoption of PBE Standards by Tier 1 and Tier 2 public sector PBE's is not permitted.

### 1 REVENUE

|                                                         | Group          |                | Parent         |                |
|---------------------------------------------------------|----------------|----------------|----------------|----------------|
|                                                         | 2013           | 2012           | 2013           | 2012           |
|                                                         | \$000          | \$000          | \$000          | \$000          |
| Health and disability services (MoH contracted revenue) | 311,548        | 302,488        | 311,426        | 302,357        |
| ACC revenue                                             | 4,202          | 4,393          | 4,202          | 4,393          |
| Inter District Patient Inflows                          | 4,472          | 4,572          | 4,472          | 4,572          |
| Interest received                                       | 1,308          | 1,884          | 1,304          | 1,876          |
| Dividends received                                      | 62             | 2              | 62             | 2              |
| Bad debts recovered                                     | 3              | 6              | 3              | 6              |
| Other revenue                                           | 3,042          | 4,140          | 2,404          | 3,428          |
|                                                         | <b>324,637</b> | <b>317,485</b> | <b>323,873</b> | <b>316,634</b> |

### 2 OTHER INCOME

|                                               | Group        |              | Parent       |              |
|-----------------------------------------------|--------------|--------------|--------------|--------------|
|                                               | 2013         | 2012         | 2013         | 2012         |
|                                               | \$000        | \$000        | \$000        | \$000        |
| Donations and bequests received               | 2,102        | 1,368        | 2,102        | 1,368        |
| Gain on sale of property, plant and equipment | 7            | 8            | 7            | 8            |
|                                               | <b>2,109</b> | <b>1,376</b> | <b>2,109</b> | <b>1,376</b> |

### 3 EMPLOYEE BENEFIT COSTS

|                                                     | Group          |                | Parent         |                |
|-----------------------------------------------------|----------------|----------------|----------------|----------------|
|                                                     | 2013           | 2012           | 2013           | 2012           |
|                                                     | \$000          | \$000          | \$000          | \$000          |
| Wages and salaries                                  | 109,151        | 103,768        | 104,282        | 99,710         |
| Contributions to defined contribution schemes       | 1,565          | 1,290          | 1,545          | 1,285          |
| Increase/(Decrease) in employee benefits provisions | 383            | 1,539          | 425            | 1,451          |
|                                                     | <b>111,099</b> | <b>106,597</b> | <b>106,252</b> | <b>102,446</b> |

### 4 OTHER EXPENSES

|                                                                               | Group        |              | Parent     |            |
|-------------------------------------------------------------------------------|--------------|--------------|------------|------------|
|                                                                               | 2013         | 2012         | 2013       | 2012       |
|                                                                               | \$000        | \$000        | \$000      | \$000      |
| Impairment of trade receivables (bad and doubtful debts)                      | 27           | 130          | 27         | 130        |
| Loss on sale of property, plant and equipment                                 | 7            | 70           | 7          | 70         |
| Audit fees - Ernst & Young (for the audit of the annual financial statements) | 228          | 220          | 203        | 191        |
| Audit fees - Verification New Zealand Limited (ACC partnership plan)          | 3            | 3            | 3          | 3          |
| Board members fees                                                            | 236          | 244          | 229        | 237        |
| Operating lease expenses                                                      | 732          | 738          | 265        | 284        |
|                                                                               | <b>1,233</b> | <b>1,405</b> | <b>734</b> | <b>915</b> |

### 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 2013 was 8% (2012: 8%).

### 6 FINANCING COSTS

|                                        | Group        |              | Parent       |              |
|----------------------------------------|--------------|--------------|--------------|--------------|
|                                        | 2013         | 2012         | 2013         | 2012         |
|                                        | \$000        | \$000        | \$000        | \$000        |
| Interest on bank overdraft             | 119          | 5            | 119          | 5            |
| Interest on loans - Ministry of Health | 1,713        | 1,819        | 1,713        | 1,819        |
|                                        | <u>1,832</u> | <u>1,824</u> | <u>1,832</u> | <u>1,824</u> |

### 7 CASH AND CASH EQUIVALENTS

|                                                             | Group        |              | Parent       |              |
|-------------------------------------------------------------|--------------|--------------|--------------|--------------|
|                                                             | 2013         | 2012         | 2013         | 2012         |
|                                                             | \$000        | \$000        | \$000        | \$000        |
| Cash at bank and in hand                                    | 4,751        | 3,433        | 4,747        | 3,407        |
| Short-term deposits maturing within 3 months of acquisition | -            | -            | -            | -            |
| Cash and cash equivalents                                   | <u>4,751</u> | <u>3,433</u> | <u>4,747</u> | <u>3,407</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       |              |
|-------------------------------------------------------|--------------|---------------|--------------|--------------|
|                                                       | 2013         | 2012          | 2013         | 2012         |
|                                                       | \$000        | \$000         | \$000        | \$000        |
| Ministry of Health                                    | 3,586        | 4,539         | 3,583        | 4,514        |
| Due from subsidiaries                                 | -            | -             | 1            | 1            |
| Due from associates                                   | 286          | 95            | 267          | 95           |
| Due from non-related parties                          | 2,714        | 5,196         | 2,643        | 4,737        |
| Prepayments                                           | 530          | 656           | 260          | 313          |
|                                                       | <u>7,116</u> | <u>10,486</u> | <u>6,754</u> | <u>9,660</u> |
| Allowance for impairment loss (a)                     | (24)         | (49)          | (24)         | (49)         |
| <b>Carrying amount of trade and other receivables</b> | <u>7,092</u> | <u>10,437</u> | <u>6,730</u> | <u>9,611</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:

|                     | <b>Group</b> |       | <b>Parent</b> |       |
|---------------------|--------------|-------|---------------|-------|
|                     | 2013         | 2012  | 2013          | 2012  |
|                     | \$000        | \$000 | \$000         | \$000 |
| <b>At 1 July</b>    | 49           | 54    | 49            | 54    |
| Charge for the year | 27           | 130   | 27            | 130   |
| Amounts written off | (52)         | (135) | (52)          | (135) |
| <b>At 30 June</b>   | 24           | 49    | 24            | 49    |

|                                                  | <b>Group</b> |       | <b>Parent</b> |       |
|--------------------------------------------------|--------------|-------|---------------|-------|
|                                                  | 2013         | 2012  | 2013          | 2012  |
|                                                  | \$000        | \$000 | \$000         | \$000 |
| Total non commercial debt                        | 81           | 111   | 81            | 111   |
| Non commercial debt with no impairment allowance | 57           | 62    | 57            | 62    |

