Taranaki District Health Board

Annual Report

TARANAKI DISTRICT HEALTH BOARD

2013-14

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

OUR AIMS

A Matou Wawata

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

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

Our Shared Vision / Te Matakite

How We Work Together and with Others (Nga Tikanga)

Me Pehea nga mahi ngatahi me etehi atu

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

We will work together by:

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

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Tony Foulkes and PHARMAC Chair Stuart McLauchlan

Taranaki DHB Friends of ED Volunteer Coordinator, Joan McCardle was awarded the Health Care Provider Service Award at the Minister of Health Volunteer Awards

INTRODUCTION BY CHAIR AND CHIEF EXECUTIVE

Welcome to the Annual Report for the Taranaki District Health Board for 2013/2014.

Welcome to the Annual Report for the Taranaki District Health Board for 2013/2014. We would like to acknowledge and thank all the Board and Committee members who have generously shared their skills and knowledge, including outgoing at December 2013, Chair Mary Bourke, and Deputy Chair Dr Peter Catt. Our Māori relationship partner, the Te Whare Punanga Korero Trust representing the eight iwi of Taranaki, has 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 vital area has continued through funding and providing programmes that target inequalities and improve access to service by implementing our Māori Health Plan, Te Matakite. This is in line with Te Kawau Maro (Taranaki Māori Health Strategy), developed together with the Māori Health sector and Te Whare Punanga Korero. The plan was informed by the 2012 Whanau Ora Health Needs Assessment. It sets challenging and practical steps to be taken in the years ahead to improve the health status of Taranaki Māori.

Throughout the year we have funded and provided health services to the value of $334m for the people Taranaki. We remained focused upon improving performance, meeting national health targets, living within our means and ensuring access to high quality services for the community while reducing health inequalities. In maintaining the balance of providing high quality services with our reducing proportion of national population funding there continues to be real challenges. It is therefore pleasing to note the slightly better than budgeted consolidated financial result for the Board and associated companies.

We have taken further 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, while 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. We have improved people's access to elective surgery by increasing our day of surgery admission rates. Every patient ready for cancer treatment has continued to receive it within the target of four weeks and our collaborative relationship with the MidCentral DHB has helped to maintain this achievement.

We reached a major milestone with the completion of Project Maunga (Taranaki Base Hospital redevelopment) which was officially opened by Hon. Tony Ryall, Minister of Health on 27 June. It was a very exciting moment for the people of Taranaki, and we are extremely grateful for the level of commitment and enthusiasm from everyone involved that has resulted in a modern fit for purpose hospital that will serve our community for many years to come. The wonderful reaction of patients and staff alike towards the improvements, including the bi-lingual signage has been great to see. The Project opened on time and within budget.

We have been very grateful for the work of the Taranaki Health Foundation who with the generous support of local organisations, businesses and individuals, enabled further value to be added to Project Maunga. Two campaigns have driven the Foundation's fundraising this year. 'Improve Your Stay' with a focus on extra patient and visitor comfort; and 'Connected Health' which supports additional technology innovations enabling clinicians to better share information to help patients.

Jacob Mills from Parafed with Tony Foulkes trying out a hand-cycle at the May Day 'Disabiility MAY Affect You' event organised by the Disability Action Group

Tony Foulkes, Pauline Lockett, Tony Ryall (Minister of Health) and Jonathan Young (MP for New Plymouth) at the official opening for Project Maunga

We have continued to improve the planning and management of staffing costs whilst also increasing new graduate clinical staff. This year over 25 students were awarded Taranaki DHB health scholarships. We have also worked to strengthen the Taranaki health workforce through collaboration with Health Workforce New Zealand, the Midland Regional Training Network and with local partners such as The Western Institute of Technology and Whakatipuranga Rima Rau.

Taranaki DHB is committed to meeting the national health targets. Improving our performance requires a 'whole of system' approach with a combination of focused attention, clinical leadership and system integration. Taranaki has made a significant contribution to meeting these health targets this year, notably by over delivering on more elective surgeries, faster access to emergency and cancer care and better prevention with more people in Taranaki getting help to quit smoking and having more diabetes and heart disease checks. 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.

Taranaki DHB is an active partner with the Midlands Health Network – PHO, working to better integrate Primary and community health services more closely with hospital services to benefit patients. This has enabled even more care to be delivered closer to home. Important collaboration to ensure people receive prompt and appropriate acute care in our Emergency Departments has also been of particular focus with Midlands Health Network.

Our partnerships with local councils and other agencies play an important role in the network of support we provide for harder to reach parents, caregivers, young and older people to access services in their own community. The implementation of the Social Sector Trial with the South Taranaki District Council has seen collaboration between the DHB, Ministries of Social Development, Education, Police and community health providers to support at risk youth. We hope such approaches can be extended to help other communities in the future.

Partnerships with other DHBs are 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 Tairawhiti, Bay of Plenty, Lakes and Waikato DHBs which audits NGO services in personal health, mental health and health of older people, as well as now providing joint service planning, workforce and internal audit teams, and information Systems leadership; and 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 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 would 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.

Pauline Lockett
CHAIR

Tony Foulkes
CHIEF EXECUTIVE

PROJECT MAUNGA

PROJECT MAUNGA
BASE HOSPITAL REDEVELOPMENT

A busy year of completing construction, moving in and officially opening the new hospital building.

Over the 2013-14 year Project Maunga, the Taranaki Base Hospital redevelopment, was completed. Staff and patients migrated in to the new hospital building in August 2013 and the official opening was held on 27 June 2014.

Project Maunga is more than a new building; it's a new way of doing things.

Construction

Earthquake safety

The new hospital building has been built to meet all the latest standards for buildings that have a special post-disaster function, such as medical emergency or surgical facilities.

The concrete frame in the building is designed to be 180% stronger than any new commercial building in Taranaki.

Demolition of Stainton Block

Once all staff and patients moved out of the old ward block, (Stainton Block), it was handed over to Fletcher Construction in early August 2013 for demolition in two parts:

- August 2013 - Soft strip: strip out of the walls/ceilings/fittings and floor coverings.
- September 2013 - mechanical demolition: excavators were used to demolish the roof and the concrete structure.

The Taranaki District Health Board and Fletcher Construction actively ensured that as much material as possible from Stainton Block was recycled. A total of 5,3000 tonne was taken away, with 95% being recycled. Concrete, steel, metals, cables and roof iron was sent to recyclers, and all rimu wood was sold on to local joinery shops or individuals.

Migration

Years of meticulous planning went into ensuring a smooth transition for patients and staff into Project Maunga.

In early August 2013, Kaumatua from all over Taranaki added their blessing to the new hospital building at a dawn ceremony.

In late August 2013, wards and services were moved into the new hospital building over a week, including approximately 100 acute patients. The moves went smoothly with the dedicated support of all staff members, patients and family members involved.

Feedback from patients and staff has been overwhelmingly positive. A 90-day post occupancy review of each ward and service was undertaken to identify any teething issues, and their solutions.

The wards and services located in the new building include:

- Sterile Services
- Operating Theatres
- Endoscopy Suite
- Ward 2A Older People's Health
- TSB Ward 2B Children & Young People
- Ward 3A General Surgery
- Ward 3B Orthopaedic and Surgical Specialties
- Ward 4A General Medicine
- Ward 4B General Medicine

Offical Opening

On Friday 27 June Health Minister Hon Tony Ryall officially opened Project Maunga. The date marked the opening of the new main entrance, as well as the bridge link between the old and new hospital buildings which was blessed by Taranaki Kaumatua at dawn on the Wednesday before the opening.

Taranaki District Health Board Chief Executive, Tony Foulkes said, "The opening was a very exciting moment for the people of Taranaki, and I am extremely grateful for the level of commitment and enthusiasm from everyone involved that has resulted in a modern fit for purpose hospital building that will serve our community for many years to come."

2013

AUGUST DEMOLITION OF STAINTON BLOCK COMMENCED

AUGUST TARANAKI KAUMATUA BLESS THE NEW HOSPITAL

AUGUST PATIENTS AND STAFF MIGRATE TO THE NEW BUILDING

AUGUST FIRST SURGERY IN NEW THEATRE

DECEMBER ENTRANCE LINK ROOF GOES ON

The people of Taranaki now have a new user friendly, modern and comfortable hospital with many new features to allow more efficient and effective working services and with the latest equipment and technology.

Mr Foulkes said, "All of this is very important but is useless without the skilled clinical and support people to be able to work in them. We have a team of extremely caring people working every day and night and they are really the heart-beat of the hospital."

"Project Maunga is not just about bricks and mortar, it is about hospital services working with primary care and other community based services to offer better care for the Taranaki people, and I hope something that the whole community can be proud of," added Mr Foulkes.

New and improved ways of working

Future proofing

Project Maunga has been designed to allow for more efficient and effective working, both now and in the future. For example, the interior walls have the ability to be configured in different ways, without major structural work, to meet changing needs in the future.

Co-location

The co-location of previously separate wards in the new hospital building means a new way of working for staff, and a better patient flow throughout the building.

Co-location is part of a wider organisational design, where the workplace supports the work and the workers. This is a core principle of Care Capacity Demand Management (CCDM) who helped in the planning and development of the new wards for Project Maunga.

One example is the co-location of the General Surgical Ward and the Orthopaedic and Surgical Specialties Ward on the third floor. This provides ease of access to amenities such as ceiling hoists and ensuites reducing the time wasted by nurses, as well as encouraging team work between the wards.

New models of care

The new models of care to coincide with the move to the new hospital building have evolved from a variety of sources, including internationally recognised best practice, Ministry of Health guidelines and staff input.

One example is a model called 'Enhanced Recovery After Surgery' (ERAS). The model sees patients being fully educated about their care and likely recovery, before their operation takes place.

"We have found that the patients length of stay has shortened, because they know what to expect - that fear factor is minimised. The patient takes an active part in their recovery; they are not just waiting on staff to instruct them on what to do. They get up earlier and recover better," said Rosemary Clements, Chief Operating Officer and Chief Nursing Adviser.

Generic placement of equipment in every ward allows staff to move seamlessly from ward to ward with the knowledge of where to find things when the need arises.

Improved endoscopy services

Unlike the old hospital building that only had one room for endoscopy, housed in an 'inefficient' old medical ward, the new endoscopy suite is located in the purpose built combined theatre ward, providing two rooms, two endoscopes and recovery.

With bowel cancer on the rise and the importance of early bowel screening, the extra facilities allow staff to work more efficiently and to see a larger volume of patients.

June 2013

August 2013

October 2013

August 2013

August 2013

New technology

Improved patient care – thanks largely to advanced technology - has gone hand-in-hand with the move into the new hospital building.

Electronic whiteboards

State-of-the-art electronic whiteboards are being used to update patient details, with the patient's particulars popping up on the appropriate screen from the moment they are admitted.

Nurses, doctors and other health professionals can then add various notes and referrals to patient details using the touch screen options.

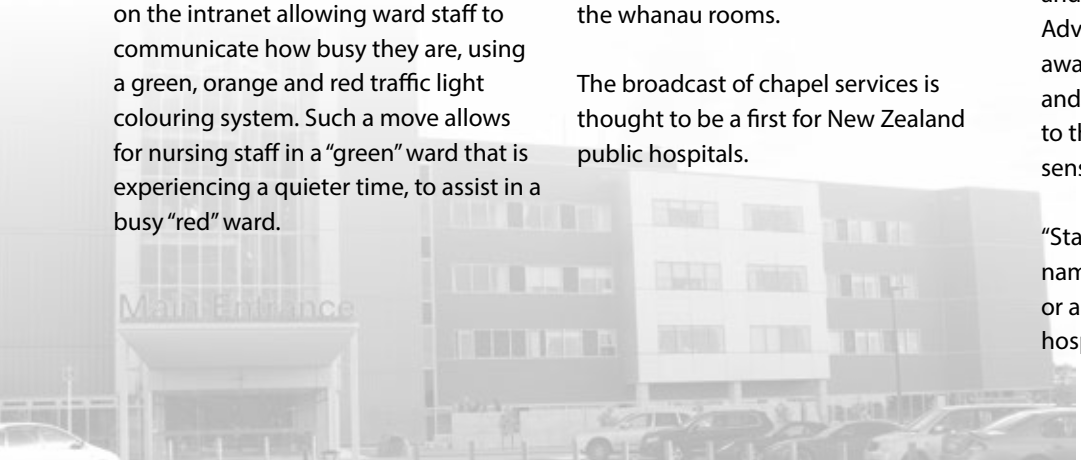
The electronic whiteboards have been instrumental in carrying out a new system of trying to discharge patients by 11am each day. When a patient is admitted to the hospital, an estimated date of discharge is highlighted on the screen. All staff involved in that patients care can then prioritise their workloads to achieve that discharge date.

Discharging patients by 11am each day frees up beds, avoiding a back-log of patients waiting for a bed.

Wireless technology

Wireless technology in the new hospital removes the need for clipboards, folders and paper to organise patients medical notes. Instead, nurses are equipped with computers on wheels (COWs) which allow for electronic notes to be updated at the bedside. Specialists and house surgeons also carry their own smart phone/pad technology to update patient notes wirelessly.

Added to the technology, is a feature on the intranet allowing ward staff to communicate how busy they are, using a green, orange and red traffic light colouring system. Such a move allows for nursing staff in a "green" ward that is experiencing a quieter time, to assist in a busy "red" ward.



Modern, comfortable environment for patients

The standout features of the new building not only originated from tours of other new hospitals, but from surveys, focus groups and liaison with stakeholders and staff.

Improved privacy

The wards in the new hospital building needed to improve patient privacy. In the old hospital there were 32-36 patients per ward, six patients per room, sharing as little as five bathrooms. This caused privacy issues and from a confidentiality point of view, was problematic.

In the new building there are double the number of single rooms and no more than four patients per room. Each room has its own ensuite toilet and separate shower. Needless to say, the reaction from patients has been extremely positive.

The design of the ensuite bathrooms has also drawn praise, particularly the accessibility features for people with disabilities. In fact, in the early planning stages, a mock ensuite was set up for the public to assess the bathrooms suitability before they were installed in the new hospital building.

Personal televisions

The introduction of personal televisions above each bed in the new hospital building has proved a popular move. The live broadcast of hospital chapel services was the first use of the available channels. Patients who are not well enough to move to the chapel can watch the service from their bed, or from one the whanau rooms.

The broadcast of chapel services is thought to be a first for New Zealand public hospitals.

Light and airy spaces with views

Part of the new building design includes large windows and low sills, allowing patients to soak up the fantastic views of the mountain to the sea from their beds. Another design feature is the head boards angled towards the window, which maximises patients views.

Children's ward artwork

The TSB Children and Young People's ward has been brightened by 'under the sea' themed artwork designed by Jennie Aitken-Hall. The art is aimed at improving the ward experience for children, young people and their families.

The playroom and rooms 1-4 have also had a film added to the bottom of the windows to improve the aesthetics. Eight long-term patients each took a photo, which was printed onto the window film along with their name.

Bilingual signage

Signage in both English and Te Reo has been installed inside the new hospital building, including the internal wayfinding, door labels and directory boards.

The outdoor entrance signage for the whole hospital has also been updated. Each sign includes a Māori welcome and the name of the entrance, which represents the waka or canoes that brought iwi to Taranaki. For example 'Aotea' is the Tukapa Street entrance. The outdoor signs were blessed by Taranaki Kaumatua in August 2013.

The signs have generated positive feedback and are a talking point for staff and visitors, says Chief Māori Health Advisor Ngawai Henare. "They raise awareness of the local Māori context and language, which in turn contributes to the ability to provide more culturally sensitive care."

"Staff quickly came to use entrance names such as 'Aotea' as a meeting place or as a route to get to certain parts of the hospital."

1350 PEOPLE EMPLOYED FOR PROJECT MAUNGA

EARTH EXCAVATED **8000 m³**

600,000 HOURS WORKED

340 TONNE OF STRUCTURAL STEEL

5,300 TONNE OF MATERIAL TAKEN AWAY WITH **95% BEING RECYCLED**

950 TONNE OF REINFORCING STEEL

3900 m³ CONCRETE POURED

$20m PAID TO WORKERS ONSITE

23,000 m² OF VINYL PLACED ON WALLS AND FLOORS

"This was a design that works well and efficiently and we think it still works as well, if not better, than anything we've seen"

Steve Berendsen, Project Manager, Project Maunga

"It's a silent ward. There's a calmness. Patients don't get woken up"

Janet Gibson, Clinical Nurse Manager, Medical Ward, Taranaki Base Hospital

"There's no comparison [to the old hospital]"

Geoff Way, patient, Taranaki Base Hospital

"It's gorgeous"
"So beautiful"
"Brilliant"
"Something for us all to be proud of"
"Lovely for staff, and a treat for patients"

From the public at the open day

April 2014

June 2014

June 2014 - Official Opening

June 2014 - Official Opening

June 2014 - Official Opening

2014

APRIL EXTERNAL SIGNS UNVEILED

JUNE ENTRANCE LINK COMPLETE

JUNE OFFICAL OPENING

TARANAKI HEALTH FOUNDATION

Taranaki Health Foundation congratulates Taranaki DHB on the success of Project Maunga

"We congratulate the Taranaki DHB staff and all involved with Project Maunga on all of their hard work and dedication provided to complete this new facility for the Taranaki community. This was a once in 50-year opportunity for our region and the staff input and participation was a crucial element in ensuring that this new facility is the best it can be," said Michael Joyce, Taranaki Health Foundation Chairman.

He described the Foundation going forward as "having the strong support of our current Partners enabling vital extras for Project Maunga such as the TSB Community Trust's largest donation in their 25 year history, enhanced comforts such as the patient televisions, and the upcoming Mobility Garden, offering onsite rehabilitation. We look forward to building strong relationships with new community donors and using our relationship with the Taranaki District Health Board to make the most of each healthcare dollar we raise as an addition to central Government funding. The Foundation is built on the guiding principles of integrity, strong ethics, transparency and professionalism, and we are working hard for the Taranaki community region wide to make the best use of the donations we receive."

1

2

Impact of Fundraising – Our donors making a difference

"There are many examples in the new hospital of the impact of the donations of our current donors," explained Rachel Church, Executive Officer of the Taranaki Health Foundation. Our donors have truly made an impact and are helping us achieve our goal of the best possible healthcare for Taranaki communities."

3

PHOTO 1: TSB Community Trust Children and Young People's Ward – reflecting the TSB Community Trust's largest donation in their 25 year history. Artwork made possible by Inglewood Lions.

PHOTO 2: Howard Wright staff who contributed to the development of the 18 new state of the art beds donated, with Hospital Redevelopment Manager Steve Berendsen (5th from left) and Taranaki Health Foundation Executive Officer Rachel Church (3rd from left).

PHOTO 3: Rachel Church, Taranaki Health Foundation Executive Officer; Peter Dryden, Managing Director Dow AgroSciences; Adrian Sole, Trustee Taranaki Health Foundation.

The TSB Community Trust's support of the TSB Children and Young People ward and the new direct silent nurse call system

TET's support of the wireless platform

Our Partners have supported our 'Connected Health' campaign providing advancements such as the Electronic Whiteboards and Computers on Wheels (C.O.W.S.)

Taranaki Health Foundation Trustees 2013-14

Michael Joyce - Chair

My background as a Dairy Farmer, Consultant and Taranaki Regional Councillor from the South Taranaki constituency enables me to bring strong leadership to the Foundation as its Chairman. The Foundation is all about having a charitable Trust that donors can support with confidence to ensure healthcare is enhanced as effectively as possible.

Bruce Moller

With 22 years experience working in business development, it is an honour to be a trustee of the Taranaki Health Foundation and use my skills to help support 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 the Taranaki community that I live in. I believe that the health and well being of our community is a shared responsibility.

Pauline Lockett

I firmly believe quality healthcare is important to everyone and I am committed to using my time and effort in achieving the goals of the Trust. I am proud of the work achieved by the Health Foundation so far and by the contributions that have been made to the Foundation to date, which I am confident will continue to be made in the 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.

Cathy Katene

I have become re-energised and am passionate about improving the quality of health care for people in Taranaki and the contribution that I can make to the Taranaki Health Foundation.

Nicola Luxton

As a lawyer with an environmental planning background, I hold a keen interest in maintaining and improving access to quality health care across the region and I am looking forward to working with the Foundation to make a positive difference for health Taranaki-wide.

Marise James

My willingness to become a trustee of the Taranaki Health Foundation is based on the simple desire to help the community help itself – to ensure that families throughout Taranaki can have access to the best possible healthcare available.

Phillip Brown

I have lived in Taranaki most of my life and I am passionate about our province and its people. In my role as a trustee and as a financial supporter of the Foundation I want to enhance healthcare services and infrastructure support for our communities ongoing health needs, happiness and prosperity.

Patient televisions were made possible by our Business Supporters and are connected to the chaplain service

Growing support of the Mobility Garden offering a welcoming onsite and real-life environment for rehabilitation as well as a beautiful space for patients and visitors to use

Foundation has raised over $6.4 million in donations

On Target

Shorter stays in

Emergency Departments

SHORTER STAYS IN ED

Target 95%
Achieved 94%

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 (ED) and the whole hospital. We continue to work towards the target of 95% of patients seen in the ED admitted, discharged, or transferred from the ED within six hours.
The number of patients presenting to the ED with minor injuries and illnesses continues to impact on this target. We are actively working with the Midlands Health Network to look at models of service delivery to support patients being seen in the most appropriate setting, such as GP's.

See the Statement of Service Performance page 60 for more on this target.

Improved access to

Elective Surgery

IMPROVED ACCESS TO ELECTIVE SURGERY

Target 100%
Achieved 113%

Taranaki DHB continues to achieve this target, across a wide range of surgical specialties. Our staff work hard to improve elective surgery results and this year has included a full review of preadmission services and the implementation of our Enhanced Recovery After Surgery (ERAS) programmes.
We are also pleased to continue to achieve our goal of no patients waiting over five months for a First Specialist Assessment. This means 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.

See the Statement of Service Performance page 64 for more on this target.

Shorter waits for

Cancer Treatment

SHORTER WAITS FOR CANCER TREATMENT

Target 100%
Achieved 100%

Every patient ready for cancer treatment continued to receive it within the target of four weeks. Taranaki DHB plans to continue our strong performance, and our collaborative relationship with the MidCentral DHB, to maintain this achievement.

See the Statement of Service Performance page 62 for more on this 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.

Increased

Immunisation

INCREASED IMMUNISATION

The target of 90% of eight-month-olds fully immunised, protecting them from illnesses such as whooping cough was achieved. The Taranaki DHB works closely with primary care organisations, hospital services, outreach immunisation services, the National Immunisation Register and Well Child Providers on strategies to improve our immunisation uptake, including early enrolment of newborns with a general practice.

Target 90%
Achieved 90%

See the Statement of Service Performance page 45 for more on this target.

Better help for

Smokers to Quit

BETTER HELP FOR SMOKERS TO QUIT

All Taranaki DHB buildings and grounds remain smoke free/auahi kore and staff are proud of a workplace and environment that encourages smokefree lifestyles. We continue to work hard to ensure patients and visitors to our hospitals are given advice about quitting smoking.

Hospital Target 95%
Achieved 96%

See the Statement of Service Performance page 43 for more on this target.

Taranaki DHB has made impressive progress on this target. Over 400,000 patients nationally were offered help to quit smoking during a visit to their GP clinic.

Primary Care Target 90%
Achieved 84%

See the Statement of Service Performance page 44 for more on this target.

More

Heart and Diabetes Checks

MORE HEART AND DIABETES CHECKS

Taranaki DHB continues to work to improve the number of eligible population having heart and diabetes checks. This includes working with Primary Health Organisations in developing their Diabetes Care Improvement Packages and Long Term Conditions programmes. Diabetes and cardiovascular disease remains one of the main causes of ill health in Taranaki.

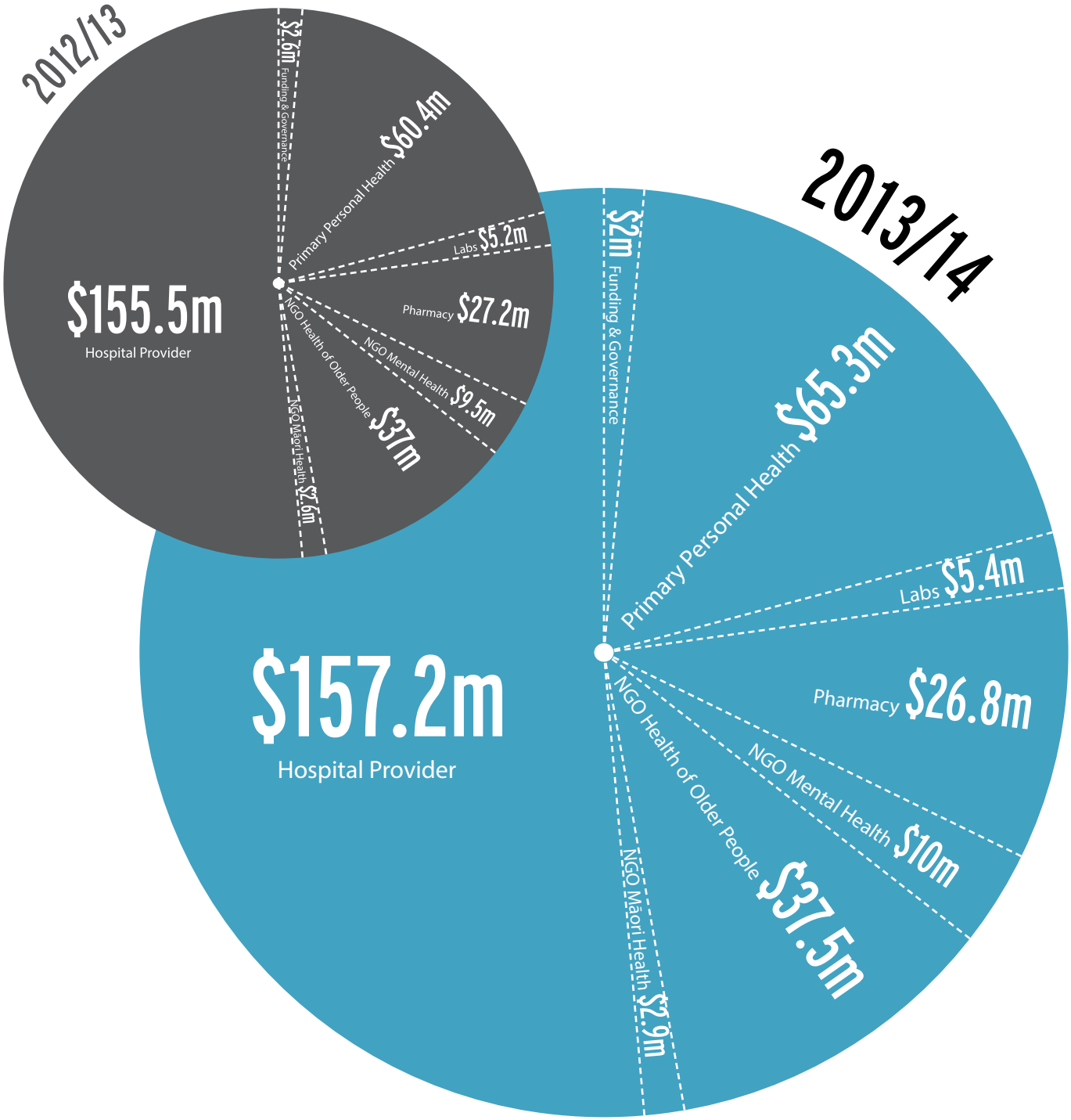
Target 90%
Achieved 88%

See the Statement of Service Performance page 53 for more on this target.

