

# ANNUAL REPORT

## 2014-15



# 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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# Our Shared Vision / Te Matakite

Taranaki Together, a Healthy Community

Taranaki Whanui, He Rohe Oranga



## 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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Matua Ramon Tito, Chief Advisor of Māori Health Ngawai Henare, COO Rosemary Clements and Tony Foulkes with the Te Kāwanatanga award for use of bilingual signage



Tony Foulkes with Chief Medical Advisor Greg Simmons and Minister of Health Dr Jonathan Coleman

# INTRODUCTION BY CHAIR AND CHIEF EXECUTIVE

## Welcome to the Annual Report for the Taranaki District Health Board for 2014/2015.

We would like to acknowledge and thank all the Board and Committee members who have generously shared their skills and knowledge. Our Māori relationship partner, Te Whare Punanga Korero Trust representing the eight iwi of Taranaki, have provided members to 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 approach to accelerating Maori health gain has been underpinned by Te Matakite Maori Health Plan together with a nationally standardised set of performance measures and monitoring framework. The approach continued to strengthen not only within the DHB but as a whole-of-system approach. Monitoring of specific measures that are linked to leading causes of morbidity and mortality for Taranaki Maori has enabled the DHB to not only reduce, but to eliminate some inequalities in access by Maori, to key services. These are major achievements which we expect will translate in time, to the achievement of health equity for our whole population.

Throughout the year we have funded 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.

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.

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.

Our clinical and support teams have again exceeded many service level targets in both hospital and community based settings. The introduction of the faster cancer target has given focus to the pathway of care for patients with a high suspicion of cancer and ongoing progress to ensuring timely access remains a priority.

The staff and patients have continued to gain the benefits of the new acute services block. The changed models of care developed with the move into a modern building are now part of our normal service delivery helping achieve improved day of surgery access and reducing length of stay.

A focus on consumer engagement has seen an increase in the number of patients and their whanau involved in service delivery planning and ensuring the changes we make are customer focused.

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





Tony Foulkes, Joan McCardle, Doug Ashby and Rosemary Clements at the Volunteers Recognition Celebration.



Rosemary Clements and Greg Simmons ready to hand out Patient Safety Week resources.

Emergency Departments has also been of particular focus with Midlands Health Network.

We have continued to improve the planning and management of staffing costs whilst also increasing new graduate clinical staff. This year 30 students were awarded Taranaki DHB health scholarships, an increase of 5 from 2014. 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.

Once again we have been very grateful for the work of the Taranaki Health Foundation whose mission is to raise funds and awareness for projects that improve quality patient care in the region. This has been achieved with the generous support of local businesses, community organisations and individuals. Two new fundraising projects were launched in 2014/15, with completion dates expected over the next eight months:

1. The 'Mobility Garden' enhancements began in March 2015, to improve both patient and visitor experience at Taranaki Base Hospital. The primary focus of the Mobility Garden is for on-site rehabilitation, but will also provide a quiet retreat for patients, their families and visitors; and

2. 'WE HEART TARANAKI' was launched in February 2015 for a new Angiography Suite. This is the very first public campaign the Foundation has undertaken, with previous fundraising focused on the corporate and philanthropy sectors.

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. Our strong collaborative approach with other DHBs has also continued through our joint venture companies, including; HealthShare with Tairāwhiti, Bay of Plenty, Lakes and Waikato DHBs which audits 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.

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.

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**

# TARANAKI HEALTH FOUNDATION



Michael Joyce, Taranaki Health Foundation Chair

The Taranaki Health Foundation has had much to celebrate about in the last financial year, with new projects capturing the hearts of the Taranaki community. Front and centre has been the launch of the new Angiography Suite campaign 'WE HEART TARANAKI' in February 2015 and the current re-development of the Mobility Garden at Taranaki Base Hospital.

The Foundation's commitment to the region is to provide patients and their families' access to the best possible healthcare infrastructure and support, to ensure improved patient wellbeing. Our mission is to raise funds and awareness for projects that improve quality patient care. Together with the Taranaki DHB, we believe we are championing projects that will make a significant difference to our people and our communities.

The Foundation also welcomed new Trustee Peter McDonald, providing a very experienced fundraising background from Central Taranaki. Peter has demonstrated commitment to health in the region with his involvement with Hospice and the Taranaki Rescue Helicopter. He adds to the high calibre of the Board members to which there are nine representatives from around Maunga Taranaki. Taranaki communities are extremely fortunate to have Peter contribute his time, wisdom and passion for healthcare to the work of the Foundation.



Peter McDonald

Ms Bry Kopu also joined the Foundation as General Manager, after running a successful national consultancy that specialises in positive Youth and Community Development. You may have met Bry in previous roles that include the Chief Executive of the Mayors Taskforce for Jobs national network and Manager Community Development at New Plymouth District Council. Mother to six year old Nikau, she was born and raised in Taranaki with whakapapa to Te Atiawa Iwi tonu and a rich Scottish heritage.



Bry Kopu

Passionate about our Taranaki community, Bry was compelled to apply for the General Manager position because of the Foundation's clear vision to support the best possible healthcare in New Zealand and the highly committed Trustees who champion that vision around the Maunga.

"We are a very generous region and often punch above our weight in areas that surprise us all. So, while we have some very challenging milestones- the regional rewards will be felt for generations... now that is great legacy to leave behind for our children and mokopuna", said Ms Kopu.

"I don't know anyone living in Taranaki who would disagree that we deserve to have access to the very best health services, qualified staff and cutting edge technology. So, the choice to focus my professional skills and energies on such an important kaupapa - was an easy one", she added.

*Chair, Michael Joyce*



Celebrating the Launch of WE HEART TARANAKI is Michael Joyce (Foundation), Brian Ropitini (Methanex NZ), Tony Foulkes (Taranaki DHB), Vanessa James (Methanex NZ), HWM Neil Volzke (Mayor of Stratford) and Dr Ian Ternouth (Cardiology, Taranaki DHB).



## WHAT HAVE WE BEEN DOING?

In partnership with the Taranaki DHB, the Foundation has the mandate to raise \$1.2 million dollars towards the development of a \$3.6 million dollar angiography suite in the new Taranaki Base Hospital. Using a one-third, one-third, one-third framework the angiography suite has been supported by a very generous grant from the Taranaki Electricity Trust (TET) of 1.2 million dollars. This pledge provided the cornerstone funding to enable the project to proceed; with the DHB providing one third and the Foundation raising the remainder from a public campaign.

The campaign was launched in February 2015 and is called WE HEART TARANAKI. This is the very first public campaign the Foundation has undertaken, with previous fundraising focussed on the corporate and philanthropy sectors.

At the launch, Methanex NZ was announced as the major corporate sponsor pledging \$375,000, which has provided a major boost to fundraising efforts.

The campaign thus far has struck a chord with many business owners and members of the public, with many citing they know someone who has been affected by coronary heart disease. So, for many it has been an easy choice to get behind the development of a new Angiography Suite. There will be many benefits to the region, including:

1. Making it easier for Taranaki residents to access angiography diagnostic and treatment services locally
2. Reducing the number of patients and their families having to travel to Waikato
3. Helping provide the best possible healthcare to Taranaki residents
4. Making it easier to attract and retain highly skilled staff.

To build community awareness during

the campaign, Foundation Partner - The Daily News has published many advertorials and new stories to promote what service groups are up to and fundraising events regionally. Other media partners have donated their time making videos and designing our campaign collateral to support key projects and events planned right through to Christmas 2015, such as:

- The Waitara Combined Services Project to raise \$60,000
- Bucket rattling at WOMAD
- Rural Women's Trust from Central Taranaki
- Ladies Lunch at Nice Hotel
- The NZME Charity Ball
- Methanex NZ staff fundraising activities
- Match Day Charity for the Chiefs Rugby Team

As at 30 June 2015, the fundraising was halfway at \$600,000. This achievement was made possible by the very generous donations from the general public and businesses investing in this worthwhile project.

## Chiefs support WE HEART TARANAKI



Sonny Bill Williams, Liam Messam and Augustine Pulu, members of the Chiefs rugby team.

The Chiefs may not have beaten the Hurricanes, but they won hearts during their latest visit to Taranaki. Their charity of choice for the Super 15 Rugby showdown in New Plymouth on June 13, was the We Heart Taranaki campaign to raise money for a new angiography machine and suite at Base Hospital. As part of their support, three players visited the hospital, where they met sick children and adults, gave out Chiefs flags and signed autographs.

Captain and loose forward Liam Messam, first-five Sonny Bill Williams and halfback Augustine Pulu spent time in the children's ward chatting with youngsters and cuddling babies. A short video was made of the evening visit to the TSB Children and Young People's Ward, and has been seen by over 9,000 people on Facebook.



# TARANAKI HEALTH FOUNDATION

## MOBILITY GARDEN SOON TO BE A NEW DESTINATION

This project began in late March and is due for launch in October 2015, and features a unique design by Murali Bhaskar of Boon Goldsmith Bhaskar Brebner Team Architects.

Murali's creativity takes advantage of the delegated area outside the new Base Hospital foyer to achieve greater use of the space by enhancing the shade, planting and surfaces. The project wouldn't have been possible without our Donors who include: Clelands Timber & Construction, Mitre10Mega, Novotel Hobson Hotel, John Rae Insurance (JRI), McKechnie, AWE, Rivet, Phoenix Shipping, Jones and Sandford Joinery, Chain Resources Group and Taranakipine. The key feature is a striking wooden sculpture in the form of a tree. It was manufactured using in-kind donations from Donors such as Taranakipine and donated local labour from Clelands Group of Companies.

The primary focus of the Mobility Garden is for on-site rehabilitation. The space will enable patients to build confidence in real-life situations undertaking physio and occupational therapies using different surfaces and stairs in an outdoor setting.

The Taranaki Blind Foundation is working with the Foundation to enhance the planting, by developing a 'scented' garden to

enrich the sensory experience for those who are hearing and sight impaired. Planting will be sensitive to the environment but add another dimension for visitors.

Mr Bhaskar said, "I wanted to design a space that would meet the needs of those recuperating but also be a destination or draw card for those visiting or working within the hospital. The large timber structure will be a unique feature of the garden emulating a tree, but also forming a large open roof canopy".

After initial consultation, the Garden's design is already gaining local accolades. Local resident and Disability Action Group member, Lance Girling-Butcher describes, "It will make a dramatic enhancement to the entrance of Taranaki Base Hospital, help those in need of mobility instruction, be a magic, restful sanctuary for the visually handicapped to visit and add to the lengthening list of interesting architectural features in the city. Another visionary feature for our home city."

The garden will be open to the public and provide a warm and welcoming environment for all patients, their families and visitors.



Bucket rattling at WOMAD March 2015



Waitara High School student volunteers at a WE HEART TARANAKI fundraiser.

**To find out more about the Taranaki Health Foundation or to make a donation please visit:  
[www.taranakihealthfoundation.org.nz](http://www.taranakihealthfoundation.org.nz) or Like us on Facebook [Support We Heart Taranaki].**







# ON TARGET



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

Shorter stays in



Emergency Departments

## SHORTER STAYS IN EMERGENCY DEPARTMENT

The target is 95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours.

Q1	Q2	Q3	Q4
93%	94%	95%	96%

Target  
95%

Improved access to



Elective Surgery

## IMPROVED ACCESS TO ELECTIVE SURGERY

The target is an increase in the volume of elective surgery by at least 4000 discharges per year.

Q1	Q2	Q3	Q4
117%	116%	120%	121%

Target  
100%

Shorter waits for



Cancer Treatment

## SHORTER WAITS FOR CANCER TREATMENT (QUARTER 1)

The target is all patients, ready for treatment, wait less than four weeks for radiotherapy or chemotherapy.

Q1
100%

Target  
100%

Faster



Cancer Treatment

## FASTER CANCER TREATMENT (QUARTER 2-4)

The target is 85 percent of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.

Q2	Q3	Q4
75%	72%	65%

Target  
85%



A giant red ball was rolled into town as part of Stoptober, the 31-day challenge to stop smoking for October



## INCREASED IMMUNISATION

The national immunisation target is 95 percent of eight-month-olds have their primary course of immunisation at six weeks, three months and five months on time.



Q1	Q2	Q3	Q4
89%	93%	91%	91%



## BETTER HELP FOR SMOKERS TO QUIT

The target is 95 percent of patients who smoke and are seen by a health practitioner in public hospitals, and 90 percent of patients who smoke and are seen by a health practitioner in primary care, are offered brief advice and support to quit smoking.



Q1	Q2	Q3	Q4
95%	97%	94%	94%



Q1	Q2	Q3	Q4
85%	86%	86%	88%



## MORE HEART AND DIABETES CHECKS

This target is 90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years.



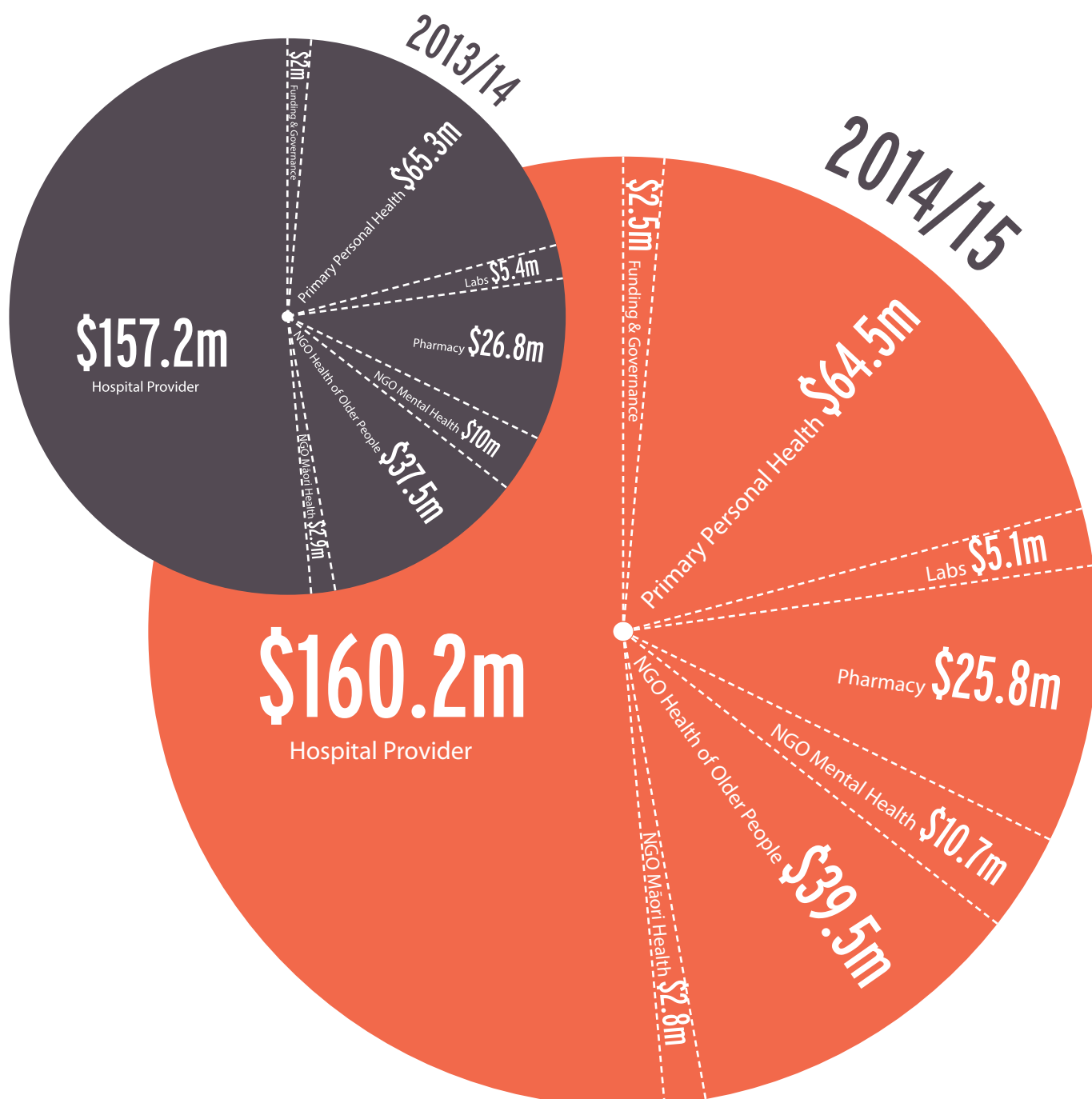
Q1	Q2	Q3	Q4
88%	90%	91%	91%

# WHERE THE MONEY GOES

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

In 2014-15 the Planning and Funding division allocated it's funding of **\$311** million as follows:

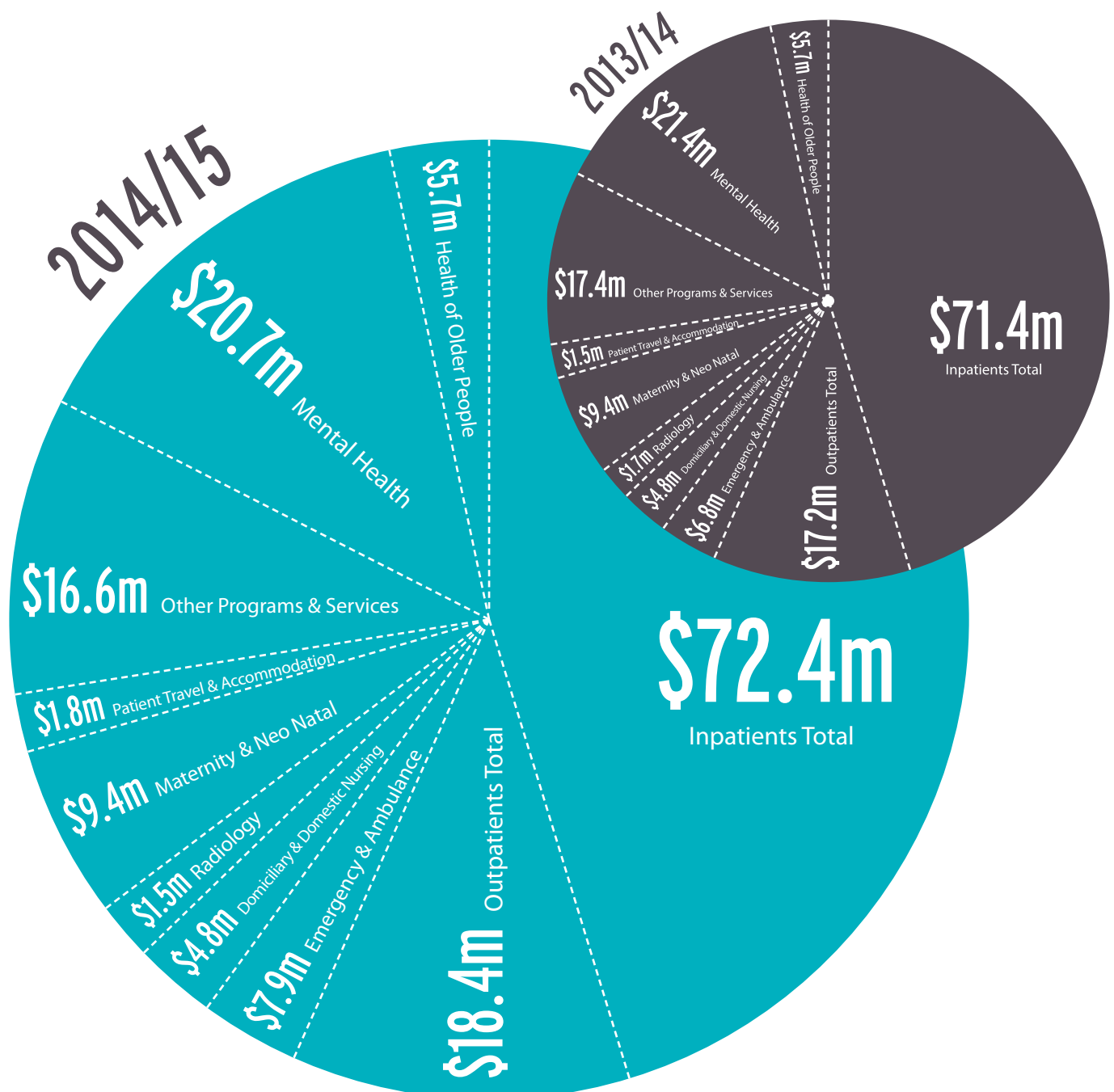
## » 2014/15 Taranaki DHB Planning and Funding Allocation





The **\$160.2** million allocated to the Hospital and Specialist Services was further allocated as follows:

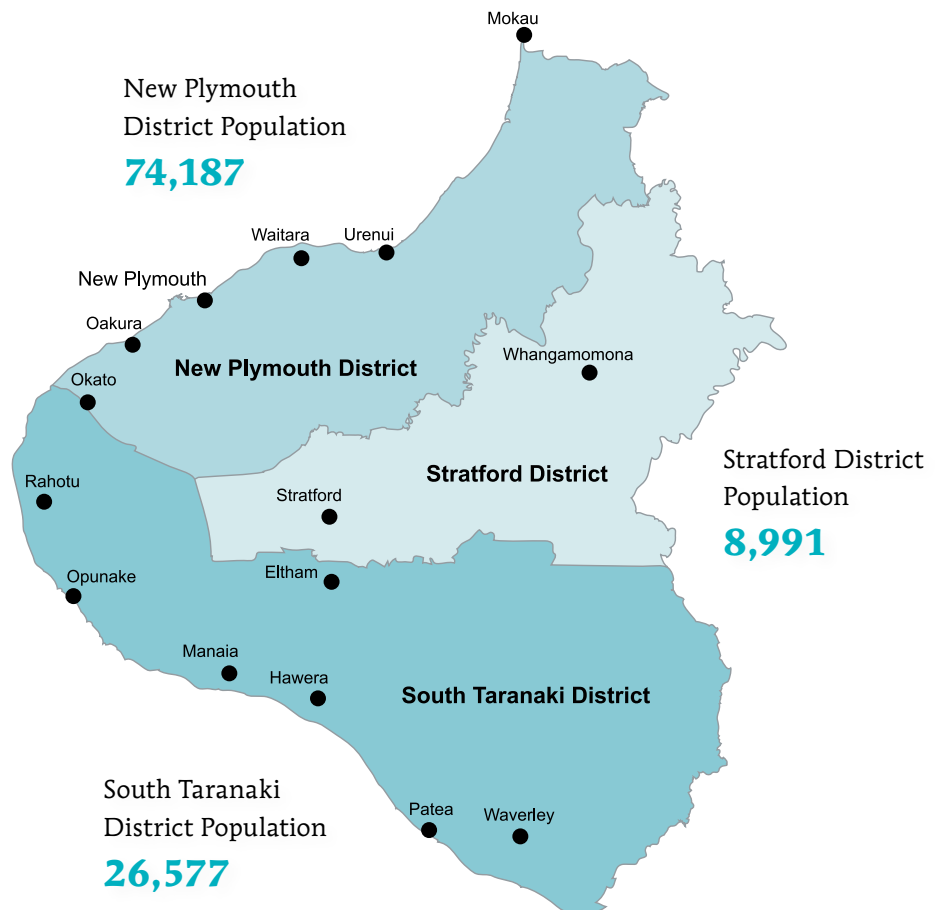
## » 2014/15 Hospital and Specialist Services Allocation



# 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, in 2014/15 Taranaki DHB served a population of 109,608\* people.

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 86.2% identified as European and other, 17.4% as Māori, 1.6% as Pacific and 3.5% 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 total number of people over the age of 65 is 17,802 (16.2%), with 5.6% of these being Māori.

A total of 36,060 people are under the age of 24 (32.9%), the number of Māori in this age group is 9,450 which represents 52.1% of Māori in the region.

## 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*

# We have...

- Hospital services at Taranaki Base Hospital and Hawera Hospital.
- Community health centres in Waitara, Stratford, Opunake, Patea and Mokau.
- Key relationship with Primary Health Organisation, The Midland Health Network with 30 aligned GP practices.
- 21 dental practices.
- 26 community pharmacies.
- Community laboratory services and radiology services.
- Community based mental health, and alcohol & addictions service providers.
- Support services for people with disability, including 28 residential facilities and rest homes.
- 16 providers of community health and home based support for older people services.
- Access to tertiary and more specialist hospital health care in other parts of New Zealand.
- Well Child / Tamariki Ora.
- Māori Health Services.