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 2013 and 2012, all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below:

|                                             | <b>Actual</b> |            | <b>Actual</b> |            |
|---------------------------------------------|---------------|------------|---------------|------------|
|                                             | 2013          | 2013       | 2012          | 2012       |
|                                             | Gross         | Impairment | Gross         | Impairment |
|                                             | \$000         | \$000      | \$000         | \$000      |
| <b>Taranaki District Health Board Group</b> |               |            |               |            |
| Not past due                                | 6,917         | -          | 9,333         | -          |
| Past due 1 - 60 days                        | 140           | -          | 980           | -          |
| Past due 61 - 90 days                       | 14            | (1)        | 27            | (1)        |
| Past due > 90 days                          | 45            | (23)       | 146           | (48)       |
|                                             | 7,116         | (24)       | 10,486        | (49)       |

### Taranaki District Health Board Parent

|                       |       |      |       |      |
|-----------------------|-------|------|-------|------|
| Not past due          | 6,574 | -    | 8,719 | -    |
| Past due 1 - 60 days  | 121   | -    | 768   | -    |
| Past due 61 - 90 days | 14    | (1)  | 27    | (1)  |
| Past due > 90 days    | 45    | (23) | 146   | (48) |
|                       | 6,754 | (24) | 9,660 | (49) |

### (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       |              |
|-------------------------------|--------------|--------------|--------------|--------------|
|                               | 2013         | 2012         | 2013         | 2012         |
|                               | \$000        | \$000        | \$000        | \$000        |
| Pharmaceuticals               | 516          | 547          | 516          | 547          |
| Surgical and Medical Supplies | 1,454        | 1,532        | 1,453        | 1,532        |
| Other Supplies                | 544          | 575          | 544          | 575          |
|                               | <u>2,514</u> | <u>2,654</u> | <u>2,513</u> | <u>2,654</u> |

Write-down of inventories amounted to \$139k for 2013 (2012 \$64k).

No inventories are pledged as security for liabilities.

## 10 OTHER FINANCIAL ASSETS

|                                                    | Group         |               | Parent        |               |
|----------------------------------------------------|---------------|---------------|---------------|---------------|
|                                                    | 2013          | 2012          | 2013          | 2012          |
|                                                    | \$000         | \$000         | \$000         | \$000         |
| <b>Current portion</b>                             |               |               |               |               |
| Short-term deposits with maturities of 3-12 months | 11,000        | 33,000        | 11,000        | 33,000        |
|                                                    | <u>11,000</u> | <u>33,000</u> | <u>11,000</u> | <u>33,000</u> |
| <b>Non-current portion</b>                         |               |               |               |               |
| 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 INVESTMENT IN SUBSIDIARY COMPANY

|                                      | Group    |          | Parent       |              |
|--------------------------------------|----------|----------|--------------|--------------|
|                                      | 2013     | 2012     | 2013         | 2012         |
|                                      | \$000    | \$000    | \$000        | \$000        |
| <b>Investment details</b>            |          |          |              |              |
| 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. It was resolved during the year to dissolve HIQ Limited, with its last trading day the 30th June 2013.

### 12 INVESTMENT IN ASSOCIATE COMPANIES

|                                                                 | Group |       | Parent |       |
|-----------------------------------------------------------------|-------|-------|--------|-------|
|                                                                 | 2013  | 2012  | 2013   | 2012  |
| (a) Investment details                                          | \$000 | \$000 | \$000  | \$000 |
| HealthShare Limited unlisted ordinary shares                    | -     | -     | -      | -     |
| HealthShare Limited Share of Retained Earnings                  | 38    | 38    | -      | -     |
| Allied Laundry Services Limited unlisted ordinary shares        | 750   | 750   | 750    | 750   |
| Allied Laundry Services Limited Share of Retained Earnings      | 118   | 90    | -      | -     |
| Fulford Radiology Services Limited unlisted ordinary shares     | 401   | 401   | 401    | 401   |
| Fulford Radiology Services Limited Share of Accumulated Deficit | (366) | (472) | -      | -     |
| Fulford Radiology Services Limited loan to purchase assets      | 300   | 300   | 300    | 300   |
|                                                                 | 1,241 | 1,107 | 1,451  | 1,451 |

There is no intention to seek repayment of the Fulford Radiology Services Limited loan of \$300k (2012: \$300k).

Details of each Associate Company are as follows:

|                            | Balance date | Interest held at 30 June 2013 | Interest held at 30 June 2012 |
|----------------------------|--------------|-------------------------------|-------------------------------|
| <b>HealthShare Limited</b> | 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 Boards.

|                                           |         |     |     |
|-------------------------------------------|---------|-----|-----|
| <b>Fulford Radiology Services Limited</b> | 30 June | 50% | 50% |
|-------------------------------------------|---------|-----|-----|

The principal activity of the associate is the provision of radiology services.

|                                        |         |     |     |
|----------------------------------------|---------|-----|-----|
| <b>Allied Laundry Services Limited</b> | 30 June | 25% | 25% |
|----------------------------------------|---------|-----|-----|

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 - 2013: | Assets | Liabilities | Equity | Revenues | Profit/(loss) |
|----------------------------------------------------|--------|-------------|--------|----------|---------------|
|                                                    | \$000  | \$000       | \$000  | \$000    | \$000         |
| Healthshare Limited                                | 3,167  | 2,975       | 192    | 6,866    | -             |
| Fulford Radiology Services Limited                 | 4,198  | 3,462       | 736    | 11,842   | 668           |
| Allied Laundry Services Limited                    | 4,898  | 1,250       | 3,648  | 7,189    | 417           |



### Summarised audited financial information - 2012:

|                                    | Assets | Liabilities | Equity | Revenues | Profit/(loss) |
|------------------------------------|--------|-------------|--------|----------|---------------|
|                                    | \$000  | \$000       | \$000  | \$000    | \$000         |
| Healthshare Limited                | 1,957  | 1,766       | 191    | 3,693    | -             |
| Fulford Radiology Services Limited | 3,428  | 3,359       | 69     | 10,924   | 211           |
| Allied Laundry Services Limited    | 4,856  | 1,386       | 3,470  | 6,622    | 353           |

The above information has been extracted from the associate companies unaudited management accounts (2013) and audited financial statements (2012).