WHERE THE MONEY GOES

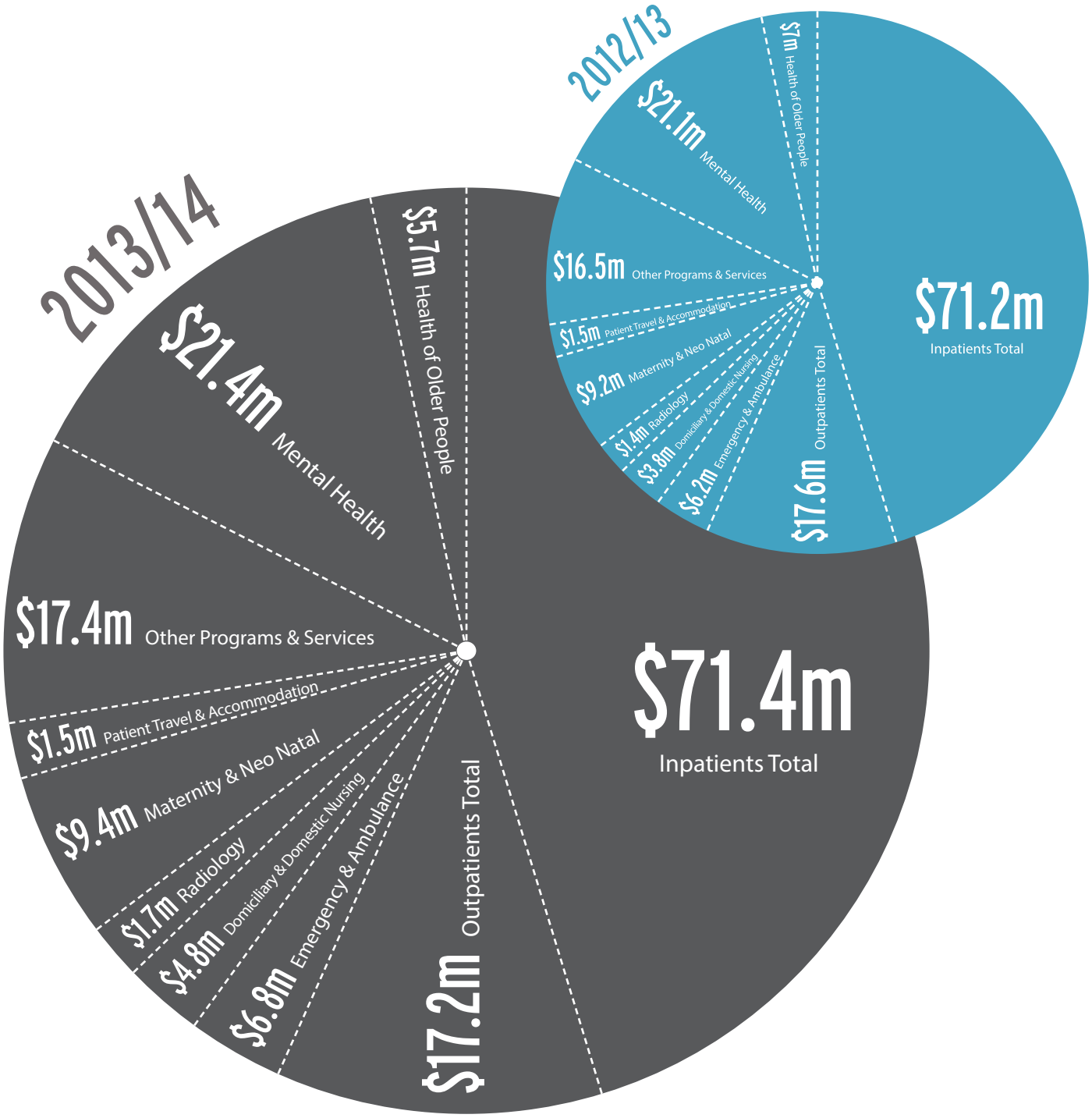
Taranaki DHB is the funder, planner and a key provider of health and disability services of the Taranaki region.

2013/14 Taranaki DHB Funding Allocation



We have 110,773 Taranaki residents.
We planned, funded and provided over $307 million of health and disability services. Of this, $157.2 million was allocated to the Hospital Provider.

2013/14 Hospital Provider Services Allocation



Other directly funded services are provided such as through ACC.

Back Beach, New Plymouth

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 110,773* people, or 2.5% of New Zealand's population. Between the 2006 and 2013 Census, the population usually resident in the region increased by 5,481 or 5.3%.
The Māori population is projected to increase to 20.6% of the total population by 2026. The European, Māori, Pacific and Asian populations have grown since 2006, as at the 2013 Census. Taranaki has 88.2% identified as European and other, 17.4% as Māori, 1.6% as Pacific and 3.4% as Asian. Note: Where a person reported more than one ethnic group, they have been counted in each applicable group. As a result percentages do not add up to 100.

Age Structure

Our population is ageing. The proportion of people over the age of 65 is higher than the national average. The proportion of people aged between 15 and 39 years is lower than the national average. A total of 21.1% are aged under 15 in Taranaki, while 45% of the Māori population is under 20.

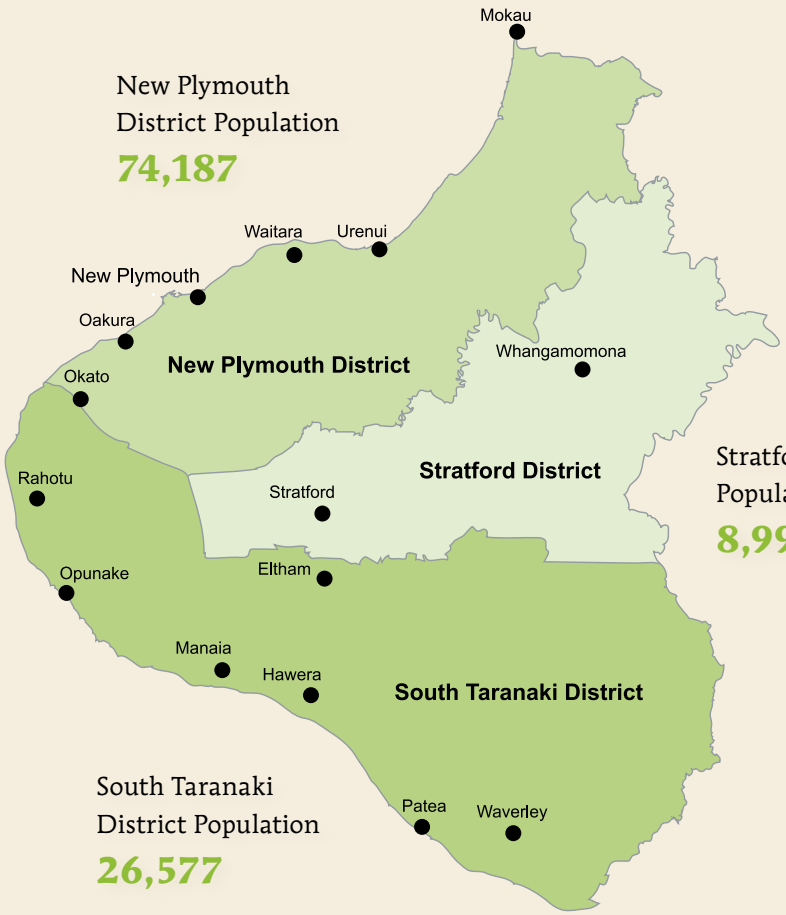
Socio-Economic Indicators

The Taranaki population sits towards the centre of the socio-economic range. There are higher percentages of people living in NZDep2013 deciles 5,6,8 & 9 and lower in decile four compared to the New Zealand average. Approximately 74% of the Māori population is resident in deciles 6-10 compared to 57% of non-Māori. Māori in Taranaki have 6-7 years less life expectancy than non-Māori.

*Based on updated information received from Statistics New Zealand Population Projection 2013

King Edward Park, Stratford

Patea Jetty



New Plymouth District Population
74,187

Stratford District Population
8,991

South Taranaki District Population
26,577

We have...

- Relationships with one Primary Health Organisation
- 32 GP practices
- 21dental practices
- 25 pharmacies
- 19 community personal health providers
- Providers of community laboratory services and radiology services
- Eight 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.

Taranaki Kaumatua bless the new hospital

Unveiling of the Taranaki DHB external signage

Māori Health

Building the capacity and capability of the Māori sector in Taranaki is a priority. Māori need to participate in the design, development and implementation of strategies to reduce health inequalities and to improve health outcomes for Māori. The Taranaki DHB takes pride in the work that has been done to protect and grow the Māori sector throughout the year, and in the face of extreme financial pressures.

The following components make up the Taranaki Māori health sector:

Te Whare Punanga Korero Trust - Māori Health Governance Group for Taranaki District Health Board. See page 31 for more about the Te Whare Punanga Korero Trust.

Te Kawau Mārō Alliance is a strategic alliance between Tui Ora Limited, Ngati Ruanui Tahua and Ngaruahine Iwi Health Service and Taranaki DHB. The alliance is the preferred provider of Māori primary health care services in Taranaki and delivers the sole Māori health services contract covering a range of primary health care services across Taranaki under an outcomes-based contract.

Whakatipuranga Rima Rau Trust is a joint venture between Te Whare Punanga Korero, the Ministry of Social Development (MSD) and the Taranaki DHB to increase the Māori health and disability workforce over ten years. A staff of three develops and delivers a range of programmes aimed at increasing the health and disability workforce.

Achievements of the Whakatipuranga Rima Rau Trust this year include:

- Supporting 55 Taranaki students studying tertiary health studies. The aim is for these students to come back to work in Taranaki once they have completed their studies.
- The continuation of the 'WhyOra' programme. To the end of June 2014, 369 students have taken part in WhyOra from 13 secondary schools and 54 are currently studying a health related subject at a tertiary institute.
- 'WhyOra' 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.

Te Roopu Paharakeke Hauora is the Māori Health directorate of the Taranaki DHB. The directorate is headed by the Chief Advisor Māori Health, a member of the Taranaki DHB Executive Management Team. The small team participates in decision-making across the funder and provider arms of the DHB to achieve improved outcomes for Māori.

Māori health and disability workforce
There is currently a lack of reliable information about the Māori health and disability workforce. The Taranaki DHB regularly collects information on its workforce, however no mechanism exists for gathering NGO workforce data. As at June 2014 the Taranaki DHB reached Māori staffing levels of 8.35% or 132 from a total of 1,713 staff, 0.35% above its target of 8%.

Taranaki Kaumatua bless the new link before the official opening

TARANAKI DHB MĀORI HEALTH PLAN PERFORMANCE DASHBOARD

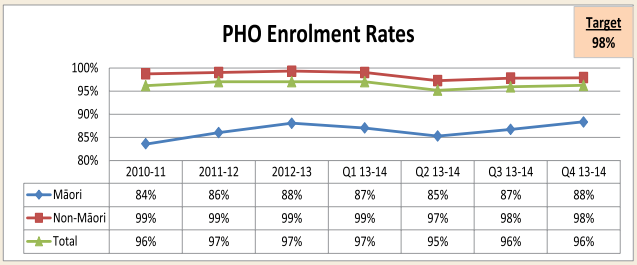
This year the DHB made important improvements to be able to gauge how well we are doing to improve the health of whānau living in Taranaki. There has been a particular focus on reducing health inequalities between Māori and non-Māori, based on addressing and monitoring key indicators of health.

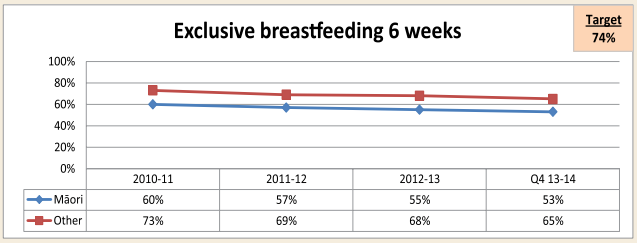
The tables on the following pages summarise the progress that's been made during the year to improve Māori health status in these key indicator areas.

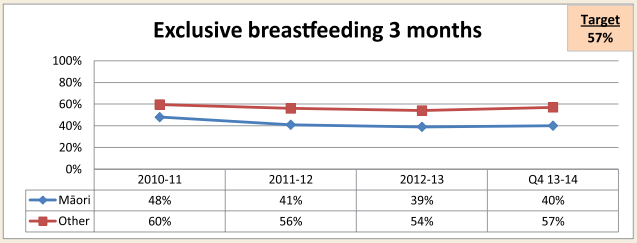
Quarter 4 Update (to July 2014)

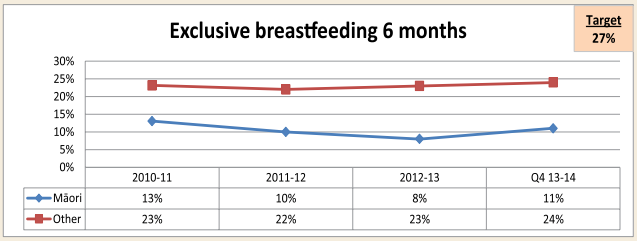
NATIONAL PRIORITIES & INDICATORS

	Indicator	Target	Māori	Non-Māori or Total	Reducing Disparity Progress	Disparity Gap
N1-Data Quality						
1	Ethnicity data accuracy in PHO registers	Audit tool still to be implemented during 2014-15				
	• The Midlands Health Network (MHN) have been monitoring the ethnicity data collected by GP Practices over the year. • Two new patient groups are being transitioned to the MHN. Following this their ethnicity enrolment data will be evaluated against the population census to assess its level of accuracy.					
N2-Access to Care						
2	Percentage of Māori enrolled in PHOs	98%	88%	98%	☒	10%
	• Primary Health Organisation (PHO) enrolments have been an issue in 2013-14, with the closure of a high needs clinic in New Plymouth and the reorganisation of GP Practices in South Taranaki. • Taranaki DHB and the MHN continue to work together to redirect patients presenting at the hospital's Emergency Departments (EDs) with minor injuries and illnesses to the most appropriate settings, such as GP Practices.					
3	ASH Rate: 0 - 4 years	<142%	111%	61%	☑	50%
	ASH Rate: 45 - 64 years	<161%	137%	66%	☑	71%
	ASH Rate: 0 - 74 years	<164%	139%	72%	☑	67%
	• ASH rates have steadily declined during the year, indicative of a range of interventions occurring in primary care. • Taranaki DHB and the MHN launched a GP/ED Overflow Clinic at Medicross Accident and Medical. The clinic provides primary health care for patients who present to Base Hospital ED with minor injuries and illnesses that should be treated in primary, rather than secondary, care.					
N3-Maternal Health						
4	Percentage of infants exclusively/fully breastfeeding at 6 weeks	74%	53%	65%	☒	12%
	Percentage of infants exclusively/fully breastfeeding at 3 months	57%	40%	57%	☒	17%
	Percentage of infants exclusively/fully breastfeeding at 6 months	27%	11%	24%	Ⓟ	13%
	• Implementation of the Mama Pepe Hauora (MPH) programme, to support mothers and their whanau to improve nutrition and increase physical activity, continued through-out Taranaki. Community Educators for the programme were appointed in late 2013. • The draft MPH Toolkit is being modified to better meet local expectations. Engagement with the five MPH communities has been undertaken and community action planning has commenced to prepare groups for the updated toolkit. • Tui Ora Ltd, La Leche League and Plunket Taranaki achieved the Breastfeeding Association Breastfeeding Community Initiative Accreditation (BFCI). • The Community Lactation Service commenced, with four scholarship recipients sitting their lactation consultant exam in July 2014. • Peer support training and service continues.					









Key to Reducing Disparity Progress

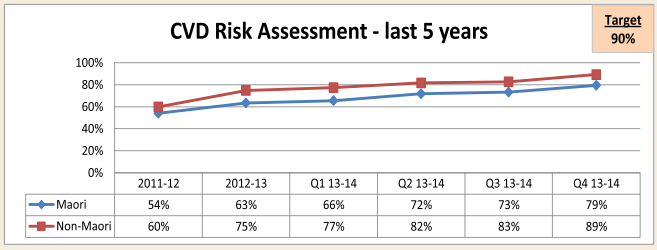
- ☑ Progressing well
- Ⓟ Some progress
- ☒ No progress or worsening
- ? Further info or work required
- ↑ Increasing gap

	Indicator	Target	Māori	Non-Māori or Total	Reducing Disparity Progress	Disparity Gap
N4-Cardiovascular Disease						
5	Percentage of high-risk patients will have received an angiogram within three days of admission	>70%	67%	69%	☑	2%
6	Percentage of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry	>95%	100%	83%	☑	-17%

- We continue to participate in regional Acute Coronary Syndrome planning. Data is now captured accurately, and produced and monitored monthly.
- In the first six months of the consistent reporting there has been a noticeable improvement in the number of high-risk patients having angiograms within three days of admission. Angiography follow-up has been consistently 100%.

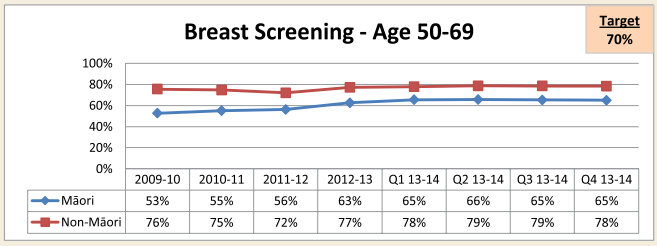
7	The proportion of the eligible population who have had their CVD risk assessed in the last five years	90%	79%	89%	☑	10%

- The Taranaki DHB has enabled the MHN PHO's to incentivise GP Practices to increase checks for cardiovascular disease and diabetes to help meet the target of 90%.
- This year there was a 16% improvement in cardiovascular disease risk assessments, and a 2% reduction in disparity with non-Māori.



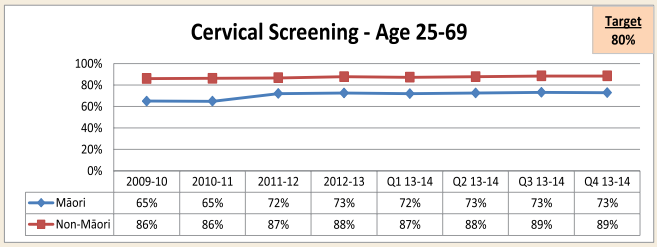
N6-Cancer						
8	Percentage of eligible women (50-69) have had a breast screen in the last two years	70%	65%	75%	Ⓟ	10%

- This year there was a 1% reduction in disparity between Māori and non-Māori breast screening results.
- A Hauora Day was held, coinciding with the launch of the breast screening bus in Waitara.
- Screening numbers for the BreastScreen Coast to Coast (BSCC) Mobile Unit continue to be monitored by the Taranaki Cancer Network and Breast Screen Aotearoa.
- The Breast Screen Aotearoa Manager continues to attend the quarterly Taranaki Cancer Network meetings, encouraging close working between the groups.
- The newly established Taranaki Māori Cancer Leadership Group held a workshop to determine its purpose, vision, values and future members. The group will work to improve the rates of breast screening among Māori women.



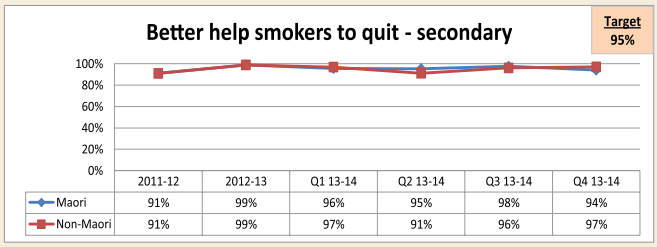
9	Percentage of eligible women (25-69) have had a cervical cancer screen in the last three years	80%	73%	89%	☒	16%

- There has been a 1% reduction in cervical screening rates for Māori compared to non-Māori this year. The Māori rate has remained at 73%, with the non-Māori rate improving by 1%.
- The Taranaki region has a three year plan focusing on PHO involvement in collaboration with the Regional Screening Unit.



N7-Smoking						
10	Percentage of adults 15+ admitted to hospital either acutely or for elective procedures who are provided with advice and help to quit	95%	94%	97%	☒	3%

- After achieving over the 'better help for smokers to quit' hospital target in the first quarter (96%) and increasing even further in the third quarter (98%), the reduction to 1% below the target in the fourth quarter is disappointing.
- The disparity between Māori and non-Māori fluctuated between -1% to +4% throughout the year, finishing at -3%.



- This year, the majority of hospital services implemented sustainable processes for capturing data and ensuring patients were screened and smoking cessation advice given. The embedding of those processes should be evident through sustained achievement of the target.

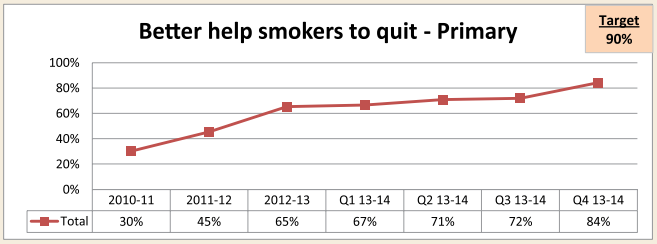
Danielle Frost, Whyora student

Huirangi Waikerepuru and Tom Rangihaeata

Minister of Health Tony Ryall and Matua Ramon Tito unveiling the plaque at the Project Maunga official opening

	Indicator	Target	Māori	Non-Māori or Total	Reducing Disparity Progress	Disparity Gap
11	Percentage of smokers in primary care who are provided with advice and help to quit - data is not provided by ethnicity	90%	N/A	84%	☑	

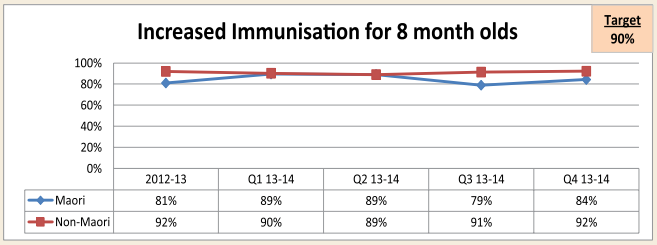
- The MHN achieved 84% of the 'better help for smokers to quit' primary care target in the fourth quarter, an increase of 17% on the first quarter result of 67%.
- To help achieve this increase a centralised campaign was undertaken including:
  - Brief advice offered to smokers that had not been seen within the year
  - Support and assistance to individual GP practices to catch up on missed opportunities
  - Smoking coordination champions appointed in each practice to coordinate smoking cessation activities
  - Setting of smoking targets within the MHN Quality Plan, met by 70% of practices
  - 99% of nurses and 91% of GPs trained in smoking cessation
  - Practices developing systems and processes to manage smoking cessation activities, including the alignment of Patient Management Systems
  - Networks with Aukati Kai Paipa providers and other stakeholders have been strengthened to provide a range of intervention options for patients on referral



N8-Immunisation

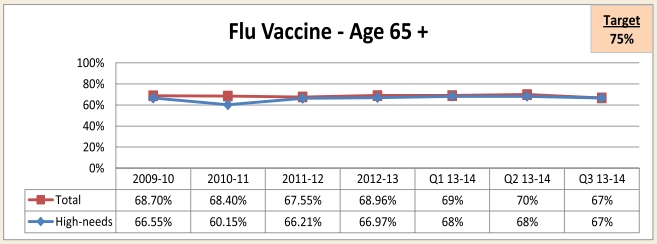
12	Percentage of 8 month olds fully immunised	90%	84%	92%	Ⓟ	8%

- Taranaki DHB met the target 90% of eight-month-olds fully immunised. The Māori result was 84%, a steady increase over the last three months of this year.
- A number of initiatives continue to be developed and implemented which will help increase this uptake.



13	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)	75%	67% high needs	67%	Ⓟ	

- The disparity between high needs and the total population was reduced by 2% (and therefore eliminated) between the 2013 and 2014 influenza seasons.
- The MHN PHO target for the 2013 influenza season of '70% of the eligible population immunised against influenza' contributed to the reduction in disparity.
- Taranaki achieved 63.4% for the high needs population, 8% short of the target of 75%.



N9-Rheumatic Fever

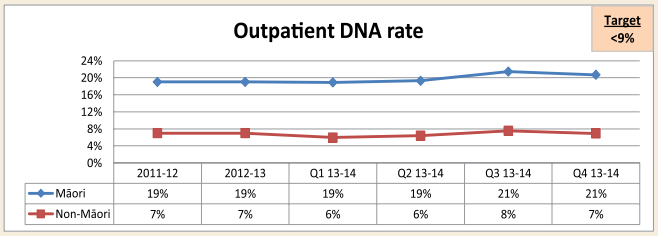
14	Hospitalisation rates per 100,000 DHB total population for acute rheumatic fever	0.8	0	0	☑	0

- A Rheumatic Fever Prevention Plan was approved by the Ministry of Health and is being implemented to ensure the appropriate preventive actions are maintained.
- Taranaki is fortunate that no Rheumatic Fever cases were notified in 2013-14.

LOCAL PRIORITIES & INDICATORS

	Indicator	Target	Māori	Non-Māori or Total	Reducing Disparity Progress	Disparity Gap
L1-Access to Services						
15	Did-Not-Attend (DNA) rate for outpatient appointments	<9%	21%	7%	↑	14%

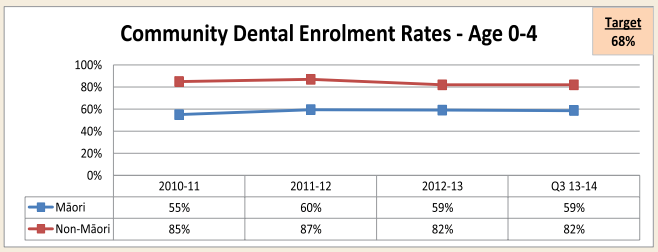
- Although disparities between Māori and non-Māori are shown to be increasing, there is a strong possibility that a portion of this is due to how the data is recorded. A project is under way to identify the true extent of DNA's so that these can be focused on.
- A new DNA project steering group and operations team was set up. They are undertaking in-depth analysis of the 35 outpatient specialty clinics that contribute to DNA rates. Colposcopy, cardiology, diabetes and dental are the priority areas.



- The Kaimahi Hauora are actively making contact with Māori booked into outpatient clinics to help overcome any barriers that may prevent them, or their children, attending their scheduled appointments. Common issues include timing of appointments and transport problems.
- One initiative to help patients get to their appointments is the Connector Bus, a collaborative project between the Taranaki DHB and WITT Polytechnic. The bus transports people from throughout Taranaki to Base Hospital or WITT.
- A cultural audit of colposcopy and diabetes pathways using the He Ritenga Treaty of Waitangi-based health audit framework was completed. This audit provided valuable insights into DNA issues, through patient and whanau interviews. The findings from the report are being used to develop possible solutions to be trialled, monitored and modified in a continuous cycle of improvement.

L2-Oral Health						
16	Percentage of Children (0-4) enrolled in DHB funded dental service	68%	59%	82%	☒	23%

- The number of Māori children enrolled in DHB dental services, as well as the disparities between Māori (59%) and non-Māori (82%), have remained static throughout the year.
- A steering group and operations team has been established to spearhead activities to increase enrolments and reduce disparities between Māori and non-Māori.



L3-Sudden Unexplained Death in Infants						
17	SUDI mortality rate per 1,000 live births of Māori infants	0.75	Data not available		☑	

- A number of multi-disciplinary programmes were implemented in 2013-14 to address SUDI.

  The programmes focused on:
  - Promoting safe sleeping environments including the Pepi-pod initiative developed by the Waikato DHB.
  - Accelerating programmes to reduce smoking.

  These programmes had a positive impact and resulted in the Ministry advising that SUDI is no longer a priority for Taranaki. However, we will continue to deliver programmes in-line with the Taranaki DHB population outcome that all children have the best start in life.

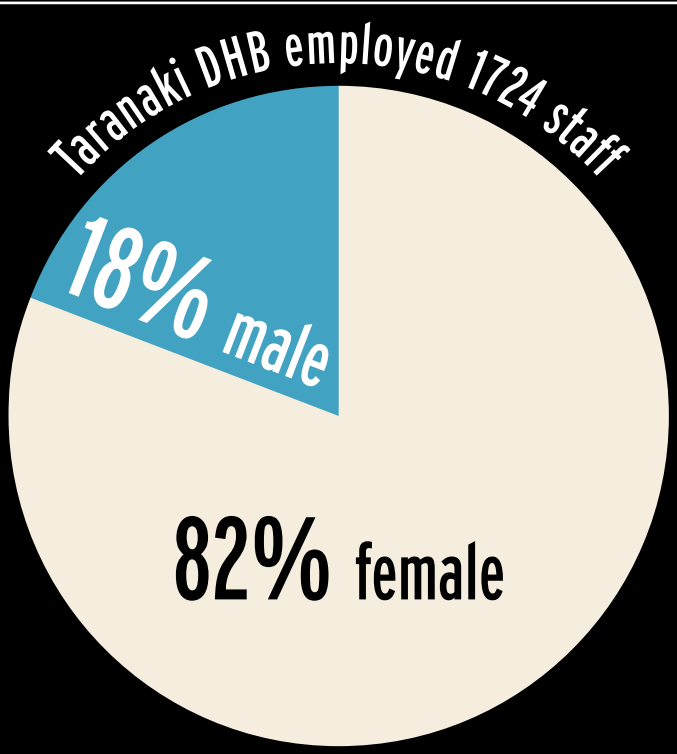
L4-Mental Health						
18	Increase the number of PMHI packages of care utilised by youth - baseline setting	N/A	17	49	?	