# 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.

## TE WHARE PUNANGA KORERO TRUST AND MAORI HEALTH

Te Whare Punanga Korero (TWPK) Trust is the Māori Health Governance Group which works strategically with the Taranaki District Health Board (TDHB) to improve Māori health and reduce and eliminate Māori health inequalities. The members of the trust represent the eight iwi of Taranaki – Ngaa Rauru, Ngati Ruanui, Nga Ruahinerangi, Taranaki, Te Atiawa, Ngati Maru, Ngati Mutunga and Ngati Tama - and in terms of the Memorandum of Understanding with Taranaki DHB - exercises mana whenua status by providing kaitiakitanga or guardianship, for all Māori living in the region. Based on the 2013 NZ census, the 18,150 Māori living in Taranaki made up nearly 17% of the total Taranaki population, while 64% of those (11,529) had whakapapa / genealogical links to one or more of the eight Taranaki iwi. In its representative capacity the TWPK Trust exercises considerable influence over the decisions of the Taranaki DHB with regard to Māori health and connection with the Māori community.

Key achievements in 2014/15 of Te Whare Punanga Korero in partnership with Taranaki DHB are summarised on the following pages.



### Members of TWPK

**Back row, left to right:** Rawinia Leatherby (Taranaki Iwi), Greg White (Ngati Tama), Te Oti Katene (Nga Ruahinerangi), Te Pahunga (Marty) Davis (Te Kahui O Rauru)

**Front row, left to right:** Ngapari Nui (Ngati Ruanui), David Tamatea (Taranaki Iwi), Te Urumairangi Ritai (Te Atiawa)

**Inset:** Tamzyn Pue (Ngati Maru), Vicki Kershaw (Ngati Mutunga).

## PAE ORA FRAMEWORK

Following the launch of Pae Ora, under the refresh of He Korowai Oranga (HKO) national Māori Health Strategy in June 2014, the Whanau Ora framework was revised to incorporate the additional elements of Pae Ora. Strengthening the focus on the determinants of health, the framework recognises that Pae Ora can only be achieved through collective action towards three key elements: Whanau Ora, Mauri Ora, and Wai Ora. The framework provides staff and others working with the DHB a shared understanding of our concept of Pae Ora and how it may be applied in practice.

The policies that sit within the Pae Ora framework include the Treaty of Waitangi principles and the Whānau Ora Goals established by the Ministerial Task Force on Whanau-Centred Initiatives<sup>1</sup>. They provide common ground for the DHB to collaborate with iwi and other sectors to address the determinants of health, while He Korowai Oranga and Te Kāwau Māro, the Māori Health Strategy for Taranaki, gives national and local health sector distinctiveness. The framework is summarised on the following page:



All Sectors		Health Sector	
Whanau Goals	Treaty of Waitangi Principles	He Korowai Oranga	Te Kawau Maro, Taranaki Maori Health Strategy
<ul style="list-style-type: none"> <li>Whanau self-management</li> <li>Healthy whanau lifestyles</li> <li>Full whanau participation in society</li> <li>Confident whanau participation in te ao Māori</li> <li>Economic security and successful involvement in wealth creation</li> <li>Whanau cohesion</li> </ul>	<b>PARTNERSHIP</b> Working together to develop strategies and services	<b>TE ARA TUATAHI</b> Whanau, hapu, iwi and Māori community dvpt	<ul style="list-style-type: none"> <li>Facilitate whanau dvpt</li> <li>Support whanau-led initiatives</li> </ul>
	<b>PARTICIPATION</b> Involving Māori at all levels of decision-making, planning and delivery	<b>TE ARA TUARUA</b> Māori participation in the health and disability sector	<ul style="list-style-type: none"> <li>Enable Iwi governance</li> <li>Māori organisational dvpt</li> <li>Māori workforce dvpt</li> </ul>
	<b>PROTECTION</b> Equality of outcomes and safe-guarding values and practices	<b>TE ARA TUATORU</b> Effective health and disability services	<ul style="list-style-type: none"> <li>Reduce health inequalities</li> <li>Improve mainstream services</li> <li>Provide high quality services</li> <li>Improve health information</li> </ul>
		<b>TE ARA TUAWHA</b> Working across sectors	<ul style="list-style-type: none"> <li>Programmes and locality-based inter-sectoral collaboration</li> </ul>

<sup>1</sup> Whanau Ora: Report of the Taskforce on Whanau-Centred Initiatives to Hon Tariana Turia, Minister for the Community and Voluntary Sector, 2010

A milestone decision was made by TWPK and Taranaki DHB in May 2015 to formally adopt the Pae Ora framework. A commitment was made to apply it across all functions of Taranaki DHB in planning and funding decisions, service design decision-making and across all services provided by Taranaki DHB.

The translation of Pae Ora into everyday work practises for the Taranaki health and disability workforce are captured in the following headline statements:

#### Mauri Ora

Every health intervention is an opportunity to contribute to shifting to, growing or supporting a flourishing mauri.

#### Whanau Ora

Every service offered or funded by the DHB should contribute knowledge and skills that empower whanau to understand and manage their own health conditions. The transfer of knowledge and skills in a way that enables integration into routine whanau practises is a key function of Whānau Ora health service provision.

#### Wai Ora

Health interventions must take into account the nature and interaction between people and the surrounding environments. Interventions should avoid or reduce risk factors, and strengthen protective factors.

## TE ARA WHAKAWAIORA – ACCELERATING IMPROVEMENTS IN MĀORI HEALTH

Te Matakite, Taranaki DHB Māori Health Plan is Taranaki DHB's primary vehicle to improve Māori health towards the whanau goals identified in the Pae Ora framework. The DHB continues to strengthen the processes and to embed these as a whole-of-system approach. This includes:

- Spreading responsibilities for performance across the DHB to relevant funding and service managers
- A monitoring process which draws on the centralised web-based monitoring tool [www.trendly.co.nz](http://www.trendly.co.nz) to access the latest performance data on Māori Health Plan national indicators and enables these to be compared across all DHB's to identify best performers
- Quarterly reporting to the joint TWPK / Taranaki DHB Board meetings and publication of results to key stakeholders
- A Māori Health Plan Steering Group which functions at an executive level and includes representation from primary and secondary care.

# HOW THE SECTOR PERFORMED TO IMPROVE MĀORI HEALTH

The table below summarises the performance of the sector during the year to improve Māori health status on ten national and two local Māori Health Plan priorities. The data presented is as at June 2015, with the exception of ASH rates (Ambulatory Sensitive or avoidable Hospitalisations) and DNA rates (Did Not Attend), due to the end of year data being unavailable at the time of writing this report:

## INDICATOR LEGEND

Target attained
Within 10% of target
10-20% away from target
Greater than 20% away from target

SYMBOL	KEY
☑	Progressing well
Ⓟ	Some progress
☒	No progress or worsening
⌚	Not yet sufficient time to judge
?	Further info or work required
↑	Increasing gap
↓	Decreasing gap
😊	Eliminated gap

## National Priorities & Indicators

	Health Issue	Indicator(s)Target	Target	Māori	Non-Māori/Total	12 Month Change	Progress To Target	Disparity Gap	Reducing Disparities Progress	Māori June 2014
1	Data Quality	Ethnicity data accuracy in PHO registers	98%	84%	93%	-4%	▼	9%	☒	88%
2	Access to care	Percentage of Māori enrolled in PHOs	98%	84%	93%	-4%	▼	9%	☒	88%
		ASH 0-74 yrs	1978	2895	1518	+211	▼	1377	↑	2684
		0-4 yrs	4428	6270	3525	+926	▼	2745	↑	5344
		45-64 yrs	2255	3341	1391	+119	▼	1950	☒	3222
3	Child health	Exclusive breastfeeding at six weeks	68%	60%	72%	+7%	▲	12%	↑	53%
		Exclusive breastfeeding at three months	54%	50%	59	+10%	▲	9%	☑	40%
		Receiving some breast milk six months	59%	53%	71%	Indicator Redefined	▲	18%	?	N/A
4	Cardiovascular disease	1. Percentage of the eligible population who have had their CVD risk assessed within the past five years (ht) *SEE BELOW	90%	88%	91%	+9%	▲	3%	☑	79%
		2. 70 percent of high-risk patients will receive an angiogram within three days of admission. ('Day of Admission' being 'Day 0')	70%	100%	75%	+33%	▲	+25%	😊	67%
		3. Over 95 percent of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days	95%	100%	91%	0%	◀▶	+9%	😊	100%
5	Cancer	1. Breast Screening, among eligible population	70%	61%	75%	-4%	▼	14%	☒	65%
		2. Cervical Screening, among eligible population	80%	65%	83%	-8%	▼	18%	☒	73%
6	Smoking	1. Hospitalised smokers provided with advice and help to quit (ht)	95%	95%	94%	+1%	◀▶	1%	😊	94%
		2. Current smokers enrolled in a PHO and provided with advice and help to quit	90%	92%	88%	-	▲	-4%	😊	Total 90%
7	Immunisation	1. Percentage of infants fully immunised by eight months of age	95%	89%	91%	+5%	▲	2%	☑	84%
		2. Seasonal influenza immunisation rates in eligible population)	75%	68%	68%	+1%	▼	0%	☒	67%
8	Rheumatic Fever	2013/2014 rheumatic fever target - number and rate reductions, 10% below three-year average	0.8/1000	0%		0%	◀▶	0%	😊	0

	Health Issue	Indicator(s)Target	Target	Māori	Non-Māori/ Total	12 Month Change	Progress To Target	Disparity Gap	Reducing Disparities Progress	Māori June 2014
9	Oral Health	Preschool Enrolments *SEE BELOW	85%	59%	81%	Indicator redefined	◀▶	22%	?	59%
10	Mental Health	Mental health Act: Section 29 Community Treatment Order indefinites comparing Māori rates with other (as per reporting to the Office of the Director of Mental Health)	117/100,000 Māori 71/100,000 Non-Māori	118	63	+16	▼	N/A	?	102/100,000

## Local Priorities & Indicators

	Health Issue	Indicator(s)Target	Target	Māori	Non-Māori/ Total	12 Month Change	Progress To Target	Disparity Gap	Reducing Disparities Progress	Māori June 2014
11	Access to Services	Did Not Attend (DNA) rate for outpatient appointments	Revised to 12%	Results unavailable						
12	Primary Mental Health	Access by Taiohi Māori to packages of primary mental health Care	51 Māori 147 Non- Māori	84	192	N/A	▲	Further work needed to understand the results		17

Targets were met and inequality eliminated on five indicators. Around half the indicators experienced either a decline or no change in result, highlighting the need for on-going focus to improve and maintain results.

\* A small sample of performance highlights during the year are summarised below.

### Cardiovascular Risk Assessments

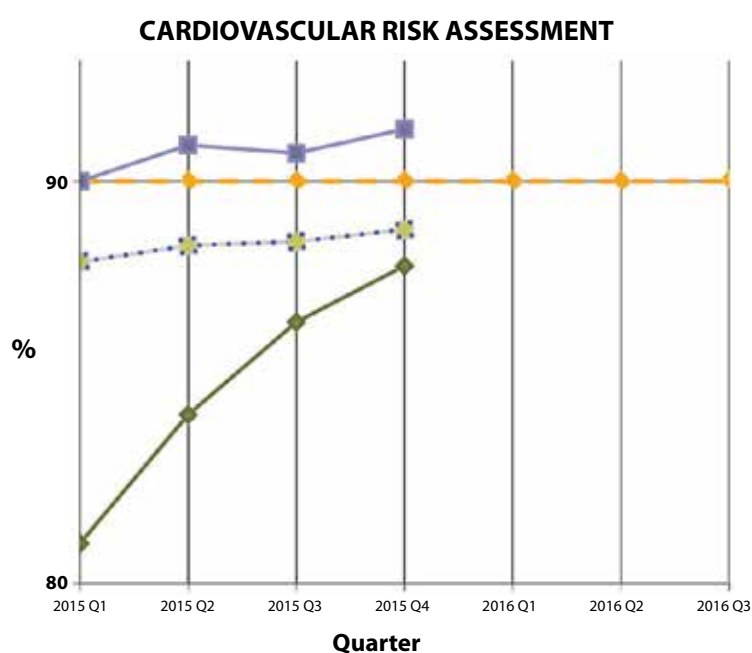
This indicator measures the percentage of 45 to 69 year olds who have had their heart and diabetes checks within the past five years. This is important as cardiovascular disease (CVD) is the leading cause of death for Māori in Taranaki and improving on it, along with prevention and management, will lead to longer life expectancy.

Taranaki DHB led the country in terms of the rate at which completion of CV risk assessments for Māori increased. Though short of the 90% target by 2%, the improvement of 9% and the reduction in disparity by more than 5%, from 9% to 3%, was cause for celebration.

Success is largely due to the Midland Health Network's Long Term Conditions program under which each GP practice has an electronic tool set that prompts both at a personal health level and a population level, who is eligible and when they are due. This includes targets for Māori. Funding is targeted at those practices with populations in need. They are also funded on outcomes against the target populations.

### Pre-School Dental Enrolments

Dental conditions are a leading cause of hospitalisation for children and adults in Taranaki. Pre-school dental enrolments are a priority because it's important that children and their parents/caregivers have access to a dental health professional early to ensure they're informed about how to look after their teeth. This also means they will have access to early treatment if needed.



Almost 100% of 0 – 4 year olds are now enrolled into an oral health service as at June 2015. However, current reporting records 2014 data only. This resulted from a simple yet significant system change which now makes auto-enrolment of new born pepi/ babies an opt-off rather than opt-on. Together with a drive to match patient management systems, the auto-enrolment system has enabled the achievement of the 2015 result.

## Breast Feeding

A programme to raise awareness among young mothers of healthy start options for mama and pepi was delivered in 33 settings to five priority communities across Taranaki. The programme, Mama Pepi Hauora, contributed to a noticeable increase in breast feeding rates.

The “Breastfeeding Welcome Here” programme now extends to more than 70 Taranaki businesses spread across the province. These businesses are accredited as being friendly environments for breast feeding as they provide suitable facilities for women to breastfeed their babies.

## Other Highlights

### Nga Tohu Reo Māori – Māori Language Awards

In November 2014, representatives from Taranaki DHB attended Nga Tohu Reo Māori Language Awards held in Rotorua. Taranaki DHB won the Government category award for its work around making Māori language more visible throughout our campuses using bilingual signage and educational resources.

The aim of the work was to ensure Māori culture was reflected in the health care environment and as a result make services more inviting for Māori. The Māori health team worked closely with Te Reo o Taranaki Trust and Te Whare Punanga Korero (TWPK) in order to provide accurate translations in the Taranaki dialect and to ensure the appropriate ‘tikanga’ or protocols were carried out through the duration of Project Maunga.



**MĀORI LANGUAGE AWARDS:** Taranaki DHB team (Matua Ramon Tito - Taranaki DHB Kaumatua, Sally Webb - Taranaki DHB Deputy Chair, Rosemary Clements - Chief Operating Officer, Ian Grant - Project Manager for Project Maunga and Ngawai Henare - Chief Advisor for Māori Health) together with members of our Iwi Relationship Board Te Whare Punanga Korero Trust and Te Reo O Taranaki.

### Māori Health Newsletter

Following strong advocacy by TWPK, Taranaki DHB has introduced a brand new Māori health newsletter called ‘E Pēwhea Ana Tō Ora?’ - ‘How’s Your Health?’ The aim of the newsletter is to provide simple information to raise awareness about issues that will help whanau manage their own health conditions better and to be able to enjoy better quality of life.

Topics that have been discussed so far directly relate to the priorities in the Māori Health Plan and include breast feeding, outpatient appointments “Did Not Attend” (DNAs), flu vaccination for 65+’s, enrolling with a GP, cervical and breast screening. The newsletter is widely distributed via TWPK, Taranaki DHB and Taranaki Māori Health Provider networks.



# WHAKATIPURANGA RIMA RAU - MAORI WORKFORCE DEVELOPMENT

Taranaki DHB joined forces with TWPK and the Ministry of Social Development (MSD) under the WRR umbrella to increase the number of Māori working in health. We had a typically busy year supporting potential candidates through various pathways to health and disability sector careers.

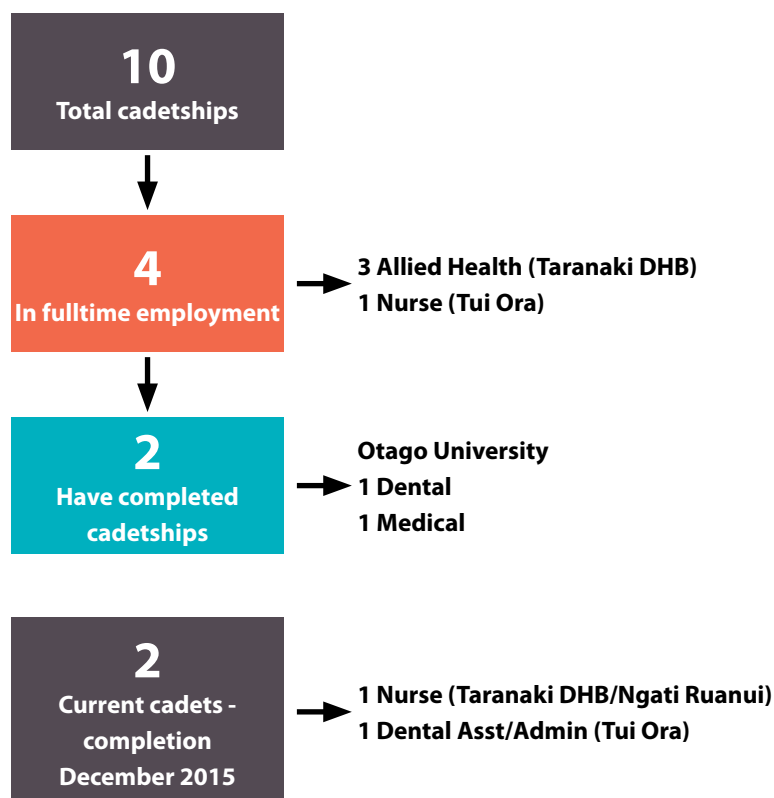
## WhyOra – Secondary Schools Programme

Health careers were profiled through the WhyOra secondary schools programme which celebrates the following statistics:

<b>Year 9 and 10 Science Exposure</b> <ul style="list-style-type: none"> <li>12 secondary schools participated including Te Pi'ipi'inga kakano Mai I Rangiatea Kura Kaupapa</li> <li>207 year 9 students</li> <li>145 year 10 students</li> </ul>	<b>Year 11, 12 and 13 Careers in Health Exposure</b> <ul style="list-style-type: none"> <li>12 secondary schools participated</li> <li>5 workshops delivered</li> <li>21 different health careers profiled</li> <li>18 DHB departments participated</li> <li>3 community health providers</li> <li>55 year 11 students</li> <li>59 year 12 students</li> <li>49 year 13 students</li> </ul>	<b>Year 13 Work Experience</b> <ul style="list-style-type: none"> <li>3 students were placed on work experience in their area of interest</li> <li>23 year 13 students have indicated an interest in the health sector</li> </ul>
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**Whakatipuranga Rima Rau's** cadetship programme supported the following 10 people on their health career journeys by placing them into paid training placements with Taranaki health providers.

## Cadetships



Two cadets are currently working in Australia but plan to return home to pursue health careers in the future.

*Taranaki DHB's newest Whakatipuranga Rima Rau (WRR) dental Cadet, Whina Waiariki, splits her time between Hawera Community Oral Health services and Ngati Ruanui Healthcare.*

*"The cadetship is such a great opportunity and I have already gained many new skills and learnt a lot about different roles in the health sector," said Whina.*

*Whina first became involved with the WRR programme through the WhyOra schools programme.*

*"I was a part of the WhyOra/ Incubator programme for about three years at high school and was told about the dental therapy cadetship through the programme".*





1

# WORKING TOGETHER *Locally*



2



3



4

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.

Taranaki DHB is helping to promote 'fizz free' as part of its work with the multi-agency **Healthy Eating and Physical Activity (Hepa) Network**. In the first week of September, Hawera hosted what is thought to be Taranaki's first fizz-free public event, Te Huihuinga o nga Tatarakihi - Taranaki Primary Schools Cultural Festival, with Hepa as the emcees.

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Taranaki DHB teamed up with Tui Ora, Plunket and Whakawhetu - national Sudden Unexpected Death in Infancy (SUDI) prevention for Māori - to help raise awareness of **Safe Sleep Day** on 5 December.

The purpose of Safe Sleep Day is to support the prevention of SUDI. Taranaki DHB and Tui Ora ran an educational stand at The Warehouse in New Plymouth on 5 December and provided resources to members of the public.

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In early December **Kidsafe Taranaki Trust celebrated 20 years** of keeping Taranaki children safe from unintentional injuries.

Kidsafe is a true community initiative, involving Taranaki DHB's Public Health Unit, Paediatrics Department and Public Health Nursing Department, as well as ACC, Plunket, Tui Ora, the Police and community volunteers.

Kidsafe Taranaki marked the 20 year milestone with an afternoon tea at Taranaki Base Hospital and was attended by around 50 Kidsafe supporters.

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Taranaki DHB supports the **SWEET** (South Working to Enable and Empower Teens) initiative, which aims to put South Taranaki youth on a better path to adulthood.

Four outcomes drive the initiative: To reduce offending, truancy, and alcohol and drug harm as well as to increase the number of young people in education, training and employment.

It focuses on five social sector agencies - Police, Justice, Health, Education and Social Development - working better together to provide more cohesive, appropriate services for South Taranaki.

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A new community lactation service called **Tiaki Ūkaipō** has been launched to protect and nurture breastfeeding throughout Taranaki. The service is funded by Taranaki DHB and coordinated by Tui Ora.

The new service involves weekly discussion groups and clinics in Waitara, New Plymouth, Stratford and Hawera, with the possibility of a coastal service in the future.

Taranaki DHB is committed to making breastfeeding mothers feel welcome at our hospitals and one way they do this is through the Breastfeeding Welcome Here spaces. There are approximately 70 sites throughout Taranaki with five Breastfeeding Welcome Here accredited spaces at Base Hospital.

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Earlier this year several Taranaki DHB board members, staff and volunteers took part in **disability responsiveness training workshops**.

The training involved simulation exercises, such as being blind-folded to simulate vision impairment; wearing earmuffs to simulate hearing impairment; being in a wheelchair or on crutches to simulate difficulty walking; and wearing ankle and wrist weights to simulate a stroke.

The workshops were held to increase awareness of what it is like to live with a disability, as well as how to approach and offer assistance to people with disabilities. The sessions were jointly run by the Taranaki Disabilities Information Centre Trust and Taranaki DHB.

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As part of **Smokefree May**, health promoters and quit coaches from the Public Health Unit and Tui Ora, in collaboration with the Taranaki Smokefree Coalition, took their work on the road to junior rugby league tournaments around Taranaki.

While the smokefree promotion covered the wider issue of smoking and giving people options to quit, it also focussed more specifically on the harmful effects of second-hand smoke in cars.

Staff set up smokefree-branded gazebos at the tournaments and gave away smokefree packs which had a range of resources, including lip balm, a tooth brush, a stress ball and information on how to go about quitting.

As another way to entice people to quit smoking, a shopping trolley filled with groceries to the same value as two packets of cigarettes was wheeled around the crowd.

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## PHOTOS

- 1 Hepa network members, made up of Tui Ora, Heart Foundation and Cancer Society workers, dressed up at the 'Fizz Free' event.
- 2 Saskia Mills, the youth case coordinator for SWEET, works closely with youth aid officers Mark Crawshaw and Pete Wright.
- 3 Māori Health Chief Advisor Ngawai Henare experienced wheelchair transport as part of the disability responsiveness training.
- 4 Kidsafe Taranaki Trust members at the 20 year celebration afternoon tea.





# WORKING TOGETHER *Regionally*



## PHOTOS

- 1 Service Improvement Advisor Mary Bird talks to members of the public about Let's PLAN.
- 2 Social Worker Laura Evelyn talks to a patient as part of the 'Team up for health' initiative.
- 3 Clinical Services Manager Leigh Cleland hands out Patient Safety Week cupcakes to Hawera staff.
- 4 A big red ball gets rolled into town as part of Stoptober, the 31-day challenge to stop smoking for October.