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

|                                                 | Group |       |
|-------------------------------------------------|-------|-------|
|                                                 | 2013  | 2012  |
|                                                 | \$000 | \$000 |
| <b>Balance at 1 July</b>                        | 1,107 | 918   |
| New investments during the year                 | -     | -     |
| Share of total recognised revenues and expenses | 134   | 189   |
| <b>Balance at 30 June</b>                       | 1,241 | 1,107 |

## 13 PROPERTY, PLANT AND EQUIPMENT

| Group and Parent                                               | Freehold Land | Freehold Buildings | Plant and Equipment | Motor Vehicles | Work in Progress | Total    |
|----------------------------------------------------------------|---------------|--------------------|---------------------|----------------|------------------|----------|
| <b>Year ended 30 June 2013</b>                                 |               |                    |                     |                |                  |          |
| Cost/revaluation 30-Jun-12                                     | 7,890         | 81,034             | 52,518              | 2,840          | 43,904           | 188,186  |
| Accumulated depreciation and impairment charges 30-Jun-12      | -             | (23,370)           | (32,559)            | (2,323)        | -                | (58,252) |
| Carrying amount 30-Jun-12                                      | 7,890         | 57,664             | 19,959              | 517            | 43,904           | 129,934  |
| Current year additions                                         | 21            | 2,763              | 5,105               | 283            | 44,623           | 52,795   |
| Current year revaluations                                      | 949           | 14,596             |                     |                |                  | 15,545   |
| Current year disposals                                         |               |                    | (7)                 | -              | -                | (7)      |
| Current year depreciation                                      | -             | (6,088)            | (5,442)             | (133)          | -                | (11,663) |
| At 30 June 2013 net of accumulated depreciation and impairment | 8,860         | 68,935             | 19,615              | 667            | 88,527           | 186,604  |
| <b>At 30 June 2013</b>                                         |               |                    |                     |                |                  |          |
| Cost or fair value                                             | 8,860         | 68,935             | 57,503              | 3,060          | 88,527           | 226,885  |
| Accumulated depreciation and impairment                        | -             | -                  | (37,888)            | (2,393)        | -                | (40,281) |
|                                                                | 8,860         | 68,935             | 19,615              | 667            | 88,527           | 186,604  |

The new clinical services block build accounts for \$77.55m (2012: \$36.20m) of the work in progress value at 30 June 2013.

| Group and Parent                                               | Freehold Land | Freehold Buildings | Plant and Equipment | Motor Vehicles | Work in Progress | Total    |
|----------------------------------------------------------------|---------------|--------------------|---------------------|----------------|------------------|----------|
| <b>Year ended 30 June 2012</b>                                 |               |                    |                     |                |                  |          |
| 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  |
| <b>At 30 June 2012</b>                                         |               |                    |                     |                |                  |          |
| 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  |

### 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 2013 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 New Zealand Institute of Chartered Accountants (NZICA), 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 2013 (2012; Nil).

### 14 INTANGIBLE ASSETS

| Group and Parent                                               | Shares | Total |
|----------------------------------------------------------------|--------|-------|
| <b>Year ended 30 June 2013</b>                                 |        |       |
| Balance at 30-Jun-12                                           | -      | -     |
| Accumulated depreciation and impairment charges 30-Jun-12      | -      | -     |
| Carrying amount 30-Jun-12                                      | -      | -     |
| Current year additions                                         | 729    | 729   |
| Amortisation charge for year                                   | -      | -     |
| At 30 June 2013 net of accumulated depreciation and impairment | 729    | 729   |
| <b>At 30 June 2013</b>                                         |        |       |
| Cost or fair value                                             | 729    | 729   |
| Accumulated depreciation and impairment                        | -      | -     |
|                                                                | 729    | 729   |

Intangible assets is the investment Taranaki District Health Board has made at 30 June 2013 in B Class Shares in HBL Limited. This investment in HBL is Taranaki District Health Boards share of the purchase of software for the implementation of the national finance, procurement, supply chain shared service.

### 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 |       |
|------------------------------------------|-------|-------|--------|-------|
|                                          | 2013  | 2012  | 2013   | 2012  |
|                                          | \$000 | \$000 | \$000  | \$000 |
| <b>Opening Balance</b>                   | 729   | 724   | -      | -     |
| Funds Received                           | 101   | 98    | -      | -     |
| Interest Received                        | 34    | 21    | -      | -     |
| Funds Spent                              | (163) | (114) | -      | -     |
| <b>Closing Balance Restricted Assets</b> | 701   | 729   | -      | -     |

#### Represented By:

|                                |     |     |   |   |
|--------------------------------|-----|-----|---|---|
| Cash at Bank                   | 18  | 4   | - | - |
| Short Term Deposits            | 677 | 719 | - | - |
| Shares & Other                 | 6   | 6   | - | - |
| <b>Total Restricted Assets</b> | 701 | 729 | - | - |

### 16 TRADE AND OTHER PAYABLES

|                                         | <b>Group</b>  |               | <b>Parent</b> |               |
|-----------------------------------------|---------------|---------------|---------------|---------------|
|                                         | 2013          | 2012          | 2013          | 2012          |
|                                         | \$000         | \$000         | \$000         | \$000         |
| Trade Payables                          | 25,913        | 21,800        | 25,374        | 21,415        |
| Capital Charge Payable                  | 782           | 1,584         | 782           | 1,584         |
| Income received in advance              | 993           | 1,339         | 993           | 1,329         |
| Interest Payable                        | 504           | 470           | 504           | 470           |
| Current Account with Subsidiary Company | -             | -             | 6,313         | 6,028         |
| Owing to Subsidiaries                   | -             | -             | 422           | 52            |
| Owing to Associates                     | 1,125         | 767           | 1,125         | 767           |
| Other Related Parties                   | 850           | 1,809         | 850           | 1,809         |
|                                         | <b>30,167</b> | <b>27,769</b> | <b>36,363</b> | <b>33,454</b> |