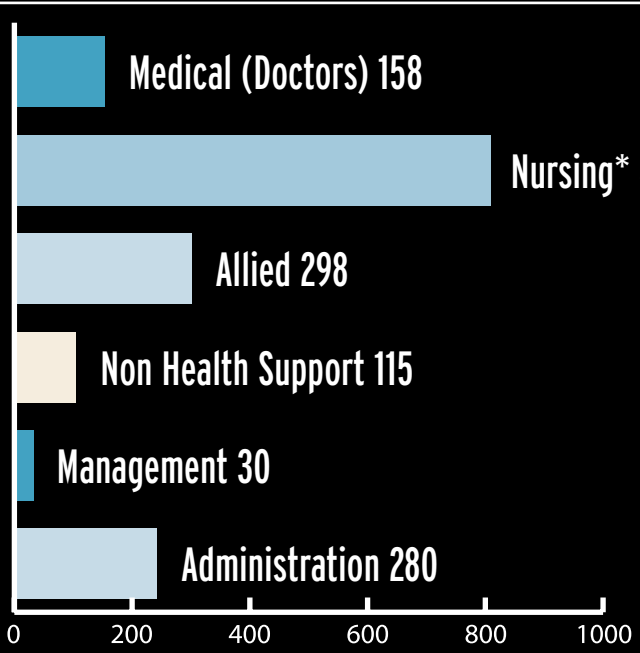
This year has provided a significant increase in activity related to youth mental health:

- Expansion of the Primary Mental Health Initiative for Public Health Nurses and School Counsellors, Social Sector Trial access to vouchers, workforce development and training spanning across all sectors, including ASIST (suicide prevention).
- Enhancing the skills for those working with youth, in particular Mental Health and Addiction, and Culture, Homes, Education, Activities, Drugs, Alcohol, Sex, Suicide (CHEADSS) training.
- Work has begun to roll out a School Based Health Services Quality Improvement Framework. This is a joint assessment process that involves both health and education

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.





*This figure includes midwives and health care assistants

Scholarships Awarded

Taranaki DHB health scholarships were awarded to 30 students in 2014 studying a range of areas including nursing, medicine, dental surgery, midwifery, social work, physiotherapy, speech language therapy, dietetics, pharmacy, occupational therapy, psychology, dental therapy and medical imaging.
Of the recipients, 33% identified as Māori.

702 Nurses

102 Health Care Assistants

27 Physiotherapists

21 Social Workers

39 Midwives

31 Occupational Therapists

18 Dental Therapists

30 Orderlies

42 Cleaners

41 Laboratory Employees

19 Pharmacy employees

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:

- 2 Consultant General Physicians
- 1 Consultant Anaesthetist
- 1 Consultant Psychiatrist
- 5 Consultants Emergency Medicine
- 1 Consultant Obstetrics and Gynaecology
- 3 Medical Officer Hawera Hospital
- 1 Medical Officer Sexual Health
- 1 Medical Officer Paediatrics

'Connector' Bus Service launch

Ngati Ruanui Health Care Centre GP Dr Meyer receives his influenza vaccination

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

Two new transport initiatives to help patients and visitors travelling to and from Base Hospital have been launched:

- **Community Coastal Transport Service** - The Community Coastal Transport Service transports people from coastal Taranaki to essential health and social service appointments. The free service was established by the Taranaki DHB Public Health Unit in partnership with the Coastal Taranaki Public Transport Trust and the New Zealand Red Cross.
- **Connector Bus Service** - The Connector Bus Service makes four return trips each weekday between Hawera and New Plymouth, transporting people to and from Base Hospital and WITT Polytechnic. The service is operated by Pickering Motors under contract to the Taranaki Regional Council and with funding support from the regions three District Councils, Taranaki DHB and WITT Polytechnic.

Immunisation Day at Ngati Ruanui Health Centre - Ngati Ruanui Health Care hosted an Immunisation Week celebration in May. Members of the public were able to discuss immunisation with health professionals in a bright and friendly environment. Thirty people received their immunisations, including childhood and influenza vaccinations.

Re-launch of 'Snack Facts' resource in Te Reo - Since 2001, the popular 'Snack Facts' pamphlets have highlighted the fat and sugar contents of popular snack foods and drinks. This year, the resource was re-launched in English and, for the first time, in Te Reo. New Plymouth kura kaupapa Māori, Te Pi'ipi'inga Kakano Mai i Rangiatea, assisted in the translation, enlisting the support of teachers and parents, some of whom work for the local Māori language trust, Te Reo O Taranaki.

Whanau Pakari started as a collaboration between Sport Taranaki and Taranaki DHB to provide a multi-disciplinary support package for children and adolescents with weight issues in Taranaki. Ambassador and professional boxer Sam Rapira joined forces with the Whanau Pakari team to provide support and inspiration.

Consistent approach to Community Palliative Care - Community palliative care patients in Stratford, Opunake and Patea began receiving home-based care by Hospice Taranaki specialist nurses in October. This brought the service in line with that of North and South Taranaki, providing a more consistent approach to palliative care across the whole of Taranaki.

Safe sleep day promotion - Taranaki DHB and Tui Ora celebrated the first nationwide 'Safe Sleep Day' to support the prevention of Sudden Unexpected Death in Infancy and cot death. This included a pepi-pod display in a local shopping mall. Pepi-pods provide babies a protected space when they sleep in, or on, an adult bed, on a couch, in a makeshift setting, or away from home.

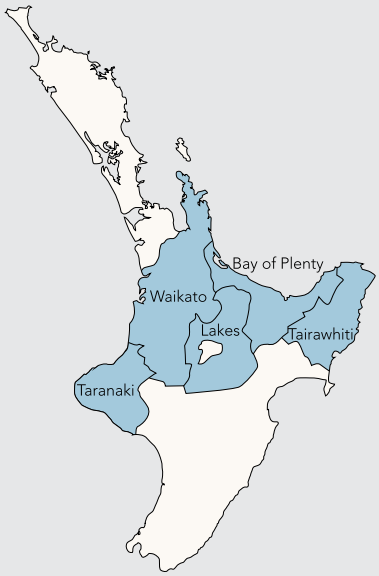
Youth Health radio show – Taranaki DHB's Taiohi Tu Youth Programme and Te Korimako o Taranaki joined together to create a live monthly radio show, 'The Parauri Panel'. The show aims to get young people to talk and think about their health, as part of a wider campaign to increase positive messages for young people.

Professional Boxer Sam Rapira and Rynan Gooch at the Whanau Pakari graduation.

Celebrating Safe Sleep Day in Centre City

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 Tairawhiti.



Our Midland Region has:

- Highest proportion of Māori
- Low proportion of the population identifying as Asian or Pacific peoples
- Higher number of people living in rural areas
- A relatively higher proportion of people living in areas identified as high deprivation (deprivation quintiles 4 and 5)
- Lower life expectancy than the New Zealand average, and
- Higher smoking rates than the New Zealand average.

Open for Better Care' patient safety campaign – In late 2013, Taranaki DHB hosted a booth to raise awareness of the new national patient safety campaign 'Open for Better Care'. The campaign focused on reducing harm from surgical site infections (SSIs), including promoting simple interventions to reduce SSIs. The campaigns three other focus areas – falls, surgery and medication – were also promoted. Midland regional DHBs are working on a combined regional approach to reduce the number of SSIs, and are fully committed to improving outcomes for patients and communities across the region.

Midwife Emergency Refresher Course – Taranaki DHB maternity educators have worked with a subgroup of the Midland Maternity Action Group to design a midwife refresher emergency course. The course has been approved by the Midwifery Council of New Zealand and is being rolled out regionally, with plans to then share nationwide. Midland maternity educators share a vision to design courses that are transferrable across the Midland Region, enabling midwives to receive the same training wherever they are, and provide sustainable and robust ongoing education programmes.

Midland Smokefree 2025 - The Taranaki DHB has continued to align its smokefree work with the Midland Smokefree 2025 framework, which in turn reflects the national goal of Smokefree Aotearoa 2025. In 2013-14 this has included the development of regional policies for smokefree areas, and the adoption and communication of the Midland Smokefree 2025 Vision Statement.

Map of Medicine tool - The web-based software tool 'Map Of Medicine' was rolled out to five DHBs in the Midland region. The tool allows clinicians across all sectors of health to work more closely together and to access evidence-based local guidance and clinical decision support at the point of care.

Aged Care innovation - Taranaki DHB's partnership with the aged care sector to help older people return home after a serious fall or injury, is one of a number of innovative approaches that has been captured in a series of stories and videos produced by the Ministry of Health. The stories and videos have been collected to share some of the initiatives that are working to improve the quality of care for our ageing population and strengthening the nursing workforce.

Governance

2013/2014

GOVERNANCE STRUCTURE

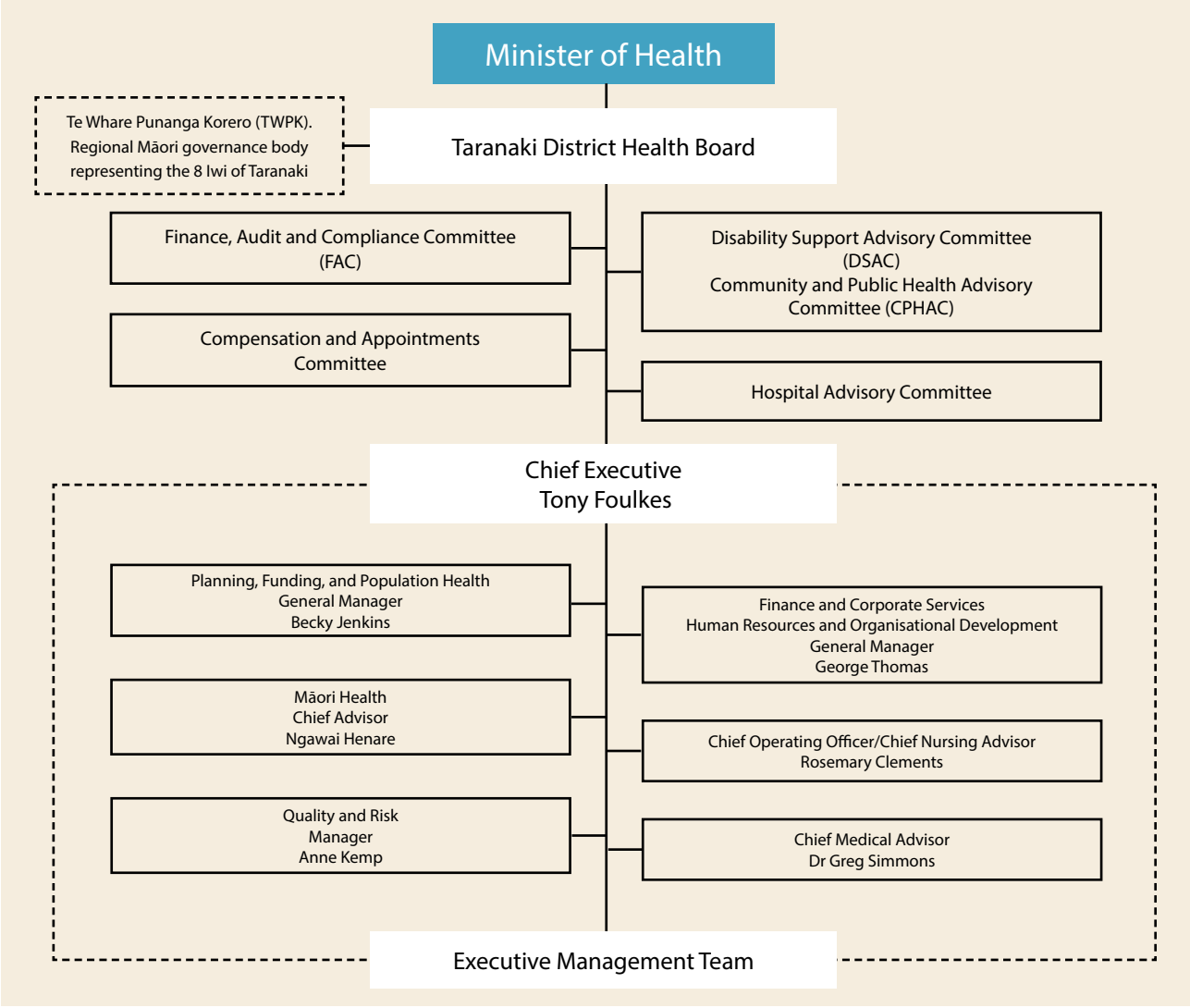
The governance structure for DHBs is set out in the NZ Public Health and Disability (NZPHD) Act 2000. The Board consists of up to 11 members and they have overall responsibility for the operation of Taranaki DHB. Seven of the members are elected as part of the three-yearly local body election process (last held in 2013) 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 is recruited to assist where needed with the work of the advisory committees. The Board publishes when and where it or its advisory committees meet and members of the public are welcome to observe most of the meetings, other than items of a confidential or commercial nature.



BOARD MEMBER PROFILES

PAULINE LOCKETT (CHAIR)

Pauline Lockett has lived in New Plymouth since 1981. Pauline was appointed to the Taranaki District Health Board in 2010 and was appointed the Chairperson in 2013. She is a member of the Health Board's Hospital Advisory Committee, the Finance, Audit and Compliance Committee and the Community and Public Health and Disability Support Advisory Committee. Pauline is a director of Landcorp Farming Limited and is the Chair of the Audit Committee.

Interest Register: PN Lockett Family Trust, Landcorp Director, Trustee of Taranaki Work Trust, Taranaki Health Foundation Trust.

SALLY WEBB (DEPUTY CHAIR)

Sally is a Ministerial appointment as Deputy Chair of the Board. She has a nursing background and has been involved in various positions across clinical, management and governance in the health sector for over 25 years. She is currently the Chair of Bay of Plenty DHB and lives in Whakatane. In addition Sally has significant leadership development experience and has run her coachng and consulting business involved in leadership development across a number of sectors since 2000. She is committed to using her skill and experience by working with the Board and management to ensure Taranaki DHB remains one of the highest performing DHBs in the country.

Interest Register: Bay of Plenty DHB – Chair, Capital Investment Committee – Member, SallyW Ltd – Director, Bectolee Partnership – Partner.

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 - South Taranaki District Council.

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 who provide legal services to Taranaki DHB, Member of the Ministry of Health to consider complaints re: advertising infant formula.

FLORA GILKISON

Flora is an elected member of the District Health Board where she is the Chair of the Community and Public Health Advisory Committee and the Disability Support Advisory Committee, a member of the Hospital Advisory Committee and the Finance and Audit Committee. She is also Chair of Fulford Radiology Services Ltd. 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.

RICHARD HANDLEY

Richard Handley BBS (Massey), Dip Ag, ACA, CMA, CMInstD. Richard's career includes 15 years in international and NZ domestic banking followed by Chief Executive positions at Lakeland Health (Rotorua and Taupo Hospitals), the Human Rights Commission, and in tertiary education Deputy Chief Executive of Unitec and Chief Executive of WITT. He is an elected member of the Taranaki DHB and is Chair of the Finance, Audit and Compliance Committee.

Interest Register: Councillor of the New Plymouth District Council and Chairman of the Finance Committee, Trustee of Taranaki Youth Trust (New WAVES), Board member - YMCA.

TE AROHA HOHAIA

Te Aroha is an appointed member of the Taranaki District Health Board. She is a member of the Health Advisory Committee and Deputy Chairperson for the Disability Services Advisory Committee and the Community & Public Health Advisory Committee. Te Aroha has professional and personal interests in community governance and local decision making. She is especially interested in the wellbeing of her mokopuna. Te Aroha is of Ngāruahine, Taranaki and Te Atiawa descent. She and her husband, Greg van Paassen live in Hawera.

Interest Register: TSB Community Trust – Trustee, South Taranaki Social Sector Trials – Advisory Group Member, Hawera Rape Crisis Incorporated – Trustee & Chairperson, Summit House Trust – Trustee & Chairperson, Access Radio Taranaki Trust – Trustee & Chairperson, Puke Ariki Trust – Trustee, Aatea Consultants Limited – trading as AATEA Solutions – Associate, Orange Cat Limited trading as OCL Consultants – Principal Consultant, Shareholder & Director, Louise Rauhuia Manuera Hohaia Whānau Trust – Responsible Trustee, School of Government Victoria University of Wellington – PhD Candidate & Research Assistant, Taranaki Families Centre Trust – Trustee.

PAT LEARY

Dr Pat Leary has 25 years experience in the health care sector. He is a practicing GP in New Plymouth and prior to this, he worked at Taranaki Base Hospital as a house surgeon and surgical registrar. Pat has been a Police Medical Officer for ten years and also co-directs the Taranaki Sexual Assault Service. Pat is a member of the Community and Public Health Advisory Committee, Disability Support Advisory Committee and Hospital Advisory Committee. Pat also currently serves on the Pinnacle Executive Committee of the Midlands Health Network Trust. Pat is married with three teenage children.

Interest Register: Director – Dr P E Leary Ltd, Director – Devon Medical Ltd, Director – TSAS Ltd (Taranaki Sexual Assault Services), Pinnacle Executive Board Member – Midlands Health Network, Police Medical Officer (contracted), Wife – Work Place Assessor – contracting to Career Force.

KEVIN NIELSEN

Kevin is a first term elected member. He was General Manager of Taranaki Newspapers before joining Hospice Taranaki. He has been Chief Executive of Hospice Taranaki for 13 years. He has been an executive member of Hospice New Zealand for seven years. He chairs the Hospital Advisory Committee of the Taranaki DHB. He was instrumental in setting up the Taranaki Cancer Network which he currently chairs.

Interest Register: CEO – Hospice Taranaki, Chair Taranaki Cancer Network, Executive Hospice NZ.

ALISON RUMBALL

Alison has had a long and extensive involvement in educational, environmental and community affairs and was an elected New Plymouth District Councillor for nine years. Tertiary qualifications as a Hearing Commissioner have given her significant experience and an insight into Government legislation and the implications that has for Health Boards. Alison is a member of the Hospital Advisory Committee and the Community & Public Health and Disability Support Advisory Committee. She is Vice President of the Taranaki Cancer Society of New Zealand, a member of the 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 both Anaesthetic Consultants at Waikato Hospital, Vice President of the Taranaki Cancer Society of New Zealand, Executive Member - Midcentral Cancer Society Appointment Committee for a new CEO, Trust Member of Midcentral Cancer Research Trust. Member of Consumer Health Reference Group for Older People.

AROARO TAMATI

Aroaro was appointed to the District Health Board in 2013. She is a member of the Finance Audit and Compliance Committee and also a member of the Hospital Advisory Committee, the Community and Public Health and the Disability Support Advisory Committee. Aroaro is a committed advocate of Māori development in Taranaki, as co-director of Te Kōpae Piripono Māori immersion ECE for 20 years (she is also a Board member of Te Pou Tiringa Incorporated, Te Kōpae Piripono's governing body) and more recently as a Māori health researcher, enrolled in a PhD in public health through the University of Otago. In 2013, Aroaro was the recipient of a Health Research Council Ngā Kanohi Kitea research grant. Aroaro is active in the Taranaki Māori community. She is secretary of Ngāti Moeahu Hapū, secretary of one of Parihaka's three active marae - Te Paepae o Te Raukura - and trustee of both the Taranaki Iwi Trust and Te Kāhui o Taranaki Trust. Aroaro also supports the venerable 18ths and 19ths held at Parihaka each month to honour the legacy of Tohu Kākahi and Te Whiti o Rongomai. Aroaro is a director of Mataara Limited.

Interest Register: Te Kopae Piripono-KM Immersion ECE – Co Director, Mataara Ltd – Director, Ngati Moeahu Hapū – Secretary, Te Paepae o Te Raukura (Parihaka) – Secretary, Taranaki Iwi Trust – Trustee, Te Kāhui o Taranaki Trust – Trustee, Te Pou Tiringa Inc – Board Member, HRC Nga Kanohi Kitea – Recipient, married to Howie Tamati, CEO of Sport Taranaki which has received health funding from the Taranaki DHB.

ADDITIONAL INTERESTS DECLARED

TONY FOULKES (CHIEF EXECUTIVE)

Interest Register: Director HealthShare Ltd. Wife employed as General Practitioner by Carefirst in New Plymouth. CareFirst is a member of Midland Health Network PHO.

Te Whare Punanga Korero

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 purpose. Some of those interactions include:

- Development of, and joint approval with the Taranaki DHB of Te Matakite, the Taranaki DHB Māori Health Plan 2013-14
- Quarterly meetings with the Taranaki DHB Board and managers to monitor progress against the Māori Health Plan
- A Taranaki DHB strategic planning workshop for Taranaki
- A member on the Hospital Advisory Committee and the Community and Public Health/Disability Support Advisory Committee
- Determining that the Taranaki DHB would have fully bilingual signage in its new hospital
- Determining, in partnership with the Taranaki DHB Board, the strategic priorities to be applied by the Te Kawau Maro Alliance, the preferred provider of Māori health services in Taranaki, in allocating discretionary funding to address Māori health needs.

Members of TWPK

Left to right: Chair Darryn Ratana (Ngaa Rauru Kiitahi), David Tamatea (Taranaki Iwi), Vicki Kershaw (Ngati Mutunga), Hinemoerangi Ngatai-Tangirua (Ngati Ruanui), Te Urumairangi Ritai (Te Atiawa), Greg White (Ngati Tama), Tom Rangihaeata (Ngati Maru).
Inset: John Hooker (Nga Ruahinerangi)

Board

2013/2014

Members' Responsibilities and Fees

Board Members, Committee Members and Directors Schedule

Name	Board Members to Nov 2013	Board Members from Dec 2013	Hospital Advisory Committee to Nov 2013	Hospital Advisory Committee from Dec 2013	Community and Public Health and Disability Support Advisory Committee to Nov 2013	Community and Public Health and Disability Support Advisory Committee from Dec 2013	Finance Audit and Compliance Committee to Nov 2013	Finance Audit and Compliance Committee from Dec 2013 Additional FACC Meeting 4 July 2013	Compensation & Appointments Committee	Allied Laundry Services Ltd	Fulford Radiology	HealthShare Ltd	Fees Paid($)
Board Members - 2013 and 2014													
Mary Bourke	* 5 of 5		5 of 5		1 of 2				✓				$17,688
Peter Catt	^ 4 of 5		4 of 5		1 of 2		5 of 6		✓				$11,078
Pauline Lockett	4 of 5	* 6 of 6	4 of 5	4 of 5	1 of 2	3 of 4	4 of 6	6 of 6	✓				$35,025
Sally Webb		^ 3 of 3 <		2 of 2 <				3 of 3 <					$15,259
Alex Ballantyne	5 of 5	5 of 6	5 of 5	5 of 5	2 of 2	4 of 4	6 of 6	5 of 6					$23,870
Ella Borrows	5 of 5		5 of 5		2 of 2								$9,613
Kura Denness	4 of 5		4 of 5		0 of 2		5 of 6		✓	✓			$8,863
Karen Eagles	5 of 5	4 of 6	5 of 5	4 of 5	1 of 2	4 of 4		1 of 1 +					$22,619
Flora Gilkison	5 of 5	6 of 6	5 of 5	5 of 5	* 2 of 2	* 4 of 4		6 of 6	✓		✓		$24,495
Richard Handley		6 of 6		5 of 5		4 of 4		* 6 of 6	✓				$14,570
Te Aroha Hohaia		5 of 6		4 of 5		^ 3 of 4		1 of 1 +					$12,758
Brian Jeffares	2 of 5		2 of 5		0 of 2								$8,363
Pat Leary		4 of 6		4 of 5		4 of 4		1 of 1 +					$12,758
Kevin Nielsen		5 of 6		5 of 5		3 of 4		6 of 6	✓				$14,383
Alison Rumball	3 of 5	6 of 6	3 of 5	5 of 5	1 of 2	3 of 4		1 of 1 +					$21,870
Aroaro Tamati		5 of 6		5 of 5		2 of 4		6 of 6					$14,008
Colleen Tuuta	3 of 5		3 of 5		1 of 2								$8,863
Co-opted Committee Members													
David Tamatea (CPHAC/DSAC Member)					2 of 2	3 of 4							$1,500
Other Directors													
Tony Foulkes, Chief Executive												✓	-
Simon Barrett, Group Financial Manager										✓	✓		-

Key:
* = Chairperson
^ = Deputy Chairperson
# = Board Chairperson Ex Officio member
+ = All Board members were FACC members for first meeting December 2013
< = S. Webb appointed Deputy Chair in May 2014

Audit Report

2013/2014

INDEPENDENT AUDITOR'S REPORT

TO THE READERS OF
TARANAKI DISTRICT HEALTH BOARD'S
FINANCIAL STATEMENTS AND PERFORMANCE INFORMATION
FOR THE YEAR ENDED 30 JUNE 2014

The Auditor-General is the auditor of Taranaki District Health Board (the Health Board). The Auditor-General has appointed me, Bruno Dente, using the staff and resources of Deloitte, to carry out the audit of the financial statements and performance information of the Health Board on her behalf.

We have audited:

- the financial statements of the Health Board on pages 75 to 106, that comprise the statement of financial position, as at 30 June 2014, 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 40 to 70 and which includes outcomes.

Unmodified opinion on the financial statements

In our opinion the financial statements of the Health Board on pages 75 to 106:

- comply with generally accepted accounting practice in New Zealand; and

- fairly reflect the Health Board's:

  - financial position as at 30 June 2014; and

  - financial performance and cash flows for the year ended on that date.

Qualified opinion on the performance information because of limited control on information from third-party health providers

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.

Our audit opinion on the performance information of the Health Board for the period ended 30 June 2013, which is reported as comparative information, was modified for the same reason.

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 on pages 40 to 70:

- complies with generally accepted accounting practice in New Zealand; and
- fairly reflects the Health Board's service performance and outcomes for the year ended 30 June 2014, including for each class of outputs:
    - its service performance compared with forecasts in the statement of forecast service performance at the start of the financial year; and
    - its 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 9 October 2014. 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 Health Board's preparation of the 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'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's framework for reporting performance; 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 have obtained all the information and explanations we have required about the financial statements. However, as referred to in our qualified opinion, we did not obtain all the information and explanations we required about the performance information of the Health Board. 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's financial position, financial performance and cash flows; and

- fairly reflect its 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.

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.

Bruno Dente
Deloitte
On behalf of the Auditor-General
Hamilton, New Zealand

Statement of Service Performance

2013/2014

Statement of Service Performance

Overview

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

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

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

We have built our performance framework for 2013/14 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.

Notes:

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

Taranaki DHB Planned and Actual Revenue and Expenditure Allocated to Output Classes 2013-14

Output Class	Planned Revenue ($000's)	Actual Revenue ($000's)	Planned Expenditure ($000's)	Actual Expenditure ($000's)
Prevention	8,404	9,025	8,492	8,092
Early Detection and Management	81,489	83,668	82,344	81,149
Intensive Assessment and Treatment Services	193,469	195,537	195,498	201,493
Rehabilitation and Support	45,615	46,169	46,093	46,939
TOTAL	328,976	334,397	332,427	337,673

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

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

Our Strategic Priorities				
Health Targets	Māori Health/ Disparities	Health of Older People	Primary Health	Wellness/Chronic Conditions

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	• An improvement in childhood oral health • Long-term conditions are detected early and managed well • Fewer people are admitted to hospital for avoidable conditions • More people maintain their functional independence	• People receive prompt and appropriate acute and arranged care • People have appropriate access to elective services • Improved health status for people with a severe mental health illness and/or addiction • More people with end-stage conditions are appropriately supported

Outputs
Statement of Service Performance Measures

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, higher mortality and higher stage at presentation. 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.