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

Allied Health & General Practices **“Team up for health”** initiative has started in 30 Taranaki General Practices (GP). This initiative is part of the Midland Health Network Long Term Conditions programme for primarily high risk/high needs patients with long term conditions (diabetes and/ or cardiovascular disease). A project team made up of social workers, dieticians, GP liaison, a pharmacist and a consumer representative, has been working with a Programme Office project lead to establish the new service.

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**Stoptober** was funded under the Ministry of Health’s Pathway to Smokefree 2025 Innovation Fund. In Taranaki it is run by the Taranaki Smokefree Coalition whose members include the Taranaki DHB, Tui Ora, Ruanui Health Centre, the Cancer Society and the Heart Foundation.

Smokers throughout NZ were encouraged to sign up in September to stop smoking in October – and beyond.

As part of the campaign, monster-sized (2m x 2m) balls popped up all over the country. At the New Plymouth launch event on September 12, a ball was rolled along the Coastal Walkway, followed by a range of activities and entertainment.

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Taranaki DHB and Midland Health Network are working together to help reduce the number of patients being treated at local emergency departments (EDs). **The Primary Options GP Overflow programme** provides support for non-acute patients. If a patient comes into ED and would be better seen by a GP, ED staff will assist them to go back to their general practice or medical centre. Patients that have been redirected on the same day only pay their usual GP fee.

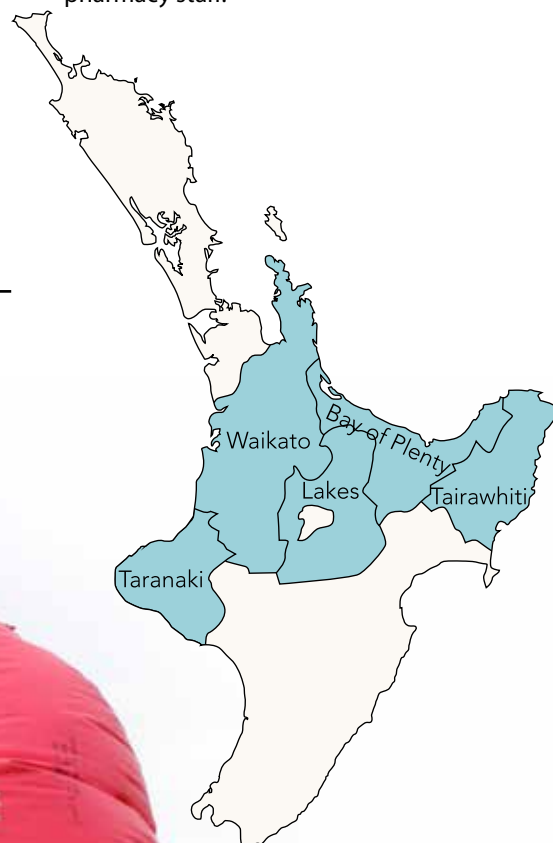
The Primary Options Acute Care programme provides general practices with access to a range of funded diagnostic and treatment services to help treat patients with acute illnesses in the community, reducing the number of acute referrals to hospitals.

By working so closely together, Taranaki DHB and Midlands Health Network are ensuring patients receive the right care, at the right place.

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**Let’s PLAN for better care** was launched as part of national Patient Safety Week. The initiative was coordinated by the Health Quality & Safety Commission and aimed to help patients prepare for healthcare appointments and find out more about their medicine at pharmacies. PLAN stands for **P**repare for your visit; **L**isten and share; **A**sk questions; **N**ote down what you need to do next.

The Let’s PLAN initiative is supported by a flyer that encourages people to plan ahead for healthcare appointments and to ask questions when there, so they fully understand their diagnosis and treatment. It also suggests questions they can ask pharmacy staff.



# GOVERNANCE



# GOVERNANCE STRUCTURE

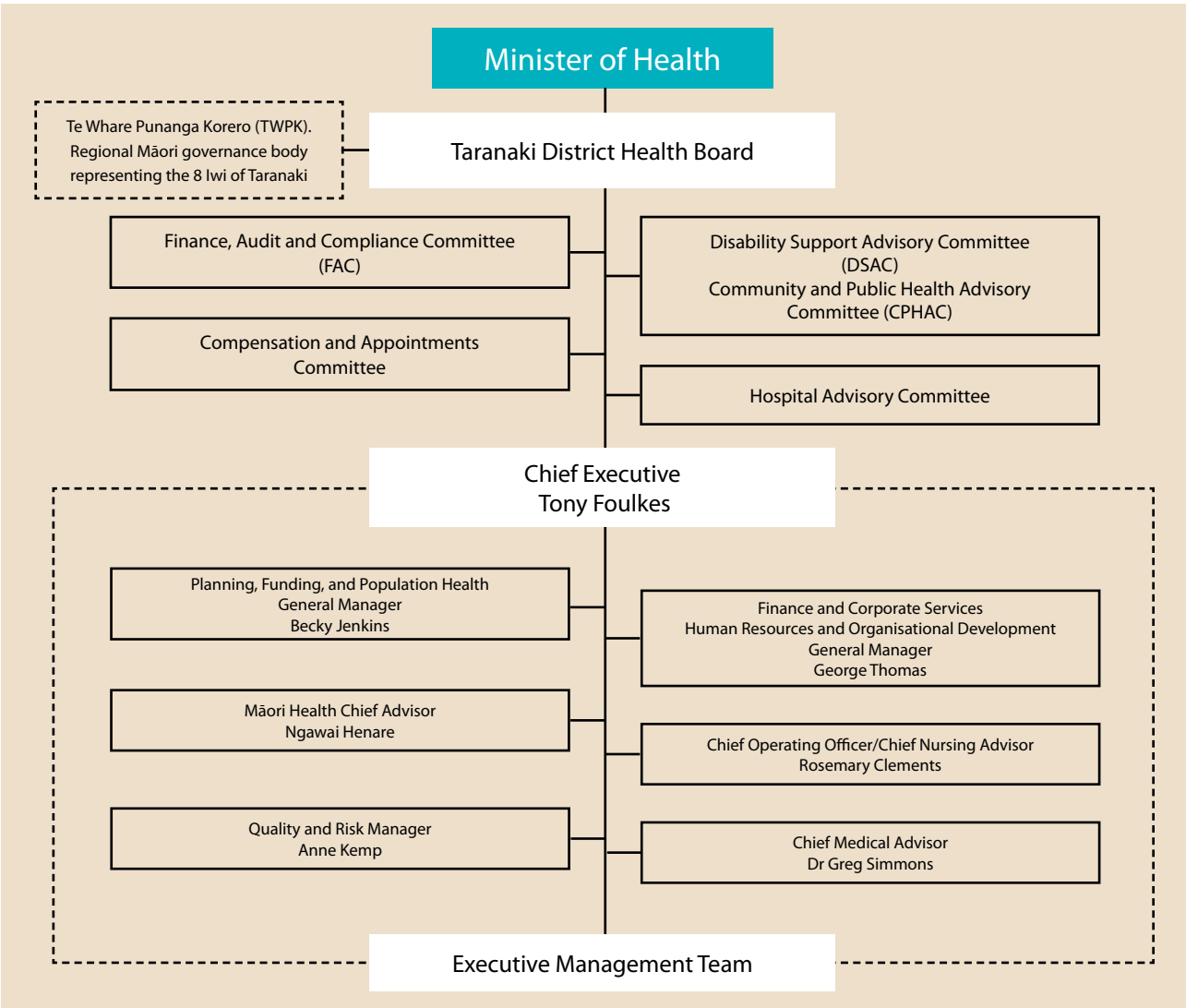
The governance structure for DHBs is set out in the NZ Public Health and Disability (NZPHD) Act 2000. The Board consists of up to 11 members and they have overall responsibility for the operation of Taranaki DHB. Seven of the members are elected as part of the three-yearly local body election process (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 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 coaching and consulting business involved in leadership development across a number of

sectors since 2000. She is committed to using her skills 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 third 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 Chair's the Community and Public Health Advisory Committee and the Disability Support Advisory Committee, is a member of the Hospital Advisory Committee and the Finance, Audit and Compliance Committee. She is also Chair of Fulford Radiology Services Ltd. Flora 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. She is a Chartered Company Secretary and Chair's the Hair and Beauty Industry Training Organisation.

**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, Chairman Trustee of Taranaki Youth Trust, 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 (wound

up February 2015), 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, Louise Rauhuia Manuera Hohaia Whānau Trust – Responsible Trustee, School of Government Victoria University of Wellington – PhD Candidate & Research Assistant, Taranaki Families Centre Trust – Trustee (resigned November 2014), Te Korowai o Ngāruahine Trust – Trustee, Te Ohu Arotake (Finance, Audit, Risk & Investment Committee) for Te Korowai o Ngāruahine Trust – Chairperson, Waiokura Marae & Reserves Trust – Responsible 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.

**Interest Register:** CEO – Hospice Taranaki, 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 this 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, and a member of the NZ Central Divisions Cancer Executive.

**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.



38

Midwives



20

Social  
Workers



167

Medical (Doctors)



17

Dental Therapists



29

Physiotherapists



683

Nurses



107

Health Care  
Assistants



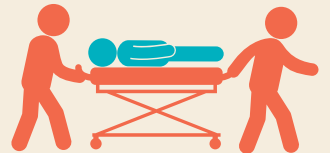
40

Laboratory  
Employees



24

Pharmacy Employees



28

Orderlies

**Scholarships  
Awarded**

Taranaki DHB health scholarships were awarded to 31 students in 2015 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, 27.7% identified as Māori.

**OUR  
PEOPLE**

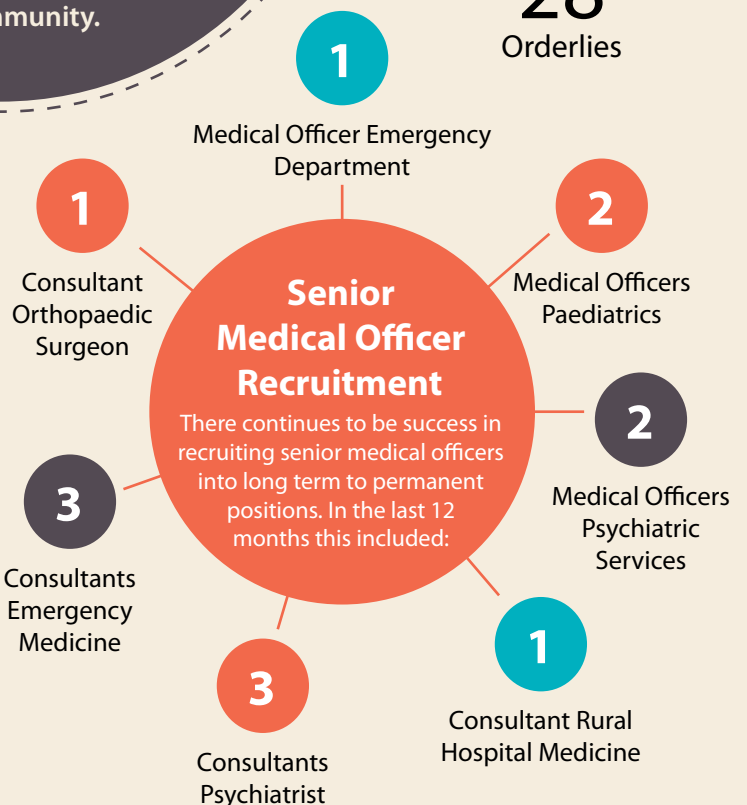
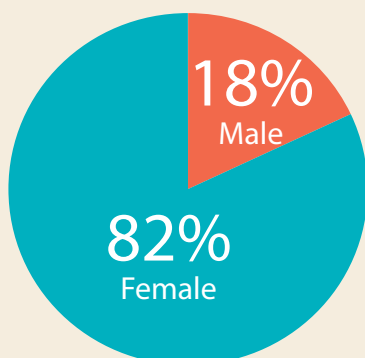
Healthcare is about people helping people. In Taranaki we have a great team of health professionals and support staff all working together for our community.

25  
Occupational  
Therapists



40

Cleaners





# BOARD MEMBERS' RESPONSIBILITIES & FEES





# Board Members, Committee Members and Directors Schedule

Name	Board Members	Hospital Advisory Committee	Community and Public Health and Disability Support Advisory Committee	Finance Audit and Compliance Committee	Compensation & Appointments Committee	Allied Laundry Services Ltd	Fulford Radiology	HealthShare Ltd	Fees Paid (\$)
<b>Board Members</b>									
Pauline Lockett	*10 of 11	10 of 11	4 of 6	10 of 11	✓				\$44,850.00
Sally Webb	^8 of 11	8 of 11		8 of 11	✓				\$27,961.96
Alex Ballantyne	10 of 11	10 of 11	6 of 6	8 of 11					\$24,870.00
Karen Eagles	11 of 11	11 of 11	6 of 6						\$23,182.50
Flora Gilkison	11 of 11	11 of 11	6 of 6	11 of 11			✓		\$26,245.00
Richard Handley	8 of 11	7 of 11	5 of 6	8 of 11	✓				\$24,682.50
Te Aroha Hohaia	8 of 11	8 of 11	6 of 6						\$22,370.00
Kevin Nielsen	10 of 11	10 of 11	5 of 6	10 of 11					\$25,745.00
Alison Rumball	9 of 11	9 of 11	4 of 6						\$22,370.00
Aroaro Tamati	8 of 11	6 of 11	5 of 6	8 of 11					\$23,620.00
Pat Leary	6 of 6	6 of 6	2 of 3						\$13,007.50
<b>Co-opted Committee Members</b>									
David Tamatea (CPHAC/DSAC Member)			5 of 6						\$1,250.00
Pat Leary (CPHAC/DSAC Member)			2 of 3						\$500.00
Te Urumairangi Ritai		10 of 11							\$2,500.00
<b>Other Directors</b>									
Tony Foulkes, Chief Executive								✓	
Simon Barrett, Group Financial Manager					✓	✓			

## Key:

\* = Chairperson

^ = Deputy Chairperson

Pat Leary resigned from Taranaki DHB January 15 as director and appointed as community member on Community and Public Health and Disability Support Advisory Committee.

# AUDIT REPORT



## INDEPENDENT AUDITOR'S REPORT

### TO THE READERS OF TARANAKI DISTRICT HEALTH BOARD'S FINANCIAL STATEMENTS AND PERFORMANCE INFORMATION FOR THE YEAR ENDED 30 JUNE 2015

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 the performance information, including the performance information for an appropriation, of the Health Board on her behalf.

We have audited:

- the financial statements of the Health Board on pages 73 to 104, that comprise the statement of financial position as at 30 June 2015, the statement of comprehensive revenue and expense, statement of changes in net assets/equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Health Board on pages 40 to 68.

#### **Unmodified opinion on the financial statements**

In our opinion:

- the financial statements of the Health Board:
- present fairly, in all material respects:
- its financial position as at 30 June 2015; and
- its financial performance and cash flows for the year then ended; and
- comply with generally accepted accounting practice in New Zealand and have been prepared in accordance with Public Benefit Entity Reporting Standards.

#### **Qualified opinion on the performance information because of limited controls on information from third-party health providers**

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 performance information of the Health Board for the period ended 30 June 2015, which is reported as comparative information, was modified for the same reason.

In our opinion, except for the effect of the matters described above, the performance information of the Health Board on pages 40 to 68:

- presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2015, including:
  - for each class of reportable outputs:
    - its standards of performance achieved as compared with forecasts included in the statement of performance expectations for the financial year;
    - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year;
  - what has been achieved with the appropriation; and
  - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure.
- complies with generally accepted accounting practice in New Zealand.

Our audit was completed on 29 October 2015. 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 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 the 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 the performance information. We were unable to determine whether there are material misstatements in the statement of performance 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 the performance information. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and the performance information, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the preparation of the Health Board's financial statements and performance information 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.

An audit also involves evaluating:

- the appropriateness of accounting policies used and whether they have been consistently applied;
- the reasonableness of the significant accounting estimates and judgements made by the Board;
- the appropriateness of the reported performance information within the Health Board's framework for reporting performance;



- the adequacy of the disclosures in the financial statements and the performance information; and
- the overall presentation of the financial statements and the performance information.

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

We believe we have obtained sufficient and appropriate audit evidence to provide a basis for our audit opinion.

## **Responsibilities of the Board**

The Board is responsible for preparing financial statements and performance information that:

- comply with generally accepted accounting practice in New Zealand and Public Benefit Entities Reporting Standards;
- present fairly the Health Board's financial position, financial performance and cash flows; and
- present fairly the Health Board's performance.

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

The Board is 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 the performance information, whether in printed or electronic form.

## **Responsibilities of the Auditor**

We are responsible for expressing an independent opinion on the financial statements and the performance information and reporting that opinion to you based on our audit. Our responsibility arises from the Public Audit Act 2001.

## **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 PERFORMANCE





## Overview

As an effective District Health Board we need to demonstrate accountability<sup>1</sup> for the intended outcomes and impacts of our population by the services/outputs that we provide. During the annual planning phase, the Statement of Forecast 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 following pages. The performance and activity measures chosen are not an exhaustive list of all our activity but they do reflect a good representation of the full range of outputs that we fund and/or provide.

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

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

We built our performance framework for 2014/15 by grouping our activities into the population long and medium term impacts we intended to influence.

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

### Notes:

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

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

# Statement of Performance

## Taranaki DHB Planned and Actual Revenue and Expenditure Allocated to Output Classes 2014-15

Output Class	Planned Revenue (\$000's)	Actual Revenue (\$000's)	Planned Expenditure (\$000's)	Actual Expenditure (\$000's)
Prevention	11,508	11,714	11,540	7,945
Early Detection and Management	81,198	83,128	81,423	75,532
Intensive Assessment and Treatment Services	200,698	202,805	201,253	213,210
Rehabilitation and Support	44,766	45,573	44,890	50,320
TOTAL	338,170	343,220	339,105	347,007

## Performance Information Statement

The 2014/15 Vote Health Estimates of Appropriations noted that performance information for selected Non-Departmental Appropriations (Health Workforce Training and Development, National Child Health Services, National Contracted Services, National Disability Support Services, National Elective Services, National Emergency Services, National Health Information Systems, National Maternity Services, National Mental Health Services, National Personal Health Services, and Primary Health Care Strategy) would be reported in part through DHBs 2014/15 Annual Reports. The Ministry of Health has advised DHBs that the Minister of Health will report this information instead of DHBs. Readers wishing to view the overall budget and performance information for these selected Non-departmental Appropriations will be able to refer to the Minister of Health's 2014/15 Vote Health Non-Departmental Expenditure Report. This report will be made available on the Ministry of Health's website.

## 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				
<ul style="list-style-type: none"><li>Fewer people smoke</li><li>Reduction in vaccine preventable diseases</li><li>Improving health behaviours</li></ul>	<ul style="list-style-type: none"><li>An improvement in childhood oral health</li><li>Long-term conditions are detected early and managed well</li><li>Fewer people are admitted to hospital for avoidable conditions</li><li>More people maintain their functional independence</li></ul>		<ul style="list-style-type: none"><li>People receive prompt and appropriate acute and arranged care</li><li>People have appropriate access to elective services</li><li>Improved health status for people with a severe mental health illness and/or addiction</li><li>More people with end-stage conditions are appropriately supported</li></ul>	
Outputs				
Statement of 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 10.

#### Improving Healthy Behaviours

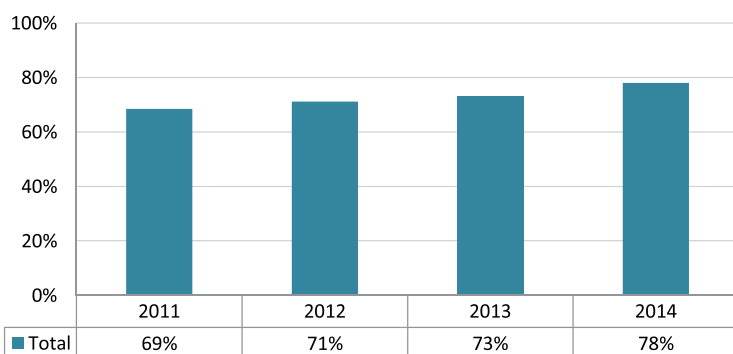
Good nutrition is fundamental to health and to the prevention of disease and disability. Nutrition-related risk factors (such as high cholesterol, high blood pressure and obesity) jointly contribute to two out of every five deaths in New Zealand each year.

# Statement of Performance

## FEWER PEOPLE SMOKE

### Impact Measures

Percentage of year 10 students in Taranaki who have never smoked



Target for 2014 was to increase on 2013 result of 71.1%

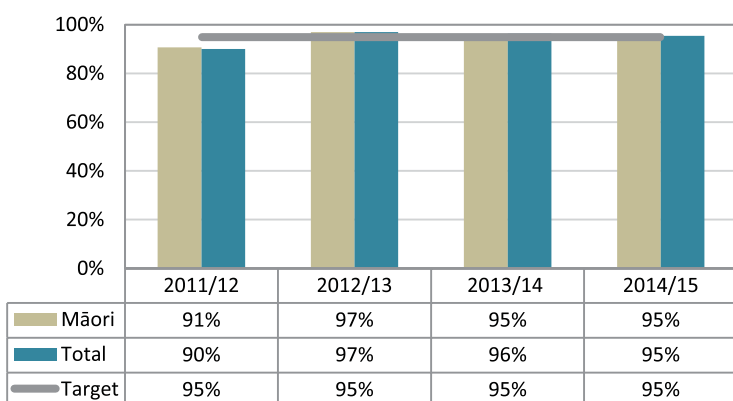
Data Source: Action on Smoking and Health (ASH) annual survey

### A further increase in the percentage of year 10 students who have never smoked

The Year 10 survey is an annual questionnaire with results gathered from around 31,000 students in New Zealand. The survey is conducted each year in schools throughout the country for the last 10 years and is one of the biggest 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 four years in the increase of year 10 students who are recorded as never having smoked.

### Output Measures

Percentage of hospitalised smokers provided with smoking cessation advice and support



Data Source: Taranaki DHB Patient Management System

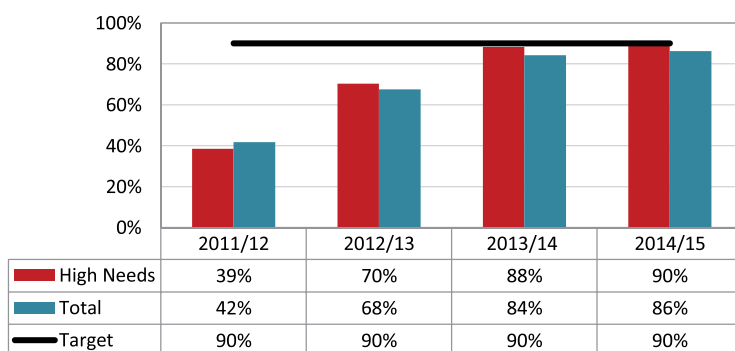
### 95% of hospitalised smokers are provided with cessation advice and support to quit

Māori	Target Achieved
Total	Target Achieved

The 95% target has been met by Taranaki DHB for both Māori and Total population for 2014/15. The DHB plans to further increase the use of nicotine replacement therapy to continue to improve on this result. Smokefree co-coordinators facilitated education and support across Taranaki DHB Hospital Services, 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.

# Statement of Performance

**Percentage of smokers in primary care seen in the last 12 months provided with smoking cessation advice and support**



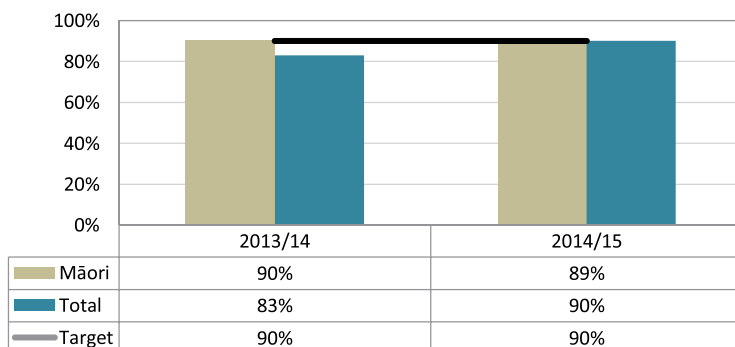
Data Source: Primary Health Organisation Performance Programme (PPP)

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

High Needs	Target Achieved
Total	Target Not Achieved

Taranaki DHB has achieved the health target percentage for high needs for 'Better Support for Smokers to Quit' in Primary Care (PHOs) General Practice for 2014/15 but has not achieved target for total population (based on an average of quarterly results). However the total population performance result has continually improved from quarter 1 (84.7%) to quarter 4 (88.19%) and is on target to achieve target in 2015/16.