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 Ministry of Health. Capital charges are paid six monthly in arrears against invoices raised by the Ministry of Health at the end of December and June. Interest paid to the Ministry of Health 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

|                             | <b>Group</b>  |               | <b>Parent</b> |               |
|-----------------------------|---------------|---------------|---------------|---------------|
|                             | 2013          | 2012          | 2013          | 2012          |
|                             | \$000         | \$000         | \$000         | \$000         |
| Government Sector Borrowing | 72,000        | 56,800        | 72,000        | 56,800        |
| <b>Total Loans</b>          | <b>72,000</b> | <b>56,800</b> | <b>72,000</b> | <b>56,800</b> |
| Less Current Portion        | -             | 7,000         | -             | 7,000         |
| <b>Term Portion</b>         | <b>72,000</b> | <b>49,800</b> | <b>72,000</b> | <b>49,800</b> |

|                             |               |               |
|-----------------------------|---------------|---------------|
| INTEREST RATES:             | 2013          | 2012          |
| Government Sector Borrowing | 3.03% - 7.02% | 3.67% - 7.32% |

|                             | <b>Group</b>  |               | <b>Parent</b> |               |
|-----------------------------|---------------|---------------|---------------|---------------|
|                             | 2013          | 2012          | 2013          | 2012          |
|                             | \$000         | \$000         | \$000         | \$000         |
| GOVERNMENT SECTOR BORROWING |               |               |               |               |
| Due for repayment:          |               |               |               |               |
| within one year             | -             | 7,000         | -             | 7,000         |
| within two years            | 12,000        | -             | 12,000        | -             |
| within three years          | 19,200        | 12,000        | 19,200        | 12,000        |
| within four years           | -             | 19,200        | -             | 19,200        |
| within five years           | 22,000        | -             | 22,000        | -             |
| after five years            | 18,800        | 18,600        | 18,800        | 18,600        |
|                             | <b>72,000</b> | <b>56,800</b> | <b>72,000</b> | <b>56,800</b> |

The term loans denoted are financed by the Ministry of Health (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 Ministry of Health 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 Ministry of Health.

### FAIR VALUE OF GOVERNMENT BORROWING

The fair value of the \$72,000k (2012: \$56,800K) of Government Borrowing at 30th June 2013 was calculated at \$73,450k (2012: \$60,643k). This calculation is done by discounting the expected future cash flows at prevailing interest rates. Ministry of Health 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

|                              | <b>Group</b>  |               | <b>Parent</b> |               |
|------------------------------|---------------|---------------|---------------|---------------|
|                              | 2013          | 2012          | 2013          | 2012          |
|                              | \$000         | \$000         | \$000         | \$000         |
| Salary & wages accrual       | 4,138         | 3,968         | 3,953         | 3,851         |
| Annual Leave                 | 13,237        | 12,843        | 12,877        | 12,442        |
| Sick Leave                   | 323           | 305           | 323           | 305           |
| Long Service Leave           | 1,329         | 1,244         | 1,329         | 1,244         |
| Retirement gratuities        | 955           | 1,090         | 955           | 1,090         |
| Continuing Medical Education | 1,554         | 1,557         | 1,554         | 1,557         |
| Sabbatical Leave             | 259           | 233           | 259           | 233           |
|                              | <b>21,795</b> | <b>21,240</b> | <b>21,250</b> | <b>20,722</b> |

#### Made up of:

|             |               |               |               |               |
|-------------|---------------|---------------|---------------|---------------|
| Current     | 21,075        | 20,142        | 20,530        | 19,624        |
| Non-current | 720           | 1,098         | 720           | 1,098         |
|             | <b>21,795</b> | <b>21,240</b> | <b>21,250</b> | <b>20,722</b> |

### 19 PROVISIONS

|                           | <b>Group</b> |           | <b>Parent</b> |           |
|---------------------------|--------------|-----------|---------------|-----------|
|                           | 2013         | 2012      | 2013          | 2012      |
|                           | \$000        | \$000     | \$000         | \$000     |
| <b>Current provisions</b> |              |           |               |           |
| ACC Partnership Programme | 15           | 11        | 15            | 11        |
|                           | <b>15</b>    | <b>11</b> | <b>15</b>     | <b>11</b> |

The liability valuation on the ACC Partnership Program has been calculated by Aon New Zealand Limited as at the 30th June 2013. 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

|                                                               | <b>Group</b>  |               | <b>Parent</b> |               |
|---------------------------------------------------------------|---------------|---------------|---------------|---------------|
|                                                               | 2013          | 2012          | 2013          | 2012          |
|                                                               | \$000         | \$000         | \$000         | \$000         |
| Net Surplus/(Loss)                                            | 7             | 198           | (98)          | (1,079)       |
| Add/(Less) Non-Cash Items:                                    |               |               |               |               |
| Depreciation                                                  | 11,663        | 10,193        | 11,663        | 10,193        |
| (Decrease)/Increase in Provision for Doubtful Debts           | (25)          | (5)           | (25)          | (5)           |
| (Decrease)/Increase in Employee Entitlements                  | 553           | 1,923         | 527           | 1,831         |
|                                                               | 12,191        | 12,111        | 12,165        | 12,019        |
| Add back items classified as investment/financing activities: |               |               |               |               |
| Decrease/(Increase) in Investments Held                       | (134)         | (189)         | -             | -             |
| Net Loss/(Gain) of Disposal of Assets                         | 1             | 61            | 1             | 61            |
|                                                               | (133)         | (128)         | 1             | 61            |
| Add/(Less) Movements in Working Capital:                      |               |               |               |               |
| (Increase)/Decrease in Receivables & Prepayments              | 3,370         | (1,641)       | 2,907         | (1,093)       |
| (Increase)/Decrease in Inventories                            | 141           | (25)          | 141           | (25)          |
| (Decrease)/Increase in Payables & Accruals                    | 2,928         | 1,441         | 3,438         | 2,260         |
|                                                               | 6,439         | (225)         | 6,486         | 1,142         |
| <b>Net Cash Inflow/(Outflow) from Operating Activities</b>    | <b>18,504</b> | <b>11,956</b> | <b>18,554</b> | <b>12,143</b> |

### 21 RELATED PARTIES - KEY MANAGEMENT PERSONNEL

|                                                 | <b>Group</b> |       | <b>Parent</b> |       |
|-------------------------------------------------|--------------|-------|---------------|-------|
|                                                 | 2013         | 2012  | 2013          | 2012  |
|                                                 | \$000        | \$000 | \$000         | \$000 |
| <b>Compensation of key management personnel</b> |              |       |               |       |
| Short-term employee benefits                    | 1,902        | 1,745 | 1,902         | 1,745 |
| Post-employment benefits                        | 33           | 16    | 33            | 16    |
| Other long-term benefits                        | -            | -     | -             | -     |
| Termination benefits                            | -            | -     | -             | -     |
|                                                 | 1,935        | 1,761 | 1,935         | 1,761 |

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



### 22 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 \$312m from the Ministry of Health to provide health services to the Taranaki area (2012: \$302m). The amount outstanding at year end was \$3.59m (2012: \$4.54m).