Reduction in Vaccine Preventable Diseases

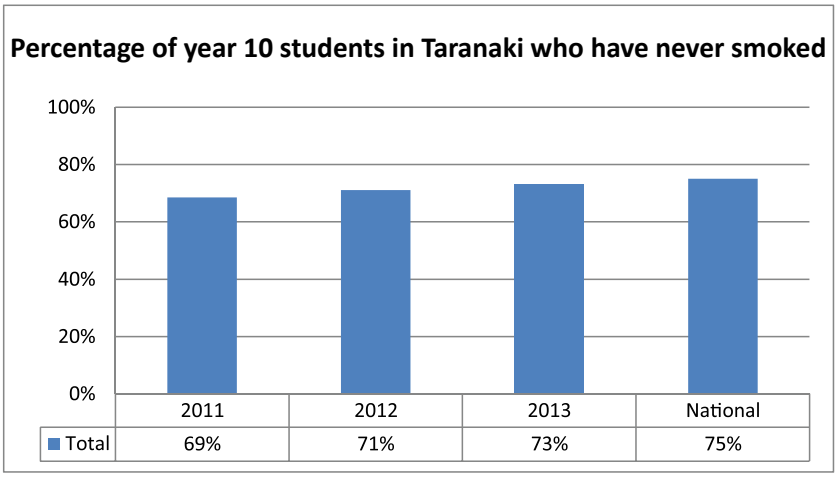
Immunisation can prevent a number of diseases and is a very cost-effective health intervention. Immunisation provides protection not only for individuals, but for the whole population by reducing the incidence of diseases and preventing them from spreading to vulnerable people or population groups. Population 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. See Health Targets on page 12.

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.

FEWER PEOPLE SMOKE

Impact Measures



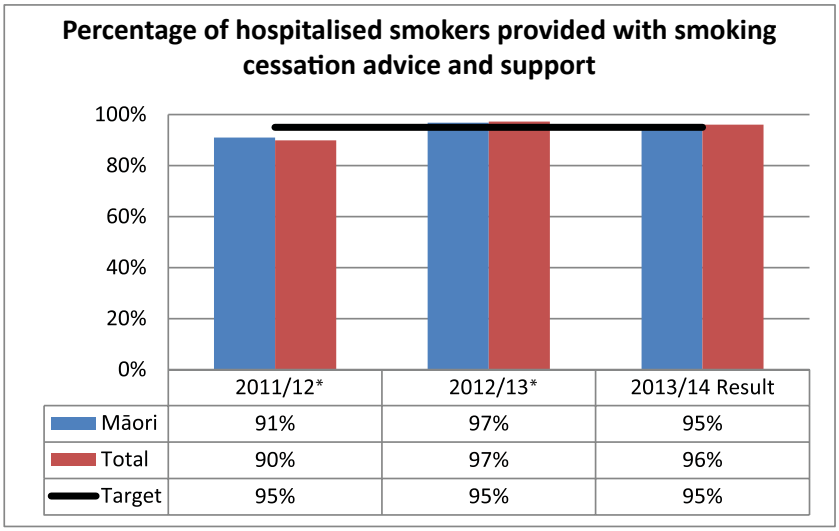
Data Source: Action on Smoking and Health (ASH) annual survey

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

Total	Target Achieved

The Year 10 survey is an annual questionnaire of around 30,000 students in New Zealand of which 878 were surveyed in Taranaki in 2013. The survey is conducted each year in schools throughout the country for the last 10 years and is one of the biggest of 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.

Output Measures



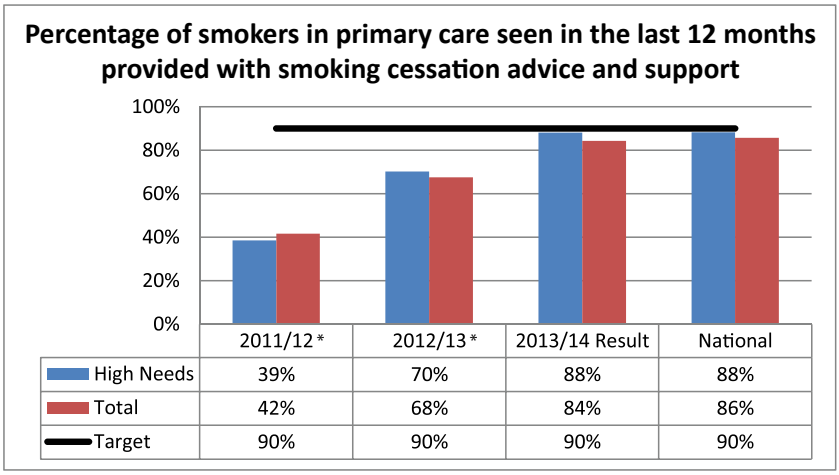
Data Source: Taranaki DHB Patient Management System

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

Māori	Target Achieved
Total	Target Achieved

The 95% target has been met by Taranaki DHB for both Māori and total for quarter 4 2013/14. 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.

*To align with the health target reporting of the same indicator this has been aligned to the quarter 4 results of the financial year.

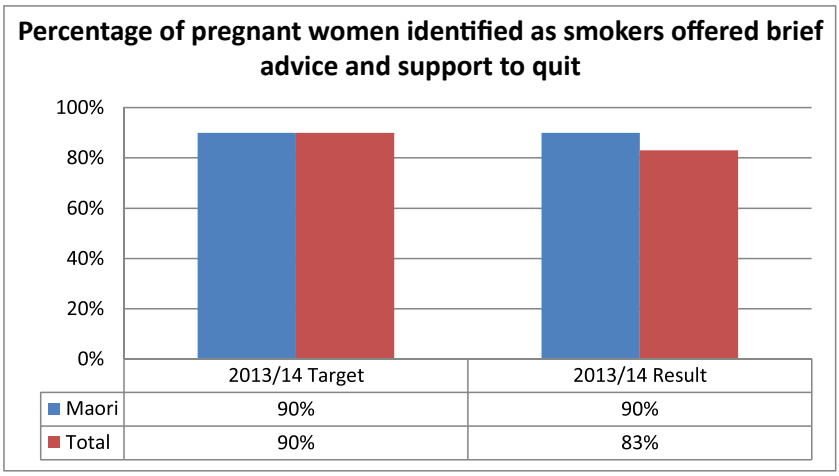


Data Source: Primary Health Organisation Performance Programme (PPP)

90% of smokers in primary care seen in the last 12 months are provided with cessation advice and support to quit

High Needs	Target Not Achieved
Total	Target Not Achieved

Taranaki DHB has not achieved the health target percentage for 'Better Support for Smokers to Quit' in Primary Care (PHOs) General Practice. However the performance result has continually improved and the end of quarter 4 result of 84% is just short of the 90% target. Taranaki is currently in line with the National result for the high needs population and the DHB will continue to provide additional support.



Data Source: Midwifery and Maternity Providers Organisation (MMPO) and Lead Maternity Carer (LMC) systems

90% of pregnant women who identify as smokers at the time of confirmation of pregnancy are offered brief advice with support to quit

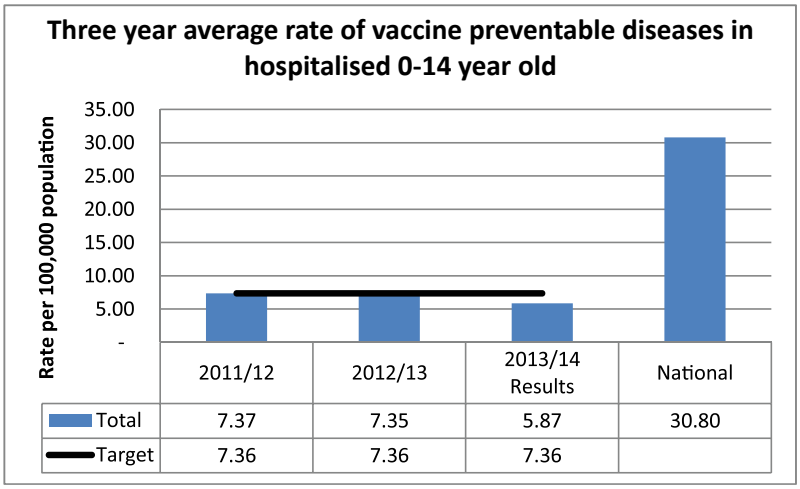
Māori	Target Achieved
Total	Target Not Achieved

The intention is that every Lead Maternity Carer (LMC)/nurse screens every pregnant woman following the ABC pathway (Ask, Brief advice, Cessation support) and gives advice around stopping smoking. They also refer to NGO and Māori health services.

* Last year the indicator used in the annual report was "brief advice" which was incorrect. This year we have used the indicator "brief advice and/or cessation support" which aligns the health target result and definition.

REDUCTION IN VACCINE PREVENTABLE DISEASES

Impact Measures



Data Source: National Minimum Dataset (NMDS)

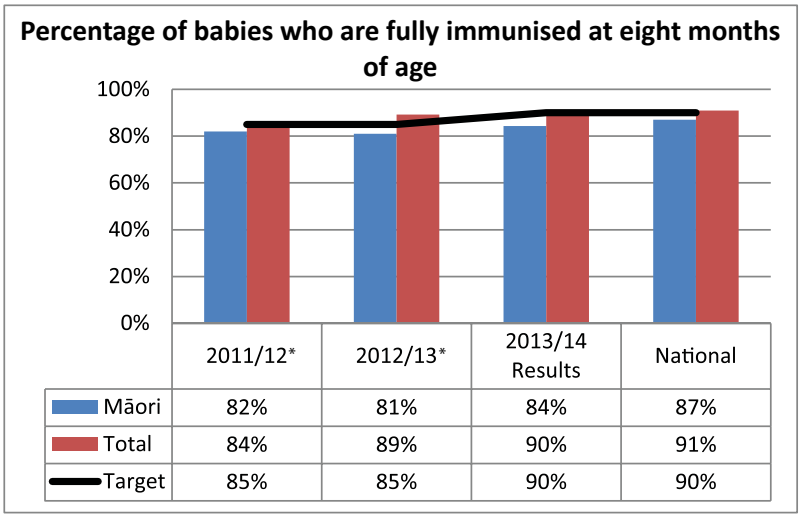
Reduction in vaccine preventable diseases

Total	Target Achieved

There has been a small reduction in the average rate of vaccine preventable diseases hospitalisation.

The reduction to 5.87 can be attributed to achieving the target of 90% of children being fully immunised. The percentage of children not immunised in our community is reducing.

Output Measures

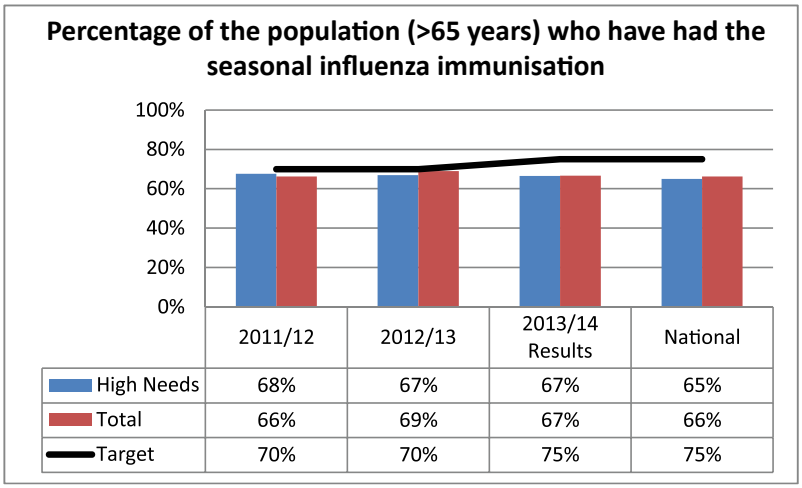


Data Source: National Immunisation Register

Target: 90% of eight month olds are fully immunised

Māori	Target Not Achieved
Total	Target Achieved

The health target for total population at quarter 4 2013/14 was met. In comparing the previous two years results, we see improvement in uptake in particular for Maori. The sector is actively working on initiatives to target the hard to reach cohort through outreach immunisation services and opportunistic vaccinations.



Data Source: Primary Health Organisation Performance Programme (PPP)

Target: 75% of the population aged 65+ years have had their seasonal influenza immunisation

High Needs	Target Not Achieved
Total	Target Not Achieved

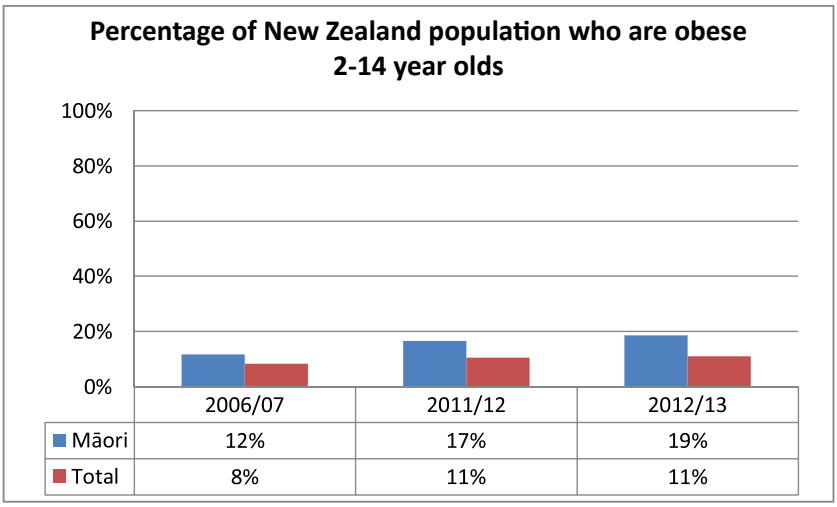
During the Immunisation Awareness Week Taranaki DHB, in partnership with the Māori Women's Welfare League, held outreach immunisation clinics where teams had an opportunity to not only promote the benefits of immunisations but also to carry out a number of flu vaccinations. Taranaki DHB did not achieve against the targets set but achieved higher than the National average. The DHB contracts for people in the community setting to be vaccinated through Te Kawau Maro outreach and Disease State Nursing services.

The national campaign which the DHB is linked into actively promotes vaccinations for >65 year olds. The DHB contracts for people in the community to be vaccinated through a contract with Te Kawau Maro outreach and Disease State Nursing services.

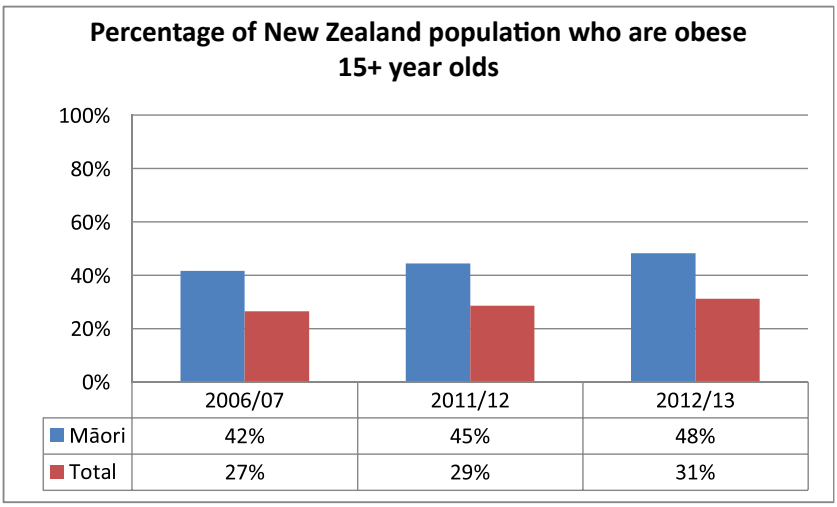
* To align with the health target reporting of the same indicator this has been aligned to the quarter 4 results of the financial year.

IMPROVING HEALTH BEHAVIOURS

Impact Measures



Data Source: New Zealand Health Survey 2012/13



Data Source: New Zealand Health Survey 2012/13

Reduction in percentage of obese population in New Zealand

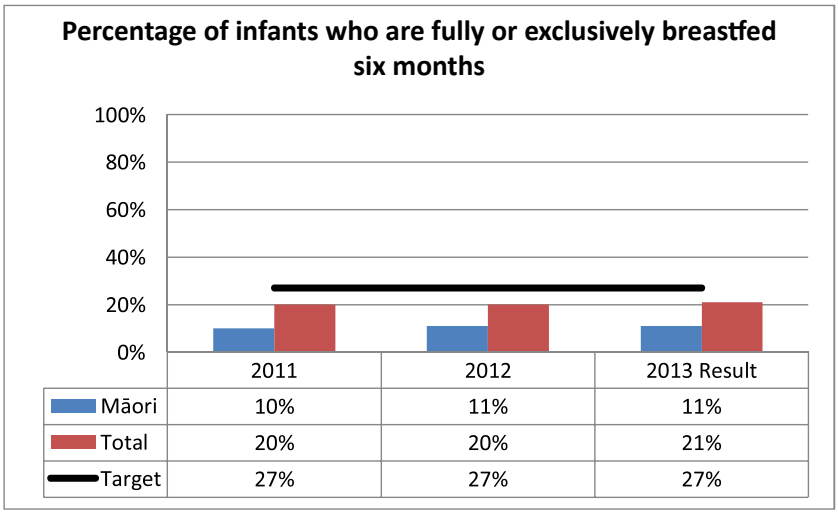
The 2012/13 New Zealand Health Survey found that almost one in three adults were obese, and almost half of Māori adults were obese. There has been an increase in obesity in males from 17% in 1997 to 30% in 2012/13; and in females from 21% in 1997 to 32% in 2012/13.

The survey also found that 1 in 9 children were obese, while one in five were overweight. 19% of Māori children were obese and children living in the most deprived areas were three times more likely to be obese. The childhood obesity rate had increased from 8% in 2006/7 to 11% in 2012/13.

Along with health promotion activities Taranaki DHB funds the Green Prescription service which aims to increase physical activity and healthy eating for those people who are at risk. A Green Prescription (GRx), available for adults and children 5-18 years (GRx Active Families), 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 a professional support person who will help set activity and nutritional goals, provide motivation, advice, and information. 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 Whanau Pakari Programme supporting healthy lifestyle intervention to children and adolescents as an extension of the GRx Active Families service.

Output Measures



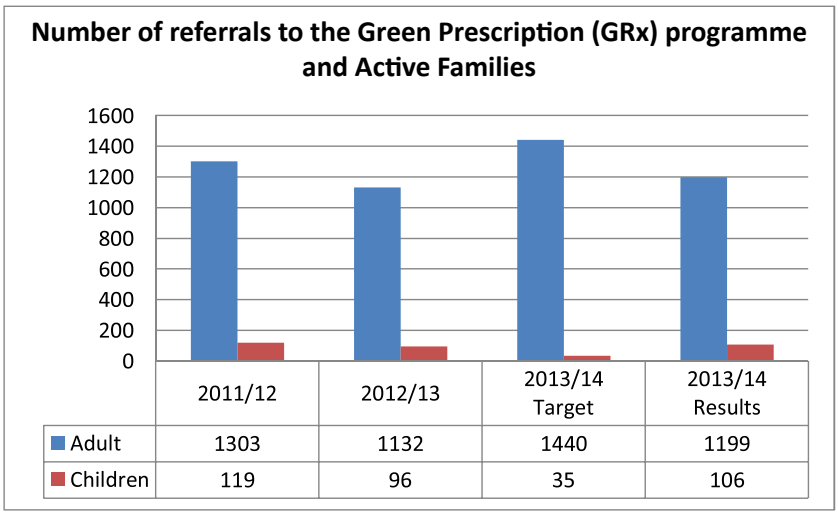
Data Source: National Plunket Data

Increasing the number of infants who are fully or exclusively breastfed six months

Māori	Target Not Achieved
Total	Target Not Achieved

The quality of data from all Well Child/Tamariki Ora (WCTO) providers has improved significantly since Baby Friendly Community Initiative (BFCI) accreditation was achieved late last year. Taranaki DHB has funded a "Mama Pepe Hauora" contract which focuses on improving physical activity, nutrition, and breastfeeding for mothers and infants in high needs communities which long-term should have flow-on effect for breastfeeding rates. In the short-term the Peer Support service and Community Lactation Clinic should support mothers having difficulties with starting or maintaining breastfeeding to continue.

Please note including partial breastfeeding in Core 4 (six month) data is now standard for all WCTO services and was due to feedback from the MoH as follows - "The Expert Advisory Group to the Quality Improvement Framework (QIF) felt that the provision of any breast milk to babies at six months of age was an indicator of service quality specifically aimed at ensuring WCTO services promote the protective effect of any exposure to breast milk over the time when other foods are introduced and for the rest of the first year of life."



Data Source: Contract Reporting

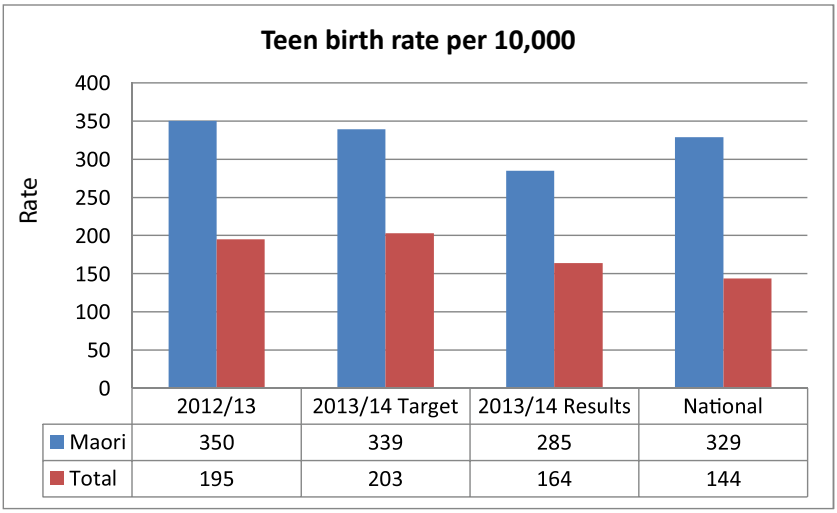
Increase in the number of referrals to the Green Prescription (GRx) programme

Adult	Target Not Achieved
Children	Target Achieved

For 2013/14 the Active Families (children) target was exceeded and for adults the target was not achieved however the '80% of the target' threshold (in the contract with the provider) was met. Adult and Active Families referrals were both up from 2012/13.

A GRx pre-diabetes and diabetes pilot run via the Midlands Health Network is being undertaken during 2014/15, which supports practice nurses to provide lifestyle advice and support in-house this may affect referrals from the participating practices but if successful it may be a more financially sustainable model of care.

Active Families referrals should remain high as the Whanau Pakari intervention continues although the formal recruitment period has ended.

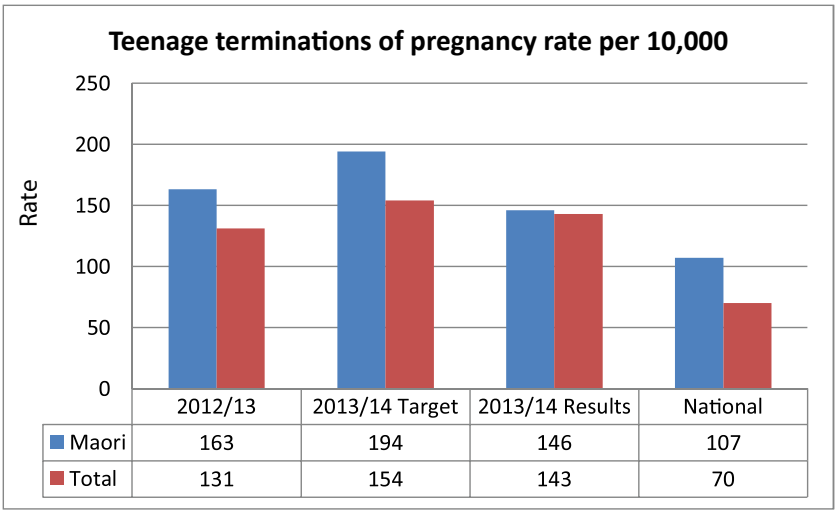


Data Source: National Minimum Dataset (NMDS)

Reduction in the teen birth rate per 10,000

Māori	Target Achieved
Total	Target Achieved

The teen birth rate in Taranaki for Māori and total population decreased in 2013/14 compared to the previous two years. The use of Jadelle contraception continues to increase in particular in South Taranaki.



Data Source: National Minimum Dataset (NMDS)

Reduction in the teenage terminations of pregnancy rate per 10,000

Māori	Target Achieved
Total	Target Achieved

The total rate of terminations of pregnancy showed a slight increase in rate per 10,000. In Taranaki this is significantly higher than the national average. Although for Māori the rate continues to decrease it remains higher than the national average.

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	People stay well in their homes and communities			
Intermediate Impacts	An improvement in childhood oral health	Long-term conditions are detected early and managed well	Fewer people are admitted to hospital for avoidable conditions	More people maintain their functional independence

An improvement in childhood oral health

Good oral health demonstrates early contact with health promotion and prevention services and reduced risk factors, such as poor diet, which has lasting benefits in terms of improved nutrition and healthier body weights. Oral health is also an integral component of lifelong health and impacts a person's comfort in eating (and ability to maintain good nutrition in old age), self esteem and quality of life. Māori children are three times more likely to have decayed, missing or filled teeth, and improved oral health is a proxy measure of equity of access and the effectiveness of mainstream services in targeting those most in need.

Long-term conditions are detected early and managed well

If we are to empower people to take greater responsibility for their health, to improve the health of our population and if we are to "contain costs" we have a significant opportunity by detecting conditions early. Early detection will lead to either successful treatment, or delaying or reducing the need for secondary and specialist care, enabling more people to stay well in their homes and communities for longer. Our greatest opportunity to do this is to manage Cardiovascular Disease (CVD or heart disease). It is one of the largest causes of death in New Zealand, and disproportionately higher for Māori. Often by the time heart problems are detected, the underlying cause of atherosclerosis (arterial disease) is usually well advanced. Our aim is to either prevent the disease by modifying risk factors such as healthy eating, exercise and avoiding smoking, or early detection and management. See Health Targets on page 12. Another major cause of death in New Zealand is cancer. If people are encouraged and supported to participate in screening programmes, this will lead to earlier detection and an increased likelihood of successful treatment.

Fewer people are admitted to hospital for avoidable conditions

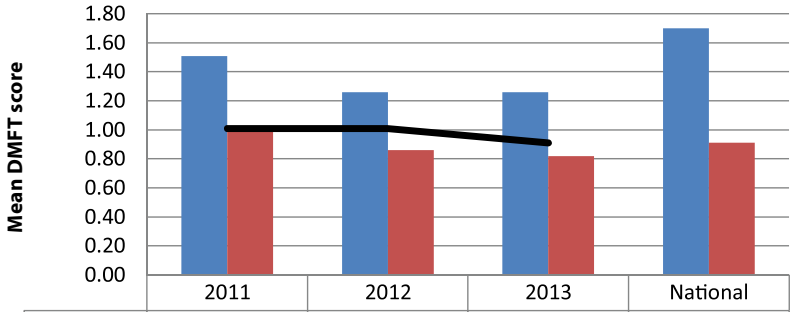
There are a number of admissions to hospital for conditions which are seen as avoidable through appropriate early intervention and a reduction in risk factors. As such, these admissions provide an indication of the effectiveness of screening, early intervention and community-based care.
A reduction in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

AN IMPROVEMENT IN CHILDHOOD ORAL HEALTH

Impact Measures



	2011	2012	2013	National
Māori	1.51	1.26	1.26	1.70
Other	1.00	0.86	0.82	0.91
Target	1.01	1.01	0.91	

Data Source: Taranaki DHB Dental Patient Management System - Titanium. Statistics New Zealand Population Projection 2013

Reduction in the mean Decayed Missing or Filled Teeth (DMFT) score at year 8

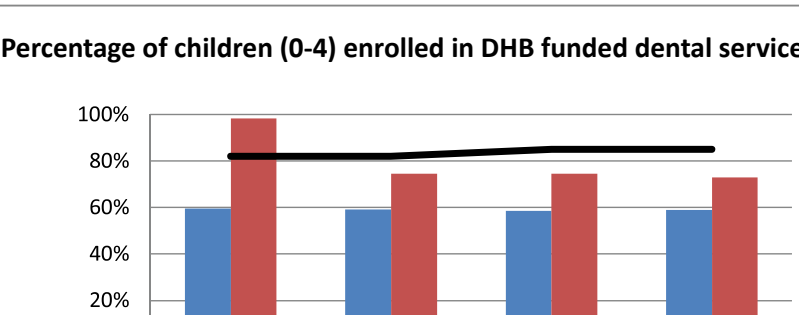
Māori	Target Not Achieved
Total	Target Achieved

This measure is a status of permanent teeth in 12 year olds in Taranaki. We continue to achieve better than the national average for this group.

The results for Māori in Taranaki although lower than the national average prompt more intensive efforts in health promotion to continue to improve the outcomes for this group.

The removal of fluoride from the New Plymouth water supply may impact in the future on these acheievments and will be closely monitored.