**Percentage of pregnant women identified as smokers offered brief advice and support to quit**



Data Source: Primary Health Organisation Performance Programme (PPP)

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

Māori	Target Not Achieved
Total	Target Achieved

While the DHB did not quite reach the target for Māori in this measure, it is pleasing to note the overall improvement for the Total population.

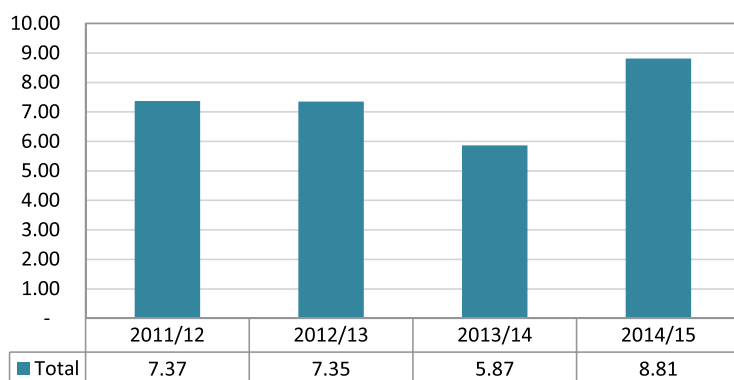
Smoking cessation information has been included in the pre and post pregnancy support services directory in all areas.

# Statement of Performance

## REDUCTION IN VACCINE PREVENTABLE DISEASES

### Impact Measures

**Three year average crude rate per 100,000 of vaccine preventable diseases in hospitalised 0-14 year olds**



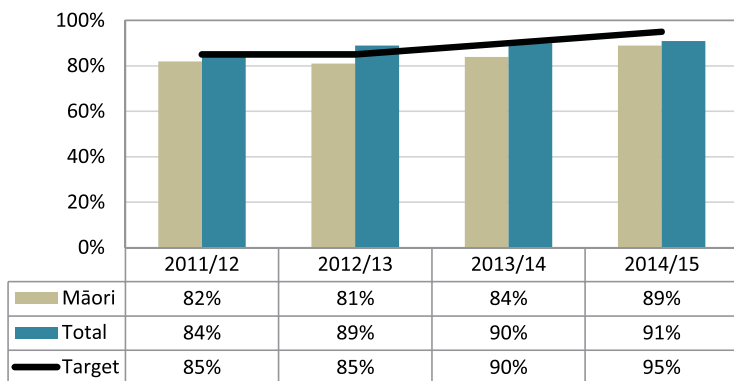
Data Source: Ministry of Health National Minimum Dataset

### Reduction in vaccine preventable diseases

In 2014/15 our aim was to decrease the incidents of preventable disease hospitalised. This measure is an indication of a system wide approach to vaccination services, unfortunately while Taranaki DHB's admission rate increased to 8.81 per 100,000, the actual number of admissions was very low. Over the past three years the number of admissions for preventable diseases in Taranaki were three in 2012/13, nil in 2013/14 and three in 2014/15.

### Output Measures

**Percentage of babies who are fully immunised at eight months of age**



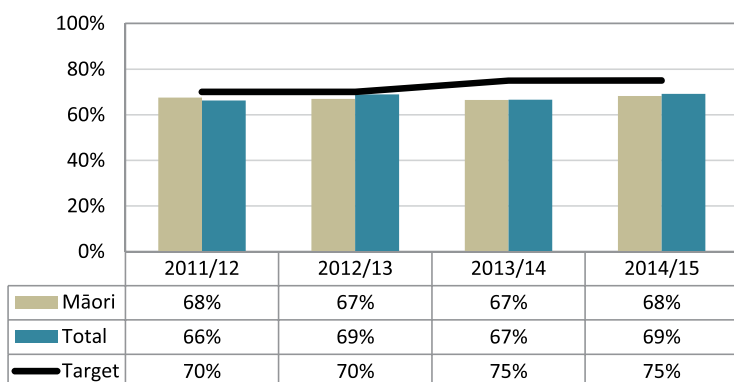
Data Source: National Immunisation Register

### 95% of babies are fully immunised at eight months old

Māori	Target Not Achieved
Total	Target Not Achieved

While Taranaki DHB did not achieve the national target for either Māori or total population, we are pleased to see continued improvement in the uptake for Māori over the last four years. The DHB undertook significant work in the area of checking the immunisation status of children as they presented across various parts of the organisation and thereby providing an opportunity to arrange for the completion of vaccinations.

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



Data Source: Primary Health Organisation Performance Programme (PPP)

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

Māori	Target Not Achieved
Total	Target Not Achieved

During Immunisation Awareness Week, Taranaki DHB, in partnership with the Māori Women's Welfare League (MWWL), 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. The DHB Funder approved funding for 160 influenza vaccinations to be provided during Marae Health Promotion days organised by the MWWL. This is an increase of 30 from the previous year.

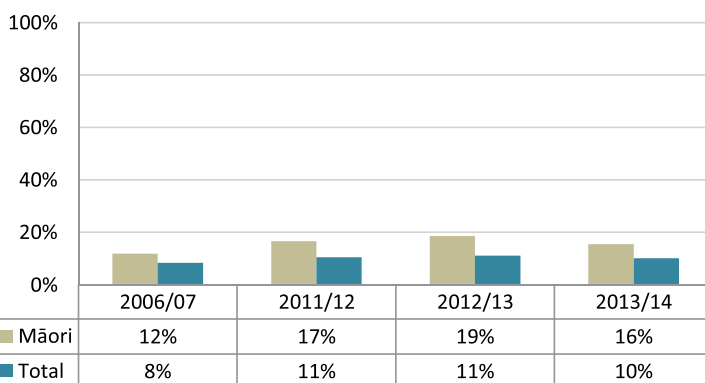


# Statement of Performance

## IMPROVING HEALTH BEHAVIOURS

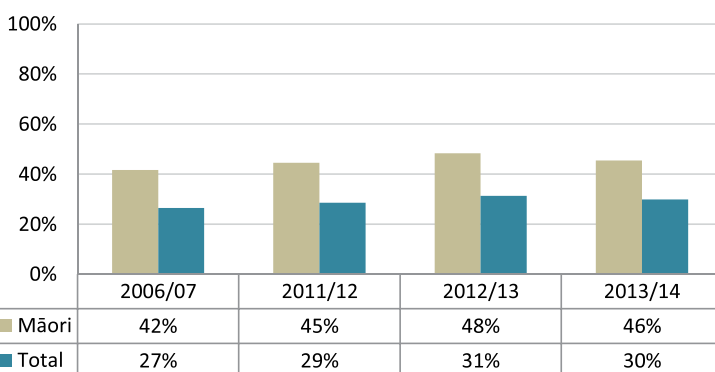
### Impact Measures

**Percentage of New Zealand population who are obese  
2-14 year olds**



Data Source: New Zealand Health Survey 2013/14

**Percentage of New Zealand Population who are obese  
15 years and older**



Data Source: New Zealand Health Survey 2013/14

### Percentage of New Zealand population who are obese

The 2013/14 New Zealand Health Survey found that three out of ten adults (30%) were obese. The obesity rate peaked in middle-aged adults (those aged 45–64 years) at 36%, dropping to 28% for those aged 75 years and over. Obesity rates were highest in Pacific adults (67%) and also high among Māori adults, among whom almost half (46%) were obese. In contrast, only one in seven Asian adults was obese (14%).

The survey also found that one in ten children aged 2–14 years (10%), were obese. There has been no significant change in the child obesity rate since 2011/12 (when it was 11%). Fifteen percent of Māori children were obese - after adjusting for age and sex differences, Māori children were nearly twice as likely to be obese as non-Māori children. One in four Pacific children (25%) was obese. After adjusting for age and sex differences, Pacific children were 3.2 times as likely to be obese as non-Pacific children. Obesity rates were lowest in Asian children (for whom the rate is 7%).

The childhood obesity rate was much higher in children living in the most deprived areas than it was for children living in the least deprived areas (the rates were 18.3% and 4.5% respectively). After adjusting for age, sex and ethnic differences, children living in the most deprived areas were 2.7 times as likely to be obese as children living in the least deprived areas.

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.

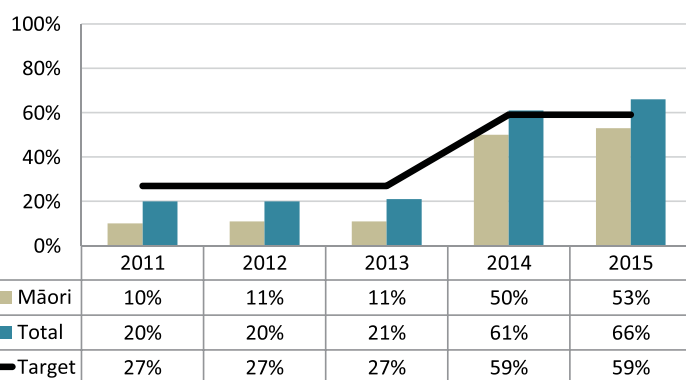
Taranaki DHB also funds the Whanau Pakari Programme supporting healthy lifestyle intervention to children and adolescents as an extension of the GRx Active Families service.

For both these measures, Taranaki DHB's aim was to reduce these incidences through a system wide approach to obesity.

# Statement of Performance

## Output Measures

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



Data Source: National Plunket Data

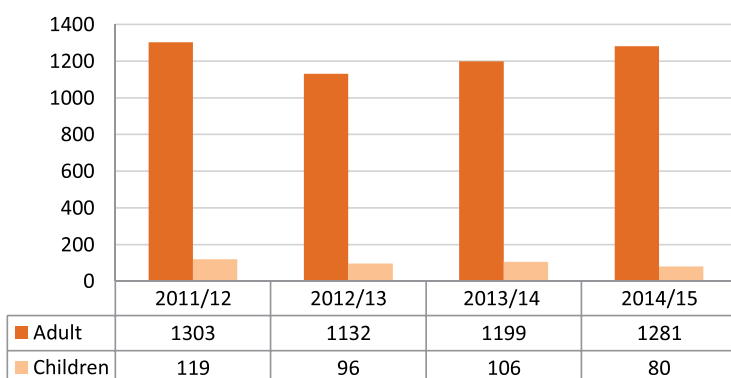
**Increasing the number of infants who are fully, exclusively or partially breastfed six months**

Māori	Target Not Achieved
Total	Target Achieved

Please note: in the 2013/14 and 2014/15 Annual Plans the DHB indicated its intention to continue to measure the percentage of infants who were fully and exclusively breast fed at 6 months. However, late in 2014 the Ministry of Health indicated its intention to change this monitoring to include those infants who are partially breast fed. This is reflected in the changed targets in the graph.

The quality of data from all Well Child Tamariki Ora (WCTO) providers has improved significantly since the Baby Friendly Community Initiative (BFCl) accreditation was achieved late last year. Our Māori Health Provider holds the Mama Pepe Hauora contract which focuses on improving physical activity, nutrition, and breastfeeding for mothers and infants in high needs communities. Addressing these areas should have flow-on effect for breastfeeding rates over the longer term. In the short-term the Peer Support service and Community Lactation Clinics support mothers having difficulties with starting or maintaining breastfeeding.

**Number of referrals to the GRx (Green Prescription) programme**



Target: Adult 1490; children 35

**Number of referrals to the GRx (Green Prescription) programme**

Adult	Target Not Achieved
Children	Target Achieved

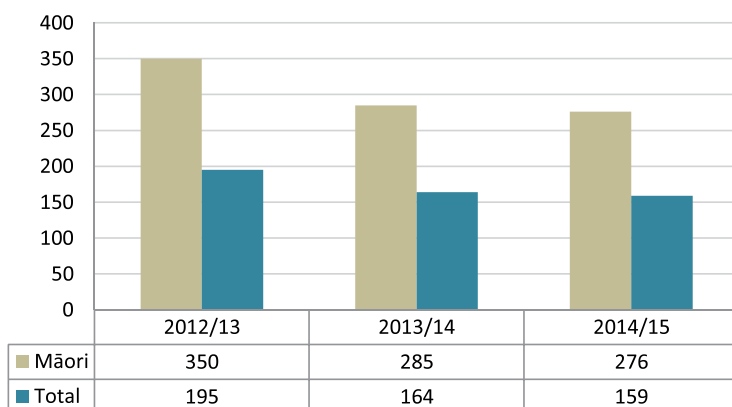
In 2014/15 the number of Adult referrals for Green Prescriptions increased, however the number of Active Families (and associated children) referrals decreased.

The 2014/15 contract with Sport Taranaki for GRx Adults and Active Families included more outcome measures and supported a goal of increased independent activity in the community following a period of GRx support.

A GRx pre-diabetes and diabetes pilot run via the Midlands Health Network supported practice nurses to provide lifestyle advice.

# Statement of Performance

**Teen birth rate per 10,000**



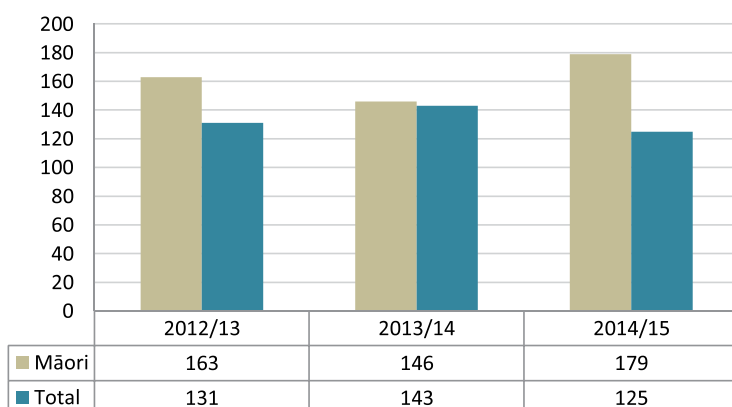
Target: Māori <350; Total population <195

**Teen birth rate per 10,000**

Māori	Target Achieved
Total	Target Achieved

The teen birth rate in Taranaki for Māori and total population decreased slightly in 2014/15 compared to the previous year and has continued to reduce over the last few years.

**Teenage terminations of pregnancy rate per 10,000**



Target: Māori <163; Total population <131

**Teenage terminations of pregnancy rate - per 10,000**

Māori	Target Not Achieved
Total	Target Achieved

The rate of terminations of pregnancy for Māori teens in Taranaki has unfortunately increased, while the number of teen terminations as a proportion of the total population has decreased. Please note the termination intervention rate is likely to influence the teen deliveries above.

# Statement of Performance

## 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 10. 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

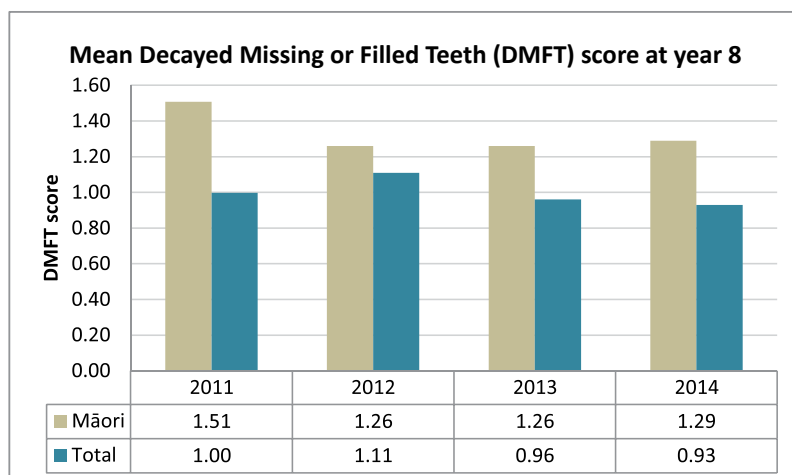
If we are to deliver on our twin goals of improving health outcomes, and reducing or eliminating health inequalities, for our older population, we aim to support people to maintain functional independence. With an increasing and ageing population, as this cohort increases, so does demand on our constrained 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.



# Statement of Performance

## AN IMPROVEMENT IN CHILDHOOD ORAL HEALTH

### Impact Measures



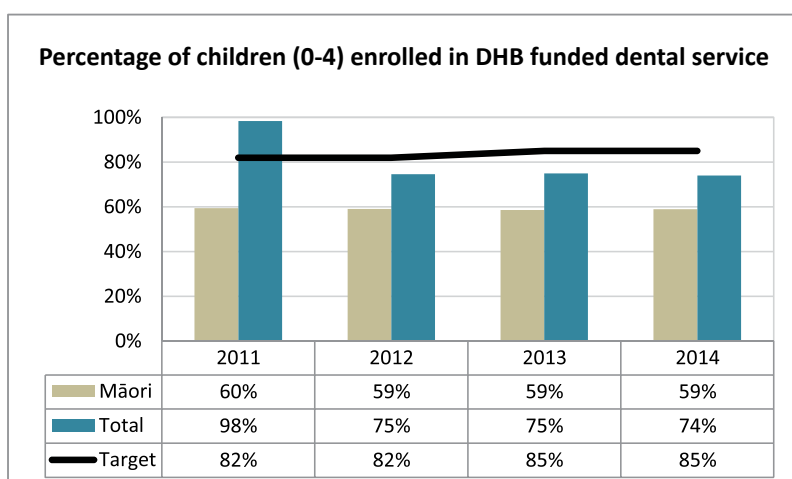
Data Source: Taranaki DHB Dental Patient Management System - Titanium. Statistics New Zealand Population Projection 2013

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

This measure is a status of permanent teeth in 12 year olds in Taranaki and requires a system wide approach to achieve the desired result of reducing DMFTs. 2014/15 results indicate that Māori continue to have a higher rate of DMFT compared the Total population of 12 year olds who have continued a downward trend over the last four years.

The removal of fluoride from the New Plymouth water supply is likely to impact in the future on these targets and will be closely monitored.

### Output Measures



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

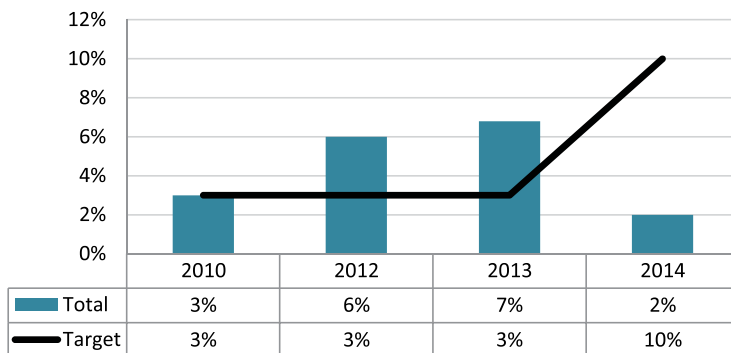
#### Percentage of children (0-4) enrolled in DHB funded dental service

Māori	Target Not Achieved
Total	Target Not Achieved

The increased target of 90% was not achieved in 2014. There has been no change for Māori and a slight increase for all 0-4 year old enrolments. It is important to note that this data is reported annually in September each year. The data relates to the previous calendar year and therefore does not necessarily reflect the results of any changes introduced in the past 12 months. In the meantime, we believe that a new online enrolment process into the oral health service on the Taranaki DHB website has allowed more information to be available to parents. 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.

# Statement of Performance

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



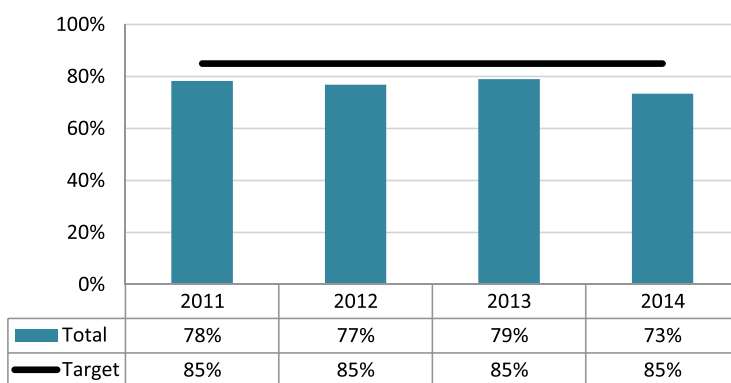
Data Source: Taranaki DHB Dental Patient Management System - Titanium. Statistics New Zealand Population Projection 2013

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

Total	N/A - Target changed mid year
-------	-------------------------------

This measure remains important to Taranaki DHB in identifying gaps in delivering oral health services to our children. Previous targets and measurements, up to and including 2013, reflected delays in receiving a fully completed treatment for the child. However in 2014, the Ministry of Health redefined both measure and target to reflect delays in attending an examination rather than completion of treatment. Consequently, we are able to report a significantly low number of non attendances. The stated target in the 2013/14 Annual Plan is therefore no longer relevant and this change will be reflected in subsequent years.

**Percentage of adolescent utilisation of DHB funded dental services**



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

**Percentage of adolescent utilisation of DHB funded dental services**

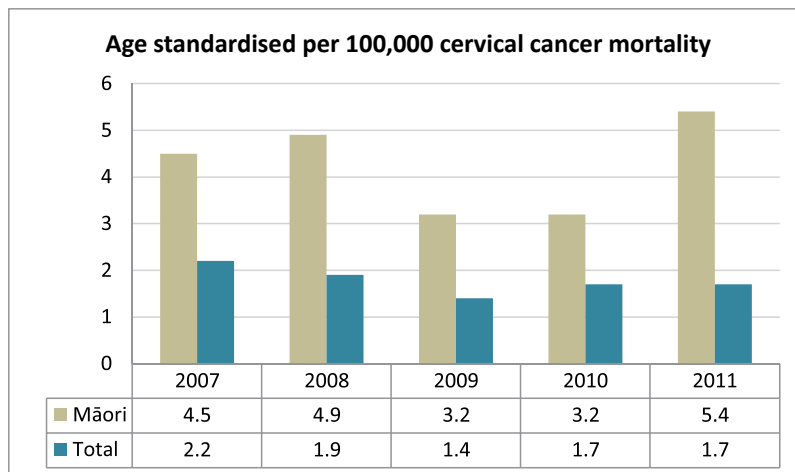
Total	Target Not Achieved
-------	---------------------

Taranaki DHB funds dental services provided in the community for children and youth aged 17 and under. The National target is that 85% of the adolescent population access funded dental services. Although the target was not met for 2014 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.

# Statement of Performance

## LONG-TERM CONDITIONS ARE DETECTED EARLY AND MANAGED WELL

### Impact Measures



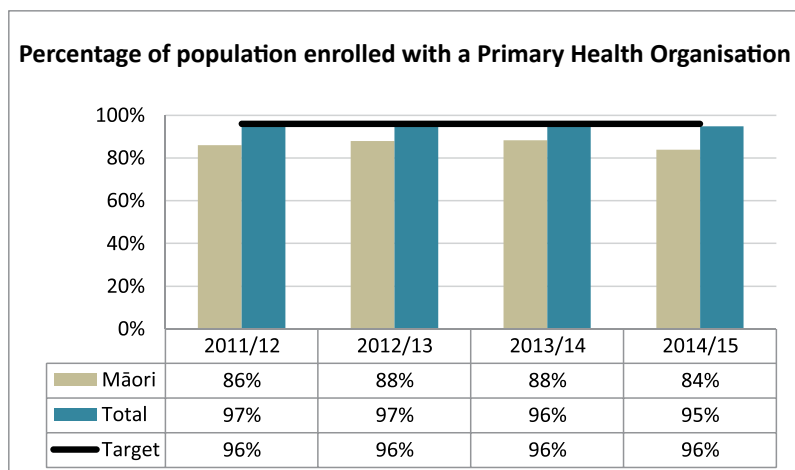
Data Source: New Zealand Cancer Registry and New Zealand Mortality Collection - standardised to the WHO world standard population.

#### Cervical Cancer Mortality - age standardised per 100,000

This measure was last published through the NZ Cancer Registry and Mortality data collection in September 2014 and is the latest available data.

This measure is important from a New Zealand perspective looking at the impact of cancer interventions across the country and the resulting health of our population. Unfortunately there has been a deterioration of results for Māori compared to previous years, however our objective remains to see a decline in the mortality rates of cervical cancer.