##### (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<br>Owed to TDHB |       | Parent<br>Income to TDHB |       |
|------------------------------------|------------------------|-------|--------------------------|-------|
|                                    | 2013                   | 2012  | 2013                     | 2012  |
|                                    | \$000                  | \$000 | \$000                    | \$000 |
| Allied Laundry Services Limited    | 62                     | 62    | 84                       | 18    |
| Fulford Radiology Services Limited | 40                     | 32    | 291                      | 315   |
| Healthshare Limited                | 164                    | -     | 77                       | -     |
| HIQ Limited                        | 1                      | 1     | 15                       | 94    |
|                                    | 267                    | 95    | 467                      | 427   |

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

|                                    | Parent<br>Owed by TDHB |       | Parent<br>Expense to TDHB |        |
|------------------------------------|------------------------|-------|---------------------------|--------|
|                                    | 2013                   | 2012  | 2013                      | 2012   |
|                                    | \$000                  | \$000 | \$000                     | \$000  |
| Allied Laundry Services Limited    | 208                    | 106   | 928                       | 938    |
| Fulford Radiology Services Limited | 830                    | 619   | 7,277                     | 7,235  |
| Healthshare Limited                | 87                     | 41    | 663                       | 392    |
| HIQ Limited                        | 422                    | 52    | 3,561                     | 3,549  |
|                                    | 1,547                  | 818   | 12,429                    | 12,114 |

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

### Board Members - 2013

| TDHB Board Member | Related Party                          | Relationship                | TDHB Transaction                                    | Expense for Year<br>30 June 2013 | Owed by TDHB<br>at 30 June 2013 |
|-------------------|----------------------------------------|-----------------------------|-----------------------------------------------------|----------------------------------|---------------------------------|
|                   |                                        |                             |                                                     | \$000                            | \$000                           |
| Alex Ballantyne   | STDC                                   | Councillor                  | Local Authority                                     | 13                               | 3                               |
| Ella Borrows      | South Taranaki Medical Trust           | Trustee                     | GP and Health Services                              | 102                              | -                               |
| Mary Bourke       | TSB Community Trust                    | Trustee                     | Community Funding                                   | -                                | -                               |
|                   | Bishops Action Foundation              | Trustee                     | Community and Health Projects                       | -                                | -                               |
|                   | WITT Polytechnic                       | Chairperson                 | Training organisation                               | 11                               | -                               |
|                   | Lotteries Community Grant Committee    | Member                      | Community Funding                                   | -                                | -                               |
|                   | New Families Interim Trust             | Trustee                     | Community and Health Projects                       | -                                | -                               |
| Peter Catt        | Family Health Care Centre              | GP and Shareholder          | GP and Health Services                              | -                                | -                               |
|                   | Taranaki Sub Faculty                   | Secretary Treasurer         |                                                     | -                                | -                               |
|                   | RNZCGP                                 |                             |                                                     | -                                | -                               |
|                   | Workforce Development Group            | Member                      |                                                     | -                                | -                               |
|                   | HIQ Ltd                                | Director                    | Information Technology Provider                     | 3,561                            | 422                             |
| Kura Denness      | Hauora Taranaki PHO (Taranaki PHO Ltd) | Chairperson                 | GP and Health Services                              | -                                | -                               |
|                   | Tui Ora Ltd                            | Chairperson                 | Health Services                                     | 8,960                            | 650                             |
|                   | Massey University                      | Council Member              | Education Provider                                  | -                                | -                               |
|                   | Pharmac                                | Director                    | DHB Funding                                         | 91                               | -                               |
|                   | 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                        | 928                              | 208                             |
| Karen Eagles      | Govett Quilliam                        | Husband Senior Partner      | Legal rep of TDHB                                   | -                                | -                               |
|                   | Plunket NZ                             | National Councillor         |                                                     | 7                                | -                               |
| Flora Gilkison    | Taranaki DHB                           | Husband employed as surgeon |                                                     | -                                | -                               |
|                   | Fulford Radiology Services             | Director                    | Supplier of Radiology Services                      | 7,277                            | 830                             |
| Brian Jeffares    | Stratford Health Trust                 | Member                      | GP and Health Services                              | 20                               | -                               |
|                   | Taranaki Electricity Trust             | Member                      | Community Funding                                   | -                                | -                               |
| Pauline Lockett   | New Plymouth District Council          | Councillor                  | Local Authority                                     | 137                              | -                               |
| Alison Rumball    | Taranaki Cancer Society                | President                   | Health Services                                     | -                                | -                               |
| Colleen Tuuta     | Tui Ora Ltd                            |                             | Health Services                                     | 8,960                            | 650                             |