Output Measures



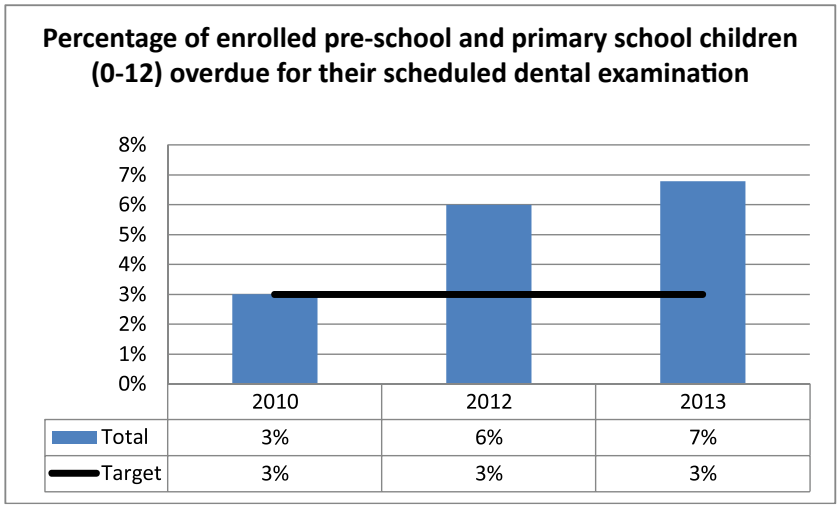
	2011	2012	2013	National
Māori	60%	59%	59%	59%
Total	98%	75%	75%	73%
Target	82%	82%	85%	85%

Data Source: Taranaki DHB Dental Patient Management System - Titanium. Statistics New Zealand Population Projection 2013

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

Māori	Target Not Achieved
Total	Target Not Achieved

This target has not been achieved in 2013 but a new multi disciplinary approach between Lead Maternity Carers (LMCs), Plunket, and Well Child/ Tamariki Ora providers should improve the enrolments for 2014 year. In addition a new online enrolment process into the oral health service on the Taranaki DHB website will allow greater opportunity for parents to participate in the enrolment process. The Menemene Mai project has been revamped and now includes a dental health professional making contact with parents of all three month old Māori babies to offer early enrolment into the community dental service.

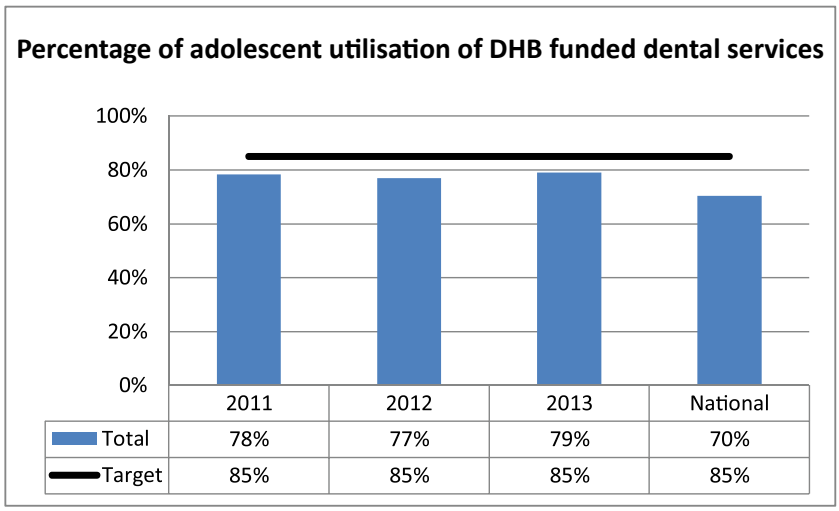


Data Source: Taranaki DHB Dental Patient Management System - Titanium. Statistics New Zealand Population Projection 2013

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

Total	Target Not Achieved

Taranaki DHB has not met the target for 2013/14. However enhanced monitoring and monthly reporting will refocus efforts over the coming year for this service.



Data Source: DHB Provider Claims plus Taranaki DHB Dental Patient Management System - Titanium. Statistics New Zealand Population Projection 2013

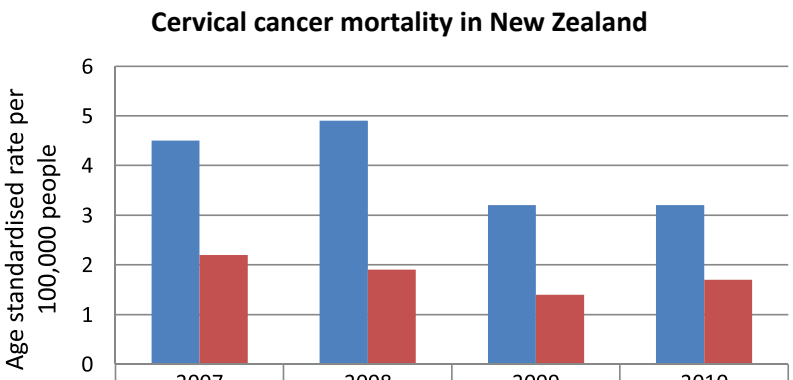
Percentage of adolescent utilisation of DHB funded dental services

Total	Target Not Achieved

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 2013 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.

LONG-TERM CONDITIONS ARE DETECTED EARLY AND MANAGED WELL

Impact Measures



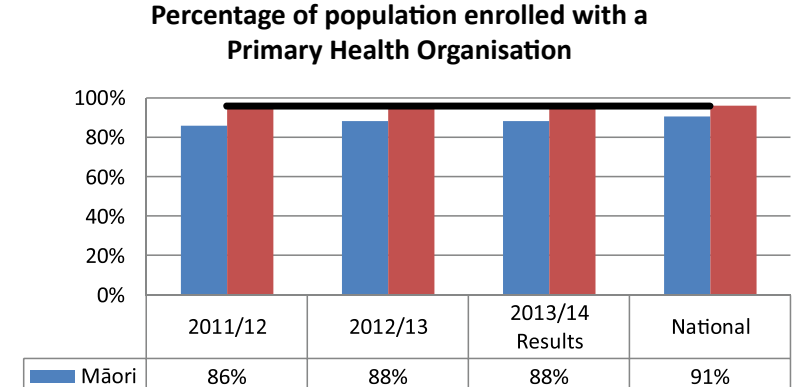
	2007	2008	2009	2010
Māori	4.5	4.9	3.2	3.2
Total	2.2	1.9	1.4	1.7

Data Source: New Zealand Cancer Registry and New Zealand Mortality Collection - standardised to the WHO world standard population.

Reduction in cervical cancer mortality in New Zealand

The national cervical cancer mortality rate has seen significant improvements for Māori over the last few years. The total rate has improved over the same period and the disparity gap has closed significantly. There is however, still room for improvement.

Output Measures



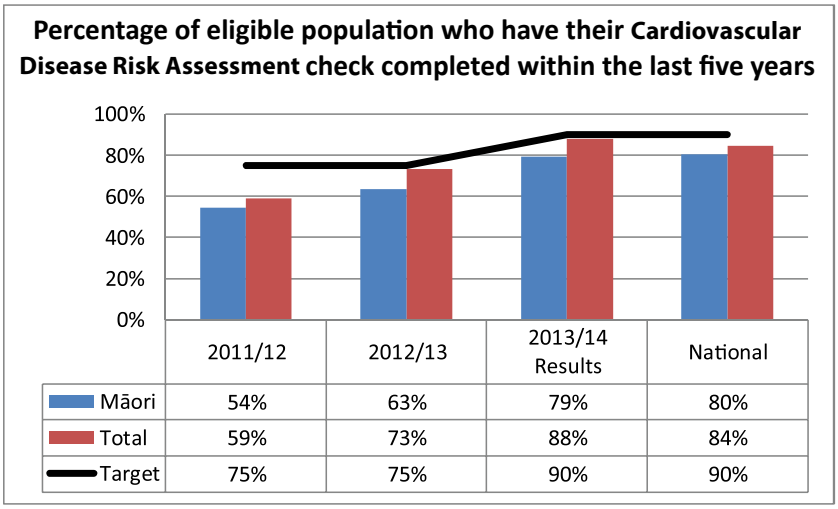
	2011/12	2012/13	2013/14 Results	National
Māori	86%	88%	88%	91%
Total	97%	97%	96%	96%
Target	96%	96%	96%	96%

Data Source: Ministry of Health PHO Enrolment Collection

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

Māori	Target Not Achieved
Total	Target 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 has achieved the total target but not has not met the target for Māori enrolment.

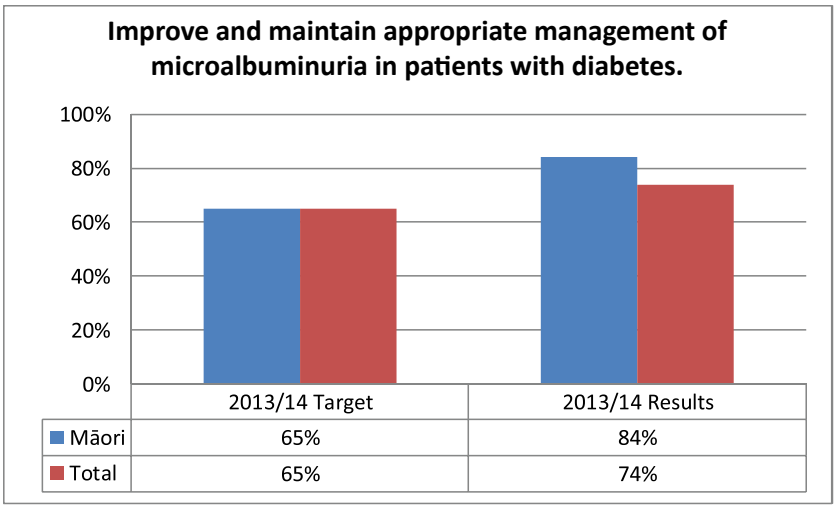


Data Source: Primary Health Organisation Performance Programme (PPP)

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

Māori	Target Not Achieved
Total	Target 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 so they can manage their health. Although Taranaki DHB did not achieve the national target of 90% 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.



Data Source: Primary Health Organisation Performance Programme (PPP)

Improve and maintain appropriate management of microalbuminuria in patients with diabetes

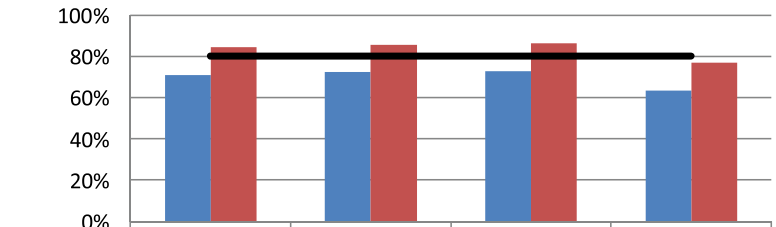
Māori	Target Achieved
Total	Target Achieved

In partnership with Taranaki DHB Midlands Health Network (MHN) has established a Long Term Conditions program.

Central to this is identification of patients with Long Term Conditions including diabetes – risk stratification.

Increasing the range of prevention strategies based around further development of self management resources, patient education and training

Improving the clinical management of these patients using clinical audit and training and education. Establishment of a multidisciplinary team (MDT) to assist in the management of these patients. MDT includes, dietician, social work, podiatry and clinical pharmacy. Development of a range of tools and enablers for MHN GP practices includes, patient prompting, common forms, personal health assessment plan, eReferrals.



	2011/12	2012/13	2013/14 Results	National
Māori	71%	73%	73%	63%
Total	85%	86%	86%	77%
Target	80%	80%	80%	80%

Data Source: National Screening Unit

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

Māori	Target Not Achieved
Total	Target Achieved

The Taranaki region continues to maintain its good overall coverage rate in Māori participation over the past few years. This is largely due to the effective working relationship between the practices and the Screening Unit who are both working towards a common goal.

New initiatives continue to be developed with our Māori Health providers to promote and support community actions targeted at high priority women. Collaboration between health providers and community groups is seen as the pathway to further success in this area.

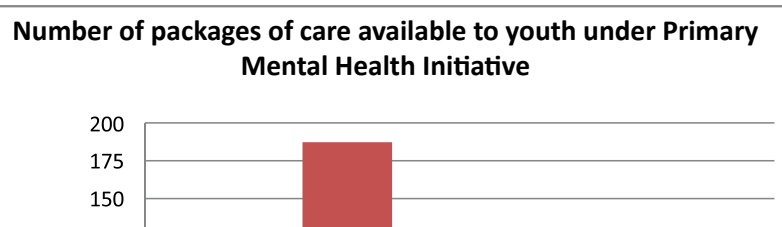
	2011/12	2012/13	2013/14 Results	National
Māori	56%	63%	65%	66%
Total	70%	76%	77%	72%
Target	70%	70%	70%	70%

Data Source: Breast Screening Aotearoa

Percentage of eligible women (50-69) have a breast screen every two years

Māori	Target Not Achieved
Total	Target Achieved

Work is ongoing in this area through the development of a Māori Cancer Leadership Group. This group is working to support Independent Service Providers (ISPs) to maximise opportunities to work in partnership with primary care providers and Māori health providers to increase breast screening numbers. Other initiatives that have taken place during the year include a successful Hauora Wellbeing Day in Waitara to coincide with the arrival of the breast screening bus. This event attracted over 100 community members and focused on improving whanau health as well as encouraging eligible women to sign up for the screening programme.



	2013/14 Target	2013/14 Results
Māori	63	45
Non-Maori	187	112

Data Source: Contract Reporting

Increase the number of packages of care available to youth under Primary Mental Health Initiative

Māori	Target Not Achieved
Non-Māori	Target Not Achieved

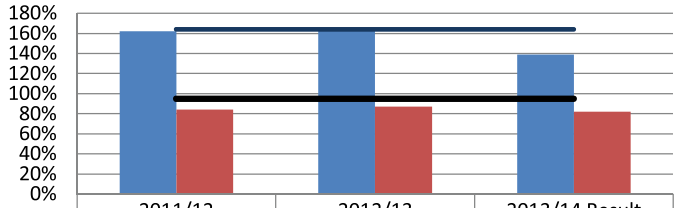
While the results showed the numbers of youth accessing the primary mental health initiative were lower than the target a number of new initiatives were introduced throughout the year to help increase access for youth to counselling and other services. Since November 2013, the public health nurses have been able to offer vouchers to young people so that they could access free counselling and in February 2014 school counsellors were able to refer young people for counselling. As part of the social sector trial a range of new resources are in the process of being implemented all of which provide increased access points to service for Taranaki youth.

*The annual plan states that screening should occur every three years which is actually incorrect. The data we get from Breast Screening Aotearoa is for a rolling 24 months.

FEWER PEOPLE ARE ADMITTED TO HOSPITAL FOR AVOIDABLE CONDITIONS

Impact Measures

The percentage of actual to national average Ambulatory Sensitive Hospitalisations 0-74 yr olds



	2011/12	2012/13	2013/14 Result
Māori	162%	165%	139%
Total	84%	87%	82%
Target	95%	95%	95%
Māori Target	164%	164%	164%

Data Source: National Minimum Dataset (NMDS)

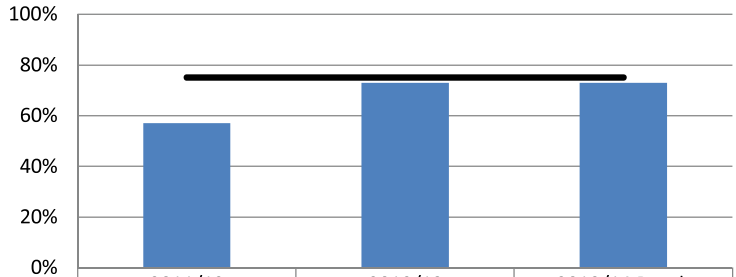
Impact Measure: Remain at or below 95% of the National Ambulatory Sensitive Hospitalisation rate

Māori 0-74	Target Achieved
Total 0-74	Target 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 which has been continued through 2013-14. Both Māori and total targets have been met for 2013/14.

Output Measures

Percentage of rest home residents receiving vitamin D supplement from their GP



	2011/12	2012/13	2013/14 Result
Total	57%	73%	73%
Target	75%	75%	75%*

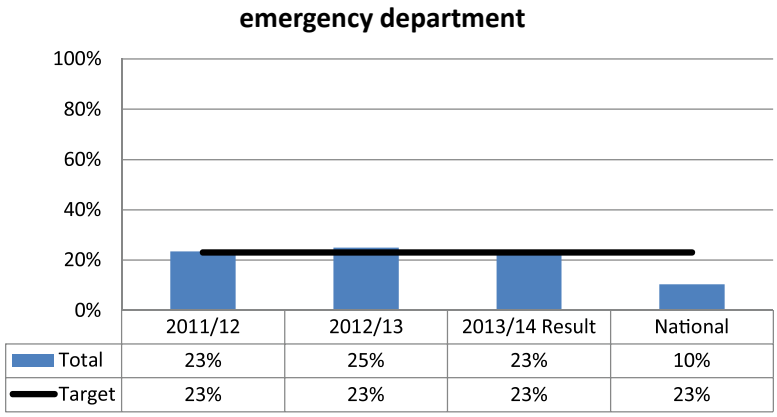
Data Source: Ministry of Health DHB claiming data

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

Total	Target 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 significant 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 and/or the consequence of those falls.

* The target in the Annual Plan has been superseded by a national target of 75% set by ACC.



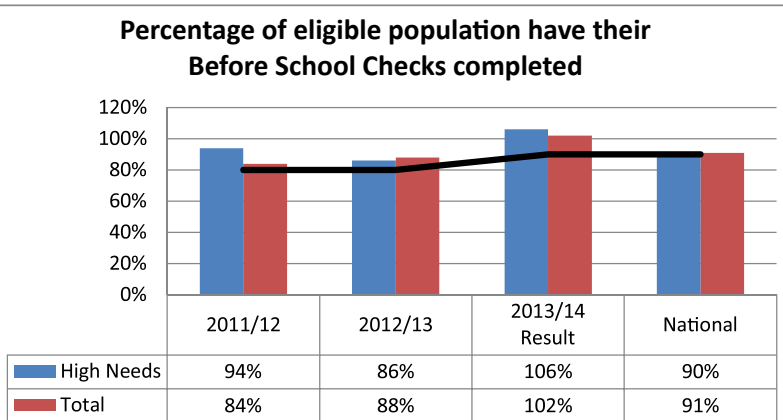
	2011/12	2012/13	2013/14 Result	National
Total	23%	25%	23%	10%
Target	23%	23%	23%	23%

Data Source: National Non-admitted Patient Collections. Statistics New Zealand Population Projection 2013

Target: <23% triage level 4 & 5s presenting to the emergency department as a % of total population

Total	Target 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. We have met the target for 2013/14 and expect it to improve further in the future.



	2011/12	2012/13	2013/14 Result	National
High Needs	94%	86%	106%	90%
Total	84%	88%	102%	91%
Target	80%	80%	90%	90%

Data Source: National Immunisation Register

Target: 90% of eligible population have their Before School Checks (B4SC) completed

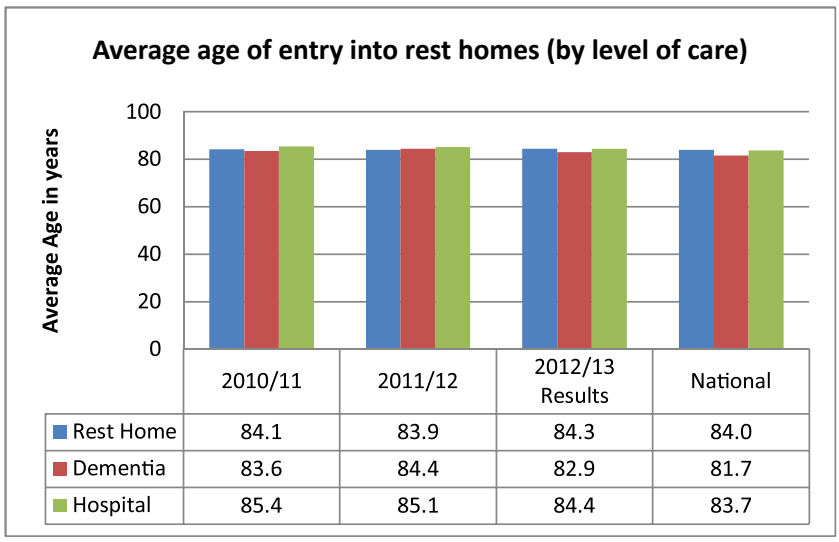
High Needs	Target Achieved
Total	Target Achieved

Taranaki continues to achieve higher than national target of 90% of all eligible children receive a Before School Check (B4SC). For high needs population the result was 16% above target and for total population 12% above. Taranaki was second out of all DHB's in its achievement. The service delivery model is delivered by public health nurses and Primary Care partners in the community and is well embedded within the community.

The 2013/14 result is over 100% due to the population projection (2006 base) being understated. With the new Census 2013 population being used as a base for next year the percentages should level out again.

MORE PEOPLE MAINTAIN THEIR FUNCTIONAL INDEPENDENCE

Impact Measures



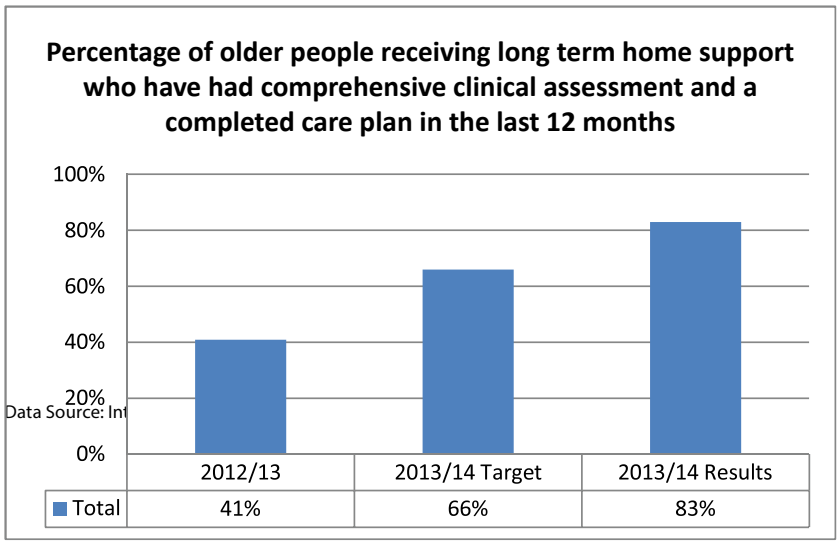
Data Source: Ministry of Health DHB Claiming data

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

Rest Home	Target Achieved
Dementia	Target Not Achieved
Hospital	Target Not Achieved

We are expecting an increase/growth in demand for aged residential care (ARC) services (due to an ageing population). We wish to support people to stay well and remain independent for as long as possible within their community by improving the models of care available. Ideally, we would like to promote a model of care that reduces the proportional length of time an older person requires services within an Aged Residential Care (ARC) facility. 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 slightly older compared to the national average age, which can infer that other support is available within the community to support the person thereby delaying the need for these services.

Output Measures



Data Source: Int

66% of older people receiving long term home support who have had comprehensive clinical assessment and a completed care plan in the last 12 months

Total	Target 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 clients who are re-assessed for their needs are to receive an InterRAI assessment.

For every dollar ($1) spent on home based support services (HBSS) how much is spent on residential care (RC)

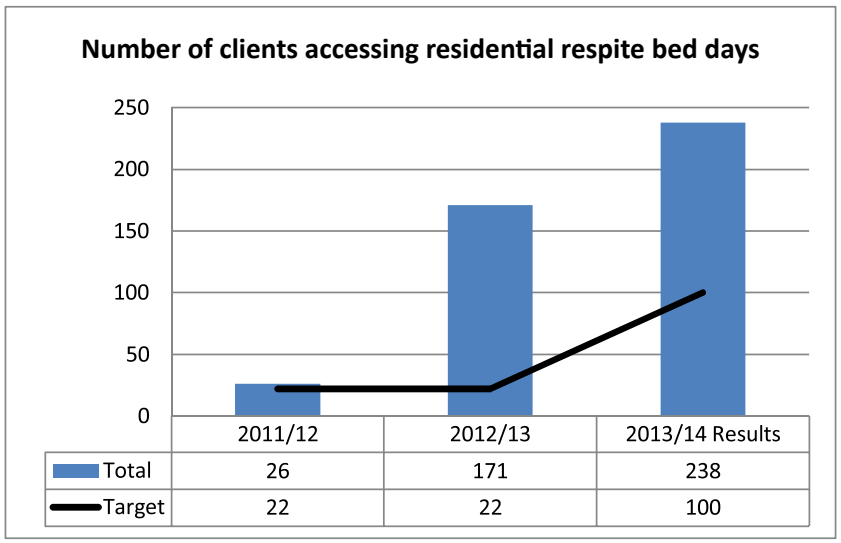
	2011/12	2012/13	2013/14 Target	2013/14 Results
HBSS	$1	$1	$1	$1
RC	$2.45	$2.34	$2.19	$2.41

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

Total	Target 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 expenditure proportional to the Home Based Support Service expenditure (i.e. more expenditure on home based support services infers that we are maintaining more people in their communities rather than needing an ARC facility). It should be noted also that aged residential care expenditure reflects a number of factors in addition to actual utilisation levels, for example asset and income thresholds, aged residential care bed day prices, and proportion of individuals at different levels of care.

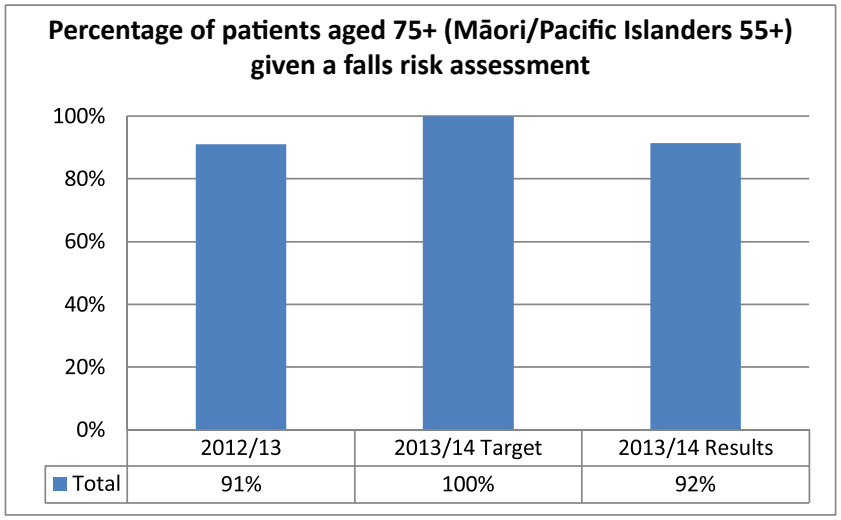


Data Source: Ministry of Health DHB Claiming data

100 clients accessing residential respite bed days

Total	Target Achieved

Taranaki DHB achieved a significant increase in the number of clients accessing residential respite services during 2013/14. 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 hours offered by dementia services field officer, 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: Taranaki DHB

Percentage of patients aged 75+ (Māori/Pacific Islanders 55+) given a falls risk assessment

Total	Target Not Achieved

Taranaki has met the Health Quality & Safety Commission's quality and safety indicator target of 90% (based on international best practice), evidenced through snapshot auditing, over the 12 month period. However meeting the 100% target continues to be a challenge. Where a patient has suffered a severe illness or injury it is not always appropriate or possible to provide a falls risk assessment when the physical care of the patient, other assessments and interventions are required and take priority.

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 page 12). 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

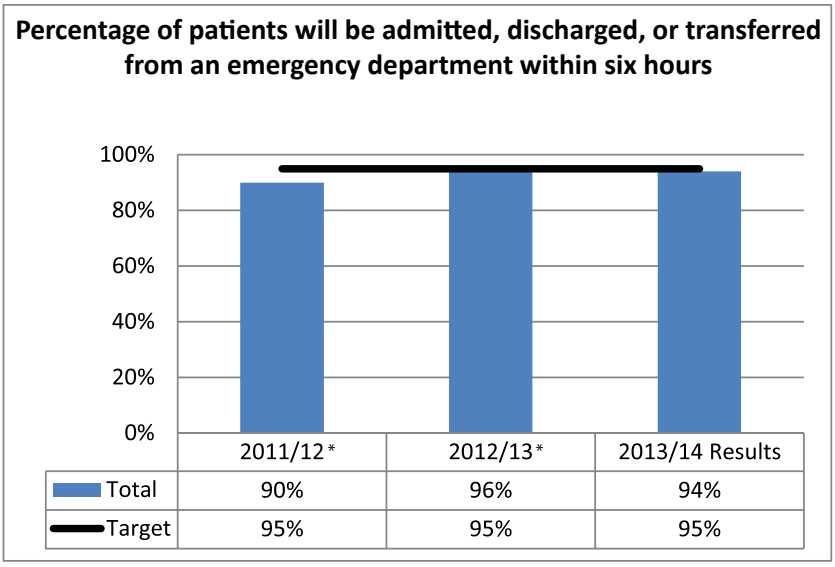
It is estimated that at any one time, 20% of the New Zealand population will have a mental illness or addiction, and 3% are severely affected by mental illness. With high suicide rates in some of our communities, we are working to reduce this rate and support our communities with Whānau Ora initiatives.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

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 an 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.