### Output Measures



Data Source: Ministry of Health PHO Enrolment Collection

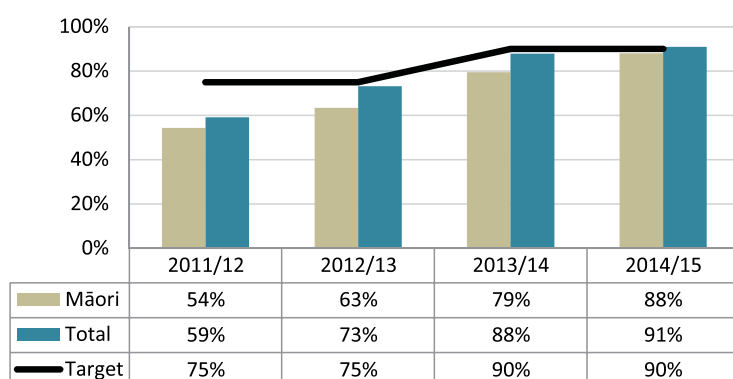
#### Percentage of population enrolled with a Primary Health Organisation (PHO)

Māori	Target Not Achieved
Total	Target Not 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 a small percentage of the population not enrolled with a PHO due to a GP practice (and resulting enrolled patients) remaining independent of the PHO.

# Statement of Performance

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



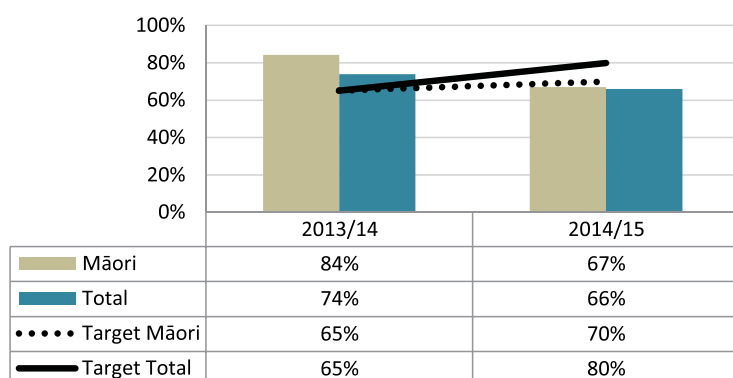
Data Source: Primary Health Organisation Performance Programme (PPP)

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

Māori	Target Not Achieved
Total	Target Achieved

Cardiovascular disease is one of the leading causes of mortality in New Zealand. Detecting and assessing risks early will enable individuals to receive support and advice in order that they can manage their health. Taranaki DHB has showed continued improvement on both Māori and total results over the last four years. The number of Total population receiving their CVDA check has met the target of 90%, and while Māori are 2% below the target, there continues to be improvement. We continue to work 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.

**Improve and maintain appropriate management of microalbuminuria in patients with diabetes**



Data Source: Primary Health Organisation Performance Programme (PPP)

Improve and maintain appropriate management of microalbuminuria in patients with diabetes

Māori	Target Not Achieved
Total	Target Not Achieved

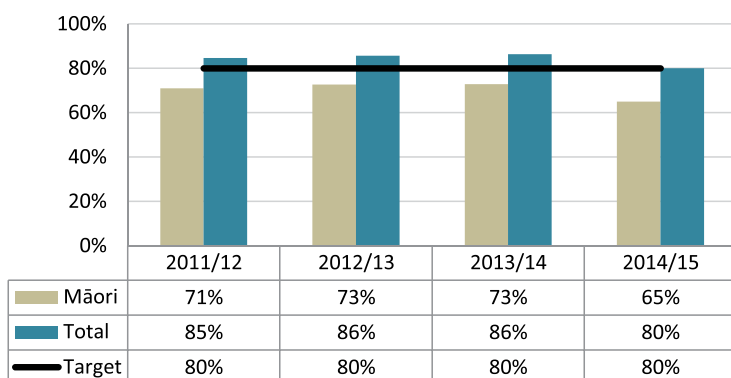
In partnership with Taranaki DHB Midlands Health Network has established a Long Term Conditions programme. Central to this is identification of patients with Long Term Conditions including diabetes – risk stratification.

Prevention strategies continue, including further development of self-management resources and patient education and training, and improvement in the clinical management of these patients using clinical audit and training and education. The use of a multidisciplinary team to assist in the management of these patients continues but has been challenging due to availability of sufficient numbers of appropriately skilled staff to undertake the MDT meetings.



# Statement of Performance

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



Data Source: National Screening Unit

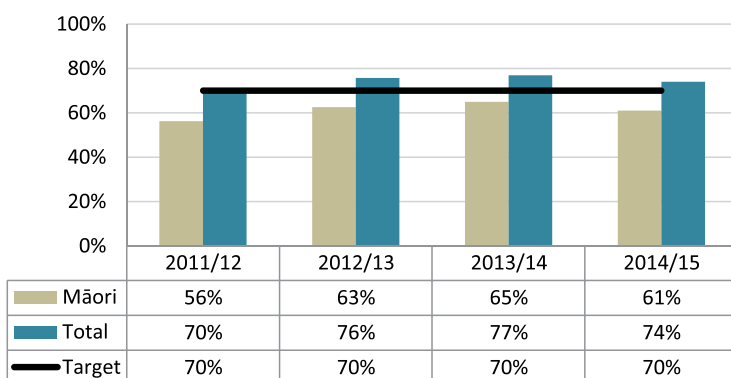
**Percentage of eligible women (25-69) have a cervical cancer screen every three years**

Māori	Target Not Achieved
Total	Target Achieved

The Taranaki region has generally had a good overall coverage rate, while it is disappointing to see a reduction (particularly in Māori) the overall Population has received coverage in line with the National target.

New initiatives will continue with our Māori Health providers to promote and support community action and development to priority women and work collaboratively with all health providers and groups.

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



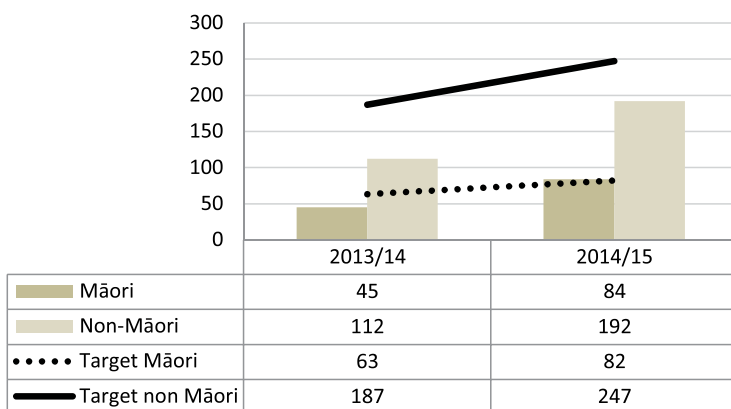
Data Source: Breast Screening Aotearoa

**Percentage of eligible women (50-69) have a breast screen every three 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 ISP's (Independent Service Providers) to maximise opportunities to work in partnership with primary care providers and Māori health providers to increase breast screening numbers. The Independent Service Provider - Ngati Ruanui Health Centre and Breast Screen Coast to Coast have undertaken promotional activities, including posters in and around Waitara and Bell Block, liaisons with GP's and networking with groups including Māori Women's Welfare League, Marae, Kohanga and Kura.

**Number of packages of care available to youth under PMHI**



Data Source: Contract Reporting

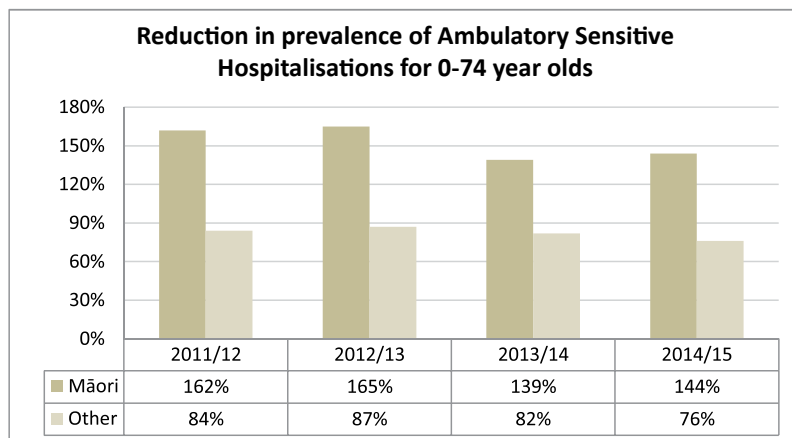
**Increase the number of packages of care available to youth under the Primary Mental Health Initiative (PMHI)**

There has been a significant improvement of uptake of Primary Mental Health Initiative (PMHI) packages of care for youth over the past year. A number of new initiatives were introduced throughout the year to help increase access for youth to counselling and other services. As part of the Social Sector trial a range of new resources were implemented, all of which provide increased access points to service for Taranaki youth.

# Statement of Performance

## FEWER PEOPLE ARE ADMITTED TO HOSPITAL FOR AVOIDABLE CONDITIONS

### Impact Measures



Target was to reduce on previously reported hospitalisations

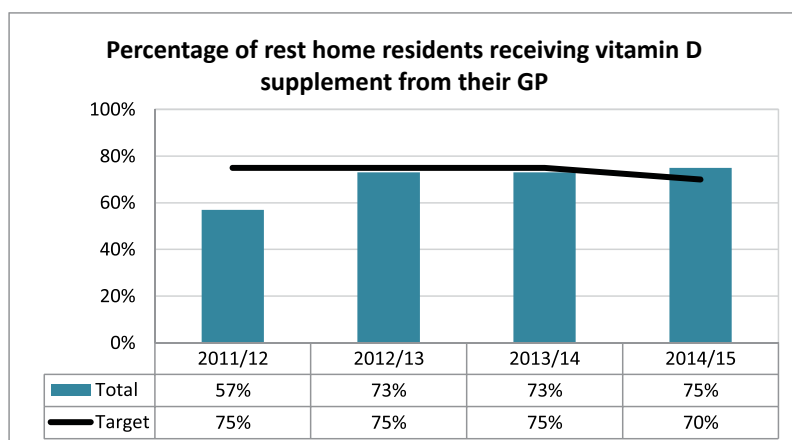
Data Source: Ministry of Health National Minimum Dataset

### Reduction in prevalence of Ambulatory Sensitive Hospitalisation (ASH)

Measuring the percentage of Ambulatory Sensitive Hospital admissions (ASH) is important in helping us to identify the effectiveness of primary care services in maintaining people's health in the community, rather than receiving care in the hospital settings. Supporting people in the community not only frees up hospital staff and resources for more acute and urgent cases, but also means that people are receiving care nearer to home and possibly at an earlier onset rather than needing acute intervention. The implementation of free care for under sixes, and more recently free care for under-thirteens, has enabled a reduction of barriers (such as cost) to accessing primary care services in the community.

While there has been a gradual reduction in total population admissions over the past three years, Māori have shown a slight increase in 2014/15.

### Output Measures



Data Source: Ministry of Health DHB claiming data

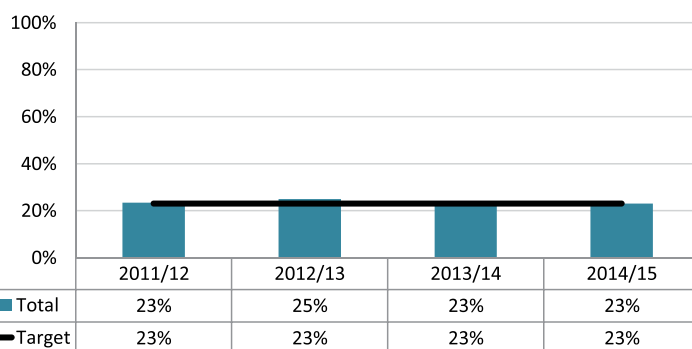
### 70% of rest home residents receive vitamin D supplement from their GP

Total	Target Achieved
-------	-----------------

Taranaki DHB has achieved the target that 70% of rest home residents receive vitamin D supplements from their GPs. We have seen a good improvement over the last three 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.

# Statement of Performance

## Less than 23% presentations to the Emergency Department are triage level 4 & 5



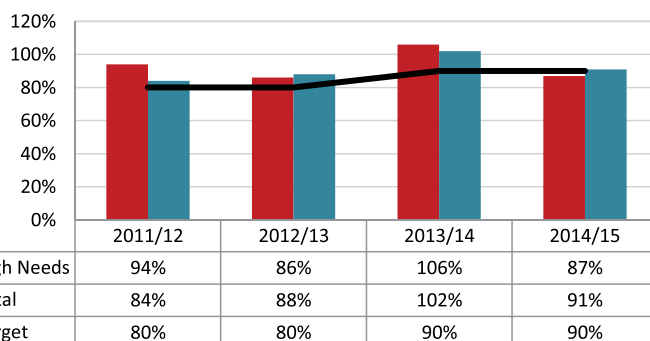
Data Source: National Non-admitted Patient Collections. Statistics New Zealand Population Projection 2013

## Less than 23% presentations to the Emergency Department are triage level 4 & 5

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 require immediate attention and treatment, while triage category 5 patients are less urgent and may even be able to be referred back to their GP for treatment. 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 2014/15 and expect it to improve further in the future.

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



Data Source: National Immunisation Register

## 90% of eligible population have their Before School Checks completed

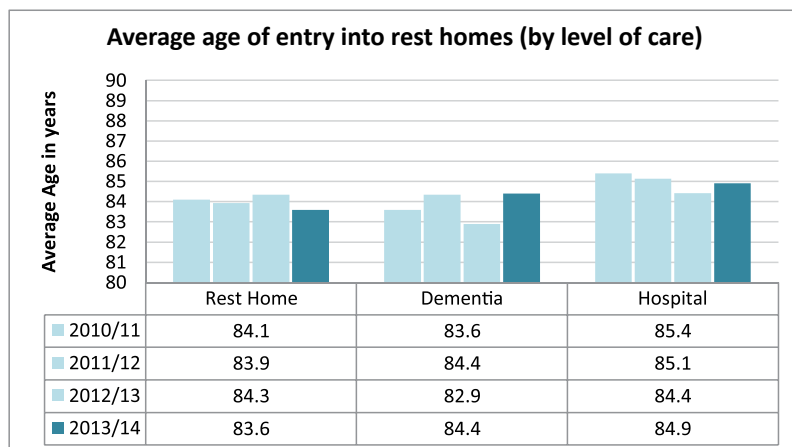
High Needs	Target Not Achieved
Total	Target Achieved

Taranaki continues to achieve higher than national target of 90% of all eligible children receive a B4SC for total population, but 3% below target for high needs population. The service delivery model is delivered by Public Health Nurses and Te Kawau Maro (Tui Ora and Ngati Ruanui) and is well embedded in the community.

# Statement of Performance

## MORE PEOPLE MAINTAIN THEIR FUNCTIONAL INDEPENDENCE

### Impact Measures

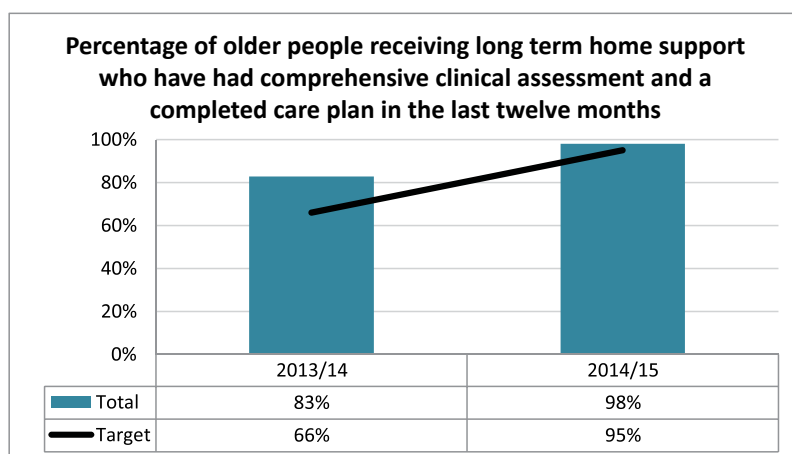


Data Source: Inter District Flow files

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

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

### Output Measures



Data Source: InterRAI and Ministry of Health DHB Claiming data

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

Total	Target Achieved
-------	-----------------

InterRAI is a nationally consistent comprehensive clinical assessment tool for older people with disability support needs. It ensures a consistent approach to assessing the support needs of older people. All older people requiring funded support services must have received an interRAI assessment before a funded support package can be put in place.

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



# Statement of Performance

**Amount spent on home based support services (HBSS) compared to the amount spent on aged residential care (ARC) for the elderly (expressed in a \$:\$ ratio)**

	2011/12	2012/13	2013/14	2014/15
HBSS:ARC	1:2.45	1:2.34	1:2.41	1:2.58

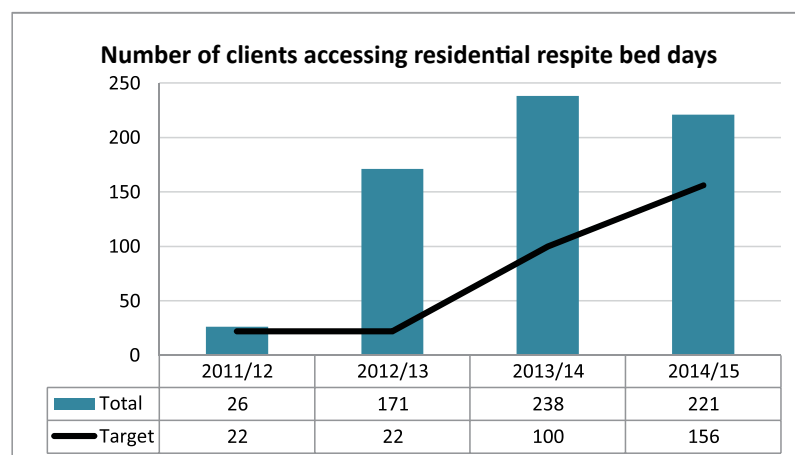
Target: to reduce the cost of rest home level of care funding compared to home based support services funding

Data Source: Local Accounting System

For those with aged related and chronic health conditions we will reduce the rate of residential care to home based funding

Total Target Not Achieved

This measure (ratio) is used to assess the level of expenditure of Residential Care compared to expenditure on Home Based 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 to reflect that fact that people were able to stay at home for longer, but at this point in time the ratio can be influenced by other factors. We therefore do not feel that this ratio can be relied upon as the sole measure of effective HBSS service delivery (for example asset and income thresholds, aged residential care bed day prices, and proportion of individuals at different levels of care).



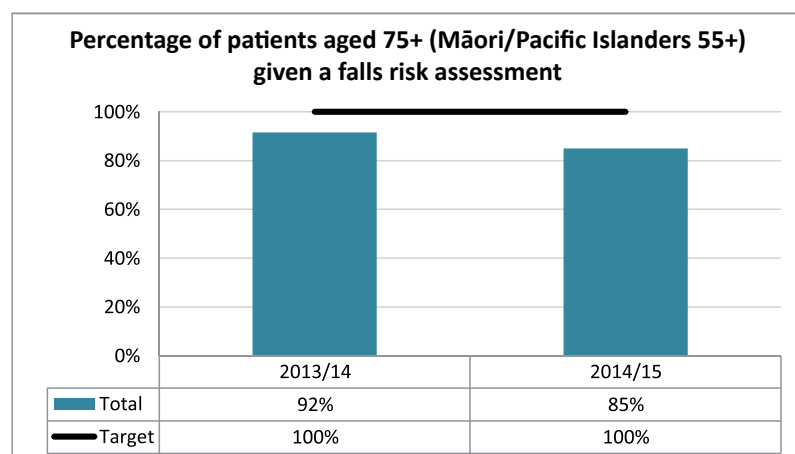
Target: increase the utilisation of respite services (2014/15 >156)

Data Source: Ministry of Health DHB Claiming data

**Number of clients accessing Residential Respite Bed Days**

Total Target Achieved

Taranaki DHB has maintained a higher number of clients accessing residential respite services during 2014/15. This is mainly due to the fact that our Needs Assessment and Coordination team have been encouraging clients who are eligible for carer support to use the option of residential respite which reduces the need for clients to pay top up fees and therefore improves access to residential based respite. We have also invested in additional dementia field officer hours aimed at working with carers and promoting the use of residential respite services which has had a positive effect on uptake of all respite services.



Data Source: Taranaki DHB

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

Total Target Not Achieved

Taranaki not been able to meet the indicator target of 90% (based on international best practice) for this intervention. Our own self imposed target of 100% continues to be a challenge, as it is not appropriate that a seriously ill patient receive a falls risk assessment when other assessments and interventions are required and take priority. This will require reviewing in the next year.

# Statement of Performance

## 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 10). 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

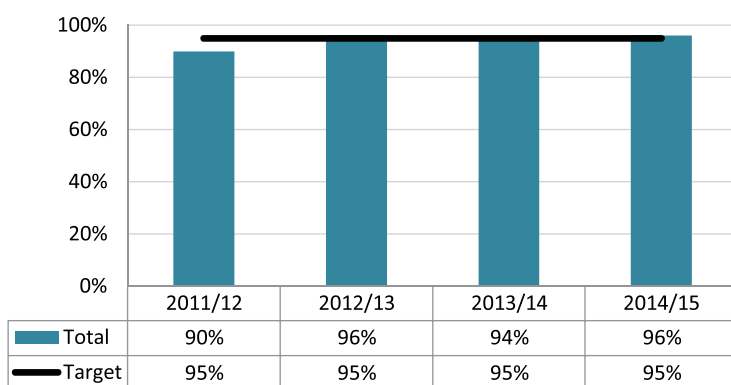
For people in our population who have end stage conditions, it is important that they, their family and Whānau are supported to cope with the situation. Our focus is on ensuring that the patient is able to live comfortably, without undue pain or suffering. Early identification and recognition of end-of-life 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.

# Statement of Performance

## PEOPLE RECEIVE PROMPT AND APPROPRIATE ACUTE AND ARRANGED CARE

### Impact Measures

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



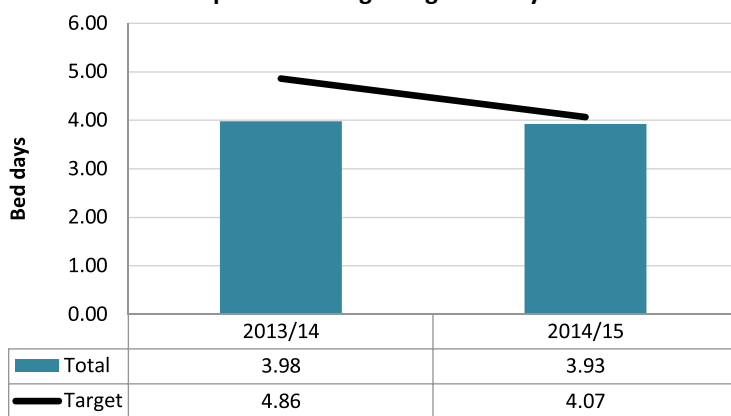
Data Source: Taranaki DHB Patient Management System

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

Continued improvement from 2011/12 has seen Taranaki DHB exceed target in 2014/15. The duration of stay in 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

Inpatient average length of stay



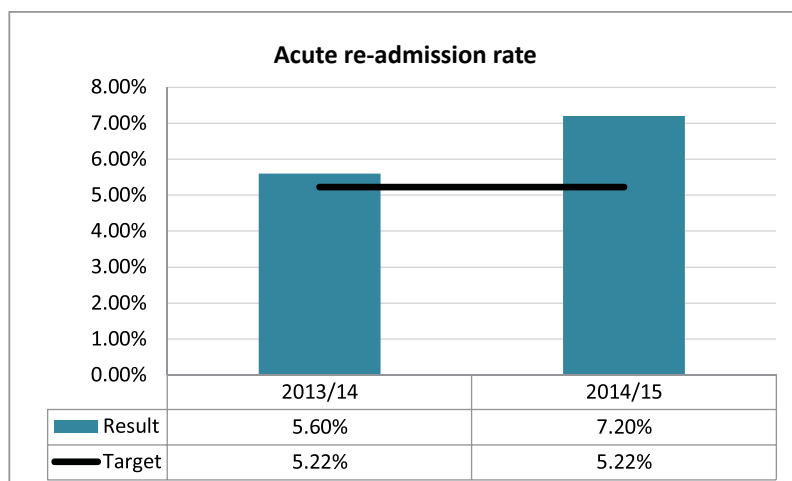
Data Source: National Minimum Dataset (NMDS)

#### Acute Inpatient average length of stay reduced

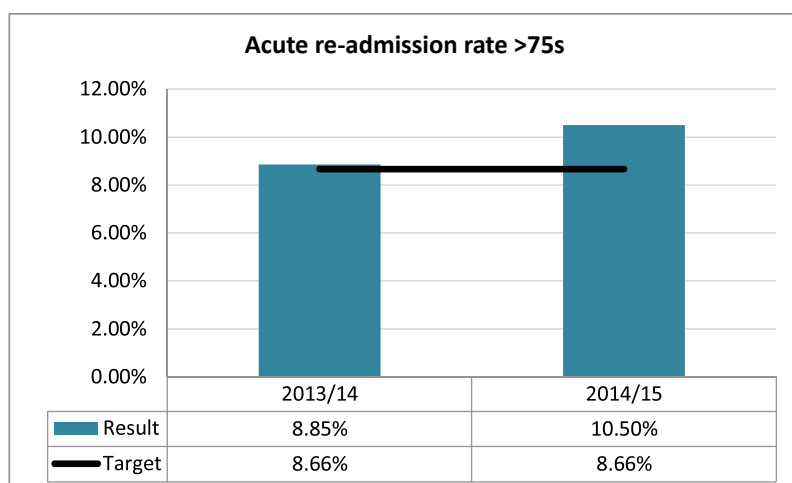
Total	Target Achieved
-------	-----------------

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.