### Board Members - 2012

| TDHB Board Member | Related Party                          | Relationship                  | TDHB Transaction                                    | Expense for Year<br>30 June 2012<br>\$000 | Owed by TDHB<br>at 30 June 2012<br>\$000 |
|-------------------|----------------------------------------|-------------------------------|-----------------------------------------------------|-------------------------------------------|------------------------------------------|
| Alex Ballantyne   | Peak Health                            | Local Management Group Member | GP and Health Services                              | -                                         | -                                        |
|                   | TSB Community Trust                    | Trustee                       | Community Funding                                   | -                                         | -                                        |
|                   | STDC                                   | Councillor                    | Local Authority                                     | 17                                        | 3                                        |
| Ella Borrows      | South Taranaki Medical Trust           | Trustee                       | GP and Health Services                              | 87                                        | 2                                        |
| Mary Bourke       | TSB Community Trust                    | Trustee                       | Community Funding                                   | -                                         | -                                        |
|                   | Bishops Action Foundation              | Trustee                       | Community and Health Projects                       | -                                         | -                                        |
|                   | WITT Polytechnic                       | Chairperson                   | Training organisation                               | 3                                         | -                                        |
|                   | Lotteries Community Grant Committee    | Member                        | Community Funding                                   | -                                         | -                                        |
|                   | New Families Interim Trust             | Trustee                       | 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                   | Secretary Treasurer           |                                                     | -                                         | -                                        |
|                   | RNZCGP                                 | Member                        |                                                     | -                                         | -                                        |
|                   | Workforce Development Group<br>HIQ Ltd | Director                      | Information Technology Provider                     | 3,549                                     | 52                                       |
| Kura Denness      | Hauora Taranaki PHO (Taranaki PHO Ltd) | Chairperson                   | GP and Health Services                              | 15                                        | -                                        |
|                   | Midland Regional Health Network        | Trustee                       | 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                | Chairperson                   | Supplier of Laundry Services                        | 938                                       | 106                                      |
| 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                                    |

### 23 FINANCIAL INSTRUMENT CATEGORIES

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

|                                    |      | Group         |               | Parent        |               |
|------------------------------------|------|---------------|---------------|---------------|---------------|
|                                    |      | 2013          | 2012          | 2013          | 2012          |
|                                    | Note | \$000         | \$000         | \$000         | \$000         |
| <b>FINANCIAL ASSETS</b>            |      |               |               |               |               |
| <b>Loans and receivables</b>       |      |               |               |               |               |
| Cash and cash equivalents          | 7    | 4,751         | 3,433         | 4,747         | 3,407         |
| Debtors and other receivables      | 8    | 6,562         | 9,781         | 6,470         | 9,298         |
| Other investments                  | 10   | 57            | 57            | 57            | 57            |
| Term deposits                      | 10   | 11,000        | 33,000        | 11,000        | 33,000        |
| Restricted Assets and Trust Funds  | 15   | 701           | 729           | -             | -             |
| <b>Total loans and receivables</b> |      | <b>23,071</b> | <b>47,000</b> | <b>22,274</b> | <b>45,762</b> |

### FINANCIAL LIABILITIES

#### Financial liabilities at amortised costs

|                                    | Note |                |               |                |               |
|------------------------------------|------|----------------|---------------|----------------|---------------|
| Trade and other payables           | 16   | 29,174         | 26,430        | 35,370         | 32,125        |
| Loans from Ministry of Health      | 17   | 72,000         | 56,800        | 72,000         | 56,800        |
| <b>Total financial liabilities</b> |      | <b>101,174</b> | <b>83,230</b> | <b>107,370</b> | <b>88,925</b> |

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

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

The fair value of the \$72,000k of loans from the Ministry of Health at 30th June 2013 was calculated at \$73,450k (2012: \$60,643k).

### 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 concentration of credit risk as government sourced revenue for Taranaki District Health Board was 97% (2012: 96%) whilst it accounted for 97% (2012: 81%) 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 - 2013

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

|                                             | Carrying value<br>\$000 | Contractual<br>Cash Flows<br>\$000 | 0-3 month<br>\$000 | 3-12 months<br>\$000 | 1-3 years<br>\$000 | 3-9 years<br>\$000 |
|---------------------------------------------|-------------------------|------------------------------------|--------------------|----------------------|--------------------|--------------------|
| <b>Non-derivative financial liabilities</b> |                         |                                    |                    |                      |                    |                    |
| Trade and other payables                    | 29,174                  | 29,174                             | 29,174             |                      |                    |                    |
| Loans and borrowings                        | 72,000                  | 81,772                             | 111                | 2,573                | 35,530             | 43,558             |
|                                             | 101,174                 | 110,946                            | 29,285             | 2,573                | 35,530             | 43,558             |

#### Group - 2012

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

|                                             | Carrying value<br>\$000 | Contractual<br>Cash Flows<br>\$000 | 0-3 month<br>\$000 | 3-12 months<br>\$000 | 1-3 years<br>\$000 | 3-9 years<br>\$000 |
|---------------------------------------------|-------------------------|------------------------------------|--------------------|----------------------|--------------------|--------------------|
| <b>Non-derivative financial liabilities</b> |                         |                                    |                    |                      |                    |                    |
| 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             |

#### Parent - 2013

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

|                                             | Carrying value<br>\$000 | Contractual<br>Cash Flows<br>\$000 | 0-3 month<br>\$000 | 3-12 months<br>\$000 | 1-3 years<br>\$000 | 3-7 years<br>\$000 |
|---------------------------------------------|-------------------------|------------------------------------|--------------------|----------------------|--------------------|--------------------|
| <b>Non-derivative financial liabilities</b> |                         |                                    |                    |                      |                    |                    |
| Trade and other payables                    | 29,057                  | 29,057                             | 29,057             |                      |                    |                    |
| Loans and borrowings                        | 72,000                  | 81,772                             | 111                | 2,573                | 35,530             | 43,558             |
|                                             | 101,057                 | 110,829                            | 29,168             | 2,573                | 35,530             | 43,558             |

#### Parent - 2012

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

|                                             | Carrying value<br>\$000 | Contractual<br>Cash Flows<br>\$000 | 0-3 month<br>\$000 | 3-12 months<br>\$000 | 1-3 years<br>\$000 | 3-7 years<br>\$000 |
|---------------------------------------------|-------------------------|------------------------------------|--------------------|----------------------|--------------------|--------------------|
| <b>Non-derivative financial liabilities</b> |                         |                                    |                    |                      |                    |                    |
| 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.



### (e) Sensitivity Analysis

In managing interest rate risk Taranaki District Health Board has adopted two strategies, (i) having term borrowings with the Ministry of Health on fixed rates, and (ii) having the maturity dates of the five individual loans to the Ministry of Health 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 2013, 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 \$110k higher/lower (2012: \$330k).