PEOPLE RECEIVE PROMPT AND APPROPRIATE ACUTE AND ARRANGED CARE

Impact Measures



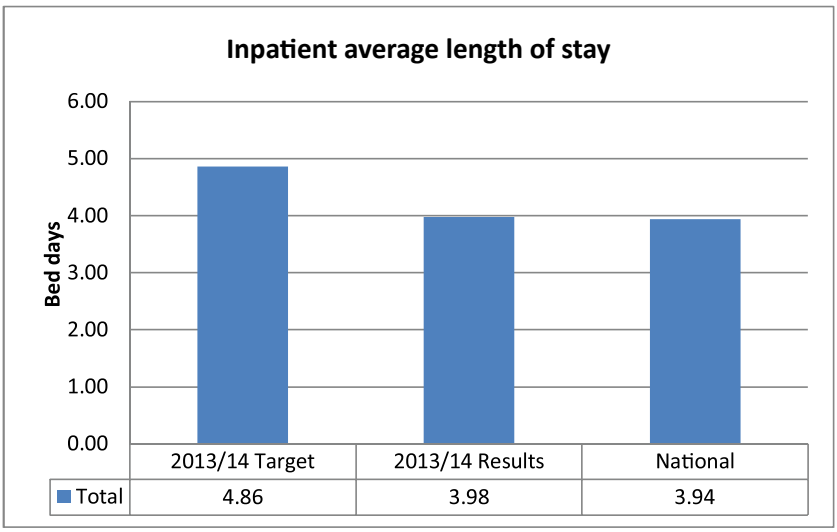
Data Source: Taranaki DHB Patient Management System

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

Total	Target Not Achieved

While Taranaki DHB did not achieve the target for the quarter 4 2013/14 we have shown improvement from the 2011/12 result. 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 the emergency department. 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 spends waiting.

Output Measures



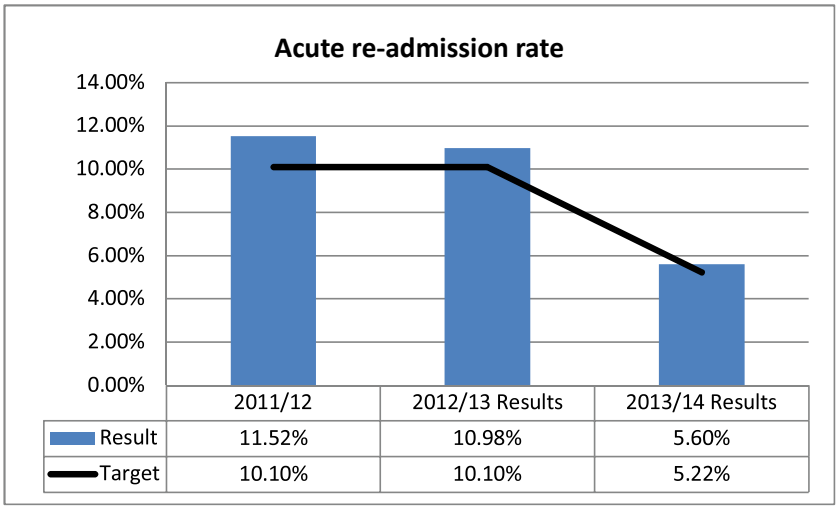
Data Source: National Minimum Dataset (NMDS)

Acute Inpatient average length of stay reduced

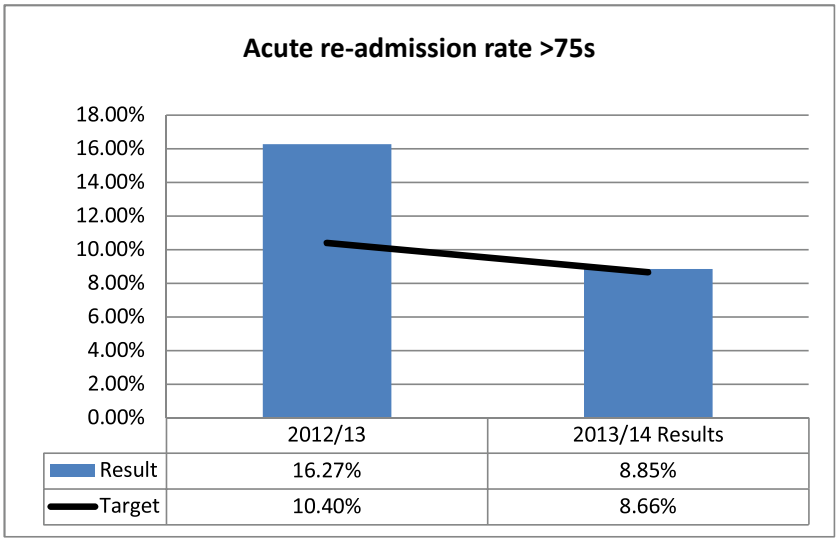
Total	Target Achieved

A patient's length of stay is impacted by numerous factors including integration activities that strengthen the ability of primary care to support 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.

* To align with the health target reporting of the same indicator this has been aligned to the quarter 4 results of the financial year.



Data Source: National Minimum Dataset (NMDS)



Data Source: National Minimum Dataset (NMDS)

Acute re-admission rate 5.22%

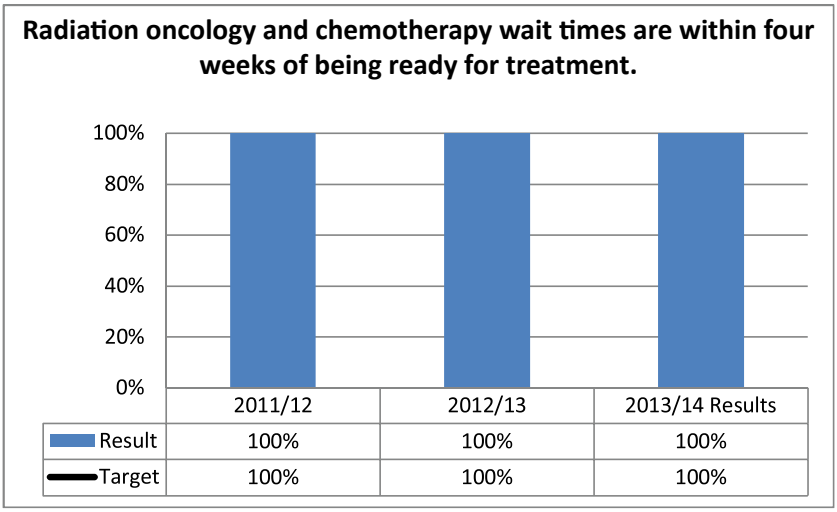
Total	Target Not Achieved

Acute re-admission rate over 75s 8.66%

Total	Target 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 re-admissions can therefore be interpreted as an indication of improving quality of acute care, in the hospital and/or primary care, ensuring that people receive timely and appropriate health and disability services.

In 2013/14 the dataset used by the Ministry of Health changed and therefore the target and corresponding results are significantly different. While we are now unable to compare against previous results this sets a baseline for future results.



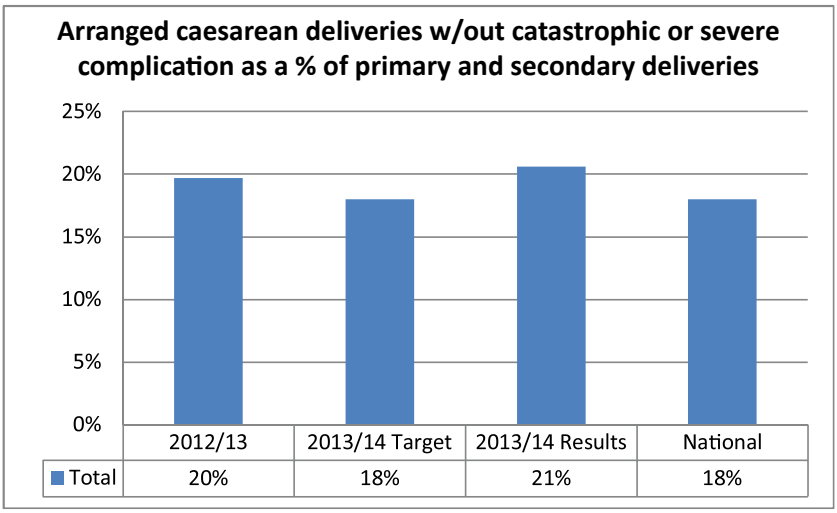
Data Source: Mid-Central DHB Patient Management System

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

Total	Target Achieved

Radiotherapy and in-patient 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.

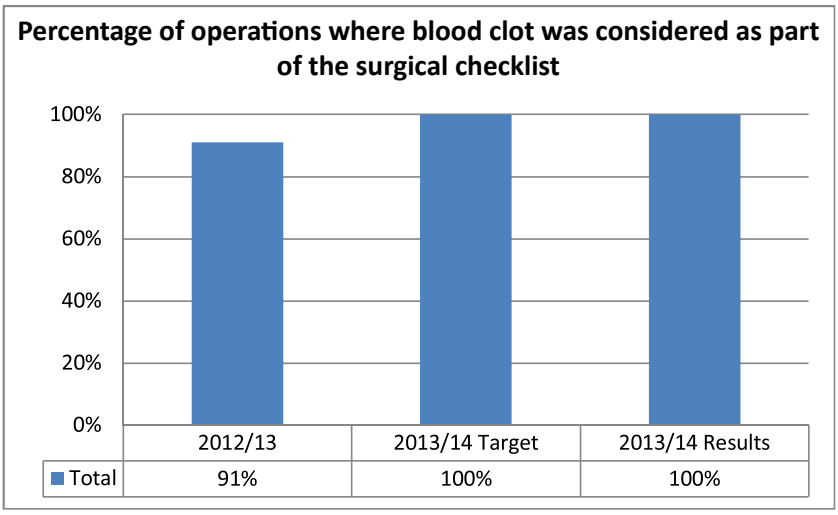


Data Source: National Minimum Dataset (NMDS)

<18% of total births require an arranged caesarean delivery without complications

Total	Target Not Achieved

Caesarean sections are an area that we actively manage and monitor to reduce the incidence of them occurring. There are some significant associated risks of having an caesarean that we are motivated to reduce. Through education, case review and improved antenatal care and advice we hope that the percentage of caesarean sections will decrease further over time.



Data Source: Taranaki DHB

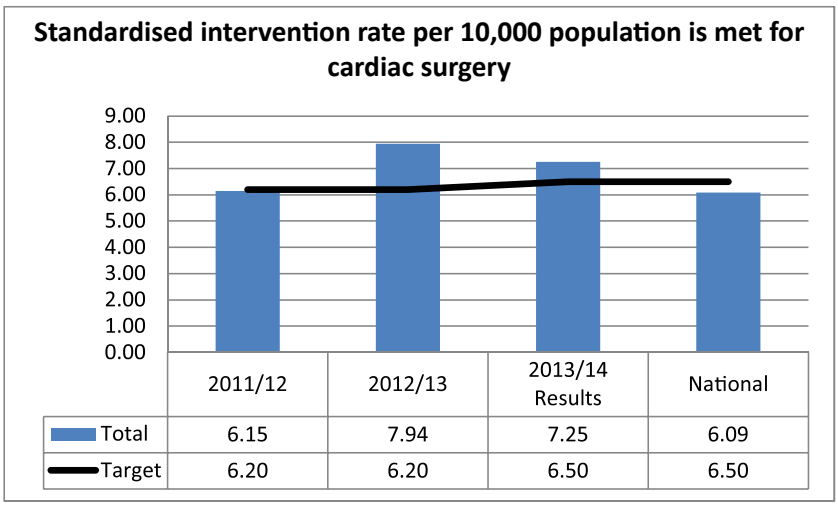
Percentage of operations where blood clot was considered as part of the surgical checklist

Total	Target Achieved

The World Health Organisation (WHO) Surgical Safety checklist is used for every patient undergoing surgery - one of the questions in the time out is "Has thromboprophylaxis been discussed?" which is a reminder for both the anaesthetist and surgeon if this has been overlooked. Each theatre also has its own sequential compression device available.

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

Total	Target Achieved

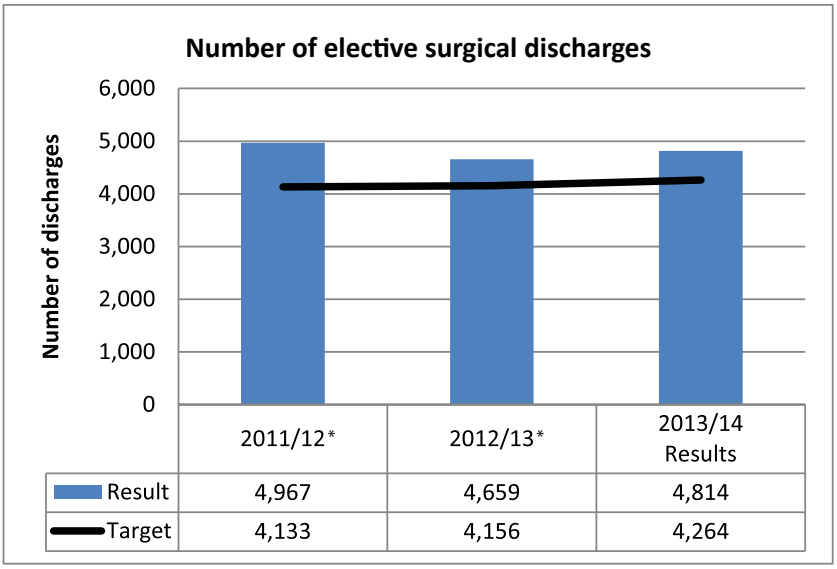
Meeting standardised intervention rates for a variety of types of surgery means that access is fair, and not dependent upon where a person lives. Taranaki has a higher rate than nationally but is not significantly higher. The vast majority of cardiac surgery is performed in Waikato for the people of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

Output Measures

ESPI 1	**All** patient referrals are acknowledged and processed within 10 working days	
	Result: 100%.	Target Achieved
ESPI 2	**No** patients wait longer than five months for their specialist assessment	
	Result: 0%.	Target Achieved
ESPI 3	Less than 5% of patients are waiting without a commitment to treat	
	Result: 0%.	Target 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%.	Target 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 GP. Taranaki DHB has achieved against all these indicators for 2013/14.

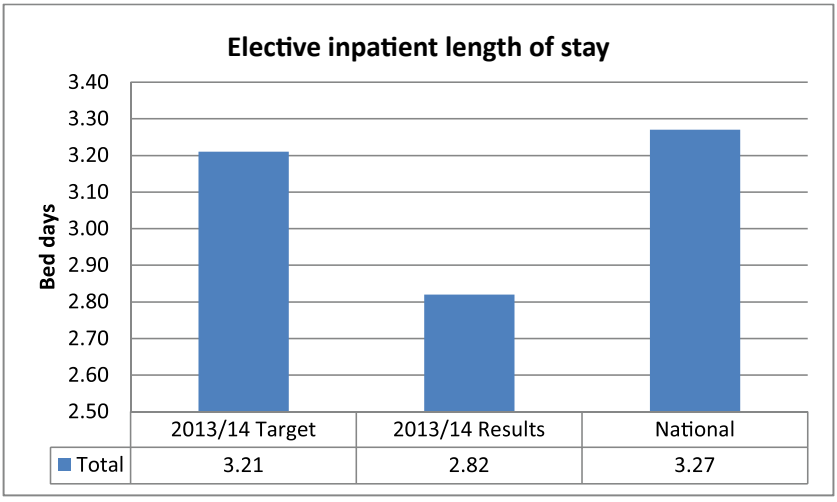


Data Source: National Minimum Dataset (NMDS)

4264 elective surgical dischargess

Total	Target Achieved

Elective surgery is for patients who do not require an operation right away. Elective procedures can significantly improve a patients quality of life including reinstating a persons independence. The Ministry requires the District Health Board to increase the number of elective events that are performed each year as part of it's plan to increase elective surgical procedures by 4,000 p.a. across the country. In this way Taranaki DHB is also addressing the increased demand due to population growth. Taranaki DHB yet again achieved the elective targets.



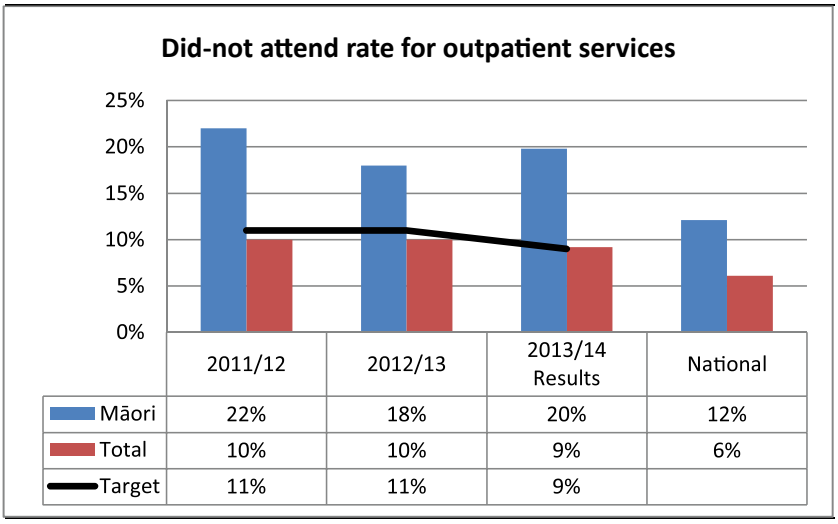
Data Source: National Minimum Dataset (NMDS)

Elective inpatient length of stay reduced

Total	Target Achieved

Taranaki DHB has made a significant improvement in elective length of stay in 2013/14.

We surpassed the target of 3.21 days to achieve 2.82 which is an excellent result locally but also against the national average. The projects delivered for Enhanced Recovery after Surgery (ERAS) have generated outstanding results in orthopaedics and general surgery and we continue to see benefits from this work.



Data Source: National Non-admitted Patient dataset

Did-not attend <9% for outpatient services

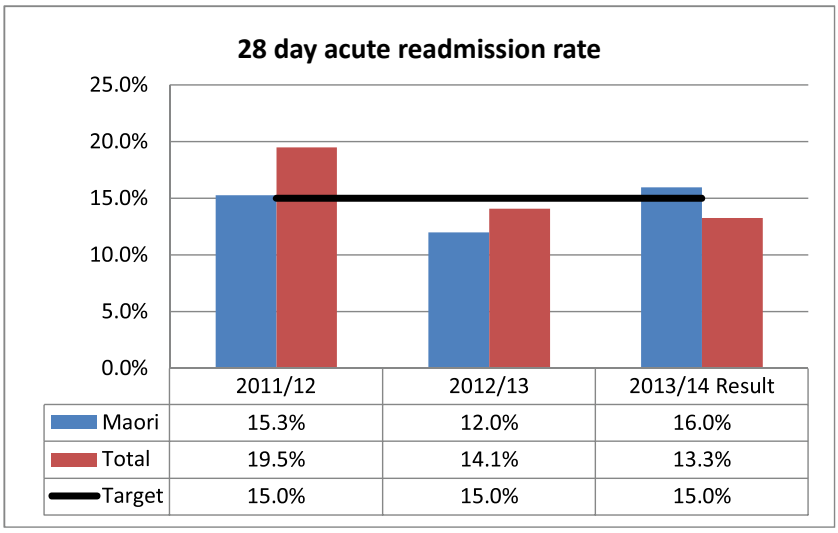
Māori	Target Not Achieved
Total	Target Achieved

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 2013/14. The Māori target was not achieved. Several initiatives were implemented including a text reminder service which alerts patients to upcoming appointments.

*To align with the health target reporting of the same indicator this has been corrected to show surgical discharges only, which excludes cardiac and dental services (as per the Ministry of Health's definition).

IMPROVED HEALTH STATUS FOR PEOPLE WITH A SEVERE MENTAL HEALTH ILLNESS AND/OR ADDICTION

Impact Measures



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

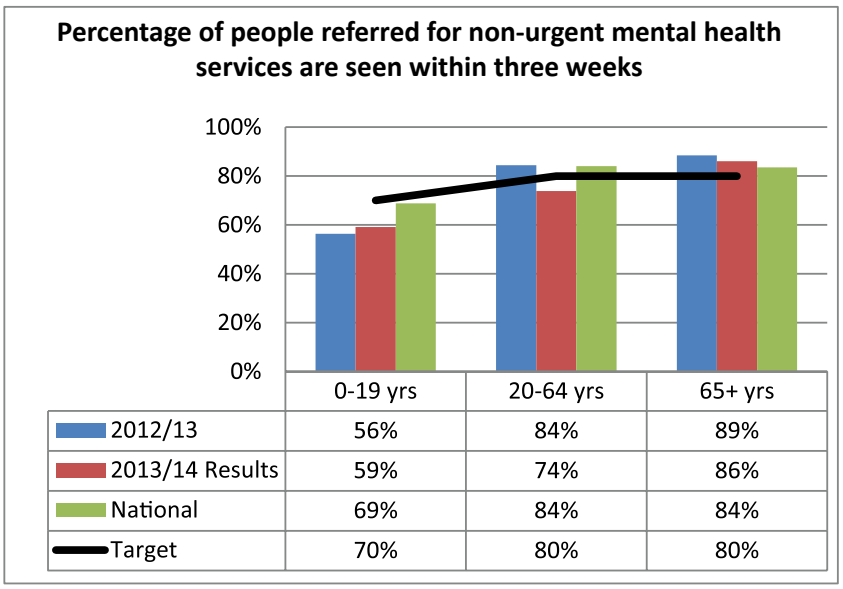
28 day acute readmission rate

Māori	Target Not Achieved
Total	Target Achieved

Fifteen Māori clients were readmitted within 28 days of discharged from Te Puna Waiora which equates to 16%. The target for Maori is 15% or less and so this target is significantly affected by a small change in numbers and the movement of a single client would make the dufference between achieving and not achieving the target.

Readmissions are monitored on a monthly basis and reported on. Clients with increased presentations will have case conferences to address re-occurring needs.

Output Measures

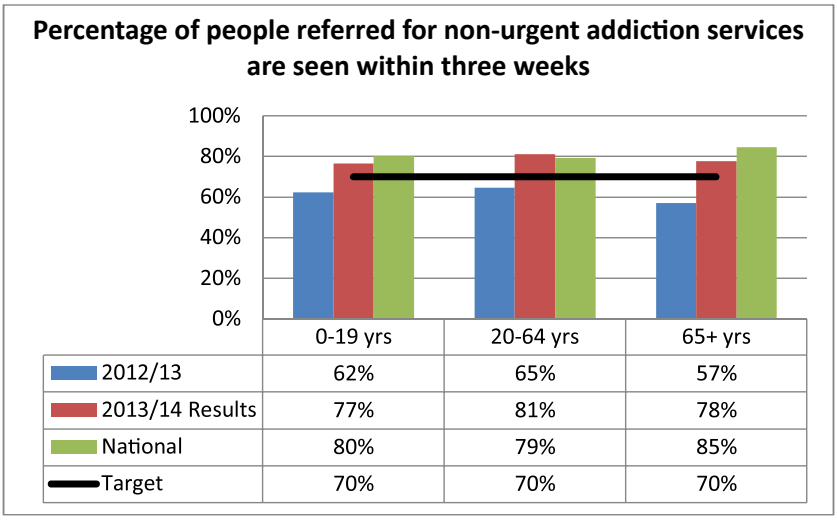


Data Source: Programme for the integration of Mental Health Data (PRMHD)

Improving the percentage of people referred for non-urgent mental health services (seen within three weeks)

0-19 years	Target Not Achieved
20-64 years	Target Not Achieved
65+ years	Target Achieved

This data reported under 2013/14 is based on client numbers during April 2013 to March 2014. In relation to the 0-19 year age band, there has been a huge improvement during the later part of 2014 as capacity issues have eased along with the new allocation model instituted last quarter, loosely based on Choice and Partnership Approach (CAPA). All wait lists in Child & Adolescent Mental Health Service (CAMHS) are actively monitored, outliers are raised by management for an action update. Monitoring of this target remains a priority. The adult intake coordinator role has combined with another specialist position so that there are now two Clinical Nurse Specialists (CNS) to work on improving responsiveness and effectiveness of services provided to the 20 to 64 age group.

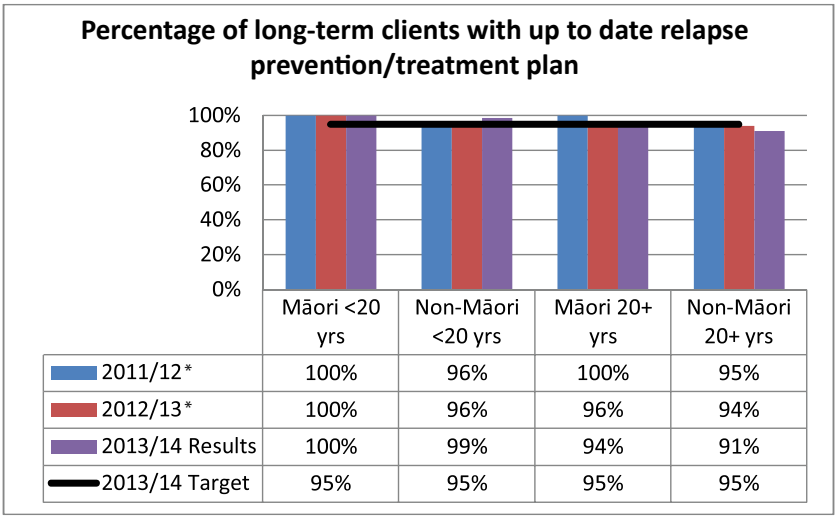


Data Source: Programme for the integration of Mental Health Data (PRMHD)

Improving the percentage of people referred for non-urgent addiction services (seen within three weeks)

0-19 years	Target Achieved
20-64 years	Target Achieved
65+ years	Target Achieved

An improvement was achieved compared to the prior year. There were vacancies during the 2012/13 year which when filled helped increase the result for 2013/14 as well as other process improvement.



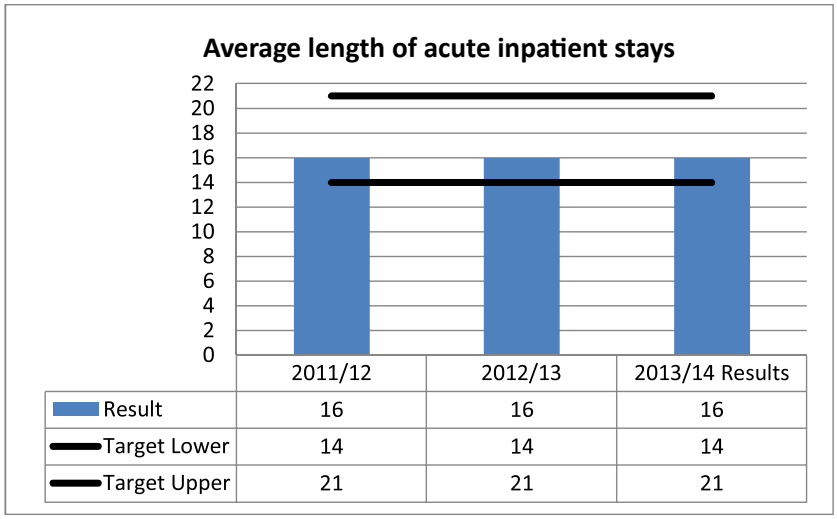
Data Source: Programme for the integration of Mental Health Data (PRMHD)

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

Māori <20 years	Target Achieved
Non-Māori <20 years	Target Achieved
Māori 20+ years	Target Not Achieved
Non-Māori 20+ years	Target 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. The 20+ targets were not reached for 2013/14 both for non-Māori and Māori. The target was a challenge for the addictions team within the service.

* Some of the percentages in last year's Annual Report were transposed or entered incorrectly.