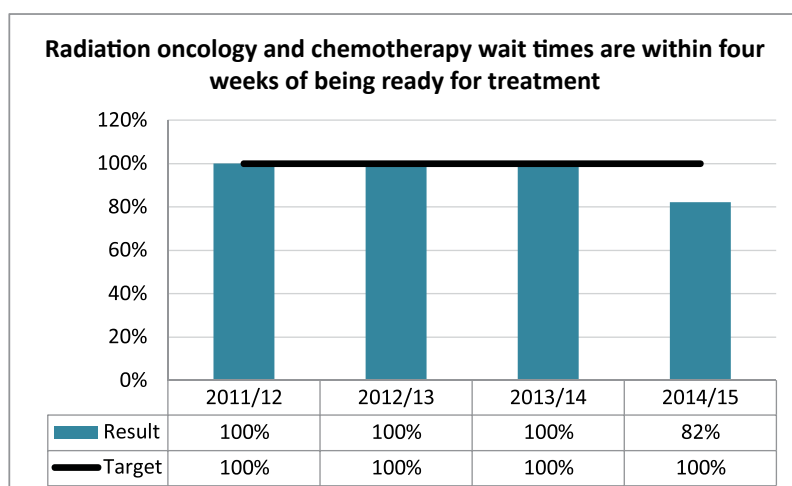
# Statement of Performance



Data Source: National Minimum Dataset (NMDs)



Data Source: National Minimum Dataset (NMDs)



Data Source: Mid-Central DHB Patient Management System

## Acute re-admission rate - 6.9%

Total	Target Not Achieved
-------	---------------------

## Acute re-admission rate over 75 years - 10.9%

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 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.

Please note that the target set is also influenced by looking at previous actual performance and will therefore change over time.

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

Total	Target Not 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.



# Statement of Performance

New Measure from Q2 2014/15

## Percentage of patients referred with a high suspicion of cancer who receive their first cancer treatment within 62 days

	2014/15
Result	65%
Target	85%

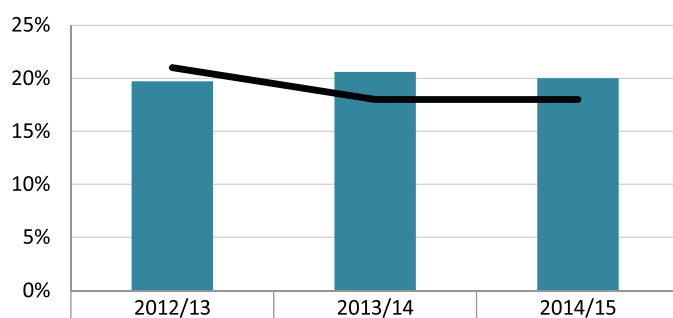
Data Source: Mid-Central DHB Patient Management System

## Percentage of patients referred with a high suspicion of cancer who receive their first cancer treatment within 62 days

Total	Target Not Achieved
-------	---------------------

This measure was introduced by the Ministry of Health in quarter two of 2014/15 and has been used as the new health target for faster cancer treatment. The results shown is quarter four's result of 2014/15.

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



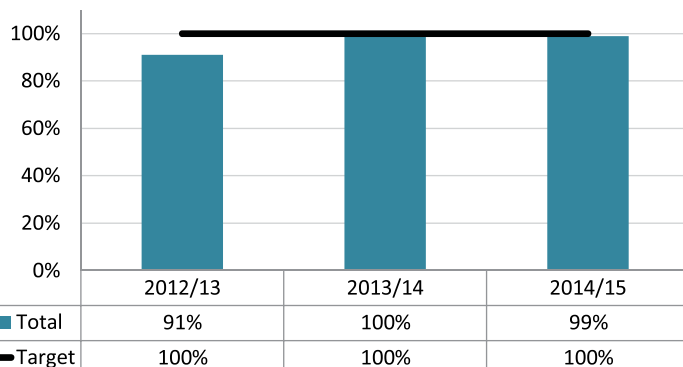
Data Source: National Minimum Dataset (NMDs)

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

Total	Target Not Achieved
-------	---------------------

There are 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 over time.

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



Data Source: Taranaki DHB

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

Total	Target Not Achieved
-------	---------------------

The 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.

# Statement of Performance

## PEOPLE HAVE APPROPRIATE ACCESS TO ELECTIVE SERVICES

### Impact Measures

#### Elective Services - Standardised Intervention Rates per 10,000

Major joint replacement - target 21 per 10,000	
Result: 19.25	Not significantly different to target
Cataract procedures - target 27 per 10,000	
Result: 33.39	Significantly above target
Cardiac surgery - target 6.5 per 10,000	
Result: 5.86	Not significantly different to target
Percutaneous revascularisation - target 12.5 per 10,000	
Result: 7.80	Significantly below target
Coronary Angiography Services - target 34.7 per 10,000	
Result: 32.66	Not significantly different to target

Data Source: Ministry of Health, Elective Services

#### Elective Services - Standardised Intervention Rates per 10,000

Meeting standardised intervention rates for a variety of types of surgery means that access is fair, and not dependent upon where a person lives. For example, the vast majority of cardiac surgery is performed in Waikato for the people of Taranaki - as our Tertiary Service Provider. We therefore rely on Waikato's processes to be able to meet national standardised intervention rates for this type of surgery.

The results reflect our status as at March 2015, with target commentary provided by the Ministry of Health.

### Output Measures

#### Summary of Elective Services Patient Flow Indicators (ESPI) results

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

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 2014/15.

Data Source: National Booking Reporting System (NBRS)

#### Summary of Elective Services Patient Flow Indicators (ESPI) results

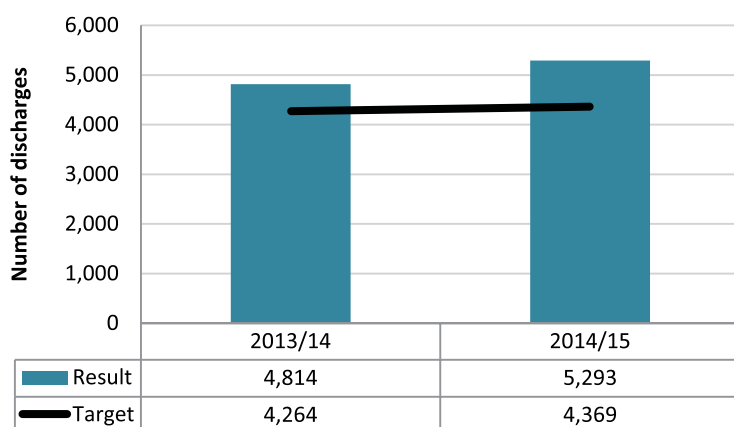
The Elective Services Patient Flow Indicators (ESPIs) are a measure of whether a DHB is meeting the patient requirements of some key decision points in a patient's journey through elective services.

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 2014/15.

# Statement of Performance

## Number of Health Target elective surgical discharges



Data Source: National Minimum Dataset (NMDS)

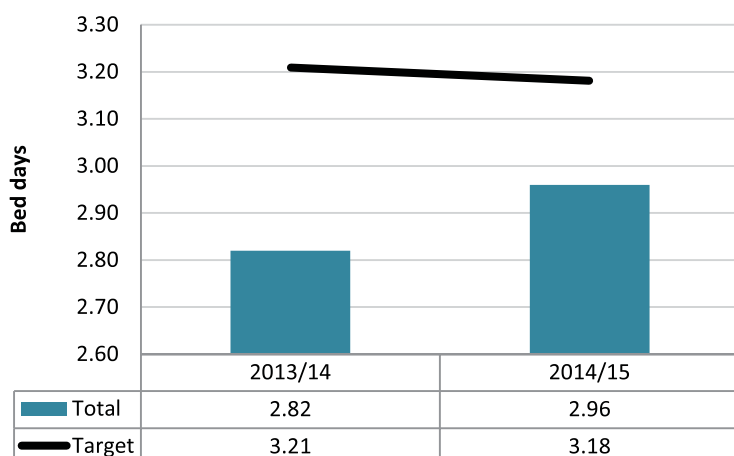
## Number of Health Target elective surgical discharges

Total	Target Achieved
-------	-----------------

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

The total number of discharges represented in the graph reflect the numbers behind the 121% health target result.

## Elective inpatient length of stay



Data Source: National Minimum Dataset (NMDS)

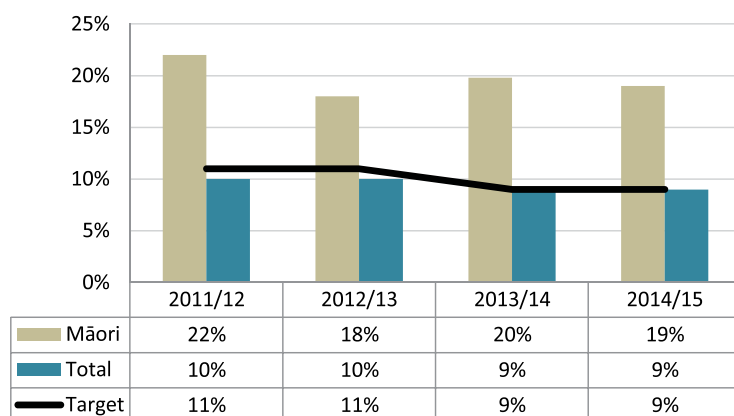
## Elective inpatient length of stay

Total	Target Achieved
-------	-----------------

Taranaki DHB made a significant improvement in elective length of stay in 2013/14 however there was a slight increase in 2014/15 due in part to the increasing complexity of cases being received and treated.

We still exceeded the target of 3.18 days to achieve 2.96 which is an excellent result locally but also against the national average. The projects delivered for Enhanced Recovery after Surgery (ERAS) have generated good results in orthopaedics and general surgery and we continue to see benefits from this work.

## Did-Not Attend rate for outpatient services



Data Source: National Minimum Dataset (NMDS)

## Did-Not Attend rate

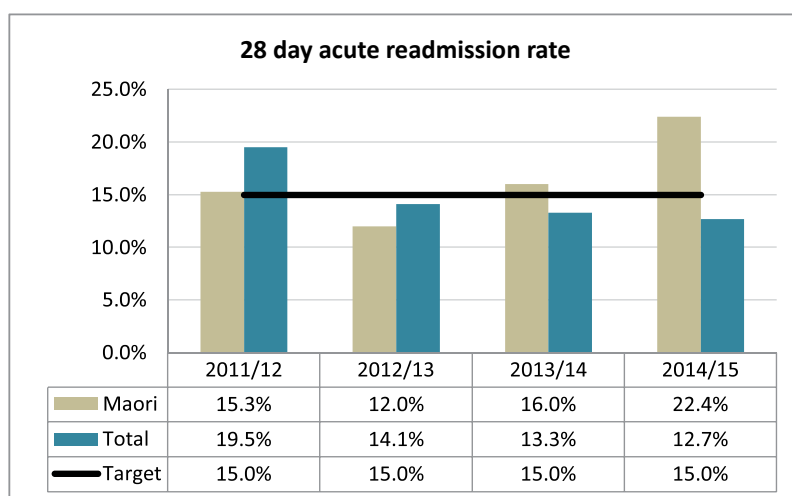
Māori	Target Not Achieved
Total	Target Not Achieved

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 not been able to achieve the ambitious target set for the total population for 2014/15. The Māori target and result remains of concern with a large discrepancy between Māori and the Total population results. Several initiatives were implemented including a text reminder service which alerts patients to upcoming appointments.

# Statement of Performance

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

### Impact Measures

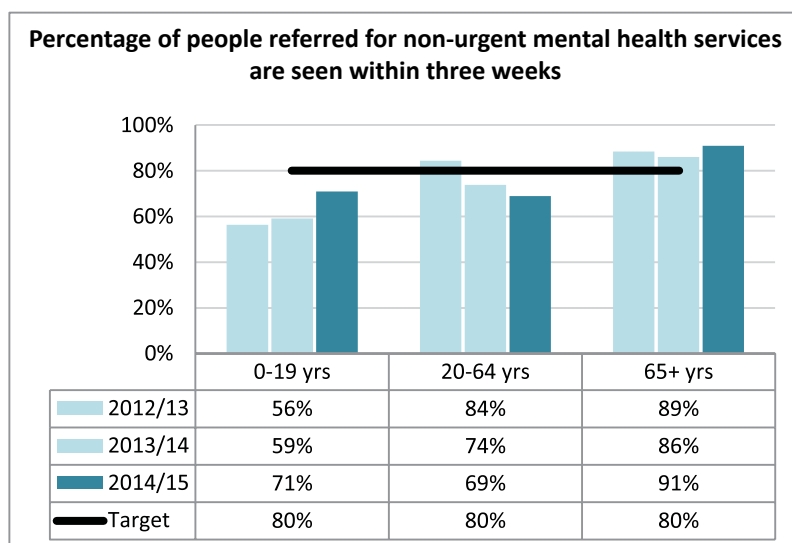


Data Source: Programme for the integration of Mental Health Data (PRMHD)

#### 28 day acute readmission rate

Readmissions are monitored on a monthly basis and reported on. Clients with increased presentations will have case conferences to address re-occurring needs. Due to the relatively low number of clients involved, 15-16 Maori clients requiring readmission takes our result to 15% (Target). Should a further one or two additional clients require readmission then the percentage moves to the current result of 22%.

### 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 are seen within three weeks

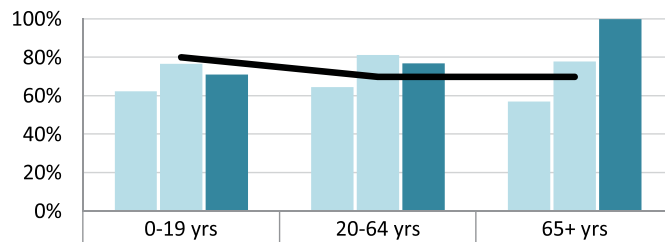
0-19 years	Target Not Achieved
20-64 years	Target Not Achieved
65+ years	Target Achieved

Ongoing improvement for the 0-19 year age band is demonstrated. This follows capacity issues easing along with the new allocation model instituted. All wait lists in Child and Adolescent Mental Health Services (CAMHS) are actively monitored, outliers are raised by management for an action update. Monitoring of this target remains a priority. Adult Intake Coordinator role has under gone a change management process merging with another specialist position so that there are two CNS to work both these roles improving responsiveness and effectiveness of services provided to the 20 to 64 age group.



# Statement of Performance

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



2012/13	62%	65%	57%
2013/14	77%	81%	78%
2014/15	71%	77%	100%
Target	80%	70%	70%

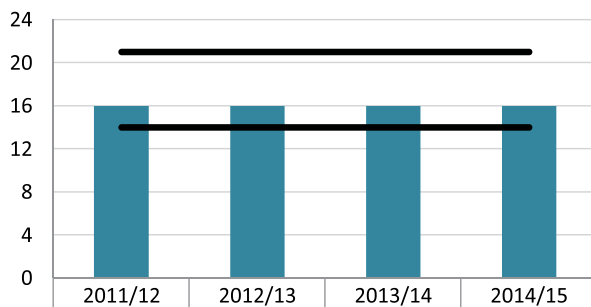
Data Source: Programme for the integration of Mental Health Data (PRMHD)

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

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

The DHB remains concerned regarding the access to non urgent services for the 0-19 age group and will focus on this in the coming year.

## Average length of stay for acute inpatients



Total	16	16	16	16
Target Lower	14	14	14	14
Target Upper	21	21	21	21

Target: 14-21 days

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

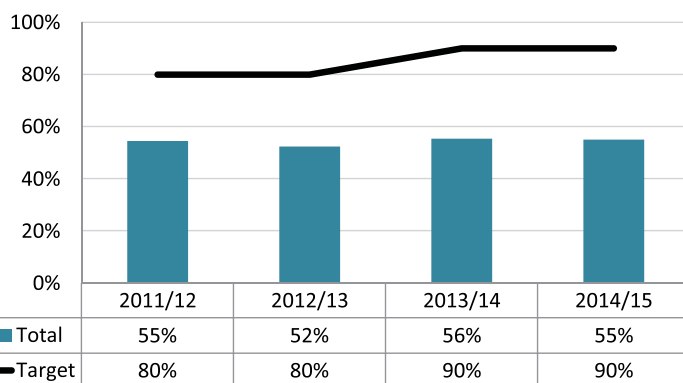
## Average length of stay for acute inpatients

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.

# Statement of Performance

**Percentage of post discharge patients seen in the community within seven days**



Target: 90-100%

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

**Percentage of post discharge patients 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 needed to maintain clinical and functional stability and to minimise the need for hospital readmission. Taranaki DHB has not achieved against this target for the past four years, however this National indicator only records clients who have been seen within seven days by adult Provider arm teams, as this is an Adult stream indicator. However at Taranaki DHB our inpatient unit is small and includes Elderly, Youth and AoD 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. A local KPI group meets monthly to 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.

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

Not Reportable

While this measure has continued to have been requested over the past three years by the Ministry of Health the numerators and denominators have changed. This has meant that the DHB is not in a position to be confidently report against this measure.

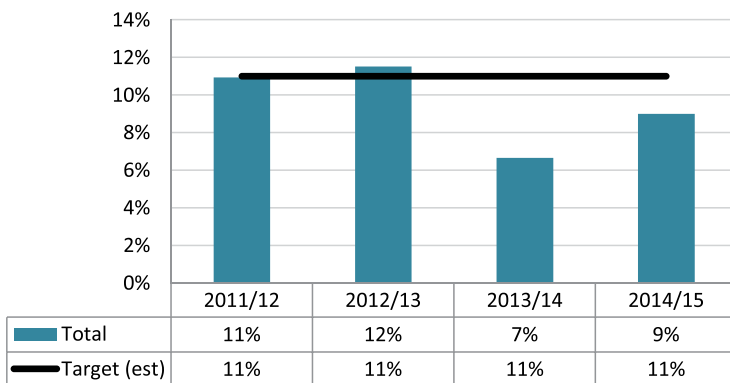
Efforts will be undertaken in 2015/16 to clarify the reporting framework required to be able to report against this measure.

# Statement of Performance

## MORE PEOPLE WITH END-STAGE CONDITIONS ARE APPROPRIATELY SUPPORTED

### Output Measures

Reduction in the percentage of palliative care clients who have an ED presentation



Data Source: Taranaki Hospice

### Reduction in the percentage of palliative care clients who have an ED presentation

Total

Target Not 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 HNZ Fundamentals of Palliative Care education programme has 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 24/7 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.

# Statement of Performance

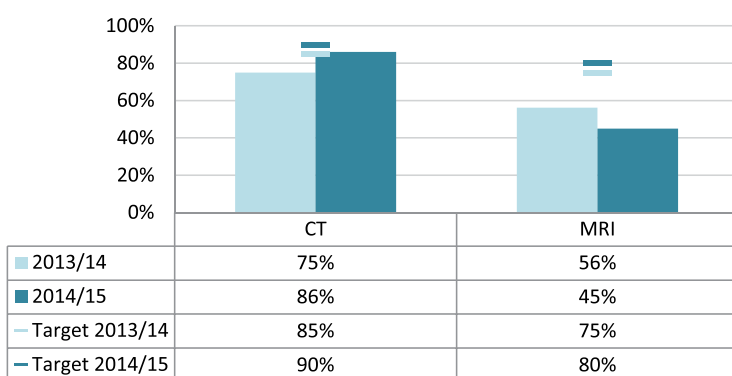
## Long Term Impact 4:

### 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

**Percentage of people with accepted referrals for CT and MRI receive scan within 42 days**



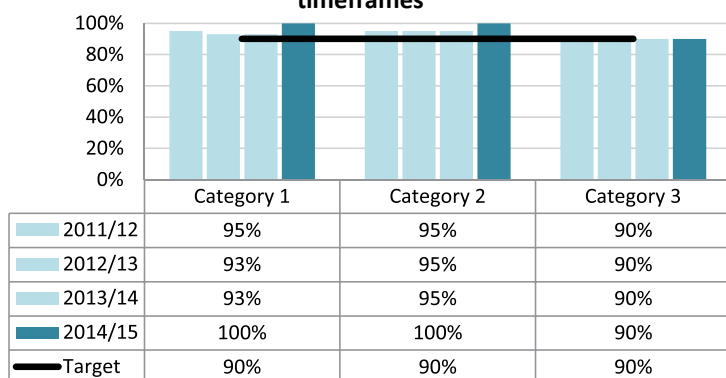
Data Source: Taranaki DHB

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

CT	Target Not Achieved
MRI	Target Not Achieved

Achievement of the CT and MRI targets remains elusive. The DHB has a joint arrangement with a private provider for radiology services and there is an expectation that services will improve in order to meet these targeted areas of diagnostic support.

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



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.





# FINANCIAL REPORT

## 2014-2015





- 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 2015, fairly reflect the financial position, operations, cash flows and service performance of the Taranaki District Health Board.