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)         |       |
|                         | 2013                   | 2012  |
|                         | \$000                  | \$000 |
| +1% (100 basis points)  | 110                    | 330   |
| -1% (100 basis points)  | (110)                  | (330) |

## 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       |               |
|-------------------------------|--------------|---------------|--------------|---------------|
|                               | 2013         | 2012          | 2013         | 2012          |
|                               | \$000        | \$000         | \$000        | \$000         |
| <b>Capital Commitments</b>    |              |               |              |               |
| Property, plant and equipment | 4,964        | 32,077        | 4,964        | 32,077        |
|                               | <u>4,964</u> | <u>32,077</u> | <u>4,964</u> | <u>32,077</u> |

### 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                      | 1,067        | 563          | 1,067        | 563          |
| Later than one and not later than two years  | 983          | 525          | 983          | 525          |
| Later than two and not later than five years | 932          | 950          | 932          | 950          |
| Later than five years                        | 92           | 118          | 92           | 118          |
|                                              | <u>3,074</u> | <u>2,156</u> | <u>3,074</u> | <u>2,156</u> |

### 27 MAJOR VARIATIONS FROM BUDGET (unaudited)

#### Income Statement Variances - Revenue

Taranaki District Health Board recorded a surplus of \$0.007 million compared with a budgeted surplus of \$2.718 million.

A total of \$2.9 million additional revenue over budget was received as follows (2012: \$2.6m):

|                                     | Variance<br>unaudited | Variance<br>unaudited |
|-------------------------------------|-----------------------|-----------------------|
|                                     | 2013                  | 2012                  |
|                                     | \$000                 | \$000                 |
| Ministry of Health Funding          | 1,416                 | 3,815                 |
| Accident Compensation Revenue (ACC) | 118                   | (1,237)               |
| Inter District Flows                | 149                   | 4                     |
| Inter Provider Revenue              | 165                   | 9                     |
| Interest Received                   | 348                   | (141)                 |
| Donations Received                  | 102                   | (742)                 |
| Other                               | 643                   | 936                   |
|                                     | <u>2,941</u>          | <u>2,644</u>          |

#### Income Statement Revenue Explanations

|                                     |                                                                                  |
|-------------------------------------|----------------------------------------------------------------------------------|
| Ministry of Health Funding          | Additional funding devolved from Ministry in excess of funding envelope advised. |
| Accident Compensation Revenue (ACC) | Increased 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 (2012: \$5.8m):

|                                        | Variance<br>Unaudited | Variance<br>Unaudited |
|----------------------------------------|-----------------------|-----------------------|
|                                        | 2013                  | 2012                  |
|                                        | \$000                 | \$000                 |
| Employee Benefit costs                 | 4,512                 | 3,890                 |
| Outsourced services                    | 1,970                 | 806                   |
| Clinical supplies                      | (465)                 | 1,644                 |
| Payments to non-health board providers | (60)                  | (1,776)               |
| Other                                  | (171)                 | 1,229                 |
|                                        | <u>5,786</u>          | <u>5,793</u>          |

#### Income Statement Expenditure Explanations

|                        |                                                                  |
|------------------------|------------------------------------------------------------------|
| Employee Benefit costs | Increased staffing hours                                         |
| Outsourced services    | Increased demand for diagnostic testing.                         |
| Clinical Supplies      | Savings on implants and drug costs.Reduced depreciation expense. |

| Variance  | Variance  |
|-----------|-----------|
| Unaudited | Unaudited |
| 2013      | 2012      |
| \$000     | \$000     |

### Balance Sheet Variances

|                               |         |       |
|-------------------------------|---------|-------|
| Cash & S/T Deposits           | 3,247   | 1,379 |
| Other Financial Assets        | 3,000   | 2,000 |
| Property, plant and equipment | 15,947  | 143   |
| Receivables & Prepayments     | (2,498) | 2,587 |
| Employee Entitlements         | 840     | 2,048 |
| Payables                      | 8,522   | 5,581 |

### Balance Sheet Explanations

|                               |                                                                                        |
|-------------------------------|----------------------------------------------------------------------------------------|
| Cash & S/T Deposits           | Timing of payments to suppliers.                                                       |
| Other Financial Assets        | Timing of payments on new Clinical Services Block.                                     |
| Property, Plant and Equipment | Land & Building Revaluation at June 2013.                                              |
| Employee Entitlements         | Timing of Payroll payments.                                                            |
| Payables                      | Capital payments for new Clinical Services Block, and timing of payments to suppliers. |

## 28 AUDITORS' REMUNERATION

### Fees to principal auditor (Ernst & Young)

|                                      | Note | Group |       | Parent |       |
|--------------------------------------|------|-------|-------|--------|-------|
|                                      |      | 2013  | 2012  | 2013   | 2012  |
|                                      |      | \$000 | \$000 | \$000  | \$000 |
| Audit of annual financial statements | 4    | 228   | 220   | 203    | 191   |
| Other assurance-related services     |      | -     | -     | -      | -     |
| Tax compliance                       |      | -     | -     | -      | -     |
| Due diligence services               |      | -     | -     | -      | -     |
|                                      |      | 228   | 220   | 203    | 191   |

### Other Audit Fees paid (non Ernst & Young)

|                                                            | Note | Group |       | Parent |       |
|------------------------------------------------------------|------|-------|-------|--------|-------|
|                                                            |      | 2013  | 2012  | 2013   | 2012  |
|                                                            |      | \$000 | \$000 | \$000  | \$000 |
| ACC Partnership Program - Verification New Zealand Limited | 4    | 3     | 3     | 3      | 3     |

### 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 2013 | Actual 2012 |
|--------------------|-------------|-------------|
| 100,000 - 110,000  | 17          | 14          |
| 110,001 - 120,000  | 15          | 16          |
| 120,001 - 130,000  | 11          | 6           |
| 130,001 - 140,000  | 5           | 1           |
| 140,001 - 150,000  | 4           | 6           |
| 150,001 - 160,000  | 5           | 5           |
| 160,001 - 170,000  | 4           | 3           |
| 170,001 - 180,000  | 2           | 5           |
| 180,001 - 190,000  | 6           | 9           |
| 190,001 - 200,000  | 5           | 6           |
| 200,001 - 210,000  | 4           | 6           |
| 210,001 - 220,000  | 3           | 4           |
| 220,001 - 230,000  | -           | 3           |
| 230,001 - 240,000  | 5           | 3           |
| 240,001 - 250,000  | 3           | 2           |
| 250,001 - 260,000  | 7           | 3           |
| 260,001 - 270,000  | 4           | 6           |
| 270,001 - 280,000  | 7           | 4           |
| 280,001 - 290,000  | 2           | 1           |
| 290,001 - 300,000  | 1           | 1           |
| 300,001 - 310,000  | 1           | 2           |
| 310,001 - 320,000  | 1           | 1           |
| 320,001 - 330,000  | 1           | -           |
| 360,001 - 370,000  | 1           | -           |
| 370,001 - 380,000  | -           | 1           |
| 450,001 - 460,000  | 1           | 1           |
|                    | <hr/>       | <hr/>       |
|                    | 115         | 109         |
| Clinicians         | <hr/>       | <hr/>       |
|                    | 97          | 90          |
| Management         | <hr/>       | <hr/>       |
|                    | 18          | 19          |
| Total              | <hr/>       | <hr/>       |
|                    | 115         | 109         |

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 134 (2012: 132).