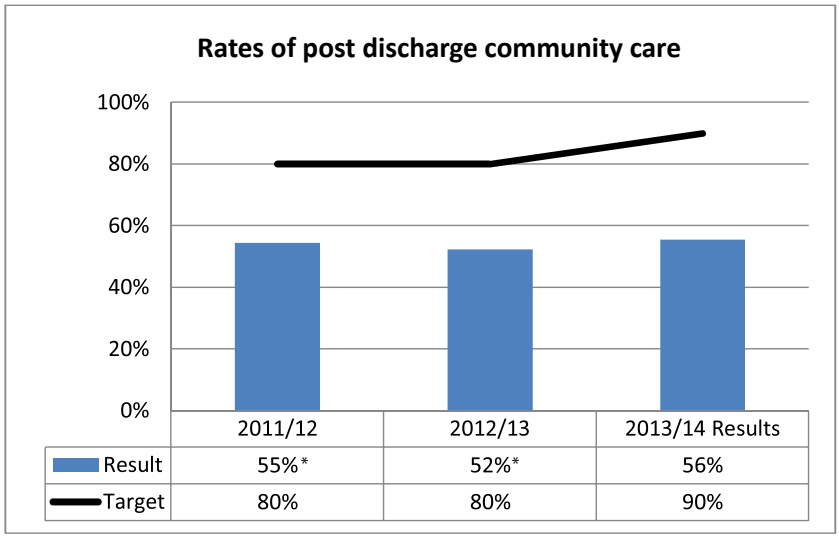


Data Source: Programme for the integration of Mental Health Data (PRMHD)

Average length of acute inpatient stays between 14-21 days

Total	Target 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.



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

90% of post discharge patients are seen in the community within seven days

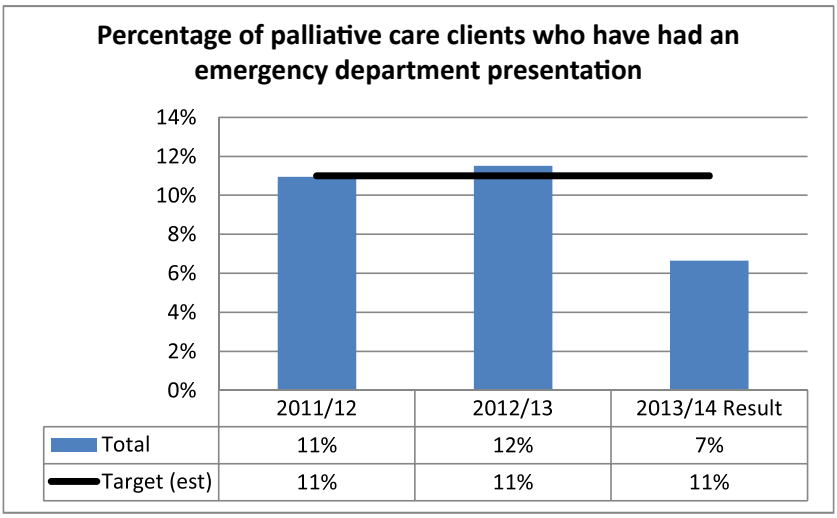
Total	Target Not Achieved

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 2013/14. There is a local Key Performance Indicator (KPI) group that meets monthly and is closely monitoring this activity. As a result changes have been made to processes to more easily monitor discharges. This local monitoring also identifies all clients not seen within seven days to establish whether it was as a result of poor business processes or not and if so investigates and implements improvements where possible. This National indicator only records clients who have been seen within seven days by adult provider arm teams (for which we attained 56%) as this is an adult stream indicator. However here at Taranaki DHB our inpatient unit is small and includes elderly, youth and alcohol & drug clients, therefore when these clients are discharged they are typically followed up by their respective service areas (non adult stream) and thus out of scope for this indicator. Internally we have been monitoring all contact by all teams upon discharge from Te Puna Waiora and can report that during 2013/14 Mental Health & Addiction services (including NGO) saw 81% of the clients within seven days of discharge.

* This year the data has come from the official PRIMHD KPI reports. Last year data was taken from locally run reports instead.

MORE PEOPLE WITH END-STAGE CONDITIONS ARE APPROPRIATELY SUPPORTED

Output Measures



Data Source: Taranaki Hospice

A reduction in the % of palliative care clients who have had an emergency department presentation

Total	Target Achieved

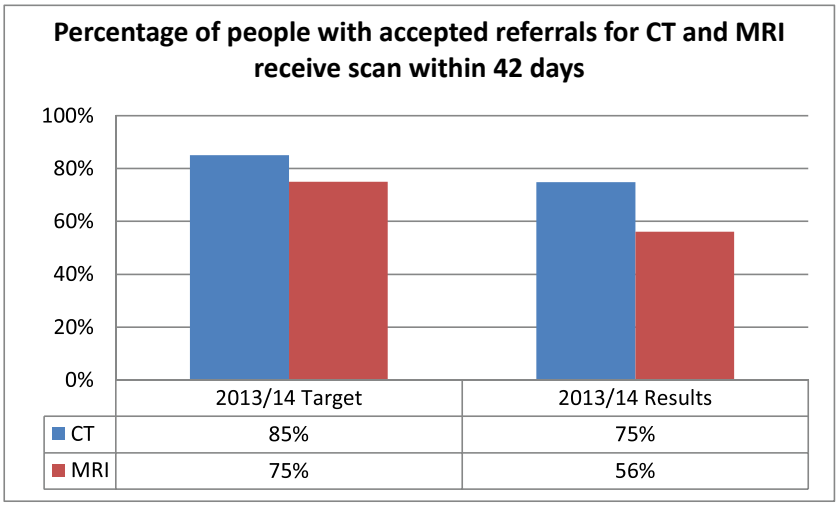
A contributing factor will be the on-going education and support provided to the aged care sector through the Hospice Taranaki Link Nurse programme. The Hospice New Zealand (HNZ) Fundamentals of Palliative Care education programme was been well received in aged care and is contributing to improvements in end of life care in that setting. As knowledge is growing the ability to prevent inappropriate admissions to ED is increased. The 24x7 telephone and the on call hospice nursing service are other factors which undoubtedly assist families/whanau to support patients in their own homes through their last days of life.

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 the 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

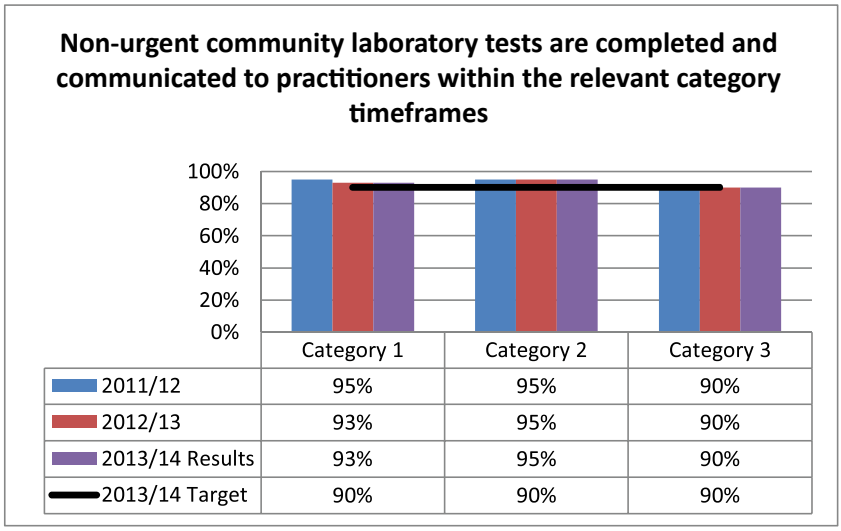


Data Source: Taranaki DHB

Improved wait times for diagnostic services - accepted referrals for CT and MRI

CT	Target Not Achieved
MRI	Target Not Achieved

CT target was almost reached by the second quarter but the number of referrals along with the complexity of cases has meant that this could not be sustained and therefore the annualised target level not met. MRI target has not been met, the provision of additional funding in September through a Ministry of Health initiative did help to remove some backlog but the increased number referrals being sent has meant that this too cannot be sustained and the target met.

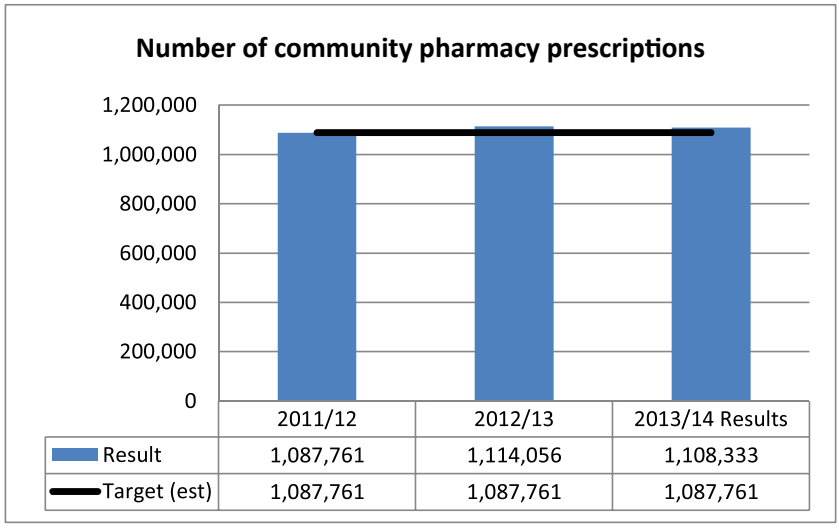


Data Source: Local contract Performance Monitoring

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

Category 1	Target Achieved
Category 2	Target Achieved
Category 3	Target 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.



Data Source: Pharmacy National Dataset

1,087,761 community pharmacy prescriptions

Total	Target Not Achieved

The new Community Pharmacy Service Delivery model has a focus on pharmacists providing medicines adherence support to people living with long term conditions in the community, thereby stabilising somewhat the number of prescriptions provided within the community.

The 2013/14 actual number of prescriptions however is only 1.9% above the level set two years previously and also represents a reduction compared to last year's results.

Financial Report

2013/2014

Statement of Responsibility

For the Year Ended 30 June 2014

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 2014, fairly reflect the financial position, operations, cash flows and service performance of the Taranaki District Health Board.

Pauline Lockett
Chairperson
9 October 2014

Sally Webb
Deputy Chairperson
9 October 2014

Tony Foulkes
Chief Executive
9 October 2014

George Thomas
Chief Financial Officer
9 October 2014

Statement of Comprehensive Income

For the Year Ended 30 June 2014

	Notes	Parent Actual June 2014 $000	Parent Budget June 2014 Unaudited $000	Group Actual June 2013 $000	Parent Actual June 2013 $000
Revenue	1	331,601	325,976	324,637	323,873
Other income	2	2,796	3,000	2,109	2,109
Total income		334,397	328,976	326,746	325,982
Employee benefit costs	3	111,195	107,637	111,099	106,252
Depreciation expense	13	12,150	14,700	11,663	11,663
Outsourced services		20,011	19,521	21,721	21,711
Clinical supplies		23,132	22,657	21,790	21,790
Infrastructure and non-clinical expenses		13,773	12,869	9,781	14,374
Payments to non-health board providers		147,882	144,621	141,938	141,938
Other expenses	4	1,614	1,267	1,271	771
Capital charge	5	6,693	5,890	5,778	5,778
Financing costs	6	1,484	3,265	1,832	1,832
Total expenses		337,934	332,427	326,873	326,109
Surplus/(Loss) before share of associates attributable to the Parent		(3,537)	(3,451)	(127)	(127)
Share of surplus/(loss) of associates	12(c)	261	-	134	134
Surplus/(Loss) after surplus/(loss) of associates		(3,276)	(3,451)	7	7
Other comprehensive income					
Revaluation of land and buildings		-	-	15,545	15,545
Total other comprehensive income/(expense)		-	-	15,545	15,545
Total comprehensive surplus/(loss) for the period attributable to the Parent		(3,276)	(3,451)	15,552	15,552

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

Group

	Notes	Public Equity	Retained Earnings / (Losses)	Asset Revaluation Reserve	Trust Fund Reserve	Total
		$000	$000	$000	$000	$000
At 30 June 2012		26,041	(3,536)	51,905	729	75,139
Comprehensive income / (expense)						
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
Transactions with the Crown						
Equity repaid to the Crown	29	(959)	-	-	-	(959)
		(959)	-	-	-	(959)
At 30 June 2013		25,082	(3,501)	67,450	701	89,732

Parent

	Notes	Public Equity	Retained Earnings / (Losses)	Asset Revaluation Reserve	Trust Fund Reserve	Total
		$000	$000	$000	$000	$000
At 30 June 2012		26,041	(4,618)	51,905	729	74,057
Comprehensive income / (expense)						
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
Transactions with the Crown						
Equity repaid to the Crown	29	(959)	-	-	-	(959)
		(959)	-	-	-	(959)
At 30 June 2013		25,082	(4,583)	67,450	701	88,650
Comprehensive income / (expense)						
Surplus / (deficit) for the year		-	(3,276)	-	-	(3,276)
Other comprehensive income		-	-	-	-	-
HIQ Realisation on dissolution	11	-	1,081	-	-	1,081
Transfer from/(to) Trust Funds Reserve		-	(57)	-	57	-
		-	(2,252)	-	57	(2,195)
Transactions with the Crown						
Equity repaid to the Crown	29	(959)	-	-	-	(959)
		(959)	-	-	-	(959)
At 30 June 2014		24,123	(6,835)	67,450	758	85,496

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

Statement of Financial Position

For the Year Ended 30 June 2014

	Notes	Parent Actual June 2014 $000	Parent Budget June 2014 Unaudited $000	Group Actual June 2013 $000	Parent Actual June 2013 $000
ASSETS					
Current assets					
Cash and cash equivalents	7	-	1,305	4,751	4,747
Trade and other receivables	8	10,513	11,200	7,092	6,730
Inventories	9	2,605	2,850	2,514	2,513
Other financial assets	10	2,890	3,000	11,000	11,000
Total current assets		16,008	18,355	25,357	24,990
Non-current assets					
Investments in subsidiaries	11	-	-	-	4,936
Investments in associates	12	1,502	1,106	1,241	1,241
Other financial assets	10	56	57	57	57
Property, plant and equipment	13	189,972	163,215	186,604	186,604
Intangible assets	14	1,351	1,351	729	729
Restricted assets & trust funds	15	758	729	701	701
Total non-current assets		193,639	166,458	189,332	194,268
TOTAL ASSETS		209,647	184,813	214,689	219,258
LIABILITIES					
Current liabilities					
Cash and cash equivalents	7	1,096	-	-	-
Trade and other payables	16	25,549	20,828	30,167	36,363
Interest bearing loans and borrowings	17	12,000	-	-	-
Employee benefits	18	22,568	19,900	21,075	20,530
Provisions	19	2	15	15	15
Total Current Liabilities		61,215	40,743	51,257	56,908
Non current liabilities					
Interest bearing loans and borrowings	17	62,000	74,000	72,000	72,000
Other Financial Liabilities		-	-	980	980
Employee benefits	18	936	1,250	720	720
Total non current liabilities		62,936	75,250	73,700	73,700
TOTAL LIABILITIES		124,151	115,993	124,957	130,608
NET ASSETS		85,496	68,820	89,732	88,650
EQUITY					
Public equity		24,123	24,124	25,082	25,082
Retained earnings/(losses)		(6,835)	(7,938)	(3,501)	(4,583)
Asset revaluation reserve		67,450	51,905	67,450	67,450
Trust fund reserve	15	758	729	701	701
TOTAL EQUITY		85,496	68,820	89,732	88,650

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 9th October 2014

Pauline Lockett
CHAIRPERSON

Sally Webb
DEPUTY CHAIRPERSON

Statement of Cash Flows

For the Year Ended 30 June 2014

		Parent		Group	Parent
		Actual	Budget	Actual	Actual
		June 2014	June 2014	June 2013	June 2013
			Unaudited		
CASHFLOWS FROM OPERATING ACTIVITIES	Notes	$000	$000	$000	$000
Cash was provided from:					
Receipts from Government and Public		330,347	328,116	328,594	327,445
Interest Received		697	300	1,308	1,304
GST (Net)		344	-	303	296
		331,388	328,416	330,205	329,045
Cash was disbursed to:					
Payments to Suppliers		212,992	202,260	192,776	196,415
Payments to Employees		108,941	106,845	110,546	105,725
Capital Charge Paid		7,474	6,690	6,581	6,581
Interest Paid		1,450	3,265	1,798	1,798
GST (Net)		–	-	-	-
		330,857	319,060	311,701	310,519
Net Cash Inflow from Operating Activities	20	531	9,356	18,504	18,526
CASHFLOWS FROM INVESTING ACTIVITIES					
Cash was provided from:					
Dividends Received		62	60	62	62
Proceeds from Short Term Deposit		8,110	-	22,000	22,000
Proceeds from Investments		1	-	-	-
Proceeds from Restricted Assets		-	-	28	28
Proceeds from Sale of Property, Plant & Equipment		31	-	7	7
		8,204	60	22,097	22,097
Cash was applied to:					
Purchase of Property, Plant & Equipment		15,566	10,000	52,795	52,795
Purchase of Intangible Assets		–	407	729	729
Restricted Assets		57	-	-	-
Short Term Deposit		-	-	-	-
		15,623	10,407	53,524	53,524
Net Cash Outflow from Investing Activities		(7,419)	(10,347)	(31,427)	(31,427)
CASHFLOWS FROM FINANCING ACTIVITIES					
Cash was provided from:					
Equity vested by Crown		-	-	-	-
Proceeds from Debt Financing		2,000	2,000	15,200	15,200
		2,000	2,000	15,200	15,200
Cash was applied to:					
Repayment of Equity		959	959	959	959
		959	959	959	959
Net Cash Outflow from Financing Activities		1,041	1,041	14,241	14,241
Net Increase/(Decrease) in Cash Held		(5,847)	50	1,318	1,340
Cash and cash equivalents at beginning of year		4,751	1,255	3,433	3,407
Cash and cash equivalents at end of year		(1,096)	1,305	4,751	4,747

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

Significant accounting policies for the year ended 30 June 2014

(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 parent financial statements comprise those of Taranaki District Health Board, a 50% investment in Fulford Radiology Services Limited, a 25% investment in Allied Laundry Services Limited and a 20% investment in HealthShare Limited. These associated entities are included as a parent activity as Taranaki District Health Board has significant influence in those entities. In 2013 these associated entities were included as part of Taranaki District Health Board consolidated results.

The Taranaki District Health Board consolidated financial statements for 2013 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 2014. The financial statements were authorised for issue by the Board on 9 October 2014.

(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.

Estimation of employee entitlement accruals

The liability relating to back pay and long term employee benefits (long service leave, gratuities and sabbatical leave) is based on a number of assumptions in relation to the estimated length of service, the timing of release of the obligation and the rate at which the obligation will be paid to be applied in determining the present value. If any of these factors changed significantly, the actual outcome could be materially different to the estimate provided in the financial statements. The carrying value of the accruals has been disclosed in note 18.

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.

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

(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.

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 invoices 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 and expensed as incurred.

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

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

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

Class of Asset	Estimated life	Depreciation rate
Land	not depreciated	n/a
Buildings	4 to 60 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 of changes in circumstances indicate that the carrying amount may not be recoverable.

Taranaki District Health Board conducts an annual internal review of asset values, which is used as a source of information to assess for any indicators of impairment. External factors, such as changes in expected future processes, technology and economic conditions, are also monitored to assess for indictors 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) Intangible Assets
The FPSC rights represent the DHB's right to access, under a service level agreement, shared finance, procurement and supply chain (FPSC) services provided using assets funded by the DHB's

The intangible asset is recognised at the cost of the capital invested by the DHB in the FPSC Programme, a national initiative, facilitated by Health Benefits Limited (HBL), whereby all 20 DHBs will move to a shared services model for the provision of finance, procurement and supply chain services.

The rights are considered to have an indefinite life as the DHBs have the ability and intention to review the service level agreement indefinitely and the fund established by HBL through the on-charging of depreciation on the FPSC assets to the DHBs will be used to, and is sufficient to, maintain the FPSC assets standard of performance or service potential indefinitely.

As the FPSC rights are considered to have an indefinite life, the intangible asset is not amortised and will be tested for impairment annually.

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

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

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

(o) Trade and Other Payables

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

(p) Interest-bearing Loans and Borrowings

All loans and borrowings are initially recognised at fair value less transaction costs. After initial recognition, all borrowings are measured at amortised cost using the effective interest method.

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

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

(q) Employee Leave Benefits

Short-term benefits

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

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

Long-term benefits

Entitlements that are payable beyond 12 months are calculated and included here.

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

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

(r) Provisions

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

ACC Partnership Program

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

(s) Income Tax

Taranaki District Health Board is a public authority under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under Section CB3 of the Income Tax Act 1994.

(t) Goods and Services Tax (GST)

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

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

(u) Standards, amendments and interpretations effective in the current period

All mandatory standards, amendments and interpretations have been adopted in the current year. None had a material impact on these financial statements.

(v) Standards, amendments and interpretations issued but not yet effective

The Minister of Commerce has approved a new Accounting Standards Framework developed by the External Reporting Board (XRB). Under this Accounting Standards Framework, the District Health Board is classified as a Public Benefit Entity (PBE) and will be required to apply NZ IFRS PBE and other New Zealand accounting standards and pronouncements that have authoritative suppport and are applicable to entities that apply NZ IFRS PBE. These standards were developed by the XRB and were issued in May 2013. The new standards will be effective for periods beginning on or after 1 July 2014.

Due to the change in the Accounting Standards Framework for PBE's, all NZ IFRS and amendments to existing NZ IFRS will not be applicable to PBE's. Therefore, the XRB has effectively frozen the financial reporting requirements for public benefit entities up until the new Accounting Standards Framework is effective. Accordingly, no disclosure has been made about new or amended NZ IFRS that exclude PBE's from their scope.

NZ IFRS 9 Financial Instruments (effective 1 January 2015)

has been amended and published and is applicable, but Taranaki District Health Board has not early adopted it. This standard will eventually replace NZ IAS 39 Financial Instruments - Recognition and Measurement and may be adopted by Taranaki District Health Board for the year ended 30 June 2016, subject to the implementation of the new PBE standards. Taranaki District Health Board will assess the impact of this standard at this time.

1 REVENUE

	Parent 2014 $000	Group 2013 $000	Parent 2013 $000
Health and disability services (MoH contracted revenue)	319,713	311,548	311,426
ACC revenue	4,648	4,202	4,202
Inter District Patient Inflows	3,790	4,472	4,472
Interest received	697	1,308	1,304
Dividends received	62	62	62
Bad debts recovered	2	3	3
Other revenue	2,689	3,042	2,404
	331,601	324,637	323,873

2 OTHER INCOME

	Parent 2014 $000	Group 2013 $000	Parent 2013 $000
Donations and bequests received	2,796	2,102	2,102
Gain on sale of property, plant and equipment	-	7	7
	2,796	2,109	2,109

3 EMPLOYEE BENEFIT COSTS

	Parent 2014 $000	Group 2013 $000	Parent 2013 $000
Wages and salaries	108,275	109,151	104,282
Contributions to defined contribution schemes	1,588	1,565	1,545
Increase/(Decrease) in employee benefits provisions	1,332	383	425
	111,195	111,099	106,252

4 OTHER EXPENSES

	Parent 2014 $000	Group 2013 $000	Parent 2013 $000
Impairment of trade receivables (bad and doubtful debts)	35	27	27
Loss on sale of property, plant and equipment	16	7	7
Audit fees - Deloitte (for the audit of the annual financial statements)	197	228	203
Audit fees - HSS Limited (ACC partnership plan)	4	3	3
Board and Advisory members fees	278	274	266
Operating lease expenses	1,084	732	265
	1,614	1,271	771

Board and Advisory members fees have been restated for 2013. In 2013 Advisory member fees were not included with Board member fees, so to be consistent with 2014 these fees have now been added.

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 2014 was 8% (2013: 8%).

6 FINANCING COSTS

	Parent 2014 $000	Group 2013 $000	Parent 2013 $000
Interest on bank overdraft	2	119	119
Interest on loans - Ministry of Health	1,482	1,713	1,713
	1,484	1,832	1,832

7 CASH AND CASH EQUIVALENTS

	Parent 2014 $000	Group 2013 $000	Parent 2013 $000
Cash at bank and in hand	(1,096)	4,751	4,747
Short-term deposits maturing within 3 months of acquisition	-	-	-
Cash and cash equivalents	(1,096)	4,751	4,747

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

	Parent 2014 $000	Group 2013 $000	Parent 2013 $000
Ministry of Health	6,054	3,586	3,583
Due from subsidiaries	-	-	1
Due from associates	111	286	267
Due from non-related parties	3,626	2,714	2,643
Prepayments	751	530	260
	10,542	7,116	6,754
Allowance for impairment loss (a)	(29)	(24)	(24)
Carrying amount of trade and other receivables	10,513	7,092	6,730

(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:

	Parent	Group	Parent
	2014	2013	2013
	$000	$000	$000
At 1 July	24	49	49
Charge for the year	35	27	27
Amounts written off	(30)	(52)	(52)
At 30 June	29	24	24

	Parent	Group	Parent
	2014	2013	2013
	$000	$000	$000
Total non commercial debt	95	81	81
Non commercial debt with no impairment allowance	66	57	57

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 2014 and 2013, all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below:

	Actual	
	2013	2013
	Gross	Impairment
	$000	$000
Taranaki District Health Board Group		
Not past due	6,915	-
Past due 1 - 30 days	121	-
Past due 31 - 60 days	34	-
Past due 61 - 90 days	3	(1)
Past due > 90 days	43	(23)
	7,116	(24)

	Actual		Actual	
	2014	2014	2013	2013
	Gross	Impairment	Gross	Impairment
	$000	$000	$000	$000
Taranaki District Health Board Parent				
Not past due	10,342	-	6,573	-
Past due 1 - 30 days	127	-	121	-
Past due 31 - 60 days	33	-	14	-
Past due 61 - 90 days	5	(2)	3	(1)
Past due > 90 days	35	(27)	43	(23)
	10,542	(29)	6,754	(24)

The ageing of debtors in the above two tables has been expanded to split Past due 1 - 60 days into Past due 1 - 30 days and 31 - 60 days. Prior year amounts have been restated to reflect this increased level of detail.

(b) Related Party Receivables

For specific amounts owing from related parties, including associate companies refer to note 22.

(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

	Parent	Group	Parent
	2014	2013	2013
	$000	$000	$000
Pharmaceuticals	466	516	516
Surgical and Medical Supplies	1,544	1,454	1,453
Other Supplies	595	544	544
	2,605	2,514	2,513

Write-down of inventories amounted to $70k for 2014 (2013 $139k).

No inventories are pledged as security for liabilities.

10 OTHER FINANCIAL ASSETS

	Parent	Group	Parent
	2014	2013	2013
	$000	$000	$000
Current portion			
Short-term deposits with maturities of 3-12 months	2,890	11,000	11,000
	2,890	11,000	11,000
Non-current portion			
Shares in King Country Energy Limited	-	1	1
Shares in Pharmacy Wholesalers Limited	56	56	56
	56	57	57

11 INVESTMENT IN SUBSIDIARY COMPANY

	Parent	Group	Parent
	2014	2013	2013
Investment details	$000	$000	$000
HIQ Limited unlisted ordinary shares	-	-	4,936
	-	-	4,936

A resolution was made by the shareholders to dissolve HIQ Limited effective from 1 July 2013. The subsidiary was amalgamated into Taranaki District Health Board on this date with the assets and liabilities being transferred at their book value with $1.081m being recognised in equity as the realisation on dissolution of the subsidiary.

12 INVESTMENT IN ASSOCIATE COMPANIES

	Parent	Group	Parent
	2014	2013	2013
(a) Investment details	$000	$000	$000
HealthShare Limited unlisted ordinary shares	-	-	-
HealthShare Limited Share of Retained Earnings	195	38	38
Allied Laundry Services Limited unlisted ordinary shares	750	750	750
Allied Laundry Services Limited Share of Retained Earnings	162	118	118
Fulford Radiology Services Limited unlisted ordinary shares	401	401	401
Fulford Radiology Services Limited Share of Accumulated Deficit	(306)	(366)	(366)
Fulford Radiology Services Limited loan to purchase assets	300	300	300
	1,502	1,241	1,241

There is no intention to seek repayment of the Fulford Radiology Services Limited loan of $300k (2013: $300k).