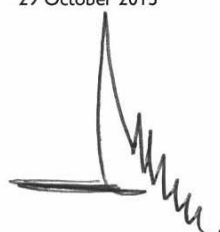
Pauline Lockett  
Chairperson  
29 October 2015



Sally Webb  
Deputy Chairperson  
29 October 2015



Rosemary Clements  
Chief Executive (Acting)  
29 October 2015



George Thomas  
Chief Financial Officer  
29 October 2015

# Statement of Comprehensive Revenue and Expense

For the Year Ended 30 June 2015

	Notes	Actual June 2015 \$000	Budget June 2015 Unaudited \$000	Actual June 2014 \$000
Revenue	1	341,553	335,670	331,601
Other income	2	1,667	2,500	2,796
<b>Total revenue</b>		<b>343,220</b>	<b>338,170</b>	<b>334,397</b>
Employee benefit costs	3	114,826	110,006	111,195
Depreciation expense	12	16,046	16,032	12,150
Outsourced services		21,308	18,493	20,011
Clinical supplies		23,786	21,632	23,132
Infrastructure and non-clinical expenses		11,520	13,770	13,773
Payments to non-health board providers		148,736	148,067	147,882
Other expenses	4	1,672	1,653	1,614
Capital charge	5	6,230	6,294	6,693
Financing costs	6	3,065	3,158	1,484
<b>Total expenses</b>		<b>347,189</b>	<b>339,105</b>	<b>337,934</b>
<b>(Loss) before share of associates</b>		<b>(3,969)</b>	<b>(935)</b>	<b>(3,537)</b>
Share of surplus of associates	11(c)	182	-	261
<b>(Loss) after surplus of associates</b>		<b>(3,787)</b>	<b>(935)</b>	<b>(3,276)</b>
<b>Other comprehensive revenue and expense</b>				
Revaluation of land and buildings		-	-	-
Total other comprehensive revenue and expense		-	-	-
<b>Total comprehensive revenue and expense</b>		<b>(3,787)</b>	<b>(935)</b>	<b>(3,276)</b>

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



# Statement of Changes in Net Assets / Equity

For the Year Ended 30 June 2015

	Note	Public Equity \$000	Accumulated Revenue and Expense \$000	Asset Revaluation Reserve \$000	Trust Fund Reserve \$000	Total \$000
<b>At 30 June 2013</b>		25,082	(4,583)	67,450	701	88,650
<b>Comprehensive revenue and expense</b>						
(Deficit) for the year		-	(3,276)	-	-	(3,276)
Other comprehensive income		-	-	-	-	-
HIQ Realisation on dissolution		-	1,081	-	-	1,081
Transfer from/(to) Trust Funds Reserve		-	(57)	-	57	-
		-	(2,252)	-	57	(2,195)
<b>Transactions with the Crown</b>						
Equity repaid to the Crown	28	(959)	-	-	-	(959)
		(959)	-	-	-	(959)
<b>At 30 June 2014</b>		24,123	(6,835)	67,450	758	85,496
<b>Comprehensive revenue and expense</b>						
(Deficit) for the year		-	(3,787)	-	-	(3,787)
Other comprehensive income		-	-	-	-	-
Transfer from/(to) Trust Funds Reserve		-	(42)	-	42	-
		-	(3,829)	-	42	(3,787)
<b>Transactions with the Crown</b>						
Equity repaid to the Crown	28	(959)	-	-	-	(959)
		(959)	-	-	-	(959)
<b>At 30 June 2015</b>		23,164	(10,664)	67,450	800	80,750

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

# Statement of Financial Position

For the Year Ended 30 June 2015

	Notes	Actual June 2015 \$000	Budget June 2015 Unaudited \$000	Actual June 2014 \$000
<b>ASSETS</b>				
<b>Current assets</b>				
Cash and cash equivalents	7	-	4,505	-
Trade and other receivables	8	14,651	7,950	10,513
Inventories	9	2,588	2,775	2,605
Other financial assets	10	2,890	2,890	2,890
<b>Total current assets</b>		<b>20,129</b>	<b>18,120</b>	<b>16,008</b>
<b>Non-current assets</b>				
Investments in associates	11	1,684	1,240	1,502
Other financial assets	10	56	57	56
Property, plant and equipment	12	182,483	181,868	189,972
Intangible assets	13	1,418	1,418	1,351
Restricted assets & trust funds	14	800	701	758
<b>Total non-current assets</b>		<b>186,441</b>	<b>185,284</b>	<b>193,639</b>
<b>TOTAL ASSETS</b>		<b>206,570</b>	<b>203,404</b>	<b>209,647</b>
<b>LIABILITIES</b>				
<b>Current liabilities</b>				
Cash and cash equivalents	7	8,266	-	1,096
Trade and other payables	15	18,883	24,342	25,549
Interest bearing loans and borrowings	16	19,200	-	12,000
Employee benefits	17	23,567	20,847	22,568
Provisions	18	60	15	2
<b>Total Current Liabilities</b>		<b>69,976</b>	<b>45,204</b>	<b>61,215</b>
<b>Non current liabilities</b>				
Interest bearing loans and borrowings	16	54,800	74,000	62,000
Employee benefits	17	1,044	775	936
<b>Total non current liabilities</b>		<b>55,844</b>	<b>74,775</b>	<b>62,936</b>
<b>TOTAL LIABILITIES</b>		<b>125,820</b>	<b>119,979</b>	<b>124,151</b>
<b>NET ASSETS</b>		<b>80,750</b>	<b>83,425</b>	<b>85,496</b>
<b>EQUITY</b>				
Public equity		23,164	23,165	24,123
Retained earnings/(losses)		(10,664)	(7,890)	(6,835)
Asset revaluation reserve		67,450	67,449	67,450
Trust fund reserve	14	800	701	758
<b>TOTAL EQUITY</b>		<b>80,750</b>	<b>83,425</b>	<b>85,496</b>

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

For and on behalf of the Board, who authorised the issue of these financial statements on the 29th October 2015.



Pauline Lockett  
CHAIRPERSON



Sally Webb  
DEPUTY CHAIRPERSON

# Statement of Cash Flows

For the Year Ended 30 June 2015

		Actual June 2015	Budget June 2015 Unaudited	Actual June 2014
<b>CASHFLOWS FROM OPERATING ACTIVITIES</b>	Note	\$000	\$000	\$000
<b>Cash was provided from:</b>				
Receipts from Government and Public		339,162	337,060	330,347
Interest Received		517	500	697
GST (Net)		-	-	344
		<u>339,679</u>	<u>337,560</u>	<u>331,388</u>
<b>Cash was disbursed to:</b>				
Payments to Suppliers		214,069	204,628	212,992
Payments to Employees		113,718	110,081	108,941
Capital Charge Paid		6,230	6,294	7,474
Interest Paid		3,154	3,158	1,450
GST (Net)		113	-	-
		<u>337,284</u>	<u>324,161</u>	<u>330,857</u>
<b>Net Cash Inflow from Operating Activities</b>	19	<u>2,395</u>	<u>13,399</u>	<u>531</u>
<b>CASHFLOWS FROM INVESTING ACTIVITIES</b>				
<b>Cash was provided from:</b>				
Dividends Received		62	60	62
Proceeds from Short Term Deposit		-	-	8,110
Proceeds from Investments		-	-	1
Proceeds from Sale of Property, Plant & Equipment		-	-	31
		<u>62</u>	<u>60</u>	<u>8,204</u>
<b>Cash was applied to:</b>				
Purchase of Property, Plant & Equipment		8,559	12,000	15,566
Purchase of Intangible Assets		67	-	-
Restricted Assets		42	-	57
		<u>8,668</u>	<u>12,000</u>	<u>15,623</u>
<b>Net Cash Outflow from Investing Activities</b>		<u>(8,606)</u>	<u>(11,940)</u>	<u>(7,419)</u>
<b>CASHFLOWS FROM FINANCING ACTIVITIES</b>				
<b>Cash was provided from:</b>				
Proceeds from Debt Financing		-	-	2,000
		<u>-</u>	<u>-</u>	<u>2,000</u>
<b>Cash was applied to:</b>				
Repayment of Equity		959	959	959
		<u>959</u>	<u>959</u>	<u>959</u>
<b>Net Cash Outflow from Financing Activities</b>		<u>(959)</u>	<u>(959)</u>	<u>1,041</u>
Net (Decrease)/Increase in Cash Held		(7,170)	500	(5,847)
Cash and cash equivalents at beginning of year		(1,096)	4,005	4,751
<b>Cash and cash equivalents at end of year</b>		<u>(8,266)</u>	<u>4,505</u>	<u>(1,096)</u>

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

**Significant accounting policies for the year ended 30 June 2015****(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 sector, public benefit entity (PS PBE), as defined under External Reporting Board (XRB) Standard A1. PS PBE's are reporting entities whose primary objective is to provide goods or services for community or social benefit and where any equity has been provided with a view to supporting that primary objective rather than for a financial return to equity holders.

The Taranaki District Health Board financial statements comprise those of Taranaki District Health Board, a 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 an activity as Taranaki District Health Board has significant influence in those entities.

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

The financial statements of Taranaki District Health Board are for the year ended 30 June 2015. The financial statements were authorised for issue by the Board on 29 October 2015.

**(b) Statement of compliance and basis of preparation**

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

These financial statements, including the comparatives, have been prepared in accordance with Public Sector PBE Accounting Standards (PS PBE IPSAS) - Tier 1. These standards are based on international Public Sector Accounting Standards (IPSAS). Previously published financial statements have been prepared in accordance with New Zealand equivalents to International Financial Reporting Standards as appropriate for public benefit entities (NZ IFRS). The impact of moving from NZ IFRS to PS PBE IPSAS was not significant. This is due to a strong degree of convergence between the two suites of standards.

The XRB issued PS PBE IPSAS that apply to the financial statements of PS PBE's for the financial years beginning on or after 1 July 2014. These financial statements have been prepared in accordance with Tier 1 PS PBE IPSAS.

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 17.

### *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 from the accounting policies adopted in the last audited financial statements other than any changes brought about by the adoption of Public Benefit Entity Standards, including Public Benefit Entity International Public Sector Accounting Standards (PBE IPSAS).

Where applicable, certain comparatives have been restated to comply with the accounting presentation adopted for the current year. This includes where additional disclosures are required to comply with NZ IFRS (PBE) standards.

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 12.

## **(c) Effect of first-time adoption of PBE standards on accounting policies and disclosures**

This is the first set of financial statements of Taranaki District Health Board that is presented in accordance with PBE standards. The District Health Board previously reported in accordance with New Zealand equivalents to International Financial Reporting Standards (NZ IFRS).

The accounting policies adopted in these financial statements are consistent with those of the previous finance year, except where the accounting or reporting requirements of a PBE standard are different to requirements under NZ IFRS as below.

The changes to accounting disclosures caused by first time application of PBE standards are as follows:

### **PBE IPSAS 1: Presentation of Financial Statements**

There are minor differences between PBE IPSAS 1 and the equivalent NZ IFRS (PBE) standard. These differences have an effect on disclosure only. The main change in disclosure resulting from the application of PBE IPSAS 1 are the following:

#### *Receivables from exchange and non-exchange transactions*

In the financial statements of the previous year, receivables were presented as a single amount in the statement of financial statements. However PBE IPSAS 1 requires receivables from exchange transactions and receivables from non-exchange transactions to be either presented separately in the statement of financial position, or disclosed in the notes to the financial statements. Taranaki District Health Board has disclosed current and prior year receivables from exchange and non-exchange transactions separately in the notes to the financial statements.

### **PBE IPSAS 23: Revenue from Non-Exchange Transactions**

PBE IPSAS 23 prescribes the financial reporting requirements for revenue arising from non-exchange transactions. There is no equivalent reporting standard under NZ IFRS. The application of this standard resulted in Taranaki District Health Board disclosing the amount of revenue classified as non-exchange.

### **PBE IPSAS 9: Revenue from Exchange Transactions**

PBE IPSAS 9 prescribes the financial reporting requirements for revenue arising from exchange transactions. There is no equivalent reporting standard under NZ IFRS. The application of this standard resulted in Taranaki District Health Board disclosing the amount of revenue classified as exchange.

## **(d) Basis of consolidation**

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

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

After applications of the equity method, Taranaki District Health Board determines whether it is necessary to recognise an additional impairment loss on Taranaki District Health Board's investment in its associate. Taranaki District Health Board determines at each reporting date whether there is any objective evidence that the investment in the associate is impaired. If this is the case Taranaki District Health Board calculates the amount of impairment as the difference between the recoverable amount of the associate and its carrying value and recognises the amount in the "share of profit of an associate" in the statement of comprehensive revenue and expense.

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

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

**(e) 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.

**(f) Revenue**

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

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

The majority of revenue earned is related to the provision of services associated with planning, funding and the provision of health services and disability services. This revenue is provided through an appropriation in association with a Crown Funding Agreement. Revenue is recognised monthly in accordance with the Crown Funding Agreement payment schedule, which allocates the appropriation equally throughout the year.

**(ii) ACC revenue**

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

**(iii) Inter district patient inflows**

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

### (g) 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.

### (h) 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.

The amount of the impairment is the difference between the carrying amount of the receivable and the present value of the amounts expected to be collected.

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

### (i) Inventories

Inventories are valued at the lower of cost, determined at weighted average value, and net realisable value. Net realisable value is the estimated selling price in the ordinary course of business, less the estimated costs of completion and selling expenses.

All inventory purchased was acquired through exchange contracts.

### (j) 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 statement of comprehensive revenue and expense.

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

### (k) Investments and Other Financial Assets

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

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

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

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.

### **(I) 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 statement of comprehensive revenue and expense. Any subsequent revaluation gains are written back through the income statement only to the extent of past deficits written off. Land and buildings are revalued every five years with the next revaluation due as at 30 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 statement of comprehensive revenue and expense, and expensed as incurred.

#### **Disposals**

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

#### **Depreciation**

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

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

<b>Class of Asset</b>	<b>Estimated life</b>	<b>Depreciation rate</b>
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 or changes in circumstances indicate that the carrying amount may not be recoverable.

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

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

### (m) Intangible Assets

The finance procurement and supply chain (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.

### (n) 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.

### (o) Operating Leases

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

### (p) Trade and Other Payables

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

All trade and other payables are exchange transactions.

### (q) 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.

### (r) 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.

#### (s) 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.

#### (t) 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.

#### (u) Goods and Services Tax (GST)

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

#### (v) 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.

#### (w) Accounting standards and interpretations issued but not yet effective

PBE Standards and interpretations that have recently been issued or amended but are not yet effective and have not been adopted by Taranaki District Health Board for the annual reporting period ending 30 June 2015, outlined in the table below:

Title	Summary	Impact on DHB financial report	Application date of standard	Application date for DHB
PBE Standards (Tier 1 and 2)	Disclosure initiative (Amendments to PBE IPSAS 1).	The revised PBE Standards are not expected to impact on the DHB.	1 Jan 2016	1 Jun 2016
PBE Standards (Tier 1 and 2)	2015 Omnibus Amendments to PBE Standards	The revised PBE Standards are not expected to impact on the DHB.	1 Jan 2016	1 Jun 2016



### 1 REVENUE

	2015	2014
	\$000	\$000
Health and disability services (MoH contracted revenue)	326,961	319,713
ACC revenue	5,188	4,648
Inter District Patient Inflows	3,594	3,790
Interest received	517	697
Dividends received	62	62
Bad debts recovered	7	2
Other revenue	5,224	2,689
	<u>341,553</u>	<u>331,601</u>

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

	2015	2014
	\$000	\$000
Non-exchange transactions	329,802	320,423
Exchange transactions	11,751	11,178
	<u>341,553</u>	<u>331,601</u>

### 2 OTHER INCOME

	2015	2014
	\$000	\$000
Donations and bequests received	1,667	2,796
Gain on sale of property, plant and equipment	-	-
	<u>1,667</u>	<u>2,796</u>

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

	2015	2014
	\$000	\$000
Non-exchange transactions	1,667	2,796
Exchange transactions	-	-
	<u>1,667</u>	<u>2,796</u>

### 3 EMPLOYEE BENEFIT COSTS

	2015	2014
	\$000	\$000
Wages and salaries	112,385	108,275
Contributions to defined contribution schemes	1,658	1,588
Increase in employee benefits provisions	783	1,332
	<u>114,826</u>	<u>111,195</u>

#### 4 OTHER EXPENSES

	2015	2014
	\$000	\$000
Impairment of trade receivables (bad and doubtful debts)	51	35
Loss on sale of property, plant and equipment	1	16
Audit fees - Deloitte (for the audit of the annual financial statements)	200	197
Audit fees - HSS Limited (ACC partnership plan)	4	4
Board and Advisory members fees	283	278
Operating lease expenses	1,133	1,084
	<u>1,672</u>	<u>1,614</u>

#### 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 2015 was 8% (2014: 8%).

#### 6 FINANCING COSTS

	2015	2014
	\$000	\$000
Interest on bank overdraft	-	2
Interest on loans - Ministry of Health	3,065	1,482
	<u>3,065</u>	<u>1,484</u>

#### 7 CASH AND CASH EQUIVALENTS

	2015	2014
	\$000	\$000
Cash at bank and in hand	(8,266)	(1,096)
Short-term deposits maturing within 3 months of acquisition	-	-
Cash and cash equivalents	<u>(8,266)</u>	<u>(1,096)</u>

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

### 8 TRADE AND OTHER RECEIVABLES

	2015	2014
	\$000	\$000
Ministry of Health	6,330	6,054
Due from associates	207	111
Due from non-related parties	6,755	3,626
Prepayments	1,411	751
	<u>14,703</u>	<u>10,542</u>
Allowance for impairment loss (a)	(52)	(29)
<b>Carrying amount of trade and other receivables</b>	<u><u>14,651</u></u>	<u><u>10,513</u></u>

#### (a) Allowance for Impairment Loss

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

Movements in the allowance for impairment loss were as follows:

	2015	2014
	\$000	\$000
<b>At 1 July</b>	29	24
Charge for the year	51	35
Amounts written off	<u>(28)</u>	<u>(30)</u>
<b>At 30 June</b>	<u><u>52</u></u>	<u><u>29</u></u>

	2015	2014
	\$000	\$000
Total non commercial debt	124	95
Non commercial debt with no impairment allowance	72	66

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 2015 and 2014, all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below:

	<b>Actual</b>		<b>Actual</b>	
	2015	2015	2014	2014
	Gross	Impairment	Gross	Impairment
	\$000	\$000	\$000	\$000
<b>Taranaki District Health Board</b>				
Not past due	14,066	-	10,342	-
Past due 1 - 30 days	125	-	127	-
Past due 31 - 60 days	134	(1)	33	-
Past due 61 - 90 days	3	(3)	5	(2)
Past due > 90 days	375	(48)	35	(27)
	<u>14,703</u>	<u>(52)</u>	<u>10,542</u>	<u>(29)</u>

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) Receivables from exchange and non-exchange transactions

	2015	2014
	\$000	\$000
Non-exchange transactions	7,513	6,149
Exchange transactions	7,138	4,364
	<u>14,651</u>	<u>10,513</u>

Bulk funding received from the Ministry of Health is received in the month it relates to. Therefore most receivables at year end relate to the provision of a specified service and are exchange receivables.

### (c) Related Party Receivables

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

### (d) Credit Risk and Effective Interest Rate Risk

Details regarding the credit risk and effective interest rate of current receivables is disclosed in note 23.

## 9 INVENTORIES

	2015	2014
	\$000	\$000
Pharmaceuticals	471	466
Surgical and Medical Supplies	1,518	1,544
Other Supplies	599	595
	<u>2,588</u>	<u>2,605</u>

Inventory recognised as an expense for the year ended 30 June 2015 totalled \$10.026m (2014: \$10.003m)

Write-down of inventories amounted to \$0.047m for 2015 (2014 \$0.070m).

No inventories are pledged as security for liabilities.

### 10 OTHER FINANCIAL ASSETS

	2015	2014
	\$000	\$000
<b>Current portion</b>		
Short-term deposits with maturities of 3-12 months	2,890	2,890
	<u>2,890</u>	<u>2,890</u>
<b>Non-current portion</b>		
Shares in CDC Pharmaceuticals Limited	56	56
	<u>56</u>	<u>56</u>

### 11 INVESTMENT IN ASSOCIATE COMPANIES

	2015	2014
	\$000	\$000
<b>(a) Investment details</b>		
Allied Laundry Services Limited unlisted ordinary shares	750	750
Allied Laundry Services Limited Share of Retained Earnings	271	162
Fulford Radiology Services Limited unlisted ordinary shares	401	401
Fulford Radiology Services Limited Share of Accumulated Deficit	(239)	(306)
Fulford Radiology Services Limited loan to purchase assets	300	300
HealthShare Limited unlisted ordinary shares	-	-
HealthShare Limited Share of Retained Earnings	201	195
	<u>1,684</u>	<u>1,502</u>

There is no intention to seek repayment of the Fulford Radiology Services Limited loan of \$0.300m (2014: \$0.300m).

#### Details of each Associate Company are as follows:

	Balance date	Interest held at 30 June 2015	Interest held at 30 June 2014
<b>HealthShare Limited</b>	30 June	20%	20%
The principal activity of the associate is the provision of contract processing, auditing services and regional initiatives for the 5 Midland Region District Health Boards.			
<b>Fulford Radiology Services Limited</b>	30 June	50%	50%
The principal activity of the associate is the provision of radiology services.			
<b>Allied Laundry Services Limited</b>	30 June	25%	25%
The principal activity of the associate is the provision of laundry services.			



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

#### Summarised unaudited financial information - for the year ended 30 June 2015:

	Assets	Liabilities	Equity	Revenues	Profit/(loss)
	\$000	\$000	\$000	\$000	\$000
Allied Laundry Services Limited	5,991	1,139	4,852	8,046	770
Fulford Radiology Services Limited	3,237	2,782	455	13,802	131
HealthShare Limited	14,516	13,083	1,433	10,996	427

#### Summarised unaudited financial information - for the year ended 30 June 2014:

	Assets	Liabilities	Equity	Revenues	Profit/(loss)
	\$000	\$000	\$000	\$000	\$000
Allied Laundry Services Limited	5,359	1,276	4,083	7,804	675
Fulford Radiology Services Limited	3,654	3,329	325	12,566	136
HealthShare Limited	5,721	4,716	1,005	7,689	34

The above information has been extracted from the associate companies unaudited management accounts (2015) and audited financial statements (2014).

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

	2015	2014
	\$000	\$000
Balance at 1 July	1,502	1,241
New investments during the year	-	-
Share of total recognised revenues and expenses	182	261
Balance at 30 June	1,684	1,502

### 12 PROPERTY, PLANT AND EQUIPMENT

	Freehold Land \$000	Freehold Buildings \$000	Plant and Equipment \$000	Motor Vehicles \$000	Work in Progress \$000	Total \$000
<b>Year ended 30 June 2015</b>						
Cost/revaluation 30 June 2014	8,860	69,244	66,085	3,152	94,788	242,129
Accumulated depreciation and impairment charges 30 June 14	-	(5,712)	(43,966)	(2,479)	-	(52,157)
Carrying amount 30 June 2014	8,860	63,532	22,119	673	94,788	189,972
Current year additions	-	80,368	16,996	33	6,895	104,292
Current year work in progress capitalised	-	-	-	-	(95,734)	(95,734)
Current year disposals	-	-	(1)	-	-	(1)
Current year depreciation	-	(7,908)	(7,963)	(175)	-	(16,046)
At 30 June 2015 net of accumulated depreciation and impairment	8,860	135,992	31,151	531	5,949	182,483
<b>At 30 June 2015</b>						
Cost or fair value	8,860	149,612	82,839	3,185	5,949	250,445
Accumulated depreciation and impairment	-	(13,620)	(51,688)	(2,654)	-	(67,962)
	8,860	135,992	31,151	531	5,949	182,483

The new clinical services block build accounts for \$Nil (2014: \$82.870m) of the work in progress value at 30 June 2015.

In the year end 30 June 2015, there is a claim of \$1.600m outstanding which relates to completed remedial work.

	Freehold Land \$000	Freehold Buildings \$000	Plant and Equipment \$000	Motor Vehicles \$000	Work in Progress \$000	Total \$000
<b>Year ended 30 June 2014</b>						
Cost/revaluation 30 June 2013	8,860	68,935	57,503	3,060	88,527	226,885
Accumulated depreciation and impairment charges 30 June 13	-	-	(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	-	9,305
Current year work in progress capitalised	-	-	-	-	6,261	6,261
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
<b>At 30 June 2014</b>						
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 \$82.870m (2013: \$77.550m) of the work in progress value at 30 June 2014.

### 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 2015 (2014: Nil).

### 13 INTANGIBLE ASSETS

	FPSC Rights \$000	Total \$000
<b>Year ended 30 June 2015</b>		
Balance at 30 June 2014	1,351	1,351
Accumulated depreciation and impairment charges 30 June 2014	-	-
Carrying amount 30 June 2014	1,351	1,351
Current year additions	67	67
Amortisation charge for year	-	-
At 30 June 2015 net of accumulated depreciation and impairment	1,418	1,418
<b>At 30 June 2015</b>		
Cost or fair value	1,418	1,418
Accumulated depreciation and impairment	-	-
	1,418	1,418
	FPSC Rights \$000	Total \$000
<b>Year ended 30 June 2014</b>		
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
<b>At 30 June 2014</b>		
Cost or fair value	1,351	1,351
Accumulated depreciation and impairment	-	-
	1,351	1,351

At 30 June 2015, the DHB had made payments totalling \$1.418m (2014: \$1.351m) to HBL in relation to the Finance, Procurement and Supply Chain ("FPSC") programme. This is a national initiative. This programme was managed by Health Benefits Limited (HBL) until 15 June 2015, at which time the FPSC programme and its net assets were transferred to a new company, NZ Health Partnerships Limited (NZHPL).

In return for these payments to HBL, Taranaki District Health Board gained FPSC rights. These rights remain with Taranaki District Health Board under NZHPL. In the event of liquidation or dissolution of NZHPL, Taranaki District Health Board shall be entitled to be paid from the surplus assets, an amount equal to their proportionate share of the liquidation value based on its proportional share of the total FPSC rights that have been issued.

The 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 Taranaki District Health Board's share of the DRC of the underlying FPSC assets.

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 to, 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.