### 30 TERMINATION PAYMENTS

For the period to 30 June 2013, 1 employee or former employee of Taranaki District Health Board received payment in respect of termination of employment totalling \$33,704 (2012: 8 payments totalling \$57,189).

### 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 \$Nil (2012: \$1,886k) for (i) Community Oral Health Service of \$Nil (2012: \$190k), and (ii) for the interRAI National DHB Implementation Project of \$Nil (2012: \$1,696k). Public equity of \$959k (2012: \$959k) was repaid to the Crown during the year. The repayments in both 2013 & 2012 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

HIQ Limited, the fully owned subsidiary of Taranaki District Health Board was dissolved, with its last trading day the 30th June 2013.

# 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 a planner and a funder, a major employer, and a 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 resources practices that assist the DHB as a good employer.

| Element/Measurement                      | Describe formal policies of procedures                                                                                                                                                                                                                                                                                                                       | Other Practices                                                                                                                                                                                                                                                                       | Priority issues                                                                                                                                                                                                                       | Action taken                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Leadership, Accountability and Culture   | Code of Conduct<br>Equal Employment Opportunities (EEO)<br>Professional Development Policy<br>Values Statements embedded through all documentation                                                                                                                                                                                                           | Leadership programme developed for new and existing managers.<br>Development and Career planning.<br>Formal management and management/union meetings.                                                                                                                                 | Foundation and advanced management training.                                                                                                                                                                                          | Policies and Procedures continuously being reviewed.<br>TDHB specific "How to" training.<br>Peer mentoring.                                                                                                                                                                                                                                                                                                                                                                                              |
| Recruitment, Selection Induction         | Recruitment and Selection Policy<br>Recruitment Guideline Procedure<br>Induction and Orientation Policy                                                                                                                                                                                                                                                      | Comprehensive Induction Programme with elements online combining eLearning modules..<br>Post-Entry Survey (3 month).<br>Recruitment training.<br>Scholarships across all disciplines.<br>Schools Career Expo.<br>Working with clinical schools to provide work experience placements. | Better management of the online talent pool to access suitable candidates<br>Use of social networking to target youth.<br>Establishing a regional microsite to target priority occupation with known critical workforce deficiencies. | Regional and national collaboration to develop a talent management procedure<br>National Health Careers website targeting students, return-to-work and international candidates.<br>Collaborate with the national Kiwi Health Jobs working group to promote the New Zealand health sector brand.<br>An interactive website, Whyora, has been developed for rangatahi Maori.<br>Implementation of the Whakatipuranga Rima Rau project to place 500 Maori into the health sector employment over 10 years. |
| Employee Development, Promotion and Exit | Study, Conference and Course Leave<br>Termination of Employment Policy and Procedure<br>Medical Incapacity Policy                                                                                                                                                                                                                                            | Exit interview and survey.<br>Coaching available to all staff.<br>Clinical Supervision.<br>Employee Assistance Programme (EAP).<br>Interpersonal skills training.                                                                                                                     | Review reasons why staff are leaving the DHB.<br>Performance Management Training programme.                                                                                                                                           | Process established to record / monitor reasons for exiting.<br>Preceptorship training.<br>Mentoring training.                                                                                                                                                                                                                                                                                                                                                                                           |
| Element/Measurement                      | Describe formal policies of procedures                                                                                                                                                                                                                                                                                                                       | Other Practices                                                                                                                                                                                                                                                                       | Priority issues                                                                                                                                                                                                                       | Action taken                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| Flexibility and Work Redesign            | Flexible Working - Request and Complaints Procedure<br>Collective employment agreements<br>Employee Participation Agreement                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                       | Future lifestyle planning.<br>Retirement courses.                                                                                                                                                                                     | Lead initiatives in the Midland region to meet the challenges of an ageing workforce                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Remuneration, Recognition and Conditions | Job Evaluation Procedure<br>Recognising Long Service Procedure<br>Superannuation contributions<br>Collective employment agreements<br>Professional Development Policy                                                                                                                                                                                        | Job Evaluation Committee.<br>Comprehensive Progression/Merit criteria via collective agreements.                                                                                                                                                                                      |                                                                                                                                                                                                                                       | Promoting employee benefits for all staff                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Harassment and Bullying Prevention       | Harassment Policy and Procedure<br>Employee Assistance Programme                                                                                                                                                                                                                                                                                             | Interpersonal skills programmes.<br>Coaching / training Union Reps.<br>Conflict Resolution.<br>Behaviours programme                                                                                                                                                                   | Resolve issues as soon as possible at first level if appropriate.                                                                                                                                                                     | HR to monitor and report to Service Managers any harassment / bullying cases.<br>Working with key unions around establishing an awareness around all behaviours in the workplace.                                                                                                                                                                                                                                                                                                                        |
| Safe and Healthy Environment             | Health and Safety Policy<br>Staff Health and Monitoring<br>Significant Hazard Control Plan<br>Material Safety Data Sheets<br>Infection Control<br>Educational Information<br>Nursing Core Procedures<br>Pharmacy Procedures<br>Clinical Practices<br>Critical Incident Debriefing<br>Occupational Health<br>Wellness Committee<br>Host Responsibility Policy | Pre-employment Health Questionnaire for all staff.<br>Employee Assistance Programme.<br>Annual flu jabs.<br>Health and Safety Reps in each work area.<br>Health and Safety orientation.<br>Police vetting.                                                                            |                                                                                                                                                                                                                                       | Quality and Risk Department responsible for majority of these procedures.<br>Recreation society available to all staff.                                                                                                                                                                                                                                                                                                                                                                                  |













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

**TARANAKI**  
like no other