Details of each Associate Company are as follows:	**Balance date**	**Interest held at 30 June 2014**	**Interest held at 30 June 2013**
HealthShare Limited	30 June	20%	20%

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

Fulford Radiology Services Limited	30 June	50%	50%

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

Allied Laundry Services Limited	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 - 2014:	**Assets**	**Liabilities**	**Equity**	**Revenues**	**Profit/(loss)**
	$000	$000	$000	$000	$000
Healthshare Limited	5,543	4,442	1,101	7,689	129
Fulford Radiology Services Limited	3,634	3,132	502	12,632	312
Allied Laundry Services Limited	5,287	1,204	4,083	7,804	675

Taranaki District Health Board's share of Associates and the Trust Fund Reserve are included as Parent activities for 2014. Amounts relating to Associates and the Trust Fund Reserve have been restated in Parent comparative amounts for the year ended June 2013.

NZ IAS 1 Presentation of Financial Statements requires an entity to present the statement of financial position with the prior period error adjusted for the previous period and the beginning of the comparative period, ie presentation of three statements of financial position are required. The financial statements do not include a statement of financial position with regards to the earliest comparative period as this is not considered to be material to the readers.

Summarised audited financial information - 2013:	Assets	Liabilities	Equity	Revenues	Profit/(loss)
	$000	$000	$000	$000	$000
HealthShare Limited	3,285	2,314	971	7,645	780
Fulford Radiology Services Limited	4,201	4,012	189	11,574	121
Allied Laundry Services Limited	4,898	1,250	3,648	7,189	417

The above information has been extracted from the associate companies unaudited management accounts (2014) and audited financial statements (2013).

(c) Movements in the carrying value of investments in associates:	Parent	
	2014	2013
	$000	$000
Balance at 1 July	1,241	1,107
New investments during the year	–	-
Share of total recognised revenues and expenses	261	134
Balance at 30 June	1,502	1,241

13 PROPERTY, PLANT AND EQUIPMENT

Parent	Freehold Land	Freehold Buildings	Plant and Equipment	Motor Vehicles	Work in Progress	Total
Year ended 30 June 2014						
Cost/revaluation 30 June 2013	8,860	68,935	57,503	3,060	88,527	226,885
Accumulated depreciation and impairment charges 30 June 2013	-	-	(37,888)	(2,393)	-	(40,281)
Carrying amount 30 June 2013	8,860	68,935	19,615	667	88,527	186,604
Current year additions	-	309	8,758	238	6,261	15,566
Current year disposals	-	-	(1)	(47)	-	(48)
Current year depreciation	-	(5,712)	(6,253)	(185)	-	(12,150)
At 30 June 2014 net of accumulated depreciation and impairment	8,860	63,532	22,119	673	94,788	189,972
At 30 June 2014						
Cost or fair value	8,860	69,244	66,085	3,152	94,788	242,129
Accumulated depreciation and impairment	-	(5,712)	(43,966)	(2,479)	-	(52,157)
	8,860	63,532	22,119	673	94,788	189,972

The new clinical services block build accounts for $82.87m (2013: $77.55m) of the work in progress value at 30 June 2014.

Group and Parent	Freehold Land	Freehold Buildings	Plant and Equipment	Motor Vehicles	Work in Progress	Total
Year ended 30 June 2013						
Cost/revaluation 30 June 2012	7,890	81,034	52,518	2,840	43,904	188,186
Accumulated depreciation and impairment charges 30 June 2012	-	(23,370)	(32,559)	(2,323)	-	(58,252)
Carrying amount 30 June 2012	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
At 30 June 2013						
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.

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 2014 (2013; Nil).

14 INTANGIBLE ASSETS

Parent	FPSC Rights	Total
Year ended 30 June 2014		
Balance at 30 June 2013	729	729
Accumulated depreciation and impairment charges 30 June 2013	-	-
Carrying amount 30 June 2013	729	729
Current year additions	622	622
Amortisation charge for year	-	-
At 30 June 2014 net of accumulated depreciation and impairment	1,351	1,351
At 30 June 2014		
Cost or fair value	1,351	1,351
Accumulated depreciation and impairment	-	-
	1,351	1,351

At 30 June 2014, the DHB had made payments totalling $1,351 (2013: $729) to HBL in relation to the Finance, Procurement and Supply Chain ("FPSC") programme, which was in progress at year end. This is a national initiative facilitated by HBL. In return for these payments, the DHB gains FPSC rights. In the event of liquidation or dissolution of HBL, the DHB shall be entitled to be paid from the surplus assets, an amount equal to, the DHB's proportionate share of the liquidation value based on its proportional share of the total FPSC rights that have been issued.

These FPSC rights have been tested for impairment by comparing the carrying amount of the intangible asset to its depreciated replacement cost (DRC), which is considered to equate to the DHB's share of the DRC of the underlying FPSC assets.

It is expected that the final costs of the FPSC programme will exceed the original budget. HBL is undertaking an exercise to determine the revised costs of the programme and following this, formal approval to proceed will be required from the DHBs. The current expectation of the Board is that the FPSC programme will proceed as originally planned. In this scenario, the DRC of the FPSC rights is considered to equate, in all material respects, to the costs capitalised to date such that the FPSC rights are not impaired. However, the future of the FPSC programme is uncertain and any future decision to re-scope or discontinue the FPSC programme will require a reassessment of the recoverable amount (ie DRC) of the FPSC rights.

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.

	Parent	Group	Parent
	2014	2013	2013
	$000	$000	$000
Opening Balance	701	729	729
Funds Received	106	101	101
Interest Received	23	34	34
Funds Spent	(72)	(163)	(163)
Closing Balance Restricted Assets	758	701	701
Represented By:			
Cash at Bank	151	18	18
Short Term Deposits	600	677	677
Shares & Other	7	6	6
Total Restricted Assets	758	701	701

16 TRADE AND OTHER PAYABLES

	Parent	Group	Parent
	2014	2013	2013
	$000	$000	$000
Trade Payables	21,408	25,913	25,374
Capital Charge Payable	-	782	782
Income received in advance	1,035	993	993
Interest Payable	538	504	504
Current Account with Subsidiary Company	-	-	6,313
Owing to Subsidiaries	-	-	422
Owing to Associates	1,083	1,125	1,125
Other Related Parties	1,485	850	850
	25,549	30,167	36,363

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.

17 INTEREST-BEARING LOANS AND BORROWINGS

	Parent	Group	Parent
	2014	2013	2013
	$000	$000	$000
Government Sector Borrowing	74,000	72,000	72,000
Total Loans	74,000	72,000	72,000
Less Current Portion	12,000	-	-
Term Portion	62,000	72,000	72,000

INTEREST RATES:	2014	2013
Government Sector Borrowing	3.03% - 7.02%	3.03% - 7.02%

	Parent	Group	Parent
	2014	2013	2013
GOVERNMENT SECTOR BORROWING	$000	$000	$000
Due for repayment:			
within one year	12,000	-	-
within two years	19,200	12,000	12,000
within three years	-	19,200	19,200
within four years	22,000	-	-
within five years	15,600	22,000	22,000
after five years	5,200	18,800	18,800
	74,000	72,000	72,000

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.

Taranaki District Health Board capitalises interest where loan advances specifically relate to major capital project. This financial year $1,618k was capitaised to the new clinical services block (2013: $1,305k).

FAIR VALUE OF GOVERNMENT BORROWING
The fair value of the $74,000k (2013: $72,000K) of Government Borrowing at 30th June 2014 was calculated at $73,881k (2013: $73,450k). This calculation is done by discounting the expected future cash flows at prevailing interest rates. The 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

	Parent	Group	Parent
	2014	2013	2013
	$000	$000	$000
Salary & wages accrual	4,875	4,138	3,953
Annual Leave	14,054	13,237	12,877
Sick Leave	367	323	323
Long Service Leave	1,430	1,329	1,329
Retirement gratuities	913	955	955
Continuing Medical Education	1,562	1,554	1,554
Sabbatical Leave	303	259	259
	23,504	21,795	21,250
Made up of:			
Current	22,568	21,075	20,530
Non-current	936	720	720
	23,504	21,795	21,250

19 PROVISIONS

	Parent	Group	Parent
	2014	2013	2013
	$000	$000	$000
Current provisions			
ACC Partnership Programme	2	15	15
	2	15	15

The liability valuation on the ACC Partnership Program has been calculated by Aon New Zealand Limited as at the 30th June 2014. 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

	Parent 2014 $000	Group 2013 $000	Parent 2013 $000
Net Surplus/(Loss)	(3,276)	7	7
Add/(Less) Non-Cash Items:			
Depreciation	12,150	11,663	11,663
(Decrease)/Increase in Provision for Doubtful Debts	5	(25)	(25)
(Decrease)/Increase in Employee Entitlements	2,254	553	527
	14,409	12,191	12,165
Add back items classified as investment/financing activities:			
Decrease/(Increase) in Investments Held	5,131	(134)	(134)
Net Loss/(Gain) of Disposal of Assets	16	1	1
	5,147	(133)	(133)
Add/(Less) Movements in Working Capital:			
(Increase)/Decrease in Receivables & Prepayments	(3,788)	3,370	2,908
(Increase)/Decrease in Inventories	(92)	141	141
(Decrease)/Increase in Payables & Accruals	(11,869)	2,928	3,438
	(15,749)	6,439	6,487
Net Cash Inflow/(Outflow) from Operating Activities	531	18,504	18,526

21 RELATED PARTIES - KEY MANAGEMENT PERSONNEL

	Parent 2014 $000	Group 2013 $000	Parent 2013 $000
Compensation of key management personnel			
Short-term employee benefits	1,830	1,902	1,902
Post-employment benefits	39	33	33
Other long-term benefits	-	-	-
Termination benefits	-	-	-
	1,869	1,935	1,935

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 $320m from the Ministry of Health to provide health services to the Taranaki area (2013: $312m). The amount outstanding at year end was $6.05m (2013: 3.59m).

(b) Inter-Group Transactions and balances:

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

	Parent Owed to TDHB		Parent Income to TDHB	
	2014	2013	2014	2013
	$000	$000	$000	$000
Allied Laundry Services Limited	62	62	79	84
Fulford Radiology Services Limited	39	40	309	291
HBL Limited	-	-	-	-
Healthshare Limited	10	164	155	77
HIQ Limited	-	1	-	15
	111	267	543	467

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

	Parent Owed by TDHB		Parent Expense to TDHB	
	2014	2013	2014	2013
	$000	$000	$000	$000
Allied Laundry Services Limited	216	208	1,017	928
Fulford Radiology Services Limited	644	830	7,805	7,277
HBL Limited	145	25	372	246
HBL Limited - FPSC rights	622	215	407	944
Healthshare Limited	222	87	1,151	663
HIQ Limited	-	422	-	3,561
	1,849	1,787	10,752	13,619

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

Board Members - 2014

TDHB Board Member	Related Party	Relationship	TDHB Transaction	Expense for Year 30 June 2014	Owed by TDHB at 30 June 2014
				$000	$000
Alex Ballantyne	S.T.A.R.T.	Trustee	Youth Services	-	-
	South Taranaki District Council	Councillor	Local Authority	135	3
Karen Eagles	Govett Quilliam	Husband Senior Partner	Legal Advice	92	3
Flora Gilkison	Fulford Radiology Services	Director	Radiology Services	7,805	741
	Taranaki DHB	Husband employed by Taranaki DHB	Employee	–	–
Richard Handley	New Plymouth District Council	Councillor	Local Authority	230	11
	Taranaki Youth Health Trust (t/a new Waves)	Trustee	Youth Services	-	-
	YMCA	Board Member	Community Services	-	-
Pat Leary	Devon Medical Limited	Director	GP and Health Services	8	1
	Midlands Health Network (incl Trust)	Through owner (Pinnacle Incorp)	Primary Health Organisation	22,426	511
	Pinnacle Incorporated	Executive Team Member	Primary Health Organisation	6	6
Pauline Lockett	New Plymouth District Council	Councillor	Local Authority	230	11
Kevin Nielsen	Hospice Taranaki	Chief Executive Officer	Health Services	2,049	175
Alison Rumball	Taranaki Cancer Society	Vice President	Health Services	6	6
Sally Webb	Bay of Plenty DHB	Chairperson	District Health Board	496	3

Former TDHB Board Members	Related Party	Relationship	TDHB Transaction	Expense for Year 30 June 2014	Owed by TDHB at 30 June 2014
				$000	$000
Mary Bourke	Bishops Action Foundation	Trustee	Community and Health Projects	-	-
	Lotteries Community Grant Committee	Member	Community Funding	-	-
	Taranaki Families Whanau Trust	Trustee	Community and Health Projects	-	-
	Taranaki Health Foundation Trust	Trustee	Community Funding	-	-
	TSB Community Trust	Trustee	Community Funding	-	-
	WITT Polytechnic	Chairperson	Training organisation	-	-
Peter Catt	Family Health Care Centre	GP and Shareholder	GP and Health Services	89	5
Kura Denness	Allied Laundry Services	Director	Supplier of Laundry Services	1,017	235
	Massey University	Council Member	Education Provider	5	-
	PHARMAC	Director	Medical Supplies	248	178
	TSB Community Trust	Trustee	Community Funding	-	-
	Tui Ora Limited	Chairperson	Health Services	9,483	697
Brian Jeffares	Taranaki Electricity Trust	Trustee	Community Funding	-	-

Board Members - 2013

TDHB Board Member	Related Party	Relationship	TDHB Transaction	Expense for Year 30 June 2013	Owed by TDHB at 30 June 2013
				$000	$000
Alex Ballantyne	Peak Health	Local Management Group Member	GP and Health Services	-	-
	STDC	Councillor	Local Authority	13	3
	TSB Community Trust	Trustee	Community Funding	-	-
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 RNZCGP	Secretary Treasurer		-	-
	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	71	27
	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

Payments and amount owing to Govett Quilliam were omitted from 2013 financial reports. These have now been added for comparison.

23 FINANCIAL INSTRUMENT CATEGORIES

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

		Parent	Group	Parent
		2014	2013	2013
FINANCIAL ASSETS	**Note**	$000	$000	$000
Loans and receivables				
Cash and cash equivalents	7	-	4,751	4,747
Debtors and other receivables	8	9,762	6,562	6,470
Other investments	10	56	57	57
Term deposits	10	2,890	11,000	11,000
Restricted Assets and Trust Funds	15	758	701	701
Total loans and receivables		13,466	23,071	22,975

FINANCIAL LIABILITIES	**Note**			
Financial liabilities at amortised costs				
Trade and other payables	16	24,514	29,174	35,370
Loans from Ministry of Health	17	74,000	72,000	72,000
Total financial liabilities		98,514	101,174	107,370

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

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

The fair value of the $74,000k of loans from the Ministry of Health at 30th June 2014 was calculated at $73,881k (2013: $73,450k).

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% (2013: 97%) whilst it accounted for 88% (2013: 97%) of receivables.

(c) Liquidity Risk

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

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

(d) Contractual Liquidity Table

Parent - 2014
The following table sets out the contractual cash flows for all financial liabilities:

	Carrying value	Contractual Cash Flows	0-3 month	3-12 months	1-3 years	3-7 years
	$000	$000	$000	$000	$000	$000
Non-derivative financial liabilities						
Trade and other payables	24,514	24,514	24,514	–	–	–
Loans and borrowings	74,000	82,727	242	14,741	22,860	44,884
	98,514	107,241	24,756	14,741	22,860	44,884

Parent - 2013
The following table sets out the contractual cash flows for all financial liabilities:

	Carrying value	Contractual Cash Flows	0-3 month	3-12 months	1-3 years	3-7 years
	$000	$000	$000	$000	$000	$000
Non-derivative financial liabilities						
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

Group - 2013
The following table sets out the contractual cash flows for all financial liabilities:

	Carrying value	Contractual Cash Flows	0-3 month	3-12 months	1-3 years	3-9 years
	$000	$000	$000	$000	$000	$000
Non-derivative financial liabilities						
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

(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 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 2014, 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 $29k higher/lower (2013: $110k).

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

Judgements of reasonably possible movements

Consolidated and Parent	**Surplus for the period**	
	Higher/(lower)	
	2014	2013
	$000	$000
+1% (100 basis points)	29	110
-1% (100 basis points)	(29)	(110)

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

	Parent	**Group**	**Parent**
	2014	2013	2013
	$000	$000	$000
Capital Commitments			
Property, plant and equipment	1,079	4,964	4,964
	1,079	4,964	4,964

Operating leases as lessee

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

Not later than one year	1,017	1,067	1,067
Later than one and not later than two years	885	983	983
Later than two and not later than five years	37	932	932
Later than five years	83	92	92
	2,022	3,074	3,074

27 MAJOR VARIATIONS FROM BUDGET (unaudited)

Income Statement Variances - Revenue

Taranaki District Health Board recorded a deficit of $3.28 million compared with a budgeted deficit of $3.45 million.

A total of $5.4 million additional revenue over budget was received as follows (2013: $2.9m):

	Variance unaudited 2014 $000	Variance unaudited 2013 $000
Ministry of Health Funding	4,844	1,416
Accident Compensation Revenue (ACC)	511	118
Inter District Flows	(347)	149
Inter Provider Revenue	73	165
Interest Received	397	348
Donations Received	(204)	102
Other	147	643
	5,421	2,941

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 less than expected.
Interest Received	Management of cash received and paid.

Income Statement Variances - Expenditure

A total of $5.5m additional expenditure over budget were incurred as follows (2013: $5.8m):

	Variance Unaudited 2014 $000	Variance Unaudited 2013 $000
Employee Benefit costs	3,558	4,382
Depreciation Expense	(2,550)	(18)
Outsourced services	490	852
Clinical supplies	475	1,775
Infrastructure and non-clinical expenses	904	(18)
Payments to non-health board providers	3,261	(2,073)
Other	(631)	893
	5,507	5,793

Prior year expense analysis has been restated to tie in with enclosed financial statement breakdown. Previoulsy depreciation has been included with other expense groupings rather than a separate item.

Income Statement Expenditure Explanations

Employee Benefit costs	Increased staffing hours.
Depreciation Expense	Deferral of capital expenditure.
Outsourced services	Increased demand for diagnostic testsing.
Clinical Supplies	Additional activity.
Infrastructure & Non-Clinical Supplies	Reduced depreciation expense, and increased capitalisation of salaries.
Payments to non-health board providers	IDF Personal Health Outflows.

	Variance Unaudited 2014 $000	Variance Unaudited 2013 $000
Balance Sheet Variances		
Cash & S/T Deposits	(2,401)	3,247
Other Financial Assets	(110)	3,000
Property, plant and equipment	26,757	15,947
Receivables & Prepayments	(687)	(2,498)
Employee Entitlements	2,354	840
Payables	4,721	8,522

Balance Sheet Explanations	
Cash & S/T Deposits	Timing of payments to suppliers.
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

	Note	Parent 2014 $000	Group 2013 $000	Parent 2013 $000
Fees to principal auditor (Deloitte)	**Note**			
Audit of annual financial statements	4	197	228	203
Other assurance-related services		-	-	-
Tax compliance		-	-	-
Due diligence services		-	-	-
		197	228	203

	Note	Parent 2014 $000	Group 2013 $000	Parent 2013 $000
Other Audit Fees paid (non Deloitte)	**Note**			
ACC Partnership Program - Verification New Zealand Limited	4	4	3	3

29 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 (2013: $Nil). Public equity of $959k (2013: $959k) was repaid to the Crown during the year. The repayments in both 2014 & 2013 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.

30 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 2014	Actual 2013
100,000 - 110,000	21	17
110,001 - 120,000	14	15
120,001 - 130,000	15	11
130,001 - 140,000	3	5
140,001 - 150,000	7	4
150,001 - 160,000	8	5
160,001 - 170,000	5	4
170,001 - 180,000	6	2
180,001 - 190,000	7	6
190,001 - 200,000	9	5
200,001 - 210,000	2	4
210,001 - 220,000	6	3
220,001 - 230,000	3	-
230,001 - 240,000	3	5
240,001 - 250,000	4	3
250,001 - 260,000	3	7
260,001 - 270,000	4	4
270,001 - 280,000	4	7
280,001 - 290,000	6	2
290,001 - 300,000	-	1
300,001 - 310,000	2	1
310,001 - 320,000	-	1
320,001 - 330,000	1	1
360,001 - 370,000	-	1
370,001 - 380,000	-	-
380,001 - 390,000	1	-
450,001 - 460,000	-	1
	134	115
Clinicians	111	97
Management	23	18
Total	134	115

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 153 (2013: 134).

31 TERMINATION PAYMENTS

For the period to 30 June 2014, 3 employee or former employee of Taranaki District Health Board received payment in respect of termination of employment for $17,656, $16,576 and $9,585 (2013: 1 payments totalling $33,704).

32 EVENTS SUBSEQUENT TO BALANCE DATE

There was no material movements or events subsequent to the balance date.

Reporting on 'good employer' practices

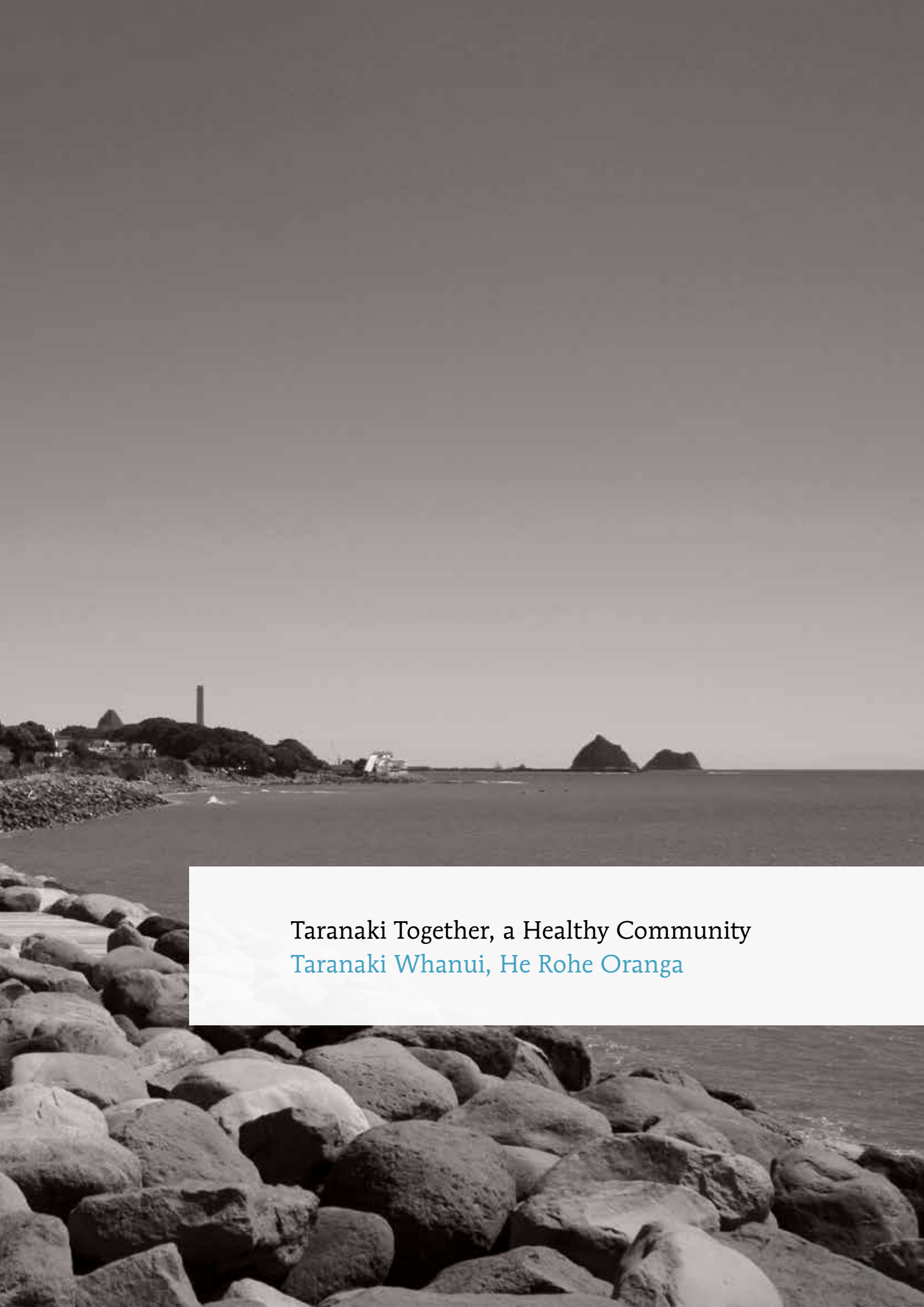
Taranaki DHB's role in workforce planning and development is to identify further strategic actions and mechanisms that when implemented will contribute to Taranaki having enough health workers with appropriate clinical skills now and into the future. Actions identified are from a perspective of the DHB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

In addition to these sector wide responsibilities, Taranaki DHB is the largest single employer of health employees in Taranaki. 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 polices of procedures	Other Practices	Priority issues	Action taken
Leadership, Accountability and Culture	Code of Conduct. Equal Employment Opportunities (EEO). Professional Development Policy. TDHB values statements. Performance Review policy.	Formal leadership programmes Suite of management development sessions Regular new managers forum Organisational forum for all employees. Development and Career planning. Formal management and management/union meetings.	Business skills sessions. Workplace leadership development alternatives.	Behaviours initiative implemented. New managers group implemented. New managers induction implemented. Additional learning sessions for managers and general staff.
Recruitment, Selection Induction	Recruitment and Selection Policy . Recruitment Guideline Procedure. Induction and Orientation Policy.	Comprehensive Induction Programme with elements online combining eLearning modules. Post-Entry Survey (3 month). Recruitment training. Scholarships across all disciplines. Schools Career Expo. Working with clinical schools to provide work experience placements.	Better management of the online talent pool to access suitable candidates. Use of social networking to target youth. Establishing a regional microsite to target priority occupation with known critical workforce deficiencies.	Regional and national collaboration to develop a talent management procedure. National Heath Careers website targeting students, return-to-work and international candidates. Collaborate with the national Kiwi Health Jobs working group to promote the New Zealand health sector brand. An interactive website, Whyora, has been developed for rangatahi Māori. Implementation of the Whakatipuranga Rima Rau project to place 500 Māori into the health sector employment over 10 years. E-learning implemented, ensuring improved compliance with induction training.
Employee Development, Promotion and Exit	Study, Conference and Course Leave. Termination of Employment Policy and Procedure. Medical Incapacity Policy. Professional Development Policy.	Exit interview and survey. Coaching available to all staff. Clinical Supervision. Employee Assistance Programme (EAP). Interpersonal skills training. Centralised training fund available. Professional development approval committee. National qualifications for non regulated workforces.	Revised education plan for 2015. Skills for managing relationships. Continue developing suite of e-learning resources. Implemented of revised learning needs analysis.	Preceptorship training. E-learning implemented to enable better access to training resources.
Flexibility and Work Redesign	Flexible Working - Request and Complaints Procedure. Collective employment agreements. Employee Participation Agreement.	Work in conjunction with individuals to meet their needs and those of the organisational.	Succession Planning.	Lead initiatives in the Midland region to meet the challenges of an ageing workforce.
Remuneration, Recognition and Conditions	Job Evaluation Procedure. Recognising Long Service Procedure Collective employment agreements.	Job Evaluation Committee. Comprehensive Progression/Merit criteria via collective agreements.		Promoting employee benefits for all staff.
Harassment and Bullying Prevention	Harassment Policy and Procedure. Employee Assistance Programme.	Interpersonal skills programmes. Coaching / training Union Reps. Conflict Resolution. Behaviours programme.	Review policy. Keep momentum around behaviours initiative and messages.	HR to monitor and report to Service Managers any harassment / bullying cases. Behaviours initiative implemented. Support network implemented.
Safe and Healthy Environment	Health and Safety Policy. Staff Health and Monitoring. Significant Hazard Control Plan. Material Safety Data Sheets. Infection Control. Educational Information . Nursing Core Procedures. Pharmacy Procedures. Clinical Practices. Critical Incident Debriefing. Occupational Health. Wellness Committee. Host Responsibility Policy.	Pre-employment Health Questionnaire for all staff. Employee Assistance Programme. Annual influenza vaccinations. Health and Safety Reps in each work area. Health and Safety orientation. Police vetting.		Quality and Risk Department responsible for majority of these procedures. Recreation society available to all staff.

Notes

Notes



Taranaki Together, a Healthy Community

Taranaki Whanui, He Rohe Oranga

TARANAKI

like no other