### 14 RESTRICTED ASSETS AND TRUST FUNDS

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

	2015	2014
	\$000	\$000
<b>Opening Balance</b>	758	701
Funds Received	134	106
Interest Received	26	23
Funds Spent	(118)	(72)
<b>Closing Balance Restricted Assets</b>	<u>800</u>	<u>758</u>
<b>Represented By:</b>		
Cash at Bank	193	151
Short Term Deposits	600	600
Shares & Other	7	7
<b>Total Restricted Assets</b>	<u>800</u>	<u>758</u>

### 15 TRADE AND OTHER PAYABLES

	2015	2014
	\$000	\$000
Trade Payables	16,195	21,408
Capital Charge Payable	-	-
Income received in advance	460	1,035
Interest Payable	449	538
Owing to Associates	831	1,083
Other Related Parties	948	1,485
	<u>18,883</u>	<u>25,549</u>

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.



### 16 INTEREST-BEARING LOANS AND BORROWINGS

	2015	2014
	\$000	\$000
Government Sector Borrowing	74,000	74,000
<b>Total Loans</b>	<b>74,000</b>	<b>74,000</b>
Less Current Portion	19,200	12,000
<b>Term Portion</b>	<b>54,800</b>	<b>62,000</b>

INTEREST RATES:	2015	2014
Government Sector Borrowing	3.03% - 4.55%	3.03% - 7.02%

	2015	2014
	\$000	\$000
<b>GOVERNMENT SECTOR BORROWING</b>		
Due for repayment:		
within one year	19,200	12,000
within two years	-	19,200
within three years	22,000	-
within four years	15,600	22,000
within five years	-	15,600
after five years	17,200	5,200
	<b>74,000</b>	<b>74,000</b>

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

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

Taranaki District Health Board capitalises interest where loan advances specifically relate to major capital project. This financial year \$Nil was capitalised to the new clinical services block (2014: \$1.618m).

#### FAIR VALUE OF GOVERNMENT BORROWING

The fair value of the \$74m (2014: \$74m) of Government Borrowing at 30th June 2015 was calculated at \$75.254m (2014: \$73.881m). 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.

### 17 EMPLOYEE BENEFITS

	2015	2014
	\$000	\$000
Salary & wages accrual	5,199	4,875
Annual Leave	14,600	14,054
Sick Leave	384	367
Long Service Leave	1,672	1,430
Retirement gratuities	898	913
Continuing Medical Education	1,649	1,562
Sabbatical Leave	209	303
	<u>24,611</u>	<u>23,504</u>
<b>Made up of:</b>		
Current	23,567	22,568
Non-current	<u>1,044</u>	<u>936</u>
	<u>24,611</u>	<u>23,504</u>

### 18 PROVISIONS

	2015	2014
	\$000	\$000
<b>Current provisions</b>		
ACC Partnership Programme	<u>60</u>	<u>2</u>
	<u>60</u>	<u>2</u>

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.

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

	2015	2014
	\$000	\$000
Net (Loss)	(3,787)	(3,276)
Add Non-Cash Items:		
Depreciation	16,046	12,150
Increase in Provision for Doubtful Debts	23	5
Increase in Employee Entitlements	<u>1,108</u>	<u>2,254</u>
	17,177	14,409
Add back items classified as investment/financing activities:		
Decrease/(Increase) in Investments Held	(183)	5,131
Net Loss of Disposal of Assets	<u>1</u>	<u>16</u>
	(182)	5,147
Movements in Working Capital:		
(Increase) in Receivables & Prepayments	(4,161)	(3,788)
Decrease/(Increase) in Inventories	17	(92)
(Decrease) in Payables & Accruals	<u>(6,669)</u>	<u>(11,869)</u>
	(10,813)	(15,749)
<b>Net Cash Inflow/(Outflow) from Operating Activities</b>	<u>2,395</u>	<u>531</u>

**20 RELATED PARTIES - KEY MANAGEMENT PERSONNEL**

	2015	2014
	\$000	\$000
<i>Board Members</i>		
Remuneration	283	269
Full-time equivalent members	1.71	1.64
<i>Executive management</i>		
Remuneration	1,650	1,600
Full-time equivalent employees	7.00	7.00
Total key management personnel remuneration	1,933	1,869
Total full-time equivalent personnel	8.71	8.64

**21 RELATED PARTY TRANSACTIONS**

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

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

**Related Party Transactions and Balances****(a) Funding**

Taranaki District Health Board received \$326.962m from the Ministry of Health to provide health services to the Taranaki area (2014: \$319.713m). The amount outstanding at year end was \$6.330m (2014: 6.054m).

**(b) Inter-Group Transactions and balances:**

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

		Owed to TDHB		Income to TDHB	
		2015	2014	2015	2014
		\$000	\$000	\$000	\$000
TDHB Transactions					
Allied Laundry Services Limited	Dividend and rents received	62	62	81	79
Fulford Radiology Services Limited	Rent and services received	77	39	309	309
HBL Limited	n/a	-	-	-	-
Healthshare Limited	IT consultancy	68	10	491	155
		207	111	881	543

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

		Owed by TDHB		Expense to TDHB	
		2015	2014	2015	2014
		\$000	\$000	\$000	\$000
Allied Laundry Services Limited		126	216	1,066	1,017
Fulford Radiology Services Limited		674	644	8,400	7,805
HBL Limited		-	145	662	372
HBL Limited - FPSC rights		-	622	67	407
Healthshare Limited		31	222	1,471	1,151
		831	1,849	11,666	10,752

Refer to note 11(a) for details of services provided to Taranaki District Health Board.

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

### Board Members - 2015

TDHB Board Member	Related Party	Relationship	TDHB Transaction with Related Party	Expense for Year 30 June 2015	Owed by TDHB at 30 June 2015
				\$000	\$000
Alex Ballantyne	S.T.A.R.T.	Trustee	Youth Services	-	-
	South Taranaki District Council	Councillor	Local Authority	14	3
Karen Eagles	Govett Quilliam	Husband Senior Partner	Legal Advice	48	3
Flora Gilkison	Fulford Radiology Services	Chairperson	Radiology Services	8,400	674
	Taranaki DHB	Husband employed by Taranaki DHB	Employee	-	-
Richard Handley	New Plymouth District Council	Councillor	Local Authority	89	29
	Taranaki Youth Health Trust (t/a new Waves)	Trustee	Youth Services	1	-
	YMCA	Board Member	Community Services	3	-
Pauline Lockett	Taranaki Health Foundation	Trustee	Fundraising	229	19
Kevin Nielsen	Hospice Taranaki	Chief Executive Officer	Health Services	2,059	197
Alison Rumball	Taranaki Cancer Society	Vice President	Health Services	75	7
Aroaro Tamati	Sports Taranaki	Vice President	Health Services	153	16
Sally Webb	Bay of Plenty DHB	Chairperson	District Health Board	431	-

Former TDHB Board Members	Related Party	Relationship	TDHB Transaction with Related Party	Expense for Year 30 June 2015	Owed by TDHB at 30 June 2015
				\$000	\$000
Pat Leary	Devon Medical Limited	Director	GP and Health Services	37	2
	Midlands Health Network (incl Trust)	Through owner (Pinnacle Incorp)	Primary Health Organisation	24,721	2,758
	Pinnacle Incorporated	Executive Team Member	Primary Health Organisation	72	7

### Board Members - 2014

TDHB Board Member	Related Party	Relationship	TDHB Transaction with Related Party	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	Chairperson	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 with Related Party	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	-	-

**22 FINANCIAL INSTRUMENT CATEGORIES**

The carrying amounts of financial instruments in each of the PBE IPSAS 30.11 categories are as follows:

		2015	2014
	Notes	\$000	\$000
<b>FINANCIAL ASSETS</b>			
<b>Loans and receivables</b>			
Cash and cash equivalents	7	-	-
Trade and other receivables	8	13,240	9,762
Other financial assets - current	10	2,890	2,890
Other financial assets - non current	10	56	56
Restricted Assets and Trust Funds	14	800	758
<b>Total loans and receivables</b>		<b>16,986</b>	<b>13,466</b>

**FINANCIAL LIABILITIES****Notes****Financial liabilities at amortised costs**

Trade and other payables	15	18,423	24,514
Interest bearing loans and borrowings	16	74,000	74,000
<b>Total financial liabilities</b>		<b>92,423</b>	<b>98,514</b>

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.

**23 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% (2014: 97%) whilst it accounted for 75% (2014: 88%) 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

#### 2015

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

	Carrying value \$000	Contractual Cash Flows \$000	0-3 months \$000	3-12 months \$000	1-3 years \$000	3-8 years \$000
<b>Non-derivative financial liabilities</b>						
Trade and other payables	18,423	18,423	18,423	-	-	-
Loans and borrowings	74,000	82,855	121	21,628	25,430	35,676
	<u>92,423</u>	<u>101,278</u>	<u>18,544</u>	<u>21,628</u>	<u>25,430</u>	<u>35,676</u>

### 2014

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

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

### (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.

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

### Judgements of reasonably possible movements

	Surplus for the period	
	Higher/(lower)	
	2015	2014
	\$000	\$000
+1% (100 basis points)	29	29
-1% (100 basis points)	(29)	(29)

## 24 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.

## 25 CAPITAL COMMITMENTS AND OPERATING LEASES

	2015 \$000	2014 \$000
<b>Capital Commitments</b>		
Property, plant and equipment	<u>1,201</u>	<u>1,079</u>
	<u>1,201</u>	<u>1,079</u>

### 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	729	1,017
Later than one and not later than two years	259	885
Later than two and not later than five years	315	37
Later than five years	<u>236</u>	<u>83</u>
	<u>1,539</u>	<u>2,022</u>

### 26 MAJOR VARIATIONS FROM BUDGET (unaudited)

#### Income Statement Variances - Revenue

Taranaki District Health Board recorded a deficit of \$3.79 million compared with a budgeted deficit of \$0.94 million.

A total of \$5.050 million additional revenue over budget was received as follows (2014: \$5.421m):

	Variance unaudited 2015 \$000	Variance unaudited 2014 \$000
Ministry of Health Funding	3,399	4,844
Accident Compensation Revenue (ACC)	529	511
Inter District Flows	(395)	(347)
Inter Provider Revenue	34	73
Interest Received	17	397
Donations Received	(833)	(204)
Other	2,299	147
	<u>5,050</u>	<u>5,421</u>

#### Income Statement Revenue Explanations

Ministry of Health Funding	Additional funding devolved from Ministry in excess of funding envelope advised.
Accident Compensation Revenue (ACC)	Utilisation of additional Theatre at Base rather than outsourcing.
Inter District Flows	Inflow of other DHB population less than expected.
Other	Insurance claim

#### Income Statement Variances - Expenditure

A total of \$8.09m additional expenditure over budget were incurred as follows (2014: \$5.5m):

	Variance Unaudited 2015 \$000	Variance Unaudited 2014 \$000
Employee Benefit costs	4,820	3,558
Depreciation Expense	14	(2,550)
Outsourced services	2,815	490
Clinical supplies	2,154	475
Infrastructure and non-clinical expenses	(2,250)	904
Payments to non-health board providers	669	3,261
Other	(138)	(631)
	<u>8,084</u>	<u>5,507</u>

#### Income Statement Expenditure Explanations

Employee Benefit costs	Increased staffing hours.
Outsourced services	Increased demand for diagnostic testing.
Clinical Supplies	Additional activity.
Infrastructure & Non-Clinical Supplies	Increased capitalisation of salaries.
Payments to non-health board providers	Increased demand for services relating to the health of older people.

	Variance Unaudited 2015 \$000	Variance Unaudited 2014 \$000
<b>Balance Sheet Variances</b>		
Cash & S/T Deposits	(12,771)	(2,401)
Other Financial Assets	-	(110)
Property, plant and equipment	615	26,757
Receivables & Prepayments	6,701	(687)
Employee Entitlements	2,989	2,354
Payables	(5,459)	4,721

### Balance Sheet Explanations

Cash & S/T Deposits	Two years of deficits plus timing of payments to suppliers.
Employee Entitlements	Timing of Payroll payments.
Payables	Timing of payments to suppliers.

## 27 AUDITORS' REMUNERATION

		2015 \$000	2014 \$000
<b>Fees to principal auditor (Deloitte)</b>	<b>Note</b>		
Audit of annual financial statements	4	200	197
Other assurance-related services		-	-
Tax compliance		-	-
Due diligence services		-	-
		<u>200</u>	<u>197</u>
		2015 \$000	2014 \$000
<b>Other Audit Fees paid (non Deloitte)</b>	<b>Note</b>		
HSS Limited (ACC Partnership Program)	4	4	4

## 28 CAPITAL MANAGEMENT

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

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 (2014: \$Nil). Public equity of \$0.959m (2014: \$0.959m) was repaid to the Crown during the year. The repayments in both 2015 & 2014 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.

### 29 EMPLOYEE REMUNERATION

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

Remuneration Range	Actual 2015	Actual 2014
100,000 - 110,000	29	21
110,001 - 120,000	12	14
120,001 - 130,000	5	15
130,001 - 140,000	8	3
140,001 - 150,000	4	7
150,001 - 160,000	11	8
160,001 - 170,000	8	5
170,001 - 180,000	3	6
180,001 - 190,000	5	7
190,001 - 200,000	10	9
200,001 - 210,000	4	2
210,001 - 220,000	4	6
220,001 - 230,000	4	3
230,001 - 240,000	1	3
240,001 - 250,000	4	4
250,001 - 260,000	4	3
260,001 - 270,000	7	4
270,001 - 280,000	4	4
280,001 - 290,000	2	6
290,001 - 300,000	2	-
300,001 - 310,000	3	2
310,001 - 320,000	2	-
320,001 - 330,000	1	1
380,001 - 390,000	-	1
390,001 - 400,000	1	-
	<u>138</u>	<u>134</u>
Clinicians	114	111
Management	<u>24</u>	<u>23</u>
Total	<u>138</u>	<u>134</u>

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 167 (2014: 153).

### 30 TERMINATION PAYMENTS

For the period to 30 June 2015, no employee or former employee of Taranaki District Health Board received payment in respect of termination of employment for \$Nil (2014: 3 payments totalling \$0.043m).

### 31 EVENTS SUBSEQUENT TO BALANCE DATE

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

# Reporting on 'good employer' practices

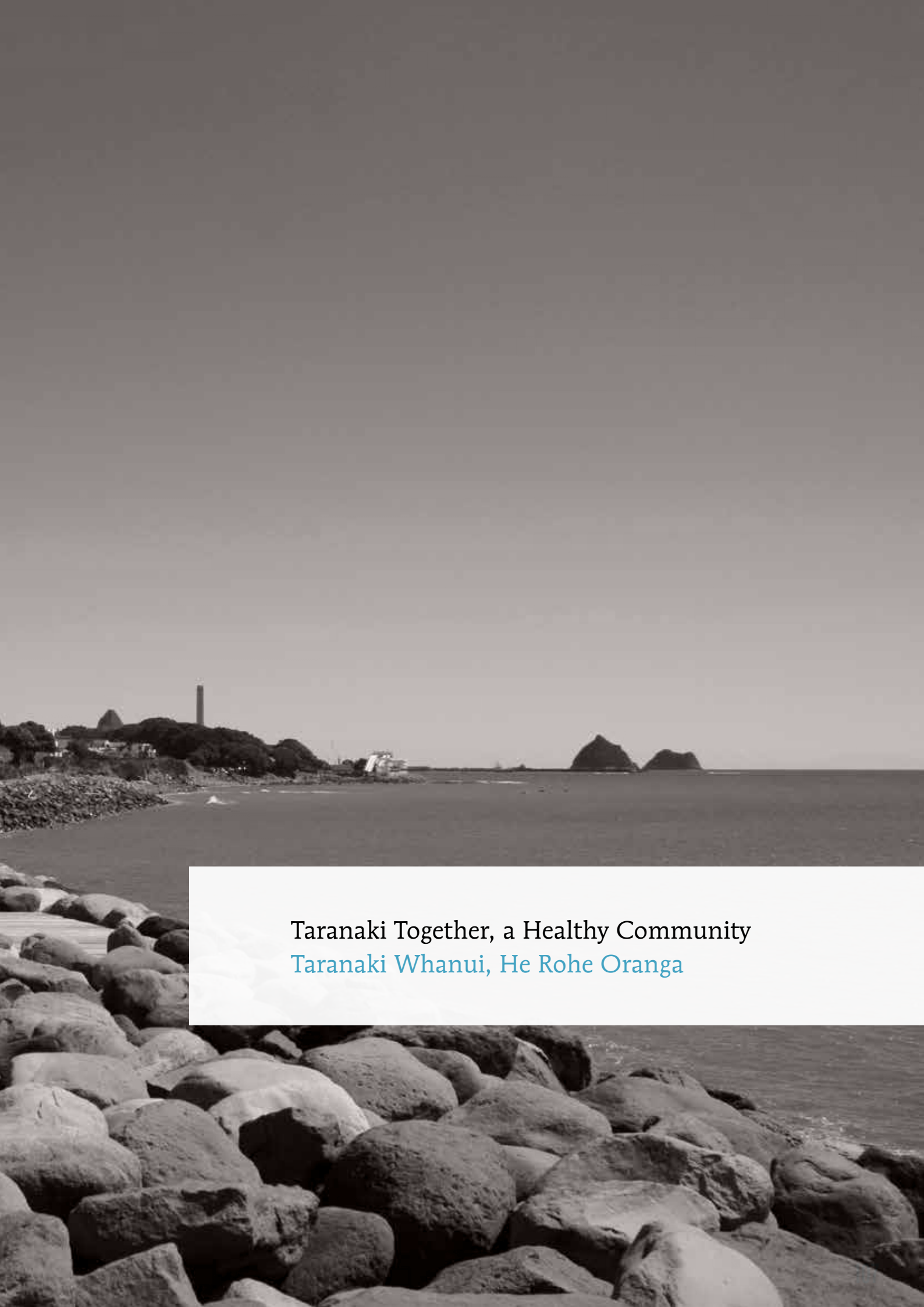
Taranaki DHB's role in workforce planning and development is to identify further strategic actions and mechanisms that when implemented will contribute to Taranaki having enough health workers with appropriate clinical skills now and into the future. Actions identified are from a perspective of the DHB 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 policies or procedures	Other Practices	Priority issues	Action taken
Leadership, Accountability and Culture	<ul style="list-style-type: none"> <li>Code of Conduct</li> <li>Equal Employment Opportunities (EEO), TDHB values statements</li> <li>Performance Review policy</li> </ul>	<ul style="list-style-type: none"> <li>Formal leadership programmes</li> <li>Suite of management development sessions</li> <li>Regular new managers forum</li> <li>Organisational forum for all employees.</li> <li>Development and Career planning.</li> <li>Formal management and management/union meetings</li> <li>New Managers Induction</li> <li>Workplace Behaviours Programme.</li> </ul>	<ul style="list-style-type: none"> <li>Business skills sessions.</li> <li>Workplace leadership development alternatives.</li> <li>Coaching/Mentoring</li> <li>Succession Planning</li> <li>Implementation of national Leadership Domains</li> </ul>	<ul style="list-style-type: none"> <li>Additional learning sessions for managers and general staff</li> <li>Implementation of organisational competencies</li> <li>Consolidation of management/leadership development programme</li> </ul>
Recruitment, Selection Induction	<ul style="list-style-type: none"> <li>Recruitment and Selection Policy</li> <li>Recruitment Guideline Procedure</li> <li>Induction and Orientation Policy</li> <li>Worker Safety Check Policy and procedures</li> </ul>	<ul style="list-style-type: none"> <li>Comprehensive Induction Programme with elements online combining eLearning modules</li> <li>Post-Entry Survey (3 months).</li> <li>Recruitment training for managers</li> <li>Recruitment and Selection Toolkit</li> <li>Scholarships across all disciplines.</li> <li>Schools Career Expo</li> <li>Working with clinical schools to provide work experience placements</li> <li>Police and Ministry of Justice criminal records checking</li> </ul>	<ul style="list-style-type: none"> <li>Better management of the online talent pool to access suitable candidates.</li> <li>Use of social networking to target youth.</li> <li>Vulnerable Children's Act and the implementation of procedures relating to this legislation.</li> <li>Focus on hard to fill occupations to reduce re-advertising</li> </ul>	<ul style="list-style-type: none"> <li>National Health Careers website targeting students, return-to-work and international candidates.</li> <li>Continue to collaborate with the national Kiwi Health Jobs working group to promote the New Zealand health sector brand.</li> <li>Continue to collaborate with the Whakatipuranga Rima Rau project to place Māori into the health sector employment over 10 years.</li> <li>Implementation of Vulnerable Children's Act procedures</li> <li>Electronic Onboarding – to improve the new hire experience</li> <li>Use networks as sources to identify potential talent</li> </ul>
Employee Development, Performance, Promotion and Exit	<ul style="list-style-type: none"> <li>Study, Conference and Course Leave.</li> <li>Termination of Employment Policy and Procedure</li> <li>Medical Incapacity Policy</li> <li>Professional Development Policy</li> <li>Performance Review Policy</li> <li>Performance and Disciplinary policy</li> <li>Employment Agreements</li> <li>Continuing Medical Education (CME) policy</li> </ul>	<ul style="list-style-type: none"> <li>Exit interview and survey.</li> <li>Coaching available to all staff.</li> <li>Clinical Supervision</li> <li>Employee Assistance Programme (EAP).</li> <li>Management development programme</li> <li>Non-clinical skills training for employee</li> <li>Professional development funding</li> <li>National qualifications for non regulated workforces</li> <li>Annual calendar of educational events</li> </ul>	<ul style="list-style-type: none"> <li>Revised education plan for 2016</li> <li>Continuing development of e-learning resources.</li> <li>Implemented of revised learning needs analysis.</li> <li>Enabling technology for accessing learning tools</li> <li>Non-regulated workforce training</li> </ul>	<ul style="list-style-type: none"> <li>Learning needs analysis undertaken</li> <li>Further e-learning courses developed</li> <li>Providing training opportunities for the non-regulated workforce</li> </ul>
Employee Engagement	<ul style="list-style-type: none"> <li>Flexible Working - Request and Complaints Procedure</li> <li>Collective employment agreements</li> <li>Employee Participation Agreement</li> </ul>	<ul style="list-style-type: none"> <li>Work in conjunction with individuals and unions in consultative manner</li> </ul>	<ul style="list-style-type: none"> <li>Ageing workforce.</li> <li>Employee engagement survey/barometer</li> </ul>	<ul style="list-style-type: none"> <li>Regional collaboration to develop actions</li> </ul>
Remuneration, Recognition and Conditions	<ul style="list-style-type: none"> <li>Job Evaluation Procedure.</li> <li>Recognising Long Service Procedure</li> <li>Collective employment agreements</li> </ul>	<ul style="list-style-type: none"> <li>Job Evaluation Committee.</li> <li>Comprehensive Progression/Merit criteria via collective agreements.</li> </ul>		<ul style="list-style-type: none"> <li>Promoting employee benefits for all staff</li> </ul>
Harassment and Bullying Prevention	<ul style="list-style-type: none"> <li>Harassment Policy and Procedure.</li> <li>Employee Assistance Programme</li> </ul>	<ul style="list-style-type: none"> <li>Interpersonal skills programmes.</li> <li>Coaching / training Union Reps.</li> <li>Conflict Resolution.</li> <li>Behaviours programme.</li> </ul>	<ul style="list-style-type: none"> <li>Keep momentum around behaviours initiative and messages</li> <li>Revise messages in the behaviours programme to enable organisational culture change</li> </ul>	<ul style="list-style-type: none"> <li>Behaviours programme reviewed</li> <li>Further rollout of behaviours programme</li> </ul>
Safe and Healthy Environment	<ul style="list-style-type: none"> <li>Relevant clinical policies and procedures</li> </ul>	<ul style="list-style-type: none"> <li>Pre-employment Health Questionnaire for all staff.</li> <li>Employee Assistance Programme.</li> <li>Annual influenza vaccinations.</li> <li>Health and Safety Reps in each work area.</li> <li>Health and Safety orientation.</li> <li>Health and safety committee</li> <li>Wellness committee</li> </ul>		<ul style="list-style-type: none"> <li>Quality and Risk Department responsible for majority of these procedures.</li> <li>Recreation society available to all staff.</li> <li>Wellness committee has run and number of wellness initiatives throughout the year</li> <li>Health and Safety requirements updated in Job description templates</li> <li>Health and safety competencies implemented in the performance review template</li> </ul>







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

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like no other